A&E Records

Patient Information

RICHARD TAYLOR

Age/Gender:	59y Old Male	Date:	23/08/2022
Address:	42 MORVENSIDE EDINBURGH,EH14 2SJ	Incident Number:	CR008991083
DOB:	10/08/1903	Incident Type:	EMG
CHI:	1008631372	Incident Location:	27 OGILFACE CRESCENT BLACKRIDGE BATHGATE, EH48 3RS
Ethnicity:	White Scottish		

Scottish Ambulance Service

NOK - NATALIE McCRUMMON 07554473550

Presenting Complaint

?RBBB/SUDDEN ONSET CONFUSION

Additional Comments

Pt 59yom, normally fit and well with Phx of stroke/TIA 2013, no current medications. Approximatey 0800 this morning. Pt was at his partners address in Bathgate when his partner noticed a sudden change in the Pts behaviour. For reasons unknown, he was suddenly confused and unable to remember simplest of details or answer simplest of questions. Partner has only known Pt for four months but jas not seen this before. Ambulance contacted, and on, Pt was sat on sofa, of good colour, engaging but was stating that he was comfused. Pt was unab;e to state day of week, his DoB or even the type of motorbike he rode. Pt denies ingestion of alcohol/drugs/medications. 12 lead carried out. ? RBBB. Print out attached. Pt tested FAST neg, denies being in any pain anywhere, no LoC and no events prior. Pt is an occasional cannabis smoker, does not drink and denies any other use of substances. Obs taken as noted below and Pt conveyed to SJH.

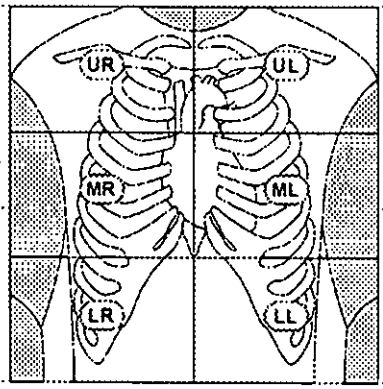
PATIENT ASSESSMENT

ACVPU Alert <C> No

A Clear

B Breathing Adequately: Yes | Respiratory Rate: 22 | SPO2: 96

Oxygen Given: No

Normal Percussion, Normal Breath Sounds, Normal Air Entry	UR		UL	Normal Percussion, Normal Breath Sounds, Normal Air Entry
Normal Percussion, Normal Breath Sounds, Normal Air Entry	MR		ML	Normal Percussion, Normal Breath Sounds, Normal Air Entry
Normal Percussion, Normal Breath Sounds, Normal Air Entry	LR		LL	Normal Percussion, Normal Breath Sounds, Normal Air Entry

C

Pulse Rate	BP	Cap Refill	ECG Rhythm
60	148/95	<=2 Secs	RBBB

Rhythm	Arm	Central/Peripheral	ECG
Reg	Right	Peripheral	12 Lead

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
13:04	60	22	148/95	96	<=2 Secs	15	Alert		36.1	5.6	Sinus Rhythm	4	4		E9888707

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
13:04	22 (2)	96 (0)		0	148 (0)	60 (0)	Alert (0)	36.1 (0)	2

HISTORY

AMPLE

Allergies	Unknown
Medication	NIL
Past Medical History	

Stroke	How Many:1 When:HAO 1 STROKE/TIA IN 2013
Last Eaten	>4 Hours Ago
Events Prior	SEE ADD COMMENTS

Social History

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

Patients General Appearance	Normal
Patient Mobility	Fully Mobile
Patient Communication	No Help Required
Patient Clinical Risk Factors	Smoker, Recreational Substances
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	12:22	Allocated	12:23	Mobile	12:24
First Resource On Scene		Crew On Scene	12:50	Crew Left Scene	13:11
Crew At Hosp		Receiving Hospital	ST JOHNS HOSPITAL	Clear Time	

Crew ID	Crew Grade	Driver
E9884172	Student Technician Level 4	YES
E9888707	Paramedic	NO

TAYLOR, RICHARD ID:1006631372 23-Aug-2022 15:21:33 NHS LOTHIAN-SJHA&E ROUTINE RECORD

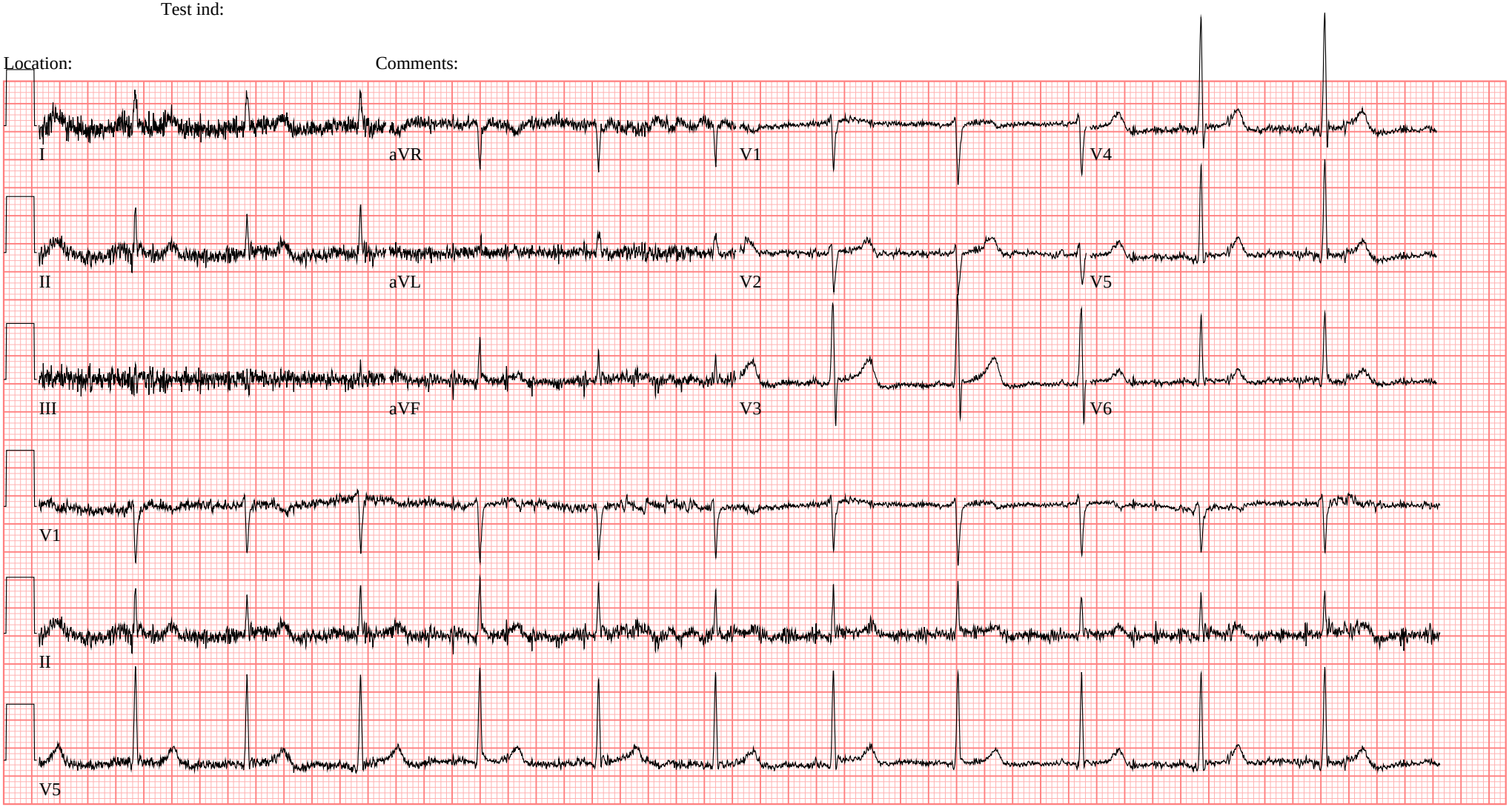
10-Jun-1963 (59 yr)
Male Unknown

Room:
Loc:230

Vent. rate	71	BPM
PR interval	116	ms
QRS duration	72	ms
QT/QTcB	390/423	ms
P-R-T axes	61 33	20

Technician:
Test ind:

Location: Comments:



25mm/s 10mm/mV 150Hz 10.1.3 12SL 243 CID: 25108

SID: 1008119 EID: 13 EDT: ORDER:

