

Seen by med student Fraser

Episode: E0001675680
Date: 09/07/2019
Time: 09:57

Monklands District General Hospital
EMERGENCY DEPARTMENT



Surname: McCracken	Forename: Isobel	Triage Category
CHI No: 1808785142	Age: 40y	
Address: 1d Cumbræ Crescent	Date of Birth: 18/08/1978	
Coatbridge Lanarkshire	Gender: Female	
Postcode: ML5 4PX	Referred by: Patient	
Telephone: 07947301884		

G.P.: CC McColgan	G.P. Telephone No.: 01236 422311
G.P. Address: Waverley Medical Practice Coatbridge Health Centre 1 Centre Park Court Coatbridge Coatbridge ML5 3AP	

Presenting Complaint: 9 human bites *3/7 ago*

Vital Signs

Temperature	
Pulse	
Resp. Rate	
Systolic BP	
Diastolic BP	
Mean Arterial Pressure	
SpO2	
FiO2	
Peak Flow	
Exp. Peak Flow	

Glasgow Coma Scale

Eye Opening	
Verbal Response	
Motor Response	
GCS Score	

Scratch

Urinalysis

Glucose	
Ketones	
Specific Gravity	
Blood	
pH	
Proteins	
Nitrates	
Leucocytes	

Visual Acuity

Visual Acuity (Right)	
Visual Acuity (Left)	
With Correction	

Pupil

Pupil Size (Right)	
Pupil Reactivity (Right)	
Pupil Size (Left)	
Pupil Reactivity (Left)	

Blood Glucose	
Pain Score	
Tetanus Cover	
Tetanus Date	
MEWS Score	
CEWS Score	

Height	
Weight	

Fast	
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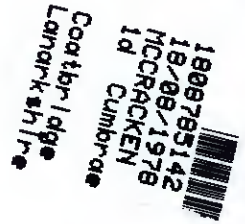
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JOSH SUTHERLAND F42 09/07/19 12:45

I HAVE CONTACTED SOCIAL WORK DEPT (CHILD SAFETY/PROTECTION)
TO DISCUSS CONCERNS OVER HOME ENVIRONMENT OF PATIENT'S
SON

NO IMMEDIATE CONCERNS
PATIENT HAS ALREADY INFORMED TEAM. I HAVE SUBMITTED
NOL.

JLS



1808785142
18/08/1978 F
MCCRACKEN Isobel JF
1d Cumberae Crescent
Coatbridge Lanarkshire ML5 4PX

☐ Hairmyres ☒ Monklands ☐ Wishaw **NHS**
Other: (specify) Lanarkshire

Management of Minor Wounds

Date Seen: 09 / 07 / 19 Time: (24 hour clock)

Phone:	Seen by: JOHN SUTHERLAND	Dominant hand: R
Accompanied by: SELF	Employment/School: UNEMPLOYED	4AT Score: (over 65 yrs) NA

Exact Mechanism of Injury

Date and time wound occurred: 06 / 07 / 19 ~10.00 (24 hour clock)

ALLEGEDLY ASSAULTED AT HOME BY ADULT DAUGHTER WHO HAS BITTEN HER 9 TIMES. WOUNDS HEALING SUSTAINABLY WELL. WORRIED ABOUT POSSIBLE BBV INFECTION. HAS 9 Y/O SON @ HOME (PREV IN CARE) PATIENT STATES SON WAS STAYING C SISTER WHEN THIS HAPPENED. HAS BEEN TAKING 10 30/500 COCAINE / DAY.

Relevant Past Medical History	Drug History (attach ECS if extensive history)
BORDERLINE PERSONALITY DISORDER	Known allergies: NKDA

Analgesia	Family/Social History
Before admission:	
On admission: DILOFENAC	
Pain Score: 2	
- If 4 or more, consider intra-nasal diamorphine	

Type of wound:

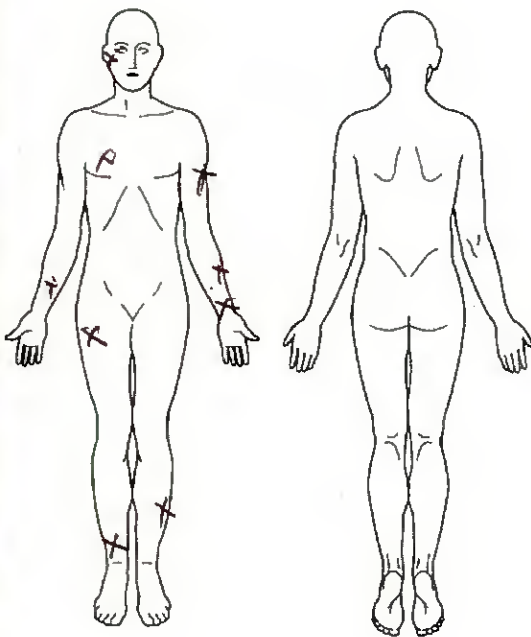
☐ Abrasion	☐ Laceration	☐ Puncture
☐ Penetrating	☐ Incised	☐ Crush
☐ Other: (specify) BITE MARKS		

Patient name:

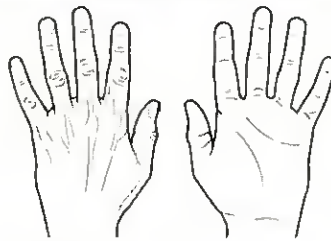
CHI number:

Examination - indicate size and depth of wound plus swelling, erythema or discharge

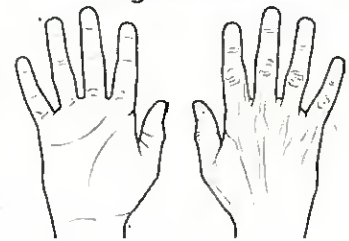
1cm
2cm
3cm
4cm
5cm
6cm
7cm
8cm
9cm
10cm



Left Hand



Right Hand



Left Foot



Right Foot



Neurovascular status:

INTACT

Wound toilet/irrigation/exploration: (indicate damage to underlying structures)

WOUNDS SUPERFICIAL, HEALING

Tetanus status: (please refer to Tetanus Guidance)

☐ Covered

☒ Revaxis

☐ Tetanus Immunoglobulin

Investigations:

INITIAL BBV SCREEN
LFTS

Results:

Diagnosis:

HUMAN BITES

Senior review (name):

Specialty referral?

☐ Yes ☐ No

If yes, who: Time:

Treatment:

REVAXIS BOOSTER

Follow-up:

☐ Dressing advice

☐ Treatment Room Nurse

☐ Review Clinic

☐ District Nurse

A WILL NEED GP
TO REPEAT BBV
SCREEN 4/52

PRINT NAME:

JOSH SUTHERLAND

Designation:

F2

Signature:

[Signature]

Discharge Time: (24 hour clock)

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RESULTS

H+	Hb	PT	Na	ALT	Calcium	Glucose	Troponin
PO2	WBC	INR	K	ALP	Adj. Calcium	CRP	Paracetamol
PCO2	Platelets	APTT	Cl	Bilirubin	Magnesium	CK	Salicylate
Bicarb		APTT _r	Bicarb	Albumin	Globulin	Amylase	Ethanol
BE	COHb	Fibrinogen	Urea	AST	T. Protein		
O2 Sat	Lactate		Creatinine	GGT			BHGG

ED PRESCRIPTION

Date	Drug	Dose	Route	Time	Signature	Given By	Checked By	Time
07/09	DICLOFENAC	50mg	o		<i>[Signature]</i>	<i>JS</i>		

DISCHARGE PRESCRIPTION

Date	Drug	Dose	Route	Time	Signature	Given By	Checked By	Time

INJURY SURVEILLANCE

For all assaults please record the following data

Date and time of assault: _____ Specific Location: _____

Type of Location:	✓	Assailant	✓	Weapon	✓	Alcohol / Drug Involvement	✓
Bar / Pub		Spouse / Partner		Body Part		Drugs	
Club		Ex Partner		Knife		Alcohol	
Street		Relative		Glass		Both	
Workplace		Friend / Acquaintance		Bottle		None	
Own Home		Bouncer		Firearm		Unknown	
Other Home		Stranger		Blunt Object			
Other Place		Customer / Client		Other / Unknown			
		Other / Unknown					

I am leaving the Emergency Department today against the advice of the doctor responsible for my care.
I have been advised that unless I continue to receive the treatment recommended by the Medical Staff my prospect of improvement or recovery may be prejudiced.

My reason for leaving is:

Signed _____ Date _____ Time _____

Witness _____ Status _____ Date _____ Time _____

COPY PAGE

Episode: E0001873028
Date: 10/07/2020
Time: 00:53

University Hospital Monklands
EMERGENCY DEPARTMENT



Surname:	McCracken	Forename:	Isabel	Triage Category
CHI No:	1808785142	Age:	41y	
Address:	1d Cumbrae Crescent	Date of Birth:	18/08/1978	
	Coatbridge	Gender:	Female	
	Lanarkshire	Referred by:	Self referral	
Postcode:	ML5 4PX			
Telephone:	07947301884			

G.P.:	NS Marcuccilli	G.P. Telephone No.:	01236 422311
G.P. Address: Waverley Medical Practice Coatbridge Health Centre 1 Centre Park Court Coatbridge Coatbridge ML5 3AP			

Presenting Complaint: taken drugs - feels well. Was advised by police to attend.

Vital Signs 0125		Glasgow Coma Scale		Urinalysis	
Temperature	36.9	Eye Opening	4	Glucose	
Pulse	98	Verbal Response	5	Ketones	
Resp. Rate	18	Motor Response	6	Specific Gravity	
Systolic BP	126	GCS Score	15	Blood	
Diastolic BP	79			pH	
Mean Arterial Pressure				Proteins	
SpO2	98%			Nitrates	
FiO2	air			Leucocytes	
Peak Flow					
Exp. Peak Flow					

Visual Acuity	
Visual Acuity (Right)	
Visual Acuity (Left)	
With Correction	

Pupil	
Pupil Size (Right)	5
Pupil Reactivity (Right)	+
Pupil Size (Left)	5
Pupil Reactivity (Left)	+

Blood Glucose	6.7
Pain Score	
Tetanus Cover	
Tetanus Date	
MEWS Score	
CEWS Score	

Height	
Weight	
Fast	



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10/7/20

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Brother also took some drugs (LSD) and intubated
Pt feels well. ~~At~~

Did not wish to visit



RESULTS

H+	Hb	PT	Na	ALT	Calcium	Glucose	Troponin
PO2	WBC	INR	K	ALP	Adj. Calcium	CRP	Paracetamol
PCO2	Platelets	APTT	Cl	Bilirubin	Magnesium	CK	Salicylate
Bicarb		APTT _r	Bicarb	Albumin	Globulin	Amylase	Ethanol
BE	COHb	Fibrinogen	Urea	AST	T. Protein		
O2 Sat	Lactate		Creatinine	GGT			BHGG

ED PRESCRIPTION

Date	Drug	Dose	Route	Time	Signature	Given By	Checked By	Time

DISCHARGE PRESCRIPTION

Date	Drug	Dose	Route	Time	Signature	Given By	Checked By	Time

INJURY SURVEILLANCE

For all assaults please record the following data

Date and time of assault: _____ Specific Location: _____

Type of Location:	✓	Assailant	✓	Weapon	✓	Alcohol / Drug Involvement	✓
Bar / Pub		Spouse / Partner		Body Part		Drugs	
Club		Ex Partner		Knife		Alcohol	
Street		Relative		Glass		Both	
Workplace		Friend / Acquaintance		Bottle		None	
Own Home		Bouncer		Firearm		Unknown	
Other Home		Stranger		Blunt Object			
Other Place		Customer / Client		Other / Unknown			
		Other / Unknown					

I am leaving the Emergency Department today against the advice of the doctor responsible for my care.
I have been advised that unless I continue to receive the treatment recommended by the Medical Staff my prospect of improvement or recovery may be prejudiced.

My reason for leaving is:

Signed  Date _____ Time _____

Witness _____ Status _____ Date _____ Time _____

COPY PAGE

MCCRACKEN, ISABEL

ID:1808785142

26-MAR-2021 18:12:49

MONKLANDS-AE_Mk ROUTINE RECORD

18-AUG-1978 (42 yr)
Female

Vent. rate	130	BPM
PR interval	150	ms
QRS duration	86	ms
QT/QTc	288/423	ms
P-R-T axes	33 30	28

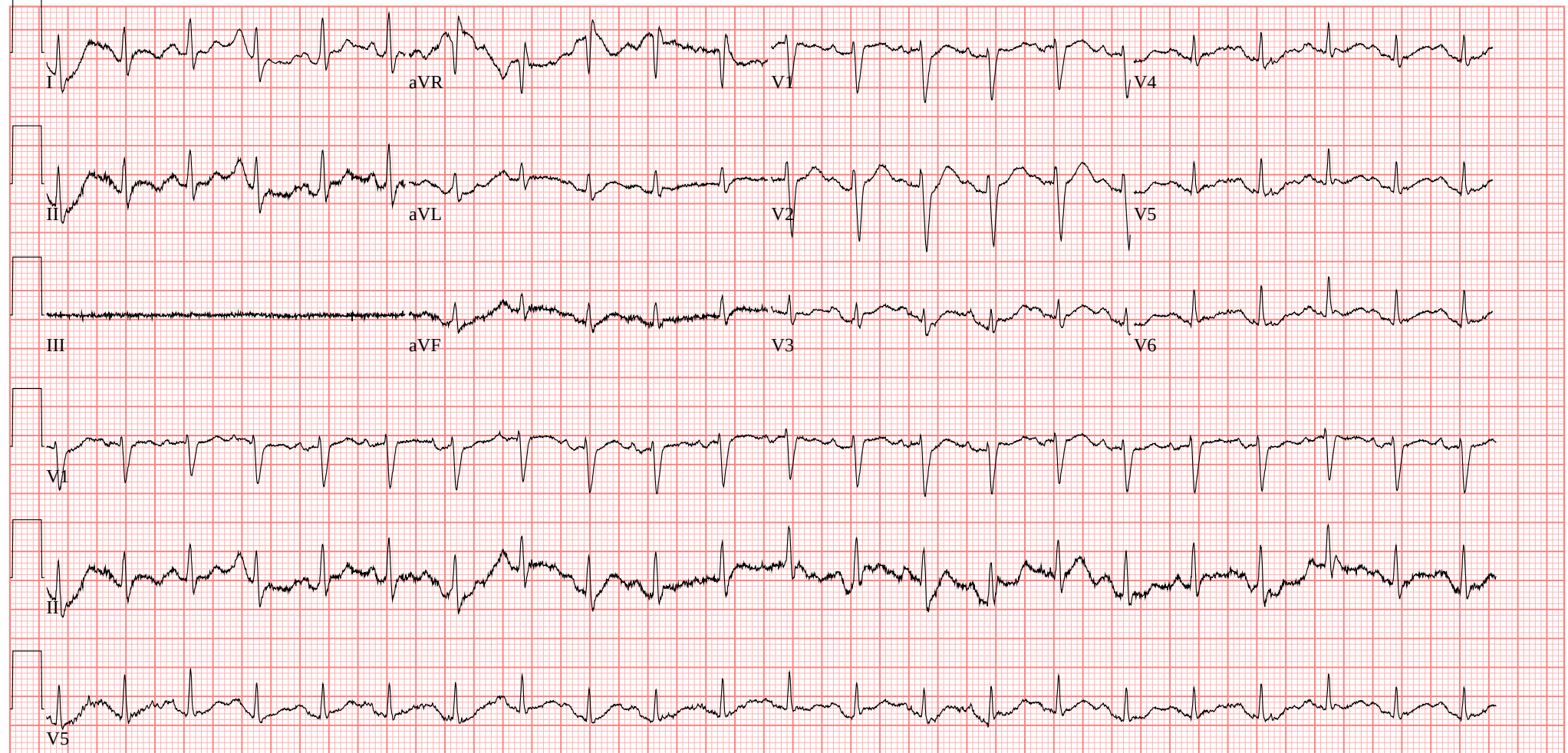
Sinus tachycardia
Otherwise normal ECG
No previous ECGs available

Room:
Loc:205

Technician:
Test ind:

Unconfirmed

Location:



25mm/s 10mm/mV 150Hz 9.0.7 12SL 243 CID: 221

SID: 561960 EID:13 EDT: ORDER:

Page 1 of 1

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Institution:

Run Date: 07-Apr-21, 10:25:18

Protocol: PNH RBC.PRO

Sample ID: MCCRACKEN ISABEL

Runtime Results

User ID: User

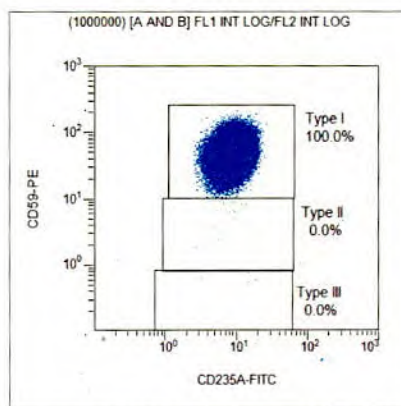
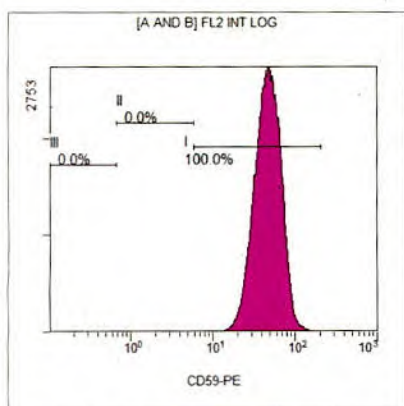
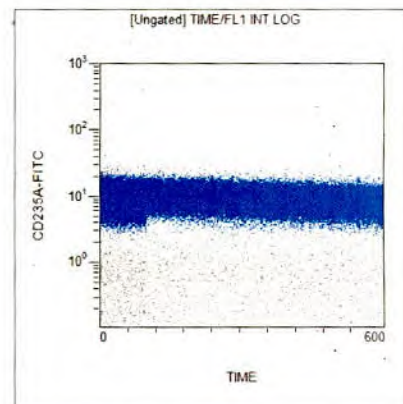
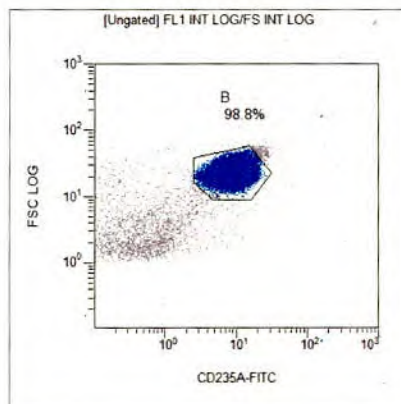
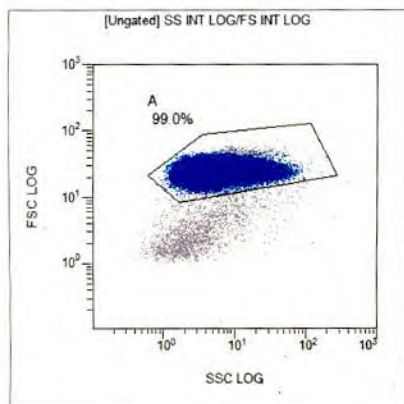
Analysis Date: 07-Apr-2021, 10:31:21

Acquisition Time/Events: 348.0s / 281223 (MANUAL)

Settings File: PNH RBC settings.PRO, 20-Jan-2011, 16:54:00

Tube ID: NoRead

Listmode File: MCCRACKEN ISABEL 1808785142 RPNH 00088444 2021-04-07.... 5247585



[A AND B] FL2 INT LOG		
Region	Number	%Gated
ALL	277650	100.00
I	277620	99.99
II	26	0.01
III	1	0.00

(1000000) [A AND B] FL1 INT LOG/FL2 INT LOG		
Region	Number	%Gated
ALL	277650	100.00
Type I	277592	99.98
Type II	66	0.02
Type III	2	0.00

PNH RBC Clone size

Type I (normal) = 100 %

Type II (partial GPI deficiency) = 0 %

Type III (Complete GPI deficiency) = 0 %

Total (Type II + type III) = 0 %

FCS Information

User
PNH_RBC
PNH_RBC
20-Jan-2011, 16:54:00
MCCRACKEN ISABEL
1808785142
RPNH

Institution:
Protocol: PNH WBC.PRO

Run Date: 07-Apr-21, 10:33:22
Sample ID: MCCRACKEN ISABEL

Runtime Results

User ID: User

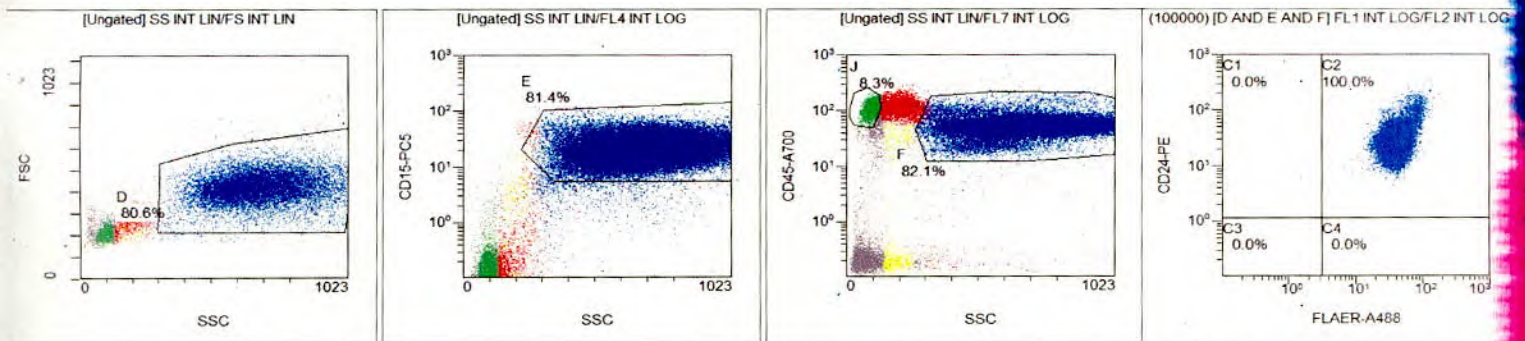
Analysis Date: 07-Apr-2021, 10:35:33

Acquisition Time/Events: 112.0s / 125838 (PROTOCOL)

Settings File: PNH WBC settings.PRO, 25-Mar-2011, 14:23:33

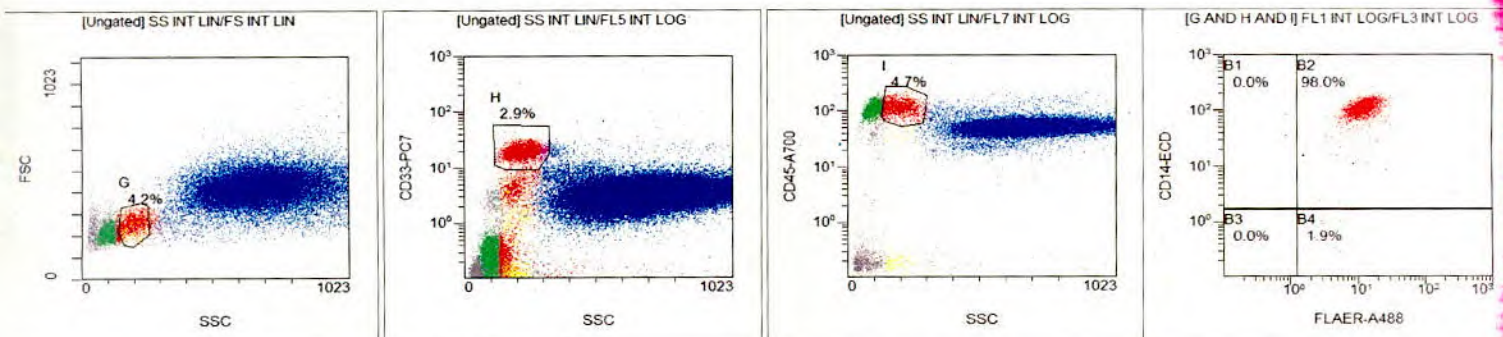
Tube ID: NoRead

Listmode File: MCCRACKEN ISABEL 1808785142 WPNH 00088445 2021-04-07...



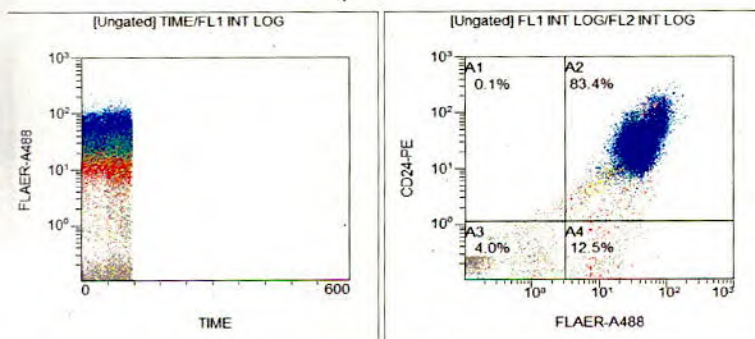
PNH Granulocyte clone size = 0%

(100000) [D AND E AND F] FL1 INT LOG/FL2 INT LOG		
Region	Number	%Gated
ALL	100000	100.00
C1	0	0.00
C2	99996	100.00
C3	1	0.00
C4	3	0.00



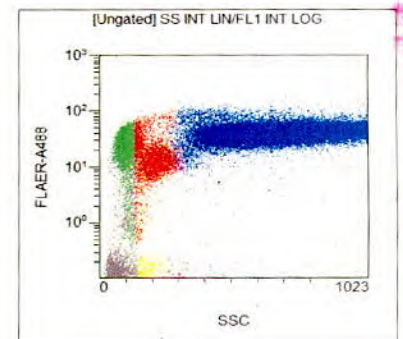
PNH Monocyte clone size = 0%

[G AND H AND I] FL1 INT LOG/FL3 INT LOG		
Region	Number	%Gated
ALL	2845	100.00
B1	0	0.00
B2	2789	98.03
B3	1	0.04
B4	55	1.93



FCS Information

User
PNH_WBC
25-Mar-2011, 14:23:33
MCCRACKEN ISABEL
1808785142
WPNH



PNH Patient Antibody Sheet

Patient Name: ISABEL MCCrackenPatient CHI number: 1808785142Date analysis performed: 7/4/2021BMS: DRG

Antibody	Manufacturer	Catalogue Number	Lot Number	Expiry Date
PNH Granulocyte and Monocyte Clone				
FLAER-A488	VH-BIO	FL2S-C	1911/4AC	30-11-2021
CD24-PE	Beckman Coulter	B92425	200019	19-11-2023
CD14-ECD	Beckman Coulter	B92391	200019	23-04-2022
CD15-PC5	Beckman Coulter	B49217	200022	25-12-2021
CD33-PC7	Beckman Coulter	B92408	200026	23-07-2021
CD45-APC-A700	Beckman Coulter	A79390	200057	13-10-2021
PNH Red Blood Cell				
CD235a- FITC	Beckman Coulter	B49206	200020	26-03-2023
CD59-PE	Invitrogen	MHCD5904	2175523	30-04-2023

MCCRACKEN, ISABEL

ID:1808785142

09-APR-2021 11:42:26

MONKLANDS-Card_M ROUTINE RECORD

18-AUG-1978 (42 yr)
Female

Vent. rate	107	BPM
PR interval	128	ms
QRS duration	90	ms
QT/QTc	343/459	ms
P-R-T axes	27 34	38

SINUS TACHYCARDIA
ABNORMAL RHYTHM ECG

Room: UNCONFIRMED REPORT
Loc:201

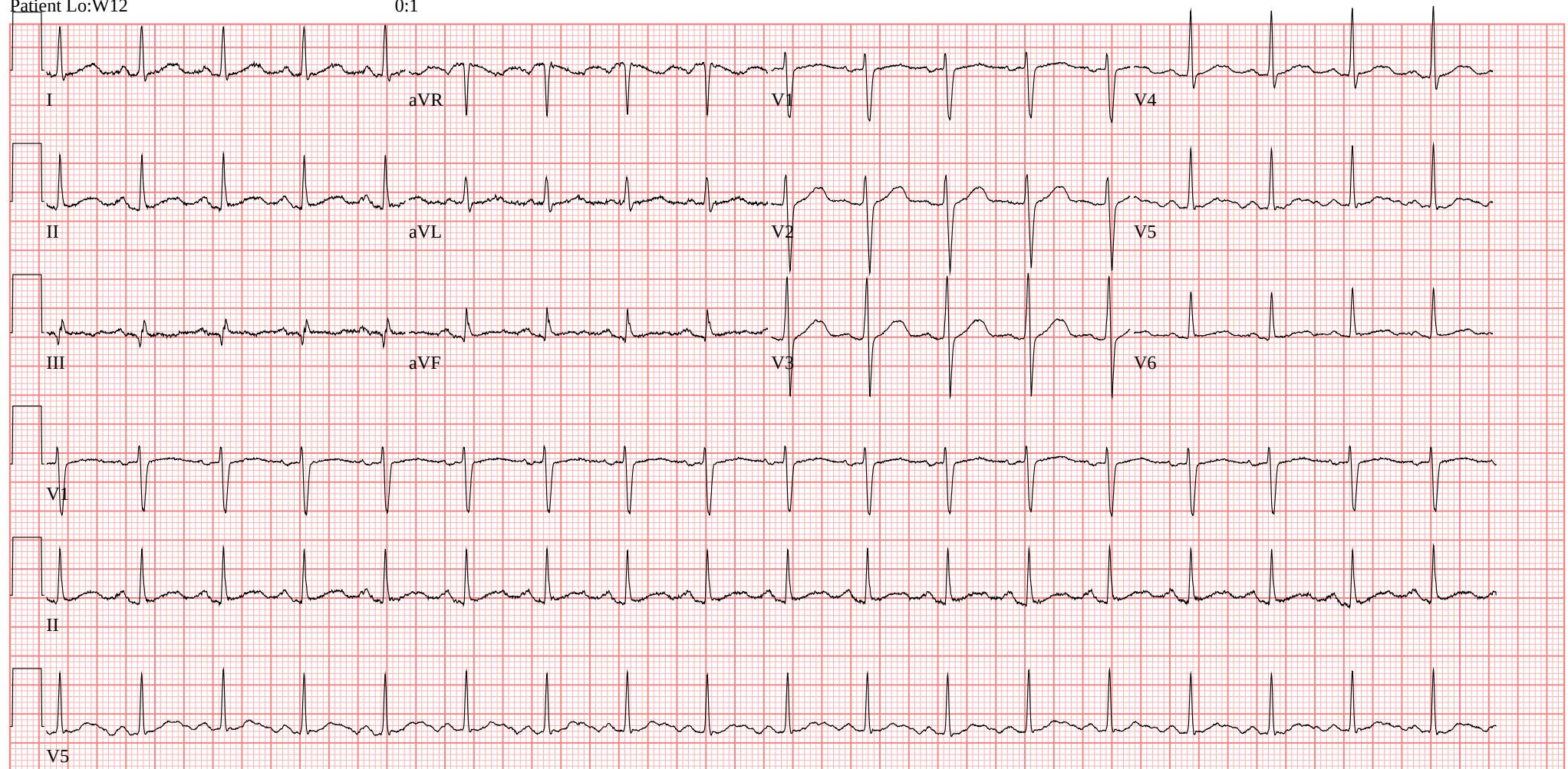
Technician: hegarty
Test ind:

Referred by: OLIVER

Unconfirmed

Patient Lo:W12

0:1



25mm/s 10mm/mV 150Hz 9.0.7 CID: 65535

SID: 561960 EID: EDT: ORDER:

Page 1 of 1

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To: N S MARCUCCILLI WAVERLEY MEDICAL PRACTICE	Re: ISABEL MCCrackEN 1D CUMBRAE CRESCENT , , COATBRIDGE , LANARKSHIRE , ML5 4PX DOB: 18/08/1978 Hosp. No.: CHI No.: 1808785142
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Date of Admission: 26/03/2021

Ward: ML Ward 12

Mode of Admission:

Consultant: Dr Scott Oliver (GENERAL MEDICINE-A1)

Admission Reason:

Discharge Date: 13/04/2021

Follow Up:

Pharmacy

WEEKLY DISPENSING PATIENT (NOT A BLISTER PACK) Weekly Dispensing Scripts collected from
Mint Pharmacy, 5 Lorne Place, Coatbridge, ML5 4FS. Telephone - 01236 437354
One week supplied on discharge.
Dispensary screen only.

Allergy/Intolerance	Reaction
***No Known Drug Allergies	
diclofenac	Unknown

Allergy records are as recorded at time and date of printing.

Drug	Dose	Route	Frequency	Duration	GP to continue
ADCAL D3 750 mg Caplets	1 caplet(s)	Oral	TWICE daily at 7am and 10pm	L/T	Y
CITALOPRAM 40 mg Tablets	40 mg	Oral	ONCE daily at 7am	L/T	Y
CYCLIZINE 50 mg Tablets	50 mg	Oral	THREE times daily - 7am;1pm;10pm PRN For nausea/vomiting	14 day(s)	N
DIAZEPAM 2 mg Tablets	2 mg	Oral	THREE times daily - 7am;1pm;10pm	L/T	Y
DIHYDROCODEINE 30 mg Tablets	30 mg	Oral	FOUR times daily - 7am;1pm;6pm;10pm PRN For pain relief	7 day(s)	Y
FOLIC ACID 5 mg Tablets	5 mg	Oral	ONCE daily at 7am	L/T	Y
PARACETAMOL 500 mg Tablets	1000 mg	Oral	FOUR times daily - 7am;1pm;6pm;10pm	L/T	Y
QUETIAPINE 150 mg Tablets	150 mg	Oral	ONCE daily at 10pm	L/T	Y
QUETIAPINE 25 mg Tablets	50 mg	Oral	ONCE daily at 7am	L/T	Y
QUETIAPINE 25 mg Tablets	25 mg	Oral	ONCE daily at midday	L/T	Y
WARFARIN AS CHARTED	1 AS CHARTED	Oral	Daily at 6pm - See Anticoagulant Chart	L/T	Y
ZOPICLONE 7.5 mg Tablets	7.5 mg	Oral	ONCE daily at 10pm PRN For sleeplessness	L/T	Y

L/T = Long-term - Please note a minimum 7 day supply of medicines will be dispensed by the hospital pharmacy unless otherwise stated.

Discharged by: Dr Victoria Gordon

To: N S MARCUCCILLI WAVERLEY MEDICAL PRACTICE	Re: ISABEL MCCRACKEN 1D CUMBRAE CRESCENT , , COATBRIDGE , LANARKSHIRE , ML5 4PX DOB: 18/08/1978 Hosp. No.: CHI No.: 1808785142
--	---

Date of Admission: 26/03/2021 **Ward:** ML Ward 12

Mode of Admission: **Consultant:** Dr Scott Oliver (GENERAL MEDICINE-A1)

Admission Reason:

Discharge Date: 19/04/2021 **Follow Up:**

Primary Diagnosis: Gram variable bacteraemia Superior mesenteric vein thrombosis

Investigations

Pharmacy WEEKLY DISPENSING PATIENT (NOT A BLISTER PACK) Weekly Dispensing Scripts collected from Mint Pharmacy, 5 Lorne Place, Coatbridge, ML5 4FS. Telephone - 01236 437354
One week supplied on discharge.
Dispensary screen only.

Clinical Progress Isabel McCracken was admitted to UHM on 27/03/21 with pyrexia, vomiting and loin pain. On admission she had derranged electrolytes, thrombocytopaenia and a raised D-dimer. She was treated with IV antibiotics and electrolyte replacement. Blood cultures grew gram variable bacteria of unclear source. AUSS was non-diagnostic. CT AP showed extensive superior mesenteric thrombus and was started on anticoagulation. She was reviewed by the surgical team who advised not for surgery unless deteriorates. Haematology advised thrombophilia screen which was normal and to consider an underlying malignancy. A completion CT of neck and chest was performed to rule out malignancy. No signs of malignancy on CT. An endoscopy and colonoscopy have been requested as an outpatient. She had mild lupus anticoagulant positive which will be repeated in 12/52. She was switched to warfarin and has been referred to the anticoagulation clinic. She is to stay on warfarin for at least 6 months.

Results Awaited myeloma screen, C3/4 compliment, JAK2, factor Vleiden, BJP urine, free light chains, ANA, anti-DNA, anti-cardi, parietal cell abs

Follow-up Anticoagulation follow-up
Repeat lupus anticoagulant in 12/52 in PIU

Medication Changes Started on Warfarin

Allergy/Intolerance	Reaction
***No Known Drug Allergies	
diclofenac	Unknown

Allergy records are as recorded at time and date of printing.

Drug	Dose	Route	Frequency	Duration	GP to continue
ADCAL D3 750 mg Caplets	1 caplet(s)	Oral	TWICE daily at 7am and 10pm	L/T	Y
CITALOPRAM 40 mg Tablets	40 mg	Oral	ONCE daily at 7am	L/T	Y
CYCLIZINE 50 mg Tablets	50 mg	Oral	THREE times daily - 7am;1pm;10pm PRN For nausea/vomiting	14 day(s)	N
DIAZEPAM 2 mg Tablets	2 mg	Oral	THREE times daily - 7am;1pm;10pm	L/T	Y

L/T = Long-term - Please note a minimum 7 day supply of medicines will be dispensed by the hospital pharmacy unless otherwise stated.

Discharged by: Dr Victoria Gordon

To: N S MARCUCCILLI WAVERLEY MEDICAL PRACTICE	Re: ISABEL MCCRACKEN 1D CUMBRAE CRESCENT , , COATBRIDGE , LANARKSHIRE , ML5 4PX DOB: 18/08/1978 Hosp. No.: CHI No.: 1808785142
--	---

Drug	Dose	Route	Frequency	Duration	GP to continue
DIHYDROCODEINE 30 mg Tablets	30 mg	Oral	FOUR times daily - 7am;1pm;6pm;10pm PRN For pain relief	7 day(s)	Y
FOLIC ACID 5 mg Tablets	5 mg	Oral	ONCE daily at 7am	L/T	Y
PARACETAMOL 500 mg Tablets	1000 mg	Oral	FOUR times daily - 7am;1pm;6pm;10pm	L/T	Y
QUETIAPINE 150 mg Tablets	150 mg	Oral	ONCE daily at 10pm	L/T	Y
QUETIAPINE 25 mg Tablets	50 mg	Oral	ONCE daily at 7am	L/T	Y
QUETIAPINE 25 mg Tablets	25 mg	Oral	ONCE daily at midday	L/T	Y
WARFARIN AS CHARTED	1 AS CHARTED	Oral	Daily at 6pm - See Anticoagulant Chart	L/T	Y
ZOPICLONE 7.5 mg Tablets	7.5 mg	Oral	ONCE daily at 10pm PRN For sleeplessness	L/T	Y

L/T = Long-term - Please note a minimum 7 day supply of medicines will be dispensed by the hospital pharmacy unless otherwise stated.

Discharged by: Dr Victoria Gordon



Inpatient prescription & administration record for

ISABEL MCCRACKEN (1808785142)

Admission: 26/03/2021 => 19/04/2021

01:20
20/04/21

Patient Demographics

1808785142

MCCRACKEN Isabel (1808785142)
DOB: 18/08/1978
1D Cumbrae Crescent, Coatbridge,
Lanarkshire,
ML5 4PX

Admitted: 26/03/2021 00:01
Discharged: 19/04/2021 09:09

Transfer history

Admission	2021-03-26 00:01:00	ML EXPECTED PT
Transfer	2021-03-26 17:05:00	ML A&E
Transfer	2021-03-27 00:14:00	ML MAU
Transfer	2021-03-27 01:31:00	ML AMRU
Transfer	2021-03-27 15:14:00	ML Ward 12

Responsible Consultant history

. No Named Consultant	26/03/21	00:01
Dr Alison Taylor	27/03/21	00:14
Dr Zoe Cousland	29/03/21	14:13
Dr Scott Oliver	05/04/21	15:30

Allergy

Admission Allergy Check performed by: Dr Rhoda Downie
Current recorded allergy (reaction): No Known Drug Allergies

Sensitivity (reaction): diclofenac(Unknown)

ADCAL D3 750 mg Caplets

☒ 27/03/21 07:00 1 caplet(s) TWICE daily at 7am and 10pm (Oral)

Dr Rhoda Downie

27/03/21	07:00	27/03/2021	08:23	Nurse Emma Crielly
27/03/21	22:00	27/03/2021	20:21	Nurse Charlene Pritchard
28/03/21	07:00	28/03/2021	08:06	Nurse Karen Gillespie
28/03/21	22:00	28/03/2021	20:40	Nurse Charlene Pritchard
29/03/21	07:00	29/03/2021	08:04	Nurse Patrick Henry
29/03/21	22:00	29/03/2021	20:10	Nurse Jacqueline McAulay
30/03/21	07:00	30/03/2021	07:51	Nurse Amanda Graham
30/03/21	22:00	30/03/2021	20:06	Nurse Jacqueline McAulay
31/03/21	07:00	31/03/2021	07:48	Nurse Karen Gillespie
31/03/21	22:00	31/03/2021	21:19	Nurse Jacqueline McAulay
01/04/21	07:00	01/04/2021	08:07	Nurse Karen Gillespie
01/04/21	22:00	01/04/2021	20:48	Nurse Adele Rooney
02/04/21	07:00	02/04/2021	08:06	Nurse Karen Gillespie
02/04/21	22:00	02/04/2021	20:37	Nurse Charlene Pritchard
03/04/21	07:00	03/04/2021	08:02	Nurse Patrick Henry
03/04/21	22:00	03/04/2021	20:22	Nurse Charlene Pritchard
04/04/21	07:00	04/04/2021	08:05	Nurse Patrick Henry
04/04/21	22:00	04/04/2021	20:04	Nurse Charlene Pritchard
05/04/21	07:00	05/04/2021	08:21	Nurse Karen Gillespie
05/04/21	22:00	05/04/2021	21:12	Nurse Sheryll Luna
06/04/21	07:00	06/04/2021	08:31	Nurse Jennifer Begley
06/04/21	22:00	06/04/2021	20:29	Nurse Sheryll Luna
07/04/21	07:00	07/04/2021	08:40	Nurse Allana McPhee
07/04/21	22:00	07/04/2021	21:18	Nurse Sheryll Luna
08/04/21	07:00	08/04/2021	08:54	Nurse Allana McPhee
08/04/21	22:00	08/04/2021	22:07	Nurse Sheryll Luna
09/04/21	07:00	09/04/2021	08:29	Nurse Amanda Graham
09/04/21	22:00	09/04/2021	20:33	Nurse Adele Rooney
10/04/21	07:00	10/04/2021	08:25	Nurse Amanda Graham
10/04/21	22:00	10/04/2021	20:41	Nurse Adele Rooney
11/04/21	07:00	11/04/2021	08:07	Nurse Amanda Graham
11/04/21	22:00	11/04/2021	20:18	Nurse Adele Rooney
12/04/21	07:00	12/04/2021	08:27	Nurse Jennifer Begley
12/04/21	22:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
13/04/21	07:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
13/04/21	22:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
14/04/21	07:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
14/04/21	22:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
15/04/21	07:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
15/04/21	22:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
16/04/21	07:00	Not Charted prior to Discharge		Ms Jennifer Hendrie

Key: Prescription details Recorded as "Admitted On" Prescribed as "Self Administer" Discontinuation details HEPMA Prescription additional notes HEPMA Patient admission notes (admission specific) HEPMA Patient retained notes (not specific to admission)

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Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, and NHS Ayrshire & Arran

ADCAL D3 750 mg Caplets

(Continued)

16/04/21	22:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
17/04/21	07:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
17/04/21	22:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
18/04/21	07:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
18/04/21	22:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
19/04/21	07:00	Not Charted prior to Discharge	Ms Jennifer Hendrie

AMOXICILLIN 500 mg Capsules

30/03/21 22:00 500 mg THREE times daily - 7am;1pm;10pm (Oral) for 3 day(s) Dr Catriona Macrae

30/03/21	22:00	30/03/2021	20:06	Nurse Jacqueline McAulay
31/03/21	07:00	31/03/2021	07:50	Nurse Karen Gillespie

Discontinued on: 31/03/2021 10:59 by: Dr Catriona Macrae . Reason: Discontinued due to conflict

AMOXICILLIN 1 g Injection

27/03/21 07:00 1 g THREE times daily - 7am;1pm;10pm (Intravenous Intermittent Infusion) Dr Rhoda Downie

27/03/21	07:00	27/03/2021	06:22	Nurse Kirsten Wilson/ Nurse Kimberly Barry
27/03/21	13:00	27/03/2021	11:53	Nurse Emma Crielly
27/03/21	22:00	27/03/2021	22:55	Nurse Charlene Pritchard
28/03/21	07:00	28/03/2021	05:21	Nurse Charlene Pritchard
28/03/21	13:00	28/03/2021	12:31	Nurse Karen Gillespie
28/03/21	22:00	28/03/2021	20:40	Nurse Charlene Pritchard
29/03/21	07:00	29/03/2021	05:33	Nurse Charlene Pritchard
29/03/21	13:00	29/03/2021	11:55	Nurse Patrick Henry
29/03/21	22:00	29/03/2021	20:10	Nurse Jacqueline McAulay
30/03/21	07:00	30/03/2021	05:34	Nurse Jacqueline McAulay
30/03/21	13:00	30/03/2021	13:06	Nurse Amanda Graham

Discontinued on: 30/03/2021 15:48 by: Dr Catriona Macrae . Reason: Discontinued due to conflict

31/03/21 13:00 1 g THREE times daily - 7am;1pm;10pm (Intravenous Intermittent Infusion) Dr Catriona Macrae

31/03/21	13:00	31/03/2021	12:28	Nurse Karen Gillespie
31/03/21	22:00	31/03/2021	21:19	Nurse Jacqueline McAulay
01/04/21	07:00	01/04/2021	07:45	Nurse Jacqueline McAulay
01/04/21	13:00	01/04/2021	12:22	Nurse Karen Gillespie
01/04/21	22:00	01/04/2021	21:57	Nurse Adele Rooney
02/04/21	07:00	02/04/2021	06:34	Nurse Adele Rooney
02/04/21	13:00	02/04/2021	12:39	Nurse Karen Gillespie
02/04/21	22:00	02/04/2021	20:37	Nurse Charlene Pritchard
03/04/21	07:00	03/04/2021	06:15	Nurse Adele Rooney
03/04/21	13:00	03/04/2021	12:47	Nurse Patrick Henry
03/04/21	22:00	03/04/2021	20:22	Nurse Charlene Pritchard
04/04/21	07:00	04/04/2021	05:11	Nurse Charlene Pritchard
04/04/21	13:00	04/04/2021	11:34	Nurse Patrick Henry
04/04/21	22:00	04/04/2021	20:04	Nurse Charlene Pritchard
05/04/21	07:00	05/04/2021	05:14	Nurse Charlene Pritchard
05/04/21	13:00	05/04/2021	12:21	Nurse Karen Gillespie

Discontinued on: 05/04/2021 17:14 by: Nurse Angela Chisholm . Reason: Discontinued due to conflict

CITALOPRAM 40 mg Tablets

27/03/21 07:00 40 mg ONCE daily at 7am (Oral) Dr Rhoda Downie

27/03/21	07:00	27/03/2021	08:23	Nurse Emma Crielly
28/03/21	07:00	28/03/2021	08:08	Nurse Karen Gillespie
29/03/21	07:00	29/03/2021	08:04	Nurse Patrick Henry
30/03/21	07:00	30/03/2021	07:52	Nurse Amanda Graham
31/03/21	07:00	31/03/2021	07:49	Nurse Karen Gillespie
01/04/21	07:00	01/04/2021	08:07	Nurse Karen Gillespie
02/04/21	07:00	02/04/2021	08:06	Nurse Karen Gillespie
03/04/21	07:00	03/04/2021	08:03	Nurse Patrick Henry
04/04/21	07:00	04/04/2021	08:05	Nurse Patrick Henry
05/04/21	07:00	05/04/2021	08:21	Nurse Karen Gillespie
06/04/21	07:00	06/04/2021	08:31	Nurse Jennifer Begley
07/04/21	07:00	07/04/2021	08:40	Nurse Allana McPhee
08/04/21	07:00	08/04/2021	08:54	Nurse Allana McPhee
09/04/21	07:00	09/04/2021	08:30	Nurse Amanda Graham
10/04/21	07:00	10/04/2021	08:25	Nurse Amanda Graham
11/04/21	07:00	11/04/2021	08:07	Nurse Amanda Graham
12/04/21	07:00	12/04/2021	08:27	Nurse Jennifer Begley
13/04/21	07:00	Not Charted prior to Discharge		Ms Jennifer Hendrie

Key: 	 Prescription details	 Recorded as "Admitted On"	 Prescribed as "Self Administer"	 Discontinuation details	 HEPMA Prescription additional notes	 HEPMA Patient admission notes (admission specific)	 HEPMA Patient retained notes (not specific to admission)
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CITALOPRAM 40 mg Tablets

(Continued)

14/04/21	07:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
15/04/21	07:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
16/04/21	07:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
17/04/21	07:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
18/04/21	07:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
19/04/21	07:00	Not Charted prior to Discharge	Ms Jennifer Hendrie

CO-AMOXICLAV 500/125mg Tablets

☒ 05/04/21 22:00 1 tablet(s) THREE times daily - 7am;1pm;10pm (Oral) for 3 day(s)

Nurse Angela Chisholm

05/04/21	22:00	05/04/2021	21:13	Nurse Sheryll Luna
06/04/21	07:00	06/04/2021	08:33	Nurse Jennifer Begley
06/04/21	13:00	06/04/2021	12:27	Nurse Jennifer Begley
06/04/21	22:00	06/04/2021	20:29	Nurse Sheryll Luna
07/04/21	07:00	07/04/2021	08:42	Nurse Allana McPhee
07/04/21	13:00	07/04/2021	12:30	Nurse Adele Rooney
07/04/21	22:00	07/04/2021	21:18	Nurse Sheryll Luna
08/04/21	07:00	08/04/2021	08:55	Nurse Allana McPhee
08/04/21	13:00	08/04/2021	12:23	Nurse Allana McPhee

CYCLIZINE 50 mg Tablets

☒ 29/03/21 18:00 50 mg THREE times daily at 7am, 1pm, and 6pm (Oral)

Dr Zoe Cousland

29/03/21	18:00	29/03/2021	16:06	Nurse Patrick Henry
30/03/21	07:00	30/03/2021	05:34	Nurse Jacqueline McAulay
30/03/21	13:00	30/03/2021	12:08	Nurse Amanda Graham
30/03/21	18:00	30/03/2021	16:36	Nurse Hayley Finnieston
31/03/21	07:00	31/03/2021	07:50	Nurse Karen Gillespie
31/03/21	13:00	31/03/2021	12:27	Nurse Karen Gillespie
31/03/21	18:00	31/03/2021	16:54	Nurse Karen Gillespie
01/04/21	07:00	01/04/2021	08:09	Nurse Karen Gillespie
01/04/21	13:00	01/04/2021	12:21	Nurse Karen Gillespie
01/04/21	18:00	01/04/2021	16:39	Nurse Karen Gillespie
02/04/21	07:00	02/04/2021	08:07	Nurse Karen Gillespie
02/04/21	13:00	02/04/2021	12:38	Nurse Karen Gillespie
02/04/21	18:00	02/04/2021	17:24	Nurse Karen Gillespie
03/04/21	07:00	03/04/2021	08:04	Nurse Patrick Henry
03/04/21	13:00	03/04/2021	12:43	Nurse Patrick Henry
03/04/21	18:00	03/04/2021	16:25	Nurse Patrick Henry
04/04/21	07:00	04/04/2021	08:06	Nurse Patrick Henry
04/04/21	13:00	04/04/2021	12:06	Nurse Patrick Henry
04/04/21	18:00	04/04/2021	17:58	Nurse Patrick Henry
05/04/21	07:00	05/04/2021	08:21	Nurse Karen Gillespie
05/04/21	13:00	05/04/2021	12:20	Nurse Karen Gillespie
05/04/21	18:00	05/04/2021	17:13	Nurse Karen Gillespie
06/04/21	07:00	06/04/2021	08:32	Nurse Jennifer Begley
06/04/21	13:00	06/04/2021	12:26	Nurse Jennifer Begley
06/04/21	18:00	06/04/2021	16:58	Nurse Jennifer Begley
07/04/21	07:00	07/04/2021	08:42	Nurse Allana McPhee
07/04/21	13:00	07/04/2021	12:29	Nurse Adele Rooney
07/04/21	18:00	07/04/2021	16:26	Nurse Allana McPhee
08/04/21	07:00	08/04/2021	08:55	Nurse Allana McPhee
08/04/21	13:00	08/04/2021	12:22	Nurse Allana McPhee
08/04/21	18:00	08/04/2021	16:18	Nurse Allana McPhee
09/04/21	07:00	09/04/2021	08:31	Nurse Amanda Graham
09/04/21	13:00	09/04/2021	12:29	Nurse Amanda Graham
09/04/21	18:00	09/04/2021	16:53	Nurse Amanda Graham
10/04/21	07:00	10/04/2021	08:27	Nurse Amanda Graham
10/04/21	13:00	10/04/2021	12:26	Nurse Amanda Graham
10/04/21	18:00	10/04/2021	17:00	Nurse Amanda Graham
11/04/21	07:00	11/04/2021	08:10	Nurse Amanda Graham
11/04/21	13:00	11/04/2021	12:31	Nurse Amanda Graham
11/04/21	18:00	11/04/2021	16:41	Nurse Amanda Graham
12/04/21	07:00	12/04/2021	08:28	Nurse Jennifer Begley
12/04/21	13:00	12/04/2021	12:12	Nurse Jennifer Begley
12/04/21	18:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
13/04/21	07:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
13/04/21	13:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
13/04/21	18:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
14/04/21	07:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
14/04/21	13:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
14/04/21	18:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
15/04/21	07:00	Not Charted prior to Discharge		Ms Jennifer Hendrie

Key: Prescription details Recorded as "Admitted On" Prescribed as "Self Administer" Discontinuation details HEPMA Prescription additional notes HEPMA Patient admission notes (admission specific) HEPMA Patient retained notes (not specific to admission)

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Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, and NHS Ayrshire & Arran

CYCLIZINE 50 mg Tablets

(Continued)

15/04/21	13:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
15/04/21	18:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
16/04/21	07:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
16/04/21	13:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
16/04/21	18:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
17/04/21	07:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
17/04/21	13:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
17/04/21	18:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
18/04/21	07:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
18/04/21	13:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
18/04/21	18:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
19/04/21	07:00	Not Charted prior to Discharge	Ms Jennifer Hendrie

DIAZEPAM 2 mg Tablets

☒ 27/03/21 07:00 2 mg THREE times daily - 7am;1pm;10pm (Oral)

Dr Rhoda Downie

27/03/21	07:00	27/03/2021	08:23	Nurse Emma Crielly
27/03/21	13:00	27/03/2021	11:53	Nurse Emma Crielly
27/03/21	22:00	27/03/2021	20:21	Nurse Charlene Pritchard
28/03/21	07:00	28/03/2021	08:06	Nurse Karen Gillespie
28/03/21	13:00	28/03/2021	12:33	Nurse Karen Gillespie
28/03/21	22:00	28/03/2021	20:40	Nurse Charlene Pritchard
29/03/21	07:00	29/03/2021	06:19	Nurse Sheryll Luna
29/03/21	13:00	29/03/2021	11:54	Nurse Patrick Henry
29/03/21	22:00	29/03/2021	20:10	Nurse Jacqueline McAulay
30/03/21	07:00	30/03/2021	07:51	Nurse Amanda Graham
30/03/21	13:00	30/03/2021	12:01	Nurse Amanda Graham
30/03/21	22:00	30/03/2021	20:06	Nurse Jacqueline McAulay
31/03/21	07:00	31/03/2021	07:48	Nurse Karen Gillespie
31/03/21	13:00	31/03/2021	12:26	Nurse Karen Gillespie
31/03/21	22:00	31/03/2021	21:19	Nurse Jacqueline McAulay
01/04/21	07:00	01/04/2021	08:07	Nurse Karen Gillespie
01/04/21	13:00	01/04/2021	12:21	Nurse Karen Gillespie
01/04/21	22:00	01/04/2021	20:48	Nurse Adele Rooney
02/04/21	07:00	02/04/2021	08:05	Nurse Karen Gillespie
02/04/21	13:00	02/04/2021	12:37	Nurse Karen Gillespie
02/04/21	22:00	02/04/2021	20:37	Nurse Charlene Pritchard
03/04/21	07:00	03/04/2021	08:02	Nurse Patrick Henry
03/04/21	13:00	03/04/2021	12:42	Nurse Patrick Henry
03/04/21	22:00	03/04/2021	20:22	Nurse Charlene Pritchard
04/04/21	07:00	04/04/2021	08:05	Nurse Patrick Henry
04/04/21	13:00	04/04/2021	12:04	Nurse Patrick Henry
04/04/21	22:00	04/04/2021	20:04	Nurse Charlene Pritchard
05/04/21	07:00	05/04/2021	08:20	Nurse Karen Gillespie
05/04/21	13:00	05/04/2021	12:20	Nurse Karen Gillespie
05/04/21	22:00	05/04/2021	21:12	Nurse Sheryll Luna
06/04/21	07:00	06/04/2021	08:31	Nurse Jennifer Begley
06/04/21	13:00	06/04/2021	12:26	Nurse Jennifer Begley
06/04/21	22:00	06/04/2021	20:29	Nurse Sheryll Luna
07/04/21	07:00	07/04/2021	08:40	Nurse Allana McPhee
07/04/21	13:00	07/04/2021	12:29	Nurse Adele Rooney
07/04/21	22:00	07/04/2021	21:18	Nurse Sheryll Luna
08/04/21	07:00	08/04/2021	08:54	Nurse Allana McPhee
08/04/21	13:00	08/04/2021	12:22	Nurse Allana McPhee
08/04/21	22:00	08/04/2021	22:07	Nurse Sheryll Luna
09/04/21	07:00	09/04/2021	08:29	Nurse Amanda Graham
09/04/21	13:00	09/04/2021	12:28	Nurse Amanda Graham
09/04/21	22:00	09/04/2021	20:33	Nurse Adele Rooney
10/04/21	07:00	10/04/2021	08:24	Nurse Amanda Graham
10/04/21	13:00	10/04/2021	12:25	Nurse Amanda Graham
10/04/21	22:00	10/04/2021	20:41	Nurse Adele Rooney
11/04/21	07:00	11/04/2021	08:06	Nurse Amanda Graham
11/04/21	13:00	11/04/2021	12:30	Nurse Amanda Graham
11/04/21	22:00	11/04/2021	20:18	Nurse Adele Rooney
12/04/21	07:00	12/04/2021	08:26	Nurse Jennifer Begley
12/04/21	13:00	12/04/2021	12:12	Nurse Jennifer Begley
12/04/21	22:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
13/04/21	07:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
13/04/21	13:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
13/04/21	22:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
14/04/21	07:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
14/04/21	13:00	Not Charted prior to Discharge		Ms Jennifer Hendrie

Key: Prescription details Recorded as "Admitted On" Prescribed as "Self Administer" Discontinuation details HEPMA Prescription additional notes HEPMA Patient admission notes (admission specific) HEPMA Patient retained notes (not specific to admission)

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DIAZEPAM 2 mg Tablets

(Continued)

14/04/21	22:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
15/04/21	07:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
15/04/21	13:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
15/04/21	22:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
16/04/21	07:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
16/04/21	13:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
16/04/21	22:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
17/04/21	07:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
17/04/21	13:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
17/04/21	22:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
18/04/21	07:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
18/04/21	13:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
18/04/21	22:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
19/04/21	07:00	Not Charted prior to Discharge	Ms Jennifer Hendrie

FOLIC ACID 5 mg Tablets

 29/03/21 07:00 5 mg ONCE daily at 7am (Oral)

Dr Paul Lyons

29/03/21	07:00	29/03/2021	08:04	Nurse Patrick Henry
30/03/21	07:00	30/03/2021	07:52	Nurse Amanda Graham
31/03/21	07:00	31/03/2021	07:49	Nurse Karen Gillespie
01/04/21	07:00	01/04/2021	08:08	Nurse Karen Gillespie
02/04/21	07:00	02/04/2021	08:07	Nurse Karen Gillespie
03/04/21	07:00	03/04/2021	08:03	Nurse Patrick Henry
04/04/21	07:00	04/04/2021	08:06	Nurse Patrick Henry
05/04/21	07:00	05/04/2021	08:21	Nurse Karen Gillespie
06/04/21	07:00	06/04/2021	08:32	Nurse Jennifer Begley
07/04/21	07:00	07/04/2021	08:41	Nurse Allana McPhee
08/04/21	07:00	Other - Record in nursing notes		Nurse Allana McPhee
09/04/21	07:00	09/04/2021	08:30	Nurse Amanda Graham
10/04/21	07:00	10/04/2021	08:26	Nurse Amanda Graham
11/04/21	07:00	11/04/2021	08:08	Nurse Amanda Graham
12/04/21	07:00	12/04/2021	08:28	Nurse Jennifer Begley
13/04/21	07:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
14/04/21	07:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
15/04/21	07:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
16/04/21	07:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
17/04/21	07:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
18/04/21	07:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
19/04/21	07:00	Not Charted prior to Discharge		Ms Jennifer Hendrie

HYDROXOCOBALAMIN 1 mg in 1mL Injection

 27/03/21 04:39 1 mg (Intramuscular)

Dr Rhoda Downie

27/03/21	04:39	27/03/2021	06:22	Nurse Kirsten Wilson/ Nurse Kimberly Barry
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MAGNESIUM- L- ASPARTATE 10 mmol Sachet

 03/04/21 22:00 10 mmol TWICE daily at 7am and 10pm (Oral) for 3 day(s)

Dr Hannah Talwar

03/04/21	22:00	03/04/2021	20:22	Nurse Charlene Pritchard
04/04/21	07:00	04/04/2021	08:07	Nurse Patrick Henry
04/04/21	22:00	04/04/2021	20:04	Nurse Charlene Pritchard
05/04/21	07:00	05/04/2021	08:25	Nurse Karen Gillespie
05/04/21	22:00	05/04/2021	21:10	Nurse Sheryl Luna
06/04/21	07:00	06/04/2021	08:33	Nurse Jennifer Begley

 07/04/21 22:00 10 mmol TWICE daily at 7am and 10pm (Oral) for 3 day(s)

Dr Eleanor Hanraads

07/04/21	22:00	07/04/2021	21:18	Nurse Sheryl Luna
08/04/21	07:00	08/04/2021	08:57	Nurse Allana McPhee
08/04/21	22:00	08/04/2021	22:08	Nurse Sheryl Luna
09/04/21	07:00	09/04/2021	08:32	Nurse Amanda Graham
09/04/21	22:00	09/04/2021	20:35	Nurse Adele Rooney
10/04/21	07:00	10/04/2021	08:27	Nurse Amanda Graham

METRONIDAZOLE 400 mg Tablets

 30/03/21 22:00 400 mg THREE times daily - 7am;1pm;10pm (Oral) for 3 day(s)

Dr Catriona Macrae

30/03/21	22:00	30/03/2021	20:06	Nurse Jacqueline McAulay
31/03/21	07:00	31/03/2021	07:51	Nurse Karen Gillespie

 Discontinued on: 31/03/2021 11:00 by: Dr Catriona Macrae . Reason: Discontinued due to conflict

METRONIDAZOLE 500 mg in 100mL Intravenous Infusion

Key: 	Prescription details		Recorded as "Admitted On"		Prescribed as "Self Administer"		Discontinuation details		HEPMA Prescription additional notes		HEPMA Patient admission notes (admission specific)		HEPMA Patient retained notes (not specific to admission)
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METRONIDAZOLE 500 mg in 100mL Intravenous Infusion

(Continued)

27/03/21 07:00 500 mg THREE times daily - 7am;1pm;10pm (Intravenous Intermittent Infusion) Dr Rhoda Downie

27/03/21	07:00	27/03/2021	06:22	Nurse Kirsten Wilson/ Nurse Kimberly Barry
27/03/21	13:00	27/03/2021	11:53	Nurse Emma Crielly
27/03/21	22:00	27/03/2021	22:55	Nurse Charlene Pritchard
28/03/21	07:00	28/03/2021	05:21	Nurse Charlene Pritchard
28/03/21	13:00	28/03/2021	12:32	Nurse Karen Gillespie
28/03/21	22:00	28/03/2021	20:40	Nurse Charlene Pritchard
29/03/21	07:00	29/03/2021	05:33	Nurse Charlene Pritchard
29/03/21	13:00	29/03/2021	11:55	Nurse Patrick Henry
29/03/21	22:00	29/03/2021	20:10	Nurse Jacqueline McAulay
30/03/21	07:00	30/03/2021	05:34	Nurse Jacqueline McAulay
30/03/21	13:00	30/03/2021	13:06	Nurse Amanda Graham

Discontinued on: 30/03/2021 15:48 by: Dr Catriona Macrae . Reason: Discontinued due to conflict

31/03/21 13:00 500 mg THREE times daily - 7am;1pm;10pm (Intravenous Intermittent Infusion) Dr Catriona Macrae

31/03/21	13:00	31/03/2021	12:28	Nurse Karen Gillespie
31/03/21	22:00	31/03/2021	21:19	Nurse Jacqueline McAulay
01/04/21	07:00	01/04/2021	07:45	Nurse Jacqueline McAulay
01/04/21	13:00	01/04/2021	12:22	Nurse Karen Gillespie
01/04/21	22:00	01/04/2021	21:57	Nurse Adele Rooney
02/04/21	07:00	02/04/2021	06:34	Nurse Adele Rooney
02/04/21	13:00	02/04/2021	12:39	Nurse Karen Gillespie
02/04/21	22:00	02/04/2021	20:37	Nurse Charlene Pritchard
03/04/21	07:00	03/04/2021	06:15	Nurse Adele Rooney
03/04/21	13:00	03/04/2021	12:47	Nurse Patrick Henry
03/04/21	22:00	03/04/2021	20:22	Nurse Charlene Pritchard
04/04/21	07:00	04/04/2021	05:11	Nurse Charlene Pritchard
04/04/21	13:00	04/04/2021	11:34	Nurse Patrick Henry
04/04/21	22:00	04/04/2021	20:04	Nurse Charlene Pritchard
05/04/21	07:00	05/04/2021	05:14	Nurse Charlene Pritchard
05/04/21	13:00	05/04/2021	12:21	Nurse Karen Gillespie

Discontinued on: 05/04/2021 17:12 by: Nurse Angela Chisholm . Reason: No longer indicated

NICOTINE (NICOTINELL) 14 mg/24hours Patches

02/04/21 07:00 1 application ONCE daily at 7am (Topical) Dr Catriona Macrae

02/04/21	07:00	02/04/2021	08:08	Nurse Karen Gillespie
03/04/21	07:00	03/04/2021	08:04	Nurse Patrick Henry
04/04/21	07:00	04/04/2021	08:07	Nurse Patrick Henry
05/04/21	07:00	05/04/2021	08:25	Nurse Karen Gillespie
06/04/21	07:00	06/04/2021	16:58	Nurse Jennifer Begley
07/04/21	07:00	07/04/2021	08:44	Nurse Allana McPhee
08/04/21	07:00	08/04/2021	08:56	Nurse Allana McPhee
09/04/21	07:00	09/04/2021	08:31	Nurse Amanda Graham
10/04/21	07:00	10/04/2021	08:27	Nurse Amanda Graham
11/04/21	07:00	11/04/2021	08:10	Nurse Amanda Graham
12/04/21	07:00	12/04/2021	08:29	Nurse Jennifer Begley
13/04/21	07:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
14/04/21	07:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
15/04/21	07:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
16/04/21	07:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
17/04/21	07:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
18/04/21	07:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
19/04/21	07:00	Not Charted prior to Discharge		Ms Jennifer Hendrie

01/04/21 09:50 1 application (Topical) Dr Catriona Macrae

01/04/21	09:50	01/04/2021	12:24	Nurse Karen Gillespie
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PARACETAMOL 500 mg Tablets

28/03/21 18:00 1,000 mg FOUR times daily - 7am;1pm;6pm;10pm (Oral) Dr Paul Lyons

28/03/21	18:00	28/03/2021	17:12	Nurse Karen Gillespie
28/03/21	22:00	28/03/2021	20:40	Nurse Charlene Pritchard
29/03/21	07:00	29/03/2021	06:19	Nurse Sheryl Luna
29/03/21	13:00	29/03/2021	11:54	Nurse Patrick Henry
29/03/21	18:00	29/03/2021	16:06	Nurse Patrick Henry
29/03/21	22:00	29/03/2021	20:10	Nurse Jacqueline McAulay
30/03/21	07:00	30/03/2021	07:52	Nurse Amanda Graham
30/03/21	13:00	30/03/2021	12:03	Nurse Amanda Graham
30/03/21	18:00	30/03/2021	16:36	Nurse Hayley Finnieston

Key: 	Prescription details		Recorded as "Admitted On"		Prescribed as "Self Administer"		Discontinuation details		HEPMA Prescription additional notes		HEPMA Patient admission notes (admission specific)		HEPMA Patient retained notes (not specific to admission)
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PARACETAMOL 500 mg Tablets

(Continued)

30/03/21	22:00	30/03/2021	20:06	Nurse Jacqueline McAulay
31/03/21	07:00	31/03/2021	07:49	Nurse Karen Gillespie
31/03/21	13:00	31/03/2021	12:26	Nurse Karen Gillespie
31/03/21	18:00	31/03/2021	16:54	Nurse Karen Gillespie
31/03/21	22:00	31/03/2021	21:19	Nurse Jacqueline McAulay
01/04/21	07:00	01/04/2021	08:08	Nurse Karen Gillespie
01/04/21	13:00	01/04/2021	12:21	Nurse Karen Gillespie
01/04/21	18:00	01/04/2021	16:39	Nurse Karen Gillespie
01/04/21	22:00	01/04/2021	21:57	Nurse Adele Rooney
02/04/21	07:00	02/04/2021	08:06	Nurse Karen Gillespie
02/04/21	13:00	02/04/2021	12:37	Nurse Karen Gillespie
02/04/21	18:00	02/04/2021	17:24	Nurse Karen Gillespie
02/04/21	22:00	02/04/2021	20:37	Nurse Charlene Pritchard
03/04/21	07:00	03/04/2021	08:03	Nurse Patrick Henry
03/04/21	13:00	03/04/2021	12:42	Nurse Patrick Henry
03/04/21	18:00	03/04/2021	16:25	Nurse Patrick Henry
03/04/21	22:00	03/04/2021	20:22	Nurse Charlene Pritchard
04/04/21	07:00	04/04/2021	08:06	Nurse Patrick Henry
04/04/21	13:00	04/04/2021	12:06	Nurse Patrick Henry
04/04/21	18:00	04/04/2021	17:58	Nurse Patrick Henry
04/04/21	22:00	04/04/2021	20:04	Nurse Charlene Pritchard
05/04/21	07:00	05/04/2021	08:21	Nurse Karen Gillespie
05/04/21	13:00	05/04/2021	12:20	Nurse Karen Gillespie
05/04/21	18:00	05/04/2021	17:13	Nurse Karen Gillespie
05/04/21	22:00	05/04/2021	21:09	Nurse Sheryll Luna
06/04/21	07:00	06/04/2021	08:31	Nurse Jennifer Begley
06/04/21	13:00	06/04/2021	12:26	Nurse Jennifer Begley
06/04/21	18:00	06/04/2021	16:58	Nurse Jennifer Begley
06/04/21	22:00	06/04/2021	20:29	Nurse Sheryll Luna
07/04/21	07:00	07/04/2021	08:40	Nurse Allana McPhee
07/04/21	13:00	07/04/2021	12:29	Nurse Adele Rooney
07/04/21	18:00	07/04/2021	16:26	Nurse Allana McPhee
07/04/21	22:00	07/04/2021	21:18	Nurse Sheryll Luna
08/04/21	07:00	08/04/2021	08:55	Nurse Allana McPhee
08/04/21	13:00	08/04/2021	12:22	Nurse Allana McPhee
08/04/21	18:00	08/04/2021	16:18	Nurse Allana McPhee
08/04/21	22:00	08/04/2021	22:07	Nurse Sheryll Luna
09/04/21	07:00	09/04/2021	08:30	Nurse Amanda Graham
09/04/21	13:00	09/04/2021	12:28	Nurse Amanda Graham
09/04/21	18:00	09/04/2021	16:53	Nurse Amanda Graham
09/04/21	22:00	09/04/2021	20:33	Nurse Adele Rooney
10/04/21	07:00	10/04/2021	08:26	Nurse Amanda Graham
10/04/21	13:00	10/04/2021	12:27	Nurse Amanda Graham
10/04/21	18:00	10/04/2021	17:01	Nurse Amanda Graham
10/04/21	22:00	10/04/2021	22:36	Nurse Adele Rooney
11/04/21	07:00	11/04/2021	08:08	Nurse Amanda Graham
11/04/21	13:00	11/04/2021	12:31	Nurse Amanda Graham
11/04/21	18:00	11/04/2021	16:41	Nurse Amanda Graham
11/04/21	22:00	11/04/2021	20:18	Nurse Adele Rooney
12/04/21	07:00	12/04/2021	08:27	Nurse Jennifer Begley
12/04/21	13:00	12/04/2021	12:12	Nurse Jennifer Begley
12/04/21	18:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
12/04/21	22:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
13/04/21	07:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
13/04/21	13:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
13/04/21	18:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
13/04/21	22:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
14/04/21	07:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
14/04/21	13:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
14/04/21	18:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
14/04/21	22:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
15/04/21	07:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
15/04/21	13:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
15/04/21	18:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
15/04/21	22:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
16/04/21	07:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
16/04/21	13:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
16/04/21	18:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
16/04/21	22:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
17/04/21	07:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
17/04/21	13:00	Not Charted prior to Discharge		Ms Jennifer Hendrie

PARACETAMOL 500 mg Tablets

(Continued)

17/04/21	18:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
17/04/21	22:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
18/04/21	07:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
18/04/21	13:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
18/04/21	18:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
18/04/21	22:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
19/04/21	07:00	Not Charted prior to Discharge	Ms Jennifer Hendrie

QUETIAPINE 150 mg Tablets

27/03/21	22:00	150 mg ONCE daily at 10pm (Oral)	Dr Rhoda Downie
27/03/21	22:00	Drug not available	Nurse Charlene Pritchard
28/03/21	22:00	28/03/2021 20:40	Nurse Charlene Pritchard
29/03/21	22:00	29/03/2021 20:10	Nurse Jacqueline McAulay
30/03/21	22:00	30/03/2021 20:06	Nurse Jacqueline McAulay
31/03/21	22:00	31/03/2021 21:19	Nurse Jacqueline McAulay
01/04/21	22:00	01/04/2021 20:48	Nurse Adele Rooney
02/04/21	22:00	02/04/2021 20:37	Nurse Charlene Pritchard
03/04/21	22:00	03/04/2021 20:22	Nurse Charlene Pritchard
04/04/21	22:00	04/04/2021 20:04	Nurse Charlene Pritchard
05/04/21	22:00	05/04/2021 21:12	Nurse Sheryll Luna
06/04/21	22:00	06/04/2021 20:28	Nurse Sheryll Luna
07/04/21	22:00	07/04/2021 21:17	Nurse Sheryll Luna
08/04/21	22:00	08/04/2021 22:07	Nurse Sheryll Luna
09/04/21	22:00	09/04/2021 20:32	Nurse Adele Rooney
10/04/21	22:00	10/04/2021 20:41	Nurse Adele Rooney
11/04/21	22:00	11/04/2021 20:19	Nurse Adele Rooney
12/04/21	22:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
13/04/21	22:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
14/04/21	22:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
15/04/21	22:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
16/04/21	22:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
17/04/21	22:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
18/04/21	22:00	Not Charted prior to Discharge	Ms Jennifer Hendrie

QUETIAPINE 25 mg Tablets

27/03/21	07:00	50 mg ONCE daily at 7am (Oral)	Dr Rhoda Downie
27/03/21	07:00	27/03/2021 08:24	Nurse Emma Crielly
28/03/21	07:00	28/03/2021 08:06	Nurse Karen Gillespie
29/03/21	07:00	29/03/2021 08:03	Nurse Patrick Henry
30/03/21	07:00	30/03/2021 07:51	Nurse Amanda Graham
31/03/21	07:00	31/03/2021 07:47	Nurse Karen Gillespie
01/04/21	07:00	01/04/2021 08:07	Nurse Karen Gillespie
02/04/21	07:00	02/04/2021 08:05	Nurse Karen Gillespie
03/04/21	07:00	03/04/2021 08:02	Nurse Patrick Henry
04/04/21	07:00	04/04/2021 08:05	Nurse Patrick Henry
05/04/21	07:00	05/04/2021 08:20	Nurse Karen Gillespie
06/04/21	07:00	06/04/2021 08:31	Nurse Jennifer Begley
07/04/21	07:00	07/04/2021 08:39	Nurse Allana McPhee
08/04/21	07:00	08/04/2021 08:53	Nurse Allana McPhee
09/04/21	07:00	09/04/2021 08:28	Nurse Amanda Graham
10/04/21	07:00	10/04/2021 08:23	Nurse Amanda Graham
11/04/21	07:00	11/04/2021 08:06	Nurse Amanda Graham
12/04/21	07:00	12/04/2021 08:26	Nurse Jennifer Begley
13/04/21	07:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
14/04/21	07:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
15/04/21	07:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
16/04/21	07:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
17/04/21	07:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
18/04/21	07:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
19/04/21	07:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
27/03/21	12:00	25 mg ONCE daily at midday (Oral)	Dr Rhoda Downie
27/03/21	12:00	27/03/2021 11:53	Nurse Emma Crielly
28/03/21	12:00	28/03/2021 12:31	Nurse Karen Gillespie
29/03/21	12:00	29/03/2021 11:54	Nurse Patrick Henry
30/03/21	12:00	30/03/2021 12:00	Nurse Amanda Graham
31/03/21	12:00	31/03/2021 12:26	Nurse Karen Gillespie
01/04/21	12:00	01/04/2021 12:21	Nurse Karen Gillespie
02/04/21	12:00	02/04/2021 12:37	Nurse Karen Gillespie
03/04/21	12:00	03/04/2021 12:42	Nurse Patrick Henry
04/04/21	12:00	04/04/2021 12:04	Nurse Patrick Henry

QUETIAPINE 25 mg Tablets

(Continued)

05/04/21	12:00	05/04/2021	12:20	Nurse Karen Gillespie
06/04/21	12:00	06/04/2021	12:26	Nurse Jennifer Begley
07/04/21	12:00	07/04/2021	12:28	Nurse Adele Rooney
08/04/21	12:00	08/04/2021	12:21	Nurse Allana McPhee
09/04/21	12:00	09/04/2021	13:34	Nurse Amanda Graham
10/04/21	12:00	10/04/2021	12:25	Nurse Amanda Graham
11/04/21	12:00	11/04/2021	12:29	Nurse Amanda Graham
12/04/21	12:00	12/04/2021	12:12	Nurse Jennifer Begley
13/04/21	12:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
14/04/21	12:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
15/04/21	12:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
16/04/21	12:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
17/04/21	12:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
18/04/21	12:00	Not Charted prior to Discharge		Ms Jennifer Hendrie

SANDO K Effervescent Tablets

02/04/21 18:00 2 tablet(s) THREE times daily at 7am, 1pm, and 6pm (Oral) for 3 day(s) Dr Catriona Macrae

02/04/21	18:00	02/04/2021	17:24	Nurse Karen Gillespie
03/04/21	07:00	03/04/2021	08:04	Nurse Patrick Henry
03/04/21	13:00	2 tablet(s) THREE times daily at 7am, 1pm, and 6pm (Oral)		Dr Hannah Talwar
03/04/21	13:00	03/04/2021	12:43	Nurse Patrick Henry

TEMOCILLIN 1 g Injection

31/03/21 22:00 2 g TWICE daily at 7am and 10pm (Intravenous Intermittent Infusion) Dr Catriona Macrae

31/03/21	22:00	31/03/2021	21:19	Nurse Jacqueline McAulay
01/04/21	07:00	01/04/2021	07:45	Nurse Jacqueline McAulay
01/04/21	22:00	01/04/2021	21:57	Nurse Adele Rooney
02/04/21	07:00	02/04/2021	06:34	Nurse Adele Rooney
02/04/21	22:00	02/04/2021	20:37	Nurse Charlene Pritchard
03/04/21	07:00	03/04/2021	06:15	Nurse Adele Rooney
03/04/21	22:00	03/04/2021	20:22	Nurse Charlene Pritchard
04/04/21	07:00	04/04/2021	05:11	Nurse Charlene Pritchard
04/04/21	22:00	04/04/2021	20:04	Nurse Charlene Pritchard
05/04/21	07:00	05/04/2021	05:14	Nurse Charlene Pritchard

Discontinued on: 05/04/2021 17:11 by: Nurse Angela Chisholm . Reason: No longer indicated

31/03/21 11:02 2 g (Intravenous Intermittent Infusion) Dr Catriona Macrae

31/03/21	11:02	31/03/2021	12:29	Nurse Karen Gillespie
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TINZAPARIN 12,000 units in 0.6ml Pre-filled Syringe

02/04/21 18:00 12,000 unit(s) ONCE daily at 6pm (Subcutaneous Bolus Injection) Dr Anne MacLeod

02/04/21	18:00	02/04/2021	17:27	Nurse Karen Gillespie
03/04/21	18:00	03/04/2021	16:26	Nurse Patrick Henry
04/04/21	18:00	04/04/2021	17:58	Nurse Patrick Henry
05/04/21	18:00	05/04/2021	17:14	Nurse Karen Gillespie
06/04/21	18:00	06/04/2021	17:00	Nurse Jennifer Begley
07/04/21	18:00	07/04/2021	16:27	Nurse Allana McPhee
08/04/21	18:00	08/04/2021	16:19	Nurse Allana McPhee

Discontinued on: 09/04/2021 11:12 by: Dr Eleanor Hanraads . Reason: Discontinued due to conflict

01/04/21 23:40 12,000 unit(s) (Subcutaneous Bolus Injection) Dr Anne MacLeod

01/04/21	23:40	01/04/2021	23:44	Nurse Adele Rooney
09/04/21	18:00	11,000 unit(s) ONCE daily at 6pm (Subcutaneous Bolus Injection)		Dr Eleanor Hanraads
09/04/21	18:00	09/04/2021	16:56	Nurse Amanda Graham
10/04/21	18:00	10/04/2021	17:01	Nurse Amanda Graham

Discontinued on: 11/04/2021 12:59 by: Dr Eleanor Hanraads . Reason: No longer indicated

WARFARIN AS CHARTED

09/04/21 18:00 1 AS CHARTED Daily at 6pm - See Anticoagulant Chart (Oral) Dr Eleanor Hanraads

09/04/21	18:00	09/04/2021	17:01	Nurse Amanda Graham
10/04/21	18:00	10/04/2021	17:00	Nurse Amanda Graham
11/04/21	18:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
12/04/21	18:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
13/04/21	18:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
14/04/21	18:00	Not Charted prior to Discharge		Ms Jennifer Hendrie
15/04/21	18:00	Not Charted prior to Discharge		Ms Jennifer Hendrie

Key: 	Prescription details		Recorded as "Admitted On"		Prescribed as "Self Administer"		Discontinuation details		HEPMA Prescription additional notes		HEPMA Patient admission notes (admission specific)		HEPMA Patient retained notes (not specific to admission)
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Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, and NHS Ayrshire & Arran

WARFARIN AS CHARTED

(Continued)

16/04/21	18:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
17/04/21	18:00	Not Charted prior to Discharge	Ms Jennifer Hendrie
18/04/21	18:00	Not Charted prior to Discharge	Ms Jennifer Hendrie

DIHYDROCODEINE 30 mg Tablets as required

29/03/21	14:25	30 mg FOUR times daily - 7am;1pm;6pm;10pm (Oral) For pain relief	Dr Oliver Denton
30.00 mg	30/03/2021	04:38	Nurse Jacqueline McAulay
30.00 mg	05/04/2021	21:12	Nurse Sheryll Luna
30.00 mg	06/04/2021	20:31	Nurse Sheryll Luna
30.00 mg	07/04/2021	21:19	Nurse Sheryll Luna
30.00 mg	08/04/2021	22:08	Nurse Sheryll Luna
30.00 mg	12/04/2021	04:54	Nurse Adele Rooney
30.00 mg	12/04/2021	12:12	Nurse Jennifer Begley

GENTAMICIN AS CHARTED as required

27/03/21	04:43	1 AS CHARTED PRN SEE PAPER CHART (Intravenous Intermittent Infusion) As charted	Dr Rhoda Downie
1.00 AS CHARTED	27/03/2021	05:15	Nurse Kirsten Wilson/ Nurse Kimberly Barry
1.00 AS CHARTED	28/03/2021	05:21	Nurse Charlene Pritchard
1.00 AS CHARTED	29/03/2021	05:20	Nurse Charlene Pritchard
1.00 AS CHARTED	30/03/2021	05:34	Nurse Jacqueline McAulay

Discontinued on: 30/03/2021 15:47 by: Dr Catriona Macrae . Reason: No longer indicated

ONDANSETRON 4 mg Tablets as required

28/03/21	16:33	4 mg every 8 hours (Oral) FOR NAUSEA/VOMITING <i>prescribed as part of either/or protocol: Ondansetron 4Mg Oral Or Iv When Required</i>	Dr Paul Lyons
4.00 mg	03/04/2021	08:05	Nurse Patrick Henry
4.00 mg	09/04/2021	22:04	Nurse Adele Rooney

ONDANSETRON 4 mg in 2mL Injection as required

28/03/21	16:33	4 mg every 8 hours (Intravenous Slow Bolus Injection) FOR NAUSEA/VOMITING <i>prescribed as part of either/or protocol: Ondansetron 4Mg Oral Or Iv When Required</i>	Dr Paul Lyons
mg	Alternative administered		Nurse Patrick Henry
mg	Alternative administered		Nurse Adele Rooney

PARACETAMOL 500 mg Tablets as required

27/03/21	18:22	1,000 mg FOUR times daily - 7am;1pm;6pm;10pm (Oral) For pain relief For pyrexia	NURSE KIM BAIRD
1,000.00 mg	27/03/2021	18:24	Nurse Karen Gillespie
1,000.00 mg	27/03/2021	22:55	Nurse Charlene Pritchard
1,000.00 mg	28/03/2021	12:34	Nurse Karen Gillespie

Discontinued on: 28/03/2021 16:32 by: Dr Paul Lyons

ZOPICLONE 7.5 mg Tablets as required

27/03/21	04:40	7.5 mg ONCE daily at 10pm (Oral) For sleeplessness	Dr Rhoda Downie
7.50 mg	27/03/2021	20:22	Nurse Charlene Pritchard
7.50 mg	28/03/2021	20:41	Nurse Charlene Pritchard
7.50 mg	02/04/2021	20:38	Nurse Charlene Pritchard
7.50 mg	05/04/2021	21:13	Nurse Sheryll Luna
7.50 mg	06/04/2021	20:30	Nurse Sheryll Luna
7.50 mg	07/04/2021	21:19	Nurse Sheryll Luna
7.50 mg	08/04/2021	22:08	Nurse Sheryll Luna

Key: 	Prescription details 	Recorded as "Admitted On" 	Prescribed as "Self Administer" 	Discontinuation details 	HEPMA Prescription additional notes 	HEPMA Patient admission notes (admission specific) 	HEPMA Patient retained notes (not specific to admission) 
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Patient level notes

Pharmacy Care Plan added by Ms Kerry McGuire on 29/03/2021 at 09:44

Title: Pharmacy Care Plan

RED

PC - Pyrexia and Loin Pain

PMH - Emotionally unstable PD, Previous back pain (slipped disk), feels different as radiating now.

Drug History - ECS and Patient and Community Pharmacy

Does patient have own at home? - Weekly dispensed medicines last given out Thursday 25/03/21.

Meds withheld -

Meds stopped - co-dydramol

Medication changes - Diazepam prescribed as 2mg TDS - patient usually takes 6mg BD. Zopiclone changed to PRN.

New medication - Paracetamol, Dihydrocodeine, Folic acid 5mg OD, IV/oral Ondansetron, Cyclizine, NRT, tinzaparin, Mg

Not prescribed - Etorcoxib 60-120mg OD not Rxd.

HT: 157 cm WT: 67.7 kg

ETOH/SMOKING: current smoker 6 a day and drinks 1-2 monthly. Takes cannabis - nil this recent week.

NEBS/home02/maint steroids:

DVT Prophylaxis LMWH/TEDs/other drug/dose/indication:

RF (CrCl): stable eGFR>59 ml/min

Plts: 67 - too low for VTE proph on admission

Care issues

Review

8/4/21 - LD (remote)

1) Finished PO abx today; CRP and WCC still raised.

2) Mesenteric vein thrombus on CT scan - on treatment dose tinzaparin at correct dose. ??plan for switch to PO.

3) Mg a bit low - on replacement with appropriate stop date.

K.McGuire Ward 12 30/03/21 10:56

1. Med rec issues - Diazepam prescribed as 2mg TDS - patient usually takes 6mg BD.

2. ?Biliary sepsis - LFTs deranged but improving slowly - Patient on day 4 of IV Gentamicin, Amoxicillin and Metronidazole - ?plan for gentamicin to stop today. If clinical deterioration occurs plan to escalate to IV Tazocin. CRP 155. WCC 21.2 and Neutrophils raised at 16.2. Monitor infection markers and IVOST when able.

3. IV Gentamicin - given 280mg on 27/03/21 at 05:15. Patient then redosed. Calculated correctly for redose. Patient given 320mg on 28/03/21 at 05:20. Patient given third dose of 320mg on 29/03/21 at 05:20.

4. Low platelets now up at 119 (prev 67) - could start enoxaparin for VTE proph

5. RF stable eGFR>59 ml/min. U+E stable. BP 102/65 mmHg - monitor. LFTs deranged.

K.McGuire Ward 12 29/03/21 09:40

1. Med rec issues - Diazepam prescribed as 2mg TDS - patient usually takes 6mg BD. Etorcoxib 60-120mg OD not Rxd.

2. ?Biliary sepsis - LFTs deranged - Patient on day 3 of IV Gentamicin, Amoxicillin and Metronidazole. If clinical deterioration occurs plan to escalate to IV Tazocin. CRP 197. WCC 27.8 and Neutrophils raised at 24.2. Monitor infection markers and IVOST when able.

3. IV Gentamicin - given 280mg on 27/03/21 at 05:15. Patient then redosed. Calculated correctly for redose. Patient given 320mg on 28/03/21 at 05:20. Patient given third dose of 320mg on 29/03/21 at 05:20.

4. Low platelets at 67 - too low for VTE proph. Monitor.

5. Potassium low at 3.1 mmol/L - not currently on oral replacement - monitor potassium

6. RF stable eGFR>59 ml/min. BP 102/65 mmHg - monitor. LFTs deranged. HR 96 bpm - monitor

Retained notes (not specific to admission)

Dispensing Note added by Ms Kerry McGuire on 29/03/2021 at 09:59:09

Title: WEEKLY DISPENSING PATIENT

WEEKLY DISPENSING PATIENT (NOT A BLISTER PACK)

Weekly Dispensing Scripts collected from Mint Pharmacy, 5 Lorne Place, Coatbridge, ML5 4FS. Telephone - 01236 437354

Key:  Prescription details  Recorded as "Admitted On"  Prescribed as "Self Administer"  Discontinuation details  HEPMA Prescription additional notes  HEPMA Patient admission notes (admission specific)  HEPMA Patient retained notes (not specific to admission)

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Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, and NHS Ayrshire & Arran

Episode: E0002001540
Date: 26/03/2021
Time: 17:04

MAJ 4
University Hospital Monklands
EMERGENCY DEPARTMENT



Surname: McCracken	Forename: Isabel	Triage Category
CHI No: 1808785142	Age: 42y	3
Address: 1d Cumrae Crescent	Date of Birth: 18/08/1978	
Coatbridge	Gender: Female	
Lanarkshire	Referred by: GP referral for admission	
Postcode: ML5 4PX		
Telephone: 07947301884		

G.P.: NS Marcuccilli	G.P. Telephone No.: 01236 422311
G.P. Address: Waverley Medical Practice Coatbridge Health Centre 1 Centre Park Court Coatbridge Coatbridge ML5 3AP	

Presenting Complaint: eta 1750, medical, D&V since last weekend, remains with vomiting, T 37.7, covid neg, P 140, +ve urinalysis

Vital Signs

Temperature	
Pulse	
Resp. Rate	
Systolic BP	
Diastolic BP	
Mean Arterial Pressure	
SpO2	
FiO2	
Peak Flow	
Exp. Peak Flow	

Glasgow Coma Scale

Eye Opening	
Verbal Response	
Motor Response	
GCS Score	

obs ✓
bloods ✓

side room -

Urinalysis

Glucose	
Ketones	
Specific Gravity	
Blood	
pH	
Proteins	
Nitrates	
Leucocytes	

Visual Acuity

Visual Acuity (Right)	
Visual Acuity (Left)	
With Correction	

Pupil

Pupil Size (Right)	
Pupil Reactivity (Right)	
Pupil Size (Left)	
Pupil Reactivity (Left)	

Blood Glucose	
Pain Score	
Tetanus Cover	
Tetanus Date	
MEWS Score	
CEWS Score	

Height	
Weight	

Fast	
------	--



COPY PAGE

1808785142
18/08/1978
MCCRACKEN
1d Cumberge
Coatbridge
Lanarkshire
F
Isabel
Crescen
M

ML5 4P8

Date: / / Pub. date: Oct. 2017 | Review date: Oct. 2020 | Issue No. 5.1

COPY PAGE

Patient name:				CHI number:						
Head Injury Observations										
Glasgow Coma Scale (GCS)	Date:									
	Time:									
	Frequency:									
	Frequency change initials:									
EYES Open	Spontaneous	4								Eyes closed by swelling = C
	To Speech	3								
	To Pain	2								
	None	1								
Best VERBAL Response	Orientated	5								Endo-tracheal tube or Trach-eostomy = T
	Confused	4								
	Inappropriate words	3								
	Incomprehensible sounds	2								
	None	1								
Best MOTOR Response	Obeys commands	6								Usually record the best arm response
	Localise pain	5								
	Withdrawal	4								
	Flexion to pain	3								
	Extension to pain	2								
	None	1								
TOTAL: (/15)										

• 1 • 2 • 3 • 4 • 5 6 7 8 Pupil Scale (mm)	Pupils	Right	Size								S sluggish + reacts - no reaction C eyes closed
		Left	Size								
	L I M B M O V E M E N T	A R M S	Normal power								Record right (R) and left (L) separately if there is a difference between the two side
			Mild weakness								
			Severe weakness								
			Spastic flexion								
			Extension								
		L E G S	No response								
			Normal power								
			Mild weakness								
Severe weakness											
Extension											
No response											
Initials:											

4AT Assessment Tool (screening for Cognitive Impairment and Delirium) - complete for over 65s as required		Score	
1. Alertness – This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating. - Normal (fully alert, but not agitated, throughout assessment) - Mild sleepiness for <10 seconds after waking, then normal - Clearly abnormal		0 0 4	
2. AMT4 – Ask the patient: age, date of birth, place (name of hospital or building), current year - No mistakes - 1 mistake - 2 or more mistakes/untestable		0 1 2	
3. Attention – Ask the patient: ‘Please tell me the months of the year in backwards order, starting at December.’ To assist initial understanding one prompt of, ‘What is the month before December?’ is permitted. - Achieves 7 months or more correctly - Starts but scores <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 (e.g. paranoia, hallucinations) arising over the last 2 weeks and still evident in the last 24 hours. - No - Yes		0 4	

Date: / /	Time: :	Initials:	4AT TOTAL SCORE:
4AT Score:			
4 or above: Possible delirium + / - cognitive impairment.			
1 - 3 : Possible cognitive impairment. More detailed cognitive assessment and informant history taking are required.			
0: Delirium or severe cognitive impairment unlikely (but delirium still possible if (4) information incomplete).			

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☐ Hairmyres☒ Monklands☐ Wishaw**NHS**
Lanarkshire

Emergency Department IV Prescription Chart

Date: 26/3/2021



1808785142

18/08/1978

F

F

MCCRACKEN Isabel
1d Cumberae CrescentCoatbridge
Lanarkshire

MLS 4PX

Fluid (Additive Medicine) IV Therapy Prescription Chart

Drug Sensitivity:

1.

2.

	Date	Fluid (BLOCK LETTERS)	Vol (ml)	Route	Duration	Signature	Serial No.	Given by	Start time	End time
		Additive Medicine	Dose (mg)				Batch No.			
A	26/3	PlasmaLyte	500	IV	STAT	[Signature]		[Signature]	13.00	
B	26/03	0.9% NaCl	500	IV	40	[Signature]				
		+ 40mmol K ⁺								
C	26/03	PLASMAlyte	500	IV	STAT	[Signature]	19/30 T40 exp: 08/21	ZL		
D	26/03	0.9% NaCl	500	IV	40	[Signature]				
		+ 40mmol K ⁺								
E										
F										
G										
H										

Rate of Flow = Vol of Fluid (ml) x 15(Drops/min) Duration (mins)
6.62 (1ml = 15 drops)**Approximated Rate for 500ml**1 hr = 120 Drops/min 6 hr = 22 Drops/min
4 hr = 30 Drops/min 8 hr = 15 Drops/min

STICK INSERTS HERE

1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumbernauld Crescent

Coatbridge
Lanarkshire

ML5 4PX

RESULTS

H+	Hb	PT	Na	ALT	Calcium	Glucose	Troponin
PO2	WBC	INR	K	ALP	Adj. Calcium	CRP	Paracetamol
PCO2	Platelets	APTT	Cl	Bilirubin	Magnesium	CK	Salicylate
Bicarb		APTT _r	Bicarb	Albumin	Globulin	Amylase	Ethanol
BE	COHb	Fibrinogen	Urea	AST	T. Protein		
O2 Sat	Lactate		Creatinine	GGT			BHGG

ED PRESCRIPTION

Date	Drug	Dose	Route	Time	Signature	Given By	Checked By	Time
26/12	AMOXICILLIN	1g	IV	19:45	<i>[Signature]</i>	OT	<i>[Signature]</i>	20:10
	CO-CODONE 30/500 II	PO	PO	20:10	<i>[Signature]</i>	Dr		20:10

DISCHARGE PRESCRIPTION

Date	Drug	Dose	Route	Time	Signature	Given By	Checked By	Time

INJURY SURVEILLANCE

For all assaults please record the following data

Date and time of assault: _____ Specific Location: _____

Type of Location:	✓	Assailant	✓	Weapon	✓	Alcohol / Drug Involvement	✓
Bar / Pub		Spouse / Partner		Body Part		Drugs	
Club		Ex Partner		Knife		Alcohol	
Street		Relative		Glass		Both	
Workplace		Friend / Acquaintance		Bottle		None	
Own Home		Bouncer		Firearm		Unknown	
Other Home		Stranger		Blunt Object			
Other Place		Customer / Client		Other / Unknown			
		Other / Unknown					

I am leaving the Emergency Department today against the advice of the doctor responsible for my care.
I have been advised that unless I continue to receive the treatment recommended by the Medical Staff my prospect of improvement or recovery may be prejudiced.

My reason for leaving is:

Signed _____ Date _____ Time _____

Witness _____ Status _____ Date _____ Time _____

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Admission Record

My Details

CHI number: 

Name: 1808785142
18/08/1978 F

Address: MCCracken Isabel
1d Cumberae Crescent
Coatbridge ML5 4FX
Lanarkshire

Postcode:

Date of birth: Age: 42

☐ Male ☐ Female

Phone number:

Preferred name:

My Contacts

Next of Kin:
Relationship:
Address:
.....
Phone number:
Alternative Con
Name:
Relationship:
Phone number(s):
.....
Power of Attorney, Guardianship (AWI):
.....
Social Work:
.....
Other: (specify)

My General Practitioner

GP: Dr. Maracallu
Practice:
.....
Phone number: 01236 422311
Community Team:
.....
.....

My Admission

Date:
Time:
Hospital: CHM
Ward: Ann
Consultant: Dr Taylor
Admitted from: EDU
Reason for admission: D+V
.....
.....
Estimated Discharge Date:

My Safety

Allergies:
NKDA
MRSA/CPE:
DNACPR:
Hospital Anticipatory Care Plan:

My Spiritual/Religious Needs

Please specify:
.....
.....
.....



Transfers	Hospital/Ward	Date	Time	Consultant
Transferred to:				
Transferred to:				

EMERGENCY DEPARTMENT USE ONLY

Emergency Department Assessment (ED Card)

CHI no

First name

DOB

Last name

Sex: ☐ M ☐ F

Address

.....

.....

or attach addressograph label here

EMERGENCY DEPARTMENT USE ONLY

Immediate physiological observations:

Pulse: (bpm)

Resp. Rate: (/min)

BP lying: (mm/Hg) ...

SpO2: on

BP standing: (mm/Hg)

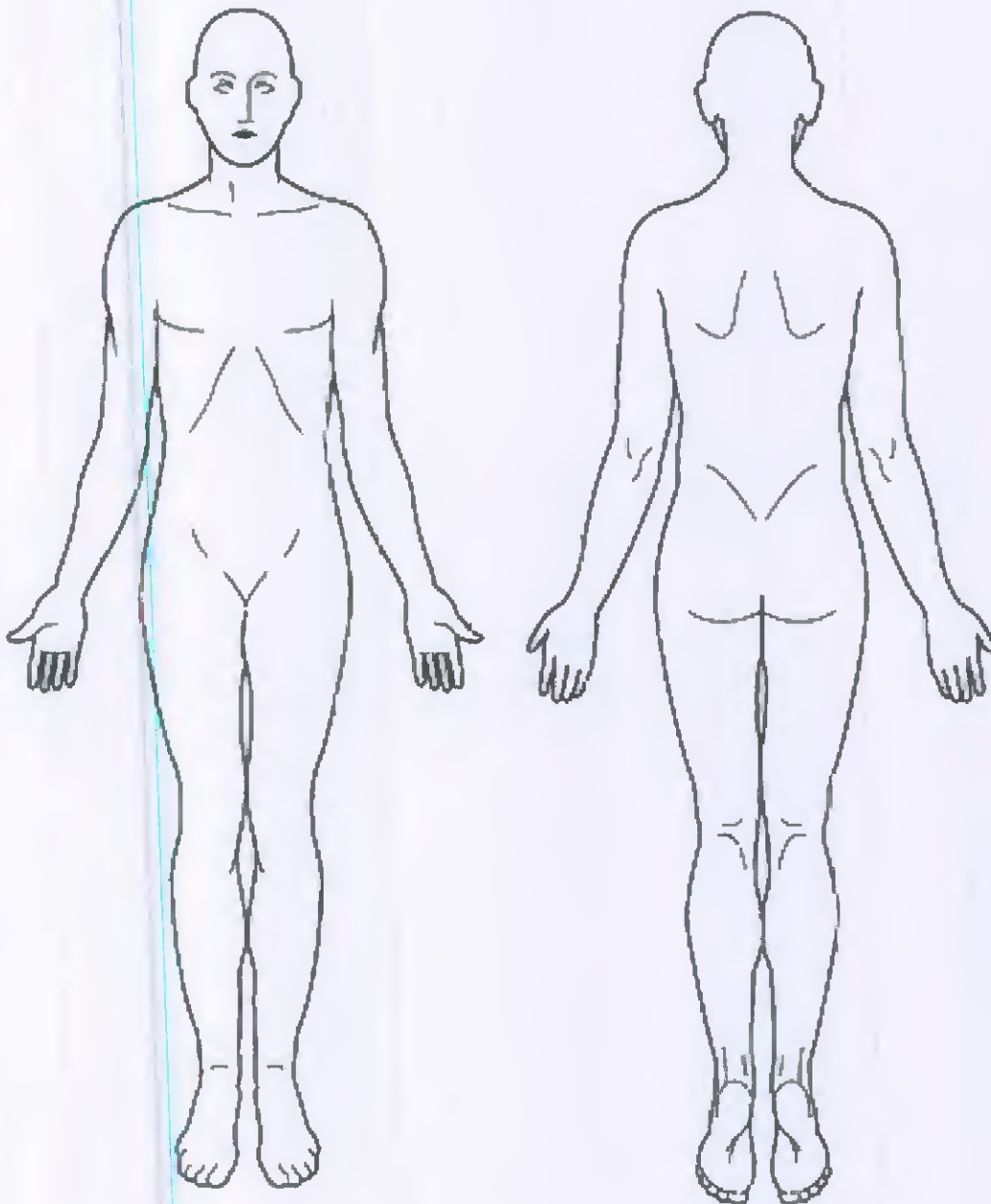
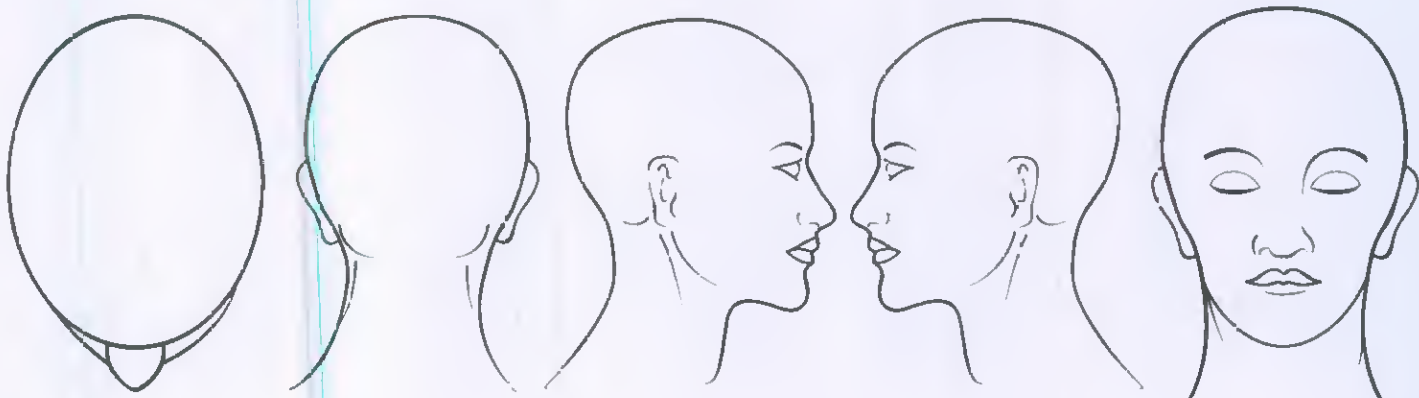
BM:

Temp: (°C)

NEWS:

CHI no
First name DOB / /
Last name Sex: ☐ M ☐ F
Address
.....
.....
or attach addressograph label here

EMERGENCY DEPARTMENT USE ONLY



CHI no
First name DOB
Last name Sex: ☐ M ☐ F
Address
.....
.....
or attach addressograph label here

ON ADMISSION

ACTIVITIES OF LIVING ASSESSMENT

1. Maintaining a safe environment

PUC insitu

GCS 15/15

2. Communicating

Can communicate an
needs

3. Breathing

RR 50B

4. Eating and drinking

↓ oral intake

↓ fluid intake

5. Eliminating

Fully Continent

6. Washing and dressing

Independent

7. Controlling body temperature

Agitated on transfer

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CHI no

First name DOB

Last name Sex: ☐ M ☐ F

Address

or attach addressograph label here

ACTIVITIES OF LIVING ASSESSMENT

9. Work and social activity

No ISSS

10. Expressing sexuality

12. End of life care

TELPO

ASSESSMENTS/FORMS FOR CONSIDERATION (tick if completed)	
1. Pre-employment	
2. Post-employment	
3. Other	

- | | |
|--|---|
| ☐ 4AT Assessment Tool and TIME Bundle | ☐ Abbey Pain Assessment and Management |
| ☐ Confusion Assessment | ☐ MUST Nutritional Screening/Nutrition Profile |
| ☐ Getting to know me | ☐ Oral Health Assessment |
| ☐ Learning Disabilities Supplementary Information | ☐ Swallow Screening Test |
| ☐ Mobility Assessment | ☐ Fluid Balance Chart |
| ☐ Falls Risk Assessment (Hospital)/Falls Bundle | ☐ FAST Alcohol Screening |
| ☐ Pressure Ulcer Risk Assessment (PURA) | ☐ Glasgow Assessment and Management of Alcohol/GMAWS Score |
| ☐ SSKIN Care Bundle | ☐ Management of Nicotine Addiction (Inpatient) |
| ☐ Assessment and Management of Wounds (including pressure ulcers) | ☐ Peripheral Vascular Catheter (PVC) Bundles |
| ☐ Foot Assessment - CPR for Feet | ☐ Discharge planning |
| ☐ MRSA/CPE Clinical Risk Assessments | ☐ Other (condition specific): |
| ☐ Stool Chart | |
| ☐ Daily Pain Assessment | |

CHI no
First name DOB
Last name Sex: ☐ M ☐ F
Address
.....
or attach addressograph label here

SOCIAL HISTORY

Lives alone? ☒ Yes ☐ Don't know Lives with:
☐ Own home ☐ Rented ☐ Sheltered accommodation ☐ Homeless ☐ Residential care
Type: ☐ Nursing care
Stairs? ☐ Yes ☐ No ☐ Respite care
Disability modifications? ☐ Yes ☐ No
Comments:
Community Support
Services/Care: ☐ Independent ☐ Family support ☐ District Nurse ☐ Macmillan Nurse
☐ Social Care ☐ Voluntary Sector ☐ Community Mental Health Team
☐ Other community teams, e.g. ICST, CARS, etc.
Care Type: ☐ Medicine prompts ☐ Meal cover ☐ Personal care (including continence management)
Details:

OBSERVATIONS

Immediate Physiological Observations:
Temperature (°C) 36.6 °C Resp. Rate (/min) 18
Pulse (bpm) 104 O2 sat on air 99.
BP lying (mmHg) 103/64 O2 sat on % O2
BP standing (mmHg) BM
NEWS Score:
Other Observations:
Height (m) (actual/estimated) Body Mass Index (BMI)
Weight (kg) (actual/estimated) Peak Flow (L/min)

URINALYSIS

Leucocytes	Ketones
Nitrites	Glucose
Protein	MSSU ☒ Yes ☐ No
pH	Pregnancy Test? ☐ Yes ☐ No Result:
Blood + + + +	
Specific Gravity	

Completed by: (PRINT NAME) Signature:
Kirsten Lisa
Designation: S/w Date: 27.3.21 Time: (24 hour)

CHI no: 
First n: 1808785142
Last n: 18/08/1978 F
Addre: MCCracken Isabel
1d Cumberge Crescent
Coatbridge
Lanarkshire ML5 4PX

Admitting Clinician: R. DOWNIE
Responsible Consultant:
Admitting Consultant: (if different from above)

MEDICAL HISTORY 27/3/21 Time of assessment: : (24 hour)

Presenting complaint:

GP ref: vomiting + diarrhoea (no other)
pyrexia + loin pain

History of presenting complaint:

42 F | Takeaway last weekend
2/7 diarrhoea after this => Bowel now opening
vomiting -> has lasted all week 17/08/21
5x day
foodstuffs & blood.
has been trying to drink + eat
1-4/10 + often.

Developed intermittent lower back pain
↳ radiating from lumbar region
around to anterior abdomen/groins
bilaterally
comes in waves. NOT affected by movement
paracetamol / co-dydramol / tramadol (friends)
not helped.
Rigorous / intermittently hot + shivery. ↓ energy

Past medical and surgical history:

Date/Duration Emotionally unstable AD
Previous back pain - "slipped disk"
- feels different as radiating
now

CHI no
First name DOB
Last name Sex: ☐ M ☐ F
Address
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or attach addressograph label here

SYSTEMS REVIEW

Cardiac:	nil	Other: blood stained
Respiratory:	nil	when blown nose
Gastrointestinal:	as HPC	
Genitourinary:	nil	
Neurological:	nil	- no lower limb symptoms
Locomotor:	nil	

FAMILY HISTORY

LIFESTYLE

Smoker?	☐ Never	☐ Ex	☒ Current	Amount: 6
Patient exposed to second hand smoke at home?	☐ Yes	☐ No		
☐ Patient advised regarding No Smoking Policy				
Alcohol intake: 1-2 monthly units/week	[National alcohol unit guidelines - no more than 14 units per week for men and women]			
Recreational drug use?	☐ Never	☐ Ex	☒ Current	
Details:	cannabis - nil this week			
Recent travel?	☐ Yes	☐ No	Drives?	☐ Yes ☐ No
If yes details:				

not working
lives w/ son age 11
independent

MEDICINES RECONCILIATION

Details obtained from:

☐ Patient's Own Drugs (PODs) ☐ Relative/Carer ☐ GP phone call
☐ Community Pharmacist ☐ Patient ☐ GP letter
☐ Emergency Care Summary ☐ Other: (specify)

[illegible]

Non-prescription medicines including herbal/homeopathic/over the counter medication

Antibiotics checked? (Route/Indication/Duration - record on cardex)

☐ Yes ☐ No

Medication history recorded by: (PRINT NAME)	Signature:	Date: / /
	Designation:	Time: : (24 hour)

Known drug allergies? (drug name and type of reaction)	☐ Yes ☐ No	Patient's own drugs stored: ☐ Not available ☐ POD locker ☐ Fridge ☐ Drug cupboard/trolley ☐ CD cupboard ☐ Returned to patient ☐ Taken home by relative/carer
Known non-drug allergies?	☐ Yes ☐ No	Signature:
Red wristband applied? (☐ N/A pre-assess)	☐ Yes ☐ No	

☐ Self medicates ☐ Drugs supported by relative/carer
 Compliance Device filled by/MAR Chart: ☐ Relative ☐ Chemist: (specify)
☐ Care at Home Service Level of Medication support: ☐ A ☐ B ☐ C ☐ D

Pharmacist/Pharmacy Technician Comments: Pharmaceutical Care Plan started? ☐ Yes ☐ No

Pharmacist/Pharmacy Technician: (PRINT NAME)	Signature:	Date: / /
	Contact number:	Time: (24 hour)

Patient Name
ISABEL MCCracken

CHI
1808785142

Date of Birth
18-Aug-1978

Age
42

Last Emergency Care Summary received 25-Mar-2021

Details obtained from:							
PODs		Relative		GP phone call		Community Pharmacist	
Patient		GP Letter		ECS with consent		Other	
Other Details							

Repeat Medication								
Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Continue	Withhold	Stop
Quetiapine 150mg tablets	28 tablet	ONE TO BE TAKEN AT NIGHT Instalments: dispense weekly		28-Feb-2020	12-Mar-2021	✓		
Quetiapine 25mg tablets	84 tablet	TWO (50MG) IN THE MORNING AND ONE (25MG) AT MIDDAY Instalments: dispense weekly		28-Feb-2020	12-Mar-2021	✓		
Hydroxocoba amin 1mg/1ml solution for injection ampoules	1 ampoule	AS DIR		06-Jan-2020	12-Mar-2021	✓		
Co-dydramol 30mg/500mg tablets	224 tablet	TAKE 1 OR 2 EVERY 4-6 HRS		29-Mar-2007	12-Mar-2021	✓		
Diazepam 2mg tablets	168 tablet	3 TWICE A DAY DISPENSE WEEKLY		10-Dec-2014	12-Mar-2021	✓		
Zopiclone 7.5mg tablets	28 tablet	ONE AT NIGHT WEEKLY DISPENSE		10-Apr-2015	12-Mar-2021	✓		
Adcal-D3 750mg/200unit caplets (Kyowa Kirin Ltd)	56 tablet	1 TABLETS TWICE A DAY		22-Mar-2019	12-Mar-2021	✓		
Citalopram 40mg tablets	28 tablet	1 TABLET DAILY Instalments: dispense weekly		15-Nov-2018	12-Mar-2021	✓		
Co-dydramol								
Diazepam								
Zopiclone								
Adcal-D3								
Citalopram								

Acute Medication (including those greater than 30 days)								
Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Continue	Withhold	Stop
Etoricoxib 60mg tablets	28 tablet	1 OR 2 TABLETS ONCE DAILY		25-Mar-2021	25-Mar-2021			

Patient Name
ISABEL MCCrackEN

CHI
1808785142

Date of Birth
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Age
42

Acute Medication (including those greater than 30 days)

Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Continue	Withhold	Stop	Comments
Desogestrel 75microgram tablets	336 tablet	1 TABLET ONCE A DAY		08-Oct-2020	08-Oct-2020	☒	☐	☐	
						☐	☐	☐	
						☐	☐	☐	

Non-prescription medicines including herbal/homeopathic/over the counter medication

Drug ID	Formulation	Comments

Known drug allergies?
Enter details below:

Yes/No

Known non-drug allergies?

Yes/No

Allergy Description

Date Recorded

Comments

H/O: drug allergy	19-Sep-2007	Diclofenac potassium 50mg tablets
No known allergies	19-Jul-1994	

How does patient take medication?

- ☐ Self Medicates ☐ Drug supervised by carer
☐ Compliance device filled by: ☐ Relative ☐ Chemist, specify:

Medication History Confirmed By:

Name:

Signature:

Date/Time:

Name:

Signature:
Contact No:

Date/Time:

Pharmacist/Pharmacy technician Comments:

Care Plan Started? Yes ☐ No ☐

delivery on Thursday

Patient Name
ISABEL MCCRACKEN

CHI
1808785142

Date of Birth
18-Aug-1978

Age
42

Last Emergency Care Summary received 25-Mar-2021

Details obtained from:						
FODs	☒	Relative	☐	GP phone call	☐	Community Pharmacist ☒
Patient	☒	GP Letter	☐	ECS with consent	☒	Other
Other Details						

Repeat Medication									
Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Continue	Withhold	Stop	Comments
Quetiapine 150mg tablets	28 tablet	ONE TO BE TAKEN AT NIGHT Instalments: dispense weekly		28-Feb-2020	12-Mar-2021	✓			
Quetiapine 25mg tablets	84 tablet	TWO (50MG) IN THE MORNING AND ONE (25MG) AT MIDDAY Instalments: dispense weekly		28-Feb-2020	12-Mar-2021	✓			
Hydrocortisone 1mg/1ml solution for injection ampoules	1 ampoule	AS DIR		06-Jan-2020	12-Mar-2021				had recently
Co-dydramol 30mg/500mg tablets	224 tablet	TAKE 1 OR 2 EVERY 4-6 HRS		28-Mar-2007	12-Mar-2021			✓	on paracetamol
Diazepam 2mg tablets	168 tablet	3 TWICE A DAY DISPENSE WEEKLY		10-Dec-2014	12-Mar-2021	✓			Accl 2mg TDS
Zopiclone 7.5mg tablets	28 tablet	ONE AT NIGHT WEEKLY DISPENSE		10-Apr-2015	12-Mar-2021	✓			changed to PRN
Accel-D3 750mg/200unit caplets (Kyowa Kirin Ltd)	56 tablet	1 TABLETS TWICE A DAY		22-Mar-2019	12-Mar-2021	✓			
Citalopram 10mg tablets	28 tablet	1 TABLET DAILY Instalments: dispense weekly		15-Nov-2018	12-Mar-2021	✓			
Citalopram	20mg tablets - 2 tabs daily					✓			

Acute Medication (including those greater than 30 days)									
Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Continue	Withhold	Stop	Comments
Etoricoxib 60mg tablets	28 tablet	1 OR 2 TABLETS ONCE DAILY		25-Mar-2021	25-Mar-2021				NOT RXD

Patient Name
ISABEL MCCRACKEN

CHI
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Date of Birth
18-Aug-1978

Age
42

Acute Medication (including those greater than 30 days)								
Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Continue	Withhold	Stop
Desogestrel 75microgram tablets	336 tab'et	1 TABLET ONCE A DAY		08-Oct-2020	08-Oct-2020			

Non-prescription medicines including herbal/homeopathic/over the counter medication

Known drug allergies? Enter details below:	Yes/No
diclofenac	
Known non-drug allergies?	Yes/No

Allergy Description	Date Recorded	Comments
H/O: drug allergy	19-Sep-2007	Diclofenac potassium 50mg tablets
No known allergies	19-Jul-1994	

How does patient take medication?			
☐ Self Medicates	☐ Drug supervised by carer	MINT PHARMACY	
☐ Compliance device filled by:	☐ Relative	☒ Chemist, specify:	01236 437354
WEEKLY DISPENSING			
Medication History Cnfrmed By:	Name:	Signature:	Date/Time:

Name: KERRY MCCOURE	Signature: Contact No: K.McCoure	Date/Time: 29/05/21 @ 10:05
Pharmacist/Pharmacy technician Comments: #404828		Care Plan Starlec? Yes ☒ No ☐

CH

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1d Cumberae Crescent

Coatbridge

Lanarkshire

ML5 4PX

INVESTIGATIONS AND RESULTS

Results

Analyte	Units	Reference Range	Date 26/3/21	Date	Date	Date
Biochemistry			Time 1815	Time	Time	Time
Sodium	mmol/L	133 – 146	127			
Potassium	mmol/L	3.5 – 5.3	2.0			
Chloride	mmol/L	95 – 108	92			
Bicarbonate	mmol/L	22 – 29	17			
Urea	mmol/L	2.5 – 7.8	8.9			
Creatinine*	umol/L	60 – 120**	118			
*If AKI - see guidance available via hyperlink in Lab browser						
eGFR	ml/min	> 59	49			
Glucose	mmol/L	3 - 6	8.7			
Amylase	U/L	0 – 100				
ALT	U/L	< 50	16			
Alk Phosphatase	U/L	30 – 130	385			
Bilirubin	umol/L	< 21	53			
Albumin	g/L	35 – 50	28			
Gamma-GT	U/L	M< 90, F<55				
Total Protein	g/L	62 – 82				
Globulin	g/L	21 – 37				
Adjusted calcium	mmol/L	2.1 – 2.6				
Magnesium	mmol/L	0.7 – 1.0	0.61			
CK	U/L	40-320 M, 25-200 F				
TNT	ng/L	<14				
CRP	mg/L	<6	239			
Lactate	mmol/L	0.6 – 2.4	4.7			
Blood Gases						
Inspired O2						
H+	nmol/L	36 – 43				
pCO2	kPa	4.6 – 6.0				
pO2	kPa	10.5 – 13.5				
Bicarbonate (calculated)	mmol/L	20 – 28				
Oxygen saturation	%					
Haematology						
HGB	g/dL	M 13.5 – 18.0, F 11.5 – 16.5	141			
WBC	X10^9/L	4.00 – 11.00	17.0			
PLT	X10^9/L	140 – 450	33			
MCV	fL	80.0 – 100.0	83.5			
ESR	mm/hr	M Age / 2 F, (Age-10) / 2				
PT Ratio		0.82 – 1.18				
PTT Ratio		0.85 – 1.13				
Fibrinogen (Clauss)	g/L	1.5 – 4.5				
D-Dimer	ng/ml		1942			
B12	pg/ml	155 – 1100	1942			
Folate	ng/ml	2.8 – 12.4				
Ferritin	ng/ml	M 28 – 285, F 14 – 186				
Other						
Lymphocytes			0.4			

**Age related reference ranges apply

Admission Record | Adult Inpatient Services | NHS.uk | Pub. date: Jan. 2019 | Review date: Dec. 2019 | Issue No. 1.2

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CHI no
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Last name Sex: ☐ M ☐ F
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Adult Risk Assessment for Venous Thromboembolism (VTE)

(Excludes Orthopaedics/Obstetrics who have specialty-specific policies)

(Adapted from GG&C VTE Risk Assessment Tool with permission)

- VTE Risk assessment must be completed for all patients on admission - sign and date as specified below
- Patients must be reassessed every **48 hours** or sooner if condition changes
- Assessment must be documented in Medicine Prescription Form
- Provide patient with information leaflet on VTE prevention

Non-operative Patients Start Here (mainly medical)

Is the patient bed-bound or expected to have reduced mobility relative to normal state for ≥ 2 days?

☐ YES

☐ NO

Patients for Surgery

Does the patient have any **Risk Factors for Thrombosis?** (tick all that apply)

- | | |
|--|--|
| ☐ Age >60 | ☐ Use of oestrogen-containing contraceptive therapy |
| ☐ Active cancer or cancer treatment | ☐ Use of hormone replacement therapy |
| ☐ Dehydration | ☐ Pregnancy or <6 weeks post partum (seek specialist advice) |
| ☐ Known thrombophilias | ☐ Critical care admission, e.g. HDU/ITU |
| ☐ Obesity (BMI >30) | ☐ Varicose veins with phlebitis |
| ☒ Current significant medical conditions, e.g. diabetic keto-acidosis, serious infection, heart failure, respiratory disease, inflammatory disease | ☐ Total anaesthetic and surgical time >90 minutes |
| | ☐ Surgery involving pelvis or lower limb with a total anaesthetic and surgical time >60 minutes |
| | ☐ Acute surgical admission with inflammatory or intra-abdominal condition |
| | ☐ Hip fracture |
| | ☐ Personal history or first degree relative with a history of VTE |

- No thromboprophylaxis required
 - Continue to reassess every 48 hours or sooner if condition changes
 - Record all reassessments in Medicine Prescription Form
- Risk Assessment Now Complete**

Pre-assessment Nurse Signature:
(if applicable)

Date: / /

☒ **YES**, 1 or more Risk Factors identified

☐ **NO** Risk Factors identified

Does the patient have any **Contraindications to Pharmacological Prophylaxis?** (tick all that apply)

- | | |
|--|--|
| ☐ Acute stroke | ☐ Neurosurgery, spinal or posterior eye surgery |
| ☐ Head injury with suspected intracranial bleed? | ☐ Day case thyroid surgery |
| ☐ Active bleeding, including suspected concealed bleeding | ☐ Lumbar puncture, epidural/spinal anaesthesia within the previous 4 hours OR expected within the next 12 hours |
| ☐ Acquired bleeding disorders, e.g. acute liver failure | ☐ Other procedure with high bleeding risk - discuss with senior if unsure |
| ☒ Thrombocytopenia ($<75 \times 10^9/l$) | ☐ Concurrent use of other anticoagulants including treatment dose heparin, Vit K antagonists e.g. Warfarin (INR ≥ 2), NOACs e.g. rivaroxaban, apixaban, edoxaban, dabigatran. |
| ☐ Uncontrolled hypertension (230/120 mmHg or higher) | ☐ Senior clinician decision not to prescribe pharmacological prophylaxis (specify reason in clinical notes) |
| ☐ Untreated inherited bleeding disorders, e.g. haemophilia or von Willebrands | ☐ Other, specify: |

*Contraindications to Anti-Embolism Stockings (AES):

- Peripheral neuropathy
- Peripheral vascular disease
- Cellulitis or gross oedema
- Leg deformity or fragile skin
- Leg/foot ulcers

☐ YES ☐ NO

☐ **NO** contraindications to Pharmacological Prophylaxis identified

☒ **YES** contraindications to Pharmacological Prophylaxis identified

- **Medical patients - Enoxaparin 40mg**
- **Surgical patients - Enoxaparin 40mg + Anti-Embolism Stockings** (*unless contraindicated)
- Prescribe Enoxaparin at 6pm (on the day of surgery, at the later of 4hr post-op or 6pm)
- **Reduce Enoxaparin to 20mg if <50kg or eGFR <30**

Discontinue at discharge or when returned to pre-morbid mobility

Doctor Name: (PRINT)

Signature:

Grade:

Date: / /

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

Outcome of VTE Risk Assessment

	Yes	No
VTE Risk Factors assessed?	☐	☐
Contraindications to pharmacological prophylaxis assessed?	☐	☐
Treatment prescribed? ☐ LMWH ☐ AES ☐ None		
Patient informed of risks and benefits of VTE thromboprophylaxis? ☐ Not applicable	☐	☐
Patient information leaflet provided?	☐	☐

Ent block - ARI & K/Ne, Plac
 ? genuine

CONSULTANT REVIEW
Consultant Assessment, Diagnosis and Treatment Plan

Personality disorder
 Back pain
 Ruptured
 vomiting/diarrhoea
 Urinary → gram pos. infect
 Ate takeaway prior to onset?
 COVID vaccine Thu 25/3

WCC188
 Bleeds TBili/ALP Pt 44 CR 212
 U&E ? PM2/12 cons
 ECG S today 13p
 LFT ? not done
 MWS (2) 104/ P 99

(R) well composes @
 Abdo soft

- 1. Fever ? urinary
- 2. Repeat COVID test and full pt
- 3. Possible food poisoning as differential

(P) Anx/ret/get
 COVID test
 Cultures - blood, urine, stool
 USS abdo (T-CT)
 Dlx haem re LFT
 B12/FH/TPT/RBV scer
 → full escalation
 Dlx surgeon if unimproving confirms cholangitis/
 cholecystitis etc
 IVI resus - further 500-1000ml then reassess

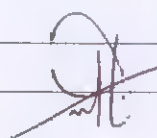
PRINT NAME: D. W. H.
 Signature: [Signature]
 Date: 27/3/21
 Time: 8.45 (24 hour)

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CHI no.
 First name DCB
 Last name Sex: ☐ M ☐ F
 Address

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Date/Time	MULTIDISCIPLINARY TEAM NOTES	Signature/Designation
28/3 16 ⁰⁰	P. Lyons consult. Meds: Amox/Clav/Gent 22 Quetiapine VTE: Not Rx (UPIK) NEWS = 2 (BP 102/65 HR 96) (6) Feels better today. Only vomited 1x today. Has ongoing stomach/bach pain. No diarrhoea. Still not eating much. Trying to drink. olt:  HSI + E + O BP 102/65 SpO2 99% on HR 96 + regular RR 17  Very tender Appraisal Soft Calves SNT Assessment: -? Biliary sepsis ongoing. ? Pancreatitis. - CRP + WCC ↑ however, subjectively seems better so I hope the time a comes. Plan: ① Add ampicillin ② Cont. to Triple Therapy ③ If deterioration → escalate to Tazocin ④ sending cultures ⑤ Analgesia ⑥ Anti-emetics ⑦ Folic Acid ⑧ IVs	

 P. Lyons
 MRCP

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CT	1808785142	
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Li	MCCRACKEN Isabel	
A	1d Cumberae Crescent	
Coatbridge		
Lanarkshire ML5 4P>		

Date/Time	MULTIDISCIPLINARY TEAM NOTES	Signature/Designation
29/03/21 09:55	PHARMACY Patient usually takes Diazepam 6mg twice a day. Currently only prescribed 2mg three times a day. Please consider increasing to 6mg BD. Thanks Kerry McCauley (PHARMACIST, #40402)	
29.3.21 1345	WR WdI 42♀. Personality disorder Musculoskeletal back pain D+V Lumbar back pain Inflammatory response Thrombocytopenic, wog @, Fibr, d-dimer TT (note recent covid vaccine) Deranged LFTs + electrolytes. Drinks 4 cans Budweiser / fortnight. Plt 23 → 67 Hb 141 141 → 113 WCC 17 → 27.8 Folate ↓ → replacement. Film: genuine thrombocytopenia, rouleaux, occasional red cell fragment CRP 239 → 197. NR/k improving No LFTs 2yr. BP 116/75 HR 82 T36.5 HR 82 RR 17 SpO2 98% RA Abdo soft. Tender RUQ Abdo discomfort improves with defecation - now formed stools.	

Date/ Time	MULTIDISCIPLINARY TEAM NOTES	Signature/ Designation
	still vomits with PO intake.	
	Plan → antiemetics analgesia continue amox / met / gent triss this pm. daily bloods incl coag please. could move from S/R if necessary	
		CONSTANT COWS 404571
	Bloods - EGFR >59 CRP 155 (197) ALP 176 (213) ALb 23 (26) Hb 114 (113) PLTS 119 (67) WCC 21.2 (27.8)	
		ACONUS NORM
30/3/24 09:15	WE CT3 Machine (42) Background: EUPD + MSK back pain	
	Issues: ① D&V - now improving - no stool cultures ② Electrolyte derangement - improved ③ Inflammatory response - on Amox / Met / Gent. D4 - BC no growth, MSK - no growth	
	NEWS = 1 (BP 109/57) afebrile	
	Feeling slightly better today - reports 5 failed	

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CHI
First 1808785142
Last 18/08/1978 F
Add MCCracken Isabel
1d Cumberdale Crescent
Coatbridge
Lanarkshire ML5 4PY

Date/Time	MULTIDISCIPLINARY TEAM NOTES	Signature/Designation
	CT3 Macrae cont. Stools in past 24^h. Vomitted once this morning - nausea settled following antiemetics. C/O back pain - radiating to groin, like normal 'spasms' but worse - controlled with analgesia O/E. sitting up in bed. WNV? mucous membranes moist  Abdomen soft, non-tender Plan - Stop antiemetic (had 4 doses) - Update bloods today - Continue analgesia & antiemetics - Push PO fluids - ? IVOST if sustained improvement	
3/8/21 09.25	CT3 Macrae ward round (42) issues: ① D&V - no further vomiting - reports further loose stools ② Electrolyte derangement K 2.6 yesterday → on replacement ③ Inflammatory response CRP ↓, ↑WCC BBV -ve ↓Albumin ④ Back pain - longstanding - improved NEWS = 1 (HR 99, afebrile) Feeling much better than when she came in still sleepy. NA v better - managing PO	CT3 PTU

CHI

First

1808785142

Last

18/08/1978

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Last

MCCRACKEN

Isabel

Addi

1d Cumberae Crescent

Coatbridge

Lanarkshire

ML5 4PY

Date/Time	MULTIDISCIPLINARY TEAM NOTES	Signature/Designation
	CTS Macrae - wake but not further loose stools overnight	
	OK. looks well.	
	WNP. mucous membranes moist	
	Abdomen SNT	
	Plan - continue Amox/Met - ? add Temocillin	
	- update bloods incl. AST, GGT & electrolytes +/- replacement as indicated	
	- Stool culture x 3	
	- CT AP	
	Wre screen depending on LFTs	CTS
31/3/21	Microbiology consult - 2117. Dr Salisbury	
1050/	Gram variable ? +ve ? urinary sepsis	
	Ⓟ Dr McCrae will call back.	
		Achushchm.
31/3/21	CTS Macrae	
	- Phoned back Dr Soulsby (micro)	
	- ⊕ BC	
	- Difficult to determine if Gram -ve / +ve at present	
	- Agrees Amox/Met/Temocillin would provide good cover until full CBS tomorrow	CTS
1/4/21	WR wd. 12.	
0940.	Diagnosis unclear	
	- sepsis unclear source	after several days Abs
	gram variable organism in BC	
	presented i D+V, back pain	
	deranged LFTs	
	ISS non-diagnostic, CT awaited.	

Admission Record | Adult Inpatient Services | NHS | Pub. date Jan. 2019 | Review date: Dec. 2019 | Issue No. 1.

