A&E Records

Surname/Forename	Sanderson, George
UHPI Number	610041369B

Episode Number	E090856

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
A&E Notes Episode/Ref: E090856 Dr Simon Barton 12/4/06	46 Male,,Working on building site on friday, wooden palatte fell from 60ft onto R shoulder/chest wall.,Increasing pain and SOB since yesterday.,,PMHx: Nil,DHx: Nil,SHx: Smokes 20 day,,O/E Tachy 105, BP 144/88, RR 25, Sats 92%, T 37.2,Uncomfortable,No obviouse/ gross external sign injury,Diffuse pain over R shoulder, scapula, chest wall (max axilla),Resp: Trachea central, resonent, transmitted upper airways noise, good AE despite shallow inspiration.,CVS/Abdo: Normal Exam,,CXR: #5/6/7th ribs, ? # scapula, increased opacification @ R heart border (?consolidation/ contusion),BG on 4L: hypoxic, PO2 8.8, sats 94%, CO2 5.6,ECG: Sinus tachy, slight tenting T's.,,D/ W: Cardiothoracics, CT,Bloods awaited,Admitt

NHS Lothian

Western General Hospital
Crewe Road South
Edinburgh
EH4 2XU

Dr Chowings
Leith Surgery
2 Duke Street
Edinburgh
EH6 8HQ

Date: 06/01/2026

Emergency Discharge Summary

Patient	George Sanderson 16/17 Pirrie Street Edinburgh EH6 5HY	**CHI**	**1210601451**
		Date of Birth / Age	12/10/1960 (65 years)
		UHPI	610041369B
		A&E Attendance Number	E6268339
Attendance Date	05/01/2026		
Attendance Time	12:38		
Mode of Arrival	Private Transport		
Source of Referral	Flow Centre		
Discharge Date	06/01/2026		
Discharge To		**Final Triage**	3 - Urgent
		Attendances in the last 12 months	1

Dear Dr Chowings

Presentation:	PC- KNOWN TO COLORECTAL, KNOWN SIGMOID STRICTURE, PAIN IN LOW ABDO STARTED ON FRIDAY, NEW RECTAL BLEED ON FRI AND SAT, PAIN ONGOING, TENDER LIF, NO BLOOD IN RECTUM ON RECTAL EXAM ?DIVERTICULITIS ?BLEED CAUSE P92 T36.9 S96% BP163/96
Diagnosis:	None
Procedures:	None

Dear Colleague,

This is an emergency care note as your patient attended the Surgical Assessment Unit at the Western General Hospital, Edinburgh.

The details of this attendance are outlined below. This is a summary of their attendance for your information only and no formal discharge letter will be issued.

CONSULTANT ON-CALL: Collie

DIAGNOSIS: Colitis/diverticulitis

INVESTIGATIONS PERFORMED: Bloods - WCC 8.7, CRP 8
CTAP: Mild segmental mural thickening related to the mid/distal sigmoid colon. Minor adjacent mesenteric injection. Appearances are most likely secondary to mild diverticulitis or alternatively colitis. Although difficult to fully assess on the current study and CT colonography 07/10/2024, there is a possible distal sigmoid/rectosigmoid junction stricture immediately distal to this mildly inflammed appearing segment (in keeping with previous colonoscopy findings).

PRESENTATION / MANAGEMENT: Presented with 2 day history of PR bleeding. Results and option of admission discussed with Mr Sanderson who decided he would prefer to go home with analgesia and worsening advice. He knows to call the helpline if ongoing or worsening issues.

MEDICATIONS ADDED ON DISCHARGE: Co-codamol

OUTPATIENT INVESTIGATIONS REQUESTED (SURGICAL TEAM PLEASE RECORD AND SEND TO CONSULTANT): None

FOLLOW-UP FROM SURGICAL TEAM: None

GP many thanks for your ongoing care

Yours sincerely,
Dr Bethany Fitt
FY2

Yours Sincerely,

Dr Keegan Chua Vi Long, Doctor

No ~~blood~~ anticoags.

NHS Lothian

Surgical Assessment Unit (SAU) Nursing Triage Checklist, WGH

Name
DOB
Unit No./C

610041369B /E6268339 M
SANDERSON George
12-Oct-60 CHI: 121 060 1451
70179 JS Chowings
16/17 Pirrie Street
EH6 5HY

151/88 95% 96 36'

Pain 8/10

Presenting History

PR bleeding past 3 days when morning bowels. Dark red blood with clots.
Feeling constipated.
Blood in toilet and on floor
Lower abdopain then going to toilet + bleeding every 20 mins
No SOB, No dizziness, No fevers
No Vomiting

Penicillin

Weight (Kg) 61.00	Height (cm) 5'C	BMI

Admission Checklist

	Initials		Initials
NEWS2 SCORE: 6	AD	Teds on YES ☐ NO ☐	
BM recorded YES ☐ NO ☐		MUST assessed (TRAK) YES ☐ NO ☐	
Bloods taken YES ☑ NO ☐	AD	Catheter insertion bundle completed YES ☐ NO ☐	
Venflon in situ YES ☑ NO ☐ Site: L) ACF Colour: Pink	AD	Falls risk assessed YES ☐ NO ☐	
Cultures taken YES ☐ NO ☐		MRSA screened YES ☐ NO ☐	
Name band YES ☑ NO ☐ Allergy band YES ☐ NO ☐	AD	4AT assessed (TRAK) YES ☐ NO ☐	
ECG required/completed? YES ☐ NO ☐		Relatives/carers aware? YES ☐ NO ☐	
Specimen of urine YES ☐ NO ☐		Patient Valuables Procedures explained? YES ☐ NO ☐	
Pregnancy test result (Ages 15 to 55) Positive ☐ Negative ☐ Reason not tested ☐			

Nurse's signature: A Dawda
Print name:

Date: 5/1/26

In Patient Records

NHS Lothian

Western General Hospital
Crewe Road South
Edinburgh
EH4 2XU

Infectious Diseases

Dr Chowings
Leith Surgery
2 Duke Street
Edinburgh
EH6 8HQ

Date: 30/01/2024

Inpatient Discharge Summary

Patient	George Sanderson 16/17 pirrie street Edinburgh EH6 5HY	**CHI**	**1210601451**
		Date of Birth / Age	12/10/1960 (63 years)
		UHPI	610041369B
Ward	Ward 43 WGH	**Admission Date**	18/01/2024
Consultant	Dr Iain D Page	**Discharge Date**	29/01/2024

Dear Dr Chowings

Allergen (Group to which Allergen belongs)	**Reaction**
PENICILLINS	2 other adverse reaction - see TRAK

Discharge Drugs:

Anoro Ellipta 55micrograms / 22micrograms/dose inhaler			
Dose	Route	Frequency	To Continue
1 Puff(s)	Inhaled	Once daily at 0700	Yes
Notes:			
Beclometasone 50micrograms/dose nasal spray			
Dose	Route	Frequency	To Continue
1 Spray(s)	BOTH nostrils	PRN PRN	Yes
Notes:			
Hydrocortisone 1% cream			
Dose	Route	Frequency	To Continue
1 Application(s)	Topical	Twice daily at 0700 & 2000 for 14 day(s)	Yes
Notes:			
Hypromellose 0.3% eye drops			
Dose	Route	Frequency	To Continue
1 Drop(s)	BOTH eyes	PRN prn	Yes
Notes:			
Miconazole 2% cream			
Dose	Route	Frequency	To Continue
1 Application(s)	Topical	Twice daily at 0700 & 2000 for 14 day(s)	Yes

Notes:			
Salbutamol 100micrograms/dose inhaler CFC free			
Dose	Route	Frequency	To Continue
2 Puff(s)	Inhaled	PRN for wheeze (COPD)	Yes
Notes:			
Sildenafil 100mg tablets			
Dose	Route	Frequency	To Continue
100 mg	Oral	PRN PRN	Yes
Notes:			
Simvastatin 40mg tablets			
Dose	Route	Frequency	To Continue
40 mg	Oral	Once daily at 2200	Yes
Notes:			
Tamsulosin 400microgram modified-release capsules			
Dose	Route	Frequency	To Continue
400 microgram	Oral	Once daily at 0700	Yes
Notes:			
Zerobase 11% cream			
Dose	Route	Frequency	To Continue
1 Application(s)	Topical	Four times daily at 0700, 1200, 1800 & 2200 PRN as required	Yes
Notes:			

FINAL DISCHARGE LETTER

PRINCIPAL DIAGNOSIS/PROCEDURE
Diagnosis:
1. Campylobacter enterocolitis
2. Septic/hypovolaemic shock
3. Pre-renal AKI
4. Metabolic acidosis
5. Post sepsis ileus

INTERVENTIONS IN CRITICAL CARE:
1. Vasopressors/fluid resuscitation
2. Antibiotics
3. Central electrolyte replacement

During admission in critical care at RIE:
Mr Sanderson was admitted with a short history of profuse vomiting, bloody diarrhoea and anuria. His renal biochemistry was profoundly deranged and required a medical treatment for hyperkalaemia, CT KUB showed no obstruction. Despite fluid resuscitation he remained hypotensive so was admitted for vasopressor support. He has made steady progress since his admission. Stool cultures have grown Campylobacter and he was started on appropriate antibiotics. His AKI was improving without needing RRT. His clotting profile has become slightly abnormal in the absence of haemolysis/bleeding/liver dysfunction. He was started a course of Vitamin K. An interval CT scan showed enterocolitis with no need for surgical input.

He was stepped down to ID at WGH on 22.01/24:
AKI continued to improve with IVF.
Mr sanderson reported increase abdominal pain with abdominal distension.
AXR: Distended loops of small bowel, diameter > 4 cm
Erect CXR: No free gas under diaphragm
NG tube was inserted as george developed an Ileus likely secondary to ileitis and profound sepsis. This was removed following clinical improvement and bowels started moving.
He was started on a 5 day course of oral Clarithromycin which was completed on 28/01/14.

At the time of discharge he is feeling well. Thank you for your ongoing care.

FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL

CHANGES TO DRUGS SINCE ADMISSION
Withheld: Lisinopril, Naproxen due to AKI. Advised to restart 1 week after loose stools have settled.

ALLERGIES / ADVERSE DRUG REACTIONS: Penicillin

SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS: Nil

CHANGES TO DNACPR STATUS / DETAILS OF TREATMENT ESCALATION PLAN: Nil

Med 3 Certificate has been issued for: ___ days/____weeks

GP to please consider the following: Please review UEs in 1 week and restart withheld medication if indicated

Should you need further information please contact: Infectious Diseases department WGH

Information contained in this letter has been discussed with the patient/carer.

Yours sincerely

O Wijesooriya
FY2

Final Discharge letter
Consultant Comment:-
I can confirm that the above patients IDL is an accurate representation of their inpatient stay.

Yours sincerely,

Electronically signed by

Dr Oliver Koch
Consultant Physician
Secretary 0131 537 2853
OK/GP

NHS Lothian

Western General Hospital
Crewe Road South
Edinburgh
EH4 2XU

Intensive Therapy

Dr Chowings
Leith Surgery
2 Duke Street
Edinburgh
EH6 8HQ

Date: 26/01/2024

Inpatient Discharge Summary

Patient	George Sanderson Flat 4 15 Quayside Street Edinburgh EH6 6EJ	**CHI** **Date of Birth / Age** **UHPI**	**1210601451** 12/10/1960 (63 years) 610041369B
Ward	Ward 20 WGH	**Admission Date**	18/01/2024
Consultant	Dr E Louise Hartley	**Discharge Date**	

Dear Dr Chowings

CRITICAL CARE IMMEDIATE DISCHARGE LETTER (CCIDL)
THIS IS A CORE CRITICAL CARE DISCHARGE DOCUMENT INTENDED FOR THE RECEIVING WARD AREA

DISCHARGE WARD: ID
DATE OF DISCHARGE: 22/01/24
DATE OF ICU ADMISSION/LENGTH OF STAY: 4

ADMISSION:
REFERRING SOURCE: MAU Trolleys
PRESENTATIONS AND SYMPTOMS: Diarrhoea and vomiting, hypotension, AKI

PRIMARY DIAGNOSIS:
1. Campylobacter enterocolitis
2. Septic/hypovolaemic shock, resolved
3. Pre-renal AKI - improving with fluid resuscitation/replacement, no need for RRT
4. Metabolic acidosis - improving

CRITICAL CARE COMPLICATIONS:
Nil

SIGNIFICANT PAST MEDICAL HISTORY:
HTN
BPH
COPD

INTERVENTIONS IN CRITICAL CARE:
1. Vasopressors/fluid resuscitation
2. Antibiotics
3. Central electrolyte replacement

CLINICAL PROGRESS / TIMELINE OF EVENTS:
Mr Sanderson was admitted with a short history of profuse vomiting, bloody diarrhoea and anuria. He had a collapse at home which prompted his presentation to hospital. His renal biochemistry was profoundly deranged and required a medical treatment for hyperkalaemia, CT KUB showed no obstruction. Despite fluid resuscitation he remained hypotensive so was admitted for vasopressor support. He has made steady progress since his admission. Stool cultures have grown Campylobacter and the appropriate antibiotics and infection control measure have been put in place. His AKI is improving and he has not required RRT. His clotting profile has become slightly abnormal in the absence of haemolysis/bleeding/liver dysfunction - we have started a course of Vitamin K and reviewing his thromboprophylaxis daily with his blood results. An interval CT scan showed enterocolitis with no need for surgical input. He is off organ support and ready for stepdown.

PHYSIOTHERAPY STATUS : SEE TRAK ENTRY

NUTRITIONAL TEAM STATUS: SEE TRAK ENTRY

ALLERGY: Penicillin (RASH)
MEDICATIONS:
CONTINUED Anoro Ellipta
WITHHELD Simvastatin, Lisinopril, Tamsulosin, Dalteparin (review daily with INR/platelets)
STOPPED
NEW Lansoprazole (only required whilst critically unwell), Pabrinex (refeeding), Nicotine patch, Paracetamol, Meropenem (renally adjusted dose, 5 day course), Nystatin, Vitamin K

KEY POINTS FOR REVIEW:
CONTINUED ISSUES - fluid balance with daily stool chart output

MEDICATIONS - review thromboprophylaxis daily with blood results, reintroduce antihypertensives/other medications as required, dose adjustments for medication as renal function improves

INVESTIGATIONS / SPECIALTY REVIEWS - ongoing Microbiology input

TEP COMPLETED: For full escalation

DELIRIUM STATUS:
IN ICU: N
AT DISCHARGE: N

DISCHARGE NEWS:

NAME: S Harris
POSITION: ST5
CONTACT: 8165
PAGE: 31673

Patient Information		Date:	18/01/2024
GEORGE SANDERSON		Incident Number:	CR010568044
Age/Gender:	64Y Old Male		
Address:	16-17 PIRRIE STREET,EH6 6EJ	Incident Type:	EMG
DOB:	12/10/1960	Incident Location:	FLAT 4 15 QUAYSIDE STREET LEITH EDINBURGH. EH6 6EJ
CHI:	1210601451		
Ethnicity:			

Scottish Ambulance Service

Presenting Complaint

GENERALLY UNWELL

Additional Comments

_ituation; AS1 Yellow 64yom; HPC - Sunday Pt has been generally unwell w/ associated symptoms of; D & V [now vomiting coffee grounds], Inc SOB, reduced urine output [no urine output since Saturday], Reduced fluid intake, reduced appetite and lethargy. Partner reports Symptoms came on and gradually become worse w/ ?coffee ground vomiting starting today. Pt partner contacted Pt own GP practice who requested Pt be conveyed to WGH ARU for further assessment. Normally well / Background; HTN , COPD / Assessment; O/a Pt lying on bed. Pt alert, GCS 15, looks generally unwell. O/e obs as recorded; Pt C/o abdominal pain; Central, tightness, constant, worsening, non-radiating, associated symptoms; Nausea & vomiting, N/a Reliving factors, PS 8/10. tx - 20G R ACF; 4mg IV ondansetron, 1G IV paracetamol / Recommendation; Pt conveyed to WGH. Monitored on route. Uneventful journey / ---------- Allergies - Penicillin NOK Partner GP - Leith surgery

PATIENT ASSESSMENT

ACVPU	Alert		<C>	No	
A	Clear				
B	**Breathing Adequately**	Yes	**Respiratory Rate** 24	**SPO2**	98
	Oxygen Given	No			

C	**Pulse Rate**	**BP**	**Cap Refill**	**ECG Rhythm**
	93	97/60	<=2 Secs	Sinus Rhythm
	Rhythm	**Arm**	**Central/Peripheral**	**ECG**
	Reg	Right	Peripheral	3 Lead
	IV(R)			
	ACF			

D	**GCS**	**Eyes**	**Voice**	**Motor**	**PEARL**
	15	Spontaneously (4)	Orientated (5)	Obeys Commands (6)	Yes

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
17:40	90	24	123/91	95		15	Alert								E9886138
17:20	90	24	108/63			15	Alert								E9886138
16:50	93	24	97/60	98	<=2 Secs	15	Alert		35.5	5.7	Sinus Rhythm	3	3		E9886138

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
16:50	24 (2)	98 (0)		0	97 (2)	93 (1)	Alert (0)	35.5 (1)	6

Drugs

Time	Drug	Desage	Units	Route	Drug Expiry Date	Pain Before	Pain After	CrewID
17:25	Ondansetron	4	mg	IV	02/2026			E9886138
17:35	Paracetamol	1	g	IV	06/2026			E9886138

HISTORY

AMPLE

Allergies PENICILLIN

Medication	AS PER ECS
Past Medical History	Hypertension, COPD
Last Eaten	>4 Hours Ago
Events Prior	SOB, NAUSEA + VOMITING , GENERALLY UNWELL - SEE ADDITIONAL COMMENTS

Social History

Lives alone	No	**Living With**	PARTNER	**Patient Occupation**	Does Not Work

Patients General Appearance	Normal
Patient Mobility	Fully Mobile
Patient Communication	No Help Required
Patient Clinical Risk Factors	None Identified
Patient Enviromental Risk Factors	None Identified

CLOSE RECORD

Treatment On Scene	Non-Emergency

Conveyance

Transport To Hospital	Normal driving	**Pre-Alert**	No		

INCIDENT LOG

Time Call Received	14:21	**Allocated**	16:36	**Mobile**	16:40
First Resource On Scene		**Crew On Scene**	16:44	**Crew Left Scene**	17:31
Crew At Hosp	17:53	**Receiving Hospital**	WESTERN GENERAL EDINBURGH	**Clear Time**	

Crew ID	Crew Grade	Driver
E9886765	Paramedic	YES
E9886138	Paramedic	NO

610041369B M
SANDERSON George
12-Oct-60 CHI: 121 060 1451
70179 JS Chowings
Flat 4 Midlothian
EH6 6EJ

63Y

NHS Lothian

Directorate of Critical Care

Date: 19/1/23

Date of admission: 19/1/23

Day number: 1

Routine Shift Checks	Day Initial	Night Initial	Comment if N/A or not achieved
EQUIPMENT CHECKS			
O^2 Cylinder Check			
Tracheostomy box check (If applicable)		N/A	
C-Circuit			SEALED
Laerdal AMBU bag			SEALED
Suction			SEALED
MONITORING CHECKS			
Invasive lines - Check and zero			
NIBP			114/68
Alarm limits - Checked/Set			
Glucometer QC			ITU UNIT
PATIENT ASSESSMENT			
Infusions/fluids match prescriptions			
Infusions and Lines in date			
Air entry assessed			
Name band in situ with CHI			
ETT Cuff pressure check		N/A	
Skin bundle check			
Allergy band check		*	PENICILLIN
PROPHYLAXIS			
FLOWTRONS			
DVT/PE			
Gastric Ulcer			
Eye care (prescribed)		N/A	HYDRONDALT

Routine Changes		Frequency of routine change
NG Tube tapes:	Change On:	DAILY
Pressure bag fluid	Change On: 22/1/23	EVERY 4 DAYS
Dry Circuit	Change On:	EVERY 7 DAYS
Flexiseal (If in situ)	Change On:	EVERY 29 DAYS
Urinary Drainage Bag	Change On: 20/1/23	EVERY 7 DAYS
HMEF	Change On:	DAILY
Closed Suction	Change On:	DAILY
Wet Circuit	Change On:	EVERY 14 DAYS
Bacterial Filter	Change On:	DAILY
Anchorfast	Change On:	EVERY 7 DAYS
Stoma bag	Change On:	DAILY

Admission Weight (kg)	
Predicted Weight (kg)	
Admission BMI	
Latest Weight (kg)	
Bowels last opened (Date)	__/__/__
If >72hrs aperients considered	Y ☐ N ☐

SEDATION AND WEANING

Sedation Hold (please tick)	
Yes	☐
No	☐
Not appropriate	☐
Ready to wean	
Yes	☐
No	☐
Not appropriate	☐

Infection Status

MRSA	
C. Difficile	
VRE	
ESBL (e.g. E Coli or Klebsiella)	
CRE/CPE	
Other:	
Patient neutropaenic?	Y ☐ N ☐
Isolation Required?	Y ☐ N ☐

BRISTOL STOOL CHART

Type 1	Separate hard lumps, like nuts. Hard to pass
Type 2	Sausage shaped but lumpy
Type 3	Like a sausage but with cracks on its surface
Type 4	Like a sausage or snake, smooth and soft
Type 5	Soft blobs with clear cut edges (passed early)
Type 6	Fluffy pieces with ragged edges, a mushy stool
Type 7	Watery, no solid pieces. Entirely liquid

NOTES

5/7 Hx DVT, bowel infarct
Enteric → AKI
Septic shock
PMH: HTN, COPD (smoker), BPH
Allergic: Penicillin

Secretions		Physiotherapy	Chest Drains	Circulation		Pressure Care	Pain Scoring	Motor Block
M Mucoid	**0** Nil	✓ Cough & expectorate	**SW** Swinging	**P** Pink	**W** Warm	**R** Right side	**0** No pain	**0** Full power in legs
MP Mucopurulent	**1** Minimal	✕ Cough & No expectorate	**ST** Static **BUB** Bubbling	**WH** White	**C** Cool	**L** Left side	**1** Mild (Doesn't distress me)	**1** Weak but can move legs
P Purulent	**2** Moderate	Ø No cough	**B** Bloodstained	**M** Mottled	**CO** Cold	**B** Back	**2** Moderate (Distresses me a bit)	**2** Able to move knees
B Bloodstained	**3** Large	**BG** Bagging	**HS** Haemoserous	✓ Pulse present	✕ Pulse absent	**Ch** In Chair	**3** Severe (Distresses a lot)	**3** Minimal movement
		BD Bird	**S** Serous			**Pr** Proned	**S** Sleeping	**4** Paralysed

Pupil Size

1	2	3	4	5	6	7	8
•	•	•	•	●	●	●	●

Eye Opening (E)	Best Verbal (V)	Best Motor (M)
4 Spontaneous	**5** Orientated	**6** Obeys commands
3 To speech	**4** Confused	**5** Localises pain
2 To pain	**3** Inappropriate words	**4** Normal flexion
1 None	**2** Incomprehensible	**3** Abnormal flexion
1 Eyes swollen	**1** None/ETT/Trach	**2** Extension
		1 None

CHI: DATE: 19/01/2024

	TIME	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
RESPIRATORY	FiO_2	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
	SpO_2	97	97	97	96	95	95	94	96	96	97	97	96	96	96	96	94	96	93	94	94	93	94	96	95
	$ETCO_2$																								
	Mode	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV
	Set Respiratory Rate																								
	Total Respiratory Rate	28	26	27	31	30	28	26	16	29	26	27	11	31	28	30	25	24	26	28	24	25	25	22	21
	Set Tidal Volume																								
	Expired Tidal Volume																								
	Minute Volume																								
	Peak Pressure / P High																								
	ASB / PS																								
	PEEP / CPAP / P Low																								
	I:E Ratio																								
	T high / T low																								
	HFNC Flow Rate																								
	30° Head Up	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Humidifier temp																								
	Inner tube change																								
	Cough / deep breath																								
	Suction																								
	Subglottic drainage																								
	Air Entry (R/L)													//											
	ETT Length																								
	ETT pressure areas																								
	Anchorfast (R/M/L)																								
	IPPB / Cough assist																								
	Fine bore suction/oral																								
TPR	°C Temp / • HR / x MAP / ▼ ▲ ABP / ▲ ▼ NIBP		37.1					37.2				37.0			36.7						36.8				36.3
	Cardiac Rhythm	ST	ST	ST	ST	ST	ST	ST	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	ST	AF	SR	SR	SR
	CVP			+14	+11	+6	+5	+1	+7	+4	+4	+1		+7	+8	+5	+4	+1	+4	+3	+4	+5	+4	+3	+10	+9
	PAP																								
	CCO																								
	Cardiac Index																								
	SV / PPV																								
	Peripheral Circulation						RETO+2																		
	Angioseal check (L/R)																								
E	Blood Glucose	6.3				7.7		8.6				8.5				6.5								7.1	
NEURO	Pain Score	0	0	0	0	0	0	0	0	0	0	0	0	NRS	0	0	0	0	0	S	DNAS	0	S	0	0
	R.A.S.S	0	0	0	0	0	0	-1	0	0	0	-1	0	0	0	0	0	0	0	S	PS	0	S	0	0
	GCS Eyes	4												4								4			
	GCS Verbal	6												6								6			
	GCS Motor (L/R)	5												5								5			
	Total GCS	15												15								15			
	CAM-ICU (+/-)													-											
	Pupil size/reaction R													3/3											
	Pupil size/reaction L													+/+											
	NPI (R /L)													PP/PP								PP/PP			
	ICP																								
	CPP																								
	ICP Treatment																								
	CSF(ml/hr)																								
	CSF Drain Set (cmH_20)																								
	Brain PbO2 (mmHg)																								
	Brain Temp (°C)																								
	Lower Limb Power (L/R)																								
CARE	Pressure care	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B
	Oral care (4 hourly)																								
	Limb physiotherapy																								
	Eye Care																								

Secretions: Mucoid; MPucopurulent; Purulent; Bloodstained

0 = Nil; 1 = Min; 2 = Mod; 3 = Large

Physiotherapy: Cough & expectorate = ✓; Cough, no expectorate = ✗; No cough = Ø; Bagging = BG; Bird = BD; R=Right M= Middle L= Left

Circulation: Pink Warm; White Cool; Mottled Cold; Pulse ✓or ✗

Pain score: 0 = No Pain; 1 = Mild; 2= Moderate; 3 = Severe; 4= Asleep

RASS: +4 Combative; +3 V. Agitated; +2 Agitated; +1 Restless; 0 Alert/calm; -1 Drowsy; -2 Light Sedation; -3 Mod Sedation; -4 Deep Sedation; -5 Unrousable

Pressure Care: Right; Left; Back / Prone; Chair

Chest Drains: Swinging; Static; Bubbling; Bloodstained; HS Haemoserous; Serous

Bloods sent (stickers)

Specimens sent

Drug Levels Required



CHI: 1210601457 DATE: 19/01/2024

		08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
DRUG INFUSIONS	Peripheral or Central (circle as appropriate)																								
	Noradrenaline 0.08 mg/ml Rate (ml/hr)	4	15	20	20	7	20	18	16	16	16	16	18	18	16	16	16	16	16	16	16	16	16	16	14
	Level	280	179	160	132	125	105	88	69	52	40	32	5	240	210	196	179	162	146	129	112	96	84	68	52
	Pump No: 5 | 5 Volume Infused		21	19	28	7	20	20	16	17	12	18	17	15	15	14	17	13	16	17	17	14	14	16	16
	Drug Mg SO4 Rate (ml/hr)					25	25	25	25	25															
	Peripheral/Central Concentration: Level					100	83	54	29	3	0														
	Pump No: Volume Infused						17	29	25	26	3														
	Drug Vancomycin Rate (ml/hr)						4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
	Peripheral/Central Concentration: 250mg/50mls Level						50	45	41	36	33	29	25	21	17	13	9	4	50	46	38	34	30	26	24
	Pump No: Volume Infused							5	4	5	3	4	4	4	4	4	4	5	4	5	5	4	4	4	4
	Drug Rate (ml/hr)																								
	Peripheral/Central Concentration: Level																								
	Pump No: Volume Infused																								
	Drug Rate (ml/hr)																								
	Peripheral/Central Concentration: Level																								
	Pump No: Volume Infused																								
	Drug Rate (ml/hr)																								
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	Peripheral/Central Concentration: Level																								
	Pump No: Volume Infused																								
	Drug Rate (ml/hr)																								
	Peripheral/Central Concentration: Level																								
	Pump No: Volume Infused																								
	TPN Rate (ml/hr)																								
	Peripheral/Central Concentration: Level																								
	Pump No: Volume Infused																								
	Hourly infusion Checks (initial)		SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	JB	JB	JB	JB	JB	JB	JB	AM	JB	JB	JB	JA
	Sub Total infusions		21	19	28	7	37	37	45	45	18	22	21	19	15	14	17	13	16	17	17	14	14	16	16
FLUIDS IN	Crystalloids	125	125	125	500		50	50	50	50	50	50	50	200	250	50	50	50	50	50	50	50	50	50	50
	Colloids		250		500																				
	Blood Products																								
	IV Medication			250	100 250	100				100			120			100	100							100	
	PCA																								
	Epidural																								
	Flush Bag (0.9% NaCl)	6	6	6	6	6	6	6	6	6	6	6	6	4	4	6	6	6	6	6	6	6	6	6	4
	NG / NJ / Jejunal																								
	Gastric Aspirate pH																								
	Oral Medication																								
	Oral		150	150			100	150	150			200				50			50		100		100	100	50
	Total Intake	125	671	965	2321	2434	2591	2684	2888	3052	3116	3384	3621	3896	4170	4355	4541	4705	4945	4932	5101	5175	5353	5586	5731
OUTPUT	Urine	0	70	110	230	70	240	260	130	190	90	60	90	100	60	70	70	60	60	100	30	50	30	50	25
	Net UF CVVHD (reset hourly)																								
	Drain 1 Observations																								
	Location: Level																								
	Hourly Amount Drained																								
	Drain 2 Observations																								
	Location: Level																								
	Hourly Amount Drained																								
	Drain 3: Observations																								
	Location: Level																								
	Hourly Amount Drained																								
	Drain 4: Observations																								
	Location: Level																								
	Hourly Amount Drained																								
	Drain 5: Observations																								
	Location: Level																								
	Hourly Amount Drained																								
	CSF drain output (hourly)																								
	Nasogastric aspirates/drained																				ESTIMATED BOWEL AMOUNT				
	Blood Loss													T7											
	Bowels	T7	T7	T7	T7	T7	T7	T7	T7			T7	T7	T7	T7					T7				T7	
	Cumulative balance (72hours) **Total Output** mls	0	70	180	410	480	720	980	1110	1300	1390	1450	1540	1640	1700	1770	1840	1900	1960	2060	2090	2140	2170	2220	2245
	Balance			+385						+792			+1081					+2810	+2853		+3035			+2986	
CVVHD	Blood Flow (mls/min)																								
	Dialysate flow (mls/hr)																								
	Access Pressure (mmHg)																								
	Return Pressure (mmHg)																								
	Pre-filter pressure (mmHg)																								
	Citrate Infusion (mmol/L)																								
	Calcium Infusion (mmol/L)																								
	Post filter iCa **(6 hrly Blue port)**																								
	Systemic iCa **(6 hrly A-Line)**																								
	Total Ca **(check daily- <3mmol)**																								
	T:I ratio (Total Ca ÷ Ionised Ca) **(check daily - < 2.5)**																								
	Changes made Initials																								
	Totals reset hourly (initial)																								
		08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07

PREVIOUS FINAL Rx

CHI: DATE:

Intravenous Fluid Prescription Chart

31675

Flush Bag	Volume	Rate	Prescribed by Sign & Print	Given By Sign & Print	Time Started	Batch No/Expiry Date
0.9% NaCl (Arterial Line)	1000ml	3 ml/h	Not required			
0.9% NaCl (CVC)	1000ml	3 ml/h	Not required			

Maintenance Fluid	Volume	Rate	Prescribed by Sign & Print	Given By Sign & Print	Time Started	Batch No/Expiry Date
0.45% NaCl / 5% dextrose	1000	50 ml/h	BARRIS	500 500	1210 01:00	23C16T4C 02/25

Resuscitation Fluid	Volume	Rate	Prescribed by Sign & Print	Given By Sign & Print	Time Started	Batch No/Expiry Date
Plasmalyte	~~1000~~ 500	STAT				
Plasmalyte	500	125				
Plasmalyte	250	STAT			0920	Albumex® 5, 500 ml LOT P100561039
HAS 5% PLT - 148	500ml 500ml	½ hr STAT				
PLASMALYTE 148	500ml	2°				

Electrolyte Replacement	Diluent Fluid	Volume	Rate	Prescribed by Sign & Print	Given By Sign & Print	Time Started	Batch No/Expiry Date
4.46mmol Ca^{2+} Gluconate	Glucose 5%	100mL	30 minutes	T. COX			23027E2 03/26
MAGNESIUM 20 mmol	GLUCOSE 5%	100 mL	4 HOURS CVS	T. COX			23013S0 02/26
4.46 mmol Ca^{2+} Gluconate	Glucose 5%	100ml	30mins	T. COX			
Calcium Gluconate 4.46mmol	5% Glucose	100 ml	30 mins	R ANDRO		20:50	23C0903 03/26

Enteral Feed/NG Water Prescription

Enteral	Type	Volume	Rate	Prescribed by	Given By	Time Started	Batch Number
NG Water		1000ml					

Haemofiltration Recording & Fluid Prescription

	Machine ID	Kidney Batch No.	Lines Batch No.	Date & Time	Comments
1					
2					

Blood flow (mls/min)	Dialysate flow (mls/hr)	Fluid removal (mls/hr)	Anticoagulation (citrate/heparin/other/nothing)	Prescribed by Nurse or Doctor (sign)	Print Name Nurse or Doctor	Date and Time

CiCa K4 (4 mmol/l K^+) - 5 L	Time	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
Signature	Initials x2																								
Name (PRINT)	Batch No																								
Exp. Date ___/___/___																									
CiCa K2 (2 mmol/l K^+) – 5L	Time	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
Signature	Initials x2																								
Name (PRINT)	Batch No																								
Exp. Date ___/___/___																									
MULTIBIC K4 (4 mmol/l K^+) - 5L	Time	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
Signature	Initials x2																								
Name (PRINT)	Batch No																								
Exp. Date ___/___/___																									
SODIUM CITRATE 4% - 1.5L	Time	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
Signature	Initials x2																								
Name (PRINT)	Batch No																								
Exp. date ___/___/___																									
Calcium Chloride 150mmol in 1500ml	Time	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
Signature	Initials x2																								
Name (PRINT)	Batch No																								
Exp. date ___/___/___																									

610041369B M
Na SANDERSON George
12-Oct-60 CHI: 121 060 1451
D.(79179 JS Chowings
Flat 4 Midlothian
EH6 6EJ
CH

NHS Lothian

Directorate of Critical Care

Date: 20/1/24

Date of admission: 19/1/24

Day number: 2

Routine Shift Checks	Day Initial	Night Initial	Comment if N/A or not achieved
EQUIPMENT CHECKS			
O^2 Cylinder Check	RM	LA	
Tracheostomy box check (If applicable)	NA	N/A	
C-Circuit	RM	LA	
Laerdal AMBU bag	RM	LA	
Suction	RM	LA	
MONITORING CHECKS			
Invasive lines - Check and zero	RM	LA	
NIBP	RM	LA	
Alarm limits - Checked/Set	RM	LA	
Glucometer QC	UNIT	UNIT	
PATIENT ASSESSMENT			
Infusions/fluids match prescriptions	RM	LA	
Infusions and Lines in date	RM	LA	
Air entry assessed	RM	LA	
Name band in situ with CHI	RM	LA	
ETT Cuff pressure check	RM	N/A	
Skin bundle check	RM	LA	
Allergy band check	RM	LA	
PROPHYLAXIS			
FLOWTRONS	RM	LA	
DVT/PE	RM	LA	Dalteparin
Gastric Ulcer	RM	LA	Lansoprazole
Eye care (prescribed)	NA	N/A	

Routine Changes		Frequency of routine change
NG Tube tapes:	Change On:	DAILY
Pressure bag fluid	Change On: 22/1/24	EVERY 4 DAYS
Dry Circuit	Change On:	EVERY 7 DAYS
Flexiseal (If in situ)	Change On:	EVERY 29 DAYS
Urinary Drainage Bag	Change On: 26/1/24	EVERY 7 DAYS
HMEF	Change On:	DAILY
Closed Suction	Change On:	DAILY
Wet Circuit	Change On:	EVERY 14 DAYS
Bacterial Filter	Change On:	DAILY
Anchorfast	Change On:	EVERY 7 DAYS
Stoma bag	Change On:	DAILY

Admission Weight (kg)	
Predicted Weight (kg)	
Admission BMI	
Latest Weight (kg)	
Bowels last opened (Date)	__/__/__
If >72hrs aperients considered	Y ☐ N ☐

SEDATION AND WEANING	
Sedation Hold (please tick)	
Yes	☐
No	☐
Not appropriate	☐
Ready to wean	
Yes	☐
No	☐
Not appropriate	☐

Infection Status	
MRSA	
C. Difficile	
VRE	
ESBL (e.g. E Coli or Klebsiella)	
CRE/CPE	
Other:	
Patient neutropaenic?	Y ☐ N ☐
Isolation Required?	Y ☐ N ☐

BRISTOL STOOL CHART	
Type 1	Separate hard lumps, like nuts. Hard to pass
Type 2	Sausage shaped but lumpy
Type 3	Like a sausage but with cracks on its surface
Type 4	Like a sausage or snake, smooth and soft
Type 5	Soft blobs with clear cut edges (passed early)
Type 6	Fluffy pieces with ragged edges, a mushy stool
Type 7	Watery, no solid pieces. Entirely liquid

NOTES

S/F Hx DVT, bowel INTAKE
ANURIC 4/7 → AKI, SEPTIC SHOCK
PMH: HTN, COPD (SMOKER) BPH
Antibiotic: FEP/CIPRO

Secretions		**Physiotherapy**	**Chest Drains**	**Circulation**		**Pressure Care**	**Pain Scoring**	**Motor Block**
M Mucoid	**0** Nil	✓ Cough & expectorate	**SW** Swinging	**P** Pink	**W** Warm	**R** Right side	**0** No pain	**0** Full power in legs
MP Mucopurulent	**1** Minimal	✗ Cough & No expectorate	**ST** Static **BUB** Bubbling	**WH** White	**C** Cool	**L** Left side	**1** Mild (Doesn't distress me)	**1** Weak but can move legs
P Purulent	**2** Moderate	Ø No cough	**B** Bloodstained	**M** Mottled	**CO** Cold	**B** Back	**2** Moderate (Distresses me a bit)	**2** Able to move knees
B Bloodstained	**3** Large	**BG** Bagging	**HS** Haemoserous	✓ Pulse present	✗ Pulse absent	**Ch** In Chair	**3** Severe (Distresses a lot)	**3** Minimal movement
		BD Bird	**S** Serous			**Pr** Proned	**S** Sleeping	**4** Paralysed

• Pupil Size								Eye Opening (E)	Best Verbal (V)	Best Motor (M)
1	2	3	4	5	6	7	8			
•	•	•	•	•	•	•	•	**4** Spontaneous **3** To speech **2** To pain **1** None **1** Eyes swollen	**5** Orientated **4** Confused **3** Inappropriate words **2** Incomprehensible **1** None/ETT/Trach	**6** Obeys commands **5** Localises pain **4** Normal flexion **3** Abnormal flexion **2** Extension **1** None

CHI: 1210601451 DATE: 20/01/24

	TIME	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
RESPIRATORY	FiO_2	Air	Air	Air	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
	SpO_2	94	94	93	96	94	96	96	94	95	94	95	94	94	95	95	95	96	96	95	96	95	94	95	96
	$ETCO_2$																								
	Mode	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV
	Set Respiratory Rate																								
	Total Respiratory Rate	26	24	13	24	28	29	22	27	29	25	31	29	27	24	24	25	24	24	21	23	22	24	22	24
	Set Tidal Volume																								
	Expired Tidal Volume																								
	Minute Volume																								
	Peak Pressure / P High																								
	ASB / PS																								
	PEEP / CPAP / P Low																								
	I:E Ratio																								
	T high / T low																								
	HFNC Flow Rate																								
	30° Head Up	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	
	Humidifier temp																								
	Inner tube change																								
	Cough / deep breath																								
	Suction																								
	Subglottic drainage																								
	Air Entry (R/L)	✓✓												✓✓											
	ETT Length																								
	ETT pressure areas																								
	Anchorfast (R/M/L)																								
	IPPB / Cough assist																								
	Fine bore suction/oral																								
TPR	Temp / HR / MAP / ABP / NIBP					36.9								36.6				36.2							
	Cardiac Rhythm	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SL	ST	ST
	CVP	5	+10	+10	+20	+19	INVSE	INVSE	+7	+8	+3	+3	+5	+4	INVSE	+1	+1		+5	+8	+11	+10	+11	+9	+12
	PAP																								
	CCO																								
	Cardiac Index																								
	SV / PPV																								
	Peripheral Circulation	PW																							
	Angioseal check (L/R)																								
E	Blood Glucose				5.7							4.9		4.7										4.9	
NEURO	Pain Score													0											
	R.A.S.S	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-1	0	-1	-3	0	-1	0	0
	GCS Eyes	4						4						4											
	GCS Verbal	5						5						5											
	GCS Motor (L/R)	6						6						6											
	Total GCS	15						15						(15)											
	CAM-ICU (+/-)																								
	Pupil size/reaction R																								
	Pupil size/reaction L																								
	NPI (R /L)																								
	ICP																								
	CPP																								
	ICP Treatment																								
	CSF(ml/hr)																								
	CSF Drain Set (cmH_20)																								
	Brain PbO2 (mmHg)																								
	Brain Temp (°C)																								
	Lower Limb Power (L/R)																								
CARE	Pressure care	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	L	B	B	B
	Oral care (4 hourly)																								
	Limb physiotherapy																								
	Eye Care																								
		08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07

Ondansetron 2 of 2

Secretions: Mucoid, MPucopurulent, Purulent, Bloodstained

0 = Nil, 1 = Min, 2 = Mod, 3 = Large

Physiotherapy: Cough & expectorate = ✓; Cough, no expectorate = *; No cough = Ø; Bagging = BG; Bird = BD; R=Right, M= Middle, L= Left

Circulation: Pink, Warm, White, Cool, Mottled, Cold; Pulse ✓or *

Pain score: 0 = No Pain, 1 = Mild, 2= Moderate, 3 = Severe, 4= Asleep

RASS: +4 Combative, +3 V. Agitated, +2 Agitated, +1 Restless, 0 Alert/calm, -1 Drowsy, -2 Light Sedation, -3 Mod Sedation, -4 Deep Sedation, -5 Unrousable

Pressure Care: Right, Left, Back / Prone, Chair

Chest Drains: Swinging, Static, Bubbling, Bloodstained, HS Haemoserous, Serous

CHI: 1210601451 DATE: 20/01/2024

		08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	
DRUG INFUSIONS	Peripheral or Central (circle as appropriate)																								
	Noradrenaline 0.08 mg/ml — Rate (ml/hr)	13	14	14	13	7	10		2	4	6	6	6	6	6	6	6	6	6	6	6	6	6	6	BWS
	Peripheral/Central Concentration: — Level	42	26	10% 227	29	213			213	240	204	199	192	186	178	174	169	160	157	148	145	139	135	127	119
	Pump No: — Volume Infused	10	16	16	13	8	6		0	3	6	5	7	6	8	4	5	9	3	9	1	6	4	8	8
	Drug Vasopressin — Rate (ml/hr)	4.1	4.1	4.1	4.1	4.1	4.1	4.1	4.1	4.1	4.1	4.1	4.1	4.1	4.1	4.1	4.1	4.1	8.3	8.3	8.3	8.3	8.3	8.3	8.3
	Peripheral/Central Concentration: — Level	21	16	11	7	4.6	50 2.5	46	41	37	33	30	25	21	15	12	9.1	100	93	81	78	89	63	53	41
	Pump No: — Volume Infused	3	5	5	4	3	6	2	5	4	4	3	5	4	6	3	3	4	7	12	3	9	6	10	12
	Drug — Rate (ml/hr)																								
	Peripheral/Central Concentration: — Level																								
	Pump No: — Volume Infused																								
	Drug — Rate (ml/hr)																								
	Peripheral/Central Concentration: — Level																								
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	Peripheral/Central Concentration: — Level																								
	Pump No: — Volume Infused																								
	TPN — Rate (ml/hr)																								
	Peripheral/Central Concentration: — Level																								
	Pump No: — Volume Infused																								
	Hourly infusion Checks (initial)	SM	RM	RM	RM	RM	RM	RM	RM	RM	RM	RM	RM	LK	LK	LK	LA	CA	LK	LA	CA	CA	LK	CA	LK
	Sub Total infusions	13	21	21	17	11	12	2	5	7	10	8	12	10	14	7	8	13	10	21	4	15	10	18	20
FLUIDS IN	Crystalloids	50	50	50	50	0	125	125	125	125	125	125	125	125	↑	125	125	125	125	125	125	125	125	~~150~~	
	Colloids — St. Dex.															↑	30	30	30	30	30	30	30	30	30
	Blood Products																								
	IV Medication			20			110	120																100	
	PCA																								
	Epidural																								
	Flush Bag (0.9% NaCl)	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
	NG / NJ / Jejunal																								
	Gastric Aspirate pH																								
	Oral Medication															100									
	Oral			200						300	100	50	50											~~150~~ 150	
	Total Intake	69	146	223	616	635	788	611	1311	1749	1990	2119	2244	2388	2402	2646	2833	3129	3240	3420	3545	3721	3917	4296	4352
OUTPUT	Urine	30	30	30	20	60	60	40	35	30	40	30	20	40	40	20		120	30	120	30	45	40	60	30
	Net UF CVVHD (reset hourly)																								
	Drain 1 Observations																								
	Location: Level																								
	Hourly Amount Drained																								
	Drain 2 Observations																								
	Location: Level																								
	Hourly Amount Drained								1																
	Drain 3: Observations																								
	Location: Level																								
	Hourly Amount Drained																								
	Drain 4: Observations																								
	Location: Level																								
	Hourly Amount Drained																								
	Drain 5: Observations																								
	Location: vomit Level											120						120						150	
	Hourly Amount Drained																								
	CSF drain output (hourly)																								
	Nasogastric aspirates/drained																						T775		
	Blood Loss																								
	Bowels	TSmall	130			T Bowel				ø		ø	T7		T7							T Smear x3		T7+++
	Cumulative balance (72hours) — **Total Output**	30	190	220	250	270	350	590	415	445	485	685	655	195	735	755		995	1025	1145	1175	1220	1295	1320	1350
	mls — **Balance**					+343		+749				+1592					+2132		+2335			+2732		+3002	
CVVHD	Blood Flow (mls/min)																								
	Dialysate flow (mls/hr)																								
	Access Pressure (mmHg)																								
	Return Pressure (mmHg)																								
	Pre-filter pressure (mmHg)																								
	Citrate Infusion (mmol/L)																								
	Calcium Infusion (mmol/L)																								
	Post filter iCa **(6 hrly Blue port)**																								
	Systemic iCa **(6 hrly A-Line)**																								
	Total Ca **(check daily- <3mmol)**																								
	T:I ratio (Total Ca ÷ Ionised Ca) **(check daily - < 2.5)**																								
	Changes made Initials																								
	Totals reset hourly (initial)																								
		08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07

DATE:

Intravenous Fluid Prescription Chart

Flush Bag	Volume	Rate	Prescribed by Sign & Print	Given By Sign & Print	Time Started	Batch No/Expiry Date
0.9% NaCl (Arterial Line)	1000ml	3 ml/h	Not required			
0.9% NaCl (CVC)	1000ml	3 ml/h	Not required			
Maintenance Fluid	**Volume**	**Rate**	**Prescribed by Sign & Print**	**Given By Sign & Print**	**Time Started**	**Batch No/Expiry Date**
NaCl 0.9%	1000ml	125ml/hr	[illegible] + VB	AC		23035355 02/26
NaCl 0.9%	1000 ml	125 ml/hr	P. Ardu	LA	21-30	23101746 08/2026
5% DEXTROSE	500 ml	30 ml/hr	R. Andrews	LA	22:00	23171745 08/2026
Resuscitation Fluid	**Volume**	**Rate**	**Prescribed by Sign & Print**	**Given By Sign & Print**	**Time Started**	**Batch No/Expiry Date**

Electrolyte Replacement	Diluent Fluid	Volume	Rate	Prescribed by Sign & Print	Given By Sign & Print	Time Started	Batch No/Expiry Date
4.46mmol Ca²⁺ Gluconate	5% Glucose	100ml	30mins	[illegible]	RN	11.00	2302703 03/26

Enteral Feed/NG Water Prescription

Enteral	Type	Volume	Rate	Prescribed by	Given By	Time Started	Batch Number
NG Water		1000ml					

Haemofiltration Recording & Fluid Prescription

	Machine ID	Kidney Batch No.	Lines Batch No.	Date & Time	Comments
1					
2					

Blood flow (mls/min)	Dialysate flow (mls/hr)	Fluid removal (mls/hr)	Anticoagulation (citrate/heparin/other/nothing)	Prescribed by Nurse or Doctor (sign)	Print Name Nurse or Doctor	Date and Time

CiCa K4 (4 mmol/l K⁺) - 5 L	Time	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
Signature	Initials x2																								
Name (PRINT)	Batch No																								
Exp. Date																									
CiCa K2 (2 mmol/l K⁺) – 5L	Time	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
Signature	Initials x2																								
Name (PRINT)	Batch No																								
Exp. Date																									
MULTIBIC K4 (4 mmol/l K⁺) - 5L	Time	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
Signature	Initials x2																								
Name (PRINT)	Batch No																								
Exp. Date																									
SODIUM CITRATE 4% - 1.5L	Time	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
Signature	Initials x2																								
Name (PRINT)	Batch No																								
Exp. date																									
Calcium Chloride 150mmol in 1500ml	Time	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
Signature	Initials x2																								
Name (PRINT)	Batch No																								
Exp. date																									

[redacted] 0041369B M 12/10/1960
Name: Sanderson, George
Flat 4,
15 Quayside Street,
Edinburgh,
D.O.B. Midlothian, EH6 6EJ
CHI 1210601451
CHI: 70179 JS Chowings

NHS Lothian

Directorate of Critical Care

Date: 21/1/24
Date of admission: 19/1/24
Day number: 3

Routine Shift Checks	Day Initial	Night Initial	Comment if N/A or not achieved
EQUIPMENT CHECKS			
O^2 Cylinder Check	RM	D	
Tracheostomy box check (If applicable)	NA	N/A	
C-Circuit	RM	D	
Laerdal AMBU bag	RM	D	
Suction	RM	D	
MONITORING CHECKS			
Invasive lines - Check and zero	RM	D	
NIBP	P	D	
Alarm limits - Checked/Set	RM	D	
Glucometer QC	UNIT	UNIT	
PATIENT ASSESSMENT			
Infusions/fluids match prescriptions	RM	D	
Infusions and Lines in date	RM	D	
Air entry assessed	RM	D	
Name band in situ with CHI	RM	D	
ETT Cuff pressure check	NA	N/A	
Skin bundle check	RM	D	
Allergy band check	RM	D	
PROPHYLAXIS			
FLOWTRONS	RM	D	
DVT/PE	RM	D	
Gastric Ulcer	RM	D	
Eye care (prescribed)	NA	N/A	

Routine Changes		Frequency of routine change
NG Tube tapes:	Change On:	DAILY
Pressure bag fluid	Change On: 22.1.24 ☐	EVERY 4 DAYS
Dry Circuit	Change On:	EVERY 7 DAYS
Flexiseal (If in situ)	Change On:	EVERY 29 DAYS
Urinary Drainage Bag	Change On: 26.1.24 ☐	EVERY 7 DAYS
HMEF	Change On:	DAILY
Closed Suction	Change On:	DAILY
Wet Circuit	Change On:	EVERY 14 DAYS
Bacterial Filter	Change On:	DAILY
Anchorfast	Change On:	EVERY 7 DAYS
Stoma bag	Change On:	DAILY

Admission Weight (kg)	
Predicted Weight (kg)	
Admission BMI	
Latest Weight (kg)	
Bowels last opened (Date)	__/__/__
If >72hrs aperients considered	Y ☐ N ☐

SEDATION AND WEANING

Sedation Hold (please tick)	
Yes	☐
No	☐
Not appropriate	☐
Ready to wean	
Yes	☐
No	☐
Not appropriate	☐

Infection Status

MRSA	
C. Difficile	
VRE	
ESBL (e.g. E Coli or Klebsiella)	
CRE/CPE	
Other:	CAMPYLOBACTER
Patient neutropaenic?	Y ☐ N ☐
Isolation Required?	Y ☐ N ☐

BRISTOL STOOL CHART

Type 1	Separate hard lumps, like nuts. Hard to pass
Type 2	Sausage shaped but lumpy
Type 3	Like a sausage but with cracks on its surface
Type 4	Like a sausage or snake, smooth and soft
Type 5	Soft blobs with clear cut edges (passed early)
Type 6	Fluffy pieces with ragged edges, a mushy stool
Type 7	Watery, no solid pieces. Entirely liquid

NOTES

Secretions		Physiotherapy	Chest Drains	Circulation		Pressure Care	Pain Scoring	Motor Block
M Mucoid	**0** Nil	✓ Cough & expectorate	**SW** Swinging	**P** Pink	**W** Warm	**R** Right side	**0** No pain	**0** Full power in legs
MP Mucopurulent	**1** Minimal	✗ Cough & No expectorate	**ST** Static **BUB** Bubbling	**WH** White	**C** Cool	**L** Left side	**1** Mild (Doesn't distress me)	**1** Weak but can move legs
P Purulent	**2** Moderate	Ø No cough	**B** Bloodstained	**M** Mottled	**CO** Cold	**B** Back	**2** Moderate (Distresses me a bit)	**2** Able to move knees
B Bloodstained	**3** Large	**BG** Bagging	**HS** Haemoserous	✓ Pulse present	✗ Pulse absent	**Ch** In Chair	**3** Severe (Distresses a lot)	**3** Minimal movement
		BD Bird	**S** Serous			**Pr** Proned	**S** Sleeping	**4** Paralysed

Pupil Size								Eye Opening (E)	Best Verbal (V)	Best Motor (M)
1	2	3	4	5	6	7	8			
								4 Spontaneous 3 To speech 2 To pain 1 None 1 Eyes swollen	5 Orientated 4 Confused 3 Inappropriate words 2 Incomprehensible 1 None/ETT/Trach	6 Obeys commands 5 Localises pain 4 Normal flexion 3 Abnormal flexion 2 Extension 1 None

CHI: 121060145 DATE: 21.1.24

	TIME	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
RESPIRATORY	FiO_2	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
	SpO_2	94	92	93	94	95	96	96	95	94	94	94	92	92	92	92	92	93	92	93	94	95	94	94	92
	$ETCO_2$																								
	Mode	SV	SV	SV	SV	SV	SV	✓	✓	✓	✓	✓	✓	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV
	Set Respiratory Rate																								
	Total Respiratory Rate	25	23	26	30	37	32	31	23	28	24	28	22	26	27	26	26	26	22	20	22	22	23	20	20
	Set Tidal Volume																								
	Expired Tidal Volume																								
	Minute Volume																								
	Peak Pressure / P High																								
	ASB / PS																								
	PEEP / CPAP / P Low																								
	I:E Ratio																								
	T high / T low																								
	HFNC Flow Rate																								
	30° Head Up	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Humidifier temp																								
	Inner tube change																								
	Cough / deep breath																								
	Suction																								
	Subglottic drainage																								
	Air Entry (R/L)	✓ ✓												✓ ✓											
	ETT Length																								
	ETT pressure areas																								
	Anchorfast (R/M/L)																								
	IPPB / Cough assist																								
	Fine bore suction/oral																								
TPR	Temp		37.1				35	36.1																	
	HR																								
	MAP																								
	ABP																								
	NIBP																								
	Cardiac Rhythm	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	ST	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
	CVP	+9	+10	+6	-1	INVSC	+6	+8	+8	+11	INVSC	+13	INVSC	+4	+4	+4	+4	Manual	+4	+4	+7	+4	+4	+4	manual
	PAP																								
	CCO																								
	Cardiac Index																								
	SV / PPV																								
	Peripheral Circulation													B		B	B	B		B		B		B	
	Angioseal check (L/R)																								
E	Blood Glucose					4.8									3.8				5.4					5.7	
NEURO	Pain Score																								
	R.A.S.S	AS	AS	0	0	0	0	0	AS	0	AS	0	AS	0	0	0	0	0	0	AS	0	AS	AS	0	AS
	GCS Eyes	4												4					4						4
	GCS Verbal	5												5					A						5
	GCS Motor (L/R)	6												6					6						6
	Total GCS	15												15					15						15
	CAM-ICU (+/-)																								
	Pupil size/reaction R																								
	Pupil size/reaction L																								
	NPI (R /L)																								
	ICP																								
	CPP																								
	ICP Treatment																								
	CSF(ml/hr)																								
	CSF Drain Set (cmH_20)																								
	Brain PbO2 (mmHg)																								
	Brain Temp (°C)																								
	Lower Limb Power (L/R)																								
CARE	Pressure care	B	B	B	CH	R4	ch-CH	CH	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	3
	Oral care (4 hourly)		✓																✓						
	Limb physiotherapy														✓				✓						
	Eye Care																								
					11	12	13	14	15	16	17	18	19	20	21	22			01	02	03	04	05	06	07