TAYLOR, RICHARD ID:1006631372 23-Aug-2022 16:30:10 NHS LOTHIAN-SJHA&E ROUTINE RECORD

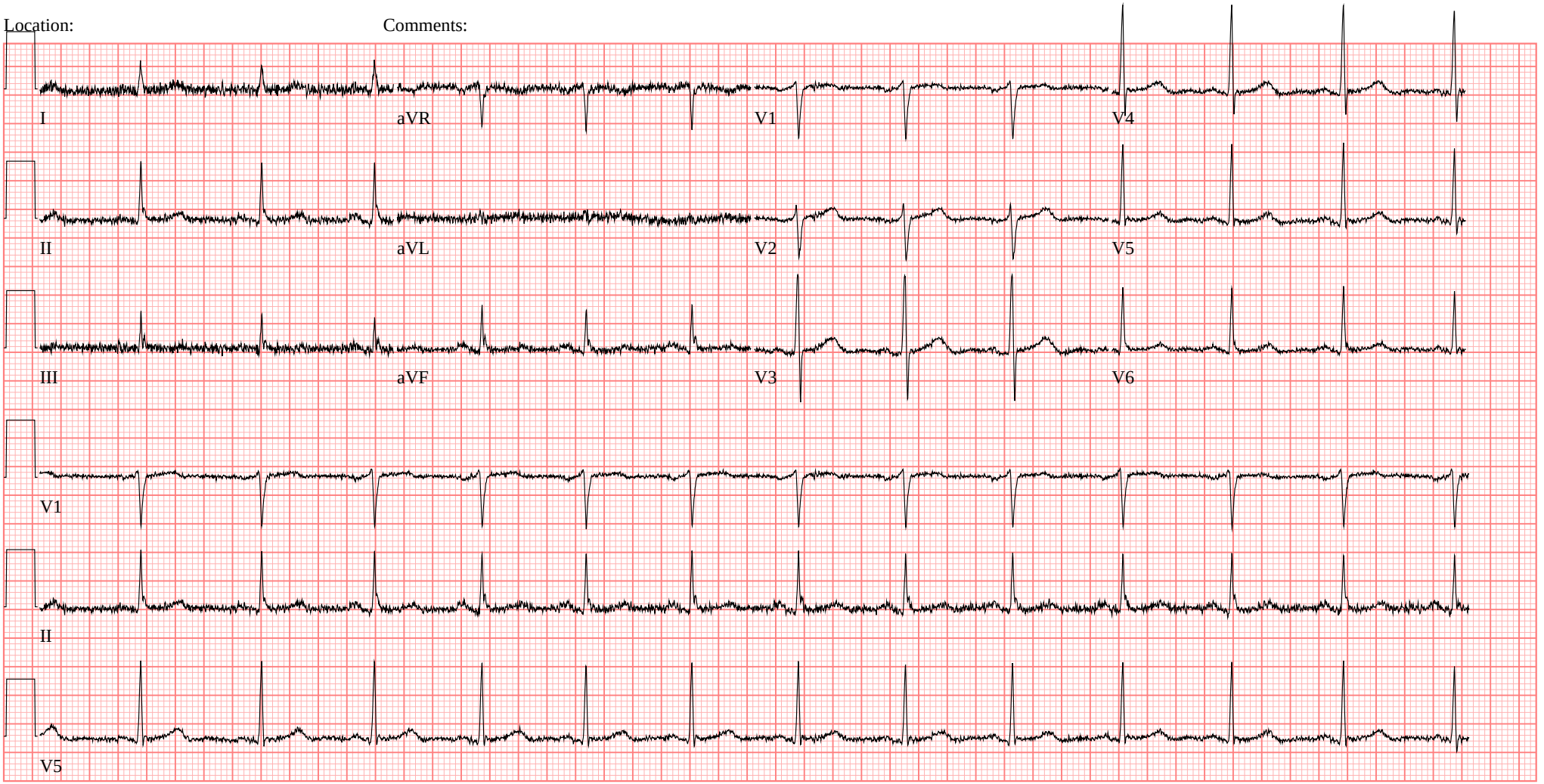
10-Jun-1963 (59 yr)
Male Unknown

Room:
Loc:230

Vent. rate	78	BPM
PR interval	142	ms
QRS duration	76	ms
QT/QTcB	386/440	ms
P-R-T axes	60 59	47

Technician:
Test ind:

Location: Comments:



25mm/s 10mm/mV 150Hz 10.1.3 12SL 243 CID: 25108

SID: 1008119 EID: 13 EDT: ORDER:

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr Hendrie
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date: 25/08/2022

Emergency Discharge Summary

Patient	Richard Taylor 42 Morvenside Edinburgh EH14 2SJ	**CHI**	**1006631372**
		Date of Birth / Age	10/06/1963 (59 years)
		UHPI	610119466W
		A&E Attendance Number	E5120401
Attendance Date	24/08/2022		
Attendance Time	09:32		
Mode of Arrival	Private Transport		
Source of Referral	Self Referral to A&E		
Discharge Date	25/08/2022		
Discharge To	SJH Medical Assessment Unit	**Final Triage**	9 - Medical Expected
		Attendances in the last 12 months	3

Dear Dr Hendrie

Presentation:	Chest pain, Confusion / reattend from last night patient got scred and left dept Temp 36.5 hr 64 bp 152/84 rr 18 sats 95% gcs 14 PEARL
Diagnosis:	Left ventricular failure,Delirium (acute confusion)
Procedures:	None
Drugs given in A&E:	None
Discharge Drugs:	

IMPRESSION/DIFFERENTIAL DIAGNOSIS:

Left ventricular failure

CLINICAL NOTES:
Clinical note: 59 year old male. Self presents

PC
confusion

HPC
note events of EPR
--thanks sandy
tells me he left department last night as he was confused about what was happening and felt like he needed to be at home
very unclear about how he got home

can't tell me what he did last night after getting home
still presents as very anxious and uneasy
appears agitated during conversation
looks to his partner to answer all questions
tells me he can't remember his date of birth or what he has been doing the past few days

DHX
omeprazole

SHX
unemployed truck driver
denies smoking
denies alcohol
recent family stressors
--estranged from his Ex partner and not able to see his children

NKDA

OE
alert
GCS 15
chest clear. equal air entry
wwp. HS 1+2+0
abdo snt
calfs snt

NEWS=0
ECG- sinus rhythm
BLOODS- pending

PLAN
from last night was for admission and observation
planned for parallel review of medicine/neurology/pyschiatry
discussed with patient
--admit medicine
--telelmetry
Worsening statement given

Patient happy with care and understands advice

Kind regards

Neil Burnside

Any queries please contact A&E Reception on 01506 523011

Yours Sincerely,

Neil Burnside, Nurse Practitioner

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr Hendrie
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date: 13/10/2022

Emergency Discharge Summary

Patient	Richard Taylor 42 Morvenside Edinburgh EH14 2SJ	**CHI**	**1006631372**
		Date of Birth / Age	10/06/1963 (59 years)
		UHPI	610119466W
		A&E Attendance Number	E5166266
Attendance Date	12/10/2022		
Attendance Time	19:17		
Mode of Arrival	Private Transport		
Source of Referral	Self Referral to A&E		
Discharge Date	12/10/2022		
Discharge To	Fracture Clinic	**Final Triage**	4 - Standard
		Attendances in the last 12 months	5

Dear Dr Hendrie

Presentation:	Injury of shoulder / arm / elbow / wrist/ hand, finger Injury tried to book to CALLMIA, no appts. ?fracture to midddle to ring finger. fall onto them from standing. wrist fused it 1945
Diagnosis:	Hand: Closed fracture : finger
Procedures:	None
Drugs given in A&E:	None
Discharge Drugs:	

Referred to: Orthopaedic Trauma Triage Clinic

CLINICAL NOTES:
Clinical note: Wright Cons EM

59 year old RHD man
injury to right hand
fell while getting out of bed
FOOSH , injured fingers on right hand
Wife has already buddy strapped them!

Xrayed from triage - minimally displaced fracture proximal phalanx of ring finger
DNVI

P: explained fracture and advised to continue with buddy strapping. Advised 6-8 weeks for full healing. Advised not to ride motorcycle in the meantime

TW
Clinical notes: Wright Cons EM

59 year old RHD man
injury to right hand
fell while getting out of bed
FOOSH , injured fingers on right hand
Wife has already buddy strapped them!

Xrayed from triage - minimally displaced fracture proximal phalanx of ring finger
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TW

FREE TEXT NOTE BELOW HERE

ADDITIONAL DETAILS:

Patient consents to be contacted by orthopaedics service by telephone: Yes
CONTACT NUMBERS:
Home - 0131 442 1596
Mobile - 07593330473
The relevant advice leaflet has been provided: Yes

Yours Sincerely,

Dr Tim Wright, Doctor

NHS LOTHIAN
Emergency Department
Adult Majors
Prescription, Administration & Observation Record

NHS Lothian

Addressograph
610119466W /E5166243 M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
70911 R Hendrie
42 Morvenside
EH14 2SJ

The section below must be completed before any medicine is prescribed/given

Previous Adverse Reactions	NO ALLERGIES	Weight kgs Actual / Estimate	Date 12/10/22

Once Only Prescription

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber Sign & Print	Time Given	Issued by (Initials)	Checked by if applicable (Initials)
12/10	18 55	Paracetamol	1g	ORAL	[illegible]	18 55	[illegible]	
12/10	18 55	Ibuprofen	400mg	ORAL	[illegible]	18 55	[illegible]	

Discharge Medication

Date & Time	Medicine (Approved Name)	Dose	Frequency	Route	Quantity	Duration	Prescriber Sign & Print	Issued by (Initials)	Checked by (Initials)