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18/08/1978

MCCRACKEN Isabel

1d Cumberae Crescent

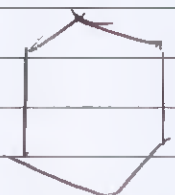
Coatbridge Lanarkshire

ML5 4P*

Date/Time	MULTIDISCIPLINARY TEAM NOTES	Signature/Designation
	News 0. Afebrile, haemodynamically stable.	
	Looks better	
	Eating / drinking / requesting to smoke!	
	Axido SNT BS @	
	Plan -> await CT + further BC information. if no deep seated infection could consider IVOST with a view to DC 24-48°.	
	Nicotine replacement	consistently cons.
01/04/21	CT3 Macrae	
17.05	CT AP - extensive superior mesenteric thrombus	
	- updated patient	
	- she is on contraceptive pill, unsure if oestrogen containing	
	- not had covid vaccine	
	Referred to surgical team for R/V	
	- surgical registrar scrubbed in theatre so referred to SHO who D/W senior	
	D/W Haematology SpR - advises depending on surgical plan should be for treatment dose LMWH & then likely warfarin 3-6/12	
	if oestrogen based contraception - should be stopped & avoided in future.	
	After bank holiday send JAK2 & paroxysmal nocturnal haematuria screen (2x GATA)	
	Re-discuss with haematology next week or earlier if any issues - may need longterm haematology f/u.	CT3

CHI no
 First name DOB
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

Date/Time	MULTIDISCIPLINARY TEAM NOTES	e/c Cons.	Signature/Designation
	A MACLEOD ST4	[Mr. Maung]	
01/04/21 2300.	(42) + CT: extensive SMV thrombosis. BG: EuPD Chronic Back Pain		
		W DID NOT HAVE COVID- VACCINE	
	Admitted 26/3/21		
	• D+V - ? ² take-away. (107 Hx)		
	• AKI + deranged electrolytes → now improved (Cr 118 → 49.)		
	• Jepsis ? source. CRP 200. WCC 16 (300).		
	↳ +ve BCx 27/3 (Gram Variable bacilli - further Cx ongoing.)		
	• ALFTs → now improved Bil 53 → 14 ALP 385 → 230 ALT 20.		
	• Thrombocytopaenia. Plts 33 → Now 216. D-dimer 1900 → 1687.		
	→ Note haem input 27/03 & today.		
	CT today given ongoing CRP and no clear diagnosis		
	• extensive SMV thrombosis to confluence of PV (no PV thromb.)		
	• Peri-partial oedema		
	• No I/H or E/H Biliary dilatation		
	• Liver ⊖.		
	• D2/O3 thickened & oedematous → no cause seen		
	• Trace free fluid @ paracolic gutter + pelvis		
	→ no free air, bowel compromise		
	ok: fws = 1 RR 16 Sat 99% BP 103/58 P 87 T: 36.5.		
	Pain now settled Diarrhoea improving no further vomiting		Soft non tender No guarding / peritonism

Fir: 1808785142
 Las: 18/08/1978 F
 Ad: MCCracken Isabel
 1d Cumbræ Crescent

Coatbridge
Lanarkshire ML5 4PX

Date/ Time	MULTIDISCIPLINARY TEAM NOTES	Signature/ Designation
	<u>Imp:</u> ? infective Gallstones → dehydrated → status + thrombus vs. thrombotic precipitating symptoms. (but thrombocytopenic on admission!)	
	<u>Plan:</u> Cont IV A/m/G 3x stool Cx Can E+D → not for surgery @ present Happy for LMWH Aware that if deteriorate may require surgery but this would be life-threatening if thrombus were to cause ischaemia given its extent. Clarity weight	
	1 mtdl w Mr Manning re T.O.C → given complex haem issues may be best to remain under joint care but we will r/v mins	
02/04/20	R/V CT3 Macra 1500 (42) Surgical R/V noted - many thanks	
	NEWS=4 (HR 114, BP 95/59, afebrile)	
	<u>Bloods</u> K 3.3 CrP 155 (207) Hb 103 urea 1.6 WCC (18.7) (16.9) creat 49 plt 281	
	Feeling well. Abdominal pain settled Loose stools x 2 (24h) wants to go home.	
	BC - still awaiting full report (Gram variable bacilli) Stool C&S in progress	
	<u>Plan</u> Continue Amox/Met/Temo pending BC result Continue LMWH Surgical R/V if deteriorate	

CH

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University Hospital:

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☐ Monklands

☐ Wishaw

Other:

Ward:

Locality/Team:



Multidisciplinary Clinical/
Continuation Notes

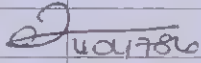
Sheet No:

Date/Time	Multidisciplinary Clinical/Continuation Notes	Signature/Designation
3/4/21	H. Talwar FYI - wle ilv	
12:15	Hx noted.	
	(42) Alw d/v /naics / abdo pain + ↳ CT AP reveals extensive superior mesenteric thrombus.	
	Issues	
	1) mesenteric thrombus - surgical rlv noted, for ? joint-core, surgeons to rlv again today (?) - On umwh as per team advice - Rr re-d/w surgery if deteriorates.	
	2) Abdo pain & diarrhoea - Needs 3x stool samples for c+s. - On amox/met. gent . Gentamicin stopped. - Bcr: still awaiting full report.	
	Now	
	NEWS=2, BP 104/50 ↔ , HR 101 , apyrexial >48°	
	Bloods 3/4: u+es ↔ K+ (N) . CRP ↓ 124 (135) LFTs ↔ /improving WCC ↓ 11.5 (18.7) Mg 0.52	
	Isabel feeling well, eager to get home for ease). Abdo pain settled. Occasional nausea still, antiemetics helping. Ongoing loose stools ~ 2-3x/day. E + D well. No issues PU.	Explained why needs to stay & Isabel understanding
	O/E: HS 1 + 11 + 0 pulse reg + good volume	
	SNT BS ✓	
	Plan	
	1) continue IV amox + met , ? IVOST tomorrow	
	2) continue umwh, ? start waitain w. bridging umwh - will d/w senior	
	3) PO Mg replacement + stop sando-k	



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Date/Time	Multidisciplinary Clinical/Continuation Notes	Signature/Designation
3/4/21	H. Talwar FY1	
17:00	Phone call to Dr Jaffer (SHO surgery) re entry from 01/04/21 from surgery stating for re-rlv by surgery. Explained will need established on long term anticoagulant for thrombus but this may be put off til after surgery if patient was for surgery. Dr Jaffer will kindly clarify surgical plan for re-rlv.	 18/08/20
3/4/21	H. Talwar FY1	
20:50	Further dltw Dr Jaffer, he apologise not been able to speak with team yet. will notify at handover tonight + they will let me know plan tomorrow.	
4/4/21	H. Talwar FY1	
15:00	Further phonecall to Dr Jaffer (surgical SHO) he informs me surgeons had decided not for intervention at handover but not communicated this. He is going to confirm w. his senior whether Isabel is for future rlv.	
16:00	Verbal handover from Dr Jaffer, surgeons will re-rlv after	
16:30	w/le rlv PM weekend. continue w medical plan until then. ② A/w O+V, rigors, abdo pain. Δ 1) Mesenteric thrombus - Not for surgical intervention at present - On LMWH as per haem advice 2) Diarrhoeal loose stools - 2-3x motions/day. Bloods UTEs ↔ LFTs ↔ Improving. K ⁺ 4.5 Mg 0.55 (0.52)	

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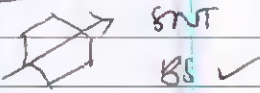
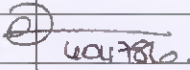
Other: Ward:

Locality/Team:



Multidisciplinary Clinical/
Continuation Notes

Sheet No:

Date/ Time	Multidisciplinary Clinical/Continuation Notes	Signature/ Designation
4/4/21	H. Taiwan cont... CRP 83 (124) Hb 100. WCC 12 (11.5) ↔ pHS 540 - diw 0/ Mann states likely in response to improving fighting infection NEWS=2, BP 105/68, HR 97. Apyrexial. on rlv: Feeling well in herself today, abdo pain settled. Ongoing loose stools. sample given for C+S. OIE  Plan 1) continue IV abx 2) I have put patient out for INR tomorrow, can commence bridging for warfarin if this is plan from tomorrow. 3) if no ↑ in mg levels tomorrow, switch to IV replacement. 4) Surgeons will come monday / tuesday. 	
5/4/21	DLWAZ W12	
1400	Note progress - imaging shows extensive superior-mesenteric vein thrombosis BCs "Seem variable bacilli" and organism failed to grow so no definite species / sensitivity CRP ↓ WCC 16.5 T (?relevance of WCC) NEWS 1 P 92 — I VOST to oral amox, pivmecillinam, metronidazole (Ask micro if alternatives better?) will need to observe response of VOST	

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Date/Time	Multidisciplinary Clinical/Continuation Notes	Signature/Designation
	likely 2/52 abs total clumpy T seen re thrombophilic screening ? @ midweek  Oliver	
	Blun Sum. Olw Dr Andy Blunsum (10 Reg) re: IVOST advised - stop metronidazole x temocillin - co-amox PO for total 7 days - if spikes temp for blood cultures ACHUNGORUM ANP	
6/4/21 1110	<u>wd12 daily RV HANRAADJ GPSTT.</u> 42 ♀ Admitted 27/3/21 fevers, D+V, lumbar- groin pain BG: personality disorder Back pain ① extensive superior mesenteric vein thrombosis CT A/P 11/4/21 on Rx dose tinzaparin - as per dlw Haem 1/4 needs JANZ r paprysmar - nocturnal nausea ^{nausea} screen - clarify if EOCp oestrogen containing - currently joint care with surgeons - Has <u>NOT</u> had covid vaccine ② Blood cultures Gram variable bacilli seen 27/3 IVOST yesterday Had 4/7 Amox/met/cent, then 5/7 Amox/met/tem	

MDT Clinica /Continuation Notes | N-HSL | Page 2 of 2

Pub. date: Feb. 2020 | Review date: 2025 | Issue no: 01

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Multidisciplinary Clinical/ Continuation Notes

Sheet No:

Date/ Time	Multidisciplinary Clinical/Continuation Notes	Signature/ Designation
6/4/24	cont. now on DI co-anoxic Afebrile CRP (67) ↓ (239) WCC 16.5 urine NAD Stool x1 Neg	
	(3) Thrombocytopenic on admission (33) Now 644	
	(4) deranged electrolytes on admission K ⁺ 2.0 Na 127 now resolved.	
	Pt says takes OCP daily with no breaks Has NOT had covid vaccine No personal hx of clots. No family hx she is aware of. - 1x miscarriage in past - feeling well. Diarrhoea settled.	
	Plan (1) thrombophilia screen. (2) clarity with micro abx (3) if spikes temp for BCs. (4) update mag level	CEH HARRISON GPST
	ECG - pt on desogestrel ocp.	
6/4	Dr Singer Haematology (unb666) 1520 unusual for pils to go from 33 → 644. As part of thrombophilia screen, need to document that pt is on anticoagulation & acute clot otherwise results will be inaccurate	

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Locality/Team: _____

Multidisciplinary Clinical/ Continuation Notes

Sheet No: _____

Date/Time	Multidisciplinary Clinical/Continuation Notes	Signature/Designation
7/14/21	cont.	
	Denies chronic cough / haemoptysis Denies wt loss / night sweats. Denies change in bowel habits (except loose stools on admission. Now soft, dark brown. No PR blood / melena) Nil odynophagia / dysphagia Nil haematuria haematuria. Still gets monthly periods News = 1 Hx (HC) Afebrile	
	Imp - Persistent leucocytosis (neutrophilia) since admission - normocytic anaemia, folate deficient. - raised ALP (normal UES), normal Ca ²⁺ , UES - pils now RT. → ? underlying cause ? haematological malignancy ? related to septic cause.	
	Plan ① cont this but I will d/w senior re. switch to DOAC ② myeloma screen ③ ? consider CT chest ④ Add on iron studies, GGT, PTH, vit D, phosphate ⑤ consider tumour markers ⑥ I will refer again to haem	
		CLIA
7/14/21	Discussed c Dr Oliver - advises add on ANCA screen & send urine ACR No need for CT chest. Suggests RT breast exam	CLIA KANDASAS GPST.



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Date/Time	Multidisciplinary Clinical/Continuation Notes	Signature/Designation
7/4/21 1635	<u>V. Gordon FY2</u> - Breast exam Examination explained and patient consented Chaperoned by SN Allan Pt denies any breast lumps, nipple changes or discharge. Also denies any axillary lumps. On inspection no dimpling, puckering of skin, rashes, visible moles, nipple inversion or scars. No palpable masses on palpation. No axillary or cervical lymphadenopathy. Imp normal breast examination.	<u>V. Gordon</u> FY2
8/4/21	<u>OLIVER LIL</u> Δ Green variable haemorrhage (?specific organism, ? source) superior mesenteric vein thrombosis Not clear if - SI upset → clot → haemorrhage - thrombophiles - malignancy Thrombophiles 1x - PNH screen -ve JAK2 / others in progress Myeloma in progress Hv / Hgb / Hct -ve She finished abx today. MWS (2) 1001 PLOS	

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Locality/Team:

Multidisciplinary Clinical/ Continuation Notes

Sheet No:

Date/ Time	Multidisciplinary Clinical/Continuation Notes	Signature/ Designation
8/4/21 (cont)	Diagnosis unclear. well EAD, considered - → finish abx opt B's tomorrow ask for final surgical review and their recommendations re Ix/Dx. D/W been re test ongoing anticoagulation (warfarin vs DOAC?) update blood tomorrow + IV van and CRP settled keep over weekend to check w/ ACR * NOT to board.	
		 D.W. McLeod GMR
8/4/21 1600	D/W surg reg Ann McLeod with d/w surg consultant - suggests u/lie / colonoscopy to ix for underlying malignancy Also CT chest - suggests d/w radiology Advises no surgical intervention required at this point	Cler HAWKINS GPST
8/4/21 1640	D/W Haem reg Towell Advises no licence for DOAC in SMV - would be Warfarin or LMWH. Advises hold off IV iron until he has opportunity to d/w consultant as it can drive response if theres an underlying myelodysplastic malignancy. if Platelets raise >1000 - can then back	pro



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Date/Time	Multidisciplinary Clinical/Continuation Notes	Signature/Designation
	Cont. consider CT - consider CT chest for malignancy - neck too - thinks WUE / colonoscopy is suitable - examine neck for lymphadenopathy. - if anything abnormal on thrombophilia screen, to call them back CLL HANDS GPST	
9/11/21 1100	<u>Ward 12 Review HANDS GPST</u> 41x as previously documented. SMT of unclear cause. Investigations urine ACR: normal thrombophilia screen in progress myeloma screen in progress (SPEP / protein EP) however → IgG (16.7) IgA (6.01) IgM (4.11) News = 3 Hb (118) BP 102/76 feels well & wants to go home. Explained that we need to transition to warfarin & do further investigations Plan ① needs urine BJP sent ② re-discuss with Haem / Dr Oliver re. IV iron? ③ start warfarin today, bridge with tiz until therapeutic ④ Bloods + BC's today. ⑤ will discuss CT chest / WUE / colonoscopy with Dr Oliver	



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Date/Time	Multidisciplinary Clinical/Continuation Notes	Signature/Designation
12/4/24	<u>OLWBZ W12</u>	
1115	Thrombophilic - mild lupus anticoag → to rpt on 12/52 @ PIV	
	→ Clarify with labs re reporting timeline for myeloma screen	
	→ send AMA/C3CL/DSDNA	
	→ Try to expedite CT chest	
	→ Have OGD/clean requests gone in? ☒	
	re BCS, afebrile	
	Possibly ☒ later	
	cc Discharge to our haematologist Mr Mawing can surgeon	
	I will look for CT thorax result re Thromboc and rpt lupus anticoag @ 12/52	
	In absence of malignancy, confirmed thrombophilic or recurrent clots I think that 6/12 anticoag probably reasonable.	
	well. Happy i alone plan	
		OLWBZ LW

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 1d Cumberae Crescent
 Coatbridge
 Lanarkshire ML5 4P>

Hospital: UHM
 Ward: 12



Treatment Escalation Plan (TEP) For Suspected or Confirmed COVID Patients

The **GOALS OF TREATMENT** should be framed by the **CONTEXT** of this admission. Does the patient have:

- Age >70: see Guidance Notes.
- An illness trajectory likely to be in the last 12 months of life?
- Morbid obesity (BMI >40) or poorly controlled diabetes with end-organ damage.
- Advanced disease: organ failure, neurological disease incl. dementia, cancer, multiple co-morbidities.
- An ASA score of ≥ 3 OR Clinical Frailty Score of ≥ 5 (see Guidance Notes) OR is a nursing home resident.
- The 4C Mortality predictor may be relevant in deciding on the need for escalation in patients who have an ASA score ≤ 2 or CFS score ≤ 4 , but who are severely ill. Discussion with ICU team member would be appropriate in such cases.
- Does the patient have specific wishes regarding appropriate / inappropriate medical interventions?

The **CONSEQUENCES** of any intervention or escalation need to be considered, including **futility** and **harms**, along with previously documented treatment/resuscitation preferences.

PATIENT'S UNDERSTANDING of their condition and proposed treatment

☒ Fully aware ☐ Has capacity but retention is uncertain ☐ Lacks decision-making capacity
 If decision-making capacity is impaired, has Section 47 AWI been completed? ☐ Yes ☐ No

GOALS OF TREATMENT

**FULL ACTIVE
TREATMENT***

SELECTIVE TREATMENT**
 Attempt to reverse acute process
if appropriate. Assess progress and
 review goals of treatment regularly.

PALLIATIVE TREATMENT***
 Provide for symptom control
 and comfort care. Ensure dignity
 if dying is imminent.

Treatment Escalation / Limitation in the Event of Deterioration

☒ **FULL ESCALATION**
ICU TEAM ASSESSMENT REQUIRED IF/WHEN PATIENT DETERIORATES*

☐ ** For consideration of Continuous Positive Airway Pressure (CPAP) in designated area or HDU*. Further consultant assessment required.
 (see Guidance Notes)

☐ ** Standard ward-based care only, with no CPAP or further escalation*

☐ *** For end of life care. Symptomatic and comfort measures only

Additional investigations, or treatments that may or may not be appropriate e.g. IV fluids, surgical procedure, imaging, antibiotics (NE. antibiotics are not appropriate for terminally ill patients)

Appropriate:

Inappropriate:

Early Warning Score monitoring (NEWS) appropriate? ☐ Yes ☐ No

CPR

☐ Yes ☐ No

A TELP must ALWAYS be used when a DNACPR order is being put in place



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Patient name: ISABEL MCCracken

CHI number: 1808785142

Discussion

If discussion is not possible at the time of initiating treatment, then it must be planned for the first available time thereafter. An existing ACP/TEP should be respected and used. If the discussion is complex, then a separate note should be written in the hospital record.

This plan has been discussed with:

The Patient

Family/Carers/Power of Attorney

ICU Team

Receiving Specialty

☐ Yes

☒ No

☐ Yes

☒ No

☐ Yes

☒ No

☐ Yes

☒ No

☐ N/A

Name of family member and relationship with whom this was discussed:

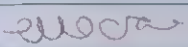
If discussion was not possible for any reason then this should be recorded:

Person Completing this Document - COMPLETING THIS SECTION IS MANDATORY

Print in Capitals:

C MCCRACKEN

Signature:



Responsible Consultant:

Position:

CT3

Date:

31/3/21

Time:

09.00

Initials:

Date:

Guidance Notes

1. This TELP is for use for patients with suspected or confirmed COVID infection. Establishing appropriate GOALS of TREATMENT should determine APPROPRIATE treatments, including limits of escalation. End-of-life care may be a legitimate and important PRIMARY GOAL.

2. ESCALATION TO ICU. If COVID patients are currently stable BUT they deteriorate later on, and escalation to ICU is to be considered, then consultation with ICU team is essential. See other more specific NHSL Guidance Notes. The 4C Mortality predictor may be relevant in deciding on the need for escalation in patients who have an ASA score ≤2 or CFS score ≤4, but who are severely ill. ICU Referral form with patient details is required.

3. ESCALATION TO CPAP. For COVID patients, setting CPAP as the limit for future escalation is often problematic. Commencing CPAP should be a consultant-led decision at the time of deterioration. If a patient deteriorates after CPAP is commenced, then consider carefully the potential need for CPAP withdrawal if it fails. Provision for palliative treatment and a dignified death are essential in this instance. See other more specific NHSL Guidance Notes.

4. AGE. For COVID patients, age is relevant as to outcomes. However, age alone is not a determining factor regarding initial treatment or later escalation.

5. PRE-ADMISSION HEALTH STATUS.

Frailty. Refer to the Clinical Frailty Score (CFS). Consider: if it is 5 or more, then escalation beyond “ward care” or “ward care with palliative treatments” is unlikely to achieve any benefits. For patients of any age with stable long-term disabilities (e.g. autism, cerebral palsy) conduct an individual assessment of frailty. Do not use the Clinical Frailty Score.

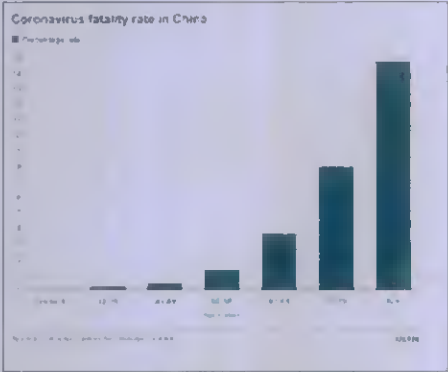
Grade	Category	Description	Grade	Category	Description
3	Managing well	Activity limited to walking	6	Moderately frail	Some problems with stairs, bathing, dressing
4	Vulnerable	Symptoms limit activities	7	Severely frail	Completely dependent for personal care
5	Mildly frail	Needs help with some ADLs	8	Very severely frail	Approaching end-of-life in days or weeks.

Co-morbidities. Refer to American Society of Anaesthesiology (ASA) score. Consider: if it is 3 or more then this should influence a decision against escalation to ICU.

Classification (ASA Grade)	Description
1	Healthy patients
2	Mild to moderate systematic disease caused by a condition or other pathological processes, and medically well controlled
3	Severe disease process which limits activity but is not incapacitating
4	Severe incapacitating disease process that is a constant threat to life
5	Moribund patient not expected to survive

6. PALLIATIVE CARE. Patients who are already or become moribund are unlikely to benefit from escalation and should be given adequate palliative care. Achieving dignity in dying is an important GOAL OF CARE for some patients. Use NHSL Record of End of Life Care, RELC.

Coronavirus fatality rate in China



Age Group	Percentage of Deaths
0-14	0.1
15-24	0.2
25-34	0.3
35-44	0.5
45-54	0.8
55-64	1.2
65-74	2.5
75-84	4.5
85-94	8.5
95-100	13.0

TEP Suspected or Confirmed COVID Patients | NHSL | Page 2 of 2

Pub. date: Oct. 2020 | Review date: Oct. 2021 | Issue No: 01

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Vent. rate 130 BPM
PR interval 150 ms
QRS duration 86 ms
QT/QTc-Baz 288/423 ms
P-R-T axes 33 30 28

REF12104772-001
Patient ID: 1808785142
Sinus tachycardia
Otherwise normal ECG

26.03.2021 18:12:49
Monklands Hospital

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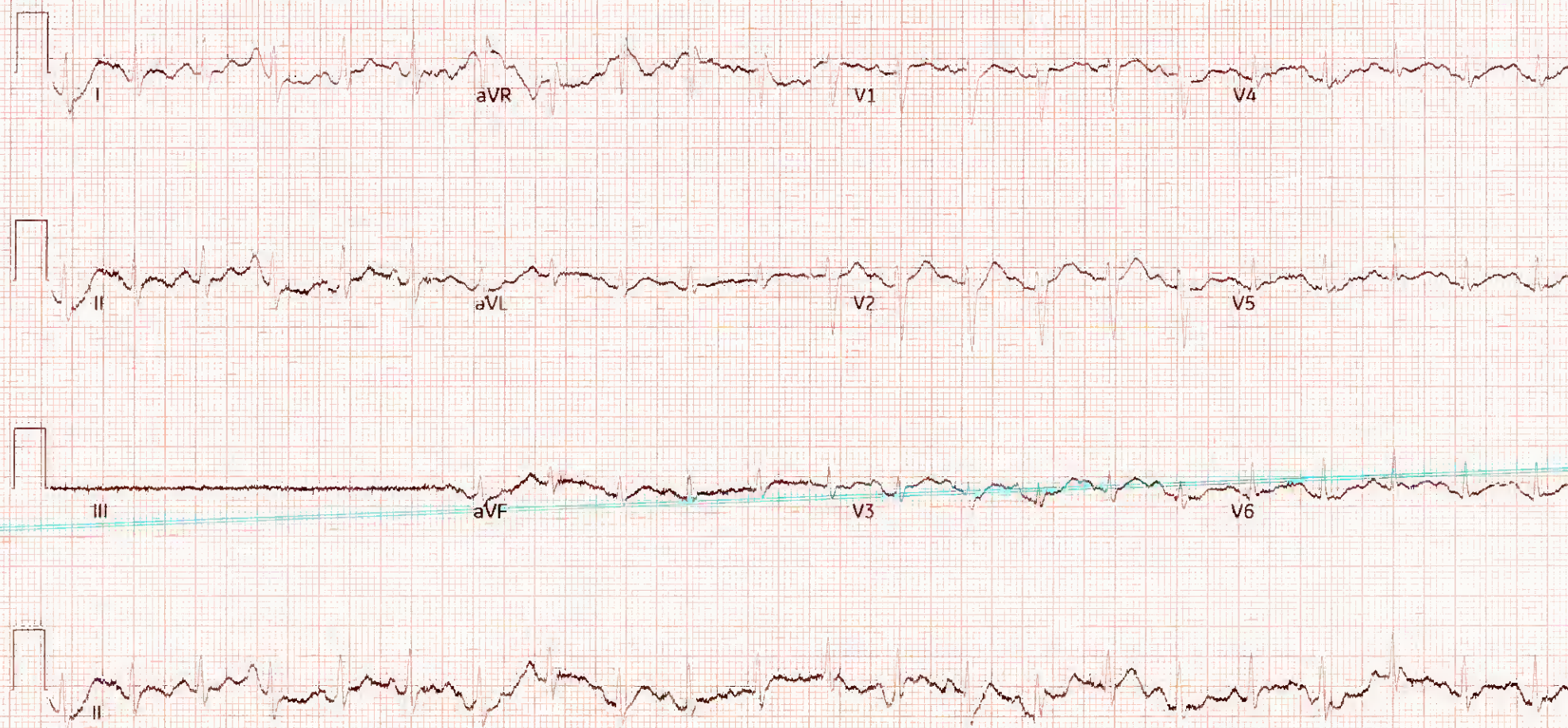
Coatbridge
Lanarkshire

ML5 4PX

Unconfirmed



Location:



Last: MCCracken
First: ISABEL
ID: 1808785142
DOB: 18-Aug-1978
Age: 42 yr
Sex: Female Ref Phy: OLIVER
Tech: hegartyc
Loc: W12

09-Apr-2021 11:42:26

Vent rate 107 BPM
PR int 128 ms
QRS dur 90 ms
QT/QTc 343/406 ms
P-R-T axes 27 34 38

SINUS TACHYCARDIA
ABNORMAL RHYTHM ECG
UNCONFIRMED REPORT

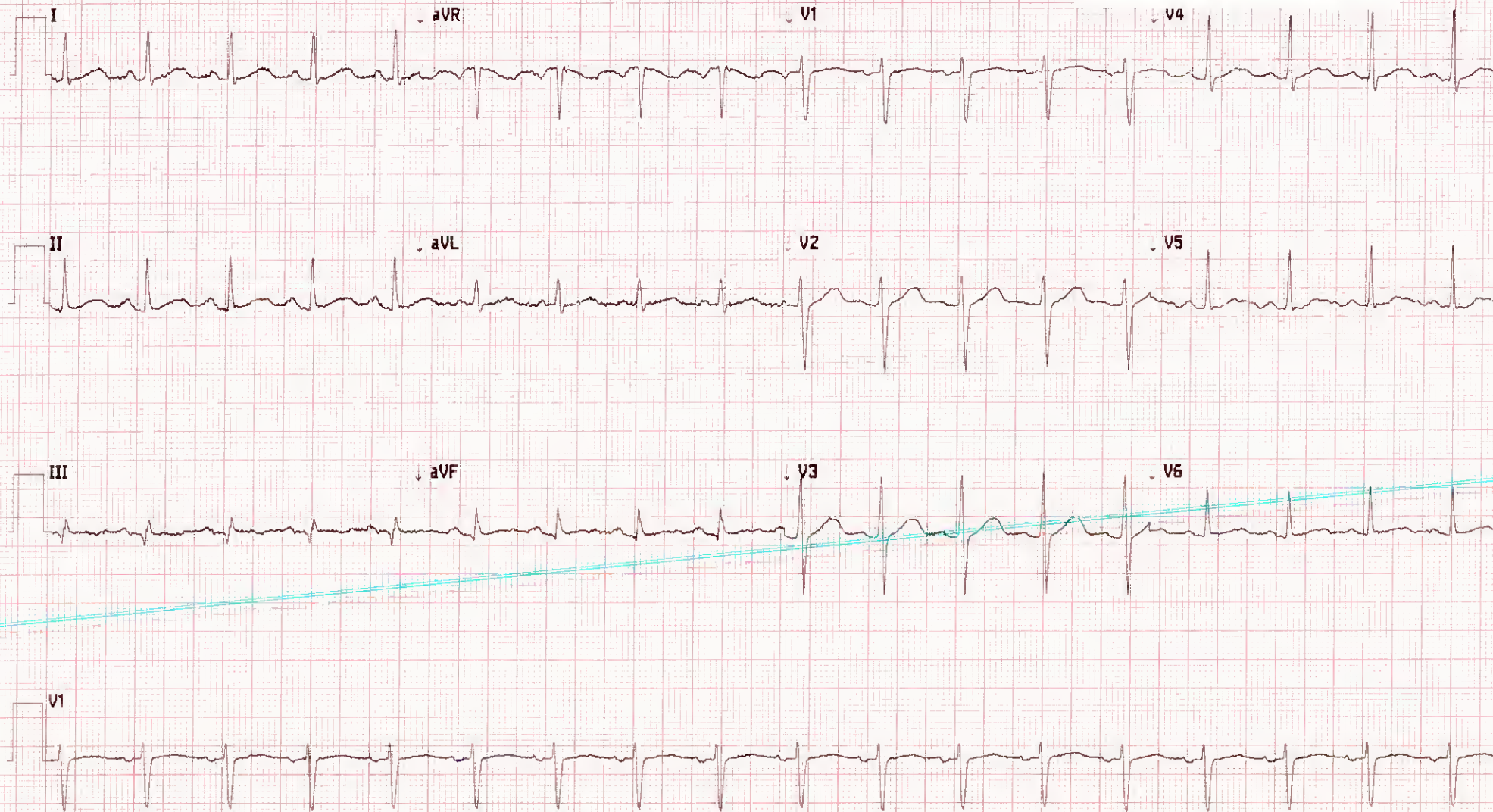
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 1808705142 18/09/1978 F MCCracken Isabel JF 1d Cumberdale Crescent Coatbridge Lanarkshire MLS 4P	Hospital: UHM Ward: 12 Booklet no.: 1 Date started: 27/3/21, Lanarkshire NHS
Person Centred Care Plan	

Guidance notes for completion:

- Before using this document please ensure you record your full details on the back page.
- Nursing staff to complete a Person Centred Care Plan (on pages 2-5) as per initial/ongoing assessment, based on the activities of living detailed in **Section 1.** below. Care plan reviews should also be recorded in this care plan section.
- Record the care given and all communications in the Record of Care/Communication with relatives and other professionals section (pages 6-15).
- Please also indicate in **Section 2.** below, any additional assessments/forms completed as part of the care planning and review process.

Patient's preferred name:
Overview of patient's presenting complaint and relevant past medical history: D+V ? BILIARY SEPSIS COVID -VE 27/3/21

SECTION 1. ACTIVITIES OF LIVING	
1. Maintaining a safe environment 2. Communicating 3. Breathing 4. Eating and drinking 5. Eliminating 6. Washing and dressing	7. Controlling body temperature 8. Mobilising 9. Work and social activity 10. Expressing sexuality 11. Sleeping 12. End of life care

SECTION 2. ASSESSMENTS/FORMS FOR CONSIDERATION <i>(tick if completed)</i>	
To be reviewed daily	
☐ 4AT Assessment Tool and TIME Bundle ☐ Confusion Assessment ☐ Getting to know me ☐ Learning Disabilities Supplementary Information ☐ Mobility Assessment ☐ Falls Risk Assessment (Hospital)/ Falls Bundle ☐ Pressure Ulcer Risk Assessment (PURA) ☐ SSkin Care Bundle ☐ Assessment and Management of Wounds (including pressure ulcers) ☐ Foot Assessment - CPR for Feet ☐ MRSA/CPE Clinical Risk Assessments ☐ Stool Chart ☐ Daily Pain Assessment	☐ Abbey Pain Assessment and Management ☐ MUST Nutritional Screening/Nutrition Profile ☐ Oral Health Assessment ☐ Swallow Screening Test ☐ Fluid Balance Chart ☐ FAST Alcohol Screening ☐ Glasgow Assessment and Management of Alcohol/GMAWS Score ☐ Management of Nicotine Addiction (If patient) ☐ Peripheral Vascular Catheter (PVC) Bundles ☐ Discharge planning ☐ Other: (condition specific)



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- Complete person centred care plan and initial/date/time as appropriate. Care plan reviews should also be recorded here.
- Care Plan should be developed/reviewed with the patient/family/carers as appropriate.
- Consider what care your patient needs and why and **identify specific actions required where possible.**

[illegible]

CHI no
 First name DOB / /
 Last name Sex: ☒ M ☐ F
 Address

 or attach addressograph label here

- Complete person centred care plan and initial/cate/time as appropriate. Care plan reviews should also be recorded here.
- Care Plan should be developed/reviewed with the patient/family/carers as appropriate.
- Consider what care your patient needs and why and **identify specific actions required where possible.**

PERSON CENTRED CARE PLAN

10. Expressing sexuality

Initials Start Date/Time End Date/Time

Identified care need:

Isabel likes to wear her own PJ's ——— NH 27/3

11. Sleeping

Identified care need:

Sleeps well - night sedation pr'd prn ——— CP 27/3

12. End of life care

Identified care need:

Isabel requires a TELP - documented in notes for full escalation. ——— NH 27/3

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Isabel

Crescent

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Lanarkshire

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• ADDRESSOGRAPH label here

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Lanarkshire

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Date/Time	Record of care/Communication with relatives and other professionals	Initials
30/3 N15	No new issues overnight lv fluids with K+ given	
31/3 16 ⁰⁰ N15	Continue IVABX therapy. Stool sample if loose Settled, no new issues.	AK
	+ve PC, Gam -ve/+ve at present, for lv Amoxicillin, met, Temocillin, will provide cover until full c/s out/21. Oral and lv medication as per hepma, no new issues on reporting	
1/4/21 16 ⁴⁵	Await CT Abdo. ?IVOST ? Home over weekend if all well. No new issues. Feeling better today. Stos sample sent for c&s.	AK
2/4/21 oral	isabel settled. Rlv by Surgical reg. c/s on bowel - stool TINE given as pr. Surgical will take over case once medical issues resolved no further complaints at present. Feels settled.	AK
2/4/21 18 ⁵⁰	No new issues. IVABX as pr. No new issues.	AK
3/4/21 16 ⁰⁵	Settled early, obs stable, meds as per hepma, no complaints offered prebed. IVAB continue. Sept. for long periods overnight	cp
4/4/21 14 ⁴³	Reviewed by medic. Continue IVab's today, IVOST Sunday ? Home Monday. Obs stable. Awaiting stool sample.	AK
4/4/21 19 ¹⁵	Early to settle, Sept well and for long periods. Obs stable. IVAB cont. No complaints offered prebed. No new concerns at this time.	cp
5/4/21 02 ³⁵	Continue on IVab's as wcc ↑ 1. Review for IVOST tomorrow Obs stable	AK
5/4/21 02 ³⁵	Settled and Sept well overnight. IVAB continue, very keen for home. Crp 83 ? for IVOST today. Obs stable. Meds as per hepma. No new concerns at this time.	cp
5/4/21	Isabel IVOST today. Monitor 48hrs	

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CI 1808785142
R 18/08/1978 F
L MCCracken Isabel
A 1d Cumbræ Crescent
Coatbridge
Lanarkshire ML5 4PX

Date/Time	Record of care/Communication with relatives and other professionals	Initials
	wishes to try nicotine gum, given losengers to try. Please order from pharmacy	all
18/20	Daughter updated.	cl
19-10	Rechent off Ward on reporting	7/10
6/4/21 0500	Obs. and meds. done. no wafon insidu. Care given as planned. → D R	
6/4/21 1200	Medication given as px. Ordered nicotine patches as no 14mg patches on ward. Awaiting medical update.	OB
7/4/21 0300	Obs. and meds. done BP remains low - asymptomatic No other new issues → D R	
7/4/21 1135	Isabel has had Meds as px on hepma. News has been stable. Pulse is 113 will continue to monitor. Independent with ADL's. No new issue's.	AD
8/4/21 0100	Still awaiting For urine sample. Obs. done. meds. taken. On oral Mg ⁺ supplements. → D R	
8/4/21 1100	Isabel had Meds as px on hepma. News stable. Pulse slightly tachy. Will inform Medics of this. Independent ADL's. MSSU sent for ACR. NO new issue's.	AD
9/4/21 0420	Vomited last night after taking thr oral Mg ⁺ . Obs. taken - remains tachy. Slept well. Care given as planned. → D R	

CH
 Fir: 1808785142
 La: 18/08/1978 F
 Ad: MCCracken Isabel
 1d Cumberae Crescent
 Coatbridge
 Lanarkshire ML5 4PX

Date/Time	Record of care/Communication with relatives and other professionals	Initials
9/4/21 16:30	Isabel remains settled today, medication given as per Hepma as charted & Stabbe which is when as I was with Isabel stayed Hepma OBS charted. Urine sample sent - Benz Jones started on Warfarin, TV on - when ↓ cep. Still to continue on TINZ. NO further issues to report @ present	AL
10/4/21 00:20	Isabel had settled night so far. Meds admin as per Hepma. News. (2) No co RN anti-emetic given. No concerns at present	AL (STN)
10/4/21 14:00	Isabel remains settled today, medication given as per Hepma OBS Charted & Stabbe. Two with all care needs. awaiting sputum sample & stool sample. NO further issues to report with Isabel	AL
10/4/21 02:00	Isabel has been settled. handled over smell of cannabis in room - Isabel has been off ward with other patient across from her back deny - call monitor. fairly settled - OBS Stabbe. — AL	
10-4-21 11:00	Isabel remains fairly settled today, medication given as per Hepma. Isabel still remains off the ward @ times with another patient in the room. Good diet & fluid intake no further issues to report	AL
12/4 02:00	Isabel fairly settled tonight. On force line to family. Went off ward for spells. no complaints. Slept for spells. — AL	

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CHI no

First name DOB

Last name Sex: ☐ M ☐ F

Address

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CHI no
First name DOB / /
Last name Sex: ☐ M ☐ F
Address

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All nursing staff using this record including bank staff, students and re-deployed staff must enter their details below in full when completing this record for the first time.

SIGNATURE RECORD

[illegible]



1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Curzon Crescent
Coatbridge
Lanarkshire ML5 4PX

JE

University Hospital:
☐ Hairmyres
☒ Monklands
☐ Wishaw

Other:

Ward:



Covid-19 Admission Screening Swabs

All patients will require to be screened for Covid-19 on admission and at day 5 of their hospital stay. Screening of patients will enable NHS Lanarkshire staff to detect asymptomatic carriers of the virus and put appropriate Covid-19 measures in place to minimise the risk of cross contamination.

If the patient is transferred to another ward after day 5 screening - patient must be screened within 4 hours of admission to new ward.

If a positive result is obtained, stop screening, follow Covid-19 guidance for positive cases. Please refer to "Transfer to Offsite Bed" step down guidance for transfer to offsite beds and Care Homes. If a patient is discharged before the result - they must be contacted if there is a positive result.

Covid-19 Admission Screening Swabs

Date of Admission	Screen taken by (PRINT NAME)	Time	Result	Patient informed by (PRINT NAME)
27/3/24	Kulb	02 ⁰⁰	☐ Positive ☒ Negative	

Day 5 Screen (DATE)	Screen taken by (PRINT NAME)	Time	Result	Patient informed by (PRINT NAME)
			☐ Positive ☐ Negative	

Transfer Screen (DATE)	Screen taken by (PRINT NAME)	Time	Result	Patient informed by (PRINT NAME)
			☐ Positive ☐ Negative	

Date of Discharge: / /

Completed by: (PRINT NAME)	Designation:
Signature:	Date: / / Time:



AS34

For additional Transfer Screening Swabs complete on next page if required

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MRSA and CPE Clinical Risk Assessments

MRSA CLINICAL RISK ASSESSMENT (Meticillin-Resistant Staphylococcus Aureus) - To be completed for all ACUTE admissions. - Do NOT complete for admissions to Maternity, Neonatal, Paediatrics, Mental Health		Yes	No
1. Has the patient any previous history of MRSA? – ask the patient and check Track Care, Labs	☐	☒	
2. Has the patient been admitted from anywhere other than their own home (e.g. prison, homeless hostel, resident in a care home) or transferred from another hospital?	☐	☒	
3. Does the patient have any wound(s)/ulcer(s) or indwelling device (e.g. peg tube, urinary catheter) which was inserted before admission?	☐	☒	
If YES to questions 1 or 2 obtain nasal and perineal swabs. If YES to question 3 obtain nasa', perineal, device, wound swabs and catheter specimen of urine (CSU), where appropriate.			
For patients admitted to Vascular, Orthopaedics, Renal and Critical Care (including attached high dependency areas) complete the Clinical Risk Assessment AND obtain nasal and perineal swabs.			

MRSA Screening Swabs	Result	Isolation	Actions
☐ Nasal		Is the patient isolated?	If a single room is not available, a risk assessment must be undertaken and the Infection Prevention and Control (IPC) team must be contacted. Out of hours, the on-call microbiologist should be informed.
☐ Perineal		☐ Yes ☐ No	
☐ Wound(s) - location:		If no, why not?	
☐ Ulcer(s) - location:		☐ Not applicable	
☐ CSU		☐ Not available	
☐ Throat		If unavailable has a clinical risk assessment been undertaken?	
☐ Other: (specify)		☐ Yes ☐ No	

PRINT NAME: <u>Karen Wison</u>	Designation: <u>S/w</u>
Signature: <u>[Signature]</u>	Date: <u>22/3/21</u> Time: <u> </u>

FOR PATIENTS WHO ARE MRSA POSITIVE: decolonisation treatment to be carried out and patient re-swabbed as per MRSA Policy, Control of Infection Manual (*access manual via FirstPort*)

CPE CLINICAL RISK ASSESSMENT (Carbapenemase Producing Enterobacteriaceae) - To be completed for admissions to all specialties		Yes	No
1. Has the patient been previously confirmed CPE positive at any time?		☐	☐
In the past 12 months:			
2. Has the patient been hospitalised outside Scotland?		☐	☐
3. Has the patient had holiday dialysis outside Scotland?		☐	☐
4. Has the patient been in close contact of a person who has been colonised or infected with CPE?		☐	☐
If YES to any question, the patient is at increased risk of CPE carriage; swab(s) should be obtained, patient isolated and IPC Team informed. Obtain rectal swab OR if swab not taken, obtain stool sample. In addition, for patients with a urinary catheter insitu, obtain CSU and if has wound(s) obtain wound swab.			

CPE Screening Swabs	Result	Isolation	Actions
☐ Rectal		Is the patient isolated? ☐ Yes ☐ No	If a single room is not available, a risk assessment must be undertaken and the IPC team must be contacted. Out of hours, the on-call microbiologist should be informed.
☐ Stool sample		If no, why not? ☐ Not applicable ☐ Not available	
☐ Wound(s) - location:		If unavailable has a clinical risk assessment been undertaken? ☐ Yes ☐ No	
☐ CSJ			
Reason for not swabbing:			

PRINT NAME:	Designation:
Signature:	Date: / / Time: COPY PAGE



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Firs 1808785142
Las 18/08/1978 F
Ad MCCracken Isabel
Id Cumbræ Crescent
Coatbridge
Lanarkshire ML5 4PX

University Hospital: ☐ Hairmyres ☒ Monklands ☐ Wishaw 
Other:
Ward: Amr
Peripheral Vascular Catheter (PVC)
Insertion, Maintenance and
Removal Bundles

PVC Insertion Bundle 1	Yes	No
Hand hygiene performed immediately before all PVC insertion procedures (WHO Moment 2)	☒	☐
A single use skin antiseptic containing 70% isopropyl alcohol and 2% chlorhexidine gluconate is used to cleanse skin and left to dry before insertion	☒	☐
Aseptic technique maintained throughout insertion procedure	☒	☐
A sterile, transparent, semipermeable dressing used to cover the catheter site	☒	☐

Size/colour: Pink Insertion site: LACF
Insertion Date: 27/3/21 Time: Signature: GP

PVC Maintenance Bundle 1	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Is the PVC still in use?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have staff informed patients/representatives of risks, care and monitoring of the device? Patient information leaflet provided	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The clinical need for the PVC has been reviewed and recorded today	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Medical staff have reviewed the need for intravenous (IV) therapy including antibiotics today and switched to oral if possible	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hand hygiene is performed immediately before accessing the line/site (WHO Moment 2)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Removal of the PVC is considered if in longer than 72 hours	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC site has been assessed; removing the PVC where there is phlebitis or inflammation at the site	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC dressings are intact	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
A single use antiseptic containing 70% isopropyl alcohol is used to clean the access hub before accessing - rub the access hub for at least 15 seconds ("scrub the hub")	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Date:												
Time:												
Initials:												

PVC Removal Bundle 1
Removal Date: / / Time: : (24 hour)
Reason for removal:
Condition of site on removal:
Signature:



CHI no:

First name: DOB:

Last name: Sex: ☐ M ☐ F

Address:

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or attach addressograph label here

PVC Insertion Bundle 2	Yes	No
Hand hygiene performed immediately before all PVC insertion procedures (WHO Moment 2)	☐	☐
A single use skin antiseptic containing 70% isopropyl alcohol and 2% chlorhexidine gluconate is used to cleanse skin and left to dry before insertion	☐	☐
Aseptic technique maintained throughout insertion procedure	☐	☐
A sterile, transparent, semipermeable dressing used to cover the catheter site	☐	☐

Size/colour: Insertion site:

Insertion Date: / / Time: Signature:

PVC Maintenance Bundle 2	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Is the PVC still in use?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have staff informed patients/representatives of risks, care and monitoring of the device? Patient information leaflet provided.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The clinical need for the PVC has been reviewed and recorded today	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Medical staff have reviewed the need for intravenous (IV) therapy including antibiotics today and switched to oral if possible	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hand hygiene is performed immediately before accessing the line/site (WHO Moment 2)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Removal of the PVC is considered if in longer than 72 hours	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC site has been assessed; removing the PVC where there is phlebitis or inflammation at the site	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC dressings are intact	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
A single use antiseptic containing 70% isopropyl alcohol is used to clean the access hub before accessing - rub the access hub for at least 15 seconds ("scrub the hub")	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Date:												
Time:												
Initials:												

PVC Removal Bundle 2
Removal Date: / / Time: : (24 hour)
Reason for removal:
Condition of site on removal:
Signature:

000705142
08/08/1978
MCCRACKEN Isabel
Id Cumberae Crescent
Coatbridge
Lanarkshire
ML3 4P>

University Hospital: ☒ Hairmyres ☐ Monklands ☒ Wishaw **NHS**
Other:
Ward: 52
Lanarkshire

Peripheral Vascular Catheter (PVC) Insertion, Maintenance and Removal Bundles

PVC Insertion Bundle 1	Yes	No
Hand hygiene performed immediately before all PVC insertion procedures (WHO Moment 2)	☒	☐
A single use skin antiseptic containing 70% isopropyl alcohol and 2% chlorhexidine gluconate is used to cleanse skin and left to dry before insertion	☒	☐
Aseptic technique maintained throughout insertion procedure	☒	☐
A sterile, transparent, semipermeable dressing used to cover the catheter site	☒	☐
Size/colour: Blue Insertion site: Rg Arm		
Insertion Date: 29 / 3 / 21 Time: 12:20 Signature:		

PVC Maintenance Bundle 1	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Is the PVC still in use?	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have staff informed patients/representatives of risks, care and monitoring of the device? Patient information leaflet provided.	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The clinical need for the PVC has been reviewed and recorded today	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Medical staff have reviewed the need for intravenous (IV) therapy including antibiotics today and switched to oral if possible	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hand hygiene is performed immediately before accessing the line/site (WHO Moment 2)	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Removal of the PVC is considered if in longer than 72 hours	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC site has been assessed; removing the PVC where there is phlebitis or inflammation at the site	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC dressings are intact	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
A single use antiseptic containing 70% isopropyl alcohol is used to clean the access hub before accessing - rub the access hub for at least 15 seconds ("scrub the hub")	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Date:	29/3	30/3												
Time:	12:30	11:30												
Initials:	CA	AG												

PVC Removal Bundle 1

Removal Date: / / Time: : (24 hour)
Reason for removal:
Condition of site on removal:
Signature:



CH' no
First name Isabel DOB
Last name McCracken Sex: ☐ M ☐ F
Address

or attach addressograph label here

PVC Insertion Bundle 2	Yes	No
Hand hygiene performed immediately before all PVC insertion procedures (WHO Moment 2)	☒	☐
A single use skin antiseptic containing 70% isopropyl alcohol and 2% chlorhexidine gluconate is used to cleanse skin and left to dry before insertion	☒	☐
Aseptic technique maintained throughout insertion procedure	☒	☐
A sterile, transparent, semipermeable dressing used to cover the catheter site	☒	☐
Size/colour: <u>Pink</u> Insertion site: <u>R wrist</u>		
Insertion Date: <u>31/3/21</u> Time: <u>07:40</u> Signature: <u>M Cooney</u>		

PVC Maintenance Bundle 2	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Is the PVC still in use?	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have staff informed patients/representatives of risks, care and monitoring of the device? Patient information leaflet provided.	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The clinical need for the PVC has been reviewed and recorded today	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Medical staff have reviewed the need for intravenous (IV) therapy including antibiotics today and switched to oral if possible	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hand hygiene is performed immediately before accessing the line/site (WHO Moment 2)	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Removal of the PVC is considered if in longer than 72 hours	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC site has been assessed; removing the PVC where there is phlebitis or inflammation at the site	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC dressings are intact	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
A single use antiseptic containing 70% isopropyl alcohol is used to clean the access hub before accessing - rub the access hub for at least 15 seconds ("scrub the hub")	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Date:	<u>31/3/21</u>													
Time:	<u>17:50</u>													
Initials:	<u>MC</u>													

PVC Removal Bundle 2
Removal Date: / / Time: : (24 hour)
Reason for removal:
Condition of site on removal:
Signature:

1808785142

18/08/1978

MCCRACKEN

1d Cumberae Crescent

Coatbridge

Lanarkshire

F

Isabel

ML5 4P>

University Hospital: ☐ Hairmyres ☐ Monklands ☐ Wishaw

NHS

Lanarkshire

Other: _____

Ward: _____

Peripheral Vascular Catheter (PVC)

Insertion, Maintenance and

Removal Bundles

PVC Insertion Bundle 1	Yes	No
Hand hygiene performed immediately before all PVC insertion procedures (WHO Moment 2)	☐	☐
A single use skin antiseptic containing 70% isopropyl alcohol and 2% chlorhexidine gluconate is used to cleanse skin and left to dry before insertion	☐	☐
Aseptic technique maintained throughout insertion procedure	☐	☐
A sterile, transparent, sem permeable dressing used to cover the catheter site	☐	☐
Size/colour: <u>Pink</u> Insertion site: <u>② arm</u>		
Insertion Date: <u> </u> / <u> </u> / <u> </u> Time: <u> </u> : <u> </u> Signature: <u>?? ABE</u>		

PVC Maintenance Bundle 1	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Is the PVC still in use?	☒	☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐
Have staff informed patients/representatives of risks, care and monitoring of the device? Patient information leaflet provided.	☒	☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐
The clinical need for the PVC has been reviewed and recorded today	☒	☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐
Medical staff have reviewed the need for intravenous (IV) therapy including antibiotics today and switched to oral if possible	☒	☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐
Hand hygiene is performed immediately before accessing the line/site (WHO Moment 2)	☒	☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐
Removal of the PVC is considered if in longer than 72 hours	☒	☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐
The PVC site has been assessed; removing the PVC where there is phlebitis or inflammation at the site	☒	☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐
The PVC dressings are intact	☒	☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐
A single use antiseptic containing 70% isopropyl alcohol is used to clean the access hub before accessing - rub the access hub for at least 15 seconds ("scrub the hub")	☒	☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐
Date:	<u>27/3</u>	<u>28/3</u>	<u>29/3</u>	<u>29/3</u>								
Time:	<u>18:00</u>	<u>03:20</u>	<u>11:10</u>	<u>12:20</u>								
Initials:	<u>W4x</u>	<u>cl</u>	<u>R</u>	<u>CA</u>								

PVC Removal Bundle 1
Removal Date: <u> </u> / <u> </u> / <u> </u> Time: <u> </u> : <u> </u> (24 hour)
Reason for removal: <u> </u>
Condition of site on removal: <u> </u>
Signature: <u> </u>



CHI no

First nameDOB

Last nameSex ☐ M ☐ F

Address

or attach addressograph label here

PVC Insertion Bundle 2	Yes	No
Hand hygiene performed immediately before all PVC insertion procedures (WHO Moment 2)	☐	☐
A single use skin antiseptic containing 70% isopropyl alcohol and 2% chlorhexidine gluconate is used to cleanse skin and left to dry before insertion	☐	☐
Aseptic technique maintained throughout insertion procedure	☐	☐
A sterile, transparent, semipermeable dressing used to cover the catheter site	☐	☐

Size/colour: Pink Insertion site: R wrist

Insertion Date: 2, 4, 21 Time: 7: 7 Signature: 7

PVC Maintenance Bundle 2	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Is the PVC still in use?	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have staff informed patients/representatives of risks, care and monitoring of the device? Patient information leaflet provided.	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The clinical need for the PVC has been reviewed and recorded today	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Medical staff have reviewed the need for intravenous (IV) therapy including antibiotics today and switched to oral if possible	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hand hygiene is performed immediately before accessing the line/site (WHO Moment 2)	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Removal of the PVC is considered if in longer than 72 hours	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC site has been assessed; removing the PVC where there is phlebitis or inflammation at the site	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC dressings are intact	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
A single use antiseptic containing 70% isopropyl alcohol is used to clean the access hub before accessing - rub the access hub for at least 15 seconds ("scrub the hub")	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Date:	3/4													
Time:	06:40													
Initials:	CP													

PVC Removal Bundle 2
Removal Date: 3, 4, 21 Time: 7: 7 (24 hour)
Reason for removal: ?
Condition of site on removal: Intact
Signature: CP

CHI n 
First n 1808785142
Last n 18/08/1978 F
Addre MCCracken Isabel
1d Cumberae Crescent
Coatbridge
Lanarkshire ML5 4PX

☐ Hairmyres☒ Monklands☐ Wishaw☐ Other (specify):

Ward:

Adult Parenteral Gentamicin: Prescribing, Administration & Monitoring Chart

Use for patients prescribed intravenous gentamicin as per NHSL dosing guidance.

Not for prophylactic indication or where synergistic doses (usually in endocarditis) are being used.

Refer to full guidance for information on EXCLUSIONS and Cautions/Contra-indications to gentamicin.

Creatinine 118 on 26/3/21
Age 42 Weight 67.7 kg Height 157 cm

Source of first dose: ☐ online calculator (preferred method)
☐ Manual calculation ☐ Weight based, creatinine not known

Initial Gentamicin Dose* 280
Predicted Frequency* 24
*this is not a prescription and may change. Doses must be prescribed individually below.

TOXICITY Before prescribing each dose check: Renal & Oto-vestibular function	Gentamicin Prescription Record				Administration Record			Monitoring Record			
	Complete each time a dose is to be given (ensuring gentamicin is prescribed 'as per chart' on the cardex)				Complete each time gentamicin is administered (in addition to the cardex)			Record ALL sample dates/times accurately below. See overleaf for monitoring advice.			
	Date to be given	Time to be given 24 h clock	Gentamicin Dose (mg)	Prescriber's signature, PRINTED name and STATUS	*Infuse in 100mls of 0.9% Saline over 30 mins*		Given by	Date of sample	Time of sample 24 h clock	Gent level (mg/L)	Action/Comments (please initial action to be taken)
				Date given	Time started 24 h clock						
Cr = micromol/L	27/3	0500	280mg	R. Downie	27/3	0515	W. KB	27/3/21	1815		☐ 21 hourly ☐ 48 hourly ☐ Withhold ☐ Stop Details/other:
Cr = 60 micromol/L	28/3/21	0500	320	Dr. Kimbous	28/3	0520	Q, Q				☐ 24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop Details/other:
Risks of prolonged treatment include nephrotoxicity and ototoxicity. If treatment is required beyond 3 days discuss with Infection Specialist/Microbiologist. If gentamicin is continued give a gentamicin patient information leaflet*. Document all details in the notes.											
Cr = 50 micromol/L	29/3	0500	320mg	Dr. Haged	29/3/21	0520	Q, 8	29/3	19:25	0.5	☒ 24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop Details/other:
Cr = micromol/L	30/3	0500	320		30/3/21	05:30	W				☐ 24 hourly ☐ 48 hourly ☐ Withhold ☒ Stop Details/other:

Never continue onto a second sheet without discussion with an Infection Specialist/Microbiologist

NB: Ensure gentamicin has not already been administered in a parallel prescription on the ED card/cardex/HEPMA or a duplicate gentamicin chart

Step 1: Calculate and prescribe the first dose of gentamicin (see overleaf for more details)

If creatinine is known - use the online gentamicin dose calculator.

- If creatinine is not known - give 5 mg/kg gentamicin (maximum 400 mg) or, if CKD 5, give 2.5 mg/kg (maximum 180 mg) on advice of senior medical staff.
- Prescribe gentamicin 'as per chart' on the medication chart (cardex/HEPMA). AVOID specifying dose or administration time on the cardex/HEPMA.
- Only administer gentamicin if it is prescribed "as per chart" on the cardex/HEPMA and on the gentamicin chart with the dose specified.
- Prescribe individual doses in the prescription record section above, specifying the date and time the dose should be given.

Step 2: Monitor creatinine and gentamicin concentration and reassess the dosage regimen

- Check gentamicin concentration after the first dose and then at least every 2 days (see overleaf for more details).
- Monitor creatinine daily. Seek advice from pharmacy if renal function is unstable (e.g. a change in creatinine of >15-20%).

Step 3: Assess daily: the ongoing need for gentamicin; signs of toxicity

- Consider an alternative agent if creatinine is increasing or the patient becomes oliguric.
- *If gentamicin continues for >3 days supply a patient information leaflet 'Gentamicin and your ears' to raise awareness of possible side effects as well as the benefits of therapy. ☐ Date:
- If gentamicin continues for >7 days, suggest referral to audiology for assessment.
- Refer to guidelines or clinical pharmacist for further advice on prescribing, monitoring and administration.

PROMPT ADMINISTRATION
within 1 hour of recognition of sepsis reduces mortality

SIGNS OF GENTAMICIN TOXICITY

RFNAI: ↓ urine output/oliguria or ↑ creatinine

OTO/ VESTIBULAR: NEW tinnitus, dizziness, poor balance,
hearing loss, oscillating vision,
unexplained nausea and/or vomiting

Toxicities may occur irrespective of gentamicin concentration

Safe Practice: Review medication cardex/HEPMA prior to administration of gentamicin to ensure patient has not had gentamicin administered within 24 hours.

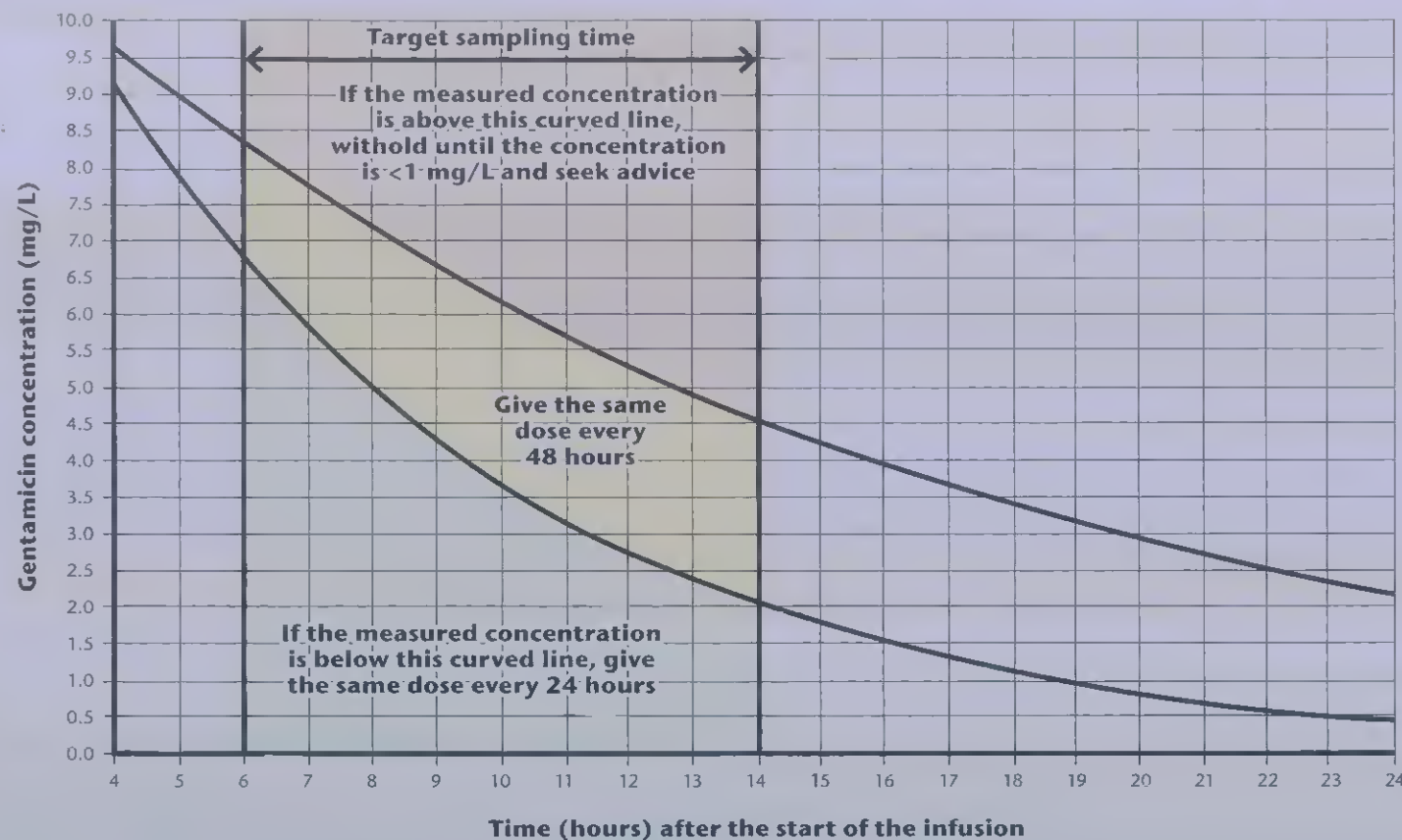
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Patient name

CHI no

Adult Parenteral Gentamicin: Prescribing, Administration & Monitoring Chart

Prescribing, monitoring, interpreting and re-prescribing advice.



If the measured concentration is unexpectedly HIGH or LOW

- Were dose and sample times recorded accurately?
- Was the correct dose administered?
- Was the sample taken from the line used to administer the drug?
- Was the sample taken during drug administration?
- Has renal function declined or improved?
- Does the patient have oedema or ascites?

If in doubt, take another sample before re-prescribing and/or contact pharmacy for advice.

Developed by:
Scottish Antimicrobial Prescribing Group,
Gentamicin and Vancomycin sub-group
based on GGC guidance

Approved by AMC: Feb 2020

Ratified by ADTC: May 2020

Review date: May 2023

Calculating the first dose of gentamicin

- If creatinine is known - use the online gentamicin dose calculator.
- If creatinine is not known - give 5 mg/kg gentamicin (maximum 400 mg) or, if CKD 5, give 2.5 mg/kg (maximum 180 mg) on advice of senior medical staff.
- Calculate the dosage regimen once creatinine becomes available prior to second scheduled dose.
- If the online calculator is not available, manually calculate the dose using full guidance on Medical Education "Drugs and Prescribing" webpage via FirstPort.

Checking the patient's gentamicin concentration

- Take a blood sample 6-14 hours after the start of the first gentamicin infusion (or after 24 hours if CrCl <21 ml/min).
- Thereafter, sample at least every 2 days.
- Record the exact time of all gentamicin samples overleaf AND on the sample request form.

Interpreting gentamicin results and re-prescribing

- Record the measured concentration overleaf.
- If creatinine clearance is ≥ 21 ml/min and therapy is to continue, plot the gentamicin concentration (measured 6-14hrs post dose) on the graph opposite & reassess the dose/dosing interval as indicated.
- If creatinine clearance is <21 ml/min and therapy is to continue, only give a further dose once the trough concentration (measured at 24 hrs, repeated after further 24hrs if high) is <1 mg/L.
- Document the action taken in the medical notes and overleaf.
- Prescribe the next dose overleaf as appropriate.
- Contact pharmacy for further advice as necessary (e.g. if renal function is changing, the gentamicin concentration is unexpectedly high or low or the concentration is on the line between dosage intervals).
- Check microbiology sensitivities and refer to IV to Oral switch policy.

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Q2

☐ Hairmyres ☒ Monklands ☐ Wishaw
☐ Other: (specify) _____
Ward: 12



Internal Transfer Record

Date of Admission: 26/3/21 Date of Transfer: 27/3/21 Time of Transfer: _____ Transferring from: AMBU to 12
Reason for transfer: ☐ Admission ☐ Specialty ☐ Decant ☐ Other: (specify) _____
Number of transfers: _____ If more than 3 transfers has senior nurse/hospital cover been notified? ☐ Yes ☐ N/A

Admitting Condition: Biliary sepsis Vomitted.
Primary Diagnosis: _____
Consultant: Dr
Next of Kin details recorded? ☐ Yes ☐ No
Informed of transfer? ☐ Yes ☐ No
If no, why: _____

B

Relevant Past History/Current Care	Allergies: NKDA	Infection Control Risk Management	Yes No
Anti-back pain	Mobility/Safety Requirements: Self caring/Mobile	MRSA Clinical Risk Assessment completed?	☐ ☐
	Red Triangle in use? ☐ Yes ☐ No	MRSA screen swabs required?	☐ ☐
	4AT Score: _____	MRSA screen swabs obtained?	☐ ☐
	Special dietary requirements? ☐ Yes ☐ No	Result if available: ☐ Positive ☐ Negative	☐ ☐
	Nil by Mouth? ☐ Yes ☐ No	Isolation required?	☐ ☐
	Fluid Balance = _____	Other infection control risk? (If yes specify)	☐ ☐
	DNACPR Status: Full	Does the patient have a pressure ulcer?	☐ ☐
	NEWS Score: 2	If yes, grade: _____	☐ ☐
	CIWA Score: _____	If yes, DATIX completed?	☐ ☐

A

IV cannula insitu? ☒ Yes ☐ No	Date inserted: _____	Estimated Discharge Date: _____	Yes No
Urinary catheter? ☐ Yes ☒ No	Date inserted: _____	Potential delays for discharge?	☐ ☐
Invasive Device? ☐ Yes ☐ No	Date inserted: _____	TrakCare updated?	☐ ☐
Other: (specify)			

R

Plan for Care: Covid - await 25/3 covid. AMO
IVF Abdo u/s d/w surgeons Met Gent

Complete as applicable:
Transfer Nurse Name: _____ Signature: _____
Receiving Nurse Name: _____ Signature: _____

Transfer Checklist
Prescription Form ☐ ☐
Patients Own Drugs medication ☐ ☐
Casenotes ☐ ☐
Nursing Notes ☐ ☐
Oxygen ☐ ☐
Valuables ☐ ☐



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Indication for anticoagulation	Target INR (range)	Recommended duration
Provoked DVT/PE	2.5 (2-3)	3 months
Unprovoked DVT/PE	2.5 (2-3)	At least 3-6 months, with indefinite to be considered
Recurrent DVT and/or PE	2.5 (2-3)	Indefinite
Recurrent DVT and/or PE while on Warfarin (INR 2-3)	3.5 (3-4)	Indefinite
Atrial fibrillation or high risk arrhythmia	2.5 (2-3)	Indefinite
Atrial fibrillation (for cardioversion)	2.5 (2-3)	Review after procedure
Aortic mechanical prosthetic valve	2.5 (2-3)	Indefinite
Mitral mechanical prosthetic valve	3.0 (2.5-3.5)	Indefinite
Bioprosthetic heart valve (selected patients)	2.5 (2-3)	3 months
Cardiomyopathy/mural thrombus/akinetic segment	2.5 (2-3)	Indefinite
For other indications, target INR and duration should be confirmed with consultant.		

Age-Adjusted Fennerty Protocol for induction of Warfarin

Day	INR	Warfarin dose (mcg) depending on age			
		≤50 years	51-65 years	66-80 years	>80 years
1	<1.4	10	9	7.5	6
2	<1.6	10	9	7.5	6
	≥1.6	0.5	0.5	0.5	0.5
3	<1.8	10	9	7.5	6
	1.8-2.5	4.0-5.0	3.5-4.5	3.0-4.0	2.5-3.0
	2.6-3.0	2.5-3.5	2.5-3.5	2.0-2.5	1.5-2.0
	3.1-3.5	1.0-2.0	1.0-2.0	0.5-1.5	0.5-1.5
	3.6-4.0	0.5	0.5	0.5	0.5
	>4	0	0	0	0
4	<1.6	10.0-15.0	9.0-13.0	7.5-11.0	6.0-9.0
	1.6-1.9	6.0-8.0	5.5-7.0	4.5-6.0	3.5-5.0
	2.0-2.6	4.5-5.5	4.0-5.0	3.5-4.5	2.5-3.5
	2.7-3.5	3.5-4.0	3.0-3.5	2.5-3.0	2.0-2.5
	3.6-4.0	3	2.5	2	1.5
	4.1-4.5	Omit today's dose then:			
		1.0-2.0	0.5-1.5	0.5-1.5	0.5-1.0
	>4.5	Withhold warfarin until INR <3, then restart on 0.5-1.0mg			

- Consider reducing dose by one third if patient is on interacting drugs especially amiodarone, has severe congestive heart failure or biventricular failure, has abnormal LFT's or has severe oxygen dependant COPD.
- When the INR result is towards the upper end of a range in the INR column, it is recommended that a warfarin dose is chosen towards the lower end of the suggested range in the age-appropriate dose column; and vice versa when INR result is towards the lower end of a INR range.
- Check INR daily for at least the first four days and thereafter regularly until within target range and stable.
- If Warfarin is started for treatment of acute VTE, continue LMWH for at least 5 days and until INR has been >2.0 for 2 days.

REVERSAL OF WARFARIN

A. Life threatening bleeding (e.g. intracranial or major GI bleed)

1. Stop Warfarin

2. Give vitamin K 5mg intravenously

3. Give IV prothrombin complex concentrate (BERIPLEX®) 25-50 units/Kg. Discuss with on call haematologist

B. Less severe bleeding e.g. haematuria, epistaxis

1. Stop Warfarin for 1-2 days

2. Give Vitamin K 1-2 mg intravenously

3. Re-assess

C. High INR but no bleeding

1. Stop Warfarin and monitor INR. Consider restarting Warfarin when INR <5.0

2. Ascertain cause of high INR

3. Consider giving Vitamin K 1mg IV or 2mg oral if INR >8 or INR 5-7.9 with risk factors for bleeding (e.g. elderly, uncontrolled hypertension, renal or liver failure, previous GI or cerebral bleed and concomitant antiplatelet)

Warfarin & other Vit K antagonist anticoagulant chart | Haematology | NI-SL | Page 2 of 2

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University Hospital: ☐ Hairmyres ☐ Monklands ☐ Wishaw **NHS**
Other:
Ward:
Lanarkshire

Peripheral Vascular Catheter (PVC) Insertion, Maintenance and Removal Bundles

PVC Insertion Bundle 1	Yes	No
Hand hygiene performed immediately before all PVC insertion procedures (WHO Moment 2)	☒	☐
A single use skin antiseptic containing 70% isopropyl alcohol and 2% chlorhexidine gluconate is used to cleanse skin and left to dry before insertion	☒	☐
Aseptic technique maintained throughout insertion procedure	☒	☐
A sterile, transparent, semi-permeable dressing used to cover the catheter site	☒	☐
Size/colour: <u>BLUE</u> Insertion site: <u>L. HAND</u>		
Insertion Date: <u>3/4/21</u> Time: <u>1:40</u> Signature: <u>M. TRAYNOR</u>		

PVC Maintenance Bundle 1	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Is the PVC still in use?	☒	☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have staff informed patients/representatives of risks, care and monitoring of the device? Patient information leaflet provided.	☒	☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
The clinical need for the PVC has been reviewed and recorded today	☒	☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
Medical staff have reviewed the need for intravenous (IV) therapy including antibiotics today and switched to oral if possible	☒	☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hand hygiene is performed immediately before accessing the line/site (WHO Moment 2)	☒	☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
Removal of the PVC is considered if in longer than 72 hours	☒	☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC site has been assessed; removing the PVC where there is phlebitis or inflammation at the site	☒	☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC dressings are intact	☒	☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
A single use antiseptic containing 70% isopropyl alcohol is used to clean the access hub before accessing - rub the access hub for at least 15 seconds ("scrub the hub")	☒	☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
Date:	<u>4/4/21</u>	<u>5/2/21</u>	<u>5/2/21</u>											
Time:	<u>11:00</u>	<u>02:35</u>	<u>08:00</u>											
Initials:	<u>MT</u>	<u>CP</u>	<u>WH</u>											

PVC Removal Bundle 1

Removal Date: 5/2/21 Time: 17:20 (24 hour)
Reason for removal: No longer required
Condition of site on removal: NIL ISSUES
Signature: [Signature]



CHI no

First name

Last name

Address

DOB

Sex: ☐ M ☐ F

or attach addressograph label here

PVC Insertion Bundle 2	Yes	No
Hand hygiene performed immediately before all PVC insertion procedures (WHO Moment 2)	☐	☐
A single use skin antiseptic containing 70% isopropyl alcohol and 2% chlorhexidine gluconate is used to cleanse skin and left to dry before insertion	☐	☐
Aseptic technique maintained throughout insertion procedure	☐	☐
A sterile, transparent, semipermeable dressing used to cover the catheter site	☐	☐

Size/colour:

Insertion site:

Insertion Date: / /

Time: :

Signature:

PVC Maintenance Bundle 2	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Is the PVC still in use?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have staff informed patients/representatives of risks, care and monitoring of the device? Patient information leaflet provided.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The clinical need for the PVC has been reviewed and recorded today	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Medical staff have reviewed the need for intravenous (IV) therapy including antibiotics today and switched to oral if possible	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hand hygiene is performed immediately before accessing the line/site (WHO Moment 2)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Removal of the PVC is considered if in longer than 72 hours	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC site has been assessed; removing the PVC where there is phlebitis or inflammation at the site	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC dressings are intact	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
A single use antiseptic containing 70% isopropyl alcohol is used to clean the access hub before accessing - rub the access hub for at least 15 seconds ("scrub the hub")	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Date:												
Time:												
Initials:												

PVC Removal Bundle 2

Removal Date: / / Time: : (24 hour)

Reason for removal:

Condition of site on removal:

Signature:

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☐ Hairmyres ☒ Monklands ☐ Wishaw
☐ Other: (specify)
Ward: Amey 12



Malnutrition Universal Screening Tool (MUST)* with Nutrition Profile

• Complete for every patient within 24 hours of admission		Date:	27/3/21	5/4/21		
• Re-assessment will take place weekly or as per risk score		Time:	04:55	12:30		
• Complete the Nutritional Profile on page 2						
Weight (kg) [(A) = actual or (E) = estimated - enter in column]			67.70	63.85		
Reason if estimated:						
Height (m) [(A) = actual or (E) = estimated - enter in column]			1.58	1.58		
Reason if estimated:						
BMI = Weight (kg) / Height (m) ²			28	26		
		Score	Score	Score	Score	Score
STEP 1: BMI Score	BMI kg/m ² <20 (>30 obese) 18.5 - 20 <18.5	0 1 2	0	0		
STEP 2: Unplanned weight loss in past 3-6 months	% <5 5 - 10 >10 Usual weight OR recent weight loss: kg	0 1 2	0	0		
STEP 3: Acute disease effect score	If the patient is acutely ill and there has been or is likely to be no nutritional intake for >5 days	2	0	0		
STEP 4: Overall risk of malnutrition	Add scores to calculate overall risk of malnutrition		0	0		
TOTAL SCORE:						
Initials:			LW	LW		

Treat as High Risk - immediate referral to dietitian (please tick as appropriate)

☐ Enteral/Parenteral feeding	☐ Stem cell/BM transplant
☐ Swallowing problems (dysphagia), e.g. stent, stricture	☐ Acute leukaemia
☐ Major ENT/Maxfax/GI surgery	☐ Organ failure, e.g. renal, liver
☐ Non-functioning gut (ileus, bowel obstruction, stasis)	☐ Decompensated Liver Disease
☐ Upper GI oncology	☐ Pressure ulcer, grade 3 or more
☐ Severe acute pancreatitis	

STEP 5: Management Guidelines	Actions Required	Initials	Date/Time
0 Low Risk	Repeat screening: Hospital - weekly, Community - monthly	<i>llh</i>	27/3
1 Medium Risk	Minimise any potential causes of poor appetite, e.g. oral infection, missing dentures, constipation, dehydration		
	Provide help and advice on food choices, eating and drinking		
	Initiate 3 day food record chart if intake poor for 2 or more days		
	Encourage snacks		
	If after 3 days more than 1/2 of meals and snacks are taken, continue to encourage with meals, offer snacks, offer full cream milk		
	If after 3 days less than 1/2 of meals and snacks are taken refer to dietitian		
	If on discharge patient remains medium risk, give 'Weigh Back Home' leaflet		
2 or more High Risk	Repeat screening weekly		
	Refer to dietitian for assessment and nutritional support (unless detrimental or no benefit is expected from nutritional support)		
	Commence all relevant actions from medium risk guidelines		
	Repeat screening weekly		





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CHI Number
Date of Birth

Date form started

Ward: 12

Coatbridge
Lanarkshire

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Safety Rounding every.....hour(s)

REVIEW 1hour(s)

REVIEW 2hour(s)

Explain purpose of rounding to offer reassurance

Escalate concerns about condition changes to nurse in charge

TIME (24 hour clock)	20	22	00	02	04	06	08	10	12	14	16	18	20	22	24	02	04	06	08	10	12	14	16	18	20	22	24
Continence care assistance - (eg, assist to toilet, hand washing, catheter care etc)	I	I	S	S	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I
Pain Review - (action appropriate to pain score or review)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hydration - (eg, drink offered /jug refilled)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Personal items at hand? - (glasses/tissue/buzzer etc)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is there anything else I can get for you before I go or anything you want to ask?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
INITIALS																											

TIME (24 hour clock)	20	22	00	02	04	06	08	10	12	14	16	18	20	22	00	02	04	06	08	10	12	14	16	18	20	22	00
Continence care assistance - (personal hygiene, hand washing, catheter care etc)	I	I	S	S	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I
Pain Review - (action appropriate to pain score or review)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hydration - (drink offered /jug refilled)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Personal items at hand? - (glasses/tissue/buzzer etc)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is there anything else I can get for you before I go or anything you want to ask?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
INITIALS																											

Y= Yes and addressed N = not required CP = further detail in care plan S = Sleeping O = off ward I = Independent

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CHI Number

Date of Birth

Date form started

Ward:12

NHS
Lanarkshire

This patient requires Intentional Safety Rounding every hour(s) REVIEW 1 hour(s) REVIEW 2 hour(s)

Explain purpose of rounding to offer reassurance

Escalate concerns about condition, changes to nurse in charge

TIME (24 hour clock)	18 ⁰⁰	19 ⁰⁰	20 ⁰⁰	21 ⁰⁰	22 ⁰⁰	23 ⁰⁰	00 ⁰⁰	01 ⁰⁰	02 ⁰⁰	03 ⁰⁰	04 ⁰⁰	05 ⁰⁰	06 ⁰⁰	07 ⁰⁰	08 ⁰⁰	09 ⁰⁰	10 ⁰⁰	11 ⁰⁰	12 ⁰⁰	13 ⁰⁰	14 ⁰⁰	15 ⁰⁰
Continence care assistance – (eg, assist to toilet, hand washing, catheter care etc)	I	I	I	I	I	S	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I
Pain Review – (action appropriate to pain score or review)	N	N	N	N	N	S	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Hydration – (eg, drink offered /jug refilled)	Y	Y	Y	Y	Y	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Personal items at hand? – (glasses/tissue/buzzer etc)	Y	Y	Y	Y	Y	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is there anything else I can get for you before I go or anything you want to ask?	Y	Y	Y	Y	Y	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
INITIALS	HW	HW	HW	HW	HW	S	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW

TIME (24 hour clock)	16 ⁰⁰	17 ⁰⁰	18 ⁰⁰	19 ⁰⁰	20 ⁰⁰	21 ⁰⁰	22 ⁰⁰	23 ⁰⁰	00 ⁰⁰	01 ⁰⁰	02 ⁰⁰	03 ⁰⁰	04 ⁰⁰	05 ⁰⁰	06 ⁰⁰	07 ⁰⁰	08 ⁰⁰	09 ⁰⁰	10 ⁰⁰	11 ⁰⁰	12 ⁰⁰	13 ⁰⁰	14 ⁰⁰	15 ⁰⁰
Continence care assistance – (personal hygiene, hand washing, catheter care etc)	I	I	I	S	S	S	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I
Pain Review – (action appropriate to pain score or review)	N	N	N	S	S	S	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Hydration – (drink offered /jug refilled)	Y	Y	Y	S	S	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Personal items at hand? – (glasses/tissue/buzzer etc)	Y	Y	Y	S	S	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is there anything else I can get for you before I go or anything you want to ask?	Y	Y	Y	S	S	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
INITIALS	HW	HW	HW	S	S	S	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW

Y= Yes and addressed N = not required OP = further detail in care plan S = Sleeping O = off ward I = Independent

intentional safety rounding sheet. MONKJ.ANDS WARD 2 M Hogg / K.McManus November 2013

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1808785142

18/08/1978

In
N: MCCRACKEN Isabel
1d Cumbrae CrescentCoatbridge
Lanarkshire

CHI Number

Date of Birth

Date form started

Ward: 12

NHS
Lanarkshire

ML5 4P

Rounding every.....hour(s)

REVIEW 1hour(s)

REVIEW 2hour(s)

Explain purpose of rounding to offer reassurance

5/4

Escalate concerns about condition changes to nurse in charge

clb clh

TIME (24 hour clock)	00 ⁰⁰	02 ⁰⁰	04 ⁰⁰	06 ⁰⁰	08 ⁰⁰	10 ⁰⁰	12 ⁰⁰	14 ⁰⁰	16 ⁰⁰	18 ⁰⁰	20 ⁰⁰	22 ⁰⁰	24 ⁰⁰	02 ⁰⁰	04 ⁰⁰	06 ⁰⁰	08 ⁰⁰	10 ⁰⁰	12 ⁰⁰	14 ⁰⁰	16 ⁰⁰	18 ⁰⁰	20 ⁰⁰	22 ⁰⁰	24 ⁰⁰
Continence care assistance - (eg, assist to toilet, hand washing, catheter care etc)	S	S			I	I	I	I	I	I	I	S	I	I	I	I	I	I	I	I	I	I	I	I	I
Pain Review - (action appropriate to pain score or review)	S	S			N	N	N	N	N	N	N	S	N	n	n	n	n	n	n	n	n	S	N	N	
Hydration - (eg, drink offered /jug refilled)	S	S			Y	Y	Y	Y	Y	Y	Y	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Personal items at hand? - (glasses/tissue/buzzer etc)	S	S			Y	Y	Y	Y	Y	Y	Y	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is there anything else I can get for you before I go or anything you want to ask?	S	S			Y	Y	Y	Y	Y	Y	Y	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
INITIALS	VM	VM			JS	JS	JS	JS	JS	JS	JS	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP

TIME (24 hour clock)	06 ⁰⁰	08 ⁰⁰	10 ⁰⁰	12 ⁰⁰	14 ⁰⁰	16 ⁰⁰	18 ⁰⁰	20 ⁰⁰	22 ⁰⁰	24 ⁰⁰	06 ⁰⁰	08 ⁰⁰	10 ⁰⁰	12 ⁰⁰	14 ⁰⁰	16 ⁰⁰	18 ⁰⁰	20 ⁰⁰	22 ⁰⁰	24 ⁰⁰	06 ⁰⁰	08 ⁰⁰	10 ⁰⁰	12 ⁰⁰	14 ⁰⁰
Continence care assistance - (personal hygiene, hand washing, catheter care etc)	S	I	I	I	I	I	I	S	S	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I
Pain Review - (action appropriate to pain score or review)	S	N	N	N	N	N	N	S	N	N	N	N	N	N	N	N	N	S	S	N	N	N	N	N	N
Hydration - (drink offered /jug refilled)	S	Y	Y	Y	Y	Y	Y	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	S	S	Y	Y	Y	Y	Y	Y
Personal items at hand? - (glasses/tissue/buzzer etc)	S	Y	Y	Y	Y	Y	Y	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	S	S	Y	Y	Y	Y	Y	Y
Is there anything else I can get for you before I go or anything you want to ask?	S	Y	Y	Y	Y	Y	Y	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	S	S	Y	Y	Y	Y	Y	Y
INITIALS	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP

Y = Yes and addressed N = not required CP = further detail in care plan

S = Sleeping

O = off ward

I = independent

intentional safety rounding sheet. MONKLANDS WARD 2 M Hogg / K. McMahon November 2013

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Intentional Safety Rounding

Name or insert Label

CHI Number

Date form started

Ward: 14

Date of Birth



This patient requires Intentional Safety Rounding every.....hour(s)

REVIEW 1hour(s)

REVIEW 2hour(s)

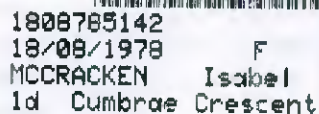
Explain purpose of rounding to offer reassurance

Escalate concerns about condition changes to nurse in charge

TIME (24 hour clock)	1600	1800	2000	2200	0000	0200	0400	0600	0800	1000	1200	1400	1600	1800	2000	2200	0000
Continence care assistance - (eg, assist to toilet, hand washing, catheter care etc)	S	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	S
Pain Review - (action appropriate to pain score or review)	S	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	S
Hydration - (eg, drink offered /jug refilled)	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	S
Personal items at hand? - (glasses/tissue/buzzer etc)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	S
Is there anything else I can get for you before I go or anything you want to ask?	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	S
INITIALS	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	MF

TIME (24 hour clock)	0600	0800	1000	1200	1400	1600	1800	2000	2200	0000	0200	0400	0600	0800	1000	1200	1400
Continence care assistance - (personal hygiene, hand washing, catheter care etc)	I	I	I	I													
Pain Review - (action appropriate to pain score or review)	N	N	N	N													
Hydration - (drink offered /jug refilled)	Y	Y	Y	Y													
Personal items at hand? - (glasses/tissue/buzzer etc)	Y	Y	Y	Y													
Is there anything else I can get for you before I go or anything you want to ask?	Y	Y	Y	Y													
INITIALS	MF	MF	MF	MF													

Y= Yes and addressed N = not required CP = further detail in care plan S = Sleeping O = off ward I = Independent



Coatbridge
Lanarkshire

ML5 4P3

61. What is the purpose of the following code?

Patient Weight Chart

Area: ☐ Community ☐ Learning Disabilities ☐ Mental Health ☐ Hairmyres Hospital
☐ Monklands Hospital ☐ Wishaw General ☐ Other Hospital: (specify) _____

Ward/Base: _____

Initial Weight: _____ kg Height: _____ cm BMI: _____ Date: ____/____/____

Weight History:

Date	Weight kg	BMI (if required)	Loss	Gain	Comments	Signature
2/4	66.70					Shus
4/4	128.20					S. C
7/4	61.75					Mac
8/4	61.75					M Kerr
9/4	61.85					Calvert
Take weigh weekly 11th April. At NOT BEFORE.						



CHI number:

ML5 4FX

Fluid Balance Chart and Daily Adult Fluid Prescription Chart

Fluid Balance Chart

Total Intake Goal today = mls

Total Output:



1808785142
18/09/1978 F
MCCRACKEN Isabel
1d Cumberae Crescent
Coatbridge
Lanarkshire ML5 4PX

Daily Adult Fluid Prescription Chart

Use an individual fluid prescription chart for
EVERY 24 HOUR PERIOD. N.B. Not suitable for Paediatrics.
Date: 27/3/21

Total Intake Goal Today (30ml/kg/24hrs) = (20-25ml/kg/24hrs in frail elderly)
Latest U&Es/Hb checked: ☐ Yes ☐ No Weight: kg

1. Assess patient	Hypovolaemic (reassess regularly)		Euvolaemic (fasting >8hrs)	Hypervolaemic (overloaded)	Special cases Consult senior	
2. Why give fluid?	Replacement	Resuscitation	Maintenance	Restriction ml	Cardiac dysfunction	
3. How much?	Estimate losses in past 24 hrs. Replacement is in addition to maintenance.	Fluid challenge 250-500ml over 5-15mins and reassess	30ml/kg/24hrs Subtract other intake Today's IV needs: = ml	Fluid restrict. Consider diuresis	Renal/ Liver failure	
Look at history, weight, U&Es, other fluid intake e.g. IV is					Obstetrics	
					Head injury	
4. Which fluid?	PlasmaLyte 148 or 0.9%NaCl+KCl for upper GI loss	PlasmaLyte 148/colloid (Isoplex)/ Blood on BTS chart	0.18%NaCl in 4%Glucose ± KCl* If Na ≤132 use PlasmaLyte 148	Consult Senior	*Give 40 mmol KCL/litre in maintenance unless K is ≥ 5.0 or renal function deteriorating	

Never give 0.18%NaCl/4%Glucose± 0.3%KCl (40mmol) at over 100ml/hr:
RISK OF HYPONATRAEMIA

Diabetes: for patients on intravenous insulin use 0.45%NaCl/5%Glucose± KCl

Weight (kg)	Maintenance Requirement /24hr (30ml/kg/24hrs)	Rate (ml/hr)	Approximate Equivalence to 500ml over x hrs
35-44	1200 ml	50	500ml 10 hrly
45-54	1500 ml	65	8 hrly
55-64	1800 ml	75	7 hrly
65-74	2100 ml	85	6 hrly
≥75	2400 ml	100 (max)	5 hrly

Maintenance Fluid (Max 100ml/hr) includes fluid for patients receiving IV insulin or subcutaneous fluids

Date/Time	Fluid +/- Additions e.g. KCl / MgSO4	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
27/3	NaCl 0.9% + 40mmol KCl	500	60	Continue	[Signature]	27/3	06:30		[Signature]	[Signature]
				Stop Review						
27/03	PLASMAlyTE	500	125ml/hr	Continue	[Signature]	27/3	10:00		[Signature]	[Signature]
				Stop Review						
27/03	PLASMAlyTE	500	100ml/hr	Continue	[Signature]	28/3	00:40		cl	
				Stop Review						
28/3	0.9% NaCl + 20mmol KCl	500	100	Continue	[Signature]	28/3	18:5		[Signature]	
				Stop Review						
28/3	0.9% NaCl	500	100	Continue	[Signature]	28/3	00:15		cl	
				Stop Review						

Resuscitation/Replacement Fluid Still hypotensive after 2000ml of resuscitation fluid? D/W with senior/ICU

Date/Time	Fluid +/- Additions e.g. KCl / MgSO4	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						

The NHSL Guidance for Intravenous Fluid and Electrolyte Prescribing and Hyponatraemia Guideline are available on the Intranet

1800705142
18/08/1978 F
MCCRACKEN Isobel
1d Cumber Crescent

Coatbridge
Lanarkshire

ML5 4Pere

University Hospital Monklands NHS
Ward: 12 Lanarkshire

Fluid Balance Chart and Daily Adult Fluid Prescription Chart

Date: 28/3/24

Fluid Balance Chart

Reason for commencement:

Yesterday's Intake = mls Output = mls

Yesterday's Intake Goal achieved? ☐ Yes ☐ No

Total Intake Goal today = mls

INTAKE					OUTPUT				
Time	Oral	IV/ Sub Cut	Enteral Feed	Type of Fluid	Urine	Drain/ Fistulae	Aspirate /Vomit	Bowel/ Stoma	Initials x4 (RN)
08:00									
09:00	150			Milk					
10:00	150			Hot choc					
11:00									
12:00	150			Juice	Put				
13:00									
14:00	150			Hot choc					
15:00	150			Juice	Put				
Sub Totals					Put				
Stop and Check	Intake (oral + IV + enteral) less than 250ml?				☐ Yes	☐ No	If yes to any question or if any concern escalate to nurse in charge/doctor		
	Urine less than 140ml?				☐ Yes	☐ No			
	Other losses more than 250ml?				☐ Yes	☐ No			
16:00									
17:00	150			Juice	Put				
18:00									
19:00									
Stop and Check									
20:00	150			Hot choc					
21:00									
22:00					Put				
23:00		120		IVAB					
24:00									
01:00									
02:00									
03:00									
04:00									
Sub Totals									
05:00		500		IVFs					
06:00		220		IVAB					
07:00									
24hr Totals									

Total Intake:

Total Output:

Fluid Balance = Total Intake - Total Output:

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Daily Adult Fluid Prescription Chart

Use an individual fluid prescription chart for EVERY 24 HOUR PERIOD. N.B. Not suitable for Paediatrics.

Date: / /

Total Intake Goal Today (30ml/kg/24hrs) = _____ (20-25ml/kg/24hrs in frail elderly)

Weight:

Latest U&Es/Hb checked: ☐ Yes ☐ No

kg

1. Assess patient	Hypovolaemic (reassess regularly)		Euvolaemic (fasting >8hrs)	Hypervolaemic (overloaded)	Special cases Consult senior	
2. Why give fluid?	Replacement	Resuscitation	Maintenance	Restriction ml	Cardiac dysfunction	
3. How much? Look at history, weight, U&Es, other fluid intake e.g. IV antibiotics	Estimate losses in past 24 hrs. Replacement is in addition to maintenance.	Fluid challenge 250-500ml over 5-15mins and reassess	30ml/kg/24hrs Subtract other intake Today's IV needs: = ml	Fluid restrict. Consider diuresis	Renal/ Liver failure	
					Obstetrics	
					Head injury	
4. Which fluid?	PlasmaLyte 148 or 0.9%NaCl+KCl for upper GI loss	PlasmaLyte 148/colloid (Isoplex)/ Blood on BTS chart	0.18%NaCl in 4%Glucose ± KCl* If Na ≤132 use PlasmaLyte 148	Consult Senior	*Give 40 mmol KCL/litre in maintenance unless K is ≥ 5.0 or renal function deteriorating	

Never give 0.18%NaCl/4%Glucose±
0.3%KCl (40mmol) at over 100ml/hr:

RISK OF HYPONATRAEMIA

Diabetes: for patients on intravenous insulin use 0.45%NaCl/5%Glucose± KCl

Weight (kg)	Maintenance Requirement /24hr (30ml/kg/24hrs)	Rate (ml/hr)	Approximate Equivalence to 500ml over x hrs
35-44	1200 ml	50	500ml 10 hrly
45-54	1500 ml	65	8 hrly
55-64	1800 ml	75	7 hrly
65-74	2100 ml	85	6 hrly
≥75	2400 ml	100 (max)	5 hrly

Maintenance Fluid (Max 100ml/hr) includes fluid for patients receiving IV insulin or subcutaneous fluids

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO ₄	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
29/3	Plasmalyte	500	100	Continue	[Signature]	29/3	00 15		cl	
				Stop Review						
				Continue						
				Stop Review						
				Continue						
				Stop Review						
				Continue						
				Stop Review						
				Continue						
				Stop Review						

Resuscitation/Replacement Fluid Still hypotensive after 2000ml of resuscitation fluid? D/W with senior/ICU

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO4	Vol ml	Rate ml/hr	After this bag		Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Stop	Review						
				Stop	Review						
				Stop	Review						
				Stop	Review						
				Stop	Review						

The NHSL Guidance for Intravenous Fluid and Electrolyte Prescribing and Hyponatraemia Guideline are available on the Intranet

1308785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumbernauld Crescent

Coatbridge
Lanarkshire

ML5 4P7

Fluid Balance Chart and Daily Adult Fluid Prescription Chart

Date: 31/03/24

Fluid Balance Chart

Reason for commencement:

Yesterday's Intake = mls Output = mls

Yesterday's Intake Goal achieved? ☐ Yes ☐ No

Total Intake Goal today = mls

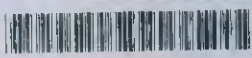
INTAKE					OUTPUT				
Time	Oral	IV/ Sub Cut	Enteral Feed	Type of Fluid	Urine	Drain/ Fistulae	Aspirate /Vomit	Bowel/ Stoma	Initials x4 (RN)
08:00	800/50			Milk					
09:00									
10:00					pit				
11:00	150			milk					
12:00	70			Soup					
13:00									
14:00									
15:00									
Sub Totals									
Stop and Check	Intake (oral + IV + enteral) less than 250ml?				☐ Yes	☐ No	If yes to any question or if any concern escalate to nurse in charge/doctor		
	Urine less than 140ml?				☐ Yes	☐ No			
	Other losses more than 250ml?				☐ Yes	☐ No			
16:00									
17:00									
18:00									
19:00									
Stop and Check									
20:00	100			milk					
21:00									
22:00	200	300		water iv Abx's	pu				
23:00									
24:00									
01:00									
02:00									
03:00									
04:00									
Sub Totals									
05:00									
06:00	100	300		water iv Abx					
07:00									
24hr Totals									

Total Intake:

Total Output:

Fluid Balance = Total Intake - Total Output:

COPY PAGE

Ctr: 
 Fin: 1808785142
 La: 18/08/1978 F
 Ad: MCCPACKEEN Isabel
 1d Cumberae Crescent
 Coatbridge
 Lanarkshire ML5 4PX

Daily Adult Fluid Prescription Chart

Use an individual fluid prescription chart for
EVERY 24 HOUR PERIOD. N.B. Not suitable for Paediatrics.

Date: / /

Total Intake Goal Today (30ml/kg/24hrs) = (20-25ml/kg/24hrs in frail elderly) Latest U&Es/Hb checked: ☐ Yes ☐ No	Weight: kg
---	----------------------------

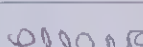
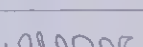
1. Assess patient	Hypovolaemic (reassess regularly)		Euvolaemic (fasting >8hrs)	Hypervolaemic (overloaded)	Special cases Consult senior	
2. Why give fluid?	Replacement	Resuscitation	Maintenance	Restriction ml	Cardiac dysfunction	
3. How much?	Estimate losses in past 24 hrs. Replacement is in addition to maintenance.	Fluid challenge 250-500ml over 5-15mins and reassess	30ml/kg/24hrs Subtract other intake Today's IV needs: = ml	Fluid restrict. Consider diuresis	Renal/ Liver failure	
Look at history, weight, U&Es, other fluid intake e.g. IV antibiotics					Obstetrics	
					Head injury	
4. Which fluid?	PlasmaLyte 148 or 0.9%NaCl+KCl for upper GI loss	PlasmaLyte 148/colloid (Isoplex)/ Blood on BTS chart	0.18%NaCl in 4%Glucose ± KCl* If Na ≤132 use PlasmaLyte 148	Consult Senior	*Give 40 mmol KCL/litre in maintenance unless K is ≥ 5.0 or renal function deteriorating	

Never give 0.18%NaCl/4%Glucose±
 0.3%KCl (40mmol) at over 100ml/hr:
RISK OF HYPONATRAEMIA

Diabetes: for patients on
 intravenous insulin use
 0.45%NaCl/5%Glucose± KCl

Weight (kg)	Maintenance Requirement /24hr (30ml/kg/24hrs)	Rate (ml/hr)	Approximate Equivalence to 500ml over x hrs
35-44	1200 ml	50	500ml 10 hrly
45-54	1500 ml	65	8 hrly
55-64	1800 ml	75	7 hrly
65-74	2100 ml	85	6 hrly
≥75	2400 ml	100 (max)	5 hrly

Maintenance Fluid (Max 100ml/hr) includes fluid for patients receiving IV insulin or subcutaneous fluids

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO4	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
30/3/21	0.9% NaCl 40mmol KCl	500	125	Continue		30/3	16:00		hf	JF
				Stop Review						
30/3/21	0.9% NaCl 40mmol KCl	500	125	Continue		30/3	22:50		gm	km
				Stop Review						
30/3/21	0.9% NaCl 40mmol KCl	500	125	Continue		31/3	02:45		gm	km
				Stop Review						
				Continue						
				Stop Review						
				Continue						
				Stop Review						

Resuscitation/Replacement Fluid Still hypotensive after 2000ml of resuscitation fluid? D/W with senior/ICU

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO4	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						

**The NHSL Guidance for Intravenous Fluid and Electrolyte Prescribing and Hyponatraemia
 Guideline are available on the Intranet**

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Fluid Balance Chart and Daily Adult Fluid Prescription Chart

Date: 1/4/24

CHI no

First name

Last name

Adc

DOB

Sex: ☐ M ☐ F

1909785142

18/08/1978

MCCRACKEN

F

Isabel

1d Cumbernauld Crescent

F Coatbridge Lanarkshire
ML5 4P3

Yesterday's Intake = mls Output = mls
Yesterday's Intake Goal achieved? ☐ Yes ☐ No
Total Intake Goal today = mls

INTAKE					OUTPUT				
Time	Oral	IV/ Sub Cut	Enteral Feed	Type of Fluid	Urine	Drain/ Fistulae	Aspirate /Vomit	Bowel/ Stoma	Initials x4 (RN)
08:00	250			milk/juice					
09:00									
10:00	250			milk					
11:00									
12:00	150			Milk					
13:00	200			Water	POT				
14:00		150		IVABX.					
15:00									
Sub Totals									
Stop and Check	Intake (oral + IV + enteral) less than 250ml?				☐ Yes	☒ No	If yes to any question or if any concern escalate to nurse in charge/doctor		
	Urine less than 140ml? N/A				☐ Yes	☐ No			
	Other losses more than 250ml?				☐ Yes	☒ No			
16:00	500			Water					
17:00	150			milk	POT				
18:00									
19:00									
Stop and Check									
20:00	Refused								
21:00									
22:00									
23:00									
24:00									
01:00									
02:00									
03:00									
04:00									
Sub Totals									
05:00									
06:00									
07:00									
24hr Totals									

Total Intake: Total Output:

Fluid Balance = Total Intake - Total Output:

6670

COPY PAGE



CHI no
First name DOB
Last name Sex: ☐ M ☐ F
Address

or attach addressograph label here

Daily Adult Fluid Prescription Chart

Use an individual fluid prescription chart for EVERY 24 HOUR PERIOD. N.B. Not suitable for Paediatrics.

Date: ____/____/____

Total Intake Goal Today (30ml/kg/24hrs) = (20-25ml/kg/24hrs in frail elderly)

Weight:

Latest U&Es/Hb checked: ☐ Yes ☐ No

kg

1. Assess patient	Hypovolaemic (reassess regularly)		Euvolaemic (fasting >8hrs)	Hypervolaemic (overloaded)	Special cases Consult senior	
2. Why give fluid?	Replacement	Resuscitation	Maintenance	Restriction ml	Cardiac dysfunction	
3. How much?	Estimate losses in past 24 hrs. Replacement is in addition to maintenance.	Fluid challenge 250-500ml over 5-15mins and reassess	30ml/kg/24hrs Subtract other intake Today's IV needs: = ml	Fluid restrict. Consider diuresis	Renal/ Liver failure	
Look at history, weight, U&Es, other fluid intake e.g. IV antibiotics					Obstetrics	
					Head injury	
4. Which fluid?	PlasmaLyte 148 or 0.9%NaCl+KCl for Upper GI loss	PlasmaLyte 148/colloid (Isoplex)/ Blood on BTS chart	0.18%NaCl in 4%Glucose $\pm$ KCl* If Na $\leq$ 132 use PlasmaLyte 148	Consult Senior	*Give 40 mmol KCL/litre in maintenance unless K is $\geq$ 5.0 or renal function deteriorating	

Never give 0.18%NaCl/4%Glucose±
0.3%KCl (40mmol) at over 100ml/hr:

RISK OF HYPONATRAEMIA

Diabetes: for patients on intravenous insulin use 0.45%NaCl/5%Glucose± KCl

Weight (kg)	Maintenance Requirement /24hr (30ml/kg/24hrs)	Rate (ml/hr)	Approximate Equivalence to 500ml over x hrs
35-44	1200 ml	50	500ml 10 hrly
45-54	1500 ml	65	8 hrly
55-64	1800 ml	75	7 hrly
65-74	2100 ml	85	6 hrly
≥75	2400 ml	100 (max)	5 hrly

Maintenance Fluid (Max 100ml/hr) includes fluid for patients receiving IV insulin or subcutaneous fluids

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO4	Vol ml	Rate ml/hr	After this bag		Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Continue							
				Stop	Review						
				Continue							
				Stop	Review						
				Continue							
				Stop	Review						
				Continue							
				Stop	Review						
				Continue							
				Stop	Review						

Resuscitation/Replacement Fluid Still hypotensive after 2000ml of resuscitation fluid? D/W with senior/ICU

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO ₄	Vol ml	Rate ml/hr	After this bag		Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Stop	Review						
				Stop	Review						
				Stop	Review						
				Stop	Review						
				Stop	Review						

The NHSL Guidance for Intravenous Fluid and Electrolyte Prescribing and Hyponatraemia Guideline are available on the Intranet

1808785142
18/08/1978
MCCRACKEN Isabel
1d Cumbrae Crescent

Cootbridge
Lanarkshire

ML5 4PY

University Hospital Monklands

Ward:

12

NHS
Lanarkshire

Fluid Balance Chart and Daily Adult Fluid Prescription Chart

Date: 2 / 4 / 21

Fluid Balance Chart

Reason for commencement:

Yesterday's Intake = mls Output = mls

Yesterday's Intake Goal achieved? ☐ Yes ☐ No

Total Intake Goal today = mls

INTAKE

OUTPUT

Time	Oral	IV/ Sub Cut	Enteral Feed	Type of Fluid	Urine	Drain/ Fistulae	Aspirate /Vomit	Bowel/ Stoma	initials x4 (RN)
08:00	150			juice					
09:00									
10:00	150			juice					
11:00									
12:00									
13:00	500			Oral Glucose					
14:00									
15:00									
Sub Totals									

Stop and
Check

Intake (oral + IV + enteral) less than 250ml?

☐ Yes

☐ No

Urine less than 140ml?

☐ Yes

☐ No

Other losses more than 250ml?

☐ Yes

☐ No

If yes to any question, or
if any concern escalate to
nurse in charge/doctor

16:00	330			juice					
17:00	150			milk					
18:00									
19:00									
Stop and Check									
20:00	150			HOT CHOC					
21:00									
22:00		220		IVAB					
23:00									
24:00									
01:00									
02:00									
03:00									
04:00									
Sub Totals									
05:00									
06:00									
07:00									
24hr Totals									

Total Intake:

Total Output:

Fluid Balance = Total Intake - Total Output:

COPY PAGE

CHI no
 First name DOB
 Last name Sex: ☐ M ☐ F
 Address

or attach addressograph label here

University Hospital Monklands **NHS**
 Ward: Lanarkshire

Daily Adult Fluid Prescription Chart

Use an individual fluid prescription chart for
 EVERY 24 HOUR PERIOD. N.B. Not suitable for Paediatrics.

Date: / /

Total Intake Goal Today (30ml/kg/24hrs) = (20-25ml/kg/24hrs in frail elderly)

Weight:

Latest U&Es/Hb checked: ☐ Yes ☐ No

..... kg

1. Assess patient	Hypovolaemic (reassess regularly)		Euvolaemic (fasting >8hrs)	Hypervolaemic (overloaded)	Special cases Consult senior	
2. Why give fluid?	Replacement	Resuscitation	Maintenance	Restriction ml	Cardiac dysfunction	
3. How much? Look at history, weight, U&Es, other fluid intake e.g. IV antibiotics	Estimate losses in past 24 hrs. Replacement is in addition to maintenance.	Fluid challenge 250-500ml over 5-15mins and reassess	30ml/kg/24hrs Subtract other intake Today's IV needs: = ml	Fluid restrict. Consider diuresis	Renal/ Liver failure	
4. Which fluid?	PlasmaLyte 148 or 0.9%NaCl+KCl for upper GI loss	PlasmaLyte 148/colloid (Isoplex)/ Blood on BTS chart	0.18%NaCl in 4%Glucose ± KCl* If Na ≤132 use PlasmaLyte 148	Consult Senior	Obstetrics	
					Head injury	
					*Give 40 mmol KCL/litre in maintenance unless K is ≥ 5.0 or renal function deteriorating	

Never give 0.18%NaCl/4%Glucose±
 0.3%KCl (40mmol) at over 100ml/hr:
RISK OF HYPONATRAEMIA

Diabetes: for patients on
 intravenous insulin use
 0.45%NaCl/5%Glucose± KCl

Weight (kg)	Maintenance Requirement /24hr (30ml/kg/24hrs)	Rate (ml/hr)	Approximate Equivalence to 500ml over x hrs
35-44	1200 ml	50	500ml 10 hrly
45-54	1500 ml	65	8 hrly
55-64	1800 ml	75	7 hrly
65-74	2100 ml	85	6 hrly
≥75	2400 ml	100 (max)	5 hrly

Maintenance Fluid (Max 100ml/hr) includes fluid for patients receiving IV insulin or subcutaneous fluids

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO ₄	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Continue						
				Stop Review						
				Continue						
				Stop Review						
				Continue						
				Stop Review						
				Continue						
				Stop Review						

Resuscitation/Replacement Fluid Still hypotensive after 2000ml of resuscitation fluid? D/W with senior/ICU

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO ₄	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						

**The NHSL Guidance for Intravenous Fluid and Electrolyte Prescribing and Hyponatraemia
 Guideline are available on the Intranet**

C
Fi 1808705142
Lz 18/08/1978 F
At MCCracken Isobel
1d Cumberae Crescent
Coatbridge
Lanarkshire ML5 4P

Fluid Balance Chart and Daily Adult Fluid Prescription Chart

Date: 3/4/21

Fluid Balance Chart

Reason for commencement:

Yesterday's Intake = mls Output = mls

Yesterday's Intake Goal achieved? ☐ Yes ☐ No

Total Intake Goal today = mls

INTAKE					OUTPUT				
Time	Oral	IV/ Sub Cut	Enteral Feed	Type of Fluid	Urine	Drain/ Fistulae	Aspirate /Vomit	Bowel/ Stoma	Initials x4 (RN)
08:00	250			COKE					
09:00	200			Water	PUT				
10:00									
11:00	30			Juice					
12:00	400			Water/Juice					
13:00									
14:00	200			WATER					
15:00	250			JUICE	PUT				
Sub Totals									
Stop and Check	Intake (Oral + IV + enteral) less than 250ml?				☐ Yes	☐ No	If yes to any question or if any concern escalate to nurse in charge/doctor		
	Urine less than 140ml?				☐ Yes	☐ No			
	Other losses more than 250ml?				☐ Yes	☐ No			
16:00	100			COKE					
17:00	300			Water					
18:00	50			Strawberry					
19:00				MILK					
Stop and Check									
20:00	100			WATER	PUT				
21:00									
22:00									
23:00									
24:00									
01:00									
02:00									
03:00									
04:00									
Sub Totals									
05:00									
06:00									
07:00									
24hr Totals									
Total Intake:					Total Output:				

Fluid Balance = Total Intake - Total Output:



Daily Adult Fluid Prescription Chart

Use an individual fluid prescription chart for EVERY 24 HOUR PERIOD. N.B. Not suitable for Paediatrics.

Date: / /

Total Intake Goal Today (30ml/kg/24hrs) = (20-25ml/kg/24hrs in frail elderly) Latest U&Es/Hb checked: ☐ Yes ☐ No	Weight: kg
---	----------------------------

1. Assess patient	Hypovolaemic (reassess regularly)		Euvolaemic (fasting >8hrs)	Hypervolaemic (overloaded)	Special cases Consult senior	
2. Why give fluid?	Replacement	Resuscitation	Maintenance	Restriction ml	Cardiac dysfunction	
3. How much?	Estimate losses in past 24 hrs. Replacement is in addition to maintenance.	Fluid challenge 250-500ml over 5-15mins and reassess	30ml/kg/24hrs Subtract other intake Today's IV needs: = ml	Fluid restrict. Consider diuresis	Renal/ Liver failure	
Look at history, weight, U&Es, other fluid intake e.g. IV antibiotics					Obstetrics	
					Head injury	
4. Which fluid?	PlasmaLyte 148 or 0.9%NaCl+KCl for upper GI loss	PlasmaLyte 148/colloid (Isoplex)/ Blood on BTS chart	0.18%NaCl in 4%Glucose ± KCl* If Na ≤132 use PlasmaLyte 148	Consult Senior	*Give 40 mmol KCL/litre in maintenance unless K is ≥ 5.0 or renal function deteriorating	

Never give 0.18%NaCl/4%Glucose±
0.3%KCl (40mmol) at over 100ml/hr:
RISK OF HYPONATRAEMIA

Weight (kg)	Maintenance Requirement /24hr (30ml/kg/24hrs)	Rate (ml/hr)	Approximate Equivalence to 500ml over x hrs
35-44	1200 ml	50	500ml 10 hrly
45-54	1500 ml	65	8 hrly
55-64	1800 ml	75	7 hrly
65-74	2100 ml	85	6 hrly
≥75	2400 ml	100 (max)	5 hrly

Diabetes: for patients on intravenous insulin use 0.45%NaCl/5%Glucose± KCl

Maintenance Fluid (Max 100ml/hr) includes fluid for patients receiving IV insulin or subcutaneous fluids

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO4	Vol ml	Rate ml/hr	After this bag		Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Continue							
				Stop	Review						
				Continue							
				Stop	Review						
				Continue							
				Stop	Review						
				Continue							
				Stop	Review						
				Continue							
				Stop	Review						

Resuscitation/Replacement Fluid Still hypotensive after 2000ml of resuscitation fluid? D/W with senior/ICU

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO4	Vol ml	Rate ml/hr	After this bag		Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Stop	Review						
				Stop	Review						
				Stop	Review						
				Stop	Review						
				Stop	Review						

The NHSL Guidance for Intravenous Fluid and Electrolyte Prescribing and Hyponatraemia Guideline are available on the Intranet

Fluid Balance Chart and Daily Adult Fluid Prescription Chart

Date: 4/4/21

Fluid Balance Chart

Reason for commencement:

Yesterday's Intake = mls Output = mls

Yesterday's Intake Goal achieved? ☐ Yes ☐ No

Total Intake Goal today = mls

INTAKE					OUTPUT				
Time	Oral	IV/ Sub Cut	Enteral Feed	Type of Fluid	Urine	Drain/ Fistulae	Aspirate /Vomit	Bowel/ Stoma	Initials x4 (RN)
08:00	200			MILK					
09:00					PU				
10:00									
11:00	330			Water					
12:00									
13:00	300			Water PU					
14:00									
15:00	300			Water					
Sub Totals									
Stop and Check	Intake (oral + IV + enteral) less than 250ml?				☐ Yes	☐ No	If yes to any question or if any concern escalate to nurse in charge/doctor		
	Urine less than 140ml?				☐ Yes	☐ No			
	Other losses more than 250ml?				☐ Yes	☐ No			
16:00	150			Water	PU				
17:00	330			Juice					
18:00	33			Water					
19:00									
Stop and Check									
20:00	400			Water					
21:00									
22:00									
23:00									
24:00									
01:00									
02:00									
03:00									
04:00									
Sub Totals									
05:00									
06:00									
07:00									
24hr Totals									

Total Intake:

Total Output:

Fluid Balance = Total Intake - Total Output:



CHI no
 First name DOB
 Last name Sex: ☐ M ☐ F
 Address

or attach addressograph label here

University Hospital Monklands

Ward:



Daily Adult Fluid Prescription Chart

Use an individual fluid prescription chart for
 EVERY 24 HOUR PERIOD. N.B. Not suitable for Paediatrics.

Date: / /

Total Intake Goal Today (30ml/kg/24hrs) = (20-25ml/kg/24hrs in frail elderly)

Weight:

Latest U&Es/Hb checked: ☐ Yes ☐ No

..... kg

1. Assess patient	Hypovolaemic (reassess regularly)		Euvolaemic (fasting >8hrs)	Hypervolaemic (overloaded)	Special cases Consult senior	
2. Why give fluid?	Replacement	Resuscitation	Maintenance	Restriction ml	Cardiac dysfunction	
3. How much?	Estimate losses in past 24 hrs. Replacement is in addition to maintenance.	Fluid challenge 250-500ml over 5-15mins and reassess	30ml/kg/24hrs Subtract other intake Today's IV needs: = ml	Fluid restrict. Consider diuresis	Renal/ Liver failure	
Look at history, weight, U&Es, other fluid intake e.g. IV antibiotics					Obstetrics	
					Head injury	
4. Which fluid?	PlasmaLyte 148 or 0.9%NaCl+KCl for upper GI loss	PlasmaLyte 148/colloid (Isoplex)/ Blood on BTS chart	0.18%NaCl in 4%Glucose ± KCl* If Na ≤132 use PlasmaLyte 148	Consult Senior	*Give 40 mmol KCL/litre in maintenance unless K is ≥ 5.0 or renal function deteriorating	

Never give 0.18%NaCl/4%Glucose±
 0.3%KCl (40mmol) at over 100ml/hr:

RISK OF HYPONATRAEMIA

Diabetes: for patients on
 intravenous insulin use
 0.45%NaCl/5%Glucose± KCl

Weight (kg)	Maintenance Requirement /24hr (30ml/kg/24hrs)	Rate (ml/hr)	Approximate Equivalence to 500ml over x hrs
35-44	1200 ml	50	500ml 10 hrly
45-54	1500 ml	65	8 hrly
55-64	1800 ml	75	7 hrly
65-74	2100 ml	85	6 hrly
≥75	2400 ml	100 (max)	5 hrly

Maintenance Fluid (Max 100ml/hr) includes fluid for patients receiving IV insulin or subcutaneous fluids

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO ₄	Vol ml	Rate ml/hr	After this bag		Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Continue							
				Stop	Review						
				Continue							
				Stop	Review						
				Continue							
				Stop	Review						
				Continue							
				Stop	Review						

Resuscitation/Replacement Fluid Still hypotensive after 2000ml of resuscitation fluid? D/W with senior/ICU

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO ₄	Vol ml	Rate ml/hr	After this bag		Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Stop	Review						
				Stop	Review						
				Stop	Review						
				Stop	Review						
				Stop	Review						

**The NHSL Guidance for Intravenous Fluid and Electrolyte Prescribing and Hyponatraemia
 Guideline are available on the Intranet**

1808785142

18/08/1978

MCCRACKEN Isabel

1d Cumberae Crescent

Coatbridge Lanarkshire

ML5 4P>

Fluid Balance Chart and

Daily Adult Fluid Prescription Chart

Date: 5/4/21

Fluid Balance Chart

Reason for commencement:

Yesterday's Intake = mls

Output = mls

Yesterday's Intake Goal achieved? ☐ Yes ☐ No

Total Intake Goal today = mls

INTAKE					OUTPUT				
Time	Oral	IV/ Sub Cut	Enteral Feed	Type of Fluid	Urine	Drain/ Fistulae	Aspirate /Vomit	Bowel/ Stoma	Initials x4 (RN)
08:00									
09:00									
10:00									
11:00									
12:00									
13:00									
14:00									
15:00									
Sub Totals									
Stop and Check	Intake (oral + IV + enteral) less than 250ml?				☐ Yes	☐ No	If yes to any question or if any concern escalate to nurse in charge/doctor		
	Urine less than 140ml?				☐ Yes	☐ No			
	Other losses more than 250ml?				☐ Yes	☐ No			
16:00									
17:00									
18:00									
19:00									
Stop and Check									
20:00									
21:00									
22:00									
23:00									
24:00									
01:00									
02:00									
03:00									
04:00									
Sub Totals									
05:00									
06:00									
07:00									
24hr Totals									
Total Intake:					Total Output:				

Fluid Balance = Total Intake - Total Output:

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Education for Patients Receiving Oral Anticoagulant Therapy

All patients receiving anticoagulant therapy must be educated at the start of therapy using this form.



	1808785142 18/08/1978 F MCCRACKEN Isabel 1d Cumberae Crescent	Initial as done
Patient Details (attach addressograph if available)	CHI 1 Coatbridge Lanarkshire ML5 4PX Surname.....	SR
Anticoagulant Pack	Give pack to patient and explain Anticoagulant Alert Card/Record Book	SR
Mode of action of warfarin	Explain how warfarin affects coagulation factors reducing the ability of blood to clot.	SR
Reason for therapy	Patient understands reason for anticoagulation.	SR
Anticipated length of therapy	Patient knows proposed length of treatment.	SR
How to take medication	When Take at same time each day, preferably before evening meal.	SR
	Action if dose is missed/wrong dose taken Take if remembered within a few hours or omit if not remembered until next day. Explain who to contact if greater dose taken.	SR
	How to make up dose from tablets Explain different colours/strengths of tablets and how to make up dose with examples.	SR
	Contact the dispensing chemist immediately if the colour of warfarin tablets supplied is different from usual.	SR
Monitoring/Target INR	Explain what INR is and the patient's target range. Explain importance of monitoring and keeping appointments. Explain need to bring record book to appointments/pharmacy.	SR
Side effects	Explain what symptoms to look for e.g. bruising/bleeding. Explain when to contact hospital or GP and how to do this. Ensure contact numbers in anticoagulant pack.	SR
Information for doctors, dentists, pharmacists etc	Explain the importance of informing anyone treating patient of anticoagulant therapy. Explain importance of carrying record book/alert card.	SR
Drug interactions	Explain problems with drug interactions/health supplements and the need to inform doctor/pharmacist/clinic of any new medication/health supplements.	SR
Alcohol considerations	Explain interaction of warfarin and alcohol. Explain that excessive regular and/or binge drinking can be dangerous.	SR
Dietary considerations	Explain importance of a balanced diet and the effect major changes in diet can have on anticoagulant therapy. Inform patient of food/drinks that can affect INR.	SR
Pregnancy	Discuss potential problems of warfarin and pregnancy and advise on contraception. Advise to inform clinic within 2 weeks of missed period.	SR

If there is any doubt about a patient's understanding regarding any part of these instructions, please take note of this and inform prescribing doctor.

Signature.....

Designation..... PHARMACEUTIST

Patient/Carer.....

Date..... 12/11/21



ME03

White Copy Anticoagulant clinic/GP practice/Green Copy Patient/Pink Copy Case Notes

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COPY PAGE

Y Oliver
W012

SOUTH GLASGOW HOSPITALS
IMMUNOLOGY REPORT

IMFLC6 Run: 709

(Tel 0141 347 8872/0141 354 9337)

Surname: MCCracken
Forename: ISABEL
DOB/Age: 18.08.78 Sex: Female
CHI/Unit No: 1808785142
Address: 1D CUMBRAE CRESCENT
Details:

Location: Haematology Dept
Monklands Hospital
Airdrie
Lanarkshire Health Board
Requestor: Not known
Ext Labno: 1045247585

SERUM FREE LIGHT CHAINS

[[CURRENT]]

Lab Number B,21.3546854
Date/Time collected 06.04.21
Date/Time received 08.04.21 14:27

Free Kappa mg/L (3.3-19.4) * 45.3
Free Lambda mg/L (5.7-26.3) * 66.9
K/L ratio (0.26-1.65) 0.68



Result Comments:

06.04.21 FreeLChain: In renal impairment, K/L ratio may increase to 0.37 - 3.1
Free lambda and kappa light chains both raised
This may be found with renal impairment and/or disorders
associated with polyclonal rise in immunoglobulins.
If screening for myeloma, suggest check immunoglobulins plus
serum and urine electrophoresis locally.
Antigen excess excluded by additional dilutions

Date reported: 16.04.21

Authoriser: Nadia Shahid IMM

Page 1 of 1

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SOUTH GLASGOW HOSPITALS
IMMUNOLOGY REPORT
(Tel 0141 347 8872/0141 354 9337)

[IMM1 Run: 709]

Surname: MCCracken
Forename: ISABEL
DOB/Age: 18.08.78 Sex: Female
CHI/Unit No: 1808785142
Address: 1D CUMBRAE CRESCENT
Diagnosis:
Details:

Location: Haematology Dept
Monklands Hospital
Airdrie
Lanarkshire Health Board
Requestor: Not known
Ext Labno: 1045245912

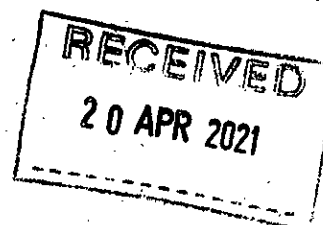
209

Lab No: B,21.3549239.L
Collected: 12.04.21
Authorised: 15.04.21

Received: 13.04.21 15:14
Authorised by: Moira Thomas IMM

COMPLEMENT C3 AND C4

Complement C3	* 2.05	g/L	(0.83-1.93)
Complement C4	0.46	g/L	(0.15-0.57)



Comments:

18-AUG-1978 (42 yr)
Female

Vent. rate
PR interval
QRS duration
QT/QTc
P-R-T axes

111
148
90
350/476
47 47

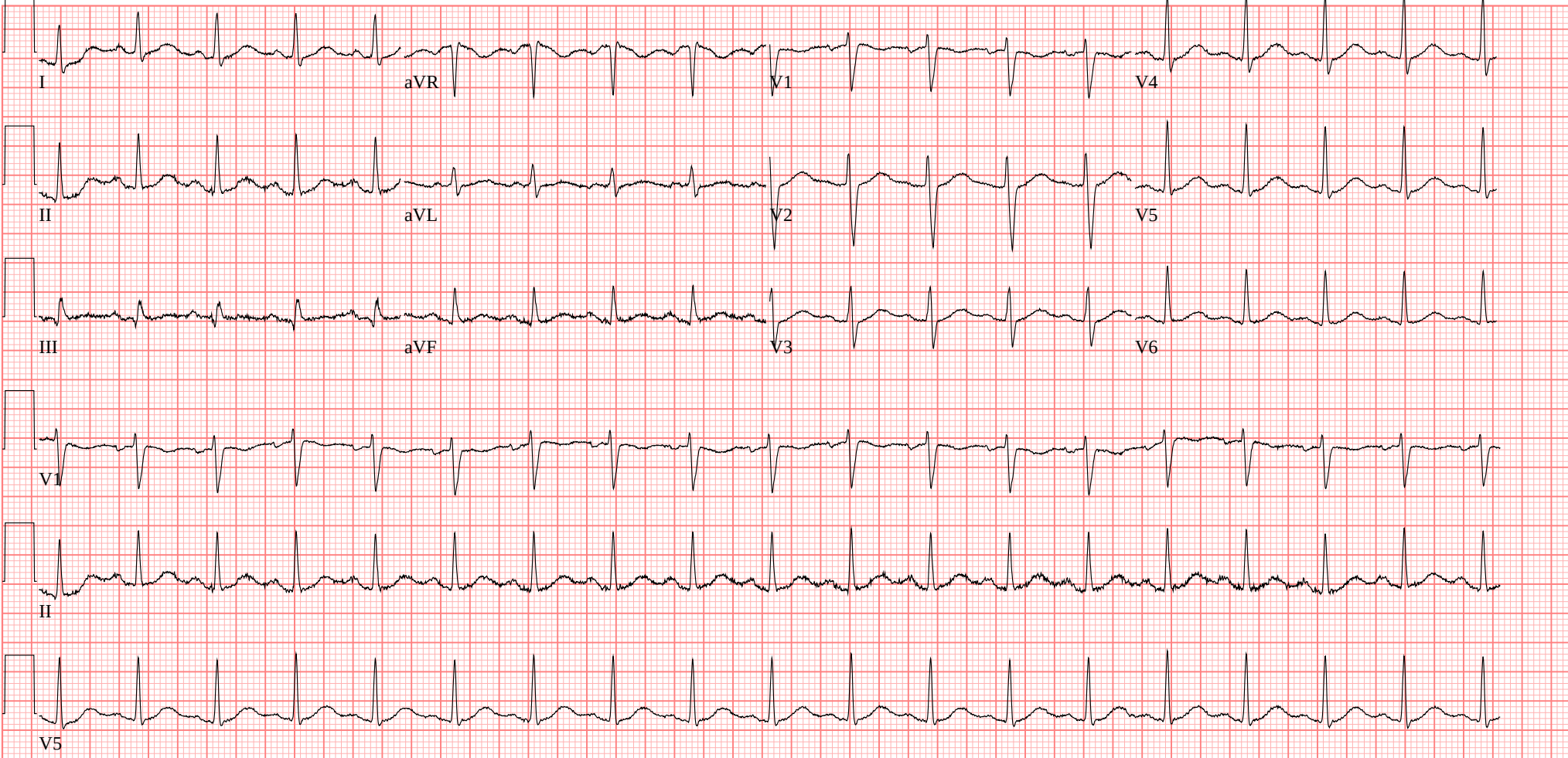
BPM
ms
ms
ms
45

Sinus tachycardia
Otherwise normal ECG
When compared with ECG of 09-APR-2021 11:42,
PREVIOUS ECG IS PRESENT

Technician:
Test ind:

Location:

Unconfirmed



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8290

West of Scotland Genetic Services

Laboratory Genetics
Level 2B, Laboratory Medicine
Queen Elizabeth University Hospital
1345 Govan Road, Glasgow G51 4TF



Email: geneticlabs@ggc.scot.nhs.uk

Tel: 0141 354 9330

Head of laboratory: Nicola Williams

ND 12

Molecular Genetics Report for Myeloproliferative Neoplasms

Consultant Haematologist
Haematology
Monklands Hospital
Monkscourt Avenue
Airdrie
ML6 0JS

Report Number: 164811

Reported: Linsey Ross

Authorised: Anne Lowe

Name of Patient:	Isabel MCCRACKEN		Date of Birth:	18/08/1978	
CHI/NHS Number:	1808785142	Sex:	Female	Date of Sample:	06/04/2021
Hospital Number:		Sample Type:	EDTA blood	Date Received:	07/04/2021
Pedigree Number:		Lab Number:	2218989	Date of Activation:	07/04/2021
Ref Lab Number:	1045247585_5	Gestation:		Date of Report:	20/04/2021

Reason for referral: Patient is being investigated for a possible Myeloproliferative Neoplasm.

Conclusion: **JAK2 variant c.1849G>T p.(Val617Phe) NOT detected.**

Results and interpretation:

Testing of DNA from this patient did not detect the pathogenic JAK2 variant c.1849G>T p.(Val617Phe).

This result does not support a diagnosis of a Myeloproliferative Neoplasm in this patient.

This result should be interpreted in the context of all clinical, morphological, and haematological findings.

Comments:

This assay will only detect the presence or absence of the c.1849G>T p.(Val617Phe) variant and can not detect other molecular causes of Myeloproliferative Neoplasms.

In order to avoid error and/or misinterpretation, transcription of the content of this report is not advised; Laboratory Genetics do not take any responsibility for the accuracy of any data/text transcribed from this report.

Technical Information:

Allele specific PCR to detect the JAK2 variant c.1849G>T p.(Val617Phe) was performed. We estimate that the level of detection for the tests performed is >5%. Reference: Bench et al., British Journal of Haematology, 2012, 160, 25-34.

20 APR 2021



IMFLC6 Run: 709

Dr Oliver
2012
SOUTH GLASGOW HOSPITALS
IMMUNOLOGY REPORT
(Tel 0141 347 8872/0141 354 9337)

Surname:	MCCRACKEN	Location:	Haematology Dept
Forename:	ISABEL		Monklands Hospital
DOB/Age:	18.08.78 Sex: Female		Airdrie
CHI/Unit No:	1808785142		Lanarkshire Health Board
Address:	1D CUMBRAE CRESCENT	Requestor:	Not known
Details:		Ext Labno:	1045247585

SERUM FREE LIGHT CHAINS

[[CURRENT]]

Lab Number	B,21.3546854
Date/Time collected	06.04.21
Date/Time received	08.04.21 14:27

Free Kappa mg/L (3.3-19.4) * 45.3

Free Lambda mg/L (5.7-26.3) * 66.9

K/L ratio (0.26-1.65) 0.68

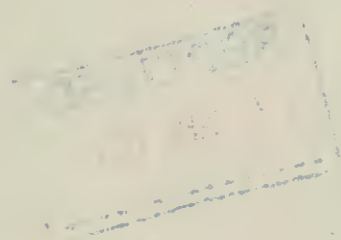


1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumbrae Crescent
Coatbridge
Lanarkshire ML5 4PX



Result Comments:

06.04.21 FreeLChain: In renal impairment, K/L ratio may increase to 0.37 - 3.1
Free lambda and kappa light chains both raised
This may be found with renal impairment and/or disorders
associated with polyclonal rise in immunoglobulins.
If screening for myeloma, suggest check immunoglobulins plus
serum and urine electrophoresis locally.
Antigen excess excluded by additional dilutions



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IMFLC6 Run: 709

Dr Oliver
2012
SOUTH GLASGOW HOSPITALS
IMMUNOLOGY REPORT
(Tel 0141 347 8872/0141 354 9337)

Surname:	MCCRACKEN	Location:	Haematology Dept
Forename:	ISABEL		Monklands Hospital
DOB/Age:	18.08.78 Sex: Female		Airdrie
CHI/Unit No:	1808785142		Lanarkshire Health Board
Address:	1D CUMBRAE CRESCENT	Requestor:	Not known
Details:		Ext Labno:	1045247585

SERUM FREE LIGHT CHAINS

[[CURRENT]]

Lab Number	B,21.3546854
Date/Time collected	06.04.21
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K/L ratio (0.26-1.65) 0.68

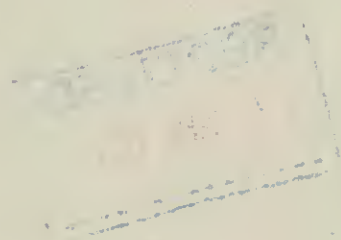


1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumbrae Crescent
Coatbridge
Lanarkshire ML5 4PX



Result Comments:

06.04.21 FreeLChain: In renal impairment, K/L ratio may increase to 0.37 - 3.1
Free lambda and kappa light chains both raised
This may be found with renal impairment and/or disorders
associated with polyclonal rise in immunoglobulins.
If screening for myeloma, suggest check immunoglobulins plus
serum and urine electrophoresis locally.
Antigen excess excluded by additional dilutions



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C099



University Hospital Monklands, Monks Court Avenue, Airdrie, ML6 0JS
Tel: 01236 748748

Page 1 of 3

DISCHARGE LETTER AND PRESCRIPTION

Serial No: 83abadbb-63e3-4068-abe2-67868c869e90

Date: 13-Apr-2021 @ 15:20 REPRINT

G.P.: N S MARCUCCILLI, WAVERLEY MEDICAL PRACTICE, COATBRIDGE HEALTH
CENTRE, 1 CENTRE PARK COURT, COATBRIDGE, ML5 3AP

Fax:

Patient: ISABEL MCCRACKEN

Hosp. No.: 1808785142

Nat. No.: 180 878 5142

Address: 1D CUMBRAE CRESCENT, COATBRIDGE, LANARKSHIRE, ML5 4PX

DOB: 18/08/1978

Admission Date: 26/03/2021

Planned Admission

Ward: ML Ward 12

Planned Discharge Date: 12/04/2021

Consultant: Dr Scott Oliver

Admission Reason:

Outpatient Appointment:

Allergy

Reaction

Allergy Status: ***No known drug allergies***

Diagnoses: Gram variable bacteraemia
Superior mesenteric vein thrombosis

Patient aware of Diagnoses: Yes

Discharge Letter Notes

Investigations

Pharmacy

WEEKLY DISPENSING PATIENT (NOT A BLISTER PACK)

Weekly Dispensing Scripts collected from Mint Pharmacy, 5 Lorne Place,
Coatbridge, ML5 4FS. Telephone - 01236 437354

One week supplied on discharge.