Secretions: Mucoid; MPucopurulent; Purulent; Bloodstained

0 = Nil; 1 = Min; 2 = Mod; 3 = Large

Physiotherapy: Cough & expectorate = ✓; Cough, no expectorate = ×; No cough = Ø; Bagging = BG; Bird = BD

R=Right; M= Middle; L= Left

Circulation: Pink Warm; White Cool; Mottled Cold; Pulse ✓or ×

Pain score: 0 = No Pain; 1 = Mild; 2= Moderate; 3 = Severe; 4= Asleep

RASS: +4 Combative; +3 V. Agitated; +2 Agitated; +1 Restless; 0 Alert/calm; -1 Drowsy; -2 Light Sedation; -3 Mod Sedation; -4 Deep Sedation; -5 Unrousable

Pressure Care: Right; Left; Back / Prone; Chair

Chest Drains: Swinging; Static; Bubbling; Bloodstained; HS Haemoserous; Serous

GENT LEVEL 8 HOURS

XA LEVEL

steady drawer

GENT LEVEL 14 HOURS

CHI: 0210601451 DATE: 21.1.24

	Peripheral or Central (circle as appropriate)		08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
DRUG INFUSIONS	Drug: NORADRENALINE	Rate (ml/hr)	5	14	12	13	13	13↓	11	12	6	6	4	3	2↑	7↓	5	6	6	6↓	5	5	5	3	2	2
	Peripheral/Central Concentration:	Level	117	105	83	72	69	55	50	34	22	24	20	21	209	202	200	194	187	183	178	171	167	164	160	159
	Pump No:	Volume Infused	2	12	22	11	13	13	5	16	9	13	3	3	3	7	2	6	7	4	5	7	4	3	4	1
	Drug: VANCOMYCIN	Rate (ml/hr)	8.3	8.3	8.3	8.3	8.3	8.3	8.3	8.3	8.3	8.3	8.3	8.3	8.3	8.3	8.3	8.3	8.3	8.3	8.3	8.3	8.3	8.3	8.3	8.3
	Peripheral/Central Concentration:	Level	38	28	10	3	0.150	9.3	88	73	72	67	60	52	41	33	26	19	9	14	10	85	78	70	57	52
	Pump No:	Volume Infused	3	10	18	7	3	7	5	15	1	5	7	8	11	8	7	7	9	10	10	10	7	8	13	5
	Drug: PCA	Rate (ml/hr)															50	50								50 (100)
	Peripheral/Central Concentration:	Level															(100)	50								
	Pump No:	Volume Infused															50	50								
	Drug	Rate (ml/hr)																								
	Peripheral/Central Concentration:	Level																								
	Pump No:	Volume Infused																								
	Drug	Rate (ml/hr)																								
	Peripheral/Central Concentration:	Level																								
	Pump No:	Volume Infused																								
	Drug	Rate (ml/hr)																								
	Peripheral/Central Concentration:	Level																								
	Pump No:	Volume Infused																								
	Drug	Rate (ml/hr)																								
	Peripheral/Central Concentration:	Level																								
	Pump No:	Volume Infused																								
	Drug	Rate (ml/hr)																								
	Peripheral/Central Concentration:	Level																								
	Pump No:	Volume Infused																								
	TPN	Rate (ml/hr)																								
	Peripheral/Central Concentration:	Level																								
	Pump No:	Volume Infused																								
	Hourly infusion Checks (initial)		RM	RM	RM	RM	RM	AL	RM	RM	AL	RM	RM	RM	RM	RM	RM	RM	RM	RM	RM	RM	RM	RM	RM	RM
	Sub Total infusions		5	22	40	18	16	20	10	91	10	15	10	11	14	15	59	63	46	14	15	17	11	11	17	6
FLUIDS IN	Crystalloids						125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125
	Colloids 5% albumin		30	50	30	30	50			30		50					30	30	30	30	30	30	30	30	30	30
	Blood Products																									
	IV Medication						100		200				140				100		100						100	
	PCA																									
	Epidural																									
	Flush Bag (0.9% NaCl)		6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
	NG / NJ / Jejunal																									
	Gastric Aspirate pH																									
	Oral Medication																									
	Oral				200			200								Sips	Sips			50					Sips	
	Total Intake		35	87	353	417	664	1015	1356	1548	1689	1868	2149	2291	2436	2581	2901	3125	3401	3577	3583	3761	3933	4105	4328	4550
OUTPUT	Urine		60	80	70	70	80	120	125	180	240	80	40	50	130	100	100	200	140	50	110	140	120	120	100	150
	Net UF CVVHD (reset hourly)																									
	Drain 1 Observations																									
	Location: Level																									
	Hourly Amount Drained																									
	Drain 2 Observations																									
	Location: Level																									
	Hourly Amount Drained																									
	Drain 3: Observations																									
	Location: Level																									
	Hourly Amount Drained																									
	Drain 4: Observations																									
	Location: Level																									
	Hourly Amount Drained																									
	Drain 5: Observations																									
	Location: Level																									
	Hourly Amount Drained																									
	CSF drain output (hourly)																									
	Nasogastric aspirates/drained																									
	Blood Loss																									
	Bowels			Small TT		TT					TT			200 TT		200 Type 7			100 Type 7	100	Urgent				750	200
	Cumulative balance (72hours) +5988 mls	**Total Output**	60	140	210	280	360	480	605	705	945	1025	1065	1315	1445	1545	1645	1945	2085	2135	2145	2285	2405	2525	2675	3075
		Balance							+561					+976					+280		+1458					+1475
CVVHD	Blood Flow (mls/min)																									
	Dialysate flow (mls/hr)																									
	Access Pressure (mmHg)																									
	Return Pressure (mmHg)																									
	Pre-filter pressure (mmHg)																									
	Citrate Infusion (mmol/L)																									
	Calcium Infusion (mmol/L)																									
	Post filter iCa **(6 hrly Blue port)**																									
	Systemic iCa **(6 hrly A-Line)**																									
	Total Ca **(check daily- <3mmol)**																									
	T:I ratio (Total Ca ÷ Ionised Ca) **(check daily - < 2.5)**																									
	Changes made Initials																									
	Totals reset hourly (initial)																									
			08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07

CHI: DATE:

Intravenous Fluid Prescription Chart

Flush Bag	Volume	Rate	Prescribed by Sign & Print	Given By Sign & Print	Time Started	Batch No/Expiry Date
0.9% NaCl (Arterial Line)	1000ml	3 ml/h	Not required			
0.9% NaCl (CVC)	1000ml	3 ml/h	Not required			

Maintenance Fluid	Volume	Rate	Prescribed by Sign & Print	Given By Sign & Print	Time Started	Batch No/Expiry Date
0.9% Nacl	1000ml	125ml/hr	[illegible]	[illegible]		23CBTRB 2/25
Plasmalyte 148	1000 ml	125 ml/hr	[illegible]	[illegible]	23:00	23-07T3A 10/25
Plasmalyte 148	1000 ml	125ml/hr	[illegible]	[illegible]		
10% DEXTROSE	500 ml	30 ml/hr	[illegible]	[illegible]	21:50	23115EP6/02/25

Resuscitation Fluid	Volume	Rate	Prescribed by Sign & Print	Given By Sign & Print	Time Started	Batch No/Expiry Date

Electrolyte Replacement	Diluent Fluid	Volume	Rate	Prescribed by Sign & Print	Given By Sign & Print	Time Started	Batch No/Expiry Date
40 mmol KCl	5% DEXTROSE	100 ml	50ml/hr	[illegible] R.ANDIKE	[illegible] CWright	21:30 06-25.	
40 mmol KCl	5% DEXTROSE	100 ml	50ml/hr	[illegible] R.ANDIKE			

Enteral Feed/NG Water Prescription

Enteral	Type	Volume	Rate	Prescribed by	Given By	Time Started	Batch Number
NG Water		1000ml					

Haemofiltration Recording & Fluid Prescription

	Machine ID	Kidney Batch No.	Lines Batch No.	Date & Time	Comments
1					
2					

Blood flow (mls/min)	Dialysate flow (mls/hr)	Fluid removal (mls/hr)	Anticoagulation (citrate/heparin/other/nothing)	Prescribed by Nurse or Doctor (sign)	Print Name Nurse or Doctor	Date and Time

CiCa K4 (4 mmol/l K^+) - 5 L	Time	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
Signature	Initials x2																								
Name (PRINT)	Batch No																								
Exp. Date __/__/__																									
CiCa K2 (2 mmol/l K^+) – 5L	Time	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
Signature	Initials x2																								
Name (PRINT)	Batch No																								
Exp. Date __/__/__																									
MULTIBIC K4 (4 mmol/l K^+) - 5L	Time	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
Signature	Initials x2																								
Name (PRINT)	Batch No																								
Exp. Date __/__/__																									
SODIUM CITRATE 4% - 1.5L	Time	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
Signature	Initials x2																								
Name (PRINT)	Batch No																								
Exp. date __/__/__																									
Calcium Chloride 150mmol in 1500ml	Time	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
Signature	Initials x2																								
Name (PRINT)	Batch No																								
Exp. date __/__/__																									

label

6100413698 | M | 12/10/1960
Sanderson, George
Flat 4,
15 Quayside Street,
Edinburgh,
Midlothian, EH6 6EJ
CHI 1210601451
70179 JS Chowings

NHS Lothian

Directorate of Critical Care

Date: 22/01/24

Date of admission: 19/01/24

Day number: 4

Routine Shift Checks	Day Initial	Night Initial	Comment if N/A or not achieved
EQUIPMENT CHECKS			
O^2 Cylinder Check	✓		
Tracheostomy box check (If applicable)	—		
C-Circuit	✓		
Laerdal AMBU bag	✓		
Suction	✓		
MONITORING CHECKS			
Invasive lines - Check and zero	✓		
NIBP	✓		
Alarm limits - Checked/Set	✓		
Glucometer QC	Cnd		
PATIENT ASSESSMENT			
Infusions/fluids match prescriptions	✓		
Infusions and Lines in date	✓		
Air entry assessed	✓		
Name band in situ with CHI	✓		
ETT Cuff pressure check	—		
Skin bundle check	✓		
Allergy band check	✓		
PROPHYLAXIS			
FLOWTRONS	—		
DVT/PE	✓		
Gastric Ulcer	✓		
Eye care (prescribed)	—		

Routine Changes		Frequency of routine change
NG Tube tapes:	Change On:	DAILY
Pressure bag fluid	Change On: 26/01/24	EVERY 4 DAYS
Dry Circuit	Change On:	EVERY 7 DAYS
Flexiseal (If in situ)	Change On:	EVERY 29 DAYS
Urinary Drainage Bag	Change On: 26/01/24	EVERY 7 DAYS
HMEF	Change On:	DAILY
Closed Suction	Change On:	DAILY
Wet Circuit	Change On:	EVERY 14 DAYS
Bacterial Filter	Change On:	DAILY
Anchorfast	Change On:	EVERY 7 DAYS
Stoma bag	Change On:	DAILY

Admission Weight (kg)	
Predicted Weight (kg)	
Admission BMI	
Latest Weight (kg)	
Bowels last opened (Date)	__/__/__
If >72hrs aperients considered	Y ☐ N ☐

SEDATION AND WEANING	
Sedation Hold (please tick)	
Yes	☐
No	☐
Not appropriate	☐
Ready to wean	
Yes	☐
No	☐
Not appropriate	☐

Infection Status	
MRSA	
C. Difficile	
VRE	
ESBL (e.g. E Coli or Klebsiella)	
CRE/CPE	
Other:	
Patient neutropaenic?	Y ☐ N ☐
Isolation Required?	Y ☐ N ☐

BRISTOL STOOL CHART	
Type 1	Separate hard lumps, like nuts. Hard to pass
Type 2	Sausage shaped but lumpy
Type 3	Like a sausage but with cracks on its surface
Type 4	Like a sausage or snake, smooth and soft
Type 5	Soft blobs with clear cut edges (passed early)
Type 6	Fluffy pieces with ragged edges, a mushy stool
Type 7	Watery, no solid pieces. Entirely liquid

NOTES

Secretions		Physiotherapy	Chest Drains	Circulation		Pressure Care	Pain Scoring	Motor Block
M Mucoid	**0** Nil	✓ Cough & expectorate	**SW** Swinging	**P** Pink	**W** Warm	**R** Right side	**0** No pain	**0** Full power in legs
MP Mucopurulent	**1** Minimal	✕ Cough & No expectorate	**ST** Static **BUB** Bubbling	**WH** White	**C** Cool	**L** Left side	**1** Mild (Doesn't distress me)	**1** Weak but can move legs
P Purulent	**2** Moderate	Ø No cough	**B** Bloodstained	**M** Mottled	**CO** Cold	**B** Back	**2** Moderate (Distresses me a bit)	**2** Able to move knees
B Bloodstained	**3** Large	**BG** Bagging	**HS** Haemoserous	✓ Pulse present	✕ Pulse absent	**Ch** In Chair	**3** Severe (Distresses a lot)	**3** Minimal movement
		BD Bird	**S** Serous			**Pr** Proned	**S** Sleeping	**4** Paralysed

• Pupil Size								Eye Opening (E)	Best Verbal (V)	Best Motor (M)
1	2	3	4	5	6	7	8			
								4 Spontaneous **3** To speech **2** To pain **1** None **1** Eyes swollen	**5** Orientated **4** Confused **3** Inappropriate words **2** Incomprehensible **1** None/ETT/Trach	**6** Obeys commands **5** Localises pain **4** Normal flexion **3** Abnormal flexion **2** Extension **1** None

CHI: 121060 1451 **DATE:** 22/01/24

	TIME	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
RESPIRATORY	FIO_2	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA												
	SpO_2	94	94	94		95	95	96	97%	97%	96%	94	95												
	$ETCO_2$																								
	Mode	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV												
	Set Respiratory Rate																								
	Total Respiratory Rate	28	31	24	27	20	26	30	29	29	33	24	28												
	Set Tidal Volume																								
	Expired Tidal Volume																								
	Minute Volume																								
	Peak Pressure / P High																								
	ASB / PS																								
	PEEP / CPAP / P Low																								
	I:E Ratio																								
	T high / T low																								
	HFNC Flow Rate																								
	30° Head Up	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓												
	Humidifier temp																								
	Inner tube change																								
	Cough / deep breath																								
	Suction																								
	Subglottic drainage																								
	Air Entry (R/L)	✓																							
	ETT Length																								
	ETT pressure areas																								
	Anchorfast (R/M/L)																								
	IPPB / Cough assist																								
	Fine bore suction/oral																								
TPR	Temp	37.0				38.9				37.0															
	HR																								
	MAP																								
	ABP																								
	NIBP																								
	Cardiac Rhythm	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR												
	CVP	nurse	nurse	+8	+8	+8	+10	nurse	nurse	nurse	+8	+10	+8												
	PAP																								
	CCO																								
	Cardiac Index																								
	SV / PPV																								
	Peripheral Circulation	Pink Pale																							
	Angioseal check (L/R)	/	/	/	/	/	/	/	/	/	/	/	/		/	/	/	/	/	/	/	/	/	/	/
E	Blood Glucose			6.1				8.9																	
NEURO	Pain Score			2/5																					
	R.A.S.S	0	0	0	-1	0	0	0	0	0	0	0	0												
	GCS Eyes	4																							
	GCS Verbal	5																							
	GCS Motor (L/R)	6																							
	Total GCS	15																							
	CAM-ICU (+/-)																								
	Pupil size/reaction R																								
	Pupil size/reaction L																								
	NPI (R /L)	/	/	/	/	/	/	/	/	/	/	/	/		/	/	/	/	/	/	/	/	/	/	/
	ICP																								
	CPP																								
	ICP Treatment																								
	CSF(ml/hr)																								
	CSF Drain Set (cmH_20)																								
	Brain PbO2 (mmHg)																								
	Brain Temp (°C)																								
	Lower Limb Power (L/R)																								
CARE	Pressure care	B	B	B	B	B	B	B	B	B	B	B	B												
	Oral care (4 hourly)																								
	Limb physiotherapy																								
	Eye Care																								
		08	09	10	11	12	13	14	15	16	17	18	19												

Sanderson, George 12/12/1960 610041398 BEHU47844278 Ward 20 HGH QC Red cap blood HGH

Sanderson, George 12/12/1960 610041398 BCEW47844280 Ward 20 HGH QC Brown cap serum GEL blood HGH

Sanderson, George 12/12/1960 610041398 NHCT47844284 Ward 20 HGH QC Green cap blood HGH

Sanderson, George 12/12/1960 610041398 NHCT47844284 Ward 20 HGH MA Swab nose mouth

Sanderson, George 12/12/1960 610041398 PNU47844284 Ward 20 HGH MA Swab perineal

+vanc. levels

Secretions
Mucoid
MPucopurulent
Purulent
Bloodstained

0 = Nil
1 = Min
2 = Mod
3 = Large

Physiotherapy
Cough & expectorate = ✓
Cough, no expectorate = ×
No cough = Ø
Bagging = BG
Bird = BD

R=Right
M= Middle
L= Left

Circulation
Pink Warm
White Cool
Mottled Cold
Pulse ✓or ×

Pain score
0 = No Pain
1 = Mild
2= Moderate
3 = Severe
4= Asleep

RASS
+4 Combative
+3 V. Agitated
+2 Agitated
+1 Restless
0 Alert/calm
-1 Drowsy
-2 Light Sedation
-3 Mod Sedation
-4 Deep Sedation
-5 Unrousable

Pressure Care
Right
Left
Back / Prone
Chair

Chest Drains
Swinging
Static
Bubbling
Bloodstained
HS
Haemoserous
Serous

CHI: 12 1060 1451 DATE: 22/01/24

	Peripheral or Central (circle as appropriate)		08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
DRUG INFUSIONS	Drug VANCOMYCIN	Rate (ml/hr)	8.3	8.3	8.3	8.3	8.3	8.3	8.3	8.3	8.3	8.3														
	Peripheral/Central Concentration:	Level	40	38	26	24	10	4/100	97	92	78	73 //														
	Pump No:	Volume Infused	12	2	12	5	11	8	5	5	14															
	Drug POTASSIUM	Rate (ml/hr)	50	50	~~80~~				50	50	50	50														
	Peripheral/Central Concentration:	Level	50	8 /	0				100	98	~~35~~	0														
	Pump No:	Volume Infused	50	42	8				0	2	04															
	Drug	Rate (ml/hr)																								
	Peripheral/Central Concentration:	Level																								
	Pump No:	Volume Infused																								
	Drug	Rate (ml/hr)																								
	Peripheral/Central Concentration:	Level																								
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	Peripheral/Central Concentration:	Level																								
	Pump No:	Volume Infused																								
	Drug	Rate (ml/hr)																								
	Peripheral/Central Concentration:	Level																								
	Pump No:	Volume Infused																								
	TPN	Rate (ml/hr)																								
	Peripheral/Central Concentration:	Level																								
	Pump No:	Volume Infused																								
	Hourly infusion Checks (initial)		✓	✓	✓	✓	AL	✓	✓	✓	✓	✓														
	Sub Total infusions		62	44	20	5	11	8	5	7	78	73														
FLUIDS IN	Crystalloids		30	30	30	30	30	30 //																		
	Colloids																									
	Blood Products																									
	IV Medication							100 → 110																		
	PCA																									
	Epidural																									
	Flush Bag (0.9% NaCl)		6	6	6	6	6	6	6	6	6	6	6 //													
	NG / NJ / Jejunal																									
	Gastric Aspirate pH																									
	Oral Medication																									
	Oral			200	200		200	400				200														
	Total Intake		98	378	654	675	922	1366	1487	1500	1584	1823														
OUTPUT	Urine		260	150	150	120	100	80	80	160	60	80	←	250												
	Net UF CVVHD (reset hourly)																									
	Drain 1 Observations																									
	Location: Level																									
	Hourly Amount Drained																									
	Drain 2 Observations																									
	Location: Level																									
	Hourly Amount Drained																									
	Drain 3: Observations																									
	Location: Level																									
	Hourly Amount Drained																									
	Drain 4: Observations																									
	Location: Level																									
	Hourly Amount Drained																									
	Drain 5: Observations																									
	Location: Level																									
	Hourly Amount Drained																									
	CSF drain output (hourly)																									
	Nasogastric aspirates/drained																									
	Blood Loss																									
	Bowels		Type 1	1			7 Small	7 Small																		
Cumulative balance (72hours)	**Total Output**		260	410	560	680	780	860	940	1100	1160	1240														
mls	**Balance**		-162	-32	+74	-5	+142	+506	+547	+400	+424	+623														
CVVHD	Blood Flow (mls/min)																									
	Dialysate flow (mls/hr)																									
	Access Pressure (mmHg)																									
	Return Pressure (mmHg)																									
	Pre-filter pressure (mmHg)																									
	Citrate Infusion (mmol/L)																									
	Calcium Infusion (mmol/L)																									
	Post filter iCa **(6 hrly Blue port)**																									
	Systemic iCa **(6 hrly A-Line)**																									
	Total Ca **(check daily- <3mmol)**																									
	T:I ratio (Total Ca ÷ Ionised Ca) **(check daily - < 2.5)**																									
	Changes made Initials																									
	Totals reset hourly (initial)																									
			08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07

CHI: 1210601451 DATE: 22/01/24

Intravenous Fluid Prescription Chart

Flush Bag	Volume	Rate	Prescribed by Sign & Print	Given By Sign & Print	Time Started	Batch No/Expiry Date
0.9% NaCl (Arterial Line)	1000ml	3 ml/h	Not required			
0.9% NaCl (CVC)	1000ml	3 ml/h	Not required			

Maintenance Fluid	Volume	Rate	Prescribed by Sign & Print	Given By Sign & Print	Time Started	Batch No/Expiry Date

Resuscitation Fluid	Volume	Rate	Prescribed by Sign & Print	Given By Sign & Print	Time Started	Batch No/Expiry Date

Electrolyte Replacement	Diluent Fluid	Volume	Rate	Prescribed by Sign & Print	Given By Sign & Print	Time Started	Batch No/Expiry Date
CALCIUM 4.5 mmol GLUCONATE	~~150~~ 5% GLUCOSE	100 ML	30 MINS CVC	HARRIS	[signature] / AK	0945	2302703 03/24 / 23H21661 7.25
KCL 40 mmol	5% DEXTROSE	100 ML	2 HOURS	HARRIS	[signature] / IKR		2309601 04/27 / 23G20661 6.25

Enteral Feed/NG Water Prescription

Enteral	Type	Volume	Rate	Prescribed by	Given By	Time Started	Batch Number
NG Water		1000ml					

Haemofiltration Recording & Fluid Prescription

	Machine ID	Kidney Batch No.	Lines Batch No.	Date & Time	Comments
1					
2					

Blood flow (mls/min)	Dialysate flow (mls/hr)	Fluid removal (mls/hr)	Anticoagulation (citrate/heparin/other/nothing)	Prescribed by Nurse or Doctor (sign)	Print Name Nurse or Doctor	Date and Time

CiCa K4 (4 mmol/l K^+) - 5 L	Time	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
Signature	Initials x2																								
Name (PRINT)	Batch No																								
Exp. Date __/__/__																									
CiCa K2 (2 mmol/l K^+) – 5L	Time	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
Signature	Initials x2																								
Name (PRINT)	Batch No																								
Exp. Date __/__/__																									
MULTIBIC K4 (4 mmol/l K^+) - 5L	Time	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
Signature	Initials x2																								
Name (PRINT)	Batch No																								
Exp. Date __/__/__																									
SODIUM CITRATE 4% - 1.5L	Time	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
Signature	Initials x2																								
Name (PRINT)	Batch No																								
Exp. date __/__/__																									
Calcium Chloride 150mmol in 1500ml	Time	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
Signature	Initials x2																								
Name (PRINT)	Batch No																								
Exp. date __/__/__																									

National Early Warning Score 2 (NEWS2) Chart

NHS Lothian

6100413698 M 12/10/1960
Sanderson, George
Flat 4,
15 Quayside Street,
Edinburgh,
Midlothian, EH6 6EJ
CHI 1210601451
70179 JS Chowings

Date chart commenced: 26/1/24

This is chart number ____ of this admission

REMEMBER
- **Record all observations** on NEWS2 chart
- **Document concerns/decisions in clinical notes**
- **Escalate** your frequency of observations
- If at any point during your assessment you are concerned about your patient - **CALL FOR HELP**

Conscious Level Chart to be completed when clinically indicated

		Date		
		Time		
GLASGOW COMA SCALE	Eyes Open	Spontaneously	4	Eyes closed by swelling = C
		To speech	3	
		To pain	2	
		None	1	
	Best Verbal Response	Orientated	5	Endotracheal tube or tracheostomy = T
		Confused	4	
		Inappropriate words	3	
		Incomprehensible sounds	2	
		None	1	
	Best Motor Response	Obey commands	6	Always record the best arm response
		Localise to pain	5	
		Flexion to pain	4	
		Abnormal flexion	3	
		Extension to pain	2	
		None	1	
		Total GCS Score		
Right Pupil		Size		* reacts - no reaction c. eye closed
		Reaction		
Left Pupil		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		
		Extension		
		No response		
	LEGS	Normal power		
		Mild weakness		
		Severe weakness		
		Extension		
		No response		
		Initials		

Pupil Scale mm 1 2 3 4 5 6 7 8

	Assess	Possible Actions
AIRWAY	Is the airway - • patent • at risk • obstructed	• suction if indicated • head tilt, chin lift / jaw thrust • airway adjuncts • administer oxygen • call 2222 if at risk
BREATHING	• respiratory rate • SpO_2 • accessory muscle use • noises +/- percussion, palpation & auscultation • position / posture	• administer prescribed oxygen to maintain saturations 94-98% (NB COPD 88-92%) • monitor SpO_2 / ABGs • consider chest x-ray • treat underlying cause • call 2222 if not breathing
CIRCULATION	• pulse • blood pressure • capillary refill time • core temperature / colour • urine output • consider 4 body cavities for fluid & blood loss (4 + on the floor) • monitor drain losses	• obtain IV access • obtain blood samples • prepare fluid challenge • initiate fluid balance chart • call 2222 if no circulation • consider initiating major haemorrhage protocol • monitor response to actions
DISABILITY A = Alert V = Voice / Verbal P = Pain U = Unresponsive	• AVPU for initial assessment • GCS, on-going neuro assessment • ABC's & treat hypoxia or hypovolaemia • blood glucose • drugs	• re-assess GCS • check blood glucose if less than 4mmols/litre activate hypoglycaemia protocol • check drug chart • remember accurate documentation
EXPOSURE	• top to toe examination • look for evidence of blood loss / rashes / drains / wounds etc	• control bleeding • treat any underlying conditions identified • reassess • maintain patient's dignity • evaluate actions

Pain and Symptom Assessment and Management

Supportive care - pain: Always score worst pain in the last 24 hours or since last assessment. If the patient has deteriorating health with limited reversibility, refer to **Scottish Palliative Care Guidelines**

Acute Pain: Score current pain on movement, e.g. deep breathing. Refer to **Acute Pain Guidelines**

Persistent pain - 6 or above which distresses the patient and is unresponsive to guidelines

↓

Call Medical Staff / Senior Nurse / Nurse Practitioner

↓

For further advice contact:

ACUTE	SPECIALIST PALLIATIVE CARE
Mon-Fri: bleep Acute Pain Team Out of Hours: on-call Anaesthetist	Mon-Fri: bleep Palliative Care Team Out of Hours: via Switchboard

Pain Score	Nausea Score	Epidural Motor Block Score please do not (✓) motor block column
0 - None Continue to assess pain at least daily	**0 - No Nausea**	**0 - Full Power**
1 - 3 Mild Continue to assess pain with routine observations, must be at least daily	**1 - Nausea** Consider anti-emetic	**1 - Weak but able to raise legs**
4 - 5 Moderate Assess, administer and review analgesia as appropriate for patient	**2 - Nausea / Vomiting** Administer anti-emetic	**2 - Able to bend knees**
6 - 10 Severe Assess, administer and review analgesia as appropriate for patient	**3 - Persistent Nausea &/or Vomiting** Contact Doctor	**3 - Minimal movement** **4 - Paralysis**
Using appropriate Lothian Guidelines	**Using guidelines prescribe / give anti-emetics and review**	If score 2 or above please immediately contact the Acute Pain Team or on-call Anaesthetist if out of hours

Addressograph

610041369B M 12/10/1960
Sanderson, George
Flat 4,
15 Quayside Street,
Edinburgh,
Midlothian, EH6 6EJ
CHI 1210601451
70179 JS Chowings

NEWS of 5 or more?

Think Sepsis!

In a patient with a **NEWS** of **5 or more** and a known infection, signs and symptoms of infection, or at risk of infection, think **'Could this be sepsis?'** and **escalate care immediately.**

Special Instructions:
Only to be completed under the direction of a senior member of the medical team

A total NEWS of ____ or individual parameter of ____
is acceptable for this patient because ____

Please escalate if ____

Print ____ Sign ____ Designation ____
Date ____ Time ____ *(only valid if signed and dated)*

***Regardless of NEWS always Escalate if concerned about a patient's condition. Escalate immediately if clinical observations cannot be obtained**

NEWS TOTAL	Monitoring Frequency	Clinical Response Document concerns/decisions in patients clinical notes
0	Minimum 12 hourly/ 4 hourly in admission areas	• continue routine NEWS monitoring
Total 1 - 4	Minimum 4-6 hourly	• inform registered nurse • registered nurse assessment • review frequency of observations • if ongoing concern, escalate to medical team • consider fluid balance chart
3 in single parameter	Minimum 1 hourly	• registered nurse assessment • medical assessment • management plan to be discussed with senior trainee or above • consider fluid balance chart
Total 5 - 6 Urgent response threshold	Minimum 1 hourly	• registered nurse assessment • urgent medical assessment • management plan to be discussed with senior trainee or above • consider senior trainee review if NEWS does not improve following initial medical assessment • consider level of monitoring required • consider anticipatory care planning (ACP) • start fluid balance chart
Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	• registered nurse to assess immediately • immediate assessment by senior trainee or above • discuss with supervising consultant • if appropriate contact Critical Care for review • consider anticipatory care planning (ACP) • start fluid balance chart

Codes for recording oxygen delivery on the NEWS2 observations chart

A	breathing air	RM	reservoir mask
N	nasal cannula (document in litres)	TM	tracheostomy mask
SM	simple mask	CP	CPAP mask
V	venturi mask and percentage (e.g device = V, % = 40)	H	humidified oxygen and percentage (e.g device = H, L/min or % = 40)
NIV	patient on NIV system	OTH	Other specify

| | | |

National Early Warning Score 2 (NEWS2) Chart

NHS Lothian

610041369B | M | 12/10/1960
Sanderson, George
Flat 4,
15 Quayside Street,
Edinburgh,
Midlothian, EH6 6EJ
CHI 1210601451
70179 JS Chowings

Date chart commenced: 22/1/24

This is chart number _____ of this admission

REMEMBER
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		Initials		

Pupil Scale mm 1 2 3 4 5 6 7 8

	Assess	Possible Actions
AIRWAY	Is the airway - • patent • at risk • obstructed	• suction if indicated • head tilt, chin lift / jaw thrust • airway adjuncts • administer oxygen • call 2222 if at risk
BREATHING	• respiratory rate • SpO_2 • accessory muscle use • noises +/- percussion, palpation & auscultation • position / posture	• administer prescribed oxygen to maintain saturations 94-98% (NB COPD 88-92%) • monitor SpO_2 / ABGs • consider chest x-ray • treat underlying cause • call 2222 if not breathing
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is acceptable for this patient because .....

Please escalate if .....

Print ..... Sign ..... Designation .....
Date ..... Time ..... *(only valid if signed and dated)*

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NEWS TOTAL	Monitoring Frequency	Clinical Response Document concerns/decisions in patient's clinical notes
0	Minimum 12 hourly/ 4 hourly in admission areas	• continue routine NEWS monitoring
Total 1 - 4	Minimum 4-6 hourly	• inform registered nurse • registered nurse assessment • review frequency of observations • if ongoing concern, escalate to medical team • consider fluid balance chart
3 in single parameter	Minimum 1 hourly	• registered nurse assessment • medical assessment • management plan to be discussed with senior trainee or above • consider fluid balance chart
Total 5 - 6 Urgent response threshold	Minimum 1 hourly	• registered nurse assessment • urgent medical assessment • management plan to be discussed with senior trainee or above • consider senior trainee review if NEWS does not improve following initial medical assessment • consider level of monitoring required • consider anticipatory care planning (ACP) • start fluid balance chart
Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	• registered nurse to assess immediately • immediate assessment by senior trainee or above • discuss with supervising consultant • if appropriate contact Critical Care for review • consider anticipatory care planning (ACP) • start fluid balance chart

Codes for recording oxygen delivery on the NEWS2 observations chart

A	breathing air	RM	reservoir mask
N	nasal cannula (document in litres)	TM	tracheostomy mask
SM	simple mask	CP	CPAP mask
V	venturi mask and percentage (e.g device = V, % = 40)	H	humidified oxygen and percentage (e.g device = H, L/min or % = 40)
NIV	patient on NIV system	OTH	Other specify

| | | |

Lothian University Hospitals NHS Trust

ADULT UNITARY PATIENT RECORD

ADMITTING HOSPITAL Western General Hospital

TYPE OF ADMISSION : Emergency

PRESENTING COMPLAINTS/REASON FOR ADMISSION

1 PC - DEHYDRATING ILLNESS,SEVERE DIOREAH AND VOMMITING , VOMMITING 8 TIMES A DAY,TOILEY EVERY
2 HOUR,COLLPASED TWICE AND LOST CONCIOUS TODAY , CONFUSED, NOT PASSING URINE, TAKING NEPROXIN
3 HX - COPD, HYPERTENSION,HIGH CHOLESTRAL OBS - TELE TRIAGE ? AKI
4

Patient wishes to be known as:

NAME & ADDRESS (PATIENT LABEL)

Hospital No 610041369B F/M: M
DOB: 12/10/1960 Age: 63

Name: George Sanderson
Address: 16/17 pirrie street

Edinburgh

EH6 5HY
Telephone No: 07742013232

Title - Mr / Mrs / Miss / Ms : Mr
Martital Status:
Religion: Unknown
Ethnic Origin:

	ADMISSION WARD	DESTINATION WARD - 1st	DESTINATION WARD - 2nd
Ward No.	WGH20		
Admission Date	18/01/2024		
Admission Time to Ward	22:33		
Admitting Nurse			
Consultant	Dr E Louise Hartley		

G.P.Details 3681077/70179 70179/8
JS Chowings
Leith Surgery, 2 Duke Street,

EH6 8HQ
Tel No: 0131 554 6471

NEXT OF KIN Martin, Jacqueline
RELATIONSHIP Partner
Address:

Contact No. 07922494936

FIRST CONTACT
RELATIONSHIP
Address:

Contact No.

Patients Relative / Next of Kin Present on Admission Y/N
IF NO:
Date & Time of Notification: Signature:

Comments: eg Night Call

Allergies / Sensitivities

CARDIO PULMONARY RESUSCITATION **Resuscitate / DO NOT Attempt Resuscitation (DNAR) (Delete as appropriate)**

Rationale if DNAR:

Signature: Print Name: Designation: Date & Time:

Consultant Signature: **Print Name:** **Date & Time**
(Within 24 hrs)

	Date/Time	DNAR Status	Signature	Print Name	Designation	Consultant Signature
Change (1)						
Change (2)						

Please document rationale for change in the progess notes.

NHS Lothian

Nursing Assessment Triage Form

610041369B /E5582169 M
SANDERSON George
12-Oct-60 CHI: 121 060 1451
70179 JS Chowings
Flat 4 Midlothian
EH6 6EJ

Date: 18/01/24 | Time of Triage: 1810

Name of nurse completing triage (print name): SrT

Subjective/Objective/Assessment/Plan (SOAP):

S: PIV since Saturday.
Passing blood in stool

O: last two days = dark red blood. ↓ urine output
Looks unwell

A: Dehydrated
SoB
? coffee ground vomit
GCS 15

P: News:
Obs, ECG, bloods, PVL, G+S

PAST MEDICAL HISTORY:

COPD
HTN
High cholesterol

ALLERGIES:

Penicillin

Pain Score:	Analgesia?: YES ☐ NO ☐
BP:	
SPO_2	
RR	
PULSE	
TEMP	
NEWS Score	
BM	
Ketones	

TRIAGE CATOGORY (please circle) 1 2 3 4 5

FALLS RISK? YES ☒ NO ☐ If YES, please affix a sticker and add a TRACK alert, and complete the 4AT in the Patient-centred Care Plan.
Yellow Falls Kit issued? YES ☒ NO ☐ If NO, provide rationale:

Enhanced Obs required: YES ☐ NO ☒ N/A ☐ | WEIGHT (kg):

IV Cannula YES ☒ NO ☐ N/A ☐ If YES, date: __/__/__

Nurse's signature:
Print name: SO

Date: __/__/__

NHS Lothian

610041369B M 12/10/1960
Sanderson, George
Flat 4,
15 Quayside Street,
Edinburgh,
Midlothian, EH6 6EJ
CHI 1210601451
70179 JS Chowings

Medical Assessment Unit
Admission Care Plan and Checklist

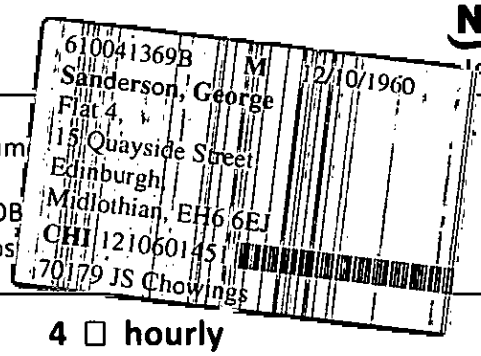
Date/time	Progress Notes	Signature/print name
19/01/24	settled at the moment. Has IDC in situ, using commode by bedside with loose bowels. Has IVF in situ and W abx. For hourly obs and close monitoring. Hourly urine output however this is poor output. Doctors aware and Crit Care Input.	AGrieve
0410	Incont of bowels, bed sheet changed and pt popped on, commode by bedside. Obs as charted and up to date - Hourly Obs.	AGrieve

NURSING ADMISSION CHECKLIST

Standard Admission Procedures	Initials
Vital signs recorded YES ☐ NO ☐ N/A ☐	
NEWS2 score recorded YES ☐ NO ☐ N/A ☐	
Name band attached YES ☐ NO ☐	
Relatives: In ED ☐ At home ☐ Not aware ☐	
Clothing and valuables: labelled: YES ☐ NO ☐ Documented YES ☐ NO ☐	
Procedures	
ECG completed: YES ☐ NO ☐	
Falls Risk assessment completed: YES ☐ NO ☐	

NHS Lothian

Medical Assessment Unit
Care Rounding



Nam

DOB

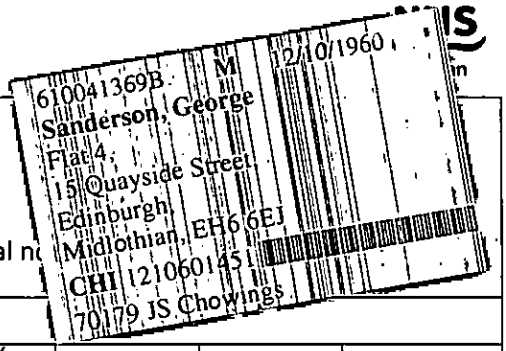
Hos

CARE ROUNDING FREQUENCY: 1 ☐ 2 ☐ 3 ☐ 4 ☐ **hourly**

Review frequency every 12 hours or if the patient's clinical condition requires

Print name of nurse reviewing:					Date: ___/___/___
Time of Round	0000	0230			
Clinical Area	MAU(T)	MAU(T)			
Care Round Leader's Initials	AG	AG			
Review Frequency of Vital Signs & Cardiac Monitoring					
Vital Signs Frequency	1	1			
Cardiac Monitoring required?	Y☐ N☑	Y☐ N☑	Y☐ N☐	Y☐ N☐	Y☐ N☐
Pain Management (refer to doctor if analgesia is required)					
Pain score (0 – 10)	0	0			
Analgesia provided	Y☐ N☑	Y☐ N☑	Y☐ N☐	Y☐ N☐	Y☐ N☐
Medication					
Is the person due any routine medication?	Y☐ N☑	Y☐ N☑	Y☐ N☐	Y☐ N☐	Y☐ N☐
Mobility – tick one option per care rounding					
Fully weight bearing	☐	☐	☐	☐	☐
Requires some assistance/uses walking aid	☑	☑	☐	☐	☐
Non weight bearing – needs full assistance	☐	☐	☐	☐	☐
Identified as at risk of falls	☐	☐	☐	☐	☐
Elimination	commode →				
Ask patient if they require the toilet	☐	☐	☐	☐	☐
Patient is self caring and can walk to toilet	☑	☑	☐	☐	☐
Patient is incontinent and needs to be checked	☐	☐	☐	☐	☐
Patient has catheter in situ - needs to be checked	☑	☑	☐	☐	☐
Nutrition and Hydration (tick one option per care rounding)					
Patient is self caring	☑	☑	☐	☐	☐
Patient needs assistance with feeding/drinks	☐	☐	☐	☐	☐
Patient is only allowed fluids	☐	☐	☐	☐	☐
Patient is **NBM**	☐	☐	☐	☐	☐
Patient has **IVI** in situ	☑	☑	☐	☐	☐
Fluid balance chart updated?	Y☑ N☐ N/A☐	Y☑ N☐ N/A☐	Y☐ N☐ N/A☐	Y☐ N☐ N/A☐	Y☐ N☐ N/A☐
Refreshments – Provided (P) Refused (R)					
Drink	P☑ R☐	P☑ R☐	P☐ R☐	P☐ R☐	P☐ R☐
Snack	P☑ R☐	P☐ R☑	P☐ R☐	P☐ R☐	P☐ R☐
Catered meal	P☐ R☑	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐

Medical Assessment Unit Care Rounding Cont'd	Name: DOB: Hospital n				



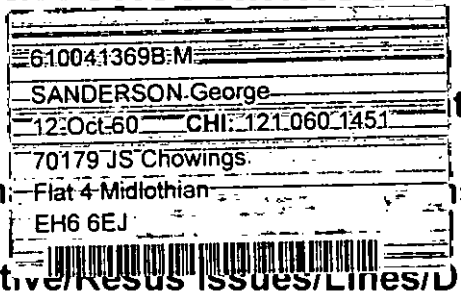
Visual Skin Inspection – tick one option per care rounding					
Patient is healthy – no concerns	☑	☑	☐	☐	☐
Visible areas of redness	☐	☐	☐	☐	☐
Broken skin and evidence of pressure ulcers	☐	☐	☐	☐	☐
Is a Waterlow assessment required?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
Is pressure relieving equipment/mattress required?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
Invasive Devices – please circle device used and tick if device in situ					
PVC /PVC insertion bundle completed	☑	☑	☐	☐	☐
Urinary catheter /catheter insertion bundle completed	☐	☐	☐	☐	☐
Infusion device	☐	☐	☐	☐	☐
NG tube / PEG tube / Tracheotomy	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐
Vulnerable person/cognitive impairment	**Is a 4AT required?** Y☐ N☐				
Family Communication					
Patient and relatives present, and have been made aware of any changes	☐	☐	☐	☐	☐
Cubicle Tidy					
Ensure area is tidy and free of obstructions	☑	☑	☐	☐	☐

Receiving Ward Nurse's signature		MAU Escort's signature:		Date: ___/___/___

MAU TROLLEYS TO WARD HANDOVER	
NEWS	
Outstanding jobs	
HEPMA administered?	YES ☐ NO ☐
Diagnosis	

Admission Pause

Current Admission



3Q1 Bleed AKI

V hypotensive
Urine output DTV
fatigue
vomit

COPD, HTN
penicillin

Operative/Resus Issues/Lines/Drains

ABx

Background

Co-morbidities
Functional status
Allergies
Infective

Ongoing Management

hyperkalaemic treatment
CTCUS NAD/A surg/IV XCT contrast
RA
NEWS 7
67/49

CXR
Other imaging
Lines
Fluid
Investigations/Bloods/G&S/Anti-microbial screening
VTE
Family
Escalation/DNACPR

fluid challenge
LL
NJ output 10C
IV Met/Gent vanc
stool samples

TARGETS

Bicarb

Tidal volume	MAP/SBP
pO_2/SaO_2	Fluid Balance
pCO_2	Sedation target
OTHER	

610041369B M 12/10/1960
Sanderson, George
Flat 4,
15 Quayside Street
Edinburgh
Midlothian, EH6 6EJ
CHI 1210601451
70179 JS Chowings

VANCOMYCIN DOSE CALCULATOR FOR ADULT PATIENTS

Produced by: NHS Lothian AMT (Using GG&C Template designed by A.Thomson)
Contact: AMT Administrator Linda.M.Robertson@nhslothian.scot.nhs.uk Version 2.9b 2023

NHS Lothian

ENTER DETAILS IN BLUE BOXES		STAT vancomy loading dose* date & time:	19/01/2024 03:32
*Fields marked * are mandatory; height can be recorded in either cm or feet & inches.*		*If loading dose is calculated as lower than maintenance dose then give the maintenance dose as a loading dose instead.*	
Patient name*	Gordon Sanderson	Dose	1000 mg
Patient CHI*	1210601451	Volume	250 ml
Indication	Sepsis	Duration of infusion	2 hours
Planned duration	5 days	Rate	125 ml/hr
Target trough levels* Select either 10-15 or 15-20. See Note 1.	16-20	REGULAR VANCOMYCIN IV MAINTENANCE DOSE	
Age* (years)	63	Mode of administration	intermittent infusion
Height* (cm)	166	Time of first maintenance dose	at 10pm on 19/01/2024, then every 24 hours
OR Height* (feet)		Dose	500 mg
(inches)		Volume	250 ml
Actual Body Weight* (kg)	55.5	Duration of infusion	1 hours
Sex* (m/f)	M	Rate	250 ml/hour
Creatinine* (µmol/L)	~~900~~	Dosage interval	24 hours
Creatinine CL (ml/min)	~~<10~~	PHARMACY CHECK (Signature/Date)	E. CHHANNA 19/1

VANCOMYCIN MONITORING FORM

	Date of level	Time sample taken	Level	Creatinine	Action taken (circle)	Name	Signature
1ST LEVEL		__:__			INCREASE / DECREASE / NO CHANGE		
2ND LEVEL		__:__			INCREASE / DECREASE / NO CHANGE		
3RD LEVEL		__:__			INCREASE / DECREASE / NO CHANGE		
4TH LEVEL		__:__			INCREASE / DECREASE / NO CHANGE		
5TH LEVEL		__:__			INCREASE / DECREASE / NO CHANGE		
6TH LEVEL		__:__			INCREASE / DECREASE / NO CHANGE		
7TH LEVEL		__:__			INCREASE / DECREASE / NO CHANGE		

FOR PATIENTS ON VANCOMYCIN FOR PROLONGED PERIODS, FURTHER MONITORING CHARTS CAN BE FOUND ON THE ANTIMICROBIAL MANAGEMENT INTRANET PAGE CLICK HERE

NOTE 1. RECOMMENDED TARGET TROUGH LEVELS

10-15
- Skin soft tissue infection (cellulitis, diabetic foot infection (no osteomyelitis))
- Wound infection
- Respiratory tract infection (HAP, CAP, aspiration pneumonia)
- Line infection without bacteraemia
- Urinary tract infection
- Intra-abdominal infection

15-20
Typically "deep seated" infections
- Bone and joint infections including prosthetic joint infection
- Endocarditis and other intravascular infections
- Any abscess or collection (liver/diverticular/appendix/brain)
- Any prosthetic material infection
- Staph aureus bacteraemia

CLICK HERE FOR ANTIMICROBIAL GUIDELINES

NOTE 2. WHEN TO CHECK VANCOMYCIN LEVELS

Blood levels should be taken up to 1 hour before the dose. Do not wait for level to return before administering the next dose.

12 hourly maintenance dosing	Trough level should be taken before the 3rd MAINTENANCE dose. When dose changed re-check trough level before 3rd NEW MAINTENANCE dose if remains on 12 hourly dosing.
24 hourly maintenance dosing	Trough level should be taken before the 2nd MAINTENANCE dose. When dose changed re-check trough level before 2nd NEW MAINTENANCE dose if remains on 24 hourly dosing.
48 hourly maintenance dosing	Trough level should be taken before the 1st MAINTENANCE dose. When dose changed re-check trough level before every MAINTENANCE dose if remains on 48 hourly dosing.

When therapeutic levels achieved continue to monitor levels every 48 hours

NHS LOTHIAN PRESCRIBING NOTES FOR INTERMITTENT VANCOMYCIN USE IN ADULTS

NHS Lothian

STEP 1. STARTING VANCOMYCIN

- Check contraindications.
- Decide on a target trough level NOTE 1.
- Use the calculator and print off the calculator page and notes and file with current patient monitoring forms.
- If unable to print immediately prescribe the recommended loading and maintenance doses in the drug chart/HEPMA. Be aware that if you print the calculator at a later date, given the change in date/time, the recommended timing of the maintenance doses may change.
- Prescribe the loading dose as close to the time recorded on the calculator (top right of chart).
- Prescribe maintenance doses only at recommended times.
- Use the \vanc code to document in the electronic patient record (TRAK) the indication and when the vancomycin level should be taken NOTE 2.
- Check U+E daily.

STEP 2. GETTING TO THERAPEUTIC LEVELS

- Document the date and time that the vancomycin level was taken on the monitoring form.
- Ensure that vancomycin is administered after the level is taken. DO NOT WAIT FOR THE LEVEL TO RETURN.
- Review the result of the level within 12 hours of it being taken.
- Document the result of the level on the monitoring form.
- Based on the target trough level chosen and information in NOTE 3 circle the required action - INCREASE/DECREASE/NO CHANGE.
- If a change in dose is required use the dose banding table NOTE 4 to choose subsequent doses as recommended.
- Prescribe the new recommended doses on the drug chart/HEPMA.
- Use the \vanc in TRAK to document when the next vancomycin level should be taken (typically every 48 hours or more frequently if renal function unstable).

STEP 3. REVIEW AND REVISE @72 HOURS

- Review IV antibiotics daily.
- At 48-72 hours review need for ongoing IV therapy and available microbiology results.
- Complete the \antibreview.
- If vancomycin level not therapeutic by 72 hours after ward pharmacist review discuss with microbiology (review antibiotic choice).
- If vancomycin is to be continued continue to monitor trough levels every 48-72 hours or as advised by the pharmacist.
- See NOTE 5 if a dose is unintentionally missed or delayed.

NOTE 5. MANAGING MISSED OR DELAYED DOSES

A DOSE DELAYED LESS THAN 1 HOUR AFTER THE PRESCRIBED TIME CAN BE ADMINISTERED WITHOUT BEING RE-WRITTEN OR OTHER ACTIONS TAKEN

Length of delay	Recommended action
More than 1 hour but less than half the maintenance dosing interval (i.e. If on 12 hourly dosing <6 hours delay, if on 24 hourly dosing <12 hours delay etc.)	Re-prescribe missed dose as once only/STAT. Give the next vancomycin dose at the ORIGINALLY PRESCRIBED TIME.
More than half the maintenance dosing interval (i.e. If on 12 hourly dosing >6 hours delay, if on 24 hourly dosing >12 hours delay etc.)	Re-prescribe missed dose as once only/STAT. Seek advice from pharmacy for further dosing.

NOTE 4. VANCOMYCIN DOSE BANDS (Sodium chloride 0.9% or glucose 5%)

DOSE, VOLUME, DURATION AND RATE	DOSING INTERVAL
500 mg in 250 ml over 1 hour = 250ml/hr	48 hours
500 mg in 250 ml over 1 hour = 250ml/hr	24 hours
750 mg in 250 ml over 1.5 hours = 166ml/hr	24 hours
500 mg in 250 ml over 1 hour = 250ml/hr	12 hours
750 mg in 250 ml over 1.5 hours = 166ml/hr	12 hours
1000 mg in 250 ml over 2 hours = 125ml/hr	12 hours
1250 mg in 250 ml over 2.5 hours = 100ml/hr	12 hours
1500 mg in 500 ml over 3 hours = 166ml/hr	12 hours
1000 mg in 250 ml over 2 hours = 125ml/hr	8 hours
1250 mg in 250 ml over 2.5 hours = 100ml/hr	6 hours
1500 mg in 500 ml over 3 hours = 166ml/hr	6 hours

INCREASE BAND

NOTE 3. ALTERING THE DOSE BASED ON THE TROUGH (PRE-DOSE) LEVELS

Trough (pre-dose) level	Guidance for target trough level 10-15mg/L	Guidance for target trough level 15-20mg/L
4.9mg/L or less	Increase 2 dose bands - consider discussing with a pharmacist	Increase 3 dose bands - consider discussing with a pharmacist
5.0-9.9mg/L	Increase 1 dose band	Increase 2 dose bands
10.0-14.9mg/L	Continue	Increase 1 dose band
15.0-19.9mg/L	Decrease 1 dose band Do not omit a dose	Continue
20.0-24.9mg/L	Decrease 2 dose bands Do not omit a dose	Decrease 1 dose band Do not omit a dose
25.0mg/L or more	Omit next dose and check level every 24 hours. Restart when level < 20mg/L and decrease 2 dose bands.	Omit next dose and check level every 24 hours. Restart when level < 25mg/L and decrease 1 dose band.

If a level of 25mg/L or more is recorded, review the timing of when the sample was taken, and ensure it is a true trough (up to 1 hour BEFORE the dose was administered) and discuss with your pharmacist.

610041369B M 2/10/1960
Sanderson, George
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CHI 1210601451
70179 JS Chowings

Gentamicin dosing calculator and monitoring chart for adult patients

Use for patients aged 16 and over. THIS IS NOT A PRESCRIPTION. ALL PRESCRIBING AND ADMINISTRATION SHOULD BE RECORDED ON HEPMA OR PRESCRIPTIO
Exclusions: Dialysis patients, myasthenia gravis patients, synergistic use, prophylaxis unless 5mg/kg recommended.
Produced by NHS Lothian Antimicrobial Management Team antimicrobial.stewardship@nhslothian.scot.nhs.uk

Enter details in the boxes below:	
Patient name	George Sanderson
Patient CHI	1210601451
Age	63
Height (cms)	166
OR Height (feet)	
(& Inches)	
Actual body weight (kg)	55.5
Sex (m/f)	M
Creatinine (µmol/L)	~~500~~ ~~900~~ 952
CrCl result (ml/min)	~~11~~ <10

CrCl = 5.5 ml/min

Gentamicin dosing recommendations	Date and time: 19/01/2024 03:39
Gentamicin dose (mg)	(≈ 2mg/kg) ~~100~~ 110
Predicted dosing interval, based on data entered	Prescribe a stat dose. Do not give further dose until level is <1mg/L.
HEPMA prescribing interval recommendation	STAT
Confirm dosing interval with levels	
Recommended date and time first gentamicin level to be taken	20/01/2024 03:39

Pharmacy check	R. CHHANNA
Sign	Date 1911

PREPARATION: Dilute dose in 100ml of sodium chloride 0.9% or glucose 5% and infuse over 30 minutes

PRESCRIBING GENTAMICIN IN HEPMA
CHOOSE: Gentamicin 80mg/2ml solution for injection ampoules
Prescribe the calculator recommended dose.
Frequency:
- XH24: if 24 hourly dosing recommended
- XH48: if 48 hourly dosing recommended
- STAT order: if not to give further dose

Administration record - complete each time gentamicin is given

Step 1. Nursing staff to record when dose was administered. Whoever takes the level should record the date and time it was taken.
Step 2. Clinical team: document the gentamicin level and renal function and complete Step 3 BEFORE the next dose of gentamicin is due.
Step 3. Clinical team: Plot the gentamicin level on the monitoring chart to confirm the dosing interval.
Nursing staff should NOT ADMINISTER the next dose of gentamicin if this section is not completed unless instructed to by clinical team. If not completed discuss with clinical team/II@N.