National Early Warning Score 2 (NEWS2) Chart

NEWS Key 0 1 2 3																					
	Date:																				
	Time:																				
A+B Respirations Breaths/min	≥25										3										
	21-24										2										
	18-20																				
	15-17																				
	12-14																				
	9-11										1										
	≤8										3										
A+B SpO_2 Scale 1 Oxygen saturation (%) Use Scale 1 if target range is 94-98%	≥96																				
	94-95										1										
	92-93										2										
	≤91										3										
SpO_2 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	≥97 on O_2										3										
	95-96 on O_2										2										
	93-94 on O_2										1										
	≥93 on air																				
	88-92																				
	86-87										1										
Tick box if using SpO_2 Scale 2	84-85										2										
Sign	≤83										3										
Air or Oxygen? Oxygen is a drug and prescribed by target range	A = Air																				
	O^2 L/min or %										2										
	Device																				
C Blood Pressure mmHg Score uses Systolic BP only If manual BP mark as M	≥220										3										
	201-219																				
	181-200																				
	161-180																				
	141-160																				
	121-140																				
	111-120																				
	101-110										1										
	91-100										2										
	81-90																				
	71-80																				
	61-70										3										
	51-60																				
	≤50																				
C Pulse Beats/min Manual pulse	≥131										3										
	121-130										2										
	111-120																				
	101-110										1										
	91-100																				
	81-90																				
	71-80																				
	61-70																				
	51-60																				
	41-50										1										
	31-40										2										
	≤30										3										
D Consciousness Score for new onset of confusion (or score if current)	Alert																				
	New Confusion										3										
	V																				
	P																				
	U																				
E Temperature °C	≥39.1°										2										
	38.1-39.0°										1										
	37.1-38.0°																				
	36.1-37.0°																				
	35.1-36.0°										1										
	≤35.0°										3										
NEWS TOTAL																					
Monitoring frequency																					
Escalation of care Y/N																					
Blood Glucose reading or N/A																					
Pain score (0-10)																					
Initials																					

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.**

Signs of Infection

- Temperature <36°c or >38°c
- Heart rate >90 beats pm
- Respiratory rate >20 breaths pm
- New confusion
- WCC <4 or >12
- Blood sugar >7.7 in non-diabetic

Addressograph

Name:

DOB:

CHI:

NEWS Total	Monitoring Frequency	Clinical Response
Total 0	Commence on 2 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
Total 1 - 4	Commence on 1 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
3 in one parameter *	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to Nurse In Charge (NIC) and Senior Medic
Total 5 - 6	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Total 7 or more	Commence on 15 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic

Special Instructions

*or increase in NEWS score of 2

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		
	LECS	Normal power		
		Mild weakness		
		Severe weakness		
		Extension		
		No response		
		Initials		

Pupil Scale mm 1 2 3 4 5 6 7 8

IV Fluid Prescription

Time Prescribed	Fluid	Volume	Rate	Prescribers Signature	Time Started	Given by (Initials)	Checked by (Initials)	Time Finished

Fluid Balance

INPUT						OUTPUT				
	IV Fluids or SC Fluids IV Medication	IV Line(s)	Oral Input		Input		Urine		Gastric	
Time	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100ml	Running Total	Time	Volume	Running Total	Volume	Running Total

Drug Infusion

Drug Name:

	Time													
	Rate (ml/hr)													
	Volume in Syringe													
Pump No	Total amount Infused													

Drug Name:

	Time													
	Rate (ml/hr)													
	Volume in Syringe													
Pump No	Total amount Infused													

NHS Lothian

St John's Hospital at Howden
Howden West
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West Lothian
EH54 6PP

Dr Hendrie
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date: 30/12/2022

Emergency Discharge Summary

Patient	Richard Taylor 42 Morvenside Edinburgh EH14 2SJ	**CHI**	**1006631372**
		Date of Birth / Age	10/06/1963 (59 years)
		UHPI	610119466W
		A&E Attendance Number	E5237225
Attendance Date	28/12/2022		
Attendance Time	15:34		
Mode of Arrival	Private Transport		
Source of Referral	Self Referral to A&E		
Discharge Date	29/12/2022		
Discharge To	SJH Medical Assessment Unit	**Final Triage**	9 - Medical Expected
		Attendances in the last 12 months	7

Dear Dr Hendrie

Presentation: Confusion, memory loss/vomiting
Diagnosis: Encephalitis [ND]
Procedures: None
Drugs given in A&E: None
Discharge Drugs:

IMPRESSION/DIFFERENTIAL DIAGNOSIS:

Encephalitis [ND]

CLINICAL NOTES:
Clinical note: PC/ confusion
HPC/ 59 male
HGV driver
TRAK down so Hx relied on partner
intracerebral bleed 10 years ago- currently not on any medications
4 episodes of what was thought to be transient global amnesia over last 4 months- with disorientation of time/ person/ place and intermittent sweats and headaches
No medical follow up
Partner got a call from patients employer today as patient was confused, driving his own car in circles as unable to recall how to get home
Partner found patient confused- unware of name, place, DOB

Self presented? Left sided facial droop and right sided weakness at at triage, and urinary incontinence- weakness resolved.
Currently only complaint is global headache despite paracetamol and ibuprofen, initermittent transient drop in GCS lasting 20 seconds with associating sinus bradycardia (80bpm drops to 40 bpm), jerking all 4 limbs but not rhythmic/seizure like, and profused sweating with paroxysmal worsening of headache
Able to recall names, and place, but nothing else
No recall of events since waking this morning

PMH/ as above
DH/ nil. ? morphine an d codeine in last admission causing stomach aches- but agrees to take some oramorph
SH/ cannabis use in the past
O/E
Sweating
Ob stable otherwise
Pupils small 2mm symmetrical and reactive to light
during the moment of unresponsiveness non responsive to trapezius squeeze , with eyes deviated to right but work up in an exaggerated jump
Able to self transfer to CT table no obvious weakness, no pronator drift
HS i+ii
Chest clear
SNT abdomen
Intermittent drop of SaO2 to 91% no relating to drop in conscious level, improves with deep breathing

IMP/ All these symptoms are very strange. Originally I questioned if these were functional in origin but patient does look very unwell and I cannot explain the diffuse sweating and transient bradycardia. ? Seizure related.
P1) with him being HGV driver and monthly recurrence- I think admission with neurology input is warranted. Currently not being treated as TIA/ stroke.
2) CTH and bloods already done- report pending
3) refer medics

ATSP approx 19:00 as sweating ++ again with vomiting (slightly pink and blood stained). Headache worse. Seems less confused. States gets headache every few weeks, no further details offered, denies photophoebia/ auro with these headaches.
CTH head: old right putamen lacunar infarct. no new intracranial pathology
WCC 16.9 UE LFT normal ranges
I am not convinced that this is migraine, but trial of sumatriptan, IV metoclopramide and IVF
may help.
Review later.
19:30 Patient rolling around in trolley screaming with abdominal pain, stating this was due to medications given. Oramorph was approx 1 hour ago and patient had large vomit not that long ago. The only other medications given since was metoclopramide. Want to self discharge.
Explained that I cannot think of alternative analgesia for him at the moment, but trial of sumatriptan.
Encourage to stay in hospital as a neurology opinion would be really useful for him with his frequent attendance with these symptoms, and I shall review him again re: analgesia need in 1 hour.

Review 20:30
Patient now comfortable and sleeping
SNT abdomen
His wife states that the confusion, jerking, sweating followed by abdominal pain seems to be the pattern of his presentation.

I have explained to her that and I do not have a clear explanation of his symptoms, but encourage him to be admitted for neurology review.

Any queries please contact A&E Reception on 01506 523011

Yours Sincerely,

Dr Jasmine Ng, Consultant

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr Hendrie
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date: 29/12/2022

Emergency Discharge Summary

Patient	Richard Taylor 42 Morvenside Edinburgh EH14 2SJ	**CHI**	**1006631372**
		Date of Birth / Age	10/06/1963 (59 years)
		UHPI	610119466W
		A&E Attendance Number	E5237225
Attendance Date	28/12/2022		
Attendance Time	15:34		
Mode of Arrival	Private Transport		
Source of Referral	Self Referral to A&E		
Discharge Date	29/12/2022		
Discharge To	SJH Medical Assessment Unit	**Final Triage**	9 - Medical Expected
		Attendances in the last 12 months	7

Dear Dr Hendrie

Presentation: Confusion, memory loss/vomiting
Diagnosis: Encephalitis [ND]
Procedures: None

This patient has been admitted to St John's hospital and a further letter will follow.

Any queries please contact A&E Reception on 01506 523011

Yours Sincerely,

A+E Nurse SJH, Nurse

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr Pigliacampo-Linley
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date: 26/08/2023

Emergency Discharge Summary

Patient	Richard Taylor 42 Morvenside Edinburgh EH14 2SJ	**CHI**	**1006631372**
		Date of Birth / Age	10/06/1963 (60 years)
		UHPI	610119466W
		A&E Attendance Number	E5449469
Attendance Date	26/08/2023		
Attendance Time	05:28		
Mode of Arrival	Emergency Ambulance		
Source of Referral	999 Emergency		
Discharge Date	26/08/2023		
Discharge To		**Final Triage**	2 - Very Urgent
		Attendances in the last 12 months	5

Dear Dr Pigliacampo-Linley

Presentation:	Head injury, head inj / BIBA Unwitnessed fall down 5 stairs. LOC. Wound to back of head. Alert at triage but not orientated to time or place. Amnesic of events. Has had alcohol and cannabis tonight. Prev stroke and brain haemmorhage. RR 15 SpO2 96% BP 13
Diagnosis:	No abnormality detected
Procedures:	None

4AT SCORE: 11

CLINICAL NOTES:
Clinical note: 60 M

PC: BIBA following fall down stairs

HPC: Partner heard him coming upstairs to bed - thinks he had made it ~5steps up when fell down stairs. Hit head on ornament at bottom. Small laceration and then ?LOC. Unresponsive to pain when ambulance arrived but breathing well and no evidence of airway compromise. Then came round and became aggitated.

Pt had had ~4 whiskeys + 3 pints + cannabis over evening. Prior to fall partner says had been himself and generally well. Partner says only time gets unresponsive in way he was when ambulance arrived was when he has his migraines.