Dispensary screen only.

Clinical Progress

Isabel McCracken was admitted to UHM on 27/03/21 with pyrexia, vomiting and loin pain. On admission she had derranged electrolytes, thrombocytopenia and a raised D-dimer. She was treated with IV antibiotics and electrolyte replacement. Blood cultures grew gram variable bacteria of unclear source. AUSS was non-diagnostic. CT AP showed extensive superior mesenteric thrombus and was started on anticoagulation. She was reviewed by the surgical team who advised not for surgery unless deteriorates. Haematology advised thrombophilia screen which was normal and to consider an underlying malignancy. A completion CT of neck and chest was performed to rule out malignancy. No signs of malignancy on CT. An endoscopy and colonoscopy have been requested as an outpatient. She had mild lupus anticoagulant positive which will be repeated in 12/52. She was switched to warfarin and has been referred to the anticoagulation clinic. She is to stay on warfarin for at least 6 months.

Results Awaited

myeloma screen, C3/4 compliment, JAK2, factor Vleiden, BJP urine, free light chains, ANA,
anti-DNA, anti-cardi, parietal cell abs

Follow-up

Anticoagulation follow-up

Medication Changes

Repeat lupus anticoagulant in 12/52 in PIU

Started on Warfarin

Discharge Medication

Drug	Dose/Route/Frequency	Duration	GP to continue	Quantity, Strength, Brand
------	----------------------	----------	----------------	---------------------------

Discharged by: Dr Victoria Gordon Bleep:

FOUNDATION YEAR 2

Dispensed By:

Checked By:

Date:

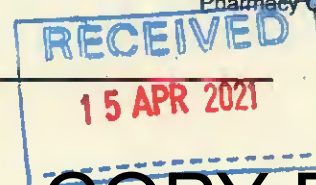
Originally Printed: 12/04/2021 @ 15:46

Revised: 13/04/2021 @ 15:20

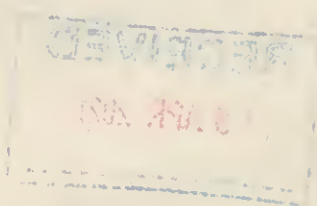
Pharmacy Copy 1/2

Collected by:

Date:



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University Hospital Monklands, Monks Court Avenue, Airdrie, ML6 0JS
Tel: 01236 748748

Page 2 of 3

DISCHARGE LETTER AND PRESCRIPTION

Serial No: 83abaddb-63e3-4068-abe2-67868c869e90

Date: 13-Apr-2021 @ 15:20 REPRINT

G.P.: N S MARCUCCILLI, WAVERLEY MEDICAL PRACTICE, COATBRIDGE HEALTH
CENTRE, 1 CENTRE PARK COURT, COATBRIDGE, ML5 3AP

Fax:

Patient: ISABEL MCCRACKEN

Hosp. No.: 1808785142

Nat. No.: 180 878 5142

Address: 1D CUMBRAE CRESCENT, COATBRIDGE, LANARKSHIRE, ML5 4PX

DOB: 18/08/1978

Admission Date: 26/03/2021

Planned Admission

Ward: ML Ward 12

Planned Discharge Date: 12/04/2021

Consultant: Dr Scott Oliver

Admission Reason:

Outpatient Appoin

Diagnoses: Gram variable bacteraemia
Superior mesenteric vein thrombosis

Patient aware of Diagnoses: Yes

1808785142
18/08/1978
MCCRACKEN Isabel F
1d Cumbrae Crescent
Coatbridge
Lanarkshire ML5 4PX

Discharge Medication

Drug	Dose/Route/Frequency	Duration	GP to continue	Quantity, Strength, Brand
ADCAL D3 750 mg Caplets	1 caplet(s) Oral TWICE daily at 7am and 10pm	L/T	Yes	
Verified by Not verified				
CITALOPRAM 40 mg Tablets	40 mg Oral ONCE daily at 7am	L/T	Yes	
Verified by Not verified				
CYCLIZINE 50 mg Tablets	50 mg Oral THREE times daily - 7am; 1pm; 10pm PRN For nausea/vomiting	14	No	
Verified by Not verified				
DIAZEPAM 2 mg Tablets	2 mg Oral THREE times daily - 7am; 1pm; 10pm	L/T	Yes	
Verified by Not verified				
DIHYDROCODEINE 30 mg Tablets	30 mg Oral FOUR times daily - 7am; 1pm; 6pm; 10pm PRN For pain relief	7	Yes	
Verified by Not verified				
FOLIC ACID 5 mg Tablets	5 mg Oral ONCE daily at 7am	L/T	Yes	
Verified by Not verified				

Discharged by: Dr Victoria Gordon Bleep:

FOUNDATION YEAR 2

Dispensed By:

Checked By:

Date:

Originally Printed: 12/04/2021 @ 15:46

Revised: 13/04/2021 @ 15:20

Pharmacy Copy 1/2

Collected by:

Date:

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University Hospital Monklands, Monkscourt Avenue, Airdrie, ML6 0JS
Tel: 01236 748748

Page 3 of 3

DISCHARGE LETTER AND PRESCRIPTION

Serial No: 83abadbb-63e3-4068-abe2-67868c869e90

Date : 13-Apr-2021 @ 15:20 REPRINT

G.P.: N S MARCUCCILLI, WAVERLEY MEDICAL PRACTICE, COATBRIDGE HEALTH
CENTRE, 1 CENTRE PARK COURT, COATBRIDGE, ML5 3AP

Fax:

Patient: ISABEL MCCracken

Hosp. No.: 1808785142

Nat. No.: 180 878 5142

Address: 1D CUMBRAE CRESCENT, COATBRIDGE, LANARKSHIRE, ML5 4PX

DOB: 18/08/1978

Admission Date 26/03/2021

Planned Admission

Ward: ML Ward 12

Planned Discharge Date: 12/04/2021

Consultant: Dr Scott Oliver

Admission Reason:

Outpatient Appc

Diagnoses: Gram variable bacteraemia
Superior mesenteric vein thrombosis

Patient aware of Diagnoses: Yes

1808785142
18/08/1978
MCCRACKEN Isabel F
1d Cumbrae Crescent
Coatbridge
Lanarkshire ML5 4PX

Discharge Medication

Drug	Dose/Route/Frequency	Duration	GP to continue	Quantity, Strength, Brand
PARACETAMOL 500 mg Tablets	1000 mg Oral FOUR times daily - 7am; 1pm; 6pm; 10pm	L/T	Yes	
Verified by Not verified				
QUETIAPINE 150 mg Tablets	150 mg Oral ONCE daily at 10pm	L/T	Yes	
Verified by Not verified				
QUETIAPINE 25 mg Tablets	50 mg Oral ONCE daily at 7am	L/T	Yes	
Verified by Not verified				
QUETIAPINE 25 mg Tablets	25 mg Oral ONCE daily at midday	L/T	Yes	
Verified by Not verified				
WARFARIN AS CHARTED	1 AS CHARTED Oral Daily at 6pm - See Anticoagulant Chart	L/T	Yes	
Verified by Not verified				
ZOPICLONE 7.5 mg Tablets	7.5 mg Oral ONCE daily at 10pm PRN For sleeplessness	L/T	Yes	
Verified by Not verified				

Discharged by: Dr Victoria Gordon Bleep:

FOUNDATION YEAR 2

Dispensed By:

Checked By:

Date:

Originally Printed: 12/04/2021 @ 15:46

Revised : 13/04/2021 @ 15:20

Pharmacy Copy 1/2

Collected by:

Date:

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Telephone education 14-4-21 @ 10:00am

21/04/21 1.30



1808785142
18/08/1978 F F
MCCRACKEN Isabel
1d Cumbrae Crescent

Coatbridge
Lanarkshire ML5 4PX

☐ UH Hairmyres

☒ UH Monklands

☐ UH Wishaw

NHS
Lanarkshire

Warfarin and other Vit K antagonist Anticoagulant chart

Consultant: Ward: 12

Oral Anticoagulant: WARFARIN

Dose on admission:

♦ Pre-anticoagulation baseline bloods (FBC, coag screen, U&E's, LFT's) done on: / / (date)

♦ If started in hospital, start date of oral anticoagulant: 09/04/21

♦ For new patients, education (checklist) on / / (date)

by: E. HANRAADS

(Name) Designation: GPST

♦ Is patient also on antiplatelet? ☐ Yes ☐ No If 'Yes', this should be stopped unless there is a specific indication.

If to continue on antiplatelet, please specify type, dose and duration:

Indication: SUPERIOR MESENTERIC PE VAIN THROMBUS

Target INR: 2-3 Duration: T.B.C.

INR RESULTS AND DAILY DOSE

Warfarin is usually administered at 18.00hrs

Anticoagulant should be prescribed and signed for on both this chart and main medicine Prescription form.

Date	Morning INR	Anticoagulant dose (mg)	Prescribed by	Administered by	Comment
9/4/21	1.2	10mg	Celt HANRAADS	ACR	
10/4/21	2.1	0.5 mg	Celt HANRAADS	ACR	
11/4	4.3	0 (NIL)	Celt		

♦ Date of discharge: / /

After discharge, next INR due on: / / (date) at: (specify place)

Anticoagulant clinic date (If different from above): / /

♦ Photocopy of the front page of Anticoagulation chart and immediate discharge form should be sent as referral documents to NHS Lanarkshire Anticoagulation Service.

♦ If patient is likely to be sensitive to warfarin and requires INR checked prior to next available Anticoagulant clinic appointment, please make arrangements at ward level prior to discharge.

♦ All patients discharged on Warfarin should have a follow-up INR check arranged prior to discharge.



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NHS Lanarkshire
www.nhslanarkshire.org.uk
Department of General Medicine
01236 748748

University Hospital
Monklands
Monks court Avenue
Airdrie
ML6 0JS



Isabel McCracken
1D Cumbrae Crescent
Coatbridge
ML5 4PX

Date Dictated: 29/04/2021
Date Typed: 03/05/2021
Ref: 2512469
Letter Ref: SO/ET
Clinic Date: 29/03/2021
CHI Barcode:



Consultant: Dr Scott Oliver

Dear Isabel McCracken

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

I have had a message from the endoscopy unit telling me that you did not attend for a planned pre-assessment in advance of a planned camera test following your recent hospital admission to Monklands Hospital. I understand the endoscopy unit were also unable to reach you on your contact phone number. From looking at the patient record system I wondered if you might have actually been admitted to hospital or been in the process of going to A&E on the day that you had been planned to come to the pre-assessment, and this might explain why people were unable to get in touch with you.

I would be grateful if you would get in touch via my secretary once you receive this letter to let me know if you would like to have the camera test re-requested. I do think it would be worth proceeding with this if you are agreeable to it. I have also let the team who I think are currently looking after you in Monklands Hospital know, and they might be in touch with you about this before you get home and read this letter.

Yours sincerely

Dr Scott Oliver
Consultant Nephrologist and Physician

Authorised on 03/05/2021 12:19:38 by Scott Oliver.

(D) Dr NS Marcuccilli
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

(P) Dr Elizabeth Ann McIntyre
Ward 12
University Hospital Monklands
Monks court Avenue
ML6 0JS

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8290

West of Scotland Genetic Services

Laboratory Genetics
Level 2B, Laboratory Medicine
Queen Elizabeth University Hospital
1345 Govan Road, Glasgow G51 4TF

Email: geneticlabs@ggc.scot.nhs.uk

Tel: 0141 354 9330

ND 12

Head of laboratory: Nicola Williams



Molecular Genetics Report for Myeloproliferative Neoplasms

Consultant Haematologist
Haematology
Monklands Hospital
Monkscourt Avenue
Airdrie
ML6 0JS

Report Number: 164811

Reported: Linsey Ross

Authorised: Anne Lowe

Name of Patient:	Isabel MCCRACKEN		Date of Birth:	18/08/1978	
CHI/NHS Number:	1808785142	Sex:	Female	Date of Sample:	06/04/2021
Hospital Number:		Sample Type:	EDTA blood	Date Received:	07/04/2021
Pedigree Number:		Lab Number:	2218989	Date of Activation:	07/04/2021
Ref Lab Number:	1045247585_5	Gestation:		Date of Report:	20/04/2021

Reason for referral: Patient is being investigated for a possible Myeloproliferative Neoplasm.

Conclusion: JAK2 variant c.1849G>T p.(Val617Phe) NOT detected.

Results and interpretation:

Testing of DNA from this patient did not detect the pathogenic JAK2 variant c.1849G>T p.(Val617Phe).

This result does not support a diagnosis of a Myeloproliferative Neoplasm in this patient.

This result should be interpreted in the context of all clinical, morphological, and haematological findings.

Comments:

This assay will only detect the presence or absence of the c.1849G>T p.(Val617Phe) variant and can not detect other molecular causes of Myeloproliferative Neoplasms.

In order to avoid error and/or misinterpretation, transcription of the content of this report is not advised; Laboratory Genetics do not take any responsibility for the accuracy of any data/text transcribed from this report.

Technical Information:

Allele specific PCR to detect the JAK2 variant c.1849G>T p.(Val617Phe) was performed. We estimate that the level of detection for the tests performed is >5%. Reference: Bench et al., British Journal of Haematology, 2012, 160, 25-34.

1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumberae Crescent

Coatbridge
Lanarkshire ML5 4PX

26 APR 2021



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NORTH GLASGOW HOSPITALS
GRI HAEMOSTASIS REPORTS. OLIVER
WARD 12

-6

Surname: MCCracken Location: Haematology Dept
Forename: ISABEL Monklands Hospital
DOB/Age: 18.08.78 Sex: Female Airdrie
CHI/Unit No: 1808785142 Lanarkshire Health Board
Address: 1D CUMBRAE CRESCENT Requestor: Not known
Diagnosis:
Clin Details: superior mesenteric vein thrombosis

1045247585

Lab No: B,21.6980438
Collected: 07.04.21 15:14
Authorised: 20.04.21

Ext Labno:
Received: 13.04.21 15:40
Authoriser: Maureen Bennie

F.V Leiden.

Absent

03 MAY 2021



Comments:

F5LEID: Tests should be repeated on a fresh sample if F.V Leiden result is inconsistent with a specific/modified APC-Resistance result.

Isabel McCracken
1D Cumbrae Crescent
Coatbridge
ML5 4PX

Date Dictated: 04/05/2021
Date Typed: 04/05/2021
Ref: 100824413
Letter Ref: AF/AMcK
CHI Barcode:



Consultant: Dr Andrew Fyfe

Dear Isabel McCracken

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

Results of recent blood tests have revealed that red cell antibodies are present in your blood. These are not harmful to you and do not need to give you cause for concern. However, should you ever be admitted to hospital in the future it is important that you tell the doctor looking after you about these antibodies and show them the enclosed card. This will allow suitable blood to be provided more quickly if you require a transfusion. For this reason you should carry the card with you at all times.

If you have any queries about this matter please do not hesitate to contact me or your own general practitioner.

Yours sincerely

Dr Andrew Fyfe
Consultant Haematologist
GMC No. 6025106

Authorised on 04/05/2021 16:54:53 by Dr Andrew Fyfe.

Dr NS Marcuccilli
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

Date Dictated: 04/05/2021
Date Typed: 04/05/2021
Ref: 100824411
Letter Ref: AF/AMcK
CHI Barcode:



Consultant: Dr Andrew Fyfe

Dear Dr Marcuccilli

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbræ Crescent, Coatbridge, ML5 4PX

Blood from the above patient was recently checked in the Transfusion Laboratory and found to contain an irregular red cell antibody stimulated by previous sensitisation.

We have issued your patient with an antibody card which should be shown to any attending Doctor if the patient is admitted to hospital. We have suggested that the card should, if possible, be carried at all times.

If you have any queries about this matter please do not hesitate to contact me.

Yours sincerely

Dr Andrew Fyfe
Consultant Haematologist
GMC No. 6025106

Authorised on 04/05/2021 16:56:19 by Dr Andrew Fyfe.

NHS Lanarkshire
www.nhslanarkshire.org.uk
Department of General Medicine

University Hospital
Monklands
Monkscourt Avenue
Airdrie
ML6 0JS



01236 748748

Dr NS Marcuccilli
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

Date Dictated: 03/05/2021
Date Typed: 05/05/2021
Ref: 2514917
Letter Ref: SO/ET
CHI Barcode:



Consultant: Dr Scott Oliver

Dear Dr Marcuccilli,

Discharge Summary

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX
Date of admission: 26/03/2021
Date of discharge: 12/04/2021

Diagnosis -

1. Extensive superior mesenteric vein thrombosis
2. Gram variable bacilli bacteremia
3. Possible underlying haematological malignancy
4. Possible thrombophilia – lupus anticoagulant detected at low titre

Procedure:

Co-Morbidities

1. Cannabis smoker
2. Back pain
3. Personality disorder

Discharge Medication:

Follow up:

As per the IDL, this 42-year-old lady presented with rigors, vomiting, diarrhoea, and bilateral lumbar to groin pain. Blood tests demonstrated thrombocytopenia, deranged electrolytes, and deranged liver function with a significant inflammatory response. Blood cultures demonstrated gram variable bacilli, but the lab were unable to identify a specific organism and the source of this was unclear. A CT scan demonstrated extensive superior mesenteric vein thrombosis. She was seen by the surgical team (Mr Maung consultant surgeon) who advised conservative management of this. She was discussed with the haematology team who advised sending a thrombophilia screen and commencing her on anticoagulation in the form of Warfarin. She had a course of antibiotics and the inflammatory response settled. Curiously her initial thrombocytopenia became a thrombocytosis.

Putting this together was challenging. It was unclear if she had originally presented with GI upset (there was a vague story of having had a takeaway before her GI symptoms began) which has then led to thrombosis, with a subsequent bacteremia because of gut upset in the context of superior mesenteric vein thrombosis. It was also unclear if there was underlying malignancy or a thrombophilia. There was no evidence of solid organ malignancy on CT imaging, and outpatient upper and lower GI endoscopy was requested to investigate this further. A thrombophilia screen was sent and

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paroxysmal nocturnal haemoglobinuria was negative, JAK 2 was negative, and ANA, DNA antibody and ANCA screens were all negative. Anti cardiolipin IgG was normal, but IgM was slightly high, and there was a plan to repeat this in 12 weeks. A myeloma screen was sent and has only in fact been reported this morning (several weeks after discharge) showing an IgG lambda paraprotein with a negative urinary Bence Jones protein.

She was discharged home with a plan to attend for an outpatient CT thorax (as a completion scan having had a CT abdomen pelvis as an inpatient), to have repeat lupus anticoagulant checked via the planned investigation unit in 12 weeks, and in the absence of a confirmed malignancy, confirmed thrombophilia, or any further venous thromboembolism, I had intended initially to treat for 6 months with anticoagulation.

Unfortunately, at the time of dictating this note I see that she has been re-admitted. For this reason I have also not given a list of medications on discharge.

Yours sincerely

Dr Scott Oliver
Consultant Nephrologist and Physician

Authorised on 07/05/2021 11:36:18 by Scott Oliver.

(P) Mr Michael Dick
Consultant Colorectal Surgeon
University Hospital Monklands
Monkscourt Avenue
Airdrie
ML6 0JS

(P) Mr Min Nyunt Maung
Consultant Surgeon
University Hospital Monklands
Airdrie
ML6 0JS

(P) Dr Iain Singer
Consultant Haematologist
Monklands Hospital
AIRDRIE
ML6 0JS

**Department of Transfusion Medicine****IMMUNOHAEMATOLOGY**Glasgow Blood Transfusion Center G12 0XB
0141 433 5808XMGTS
1042092814
WD26

Name (Surname & Forename) & Address:

EDD / Gestⁿ:**MCCRACKEN, ISABEL**
1D CUMBRAE CRESCENT
COATBRIDGE

Date Specimen Received:

ML5 4PX

Report Date: 28/04/2021 05:21
30/04/2021Sex: Female
D.O.B.: 18/08/1978

CHI / Unit No.: 1808785142

SNBTS No.: 1001830521

Results for Sample Number:

10330003421034

Date Drawn: 27/04/2021 23:15

Date Received: 28/04/2021 05:21

ABO : A

Rh D : Positive

Antigens : k+ E- C+ K+ c+ e+

Antibody Status : POS (Positive)

Antibodies: Auto AHG Reactive Antibody

MAY 7 10:53

Other results:

Anti - IgG : IgG Positive (3+) Anti - C3d : C3d Negative

Comments:

Auto anti-K (big K) present by IAT.

Signed: *G. Hall* 01 MAY 2021

Report Destination:

Copies of Report to:

LABORATORY MANAGER
Blood Bank
Monklands Hospital
Monkscourt AvenueMonklands Hospital
Monkscourt Avenue

Airdrie, ML6 0JS

Airdrie, ML6 0JS

**Department of Transfusion Medicine****Specimen Number:**Glasgow Blood Transfusion Center G12 0XB
0141 433 5808**Request for Further Serological Investigation**

Name (Surname & Forename) & Address:

Time & Date Specimen Received:

MCCRACKEN, ISABEL
1D CUMBRAE CRESCENT
COATBRIDGE28/04/2021 05:21
Report Destination:

ML5 4PX

Blood Bank
Monklands Hospital

Copies of Report to:

D.O.B.:

SNBTS No.:

Unit No.: 18/08/1978

1001830521

1808785142

Please detail any additional information or
changes since last sample:Anti-D Prophylaxis YES/NO:
(If Yes, Please Give Date & Reason)EDD / Gestⁿ:

Date Sample Taken:

Requested By:

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**Department of Transfusion Medicine****IMMUNOHAEMATOLOGY**

Glasgow Blood Transfusion Center G12 0XB
0141 433 5808

XMBTS**1042092828****W26**

Name (Surname & Forename) & Address:

EDD / Gestⁿ:**MCCRACKEN, ISABEL**

Date Specimen Received:

1D CUMBRAE CRESCENT
COATBRIDGE

30/04/2021 16:40

ML5 4PX

Report Date:

Sex: Female

SNBTS No.:

D.O.B.: 18/08/1978 CHI / Unit No.: 1808785142

1001830521

Results for Sample Number: 10330003424610

Date Drawn: 30/04/2021 10:10

Date Received: 30/04/2021 16:40

ABO : A

Rh D : Positive

Antibody Status : POS (Positive)

Antibodies: Auto AHG Reactive Antibody



MAY 7 10:51

Other results:

Anti - IgG : IgG Positive (1+) Anti - C3d : C3d Negative

Comments:

Probable auto anti-K (big K) present by IAT.

Signed:

[Signature]

Report Destination:

Copies of Report to:

LABORATORY MANAGER
Blood Bank
Monklands Hospital
Monkscourt AvenueMonklands Hospital
Monkscourt Avenue

Airdrie, ML6 0JS

Airdrie, ML6 0JS



8098

**Department of Transfusion Medicine****Specimen Number:**

Glasgow Blood Transfusion Center G12 0XB
0141 433 5808

Bar Code

Request for Further Serological Investigation

Name (Surname & Forename) & Address:

Time & Date Specimen Received:

MCCRACKEN, ISABEL

30/04/2021 16:40

1D CUMBRAE CRESCENT
COATBRIDGE

Report Destination:

ML5 4PX

Blood Bank
Monklands Hospital

Copies of Report to:

D.O.B.: 18/08/1978 SNBTS No.: 1001830521
Unit No.: 1808785142Please detail any additional information or
changes since last sample:Anti-D Prophylaxis YES/NO:
(If Yes, Please Give Date & Reason)EDD / Gestⁿ:

Date Sample Taken:

Requested By:

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MCCRACKEN, ISABEL

ID:1808785142

10-MAY-2021 11:53:20

MONKLANDS-Card_M ROUTINE RECORD

18-AUG-1978 (42 yr)
Female

Vent. rate	106	BPM
PR interval	167	ms
QRS duration	89	ms
QT/QTc	362/482	ms
P-R-T axes	40 31	33

SINUS TACHYCARDIA
NONSPECIFIC T-WAVE ABNORMALITY
ABNORMAL RHYTHM ECG
UNCONFIRMED REPORT

Room:
Loc:201

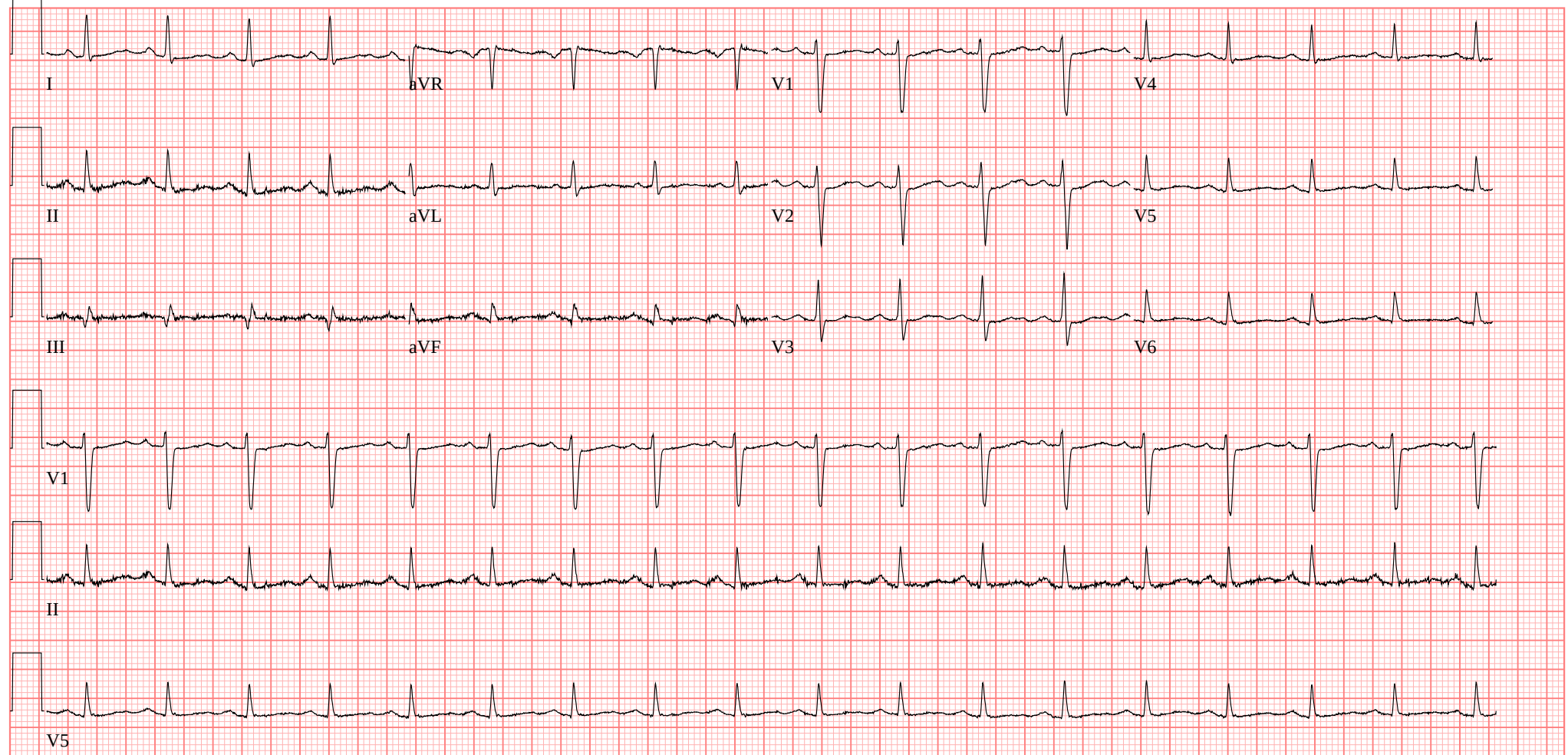
Technician: CH
Test ind:

Referred by: W7

Unconfirmed

Patient Lo:W7

0:1



25mm/s 10mm/mV 150Hz 9.0.7 CID: 65535

SID: 561960 EID: EDT: ORDER:

Page 1 of 1

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8290

West of Scotland Genetic Services

Laboratory Genetics
Level 2B, Laboratory Medicine
Queen Elizabeth University Hospital
1345 Govan Road, Glasgow G51 4TF

Email: geneticlabs@ggc.scot.nhs.uk

Tel: 0141 354 9330



Head of laboratory: Nicola Williams

Molecular Genetics Report for Myeloproliferative Neoplasms

Consultant Haematologist
Haematology
Monklands Hospital
Monks court Avenue
Airdrie
ML6 0JS

Report Number: 166680

Reported: Linsey Ross

Authorised: Anne Lowe

WD 12

Name of Patient:	Isabel MCCracken		Date of Birth:	18/08/1978	
CHI/NHS Number:	1808785142	Sex:	Female	Date of Sample:	06/04/2021
Hospital Number:		Sample Type:	EDTA blood	Date Received:	07/04/2021
Pedigree Number:		Lab Number:	2218989	Date of Activation:	29/04/2021
Ref Lab Number:	1045247585 - 7	Gestation:		Date of Report:	11/05/2021

Reason for referral: Patient is being investigated for a possible Myeloproliferative Neoplasm. Previous analysis did not detect the JAK2 variant c.1849G>T p.(Val617Phe)- see previous molecular report. Subsequent MPL and CALR analysis requested.

Conclusion: No pathogenic MPL or CALR variants detected (see interpretation).

Results and interpretation:

Testing of DNA from this patient did not detect the pathogenic MPL variant c.1544G>T p.(Trp515Leu) or any insertions or deletions in exon 9 of the CALR gene.

This result does not support a diagnosis of a Myeloproliferative Neoplasm in this patient.

This result should be interpreted in the context of all clinical, morphological and haematological findings.

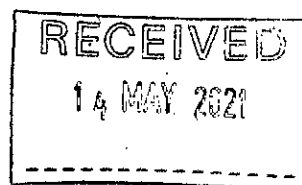
**Comments:**

Deletions and insertions in exon 9 of CALR and the MPL variant c.1544G>T p.(Trp515Leu) have been reported in a subset of patients with ET and PMF (2).

In order to avoid error and/or misinterpretation, transcription of the content of this report is not advised; Laboratory Genetics do not take any responsibility for the accuracy of any data/text transcribed from this report.

Technical Information:

Allele specific PCR to detect the MPL variant c.1544G>T p.(Trp515Leu) was performed. Fragment analysis of CALR exon 9 was performed to detect deletions and insertions. We estimate that the level of detection for the tests performed is >5%. Reference (1) Bench et al., British Journal of Haematology, 2012, 160, 25-34. (2) Klampfl et al., New Eng J Med 2013. 369 (25), 2379-2390.





8290

West of Scotland Genetic Services

Laboratory Genetics
Level 2B, Laboratory Medicine
Queen Elizabeth University Hospital
1345 Govan Road, Glasgow G51 4TF

Email: geneticlabs@ggc.scot.nhs.uk

Tel: 0141 354 9330



Head of laboratory: Nicola Williams

Molecular Genetics Report for Myeloproliferative Neoplasms

Consultant Haematologist
Haematology
Monklands Hospital
Monkscourt Avenue
Airdrie
ML6 0JS

Report Number: 166680

Reported: Linsey Ross

Authorised: Anne Lowe

WD 12

Name of Patient:	Isabel MCCRACKEN		Date of Birth:	18/08/1978	
CHI/NHS Number:	1808785142	Sex:	Female	Date of Sample:	06/04/2021
Hospital Number:		Sample Type:	EDTA blood	Date Received:	07/04/2021
Pedigree Number:		Lab Number:	2218989	Date of Activation:	29/04/2021
Ref Lab Number:	1045247585 - 7	Gestation:		Date of Report:	11/05/2021

Reason for referral: Patient is being investigated for a possible Myeloproliferative Neoplasm. Previous analysis did not detect the JAK2 variant c.1849G>T p.(Val617Phe)- see previous molecular report. Subsequent MPL and CALR analysis requested.

Conclusion: No pathogenic MPL or CALR variants detected (see interpretation).

Results and interpretation:

Testing of DNA from this patient did not detect the pathogenic MPL variant c.1544G>T p.(Trp515Leu) or any insertions or deletions in exon 9 of the CALR gene.

This result does not support a diagnosis of a Myeloproliferative Neoplasm in this patient.

This result should be interpreted in the context of all clinical, morphological and haematological findings.

**Comments:**

Deletions and insertions in exon 9 of CALR and the MPL variant c.1544G>T p.(Trp515Leu) have been reported in a subset of patients with ET and PMF (2).

In order to avoid error and/or misinterpretation, transcription of the content of this report is not advised; Laboratory Genetics do not take any responsibility for the accuracy of any data/text transcribed from this report.

Technical Information:

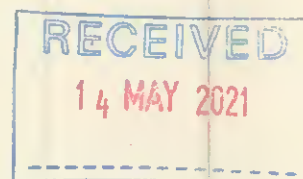
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1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumberae Crescent

Coatbridge
Lanarkshire

ML5 4PX



Report Number: 166680

ver 210301

Page 1 of 1

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NHS Lanarkshire
Monklands Hospital
GASTROSCOPY REPORT

Name: **Isabel MCCracken (F)**
Date of birth: **18/08/1978**
NHS No: **1808785142**
Case Note No: **1808785142**

Address: **1d Cumbrae Crescent**
Coatbridge
Lanarkshire
ML5 4PX

GP: **Dr NS Marcuccilli**
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge

Procedure date: **21st May 2021 (16:03)**
Priority: **Urgent**
Status: **Outpatient/NHS**
Hospital: **Monklands Hospital**
Ward: **Ward - Not specified**
Referring Cons: **Mr Michael Dick**

Indications

?upper GI neoplasm.

Consultant/Endoscopist

Dr Alan Thomas Clarke

Report

The scope was retroflexed in the stomach.
The procedure was completed successfully to D2.

Instrument

MK - GIF-HQ290 - 2857435

Site b: An area extending from the antrum to the middle body

Gastritis: mild erythematous/exudative with no bleeding.

Premedication

Xylocaine (Spray) 100 mg

Diagnoses

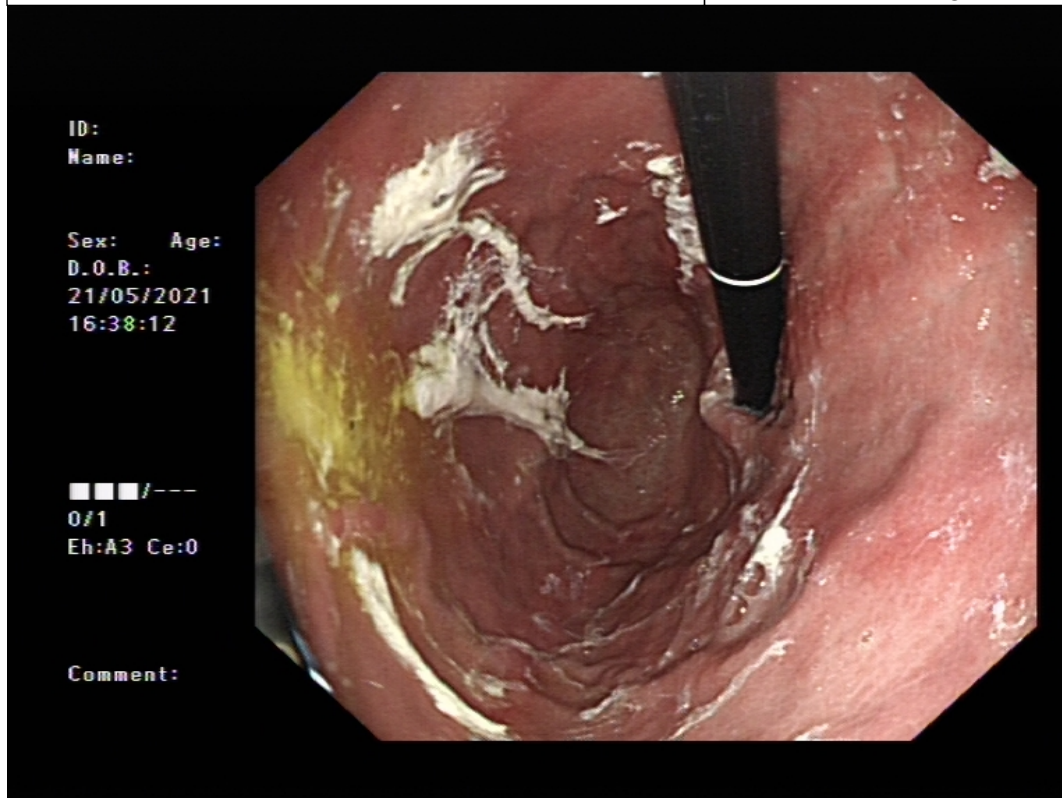
OESOPHAGUS. Normal.
STOMACH. Non-erosive gastritis.
DUODENUM. Normal.

Advice/Comments

Biliary gastritis. Nil else of note. CLO not done (on PPI)

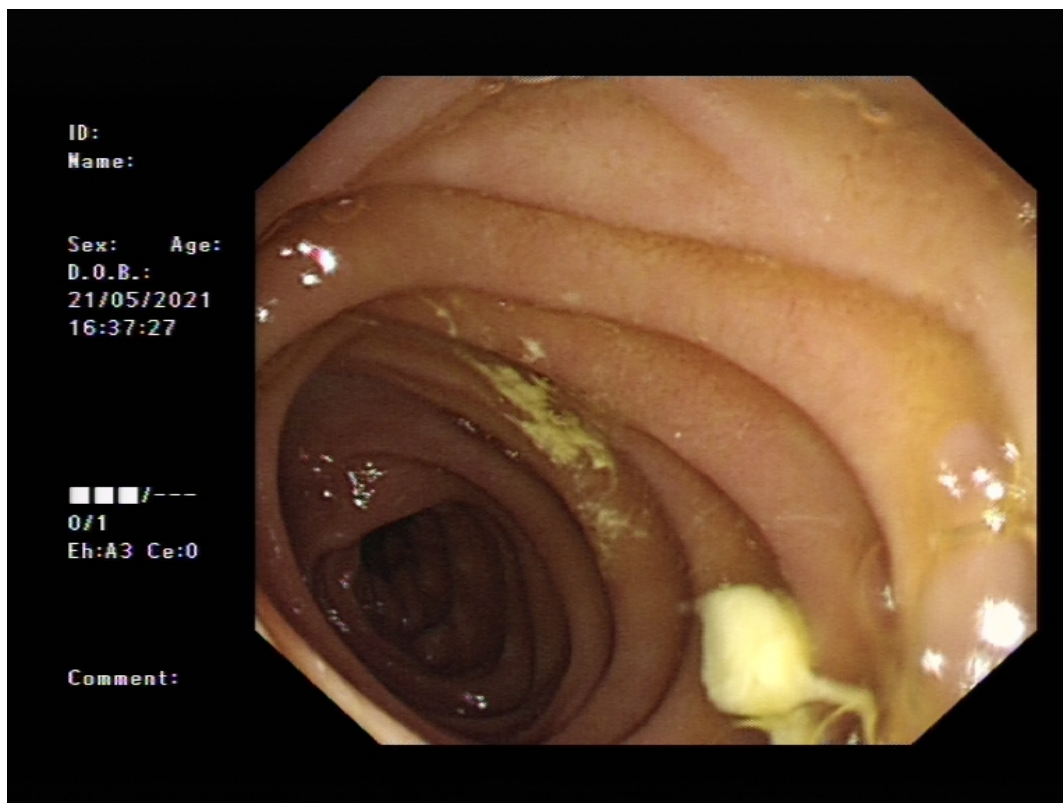
Dr Alan Thomas Clarke
Consultant Gastroenterologist
c.c. Mr Michael Dick (Monklands surgeons)

Name:	Isabel MCCRACKEN, 1978-08-18 (F)	Address:	1d Cumbrae Crescent Coatbridge Lanarkshire ML5 4PX
CHI No:	1808785142		
Case Note No:	1808785142		



An area extending from the antrum to the middle body_1

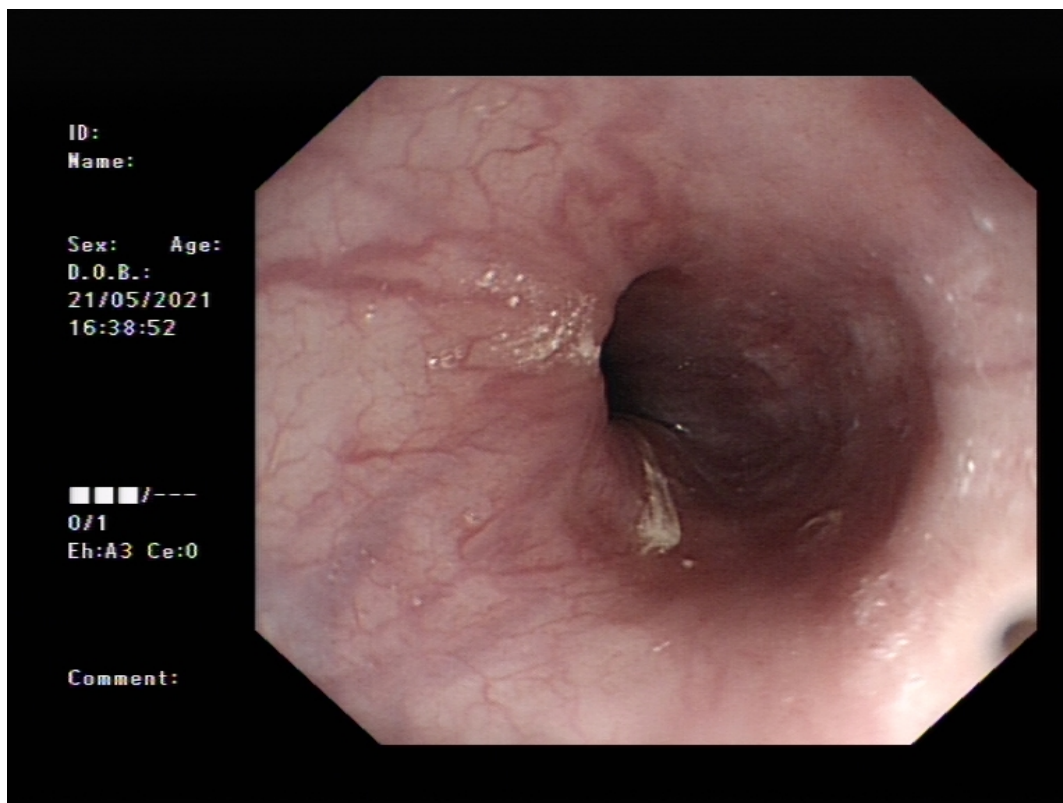
Name:	Isabel MCCRACKEN, 1978-08-18 (F)	Address:	1d Cumbrae Crescent
CHI No:	1808785142		Coatbridge
Case Note No:	1808785142		Lanarkshire
			ML5 4PX



Second part_1

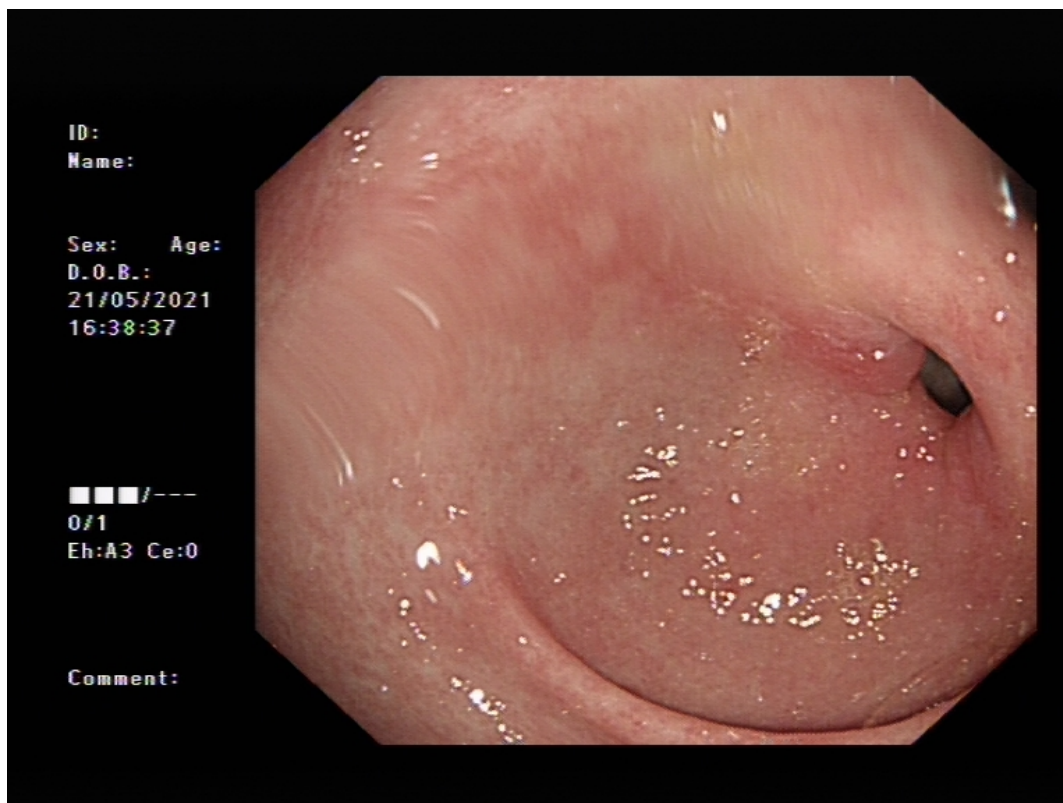
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Name:	Isabel MCCRACKEN, 1978-08-18 (F)	Address:	1d Cumbrae Crescent Coatbridge Lanarkshire ML5 4PX
CHI No:	1808785142		
Case Note No:	1808785142		



Lower oesophagus_1

Name:	Isabel MCCRACKEN, 1978-08-18 (F)	Address:	1d Cumbrae Crescent
CHI No:	1808785142		Coatbridge
Case Note No:	1808785142		Lanarkshire
			ML5 4PX



An area extending from the antrum to the middle body_2

Not done? 2015 if able

VRE + ve

21/5/21

1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumberae Crescent

Coatbridge
Lanarkshire ML5 4PX

Ward: 7

Monklands Hospital NHS
Lanarkshire

Outpatient Dept

Hospital Endoscopy Request

Contact phone number: 2063 (*Denotes a mandatory field)

*Referral date: 21/05/21

For referrals of hospital inpatients or outpatients for endoscopic examination. Supply as much information as possible. Do not use this form to request gastroenterology ward review. Responsibility for the patient's fitness to undergo endoscopy is with the referring clinician.

Phone: Home:	Inpatient: Estimated date of discharge: 21/05/21
Mobile:	Outpatient: Need for transport? ☐ Yes ☒ No
	Overnight stay? ☐ Yes ☒ No
Investigation requested:	☒ Upper GI Endoscopy ☐ Colonoscopy
	☐ Flexible Sigmoidoscopy ☐ Insertion of PEG tube
Urgency:	☒ Inpatient (within 1 week) ☐ Urgent outpatient (within 3-4 weeks) ☐ Routine outpatient
Previous medical history:	☒ Previous gastric surgery: Ileocolic resection + end ileostomy
	☐ Previous small bowel or colonic surgery:
	☐ Significant liver disease:

Reason for request

Upper GI*	Lower GI*
☐ Iron deficiency anaemia	☐ IDA (has already had OGD)
*Hb: 86 g/dl *MCV: 86.3 fl	*Hb: g/dl *MCV: fl
*Ferritin: ng/ml	*Ferritin: ng/ml
☐ Dysphagia	☐ Rectal bleeding (see protocol)
☐ Variceal surveillance	☐ Bloody diarrhoea
☐ Episode melaena	☐ Abdominal mass
☐ Atypical chest pain	☐ FU polyps
☒ Other: (specify)	☐ FU previous carcinoma
	☐ Other: (specify)

Brief history of complaint: 42 admitted with extension of SMV thrombus despite being on warfarin. Now on Hinz Rx dose. Underwent ileocolic resection + end ileostomy. High suspicion of malignancy.

Patient fitness:	*Warfarin or other anticoag? ☒ Yes ☐ No
*ASA Grade: (If grade 3 or above, discuss)	Reason: Hinz Rx - SMV thrombus
☐ I Normal healthy patient	*Diabetes mellitus: ☐ Yes ☒ No
☒ II Mild systemic disease with no functional limitations	☐ Diet only
☐ III Moderate systemic disease with functional limitations	☐ Oral hypoglycaemics
☐ IV Severe systemic disease with a constant threat to life	☐ Insulin
☐ Cardiac failure	*Able to give own consent? ☒ Yes ☐ No
☐ Prosthetic heart valve, previous SBE	*Fit for OP bowel prep? ☒ Yes ☐ No
☐ Renal failure (U Cr)	*Requesting clinician: (PRINT NAME)
☐ Severe respiratory disease	Dr. Birch-Moore
*Referring consultant: (PRINT NAME)	Mr. Dick
Grade: F2	*Signature:
Page/DECT phone no: 404792	

OFFICE/GI USE ONLY

Date received: / /	☐ Diabetic protocol	☐ Anticoag protocol	☐ Suitable for NE
	☐ IP stay required for OP tests: ☐ Pre-test ☐ Post-test	☐ Cancer tracker needed	
	☐ Accept ☐ Reject ☐ Routine ☐ Urgent		
	☐ Any list ☐ Specific list:	Dr/Mr:	
Reason for rejection:	☐ Insufficient information (points indicated)	☐ Other investigation more suitable: (specify)	
	☐ Endoscopy contraindicated	☐ Other: (specify)	
	☐ Please discuss with a GI consultant		

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13/11/12

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1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumberae Crescent
Coatbridge
Lanarkshire ML5 4PX

University Hospital:
☐ Hairmyres ☒ Monklands ☐ Wishaw
Other:
Ward: 7

Covid-19 Risk Assessment

Completed by:

Name Dr. Birch-Madsen PRINT NAME
Signature [Signature]
Date 17/05/21 Time 12.01.

Admissions assessment

Covid-19 test result

♦ Positive:	☐ swab or	☐ sputum?	☐ Not Yet Available
♦ Negative:	☒ swab or	☐ sputum?	☐ Not Undertaken

Covid-19 symptom checker

Tick Yes or No for each of the following. Yes indicates clinical concern.
Patients will be classed as higher risk of Covid-19, if any are ticked Yes.

♦ Unexplained Temperature >37.8°C ☐ Yes ☒ No	♦ Unexplained reduction in oxygen saturation ☐ Yes ☒ No
♦ Cough ☐ Yes ☒ No	♦ Unexplained low lymphocytes count (i.e. <1) ☐ Yes ☒ No
♦ Headache ☐ Yes ☒ No	♦ CXR Abnormal - if done ☐ Yes ☒ No
♦ Sore Throat ☐ Yes ☒ No	♦ Chest CT Abnormal - if done ☐ Yes ☒ No
♦ Recent shortness of breath ☐ Yes ☒ No	♦ Unexplained Nausea / Vomiting / Diarrhoea / Abdominal pain ☐ Yes ☒ No
♦ Myalgia ☐ Yes ☒ No	
♦ Loss of taste or sense of smell ☐ Yes ☐ No	
♦ Recent close contact with persons with any of the above ☐ Yes ☐ No	♦ Other Clinical Concern e.g. Adult with incapacity ☐ Yes ☒ No

Theatre Assessment

Decision:	☐ Red	☐ Green
Surgeon:	Name	Date / /
	Signature	Time :
Anaesthetist:	Name	Date / /
	Signature	Time :

Renewed decision (after 24 hours):	☐ Red	☐ Green
Surgeon:	Name	Date / /
	Signature	Time :
Anaesthetist:	Name	Date / /
	Signature	Time :



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To: N S MARCUCCILLI WAVERLEY MEDICAL PRACTICE	Re: ISABEL MCCRACKEN 1D CUMBRAE CRESCENT , , COATBRIDGE , LANARKSHIRE , ML5 4PX DOB: 18/08/1978 Hosp. No.: CHI No.: 1808785142
--	---

Date of Admission: 27/04/2021 **Ward:** ML Ward 07

Mode of Admission: **Consultant:** Mr Michael Dick (GENERAL SURGERY-C1)

Admission Reason: Low INR

Discharge Date: 25/05/2021 **Follow Up:**

Primary Diagnosis: Extention of SMV thrombus. Ileocaecal resection + end ileostomy for venous ischaemia VRE positive Pelvic collection

Co-Morbidities Known SMV thrombus (march 2021) - on warfarin

Investigations OGD biliary gastritis 21/05/21

Pharmacy Rework 24/5/21 - Remove Sando K, add Co-amoxiclav
Weekly Dispensing in Skillets collected from Mint Pharmacy, 5 Lorne Place, Coatbridge, ML5 4FS.
Telephone - 01236 437354
1 week supplied on d/c

Clinical Progress Patient admitted on 07/04/21 from an anticoagulation clinic with a low INR and being generally unwell and loose bowels. Patient had attended the anticoagulation clinic the previous day with a high INR and given vitamin K. Patient was noted to be anaemic on admission so was transfused 2 units of PRC. Patient was bridged with LMWH. CXR showed mild atelectasis. Patients CRP and WCC were highly raised on so patient was treated with amox/met/gent IV. A CT AP was performed which showed extension of the SMV thrombus and potential small bowel venous ischaemia/infarction. Patient underwent a ileocaecal resection and ileostomy for venous ischaemia. Patient was discussed with haematology who advised for patient to stay on LMWH long term. Biopsies negative for malignancy. Updated CT AP due to persistently raised inflammatory markers showed a collection adjacent to hemicolectomy suture line. She was restarted on IV antibiotics (mero and vanc) and switched to PO co-amox.

Results Awaited Patients antibiotics were escalated during their admission and their condition improved. Patient was noted to be drowsy during admission so their diazepam and zopiclone were stopped. Outpatient flexible sigmoidoscopy requested as an outpatient.
Bone marrow biopsies and full thrombophilia screen awaited

Follow-up Outpatient flexible sigmoidoscopy in 6 weeks
bone marrow biopsies to be chased
CT PET booked 27/5/21
Haematology follow up 4-6 weeks following PET scan
Follow up with Mr Dick in clinic in 2/5/21 time

Medication Changes Zopiclone and diazepam withheld due to drowsiness - GP please r/v need and restart if appropriate.
Tinzeparin 10,000 units OD, omeprazole, codeine and loperamide started
Dihydrocodeine and warfarin stopped.
2 weeks co-amoxiclav to be completed at discharge

L/T = Long-term - Please note a minimum 7 day supply of medicines will be dispensed by the hospital pharmacy unless otherwise stated.

Discharged by: Dr Samuel Birch-Machin

To: N S MARCUCCILLI WAVERLEY MEDICAL PRACTICE	Re: ISABEL MCCRACKEN 1D CUMBRAE CRESCENT , , COATBRIDGE , LANARKSHIRE , ML5 4PX DOB: 18/08/1978 Hosp. No.: CHI No.: 1808785142
--	---

Allergy/Intolerance	Reaction
***No Known Drug Allergies	
diclofenac	Unknown

Allergy records are as recorded at time and date of printing.

Drug	Dose	Route	Frequency	Duration	GP to continue
ADCAL D3 750 mg Caplets	1 caplet(s)	Oral	TWICE daily at 7am and 10pm	L/T	Y
CITALOPRAM 40 mg Tablets	40 mg	Oral	ONCE daily at 7am	L/T	Y
CO-AMOXICLAV 500/125mg Tablets	1 tablet(s)	Oral	THREE times daily - 7am;1pm;10pm for 14 day(s)	14 day(s)	N
CODEINE PHOSPHATE 30 mg Tablets	30 mg	Oral	THREE times daily at 7am, 1pm, and 6pm	L/T	Y
FOLIC ACID 5 mg Tablets	5 mg	Oral	ONCE daily at 7am	L/T	Y
LOPERAMIDE 2 mg Capsules	2 mg	Oral	THREE times daily - 7am;1pm;10pm	L/T	Y
OMEPRAZOLE 20 mg Capsules	20 mg	Oral	TWICE daily at 7am and 6pm	L/T	Y
PARACETAMOL 500 mg Tablets	1000 mg	Oral	FOUR times daily - 7am;1pm;6pm;10pm	L/T	Y
QUETIAPINE 150 mg Tablets	150 mg	Oral	ONCE daily at 10pm	L/T	Y
QUETIAPINE 25 mg Tablets	50 mg	Oral	ONCE daily at 7am	L/T	Y
QUETIAPINE 25 mg Tablets	25 mg	Oral	ONCE daily at midday	L/T	Y
TINZAPARIN 10,000 units in 0.5ml Pre-filled Syringe	10000 unit(s)	Subcutaneous Bolus Injection	ONCE daily at 6pm	L/T	Y

L/T = Long-term - Please note a minimum 7 day supply of medicines will be dispensed by the hospital pharmacy unless otherwise stated.

Discharged by: Dr Samuel Birch-Machin



Inpatient prescription & administration record for

ISABEL MCCRACKEN (1808785142)

Admission: 27/04/2021 => 25/05/2021

01:30
26/05/21

Patient Demographics

1808785142

MCCRACKEN Isabel (1808785142)
DOB: 18/08/1978
1D Cumbrae Crescent, Coatbridge,
Lanarkshire,
ML5 4PX

Admitted: 27/04/2021 10:25
Discharged: 25/05/2021 16:36

Transfer history

Admission	2021-04-27 10:25:00	ML A&E
Transfer	2021-04-27 12:44:00	ML MAU
Transfer	2021-04-28 22:29:00	ML Ward 26
Transfer	2021-05-01 12:09:00	ML Ward 07

Responsible Consultant history

. No Named Consultant	27/04/21	10:25
Dr Liz Mcintyre	27/04/21	12:44
Mr Michael Dick	03/05/21	13:51
Dr Scott Oliver	10/05/21	14:41
Mr Michael Dick	13/05/21	14:07

Allergy

Admission Allergy Check performed by:
Current recorded allergy (reaction): No Known Drug Allergies

Sensitivity (reaction): diclofenac(Unknown)

ADCAL D3 Chewable Tablets

☒ 27/04/21 22:00 1 tablet(s) TWICE daily at 7am and 10pm (Chew)

Dr Jordanna Deosaran

27/04/21	22:00	27/04/2021	22:51	NURSE HANNAH PATERSON
28/04/21	07:00	28/04/2021	08:37	Nurse Kirstin Napier/ Nurse Zoe Luke
28/04/21	22:00	Other - Record in nursing notes		NURSE Coleen Markey
29/04/21	07:00	29/04/2021	05:59	NURSE Coleen Markey/ NURSE VICTORIA MILLS

☒ Discontinued on: 29/04/2021 15:21 by: Ms Sarah Connelly . Reason: Discontinued due to conflict

ADCAL D3 750 mg Caplets

☒ 29/04/21 22:00 1 caplet(s) TWICE daily at 7am and 10pm (Oral)

Ms Sarah Connelly

29/04/21	22:00	29/04/2021	22:40	NURSE Coleen Markey
30/04/21	07:00	30/04/2021	05:45	NURSE Coleen Markey
30/04/21	22:00	30/04/2021	21:29	Nurse Arlene Wilkie/ Nurse Allison McLean
01/05/21	07:00	01/05/2021	06:37	Nurse Arlene Wilkie/ Nurse Allison McLean
01/05/21	22:00	01/05/2021	21:21	NURSE Janice Mead
02/05/21	07:00	02/05/2021	08:38	NURSE Amy Thomson
02/05/21	22:00	02/05/2021	20:41	NURSE Amanda Kane
03/05/21	07:00	03/05/2021	09:03	Nurse Tracy Hassan
03/05/21	22:00	03/05/2021	22:05	Nurse Meghan Stevenson
04/05/21	07:00	04/05/2021	08:55	Nurse Tracy Hassan
04/05/21	22:00	04/05/2021	20:44	NURSE Janice Mead
05/05/21	07:00	05/05/2021	09:01	NURSE Andrea McMullen
05/05/21	22:00	05/05/2021	22:03	NURSE Janice Mead
06/05/21	07:00	06/05/2021	09:20	Nurse Tracy Hassan
06/05/21	22:00	06/05/2021	21:07	NURSE Amy Thomson
07/05/21	07:00	07/05/2021	08:32	NURSE Emma Harvie
07/05/21	22:00	07/05/2021	20:23	NURSE Heather McBride
08/05/21	07:00	08/05/2021	08:57	NURSE Claire Ferguson
08/05/21	22:00	08/05/2021	21:12	Nurse Sophie McPheat
09/05/21	07:00	09/05/2021	08:40	NURSE Emma Harvie
09/05/21	22:00	09/05/2021	20:43	NURSE Amy Thomson
10/05/21	07:00	10/05/2021	08:58	STDN GILLIAN DAVIDSON
10/05/21	22:00	10/05/2021	20:49	Nurse Tracy Hassan
11/05/21	07:00	11/05/2021	08:16	NURSE Stephanie McLellan
11/05/21	22:00	11/05/2021	21:22	Nurse Tracy Hassan
12/05/21	07:00	12/05/2021	08:37	Nurse Meghan Stevenson
12/05/21	22:00	12/05/2021	20:59	NURSE Angela Veldon
13/05/21	07:00	13/05/2021	12:05	NURSE Clare Martin
13/05/21	22:00	13/05/2021	21:04	NURSE Rachel O'Hanlon
14/05/21	07:00	14/05/2021	08:44	NURSE Emma Harvie
14/05/21	22:00	14/05/2021	20:45	NURSE Stephanie McLellan
15/05/21	07:00	15/05/2021	08:58	NURSE Amy Thomson

Key: Prescription details Recorded as "Admitted On" Prescribed as "Self Administer" Discontinuation details HEPMA Prescription additional notes HEPMA Patient admission notes (admission specific) HEPMA Patient retained notes (not specific to admission)

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ADCAL D3 750 mg Caplets

(Continued)

15/05/21	22:00	15/05/2021	21:08	Nurse Rachel Donnelly
16/05/21	07:00	16/05/2021	08:45	NURSE Andrea McMullen
16/05/21	22:00	16/05/2021	21:22	NURSE Stephanie McLellan
17/05/21	07:00	17/05/2021	08:19	NURSE Andrea McMullen
17/05/21	22:00	17/05/2021	20:49	NURSE Amy Thomson
18/05/21	07:00	18/05/2021	08:18	NURSE Andrea McMullen
18/05/21	22:00	18/05/2021	20:17	NURSE Amy Thomson
19/05/21	07:00	19/05/2021	07:50	NURSE Heather McBride
19/05/21	22:00	19/05/2021	21:02	NURSE Amy Thomson
20/05/21	07:00	20/05/2021	08:40	Nurse Meghan Stevenson
20/05/21	22:00	20/05/2021	20:44	NURSE Rachel O'Hanlon
21/05/21	07:00	21/05/2021	08:32	STDN RACHEL THOMAS/ Nurse Rachel McKenny
21/05/21	22:00	21/05/2021	20:54	NURSE Emma Harvie
22/05/21	07:00	22/05/2021	08:54	NURSE Nicola Kelly
22/05/21	22:00	22/05/2021	21:24	NURSE Angela Veldon
23/05/21	07:00	23/05/2021	08:08	NURSE Andrea McMullen
23/05/21	22:00	23/05/2021	21:21	NURSE Heather McBride
24/05/21	07:00	24/05/2021	08:37	NURSE Andrea McMullen
24/05/21	22:00	24/05/2021	20:11	NURSE Emma Harvie
25/05/21	07:00	25/05/2021	09:28	Nurse Tracy Hassan

AMOXICILLIN 1 g Injection

27/04/21 22:00 1 g THREE times daily - 7am;1pm;10pm (Intravenous Intermittent Infusion) Dr Jordanna Deosaran

27/04/21	22:00	27/04/2021	22:50	NURSE HANNAH PATERSON
28/04/21	07:00	28/04/2021	08:35	Nurse Kirstin Napier/ Nurse Zoe Luke
28/04/21	13:00	28/04/2021	14:54	Nurse Kirstin Napier/ Nurse Louise Lindsay

Discontinued on: 28/04/2021 15:56 by: Dr Jordanna Deosaran . Reason: Discontinued due to conflict

27/04/21 13:51 1 g (Intravenous Intermittent Infusion) Dr Jordanna Deosaran

27/04/21	13:51	27/04/2021	14:42	Nurse Zoe Luke/ Nurse Louise Lindsay
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CITALOPRAM 40 mg Tablets

28/04/21 07:00 40 mg ONCE daily at 7am (Oral) Dr Jordanna Deosaran

28/04/21	07:00	28/04/2021	08:41	Nurse Kirstin Napier/ Nurse Zoe Luke
29/04/21	07:00	29/04/2021	05:59	NURSE Coleen Markey/ NURSE VICTORIA MILLS
30/04/21	07:00	30/04/2021	05:45	NURSE Coleen Markey
01/05/21	07:00	01/05/2021	06:37	Nurse Arlene Wilkie/ Nurse Allison McLean
02/05/21	07:00	02/05/2021	08:37	NURSE Amy Thomson
03/05/21	07:00	03/05/2021	09:03	Nurse Tracy Hassan
04/05/21	07:00	04/05/2021	08:54	Nurse Tracy Hassan
05/05/21	07:00	05/05/2021	09:00	NURSE Andrea McMullen
06/05/21	07:00	Dose withheld on Dr's instruction		Nurse Tracy Hassan
07/05/21	07:00	07/05/2021	08:32	NURSE Emma Harvie
08/05/21	07:00	08/05/2021	08:56	NURSE Claire Ferguson
09/05/21	07:00	09/05/2021	08:39	NURSE Emma Harvie
10/05/21	07:00	10/05/2021	08:58	STDN GILLIAN DAVIDSON
11/05/21	07:00	11/05/2021	08:15	NURSE Stephanie McLellan
12/05/21	07:00	12/05/2021	08:36	Nurse Meghan Stevenson
13/05/21	07:00	13/05/2021	12:05	NURSE Claire Martin
14/05/21	07:00	14/05/2021	08:44	NURSE Emma Harvie
15/05/21	07:00	15/05/2021	08:58	NURSE Amy Thomson
16/05/21	07:00	16/05/2021	08:44	NURSE Andrea McMullen
17/05/21	07:00	17/05/2021	08:19	NURSE Andrea McMullen
18/05/21	07:00	18/05/2021	08:13	NURSE Andrea McMullen
19/05/21	07:00	19/05/2021	07:50	NURSE Heather McBride
20/05/21	07:00	20/05/2021	08:40	Nurse Meghan Stevenson
21/05/21	07:00	21/05/2021	08:31	STDN RACHEL THOMAS/ Nurse Rachel McKenny
22/05/21	07:00	22/05/2021	08:54	NURSE Nicola Kelly
23/05/21	07:00	23/05/2021	08:07	NURSE Andrea McMullen
24/05/21	07:00	24/05/2021	08:35	NURSE Andrea McMullen
25/05/21	07:00	25/05/2021	09:27	Nurse Tracy Hassan

CO-AMOXICLAV 500/125mg Tablets

25/05/21 13:00 1 tablet(s) THREE times daily - 7am;1pm;10pm (Oral) for 14 day(s) Dr Hannah Talwar

25/05/21	13:00	Patient unavailable		NURSE Diane Russell
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CO-AMOXICLAV 1000mg / 200mg Injection

Key:							
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CO-AMOXICLAV 1000mg / 200mg Injection

(Continued)

20/05/21 22:00 1.2 g THREE times daily - 7am;1pm;10pm (Intravenous Intermittent Infusion)

Dr Ryan Clark

20/05/21	22:00	20/05/2021	20:45	NURSE Rachel O'Hanlon
21/05/21	07:00	21/05/2021	07:00	NURSE Rachel O'Hanlon
21/05/21	13:00	21/05/2021	12:52	NURSE Amy Savage
21/05/21	22:00	21/05/2021	20:54	NURSE Emma Harvie
22/05/21	07:00	22/05/2021	05:08	NURSE Gillian Wright
22/05/21	13:00	22/05/2021	12:59	NURSE Nicola Kelly
22/05/21	22:00	22/05/2021	21:26	NURSE Angela Veldon
23/05/21	07:00	23/05/2021	05:32	NURSE Gillian Wright
23/05/21	13:00	23/05/2021	13:21	Nurse Rachel McKenny
23/05/21	22:00	23/05/2021	21:21	NURSE Heather McBride
24/05/21	07:00	24/05/2021	08:39	NURSE Andrea McMullen
24/05/21	13:00	24/05/2021	13:12	NURSE Diane Russell
24/05/21	22:00	24/05/2021	20:11	NURSE Emma Harvie
25/05/21	07:00	25/05/2021	05:24	NURSE Nicola Kelly

Discontinued on: 25/05/2021 10:09 by: Dr Hannah Talwar . Reason: Discontinued due to conflict

CODEINE PHOSPHATE 30 mg Tablets

06/05/21 13:00 30 mg THREE times daily at 7am, 1pm, and 6pm (Oral)

Dr Samuel Birch-Machin

06/05/21	13:00	06/05/2021	12:42	Nurse Tracy Hassan
06/05/21	18:00	06/05/2021	17:47	Nurse Tracy Hassan
07/05/21	07:00	07/05/2021	08:32	NURSE Emma Harvie
07/05/21	13:00	07/05/2021	12:29	Nurse Sophie McPheat
07/05/21	18:00	07/05/2021	16:36	NURSE Emma Harvie
08/05/21	07:00	08/05/2021	08:58	NURSE Claire Ferguson
08/05/21	13:00	08/05/2021	12:43	Nurse Jamie Bryceland
08/05/21	18:00	08/05/2021	17:25	Nurse Jamie Bryceland
09/05/21	07:00	09/05/2021	08:41	NURSE Emma Harvie
09/05/21	13:00	09/05/2021	13:04	Nurse Rachel McKenny
09/05/21	18:00	09/05/2021	16:42	NURSE Emma Harvie
10/05/21	07:00	10/05/2021	08:59	STDN GILLIAN DAVIDSON
10/05/21	13:00	10/05/2021	12:13	NURSE Heather McBride
10/05/21	18:00	10/05/2021	16:33	NURSE Heather McBride
11/05/21	07:00	11/05/2021	08:17	NURSE Stephanie McLellan
11/05/21	13:00	11/05/2021	11:58	NURSE Heather McBride
11/05/21	18:00	11/05/2021	16:58	Nurse Meghan Stevenson
12/05/21	07:00	12/05/2021	08:38	Nurse Meghan Stevenson
12/05/21	13:00	12/05/2021	12:20	NURSE Clare Martin
12/05/21	18:00	12/05/2021	16:39	Nurse Meghan Stevenson
13/05/21	07:00	13/05/2021	08:57	NURSE Amy Thomson
13/05/21	13:00	13/05/2021	12:07	NURSE Clare Martin
13/05/21	18:00	13/05/2021	17:08	NURSE Amy Thomson
14/05/21	07:00	14/05/2021	08:45	NURSE Emma Harvie
14/05/21	13:00	14/05/2021	12:52	Nurse Jamie Bryceland
14/05/21	18:00	14/05/2021	16:28	NURSE Emma Harvie
15/05/21	07:00	15/05/2021	08:59	NURSE Amy Thomson
15/05/21	13:00	15/05/2021	12:27	NURSE Amy Thomson
15/05/21	18:00	15/05/2021	17:15	NURSE Diane Russell
16/05/21	07:00	16/05/2021	06:32	Nurse Rachel Donnelly
16/05/21	13:00	16/05/2021	13:02	NURSE Diane Russell
16/05/21	18:00	16/05/2021	17:13	NURSE Claire Ferguson
17/05/21	07:00	17/05/2021	08:21	NURSE Andrea McMullen
17/05/21	13:00	17/05/2021	12:37	Nurse Pauline Henderson
17/05/21	18:00	Other - Record in nursing notes		NURSE Amy Thomson
18/05/21	07:00	18/05/2021	08:15	NURSE Andrea McMullen
18/05/21	13:00	18/05/2021	12:26	Nurse Rachel McKenny
18/05/21	18:00	18/05/2021	16:40	Nurse Rachel McKenny
19/05/21	07:00	19/05/2021	07:50	NURSE Heather McBride
19/05/21	13:00	19/05/2021	12:05	Nurse Rachel McKenny
19/05/21	18:00	19/05/2021	17:12	STDN RACHEL THOMAS/ Nurse Rachel McKenny
20/05/21	07:00	20/05/2021	08:41	Nurse Meghan Stevenson
20/05/21	13:00	20/05/2021	12:05	NURSE Clare Martin
20/05/21	18:00	20/05/2021	16:22	Nurse Meghan Stevenson
21/05/21	07:00	21/05/2021	08:34	STDN RACHEL THOMAS/ Nurse Rachel McKenny
21/05/21	13:00	21/05/2021	12:52	NURSE Amy Savage
21/05/21	18:00	21/05/2021	18:04	NURSE Amy Savage
22/05/21	07:00	22/05/2021	08:54	NURSE Nicola Kelly
22/05/21	13:00	22/05/2021	12:58	NURSE Nicola Kelly
22/05/21	18:00	22/05/2021	17:22	Nurse Tracy Hassan

Key: Prescription details Recorded as "Admitted On" Prescribed as "Self Administer" Discontinuation details HEPMA Prescription additional notes HEPMA Patient admission notes (admission specific) HEPMA Patient retained notes (not specific to admission)

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CODEINE PHOSPHATE 30 mg Tablets

(Continued)

23/05/21	07:00	23/05/2021	08:09	NURSE Andrea McMullen
23/05/21	13:00	23/05/2021	13:21	Nurse Rachel McKenny
23/05/21	18:00	23/05/2021	16:49	NURSE Andrea McMullen
24/05/21	07:00	24/05/2021	08:39	NURSE Andrea McMullen
24/05/21	13:00	24/05/2021	13:27	NURSE Diane Russell
24/05/21	18:00	24/05/2021	18:14	Nurse Rachel McKenny
25/05/21	07:00	25/05/2021	09:29	Nurse Tracy Hassan
25/05/21	13:00	Patient unavailable		NURSE Diane Russell

DIAZEPAM 2 mg Tablets

27/04/21	18:00	2 mg THREE times daily at 7am, 1pm, and 6pm (Oral)		Dr Jordanna Deosaran
27/04/21	18:00	27/04/2021	18:17	Nurse Zoe Luke
28/04/21	07:00	28/04/2021	08:36	Nurse Kirstin Napier/ Nurse Zoe Luke
28/04/21	13:00	28/04/2021	14:53	Nurse Kirstin Napier/ Nurse Louise Lindsay
28/04/21	18:00	28/04/2021	17:16	Nurse Kirstin Napier
29/04/21	07:00	29/04/2021	06:15	NURSE Coleen Markey
29/04/21	13:00	29/04/2021	13:06	Nurse Chloe Nisbet/ Nurse Ciara Rogers
29/04/21	18:00	29/04/2021	18:11	NURSE Jillian Kinney/ NURSE Yvonne Cairney
30/04/21	07:00	30/04/2021	05:45	NURSE Coleen Markey
30/04/21	13:00	30/04/2021	12:04	Nurse Chloe Nisbet/ NURSE Leeanne Russell
30/04/21	18:00	30/04/2021	17:34	Nurse Aimee Herriot/ Nurse Chloe Nisbet
01/05/21	07:00	01/05/2021	06:37	Nurse Arlene Wilkie/ Nurse Allison McLean
01/05/21	13:00	01/05/2021	12:49	NURSE Diane Russell
01/05/21	18:00	01/05/2021	17:01	NURSE Stephanie McLellan
02/05/21	07:00	02/05/2021	08:37	NURSE Amy Thomson
02/05/21	13:00	02/05/2021	12:24	Nurse Tracy Hassan
02/05/21	18:00	02/05/2021	16:35	NURSE Amy Thomson
03/05/21	07:00	03/05/2021	09:02	Nurse Tracy Hassan
03/05/21	13:00	Other - Record in nursing notes		Nurse Tracy Hassan
03/05/21	18:00	Other - Record in nursing notes		Nurse Tracy Hassan
04/05/21	07:00	Dose withheld on Dr's instruction		Nurse Tracy Hassan
04/05/21	13:00	Dose withheld on Dr's instruction		Nurse Jamie Bryceland
04/05/21	18:00	Other - Record in nursing notes		Nurse Tracy Hassan
05/05/21	07:00	05/05/2021	09:00	NURSE Andrea McMullen
05/05/21	13:00	Other - Record in nursing notes		Nurse Pauline Henderson
05/05/21	18:00	05/05/2021	17:17	Nurse Pauline Henderson
06/05/21	07:00	Dose withheld on Dr's instruction		Nurse Tracy Hassan
06/05/21	13:00	Suspended		
06/05/21	18:00	Suspended		
07/05/21	07:00	Suspended		
07/05/21	13:00	Suspended		
07/05/21	18:00	Suspended		
08/05/21	07:00	Suspended		
08/05/21	13:00	Suspended		
08/05/21	18:00	Suspended		
09/05/21	07:00	Suspended		
09/05/21	13:00	Suspended		
09/05/21	18:00	Suspended		
10/05/21	07:00	Suspended		
10/05/21	13:00	Suspended		
10/05/21	18:00	Suspended		
11/05/21	07:00	Suspended		
11/05/21	13:00	Suspended		
11/05/21	18:00	Suspended		
12/05/21	07:00	Suspended		
12/05/21	13:00	Suspended		
12/05/21	18:00	Suspended		
13/05/21	07:00	Suspended		
13/05/21	13:00	Suspended		
13/05/21	18:00	Suspended		
14/05/21	07:00	Suspended		
14/05/21	13:00	Suspended		
14/05/21	18:00	Suspended		
15/05/21	07:00	Suspended		
15/05/21	13:00	Suspended		
15/05/21	18:00	Suspended		
16/05/21	07:00	Suspended		
16/05/21	13:00	Suspended		
16/05/21	18:00	Suspended		
17/05/21	07:00	Suspended		
17/05/21	13:00	Suspended		

Key: 	 Prescription details	 Recorded as "Admitted On"	 Prescribed as "Self Administer"	 Discontinuation details	 HEPMA Prescription additional notes	 HEPMA Patient admission notes (admission specific)	 HEPMA Patient retained notes (not specific to admission)
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DIAZEPAM 2 mg Tablets

(Continued)

17/05/21	18:00	Suspended
18/05/21	07:00	Suspended
18/05/21	13:00	Suspended
18/05/21	18:00	Suspended
19/05/21	07:00	Suspended
19/05/21	13:00	Suspended
19/05/21	18:00	Suspended
20/05/21	07:00	Suspended
20/05/21	13:00	Suspended
20/05/21	18:00	Suspended
21/05/21	07:00	Suspended
21/05/21	13:00	Suspended
21/05/21	18:00	Suspended
22/05/21	07:00	Suspended
22/05/21	13:00	Suspended
22/05/21	18:00	Suspended
23/05/21	07:00	Suspended
23/05/21	13:00	Suspended
23/05/21	18:00	Suspended
24/05/21	07:00	Suspended
24/05/21	13:00	Suspended
24/05/21	18:00	Suspended
25/05/21	07:00	Suspended
25/05/21	13:00	Suspended

ENOXAPARIN PF SYRINGE 60 mg in 0.6mL Injection

30/04/21 18:00 60 mg TWICE daily at 7am and 6pm (Subcutaneous Bolus Injection)

Ms Sarah Connelly

30/04/21	18:00	30/04/2021	18:40	Nurse Chloe Nisbet/ NURSE Leeanne Russell
01/05/21	07:00	01/05/2021	06:37	Nurse Arlene Wilkie/ Nurse Allison McLean
01/05/21	18:00	01/05/2021	17:02	NURSE Stephanie McLellan
02/05/21	07:00	02/05/2021	08:39	NURSE Amy Thomson
02/05/21	18:00	02/05/2021	16:35	NURSE Amy Thomson
03/05/21	07:00	03/05/2021	09:08	Nurse Tracy Hassan
03/05/21	18:00	03/05/2021	16:49	Nurse Tracy Hassan
04/05/21	07:00	04/05/2021	08:58	Nurse Tracy Hassan
04/05/21	18:00	04/05/2021	17:05	Nurse Tracy Hassan
05/05/21	07:00	05/05/2021	09:03	NURSE Andrea McMullen
05/05/21	18:00	05/05/2021	17:18	Nurse Pauline Henderson
06/05/21	07:00	06/05/2021	09:20	Nurse Tracy Hassan
06/05/21	18:00	06/05/2021	17:46	Nurse Tracy Hassan
07/05/21	07:00	07/05/2021	08:32	NURSE Emma Harvie
07/05/21	18:00	07/05/2021	16:36	NURSE Emma Harvie
08/05/21	07:00	08/05/2021	08:58	NURSE Claire Ferguson
08/05/21	18:00	08/05/2021	17:26	Nurse Jamie Bryceland
09/05/21	07:00	09/05/2021	08:40	NURSE Emma Harvie
09/05/21	18:00	09/05/2021	16:42	NURSE Emma Harvie
10/05/21	07:00	10/05/2021	08:59	STDN GILLIAN DAVIDSON
10/05/21	18:00	10/05/2021	16:33	NURSE Heather McBride
11/05/21	07:00	11/05/2021	08:21	NURSE Stephanie McLellan

Discontinued on: 11/05/2021 12:46 by: Dr Samuel Birch-Machin . Reason: No longer indicated

ENSURE TWOAL

06/05/21 18:00 125 mL TWICE daily at 7am and 6pm (Oral)

Dr Samuel Birch-Machin

06/05/21	18:00	06/05/2021	17:47	Nurse Tracy Hassan
07/05/21	07:00	07/05/2021	08:32	NURSE Emma Harvie
07/05/21	18:00	07/05/2021	16:36	NURSE Emma Harvie
08/05/21	07:00	Patient refused		NURSE Claire Ferguson
08/05/21	18:00	Patient refused		Nurse Jamie Bryceland
09/05/21	07:00	09/05/2021	08:41	NURSE Emma Harvie
09/05/21	18:00	09/05/2021	16:42	NURSE Emma Harvie
10/05/21	07:00	10/05/2021	08:59	STDN GILLIAN DAVIDSON
10/05/21	18:00	Patient refused		NURSE Heather McBride
11/05/21	07:00	Patient refused		NURSE Stephanie McLellan
11/05/21	18:00	Patient refused		Nurse Meghan Stevenson
12/05/21	07:00	Patient refused		Nurse Meghan Stevenson
12/05/21	18:00	Patient refused		Nurse Meghan Stevenson
13/05/21	07:00	13/05/2021	12:06	NURSE Clare Martin
13/05/21	18:00	13/05/2021	17:08	NURSE Amy Thomson
14/05/21	07:00	14/05/2021	08:45	NURSE Emma Harvie

ENSURE TWO CAL

(Continued)

14/05/21	18:00	14/05/2021	16:28	NURSE Emma Harvie
15/05/21	07:00	Patient refused		NURSE Amy Thomson
15/05/21	18:00	Patient refused		NURSE Diane Russell
16/05/21	07:00	16/05/2021	08:46	NURSE Andrea McMullen
16/05/21	18:00	Patient refused		NURSE Claire Ferguson
17/05/21	07:00	Patient refused		NURSE Andrea McMullen
17/05/21	18:00	Other - Record in nursing notes		NURSE Amy Thomson
18/05/21	07:00	Patient refused		NURSE Andrea McMullen
18/05/21	18:00	18/05/2021	16:40	Nurse Rachel McKenny
19/05/21	07:00	Patient refused		NURSE Heather McBride
19/05/21	18:00	19/05/2021	17:10	STDN RACHEL THOMAS/ Nurse Rachel McKenny
20/05/21	07:00	20/05/2021	08:43	Nurse Meghan Stevenson
20/05/21	18:00	Patient refused		Nurse Meghan Stevenson
21/05/21	07:00	Patient refused		STDN RACHEL THOMAS
21/05/21	18:00	21/05/2021	18:03	NURSE Amy Savage
22/05/21	07:00	Patient refused		NURSE Nicola Kelly
22/05/21	18:00	Patient refused		Nurse Tracy Hassan
23/05/21	07:00	Patient refused		NURSE Andrea McMullen
23/05/21	18:00	Patient refused		NURSE Andrea McMullen
24/05/21	07:00	Patient refused		NURSE Andrea McMullen
24/05/21	18:00	Patient refused		Nurse Rachel McKenny
25/05/21	07:00	25/05/2021	09:29	Nurse Tracy Hassan

FOLIC ACID 5 mg Tablets

Rx 28/04/21 07:00 5 mg ONCE daily at 7am (Oral)

Dr Jordanna Deosaran

28/04/21	07:00	28/04/2021	08:36	Nurse Kirstin Napier/ Nurse Zoe Luke
29/04/21	07:00	29/04/2021	05:59	NURSE Coleen Markey/ NURSE VICTORIA MILLS
30/04/21	07:00	30/04/2021	05:45	NURSE Coleen Markey
01/05/21	07:00	01/05/2021	06:37	Nurse Arlene Wilkie/ Nurse Allison McLean
02/05/21	07:00	02/05/2021	08:37	NURSE Amy Thomson
03/05/21	07:00	03/05/2021	09:02	Nurse Tracy Hassan
04/05/21	07:00	04/05/2021	08:54	Nurse Tracy Hassan
05/05/21	07:00	05/05/2021	09:00	NURSE Andrea McMullen
06/05/21	07:00	06/05/2021	09:19	Nurse Tracy Hassan
07/05/21	07:00	07/05/2021	08:31	NURSE Emma Harvie
08/05/21	07:00	08/05/2021	08:56	NURSE Claire Ferguson
09/05/21	07:00	09/05/2021	08:39	NURSE Emma Harvie
10/05/21	07:00	10/05/2021	08:58	STDN GILLIAN DAVIDSON
11/05/21	07:00	11/05/2021	08:13	NURSE Stephanie McLellan
12/05/21	07:00	12/05/2021	08:35	Nurse Meghan Stevenson
13/05/21	07:00	13/05/2021	12:05	NURSE Clare Martin
14/05/21	07:00	14/05/2021	08:44	NURSE Emma Harvie
15/05/21	07:00	15/05/2021	08:58	NURSE Amy Thomson
16/05/21	07:00	16/05/2021	08:44	NURSE Andrea McMullen
17/05/21	07:00	17/05/2021	08:18	NURSE Andrea McMullen
18/05/21	07:00	18/05/2021	08:13	NURSE Andrea McMullen
19/05/21	07:00	19/05/2021	07:50	NURSE Heather McBride
20/05/21	07:00	20/05/2021	08:42	Nurse Meghan Stevenson
21/05/21	07:00	21/05/2021	08:30	STDN RACHEL THOMAS/ Nurse Rachel McKenny
22/05/21	07:00	22/05/2021	08:53	NURSE Nicola Kelly
23/05/21	07:00	23/05/2021	08:07	NURSE Andrea McMullen
24/05/21	07:00	24/05/2021	08:35	NURSE Andrea McMullen
25/05/21	07:00	25/05/2021	09:27	Nurse Tracy Hassan

LOPERAMIDE 2 mg Capsules

Rx 08/05/21 22:00 2 mg THREE times daily - 7am;1pm;10pm (Oral)

Dr Esme Beer

08/05/21	22:00	08/05/2021	21:12	Nurse Sophie McPheat
09/05/21	07:00	09/05/2021	08:41	NURSE Emma Harvie
09/05/21	13:00	09/05/2021	13:05	Nurse Rachel McKenny
09/05/21	22:00	09/05/2021	20:43	NURSE Amy Thomson
10/05/21	07:00	10/05/2021	08:59	STDN GILLIAN DAVIDSON
10/05/21	13:00	10/05/2021	12:16	NURSE Heather McBride
10/05/21	22:00	10/05/2021	20:49	Nurse Tracy Hassan
11/05/21	07:00	11/05/2021	08:17	NURSE Stephanie McLellan
11/05/21	13:00	11/05/2021	11:58	NURSE Heather McBride
11/05/21	22:00	11/05/2021	21:23	Nurse Tracy Hassan
12/05/21	07:00	12/05/2021	08:38	Nurse Meghan Stevenson
12/05/21	13:00	12/05/2021	12:20	NURSE Clare Martin
12/05/21	22:00	12/05/2021	21:00	NURSE Angela Veldon
13/05/21	07:00	Nil by mouth/fasting		NURSE Clare Martin
13/05/21	13:00	13/05/2021	12:07	NURSE Clare Martin

Key: Rx Prescription details Recorded as "Admitted On" Prescribed as "Self Administer" Discontinuation details HEPMA Prescription additional notes HEPMA Patient admission notes (admission specific) HEPMA Patient retained notes (not specific to admission)

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LOPERAMIDE 2 mg Capsules

(Continued)

13/05/21	22:00	13/05/2021	21:05	NURSE Rachel O'Hanlon
14/05/21	07:00	14/05/2021	08:45	NURSE Emma Harvie
14/05/21	13:00	14/05/2021	12:53	Nurse Jamie Bryceland
14/05/21	22:00	14/05/2021	20:46	NURSE Stephanie McLellan
15/05/21	07:00	15/05/2021	09:00	NURSE Amy Thomson
15/05/21	13:00	15/05/2021	12:27	NURSE Amy Thomson
15/05/21	22:00	15/05/2021	21:09	Nurse Rachel Donnelly
16/05/21	07:00	16/05/2021	08:45	NURSE Andrea McMullen
16/05/21	13:00	16/05/2021	13:02	NURSE Diane Russell
16/05/21	22:00	16/05/2021	21:23	NURSE Stephanie McLellan
17/05/21	07:00	17/05/2021	08:21	NURSE Andrea McMullen
17/05/21	13:00	17/05/2021	12:37	Nurse Pauline Henderson
17/05/21	22:00	17/05/2021	20:49	NURSE Amy Thomson
18/05/21	07:00	18/05/2021	08:19	NURSE Andrea McMullen
18/05/21	13:00	18/05/2021	12:27	Nurse Rachel McKenny
18/05/21	22:00	18/05/2021	20:17	NURSE Amy Thomson
19/05/21	07:00	19/05/2021	07:50	NURSE Heather McBride
19/05/21	13:00	19/05/2021	12:06	Nurse Rachel McKenny
19/05/21	22:00	19/05/2021	21:02	NURSE Amy Thomson
20/05/21	07:00	20/05/2021	08:41	Nurse Meghan Stevenson
20/05/21	13:00	20/05/2021	12:05	NURSE Clare Martin
20/05/21	22:00	20/05/2021	20:45	NURSE Rachel O'Hanlon
21/05/21	07:00	21/05/2021	08:34	STDN RACHEL THOMAS/ Nurse Rachel McKenny
21/05/21	13:00	21/05/2021	12:52	NURSE Amy Savage
21/05/21	22:00	21/05/2021	20:54	NURSE Emma Harvie
22/05/21	07:00	22/05/2021	08:55	NURSE Nicola Kelly
22/05/21	13:00	22/05/2021	12:59	NURSE Nicola Kelly
22/05/21	22:00	22/05/2021	21:25	NURSE Angela Veldon
23/05/21	07:00	23/05/2021	08:10	NURSE Andrea McMullen
23/05/21	13:00	23/05/2021	13:21	Nurse Rachel McKenny
23/05/21	22:00	23/05/2021	21:21	NURSE Heather McBride
24/05/21	07:00	24/05/2021	08:39	NURSE Andrea McMullen
24/05/21	13:00	24/05/2021	13:27	NURSE Diane Russell
24/05/21	22:00	24/05/2021	20:11	NURSE Emma Harvie
25/05/21	07:00	25/05/2021	09:29	Nurse Tracy Hassan
25/05/21	13:00	Patient unavailable		NURSE Diane Russell

MEROPENEM 1 g Injection

 ALERT Antibiotic Indication added by Dr Samuel Birch-Machin on 04/05/2021 at 14:31

Title: ALERT drug

Started as per micro advice

 04/05/21 22:00 1 g THREE times daily - 7am;1pm;10pm (Intravenous Intermittent Infusion) Dr Samuel Birch-Machin

04/05/21	22:00	04/05/2021	21:41	NURSE Janice Mead
05/05/21	07:00	05/05/2021	06:43	Nurse Meghan Stevenson
05/05/21	13:00	05/05/2021	12:42	Nurse Pauline Henderson
05/05/21	22:00	05/05/2021	22:57	NURSE Diane Russell
06/05/21	07:00	06/05/2021	09:20	Nurse Tracy Hassan
06/05/21	13:00	06/05/2021	12:41	Nurse Tracy Hassan
06/05/21	22:00	06/05/2021	21:08	NURSE Amy Thomson
07/05/21	07:00	07/05/2021	06:36	NURSE Janice Mead
07/05/21	13:00	07/05/2021	16:36	NURSE Emma Harvie
07/05/21	22:00	07/05/2021	20:24	NURSE Heather McBride
08/05/21	07:00	08/05/2021	05:40	NURSE Amy Thomson
08/05/21	13:00	08/05/2021	12:43	Nurse Jamie Bryceland
08/05/21	22:00	08/05/2021	21:00	Nurse Sophie McPheat
09/05/21	07:00	09/05/2021	06:33	Nurse Sophie McPheat
09/05/21	13:00	09/05/2021	13:04	Nurse Rachel McKenny
09/05/21	22:00	09/05/2021	20:43	NURSE Amy Thomson
10/05/21	07:00	10/05/2021	05:47	Nurse Sophie McPheat
10/05/21	13:00	10/05/2021	12:13	NURSE Heather McBride

 10/05/21 22:00 1 g THREE times daily - 7am;1pm;10pm (Intravenous Intermittent Infusion) Dr Samuel Birch-Machin

10/05/21	22:00	10/05/2021	20:49	Nurse Tracy Hassan
11/05/21	07:00	11/05/2021	05:55	NURSE Amanda Kane
11/05/21	13:00	11/05/2021	11:58	NURSE Heather McBride
11/05/21	22:00	11/05/2021	21:23	Nurse Tracy Hassan
12/05/21	07:00	12/05/2021	05:55	Nurse Tracy Hassan
12/05/21	13:00	12/05/2021	12:19	NURSE Clare Martin

Key:  Prescription details  Recorded as "Admitted On"  Prescribed as "Self Administer"  Discontinuation details  HEPMA Prescription additional notes  HEPMA Patient admission notes (admission specific)  HEPMA Patient retained notes (not specific to admission)

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MEROPENEM 1 g Injection

(Continued)

 **ALERT Antibiotic Indication** added by **Dr Samuel Birch-Machin** on 04/05/2021 at 14:31

Title: ALERT drug

Started as per micro advice

☒	04/05/21	14:30	1 g (Intravenous Intermittent Infusion)	Dr Samuel Birch-Machin
	04/05/21	14:30	04/05/2021 17:13	Nurse Tracy Hassan
☒	19/05/21	22:00	1 g THREE times daily - 7am;1pm;10pm (Intravenous Intermittent Infusion)	Dr Hannah Talwar
	19/05/21	22:00	19/05/2021 21:02	NURSE Amy Thomson
	20/05/21	07:00	20/05/2021 05:25	NURSE Amy Thomson
	20/05/21	13:00	20/05/2021 12:04	NURSE Clare Martin

 Discontinued on: 20/05/2021 15:38 by: Dr Ryan Clark . Reason: No longer indicated**METRONIDAZOLE 500 mg in 100mL Intravenous Infusion**

☒	27/04/21	22:00	500 mg THREE times daily - 7am;1pm;10pm (Intravenous Intermittent Infusion)	Dr Jordanna Deosaran
	27/04/21	22:00	27/04/2021 22:51	NURSE HANNAH PATERSON
	28/04/21	07:00	28/04/2021 08:35	Nurse Kirstin Napier/ Nurse Zoe Luke
	28/04/21	13:00	28/04/2021 14:54	Nurse Kirstin Napier/ Nurse Louise Lindsay

 Discontinued on: 28/04/2021 15:57 by: Dr Jordanna Deosaran . Reason: No longer indicated

☒	27/04/21	13:51	500 mg (Intravenous Intermittent Infusion)	Dr Jordanna Deosaran
	27/04/21	13:51	27/04/2021 14:42	Nurse Zoe Luke/ Nurse Louise Lindsay
☒	28/04/21	22:00	500 mg THREE times daily - 7am;1pm;10pm (Intravenous Intermittent Infusion)	Dr Jordanna Deosaran
	28/04/21	22:00	28/04/2021 21:20	Dr Ruth Rae
	29/04/21	07:00	29/04/2021 05:59	NURSE Coleen Markey/ NURSE VICTORIA MILLS

 Discontinued on: 29/04/2021 11:09 by: Ms Sarah Connelly . Reason: No longer indicated

☒	04/05/21	13:00	500 mg THREE times daily - 7am;1pm;10pm (Intravenous Intermittent Infusion)	Dr Lily Lei
	04/05/21	13:00	04/05/2021 13:02	Nurse Jamie Bryceland

 Discontinued on: 04/05/2021 14:29 by: Dr Samuel Birch-Machin . Reason: No longer indicated

☒	04/05/21	08:44	500 mg (Intravenous Intermittent Infusion)	Dr Lily Lei
	04/05/21	08:44	04/05/2021 09:00	Nurse Tracy Hassan

NEFOPAM 30 mg Tablets

☒	30/04/21	13:00	30 mg THREE times daily - 7am;1pm;10pm (Oral) for 3 day(s)	Ms Sarah Connelly
	30/04/21	13:00	30/04/2021 12:04	Nurse Chloe Nisbet/ NURSE Leeanne Russell
	30/04/21	22:00	30/04/2021 21:29	Nurse Arlene Wilkie/ Nurse Allison McLean
	01/05/21	07:00	01/05/2021 06:37	Nurse Arlene Wilkie/ Nurse Allison McLean
	01/05/21	13:00	01/05/2021 12:50	NURSE Diane Russell
	01/05/21	22:00	01/05/2021 21:21	NURSE Janice Mead
	02/05/21	07:00	02/05/2021 08:38	NURSE Amy Thomson
	02/05/21	13:00	02/05/2021 12:24	Nurse Tracy Hassan
	02/05/21	22:00	02/05/2021 20:44	NURSE Amanda Kane
	03/05/21	07:00	03/05/2021 09:04	Nurse Tracy Hassan

OMEPRAZOLE 20 mg Capsules

☒	05/05/21	18:00	20 mg TWICE daily at 7am and 6pm (Oral)	Dr Lily Lei
	05/05/21	18:00	05/05/2021 17:18	Nurse Pauline Henderson
	06/05/21	07:00	06/05/2021 09:20	Nurse Tracy Hassan
	06/05/21	18:00	06/05/2021 17:47	Nurse Tracy Hassan
	07/05/21	07:00	07/05/2021 08:32	NURSE Emma Harvie
	07/05/21	18:00	07/05/2021 16:36	NURSE Emma Harvie
	08/05/21	07:00	08/05/2021 08:58	NURSE Claire Ferguson
	08/05/21	18:00	08/05/2021 17:25	Nurse Jamie Bryceland
	09/05/21	07:00	09/05/2021 08:41	NURSE Emma Harvie
	09/05/21	18:00	09/05/2021 16:42	NURSE Emma Harvie
	10/05/21	07:00	10/05/2021 08:59	STDN GILLIAN DAVIDSON
	10/05/21	18:00	10/05/2021 16:33	NURSE Heather McBride
	11/05/21	07:00	11/05/2021 08:16	NURSE Stephanie McLellan
	11/05/21	18:00	11/05/2021 16:57	Nurse Meghan Stevenson
	12/05/21	07:00	12/05/2021 08:37	Nurse Meghan Stevenson
	12/05/21	18:00	12/05/2021 16:38	Nurse Meghan Stevenson
	13/05/21	07:00	13/05/2021 12:06	NURSE Clare Martin
	13/05/21	18:00	13/05/2021 17:08	NURSE Amy Thomson

Key: 	 Prescription details	 Recorded as "Admitted On"	 Prescribed as "Self Administer"	 Discontinuation details	 HEPMA Prescription additional notes	 HEPMA Patient admission notes (admission specific)	 HEPMA Patient retained notes (not specific to admission)
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OMEPRAZOLE 20 mg Capsules

(Continued)

14/05/21	07:00	14/05/2021	08:45	NURSE Emma Harvie
14/05/21	18:00	14/05/2021	16:28	NURSE Emma Harvie
15/05/21	07:00	15/05/2021	08:59	NURSE Amy Thomson
15/05/21	18:00	15/05/2021	17:15	NURSE Diane Russell
16/05/21	07:00	16/05/2021	08:45	NURSE Andrea McMullen
16/05/21	18:00	16/05/2021	17:13	NURSE Claire Ferguson
17/05/21	07:00	17/05/2021	08:20	NURSE Andrea McMullen
17/05/21	18:00	Other - Record in nursing notes		NURSE Amy Thomson
18/05/21	07:00	18/05/2021	08:14	NURSE Andrea McMullen
18/05/21	18:00	18/05/2021	16:39	Nurse Rachel McKenny
19/05/21	07:00	Nil by mouth/fasting		NURSE Heather McBride
19/05/21	18:00	19/05/2021	17:11	STDN RACHEL THOMAS/ Nurse Rachel McKenny
20/05/21	07:00	20/05/2021	08:41	Nurse Meghan Stevenson
20/05/21	18:00	20/05/2021	16:21	Nurse Meghan Stevenson
21/05/21	07:00	21/05/2021	08:33	STDN RACHEL THOMAS/ Nurse Rachel McKenny
21/05/21	18:00	21/05/2021	18:03	NURSE Amy Savage
22/05/21	07:00	22/05/2021	08:54	NURSE Nicola Kelly
22/05/21	18:00	22/05/2021	17:21	Nurse Tracy Hassan
23/05/21	07:00	23/05/2021	08:08	NURSE Andrea McMullen
23/05/21	18:00	23/05/2021	16:48	NURSE Andrea McMullen
24/05/21	07:00	24/05/2021	08:37	NURSE Andrea McMullen
24/05/21	18:00	24/05/2021	18:13	Nurse Rachel McKenny
25/05/21	07:00	25/05/2021	09:29	Nurse Tracy Hassan
05/05/21	09:57	20 mg	(Oral)	Dr Lily Lei
05/05/21	09:57	05/05/2021	10:25	Nurse Jamie Bryceland

PARACETAMOL 500 mg Tablets

30/04/21	13:00	1,000 mg FOUR times daily - 7am;1pm;6pm;10pm (Oral)		Ms Sarah Connelly
30/04/21	13:00	30/04/2021	12:04	Nurse Chloe Nisbet/ NURSE Leeanne Russell
30/04/21	18:00	30/04/2021	17:34	Nurse Aimee Herriot/ Nurse Chloe Nisbet
30/04/21	22:00	30/04/2021	21:29	Nurse Arlene Wilkie/ Nurse Allison McLean
01/05/21	07:00	01/05/2021	06:37	Nurse Arlene Wilkie/ Nurse Allison McLean
01/05/21	13:00	01/05/2021	12:49	NURSE Diane Russell
01/05/21	18:00	01/05/2021	17:02	NURSE Stephanie McLellan
01/05/21	22:00	01/05/2021	21:21	NURSE Janice Mead
02/05/21	07:00	02/05/2021	08:38	NURSE Amy Thomson
02/05/21	13:00	02/05/2021	12:24	Nurse Tracy Hassan
02/05/21	18:00	02/05/2021	16:35	NURSE Amy Thomson
02/05/21	22:00	02/05/2021	20:43	NURSE Amanda Kane
03/05/21	07:00	03/05/2021	09:04	Nurse Tracy Hassan
03/05/21	13:00	03/05/2021	12:46	STDN GILLIAN DAVIDSON
03/05/21	18:00	03/05/2021	16:46	Nurse Tracy Hassan
03/05/21	22:00	03/05/2021	22:05	Nurse Meghan Stevenson
04/05/21	07:00	04/05/2021	08:55	Nurse Tracy Hassan
04/05/21	13:00	04/05/2021	13:00	Nurse Jamie Bryceland
04/05/21	18:00	04/05/2021	17:05	Nurse Tracy Hassan
04/05/21	22:00	04/05/2021	20:46	NURSE Janice Mead
05/05/21	07:00	05/05/2021	06:45	Nurse Meghan Stevenson
05/05/21	13:00	05/05/2021	12:42	Nurse Pauline Henderson
05/05/21	18:00	05/05/2021	17:18	Nurse Pauline Henderson
05/05/21	22:00	05/05/2021	22:03	NURSE Janice Mead
06/05/21	07:00	06/05/2021	09:20	Nurse Tracy Hassan
06/05/21	13:00	06/05/2021	12:41	Nurse Tracy Hassan
06/05/21	18:00	06/05/2021	17:45	Nurse Tracy Hassan
06/05/21	22:00	06/05/2021	21:07	NURSE Amy Thomson
07/05/21	07:00	07/05/2021	08:32	NURSE Emma Harvie
07/05/21	13:00	07/05/2021	12:29	Nurse Sophie McPheat
07/05/21	18:00	07/05/2021	16:36	NURSE Emma Harvie
07/05/21	22:00	07/05/2021	20:23	NURSE Heather McBride
08/05/21	07:00	08/05/2021	08:57	NURSE Claire Ferguson
08/05/21	13:00	08/05/2021	12:42	Nurse Jamie Bryceland
08/05/21	18:00	08/05/2021	17:24	Nurse Jamie Bryceland
08/05/21	22:00	08/05/2021	21:12	Nurse Sophie McPheat
09/05/21	07:00	09/05/2021	08:40	NURSE Emma Harvie
09/05/21	13:00	09/05/2021	13:04	Nurse Rachel McKenny
09/05/21	18:00	09/05/2021	16:42	NURSE Emma Harvie
09/05/21	22:00	09/05/2021	20:43	NURSE Amy Thomson
10/05/21	07:00	10/05/2021	08:59	STDN GILLIAN DAVIDSON
10/05/21	13:00	10/05/2021	12:13	NURSE Heather McBride
10/05/21	18:00	10/05/2021	16:33	NURSE Heather McBride

Key: Prescription details Recorded as "Admitted On" Prescribed as "Self Administer" Discontinuation details HEPMA Prescription additional notes HEPMA Patient admission notes (admission specific) HEPMA Patient retained notes (not specific to admission)

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PARACETAMOL 500 mg Tablets

(Continued)

10/05/21	22:00	10/05/2021	20:49	Nurse Tracy Hassan
11/05/21	07:00	11/05/2021	08:15	NURSE Stephanie McLellan
11/05/21	13:00	11/05/2021	11:55	NURSE Heather McBride
11/05/21	18:00	11/05/2021	16:56	Nurse Meghan Stevenson
11/05/21	22:00	11/05/2021	21:22	Nurse Tracy Hassan
12/05/21	07:00	12/05/2021	08:37	Nurse Meghan Stevenson
12/05/21	13:00	12/05/2021	12:19	NURSE Clare Martin
12/05/21	18:00	12/05/2021	16:38	Nurse Meghan Stevenson
12/05/21	22:00	12/05/2021	21:00	NURSE Angela Veldon
13/05/21	07:00	13/05/2021	08:57	NURSE Amy Thomson
13/05/21	13:00	13/05/2021	12:07	NURSE Clare Martin
13/05/21	18:00	13/05/2021	17:08	NURSE Amy Thomson
13/05/21	22:00	13/05/2021	21:05	NURSE Rachel O'Hanlon
14/05/21	07:00	14/05/2021	08:44	NURSE Emma Harvie
14/05/21	13:00	14/05/2021	12:51	Nurse Jamie Bryceland
14/05/21	18:00	14/05/2021	16:28	NURSE Emma Harvie
14/05/21	22:00	14/05/2021	20:46	NURSE Stephanie McLellan
15/05/21	07:00	15/05/2021	08:58	NURSE Amy Thomson
15/05/21	13:00	15/05/2021	12:27	NURSE Amy Thomson
15/05/21	18:00	15/05/2021	17:14	NURSE Diane Russell
15/05/21	22:00	15/05/2021	21:08	Nurse Rachel Donnelly
16/05/21	07:00	16/05/2021	06:31	Nurse Rachel Donnelly
16/05/21	13:00	16/05/2021	13:02	NURSE Diane Russell
16/05/21	18:00	16/05/2021	17:13	NURSE Claire Ferguson
16/05/21	22:00	16/05/2021	21:23	NURSE Stephanie McLellan
17/05/21	07:00	17/05/2021	08:20	NURSE Andrea McMullen
17/05/21	13:00	17/05/2021	12:36	Nurse Pauline Henderson
17/05/21	18:00	Other - Record in nursing notes		NURSE Amy Thomson
17/05/21	22:00	17/05/2021	20:49	NURSE Amy Thomson
18/05/21	07:00	18/05/2021	08:14	NURSE Andrea McMullen
18/05/21	13:00	18/05/2021	12:26	Nurse Rachel McKenny
18/05/21	18:00	18/05/2021	16:39	Nurse Rachel McKenny
18/05/21	22:00	18/05/2021	20:17	NURSE Amy Thomson
19/05/21	07:00	19/05/2021	07:50	NURSE Heather McBride
19/05/21	13:00	19/05/2021	12:05	Nurse Rachel McKenny
19/05/21	18:00	19/05/2021	17:10	STDN RACHEL THOMAS/ Nurse Rachel McKenny
19/05/21	22:00	19/05/2021	21:02	NURSE Amy Thomson
20/05/21	07:00	20/05/2021	08:41	Nurse Meghan Stevenson
20/05/21	13:00	20/05/2021	12:05	NURSE Clare Martin
20/05/21	18:00	20/05/2021	16:21	Nurse Meghan Stevenson
20/05/21	22:00	20/05/2021	20:45	NURSE Rachel O'Hanlon
21/05/21	07:00	21/05/2021	08:33	STDN RACHEL THOMAS/ Nurse Rachel McKenny
21/05/21	13:00	21/05/2021	12:52	NURSE Amy Savage
21/05/21	18:00	21/05/2021	18:02	NURSE Amy Savage
21/05/21	22:00	21/05/2021	20:54	NURSE Emma Harvie
22/05/21	07:00	22/05/2021	08:54	NURSE Nicola Kelly
22/05/21	13:00	22/05/2021	12:58	NURSE Nicola Kelly
22/05/21	18:00	22/05/2021	17:21	Nurse Tracy Hassan
22/05/21	22:00	22/05/2021	21:25	NURSE Angela Veldon
23/05/21	07:00	23/05/2021	08:08	NURSE Andrea McMullen
23/05/21	13:00	23/05/2021	13:21	Nurse Rachel McKenny
23/05/21	18:00	23/05/2021	16:48	NURSE Andrea McMullen
23/05/21	22:00	23/05/2021	21:21	NURSE Heather McBride
24/05/21	07:00	24/05/2021	08:37	NURSE Andrea McMullen
24/05/21	13:00	24/05/2021	13:27	NURSE Diane Russell
24/05/21	18:00	24/05/2021	18:13	Nurse Rachel McKenny
24/05/21	22:00	24/05/2021	20:11	NURSE Emma Harvie
25/05/21	07:00	25/05/2021	09:29	Nurse Tracy Hassan
25/05/21	13:00	Patient unavailable		NURSE Diane Russell

PARACETAMOL 10 mg in 1mL Infusion

	29/04/21	07:00	750 mg FOUR times daily - 7am;1pm;6pm;10pm (Intravenous Intermittent Infusion)	Dr Ruth Rae
29/04/21	07:00	29/04/2021	05:59	NURSE Coleen Markey/ NURSE VICTORIA MILLS
29/04/21	13:00	29/04/2021	13:06	Nurse Chloe Nisbet/ Nurse Ciara Rogers
29/04/21	18:00	29/04/2021	18:11	NURSE Jillian Kinney/ NURSE Yvonne Cairney
29/04/21	22:00	29/04/2021	22:40	NURSE Coleen Markey
30/04/21	07:00	30/04/2021	05:45	NURSE Coleen Markey

 Discontinued on: 30/04/2021 11:26 by: Ms Sarah Connelly . Reason: Discontinued due to conflict

Key: 	 Prescription details	 Recorded as "Admitted On"	 Prescribed as "Self Administer"	 Discontinuation details	 HEPMA Prescription additional notes	 HEPMA Patient admission notes (admission specific)	 HEPMA Patient retained notes (not specific to admission)
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PARACETAMOL 10 mg in 1mL Infusion

(Continued)

 28/04/21 22:34 750 mg (Intravenous Intermittent Infusion)

Dr Ruth Rae

28/04/21	22:34	28/04/2021	22:34	Dr Ruth Rae
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PIPERACILLIN/TAZOBACTAM 4g/0.5g Injection
 28/04/21 22:00 4.5 g THREE times daily - 7am;1pm;10pm (Intravenous Intermittent Infusion)

Dr Jordanna Deosaran

28/04/21	22:00	28/04/2021	21:20	Dr Ruth Rae
29/04/21	07:00	29/04/2021	05:59	NURSE Coleen Markey/ NURSE VICTORIA MILLS
29/04/21	13:00	29/04/2021	13:06	Nurse Chloe Nisbet/ Nurse Ciara Rogers
29/04/21	22:00	29/04/2021	22:40	NURSE Coleen Markey
30/04/21	07:00	30/04/2021	05:45	NURSE Coleen Markey
30/04/21	13:00	30/04/2021	12:04	Nurse Chloe Nisbet/ NURSE Leeanne Russell
30/04/21	22:00	30/04/2021	21:29	Nurse Arlene Wilkie/ Nurse Allison McLean
01/05/21	07:00	01/05/2021	06:37	Nurse Arlene Wilkie/ Nurse Allison McLean

 01/05/21 13:00 4.5 g THREE times daily - 7am;1pm;10pm (Intravenous Intermittent Infusion)

Dr Sanjiv Chohan

01/05/21	13:00	01/05/2021	14:08	NURSE Diane Russell
01/05/21	22:00	01/05/2021	22:02	NURSE Janice Mead
02/05/21	07:00	02/05/2021	06:37	NURSE Janice Mead
02/05/21	13:00	02/05/2021	12:24	Nurse Tracy Hassan

 Discontinued on: 02/05/2021 20:03 by: Dr Samuel Birch-Machin . Reason: No longer indicated

 28/04/21 15:56 4.5 g (Intravenous Intermittent Infusion)

Dr Jordanna Deosaran

28/04/21	15:56	28/04/2021	16:00	Nurse Kirstin Napier
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 02/05/21 22:00 4.5 g THREE times daily - 7am;1pm;10pm (Intravenous Intermittent Infusion)

Dr Samuel Birch-Machin

02/05/21	22:00	02/05/2021	20:44	NURSE Amanda Kane
03/05/21	07:00	03/05/2021	05:33	NURSE Amanda Kane
03/05/21	13:00	03/05/2021	16:52	Nurse Tracy Hassan
03/05/21	22:00	03/05/2021	22:22	NURSE Diane Russell
04/05/21	07:00	04/05/2021	06:32	Nurse Meghan Stevenson
04/05/21	13:00	04/05/2021	13:02	Nurse Jamie Bryceland

 Discontinued on: 04/05/2021 14:29 by: Dr Samuel Birch-Machin . Reason: No longer indicated
QUETIAPINE 150 mg Tablets
 29/04/21 22:00 150 mg ONCE daily at 10pm (Oral)

Ms Sarah Connelly

29/04/21	22:00	29/04/2021	22:40	NURSE Coleen Markey
30/04/21	22:00	30/04/2021	21:29	Nurse Arlene Wilkie/ Nurse Allison McLean
01/05/21	22:00	01/05/2021	21:33	NURSE Janice Mead
02/05/21	22:00	02/05/2021	20:41	NURSE Amanda Kane
03/05/21	22:00	03/05/2021	22:04	Nurse Meghan Stevenson
04/05/21	22:00	04/05/2021	20:45	NURSE Janice Mead
05/05/21	22:00	05/05/2021	22:03	NURSE Janice Mead
06/05/21	22:00	06/05/2021	21:07	NURSE Amy Thomson
07/05/21	22:00	07/05/2021	20:23	NURSE Heather McBride
08/05/21	22:00	08/05/2021	21:12	Nurse Sophie McPheat
09/05/21	22:00	09/05/2021	20:43	NURSE Amy Thomson
10/05/21	22:00	10/05/2021	20:49	Nurse Tracy Hassan
11/05/21	22:00	11/05/2021	21:22	Nurse Tracy Hassan
12/05/21	22:00	12/05/2021	20:59	NURSE Angela Veldon
13/05/21	22:00	13/05/2021	21:04	NURSE Rachel O'Hanlon
14/05/21	22:00	14/05/2021	20:45	NURSE Stephanie McLellan
15/05/21	22:00	15/05/2021	21:08	Nurse Rachel Donnelly
16/05/21	22:00	16/05/2021	21:22	NURSE Stephanie McLellan
17/05/21	22:00	17/05/2021	20:49	NURSE Amy Thomson
18/05/21	22:00	18/05/2021	20:17	NURSE Amy Thomson
19/05/21	22:00	19/05/2021	21:02	NURSE Amy Thomson
20/05/21	22:00	20/05/2021	20:45	NURSE Rachel O'Hanlon
21/05/21	22:00	21/05/2021	20:54	NURSE Emma Harvie
22/05/21	22:00	22/05/2021	21:25	NURSE Angela Veldon
23/05/21	22:00	23/05/2021	21:21	NURSE Heather McBride
24/05/21	22:00	24/05/2021	20:11	NURSE Emma Harvie

QUETIAPINE 25 mg Tablets
 28/04/21 07:00 50 mg ONCE daily at 7am (Oral)

Dr Jordanna Deosaran

28/04/21	07:00	28/04/2021	08:41	Nurse Kirstin Napier/ Nurse Zoe Luke
29/04/21	07:00	29/04/2021	05:59	NURSE Coleen Markey/ NURSE VICTORIA MILLS
30/04/21	07:00	30/04/2021	05:45	NURSE Coleen Markey

Key:  Prescription details  Recorded as "Admitted On"  Prescribed as "Self Administer"  Discontinuation details  HEPMA Prescription additional notes  HEPMA Patient admission notes (admission specific)  HEPMA Patient retained notes (not specific to admission)

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QUETIAPINE 25 mg Tablets

(Continued)

01/05/21	07:00	01/05/2021	06:37	Nurse Arlene Wilkie/ Nurse Allison McLean
02/05/21	07:00	02/05/2021	08:38	NURSE Amy Thomson
03/05/21	07:00	03/05/2021	09:03	Nurse Tracy Hassan
04/05/21	07:00	04/05/2021	08:54	Nurse Tracy Hassan
05/05/21	07:00	05/05/2021	09:01	NURSE Andrea McMullen
06/05/21	07:00	Dose withheld on Dr's instruction		Nurse Tracy Hassan
07/05/21	07:00	07/05/2021	08:32	NURSE Emma Harvie
08/05/21	07:00	08/05/2021	08:56	NURSE Claire Ferguson
09/05/21	07:00	09/05/2021	08:40	NURSE Emma Harvie
10/05/21	07:00	10/05/2021	08:58	STDN GILLIAN DAVIDSON
11/05/21	07:00	11/05/2021	08:15	NURSE Stephanie McLellan
12/05/21	07:00	12/05/2021	08:36	Nurse Meghan Stevenson
13/05/21	07:00	Nil by mouth/fasting		NURSE Clare Martin
14/05/21	07:00	14/05/2021	08:44	NURSE Emma Harvie
15/05/21	07:00	15/05/2021	08:58	NURSE Amy Thomson
16/05/21	07:00	16/05/2021	08:44	NURSE Andrea McMullen
17/05/21	07:00	17/05/2021	08:19	NURSE Andrea McMullen
18/05/21	07:00	18/05/2021	08:19	NURSE Andrea McMullen
19/05/21	07:00	19/05/2021	07:49	NURSE Heather McBride
20/05/21	07:00	20/05/2021	08:40	Nurse Meghan Stevenson
21/05/21	07:00	21/05/2021	08:32	STDN RACHEL THOMAS/ Nurse Rachel McKenny
22/05/21	07:00	22/05/2021	08:54	NURSE Nicola Kelly
23/05/21	07:00	23/05/2021	08:07	NURSE Andrea McMullen
24/05/21	07:00	24/05/2021	08:36	NURSE Andrea McMullen
25/05/21	07:00	25/05/2021	09:28	Nurse Tracy Hassan

☒ 28/04/21 12:00 25 mg ONCE daily at midday (Oral) Dr Jordanna Deosaran

28/04/21	12:00	28/04/2021	14:53	Nurse Kirstin Napier/ Nurse Louise Lindsay
29/04/21	12:00	29/04/2021	12:58	Nurse Chloe Nisbet
30/04/21	12:00	30/04/2021	12:04	Nurse Chloe Nisbet/ NURSE Leeanne Russell
01/05/21	12:00	01/05/2021	12:49	NURSE Diane Russell
02/05/21	12:00	02/05/2021	12:23	Nurse Tracy Hassan
03/05/21	12:00	03/05/2021	12:46	STDN GILLIAN DAVIDSON
04/05/21	12:00	04/05/2021	13:00	Nurse Jamie Bryceland
05/05/21	12:00	05/05/2021	12:41	Nurse Pauline Henderson
06/05/21	12:00	06/05/2021	12:53	Nurse Tracy Hassan
07/05/21	12:00	07/05/2021	12:29	Nurse Sophie McPheat
08/05/21	12:00	08/05/2021	12:42	Nurse Jamie Bryceland
09/05/21	12:00	09/05/2021	13:05	Nurse Rachel McKenny
10/05/21	12:00	10/05/2021	12:13	NURSE Heather McBride
11/05/21	12:00	11/05/2021	11:55	NURSE Heather McBride
12/05/21	12:00	12/05/2021	12:19	NURSE Clare Martin
13/05/21	12:00	13/05/2021	12:06	NURSE Clare Martin
14/05/21	12:00	14/05/2021	12:50	Nurse Jamie Bryceland
15/05/21	12:00	15/05/2021	12:27	NURSE Amy Thomson
16/05/21	12:00	16/05/2021	13:01	NURSE Diane Russell
17/05/21	12:00	17/05/2021	12:35	Nurse Pauline Henderson
18/05/21	12:00	18/05/2021	12:26	Nurse Rachel McKenny
19/05/21	12:00	19/05/2021	12:05	Nurse Rachel McKenny
20/05/21	12:00	20/05/2021	12:05	NURSE Clare Martin
21/05/21	12:00	21/05/2021	12:51	NURSE Amy Savage
22/05/21	12:00	22/05/2021	12:58	NURSE Nicola Kelly
23/05/21	12:00	23/05/2021	13:20	Nurse Rachel McKenny
24/05/21	12:00	24/05/2021	13:27	NURSE Diane Russell
25/05/21	12:00	Patient unavailable		NURSE Diane Russell

SANDO K Effervescent Tablets

☒ 11/05/21 18:00 1 tablet(s) THREE times daily at 7am, 1pm, and 6pm (Oral) for 3 day(s)

Dr Samuel Birch-Machin

11/05/21	18:00	11/05/2021	16:58	Nurse Meghan Stevenson
12/05/21	07:00	12/05/2021	08:38	Nurse Meghan Stevenson
12/05/21	13:00	12/05/2021	12:21	NURSE Clare Martin
12/05/21	18:00	12/05/2021	16:39	Nurse Meghan Stevenson
13/05/21	07:00	Nil by mouth/fasting		NURSE Clare Martin
13/05/21	13:00	13/05/2021	12:07	NURSE Clare Martin
13/05/21	18:00	13/05/2021	17:09	NURSE Amy Thomson
14/05/21	07:00	14/05/2021	08:46	NURSE Emma Harvie
14/05/21	13:00	14/05/2021	12:54	Nurse Jamie Bryceland

TINZAPARIN 10,000 units in 0.5ml Pre-filled Syringe

Key: 	 Prescription details	 Recorded as "Admitted On"	 Prescribed as "Self Administer"	 Discontinuation details	 HEPMA Prescription additional notes	 HEPMA Patient admission notes (admission specific)	 HEPMA Patient retained notes (not specific to admission)
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TINZAPARIN 10,000 units in 0.5ml Pre-filled Syringe

(Continued)

27/04/21	18:00	10,000 unit(s) ONCE daily at 6pm (Subcutaneous Bolus Injection)	Dr Jordanna Deosaran
27/04/21	18:00	27/04/2021 18:22	Nurse Zoe Luke
28/04/21	18:00	Dose withheld on Dr's instruction	Nurse Kirstin Napier
29/04/21	18:00	Suspended continued	Ms Sarah Connelly

Discontinued on: 30/04/2021 11:29 by: Ms Sarah Connelly . Reason: Discontinued due to conflict

11/05/21	18:00	10,000 unit(s) ONCE daily at 6pm (Subcutaneous Bolus Injection)	Dr Samuel Birch-Machin
11/05/21	18:00	11/05/2021 16:59	Nurse Meghan Stevenson
12/05/21	18:00	12/05/2021 16:40	Nurse Meghan Stevenson
13/05/21	18:00	13/05/2021 17:09	NURSE Amy Thomson
14/05/21	18:00	14/05/2021 16:28	NURSE Emma Harvie
15/05/21	18:00	15/05/2021 17:25	NURSE Diane Russell
16/05/21	18:00	16/05/2021 17:16	NURSE Claire Ferguson
17/05/21	18:00	17/05/2021 23:43	NURSE Claire Ferguson
18/05/21	18:00	18/05/2021 16:40	Nurse Rachel McKenny
19/05/21	18:00	19/05/2021 17:12	STDN RACHEL THOMAS/ Nurse Rachel McKenny
20/05/21	18:00	20/05/2021 16:24	Nurse Meghan Stevenson
21/05/21	18:00	21/05/2021 18:06	NURSE Amy Savage
22/05/21	18:00	22/05/2021 17:23	Nurse Tracy Hassan
23/05/21	18:00	23/05/2021 16:49	NURSE Andrea McMullen
24/05/21	18:00	24/05/2021 18:14	Nurse Rachel McKenny

WARFARIN AS CHARTED

27/04/21	18:00	1 AS CHARTED Daily at 6pm - See Anticoagulant Chart (Oral)	Dr Jordanna Deosaran
27/04/21	18:00	Order suspended	Dr Jordanna Deosaran
28/04/21	18:00	Suspended continued	Dr Samuel Birch-Machin
29/04/21	18:00	Suspended continued	Dr Samuel Birch-Machin
30/04/21	18:00	Suspended continued	Dr Samuel Birch-Machin
01/05/21	18:00	Suspended continued	Dr Samuel Birch-Machin
02/05/21	18:00	Suspended continued	Dr Samuel Birch-Machin
03/05/21	18:00	Suspended continued	Dr Samuel Birch-Machin
04/05/21	18:00	Suspended continued	Dr Samuel Birch-Machin
05/05/21	18:00	Suspended continued	Dr Samuel Birch-Machin
06/05/21	18:00	Suspended continued	Dr Samuel Birch-Machin
07/05/21	18:00	Suspended continued	Dr Samuel Birch-Machin
08/05/21	18:00	Suspended continued	Dr Samuel Birch-Machin
09/05/21	18:00	Suspended continued	Dr Samuel Birch-Machin
10/05/21	18:00	Suspended continued	Dr Samuel Birch-Machin
11/05/21	18:00	Suspended continued	Dr Samuel Birch-Machin
12/05/21	18:00	Suspended continued	Dr Samuel Birch-Machin
13/05/21	18:00	Suspended continued	Dr Samuel Birch-Machin
14/05/21	18:00	Suspended continued	Dr Samuel Birch-Machin
15/05/21	18:00	Suspended continued	Dr Samuel Birch-Machin
16/05/21	18:00	Suspended continued	Dr Samuel Birch-Machin
17/05/21	18:00	Suspended continued	Dr Samuel Birch-Machin
18/05/21	18:00	Suspended continued	Dr Samuel Birch-Machin

Discontinued on: 19/05/2021 12:28 by: Dr Samuel Birch-Machin . Reason: No longer indicated

DIHYDROCODEINE 30 mg Tablets as required

27/04/21	13:53	30 mg FOUR times daily - 7am;1pm;6pm;10pm (Oral) For pain relief	Dr Jordanna Deosaran
	30.00 mg	27/04/2021 22:51	NURSE HANNAH PATERSON

Discontinued on: 28/04/2021 22:35 by: Dr Ruth Rae . Reason: Discontinued due to conflict

GENTAMICIN AS CHARTED as required

27/04/21	13:52	1 AS CHARTED PRN SEE PAPER CHART (Intravenous Intermittent Infusion) As charted	Dr Jordanna Deosaran
	1.00 AS CHARTED	27/04/2021 16:01	Nurse Zoe Luke/ Nurse Louise Lindsay
	1.00 AS CHARTED	28/04/2021 17:16	Nurse Kirstin Napier

Discontinued on: 29/04/2021 11:08 by: Ms Sarah Connelly . Reason: No longer indicated

ICU MAGNESIUM SULFATE REPLACEMENT as required

29/04/21	06:23	20 mmol (Intravenous Intermittent Infusion) Rate: As per prescriber ON PRESCRIBER REVIEW ONLY	DR Anthony McKie
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Discontinued on: 01/05/2021 10:43 by: Dr Dominique Black . Reason: No longer indicated

MORPHINE SULFATE 10 mg in 1mL Injection as required

Key:		Prescription details		Recorded as "Admitted On"		Prescribed as "Self Administer"		Discontinuation details		HEPMA Prescription additional notes		HEPMA Patient admission notes (admission specific)		HEPMA Patient retained notes (not specific to admission)
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MORPHINE SULFATE 10 mg in 1mL Injection as required

(Continued)

ⓧ 30/04/21 11:32 2.5 mg Every HOUR (Subcutaneous Bolus Injection) For pain *prescribed as part of either/or protocol: Morphine S/C Injection 2.5Mg/5Mg When Required* Ms Sarah Connelly

2.50 mg	30/04/2021	12:13	Nurse Chloe Nisbet/ NURSE Leeanne Russell
mg	Alternative administered		Nurse Allison McLean
mg	Alternative administered		Nurse Arlene Wilkie
mg	Alternative administered		NURSE Janice Mead
mg	Alternative administered		NURSE Janice Mead
mg	Alternative administered		NURSE Amanda Kane
mg	Alternative administered		Nurse Tracy Hassan
mg	Alternative administered		Nurse Meghan Stevenson
mg	Alternative administered		Nurse Tracy Hassan
mg	Alternative administered		Nurse Jamie Bryceland
mg	Alternative administered		NURSE Janice Mead
mg	Alternative administered		Nurse Meghan Stevenson
mg	Alternative administered		NURSE Janice Mead
mg	Alternative administered		NURSE Gillian Wright
mg	Alternative administered		Nurse Sophie McPheat
mg	Alternative administered		Nurse Sophie McPheat
mg	Alternative administered		NURSE Amy Thomson

ⓧ Discontinued on: 08/05/2021 13:13 by: Dr Esme Beer . Reason: Discontinued due to conflict

ⓧ 30/04/21 11:32 5 mg Every HOUR (Subcutaneous Bolus Injection) For pain *prescribed as part of either/or protocol: Morphine S/C Injection 2.5Mg/5Mg When Required* Ms Sarah Connelly

mg	Alternative administered		Nurse Chloe Nisbet
5.00 mg	01/05/2021	03:18	Nurse Allison McLean/ Nurse Arlene Wilkie
5.00 mg	01/05/2021	06:18	Nurse Arlene Wilkie/ Nurse Allison McLean
5.00 mg	01/05/2021	21:39	NURSE Janice Mead/ Nurse Jamie Bryceland
5.00 mg	02/05/2021	04:20	NURSE Janice Mead/ Nurse Rachel Donnelly
5.00 mg	02/05/2021	21:39	NURSE Amanda Kane/ Nurse Rachel Donnelly
5.00 mg	03/05/2021	09:31	Nurse Tracy Hassan/ Nurse Pauline Henderson
5.00 mg	03/05/2021	23:57	Nurse Meghan Stevenson/ NURSE Emma Harvie
5.00 mg	04/05/2021	09:26	Nurse Tracy Hassan/ NURSE Stephanie McLellan
5.00 mg	04/05/2021	12:11	Nurse Jamie Bryceland/ Nurse Tracy Hassan
5.00 mg	04/05/2021	21:42	NURSE Janice Mead/ NURSE Diane Russell
5.00 mg	05/05/2021	07:30	Nurse Meghan Stevenson/ NURSE Angela Veldon
5.00 mg	05/05/2021	20:42	NURSE Janice Mead/ NURSE Diane Russell
5.00 mg	06/05/2021	20:19	NURSE Gillian Wright/ NURSE Janice Mead
5.00 mg	07/05/2021	09:46	Nurse Sophie McPheat/ NURSE Kimberly Blower
5.00 mg	07/05/2021	18:51	Nurse Sophie McPheat/ STDN RACHEL THOMAS
5.00 mg	07/05/2021	22:45	NURSE Amy Thomson/ NURSE Gillian Wright

ⓧ Discontinued on: 08/05/2021 13:13 by: Dr Esme Beer . Reason: Discontinued due to conflict

MORPHINE SULFATE 10 mg in 5mL Oral Solution as required

ⓧ 08/05/21 13:12 5 mg Every HOUR (Oral) For pain *prescribed as part of either/or protocol: Morphine Oral Solution 5Mg/10Mg When Required* Dr Esme Beer

5.00 mg	08/05/2021	15:22	NURSE Claire Ferguson
mg	Alternative administered		Nurse Sophie McPheat
mg	Alternative administered		NURSE Emma Harvie
mg	Alternative administered		STDN GILLIAN DAVIDSON
mg	Alternative administered		STDN RACHEL THOMAS
mg	Alternative administered		NURSE Stephanie McLellan
5.00 mg	12/05/2021	08:41	Nurse Meghan Stevenson
5.00 mg	14/05/2021	00:07	NURSE Rachel O'Hanlon

ⓧ 08/05/21 13:12 10 mg Every HOUR (Oral) For pain *prescribed as part of either/or protocol: Morphine Oral Solution 5Mg/10Mg When Required* Dr Esme Beer

mg	Alternative administered		NURSE Claire Ferguson
10.00 mg	08/05/2021	21:14	Nurse Sophie McPheat
10.00 mg	09/05/2021	10:41	NURSE Emma Harvie
10.00 mg	10/05/2021	09:16	STDN GILLIAN DAVIDSON
10.00 mg	10/05/2021	15:23	STDN RACHEL THOMAS
10.00 mg	11/05/2021	08:23	NURSE Stephanie McLellan
mg	Alternative administered		Nurse Meghan Stevenson
mg	Alternative administered		NURSE Rachel O'Hanlon

MORPHINE SULFATE PCA as required

Key: ⓧ Prescription details Recorded as "Admitted On" Prescribed as "Self Administer" Discontinuation details HEPMA Prescription additional notes HEPMA Patient admission notes (admission specific) HEPMA Patient retained notes (not specific to admission)

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MORPHINE SULFATE PCA as required

(Continued)

⊗ 28/04/21 22:34 1 AS CHARTED (Intravenous Continuous Infusion) PATIENT CONTROLLED

Dr Ruth Rae

ⓘ Discontinued on: 30/04/2021 11:32 by: Ms Sarah Connelly . Reason: Discontinued due to conflict

PARACETAMOL 500 mg Tablets as required

⊗ 27/04/21 13:53 500 mg FOUR times daily - 7am;1pm;6pm;10pm (Oral) For pain relief For pyrexia

Dr Jordanna Deosaran

500.00 mg 27/04/2021 17:20
500.00 mg 27/04/2021 22:51

Nurse Zoe Luke
NURSE HANNAH PATERSON

ⓘ Discontinued on: 28/04/2021 22:33 by: Dr Ruth Rae . Reason: Discontinued due to conflict

VANCOMYCIN AS CHARTED as required

⊗ 04/05/21 14:31 1 AS CHARTED PRN SEE PAPER CHART (Intravenous Intermittent Infusion) As Charted

Dr Samuel Birch-Machin

1.00 AS CHARTED	04/05/2021	15:00	Nurse Tracy Hassan
1.00 AS CHARTED	04/05/2021	15:00	Nurse Tracy Hassan
1.00 AS CHARTED	05/05/2021	03:23	NURSE Diane Russell
1.00 AS CHARTED	05/05/2021	03:23	NURSE Diane Russell
1.00 AS CHARTED	06/05/2021	21:40	NURSE Amy Thomson
1.00 AS CHARTED	06/05/2021	21:40	NURSE Amy Thomson
1.00 AS CHARTED	07/05/2021	22:20	NURSE Amy Thomson
1.00 AS CHARTED	07/05/2021	22:20	NURSE Amy Thomson
1.00 AS CHARTED	08/05/2021	11:05	NURSE Kimberly Blower
1.00 AS CHARTED	08/05/2021	11:05	NURSE Kimberly Blower
1.00 AS CHARTED	09/05/2021	12:30	Nurse Rachel McKenny
1.00 AS CHARTED	09/05/2021	12:30	Nurse Rachel McKenny
1.00 AS CHARTED	10/05/2021	00:33	NURSE Amy Thomson
1.00 AS CHARTED	10/05/2021	00:33	NURSE Amy Thomson
1.00 AS CHARTED	10/05/2021	00:40	Nurse Sophie McPheat
1.00 AS CHARTED	10/05/2021	00:40	Nurse Sophie McPheat
1.00 AS CHARTED	10/05/2021	12:41	NURSE Heather McBride
1.00 AS CHARTED	10/05/2021	12:41	NURSE Heather McBride

ⓘ Discontinued on: 14/05/2021 10:38 by: Dr Samuel Birch-Machin . Reason: No longer indicated

⊗ 14/05/21 10:30 1 AS CHARTED PRN SEE PAPER CHART (Intravenous Intermittent Infusion) As Charted

Dr Samuel Birch-Machin

ⓘ Discontinued on: 14/05/2021 10:39 by: Dr Samuel Birch-Machin . Reason: No longer indicated

⊗ 19/05/21 18:14 1 AS CHARTED PRN SEE PAPER CHART (Intravenous Intermittent Infusion) As Charted

Dr Hannah Talwar

1.00 AS CHARTED 19/05/2021 18:47 NURSE Diane Russell
1.00 AS CHARTED 20/05/2021 06:45 NURSE Amy Thomson

ⓘ Discontinued on: 20/05/2021 15:38 by: Dr Ryan Clark . Reason: No longer indicated

ZOPICLONE 7.5 mg Tablets as required

⊗ 27/04/21 13:54 7.5 mg ONCE daily at 10pm (Oral) For sleeplessness

Dr Jordanna Deosaran

7.50 mg	27/04/2021	22:51	NURSE HANNAH PATERSON
7.50 mg	01/05/2021	21:33	NURSE Janice Mead
7.50 mg	02/05/2021	21:04	NURSE Amanda Kane
7.50 mg	04/05/2021	20:46	NURSE Janice Mead
7.50 mg	05/05/2021	22:04	NURSE Janice Mead

Key: 

Prescription details



Recorded as "Admitted On"



Prescribed as "Self Administer"



Discontinuation details



HEPMA Prescription additional notes



HEPMA Patient admission notes (admission specific)



HEPMA Patient retained notes (not specific to admission)

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HEPMA MAP
V1.0

Patient level notes

 Pharmacy Care Plan added by Ms Sarah Connelly on 29/04/2021 at 15:19

Title: Pharmacy Use Only

Key:  Prescription details  Recorded as "Admitted On"  Prescribed as "Self Administer"  Discontinuation details  HEPMA Prescription additional notes  HEPMA Patient admission notes (admission specific)  HEPMA Patient retained notes (not specific to admission)

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Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, and NHS Ayrshire & Arran

RED / AMBER / GREEN

PC - right hemi

PMH - superior mesenteric vein thrombosis, personality disorder

Drug History -

PT/POD/GP/ECS/other - community pharmacy

Does patient have own at home? -

Meds withheld -

Meds stopped -

Medication changes -

New medication - loperamide, morphine, codeine

Not prescribed -

HT: 158cm WT: 63kg - 5/4/21

ETOH/SMOKING:

NEBS/homeO2/maint steroids:

DVT Prophylaxis LMWH/TEDs/other : Tx dose Tinz LT

RF (CrCl):Cr 32

Plts: 794

Warfarin

Confirmed with: patient/**DAWN**/yellow booklet/DN/other

Anticoagulation clinic informed of admission (2953):was admitted from anticoag clinic

All details documented on inpatient warfarin chart:

Location of patient's yellow book:

Indication:mesenteric thrombus

Target INR:2.0-3.0

Date of last INR appointment (pre-admission): has been on 0.5mg due to high INR - only started recently

INR:

Dose:

TTR (time in therapeutic range) [review if <65%]::

Date of next appointment:

Dose on discharge:

Follow up arrangements:

Care issues

1. For tinz instead of warfarin (unsafe to go back on warfarin noted from haem)

Review

FC 19/5

Abx not required due to stable CRP and pt clinically well. Note deeper collection and static CRP so for CTAP today

Warfarin- should be stopped

Analgesia- last had PRN morphine 14/5, Monitor use

AB 14/05/21

Notes state cont abx but not on any? Clarify with Sam

NEWS 4 BP 110/61 Pulse 111 - monitor

AB 13/05/21

Abx finished.