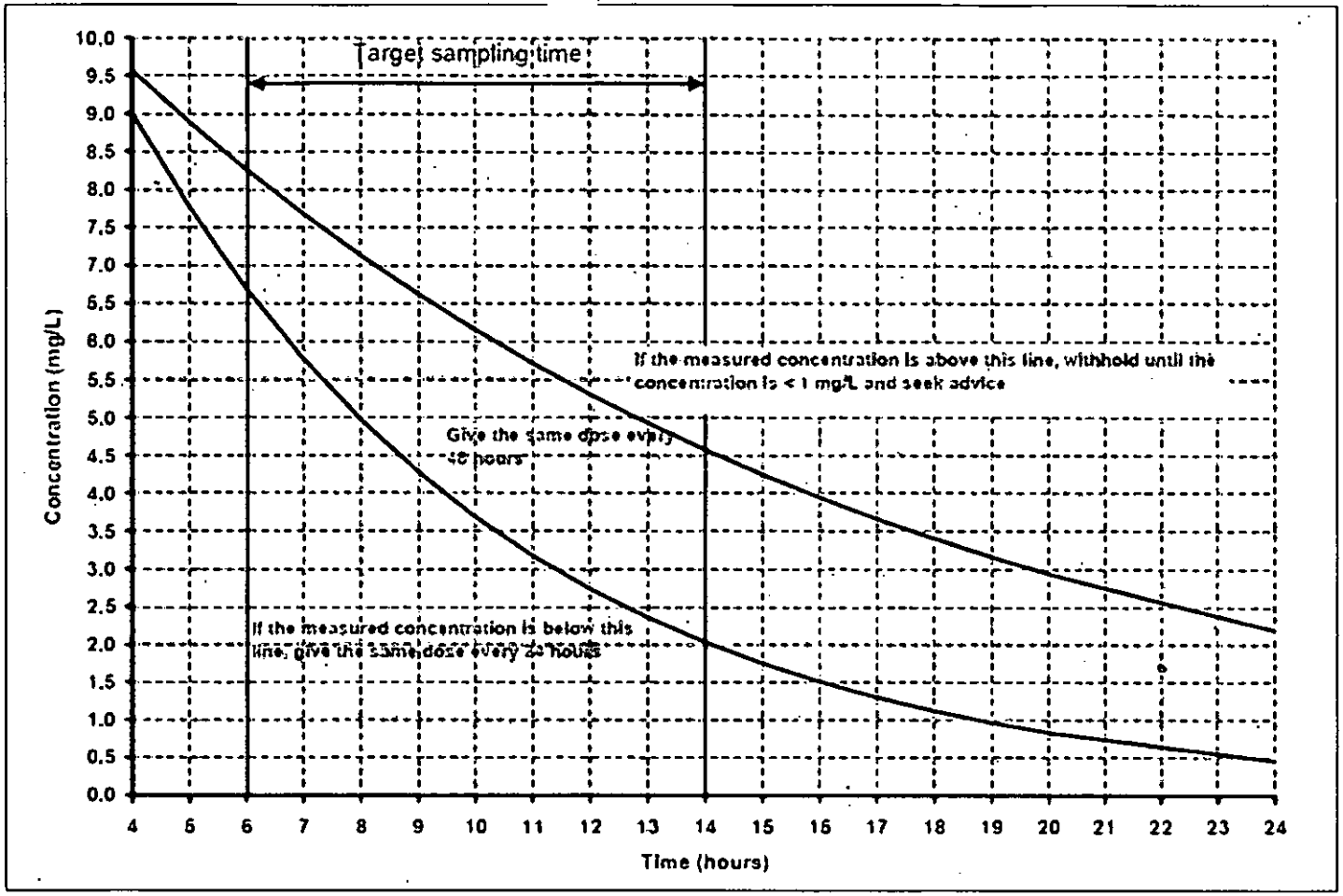
	Date and time dose administered	Date and time level taken	Gentamicin level mg/L	Creatinine µmol/L	Does the dosing interval need to change?	Has the dosing interval been amended on HEPMA?	Confirm date and time of next gentamicin dose	Name	Signature
Dose 1	19/01/24 0350	20/01/YY 05:30	1.6		Yes (No)	Yes, amended / No change required	DD/MM/YY hh:mm		
Dose 2	21/01/24 hh:mm	22/1/24 h22:10			Yes / No	Yes, amended / No change required	DD/MM/YY hh:mm		
Dose 3	DD/MM/YY hh:mm	DD/MM/YY hh:mm			Yes / No	Yes, amended / No change required	DD/MM/YY hh:mm		

@72 hours review need for ongoing antibiotics - stop or justify continue. Document outcome of review using \antibreview

Continued IV gentamicin is acceptable after 72 hours, for up to 5 days in total, where the patient is improving, oral route is not available, and there is no deterioration in renal function or hearing. Look at the Antimicrobial Companion for IV to oral switch options. CLICK HERE FOR GENTAMICIN : HOW TO USE IT WELL! NOTES

Dose 4	DD/MM/YY hh:mm	DD/MM/YY hh:mm			Yes / No	Yes, amended / No change required	DD/MM/YY hh:mm		
	DD/MM/YY hh:mm	DD/MM/YY hh:mm			Yes / No	Yes, amended / No change required	DD/MM/YY hh:mm		

GENTAMICIN MONITORING CHART



SIGNS OF GENTAMICIN TOXICITY

RENAL
- Decreased urine output/oliguria
- Increasing serum creatinine

OTO/VESTIBULAR - development of new:
- Tinnitus or hearing loss
- Dizziness or poor balance
- Oscillating vision

MONITORING GENTAMICIN

- Take a gentamicin level (and U&Es) at the time suggested on the calculator:
  - If CrCl >=21 @ 6-14 hours after the start of the infusion
  - if CrCl <21 @ 24 hours after the start of the infusion
- Record the exact date and time the sample was taken.
- Record the serum concentration.
- Determine appropriate dosing interval from the chart. The plot will indicate one of 3 options:
  1. Continue present dosage regimen (either 24 hourly or 48 hourly)
  2. Change dosing interval (calculator predicted 24 or 48 hourly but levels indicate need to change interval on HEPMA or prescription chart)
  3. Withhold any further dose until level <1 mg/L
- If the concentration falls exactly on the line, choose the option above the line and seek advice from pharmacy. Also seek advice from pharmacy if the concentration is exceptionally high or low.
- Continue to take gentamicin levels after each administration and daily U&Es.

CRITICAL CARE, WESTERN GENERAL HOSPITAL

610041369B M
SANDERSON George
12-Oct-60 CHI: 121 060 1451
70179 JS Chowings
Flat 4 Midlothian
EH6 6EJ

ALLERGIES: * Penicillin ✓
PASSWORD:
Date of Admission: 19/01/2024
Admitted From: RAW
ICU Consultant:
Parent Consultant/Speciality:

Religion:	Contact 1	Contact 2
Name	SHERRENE MARTIN	
Relationship	PARTNER	
Contact Number	Address: 07922-494936	Address:
	Email:	

Reason For Admission:

S/T Hx DSV
↓ ORAL INTAKE
ANURIC => AKI
SEPTIC SHOCK

Other information:

↓ BP
COPD - SMOKER
BPH ↳ NICOTINE PATCH

Wardwatcher: Adm Page	✓
Admission 12 Ld ECG	
CPE/MRSA Trak Risk Assessment	
MRSA admission screen	✓
CPE screening (if applicable) Day1 ☐ Day 3 ☐ Day 5 ☐	
COVID Positive ☐ Query ☐	
COVID Negative	
Laser band in situ?	✓
Patient Belongings Listed	
Trak: Waterlow Score	✓
Trak: Falls Risk Assessment	✓
Trak: MUST Score	✓
Trak: Bedrails Assessment	
Permission for Welcome Pack	
Permission for vCreate	
DISCHARGE CHECKLIST	
TRAK D/C or Transfer	
Tracheostomy Box (if applicable)	
NOK aware	

Patient Valuables

Kept on person* ☑
Ward safe (max £30) ☐ Receipt No:
Returned to family ☐

Nurse Sign _____ Print SC(AW)
Relative Sign _____ Print _____
(* explain NHS Lothian Policy)

DISCHARGE PLANNING

Date of referral:
Ward/Hospital Accepted:
Receiving Consultant:
Discharge Transport: Ref:

Police Reference Number:

CRITICAL CARE, WESTERN GENERAL HOSPITAL

610041369B M 12/10/1960
Sanderson, George
Flat 4,
15 Quayside Street,
Edinburgh,
Midlothian, EH6 6EJ
CHI 1210601451
70179 JS Chowings

ALLERGIES:

PASSWORD:

Date of Admission:
Admitted From:

ICU Consultant:
Parent Consultant/Speciality:

Religion:	Contact 1	Contact 2
Name		
Relationship		
Contact Number	*Address:* ☎ *Email:*	*Address:* ☎

Reason For Admission:

Other information:

Patient Valuables

Kept on person* ☐
Ward safe (max £30) ☐ **Receipt No:** _____
Returned to family ☐

Nurse Sign _____ ***Print*** _____
Relative Sign _____ ***Print*** _____
(* explain NHS Lothian Policy)

Wardwatcher: Adm Page
Admission 12 Ld ECG
CPE/MRSA Trak Risk Assessment
MRSA admission screen
CPE screening (if applicable) Day1 ☐ Day 3 ☐ Day 5 ☐
COVID Positive ☐ **Query** ☐
COVID Negative
Laser band in situ?
Patient Belongings Listed
Trak: Waterlow Score
Trak: Falls Risk Assessment
Trak: MUST Score
Trak: Bedrails Assessment
PCCP
DISCHARGE CHECKLIST
MRSA DISCHARGE SCREEN
TRAK D/C or Transfer
Tracheostomy Box (if applicable)
NOK aware

DISCHARGE PLANNING
Date of referral:
Ward/Hospital Accepted:
Receiving Consultant:
Discharge Transport: **Ref:**

Police Reference Number:

ACCOUNTABILITY RECORD

Date	Shift	Name (Print CLEARLY)	ACP	HAI	Signature	Initials
19.1.24						
19.1.24						
20.1.24	D	ROSSI MACDONALD				RM
20.1.24	N	LORNA ARCHIBALD				LA
21.1.24	D	ROSS MACDONALD				RM
21/1/24	N	Dana Mucha	✓			
22/1/24	D	Emi REDMOND				

PRESCRIPTION AND ADMINISTRATION RECORD

NHS Lothian

Date of Admission: 19/1/24

Critical Care and Cardiothoracic Surgery with immunosuppressants chart

____ of ____

Hospital/Ward: Consultant:

Weight: 55.5kg Height:

If re-written, date:

DISCHARGE PRESCRIPTION

Date completed: Completed by:

Name o 6100041369B M
SANDERSON George
CHI Nu 12-Oct-60 CHI: 121060 1451
D.O.B. 70179 JS Chowings
Flat 4 Midlothian
EH6 6EJ

OTHER MEDICINE CHARTS IN USE		PREVIOUS ADVERSE REACTIONS - This section must be completed before any medicine is given except in exceptional circumstances		None known ☐	
Date	Type of Chart	Medicine / Agent	Description of reaction	Completed by (sign, print & designation)	Date
19/1/24	CEFTRIAXONE	PENICILLIN		[signature]	19/1

- Write clearly in block capitals, using a black ballpoint pen
- Use approved names for medicines
- Never alter a prescription
- Route of administration

The only acceptable abbreviations are:

IV	- intravenous	SL	- sublingual	NG	- nasogastric
IM	- intramuscular	PR	- per rectum	ID	- intradermal
SC	- subcutaneous	PV	- per vagina	TOP	- topical
INHAL	- inhaled	NEB	- nebulised		

Never abbreviate ORAL or INTRATHECAL
Specify RIGHT or LEFT for eye and ear preparations

- Write the medicine dose clearly
  - The only acceptable abbreviations are:
    g - gram mg - milligram ml - millilitre
    all other doses must be written out in full eg. micrograms
  - Avoid decimal points eg. 100 micrograms (not 0.1mg). If unavoidable, write zero in front of the decimal point
  - Prescribe liquids by writing the dose in mg
  - For 'as required' medicines, state the symptoms to be relieved, the minimum time interval between doses and the maximum daily dose
  - Write units as 'units' not 'iu'

CODES FOR NON-ADMINISTRATION OF PRESCRIBED MEDICINE

If a dose is not administered as prescribed, initial and enter a code in the column with a circle drawn round the code according to the reason as shown below. **Inform the responsible doctor in the appropriate timescale.**

1. Patient refuses
2. Patient not present
3. Medicines not available - CHECK ORDERED
4. Asleep / drowsy
5. Administration route not available - CHECK FOR ALTERNATIVE
6. Vomiting / nausea
7. Time varied on doctor's instructions
8. Once only / as required medicine given
9. Dose withheld on doctor's instructions
10. Possible adverse reaction / side effect

CONTENTS:	PAGE	CONTENTS:	PAGE
Once Only Prescriptions	2 - 5	Adoport®/Prograf®/Advagraf®/Ciclosporin Chart	28
Regular Therapy	6 - 17		
Continuous Drug Infusions	18 - 23		
As Required Therapy	24 - 27		

OXYGEN

Start Date	Start Time	Route Mask (%)	Route Prongs (l/min)	Prescriber - Sign + Print	Administered by	Stop Date	Stop Time

Regular Therapy

Continuous Drug Infusions

As Required Therapy

Name:..... D.O.B.:..... CHI Number:.....

Once Only Medication

Date	Time to be given	Medicine	Dose/Amount	Route	Fluid	Volume	Rate/Duration	Prescriber (sign + print)	Time given	Given by / Checked by
19/1	0700	METRONIDAZOLE	3mg	IV	Bolus 1ml at time	6ml		[illegible]		[illegible]
19/1	0800	VANCOMYCIN	1000mg	IV				[illegible]	0710	[illegible]
19/1	12:00	LANSOPRAZOLE	30mg	ORAL				[illegible]	1500	[illegible]
20/1	23:15	ZOPICLONE	3.75mg	PO				[illegible]	23.20	LA
21/01	11:30	GENTAMICIN	110mg	IV				[illegible]	1330	[illegible]

Name:..... D.O.B.:..... CHI Number:.....

Once Only Medication

Date	Time to be given	Medicine	Dose/Amount	Route	Fluid	Volume	Rate/Duration	Prescriber (sign + print)	Time given	Given by / Checked by

Name:..... D.O.B.:..... CHI Number:.....

Once Only Medication

Date	Time to be given	Medicine	Dose/Amount	Route	Fluid	Volume	Rate/Duration	Prescriber (sign + print)	Time given	Given by / Checked by

Name:..... D.O.B.:..... CHI Number:.....

Once Only Medication

Date	Time to be given	Medicine	Dose/Amount	Route	Fluid	Volume	Rate/Duration	Prescriber (sign + print)	Time given	Given by Checked by

Name:..... D.O.B.:..... CHI Number:.....

Regular Therapy

Regular Therapy

			Date/ Time ▼	19/1	20/1	21/1	22/1/24	
Medicine (Approved Name) GENTAMICIN		For Use	06	04	9	[9		
Dose / Amount 440 110mg	Route IV	Quantity	10		r.v level	Level r.v		
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date 19/1	Pharmacy	14					
Comments/Indication/Review Date ~2mg/kg CrCl: 5-5			18					
			22					
Prescriber - sign + print			24					
Medicine (Approved Name) METRONIDAZOLE		For Use	06					
Dose / Amount 500mg	Route IV	Quantity	10					
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date 19/1	Pharmacy	14					
Comments/Indication/Review Date			18					
			22					
Prescriber - sign + print			24					
Medicine (Approved Name) SODIUM ZIRCONIUM		For Use	06		JD			
Dose / Amount 10mg	Route ORAL	Quantity	10					
Diluent/Undiluted + Volume		Date	12	3	PM	AM 9		
Rate/Duration	Start Date 19/1	Pharmacy	14					
Comments/Indication/Review Date ↑K / 24U daily			18					
			22	JD	LA			
Prescriber - sign + print			24					
Medicine (Approved Name) ANORO ELLIPTA		For Use	06					
Dose / Amount 1 PUFF	Route INH	Quantity	10	8 SELF	PM SELF	AM SELF	SELF	
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date	Pharmacy	14					
Comments/Indication/Review Date 55/22 dose			18					
			22					
Prescriber - sign + print			24					

Name:..... D.O.B.:..... CHI Number:.....

Regular Therapy

Regular Therapy

Date/ Time									
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Time change

Name:..... D.O.B.:..... CHI Number:.....

Regular Therapy

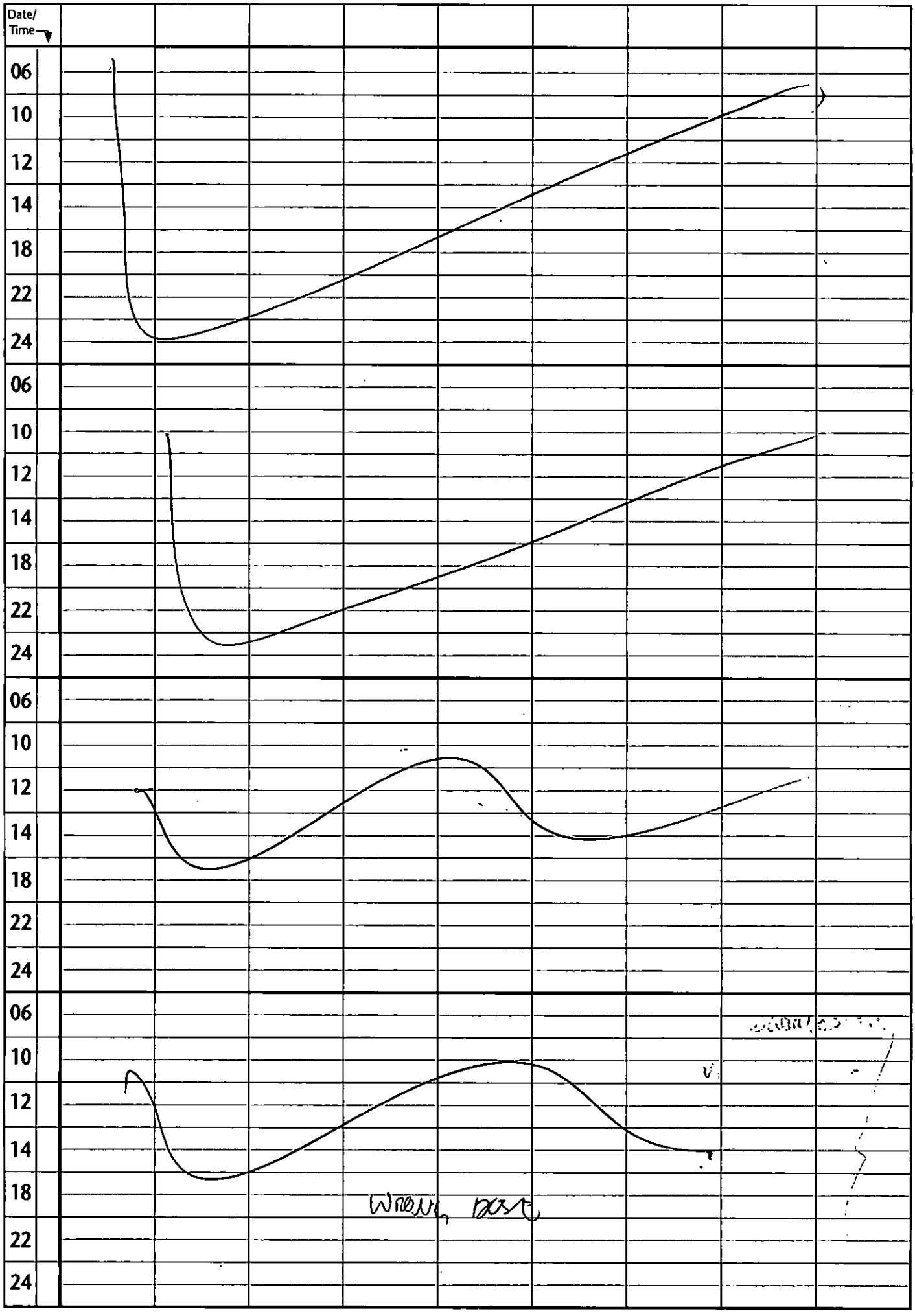
Regular Therapy

				Date/Time →	1a/1/24	2a/1/24			
Medicine (Approved Name): SIMVASTATIN			For Use	06					
Dose / Amount: 40mg	Route: ORAL		Quantity	10					
Diluent/Undiluted + Volume			Date	12					
Rate/Duration	Start Date: 19/1		Pharmacy	14					
Comments/Indication/Review Date				18					
				22	9	9	9		
Prescriber - sign + print: [illegible]				24	↓ POOR RENAL FUNCTION				
Medicine (Approved Name): LISINOPRIL			For Use	06					RLN
Dose / Amount: 10mg	Route: ORAL		Quantity	10	9	9	9	9	
Diluent/Undiluted + Volume			Date	12					
Rate/Duration	Start Date: 19/1		Pharmacy	14					
Comments/Indication/Review Date				18		hold (see 19/1)			
				22					
Prescriber - sign + print: [illegible]				24					
Medicine (Approved Name): TAMSULOSIN MR			For Use	06					RLN
Dose / Amount: 400 micrograms	Route: ORAL		Quantity	10	9	9	9	9	
Diluent/Undiluted + Volume			Date	12					
Rate/Duration	Start Date: 19/1		Pharmacy: RC 1911	14					
Comments/Indication/Review Date: withhold while catheter				18		hold due to renal impairment			
				22					
Prescriber - sign + print: [illegible]				24					
Medicine (Approved Name): DALTEPARIN			For Use	06					
Dose / Amount: 2500 units	Route: SC		Quantity	10					
Diluent/Undiluted + Volume			Date	12					
Rate/Duration	Start Date: 19/1		Pharmacy	14					
Comments/Indication/Review Date				18					
				22					
Prescriber - sign + print: [illegible]				24					

Name:..... D.O.B.:..... CHI Number:.....

Regular Therapy

Regular Therapy



Name:..... D.O.B.:..... CHI Number:.....

Regular Therapy

Regular Therapy

			Date/ Time	19/01	20/01	21/01	22/1/24	
Medicine (Approved Name) DALTEPARIN		For Use	06					
Dose / Amount 5000 units	Route SC	Quantity	10					
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date 19/01	Pharmacy RENAL	14					
Comments/Indication/Review Date VTE PROPHYLAXIS			18		PM/AC	PM/AC	X	
			22			Anti-Xa level POST DOSE	INR 1-5	
Prescriber - sign + print MOO T-UK			24					
Medicine (Approved Name) LANSOPRAZOLE		For Use	06		JA	LA	L	
Dose / Amount 30mg	Route ORAL	Quantity	10					
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date 19/01/24	Pharmacy	14					
Comments/Indication/Review Date STRESS ULCER PROPHYLAXIS			18					
			22					
Prescriber - sign + print RUTH BEGBIE			24					
Medicine (Approved Name) FABRINEX		For Use	06					
Dose / Amount 1 PAIR VIALS	Route IV	Quantity	10					
Diluent/Undiluted + Volume		Date	12		AC	AC	AC	
Rate/Duration	Start Date 19	Pharmacy	14					
Comments/Indication/Review Date			18					
			22					
Prescriber - sign + print RUTH BEGBIE			24					
Medicine (Approved Name) METRONIDAZOLE		For Use	06		JA	LA	AC	
Dose / Amount 500mg	Route IV	Quantity	10					
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date 19/01	Pharmacy	14		AC	AC	AC	
Comments/Indication/Review Date			18					
			22		AC	AC	AC	
Prescriber - sign + print MOO T-UK			24					

Name:..... D.O.B.:..... CHI Number:.....

Regular Therapy

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Name:..... D.O.B.:..... CHI Number:.....

Regular Therapy

Regular Therapy

			Date/ Time	20/1/24	21.1.24	22/1/24		
Medicine (Approved Name): NICOTINE PATCH		For Use	06		LA			
Dose / Amount: 21 mg	Route: TCP	Quantity	10					
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date: 19/1/24	Pharmacy	14					
Comments/Indication/Review Date: 1 PATCH / 24 hours			18					
			22					
Prescriber - sign + print: P. ANDREW			24					
Medicine (Approved Name): Paracetamol		For Use	06					
Dose / Amount: 1g	Route: PO/IV	Quantity	10					
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date: 21/1	Pharmacy	14					
Comments/Indication/Review Date			18					
			22					
Prescriber - sign + print			24					
Medicine (Approved Name): Meropenem		For Use	06					
Dose / Amount: 1g	Route: IV	Quantity	10					
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date: 21/1	Pharmacy	14					
Comments/Indication/Review Date: 5 DAY COURSE			18					
			22					
Prescriber - sign + print			24					
Medicine (Approved Name): NYSTATIN		For Use	06					
Dose / Amount: 100 000 UNITS	Route: TOP ORAL TO TONGUE	Quantity	10					
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date: 22/1/24	Pharmacy	14					
Comments/Indication/Review Date: Oral thrush 7d + 48° after symps resolved			18					
			22					
Prescriber - sign + print			24					

Name:..... D.O.B.:..... CHI Number:.....

Regular Therapy

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Name:..... D.O.B.:..... CHI Number:.....

Regular Therapy

				Date/ Time ▼	22/1				
Medicine (Approved Name) Vitamin K		For Use		06					
Dose / Amount 10mg	Route IV	Quantity		10					
Diluent/Undiluted + Volume		Date		12					
Rate/Duration	Start Date 22/1/24	Pharmacy		(14)	AR E				
Comments/Indication/Review Date 3 days decreased dose				18					
				22					
Prescriber - sign + print FCP NRP442				24					
Medicine (Approved Name) SANDO K		For Use		(06)					
Dose / Amount 2 TABS	Route ORAL	Quantity		10					
Diluent/Undiluted + Volume		Date		12					
Rate/Duration	Start Date 22/1/24	Pharmacy		14					
Comments/Indication/Review Date Review U&E daily				(18)	AR				
				22					
Prescriber - sign + print HARRIS				24					
Medicine (Approved Name)		For Use		06					
Dose / Amount	Route	Quantity		10					
Diluent/Undiluted + Volume		Date		12					
Rate/Duration	Start Date	Pharmacy		14					
Comments/Indication/Review Date				18					
				22					
Prescriber - sign + print				24					
Medicine (Approved Name)		For Use		06					
Dose / Amount	Route	Quantity		10					
Diluent/Undiluted + Volume		Date		12					
Rate/Duration	Start Date	Pharmacy		14					
Comments/Indication/Review Date				18					
				22					
Prescriber - sign + print				24					

Name:..... D.O.B.:..... CHI Number:.....

Regular Therapy

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Name:..... D.O.B.:..... CHI Number:.....

Regular Therapy

			Date/ Time					
Medicine (Approved Name)		For Use	06					
Dose / Amount	Route	Quantity	10					
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date	Pharmacy	14					
Comments/Indication/Review Date			18					
			22					
Prescriber - sign + print			24					
Medicine (Approved Name)		For Use	06					
Dose / Amount	Route	Quantity	10					
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date	Pharmacy	14					
Comments/Indication/Review Date			18					
			22					
Prescriber - sign + print			24					
Medicine (Approved Name)		For Use	06					
Dose / Amount	Route	Quantity	10					
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date	Pharmacy	14					
Comments/Indication/Review Date			18					
			22					
Prescriber - sign + print			24					
Medicine (Approved Name)		For Use	06					
Dose / Amount	Route	Quantity	10					
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date	Pharmacy	14					
Comments/Indication/Review Date			18					
			22					
Prescriber - sign + print			24					

Name:..... D.O.B.:..... CHI Number:.....

Regular Therapy

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Name: GEORGE SANDISON D.O.B.: 12/10/60 CHI Number: 121060 1451

Continuous Drug Infusions

Medicine (Approved Name) NORADRENALINE	Date	19/1/24				
	Time	1750				
Dose / Amount 20mg | **Total Volume** 250 | **Route** IV	Signatures	[signature]				
Glucose 5% / Water for Injections — Sodium Chloride 0.9% / Undiluted	Date	20/1/24				
	Time	1150				
Rate/Duration 0-20ml/hr | **Start Date** | **Pharmacy** RCH11	Signatures	[signature]				
Comments/Indication/Review Date	Date	21/1/24				
	Time	1505				
Prescriber - sign + print [signature]	Signatures	[signature]				
Medicine (Approved Name) VANCOMYCIN	Date	19/1/24	19/1/24			
	Time	1300	23:30			
Dose / Amount 250mg | **Total Volume** 50mL | **Route** IV	Signatures	[signature]	[signature]			
Glucose 5% / Water for Injections — Sodium Chloride 0.9% / Undiluted	Date					
	Time					
Rate/Duration OVER 12 HRS | **Start Date** | **Pharmacy**	Signatures					
Comments/Indication/Review Date INTRA-ABDOMINAL SEPSIS - R/V @ 48HRS	Date					
	Time					
Prescriber - sign + print RUTH BEGBIE	Signatures					
Medicine (Approved Name) VANCOMYCIN	Date	20/1/24	22/1/24			
	Time	2400	1235			
Dose / Amount 500mg | **Total Volume** 100mL | **Route** IV	Signatures	[signature]	[signature]			
Glucose 5% / Water for Injections — Sodium Chloride 0.9% / Undiluted	Date	21/1/24				
	Time	1200				
Rate/Duration 8.3mls/hr | **Start Date** 20/01 | **Pharmacy**	Signatures	[signature]				
Comments/Indication/Review Date INTRA-ABDOMINAL SEPSIS UP TITRATED DUE TO LOW LEVEL 20/01	Date	22/1/24				
	Time	0140				
Prescriber - sign + print LLOYD T. LOCK	Signatures	[signature]				
Medicine (Approved Name) VANCOMYCIN	Date					
	Time					
Dose / Amount 375 mg | **Total Volume** | **Route**	Signatures					
Glucose 5% / Water for Injections — Sodium Chloride 0.9% / Undiluted	Date					
	Time					
Rate/Duration | **Start Date** | **Pharmacy**	Signatures					
Comments/Indication/Review Date	Date					
	Time					
Prescriber - sign + print	Signatures					
Medicine (Approved Name)	Date					
	Time					
Dose / Amount | **Total Volume** | **Route**	Signatures					
Glucose 5% / Water for Injections — Sodium Chloride 0.9% / Undiluted	Date					
	Time					
Rate/Duration | **Start Date** | **Pharmacy**	Signatures					
Comments/Indication/Review Date	Date					
	Time					
Prescriber - sign + print	Signatures					

Name:..... D.O.B.:..... CHI Number:.....

Date									
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Name:..... D.O.B.:..... CHI Number:.....

Medicine (Approved Name)			Date			
			Time			
Dose / Amount	Total Volume	Route	Signatures			
Glucose 5%	Sodium Chloride 0.9%		Date			
Water for Injections	Undiluted		Time			
Rate/Duration	Start Date	Pharmacy	Signatures			
Comments/Indication/Review Date			Date			
			Time			
Prescriber - sign + print			Signatures			
Medicine (Approved Name)			Date			
			Time			
Dose / Amount	Total Volume	Route	Signatures			
Glucose 5%	Sodium Chloride 0.9%		Date			
Water for Injections	Undiluted		Time			
Rate/Duration	Start Date	Pharmacy	Signatures			
Comments/Indication/Review Date			Date			
			Time			
Prescriber - sign + print			Signatures			
Medicine (Approved Name)			Date			
			Time			
Dose / Amount	Total Volume	Route	Signatures			
Glucose 5%	Sodium Chloride 0.9%		Date			
Water for Injections	Undiluted		Time			
Rate/Duration	Start Date	Pharmacy	Signatures			
Comments/Indication/Review Date			Date			
			Time			
Prescriber - sign + print			Signatures			
Medicine (Approved Name)			Date			
			Time			
Dose / Amount	Total Volume	Route	Signatures			
Glucose 5%	Sodium Chloride 0.9%		Date			
Water for Injections	Undiluted		Time			
Rate/Duration	Start Date	Pharmacy	Signatures			
Comments/Indication/Review Date			Date			
			Time			
Prescriber - sign + print			Signatures			
Medicine (Approved Name)			Date			
			Time			
Dose / Amount	Total Volume	Route	Signatures			
Glucose 5%	Sodium Chloride 0.9%		Date			
Water for Injections	Undiluted		Time			
Rate/Duration	Start Date	Pharmacy	Signatures			
Comments/Indication/Review Date			Date			
			Time			
Prescriber - sign + print			Signatures			
Medicine (Approved Name)			Date			
			Time			
Dose / Amount	Total Volume	Route	Signatures			
Glucose 5%	Sodium Chloride 0.9%		Date			
Water for Injections	Undiluted		Time			
Rate/Duration	Start Date	Pharmacy	Signatures			
Comments/Indication/Review Date			Date			
			Time			
Prescriber - sign + print			Signatures			

Name:..... D.O.B.:..... CHI Number:.....

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Name:..... D.O.B.:..... CHI Number:.....

Medicine (Approved Name)			Date			
			Time			
Dose / Amount	Total Volume	Route	Signatures			
Glucose 5%	Sodium Chloride 0.9%		Date			
Water for Injections	Undiluted		Time			
Rate/Duration	Start Date	Pharmacy	Signatures			
Comments/Indication/Review Date			Date			
			Time			
Prescriber - sign + print			Signatures			
Medicine (Approved Name)			Date			
			Time			
Dose / Amount	Total Volume	Route	Signatures			
Glucose 5%	Sodium Chloride 0.9%		Date			
Water for Injections	Undiluted		Time			
Rate/Duration	Start Date	Pharmacy	Signatures			
Comments/Indication/Review Date			Date			
			Time			
Prescriber - sign + print			Signatures			
Medicine (Approved Name)			Date			
			Time			
Dose / Amount	Total Volume	Route	Signatures			
Glucose 5%	Sodium Chloride 0.9%		Date			
Water for Injections	Undiluted		Time			
Rate/Duration	Start Date	Pharmacy	Signatures			
Comments/Indication/Review Date			Date			
			Time			
Prescriber - sign + print			Signatures			
Medicine (Approved Name)			Date			
			Time			
Dose / Amount	Total Volume	Route	Signatures			
Glucose 5%	Sodium Chloride 0.9%		Date			
Water for Injections	Undiluted		Time			
Rate/Duration	Start Date	Pharmacy	Signatures			
Comments/Indication/Review Date			Date			
			Time			
Prescriber - sign + print			Signatures			
Medicine (Approved Name)			Date			
			Time			
Dose / Amount	Total Volume	Route	Signatures			
Glucose 5%	Sodium Chloride 0.9%		Date			
Water for Injections	Undiluted		Time			
Rate/Duration	Start Date	Pharmacy	Signatures			
Comments/Indication/Review Date			Date			
			Time			
Prescriber - sign + print			Signatures			

Name:..... D.O.B.:..... CHI Number:.....

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Name:..... D.O.B.:..... CHI Number:.....

As Required Therapy

Medicine (Approved Name): SALBUTAMOL		For Use	Date				
			Time				
Dose + Frequency + Maximum: 2 PUFF QDS	Route: INH	Quantity	Dose				
			Signature(s)				
Indication + Notes: SOB / WHEEZE	Start Date	Date	Date				
			Time				
Prescriber - Sign + Print: [illegible]		Pharmacy	Dose				
			Signature(s)				
Medicine (Approved Name): ONDANSETRON		For Use	Date	20/1/24	21/1/24		
			Time	1835	1835		
Dose + Frequency + Maximum: 4-8mg TDS 8°	Route: IV/IM/ ORAL	Quantity	Dose	4mg	4mg		
			Signature(s)	[illegible] AE	[illegible] AE		
Indication + Notes: N+V	Start Date	Date	Date	21.1.24	21		
			Time	07.05			
Prescriber - Sign + Print: [illegible]		Pharmacy	Dose	4mg			
			Signature(s)	[illegible]			
Medicine (Approved Name): PARACETAMOL		For Use	Date	19/1/24			
			Time	1625			
Dose + Frequency + Maximum: 1g QDS Max 4g/24hrs	Route: ORAL / IV	Quantity	Dose	1g			
			Signature(s)	[illegible]			
Indication + Notes: PAIN + PYREXIA	Start Date: 19/01	Date	Date				
			Time				
Prescriber - Sign + Print: [illegible]		Pharmacy	Dose				
			Signature(s)				
Medicine (Approved Name): ORAMORPH		For Use	Date	19/1/24	20/1/24	20.1.24	
			Time	20:23	0315	22.30	
Dose + Frequency + Maximum: 2.5mg 4hourly	Route: ORAL	Quantity	Dose	2.5mg	2.5mg	2.5mg	
			Signature(s)	[illegible]	AM	[illegible]	
Indication + Notes: PAIN LOW DOSE DUE TO AKI	Start Date: 19/01	Date	Date	20/1/24	20/1/24	21/1/24	
			Time	1000	1755	1115	
Prescriber - Sign + Print: [illegible] T. LOY		Pharmacy	Dose	2.5mg	2.5mg	2.5mg	
			Signature(s)	[illegible]	[illegible]	[illegible]	
Medicine (Approved Name): ONDANSETRON		For Use	Date				
			Time				
Dose + Frequency + Maximum: 4mg TDS MAX 12mg/24hrs	Route: ORAL / IV	Quantity	Dose				
			Signature(s)				
Indication + Notes: N+V	Start Date: 21/1	Date	Date				
			Time				
Prescriber - Sign + Print: [illegible] T. LOY		Pharmacy	Dose				
			Signature(s)				

As Required Therapy

Name:..... D.O.B.:..... CHI Number:.....

As Required Therapy

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Time									
Dose									
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Name:..... D.O.B.:..... CHI Number:.....

As Required Therapy

Medicine (Approved Name): CYCLIZINE		For Use	Date	21.1.24	22/1/24		
			Time	1440	0130		
Dose + Frequency + Maximum: 50mg TDS MAX150mg/24hrs	Route: ORAL/IV	Quantity	Dose	50mg	50mg/0		
			Signature(s)				
Indication + Notes: N+V	Start Date: 21/01	Date	Date				
			Time				
Prescriber - Sign + Print		Pharmacy	Dose				
			Signature(s)				
Medicine (Approved Name): Oramorph		For Use	Date	21.1.24	22/1/24	22/01/24	22/01/24
			Time	1440	600	1000	1455
Dose + Frequency + Maximum: 2.5mg 4 hrly PRN	Route: PO	Quantity	Dose		2.5mg/0	2.5mg	2.5mg
			Signature(s)				
Indication + Notes	Start Date: 21/1	Date	Date				
			Time				
Prescriber - Sign + Print		Pharmacy	Dose				
			Signature(s)				
Medicine (Approved Name): ORAL MORPHINE SOLUTION		For Use	Date	22/01/24			
			Time	1600			
Dose + Frequency + Maximum: 5mg 2°	Route: ORAL	Quantity	Dose	~~2.5mg~~ 5mg			
			Signature(s)				
Indication + Notes: PAIN, ↑ as treated	Start Date: 22/1/24	Date	Date				
			Time				
Prescriber - Sign + Print		Pharmacy	Dose				
			Signature(s)				
Medicine (Approved Name)		For Use	Date				
			Time				
Dose + Frequency + Maximum	Route	Quantity	Dose				
			Signature(s)				
Indication + Notes	Start Date	Date	Date				
			Time				
Prescriber - Sign + Print		Pharmacy	Dose				
			Signature(s)				
Medicine (Approved Name)		For Use	Date				
			Time				
Dose + Frequency + Maximum	Route	Quantity	Dose				
			Signature(s)				
Indication + Notes	Start Date	Date	Date				
			Time				
Prescriber - Sign + Print		Pharmacy	Dose				
			Signature(s)				

As Required Therapy

Name:..... D.O.B.:..... CHI Number:.....

As Required Therapy

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1 dose
22/1/24

As Required Therapy

Name:..... D.O.B.:..... CHI Number:.....

ADOPORT®/PROGRAF®/ADVAGRAF®/CICLOSPORIN CHART

Tacrolimus *(Adaport®/Pragraf®/Advagraf®)*

**** Prescribe by brand name to avoid confusion between different formulations ****

Dosage information

- Refer to relevant protocol for dosage and target level. If in any doubt – consult specialist team
- Adoport ® and Prograf® are twice daily formulations
- Advagraf® is a prolonged release formulation which should be given once daily
- Post transplant start with Adoport®

Ciclosporin

Dosage information

- Refer to relevant protocol for dosage and target level. If in any doubt – consult specialist team
- ciclosporin is given twice daily

Date	Blood level	ADOPORT®/PROGRAF®/ADVAGRAF®/CICLOSPORIN *(Please Circle)*					
		10 am			10 pm Adoport®/Prograf®/Ciclosporin only		
		Oral Dose	Prescriber sign + print	Given by	Oral Dose	Prescriber sign + print	Given by

610041369B M 12/10/1960
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15 Quayside Street,
Edinburgh,
Midlothian, EH6 6EJ
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70179 JS Chowings

NHS Lothian

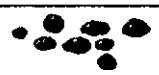
Bowel chart

Name: GEORGE SANDERSON CHI: 121 060 1451

Ask the patient how often their bowels would normally move: _____

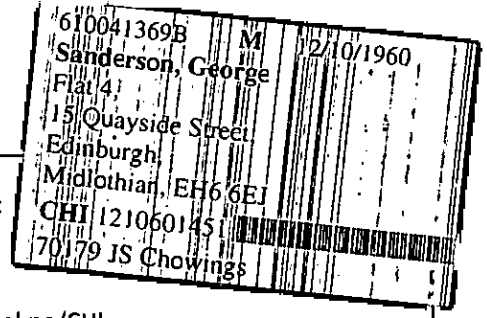
Please complete the chart in full each time the patient moves their bowels including time, the BSF (1-7) and amount passed.

Bristol Stool Form scale (BSF)

BSF 1	BSF 2	BSF 3	BSF 4	BSF 5	BSF 6	BSF 7
						
Separate hard lumps, like nuts (hard to pass)	Sausage-shaped but lumpy	Like a sausage but with cracks on its surface	Like a sausage or snake, smooth and soft	Soft blobs with clear-cut edges (passed easily)	Fluffy pieces with ragged edges, a mushy stool	Watery, no solid pieces Entirely liquid

Date	Time	BSF (1-7) and size/amount (small, medium, large)	Comments
e.g. 01/01/99	0900	2 medium	Sat for 15 minutes, straining
20/1/24	02:45	T7 ++	BEDPAN
20/1/24	06:30	T7	BEDPAN
20/1/24	0800	T7	Bedpan
20/1/24	0900	T7+	Bedpan
20/1/24	1200	T7	Bedpan
20/1/24	1900	T7	"
20.1.24	2125	T7	Bedpan
21.1.24	0400	T7	Bed pan
21.1.24	0410	T7 small	Bed pan
21.1.24	0415	T7	Bed pan
21.1.24	0500	T7 small	Bed pan
21.1.24	0700	T7 large	Bed pan

Date	Time	BSF (1-7) and size/amount (small, medium, large)	Comments
e.g. 01/01/99	0900	2 medium	Sat for 15 minutes, straining
21.1.24	07:30	T7 large	Bedpan
21/1/24	22:00	Type 7 watery	Bedpan
21/1/24	23:50	T7 small	bedpan
22/1/24	1:00	T7 medium	bed pan
22/1/24	03:30	T7 large	incontinent.
22/1/24	03:40	T7 small	bedpan.
22/1/24	6:00	T7 small	bed pan
22/01/24	0850	T7 Small	Bedpan
22/01/24	1230	T7 Small	Bedpan
22/01/24	1300	T7 Small	Bedpan.
22/01/24	18:50	T7 Small	Bedpan
22/1/24	23:30	7 med	green slime/bedpan
25/1/24	00.30	7 large	green lumpy/bed P
25/1	8:00	7 Large	Bed Pan
25/1	11:00	7 Large	Bed Pan
25/1	14:00	7 Large	Bed Pan / Dark Green
25/1	17.40	7 Large	Green Slime / Bed Pan Commode
24/1	18:40	7 Large	" " commode
24/1	23:50	7 large	Dark Green
25/1	0110	7 large	dark Green
	0700	7 large	Dark green
	1100	7 med	" "
	1400	7 med	" "
	1430	7 small	" "
	02	6/7 mixed % urine	500ml brown
	08	6/7 " "	400ml brown
28/1	0600	7/ medium	faeces.
	1000	6/7 med	faeces.
	1400	6/7 small	faeces
	1500	6/7 small	faeces



Department of Nutrition & Dietetics
Food/Fluid Record Chart
please record for a minimum of 3 days, or as directed

Name:

DOB:

Hospital no/CHI:

Food Allergies:

Use the chart to assess the patient's nutritional intake. Please **circle** the food/fluid items given and amounts **consumed** by the patient, and provide as much information as possible regarding quantities consumed - e.g. Bread 1 slice, mince 2 tablespoons, custard ½ bowl, milk one glass

Date 27/1/24 Ward: 43	Comments/ Amounts	Date ___/___/___ Ward:	Comments/ Amounts	Date ___/___/___ Ward:	Comments/ Amounts
Breakfast fruit/ fruit juice cereal/ porridge bread/ roll/ toast butter/margarine jam/ marmalade tea/ coffee/ milk Sugar	all all	**Breakfast** fruit/ fruit juice cereal/ porridge bread/ roll/ toast butter/margarine jam/ marmalade tea/ coffee/ milk Sugar		**Breakfast** fruit/ fruit juice cereal/ porridge bread/ roll / toast butter/margarine jam/ marmalade tea/ coffee/ milk Sugar	
Mid Morning tea/ coffee/ milk supplement biscuit/cake	all. all	**Mid Morning** tea/ coffee / milk supplement biscuit/cake		**Mid Morning** tea/ coffee / milk supplement biscuit/cake	
Lunch soup/ fruit juice meat/ fish potatoes /rice pasta/ bread vegetables/ salad pudding/ fruit/ drink		**Lunch** soup/ fruit juice meat/ fish potatoes /rice pasta/ bread vegetables/ salad pudding/ fruit/ drink		**Lunch** soup/ fruit juice meat/ fish potatoes /rice pasta/ bread vegetables/ salad pudding/ fruit/ drink	
Mid Afternoon tea/ coffee/ milk supplement biscuit/cake		**Mid Afternoon** tea/ coffee/ milk supplement biscuit/cake		**Mid Afternoon** tea/ coffee/ milk supplement biscuit/cake	
Evening Meal soup/ fruit juice meat/ fish potatoes /rice pasta/ bread vegetables/ salad pudding/ fruit/ drink		**Evening Meal** soup/ fruit juice meat/ fish potatoes /rice pasta/ bread vegetables/ salad pudding/ fruit/ drink		**Evening Meal** soup/ fruit juice meat/ fish potatoes /rice pasta/ bread vegetables/ salad pudding/ fruit/ drink	
Supper tea/ coffee/ milk biscuit/ toast sandwich		**Supper** tea/ coffee/ milk biscuit/ toast sandwich		**Supper** tea/ coffee/ milk biscuit/ toast sandwich	
Extras sweets/ chocolate fruit crisps drink		**Extras** sweets/ chocolate fruit crisps drink		**Extras** sweets/ chocolate fruit crisps drink	

Please complete as accurately as possible to support nutritional assessment by the dietetic and medical staff

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Sanderson, George
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15 Quayside Street, ...
Edinburgh,
Midlothian, EH6 6EJ
CHI 1210601451
70179 JS Chowings

Department of Nutrition & Dietetics
Food/Fluid Record Chart
please record for o minimum of 3 doys, or os directed

Nam
DOB
Hosp

Food Allergies:

Use the chart to assess the patient's nutritional intake. Please **circle** the food/fluid items given and amounts **consumed** by the patient, and provide as much information as possible regarding quantities consumed e.g. Bread 1 slice, mince 2 tablespoons, custard ½ bowl, milk one glass

Date 20/1/24 Ward: 20	Comments/ Amounts	Date 21/1/24 Ward: 20	Comments/ Amounts	Date 22/01/24 Ward:	Comments/ Amounts
Breakfast fruit/ fruit juice cereal/ porridge bread/ roll/ (toast) butter/margarine jam/ marmalade tea/ (coffee)/ milk Sugar	2 mouth full Half a cup.	**Breakfast** fruit/ fruit juice cereal/ porridge bread/ roll/ toast butter/margarine jam/ marmalade tea/ coffee/ milk Sugar	NONE	**Breakfast** fruit/ fruit juice cereal/ porridge bread/ roll/ toast butter/margarine jam/ marmalade tea/ coffee/ milk Sugar	Refused
Mid Morning tea/ coffee / milk supplement biscuit/cake	✓	**Mid Morning** (tea/ coffee)/ milk supplement biscuit/cake	w/ sugar half a cup	**Mid Morning** tea/ coffee / milk supplement biscuit/cake	Coffee – Half
Lunch soup/ fruit juice meat/ fish Haggis potatoes /rice pasta/ bread vegetables/ salad pudding/ fruit/ drink	2 x mouth fulls	**Lunch** (soup)/ fruit juice meat/ fish potatoes /rice pasta/ bread vegetables/ salad pudding/ fruit/ drink	full soup.	**Lunch** soup/ fruit juice meat/ fish potatoes /rice pasta/ bread vegetables/ salad pudding/ fruit/ drink	Soup all + Banana
Mid Afternoon tea/ coffee/ milk supplement biscuit/cake	✓	**Mid Afternoon** tea/ coffee/ milk supplement biscuit/cake	NIL ✓	**Mid Afternoon** tea/ coffee/ milk supplement biscuit/cake	
Evening Meal soup/ fruit juice meat/ fish potatoes /rice pasta/ bread vegetables/ salad pudding/ fruit/ drink ICECREAM		**Evening Meal** soup/ fruit juice meat/ fish potatoes /rice pasta/ bread vegetables/ salad pudding/ fruit/ drink	NIL ✓	**Evening Meal** soup/ fruit juice meat/ fish potatoes /rice pasta/ bread vegetables/ salad pudding/ fruit/ drink	~~2~~ 3 stories portion
Supper tea/ coffee/ milk biscuit/ toast sandwich		**Supper** tea/ coffee/ milk biscuit/ toast sandwich		**Supper** tea/ coffee/ milk biscuit/ toast sandwich	
Extras sweets/ chocolate fruit crisps drink		**Extras** sweets/ chocolate fruit crisps drink		**Extras** sweets/ chocolate fruit crisps drink	

Please complete as accurately as possible to support nutritional assessment by the dietetic and medical staff

18/1/24 ©

610041369B E5582169 M
SANDERSON George
12-Oct-60 CHI: 121 060 1451
70179 JS Chowings
Flat 4 Midlothian
EH6 6EJ

ADULT FLUID PRESCRIPTION CHART

Date 18/1/24 Sheet no 1

Ward MAU trolley 3

NHS Lothian

IV fluids for adults: for more details, see pocket guideline or App

Consider volume status: Hypovolaemic / Euvolaemic / Hypervolaemic

Does your patient need IV fluids? If so, are they needed for:

Maintenance, Replacement, or Resuscitation?

Write in Maintenance requirements in next 24 hours:

Weight (kg)

Essential

Volume 30ml/kg	Sodium 1mmol/kg	Potassium 1mmol/kg (unless $K^+ > 5.0$)
ml	mmol	mmol

Estimated oral intake in the next 24 hours _____ ml. Oral intake will reduce the intravenous volume required

Never give more than 100 ml/hr of 0.18% NaCl / 4% Glucose: risk of hyponatraemia

If Sodium ≤132 mmol/l, then Plasmalyte 148 should be used for maintenance. Plasmalyte 148 not to be used for maintenance in other circumstances

Weight (kg)	Maintenance Fluid Requirement in 24hr	Rate (ml/hr)	Equivalent to 1000 ml over:
35-44	1200 ml	50	20 hr
45-54	1500 ml	65	16 hr
55-64	1800 ml	75	14 hr
65-74	2100 ml	85	12 hr
≥75	2400 ml	100 (max)	10 hr

Prescribe ***Maintenance fluids and diabetic fluids*** *here.* ***Max rate is 100ml/hr.***

Prescribe subcutaneous fluids using SC guidelines *Use separate prescription chart if more bags are required Mark as 'Sheet 2'*

Type + Additions	*Vol (ml)*	*IV/ SC*	*Rate (ml/hr)*	Start time	Finish time	Prescribed by (Sign and Print)	Set up by (Sign and Print)

Use the box below to prescribe any additional fluids that are required for ***Replacement*** *or* ***Resuscitation***

Plasmalyte	500	IV	STAT	19h0		D Chaudhri	
Plasmalyte	500	IV	~~500~~ STAT	19h0		D Chaudhri	
0.9% NaCl	500	IV	STAT				
0.9% NaCl	500	IV	STAT			omcarvan.	AM 02:20

Resuscitation: *give Fluid Challenge 250 to 500ml Plasmalyte 148 over 5 to 15 min. Stop and assess before repeat. Request senior / ICU opinion if 2000ml insufficient*

Date 15/01/24

ADULT FLUID BALANCE CHART

Name: _____

CHI/Unit No.

Today's PEG/NG Feed: _____ ml/24hr TPN _____ ml/24hr

Total Input Goal: _____ ml in 24hr

Fluid Restriction: _____ ml in 24hr

	IV FLUIDS or SC FLUIDS IV MEDICATION	Line 1	ORAL INPUT LINE 2		ENTERAL: NG/ PEG / RIG	TPN/Other Line 2	URINE		GASTRIC	DRAIN 1	DRAIN 2 OTHER
	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type ~~e.g. Tea~~	Volume e.g. 100 ml	Volume	Volume	Volume	Running Total	Volume	Volume	Volume
06.00								/			
07.00								/			
08.00								/			
09.00								/			
10.00								/			
11.00								/			
12.00								/			
Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print											
13.00								/			
14.00								/			
15.00								/			
16.00								/			
Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print											
17.00								/			
18.00								/			
19.00								/			
20.00	Plasmalyte	1000.						/			
21.00	1.26% Bicarb / 0.9% NaCl	500.	125					/			
22.00	Bicarb 1.26%		125				40	/			
23.00	Saline 0.9% / Bicarb 1.26%	500	125				0	/			
24.00	Bicarb 1.26%		125				0	/			
01.00	Saline 0.9%	500.					0	/			
02.00	Bicarb 1.26%		125				4	/			
03.00	/ Bicarb 1.26%		125					/			
04.00	Bicarb 1.26%		125					/			
05.00	Saline 0.9% Bicarb 1.26%	500.	125					/			
Totals		A		B	C	D	E		F	G	H
	Total input and output ~~[illegible]~~			A+B+C+D	Total in	~~[illegible]~~			E+F+G+H	Total out	[illegible] ml
NOTES									24 Hr Balance		

See NI[illegible]othi[illegible]uidance for Intravenous Fluid and Elec[illegible]te p[illegible]ribing (on Intranet)

18/1/24 (2)

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Edinburgh,
EH6 5HY

CHI 1210601451

70179 JS Chowings

ADULT FLUID PRESCRIPTION CHART

NHS Lothian

Date 18/1/24 Sheet no (2)

Ward MAU

IV fluids for adults: for more details, see pocket guideline or App

Consider volume status: Hypovolaemic / Euvolaemic / Hypervolaemic

Does your patient need IV fluids? If so, are they needed for:

Maintenance, Replacement, or Resuscitation?