PMH:
Previous stroke - but no functional residual deficit according to partner

Previous interaction with neurology at end of last year
1) Subjective memory complaints typically in association with headache - probable migraine with possible dissociative amnesia
2) Transient episode of altered awareness with no particular clinical pointers (28 December 2022)
2.1) MRI: old right putamen haemorrhagic lacune (2022)
3) Previous admission to hospital with confusion (August 2022)
4) Road traffic accident whilst smoking cannabis (January 2019)
5) Mental health problems
5.1) Recent review by Psychiatry for depression (2022) and Clinical Psychology (February 2023)
5.2) Episode of deliberate self-harm (2019)
6) Right lentiform nucleus cerebral haemorrhage (2004)
6.1) Presentation with frontal and right temporal headache with associated reduction in conscious level

Partner says doesn't take any regular medications

Allergy - partner says sensative to morphine and codeine

Works - ?still as HGV driver although partner says hasn't driven the lorries in a while just helps building performance stages.
Alcohol - drinks occasionally
Drugs - cannabis almost every night before bed
Smokes - ~8/day

On r/v
Initially pt breathing normally and with normal obs but unable to get response to pain despite sternal rub + supraorbital pressure applied by myself and Reg (Dr R McLatchie). Appears to be element of ?functionality to this. Within 5 minutes sat up but apparently confused. Got up from bed and walked to toilet + then wanting to leave A&E.

Partner persuaded to stay but then on walking back to bed pt went stiff and fell laterally into a door head first. Then began crying out in pain on ground. Pt transferred to trolley. No obvious new injury. Escorted straight to CT head. On route pt only really responding appropriately to partner - ignoring everyone else.

Compliant in scanner.

On return to dept pt repeatedly saying doesn't understand why he's in hospital.

O/E
A - alert
B - Sats 98% on RA, RR 16, Chest clear
C - HR 70 BP 149/93, PWAWP
D - T 36, PEARL

Attempted neuro exam - pt poorly compliant with instructions - taking multiple repetitions for pt to follow instructions. Unusual affect. Partner says this affect is unusual for him.
H test - describes double vision.
Power - appears to have 5/5 in all 4 limbs, denies any gross sensation changes.
2 x small lacerations on upper posterior scalp. Both superficial. Smaller <0.5cm, larger ~1.5cm.

Plan:
Await CT head result
Scalp lacerations cleaned with saline and larger glued with flexifuse

Bloods sent in case requires admission for observation
Handed over to day team

R Aldridge SHO Locum SJH A&E

Emma Stewart ST5 EM
Reviewed with results
Partner present

Currently very eager to go home
Walking around dept - pacing
More amenable to chat now

Aware in SJH - knows fell over at home and hit head

Bloods N
CTH Nil acute

DW him and partner - no clear reason to force to stay - they want to go - partner happy to supervice at home - any worsening or unable to keep safe will return
Likley will resolve with time at home
Clear worsening statement
Any queries please contact A&E Reception on 01506 523011

Yours Sincerely,

Dr Rachel Aldridge, Doctor

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr Pigliacampo-Linley
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date: 26/08/2023

Emergency Discharge Summary

Patient	Richard Taylor 42 Morvenside Edinburgh EH14 2SJ	**CHI**	**1006631372**
		Date of Birth / Age	10/06/1963 (60 years)
		UHPI	610119466W
		A&E Attendance Number	E5449469
Attendance Date	26/08/2023		
Attendance Time	05:28		
Mode of Arrival	Emergency Ambulance		
Source of Referral	999 Emergency		
Discharge Date	26/08/2023		
Discharge To		**Final Triage**	2 - Very Urgent
		Attendances in the last 12 months	5

Dear Dr Pigliacampo-Linley

Presentation:	Head injury, head inj / BIBA Unwitnessed fall down 5 stairs. LOC. Wound to back of head. Alert at triage but not orientated to time or place. Amnesic of events. Has had alcohol and cannabis tonight. Prev stroke and brain haemmorhage. RR 15 SpO2 96% BP 13
Diagnosis:	No abnormality detected
Procedures:	None

4AT SCORE: 11

CLINICAL NOTES:
Clinical note: 60 M

PC: BIBA following fall down stairs

HPC: Partner heard him coming upstairs to bed - thinks he had made it ~5steps up when fell down stairs. Hit head on ornament at bottom. Small laceration and then ?LOC. Unresponsive to pain when ambulance arrived but breathing well and no evidence of airway compromise. Then came round and became aggitated.

Pt had had ~4 whiskeys + 3 pints + cannabis over evening. Prior to fall partner says had been himself and generally well. Partner says only time gets unresponsive in way he was when ambulance arrived was when he has his migraines.

PMH:
Previous stroke - but no functional residual deficit according to partner

Previous interaction with neurology at end of last year
1) Subjective memory complaints typically in association with headache - probable migraine with possible dissociative amnesia
2) Transient episode of altered awareness with no particular clinical pointers (28 December 2022)
2.1) MRI: old right putamen haemorrhagic lacune (2022)
3) Previous admission to hospital with confusion (August 2022)
4) Road traffic accident whilst smoking cannabis (January 2019)
5) Mental health problems
5.1) Recent review by Psychiatry for depression (2022) and Clinical Psychology (February 2023)
5.2) Episode of deliberate self-harm (2019)
6) Right lentiform nucleus cerebral haemorrhage (2004)
6.1) Presentation with frontal and right temporal headache with associated reduction in conscious level

Partner says doesn't take any regular medications

Allergy - partner says sensative to morphine and codeine

Works - ?still as HGV driver although partner says hasn't driven the lorries in a while just helps building performance stages.
Alcohol - drinks occasionally
Drugs - cannabis almost every night before bed
Smokes - ~8/day

On r/v
Initially pt breathing normally and with normal obs but unable to get response to pain despite sternal rub + supraorbital pressure applied by myself and Reg (Dr R McLatchie). Appears to be element of ?functionality to this. Within 5 minutes sat up but apparently confused. Got up from bed and walked to toilet + then wanting to leave A&E.

Partner persuaded to stay but then on walking back to bed pt went stiff and fell laterally into a door head first. Then began crying out in pain on ground. Pt transferred to trolley. No obvious new injury. Escorted straight to CT head. On route pt only really responding appropriately to partner - ignoring everyone else.

Compliant in scanner.

On return to dept pt repeatedly saying doesn't understand why he's in hospital.

O/E
A - alert
B - Sats 98% on RA, RR 16, Chest clear
C - HR 70 BP 149/93, PWAWP
D - T 36, PEARL

Attempted neuro exam - pt poorly compliant with instructions - taking multiple repetitions for pt to follow instructions. Unusual affect. Partner says this affect is unusual for him.
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Yours Sincerely,

Dr Rachel Aldridge, Doctor

NHS Lothian

Emergency Department SJH
Care Rounding

610119466W /E5449469 M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
70911 CG Pigliacampo-Linley
42 Morvenside
EH14 2SJ

NURSING ADMISSION CHECKLIST				
Standard Admission Procedures				**Initials**
Vital signs recorded	☑ YES	☐ NO	☐ N/A	RM
NEWS 2 score recorded	☑ YES	☐ NO	☐ N/A	RM
Name band attached	☑ YES	☐ NO		RM
Relatives	☑ IN ED	☐ AT HOME	☐ NOT AWARE	RM
Clothing and valuables - Labelled	☐ YES	☐ NO		
Clothing and valuables - Documented	☐ YES	☐ NO		
Falls risk assessment - Completed	☐ YES	☐ NO		
Falls risk assessment - Documented	☐ YES	☐ NO		
4 AT assessment completed	☑ YES	☐ NO	☐ N/A	RM
Swallow screen completed (within 4 hours of arrival)	☐ YES	☐ NO	☑ N/A	RM
Resus Status	For CPR ☐	DNACPR ☐		

Procedures				**Initials**
ECG completed	☐ YES	☑ NO	☐ N/A	RM

Presenting Complaint: Fall head injury.