K+ normalised - r/v replacement

To cont tinz LT as per haem - warfarin stopped

For OGD today.

AB 11/05/21

Vanc & mero to finish tomorrow as per docs. Level done pre dose today 17.3mg/L. CRP 96 WBC

K+ 3.4 ?for replacement - discuss with Sam

NEWS 2 Pulse 126 ?ECG results

AB 10/05/21

Vanc - level done yesterday before dose given 15.2mg/L - ok to maintain if surg team happy with progress

To complete a week - to finish tomorrow. R/v tomorrow
Remains on enox BD - clarify plan prior to d/c, might go home in 24 to 48 hrs
NEWS 4 BP 101/69 Pulse 131 - for ECG. monitor

AB 07/05/21

Continues on vanc at same dose - inflamm markers improving
Micro advised a week's abx therapy - cont to monitor vanc levels as appropriate, U&Es ok
INR 1.8 - remains on tx dose enox ?plan for anticoag
NEWS 4 BP 98/72 Pulse 118 - monitor

AB 06/05/21

Vanc level done pre 4th dose - 10.3mg/L, if responding can stay on current dose - if not could increase to 1500mg?
Await CRP/WBC
ABx duration to be discussed with micro
Codeine 30mg QDS added
NEWS 2 Pulse 118 - monitor

AB 05/05/21

U&Es ok
Started on mero and vanc - Vanc calc as 1250mg 12hrly, level due before 4th dose tomorrow am. CRP 240 WBC 15 -
cont to monitor
NEWS 3 BP 106/59 pulse 114 - monitor

AB 04/05/21

Heparin stopped. Now on enox BD, LT plan for anticoag?
CRP 338 WBC 20.4 - now on taz and metro, U&Es ok for taz dose - monitor
NEWS 6 Pulse 132 Temp 38.1 RR 24 - monitor

Retained notes (not specific to admission)

 **Dispensing Note** added by **Ms Kerry McGuire** on 29/03/2021 at 09:59:09

Title: WEEKLY DISPENSING PATIENT

WEEKLY DISPENSING PATIENT (NOT A BLISTER PACK)

Weekly Dispensing Scripts collected from Mint Pharmacy, 5 Lorne
Place, Coatbridge, ML5 4FS. Telephone - 01236 437354]

Stop Tinz when warfarin therapeutic

 **Dispensing Note** added by **Ms Kerry McGuire** on 29/03/2021 at 09:59:09

Title: WEEKLY DISPENSING PATIENT

WEEKLY DISPENSING PATIENT (NOT A BLISTER PACK)

Weekly Dispensing Scripts collected from Mint Pharmacy, 5 Lorne
Place, Coatbridge, ML5 4FS. Telephone - 01236 437354

NHS Lanarkshire
www.nhs.uk/lanarkshire.org.uk
 Department of General Medicine

01236 748748

Dr NS Marcuccilli
 Waverley Medical Practice
 Coatbridge Health Centre
 1 Centre Park Court
 Coatbridge
 ML5 3AP

University Hospital
 Monklands
 Monkscourt Avenue
 Airdrie
 ML6 0JS



Date Dictated: 03/05/2021
 Date Typed: 05/05/2021
 Ref: 2514917
 Letter Ref: SO/ET
 CHI Barcode:



Consultant: Dr Scott Oliver

Dear Dr Marcuccilli,

Discharge Summary

Patient Name: Isabel McCracken
 Patient date of birth: 18/08/1978
 Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX
 Date of admission: 26/03/2021
 Date of discharge: 12/04/2021

Diagnosis -

1. Extensive superior mesenteric vein thrombosis
2. Gram variable bacilli bacteremia
3. Possible underlying haematological malignancy
4. Possible thrombophilia – lupus anticoagulant detected at low titre

Procedure:

Co-Morbidities

1. Cannabis smoker
2. Back pain
3. Personality disorder

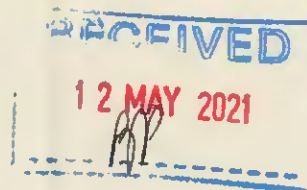
Discharge Medication:

Follow up:

As per the IDL, this 42-year-old lady presented with rigors, vomiting, diarrhoea, and bilateral lumbar to groin pain. Blood tests demonstrated thrombocytopenia, deranged electrolytes, and deranged liver function with a significant inflammatory response. Blood cultures demonstrated gram variable bacilli, but the lab were unable to identify a specific organism and the source of this was unclear. A CT scan demonstrated extensive superior mesenteric vein thrombosis. She was seen by the surgical team (Mr Maung consultant surgeon) who advised conservative management of this. She was discussed with the haematology team who advised sending a thrombophilia screen and commencing her on anticoagulation in the form of Warfarin. She had a course of antibiotics and the inflammatory response settled. Curiously her initial thrombocytopenia became a thrombocytosis.

Putting this together was challenging. It was unclear if she had originally presented with GI upset (there was a vague story of having had a takeaway before her GI symptoms began) which has then led to thrombosis, with a subsequent bacteremia because of gut upset in the context of superior mesenteric vein thrombosis. It was also unclear if there was underlying malignancy or a thrombophilia. There was no evidence of solid organ malignancy on CT imaging, and outpatient upper and lower GI endoscopy

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 VED.



Q. 10/10/10
10/10/10
10/10/10

was requested to investigate this further. A thrombophilia screen was sent and paroxysmal nocturnal haemoglobinuria was negative, JAK 2 was negative, and ANA, DNA antibody and ANCA screens were all negative. Anti cardiolipin IgG was normal, but IgM was slightly high, and there was a plan to repeat this in 12 weeks. A myeloma screen was sent and has only in fact been reported this morning (several weeks after discharge) showing an IgG lambda paraprotein with a negative urinary Bence Jones protein.

She was discharged home with a plan to attend for an outpatient CT thorax (as a completion scan having had a CT abdomen pelvis as an inpatient), to have repeat lupus anticoagulant checked via the planned investigation unit in 12 weeks, and in the absence of a confirmed malignancy, confirmed thrombophilia, or any further venous thromboembolism, I had intended initially to treat for 6 months with anticoagulation.

Unfortunately, at the time of dictating this note I see that she has been re-admitted. For this reason I have also not given a list of medications on discharge.

Yours sincerely

Dr Scott Oliver
Consultant Nephrologist and Physician

Authorised on 07/05/2021 11:36:18 by Sc

(P) Mr Michael Dick
Consultant Colorectal Surgeon
University Hospital Monklands
Monkscourt Avenue
Airdrie
ML6 0JS

1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumberae Crescent
Coatbridge
Lanarkshire ML5 4PX

(P) Mr Min Nyunt Maung
Consultant Surgeon
University Hospital Monklands
Airdrie
ML6 0JS

(P) Dr Iain Singer
Consultant Haematologist
Monklands Hospital
AIRDRIE
ML6 0JS

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AmrKw

Episode: E0002019725
Date: 27/04/2021
Time: 10:25

University Hospital Monklands
EMERGENCY DEPARTMENT



Surname: McCracken	Forename: Isabel	Triage Category
CHI No: 1808785142	Age: 42y	
Address: 1d Cumbrae Crescent Coatbridge Lanarkshire	Date of Birth: 18/08/1978	
	Gender: Female	
	Referred by: Self referral	
Postcode: ML5 4PX		
Telephone: 07947301884		

G.P.: NS Marcuccilli	G.P. Telephone No.: 01236 422311
G.P. Address: Waverley Medical Practice Coatbridge Health Centre 1 Centre Park Court Coatbridge Coatbridge ML5 3AP	

Presenting Complaint: Unwell at INR clinic / vomiting

Vital Signs

Temperature	37
Pulse	117
Resp. Rate	
Systolic BP	115
Diastolic BP	76
Mean Arterial Pressure	
SpO2	96
FiO2	
Peak Flow	
Exp. Peak Flow	

Glasgow Coma Scale

Eye Opening	
Verbal Response	
Motor Response	
GCS Score	

Urinalysis

Glucose	
Ketones	
Specific Gravity	
Blood	
pH	
Proteins	
Nitrates	
Leucocytes	

Visual Acuity

Visual Acuity (Right)	
Visual Acuity (Left)	
With Correction	

Pupil

Pupil Size (Right)	
Pupil Reactivity (Right)	
Pupil Size (Left)	
Pupil Reactivity (Left)	

Blood Glucose	
Pain Score	
Tetanus Cover	
Tetanus Date	
MEWS Score	
CEWS Score	

Height	
Weight	

Fast	
------	--



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74



1808785142

18/08/1978

MCCRACKEN

1d Cumbræ Crescent

F

Isabel

Cumbræ Crescent

Coatbridge

Lanarkshire

ML5 4PX

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1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumberae Crescent

Coatbridge
Lanarkshire

ML5 4PX

☐ Hairmyres

☒ Monklands

☐ Wishaw

NHS
Lanarkshire

Emergency Department IV Prescription Chart

Date: 27 / 4 / 21

Fluid (Additive Medicine) IV Therapy Prescription Chart

Drug Sensitivity:

1.

2.

	Date	Fluid (BLOCK LETTERS)	Vol (ml)	Route	Duration	Signature	Serial No.	Given by	Start time	End time
		Additive Medicine	Dose (mg)				Batch No.			
A	27/04	PLASMAITE	500	IV	4 hrs	[Signature]	214117 4C 12/22	H. Joseph	20	12
B	27/04	PLASMAITE	500	IV	4 hrs	[Signature]				
		0.9% NaCl								
		40 mmol KCl								
C	27/04	PLASMAITE	500	IV	4 hrs	[Signature]				
D	27/04	PLASMAITE	500	IV	6 hrs	[Signature]				
E										
F										
G										
H										

Rate of Flow = Vol of Fluid (ml) x 15

(Drops/min) Duration (mins)
6.62 (1ml = 15 drops)

Approximated Rate for 500ml

1 hr = 120 Drops/min 6 hr = 22 Drops/min
4 hr = 30 Drops/min 8 hr = 15 Drops/min

CH
Firs 1808785142
Las 18/08/1978 F
Ad MCCracken Isabel
1d Cumberae Crescent
Coatbridge
Lanarkshire
MLS 4PX

☐ Hairmyres ☒ Monklands ☐ Wishaw **NHS**
Lanarkshire

Emergency Department Nursing Record

Date: 27 / 04 / 2021

Nurse in charge of patient's care:

Name band on?

☐ Yes ☐ No

History of Events

Pre-hospital care: *from anticoagulation clinic.*

Presenting complaint/history: *attended clinic this am as INR >8 yesterday & given oral vit K (INR 1.1 today). Vomiting today, diarrhoea at home.*

Past medical history: *mesenteric thrombosis, depression.*

Medication:

Allergies: *NIKOR.*

☐ Sepsis? - Sepsis 6 completed	☐ Pressure Ulcer Risk? - PURA completed
☐ Child Protection concern	☐ SSKIN Care Bundle commenced
☐ Adult Support and Protection concern	☐ Learning Disabilities
☐ Falls Risk? - Falls Bundle completed	☐ Dementia/Cognitive impairment

} Relevant documents completed

Peripheral Vascular Catheter (PVC) Insertion

Reason for PVC insertion:

☐ IV fluids ☐ IV drugs

☐ Suspected haemorrhage ☐ Diagnostic tests

Insertion date: / / Insertion time: :

Size/colour: Insertion site:

Signature:

Urinalysis

Leucocytes	Nitrites	Protein	pH
Blood	S.G.	Ketones	Glucose
Pregnancy test	MSSU sent		

Record of Intentional Rounding - ask whenever patient visited, but no less than every 2 hours

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

Date	Time	Initials	Time	Initials	Time	Initials	Time	Initials	Time	Initials



Next of Kin:

Relationship:

Contact number:

Next of Kin in department? ☐ Yes ☐ No

Next of Kin aware patient in department? ☐ Yes ☐ No

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Date/ Time	Record of Communication with Relatives and Carers	Initials

Emergency Department Nursing Record | Emergency Departments | NHS.uk | Page 2 of 4

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Head Injury Observations

Glasgow Coma Scale (GCS)		Date:																
		Time:																
		Frequency:																
		Frequency change initials:																
EYES Open	Spontaneous	4																Eyes closed by swelling = C
	To Speech	3																
	To Pain	2																
	None	1																
Best VERBAL Response	Orientated	5																Endo-tracheal tube or Trach-eostomy = T
	Confused	4																
	Inappropriate words	3																
	Incomprehensible sounds	2																
	None	1																
Best MOTOR Response	Obeys commands	6																Usually record the best arm response
	Localise pain	5																
	Withdrawal	4																
	Flexion to pain	3																
	Extension to pain	2																
	None	1																
TOTAL: (/15)																		

• 1 • 2 3 4 5 6 7 8 Pupil Scale (mm)	Pupils	Right	Size																S sluggish + reacts - no reaction C eyes closed
			Reaction																
		Left	Size																
			Reaction																
	LIMB MOVEMENTS	ARMS	Normal power																Record right (R) and left (L) separately if there is a difference between the two side
			Mild weakness																
			Severe weakness																
			Spastic flexion																
			Extension																
			No response																
LEGS		Normal power																	
		Mild weakness																	
		Severe weakness																	
		Extension																	
		No response																	
Initials:																			

4AT Assessment Tool (screening for Cognitive Impairment and Delirium) - complete for over 65s as required	Score
1. Alertness – This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating. - Normal (fully alert, but not agitated, throughout assessment) - Mild sleepiness for <10 seconds after waking, then normal - Clearly abnormal	0 0 4
2. AMT4 – Ask the patient: age, date of birth, place (name of hospital or building), current year - No mistakes - 1 mistake - 2 or more mistakes/untestable	0 1 2
3. Attention – Ask the patient: ‘Please tell me the months of the year in backwards order, starting at December.’ To assist initial understanding one prompt of, ‘What is the month before December?’ is permitted. - Achieves 7 months or more correctly - Starts but scores <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 (e.g. paranoia, hallucinations) arising over the last 2 weeks and still evident in the last 24 hours. - No - Yes	0 4

Date: / /	Time: :	Initials:	4AT TOTAL SCORE:
------------------------------------	----------------------------	------------------------	-------------------------

4AT Score:
4 or above: Possible delirium + / - cognitive impairment.
1 - 3 : Possible cognitive impairment. More detailed cognitive assessment and informant history taking are required.
0: Delirium or severe cognitive impairment unlikely (but delirium still possible if (4) information incomplete).

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Patient History

Patient Name:	Isabel McCracken	Hospital Number:	1808785142	Start Date:	09/04/2021
Address:	1d Cumbrae Crescent			Stop Date:	08/10/2021
	Coatbridge ML5 4PX			Patient Status	Admitted

Date of Birth: 18/08/1978
NHS No: 1808785142
Telephone: 07847275284

GP/Consultant Details

Referring GP: Marcuccilli
Referring GP Organisation: Waverley Medpractice (61447)
Consultant: Marcuccilli
Consultant Organisation: Waverley Medpractice (61447)

Treatment Plan

Diagnosis: Mesenteric Thrombosis

INR Target: 2.5

Next Visit: Thursday April 29, 2021

Dosing Regime: Wishaw warfarin regime

% Time in Range:

% Time above Range:

% Time below Range:

No of DNAs in last year: 0

Contact Details

Contact Type	Name	Phone	Fax
GP	Marcucci, NS		
Next Of Kin	jade		

Recent History

	Date	INR	Daily Dose	Dose	Miss/Boost Dose
Current	27/04/2021	1.1	0.50	0.5mg daily	
	26/04/2021	8.0	0.50	0.5mg daily	Take 0 mg for 2 days, then:
	23/04/2021	6.2	0.50	0.5mg daily	Take 0 mg for 2 days, then:
	19/04/2021	6.5	1.00	1mg daily	Take 0 mg for 2 days, then:
	15/04/2021	2.4	1.57	3 days 1mg, 4 days 2mg	
	12/04/2021	2.9	1.00		

STICK INSERTS HERE

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RESULTS

H+	Hb	PT	Na	ALT	Calcium	Glucose	Troponin
PO2	WBC	INR	K	ALP	Adj. Calcium	CRP	Paracetamol
PCO2	Platelets	APTT	Cl	Bilirubin	Magnesium	CK	Salicylate
Bicarb		APTT _r	Bicarb	Albumin	Globulin	Amylase	Ethanol
BE	COHb	Fibrinogen	Urea	AST	T. Protein		
O2 Sat	Lactate		Creatinine	GGT			BHGG

ED PRESCRIPTION

Date	Drug	Dose	Route	Time	Signature	Given By	Checked By	Time

DISCHARGE PRESCRIPTION

Date	Drug	Dose	Route	Time	Signature	Given By	Checked By	Time

INJURY SURVEILLANCE

For all assaults please record the following data

Date and time of assault: _____ Specific Location: _____

Type of Location:	✓	Assailant	✓	Weapon	✓	Alcohol / Drug Involvement	✓
Bar / Pub		Spouse / Partner		Body Part		Drugs	
Club		Ex Partner		Knife		Alcohol	
Street		Relative		Glass		Both	
Workplace		Friend / Acquaintance		Bottle		None	
Own Home		Bouncer		Firearm		Unknown	
Other Home		Stranger		Blunt Object			
Other Place		Customer / Client		Other / Unknown			
		Other / Unknown					

I am leaving the Emergency Department today against the advice of the doctor responsible for my care.
I have been advised that unless I continue to receive the treatment recommended by the Medical Staff my prospect of improvement or recovery may be prejudiced.

My reason for leaving is:

Signed _____ Date _____ Time _____

Witness _____ Status _____ Date _____ Time _____

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Measurement report

28.4.2021 21:43

Serial number : 15006

Instrument ID : ITU Dept.

Operator ID : MK001640

Monklands Hospital

Pat. ID 1808785142

Last name McCracken

Blood type Arterial

Blood gas

H ⁺	34.77 nmol/L (-)	[	35.48 -	44.67]
PCO ₂	5.25 kPa	[	4.67 -	6.00]
PO ₂	25.32 kPa (+)	[	10.67 -	13.33]

Calc. values

BE	3.2 mmol/L
cHCO ₃ ⁻	27.3 mmol/L

Temperature 37.0 °C

H⁺^t 34.8 nmol/L

PCO₂^t 5.25 kPa

PO₂^t 25.32 kPa

Electrolytes

Na ⁺	132.8 mmol/L (-)	[	135.0 -	148.0]
K ⁺	3.16 mmol/L (-)	[	3.50 -	4.50]
Cl ⁻	93.0 mmol/L (-)	[	98.0 -	107.0]
Ca ²⁺	1.012 mmol/L (--)	[	1.120 -	1.320]
Hct	33.6 % (-)#	[	35.0 -	50.0]

COOX

tHb	84.6 g/L (-)	[	120.0 -	150.0]
COHb	1.9 %	[	0.5 -	2.5]
MetHb	0.4 % #	[	0.4 -	1.5]
HHb	0.6 % (-)#	[	1.0 -	5.0]
O ₂ Hb	97.1 %	[	95.0 -	99.0]
SO ₂	99.4 % (+)	[	75.0 -	99.0]
AG	15.6 mmol/L			

Metabolites

Glu	8.32 mmol/L (++)	[	3.33 -	6.10]
Lac	0.76 mmol/L	[	0.44 -	2.22]

Note: Ensure reference ranges match sample type.

... check plausibility

... check Hct result

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653

Roche

Measurement report

28.4.2021 21:40

Serial number : 15006

Instrument ID : ITU Dept.

Operator ID : MK001640

Monklands Hospital

Pat. ID 1808785142

Last name McCracken

Blood type Arterial

Blood gas

H ⁺	33.21 nmol/L (-)	[	35.48 -	44.67]
PCO ₂	4.89 kPa	[	4.67 -	6.00]
PO ₂	25.82 kPa (+)	[	10.67 -	13.33]

Calc. values

BE	3.0 mmol/L
cHCO ₃ ⁻	26.6 mmol/L

Temperature 37.7 °C

H⁺ 34.0 nmol/LPCO₂^t 5.04 kPaPO₂^t 26.31 kPa

Electrolytes

Na ⁺	134.5 mmol/L (-)	[	135.0 -	148.0]
K ⁺	3.24 mmol/L (-)	[	3.50 -	4.50]
Cl ⁻	93.0 mmol/L (-)	[	98.0 -	107.0]
Ca ²⁺	1.043 mmol/L (-)	[	1.120 -	1.320]
Hct	31.9 % (-)#	[	35.0 -	50.0]

COOX

tHb	84.6 g/L (-)	[	120.0 -	150.0]
COHb	2.0 %	[	0.5 -	2.5]
MetHb	0.5 % #	[	0.4 -	1.5]
HHb	0.5 % (-)#	[	1.0 -	5.0]
O ₂ Hb	97.0 %	[	95.0 -	99.0]
SO ₂	99.5 % (+)	[	75.0 -	99.0]
AG	18.1 mmol/L			

Metabolites

Glu	Insufficient sample (5)	[	3.33 -	6.10]
Lac	Insufficient sample (5)	[	0.44 -	2.22]

Note: Ensure reference ranges match sample type.

... check plausibility

... check Hct result

COPY PAGE

CONSENT FORM



For Medical or Dental Investigation, Treatment or Operation 1808785142
 Hospital Monklands Patie MCCracken Isabel
 Unit Number..... Othe Coatbridge
 Sex (please tick box): ☐ Male ☒ Female Date Lanarkshire ML5 4PX

To be completed by the medical, dental, nursing or paramedical practitioner (see notes overleaf).

Type of operation, investigation or treatment for which written evidence of consent is considered appropriate:

Laparoscopy +/- Laparotomy + Probes AS
Repaired +/- Bowel Resection
+/- Sgra

I confirm that I have explained to the patient in terms which in my judgement are suited to his/her understanding (and/or to one of his/her parents or guardians), the proposed operation, investigation or treatment, including options available, and if relevant, the need for anaesthesia or sedation. I also confirm that I have explained the intended benefits and serious or frequently occurring risks and any extra procedures that may become necessary during the procedure (please specify):

Bleeding / Infection / ME / CVA / DVT / PE
Death - NELA Rate 9% → 38.5% dependent on vascular

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

The following leaflet/tape has been provided

Signature [Signature] Date 28/4/2021
 Name & Status of Practitioner: M. Dickson

STATEMENT OF PATIENT (or Parent or Guardian if appropriate) PLEASE READ THE ADVICE OVERLEAF

I am the patient/parent/guardian (delete as necessary)

- ❖ I agree to the procedure or course of treatment described on this form which has been explained to me by the practitioner named above.
- ❖ I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.
- ❖ I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this (this only applies to patients having general or regional anaesthesia).
- ❖ I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.
- ❖ I have been told about additional procedures that may become necessary during my treatment. I have listed below any procedures that I **DO NOT** wish to be carried out without further discussion

Signature X ISADOL [Signature] Name 28/4/21
 Address..... Date.....

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance) On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

Signed..... Date.....
 Name (PRINT)..... Job title.....



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NOTES TO:

ALL HEALTH PRACTITIONERS

(DOCTORS, DENTISTS, NURSES, PROFESSIONS ALLIED TO MEDICINE)

A patient has an absolute legal right to grant or withhold consent prior to examination or treatment. Patients should be given sufficient information, in a way that they can understand, about the proposed treatment and the possible alternatives. Patients must be allowed to decide whether they will agree to the treatment and they may refuse or withdraw consent to the treatment at any time. The patient's consent to treatment should be recorded on this consent form (*further guidance is given in Lanarkshire Acute Hospitals Policy Statement*).

PATIENTS

- ❖ Please read this form and these notes very carefully
- ❖ The health practitioner is here to help you. He or she will explain the proposed treatment and what the alternatives are. You can ask any questions and seek further information.
- ❖ You can refuse treatment. If there is anything that you don't understand about the explanation, or if you want more information you should ask the practitioner before signing.
- ❖ You may ask for a relative or a friend or a nurse to be present.
- ❖ Please check that all the information on the form is correct. If it is and you understand the explanation, then sign the form.
- ❖ Training doctors, dentists, nurses and other health professionals is essential to the continuation of the health service and improving the quality of care. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a senior doctor, dentist, nurse or health professional.
- ❖ You may, however, decline to be involved in the formal training of medical, dental, nursing and other students without this adversely affecting your care and treatment. You must tell a senior Doctor or Nurse if you do not wish students to be involved in your care and you should write this over the page in the space for things that you do not wish to happen without your being given the chance to consider them first.

1808785142
18/08/1978 F
MCCRACKEN Isabel JF
1d Cumberae Crescent

Coatbridge
Lanarkshire ML5 4PX

☐ Hairmyres ☒ Monklands ☐ Wishaw

Ward: MAU

NHS
Lanarkshire

Pre-operative Checklist

Date: 28/4/21

Trolley/bed checked for head down tilt and O2/accessories?

☒ Yes ☐ No

Patient/Procedure	Ward Yes No N/A	Reception Yes No N/A	Theatre Yes No N/A
Identity band insitu and correct?	☒	☒	☒
Consent form completed and checked against list?	☒	☒	☒
Correct site marked and documented?	☒	☒	☒
Adults with Incapacity form completed?	☒	☒	☒
PVC dressing timed/dated?	☒	☒	☒
Allergies	Yes No N/A	Yes No N/A	Yes No N/A
Known allergies/sensitivity/reaction?	☐ ☒	☐ ☒	☐ ☒
If yes give details:			
Red wristband insitu?	☐ ☒	☐ ☒	☐ ☒
Fasting	Yes No N/A	Yes No N/A	Yes No N/A
Fasted from - specify time (24 hour)	Food: 16.00 Fluid: 15.00	16.00 SIPS with meds	16.00 SIPS with meds
Premedication given?	☒	☒	☒
Has patient taken usual medication/inhaler?	☒	☒	☒
Drug kardex and all notes present?	☒	☒	☒
DVT prophylaxis as per protocol? FLOWTRANS Please	☒	☒	☒
Labs	Yes No N/A	Yes No N/A	Yes No N/A
Up to date blood results available on Clinical Portal?	☒	☒	☒
MRSA swab positive?	☒	☒	☒
Group and Save?	☒	☒	☒
X matched blood available?	☒	☒	☒
ECG available	☒	☒	☒
X-rays/PACS?	☒	☒	☒
Personal	Yes No N/A	Yes No N/A	Yes No N/A
Jewellery/piercings removed/taped? If yes, where stored:	☐ ☒	☐ ☒	☐ ☒
False nails/nail polish removed?	☐ ☒	☐ ☒	☐ ☒
Contact lenses/glasses removed? If yes, where stored:	☐ ☒	☐ ☒	☐ ☒
Make up removed?	☐ ☒	☐ ☒	☐ ☒
Underwear insitu? If yes: ☐ disposable ☐ cotton	☐ ☒	☐ ☒	☐ ☒
Dentures removed? If yes, where stored:	☐ ☒	☐ ☒	☐ ☒
Crowns, caps, loose teeth? If yes, specify:	☐ ☒	☐ ☒	☐ ☒
Hearing aid removed? If yes, where stored:	☐ ☒	☐ ☒	☐ ☒
Does the patient have implants/prosthesis/pacemaker?	☐ ☒	☐ ☒	☐ ☒
If yes specify:			
Other relevant conditions	Yes No N/A		
Does the patient have diabetes?	☐ ☒		
If yes, insulin dependent? Blood glucose:	☐ ☒		
Insulin pump insitu?	☐ ☒		
Is the patient pregnant?	☐ ☒		
Pregnancy test completed?	☐ ☒		
Has the patient ever been notified that they are at increased risk of CJD or vCJD for public health purposes? If 'yes' refer to policy and discuss with Infection Prevention and Control Team	☐ ☒		

Pre-operative observations:

Blood pressure: 108/60

Pulse: 105

SpO2: 99% (A)

Temperature: 37.9

NEWS:

Weight:

Additional comments/details:

Signature: Ward/Admission

Signatures: Recovery/Ward

Signatures: Recovery/Theatre

[Signature]

1. *[Signature]*
2. *[Signature]*

1. *[Signature]*
2. *[Signature]*

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CHI no. 

F 1808785142
 L 18/08/1978 F
 A MCCracken Isabel
 1d Cumbernauld Crescent
 Coatbridge ML5 4PX
 Lanarkshire

Hospital/Site: UHM
 Clinic/Ward: MAU



Special Covid 19 Patient Agreement to Investigation or Treatment Consent Form

➔ This form must be used in conjunction with the routine
 NHS Patient Agreement to Investigation or Treatment Consent Form. ➔

I understand that I am opting for a treatment/procedure/surgery that I agree is necessary after discussion with:

JOSHUA THURSEN

(Clinician name)

This is for the following procedure:

LAPAROSCOPY, LAPARECTOMY + PROCEED

(Procedure name)

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organisation (WHO). I further understand that COVID-19 is extremely infectious and is believed to spread by person-to-person contact. As a result, the Scottish Government currently recommend social distancing. I understand that social distancing is not always possible while I am receiving hospital care.

I recognise that all the staff within NHS Lanarkshire are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is still a risk of becoming infected with COVID-19 by proceeding with this treatment/ procedure/ surgery.

I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment/procedure/surgery.

I understand that even if I have been tested for COVID-19 and receive a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID-19 after the test. I understand that if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment/ procedure/ surgery can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before, during or after my treatment/ procedure/ surgery may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalisation that may require medical therapy, Intensive Care treatment and possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. Those with pre-existing health conditions appear to be at a greater risk of significant complication from COVID-19 infection, and I have discussed my risks with my clinician.



N003

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1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumberae Crescent

Coatbridge
Lanarkshire

ML5 4PX

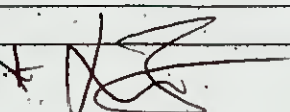
(Document pre-existing conditions below):

In addition, after my elective treatment/ procedure/ surgery, I may need additional care that may require me to go to an emergency department or a hospital.

I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment/ procedure/ surgery itself.

I further understand that my treatment/ procedure/ surgery may be cancelled at short notice due to unexpected changes in the pandemic within NHS Lanarkshire.

I have been given the option to discuss if I can defer my treatment/ procedure/ surgery to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment/ procedure/ surgery.

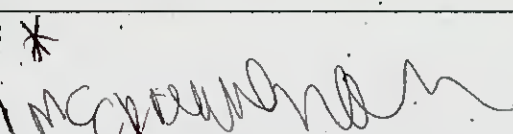
Clinician's Signature: 

Date: 28/4/21

Print Name:

JOSHUA THOMPSON

Grade: ST3

Patient's Signature: 

Date:

Print Name:

A witness or interpreter should sign below if the patient is unable to sign / speak English but has indicated their consent. Young people / children may also like a parent to sign here.

Witness Signature:

Date

Print Name:

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Admission Record

My Details

CHI number: 

Name: 1808785142
18/08/1978 F

Address: MCCracken Isabel
1d Cumberae Crescent
Coatbridge
Lanarkshire ML5 4PX

Postcode:

Date of birth: Age: 42

☐ Male ☒ Female

Phone number:

Preferred name: Issy

My Contacts

Next of Kin:

Relationship:

Address:

Phone number:

Alternative Contact Name:

Relationship:

Phone number(s):

Power of Attorney, Guardianship (AWI):

Social Work:

Other: (specify)

My General Practitioner

GP: Waverly Medical

Practice: Practice Coatbridge

Phone number: 01236 422311

Community Team:

My Admission

Date: 27/04/21

Time: 12:45

Hospital: WGH

Ward: M04

Consultant:

Admitted from:

Reason for admission: unwell, vomiting

Estimated Discharge Date:

My Safety

Allergies: NKA

MRSA/CPE: NIL

DNACPR:

Hospital Anticipatory Care Plan:

My Spiritual/Religious Needs

Please specify:

.....

.....

.....



Transfers	Hospital/Ward	Date	Time	Consultant
Transferred to:				
Transferred to:				

or attach addressograph label here

EMERGENCY DEPARTMENT USE ONLY

Emergency Department Assessment (ED Card)

CHI no
First name DOB /..... /.....
Last name Sex: ☐ M ☐ F
Address
.....
.....

or attach addressograph label here

EMERGENCY DEPARTMENT USE ONLY

Immediate physiological observations:

Pulse: (bpm) Resp. Rate: (/min)
BP lying: (mm/Hg) SpO2: on
BP standing: (mm/Hg) BM:
Temp: (°C) NEWS:

EMERGENCY DEPARTMENT USE ONLY

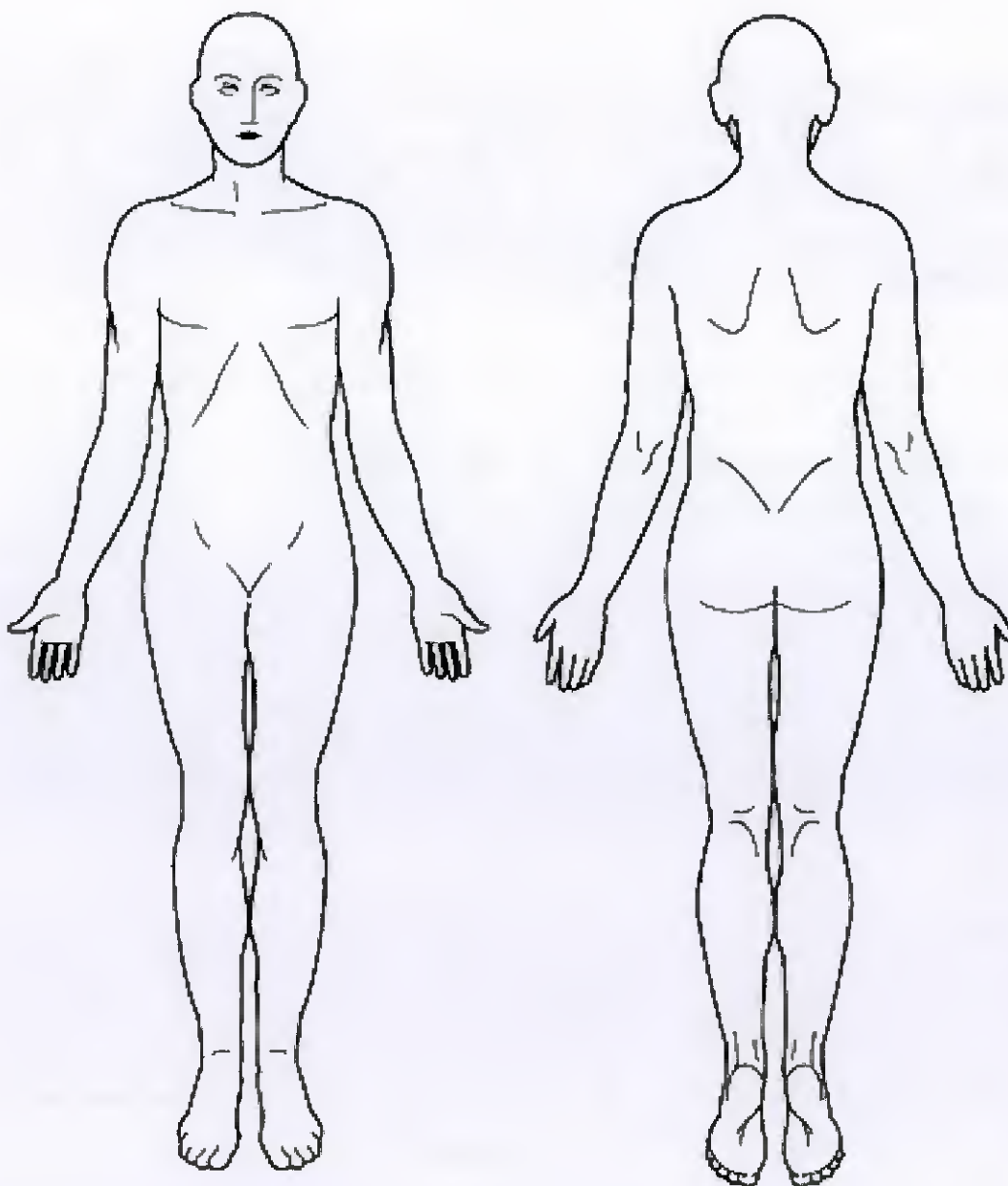
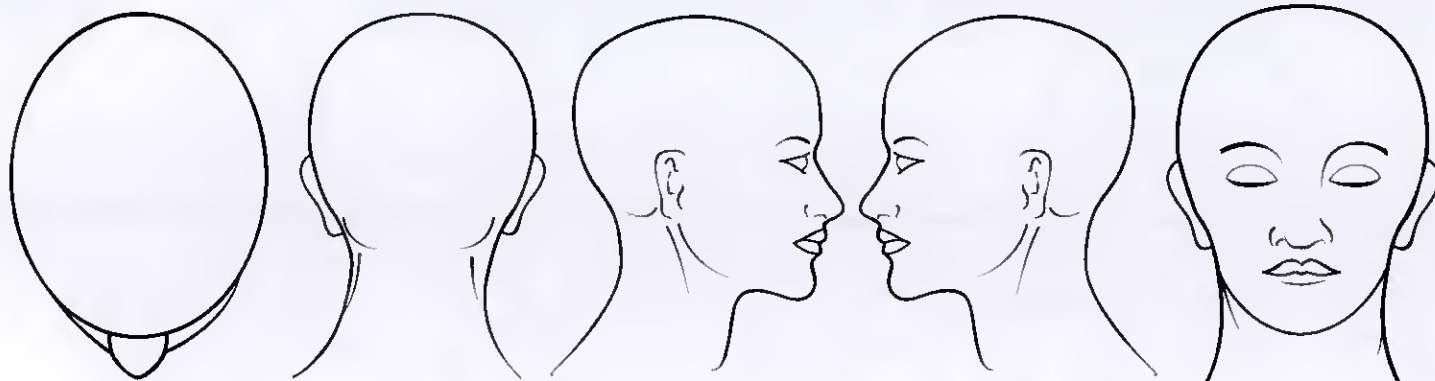
CHI no

First name DOB / /

Last name Sex: ☐ M ☐ F

Address

or attach addressograph label here



EMERGENCY DEPARTMENT USE ONLY

CHI no
 First name DOB / /
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

ON ADMISSION

ACTIVITIES OF LIVING ASSESSMENT

1. Maintaining a safe environment - Alert + orientated
 - Buzzer to hand.
2. Communicating - No issues communicating own needs
 - Wears reading + distance glasses.
3. Breathing - No issues
 - Maintains own airway
4. Eating and drinking - Normal diet.
5. Eliminating - No issues.
6. Washing and dressing - Independent
7. Controlling body temperature - Pyrexial on admission.

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CHI no
 First name DOB / /
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

ACTIVITIES OF LIVING ASSESSMENT

8. Mobilising - Unsteady on feet
 - fell last night.

9. Work and social activity

10. Expressing sexuality

11. Sleeping - sleeping tablet.
 - unable to sleep due to anxiety.

12. End of life care

ASSESSMENTS/FORMS FOR CONSIDERATION (tick if completed)

- | | |
|--|---|
| ☐ 4AT Assessment Tool and TIME Bundle | ☐ Abbey Pain Assessment and Management |
| ☐ Confusion Assessment | ☐ MUST Nutritional Screening/Nutrition Profile |
| ☐ Getting to know me | ☐ Oral Health Assessment |
| ☐ Learning Disabilities Supplementary Information | ☐ Swallow Screening Test |
| ☐ Mobility Assessment | ☐ Fluid Balance Chart |
| ☐ Falls Risk Assessment (Hospital)/Falls Bundle | ☐ FAST Alcohol Screening |
| ☐ Pressure Ulcer Risk Assessment (PURA) | ☐ Glasgow Assessment and Management of Alcohol/GMAWS Score |
| ☐ SSKIN Care Bundle | ☐ Management of Nicotine Addiction (Inpatient) |
| ☐ Assessment and Management of Wounds (including pressure ulcers) | ☐ Peripheral Vascular Catheter (PVC) Bundles |
| ☐ Foot Assessment - CPR for Feet | ☐ Discharge planning |
| ☐ MRSA/CPE Clinical Risk Assessments | ☐ Other (condition specific): |
| ☐ Stool Chart | |
| ☐ Daily Pain Assessment | |

CHI no
 First name DOB
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

SOCIAL HISTORY

Lives alone? ☐ Yes ☐ Don't know Lives with: daughter

☐ Own home ☒ Rented ☐ Sheltered accommodation ☐ Homeless ☐ Residential care
 Type:
☐ Nursing care
☐ Respite care

Stairs? ☐ Yes ☐ No
 Disability modifications? ☐ Yes ☐ No
 Comments:

Community Support

Services/Care: ☐ Independent ☒ Family support ☐ District Nurse ☐ Macmillan Nurse
☐ Social Care ☐ Voluntary Sector ☐ Community Mental Health Team
☐ Other community teams, e.g. ICST, CARS, etc.

Care Type: ☐ Medicine prompts ☐ Meal cover ☐ Personal care (including continence management)
 Details:

OBSERVATIONS

Immediate Physiological Observations:

Temperature (°C) Resp. Rate (/min)
 Pulse (bpm) O₂ sat on air
 BP lying (mmHg) O₂ sat on % O₂
 BP standing (mmHg) BM

NEWS Score:

Other Observations:

Height (m) (actual/estimated) Body Mass Index (BMI)
 Weight (kg) 58.6 kg (actual/estimated) Peak Flow (L/min)

URINALYSIS

Leucocytes <u>/</u>	Ketones <u>/</u>
Nitrites <u>/</u>	Glucose
Protein <u>Trace</u>	MSSU ☒ Yes ☐ No
pH <u>/</u>	Pregnancy Test? ☐ Yes ☐ No Result:
Blood <u>+</u>	
Specific Gravity <u>1010</u>	

Completed by: (PRINT NAME) <u>Zoe Will</u>	Signature: <u>[Signature]</u>
Designation: <u>[Signature]</u>	Date: <u>27/4/21</u> Time: <u>15:10</u> (24 hours)

CHI no
 First name DOB / /
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

Admitting Clinician:

J. Deesaran ST3

Responsible Consultant:

Admitting Consultant:

(if different from above)

MEDICAL HISTORY

Time of assessment: : (24 hour)

Presenting complaint:

(42) Referral from anti-coag clinic - pale; INR 1.1 (mesenteric thrombus), vomiting

History of presenting complaint:

- feeling generally unwell over past couple days
- ongoing vomiting - has been struggling to keep fluid + food down for past 2/3. only managing with sips. (vomiting ongoing since admission - no obs. food trigger)
- feels thirsty
- bowel moving - loose/soft stool yet - intermittent diarrhoea + constipation.
- denies heart burn/indigestion/sensation of food sticking
- lower back pain - using hot water bottles
- no flank/loin to groin pain.
- occasional mild abdominal discomfort - none at present
- INR 8 yesterday - given VIT K in anti-coag clinic. no overt bleeding
- MR subtherapeutic today - so will need to dose Tinz cover until warf therapeutic

Past medical and surgical history:

Date/Duration

- Recent admission March - DVT; der. UFTS.
 - +ve BCLs - gain strain variable - diff to determine if met - no.
 - treated with type therapy
 - CTAP: extensive superior mesenteric thrombus
 - (UFTS; 1d-dimer - did not have and vaccine)
 - managed with MCH > warf,
 - (Thrombophilia screen - mildly raised anti-cardiolipin abs); TACS
 - no end. of malignancy.

CHI no.

First name DOB / /

Last name Sex: ☐ M ☐ F

Address

.....

.....

or attach addressograph label here

SYSTEMS REVIEW

Cardiac:

Respiratory:

Gastrointestinal:

Genitourinary:

Neurological:

Locomotor:

FAMILY HISTORY

LIFESTYLE

Smoker? ☐ Never ☐ Ex ☒ Current Amount: 7/day

Patient exposed to second hand smoke at home? ☐ Yes ☐ No

☐ Patient advised regarding No Smoking Policy

Alcohol intake: 4 beers every Friday units/week

[National alcohol unit guidelines - no more than 14 units per week for men and women]

Recreational drug use? ☐ Never ☐ Ex ☐ Current

Details:

Present travel? ☐ Yes ☐ No Drives? ☐ Yes ☐ No

Details:

- Lives with 11 year old son - being looked after by
- ind. with ASD but struggling for
Feeling gen unwell

MEDICINES RECONCILIATION

Details obtained from:

- ☐ Patient's Own Drugs (PODs) ☐ Relative/Carer ☐ GP phone call
☐ Community Pharmacist ☐ Patient ☐ GP letter
☐ Emergency Care Summary ☐ Other: (specify)

[illegible]

Antibiotics checked? (Route/Indication/Duration - record on cardex)

☐ Yes ☐ No

Medication history recorded by:
(PRINT NAME)

Signature:

Date: _____ / _____ / _____

Designation:

Time: : (24 hour)

Known drug allergies?

(drug name and type of reaction)

☒ Yes ☐ No

Patient's own drugs stored:

- ☐ Not available ☐ POD locker
☐ Fridge ☐ Drug cupboard/trolley
☐ CD cupboard ☐ Returned to patient
☐ Taken home by relative/carer

Known non-drug allergies?

☐ Yes ☐ No

Red wristband applied? (☐ N/A pre-assess) ☐ Yes ☐ No

Signature:

- ☐ Self medicates ☐ Drugs supported by relative/carer

Compliance Device filled by/MAR Chart: ☐ Relative ☐ Chemist: (specify)

☐ Care at Home Service Level of Medication support: ☐ A ☐ B ☐ C ☐ DPharmacist/Pharmacy Technician Comments: Pharmaceutical Care Plan started? ☐ Yes ☐ No**Pharmacist/Pharmacy Technician:**
(PRINT NAME)

Signature:

Date: ____/____/____

Contact number:

Time: 00:00 (24 hours)

Patient Name
ISABEL MCCracken

CHI
1808785142

Date of Birth
18-Aug-1978

Age
42

Last Emergency Care Summary received 19-Apr-2021

Details obtained from:					
PODs	☒	Relative	☐	GP phone call	☒
Patient	☒	GP Letter	☐	ECS with consent	☒
Other Details				Community Pharmacist	☒
				Other	

Repeat Medication									
Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Continue	Withhold	Stop	Comments
Diazepam 2mg tablets	84 tablet	ONE TO BE TAKEN THREE TIMES A DAY Instalments: DISPENSE WEEKLY		13-Apr-2021	13-Apr-2021	✓			
Paracetamol 500mg tablets	224 tablet	2 TABLETS FOUR TIMES A DAY WHEN REQUIRED Instalments: DISPENSE WEEKLY		13-Apr-2021	13-Apr-2021	✓			Δ 10
Dihydrocodeine 30mg tablets	112 tablet	ONE TO BE TAKEN FOUR TIMES A DAY WHEN REQUIRED FOR PAIN RELEIF Instalments: DISPENSE WEEKLY		13-Apr-2021	13-Apr-2021	✓			Δ PCA
Warfarin 1mg tablets	56 tablet	AS DIRECTED		13-Apr-2021	13-Apr-2021	✓			Δ 100mg
Warfarin 3mg tablets	56 tablet	AS DIRECTED		13-Apr-2021	13-Apr-2021	✓			
Zopiclone 7.5mg tablets	28 tablet	ONE AT NIGHT WHEN REQUIRED Instalments: DISPENSE WEEKLY		10-Apr-2015	12-Apr-2021	✓			
Quetiapine 25mg tablets	84 tablet	TWO (50MG) IN THE MORNING AND ONE (25MG) AT MIDDAY Instalments: dispense weekly		28-Feb-2020	12-Apr-2021	✓			
Quetiapine 150mg tablets	28 tablet	ONE TO BE TAKEN AT NIGHT Instalments: dispense weekly		28-Feb-2020	12-Apr-2021	✓			
Adcal-D3 750mg/200unit caplets (Kyowa Kirin Ltd)	56 tablet	1 TABLETS TWICE A DAY		22-Mar-2019	12-Apr-2021	✓			
Citalopram 40mg tablets	28 tablet	1 TABLET DAILY Instalments: dispense weekly		15-Nov-2018	12-Apr-2021	✓			
Hydroxocobalamin 1mg/1ml solution for injection ampoules	1 ampoule	AS DIR		06-Jan-2020	12-Mar-2021				

SKULLS

BO

COPY PAGE

1808785142

18/08/1978

MCCRACKEN

1d Cumbrae Crescent

Coatbridge
Lanarkshire

ML5 4PX

CHI
1808785142Date of Birth
18-Aug-1978Age
42

Repeat Medication

Frequency	Medication Start Date	Prescription Date	Continue	Withhold	Stop	Comments

Acute Medication (including those greater than 30 days)

Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Continue	Withhold	Stop	Comments
Prochlorperazine 5mg tablets	168 tablet	1 THREE TIMES A DAY		15-Apr-2021	15-Apr-2021				
Folic acid 5mg tablets	112 tablet	1 EVERY MORNING Notes for patient: This is a 4 month course of folic acid, please complete the course then make arrangements for a blood test to check your folate level.		13-Apr-2021	13-Apr-2021				
Etoricoxib 60mg tablets	28 tablet	1 OR 2 TABLETS ONCE DAILY		25-Mar-2021	25-Mar-2021				

Non-prescription medicines including herbal/homeopathic/over the counter medication

--

Known drug allergies?
Enter details below:

Yes/No

Known non-drug allergies?

Yes/No

Allergy Description	Date Recorded	Comments
H/O: drug allergy	19-Sep-2007	Diclofenac potassium 50mg tablets

Patient Name
ISABEL MCCrackEN

CHI
1808785142

Date of Birth
18-Aug-1978

Age
42

Allergy Description	Date Recorded	Comments
No known allergies	19-Jul-1994	

How does patient take medication?

- ☐ Self Medicates ☐ Drug supervised by carer
☐ Compliance device filled by: ☐ Relative ☐ Chemist, specify:

Medication History Confirmed By:	Name:	Signature:	Date/Time:
----------------------------------	-------	------------	------------

Name: SARAH CONNELLY	Signature:  Contact No: 604881	Date/Time: 29/4/21
----------------------	--	--------------------

Pharmacist/Pharmacy technician Comments:

Care Plan Started? Yes ☐ No ☐

DAWN AC
mesenteric thrombus

2.0-3.0 26wks from 9/4/21.

? Dose → LAST DOSE 0.5MG DAILY.

CHI no
 First name DOB / /
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

RR 18
 sats 100% (4)

Temp 36.5
 #R 93 BP 98/66

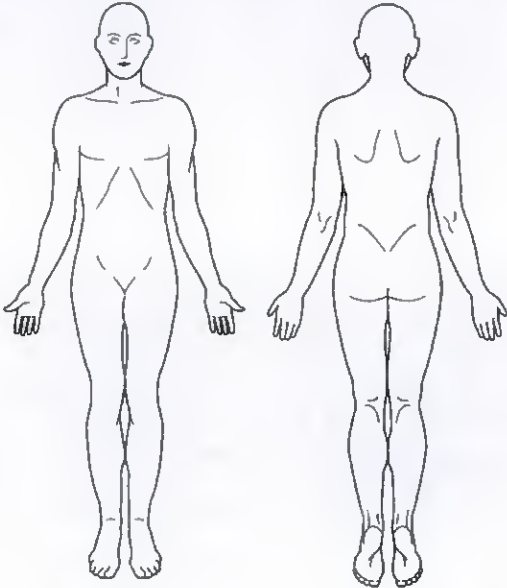
CLINICAL EXAMINATION

Systemic Inflammatory Response Syndrome (SIRS) Criteria:

HR > 90 ☐ Yes ☐ No WBC < 4 or > 12 ☐ Yes ☐ No
 RR > 20 ☐ Yes ☐ No Temp < 36 or > 38 ☐ Yes ☐ No

SIRS Score:

	Yes	No
Jaundice	☐	☐
Pallor	☐	☐
Lymphadenopathy	☐	☐
Clubbing	☐	☐
Cyanosis	☐	☐
Rash	☐	☐



feels comfortable at rest.

livedo retic from hot water bottle base back.

non tender on palp

Cardiovascular System

Pulse
 JVP
 Apex
 HS/murmurs ? *off* *unusual* *I + II*
 Oedema *na.*

Peripheral Pulses:

	R	L
Femoral	☐	☐
Popliteal	☐	☐
Dors. Pedis	☐	☐
Post. Tibial	☐	☐

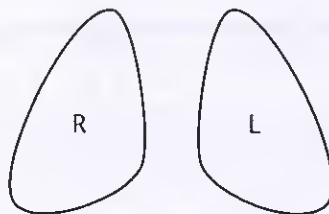
CHI no
 First name DOB / /
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

Respiratory

Trachea
 Expansion
 Percussion
 Breath sounds

*vesicular
 breath
 sounds*



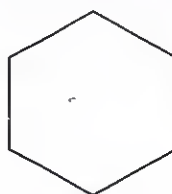
SpO₂ Set Target:

- ☐ 94 - 98%
☐ 88 - 92%
☐ Other: (specify)

Initials:

Abdomen

Distension
 Tenderness
 Organomegaly
 Hernia
 Bowel sounds
 PR



*Abdo SNT
 BS present*

Ly

NEUROLOGICAL AND LOCOMOTOR

Evidence of confusion or delirium?

☐ Yes ☒ No

4AT Score: - If score is 4 or more refer to **TIME Bundle**

Glasgow Coma Scale	Eye opening	best Verbal response	best Motor response
Eye 4/4	4. spontaneous	5. orientated	6. obeys commands
Verbal 5/5	3. to speech	4. confused	5. localise pain
Motor 6/6	2. to pain	3. inappropriate words	4. withdrawal
Total 15/15	1. none	2. incomprehensible sounds	3. flexion to pain
		1. none	2. extension to pain
			1. none

Speech		Right arm	Left arm
Pupils	Tone		
Fundi	Power	/5	/5
Eye Movements	Sensation		
V motor	Co-ordination		
V corneals, sensory		Right leg	Left leg
VII facial	Tone		
VIII hearing	Power		
IX X gag reflex, palate	Sensation		
XI trapezii, sternomastoids	Co-ordination		
XII tongue		Reflexes	
	Biceps C5 - 6		
	Triceps C7 - 8		
	Supinator C5 - 6		
	Knee L3 - 4		
	Ankle S1 - 2		
	Plantars		

*not formally assessed
 no gross abnormalities*

CHI no
 First name DOB / /
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

H+35
 amylase 1.1

INVESTIGATIONS AND RESULTS			Results			
Analyte	Units	Reference Range	Date 27/01	Date	Date	Date
Biochemistry			Time	Time	Time	Time
Sodium	mmol/L	133 – 146	130			
Potassium	mmol/L	3.5 – 5.3	2.9			
Chloride	mmol/L	95 – 108	84			
Bicarbonate	mmol/L	22 – 29	33			
Urea	mmol/L	2.5 – 7.8	7.7			
Creatinine*	umol/L	60 – 120**	63			
*If AKI - see guidance available via hyperlink in Lab browser						
eGFR	ml/min	> 59	259			
Glucose	mmol/L	3 – 6				
Amylase	U/L	0 – 100				
ALT	U/L	< 50	9			
Alk Phosphatase	U/L	30 – 130	442			
Bilirubin	umol/L	< 21	21			
Albumin	g/L	35 – 50	25			
Gamma-GT	U/L	M< 90, F<55				
Total Protein	g/L	62 – 82				
Globulin	g/L	21 – 37				
Adjusted calcium	mmol/L	2.1 – 2.6	2.59			
Magnesium	mmol/L	0.7 – 1.0	0.6			
CK	U/L	40-320 M, 25-200 F				
TNT	ng/L	<14				
CRP	mg/L	<6	145			
Lactate	mmol/L	0.6 – 2.4				
Blood Gases						
Inspired O ₂						
H+	nmol/L	36 – 43				
pCO ₂	kPa	4.6 – 6.0				
pO ₂	kPa	10.5 – 13.5				
Bicarbonate (calculated)	mmol/L	20 – 28				
Oxygen saturation	%					
Haematology						
HGB	g/dL	M 13.5 – 18.0, F 11.5 – 16.5	77			
WBC	X10 ⁹ /L	4.00 – 11.00	43.7			
PLT	X10 ⁹ /L	140 – 450	743			
MCV	fL	80.0 – 100.0	82.6			
ESR	mm/hr	M Age / 2 F, (Age-10) / 2				
PT Ratio		0.82 – 1.18				
PTT Ratio		0.85 – 1.13				
Fibrinogen (Clauss)	g/L	1.5 – 4.5				
D-Dimer	ng/ml					
B12	pg/ml	155 – 1100				
Folate	ng/ml	2.8 – 12.4				
Ferritin	ng/ml	M 28 – 285, F 14 – 186				
Other						

**Age related reference ranges apply

CHI no
First name DOB / /
Last name Sex: ☐ M ☐ F
Address
.....
or attach addressograph label here

☐ Hairmyres ☐ Monklands ☐ Wishaw
Ward:

Adult Risk Assessment for Venous Thromboembolism (VTE)

(Excludes Orthopaedics/Obstetrics who have specialty-specific policies)

(Adapted from GG&C VTE Risk Assessment Tool with permission)

- VTE Risk assessment must be completed for all patients on admission - sign and date as specified below
- Patients must be reassessed every **48 hours** or sooner if condition changes
- Assessment must be documented in Medicine Prescription Form
- Provide patient with information leaflet on VTE prevention

Non-operative Patients Start Here (mainly medical)

Is the patient bed-bound or expected to have reduced mobility relative to normal state for ≥ 2 days?

☒ **YES**

☐ **NO**

Patients for Surgery

Does the patient have any **Risk Factors for Thrombosis?** (tick all that apply)

- | | |
|---|--|
| ☐ Age >60 | ☐ Use of oestrogen-containing contraceptive therapy |
| ☒ Active cancer or cancer treatment | ☐ Use of hormone replacement therapy |
| ☐ Dehydration | ☐ Pregnancy or <6 weeks post partum (seek specialist advice) |
| ☐ Known thrombophilias | ☐ Critical care admission, e.g. HDU/ITU |
| ☐ Obesity (BMI >30) | ☐ Varicose veins with phlebitis |
| ☐ Current significant medical conditions, e.g. diabetic keto-acidosis, serious infection, heart failure, respiratory disease, inflammatory disease | ☐ Total anaesthetic and surgical time >90 minutes |
| | ☐ Surgery involving pelvis or lower limb with a total anaesthetic and surgical time >60 minutes |
| | ☐ Acute surgical admission with inflammatory or intra-abdominal condition |
| | ☐ Hip fracture |
| | ☐ Personal history of first degree relative with a history of VTE |

- No thromboprophylaxis required
- Continue to reassess every 48 hours or sooner if condition changes
- Record all reassessments in Medicine Prescription Form

Risk Assessment Now Complete

Pre-assessment Nurse Signature:
(if applicable)

Date: / /

☒ **YES, 1 or more Risk Factors identified**

☐ **NO Risk Factors identified**

Does the patient have any **Contraindications to Pharmacological Prophylaxis?** (tick all that apply)

- | | |
|--|--|
| ☐ Acute stroke | ☐ Neurosurgery, spinal or posterior eye surgery |
| ☐ Head injury with suspected intracranial bleed? | ☐ Day case thyroid surgery |
| ☐ Active bleeding, including suspected concealed bleeding | ☐ Lumbar puncture, epidural/spinal anaesthesia within the previous 4 hours OR expected within the next 12 hours |
| ☐ Acquired bleeding disorders, e.g. acute liver failure | ☐ Other procedure with high bleeding risk - discuss with senior if unsure |
| ☐ Thrombocytopenia ($<75 \times 10^9/l$) | ☐ Concurrent use of other anticoagulants including treatment dose heparin, Vit K antagonists e.g. Warfarin (INR ≥ 2), NOACs e.g. rivaroxaban, apixaban, edoxaban, dabigatran. |
| ☐ Uncontrolled hypertension (230/120 mmHg or higher) | ☐ Senior clinician decision not to prescribe pharmacological prophylaxis (specify reason in clinical notes) |
| ☐ Untreated inherited bleeding disorders, e.g. haemophilia or von Willebrands | ☐ Other, specify: |

☐ **NO** contraindications to Pharmacological Prophylaxis identified

☐ **YES** contraindications to Pharmacological Prophylaxis identified

- **Medical patients - Enoxaparin 40mg**
- **Surgical patients - Enoxaparin 40mg + Anti-Embolism Stockings** (*unless contraindicated)
- Prescribe Enoxaparin at 6pm (on the day of surgery, at the later of 4hr post-op or 6pm)
- **Reduce Enoxaparin to 20mg if $<50\text{kg}$ or eGFR <30**

Discontinue at discharge or when returned to pre-morbid mobility

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

Outcome of VTE Risk Assessment

	Yes	No
VTE Risk Factors assessed?	☐	☐
Contraindications to pharmacological prophylaxis assessed?	☐	☐
Treatment prescribed? ☐ LMWH ☐ AES ☐ None		
Patient informed of risks and benefits of VTE thromboprophylaxis? ☐ Not applicable	☐	☐
Patient information leaflet provided?	☐	☐

Doctor Name: (PRINT)

Dr. Anna Dossava

Signature:

Grade: *SR3*

Date: *27.04.21*

CHI no
 First name DOB / /
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

2107

CLINICAL ASSESSMENT OUTCOME AND PLAN

Initial Investigations	Result
☐ ECG	Rate 111 no ab. ischaemic changes
☐ CXR	unremarkable
☐ AXR	
☐ Other radiology (specify)	
☐ Other investigation (specify)	

Active Problem and Differential Diagnosis

1. Anaemia: Hb 77 - no overt bleeding	5.
2. Subtherapeutic - mes. thrombus INR	6.
3. MUCC 43.7 - Biochem not back. - 2 intra-abdominal	7.
4. Vomiting + occasional loose stool { - at least 262 hx of worsening Sx. - related to mes. thrombus vs. infection.	8.

Initial Management Plan

- 1) Bld + IV access - add gaurd ✓
- 2) needs BCs
- 3) needs weight to prescribe Tinz ☐ (until INR therapeutic a warf)
- 4) commence triple abx therapy - given prev recent the BC.
- 5) have ~~two~~ 4p + saved PRCs. not yet X-matched. 2 units if req.
- 6) needs CXR ☐
- 7) ? Should we do CTAP - to look for - 2 intra-abd bleed
 - any end. of haematomas given with
 - ? ~~not~~ any end of ischaemic in context of extensive SMA thrombus
- 8) urine culture ☐
- 9) stool cultures*3 - if loose ☐
- 10) CXR ☐

Has Medicines Reconciliation been completed? (see page 12)

☐ Yes ☐ No

Has VTE Risk Assessment been completed? (see page 16)

☐ Yes ☐ No

Has Adults with Incapacity (AWI) been considered? (see page 1)

☐ Yes ☐ N/A

Admitting Clinician: (PRINT NAME)

Jordana Dargatzis

Signature:

Designation: ST3

Department:

Bleep:

Date: 27/04/21 Time: 12:35

CHI no ...
 First name
 Last name 1808785142
 Address 18/08/1978 F
 MCCracken Isabel
 1d Cumbernauld Crescent
 Coatbridge
 Lanarkshire

MLS 4PX

RR 18
 Sat 100% AIR
 Afebrile
 HR 95
 98/60



Soft.
 Fullness in
 epigastrium.
 Tender as shaded

No LN.
 No rash

(R) pupil > (L) reactive
 H 5 4 11 + 6 ° Mm ° Rub No s

CONSULTANT REVIEW

Consultant Assessment, Diagnosis and Treatment Plan

27.4.27 PTWR NO LAN for DR MCINTYRE
 MAU 42 ♀
 14:15

1. Recent admission : ? sepsis
- : sup. mesenteric thrombus
- : +ve A-cardiolipin Ab
- : c/o Warfarin

→ 1. 2/7 Malaise

2. Vomiting, struggling to keep food down
3. Lower back pain - "chronic" → 2/52
4. INR 8 yesterday → Vit K → INR 1.1
5. HL drop 95 → 77 in last 2/52 but no overt blood loss.

ECG: SR III PR / QTC (N) NIL acute.

CXR: PA Erect. No A/P. Lungs clear.

Urine: Not done

Covid swab: -

Bloods: Na 130 K2.9 CL 84 Bili 33 Mag 0.6
 Urea 7.7 (1.5-2) LACTATE ? □
 ALP 442 (↑) Bld 21 ALB 25
 CRP 415
 WCC 43.7 (Neut 39.1)
 HL 77 Plt 743 MCV 82.6

IMP: -

1. Concern RE recurrent sepsis
 (? Intra-abdominal
 (? Abscess / collection)
 (?? Discitis)
2. Dehydrated ; AKI (Pre-renal)

PRINT NAME:

CNOLAN

Signature:

CNOLAN

Date: 27/4/21

Time: 14:37 (24 hour)

COPY PAGE

CH 
 Fir 1808785142
 La 18/08/1978 F
 Ac MCCracken Isabel
 1d Cumbernauld Crescent
 Coatbridge
 Lanarkshire ML5 4PX

CONSULTANT POST TAKE WARD ROUND CHECKLIST - FOR CONSIDERATION

1. Resuscitation Status
☒ For CPR
☐ for CPR, pending further assessment/information/discussion
☐ DNACPR, form completed and countersigned
 If DNACPR - Hospital Anticipatory Care Plan: ☐ HDU ☐ Ward level

2. VTE Risk Assessment
☐ Documentation completed (see page 16)

3. Medicines Reconciliation
☐ Reviewed and documentation completed (see page 12)

4. Boarding Risk Assessment
 (complete as per local hospital/departmental policy)
☐ Not applicable
☐ Low/Intermediate
☒ High

5. Responsible consultant
 - correctly recorded on page 5 and on TrakCare
☐ Yes ☐ No

6. Estimated Discharge Date (EDD)
☐ <24 hours ☐ 24 - 72 hours ☒ >72 hours

7. If downstream bed required
☒ General Medicine
☒ Medical speciality (specify) ID.
☐ General Surgery
☐ Surgical speciality (specify)
☐ Other (specify)

PRINT NAME:  **Signature:** 

ADDITIONAL COMMENTS

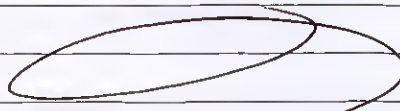
3. Falling Hb → ? Retroperitoneal haem
 ?? Haemolysis ; No overt blood loss.

4. Recent Dx mesenteric v. thrombosis
 (NB: altho also prev. thrombocytopenia, this was on
 hosp admitting duty + not current; No assoc'd
 heparin or Covid Vaccine)

PLAN.

1. UA +/- MSSU
2. IV Crystalloid → (N) Saline for now + KCl
3. Lactate, XM 24 PRC, LDH, Coombs, Haptoglobin
4. ALC ☒
5. IV A, M, G
6. Echo
7. CT AP ± Contrast please
8. Consider MRI spine
9. Give Tinz for now (w/H Warfarin @ present)

CHI: 
 First: 1808785142
 Last: 18/08/1978 F
 MCCRACKEN Isabel
 Addr: 1d Cumberge Crescent
 Coatbridge
 Lanarkshire ML5 4PX

Date/Time	MULTIDISCIPLINARY TEAM NOTES	Signature/Designation
27/14/21 15:15	Written in retrospect. Patient admitted to Mbu. Patient alert and orientated. Patients observations charted New ③ due to BP and P. Card snob obtained from patient. Snob offered to patient and refused. White wristband insert. IV antibiotics given as per Hepma. Patient remains on IV fluids. Issy is comfortable at present. <u>Waiting to see medic review.</u>	for unkel (JIN)
27/14/21 17:20	Patients observations charted new ③ due to P 117 and T 38.0. PRN paracetamol given for temperature. BII medication given as per Hepma. Metronidazole given at 5pm, running slow due to other antibiotics running. Issy managed ice cream and is comfortable at present.	for unkel (JIN)
27/04/21 18:00	CTAP booked for tomorrow am call from bld bank - + obs. - req. Fisher sampler to send to Glasgow - will get 2 units available in case she needs PRE in next day or 2.	
	- Rehis 37. - Jordan in blood bank advised that Coombs is +ve - LDH (M) haptoglobin (M) awaiting Bal 21	
	Plan 1) 3 pink blood bottles to bld bank 2) D/w Karen on call tomorrow during the day re: +ve Coombs 2 - prefer but @ LDH 3) CTAP tomorrow.	
	 JIN	

CHI no

Firs

Last 1808785142

18/08/1978 F

Add MCCracken Isabel

1d Cumbernauld Crescent

Coatbridge
Lanarkshire

ML5 4PX

Date/Time	MULTIDISCIPLINARY TEAM NOTES	Signature/Designation
27/4/21 1930	Patients observations charted @ 18:30 News ④ due to T: 38.8 P: 124. Applied cold compresses on Issy's head. Alerted medic staff. Advised to chart obs, run stat fluids and check obs after. Observations charted News ⑤, alerted medic staff, stat fluids running and will continue to monitor.	zoe uckel (S/N)
27/4/21 2020	Patients observations re-charted News ⑥ due to R: 23, P: 116 BP: 93/52. medic staff alerted & change in News, will continue to monitor.	zoe uckel (S/N)
27/4/21 2022	Days 14+1 Note above - still clinically dry - only had 500 ml in. HR 116 bpm 12/1 + feeling bit better after further stat 250ml. Very certain she does not want tablets - emphasized importance of accurate fluid balance given PRR & BP - will move in toilet for now ① accurate urine output 2x 500ml PlasmaLyte over 2 nd end + RIV - hopefully the for NaCl + 40mmol KCl Repeat bloods inc. lactate tonight please	
27/4/21 2320	News ③ Medication given as charted. IV fluids running. Fluid balance up to date. Repeat bloods obtained including gen level. 3x CxS samples, lactate. Says 'feeling much better.' 1 st obs to continue	HM SW

1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumbrae Crescent

Coatbridge
Lanarkshire ML5 4PX

Date/ Time	MULTIDISCIPLINARY TEAM NOTES	Signature/ Designation
28/4	SHTO MAU	
02:00		
	Hg 63 (77) ↳ midday ↳ 23:00	
	2 units crossmatched - is abs(+) so will need to wait for samples sent to glasgow if needing further bloods	
	On assessment - feels well - no complaints Denies chest / abdom / back pain Denies bleeding from anywhere. Appears pale. Denies SOB.	
	On IV amox / met / gent for sepsis unknown source	
	NEWS (3) RR 18 SpO2 97% OA Temp 36.4 °C Pulse 90 regular - CRT 3s peripherally BP 95/76 Alert + orientated, GCS 15.	
	  HS H+U+O Urine	
	Plan: Transfuse 2 units PRC overnight Await CT CAP man.	
		 SJO/205 12/2

CHI
First 1808785142
Last 18/08/1978 F
Add MCCracken Isabel
1d Cumbrae Crescent
Coatbridge
Lanarkshire ML5 4PX

Date/Time	MULTIDISCIPLINARY TEAM NOTES	Signature/Designation
28/04/2019	Requested PRC x 1 unit from labs	
0305	- cannot receive from labs to say blood not available as still being cross matched	HM SW
28/04/2019	Fy2 SJPKWT MAU	
0430	Informed by NS no blood available yet D/w registrar on call re ? emergency transfuse in CONCERN , agreed as holding BP OK (102/61) pulse 97, alert, no overt bleeding - INR 1.1 yesterday plan: monitor obs hourly Bloods E/cam including coag / FBC	
28/04/2019		SJPKWT 1542
0900	NBNS (1). Repeat bloods obtained. Medic called to prescribe genc and check INR level	HM SW
28/04/2019		
08:29	Mirade Adiguna CR MAU A 42yr old lady admitted yesterday with Anaemia (Hb-77), Subtherapeutic INR (1.1) Leukocytosis loose stool + vomiting BA - On warfarin for mesenteric thrombus NEWS = 1 BP = 107/71, PR-97, T=37, SpO2-98%, RR-17cpm	

COPY PAGE

CHI no.
 First name DOB / /
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

Date/ Time	MULTIDISCIPLINARY TEAM NOTES	Signature/ Designation
	<u>Meds</u>	
	- warfarin withheld at present	
	- On Tinzaparin to cover until IMR @ target (2-3)	
	- 1V met + Amox. Today's 1st dose yet	
	- 1V Gent - 2nd dose for 16:00 today if levels ok.	
	<u>Bloods</u>	
	Sodium 132 (136)	Hb 63 (63)
	CL - 94 (87)	Platelets 682 (641)
	HCO ₃ - 31 (31)	WBC 27.6 (34.5)
	Cr - 43 (53)	Urea 23.3 (29.7)
	ALP - 228 (442)	IMR 1.1
	Ab - 21 (25)	
	CRP - 283 (272)	
	Mg ²⁺ 0.65 (0.60)	
	CXR - Nil acute	
	CT Abdo pelvis - awaited.	
	Patient seen.	
	Feels "fired". Stools more formed, vomited once this morning	
	Passing urine normally. Haematuria ^o , haematochezia ^o , haematemesis ^o	
	Abd	
	Soft, supra-pubic tenderness.	
	Chest	
	Clinically clear.	
	HS - 18/11 only.	
	While observing patient, informed by SM had just spiked a temp.	
	PR - 170 bpm, SpO ₂ - 92%, T - 38.5°C, RR - 1226/min	
	BP - 98/55 mmHg.	
	<u>Plan</u>	
	1) Paracetamol stat	
	2) Blood cultures away	

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Date/Time	MULTIDISCIPLINARY TEAM NOTES	Signature/Designation
	3. Transfuse ASAP	
	4. Chase CT - will call radiology to possibly fast-track this.	
	5. monitor observations closely.	
	6. chase msu & BC, meanwhile CT antibiotics.	
	7. Gent level.	Adjumo
28/4/21 1145	Patient independent with personal care. Mobile and independent around room. No elimination concerns offered. Observations as charted, news=5 prior to 1st unit of PRC. Temp 38.5°C, HR 122bpm, BP 98/55mmHg. Medical staff informed, given 500mg PRN paracetamol, medical staff happy to commence PRC. Observations improved since commencing transfusion. For CT between units. Blood sent for gent level.	(K. JAPRA Sp) <i>Adjumo</i>
	(as I requested the scan yesterday. call from radiologist that CT v. abnormal	
28/4/21 1633	J. Desai ST3	
AKURU-CTAP	- increasing thrombus burden from SUV through main PV and into the intra-hepatic components of the portal vein. new distal mesenteric venous gas - possible reasons include mesenteric venous infarction, cavitation of mesenteric abscess or infected distal SV SUV thrombus with gas forming organism. - concern also potential for small bowel venous ischaemia or infarction or possible underlying undiagnosed chronic IBD with interloop abscess.	
(note: I checked last year scan + looked for this am. Time changed following at this point)		
	- currently: RR 16 Temp 36.5 BP 99/65 Sat 97.1(A) HR 95 - Rx tells me she feels okay - just a bit sore when I'd	

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- cont. TNA.

paraprot - IgG lambda

- hold off steroids.

334 hrs

Date/Time	MULTIDISCIPLINARY TEAM NOTES	Signature/Designation
28/04	cont'd -	
	keep examining her abdo.	
	X Abdo soft	
	there some epigastric tenderness.	
	-	
	*** note: cons Dr. Stuart (radiologist) spoke to Dr. Goyal + advised of CT results + plan made as below ***	
	Dr. Goyal - explained above	
	Reg. Nur. - he was kindly + v.	
	Therapist - ? for surgical intervention	
	'will need higher level of monitor -	
	Dr. Muro - advised change to Tazocin + Met + Gent with plan of changing to Meropenem + Vinc +/- Oct if deteriorates.	
	Dr. Haem - advised we discussed current issues +	
	Reg. Mat. - v. Hb + progressive thrombosis	
	- advised she could be too haemorrhaging but not so far	
	- continue treating infection	
	- surgery	
	- monitoring haemoglobin bds	
	- PRCS	
	- Rx LMWH	
	- not for steroids at present.	
	- exact cause of thrombosis not quite clear. She does have double the antithrombin but yet had the result of paraprotein IgG clots	
	- He will discuss with her care + blood bank to see if anything further to add	

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22/01	cont'd - - At present, continue Rx dose Tinz. - check anti-TTHA levels 334hrs after dose Tinz known to ensure we are adequately anticoagulating - they will check back in tomorrow 10:00 - possibly doing a bone marrow d/w M - explained presentation + current issues - leg Johnny haemodynamic stat. - will kindly try after surgery if possible so to be clear if they know if there is a plan for surgical intervention. - I will d/w P's family after surgical RV.	
21	Thrombus ST3/ DICK (con) GEN SURGEON	ST3
16:30	422 BG: SMV Thrombus on CT last month Discharged on warfarin Admitted from INR clinic c INR 8.0. Patient relatively uncomplaining but found to have WCC 40, CRP 400 so repeat CTAP this afternoon - extension of Thrombus into hepatic portal system, splenic vein, down SMV into mesenteric (where it associates with a soft tissue mass containing gas)	

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	- bowel enhances - no overt obstruction - jej/duodenum thickened - gas in SUV - concerning of venous ischaemia	
	On review: Alert & orientated - no abdominal pain - chronic back pain, possibly slightly worse. - has felt fatigued, exhausted last 3 days.	
	End of bed assessment does not correlate with scan findings. Looks well.	
	BP 99/60 Apparent HR 95	
	soft	
	lactate 1.0 Hb 63 → on 2nd unit PRc now CRP 400 on admission. Catheter → good VO. WCC 40. Had IV A/M/G	
	Imp: Will need theatre & laparoscopy + lapotomy to assess bowel at least.	
	Plan: NBM. IVF. IV Abx. Catheter Anaesthetic RV. Back Consent. Update family - may do poorly given extent of CT. Dix vascular Dix haematology.	
	<i>[Signature]</i> (JTS) THOMPSON	

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28/4/21 1835	Indication <u>Deterioration</u> Residual Volume (ml) <u>400</u> Colour of Urine <u>straw</u> Easy Insertion? <u>Y</u> N If No, why? Name <u>E. Reid</u> Signed <u>Sn</u> Date <u>28/04/21</u> BRILLANT AquaFlete REF A310112 All-Silicone (IPN053452) Long-Term ☒ (up to 12 weeks use) Standard, 2-way Foley LOT KME20K1201 SIZE Ch. 12 O. D. 4.0mm/10ml 2025-09-28 Teleflex Medical, IDA Business & Technology Park, Dublin Road, Athlone, Co. Westmeath, Ireland Patient attended for CT between transfusions Multiple clots in hepatic portal vein and bowel. Surgical r/v - for urgent theatre. Biopsy sent as patient will require ICU bed afterwards. Daughter present and updated by nursing and medical staff. Once patient stable in ICU, could staff conduct to update her. Observations as charted, remains hypotensive and tachycardic. No transfusion reaction. IDUC inserted by student nurse Reid under supervision of SN Napier. Easy insertion, no concerns.	(Knapier SN) L. Napier

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28/4/21	Thompson (ST3)	
17:50	MR DICK d/w vascular reg (Cindy) who had reviewed images with vascular consultant. Vascular can offer nothing surgical with regards to the extensive Venous Thrombosis. There is no concern about arterial perfusion on CT. I have d/w been consultant: - most Tx already covered during last admission - He would check a D-dimer (if high would point to cancer) - Send tumour markers. - Post op - anticoagulation → wait 6 hrs & if AD stable start an unfractionated heparin infusion, <u>without</u> an initial bolus & aim to have ratio closer to 2 than 3. We have also counselled patient in presence of daughter & explained the risk to life (NELA 10-40% mortality)	 Thompson (ST3)

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3/4/21	Physiotherapy	
14/8	S. Pt. validly declined physio input as reports too fatigued & not fit for it. Discussed same with nursing team and also report patient not medically fit for PT input @ present as ? Sepsis. P. will leave with medical and nursing staff in 7 and remain as able.	C. WARDEN C. WARDEN (BSP)
4/5/21	MR MR Sallam (42) A/W MR /mrtal vein thrombosis. Had @ hemi + end + iliofemur. NEWS 2 6 RR = 24 SATS = 95 BP = Temp 38.1 mildly distended abdo stom working cervix short soft, tender RIF and LF, mnd looks clean catheter draining clear urine plan - rpt bloods + lactate → rpt CT-CAAP if ↑ lactate - chase C&A - mnd advice 5/5/21 04/05/21 - email sent to m. zro	



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4/5/21	Isabel brother phoned ward to raise concerns regarding nursing care, advised Unit need to D/W N.O.K. Daughter then came on phone raising same concerns re stoma analgesia and sepsis, stating not being informed regarding her Mum's care. SN Hassan informed she updated Isabel's daughter at visiting yesterday. FYI Lily contacted and asked by myself to update back to inform her of the above.	<i>[Signature]</i> C/N
4/5/21	<u>E41 Lei</u> Updated daughter regarding Isabel's progress. Said her inflam markers still high and we have done super screen to find source of inflammation/infection and she is on 2 abx. We have sent mmo a letter to see if they have anything to add and if she were to deteriorate, we would likely scan her again. I said we would update if anything changes. Sam B/M acted on mmo advice. Now on men & vane. + asked for VRE screen.	L Lei 404735
4/5/21 3:15pm	Physiotherapy 3) PT consented to Rx @ 2:55pm - Chris Waddell (PT) 6) PT lying in bed. Lie -> sit - max AOI + AOI to hold attachments. Mob - AOI + AOI to hold attachment. 10M, slow steady pace, reciprocal step pattern. Rx: marching on spot, leg knee lifts at bedside	<i>[Signature]</i> Helen Frame cont/... Helen Frame

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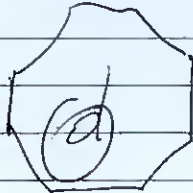
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2/5/14	W/N Stuart D3 Ileocolic resection + end ileostomy  Pry mucous membrane. Stoma active Soft NAS 3 122 bpm	
	(P) DVF Feeding and drinking Monitor urine output	
3/5/2014 10.30	W/N CUMMINGS (WAT3) D5 post ileocolic resection + end ileostomy for removal of ischaemia. - on paracetamol (Day 4) EWS of 5 - BP 93/59. HR 117 Temp 38° Bloods 2/5: CRP 292(106) (115) WCC 24.5(13.2)(26.9) Hb 77(77)(89) Cough pain in abdo worse Stoma moving molline more looks clean  Soft slightly distended tender diffusely  Catheter drawing Wet urine	

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Date/Time	Multidisciplinary Clinical/Continuation Notes	Signature/Designation
	plus - Blood cultures ☒ - urine dip +/- CSU - stool culture - CXR ☒ - D/W team timing of restarting anticoagulation - Two once mobile and bloody better	
		Lili 404731
3/5/21 12:45	<u>F41 Lei</u> Spoke to Dr. Caroline Betts (Hem) regarding anticoagulation and possibility of restarting warfarin. She has D/W team who specialises in thromboses and they find it unusual that she would have had breakthrough thrombosis extension on anticoagulation (although was subtherapeutic INR on admission) → ? malignancy. Were wondering if biopsy sent. Mr. Oric said appendix sent for pathology. If negative, they advised PET scan sometime down the line once she has recovered from surgery and any ongoing infection. Given possibility of underlying malignancy and thrombosis extension on warfarin, would not advise to restart warfarin. Keep on LMWH for now → enox BD or can switch to tinza daily if renal function remains ≥ 30 and low bleeding risk. Spoke to reg (Clodagh) regarding abx given temp spike and ↑ CRP. As WCC ↓ and no source, advised to continue Tinza for now. If additional temp spike → start mono + vanc +/- gent.	
		Lili 404731



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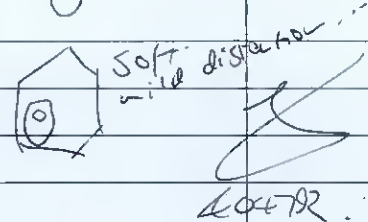
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4/5/21	Physiotherapy /cont...	
3.15pm	Rx: mob & Aol + Aol to hold attachments 10M.	
	A) Pt managed well, keen to get attachments removed.	Helen Frame -
	P) Continue mob Px as able.	HELEN FRAME (SHSW)
05/05/21	<u>W R Sallow</u>	
09.00	NEWS - 2 - 107/72, HR 102 Switched to meropenem + vanc yesterday as per micro. (See chart) Good urine out put Stomach - 400mls - liquid Feels a bit better than yesterday.	
	<u>Plan</u> ① FUL ② Overprone BD ③ Continue abx.	
5/5/21	Physiotherapy seen at 3:25pm, notes at 3:40pm ⑤ Patient consented to input, happy to do more walking px. Normally ① mobile & no aids, adl's, 8 stairs outdoors, 2 rails present, nil inside ⑥ Patient ^{perkins} lying in bed, catheter, IV fluids, drain in situ LTS achieved & min Aol, used arm chair of chair. STS ① Mobilised & 2wuf achieved ① approx 20-25m, needed Aol & attachments, had a reciprocal gait, slow but steady. Stand to lie ① Rx ① bed mobility ② Mobility px & 2wuf. ③ Patient requiring Aol & attachments, is ① & 2wuf, managed to walk a longer distance today. Patient again expressing removal of & catheter, advised it was the doctors decision ④ R/V 1/7 Aim ① & no aids when attachments come off ? stick Stair px when able.	



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05/05/21	NR hr 5040L NEWS-1 - HR 62 bpm Albumin - 19 CRP 240 ↓ Ua 17 ↓ Stool + MSU - negative Blood culture - negative - 7 pending - on meropenem - on enoxaparin 30 - High Stone output - 1800 - E+O well - mobilising Plan? ① oral enoxaparin ② discuss with uro re length of treatment ③ Add Colicine 3mg TDS ④ Log bag for catheter	
6/5/21	Physiotherapy PT. S.A politely declined physiotherapy @ 13⁴⁵ pm as currently on phone with family. C. NA A. Unable to engage patient in rehab at present P. Winter will attempt to re-engage patient again this afternoon or in 7. Note PT input currently limited due to allomants and catheters in situ. Encourage patient to mobilise on ward as able with N/S + wheeled Zimmer	 with distal soft <i>[Signature]</i> C. Mander C. Mander (BSP)

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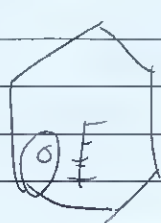
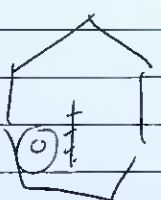
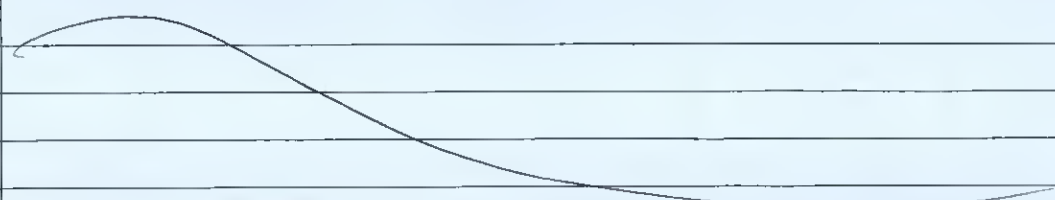
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06/05/21 14:30	WR Mr Dick: Patient alert + well. - High stoma output - Stoma pink + functioning - contents of stoma = liquid  Plan: ① Continue out. ② Add loperamide for 2mg TDS ③ Continue abx for now.. ④ Con portfolio. ⑤ Drain out.	
06/05/21 15:24	FZ Bird-Hodson: discussion with micro - advised treatment of 7/7 duration with 17% be adequate..	
7/5/21	WR Mactier NEWS = 4 BP 98/72 HR 118  soft, mild tenderness Stoma - 300ml since yesterday (on codeine + loperamide + PPI) Feels ok - eob - still do some abdo pain - only str morphine if requiring a lot of analgesia 	

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Date/Time	Multidisciplinary Clinical/Continuation Notes	Signature/Designation
7/5/21	Physiotherapy 9⁵⁰ am S. Verbal consent obtained. Pt Reports has been mobilising on ward with wheeled Zimmer with nil concerns. Mobility still limited @ times 2 ongoing Abdo pain O. Tympanum been on around, abt & Abdo drain bag in situ Due to Sitting: Min tol Sitting Δ: Independent Set to Stand: Independent. safe and steady on Standing Δ: Independent unaided. very mild supraclavicular Sway after >3min Mobility: Minimal for Elbow crutch Medicated ~15 mins safely on ward Assistance only required for management of drain bag Repositioned Rx ① Assisted Elbow crutch x1 ② Mobility practice $\pm$ E/c ~15m A Mobility improving with med. Safe to mobilise with Elbow crutch $\pm$ minimal tol f Review as able to progress mobility aim indep $\pm$ +/- E/c.	
8/5/21	Mr <u>Kathen</u> 0938 Post op right hemi 28/4 On Tx dose enoxaparin for SMV thrombus. On IV abx till 11/5 NEWS=2 apobnile Feeds 'alright' HR 122 Stoma producing a lot. Plan ① ENSURE on loperamide ② Recheck HR $\rightarrow$ if persistent needs ECG ③ Aceurate stool	L. WADDELL (BSPT)

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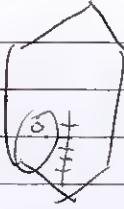
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	<u>9/5/21</u> <u>WR Kettel</u> Feeling OK. E+D. NEWS 2 Stoma → 750ml volume ↓ on loperamide + codeine Emphasised importance of being mobile. Plan: > r/v need after dx tomorrow > Stoma needs to be less active before (H) and ↑ fitness. ② 2000	
10.5.21	5) Pt agreeable to Rx @ 9am 9.15am 6) Pt lying in bed. Lie → sit → stand (I) to elc mob c̄ elc 50M around ward (I) reciprocal step pattern, steady pace, safe turning Rx: mob c̄ elc (I) 50M, mob c̄ no aids 5M, felt tired + wanted elc for security but managed to mob (I) A) Pt keen to get home, mob c̄ elc (I) can mob (I) when not tired. p) Continue to mob c̄ elc to toilet + short distances. Aim to mob (I) tomorrow.	Helen Frame HELEN FRAME (SHCSW)
16/05/21	<u>WR Mr Thompson</u> NEWS - 4 - MR 131, GP 101/62,, (R) Hemicolectomy.. SMU from bus → on enox 30 on IV ubx for 7/7. ~12 days post op. Plan: ① Hold f/Stops out today ② Ech. ② Acutely measure stoma output ④ ? (H) 24-60L	

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Date/Time	Multidisciplinary Clinical/Continuation Notes	Signature/Designation
11/05/21 09:00	WR Mr Thompson; NEWS 2 - FLL 126 VRE positive. Snu thrombus (2) Hemicolectomy CRP 82. (WCC + neutro (N)) Stoma feels like its tightening up Stoma out put ~ 200mls overnight. Pt looks well. Plan: ① Leave remaining staples in for now - (4) tomorrow. ② Close Swab. of wound. ③ finish course of abx ④ Close with haematology regarding outflow ⑤ Out patient flexing  Soft. 404272.	
11/5/21 12:45	Physiotherapy/PT. S. Verbal consent obtained. Note Patient now in suite room as VRE +ve. Pt reports managing 'well' on feet and no longer requires elbow crutches. ① Lying in bed on armbar, able to sit. Lie to Sit: Independent Sitting Balance: Independent Sit to Stand: Independent Standing Balance: Independent Mobility: Independent - nil aids. Perceptual eval - inadequate for clearance. Mapped ~ 30 mops surgery in assessment. Safe and steady Rx, Mobility remain w/x A, Mobility remains @ Baseline. Able to mobilise moderate distances with nil aids. P, Stairs practice for 7 then discharge of nil issues from OPT.	

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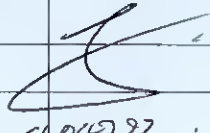
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11/05/21	<u>f1 3rd Med.</u> OP Flex Sig request sent ✓ O/w haematology on call. Advised pt is to remain on chemo for now as it is unsafe to go back onto work. It can be considered whether to switch to AmZ for going with. Advised they would push forward the bone marrow samples for ? malignancy and would call back today/tomorrow with advice. Hold off PET scan for now until we know bone marrow results. If no call back by tomorrow IL contact <u>haem</u> . Plan: ① Pt switch to AmZ 10,000 units SC from tonight	 204992
12/5/21 09:05	<u>we pick</u> weel this morning E+D Mobile Stanna making Note dlu haem - chase BM biopsy Plan: IP OAD tomorrow Liaise e haem re timing of PET CT Clips out	 204992

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Date/Time	Multidisciplinary Clinical/Continuation Notes	Signature/Designation
12/5/21	Physiotherapy, seen at 9:00am, notes at 9:22am ① Patient consented to input, seen in Helen Frame BSPT assistant. Confirmed has 8 steps outside in rail present, nil stairs inside ② Patient lying in bed LTS achieved ①, abid effortful but managed SFS ① Mobilised in no aids achieved ① approx 10-12m, reciprocal gait, cadence slow but steady. Stair px achieved 11 steps ↑ + ↓ achieved ①, used 2 hands in rail, ↑ SOB but managed, had a standing break at top of stairs Sto Stand to lie ✓ ① ① ① Bed t/f px ② Mobility px in no aids ③ Stair px in 1 rail ④ ① Patient ① ly mobilising in no aids, and ① + safe on stairs. Patient happy to take crutch home for long distances, daughter going to live in her for a while to help if needed. Has no concerns or issues for ①. ① ① D/C from PT	Karl Stummer KARLSTUMMER BSPT
12/5/21	<u>F4141</u> Spoke to Helen Carr (Dr. Mitchell). Mammogram + trephine not back yet. As for timing of PET scan → delay 2-3 weeks post-op but generally takes 2-3 weeks to report date so could order it now.	L. Leis 404739



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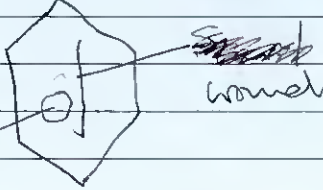
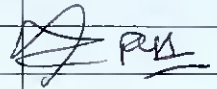
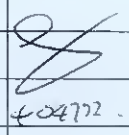
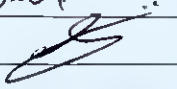
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13/11/21	WR Thompson Port BCR, NEWS = 3 BP = 109/63 HR = 117 Pain improving. feels bag contacty wound least remaining clips in today and out tomorrow. Bag  See haematoma in wound. Plan: 1 - Send PET CT report over 2 - Repair Wounds ? 1.00XT. 3 - Await heparin/fapinate for BM. 4 - Await OAD.	
14/05/21	WR Lawson: NEWS-4 - SpO2 95%, BP 110/61, HR 111. CRP ↑ on 7U abx SMV Phrombus - on Hnz PET requested ETO ok Plan: ① continue abx - 1.00XT ② Await Scope + PET ③ Await bone marrow	
14/05/21	F1 Birch-Lahr: OIS discussion with Dr. Brooke regarding abx therapy. In light of pt being clinically well... and CRP stable. no need for further abx at present.	

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Date/Time	Multidisciplinary Clinical/Continuation Notes	Signature/Designation
4/05/21 0935	Infection Prevention and Control - VRE isolated in swabs sent on 04/05/21. Please monitor for any loose stools or any clinical signs of infection.	IPCN Dunnead
15/5	<u>MR Anderson</u> Stoma working Haemorrhagic fluid from wound site & feculent matter near incision but can't tell if from stoma bag or wound. ↳ Dressing on first → then stoma bag	
	<u>Plan</u> - awaiting OGD next week - monitor wound site	
17/05/21 09:00	<u>MR Thompson:</u> NEWS - 2 - a general up + walking... wound doesn't appear to be leaking, a little open at infero aspect. Lost had food last night. <u>Plan:</u> ① Remove staples + redress ② Await OGD ③ Swab bottom of wound. ④ Likely ① 24-48hrs	W. L. L. L. SMT. 404722.

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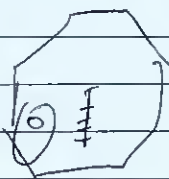
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Other: Ward:

Locality/Team:

Multidisciplinary Clinical/ Continuation Notes

Sheet No:

Date/Time	Multidisciplinary Clinical/Continuation Notes	Signature/Designation
18/5/21	H. NEWMARK FEL	
	ⓈⓈ Ⓢ hemi + end deconvolvement for various schennum ↓ NEWS 4 : Sat 957 on RDA BP 100/66 Ayrcaial Pulse 104 CAP 102 (107) Abx run stopped WCC 6.2 (6.9) O/E  SMT Staples now removed Wound discharging small amount from inferior part Plan OGO today - currently NBM Chase micr ⓈⓈ tomorrow with RDA as previously organised PET + fleri sig as previously organised	
18/5/21	H. NEWMARK FEL	
14:20	D/Lr Endoregry - Pt is on the list however will not happen today due to emergency bleeders Pt can E&D. Fast again from midnight! Could the scope be done as an urgent outpatient? It needs input from other Dr Clarke.	

Date/Time	Multidisciplinary Clinical/Continuation Notes	Signature/Designation
19/5/21	HR Thompson (ST3)	
09/5	NEWS = 3 HR 105 BP 90/60	
	CRP 102 (107) WCC 6.2 Hb 80	
	Well today	
	Mobile. E&D. Managing stoma	
	Still awaiting OGD.	
	Bottom of laparotomy wound has dehisced superficially	
	 soft no tender.	Sited pending 17/5/21 no graft 15/5/21
	Plan: If OGD not happening today change to urgent OP. Will need colonoscopy with enema. PET CT in a couple of weeks. CTAP today given static CRP & wound ? deeper collection. Aim @ femoral with DNs to manage wound.	
		 Thompson (ST3)

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Locality/Team: WARD PT

Multidisciplinary Clinical/ Continuation Notes

Sheet No: 1

Date/ Time	Multidisciplinary Clinical/Continuation Notes	Signature/ Designation
17/5/24	REMOVED, REMAINING CLIPS REMOVED, (11) WOUND CLEANSSED WITH SALINE POLYMEM APPLIED TO SLOUGHY AREA AND A LARGE URGOTUL APPLIED FOR ABSORPTION + PROTECTION. SWAB OBTAINED FROM BOTTOM OF WOUND FOR MICROBIOLOGY, NO PRESENT CONCERNS ———	JM
17/5	ISABEL WAS FASTING FOR AN OGD TODAY HOWEVER, IT WAS CANCELLED. TO FAST AFTER BREAKFAST TOMORROW FOR OGD. LIGHT BREAKFAST ONLY. NEWS STABLE + ALL MEDS ADMINISTERED AS PER HEPMA. FOR OUTPATIENT PET SCAN, NO ISSUES AT PRESENT ———	JM
17/5/24	Isabel appears settled, obs charted, and no medication given as per hepma. Wound redressed prior to settling, no issues. Slept well overnight. Fasting for potential OGD later today. No contact with relatives.	J
17/5/24	Seen by stoma care nurse appliance reviewed under supervision. Coped well. Stoma healthy, peristomal skin improved, now intact. Active of faecal fluid, still using a convex appliance. Settled at present.	I. Robertson
18/5 1330	Isabel has been fasting for OGD. All meds administered as per hepma. Obs stable & charted Able to manage stoma independently. Speaking to stoma nurses to discuss discharge. Stoma nurses will provide Isabel with discharge pack and arrange for an follow-up	GO/be
18/5 1830	OGD now cancelled for today. To fast from midnight for OGD tomorrow.	GO/be

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Date/Time	Multidisciplinary Clinical/Continuation Notes	Signature/Designation
18/5/21 N/D	Isabel settled + stable overnight NEWS - no changes, same ongoing issues. Independent with stoma, no complaints offered. No contact with family.	CR
07.55 19/5/21	Seen by Stoma care renewed appliance under supervision, coped well. Stoma healthy, active faecal fluid. Lots of flatus in pouch. I have suggested may be due to fasting however going for OGD today. Settled at present.	I. Robertson
1825	Isabel has been settled today. Obs as charted and all meds administered as prescribed. Started on IVAB (Vanc and Meropenem) as CT showed collections. Awaits OGD. No new issues reported at this time.	DR
N/D	Isabel settled + stable, NEWS 3. No new issues, uncomplaining. No contact with family.	A
20/5/21 0940	SIB Stoma Care Nurse - independent with stoma care. Appliance not renewed today. Active faecal fluid + Isabel emptying independently. Supps given Isabel fasting for OGD news 4 due to BP + HRA. OGD cancelled. Encouraged oral intake. News 3. SIB surgical team - made aware of news, 'commenced' on IVF for OGD as dp. Discussed with radiology for drainage of collection awaiting ckt/time from radiology. Isabel aware of same. IVF in progress. To continue IV vanc - for level before 2m dose.	fluo
14 ⁰⁰	IVAB now changed to IV Co-amox (due tonight)? await drainage of collection	NK.
18 ⁰⁰		



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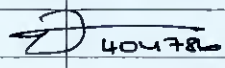
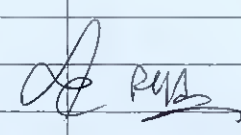
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Other: Ward:

Locality/Team:

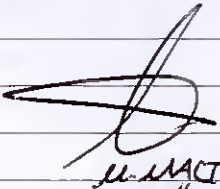
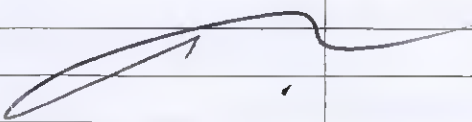
Multidisciplinary Clinical/ Continuation Notes

Sheet No:

Date/Time	Multidisciplinary Clinical/Continuation Notes	Signature/Designation
19/5/21	H. Talwar FY1	
17:50	Phone call from Ms Macleod regarding CT AP results. Report: new peripherally enhancing collection of gas + fluid at in pelvis adjacent to @ hemicolectomy suture line. ↳ report printed & placed in notes. Plan from Ms Macleod: 1) Restart abx ☒ 2) Put out for coag tomorrow ☒ Most recent previous abx = meropenem + vancomycin as per micro advice as pt VRE +ve. Ms Macleod advises restart merop + vanc & then d/w micro tomorrow.	 404786
20/5/21	WOL MHAFTER FOR DICK, Discussed collecta in drained cavity & explained the plan to discuss options w/ Mr Dick. Discussed the possibility of draining collecta w/ antibiotics alone. Otherwise well. Swabs, mobilising well. Plan, 1 - Discuss plan w/ Mr Dick 2 - D/w micro	 PMS

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Date/ Time	Multidisciplinary Clinical/Continuation Notes	Signature/ Designation
20/5/21 1430	ST2 <u>MACTEC</u> following d/w Mr Dick, I have discussed with IR re drainage (Dr Reuben). → High risk due to proximity to bowel. → Unable to fit on list tomorrow as patient VRE ⊕ & other patients on list chemotherapy patients; no time for room cleaning. → Advised cons. mx @ present & rescan/ re-discuss next week. Patient & NS informed of plan. Ryan (FY1) will have with microbiology re abx therapy.	
21/5/21 0900	WRE Maxon STST Newmark FY2 Above with Plan from mms for augmentation but to start lack of clinical change. News 3 (Sept 91 11/27). Otherwise well. Plan for conservative management over weekend & reassess on Monday.	 M. MACTEC #407906
27/5/21	WRE Andrew, Col. abx - Mark Woods	 Andrew



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Multidisciplinary Clinical/ Continuation Notes

Sheet No: 2

Date/Time	Multidisciplinary Clinical/Continuation Notes	Signature/Designation
21/5/21 0200	Isabel Settled. obs stable, NEWS 2 due to ongoing hypotension + HR 94. IVF + IVD given up to date. No Gd pain. Dressing intact. No family contact overnight.	
1315	Isabel has been stable today, obs stable & charted. Independent with stoma care, due for OAD today. Wound dressings are dry & intact, will redress after OAD.	
21/5/21 1845	attended OAD - Gastritis S/C 1/2 Stoma on return. No contact from family.	
21/5/21 NO	Isabel settled overnight, obs stable. Ind. with stoma care. No new issues. All meds + I/VAB given as charted.	
22/5/21 1245	Isabel news score 2-4, continue to monitor. meds as per hepma. Seen by surgical team - continue AB awaiting new Venflon. I/VAB as per P.T. Dressing intact Stoma active.	
1910	No contact from family.	
22/05/21 (NS)	Observations stable, apyrexial NEWS = 3 Due medication given. No pain, No nausea reported. Dressing dry + intact. Stoma self care with. Nil issues raised. Independent + self caring with AB's. Slept fairly well. Voiced nil concerns. Settled + comfortable night. Nil contact from family/friends.	
23/5/21 1020	Isabel settled today. obs charted NEWS ③ due to hypotension - encouraged oral fluids.	

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Date/Time	Multidisciplinary Clinical/Continuation Notes	Signature/Designation
23/5/21 10 ¹⁰	Meds given as pxd. Diet + fluid taken. No complaints. Independent with personal care. NR - Cont IVAB for conservative management of collection. Not for drainage at present. Settled night. Slept well. No new issues. No contact from family.	NR
24/5/21 10 ¹⁰	Seen by Stoma care nurse self caring with stoma. Reviewed appliance under supervision, copied well. Stoma healthy, flush with peristomal skin which is intact. Active of faecal fluid. NS m'Cracken states she is only emptying her pouch 1-2pt/day and it is active of thick faecal fluid. She is aware what output should be like. Supplies given. Hoping for discharge home.	1 Robertson
24/5/21 1608	Isobel Settled today. As charted. NEWS 2. Meds given as pxd. Diet + fluid taken. No complaints. NR - ? Hem tomorrow ? IVOST. Await blood results ? CT as OP.	
NS.	Isobel Settled + uncomplaining. IVAB given up to date. No new issues, no family contact overnight. ? home tomorrow.	
25/5/21 10 ¹⁰	Isobel has been reviewed by surgical team this am. For discharge to home with Tinzaparin. For 2wks OAB. For follow up at Mr Dicks clinic in 2wks. Has CT Scan appt at Graftonville - Isobel is aware of this and can get her brother or law to take her. DV Referral to be done for midline wound dressing. For OP Scope - will be sent appt in post. Obs as charted and all medications administered as prescribed.	J, SW

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Multidisciplinary Clinical/ Continuation Notes

Sheet No:

Date/Time	Multidisciplinary Clinical/Continuation Notes	Signature/Designation
21/05/21	Mr Sharma Stable. Continue IV abx over weekend. BP low. Plan 1) continue IV abx 2) Prim oral fluids. Rhepat	
24/5/21	MR THOMPSON Bloods noted, inflam markers ↓. CT from last week noted. Pain free, E+D well. mobilising Stoma working well Plan 1) liaise w. MD for ? d/c w. long term PD abx 2) ? push-back PET scan until collection settled 3) Am @ 8001. 4) Continue IV abx for now. 421780	
24/5/21	MR. Dick 1015am - A. well. - Note xray drainage not possible due to results based - A given to be given to CMTL - Note OAD on fluids → Bil. gals only Mr - taken back if in per (T) st for CT PET on nurse - will need at least 1/2 weeks	

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Date/Time	Multidisciplinary Clinical/Continuation Notes	Signature/Designation
24/5/21	<u>FY1 Bee</u> FY1 Talwar informs me that surgical reg JOSH has requested she is d/c with 2/52 of antibiotics.	
25/5/21	<u>WR THOMPSON</u> Feeling okay in self. E+D well Wound okay managing w- dressings Isabel happy w. plan <u>Plan</u> 1) IVOST 2) (H) today 3) will need treatment dok daltapain @ (H). → Nurses will teach the patient 4) 2/52 PO abx at d/c 5) Keep PET scan apt for thursday 6) Flu in 2/52 @ Mr Dick's clinic 7) DN referral for twice weekly dressing changes/wound care.	<u>Bee</u>
25/5/21	<u>H. Talwar FY1</u> 16:30 phone call w. Dr Betts (Haem consultant) re: BM biopsies + haem flu. she is aware of pt's case I advised of results pending she is aware + thinks one of the consultants is processing. she will check w. the team that they are being done + they will liaise w. genetics lab if cytogenetics required. she will also arrange for haematology flu in 4-6 weeks after her PET scan. I will put this in d/c letter.	<u>40478</u>

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Multidisciplinary Clinical/ Continuation Notes

Sheet No:

Date/Time	Multidisciplinary Clinical/Continuation Notes	Signature/Designation
25/5/21 12.25	Seen by Obama care nurse Isabel has independently removed her own pouch. Supplies given for discharge home. I have given her written information relative to surgery, contact numbers and follow up advice. She is aware of output consistency for verbal via video at Obama clinic 11.6/21, will phone us prior to this if need be.	Robertson
25/5/21 10	Isabel discharged to home. Script given. Venflon removed. Daughter picked Isabel up.	OR

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Critical Care Units Multidisciplinary Admission Record

Preferred name: 1221e	Next of kin Relationship Address:
Phone - Day: ☐ N/A - Evening:	Postcode: Phone - - E
Age: 52 Occupation: Works from home?	Other contact Relationship Address:
Does the patient have any spiritual or religious needs? ☐ Yes ☐ No If yes, details:	Postcode: Phone - - E
GP name: Address: Waverly Medical Practice, Coatbridge Postcode: Phone number: 01236 422311 Fax number:	
Relatives present? ☐ Yes ☐ No	Relatives contacted? ☐ Yes ☐ No

Admission to Critical Care

Admission date: 28 / 4 / 21 Admission time: 24 : 00 (24 hour) Admitting specialty: (specify) GENORL SURGERY ☒ Consultant informed of admission by: (signature) Referring consultant: DICK Admitting consultant (ITU): GUHA Admitting SHO: Admitting nurse:	Diagnosis: BILIARY COLIC Allergies: ALLOPENAL Height: m Weight: kg
--	--

Clothing and valuables with patient? ☐ Yes ☒ No If yes, specify what was done with them:

Lines on admission:

Urinary Catheter

Date inserted: / /	Size: 12ch
Type: IDC	Inserted: ☐ In ICU ☒ Outwith
Admitting nurse signature: Cath O'Brien	Designation: RGN

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History and Examination

Presenting complaint

post op emergency $\textcircled{R}$ hemicolectomy +
end ileostomy

History of presenting complaint

1 month ago diagnosis of superior mesenteric vein thrombosis $\rightarrow$
worsened. Presented ~~with~~ with worsening pain. INR 8 $\rightarrow$
reversed, given tinzaparin last night. CT showed gas in mesenteric
venous system + power enhancement of bowel $\rightarrow$ laparotomy.

Previous medical history

At laparotomy mesenteric mass could be felt - ? thrombus
Appendix abnormal & adherent to intraabdominal structures (when
large volume peritoneal fluid - ? reactive, not faecal.
One brisk bleed intraop, probably less than 500ml.

Pac of Hb 63 - transfused 2 units CRBC + 1 further unit
intraop.

Personality disorder

Family and social history

Examination on admission

Cardiovascular system

1-1-0 98/76 WHR

Respiratory system

O₂ 100% on 2L nasal + ch

Gastro-intestinal system

abd. clg, stmpink

Central nervous system

ACS 16

Genito-urinary/Renal system

cdv.

Drug history and current medication on admission to hospital

Wartan
Citalopram
Quetiapine
Narapam

Drug history and current medication on admission to ICU

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Problems:

1. post op haemorrhage
2. ? intra abdominal malignancy
3. superior mesenteric vein thrombosis
4. antiwaragulant suspended
5. anaemia
- 6.

Adults with Incapacity?

☐ Yes ☐ No

DNACPR?

☐ Yes ☐ No

Hospital Anticipatory Care Plan?

☐ Yes ☐ No

Plan:

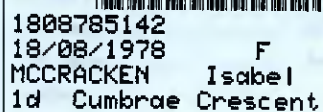
(tick when completed)

1. Prescribe drug prescription form ☒
2. ECG ☐
3. Chest x-ray ☒
4. FBC, Coag, U&Es, LFTs, Ca, PO4, Mg, ☒
5. Pregnancy test (blood) ☒
6. Prescribe fluids ☐
7. Are lines/drains/intubation required?
Record site and technique below ☐
8. Prescribe insulin as per protocol ☐
9. DVT prophylaxis as per protocol ☐
10. Stress Ulcer Prophylaxis as per protocol ☐
11. Feeding plan as per protocol ☐
12. Spoken to relatives?
Get background history
Fill in family communication sheet ☐

13. Antiwaragulant plan to be discussed with surgeon in am. ☐
14. free fluids overnight ☐
15. ☐
16. ☐
17. ☐
18. ☐
19. ☐
20. ☐
21. ☐
22. ☐
23. ☐

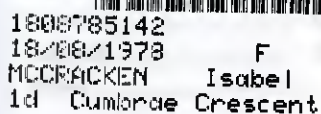
Admitting SHO Signature:

PRINT NAME:



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		08	09	10	11	12	13	14	15	16	17	18	19	20	21	22
-FiO ₂																
Vent Mode																
IMV Rate																
Rate																
SpO ₂																
TIDAL Volume																
Minute Volume																
PC/PS																
PEEP/CPAP																
Airway Pressure																
ET CO ₂																
Tracheal Secretions																
Cuff Pressure																
Air Entry R/L																
Chest Drains	Swinging															
	Bubbling															
Pain Score																
RASS Score																
CAM ICU																
Bundle Check																
Blood Pressure	Temperature	Pulse	40°													
			200													
			39°													
			180													
			38°													
			160													
			37°													
			140													
			36°													
			120													
			35°													
100																
34°																
80																
33°																
60																
32°																
40																
Cardiac Rhythm																
MAP																
Blood Glucose																
Insulin (units/hour)																
INOTROPES																
Pt/bed Position																
Optic/Oral Hygiene																
Mouth care																
Mobilisation																
Staff Initials:																

5L	2L	2L	2L	2L	2L	2L	2L
F/M	N/C	N/C	N/C	N/C	N/C	N/C	N/C
13	16	10	17	25	24	22	9
100/	100/	100/	100/	100/	100/	100/	100/

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Ventilation

Air entry: 

H = Harsh
Q = Quiet
W = Wheezy
Tick (✓) if air entry present

Tracheal Secretions

1 = Scanty M = Muroid
2 = Moderate B = Blood stained
3 = Profuse P = Purulent

Patient Position

1 = 45° head up 4 = Left
2 = Supine 5 = Right
3 = Prone 6 = Out of bed

Mobilisation Codes

D = Dangle S = Stand
C = Chair W = Walk

Notes

✓	✓	✓	✓	✓	✓	✓	✓
0	0	S	S	S	S	S	1
0	0	S	S	S	S	S	0
we							
36.7	36.6	36.5	36.5	-	36.6	-	35.7

99	98	104	90	93	99	96	94
99	99	92	92	90	86	90	83
✓	✓	✓	✓	✓	✓	✓	✓
61	69	70	65	68	61	59	68
SR	SR	SR	SR	SR	SR	SR	SR
79	84	86	75	74	78	76	77
5.2						8.1	

145 545 545 545 545 545 545 545

on on on on on on on on

	Day	Night
Pupils reacting? (tick if 'yes')		✓
ID band checked? (initial for each shift)		CM

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Fluid Intake

Previous day:				Fluid in:				Fluid out:				Balance:			
Time	Flush	IV	IV	IV	IV	IV	IV	IV	IV	IV		Naso-Gastric	Oral	Total	Accumulation
0800															
0900															
1000															
1100															
1200															
1300															
1400															
1500															
1600															
1700															
1800															
1900															
2000															
2100															
2200															
2300															
2400	3												3	3	
0100	3													23	26
0200	3													107	113
0300	3													75	188
0400	3													109	297
0500	3													81	378
0600	3													72	450
0700	3													324	774

IV Fluid Prescription Chart

	Date	Fluid (BLOCK LETTERS)	Vol (mg)	Route	Duration	Signature	Serial No.	Given by	Start time	End time
		Additive Medicine	Dose (mg)							
1	18/08	0.1g/kg fclt. dextrose	1000	IV	60-80					
2										
3										
4										
5										
6										


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Fluid Output

Time	Drains			Bowels	Urine	Gastric	UF Volume	Total	Accumulation	Balance	Notes
	1	2	3								
0800											
0900											
1000											
1100											
1200											
1300											
1400											
1500											
1600											
1700											
1800											
1900											
2000											
2100											
2200											
2300											
2400					20			20	20	-17	
0100					30			30	50	-24	
0200					55			55	105	+8	
0300					45			45	150	+38	
0400					70			70	220	+77	
0500					60			60	280	+98	
0600					60			60	340	+110	
0700					100			100	440	+334	

IV Fluid Prescription Chart

	Date	Fluid (BLOCK LETTERS)	Vol (mg)	Route	Duration	Signature	Serial No.	Given by	Start time	End time
		Additive Medicine	Dose (mg)				Batch No.			
7										
8										
9										
10										
11										
12										

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Coatbridge
Lanarkshire ML5 4PX

Evaluation of Nursing Care Plan

Initial for shift as applicable » D N

Respiratory: (as per protocol)

Patient on SL na face mask on admission. Changed to 2L na nasal cannula. Remains on N/C for the purpose of PCA. Respiratory rate stable. Sats >98%. Not coughing or expectorating.

cm

Cardiovascular: (as per protocol)

3xPRC given 28/4 out with unit. No post op 9.9 Magnesium 0.55 - mg⁺ replaced. Arterial line inaccurate - manual bp carried out. Apyrexia.

cm

Nutrition/Hydration: (as per protocol)

Allowed oral fluids only. NG remains on free drainage. Patient attempting to remove NG explained that it would have to be in situ until surgical team suggest otherwise.

cm

Renal/Elimination: (as per protocol)

Bowels opened	Yes	No	Formed	Soft	Loose	Days since BO	Nos of BM	Lax	Sample sent
Day				Stoma					
Night									

Fair urine volumes. Stoma pink warm faecal matter present.

cm

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Evaluation of Nursing Care Plan (continued)

Initial for shift as applicable ► D N

Pain/Sedation: (as per protocol)

PCA instu, commenced in ward. Re-education given - patient now using well. Paracetamol given. ORASS - O Alert and orientated.

CM

Mobility/Hygiene: (as per protocol)

Pressure Ulcer Risk Assessment - frequency: 4 Standard
Surface - ensure appropriate and functioning - on Standard mattress
Skin inspection - check and document if damage present
☐ Heel protectors ☒ Flowtrons

Skin intact. Regular pressure area care given. Mouthcare not given at night as patient refused. Patient wants to brush own teeth when up to sit this morning.

CM

Wound/Wound drain: (as per protocol)

Malecot drain instu. Midline wound clean dry and intact.

Psychological/Neurological care: (as per protocol)

All care explained, reassurance given.

CM

Other:

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☐ Hairmyres ☐ Monklands ☐ Wishaw

Ward:

NHS
Lanarkshire

MRSA and CPE Clinical Risk Assessments

MRSA CLINICAL RISK ASSESSMENT (Meticillin-Resistant Staphylococcus Aureus)

- To be completed for all ACUTE admissions.

- Do NOT complete for admissions to Maternity, Neonatal, Paediatrics, Mental Health

Yes No

1. Has the patient any previous history of MRSA? – ask the patient and check Track Care, Labs
2. Has the patient been admitted from anywhere other than their own home (e.g. prison, homeless hostel, resident in a care home) or transferred from another hospital?
3. Does the patient have any wound(s)/ulcer(s) or indwelling device (e.g. peg tube, urinary catheter) which was inserted before admission?

☐	☐
☐	☐
☐	☐

If **YES** to questions 1 or 2 obtain nasal and perineal swabs. If **YES** to question 3 obtain nasal, perineal, device, wound swabs and catheter specimen of urine (CSU), where appropriate.

For patients admitted to Vascular, Orthopaedics, Renal and Critical Care (including attached high dependency areas) complete the Clinical Risk Assessment **AND** obtain nasal and perineal swabs.

MRSA Screening Swabs	Result	Isolation	Actions
☒ Nasal		Is the patient isolated?	If a single room is not available, a risk assessment must be undertaken and the Infection Prevention and Control (IPC) team must be contacted. Out of hours, the on-call microbiologist should be informed.
☒ Perineal		☐ Yes ☐ No	
☐ Wound(s) - location:		If no, why not?	
☐ Ulcer(s) - location:		☐ Not applicable	
☐ CSU		☐ Not available	
☐ Throat		If unavailable has a clinical risk assessment been undertaken?	
☐ Other: (specify)		☐ Yes ☐ No	

PRINT NAME: C. Markey

Designation:

Signature: 

Date: / / Time: :

FOR PATIENTS WHO ARE MRSA POSITIVE: decolonisation treatment to be carried out and patient re-swabbed as per MRSA Policy, Control of Infection Manual (access manual via FirstPort)

CPE CLINICAL RISK ASSESSMENT (Carbapenemase Producing Enterobacteriaceae)

- To be completed for admissions to all specialties

Yes No

1. Has the patient been previously confirmed CPE positive at any time?

☐	☐
--------------------------	--------------------------

In the past 12 months:

2. Has the patient been hospitalised outside Scotland?
3. Has the patient had holiday dialysis outside Scotland?
4. Has the patient been in close contact of a person who has been colonised or infected with CPE?

☐	☐
☐	☐
☐	☐

If **YES to any question**, the patient is at increased risk of CPE carriage; swab(s) should be obtained, patient isolated and IPC Team informed. Obtain **rectal** swab **OR** if swab not taken, obtain **stool sample**. In addition, for patients with a urinary catheter insitu, obtain **CSU** and if has wound(s) obtain **wound** swab.

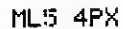
CPE Screening Swabs	Result	Isolation	Actions
☐ Rectal		Is the patient isolated?	If a single room is not available, a risk assessment must be undertaken and the IPC team must be contacted. Out of hours, the on-call microbiologist should be informed.
☐ Stool sample		☐ Yes ☐ No	
☐ Wound(s) - location:		If no, why not?	
☐ CSU		☐ Not applicable	
		☐ Not available	
Reason for not swabbing:		If unavailable has a clinical risk assessment been undertaken?	
		☐ Yes ☐ No	

PRINT NAME:

Designation:

Signature:

Date: / / Time: :



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CCU Monklands Multidisciplinary Admission Record | Acute Care Services | NHSL | Page 16 of 16 Pub. date: Sep. 2018 | Review date: Sep. 2021 | Issue No: 02

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Ward: 26

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Critical Care Units Multidisciplinary Progress Record

Date: 30/4/21 Age: 42 Date admitted: 29/04/21 Day number: 2

Consultant:

Reviewing ITU Consultant:

Tubes and Lines

Position and Days in situ	CVP:	Arterial: R Radial (3)	Dialysis:	Urinary catheter: (3)
Tracheal Tube:	Size:	Position at lips:	Days in situ:	

Diagnosis

SMV thrombosis

Day 2 post op R hemicolectomy
+ end ileostomy

General condition/Changes in last 24 hours

UF heparin infusion - pTR 1.3 this AM.
Radial line replaced overnight
Pain reasonably controlled.

Cardiovascular

HR/Rhythm: 97 sin CVP:
BP (S/D/M): 107/59(77)
Cardiac output
Murmurs? 1+1+0 New?
Lactate? 2

Drugs: Nil

Oedema-peripheral/sacral Nil
Peripheral perfusion: Hands Feet WWP

Respiratory

Examination



Ventilation

RR 14
VT
PEEP
PAP

Oxygenation

FiO2 2L O2 NC
SpO2 98%
PaO2
PaCO2

Gastro-Intestinal

Examination

Stoma
working,
looks
healthy



BS +ve
Abdom soft
No shakethrough

Nutrition
Prokinetic?
Insulin?

Eating small volumes; oral fluids

Bowels open/Diarrhoea?
Drains

IAP:

Gastro-Intestinal

UOP: 40-120ml/w

Last 24 hour balance: +ve 1275

Volume status

RRT

Neuro

E Spont
M Command
V Appropriate 15/15

Sedatives
Paralysis?
Sedation Score
Able to wake today?

New Neurology?
Pupils PEARL
Limb movement
Reflexes
Delirium? ☐ Yes ☐ No

Microbiology - sheet updated?

Antibiotic

Date Started

Other

Organisms isolated: (source and date)

1. Tarocin
2.
3.
4.
Temp. 36.7 CRP 115(↓)

1. Tarocin
2.
3.
4.

28/4/21

Signature: TRAIN FY1

Designation: FY1

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Medical Review

Adults with Incapacity? ☐ Yes ☐ No

DNACPR? ☐ Yes ☐ No

Hospital Anticipatory Care Plan? ☐ Yes ☐ No



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Problem:

1. Day 2 post op
R hemicolectomy + end ileostomy
- Stoma nurse r/v yesterday

2. Analgesia - PCA ongoing

3. SMV Thrombosis
→ ON UF heparin - ~~ACTH~~ PTR 1.3
(no bolus as per haem)

4. Tachycardia

5. ↑WCC (26)

6. ↓Mg (0.77 today)

7. Albumin 16.

8. Antibodies - requires crossmatch
+ blood PRC from Glasgow.

9. Sleepy - on quetiapine / citalopram /
diazepam

Pt's goals

10. - Up to sit
- Daughter to come in
with tastier foods

Plan:

→ Surgical r/v ✓

→ E+D as tolerated ± maintenance fluid
to ensure euvolaemia

→ ? tazocin stop date

→ Pain team r/v @
switch to s/c morphine

→ ~~tin2~~ switch - discuss w/ haem +
surgery ~~Abong~~ enox BD starting 6pm

→ Chase haem Ix + ? bone marrow
bx

→ ECG ✓

→ ON tazocin: monitor

→ ~~2 replace~~

→ ? dietician input if due course

→ Ensure cross matched + 2-3 units
available at CHM ✓

Target

SpO₂ 794%.

Map > 65

VO > 0.5ml/kg/hr (>30ml/hr)

Fluid balance ± 500ml

Verbally: Mr McDonald
agrees safest anticoagulant
is most appropriate

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Date/Time	Medical Progress Notes	Signature/Designation
30/4/21	W R MacDonald Progressing well remains sore - appropriate for operation stomach working and looks healthy. Question about anticoagulation. I think think the risks of further thrombosis outweigh the risk of further bleeding at this stage so anticoagulation should be continued. <i>[Signature]</i> COWS	
DAILY GOALS Diagnosis documented? YES/NO Sedation break Sedation target score: by hrs YES/NO YES/NO Ventilation/Resp goals documented? ARDS YES/NO YES/NO CVS Plan/goals documented? Fluid balance Target ml by ±500 hrs Can use diuretic? YES/NO Mobilisation plan documented Refer to decision making tool Any lines venflons put in outwith ICU? Venflons/Lines to be removed? Chlorhexidine gel prescribed BD? Changes to DVT prophylaxis? Changes to Stress Ulcer Prophylaxis? Ask team -anything else we should be doing? Verbal handover of goals Are patients own goals documented YES/NO/N/A - up to st YES/NO YES/NO YES/NO YES/NO YES/NO YES/NO YES/NO YES/NO/N/A EVENING REVIEW Daytime plan/goals achieved Ventilation/Resp goals documented? CVS Plan/goals documented? Fluid Balance ml Can use diuretic YES/NO YES/NO YES/NO YES/NO N/A Sat 94% MAP 705		

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Date/Time	Medical Progress Notes	Signature/Designation
30/04/21 13:30	Polio 154 HME (42) + Cephalexin → Admin = whole, Se 2i SMV (bacteria) late March / early April 2021. - established on receiving gtpentyl Ureure & dactyl - JAK2 / PAK-1, Thymidylate synthase Wally for (AKG (MVC-16), Wally for ACA (Gm) (on time & time of G- was likely - all reports in anti-β2 GPE gtpentyl hyperin) - CT N/T 12/04 → shift and (V), unj also (bacteria) CT AP 01/04 → initial scan (bacteria) No evidence sigmoid hyperin, unj, long lesions in CT 8g IgG PO for 06/04/21 → reported 27/04/21 e. auto-anti K AB: dactyl (proceedure however) (@ CH/31.1 / actus) - Reported 28/4 = 2/2 for g. whole Se, pnc, unsty & dactylate - (the 2 → 8 since PC in unsty (? 2 dactyl at K) - gain - vit K 27/4 e. the 1-1 on admin - CT gtpentyl show pyogenic (bacteria) of SMV/PA, e. gtpentyl of (bacteria) → surgical (bacteria) pyogenic (bacteria) e. (bacteria) / (bacteria) - Admin also ? act - Apperion appears extra-ep. about ? (bacteria) - low set for path. Now using in ITU & waiting to drain. → DTD	

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☐ Hairmyres☒ Monklands☐ Wishaw

NHS
Lanarkshire

Other hospital: (specify)

Locality/Team:

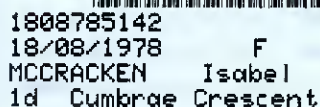
Multidisciplinary Clinical/ Continuation Notes

Sheet No: Ward:

Date/ Time	Multidisciplinary Clinical/Continuation Notes	Signature/ Designation
30/4/24 → atd	Parker JCU taken Dance request to rft sets / pins / right legs. No more (pymia) also / pins under for ble pin let ~ 2/2 22 weeks +- igate. Exhibit and for yellow Tx re: PEGPS in what pymia blinking (→ CPA/MN as skin) as evidence for blue cancer Consulted for same → pink (pym, bloody, igate, frequent ground / skin, yellow) exhibit & exhibit. Amor of 2 bloody only given on Vorn but not not PATE (1) e gently page to present in mental environment. Amor to present. Amor exhibit also e/pu for (dythre) who also agreed to present. BMA request → Amors, @ PEE 4.25 2% lab work Sydney exhibit → Aspire (for, respiratory, also / respiratory, genetics) Taylor Well blood. Respiratory symptoms. No immediate complications NO e/pu and e/pu - further follow-up e/pu for present status (further, anti-infectives) to be placed there to monitor Respiratory symptoms 2-4 weeks - if anything worsens we will ignore	

CHI no 1808785142
First no 18/08/1978
Last no MCCracken F
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Crescent
Coatbridge
Lanarkshire
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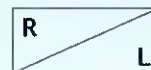
		08	09	10	11	12	13	14	15	16	17	18	19	20	21	22
-FiO ₂		2L	2L	2L	2L	1L	1L		1L	1L	Air		1L	1L		
Vent Mode		NC	NC	NC	NC	NC	NC		NC	NC			NC	NC		
IMV Rate																
Rate		8	9	12	18	11	12		8	10	9		9	12		
SpO ₂		99	97%	98%	96%	97%	98%		100%	100	95%		96%	98%		
TIDAL Volume																
Minute Volume																
PC/PS																
PEEP/CPAP																
Airway Pressure																
ET CO ₂																
Tracheal Secretions																
Cuff Pressure																
Air Entry R/L		✓	✓	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	
Chest Drains	Swinging															
	Bubbling															
Pain Score		2	1	1	1	1	0		0	0	0		0	0		
RASS Score		0	0	0	0	0	0		0	0	0		0	0		
CAM ICU																
Bundle Check		✓														
Temp		36.7			36.5	36.5	36.4		36.3		36.1		36.2	36.4		
Blood Pressure	Temperature															
	Pulse															
	40°															
	39°															
	38°															
	37°															
	36°															
	35°	111	107	104	112	97	103		99	98	95		96	95		
	34°	104	101	100	100	99	97		94	90	92		88	92		
	33°									88						
32°	63	62	59	68	57	56		56	60	58		54	52			
40																
Cardiac Rhythm		ST	ST	ST	ST	SR	SR		SR	SR	SR		SR	SR		
MAP		77	77	79	83	78	73		71	74	70		68	67		
Blood Glucose		5.6						6.4								
Insulin (units/hour)																
INOTROPES																
Pt/bed Position		1 30	4 30	4 30	6	6	1 30		1 30	1 30	4 30		4 30	4 30		
Optic/Oral Hygiene			✓				✓									
Mouth care			✓				✓									
Mobilisation					✓	C										
Staff Initials:		KF	ON	ON	KF	KF	KF		KF	ON	KF		ON	ON		

IL NIC	IL NIC	IL MC	IL MC	IL NIC
B	12	12	15	18
93%	100%	98	98%	99%
✓✓	✓	✓	✓	✓
5	8	0	2	2
5	0	0	0	0
	35.8	36.2	35.9	36.0
94 ↑ 102	88 ↑ 93	95 ↑ 65	91 ↑ 62	91 ↑ 90
✓ 54	✓ 51	✓ 65	✓ 62	✓ 56
ST. 68	SR 67	SR 75	SR 74	SR 69
540	(DAC) 40	40	(DAC) 40	DAC 40
AN	AN	AN	AN	AN

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Ventilation

Air entry:



H = Harsh

Q = Quiet

W = Wheezy

Tick (✓) if air entry present

Tracheal Secretions

1 = Scanty

2 = Moderate

3 = Profuse

M = Mucoid

B = Blood

stained

P = Purulent

Patient Position

1 = 45° head

up

2 = Supine

3 = Prone

4 = Left

5 = Right

6 = Out of

Category:

Mobilisation Codes

D = Dangle

C = Chair

S = Stand

W = Walk

Notes

Subcut morphine
given @ 1220.