Write in Maintenance requirements in next 24 hours:

Weight (kg) 55.55 Essential

Volume 30ml/kg	Sodium 1mmol/kg	Potassium 1mmol/kg (unless $K^+ > 5.0$)
ml	mmol	mmol

Estimated oral intake in the next 24 hours _____ ml. Oral intake will reduce the intravenous volume required

Never give more than 100 ml/hr of 0.18% NaCl / 4% Glucose: risk of hyponatraemia

If Sodium ≤132 mmol/l, then Plasmalyte 148 should be used for maintenance. Plasmalyte 148 not to be used for maintenance in other circumstances

Weight (kg)	Maintenance Fluid Requirement in 24hr	Rate (ml/hr)	Equivalent to 1000 ml over:
35-44	1200 ml	50	20 hr
45-54	1500 ml	65	16 hr
55-64	1800 ml	75	14 hr
65-74	2100 ml	85	12 hr
≥75	2400 ml	100 (max)	10 hr

Prescribe ***Maintenance fluids and diabetic fluids*** *here.* ***Max rate is 100ml/hr.***

Prescribe subcutaneous fluids using SC guidelines *Use separate prescription chart if more bags are required Mark as 'Sheet 2'*

	Type + Additions	***Vol (ml)***	***IV/ SC***	***Rate (ml/hr)***	Start time	Finish time	Prescribed by (Sign and Print)	Set up by (Sign and Print)
(5)	0.9% Saline	~~1000~~ 500	IV	~~500~~ STAT	05[15]		A Tyndall	
(6)	[illegible]							

Use the box below to prescribe any additional fluids that are required for ***Replacement*** *or* ***Resuscitation***

Inf (1)	1.26% Sodium Bicarbonate	500	IV	125	2100		C Sloan	MB / AG
Inf (2)	0.9% SALINE	500	IV	~~125~~ STAT	2130		D. Chisholm	LB/AG
(3)	0.9% NaCl	~~1000~~ 500	IV	500			[illegible]	[illegible]
(4)	1.26% HCO_3^-	500	IV	125	0230		A Tyndall	AG / DM
(5)	0.9% NaCl	500	IV	STAT	0125		A Tyndall	AG / DM

Resuscitation: *give Fluid Challenge 250 to 500ml Plasmalyte 148 over 5 to 15 min. Stop and assess before repeat. Request senior / ICU opinion if 2000ml insufficient*

Date 18/01/24
Name: George sanderson
CHI/Unit No. 1710760

ADULT FLUID BALANCE CHART

Today's PEG/NG Feed: _____ ml/24hr TPN _____ ml/24hr

Total Input Goal: _____ ml in 24hr
Fluid Restriction: _____ ml in 24hr

	IV FLUIDS or SC FLUIDS IV MEDICATION	Line 1	ORAL INPUT		ENTERAL: NG/ PEG / RIG	TPN/Other Line 2	URINE		GASTRIC	DRAIN 1	DRAIN 2 OTHER
	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100 ml	Volume	Volume	Volume	Running Total	Volume	Volume	Volume
06.00								/			
07.00								/			
08.00								/			
09.00								/			
10.00								/			
11.00								/			
12.00								/			
Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print											
13.00								/			
14.00								/			
15.00								/			
16.00								/			
Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print											
17.00								/			
18.00								/			
19.00								/			
20.00								/			
21.00								/			
22.00							40	/			
23.00							0	/			
24.00							0	/			
01.00							4	/			
02.00							0	/			
03.00							0	/			
04.00								/			
05.00								/			
Totals		A		B	C	D		E	F	G	H
	Total input and output			A+B+C+D	Total in	3800			E+F+G+H	Total out	40
NOTES									24 Hr Balance		

See NH thi: iuidance for Intravenous Fluid and Electr e p ribing (on Intranet)

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ADULT FLUID PRESCRIPTION CHART

NHS Lothian

Date 23/1/24 | Sheet no

Ward 43

IV fluids for adults: for more details, see pocket guideline or App

Consider volume status: Hypovolaemic / Euvolaemic / Hypervolaemic

Does your patient need IV fluids? If so, are they needed for:

Maintenance, Replacement, or Resuscitation?

Write in Maintenance requirements in next 24 hours:

Weight (kg) _____ Essential

Volume 30ml/kg	Sodium 1mmol/kg	Potassium 1mmol/kg (unless $K^+ > 5.0$)
ml	mmol	mmol

Estimated oral intake in the next 24 hours _____ ml. Oral intake will reduce the intravenous volume required

Never give more than 100 ml/hr of 0.18% NaCl / 4% Glucose: risk of hyponatraemia

If Sodium ≤132 mmol/l, then Plasmalyte 148 should be used for maintenance. Plasmalyte 148 not to be used for maintenance in other circumstances

Weight (kg)	Maintenance Fluid Requirement in 24hr	Rate (ml/hr)	Equivalent to 1000 ml over:
35-44	1200 ml	50	20 hr
45-54	1500 ml	65	16 hr
55-64	1800 ml	75	14 hr
65-74	2100 ml	85	12 hr
≥75	2400 ml	100 (max)	10 hr

Prescribe ***Maintenance fluids and diabetic fluids*** *here.* ***Max rate is 100ml/hr.***

Prescribe subcutaneous fluids using SC guidelines *Use separate prescription chart if more bags are required Mark as 'Sheet 2'*

Type + Additions	***Vol (ml)***	***IV/ SC***	***Rate (ml/hr)***	Start time	Finish time	Prescribed by (Sign and Print)	Set up by (Sign and Print)
~~Add Nac Plasmalyte 148~~	~~1000~~	~~IV~~					
~~Add 0.18% Glucose 4%~~ Plasmalyte 148	1000	IV	100				

Use the box below to prescribe any additional fluids that are required for ***Replacement*** *or* ***Resuscitation***

Plasmalyte 148	500	IV	Bolus				

Resuscitation: *give Fluid Challenge 250 to 500ml Plasmalyte 148 over 5 to 15 min. Stop and assess before repeat. Request senior / ICU opinion if 2000ml insufficient*

Date___/___/___

Name: _____

CHI/Unit No.

ADULT FLUID BALANCE CHART

Total Input Goal: _____ml in 24hr

Today's PEG/NG Feed: _____ml/24hr TPN _____ml/24hr Fluid Restriction: _____ml in 24hr

	IV FLUIDS or SC FLUIDS IV MEDICATION	Line 1	ORAL INPUT		ENTERAL: NG/ PEG / RIG	TPN/Other Line 2	URINE		GASTRIC	DRAIN 1	DRAIN 2 OTHER
	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100 ml	Volume	Volume	Volume	Running Total	Volume	Volume	Volume
06.00								/			
07.00								/			
08.00								/			
09.00								/			
10.00								/			
11.00								/			
12.00								/			
Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print											
13.00								/			
14.00								/			
15.00								/			
16.00								/			
Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print											
17.00								/			
18.00								/			
19.00								/			
20.00								/			
21.00			Water 100					/			
22.00								/			
23.00			tea	150				/			
24.00								/			
01.00								/			
02.00	Plasmalyte (500)	500						/			
03.00								/			
04.00	Plasmalyte	1000					480	/ 480			
05.00								/			
Totals		A		B	C	D	550	E	F	G	H
	Total input and output			A+B+C+D	Total in				E+F+G+H	Total out	
NOTES									24 Hr Balance		

See NHS Lothi: Guidance for Intravenous Fluid and Electrolyte p scribing (on Intranet)

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ADULT FLUID PRESCRIPTION CHART

NHS Lothian

Date 23/1 | Sheet no

Ward 4:3

IV fluids for adults: for more details, see pocket guideline or App

Consider volume status: Hypovolaemic / Euvolaemic / Hypervolaemic

Does your patient need IV fluids? If so, are they needed for:

Maintenance, Replacement, or Resuscitation?

Write in Maintenance requirements in next 24 hours:

Weight (kg)

Essential

Volume 30ml/kg	Sodium 1mmol/kg	Potassium 1mmol/kg (unless $K^+ > 5.0$)
ml	mmol	mmol

Estimated oral intake in the next 24 hours _____ ml. Oral intake will reduce the intravenous volume required

Never give more than 100 ml/hr of 0.18% NaCl / 4% Glucose: risk of hyponatraemia

If Sodium ≤132 mmol/l, then Plasmalyte 148 should be used for maintenance. Plasmalyte 148 not to be used for maintenance in other circumstances

Weight (kg)	Maintenance Fluid Requirement in 24hr	Rate (ml/hr)	Equivalent to 1000 ml over:
35-44	1200 ml	50	20 hr
45-54	1500 ml	65	16 hr
55-64	1800 ml	75	14 hr
65-74	2100 ml	85	12 hr
≥75	2400 ml	100 (max)	10 hr

Prescribe ***Maintenance fluids and diabetic fluids*** *here.* ***Max rate is 100ml/hr.***

Prescribe subcutaneous fluids using SC guidelines *Use separate prescription chart if more bags are required Mark as 'Sheet 2'*

Type + Additions	***Vol (ml)***	***IV/ SC***	***Rate (ml/hr)***	Start time	Finish time	Prescribed by (Sign and Print)	Set up by (Sign and Print)
NaCl 0·18% / dex 4% + 40 mmol KCl	1000	IV	100	0830			

Use the box below to prescribe any additional fluids that are required for ***Replacement*** *or* ***Resuscitation***

Resuscitation: *give Fluid Challenge 250 to 500ml Plasmalyte 148 over 5 to 15 min. Stop and assess before repeat. Request senior / ICU opinion if 2000ml insufficient*

Date___/___/___

Name: _____

CHI/Unit No.

ADULT FLUID BALANCE CHART

Today's PEG/NG Feed: _____ ml/24hr TPN _____ ml/24hr

Total Input Goal: _____ ml in 24hr

Fluid Restriction: _____ ml in 24hr

	IV FLUIDS or SC FLUIDS IV MEDICATION	Line 1	ORAL INPUT		ENTERAL: NG/ PEG / RIG	TPN/Other Line 2	URINE		GASTRIC	DRAIN 1	DRAIN 2 OTHER
	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100 ml	Volume	Volume	Volume	Running Total	Volume	Volume	Volume
06.00			H20 (250)								
07.00	Plasmalyte	100	juice (150)	150			280	280			
08.00	(600 cont'd)	100	20% coffee (100)	100/250							
09.00							180	460			
10.00											
11.00			H20	100/350							
12.00	Rob Wnck 8 Flush	150					280	740			
Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print											
13.00			coffee	100							
14.00											
15.00			coffee	100			300	1040			
16.00			tea	250			200	1250			
Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print											
17.00			Milk	150							
18.00			Soup	100							
19.00							180	1430			
20.00											
21.00											
22.00			Water	750/1200			480	1910			
23.00											
24.00	NaCl 0.18%, Dex 4% +40mmol KCl	100					350	2260			
01.00		100									
02.00		100									
03.00		200					340	2600			
04.00		100									
05.00		100					450	3050			
Totals		A 1000		B	C	D	E		F	G	H
	Total input and output			A+B+C+D	Total in	2300			E+F+G+H	Total out	
NOTES									24 Hr Balance		

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ADULT FLUID PRESCRIPTION CHART

NHS Lothian

Date	Sheet no
24/10	

Ward

IV fluids for adults: for more details, see pocket guideline or App

Consider volume status: Hypovolaemic / Euvolaemic / Hypervolaemic

Does your patient need IV fluids? If so, are they needed for:

Maintenance, Replacement, or Resuscitation?

Write in Maintenance requirements in next 24 hours:

Weight (kg)

Essential

Volume 30ml/kg	Sodium 1mmol/kg	Potassium 1mmol/kg (unless $K^+ > 5.0$)
ml	mmol	mmol

Estimated oral intake in the next 24 hours _____ ml. Oral intake will reduce the intravenous volume required

Never give more than 100 ml/hr of 0.18% NaCl / 4% Glucose: risk of hyponatraemia

If Sodium ≤132 mmol/l, then Plasmalyte 148 should be used for maintenance. Plasmalyte 148 not to be used for maintenance in other circumstances

Weight (kg)	Maintenance Fluid Requirement in 24hr	Rate (ml/hr)	Equivalent to 1000 ml over:
35-44	1200 ml	50	20 hr
45-54	1500 ml	65	16 hr
55-64	1800 ml	75	14 hr
65-74	2100 ml	85	12 hr
≥75	2400 ml	100 (max)	10 hr

Prescribe ***Maintenance fluids and diabetic fluids*** *here.* ***Max rate is 100ml/hr.***

Prescribe subcutaneous fluids using SC guidelines *Use separate prescription chart if more bags are required Mark as 'Sheet 2'*

Type + Additions	*Vol (ml)*	*IV/ SC*	*Rate (ml/hr)*	Start time	Finish time	Prescribed by (Sign and Print)	Set up by (Sign and Print)
0.18% NaCl / 4% Dex	1000	IV	100				

Use the box below to prescribe any additional fluids that are required for ***Replacement*** *or* ***Resuscitation***

Resuscitation: *give Fluid Challenge 250 to 500ml Plasmalyte 148 over 5 to 15 min. Stop and assess before repeat. Request senior / ICU opinion if 2000ml insufficient*

Date___/____/____

Name: _____

CHI/Unit No.

ADULT FLUID BALANCE CHART

Today's PEG/NG Feed: _____ ml/24hr TPN _____ ml/24hr

Total Input Goal: _____ ml in 24hr

Fluid Restriction: _____ ml in 24hr

	IV FLUIDS or SC.FLUIDS IV MEDICATION	Line 1	ORAL INPUT		ENTERAL: NG/ PEG / RIG	TPN/Other Line 2	URINE		GASTRIC	DRAIN 1	DRAIN 2 OTHER
	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100 ml	Volume	Volume	Volume	Running Total	Volume	Volume	Volume
06.00							/				
07.00							/				
08.00							/				
09.00							/				
10.00							/				
11.00							/				
12.00							/				
Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print											
13.00							/				
14.00							/				
15.00							/				
16.00							/				
Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print											
17.00							/				
18.00							/				
19.00							/				
20.00							/				
21.00							/				
22.00							/				
23.00							/				
24.00							/				
01.00							/				
02.00							/				
03.00							/				
04.00							/				
05.00							/				
Totals		A		B	C	D	E		F	G	H
	Total input and output			A+B+C+D	Total in				E+F+G+H	Total out	
NOTES									24 Hr Balance		

See NHS Lothia uidance for Intravenous Fluid and Electrolyte pr ibing (on Intranet)

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ADULT FLUID PRESCRIPTION CHART

NHS Lothian

Date 24/01/24 | Sheet no

Ward 43

IV fluids for adults: for more details, see pocket guideline or App

Consider volume status: Hypovolaemic / Euvolaemic / Hypervolaemic

Does your patient need IV fluids? If so, are they needed for:

Maintenance, Replacement, or Resuscitation?

Write in Maintenance requirements in next 24 hours:

Weight (kg) _____ Essential

Volume 30ml/kg	Sodium 1mmol/kg	Potassium 1mmol/kg (unless $K^+ > 5.0$)
ml	mmol	mmol

Estimated oral intake in the next 24 hours _____ ml. Oral intake will reduce the intravenous volume required

Never give more than 100 ml/hr of 0.18% NaCl / 4% Glucose: risk of hyponatraemia

If Sodium ≤132 mmol/l, then Plasmalyte 148 should be used for maintenance. Plasmalyte 148 not to be used for maintenance in other circumstances

Weight (kg)	Maintenance Fluid Requirement in 24hr	Rate (ml/hr)	Equivalent to 1000 ml over:
35-44	1200 ml	50	20 hr
45-54	1500 ml	65	16 hr
55-64	1800 ml	75	14 hr
65-74	2100 ml	85	12 hr
≥75	2400 ml	100 (max)	10 hr

Prescribe ***Maintenance fluids and diabetic fluids*** *here.* ***Max rate is 100ml/hr.***

Prescribe subcutaneous fluids using SC guidelines *Use separate prescription chart if more bags are required Mark as 'Sheet 2'*

Type + Additions	*Vol (ml)*	*IV/ SC*	*Rate (ml/hr)*	Start time	Finish time	Prescribed by (Sign and Print)	Set up by (Sign and Print)
NaCl 0.18% + 4% Dextrose	1000ml	IV	100ml			[signature]	[signature]
~~NaCl 0.18% + 4% + 40mmol KCl~~							
~~NaCl 0.18% + 4% Dextrose~~						[signature]	
~~1000ml KCl~~	1000ml	IV	100ml				

Use the box below to prescribe any additional fluids that are required for ***Replacement*** *or* ***Resuscitation***

Resuscitation: *give Fluid Challenge 250 to 500ml Plasmalyte 148 over 5 to 15 min. Stop and assess before repeat. Request senior / ICU opinion if 2000ml insufficient*

Date 26/01/24

Name: _____

CHI/Unit No.

ADULT FLUID BALANCE CHART

Today's PEG/NG Feed: _____ ml/24hr TPN _____ ml/24hr

Total Input Goal: _____ ml in 24hr

Fluid Restriction: _____ ml in 24hr

	IV FLUIDS or SC FLUIDS IV MEDICATION	Line 1	ORAL INPUT		ENTERAL: NG/ PEG / RIG	TPN/Other Line 2	URINE		GASTRIC	DRAIN 1	DRAIN 2 OTHER
	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100 ml	Volume	Volume	Volume	Running Total	Volume	Volume	Volume
06.00								/			
07.00								/			
08.00								/			
09.00							300	/ 300			
10.00								/			
11.00								/			
12.00							200	/ 500			
Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print											
13.00							300	/ 800			
14.00								/			
15.00								/			
16.00								/			
Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print									80 Type 7		
17.00							500	/ 1300			
18.00							200	/ 1500			
19.00								/			
20.00	0.18%NaCl, 4% Dextrose +40 KCl	100	water (tea)	50				/			
21.00		100						/	250		
22.00		100	water	50			Ketch open	/			
23.00		100	coffee	200			100	/ 1600			
24.00		100						/	200		
01.00			water	100				/			
02.00							200	/ 1800			
03.00							200	/ 2000	200/650		
04.00								/			
05.00							500	/ 2500			
Totals		A		B	C	D	E		F	G	H
	Total input and output			A+B+C+D	Total in	1900			E+F+G+H	Total out	3150
NOTES									24 Hr Balance		

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ADULT FLUID PRESCRIPTION CHART

NHS Lothian

Date 25/1/24 Sheet no

Ward 43

IV fluids for adults: for more details, see pocket guideline or App

Consider volume status: Hypovolaemic / Euvolaemic / Hypervolaemic

Does your patient need IV fluids? If so, are they needed for:

Maintenance, Replacement, or Resuscitation?

Write in Maintenance requirements in next 24 hours:

Weight (kg)
Essential

Volume 30ml/kg	Sodium 1mmol/kg	Potassium 1mmol/kg (unless $K^+ > 5.0$)
ml	mmol	mmol

Estimated oral intake in the next 24 hours _____ ml. Oral intake will reduce the intravenous volume required

Never give more than 100 ml/hr of 0.18% NaCl / 4% Glucose: risk of hyponatraemia

If Sodium ≤132 mmol/l, then Plasmalyte 148 should be used for maintenance. Plasmalyte 148 not to be used for maintenance in other circumstances

Weight (kg)	Maintenance Fluid Requirement in 24hr	Rate (ml/hr)	Equivalent to 1000 ml over:
35-44	1200 ml	50	20 hr
45-54	1500 ml	65	16 hr
55-64	1800 ml	75	14 hr
65-74	2100 ml	85	12 hr
≥75	2400 ml	100 (max)	10 hr

Prescribe ***Maintenance fluids and diabetic fluids*** *here.* ***Max rate is 100ml/hr.***

Prescribe subcutaneous fluids using SC guidelines *Use separate prescription chart if more bags are required Mark as 'Sheet 2'*

Type + Additions	***Vol (ml)***	***IV/ SC***	***Rate (ml/hr)***	Start time	Finish time	Prescribed by (Sign and Print)	Set up by (Sign and Print)
[redacted] Vole	1000	IV	85mL	0800		MP Edmonson	CE MP

Use the box below to prescribe any additional fluids that are required for ***Replacement*** *or* ***Resuscitation***

Resuscitation: *give Fluid Challenge 250 to 500ml Plasmalyte 148 over 5 to 15 min. Stop and assess before repeat. Request senior / ICU opinion if 2000ml insufficient*

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ADULT FLUID BALANCE CHART

Today's PEG/NG Feed: _____ ml/24hr TPN _____ ml/24hr

Total Input Goal: _____ ml in 24hr
Fluid Restriction: _____ ml in 24hr

		Line 1	ORAL INPUT		ENTERAL: NG/ PEG / RIG	TPN/Other Line 2	URINE		GASTRIC	DRAIN 1	DRAIN 2 OTHER
	e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100 ml	Volume	Volume	Volume	Running Total	Volume	Volume	Volume
06.00											
07.00							220				
08.00	0.18% Nad 84/day	(1000)	Tea	200ml							
09.00			Water	150ml.							
10.00											
11.00			Coffee	200ml					30		
12.00							500		TWOCKED ✓		
Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print											
13.00							50ml		post twok		
14.00											
15.00			Coffee	200ml			364	(mixed)			
16.00											
Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print											
17.00			Juice	200ml			107	(mixed)			
18.00											
19.00											
20.00											
21.00											
22.00											
23.00											
24.00											
01.00											
02.00							300	mixed			
03.00											
04.00											
05.00							450	mixed			
Totals		A		B	C	D	E		F	G	H
	Total input and output			A+B+C+D	Total in				E+F+G+H	Total out	
NOTES									24 Hr Balance		

See NHS Lothi: Guidance for Intravenous Fluid and Electrolyte p scribing (on Intranet)

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ADULT FLUID PRESCRIPTION CHART

NHS Lothian

Date 26/1/23 | Sheet no

Ward 43

IV fluids for adults: for more details, see pocket guideline or App

Consider volume status: Hypovolaemic / Euvolaemic / Hypervolaemic

Does your patient need IV fluids? If so, are they needed for:

Maintenance, Replacement, or Resuscitation?

Write in Maintenance requirements in next 24 hours:

Weight (kg)

_____

Essential

Volume 30ml/kg	Sodium 1mmol/kg	Potassium 1mmol/kg (unless $K^+ > 5.0$)
ml	mmol	mmol

Estimated oral intake in the next 24 hours _____ ml. Oral intake will reduce the intravenous volume required

Never give more than 100 ml/hr of 0.18% NaCl / 4% Glucose: risk of hyponatraemia

If Sodium ≤132 mmol/l, then Plasmalyte 148 should be used for maintenance. Plasmalyte 148 not to be used for maintenance in other circumstances

Weight (kg)	Maintenance Fluid Requirement in 24hr	Rate (ml/hr)	Equivalent to 1000 ml over:
35-44	1200 ml	50	20 hr
45-54	1500 ml	65	16 hr
55-64	1800 ml	75	14 hr
65-74	2100 ml	85	12 hr
≥75	2400 ml	100 (max)	10 hr

Prescribe ***Maintenance fluids and diabetic fluids*** *here.* ***Max rate is 100ml/hr.***

Prescribe subcutaneous fluids using SC guidelines *Use separate prescription chart if more bags are required Merk as 'Sheet 2'*

Type + Additions	***Vol (ml)***	***IV/ SC***	***Rate (ml/hr)***	Start time	Finish time	Prescribed by (Sign and Print)	Set up by (Sign and Print)

Use the box below to prescribe any additional fluids that are required for ***Replacement*** *or* ***Resuscitation***

Resuscitation: *give Fluid Challenge 250 to 500ml Plasmalyte 148 over 5 to 15 min. Stop and assess before repeat. Request senior / ICU opinion if 2000ml insufficient*

Date 26/1/23
Name: G Sanderson
CHI/Unit No.

ADULT FLUID BALANCE CHART

Today's PEG/NG Feed: _____ ml/24hr TPN _____ ml/24hr

Total Input Goal: _____ ml in 24hr
Fluid Restriction: _____ ml in 24hr

	IV FLUIDS or SC FLUIDS IV MEDICATION	Line 1	ORAL INPUT		ENTERAL: NG/ PEG / RIG	TPN/Other Line 2	URINE		GASTRIC	DRAIN 1	DRAIN 2 OTHER
	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100 ml	Volume	Volume	Volume	Running Total	Volume	Volume	Volume
06.00							/				
07.00							/				
08.00		100mls	coffee				/				
09.00		250mls	coffee				/				
10.00							/				
11.00							/				
12.00		250mls	H_2O				/				
Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print											
13.00							/				
14.00		1000mls	H_2O				/				
15.00							/				
16.00							/				
Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print											
17.00							/				
18.00							/				
19.00							/				
20.00							/				
21.00							/				
22.00							/				
23.00							/				
24.00							/				
01.00							/				
02.00							/				
03.00							/				
04.00							/				
05.00							/				
Totals		A		B	C	D	E		F	G	H
	Total input and output			A+B+C+D	Total in				E+F+G+H	Total out	
NOTES									24 Hr Balance		

ADULT FLUID PRESCRIPTION CHART

610041369B M 12/10/1960
Sanderson, George
Flat 4,
15 Quayside Street,
Edinburgh, 1[illegible]
Midlothian, EH6 6EJ
CHI 1210601451
70179 JS Chowings

Date 27/01/24 | Sheet no

Ward 43

NHS Lothian

[illegible] details, see pocket guideline or App

Consider volume status: Hypovolaemic / Euvolaemic / Hypervolaemic

Does your patient need IV fluids? If so, are they needed for:

Maintenance, Replacement, or Resuscitation?

Write in Maintenance requirements in next 24 hours:

Weight (kg) _____ Essential

Volume 30ml/kg	Sodium 1mmol/kg	Potassium 1mmol/kg (unless $K^+ > 5.0$)
ml	mmol	mmol

Estimated oral intake in the next 24 hours _____ ml. Oral intake will reduce the intravenous volume required

Never give more than 100 ml/hr of 0.18% NaCl / 4% Glucose: risk of hyponatraemia

If Sodium ≤132 mmol/l, then Plasmalyte 148 should be used for maintenance. Plasmalyte 148 not to be used for maintenance in other circumstances

Weight (kg)	Maintenance Fluid Requirement in 24hr	Rate (ml/hr)	Equivalent to 1000 ml over:
35-44	1200 ml	50	20 hr
45-54	1500 ml	65	16 hr
55-64	1800 ml	75	14 hr
65-74	2100 ml	85	12 hr
≥75	2400 ml	100 (max)	10 hr

Prescribe ***Maintenance fluids and diabetic fluids*** *here.* ***Max rate is 100ml/hr.***

Prescribe subcutaneous fluids using SC guidelines *Use separate prescription chart if more bags are required Mark as 'Sheet 2'*

Type + Additions	***Vol (ml)***	***IV/ SC***	***Rate (ml/hr)***	Start time	Finish time	Prescribed by (Sign and Print)	Set up by (Sign and Print)

Use the box below to prescribe any additional fluids that are required for ***Replacement*** *or* ***Resuscitation***

Resuscitation: *give Fluid Challenge 250 to 500ml Plasmalyte 148 over 5 to 15 min. Stop and assess before repeat. Request senior / ICU opinion if 2000ml insufficient*

Date 27/01/24
Name: G Sanderson
CHI/Unit No.

ADULT FLUID BALANCE CHART

Today's PEG/NG Feed: _____ ml/24hr TPN _____ ml/24hr

Total Input Goal: _____ ml in 24hr
Fluid Restriction: _____ ml in 24hr

	IV FLUIDS or SC FLUIDS IV MEDICATION	Line 1	ORAL INPUT		ENTERAL: NG/ PEG / RIG	TPN/Other Line 2	URINE		GASTRIC	DRAIN 1	DRAIN 2 OTHER
	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100 ml	Volume	Volume	Volume	Running Total	Volume	Volume	Volume
06.00							/				
07.00							/				
08.00			H^2O	700			/				
09.00			COFFEE(2x)	200			/				
10.00							/				
11.00			COFFEE	150			TOILET				
12.00			H^2O	300	1350		/				
Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print											
13.00							/				
14.00							/				
15.00							/				
16.00							/				
Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print											
17.00							/				
18.00							/				
19.00							/				
20.00							/				
21.00							/				
22.00							/				
23.00							/				
24.00							/				
01.00							/				
02.00							/				
03.00							/				
04.00							/				
05.00							/				
Totals		A		B	C	D	E		F	G	H
	Total input and output			A+B+C+D	Total in				E+F+G+H	Total out	

NOTES

24 Hr Balance

See NHS Lothi Guidance for Intravenous Fluid and Electrolyte p ribing (on Intranet)

Ward: 43 Site: WGH Date: 13/11/24

This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency.

1hrly 2 hrly (3 hrly) ____hrly (please circle/complete)

Print name and sign

Addressograph, or

Name 610041369B M 12/10/1960
Sanderson, George
DOB Flat 4,
15 Quayside Street,
Edinburgh,
Midlothian, EH6 6EJ
Unit no. / CH CHI 1210601451
70179 JS Chowings

Codes (Y) Yes, (N) No, (N/A) not applicable,(D) Declined (AS) Asleep (I) Independent, (NW) not or... ward, (TH) Theatre,

Time of Care Rounding Document the exact time care rounding took place e.g. 0830	0830	11	1417	00	20	23	05						
	08.00 am ← 24 hour period → 07.00 am												
Pressure Area Care — **Waterlow score less than 10 low risk requires only a daily skin review:** Use codes for outcome of skin review													
Waterlow 10+ - Visual Skin Check (tick)	✓	✓		✓									
Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister	I	H	I	H	H	L	D						
Vulnerable areas? (circle areas of damage)	Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other.....												
If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan													
Have you changed position since last CR?	Y	Y	D	N	N	N	N						
Positioning (R) or (L) side (B) Back (C) Chair	S	B	B	B	B	B	B						
Mattress type / Cushion type	*please state type:*												
Elimination — Do you need the toilet?	D	N	D	N	N	N	N						
Is the patient continent of urine? (at time of Care Rounding)	IDC	IDC	IDC	IDC	IDC	IDC	IDC						
Continence product changed/offered?	Y	Y	Y	Y	Y	Y	Y						
Catheter care performed?	Y	Y	Y	Y	Y	Y	Y						
Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact													
Is patient continent of faeces? (at time of Care Rounding)	Y	Y	Y	Y	Y	Y	Y						
Bowel function monitored	Observe bowel function and update daily												
Food, Fluid & Nutrition — Would you like a drink? Ensure fluids are within easy reach	Y	Y	Y	Y	N	N	N						
Fluid Balance Chart (if clinically indicated)	Y	Y	Y	Y	Y	Y	Y						
When did you last eat?	—	/	/	/	D	D	D						
(B) Breakfast (L) Lunch (D) Dinner (S) Snack (NBM) Nil by Mouth (A) Assistance Update Food Chart if required													
Oral Hygiene Performed (ref to risk assessment)	I	Y	D	N	N	N	N						
Falls — Appropriate Footwear?	Y	Y	Y	Y	Y	Y	Y						
Walking aid available(and within reach)	D	N	D	N	N	N	N						
Area de-cluttered?	Y	Y	Y	Y	Y	Y	Y						
Chair and bed height assessed?	Y	Y	Y	Y	Y	Y	Y						
Falls alarm in use and attached?	D	N	D	N	N	/	/						
Glasses available for use? (if worn) Hearing aid available for use? (if worn)	D	N	N	N	N	Y	Y						
Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐													
Pain — Are you in pain?	D	N	D	N	N	N	N						
Analgesia Given?	D	N	N	N	N	N	N						
General — Peripheral Venous Cannula observed?	Y	Y	Y	Y	Y	Y	Y						
Observe for signs of inflammation/swelling at every CR session. **Bundle/VIP score to be updated daily**													
Are you comfortable? Y/N	Y	Y	Y	Y	Y	Y	Y						
Anything else I can do for you?	D	N	D	N	N	N	N						
Buzzer within easy reach	Y	Y	Y	Y	Y	Y	Y						
Personal Care *Type* SHOWER *(specify)* **Time Given** ____													
Initials = document at time of care delivery	CG	LK	CG	LK	[illegible]								

Ward: L3 Site: WGH Date: 2/11/24

610041369B M 12/10/1960
Sanderson, George
Flat 4,
15 Quayside Street
Edinburgh
Midlothian, EH6 6EJ
CHI 1210601451
70179 JS Chowings

This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency.

1hrly 2 hrly 3 hrly _____hrly (please circle/complete)

Print name and sign _____

Name

OOB

Unit no. / CHI

Codes (Y) Yes, (N) No, (N/A) not applicable,(D) Declined (AS) Asleep (I) Independent, (NW) not on ward, (TH) Theatre,

Time of Care Rounding Document the exact time care rounding took place e.g. 0830	2123	0130	0530											
	08.00 am ◄					24 hour period ►								07.00 am
Pressure Area Care — **Waterlow score less than 10 low risk requires only a daily skin review:** Use codes for outcome of skin review														
Waterlow 10+ - Visual Skin Check (tick)														
Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister	H	H	H	H										
Vulnerable areas? (circle areas of damage)	Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other.....													
If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan														
Have you changed position since last CR?	Y	N	N	N										
Positioning (R) or (L) side (B) Back (C) Chair	B	B	B	B										
Mattress type / Cushion type	*please state type:*													
Elimination — Do you need the toilet?	Y	N	N	N										
Is the patient continent of urine? (at time of Care Rounding)	Inc	Inc	Inc	Inc										
Continence product changed/offered?	O	O	O	O										
Catheter care performed?	Y	N	N	N										
Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact														
Is patient continent of faeces? (at time of Care Rounding)	Y	Y	Y	Y										
Bowel function monitored	Observe bowel function and update daily													
Food, Fluid & Nutrition — Would you like a drink? Ensure fluids are within easy reach	I	I	I	I										
Fluid Balance Chart (if clinically indicated)														
When did you last eat?	D	D	D	D										
(B) Breakfast (L) Lunch (D) Dinner (S)Snack (NBM) Nil by Mouth (A) Assistance Update Food Chart if required														
Oral Hygiene Performed (ref to risk assessment)	N	N	N	N										
Falls — Appropriate Footwear?	Y	Y	Y	Y										
Walking aid available(and within reach)														
Area de-cluttered?	Y	Y	Y	Y										
Chair and bed height assessed?	Y	Y	Y	Y										
Falls alarm in use and attached?														
Glasses available for use? (if worn) Hearing aid available for use? (if worn)	Y	Y	Y	Y										
Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐														
Pain — Are you in pain?	N	N	N	N										
Analgesia Given?	N/A	N/A	N/A	N/A										
General — Peripheral Venous Cannula observed?	PVC	PVC	PVC	PVC										
Observe for signs of inflammation/swelling at every CR session. **Bundle/VIP score to be updated daily**														
Are you comfortable? Y/N	Y	Y	Y	Y										
Anything else I can do for you?	N	N	N	N										
Buzzer within easy reach	Y	Y	Y	Y										
Personal Care *Type* _____ *(specify)* **Time Given** _____														
Initials — document at time of care delivery														

Ward: 43 Site: NSH Date: 25/01/24

This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency.

1hrly 2 hrly 3 hrly ____ hrly (please circle/complete)

Print name and sign

610041369B M 12/10/1960
Sanderson, George
Flat 4,
15 Quayside Street,
Edinburgh,
Midlothian, EH6 6EJ
CHI 1210601451
70179 JS Chowings

NHS Lothian

Codes (Y) Yes, (N) No, (N/A) not applicable, (D) Declined (AS) Asleep (I) Independent, (NW) not on ward, (TH) Theatre,

Time of Care Rounding Document the exact time care rounding took place e.g. 0830	11[09] 14:44	17	20	23	02	05						
	08.00 am	← 24 hour period →										07.00 am

Pressure Area Care

Waterlow score less than 10 low risk requires only a daily skin review: Use codes for outcome of skin review												
Waterlow 10+ - Visual Skin Check (tick)	Y	N		N	N	N	N					
Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister	H	N/A	N/B	NS	NS	NS	NS					
Vulnerable areas? (circle areas of damage)	Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other.....											
If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan												
Have you changed position since last CR?	Y	Y	Y	Y	Y	Y	Y					
Positioning (R) or (L) side (B) Back (C) Chair	C Bed	B	B	B	B	UP						
Mattress type / Cushion type	please state type:											

Elimination

Do you need the toilet?	I	I	I	I	I	I	I					
Is the patient continent of urine? (at time of Care Rounding)	10C	10C	Y	Y	Y	Y	Y					
Continence product changed/offered?	Y	Y	Y	I	I	I	I					
Catheter care performed?	I	I	N/A	n/a	/	/	/					
Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact												
Is patient continent of faeces? (at time of Care Rounding)	Y	N	Y	Y	Y	Y	Y					
Bowel function monitored	Observe bowel function and update daily											

Food, Fluid & Nutrition

Would you like a drink? Ensure fluids are within easy reach	WL	Y	Y	W	W	W	W					
Fluid Balance Chart (if clinically indicated)	Y	N	Y	Y	Y	Y	Y					
When did you last eat?	B	L	L	S	S	S	S					
(B) Breakfast (L) Lunch (D) Dinner (S) Snack (NBM) Nil by Mouth (A) Assistance Update Food Chart if required												
Oral Hygiene Performed (ref to risk assessment)	I	I	I	I	I	I	I					

Falls

Appropriate Footwear?	Y	Y	Y	Y	Y	Y	Y					
Walking aid available (and within reach)	Y	Y	Y	Y	Y	Y	Y					
Area de-cluttered?	Y	Y	Y	Y	Y	Y	Y					
Chair and bed height assessed?	/	/	/	Y	Y	Y	Y					
Falls alarm in use and attached?	/	/	/	n/a	n/a	n/a	/					
Glasses available for use? (if worn) Hearing aid available for use? (if worn)	N	Y	Y	Y	Y	Y	Y					
Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐												

Pain

Are you in pain?	N	N	N	N	N	N	N					
Analgesia Given?	N	N	N	N	N	N	N					

General

Peripheral Venous Cannula observed?	Y	Y	Y	Y	Y	Y	Y					
Observe for signs of inflammation/swelling at every CR session (Bundle/VIP score to be updated daily												
Are you comfortable? Y/N	Y	Y	Y	Y	Y	Y	Y					
Anything else I can do for you?	N	N	N	N	N	N	N					
Buzzer within easy reach	Y	Y	Y	Y	Y	Y	Y					

Personal Care *Type* _____ *(specify)* **Time Given** _____

Initials – document at time of care delivery												

Ward: 43 Site: NGH Date: 24/1/24

This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency.

1hrly **2 hrly** **3 hrly** _____**hrly** (please circle/complete)

Print name and sign _____

610041369B · M 12/10/1960
Sanderson, George
Flat 4,
15 Quayside Street,
Edinburgh,
Midlothian, EH6 6EJ
CHI 1210601451
70179 JS Chowings

NHS Lothian

Codes (Y) Yes, (N) No, (N/A) not applicable,(D) Declined (AS) Asleep (I) Independent, (NW) not on ward, (TH) Theatre,

Time of Care Rounding Document the exact time care rounding took place e.g. 0830	800	1200	1500	1800	20	2300	0200	05				
	08.00 am ← 24 hour period → 07.00 am											
Pressure Area Care — **Waterlow score less than 10 low risk requires only a daily skin review:** Use codes for outcome of skin review												
Waterlow 10+ - Visual Skin Check (tick)	X	✓	✓	✓	N	N	N	N				
Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister	NS	H	H	H	NS	NS	NS	NS				
Vulnerable areas? (circle areas of damage)	Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other.....											
If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan												
Have you changed position since last CR?	N	N	N	N	N	Y	Y	Y				
Positioning (R) or (L) side (B) Back (C) Chair	B	B	B	B	B	B	B	B				
Mattress type / Cushion type	*please state type:*											
Elimination — Do you need the toilet?	N	N	Y	Y	N	N	N	N				
Is the patient continent of urine? (at time of Care Rounding)	~~F~~	~~F~~	IDC	→				IDC				
Continence product changed/offered?	N	N	N	N	N	N	N	Y				
Catheter care performed?	N	Y	N	N	N	Y	Y	Y				
Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact												
Is patient continent of faeces? (at time of Care Rounding)	Y	Y	Y	Y	Y	Y	Y	Y				
Bowel function monitored	Observe bowel function and update daily											
Food, Fluid & Nutrition — Would you like a drink? Ensure fluids are within easy reach	Y	N	N	N	as	W	W	W				
Fluid Balance Chart (if clinically indicated)	~~N~~ Y	~~N~~ Y	Y	Y	Y	Y	Y	Y				
When did you last eat?	B	B	NIL ~~BY MOUTH~~					S				
(B) Breakfast (L) Lunch (D) Dinner (S)Snack (NBM) Nil by Mouth (A) Assistance Update Food Chart if required												
Oral Hygiene Performed (ref to risk assessment)	I	I	Y	Y	N	I	I	I				
Falls — Appropriate Footwear?	Y	Y	Y	Y	Y	Y	Y	Y				
Walking aid available(and within reach)	Y	Y	Y	Y	Y	Y	Y	Y				
Area de-cluttered?	Y	Y	Y	Y	Y	Y	Y	Y				
Chair and bed height assessed?	Y	Y	Y	Y	Y	Y	Y	Y				
Falls alarm in use and attached?	Y	Y	Y	Y	na	na	na	na				
Glasses available for use? (if worn) Hearing aid available for use? (if worn)	Y	Y	Y	Y	Y	Y	Y	Y				
Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐												
Pain — Are you in pain?	N	N	N	N	as	N	N	N				
Analgesia Given?	N	N	N	N	as	N	N	N				
General — Peripheral Venous Cannula observed?	Y	Y	Y	Y	Y	Y	Y	Y				
Observe for signs of inflammation/swelling at every CR session. **Bundle/VIP score to be updated daily**												
Are you comfortable? Y/N	Y	Y	Y	Y	as	Y	Y	Y				
Anything else I can do for you?	N	N	N	N	as	N	N	N				
Buzzer within easy reach	Y	Y	Y	Y	Y	Y	Y	Y				
Personal Care *Type* _____ *(specify)* **Time Given** _____												
Initials – document at time of care delivery	LK	LK	LK	LK	[illegible]	[illegible]	[illegible]	[illegible]				

Ward: 43 Site: Wat Date: 24/01/24

This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency.

1hrly 2 hrly 3 hrly ____hrly (please circle/complete)

Print name and sign

Addressograph, or

610041369B M 12/10/1960
Sanderson, George
Flat 4,
15 Quayside Street,
Edinburgh,
Midlothian, EH6 6EJ
CHI 1210601451
70179 JS Chowings

NHS Lothian

34

Codes (Y) Yes, (N) No, (N/A) not applicable, (D) Declined (AS) Asleep (I) Independent, (NW) not on ward, (TH) Theatre,

Time of Care Rounding Document the exact time care rounding took place e.g. 0830	0900	1200	1430	1730	2200	0000	0300	0500					
	08.00 am ◄ 24 hour period ► 07.00 am												
Pressure Area Care — **Waterlow score less than 10 low risk requires only a daily skin review:** Use codes for outcome of skin review													
Waterlow 10+ - Visual Skin Check (tick)	N	N	✓	✓	✓								
Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister	NS	NS	H	D	NS	N	N	H					
Vulnerable areas? (circle areas of damage)	Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other.... FACC												
If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan													
Have you changed position since last CR?	Y	Y	Y	Y	Y	Y	Y	Y					
Positioning (R) or (L) side (B) Back (C) Chair	B	B	C	B	B	L	L	L					
Mattress type / Cushion type	*please state type:*												
Elimination — Do you need the toilet?	I	I	Y	I	1	1	1	Y					
Is the patient continent of urine? (at time of Care Rounding)	Y	Y	Y	Y	Y	Y	Y	Y					
Continence product changed/offered?	NA	NA	ND	NA	N	N	NG	NG					
Catheter care performed?	NA	NA	ND	NA	N	N	NG	NG					
Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact													
Is patient continent of faeces? (at time of Care Rounding)	Y	Y	Y	Y	Y	Y	Y	Y					
Bowel function monitored	Observe bowel function and update daily												
Food, Fluid & Nutrition — Would you like a drink? Ensure fluids are within easy reach	W	W	Y	W	3	D	D	D					
Fluid Balance Chart (if clinically indicated)	Y	Y	Y	NA	N	N	N	N					
When did you last eat?	B	B	B	L	S	D	D	D					
(B) Breakfast (L) Lunch (D) Dinner (S) Snack (NBM) Nil by Mouth (A) Assistance Update Food Chart if required													
Oral Hygiene Performed (ref to risk assessment)	I	I	I	I	1	I	I	I					
Falls — Appropriate Footwear?	Y	Y	Y	Y	Y	Y	Y	Y					
Walking aid available (and within reach)	NA	NA	ND	NA	N	N	N	N					
Area de-cluttered?	Y	Y	Y	Y	Y	Y	Y	Y					
Chair and bed height assessed?	NA	NA	ND	NA	Y	Y	Y						
Falls alarm in use and attached?	NA	NA	ND	NA	N	NG	N	N					
Glasses available for use? (if worn) Hearing aid available for use? (if worn)	I	I	Y	I	1	1	Y	Y					
Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐													
Pain — Are you in pain?	N	N	N	N	N	N	AD	N					
Analgesia Given?	N	N	N	N	N	N	Y	N					
General — Peripheral Venous Cannula observed?	Y	Y	Y	Y	Y	Y	Y	Y					
Observe for signs of inflammation/swelling at every CR session. **Bundle/VIP score to be updated daily**													
Are you comfortable? Y/N	Y	Y	Y	Y	Y	Y	Y	Y					
Anything else I can do for you?	N	N	N	N	N	N	N	N					
Buzzer within easy reach	Y	Y	Y	Y	Y	Y	Y						
Personal Care *Type* _____ *(specify)* **Time Given** _____													
Initials – document at time of care delivery	CM	CM	BG	CM	[illegible]								

Ward: 43 Site: Ward Date: 26/1/24

This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency.

1hrly 2 hrly 3 hrly 4 hrly (please circle/complete)

Print name and sign M

Addressograph, or

610041369B M 12/10/1960
Sanderson, George
Flat 4,
15 Quayside Street,
Edinburgh,
Midlothian, EH6 6EJ
CHI 1210601451
70179 JS Chowings

NHS Lothian

Codes (Y) Yes, (N) No, (N/A) not applicable,(D) Declined (AS) Asleep (I) Independent, (NW) not on ward, (TH) Theatre,

Time of Care Rounding Document the exact time care rounding took place e.g. 0830	04:00	12:00	16:10	20:00	00:30	06:00							
	08.00 am ← 24 hour period → 07.00 am												
Pressure Area Care — **Waterlow score less than 10 low risk requires only a daily skin review:** Use codes for outcome of skin review													
Waterlow 10+ - Visual Skin Check (tick)	✓	✓	NS	✓	✓	✓	✓						
Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister	H	H	✓	N/S	N/S	✓	NS						
Vulnerable areas? (circle areas of damage)	Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other.....												
If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan													
Have you changed position since last CR?	Y	Y	Y	Y	Y	Y	Y						
Positioning (R) or (L) side (B) Back (C) Chair	L	L	B	B	B	R	B						
Mattress type / Cushion type	*please state type:*												
Elimination — Do you need the toilet?	Y	Y	Y	Y	Y	I	I						
Is the patient continent of urine? (at time of Care Rounding)	Y	Y	Y	Y	Y	|	Y						
Continence product changed/offered?	Y	Y	N/A	✓	✓	|	✓						
Catheter care performed?	N	N	N/A	✓	✓	|	✓						
Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact													
Is patient continent of faeces? (at time of Care Rounding)	N	N	NOT Y	N	N	|	Y						
Bowel function monitored	Observe bowel function and update daily												
Food, Fluid & Nutrition — Would you like a drink? Ensure fluids are within easy reach	WR	WR	WR	N	N	WR	N						
Fluid Balance Chart (if clinically indicated)	Y	Y	Y	Y	Y	Y	Y						
When did you last eat?	B	L	L	D	D	S	S						
(B) Breakfast (L) Lunch (D) Dinner (S)Snack (NBM) Nil by Mouth (A) Assistance Update Food Chart if required													
Oral Hygiene Performed (ref to risk assessment)	Y	Y	I	I	I	I	I						
Falls — Appropriate Footwear?	Y	Y	Y	Y	Y	Y	Y						
Walking aid available(and within reach)	N	N	N/A	N/A	✓	N/A	N/A						
Area de-cluttered?	Y	Y	Y	Y	Y	✓	✓						
Chair and bed height assessed?	Y	Y	Y	Y	Y	✓	✓						
Falls alarm in use and attached?	N	N	N/A	N/A	N/A	N/A	N/A						
Glasses available for use? (if worn) Hearing aid available for use? (if worn)	Y	Y	Y ✓ N	Y N	Y	Y N	Y N						
Requires close observation for commode, toilef, bathing or showering Y ☐ N ☐													
Pain — Are you in pain?	N	N	N	N	N	N	N						
Analgesia Given?	Y	Y	Y	Y	N	N	N						
General — Peripheral Venous Cannula observed?	Y	Y	Y	Y	N/A	Y	Y						
Observe for signs of inflammation/swelling at every CR session. **Bundle/VIP score to be updated daily**													
Are you comfortable? Y/N	Y	Y	Y	Y	Y	Y	Y						
Anything else I can do for you?	N	N	N	N	N	N	N						
Buzzer within easy reach	Y	Y	Y	Y	Y	Y	Y						

Personal Care *Type* Independent *(specify)* **Time Given** _____

Initials – document at time of care delivery	M	M	PP	M	RH	AS	EN						

Ward: 43 Site: WGH Date: 28/1/24

This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency.

1hrly 2 hrly (3 hrly) ____hrly (please circle/complete)

Print name and sign Cathy S.