Date/time	Progress Notes	Signature/print name
0530	Triaged - Cat 2. Fall/Injury with LOC.	
	ACS 14.	RM
0700	News + ACS recorded. Pt had previous fall - CT scan given - Head fall in department as pt was agitated.	
0800	Pt agitated - wants to go	

NHS Lothian

Date/time	Progress Notes	Signature/print name
	home + threatening to leave the hospital. Pt's partner is present. Offered pt a drink - Pt refused	

NHS Lothian

CARE ROUNDING

HOURLY FREQUENCY	☒ 1	☐ 2	☐ 3	☐ 4
Review frequency every 12 hours or if the patient's clinical condition requires				

Print name of nurse reviewing: [illegible] Date: 26/8/23

Time of Round	0530	0800			
Clinical Area	Mag II	RMH			
Care Round Leader's Initials	[illegible]	[illegible]			
Review Frequency of Vital Signs & Cardiac Monitoring					
Vital Signs Frequency	1°	4			
Cardiac Monitoring required?	☐ Y ☒ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Pain score (0-10)					
Analgesia provided	☐ Y ☒ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
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	☐	☐	☐	☐	☐
Ask patient if they require the toilet	☒	☐	☐	☐	☐
Patient is self-caring and can walk to toilet	☐	☐	☐	☐	☐
Patient has issues with incontinence - assist with personal care as needed	☐ Reviewed	☐ Reviewed	☐ Reviewed	☐ Reviewed	☐ Reviewed
Personal care	☐ Given	☐ Given	☐ Given	☐ Given	☐ Given
Personal care	☒ Not required	☐ Not required	☐ Not required	☐ Not required	☐ Not required
Patient has catheter in situ- assist patient as needed (THINK FLUID BALANCE CHART)	☐ Patent & draining?	☐ Patent & draining?	☐ Patent & draining?	☐ Patent & draining?	☐ Patent & draining?
Personal care	☐ Offered	☐ Offered	☐ Offered	☐ Offered	☐ Offered
Personal care	☐ Given	☐ Given	☐ Given	☐ Given	☐ Given
Personal care	☒ Declined/Not required	☐ Declined/Not required	☐ Declined/Not required	☐ Declined/Not required	☐ Declined/Not required
Nutrition and Hydration (tick one option) *THINK SWALLOW					
Patient is self-caring (ensure nutrition and hydration needs are still being met)	☒	☐	☐	☐	☐
Patient needs assistance with feeding/drinks and have been given help	☐	☐	☐	☐	☐
Patient for fluids only- ensure signage appropriate above bed/trolley	☐	☐	☐	☐	☐
Patient is NBM* (are background fluids required? Review signage is appropriate above the bed/trolley)	☐	☐	☐	☐	☐
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) Declined (D)					
Drink	☐ P ☐ D	☐ P ☐ D	☐ P ☐ D	☐ P ☐ D	☐ P ☐ D
Snack	☐ P ☐ D	☐ P ☐ D	☐ P ☐ D	☐ P ☐ D	☐ P ☐ D
Catered meal	☐ P ☐ D	☐ P ☐ D	☐ P ☐ D	☐ P ☐ D	☐ P ☐ D

NHS Lothian

Emergency Department Care Rounding

(addressograph, or handwritten)

Name:

DOB:

Hospital no/CHI:

CARE ROUNDING										
Time of Round	0530		0800							
Clinical Area	Magill		RM 11							
Care Round Leader's Initials	RM		FB							
Review Frequency of Vital signs and Cardiac Monitoring										
Vital signs frequency monitoring	1°		1°							
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 (AND COMPLETED)?	☐ 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	✓		✓							
Cubicle Tidy										
Ensure area is tidy and free of obstructions	✓		✓							

EMERGENCY DEPARTMENT TO WARD HANDOVER		
NEWS		
Outstanding jobs		
Medications administered?	☐ Y	☐ N
Diagnosis and relevant information		

NHS LOTHIAN
Emergency Department
Adult Majors
Prescription, Administration & Observation Record

NHS Lothian

610119466W /E5449469 M
TAYLOR Richard
10-Jun-63 **CHI:** 100 663 1372
70911 CG Pigliacampo-Linley
42 Morvenside
EH14 2SJ

h

The section below must be completed before any medicine is prescribed/given

Previous Adverse Reactions	NKDA	Weight kgs Actual / Estimate	Date 26/8/15

Once Only Prescription

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber Sign & Print	Time Given	Issued by (Initials)	Checked by if applicable (Initials)

Discharge Medication

Date & Time	Medicine (Approved Name)	Dose	Frequency	Route	Quantity	Duration	Prescriber Sign & Print	Issued by (Initials)	Checked by (Initials)

NHS LOTHIAN
Emergency Department
Adult Majors
Prescription, Administration & Observation Record

NHS Lothian

610119466W /E5449469 M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
70911 CG Pigliacampo-Linley
42 Morvenside
EH14 2SJ

h

The section below must be completed before any medicine is prescribed/given

Previous Adverse Reactions		Weight	Date
	NKDA	kgs Actual / Estimate	26/8/25

Once Only Prescription

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber Sign & Print	Time Given	Issued by (Initials)	Checked by if applicable (Initials)

Discharge Medication

Date & Time	Medicine (Approved Name)	Dose	Frequency	Route	Quantity	Duration	Prescriber Sign & Print	Issued by (Initials)	Checked by (Initials)

National Early Warning Score 2 (NEWS2) Chart

| NEWS Key 0 1 2 3 | | Date: 26/8/23 05. | | |

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.**

Signs of Infection

- Temperature <36°c or >38°c
- Heart rate >90 beats pm
- Respiratory rate >20 breaths pm
- New confusion
- WCC <4 or >12
- Blood sugar >7.7 in non-diabetic

Addressograph

Name:

DOB:

CHI:

NEWS Total	Monitoring Frequency	Clinical Response
Total 0	Commence on 2 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
Total 1 - 4	Commence on 1 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
3 in one parameter *	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to Nurse In Charge (NIC) and Senior Medic
Total 5 - 6	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
[illegible]	Commence on 15 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic

Special Instructions

*or increase in NEWS score of 2

Conscious Level Chart to be completed when clinically indicated

| | | |

IV Fluid Prescription

Time Prescribed	Fluid	Volume	Rate	Prescribers Signature	Time Started	Given by (Initials)	Checked by (Initials)	Time Finished

Fluid Balance

INPUT						OUTPUT				
	IV Fluids or SC Fluids IV Medication	IV Line(s)	Oral Input		Input		Urine		Gastric	
Time	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100ml	Running Total	Time	Volume	Running Total	Volume	Running Total

Drug Infusion

Drug Name:

	Time													
	Rate (ml/hr)													
	Volume in Syringe													
Pump No	Total amount Infused													

Drug Name:

	Time													
	Rate (ml/hr)													
	Volume in Syringe													
Pump No	Total amount Infused													

Patient Information

RICHARD TAYLOR

Age/Gender: 60Y Old Male
Address: 27 OGILFACE CRESCENT BLACKRIDGE BATHGATE,EH48 3RS
DOB: 10/06/1963
CHI:
Ethnicity:

Date: 26/08/2023
Incident Number: CR010117221
Incident Type: EMG
Incident Location: 27 OGILFACE CRESCENT BLACKRIDGE BATHGATE, EH48 3RS

Scottish Ambulance Service

Presenting Complaint

UNWITNESSED FALL

Additional Comments

999 call for 60yom who had unwitnessed fall with head injury. Pt has hx of bleed on brain and stroke 9 years ago. On pt was lying on floor unresponsive to shoulder pinch but well perfused with no respiratory distress. Pts partner was present. Pts partner states that he had been drinking alcohol since 2000hrs and smoked cannabis. Pts partner had went to bed and heard pt fall down at least 4 stairs.Now lying in livingroom after partner assisted him there.Full set of obs taken including 3 lead ecg.Head to toe exam carried out and x2 head wounds to upper occiput.no longer bleeding. Pt woke up agitated with acute confusion during examination.Partner advises that he can be unpredictable after drinking and is known to lash out.Crew intended to fully immobilise given hx of event but pt aggitated.Extracated on ibex chair.Tried to run out of ambulance.Reassurance and encouragement given.2nd crew member also travelled in back for safety.

PATIENT ASSESSMENT

ACVPU Unresponsive **<C>** No

A Clear

B **Breathing Adequately** Yes **Respiratory Rate** 14 **SPO2** 96

C

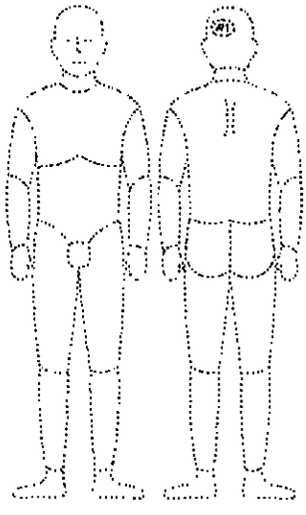
Pulse Rate	BP	Cap Refill	ECG Rhythm
68	118/80	<=2 Secs	Sinus Rhythm

Rhythm	Arm	Centrel/Peripheral	ECG
Reg	Right	Peripheral	3 Lead

D

GCS	Eyes	Voice	Motor	PEARL
3	No Response (1)	No Response (1)	No Response (1)	Yes

E



Wounds

ID	Body Part	Wounds	Treatments
W1	Back Head	Laceration	None

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
05:20	52		145/92	97		14									E9886691
05:03	97		146/95	96		14	Acute Confusion								E9886691
04:21	68	14	118/80	96	<=2 Secs	3	Unresponsive		34.9	6.9	Sinus Rhythm	3	3		E9886691

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
04:21	14 (0)	96 (0)		0	118 (0)	68 (0)	Unresponsive (3)	34.9 (3)	8

HISTORY

AMPLE

Allergies	None
Medication	ANTIDEPRESSANTS
Past Medical History	BLEED ON BRAIN
Stroke	**How Many:** 1 **When:** 2014
Last Eaten	>4 Hours Ago
Events Prior	IN NOTES

Social History

Lives alone	No	**Living With**	PARTNER
Patients General Appearance	Normal		
Patient Mobility	Fully Mobile		
Patient Communication	No Help Required		
Patient Clinical Risk Factors	Alcohol, Smoker, Recreational Substances		
Patient Enviromental Risk Factors	None Identified		

Safeguarding

Safeguarding History	Drug Abuse, Alcohol Abuse		
Safeguarding Assessment	Adult >= 18	**Safeguarding Category Of Risk**	Medium

CLOSE RECORD

Treatment On Scene	Non-Emergency

Conveyance

Transport To Hospital	Normal driving	**Pre-Alert**	No	**Patient Accompanied By**	PARTNER

INCIDENT LOG

Time Call Received	03:04	**Allocated**	03:42	**Mobile**	03:42
First Resource On Scene		**Crew On Scene**	04:09	**Crew Left Scene**	04:54
Crew At Hosp		**Receiving Hospital**	ST JOHNS HOSPITAL	**Clear Time**	

Crew ID	Crew Grade	Driver
E001981X	Paramedic	YES
E9886691	Student Technician Level 4	NO

NHS Lothian

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

Dr CG Pigliacampo-Linley
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date: 22/10/2023

Emergency Discharge Summary

Patient	Richard Taylor 42 Morvenside Edinburgh EH14 2SJ	**CHI**	**1006631372**
		Date of Birth / Age	10/06/1963 (60 years)
		UHPI	610119466W
		A&E Attendance Number	E5501622
Attendance Date	21/10/2023	**Contact**	Taylor Arrices
Attendance Time	16:44		
Mode of Arrival	Emergency Ambulance		
Source of Referral	999 Emergency		
Discharge Date	22/10/2023		
Discharge To			

Dear Dr CG Pigliacampo-Linley

Presentation: Fainting episode, Collapse. T2. New neurological deficit <24 hours. Witnessed collapse ? seizure activity 4pm approx. New confusion today intermittently. C/O headache. PMH: Anxiety related collapses previously. NEWS 0. C Valente CN collapse.