New Art uno bag
change @ 1500.

Hep infusion off
@ 1700 - per
enoxaparin at
6pm ☒

	Day	Night
Pupils reacting? (tick if 'yes')	✓	✓
ID band checked? (initial for each shift)	✓	✓

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Fluid Intake

Previous day:				Fluid in: 3335				Fluid out: 2060				Balance: +1275			
Time	Flush	IV	IV	IV	IV	IV	IV	IV	IV			Naso-Gastric	Oral	Total	Accumulation
0800	3	1.8	1.1					100					50	155	155
0900	3	1.8	10.3										5	5	160
1000	3	1.8	12.2										5	5	165
1100	3	1.8	14.3										200	205	370
1200	3	1.8	15.9										500	505	875
1300	3	1.8	17.7										5	5	880
1400															
1500	6	3.6	3.3					100					400	510	1390
1600	3	1.8	2.6										5	5	1395
1700	3	OFF											3	3	1398
1800															
1900	6												500	506	1904
2000	3												20	23	1927
2100													20	23	1927
2200	6	100											50	156	2083
2300															
2400	6												100	106	2189
0100															
0200	6												6	6	2195
0300															
0400	6												10	26	2221
0500															
0600	6	100											50	156	2371
0700															

IV Fluid Prescription Chart

No	Date	Fluid (BLOCK LETTERS)	Vol (mg)	Route	Duration	Signature	Serial No.	Given by	Start time	End time
		Additive Medicine	Dose (mg)				Batch No.			
1	30/14	Sodium Chloride 0.9%	500 ml	Art line	72 hrs		21312 T44	C. Isabel	15:00	
2										
3										
4										
5										
6										

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Fluid Output

Q

Time	Drains			Bowels	Urine	Gastric	UF Volume	Total	Accumulation	Balance	Notes
	1	2	3								
0800					85			85	85 + 70		@0810 APTT 1.3 ↑ 1.8 nls/hr @1420 APTT 2.3 rate remains 1.8 nls/hr
0900					120			120	205 + 45		
1000					40			40	245 - 80		
1100					90			90	335 + 35		
1200					105			105	440 + 435		
1300					40			40	480 + 400		
1400											
1500					20			20	500 + 890		
1600					85			85	585 + 810		
1700					160			160	745 + 653		
1800											
1900					95			95	840 + 1064		
2000					160			160	1000 + 927		
2100											
2200					300			300	1300 + 783		
2300											
2400					180			180	1480 + 709		
0100											
0200					120			120	1600 + 595		
0300											
0400					180			180	1680 + 541		
0500											
0600				300	110			610	1740 + 637		
0700											

IV Fluid Prescription Chart

	Date	Fluid (BLOCK LETTERS)	Vol (mg)	Route	Duration	Signature	Serial No.	Given by	Start time	End time
		Additive Medicine	Dose (mg)				Batch No.			
7										
8										
9										
10										
11										
12										

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Coatbridge

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Evaluation of Nursing Care Plan

Initial for shift as applicable ► D N

Respiratory: (as per protocol)

RR remains stable throughout day. Currently on 1 litre via NC with sats 94-98%. AHeup made on Air - desaturated to 90%. Managing to cough on request. CN

Remains on 1L NLC overnight to maintain sats >94%. RR stable. AN

Cardiovascular: (as per protocol)

Remains unsupported. Heart rate SR/ST. Apyrexial. R Radial art line in place. CN

Hypotensive, HR - SR/ST. Apyrexial. MAP 765 unsupported AN

Nutrition/Hydration: (as per protocol)

Managed good oral fluids throughout day managing reasonable diet with encouragement, improving from previous day. BM's Stable CN

Managed oral fluids overnight with lots of encouragement + some sicks. AN

Renal/Elimination: (as per protocol)

Bowels opened	Yes	No	Formed	Soft	Loose	Days since BO	Nos of BM	Lax	Sample sent
Day	✓		Stoma						
Night	✓								

Stoma in situ - active throughout day. Urinary catheter remains in situ - draining good volumes. AN

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Evaluation of Nursing Care Plan (continued)

Initial for shift as applicable ► D N

Pain/Sedation: (as per protocol)

Regular paracetamol and nefopam. Subcut morphine as per patient request - required x1 throughout the day. CN

Regular meds given as per protocol. S/c morphine given with good effect. An

Mobility/Hygiene: (as per protocol)

Pressure Ulcer Risk Assessment - frequency: 4th hourly.

Surface - ensure appropriate and functioning - on Normal Foam mattress

Skin inspection - check and document if damage present

☐ Heel protectors ☒ Flowtrons

Regular PAC carried out, skin intact. Flowtrons remain in place. Assisted with all aspects of personal care throughout the day. Assisted with hair wash. Mobilised to chair to sit for two hours. CN

PAC delivered, skin intact. Dressings dry and intact. Personal care given. Flowtrons in situ. An

Wound/Wound drain: (as per protocol)

Rectal drain remains in situ, nil drainage. Mepore dressing to bone marrow aspirate site. Mepore dressing to midline wound. CN

Rectal drain in situ - nil drained overnight. Dressings intact & dry. An

Psychological/Neurological care: (as per protocol)

All aspects of care explained to patient and consent gained. CN

All care delivered explained. An

Other:

Switched from IV heparin continuous infusion to subcut BD clexane today. CN

Hb 77 - Drs aware. An

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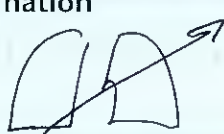
Critical Care Units Multidisciplinary Progress Record

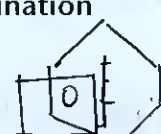
Date: 29/04/21 Age: 42 Date admitted: 29/04/21 Day number: 1
Consultant: DICK Reviewing ITU Consultant:

Tubes and Lines
Position and Days in situ: CVP: R Radial (2) Arterial: Dialysis: Urinary catheter: (2)
Tracheal Tube: Size: Position at lips: Days in situ:

Diagnosis SMV thrombosis
Pay 1 part of laparotomy, R hernia
+ end ileostomy
General condition/Changes in last 24 hours Sleepy
Not anticoagulated overnight

Cardiovascular
HR/Rhythm: 76 sinus CVP: Drugs: Nil
BP (S/D/M): 82/53 (66)
Cardiac output
Murmurs? 1+11+0 New?
Lactate? Oedema-peripheral/sacral Nil
Peripheral perfusion: Hands Feet Nil oedema

Respiratory
Examination: 
Ventilation: RR 12 VT PEEP PAP
Oxygenation: FiO2 2L NC SpO2 100% PaO2 PaCO2

Gastro-Intestinal
Examination:  BS +ve Abds soft No shivering on wound.
Nutrition: Prokinetic? Insulin? NG free drainage oral fluids
Bowels open/Diarrhoea? Drains IAP:

Gastro-Intestinal
UOP 90-100ml/hr
Last 24 hour balance: +334
Volume status RRT

Neuro
E Spont M Command V Appropriate
Sedatives Paralysis? Sedation Score Able to wake today?
New Neurology? Pupils Limb movement Reflexes Delirium? ☐ Yes ☐ No

Microbiology - sheet updated?
Organisms isolated: (source and date)
1. 2. 3. 4.
Temp. 36.1 CRP
Antibiotic: 1. Pip/taz 2. metro 3. gent 4.
Date Started Other

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1d Cumberae Crescent

MF

Coatbridge
Lanarkshire ML5 4PX

Medical Review

Adults with Incapacity? ☐ Yes ☐ No
DNACPR? ☐ Yes ☐ No
Hospital Anticipatory Care Plan? ☐ Yes ☐ No

Problem:

1. Day 1 post op laparotomy, limited R hemicolectomy + end ileostomy
2. SMV thrombosis - currently not aspirated
?intra-abdo malignancy
3. ↓Na 131
4. Albumin 17
5. ↓Mg overnight
6. Sleepy - on quetiapine + citalopram + diazepam
7. Anaemia - 2 units PRC yesterday + 1 unit intraoperative
8. Arterial line ? ↓ function
9. Antibodies on blood → requires blood from Glasgow

10.

Plan:

- 1) Surgical plan: Remove NG
Allow drinks as able
Contact stoma nurse
 - 2) Abx - piptaz, metro, gent
?rationalize to piptaz ✓
 - 3) Haem advice: heparin infusion without initial bolus.
(surgeons ~~not~~ happy with this)
 - 4) ^{Send} B₂ glycoprotein I; anticardiolipin, lupus anticoagulant →
 - 5) Monitor electrolytes; use plasma/lyte as maintenance
 - 6) ?suspend diazepam/reduce to PRN
 - 7) Monitor Hb - ?further Transfusion
 - 8) Pathology chase re tissue intraoperatively.
 - 9) Replace/remove arterial line
 - 10) Bone marrow biopsy tomorrow
- Targets
- Spo₂ > 94%
 - Map ≥ 65
 - UD > 0.5ml/kg/hr
 - Fluid balance ± 500ml
- 11) Have 2 units PRC available

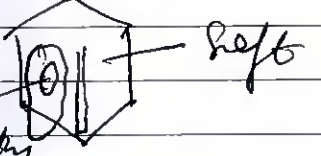
Dr. Tran

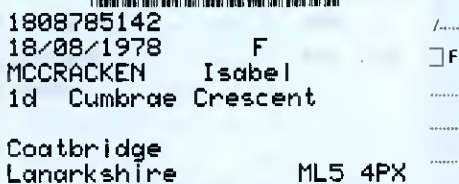
Date/Time	Medical Progress Notes	Signature/Designation
	DAILY GOALS Diagnosis documented? ☒ YES ☐ NO Sedation break ☒ YES ☐ NO Sedation target score: by hrs Ventilation/Resp goals documented? ☒ YES ☐ NO ARDS ☒ YES ☐ NO CVS Plan/goals documented? ☒ YES ☐ NO Fluid balance Target ml by ± 500 hrs Can use diuretic? ☒ YES ☐ NO Mobilisation plan documented YES/NO/N/A Refer to decision making tool Any lines venflons put in outwith ICU? ☒ YES ☐ NO venflons/Lines to be removed? ☒ YES ☐ NO Venflon Chlorhexidine gel prescribed BD? ☒ YES ☐ NO Changes to DVT prophylaxis? ☒ YES ☐ NO Changes to Stress Ulcer Prophylaxis? ☒ YES ☐ NO $\rightarrow$ APPT hepatic Ask team -anything else we should be doing? Verbal handover of goals ☒ YES ☐ NO Are patients own goals documented YES/NO/N/A EVENING REVIEW Daytime plan/goals achieved Ventilation/Resp goals documented? YES/NO CVS Plan/goals documented? YES/NO Fluid Balance ml Can use diuretic YES/NO	
29/4/21	<u>PHI TRAIN</u> - call to transition 11.30 3 units PRC at UHM, in transition lab available. (they are aware that has re antibodies)	<i>[Signature]</i> TRAIN FY1

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Date/Time	Medical Progress Notes	Signature/Designation
29/04/21	MR MD	
10:07am	- Patient Seen. - HR = 77bpm. - Had surgery 1/2 ago. Appendicectomy also done during surgery. - On Anti thrombotics for blood clots. - clotting much from the NG-tube.  Stomach healthy Mot working (P) - Clamping NG tube & possibly removing it - Call Stone Hurles to renal - Remove NG Tube - Give patient a cup of tea	
22 ¹⁵	Mchae Night Dr pot (limited) @ hemi for Smv Hender, 1 appendic abn. at lupus ABs. + atypical blood ABs. - under Hepen infus - - variable at the - PCA - fully CP on ABx asleep + comfortable Sp. accl. W/L. HR 24/4 (78) 74/50 u/o 60ml H ₂ O F/B @ 1680 excreting fluid Bacteriuria, but this is acceptable, no feverish @ radial at the veinsetted aseptically using selctige. Starts 21. lignocaine + long At line put in.	Dr Johnson



Date/ Time	Nursing and Allied Health Profession Progress Notes	Signature/ Designation
29.4.21	ACUTE PAIN	CNS CONNELLY
0930	Review of Isobel. Events noted. Extremely sleepy this am - fairly hard to rouse. c/o some mild abdominal pain - reminded to use PCA. Currently on IV paracetamol 750mg qds and Morphine PCA - 12mg used. Taking some medications orally - for fluids only. PLAN - PAIN - Continue IV paracetamol 750mg qds - Keep PCA. - Could add neopren 30mg tid for 3 days.	
29/4/21	SIB Stoma Care Nurse - ileostomy healthy - 1140 minimal faecal fluid in appliance. Stoma supplies provided. ASKE	1/11/21

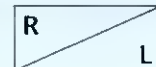
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23	24	01	02	03	04	05	06	07	08
2L MC.	2L MC		2L MC		2L MC		2L MC		
8	12		11		12		11		
98%	96%		97%		96%		97%		
✓					✓		✓		
S.	O		S		O		S.		
36.4.			36.6.				36.7		
101 ✓	110 ✓		111 ✓		962 ✓		110 ✓		
78	82		87		95		112		
67	60		59		78		55		
SR. 72	SR 71		SR. 73.		SR 81		ST. 7A.		
435	PAK 535		535		535		535		
10			10.		535		10		

Ventilation

Air entry:



H = Harsh

Q = Quiet

W = Wheezy

Tick (✓) if air entry present

Tracheal Secretions

1 = Scanty

2 = Moderate

3 = Profuse

M = Mucoïd

B = Blood

stained

P = Purulent

Patient Position

1	= 45° head
---	------------

up

2 = Supine

3 = Prone

4 = Left

5 = Right

6 = Out of bed

Mobilisation Codes

D = Dangle

C = Chair

S = Stand

W = Walk

Notes

1645-coag Screen
4hr hep infusion
sample obtained.

	Day	Night
Pupils reacting? (tick if 'yes')	✓	
ID band checked? (initial for each shift)	VF	



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Fluid Intake

Previous day:					Fluid in: 774				Fluid out: 440				Balance: 7334			
Time	Flush	IV	IV	IV	IV	IV	IV	IV	IVF	IVD			Naso-Gastric	Oral	Total	Accumulation
0800	3								117						146	146
0900	3								135						141	287
1000																
1100	6								78						84	371
1200	3								94					400	497	868
1300	3	1							640	200				100	310	1178
1400	3	1							07					400	501	1679
1500	3	1							36	407				100	140	1819
1600	3	1							OFF					730	734	2553
1700	3	1							4					200	204	2757
1800	3	1							OFF					4.4	4	2761
1900	3	1												100	104	2865
2000	3	1													4	2895
2100																
2200	6	2													8	2903
2300																
2400	6	2													8	2911
0100																
0200	6	2													8	2919
0300																
0400	6	1													7	2926
0500																
0600	6	3												400	409	3335
0700																

IV Fluid Prescription Chart

	Date	Fluid (BLOCK LETTERS)	Vol (mg)	Route	Duration	Signature	Serial No.	Given by	Start time	End time
		Additive Medicine	Dose (mg)				Batch No.			
1	29/4/21	Plasmalyte	500	IV	60-80 ml/hr	<i>[Signature]</i>	12/22	L. Clelland	1350	
2	29/4/21	Plasmalyte	500	IV	60-80 ml/hr	<i>[Signature]</i>				
3		O-Block + 4t. dextrose	600	IV	40-60	<i>[Signature]</i>				
4										
5										
6										

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Fluid Output

Time	Drains		Bowels	Urine	Gastric	UF Volume	Total	Accumulation	Balance	Notes
	2	3								
0800				95			95	95	+51	
0900										
1000				120			120	215	+72	
1100				50			50	265	+106	
1200				105	150		255	520	+348	
1300				120	50		170	690	+488	
1400				15	80		95	785	+894	
1500				30			30	815	+1004	
1600				200			200	1015	+1538	
1700				65			65	1080	+1677	NG removed.
1800				30			30	1110	+1651	
1900				40			40	1150	+1715	
2000				60			60	1210	+1685+	
2100										
2200				90			90	1300	+1603	
2300										
2400				300				1600		
0100										
0200				300				1900	1019+	
0300										
0400				100				2000	+926	
0500										
0600				60				2060	1275+	
0700										

IV Fluid Prescription Chart

	Date	Fluid (BLOCK LETTERS)	Vol (mg)	Route	Duration	Signature	Serial No.	Given by	Start time	End time
		Additive Medicine	Dose (mg)				Batch No.			
7										
8										
9										
10										
11										
12										

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Evaluation of Nursing Care Plan

Initial for shift as applicable ► D N

Respiratory: (as per protocol)

RR stable. Sats >98% Throughout day. Remains on oxygen therapy as has PCA - 2L W.C.

cn 10

Cardiovascular: (as per protocol)

Unsupported. Art line not working, remain in situ as needing regular bloods obtained. HR IR. Apyrexia at present. Commenced on heparin infusion due coag blood sample @ 2045. 3 PVC's in situ. Bloods sent this am. ↑ Heparin as per infusion chart. Resited arterial line. this am. Bloods later

cn

W

Nutrition/Hydration: (as per protocol)

managing light diet and good oral fluids. Stopped maintenance fluids as balance became positive, no further actions to be taken as per medics. BMU have been stable NG out. on liberating fluid

cn

Renal/Elimination: (as per protocol)

Bowels opened	Yes	No	Formed	Soft	Loose	Days since BO	Nos of BM	Lax	Sample sent
Day			Stoma						
Night	✓								

Good urine volumes. Stoma small amount of faecal fluid. Pink and warm to touch on

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Evaluation of Nursing Care Plan (continued)
 Initial for shift as applicable ► D N

Pain/Sedation: (as per protocol)
 Regular IV Paracetamol. PCA remains in place.
 Regular diazepam. on 10.

Mobility/Hygiene: (as per protocol)
 Pressure Ulcer Risk Assessment - frequency: 40
 Surface - ensure appropriate and functioning - on mattress
 Skin inspection - check and document if damage present
☐ Heel protectors ☒ Flowtrons
 Assisted with bed bath this morning
 and aspects of personal care. Regular
 PAC carried out. Skin intact
 no issues. Patient moving around
 bed independently. on

Wound/Wound drain: (as per protocol)
 Rectal drain remains in situ. on
 Nil u drain. Mepore to machine. no
 staining seen and intact. 0

Psychological/Neurological care: (as per protocol).
 All aspects care explained to patient and
 consent gained. on

Other:

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CCU Monklands Multidisciplinary Progress Record | Acute Care Services | NHSL | Page 12 of 12 Pub. date: Sep. 2018 | Review date: Sep. 2021 | Issue No: 03

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Critical Care Units Multidisciplinary Progress Record

Date: 01/05/21 Age: 42 Date admitted: 29/04/21 Day number: 3

Consultant: Reviewing ITU Consultant:

Tubes and Lines

Position and Days in situ	CVP:	Arterial: Radial (4)	Dialysis:	Urinary catheter: (4)
Tracheal Tube:	Size:	Position at lips:	Days in situ:	

Diagnosis	General condition/Changes in last 24 hours
SPT V Thrombus + ischaemic colon → Rheumatic colitis	Well.

Cardiovascular

HR/Rhythm: 98 S/D	CVP:	Drugs: Nil
BP (S/D/M):		
Cardiac output 90/50		
Murmurs? Nil	New?	Oedema-peripheral/sacral Nil
Lactate? 1.5		Peripheral perfusion: Hands Feet Well

Respiratory

Examination: Chest clear	Ventilation: Spont	Oxygenation:
	RR	FiO2 1.2/min Nil
	VT	SpO2 98%
	PEEP	PaO2
	PAP	PaCO2

Gastro-Intestinal

Examination: Ileostomy 300ml/24h Soh 15/16h	Nutrition: E+D Prokinetic? Insulin? Bowels open/Diarrhoea? Drains	Rectal drain - Nil IAP:
--	---	----------------------------

Gastro-Intestinal

UOP: 50-90ml/L	Volume status: Euvolaemic	RRT: Nil
Last 24 hour balance:		

Neuro

E 4	Sedatives: Nil	New Neurology? No
M 6	Paralysis?	Pupils
V 5	Sedation Score	Limb movement
	Able to wake today?	Reflexes
		Delirium? ☐ Yes ☒ No

Microbiology - sheet updated?	Antibiotic	Date Started	Other
Organisms isolated: (source and date)	1. Tarceva		
1. Nil	2.		
2.	3.		
3.	4.		
Temp. CRP/DOL			

Signature: Designation: COPY PAGE



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or attach addressograph label here

Medical Review

Adults with Incapacity?

☐ Yes ☒ No

DNACPR?

☐ Yes ☒ No

Hospital Anticipatory Care Plan?

☐ Yes ☒ No

Problem:

1. Right hemiparesis
- venous ischaemic
2. SMV thrombus
- On enoxaparin
3. heparin anticoagulant
4. Previous extensor of
thrombus on warfarin.
5. 
- 6.
- 7.
- 8.
- 9.
- 10.

Plan:

Stop date Tazocin 3/5/21

Mobilise → walk

Stop dam → ward.

No change to analgesia

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-FiO ₂	IL	IL																		
Vent Mode	N/C	N/C																		
IMV Rate																				
Rate	14	16																		
SpO ₂	100%	100%																		
TIDAL Volume																				
Minute Volume																				
PC/PS																				
PEEP/CPAP																				
Airway Pressure																				
ET CO ₂																				
Tracheal Secretions																				
Cuff Pressure																				
Air Entry R/L	✓✓	✓✓																		
Chest Swinging																				
Drains Bubbling																				
Pain Score	1	1																		
RASS Score	0	0																		
CAM ICU																				
Bundle Check																				
Temp	36.4	36.3																		
Blood Pressure Temperature Pulse	40°																			
	200																			
	39°																			
	180																			
	38°																			
	160																			
	37°																			
	140																			
	36°																			
	120																			
Blood Pressure Temperature Pulse	35°																			
	100																			
	34°	89	89																	
	80	89	89																	
	33°																			
	60																			
	32°																			
	40																			
	43	43	44																	
Cardiac Rhythm	SR	SR																		
MAP	57	60																		
Blood Glucose																				
Insulin (units/hour)																				
INOTROPES																				
Pt/bed Position	4/0	4/0																		
Optic/Oral Hygiene																				
Mouth care																				
Mobilisation																				
Staff Initials:	yc	yc																		

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Ventilation

Air entry:



H = Harsh

Q = Quiet

W = Wheezy

Tick (✓) if air entry present

Tracheal Secretions

1 = Scanty

2 = Moderate

3 = Profuse

M = Mucoid

B = Blood

stained

P = Purulent

Patient Position

1 = 45° head

up

2 = Supine

3 = Prone

4 = Left

5 = Right

6 = Out of bed

Mobilisation Codes

D = Dangle

C = Chair

S = Stand

W = Walk

Notes

	Day	Night
Pupils reacting? (tick if 'yes')	✓	
ID band checked? (initial for each shift)	yc	

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Fluid Intake

Previous day:					Fluid in:				Fluid out:				Balance:			
Time	Flush	IV	IV	IV	IV	IV	IV	IV	IV	IV			Naso-Gastric	Oral	Total	Accumulation
0800	6													50	56	56
0900																
1000	6													250	250	306
1100																
1200																
1300																
1400																
1500																
1600																
1700																
1800																
1900																
2000																
2100																
2200																
2300																
2400																
0100																
0200																
0300																
0400																
0500																
0600																
0700																

IV Fluid Prescription Chart

	Date	Fluid (BLOCK LETTERS)	Vol (mg)	Route	Duration	Signature	Serial No.	Given by	Start time	End time
		Additive Medicine	Dose (mg)				Batch No.			
1										
2										
3										
4										
5										
6										

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Lanarkshire

Fluid Output

Time	Drains			Bowels	Urine	Gastric	UF Volume	Total	Accumulation	Balance	Notes
	① RECTAL	2	3								
0800	NJ				100			100	100	-44	
0900											
1000					60			60	160	+146	
1100											
1200											
1300											
1400											
1500											
1600											
1700											
1800											
1900											
2000											
2100											
2200											
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0600											
0700											

IV Fluid Prescription Chart

	Date	Fluid (BLOCK LETTERS)	Vol (mg)	Route	Duration	Signature	Serial No.	Given by	Start time	End time
		Additive Medicine	Dose (mg)				Batch No.			
7										
8										
9										
10										
11										
12										

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Evaluation of Nursing Care Plan

Initial for shift as applicable » D N

Respiratory: (as per protocol)

Saturation on Room Air. Resp Rate Stable ye

Cardiovascular: (as per protocol)

BP unsupported - Hypotensive medics aware
Heart Rate SR ye

Nutrition/Hydration: (as per protocol)

Free fluids light diet. ye

Renal/Elimination: (as per protocol)

Bowels opened	Yes	No	Formed	Soft	Loose	Days since BO	Nos of BM	Lax	Sample sent
Day	✓		STOMA						
Night									

Passing good volumes of urine ye

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Coatbridge
Lanarkshire

ML5 4PX

Evaluation of Nursing Care Plan (continued)

Initial for shift as applicable ►

D**N****Pain/Sedation:** (as per protocol)Regular Nefopam and Paracetamol for Pain
Can have Subcut Morphine if required

ye

Mobility/Hygiene: (as per protocol)

Pressure Ulcer Risk Assessment - frequency:

Surface - ensure appropriate and functioning - on mattress

Skin inspection - check and document if damage present

☐ Heel protectors☐ FlowtronsMinimal assistance required with mobility
personal hygiene

ye

Wound/Wound drain: (as per protocol)

Mid line wound - dressing dry and intact.

Dressing on hip following bone marrow aspirate

ye

ye

Psychological/Neurological care: (as per protocol)

Reassurance given and care explained

ye

Other:**COPY PAGE**



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☐ Hairmyres ☒ Monklands ☐ Wishaw
Ward: T

NHS
Lanarkshire

Inpatient Endoscopy

Date: 13/5/21 Time: 0830 (24 hour)

Ward staff to complete details on Page 1 and Check 1 on Page 4 Checklist

Proposed Procedure:

- ☐ Bronchoscopy ☐ Colonoscopy ☐ ERCP
☐ Flexible Cystoscopy ☐ Flexible Sigmoidoscopy ☒ Gastroscopy
☐ PEG ☐ Other: (specify) _____

Consultant:

M Dick

Baseline Observations:

Temperature: 37.7 Blood Pressure: 109/63 Heart Rate: 117
Respirations: 14 SpO2: 96/01A NEWS Score: 3
Pain Score: 0 4AT Score: N/A (for patients over 65 years as appropriate see p.2)

History of presenting complaint:

Available on Clinical Portal? ☐ Yes ☐ No

R Hemi, End ileostomy & appendicectomy
28/4/21.

Past Medical History - please tick all that apply and give details below

- ☐ Alcohol ☐ Angina ☐ Asthma/Bronchitis/COPD ☐ Diabetes
☐ Epilepsy/Fits/Fainting ☐ Glaucoma/Eye surgery ☐ High blood pressure ☐ Cardiac related events
☐ Jaundice/Hepatitis ☐ Recreational drugs ☐ Sedation/Anaesthetics ☐ Smoking
☐ Tuberculosis ☐ Other: (specify) _____

Details/Actions:

SMV Thrombosis - on warfarin - Clozapine
Iron deficiency.



Completed by: (PRINT NAME)

G WRIGHT

Signature:

Designation:

SN

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4AT Assessment Tool
 (Screening for Cognitive Impairment and Delirium)
 ☒ **Not applicable**

Complete for all patients over 65 years if required

Date:		
Time:		
Initials:		
1. Alertness – This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating. - Normal (fully alert, but not agitated, throughout assessment) - Mild sleepiness for <10 seconds after waking, then normal - Clearly abnormal	0 0 4	
2. AMT4 – Ask the patient: age, date of birth, place (name of the hospital or building), current year - No mistakes - 1 mistake - 2 or more mistakes/untestable	0 1 2	
3. Attention – Ask the patient: ‘Please tell me the months of the year in backwards order, starting at December.’ To assist initial understanding one prompt of, ‘What is the month before December?’ is permitted. - Achieves 7 months or more correctly - Starts but scores <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 (e.g. paranoia, hallucinations) arising over the last 2 weeks and still evident in the last 24 hours. - No - Yes	0 4	
4AT TOTAL SCORE:		

4AT Score:

4 or above: Possible delirium + / - cognitive impairment.

1 - 3 : Possible cognitive impairment. More detailed cognitive assessment and informant history taking are required.

0: Delirium or severe cognitive impairment unlikely (but delirium still possible if (4) information incomplete).

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Pregnancy Status Questionnaire

- complete for patients 55 years and under

☐ Not applicable

Legislation requires that a patient's pregnancy status should be ascertained and recorded before certain surgical procedures. This information should then be used to determine actions that are required to help protect the patient and foetus before surgery. We cannot perform your surgery if this is not completed.

Please answer the following questions:

- Have your periods not started or was your last period more than 2 years ago? ☐ Yes ☒ No
If yes, please complete the signature and date section below.
- Have you had a hysterectomy or sterilisation? ☐ Yes ☒ No
If yes, please complete the signature and date section below.
- What was the first day of your last period? Date: 19/4/21
- Is there any possibility that you might be pregnant? ☐ Yes ☒ No
If yes, please discuss with the Consultant/Nurse in Charge before your operation and complete the signature and date section below.

If no, please complete the signature and date section below.

Patient Signature:

Isabel McCracken

Date:/...../.....

Nurse Signature:

[Signature]

Date: 13/5/21

Notes:

- Implementation/Rationale for questionnaire:** The National Institute for Health and Care Excellence (NICE) guideline on perioperative tests recommend that pregnancy testing should be carried out for a woman who says its possible that she may be pregnant. This guideline also states that local pre-operative assessment policies should be reviewed to ensure that pregnancy status is checked within the immediate pre-operative period in accordance with these guidelines.
- Confidentiality/Use of information:** At all times great care is taken to ensure that high standards of confidentiality are maintained in respect of information held. This 'Data Protection Act 1998' gives you the right of access to any personal information which NHS Lanarkshire holds about you, either in manual records or electronic records. If you would like more information about your rights under the act, you should contact the Records Officer at the hospital.

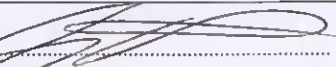
PVC Insertion Bundle	Yes	No
Hand hygiene performed immediately before all PVC insertion procedures (WHO Moment 2)	☐	☐
A single use skin antiseptic containing 70% isopropyl alcohol is used to cleanse skin and left to dry before insertion	☐	☐
Aseptic technique maintained throughout insertion procedure	☐	☐
A sterile, transparent, semipermeable dressing used to cover the catheter site	☐	☐
Size/colour: Insertion site:		
Insertion date:/...../..... Time::..... Signature:		

1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumbernauld Crescent

Coatbridge
Lanarkshire ML5 4PX

Pre-Procedure Checklist	Yes No N/A	Comments	Check 1	Check 2
Check you have the correct patient - name, address, date of birth	Y.		☐	☐
Check the patient has the correct name band on	Y.		☐	☐
Check the patient is having the correct procedure	Y.		☐	☐
Check the patient has consented for the correct procedure			☐	☐
Is the patient having sedation?	☐ ☐	☐ Throat spray	☐	☐
Has the patient ever been notified that they are at increased risk of CJD or vCJD for public health purposes?	☐ ☒	If 'yes' refer to policy and discuss with Infection Prevention and Control Team	☐	☐
Bowel preparation completed?	☐ ☐ ☒	Name of prep: Time given: : (if applicable)	☐	☐
Does the patient have any allergies? If yes, red name band applied?	☒ ☐ ☒ ☐	If yes, details: <u>Diclofenic</u>	☐	☐
Does the patient have dentures? If yes, have they been removed?	☒ ☐ ☒ ☐	☐ Caps ☐ Crowns ☐ Loose	☐	☐
Is the patient fasted?	☒ ☐ <u>sips</u>	Last ate: <u>18.00</u> (24 hour) - <u>12/5/21</u> Last drank: <u>07.00</u> (24 hour) Date: <u>13/5/21</u>	☐	☐
Does the patient have diabetes? ☐ Diet ☐ Tablet ☐ Insulin	☐ ☒	If yes, BM: mmols Time checked: : (24 hour) Further actions:	☐	☐
Is the patient pregnant? Test carried out?	☐ ☒ ☐ ☐ ☒ ☐		☐	☐
Is the patient on Warfarin or other anti-coagulants? <u>Clo timzapran</u>	☒ ☐	If yes, details: <u>- 12/5/21</u> Time given: <u>17.00</u> (24 hour)	☐	☐
Is INR available?	☒ ☐	If yes, details:	☐	☐
Does the patient have any internal metalwork or pacemaker?	☐ ☒	If yes, details:	☐	☐
Infection risk suspected/identified, e.g. HIV, hepatitis B or C?	☐ ☒	If yes, details:	☐	☐

Pre-Procedure Checklist	Yes No N/A	Additional Clinical Records Present	Yes No
Patient's gown on	☒ ☐	Case notes	☒ ☐
Underwear removed?	☒ ☐	Nursing notes	☒ ☐
Antibiotic prophylaxis given in ward if required?	☐ ☐ ☐	Medicine Prescription Form <u>MEPMA</u>	☐ ☐
		Fluid regime	☐ ☐
		Blood collection slip	☐ ☐

Check 1. Signature: 
Time: 08.30 (24 hour) [Ward to complete]

Check 2. Signature:
Time: : (24 hour)

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CONSENT FORM

For Medical or Dental Investigation, Treatment or Operation

Hospital

Patient's S

1808785142

18/08/1978

F

MCCRACKEN

Isabel

1d Cumberae Crescent

Unit Number.....

Other Na

Coatbridge

Date of B Lanarkshire

ML5 4PX

Sex (please tick box): ☐ Male ☐ Female

To be completed by the medical, dental, nursing or paramedical practitioner (see notes overleaf).

Type of operation, investigation or treatment for which written evidence of consent is considered appropriate:

I confirm that I have explained to the patient in terms which in my judgement are suited to his/her understanding (and/or to one of his/her parents or guardians), the proposed operation, investigation or treatment, including options available, and if relevant, the need for anaesthesia or sedation. I also confirm that I have explained the intended benefits and serious or frequently occurring risks and any extra procedures that may become necessary during the procedure (please specify):

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

The following leaflet/tape has been provided:

Signature

Date

Name & Status of Practitioner:

STATEMENT OF PATIENT (or Parent or Guardian if appropriate) PLEASE READ THE ADVICE OVERLEAF

I am the patient/parent/guardian (delete as necessary)

- ❖ I agree to the procedure or course of treatment described on this form which has been explained to me by the practitioner named above.
- ❖ I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.
- ❖ I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this (this only applies to patients having general or regional anaesthesia).
- ❖ I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.
- ❖ I have been told about additional procedures that may become necessary during my treatment. I have listed below any procedures that I **DO NOT** wish to be carried out without further discussion

Signature

Name

Address

Date

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance) On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

Signed

Date

Name (PRINT)

Job title

COPY PAGE

NOTES TO:

ALL HEALTH PRACTITIONERS

(DOCTORS, DENTISTS, NURSES, PROFESSIONS ALLIED TO MEDICINE)

A patient has an absolute legal right to grant or withhold consent prior to examination or treatment. Patients should be given sufficient information, in a way that they can understand, about the proposed treatment and the possible alternatives. Patients must be allowed to decide whether they will agree to the treatment and they may refuse or withdraw consent to the treatment at any time. The patient's consent to treatment should be recorded on this consent form (*further guidance is given in Lanarkshire Acute Hospitals Policy Statement*).

PATIENTS

❖ Please read this form and these notes very carefully

❖ The health practitioner is here to help you. He or she will explain the proposed treatment and what the alternatives are. You can ask any questions and seek further information.

❖ You can refuse treatment. If there is anything that you don't understand about the explanation, or if you want more information you should ask the practitioner before signing.

❖ You may ask for a relative or a friend or a nurse to be present.

❖ Please check that all the information on the form is correct. If it is and you understand the explanation, then sign the form.

❖ Training doctors, dentists, nurses and other health professionals is essential to the continuation of the health service and improving the quality of care. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a senior doctor, dentist, nurse or health professional.

❖ You may, however, decline to be involved in the formal training of medical, dental, nursing and other students without this adversely affecting your care and treatment. You must tell a senior Doctor or Nurse if you do not wish students to be involved in your care and you should write this over the page in the space for things that you do not wish to happen without your being given the chance to consider them first.

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 L MCCracken Isabel
 A 1d Cumberae Crescent
 Coatbridge
 Lanarkshire ML5 4PX

Procedure

Time in: : (24 hour) ☐ Endoscopy Pause

Scope 1 No: Scope 2 No:

Endoscopist:

Procedure(s) Performed

☐ Patient consent withdrawn

Diathermy plate applied? ☐ Yes ☐ No If yes site: ☐ Removed

Condition of skin checked post procedure: ☐ Satisfactory ☐ Unsatisfactory

Medication administered: ☐ No sedation

Throat spray: Time: : If yes, nil by mouth 30/60/90/120 minutes (delete as applicable)

Topical Lignocaine: mls Time: : IV Alfentanil: mcgs Time: :

IV Midazolam: mgs Time: : IV Flumazenil: mcgs Time: :

IV Pethidine: mgs Time: : IV Naxolone: mgs Time: :

IV Buscopan: mgs Time: : Oxygen: litres Time: :

IV Fentanyl: mcgs Time: : Nitrous Oxide - self administration:

Other: (specify) Time: : ☐ Yes ☐ No ☐ N/A Time: :

Comfort Score: **AVPU Score:**

Pulse oximetry - SpO2: **Heart Rate:**

Samples/Interventions:

☐ APC ☐ Biopsies ☐ Gastric balloon/removal ☐ Sphincterotomy (ERCP)

☐ Aspirate ☐ Brushes/slides ☐ Haemorrhoidal banding ☐ Stent insertion

☐ Balloon dilatation ☐ CLOtest ☐ Injection of ink ☐ Variceal banding/injection

☐ Balloon trawl (ERCP) ☐ Endoscopic muc ☐ Polypectomy

☐ Other: (specify)

Nursing Assessment/Comments: **Time to Recovery:** :

.....

.....

.....

.....

.....

.....

.....

Completed by: (PRINT NAME) **Designation:**

Signature:

Scope Cleaning – complete only if required as per local hospital/dept. policy ☐ Not applicable

1. Social clean in room by:

Signature: **Date:** / / **Time:** :

Processed before disinfection by:

Signature: **Date:** / / **Time:** :

2. Social clean in room by:

Signature: **Date:** / / **Time:** :

Processed before disinfection by:

Signature: **Date:** / / **Time:** :

Affix Theatre Labels Here

COPY PAGE

Patient name:	CHI number:
----------------------	--------------------

Head Injury Observations															
Glasgow Coma Scale (GCS)	Date:														
	Time:														
	Frequency:														
	Frequency change initials:														
EYES Open	Spontaneous	4													Eyes closed by swelling = C
	To Speech	3													
	To Pain	2													
	None	1													
Best VERBAL Response	Orientated	5													Endo-tracheal tube or Trach-eostomy = T
	Confused	4													
	Inappropriate words	3													
	Incomprehensible sounds	2													
	None	1													
Best MOTOR Response	Obeys commands	6													Usually record the best arm response
	Localise pain	5													
	Withdrawal	4													
	Flexion to pain	3													
	Extension to pain	2													
	None	1													
TOTAL: (/15)															

	Pupils	Right	Size Reaction											S sluggish + reacts - no reaction C eyes closed	
		Left	Size Reaction												
	LIMB MOVEMENT	ARMS	Normal power												Record right (R) and left (L) separately if there is a difference between the two sides
			Mild weakness												
			Severe weakness												
			Spastic flexion												
			Extension												
			No response												
		LEGS	Normal power												
			Mild weakness												
Severe weakness															
Extension															
		No response													
Initials:															

National Early Warning Score (NEWS) Actions and Escalation			
Delirium Acute Change - Complete 4AT - inform Nurse in Charge - escalate to Medical staff/HECT			
NEWS 0 - Refer Observation Policy first 48 hours of admission - Minimum 12 hourly observations	NEWS 1 - 4 Inform Nurse in Charge - Lower risk - Respond within 60 mins - ABC - Minimum 4 hourly observations	NEWS ≥5 or 3 in one parameter Inform Nurse in Charge - Medium risk - Urgent assessment doctor/HECT - Respond within 30 mins - ABC - reassess - Start Fluid Balance - Minimum hourly observations	NEWS ≥7 Inform Nurse in Charge - High risk - Senior doctor/HECT assess - Urgent attendance - ABC - reassess - Continuous monitoring - Consider 2222 call - Consider critical care - Document escalation plan

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1808785142
18/08/1978 F
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Coatbridge
Lanarkshire ML5 4PX

☐ Hairmyres ☒ Monklands ☐ Wishaw
Ward: 7



Inpatient Endoscopy

Date: 21/5/21 Time: 10:00 (24 hour)

Ward staff to complete details on Page 1 and Check 1 on Page 4 Checklist

Proposed Procedure:

- ☐ Bronchoscopy ☐ Colonoscopy ☐ ERCP
☐ Flexible Cystoscopy ☐ Flexible Sigmoidoscopy ☐ Gastroscopy
☐ PEG ☒ Other: (specify) OGD

Consultant:

SHARAF

Baseline Observations:

Temperature: 36.1 Blood Pressure: 91/63 Heart Rate: 97
Respirations: 14 SpO2: 98 NEWS Score: 3
Pain Score: 1 4AT Score: (for patients over 65 years as appropriate see p.2)

History of presenting complaint:

Available on Clinical Portal? ☒ Yes ☐ No

R hemi, end ileostomy & appendix
Septic

Past Medical History - please tick all that apply and give details below

- ☐ Alcohol ☐ Angina ☐ Asthma/Bronchitis/COPD ☐ Diabetes
☐ Epilepsy/Fits/Fainting ☐ Glaucoma/Eye surgery ☐ High blood pressure ☐ Cardiac related events
☐ Jaundice/Hepatitis ☐ Recreational drugs ☐ Sedation/Anaesthetics ☒ Smoking
☐ Tuberculosis ☐ Other: (specify)

Details/Actions:

VRE+ + on TINZ



Completed by: (PRINT NAME)

GILLIAN DAVIDSON

Signature:

Gillian Davidson

Designation:

STUDENT NURSE

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4AT Assessment Tool (Screening for Cognitive Impairment and Delirium)	☐ Not applicable
Complete for all patients over 65 years if required	

4AT Score:

4 or above: Possible delirium + / - cognitive impairment.

1 - 3 : Possible cognitive impairment. More detailed cognitive assessment and informant history taking are required.

0: Delirium or severe cognitive impairment unlikely (but delirium still possible if (4) information incomplete).

CHI no
 First name DOB / /
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

Pregnancy Status Questionnaire - complete for patients 55 years and under

☐ **Not applicable**

Legislation requires that a patient's pregnancy status should be ascertained and recorded before certain surgical procedures. This information should then be used to determine actions that are required to help protect the patient and foetus before surgery. We cannot perform your surgery if this is not completed.

Please answer the following questions:

1. Have your periods not started or was your last period more than 2 years ago? ☐ Yes ☒ No
If yes, please complete the signature and date section below.
2. Have you had a hysterectomy or sterilisation? ☐ Yes ☒ No
If yes, please complete the signature and date section below.
3. What was the first day of your last period? Date: 19.03.21
4. Is there any possibility that you might be pregnant? ☐ Yes ☒ No
If yes, please discuss with the Consultant/Nurse in Charge before your operation and complete the signature and date section below.

If no, please complete the signature and date section below.

Patient Signature: J McCracken	Date: 21.5.21
Nurse Signature: [Signature]	Date: 21.5.21

Notes:

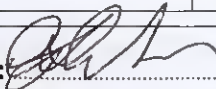
- **Implementation/Rationale for questionnaire:** The National Institute for Health and Care Excellence (NICE) guideline on perioperative tests recommend that pregnancy testing should be carried out for a woman who says its possible that she may be pregnant. This guideline also states that local pre-operative assessment policies should be reviewed to ensure that pregnancy status is checked within the immediate pre-operative period in accordance with these guidelines.
- **Confidentiality/Use of information:** At all times great care is taken to ensure that high standards of confidentiality are maintained in respect of information held. This 'Data Protection Act 1998' gives you the right of access to any personal information which NHS Lanarkshire holds about you, either in manual records or electronic records. If you would like more information about your rights under the act, you should contact the Records Officer at the hospital.

PVC Insertion Bundle	Yes	No
Hand hygiene performed immediately before all PVC insertion procedures (WHO Moment 2)	☐	☐
A single use skin antiseptic containing 70% isopropyl alcohol is used to cleanse skin and left to dry before insertion	☐	☐
Aseptic technique maintained throughout insertion procedure	☐	☐
A sterile, transparent, semipermeable dressing used to cover the catheter site	☐	☐
Size/colour: Insertion site: Insertion date: / / Time: : Signature:		

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1d Cumberae Crescent
Coatbridge
Lanarkshire ML5 4PX

Pre-Procedure Checklist	Yes No N/A	Comments	Check 1	Check 2
Check you have the correct patient - name, address, date of birth			☒	☒
Check the patient has the correct name band on			☒	☒
Check the patient is having the correct procedure			☒	☒
Check the patient has consented for the correct procedure			☒	☒
Is the patient having sedation?	☐ ☐	☐ Throat spray	☒	☒
Has the patient ever been notified that they are at increased risk of CJD or vCJD for public health purposes?	☐ ☒	If 'yes' refer to policy and discuss with Infection Prevention and Control Team	☒	☒
Bowel preparation completed?	☐ ☐ ☒	Name of prep: Time given: : (if applicable)	☒	☒
Does the patient have any allergies? If yes, red name band applied?	☐ ☒ ☐ ☐	If yes, details: Patient has red band but states no allergies - Clinical Portal states Allergy to Diclofenac 2007	☒	☒
Does the patient have dentures? If yes, have they been removed?	☒ ☐ ☒ ☐	☐ Caps ☐ Crowns ☐ Loose	☒	☒
Is the patient fasted?	☒ ☒	Last ate: 19 : 00 (24 hour) Last drank: 08 : 00 (24 hour) Date: 21 / 05 / 21	☒	☒
Does the patient have diabetes? ☐ Diet ☐ Tablet ☐ Insulin	☐ ☒	If yes, BM: mmols Time checked: : (24 hour) Further actions:	☒	☒
Is the patient pregnant? Test carried out?	☐ ☒ ☐ ☐ ☒ ☐		☒	☒
Is the patient on Warfarin or other anti-coagulants?	☒ ☐	If yes, details: TINZ 20/5 Time given: 1 : (24 hour)	☒	☒
Is INR available?	☐ ☒	If yes, details:	☒	☒
Does the patient have any internal metalwork or pacemaker?	☐ ☒	If yes, details:	☒	☒
Infection risk suspected/identified, e.g. HIV, hepatitis B or C?	☐ ☒	If yes, details:	☒	☒

Pre-Procedure Checklist	Yes No N/A	Additional Clinical Records Present	Yes No
Patient's gown on	☐ ☒	Case notes	☒ ☐
Underwear removed?	☐ ☒	Nursing notes	☒ ☐
Antibiotic prophylaxis given in ward if required?	☐ ☐ ☒	Medicine Prescription Form	☒ ☐
		Fluid regime	☐ ☐
		Blood collection slip	☐ ☐

Check 1. Signature: 

Time: 10 : 00 (24 hour) [Ward to complete]

Check 2. Signature: 

Time: : (24 hour)

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CONSENT FORM

For Medical or Dental Investigation, Treatment or Operation

Hospital

Unit Number.....

Sex (please tick box): ☐ Male ☐ Female

To be completed by the medical, dental, nursing or paediatric professional

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1d Cumbernauld Crescent

Coatbridge
Lanarkshire

MLS 4PX

(leaf).

Type of operation, investigation or treatment for which written evidence of consent is considered appropriate:

Upper GI Endoscopy
+ 1 - biopsy

I confirm that I have explained to the patient in terms which in my judgement are suited to his/her understanding (and/or to one of his/her parents or guardians), the proposed operation, investigation or treatment, including options available, and if relevant, the need for anaesthesia or sedation. I also confirm that I have explained the intended benefits and serious or frequently occurring risks and any extra procedures that may become necessary during the procedure (please specify):

Bleeding, perforation
damage to teeth, infection

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

The following leaflet/tape has been provided:

Signature

Date

Name & Status of Practitioner:

STATEMENT OF PATIENT (or Parent or Guardian if appropriate) PLEASE READ THE ADVICE OVERLEAF

I am the patient/parent/guardian (delete as necessary)

- ❖ I agree to the procedure or course of treatment described on this form which has been explained to me by the practitioner named above.
- ❖ I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.
- ❖ I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this (this only applies to patients having general or regional anaesthesia).
- ❖ I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.
- ❖ I have been told about additional procedures that may become necessary during my treatment. I have listed below any procedures that I **DO NOT** wish to be carried out without further discussion

Signature

Name

Address

Date

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance) On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

Signed

Date

Name (PRINT)

Job title

21/5/22

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NOTES TO:

ALL HEALTH PRACTITIONERS

(DOCTORS, DENTISTS, NURSES, PROFESSIONS ALLIED TO MEDICINE)

A patient has an absolute legal right to grant or withhold consent prior to examination or treatment. Patients should be given sufficient information, in a way that they can understand, about the proposed treatment and the possible alternatives. Patients must be allowed to decide whether they will agree to the treatment and they may refuse or withdraw consent to the treatment at any time. The patient's consent to treatment should be recorded on this consent form (*further guidance is given in Lanarkshire Acute Hospitals Policy Statement*).

PATIENTS

- ❖ Please read this form and these notes very carefully
- ❖ The health practitioner is here to help you. He or she will explain the proposed treatment and what the alternatives are. You can ask any questions and seek further information.
- ❖ You can refuse treatment. If there is anything that you don't understand about the explanation, or if you want more information you should ask the practitioner before signing.
- ❖ You may ask for a relative or a friend or a nurse to be present.
- ❖ Please check that all the information on the form is correct. If it is and you understand the explanation, then sign the form.
- ❖ Training doctors, dentists, nurses and other health professionals is essential to the continuation of the health service and improving the quality of care. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a senior doctor, dentist, nurse or health professional.
- ❖ You may, however, decline to be involved in the formal training of medical, dental, nursing and other students without this adversely affecting your care and treatment. You must tell a senior Doctor or Nurse if you do not wish students to be involved in your care and you should write this over the page in the space for things that you do not wish to happen without your being given the chance to consider them first.

1808785142
18/08/1978 F F
MCCRACKEN Isabel
1d Cumberae Crescent
Coatbridge
Lanr kshire ML5 4PX

Procedure
Time in: 16:05 (24 hour) ☒ Endoscopy Pause
Scope 1 No: 435 Scope 2 No:
Endoscopist: DR CLARKE

Procedure(s) Performed
☐ Patient consent withdrawn

ENDOSCOPY.

Diathermy plate applied? ☐ Yes ☒ No If yes site: ☐ Removed
Condition of skin checked post procedure: ☐ Satisfactory ☐ Unsatisfactory

Medication administered: ☒ No sedation
Throat spray: 100ml Time: 16:06 If yes, nil by mouth (30/60/90/120 minutes (delete as applicable))
Topical Lignocaine: mls Time: IV Alfentanil: mcgs Time:
IV Midazolam: mgs Time: IV Flumazenil: mcgs Time:
IV Pethidine: mgs Time: IV Naxolone: mgs Time:
IV Buscopan: mgs Time: Oxygen: litres Time:
IV Fentanyl: mcgs Time: Nitrous Oxide - self administration:
Other: (specify) Time: ☐ Yes ☐ No ☒ N/A Time:

Comfort Score: 0 **AVPU Score:** A
Pulse oximetry - SpO2: 97 **Heart Rate:** 112

Samples/Interventions:
☐ APC ☐ Biopsies ☐ Gastric balloon/removal ☐ Sphincterotomy (ERCP)
☐ Aspirate ☐ Brushes/slides ☐ Haemorrhoidal banding ☐ Stent insertion
☐ Balloon dilatation ☐ CLOtest ☐ Injection of ink ☐ Variceal banding/injection
☐ Balloon trawl (ERCP) ☐ Endoscopic muc ☐ Polypectomy
☐ Other: (specify)

Nursing Assessment/Comments: Time to Recovery:
Patient Settled Reassurance given
THROUGHOUT WITH GOOD EFFECT -
NO COMPLAINTS OFFERED.

Completed by: (PRINT NAME) Anna C. McKenna / P. McKenna
Signature: [Signature] / P. McKenna
Designation: Subst nurse / SN

Scope Cleaning – complete only if required as per local hospital/dept. policy ☐ Not applicable

1. Social clean in room by:
Signature: Date: Time:
Processed before disinfection by:
Signature: Date: Time:

2. Social clean in room by:
Signature: Date: Time:
Processed before disinfection by:
Signature: Date: Time:

Affix Theatre Labels Here

1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumbrae Crescent

[Coatbridge]
[Lanarkshire ML5 4PX]
[Endoscope copy]
[Book Out]
[Date 21/05/2021 Time 14:49.]
[Serial]
[Hook 09]
[Start Make OLYMPUS]
[End Model GIF-HQ290]
[Date Serial No 2857435]
[GS1]
[Cycle Cycle No 6038]
[Load 0 Booked In 19/05/2021 Time 17:30]
[Name Name: lynsey fraser. ID: 11]
[Unload Chan Temp 30]
[Name Chan RH 13]
[Cab Temp 28]
[Cab RH 21]
[Hookup]
[Serial Booked Out 21/05/2021 Time 14:49]
[GS1 Name: eleanor simpson. ID: 18]
[Control: OK]
[IMS : OK]
[OLYM]
[Serial]
[GS1]
[Revis]
[IMS V Cante Medical]
[31 Day Endoscope Drying Cabinet]
[Contr EDC22035]
[IMS V]
[Record copy]
[Conti Book Out]
[Date 21/05/2021 Time 14:49.]
[Last]
[Hook 09]
[Suct Make OLYMPUS]
[Biop Model GIF-HQ290]
[Wate Serial No 2857435]
[Air GS1]
[Aux Cycle No 6038]
[Aux]
[RB Booked In 19/05/2021 Time 17:30]
[Leal Name: lynsey fraser. ID: 11]
[Chan Temp 30]
[Det Chan RH 13]
[Dis Cab Temp 28]
[Fir Cab RH 21]
[Booked Out 21/05/2021 Time 14:49.]
[Det Name: eleanor simpson. ID: 18.]
[Dis Control: OK]
[Fir IMS : OK]
[Dex 00001921/8000000016]
[Part B 00001721/8000000027]
[Part A]

 0 = No pain
 1 = Mild pain
 2 = Moderate pain
 3 = Severe pain
 4 = Excruciating/
Worst pain
imaginable

Hospital:

Ward:.....

NEWS Chart

Record head injury observations over page

See over page for NEWS Actions

[illegible]

COPY PAGE

Head Injury Observations															
Glasgow Coma Scale (GCS)	Date:														
	Time:														
	Frequency:														
	Frequency change initials:														
EYES Open	Spontaneous	4													Eyes closed by swelling = C
	To Speech	3													
	To Pain	2													
	None	1													
Best VERBAL Response	Orientated	5													Endo-tracheal tube or Tracheostomy = T
	Confused	4													
	Inappropriate words	3													
	Incomprehensible sounds	2													
	None	1													
Best MOTOR Response	Obeys commands	6													Usually record the best arm response
	Localise pain	5													
	Withdrawal	4													
	Flexion to pain	3													
	Extension to pain	2													
	None	1													
TOTAL: (/15)															

Pupil Scale (mm)	Pupils	Right	Size													S sluggish + reacts - no reaction C eyes closed	
		Left	Size														
	LIMB MOVEMENT	ARMS	Normal power														Record right (R) and left (L) separately if there is a difference between the two sides
			Mild weakness														
			Severe weakness														
			Spastic flexion														
			Extension														
			No response														
		LEGS	Normal power														
			Mild weakness														
Severe weakness																	
Extension																	
		No response															
Initials:																	

National Early Warning Score (NEWS) Actions and Escalation			
Delirium Acute Change - Complete 4AT - inform Nurse in Charge - escalate to Medical staff/HECT			
NEWS 0 - Refer Observation Policy first 48 hours of admission - Minimum 12 hourly observations	NEWS 1 - 4 Inform Nurse in Charge - Lower risk - Respond within 60 mins - ABC - Minimum 4 hourly observations	NEWS ≥5 or 3 in one parameter Inform Nurse in Charge - Medium risk - Urgent assessment doctor/HECT - Respond within 30 mins - ABC - reassess - Start Fluid Balance - Minimum hourly observations	NEWS ≥7 Inform Nurse in Charge - High risk - Senior doctor/HECT assess - Urgent attendance - ABC - reassess - Continuous monitoring - Consider 2222 call - Consider critical care - Document escalation plan

CHI no
First name DOB f..... f.....
Last name Sex: ☐ M ☐ F
Address
.....
.....
.....
or attach addressograph label here

Nursing Evaluation/Comments/Follow-up

[illegible]

Discharge Checklist	Yes	No	N/A		Yes	No	N/A
Dentures returned with patient	☐	☐	☐	Transferred to ward at:	☐	☐	☐
Patient able to drink/eat at:				– Time: :			
– Time: :				Other: (specify)			
Verbal handover given to:							
.....							

Additional Comments/Notes:

Completed by: (PRINT NAME)	Designation:
Signature:	Time: : (24 hour)

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 Date: Oct. 2017 | Review date: Oct. 2020 | Issue: 10.3.1

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Monklands Hospital

GASTROSCOPY REPORT

Name: **Isabel MCCracken (F)**
Date of birth: **18/08/1978**
CHI No: **1808785142**
Case note no.: **1808785142**

Address: **1d Cumbrae Crescent
Coatbridge
Lanarkshire
ML5 4PX**

GP: **Dr NS Marcuccilli
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge**

Procedure date: **21st May 2021 (16:03)**
Priority: **Urgent**
Status: **Outpatient/NHS**
Hospital: **Monklands Hospital**
Referring Cons: **Mr Michael Dick**

Indications

?upper GI neoplasm.

Consultant/Endoscopist

Dr Alan Thomas Clarke

Report

The scope was retroflexed in the stomach.
The procedure was completed successfully to D2.

Instrument

MK - GIF-HQ290 - 2857435

Site b: An area extending from the antrum to the middle body

Gastritis: mild erythematous/exudative with no bleeding.

Premedication

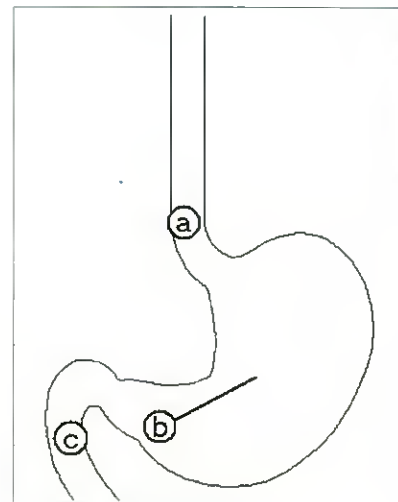
Xylocaine (Spray) 100 mg

Diagnosis

OESOPHAGUS. Normal.
STOMACH. Non-erosive gastritis.
DUODENUM. Normal.

Advice/comments

Biliary gastritis. Nil else of note. CLO not done (on PPI)



- a: Lower oesophagus (photographed)
- b: An area extending from the antrum to the middle body (photographed)
- c: Second part (photographed)


Dr Alan Thomas Clarke
Consultant Gastroenterologist
c.c. Mr Michael Dick (Monklands surgeons)

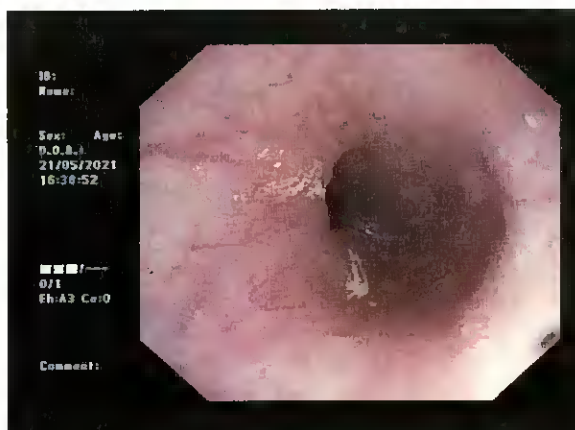


Monklands Hospital
GASTROSCOPY REPORT

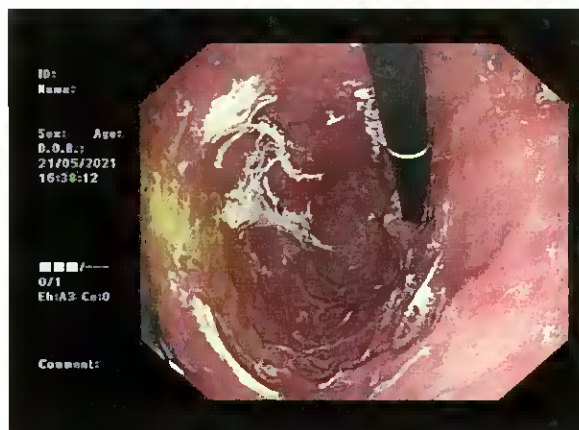
Name: **Isabel MCCracken (F)**
Date of birth: **18/08/1978**
CHI No: **1808785142**
Case note no.: **1808785142**

Address: **1d Cumbrae Crescent
Coatbridge
Lanarkshire
ML5 4PX**

Procedure date: **21st May 2021 (16:03)**



Site a: Lower oesophagus



Site b: An area extending from the antrum to the middle body
Gastritis: mild erythematous/exudative with no bleeding.



Site b: An area extending from the antrum to the middle body
Gastritis: mild erythematous/exudative with no bleeding.



Site c: Second part

1808785142
18/08/1978
MCCRACKEN
1d Cumberae Crescent
Coatbridge
Lanarkshire

F
Isabel
ML5 4PX

878
□ F

graph label here

University Hospital

□ Hairmyres

□ Monkslands

□ Wishaw

NHS
Lanarkshire

404789 - Orkay

Anaesthetic Record

Proposed operation:

Laparotomy

Assessed by:

Orkay

□ Clinic

□ Ward

□ Theatre Suite

□ Consent

□ Adults with Incapacity

Proposed date:

28/4/21

Assessment date:

28/4/21

Actual date of anaesthetic:

28/4/21

Pre-operative/Fasting Instructions (please allow water until 2 hours pre-op unless otherwise instructed)

Date	Time	Premedication	Dose	Route	Ordered by	Given by	Time given

Age: 42

Height:

Weight:

ASA: □ 1 □ 2 □ 3 ☒ 4 □ 5 ☒ E NCEPOD Cat

Relevant Anaesthetic history/Examination/Other *no pre SA*
no pre SA pre SA

CVS

RS 6 day
demon cough. extolance good.

27/3/21 SMV thrombosis - wait treated
INR now 1.1
Hb 63 - 2 units CBC transfused

non deficiency.

Warfarin reversed - started on heparin - last
dose yesterday - now suspended

Airway assessment *present*

MP II

32

Fasting status *3hrs*

Reflux *wanted today*

Current drug therapy

adcal D3 -
citalopram -
cyclosporine DTC
diuretic -
forale -
paracetamol -
quetiapine -
warfarin (stopped)
zopiclone -

metronidazole
toz ✓
tinz ✓
gent ✓
3 dose

gent

Technique and risks discussed

High Risk GA R81 A line central line
ITU post op

Allergies

DICLOFENAC.

NELA/P-Possum Risk: *40% worst* Planned post op destination:

OK for NSAIDS

□ Yes

☒ No

Na 132	K 3.7	Urea 4	Creatinine 43	CXR	Other Mg 0.65
Hb 63	WBC 27.6	Plats 682	eGFR	ECG ST	all 20
PT	APTT	Gp&S	XMatch		CRP 283

Patient Safety Issues

ID check: ☒ Yes □ No

Named consultant: R. RAE

Antibiotic Prophylaxis as per protocol: □ Yes □ No ☒ N/A

Thromboprophylaxis as per protocol: ☒ Yes □ No □ N/A

Case discussed with named consultant: ☒ Yes □ No □ N/A

COVID-ve 27/4/21

already on Abx

COPY PAGE



LAT416

NMAHP.ANAESR.19_07372.L

1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumbrae Crescent
Coatbridge
Lanarkshire ML5 4PX

IV Cannulae:

☒ L R Hand / Arm / Foot G 18
☒ L R Hand / Arm / Foot G 16
☐ Comply with NHSL PVC insertion bundle

Airway:

☐ Face Mask
SAD size:
ETT size: 7.5
Cuffed / Uncuffed

Type:
Type: PORTEX
Oral / Nasal

Laryngoscopy Grade (direct): I
Laryngoscopy Grade (indirect): Full view
Laryngoscopy Device: McGrath
☒ Filter ☒ HME Pack In / Out

Ventilation:

☐ Spontaneous
Mode: *VC-AF*

☒ Controlled
Circuit: *circle*

Other:

Position:
☒ Eyes taped
 Warmers: ☒ Forced air *off due to pyrexia* ☒ Fluids

IV Fluids

- ① Plasmalyte 500ml.
- ② Plasmalyte 500ml
- ③ PL + 20mmol KCl 500ml
- ④ CRBC 273ml. 9101621 0852064

Sheet 1

Start Time:

Finish Time:

☒ Machine checked	☒ ECG	☒ FiO ₂	☒ Temp	☒ Disconnect/Paw	☒ Surgical pause
☒ Pre O ₂	☒ NIBP	☒ EtAA	☒ TOF	☐ CVP	
☒ RSI & CP	☒ SpO ₂	☒ EtCO ₂	☒ ABP	☐ CO	

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
ALFENTANIL (MG)	1														
PROPOFOL (MG)	100														
ROCURONIUM (MG)	50			20					10		+10				
DEXAMETHASONE (MG)		6.6													
MORPHINE (MG)			2 +2			+2		+2+2			+2				+2
CALCIUM GLUCONATE (mg)										10					
DARUNAVIR (mg)											750				
NETARAMINOL (ml/L)	5 →			→ 2 → 4 →	↓ 3	3	3	3	3	3	4.5	4.4	4	4	4
Vent parameters	400 x 18					12 ± 16									
FiO ₂	1-0	0.5	0.4	0.4	0.41	0.44	0.51	0.51	0.52	0.52	0.36	0.36	0.34	0.32	0.31
SpO ₂	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Et CO ₂	4.9	5.2	4.8	4.7	4.6	4.3	4.6	4.5	4.7	4.6	4.6	4.8	4.6	4.4	4.4
Et AA	1.54	1.37	1.95	2.0	2.3	2.15	2.07	2.03	2.06	2.07	2.28	2.07	2.0	1.93	1.93
Temp °C	38.0		38.5		38.3	37.9	37.9	37.8	37.6						
IV Fluid No.	(1) →			→ (2) →							(3)				
Events	19:30		20:00				21:00		21:30		22:00		22:30		23:00
A A-line & IV access	(A) (B) (C) (E) (F) (G)						H				(I)				
B Induction															
C NG tube															
E Positioning															
F KTS 20.15															
G Conversion to Laparoscopy 20.26															
H TAZ (MKT)															
I Spontaneous Breeds															
Blood Loss									385		2130				
Urine (mL)			260				1200/mL						175		

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Special Comments (difficulties, critical incidents, invasive line insertion)

A-line - asepsis, @ Radial, awake, 1% lidocaine to skin & subcut tissue, flowswitch, sutured into place, ~~asx~~
No immediate complications.



1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumberae Crescent

Coatbridge
Lanarkshire ML5 4PX

Regional Anaesthesia/Analgesia (instituted pre/post operatively)

Description

- ☐ Asepsis
☐ Nerve stimulator
☐ Ultrasound

Drugs Used

Volume/dose

Operation Performed: LAPAROSCOPY → LAPAROTOMY. (R) hemicolectomy + end ileostomy

Surgeon: DICK/THOMPSON

Grade: CONS/ST3

Anaesthetist: RAE/KELLNER

Grade: CONS/ST5

Instructions to Recovery

Analgesia: As per recovery protocols IV as required to a total of: ☐ Morphine mg
☐ Fentanyl micrograms
☐ Morphine/Alfentanil mls

SMV thrombosis - Heparin suspended.
- please discuss further management with
surgeon in am.

- ☒ PCA Chart
☐ Intrathecal Opiate Chart
☐ Epidural Chart
☐ Local Anaesthetic Infusion Chart

Free oral fluids overnight

Oxygen titrate to SpO₂

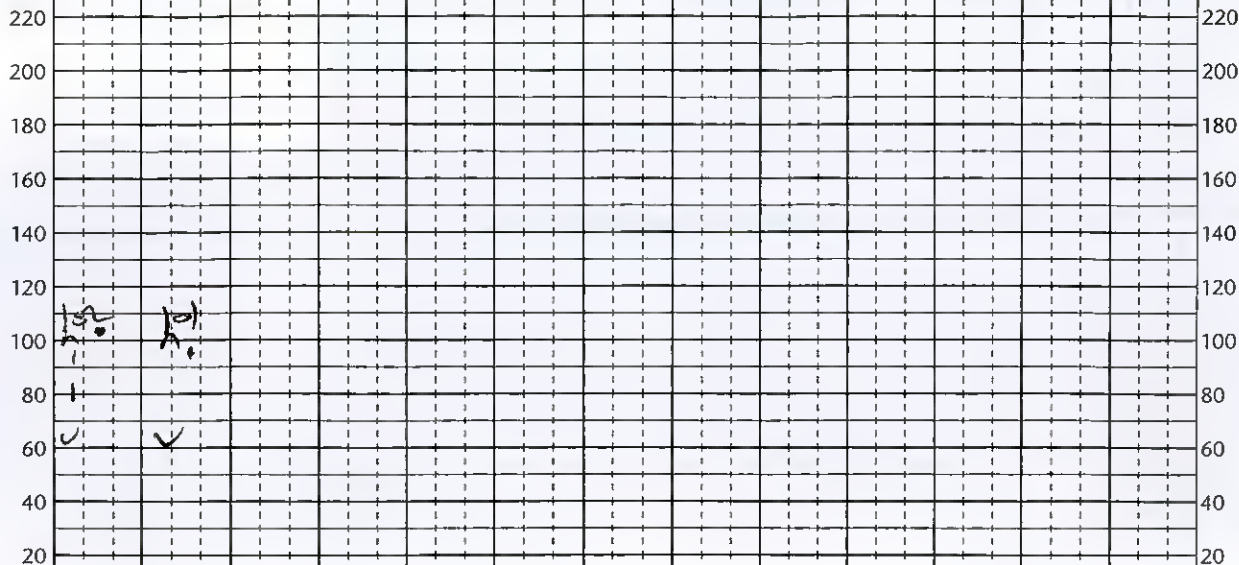
Fluids (volume and rate) 1. Maintenance fluids + boluses / blood dependency on H₂
2.
3.

Other

Anaesthetist's Signature:

Recovery Observations

Time: 13:40 13:55 00:10



Airway/Type *OLM*

O₂ Therapy *SL SL*

SpO₂ *99% 100%*

Respiratory Rate

ECG *✓*

Temperature *36.3*

Sedation Score *5 5*

Pain Score *0 0*

Nausea/vomiting *X*

Wound check *✓ ✓*

Dressing *Meplac ✓ ✓*

Colour/Sensation /Movement

BM

PV

Urine mls *45*

Urine tot *100*

Drain 1

Drain 2

Rectal Olain

Drug and Route

Time	Drug	Dose	Route	Given by

Beta Blocker Resumed (if appropriate)

IV Fluid	Volume	Rate	Serial No.	Given by	Start	Finish

Recovery Comments/Instructions to Ward Staff

Signature: *[Signature]*
 Designation: *Staff nurse*
 Time discharged from Recovery: *00:10*
 Anaesthetic Record | Anaesthetic Services | NHSL | Page 4 of 4

1808785142
 18/08/1978 F
 MCCracken Isabel F
 1d Cumberae Crescent
 Coatbridge
 Lanarkshire ML5 4PX

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1808785142
18/08/1978 F F
MCCRACKEN Isabel
1d Cumberae Crescent

Coatbridge
Lanarkshire ML5 4PX

Sheet 2

University Hospital:

☐ Hairmyres

☐ Monklands

☐ Wishaw



Anaesthetic Record

Proposed operation:

Lapatomy

Proposed date:

Assessed by:

☐ Clinic ☐ Ward ☐ Theatre Suite

☐ Consent ☐ Adults with Incapacity

Assessment date:

Actual date of anaesthetic: *28/4/21*

Pre-operative/Fasting Instructions (please allow water until 2 hours pre-op unless otherwise instructed)

Date	Time	Premedication	Dose	Route	Ordered by	Given by	Time given

Age:

Height:

Weight:

ASA: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ E NCEPOD Cat

Relevant Anaesthetic history/Examination/Other

CVS

RS

see sheet 1

Airway assessment

Fasting status

Reflux

Current drug therapy

Technique and risks discussed

Allergies

NELA/P-Possum Risk:

Planned post op destination:

OK for NSAIDS

☐ Yes

☐ No

Na	K	Urea	Creatinine	CXR	Other
Hb	WBC	Plats	eGFR	ECG	
PT	APTT	Gp&S	XMatch		

Patient Safety Issues

ID check: ☐ Yes ☐ No

Named consultant:

Antibiotic Prophylaxis as per protocol: ☐ Yes ☐ No ☐ N/A

Thromboprophylaxis as per protocol: ☐ Yes ☐ No ☐ N/A

Case discussed with named consultant: ☐ Yes ☐ No ☐ N/A



IV Fluids
(5) PL 500ml

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Special Comments (difficulties, critical incidents, invasive line insertion)

CHI no
First name DOB / /
Last name Sex: ☐ M ☐ F
Address
.....
.....
or attach addressograph label here

Regional Anaesthesia/Analgesia (instituted pre/post operatively)

Description

- ☐ Asepsis
☐ Nerve stimulator
☐ Ultrasound

Drugs Used

Volume/dose

Operation Performed:

(R) hemicolectomy + end ileostomy

Surgeon:

Dicks

Grade:

Anaesthetist:

R. B. E.

Grade:

Instructions to Recovery

Analgesia: As per recovery protocols IV as required to a total of:

- ☐ Morphine mg
☐ Fentanyl micrograms
☐ Morphine/Alfentanil mls

- ☐ PCA Chart
☐ Intrathecal Opiate Chart
☐ Epidural Chart
☐ Local Anaesthetic Infusion Chart

Oxygen

Fluids (volume and rate) 1.
2.
3.

Other

Anaesthetist's Signature:

R. B. E.

Recovery Observations

[illegible]

Drug and Route				
Time	Drug	Dose	Route	Given by

Beta Blocker Resumed (if appropriate)

IV Fluid	Volume	Rate	Serial No.	Given by	Start	Finish

Recovery Comments/Instructions to Ward Staff

CHI no.

First name DOB

Last name Sex: ☐ M ☐ F

Address

or attach addressograph label here

Signature: _____

Designation:

Time discharged from Recovery: _____ : _____

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1808785142
18/08/1978 F
MCCRACKEN Isabel F
1d Cumberae Crescent
Coatbridge Lanarkshire ML5 4PX

☐ Hairmyres ☒ Monklands ☐ Wishaw

NHS
Lanarkshire

Operation Record

Date: 28/9/2021 Time Begun: : (24 hour)

Named Surgical Consultant:

M. Dice

Named Anaesthetic Consultant:

J. Rae

Surgeon:

M. Dice / J. Thompson / R. Curran -
Senior

Anaesthetist:

J. Rae

Assistant:

☒ GA ☐ LA ☐ LA and sedation

Regional:

Prophylactic antibiotics given?

☒ Yes ☐ No

specify: Santonin / Flap / Amoxicillin

Operation(s) Performed:

Laparoscopy (carcinoma)

Time Finished: : (24 hour)

Laparoscopy, LIMITED DISSEMINATION + END ILEOSTOMY.

☒ Emergency

☐ Elective

Findings:

Pre-op:- Smv thrombosis, CVP > 900, concern on CT
over possible venous ischaemia.
? Abscess in small bowel mesenteris.
Fiber smv thrombosis - also concern over
underlying malignancy.

Small bowel - healthy & pink with no ischaemia
- possible fat stranding in terminal ileum (but subtle if true).
- Appendix - lying retro - small bowel mesenteris st in abscess
caus. Appendix appeared abnormal, tip perforated (? underlying
appendix cancer) & auto amputated. - No gross colonic mass
palpable - Stomach (N) - Hard palpable areas in
uncertain if related

Description of Procedure:

Small bowel mesenteris - SB / Lve - (N).
to Smv thrombosis.

Shin prepared & draped. Supine position. - Cutdown
at umbilicus & 12cm port blunt port inserted.
- on entering abdomen - Widespread free fluid
(serous / tinged green) - decision made for
Laparoscopy (midline). - Trocar placed.
- Inspection of abscess. - Fiber only abnormal



1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumberae Crescent

Coatbridge
Lanarkshire ML5 4PX

fully in appendix. - Small vessel (terminal ileum) was
carefully isolated off above cavity (2 x areas) within
~ 11cm of I.C. valve. (no small bowel injury). - For
for above cavity sent for culture. Blunt dissection
to gain access to cavity & to free appendix.
- Becom note (given possibility of appendix cancer & appendix
base of uncertain quality to be off) for limited right
hemicolectomy. - Given possible clot in vessels &
decided to keep mobilisation adjacent to small bowel
& caecum. - After color mobilised & freed from
lymph nodes & ligature used to divide vessels

Tissue sent for pathological examination:

Limited (R) ileal hemicolectomy

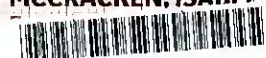
adjacent to colon.
- distal terminal ileum divided 91cm/100cm
(incorporated 2 areas within above
cavity). & ligature used to run
along terminal ileum.

Post-operative instructions:

- ICU level ②.
- No. anticoagulation prophyl.
- Continue IV Abx.
- NS free drainage.
- Oral fluids.

- Some bleeding encountered from
junction between small bowel vessels
& resection - 2/2 sutured & suture
used. - Wound & lacerations closed.
- Flap & tampons to resect area
& posterior abd. wall on right side.
- Leaky fistula in RIF (pre-mixed)
with interposed No. 13 suture. (Sputum).
Close: - 1/0 nylon continues to
ligature & clips.

- Noon



1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumbernauld Crescent

Vent. rate 111 BPM
PR interval 148 ms
QRS duration 90 ms
QT/QTc-Baz 350/476 ms
P-R-T axes 47 47 45

Patient ID: 1808785142
Sinus tachycardia
Otherwise normal ECG

27.04.2021 10:49:45
Monklands Hospital



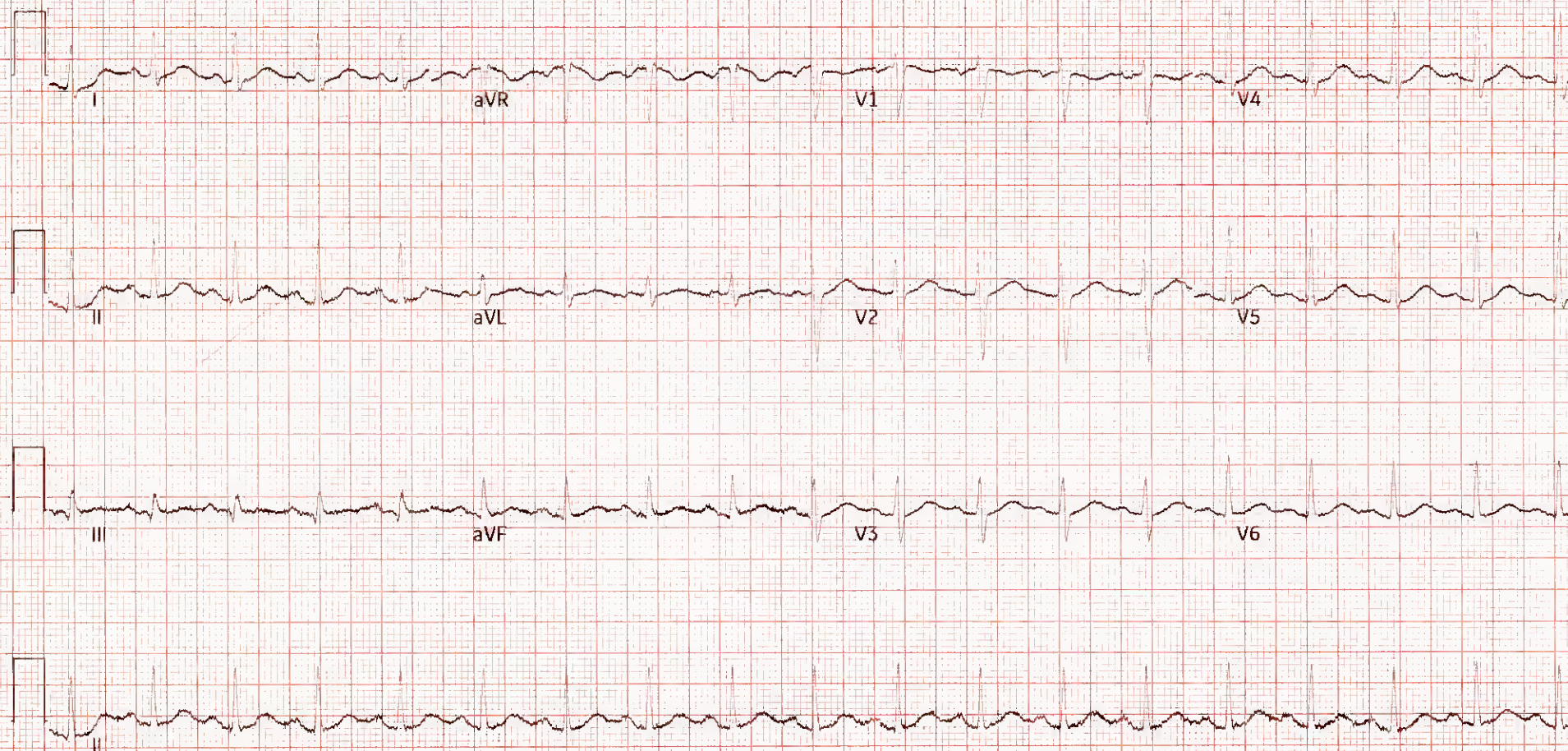
RP02

Coatbridge
Lanarkshire

ML5 4PX

Location:

Unconfirmed



30.04.2021 09:52:12

Monklands Hospital

RP02

Vent. rate 97 BPM
PR interval 166 ms
QRS duration 86 ms
QT/QTc-Baz 368/467 ms
P-R-T axes 64 45 42°

Normal sinus rhythm
Normal ECG



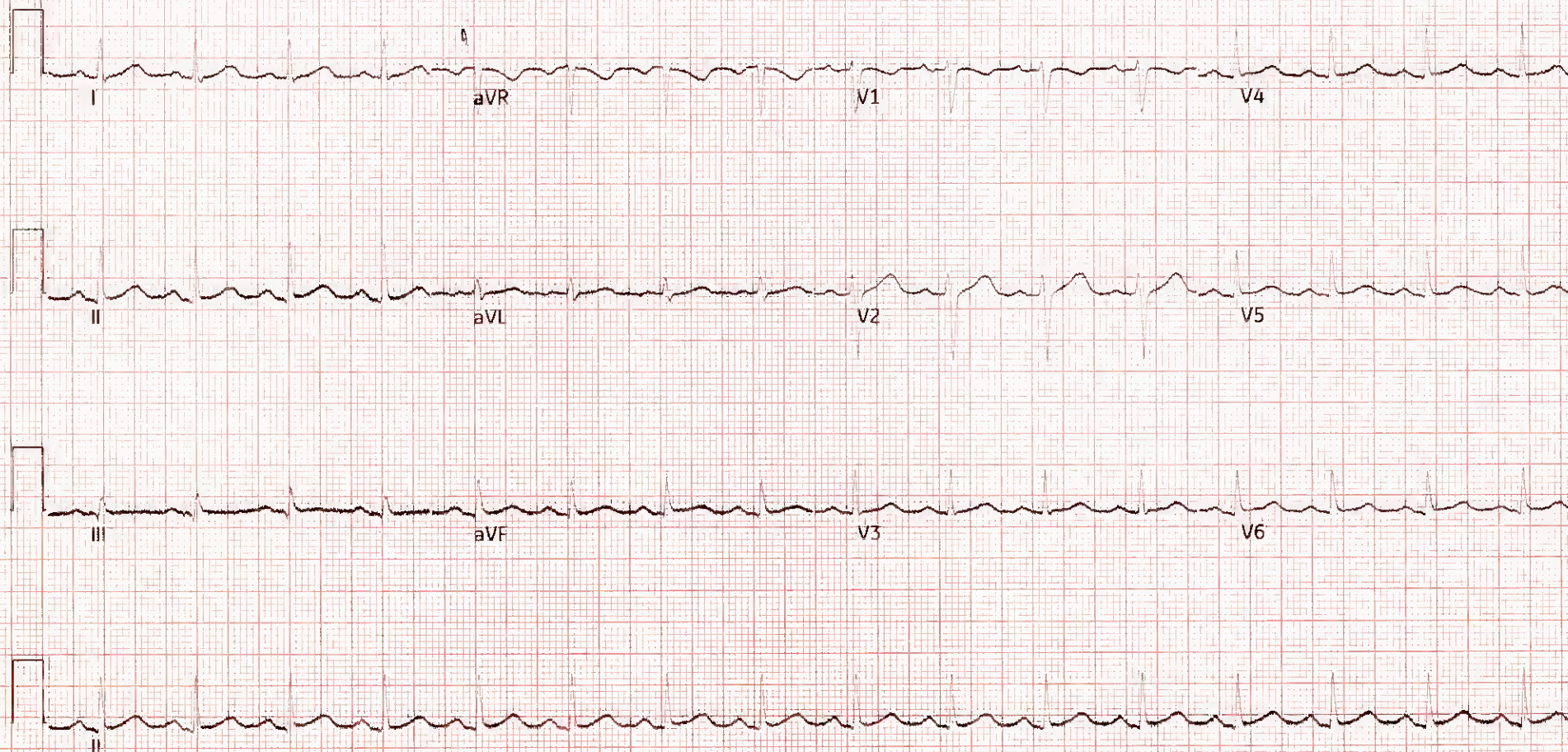
1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumberae Crescent

Location:

Coatbridge
Lanarkshire

ML5 4PX

Unconfirmed



Last: MCCracken
First: ISABEL
ID: 1808785142
DOB: 18-Aug-1978
Age: 42 yr
Sex: Female Ref Phy: W7
Tech: CH
Loc: W7

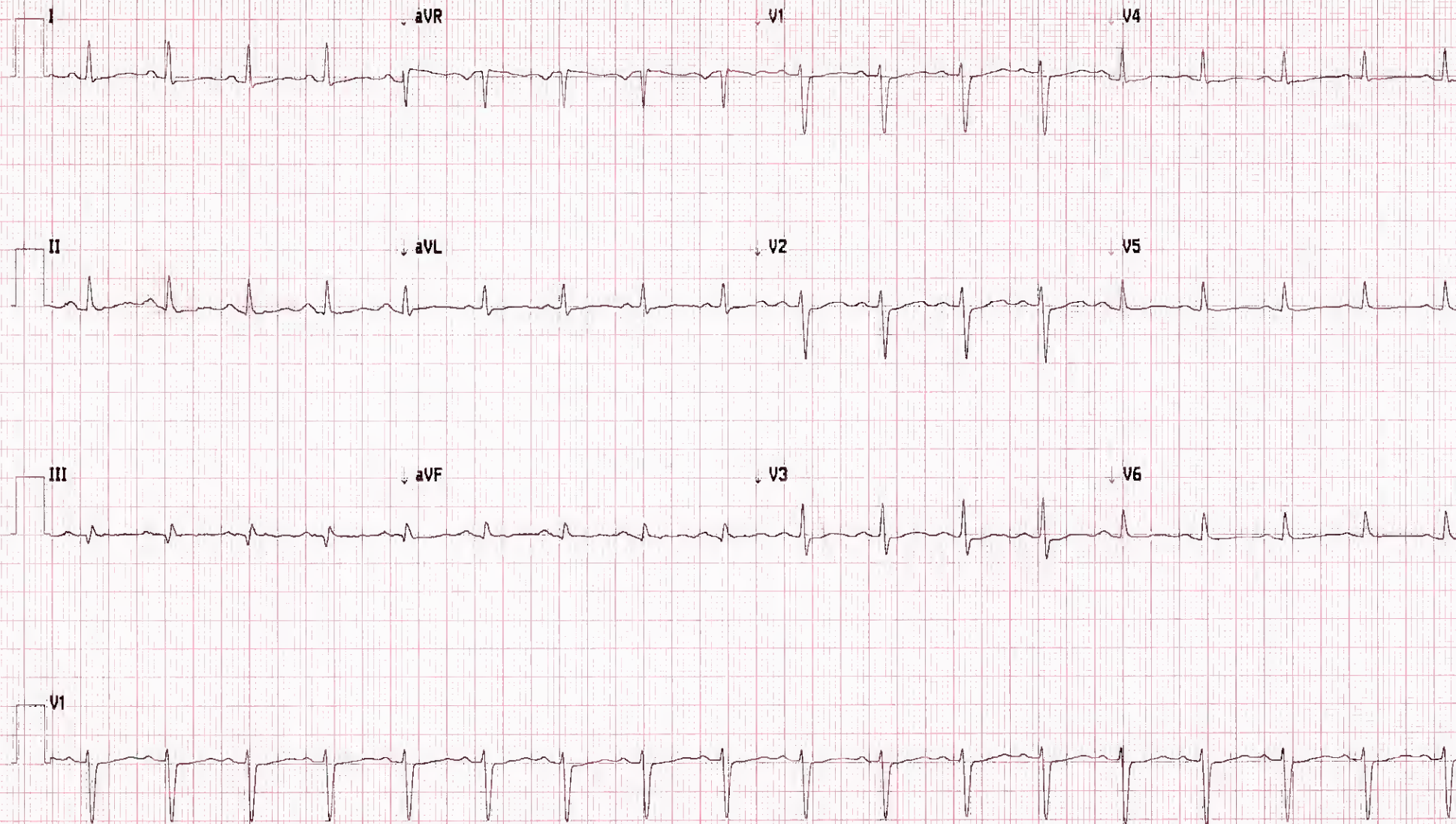
10-May '21 11:53:20
Vent rate 106 BPM
PR int 167 ms
QRS dur 89 ms
QT/QTc 362/424 ms
P-R-T axes 40 31 33

SINUS TACHYCARDIA
NONSPECIFIC T-WAVE ABNORM. Y
ABNORMAL RHYTHM ECG
UNCONFIRMED REPORT

Sinus tachy 106



RP02



Treatment Escalation Plan FOR NON-COVID PATIENTS

A TEP should be used for **all admissions not related to COVID infection** (separate *pro forma* available).
If **palliative surgery** is being considered in a patient with CFS $\geq$ 6, e.g. repair of #NOF, a TEP to guide management of potential post-op. complications is strongly advised.

The **GOALS OF TREATMENT** should be framed by the **CONTEXT** of this admission. Does the patient have ...

- An illness trajectory likely to be in the last 12 months of life?
- An ASA score of $\geq$ 3 OR Clinical Frailty Score of $\geq$ 6 (see Guidance Notes) OR is a nursing home resident?
- Advanced disease: organ failure, neurological disease incl. dementia, cancer, multiple co-morbidities?
- Refractory abnormal observations e.g. GCS $<$ 5, BP $<$ 60 systolic, SaO $_2$ $<$ 85% in which a diagnosis of dying has been confirmed and documented?

The **CONSEQUENCES** of any intervention or escalation need to be considered, including **futility** and **harms**, along with previously documented treatment / resuscitation **preferences**.

PATIENT'S UNDERSTANDING of their condition and proposed treatment

Fully aware ☒ Has capacity but retention is uncertain ☐ Lacks decision-making capacity ☐

If decision-making capacity is impaired, has Section 47 AWI been completed? YES ☐ NO ☐

GOALS OF TREATMENT

**FULL ACTIVE
TREATMENT***

SELECTIVE TREATMENT**
Attempt to reverse acute process *if appropriate*. Assess progress and review goals of treatment regularly.

PALLIATIVE TREATMENT***
Provide for symptom control and comfort care. Ensure dignity if dying is imminent.

TREATMENT ESCALATION / LIMITATION PREFERENCES in the event of future deterioration:

*FOR FULL ESCALATION ☒

**ESCALATE / LIMIT TREATMENT (select one of these four principal options + others in blue box):

ICU referral (for possible mech. ventilation) ☐ Transfer to HDU / CCU (for NIV, inotropes etc.) ☐

Ward care: no further major escalation ☐ *****Ward care: symptom control and comfort** ☒

Invasive procedures (state) e.g. operation, NIV, stenting	YES	NO	Intravenous access	YES	NO	Feeding: NG, PEG, TPN	YES	NO
Imaging other than plain X-rays	YES	NO	Intravenous fluids	YES	NO	Oral feeding: (with accepted aspiration risk)	YES	NO
Blood sampling	YES	NO	Subcutaneous fluids	YES	NO	Blood transfusion	YES	NO
ABG	YES	NO	Oral antibiotics	YES	NO	Observations / Early Warning Scoring	YES	NO
			IV antibiotics	YES	NO			

Additional investigations or treatments that may or may not be appropriate (See next page, section 7, for possible choices):

APPROPRIATE

INAPPROPRIATE

CPR YES ☒ NO ☐

A TEP must ALWAYS be used when a DNACPR order is being put in place.



Discussion If discussion is not possible at the time of initiating treatment, then it must be planned for the first available time thereafter. An existing ACP / TEP should be respected and used. If the discussion is complex, then a separate note should be written in the hospital record.

This Plan has been discussed with: Name of family member & relationship with whom this was discussed:

THE PATIENT YES ☐ NO ☐
 FAMILY/CARERS/POA YES ☐ NO ☐
 ICU TEAM N/A ☐ YES ☐ NO ☐
 RECEIVING SPECIALTY YES ☐ NO ☐

If discussion was not possible for any reason then this should be recorded:

Person completing this document. COMPLETING THIS SECTION IS MANDATORY

(Signature) *Jordanna Deasava* (Print in Capitals) *JORDANNA DEASAVA*
 (Position) *STB* (Date) *27/04/21*
 (Responsible consultant) *GNLAW* (Initials and date) *GN 27.4.21*

Guidance Notes

- The **AIM** of any TEP is to optimise treatment so that in the event of deterioration, it is APPROPRIATE. The **GOALS of TREATMENT** should ensure that a patient's VALUES AND PREFERENCES are respected, and that medical harms are avoided. APPROPRIATE TREATMENT may mean introducing palliative treatments immediately on admission.
 - The Plan should be **INITIALLED BY THE LEAD CLINICIAN** within 24 hours. It should be **REVIEWED REGULARLY** during an admission. Do not make multiple entries on to a Plan - replace the existing one with an updated fresh one. Any old Plan should have "OBSOLETE" written across it with date and initials. REFER TO PLAN IN DISCHARGE LETTER.
 - DNACPR** Discussing DNACPR in isolation or prior to discussing other treatment choices is fraught with hazard. A TEP must ALWAYS be used when a DNACPR order is put in place. A separate form is required for DNACPR. NB If Clinical Frailty Score is 6 or more, then CPR will not result in survival to hospital discharge.
 - ESCALATION TO ICU.** If ICU is to be considered, then consultation with the ICU consultant is essential. Ideally whether or not the patient will be referred to ICU should be decided at the time of admission or during a ward round, and not when a patient "crashes" or the EWS increases. If in doubt, request an early ICU consultation.
 - AGE.** Age alone is not a determining factor regarding treatment escalation / limitation.
 - PRE-ADMISSION HEALTH STATUS.** The yellow box on page 1 gives you a check list to be considered. The **CONTEXT** is critical for setting the **GOALS OF TREATMENT** and the **TEP PREFERENCES**.
- Frailty.** The Clinical Frailty Scale may be useful. Consider: If it is 5 or more, then escalation beyond "ward care" or "ward care with palliative treatments" needs to be weighed carefully. For patients of any age with stable long-term disabilities (e.g. autism, cerebral palsy) do not use the Clinical Frailty Scale ©.

Grade	Category	Description	Grade	Category	Description
3	Managing well	Activity limited to walking	6	Moderately frail	Some problems with stairs, bathing, dressing
4	Vulnerable	Symptoms limit activities	7	Severely frail	Completely dependent for personal care
5	Mildly frail	Needs help with some ADLs	8	Very severely frail	Approaching end-of-life in days or weeks

Co-morbidities. The American Society of Anaesthesiology (ASA) grade may be useful ©. If grade is 4 or more then this should influence any consideration of ICU referral.

Grade	Description	Grade	Description
1	Healthy patients	3	Severe disease process which limits activity but is not incapacitating
2	Mild to moderate systematic disease caused by a condition or other pathological processes, and medically well controlled.	4	Severe incapacitating disease process that is a constant threat to life
		5	Moribund patient not expected to survive

7. ADDITIONAL APPROPRIATE/ INAPPROPRIATE INTERVENTIONS should be actively considered. Insert in blue box on page 1. If a patient is dying, using the Record of End of Life Care (RELC) is strongly recommended.

Blood products e.g. platelets	Central line / dialysis line	Deactivation of defibrillator	Diuretics, oral or i.v.	Emergency endoscopy	Inotropes / pressors	Nasal high flow O ₂
Nephrostomy	Peritoneal drainage	Pleural drainage	Renal replacement	Sengstaken tube	Thrombolysis	Transfer to medical ward

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1808785142
18/08/1978 F JF
HCCRACKEN Isabel
1d Cumberae Crescent
Coatbridge
Lanarkshire ML15 4PX

Hospital: UHM
Ward: 7
Booklet no.: 1 Date started: 1/5/21 NHS Lanarkshire

Person Centred Care Plan

Guidance notes for completion:

- Before using this document please ensure you record your full details on the back page.
- Nursing staff to complete a Person Centred Care Plan (on pages 2-5) as per initial/ongoing assessment, based on the activities of living detailed in **Section 1**. below. Care plan reviews should also be recorded in this care plan section.
- Record the care given and all communications in the Record of Care/Communication with relatives and other professionals section (pages 6-15).
- Please also indicate in **Section 2**. below, any additional assessments/forms completed as part of the care planning and review process.

Patient's preferred name: Isabel.

Overview of patient's presenting complaint and relevant past medical history:

R Herni, End Ileostomy + Appendicetomy

SECTION 1. ACTIVITIES OF LIVING

- | | |
|-----------------------------------|---------------------------------|
| 1. Maintaining a safe environment | 7. Controlling body temperature |
| 2. Communicating | 8. Mobilising |
| 3. Breathing | 9. Work and social activity |
| 4. Eating and drinking | 10. Expressing sexuality |
| 5. Eliminating | 11. Sleeping |
| 6. Washing and dressing | 12. End of life care |

SECTION 2. ASSESSMENTS/FORMS FOR CONSIDERATION *(tick if completed)*

To be reviewed daily

- | | |
|--|---|
| ☐ 4AT Assessment Tool and TIME Bundle | ☐ Abbey Pain Assessment and Management |
| ☐ Confusion Assessment | ☐ MUST Nutritional Screening/Nutrition Profile |
| ☐ Getting to know me | ☐ Oral Health Assessment |
| ☐ Learning Disabilities Supplementary Information | ☐ Swallow Screening Test |
| ☐ Mobility Assessment | ☐ Fluid Balance Chart |
| ☐ Falls Risk Assessment (Hospital)/ Falls Bundle | ☐ FAST Alcohol Screening |
| ☐ Pressure Ulcer Risk Assessment (PURA) | ☐ Glasgow Assessment and Management of Alcohol/GMAWS Score |
| ☐ SSKIN Care Bundle | ☐ Management of Nicotine Addiction (Inpatient) |
| ☐ Assessment and Management of Wounds (including pressure ulcers) | ☐ Peripheral Vascular Catheter (PVC) Bundles |
| ☐ Foot Assessment - CPR for Feet | ☐ Discharge planning |
| ☐ MRSA/CPE Clinical Risk Assessments | ☐ Other: (condition specific) |
| ☐ Stool Chart | |
| ☐ Daily Pain Assessment | |



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- Complete person centred care plan and initial/date/time as appropriate. Care plan reviews should also be recorded here.
- Care Plan should be developed/reviewed with the patient/family/carers as appropriate.
- Consider what care your patient needs and why and **identify specific actions required where possible.**



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MCCRACKEN Isabel
Ad 1d Cumberae Crescent
Coatbridge
Lanarkshire ML5 4PX

- Complete person centred care plan and initial/date/time as appropriate. Care plan reviews should also be recorded here.
- Care Plan should be developed/reviewed with the patient/family/carers as appropriate.
- Consider what care your patient needs and why and **identify specific actions required where possible.**

PERSON CENTRED CARE PLAN

7. Controlling body temperature

Initials	Start Date/Time	End Date/Time
----------	-----------------	---------------

Identified care need:

Within normal range

DR I/S

8. Mobilising

Identified care need:

Normally independent

DR I/S

9. Work and social activity

Identified care need:

No issues

DR I/S

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- Complete person centred care plan and initial/date/time as appropriate. Care plan reviews should also be recorded here.
- Care Plan should be developed/reviewed with the patient/family/carers as appropriate.
- Consider what care your patient needs and why and **identify specific actions required where possible.**

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 F 18/08/1978 F
 L MCCracken Isabel
 A1d Cumbrae Crescent
 Coatbridge
 Lanarkshire ML5 4PX

Date/Time	Record of care/Communication with relatives and other professionals	Initials
1/5/21 17 ²⁵	Isabel has been settled to since transferring to Ward 7. To continue on IVAS. Stoma active. Obs as charted and all medications administered as pxd. Hypotensive at last obs check however this is normal for Isabel. No new issues reported at this time. Family updated.	
1/5/21 ND	Isabel settled this evening. Stoma active. observations obtained and charted news score of 3. 2 for Bp, 4 for pulse. Assisted with personal care. All medication administered as per hepma. no new concerns at this present time.	OR
21/5/21 10.	Isabel appears settled, obs charted, remains hypotensive. Assistance given with personal care. S/B surgical team, to encourage F fluid and diet, IVF to continue, aim for urine volumes to be greater than 30ml/hr. Stoma active, rectal drain remains. No contact with relatives.	AS
ND	Obs as charted, remains hypotensive IVF & IVAS continue, urine output as charted, Stoma active overnight.	J
3/5/21	Wound exposed - clips in situ	McA PH
3/5/21	Updated S/W to advise no date for discharge as yet. All meds administered as per hepma. Obs stable, slightly pyrexia and paracetamol given.	T4
WIR	Mr Dick - ? Septic for IV fluids and antibiotics. For stool sample and culture.	

1808785142
 18/08/1978 F
 MCCRAICKEN Isabel
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 Coatbridge
 Lancashire ML5 4PX

Date/Time	Record of care/Communication with relatives and other professionals	Initials
	to be obtained. Patient very drowsy throughout the day - Diazepam withheld - NEWS score down to 3	
ND	Isabel do some pain prior to settling. Analgesia given with some effect. 4° obs. NEWS (4) @ 0030 tachy & hypotensive. IVF ongoing. Rechecked. NEWS (2) BP 101/66 & HR 105. Cath patent and draining good vols. IVAB cont. No new issues raised.	MS
4/5/24 11-15	Isabel was receiving a 7 this morning > Resp, tachy, pyrexia and sat. Paracetamol administered, analgesia administered. News score now (2) due to still being tachy. MSSU positive for protein and blood send MSSU. Rpt bloods taken by doctor. Pt settled. All meds administered as per hepma however diazepam withheld as making patient very sleepy along with her other meds.	TU
12:55	Seen by home care nurse introduced myself and discussed surgery. Given written information relative to surgery and contact number. Appliance removed. Stoma healthy. peristomal skin intact. Active of loose faecal fluid - high output system and elephant tubing in situ. Pileook observe output. Settled but sleepy as present.	TU
1500	Continuing to monitor Isabel. She is	

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 Last name Sex: ☐ M ☐ F
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Date/Time	Record of care/Communication with relatives and other professionals	Initials
1700	To continue with IVF and IVA. A Swab was taken of her wound and sent for cultures. A stool sample was obtained and sent for cultures. Bloods were taken and sent. A Rectal VRE swab to be obtained. Isabel's daughter called in regards to her care. She was concerned that others in the room had spoken to her sister about her mother's care and staff had not updated them. I have confirmed I spoke to (daughter) yesterday and updated about sepsis and treated IVF and IVAB and withholding diazepam. This information had not been passed on to the daughter who called the ward. Kim (staff nurse) has called and spoken to (daughter) and explained the situation. (daughter) is now happy and medics have also called to update.	GR
1800	Isabel appears settled obs as charted, medication as per PRN morphine given catheter Patent, IV vancomycin given @ 03-15. No family contact on.	JY
08.03 05/02/21	Seen by home care nurse appliance intake. Has passed 1200mls over last 24hrs. Stoma active green/brown coloured fluid and it remains loose in consistency. Abdomen slightly distended. Still soft to touch. Settled at present. I have answered Isabel's questions and discussed post-op follow up. I have advised (daughter) to	

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 Last name Sex: ☐ M ☐ F
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Date/Time	Record of care/Communication with relatives and other professionals	Initials
5/5/21 08.00	we will teach her stoma care and happy to educate her daughter nearer discharge	Robson
6/5/21 n/s	Word round - IV fluids continue. IVABS as charted. Stoma active - on high output bag. Urine output satisfactory. Medication as per, obs stable. Vanc level to be obtained prior to done.	Ph
6/5/21 1040	SIB Stoma Care Nurse - appliance request. Stoma healthy. Peristomal skin intact. High output system still insin.	flw
1400	Word round - await wound swab. Remove rectal drain + catheter. Continue IV antibiotics. Patient encouraged to mobilise. Chase pathology commerce on coherence for stoma output.	Ph
6/5/21 19:10	patient dress to abdomen. Reduced risk of infection just exclude. will need reduced tomorrow.	n
6/5/21 NO.	Isabel appears settled, obs charted, per medication given as per hep. Wound changed prior to settling, high output bag remains on stoma. IVAB continue and given up to date. Vanc given at 21:40. encouragement given when mobilising. No other issues. No contact with relatives.	Ph
7.5.21	Isabel settled. Analgesia given with effect. Assisted to LTR. Encouraged to sit up / mobilise. PT ongoing. Stoma	

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18/08/1978 F
MCCRACKEN Isabel JF
1d Cumberae Crescent

Coatbridge
Lanarkshire ML5 4PX

Date/Time	Record of care/Communication with relatives and other professionals	Initials
	education ongoing. Vanc given 1020. Dressing intact. No Family Contact Current	J
7/5/21	SIB Stoma Care Nurse - appliance renewed. Isobel participated in Stoma Care - managed well. Stoma healthy + peristomatal skin intact	flm
ND	Isobel mobile to toilet before settling. Obs stable Apyrexial. Meels as per HEPMA. Settled early. Slept well. No issues stoma appliance intact	flm
8/5/21	SIB Mr Kitchin this Am - to commence on loperamide Am for stoma, maintain fluid balance, NEWS2 this Am for HR 122, for tch if remains tachy. Isobel self caring this Am, no complaints offered. No contact for family.	A
Pm.	Isobel settled + stable, PRN analgesia given with good effect, 1/2 loperamide. Vancomycin level to be done before evening dose. Dressing renewed to midline wand no contact for family.	A
ND	Isobel c/o some pain prior to settling oramorph given with good effect. Venflon removed from L anti cubital fossa as sore and hard to touch. Venflon resited. IV AB given. IV Vanc given. Vanc level dbt prior to dose Mobilised to toilet. No family contact. No new issues raised.	MS
9.5.21 1400	Isobel Settled. Analgesia given with effect. Accurate Fluid balance, asked to use Shells, Stoma output remains high. SIB Surgeons -	



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18/08/1978

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JF

MCCRACKEN Isabel

1d Cumbrae Crescent

Coatbridge
Lanarkshire

ML5 4PX

Date/Time	Record of care/Communication with relatives and other professionals	Initials
	to mobilise / Sit in chair. Dressing intact. IVAB given up to date. No family contact.	2
9/5/21 NO	Isabel refused supper prior to settling. Meds given as per hepma. NEWS stable as directed. PRN analgesia given with good effect. Slept well overnight no contact with family.	BMop
09.40	Seen by Stoma nurse rechecked appliance under supervision. Coped well. Stoma healthy, peristomal skin intact. Unable to assess fluid ^{stoma} output as nil on fluid chart. I have asked Isabel to use bowls when emptying her stoma to enable us to monitor output. Active of faecal fluid.	1 Robbleson
10/5/21 @ 10.10	MEDICATION ADMINISTERED AS PER HEPA NEWS STABLE, SEEN BY PHNSK THIS MORNING, NO CONCERNS AT PRESENT —	JM
Wk	Continue IVAB. Remove alternative clips & swab wound ✓ IV Vanc given @ 12.40 IVAB continue Isabel settled	
14 ⁰⁰	this afternoon VRE +ve - Now isolated Family updated, Further IV Vanc PR Stoma patent. No other	AM
18 ⁰⁰	issues this evening	AM

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Date/Time	Record of care/Communication with relatives and other professionals	Initials
05	Removed stitches (alternate), swab taken from wound. Cleaned wound and redressed with watband border	BJ
10/5/21	Isobel has remained settled this evening. No Obs obtained and stable. All meds administered as per Lpma. IVAB continued and Vanc administered at 00.45. No new concerns overnight.	TY
11/5/21	Isobel independent IVAB/Meds given as per HEPMA. PRN oramorph also taken. Stoma active. Obs stable (HRN) Apyrexial. F/D taken. Stool sample sent for C+S.	
12/00	Seen by Stoma care nurse rechecked appliance under supervision. Coped well. Stoma active of fecal fluid. Supplies given. Settled at present.	12/00/21
17/00	SLB team - remove alternate clips tomorrow, chase wound swab. Complete 7/2 of Albiotics. Aim home Wed/Thurs with OP colonoscopy. Warfarin to restart Wednesday.	MS
17/30	No new issues raised. Stool sample sent for C+S. Isabel to have Tinzaparin (also continue after discharge). Same observed self administering at dinner time - did well. No concerns at present.	MS
18/00	Condition unchanged. IV Vanc @ 0040. Stoma active.	MS

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1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumberae Crescent

Coatbridge
Lanarkshire

ML5 4PX

— PATIENT HERE

Date/Time	Record of care/Communication with relatives and other professionals	Initials
	No contact from family	Kid
12/5/21 09.50	Seen by Stoma care nurse & noted appliance under supervision coped well. Stoma mainly healthy, sloughy around periphery. Active faecal/bile coloured fluid. Settled at present. Self emptying her pouch - emptied 3 times yesterday.	1 Robertson
1130	S/B MD for IP OGD tom. All clips to be removed. Incl with shower. IVAB cont. D/C from PT.	
1800	Updated daughter via phone. Alternative clips removed. Wound dressed with sterile swabs & Urgotul. Mob & incl around room. Vanc d/c. All meds given as per Hepma. Isabel administered tinz. No new issues raised.	MS
12/5/21 N/D. 13/5/21 10.	Isobel settled tonight - obs remain stable, Apyrexial all meds given as per Hepma. Slept well overnight. Isobel settled, Obs as charted. Temp 37.7 - fast for scope - oral analgesia given with sips only. Check list complete. Await consent. Wound intact. S/B surgical team.	MS
	Stoma active faecal/bile fluid. Independent to toilet. No further issues.	AW
11.50	Seen by Stoma care nurse appliance removed under supervision, coped well. Stoma remains mainly healthy, sloughy around periphery peripheral skin healthy and intact. Active bile/faecal coloured fluid - please monitor output as to consistency.	1 Robertson
1750	Isabel has remained settled.	

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Date/Time	Record of care/Communication with relatives and other professionals	Initials																																								
	scope today. Can eat + drink. Obs as charted and all meds administered as prescribed. No new issues. reported at the time of writing	DR																																								
13/5/21 ND.	Isobel settled tonight - Obs checked 80. News stable. Routine meds given + PRN oramorph. Asleep for long periods. Await ILP OGD, NO contact with relatives -	Roh																																								
14/5/21 0840	SIB Stoma Care Nurse - Isobel renewed appliance independently - managed well. Stoma healthy + active thick fecal fluid	plm																																								
14/5/21 0905	Infection, Prevention and Control Nurse VRE isolated on 04/05/21. Please monitor for any loose stools or any clinical signs of infection.	Shirley (IPCN)																																								
Generic Infection Prevention and Control Advice Sticker Alert Organism/Condition: VRE <table><thead><tr><th></th><th>In Place</th><th>Required</th><th>N/A</th></tr></thead><tbody><tr><td>Isolation</td><td>✓</td><td></td><td></td></tr><tr><td>Risk Assessment</td><td>✓</td><td></td><td></td></tr><tr><td>Door Sign</td><td>✓</td><td></td><td></td></tr><tr><td>Quick Reference Guide</td><td>✓</td><td></td><td></td></tr><tr><td>Screens/Stool Chart</td><td>✓</td><td></td><td></td></tr><tr><td>Inform medical staff of diagnosis</td><td>✓</td><td></td><td></td></tr><tr><td>Treatment/Decolonisation</td><td>✓</td><td></td><td></td></tr><tr><td>Daily room/bed space clean with: Anchor plus</td><td>✓</td><td></td><td></td></tr><tr><td>Patient Information Leaflet Advised</td><td></td><td></td><td></td></tr></tbody></table> ☒ Adhere to Standard Infection Control Precautions ☐ Adhere to Transmission Based Precautions Refer to the Infection Prevention and Control Manual for further information Contact the Infection Prevention and Control Nurse on 01698 366309 for further advice if required.				In Place	Required	N/A	Isolation	✓			Risk Assessment	✓			Door Sign	✓			Quick Reference Guide	✓			Screens/Stool Chart	✓			Inform medical staff of diagnosis	✓			Treatment/Decolonisation	✓			Daily room/bed space clean with: Anchor plus	✓			Patient Information Leaflet Advised			
	In Place	Required	N/A																																							
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Treatment/Decolonisation	✓																																									
Daily room/bed space clean with: Anchor plus	✓																																									
Patient Information Leaflet Advised																																										
14/5 1300	Settled today. obs stable + charted. All meds given as																																									

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Date/Time	Record of care/Communication with relatives and other professionals	Initials
	per hepma. W R ^o cnt abx, Await scope + bone marrow. Stoma active. No contact from family.	RD
15/5/21 NO	Settled overnight. Self caring with stoma with encouragement. Slept well.	Sm
15/5/21 1350	Isabel has been settled today. Seen by Mr Anderson on Ward Round - dressings to be changed - same done. Dressings and stoma bag changed. Obs as charted and all medications administered as prescribed. No new issues reported. To continue on Tinz. Await OGID and Bone Marrow test.	DR
NO	Settled overnight. obs checked 8 ^o . New stable. All meds given as per hepma. No complaints of pain. No contact from family. No new issues reported at time of writing. Slept well.	RD
110. 16/5/21.	No changes today, awaiting OGID. Settled + stable New 2- remains hypotensive 102/63, HR 101. Independent with stoma today. No new issues. No contact from family.	R
16/5/21 NO	Isabel remains settled and obs stable as charted. All meds administered as per hepma. No new concerns.	MY
10.30 17/5/21	Seen by stoma care nurse appliance renewed under supervision, coped well. Stoma flush with peristomal skin that has an area of erythema around same. Given soft convex bag and belt to try. Stoma active of faecal fluid.	18/5/21
17/5/21 1100	HAND HYGIENE PERFORMED, WOUND DRESSING	

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MCCRACKEN Isabel

A 1d Cumberae Crescent

Coatbridge
Lanarkshire ML5 4PX

Fluid Balance Chart and Daily Adult Fluid Prescription Chart

Date: 18/5/21

Fluid Balance Chart

Reason for commencement:

Yesterday's Intake = mls Output = mls

Yesterday's Intake Goal achieved? ☐ Yes ☐ No

Total Intake Goal today = mls

INTAKE					OUTPUT				
Time	Oral	IV/ Sub Cut	Enteral Feed	Type of Fluid	Urine	Drain/ Fistulae	Aspirate /Vomit	Bowel/ Stoma	Initials x4 (RN)
08:00									
09:00								200	
10:00									
11:00									
12:00									
13:00									
14:00									
15:00									
Sub Totals									
Stop and Check	Intake (oral + IV + enteral) less than 250ml?				☐ Yes	☐ No	If yes to any question or if any concern escalate to nurse in charge/doctor		
	Urine less than 140ml?				☐ Yes	☐ No			
	Other losses more than 250ml?				☐ Yes	☐ No			
16:00									
17:00									
18:00									
19:00									
Stop and Check									
20:00									
21:00									
22:00									
23:00									
24:00									
01:00									
02:00									
03:00									
04:00									
Sub Totals									
05:00									
06:00									
07:00									
24hr Totals									
Total Intake:					Total Output:				



Fluid Balance = Total Intake - Total Output:

CHI no
 First name DOB / /
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

Daily Adult Fluid Prescription Chart

Use an individual fluid prescription chart for
EVERY 24 HOUR PERIOD. N.B. Not suitable for Paediatrics.

Date: / /

Total Intake Goal Today (30ml/kg/24hrs) = (20-25ml/kg/24hrs in frail elderly)

Weight:

Latest U&Es/Hb checked: ☐ Yes ☐ No

..... kg

1. Assess patient	Hypovolaemic (reassess regularly)		Euvolaemic (fasting >8hrs)	Hypervolaemic (overloaded)	Special cases Consult senior	
2. Why give fluid?	Replacement	Resuscitation	Maintenance	Restriction ml	Cardiac dysfunction	
3. How much? Look at history, weight, U&Es, other fluid intake e.g. IV antibiotics	Estimate losses in past 24 hrs. Replacement is in addition to maintenance.	Fluid challenge 250-500ml over 5-15mins and reassess	30ml/kg/24hrs Subtract other intake Today's IV needs: = ml	Fluid restrict. Consider diuresis	Renal/ Liver failure	
4. Which fluid?	PlasmaLyte 148 or 0.9%NaCl+KCl for upper GI loss	PlasmaLyte 148/colloid (Isoplex)/ Blood on BTS chart	0.18%NaCl in 4%Glucose ± KCl* If Na ≤132 use PlasmaLyte 148	Consult Senior	Obstetrics	
					Head injury	
					*Give 40 mmol KCL/litre in maintenance unless K is ≥ 5.0 or renal function deteriorating	

Never give 0.18%NaCl/4%Glucose±
 0.3%KCl (40mmol) at over 100ml/hr:

RISK OF HYPONATRAEMIA

Diabetes: for patients on
 intravenous insulin use
 0.45%NaCl/5%Glucose± KCl

Weight (kg)	Maintenance Requirement /24hr (30ml/kg/24hrs)	Rate (ml/hr)	Approximate Equivalence to 500ml over x hrs
35-44	1200 ml	50	500ml 10 hrly
45-54	1500 ml	65	8 hrly
55-64	1800 ml	75	7 hrly
65-74	2100 ml	85	6 hrly
≥75	2400 ml	100 (max)	5 hrly

Maintenance Fluid (Max 100ml/hr) includes fluid for patients receiving IV insulin or subcutaneous fluids

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO4	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Continue						
				Stop Review						
				Continue						
				Stop Review						
				Continue						
				Stop Review						
				Continue						
				Stop Review						

Resuscitation/Replacement Fluid Still hypotensive after 2000ml of resuscitation fluid? D/W with senior/ICU

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO4	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						

**The NHSL Guidance for Intravenous Fluid and Electrolyte Prescribing and Hyponatraemia
 Guideline are available on the Intranet**

CHI
Firm 1808785142
18/08/1978
MCCRACKEN F
1d Cumberae Crescent
Coatbridge
Lanarkshire
ML5 4PX

Fluid Balance Chart and Daily Adult Fluid Prescription Chart

Date: 9/5/7

Fluid Balance Chart

Reason for commencement:

Yesterday's Intake = mls Output = mls

Yesterday's Intake Goal achieved? ☐ Yes ☐ No

Total Intake Goal today = mls

INTAKE					OUTPUT				
Time	Oral	IV/ Sub Cut	Enteral Feed	Type of Fluid	Urine	Drain/ Fistulae	Aspirate /Vomit	Bowel/ Stoma	Initials x4 (RN)
08:00	800			EWAC/water					
09:00					P.U.T (advised to use Shall)				
10:00									
11:00								100	
12:00	300	100		1UAB/water					
13:00		250		1UAB					
14:00									
15:00									
Sub Totals									

Stop and Check	Intake (oral + IV + enteral) less than 250ml?				☐ Yes	☐ No	If yes to any question or if any concern escalate to nurse in charge/doctor		
	Urine less than 140ml?				☐ Yes	☐ No			
	Other losses more than 250ml?				☐ Yes	☐ No			
16:00									
17:00									
18:00									
19:00									
Stop and Check									
20:00									
21:00									
22:00									
23:00									
24:00									
01:00									
02:00									
03:00									
04:00									
Sub Totals									
05:00									
06:00									
07:00									
24hr Totals									

Total Intake:

Total Output:



Fluid Balance = Total Intake - Total Output:

CHI no
 First name DOB / /
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

University Hospital Monklands



Ward:

Lanarkshire

Daily Adult Fluid Prescription Chart

Use an individual fluid prescription chart for
EVERY 24 HOUR PERIOD. N.B. Not suitable for Paediatrics.

Date: / /

Total Intake Goal Today (30ml/kg/24hrs) = (20-25ml/kg/24hrs in frail elderly)

Weight:

Latest U&Es/Hb checked: ☐ Yes ☐ No

..... kg

1. Assess patient	Hypovolaemic (reassess regularly)		Euvolaemic (fasting >8hrs)	Hypervolaemic (overloaded)	Special cases Consult senior	
2. Why give fluid?	Replacement	Resuscitation	Maintenance	Restriction ml	Cardiac dysfunction	
3. How much? Look at history, weight, U&Es, other fluid intake e.g. IV antibiotics	Estimate losses in past 24 hrs. Replacement is in addition to maintenance.	Fluid challenge 250-500ml over 5-15mins and reassess	30ml/kg/24hrs Subtract other intake Today's IV needs: = ml	Fluid restrict. Consider diuresis	Renal/ Liver failure	
4. Which fluid?	PlasmaLyte 148 or 0.9%NaCl+KCl for upper GI loss	PlasmaLyte 148/colloid (Isoplex)/ Blood on BTS chart	0.18%NaCl in 4%Glucose ± KCl* If Na ≤132 use PlasmaLyte 148	Consult Senior	Obstetrics	
					Head injury	
					*Give 40 mmol KCL/litre in maintenance unless K is ≥ 5.0 or renal function deteriorating	

Never give 0.18%NaCl/4%Glucose±
 0.3%KCl (40mmol) at over 100ml/hr:

RISK OF HYPONATRAEMIA

Diabetes: for patients on
 intravenous insulin use
 0.45%NaCl/5%Glucose± KCl

Weight (kg)	Maintenance Requirement /24hr (30ml/kg/24hrs)	Rate (ml/hr)	Approximate Equivalence to 500ml over x hrs
35-44	1200 ml	50	500ml 10 hrly
45-54	1500 ml	65	8 hrly
55-64	1800 ml	75	7 hrly
65-74	2100 ml	85	6 hrly
≥75	2400 ml	100 (max)	5 hrly

Maintenance Fluid (Max 100ml/hr) includes fluid for patients receiving IV insulin or subcutaneous fluids

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO4	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Continue						
				Stop Review						
				Continue						
				Stop Review						
				Continue						
				Stop Review						
				Continue						
				Stop Review						
				Continue						
				Stop Review						

Resuscitation/Replacement Fluid Still hypotensive after 2000ml of resuscitation fluid? D/W with senior/ICU

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO4	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						

**The NHSL Guidance for Intravenous Fluid and Electrolyte Prescribing and Hyponatraemia
 Guideline are available on the Intranet**

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1808705142
18/08/1978 F
MCCRACKEN Isabel
1d Cumberae Crescent
Coatbridge Lanarkshire ML5 4PX

Fluid Balance Chart and Daily Adult Fluid Prescription Chart

Date: 8/5/21

Fluid Balance Chart

Reason for commencement:

Yesterday's Intake = mls Output = mls

Yesterday's Intake Goal achieved? ☐ Yes ☐ No

Total Intake Goal today = mls

INTAKE					OUTPUT				
Time	Oral	IV/ Sub Cut	Enteral Feed	Type of Fluid	Urine	Drain/ Fistulae	Aspirate /Vomit	Bowel/ Stoma	Initials x4 (RN)
08:00	100								
09:00					Art.	asked to use shells			
10:00	300			WATER					
11:00		250		WAB					
12:00	200								
13:00		100		WAB.					
14:00					350				
15:00									
Sub Totals	600	350			350				
Stop and Check	Intake (oral + IV + enteral) less than 250ml?				☐ Yes	☐ No	If yes to any question or if any concern escalate to nurse in charge/doctor		
	Urine less than 140ml?				☐ Yes	☐ No			
	Other losses more than 250ml?				☐ Yes	☐ No			
16:00	250			H2O					
17:00					330				
18:00									
19:00	100			H2O	200			750	
Stop and Check	350				530			750	
20:00									
21:00									
22:00									
23:00									
24:00									
01:00									
02:00									
03:00									
04:00									
Sub Totals									
05:00									
06:00									
07:00									
24hr Totals									
Total Intake:					Total Output:				

Fluid Balance = Total Intake - Total Output:

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CHI no
 First name DOB / /
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

University Hospital Monklands



Ward: Lanarkshire

Daily Adult Fluid Prescription Chart

Use an individual fluid prescription chart for
 EVERY 24 HOUR PERIOD. N.B. Not suitable for Paediatrics.

Date: / /

Total Intake Goal Today (30ml/kg/24hrs) = (20-25ml/kg/24hrs in frail elderly)

Weight:

Latest U&Es/Hb checked: ☐ Yes ☐ No

..... kg

1. Assess patient	Hypovolaemic (reassess regularly)		Euvolaemic (fasting >8hrs)	Hypervolaemic (overloaded)	Special cases Consult senior	
2. Why give fluid?	Replacement	Resuscitation	Maintenance	Restriction ml	Cardiac dysfunction	
3. How much? Look at history, weight, U&Es, other fluid intake e.g. IV antibiotics	Estimate losses in past 24 hrs. Replacement is in addition to maintenance.	Fluid challenge 250-500ml over 5-15mins and reassess	30ml/kg/24hrs Subtract other intake Today's IV needs: = ml	Fluid restrict. Consider diuresis	Renal/ Liver failure	
4. Which fluid?	PlasmaLyte 148 or 0.9%NaCl+KCl for upper GI loss	PlasmaLyte 148/colloid (Isoplex)/ Blood on BTS chart	0.18%NaCl in 4%Glucose ± KCl* If Na ≤132 use PlasmaLyte 148	Consult Senior	Obstetrics	
					Head injury	
					*Give 40 mmol KCL/litre in maintenance unless K is ≥ 5.0 or renal function deteriorating	

Never give 0.18%NaCl/4%Glucose±
 0.3%KCl (40mmol) at over 100ml/hr:

RISK OF HYPONATRAEMIA

Diabetes: for patients on

intravenous insulin use

0.45%NaCl/5%Glucose± KCl

Weight (kg)	Maintenance Requirement /24hr (30ml/kg/24hrs)	Rate (ml/hr)	Approximate Equivalence to 500ml over x hrs
35-44	1200 ml	50	500ml 10 hrly
45-54	1500 ml	65	8 hrly
55-64	1800 ml	75	7 hrly
65-74	2100 ml	85	6 hrly
≥75	2400 ml	100 (max)	5 hrly

Maintenance Fluid (Max 100ml/hr) includes fluid for patients receiving IV insulin or subcutaneous fluids

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO ₄	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Continue						
				Stop Review						
				Continue						
				Stop Review						
				Continue						
				Stop Review						
				Continue						
				Stop Review						

Resuscitation/Replacement Fluid Still hypotensive after 2000ml of resuscitation fluid? D/W with senior/ICU

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO ₄	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						

**The NHSL Guidance for Intravenous Fluid and Electrolyte Prescribing and Hyponatraemia
 Guideline are available on the Intranet**

CHI no
 First name DOB / /
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

Fluid Balance Chart and Daily Adult Fluid Prescription Chart

Date: 6 / 5 / 21

Fluid Balance Chart

Reason for commencement:

Yesterday's Intake = mls Output = mls

Yesterday's Intake Goal achieved? ☐ Yes ☐ No

Total Intake Goal today = mls

INTAKE					OUTPUT				Initials x4 (RN)
Time	Oral	IV/ Sub Cut	Enteral Feed	Type of Fluid	Urine	Drain/ Fistulae	Aspirate /Vomit	Bowel/ Stoma	
08:00									
09:00					600				
10:00					cath removed				
11:00									
12:00									
13:00									
14:00									
15:00									
Sub Totals									
Stop and Check	Intake (oral + IV + enteral) less than 250ml?				☐ Yes	☐ No	If yes to any question or if any concern escalate to nurse in charge/doctor		
	Urine less than 140ml?				☐ Yes	☐ No			
	Other losses more than 250ml?				☐ Yes	☐ No			
16:00									
17:00									
18:00									
19:00									
Stop and Check									
20:00									
21:00									
22:00									
23:00									
24:00									
01:00									
02:00									
03:00									
04:00									
Sub Totals									
05:00									
06:00									
07:00									
24hr Totals									
Total Intake:					Total Output:				



Fluid Balance = Total Intake - Total Output:

CHI no
 First name DOB / /
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

Daily Adult Fluid Prescription Chart

Use an individual fluid prescription chart for
EVERY 24 HOUR PERIOD. N.B. Not suitable for Paediatrics.

Date: / /

Total Intake Goal Today (30ml/kg/24hrs) = (20-25ml/kg/24hrs in frail elderly)

Weight:

Latest U&Es/Hb checked: ☐ Yes ☐ No

..... kg

1. Assess patient	Hypovolaemic (reassess regularly)		Euvolaemic (fasting >8hrs)	Hypervolaemic (overloaded)	Special cases Consult senior	
2. Why give fluid?	Replacement	Resuscitation	Maintenance	Restriction ml	Cardiac dysfunction	
3. How much? Look at history, weight, U&Es, other fluid intake e.g. IV antibiotics	Estimate losses in past 24 hrs. Replacement is in addition to maintenance.	Fluid challenge 250-500ml over 5-15mins and reassess	30ml/kg/24hrs Subtract other intake Today's IV needs: = ml	Fluid restrict. Consider diuresis	Renal/ Liver failure	
4. Which fluid?	PlasmaLyte 148 or 0.9%NaCl+KCl for upper GI loss	PlasmaLyte 148/colloid (Isoplex)/ Blood on BTS chart	0.18%NaCl in 4%Glucose ± KCl* If Na ≤132 use PlasmaLyte 148	Consult Senior	Obstetrics	
					Head injury	
					*Give 20 mmol (0.3%) KCL/500ml in maintenance unless K is ≥ 5.0 or renal function deteriorating	

Never give 0.18%NaCl/4%Glucose±
 0.3%KCl (20mmol) at over 100ml/hr:

RISK OF HYPONATRAEMIA

Diabetes: for patients on
 intravenous insulin use
 0.45%NaCl/5%Glucose± KCl

Weight (kg)	Maintenance Requirement /24hr (30ml/kg/24hrs)	Rate (ml/hr)	Approximate Equivalence to 500ml over x hrs
35-44	1200 ml	50	500ml 10 hrly
45-54	1500 ml	65	8 hrly
55-64	1800 ml	75	7 hrly
65-74	2100 ml	85	6 hrly
≥75	2400 ml	100 (max)	5 hrly

Maintenance Fluid (Max 100ml/hr) includes fluid for patients receiving IV insulin or subcutaneous fluids

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO ₄	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Continue						
				Stop Review						
				Continue						
				Stop Review						
				Continue						
				Stop Review						
				Continue						
				Stop Review						

Resuscitation/Replacement Fluid Still hypotensive after 2000ml of resuscitation fluid? D/W with senior/ICU

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO ₄	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						

**The NHSL Guidance for Intravenous Fluid and Electrolyte Prescribing and Hyponatraemia
 Guideline are available on the Intranet**

CHI no
First name Isabel DOB / /
Last name McCracken ☐ M ☐ F
Address
.....
.....
or attach addressograph label here

Fluid Balance Chart and Daily Adult Fluid Prescription Chart

Date: 5/5/21

Fluid Balance Chart

Reason for commencement:

Yesterday's Intake = mls Output = mls

Yesterday's Intake Goal achieved? ☐ Yes ☐ No

Total Intake Goal today = mls

INTAKE					OUTPUT				
Time	Oral	IV/ Sub Cut	Enteral Feed	Type of Fluid	Urine	Drain/ Fistulae	Aspirate /Vomit	Bowel/ Stoma	Initials x4 (RN)
08:00	150				250			800	
09:00		100		IVABS					
10:00									
11:00	100			milk					
12:00		100		IVABS	250				
13:00		500							
14:00									
15:00									
Sub Totals									
Stop and Check	Intake (oral + IV + enteral) less than 250ml?				☐ Yes	☐ No	If yes to any question or if any concern escalate to nurse in charge/doctor		
	Urine less than 140ml?				☐ Yes	☐ No			
	Other losses more than 250ml?				☐ Yes	☐ No			
16:00									
17:00									
18:00									
19:00									
Stop and Check									
20:00									
21:00									
22:00								1000	
23:00									
24:00									
01:00									
02:00									
03:00									
04:00									
Sub Totals									
05:00									
06:00									
07:00									
24hr Totals									
Total Intake:					Total Output:				



Fluid Balance = Total Intake - Total Output:

CHI no
 First name DOB / /
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

Daily Adult Fluid Prescription Chart

Use an individual fluid prescription chart for
 EVERY 24 HOUR PERIOD. N.B. Not suitable for Paediatrics.