Addressograph, or

610041369B M 12/10/1960
Sanderson, George
Flat 4,
15 Quayside Street
Edinburgh
Midlothian, EH6 6EJ
CHI 1210601451
70179 JS Chowings

NHS Lothian

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Pressure Area Care	**Waterlow score less than 10 low risk requires only a daily skin review:** Use codes for outcome of skin review												
	Waterlow 10+ - Visual Skin Check (tick)	✓	NS	✓	✓				N				
	Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister		✓	H	H	H	H	H	NS	H			
	Vulnerable areas? (circle areas of damage)	Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other.....											
	If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan												
	Have you changed position since last CR?	Y	Y	Y	Y	Y	Y	Y	Y	Y			
	Positioning (R) or (L) side (B) Back (C) Chair	C	B	B	B	B	B	L	B	B			
	Mattress type / Cushion type	*please state type:*											
Elimination	Do you need the toilet?	I	I	I	I	I	I	I	AS	I			
	Is the patient continent of urine? (at time of Care Rounding)	Y	Y	Y	Y	Y	Y	Y	NS	I			
	Continence product changed/offered?	N	NIR	N	N	NC	NC	NC	NS	NC			
	Catheter care performed?	NA	NIR	N	N				NA	NC			
	Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact												
	Is patient continent of faeces? (at time of Care Rounding)	Y	Y	Y	Y	Y	Y	Y	NS	Y			
	Bowel function monitored	Observe bowel function and update daily											
Food, Fluid & Nutrition	Would you like a drink? Ensure fluids are within easy reach	W	Y	W	W	W	W	W	AS	W			
	Fluid Balance Chart (if clinically indicated)	N	N	N	N	N	N	N	NA	N			
	When did you last eat?	B	B	L	S	S	S	S	S	B			
	(B) Breakfast (L) Lunch (D) Dinner (S)Snack (NBM) Nil by Mouth (A) Assistance Update Food Chart if required												
	Oral Hygiene Performed (ref to risk assessment)	I	I	I	I	N	N	N	AS	Y			
Falls	Appropriate Footwear?	Y	Y	Y	Y	Y	Y	Y	Y	N.			
	Walking aid available(and within reach)	Y	Y	Y	Y	Y	Y	Y					
	Area de-cluttered?	Y	Y	Y	Y	Y	Y	Y	N	Y			
	Chair and bed height assessed?	Y	Y	Y	Y	Y	Y	Y	N	Y			
	Falls alarm in use and attached?	N	NIR	N	N				NA	N.			
	Glasses available for use? (if worn) Hearing aid available for use? (if worn)	N	Y	Y	N	N	N	N	N	N			
	Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐												
Pain	Are you in pain?	N	N	N	N	N	N	N	AS	N			
	Analgesia Given?	N	N	N	N	N	N	N	AS	N			
General	Peripheral Venous Cannula observed?	Y	Y	Y	Y	Y	Y	Y	Y	Y			
	Observe for signs of inflammation/swelling at every CR session. Bundle/VIP score to be updated daily												
	Are you comfortable? Y/N	Y	Y	Y	Y	Y	Y	Y	AS				
	Anything else I can do for you?	N	N	N	N	N	N	N	AS	N			
	Buzzer within easy reach	Y	Y	Y	Y	Y	Y	Y	Y	1			
Personal Care *Type* _____ *(specify)* **Time Given** _____													
Initials – document at time of care delivery	Y		SM	SM	P	D	K		V				

Ward: 43 Site: WGH Date: 3d/12/24

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1hrly 2 hrly (3 hrly) ___hrly (please circle/complete)

Print name and sign QF

Addressograph. or

610041369B M 12/10/1960

Name Sanderson, George

16/17 pirrie street, Edinburgh, EH6 5HY

DOB Ge

CHI 1210601451

Unit no. / CHI 70179 JS Chowings

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	08.00 am ← 24 hour period → 07.00 am												
Pressure Area Care	**Waterlow score less than 10 low risk requires only a daily skin review:** Use codes for outcome of skin review												
	Waterlow 10+ - Visual Skin Check (tick)	✓	NS	NS	N								
	Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister	NS		NS									
	Vulnerable areas? (circle areas of damage)	Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other.....											
	If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan												
	Have you changed position since last CR?	Y	Y	Y	Y								
	Positioning (R) or (L) side (B) Back (C) Chair	B	B	B	VP								
	Mattress type / Cushion type	*please state type:*											
Elimination	Do you need the toilet?	I	I	I	I								
	Is the patient continent of urine? (at time of Care Rounding)	Y	Y	Y	Y								
	Continence product changed/offered?	Y	O	Y	/								
	Cathefer care performed?	NA	—	NA	/								
	Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact												
	Is patient continent of faeces? (at time of Care Rounding)	Y	Y	Y	Y								
	Bowel function monitored	Observe bowel function and update daily											
Food, Fluid & Nutrition	Would you like a drink? Ensure fluids are within easy reach	W	wtd	wtd	wtd								
	Fluid Balance Chart (if clinically indicated)	NA	—	—	—								
	When did you last eat?	B	S	L	D								
	(B) Breakfast (L) Lunch (D) Dinner (S)Snack (NBM) Nil by Mouth (A) Assistance Update Food Chart if required												
	Oral Hygiene Performed (ref to risk assessment)	I	I	I	I								
Falls	Appropriate Footwear?	Y	Y	Y	Y								
	Walking aid available(and within reach)	NA	—	—	—								
	Area de-cluttered?	Y	Y	Y	Y								
	Chair and bed height assessed?	Y	Y	—	—								
	Falls alarm in use and attached?	NA	—	—	—								
	Glasses available for use? (if worn) Hearing aid available for use? (if worn)	N	—	Y	Y								
	Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐												
Pain	Are you in pain?	N	N	N	N								
	Analgesia Given?	N	N	N	N								
General	Peripheral Venous Cannula observed?	N	N	N	N								
	Observe for signs of inflammation/swelling at every CR session. **Bundle/VIP score to be updated daily**												
	Are you comfortable? Y/N	Y	Y	Y	Y								
	Anything else I can do for you?	N	N	N	N								
	Buzzer within easy reach	Y	Y	Y	Y								
Personal Care *Type* ___ *(specify)*	**Time Given** ___												
Initials – document at time of care delivery	[illegible]												

NHS Lothian

Transfer of Patient's Property Record

Ward 20 ICU

610041369B M
SANDERSON George
Na 12-Oct-60 CHI: 121 060 1451
70179 JS Chowings
DC Flat 4 Midlothian
EH6 6EJ
Hc

Transfer date: __/__/__

	Item of Property	On Transfer from	On Transfer to
☐	Coat		
☐	Dentures		
☐	Dressing Gown	✓	
☐	Gloves		
☐	Handbag		
☐	Hearing Aid		
☐	Holdall/Case		
☐	Jumper/Cardigan		
☐	Nightdress		
☐	Prosthesis (please specify)		
☐	Pyjamas		
☐	Razor/Electric razor		
☐	Scarf		
☐	Spectacles		
☐	Spongebag		
☐	Shirt/Blouse	T shirt 1X	
☐	Shoes/Boots		
☐	Skirt/Dress		
☐	Slippers/Socks	✓ ✓	
☐	Trousers		
☐	Underpants/Knickers	✓	
☐	Vest/Bra		
☐	Walking Aid		
☐	Wallet/Purse		
	Toilet Bag	1X	
	Towel	✓	
	mobile phone	1X	
	Glasses	1X	

Valuables on admission? YES ☐ NO ☐ Destination: ☐ Home ☐ Hospital Safe

Staff Signature 1 Print name/designation		
Staff Signature 2 Print name/designation		

610041369B M
SANDERSON George
12-Oct-60 CHI: 121-060-1451
70179 JS Chowings
Flat 4 Midlothian
EH6 6EJ

63Y

NHS Lothian

Directorate of Critical Care

Date: 19/1/23

Date of admission: 19/1/23

Day number: 1

Routine Shift Checks	Day Initial	Night Initial	Comment if N/A or not achieved
EQUIPMENT CHECKS			
O^2 Cylinder Check			
Tracheostomy box check (If applicable)		N/A	
C-Circuit			SEALED
Laerdal AMBU bag			SEALED
Suction			SEALED
MONITORING CHECKS			
Invasive lines - Check and zero			
NIBP			MAP 65
Alarm limits - Checked/Set			
Glucometer QC			ID UNIT
PATIENT ASSESSMENT			
Infusions/fluids match prescriptions			
Infusions and Lines in date			
Air entry assessed			
Name band in situ with CHI			
ETT Cuff pressure check		N/A	
Skin bundle check		MDK	
Allergy band check		*	PENICILLIN
PROPHYLAXIS			
FLOWTRONS			
DVT/PE			
Gastric Ulcer			
Eye care (prescribed)		N/A	HYDRONDAULT

Routine Changes		Frequency of routine change
NG Tube tapes:	Change On:	DAILY
Pressure bag fluid	Change On: 22/1/23	EVERY 4 DAYS
Dry Circuit	Change On:	EVERY 7 DAYS
Flexiseal (If in situ)	Change On:	EVERY 29 DAYS
Urinary Drainage Bag	Change On: 26/1/23	EVERY 7 DAYS
HMEF	Change On:	DAILY
Closed Suction	Change On:	DAILY
Wet Circuit	Change On:	EVERY 14 DAYS
Bacterial Filter	Change On:	DAILY
Anchorfast	Change On:	EVERY 7 DAYS
Stoma bag	Change On:	DAILY

Admission Weight (kg)	
Predicted Weight (kg)	
Admission BMI	
Latest Weight (kg)	
Bowels last opened (Date)	__/__/__
If >72hrs aperients considered	Y ☐ N ☐

SEDATION AND WEANING	
Sedation Hold (please tick)	
Yes	☐
No	☐
Not appropriate	☐
Ready to wean	
Yes	☐
No	☐
Not appropriate	☐

Infection Status	
MRSA	
C. Difficile	
VRE	
ESBL (e.g. E Coli or Klebsiella)	
CRE/CPE	
Other:	
Patient neutropaenic?	Y ☐ N ☐
Isolation Required?	Y ☐ N ☐

BRISTOL STOOL CHART	
Type 1	Separate hard lumps, like nuts. Hard to pass
Type 2	Sausage shaped but lumpy
Type 3	Like a sausage but with cracks on its surface
Type 4	Like a sausage or snake, smooth and soft
Type 5	Soft blobs with clear cut edges (passed early)
Type 6	Fluffy pieces with ragged edges, a mushy stool
Type 7	Watery, no solid pieces. Entirely liquid

NOTES

5/7 Hx DVT, bowel infarct
Enteric → AKI
Septic shock
PMH: HTN, COPD (smoker), BPH
Allergic: Penicillin

Secretions		Physiotherapy	Chest Drains	Circulation		Pressure Care	Pain Scoring	Motor Block
M Mucoid	**0** Nil	✓ Cough & expectorate	**SW** Swinging	**P** Pink	**W** Warm	**R** Right side	**0** No pain	**0** Full power in legs
MP Mucopurulent	**1** Minimal	✕ Cough & No expectorate	**ST** Static **BUB** Bubbling	**WH** White	**C** Cool	**L** Left side	**1** Mild (Doesn't distress me)	**1** Weak but can move legs
P Purulent	**2** Moderate	Ø No cough	**B** Bloodstained	**M** Mottled	**CO** Cold	**B** Back	**2** Moderate (Distresses me a bit)	**2** Able to move knees
B Bloodstained	**3** Large	**BG** Bagging	**HS** Haemoserous	✓ Pulse present	✕ Pulse absent	**Ch** In Chair	**3** Severe (Distresses a lot)	**3** Minimal movement
		BD Bird	**S** Serous			**Pr** Proned	**S** Sleeping	**4** Paralysed

• Pupil Size								Eye Opening (E)	Best Verbal (V)	Best Motor (M)
1	2	3	4	5	6	7	8			
•	•	•	•	•	•	•	•	**4** Spontaneous **3** To speech **2** To pain **1** None **1** Eyes swollen	**5** Orientated **4** Confused **3** Inappropriate words **2** Incomprehensible **1** None/ETT/Trach	**6** Obeys commands **5** Localises pain **4** Normal flexion **3** Abnormal flexion **2** Extension **1** None

National Early Warning Score 2 (NEWS2) Chart

NHS Lothian

Address

Nar 610041369B /E5582169 M
SANDERSON George
DOE 12-Oct-60 CHI: 121 060 1451
70179 JS Chowings
Flat 4 Midlothian
CHI: EH6 6EJ

Date chart commenced:

This is chart number of this admission

Conscious Level Chart to be completed when clinically indicated

	Date		
	Time		
GLASGOW COMA SCALE – Eyes Open	Spontaneously	4	Eyes closed by swelling = C
	To speech	3	
	To pain	2	
	None	1	
GLASGOW COMA SCALE – Best Verbal Response	Orientated	5	Endotracheal tube or tracheostomy = T
	Confused	4	
	Inappropriate words	3	
	Incomprehensible sounds	2	
	None	1	
GLASGOW COMA SCALE – Best Motor Response	Obey commands	6	Always record the best arm response
	Localise to pain	5	
	Flexion to pain	4	
	Abnormal flexion	3	
	Extension to pain	2	
	None	1	
	Total GCS Score		
Right Pupil	Size		+ reacts; - no reaction c. eye closed
	Reaction		
Left Pupil	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		
	Extension		
	No response		
LIMB MOVEMENT – LEGS	Normal power		
	Mild weakness		
	Severe weakness		
	Extension		
	No response		
	Initials		

Pupil Scale mm 1 2 3 4 5 6 7 8

REMEMBER
- **Record all observations** on NEWS2 chart
- **Document concerns/decisions in clinical notes**
- **Escalate** your frequency of observations
- If at any point during your assessment you are concerned about your patient - **CALL FOR HELP**

	Assess	Possible Actions
AIRWAY	Is the airway - • patent • at risk • obstructed	• suction if indicated • head tilt, chin lift / jaw thrust • airway adjuncts • administer oxygen • call 2222 if at risk
BREATHING	• respiratory rate • SpO_2 • accessory muscle use • noises +/- percussion, palpation & auscultation • position / posture	• administer prescribed oxygen to maintain saturations 94-98% (NB COPD 88-92%) • monitor SpO_2 / ABGs • consider chest x-ray • treat underlying cause • call 2222 if not breathing
CIRCULATION	• pulse • blood pressure • capillary refill time • core temperature / colour • urine output • consider 4 body cavities for fluid & blood loss (4 + on the floor) • monitor drain losses	• obtain IV access • obtain blood samples • prepare fluid challenge • initiate fluid balance chart • call 2222 if no circulation • consider initiating major haemorrhage protocol • monitor response to actions
DISABILITY A = Alert V = Voice / Verbal P = Pain U = Unresponsive	• AVPU for initial assessment • GCS, on-going neuro assessment • ABC's & treat hypoxia or hypovolaemia • blood glucose • drugs	• re-assess GCS • check blood glucose if less than 4mmols/litre activate hypoglycaemia protocol • check drug chart • remember accurate documentation
EXPOSURE	• top to toe examination • look for evidence of blood loss / rashes / drains / wounds etc	• control bleeding • treat any underlying conditions identified • reassess • maintain patient's dignity • evaluate actions

Pain and Symptom Assessment and Management

Supportive care - pain: Always score worst pain in the last 24 hours or since last assessment. If the patient has deteriorating health with limited reversibility, refer to **Scottish Palliative Care Guidelines**

Acute Pain: Score current pain on movement, e.g. deep breathing. Refer to **Acute Pain Guidelines**

Persistent pain - 6 or above which distresses the patient and is unresponsive to guidelines

↓

Call Medical Staff / Senior Nurse / Nurse Practitioner

↓

For further advice contact:

ACUTE	SPECIALIST PALLIATIVE CARE
Mon-Fri: bleep Acute Pain Team Out of Hours: on-call Anaesthetist	Mon-Fri: bleep Palliative Care Team Out of Hours: via Switchboard

Pain Score	Nausea Score	Epidural Motor Block Score please do not (✓) motor block column
0 - None Continue to assess pain at least daily	**0 - No Nausea**	**0 - Full Power**
1 - 3 Mild Continue to assess pain with routine observations, must be at least daily	**1 - Nausea** Consider anti-emetic	**1 - Weak but able to raise legs**
4 - 5 Moderate Assess, administer and review analgesia as appropriate for patient	**2 - Nausea / Vomiting** Administer anti-emetic	**2 - Able to bend knees**
6 - 10 Severe Assess, administer and review analgesia as appropriate for patient	**3 - Persistent Nausea &/or Vomiting** Contact Doctor	**3 - Minimal movement** **4 - Paralysis**
Using appropriate Lothian Guidelines	**Using guidelines prescribe / give anti-emetics and review**	If score 2 or above please immediately contact the Acute Pain Team or on-call Anaesthetist if out of hours

Ref: MPS NHS Lothian 2018 Printed January 2019 V1.1 Review December 2021 LOT 1651

National Early Warning Score 2 (NEWS2) Chart

NHS Lothian

Address

Nar 610041369B /E5582169 M
SANDERSON George
DOE 12-Oct-60 CHI: 121 060 1451
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Date chart commenced:

This is chart number of this admission

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	Time		
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	To pain	2	
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	Confused	4	
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	Mild weakness		
	Severe weakness		
	Extension		
	No response		
LIMB MOVEMENT – LEGS	Normal power		
	Mild weakness		
	Severe weakness		
	Extension		
	No response		
	Initials		

Pupil Scale mm 1 2 3 4 5 6 7 8

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	Assess	Possible Actions
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DISABILITY A = Alert V = Voice / Verbal P = Pain U = Unresponsive	• AVPU for initial assessment • GCS, on-going neuro assessment • ABC's & treat hypoxia or hypovolaemia • blood glucose • drugs	• re-assess GCS • check blood glucose if less than 4mmols/litre activate hypoglycaemia protocol • check drug chart • remember accurate documentation
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1 - 3 Mild Continue to assess pain with routine observations, must be at least daily	**1 - Nausea** Consider anti-emetic	**1 - Weak but able to raise legs**
4 - 5 Moderate Assess, administer and review analgesia as appropriate for patient	**2 - Nausea / Vomiting** Administer anti-emetic	**2 - Able to bend knees**
6 - 10 Severe Assess, administer and review analgesia as appropriate for patient	**3 - Persistent Nausea &/or Vomiting** Contact Doctor	**3 - Minimal movement** **4 - Paralysis**
Using appropriate Lothian Guidelines	**Using guidelines prescribe / give anti-emetics and review**	If score 2 or above please immediately contact the Acute Pain Team or on-call Anaesthetist if out of hours

Ref: MPS NHS Lothian 2018 Printed January 2019 V1.1 Review December 2021 LOT 1651

Addressograph

610041369B M 12/10/1960
Sanderson, George
16/17 pirrie street,
Edinburgh,
EH6 5HY

CHI 1210601451
70179 JS Chowings

NEWS of 5 or more?

Think Sepsis!

In a patient with a **NEWS** of **5 or more** and a known infection, signs and symptoms of infection, or at risk of infection, think **'Could this be sepsis?'** and **escalate care immediately.**

Special Instructions:
Only to be completed under the direction of a senior member of the medical team

A total NEWS of ____ or individual parameter of ____
is acceptable for this patient because ____

Please escalate if ____

Print ____ Sign ____ Designation ____
Date ____ Time ____ *(only valid if signed and dated)*

***Regardless of NEWS always Escalate if concerned about a patient's condition. Escalate immediately if clinical observations cannot be obtained**

NEWS TOTAL	Monitoring Frequency	Clinical Response Document concerns/decisions in patients clinical notes
0	Minimum 12 hourly/ 4 hourly in admission areas	• continue routine NEWS monitoring
Total 1 - 4	Minimum 4-6 hourly	• inform registered nurse • registered nurse assessment • review frequency of observations • if ongoing concern, escalate to medical team • consider fluid balance chart
3 in single parameter	Minimum 1 hourly	• registered nurse assessment • medical assessment • management plan to be discussed with senior trainee or above • consider fluid balance chart
Total 5 - 6 Urgent response threshold	Minimum 1 hourly	• registered nurse assessment • urgent medical assessment • management plan to be discussed with senior trainee or above • consider senior trainee review if NEWS does not improve following initial medical assessment • consider level of monitoring required • consider anticipatory care planning (ACP) • start fluid balance chart
Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	• registered nurse to assess immediately • immediate assessment by senior trainee or above • discuss with supervising consultant • if appropriate contact Critical Care for review • consider anticipatory care planning (ACP) • start fluid balance chart

Codes for recording oxygen delivery on the NEWS2 observations chart

A	breathing air	RM	reservoir mask
N	nasal cannula (document in litres)	TM	tracheostomy mask
SM	simple mask	CP	CPAP mask
V	venturi mask and percentage (e.g device = V, % = 40)	H	humidified oxygen and percentage (e.g device = H, L/min or % = 40)
NIV	patient on NIV system	OTH	Other specify

Date / Time																							
Circulation																							
Sensation																							
Movement																							

NEWS Key 0 1 2 3

		Date:	15																				Date
		Time:	18	2015	22	2400	0300	0401	0720	0940	1350	1850											
A+B Respirations Breaths/min		≥25				33	29	25	27	32	36												≥25
		21-24			24																		21-24
		18-20	20	18																			18-20
		15-17																					15-17
		12-14																					12-14
		9-11																					9-11
		≤8																					≤8
A+B SpO2 Scale 1 Oxygen saturation (%) Use Scale 1 if target range is 94-98%		≥96		96	96	96	96	96	96	96	96												≥96
		94-95	Nil																				94-95
		92-93																					92-93
		≤91																					≤91
SpO2 Scale 2* Oxygen saturation (%) Use Scale 2 if target range is 88-92% eg. in hypercapnic respiratory failure. * ONLY use Scale 2 under the direction of a qualified clinician. Tick box if using SpO2 Scale 2 ☐		≥97 on O2																					≥97 on O2
		95-96 on O2																					95-96 on O2
		93-94 on O2																					93-94 on O2
		≥93 on air																					≥93 on air
		88-92																					88-92
		86-87																					86-87
		84-85																					84-85
		≤83																					≤83
Air or Oxygen? Oxygen is a drug and prescribed by target range		A = Air	A	A	A	A	A	A	A	A	A												A = Air
		O2 L/min or %																					O2 L/min or %
		Device																					Device
C Blood Pressure mmHg Score uses Systolic BP only If manual BP mark as M		≥220																					≥220
		201-219																					201-219
		181-200																					181-200
		161-180																					161-180
		141-160																					141-160
		121-140																					121-140
		111-120																					111-120
		101-110																					101-110
		91-100		95																			91-100
		81-90	86		83	85	84	86															81-90
		71-80	n						80														71-80
		61-70		68						66	67												61-70
		51-60			55	58	52		55	42	69												51-60
		≤50	V		50																		≤50
C Pulse Beats/min Manual pulse		≥131																					≥131
		121-130																					121-130
		111-120																					111-120
		101-110				104	105		110	106	109												101-110
		91-100	96	93	93			100															91-100
		81-90																					81-90
		71-80																					71-80
		61-70																					61-70
		51-60																					51-60
		41-50																					41-50
		31-40																					31-40
		≤30																					≤30
D Consciousness Score for new onset of confusion (no score if chronic)		Alert	A	A	A	A	A	A	A	A	A												Alert
		New Confusion																					New Confusion
		V																					V
		P																					P
		U																					U
E Temperature °c		≥39.1°																					≥39.1°
		38.1-39.0°																					38.1-39.0°
		37.1-38.0°																					37.1-38.0°
		36.1-37.0°			36	36	36	36	36	36	36												36.1-37.0°
		35.1-36.0°	35.7	35.8																			35.1-36.0°
		≤35.0°																					≤35.0°
NEWS TOTAL			6	4		7	7	7	7	7	7												**Total**
Monitoring frequency			1'	1'		1'	1'	1'	1'	30	30												Monitoring
Escalation of care Y/N			Y	Y		Y	Y	Y	Y	Y	Y												Escalation
Initials			ST	AG		AG	AG	AG	AG	AG	LB												Initials
Urine output recorded Y/N																							Urine output
Blood Glucose level or N/A																							Blood Glucose
Pain score (0-10)																							Pain
Nausea score (0-3)																							Nausea
Motor Block score (0-4) or N/A																							Motor Block

Reproduced from Royal College of Physicians. National Early Warning Score (NEWS) 2: Standardising the assessment of acute illness severity in the NHS. Updated report of a working party. London: RCP, 2017

LOT228 June 2015

Hospital Number	610041369B M
Name	SANDERSON Geo...
D.O.B.	12-Oct-60 CHI: 121 060 1451
Admission Date:	70179 JS Chowings Flat 4 Midlothian EH6 6EJ

NHS Lothian

Directorate of Critical Care

Invasive Devices Record

*Day 1 = Day of insertion *Score through box and date when line removed

Intubation - Endotracheal

Date **Time** **Operator**

Grade of View (circle appropriate): I II III IV

Tube Size: **Tube Type:**

Distance @ Lip: **Distance @ Teeth:**

Procedure Checklist: **Difficulties/Adjuncts/Complications:**

- Preoxygenation ❒
- Cricoid ❒
- Capnography ❒
- Auscultation ❒
- CXR ❒

Operator's Signature:

Days in situ	1	2	3	4	5	6	7	8	9	10	11	12
Cuff Pressure												
Distance@lip												
Dressing/tapes												

Tracheostomy

Date **Time** **Operator**

Tube Size:

Tube Type:

Procedure Checklist: **Difficulties/Adjuncts/Complications:**

- Preoxygenation ❒
- Capnography ❒
- Auscultation ❒
- CXR ❒

Securing method used:

Bed head sign completed and safety box by bedspace ❒

Operator's Signature:

Days in situ	1	2	3	4	5	6	7	8	9	10	11	12
Cuff Pressure												
Tapes/Device												
Dressing												

Invasive Line

Line Type (circle): CVC Arterial CVVH PA cath

Date: 19/1 **Time:** 0700 **Operator:** DMcAvoy

Site: RIJV

USS: Anatomy check Visualised insertion Not used

Procedure Checklist: **Difficulties/Adjuncts/Complications:**

- Antiseptic hand scrub ☑
- Gown/gloves/hat/mask ☑
- CHG skin prep ☑
- Aseptic insertion ☑
- Stitched to secure ☑
- Line transduced ☑
- Line saved for TPN ❒

Removed 22/01/23 DMcAvoy

Operator's Signature:

Post insertion CXR YES ☑ N/A ❒ reviewed by:

Days in situ	1 (19/1)	2 (20/1)	3 (21/1)	4	5	6	7	8	9	10	11	12
Site Clean Y/N	Y	Y	Y									
Drsng/Flush Y/N	Y	Y	Y									
Still required Y/N	Y	Y	Y									

Invasive Line

Line Type (circle): CVC Arterial CVVH PA cath

Date: ~~19/1~~ **Time:** 0630 **Operator:** DMcAvoy

Site: R radial

USS: Anatomy check Visualised insertion Not used

Procedure Checklist: **Difficulties/Adjuncts/Complications:**

- Antiseptic hand scrub ☑
- Gown/gloves/hat/mask ☑
- CHG skin prep ☑
- Aseptic insertion ☑
- Stitched to secure ☑
- Line transduced ☑
- Line saved for TPN ❒

Operator's Signature:

Post insertion CXR YES ❒ N/A ☑ reviewed by:

Days in situ	1 (19/1)	2 (20/1)	3 (21/1)	4	5	6	7	8	9	10	11	12
Site Clean Y/N	Y	Y	Y									
Drsng/Flush Y/N	Y	Y	Y									
Still required Y/N	Y	Y	Y									

Invasive Line

Line Type (circle): CVC Arterial CVVH PA cath

Date: 19/1 **Time:** 0700 **Operator:** DMcAvoy

Site: RIJV

USS: Anatomy check Visualised insertion Not used

Procedure Checklist: **Difficulties/Adjuncts/Complications:**

- Antiseptic hand scrub ☑
- Gown/gloves/hat/mask ☑
- CHG skin prep ☑
- Aseptic insertion ☑
- Stitched to secure ☑
- Line transduced ☑
- Line saved for TPN ❒

Removed 22/01/23 DMcAvoy

Operator's Signature:

Post insertion CXR YES ☑ N/A ❒ reviewed by:

Days in situ	1 (19/1)	2 (20/1)	3 (21/1)	4	5	6	7	8	9	10	11	12
Site Clean Y/N	Y	Y	Y									
Drsng/Flush Y/N	Y	Y	Y									
Still required Y/N	Y	Y	Y									

Invasive Line

Line Type (circle): CVC Arterial CVVH PA cath

Date: **Time:** **Operator:**

Site:

USS: Anatomy check Visualised insertion Not used

Procedure Checklist: **Difficulties/Adjuncts/Complications:**

- Antiseptic hand scrub ❒
- Gown/gloves/hat/mask ❒
- CHG skin prep ❒
- Aseptic insertion ❒
- Stitched to secure ❒
- Line transduced ❒
- Line saved for TPN ❒

Operator's Signature:

Post insertion CXR YES ❒ N/A ❒ reviewed by:

Days in situ	1	2	3	4	5	6	7	8	9	10	11	12
Site Clean Y/N												
Drsng/Flush Y/N												
Still required Y/N												

Peripheral Venous catheter

Date: ? **Time:** ? **Operator:**

Size (circle): Blue Pink Green Brown Grey

Site: Right Left Hand ACF Forearm Foot

Procedure Checklist: **Difficulties/Complications:**

- Hand hygiene ❒
- CHG skin prep ❒
- Aseptic insertion ❒
- Needle free port ❒
- Dressing dated ❒

Days in situ	1	2	3	4	5	6	7	8	9	10	11	12
Site Clean Y/N												
Still req'd Y/N												

Peripheral Venous catheter

Date: **Time:** **Operator:**

Size (circle): Blue Pink Green Brown Grey

Site: Right Left Hand ACF Forearm Foot

Procedure Checklist: **Difficulties/Complications:**

- Hand hygiene ❒
- CHG skin prep ❒
- Aseptic insertion ❒
- Needle free port ❒
- Dressing dated ❒

Days in situ	1	2	4	5	6	7	8	9	10	11	12
Site Clean Y/N											
Still req'd Y/N											

*Day 1 = Day of insertion

*Score through box and date when line removed

Peripheral Venous catheter

Date: **Time:** **Operator:**

Size (circle): Blue Pink Green Brown Grey

Site: Right Left Hand ACF Forearm Foot

Procedure Checklist:
Hand hygiene ❒
CHG skin prep ❒
Aseptic insertion ❒
Needle free port ❒
Dressing dated ❒

Difficulties/Complications:

Days in situ	1	2	3	4	5	6	7	8	9	10	11	12
Site Clean Y/N												
Still req'd Y/N												

Peripheral Venous catheter

Date: **Time:** **Operator:**

Size (circle): Blue Pink Green Brown Grey

Site: Right Left Hand ACF Forearm Foot

Procedure Checklist:
Hand hygiene ❒
CHG skin prep ❒
Aseptic insertion ❒
Needle free port ❒
Dressing dated ❒

Difficulties/Complications:

Days in situ	1	2	3	4	5	6	7	8	9	10	11	12
Site Clean Y/N												
Still req'd Y/N												

Peripheral Venous catheter

Date: **Time:** **Operator:**

Size (circle): Blue Pink Green Brown Grey

Site: Right Left Hand ACF Forearm Foot

Procedure Checklist:
Hand hygiene ❒
CHG skin prep ❒
Aseptic insertion ❒
Needle free port ❒
Dressing dated ❒

Difficulties/Complications:

Days in situ	1	2	3	4	5	6	7	8	9	10	11	12
Site Clean Y/N												
Still req'd Y/N												

Peripheral Venous catheter

Date: **Time:** **Operator:**

Size (circle): Blue Pink Green Brown Grey

Site: Right Left Hand ACF Forearm Foot

Procedure Checklist:
Hand hygiene ❒
CHG skin prep ❒
Aseptic insertion ❒
Needle free port ❒
Dressing dated ❒

Difficulties/Complications:

Days in situ	1	2	3	4	5	6	7	8	9	10	11	12
Site Clean Y/N												
Still req'd Y/N												

Nasogastric intubation

Date: **Time:** **Operator:**

Size: **Type** (circle): Standard 7day Fine bore 31 days **Nostril: R / L**

Post Procedure Checklist:
Aspirate Yes ❒ No ❒ pH confirms placement? Yes ❒ No ❒
CXR required? Yes ❒ No ❒
External cables/wires removed pre CXR ❒
Length at Nostril: **Aspirate pH:**
Bridle ❒
Senior Doctor confirming tube safe to use:

Length at nostril- record each day/prn * change to fine bore

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

Nasogastric intubation

Date: **Time:** **Operator:**

Size: **Type** (circle): Standard 7day Fine bore 31 days **Nostril: R / L**

Post Procedure Checklist:
Aspirate Yes ❒ No ❒ pH confirms placement? Yes ❒ No ❒
CXR required? Yes ❒ No ❒
External cables/wires removed pre CXR ❒
Length at Nostril: **Aspirate pH:**
Bridle ❒
Senior Doctor confirming tube safe to use:

Length at nostril- record each day/prn * change to fine bore

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

Indwelling Urinary Catheter

Date: 18/1/24 **Time:** **Operator:**

Catheter - Size: 10fg 12fg 14fg
Type: PTFE Silicone Male Female Suprapubic
Volume in balloon: **Catheter expiry date:** 28days 12 weeks

Procedure Checklist:
Hand hygiene ❒
Aseptic insertion ❒
Catheter secured ❒
Lubricant used, expiry date/batch number

Difficulties/complications

Operator Signature:

Days in situ	1	2	3	4	5	6	7	8	9	10	11	12
	18/1	19/1	20/1									
BD cath care Y/N	Y	Y	Y									
Still required Y/N	Y	Y	Y									
Drain bag dated	Y	Y	Y									

Indwelling Urinary Catheter

Date: **Time:** **Operator:**

Catheter - Size: 10fg 12fg 14fg
Type: PTFE Silicone Male Female Suprapubic
Volume in balloon: **Catheter expiry date:** 28days 12 weeks

Procedure Checklist:
Hand hygiene ❒
Aseptic insertion ❒
Catheter secured ❒
Lubricant used, expiry date/batch number

Difficulties/complications

Operator Signature:

Days in situ	1	2	3	4	5	6	7	8	9	10	11	12
BD cath care Y/N												
Still required Y/N												
Drain bag dated												

GENERIC DEVICE RECORD

Use for other invasive devices i.e. ICP bolts, intercostal, wound, rectal & CSF drains.

Device:

Insertion Date: **Time:**

Size: **Type:**

Insertion details:

Monitoring requirements:

Operator Signature:

Device:

Insertion Date: **Time:**

Size: **Type:**

Insertion details:

Monitoring requirements:

Operator Signature:

Day one = Day of insertion

Every device in situ should be recorded - If device inserted elsewhere please note
Record removal by scoring through box and da

Draft Oct13 RIE CCQIT

GE Healthcare

SANDERSON, GEORGE
Male
12.10.1960 (63 Years)

Vent. rate		BPM
PR interval		ms
QRS duration		ms
QT/QTc-Baz	364/442	ms
P-R-T axes	70 82	76

Patient ID: 1210601451
Normal sinus rhythm
Normal ECG

18.01.2024 18:26:21
Western General Hospital

610041369B M 12/10/1960
Sanderson, George
Flat 4,
15 Quayside Street,
Edinburgh,
Midlothian, EH6 6EJ
CHI 1210601451
70179 JS Chowings

Location:
Comments:

Unconfirmed

I aVR V1 V4

II aVL V2 V5

III aVF V3 V6

II

25mm/s 10.0mm/mV 0.56-100 Hz ZPD 50 Hz MAC™ VU360 1.02 SP01 12SL v23.1 4 by 2.5s + 1 rhythm Id Page 1 of 1

SANDERSON, GEORGE ID:1210601451 18-Jan-2024 18:25:08 NHS LOTHIAN-WGHARU ROUTINE RECORD

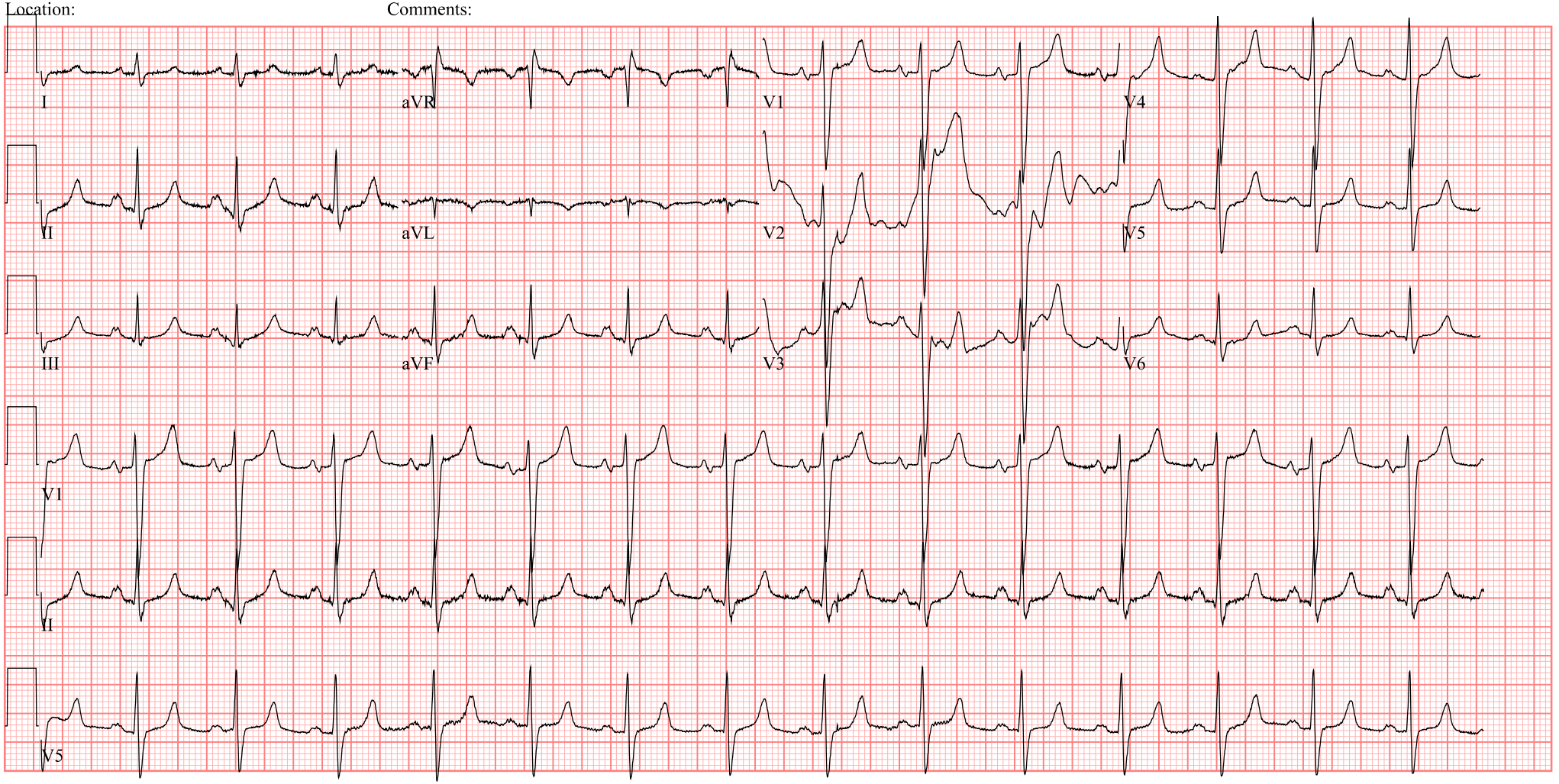
12-Oct-1960 (63 yr)
Male

Room:
Loc:320

Vent. rate	88	BPM
PR interval	152	ms
QRS duration	104	ms
QT/QTcB	364/440	ms
P-R-T axes	73 82	76

Technician:
Test ind:

Location: Comments:



25mm/s 10mm/mV 150Hz 10.1.3 12SL 243 CID: 39226

SID: 1053422 EID: 13 EDT: ORDER:

SANDERSON, GEORGE ID:1210601451 18-Jan-2024 18:26:21 NHS LOTHIAN-WGHARU ROUTINE RECORD

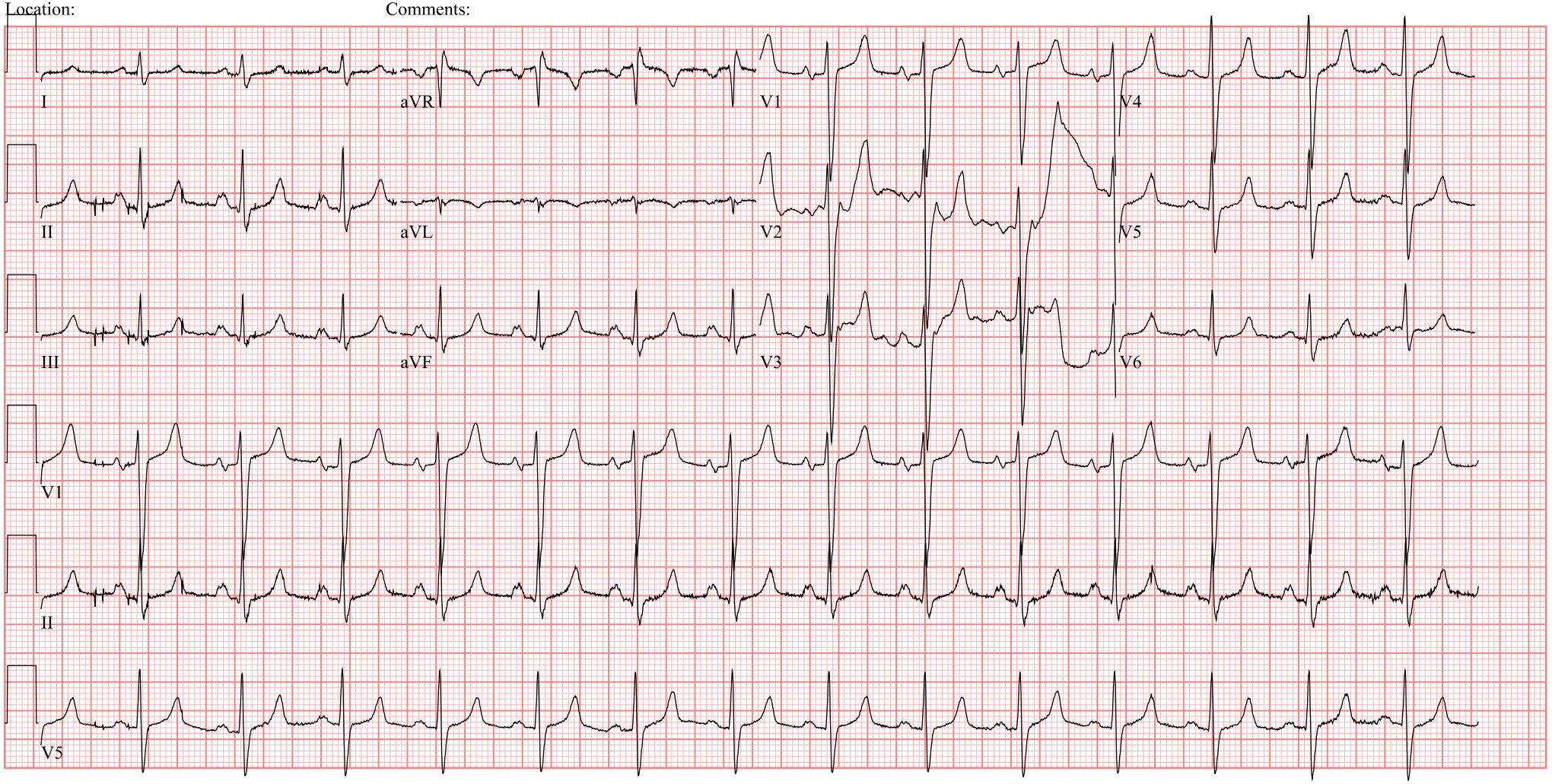
12-Oct-1960 (63 yr)
Male

Room:
Loc:320

Vent. rate	89	BPM
PR interval	156	ms
QRS duration	96	ms
QT/QTcB	364/442	ms
P-R-T axes	70 82	76

Technician:
Test ind:

Location: Comments:



25mm/s 10mm/mV 150Hz 10.1.3 12SL 243 CID: 39226

SID: 1053422 EID: 13 EDT: ORDER:

Progress Notes

Patient & GP Information

UHPI Number	610041369B
CHI Number	1210601451
Episode Number	I0000244921
Surname/Forename	Sanderson, George
Date of Birth	10/12/60
Sex	Male
Patient Address.	16/17 Pirrie Street Edinburgh EH6 5HY
Registered GP	JS Chowings
GP Address.	Leith Surgery,2 Duke Street,Edinburgh, EH6 8HQ

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Patient & GP Information

610041369B	610041369B
1210601451	1210601451
I0001227915	I0005843959
Sanderson, George	Sanderson, George
10/12/60	10/12/60
Male	Male
16/17 Pirrie Street Edinburgh EH6 5HY	16/17 Pirrie Street Edinburgh EH6 5HY
JS Chowings	JS Chowings
Leith Surgery,2 Duke Street,Edinburgh, EH6 8HQ	Leith Surgery,2 Duke Street,Edinburgh, EH6 8HQ

Surname/Forename	Sanderson, George
UHPI Number	610041369B

Episode Number	I0000244921

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Ward Round Episode/Ref: I0005843959 Dr E Louise Hartley 1/19/24 12:06 Dr Mohamed M M Shoaeir	CRITICAL CARE CONSULTANT WARDROUND (CCCW) REVIEWING CONSULTANT: Shoaeir/Morgan Unwell since Sunday with bloody diarreah and vomiting Minimal oral intake Vasovagal episodes Trollys..> - AKI..> Acidosis and high K -prepheral shut down, systolic down to 60 -Non contrast CT showed no ischaemia/perforation - Vanc/gent/metronidazole - Discussed with renal team ICU - CVC/ dialysis line - more fluid resus - lactate improved - produce some concentrated urine - Vasopressors - still cool prephery Bloods - AKI - HB 144 - platelets 282 plan CT abdomen with contrast if lacate raised HAS 5% 500 ml bolus NO need for CRRT for now Stool cultures results updates coagulation profile Recnet renal functions ECHO Pabrinex ketons Dextrose Adjust ABs doses MOBILISATION GOAL: sit to chair SEDATION GOAL: not sedated FLUID BALANCE GOAL: VENTILATION GOAL: SV INVASIVE LINES REVIEWED?: Y RADIOLOGY REVIEWED?: Y AWI/CAPACITY ASSESSED?: Y ANTIBIOTIC INDICATION & REVIEW DATE ON KARDEX?: Y ISSUES TO RAISE ON MICRO. ROUND:

Surname/Forename	Sanderson, George
UHPI Number	610041369B

Episode Number	I0000244921

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0005843959 Dr Iain D Page 1/27/24 13:09 Dr Osuri Wijesooriya	FINAL DISCHARGE LETTER PRINCIPAL DIAGNOSIS/PROCEDURE Diagnosis: 1. Campylobacter enterocolitis 2. Septic/hypovolaemic shock 3. Pre-renal AKI 4. Metabolic acidosis 5. Post sepsis ileus INTERVENTIONS IN CRITICAL CARE: 1. Vasopressors/fluid resuscitation 2. Antibiotics 3. Central electrolyte replacement During admission in critical care at RIE: Mr Sanderson was admitted with a short history of profuse vomiting, bloody diarrhoea and anuria. His renal biochemistry was profoundly deranged and required a medical treatment for hyperkalaemia, CT KUB showed no obstruction. Despite fluid resuscitation he remained hypotensive so was admitted for vasopressor support. He has made steady progress since his admission. Stool cultures have grown Campylobacter and he was started on appropriate antibiotics. His AKI was improving without needing RRT. His clotting profile has become slightly abnormal in the absence of haemolysis/bleeding/liver dysfunction. He was started a course of Vitamin K. An interval CT scan showed enterocolitis with no need for surgical input. He was stepped down to ID at WGH on 22.01/24: AKI continued to improve with IVF. Mr sanderson reported increase abdominal pain with abdominal distension. AXR: Distended loops of small bowel, diameter > 4 cm Erect CXR: No free gas under diaphragm NG tube was inserted as george developed an Ileus likely secondary to ileitis and profound sepsis. This was removed following clinical improvement and bowels started moving. He was started on a 5 day course of oral Clarithromycin which was completed on 28/01/14. At the time of discharge he is feeling well. Thank you for your ongoing care. FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL CHANGES TO DRUGS SINCE ADMISSION Withheld: Lisinopril, Naproxen due to AKI. Advised to restart 1 week after loose stools have settled. ALLERGIES / ADVERSE DRUG REACTIONS: Penicillin SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS: Nil CHANGES TO DNACPR STATUS / DETAILS OF TREATMENT ESCALATION PLAN: Nil Med 3 Certificate has been issued for: ___ days/____weeks GP to please consider the following: Please review UEs in 1 week and restart withheld medication if indicated Should you need further information please contact: Infectious Diseases department WGH Information contained in this letter has been discussed with the patient/carer. Yours sincerely O Wijesooriya FY2 Final Discharge letter Consultant Comment:- I can confirm that the above patient's IDL is an accurate representation of their inpatient stay. Yours sincerely,

Surname/Forename	Sanderson, George
UHPI Number	610041369B

Episode Number	I0000244921

Note Details	Clinical Notes
	Electronically signed by Dr Oliver Koch Consultant Physician Secretary 0131 537 2853 OK/GP

Surname/Forename	Sanderson, George
UHPI Number	610041369B

Episode Number	I0000244921

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Dr Iain D Page 1/27/24 13:45 Dr Osuri Wijesooriya	FY2 Weekend review Issues: 1. Enterocolitis secondary to Campylobacter 2. Sepsis and severe AKI secondary to above requiring ITU support / vasopressors. Did not require RRT. 3. Ileus - Secondary to colitis / Severe sepsis NEWS 1 - HR 108, BP 127/80 Bowel chart - Not upto date Today Seen with wife at bedside Lying in bed Feeling well Not in pain Passed bowels 5 times this morning – Loose stools Eating and drinking well States he feels well enough to go home O/E Abdomen - Distended, R sided and epigastric pain on palpation - Hyperresonant throughout the abdomen - Bowel sounds present HS I+II Chest clear Plan: 1) Continue Clarithromycin 28/01 2) Bloods tomorrow 3) Review tomorroe post bloods ? home Above discussed with Dr McCaughan O Wijesooriya FY2

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005843959 Dr Iain D Page 1/27/24 19:51 Claire Yilmaz	Person-Centred Care Ind with ADLs Bright and chatty with staff Deterioration and Escalation NEWS 1 due to HR 1207 - ongoing Pressure Area Care Skin to face dry - creams prescibed and independent with applying Dressing from previous CVC clean and intact Mobility Independently mobile Bladder and Bowel Function This evening George reported still having some pain when passing urine since TWOK but states passing good amounts. Also reported pain when passing stool but states not constipated - medical team updated and for MSU and they will examine. Medicine Management Medication as per HEPMA, no issues Pain Management No pain reported Infection Prevention and Control PVC insitu dressing clean and intact VIP 0 - for removal Food Fluid and Nutrition Orla intake good, managing very well with fluid intake and ensures as prescribed

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005843959 Dr Iain D Page 1/28/24 03:56 Anne Flynn	Deterioration and Escalation NEWS stable. Remains tachy. Mobility mobilising around cubicle Infection Prevention and Control nursed in isolation with appropriate PPE Food Fluid and Nutrition tolerating diet and fludis

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Dr Iain D Page 1/28/24 15:12 Dr Osuri Wijesooriya	FY2 Weekend review Issues: 1. Enterocolitis secondary to Campylobacter 2. Sepsis and severe AKI secondary to above requiring ITU support / vasopressors. Did not require RRT. 3. Ileus - Secondary to colitis / Severe sepsis NEWS Bowel chart - Today Seen with wife at bedside Lying in bed States he feels well with no pain Opened bowels 4 times - Loose stools Eating and drinking ok Has noticed piles over the last week - Painful Last dose of Clarythromycin today O/E Abdomen - Distended abdomen - Generalsed pain on palpation, worse over the left and epigastric region - Hyperresonant percussion throughout the abdomen - Bowel sounds present - HS I+II - Chest clear Examination of back passage - Grade 4 haemorrhoid present on examination - Erythema and pain on plaption of the surrounding area Plan: 1) Chase bloods 2) Anusol cream 3) Upto date bowel chart O Wijesooriya FY2

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005843959 Dr Iain D Page 1/28/24 16:27 Lucy Bull	Person-Centred Care Patient independent with a shower. George reported that he has been to toilet 4 times see bowel chartm. He appear to have had a settled day care of plan continues.GCS 1/15 news 1 Deterioration and Escalation GCS 15/15 news score 1 Pressure Area Care George is able to reposition himself for comfort Mobility Independent Bladder and Bowel Function Continent of urine has had type 6/7 stool chart maintained Medicine Management Medication given as per hepma Pain Management No concerns with pain expressed regular analgesia given Infection Prevention and Control Remains barrier nursed Food Fluid and Nutrition Poor diet intake on suppliments

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005843959 Dr Iain D Page 1/29/24 01:34 Anne Flynn	Deterioration and Escalation NEWS stable Mobility Indep mobile Bladder and Bowel Function no report of diarrhoea overnight Medicine Management continues on oral abx zopiclone administered as prescribed Infection Prevention and Control nursed in isolation with appropriate PPE Food Fluid and Nutrition tolerating diet and fluids

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Dietician 1/29/24 16:23 Lianne Gordon	Dietitian review on ward 43, patient resting in bed. Anthro: Wt: 54.2Kg (28/1/24) Ht: 1.71 BMI: 18.5 Usual weight 9 stone (57Kg) Weight loss: 5% weight loss. George reports his appetite is improving although dislikes hospital food. Due to be discharged later today. Has been tolerating oral nutritional support and is keen to continue with this on discharge for a month to help regain weight. Biochem: 29/1/24 Creat: 51 Clinical: Reports BO x 9 in past 24 hours type 6-7 Not yet seen by medical team, however likely for discharge later today. Dietetic: George reports his appetite is improving although dislikes hospital food. Due to be discharged later today. Has been tolerating oral nutritional support and is keen to continue with this on discharge for a month to help regain weight. Plan: I have provided with 1 weeks supply ONS for discahrge (Vanilla and strawberry) I will ask Prescribing team to follow up to review progress. I will ask GP to prescribe ONS for 4 weeks post discharge.Lianne Gordon Dietitian WGH Tel 0131 5371298

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Dr Oliver Koch 1/29/24 17:15 Dr Amy Stewart	Ward Round Dr Koch 1. Enterocolitis secondary to Campylobacter 2. Sepsis and severe AKI secondary to above requiring ITU support / vasopressors. Did not require RRT. 3. Ileus - Secondary to colitis / Severe sepsis OE Reports ongoing stool 8 times per day - intermittent loose Abdo still tender in places but otherwise soft Plan 1 - Ooption to include another 24 hours to ensure settling and up mobilising around room and not dizxzy - Explained if rush home may find symptoms too much and end up readmitted - Needs sick line for work on discharge please A stewart ST4

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Dr Oliver Koch 1/29/24 17:43 Dr James Millwater	Millwater FY2 George thought he was to be discharged this evening. Seems to have bene miscommunication from WR. Wife present and both george and wife keen for him to get home this evening. Currently NEWS 1 - mildly tachy (persistent throughout admission) Has opened bowels twice today which is much improved compared to yesterday. Have advised to not take lisinopril until bowels have completely settled due to risk of AKI. Discussed with ST4 stewart - if George is adamant he wants to go this evening then this is ok but he should be aware of risks of re-admission if discharge too early. Not going home with any new medications (other than creams for skin which had been prescribed by GP prior to admission) so no need for pharmacy. Home tonight with strict worsening advice JM FY2

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Note Details	Clinical Notes
Outpatient Clinic Letter Episode/Ref: I0005843959 Dietician 2/1/24 09:17 Lianne Gordon	Dietetic Assessment on 29/1/24 on ward 43 at Western General Hospital Purpose of letter: hospital discharge summary Diet Therapy Proposed Outcome: Recommendation: Oral Nutritional Supplements (ONS) Required *****NUTRITION PRESCRIPTION REQUEST***** Product Name: Ensure Plus Flavour: strawberry and chocolate Volume/weight per serve: 200ml Quantity per day: 400ml Total volume/weight per 28 days: 11,200ml (5600ml of each flavour) Duration (weeks): 4 weeks Indication for ACBS: disease related malnutrition Justification for Non-First Line ONS: Patient preference. Summary of Dietetic Assessment Wt: 54.2Kg (28/1/24) Ht: 1.71 BMI: 18.5 Usual weight 9 stone (57Kg) Weight loss: 5% weight loss. MUST Score: 1 Other: Recovering from Campylobacter Follow Up Arrangements: For review with prescribing team by telephone call. Please do not hesitate to contact the department if any other information is required. Yours sincerely Lianne Gordon Dietitian WGH Telephone number 0131 5371298 C.C.: Prescribing dietitians

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Dr E Louise Hartley 1/19/24 14:24 Dr Alastair J Morgan	CRITICAL CARE MICROBIOLOGY ROUND (CCMR) MICROBIOLOGY CONSULTANT PRESENT: Etherson SENIOR ICU STAFF PRESENT: Morgan GRADE: Cons PROVISIONAL NEW RESULTS: Diarrhoea (blood in stool) and AKI. CHANGE REQUIRED: No - V/M/G appropriate. If deteriorates, need anti-toxin coverage with linezolid/ meropenem. AGREED PLAN (All changes on Micro WR should be agreed by both ICU and Micro consultants): ANTIMICROBIAL DE-ESCALATION PLAN: Linezolid/meropenem ANTIMICROBIAL ESCALATION PLAN:

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005843959 Dr E Louise Hartley 1/19/24 17:05 Stuart Fleming-Cain	Person-Centred Care Alert & orientated at handover. SV on RA. Visited by partner and family members today. Deterioration and Escalation SV on RA; SpO2 >95%. SR-ST, BP supported with noradrenaline titrated to achieve target MAP >65mmHg. Apyrexial. Right radial arteial line @ day 1. RIJ CVC @ day 1. RIJ CVVH line @ day 1. PVC LACF @ day 2. Pressure Area Care Pressure areas intact. Excoriated around anus/between buttocks due to frequency and nature of bowel action. Cavilon Advanced applied. Bladder and Bowel Function IDUC in situ; P&D. George is now producing urine in good volumes. Urgency with opening bowels.Type 7 and frequent. Medicine Management Regular medication charted with ITU prophylaxis additions. Current smoker using nicotine patches 21mcg/24hrs - needs prescribing for changing tomorrow. Pain Management Reporting abdominal cramping. Paracetamol given to good effect. Infection Prevention and Control Continues on vancomycin continuous infusion, gentamicin and metronidazole. Food Fluid and Nutrition Able to eat and drink normal diet; appetite poor. Needs encouragement. Tolerating oral fluids; no nausea. BSL = 8.6mmols/L. Ketones 0.2mmols/L. Altered Stage of Cognition Alert, orientated and appropriate. GCS = 15/15. RASS = 0/-1.

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Dr E Louise Hartley 1/19/24 18:24 Dr Alastair J Morgan	PM CRITICAL CARE CONSULTANT WARDROUND (PMCCCW) PM CONSULTANT REVIEW: Morgan TIME: 18:15 Diarrhoea/vomiting - 5/7 history - blood in stool ?campylobacter Renal failure - Cr >900 Elevated lactate Improvement in BE to -8, lactate now 1. Passing excellent volumes of urine Subjectively feeling much improved Noradrenaline 17mls single strength - remains room for additional volume (mucous membranes remain dry), though passing excellent volumes of urine. Low grade pyrexia/pulse <100. Behaving like a gram-negative sepsis ? translocation. Lisinopril/tamsulosin will not be helping. - no acute indication for CTAP with contrast as reassuring markers such as lactate clearance. - Repeat bloods including renal function and LFs - Hold steroids for now but if on >20mls single strength then probably should be added - further plasmalyte 500mls over 2 hours. MOBILISATION GOAL ACHIEVED?: Yes FLUID BALANCE GOAL ACHIEVED?: Yes

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005843959 Dr E Louise Hartley 1/20/24 02:08 Jonathan Amihan	Person-Centred Care Received patient alert introduced myself and gained consent on all intervention. Able to communicate verbally and get in touch with freinds and family with his mobile phone. George in good spirit and slept well overnight. Deterioration and Escalation Respiratory: Self ventilating on room air achieving sats> 92% known COPD and smoker nicotine patch in use. RR remains elevated but no signs of increased WOB Able to cough and deep breath, Clear air entry on auscultation. ABG showing good gas exchange. Cardiovascular: BP supported by single strength norad aiming for MAP>65 wean as able. HR remains sinus rhythm Apyrexial currently on continous infusion of Vancomycin and TDS metronidazole for ABX A/W gentamicin level with the morning bloods for the dosing as per Dr Na gradually improving on maintenance fluid 0.45% Nacl / 5% glucose Ca replaced overnight , K @ 3.1 drs aware not to act yet as pt got AKI CRT<2 secs peripheries warm and well perfused. VTE on deltaparin and flowtrons Pressure Area Care Pressure areas intact, redness and sore on the sacrum due to loose Cavillon advanced applied. Self positioning in bed Mobility Good power on all limbs, able to reposition himself Bladder and Bowel Function IDC in situ improved urine output Urea @ 29 and creatinin @ 634 egfr 8 Multiple BO type 7 during the day and start of the night settled overnight Bedpan near bed side patient able to use it independently just need assitance in cleaning and removal Medicine Management All medication given as charted Pain Management Complain of abdo pain claimed that Paracetamol did not do anything, given 2.5mg of Oramorph PRN 2x during the night with good effect. Infection Prevention and Control Barrier nursing due to D&V, 2x stool sample sent during the day 1st sample -ve of c-diff taken 18/1/24 Right radial arteial line @ day 1. RIJ CVC @ day 1. RIJ CVVH line @ day 1. PVC LACF @ day 2. All VIP 0 Food Fluid and Nutrition Patient can E&D independently but currently poor intake due to diarrhoea and nausea Managing to drink good amount, currently not for fluid restriction No episode of vomiting or requiring PRN antiemetic Blood glucose within range Altered Stage of Cognition

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Note Details	Clinical Notes
	GCS 15/15 RASS 0 -ve delirioum PEARL 3+ Normal power on all limbs

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0005843959 Dr E Louise Hartley 1/20/24 10:02 Dr Thomas Cox	CRITICAL CARE DAILY REVIEW (CCDR) DAY OF CC STAY: 2 REVIEWER: T.Cox ST2 CONSULTANT: M. Shoeir ADMITTING DIAGNOSIS: Septic shock EVENT LIST: Unwell since Sunday - D+V with no oral intake. Collapse at home so came to WGH for assessment. On arrival hypotensive with significant AKI, hyperkalaemia and raised inflammatory markers. Anuric. Ongoing burden of loose stools. Received fluid resuscitation and medical management of hyperkalaemia Commenced on Vancomycin, Gentamicin + Metronidazole CT KUB - no obstructing renal stone or other significant abdominal pathology identified Given further fluid resuscitation but remained significantly hypotensive and anuric Transferred to ICU --> CVC, VasCath, A-line, Noradrenaline and further resuscitation ACTIVE PROBLEMS: 1. Septic shock - ?Intra-abdominal cause - presumed enterocolitis but not seen on non-contrast CT - Vancomycin, Metronidazole, Gentamicin 2. Ongoing Diarrhoea - C. Diff negative, other cultures awaited - Ongoing losses 3. Significant AKI - Baseline Cr 61 in September 2023 - Hyponatraemic - 1 episode of hyperkalaemia, medically managed, K+ normal since 4. Compensated metabolic acidosis - Improving, BE now -6.8 RESPIRATORY: RR 21 Sats 94% RA Chest clear anteriorly No respiratory distress, able to speak in full sentences CVS: Warm peripherally. CRT= 2 secs. Pulse regular, good volume Mucous membranes No peripheral oedema HR 88 BP 118/56 Norad SS @ 14mls/hr MAP 79 CNS: Alert + orientated Able to move all 4 limbs No gross neurological deficit evident PAIN: Complaining of abdominal pain Paracetamol 1g QDS PRN Oramorph 2.5mg 4 hrly PRN - 2 uses since yesterday evening DELIRIUM: No evidence of delirium RASS = 0 CAM-ICU status +ve/-ve : -ve If +ve Delirium Tool complete Y/N GI / NUTRITION: Abdomen soft, significant widespread generalised abdominal tenderness Denies ongoing nausea or vomiting. Managed small amount of oral intake today, half slice of toast, cup of tea Ongoing T7 foul smelling stool - dark brown BM's stable 7.1 RENAL / FLUIDS: UO 30-50mls/hr, clear yellow urine +ve 3L since admission however probably more negative than this due to bowel losses

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Note Details	Clinical Notes
	Has mixed bag running @50mls/hr MICROBIOLOGY: C. Diff -ve 2 x urine cultures awaited 2 x BC's awaited 1 x stool cultures awaited MAX TEMP IN PAST 24HRS: 37.2 WCC: 40.8 (rising) ANTIBIOTIC REVIEW: Gentamicin - level 1.6 today Metronidazole 500mg TDS Vancomycin 500mg / 24 hours cont infusion INVASIVE DEVICES (Consider changing CVC after 7 days or suspicion of infection): CVC AGE: D2 CVC SITE APPEARANCE: Clean + dry VasCath AGE: D2 VasCath SITE APPEARANCE: Clean + dry A LINE AGE: D2 A LINE SITE APPEARANCE: Clean + dry LINES STILL REQUIRED?: Yes RADIOLOGY REVIEW: Yes MEDICATION REVIEW: Witheld due to poor renal function: Naproxen Lisinopril Simvastatin Tamsulosin THROMBOPROPHYLAXIS: Dalteparin 5000 units ULCER PROPHYLAXIS: Lansoprazole OVERALL IMPRESSION: Clinically improving - Norad reduced - Feel subjectively better - More fluid replete - Significant biochemical improvement in AKI, passing good urine, BEs improving However, significant rise in WCC and ongoing abdominal pain. Think there should be a low threshold for repeat imaging if any deterioration/rising lactate/WCC continues to increase PROVISIONAL PLAN: - Continue to withold above listed medications due to renal failure - Replace Ca2+ further - Wean Norad as able - Chase micro results - Review maintenance fluids ?needs more isotonic Na+ - Encourage oral intake - Low threshold for further imaging - Add on Vanc level

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Nurse 1/19/24 07:59 Will Gray	NURSING NOTES George transferred to ITU from MAU this morning around 06:30hrs. Introduced myself to George and connected him to ITU monitoring. IV fluids given - Plasmalyte (Stat 500mls and then further 125mls/ hr). Catheter insitu, nil volumes at present.