CLINICAL NOTES:
Clinical note: O Hawkes CDF

I initially planned to review this gentleman as he was up-triaged having had a collapse in the waiting room
Has been on a cardiac monitor since
Since became increasingly agitated and got up, tore off leads and walked out of the department
Did not respond to verbal de-escalation.
Stormed out of department and onto road accompanied by son and daughter, who tell me has been having regular collapses every few days or so
Has been increasingly confused and disorientated

Son and daughter have since brought back to dpeartment
Very agitated
When asked where he is, says 'just here'
Was mobilising around department looking for phone
Had a further collapse in pod C

On my arrival, seated in chair, unresponsive to voice
Pale, breathing, no concerns about airway compromise
WWP pulse regular HS I+II+0
Lasted approx 30s, then came round suddenly
Able to trnasfer to trolley, very unsteady on feet

Complaining of severe posteroir headache
Tells me similar to previous stroke

Asking to go home as wants to go back to work on Monday
Tells me works as a HGV driver
I have told him strongly that he cannot drive whilst having unexplained collapses and must inform the DVLA - legal duty to do so
I note has previously been told not to drive following neurology review

VBG following collapse is reassuring - pH 7.4 lactate 0.9 BM 7

Accepting of some oral diazepam
I have ahnded over to night team for more formal review and assessment
Son and daughter currently with pt - contact numbers on trak if absconds again
Now settled and sleepig

Above discussed with Dr Kerslake, ED Cons

Yours Sincerely,

Olivia Hawkes, Doctor

NHS Lothian

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

Dr CG Pigliacampo-Linley
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date: 22/10/2023

Emergency Discharge Summary

Patient	Richard Taylor 42 Morvenside Edinburgh EH14 2SJ	**CHI**	**1006631372**
		Date of Birth / Age	10/06/1963 (60 years)
		UHPI	610119466W
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Discharge To			

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CLINICAL NOTES:
Clinical note: 60M ?seizures

SAS: Called for collpase in pub
GCS 14 on rrival
Family report chest pain, forgetfullness, vacant episodes

Seen with son (lives with him) and daughter present. Multiple complaints.

Headache started yesterday AM
Otherwise normal throughout day. Became upset in evening due to relationship problems
Went to bed
Woke up this AM- son says was forgetful. Can have periods of forgetfullness that resolve spontaneously
Went to go to work- headache too sore so went later
Went to pub approx 1700
From family friend at pub: looked sweaty/pale, collapsed at pub, unable to be woken up, SAS called
In ED- became agitated and wanted to leave.
Collapse as documented by Dr Hawkes, with thanks

Over last couple of weeks:
Headache
- Occipital, constant, gradual onset

- Nil worsening/relieving. Not tried anaglesia. States very severe, can keep him up at night
- Painful eyes associated with this
- No other visual change/neurological change

Collapses- from family
- Feels generally unwell prior- unable to explain further
- Collapses to floor with fine tremor of all limbs, unresponsive
- No urinary/bowel incontience
- Lasts 30 secs before can sometimes reoccur.
- Aware has been told not to drive previously- son states he went back to driving when had fewer collapses.
- Has been happening 4-5 tmes/day last couple of days

Chest pain
- Central chest pain, at rest and on walking, no radiation
- Lasts 5 hours at time. No associated symptoms
- Taking street tramadol for pain
- Happening daily

PR bleeding
- Unable to say time frame
- Fresh blood on wiping and darker in pan, not mixed with stool. No maleana
- Not seen GP- although I note has been referred to colorectal and DNAd multiple appointments/FIT testing
- No other change in bowel habit

PMHx
Previous stroke - but no functional residual deficit according to partner
Previous interaction with neurology at end of last year
1) Subjective memory complaints typically in association with headache - probable migraine with possible dissociative amnesia
2) Transient episode of altered awareness with no particular clinical pointers (28 December 2022)
2.1) MRI: old right putamen haemorrhagic lacune (2022)
3) Previous admission to hospital with confusion (August 2022)
4) Road traffic accident whilst smoking cannabis (January 2019)
5) Mental health problems
5.1) Recent review by Psychiatry for depression (2022) and Clinical Psychology (February 2023)
5.2) Episode of deliberate self-harm (2019)
6) Right lentiform nucleus cerebral haemorrhage (2004)
6.1) Presentation with frontal and right temporal headache with associated reduction in conscious level

FHx
Dad dementia

DHx
ADR: morphine, coedine
Nil reg

SHx
At hoem with son and daughter
Smokes pack/day. 1 oz cannabis/week
Nil alcohol. Denies IVDU

O/E
NEWS 0

A: Patent
B: Clear bilateral A/E
C: HS 1+2+0 reg WWP
D: SNT BS present
E: Calves SNT
CN II-XII intact, PEARL
Tone, power and sensation intact all limbs
Reflexes all ellicted, planters downgoinig

Imp
Collapse ?cause
- Has brain pathology that would predepose to seizures, but observed episode not typical
Chronic headaches
- ?migraine vs tramadol overuse
- No red flags

Ix
ECG: NSR 61bpm, nil acute
Bloods- unremarkable

Discussed with family and pt here to r/o emergency issues and to plan appropriate f/u Ix
In agreement- state pt is "stoical" in issues with engaging with healthcare
Explained first fit clinic would provide a good opportunity to Ix symptoms
Son asking if appointments can be addressed to him- explained pt has capacity to engage as he chooses

Advised due to category 2 license we have legal obligation to infrom DVLA about driving. Explained diagnosis and control of episodes could allow license to re-instated
Pt became very angry at this- states he has to work to support his 16 children.
Stormed out of ED, refused to sign self discharge form. Appears to understand risks and has capacity. Cannula removed, highlighted to family can represent at any time.

K Hill EM ST1

Yours Sincerely,

Dr Kirsty Hill, Doctor

10/10/2023 Incident Number: CR/01/2744

Patient Information		Date:	21/10/2023
RICHARD TAYLOR		Incident Number:	CR01/2744
Age/Gender:	60 years 4 months 11 days Old Male	Incident Type:	EMG
Address:	42 MORVENSIDE EDINBURGH EH142SJ	Incident Location:	O/S THE W WESTSIDE EDINBURG
DOB:	10/06/1963		
CHI:	1006631372		
Ethnicity:			

610119466W /E5501622 M
TAYLOR Richard
1[illegible] Jun-63 CHI: 100 663 1372
70911 CG Pigliacampo-Linley
42 M[illegible]rvenside
EH14 2SJ

Presenting Complaint

?COLLAPSE

Additional Comments

S/ 999 call to 60 YOM ?collapsed in bar. Ongoing hx of panic attacks ? Anxiety related attacks. New acute chest pain today. ?son describes dad as being extremely forgetful, more than usual. B/ similiar episodes prior which havent been investigated prev. Family adv first collapse. Limited medication taken re ecs. No hx of seizures / diabetes etc. A/ pt confused gcs14 lay supine on public house floor. Vacant episodes prior crew arrival. No alcohol or recreational drug use. Unknown if pt banged head during colapse. Acutely overwhelmed on crew arrival. Pt self mobilised to amb with assistance. 12 lead = nsr. All obs within normal limits. Slight blurred vision / headache and pain behind eyes. R/ c[illegible]eyed to neri further assessment. Calm and stable on route. Son with pt.