Date: 5 / 5 / 21

Total Intake Goal Today (30ml/kg/24hrs) = (20-25ml/kg/24hrs in frail elderly)

Weight:

Latest U&Es/Hb checked: ☒ Yes ☐ No

..... kg

1. Assess patient	Hypovolaemic (reassess regularly)		Euvolaemic (fasting >8hrs)	Hypervolaemic (overloaded)	Special cases Consult senior	
2. Why give fluid?	Replacement	Resuscitation	Maintenance	Restriction ml	Cardiac dysfunction	
3. How much? Look at history, weight, U&Es, other fluid intake e.g. IV antibiotics	Estimate losses in past 24 hrs. Replacement is in addition to maintenance.	Fluid challenge 250-500ml over 5-15mins and reassess	30ml/kg/24hrs Subtract other intake Today's IV needs: = ml	Fluid restrict. Consider diuresis	Renal/ Liver failure	
4. Which fluid?	PlasmaLyte 148 or 0.9%NaCl+KCl for upper GI loss	PlasmaLyte 148/colloid (Isoplex)/ Blood on BTS chart	0.18%NaCl in 4%Glucose ± KCl* If Na ≤132 use PlasmaLyte 148	Consult Senior	Obstetrics	
					Head injury	
					*Give 40 mmol KCL/litre in maintenance unless K is ≥ 5.0 or renal function deteriorating	

Never give 0.18%NaCl/4%Glucose±
 0.3%KCl (40mmol) at over 100ml/hr:

RISK OF HYPONATRAEMIA

Diabetes: for patients on
 intravenous insulin use
 0.45%NaCl/5%Glucose± KCl

Weight (kg)	Maintenance Requirement /24hr (30ml/kg/24hrs)	Rate (ml/hr)	Approximate Equivalence to 500ml over x hrs
35-44	1200 ml	50	500ml 10 hrly
45-54	1500 ml	65	8 hrly
55-64	1800 ml	75	7 hrly
65-74	2100 ml	85	6 hrly
≥75	2400 ml	100 (max)	5 hrly

Maintenance Fluid (Max 100ml/hr) includes fluid for patients receiving IV insulin or subcutaneous fluids

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO4	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
5/5/21	PLASMA LYTE	500	75	Continue Stop Review	L. J. ...	5/5	13:00		PH	
5/5/21	PLASMA LYTE	500	75	Continue Stop Review	L. J. ...	5/5	13:40		DL	
5/5/21	PLASMA LYTE	500	75	Continue Stop Review	L. J. ...					
				Continue Stop Review						
				Continue Stop Review						

Resuscitation/Replacement Fluid Still hypotensive after 2000ml of resuscitation fluid? D/W with senior/ICU

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO4	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						

**The NHSL Guidance for Intravenous Fluid and Electrolyte Prescribing and Hyponatraemia
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18/08/1978 F
MCCRACKEN Isabel
1d Cumberae Crescent
Coatbridge
Lanarkshire ML5 4PX

Fluid Balance Chart and Daily Adult Fluid Prescription Chart

Date: 04/05/21

Fluid Balance Chart

Reason for commencement:

Yesterday's Intake = mls Output = mls

Yesterday's Intake Goal achieved? ☐ Yes ☐ No

Total Intake Goal today = mls

INTAKE					OUTPUT					
Time	Oral	IV/ Sub Cut	Enteral Feed	Type of Fluid	Urine	Drain/ Fistulae	Aspirate /Vomit	Bowel/ Stoma	Initials x4 (RN)	
08:00	150			milk						
09:00					600	CBE				
10:00	150			Juice				150		
11:00	150			water						
12:00	500			water						
13:00								250	elephant tuning applied	
14:00										
15:00										
Sub Totals										
Stop and Check	Intake (oral + IV + enteral) less than 250ml? ☐ Yes ☐ No				Urine less than 140ml? ☐ Yes ☐ No		Other losses more than 250ml? ☐ Yes ☐ No			If yes to any question or if any concern escalate to nurse in charge/doctor
16:00										
17:00										
18:00										
19:00										
Stop and Check										
20:00										
21:00										
22:00										
23:00										
24:00					600					
01:00		500		IVF						
02:00										
03:00		300		IVF						
04:00										
Sub Totals										
05:00					600					
06:00										
07:00		600		IVF + IVAB	140					
24hr Totals										
Total Intake:					Total Output:					



Fluid Balance = Total Intake - Total Output:

CHI no
 First name DOB / /
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

University Hospital Monklands



Ward:

Lanarkshire

Daily Adult Fluid Prescription Chart

Use an individual fluid prescription chart for
 EVERY 24 HOUR PERIOD. N.B. Not suitable for Paediatrics.

Date: 04/05/20

Total Intake Goal Today (30ml/kg/24hrs) = (20-25ml/kg/24hrs in frail elderly)	Weight: kg
Latest U&Es/Hb checked: ☐ Yes ☐ No	

1. Assess patient	Hypovolaemic (reassess regularly)		Euvolaemic (fasting >8hrs)	Hypervolaemic (overloaded)	Special cases Consult senior	
2. Why give fluid?	Replacement	Resuscitation	Maintenance	Restriction ml	Cardiac dysfunction	
3. How much?	Estimate losses in past 24 hrs. Replacement is in addition to maintenance.	Fluid challenge 250-500ml over 5-15mins and reassess	30ml/kg/24hrs Subtract other intake Today's IV needs: = ml	Fluid restrict. Consider diuresis	Renal/ Liver failure	
Look at history, weight, U&Es, other fluid intake e.g. IV antibiotics					Obstetrics	
					Head injury	
4. Which fluid?	PlasmaLyte 148 or 0.9%NaCl+KCl for upper GI loss	PlasmaLyte 148/colloid (Isoplex)/ Blood on BTS chart	0.18%NaCl in 4%Glucose ± KCl* If Na ≤132 use PlasmaLyte 148	Consult Senior	*Give 40 mmol KCL/litre in maintenance unless K is ≥ 5.0 or renal function deteriorating	

Never give 0.18%NaCl/4%Glucose±
 0.3%KCl (40mmol) at over 100ml/hr:

RISK OF HYPONATRAEMIA

Diabetes: for patients on
 intravenous insulin use
 0.45%NaCl/5%Glucose± KCl

Weight (kg)	Maintenance Requirement /24hr (30ml/kg/24hrs)	Rate (ml/hr)	Approximate Equivalence to 500ml over x hrs
35-44	1200 ml	50	500ml 10 hrly
45-54	1500 ml	65	8 hrly
55-64	1800 ml	75	7 hrly
65-74	2100 ml	85	6 hrly
≥75	2400 ml	100 (max)	5 hrly

Maintenance Fluid (Max 100ml/hr) includes fluid for patients receiving IV insulin or subcutaneous fluids

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO4	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
04/05	PlasmaLyte	500	125	Continue		4/5	1930		JU	
				Stop Review						
04/05	PlasmaLyte	500	125	Continue		4/5	1945		DR	
				Stop Review						
04/05	PlasmaLyte	500	100	Continue		5/5	0100		MS	
				Stop Review						
04/05	PLASMA-LYTE	500	100	Continue		5/5	0700		MS	
				Stop Review						
				Continue						
				Stop Review						

Resuscitation/Replacement Fluid Still hypotensive after 2000ml of resuscitation fluid? D/W with senior/ICU

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO4	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						

**The NHSL Guidance for Intravenous Fluid and Electrolyte Prescribing and Hyponatraemia
 Guideline are available on the Intranet**

1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumbræ Crescent
Coatbridge
Lanarkshire ML5 4PX

Fluid Balance Chart and Daily Adult Fluid Prescription Chart

Date: 3 / 5 / 21

Fluid Balance Chart

Reason for commencement:

Yesterday's Intake = 2150 mls Output = 2470 mls
Yesterday's Intake Goal achieved? ☐ Yes ☐ No
Total Intake Goal today = mls -320

INTAKE					OUTPUT				
Time	Oral	IV/ Sub Cut	Enteral Feed	Type of Fluid	Urine	Drain/ Fistulae	Aspirate /Vomit	Bowel/ Stoma	Initials x4 (RN)
08:00	250	100		IV ABS	150	Nil		Nil	
09:00									
10:00									
11:00									
12:00	Nil	170			250			200	
13:00					360				
14:00									
15:00		100		IV ABS					
Sub Totals		370			760				
Stop and Check	Intake (oral + IV + enteral) less than 250ml?				☐ Yes	☐ No	If yes to any question or if any concern escalate to nurse in charge/doctor		
	Urine less than 140ml?				☐ Yes	☐ No			
	Other losses more than 250ml?				☐ Yes	☐ No			
16:00	150	500			350			100	
17:00									
18:00									
19:00									
Stop and Check									
20:00									
21:00									
22:00		100		IV AB				500	
23:00									
24:00								200	
01:00									
02:00									
03:00									
04:00									
Sub Totals									
05:00									
06:00					600			500	
07:00		100		IV AB					
24hr Totals									
Total Intake:					Total Output:				



Fluid Balance = Total Intake - Total Output:

CHI no
 First name DOB
 Last name
 Address 1808785142
 18/08/1978 F
 MCCracken Isabel
 1d Cumbera Crescent
 Coatbridge
 Lanarkshire

University Hospital Monklands **NHS**
 Ward: Lanarkshire

Daily Adult Fluid Prescription Chart

Use an individual fluid prescription chart for
EVERY 24 HOUR PERIOD. N.B. Not suitable for Paediatrics.

Date: / /

Total ML5 4PX g/24hrs = (20-25ml/kg/24hrs in frail elderly)
Latest U&Es/Hb checked: ☐ Yes ☐ No

Weight:
 kg

1. Assess patient	Hypovolaemic (reassess regularly)		Euvolaemic (fasting >8hrs)	Hypervolaemic (overloaded)	Special cases Consult senior	
2. Why give fluid?	Replacement	Resuscitation	Maintenance	Restriction ml	Cardiac dysfunction	
3. How much?	Estimate losses in past 24 hrs. Replacement is in addition to maintenance.	Fluid challenge 250-500ml over 5-15mins and reassess	30ml/kg/24hrs Subtract other intake Today's IV needs: = ml	Fluid restrict. Consider diuresis	Renal/Liver failure	
Look at history, weight, U&Es, other fluid intake e.g. IV antibiotics					Obstetrics	
					Head injury	
4. Which fluid?	PlasmaLyte 148 or 0.9%NaCl+KCl for upper GI loss	PlasmaLyte 148/colloid (Isoplex)/ Blood on BTS chart	0.18%NaCl in 4%Glucose ± KCl* If Na ≤132 use PlasmaLyte 148	Consult Senior	*Give 40 mmol KCL/litre in maintenance unless K is ≥ 5.0 or renal function deteriorating	

Never give 0.18%NaCl/4%Glucose± 0.3%KCl (40mmol) at over 100ml/hr:
RISK OF HYPONATRAEMIA

Diabetes: for patients on intravenous insulin use 0.45%NaCl/5%Glucose± KCl

Weight (kg)	Maintenance Requirement /24hr (30ml/kg/24hrs)	Rate (ml/hr)	Approximate Equivalence to 500ml over x hrs
35-44	1200 ml	50	500ml 10 hrly
45-54	1500 ml	65	8 hrly
55-64	1800 ml	75	7 hrly
65-74	2100 ml	85	6 hrly
≥75	2400 ml	100 (max)	5 hrly

Maintenance Fluid (Max 100ml/hr) includes fluid for patients receiving IV insulin or subcutaneous fluids

Date/Time	Fluid +/- Additions e.g. KCl / MgSO4	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
3/5/20	PLASMAlyte	500ml	125ml/hr	Continue		3/5	1200		PH	
				Stop Review						
3/5/20	PLASMAlyte	500ml	125ml/hr	Continue		3/5	1600		PH	
				Stop Review						
3/5/21	PlasmaLyte	500	85	Continue		4/5	0040		F	
				Stop Review						
3/5/21	PlasmaLyte	500	65	Continue						
				Stop Review						

Resuscitation/Replacement Fluid Still hypotensive after 2000ml of resuscitation fluid? D/W with senior/ICU

Date/Time	Fluid +/- Additions e.g. KCl / MgSO4	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						

The NHS Guidance for Intravenous Fluid and Electrolyte Prescribing and Hyponatraemia Guideline are available on the Intranet


 1808785142
 18/08/1978 F
 MCCracken Isabel JF
 1d Cumberae Crescent
 Coatbridge Lanarkshire ML5 4PX

Fluid Balance Chart and Daily Adult Fluid Prescription Chart

Date: 21/5/21

Fluid Balance Chart

Reason for commencement:

Yesterday's Intake = mls Output = mls

Yesterday's Intake Goal achieved? ☐ Yes ☐ No

Total Intake Goal today = mls

INTAKE					OUTPUT				
Time	Oral	IV/ Sub Cut	Enteral Feed	Type of Fluid	Urine	Drain/ Fistulae	Aspirate /Vomit	Bowel/ Stoma	Initials x4 (RN)
08:00								50	
09:00									
10:00									
11:00									
12:00	200			Juice					
13:00									
14:00					380				
15:00									
Sub Totals	200				380				
Stop and Check	Intake (oral + IV + enteral) less than 250ml? ☐ Yes ☐ No Urine less than 140ml? ☐ Yes ☐ No Other losses more than 250ml? ☐ Yes ☐ No				If yes to any question or if any concern escalate to nurse in charge/doctor				
16:00	20								
17:00					600				
18:00									
19:00	150								
Stop and Check									
20:00	150				140				
21:00								200	
22:00		100		100					
23:00	200								
24:00					300				
01:00									
02:00									
03:00		1000		100				500	
04:00					300				
Sub Totals									
05:00	150								
06:00									
07:00									
24hr Totals	1050	1100			1720			750	
Total Intake: 2150					Total Output: 2470				

Fluid Balance = Total Intake - Total Output:

-320

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F1808785142
18/08/1978 F
MCCRACKEN Isabel
Ald Cumberae Crescent
Coatbridge
Lanarkshire ML5 4PX

Daily Adult Fluid Prescription Chart

Use an individual fluid prescription chart for
EVERY 24 HOUR PERIOD. N.B. Not suitable for Paediatrics.

Date: / /

Total Intake Goal Today (30ml/kg/24hrs) = (20-25ml/kg/24hrs in frail elderly)
Latest U&Es/Hb checked: ☐ Yes ☐ No **Weight:** kg

1. Assess patient	Hypovolaemic (reassess regularly)		Euvolaemic (fasting >8hrs)	Hypervolaemic (overloaded)	Special cases Consult senior	
2. Why give fluid?	Replacement	Resuscitation	Maintenance	Restriction ml	Cardiac dysfunction	
3. How much?	Estimate losses in past 24 hrs. Replacement is in addition to maintenance.	Fluid challenge 250-500ml over 5-15mins and reassess	30ml/kg/24hrs Subtract other intake Today's IV needs: = ml	Fluid restrict. Consider diuresis	Renal/ Liver failure	
Look at history, weight, U&Es, other fluid intake e.g. IV antibiotics					Obstetrics	
					Head injury	
4. Which fluid?	PlasmaLyte 148 or 0.9%NaCl+KCl for upper GI loss	PlasmaLyte 148/colloid (Isoplex)/ Blood on BTS chart	0.18%NaCl in 4%Glucose ± KCl* If Na ≤132 use PlasmaLyte 148	Consult Senior	*Give 40 mmol KCL/litre in maintenance unless K is ≥ 5.0 or renal function deteriorating	

Never give 0.18%NaCl/4%Glucose±
0.3%KCl (40mmol) at over 100ml/hr:
RISK OF HYPONATRAEMIA

Diabetes: for patients on
intravenous insulin use
0.45%NaCl/5%Glucose± KCl

Weight (kg)	Maintenance Requirement /24hr (30ml/kg/24hrs)	Rate (ml/hr)	Approximate Equivalence to 500ml over x hrs
35-44	1200 ml	50	500ml 10 hrly
45-54	1500 ml	65	8 hrly
55-64	1800 ml	75	7 hrly
65-74	2100 ml	85	6 hrly
≥75	2400 ml	100 (max)	5 hrly

Maintenance Fluid (Max 100ml/hr) includes fluid for patients receiving IV insulin or subcutaneous fluids

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO4	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
02/05/21	0.18% NaCl / 4% Glucose + 40mmol KCl	1000	85	Continue	LSM	2/5/21	13:45		TU	
02/05/21	0.18% NaCl / 4% Glucose + 40mmol KCl	1000	85	Continue	LSM	2/5/21	03:05		RO	
				Continue						
				Continue						
				Continue						
				Continue						
				Continue						
				Continue						

Resuscitation/Replacement Fluid Still hypotensive after 2000ml of resuscitation fluid? D/W with senior/ICU

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO4	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Stop						
				Stop						
				Stop						
				Stop						
				Stop						

The NHSL Guidance for Intravenous Fluid and Electrolyte Prescribing and Hyponatraemia
Guideline are available on the Intranet

CHI 1808785142
 First 18/08/1978 F
 Last MCCracken Isabel
 Add 1d Cumberae Crescent
 Coatbridge Lanarkshire ML5 4PX
 or attach addressograph label here

Fluid Balance Chart and Daily Adult Fluid Prescription Chart

Date: 1/5/21

Fluid Balance Chart									
Reason for commencement:					Yesterday's Intake = _____ mls Output = _____ mls Yesterday's Intake Goal achieved? ☐ Yes ☐ No Total Intake Goal today = _____ mls				
INTAKE					OUTPUT				
Time	Oral	IV/ Sub Cut	Enteral Feed	Type of Fluid	Urine	Drain/ Fistulae	Aspirate /Vomit	Bowel/ Stoma	Initials x4 (RN)
08:00									
09:00									
10:00									
11:00									
12:00									
13:00									
14:00									
15:00									
Sub Totals									
Stop and Check	Intake (oral + IV + enteral) less than 250ml?				☐ Yes	☐ No	If yes to any question or if any concern escalate to nurse in charge/doctor		
	Urine less than 140ml?				☐ Yes	☐ No			
	Other losses more than 250ml?				☐ Yes	☐ No			
16:00									
17:00									
18:00									
19:00									
Stop and Check									
20:00									
21:00									
22:00	150				500				
23:00		100		IV AB					
24:00									
01:00									
02:00									
03:00									
04:00	100				600				
Sub Totals									
05:00									
06:00									
07:00		100			180				
24hr Totals	250	200			1280				
Total Intake:					Total Output: 1280				



Fluid Balance = Total Intake - Total Output:

CHI no
 First name DOB / /
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

University Hospital Monklands



Ward: Lanarkshire

Daily Adult Fluid Prescription Chart

Use an individual fluid prescription chart for
 EVERY 24 HOUR PERIOD. N.B. Not suitable for Paediatrics.

Date: / /

Total Intake Goal Today (30ml/kg/24hrs) = (20-25ml/kg/24hrs in frail elderly)

Weight:

Latest U&Es/Hb checked: ☐ Yes ☐ No

..... kg

1. Assess patient	Hypovolaemic (reassess regularly)		Euvolaemic (fasting >8hrs)	Hypervolaemic (overloaded)	Special cases Consult senior	
2. Why give fluid?	Replacement	Resuscitation	Maintenance	Restriction ml	Cardiac dysfunction	
3. How much? Look at history, weight, U&Es, other fluid intake e.g. IV antibiotics	Estimate losses in past 24 hrs. Replacement is in addition to maintenance.	Fluid challenge 250-500ml over 5-15mins and reassess	30ml/kg/24hrs Subtract other intake Today's IV needs: = ml	Fluid restrict. Consider diuresis	Renal/ Liver failure	
4. Which fluid?	PlasmaLyte 148 or 0.9%NaCl+KCl for upper GI loss	PlasmaLyte 148/colloid (Isoplex)/ Blood on BTS chart	0.18%NaCl in 4%Glucose ± KCl* If Na ≤132 use PlasmaLyte 148	Consult Senior	Obstetrics	
					Head injury	
					*Give 40 mmol KCL/litre in maintenance unless K is ≥ 5.0 or renal function deteriorating	

Never give 0.18%NaCl/4%Glucose±
 0.3%KCl (40mmol) at over 100ml/hr:

RISK OF HYPONATRAEMIA

Diabetes: for patients on
 intravenous insulin use
 0.45%NaCl/5%Glucose± KCl

Weight (kg)	Maintenance Requirement /24hr (30ml/kg/24hrs)	Rate (ml/hr)	Approximate Equivalence to 500ml over x hrs
35-44	1200 ml	50	500ml 10 hrly
45-54	1500 ml	65	8 hrly
55-64	1800 ml	75	7 hrly
65-74	2100 ml	85	6 hrly
≥75	2400 ml	100 (max)	5 hrly

Maintenance Fluid (Max 100ml/hr) includes fluid for patients receiving IV insulin or subcutaneous fluids

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO ₄	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Continue						
				Stop Review						
				Continue						
				Stop Review						
				Continue						
				Stop Review						
				Continue						
				Stop Review						

Resuscitation/Replacement Fluid Still hypotensive after 2000ml of resuscitation fluid? D/W with senior/ICU

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO ₄	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						

**The NHSL Guidance for Intravenous Fluid and Electrolyte Prescribing and Hyponatraemia
 Guideline are available on the Intranet**


 1808785142
 18/08/1978 F F
 MCCracken Isabel
 1d Cumberae Crescent
 Coatbridge
 Lanarkshire ML5 4PX

Fluid Balance Chart and Daily Adult Fluid Prescription Chart

Date: 22/5/21

Fluid Balance Chart

Reason for commencement:

Yesterday's Intake = mls Output = mls

Yesterday's Intake Goal achieved? ☐ Yes ☐ No

Total Intake Goal today = mls

INTAKE					OUTPUT				
Time	Oral	IV/ Sub Cut	Enteral Feed	Type of Fluid	Urine	Drain/ Fistulae	Aspirate /Vomit	Bowel/ Stoma	Initials x4 (RN)
08:00									
09:00									
10:00	500			WATER					
11:00									
12:00									
13:00									
14:00									
15:00									
Sub Totals									
Stop and Check	Intake (oral + IV + enteral) less than 250ml?				☐ Yes	☐ No	If yes to any question or if any concern escalate to nurse in charge/doctor		
	Urine less than 140ml?				☐ Yes	☐ No			
	Other losses more than 250ml?				☐ Yes	☐ No			
16:00									
17:00									
18:00									
19:00									
Stop and Check									
20:00									
21:00									
22:00									
23:00									
24:00									
01:00									
02:00									
03:00									
04:00									
Sub Totals									
05:00									
06:00									
07:00									
24hr Totals									

Total Intake:

Total Output:



Fluid Balance = Total Intake - Total Output:

CHI no
 First name DOB / /
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

Daily Adult Fluid Prescription Chart

Use an individual fluid prescription chart for
 EVERY 24 HOUR PERIOD. N.B. Not suitable for Paediatrics.

Date: / /

Total Intake Goal Today (30ml/kg/24hrs) = (20-25ml/kg/24hrs in frail elderly)

Weight:

Latest U&Es/Hb checked: ☐ Yes ☐ No

..... kg

1. Assess patient	Hypovolaemic (reassess regularly)		Euvolaemic (fasting >8hrs)	Hypervolaemic (overloaded)	Special cases Consult senior	
2. Why give fluid?	Replacement	Resuscitation	Maintenance	Restriction ml	Cardiac dysfunction	
3. How much? Look at history, weight, U&Es, other fluid intake e.g. IV antibiotics	Estimate losses in past 24 hrs. Replacement is in addition to maintenance.	Fluid challenge 250-500ml over 5-15mins and reassess	30ml/kg/24hrs Subtract other intake Today's IV needs: = ml	Fluid restrict. Consider diuresis	Renal/ Liver failure	
4. Which fluid?	PlasmaLyte 148 or 0.9%NaCl+KCl for upper GI loss	PlasmaLyte 148/colloid (Isoplex)/ Blood on BTS chart	0.18%NaCl in 4%Glucose ± KCl* If Na ≤132 use PlasmaLyte 148	Consult Senior	Obstetrics	
					Head injury	
					*Give 40 mmol KCL/litre in maintenance unless K is ≥ 5.0 or renal function deteriorating	

Never give 0.18%NaCl/4%Glucose±
 0.3%KCl (40mmol) at over 100ml/hr:
RISK OF HYPONATRAEMIA

Diabetes: for patients on
 intravenous insulin use
 0.45%NaCl/5%Glucose± KCl

Weight (kg)	Maintenance Requirement /24hr (30ml/kg/24hrs)	Rate (ml/hr)	Approximate Equivalence to 500ml over x hrs
35-44	1200 ml	50	500ml 10 hrly
45-54	1500 ml	65	8 hrly
55-64	1800 ml	75	7 hrly
65-74	2100 ml	85	6 hrly
≥75	2400 ml	100 (max)	5 hrly

Maintenance Fluid (Max 100ml/hr) includes fluid for patients receiving IV insulin or subcutaneous fluids

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO ₄	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Continue						
				Stop Review						
				Continue						
				Stop Review						
				Continue						
				Stop Review						
				Continue						
				Stop Review						

Resuscitation/Replacement Fluid Still hypotensive after 2000ml of resuscitation fluid? D/W with senior/ICU

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO ₄	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						

**The NHSL Guidance for Intravenous Fluid and Electrolyte Prescribing and Hyponatraemia
 Guideline are available on the Intranet**

1808785142

18/08/1978

F

MCCRACKEN Isabel

1d Cumberae Crescent

Coatbridge Lanarkshire

ML5 4PX

Fluid Balance Chart and

Daily Adult Fluid Prescription Chart

Date: 20/05/21

Fluid Balance Chart

Reason for commencement:

Yesterday's Intake = mls Output = mls

Yesterday's Intake Goal achieved? Yes No

Total Intake Goal today = mls

INTAKE					OUTPUT				
Time	Oral	IV/ Sub Cut	Enteral Feed	Type of Fluid	Urine	Drain/ Fistulae	Aspirate /Vomit	Bowel/ Stoma	Initials x4 (RN)
08:00	FAST	ING							
09:00	FAST								
10:00	FAST	250		IVAB					
11:00	FAST								
12:00	200			Juice					
13:00									
14:00	200			Juice					
15:00									
Sub Totals	400								
Stop and Check	Intake (oral + IV + enteral) less than 250ml? Yes No				Urine less than 140ml? Yes No				If yes to any question or if any concern escalate to nurse in charge/doctor
	Other losses more than 250ml? Yes No								
16:00									
17:00									
18:00									
19:00									
Stop and Check									
20:00									
21:00									
22:00									
23:00									
24:00									
01:00									
02:00									
03:00									
04:00									
Sub Totals									
05:00									
06:00									
07:00									
24hr Totals									
Total Intake:					Total Output:				



Fluid Balance = Total Intake - Total Output:

CHI no
 First name Isobel DOB
 Last name McCracken Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

University Hospital Monklands



Ward: 7

Lanarkshire

Daily Adult Fluid Prescription Chart

Use an individual fluid prescription chart for
 EVERY 24 HOUR PERIOD. N.B. Not suitable for Paediatrics.

Date: 20/05/20

Total Intake Goal Today (30ml/kg/24hrs) = (20-25ml/kg/24hrs in frail elderly)

Weight:

Latest U&Es/Hb checked: ☐ Yes ☐ No

..... kg

1. Assess patient	Hypovolaemic (reassess regularly)		Euvolaemic (fasting >8hrs)	Hypervolaemic (overloaded)	Special cases Consult senior	
2. Why give fluid?	Replacement	Resuscitation	Maintenance	Restriction ml	Cardiac dysfunction	
3. How much? Look at history, weight, U&Es, other fluid intake e.g. IV antibiotics	Estimate losses in past 24 hrs. Replacement is in addition to maintenance.	Fluid challenge 250-500ml over 5-15mins and reassess	30ml/kg/24hrs Subtract other intake Today's IV needs: = ml	Fluid restrict. Consider diuresis	Renal/ Liver failure	
4. Which fluid?	PlasmaLyte 148 or 0.9%NaCl+KCl for upper GI loss	PlasmaLyte 148/colloid (Isoplex)/ Blood on BTS chart	0.18%NaCl in 4%Glucose ± KCl* If Na ≤132 use PlasmaLyte 148	Consult Senior	Obstetrics	
					Head injury	
					*Give 40 mmol KCL/litre in maintenance unless K is ≥ 5.0 or renal function deteriorating	

Never give 0.18%NaCl/4%Glucose±
 0.3%KCl (40mmol) at over 100ml/hr:

RISK OF HYPONATRAEMIA

Diabetes: for patients on
 intravenous insulin use
 0.45%NaCl/5%Glucose± KCl

Weight (kg)	Maintenance Requirement /24hr (30ml/kg/24hrs)	Rate (ml/hr)	Approximate Equivalence to 500ml over x hrs
35-44	1200 ml	50	500ml 10 hrly
45-54	1500 ml	65	8 hrly
55-64	1800 ml	75	7 hrly
65-74	2100 ml	85	6 hrly
≥75	2400 ml	100 (max)	5 hrly

Maintenance Fluid (Max 100ml/hr) includes fluid for patients receiving IV insulin or subcutaneous fluids

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO4	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
20/5	PLASMA-LYTE	500	85	Continue		20/5	14 40		nkc	
				Stop Review						
20/5	PLASMA-LYTE	500	85	Continue		20/5	21 40		SM	
				Stop Review						
				Continue						
				Stop Review						
				Continue						
				Stop Review						
				Continue						
				Stop Review						

Resuscitation/Replacement Fluid Still hypotensive after 2000ml of resuscitation fluid? D/W with senior/ICU

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO4	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						

**The NHSL Guidance for Intravenous Fluid and Electrolyte Prescribing and Hyponatraemia
 Guideline are available on the Intranet**

COPY PAGE

CHI no
 First name DOB / /
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

University Hospital Monklands



Ward:

Daily Adult Fluid Prescription Chart

Use an individual fluid prescription chart for
 EVERY 24 HOUR PERIOD. N.B. Not suitable for Paediatrics.

Date: / /

Total Intake Goal Today (30ml/kg/24hrs) = (20-25ml/kg/24hrs in frail elderly)

Weight:

Latest U&Es/Hb checked: ☐ Yes ☐ No

..... kg

1. Assess patient	Hypovolaemic (reassess regularly)		Euvolaemic (fasting >8hrs)	Hypervolaemic (overloaded)	Special cases Consult senior	
2. Why give fluid?	Replacement	Resuscitation	Maintenance	Restriction ml	Cardiac dysfunction	
3. How much? Look at history, weight, U&Es, other fluid intake e.g. IV antibiotics	Estimate losses in past 24 hrs. Replacement is in addition to maintenance.	Fluid challenge 250-500ml over 5-15mins. and reassess	30ml/kg/24hrs Subtract other intake Today's IV needs: = ml	Fluid restrict. Consider diuresis	Renal/ Liver failure	
4. Which fluid?	PlasmaLyte 148 or 0.9%NaCl+KCl for upper GI loss	PlasmaLyte 148/colloid (Isoplex)/ Blood on BTS chart	0.18%NaCl in 4%Glucose ± KCl* If Na ≤132 use PlasmaLyte 148	Consult Senior	Obstetrics	
					Head injury	
					*Give 40 mmol KCL/litre in maintenance unless K is ≥ 5.0 or renal function deteriorating	

Never give 0.18%NaCl/4%Glucose±
 0.3%KCl (40mmol) at over 100ml/hr:

RISK OF HYPONATRAEMIA

Diabetes: for patients on
 intravenous insulin use
 0.45%NaCl/5%Glucose± KCl

Weight (kg)	Maintenance Requirement /24hr (30ml/kg/24hrs)	Rate (ml/hr)	Approximate Equivalence to 500ml over x hrs
35-44	1200 ml	50	500ml 10 hrly
45-54	1500 ml	65	8 hrly
55-64	1800 ml	75	7 hrly
65-74	2100 ml	85	6 hrly
≥75	2400 ml	100 (max)	5 hrly

Maintenance Fluid (Max 100ml/hr) includes fluid for patients receiving IV insulin or subcutaneous fluids

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO ₄	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Continue						
				Stop Review						
				Continue						
				Stop Review						
				Continue						
				Stop Review						
				Continue						
				Stop Review						

Resuscitation/Replacement Fluid Still hypotensive after 2000ml of resuscitation fluid? D/W with senior/ICU

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO ₄	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						

**The NHSL Guidance for Intravenous Fluid and Electrolyte Prescribing and Hyponatraemia
 Guideline are available on the Intranet**

1808785142
18/08/1978 F F
MCCRACKEN Isabel
1d Cumberae Crescent
Coatbridge
Lanarkshire ML5 4PX

Fluid Balance Chart and Daily Adult Fluid Prescription Chart

Date: 13 / 5 / 21

Fluid Balance Chart

Reason for commencement:

Yesterday's Intake = mls Output = mls

Yesterday's Intake Goal achieved? ☐ Yes ☐ No

Total Intake Goal today = mls

INTAKE					OUTPUT				Initials x4 (RN)
Time	Oral	IV/ Sub Cut	Enteral Feed	Type of Fluid	Urine	Drain/ Fistulae	Aspirate /Vomit	Bowel/ Stoma	
08:00									
09:00								300	
10:00									
11:00								50	
12:00									
13:00									
14:00									
15:00									
Sub Totals									
Stop and Check	Intake (oral + IV + enteral) less than 250ml?				☐ Yes	☐ No	If yes to any question or if any concern escalate to nurse in charge/doctor		
	Urine less than 140ml?				☐ Yes	☐ No			
	Other losses more than 250ml?				☐ Yes	☐ No			
16:00									
17:00									
18:00									
19:00									
Stop and Check									
20:00									
21:00									
22:00									
23:00									
24:00									
01:00									
02:00									
03:00									
04:00									
Sub Totals									
05:00									
06:00									
07:00									
24hr Totals									
Total Intake:					Total Output:				



Fluid Balance = Total Intake - Total Output:

CHI no
 First name DOB / /
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

University Hospital Monklands



Ward:

Lanarkshire

Daily Adult Fluid Prescription Chart

Use an individual fluid prescription chart for
 EVERY 24 HOUR PERIOD. N.B. Not suitable for Paediatrics.

Date: / /

Total Intake Goal Today (30ml/kg/24hrs) = (20-25ml/kg/24hrs in frail elderly)

Weight:

Latest U&Es/Hb checked: ☐ Yes ☐ No

..... kg

1. Assess patient	Hypovolaemic (reassess regularly)		Euvolaemic (fasting >8hrs)	Hypervolaemic (overloaded)	Special cases Consult senior	
2. Why give fluid?	Replacement	Resuscitation	Maintenance	Restriction ml	Cardiac dysfunction	
3. How much? Look at history, weight, U&Es, other fluid intake e.g. IV antibiotics	Estimate losses in past 24 hrs. Replacement is in addition to maintenance.	Fluid challenge 250-500ml over 5-15mins and reassess	30ml/kg/24hrs Subtract other intake Today's IV needs: = ml	Fluid restrict. Consider diuresis	Renal/ Liver failure	
4. Which fluid?	PlasmaLyte 148 or 0.9%NaCl+KCl for upper GI loss	PlasmaLyte 148/colloid (Isoplex)/ Blood on BTS chart	0.18%NaCl in 4%Glucose ± KCl* If Na ≤132 use PlasmaLyte 148	Consult Senior	Obstetrics	
					Head injury	
					*Give 40 mmol KCL/litre in maintenance unless K is ≥ 5.0 or renal function deteriorating	

Never give 0.18%NaCl/4%Glucose±
 0.3%KCl (40mmol) at over 100ml/hr:

RISK OF HYPONATRAEMIA

Diabetes: for patients on
 intravenous insulin use
 0.45%NaCl/5%Glucose± KCl

Weight (kg)	Maintenance Requirement /24hr (30ml/kg/24hrs)	Rate (ml/hr)	Approximate Equivalence to 500ml over x hrs
35-44	1200 ml	50	500ml 10 hrly
45-54	1500 ml	65	8 hrly
55-64	1800 ml	75	7 hrly
65-74	2100 ml	85	6 hrly
≥75	2400 ml	100 (max)	5 hrly

Maintenance Fluid (Max 100ml/hr) includes fluid for patients receiving IV insulin or subcutaneous fluids

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO ₄	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
13/5	0.18% NaCl + 4% Glucose	1000	85	Continue		13/5	10.10.		BN	
				Stop Review						
13/5	0.18% NaCl + 4% Glucose	1000	85	Continue						
				Stop Review						
				Continue						
				Stop Review						
				Continue						
				Stop Review						
				Continue						
				Stop Review						

Resuscitation/Replacement Fluid Still hypotensive after 2000ml of resuscitation fluid? D/W with senior/ICU

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO ₄	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						

**The NHSL Guidance for Intravenous Fluid and Electrolyte Prescribing and Hyponatraemia
 Guideline are available on the Intranet**

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☐ Hairmyres ☒ Monklands ☐ Wishaw

Other: (specify)

Ward: 7

Adult Vancomycin intermittent IV Infusion Prescription, Administration and Monitoring Chart For patients ≥ 16 years

Use online Vancomycin calculator available at:

NHS Lanarkshire FirstPort: Applications > MEDED > Drugs and Prescribing > Pharmacy calculators.
Antimicrobial Companion App – available in Apple App store and Play Store for android (select NHS Lanarkshire)

PROMPT ADMINISTRATION of antibiotics within 1 hour of recognising sepsis reduces mortality

All patients on vancomycin MUST have a vancomycin prescription, administration and monitoring chart held with the patient notes which MUST be completed after each dose.

This policy covers the use of intravenous vancomycin prescribed as an intermittent (pulsed) infusion.
This policy does not apply to the use of vancomycin in ICU, Renal or patients receiving haemodialysis or haemofiltration.

Step 1 Document baseline requirements

- Document patient's weight (kg), height (cm or feet and inches), age and serum creatinine (micromol/L)

Age 42... Sex: ☐ M ☒ F Weight 57.5 kg Height 157 cm Creatinine 36 on 19/05/21

Calculator dose: Loading dose 1000 mg Initial regimen: 1250 mg, ☒ 12 ☐ 24 ☐ 48Hrs

Source of initial dosage regimen:

☒ Online calculator (preferred method) ☐ Manual calculation ☐ Loading dose only, creatinine awaited

Step 2 Loading infusion *

*see step 4 for administration

- The loading dose is based on **actual** body weight (ABW). • It does not depend on creatinine clearance.

Actual body weight (ABW)	Dose
<40 kg	750 mg
40 - 59 kg	1000 mg
60 - 90 kg	1500 mg
>90 kg	2000 mg

Step 3 Maintenance intermittent infusion dose

Calculate maintenance dose using ON-LINE CALCULATOR (based on renal function).

- Give first maintenance infusion 12, 24 or 48 hours after loading infusion according to recommended dose interval.
- In order to facilitate the more convenient timing of administration and monitoring of vancomycin, the **FIRST MAINTENANCE** dose may be given up to 6 hours earlier (if 12 or 24 hourly dosing) or up to 12 hours earlier (if 48 hourly dosing)

Step 4 Preparation and Administration

- Reconstitute with the required volume of water for injection (10 ml water for a 500 mg vial & 20 ml water for a 1 gram vial).
- Vancomycin must be diluted before administration -**
Further dilute the vancomycin by adding it to an intravenous bag of sodium chloride 0.9% or glucose 5%.
e.g. 1000mg added to 250ml sodium chloride 0.9%
- Maximum concentration for peripheral infusion 5 mg/ml**
- Vancomycin must be administered by intravenous infusion at a rate no greater than 10 mg/minute.**
Failure to do so can result in anaphylaxis, shock and red man syndrome.

Vancomycin Dose	Volume of diluents – sodium chloride 0.9% or glucose 5%	Duration of infusion
500mg	250ml	60 minutes
750mg	250ml	90 minutes
1000mg	250ml	120 minutes
1250mg	250ml	150 minutes
1500mg	500ml	180 minutes
2000mg	500ml	240 minutes



Patient name: ISABEL McCRACKEN

CHI No: 1808785142

Step 5 Vancomycin prescription, administration and monitoring chart

- Prescribe vancomycin on prescription chart below and on drug cardex/HEPMA 'as per chart'
- Prescribe single loading dose and all maintenance doses until the first vancomycin level is available
- Document date and time of level required
- Record exact times of all doses administered below
- Check and document creatinine (Cr) daily. Review therapy if renal function is unstable (eg. change in Cr of >15-20%) and seek advice.

Date	Creatinine (μmol/l)	Time	Vancomycin Dose (mg)	Prescriber's Signature	Time infusion commenced	Nurses' Signatures	Level required		Sample taken		Measured Trough Level mg/L
							Date	Time	Date	Time	
19/05	Loading dose	18:15	1000		18:30						
20/05	36	06:15	1250		06:45						
20/05		18:15	1250								
21/05		06:15	1250								
Review need for continuing therapy, Discuss with senior clinician, ID or microbiology, Discontinue if appropriate											

Step 6 Monitoring of Vancomycin concentrations

- Target trough concentration 10-20 mg/L
- Check and document creatinine daily. Recalculate creatinine clearance and dose if there is a change in creatinine.
- Check trough (pre dose) concentration immediately before the fourth dose (within 48 hours) or sooner if renal function is impaired or deteriorating.
- Ongoing monitoring check trough (pre dose) level every 72 hours or daily if renal function changes significantly.
- Document complete information on dose, administration and sample times on the sample request and the prescription chart.
- Document level and next dose on the prescription chart and the case notes.
- Give next dose pending trough result unless renal function is deteriorating.

Step 7 Adjustment of Vancomycin Doses

- Always check that the dosage history and sampling time are correct before making adjustments.
- Advice is available from clinical pharmacist or microbiologist
- After dose adjustment take a trough level at 24 hours and again 24 hours later to ensure that the new dose is appropriate.

Vancomycin trough concentration	Suggested dose change
<10 mg/L	Increase the dose by 50% and consider reducing the dosage interval. Always seek advice if you are unsure or if the current dose is > 2500 mg daily.
10 – 15 mg/L	If the patient is responding maintain the present dosage regimen. If the patient is seriously ill consider increasing the dose amount or reducing the dosage interval to achieve a trough level of 15 – 20 mg/L.
15 – 20 mg/L	Maintain the present dosage regimen
>20 mg/L	Withhold until <20 mg/L then seek advice

S

CHI no
 First name Isobel DOB 42
 Last name McCracken Sex: ☐ M ☒ F
 Address

or attach addressograph label here

☐ Hairmyres ☐ Monklands ☐ Wishaw
☐ Other: (specify)
 Ward:

NHS
 Lanarkshire

Visitor Booked @ 13⁰⁰.

Internal Transfer Record

Date of Admission: / / Date of Transfer: 01 / 05 / 21 Time of Transfer: : Transferring from: 26 to 7

Reason for transfer: ☐ Admission ☐ Specialty ☐ Decant ☐ Other: (specify)

Number of transfers: **If more than 3 transfers has senior nurse/hospital cover been notified?** ☐ Yes ☐ N/A

Admitting Condition: R Hemi, end ileostomy + Appendicectomy
 Primary Diagnosis:
 Consultant: MD
 Next of Kin details recorded? ☐ Yes ☐ No
 Informed of transfer? ☐ Yes ☐ No
 If no, why:

B

Relevant Past History/Current Care	Allergies:	Infection Control Risk Management	Yes No
Stoma - Pink - active	NKDA	MRSA Clinical Risk Assessment completed?	☐ ☐
Rectal drain - Nil	Mobility/Safety Requirements:	MRSA screen swabs required?	☐ ☐
midline wound mepore.	Ass x1	MRSA screen swabs obtained?	☐ ☐
(R) Hip dressing following Bone	Red Triangle in use? ☐ Yes ☐ No	Result if available: ☐ Positive ☐ Negative	☐ ☐
marrow Asp.	4AT Score:	Isolation required?	☐ ☐
	Special dietary requirements? ☐ Yes ☐ No	Other infection control risk? (If yes specify)	☐ ☐
	<u>F/Light Diet</u>		
	Nil by Mouth? ☐ Yes ☐ No	Does the patient have a pressure ulcer?	☐ ☐
	Fluid Balance =	If yes, grade:	☐ ☐
		If yes, DATIX completed?	☐ ☐

A

IV cannula insitu? ☐ Yes ☐ No Date inserted: / /	DNACPR Status: <u>BP↓ - Normally Hypotensive</u>	Estimated Discharge Date: / /
Urinary catheter? ☐ Yes ☐ No Date inserted: / /	NEWS Score:	Potential delays for discharge? ☐ ☐
Invasive Device? ☐ Yes ☐ No Date inserted: / /	CIWA Score:	TrakCare updated? ☐ ☐
Other: (specify)		

R

Plan for Care: <u>NAB until 03/05/21</u> <u>BD 60mg enoxaparin</u>	Transfer Checklist
Complete as applicable:	Prescription Form ☐ ☐
Transfer Nurse Name: Signature:	Patients Own Drugs medication ☐ ☐
Receiving Nurse Name: Signature:	Casenotes ☐ ☐
	Nursing Notes ☐ ☐
	Oxygen ☐ ☐
	Valuables ☐ ☐



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University Hospital:

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Other:

Ward: MU11

Covid-19 Admission Screening Swabs

All patients will require to be screened for Covid-19 on admission and at day 5 of their hospital stay. Screening of patients will enable NHS Lanarkshire staff to detect asymptomatic carriers of the virus and put appropriate Covid-19 measures in place to minimise the risk of cross contamination.

If the patient is transferred to another ward after day 5 screening - **patient must be screened within 4 hours of admission to new ward.**

If a positive result is obtained, stop screening, follow Covid-19 guidance for positive cases. Please refer to "Transfer to Offsite Bed" step down guidance for transfer to offsite beds and Care Homes. If a patient is discharged before the result - they must be contacted if there is a positive result.

Covid-19 Admission Screening Swabs				
Date of Admission	Screen taken by (PRINT NAME)	Time	Result	Patient informed by (PRINT NAME)
27/4/21	Joe Miller		☐ Positive ☐ Negative	

Day 5 Screen (DATE)	Screen taken by (PRINT NAME)	Time	Result	Patient informed by (PRINT NAME)
			☐ Positive ☐ Negative	

Transfer Screen (DATE)	Screen taken by (PRINT NAME)	Time	Result	Patient informed by (PRINT NAME)
			☐ Positive ☐ Negative	

Date of Discharge: / /

Completed by: (PRINT NAME)	Designation:
Signature:	Date: / / Time: :



For additional Transfer Screening Swabs complete on next page as required.

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Ward:



Stoma Care

Consultant: MR DICK

Preferred name:	Referred by:
Phone - Home:	☐ Consultant ☐ Colorectal/Stoma Care Nurse (SCN)
- Mobile: <u>07947301884</u>	☐ Other: (specify)
Relationship status:	Date referred to SCN: / /
Partner/relative present? ☐ Yes ☐ No	Date seen by SCN: / /
Next of Kin:	Admission date: / /
Relationship:	Surgery date: / /
Contact num:	Seen in: ☐ Ward ☐ Clinic ☐ Home
GP: <u>DR MACCICKILLI</u>	Potential discharge problems? ☐ Yes ☐ No
Contact number: <u>01234 422311</u>	If yes, give details:
Height: m	
Weight: kg	
BMI:	

Stoma Care Pre-op Assessment

Actual/Potential Diagnosis:

- ☐ Bladder cancer ☐ Diverticular disease ☐ Interstitial Cystitis ☐ Fistula: (specify)
☐ Bowel cancer ☐ Rectal cancer ☐ Crohn's Disease ☐ Incontinence: faecal/urinary/both
☐ Ulcerative Colitis ☐ Other: (specify)

Intended Surgical Procedure:

- ☐ Abdo-perineal excision rectum ☐ Subtotal colectomy ☐ Formation of ileostomy
☐ Anterior resection rectum ☐ Total colectomy ☐ Formation of colostomy
☐ Right hemicolectomy ☐ Sigmoid colectomy ☐ Hartmann's procedure
☐ Left hemicolectomy ☐ Panproctocolectomy ☐ Cystectomy with ileal conduit
☐ Other: (specify)

Type of Procedure:

- ☐ Open ☐ Laparoscopic ☐ Trephine
Type of Surgery: ☐ Elective ☐ Emergency Bowel prep required? ☐ Yes ☐ No
Type of Stoma: ☐ Colostomy ☐ Ileostomy ☐ Ileostomy/pouch formation ☐ Urostomy

Pre-operative Counselling and Advice

- ☐ 1. Understanding of surgical procedure and potential complications clarified with patient.
☐ 2. Stoma site, function and effects of stoma on lifestyle discussed.
☐ 3. Stoma appliance change demonstrated using teaching aid.
☐ 4. Pouch emptying demonstrated and stoma supplies given.
☐ 5. Post-op follow up care discussed.
☐ 6. Stoma care booklets supplied and SCN contact numbers given.
☐ 7. Voluntary organisation contact number/booklets given/visitor offered - accepted/declined
☐ 8. ASCN parastomal hernia assessment carried out (see page 10).
☐ 9. Abdominal core exercises explained and leaflet given.
☐ 10. Healthy lifestyle advice given, i.e. weight reduction, smoking cessation.

Additional Comments - Problems identified - anxieties, poor eyesight, limited manual dexterity, skin/drug allergies, physical disabilities



Completed by: (PRINT NAME)

Designation:

Signature:

Time: : (24 hour)

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 Coatbridge
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Stoma Siting

- ☐ 1. Abdominus Rectus muscle identified.
☐ 2. Planned incision site identified.
☐ 3. Waistline, umbilicus, iliac crests identified and avoided.
☐ 4. Obvious creases/scars identified and avoided.
☐ 5. Preferred site visible - lying, standing, sitting, bending and consented to with patient:
 Site marked with indelible pen: ☐ Left side ☐ Right side
☐ 6. Sited by: ☐ Consultant ☐ Registrar ☐ Stoma Nurse ☐ Ward Sister
☐ Other: (specify)

Additional Comments:

Number of times
seen pre-op:

Treatment Plan discussed with patient/carer? ☐ Yes ☐ No

Completed by: (PRINT NAME)

Designation:

Signature:

Date: / / Time: : (24 hour)

Post-operative Assessment - to be completed by ward nursing staff

Type of stoma: ☐ Colostomy ☐ Urostomy ☐ Loop
☐ Ileostomy ☐ Mucous fistula ☐ End
☐ Ileostomy/pouch formation ☐ Caecostomy ☐ Transverse

Condition of
stoma:
(see codes in key
on page 3)

Stoma appearance:

Stoma activity:

Additional Comments:

Completed by: (PRINT NAME)

Designation:

Signature:

Date: / / Time: : (24 hour)

Date/ Time	Notes/Evaluation of Care/Communication with Relatives	Signature/ Designation

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Stoma Care Teaching Plan Key				
Stoma Appearance (through pouch)	Stoma Activity	Peristomal Skin	Self Care Codes	Progress Stage
Healthy Necrotic Ischaemic Oedematous Prolapsed Flush Retracted Stents insitu Rod insitu	Inactive Haemoserous fluid Bile coloured fluid Faecal fluid Formed faeces Flatus Urine: • clear • foul smelling • haematuria	Healthy Inflamed Excoriated Mucocutaneous-separation Other: (specify)	A. Look at stoma B. Observe appliance change C. Assemble equipment D. Remove stoma pouch E. Clean and dry stoma F. Re-apply new pouch G. Dispose of used equipment H. Empty and clean end of pouch (ileostomy) I. Empty pouch (urostomy) J. Attach and remove night drainage (urostomy) K. Able to undertake own care L. Unable to undertake own care	Stoma care carried out by: 1. Nurse 2. Patient and nurse 3. Patient alone

Stoma Care Teaching Plan - record progress of stoma care/teaching plan each day using the key above

	Stoma Size	Stoma Appearance	Stoma Activity	Peristomal Skin	Self Care Code	Progress Stage
Post-op Day: 1	—	Healthy	min. faecal fluid		L	1.
	How did the patient feel when undertaking stoma care? Not sure how she will manage.					
	Additional Comments: Bach intact					
	Completed by: (PRINT NAME) T. TALLO			Designation: SCN		
	Signature: [Signature]			Date: 29/6/21 Time: 14:20 (24 hour)		

	Stoma Size	Stoma Appearance	Stoma Activity	Peristomal Skin	Self Care Code	Progress Stage
Post-op Day: 6	temp	healthy	loose faecal fluid	intact	A.B	1
	How did the patient feel when undertaking stoma care? Hopes she will manage.					
	Additional Comments: please observe output. High output "elephant tubing" applied					
	Completed by: (PRINT NAME) ROBERTSON			Designation: SCN		
	Signature: [Signature]			Date: 4/5/21 Time: 12:58 (24 hour)		

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Stoma Care Teaching Plan - record progress of stoma care/teaching plan each day using the key on page 4

Stoma Size	Stoma Appearance	Stoma Activity	Peristomal Skin	Self Care Code	Progress Stage
7		loose brown/green coloured fluid			
How did the patient feel when undertaking stoma care?					
Additional Comments: pouch intact, not renewed. Elephant tubing in situ. Abdomen slightly distended					
Completed by: (PRINT NAME) I Robertson			Designation: SCN		
Signature: I Robertson			Date: 5/5/21 Time: 08:00 (24 hour)		

Stoma Size	Stoma Appearance	Stoma Activity	Peristomal Skin	Self Care Code	Progress Stage
Temp	Healthy	fecal fluid	intact	AB	1
How did the patient feel when undertaking stoma care?					
Feels will manage when					
Additional Comments:					
Completed by: (PRINT NAME) TIALLO			Designation: SCN		
Signature: TIALLO			Date: 6/5/21 Time: 10:40 (24 hour)		

Stoma Size	Stoma Appearance	Stoma Activity	Peristomal Skin	Self Care Code	Progress Stage
Temp	Healthy	fecal fluid	intact	CDE4	2
How did the patient feel when undertaking stoma care?					
Feels did OK.					
Additional Comments:					
Encourage stoma care over weekend.					
Completed by: (PRINT NAME) TIALLO			Designation: SCN		
Signature: TIALLO			Date: 7/5/21 Time: 10:30 (24 hour)		

Stoma Size	Stoma Appearance	Stoma Activity	Peristomal Skin	Self Care Code	Progress Stage
Temp	Healthy	fecal fluid	intact	A, C, D, E, F, G	3
How did the patient feel when undertaking stoma care?					
Feels she will manage					
Additional Comments: Asked to use bowls. Please monitor stoma output					
Completed by: (PRINT NAME) I Robertson			Designation: SCN		
Signature: I Robertson			Date: 10/5/21 Time: 09:40 (24 hour)		

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Stoma Care Teaching Plan - record progress of stoma care/teaching plan each day using the key on page 4

	Stoma Size	Stoma Appearance	Stoma Activity	Peristomal Skin	Self Care Code	Progress Stage
Post-op Day:	temp	Healthy	Intact fecal fluid	Intact	ABK	3
	How did the patient feel when undertaking stoma care? feels she will manage					
	Additional Comments:					
	Completed by: (PRINT NAME) BISI Lukosi			Designation: Staff Nurse		
	Signature: <i>[Signature]</i>			Date: 11/5/21 Time: 10:00 (24 hour)		

	Stoma Size	Stoma Appearance	Stoma Activity	Peristomal Skin	Self Care Code	Progress Stage
Post-op Day:	temp	healthy, slightly around periphery	fecal / bile coloured fluid	intact	A, C, D, E, F, G	3
	How did the patient feel when undertaking stoma care? feels she will manage stoma care at home					
	Additional Comments:					
	Completed by: (PRINT NAME) I ROBERTSON			Designation: SCN		
	Signature: <i>[Signature]</i>			Date: 12/5/21 Time: 09:50 (24 hour)		

	Stoma Size	Stoma Appearance	Stoma Activity	Peristomal Skin	Self Care Code	Progress Stage
Post-op Day:	temp	as above	loose bile fecal coloured fluid	intact	A, C, D, E, F, G	3
	How did the patient feel when undertaking stoma care? feels she will manage stoma care at home					
	Additional Comments:					
	Completed by: (PRINT NAME) I ROBERTSON			Designation: SCN		
	Signature: <i>[Signature]</i>			Date: 13/5/21 Time: 11:50 (24 hour)		

	Stoma Size	Stoma Appearance	Stoma Activity	Peristomal Skin	Self Care Code	Progress Stage
Post-op Day:	temp	as above	thick fecal fluid	intact	K	3
	How did the patient feel when undertaking stoma care? feels she can manage					
	Additional Comments:					
	Completed by: (PRINT NAME) J TALLU			Designation: SCU		
	Signature: <i>[Signature]</i>			Date: 14/5/21 Time: 08:40 (24 hour)		



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Stoma Care Teaching Plan - record progress of stoma care/teaching plan each day using the key on page 4

Stoma Size	Stoma Appearance	Stoma Activity	Peristomal Skin	Self Care Code	Progress Stage
temp	healthy flush with skin	faecal fluid	erythema around stoma	A, C, D, E, F, G, H	3
How did the patient feel when undertaking stoma care? feels she will manage					
Additional Comments: belt applied and soft convex bag					
Completed by: (PRINT NAME) I ROBERTSON			Designation: SCN		
Signature: I Robertson			Date: 17/5/21 Time: 10:30 (24 hour)		

Stoma Size	Stoma Appearance	Stoma Activity	Peristomal Skin	Self Care Code	Progress Stage
temp	as above	faecal fluid	intact	K	3
How did the patient feel when undertaking stoma care? feels she is managing her stoma.					
Additional Comments:					
Completed by: (PRINT NAME) I ROBERTSON			Designation: SCN		
Signature: I Robertson			Date: 18/5/21 Time: 11:00 (24 hour)		

Stoma Size	Stoma Appearance	Stoma Activity	Peristomal Skin	Self Care Code	Progress Stage
temp	healthy flush with skin	faecal fluid	intact	K	3
How did the patient feel when undertaking stoma care? feels she will manage at home.					
Additional Comments: for OGD today ? home tomorrow					
Completed by: (PRINT NAME) ROBERTSON			Designation: SCN		
Signature: I Robertson			Date: 19/5/21 Time: 08:55 (24 hour)		

Stoma Size	Stoma Appearance	Stoma Activity	Peristomal Skin	Self Care Code	Progress Stage
temp	Healthy	faecal fluid	-	K	3
How did the patient feel when undertaking stoma care? Feels can manage.					
Additional Comments: Pouch not renewed					
Completed by: (PRINT NAME) TTACW			Designation: SCN		
Signature: [Signature]			Date: 20/5/21 Time: 09:40 (24 hour)		

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Stoma Care Teaching Plan - record progress of stoma care/teaching plan each day using the key on page 4

Stoma Size	Stoma Appearance	Stoma Activity	Peristomal Skin	Self Care Code	Progress Stage
temp	healthy flush thick	fecal fluid	intact	K	3
How did the patient feel when undertaking stoma care? Feels she will manage at home					
Additional Comments: Aware what output should be like + what to do if not					
Completed by: (PRINT NAME) I Robertson			Designation: SCN		
Signature: I Robertson			Date: 24/5/21 Time: 10:10 (24 hour)		

Stoma Size	Stoma Appearance	Stoma Activity	Peristomal Skin	Self Care Code	Progress Stage
temp		thick faecal fluid		K	3
How did the patient feel when undertaking stoma care? States she will manage					
Additional Comments: Self caring has renewed pouch					
Completed by: (PRINT NAME) I Robertson			Designation: SCN		
Signature: I Robertson			Date: 25/5/21 Time: 12:25 (24 hour)		

Stoma Size	Stoma Appearance	Stoma Activity	Peristomal Skin	Self Care Code	Progress Stage
How did the patient feel when undertaking stoma care?					
Additional Comments:					
Completed by: (PRINT NAME)			Designation:		
Signature:			Date: / / Time: : (24 hour)		

Stoma Size	Stoma Appearance	Stoma Activity	Peristomal Skin	Self Care Code	Progress Stage
How did the patient feel when undertaking stoma care?					
Additional Comments:					
Completed by: (PRINT NAME)			Designation:		
Signature:			Date: / / Time: : (24 hour)		

CH 
 Fir: 1808785142
 Las: 18/08/1978 F
 Ad MCCracken Isabel
 1d Cumberae Crescent

 Coatbridge
 Lanarkshire ML5 4PX

Discharge Checklist	Yes	No	Details
Patient able to undertake own stoma care on discharge?	☒	☐	
Stoma condition on discharge: ☒ Healthy ☐ Necrotic ☐ Retracted ☐ Mucocutaneous separation ☐ Prolapsed ☐ Parastomal hernia ☐ Oedematous ☐ Sloughy ☐ Other: (specify)			
Does the patient have adequate supplies? (e.g. drainable - 10 bags, closed - 30 bags, urostomy - 10 bags)	☒	☐	
Patient given Stoma Care Nurse's contact details?	☒	☐	
Patient given written literature relevant to surgery?	☒	☐	
Stoma care nurse informed of discharge?	☒	☐	
Patient discharged on or before 6 - 10th post-op day?	☐	☒	Discharge date: 25 / 5 / 21

Completed by: (PRINT NAME) <i>1 ROBERTSON</i>	Designation: <i>SW</i>
Signature: <i>1 ROBERTSON</i>	Date: <i>25 / 6 / 21</i> Time: <i>12.25</i> (24 hour)

[illegible]

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 F 18/08/1978 F
 L MCCracken Isabel
 A 1d Cumberae Crescent
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 Lanarkshire ML5 4PX

Stoma Care Audit	1 st -3 rd Day Post-op	7 th -10 th Day Post-op
Retraction of stoma: 0 = No retraction 1 = Superior retraction 2 = Inferior retraction 3 = Circumferential retraction 4 = Dehissed/mucocutaneous separation	☐	☐
Prolapse: 0 = No prolapse 1 = Minor prolapse not affecting appliance 2 = Major prolapse affecting appliance	☐	☐
Stenosis of stoma: 0 = No stenosis 1 = Minor stenosis 2 = Significant stenosis requiring further surgery	☐	☐
Stoma associated hernia: 0 = No hernia present 1 = Small hernia not affecting appliance 2 = Large hernia not affecting appliance 3 = Large hernia not affecting appliance	☐	☐
Leakage from appliance: 0 = No leakage 1 = 1 - 2 2 = More than 2	Day ☐ Night ☐	☐ ☐
Soiling through leakage: 0 = No soiling 1 = Change of clothing 2 = Change of bed linen 3 = Change of clothing and bed linen	Day ☐ Night ☐	☐ ☐
Night time emptying: 0 = No emptying 1 = Once overnight 2 = Twice overnight 3 = More than twice	☐	☐
Skin changes: 0 = No excoriation 1 = Minor changes not affecting appliance 2 = Major changes affecting appliance	☐	☐
Odour: 0 = No odour 1 = Noticed by patient 2 = Noticed by others	☐	☐
Use of accessories: Cream/powder Washer/paste Convexity Belt Other: (specify) <i>HIGH OUTPUT SYSTEM</i>	☐ ☐ ☐ ☐ ☒	☐ ☐ ☒ ☐ ☐
TOTAL:	7	0

CHI no
 First name DOB / /
 Last name Sex: ☐ M ☐ F
 Address

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CLINICAL ASSESSMENT IDENTIFYING RISK FOR PARASTOMAL HERNIA

1 – low risk 2 – medium risk 3 – high risk

Predisposing consideration	Risk factor	Value	Total
Age	Age 5-15	1	
	Over 70	3	
BMI	Obese	3	
Occupation/ lifestyle	Manual *	3	
	Young family	2	
Activity	Fairly active	2	
	Gym/physical exercise	3	
Surgery/Stoma site	Robotic / laproscopic surgery	2	
	Transverse colostomy	3	
	Colostomy	2	
	Stoma out of rectus muscle	2	
	Previous parastomal hernia repair	3	
	Trephine stoma	2	
	Aperture >35mm	3	
	Open wound	1	
Diagnosis	Multiple stoma	1	
	Malignancy	2	
	Diverticular	2	
	Existing hernia (any)*	3	
	Previous hernia	3	
	AAA	1	
	Connective tissue disorders	2	
	On assessment Diabetic & within 6months of surgery	3	
Smoking	Smoker	3	
Medication	On assessment on Steroids & within 1 year of surgery	3	
	Steroids long term	1	
	Currently having Chemotherapy	1	
	Currently undertaking Pelvic radiotherapy	3	
Raised intra abdominal pressure	COPD/Emphysema	3	
	Ascites	3	
	Acute constipation (colo/uro)	1	
	Existing hernia and heavy manual work and physical exercise are high risk irrelevant of score	Total	

Total risk score: Low risk : 0-15 High risk : 16 and above

Based on your assessment what would be your recommended support garment product: (please circle)

Light support Firm support garment Prescription required Y/N

None (clinical reason)..... Declined by patient

Based on your assessment, what would your clinical recommendation for a support garment be

Name/ code of product (if appropriate)

Other notes to support choice of product:



Association of Stoma Care Nurses UK
 ASCN/WSO – V3 Nov 2016

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CHI no

Hospital/Location: monklandsWard/Base: 7


1808785142

18/08/1978

MCCRACKEN Isabel
1d Cumber CrescentCoatbridge
Lanarkshire

ML5 4PX

1 ☐ F

Assessment and Management of Wounds (including Pressure Ulcers)

For information: assessment completion please see Tissue Viability Section on FirstPort:

- Wound Documentation Guidance:

<http://firstport2/staff-support/tissue-viability-service/Documents/Guidelines%20for%20completion%20of%20wound%20assessment%20documentation.pdf>

- EPUAP Grading Tool:

<http://firstport2/staff-support/tissue-viability-service/Documents/EPUAP%20Grading%20Tool.pdf>

Preferred name:

Admission date: 1/5/21Wound/pressure ulcer documentation start date: 6/5/21

Origin of development of ulcer/tissue damage:

☐ Hospital acquired☐ Community acquired☐ Care Home acquired☐ Unknown

Type of wound	If required refer to	Date referred
☐ Diabetic foot ulcer	Podiatry	
☐ Complex foot ulcer	Podiatry	
☐ Venous leg ulcer	Dermatology	
☐ Weeping legs	Dermatology	
☐ Dermatitis	Dermatology	
☐ Vasculitis	Dermatology	
☒ Surgical wound	Tissue Viability	
☐ Pressure ulcer	Tissue Viability	
☐ Other: (specify)	Tissue Viability	

Action Plan	Yes No N/A	Comments/Details	Date
Consultant informed of wound	☐ ☒ ☐		
Relatives/carers informed of wound	☒ ☐ ☐		
Management of wound discussed with patient and relatives/carers	☒ ☐		
Prevention of Pressure Ulcer information leaflet given to patient/relatives/carers	☐ ☒ ☐		
SSKIN Care Bundle commenced	☐ ☒ ☐		
DATIX recorded for newly acquired Grade 2, 3 and 4 pressure ulcers	☐ ☒ ☐	Recorded by:	
Commenced on pressure reducing equipment? (If yes, give details)	☐ ☒ ☐		

Factors which could delay healing: (please tick all that are relevant)

- | | | | |
|--|---|--|---|
| ☒ Immobility | ☒ Poor nutrition | ☐ Diabetes | ☐ Circulatory disease |
| ☐ Anaemia | ☐ Medication | ☐ Wound infection | ☐ Respiratory disease |
| ☐ Inotropes | ☒ Anti-coagulants | ☐ Oedema | ☐ Steroids ☐ Incontinence |
| ☐ Chemotherapy | ☐ Other: (specify) | | |

Allergies and Sensitivities:

Nicola



CHI no
 First name DOB
 Last name Sex: ☐ M ☐ F
 Address

Refer to Medical Illustration for photography? ☐ Yes ☒ No
 If yes, date(s) referred:

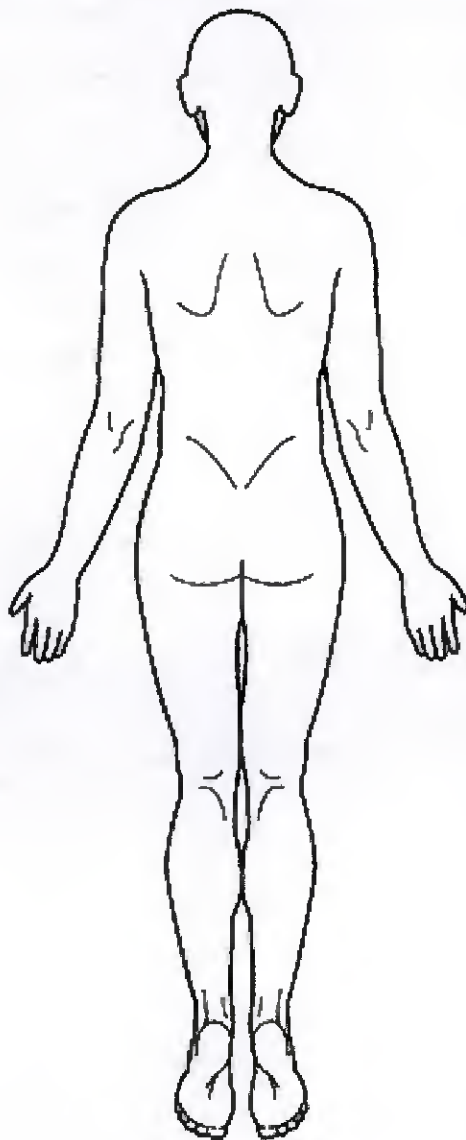
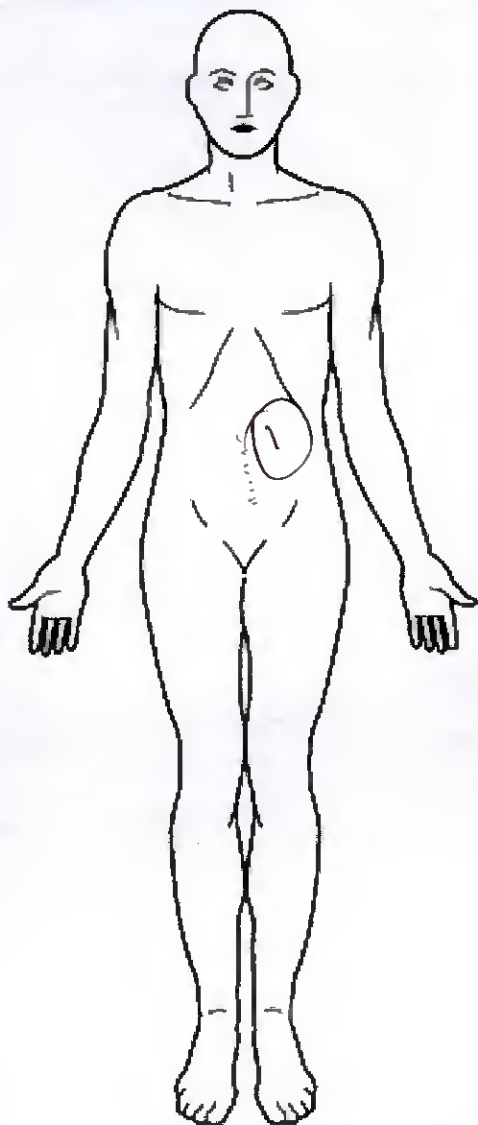
If patient able, consent given for casenotes and teaching? ☐ Yes ☒ No

Location of Wound(s) on Body - mark the location of each wound with a number

Duration of Wound(s):

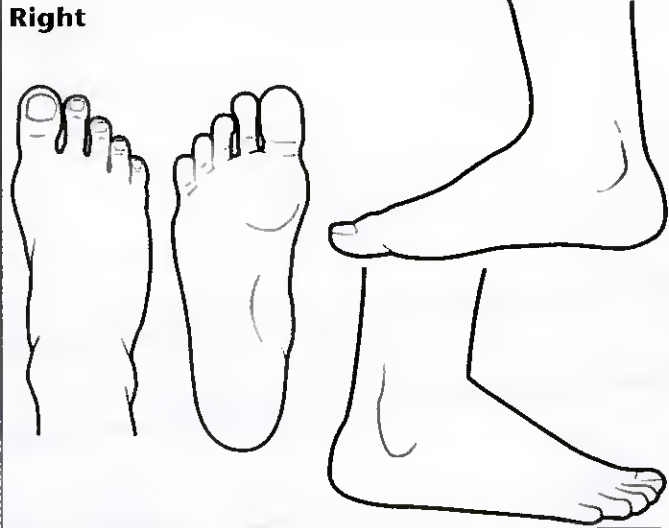
Front

Back



Left

Right



CHI no
 First name DOB
 Last name Sex: ☐ M ☐ F
 Address

Wound Assessment and Treatment Plan/Evaluation of Care

- Complete on initial assessment and thereafter for acute wounds at least weekly or if any improvement or deterioration noted; for chronic wounds at least two weekly or if any improvement or deterioration noted. Unless advised otherwise by specialist service/manager.
- **Use an additional wounds continuation document for each additional wound/continuation of wound care.**
- Ensure all episodes of wound care are recorded within relevant documentation, for example Nursing Care Record

Wound Site/Number:	①		
Date/Time of Assessment:	6/5/24	8/5/24	
Grade of pressure ulcer: (enter grade or N/A)	NA	/	
Grade of diabetic foot ulcer (TEXAS Scale): (enter grade or N/A)	NA	/	
Pre-dressing Analgesia required? (tick)	NO	no	
Wound dimensions: Length (cm)	20	20	
Width (cm)	2	2	
Depth (cm)	/	/	
Wound tracking @ o'clock	N	N	
Wound undermining @ o'clock	U	U	
Tissue Type on Wound Bed: (enter percentage)	fragile -	fragile	
Wound Exudate Levels/Type:	medium	medium	
Peri-Wound Skin:	Peri	intact	
Clinical Signs of Infection? (enter Yes/No)	Yes	✓	
Wound swab for culture? (enter Yes/No)	yes	no	
Assessor: (Signature)			
Dressing renewed by: (Signature)			

Cleaning Method and Product Choices/Subsequent Changes

Date	Cleaning method and products/ Subsequent Product Changes	Frequency	Aim/rationale for product Use	Discussed/ agreed with patient?	Signature
6/5/24	Cleansed with normal saline, dressed with wound pad + waterproof border	7-8 day	☒ Cleanse ☒ Absorption ☐ Debridement ☐ Reduce oedema ☐ Palliative/Conservative ☐ Reduce bacterial load ☐ Hydration ☒ Protection	yes	
8/5/24	Cleaned with proctosan urgo cream + wound pad applied.		☒ Cleanse ☒ Absorption ☐ Debridement ☐ Reduce oedema ☐ Palliative/Conservative ☐ Reduce bacterial load ☐ Hydration ☐ Protection	yes	
			☐ Cleanse ☐ Absorption ☐ Debridement ☐ Reduce oedema ☐ Palliative/Conservative ☐ Reduce bacterial load ☐ Hydration ☐ Protection		
			☐ Cleanse ☐ Absorption ☐ Debridement ☐ Reduce oedema ☐ Palliative/Conservative ☐ Reduce bacterial load ☐ Hydration ☐ Protection		

CHI no

First name DOB

Last name Sex: ☐ M ☐ F

Address

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Wound Assessment and Treatment Plan/Evaluation of Care

- Complete on initial assessment and thereafter for acute wounds at least weekly or if any improvement or deterioration noted; for chronic wounds at least two weekly or if any improvement or deterioration noted. Unless advised otherwise by specialist service/manager.
- **Use an additional wounds continuation document for each additional wound/continuation of wound care.**
- Ensure all episodes of wound care are recorded within relevant documentation, for example Personal Care Record

Wound Site/Number:				
Date/Time of Assessment:				
Grade of pressure ulcer: (enter grade or N/A)				
Grade of diabetic foot ulcer (TEXAS Scale): (enter grade or N/A)				
Pre-dressing Analgesia required? (tick)				
Wound dimensions: Length (cm)				
Width (cm)				
Depth (cm)				
Wound tracking @ o'clock				
Wound undermining @ o'clock				
Tissue Type on Wound Bed: (enter percentage)				
Wound Exudate Levels/Type:				
Peri-Wound Skin:				
Clinical Signs of Infection? (enter Yes/No)				
Wound swab for culture? (enter Yes/No)				
Assessor: (Signature)				
Dressing renewed by: (Signature)				

Cleaning Method and Product Choices/Subsequent Changes

Date	Cleaning method and products/ Subsequent Product Changes	Frequency	Aim/rationale for product Use	Discussed/ agreed with patient?	Signature
			☐ Cleanse ☐ Hydration ☐ Absorption ☐ Protection ☐ Debridement ☐ Reduce oedema ☐ Palliative/Conservative ☐ Reduce bacterial load		
			☐ Cleanse ☐ Hydration ☐ Absorption ☐ Protection ☐ Debridement ☐ Reduce oedema ☐ Palliative/Conservative ☐ Reduce bacterial load		
			☐ Cleanse ☐ Hydration ☐ Absorption ☐ Protection ☐ Debridement ☐ Reduce oedema ☐ Palliative/Conservative ☐ Reduce bacterial load		
			☐ Cleanse ☐ Hydration ☐ Absorption ☐ Protection ☐ Debridement ☐ Reduce oedema ☐ Palliative/Conservative ☐ Reduce bacterial load		

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 18/08/1978 F
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 MLS 4PX

University Hospital: ☐ Hairmyres ☐ Monklands ☒ Wishaw **NHS**
 Other: Lanarkshire

Ward: 7

Peripheral Vascular Catheter (PVC) Insertion, Maintenance and Removal Bundles

PVC Insertion Bundle 1	Yes	No
Hand hygiene performed immediately before all PVC insertion procedures (WHO Moment 2)	☐	☐
A single use skin antiseptic containing 70% isopropyl alcohol and 2% chlorhexidine gluconate is used to cleanse skin and left to dry before insertion	☐	☐
Aseptic technique maintained throughout insertion procedure	☐	☐
A sterile, transparent, semipermeable dressing used to cover the catheter site	☐	☐

Size/colour: Pink Insertion site: R arm
 Insertion Date: 19/08/21 Time: Signature:

PVC Maintenance Bundle 1	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Is the PVC still in use?	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have staff informed patients/representatives of risks, care and monitoring of the device? Patient information leaflet provided.	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
The clinical need for the PVC has been reviewed and recorded today	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
Medical staff have reviewed the need for intravenous (IV) therapy including antibiotics today and switched to oral if possible	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hand hygiene is performed immediately before accessing the line/site (WHO Moment 2)	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
Removal of the PVC is considered if in longer than 72 hours	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC site has been assessed; removing the PVC where there is phlebitis or inflammation at the site	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC dressings are intact	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
A single use antiseptic containing 70% isopropyl alcohol is used to clean the access hub before accessing - rub the access hub for at least 15 seconds ("scrub the hub")	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
Date:	<u>20/8/22</u>											
Time:	<u>09:45</u>											
Initials:	<u>NE se</u>											

PVC Removal Bundle 1

Removal Date: / / Time: : (24 hour)
 Reason for removal:
 Condition of site on removal:
 Signature:



CHI no
 First name DOB / /
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

PVC Insertion Bundle 2	Yes	No
Hand hygiene performed immediately before all PVC insertion procedures (WHO Moment 2)	☐	☐
A single use skin antiseptic containing 70% isopropyl alcohol and 2% chlorhexidine gluconate is used to cleanse skin and left to dry before insertion	☐	☐
Aseptic technique maintained throughout insertion procedure	☐	☐
A sterile, transparent, semipermeable dressing used to cover the catheter site	☐	☐

Size/colour: Insertion site:
 Insertion Date: / / Time: : Signature:

PVC Maintenance Bundle 2	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Is the PVC still in use?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have staff informed patients/representatives of risks, care and monitoring of the device? Patient information leaflet provided.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The clinical need for the PVC has been reviewed and recorded today	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Medical staff have reviewed the need for intravenous (IV) therapy including antibiotics today and switched to oral if possible	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hand hygiene is performed immediately before accessing the line/site (WHO Moment 2)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Removal of the PVC is considered if in longer than 72 hours	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC site has been assessed; removing the PVC where there is phlebitis or inflammation at the site	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC dressings are intact	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
A single use antiseptic containing 70% isopropyl alcohol is used to clean the access hub before accessing - rub the access hub for at least 15 seconds ("scrub the hub")	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Date:												
Time:												
Initials:												

PVC Removal Bundle 2

Removal Date: / / Time: : (24 hour)

Reason for removal:

Condition of site on removal:

Signature:

CHI no
 First name DOB / /
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

University Hospital: ☐ Hairmyres ☐ Monklands ☐ Wishaw **NHS**
 Other: Lanarkshire

Ward:

Peripheral Vascular Catheter (PVC) Insertion, Maintenance and Removal Bundles

PVC Insertion Bundle 1	Yes	No
Hand hygiene performed immediately before all PVC insertion procedures (WHO Moment 2)	☒	☐
A single use skin antiseptic containing 70% isopropyl alcohol and 2% chlorhexidine gluconate is used to cleanse skin and left to dry before insertion	☒	☐
Aseptic technique maintained throughout insertion procedure	☒	☐
A sterile, transparent, semipermeable dressing used to cover the catheter site	☒	☐

Size/colour: Blue Insertion site: R
 Insertion Date: 13/5/21 Time: Signature: S. Lament

PVC Maintenance Bundle 1	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Is the PVC still in use?	☐	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have staff informed patients/representatives of risks, care and monitoring of the device? Patient information leaflet provided.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The clinical need for the PVC has been reviewed and recorded today	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Medical staff have reviewed the need for intravenous (IV) therapy including antibiotics today and switched to oral if possible	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hand hygiene is performed immediately before accessing the line/site (WHO Moment 2)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Removal of the PVC is considered if in longer than 72 hours	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC site has been assessed; removing the PVC where there is phlebitis or inflammation at the site	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC dressings are intact	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
A single use antiseptic containing 70% isopropyl alcohol is used to clean the access hub before accessing - rub the access hub for at least 15 seconds ("scrub the hub")	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Date:	<u>17/5</u>											
Time:	<u>08:15</u>											
Initials:	<u>KC</u>											

PVC Removal Bundle 1
Removal Date: / / Time: : (24 hour)
Reason for removal:
Condition of site on removal:
Signature:



CHI no
 First name DOB
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

PVC Insertion Bundle 2	Yes	No
Hand hygiene performed immediately before all PVC insertion procedures (WHO Moment 2)	☐	☐
A single use skin antiseptic containing 70% isopropyl alcohol and 2% chlorhexidine gluconate is used to cleanse skin and left to dry before insertion	☐	☐
Aseptic technique maintained throughout insertion procedure	☐	☐
A sterile, transparent, semipermeable dressing used to cover the catheter site	☐	☐

Size/colour: Pink Insertion site: R arm
 Insertion Date: 13/5/21 Time: Signature:

PVC Maintenance Bundle 2	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Is the PVC still in use?	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have staff informed patients/representatives of risks, care and monitoring of the device? Patient information leaflet provided.	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
The clinical need for the PVC has been reviewed and recorded today	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
Medical staff have reviewed the need for intravenous (IV) therapy including antibiotics today and switched to oral if possible	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hand hygiene is performed immediately before accessing the line/site (WHO Moment 2)	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
Removal of the PVC is considered if in longer than 72 hours	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC site has been assessed; removing the PVC where there is phlebitis or inflammation at the site	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC dressings are intact	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
A single use antiseptic containing 70% isopropyl alcohol is used to clean the access hub before accessing - rub the access hub for at least 15 seconds ("scrub the hub")	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
Date:	<u>14/5</u>	<u>16/5</u>										
Time:	<u>1000</u>											
Initials:	<u>10</u>											

PVC Removal Bundle 2
Removal Date: / / Time: (24 hour)
Reason for removal:
Condition of site on removal:
Signature:

Intentional Safety Rounding

Name or insert Label	CHI Number	Date form started	Ward
STALINI	Date of Birth	Date of Birth	Date of Birth

This patient requires Intentional Safety Rounding every hour(s) REVIEW 1 hour(s) REVIEW 2 hour(s)

Explain purpose of rounding to offer reassurance 6/5/21 *Escalate concerns about condition changes to nurse in charge*

TIME (24 hour clock)	1400	1600	1800	20	22	00	02	04	06	0800	1000	12	1400	1600	1800	20	22	MN	02	04	06
Continence care assistance – (eg, assist to toilet, hand washing, catheter care etc)	I	I	I	I	S	S	S	S	S	I	I	I	I	I	I	I	I	S	S	S	S
Pain Review – (action appropriate to pain score or review)	Y	Y	Y	Y	S	S	S	S	S	Y	Y	Y	Y	Y	Y	Y	Y	S	S	S	S
Hydration – (eg, drink offered /jug refilled)	Y	Y	Y	Y	S	S	S	S	S	Y	Y	Y	Y	Y	Y	Y	Y	S	S	S	S
Personal items at hand? – (glasses/tissue/buzzer etc)	Y	Y	Y	Y	S	S	S	S	S	Y	Y	Y	Y	Y	Y	Y	Y	S	S	S	S
Environmental scan – (clean, tidy and no clutter, trip/fall risk)	Y	Y	Y	Y	S	S	S	S	S	Y	Y	Y	Y	Y	Y	Y	Y	S	S	S	S
Is there anything else I can get for you before I go or anything you want to ask?	Y	Y	Y	Y	S	S	S	S	S	Y	Y	Y	Y	Y	Y	Y	Y	S	S	S	S
INITIALS	AS	YU	AS	N	N	N	N	N	N	AS	YU	S	S	S	S	S	S	AS	YU	AS	YU

TIME (24 hour clock)	08	10	12	14	16	18	20	22	MN	02	04	06	0800	1000	1200	14	16	18	20	22	24
Continence care assistance – (personal hygiene, hand washing, catheter care etc)	Y	Y	Y	Y	Y	Y	Y	Y	Y				I	I	I	I	I	I	I	I	I
Pain Review – (action appropriate to pain score or review)	Y	Y	Y	Y	Y	Y	Y	Y	Y				Y	Y	Y	Y	Y	Y	Y	Y	Y
Hydration – (drink offered /jug refilled)	Y	Y	Y	Y	Y	Y	Y	Y	Y				Y	Y	Y	Y	Y	Y	Y	Y	Y
Personal items at hand? – (glasses/tissue/buzzer etc)	Y	Y	Y	Y	Y	Y	Y	Y	Y				Y	Y	Y	Y	Y	Y	Y	Y	Y
Environmental scan – (clean, tidy and no clutter, trip/fall risk)	Y	Y	Y	Y	Y	Y	Y	Y	Y				Y	Y	Y	Y	Y	Y	Y	Y	Y
Is there anything else I can get for you before I go or anything you want to ask?	Y	Y	Y	Y	Y	Y	Y	Y	Y				Y	Y	Y	Y	Y	Y	Y	Y	Y
INITIALS	AS	YU	AS	N	N	N	N	N	N				AS	YU	AS	N	N	N	N	N	N

Y = Yes and addressed N = not required CP = further detail in care plan S = Sleeping O = off ward I = Independent
Intentional safety rounding sheet: MONKLANDS WARD 12 M Hogi November 2013

COPY PAGE

1800785142
18/08/1978
MCCracken Isabel
1d Cumberdale Crescent

Coatbridge
Lanarkshire

ML5 4PX

CHO9

CHO9

CHO9

7 CHO9

NHS
Lanarkshire

Form started: CH1 Number: form started: Ward: Date form started: 1/5/21 Ward: 7

Safety Rounding every: hour(s) REVIEW 1: hour(s) REVIEW 2: hour(s)

Explain purpose of rounding to offer reassurance

Escalate concerns about condition changes to nurse in charge

TIME (24 hour clock)	12	14	16	18	20	22	00	02	04	06	08	10	12	14	16	18	20	22	00	02	04	06	08	10	12	14	16
Continence care assistance – (eg, assist to toilet, hand washing, catheter care etc)	Y	Y	Y		Y	Y	Y						Y	Y	S	S	Y	S	Y	S	Y	S	Y	S	Y	Y	Y
Pain Review – (action appropriate to pain score or review)	Y	Y	Y		Y	Y	Y						Y	Y	S	S	Y	S	Y	S	Y	S	Y	S	Y	Y	Y
Hydration – (eg, drink offered /jug refilled)	Y	Y	Y		Y	Y	Y						Y	Y	S	S	Y	S	Y	S	Y	S	Y	S	Y	Y	Y
Personal items at hand? – (glasses/tissue/buzzer etc)	Y	Y	Y		Y	Y	Y						Y	Y	S	S	Y	S	Y	S	Y	S	Y	S	Y	Y	Y
Environmental scan – (clean, tidy and no clutter, trip/fall risk)	Y	Y	Y		Y	Y	Y						Y	Y	S	S	Y	S	Y	S	Y	S	Y	S	Y	Y	Y
Is there anything else I can get for you before I go or anything you want to ask?	Y	Y	Y		Y	Y	Y						Y	Y	S	S	Y	S	Y	S	Y	S	Y	S	Y	Y	Y
INITIALS	LF	LF	LF		TH	TH	TH						AX	AX	AX	AX	AX	AX	AX	AX	AX	AX	AX	AX	AX	AX	AX

TIME (24 hour clock)	18	20	22	00	02	04	06	08	10	12	14	16	08	10	12	14	16	08	10	12	14	16	08	10	12	14	16
Continence care assistance – (personal hygiene, hand washing, catheter care etc)	Y	Y	Y	S	S	S	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Pain Review – (action appropriate to pain score or review)	Y	Y	Y	S	S	S	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Hydration – (drink offered /jug refilled)	Y	Y	Y	S	S	S	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Personal items at hand? – (glasses/tissue/buzzer etc)	Y	Y	Y	S	S	S	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Environmental scan – (clean, tidy and no clutter, trip/fall risk)	Y	Y	Y	S	S	S	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is there anything else I can get for you before I go or anything you want to ask?	Y	Y	Y	S	S	S	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
INITIALS	KE	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS

not Yes and No depressed etc not required GP S for needs in care plan or ward = sleeping O = off-ward I = Independent

1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumberae Crescent

CHI Number form started: [blank] Date form start: [blank] Ward: [blank]
Date of Birth: [blank]

NHS Safety Rounding
Lanarkshire

Coatbridge
Lanarkshire

ML5 4PX safety Rounding every 1 hour(s) REVIEW 1 hour(s) REVIEW 2 hour(s)

Explain purpose of rounding to offer reassurance

Escalate concerns about condition changes to nurse in charge

TIME (24 hour clock)	0800	1000	1200	1400	1600	1800	2000	2200	0000	0200	0400	0600	0800	1000	1200	1400	1600	1800	2000	2200	0000
Continence care assistance - (eg, assist to toilet, hand washing, catheter care etc)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Pain Review - (action appropriate to pain score or review)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Hydration - (eg, drink offered /jug refilled)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Personal items at hand? - (glasses/tissue/buzzer etc)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Environmental scan - (clean, tidy and no clutter, trip/fall risk)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is there anything else I can get for you before I go or anything you want to ask?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
INITIALS	CC	CC	CC	CC	CC	CC	CC	CC	CC	CC	CC	CC	CC	CC	CC	CC	CC	CC	CC	CC	CC

TIME (24 hour clock)	0800	1000	1200	1400	1600	1800	2000	2200	0000	0200	0400	0600	0800	1000	1200	1400	1600	1800	2000	2200	0000
Continence care assistance - (personal hygiene, hand washing, catheter care etc)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Pain Review - (action appropriate to pain score or review)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Hydration - (drink offered /jug refilled)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Personal items at hand? - (glasses/tissue/buzzer etc)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Environmental scan - (clean, tidy and no clutter, trip/fall risk)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is there anything else I can get for you before I go or anything you want to ask?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
INITIALS	AR	AR	AR	AR	AR	AR	AR	AR	AR	AR	AR	AR	AR	AR	AR	AR	AR	AR	AR	AR	AR

Y = Yes and addressed N = not required CP = further detail in care plan S = Sleeping O = off ward I = Independent

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Intentional Safety Rounding

Name or insert Label SABU MCCracken	CHI Number [blank]	Ward [blank]	Date form started [blank]	Ward [blank]
Date of Birth [blank]		[blank]		



This patient requires Intentional Safety Rounding every.....hour(s) REVIEW 1.....hour(s) REVIEW 2.....hour(s)

Explain purpose of rounding to offer reassurance

Escalate concerns about condition changes to nurse in charge

TIME (24 hour clock)	00	02	04	06	08	10	12	14	16	18	20	22	00	02	04	06	08	10	20	22	00	02
Continence care assistance – (eg, assist to toilet, hand washing, catheter care etc)	S	S	S	I	Y	I	I	I	I	I	I	I	S	S	S	S	I	I	I	I	S	S
Pain Review – (action appropriate to pain score or review)	S	S	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	S	S	S	S	Y	Y	Y	Y	S	S
Hydration – (eg, drink offered /jug refilled)	S	S	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	S	S	S	S	Y	Y	Y	Y	S	S
Personal items at hand? – (glasses/tissue/buzzer etc)	S	S	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	S	S	S	S	Y	Y	Y	Y	S	S
Environmental scan – (clean, tidy and no clutter, trip/fall risk)	S	S	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	S	S	S	S	Y	Y	Y	Y	S	S
Is there anything else I can get for you before I go or anything you want to ask?	S	S	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	S	S	S	S	Y	Y	Y	Y	S	S
INITIALS	mm	mm	mm	mm	mm	mm	mm	mm	mm	mm	mm	mm	mm	mm	mm	mm	mm	mm	mm	mm	mm	mm

TIME (24 hour clock)	04	06	08	10	12	14	16	18	20	22	00	02	04	06	
Continence care assistance – (personal hygiene, hand washing, catheter care etc)	S	S	Y	I	I	I	I	I	I	I	I	I	I	I	
Pain Review – (action appropriate to pain score or review)	S	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Hydration – (drink offered /jug refilled)	S	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Personal items at hand? – (glasses/tissue/buzzer etc)	S	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Environmental scan – (clean, tidy and no clutter, trip/fall risk)	S	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Is there anything else I can get for you before I go or anything you want to ask?	S	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
INITIALS	mm	mm	mm	mm	mm	mm	mm	mm	mm	mm	mm	mm	mm	mm	

Y= Yes and addressed N= not required CP= further detail in care plan S = Sleeping O = off ward I = Independent

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1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumbrae Crescent

Coatbridge
Lanarkshire

ML5 4PX safety Rounding every.....hour(s)

CHI Number
Date of Birth

Date form started

Ward: 7

REVIEW 1hour(s)

REVIEW 2 hour(s)



Explain purpose of rounding to offer reassurance

Escalate concerns about condition changes to nurse in charge

TIME (24 hour clock)	08	10	12	14	16	18	20	22	24	02	04	06	08	10	12	14	16	18	20	22	24
Continence care assistance – (eg, assist to toilet, hand washing, catheter care etc)	L	I	I	I	I	I	S	S	S	S	S	S	S	I	I						
Pain Review – (action appropriate to pain score or review)	Y	Y	Y	Y	Y	Y	S	S	S	S	S	S	S	Y	Y						
Hydration – (eg, drink offered /jug refilled)	Y	Y	Y	Y	Y	Y	S	S	S	S	S	S	S	Y	Y						
Personal items at hand? – (glasses/tissue/buzzer etc)	Y	Y	Y	Y	Y	Y	S	S	S	S	S	S	S	Y	Y						
Environmental scan – (clean, tidy and no clutter, trip/fall risk)	Y	Y	Y	Y	Y	Y	S	S	S	S	S	S	S	Y	Y						
Is there anything else I can get for you before I go or anything you want to ask?	Y	Y	Y	Y	Y	Y	S	S	S	S	S	S	S	Y	Y						
INITIALS	AR	AR	AR	AR	E	E	E	E	E	E	E	E	E	Y	Y						

TIME (24 hour clock)																					
Continence care assistance – (personal hygiene, hand washing, catheter care etc)																					
Pain Review – (action appropriate to pain score or review)																					
Hydration – (drink offered /jug refilled)																					
Personal items at hand? – (glasses/tissue/buzzer etc)																					
Environmental scan – (clean, tidy and no clutter, trip/fall risk)																					
Is there anything else I can get for you before I go or anything you want to ask?																					
INITIALS																					

Y= Yes and addressed N = not required CP = further detail in care plan
intentional safety rounding sheet. MONKLANDS WARD 12 M Hogg November 2013

S = Sleeping

O = off ward I = Independent

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Ir 1808785142
 18/08/1978 F
 MCCracken Isabel
 1d Cumberae Crescent

CHI Number	Date form started	Ward:
Date of Birth	19.5.21	7



T Coatbridge Lanarkshire ML5 4PX
 ty Rounding every.....hour(s) REVIEW 1hour(s) REVIEW 2 hour(s)

Explain purpose of rounding to reassurance 19.05.21 *Escalate concerns about condition changes to nurse in charge*

TIME (24 hour clock)	08	10	12	14	16	18	20	22	00	02	04	06	08	10	12	14	16	18	2000	2200	2400
Contenance care assistance – (eg. assist to toilet, hand washing, catheter care etc)	1	S	Y	Y	Y	Y	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I
Pain Review – (action appropriate to pain score or review)	Y	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	7	7	7
Hydration – (eg. drink offered /jug refilled)	Y	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	7	7	7
Personal items at hand? – (glasses/tissue/buzzer etc)	Y	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	7	7	7
Environmental scan – (clean, tidy and no clutter, trip/fall risk)	Y	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	7	7	7
Is there anything else I can get for you before I go or anything you want to ask?	Y	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	7	7	7
INITIALS	AS	AS	AS	AS	AS	AS	U	U	U	U	U	U	AS	AS	AS	AS	U	U	U	U	U

TIME (24 hour clock)	2000	2200	0000	0200	0400	0600	0800	1000	1200	1400	1600	1800	2000	2200	2400	0200	0400	0600	0800	1000	1200	1400	1600	1800	2000
Contenance care assistance – (personal hygiene, hand washing, catheter care etc)	S	S	S	Y	Y	I	I	O	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	
Pain Review - (action appropriate to pain score or review)	S	S	S	Y	Y	Y	Y	O	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Hydration – (drink offered /jug refilled)	S	S	S	Y	Y	Y	Y	O	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Personal items at hand? – (glasses/tissue/buzzer etc)	S	S	S	Y	Y	Y	Y	O	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Environmental scan – (clean, tidy and no clutter, trip/fall risk)	S	S	S	Y	Y	Y	Y	O	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Is there anything else I can get for you before I go or anything you want to ask?	S	S	S	Y	Y	Y	Y	O	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
INITIALS	G	G	G	K	K	O	O	O	K	K	O	O	O	O	O	O	O	O	O	O	O	O	O	O	

Y= Yes and addressed N = not required CP = further detail in care plan S = Sleeping O = off ward I = Independent

CI 1808785142
 FI 18/08/1978 F
 L MCCracken Isabel
 A 1d Cumbernauld Crescent
 Coatbridge
 Lanarkshire ML5 4PX

University Hospital: ☐ Hairmyres ☒ Monklands ☐ Wishaw **NHS**
 Other: Lanarkshire

Ward: 7

Peripheral Vascular Catheter (PVC) Insertion, Maintenance and Removal Bundles

PVC Insertion Bundle 1	Yes	No
Hand hygiene performed immediately before all PVC insertion procedures (WHO Moment 2)	☒	☐
A single use skin antiseptic containing 70% isopropyl alcohol and 2% chlorhexidine gluconate is used to cleanse skin and left to dry before insertion	☒	☐
Aseptic technique maintained throughout insertion procedure	☒	☐
A sterile, transparent, semipermeable dressing used to cover the catheter site	☒	☐

Size/colour: Blue Insertion site: L. Arm
 Insertion Date: 22/5/21 Time: 13:10 Signature: M. Bury

PVC Maintenance Bundle 1	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Is the PVC still in use?	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have staff informed patients/representatives of risks, care and monitoring of the device? Patient information leaflet provided.	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The clinical need for the PVC has been reviewed and recorded today	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Medical staff have reviewed the need for intravenous (IV) therapy including antibiotics today and switched to oral if possible	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hand hygiene is performed immediately before accessing the line/site (WHO Moment 2)	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Removal of the PVC is considered if in longer than 72 hours	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC site has been assessed; removing the PVC where there is phlebitis or inflammation at the site	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC dressings are intact	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
A single use antiseptic containing 70% isopropyl alcohol is used to clean the access hub before accessing - rub the access hub for at least 15 seconds ("scrub the hub")	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Date:	<u>25/5</u>											
Time:	<u>9am</u>											
Initials:	<u>M</u>											

LAT622

PVC Removal Bundle 1

Removal Date: / / Time: : (24 hour)
 Reason for removal:
 Condition of site on removal:
 Signature:



CHI no
 First name DOB / /
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

PVC Insertion Bundle 2	Yes	No
Hand hygiene performed immediately before all PVC insertion procedures (WHO Moment 2)	☐	☐
A single use skin antiseptic containing 70% isopropyl alcohol and 2% chlorhexidine gluconate is used to cleanse skin and left to dry before insertion	☐	☐
Aseptic technique maintained throughout insertion procedure	☐	☐
A sterile, transparent, semipermeable dressing used to cover the catheter site	☐	☐

Size/colour: Insertion site:
 Insertion Date: / / Time: : Signature:

PVC Maintenance Bundle 2	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Is the PVC still in use?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have staff informed patients/representatives of risks, care and monitoring of the device? Patient information leaflet provided.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The clinical need for the PVC has been reviewed and recorded today	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Medical staff have reviewed the need for intravenous (IV) therapy including antibiotics today and switched to oral if possible	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hand hygiene is performed immediately before accessing the line/site (WHO Moment 2)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Removal of the PVC is considered if in longer than 72 hours	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC site has been assessed; removing the PVC where there is phlebitis or inflammation at the site	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC dressings are intact	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
A single use antiseptic containing 70% isopropyl alcohol is used to clean the access hub before accessing - rub the access hub for at least 15 seconds ("scrub the hub")	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Date:												
Time:												
Initials:												

PVC Removal Bundle 2
Removal Date: / / Time: : (24 hour)
Reason for removal:
Condition of site on removal:
Signature:

1808785142
 18/08/1978 F
 MCCracken Isabel
 1d Cumbernauld Crescent
 Coatbridge Lanarkshire ML5 4PX

University Hospital: ☐ Hairmyres ☒ Monklands ☐ Wishaw **NHS**
 Other: Lanarkshire

Ward: 7

Peripheral Vascular Catheter (PVC) Insertion, Maintenance and Removal Bundles

PVC Insertion Bundle 1	Yes	No
Hand hygiene performed immediately before all PVC insertion procedures (WHO Moment 2)	☒	☐
A single use skin antiseptic containing 70% isopropyl alcohol and 2% chlorhexidine gluconate is used to cleanse skin and left to dry before insertion	☒	☐
Aseptic technique maintained throughout insertion procedure	☒	☐
A sterile, transparent, semipermeable dressing used to cover the catheter site	☒	☐

Size/colour: Blue Insertion site: L.Arm
 Insertion Date: 9/5/21 Time: 12:55 Signature: M. Bug

PVC Maintenance Bundle 1	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Is the PVC still in use?	☒	☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐
Have staff informed patients/representatives of risks, care and monitoring of the device? Patient information leaflet provided.	☒	☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐
The clinical need for the PVC has been reviewed and recorded today	☒	☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐
Medical staff have reviewed the need for intravenous (IV) therapy including antibiotics today and switched to oral if possible	☒	☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐
Hand hygiene is performed immediately before accessing the line/site (WHO Moment 2)	☒	☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐
Removal of the PVC is considered if in longer than 72 hours	☒	☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐
The PVC site has been assessed; removing the PVC where there is phlebitis or inflammation at the site	☒	☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐
The PVC dressings are intact	☒	☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐
A single use antiseptic containing 70% isopropyl alcohol is used to clean the access hub before accessing - rub the access hub for at least 15 seconds ("scrub the hub")	☒	☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐
Date:	<u>11/5</u>	<u>12/5</u>	<u>13/5</u>	<u>20/5</u>								
Time:	<u>9⁰⁰</u>	<u>08⁰⁰</u>	<u>08⁰⁰</u>	<u>08⁰⁰</u>								
Initials:	<u>4</u>	<u>DM</u>	<u>GW</u>	<u>KC</u>								

PVC Removal Bundle 1

Removal Date: / / Time: : (24 hour)

Reason for removal:

Condition of site on removal:

Signature:



CHI no
 First name DOB / /
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

PVC Insertion Bundle 2	Yes	No
Hand hygiene performed immediately before all PVC insertion procedures (WHO Moment 2)	☒	☐
A single use skin antiseptic containing 70% isopropyl alcohol and 2% chlorhexidine gluconate is used to cleanse skin and left to dry before insertion	☒	☐
Aseptic technique maintained throughout insertion procedure	☒	☐
A sterile, transparent, semipermeable dressing used to cover the catheter site	☒	☐

Size/colour: Pink Insertion site: Ⓟ
 Insertion Date: 19/5/21 Time: Signature: S. Lamart

PVC Maintenance Bundle 2	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Is the PVC still in use?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have staff informed patients/representatives of risks, care and monitoring of the device? Patient information leaflet provided.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The clinical need for the PVC has been reviewed and recorded today	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Medical staff have reviewed the need for intravenous (IV) therapy including antibiotics today and switched to oral if possible	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hand hygiene is performed immediately before accessing the line/site (WHO Moment 2)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Removal of the PVC is considered if in longer than 72 hours	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC site has been assessed; removing the PVC where there is phlebitis or inflammation at the site	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC dressings are intact	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
A single use antiseptic containing 70% isopropyl alcohol is used to clean the access hub before accessing - rub the access hub for at least 15 seconds ("scrub the hub")	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Date:												
Time:												
Initials:												

PVC Removal Bundle 2
Removal Date: / / Time: : (24 hour)
Reason for removal:
Condition of site on removal:
Signature:

CHN no
FIR
La: 1808785142
18/08/1978 F
Ad MCCracken Isabel
1d Cumbernae Crescent
Coatbridge
Lanarkshire ML5 4PX

☐ Hairmyres ☐ Monklands ☐ Wishaw **NHS**
☐ Other (specify) Lanarkshire

Ward:

Peripheral Vascular Catheter (PVC) Insertion and Maintenance Bundles

PVC Insertion Bundle 1	Yes	No
Hand hygiene performed immediately before all PVC insertion procedures (WHO Moment 2)	☒	☐
A single use skin antiseptic containing 70% isopropyl alcohol is used to cleanse skin and left to dry before insertion	☒	☐
Aseptic technique maintained throughout insertion procedure	☒	☐
A sterile, transparent, semipermeable dressing used to cover the catheter site	☒	☐

Size/colour: Pink Insertion site: ②
 Insertion Date: 4 / 5 / 20 Time: Signature: S. Lamont

PVC Maintenance Bundle 1	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Is the PVC still in use?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have staff informed patients/representatives of risks, care and monitoring of the device? Patient information leaflet provided.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The clinical need for the PVC has been reviewed and recorded today	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Medical staff have reviewed the need for intravenous (IV) therapy including antibiotics today and switched to oral if possible	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hand hygiene is performed immediately before accessing the line/site (WHO Moment 2)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Removal of the PVC is considered if in longer than 72 hours	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC site has been assessed; removing the PVC where there is phlebitis or inflammation at the site	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC dressings are intact	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
A single use antiseptic containing 70% isopropyl alcohol is used to clean the access hub before accessing - rub the access hub for at least 15 seconds ("scrub the hub")	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Date:												
Time:												
Initials:												



CHI no
 First name DOB / /
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

PVC Insertion Bundle 2		Yes	No
Hand hygiene performed immediately before all PVC insertion procedures (WHO Moment 2)	☒	☐	☐
A single use skin antiseptic containing 70% isopropyl alcohol is used to cleanse skin and left to dry before insertion	☒	☐	☐
Aseptic technique maintained throughout insertion procedure	☒	☐	☐
A sterile, transparent, semipermeable dressing used to cover the catheter site	☒	☐	☐
Size/colour: <u>Pink</u> Insertion site: <u>L hand</u>			
Insertion Date: <u>7/5/21</u> Time: <u>07:05</u> Signature: <u>MMcAnley</u>			

PVC Maintenance Bundle 2	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Is the PVC still in use?	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have staff informed patients/representatives of risks, care and monitoring of the device? Patient information leaflet provided.	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The clinical need for the PVC has been reviewed and recorded today	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Medical staff have reviewed the need for intravenous (IV) therapy including antibiotics today and switched to oral if possible	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hand hygiene is performed immediately before accessing the line/site (WHO Moment 2)	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Removal of the PVC is considered if in longer than 72 hours	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC site has been assessed; removing the PVC where there is phlebitis or inflammation at the site	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC dressings are intact	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
A single use antiseptic containing 70% isopropyl alcohol is used to clean the access hub before accessing - rub the access hub for at least 15 seconds ("scrub the hub")	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Date:	<u>8/5</u>													
Time:	<u>0920</u>													
Initials:	<u>OP</u>													

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University Hospital: ☐ Hairmyres ☐ Monklands ☐ Wishaw **NHS**
 Other: Lanarkshire

Ward:

Peripheral Vascular Catheter (PVC) Insertion, Maintenance and Removal Bundles

PVC Insertion Bundle 1	Yes	No
Hand hygiene performed immediately before all PVC insertion procedures (WHO Moment 2)	☒	☐
A single use skin antiseptic containing 70% isopropyl alcohol and 2% chlorhexidine gluconate is used to cleanse skin and left to dry before insertion	☒	☐
Aseptic technique maintained throughout insertion procedure	☒	☐
A sterile, transparent, semipermeable dressing used to cover the catheter site	☒	☐

Size/colour: Pink Insertion site: ② Arm
 Insertion Date: 30/4/21 Time: ? : Signature:

PVC Maintenance Bundle 1	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Is the PVC still in use?	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have staff informed patients/representatives of risks, care and monitoring of the device? Patient information leaflet provided.	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
The clinical need for the PVC has been reviewed and recorded today	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
Medical staff have reviewed the need for intravenous (IV) therapy including antibiotics today and switched to oral if possible	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hand hygiene is performed immediately before accessing the line/site (WHO Moment 2)	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
Removal of the PVC is considered if in longer than 72 hours	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC site has been assessed; removing the PVC where there is phlebitis or inflammation at the site	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC dressings are intact	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
A single use antiseptic containing 70% isopropyl alcohol is used to clean the access hub before accessing - rub the access hub for at least 15 seconds ("scrub the hub")	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
Date:	2/5		4/5									
Time:	0845		0945									
Initials:	TM		LM									

PVC Removal Bundle 1

Removal Date: / / Time: : (24 hour)
 Reason for removal:
 Condition of site on removal:
 Signature:



CHI no
 First name DOB / /
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

PVC Insertion Bundle 2	Yes	No
Hand hygiene performed immediately before all PVC insertion procedures (WHO Moment 2)	☐	☐
A single use skin antiseptic containing 70% isopropyl alcohol and 2% chlorhexidine gluconate is used to cleanse skin and left to dry before insertion	☐	☐
Aseptic technique maintained throughout insertion procedure	☐	☐
A sterile, transparent, semipermeable dressing used to cover the catheter site	☐	☐
Size/colour: <u>Pink</u> Insertion site: <u>(L) ARM</u> Insertion Date: <u>7/5/21</u> Time: <u>06:00</u> Signature:		

PVC Maintenance Bundle 2	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Is the PVC still in use?	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have staff informed patients/representatives of risks, care and monitoring of the device? Patient information leaflet provided.	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The clinical need for the PVC has been reviewed and recorded today	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Medical staff have reviewed the need for intravenous (IV) therapy including antibiotics today and switched to oral if possible	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hand hygiene is performed immediately before accessing the line/site (WHO Moment 2)	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Removal of the PVC is considered if in longer than 72 hours	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC site has been assessed; removing the PVC where there is phlebitis or inflammation at the site	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC dressings are intact	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
A single use antiseptic containing 70% isopropyl alcohol is used to clean the access hub before accessing - rub the access hub for at least 15 seconds ("scrub the hub")	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Date: <u>7/5</u>												
Time: <u>0830</u>												
Initials: <u>BM</u>												

PVC Removal Bundle 2
Removal Date: / / Time: : (24 hour)
Reason for removal:
Condition of site on removal:
Signature:

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☐ Other: (specify)
Ward: 7

Malnutrition Universal Screening Tool (MUST)* with Nutrition Profile

- Complete for every patient within 24 hours of admission
- Re-assessment will take place weekly or as per risk score
- Complete the Nutritional Profile on page 2

Date: 02/05/15 11/5 25/5
Time: 09/15 09/30 08/10 09/30

Weight (kg) [(A) = actual or (E) = estimated - enter in column]
Reason if estimated: 61kg 58.65 57.5 57.10
Height (m) [(A) = actual or (E) = estimated - enter in column]
Reason if estimated: 5'2 5'2 1.58 1.58
BMI = Weight (kg) / Height (m²)
24 24 23 23

		Score	Score	Score	Score	Score
STEP 1: BMI Score	BMI kg/m ² <20 (>30 obese) 18.5 - 20 <18.5	0 1 2	0	0	0	0
STEP 2: Unplanned weight loss in past 3-6 months	% <5 5 - 10 >10 Usual weight OR recent weight loss: kg	0 1 2	0	0	0	0
STEP 3: Acute disease effect score	If the patient is acutely ill and there has been or is likely to be no nutritional intake for >5 days	2	0	0	0	0
STEP 4: Overall risk of malnutrition	Add scores to calculate overall risk of malnutrition		0	0	0	0
TOTAL SCORE:						
Initials:			LM	8	KC	JM

Treat as High Risk - immediate referral to dietitian (please tick as appropriate)

☐ Enteral/Parenteral feeding	☐ Stem cell/BM transplant
☐ Swallowing problems (dysphagia), e.g. stent, stricture	☐ Acute leukaemia
☐ Major ENT/Maxfax/GI surgery	☐ Organ failure, e.g. renal, liver
☐ Non-functioning gut (ileus, bowel obstruction, stasis)	☐ Decompensated Liver Disease
☐ Upper GI oncology	☐ Pressure ulcer, grade 3 or more
☐ Severe acute pancreatitis	

STEP 5: Management Guidelines	Actions Required	Initials	Date/Time
0 Low Risk	Repeat screening: Hospital - weekly, Community - monthly		
1 Medium Risk	Minimise any potential causes of poor appetite, e.g. oral infection, missing dentures, constipation, dehydration		
	Provide help and advice on food choices, eating and drinking		
	Initiate 3 day food record chart if intake poor for 2 or more days		
	Encourage snacks		
	If after 3 days more than 1/2 of meals and snacks are taken, continue to encourage with meals, offer snacks, offer full cream milk		
	If after 3 days less than 1/2 of meals and snacks are taken refer to dietitian		
	If on discharge patient remains medium risk, give 'Weigh Back Home' leaflet		
2 or more High Risk	Repeat screening weekly		
	Refer to dietitian for assessment and nutritional support (unless detrimental or no benefit is expected from nutritional support)		
	Commence all relevant actions from medium risk guidelines		
	Repeat screening weekly		



CHI no
 First name DOB
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

Nutrition Profile

- Patients unable to make decisions on their food and fluid choices should have a detailed dietary and fluid preference recorded.

Nutrition Profile	Yes	No
Patient's eating and drinking likes and dislikes: (including appetite and/or NBM status)		
Does the patient have special dietary requirements? (e.g. vegetarian; texture modified diet and fluids; halal; kosher) If yes, give details:	☐	☒
Is the patient on oral nutritional supplements?	☐	☐
Are there any contributing factors that may affect food intake? (such as physical, e.g. swallowing difficulties; physiological, e.g. nausea; psychological, e.g. dementia; social or environmental) If yes, give details:	☐	☒
Swallow Screening Test undertaken?	☐	☐
Referred to Speech and Language Therapy?	☐	☐
Does the patient have any food allergies? If yes, give details:	☐	☐
Is there a need for equipment and/or assistance with eating and drinking? If yes, give details:	☐	☒
Referred to Occupational Therapy?	☐	☐
Food in Hospital information booklet given?	☐	☐

Completed by: (PRINT NAME) KIRSTY CLARK	Designation: CSW
Signature: K. Clark	Date: 17 / 5 / 21 Time: 08:10

* The 'Malnutrition Universal Screening Tool' ('MUST') is reproduced here with the kind permission of BAPEN (British Association for Parenteral and Enteral Nutrition). For further information on 'MUST' see www.bapen.org.uk.

2

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Lanarkshire

University Hospital:

☐ Hairmyres ☐ Monklands ☐ Wishaw

Other: (specify)

Ward:

NHS
Lanarkshire

Adult Vancomycin intermittent IV Infusion Prescription, Administration and Monitoring Chart For patients ≥ 16 years

Use online Vancomycin calculator available at:

NHS Lanarkshire FirstPort: Applications >MEDED >Drugs and Prescribing >Pharmacy calculators.
Antimicrobial Companion App –available in Apple App store and Play Store for android (select NHS Lanarkshire)

PROMPT ADMINISTRATION of antibiotics within 1 hour of recognising sepsis reduces mortality

All patients on vancomycin **MUST** have a vancomycin prescription, administration and monitoring chart held with the patient notes which **MUST** be completed after each dose.

This policy covers the use of intravenous vancomycin prescribed as an intermittent (pulsed) infusion.

This policy does not apply to the use of vancomycin in ICU, Renal or patients receiving haemodialysis or haemofiltration.

Step 1 Document baseline requirements

• Document patient's weight (kg), height (cm or feet and inches), age and serum creatinine (micromol/L)

Age Sex: ☐ M ☐ F Weight kg Height Creatinine on / /

Calculator dose: Loading dose mg Initial regimen: mg, ☐ 12 ☐ 24 ☐ 48Hrs

Source of initial dosage regimen:

☐ Online calculator (preferred method) ☐ Manual calculation ☐ Loading dose only, creatinine awaited

Step 2 Loading infusion *

* see step 4 for administration

• The loading dose is based on **actual** body weight (ABW). • It does not depend on creatinine clearance.

Actual body weight (ABW)	Dose
<40 kg	750 mg
40 - 59 kg	1000 mg
60 - 90 kg	1500 mg
>90 kg	2000 mg

Step 3 Maintenance intermittent infusion dose

Calculate maintenance dose using **ON-LINE CALCULATOR (based on renal function)**.

- Give first maintenance infusion 12, 24 or 48 hours after loading infusion according to recommended dose interval.
- In order to facilitate the more convenient timing of administration and monitoring of vancomycin, the **FIRST MAINTENANCE** dose may be given up to 6 hours earlier (if 12 or 24 hourly dosing) or up to 12 hours earlier (if 48 hourly dosing)

Step 4 Preparation and Administration

- Reconstitute with the required volume of water for injection (10 ml water for a 500 mg vial & 20 ml water for a 1 gram vial).
- **Vancomycin must be diluted before administration** -
Further dilute the vancomycin by adding it to an intravenous bag of sodium chloride 0.9% or glucose 5%.
e.g. 1000mg added to 250ml sodium chloride 0.9%
- **Maximum concentration for peripheral infusion 5 mg/ml**
- **Vancomycin must be administered by intravenous infusion at a rate no greater than 10 mg/minute.**
Failure to do so can result in anaphylaxis, shock and red man syndrome.

Vancomycin Dose	Volume of diluents – sodium chloride 0.9% or glucose 5%	Duration of infusion
500mg	250ml	60 minutes
750mg	250ml	90 minutes
1000mg	250ml	120 minutes
1250mg	250ml	150 minutes
1500mg	500ml	180 minutes
2000mg	500ml	240 minutes



2

Patient name: <u>Isobel McCrocker</u>	CHI No:
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Step 5 Vancomycin prescription, administration and monitoring chart

- Prescribe vancomycin on prescription chart below and on drug cardex/HEPMA 'as per chart'
- Prescribe single loading dose and all maintenance doses until the first vancomycin level is available
- Document date and time of level required
- Record exact times of all doses administered below
- Check and document creatinine (Cr) daily. Review therapy if renal function is unstable (eg. change in Cr of >15-20%) and seek advice.

Date	Creatinine (μmol/l)	Time	Vancomycin Dose (mg)	Prescriber's Signature	Time infusion commenced	Nurses' Signatures	Level required		Sample taken		Measured Trough Level mg/L
							Date	Time	Date	Time	
			Loading dose								
9/5		24:00	1250	<i>[Signature]</i>	00:40	<i>[Signature]</i>	9/5	00:07	9/5	00:07	15-2
10/5		12:00	1250	<i>[Signature]</i>	12:40	<i>[Signature]</i>					
10/5		00:40	1250	<i>[Signature]</i>	00:40	<i>[Signature]</i>					
12/5		12:40	1250	<i>[Signature]</i>	12:40	<i>[Signature]</i>	11/5	11:30	11/5	10:30	17-3
Review need for continuing therapy, Discuss with senior clinician, ID or microbiology, Discontinue if appropriate											
12/5		00:40	1250	<i>[Signature]</i>	00:40	<i>[Signature]</i>					
12/5		12:40	1250	<i>[Signature]</i>	13:00	<i>[Signature]</i>					
STOP											

Step 6 Monitoring of Vancomycin concentrations

- Target trough concentration 10 - 20 mg/L
- Check and document creatinine daily. Recalculate creatinine clearance and dose if there is a change in creatinine.
- Check trough (pre dose) concentration immediately before the fourth dose (within 48 hours) or sooner if renal function is impaired or deteriorating.
- Ongoing monitoring check trough (pre dose) level every 72 hours or daily if renal function changes significantly.
- Document complete information on dose, administration and sample times on the sample request and the prescription chart.
- Document level and next dose on the prescription chart and the case notes.
- Give next dose pending trough result unless renal function is deteriorating.

Step 7 Adjustment of Vancomycin Doses

- Always check that the dosage history and sampling time are correct before making adjustments.
- Advice is available from clinical pharmacist or microbiologist
- After dose adjustment take a trough level at 24 hours and again 24 hours later to ensure that the new dose is appropriate.

Vancomycin trough concentration	Suggested dose change
<10 mg/L	Increase the dose by 50% and consider reducing the dosage interval. Always seek advice if you are unsure or if the current dose is > 2500 mg daily.
10 – 15 mg/L	If the patient is responding maintain the present dosage regimen. If the patient is seriously ill consider increasing the dose amount or reducing the dosage interval to achieve a trough level of 15 – 20 mg/L.
15 – 20 mg/L	Maintain the present dosage regimen
>20 mg/L	Withhold until <20 mg/L then seek advice

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Ward:



MRSA and CPE Clinical Risk Assessments

MRSA CLINICAL RISK ASSESSMENT (Meticillin-Resistant Staphylococcus Aureus)
- To be completed for all ACUTE admissions.
- Do NOT complete for admissions to Maternity, Neonatal, Paediatrics, Mental Health

	Yes	No
1. Has the patient any previous history of MRSA? – ask the patient and check Track Care, Labs	☐	☒
2. Has the patient been admitted from anywhere other than their own home (e.g. prison, homeless hostel, resident in a care home) or transferred from another hospital?	☐	☒
3. Does the patient have any wound(s)/ulcer(s) or indwelling device (e.g. peg tube, urinary catheter) which was inserted before admission?	☐	☒

If **YES** to questions 1 or 2 obtain nasal and perineal swabs. If **YES** to question 3 obtain nasal, perineal, device, wound swabs and catheter specimen of urine (CSU), where appropriate.

For patients admitted to Vascular, Orthopaedics, Renal and Critical Care (including attached high dependency areas) complete the Clinical Risk Assessment **AND** obtain nasal and perineal swabs.

MRSA Screening Swabs	Result	Isolation	Actions
☐ Nasal		Is the patient isolated? ☐ Yes ☐ No	If a single room is not available, a risk assessment must be undertaken and the Infection Prevention and Control (IPC) team must be contacted. Out of hours, the on-call microbiologist should be informed.
☐ Perineal		If no, why not? ☐ Not applicable ☐ Not available	
☐ Wound(s) - location:			
☐ Ulcer(s) - location:			
☐ CSU			
☐ Throat		If unavailable has a clinical risk assessment been undertaken? ☐ Yes ☐ No	
☐ Other: (specify)			

PRINT NAME: ZOE WILK	Designation: S/W
Signature: [Signature]	Date: 27/4/21 Time: 18:15

FOR PATIENTS WHO ARE MRSA POSITIVE: decolonisation treatment to be carried out and patient re-swabbed as per MRSA Policy, Control of Infection Manual (access manual via FirstPort)

CPE CLINICAL RISK ASSESSMENT (Carbapenemase Producing Enterobacteriaceae)
- To be completed for admissions to all specialties

	Yes	No
1. Has the patient been previously confirmed CPE positive at any time?	☐	☐
In the past 12 months:		
2. Has the patient been hospitalised outside Scotland?	☐	☐
3. Has the patient had holiday dialysis outside Scotland?	☐	☐
4. Has the patient been in close contact of a person who has been colonised or infected with CPE?	☐	☐

If **YES to any question**, the patient is at increased risk of CPE carriage; swab(s) should be obtained, patient isolated and IPC Team informed. Obtain **rectal** swab **OR** if swab not taken, obtain **stool sample**. In addition, for patients with a urinary catheter insitu, obtain **CSU** and if has wound(s) obtain **wound** swab.

CPE Screening Swabs	Result	Isolation	Actions
☐ Rectal		Is the patient isolated? ☐ Yes ☐ No	If a single room is not available, a risk assessment must be undertaken and the IPC team must be contacted. Out of hours, the on-call microbiologist should be informed.
☐ Stool sample		If no, why not? ☐ Not applicable ☐ Not available	
☐ Wound(s) - location:			
☐ CSU			
Reason for not swabbing:		If unavailable has a clinical risk assessment been undertaken? ☐ Yes ☐ No	

PRINT NAME:	Designation:
Signature:	Date: / / Time:



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Coatbridge
Lanarkshire

ML5 4PX

University Hospital:

☐ Hairmyres ☒ Monklands ☐ Wishaw

Other: (specify)

Ward: 7

NHS
Lanarkshire

Adult Vancomycin intermittent IV Infusion Prescription, Administration and Monitoring Chart For patients ≥ 16 years

Use online Vancomycin calculator available at:

NHS Lanarkshire FirstPort: Applications > MEDED > Drugs and Prescribing > Pharmacy calculators.
Antimicrobial Companion App – available in Apple App store and Play Store for android (select NHS Lanarkshire)

PROMPT ADMINISTRATION of antibiotics within 1 hour of recognising sepsis reduces mortality

All patients on vancomycin MUST have a vancomycin prescription, administration and monitoring chart held with the patient notes which MUST be completed after each dose.

This policy covers the use of intravenous vancomycin prescribed as an intermittent (pulsed) infusion.

This policy does not apply to the use of vancomycin in ICU, Renal or patients receiving haemodialysis or haemofiltration.

Step 1 Document baseline requirements

- Document patient's weight (kg), height (cm or feet and inches), age and serum creatinine (micromol/L)

Age 42 Sex: ☐ M ☐ F Weight 61 kg Height 157 cm Creatinine 48 on 02/05/21

Calculator dose: Loading dose 1500 mg Initial regimen: 1250 mg, ☒ 12 ☐ 24 ☐ 48Hrs

Source of initial dosage regimen:

☒ Online calculator (preferred method) ☐ Manual calculation ☐ Loading dose only, creatinine awaited

Step 2 Loading infusion *

*see step 4 for administration

- The loading dose is based on **actual** body weight (ABW). • It does not depend on creatinine clearance.

Actual body weight (ABW)	Dose
<40 kg	750 mg
40 - 59 kg	1000 mg
60 - 90 kg	1500 mg
>90 kg	2000 mg

Step 3 Maintenance intermittent infusion dose

Calculate maintenance dose using **ON-LINE CALCULATOR (based on renal function)**.

- Give first maintenance infusion 12, 24 or 48 hours after loading infusion according to recommended dose interval.
- In order to facilitate the more convenient timing of administration and monitoring of vancomycin, the FIRST MAINTENANCE dose may be given up to 6 hours earlier (if 12 or 24 hourly dosing) or up to 12 hours earlier (if 48 hourly dosing)

Step 4 Preparation and Administration

- Reconstitute with the required volume of water for injection (10 ml water for a 500 mg vial & 20 ml water for a 1 gram vial).
- Vancomycin must be diluted before administration -**
Further dilute the vancomycin by adding it to an intravenous bag of sodium chloride 0.9% or glucose 5%.
e.g. 1000mg added to 250ml sodium chloride 0.9%
- Maximum concentration for peripheral infusion 5 mg/ml**
- Vancomycin must be administered by intravenous infusion at a rate no greater than 10 mg/minute.**
Failure to do so can result in anaphylaxis, shock and red man syndrome.

Vancomycin Dose	Volume of diluents – sodium chloride 0.9% or glucose 5%	Duration of infusion
500mg	250ml	60 minutes
750mg	250ml	90 minutes
1000mg	250ml	120 minutes
1250mg	250ml	150 minutes
1500mg	500ml	180 minutes
2000mg	500ml	240 minutes



Patient name:	CHI No:
---------------	---------

Step 5 Vancomycin prescription, administration and monitoring chart

- Prescribe vancomycin on prescription chart below and on drug cardex/HEPMA 'as per chart'
- Prescribe single loading dose and all maintenance doses until the first vancomycin level is available
- Document date and time of level required
- Record exact times of all doses administered below
- Check and document creatinine (Cr) daily. Review therapy if renal function is unstable (eg. change in Cr of >15-20%) and seek advice.

Date	Creatinine (μmol/l)	Time	Vancomycin Dose (mg)	Prescriber's Signature	Time infusion commenced	Nurses' Signatures	Level required		Sample taken		Measured Trough Level mg/L
							Date	Time	Date	Time	
04/05		15:00	1500	[Signature]	15:15	JB/RS					
05/05		03:00	1250	[Signature]	03:20	[Signature]					
05/05		15:00	1250	[Signature]	16:20	[Signature]					
06/05		03:00	1250	[Signature]	06:00	[Signature]	06/05	02:00	06/05	05:45	10.3.
06/05		18:00	1250	[Signature]	21:40	[Signature]					
Review need for continuing therapy, Discuss with senior clinician, ID or microbiology, Discontinue if appropriate											
07/05		06:00	1250	[Signature]	10:20	[Signature]					
07/05		18:00	1250	[Signature]	22:20	[Signature]					
08/05		06:00	1250	[Signature]	10:50	JB/KJS	08/05	05:00			NOT DONE
08/05		22:20	1250	[Signature]	22:55	[Signature]	08/05	21:00			15.2 @ 12pm
09/05		12:00	1250	[Signature]	12:30	[Signature]					

Step 6 Monitoring of Vancomycin concentrations

- Target trough concentration 10 - 20 mg/L
- Check and document creatinine daily. Recalculate creatinine clearance and dose if there is a change in creatinine.
- Check trough (pre dose) concentration immediately before the fourth dose (within 48 hours) or sooner if renal function is impaired or deteriorating.
- Ongoing monitoring check trough (pre dose) level every 72 hours or daily if renal function changes significantly.
- Document complete information on dose, administration and sample times on the sample request and the prescription chart.
- Document level and next dose on the prescription chart and the case notes.
- Give next dose pending trough result unless renal function is deteriorating.

Step 7 Adjustment of Vancomycin Doses

- Always check that the dosage history and sampling time are correct before making adjustments.
- Advice is available from clinical pharmacist or microbiologist
- After dose adjustment take a trough level at 24 hours and again 24 hours later to ensure that the new dose is appropriate.

Vancomycin trough concentration	Suggested dose change
<10 mg/L	Increase the dose by 50% and consider reducing the dosage interval. Always seek advice if you are unsure or if the current dose is > 2500 mg daily.
10 – 15 mg/L	If the patient is responding maintain the present dosage regimen. If the patient is seriously ill consider increasing the dose amount or reducing the dosage interval to achieve a trough level of 15 – 20 mg/L.
15 – 20 mg/L	Maintain the present dosage regimen
>20 mg/L	Withhold until <20 mg/L then seek advice

S. OLIVER
WARD 12

-6

[PAGE 1 OF 1]

NORTH GLASGOW HOSPITALS
GRI HAEMOSTASIS REPORT

Surname: [REDACTED]
Forename: 1808785142
DOB/Age: 18/08/1978 F
CHI/Unit: MCCracken Isabel e
Address: 1d Cumbræ Crescent
Diagnosis: Coatbridge ML5 4PX
Clin Det: Lanarkshire

Location: Haematology Dept
Monklands Hospital
Airdrie
Lanarkshire Health Board
Requestor: Not known

1045247585

Lab No: B,21.6980438
Collected: 07.04.21 15:14
Authorised: 20.04.21

Ext Labno:
Received: 13.04.21 15:40
Authoriser: Maureen Bennie

F.V Leiden.

Absent

03 MAY 2021



Comments:

F5LEID: Tests should be repeated on a fresh sample if F.V Leiden result is inconsistent with a specific/modified APC-Resistance result.

CAC5

1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumberae Crescent
Coatbridge
Lanarkshire ML5 4PX

INTENSIVE CARE UNIT DISCHARGE SUMMARY

Date of Hospital Admission: 27/04/21
Date of ICU Admission: 28/04/21
Date of ICU Discharge: 01/05/21

Primary Consultant: MR OICK
ICU Consultant: DR GUHA
Destination Ward: 7

Summary of ICU Admission

Admitted post-op emergency laparotomy. @ hemicolectomy and end ileostomy + appendicectomy (appendix abnormal)
History of superior mesenteric vein thrombosis last few weeks
typus anticoagulant Abs and anaemia

Current Problems	Plan
post-op ↳ doing well ↳ stoma moving	→ E+D as tolerated → finish course of tazocin (stop date on HEPMA)
superior mesenteric vein thrombosis + anaemia	→ haem have reviewed and performed a bone marrow aspirate/trephine → now on BD dexam at treatment dose.
? intraabdominal malignancy	→ pathology awaited post-op

Outstanding Investigations / Referrals

Haem investigations
Pathology from surgery



1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumberae Crescent
Coatbridge
Lanarkshire ML5 4PX

Targets

sO₂: 294%

BP: MAP 760

UO: 235ml/hr

Checklist

GCS:

E 4 V 5 M 6

Delirium? Y / N

Tracheostomy?

Y / N
Tube type:

Due change:

Tracheostomy nurse informed: ☐

Central line?

Y / N

Due change:

Safe swallow?

Y / N

Nutrition: Oral / NG / TPN

For readmission to ICU?

Y / N / Uncertain

Family informed of discharge ☐

DNACPR?

Y / N

Check Imaging Signed Off ☐

Ward kardex:

☐ see HEPMA

Antibiotic duration written ☒

Drugs stopped, reason, & plan:

Ward doctor informed:

Name: surgical SHO

Grade:

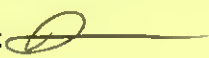
Page: 404661

Completed by:

Name: D. Buter

Grade:

CT1

Signature: 

STEPDOWN REVIEW

to be completed by ward doctor

Observations checked:

☐

Plan reviewed:

☐

Kardex reviewed:

☐

Discussed with nurse:

☐

Senior informed?

Y / N

Bloods requested:

☐

Completed by:

Name:

Grade:

Page:

Signature:

PLEASE ATTACH PATIENT EXAM LABEL

CHI No:

1808785142

18/08/1978

Name:

MCCRACKEN

F

Isabel

1d Cumberae Crescent

Date of Birth:

Coatbridge
Lanarkshire

ML5 4PX

Examination:



W003

Pregnancy Status Questionnaire

Legislation requires that a patient's pregnancy status should be ascertained and recorded prior to certain radiological examination. This information should then be used to determine actions that are required to help to protect the patient and foetus from harmful x-rays.

In order to comply with this could you answer the following questions? If there is anything that you do not understand or need clarified please ask a member of staff.

If you have **not started** having periods, or if your **last period** was more than two years ago, simply sign and date this confidential questionnaire. Otherwise we cannot perform your examination.

1. Have you had a hysterectomy or sterilisation ?

YES

☐

You do not have to answer any further questions. Please date and sign below.

NO

☒

Please answer the following questions

2. What was the first day of your last period ? 9/3/21 dd/mm/yy

3. Is there any possibility that you might be pregnant ? NO ☐ YES ☒

If YES then please discuss with Radiologist or Radiographer carrying out your examination.

4. The risks and benefits of proceeding with this examination have been discussed with me and I'm happy to proceed with this examination.

Patients signature: [Signature]

Date: 28/4/21



Confidentiality and Use of Patients's Information

For the purposes of your present and future medical treatment, details of your medical care will be recorded. Some use may be made of this information for research purposes and to indicate the kind of future health services which patients may require; some will be processed on a computer. At all times great care is taken to ensure that high standards of confidentiality are maintained in respect of all information held.