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0005843959 Dr E Louise Hartley 1/20/24 12:04 Dr Mohamed M M Shoaeir	CRITICAL CARE CONSULTANT WARDROUND (CCCW) REVIEWING CONSULTANT: Shoaeir/Duncan Unwell since Sunday with bloody diarreah and vomiting Minimal oral intake Vasovagal episodes Trollys..> - AKI..> Acidosis and high K -prepheral shut down, systolic down to 60 -Non contrast CT showed no ischaemia/perforation - Vanc/gent/metronidazole - Discussed with renal team ICU - CVC/ dialysis line - more fluid resus - lactate improved - produce some concentrated urine - Vasopressors - still cool prephery Bloods - AKI Recent issues - Improving acidosis and renal functions - NA wean down - ongoing bowel losses - Low Na 126 and chloride 91 - Start some oral intake - Abdomen still tender, WBC 40 - cultures negative so far Plan IV fluids NA chloride 125 ml/hr 1L Encourge oral intake CT abdomen with contrast if lacate raised Vanc/Gent levels MOBILISATION GOAL: sit up in bed SEDATION GOAL: off sedation FLUID BALANCE GOAL: positive INVASIVE LINES REVIEWED?: Y RADIOLOGY REVIEWED?: Y AWI/CAPACITY ASSESSED?: Y ANTIBIOTIC INDICATION & REVIEW DATE ON KARDEX?: Y ANY ISSUES TO RAISE WITH MICRO:

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005843959 Dr E Louise Hartley 1/20/24 18:23 Ross MacDonald	Person-Centred Care Introduced myself to George and explained my role. Reoirentated to time and place. All care explained prior to performing. Privacy and dignity maintained at all times. George is orientated and alert and making jokes. In good humour despite pain in stomach. Fully aware of what is happening and how we are progressing Deterioration and Escalation Self ventilating on room air with RR 21-24 and SPO2 96%, Chest sounds clear throughout. BP is 89/45 with MAP 65 on 14ml/hr norad. Weaned throughout the day and currently on 0ml/hr norad and BP 122/55 MAP 80. HR 98. Temp 36.9 Update - MAP lowered to zero. Managed two hours then restarted currently running at 6ml/hr. Pressure Area Care Regularly offering positional changes but George is sorting himself out for comfort. He has a sore sacrum and so is adjusting his position often. Bladder and Bowel Function IDC patent and draining Bowels type 7 frequently. George is able to put himself onto the bed pan. Medicine Management all medications as per kardex. Pain Management 1x PRN oramorph Infection Prevention and Control loose stools so contact precautions in place. Chlroclean outside the room Food Fluid and Nutrition diet and fluid as able update - not eating a lot, food chart started. update - vomit at 1900hrs. ondansetron given. sick bowls nearby. Altered Stage of Cognition RASS 0 GCS 15

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0005843959 Dr E Louise Hartley 1/20/24 21:46 Dr Mohamed M M Shoaeir	PM CRITICAL CARE CONSULTANT WARDROUND (PMCCCW) PM CONSULTANT REVIEW: Shoaeir TIME: 21:40 NA 5ml/hr, perfused NACL 0.9: 125 ml/hr , Na 126 in formal blood BW 4 this evening Start Dextrose 5 % 30 ml/hr overnight Start oral intake MOBILISATION GOAL ACHIEVED?: Y FLUID BALANCE GOAL ACHIEVED?: Y

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005843959 Dr E Louise Hartley 1/21/24 07:53 Lorna Archibald	Person-Centred Care Introduced myself to George, as he likes to be known. Explained care for this shift which George agreed to. George understands what is happening. Care given with privacy, dignity and respect. Nil phone calls, partner had visited earlier in the day. Deterioration and Escalation Self ventilating on room air. Spo2 94 to 96%. Respiratory rate 24 to 27 breaths. Air entry to chest, a bit quieter on upper right side. Occasional coughing, non productive. Satisfactory ABG. Heart rate 90 sinus rhythm. BP supported with single strength noradrenaline 6ml/hr maining a MAP of 65. Temperature 36.6. peripherally warm to touch, hands and feet. Right radial A line, right IJ CVC, pink venflon left arm, all intact and patent. Pressure Area Care Skin and pressure areas intact. Nimbus air mattress, dislikes flowtrons, occassionally on, dalteparin. Quite independent. Assistance of one person required. Adjusts positin as equired. Mobility Unable to assess mobility. George is in bed. Bladder and Bowel Function Passing urine into catheter bag via IDC, patent and draing. Bowels opened x1 so far, type 7. Update Bowels opened six times overnight. Stool specimen sent 21.01.2024. Medicine Management Medicines given as per kardex. Allergic to penicillin., allergy band insitu. Noradrenaline in progress. IV vancomycindose changed as level is 11. Ondansetron given for sickness this morning. Pain Management Oromorph given for abdominal pain with some good effect. Infection Prevention and Control Loose stools, nursed in a side room using contact precautions and chlor cleaning the room. Food Fluid and Nutrition Can eat and drink as able. Taking small amount of oral fluid. IV hydration in progress. Commenced IV 5% Dextrose 30ml/hr. BM 4.7mmol/l Vomited 120mls watery brown fluid. Altered Stage of Cognition GCS 15. RASS 0. Zopiclone 3.75mg given.

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0005843959 Dr E Louise Hartley 1/21/24 09:51 Dr Thomas Cox	CRITICAL CARE DAILY REVIEW (CCDR) DAY OF CC STAY: 3 REVIEWER: T.Cox ST2 CONSULTANT: A. Velagapudi ADMITTING DIAGNOSIS: Septic shock EVENT LIST: Unwell since Sunday - D+V with no oral intake. Collapse at home so came to WGH for assessment. On arrival hypotensive with significant AKI, hyperkalaemia and raised inflammatory markers. Anuric. Ongoing burden of loose stools. Received fluid resuscitation and medical management of hyperkalaemia Commenced on Vancomycin, Gentamicin + Metronidazole CT KUB - no obstructing renal stone or other significant abdominal pathology identified Given further fluid resuscitation but remained significantly hypotensive and anuric Transferred to ICU --> CVC, VasCath, A-line, Noradrenaline and further resuscitation ACTIVE PROBLEMS: 1. Septic shock - ?Intra-abdominal cause - presumed enterocolitis but not seen on non-contrast CT - Vancomycin, Metronidazole, Gentamicin 2. Ongoing Diarrhoea - C. Diff negative, other cultures awaited - Ongoing losses 3. Significant AKI - Baseline Cr 61 in September 2023 - Hyponatraemic - 1 episode of hyperkalaemia, medically managed, K+ normal since 4. Metabolic acidosis RESPIRATORY: RR 23 Sats 92% RA Chest clear anteriorly No respiratory distress, able to speak in full sentences CVS: Warm peripherally. CRT= 2 secs. Pulse regular, good volume Mucous membranes still slightly dry No peripheral oedema HR 93 BP 103/55 Norad SS @ 14mls/hr MAP 69 CNS: Alert + orientated Able to move all 4 limbs No gross neurological deficit evident PAIN: Complaining of abdominal pain Paracetamol 1g QDS PRN Oramorph 2.5mg 4 hrly PRN DELIRIUM: No evidence of delirium RASS = 0 CAM-ICU status +ve/-ve : -ve If +ve Delirium Tool complete Y/N GI / NUTRITION: Abdomen soft, widespread generalised abdominal tenderness ongoing Vomiting again yesterday Ongoing T7 foul smelling stool - dark brown BM's 4.9, background glucose 5% started yesterday due to borderline BM's No oral intake today so far RENAL / FLUIDS: UO 40-80mls/hr, clear yellow urine +ve 6L since admission however probably more negative than this due to bowel losses

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Note Details	Clinical Notes
	MICROBIOLOGY: C. Diff -ve x 2 Urine culture -ve BC's awaited MAX TEMP IN PAST 24HRS: 36.9 WCC: 41.3 ANTIBIOTIC REVIEW: Gentamicin - level 0.7 today - due further dose Metronidazole 500mg TDS Vancomycin 100mg/ 24 hours cont infusion, increased yesterday due to low level, level today .16.4 INVASIVE DEVICES (Consider changing CVC after 7 days or suspicion of infection): CVC AGE: D3 CVC SITE APPEARANCE: Clean + dry VasCath AGE: D3 VasCath SITE APPEARANCE: Clean + dry A LINE AGE: D3 A LINE SITE APPEARANCE: Clean + dry LINES STILL REQUIRED?: Yes RADIOLOGY REVIEW: Yes MEDICATION REVIEW: Witheld due to poor renal function: Naproxen Lisinopril Simvastatin Tamsulosin THROMBOPROPHYLAXIS: Dalteparin 5000 units ULCER PROPHYLAXIS: Lansoprazole OVERALL IMPRESSION Slightly labile Noradrenaline requirement WCC static with ongoing abdominal pain Hyponatraemia improving with normal saline PROVISIONAL PLAN: - Continue to withold above listed medications due to renal failure - Chase remaining bloods - Further Gentamicin dose today - 110mg again today (2mg/kg), do not repeat until level <1 - Vancomycin level in range - Anti-Xa level post Dalteparin tonight - Chase micro results - Continue background NaCl 0.9% - Encourage oral intake, stop dextrose if manages something to eat - ?Do we repeat abdominal imaging with contrast - ?VasCath out today - unlikely to need filter

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0005843959 Dr E Louise Hartley 1/21/24 12:19 Dr Ruth Begbie	CRITICAL CARE CONSULTANT WARDROUND (CCCW) REVIEWING CONSULTANT: Velagapudi Admitted following diarrhoeal illness leading to mixed septic hypovolemic shock and severe pre renal acute kidney injury. Biochemistry improving and passing good volumes of urine with fluid replacement. Cardiovascularly improving; management period without vasopressor support yesterday however noradrenaline back on this morning at 14mL/hr following worsening losses overnight. BMs low so background glucose infusion commenced given minimal oral intake. Cultures negative thus far. Continues on vanc, met and gent. Escalating white cell count yesterday. Ongoing constant generalised abdominal pain and vasopressor requirement. CT KUB on admission but no contrast imaging during this admission. IMPRESSION: Likely remains intravascularly deplete resulting in increased vasopressor requirement. PLAN: Xa level between 9 and 10pm Low threshold for CT AP with contrast if further deterioration --> Campylobacter positive. Booked CT abdomen with contrast. Will discuss with surgeons based on findings. Change 0.9% NaCl to plasmalyte Regular paracetamol MOBILISATION GOAL: Out to chair FLUID BALANCE GOAL: Positive INVASIVE LINES REVIEWED (Should lines be removed/replaced/maintained)?: Y RADIOLOGY REVIEWED?: Y ANTIBIOTIC INDICATION & REVIEW DATE ON KARDEX?: Y (Please amend kardex if applicable)

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005843959 Dr E Louise Hartley 1/21/24 17:15 Ross MacDonald	Person-Centred Care Reintroduced myself to George and explained my role. all care explained prior to perfroming and consent received. Privacy and diginity maintained at all times. Partner and friend in visiting today. Deterioration and Escalation self ventilating on room air with SPO2 94%, RR 28. CVS BP 120/55 MAP 72, aiming for MAP above 65. MAP variable throghout today and NORAD has ranged from 4ml to 16ml/hr. Temp 36.1 CT scan of abdo at 1545hrs. Pressure Area Care up to the chair for a few hours this morning. able to reposition in bed himself Mobility transfer with asssitance of 1 for lines. slightly unsteady, may need 2 persons if struggiling. Bladder and Bowel Function IDC patent and draining Bowels x 2 opening today. type 7. Medicine Management all medications as per kardex Pain Management regular paracetamol and PRN oramorph Infection Prevention and Control confirmed campylobacter in faeces. precautions in place Food Fluid and Nutrition can eat and drink as able. Low food input and needs encouragement but George is reluctant to eat due to vomiting. food chart in place. Has has a bowel of soup at lunch time. Altered Stage of Cognition RASS 0 GCS 15

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Dr E Louise Hartley 1/21/24 17:52 Dr Thomas Cox	CRITICAL CARE MICROBIOLOGY ROUND (CCMR) MICROBIOLOGY CONSULTANT PRESENT: Dr Henderson SENIOR ICU STAFF PRESENT: A. Velagapudi GRADE: Cons PROVISIONAL NEW RESULTS: Campylobacter in stool Sensitivities awaited Advised CT A/P +/- Surgical review Wanted to clarify travel history and penicillin allergy Dr Velagapudi has clarified above - No foreign travel, last time patient was abroad was when patient was fighting in the Falklands - Penicillin allergy is a rash CHANGE REQUIRED: YES AGREED PLAN (All changes on Micro WR should be agreed by both ICU and Micro consultants): Continue Vancomycin + Metronidazole Stop Gentamicin. Commence Meropenem 1g BD (due to current renal function ANTIMICROBIAL DE-ESCALATION PLAN: n/a ANTIMICROBIAL ESCALATION PLAN: As above.

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Dr E Louise Hartley 1/21/24 18:48 Dr Thomas Cox	T.Cox ST2 CT Results noted D/W Colorectal Reg CT essentially demonstrates expected findings for infective enterocolitis. At present no need for surgical input. If deteriorates then can consider re-imaging and re-discuss with surgical team. Suggested touching base with gastroenterology team for advice to see if they would advise steroids etc. Attempted to contact GI Reg via switch but unable to get through. Will try again later but may need to discuss tomorrow.

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0005843959 Dr E Louise Hartley 1/21/24 21:41 Dr Amit Velagapudi	PM CRITICAL CARE CONSULTANT WARDROUND (PMCCCW) PM CONSULTANT REVIEW: Amit Velagapudi TIME: 21:30 CT result noted. Discussed with colorectal reg, but does not require surgical intervention currently. Blood glucose levels remain low due to poor oral intake. Commenced in 10% dextrose to reduce water load due to hyponatraemia. Looks comfortable. Low threshold to repeat ct and discuss with surgeons if deteriorates.

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005843959 Dr E Louise Hartley 1/22/24 02:24 Dana McCrae	Person-Centred Care I introduced myself to George All care explained and delivered with dignity Deterioration and Escalation Respiratory; SV RA Sat 92% AE throughout Cardiovaskul. R radial Aline Aim MAP >65 On SS Norad rate between 2-7 mls/hr HR SR Peripherally warm Apyrexial Lines intact Pressure Area Care On Nimbus matrass Bottom sore from ongoing diarhoea Skin intact Cavilon applied for comfort Mobility Needs assistence of 2 + slide Bladder and Bowel Function Ongoing diarhoea Watery stool tyoe 7 - frequent over night Cathetrised Good urine output Medicine Management I.V. Noradrenaline I.V. fluids Continous Vanc.infusion I.v ABX I.v. Paracetamol For other drugs see kardex Pain Management On regular paracetamol On PRN oramorph No complains of pain over night Infection Prevention and Control Campylobacter in stool Nurse barier + contact protection in place Food Fluid and Nutrition Normal diet and fluids Poor appetite On food chart No really eating Bms low _ on I.v 10% dex. Bm 5.4 over night

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Note Details	Clinical Notes
	Altered Stage of Cognition GCS 15 Alert and orientated Rass 0 Settled and slept well Cam ICU negative

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Dr Sophie Hannah Harris 1/22/24 09:07 Dr Sophie Hannah Harris	CRITICAL CARE DAILY REVIEW (CCDR) DAY OF CC STAY: 4 REVIEWER: Harris CONSULTANT: Shoeair/Morgan ADMITTING DIAGNOSIS: Hypovolaemic shock/AKI Unwell since 14/1/23 - D+V, no oral intake, collapse, anuric Significant AKI, vasopressor requirement Infective campylobacter enterocolitis ACTIVE PROBLEMS: 1. Septic shock - Enterocolitis, no surgical issues on CT 21/01/24 - Vancomycin, Metronidazole, Meropenem 2. Campylobacter enterocolitis - ongoing diarrhoea with intermittent vaspopressor requirement dependent on bowel losses - worsening abdominal pain and distension 3. Significant AKI - Baseline Cr 61 in September 2023 - Hyponatraemic - 1 episode of hyperkalaemia, medically managed, K+ normal since 4. Compensated metabolic acidosis - Improving, BE now -3.8 5. Derange clotting - no bleeding, LFTs NAD, ptl normal RESPIRATORY: SV sats 94% on RA Chest clear,comfortable CVS: HR 95 sinus, BP 125/58 (80) unsupported HS pure, warm peripheries, no oedema NA off since 0700 (2-7ml/hr SS yesterday) Lac 0.5, Hb 111 CNS: GCS 15 PAIN: Generalised abdominal pain and distension, feels getting worse. Responsive to analgesia DELIRIUM: Nil GI / NUTRITION: Mildy distended, soft, tympanic abdomen Bowel sounds present 8 Type 7 bowel motions yesterday BM 5.7 this morning on 30ml/hr glucose 10% Poor oral intake for solids, able to drink Tongue coated - thrush RENAL / FLUIDS: Ongoing AKI/biochemical improvement Ur 27.5 (31.7), Na 132 (129), K 3.4 (3.7), Cr 283 (525) BE - 3.8 IN 4.5, OUT 3, +1.5L MICROBIOLOGY: Campylobacter in faeces 18/1/24 MAX TEMP IN PAST 24HRS: 37.1 WCC: 26.9 (41) ANTIBIOTIC REVIEW: Meropenem D2 Vancomycin D3 Metronidazole D4 INVASIVE DEVICES (Consider changing CVC after 7 days or suspicion of infection): CVC AGE: RIJ CVC + Vascath D4 CVC SITE APPEARANCE: Clean A LINE AGE: R Radial D4

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	A LINE SITE APPEARANCE: Clean LINES STILL REQUIRED?: Vascath not required RADIOLOGY REVIEW: Y MEDICATION REVIEW: Y THROMBOPROPHYLAXIS: Y, Xa level 0.2 yesterday, hold in light of INR ULCER PROPHYLAXIS: Y OVERALL IMPRESSION: Steady improvement Slight concern given worsening abdominal pain/distension but reassuring lactate/CT yesterday/NA off -low threshold for repeating if deteriorates Uncertain why clotting is worsening PROVISIONAL PLAN: Hold dalteparin Consider Pabrinex ?refeeding risk now Encourage oral diet, ?dietician review Replace Ca/K Wean NA as able Vascath out Sit out today Continue glucose source whilst not eating Nystatin for thrush

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Dr E Louise Hartley 1/19/24 08:08 Dr Dean McAvoy	McAvoy ACCS 2 Patient admitted to ICU around 06:30 following discussing with HAN med reg BP had dropped again to 60 systolic and George still not PU On admission to unit cerebrating NIBP 94/56 On insertion of A-line under US guidance radial artery initially visualised but small calibre; after preparing line George became more unwell; still conversant but radial pulse no longer palpable or visualised with US. BP rechecked 74/41 Bolused 0.5mg metaraminol and A-line secured promptly Invasive BP 89/60 Boluses 250ml crystalloid Proceeded to Insertion of CVC and CVVH line in RIJV IVF running During procedure George reported feeling well but did have several episodes of hypotension noted on monitor which responded to further boluses of metarminol Both lines secured and CVP trace witnessed -Advised to commence on noradrenaline infusion Plan: CXR For IV vanc now 1000mg as not had in MAU Stabilse BP prior to commencing on CVVH Admission bloods and ABG Clarify further doses of abx and meds in view of renal function Central line BCx sent Ensure full septic screen Consider further imaging mane

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Physiotherapist 1/22/24 09:27 Aoife Birthistle	Physiotherapy at 0920 Patient's notes have been screened daily since admission. Chest stable - currently SV on RA with SpO2 of 97%. Discussion with nursing staff - nil further chest concerns highlighted, report currently min asssitance/ supervision due to attachments and will be getting patient up to chair soon. Plan: Continue to monitor - assess and treat as indicated. Aoife Birthistle B6PT Bleep 8457

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Note Details	Clinical Notes
Specialty Review Episode/Ref: I0005843959 Infection Service 1/22/24 10:18 Julia M Carrington	IPCN Julia Carrington discussed with S/N Amy Campbell Organism: Campylobacter isolated from sample obtained: ME337075R 18/01/2024 Transmission based precautions: contact precautions Patient placement: isolate with contact precaution sign on door, please consider use of face mask if risk of splash Hand hygiene: soap and water or alcohol gel Environmental cleaning: room, bathroom facilities & all equipment cleaned with Chlor-clean Linen: treat all as infectious in alginate bag – red linen stream Documentation: Bristol Stool & Fluid Balance charts IPCN notes: refer to Infection Prevention & Control intranet pages inc loose stool policy. Terminal cleaning of patient bed space/isolation room and toilet facilities on patient discharge/transfer or bed move as per NHS Lothian Terminal Cleaning Protocol.

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0005843959 Dr E Louise Hartley 1/22/24 12:45 Dr Mohamed M M Shoaeir	CRITICAL CARE CONSULTANT WARDROUND (CCCW) REVIEWING CONSULTANT: Shoaeir/Morgan Unwell since Sunday with bloody diarreah and vomiting Minimal oral intake Vasovagal episodes Trollys..> - AKI..> Acidosis and high K -prepheral shut down, systolic down to 60 -Non contrast CT showed no ischaemia/perforation - Vanc/gent/metronidazole - Discussed with renal team ICU - CVC/ dialysis line - more fluid resus - lactate improved - produce some concentrated urine - Vasopressors - still cool prephery Bloods - AKI Recent issues - Campylobacter in faeces 18/1/24 - Improving acidosis and renal functions - NA wean down now off - ongoing bowel losses, abdomen distended - Low Na 132 - Start some oral intake - Abdomen still tender, WBC 46 Plan Remove CVC / Dilaysis line If NA remiains off Today Encourge oral intake Vit K for three days MOBILISATION GOAL: sit to chair SEDATION GOAL: off sedation FLUID BALANCE GOAL: neutral to positive 500 ml INVASIVE LINES REVIEWED?: Y RADIOLOGY REVIEWED?: Y AWI/CAPACITY ASSESSED?: Y ANTIBIOTIC INDICATION & REVIEW DATE ON KARDEX?:Y ANY ISSUES TO RAISE WITH MICRO:

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Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0005843959 Dr E Louise Hartley 1/22/24 14:13 Dr Sophie Hannah Harris	CRITICAL CARE IMMEDIATE DISCHARGE LETTER (CCIDL) ***THIS IS A CORE CRITICAL CARE DISCHARGE DOCUMENT INTENDED FOR THE RECEIVING WARD AREA*** DISCHARGE WARD: ID DATE OF DISCHARGE: 22/01/24 DATE OF ICU ADMISSION/LENGTH OF STAY: 4 ADMISSION: • REFERRING SOURCE: MAU Trolleys • PRESENTATIONS AND SYMPTOMS: Diarrhoea and vomiting, hypotension, AKI PRIMARY DIAGNOSIS: 1. Campylobacter enterocolitis 2. Septic/hypovolaemic shock, resolved 3. Pre-renal AKI - improving with fluid resuscitation/replacement, no need for RRT 4. Metabolic acidosis - improving CRITICAL CARE COMPLICATIONS: Nil SIGNIFICANT PAST MEDICAL HISTORY: HTN BPH COPD INTERVENTIONS IN CRITICAL CARE: 1. Vasopressors/fluid resuscitation 2. Antibiotics 3. Central electrolyte replacement CLINICAL PROGRESS / TIMELINE OF EVENTS: Mr Sanderson was admitted with a short history of profuse vomiting, bloody diarrhoea and anuria. He had a collapse at home which prompted his presentation to hospital. His renal biochemistry was profoundly deranged and required a medical treatment for hyperkalaemia, CT KUB showed no obstruction. Despite fluid resuscitation he remained hypotensive so was admitted for vasopressor support. He has made steady progress since his admission. Stool cultures have grown Campylobacter and the appropriate antibiotics and infection control measure have been put in place. His AKI is improving and he has not required RRT. His clotting profile has become slightly abnormal in the absence of haemolysis/bleeding/liver dysfunction - we have started a course of Vitamin K and reviewing his thromboprophylaxis daily with his blood results. An interval CT scan showed enterocolitis with no need for surgical input. He is off organ support and ready for stepdown. PHYSIOTHERAPY STATUS : SEE TRAK ENTRY NUTRITIONAL TEAM STATUS: SEE TRAK ENTRY ALLERGY: Penicillin (RASH) MEDICATIONS: • CONTINUED Anoro Ellipta • WITHHELD Simvastatin, Lisinopril, Tamsulosin, Dalteparin (review daily with INR/platelets) • STOPPED • NEW Lansoprazole (only required whilst critically unwell), Pabrinex (refeeding), Nicotine patch, Paracetamol, Meropenem (renally adjusted dose, 5 day course), Nystatin, Vitamin K KEY POINTS FOR REVIEW: • CONTINUED ISSUES - fluid balance with daily stool chart output • MEDICATIONS - review thromboprophylaxis daily with blood results, reintroduce antihypertensives/other medications as required, dose adjustments for medication as renal function improves • INVESTIGATIONS / SPECIALTY REVIEWS - ongoing Microbiology input TEP COMPLETED: For full escalation DELIRIUM STATUS: • IN ICU: N

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	• AT DISCHARGE: N DISCHARGE NEWS: NAME: S Harris POSITION: ST5 CONTACT: 8165 PAGE: 31673

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Dietician 1/22/24 14:34 Caitlin Cooney	Dietitian Poor intake ~1 week noted. Nil capacity to review today - plan for full dietetic assessment tomorrow. Caitlin Gilfillan Critical Care Dietitian Bleep 8498

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Note Details	Clinical Notes
Specialty Review Episode/Ref: I0005843959 Infection Service 1/22/24 14:52 Julia M Carrington	Routine ward visit, spoke with S/N Eoin, who reported that type 7 stool is still being passed, Eoin has informed me that BSC being completed. Contact precaution poster in place and patient isolated in single room.

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Dr E Louise Hartley 1/22/24 15:15 Dr Sophie Horrocks	CRITICAL CARE MICROBIOLOGY ROUND (CCMR) MICROBIOLOGY CONSULTANT PRESENT: Dr N Henderson SENIOR ICU STAFF PRESENT: M Shoaeir GRADE: Acting consultant PROVISIONAL NEW RESULTS: No CHANGE REQUIRED: YES AGREED PLAN (All changes on Micro WR should be agreed by both ICU and Micro consultants): Stop vanc Stop metronidazole Continue meropenem for 5 days and then review ANTIMICROBIAL DE-ESCALATION PLAN: NA ANTIMICROBIAL ESCALATION PLAN: NA

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Dr E Louise Hartley 1/22/24 16:43 Sarah Laidlaw	Accepted for ID under Dr Page. Awaiting bed now.

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005843959 Dr E Louise Hartley 1/22/24 19:15 Eoin Redmond	Person-Centred Care Introduced myself to George. All aspects of care explained and provided with Geogres consent. Privacy, dignity and respect maintained at all times. Son, granddaugther and wife visited today. Deterioration and Escalation RESPIRATORY: Self ventilating on room air. Able to cough and clear. Air entry audabile throughout. CARDIOVASCULAR: Continous sinus rhythm- Blood pressure unsupported- self achieving MAP >65mmhg. Afebrile. warm and well perfused. Had K and Ca replaced today. New cannula this evening and for all lines bar that to be removed. Pressure Area Care George can indepdently relieve his own pressure areas in bed. Has refused to get into a chair today. Did manage to have a wash which required setting up. Skin appears intact. Some scratches on legs. Dermol put on R elbow for itch. Refused to have flotrons on. Mobility Supervision to push self up the bed with glidesheet due to lines. Bladder and Bowel Function Catheter patent and draining good volumes. Moving bowels into bedpan. Bristol stool chart insitu. Medicine Management Medications administered as per kardex. Pain Management C/O abdo pain- oramph administered. Drs informed that he was still in pain, dose increased. Frequency 2 hourly. Aware to buzz to for pain relief. Infection Prevention and Control Aware of infection status- nursed in sideroom. Contact precautions insitu. Food Fluid and Nutrition Poor intake this morning but has picked up this lunch-evening. Bm stable. Altered Stage of Cognition Alert and orientated. GCS 15 Discharge Planning To be discharged to ward 20 tonight.

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Nurse 1/22/24 19:21 Eoin Redmond	REASON FOR AND DATE OF ADMISSION TO HOSPITAL: 19/01- 5/7 history of D&V. REASON FOR ADMISSION TO CRITICAL CARE: 1. Campylobacter enterocolitis 2. Septic/hypovolaemic shock, resolved 3. Pre-renal AKI - improving with fluid resuscitation/replacement, no need for RRT 4. Metabolic acidosis - improving ACCEPTING/SURGICAL CONSULTANT: ID ? Consultant. SUMMARY OF TREATMENT: 1. Vasopressors/fluid resuscitation 2. Antibiotics 3. Central electrolyte replacement ALLERGIES: Penicillin OUTSTANDING PLANS/ INVESTIGATIONS: Nil CURRENT NEWS AND GCS (SPECIFY REASON FOR SCORES): GCS 15 MOBILITY+MDT INVOLVEMENT: NUTRITIONAL STATUS: On food record chart for last 3 days due to poor intake. Intake now picking up. BM stable- was on dextrose to aid with blood sugars. SKIN INTEGRITY: Intact, Scratches on legs. INFECTION STATUS+ MRSA DISCHARGE SCREEN: Campylobacter enterocolitis +ve, contact precautions. Sideroom.

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Physiotherapist 1/19/24 09:24 Hannah Fletcher	Physiotherapy No indication for PT input at present. No chest concerns at present. PT to monitor and screen notes and input as required. Hannah Fletcher B6PT Bleep 8164

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Nurse 1/23/24 01:25 Galina Devlin	transfered to the ward. alert/orientated. mobility TBA. IDC patient/draining. skin is intact. uses bed pans. had 1 BO type 7 med size green and slimy. NEWS 3 BP 105/59, pulse 99, sats 94%. no other issue to rport.

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Dr Oliver Koch 1/23/24 03:35 Dr Jane Greenwood	HaN review - fluid review ICU step down today -Campylobacter enterocolitis -Pre renal AKI (improving), currently aiming for neutral to positive 500 ml fluid balance -Metabolic acidosis (improving) Bloods 22/01 - urea 27, Na 132, K 3.4, creat 283, eGFR 20 No urine output measured from today, no IVF since admission to ward Currently Lying in bed, appears comfortable Woke on entry to the room but says he usually wakes at 4 am anyway as lorry driver Feeling generally okay in himself, ongoing loose stools (2 x large this evening) No pain anywhere at the moment Managing some oral intake mainly fluids, not feeling particularly dehydrated No dizziness or feeling of heart racing O/E NEWS 4 - HR 97, BP 104 sys, temp 37.1, RR 20, sats 94% ORA WWP, CRT 3 seconds, pulse regular slightly weak, reduced skin turgor, dry mucous membranes, calves soft no evidence of any peripheral oedema Catheter in situ - draining moderately concentrated urine, approx 320 mls in urometer Imp: clinically dry, ongoing diarrhoea and significant AKI Plan 1. Cont encourage oral intake 2. IVF - stat and maintenance bag (given Na 132, plasmalyte 148) 3. Close monitoring of fluid balance aiming neutral to 500 ml positive 4. Repeat U+Es day time J Greenwood FY2

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Dr Oliver Koch 1/23/24 07:01 Dr Jane Greenwood	HOSPITAL at NIGHT / WEEKEND Type of Request: Task Assigned To: Dr Jane Marie Greenwood Time Seen: No data entered Problem/Request: IV Fluids Outcome: ICU step down Enterocolitis with pre renal AKI Tachy and hypotensive, clinically dry IV fluid stat and fast maintenance For day time U+E and fluid balance

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0005843959 Dr Iain D Page 1/23/24 11:15 Dr James Millwater	WR Page 63 year old admitted with severe diarrhoea and vomiting. Background of COPD, BPH and HTN Normally independent, lives with wife, works as truck driver Admitted to ICU from front door given refractory hypotension in context of sepsis and Stage 3 AKI. Did not require RRT in ICU but required vasopressors. Step down to ward on 22/01. Issues: 1. Colitis secondary to campylobacter 2. Sepsis secondary to above 3. AKI - Improving Bloods 22/01 - WCC 26 (41) - eGFR 20 (5) - Creat 283 (1000 on admission) - K+ 3.4 - MIldly deranged coag likely secondary to sepsis - Alb 17 On review: NEWS 4 - Normotensive Reports feeling 'fine' today. Discussed admission so far. Reports his abomen still feels very distended. Not managing to eat still - feels his stomach is distended and bloated which is preventing him from eating. He denies vomiting. Bowels no opening regularly. Mobilising independently around the room - has had a shower this morning. OE: WWP. Normal CRT. Nil pedal oedema. No evidence of DVT Abdomen - distended. Some generlaised tenderness. Dullness in flanks - likely fluid in 3rd sdpace secondary to sepsis / low albumin Bowel sounds present. Chest - clear CLinically euvolemic Plan: Laxatives - senna ON - Px on HEPMA Stop IV fluids after current bag and encourage oral fluid intake Record urine output - at risk of recovery diuresis Stop pabrinex, vit k, meropenem and lansoprazole - done STart clarithromycin oral 5 day course - if sensitivites back and is senstivie to meropenem then can include this in 5 day course - Px on HEPMA Chase bloods today

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Dr Iain D Page 1/23/24 16:31 Dr Francesca Wightman	ATSP due to increased abdo pain & distension 63M ITU stepdown 22/01 for sepsis secondary to Campylobacter colitis. IVOS today from meropenem to clari. Currently: Reporting increased pain in a band across his abdomen, sharp stabbing pain, initially intermittent and now constant. Only relieved by oramorph. Feels his abdomen looks more distended , approx 30% larger compared to this AM. NS also feels it looks more distended. Opened bowels this AM - T7 large, green. Nil since and onset of Sx after bowel movement. Passing wind ok. Denies any nausea or vomiting. Managed to eat lunch & taking oral fluids ok. O/E: NEWS 2 - BP 114/74, HR 99, Sats 94% RA, temp 36.9 (stable) FBC: INPUT - 1550mls, OUTPUT 1250mls Alert & conversant, looks settled Abdomen looks distended - was not present on WR to compare to this MA but noted to be distended at this point No bruising affecting the flanks. Generalised tenderness on palpation across abdo, worse in LIF, with involuntary guarding. No rebound tenderness. Radial pulse regular & tachy Imp: worsening abdo pain and possible increased distension on BG of campylocbacter colitis - need to exclude perforation. Plan: - AXR & erect CXR this evening - Bloods including lactate - Analgesia as required - Monitor BP, stable at present - Consider discussion with the surgeons following XRs & bloods FY2 Wightman

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005843959 Dr Iain D Page 1/23/24 17:03 Marianne Hume	Person-Centred Care George had asst with a shower this morning, was fairly independent. Abdomen seems quite distendend, medical team aware, to attend xray this evening. Deterioration and Escalation NEWS 2 - sats 94%, HR 99 Bladder and Bowel Function IDC in situ, FBC completed Medicine Management All meds given as per HEPMA

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Dr Iain D Page 1/23/24 18:55 Dr Francesca Wightman	AXR - distended loops of small bowel, diameter >4cm, significant change from prior AXR 18/01 CXR - no free gas under the diaphragm, flattening of hemidiaphragms Bloods - in prog Imp - ?small bowel obstruction ?inflammatory ileus D/W Surgical SHO Jess re recommendation for further Ix/ongoing management - will kindly d/w their reg and get back in touch, many thanks FY2 Wightman

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Dr Jane Marie Greenwood 1/23/24 23:04 Dr Jane Greenwood	HaN Review - ATSP re chasing surgical plan Issues 1. ICU step down - enterocolitis, significant pre renal AKI 2. New abdominal pain/distension Currently Sat up in bed, alert and orientated Gradual onset abdominal pain, generalised over whole abdomen, stabbing in nature, not intermittent, no exacerbating factors No nausea/vomiting BO at 17:00 small volume but still loose, still passing flatus earlier in evening O/E NEWS 5 - RR 27, sats 97%, BP 128/82, HR 100, temp 37.3 A patent B slightly increased WOB, chest sound clear anteriorly, no evidence of cyanosis C WWP, CRT < 2 seconds, slightly dry mucous membranes with slough on tongue, JVPNE, abdomen distended and tender but does not feel peritonitic, dull on percussion, very quiet bowel sounds, calves soft not swollen D GCS 15 E apyrexial, cannula L forearm with associated redness/rash Bloods - lactate 1.4, Hb 112, WCC 22 (23), urea 15.9 (27), CRP 80 AXR - distended loops of small bowel, diameter > 4 cm CXR - no free gas under diaphragm Discussed with colorectal reg on call Recent CT - Diffusely dilated small bowel loops, continuing to the transition point in the distal ileum, where the distal ileum becomes diffusely thickened. There is also diffuse thickening of the colon noted. This is likely to be related to the campylobacter enteritis and proximal small bowel dilatation may be secondary to the distal small bowel thickening, with no other cause of obstruction demonstrated AXR reviewed - small bowel dilatation Unlikely for SB resection / surgical, thinks most likely terminal ileitis secondary to campylobacter and probable ileus development contributing to distension/discomfort Advised discussion with GI in morning for further investigation/management, does not think further CT at this point will add anything Plan 1. Discuss GI in morning - ?terminal ileitis secondary to campylobacter -> scoping or MRI? 2. Pass NG and NBM 3. IVF 4. Cannula change 5. Analgesia - oramorph 5 mg PRN 2 hourly J Greenwood FY2

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Dr Iain D Page 1/24/24 04:50 Tracey J Dalrymple	HOSPITAL at NIGHT / WEEKEND Type of Request: COORDINATOR Advice Assigned To: Tracey J Dalrymple Time Seen: No data entered Problem/Request: Wd staff asked to pass NG tube as per surgical plan to be on free drainage NG passed by ward staff - draining yellow coloured fluid- PH is 7.5 phoned for advice as PH to low Outcome: Advised that as NG for free drainage only & yielding bilious fluid- advised to follow NGT protocol Discussed with H@N Dr covering as draining currently & NGT not being used for feeding to leave as is, Any issues to call back- Extremely High acuity throughout hospital currently day team can rv if CXR needed

Surname/Forename	Sanderson, George
UHPI Number	610041369B

Episode Number	I0000244921

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Nurse 1/24/24 06:20 Ege Trestip	Alert and orientated. Ongoing News 5-6. High RR 24-28, Sats 93%, HR 97. Known COPD. Appears comfortable. Seen my night doctor regarding results of AXR. Asked to pass an NG for drainage. S/N Erland passed a wide NG with Georges' consent. NG initiallty passed to 84cm, started draining small volumes bright yellow fluid. Ph 7.5. Phoned HAN for advice, advised as it is for drainage no need for XR and to keep in place for now. Phoned ward 24 for further advice. S/N from ward 24 said usually when wide NG passed for drainage, NG starts draining large volumes of gastric content so clear it is in the the stomach. She advised to pull the NG out to around 60 cm as this is more common measurement usually. At 84cm NG was draining more bright yellow liquid. pulled out to 64cm. Less drainage, same yellow. Ph remains 7.5. Observations have remained same through the night. No coughing noted. PRN Oramorph given for abdo pain. Found NG quite uncomfortable, settled more once pulled out to 64cm and managed to fall asleep. Cannula resited as asked by doctor. IVI+Kcl in progress. Catheter draining good volumes.

Surname/Forename	Sanderson, George
UHPI Number	610041369B

Episode Number	I0000244921

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Dr Iain D Page 1/24/24 08:52 Dr Jane Greenwood	HOSPITAL at NIGHT / WEEKEND Type of Request: Task Assigned To: Dr Jane Marie Greenwood Time Seen: No data entered Problem/Request: Please chase surgical plan 63M ITU stepdown 22/01 for sepsis secondary to Campylobacter colitis. IVOS today from meropenem to clari. C/O increased abdominal pain & distension this afternoon. Passing wind & bowel movements, E&D ok, no N&V. NEWS stable (2) HR 102, BP 128/80, afebrile AXR shows dilated small bowel suspicious for ?small bowel obstruction ?inflammatory ileus D/W surgical SHO at 18:30 who advised they would be back in contact with recommendations re management - yet to be contacted back, please chase. Many thanks Outcome: See full trak entry Discussed with colorectal surgery - advised NG tube, early discussion with GI

Surname/Forename	Sanderson, George
UHPI Number	610041369B

Episode Number	I0000244921

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Dr Iain D Page 1/24/24 10:01 Dr James Millwater	Daily review - Millwater FY2 Issues: 1. Enterocoloitis secondary to Campylobacter 2. Sepsis and severe AKI secondary to above requiring ITU support / vasopressors. Did not require RRT. 3. Ileus - Secondary to colitis / Severe sepsis Note events overnight - discussed with colorectal. Ileus, no indication for surgical input. Advised discussion with GI. Discussed with Dr Page this morning who is happy that Ileus secondary to severe sepsis and no discussion with GI indicated at this time. Continue with NG and IV fluids. Bloods 23/01 HB 112 WCC 22 (26) Renal function normal CRP 80 On review: NEWS 5 - Sats 93% OA. RR 24 HR 97 BP 138/81 George reporting that he is uncomfortable with the NG. He did not sleep well overnight. He notes a definite improvement in his abdominal distention and pain since the NG was inserted. IV fluids continue. He reports a small bowel movement this morning but it was green and very mucousy. He does not feel nauseated and is not vomting. Denies any other new symptoms. Some abdominal pain / discomfort remains. OE: Abdo remains distended / tense. Reports less so than yesterday evening. MIld tenderness throughout. Bowel sounds active. nil pedal oedema. Clinically euvolemic 200mls in Bag attached to NG. NS report that lots of fluid had come out initially from ryles tube at 83cm but it was pulled back as this was felt to be too far and since then much less fluid has drained. Imp: Ileus - bowel movement this morning sounds mainly mucus possibly due to ongoing inflammation and not sure it represents a resolving ileus. Has noticed benefit from ryles tube being in situ. AKI resolved. Plan: Ryles tube to remain in this morning. Can attempt to spiggot later today if still managing fluids and no more has drained into bag. George happy with this and understand that if it is removed too soon then it may just need to be reinserted. Advised George that it is best to keep going with clear fluids at present. MOnitor output from ryles on fluid chart Chase bloods today. Chase sensitivites from stool MC+S Continue IV fluids JM Fy2

Surname/Forename	Sanderson, George
UHPI Number	610041369B

Episode Number	I0000244921

Note Details	Clinical Notes
Ward Round Episode/Ref: I0005843959 Dr E Louise Hartley 1/19/24 10:47 Dr Thomas Cox	CRITICAL CARE DAILY REVIEW (CCDR) DAY OF CC STAY: 1 REVIEWER: T.Cox ST2 CONSULTANT: A. Morgan / M. Shoeir ADMITTING DIAGNOSIS: Septic shock EVENT LIST: Unwell since Sunday - D+V with no oral intake. Collapse at home so came to WGH for assessment. On arrival hypotensive with significant AKI, hyperkalaemia and raised inflammatory markers. Anuric. Ongoing burden of loose stools. Received fluid resuscitation and medical management of hyperkalaemia Commenced on Vancomycin, Gentamicin + Metronidazole CT KUB - no obstructing renal stone or other significant abdominal pathology identified Given further fluid resuscitation but remained significantly hypotensive and anuric Transferred to ICU --> CVC, VasCath, A-line, Noradrenaline and further resuscitation ACTIVE PROBLEMS: 1. Septic shock - ?Intra-abdominal cause - presumed enterocolitis but not seen on non-contrast CT - Vancomycin, Metronidazole, Gentamicin 2. Diarrhoea - Too early for culture results - Ongoing losses 3. Significant AKI - Baseline Cr 61 in September 2023 - Anuric - Hyponatraemic, hyperkalaemia 4. Compensated metabolic acidosis - Improving RESPIRATORY: RR 28 Sats 97% RA Chest clear anteriorly No respiratory distress, able to speak in full sentences CVS: Cool hands. CRT= 4 secs. Pulse regular, tachycardic, slightly thready Dry mucous membranes No peripheral oedema HR 103 BP 106/48 Norad SS @ 20mls/hr CNS: Alert + orientated Able to move all 4 limbs No gross neurological deficit evident PAIN: Denies pain DELIRIUM: No evidence of delirium RASS = 0 CAM-ICU status +ve/-ve : -ve If +ve Delirium Tool complete Y/N GI / NUTRITION: Abdomen soft, significant widespread lower abdominal tenderness Denies ongoing nausea or vomiting Ongoing T7 foul smelling stool - dark brown BM's stable, 6.3 Sipping water. No food as of yet. RENAL / FLUIDS: Passed 70mls Urine in last hour - dark brown concentrated urine Has had around 4L in PLT-148 @125mls/hr

Surname/Forename	Sanderson, George
UHPI Number	610041369B

Episode Number	I0000244921

Note Details	Clinical Notes
	500mls HAS 5% going at 250mls/hr MICROBIOLOGY: Stool sample 18/01 - in progress Urine culture 18/01 - not in progress Stool sample 19/01 - collected but not yet in progress CVC BC's 19/01 - collected but no yet in progress MAX TEMP IN PAST 24HRS: 37.1 WCC: 24.0 ANTIBIOTIC REVIEW: Gentamicin 110mg @ 3:54 Metronidazole 500mg TDS Vancomycin 1000mg loading dose INVASIVE DEVICES (Consider changing CVC after 7 days or suspicion of infection): CVC AGE: D1 CVC SITE APPEARANCE: Clean + dry VasCath AGE: D1 VasCath SITE APPEARANCE: Clean + dry A LINE AGE: D1 A LINE SITE APPEARANCE: Clean + dry LINES STILL REQUIRED?: Yes RADIOLOGY REVIEW: Yes MEDICATION REVIEW: Witheld due to poor renal function: Naproxen Lisinopril Simvastatin Tamsulosin THROMBOPROPHYLAXIS: Dalteparin 5000 units ULCER PROPHYLAXIS: Nil - ?needs OVERALL IMPRESSION: Septic shock with escalating Norad requirement Remains significantly dehydrated with room for further fluid Significant renal failure but improving acidosis, K+ safe and starting to make urine PROVISIONAL PLAN: - Withold above listed medications due to renal failure - Further PLT-148 500ml bolus - Replace Ca2+ - Replace Mg2+ however replace Ca2+ first as Mg2+ might cause further hypotension - Send urine culture now making urine - D/W Microbiology re ABX rationalisation - ?Tazocin instead of Gent + Vancomycin - If to remain on current ABX regiment then needs Vancomycin infusion + Gentamicin level at 03:50 on 20/01 - Anti-Xa level after 3rd dose of Dalteparin - ?Needs contrast imaging

Surname/Forename	Sanderson, George
UHPI Number	610041369B

Episode Number	I0000244921

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Nurse 1/25/24 05:29 Ege Trestip	Alert and orientated. News 5 last night, ongoing high RR 28bpm . Rpt obs News 2. Gearoge appeared comfortable despite high RR. Catheter patent and draining well. IVI with Kcl in progress from start of shift. K+ 4.7 from last morning. Further bag with 40 mmol Kcl prescribed. Phoned HAN for review of fluids as George no longer has an NG tube and potentially giving too much IV potassium. Advised hospital very busy tonight, to with-hold further bad with Kcl and doctor to review when able. Ongoing loose stools, Type 7, dark green stool. Using the commode overnight. Stool and FBC maintained. Advised by day staff that George was allowed soup and ice cream for dinner yesterday. Not documented what diet appropriate currently.