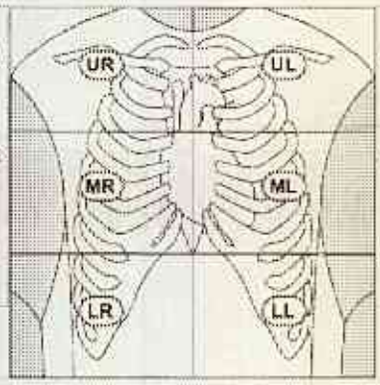
PATIENT ASSESSMENT

ACVPU	Acute Confusion		**<C>**	No
A	Clear			
B	**Breathing Adequately** Yes		**Respiratory Rate** 18	**SPO2** 98

Normal Percussion, Normal Breath Sounds, Normal Air Entry — UR

Normal Percussion, Normal Breath Sounds, Normal Air Entry — MR

Normal Percussion, Normal Breath Sounds, Normal Air Entry — LR



UL Normal Percussion, Normal Breath Sounds, Normal Air Entry

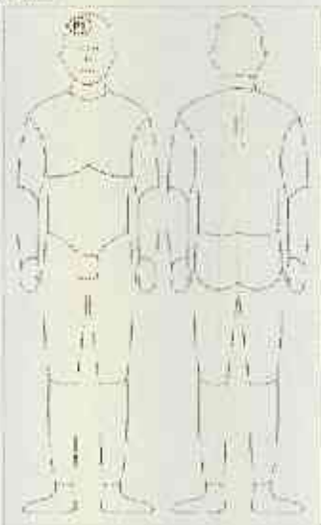
ML Normal Percussion, Normal Breath Sounds, Normal Air Entry

LL Normal Percussion, Normal Breath Sounds, Normal Air Entry

C	**Pulse Rate**	**BP**	**Cap Refill**	**ECG Rhythm**
	86	119/75	<=2 Secs	Sinus Rhythm
	Rhythm	**Arm**	**Central/Peripheral**	**ECG**
		Right		12 Lead

D	**GCS**	**Eyes**	**Voice**	**Motor**	**PEARL**
	14	Spontaneously (4)	Confused (4)	Obeys Commands (6)	Yes

E



Pain

ID	Body Part	Pain Scale
P1	Head	4

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
16:23	86	18	119/75	98	<=2 Secs	14	Alert		37.1	7.6	Sinus Rhythm	4	4		E9881907

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
16:23	18 (0)	98 (0)		0	119 (0)	86 (0)	Alert (0)	37.1 (0)	0

HISTORY

AMPLE

Allergies	None
Medication	POLYPHARMACY
Last Eaten	Unknown

CLOSE RECORD

Treatment On Scene Non-Emergency

Conveyance

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

INCIDENT LOG

Time Call Received	15:41	**Allocated**	15:42	**Mobile**	15:44
First Resource On Scene		**Crew On Scene**	15:59	**Crew Left Scene**	16:24
Crew At Hosp		**Receiving Hospital**	NEW EDINBURGH ROYAL INFIRMARY	**Clear Time**	

Crew ID	Crew Grade	Driver
E9886224	Ambulance Technician	YES
E9881907	Newly Qualified Paramedic	NO

Neuro 065.

NHS LOTHIAN
Emergency Department
Adult Majors
Prescription, Administration & Observation Record

NHS Lothian

610119466W /E5501622 M
TAYLOR Richard
10-Jun-63 CHI 100 663 1372
70911 CG Pigliacampo-Linley
42 Morvenside
EH14 2SJ

The section below must be completed before any medicine is prescribed/given

Previous Adverse Reactions		Weight kgs Actual / Estimate	Date
	NKDA		21/10

Once Only Prescription

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber Sign & Print	Time Given	Issued by (Initials)	Checked by if applicable (Initials)
21/10	2153	DIAZEPAM	2mg	ORAL	[signature]	2305	[signature]	

Discharge Medication

Date & Time	Medicine (Approved Name)	Dose	Frequency	Route	Quantity	Duration	Prescriber Sign & Print	Issued by (Initials)	Checked by (Initials)

National Early Warning Score 2 (NEWS2) Chart

| NEWS Key 0 1 2 3 | | |

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.**

Signs of Infection

- Temperature <36°c or >38°c
- Heart rate >90 beats pm
- Respiratory rate >20 breaths pm
- New confusion
- WCC <4 or >12
- Blood sugar >7.7 in non-diabetic

Addressograph

Name:

DOB:

CHI:

NEWS Total	Monitoring Frequency	Clinical Response
Total 0	Commence on 2 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
Total 1 - 4	Commence on 1 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
3 in one parameter *	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to Nurse In Charge (NIC) and Senior Medic
Total 5 - 6	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Total 7 or more	Commence on 15 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic

Special Instructions

*or increase in NEWS score of 2

Conscious Level Chart to be completed when clinically indicated

| | | |

IV Fluid Prescription

Time Prescribed	Fluid	Volume	Rate	Prescribers Signature	Time Started	Given by (Initials)	Checked by (Initials)	. Time Finished

Fluid Balance

INPUT						OUTPUT				
	IV Fluids or SC Fluids IV Medication	**IV Line(s)**	**Oral Input**		**Input**		**Urine**		**Gastric**	
Time	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100ml	Running Total	Time	Volume	Running Total	Volume	Running Total

Drug Infusion

Drug Name:

	Time													
	Rate (ml/hr)													
	Volume in Syringe													
Pump No	Total amount nfused													

Drug Name:

	Time													
	Rate (ml/hr)													
	Volume in Syringe													
Pump No	Total amount Infused													

TAYLOR, RICHARD
Male
10.06.1963 (60 Years)

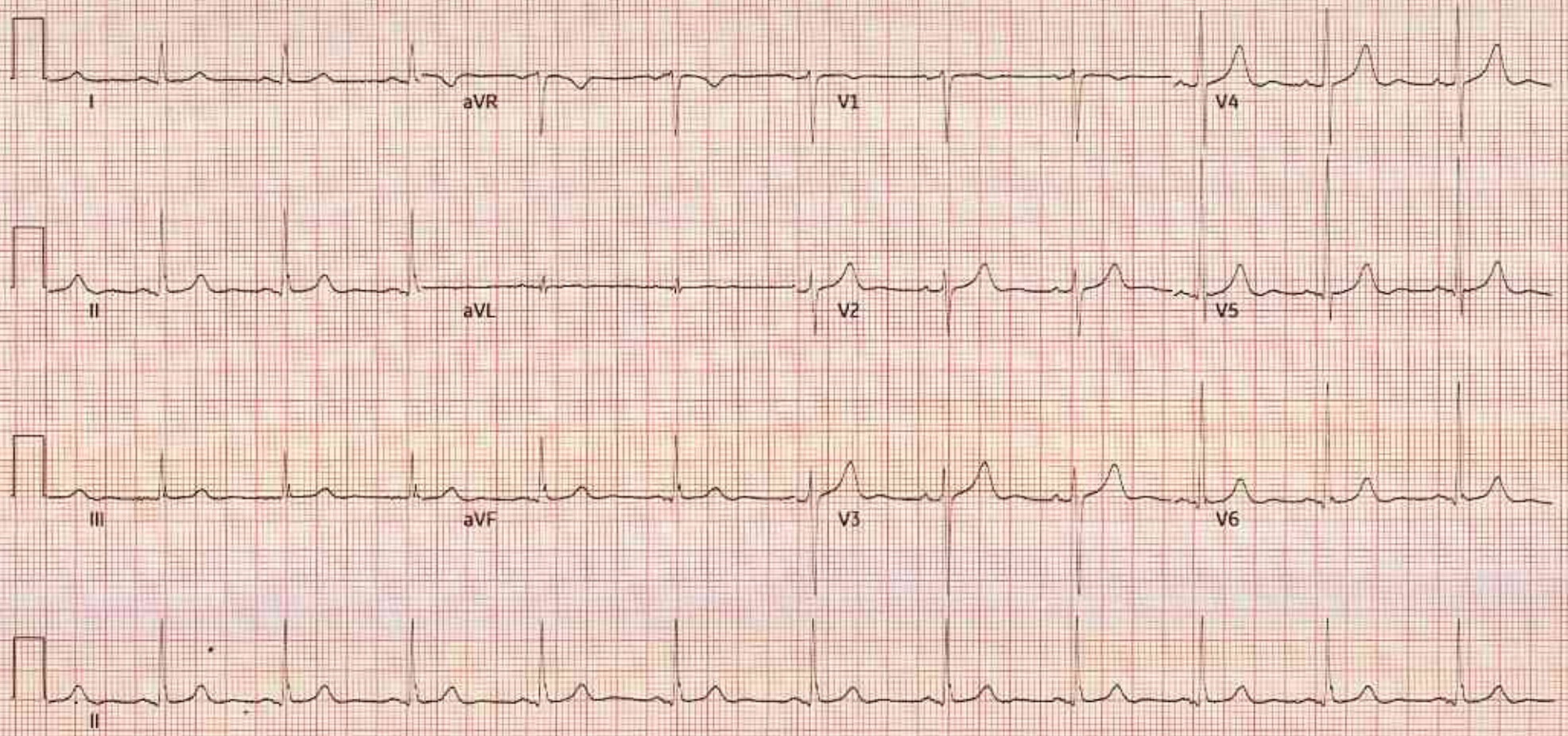
Vent. rate	76	BPM
PR interval	130	ms
QRS duration	92	ms
QT/QTc-Baz	398/429	ms
P-R-T axes	51 65 59	

Patient ID: 1006631372
Normal sinus rhythm
Normal ECG

21.10.2023 20:33:38
Royal Inf of Edinburgh

Location:
Comments:

Unconfirmed



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

GE Healthcare

610119466W /E5501622 M
TAYLOR Richard
10-Jun-63 **CHI:** 100 663 1372
70911 CG Pigliacampo-Linley
42 Morvenside
EH14 2SJ

Vent. rate	59	BPM
PR interval	120	ms
QRS duration	88	ms
QT/QTc-Baz	398/394	ms
P-R-T axes	-8 36	-51

Patient ID: 0000000000

Sinus bradycardia
Cannot rule out Inferior infarct , age undetermined
Abnormal ECG