The "Data Protection Act 2018" gives you the right of access to any personal information which NHS Lanarkshire holds about you either in manual records or electronic records. If you wish to apply for access to your data, or if you would like more information about your rights under the Act you should, in the first instance, contact the Health Records Officer at the hospital.

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Safe Positioning and Pressure Area Care Checklist – COMPLETE EVERY 2 HOURS

1808785142
18/08/1978 F
Patient MCCracken Isabel
1d Cumbernauld Crescent

Date: 28/4/21

Coatbridge
Lanarkshire
ML5 4PX
Consultant Surgeon: Mr Dick

Consultant Anaesthetist: Dr Rae

Anaesthetic Assistant: Alan Fegan

Pre-operative skin inspection: ✓

Skin Excoriation Level: mild / moderate / severe / N/A (Please Circle)

Identify any areas of concern: N/A

Patient Position: Supine

Procedure Start Time: 20-10

TIME	22:10						
Move SpO ₂ probe	✓						
Check pressure points / move as required	✓						
Position change, even temporarily e.g. lower legs if in lithotomy position	✓						
NIBP time / consider A-line?	A-line in situ						
Check temperature	37.5						
Any unexpected events or issues? e.g. equipment/staffing? (document on reverse if applicable)	NIL						

*Anaesthetic assistant please initial boxes to indicate that checks have been carried out.



AS34

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Additional Info:

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ME01



1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumberae Crescent

Cambridge
Lanarkshire ML5 4PX

Patient weight..... kg

☐ Hairmyres ☒ Monklands ☐ Wishaw
Ward NHS Lanarkshire

Intravenous Heparin Prescription and Administration Chart

This document must be retained

Each prescription must be completed fully and unambiguously.
FULL SIGNATURE TO BE USED.

1. Intravenous Heparin Bolus Prescription

Date	Baseline APTTr	Route	Time	Drug/dose	Dose	Rate
		IV		Heparin sodium 5,000 units		Over 5 minutes
Prescriber signature		Time given		Prepared by		Checked by

2. Intravenous Heparin Ongoing Prescription

Date	Drug	Dose	Prescriber signature
	Heparin 1,000 units per ml	To be given as per APTTr	

3. APTTr Monitoring /Rate Change

Commence maintenance infusion immediately after bolus dose is administered. Give heparin 18 Units/kg/hour (adjust to the nearest 100 units). The maximum initial infusion rate should not exceed 1,800 units/hour which is 1.8ml/hr.

APTTr Monitoring/Rate Change

Date/time of APTTr result	APTTr ratio	Rate to be administered (ml/hr)	Prescriber's signature	Rate changed by	Date/time of change
30/4/21 0130	1.4	1.6ml			
30/4/21 0810	1.3	1.8ml			
30/4/21 1410	2.3	1.8ml			

4. Preparation Details

(to be completed by Nursing/Midwifery staff)

Date	Start time	Prepared by	Checked by	Rate set by (ml/hr)	Checked by

5. Administration check (to be completed hourly by Nursing/Midwifery staff)

Date	Time	Rate setting (ml/hr)	Total vol infused	Volume remaining	Checked by	Date	Time	Rate setting (ml/hr)	Total Vol infused	Volume remaining	Checked by
30.4	0130	1.6ml									
30.4	1420	1.8ml	18.7	1.3	ON						



STOP AT 5PM UNLESS OTHERWISE ADVISED
SUMMER
30/4/21.



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ME01

1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumbrae Crescent
Cowbridge
Lanarkshire ML5 4PX

Patient
Weight kg

Intravenous Heparin Prescription and Administration Chart

Heparin **MUST** be prescribed on an inpatient drug cardex.

This is only an infusion chart rather than a comprehensive guideline.

5,000 units/ml heparin vials should be used at all times

Dose (Day 1 and onwards) As for all patients to be started on any anticoagulant therapy, a baseline coagulation screen should be checked prior to starting IV Heparin therapy. Patients should be given a 5,000 unit loading dose, given over 5 minutes. Start infusion at **18 units/kg/hour** (adjust to the nearest 100 units) e.g. for a 70kg patient this would be 1.2ml/hour i.e. 1,200 units/hour. The **maximum initial** infusion rate should not exceed 1,800 units/hour (which is 1.8 ml/hr). If patient is at a high risk of bleeding, start at 1000 units/hour. Monitor the APTTr 6 hours after starting the infusion and then adjust the infusion rate according to the table (see below) **to the nearest 100 units**. Undertake subsequent monitoring and adjustment of the infusion rate as suggested by the tables below.

• **DO NOT** adjust the concentration of the infusion to alter the dose, **only change the rate of infusion. See monitoring guidance below.**

Monitoring

- **APTT:** As above monitor APTTr 6 hours after starting the infusion and then adjust as below. Then monitor every **24** hours when in range (during normal laboratory hours) and **4** hours after any dose change. Dosing adjustments should be made using the tables below. *Maximum bolus dose for heparin is 5,000 units.*
- **Potassium:** Baseline level plus twice weekly whilst on treatment. Risk of hyperkalaemia if diabetes mellitus, chronic renal failure, pre-existing metabolic acidosis or potassium sparing drugs.
- **Platelets:** Baseline level and then on alternate days. If a fall in platelet count >50% or unexplained additional thrombosis, discuss with a Consultant Haematologist **immediately** to assess for risk of heparin induced thrombocytopenia.

APTT	Rate adjustment	Timing of next APTTr monitoring
>4.00	Stop for 60 minutes and recheck APTTr, before recommencing at a rate reduced by 300-500 units/hour	4 hours
3.5 - 4.0	Stop for 60 minutes and reduce heparin by 200 units/hour	4 hours
2.9 - 3.4	Stop for 30 minutes and reduce heparin by 100 units/hour	4 hours
1.8 - 2.8	No change	24 hours
1.2 - 1.7	Increase heparin by 200 units/hour	4 hours
< 1.2	Increase heparin by 400 units/hour and consider further bolus of 5,000 units heparin	

Rarely should patients required infusion rates >1.6 - 2ml/hour. If target APTT ratio of 1.8 - 2.8 is not being achieved with a dose of 1.6ml/hour, then monitor anti factor Xa level (target 0.35 - 0.7 units/ml).

Heparin Dose change	Infusion rate change
100 Units/hour	0.1 ml/hour
200 Units/hour	0.2 ml/hour
300 Units/hour	0.3 ml/hour
400 Units/hour	0.4 ml/hour

Management of bleeding whilst on heparin

- Stop infusion. Most heparin induced bleeding can be controlled by simply stopping the infusion.
- Discuss with the Consultant Haematologist on-call.
- Use protamine (1 mg reverses 100 Units heparin), only if recommended by haematology. Administer protamine up to a maximum of 50 mg in a single dose as slow IV infusion over 10 minutes. Risk of allergic reactions if fish allergy, post vasectomy, or previous treatment with protamine insulin.
- The concomitant use of anti platelet drugs, other anticoagulant agents and NSAIDs all increase the risk of haemorrhage.

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Monklands Hospital Critical Care Unit

Nursing Discharge/Transfer Summary

CA05

Date: 1/5/21

Time:

Diagnosis: Right Hemicolectomy and
end ileostomy, appendectomy (abnormal appendix)



1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumberae Crescent

Coatbridge
Lanarkshire

ML5 4PX

Days in unit: 3

Post-op days: 3

	Position	Days insitu	Reviewed today?
Central Line			
Arterial Line			
PVC's	X 2		
Urinary Catheter	IOUC	4	
Drains	Rectal drain	4	
Other			

Respiratory on Hase on therapy via nte Room O2 Sat. greater than 98% Air Resp Rate Stable Coughing Not expectorating	Cardiovascular BE unsupported Slightly hypotensive Heart rate SA afixrenal
Intake/Output good oral intake - light diet dietician input required Stoma inscty - active Passes good volume urine via IOUC	Pain/Neuro Regular paracetamol / Nefopam Subcut morphine PRN Regular diazepam
Wound/Old Lines Midline wound rectal drain inscty - not drained dressing to right hip (bone marrow aspirate)	Hygiene/Mobility Minimal assistance with hygiene + mobilising with assistance of 2
Relatives NOK daughter Kimberly McCracken visits daily by appointment	Other 10 taz x 3 daily clo 3d enoxaparin 60mg for anticoag.

News Score:

3

4AT Score:

Nurse's Signature:

[Signature]



CL15

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1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumberae Crescent
Coatbridge
Lanarkshire ML5 4PX

ME01

Monklands Hospital



Patient Controlled Analgesia chart

Date: 28/4/21 Ward: 26
Procedure: LIMITED RIGHT HEMICECTOMY
Surgeon: DOCK
Anaesthetist: DR. RAE
Technique: SA
Local type:

Step down analgesia

1.
2.
3.

Drug prescription

NSAID administered intra operatively Yes ☐ No ☒ If "No", reason: ANALGIC DEPENDENT

Drug	Conc. (mg/ml)	Bolus (mg)	Lockout (min)	Prescribed by (signature)	Refill if required (signature)
MORPHINE	2	1	5	DR. RAE	

Patient observations

Check and record the following 1/4 hourly for one hour, hourly for four hours, then four hourly if stable.

1. Respiratory rate, pulse and blood pressure.
2. Sedation score.
3. Pain score.
4. IV site (for leaks, tissueing, obstruction).
5. Volume infused and remaining in pump (continue hourly).

Possible problems

1. Respiratory Depression = respiratory rate less than 8 per minute and/or patient difficult/impossible to rouse (sedation score 2 or 3).
 - A. Call anaesthetist (bleep 103). Give basic life support and arrest call if not breathing.
 - B. Check airway is clear and give oxygen 8 litres per minute by mask.
 - C. Give naloxone (NARCAN) 0.4mg I.M. (nurse) or 0.2mg I.V. (doctor) and repeat if no response after 5 minutes.
2. Inadequate Pain Relief
Check I.V. site and that patient understands the technique.
Call ward doctor or bleep 103 for on-call anaesthetist if I.V. site is not the problem.
3. Nausea/Vomiting
Give antiemetics. If standard drugs have failed, consider ondansetron 4mg I.V.

DUTY ANAESTHETIST BLEEP NO. = 103



FRM: PACOAN 97413.M

Sedation score.

0 = Awake
 S = Normal sleep
 1 = Drowsy, easily roused:
 eyes open to speech/
 gentle shaking
 2 = Sedate difficult to
 rouse, eyes open only
 to vigorous shaking
 3 = Unroutable,
 unconscious

Pain score

0 = No pain
 1 = Mild pain
 2 = Moderate pain
 3 = Severe pain
 4 = Worst pain
 imaginable
 If pain score 3 or 4 see
 "inadequate pain relief"
 (overleaf).

Complication

1. Nausea & vomiting
 2. Itching
 3. Respiratory
 depression
 4. Over sedation
 5. Inadequate
 pain control
 6. Constipation
 7. Other

Action

1. Re-education
 2. Additional
 oral/analgesia
 3. Suspend PCA
 4. Withdraw PCA
 5. Narcan
 6. Piriton
 7. Prochlorperazine
 8. Ondansetron
 9. Metoclopramide
 10. Cyclizine
 11. Laxative
 12. Droperidol
 13. Contact APT/
 page 103

If sedation score is
 2 or 3 call anaesthetist
 (bleep 103), and give
 oxygen and naloxone
 as prescribed overleaf.

N+V ☐ Yes ☐ No
 Rating ☐ Mild ☐ Moderate ☐ Severe

If pain score ≥ 2 please complete action

Satisfaction with PCA

☐ VS ☐ S ☐ N ☐ D ☐ VD

Time/Date	Resp.	Sed.	Pain score Movement	IV	Volume		Total Attempts	Total Given	Complication	Action	Signature
					Reservoir (mls)	Used (mg)					
29/4 01 ⁰⁰	14	0	1	✓	97.7	1.0	1	1	x	1	CM
02 ⁰⁰	9	S	-	✓	96.2	4	4	4	x	-	SM
03 ⁰⁰	16	S	S	✓	95.7	5	7	5	x	x	CM
04 ⁰⁰	22	S	S	✓	95.7	5	7	5	x	x	CM
05 ⁰⁰	19	S	S	✓	95.7	5	7	5	x	x	CM
06 ⁰⁰	20	S	S	✓	95.2	6	8	6	x	x	CM
07 ⁰⁰	10	S	S	✓	92.7	11	18	11	x	x	CM
09 ⁰⁰	11	0	2	✓	92.2	12	14	12	x	x	CN
11 ⁰⁰	16	0	2	✓	90.2	16	18	16	x	x	KF
13 ⁰⁰	16	0	3	✓	86.7	23	32	23	x	x	KF
15 ⁰⁰	12	0	1	✓	84.7	27mg	36	27	x	x	CN
18 ⁰⁰	17	0	1	✓	79.7	37	50	37	x	x	KF
21 ⁰⁰	16	0	1	✓	71.2	41	75	41	x	x	CM
02 ⁰⁰	14	0	1	✓	71.2	42	78	42	x	x	CM
06 ⁰⁰	30	0	2	✓	73.9	49	88	49	x	x	CM
08 ⁰⁰	10	0	2	✓	70.7	55	99	55	x	x	KF
12 ⁰⁰	PCA Removed				64						

Morphine destroyed = 64 mls mg

12.8mg

Nurse signature one

Nurse signature two

Please ensure that dose infused is recorded in the patient's nursing notes

Alexander

Wally



1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumberae Crescent
Coatbridge Lanarkshire ML5 4PX

☐ F

Fluid Balance Chart and Daily Adult Fluid Prescription Chart

Date: / /

Fluid Balance Chart

Reason for commencement:
IP/OP

Yesterday's Intake = mls Output = mls
Yesterday's Intake Goal achieved? ☐ Yes ☐ No
Total Intake Goal today = mls

INTAKE					OUTPUT				
Time	Oral	IV/ Sub Cut	Enteral Feed	Type of Fluid	Urine	Drain/ Fistulae	Aspirate /Vomit	Bowel/ Stoma	Initials x4 (RN)
08:00									
09:00									
10:00									
11:00									
12:00									
13:00									
14:00									
15:00									
Sub Totals									
Stop and Check	Intake (oral + IV + enteral) less than 250ml ? ☐ Yes ☐ No Urine less than 140ml ? ☐ Yes ☐ No Other losses more than 250ml ? ☐ Yes ☐ No				If yes to any question or if any concern escalate to nurse in charge/doctor				
16:00									
17:00									
18:00									
19:00									
Stop and Check									
20:00		250		IVF					
21:00	350			Tea, water 120					
22:00	100	20		Lozamide IV ASX					
23:00		100		IV ASX					
24:00									
01:00		500		IVF					
02:00					435				
03:00									
04:00	150	150		water					
Sub Totals									
05:00	150	500		water IVF					
06:00									
07:00									
24hr Totals									
Total Intake:					Total Output:				



Fluid Balance = Total Intake - Total Output:

COPY PAGE

CAT257 AHP.FBD.FPM.20_14272.L

CHI 1808785142
First 18/08/1978 F
Last MCCracken Isabel
Add 1d Cumber Crescent
Coatbridge
Lanarkshire ML5 4PX
or attach addressograph label here

University Hospital Monklands

NHS
Lanarkshire

Ward:

Daily Adult Fluid Prescription Chart

Use an individual fluid prescription chart for
EVERY 24 HOUR PERIOD. N.B. Not suitable for Paediatrics.

Date: 28/11/21

Total Intake Goal Today (30ml/kg/24hrs) = (20-25ml/kg/24hrs in frail elderly)

Latest U&Es/Hb checked: ☐ Yes ☐ No

Weight:

..... kg

1. Assess patient	Hypovolaemic (reassess regularly)		Euvolaemic (fasting >8hrs)	Hypervolaemic (overloaded)	Special cases Consult senior	
2. Why give fluid?	Replacement	Resuscitation	Maintenance	Restriction ml	Cardiac dysfunction	
3. How much? Look at history, weight, U&Es, other fluid intake e.g. IV antibiotics	Estimate losses in past 24 hrs. Replacement is in addition to maintenance.	Fluid challenge 250-500ml over 5-15mins and reassess	30ml/kg/24hrs Subtract other intake Today's IV needs: = ml	Fluid restrict. Consider diuresis	Renal/ Liver failure	
4. Which fluid?	PlasmaLyte 148 or 0.9%NaCl+KCl for upper GI loss	PlasmaLyte 148/colloid (Isoplex)/ Blood on BTS chart	0.18%NaCl in 4%Glucose ± KCl* If Na ≤132 use PlasmaLyte 148	Consult Senior	Obstetrics	
					Head injury	
					*Give 40 mmol KCL/litre in maintenance unless K is ≥ 5.0 or renal function deteriorating	

Never give 0.18%NaCl/4%Glucose±
0.3%KCl (40mmol) at over 100ml/hr:

RISK OF HYPONATRAEMIA

Diabetes: for patients on

intravenous insulin use

0.45%NaCl/5%Glucose± KCl

Weight (kg)	Maintenance Requirement /24hr (30ml/kg/24hrs)	Rate (ml/hr)	Approximate Equivalence to 500ml over x hrs
35-44	1200 ml	50	500ml 10 hrly
45-54	1500 ml	65	8 hrly
55-64	1800 ml	75	7 hrly
65-74	2100 ml	85	6 hrly
≥75	2400 ml	100 (max)	5 hrly

Maintenance Fluid (Max 100ml/hr) includes fluid for patients receiving IV insulin or subcutaneous fluids

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO4	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
27/11/21 19:00	NaCl 0.9%	250	50	Continue	INT1	27/11	19:16		HL	
				Stop Review						
27/11/21 20:30	PLASMAlyte	500	20	Continue		27/11	20:40		HP	
				Stop Review						
"	PLASMAlyte	500	20	Continue		27/11	22:40		HP	
				Stop Review						
"	NaCl 0.9% 40mmol KCl	500	40	Continue		28/11	01:00		HP	GM
				Stop Review						

Resuscitation/Replacement Fluid Still hypotensive after 2000ml of resuscitation fluid? D/W with senior/ICU

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO4	Vol ml	Rate ml/hr	After this bag	Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						
				Stop Review						

The NHSL Guidance for Intravenous Fluid and Electrolyte Prescribing and Hyponatraemia
Guideline are available on the Intranet

CAOS

Time: 1515

Time: 1515

Days in unit:

Post-op days:

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	Position	Days insitu	Reviewed today?
Central Line			
Arterial Line	R Radial		
PVC's	X2 PVCs		
Urinary Catheter	10UC	(3)	
Drains	Rectal Drain	(3)	
Other			

Respiratory	Cardiovascular
On 11L O ₂ therapy via NC. O ₂ sat. greater than 98% RR stable coughing - not expectorating.	currently unsupported BP. slightly hypotensive at times. HR both SR and ST today. apyrexial.
Intake/Output	Pain/Neuro
Intake - good oral fluids, light diet, dietician input required. Output - stoma insitu (active) - IDUC insitu passing good vols.	regular paracetamol. regular nefopam. subcut morphine. regular diazepam - MH
Wound/Old Lines	Hygiene/Mobility
mid line wound rectal drain insitu dressing to right hip (bone marrow bx)	minimal assistance with hygiene mobilising from side of bed and into chair with A02.
Relatives	Other
NOK: Kimberly McCracken (daughter) visiting ward daily by appointment up to date with plan.	IV Taz x 3 daily. Heparin infusion d/c 5pm - commenced on 29/11 30/11 B0 enoxaparin for anticoag



CL15

News Score:

4AT Score:

Nurse's Signature:

CNometer (S/N)

1 ferdig på Stå/nuse.

COPY PAGE


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Fluid Balance Chart and Daily Adult Fluid Prescription Chart

Date: / /

Fluid Balance Chart									
Reason for commencement:					Yesterday's Intake = mls Output = mls Yesterday's Intake Goal achieved? ☐ Yes ☐ No Total Intake Goal today = mls				
INTAKE					OUTPUT				
Time	Oral	IV/ Sub Cut	Enteral Feed	Type of Fluid	Urine	Drain/ Fistulae	Aspirate /Vomit	Bowel/ Stoma	Initials x4 (RN)
08:00	200			water	420				kw
09:00	100			water					
10:00									
11:00	300			water					
12:00		271		blood (ix PRC)					
13:00									
14:00									
15:00									
Sub Totals									
Stop and Check	Intake (oral + IV + enteral) less than 250ml?				☐ Yes	☐ No	If yes to any question or if any concern escalate to nurse in charge/doctor		
	Urine less than 140ml?				☐ Yes	☐ No			
	Other losses more than 250ml?				☐ Yes	☐ No			
16:00									
17:00									
18:00									
19:00									
Stop and Check									
20:00									
21:00									
22:00									
23:00									
24:00									
01:00									
02:00									
03:00									
04:00									
Sub Totals									
05:00									
06:00									
07:00									
24hr Totals									
Total Intake:					Total Output:				



Fluid Balance = Total Intake - Total Output:

CHI no
 First name DOB / /
 Last name Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

University Hospital Monklands



Ward:

Lanarkshire

Daily Adult Fluid Prescription Chart

Use an individual fluid prescription chart for
 EVERY 24 HOUR PERIOD. N.B. Not suitable for Paediatrics.

Date: / /

Total Intake Goal Today (30ml/kg/24hrs) = (20-25ml/kg/24hrs in frail elderly)

Weight:

Latest U&Es/Hb checked: ☐ Yes ☐ No

..... kg

1. Assess patient	Hypovolaemic (reassess regularly)		Euvolaemic (fasting >8hrs)	Hypervolaemic (overloaded)	Special cases Consult senior	
2. Why give fluid?	Replacement	Resuscitation	Maintenance	Restriction ml	Cardiac dysfunction	
3. How much? Look at history, weight, U&Es, other fluid intake e.g. IV antibiotics	Estimate losses in past 24 hrs. Replacement is in addition to maintenance.	Fluid challenge 250-500ml over 5-15mins and reassess	30ml/kg/24hrs Subtract other intake Today's IV needs: = ml	Fluid restrict. Consider diuresis	Renal/ Liver failure	
					Obstetrics	
					Head injury	
4. Which fluid?	PlasmaLyte 148 or 0.9%NaCl+KCl for upper GI loss	PlasmaLyte 148/colloid (Isoplex)/ Blood on BTS chart	0.18%NaCl in 4%Glucose ± KCl* If Na ≤132 use PlasmaLyte 148	Consult Senior	*Give 40 mmol KCL/litre in maintenance unless K is ≥ 5.0 or renal function deteriorating	

Never give 0.18%NaCl/4%Glucose±
 0.3%KCl (40mmol) at over 100ml/hr:

RISK OF HYPONATRAEMIA

Diabetes: for patients on
 intravenous insulin use
 0.45%NaCl/5%Glucose± KCl

Weight (kg)	Maintenance Requirement /24hr (30ml/kg/24hrs)	Rate (ml/hr)	Approximate Equivalence to 500ml over x hrs
35-44	1200 ml	50	500ml 10 hrly
45-54	1500 ml	65	8 hrly
55-64	1800 ml	75	7 hrly
65-74	2100 ml	85	6 hrly
≥75	2400 ml	100 (max)	5 hrly

Maintenance Fluid (Max 100ml/hr) includes fluid for patients receiving IV insulin or subcutaneous fluids

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO4	Vol ml	Rate ml/hr	After this bag		Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Continue							
				Stop	Review						
				Continue							
				Stop	Review						
				Continue							
				Stop	Review						
				Continue							
				Stop	Review						

Resuscitation/Replacement Fluid Still hypotensive after 2000ml of resuscitation fluid? D/W with senior/ICU

Date/ Time	Fluid +/- Additions e.g. KCl / MgSO4	Vol ml	Rate ml/hr	After this bag		Prescribed by (Sign/Print)	Date	Start time	Stop Time	Given by	Checked by
				Stop	Review						
				Stop	Review						
				Stop	Review						
				Stop	Review						
				Stop	Review						

**The NHSL Guidance for Intravenous Fluid and Electrolyte Prescribing and Hyponatraemia
 Guideline are available on the Intranet**

Indication for anticoagulation	Target INR (range)	Recommended duration
Provoked DVT/PE	2.5 (2-3)	3 months
Unprovoked DVT/PE	2.5 (2-3)	At least 3-6 months, with indefinite to be considered
Recurrent DVT and/or PE	2.5 (2-3)	Indefinite
Recurrent DVT and/or PE while on Warfarin (INR 2-3)	3.5 (3-4)	Indefinite
Atrial fibrillation or high risk arrhythmia	2.5 (2-3)	Indefinite
Atrial fibrillation (for cardioversion)	2.5 (2-3)	Review after procedure
Aortic mechanical prosthetic valve	2.5 (2-3)	Indefinite
Mitral mechanical prosthetic valve	3.0 (2.5-3.5)	Indefinite
Bioprosthetic heart valve (selected patients)	2.5 (2-3)	3 months
Cardiomyopathy/mural thrombus/akinetic segment	2.5 (2-3)	Indefinite
For other indications, target INR and duration should be confirmed with consultant.		

Age-Adjusted Fennerty Protocol for induction of Warfarin

Day	INR	Warfarin dose (mg) depending on age			
		≤50 years	51-65 years	66-80 years	>80 years
1	<1.4	10	9	7.5	6
2	<1.6	10	9	7.5	6
	≥1.6	0.5	0.5	0.5	0.5
3	<1.8	10	9	7.5	6
	1.8-2.5	4.0-5.0	3.5-4.5	3.0-4.0	2.5-3.0
	2.6-3.0	2.5-3.5	2.5-3.5	2.0-2.5	1.5-2.0
	3.1-3.5	1.0-2.0	1.0-2.0	0.5-1.5	0.5-1.5
	3.6-4.0	0.5	0.5	0.5	0.5
	>4	0	0	0	0
4	<1.6	10.0-15.0	9.0-13.0	7.5-11.0	6.0-9.0
	1.6-1.9	6.0-8.0	5.5-7.0	4.5-6.0	3.5-5.0
	2.0-2.6	4.5-5.5	4.0-5.0	3.5-4.5	2.5-3.5
	2.7-3.5	3.5-4.0	3.0-3.5	2.5-3.0	2.0-2.5
	3.6-4.0	3	2.5	2	1.5
	4.1-4.5	Omit today's dose then:			
		1.0-2.0	0.5-1.5	0.5-1.5	0.5-1.0
	>4.5	Withhold warfarin until INR <3, then restart on 0.5-1.0mg			

- Consider reducing dose by one third if patient is on interacting drugs especially amiodarone, has severe congestive heart failure or biventricular failure, has abnormal LFT's or has severe oxygen dependant COPD.
- When the INR result is towards the upper end of a range in the INR column, it is recommended that a warfarin dose is chosen towards the lower end of the suggested range in the age-appropriate dose column; and vice versa when INR result is towards the lower end of a INR range.
- Check INR daily for at least the first four days and thereafter regularly until within target range and stable.
- If Warfarin is started for treatment of acute VTE, continue LMWH for at least 5 days and until INR has been >2.0 for 2 days.

REVERSAL OF WARFARIN

- Life threatening bleeding (e.g. intracranial or major GI bleed)
 - Stop Warfarin
 - Give vitamin K 5mg intravenously
 - Give IV prothrombin complex concentrate (BERIPLEX®) 25-50 units/Kg. Discuss with on call haematologist
- Less severe bleeding e.g. haematuria, epistaxis
 - Stop Warfarin for 1-2 days
 - Give Vitamin K 1-2 mg intravenously
 - Re-assess
- High INR but no bleeding
 - Stop Warfarin and monitor INR. Consider restarting Warfarin when INR <5.0
 - Ascertain cause of high INR
 - Consider giving Vitamin K 1mg IV or 2mg oral if INR >8 or INR 5-7.9 with risk factors for bleeding (e.g. elderly, uncontrolled hypertension, renal or liver failure, previous GI or cerebral bleed and concomitant antiplatelet)

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or attach addressograph form

☐ Hairmyres ☐ Monklands ☐ Wishaw ☐ Other (specify):

Ward: M14

Adult Parenteral Gentamicin: Prescribing, Administration & Monitoring Chart

Use for patients prescribed intravenous gentamicin as per NHSL dosing guidance.

Not for prophylactic indication or where synergistic doses (usually in endocarditis) are being used.

Refer to full guidance for information on EXCLUSIONS and Cautions/Contra-indications to gentamicin.

Creatinine 63 on 27/04/21
Age 42 Weight 88.6 kg Height 157 cm

Source of first dose: ☐ online calculator (preferred method)
☐ Manual calculation ☐ Weight based, creatinine not known

Initial Gentamicin Dose* 280 *this is not a prescription and may change. Doses must be prescribed individually below.
Predicted Frequency* 24 hourly

TOXICITY Before prescribing each dose check: Renal & Oto-vestibular function	Gentamicin Prescription Record				Administration Record			Monitoring Record			
	Complete each time a dose is to be given (ensuring gentamicin is prescribed 'as per chart' on the cardex)				Complete each time gentamicin is administered (in addition to the cardex)			Record ALL sample dates/times accurately below. See overleaf for monitoring advice.			
	Date to be given	Time to be given 24 h clock	Gentamicin Dose (mg)	Prescriber's signature, PRINTED name and STATUS	*Infuse in 100mls of 0.9% Saline over 30 mins*		Given by	Date of sample	Time of sample 24 h clock	Gent level (mg/L)	Action/Comments (please initial action to be taken)
				Date given	Time started 24 h clock						
Cr = <u>63</u> micromol/L	<u>28/4</u>	<u>15⁰⁰</u>	<u>280</u>	<u>[Signature]</u>	<u>27/4/21</u>	<u>1610</u>	<u>E.H.</u>				☐ 24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop Details/other:
Cr = <u>53</u> micromol/L	<u>28/4</u>	<u>16⁰⁰</u>	<u>280mg</u>	<u>[Signature]</u>	<u>28/4/21</u>	<u>1730</u>	<u>W.H.</u>				☐ 24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop Details/other:
Risks of prolonged treatment include nephrotoxicity and ototoxicity. If treatment is required beyond 3 days discuss with Infection Specialist/Microbiologist. If gentamicin is continued give a gentamicin patient information leaflet*. Document all details in the notes.											
Cr = <u> </u> micromol/L											☐ 24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop Details/other:
Cr = <u> </u> micromol/L											☐ 24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop Details/other:

Never continue onto a second sheet without discussion with an Infection Specialist/Microbiologist

NB: Ensure gentamicin has not already been administered in a parallel prescription on the ED card/cardex/HEPMA or a duplicate gentamicin chart

Step 1: Calculate and prescribe the first dose of gentamicin (see overleaf for more details)

If creatinine is known - use the online gentamicin dose calculator.

- If creatinine is not known - give 5 mg/kg gentamicin (maximum 400 mg) or, if CKD 5, give 2.5 mg/kg (maximum 180 mg) on advice of senior medical staff.
- Prescribe gentamicin 'as per chart' on the medication chart (cardex/HEPMA). AVOID specifying dose or administration time on the cardex/HEPMA.
- Only administer gentamicin if it is prescribed "as per chart" on the cardex/HEPMA and on the gentamicin chart with the dose specified.
- Prescribe individual doses in the prescription record section above, specifying the date and time the dose should be given.

Step 2: Monitor creatinine and gentamicin concentration and reassess the dosage regimen

- Check gentamicin concentration after the first dose and then at least every 2 days (see overleaf for more details).
- Monitor creatinine daily. Seek advice from pharmacy if renal function is unstable (e.g. a change in creatinine of >15-20%).

Step 3: Assess daily: the ongoing need for gentamicin; signs of toxicity

- Consider an alternative agent if creatinine is increasing or the patient becomes oliguric.
- *If gentamicin continues for >3 days supply a patient information leaflet 'Gentamicin and your ears' to raise awareness of possible side effects as well as the benefits of therapy. ☐ Date:
- If gentamicin continues for >7 days, suggest referral to audiology for assessment.
- Refer to guidelines or clinical pharmacist for further advice on prescribing, monitoring and administration.

PROMPT ADMINISTRATION

within 1 hour of recognition of sepsis reduces mortality

SIGNS OF GENTAMICIN TOXICITY

RENAL: ↓ urine output/oliguria or ↑ creatinine

OTO/ VESTIBULAR: NEW tinnitus, dizziness, poor balance, hearing loss, oscillating vision, unexplained nausea and/or vomiting

Toxicities may occur irrespective of gentamicin concentration

Safe Practice: Review medication cardex/HEPMA prior to administration of gentamicin to ensure patient has not had gentamicin administered within 24 hours

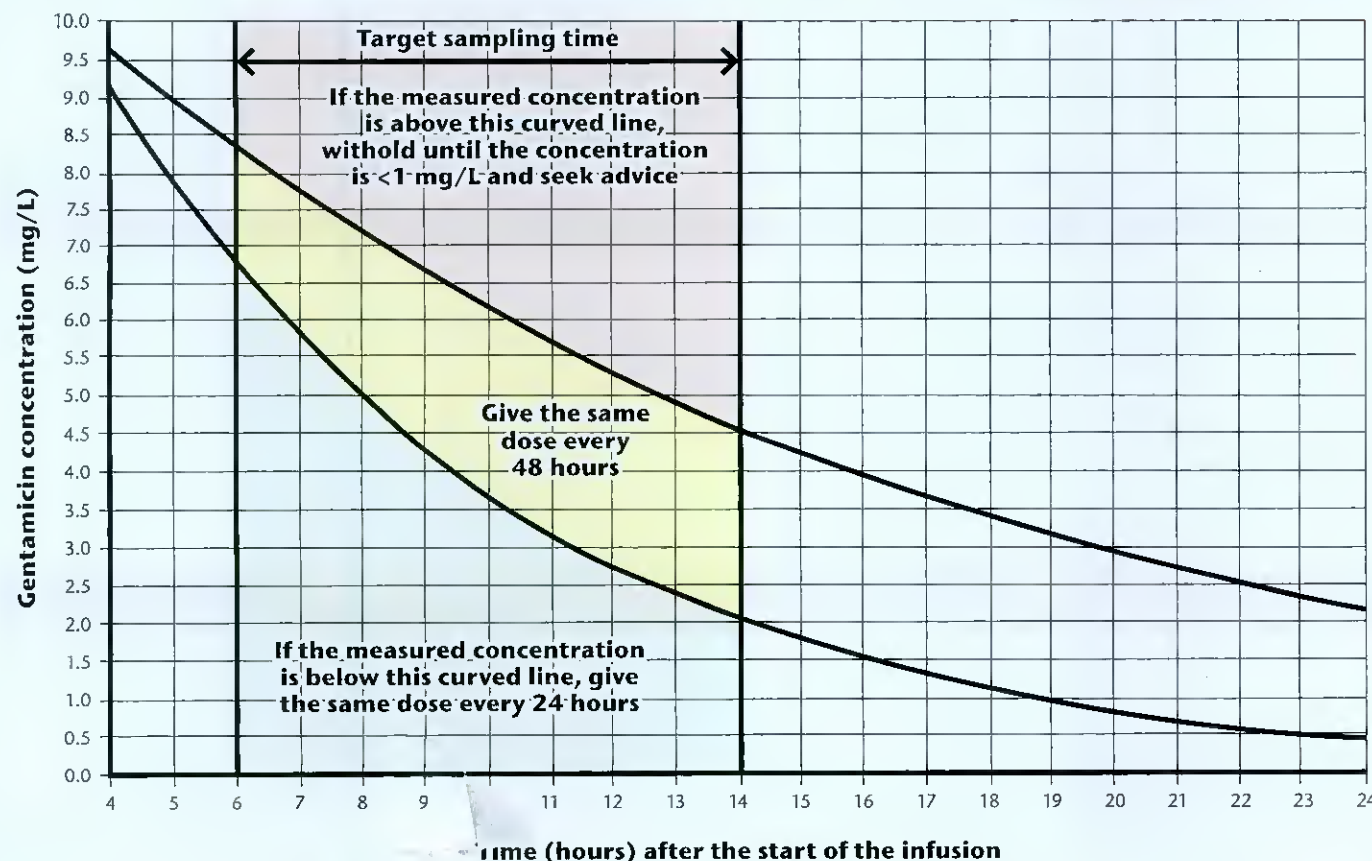
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Patient name

CHI no

Adult Parenteral Gentamicin: Prescribing, Administration & Monitoring Chart

Prescribing, monitoring, interpreting and re-prescribing advice.



If the measured concentration is unexpectedly HIGH or LOW

- Were dose and sample times recorded accurately?
- Was the correct dose administered?
- Was the sample taken from the line used to administer the drug?
- Was the sample taken during drug administration?
- Has renal function declined or improved?
- Does the patient have oedema or ascites?

If in doubt, take another sample before re-prescribing and/or contact pharmacy for advice.

Developed by:
Scottish Antimicrobial Prescribing Group,
Gentamicin and Vancomycin sub-group
based on GGC guidance

Approved by AMC: Feb 2020

Ratified by ADTC: May 2020

Review date: May 2023

Calculating the first dose of gentamicin

- If creatinine is known - use the online gentamicin dose calculator.
- If creatinine is not known - give 5 mg/kg gentamicin (maximum 400 mg) or, if CKD 5, give 2.5 mg/kg (maximum 180 mg) on advice of senior medical staff.
- Calculate the dosage regimen once creatinine becomes available prior to second scheduled dose.
- If the online calculator is not available, manually calculate the dose using full guidance on Medical Education "Drugs and Prescribing" webpage via FirstPort.

Checking the patient's gentamicin concentration

- Take a blood sample 6-14 hours after the start of the first gentamicin infusion (or after 24 hours if CrCl <21 ml/min).
- Thereafter, sample at least every 2 days.
- Record the exact time of all gentamicin samples overleaf AND on the sample request form.

Interpreting gentamicin results and re-prescribing

- Record the measured concentration overleaf.
- If creatinine clearance is ≥ 21 ml/min and therapy is to continue, plot the gentamicin concentration (measured 6-14hrs post dose) on the graph opposite & reassess the dose/dosing interval as indicated.
- If creatinine clearance is <21 ml/min and therapy is to continue, only give a further dose once the trough concentration (measured at 24 hrs, repeated after further 24hrs if high) is <1 mg/L.
- Document the action taken in the medical notes and overleaf.
- Prescribe the next dose overleaf as appropriate.
- Contact pharmacy for further advice as necessary (e.g. if renal function is changing, the gentamicin concentration is unexpectedly high or low or the concentration is on the line between dosage intervals).
- Check microbiology sensitivities and refer to IV to Oral switch policy.

CHI: 
 First: 1808785142
 Last: 18/08/1978 F
 Add: MCCracken Isabel
 1d Cumberge Crescent
 Coatbridge
 Lanarkshire ML5 4PX

University Hospital: ☐ Hairmyres ☒ Monklands ☐ Wishaw NHS
 Other: Lanarkshire
 Ward: MMA
Peripheral Vascular Catheter (PVC)
Insertion, Maintenance and
Removal Bundles

PVC Insertion Bundle 1	Yes	No
Hand hygiene performed immediately before all PVC insertion procedures (WHO Moment 2)	☒	☐
A single use skin antiseptic containing 70% isopropyl alcohol and 2% chlorhexidine gluconate is used to cleanse skin and left to dry before insertion	☒	☐
Aseptic technique maintained throughout insertion procedure	☒	☐
A sterile, transparent, semipermeable dressing used to cover the catheter site	☒	☐

Size/colour: pink Insertion site: ① wrist
 Insertion Date: 27/4/21 Time: 13:15 Signature: [Signature]

PVC Maintenance Bundle 1	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Is the PVC still in use?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have staff informed patients/representatives of risks, care and monitoring of the device? Patient information leaflet provided.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The clinical need for the PVC has been reviewed and recorded today	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Medical staff have reviewed the need for intravenous (IV) therapy including antibiotics today and switched to oral if possible	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hand hygiene is performed immediately before accessing the line/site (WHO Moment 2)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Removal of the PVC is considered if in longer than 72 hours	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC site has been assessed; removing the PVC where there is phlebitis or inflammation at the site	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The PVC dressings are intact	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
A single use antiseptic containing 70% isopropyl alcohol is used to clean the access hub before accessing - rub the access hub for at least 15 seconds ("scrub the hub")	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Date:														
Time:														
Initials:														

PVC Removal Bundle 1

Removal Date: / / Time: : (24 hour)
 Reason for removal:
 Condition of site on removal:
 Signature:



Dr Rae

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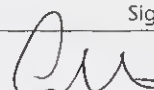
HOSP/CHI no.

Ward,Hosp -

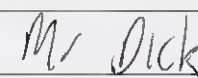
26. UHM

Theatre

4

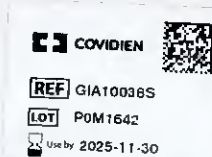
Counts	ScrubNurse (s) Print name	Circulating Nurse (s) - Signature & Print name
Pre - OP Swab count correct	KYLE CROZIER	 / C-MACKNAMARA
Pre - OP Instrument count correct	KYLE CROZIER	 / C-MCKNAMARA
Final Swab count correct	E Doyle	E Baird 
Final Instrument count correct	E Doyle	E Baird 
Final Swab dispatch count correct	E Doyle	E Baird 
Scrub Nurse Verification - Please sign on page underneath		
I have reviewed this count sheet and can verify my count(s) correct		
Scrub Nurse 1 - Signature - K. Crozier		
Scrub Nurse 2 - Signature -		
To be signed by replacement scrub nurse if applicable		

Handover count in event of replacement of scrub nurse during procedure

	Outgoing Scrub Nurse - Print Name	Incoming Scrub Nurse - Print Name	Circulating Nurse (s) - Signature & Print name
Outgoing Count To be completed for permanent or temporary replacement			
Incoming Count To be completed for permanent or temporary replacement			

Operation Rigniv Hemicolectomy + End ileostomy

Tally of each item used - add any items specific to your speciality

Swabs (2x2)		Tapes		Bile bag		 
Swabs (10x10)		Sloops/Slings		Instrument with detachable parts e.g.screws		
abdominal packs	20	Bulldogs				
Sutures	14	Shods				
ades	2	Tibbs Cannula		Path X1		
IV needles	1	Ports				
Syringes	2	Staple gun inserts		Back. x3		
Discard-a-pad	1	Spears				
Diathermy pencil	1	Throat packs - Anae		Ports 3		
Diathermy tips	2	Throat packs - Scrub		TROCAR 2		
Scratch pad	1	Retrieval Bag (Bert)				
Reels	2	Digital Tourniquets		Red 1		
Patties		Arrows				
Pledgelets		Anti fog				

Discrepancy in count - Actions and outcomes

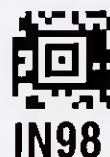
Count in which discrepancy occurred

Details

Actions taken and outcome (i.e. Swabs isolated search undertaken wound explored X - Ray taken) -

Scrub nurses signature if count still incorrect following all possible actions

Surgeons signature if count incorrect following all possible actions



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NELA Risk Calculator



Patient name	Isabel McCracken
Hospital Number	1808785142
Age on arrival?	42
Sex	Female
Hospital / Ward	UHM MAU
Consultant	MD
What was the ASA score?	3: Severe systemic disease, not life-threatening
Serum sodium concentration (mmol/l)	132 mmol/l
Serum potassium concentration (mmol/l)	3.7 mmol/l
Serum urea concentration (mmol/l)	4 mmol/l
Serum creatinine (micromol/l)	43 micromol/l
Haemoglobin (g/l)	63 g/l
Serum white cell count ($\times 10^9 / l$)	27.6 $\times 10^9 / l$
Pulse rate (bpm)	95
Systolic blood pressure (mmhg)	99 mmhg
Glasgow coma scale	15
Select an option that best describes this patient's ECG	No abnormalities
Select an option that best describes this patient's cardiac signs and chest xray appearance	No failure
Select an option that best describes this patient's respiratory history and chest xray appearance?	Dyspnoea on exertion or CXR: mild COPD
Select the operative severity of the intended surgical intervention?	Major+
Including this operation, how many operations has the patient had in the 30 day period prior to this procedure?	1
Based on your clinical experience of the intended surgery, please estimate the likely intraoperative blood loss (ml)	501-999
Please select a value that best describes the likely degree of peritoneal soiling	Localised pus
What severity of malignancy is anticipated to be present?	None
Please select the <i>urgency</i> of surgical intervention	1.Immediate (<2 hours)
Estimated mortality using NELA risk adjustment model:	8%
Estimated morbidity using POSSUM risk adjustment model:	97.1%

The NELA risk calculator does not use cookies or store any data entered



1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumbernae Crescent
Coatbridge
Lanarkshire ML5 4PX

☐ Hairmyres ☒ Monklands ☐ Wishaw
☐ St. Andrew's Hospice ☐ Other (specify)



Transfusion Record (Inpatient)

Date: 28 / 4 / 21 Ward:

LANARKSHIRE BLOOD TRANSFUSION POLICY MUST BE ADHERED TO

Check if this patient has an Advance Directive refusing blood/blood components

Practitioner Checklist

Reason for transfusion:

Hg 77 → 62, unknown cause

Pre-transfusion Hb: 62

Special requirements: (also record on authorisation chart, page 2)

- ☐ Irradiated blood
☐ CMV negative
☐ Blood warmer

Has this patient had a reaction to previous transfusion?

☐ Yes ☐ No

If yes, give details:

Consent

Blood transfusion information leaflets are available and include (on the back page) a removable label to record discussion with the patient. Please use and record for first transfusion episode and affix to inside of case notes. For further transfusions record consent in tick boxes below:

Has this patient given informed consent?

☐ Incapacitated ☒ Yes ☐ No

(If incapacitated, please ensure retrospective discussion takes place and document on page 4)

Has a patient information leaflet been offered/given to the patient?

☐ Yes ☐ Not applicable ☒ None available

Pre-Transfusion Checklist (complete for every unit given)

Take the component and patient's case notes/Transfusion Record to the bedside

Unit	Patent IV access	Baseline observations	Inspect bag	Check expiry date	Positive patient ID	Wristband check	Component ID	Initials (Delete column 2 if using single check)	
1	☒	☒	☒	☒	☒	☒	☒	he	ks
2	☒	☒	☒	☒	☒	☒	☒	he	ks
3	☐	☐	☐	☐	☐	☐	☐		
4	☐	☐	☐	☐	☐	☐	☐		
5	☐	☐	☐	☐	☐	☐	☐		
6	☐	☐	☐	☐	☐	☐	☐		

NB. Blood/blood components of different ABO and Rh group to the patient may be compatible.

Only proceed with transfusion if the above details are correct.
If in doubt, **DO NOT** proceed – contact Transfusion Lab.

RIGHT BLOOD → RIGHT PATIENT @ RIGHT TIME



First Name:

Second Name:

CHI No/Unique identifier:

BLOOD COMPONENT AUTHORISATION CHART (Prescription)					Donation Label (attach label or complete as required)		Volume of bag	Finish time
UNIT 1	Date: 28/4	VOL: (unit/pool/mls)	☐ Irradiated	Authorised signature: <i>[Signature]</i>	Donation No: G101 621 010 505 N Component: RBC Signature 1: <i>[Signature]</i> Signature 2: <i>[Signature]</i>	Date Given: 28/4/21 Time Given: 0925	27mls.	1230
	Blood component: PRC	Duration: 3 1/4 (max 3 1/2 hours)	☐ CMV negative ☐ Blood warmer					
UNIT 2	Date: 28/4	VOL: (unit/pool/mls)	☐ Irradiated	Authorised signature: <i>[Signature]</i>	Donation No: G101 621 074 706 8 Component: RBC Signature 1: <i>[Signature]</i> Signature 2: <i>[Signature]</i>	Date Given: 28/4/21 Time Given: 1535	286mls	
	Blood component: PRC	Duration: 3 1/4 (max 3 1/2 hours)	☐ CMV negative ☐ Blood warmer					
UNIT 3	Date: 28/4	VOL: (unit/pool/mls)	☐ Irradiated	Authorised signature: <i>[Signature]</i>	Donation No: G101 621 035 206 C Component: RBC Signature 1: <i>[Signature]</i> Signature 2: <i>[Signature]</i>	Date Given: 28/4/21 Time Given: 2220	(May 21) 273mls	
	Blood component: PRC	Duration: (max 3 1/2 hours)	☐ CMV negative ☒ Blood warmer					
UNIT 4	Date:	VOL: (unit/pool/mls)	☐ Irradiated	Authorised signature:	Component: Signature 1: Signature 2: (Delete signature 2 if using single check)	Date given: Time given:		
	Blood component:	Duration: (max 3 1/2 hours)	☐ CMV negative ☐ Blood warmer					
UNIT 5	Date:	VOL: (unit/pool/mls)	☐ Irradiated	Authorised signature:	Donation number: Component: Signature 1: Signature 2: (Delete signature 2 if using single check)	Date given: Time given:		
	Blood component:	Duration: (max 3 1/2 hours)	☐ CMV negative ☐ Blood warmer					
UNIT 6	Date:	VOL: (unit/pool/mls)	☐ Irradiated	Authorised signature:	Donation number: Component: Signature 1: Signature 2: (Delete signature 2 if using single check)	Date given: Time given:		
	Blood component:	Duration: (max 3 1/2 hours)	☐ CMV negative ☐ Blood warmer					

Consider pre-medication required. Consider diuretic to reduce the risk of Transfusion Associated Circulatory Overload (TACO)

Date	Medicine	Dose	Method of Admin.	Time	Doctor's signature	Given by (signature)	Checked by (signature)	Time given

COPY PAGE

First Name:

Second Name:

CHI No/Unique identifier:

Observation Chart

MINIMUM observations **FOR EACH UNIT** as follows: **AT START OF UNIT, 15 MINUTES**, then **HOURLY** and upon **COMPLETION OF THE FINAL UNIT**
Record more frequently if the patient's condition warrants it.

UNIT NUMBER	1	1	1	1	1	1	2	2	2	2	2								
Date	28/4/20	28/4/20	28/4/20	28/4/20	28/4/20	28/4/20	28/4/20	28/4/20	28/4/20	28/4/20	28/4/20								
Time	08:05	09:40	10:05	10:30	11:30	12:30	13:10	15:35	15:50	16:00	17:00	18:00							
Initials	KM	ER	ER	KN	KN	EL	ER	KN	KN	KN	KN	KN							
Temperature	38.5	38.2	38.2	37.7	37.1	36.8	36.9	37.4	37.4	37.9	37.9								
MEWS Score uses systolic BP	97%	97%	96%	98%	97%	98%	98%	96%	97%	98%	98%	99%							
Pulse/Blood Pressure	120/98	120/98	117/103	111/110	101/95	95/97	112/72	102/96	96/95	98/95	102/95	108/90							
Respirations	17	17	17	16	15	18	16	15	16	16	16	18							
MEWS Score	5	5	4	3	2	3	1	2	3	3	2	18							
*Giving Set	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓							

*Initial relevant box if carried out. Giving set must be changed after 12 hours continuous use and before any platelet transfusion.

TRANSFUSION COMPLETED WITHOUT REACTION? ☐ Yes ☐ No (If no, give details on page 4)

☐ Patient advised that delayed transfusion reaction can occur up to 14 days post transfusion and to seek medical advice when necessary

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First Name:

Second Name:

CHI No/Unique identifier:

Blood Transfusion Reaction Summary

Minor Transfusion Reaction

Significant increase in temperature (<2 °C above baseline)

Patient develops urticaria (nettle rash)

Patient complains of shortness of breath

Major Transfusion Reaction

A major transfusion reaction is suggested by any/all of the following:

high pyrexia (>2 °C increase in temperature);
tachycardia, hypo/hyper tension, flushing, dyspnoea,
rigors, shock, respiratory distress; bone, muscle, chest
and/or abdominal pain

- ♦ STOP THE TRANSFUSION – Undertake rapid clinical assessment.
- ♦ Check the patient ID/compatibility label, visually assess unit.
- ♦ Is there evidence of life threatening **Airway** and/or **Breathing** and/or **Circulatory** problems and/or wrong blood given and/or contaminated unit?

No

Yes

Inform Medical Staff

Consider administration of:

Paracetamol (1g Orally)

Chlorpheniramine (10mg IV)

May need diuretic prescribed

If clinical status allows, re-start blood component at a slower rate but within timescales and monitor patient closely

Severe/Life Threatening:

- ♦ Call for urgent medical help
- ♦ Initiate resuscitation – ABCDE
- ♦ Is haemorrhage likely to be causing hypotension? If not discontinue transfusion
- ♦ Take down unit/giving set, maintain venous access
- ♦ Monitor patient, e.g. TPR, BP, urine output, O₂ sats (catheterise if necessary)

- ♦ If likely severe allergic reaction – give chlorpheniramine and hydrocortisone, oxygen, and salbutamol nebuliser (2.5 or 5 mg). Consider adrenaline (0.5 ml of 1/1000 IM)
- ♦ If bacterial contamination likely - start antibiotics
- ♦ Use BP, pulse, urine output to guide IV fluid resuscitation
- ♦ Inform Transfusion Lab and return unit

If shortness of breath predominates, consider Transfusion Related Acute Lung Injury (TRALI) or Transfusion Associated Circulatory Overload (TACO)

Document in patient notes

Doctor informed of transfusion reaction?

☐ Yes ☐ No

Doctor's name:

Person reporting reaction:

Time (24 hour clock): :

Date: / /

Inform Transfusion Lab of reactions and incidents immediately. (They will advise of next steps)

Time (24 hour clock): :

☐ DATIX completed, DATIX Reference number:

Name of reporter:

NB. Near misses should also be reported in DATIX**The lab will report nationally as required and discuss at Hospital Transfusion Committee meetings**

Additional comments

Signature

Date

☐ Hairmyres☒ Monklands☐ Wishaw

Other (specify)

1808785142
18/08/1978 F F
MCCRACKEN Isabel
1d Cumbræ Crescent

Coatbridge
Lanarkshire

ML5 4PX

Ward: 7

Direct Dial Phone: 01236 42301

Primary Care Referral

DISTRICT NURSES FAX

Coatbridge District Nursing Team

Consultant/Specialty: M.D.

Patients Details

Phone: Day Time (or mobile) 07947301884

Evening (or mobile) 11

Lives alone

☐ Yes☒ No

LIVES WITH SON

Next of Kin/Carer

Name

Address

Phone

General Practitioner

Name: NS MARCUCCI

Address: WAVERLY MEDICAL
1 CENTRE PARK COURT
COATBRIDGE
ML5 3AP

Phone: 01236 422311

Date of Admission: 1/5/21

Date of Discharge: 25/5/21

Discharge Address: (if different)

Allergies:

NONE

Relevant Past History:

VRE+

Reason for Admission

R HERNIA, END ILEOSTOMY +
APPENDIX 15 DAYS POSTOP

Diagnosis

Patient Aware ☒ Yes ☐ No

Dependency

Yes No

Ambulant

☐ ☐

Self-Care Skills

☐ ☐

Bed Fast

☐ ☐

Help eating/drinking - MUST Score

☐ ☐

Help Bathing

☐ ☐

Continent Urine

☐ ☐

Continent Faeces

☐ ☐

Skin Integrity

☐ ☐

Waterlow Score

☐ ☐

Confusion

☐ ☐

Infection Control - VRE+

☒ ☐

Services

Yes No

District Nurse Visit

☒ ☐

Treatment Room Nurse

☐ ☐

Home Care - Social Work

☐ ☐

Public Health Nurse

☐ ☐

Macmillan Nurse

☐ ☐

Other (specify)

☐ ☐

5-7 Days Dressing

☒ Yes ☐ No

5-7 Days Discharge Medication

☐ Yes ☐ No

Reason for Referral

WOUND TO MIDLINE

PATIENT HAS SUPPLY OF DRESSINGS

Date of First Visit: 26/5/21

PATIENT SELF ADMINISTERING TIZ INJECTION

PLEASE REMOVE SHARPS BIN WHEN
REQUIRED

Health & Safety Issues:

FULL PRE, PT IS VRE+.

Name: (PRINT)

JENNIFER HADEN

Signature:

J Haden

Date:

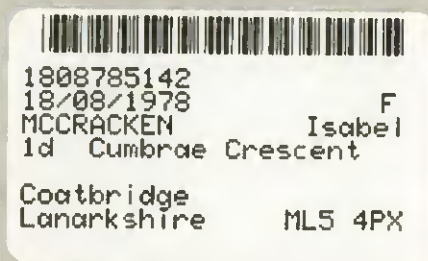
25/5/21





Wishaw General Hospital
50 Netherton Street
Wishaw
ML2 0DP

19/05/2021



Appointment Booking Office Direct Dial: 01236 712993

Ms Isabel McCracken
1d Cumbrae Crescent

RP37

Coatbridge
ML5 4PX

Dear Ms. McCracken

Your Reference: CHI Number 1808785142

You were referred to the Endoscopy Unit with symptoms thought to be coming from your stomach/bowel.

We wrote to you recently inviting you to contact us to make an appointment to attend the Endoscopy Unit, unfortunately you have not responded to our communication to you and you have been subsequently been removed from the Endoscopy waiting list.

We have copied this letter to both your General Practitioner and your Hospital Consultant. If you have any ongoing concerns you should discuss this with your General Practitioner.

Yours sincerely
Elizabeth Dolan

Directorate Support Manager

PatientBooking.WG@lanarkshire.scot.nhs.uk

We have an email address available for appointment cancellations/queries. Please note that we are unable to book or reschedule appointments through this email.

Copy to Dr Eliana Saffouri (Hospital Consultant) and GP,
Dr NS Marcuccilli,
Waverley Medical Practice, Coatbridge Health Centre, 1 Centre Park Court, Coatbridge
ML5 3AP

Office reference: PFBREMOVAL

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NHS Lanarkshire
www.nhslanarkshire.org.uk
Department of General Medicine
01236 748748

University Hospital
Monklands
Monkscourt Avenue
Airdrie
ML6 0JS



Isabel McCracken
1D Cumbrae Crescent
Coatbridge
ML5 4PX

Date Dictated: 29/04/2021
Date Typed: 03/05/2021
Ref: 2512469
Letter Ref: SO/ET
Clinic Date: 29/03/2021
CHI Barcode:



Consultant: Dr Scott Oliver

Dear Isabel McCracken

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

I have had a message from the endoscopy unit telling me that you did not attend for a planned pre-assessment in advance of a planned camera test following your recent hospital admission to Monklands Hospital. I understand the endoscopy unit were also unable to reach you on your contact phone number. From looking at the patient record system I wondered if you might have actually been admitted to hospital or been in the process of going to A&E on the day that you had been planned to come to the pre-assessment, and this might explain why people were unable to get in touch with you.

I would be grateful if you would get in touch via my secretary once you receive this letter to let me know if you would like to have the camera test re-requested. I do think it would be worth proceeding with this if you are agreeable to it. I have also let the team who I think are currently looking after you in Monklands Hospital know, and they might be in touch with you about this before you get home and read this letter.

Yours sincerely

Dr Scott Oliver
Consultant Nephrologist and Physician

Authorised on 03/05/2021 12:19:38 by Scott Oliver.

(D) Dr NS Marcuccilli
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

07 MAY 2021

(P) Dr Elizabeth Ann McIntyre
Ward 12
University Hospital Monklands
Monkscourt Avenue
ML6 0JS

1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumbrae Crescent
Coatbridge
Lanarkshire ML5 4PX

Esca

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www.nhslanarkshire.org.uk
Department of General Surgery
01236 748748
sDeptinfo

University Hospital
Monklands
Monkscourt Avenue
Airdrie
ML6 0JS



Mr Michael Dick
Consultant Colorectal Surgeon
University Hospital Monklands
Monkscourt Avenue
Airdrie
ML6 0JS

Date Dictated: 08/06/2021
Date Typed: 11/06/2021
Ref: 2916512
Letter Ref: TT/JD
CHI Barcode:



Consultant:

Dear Mr Dick

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

As I am sure you are aware, this lady was recently discharged home from ward 4 following ileocaecal resection formation of end ileostomy for ischemia and pelvic collection.

I reviewed this lady at the stoma clinic today, Tuesday 8/6/21. She attended the consultation with her sister.

On examination today her ileostomy is healthy, although there is an area of discoloration but I feel this may be due to the convexity appliance. She changes her bag every second or third and is not experiencing any issues with leakages. She states it is mostly active of thick faecal fluid and she feels she is coping well with her stoma care. She still has an abdominal dressing which she attends her practice nurse weekly for review. She is due for a PET scan on 16/6/21. She was enquiring how long she had to continue taking her Tinzaparin and I have advised her to discuss this with her GP.

I have arranged to see her in three weeks' time when she attends the planned investigation unit on 29/6/21. She has our contact number should she require review sooner.

Yours sincerely

Tracy Tallo
Stoma Care Nurse

Authorised on 15/06/2021 07:40:06 by Tracy Tallo.

(D) Dr NS Marcuccilli
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

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IMMUNOPATHOLOGY

DMR 375

Tayside Clinical Laboratory Services

Telephone 01382 632539

Internal Ext. 32539

Name: MCCracken

Isabel

Sex: F

PID:

1808785142

DoB: 18 Aug 1978

Lab No: I210455255

Monklands District Gen. Hosp.

Clinician:

- NOT GIVEN

MONKBM NG

IgM Anti Cardiolipin Antibody	4	MPL U/ml	(	0-40	)
Anti B 2 Glycoprotein IgM	<2.9	U/ml	(	0-10	)
IgG Anti Cardiolipin Antibody	7	GPL U/ml	(	0-40	)
Anti B 2 Glycoprotein IgG	1	U/ml	(	0-10	)

Lab. Comments:

Sample is blood unless
otherwise stated

Sample Date/Time

29 Apr 2021 11:30

Clin. Details: Specimen number 1045418458
MV Thrombosis ?cause
Test Name: B2 Glycoprotein- 1 Abs

15 JUN 2021



LA01

Request Entered: 06 May 2021 10:29

Report Printed: 09 Jun 2021 14:43

REPORT RECEIVED

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DOCTOR'S INITIALS

NHS Lanarkshire
www.nhslanarkshire.org.uk
Department of General Surgery
Colorectal Department
Miss Sharma & Mr Dick
01236 712721

Monklands Hospital
Monkscourt Avenue
Airdrie
ML6 0JS



Dr NS Marcuccilli
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

Date Dictated: 17/06/2021
Date Typed: 21/06/2021
Ref: 2926219
Letter Ref: MM/JR
CHI Barcode:



Consultant: Mr Michael M Dick

Dear Dr Marcuccilli,

Discharge Summary

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrac Crescent, Coatbridge, ML5 4PX
Date of admission: 27/04/2021
Date of discharge: 25/05/2021

Diagnosis: Extensive SMV thrombus
Terminal ileum mesenteric abscess
Pelvic collection
VRE positive

Procedure: CT abdomen and pelvis 28.04.21
Diagnostic laparoscopy + laparotomy, limited right hemicolectomy and end ileostomy
28.04.21
CT abdomen and pelvis 19.05.21
Gastroscopy 21.05.21

Co-Morbidities

1. Gastritis
2. Back pain
3. Personality disorder
4. Cannabis smoker

Follow up: CT PET scan
Haematology outpatient clinic
Mr Dick outpatient clinic
Outpatient flexible sigmoidoscopy (6 weeks)

This 42-year-old female was admitted with back pain and feeling generally unwell. She had a recent admission under the medical team with an extensive superior mesenteric thrombus; the cause of which was not identified. At admission, INR was elevated (>8) and she underwent an urgent CT abdomen and pelvis to look for any further extension of the thrombus and/or any evidence of ischaemic gut. CT scan revealed increased thrombus burden and raised the possibility of venous ischaemia of the gut. She was taken to theatre for a diagnostic laparoscopy. Intraoperative findings showed no evidence of small bowel ischaemia but some fat stranding near the terminal ileum and a possible mesenteric abscess; the appendix also appeared abnormal. Laparotomy, limited right hemicolectomy and end ileostomy was performed. Subsequent

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pathology has shown an appendiceal diverticulum but no evidence of malignancy. Ms McCracken was recovered in the intensive care unit before step down to the ward.

Ms McCracken had positive blood cultures for VRE. She was discussed with the microbiology team and completed a course of antibiotics as per their advice. Her post-operative progress was slow. She suffered minor superficial wound dehiscence managed conservatively, and had issues with a high output stoma which responded to Loperamide. She underwent a repeat CT scan which revealed a small localised collection around the hemicolectomy suture line. The possibility of drainage was discussed with interventional radiology team but a clinical decision was made to manage this conservatively. She also underwent a gastroscopy whilst an inpatient which revealed non-erosive gastritis only. An outpatient flexible sigmoidoscopy has been requested.

Her case was discussed with haematology who advised bone marrow biopsies, a thrombophilia screen and a CT PET scan given the rarity of developing worsening thrombus whilst anticoagulated. With regards to anticoagulation, they advised treatment dose Tinzaparin once daily and they will follow her up with the results of the above investigations in the outpatient clinic.

Clinically improving she was fit for discharge on the above date with follow up in Mr Dick's outpatient clinic in 2-3 weeks.

Yours sincerely

Mhairi Mactier
ST2 in General Surgery

Authorised on 24/06/2021 17:25:30 by Mhairi Mactier.



8290

Email: geneticlabs@ggc.scot.nhs.uk

West of Scotland Genetic Services

Laboratory Genetics
Level 2B, Laboratory Medicine
Queen Elizabeth University Hospital
1345 Govan Road, Glasgow G51 4TF

Tel: 0141 354 9330



Head of laboratory: Nicola Williams

Cytogenetic report

Dr Caroline Betts
Consultant Haematologist
Monklands Hospital
Monkscourt Avenue
Airdrie
ML6 0JS

Report Number: 166297

Reported: Jaclyn Toland

Authorised: Lindsay Bennett

Name of Patient: Isabel MCCracken		Date of Birth: 18/08/1978	
CHI/NHS Number: 1808785142	Sex: Female	Date of Sample: 30/04/2021	
Hospital Number:	Sample Type: Bone Marrow	Date Received: 04/05/2021	
Pedigree Number:	Lab Number: 3211696	Date of Activation: 04/05/2021	
Ref Lab Number: 1045013059	Gestation:	Date of Report: 06/05/2021	

Reason for referral: ?LPD/?Myeloma. Storage requested.

Conclusion: **Sample cultured and stored**

Results and interpretation:

Cytogenetic testing has not been carried out on this bone marrow specimen. Cultured preparations have been stored as requested on the referral form.



Please let us know, as soon as possible, if you do require cytogenetic analysis.

Comments:

In order to avoid error and/or misinterpretation, transcription of the content of this report is not advised; Laboratory Genetics do not take any responsibility for the accuracy of any data/text transcribed from this report.

Technical Information:

Unstimulated overnight cultures stored.

25/6/21



8290

West of Scotland Genetic Services

Laboratory Genetics
Level 2B, Laboratory Medicine
Queen Elizabeth University Hospital
1345 Govan Road, Glasgow G51 4TF

Email: geneticlabs@ggc.scot.nhs.uk

Tel: 0141 354 9330

Head of laboratory: Nicola Williams



Cytogenetic Report

Dr Caroline Betts
Consultant Haematologist
Monklands Hospital
Monkscourt Avenue
Airdrie
ML6 0JS

Report Number: 166302

Reported: Jaclyn Toland

Authorised: Lindsay Bennett

Name of Patient: Isabel MCCracken		Date of Birth: 18/08/1978	
CHI/NHS Number: 1808785142	Sex: Female	Date of Sample: 30/04/2021	
Hospital Number:	Sample Type: Bone Marrow (EDTA)	Date Received: 04/05/2021	
Pedigree Number:	Lab Number: 3211697	Date of Activation: 04/05/2021	
Ref Lab Number: 1045013059	Gestation:	Date of Report: 06/05/2021	

Reason for referral: ?LPD/?Myeloma. Storage requested.

Conclusion: **CD138+ selected plasma cells stored**

Results and interpretation:

Cytogenetic analysis has not been carried out on this marrow specimen. CD138+ selected plasma cells have been stored as requested on the referral form.

Please let us know, as soon as possible, if a diagnosis of Myeloma is confirmed and prognostic FISH testing is required.

Comments:

In order to avoid error and/or misinterpretation, transcription of the content of this report is not advised; Laboratory Genetics do not take any responsibility for the accuracy of any data/text transcribed from this report.

Technical Information:

CD138+ plasma cells were selected from a bone marrow aspirate



25/6/21

www.nhslanarkshire.org.uk
Department of Haematology
Unit Secretary: 01236 712099
Day unit: 01236 712343
Inpatients: 01236 712152

Isabel McCracken
1D Cumbrae Crescent
Coatbridge
ML5 4PX

University Hospital Monklands
Monks court Avenue
Airdrie
ML6 0JS



Date Dictated: 13/07/2021
Date Typed: 13/07/2021
Ref: 100863263
Letter Ref: CLB/YA
CHI Barcode:



Consultant:

Dear Isabel McCracken

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

PHLEBOTOMY SERVICE FOR PATIENTS

To help ensure your bloods are taken in **advance of your next appointment** the clinic staff will give you bloods forms to take to your GP along with instruction on when they should be carried out. Please contact your GP Practice to make an appointment with your Treatment Room Nurse to have your bloods taken.

In the event of the current situation due to Coronavirus may have resulted in your GP Surgery being closed and you are unable to get these carried out there will be a service available at the 3 hospitals running **Monday – Friday 9am – 2pm.**

To help reduce the volume of patients attending at the same time, appointments will be required to be scheduled therefore, can I ask that you call to make an appointment. Please call the hospital site suitable for you to attend on the number below.

- University Hospital Monklands- 01698 753433
- University Hospital Wishaw – 01698 366840
- University Hospital Hairmyres- 01355 584825

The staff will allocate a time within the opening hours above and advise of the area within the hospital to attend. Please bring your blood forms with you.

We also ask for you to attend the appointment on your own and for family or friends who accompany you to remain in the car or outside.

Yours sincerely

Dr Caroline Betts
Consultant Haematologist
GMC No: 7020077

Authorised on 13/07/2021 10:18:22 by Typist Yvonne Allison, not verified by Consultant.

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SURNAME		 1808785142 18/08/1978 MCCracken F 1d Cumberae Crescent Isabel Coatbridge Lanarkshire ML5 4PX		CLINICAL NOTES
FORENAMES				
DATE				
22/6/21				
	Wilson - ? thought food poisoning (~ 1/52) → post sickness & diarrhoea - Abdominal pain - Feeling dizzy. Junduced.			
	- Otherwise fit & well. - Sore back pain. - 5 children - 4 > 20yrs. 1 12yrs. 5 Ms. Unremarkable pregnancies.			
	- Smoker → 2/3 day → 13yrs. Alcohol → February → Friday night → 4 cns beer. 2 cns cider.			
	2 brothers 2 sisters			
	↓			
	Stays at (H) Wilson. ↳ Not worked for a while.			
	→ PET centre □ ↳ am ✓			



NHS Lanarkshire
www.nhslanarkshire.org.uk
Department of General Medicine
01236 748748

University Hospital
Monklands
Monks court Avenue
Airdrie
ML6 0JS

1092
NHS
Lanarkshire

Isabel McCracken
1D Cumbrae Crescent
Coatbridge
ML5 4PX

Date Dictated: 29/04/2021
Date Typed: 03/05/2021
Ref: 2512469
Letter Ref: SO/ET
Clinic Date: 29/03/2021
CHI Barcode:



Consultant:

Dr Scott Oliver

Dear Isabel McCracken

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

I have had a message from the endoscopy unit telling me that you did not attend for a planned pre-assessment in advance of a planned camera test following your recent hospital admission to Monklands Hospital. I understand the endoscopy unit were also unable to reach you on your contact phone number. From looking at the patient record system I wondered if you might have actually been admitted to hospital or been in the process of going to A&E on the day that you had been planned to come to the pre-assessment, and this might explain why people were unable to get in touch with you.

I would be grateful if you would get in touch via my secretary once you receive this letter to let me know if you would like to have the camera test re-requested. I do think it would be worth proceeding with this if you are agreeable to it. I have also let the team who I think are currently looking after you in Monklands Hospital know, and they might be in touch with you about this before you get home and read this letter.

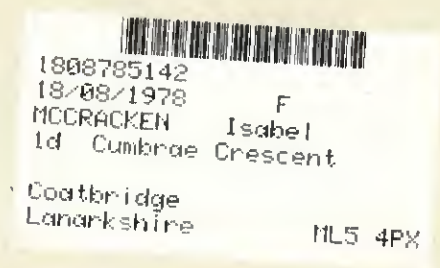
Yours sincerely

Dr Scott Oliver
Consultant Nephrologist and Physician

Authorised on 03/05/2021 12:19:38 by Scott Oliver.

(D) Dr NS Marcuccilli
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

(P) Dr Elizabeth Ann McIntyre
Ward 12
University Hospital Monklands
Monks court Avenue
ML6 0JS



11/6/21

SCOT

Had this as
wpt 21/5/21
I can
This patient called to
say she wants to go
ahead with the
camera test. She was
in hospital from 27/4/21
till 26/5/21 so that's
why she couldn't attend
for pre-assessment

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Department of General Surgery
01236 748748
sDeptinfo

Monklands Hospital
Monks court Avenue
Airdrie
ML6 0JS



Dr NS Marcuccilli
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

Date Dictated: 27/07/2021
Date Typed: 27/07/2021
Ref: 2956057
Letter Ref: IRJD
CHI Barcode:



Consultant: Nurse Isabell Robertson

Dear Dr Marcuccilli

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

I reviewed this lady again via video call today, Tuesday 27/7/21. I am pleased to see that Mrs McCracken is competently managing her stoma care, however does have an area which she states is excoriation around her stoma.

On examination today her ileostomy is healthy, however she has a marked area of erythema, which appears to be outwith the adhesive area. I am unsure whether it is a contact dermatitis due to the appliances. I have recommended that she use a barrier wand prior to her present appliance and I have also sent her a supply of cotton covers, to see if this resolves the situation.

She is attending the pre-assessment department on 6/8/21, therefore I have also arranged to review her peristomal skin at this time. Mrs McCracken does know how to contact me should she require to be reviewed earlier. She had advised me that since recommencing her Loperamide her stoma is now active of thick faecal fluid and she empties her pouch three times per day. She feels that her general condition is otherwise progressing well.

I shall keep you informed of her progress.

Yours sincerely

I Robertson
Stoma Care Sister

Authorised on 29/07/2021 08:48:22 by Miss Isabell Robertson.

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Dr NS Marcuccilli
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

Date Dictated: 13/07/2021
Date Typed: 20/07/2021
Ref: 281679
Letter Ref: CLB / KMc
Clinic Date: 22/06/2021
CHI Barcode:



Consultant: Dr Caroline Betts

Dear Dr Marcuccilli

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

Reason for referral: Presented with extensive superior mesenteric thrombosis in March 2021
Initially anticoagulated with Warfarin
Readmission with extension of thrombosis despite supra-therapeutic INR
Currently on Tinzaparin

I reviewed this 42-year-old lady via telephone in the haematology clinic on 22 June 2021. As you will be aware, this lady presented initially in March 2021 with a week long history of what she described as food poisoning. She described abdominal pain, vomiting, rigors and diarrhoea. She felt very dizzy and thought that she may be jaundiced. Her bloods initially demonstrated a thrombocytopenia with deranged electrolytes and deranged liver function. She grew a gram variable bacilli in her blood cultures but the Lab were unable to identify a specific organism. A CT of her abdomen at that time demonstrated extensive superior mesenteric vein thrombosis and after discussion with the Surgical Team she was initially managed conservatively with intravenous antibiotics. It was difficult to piece together whether she had presented with an idiopathic superior mesenteric vein thrombosis or whether the thrombosis was secondary to abdominal inflammation. During her initial admission she was extensively imaged to look for evidence of malignancy and none could be found. She was also screened for PNH which was negative and had a JAK2 sent which was also negative. She was noted to have a positive lupus anticoagulant but this was done on anticoagulation. She is also known to have a slightly high IgM anticardiolipin antibody. She was initially discharged home on Warfarin and unfortunately was subsequently found to have a high INR in the Community. This was reversed with a small amount of vitamin K but later that night she represented with worsening back pain and feeling unwell. She had a further CT abdomen and pelvis on 28 April which unfortunately revealed an extension of her thrombosis and possibly some venous ischaemia of her gut. She was therefore taken to theatre for a diagnostic laparoscopy and required a limited right hemi-colectomy with end ileostomy. During that admission she also had positive blood cultures for VRE which required intravenous antibiotics. She had a small localised collection around her site of her hemi-colectomy and this was managed with intravenous antibiotics. Given it was unusual to extend the thrombus when she was supratherapeutically anticoagulated, the decision was made to switch her to treatment dose Tinzaparin and to search for a potential malignant cause for her thrombosis.

Mrs McCracken told me that usually she is fit and well. She has some ongoing mild back pain. She has no particular significant past medical history and did not describe any history of venous thromboses in the family. She has had 5 children, 4 of whom are over the age of 20 and she has a 12-year-old at home with her. She describes her pregnancies as being uneventful. She is a smoker, smoking 2-3 cigarettes per day and has done so since the age of 13. Prior to her admission in March she was drinking approximately 4 cans of beer and 2 cans of cider on a Friday night only but she has been absent from alcohol since her discharge from Hospital in April. She currently lives at home with her son and is not working.

Cont/...

I discussed with Mrs McCracken that at present we do not have a good explanation for why she had her venous thrombosis and also particularly why she extended her mesenteric vein thrombosis. She had been discharged home from

Monklands with a plan for a CT PET scan to look for an occult source of malignancy. She had gone along for this but unfortunately was unable to stay for the full investigation. I will therefore contact the PET Centre to see whether she could be reappointed.

During her 2nd admission it was noted that her initial thrombocytopenia, which I suspect was sepsis related, had become a thrombocytosis. Given the concern that she may potentially have an underlying myeloproliferative neoplasm as a cause of her abdominal thrombosis, she had a bone marrow aspirate and trephine done. This revealed the presence of approximately 10% plasma cells, the majority of which appeared to be kappa restricted. There was no evidence of a myeloproliferative neoplasm on her trephine. She is known to be JAK2, CALR and MPL negative. Cytogenetics were not performed. She does have stored CD138 positive cells for FISH testing and I will contact the Lab and ask if they can do these for us in view of her plasma cell population that was identified in her bone marrow.

In terms of thrombophilia screening, she had an initial thrombophilia screen carried out on 06.04.21 when she presented with her acute thrombosis. This has to be interpreted with caution as she was on anticoagulation at the time but showed that she had a mildly elevated activated protein T ratio, normal antithrombin activity, normal protein C and normal protein S activity. She subsequently went on to have Factor V Leiden genetics checked and these were normal. She has had lupus anticoagulant checked on 3 subsequent occasions, all of which have been very mildly positive with a ratio of 1.2, our upper limit of normal being 1.19. These were all done on anticoagulation and therefore I suspect this is a false positive result. Anticardiolipins were elevated on initial testing in April but subsequently returned to normal. She also had serum free light chains checked in April and these showed that she had an elevated kappa and lambda but with a normal K/L ratio. These will need repeating. She has also had her Beta2 glycoprotein antibodies checked and these are normal as well.

In summary, I said to Mrs McCracken on the phone that at present we do not have a good explanation for why she has had her superior mesenteric vein thrombosis. I note from her discharge letters from the General Medical Team it states that she is a Cannabis smoker and certainly this can increase the risk of a thrombosis as well. She did not admit to this when I spoke to her. I said to her that I think we need to have a PET scan done to make sure that there is not an underlying malignant cause for her thrombosis. The finding of a presumably clonal plasma cell population on her bone marrow is somewhat of a surprise and she was certainly noted to have a paraprotein of 7.8g/l in April. This was in the context of a very acute inflammatory response. We will have to follow this up and I will post a blood form to ask if she can have her paraprotein, immunoglobulins and serum free light chains updated. She has not had a Beta2 microglobulin done and therefore I will ask if this can be done as well. In terms of anticoagulation I said to her she should remain on her Tinzaparin at present. I think once her PET scan has been done, if we know that she does not have a solid malignancy as the cause underlying this then we can probably think about potentially switching her to a DOAC for ongoing anticoagulation. She has already completed an initial 3 months of anticoagulation by the end of this week. I said to her that I think it is very difficult to justify taking her off anticoagulation to repeat her thrombophilia screening given the extent that her thrombosis increased especially in the context of a potentially high INR. She is very keen to be able to swap to an oral agent as she is finding the ongoing Tinzaparin injections very difficult. I said to her we should plan to catch up with her in about 6 weeks time and I will try and contact the PET Centre to reschedule her PET scan. I will also post her a blood form to have her bloods updated.

Yours sincerely

Dr Caroline Betts
Consultant Haematologist
GMC No: 7020077

Authorised on 09/08/2021 16:24:13 by Dr Caroline Betts.

(P) Dr Scott Oliver
 Consultant Nephrologist
 University Hospital Monklands
 Monkscourt Avenue
 Airdrie
 ML6 0JS

(P) Mr Michael Dick
 Consultant Colorectal Surgeon
 University Hospital Monklands
 Monkscourt Avenue
 Airdrie
 ML6 0JS

Haematology referral guidance is available at: <http://www.nhslcg.scot.nhs.uk/?cat=100>

www.nhslanarkshire.org.uk

Department of Haematology
Haematology Secretary 01236 712094
Haematology day unit 01236 712343
Haematology ward 01236 712152

University Hospital Monklands
Monks court Avenue
Airdrie
ML6 0JS



Isabel McCracken
1D Cumbrae Crescent
Coatbridge
ML5 4PX

Date Dictated: 13/07/2021
Date Typed: 16/07/2021
Ref: 281682
Letter Ref: CB / CM
CHI Barcode:



Consultant:

Dear Mrs McCracken

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

Further to your haematology appointment on the 22nd of June 2021 I enclose a blood form to have some bloods updated. It has been sometime since we have checked your haemoglobin and platelet levels. It was also identified during your first admission in Monklands that you had a slightly increased level of protein in the blood. This may have been due to the fact you were very unwell with infection at the time but it would be prudent to repeat these levels to see what is happening with this. I would be grateful if you could make an appointment at your GP practice to have these done. We will plan to catch up with you in the haematology clinic as already arranged.

Yours sincerely

Dr Caroline Betts
Consultant Haematologist
GMC No: 7020077

Authorised on 09/08/2021 16:24:35 by Dr Caroline Betts.

(D) Dr NS Marcuccilli
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

COPY PAGE

NHS Lanarkshire
Monklands Hospital
SIGMOIDOSCOPY REPORT

Name: **Isabel MCCracken (F)**
Date of birth: **18/08/1978**
NHS No: **1808785142**
Case Note No: **1808785142**

Address: **1d Cumbrae Crescent**
Coatbridge
Lanarkshire
ML5 4PX

GP: **Dr NS Marcuccilli**
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge

Procedure date: **10th August 2021 (11:45)**
Priority: **Routine**
Hospital: **Monklands Hospital**
Ward: **(none)**
Referring Cons: **Mr Michael Dick**

Indications

Patient had limited Right Hemi for appendix diverticulum and abscess May 2021. Listed for flexi sig.
Clinically important comments: Post op CT showed large collection next to the colonic staple line of the right colon which is within the abdomen. Patient also has extensive splanchnic vein thrombosis and is on treatment dose LMWH which was taken last night.

Consultant/Endoscopist

Mr John Anderson

Advice/Comments

Patient cancelled as on treatment dose of LMWH which was taken last night. Patient should be re booked and need to be off her LMWH for 24 hours. For repeat scope on Mr Dick's list.

Follow up

Further procedure(s): Sigmoidoscopy in 4 weeks.

DNA

The hospital cancelled this procedure

Mr John Anderson
Consultant Colorectal Surgeon
c.c. Mr Michael Dick (Monklands surgeons)

www.nhslanarkshire.org.uk
Department of General Surgery
01236 748748
sDeptinfo

Monklands Hospital
Monks court Avenue
Airdrie
ML6 0JS



Dr NS Marcuccilli
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

Date Dictated: 06/08/2021
Date Typed: 09/08/2021
Ref: 2964893
Letter Ref: TT/JD
CHI Barcode:



Consultant:

Dear Dr Marcuccilli

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

I reviewed this lady at the stoma clinic today, Friday 6/8/21 for a routine follow-up. Mrs McCracken continues to competently manage her stoma care.

On examination today her ileostomy is healthy, although flush with her skin. She still has an area of erythema which is out with the adhesive area of her appliance. She has been using a barrier wand for the past few days and she can see an improvement in this. I have advised her to continue using the barrier and to offset the flange slightly so that there is no contact with this area of erythema. She has experienced a couple of leakages overnight and I have advised her to wear a belt. We may have to consider alternative appliances if this area of excoriation does not resolve.

I have arranged routine follow-up in two months, however Mrs McCracken has agreed to contact me, if the issues with her peristomal skin are not alleviated with the barrier. I shall keep you informed of her progress.

Yours sincerely

Tracy Tallo
Stoma Care Nurse

Authorised on 10/08/2021 13:16:52 by Tracy Tallo.

COPY PAGE

C 1808785142
F 18/08/1978 F
L MCCracken Isabel F
A 1d Cumbernauld Crescent
Coatbridge
Lanarkshire ML5 4PX

University Hospital:

☐ Hairmyres ☒ Monklands ☐ Wishaw

NHS
Lanarkshire

Day Case Endoscopy

Date: 10/8/21

Arrival Time: 10 : Admission Time: : (24 hour)

Proposed Procedure:

- ☐ Bronchoscopy ☐ Colonoscopy
☐ ERCP ☐ Flexible Cystoscopy
☒ Flexible Sigmoidoscopy ☐ Gastroscopy
☐ PEG ☐ Other (specify)

Referring Consultant:

Escort:

Contact number:

Transport confirmed?

☐ Yes ☐ No

Patient Details - patient to complete this page (if appropriate)

Preferred name:

Phone: Home:

Mobile:

GP:

Practice:

Waverly Practice

Phone number:

07836 422311

Next of Kin:

Relationship:

Address:

Postcode:

Contact phone:

Do you have spiritual or religious needs?

☐ Yes ☐ No

If yes give details:

Do you have any special dietary requirements?

☐ Yes ☐ No

If yes give details:

Past Medical History - please tick all that apply and give details below

- ☐ Alcohol ☐ Angina ☐ Asthma/Bronchitis/COPD ☐ Diabetes
☐ Epilepsy/Fits/Fainting ☐ Glaucoma/Eye surgery ☐ High blood pressure ☐ Cardiac related events
☐ Jaundice/Hepatitis ☐ Recreational drugs ☐ Sedation/Anaesthetics ☒ Smoking
☐ Tuberculosis ☐ Other: (specify)

Details:

Cancelled

Do you have any other health problems?

Please list any medications you take here:

Omeprazole

Hydroxocobalamin

Oestradiol

Citalopram

Loperamide

Co-Q10

Tinzaparin * - last night

Ad Cal.

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1808785142

18/08/1978

MCCRACKEN

1d Cumberae Crescent

Coatbridge

Lanarkshire

F

Isabel

ML5 4PX

]

F

4AT Assessment (screening for Cognitive Impairment and Delirium - over 65s only)	Yes No N/A	Falls Risk Assessment (over 65s only)	Yes No N/A
4AT screening carried out? (see page 3)	☐ ☐ ☒	Falls Risk Assessment required?	☐ ☐ ☒
If yes, further action required?	☐ ☐ ☐	Have you fallen once or more in the past 12 months?	☐ ☐ ☐
MRSA Status (complete if applicable)		Do you have any unsteadiness on your feet or difficulty with walking or balance?	☐ ☐ ☐
Previous MRSA history?	☐ ☐ ☐	Have you ever found yourself on the ground but were unsure why?	☐ ☐ ☐
MRSA screen obtained?	☐ ☐ ☐	If yes to any above red triangle in use?	☐ ☐ ☐
Infection risk suspected/identified?	☐ ☐ ☐		
Senses			
Sight impaired?	☐ ☐ ☐		
Hearing impaired?	☐ ☐ ☐		
Communication		Mobility	
Does the patient require an interpreter?	☐ ☐ ☐	Independent?	☐ ☐ ☐
		Requires aids?	☐ ☐ ☐
Details/Actions/Comments:			

Patient Valuable Disclaimer

NHS Lanarkshire accepts no responsibility for loss or damage of any patient valuables or money however the loss or damage may occur, unless deposited for safekeeping.

- I have been informed of the hospital arrangements for safekeeping of valuables and money.
- I have been advised to send home or hand over valuables and money for safekeeping while I am in hospital.
- I have decided to take responsibility for my valuables and money while I remain in hospital.

I have read and understood the above.

Patient name: (PRINT) Signature:

Admitting Nurse: (PRINT NAME)	Designation:
<i>K8WLLION</i>	<i>AN</i>
Signature:	
<i>com</i>	

Date/Time Prescribed	Drug	Dose	Route	Doctor's Signature	Given by	Time Given


 1808785142
 18/08/1978 F
 MCCracken Isabel JF
 1d Cumberae Crescent
 Coalbridge
 Lanarkshire ML5 4PX

4AT Assessment Tool

(Screening for Cognitive Impairment and Delirium)

☒ Not applicable

Complete for all patients over 65 years if required

Date:		
Time:		
Initials:		
1. Alertness – This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.	0 0 4	
2. AMT4 – Ask the patient: age, date of birth, place (name of the hospital or building), current year	0 1 2	
3. Attention – Ask the patient: ‘Please tell me the months of the year in backwards order, starting at December.’ To assist initial understanding one prompt of, ‘What is the month before December?’ is permitted.	0 1 2	
4. Acute change or fluctuating course - Evidence of significant change or fluctuation in: alertness, cognition, other mental function (e.g. paranoia, hallucinations) arising over the last 2 weeks and still evident in the last 24 hours.	0 4	
4AT TOTAL SCORE:		

4AT Score:

4 or above: Possible delirium + / - cognitive impairment.

1 - 3 : Possible cognitive impairment. More detailed cognitive assessment and informant history taking are required.

0: Delirium or severe cognitive impairment unlikely (but delirium still possible if (4) information incomplete).

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1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumberae Crescent
Coatbridge
Lanarkshire ML5 4PX

Pregnancy Status Questionnaire

- complete for patients 55 years and under

☐ Not applicable

Legislation requires that a patient's pregnancy status should be ascertained and recorded before certain surgical procedures. This information should then be used to determine actions that are required to help protect the patient and foetus before surgery. We cannot perform your surgery if this is not completed.

Please answer the following questions:

1. Have your periods not started or was your last period more than 2 years ago? ☐ Yes ☒ No
If yes, please complete the signature and date section below.
2. Have you had a hysterectomy or sterilisation? ☐ Yes ☒ No
If yes, please complete the signature and date section below.
3. What was the first day of your last period? Date: / / 4 months .
4. Is there any possibility that you might be pregnant? ☐ Yes ☒ No
If yes, please discuss with the Consultant/Nurse in Charge before your operation and complete the signature and date section below.
If no, please complete the signature and date section below.

Patient Signature:

Imccracken

Date: / /

Nurse Signature:

Date: / /

Notes:

- **Implementation/Rationale for questionnaire:** The National Institute for Health and Care Excellence (NICE) guideline on perioperative tests recommend that pregnancy testing should be carried out for a woman who says its possible that she may be pregnant. This guideline also states that local pre-operative assessment policies should be reviewed to ensure that pregnancy status is checked within the immediate pre-operative period in accordance with these guidelines.
- **Confidentiality/Use of information:** At all times great care is taken to ensure that high standards of confidentiality are maintained in respect of information held. This 'Data Protection Act 1998' gives you the right of access to any personal information which NHS Lanarkshire holds about you, either in manual records or electronic records. If you would like more information about your rights under the act, you should contact the Records Officer at the hospital.

PVC Insertion Bundle

Hand hygiene performed immediately before all PVC insertion procedures (WHO Moment 2)
A single use skin antiseptic containing 70% isopropyl alcohol is used to cleanse skin and left to dry before insertion
Aseptic technique maintained throughout insertion procedure
A sterile, transparent, semipermeable dressing used to cover the catheter site

Yes No

☐	☐
☐	☐
☐	☐
☐	☐

Size/colour:

Insertion site:

Insertion date: / / **Time:** :

Signature:

C
Fit 1808785142
La 18/08/1978 F
Ad MCCracken Isabel
1d Cumberae Crescent
Coatbridge ML5 4PX
Lanarkshire

Baseline Observations - record on NEWS Chart as per local policy

Temperature: 37 Blood Pressure: 117/78
Heart Rate: 78 Respirations: 16
SpO2: 100 NEWS Score: 0
Pain Score: 0

Pre-Procedure Checklist	Yes No N/A	Comments	Check 1	Check 2
Is the referral letter available?	☒		☐	☐
Check you have the correct patient – name, address, date of birth	☒		☐	☐
Check the patient has the correct name band on	☒		☐	☐
Check the patient is having the correct procedure			☐	☐
Check the patient has consented for the correct procedure			☐	☐
Is the patient having sedation? If yes, check they have a responsible adult to collect them for discharge and stay with them for 24 hours and are advised not to leave unit until escort arrives	☐ ☒	☐ Throat spray	☐	☐
Has the patient ever been notified that they are at increased risk of CJD or vCJD for public health purposes?	☐ ☒	If 'yes' refer to policy and discuss with Infection Prevention and Control Team	☐	☐
Bowel preparation completed? ☒ Home ☐ Hospital	☐ ☐ ☐	Name of prep: unable to tolerate Time given: : (if applicable)	☐	☐
Does the patient have any allergies? If yes, red name band applied?	☒ ☐ ☒ ☐	If yes, details: ~ Diclofenac	☐	☐
Does the patient have dentures? If yes, have they been removed?	☐ ☐ ☐ ☐	☐ Caps ☐ Crowns ☐ Loose	☐	☐
Is the patient fasted?	☐ ☐	Last ate: : (24 hour) Last drank: : (24 hour) Date: / /	☐	☐
Does the patient have diabetes? ☐ Diet ☐ Tablet ☐ Insulin	☐ ☐	If yes, BM: mmols Time checked: : (24 hour) Further actions:	☐	☐
Is the patient pregnant? Test carried out?	☐ ☐ ☐ ☐ ☐ ☐		☐	☐
Is the patient on Warfarin or other anti-coagulants?	☒ ☐	If yes, details: Tard Enoxaparin Time given: 17:00 (24 hour) 9/8/21	☐	☐
Is INR available?	☐ ☒	If yes, details:	☐	☐
Does the patient have any internal metalwork or pacemaker?	☐ ☐	If yes, details:	☐	☐
Infection risk suspected/identified, e.g. HIV, hepatitis B or C?	☐ ☐	If yes, details:	☐	☐

Check 1. Signature:

Time: : (24 hour)

Check 2. Signature:

Time: : (24 hour)

COPY PAGE

	
1808785142	
18/08/1978	F
MCCRACKEN	Isabel
1d Cumberae Crescent	
Coatbridge	
Lanarkshire	ML5 4PX

Hospital/Site: _____
Clinic/Ward: _____



Patient Agreement to Investigation or Treatment Consent Form

Special requirements: (e.g. other language, other communication method)

Statement of Health Professional (to be completed by health professional with appropriate knowledge of proposed procedure as specified in consent policy)

Describe proposed operation, investigation or other treatment.
Where appropriate specify site or side (write in full).

Specific risks/complications

Please detail any specific risk/complications related to the procedure that were discussed. Please reference any information leaflets the patient has been given on the procedure that includes risk and complications.

- ☐ I have discussed the intended benefits of the treatment advised and risks of any available alternative treatments (including no treatment).
- ☐ I have discussed the side effects of the treatment advised, which could affect the patient straight away or in the future, and that there may be some side effects not listed because they are rare or have not yet been reported. Each patient may experience side effects differently.
- ☐ I have discussed what the treatment is likely to involve (including inpatient/outpatient treatment, timing of the treatment, blood and any additional tests, follow-up appointments, etc.) and location.
- ☐ I have explained to the patient that he/she has the right to stop this treatment at any time and should contact the responsible consultant or team if they wish to do so.
- ☐ I have discussed concerns of particular importance to the patient in regard to treatment.

Completed by: (PRINT NAME)	Job Title:
Signature:	Date: _____ / _____ / _____ Time: _____ : _____

CHI r
First 1808785142
Last 18/08/1978 F
Addr MCCracken Isabel
1d Cumberae Crescent
Coatbridge
Lanarkshire ML5 4PX

Statement to be Completed by Patient or Parent/Guardian*
(*parental responsibility for a minor without capacity)

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

I understand:

- The procedure, important risks and appropriate alternatives, which have been explained to me by the health professional named on this form.
- Who will be performing the procedure on the day.
- That any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to the medical treatment proposed, to safeguard or promote physical or mental health.
- That examination for the purpose of teaching will not be undertaken without my consent.

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

I agree: (tick as applicable)

- ☐ To the administration of an anaesthetic or to sedation if required.
- ☐ To the procedure named on this form.
- ☐ To photographic images and video recordings being held in records, and made available for teaching, audit and ethically-approved research purposes, to improve the quality of patient care.
- ☐ To the emergency administration of blood or blood products.

Patient Refusal for Blood Products

Please sign here if you decline to consent to the emergency administration of blood or blood products, **even if this results in death.**

Signature: (Patient or Parent/Guardian)

Date: / /

Signature: (Health Professional)

Date: / /

A witness or interpreter should sign below if the patient is unable to sign/speak English but has indicated his/her consent. Young people/children may also like a parent to sign here (see consent policy).

Signature:

Name: (PRINT)

Date: / /

Patient or Parent/Guardian * Agreement to Treatment

Signature:

Name: (PRINT)

Date: / /

COPY PAGE

CHI no
1808785142
18/08/1978 F F
MCCRACKEN Isabel
1d Cumberae Crescent
Coatbridge Lanarkshire ML5 4PX

Procedure

Time in: : (24 hour) ☐ Endoscopy Pause
Scope 1 No: Scope 2 No:
Endoscopist:

Procedure(s) Performed

☐ Patient consent withdrawn

Diathermy plate applied? ☐ Yes ☐ No If yes site: ☐ Removed
Condition of skin checked post procedure: ☐ Satisfactory ☐ Unsatisfactory

Medication administered: ☐ No sedation

Throat spray: Time: : If yes, nil by mouth 30/60/90/120 minutes (delete as applicable)
Topical Lignocaine: mls Time: : IV Alfentanil: mcgs Time: :
IV Midazolam: mgs Time: : IV Flumazenil: mcgs Time: :
IV Pethidine: mgs Time: : IV Naxolone: mgs Time: :
IV Buscopan: mgs Time: : Oxygen: litres Time: :
IV Fentanyl: mcgs Time: : Nitrous Oxide - self administration:
Other: (specify) Time: : ☐ Yes ☐ No ☐ N/A Time: :

Comfort Score:

AVPU Score:

Pulse oximetry - SpO2:

Heart Rate:

Samples/Interventions:

☐ APC ☐ Biopsies ☐ Gastric balloon/removal ☐ Sphincterotomy (ERCP)
☐ Aspirate ☐ Brushes/slides ☐ Haemorrhoidal banding ☐ Stent insertion
☐ Balloon dilatation ☐ CLOtest ☐ Injection of ink ☐ Variceal banding/injection
☐ Balloon trawl (ERCP) ☐ Endoscopic muc ☐ Polypectomy
☐ Other: (specify)

Nursing Assessment/Comments:

Time to Recovery: :

Completed by: (PRINT NAME)

Designation:

Signature:

Scope Cleaning – complete only if required as per local hospital/dept. policy

☐ Not applicable

1. Social clean in room by:

Signature:

Date: / /

Time: :

Processed before disinfection by:

Signature:

Date: / /

Time: :

2. Social clean in room by:

Signature:

Date: / /

Time: :

Processed before disinfection by:

Signature:

Date: / /

Time: :

Affix Theatre Labels Here

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Coatbridge
Lanarkshire

ML5 4PX

-  0 = No pain
 1 = Mild pain
 2 = Moderate pain
 3 = Severe pain
 4 = Excruciating/
Worst pain
imaginable

Hospital: _____

Ward: _____

NEWS Chart

Record head injury observations over page

See over page for NEWS Actions

[illegible]

[illegible][illegible]

National Early Warning Score (NEWS) Actions and Escalation			
Delirium Acute Change - Complete 4AT - inform Nurse in Charge - escalate to Medical staff/HECT			
NEWS 0 - Refer Observation Policy first 48 hours of admission - Minimum 12 hourly observations	NEWS 1 - 4 Inform Nurse in Charge - Lower risk - Respond within 60 mins - ABC - Minimum 4 hourly observations	NEWS ≥ 5 or 3 in one parameter Inform Nurse in Charge - Medium risk - Urgent assessment doctor/HECT - Respond within 30 mins - ABC - reassess - Start Fluid Balance - Minimum hourly observations	NEWS ≥ 7 Inform Nurse in Charge - High risk - Senior doctor/HECT assess - Urgent attendance - ABC - reassess - Continuous monitoring - Consider 2222 call - Consider critical care - Document escalation plan

C 1808785142
F 18/08/1978 F
L MCCracken Isabel F
A 1d Cumberae Crescent
Coatbridge
Lanarkshire ML5 4PX

or attach addressograph label here

Nursing Evaluation/Comments/Follow-up

PVC Maintenance Bundle

Yes No N/A

Is the PVC still in use?
The clinical need for the PVC has been reviewed and recorded today
Medical staff have reviewed the need for intravenous (IV) therapy including antibiotics today and switched to oral if possible
Hand hygiene is performed immediately before accessing the line/site (WHO Moment 2)
Removal of the PVC is considered if in longer than 72 hours
The PVC site has been assessed; removing the PVC where there is phlebitis or inflammation at the site
The PVC dressings are intact
A single use antiseptic containing 70% isopropyl alcohol is used to clean the access hub before accessing - rub the access hub for at least 15 seconds ("scrub the hub")

☐	☐	☐
☐	☐	☐
☐	☐	☐
☐	☐	☐
☐	☐	☐
☐	☐	☐
☐	☐	☐

Date: / Time: Signature:

Post Sedation Discharge Scoring System		☐ Not applicable	Score						
Vital Signs	BP and pulse within 20% of pre-admission baseline	2							
	BP and pulse 20 – 40% of pre-admission baseline	1							
	BP and pulse 40% of pre-admission baseline	0							
Activity Level	Steady gait, no dizziness, or meets pre-procedure level	2							
	Requires assistance	1							
	Unable to ambulate	0							
Nausea/Vomiting	No	2							
	Yes	0							
Pain	Pain score 0 – 2	2							
	Pain score 3 – 4	0							
Neuro Response (AVPU)	Alert or Voice	2							
	Pain	1							
	Unresponsive	0							
TIME									
TOTAL									

Maximum Score is 10: Patients scoring 9 are fit for discharge

Discharge Checklist	Yes No N/A		Yes No N/A
Tolerating fluids and diet	☐ ☐ ☐	Escort/carer available	☐ ☐ ☐
Patient advised to commence food and drink after 30 / 60 / 90 / 120 minutes (for throat spray only - delete as applicable)	☐ ☐ ☐	Private transport available	☐ ☐ ☐
IV cannula removed	☐ ☐ ☐	Ambulance/hospital transport arranged	☐ ☐ ☐
Has passed urine (if applicable)	☐ ☐ ☐	– Time: : :	
PR bleeding - if yes, comment below	☐ ☐ ☐	Written/verbal information given	☐ ☐ ☐
Belongings/valuables returned	☐ ☐ ☐	Contact details given	☐ ☐ ☐
		Letter to GP given	☐ ☐ ☐

Additional Comments/Notes:
Patient's procedure cancelled today due to ~~the~~ ^{KJ} Tanziparin in last 24 hours. Rebook with Mr Brock.

Completed by: (PRINT NAME) KENNELLION Designation: SN
Signature: KEN Discharge Time: 11:55 (24 hours)

COPY PAGE

CHI 

Firs 1808785142

18/08/1978 F

Las MCCracken Isabel

Add 1d Cumberae Crescent

Coatbridge ML5 4PX

Lanarkshire

or attach addressograph label here

Hospital/Site:

Clinic/Ward:



Special Covid 19 Patient Agreement to Investigation or Treatment Consent Form


**This form must be used in conjunction with the routine
NHSL Patient Agreement to Investigation or Treatment Consent Form.**


I understand that I am opting for a treatment/procedure/surgery that I agree is necessary after discussion with:

_____ (Clinician name)

This is for the following procedure:

sigmoidoscopy

_____ (Procedure name)

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organisation (WHO). I further understand that COVID-19 is extremely infectious and is believed to spread by person-to-person contact. As a result, the Scottish Government currently recommend social distancing. I understand that social distancing is not always possible while I am receiving hospital care.

I recognise that all the staff within NHS Lanarkshire are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is still a risk of becoming infected with COVID-19 by proceeding with this treatment/ procedure/ surgery.

I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment/procedure/surgery.

I understand that even if I have been tested for COVID-19 and receive a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID-19 after the test. I understand that if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment/ procedure/ surgery can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before, during or after my treatment/ procedure/ surgery may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalisation that may require medical therapy, Intensive Care treatment and possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. Those with pre-existing health conditions appear to be at a greater risk of significant complication from COVID-19 infection, and I have discussed my risks with my clinician.

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(Document pre-existing conditions below):

.....

.....

.....

.....

.....

In addition, after my elective treatment/ procedure/ surgery, I may need additional care that may require me to go to an emergency department or a hospital.

I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment/ procedure/ surgery itself.

I further understand that my treatment/ procedure/ surgery may be cancelled at short notice due to unexpected changes in the pandemic within NHS Lanarkshire.

I have been given the option to discuss if I can defer my treatment/ procedure/ surgery to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment/ procedure/ surgery.

Clinician's Signature:

Date:

Print Name:

Grade:

Patient's Signature: *McCrae*

Date:

Print Name:

A witness or interpreter should sign below if the patient is unable to sign / speak English but has indicated their consent. Young people / children may also like a parent to sign here.

Witness Signature:

Date

Print Name:

COPY PAGE

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1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumberae Crescent
Coatbridge
Lanarkshire ML5 4PX

University Hospital:

☐ Hairmyres ☒ Monklands ☐ Wishaw

Other:

Ward: Endoscopy

NHS
Lanarkshire

Covid-19

Risk Assessment

Completed by:

Name Danielle McLaren PRINT NAME

Signature Danielle McLaren

Date 10/8/21 Time 10:50

Admissions assessment

Covid-19 test result

♦ Positive: ☐ swab or ☐ sputum? ☐ Not Yet Available
♦ Negative: ☐ swab or ☐ sputum? ☐ Not Undertaken

Covid-19 symptom checker

Tick Yes or No for each of the following. Yes indicates clinical concern.
Patients will be classed as higher risk of Covid-19, if any are ticked Yes.

♦ Unexplained Temperature >37.8°C <u>37</u> ☐ Yes ☒ No	♦ Unexplained reduction in oxygen saturation ☐ Yes ☐ No
♦ Cough ☐ Yes ☒ No	♦ Unexplained low lymphocytes count (i.e. <1) ☐ Yes ☐ No
♦ Headache ☐ Yes ☒ No	♦ CXR Abnormal - if done ☐ Yes ☐ No
♦ Sore Throat ☐ Yes ☒ No	♦ Chest CT Abnormal - if done ☐ Yes ☐ No
♦ Recent shortness of breath ☐ Yes ☒ No	♦ Unexplained Nausea / Vomiting / Diarrhoea / Abdominal pain ☐ Yes ☐ No
♦ Myalgia ☐ Yes ☒ No	
♦ Loss of taste or sense of smell ☐ Yes ☒ No	
♦ Recent close contact with persons with any of the above ☐ Yes ☒ No	♦ Other Clinical Concern e.g. Adult with incapacity ☐ Yes ☐ No

Theatre Assessment

Decision:	☐ Red	☐ Green
Surgeon: Name	Date / /	
Signature	Time :	
Anaesthetist: Name	Date / /	
Signature	Time :	

Renewed decision (after 24 hours):	☐ Red	☐ Green
Surgeon: Name	Date / /	
Signature	Time :	
Anaesthetist: Name	Date / /	
Signature	Time :	



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Department of Haematology
Haematology Secretary 01236 712094
Haematology day unit 01236 712343
Haematology ward 01236 712152

Isabel McCracken
1D Cumbrae Crescent
Coatbridge
ML5 4PX

University Hospital Monklands
Monks court Avenue
Airdrie
ML6 0JS



Date Dictated: 18/08/2021
Date Typed: 18/08/2021
Ref: 100882503
Letter Ref: NJ / CM
CHI Barcode:



Consultant:

Dear Isabel McCracken

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

PHLEBOTOMY SERVICE FOR PATIENTS

To help ensure your bloods are taken in advance of your next appointment, additional Phlebotomy Clinics have been set up in the 3 Hospital Sites. To support this the clinic staff will give/send out your bloods forms to enable you to take them along on the day of your appointment to have bloods taken.

If you require bloods to be taken then please **do not** contact your GP Surgery as an appointment can be made at your nearest Hospital; the service is available at your nearest hospital running **Monday – Friday from 9am – 2pm.**

To help reduce the volume of patients attending at the same time, appointments will be required to be scheduled, therefore can I ask that you call to make an appointment. Please call the hospital site suitable for you to attend on the number below.

- University Hospital Monklands- 01236 712343
- University Hospital Wishaw – 01698 366310
- University Hospital Hairmyres- 01355 584825

The staff will allocate a time within the opening hours above and advise of the area within the hospital to attend. Please bring your blood forms with you.

We also ask for you to attend the appointment on your own and for family or friends who accompany you to remain in the car or outside.

Yours sincerely

Dr Nkemdirim Jacob
ST5 in Haematology
GMC No.6124397

Authorised on 18/08/2021 10:32:39 by Typist Claire Murray, not verified by Consultant.

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[illegible]

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www.nhslanarkshire.org.uk
Department of General Surgery
01236-712142
sDeptinfo
University Hospital Monklands

University Hospital Monklands
Monks court Avenue
Airdrie
ML6 0JS



Dr NS Marcuccilli
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

Date Dictated: 24/08/2021
Date Typed: 27/08/2021
Ref: 2978462
Letter Ref: AJM/AC
Clinic Date: 23/08/2021
CHI Barcode:



Consultant: Mr Michael Martin Dick

Dear Dr Marcuccilli

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbræ Crescent, Coatbridge, ML5 4PX

I reviewed this lady in Mr Dick's clinic today. She had a right hemicolectomy in April complicated by mesenteric thrombosis which she remains on anti-coagulation and is under review by haematology. Most recently they requested a pet CT scan which was done 6 weeks ago to determine whether she could have a malignancy or not. This has not shown any evidence of malignancy.

Mr Dick has been debating a colonoscopy, it may well be, as it will be difficult to give her bowel prep that we accept the pet CT being sufficient to rule out any abnormality. I note that she had some abnormality in her gullet but has had an upper GI endoscopy this year which didn't show any evidence of a cancer.

She is quite keen to get a reversal, I explained that the key element to that is ensuring she is not at risk of a further blood clot and the venous drainage to her bowel is going to be adequate otherwise she is likely to run into a complication. I said that she will obviously need further review to haematology and I will copy this letter to them and we will assess her in 3-month time.

Yours sincerely

Mr Alisdair MacDonald
Consultant Colorectal Surgeon

Authorised on 01/09/2021 10:14:20 by Mr Alisdair MacDonald.

(P) Haematology Consultant on call
Haematology Department
University Hospital Monklands
ML6 0JS

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www.nhslanarkshire.org.uk
Department of Haematology
Unit Secretary: 01236 712099
Day unit: 01236 712343
Inpatients: 01236 712152

University Hospital Monklands
Monks court Avenue
Airdrie
ML6 0JS



Dr NS Marcuccilli
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

Date Dictated: 17/08/2021
Date Typed: 01/09/2021
Ref: 285003
Letter Ref: AI/YA
Clinic Date: 17/08/2021
CHI Barcode:



* 1 8 0 8 7 8 5 1 4 2 *

Consultant: Dr Lindsay Mitchell

Dear Dr Marcuccilli

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbræ Crescent, Coatbridge, ML5 4PX

Reason for referral: Presented with extensive superior mesenteric thrombosis in March 2021
Initially anticoagulated with Warfarin
Readmission with extension of thrombosis despite supra-therapeutic INR
In April 2021
Currently on Tinzaparin
Difficult to establish whether superior mesenteric vein thrombosis was primary
Or secondary event since this was ??? with intra-abdominal infection.
PNH clone negative
Jak 2 negative
Borderline Lupus antigen
Borderline IgM cardiolipin
Inconclusive thrombophilia screen (on anticoagulation)
Bone marrow biopsy showed a population of clonal plasma cells at 10%
Low paraprotein level in April 7.8; now reduced to 2.9.

A recent PET CT showed patchy inflammatory FGD uptake in the right iliac fossa collection which has significantly reduced in size, no evidence of malignancy.

I reviewed Mrs McCracken by telephone on 17th August 2021. I note a very detailed letter from Dr Betts from the beginning of July.

Mrs McCracken has been managing with her Tinzaparin injections well. Over the last 4 weeks she noticed some improvement in how she feels. I now have the results of her PET scan which do not suggest any malignancy. I note that Dr Betts was considering switching Mrs McCracken to Apixaban if her PET scan is normal. She has now completed more than three months of anticoagulation. **I would appreciate if you could substitute Tinzaparin with a prophylactic dose Apixaban (2.5mg BD).** We will review Mrs McCracken in this clinic in four weeks.

Yours sincerely

Dr Andrejs Ivanovs
ST7 in Haematology
GMC No. 7073528

Authorised on 03/09/2021 16:11:46 by Andrejs Ivanovs.

Haematology referral guidance is available at: <http://www.nhslcg.scot.nhs.uk/?cat=100>

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SOUTH GLASGOW HOSPITALS
IMMUNOLOGY REPORT

IMFLC6 Run: 847

(Tel 0141 347 8872/0141 354 9337)

Surname: MCCracken
Forename: ISABEL
DOB/Age: 18.08.78 Sex: Female
CHI/Unit No: 1808785142
Address: 1D CUMBRAE CRESCENT
Details:

Location: Haematology
Wishaw General Hospital
50 Netherton St Wishaw
Lanarkshire Health Board
Requestor: Not known
Ext Labno: 1105982486

Dr C Betts
MK Hiden

SERUM FREE LIGHT CHAINS

	[[CURRENT]]	
Lab Number	B,21.3657909	B,21.3546854
Date/Time collected	27.10.21	06.04.21
Date/Time received	28.10.21 13:54	08.04.21 14:27
Free Kappa mg/L (3.3-19.4)	17.0	45.3
Free Lambda mg/L (5.7-26.3) *	30.5	66.9
K/L ratio (0.26-1.65)	0.56	0.68



RECEIVED IN

05 NOV 2021

LABORATORY DIRECTORATE
WISHAW GENERAL HOSPITAL

Result Comments:

27.10.21 FreeLChain: In renal impairment, K/L ratio may increase to 0.37 - 3.1

Dr NS Marcuccilli
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

Date Dictated: 16/11/2021
Date Typed: 17/11/2021
Ref: 3047988
Letter Ref: IR/SG
Clinic Date: 16/11/2021
CHI Barcode:



Consultant: Nurse Isabell Robertson

Dear Dr Marcuccilli

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

I reviewed this lady again via video call today Tuesday 16th November. I am pleased to see that Mrs McCracken is competently managing her stoma care however disappointingly has had occasional leakages over the last week.

On examination today her ileostomy is healthy although is sitting flush with her peristomal skin. She still has an area of erythema immediate below her stoma. I also noted some undermining on her flange when she removed her pouch.

I have recommended that she use a washer prior to her appliance and also arranged for her to be sent alternative products to try. Mrs McCracken suspects that the leakages are due to her dietary intake. She feels that otherwise her general recovery is progressing well. Her appetite is good and she is mobilising as able. She has been reviewed by Mr Dick and does have a further follow up appointment with him.

I have arranged to review her at the stoma clinic in 4 weeks' time and she has agreed to contact me to inform me whether the new products have resolved the leakage issue.

I shall keep you informed of her progress.

Yours sincerely

I Robertson
Stoma Care Sister

Authorised on 18/11/2021 16:44:04 by Miss Isabell Robertson.

SOUTH GLASGOW HOSPITALS
IMMUNOLOGY REPORT
(Tel 0141 347 8872/0141 354 9337)

Surname: 
Forename: 1808785142
DOB/Age: 18/08/1978
CHI/Unit No: MCCracken F
Address: 1d Cumbræ Crescent Isabel
Details: Coatbridge
Lanarkshire ML5 4PX

Location: Haematology
Wishaw General Hospital
50 Netherton St Wishaw
Lanarkshire Health Board
Requestor: Not known
Ext Labno: 1105982486

Dr C Betts
MK Haden

SERUM FREE LIGHT CHAINS

[[CURRENT]]

Lab Number	B,21.3657909	B,21.3546854
Date/Time collected	27.10.21	06.04.21
Date/Time received	28.10.21 13:54	08.04.21 14:27
Free Kappa mg/L (3.3-19.4)	17.0	45.3
Free Lambda mg/L (5.7-26.3) *	30.5	66.9
K/L ratio (0.26-1.65)	0.56	0.68

PL



LA01

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05 NOV 2021

LABORATORY DIRECTORATE
WISHAW GENERAL HOSPITAL

Result Comments:

27.10.21 FreeLChain: In renal impairment, K/L ratio may increase to 0.37 - 3.1

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1958 MAR 20

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www.nhslanarkshire.org.uk
Department of Haematology
Haematology Secretary 01236 712094
Haematology day unit 01236 712343
Haematology ward 01236 712152

University Hospital Monklands
Monks court Avenue
Airdrie
ML6 0JS



Dr NS Marcuccilli
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

Date Dictated: 19/10/2021
Date Typed: 28/10/2021
Ref: 291741
Letter Ref: CLB / CM
Clinic Date: 19/10/2021
CHI Barcode:



Consultant: Doctor Caroline Louise Betts

Dear Dr Marcuccilli

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbræ Crescent, Coatbridge, ML5 4PX

Diagnosis **Presented with superior mesenteric thrombosis in March 2021.**
Initially anti coagulated with Warfarin but subsequent readmission with extension of thrombosis despite supratherapeutic INR
This cause venous ischemia of her gut requiring limited right hemicolectomy with end ileostomy.
Episode of VRE septicaemia requiring intravenous antibiotics.
Treated with 5 months of treatment dose Tinzaparin now on Apixaban 2.5mg bd
Initial presentation was with thrombocytopenia which then became a thrombocytosis.
Bone marrow aspirate and trephine done to exclude a myeloproliferative neoplasm. This demonstrated a reactive marrow only but there was also a clonal plasma cell population of 10% picked up.
Current IgG paraprotein is 2.9g/l

I reviewed Mrs McCracken by telephone at the haematology clinic on the 19th of October 2021. Thank you for switching her to Apixaban which she has been on for the last couple of weeks. She has not noticed any particular changes with this medication. Unfortunately she had a couple of weeks of diarrhoea which she thinks is related to a bug as her family were also affected. She has some fleeting abdominal pain but is otherwise feeling quite well. Her only other complaint was of some hair loss which I wonder might be related to her Apixaban or possibly might be related to an acute stress response following her illness.

We discussed again that we do not have a particularly good explanation for why she had her venous thrombosis and particularly why she had an extension of it. She has been thoroughly investigated for underlying causes and is known to be JAK 2, CALR and MPL negative. She has had a negative PNH screen and she has had a normal CT PET to look for an occult source of malignancy. She is known to have a positive lupus anticoagulant, but this is all in the context of anticoagulation. She has also had her anticardiolipin antibodies checked and her Beta 2 glycoprotein antibodies checked, all of which are negative. I said to Mrs McCracken on the phone that at the moment I think the best course of action would be to keep her on Apixaban 2.5mg bd. There is also the concern that she probably has a monoclonal gammopathy of uncertain significance as highlighted in her marrow and detectable paraprotein on 2.9g/l. This will obviously need an eye kept on it and therefore we will plan to see her in the haematology clinic on a 3-4 monthly basis. I see she has been reviewed by Mr MacDonald as there is some consideration that they might reverse her stoma. He has some concerns about the venous drainage of her bowel and therefore I think it is probably sensible if we reimagine her abdomen. Her last blood counts were done in July and we will need an updated eGFR for this. I will post her a blood form to have her bloods updated and will plan to catch up with her in 3 months' time.

Yours sincerely

Dr Caroline Betts
Consultant Haematologist
GMC No: 7020077

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Authorised on 13/12/2021 15:23:34 by Dr Caroline Betts.

Haematology referral guidance is available at: <http://www.nhslcg.scot.nhs.uk/?cat=100>

NB: Bloods completely resolved and no evidence of a paraprotein on recent serum electrophoresis.

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Mr Michael Dick
Consultant Colorectal Surgeon
Monklands Hospital
Monkscourt Avenue
Airdrie
ML6 0JS

Date Dictated: 14/12/2021
Date Typed: 15/12/2021
Ref: 3071915
Letter Ref: IR/SG
Clinic Date: 13/12/2021
CHI Barcode:



Consultant:

Dear Mr Dick

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

I reviewed this lady via video call today Tuesday 14th December. I am pleased to see that Mrs McCracken has competently managed her stoma care and experienced no major problems.

On examination today her ileostomy is healthy and her peristomal skin remains intact. She advised me that she changes her pouch every second day however is still at times having to empty her appliance 2 to 3 times overnight. She advised me that she has discussed this with her GP who had obtained a stool specimen and she is taking Loperamide as required. She is aware of potential complications and what to do in the event of any occurring and she will contact her GP should her output remain watery in consistency.

I have arranged for her to be sent larger appliances and arranged to review her again at the stoma clinic in 4 weeks' time. She has agreed to contact me by telephone next week and inform whether the new appliances are more suitable. She also informed me that she is currently awaiting a CT scan and does have a follow up appointment with yourself in March of next year.

Mrs McCracken does know how to contact me should she require to be reviewed earlier. I shall keep you informed of her progress.

Yours sincerely

I Robertson
Stoma Care Sister

Authorised on 16/12/2021 07:37:35 by Miss Isabell Robertson.

(D) Dr NS Marcuccilli
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

Dr NS Marcuccilli
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

Date Dictated: 10/02/2022
Date Typed: 17/02/2022
Ref: 3115059
Letter Ref: IR/SG
Clinic Date: 10/02/2022
CHI Barcode:



* 1 8 0 8 7 8 5 1 4 2 *

Consultant: Nurse Isabell Robertson

Dear Dr Marcuccilli

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbræ Crescent, Coatbridge, ML5 4PX

I reviewed this lady again via video call today Thursday 10th February. I am pleased to see that Mrs McCracken continues to competently manage her stoma care and is experiencing no problems.

On examination today her ileostomy is healthy and her peristomal skin is intact. She advises me that she is still emptying her pouch 3-4 times throughout the day and once overnight. She renews her appliance every second day and informed me that her stoma output continues to be loose at times however she is taking Loperamide. She advised me that she has been having colicky abdominal pain for 3 days however has noticed no change in her stoma output and has not found this to be foul smelling. She is also having no abdominal distention and states that her stoma is functioning normally. I have suggested that she discuss this yourself if it continues. She has both haematology and colorectal follow up appointments and is hoping that Mr Dick will consider reversing her stoma in the near future.

Unfortunately, she did not receive the alternative products prior to Christmas, therefore I have arranged for her to be sent further samples and will review her at the stoma clinic via video call in 2 months' time. She does know how to contact me should she be required to be reviewed earlier or change stoma produces. I shall keep you informed of her progress.

I have suggested
Yours sincerely

I Robertson
Stoma Care Sister

Authorised on 22/02/2022 07:51:10 by Miss Isabell Robertson.

www.nhslanarkshire.org.uk

Department of Haematology
Secretary: 01698 752052
Day Unit: 01698 752042
Inpatients: 01698 752047

Isabel McCracken
1D Cumberae Crescent
Coatbridge
ML5 4PX

University Hospital Monklands
Monks court Avenue
Airdrie
ML6 0JS



Date Dictated: 22/02/2022
Date Typed: 22/02/2022
Ref: 100979406
Letter Ref: LDM/YA
CHI Barcode:



Consultant: Dr Lindsay Mitchell

Dear Isabel McCracken

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumberae Crescent, Coatbridge, ML5 4PX

OUTPATIENT APPOINTMENT – University Hospital Monklands

We regret to inform you that, due to unforeseen circumstances, your outpatient appointment for Monklands Hospital as detailed below has been **cancelled**.

Specialty	Haematology
Consultant	Dr Lindsay Mitchell
Date	23.03.22
Time	16.30

A further appointment will be sent out to you in due course.

We would like to apologise again for any inconvenience this appointment cancellation may cause you.

Yours sincerely

Dr Lindsay D Mitchell
Consultant Haematologist
GMC No: 3491559

Authorised on 22/02/2022 13:21:19 by Typist Yvonne Allison, not verified by Consultant.

COPY PAGE

www.nhslanarkshire.org.uk
Department of General Surgery
01236 748748
sDeptinfo

Monklands Hospital
Monkscourt Avenue
Airdrie
ML6 0JS



Mr Michael Dick
Consultant Colorectal Surgeon
University Hospital Monklands
Monkscourt Avenue
Airdrie
ML6 0JS

Date Dictated: 12/04/2022
Date Typed: 20/04/2022
Ref: 3163414
Letter Ref: TT/JD
CHI Barcode:



Consultant:

Dear Mr Dick

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbræ Crescent, Coatbridge, ML5 4PX

I reviewed this lady via video call today, Tuesday 12/4/22 for her routine follow-up.

As I am sure you are aware, this lady had right hemicolectomy in April 2021. This lady is currently under review by the haematologist as she was found to have a mesenteric thrombosis. I am delighted to see that Mrs McCracken is coping well with her stoma.

On examination her ileostomy is healthy and her peristomal skin is intact. The output is still variable and can sometimes be high and she manages this by adjusting her dose of Loperamide. On average, she empties her appliance approximately three times per day and is up at least twice overnight. Although Mrs McCracken is able to competently manage her stoma care, she is very keen to discuss reversal surgery.

As she is now a year post-op, I have not arranged any routine follow-up with ourselves, however she has our direct dial number and I will happily review her in the future should this be necessary.

Yours sincerely

Tracy Tallo
Stoma Care Nurse

Authorised on 21/04/2022 14:54:10 by Tracy Tallo.

(D) Dr NS Marcuccilli
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

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www.nhslanarkshire.org.uk
Department of General Surgery
01698 752155
General Surgery

Monklands Hospital
Monks court Avenue
Airdrie
ML6 0JS



Dr NS Marcuccilli
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

Date Dictated: 20/07/2022
Date Typed: 21/07/2022
Ref: 3240068
Letter Ref: MD/AD
Clinic Date: 20/07/2022
CHI Barcode:



Consultant: Mr Michael Martin Dick

Dear Dr Marcuccilli

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

I reviewed this lady back in the clinic today, she is doing very well. We discussed that she had been investigated by the Haematologists and they couldn't find an obvious cause for her mesenteric thrombosis. She remains on apixaban at present. She has had a CT PET scan and an upper GI endoscopy last year which don't show any evidence of any malignancy anywhere.

We discussed about reversal of her stoma which she is quite keen for. I explained to her that we would need to take her off her apixaban, give her a general anaesthetic and perform a laparotomy with anastomosis. An anastomotic leak rate is usually about 5% and if this were to occur and she may become unwell and require further surgery (most likely requiring a further stoma and admission to ICU). I also explained that it is quite difficult to quantify risks for her given that we are uncertain why she has developed mesenteric thrombosis and that by coming off apixaban there is a risk that she could develop further thrombosis and have another mesenteric ischemic or infarction of her small bowel related to this which potentially could be life threatening.

When presented with the risks today she is happy to delay or postpone any surgery in terms of intervention. I did also offer her the opportunity of a second opinion if she was wishing to proceed immediately to reversal.

On balance I think she is beginning to manage her stoma and appreciates the risks involved with reversal and would prefer to leave things along at present. I have arranged to see her back in a year's time.

Yours sincerely

Mr Michael Dick
Consultant Colorectal Surgeon

Authorised on 22/08/2022 11:08:09 by Michael Dick.

(P) Dr L Mitchell
Consultant Haematologist
University Hospital Monklands
Monks court Avenue
Airdrie
ML6 0JS

(P) Tracy Tallo

COPY PAGE

Stoma Care Department
Ward 7
University Hospital Monklands
Monkscourt Avenue
ML6 0JS

C099



www.nhs.uk
 Department of General Surgery
 01698 752155
 General Surgery

Monklands Hospital
 Monks court Avenue
 Airdrie
 ML6 0JS

Dr NS Marcuccilli
 Waverley Medical Practice
 Coatbridge Health Centre
 1 Centre Park Court
 Coatbridge
 ML5 3AP

Date Dictated: 20/07/2022
 Date Typed: 21/07/2022
 Ref: 3240068
 Letter Ref: MD/AD
 Clinic Date: 20/07/2022
 CHI Barcode:



* 1 8 0 8 7 8 5 1 4 2 *

Consultant: Mr Michael Martin Dick

Dear Dr Marcuccilli

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

I reviewed this lady back in the clinic today, she is doing very well. We discussed that she had been investigated by the Haematologists and they couldn't find an obvious cause for her mesenteric thrombosis. She remains on apixaban at present. She has had a CT PET scan and an upper GI endoscopy last year which don't show any evidence of any malignancy anywhere.

We discussed about reversal of her stoma which she is quite keen for. I explained to her that we would need to take her off her apixaban, give her a general anaesthetic and perform a laparotomy with anastomosis. An anastomotic leak rate is usually about 5% and if this were to occur and she may become unwell and require further surgery (most likely requiring a further stoma and admission to ICU). I also explained that it is quite difficult to quantify risks for her given that we are uncertain why she has developed mesenteric thrombosis and that by coming off apixaban there is a risk that she could develop further thrombosis and have another mesenteric ischemic or infarction of her small bowel related to this which potentially could be life threatening.

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On balance I think she is beginning to manage her stoma and appreciates the risks involved with reversal and would prefer to leave things along at present. I have arranged to see her back in a years' time.

Yours sincerely

Mr Michael Dick
 Consultant Colorectal Surgeon

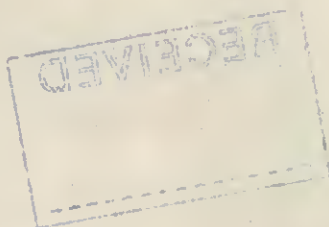
Authorised on 22/08/2022 11:08:09 by Michael Dick.

(P) Dr L Mitchell
 Consultant Haematologist
 University Hospital Monklands
 Monks court Avenue
 Airdrie
 ML6 0JS



(P) Tracy Tallo
 Stoma Care Department
 Ward 7
 Monklands

COPY PAGE

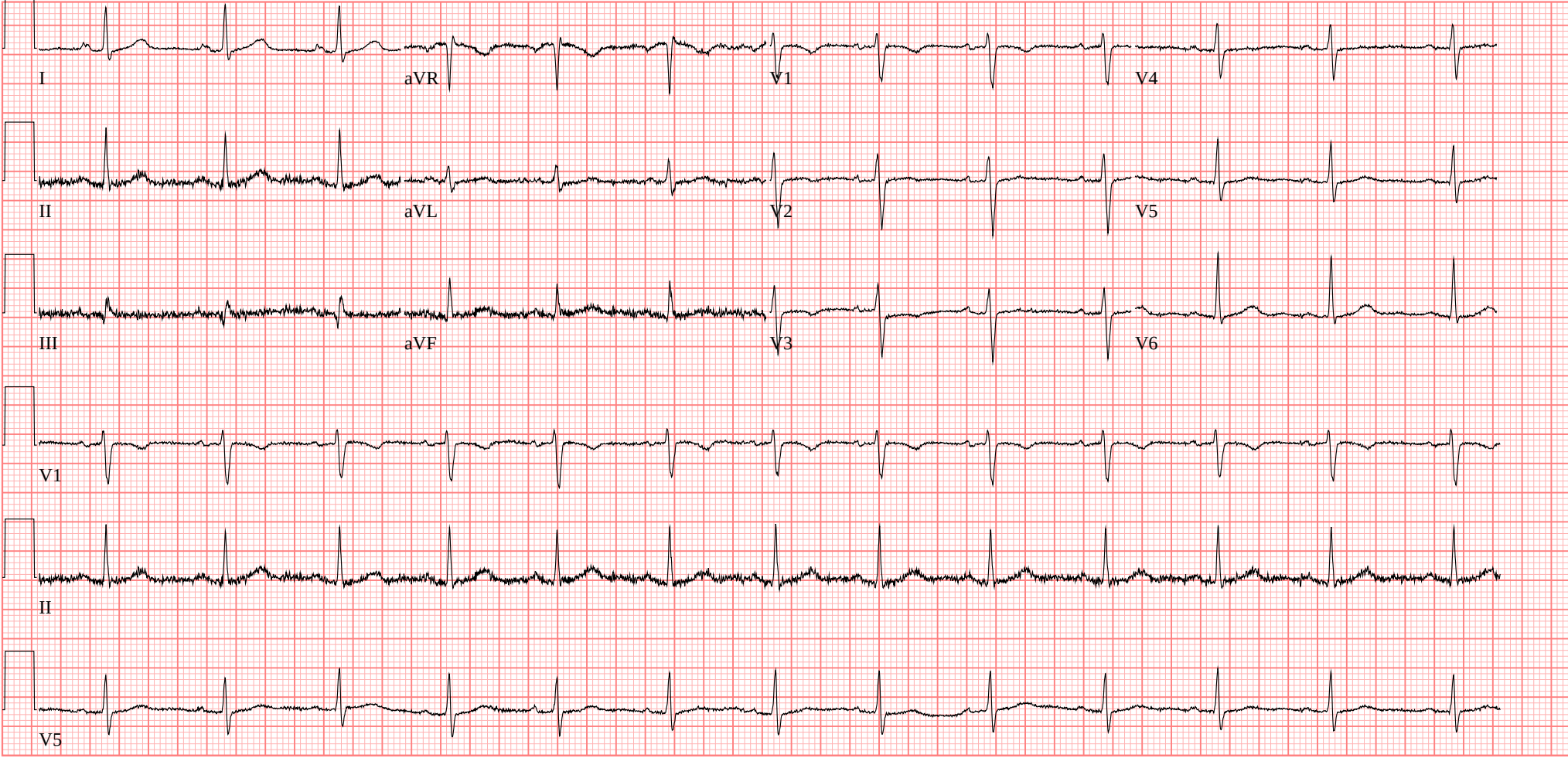


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Technician:
Test ind:

Location:

Unconfirmed



Episode: E0002369488
Date: 14/12/2022
Time: 13:01

University Hospital Monklands
EMERGENCY DEPARTMENT



Surname:	McCracken	Forename:	Isabel	Triage Category
CHI No:	1808785142	Age:	44y	
Address:	1d Cumbrae Crescent	Date of Birth:	18/08/1978	
	Coatbridge	Gender:	Female	
	Lanarkshire	Referred by:	Self referral	
Postcode:	ML5 4PX			
Telephone:	07305387304			

G.P.:	NS Marcuccilli	G.P. Telephone No.:	01236 422311
G.P. Address: Waverley Medical Practice Coatbridge Health Centre 1 Centre Park Court Coatbridge Coatbridge ML5 3AP			

Presenting Complaint: ~~head injury 2/09~~ on blood thinners, ~~headaches~~, sweats, nausea *UNWELL*
Stomach Problem

Vital Signs		Glasgow Coma Scale		Urinalysis	
Temperature		Eye Opening		Glucose	
Pulse		Verbal Response		Ketones	
Resp. Rate		Motor Response		Specific Gravity	1.030
Systolic BP		GCS Score		Blood	Trace
Diastolic BP				pH	6
Mean Arterial Pressure				Proteins	Trace
SpO2				Nitrates	
FiO2				Leucocytes	
Peak Flow					
Exp. Peak Flow					

Visual Acuity		Pupil	
Visual Acuity (Right)		Pupil Size (Right)	
Visual Acuity (Left)		Pupil Reactivity (Right)	
With Correction		Pupil Size (Left)	
		Pupil Reactivity (Left)	

Blood Glucose	
Pain Score	
Tetanus Cover	
Tetanus Date	
MEWS Score	
CEWS Score	

Height	
Weight	
Fast	



14/12/27

15:10

EUSE CANTFIELD (FNU).