Surname/Forename	Sanderson, George
UHPI Number	610041369B

Episode Number	I0000244921

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Dr Iain D Page 1/25/24 07:41 Emma Hutchinson	HOSPITAL at NIGHT / WEEKEND Type of Request: Task Assigned To: Emma Hutchinson Time Seen: No data entered Problem/Request: IVF Outcome: No data entered

Surname/Forename	Sanderson, George
UHPI Number	610041369B

Episode Number	I0000244921

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Dr Iain D Page 1/25/24 10:47 Kate Stephen (PA)	WR Dr Page Issues: 1. Enterocolitis secondary to Campylobacter 2. Sepsis and severe AKI secondary to above requiring ITU support / vasopressors. Did not require RRT. 3. Ileus - Secondary to colitis / Severe sepsis Note events overnight - discussed with colorectal. Ileus, no indication for surgical input. Advised discussion with GI. Discussed with Dr Page this morning who is happy that Ileus secondary to severe sepsis and no discussion with GI indicated at this time. Continue with NG and IV fluids. Concern yesterday over surgical abdomen- normal lactate, active bowels Ryles tube came out yesterday APEX reviewed NEWS 5- RR 26, sats 95% , HR 97 Bloods reviewed - high WCC , CRP falling, renal function improving AXR yesterday - dilated small bowel loops Stool chart - large volume T7 , on senna last stool sample 21st, no campylobacter Today lying in bed ongoing loose stool, passing gas keen to eat and drink as normal Plan: Fluid balance assessment daily can stop IV fluids after this bag today, for gongoin assessment encourage oral intake complete 5 days Clarithromycin stop senna TWOC K Stephen PA

Surname/Forename	Sanderson, George
UHPI Number	610041369B

Episode Number	I0000244921

Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005843959 Dr Iain D Page 1/25/24 16:25 Leo Anderson	Person-Centred Care George settled over course of day Deterioration and Escalation George's NEWS remains stable Pressure Area Care George reports skin intact, dressing to central line site changed (healing well, ?will just need removing in 3 days time) Mobility George mobilising independently to and from toilet Bladder and Bowel Function George reports bowels still active +++ however they are becoming less frequent Medicine Management medication as per hepma Pain Management George denies pain thus far Infection Prevention and Control George nursed in side room Food Fluid and Nutrition George independent with intake, continues with IV fluids

Surname/Forename	Sanderson, George
UHPI Number	610041369B

Episode Number	I0000244921

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Dr Iain D Page 1/26/24 00:37 Dr Jane Greenwood	HaN Review - ATSP re fluid review Issues 1. ICU step down - campylobacter enterocolitis 2. Pre renal AKI - improving 3. Post sepsis ileus Note plan from day team, stop IVF after bag from the day shift Currently Lying in bed alert Feeling generally well in himself Has been managing good oral intake of fluids throughout the day Feeling a bit dry mouthed but not overtly dehydrated, no headaches TWOC'd today, passing urine without any issues - cannot comment if concentrated or not/specific volume Abdominal pain improving, passing wind O/E HR 96 (persistent), BP 130 sys, RR 16, sats 96% ORA, afebrile WWP, CRT < 3 seconds, dry skin with flaking, moist mucous membranes, calves soft not swollen/ tender UO - charted up until TWOC and then approximations, approx 800 mls documented as output Bloods - eGFR >60, urea 4.5 (9), creatinine 61 (69) Imp: euvolaemic, dry flaky skin (was prescribed something by GP for this, has not been having) Plan 1. No further IVF overnight but close monitoring - ongoing loose stools 2. Hydrocortisone 1% / miconazole 2% cream (as per acute ECS) 3. Zerobase J Greenwood FY2

Surname/Forename	Sanderson, George
UHPI Number	610041369B

Episode Number	I0000244921

Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005843959 Dr Iain D Page 1/26/24 01:53 Chantel McDaid	Person-Centred Care George has had a settled night, managing independently to and back from toilet, has slept on/off throughout the evening Deterioration and Escalation NEWs 1 due to HR 110 Bladder and Bowel Function George reports he has passed loose stool several timews throughout the evening. Medicine Management Medciations given as per HEPMA IVI review - no longer required Pain Management PRN morphine sulphate given as per HEPMA

Surname/Forename	Sanderson, George
UHPI Number	610041369B

Episode Number	I0000244921

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Dr Iain D Page 1/26/24 02:07 Dr Jane Greenwood	HOSPITAL at NIGHT / WEEKEND Type of Request: Task Assigned To: Dr Jane Marie Greenwood Time Seen: No data entered Problem/Request: fluid review Outcome: See trak entry

Surname/Forename	Sanderson, George
UHPI Number	610041369B

Episode Number	I0000244921

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Nurse 1/26/24 15:23 Roisin Leddy	George had a settled day. Alert and orientated. Independent with ADLs. Meds charted as per Hepma. EWS stable as charted. Fair oral intake. Managing soups, puddings and to encourage fluids. FBC in place. Food chart in place. Multiple reports of BO. Stool sample obtained (x) Stool chart in place. Independently mobile around room. Passing urine freely but experiencing loose stool so wearing P+P for comfort. No new clinical concerns. Roisin Leddy - Staff Nurse

Surname/Forename	Sanderson, George
UHPI Number	610041369B

Episode Number	I0000244921

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Dr Iain D Page 1/26/24 15:42 Dr Osuri Wijesooriya	WR Dr Page Issues: 1. Enterocolitis secondary to Campylobacter 2. Sepsis and severe AKI secondary to above requiring ITU support / vasopressors. Did not require RRT. 3. Ileus - Secondary to colitis / Severe sepsis NEWS 1 – HR 101 Bloods 25/01: Hb 113, WCC 19.4, Neut 16.11, creat 61, ALP 168, CRP 29 AXR 24/01: Dilated small bowel loops Stool chart 25/01 - T6/7 mixed with urine 400ml Brown Today Lying in bed Feeling well Passed bowels – Soft stools Eating and drinking well Happy to increase fluid intake O/E Abdomen soft, mildly tender epigastric pain Bowel sounds present HS I+II Chest clear Plan: 1) Daily fluid chart 2) Encourage oral intake 3) Continue Clarithromycin 28/01 O Wijesooriya FY2

Surname/Forename	Sanderson, George
UHPI Number	610041369B

Episode Number	I0000244921

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Dietician 1/26/24 17:03 Lianne Gordon	Dietetic Nutritional Assessment on ward 43,, WGH, resting in bed. Consent obtained Anthropometry Weight (kg): nil recorded Height (m): reports 5'6" (167m) BMI (kg/m2): Weight history: friends report george has lost weight. Not quantified. usually 9st. % weight change: MUST score: Other: Biochemistry: 25/1/24, Creat 61, CRP 29, WCC 19.4 Clinical information: Admitted on 18/12 with diarrhoea and vomiting and no uring output. Issues: 1. Enterocolitis secondary to Campylobacter 2. Sepsis and severe AKI secondary to above requiring ITU support / vasopressors. Did not require RRT. 3. Ileus - Secondary to colitis / Severe sepsis Dietetic: Oral intake is improving. Discussed using oral nutritional support while appetite and oral intake is improving to prevent further weight loss. Environmental/Behavioural/Social: Lives with wife and dog, Normally independent, Works as truck driver Functional: Usually independent. Patient Focused/Patient Goals: Estimated Nutritional Requirements: (Using 57Kg) Energy: 23kcal/Kg x PAL = 1573 Protein: 1.2-1.5g protein: 68.4 - 85.5g Strategy/Plan: Dietetic Goals and Indicator Actions Implementation: To trial Ensure plus Milkshake bd. Food chart. Please weigh if able.Monitor and Review: Ongoing dietetic review Lianne Gordon Dietitian WGH Extn 31298

Surname/Forename	Sanderson, George
UHPI Number	610041369B

Episode Number	I0000244921

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005843959 Nurse 1/27/24 01:09 Callum Logan	quiet night for george has been settled in bed. sleeping well at this time. given zopliclone 3.75 seems to have had good effect. NEWS stable managing ind no loose stools at this time. medicaiotns given as per hepma no further concerns at this time

Surname/Forename	Sanderson, George
UHPI Number	610041369B

Episode Number	I0000244921

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0000244921 Mr JT Reid 5/24/05	DIAGNOSIS: Right lateral meniscal bucket handle tear,,PROCEDURE: Right knee arthroscopy, excision of bucket handle lateral meniscal tear. Uncomplicated,,PLAN: Full weightbearing activities as tolerated. Follow up in fracture clinic in six weeks time. ,,Yours sincerely,,,Jeffrey Reid,Locum Consultant Orthopaedic Surgeon,

Surname/Forename	Sanderson, George
UHPI Number	610041369B

Episode Number	I0000244921

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0001227915 Mr W Walker 1/15/07	DIAGNOSIS: Traumatic fractured rib on right side.,PROCEDURE: Observation and analgesia,,This 46 year old gentleman was admitted to A & E after a trauma. Three days ago he was working on a building site when a large wooden pallet fell from 60 feet and hit his right shoulder. Since then he had been complaining of pain on the right side and some discomfort, so he was admitted to A & E. On admission to A & E his heart rate was 104, normal sinus rhythm and blood pressure was satisfactory. His respiratory rate was 26 per minute and he was saturating at 92% on room air. There was decreased air entry in the right lower zone. Chest X-ray showed a fractured rib on the right side. There was no pneumothorax and no haemothorax. ECG done at that time showed a heart rate of 99 in sinus rhythm and no ischaemia.,,He was admitted to the High Dependency Unit for observation and analgesia. His blood investigation showed a high white cell count, so he was started on some antibiotics. He had a CT scan which showed a fracture of the right fourth rib but there was no lung contusion. There was some evidence of left consolidation, but no pneumothorax. After two days he was transferred back to the Ward where his further recovery was uneventful, except for pain control. His analgesia was increased and this settled his pain problem. His further recovery at ward level was uneventful and he was discharged home on 12th December 2006. He will be seen in the Clinic in six weeks time.,,Yours sincerely,,,DHARMENDRA AGRAWAL,Specialist Registrar,,,for enquiries telephone 0131 242 3927

Clinic Letters

University Hospitals Division

Royal Infirmary of Edinburgh
51 Little France Crescent
Old Dalkeith Road
Edinburgh
EH16 4SA

NHS Lothian

Thoracic Surgery

Dr Chowings
Leith Surgery
2 Duke Street
Edinburgh
EH6 8HQ

Date First Created:	24/01/2007
Date/Time Printed:	15/05/2026 10:45
Our Ref:	610041369B
CHI:	1210601451

Patient:	Mr George Sanderson 16/17 Pirrie Street Edinburgh EH6 5HY	**UHPI:** **Date of Birth:**	610041369B 12/10/1960
Specialty:	Thoracic Surgery	**Consultant:**	Mr W Walker

I reviewed Mr Sanderson in Mr Walker's outpatient clinic today. He had a traumatic fractured rib on the right side in early December 2006.

Today he is still complaining of chest pain especially during movement and for which he is still taking Paracetamol p.r.n. He has not yet gone back to work and as you will recall he has quite a heavy job.

On clinical examination there is bilateral air entry that is a bit reduced on the right base and on chest Xray the lungfields are clear. The right costophrenic angle is obliterated, change that is consistent with a small haemothorax that was present at the time of the original admission.

I explained to Mr Sanderson that he should try gradually to get back to his usual physical activity, preparing himself to go back to work. At the same time, I told him that he is the best person to evaluate his physical status in terms of pain and strength and to know when he will be ready to work normally. As an option I suggested to him to work, with the agreement of his employer, for perhaps half-days for the first week.

I do not think we need to see Mr Sanderson again in our clinic, but we would be happy to be contacted for any further information or problem.

Yours sincerely

Dr G Casali
Clinical Fellow in Thoracic Surgery

GC/rjh

University Hospitals Division
Western General Hospital
Crewe Road South
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EH4 2XU

NHS Lothian

Endocrine

Dr Chowings
Leith Surgery
2 Duke Street
Edinburgh
EH6 8HQ

Date First Created:	19/01/2011
Date/Time Printed:	15/05/2026 10:46
Our Ref:	610041369B
CHI:	1210601451

Patient:	Mr George Sanderson 16/17 Pirrie Street Edinburgh EH6 5HY	**UHPI:** **Date of Birth:**	610041369B 12/10/1960
Specialty:	Endocrine	**Consultant:**	Professor PL Padfield

I am not at all sure if this man will have physical illness to explain his lack of erectile function, his biochemistry is really quite borderline and the testosterone was taken at 3.00pm in the afternoon.

He complained to you of some erectile dysfunction although on talking to him there is no suggestion of any lack of libido. He shaves as often as he ever did and is aware that he does get morning erections.

You checked his testosterone and this was 9.6 with a calculated free testosterone of 161. His thyroid function is normal.

I note he takes Simvastatin for cardiovascular risk protection but I think you reduced the dose recently because of side effects. His most recent cholesterol in September of last year was 5.3. If I understand TRAK correctly his diagnostic level in April 2009 was 6 with an HDL of 1.64. He is a heavy smoker and his father died of a coronary in his sixties. Whether or not he crosses the 20% threshold for intervention (10 year CVR). I would agree with your treatment with Simvastatin although I think you should give him a more appropriate dose of Atorvastatin.

His problems regarding erectile dysfunction have been present for at least a year. I have pointed out that he smokes 20 cigarettes per day approximately because he rolls his own but it used to be twice that. He admits to 15 pints of beer at weekends.

Physical examination was unremarkable in the sense that he had normal male genitalia and normal body hair. He was quite wheezy when I listened to his chest but hard sounds were normal as were peripheral pulses. His blood pressure recorded here was 177/102, 167/103 and I have simply arranged to recheck his testosterone again in the morning and I have asked him to call and see you at least once in the next month before we see him again to have an early morning testosterone level. We are shifting away again from the use of SHBG so all you need to measure is the testosterone.

University Hospitals Division

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NHS Lothian

Endocrine

Dr Chowings
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EH6 8HQ

Date First Created:	19/01/2011
Date/Time Printed:	15/05/2026 10:46
Our Ref:	610041369B
CHI:	1210601451

In general whenever the testosterone is on the low side the next test to be done should be LH and FSH to see if there is a problem at the level of pituitary or gonads themselves and I have done this today.

We will see him in a month.

Best wishes.

Yours sincerely

Professor Paul L Padfield
Consultant Physician
plp/jm

PS It was our nursing staff who measured this man's blood pressure after I dictated this letter. If these blood pressures are representative then he needs treatment for this as well as his cholesterol.

University Hospitals Division

Western General Hospital
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NHS Lothian

Endocrine

Dr Chowings
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EH6 8HQ

Date First Created:	23/02/2011
Date/Time Printed:	15/05/2026 10:46
Our Ref:	610041369B
CHI:	1210601451

Patient:	Mr George Sanderson 16/17 Pirrie Street Edinburgh EH6 5HY	**UHPI:** **Date of Birth:**	610041369B 12/10/1960
Specialty:	Endocrine	**Consultant:**	Professor PL Padfield

I reviewed Mr Sanderson in the clinic today. He had presented with erectile dysfunction. He was initially found to have a borderline low testosterone level of 9.6 in September 2010. Subsequently his testosterone level was 11.4 at the beginning of January and then has gone up to 16.2 on 27th January without any hormone replacement. Pituitary function is normal. On further questioning today he mentioned his primary problem is erectile dysfunction. His libido is good and his energy levels are reasonably fine. As a result I have prescribed some viagra and after having discussion with Dr Strachan have discharged him from this clinic. This is because he does not have any hormonal abnormalities which he needs to be addressed. If any issues occur, please do not hesitate to contact us again.

Yours sincerely,

Gourab Chaudhry
SpR

NHS Lothian

Western General Hospital
Crewe Road South
Edinburgh EH4 2XU

Dr Scott
Dr Roderick J Scott & partners
Leith Walk Surgery
60 Leith Walk
Edinburgh
EH6 5HB

Date: 08/07/2011

Outpatient Clinic Letter

Patient	George Sanderson 16/17 Pirrie Street Edinburgh EH6 5HY	**CHI** **Date of Birth / Age** **UHPI**	**1210601451** 12/10/1960 (50 years) 610041369B
Specialty	Cardiology	**Attendance Date**	28/06/2011
Consultant	Prof DE Newby		

Dear Dr Scott

DIAGNOSIS
1 Probable hypertension with mild LVH
2 Hyperlipidaemia

CURRENT MEDICATIONS
Simvastatin 10 mg nocte

RECOMMENDATIONS
1 24 hour ambulatory blood pressure monitor
2 Start Sildenafil 50 mg prn

FOLLOW UP
Discharge from clinic

Many thanks for referring Mr Sanderson to the cardiology clinic where I reviewed him today on behalf of Professor Newby. He continues to have problems with erectile dysfunction and I note the previous correspondence from Professor Padfield. Today he denied any cardiovascular symptoms. He has an active job, he is a scaffolder and denies any exertional symptoms. He continues to smoke at least 40 cigarettes per day (roll-ups) and drinks 10-15 pints of beer at the weekend. Other than mild hyperlipidaemia he has no significant past medical history and no significant family history of cardiovascular disorders.

On examination today his blood pressure was 148/89. He was thin with a weight of 55 kilos. Pulse was 84 and regular with a normal character. The JVP was not elevated and there was no ankle oedema. Heart sounds I and II were present with no added sounds or murmurs. There were no carotid bruits.

12 lead ECG showed sinus rhythm with a normal axis and LVH by voltage criteria.

We went on to perform an echocardiogram which showed good left ventricular systolic function with mild concentric LVH and no other significant abnormalities.

I suspect that Mr Sanderson's mild left ventricular hypertrophy is on the basis of hypertension. I note that he has had some normal readings in your surgery. In order to clarify matters I have today requested 24 hour ambulatory blood pressure monitoring and I will forward the results to you when they are available. If this confirms hypertension then, in view of his LVH he would certainly merit anti-hypertensive treatment, probably with an ACE inhibitor in the first instance. I can see no contraindication to Sildenafil and would be happy for this to be prescribed. I have not made any arrangements for further follow up but please do not hesitate to get in touch if you feel we can be of further assistance.

Best wishes.

Yours sincerely,

ALAN JAPP
Cardiology Registrar

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NHS Lothian

Cardiology

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Date First Created:	24/08/2011
Date/Time Printed:	15/05/2026 10:47
Our Ref:	610041369B
CHI:	1210601451

Patient:	Mr George Sanderson 16/17 Pirrie Street Edinburgh EH6 5HY	**UHPI:** **Date of Birth:**	610041369B 12/10/1960
Specialty:	Cardiology	**Consultant:**	Prof DE Newby

I write on behalf of one of my colleagues, Dr Japp, who reviewed you in Professor Newby's cardiology clinic at the end of June. You will remember he had arranged for you to have a 24 hour blood pressure monitor attached.

This 24 hour recording suggests that your blood pressure is borderline elevated. The average blood pressure when you were awake was 137/91. My feeling on this given that you do have some mild thickening of your heart muscle is that we should commence you on a single tablet to treat this. This tablet is not going to make you feel any better but it should mitigate the risk of you running into problems over the coming years with things such as heart attack and stroke.

Perhaps you could pop along and catch up with your own doctor to discuss this further.

Yours sincerely,

ANDREW LUCKING
Specialist Registrar

copy to
Dr Scott Leith Walk Surgery 60 Leith Walk Edinburgh EH6 5HB

PS TO DR SCOTT
Dear Dr Scott
The ambulatory blood pressure recording showed a mean blood pressure during the day of 137/91 with an average blood pressure while sleeping of 107/63. These indices as discussed above are borderline but I think in the presence of LVH we should go ahead and treat him. My suggestion would be an ACE inhibitor in the first instance.

A LUCKING

NHS Lothian

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Dr Chowings
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Date: 09/10/2018

Outpatient Clinic Letter

Patient	George Sanderson 16/17 Pirrie Street Edinburgh EH6 5HY	**CHI** **Date of Birth / Age** **UHPI**	**1210601451** 12/10/1960 (57 years) 610041369B
Specialty **Consultant**	Urology Mr Alexander Laird	**Attendance Date**	26/09/2018

Dear Dr Chowings

Ref:al/kh

Diagnosis - Lower urinary tract symptoms. Abnormal DRE.
Treatment - Tamsulosin 400mcg once daily.
Follow up - Multiparametric MRI.

Thank you for referring Mr Sanderson who is a 57yr old man with COPD and hypertension, who stopped smoking 5 weeks ago. He has longstanding lower urinary tract symptoms with frequency, poor flow and incomplete emptying and nocturia x 2. He denies any urgency or urge incontinence and has no dysuria or haematuria. I note you documented an abnormal DRE in your referral letter.

On examination today, Mr Sanderson's abdomen is soft and non-tender, genitalia are unremarkable. DRE reveals a relatively small prostate, however there are to definite nodules on the left side of the prostate. I note you checked PSA which is 0.7. Flow studies were performed today, Mr Sanderson had a peak flow of 16.1mls/sec having voided 242mls over 28 secs. His residual volume was 195mls.

Mr Sanderson appears to have symptoms of bladder outflow obstruction, although his prostate is rather small on examination. I have suggested a trial of Tamsulosin. His DRE is clearly abnormal, the nodules were very hard and I do wonder whether there is some calcification of the prostate rather than prostate cancer. I have suggested as such to Mr Sanderson, although indicated that prostate MRI would be useful to exclude any clinically significant prostate cancer that would be non PSA secreting. I have requested this today, I have indicated that should there be an abnormality that is not a stone, then we may need to proceed to TRUS biopsy. I discussed the procedure and associated risks including blood in the urine, Pr and ejaculate, infection which can be severe and require admission and non-diagnostic test. Mr Sanderson is happy to be appointed MRI and to TRUS biopsy if required. I will be in contact when the result is available.

Yours sincerely

Mr Alex Laird
Consultant Urologist

610041369B M 12/10/1960
Sanderson, George
16/17 Pirrie Street,
Edinburgh,
Midlothian,
EH6 5HY
CHI 1210601451
70179 JS Chowings

WGH HOSPITAL
Date 26/9/18

Dear Doctor,

Your patient attended the UROLOGY Out-patient clinic today.

Recommendation

I would be grateful if you would prescribe the following:

DRUGS & Form	Dose and frequency	Anticipated length of course
TAMSULOSIN	400micrograms	OD
2		

He/She will attend again in For MRI prostate

A full letter will follow.

Yours sincerely,

STATUS CNS.

LHB 474

610041369B M 12/10/1960
Sanderson, George
16/17 Pirrie Street,
Edinburgh,
Midlothian,
EH6 5HY
CHI 1210601451
70179 JS Chowings
Ward / Clinical Area

NHS Lothian

PATIENT PROGRESS / COMMUNICATION SHEET

State Action(s) taken After Exception Reporting
Each entry should be dated and timed

Date & Time	Progress Notes / Problems Action Taken & Investigations Required	Signature (Print name & designation)
26/09/18	Urology exam clinic Mr A Laird = Freq = Incomplete empty = poor flow = 2/7 = ↓ Urgency & UI = Rx 07 L	

0041369B M 12/10/1960
nderson, George
/17 Pirrie Street,
lmburgh,
idlothian,
46 5HY
H1 1210601451
179 JS Chowings

NHS Lothian

/ Clinical Area

PATIENT PROGRESS / COMMUNICATION SHEET

State Action(s) taken After Exception Reporting
Each entry should be

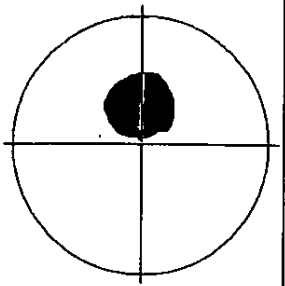
Progress Notes / Pro
Action Taken & Investigations R

610041369B M 12/10/196
Sanderson, George
16/17 Pirrie Street,
Edinburgh,
Midlothian,
EH6 5HY
CHI 1210601451
70179 JS Chowings

Procedure Code
Physician
Operator ID
Patient Name
Patient ID
26.9.2018 17:58
Exam Time And Date

BladderScan® BVI9400 Results Verathon Medical BVI 9400

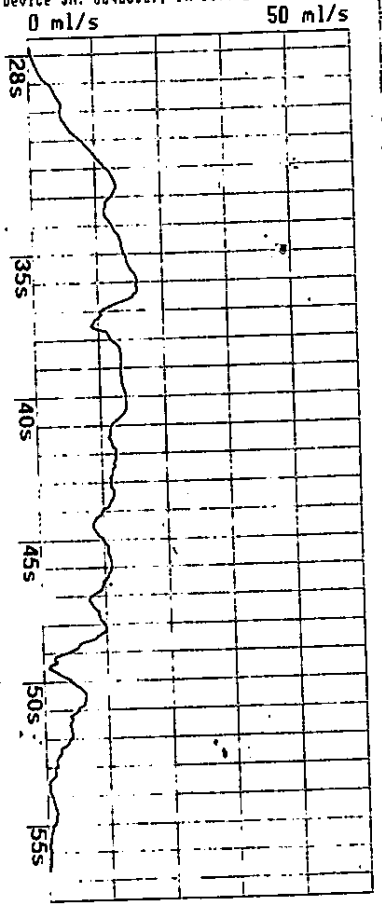
Urine Volume 195ml



610041369B M 12/10/1960
Sanderson, George
16/17 Pirrie Street,
Edinburgh,
Midlothian,
EH6 5HY
CHI 1210601451
70179 JS Chowings

Signature
& designation)

DYNAMICS
Uroflowmetry Measurement Protocol #5705
Device SN: 82420887, FW rev. 2.4



Results

Date:	20-Sep-2018 06:49
Voiding Time:	28 s
Flow Time:	28 s
Time To Max Flow:	9 s
Max Flow Rate:	16.1 ml/s
Avg Flow Rate:	8.8 ml/s
Voided Volume:	242 ml

Patient Information

ID: _____

Name: _____

NHS Lothian

Western General Hospital
Crewe Road South
Edinburgh
EH4 2XU

Dr Chowings
Leith Surgery
2 Duke Street
Edinburgh
EH6 8HQ

Date: 01/11/2018

Outpatient Clinic Letter

Patient	George Sanderson 16/17 Pirrie Street Edinburgh EH6 5HY	**CHI** **Date of Birth / Age** **UHPI**	**1210601451** 12/10/1960 (58 years) 610041369B
Specialty	Urology	**Attendance Date**	13/10/2018
Consultant	Mr Alexander Laird (Extra)		

Dear Dr Chowings

I have the results of your recent MRI scan. This confirms your prostate is small with no evidence of prostate cancer. The hard areas felt in the prostate are indeed areas of calcification which are what I suspected. Your PSA is reassuringly low at 0.7 and as such I do not think you need any further follow up in this regard.

You do obviously have urinary symptoms and we suggested a trial of Tamsulosin. I will review you in Outpatients in approximately 3 months time to assess your symptomatic response.

With kind regards.
Yours sincerely

Alexander Laird
Consultant Urological Surgeon

Letter sent to patient with copy sent electronically to GP

NHS Lothian

Western General Hospital
Outpatient Department
Lower Ground Floor
Anne Ferguson Building
Crewe Road South
Edinburgh EH4 2XU

Dr Chowings
Leith Surgery
2 Duke Street
Edinburgh
EH6 8HQ

Date: 14/02/2019

Outpatient Clinic Letter

Patient	George Sanderson 16/17 Pirrie Street Edinburgh EH6 5HY	**CHI** **Date of Birth / Age** **UHPI**	**1210601451** 12/10/1960 (58 years) 610041369B
Specialty **Consultant**	Urology Mr Alexander Laird	**Attendance Date**	30/01/2019

Dear Dr Chowings

Ref:al/kh

Diagnosis - Lower urinary tract symptoms.
Treament - Tamsulosin.
Follow up - None.

I reviewed Mr Sanderson in clinic today. He has noticed improvement with Tamsulosin. He does not find his urinary symptoms overly bothersome.

We discussed alternative and additional treatments. He is happy to continue with Tamsulosin longterm. I have therefore discharged him back to your care. Obviously if his symptoms were to worsen, then I would be happy to see him back following re-referral. I have not arranged routine review at this time.

Yours sincerely

Mr Alex Laird
Consultant Urologist

NHS Lothian

Western General Hospital
Crewe Road South
Edinburgh
EH4 2XU

Infectious Diseases

Dr Chowings
Leith Surgery
2 Duke Street
Edinburgh
EH6 8HQ

Date: 01/02/2024

Outpatient Clinic Letter

Patient	George Sanderson 16/17 pirrie street Edinburgh EH6 5HY	**CHI** **Date of Birth / Age** **UHPI**	**1210601451** 12/10/1960 (63 years) 610041369B
Attendance Date			
Consultant	Dr Oliver Koch		

Dear Dr Chowings

Dietetic Assessment on 29/1/24 on ward 43 at Western General Hospital

Purpose of letter: hospital discharge summary
Diet Therapy Proposed Outcome:
Recommendation: Oral Nutritional Supplements (ONS) Required

*****NUTRITION PRESCRIPTION REQUEST*****
Product Name: Ensure Plus
Flavour: strawberry and chocolate
Volume/weight per serve: 200ml
Quantity per day: 400ml
Total volume/weight per 28 days: 11,200ml (5600ml of each flavour)
Duration (weeks): 4 weeks
Indication for ACBS: disease related malnutrition
Justification for Non-First Line ONS: Patient preference.

Summary of Dietetic Assessment
Wt: 54.2Kg (28/1/24)
Ht: 1.71
BMI: 18.5
Usual weight 9 stone (57Kg)
Weight loss: 5% weight loss.
MUST Score: 1
Other: Recovering from Campylobacter

Follow Up Arrangements: For review with prescribing team by telephone call.

Please do not hesitate to contact the department if any other information is required.

Yours sincerely

Lianne Gordon
Dietitian WGH
Telephone number 0131 5371298

C.C.: Prescribing dietitians

NHS Lothian

Western General Hospital
Day Bed Suite
Ground Floor
Anne Ferguson Building
Crewe Road South
Edinburgh EH4 2XU

Diagnostic Procedure

Dr Chowings
Leith Surgery
2 Duke Street
Edinburgh
EH6 8HQ

Date: 25/10/2024

Outpatient Clinic Letter

Patient	George Sanderson 16/17 Pirrie Street Edinburgh EH6 5HY	**CHI** **Date of Birth / Age** **UHPI**	**1210601451** 12/10/1960 (64 years) 610041369B
Attendance Date	07/10/2024		
Consultant	Mr Peter G Vaughan-Shaw		

Dear Dr Chowings

We failed to get through a tight stricture at the time of colonoscopy for this chap and he went straight on to have a CT colonoscopy the same day. I am pleased to say that this did not provide any significant concerns in his bowel, although it is not a fully optimal test. I think given the presence of the stricture, with benign biopsies, I am fairly satisfied that this does not represent a concerning malignant issue. As such, I think it is reasonable to leave things as they are for now. If he has any evolving symptoms I would be happy to review things urgently but in the meantime, I have requested a routine clinic appointment to see how things are going.

Yours sincerely,

Mr Peter Vaughan-Shaw
Consultant Colorectal Surgeon
PVS/DR
Dictated 22/10/24

CC
Patient.

NHS LOTHIAN **PLEASE COMPLETE AND BRING TO APPOINTMENT**

Addressograph or Forename GEORGE Surname SANDERSON Unit number CHI 1210601451 Address 16/17 PIRRIE STREET. *(including Postcode)* EDINBURGH EH6 5HY **Preferred Name** GEORGE Tel. number 07 742 013 232	Arrived in .....unit for procedure Date: 071024 & time: GP Name DR. JEREMY CHOWINGS Address 2, DUKE STREET EDINBURGH EH6 8HQ Religion PROTESTANT Ethnic Origin WHITE **Consultant:**
Next of Kin: Name/address JACQUELINE TOD – wife Tel. number(s): ~~home~~ mobile 07 922 494 936	**Proposed Procedure: with Sedation** Yes ☑ No ☐ ☑ Colonoscopy ..... ☐ Endoscopy ..... ☐ Flexible Sigmoidoscopy ..... ☐ Pouch Endoscopy ..... ☐ *Other* .....
ALLERGIES: PENICILLIN. document if pt has no known allergies/sensitivities	**Other** ☐ ..... Proposed date: & time: Date confirmed by patient as suitable ☐

KEY TO INITIALS OF ALL STAFF COMPLETING THIS ICP

	Print name	Designation	Initials	Signature	date
1	Jmca French	SN	JF		7/10/24
2	Oseen Igoe	STN	OI		7/10/24.
3	J. Moloney	SN	J		7/10/24
4	ADay	SN	AD		7/10/24
5	MMcM	DCN	MM	MMcM	7/10/24.
6					
7					
8					

a) **SIGHT / HEARING / DIFFICULTIES WITH UNDERSTANDING or COMMUNICATION**: eg Interpreter
N ☑, Y ☐ *specify* .....

b) **OVERNIGHT CARE** N/A ☐, or Escort Y / N (who)..... Transport ...wife...
24hr Care Y / N (who)...wife..... I/P bed required Yes ☐, No ☐
PHONE NUMBER .....SAA

eGFR

c) **MOBILITY:** Wheelchair Y / (N) Walking Aid Y / (N). requires: Hoist ☐

FALLS RISK ASSESSMENT REQUIRED Y / N

d) **HOSPITAL TRANSPORT**: Required N ☑, Y ☐. If Yes, reason why .....
If Ordered date: Type Ref No.....

An Integrated Care Pathway is intended as a guide to treatment & an aid to documenting patient's progress.
Clinicians are free to exercise their own professional judgements as appropriate.
Alterations to the care noted is recorded as a Variance ['VAR'] & explained in Variance section at the end.

NHS LOTHIAN **PLEASE COMPLETE AND BRING TO APPOIN**

610041369B M 12/10/1960
Sanderson, George
16/17 Pirrie Street,
Edinburgh,
EH6 5HY

CHI 1210601451
70179 JS Chowings

severity, frequency, duration, recent changes : what where how etc ..

Addressograph or

Nam
Dob
Unit

Patient to complete this Pre-Procedural Assessment

for information for the staff to know before the procedure

Clinical Assessment

Have you ever had any of the following:	No	Yes
1. Heart attack or Stroke	☑	☐
2. Angina / Chest Pains on exercise or at night	☑	☐
3. Heart murmur	☑	☐
4. Heart Valve replacement	☑	☐
5. Do you have a Pacemaker	☑	☐
6. High Blood Pressure	☐	☑
7. Asthma or Bronchitis . COPD. - fairly controlled	☐	☑
8. Shortness of Breath	☐	☑
9. Diabetes	☑	☐
10. Epilepsy	☑	☐
11. Glaucoma	☑	☐
12. Could you be pregnant?	☑	☐
13. Do you use recreational drugs	☑	☐
14. Any noticeable weight loss over last 3-6 months?	☑	☐
15. Have you ever been contacted as 'at risk of CJD' (CreutzfeldJacob disease)for public health purposes?	☑	☐

If YES: Insulin ☐, Diet ☐, or Tablets ☐

Nurse record of BM [redacted]

Are you taking any of the following medication:	No	Yes
i. Aspirin	☑	☐
ii. Clopidogrel	☑	☐
iii. Warfarin	☑	☐
If Yes, did you receive instructions about stopping?	☐	☐
What were they?		

If YES: INR result .....

Nurse comments in shaded areas

inhalers in locker

CURRENT MEDICATIONS – including complementary medicines / vitamins etc

Tick if none ☐

	Drugs	dose	frequency		Drugs	dose	frequency
1	LISINOPRIL	10mg	1 per day	7	SILDENAFIL	AS REQUIRED	100mg
2	TAMSULOSIN	400 micrograms	1 per day	8			
3	SIMVASTATIN	40mg	1 per day	9			
4	SALOMOL	100 micrograms	As Required	10			
5	NASOBEC	50 micrograms	2 per day	11			
6	ANORO/VILANTEROL	55/22 mcg	1 per day	12			

* * **Staff –be aware that 'Allergies & Sensitivities' are to be noted on front cover** ✓

* * YES.

NHS LOTHIAN **PLEASE COMPLETE AND BRING TO APPOINTMENT**

Have you had previous operations (including what, where, dates etc) & were there any complications

Please list any other health problems

Would you like any information to be discussed in private YES ☐ NO ☑

Admitting Nurse initials JF date 7/10/24 time 0832

57.8kg.

08.30

NHS Lothian

610041369B M 12/10/1960
Sanderson, George
16/17 Pirrie Street,
Edinburgh,
EH6 5HY
DOB:
CHI 1210601451
70179 JS Chowings

Endoscopy Unit
Integrated Care Pathway (ICP)

Pt preferred name:	Telephone no:
Arrived in DBS unit. Date: 07/10/24 Time: 07.55	Consultant:
NoK name and address: Telephone no: Relationship to patient:	
GP name and address:	
Allergies? None known ☐ Yes ☐ (please detail):	
Proposed procedure: ☐ Colonoscopy ☐ Gastroscopy ☐ Flexible sigmoidoscopy ☐ Pouch endoscopy ☐ Endoscopic Ultrasound (EUS) ☐ Other: with sedation? YES ☐ NO ☐	
Proposed date/time:	Patient confirmed that date is suitable? YES ☐

KEY TO INITIALS OF ALL STAFF COMPLETING THIS ICP

Print name	Designation	Initials	Signature	date
1				
2				
3				
4				
5				
6				

Any difficulties with understanding and communication? e.g. interpreter, learning disabilities
No ☐ Yes ☐ Specify if Yes:

Any mobility issues? ☐ wheelchair user ☐ walking aid(s) ☐ hoist
☐ Is there any limitation to patient's position?

Falls risk assessment required? YES ☐ NO ☐

Post-procedure care: 12 hr care? YES ☐ NO ☐ Name: Phone:
Adult taking pt home? YES ☐ NO ☐ Name: Phone:

Hospital transport required? YES ☐ NO ☐

Hospital admission: I/P bed required? YES ☐ NO ☐ Reason(s):

Hospital/ward:

Approved: Dec 2023
Review: Dec 2026

NHS

610041369B M 12/10/1960
Sandersun, George
16/17 Pirrie Street,
Na Edinburgh,
EH6 5HY
DC
Hc CHI 1210601451
70179 JS Chowings

Endoscopy Unit
Integrated Care Pathway (ICP)
Pre-Procedure Assessment

To the patient: please complete this assessment before you h... your procedure. Thank you.

Have you ever had any of the following?:	Tick No or Yes	Nurse's comments
Heart attack or stroke	No ☐ Yes ☐	
Heart problems – implant/stent	No ☐ **YES** ☐	
Do you have a pacemaker fitted?	No ☐ Yes ☐	
High blood pressure	No ☐ Yes ☐	
Respiratory (breathing) problems	No ☐ **YES** ☐	
Shortness of breath	No ☐ Yes ☐	
Diabetes	No ☐ **YES** ☐	☐ Insulin ☐ Diet ☐ Tablets
Epilepsy	No ☐ Yes ☐	BM:
Glaucoma	No ☐ Yes ☐	
Could you be pregnant?	No ☐ Yes ☐	
Do you use recreational drugs?	No ☐ Yes ☐	
Any noticeable weight loss in the past 3-6 months?	No ☐ Yes ☐	
Have you ever been contacted as at risk of Creutzfeld Jakob disease (CJD) for public health purposes?	No ☑ Yes ☐	
Are you taking any of the following medications?	**Tick No or Yes**	**Nurse's comments**
Clopidogrel	No ☐ Yes ☐	
Warfarin	No ☐ **YES** ☐	**INR:** **Date:**
Aspirin	No ☐ Yes ☐	
Other anticoagulant(s) e.g. *apixaban, Rivaroxaban, Dabigatran, Edoxaban, Daltaporin*	No ☐ Yes ☐	
Proton pump inhibitor (PPI) e.g. *Omeprazole, Lansoprazole, Esomeprazole, Pantoprazole*	No ☐ Yes ☐	
Did you receive instructions about stopping the above medications? If Yes, what were they?	No ☐ Yes ☐	

Current medications including 'Over the counter' and complementary medicines, vitamins & minerals. **None** ☐

Medication name	Dose	Frequency	Medication name	Dose	Frequency
1			7		
2			8		
3			9		
4			10		
5			11		
6			12		

To staff – allergies/sensitivities to be noted on page 1

Reason(s) for procedure:

Relevant past medical history including surgical operations:

Would you like any information discussed in private? YES ☐ NO ☐

Admitting nurse initials: Date: ___/___/___ Time:

NHS Lothian

610041369B M 12/10/1960
Sanderson, George
16/17 Pirrie Street, [illegible]
N: Edinburgh,
EH6 5HY
DOB
CHI 1210601451
Hc 70179 JS Chowings

Endoscopy Unit
Integrated Care Pathway (ICP)
Pre-Procedure Checklist

For pre-procedure ONCE ONLY medications – use the Prescription/Administration Chart page 6

	On admission	Endoscopy PAUSE	Notes
Orientation to the ward/dept/unit	Y ☑ N ☐		
Patient identification checked & name band(s) applied	Y ☑ N ☐	Y ☑ N ☐	
ALLERGIES RE-CHECKED (same as on page 1)	Y ☑ N ☐	Y ☑ N ☐	Penicillin
Correct procedure	Y ☑ N ☐	Y ☑ N ☐	
Pre, Peri and Post procedure care explained	Y ☑ N ☐		
Explanation of withdrawing consent during procedure	Y ☑ N ☐	Y ☑ N ☐	
Ensure baseline obs (Obs chart page 4)	Y ☑ N ☐		
Last food: date 06/10/24 time 12:00	Y ☑ N ☐		
Last drink: date 06/10/24 time 20:00	Y ☑ N ☐		
Bowel prep taken / phosphate enema given or N/A ☐	Y ☑ N ☐	Y ☑ N ☐	Plenvu
Entonox checklist completed	Y ☐ N ☑		
Taken routine drug therapy	Y ☐ N ☑		
Any other relevant issues identified (specify if Yes)			
Jewellery REMOVED/TAPED or N/A ☑	Y ☑ N ☐	Y ☐ N ☐	
Belongings secured	Y ☑ N ☐		
Hearing Aids in situ: ☐ L ☐ R or N/A ☑	Y ☐ N ☑	Y ☐ N ☐	
Dentures in situ: ☐ Top ☐ Bottom ☑ Full or N/A ☐	Y ☑ N ☐	Y ☐ N ☐	
Orthopaedic Metal Implants	Y ☐ N ☑	Y ☐ N ☑	
Glasses sent with patient	Y ☑ N ☑	Y ☐ N ☑	
Spare Stoma bag sent or N/A ☑	Y ☐ N ☑	Y ☐ N ☐	
Patient's permission for presence of medical student / work experience student graded	Y ☑ N ☐	Y ☐ N ☐	
Consent form signed	Y ☑ N ☐	Y ☑ N ☐	

Pre-procedure nurse check initials: JF/CJ	Date 7/10/24 time: 0830
Procedure room nurse initials:	Date: 7/10/24 time:
PAUSE COMPLETED BY:	

NHS
lothian

610041369B M 12/10/1960
Sanderson, George
16/17 Pirrie Street, [illegible]
Nam Edinburgh,
EH6 5HY
DOB:
CHI 1210601451
Hosp 70179 JS Chowings

Endoscopy Unit
Integrated Care Pathway (ICP)
Pre, Peri and Post-Procedure Obs

	Time	08:45	9.16	09 35	09 50	10 05	10 20	10 40							
Respirations Breaths/min	≥25														
	18-20														
	15-17	17	16-	talk	talk	talk									
	12-14						14	14							
	9-11														
	≤8														
SpO2 (%)	≥96		96	99	99	98	97	96							
	94-95	95	95												
	92-93														
	≤91														
Air or Oxygen	A =Air	A	A	2L	2L	RA	RA	RA							
	O2 L/min														
Blood Pressure	≥220														
	201-219														
	181-200														
	161-180														
	141-160														
	121-140					129	129	104							
	111-120					↑	↑	↑							
	101-110	105													
	91-100	↕					L	↓							
	81-90					79									
	71-80	73													
	61-70														
	51-60						N								
	≤50														
Pulse	≥131														
	121-130														
	111-120														
	101-110														
	91-100	98	95	92	92	92									
	81-90														
	71-80														
	61-70														
	51-60														
	41-50														
	≤40														
Sedation	0 (None, patient alert)		0	0-1	0-1	0-1	0	0							
	1- Mild, occasionally drowsy	1													
	2- Mild, frequently drowsy														
	3-severe, somnolent														
	S-Normal, sleep														
Temperature	≥39.1														
	38-1-39.0														
	37.1-38.0														
	36.1-37.0	36.3													
	35.1-36.0														
	≤35														
Blood Glucose Level or N/A			/	NA	NA	NA									
Pain score (0-10)				0	0	0	0	0							
Nausea score(0-3)			/	0	0	0	0	0							

Approved: Dec 2023
Review: Dec 2026

-- WASH CYCLE PASSED --

Cantel	RapidAER
Serial No	RA0067
Start	16h 26m
End	16h 47m
Date	03-10-2024
Cycle No	24751
Load Operator	8
Name	laurine
Unload Operator	92
Name	PAUL HART

-- Hookup --

CANTEL	RAH219
Serial No	141
GS1	

-- Endoscope --

OLYMPUS	CF-H0290L
Serial No	2953174
GS1	
IMS Verify	Enabled
Control	Pass
IMS Verify	Pass
Contact Time	5 Minutes
Last SD	03-10-2024 at 01h 05m
Suction	Av Flow 958 ml
Biopsy	Av Flow 876 ml
Water	Av Flow 224 ml
Air	Av Flow 219 ml
Aux 1	Av Flow 202 ml
Aux 2	Not tested
RB	Not tested
Leak Test	Av Pres 213 mb

-- Conductivity --

Detergent	1372 uS
Disinfectant	1247 uS
Final Rinse	11 uS

-- Temperature --

Detergent	26.2 deg
Disinfectant	29.4 deg
Final Rinse	28.6 deg

-- Chemical Batch/Lot & Serial No --

Detergent	24000458/D000000839
Part B	24000520/B000001354
Part A	24000522/A000002770

-- WASH CYCLE PASSED --

Cantel	RapidAER
Serial No	RA0066
Start	12h 41m
End	13h 01m
Date	04-10-2024
Cycle No	24065
Load Operator	79
Name	Santosh
Unload Operator	38
Name	jackie

-- Hookup --

CANTEL	RAH219
Serial No	148
GS1	

-- Endoscope --

OLYMPUS	PCF-H290DL
Serial No	2930648
GS1	
IMS Verify	Enabled
Control	Pass
IMS Verify	Pass
Contact Time	5 Minutes
Last SD	04-10-2024 at 01h 05m
Suction	Av Flow 867 ml
Biopsy	Av Flow 858 ml
Water	Av Flow 127 ml
Air	Av Flow 111 ml
Aux 1	Av Flow 127 ml
Aux 2	Not tested
RB	Not tested
Leak Test	Av Pres 214 mb

-- Conductivity --

Detergent	1361 uS
Disinfectant	1184 uS
Final Rinse	-12 uS

-- Temperature --

Detergent	26.2 deg
Disinfectant	28.0 deg
Final Rinse	24.0 deg

-- Chemical Batch/Lot & Serial No --

Detergent	24000335/D000000317
Part B	24000520/B000000470
Part A	24000522/A000002780

Cantel Medical
7 Day Endoscope Drying Cabinet
EDC22405

Record copy
Book Out
Date 07/10/2024 Time 07:41.

Hook	03
Make	OLYMPUS
Model	CF-H0290L
Serial No	2953174
GS1	
Cycle No	5886

Booked In 03/10/2024 Time 16:44
Name: Paul. ID: 37

Chan Temp	24
Chan RH	15
Cab Temp	21
Cab RH	23

Booked Out 07/10/2024 Time 07:41.
Name: Steven Wood. ID: 7.
Control: OK
IMS : OK

Cantel Medical
7 Day Endoscope Drying Cabinet
EDC22403

Endoscope copy
Book Out
Date 07/10/2024 Time 09:40.

Hook	01
Make	OLYMPUS
Model	PCF-H290DL
Serial No	2930648
GS1	
Cycle No	3155

Booked In 04/10/2024 Time 13:01
Name: Jackie Anderson. ID: 2

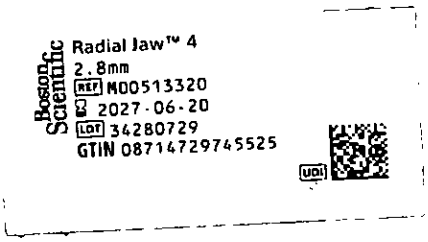
Chan Temp	23
Chan RH	14
Cab Temp	25
Cab RH	25

Booked Out 07/10/2024 Time 09:40
Name: Steven Wood. ID: 7
Control: OK
IMS : OK

610041369B M 12/10/1960
Sanderson, George
16/17 Pirrie Street,
Edinburgh,
EH6 5HY
CHI 1210601451
70179 JS Chowings

Endoscopy Unit Integrated Care Pathway (ICP) Endoscope Tickets	Nam: DOB Hosp:

Single use medical equipment labels



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Sanderson, George
16/17 Pirrie Street,
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Endoscopy Unit
Integrated Care Pathway (ICP)

MEDICATION PRESCRIPTION AND ADMINSTRATION RECORD

Date	Medication (Approved name)	Route	Dose	Time	Dose	Time	Dose	Time	Total	Prescriber (sign + print)	Given By
7/10	Oxygen	~~Nasal~~ Mask	2 l/min	09:24	l/min	:	l/min	:			
	fentanyl	IV	50mcg	09:25	25mcg	09:52		:	75mcg	JMiller	JM
	midazolam	IV	2mg	09:25		:		:	2mg	JMiller	JM
24				:		:		:			
				:		:		:			
				:		:		:			
				:		:		:			

PERI-PROCEDURE CARE

	Time - Initials
Cannula site L ACF Size 22g ☐ Skin Prep ☑ Handwash ☐ Gloves ☐ Aseptic Insertion ☐ Dressing labelled Difficulties/complication/deviation from standard technique? YES ☐ NO ☑	
BIOPSIES TAKEN: ☑ OESOPHAGEAL ☐ GASTRIC ☐ DUODENAL ☐ CLO TEST ☐ COLON ☐ POLYP/S ☐ OTHER: Sigmoid bx	Number of Biopsy Pots (1)
Oral Suction required Yes ☐ or N/A ☑	
Diathermy: none required ☑ Monopolar ☐, Bipolar ☐ site	
Procedure Room Nurse initials* JM/AD	Date: 7/10/24

POST PROCEDURE

Procedure performed ☐ Upper GI Endoscopy ☑ Colonoscopy ☐ Flexible Sigmoidoscopy
☐ EUS ☐ Other (please specify):

PROCEDURE SUMMARY: procedure comfort mild ☑, moderate ☐, severe ☐

Withdrawal time: (For colonoscopy only).....

TREATMENT GIVEN:.. YES ☐ NO ☐... **Specify:**.....

Follow-up required: N/A ☐, YES ☑ If YES, *specify* CT colon + await path

Please refer to Discharge Summary Yes ☐ N/A ☑

SPECIFIC INSTRUCTIONS TO STAFF POST-PROCEDURE:
Rectosigmoid stricture - unable to pass with PCF

Patient can DRINK Yes ☑ NO ☐ after ..... ☐	Patient can EAT Yes ☑ NO ☐ after ..... ☐
Suitable for NURSE-LED DISCHARGE? YES ☑ NO ☐	
Endoscopist's signature: JMiller	Date and time: 7.10.24 10.10
Print name: J. Miller	Designation: ST7

Approved: Dec 2023
Review: Dec 2026

NHS

610041369B M 12/10/1960
Sanderson, George
16/17 Pirrie Street, [illegible] ph, or
Nar Edinburgh,
EH6 5HY
DO
CHI 1210601451
Hospital no, Chowings 70179 JS

Endoscopy Unit
Integrated Care Pathway (ICP)
POST PROCEDURE AND DISCHARGE CRITERIA

POST PROCEDURE			Initials	Comments p8
1	Trolley lowered, bed rails in situ, buzzer given	Y ☑ N/A ☐	initials	12:00
2	Observations recorded: on return *time* 1010	Y ☑ N/A ☐	initials	NBM & CT scan
	at 30mins	Y ☑ N/A ☐	initials	
	after 1 hour	Y ☐ N/A ☐	initials	
NOTE: Obs regime to follow is O_2 sats, TPR, BP Sedation, Pain & Nausea scores [recorded on page 4]				

DISCHARGE CRITERIA			Initials	Comments p8
1	Discharged/Reviewed by Endoscopist ND	Y ☑ N/A ☐	initials	After CT Scan
2	Transport home arranged Collection time: 1145	Y ☑ N/A ☐	initials	1230.
3	Vital signs stable and satisfactory	Y ☑ N/A ☐	initials	
4	Alert and orientated (as on admission)	Y ☑ N/A ☐	initials	
5	Pain controlled	Y ☑ N/A ☐	initials	
6	Nausea controlled, no vomiting	Y ☑ N/A ☐	initials	
7	Tolerating fluids/~~diet~~ clear fluids only for CT scan [If Throat Spray, drink at 30mins after receiving spray]	Y ☑ N/A ☐	initials	
8	Mobilising as on admission	Y ☑ N/A ☐	initials	
9	Patient told if further pathological specimens will be available, from whom and when	Y ☑ N/A ☐	initials	
10	Patient informed when needs to restart anticoagulants	Y ☐ N/A ☑	initials	
11	Discharge information given	Y ☑ N/A ☐	initials	
12	IV cannula removed	Y ☐ N/A ☑	initials	CT to remove
13	Identity bracelet removed	Y ☐ N/A ☐	initials	
14	Collected by a responsible adult	Y ☐ N/A ☐	initials	
15	Responsible adult at home for first 24h	Y ☐ N/A ☐	initials	
DISCHARGE CRITERIA MET? YES ☑ **NO*** ☐ (*record as variance)			initials	
Patient discharged or back to relative/carer/support person ☑ **or N/A** ☐			initials	
Time patient left the department: 1200			initials	

CT dept aware that patients cannula is to be removed prior to D/C where

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Endoscopy Unit Integrated Care Pathway (ICP) Multi disciplinary Progress Notes/Problems	Addressograph, or Name: DOB: Hospital no/CHI:

Date/time	Include action taken, investigations required	Signature, print name/ designation
2 July 10:00	Difficult to proceed past Sigmoid so procedure stopped. PCF unable to proceed any further, biopsies obtained and sent. Patient awake colonoscopy was not completed. No complications noted.	DoD

Surgical Safety Checklist

(adapted for Endoscopy Unit, WGH NHS Lothian)

NHS Lothian

6100413698 M 12/10/1960
Sanderson, George
16/17 Pirrie Street,
Edinburgh,
EH6 5HY

CHI 1210601451
70179 JS Chowings –

DATE	7/10/24
ROOM	1
SITE	WGH
OPERATOR	Dr Vaughan-Shaw
PROCEDURE	colonoscopy

Please complete ALL boxes

SIGN IN (To be read out loud)

Pre-procedure

Member verbally confirms with the team:	YES	NO
All staff followed hand hygiene protocol?	☑	☐
Patient confirmed his/her identity, procedure and consent	☑	☐
Discussion with patient raising R. arm to withdraw consent during procedure	☑	☐
Correct case notes available?	☑	☐
Confirmed scope number and label match and scope within time limit	☑	☐
Confirm endoscopist & nurse checked medication	☑	☐ N/A
Confirm with endoscopist amount given	☑	☐ N/A
Initial or Signature:	[signature]	

SIGN OUT (To be read out loud)

Post-procedure

Member verbally confirms with the team:	YES	NO
All staff followed hand hygiene protocol?	☑	☐
Have the specimens been labelled correctly	☑	☐ N/A
Is a follow up appointment required?	☐	☐ N/A
Patient follow up details placed in relevant sheet in secretary's office	☐	☐ N/A
Confirm amount medication being discarded	☑	☐ N/A
Initial or Signature:	[signature]	

Please record any Issues Identified

Await pathology

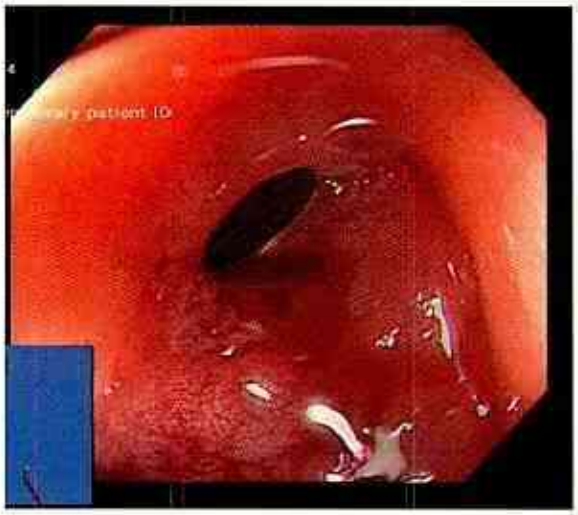
NHS Lothian

Western General Hospital, Edinburgh

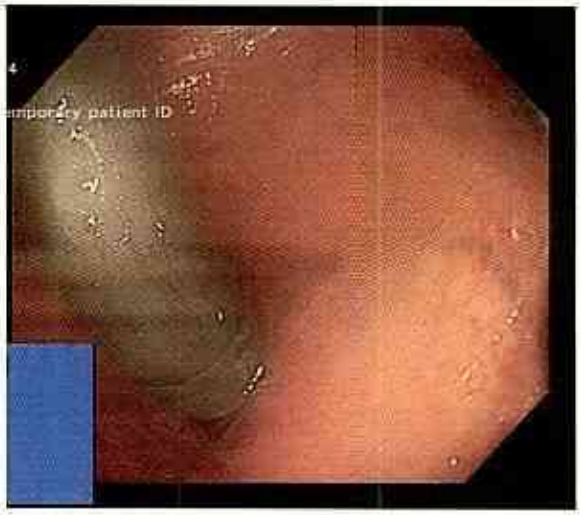
COLONOSCOPY REPORT

Name:	**George SANDERSON (M)**	Address:	**16-17 Pirrie Street**
Date of birth:	**12/10/1960**		**Leith**
CHI No:	**1210601451**		**Edinburgh**
Case note no.:	**6100413698**		**EH6 5HY**

Procedure date: **7th October 2024 (09:23)**



Site a: Rectosigmoid junction
Calibre: obstruction.



Site b: Anal margin

Peter Vaughan-Shaw
Consultant

NHS Lothian

Western General Hospital, Edinburgh

COLONOSCOPY REPORT

Name:	**George SANDERSON (M)**	Address:	**16-17 Pirrie Street**
Date of birth:	**12/10/1960**		**Leith**
CHI No:	**1210601451**		**Edinburgh**
Case note no.:	**610041369B**		**EH6 5HY**

GP: **CHOWINGS, JEREMY**
Leith Surgery
2 Duke Street
Edinburgh
EH6 8HQ

Procedure date: **7th October 2024 (09:23)**
Priority: **Urgent**
Hospital: **Not specified**

Indications
Altered bowel habit - loose stools.
Clinically important comments: CIBH, qFIT 142, 102. Admission to ICU with Campylobacter sepsis Jan 24.

Consultant/Endoscopist
List consultant: Peter Vaughan-Shaw
Endoscopist No1: Peter Vaughan-Shaw
Endoscopist No2: Janice Miller
Nurses: S/N Jackie Moloney
Staff Nurse Andrea Davies, S/N

Report
Bowel preparation with plenvu was good
The colon was insufflated with CO2.
A digital rectal examination was performed.
The colonoscope was inserted via the anus to the recto-sigmoid, insertion confirmed by Anatomy & Scope Guide and limited by stricturing lesion rectosigmoid - unable to pass with PCF. The scope was retroflexed in the rectum.
There were no peri-operative complications.

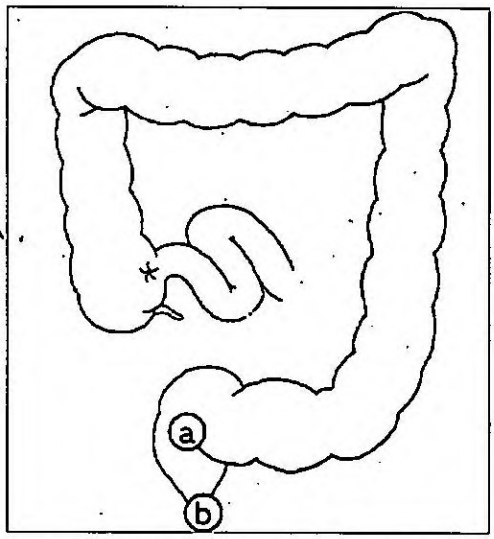
Site a: Rectosigmoid junction
Calibre: obstruction.
Specimens: 4x biopsy.

Instrument
CF HQ290L 2953174

Premedication
Fentanyl (IV) 75 mcg
Midazolam (IV) 2 mg

Diagnosis
Inflammatory stricture.