44
♀
PL: ① HI September. Headaches since.

② 3x shooting CPs this morning.

③ General malaise. Feeling hot + cold. Vomiting 3/7. Watery stool in stoma bag.

HPL: ① HI. Fell forwards carrying grandson. Nil preceding dx. Hit forehead on floor. Nil lacerations/other injury.

Felt okay after but 3/7 headache - throbbing on top of head.

Similar episode this morning + vomit.

② 3x shooting CP in quick succession this morning. No more. Over @ side of ribs. Not pleuritic. Severe. Nil associated dx.

③ Feeling hot + cold for 3-4/7. Associated with nausea + vomiting (1x this AM. 3x yesterday). "Watery". No haematemesis. Stoma output normally like chocolate porridge but much more watery over past few days.

PMH: EUPD.

Extensive superior mesenteric vein thrombosis (apixaban)

② haemolysis (2011) - unknown

PH: NEWS

Paracetamol - diltiazem - ran.

SH: ①.

Lives with son.

Mild alcohol.

Smokes ~20 puffs of cannabis / day (!!).

OE: NEWS 0.

clear.

W111110.

COPY PAGE

1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumbrae Crescent
Coatbridge
Lanarkshire ML5 4PX

 0 = No pain
 1 = Mild pain
 2 = Moderate pain
 3 = Severe pain
 4 = Excruciating/
Worst pain
imaginable

Hospital: mm
Ward: 30

NEWS Chart

Record head injury observations over page

[illegible]

Head Injury Observations	
1	2
3	4
5	6
7	8
9	10
11	12
13	14
15	16
17	18
19	20
21	22
23	24
25	26
27	28
29	30
31	32
33	34
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37	38
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47	48
49	50
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59	60
61	62
63	64
65	66
67	68
69	70
71	72
73	74
75	76
77	78
79	80
81	82
83	84
85	86
87	88
89	90
91	92
93	94
95	96
97	98
99	100

Glasgow Coma Scale (GCS)	Date:														
	Time:														
	Frequency:														
	Frequency change initials:														
EYES Open	Spontaneous	4													Eyes closed by swelling = C
	To Sound	3													
	To Pressure	2													
	None	1													
	Non testable	NT													
Best VERBAL Response	Orientated	5													Endo-tracheal tube or Trach-eostomy = T
	Confused	4													
	Words	3													
	Sounds	2													
	None	1													
	Non testable	NT													
Best MOTOR Response	Obeys commands	6													Usually record the best arm response
	Localising	5													
	Normal flexion	4													
	Abnormal flexion	3													
	Extension	2													
	None	1													
Non testable		NT													
TOTAL: (/15)															

•	1	Pupils	Right	Size															S sluggish + reacts - no reaction C eyes closed	
•	2			Reaction																
	3		Left	Size																
	4			Reaction																
	5	L I M B M O V E M E N T	A R M S	Normal power															Record right (R) and left (L) separately if there is a difference between the two side	
	6			Mild weakness																
	7			Severe weakness																
	8			Spastic flexion																
				Extension																
			No response																	
			L E G S	Normal power																
				Mild weakness																
				Severe weakness																
				Extension																
		No response																		
				Initials:																

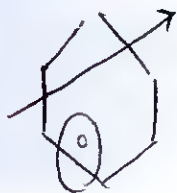
4AT Assessment Tool (screening for Cognitive Impairment and Delirium) - complete for over 65s as required	Score
1. Alertness – This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating. - Normal (fully alert, but not agitated, throughout assessment) - Mild sleepiness for <10 seconds after waking, then normal - Clearly abnormal	0 0 4
2. AMT4 – Ask the patient: age, date of birth, place (name of hospital or building), current year - No mistakes - 1 mistake - 2 or more mistakes/untestable	0 1 2
3. Attention – Ask the patient: ‘Please tell me the months of the year in backwards order, starting at December.’ To assist initial understanding one prompt of, ‘What is the month before December?’ is permitted. - Achieves 7 months or more correctly - Starts but scores <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 (e.g. paranoia, hallucinations) arising over the last 2 weeks and still evident in the last 24 hours. - No - Yes	0 4

Date: _____ **Time:** _____ **Initials:** _____ **4AT TOTAL SCORE:** _____

4AT Score: _____

4 or above: Possible delirium + / - cognitive impairment.

0: Delirium or severe cognitive impairment unlikely (but delirium still possible if (4) information incomplete)



SNT.

BS+.

stoma active - stool in bag. not overly watery

HT SNT.
symmetries.

Urine in foil bowl
by bedside - dark but
good volume.

IMP: ? infection ? migraines element following H1.

PLAN: Bloods

CXR.

Uti

Dipstick + MSSU is (+) re.

OLW series thereafter ? need for further
imaging

→ advised not for
CThead

UPDATE:
18:00

OLW out again

CXR NAD

Uti NAD

Dipstick no infection

Feels well.

Worsening advice
given



CLONFLOR (PWL)

CLONFLOR
(PWL)

1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumbrae Crescent

Coatbridge
Lanarkshire

ML5 4PX

Siemens
Clinitek Status®

Serial Number: 53596

Patient Name: CDU

Patient ID: 1540

Clinitek® hCG
Lot Number 080923

Expiration date 2023-09-30

Test date 12-14-2022
Time 4:31PM

Operator SGM
Test number 4460

hCG Negative

COPY PAGE

STICK INSERTS HERE

RESULTS

H+	Hb	PT	Na	ALT	Calcium		Troponin
PO2	WBC	INR	K	ALP	Adj. Calcium	CRP	Paracetamol
PCO2	Platelets	APTT	Cl	Bilirubin	Magnesium	CK	Salicylate
Bicarb		APTT _r	Bicarb	Albumin	Globulin	Amylase	Ethanol
BE	COHb	Fibrinogen	Urea	AST	T. Protein		
O2 Sat	Lactate		Creatinine	GGT			BHGG

180878514
18/08/1977
MCCRACKEN
Cumber
-dose
-atbr l d g
-anarkshi

ED PRESCRIPTION

Date	Drug	Dose	Route	Time	Signature	Given By	Checked By	Time

DISCHARGE PRESCRIPTION

Date	Drug	Dose	Route	Time	Signature	Given By	Checked By	Time

INJURY SURVEILLANCE

For all assaults please record the following data

Date and time of assault: _____

Specific Location: _____

Type of Location:	✓	Assailant	✓	Weapon	✓	Alcohol / Drug Involvement	✓
Bar / Pub		Spouse / Partner		Body Part		Drugs	
Club		Ex Partner		Knife		Alcohol	
Street		Relative		Glass		Both	
Workplace		Friend / Acquaintance		Bottle		None	
Own Home		Bouncer		Firearm		Unknown	
Other Home		Stranger		Blunt Object			
Other Place		Customer / Client		Other / Unknown			
		Other / Unknown					

I am leaving the Emergency Department today against the advice of the doctor responsible for my care.
I have been advised that unless I continue to receive the treatment recommended by the Medical Staff my prospect of improvement or recovery may be prejudiced.

My reason for leaving is:

Signed _____ Date _____ Time _____

Witness _____ Status _____ Date _____ Time _____

Vent. rate 78 BPM
PR interval 166 ms
QRS duration 78 ms
QT/QTc-Baz 368/419 ms
P-R-T axes 15 46 46

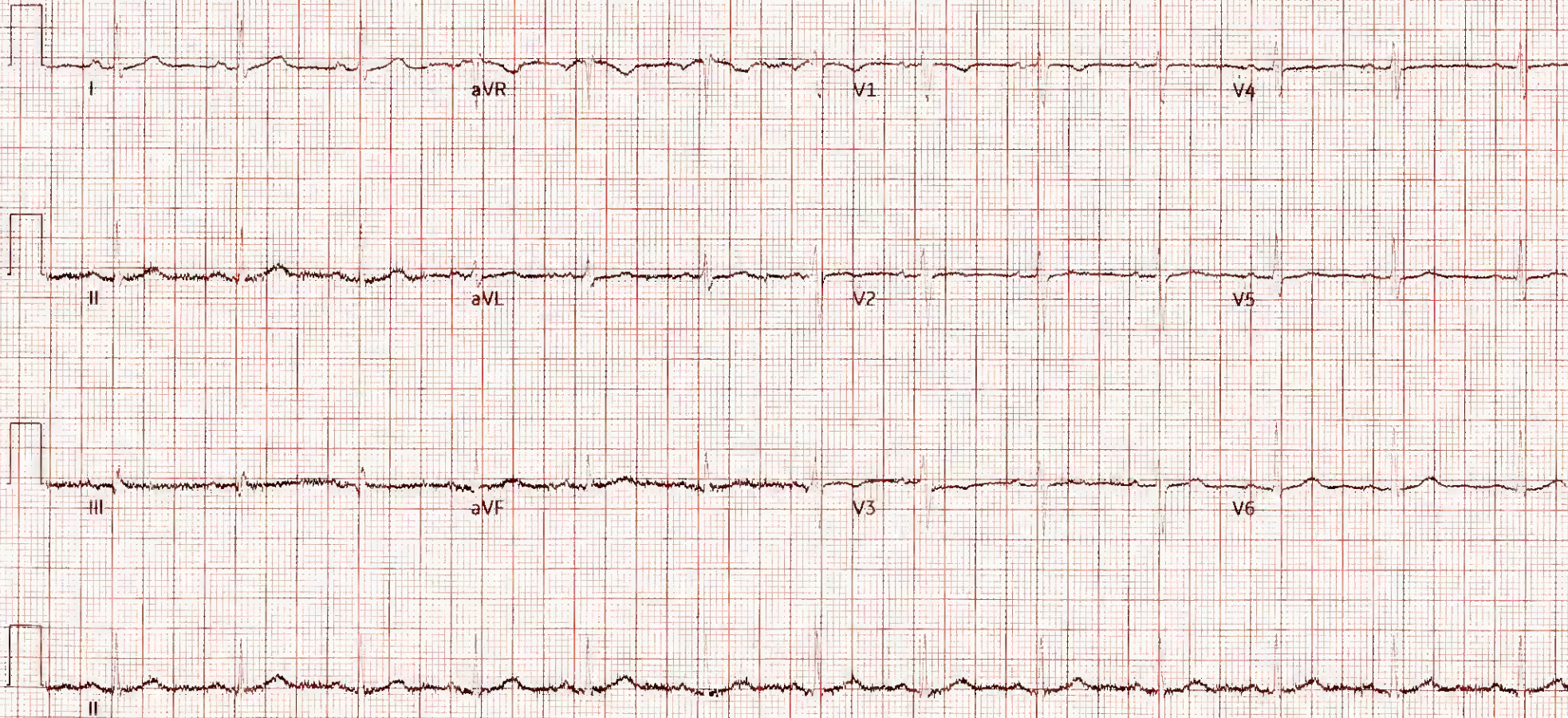
Patient ID: 1808785142
Normal sinus rhythm
Nonspecific T wave abnormality
Abnormal ECG

14.12.2022 16:35:55
Monklands Hospital

Location:

CEMEX

Unconfirmed



www.nhslanarkshire.org.uk
Department of General Surgery
01236 748748
sDeptinfo

University Hospital Monklands
Monks court Avenue
Airdrie
ML6 0JS



Dr NS Marcuccilli
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

Date Dictated: 14/02/2023
Date Typed: 21/02/2023
Ref: 3410703
Letter Ref: TT/JD
CHI Barcode:



Consultant: Nurse Tracy Tallo

Dear Dr Marcuccilli

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

I reviewed this lady at the stoma clinic today, Tuesday 14/2/23, following a self-referral.

Mrs McCracken has been experiencing regular leakages from her appliance. She states that she tried using washers however these did not resolve the issues with leakage.

On examination today her ileostomy is flush with her skin, her peristomal skin is intact. There is an area of discoloration but I believe this is due to the deep convexity appliance. I feel that her stoma has changed shape and size since last clinic review and I have created a new template for her. I have advised her to discontinue using the washer and just try the new template. I have also suggested that she may benefit from using a belt.

I have arranged a telephone consultation next week and I will review her again at the stoma clinic should this be necessary.

Yours sincerely

Tracy Tallo
Stoma Care Nurse

Authorised on 21/02/2023 16:01:51 by Tracy Tallo.

COPY PAGE



1808785142
18/08/1978 F
MCCRACKEN Isabel
1d Cumbrae Crescent
Coatbridge
Lanarkshire ML5 4PX



S O U T H G L A S G O W H O S P I T A L S

I M M U N O L O G Y R E P O R T

IMFLC6 Run: 256

(Tel 0141 347 8872/0141 354 9337)

Surname: MCCRACKEN	Location: Haematology
Forename: ISABEL	Wishaw General Hospital
DOB/Age: 18.08.78 Sex: Female	50 Netherton St Wishaw
CHI/Unit No: 1808785142	Lanarkshire Health Board
Address: 1D CUMBRAE CRESCENT	Requestor: Not known
Details:	Ext Labno: 3077212238

SERUM FREE LIGHT CHAINS

[[CURRENT]]

Lab Number	B,23.3628427	B,21.3657909	B,21.3546854
Date/Time collected	14.07.23	27.10.21	06.04.21
Date/Time received	18.07.23 12:21	28.10.21 13:54	08.04.21 14:27
 Free Kappa mg/L (3.3-19.4)	 18.9	 17.0	 45.3
Free Lambda mg/L (5.7-26.3) *	29.4	30.5	66.9
K/L ratio (0.26-1.65)	0.64	0.56	0.68



Result Comments:

14.07.23 FreeLChain: In renal impairment, K/L ratio may increase to 0.37 - 3.1
 Antigen excess rare but cannot be excluded. If results do not agree
 with clinical/lab findings, contact Immunology on 0141 347 8872

Dr. El-Abdulla
Imm Haem OPD

RECEIVED IN
 24 JUL 2023

Date reported: 20.07.23

Authoriser: Nadia Shahid IMM

LABORATORY DIRECTORATE
 WISHAW GENERAL HOSPITAL

COPY PAGE

www.nhslanarkshire.org.uk

Department of Haematology
Secretary: 01698 752050
Day Unit: 01698 752042
Ward 16: 01698 752047

University Hospital
Monklands
Monkscourt Avenue
Airdrie
ML6 0JS



Isabel McCracken
1D Cumbrae Crescent
Coatbridge
ML5 4PX

Date Dictated: 03/07/2023
Date Typed: 22/07/2023
Ref: 359383
Letter Ref: MEA / KMc
Clinic Date: 03/07/2023
CHI Barcode:



* 1 8 0 8 7 8 5 1 4 2 *

Consultant: Dr Mohammed Khaled El-Abdulla

Dear Isabel McCracken

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

I tried to contact you today via your mobile (07305387304) to carry out a telephone consultation. Unfortunately, you were not available and I have left a voicemail. I cannot see any updated bloods on our system and I am therefore sending you a blood form and would be most grateful if you could attend your GP surgery to have these checked as soon as possible. I will reschedule your telephone appointment for 2 months time.

Yours sincerely

Dr Mohammed El-Abdulla
University Hospital Monklands
Haematology
GMC 5207273

Authorised on 25/07/2023 13:55:16 by Dr Mohammed El-Abdulla.

(D) Dr SA Connolly
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

COPY PAGE

SOUTH GLASGOW HOSPITALS
IMMUNOLOGY REPORT
(Tel 0141 347 8872/0141 354 9337)

INPLC6 Run: 256

Surname:
Forename:
DOB/Age:
CHI/Unit No:
Address:
Details:

1808785142
18/08/1978 F
MCCRACKEN, Isabel
1d Cumberae Crescent, Coatbridge,
Lanarkshire

Location: Haematology
Wishaw General Hospital
50 Netherton St Wishaw
Lanarkshire Health Board
Requestor: Not known
Ext Labno: 3077212238

MLS 4PX

SERUM FREE LIGHT CHAINS

[[CURRENT]]

Lab Number	B,23.3628427	B,21.3657909	B,21.3546854
Date/Time collected	14.07.23	27.10.21	06.04.21
Date/Time received	18.07.23 12:21	28.10.21 13:54	08.04.21 14:27
Free Kappa mg/L (3.3-19.4)	18.9	17.0	45.3
Free Lambda mg/L (5.7-26.3) *	29.4	30.5	66.9
K/L ratio (0.26-1.65)	0.64	0.56	0.68

[Handwritten signature]



LA01

Result Comments:

14.07.23 FreeLChain: In renal impairment, K/L ratio may increase to 0.37 - 3.1
Antigen excess rare but cannot be excluded. If results do not agree
with clinical/lab findings, contact Immunology on 0141 347 8872

Dr. El-Abdulla
Wishaw Haem OPD

RECEIVED IN

24 JUL 2023

Date reported: 20.07.23

Authoriser: Nadia Shahid IMM

LABORATORY DIRECTORATE
WISHAW GENERAL HOSPITAL

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WISHAW GENERAL HOSPITAL
LABORATORY DIRECTORATE

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www.nhslanarkshire.org.uk
Department of General Surgery
01698 752155
General Surgery
Monklands Hospital

University Hospital
Monklands
Monks court Avenue
Airdrie
ML6 0JS



Dr I Roiatti
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

Date Dictated: 28/08/2023
Date Typed: 29/08/2023
Ref: 3569452
Letter Ref: MD/GM
Clinic Date: 28/08/2023
CHI Barcode:



Consultant: Mr Michael Martin Dick

Dear Dr Roiatti

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

I reviewed this lady back in clinic today.

She is managing well with her stoma as supported by the stoma nurses. We discussed again the possibility of reversal but given the extensive thrombus before and she would have to come off her Apixaban for any operation then she is happy just to leave things at present.

I will see her back in clinic in one years time and we can reassess things.

Yours sincerely

Mr Michael Dick
Consultant Colorectal Surgeon (University Hospitals Monklands and Hairmyres)
Honorary Clinical Associate Professor (University of Glasgow)

Authorised on 04/09/2023 09:27:23 by Michael Dick.

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Dr I Roiatti
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

Date Dictated: 12/09/2023
Date Typed: 13/09/2023
Ref: 367326
Letter Ref: FJ/CLB/VW
Clinic Date: 12/09/2023
CHI Barcode:



Consultant: Doctor Caroline Louise Betts

Dear Dr Roiatti

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

Diagnoses: Presented with superior mesenteric thrombosis in March 2021.
Initially anti-coagulated with Warfarin but subsequent readmission with extension of thrombosis despite serotherapeutic INR
This cause venous ischemia of her gut requiring limited right hemicolectomy with end ileostomy.
Episode of VRE septicaemia requiring intravenous antibiotics.
Treated with 5 months of treatment dose Tinzaparin now on Apixaban 2.5mg bd
Initial presentation was with thrombocytopenia which then became a thrombocytosis.
Bone marrow aspirate and trephine done to exclude a myeloproliferative neoplasm. This demonstrated a reactive marrow only but there was also a clonal plasma cell population of 10% picked up.
Current IgG paraprotein not detected

Bloods 14/7/23: Hb 149 Plat 231 WCC 8.9 Neut 5.4 Serum free light chains – free kappa 18.9
Free lambda 29.4 – K/L ratio 0.64. No paraprotein detected from sample of 14/7/23.

I had a telephone consultation with this lady on the 12 September, 2023.

She is well and does not report any new symptoms. I have explained to her the paraprotein previously detected in her blood IgG paraprotein is not detectable. Her renal function and calcium are normal and there is no evidence of disease progression of her MGUS. It seems to be she doesn't know anything about MGUS so I will send her a leaflet about this. We will do a further telephone assessment in four months' time.

Yours sincerely

Dr Mohammed El-Abdulla
University Hospital Monklands
Haematology
GMC 5207273

Authorised on 15/09/2023 15:23:56 by Dr Mohammed El-Abdulla.

<https://nhslguidelines.scot.nhs.uk/referral-pathways/haematology-referral-pathways/>

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Isabel McCracken
1D Cumbrae Crescent
Coatbridge
ML5 4PX

Date Dictated: 08/01/2024
Date Typed: 08/01/2024
Ref: 101405589
Letter Ref: CLB / KMc
CHI Barcode:



Consultant: Dr Caroline Betts

Dear Isabel McCracken

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

OUTPATIENT APPOINTMENT – University Hospital Monklands

We regret to inform you that, due to unforeseen circumstances, your outpatient appointment for Monklands Hospital as detailed below has been cancelled.

Specialty	Haematology
Consultant	Dr Caroline Betts
Date	30.01.24
Time	11.45

A further appointment will be sent out to you in due course.

If transport has been requested for this appointment you will be required to contact Scottish Ambulance Service on **0300 123 1236** to cancel.

We would like to apologise again for any inconvenience this appointment cancellation may cause you.

Yours sincerely

Dr Caroline Betts
Consultant Haematologist
GMC No: 7020077

Authorised on 08/01/2024 13:07:48 by Typist Karen McGuire, not verified by Consultant.

www.nhslanarkshire.org.uk
Department of General Surgery
01236 748748
sDeptinfo

University Hospital
Monklands
Monkscourt Avenue
Airdrie
ML6 0JS



Dr I Roiatti
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

Date Dictated: 27/02/2024
Date Typed: 29/02/2024
Ref: 3730274
Letter Ref: TT/JD
CHI Barcode:



Consultant: Nurse Tracy Tallo

Dear Dr Roiatti

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

I reviewed this lady at the stoma clinic today, Tuesday 27/2/24, following a self-referral.

Ms McCracken was concerned regarding an excoriated area on her peristomal skin and she had been having some leakages from her appliance.

On examination today her ileostomy is healthy although remains flush with her skin. There is an area of discoloration, however I feel this is due to the convexity appliance. There certainly was no signs of any broken areas.

Today I have changed the cutting of the aperture and created a new template and hopefully this will resolve the issues with leakages. If not, I have advised Ms McCracken to contact us for further review.

She did mention that she has had a feeling of pressure PR. I advised her to discuss this with a view to prescribing a micro enema or suppositories, if you felt this appropriate.

Yours sincerely

Tracy Tallo
Stoma Care Nurse

Authorised on 12/03/2024 13:01:17 by Tracy Tallo.

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Department of General Surgery
01236-712142
sDeptinfo
University Hospital Monklands

University Hospital
Monklands
Monkscourt Avenue
Airdrie
ML6 0JS



Dr C McDowall
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

Date Dictated: 18/03/2024
Date Typed: 04/04/2024
Ref: 3747743
Letter Ref: AC
Clinic Date: 18/03/2024
CHI Barcode:



Consultant: Mr Nusrat Rasool Cheema

Dear Dr McDowall

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

Presenting complaint: Nausea, vomiting and discomfort while having food

Past medical history: Laparotomy for SMV thrombosis in 2021 which required right hemicolectomy and ileostomy, cannabis smoker and personality order.

Management plan: Gastroscopy

Thank you for referring this lady to the surgical clinic where I reviewed her today in a telephone consultation. She has been having symptoms of upper abdominal discomfort and vomiting and gastroesophageal reflux for four months. She denies any history of weight loss or changes in her bowel habits. Gastroscopy three years ago shows inflammation only.

I have advised Isabell to stop smoking as its can cause irritation to stomach along other other side effects.

I have requested gastroscopy to investigate these symptoms, Isabell has kindly agreed to this plan. She will be reviewed in the outpatient clinic following the results of these investigations.

Yours sincerely

Nusrat Cheema
Locum Consultant in General Surgery

Authorised on 17/04/2024 16:33:41 by Mr Nusrat Cheema.

COPY PAGE

NHS Lanarkshire
Monklands Hospital
GASTROSCOPY REPORT

Name: **Isabel MCCracken (F)**
Date of birth: **18/08/1978**
NHS No: **1808785142**
Case Note No: **1808785142**

Address: **1d Cumbrae Crescent**
Coatbridge
Lanarkshire
ML5 4PX

GP: **Dr I Roiatti**
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge

Procedure date: **3rd June 2024 (16:18)**
Priority: **Urgent**
Hospital: **Monklands Hospital**
Ward: **(none)**
Referring Cons: **Mr Nusrat Cheema**

Indications

Clinically important comments: Upper abdominal discomfort, nausea and vomiting
Recently seen in a surgical clinic - advised to stop smoking
Not been on PPI (hadn't noticed any symptom benefit and was concerned about interactions with her B12 injection - saw this on TikTok).

Report

The scope was retroflexed in the stomach.
The procedure was completed successfully to D2. The whole upper gastro-intestinal tract was normal.

Site d: Antrum

Specimens: Urease test for H.pylori.

Advice/Comments

Nil of concern seen within the visualised upper GI tract
Not been taking PPI so CLO test taken - please offer eradication if positive
Otherwise advice per clinic letter stands (consider smoking cessation, including cannabis)
Can resume Apixaban tomorrow

Follow up

Return to the GI surgeon.

Consultant/Endoscopist

Dr Adam Wimpres
Nurses: SN Angela McArthur, RN
staff nurse gillian canavan

Instrument

MK - GIF-HQ290 - 2857410

Premedication

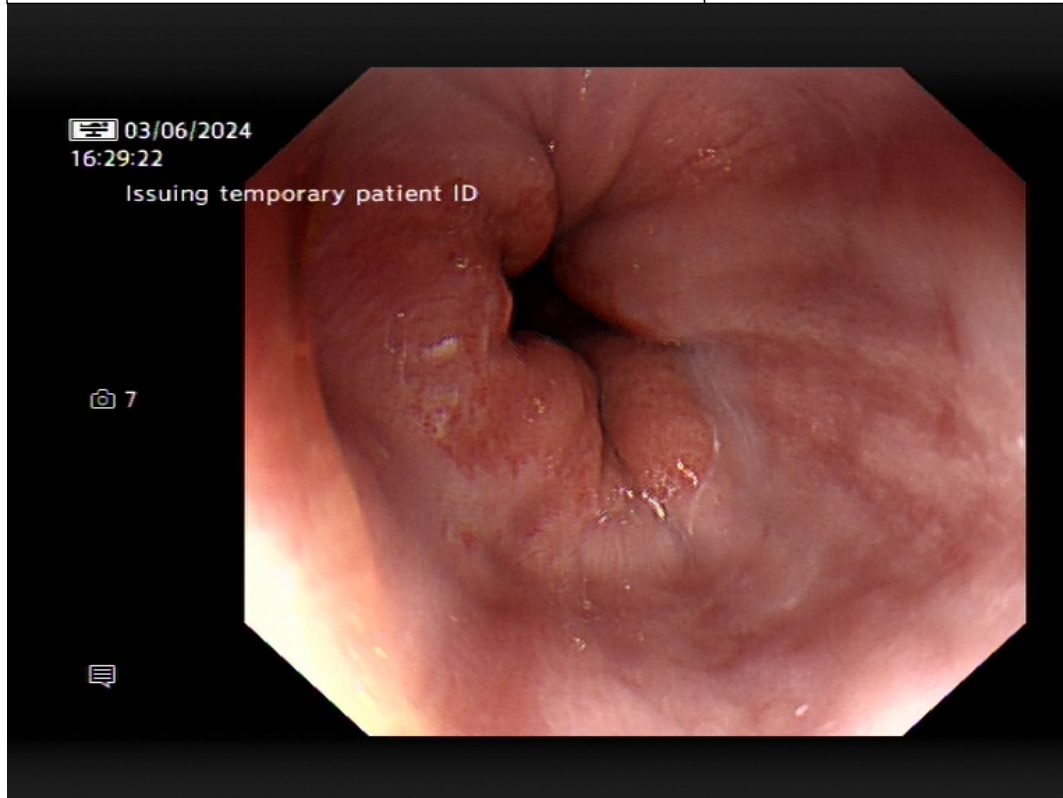
Xylocaine (Spray) 100 mg

Dr Adam Wimpres

Specialty Doctor in Gastroenterology

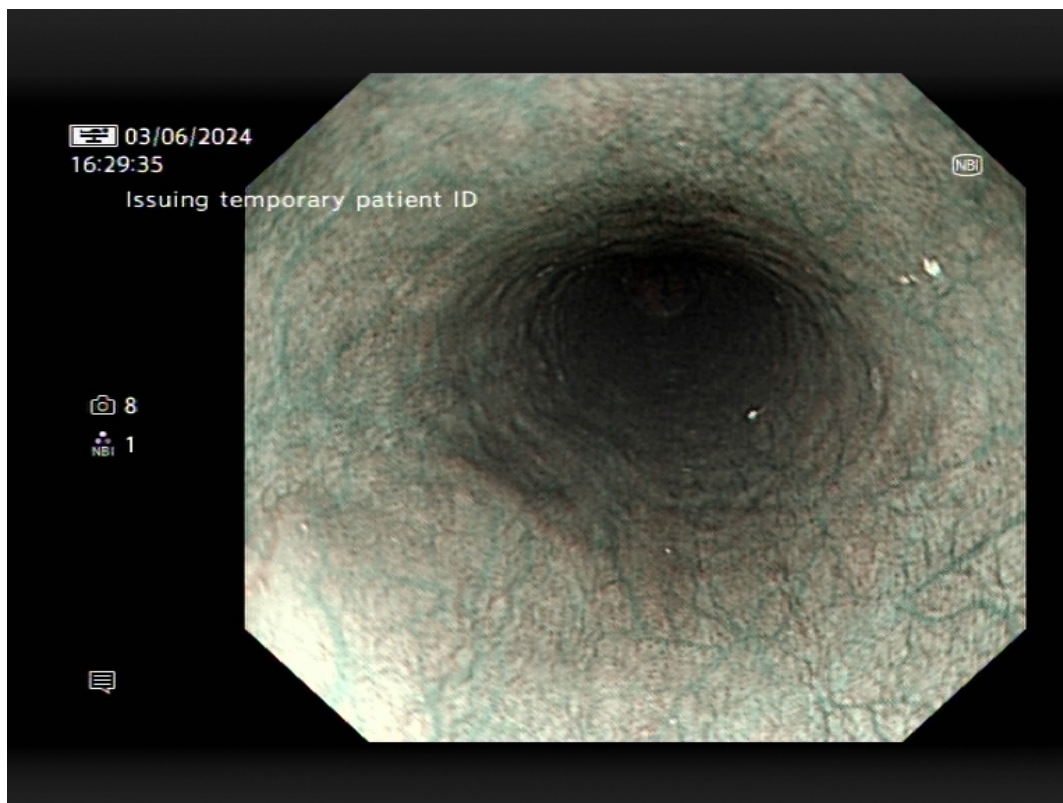
c.c. Mr Nusrat Cheema (Monklands surgeons)
McCracken, Isabel

Name:	Isabel MCCRACKEN, 1978-08-18 (F)	Address:	1d Cumbrae Crescent
CHI No:	1808785142		Coatbridge
Case Note No:	1808785142		Lanarkshire
			ML5 4PX



Lower oesophagus_1

Name:	Isabel MCCRACKEN, 1978-08-18 (F)	Address:	1d Cumbrae Crescent Coatbridge Lanarkshire ML5 4PX
CHI No:	1808785142		
Case Note No:	1808785142		



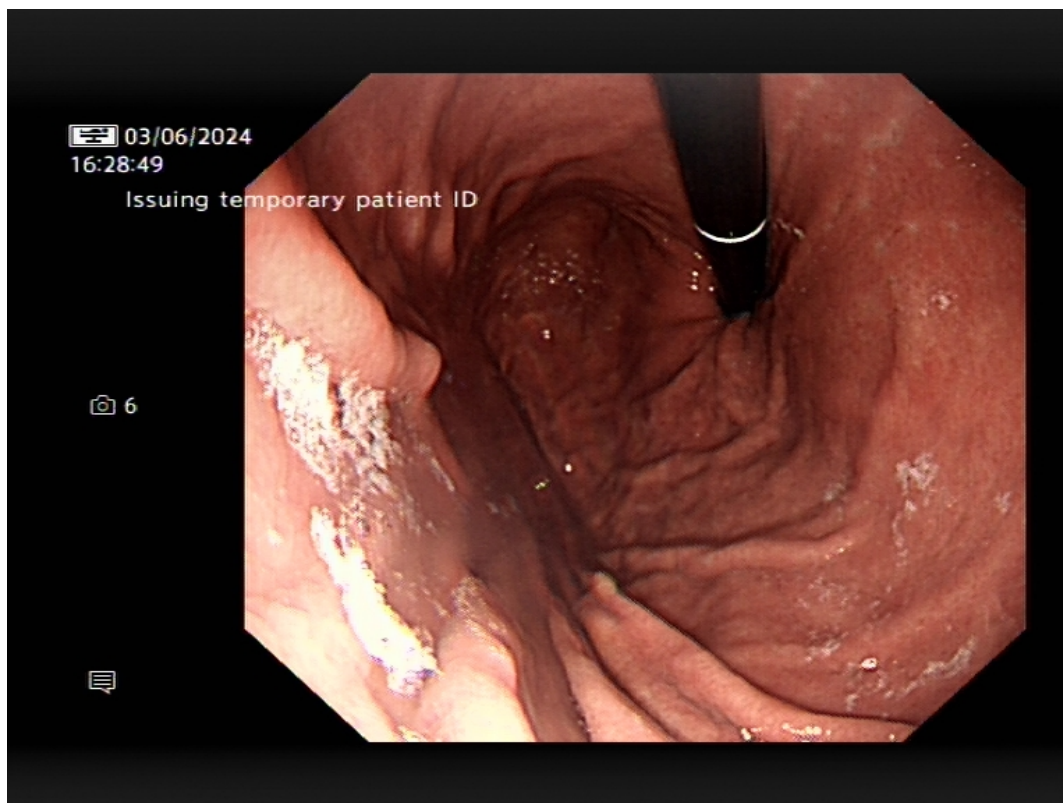
Middle oesophagus_1

Name:	Isabel MCCRACKEN, 1978-08-18 (F)	Address:	1d Cumbrae Crescent
CHI No:	1808785142		Coatbridge
Case Note No:	1808785142		Lanarkshire
			ML5 4PX



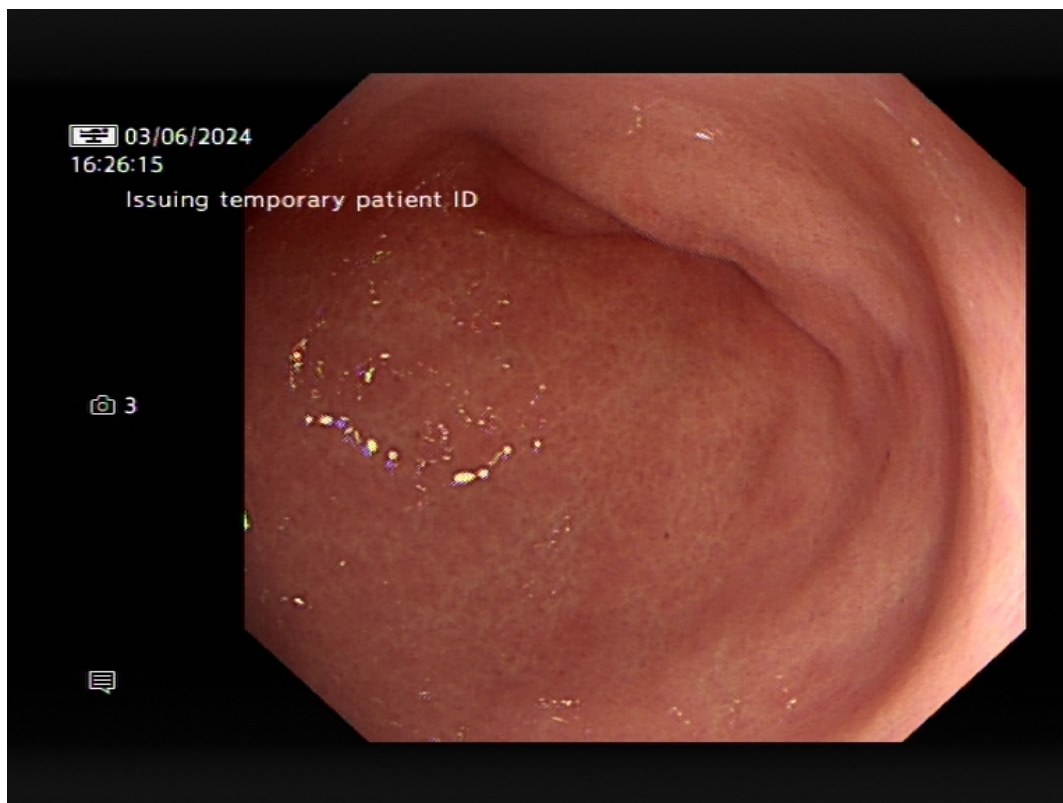
Second part_1

Name:	Isabel MCCRACKEN, 1978-08-18 (F)	Address:	1d Cumbrae Crescent
CHI No:	1808785142		Coatbridge
Case Note No:	1808785142		Lanarkshire
			ML5 4PX



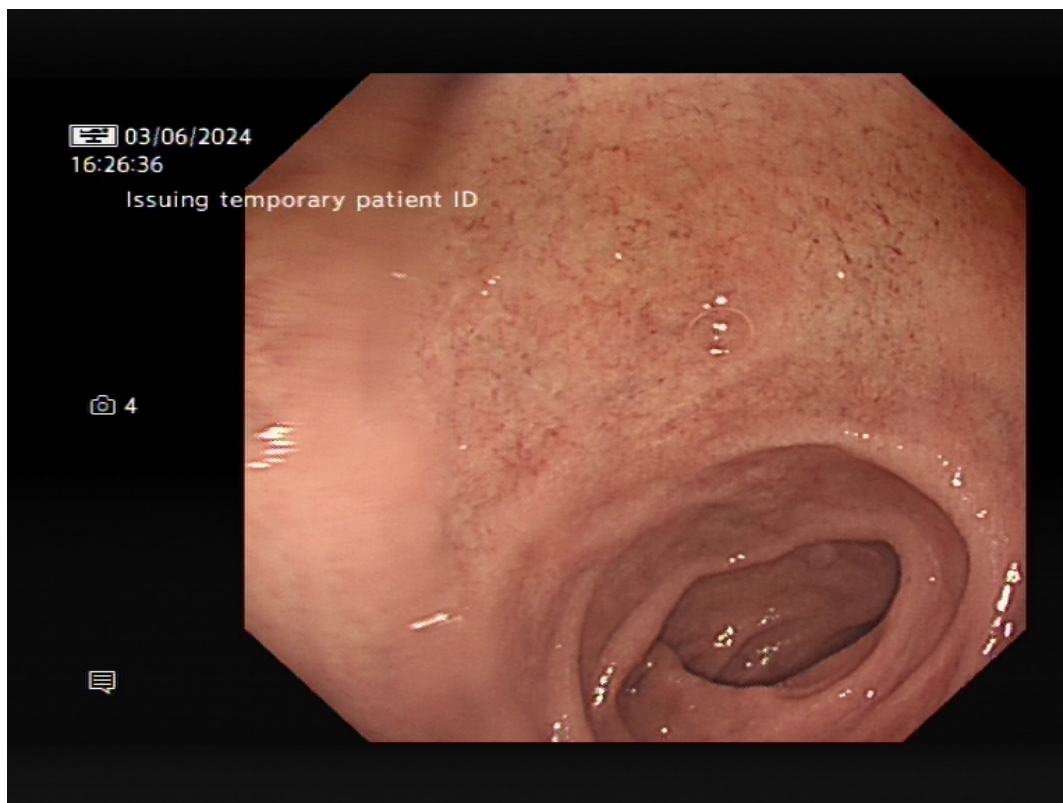
Fundus_1

Name:	Isabel MCCRACKEN, 1978-08-18 (F)	Address:	1d Cumbrae Crescent
CHI No:	1808785142		Coatbridge
Case Note No:	1808785142		Lanarkshire
			ML5 4PX



Antrum_1

Name:	Isabel MCCRACKEN, 1978-08-18 (F)	Address:	1d Cumbrae Crescent Coatbridge Lanarkshire ML5 4PX
CHI No:	1808785142		
Case Note No:	1808785142		



First part_1

CF
Fir 1808785142
La 18/08/1978 F
MCCRACKEN, Isabel
Av 1d Cumberae Crescent,
Coatbridge, Lanarkshire
ML5 4PX

University Hospital:

☐ Hairmyres ☒ Monklands ☐ Wishaw



Day Case Endoscopy

Date: 3.6.24

Arrival Time: 14:18 Admission Time: 14:20 (24 hour)

Proposed Procedure:

- | | |
|---|---|
| ☐ Bronchoscopy | ☐ Colonoscopy |
| ☐ ERCP | ☐ Flexible Cystoscopy |
| ☐ Flexible Sigmoidoscopy | ☒ Gastroscopy |
| ☐ PEG | ☐ Other (specify) |

Referring Consultant:

Escort:

Contact number:

Transport confirmed?

☐ Yes ☒ No

Patient Details - patient to complete this page (if appropriate)

Preferred name:

Phone: Home:

Mobile:

GP:

Practice: Waverly Practice

Next of Kin:

Relationship:

Address:

Postcode:

Contact pho

Phone number:

Do you have spiritual or religious needs?

☐ Yes ☒ No

If yes give details:

Do you have any special dietary requirements?

☐ Yes ☒ No

If yes give details:

Past Medical History - please tick all that apply and give details below

- | | | | |
|---|--|---|---|
| ☐ Alcohol | ☐ Angina | ☐ Asthma/Bronchitis/COPD | ☐ Diabetes |
| ☐ Epilepsy/Fits/Fainting | ☐ Glaucoma/Eye surgery | ☐ High blood pressure | ☐ Cardiac related events |
| ☐ Jaundice/Hepatitis | ☐ Recreational drugs | ☐ Sedation/Anaesthetics | ☒ Smoking |
| ☐ Tuberculosis | ☒ Other: (specify) | 20-30 a day. | |

Details:

Stoma bag - 11estomy 2021 for SMV thrombosis
on APIXABAN

Do you have any other health problems?

Please list any medications you take here:

~~As~~ Dihydrocodeine

methocarbamol

Glycerol suppositories

Citalopram

Loperamide

~~As~~ Apixaban - not taken today

Co-codamol

Omeprazole - not taken for few months

Quetiapine

B12 Injection



C 
 File **1808785142**
 La **18/08/1978** **F**
 Ao **MCCRACKEN, Isabel** ☐ F
1d Cumberae Crescent,
Coatbridge, Lanarkshire
ML5 4PX
 or attach addressograph label here

4AT Assessment (screening for Cognitive Impairment and Delirium - over 65s only)	Yes No N/A	Falls Risk Assessment (over 65s only)	Yes No N/A
4AT screening carried out? (see page 3)	☐ ☐ ☒	Falls Risk Assessment required?	☐ ☐ ☒
If yes, further action required?	☐ ☐ ☐	Have you fallen once or more in the past 12 months?	☐ ☒ ☐
MRSA Status (complete if applicable)		Do you have any unsteadiness on your feet or difficulty with walking or balance?	☐ ☒ ☐
Previous MRSA history?	☐ ☒ ☐	Have you ever found yourself on the ground but were unsure why?	☐ ☒ ☐
MRSA screen obtained?	☐ ☒ ☐	If yes to any above red triangle in use?	☐ ☐ ☒
Infection risk suspected/identified?	☐ ☒ ☐	Mobility	
Senses		Independent?	☒ ☐ ☐
Sight impaired?	☐ ☒ ☐	Requires aids?	☐ ☐ ☒
Hearing impaired?	☐ ☒ ☐		
Communication			
Does the patient require an interpreter?	☐ ☒ ☐		

Details/Actions/Comments:

procedure explained & Understood

Patient Valuables Disclaimer

NHS Lanarkshire accepts no responsibility for loss or damage of any patient valuables or money however the loss or damage may occur, unless deposited for safekeeping.

- I have been informed of the hospital arrangements for safekeeping of valuables and money.
- I have been advised to send home or hand over valuables and money for safekeeping while I am in hospital.
- I have decided to take responsibility for my valuables and money while I remain in hospital.

I have read and understood the above.

Patient name: (PRINT)

Signature: *X i macRacken*

Admitting Nurse: (PRINT NAME)

Cmacdonald

Signature:

Cmacdonald

Designation:

Student

Date/Time Prescribed	Drug	Dose	Route	Doctor's Signature	Given by	Time Given

Ct
Fm
La
Ac

1808785142
18/08/1978
MCCRACKEN, Isabel
1d Cumbrae Crescent,
Coatbridge, Lanarkshire

F
☐ F

ML5 4PX
or attach addressograph label here

4AT Assessment Tool
(Screening for Cognitive Impairment and Delirium)

☒ Not applicable

Complete for all patients over 65 years if required

	Date:	
	Time:	
	Initials:	
1. Alertness – This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating. - Normal (fully alert, but not agitated, throughout assessment) - Mild sleepiness for <10 seconds after waking, then normal - Clearly abnormal	0 0 4	
2. AMT4 – Ask the patient: age, date of birth, place (name of the hospital or building), current year - No mistakes - 1 mistake - 2 or more mistakes/untestable	0 1 2	
3. Attention – Ask the patient: ‘Please tell me the months of the year in backwards order, starting at December.’ To assist initial understanding one prompt of, ‘What is the month before December?’ is permitted. - Achieves 7 months or more correctly - Starts but scores <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 (e.g. paranoia, hallucinations) arising over the last 2 weeks and still evident in the last 24 hours. - No - Yes	0 4	
4AT TOTAL SCORE:		

4AT Score:

4 or above: Possible delirium + / - cognitive impairment.

1 - 3 : Possible cognitive impairment. More detailed cognitive assessment and informant history taking are required.

0: Delirium or severe cognitive impairment unlikely (but delirium still possible if (4) information incomplete).

CHI
First 1808785142
Last 18/08/1978 F
Add MCCracken, Isabel
1d Cumbrae Crescent,
Coatbridge, Lanarkshire
ML5 4PX

Pregnancy Status Questionnaire
 - complete for patients 55 years and under

☐ Not applicable

Legislation requires that a patient's pregnancy status should be ascertained and recorded before certain surgical procedures. This information should then be used to determine actions that are required to help protect the patient and foetus before surgery. We cannot perform your surgery if this is not completed.

Please answer the following questions:

1. Have your periods not started or was your last period more than 2 years ago?

☐ Yes
 ☒ No

If yes, please complete the signature and date section below.

2. Have you had a hysterectomy or sterilisation?

☐ Yes
 ☒ No

If yes, please complete the signature and date section below.

3. What was the first day of your last period? Date:

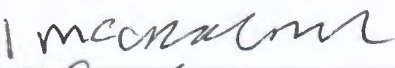
last month

4. Is there any possibility that you might be pregnant?

☐ Yes
 ☒ No

If yes, please discuss with the Consultant/Nurse in Charge before your operation and complete the signature and date section below.

If no, please complete the signature and date section below.

Patient Signature: 

Date: 8, 6, 24

Nurse Signature: 

Date: 3, 6, 24

Notes:

- Implementation/Rationale for questionnaire:** The National Institute for Health and Care Excellence (NICE) guideline on perioperative tests recommend that pregnancy testing should be carried out for a woman who says its possible that she may be pregnant. This guideline also states that local pre-operative assessment policies should be reviewed to ensure that pregnancy status is checked within the immediate pre-operative period in accordance with these guidelines.
- Confidentiality/Use of information:** At all times great care is taken to ensure that high standards of confidentiality are maintained in respect of information held. This 'Data Protection Act 1998' gives you the right of access to any personal information which NHS Lanarkshire holds about you, either in manual records or electronic records. If you would like more information about your rights under the act, you should contact the Records Officer at the hospital.

PVC Insertion Bundle	Yes	No
Hand hygiene performed immediately before all PVC insertion procedures (WHO Moment 2)	☐	☐
A single use skin antiseptic containing 70% isopropyl alcohol is used to cleanse skin and left to dry before insertion	☐	☐
Aseptic technique maintained throughout insertion procedure	☐	☐
A sterile, transparent, semipermeable dressing used to cover the catheter site	☐	☐

Size/colour:

Insertion site:

Insertion date: / /

Time: :

Signature:

Ci: 
 Fi: **1808785142**
 Le: **18/08/1978** F ☐ F
 At: **MCCRACKEN, Isabel**
 **1d Cumberae Crescent,**
 **Coatbridge, Lanarkshire**

ML5 4PX

Baseline Observations - record on NEWS Chart as per local policy

Temperature: **37.1** Blood Pressure: **96/66**
 Heart Rate: **96** Respirations: **16**
 SpO2: **97** NEWS Score: **(3)**
 Pain Score: **0**

Pre-Procedure Checklist	Yes No N/A	Comments	Check 1	Check 2
Is the referral letter available?	☒		☒	☒
Check you have the correct patient – name, address, date of birth	☒		☒	☒
Check the patient has the correct name band on	☒		☒	☒
Check the patient is having the correct procedure	☒	OAD	☒	☒
Check the patient has consented for the correct procedure	☒		☒	☒
Is the patient having sedation? <i>If yes, check they have a responsible adult to collect them for discharge and stay with them for 24 hours and are advised not to leave unit until escort arrives</i>	☐ ☒	☒ Throat spray	☒	☒
Has the patient ever been notified that they are at increased risk of CJD or vCJD for public health purposes?	☐ ☒	If 'yes' refer to policy and discuss with Infection Prevention and Control Team	☒	☒
Bowel preparation completed? ☐ Home ☐ Hospital	☐ ☐ ☒	Name of prep: Time given: : (if applicable)	☒	☒
Does the patient have any allergies? If yes, red name band applied?	☒ ☒	If yes, details: Diclofenac	☒	☒
Does the patient have dentures? If yes, have they been removed?	☒ ☒	☐ Caps ☐ Crowns ☐ Loose	☒	☒
Is the patient fasted?	☒ ☐	Last ate: 06:30 (24 hour) 3/6/24 Last drank: 13:20 (24 hour) Sips water Date: / /	☒	☒
Does the patient have diabetes? ☐ Diet ☐ Tablet ☐ Insulin	☐ ☒	If yes, BM: mmols Time checked: : (24 hour) Further actions:	☒	☒
Is the patient pregnant? Test carried out?	☐ ☐ ☒		☒	☒
Is the patient on Warfarin or other anti-coagulants?	☒ ☐	If yes, details: Apixaban Time given: NOT TAKEN TODAY (24 hour)	☒	☒
Is INR available?	☐ ☒	If yes, details:	☒	☒
Does the patient have any internal metalwork or pacemaker?	☐ ☒	If yes, details:	☒	☒
Infection risk suspected/identified, e.g. HIV, hepatitis B or C?	☐ ☒	If yes, details:	☒	☒

Check 1. Signature: *macdonald. / 1000*
Time: **14:20** (24 hour)

Check 2. Signature: *ly*
Time: **16:15** (24 hour)

1808785142

18/08/1978

F

MCCRACKEN, Isabel
1d Cumberae Crescent,
Coatbridge, LanarkshireM ☐ F

ML5 4PX

Statement to be Completed by Patient or Parent/Guardian*
(*parental responsibility for a minor without capacity)

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

I understand:

- The procedure, important risks and appropriate alternatives, which have been explained to me by the health professional named on this form.
- Who will be performing the procedure on the day.
- That any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to the medical treatment proposed, to safeguard or promote physical or mental health.
- That examination for the purpose of teaching will not be undertaken without my consent.

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

I agree: (tick as applicable)

- ☐ To the administration of an anaesthetic or to sedation if required.
- ☐ To the procedure named on this form.
- ☐ To photographic images and video recordings being held in records, and made available for teaching, audit and ethically-approved research purposes, to improve the quality of patient care.
- ☐ To the emergency administration of blood or blood products.

Patient Refusal for Blood Products

Please sign here if you decline to consent to the emergency administration of blood or blood products, **even if this results in death.**

Signature: (Patient or Parent/Guardian)**Date:** / /**Signature:** (Health Professional)**Date:** / /

A witness or interpreter should sign below if the patient is unable to sign/speak English but has indicated his/her consent. Young people/children may also like a parent to sign here (see consent policy).

Signature:**Name:** (PRINT)**Date:** / /**Patient or Parent/Guardian * Agreement to Treatment****Signature:****Name:** (PRINT)**Date:** / /

CHI: 
First: 1808785142
Last: 18/08/1978 F
Addr: MCCracken, Isabel
1d Cumberae Crescent,
Coatbridge, Lanarkshire
ML5 4PX

Procedure

Time in: 16:20 (24 hour) ☒ Endoscopy Pause
Scope 1 No: 410 Scope 2 No:
Endoscopist: Dr Wimpess

Procedure(s) Performed OGD

☐ Patient consent withdrawn

Diathermy plate applied? ☐ Yes ☐ No If yes site: ☐ Removed
Condition of skin checked post procedure: ☐ Satisfactory ☐ Unsatisfactory

Medication administered: ☐ No sedation
Throat spray: 100mg Time: 16:24 If yes, nil by mouth 30/60/90/120 minutes (delete as applicable)
Topical Lignocaine: mls Time: IV Alfentanil: mcgs Time:
IV Midazolam: mgs Time: IV Flumazenil: mcgs Time:
IV Pethidine: mgs Time: IV Naxolone: mgs Time:
IV Buscopan: mgs Time: Oxygen: litres Time:
IV Fentanyl: mcgs Time: Nitrous Oxide - self administration:
Other: (specify) Time: ☐ Yes ☐ No ☐ N/A Time:

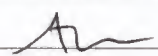
Comfort Score: 0 **AVPU Score:** A
Pulse oximetry - SpO2: 99% **Heart Rate:** 98

Samples/Interventions:

☐ APC ☐ Biopsies ☐ Gastric balloon/removal ☐ Sphincterotomy (ERCP)
☐ Aspirate ☐ Brushes/slides ☐ Haemorrhoidal banding ☐ Stent insertion
☐ Balloon dilatation ☒ CLOtest ☐ Injection of ink ☐ Variceal banding/injection
☐ Balloon trawl (ERCP) ☐ Endoscopic muc ☐ Polypectomy
☐ Other: (specify)

Nursing Assessment/Comments: Time to Recovery: 16:30

Gastrosocopy commenced. Reassurance given throughout

Completed by: (PRINT NAME) ANGELA MCCracken **Designation:** Nurse
Signature: 

Scope Cleaning – complete only if required as per local hospital/dept. policy ☐ Not applicable

1. Social clean in room by:
Signature: **Date:** / / **Time:** : :
Processed before disinfection by:
Signature: **Date:** / / **Time:** : :
2. Social clean in room by:
Signature: **Date:** / / **Time:** : :
Processed before disinfection by:
Signature: **Date:** / / **Time:** : :

1808785142
18/08/1978 F
MCCRACKEN, Isabel
1d Cumbrae Crescent,
Coatbridge, Lanarkshire

ML5 4PX

-- WASH CYCLE PASSED --

[Cante] RapidAER
[Serial No RAD147

[Start 14h 18m
[End 14h 41m
[Date 03-06-2024

[Cycle No 7466

[Load Operator 43
[Name Raymond Allan

[Unload Operator 12
[Name Laura mcphie

-- Hookup --
[Hookup No 219
[Serial No 219-065
[Barcode

-- Endoscope --
[OLYM GIF-HQ290
[Serial No 2857410
[Barcode
[Revision a

[IMS Verify Enabled

[Control Pass
[IMS Verify Pass

[Contact Time 5 Minutes

[Last SD 03-06-2024 at 06h 35m

[Suction Av Flow 805 ml
[Biopsy Av Flow 939 ml
[Water Av Flow 153 ml
[Air Av Flow 345 ml
[Aux 1 Av Flow 183 ml
[Aux 2 Not tested
[RB Not tested
[Leak Test Av Pres 203 mb

-- Conductivity --
[Detergent 1289 uS
[Disinfectant 1324 uS
[Final Rinse 0 uS

-- Temperature --
[Detergent 27.2 deg
[Disinfectant 29.5 deg
[Final Rinse 25.0 deg

-- Chemical Batch/Lot & Serial No --
[Detergent 23000954/000000671
[Part B 24000137/8000001994
[Part A 24000066/8000003415

Boston
Scientific
2.8mm
Radial Jaw™ 4
Lot M00513380
2027-01-11
Lot 33199052
GTIN 08714729745648



ML5 4PX

 0 = No pain
 1 = Mild pain
 2 = Moderate pain
 3 = Severe pain
 4 = Excruciating/
Worst pain
imaginable

Hospital: UFIM
Ward: Endo

NEWS Chart

Record head injury observations over page
See over page for NEWS Actions

Date	03/6/16	
Time	1430	
Frequency	PRN	
Frequency change initials	CM	
Respiratory Rate (enter number)	≥25	3
	21-24	2
	12-20	1
	9-11	1
	≤8	3
Complete only ONE SpO2 section based on target saturations. Ensure oxygen is prescribed on Prescription Form		
SpO2 Target ☐ 94-98% Initials:	≥96	3
	94-95	1
	92-93	2
	≤91	3
SpO2 Target ☐ 88-92% Initials:	≥88	3
	84-87	1
	81-83	2
	≤80	3
Inspired O2 Air (insert 'A')	%	2
Temperature (record with a dot • and join with a line -)	39°	2
	38°	1
	37°	1
	36°	1
	35°	3
Pulse Rate (record with a dot • and join with a line -)	150	3
	140	3
	130	3
	120	2
	110	2
	100	1
	90	1
	80	
	70	
	60	
	50	1
	40	3
		3
		3
		3
NEW SCORE uses Systolic BP Blood Pressure (Mark as shown)	230	3
	220	3
	210	
	200	
	190	
	180	
	170	
	160	
	150	
	140	
	130	
	120	
	110	1
	100	2
	90	3
80	3	
70	3	
60	3	
50	3	
Conscious Level	Alert	0
	V / P / U	3
NEWS TOTAL (with all obs)		3
Fluid Bal? Yes/No		- / -
Blood Sugar (BM)		- / -
Pain Score		0 / 0
Delirium- acute change? Yes/No		- / -
NEWS Escalated? Yes/No/HACP		- / -
Initials		AN

Head Injury Observations															
Glasgow Coma Scale (GCS)	Date:														
	Time:														
	Frequency:														
	Frequency change initials:														
EYES Open	Spontaneous	4													Eyes closed by swelling = C
	To Speech	3													
	To Pain	2													
	None	1													
Best VERBAL Response	Orientated	5													Endo-tracheal tube or Trach-eostomy = T
	Confused	4													
	Inappropriate words	3													
	Incomprehensible sounds	2													
	None	1													
Best MOTOR Response	Obeys commands	6													Usually record the best arm response
	Localise pain	5													
	Withdrawal	4													
	Flexion to pain	3													
	Extension to pain	2													
	None	1													
TOTAL: (/15)															

	Pupils	Right	Size											S sluggish + reacts - no reaction C eyes closed	
		Left	Size												
	LIMB MOVEMENT	ARMS	Normal power												Record right (R) and left (L) separately if there is a difference between the two sides
			Mild weakness												
			Severe weakness												
			Spastic flexion												
			Extension												
			No response												
		LEGS	Normal power												
			Mild weakness												
Severe weakness															
Extension															
		No response													
Initials:															

National Early Warning Score (NEWS) Actions and Escalation			
Delirium Acute Change - Complete 4AT - inform Nurse in Charge - escalate to Medical staff/HECT			
NEWS 0 - Refer Observation Policy first 48 hours of admission - Minimum 12 hourly observations	NEWS 1 - 4 Inform Nurse in Charge - Lower risk - Respond within 60 mins - ABC - Minimum 4 hourly observations	NEWS ≥5 or 3 in one parameter Inform Nurse in Charge - Medium risk - Urgent assessment doctor/HECT - Respond within 30 mins - ABC - reassess - Start Fluid Balance - Minimum hourly observations	NEWS ≥7 Inform Nurse in Charge - High risk - Senior doctor/HECT assess - Urgent attendance - ABC - reassess - Continuous monitoring - Consider 2222 call - Consider critical care - Document escalation plan

CHI n
First r
Last r **1808785142**
Last r **18/08/1978** F
Addn **MCCRACKEN, Isabel**
1d Cumbrae Crescent,
Coatbridge, Lanarkshire
ML5 4PX

Nursing Evaluation/Comments/Follow-up
Settled post procedure

PVC Maintenance Bundle	Yes	No	N/A
Is the PVC still in use?	☐	☐	☒
The clinical need for the PVC has been reviewed and recorded today	☐	☐	☐
Medical staff have reviewed the need for intravenous (IV) therapy including antibiotics today and switched to oral if possible	☐	☐	☐
Hand hygiene is performed immediately before accessing the line/site (WHO Moment 2)	☐	☐	☐
Removal of the PVC is considered if in longer than 72 hours	☐	☐	☐
The PVC site has been assessed; removing the PVC where there is phlebitis or inflammation at the site	☐	☐	☐
The PVC dressings are intact	☐	☐	☐
A single use antiseptic containing 70% isopropyl alcohol is used to clean the access hub before accessing - rub the access hub for at least 15 seconds ("scrub the hub")	☐	☐	☐

Date: / / **Time:** : **Signature:**

Post Sedation Discharge Scoring System		☒ Not applicable	Score						
Vital Signs	BP and pulse within 20% of pre-admission baseline	2							
	BP and pulse 20 – 40% of pre-admission baseline	1							
	BP and pulse 40% of pre-admission baseline	0							
Activity Level	Steady gait, no dizziness, or meets pre-procedure level	2							
	Requires assistance	1							
	Unable to ambulate	0							
Nausea/Vomiting	No	2							
	Yes	0							
Pain	Pain score 0 – 2	2							
	Pain score 3 – 4	0							
Neuro Response (AVPU)	Alert or Voice	2							
	Pain	1							
	Unresponsive	0							
		TIME							
		TOTAL							

Maximum Score is 10: Patients scoring 9 are fit for discharge

Discharge Checklist	Yes	No	N/A		Yes	No	N/A
Tolerating fluids and diet <i>Declined</i>	☐	☒	☐	Escort/carers available	☐	☐	☒
Patient advised to commence food and drink after 30 / 60 / 90 / 120 minutes (for throat spray only - delete as applicable)	☐	☐	☒	Private transport available	☐	☐	☐
IV cannula removed	☐	☐	☒	Ambulance/hospital transport arranged	☐	☐	☐
Has passed urine (if applicable)	☐	☐	☒	Time: :	☒	☐	☐
PR bleeding - if yes, comment below	☐	☐	☒	Written/verbal information given	☒	☐	☐
Belongings/valuables returned	☒	☐	☐	Contact details given	☒	☐	☐
				Letter to GP given	☐	☒	☐

Additional Comments/Notes:
Copy of report and disk

Completed by: (PRINT NAME) <i>K. J. Wilson</i>	Designation: <i>SN</i>
Signature: <i>Km</i>	Discharge Time: <i>16:45</i> (24 hour)

APPENDIX 2

1808785142

18/08/1978 F
MCCRACKEN, Isabel
1d Cumbrae Crescent,
Coatbridge, Lanarkshire

ML5 4PX

SAFETY PRE-PROCEDURE PAUSE (ENDOSCOPIST LED)

(CIRCLE) SEDATION THROAT SPRAY ENTONOX
(ENTONOX CL) ☐

TEAM INTRODUCTION TO PATIENT	✓
CORRECT PATIENT/ID BAND	✓
CORRECT HEALTH RECORDS	✓
CONFIRM PROCEDURE/PATIENT ON LIST	✓
CONSENT SIGNED	✓
REASON FOR PROCEDURE Nausea & vomiting ? ulcer	

ALLERGIES	Aclofenac
ANTICOAGULATION (CARD IN PLACE)	Apixaban taken 21/6/24.
MEDICATION CONCERNS	course abx
CLINICAL CONCERNS	VRE 2021. 2021.
THERAPEUTICS REQUIRED/SAFE TO USE	Apixaban.

IS THE PATIENT AT AN INCREASED RISK OF BLEEDING	Y	<u>N</u>	N/A
If yes: Has the patient been cross matched?			
Plan of Escalation?			
Good venous access?			

WHERE RADIATION IS USED	Y	N	<u>Not</u>
IS EVERYONE WEARING RADIATION PROTECTION AND BADGES?			

ARE YOU SAFE TO START?

YES

NO

SIGN:

[Signature]

NHS X is committed to the provision of a service that is fair, accessible and meets the needs of all individuals

APPENDIX 3

POST PAUSE/RECOVERY PLAN			
	YES	NO	N/A
REPORT COMPLETED	☒		
HISTOLOGY CHECKED			☒ C10 test ✓
RECOVERY INSTRUCTIONS (ENDOSCOPIST CLINICAL JUDGMENT)	☒		OBSERVATIONS: XI SPO2 HR.
THROAT SPRAY	☒		TIME 1624.
SEDATION		☒	TIME
NIL BY MOUTH	☒		UNTIL 20 mins.
BLOODS (ENDOSCOPIST ORDERED + PRINTED)	☒		
WHEN ANTICOAGULANTS TO RESTART	☒		Continue as normal
ENDOSCOPIST TO REVIEW		☒	
FOLLOW UP/MEDICATION PLAN	☒		As per report (WHAT HAPPENS NEXT/SUSPICION PATHWAY)

PROCEDURE ROOM STAFF SIGNATURE

[Signature]

NHS X is committed to the provision of a service that is fair, accessible and meets the needs of all individuals

PATIENT AGREEMENT TO ENDOSCOPIC INVESTIGATION OR TREATMENT
Name of Procedure:- Gastroscopy/endoscopy

Inspection of the upper gastrointestinal tract with a flexible endoscope (with or without biopsy, photography, removal of polyps, injection treatment).

STATEMENT OF PATIENT

You have the right to change your mind at any time, including after you have signed this form.

I have read and understood the information in the attached leaflet. The intended benefits are to diagnose and treat a possible cause for my symptoms or to review the findings of a previous endoscopy. The possible serious risks include haemorrhage, aspiration or an adverse reaction to sedation (if required) or a perforation.

I agree to the procedure described in my letter and on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience. Where a trainee performs the examination, this will be undertaken under supervision by a fully qualified practitioner.

Signed

Imcenaan

NAME (Print in Capitals): _____

If you would like to ask further questions do not sign the form now. Bring it with you and you can sign it after you have talked to a health care professional

CONFIRMATION OF CONSENT

(To be completed by a health care professional when you are admitted for your procedure.)

I have confirmed that the patient/parent/guardian understands what the procedure involves including the benefits and risks.

I have confirmed that the patient/parent/guardian has no questions and wishes the procedure to go ahead.

Signed

[Signature]

Date

3/6/2024.

Name

Dr Adam Wimpers

Title

SAS.



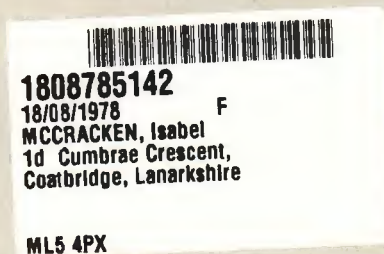
1808785142
18/08/1978 F
MCCRACKEN, Isabel
1d Cumbrae Crescent,
Coatbridge, Lanarkshire

ML5 4PX

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Monklands Hospital ENDOSCOPY SUITE



Patient has had a full explanation of the risks and benefits of Throat Spray or Sedation for their procedure being carried out.

Patient has opted for: Throat Spray / Sedation (please circle)

Further comments

Patients Signature:

I McCracken

Nurse Signature:

C Macdonald

DATE:

03/06/24

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ca9

MONKLANDS HOSPITAL
ENDOSCOPY UNIT

16.25

DIRECT UREASE (CLO TEST) RESULT

PATIENT		DIRECT UREASE	
 1808785142 18/08/1978 F MCCRACKEN Isabel 1d Cumbrae Crescent Coatbridge ML5 4PX		POSITIVE (Indicating current infection with Helicobacter Pylori) NEGATIVE	
CONSULTANT M ^r Cheeme	WARD Endo	SIGNED A	DATE 3/6/24

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Department of General Surgery
01236 748748
sDeptinfo

University Hospital
Monklands
Monkscourt Avenue
Airdrie
ML6 0JS



Dr I Roiatti
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

Date Dictated: 10/10/2024
Date Typed: 14/10/2024
Ref: 3930318
Letter Ref: IR/JD
CHI Barcode:



Consultant: Nurse Isabell Robertson

Dear Dr Roiatti

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

I reviewed this lady at the stoma clinic today, Thursday 10/10/24, following a self-referral.

You may recall she had formation of an end ileostomy in April 2021 under the care of Mr Dick. Her main concern is that she has noticed a broken area below her stoma.

On examination today her ileostomy is healthy and her peristomal skin is mainly intact. She does however have a tiny area of macerated skin below her stoma. I have recommended that she continue with her barrier spray and also given her a washer and advised her to use half of a washer below her stoma. I have also again reiterated that she should wear a belt to aid security. She currently empties her appliance approximately 5-6 times per day, takes Loperamide and renews her pouch every day.

Unfortunately, as yet she has had no follow-up appointment with Mr Dick, however has been seen by Mr Cheema. I have contacted Mr Dick's secretary who is arranging for her to have a telephone consultation next month.

I have made no further follow-up at the stoma clinic, however Mrs McCracken has agreed to contact me by telephone and advise me whether the washer has resolved the peristomal skin issue. If not, I would be happy to review her again at the stoma clinic and she does know how to contact me.

I shall keep you informed of her progress.

Yours sincerely

I Robertson
Stoma Care Sister

Authorised on 14/10/2024 16:42:38 by Miss Isabell Robertson.

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Dr I Roiatti
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

Date Dictated: 17/10/2024
Date Typed: 22/10/2024
Ref: 3936286
Letter Ref: TT/JD
CHI Barcode:



Consultant: Nurse Tracy Tallo

Dear Dr Roiatti

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

Stoma Care Patient Summary

☐

Hairmyres

☐

Monklands

☐

Wishaw



Stoma Care Nurse Specialists Contact Details: (or 24 hour voicemail)

Myra Patterson /
Annemarie McLeary
Wishaw General
Tel: 01698 366185

Isabell Robertson/Tracy Tallo
Monklands Hospital
Tel: 01236 712275

Clare McLaughlin/Jackie Balfour
Hairmyres Hospital
Tel: 01355 584404

Reason for review: additional product

Type & condition: ileostomy

Dispensing Appliance Contractor:

Prescription arrangements explained and stoma appliance prescription details

☐ Yes

☐ No

All previous Stoma product recommendations should now be discontinued.

Please refer to the list below for current products.

Appliance	Brand	Size	Code Series No.	No. in Pack	Approx No. Required in 4 Weeks	Not on Formulary
SenSura mio ileostomy bag	Coloplast		16642	10	3	
Adhesive remover spray	Salts	50mls	WAP	each	1	
Brava protective seals	Coloplast		12033	30	1	

Review Outcome: This supersedes any previous correspondence.

COPY PAGE

Yours sincerely

Tracy Tallo
Stoma Care Nurse

Authorised on 29/10/2024 12:57:51 by Tracy Tallo.

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Department of General Surgery
01698 752155
General Surgery
Monklands Hospital

University Hospital
Monklands
Monkscourt Avenue
Airdrie
ML6 0JS



Dr I Roiatti
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

Date Dictated: 11/11/2024
Date Typed: 12/11/2024
Ref: 3957391
Letter Ref: MD/GM
Clinic Date: 07/11/2024
CHI Barcode:



Consultant: Mr Michael Martin Dick

Dear Dr Roiatti

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

I had a telephone consultation with this lady today. She had an end-ileostomy following her surgery about three years ago. She has been having some trouble with skin excoriation relating to the ileostomy. She thinks this is related to picking up "bugs" from her grandchildren. The Stoma Nurses have been working with her and have also given her a barrier to try and see if this helps.

I wonder if you could prescribe her some dioralyte sachets to take intermittently to see if this would help thicken things up. She was also wanting to stop her Omeprazole but I have advised that she should continue this to reduce down the output from her stoma. I had said she can take this at night as she said she felt this was making her feel quite drowsy during the day. I have suggested this is unlikely due to the Omeprazole but if she takes it at night this might help.

I will get an appointment sent out for another six months.

Yours sincerely

Mr Michael Dick
Consultant Colorectal Surgeon
Honorary Clinical Associate Professor (University of Glasgow)

Authorised on 14/11/2024 13:48:34 by Michael Dick.

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Dr I Roiatti
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

Date Dictated: 14/04/2025
Date Typed: 23/04/2025
Ref: 4095919
Letter Ref: IR/JD
CHI Barcode:



Consultant: Nurse Isabell Robertson

Dear Dr Roiatti

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

Stoma Care Patient Summary	☐	Hairmyres	
	☐	Monklands	
	☐	Wishaw	
Stoma Care Nurse Specialists Contact Details: (or 24 hour voicemail)			
Myra Patterson / Annemarie McLeary Wishaw General Tel: 01698 366185	Isabell Robertson/Tracy Tallo Monklands Hospital Tel: 01236 712275	Clare McLaughlin/Jackie Balfour Hairmyres Hospital Tel: 01355 584404	
Reason for review: product review			
Type & condition: ileostomy			
Dispensing Appliance Contractor: Charter			

Prescription arrangements explained and stoma appliance prescription details					☐ Yes	☐ No
<u>All previous Stoma product recommendations should now be discontinued.</u>						
<u>Please refer to the list below for current products.</u>						
Appliance	Brand	Size	Code Series No.	No. in Pack	Approx No. Required in 4 Weeks	Not on Formulary
SenSura deep convex black pouch	Coloplast	ST	18941	10	3	
Protective seals	Coloplast		12033	30	1	
Adhesive remover spray	Salts	50mls	WAP	each	1	
Review Outcome: This stoma summary document supersedes all previous stoma summary documents.						

Authorised on 24/04/2025 08:42:31 by Miss Isabell Robertson.

Dr I Roiatti
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

Date Dictated: 20/05/2025
Date Typed: 29/05/2025
Ref: 4127778
Letter Ref: IR/JD
CHI Barcode:



Consultant: Nurse Isabell Robertson

Dear Dr Roiatti

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

Stoma Care Patient Summary	☐	Hairmyres	
	☐	Monklands	
	☐	Wishaw	
Stoma Care Nurse Specialists Contact Details: (or 24 hour voicemail)			
Myra Patterson / Annemarie McLeary Wishaw General Tel: 01698 366185	Isabell Robertson/Tracy Tallo Monklands Hospital Tel: 01236 712275	Clare McLaughlin/Jackie Balfour Hairmyres Hospital Tel: 01355 584404	

Reason for review: product review

Type & condition: ileostomy

Dispensing Appliance Contractor: Charter

Prescription arrangements explained and stoma appliance prescription details	☐ Yes	☐ No				
<u>All previous Stoma product recommendations should now be discontinued.</u>						
<u>Please refer to the list below for current products.</u>						
Appliance	Brand	Size	Code Series No.	No. in Pack	Approx No. Required in 4 Weeks	Not on Formulary
SenSura mio ileostomy pouch	Coloplast	ST	18941	10	3	
Protective seals	Coloplast		12033	30	1	
Adhesive remover spray	Salts	50mls	WAP	each	1	
Medi derma S non sting barrier film	Medicare plus	30mls	60796	each	1*	

Review Outcome: * this quantity will be ordered on a six monthly basis.
This stoma summary document supersedes all previous stoma summary documents.

Authorised on 02/06/2025 08:47:50 by Miss Isabell Robertson.

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01698 752155
General Surgery
Monklands Hospital

University Hospital
Monklands
Monkscourt Avenue
Airdrie
ML6 0JS



Dr I Roiatti
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

Date Dictated: 23/06/2025
Date Typed: 26/06/2025
Ref: 4159387
Letter Ref: MD/GM
Clinic Date: 23/06/2025
CHI Barcode:



Consultant: Mr Michael Martin Dick

Dear Dr Roiatti

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

Plan: Colonoscopy.

I reviewed this lady back in the clinic today. She has been doing quite well and explained a little bit of weight loss. Her stoma is working well.

I am going to arrange a colonoscopy for de-functioning colon just to make sure there is no changes within that.

I will copy this letter to the Haematology department as she was due to see them back in January 2024 but they cancelled the appointment and it doesn't look like they have sent out a new one. If they could look into this that would be great.

Many thanks.

Yours sincerely

Mr Michael Dick
Consultant Colorectal Surgeon
Honorary Clinical Associate Professor (University of Glasgow)

Authorised on 27/06/2025 10:20:24 by Michael Dick.

(P) Department of Haematology
University Hospital Monklands
ML6 0JS

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Department of General Surgery
01698 752155
General Surgery
Monklands Hospital

University Hospital
Monklands
Monkscourt Avenue
Airdrie
ML6 0JS



Dr I Roiatti
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

Date Dictated: 23/06/2025
Date Typed: 26/06/2025
Ref: 4159387
Letter Ref: MD/GM
Clinic Date: 23/06/2025
CHI Barcode:



* 1 8 0 8 7 8 5 1 4 2 *

Consultant: Mr Michael Martin Dick

Dear Dr Roiatti

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

Plan: Colonoscopy.

I reviewed this lady back in the clinic today. She has been doing quite well and explained a little bit of weight loss. Her stoma is working well.

I am going to arrange a colonoscopy for de-functioning colon just to make sure there is no changes within that.

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Many thanks.

Yours sincerely

Mr Michael Dick
Consultant Colorectal Surgeon
Honorary Clinical Associate Professor (University of Glasgow)

Authorised on 27/06/2025 10:20:24 by Michael Dick.

(P) Department of Haematology
University Hospital Monklands
ML6 0JS

Review TA in 3-4 months

699

1808785142
18/08/1978 F
MCCRACKEN, Isabel
1d Cumbrae Crescent, Coatbridge,
Lanarkshire
ML5 4PX



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CH: 1808785142
 Flr: 18/08/1978
 La: MCCracken Isabel
 Ad: 1d Cumbrae Crescent
 Coatbridge ML5 4PX
 or attach addressograph label here

Ward: _____
 Monklads Hospital NHS
 Outpatient Dept. Lanarkshire

Hospital Endoscopy Request

Contact phone number: 2063 (*Denotes a mandatory field)

*Referral date: 23/6/21

For referrals of hospital inpatients or outpatients for endoscopic examination. Supply as much information as possible. Do not use this form to request gastroenterology ward review. Responsibility for the patient's fitness to undergo endoscopy is with the referring clinician.

Phone: Home:	Inpatient: Estimated date of discharge: ____/____/____
Mobile:	Outpatient: Need for transport? ☐ Yes ☒ No
	Overnight stay? ☐ Yes ☒ No
Investigation requested:	☐ Upper GI Endoscopy ☒ Colonoscopy ☐ Flexible Sigmoidoscopy ☐ Insertion of PEG tube
Urgency:	☐ Inpatient (within 1 week) ☐ Urgent outpatient (within 3-4 weeks) ☒ Routine outpatient
Previous medical history:	☐ Previous gastric surgery: _____ ☒ Previous small bowel or colonic surgery: <u>Right hemi</u> ☐ Significant liver disease: _____

Reason for request

Upper GI* ☐ Iron deficiency anaemia *Hb: _____ g/dl *MCV: _____ fl *Ferritin: _____ ng/ml ☐ Dysphagia ☐ Weight loss (>3kg in 3/12) ☐ Variceal surveillance ☐ Episode haematemesis ☐ Episode melaena ☐ Atypical chest pain ☐ Other: (specify) _____	Lower GI* ☐ IDA (has already had OGD) *Hb: _____ g/dl *MCV: _____ fl *Ferritin: _____ ng/ml ☐ Rectal bleeding (see protocol) ☐ Bloody diarrhoea ☐ Abdominal mass ☐ FU polyps ☐ FU previous carcinoma ☐ Other: (specify) _____
--	--

Brief history of complaint:

Right hemidefect + Abc for ISCHAEMIA M-Dice L115 only

Patient fitness: *ASA Grade: (If grade 3 or above, discuss) ☐ I Normal healthy patient ☒ II Mild systemic disease with no functional limitations ☐ III Moderate systemic disease with functional limitations ☐ IV Severe systemic disease with a constant threat to life ☐ Cardiac failure ☐ Prosthetic heart valve, previous SBE ☐ Renal failure (U _____ Cr _____) ☐ Severe respiratory disease	*Warfarin or other anticoag? ☒ Yes ☐ No Reason: <u>Alxaban</u> *Diabetes mellitus: ☐ Yes ☐ No ☐ Diet only ☐ Oral hypoglycaemics ☐ Insulin *Able to give own consent? ☐ Yes ☐ No *Fit for OP bowel prep? ☐ Yes ☒ No *Referring consultant: (PRINT NAME) <u>Dice</u> *Signature: <u>[Signature]</u>
*Requesting clinician: (PRINT NAME) <u>Dice</u> Grade: <u>Cos</u> Page/DECT phone no: _____	

OFFICE/GI USE ONLY

Date received: ____/____/____

☐ Diabetic protocol ☐ Anticoag protocol ☐ Suitable for NE

☐ IP stay required for OP tests: ☐ Pre-test ☐ Post-test ☐ Cancer tracker needed

☐ Accept ☐ Reject ☐ Routine ☐ Urgent

☐ Any list ☐ Specific list: _____ Dr/Mr: _____

Reason for rejection:

☐ Insufficient information (points indicated) ☐ Other investigation more suitable: (specify) _____

☐ Endoscopy contraindicated

☐ Please discuss with a GI consultant ☐ Other: (specify) _____



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Department of Haematology
SEC - 01698 752052
Day Unit - 01698 752042
Ward 16 - 01698 752047

University Hospital
Monklands
Monkscourt Avenue
Airdrie
ML6 0JS



Isabel McCracken
1D Cumbrae Crescent
Coatbridge
ML5 4PX

Date Dictated: 12/11/2025
Date Typed: 23/11/2025
Ref: 463952
Letter Ref: PBY/AH
CHI Barcode:



Consultant: Dr Iain Singer

Dear Isabel McCracken

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

I tried to contact you multiple times today 11/11/2025, however I have not been able to get through to you.

I also do note from the system you have not had updated bloods this year. I will send out 2-blood forms. I would be pleased if you could kindly get your bloods updated with one of the blood forms and keep the other for the next consultation.

I will simply appoint you for another assessment in 2-months.

Yours sincerely

Dr Philpa Garnet Boachie-Yiadom
Clinical Fellow in Haematology
GMC No. 7905679

Authorised on 08/12/2025 13:40:09 by Philpa Garnet Boachie-Yiadom.

(D) Dr I Roiatti
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

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SOUTH GLASGOW HOSPITALS

IMMUNOLOGY REPORT

(Tel 0141 347 8872/0141 354 9337)

IMFLC6 Run: 895

Surname: MCCRACKEN
Forename: ISABEL
DOB/Age: 18.08.78 Sex: Female
CHI/Unit No: 1808785142
Address: 1D CUMBRAE CRESCENT
Details:

Location: Haematology
Wishaw General Hospital
50 Netherton St Wishaw
Lanarkshire Health Board
Requestor: Not known
Ext Labno: 5128034675

Dr Garnet Haem,
MR OPD

SERUM FREE LIGHT CHAINS

[[CURRENT]]

Lab Number	B, 26.3470762	B, 23.3628427	B, 21.3657909	B, 21.3546854
Date/Time collected	31.12.25	14.07.23	27.10.21	06.04.21
Date/Time received	06.01.26 13:27	18.07.23 12:21	28.10.21 13:54	08.04.21 14:27
Free Kappa mg/L (3.3-19.4)	15.7	18.9	17.0	45.3
Free Lambda mg/L (5.7-26.3) *	30.4	29.4	30.5	66.9
K/L ratio (0.26-1.65)	0.52	0.64	0.56	0.68

RECEIVED IN

12 JAN 2026

LABORATORY DIRECTORATE
WISHAW GENERAL HOSPITAL

Result Comments:

31.12.25 FreeLightChain: In renal impairment, K/L ratio may increase to 0.37 - 3.1

Antigen excess rare but cannot be excluded. If results do not agree
with clinical/lab findings, contact Immunology on 0141 347 8872

www.nhslanarkshire.org.uk
Department of General Surgery
sPrefPhoneNo
sDeptinfo
sAdddeptinfo

University Hospital Wishaw
50 Netherton Street
Wishaw
ML2 0DP



Dr I Roiatti
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

Date Dictated: 19/01/2026
Date Typed: 19/01/2026
Ref: 101983486
Letter Ref: 2404635247
Clinic Date: 19/01/2026
CHI Barcode:



Consultant:

Dear Dr Roiatti

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

Situation

Check Flex Sig.

Background

Previous right hemi-colectomy 2021 end to end Ileostomy for TI Abscess , longterm Apixaban.

Assessment

Omit evening dose and morning dose of Apixaban. Patient sad she requires no prep according to Mr Dick. All other meds discussed continue. Patient nervous and has just lost her 49 year old sister. She requires sedation.

Recommendations

- a) Acute actions
- b) Primary care and patient actions

Yours sincerely

Rosemary Paterson
Nurse Endoscopist

Authorised on 19/01/2026 10:53:33 by Rosemary Paterson.

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NHS Lanarkshire
Monklands Hospital
COLONOSCOPY REPORT

Name: **Isabel MCCracken (F)**
Date of birth: **18/08/1978**
NHS No: **1808785142**
Case Note No: **1808785142**

Address: **1d Cumbrae Crescent**
Coatbridge
Lanarkshire
ML5 4PX

GP: **Dr I Roiatti**
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge

Procedure date: **4th February 2026 (15:07)**
Priority: **Surveillance**
Hospital: **Monklands Hospital**
Ward: **(none)**
Referring Cons: **Mr Michael Dick**

Indications

Clinically important comments: Previous right hemicolectomy 2021 with end to end ileostomy for TI abscess. Colonoscopy for de-functioning colon to assess any changes.

Discussion today: took cannabix 20mins prior to attending department & takes this every day. Advised unable to offer sedation & entanox due to side effects - patient quite upset but willing to go ahead without any medication.
Apixaban last taken 24hours ago. History splenic vein thrombosis.

Report

A digital rectal examination was performed.
The colonoscope was inserted via the anus to the rectum, insertion limited by Patient Anxiety +++/ patient withdrew consent. The examination to the limit of insertion was normal.

Advice/Comments

Patient immediately withdrew consent after in intubated scope into rectum. Anxiety +++ Procedure abandoned.

To be relised - patient to avoid taking cannabis for 72 hours prior to next colonoscopy to be offered sedation.

Follow up

Further procedure(s): Colonoscopy in 4 weeks.

Ms Sandra Paterson
Nurse Endoscopist
c.c. Mr Michael Dick (Monklands surgeons)
McCracken, Isabel

Consultant/Endoscopist

List consultant: Mr Michael Dick
Endoscopist No1: Ms Sandra Paterson
Nurses: SN Kate Scullion
SN Angela McArthur, RN

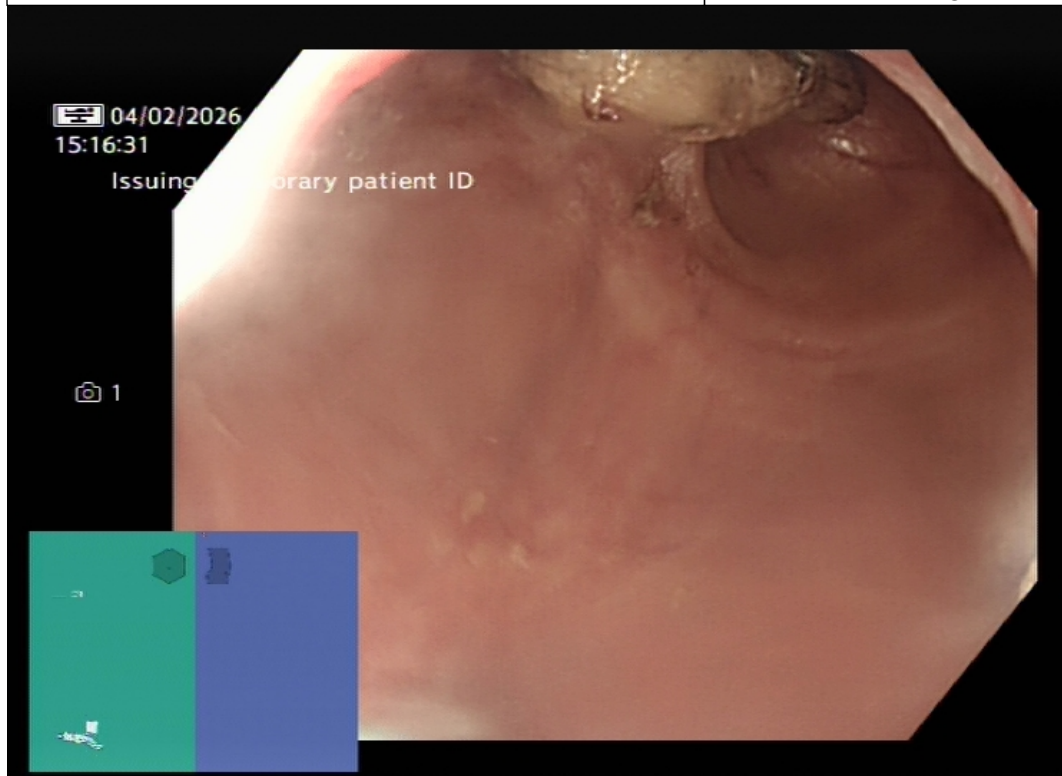
Instrument

MK- CF-EZ1500DL 2506584

Premedication

No medication given

Name:	Isabel MCCRACKEN, 1978-08-18 (F)	Address:	1d Cumbrae Crescent Coatbridge Lanarkshire ML5 4PX
CHI No:	1808785142		
Case Note No:	1808785142		



Rectum_1

Dr I Roiatti
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

Date Dictated: 21/01/2026
Date Typed: 04/02/2026
Ref: 472837
Letter Ref: MEA / CM
Clinic Date: 21/01/2026
CHI Barcode:



Consultant: Dr Mohammed Khaled El-Abdulla

Dear Dr Roiatti

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbræ Crescent, Coatbridge, ML5 4PX

Diagnoses: Presented with superior mesenteric thrombosis in March 2021.
Initially anti-coagulated with Warfarin but subsequent readmission with extension of thrombosis despite serotherapeutic INR
This cause venous ischemia of her gut requiring limited right hemicolectomy with end ileostomy.
Episode of VRE septicaemia requiring intravenous antibiotics.
Treated with 5 months of treatment dose Tinzaparin now on Apixaban 2.5mg bd
Initial presentation was with thrombocytopenia which then became a thrombocytosis.
Bone marrow aspirate and trephine done to exclude a myeloproliferative neoplasm. This demonstrated a reactive marrow only but there was also a clonal plasma cell population of 10% picked up.
Current IgG paraprotein not detected

Results 31.12.25: Hb 147 Plats 254 WCC 9 Neut 5.4
Paraprotein - no significant abnormality detected

I had a telephone consultation with this lady today on the 21.01.26. She is well and she does not report any new symptoms. Her paraprotein is not detectable. Her renal function and calcium are normal. There is no evidence of disease progress of her MGUS. We will continue our observational policy and will do another telephone assessment in 6 months' time.

Yours sincerely

Dr Mohammed El-Abdulla
University Hospital Monklands
Locum Doctor in Haematology
GMC 5207273

Authorised on 05/02/2026 09:54:22 by Dr Mohammed El-Abdulla.

<https://nhslguidelines.scot.nhs.uk/referral-pathways/haematology-referral-pathways/>

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Department of General Surgery
01698 366711
Jan Kidd - Secretary

University Hospital Wishaw
50 Netherton Street
Wishaw
ML2 0DP



Isabel McCracken
1D Cumbrae Crescent
Coatbridge
ML5 4PX

Date Dictated: 04/02/2026
Date Typed: 05/02/2026
Ref: 4368858
Letter Ref: JK
Clinic Date: 04/02/2026
CHI Barcode:



Consultant: Mr Michael M Dick

Dear Ms McCracken

Patient Name: Isabel McCracken
Patient date of birth: 18/08/1978
Patient Address: 1D Cumbrae Crescent, Coatbridge, ML5 4PX

It was lovely to meet you in Monklands General Hospital on 4th February where you attended for your colonoscopy procedure.

Mr Dick had arranged this for you to assess your defunctioning colonoscopy. You have a past medical history of a previous right hemicolectomy with end ileostomy for TI abscess in May 2021.

Unfortunately, I was unable to offer you any sedation or Entonox as you had advised the staff that you take cannabis daily and you had taken cannabis 20 minutes prior to entering the Endoscopy Department.

To be safely offered sedation or Entonox you cannot have any cannabis in your system.

You did agree to try without any medication, however, you immediately withdrew consent after I intubated the scope.

You have agreed to be re-listed. I would advise you to withhold cannabis for 72 hours before your next colonoscopy so that we can offer you the sedation safely

Yours kindly

Sandra Paterson
Nurse Endoscopist

Authorised on 06/02/2026 10:20:46 by Sandra Paterson.

(D) Dr I Roiatti
Waverley Medical Practice
Coatbridge Health Centre
1 Centre Park Court
Coatbridge
ML5 3AP

(P) Mr Michael Dick
Consultant Surgeon
University Hospital Monklands
Monks court Avenue
AIRDRIE
ML6 0JS

COPY PAGE

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F
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A

1808785142
18/08/1978
MCCRACKEN, Isabel
1d Cumberae Crescent,
Coatbridge, Lanarkshire

ML5 4PX
or attach addressograph label here

University Hospital:
☐ Hairmyres ☒ Monklands ☐ Wishaw



Day Case Endoscopy

Identifies as: She

Date: 4/2/26

Arrival Time: 11:02 Admission Time: 14:05 (24 hour)

Proposed Procedure:

- ☐ Bronchoscopy ☒ Colonoscopy
☐ Endoscopic retrograde cholangiopancreatography (ERCP)
☐ Flexible Cystoscopy
☐ Flexible Sigmoidoscopy ☐ Gastroscopy
☐ Percutaneous endoscopic gastrostomy (PEG)
☐ Other (specify)

Referring Consultant:

Escort:

Contact
Transport

Patient Details - patient to complete this page (if appropriate)

Preferred name: * 1224 *

Phone: Home:

Mobile:

GP:

Practice: Waverly Practice

Next of Kin

Relation:

Address:

Postcode

Contact

Phone number:

Do you have spiritual or religious needs?

☐ Yes ☒ No

If yes give details:

Do you follow a modified/special diet?

☐ Yes ☒ No

If yes give details:

Do you have any issues with swallowing?

☐ Yes ☒ No

If yes give details:

Past Medical History - please tick all that apply and give details below

- ☐ Alcohol ☐ Angina ☐ Asthma/Bronchitis/COPD ☐ Diabetes
☐ Epilepsy/Fits/Fainting ☐ Glaucoma/Eye surgery ☐ High blood pressure ☐ Cardiac related events
☐ Jaundice/Hepatitis ☒ Recreational drugs ☒ Sedation/Anaesthetics ☐ Smoking
☐ Tuberculosis ☐ Other: (specify) NO ISSUES

Details:

* Cannabis - Had 20mins ago

* VRE MAY 2021 *

DVT -> PE 2021

Do you have any other health problems? mental health - personality disorder

* Has stomach issues

Please list any medications you take here:

Quetiapine - not had for couple of days

Apixaban last had 2/2/26

Loperamide - last had 2/2/26

VIBIZ



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18/08/1978

MCCracken, Isabel

1d Cumberae Crescent,

Coatbridge, Lanarkshire

1

F

ML5 4PX

4AT Assessment (screening for Cognitive Impairment and Delirium - over 65s only)	Yes No N/A	Falls Risk Assessment (over 65s only)	Yes No N/A
4AT screening carried out? (see page 3)	☐ ☐ ☒	Falls Risk Assessment required?	☐ ☐ ☒
If yes, further action required?	☐ ☐ ☐	Have you fallen once or more in the past 12 months?	☐ ☐ ☐
MRSA Status (complete if applicable)		Do you have any unsteadiness on your feet or difficulty with walking or balance?	☐ ☐ ☐
Previous MRSA history?	☐ ☒ ☐	Have you ever found yourself on the ground but were unsure why?	☐ ☐ ☐
MRSA screen obtained?	☐ ☒ ☐	If yes to any above red triangle in use?	☐ ☐ ☐
Infection risk suspected/identified?	☐ ☒ ☐		
Senses			
Sight impaired?	☐ ☒ ☐		
Hearing impaired?	☐ ☒ ☐		
Communication			
Does the patient require an interpreter?	☐ ☒ ☐	Mobility	
		Independent?	☒ ☐ ☐
		Requires aids?	☐ ☐ ☒
Details/Actions/Comments:			

Patient Valuables Disclaimer

NHS Lanarkshire accepts no responsibility for loss or damage of any patient valuables or money however the loss or damage may occur, unless deposited for safekeeping.

- I have been informed of the hospital arrangements for safekeeping of valuables and money.
- I have been advised to send home or hand over valuables and money for safekeeping while I am in hospital.
- I have decided to take responsibility for my valuables and money while I remain in hospital.

I have read and understood the above. *Can take valuables into room.*

Patient name: (PRINT) _____ Signature: _____

Admitting Nurse: (PRINT NAME)	Designation:
<i>LYNN MCENTAN</i>	<i>RN</i>
Signature:	
<i>Lynn McEntan</i>	

Date/Time Prescribed	Drug	Dose	Route	Doctor's Signature	Given by	Time Given



1808785142

18/08/1978

F

MCCRACKEN, Isabel

1d Cumberae Crescent,
Coathbridge, Lanarkshire

ML5 4PX

or attach addressograph label here

☐ F

4AT Assessment Tool

(Screening for Cognitive Impairment and Delirium)

☒ Not applicable

Complete for all patients over 65 years if required

	Date:	
	Time:	
	Initials:	
1. Alertness – This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating. - Normal (fully alert, but not agitated, throughout assessment) - Mild sleepiness for <10 seconds after waking, then normal - Clearly abnormal	0 0 4	
2. AMT4 – Ask the patient: age, date of birth, place (name of the hospital or building), current year - No mistakes - 1 mistake - 2 or more mistakes/untestable	0 1 2	
3. Attention – Ask the patient: 'Please tell me the months of the year in backwards order, starting at December.' To assist initial understanding one prompt of, 'What is the month before December?' is permitted. - Achieves 7 months or more correctly - Starts but scores <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 (e.g. paranoia, hallucinations) arising over the last 2 weeks and still evident in the last 24 hours. - No - Yes	0 4	
4AT TOTAL SCORE:		

4AT Score:

4 or above: Possible delirium + / - cognitive impairment.

1 - 3 : Possible cognitive impairment. More detailed cognitive assessment and informant history taking are required.

0: Delirium or severe cognitive impairment unlikely (but delirium still possible if (4) information incomplete).

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1808785142
 18/08/1978 F
MCCRACKEN, Isabel
 1d Cumber Crescent,
 Coatbridge, Lanarkshire
 W L5 4PX
 or attach addressograph label here

Baseline Observations - record on NEWS Chart as per local policy

Temperature: 36.6 Blood Pressure: 104/77
 Heart Rate: 98 Respirations: 19
 SpO2: 97% NEWS Score: (1)
 Pain Score: 0

Pre-Procedure Checklist	Yes No N/A	Comments	Check 1	Check 2
Is the referral letter available?			☒	☒
Check you have the correct patient - name, address, date of birth			☒	☒
Check the patient has the correct name band on			☒	☒
Check the patient is having the correct procedure			☒	☒
Check the patient has consented for the correct procedure			☒	☒
Is the patient having sedation? If yes, check they have a responsible adult to collect them for discharge and stay with them for 24 hours and are advised not to leave unit until escort arrives	☒ ☐	☐ Throat spray Daughter collecting @ Spm carer at home for 24hrs	☒	☒
Has the patient ever been notified that they are at increased risk of CJD or vCJD for public health purposes?	☐ ☒	If 'yes' refer to policy and discuss with Infection Prevention and Control Team	☒	☒
Bowel preparation completed? ☒ Home ☐ Hospital	☒ ☐ ☐	Name of prep: <u>Moviprep</u> Time given: <u>Not managed</u> (if applicable) <u>Dark brown liquid</u>	☒	☒
Does the patient have any allergies? If yes, red name band applied?	☒ ☒	If yes, details: <u>Diclofenac</u>	☒	☒
Does the patient have dentures? If yes, have they been removed?	☒ ☒	☐ Caps ☒ Crowns ☐ Loose	☒	☒
Is the patient fasted?	☒ ☐	Last ate: <u>17:30</u> (24 hour) <u>few forkfuls</u> Last drank: <u>18:00</u> (24 hour) <u>Sips water</u> Date: <u>22/26</u> <u>all morning</u>	☒	☒
Does the patient have diabetes? ☐ Diet ☐ Tablet ☐ Insulin	☐ ☒	If yes, BM: mmols Time checked: : (24 hour) Further actions:	☒	☒
Is the patient pregnant? Test carried out?	☐ ☒ ☐		☒	☐
Is the patient on Warfarin or other anti-coagulants?	☒ ☐	If yes, details: <u>Apixaban</u> Time given: <u>2/2/26</u> (24 hour)	☒	☒
Is INR available?	☐ ☐	If yes, details:	☐	☐
Does the patient have any internal metalwork or pacemaker?	☐ ☒	If yes, details:	☒	☒
Infection risk suspected/identified, e.g. HIV, hepatitis B or C?	☐ ☒	If yes, details:	☒	☒

Check 1. Signature: Lynn Mann Time: 14:17 (24 hour)
 Check 2. Signature: KSCULLION Time: 15:06 (24 hour)

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1808785142

18/08/1978

MCCRACKEN, Isabel

1d Cumbrae Crescent,

Coatbridge, Lanarkshire

F

re

ML5 4PX

Procedure

Time in: 15:00 (24 hour) ☒ Endoscopy Pause

Scope 1 No: 584 Scope 2 No:

Endoscopist: Sandra Paterson

Procedure(s) Performed Colonoscopy

☐ Patient consent withdrawn

Diathermy plate applied? ☐ Yes ☐ No If yes site: ☐ Removed

Condition of skin checked post procedure: ☐ Satisfactory ☐ Unsatisfactory

Medication administered: ☐ No sedation

Throat spray: Time: If yes, nil by mouth 30/60/90/120 minutes (delete as applicable)

Topical Lignocaine: mls Time: IV Alfentanil: mcgs Time:

IV Midazolam: mgs Time: IV Flumazenil: mcgs Time:

IV Pethidine: mgs Time: IV Naxolone: mgs Time:

IV Buscopan: mgs Time: Oxygen: litres Time:

IV Fentanyl: mcgs Time: Nitrous Oxide - self administration:

Other: (specify) Time: ☐ Yes ☐ No ☐ N/A Time:

Comfort Score: 1 AVPU Score: A

Pulse oximetry - SpO₂: 100% Heart Rate: 98

Samples/Interventions:

☐ Argon plasma coagulation (APC) ☐ Biopsies ☐ Gastric balloon/removal

☐ Sphincterotomy (ERCP) ☐ Aspirate ☐ Brushes/slides

☐ Haemorrhoidal banding ☐ Stent insertion ☐ Balloon dilatation

☐ Campylobacter-like organism (CLO) test ☐ Injection of ink ☐ Variceal banding/injection

☐ Balloon trawl (ERCP) ☐ Endoscopic muc ☐ Polypectomy

☐ Other: (specify)

Nursing Assessment/Comments: Time to Recovery: 15:15

Colonoscopy commenced. On insertion of scope patient withdrew consent. Unable to tolerate procedure.

Completed by: (PRINT NAME) A. McArthur Designation:

Signature: A McArthur Staff nurse

Scope Cleaning – complete only if required as per local hospital/dept. policy ☐ Not applicable

1. Social clean in room by: Signature: Date: Time:

Processed before disinfection by: Signature: Date: Time:

2. Social clean in room by: Signature: Date: Time:

Processed before disinfection by: Signature: Date: Time:

[--- WASH CYCLE P 1808785142
 18/08/1978 F
 MCCRACKEN Isabel

[Cante]	Ra	[Cante]	Medical
[Serial No	RA	[31 Day Endoscope Drying Cabinet	
[Start	13l	[EDC22035	
[End	13l	[Endoscope copy	
[Date	03	[Book Out	
[Cycle No	17	[Date 04/02/2026	Time 14:05.
[Load Operator	12	[Hook	03
[Name	1a	[Make	olympus
[Unload Operator	12	[Model	cf-ez1500d1
[Name	1a	[Serial No	2506584
[--- Ho		[GS1	
[Hookup No		[Cycle No	11411
[Serial No		[Booked In 03/02/2026	Time 13:35
[GS1		[Name: laura mcphée. ID:	3
[--- E		[Chan Temp	28
[OLYM		[Chan RH	11
[Serial No		[Cab Temp	28
[GS1		[Cab RH	14
[Revision		[Booked Out 04/02/2026	Time 14:05
[IMS Verify		[Name: Raymond Allan. ID:	33
[Control		[Control: OK	
[IMS Verify		[IMS : OK	

[Last SD	[Cante]	Medical
[Suction	[31 Day Endoscope Drying Cabinet	
[Biopsy	[EDC22035	
[Water	[Record copy	
[Air	[Book Out	
[Aux 1	[Date 04/02/2026	Time 14:05.
[Aux 2	[Hook	03
[RB	[Make	olympus
[Leak Test	[Model	cf-ez1500d1
[Detergent	[Serial No	2506584
[Disinfectant	[GS1	
[Final Rinse	[Cycle No	11411
[Detergent	[Booked In 03/02/2026	Time 13:35
[Disinfectant	[Name: laura mcphée. ID:	3
[Final Rinse	[Chan Temp	28
[--- Chemical	[Chan RH	11
[Disinfectant	[Cab Temp	28
[Disinfectant	[Cab RH	14
[Disinfectant	[Booked Out 04/02/2026	Time 14:05.
[Disinfectant	[Raymond Allan. ID:	33.
[Disinfectant	[Control: OK	
[Disinfectant	[: OK	

1808785142
 18/08/1978 F
 MCCRACKEN Isabel

[illegible]

Pain Assessment Chart

0 NO PAIN			1 MILD PAIN			2 MODERATE PAIN			3 SEVERE PAIN			4 Worst Pain imaginable		
A	B	C	A	B	C	A	B	C	A	B	C	A	B	C
A = No limitation of relevant activity due to pain B = Mild limitation of relevant activity due to pain C = Unable to complete activity due to pain														

CHI
First 1808785142
18/08/1978 F
Last MCCracken, Isabel
Add 1d Cumbrae Crescent,
Coatbridge, Lanarkshire
ML5 4PX
or attach addressograph label here

Nursing Evaluation/Comments/Follow-up
Returned to recovery
obs recorded
cannula removed
Diet + fluid given.

Visual Infusion Phlebitis (VIP) score 2-5 – Remove Peripheral Vascular Catheter (PVC); VIP 2-5 - Inform Senior clinician/medic.

Anti-microbial guideline on firstport.

	0 to 24 hours from insertion		25 to 48 hours from insertion		to 72 hours from insertion	
Record date & time of inspection (should be completed 12hrly)	Date Time	Date Time	Date Time	Date Time	Date Time	Date Time
Reason PVC still required	not req					
Need for IV therapy (including antibiotics) has been made by clinical staff and is still required	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
VIP score (0-5) (Please circle)	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5

Post Sedation Discharge Scoring System		☐ Not applicable	Score						
Vital Signs	BP and pulse within 20% of pre-admission baseline	2							
	BP and pulse 20 – 40% of pre-admission baseline	1							
	BP and pulse 40% of pre-admission baseline	0							
Activity Level	Steady gait, no dizziness, or meets pre-procedure level	2							
	Requires assistance	1							
	Unable to ambulate	0							
Nausea/Vomiting	No	2							
	Yes	0							
Pain	Pain score 0 – 2	2							
	Pain score 3 – 4	0							
Neuro Response (AVPU)	Alert or Voice	2							
	Pain	1							
	Unresponsive	0							
		TIME							
		TOTAL							

Maximum Score is 10: Patients scoring 9 are fit for discharge

Discharge Checklist	Yes	No	N/A		Yes	No	N/A
Tolerating fluids and diet	☒	☐	☐	Escort/carer available	☒	☐	☐
Patient advised to commence food and drink after 30 / 60 / 90 / 120 minutes (for throat spray only - delete as applicable)	☐	☐	☒	Private transport available	☒	☐	☐
IV cannula removed	☒	☐	☐	Ambulance/hospital transport arranged	☐	☐	☒
Has passed urine (if applicable)	☐	☐	☒	- Time: : :	☒	☐	☐
PR bleeding - if yes, comment below	☐	☒	☐	Written/verbal information given	☒	☐	☐
Belongings/valuables returned	☐	☐	☒	Contact details given	☒	☐	☐
	☐	☐	☒	Letter to GP given	☐	☐	☒

Additional Comments/Notes:
Isabel aware of follow up.

Completed by: (PRINT NAME) Rmce	Designation: SN
Signature: <i>[Signature]</i>	Discharge Time: 15:30 (24 hours)

McCracken/1808785142

PATIENT AGREEMENT TO ENDOSCOPIC INVESTIGATION OR TREATMENT

Name of Procedure:- Colonoscopy

Inspection of the lower gastrointestinal tract with a flexible endoscope (with or without biopsy, photography, removal of polyps, injection treatment).

STATEMENT OF PATIENT

You have the right to change your mind at any time, including after you have signed this form.

I have read and understood the information in the attached leaflet. The intended benefits are to diagnose and treat a possible cause for my symptoms or to review the findings of a previous endoscopy. The possible serious risks include rectal bleeding, an adverse reaction to sedation (if required), perforation, haemorrhage or missed abnormalities.

I agree to the procedure described in my letter and on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience. Where a trainee performs the examination, this will be undertaken under supervision by a fully qualified practitioner.

Signed

Kathel McCracken

NAME (Print in Capitals):

ISABELL MCCRACKEN

If you would like to ask further questions do not sign the form now. Bring it with you and you can sign it after you have talked to a health care professional

CONFIRMATION OF CONSENT

(To be completed by a health care professional when you are admitted for your procedure.)

I have confirmed that the patient/parent/guardian understands what the procedure involves including the benefits and risks.

I have confirmed that the patient/parent/guardian has no questions and wishes the procedure to go ahead.

Signed

OK

Date

4/2/16

Name

OK

Title

WC

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1808785142
18/08/1978 F
MCCRACKEN, Isabel
1d Cumberae Crescent,
Coatbridge, Lanarkshire
ML5 4PX

University Hospital:

☐ Hairmyres

☒ Monklands

☐ Wishaw

NHS
Lanarkshire

Checklist for the use of 50% Nitrous Oxide and 50% Oxygen (Entonox)

Checklist	Yes	No
1. Is the patient unable to hold a facemask or mouthpiece?	☐	☒
2. Does the patient have any impairment to their conscious level?	☐	☒
3. Does the patient have any compromise to their airways?	☐	☒
4. Does the patient have any maxillofacial injuries/ear surgery/disease or trauma?	☐	☒
5. Does the patient have an air embolism or bowel obstruction, or gross abdominal distension?	☐	☒
6. Has the patient had recent air encephelography? <i>prev. clot -> Stroke</i>	☐	☒
7. Does the patient have severe cardiac disease e.g. mitral valve disease, or underwent recent coronary bypass surgery?	☐	☒
8. Does the patient have severe respiratory disease? e.g. COPD; chest trauma, pneumothorax, recent chest drain insertion/removal?	☐	☒
9. Has the patient had eye surgery involving gas bubble insertion in the last 9 weeks?	☐	☒
10. Has the patient been involved in a recent deep sea dive (in last 48 hours) and/or decompression sickness?	☐	☒
11. Does the patient have any bone-marrow insufficiency	☐	☒
12. Is the patient in the first trimester of pregnancy or currently trying to become pregnant?	☐	☐

If yes to any of the above, give details and inform doctor for final decision:

patient has used cannabis today - contra-indicated.

KRM

50% Nitrous Oxide and 50% Oxygen prescribed and given? ☐ Yes ☐ No

NB. If the patient has 50% Nitrous Oxide and 50% Oxygen for analgesia, 30 minute discharge applies.

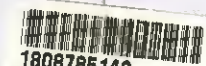


Completed by: (PRINT NAME)	Designation:
Signature:	Date: / / Time: :

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SURNAME

FORENAMES



1808785142
18/08/1978 F
MCCRACKEN, Isabel
1d Cumberae Crescent, Coatbridge,
Lanarkshire

CLINICAL NOTES

DATE

ML5 4PX

21/01/2020

D- NGUS

no pp detected

- well

plm: fln tel 61/2

or MEl- Abbltg



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SOUTH GLASGOW HOSPITALS

IMMUNOLOGY REPORT

(Tel 0141 347 8872/0141 354 9337)

IMFLC6 Run: 895

Surname:
Forename:
DOB/Age:
CHI/Unit No:
Address:
Details:



1808785142

18/08/1978 F

MCCRACKEN, Isabel

1d Cumbrae Crescent, Coatbridge,

Lanarkshire

Location: Haematology
Wishaw General Hospital
50 Netherton St Wishaw
Lanarkshire Health Board

Requestor: Not known
Ext Labno: 5128034675

Dr Garnet Haem
MR OPD

ML5 4PX

SERUM FREE LIGHT CHAINS

[[CURRENT]]

Lab Number	B,26.3470762	B,23.3628427	B,21.3657909	B,21.3546854
Date/Time collected	31.12.25	14.07.23	27.10.21	06.04.21
Date/Time received	06.01.26 13:27	18.07.23 12:21	28.10.21 13:54	08.04.21 14:27
Free Kappa mg/L (3.3-19.4)	15.7	18.9	17.0	45.3
Free Lambda mg/L (5.7-26.3) *	30.4	29.4	30.5	66.9
K/L ratio (0.26-1.65)	0.52	0.64	0.56	0.68

RECEIVED IN

12 JAN 2026

LABORATORY DIRECTORATE
WISHAW GENERAL HOSPITAL

LA01

Result Comments:

31.12.25 FreeLChain: In renal impairment, K/L ratio may increase to 0.37 - 3.1

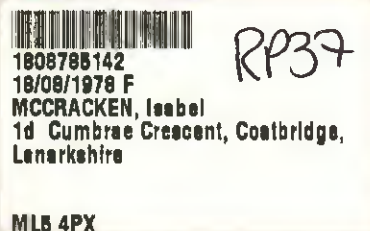
Antigen excess rare but cannot be excluded. If results do not agree
with clinical/lab findings, contact Immunology on 0141 347 8872

RECEIVED IN

LAJ
GENERAL
MEMORANDUM
FOR THE DIRECTOR

Wishaw General Hospital
50 Netherton Street
Wishaw
ML2 0DP

23/02/2026



Appointment Booking Office Direct Dial: 01698 687441

Ms Isabel McCracken
1d Cumbrae Crescent

Coatbridge
ML5 4PX

Dear Ms McCracken

Your Reference: CHI Number 1808785142

You were referred to the Endoscopy Unit with symptoms thought to be coming from your stomach/bowel.

We wrote to you recently inviting you to contact us to make an appointment to attend the Endoscopy Unit, unfortunately you have not responded to our communication to you and you have been subsequently been removed from the Endoscopy waiting list.

We have copied this letter to both your General Practitioner and your Hospital Consultant. If you have any ongoing concerns you should discuss this with your General Practitioner.

Yours sincerely

PatientBooking.WG@lanarkshire.scot.nhs.uk

We have an email address available for appointment cancellations/queries. Please note that we are unable to book or reschedule appointments through this email.

Copy to Mr Michael M Dick (Hospital Consultant) and GP,
Dr I Roiatti,
Waverley Medical Practice, Coatbridge Health Centre, 1 Centre Park Court, Coatbridge
ML5 3AP

Office reference: PFBREMOVAL

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Radiology Report

Patient Name:	Mccracken Isabel	Report Date:	13-Mar-2011 13:05
Patient ID:	1808785142	Accession No.:	L103127893501
Patient Birth Date:	18-Aug-1978	Report Status:	F
Referring Physician:	AE CONSULTANT	Reason For Study:	

31278935 13/03/2011 XR Cervical Spine

Clinical History: Assault.

The odontoid peg is tilted slightly posteriorly. There is no obvious associated fracture, and I note the patient has symptoms referable to the lower cervical region. Nonetheless if there is any clinical doubt further imaging is suggested. No other significant abnormality demonstrated with preservation of normal cervical alignment. Verified by: Dr J Guse, Consultant Radiologist on 13/03/2011

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Radiology Report

Patient Name:	Mccracken Isabel	Report Date:	16-Jun-2011 08:03
Patient ID:	1808785142	Accession No.:	L103140879701
Patient Birth Date:	18-Aug-1978	Report Status:	F
Referring Physician:	AE CONSULTANT	Reason For Study:	

31408797 15/06/2011 XR Ankle Lt

Clinical History:

Assaulted.? Fracture.

Report:

Soft tissue swelling overlying the lateral malleolus but no definite fracture. Well corticated piece of bone adjacent to the tip of the lateral facet consistent with either os subfibularis or r an old none healed fracture.

Verified by: Dr Yahya Husami, Consultant Radiologist on 16/06/2011

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Radiology Report

Patient Name:	McCracken Isabel	Report Date:	24-Dec-2014 15:36
Patient ID:	1808785142	Accession No.:	D105000635240
Patient Birth Date:	18-Aug-1978	Report Status:	F
Referring Physician:	N/A Applicable Not	Reason For Study:	

Clinical Reason: Depo 5 years.

Report: The T-Score for the lumbar spine is -0.7. Lumbar spine bone density is within normal limit.

The T-Score for the hips is -1.3. The hips are osteopaenic and at moderately increased risk of fracture.

Dictated by: Dr Grant Baxter

Verified by: Dr Grant Baxter

Reported by :

Verified by : *Baxter Dr Grant*

Produced by Carestream Health PACS

Radiology Report

Examination performed at: **University Hospital Monklands**

Patient Name:	Mccracken, Isabel	Exam Date:	26/03/2021
Patient ID:	1808785142	Exam Number:	L104222510201
Patient Date of Birth:	18/08/1978	Report Date:	27/03/2021 16:45:56
Referring Consultant:	Dr Carole Neff, ED	Referring Dept/Location:	Monklands Emergency Dept

Examination: XR Chest

Accession: L104222510201, Date: 26/03/2021, Procedure: XR Chest

Clinical Indication: unwell D&V hypotension signs of sepsis ? LRTI

Dose: 5.6cGy cm2

Report: Normal heart and mediastinal contours. No evidence of active pulmonary disease.

Dr Alastair McGhee, Consultant Radiologist. GMC number 3673113

Radiology Report

Examination performed at: University Hospital Monklands

Patient Name:	Mccracken, Isabel	Exam Date:	29/03/2021
Patient ID:	1808785142	Exam Number:	L104223228601
Patient Date of Birth:	18/08/1978	Report Date:	29/03/2021 15:20:48
Referring Consultant:	Juliana Allison	Referring Dept/Location:	Acute Medical Receiving Unit (wd19)

Examination: US Abdomen

Accession: L104223228601, Date: 29/03/2021, Procedure: US Abdomen

Clinical Indication: suspected biliary sepsis ?cholecystitis ?cholangitis. pt with rigors, vomiting and diarrhoea

Report: The liver is normal in size and texture with no focal liver lesion demonstrated. The midline structures were obscured by overlying bowel gas. There is a focal area of cortical scarring at the upper pole of the left kidney, both kidneys are otherwise unremarkable. Gallbladder, common bile duct and spleen appeared normal.

Verified By: Louise Miller, Sonographer, RA46136

Radiology Report

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Examination performed at: University Hospital Monklands

Patient Name:	Mccracken, Isabel	Exam Date:	01/04/2021
Patient ID:	1808785142	Exam Number:	L104224748601
Patient Date of Birth:	18/08/1978	Report Date:	01/04/2021 16:43:28
Referring Consultant:	Catriona Macrae	Referring Dept/Location:	MK Ward 12

Examination: CT Abdomen pelvis with contrast

Accession: L104224748601, Date: 01/04/2021, Procedure: CT Abdomen pelvis with contrast

Clinical indication: Admitted with backpain, rigors, diarrhoea and vomiting, deranged LFTs. AUSS - NAD. On amox/met/gent, CRP remains raised, WCC climbing, albumin falling, ongoing diarrhoea ?colitis ?intrabdominal collection

Report

Technique: CT abdomen and pelvis with portalvenous contrast.

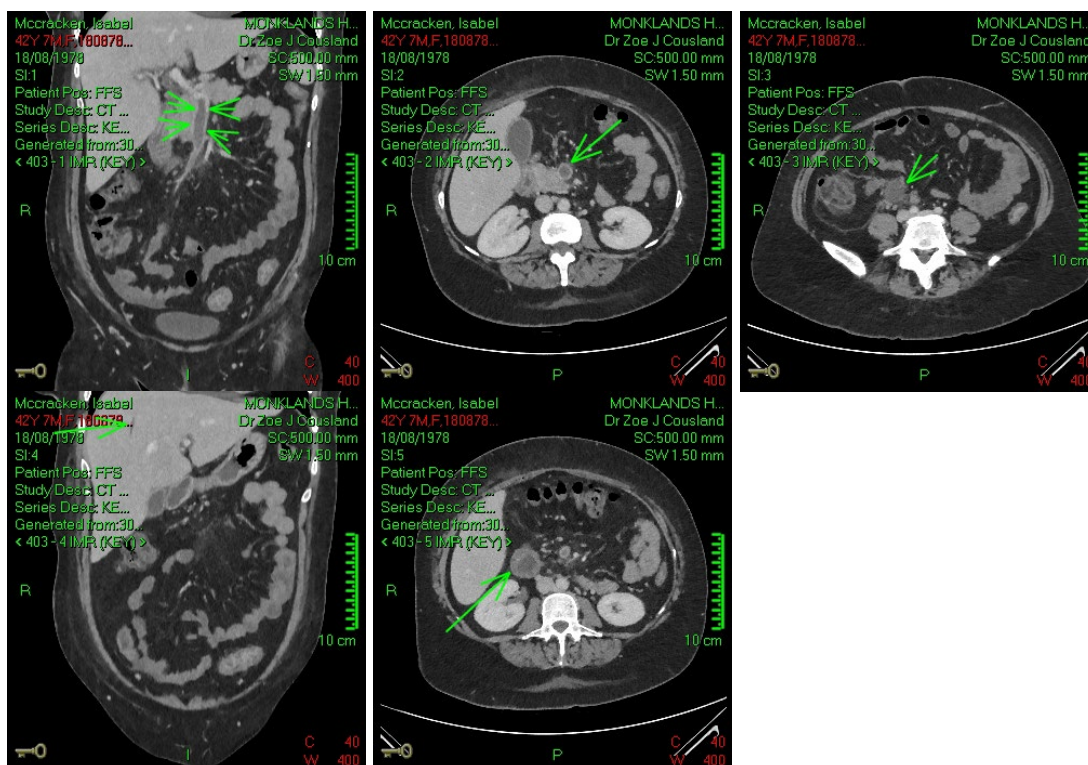
There is no enhancement within the lumen of the superior mesenteric vein. The vein and several its branches are distended. Appearance in keeping with the superior mesenteric vein thrombosis. This extends to the level of the confluence with the portal vein (which is patent). There is prominent expansion of the vein at the level of the L4 vertebral body probably with some surrounding inflammatory fat changes. A small linear low density structure within segment 8 may reflect thrombus within a small portal vein branch. Periportal oedema is noted more proximally. No intra or extra hepatic biliary tree dilatation. No liver mass lesions. The wall of the second and third parts of the duodenum is thickened and oedematous but otherwise the wall of the small and large bowel has a normal appearance. Trace of free fluid in the right paracolic gutter and dependently within the pelvis. Gallbladder, pancreas, spleen, adrenals and kidneys have a normal appearance.

Low-volume right basal atelectasis and a small right pleural effusion. Minimal left basal atelectasis. Mild - moderate degenerative change L5/S1. No other significant skeletal pathology demonstrated.

Conclusion:
Extensive superior mesenteric vein thrombus.

Case discussed with referring clinician. Urgent surgical and haematological opinion advised.

Verified by: Dr Kenneth Mitchell, Consultant Radiologist, GMC 4186308



Radiology Report

Examination performed at: **University Hospital Monklands**

Patient Name:	Mccracken, Isabel	Exam Date:	12/04/2021
Patient ID:	1808785142	Exam Number:	L104228733101
Patient Date of Birth:	18/08/1978	Report Date:	12/04/2021 15:07:57
Referring Consultant:	Dr Eleanor Hanraads	Referring Dept/Location:	MK Ward 12

Examination: CT Neck and thorax with contrast

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Accession: L104228733101, Date: 12/04/2021, Procedure: CT Neck and thorax with contrast

Clinical Indication: pt admitted with extensive superior mesenteric vein thrombosis. unclear cause as to why she has this. thrombophilia screen in progress, no family hx of same. no pharmacological causes identified. found on CT abdo pelvis. denies any symptoms of malignancy but ?underlying cause. bloods deranged with normocytic anaemia, marked thrombocytosis, persistent leukocytosis (neutrophilia) although afebrile. CXR looks ok but pt lifelong smoker of cannabis and cigarettes. please do ct chest and neck to look for underlying malignancy / lymphadenopathy in keeping with haematological ca.

CT Neck and thorax with contrast

Report:

IV contrast enhanced examination in a portal venous phase.

A few shotty appearing cervical nodes however none these appear pathological in nature. No significant axillary, hilar or mediastinal nodes.

No intrapulmonary or endobronchial mass lesion. Minor bilateral dependent changes.

Within the partially imaged upper abdomen there has been worsening progression of the thrombus within the SMA which now extends to involve the main portal vein and both right and left portal vein branches. This appears to be slightly more extensive within the right portal vein branch.

Heterogeneous parenchymal enhancement of the liver which is likely due to the large volume of thrombus within the portal veins. Satisfactory enhancement of the partially imaged hepatic veins.

No concerning skeletal lesions.

Summary: No convincing evidence of malignancy. Progression of the portal venous thrombus when compared to the previous CT.

Verified by: Dr Raymond Rueben Consultant Radiologist GMC 7277442

Radiology Report

Examination performed at: **University Hospital Monklands**

Patient Name:	Mccracken, Isabel	Exam Date:	27/04/2021
Patient ID:	1808785142	Exam Number:	L104235566301
Patient Date of Birth:	18/08/1978	Report Date:	28/04/2021 10:36:35
Referring Consultant:	Dr Jordanna Deosaran	Referring Dept/Location:	MK Medical Assessment Unit

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Examination: XR Chest

Accession: L104235566301, Date: 27/04/2021, Procedure: XR Chest

Clinical Indication: 42 year old female admitted feeling generally unwell. WCC 43. Please can we do CXR ? any evidence of infection ? Thanks

Report:

Cardiothoracic ratio is normal. Lungs are clear.

Verified by: Dr Munir Ahmad, Consultant Radiologist, GMC 6145215

Radiology Report

Examination performed at: **University Hospital Monklands**

Patient Name:	Mccracken, Isabel	Exam Date:	28/04/2021
Patient ID:	1808785142	Exam Number:	L104235683801
Patient Date of Birth:	18/08/1978	Report Date:	28/04/2021 14:54:31
Referring Consultant:	Dr Jordanna Deosaran	Referring Dept/Location:	MK Medical Assessment Unit

Examination: CT Abdomen pelvis with contrast

Accession: L104235683801, Date: 28/04/2021, Procedure: CT Abdomen pelvis with contrast

Examination:

CT Abdomen pelvis with contrast

Clinical Indication:

42 year old female recent admission with extensive mesenteric thrombus. Over past few weeks increased committing, feeling generally unwell and back pain. INR > 8 yesterday and reversed with vitk and now subtherapeutic. Hb drifted down to 77, wcc 44, CRP >400. Tachy and BP 95 systolic. We have commenced triple abx therapy. please can we do CTAP ? any evidence of collection or worsening again of thrombus burden or evidence of ischaemia or any bleed given high INR and fall in Hb with no external source of blood loss. many thanks

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Report:

Images acquired in the portal venous phase.
Comparison made with CT of 12/04/2021 and 1/4/21.

There is more extensive thrombosis of the portal venous system extending into the intrahepatic components of the portal vein. There is also thrombus in the most medial segment of the splenic vein at its confluence with the SMV. The mesentery appears extremely congested - more so when compared to previous imaging - likely a consequence of increased venous back pressure.

At the inferior aspect of the small bowel mesentery, mesenteric vein thrombus can be followed to an ovoid area of soft tissue attenuation which appears sited within the mesentery - expanded tributary with thrombus? Mesenteric abscess? This has reduced in volume since previous scan and now contains gas, some of which seems to be within the lumen of the mesenteric vein tributaries.

There is no intramural bowel gas, but the presence of gas in the mesenteric vessels raises the possibility of mesenteric venous ischaemia/infarction or a cavitating abscess.
The hepatic veins continue to enhance appropriately.
No evidence of intra-hepatic duct dilatation or any focal liver lesion.

As before there remains fluid in the pericolic gutter and pelvis. The overall volume of this has marginally increased, but there is no evidence of haemorrhage.

No evidence of small or large bowel dilatation. There are multiple loops of oedematous and thickened duodenal and jejunal loops, but no focal pathology. The bowel continues to enhance with contrast, though a little less than on previous scan, raising the possibility of venous ischaemia. The ascending colon wall is of fat attenuation raising the possibility of chronic inflammation. An underlying inflammatory bowel disease, with an interloop abscess is also a possibility.

The kidneys, spleen, gallbladder, and pancreas are unremarkable.

The imaged base of the lungs are clear.
No substantive abdominal or pelvic lymphadenopathy.
No concerning skeletal abnormality.

Conclusion:

Increasing thrombus burden from the SMV through main portal vein and into the intra-hepatic components of the portal vein. New distal mesenteric venous gas - possible reasons include mesenteric venous infarction, cavitation of mesenteric abscess or infected distal SMV thrombus with gas forming organism. Concern over potential for small bowel venous ischaemia or infarction or possible underlying undiagnosed chronic inflammatory bowel disease with interloop abscess. An urgent surgical review is suggested. Consider higher level care - HDU/ITU?

Findings discussed Dr. Goyal, Medical Consultant at the time of reporting.

Provisional Report by: Dr Faheem Ahmad, Radiology Specialist Registrar (GMC 7020143)
Verified by: Dr. Leigh Smart, Consultant Radiologist, GMC 6024739

Radiology Report

Examination performed at: **University Hospital Monklands**

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Patient Name:	Mccracken, Isabel	Exam Date:	03/05/2021
Patient ID:	1808785142	Exam Number:	L104238028501
Patient Date of Birth:	18/08/1978	Report Date:	03/05/2021 17:13:49
Referring Consultant:	Dr Lily Lei	Referring Dept/Location:	MK Ward 7

Examination: XR Chest

Accession: L104238028501, Date: 03/05/2021, Procedure: XR Chest

Clinical Indication: day 5 postop from ileocaecal resection and end ileostomy for venous ischaemic. on taz but CRP more than doubled on last bloods (272) and WCC 26.9. Need to rule out LRTI.

Dose: 17.7cGy cm2

Report: AP image. The heart size cannot be accurately assessed but it is probably not enlarged.. Normal mediastinal contours. There is some minor atelectasis at the left angle but otherwise the lungs are unremarkable. No free air under diaphragm.

Dr Alastair McGhee, Consultant Radiologist. GMC number 3673113

Radiology Report

Examination performed at: **University Hospital Monklands**

Patient Name:	Mccracken, Isabel	Exam Date:	19/05/2021
Patient ID:	1808785142	Exam Number:	L104245418701
Patient Date of Birth:	18/08/1978	Report Date:	19/05/2021 16:53:39
Referring Consultant:	Joshua Thompson	Referring Dept/Location:	MK Ward 7

Examination: CT Abdomen pelvis with contrast

Accession: L104245418701, Date: 19/05/2021, Procedure: CT Abdomen pelvis with contrast

Clinical Indication: Presented with extensive SMV thrombus (into portal, splenic, mesenteric branch) and suspicion of venous ischaemia. Laparotomy revealed viable bowel but abscess in mesentery near TI involving tip of appendix. Had a limited right hemicolectomy and end ileostomy. Pathology

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returned as benign. Thrombophilia screen so far negative. Plan is for BM biopsy, PET CT and scopes to try and exclude overt malignancy. Now a few weeks post op with persistent inflammatory markers. Clinically there is superficial wound dehiscence inferior aspect laparotomy wound and discharged haematoma. Can you exclude any deeper collection in the abdominal wall or pelvis? Has the SMV thrombus progressed?

CT Abdomen pelvis with contrast

Report: Comparison is made with previous CT dated 28/04/2021.

The previously demonstrated, subsequently surgically proven abscess in the mesentery has been resected along with a limited right hemicolectomy and formation of an anterior abdominal wall ileostomy.

There is contrast within the residual proximal colon - route of administration unclear. Adjacent to the suture line at the proximal residual colon, there is a new collection of fluid and gas which appears loculated and has a thin enhancing margin. No leakage of contrast from the adjacent colon into this collection. This collection measures 7.7 x 5 x 9.7 cm and extends inferiorly, anterior to the uterine fundus.

Separately, there is free fluid in the pelvis, left side of the abdomen, Morison's pouch and around stomach and spleen. No free intraperitoneal gas seen.

There is chronic complete occlusion of the intra and extrahepatic portal vein, splenic vein and superior aspect of the SMV with venous collaterals developing around the porta hepatis.

The inferior aspect of the laparotomy wound appears dehiscent with a few bubbles of gas visible in the subcutaneous tissues here. There is no collection around this site. There is some fat stranding in the greater omentum.

There is a little gas within the urinary bladder, though no catheter is seen. Has there been recent instrumentation or catheterisation to explain this? If not, I cannot exclude a fistula.

There is a new small left pleural effusion with associated passive left basal atelectasis.

Degenerative changes noted in the lower lumbar spine. Nil else of note in the visible skeleton.

Summary: New peripherally enhancing loculated collection of gas and fluid in the right iliac fossa, adjacent to the limited right hemicolectomy suture line, extending into the pelvis, anterior to the uterus and extensive free intraperitoneal fluid. Dehiscent inferior laparotomy wound. Chronic extensive splanchnic vein thrombosis with development of venous collaterals at porta hepatis.

Highlight to referrer UHM

Verified by: Dr. Leigh Smart, Consultant Radiologist, GMC 6024739

Radiology Report

Examination performed at: **University Hospital Wishaw**

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Patient Name:	Mccracken, Isabel	Exam Date:	17/08/2022
Patient ID:	1808785142	Exam Number:	L304456125701
Patient Date of Birth:	18/08/1978	Report Date:	17/08/2022 15:32:49
Referring Consultant:	GP Referral	Referring Dept/Location:	JOHNSTON LAURA

Examination: CT Head

Accession: L304456125701, Date: 17/08/2022, Procedure: CT Head

Clinical Indication: Intermittent headache. Head injury earlier this year.

Study Date: 17/08/2022

Report: Normal ventricles, cisterns and sulci. No acute focal intracranial lesion. Normal bony appearances. No abnormality of the visualised sinuses.

No acute focal intracranial lesion identified.

Final Sign By: Dr. John Addison, Consultant Radiologist, GMC 3170919

Radiology Report

Examination performed at: **University Hospital Monklands**

Patient Name:	Mccracken, Isabel	Exam Date:	14/12/2022
Patient ID:	1808785142	Exam Number:	L104509981201
Patient Date of Birth:	18/08/1978	Report Date:	15/12/2022 09:39:51
Referring Consultant:	Dr Elise Joelle Cranfield	Referring Dept/Location:	Monklands Emergency Dept

Examination: XR Chest

Accession: L104509981201, Date: 14/12/2022, Procedure: XR Chest

Clinical Indication: 44F admitted CP, fevers feeling hot and cold. ?LRTI

XR Chest

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Report:

Normal cardiomediastinal contours. There is minor left basal atelectasis as before. Lungs are otherwise clear.

No significant change since 03/05/2021.

Verified by: Dr. Killian Mac a' Bhaird (Consultant Radiologist) GMC 7495687

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