Advice/comments
Narrowed rectosigmoid, likely diverticular. Biopsies taken. For urgent CT colonoscopy. Patient complains of urgency and frequency, up to 5x per day. NB pictures are suggestive of a diverticulum, but the colonic mucosa was visible beyond this. Unable to pass despite PCF.



a: *Rectosigmoid junction (photographed)*
b: *Anal margin (photographed)*

Peter Vaughan-Shaw
Consultant
c.c. Sanderson, George

NHS

610041369B M 12/10/1960
Sanderson, George
16/17 Pirrie Street,
Edinburgh,
EH6 5HY
CHI 1210601451
70179 JS Chowings

Consent Form for a Colonoscopy (with Plenvu)

Name of procedure/investigation: Colonoscopy

Inspection of the colon using a flexible scope – with or without a biopsy and/or a polypectomy.
Please read the patient information leaflet for further details: Colonoscopy with Plenvu version 1.0

This procedure will involve:
Intravenous analgesia ☑ Inhaled analgesia (Entonox) ☐ Sedation ☑ None ☐

Following a request for further information: Statement of the healthcare professional

With appropriate knowledge of the proposed procedure, I have explained the procedure to the patient, in particular:

The intended benefits of the procedure: As discussed

The possible risks involved. I have discussed and listed below the significant, unavoidable and/or frequently occurring risks, including any risks that may be of specific concern to the patient:

Risks specific to colonoscopy are bleeding, perforation, incomplete procedure, and missed pathology

Patient is aware of the risks

The benefits and risks of alternative treatments that might be offered for this patient – including the option of no treatment: As discussed

Any extra procedure(s) that might become necessary during this procedure
e.g. blood transfusion ☑ Other procedure (please state) ☑ CT Scan

Healthcare Professional's signature:
Print name and job title: Janice French SN

Date: 7/16/24

Statement of interpreter *(where appropriate)*

I have interpreted the information above to the patient/parent to the best of my ability and in a way in which I believe that she / he / they can understand

Signature:
Print name:
Or, please note the telephone interpreter ID number:

Date: __/__/__

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To the patient
You have the right to change your mind at any time, including after you have signed this consent form. I have read and understood the information in the patient information leaflet. I confirm that the risks, benefits and alternatives of this procedure have been discussed with me and that my questions have been answered to my satisfaction and understanding. I wish to proceed with the planned procedure.

Signature: G S Print name: GEORGE SAWDERSON	Date: 7/10/24
If signing for a child or young person *(delete if not applicable)* I confirm that I am a person with parental responsibility for the patient named on this form:	
Signature: Relationship to the patient:	Date: __/__/__
If the patient is unable to sign but has indicated his/her consent, a witness should sign below:	
Signature (Witness) Print name: Address:	Date: __/__/__

Confirmation of Consent (where the procedure/treatment has been discussed in advance)	
On behalf of the team treating the patient, I have confirmed with the patient that she/he has no further questions and wishes the treatment/procedure to go ahead.	
Healthcare Professional's signature: Print name and job title: Janice French SIN	Date: 7/10/24

Withdrawal of patient consent	
The option of withdrawing consent has been discussed and agreed by the team treating the patient.	
Signature: G S Print name: G. SAWDERSON	Date: 7/10/24
Healthcare Professional's signature: Print name and job title: Janice French SIN	Date: 7/10/24

Lothian NHS Board

Anaesthetics, Theatres & Critical Care
Anne Ferguson Building
Western General Hospital
Crewe Road South
EDINBURGH EH4 2XU

Telephone 0131 537 1652

www.nhslothian.scot

Mr Peter Vaughan-Shaw
Consultant Colorectal Surgeon
Western General Hospital
Crewe Road South
EDINBURGH EH4 2XU

Date 4 April 2025
Your Ref
Our Ref 610041369B
CHI 1210601451

Enquiries to Anaesthetics Department
Extension 31652
Direct Line 0131 537 1652

Dear Mr Vaughan-Shaw

Re: George Sanderson, 16/17 Pirrie Street, Edinburgh, EH6 5HY

Thank you for your referring this 64 year old gentleman to the Anaesthetic Consultant Led Clinic who I reviewed today alongside Senior Anaesthetic Registrar, Dr Reema Patel and this gentleman's partner, Jacqueline Martin. I understand he has a structure in the left side of his colon and that your assessment is that this is currently likely to be a benign structure. This gentleman has presented with changes in bowel habit, primarily manifesting as urgency and frequency, these symptoms are persisting and are significant ongoing burden to him.

Past Medical History:
Respiratory
Smoking 40 cpd from teenage years
Formal COPD diagnosis 2015

- Managed by his General Practitioner
- Manifested in morning cough, productive of clear phlegm
- Intermittent wheeze
- Infrequent infective exacerbations
- No evidence of oral steroids or antibiotics in the last 24 months
- No attendances at the Emergency Department or Acute Services for breathlessness

Cardiovascular
Hypertension and some evidence of LVH back in 2011
He describes no history of MI, angina, palpitations, PND, orthopnoea, stroke or TIA
I note some evidence of vascular disease by way of an incidental finding of SMA stenosis on his CT colon.

Other
Benign Prostatic Hypertrophy
ITU admission January 2024 with Campylobacter enterocolitis

Our Values Into Action
disability confident LEADER
CARER POSITIVE Employer in Scotland EXEMPLARY
We are a Living Wage Employer

Headquarters
Mainpoint
102 West Port
Edinburgh EH3 9DN

Chair Professor John Connaghan CBE
Chief Executive Professor Caroline Hiscox
Lothian NHS Board is the common name of Lothian Health Board

- Septic shock
- AKI
- Acidosis
- Deranged clotting

Managed with vasopressors, antibiotics and Vitamin K.

Medications:
Penicillin Allergy – rash and an episode of collapse

Zerobase
Sildenafil (PRN) (should admit for 72 hours prior to any planned general anaesthetic)
Anoro Ellipta – 1 puff daily
Salbutamol – 2 puffs as required (used approximately x2 per day)
Beclomethasone nasal spray
Tamsulosin modified release OD
Simvastatin 40mg nocte
Omeprazole 20mg OD
Naproxen
Lisinopril 10mg OD
CosmoCol sachets

Function:
He is currently independent with his ADLs such as dressing and showering. He ambulates through activities such as walking room to room and a single flight of stairs with no shortness of breath and without stopping. He works as a bin lorry driver and manages to walk his dog a few miles at a time most days and enjoys activities such as fishing without being limited by breathlessness.

Impression and Summary:
I discussed with him today that he does an elevated risk profile with regards to cardio/respiratory complications. Using the NSQIP calculator, I described potential serious complications for a laparoscopic procedure as a risk of have one of an adverse cardiac event, such as a heart attack or sudden stopping of the heart, pneumonia, kidney failure, blood clot in the legs or the lungs, a need to return to the operating theatre due to a problem, wound infection, sepsis, intubation, reintubation post operatively, kidney failure, urinary tract infection or wound disruption.

An indicative risk of having one of these complications in the first 30 days was estimated approximately 15% compared to an average risk of one of these complications being 7.3%. An estimated mortality or risk to life at approximately 3.4% (average 0.3%) and using the ARISCAT score to estimate the risk of post operative pulmonary complications (a composite including respiratory failure, infection, pleural effusion, atelectasis, pneumothorax, bronchospasm, aspiration pneumonitis) with an estimated risk of approximately 13% of an in-hospital post operative pulmonary complication. In discussing this with him, I have emphasised that fact that does have a vulnerable chest and that a significant post operative respiratory complication could carry a risk to

his life. He has articulated that from his perspective his symptoms are a significant ongoing burden for him and that would still like to pursue a surgical option.

General Practitioner:
Dear GP
This 64 year old gentleman is currently being considered for a major bowel resection and has indicated to me today that he would seriously consider smoking cessation and would be willing to engage with any smoking cessation services the Primary Care Team would be able to offer him.

Kind regards.

Yours sincerely

Michael Wylie

Dr Michael Wylie
Consultant Anaesthetist
Western General Hospital

cc Dr J S Chowings, GP, Leith Surgery
George Sanderson, Patient

NHS Lothian

Western General Hospital
Outpatient Department
Ground Floor
Anne Ferguson Building
Crewe Road South
Edinburgh EH4 2XU

Preoperative Assessment

Dr Chowings
Leith Surgery
2 Duke Street
Edinburgh
EH6 8HQ

Date: 11/04/2025

Outpatient Clinic Letter

Patient	George Sanderson 16/17 Pirrie Street Edinburgh EH6 5HY	**CHI** **Date of Birth / Age** **UHPI**	**1210601451** 12/10/1960 (64 years) 610041369B
Attendance Date	03/04/2025		
Consultant	WGH Preoperative Assessment Anaesthetic Clinic		

Dear Dr Chowings

This patient with a likely benign diverticular stricture has now had an anaesthetic assessment. There are some concerns with regards to his ongoing smoking and I think in the first instance, it would be best to see if he could give this up for a couple of months prior to surgery. This would be very helpful in terms of reducing the risks around the time of his operation. I am afraid that given the scan which shows a significant narrowing of his arteries, a join in the bowel would be quite dangerous and it is likely that he will need a stoma at the time of surgery (Colostomy).

I have suggested in the first instance, I see him back in my clinic, in a couple of months time to see how he is getting on.

Yours Sincerely

Mr Peter Vaughan-Shaw
Consultant Colorectal Surgeon

Ref PGVS/DT

Cc - Patient

Name: George Sanderson

D.O.B.

CHI Number: 1210601451

(Attach printed label here)

CHRONOLOGICAL PROGRESS SHEET

3/4/25 HOME WGH
letter TRAK
HC 170 wt 57.6 BMI

Date & Time	Problem No.		Signature (& print) Designation
		Allergy – Penicillin 57.6kg Sats 96% RA HC 170cm wt 57.6kg BMI	
3/4/25	(64) →	Partner – J. Mark	Hgb 142
		PVS – likely benign structure left Colon	Plt 276
Urgency	Email	→ ? Lap hist antiox resection	Vit D ✓ eGFR >60
		Surgical smoking hx 75 pack yr hx	
	Urgency / diarrhoea	– CT Colo. – incidental SMA Stenosis	
		Subpleural bands	
		Gall 24 – failed to get Hyal titre @ colonoscopy	
	R-o-M ?		
PMHx		Jan 24	
Respiratory	– Smoking	– Campylobacter enterocolitis	
		Septic Shock	
	COPD (2015)	AKI	Mx – Vasopressor
		Acidosis	Antibiotics
Mx – GS		Pericarditis	
– Morning cough	– productive clear phlegm	dthy → v.l hx	
– wheeze – few times/week			
– Interferon IE 24 month			
CVS	– LVH 2011		
	Hpt	Function –	
ΦMI / ΦAngina / ΦPE/pulm / epilepsy / Vertigo		ADLs – Dressed	✓
ΦStroke / ΦTIA		Showered	✓
		Rem Rom – ok	✓
BPH		Stairs – ok – ΦSOB / ΦJelly	
		Works – B.A long drive	
		Walk dog few mile	SR/nAxis ECG ✓
Medications	Penicillin – ~~Allergy~~ – Rash Hi-Collapse	Fishing	Consider
Zerbaxa	Cosmocol sachets		– PFTs X
Sildenafil (PRN)			– ECHO X
Anoro Ellipta 55/25mcg 1 puff OD		NSAIDS – Serum creatinine	
Beclomethasone nasal spray		15% (Average 7%)	
Tranexamic acid 500mg	MR OD	Methotrexate 3% (Average 0.3%)	
Simvastatin 40mg	Noote	ARB/ACEI 13% Computer	✓
Salbutamol 1 puff (PRN)	X2/day	Inhaler Patient compliant	
Omeprazole 20mg OD	with Naproxen		
Naproxen 500mg BD		letter dictated ✓	

M. White

SANDERSON, GEORGE ID:1210601451 03-Apr-2025 09:48:07 NHS LOTHIAN-WGHECG ROUTINE RECORD

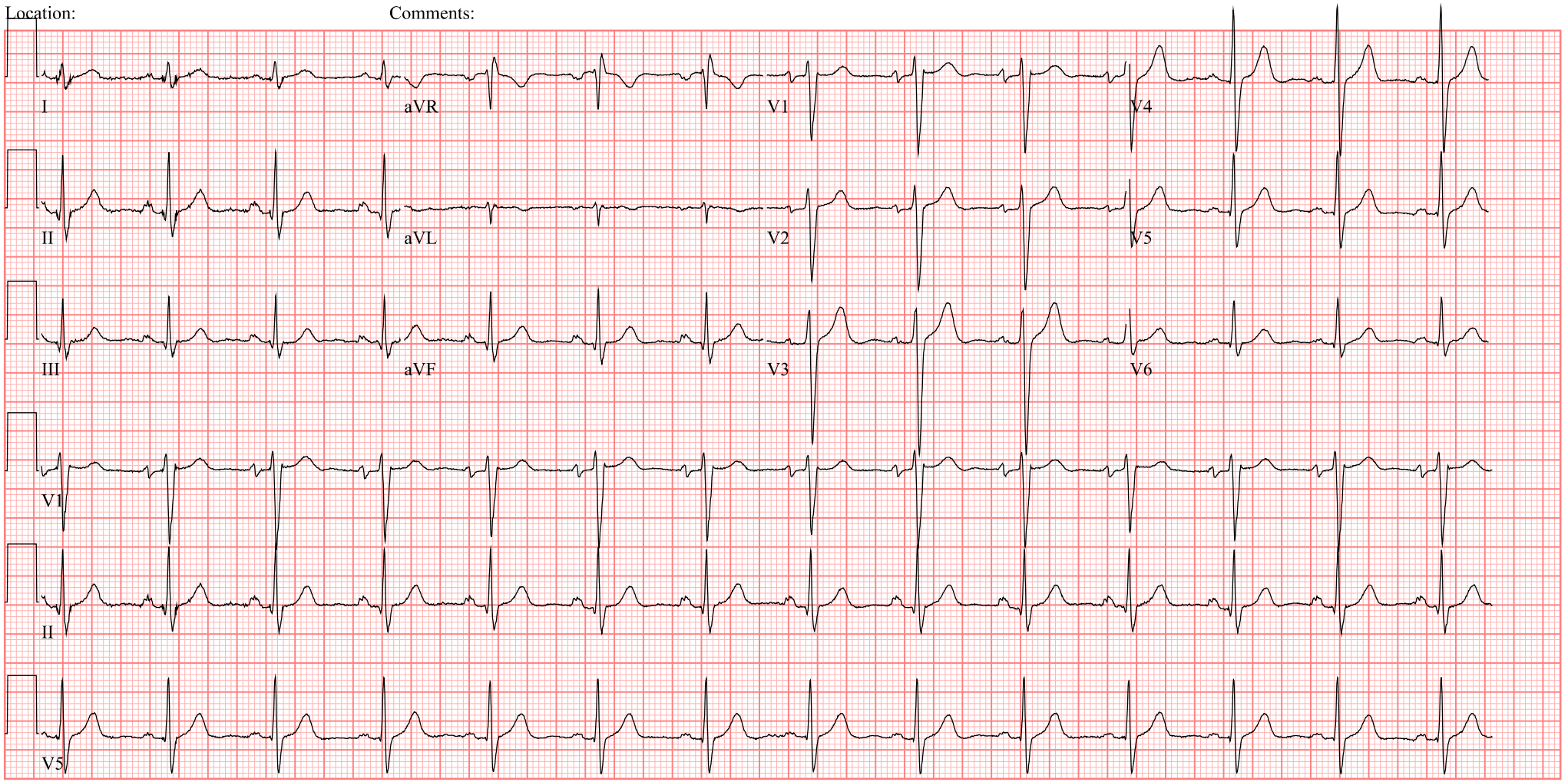
12-Oct-1960 (64 yr)
Male

Room:
Loc:310

Vent. rate	82	BPM
PR interval	142	ms
QRS duration	98	ms
QT/QTcB	342/399	ms
P-R-T axes	71 82	65

Technician: cc
Test ind:

Location: Comments:



25mm/s 10mm/mV 150Hz 10.1.3 12SL 243 CID: 62623

SID: 1053422 EID: 13 EDT: ORDER:

NHS Lothian

Western General Hospital
Outpatient Department
Lower Ground Floor
Anne Ferguson Building
Crewe Road South
Edinburgh EH4 2XU

Colorectal General Surgery

Dr Chowings
Leith Surgery
2 Duke Street
Edinburgh
EH6 8HQ

Date: 09/04/2025

Outpatient Clinic Letter

Patient	George Sanderson 16/17 Pirrie Street Edinburgh EH6 5HY	**CHI** **Date of Birth / Age** **UHPI**	**1210601451** 12/10/1960 (64 years) 610041369B
Attendance Date	24/03/2025		
Consultant	Mr Peter G Vaughan-Shaw		

Dear Dr Chowings

This patient had a bowel colonoscopy in October due to some diarrhoea and a raised qFIT sample. We were unable to get through an area of sigmoid disease, with some diverticular disease, which was felt to have a stricture in it. A completion CT colonoscopy demonstrated no other concerns, but was somewhat limited given the failure of the left side of the bowel to filly inflate. George has continued issues with loose stool, up to seven times per day, significant faecal urgency, frequency and some incontinence. This is clearly difficult for him with his job as a bin lorry driver. He also feels he has lost some weight of around ten pounds. He is not clearly getting significant abdominal distension or abdominal pain. He is complaining of some left-sided lower groin pain.

Whilst past medical history is relatively unremarkable, there is a history of COPD and George is a lifetime smoker, up to thirty times per day. He was also admitted that last year with campylobacter gastroenteritis, requiring ICU admission perhaps suggesting some fragility. Furthermore, as noted on a CT scan that there is 50% stenosis of his SMA suggesting the risk of mesenteric supply to his colon and any bowel anastomosis.

On examination, the abdomen is soft non-tender with no masses or organomegaly. There are no surgical incisions, no distension and no masses. There is no clear hernia felt in the left groin.

I have today explained the findings from the scan and the camera test with aid of a diagram. I have explained that this is felt that this is likely to be diverticular disease, although we have been unable to fully exclude bowel cancer. Ultimately, the only option going forward I think would be to leave things as they are and accept his current symptoms or proceed to a bowel operation. George presented with his partner today and they are aware of the enormity of a major bowel operation, especially in terms of his smoking history and his lungs. They are aware of the risk of death, risk to bowel, anastomotic leak (leakage in the bowel join), risk of heart attack, stroke, bleeding or blood clots following surgery.

Given that this is not clearly cancer and the potential surgical risks, I have today requested a high risk surgical clinic

for George to ensure we are not considering surgery which would ultimately have too high a pre-optive risk profile. Once, I have results from this I will feed back to George and we will move forward from there. I am afraid there is no clear symptomatic advice to give at present.

Many thanks,

Yours sincerely

Mr Peter Vaughan-Shaw
Consultant Colorectal Surgeon

Ref: PGVS/HM
Dictated 24th March 2025
cc - Patient

Mr George Sanderson
16/17 Pirrie Street
Edinburgh
EH6 5HY

University Hospitals Division

Western General Hospital
Crewe Road South
Edinburgh
EH4 2XU

NHS Lothian

Preoperative Assessment

Dr Chowings
Leith Surgery
2 Duke Street
Edinburgh
EH6 8HQ

Date First Created: 26/03/2025
Date/Time Printed: 15/05/2026 10:49
Our Ref: 610041369B
CHI: 1210601451

Patient:	Mr George Sanderson 16/17 Pirrie Street Edinburgh EH6 5HY	**UHPI:** **Date of Birth:**	610041369B 12/10/1960
Specialty:	Preoperative Assessment	**Consultant:**	WGH Preoperative Assessment Anaesthetic Clinic

Dear Mr Sanderson

Re: Preoperative Assessment Anaesthetic Clinic Appointment

Your surgeon has requested that you attend for an anaesthetic assessment prior to consideration of surgery.

An appointment has been made for you in the Anaesthetic Assessment Clinic:

Specialty & Consultant: Pre-operative Assessment, WGH Pre-operative Assessment Anaesthetic Clinic

Date & Time: Thursday, 3rdApril 2025 at 09:00

The Clinic is situated within the Pre-Admission Clinic on the Ground Floor of the Anne Ferguson Building at the Western General Hospital (directly behind the cafeteria). Please note, parking at the hospital can be a challenge, please allow time for this, it is important to attend the appointment at the stated time.

If, for any reason you are unable to attend, please contact the Anaesthetics Department on 0131 537 1652. If the telephone is unattended please leave a brief message together with your name and contact telephone number.

Yours sincerely

NHS Lothian

Western General Hospital
Outpatient Department
Lower Ground Floor
Anne Ferguson Building
Crewe Road South
Edinburgh EH4 2XU

Colorectal General Surgery

Dr Chowings
Leith Surgery
2 Duke Street
Edinburgh
EH6 8HQ

Date: 11/12/2025

Outpatient Clinic Letter

Patient	George Sanderson 16/17 Pirrie Street Edinburgh EH6 5HY	**CHI** **Date of Birth / Age** **UHPI**	**1210601451** 12/10/1960 (65 years) 610041369B
Attendance Date	17/11/2025		
Consultant	Mr Peter G Vaughan-Shaw		

Dear Dr Chowings

I saw George in the follow-up clinic. He is having very little issues with his bowel. He opens his bowels once a day. There is no significant pain, no diarrhoea, no urgency or frequency, there is no instances or evidence of obstruction around the known sigmoid stricture. He continues to smoke and as such I think surgical intervention is not indicated and even if it was, it would have to be approached cautiously given his high risk of stoma and perioperative morbidity. As such, I am delighted his symptoms are minimal and as such I have today discharged him back to your care.

He should ensure plenty of fruit, fibre and fluid in the diet. If he is getting anything consistent with a hold-up in his large bowel, he might benefit from some osmotic laxatives and a low residue diet.

Many thanks,

Yours sincerely,

Mr Peter Vaughan-Shaw
Consultant Colorectal Surgeon

Ref: PGVS/HM
Dictated 18th November 2025
cc - Patient

Mr George Sanderson
16/17 Pirrie Street
Edinburgh
EH6 5HY

NHS Lothian

Immediate Outpatient Letter

Serial number 1138157

IN CONFIDENCE

Hospital : W + T Department : ..th J Consultant : (Cunn.

Name and address of General Practitioner

J. Chowings
Leith Surgery
EH6 8HQ.

Mr/Mrs/Miss

Surname:

First Name:

Address:

610041369B /E6268339 M
SANDERSON George
12-Oct-60 CHI: 121 060 1451
70179 JS Chowings
16/17 Pirrie Street
EH6 5HY

Weight (where applicable)

Your patient attended the clinic on: _____

Recommendations/comments:

Follow-up advice: To attend hospital for further review in _____

To attend GP surgery Y / N

Follow-up required Y / N

Medication: The following medicines are recommended. Only those items that must be initiated immediately have been provided from the hospital pharmacy, as indicated under the 'Quantity to be provided' section.

Pharmacy use:

Medicine and Form	Oose	Administration Times					Additional Instructions (including length of treatment course)	Quantity to be provided *	LIF **	Dispensed/ Issued by:	Checked by:
1. CO-CODAMOL	30/500						Max 8/24	7 DITH			
2.											
3.											
4.											
5.											
6.											

N.B. * A 14 day supply should be provided from the hospital if required unless a shorter or longer course is appropriate.

** Tick the box if the medicine is not on the Lothian Joint Formulary, and include an explanatory note for non-Formulary medicines under Recommendations/comments.

Prescribed by : _____ (sign) Date : 6/1/26

RTT _____ (print)

Contact for advice : _____ Tel/bleep no. : _____

WHITE COPY - TO PHARMACY *PINK COPY - G.P.* *BLUE COPY - CASENOTES*

RIE 334

Referrals

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

Endocrinology A81
L Basic SIGN Referral

Western General Hospital (S116H)
Crewe Road South
Edinburgh
EH4 2XU

Urgency of referral	Routine
Date of referral	21/10/2010
Date submitted	21/10/2010
UCPN	101001156984H

PATIENT DETAILS

Surname	SANDERSON
Forename(s)	GEORGE
Title	MR Sex Male
Date of birth	12/10/1960
CHI no.	1210601451
Previous Surname	

Address

16-17 PIRRIE STREET
LEITH
EDINBURGH
EH6 5HY

Contact number(s)

REFERRING PRACTITIONER DETAILS

Name	Dr. Roderick Scott
GMC code	2556943 GP code 49441
Practice name	LEITH WALK SURGERY (70179)
Practice code	70179

Practice address

60 LEITH WALK
EDINBURGH
EH6 5HB

Contact number(s)

Voice : 0131 554 6471

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: Hypogonadism

Comment: I would be most grateful for your assessment of this patient who presented initially with erectile dysfunction. He has borderline low testosterone and he has raised cholesterol and triglycerides,(he is on Simvastatin medication for this), and borderline thyroid function tests. I was considering prescribing testosterone replacement therapy for him but I would be grateful for your assessment and advice with respect to this. Thank you for seeing him.

Reason for referral

Care type requested: Out Patient - New

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & Medium Priority)

Description	Modifier	Extension	Start Date	Date Recorded
Multiple fractures of ribs		TRAUMATIC RIB #'S 2 PNEUMONIA	10/12/2006	10/12/2006
Meniere's disease			11/08/2005	11/08/2005
Acute meniscal tear, lateral, bucket handle tear			02/06/2005	02/06/2005

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
NICOTINE patch 14mg	02326002	patch(es)	APPLY DAILY dsip weekly		02/09/2010		02/09/2010
SIMVASTATIN tabs 10mg	06380001	tablet(s)	TAKE ONE AT NIGHT		13/05/2009		02/09/2010

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
NICOTINE patch 21mg	02326003	patch(es)	APPLY DAILY DISP WEEKLY		02/09/2010		02/09/2010
NICOTINE patch 21mg	02326003	patch(es)	APPLY DAILY DISP WEEKLY		19/08/2010		19/08/2010
CLARITHROMYCIN tabs 250mg	05468001	tablet(s)	TAKE ONE EVERY 12 HRS		19/08/2010		19/08/2010

Clinical warnings

Allergies

Description	Comment	Modifier	Start Date	Recorded Date
H/O: drug allergy	Drug code for allergy: PENICILLIN G inj 600mg/vial, Reaction type: Allergy, Read code for reaction: H/O: collapse [147C.00], Certainty of allergy: Likely, Severity of allergy: Moderate.			12/06/2008

Additional relevant information

Smoking history (Encounters): Cigarette smoker , Date recorded: 19-Aug-2010
Alcohol history (Encounters): Alcohol units per week , Date recorded: 13-May-2009
Exercise history (Encounters): Avoids even trivial exercise , Date recorded: 23-Apr-2009
Patient Weight in Kilograms:59
Patient Height in Metres:1.676

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

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

Cardiology A2
L General Cardiology

Western General Hospital (S116H)
Crewe Road South
Edinburgh
EH4 2XU

Urgency of referral	Routine
Date of referral	14/04/2011
Date submitted	15/04/2011
UCPN	101001868481M

PATIENT DETAILS

Surname	SANDERSON
Forename(s)	GEORGE
Title	MR Sex Male
Date of birth	12/10/1960
CHI no.	1210601451
Previous Surname	

Address

16-17 PIRRIE STREET
LEITH
EDINBURGH
EH6 5HY

Contact number(s)

REFERRING PRACTITIONER DETAILS

Name	Dr. Roderick Scott
GMC code	2556943 GP code 49441
Practice name	LEITH WALK SURGERY (70179)
Practice code	70179

Practice address

60 LEITH WALK
EDINBURGH
EH6 5HB

Contact number(s)

Voice : 0131 554 6471

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: Electrocardiographic LVH; normotensive; proposed commencement of Sildenafil

Comment: Dear Doctor I would be grateful for your advice and possible investigation of this patient. He initially presented with erectile dysfunction. As he had a borderline low testosterone and raised cholesterol triglycerides (already on Simvastatin for this), I considered prescribing testosterone replacement therapy at least in part, because of the cardiovascular risk associated with low testosterone. The upshot of the three visits to endocrinology unit however, was of the opinion that his testosterone level was normal and indeed his testosterone level when measured on subsequent occasions had risen from 9 to 16, now well within the normal limits. They did however, uncover a BP of 177/103 which led to an ECG, the result of which is attached. They recommended his prescription should be Sildenafil at a dose of 100 mg a day. In the event it transpires that 50 mg daily is a sufficient dose to provide a clinical affect. Having received the ECG showing left ventricular hypertrophy, I reviewed his BP which was taken in the surgery, which failed to show any significant level similar to that found at the endocrine clinic. I was therefore left wondering whether his LVH was purely an artefactual electrocardiographic finding, or whether there was a structural lesion unrelated to his modest, if at all, raised BP. Clinically he has no abnormal signs, in particular his lung fields are clear and his cardiac sounds are normal. I wondered whether it would be helpful to image this chap, to clarify whether there is any other cause for his LVH, or indeed whether he has that diagnosis. On a secondary point, I would be most grateful for your advice concerning the prescription of Sildenafil in this patient and the risks associated with that. I should mention that he has chest pain which I feel is musculoskeletal, related to his occupation working as a scaffold. It appears he has some muscle stiffness in the morning and I have encouraged him to massage these areas to see if this improves the symptoms. Thank you for seeing him. Yours faithfully Dr r J Scott

Investigations

Description	Result	Date
Other :	See letter text please.	

Reason for referral

Care type requested: Out Patient - New

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & Medium Priority)

Description	Modifier	Extension	Start Date	Date Recorded
Multiple fractures of ribs		TRAUMATIC RIB #'S 2 PNEUMONIA	10/12/2006	10/12/2006
Meniere's disease			11/08/2005	11/08/2005
Acute meniscal tear, lateral, bucket handle tear			02/06/2005	02/06/2005

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
SILDENAFIL tabs 50mg	10511002	tablet(s)	AS DIRECTED SLS		16/03/2011		16/03/2011
NICOTINE patch 14mg	02326002	patch(es)	APPLY DAILY		02/09/2010		15/11/2010

SIMVASTATIN tabs 10mg	06380001	tablet(s)	dsip weekly TAKE ONE AT NIGHT		13/05/2009	15/11/2010

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
OMEPRAZOLE gastro-res cap 20mg	05588001	capsule(s)	TAKE ONE DAILY WITH DICLOFENAC		13/04/2011		13/04/2011
DICLOFENAC SODIUM mr cap 75mg	01029001	capsule(s)	TWICE A DAY WIOTH OMEPRAZOLE		13/04/2011		13/04/2011

Clinical warnings

Allergies

Description	Comment	Modifier	Start Date	Recorded Date
H/O: drug allergy	Drug code for allergy: PENICILLIN G inj 600mg/vial, Reaction type: Allergy, Read code for reaction: H/O: collapse [147C.00], Certainty of allergy: Likely, Severity of allergy: Moderate.			12/06/2008

Additional relevant information

Smoking history (Encounters): Cigarette smoker , Date recorded: 16-Mar-2011
Alcohol history (Encounters): Alcohol units per week , Date recorded: 13-May-2009
Exercise history (Encounters): Avoids even trivial exercise , Date recorded: 23-Apr-2009
Patient Weight in Kilograms:59
Patient Height in Metres:1.676

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

ECG Department
Leith Community Treatment Centre
Junction Place, Edinburgh, EH6 5JQ
☎ *0131 – 536 6449* Fax *0131 536 6435*

NHS Lothian

Request Form

Patient	G.P.
Name: SANDERSON George DoB: 12/10/1960 CHI: 1210601451 M Addr: 16-17 Pirrie Street, Leith, Edinburgh, EH6 5HY Post code: *(essential if ambulance required)* Telephone no.	Name: Dr R J Scott Surgery: Leith Walk Surgery Address: 60 Leith Walk, Edinburgh 70179 49441 0131 554 6471 Telephone no.

Clinical details (including medication & B.P.)

152 | 102 — ↑ global HW scan
Re Rx ↑BP.

☑ **12 lead ECG** M Tu Th
open access [redacted] 0930-1230

☐ **Ambulatory E.C.G. Monitor**

Hospital choice:
☑ Leith CTC
☐ Roodlands General Hospital

☑ NHS patient
☐ private patient

I, Dr. Scott, agree for the above department/s to carry out the indicated test/s.

Date: 15.3.11

Please send requests to **ECG Department, Leith Community Treatment Centre, Junction Place, EDINBURGH EH6 5JQ. ☎ 0131 536 6449 Fax 0131 536 6435**

1210601451 24/03/2011 10:17:34 SANDERSON, GEORGE

Born 12/10/1960 Male

Dept: LEITH WALK (00)

Oper: GD

Rate	73	. Sinus rhythm.....normal P axis, V-rate 60- 99
		. Probable left ventricular hypertrophy.....multiple LVH criteria
PR	148	. ST elev, probable normal early repol pattern.....ST elevation, age<55
QRSD	98	
QT	353	
QTc	389	

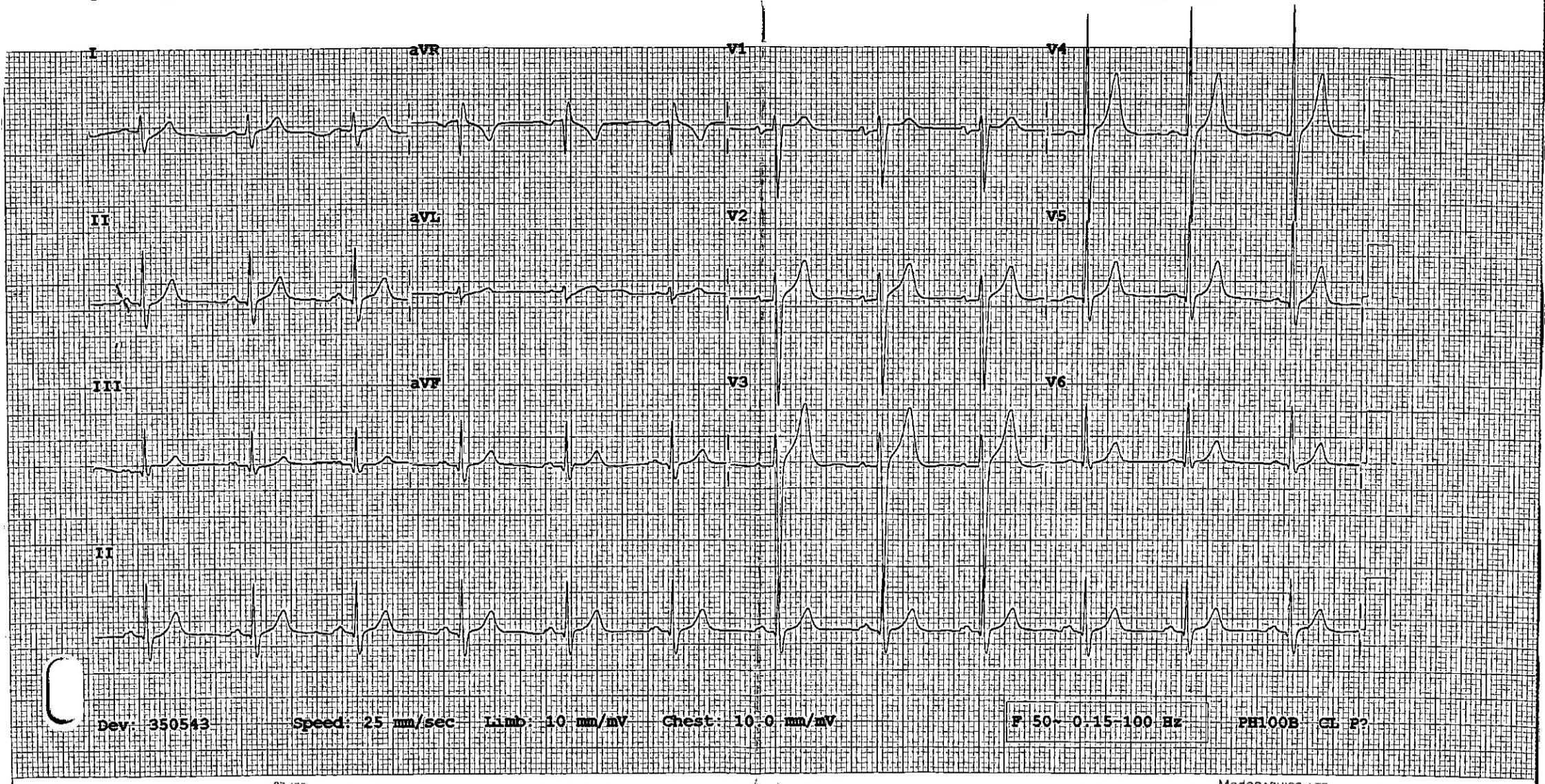
--AXIS--

P	49
QRS	71
T	46

- ABNORMAL ECG -

Requested by: SCOTT

Unconfirmed Diagnosis



MedGRAPHICS LTD

NHS Lothian - Imaging Request

Referral To	Leith Community Treatment Centre Clinical Radiology L Radiology Walk In
Urgency of referral	Routine
Date of referral	09/01/2015
Date submitted	09/01/2015

PATIENT DETAILS

CHI number:	1210601451
Name:	MR GEORGE SANDERSON
Date of birth:	12/10/1960
Sex:	Male

Contact Details

16-17 PIRRIE STREET
LEITH
EDINBURGH
EH6 5HY

Voice (Mobile) : 07598574131

REFERRING PRACTITIONER DETAILS

Name:	Dr Jeremy Chowings (GMC: 3681077)
Practice:	LEITH WALK SURGERY
Phone:	Voice : 0564765034

Practice address

LEITH WALK SURGERY
60 LEITH WALK
EDINBURGH
EH6 5HB

INVESTIGATION REQUESTED

Test Requested: Chest

Reason for Request: 3-4 cough and now severe wheezy bronchitis

CLINICAL INFORMATION

Investigations

Description	Result	Date
Chronic Cough :	true	
Please provide smoking status :	Smoker	
Could the patient be pregnant? :	Blank	

NHS Lothian - Imaging Request

Referral To	Leith Community Treatment Centre Clinical Radiology L Radiology Walk In
Urgency of referral	Routine
Date of referral	11/02/2015
Date submitted	11/02/2015

PATIENT DETAILS

CHI number:	1210601451
Name:	MR GEORGE SANDERSON
Date of birth:	12/10/1960
Sex:	Male

Contact Details

16-17 PIRRIE STREET
LEITH
EDINBURGH
EH6 5HY

Voice (Mobile) : 07598574131

REFERRING PRACTITIONER DETAILS

Name:	Dr Jeremy Chowings (GMC: 3681077)
Practice:	LEITH WALK SURGERY
Phone:	Voice : 0564765034

Practice address

LEITH WALK SURGERY
60 LEITH WALK
EDINBURGH
EH6 5HB

INVESTIGATION REQUESTED

Test Requested: Chest

Reason for Request: R sided signs on CXR in mid Jan. Rpt after antibiotics suggested end of |Feb.

CLINICAL INFORMATION

Investigations

Description	Result	Date
Infection :	true	
Please provide smoking status :	Smoker	
Could the patient be pregnant? :	Blank	

NHS Lothian - Imaging Request

Referral To	Leith Community Treatment Centre Clinical Radiology L Radiology Walk In
Urgency of referral	Routine
Date of referral	26/03/2015
Date submitted	26/03/2015

PATIENT DETAILS

CHI number:	1210601451
Name:	MR GEORGE SANDERSON
Date of birth:	12/10/1960
Sex:	Male

Contact Details

16-17 PIRRIE STREET
LEITH
EDINBURGH
EH6 5HY

Voice (Mobile) : 07598574131

REFERRING PRACTITIONER DETAILS

Name:	Dr Jeremy Chowings (GMC: 3681077)
Practice:	LEITH WALK SURGERY
Phone:	Voice : 0564765034

Practice address

LEITH WALK SURGERY
60 LEITH WALK
EDINBURGH
EH6 5HB

INVESTIGATION REQUESTED

Test Requested: Chest

Reason for Request: Further FU XR as advised - patient clinically better, attending smoking cessation and diagnosed with COPD

CLINICAL INFORMATION

Investigations

Description	Result	Date
Infection :	true	
Please provide smoking status :	Smoker	
Could the patient be pregnant? :	Blank	

NHS Lothian - Imaging Request

Referral To	Leith Community Treatment Centre Clinical Radiology L Radiology Walk In
Urgency of referral	Routine
Date of referral	07/05/2015
Date submitted	07/05/2015

PATIENT DETAILS

CHI number:	1210601451
Name:	MR GEORGE SANDERSON
Date of birth:	12/10/1960
Sex:	Male

Contact Details

16-17 PIRRIE STREET
LEITH
EDINBURGH
EH6 5HY

Voice (Mobile) : 07598574131

REFERRING PRACTITIONER DETAILS

Name:	Dr. Jeremy Chowings (GMC: 3681077)
Practice:	Leith Walk Surgery (70179)
Phone:	Voice : 0131 554 6471

Practice address

60 Leith Walk
Edinburgh
EH6 5HB

INVESTIGATION REQUESTED

Test Requested: Chest

Reason for Request: FU XR as advised. Pt clinically better and diagnosed with COPD since. DNA'd last XR request

CLINICAL INFORMATION

Investigations

Description	Result	Date
Could the patient be pregnant? :	Blank	

NHS Lothian - Imaging Request

Referral To	Leith Community Treatment Centre Clinical Radiology L Radiology Walk In
Urgency of referral	Routine
Date of referral	11/06/2015
Date submitted	11/06/2015

PATIENT DETAILS

CHI number:	1210601451
Name:	MR GEORGE SANDERSON
Date of birth:	12/10/1960
Sex:	Male

Contact Details

16-17 PIRRIE STREET
LEITH
EDINBURGH
EH6 5HY

Voice (Mobile) : 07598574131

REFERRING PRACTITIONER DETAILS

Name:	Dr Jeremy Chowings (GMC: 3681077)
Practice:	LEITH WALK SURGERY
Phone:	Voice : 0564765034

Practice address

LEITH WALK SURGERY
60 LEITH WALK
EDINBURGH
EH6 5HB

INVESTIGATION REQUESTED

Test Requested:	**Shoulder left**
Reason for Request:	Pain in both shoulders L>R for many months but good ROM with some crepitus. Deep nagging ache worse than clinical findings?? Any obvious bony abnormality?

CLINICAL INFORMATION

Investigations

Description	Result	Date
Suspected :	Arthritis	
Could the patient be pregnant? :	Blank	

NHS Lothian - Referral Letter

Referral To	Western General Hospital Urology L Prostate Disease
Urgency of referral	Urgent - Suspected Cancer
Date of referral	03/09/2018
Date submitted	03/09/2018
UCPN	101016892500J

PATIENT DETAILS

CHI number:	1210601451
Name:	MR GEORGE SANDERSON
Date of birth:	12/10/1960
Sex:	Male

Contact Details

16-17 PIRRIE STREET
LEITH
EDINBURGH
EH6 5HY

Voice (Mobile) : 07598574131

REFERRING PRACTITIONER DETAILS

Name:	Dr. Jeremy Chowings (GMC: 3681077)
Practice:	Leith Surgery (70179)
Phone:	Voice : 0131 554 6471

Practice address

2 Duke Street
Edinburgh
EH6 8HQ

CLINICAL INFORMATION

Reason for Referral: Abnormal feeling prostate on examination

Main Referral Text:

Dear Doctor

I'd be grateful for your review of this gentleman who has been complaining of increasing prostate-type symptoms over the past 12 months, including nocturia twice at night, a poor stream and increased frequency. A PSA undertaken by one of my colleagues in the Summer was normal (result attached).

On routine rectal examination today he had an abnormal feeling prostate. The right lobe of the prostate felt significantly harder and the sulcus was not as obvious as normal. I am aware there is a good chance that this could still turn out to be a benign condition and both myself and Mr Sanderson are happy to manage this here in primary care, if this turns out to be the case.

Many thanks for your help in this matter.

Kind regards

Dr J Chowings

Examinations and Investigations

Description	Result	Date
Enlarged Prostate? :	true	
Altered Texture of Prostate? :	true	

Investigations

Description	Result	Date
IPSS Total Score :	8-19 (Moderate)	
PSA :	Not Done	
Urinalysis :	Result Normal	
U&E :	Result Normal	

Pre-existing conditions (High & Medium Priority)

Description	Modifier	Extension	Start Date	Date Recorded
[X]Depressive episode	New event		30/08/2018	30/08/2018
Chronic obstructive pulmonary disease	New event		26/03/2015	26/03/2015
Essential hypertension	New event		28/06/2011	28/06/2011

Left ventricular hypertrophy	New event		28/06/2011	28/06/2011
Multiple fractures of ribs		TRAUMATIC RIB #'S 2 PNEUMONIA	10/12/2006	10/12/2006
Meniere's disease			11/08/2005	11/08/2005
Acute meniscal tear, lateral, bucket handle tear			02/06/2005	02/06/2005

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

Drug name	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Naproxen 500mg tablets	tablet	1 TABLET TWICE DAILY WITH MEA[more]		28/04/2017		05/06/2018
Hypromellose 0.3% eye drops	ml	INSTIL ONE DROP UP TO ONCE EV[more]		07/02/2018		05/06/2018
Umeclidinium bromide 65micrograms/dose / Vilanterol 22micrograms/dose dry powder inhaler	dose	1 INHALATION ONCE DAILY		10/05/2017		05/06/2018
Salbutamol 100micrograms/dose inhaler CFC free	dose	1 TO 2 PUFFS UP TO FOUR TIMES[more]		26/03/2015		05/06/2018
Simvastatin 40mg tablets	tablet	TAKE ONE AT NIGHT		13/05/2009		05/06/2018
Sildenafil 100mg tablets	tablet	ONE AS NEEDED SLS RULES		16/03/2011		05/06/2018
Omeprazole 20mg gastro-resistant capsules	capsule	TAKE ONE DAILY WITH NAPROXEN		01/09/2011		05/06/2018
Lisinopril 20mg tablets	tablet	TAKE ONE DAILY		19/10/2011		05/06/2018

Clinical warnings

Allergies

Description	Comment	Modifier	Start Date	Recorded Date
H/O: drug allergy	Drug code for allergy: Penicillin G 600mg/vial injection, Reaction type: Allergy, Read code for reaction: H/O: collapse [147C.00], Certainty of allergy: Likely, Severity of allergy: Moderate.			12/06/2008

Additional information

Referral to:Suspected Cancer Clinic

Smoking history (Encounters):Current smoker Date recorded:18-Jun-2018

Alcohol history (Encounters):Alcohol consumption Date recorded:24-Jan-2018

Exercise history (Encounters):Exercise grading Date recorded:24-Jan-2018

Patient Weight in Kilograms:59

Patient Height in Metres:1.68

NHS Lothian - Referral Letter

Referral To	Western General Hospital General Surgery - Colorectal (Urgent) LI Urgent Colorectal Cancer
Urgency of referral	Urgent - Suspected Cancer
Date of referral	22/08/2024
Date submitted	22/08/2024
UCPN	1010339795546

PATIENT DETAILS

CHI number:	1210601451
Name:	MR GEORGE SANDERSON
Date of birth:	12/10/1960
Sex:	Male

Contact Details

16-17 PIRRIE STREET
LEITH
EDINBURGH
EH6 5HY

Voice (Mobile) : 07742013232

REFERRING PRACTITIONER DETAILS

Name:	Dr. Jeremy Chowings (GMC: 3681077)
Practice:	Leith Surgery (70179)
Phone:	Voice : 0131 554 6471

Practice address

2 Duke Street
Edinburgh
EH6 8HQ

CLINICAL INFORMATION

Reason for Referral: 8 weeks of loose stools not settling

Main Referral Text:

Dear Dr,

I would value your assessment of this gentleman who has had loose stools 3-4 x a day for about 2 months. he previously opened his bowels 1 x a day. Examination of rectum and abdomen are unremarkable except for some piles.

He had an admission with campylobacter in January 2024 but symptoms had fully resolved long before this new change.

I have repeated his stool culture along with his bloods.

Kind regards,

Jeremy Chowings

Investigations

Description	Result	Date
Age :	over 40	
Duration of Symptoms :	greater than 4 weeks	
Suspicion of bowel cancer (if no please use Colorectal – Basic Sign Referral :	Yes	
Persistent (more than 4 weeks) change in bowel habit especially to looser stools (NOT simple constipation :	true	
FBC :	results awaited	
eGFR>30 :	results awaited	
Liver function blood tests :	results awaited	
Is patient fit/cooperative to go 'direct to test', including taking bowel prep :	Yes	

Pre-existing conditions (High & Medium Priority)

Description	Modifier	Extension	Start Date	Date Recorded
Malnutrition NOS	New event	disease related	05/02/2024	05/02/2024
Metabolic acidosis NEC			18/01/2024	18/01/2024
Acute kidney injury		pre-renal	18/01/2024	18/01/2024
[D]Hypovolaemic shock		/septic	18/01/2024	18/01/2024
Enterocolitis		campylobacter	18/01/2024	18/01/2024
Nasal obstruction	New event	TRIAL OF BECONASE	14/03/2022	14/03/2022
BPH - benign prostatic hypertrophy			27/09/2018	27/09/2018

[X]Depressive episode	New event		30/08/2018	30/08/2018
Chronic obstructive pulmonary disease	New event		26/03/2015	26/03/2015
Essential hypertension	New event		28/06/2011	28/06/2011
Left ventricular hypertrophy	New event		28/06/2011	28/06/2011
Multiple fractures of ribs		TRAUMATIC RIB #'S 2 PNEUMONIA	10/12/2006	10/12/2006
Acute meniscal tear, lateral, bucket handle tear			02/06/2005	02/06/2005

Past procedures (High and Medium Priority)

Procedure	Comment	Modifier	Date Performed	Date Recorded
Hypertension annual review			14/11/2022	14/11/2022

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

Drug name	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Omeprazole 20mg gastro-resistant capsules	capsule	TAKE ONE DAILY WITH NAPROXEN		01/09/2011		07/08/2024
Lisinopril 10mg tablets	tablet	1 TABLET ONCE A DAY. STOP TEM[more]		01/03/2024		07/08/2024
Naproxen 500mg tablets	tablet	1 TABLET TWICE DAILY WITH MEA[more]		28/04/2017		31/07/2024
Tamsulosin 400microgram modified-release capsules	capsule	1 DAILY		27/09/2018		07/08/2024
Simvastatin 40mg tablets	tablet	TAKE ONE AT NIGHT		13/05/2009		07/08/2024
Sildenafil 100mg tablets	tablet	ONE AS NEEDED SLS RULES		16/03/2011		07/08/2024
Salbutamol 100micrograms/dose inhaler CFC free	dose	1 TO 2 PUFFS UP TO FOUR TIMES[more]		26/03/2015		07/08/2024
Hypromellose 0.3% eye drops	ml	INSTIL ONE DROP UP TO ONCE EV[more]		07/02/2018		07/08/2024
Anoro Ellipta 55micrograms/dose / 22micrograms/dose dry powder inhaler (GlaxoSmithKline UK Ltd)	dose	1 INHALATION ONCE DAILY		10/05/2017		04/06/2024
Beclometasone 50micrograms/dose nasal spray	dose	2 PUFFS TO EACH NOSTRIL TWICE A DAY		14/03/2022		07/08/2024
Zerobase 11% cream (Thornton & Ross Ltd)	gram	APPLY FOUR TIMES DAILY AND AS[more]		01/02/2024		18/04/2024

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Lisinopril 10mg tablets	tablet	1 TABLET ONCE A DAY. STOP TEM[more]		01/03/2024		07/08/2024
Naproxen 500mg tablets	tablet	1 TABLET TWICE DAILY WITH MEA[more]		28/04/2017		31/07/2024

Clinical warnings

Allergies

Description	Comment	Modifier	Start Date	Recorded Date
H/O: drug allergy	Drug code for allergy: Penicillin G 600mg/vial injection, Reaction type: Allergy, Read code for reaction: H/O: collapse [147C.00], Certainty of allergy: Likely, Severity of allergy: Moderate.		12/06/2008	12/06/2008

Additional information

Patient Weight in Kilograms:56.6

Patient Height in Metres:1.72

Patient BMI:19.1

Patient Blood Pressure (Systolic):118
Patient Blood Pressure (Diastolic):73
Smoking history (Screening):Ex smoker Date Recorded:08-Feb-2024
Smoking history (Encounters):Ex smoker Date Recorded:08-Feb-2024
Alcohol history (Screening):Alcohol consumption Date Recorded:08-Feb-2024
Alcohol history (Encounters):Alcohol consumption Date Recorded:08-Feb-2024
Exercise history (Screening):Exercise grading Date Recorded:11-Oct-2021
Exercise history (Encounters):Exercise grading Date Recorded:11-Oct-2021

NHS Lothian - Referral Letter

Referral To	Western General Hospital Flow Centre Referral LI Flow Centre Referral
Urgency of referral	Urgent
Date of referral	05/01/2026
Date submitted	05/01/2026
UCPN	101038652203N

PATIENT DETAILS

CHI number:	1210601451
Name:	MR GEORGE SANDERSON
Date of birth:	12/10/1960
Sex:	Male

Contact Details

16-17 PIRRIE STREET
LEITH
EDINBURGH
EH6 5HY

Voice (Mobile) : 07742013232

REFERRING PRACTITIONER DETAILS

Name:	Dr. Mary Sinclair (GMC: 6147992)
Practice:	Leith Surgery (70179)
Phone:	Voice : 0131 554 6471

Practice address

2 Duke Street
Edinburgh
EH6 8HQ

CLINICAL INFORMATION

Reason for Referral:	New rectal bleeding and abdominal pain. Known to colorectal
Main Referral Text:	Background sigmoid stricture, cause ?diverticular disease, bowel ca not excluded. 4/7 pain in lower abdomen, central and LIF. Blood PR Friday and Saturday. Dark red, some clots. Pain was severe over w/e when opened bowels. Pain milder now but still constant, worse when coughing. o/e: obs stable. Tender LIF, voluntary guarding. DRE, chaperone declined. Soft brown stool on glove, no blood. T36.9, P92, sats 96, BP 163/96 Thank you.

Investigations

Description	Result	Date
Discussed with Receiving Service? :	Yes	
Receiving Specialty :	Surgeons SAU	

Pre-existing conditions (High & Medium Priority)

Description	Modifier	Extension	Start Date	Date Recorded
Diverticulitis			07/10/2024	07/10/2024
Congenital stricture of rectum			07/10/2024	07/10/2024
Malnutrition NOS	New event	disease related	05/02/2024	05/02/2024
Metabolic acidosis NEC			18/01/2024	18/01/2024
Acute kidney injury		pre-renal	18/01/2024	18/01/2024
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Acute meniscal tear, lateral, bucket handle tear			02/06/2005	02/06/2005

Past procedures (High and Medium Priority)

Procedure	Comment	Modifier	Date Performed	Date Recorded

Hypertension annual review	14/11/2022	14/11/2022

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Beclometasone 50micrograms/dose nasal spray	dose	2 PUFFS TO EACH NOSTRIL TWICE A DAY		14/03/2022		10/11/2025
Anoro Ellipta 55micrograms/dose / 22micrograms/dose dry powder inhaler (GlaxoSmithKline UK Ltd)	dose	1 INHALATION ONCE DAILY		10/05/2017		10/11/2025
Hypromellose 0.3% eye drops	ml	INSTIL ONE DROP UP TO ONCE EV[more]		07/02/2018		10/11/2025
Salbutamol 100micrograms/dose inhaler CFC free	dose	1 TO 2 PUFFS UP TO FOUR TIMES[more]		26/03/2015		10/11/2025
Sildenafil 100mg tablets	tablet	ONE AS NEEDED SLS RULES		16/03/2011		10/11/2025
Simvastatin 40mg tablets	tablet	TAKE ONE AT NIGHT		13/05/2009		10/11/2025
Tamsulosin 400microgram modified-release capsules	capsule	1 DAILY		27/09/2018		10/11/2025
Lisinopril 10mg tablets	tablet	1 TABLET ONCE A DAY. STOP TEM[more]		01/03/2024		10/11/2025
Omeprazole 20mg gastro-resistant capsules	capsule	TAKE ONE DAILY WITH NAPROXEN		01/09/2011		10/11/2025

Clinical warnings

Allergies

Description	Comment	Modifier	Start Date	Recorded Date
H/O: drug allergy	Drug code for allergy: Penicillin G 600mg/vial injection, Reaction type: Allergy, Read code for reaction: H/O: collapse [147C.00], Certainty of allergy: Likely, Severity of allergy: Moderate.		12/06/2008	12/06/2008

Additional information

Patient Weight in Kilograms:58
Patient Height in Metres:1.72
Patient BMI:19.6
Patient Blood Pressure (Systolic):163
Patient Blood Pressure (Diastolic):96
Smoking history (Screening):Cigarette smoker Date Recorded:06-Oct-2025
Smoking history (Encounters):Cigarette smoker Date Recorded:06-Oct-2025
Alcohol history (Screening):Alcohol consumption Date Recorded:06-Oct-2025
Alcohol history (Encounters):Alcohol consumption Date Recorded:06-Oct-2025
Exercise history (Screening):Exercise grading Date Recorded:06-Oct-2025
Exercise history (Encounters):Exercise grading Date Recorded:06-Oct-2025