21.10.2023 17:17:11
Royal Inf of Edinburgh

Location:
Comments:

collapse
? seizure

collapse
Inferior TWI
Rpt 30 min

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

TAYLOR, RICHARD ID:1006631372 21-Oct-2023 20:33:38 NHS LOTHIAN-RIE_ED ROUTINE RECORD

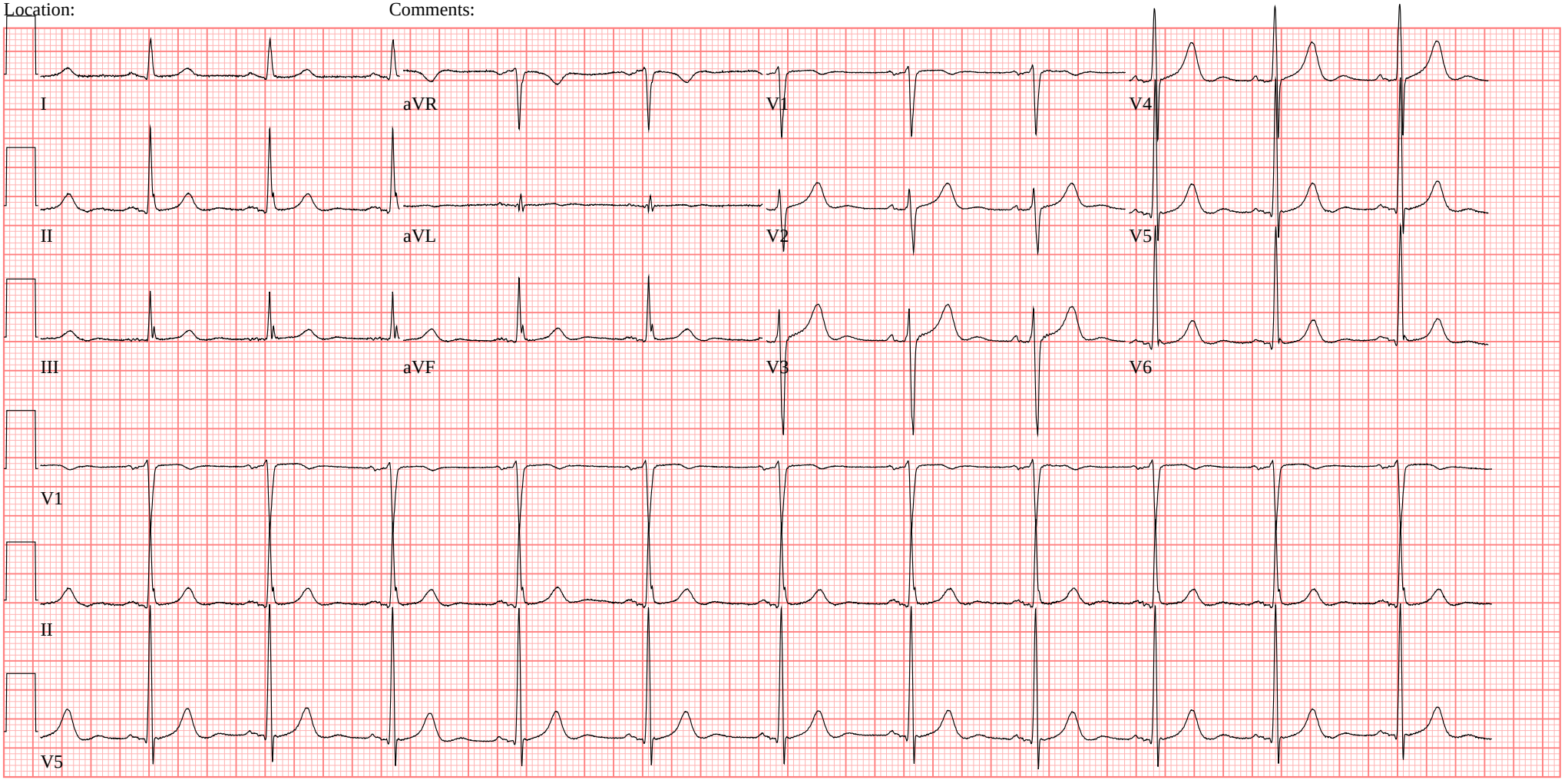
10-Jun-1963 (60 yr)
Male Unknown

Room:
Loc:40

Vent. rate	70	BPM
PR interval	130	ms
QRS duration	92	ms
QT/QTcB	398/429	ms
P-R-T axes	51 65	59

Technician:
Test ind:

Location: Comments:



25mm/s 10mm/mV 150Hz 10.1.3 12SL 243 CID: 38529

SID: 1008119 EID: 13 EDT: ORDER:

TAYLOR, RICHARD ID:1006631372 21-Oct-2023 20:34:55 NHS LOTHIAN-RIE_ED ROUTINE RECORD

10-Jun-1963 (60 yr)
Male Unknown

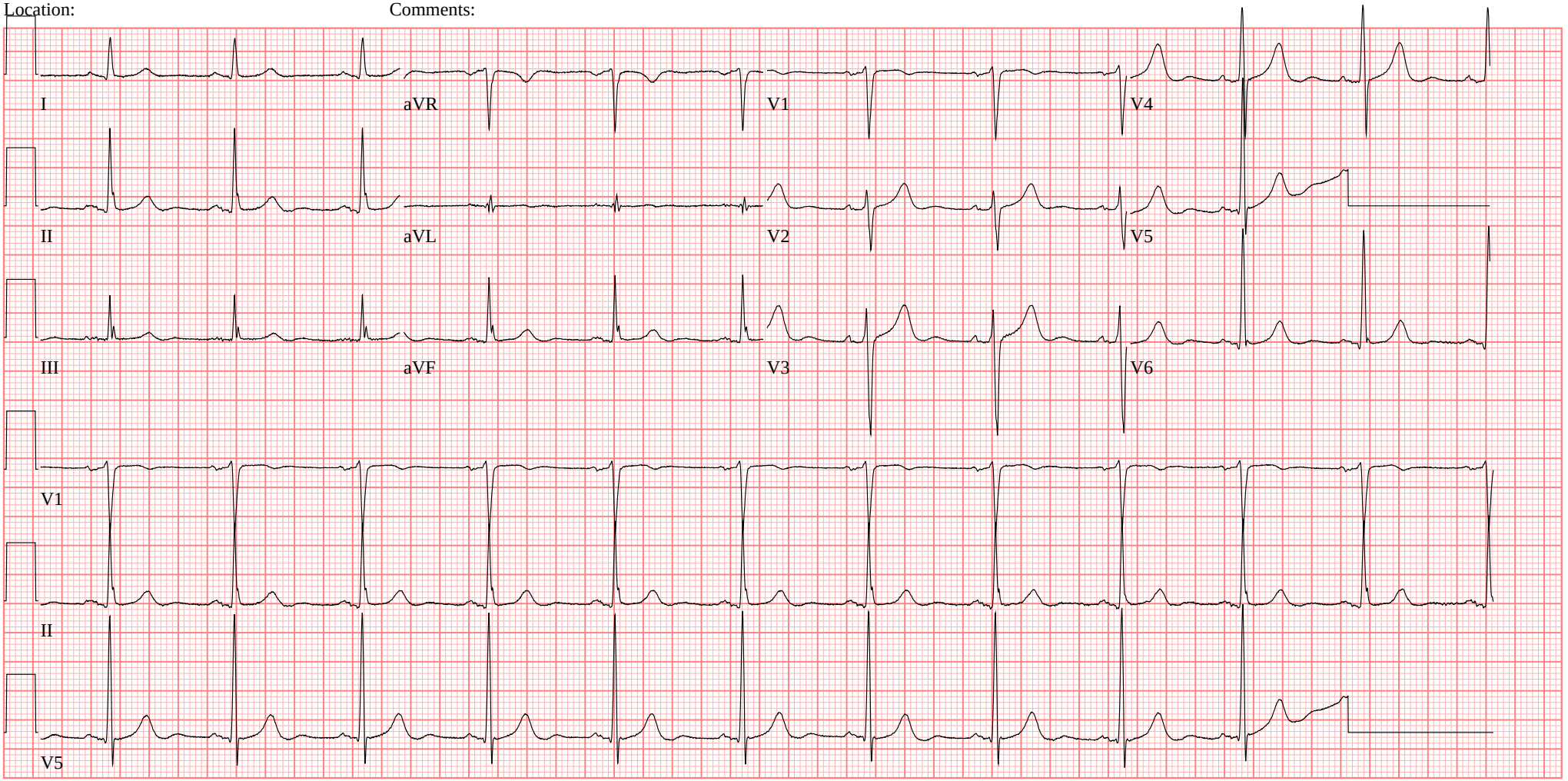
Room:
Loc:40

Vent. rate	70	BPM
PR interval	130	ms
QRS duration	88	ms
QT/QTcB	384/414	ms
P-R-T axes	41 65	60

Technician:
Test ind:

Location:

Comments:



25mm/s 10mm/mV 150Hz 10.1.3 12SL 243 CID: 38529

SID: 1008119 EID: 13 EDT: ORDER:

NHS Lothian
University Hospital Services

Department of Emergency Medicine

Dr. Dave McKean ED Clinical Director
Ray Middlemiss ED Clinical Nurse Manager
The Royal Infirmary of Edinburgh
51 Little France Crescent, Edinburgh, EH16 4SA
Tel: 0131 242 1900 Fax: 0131 242 1344

NHS Lothian

A/E no. E5501622
Previous no. E5449469
UHPI no. 610119466W
CHI no. 1006631372

Patient Information

Surname	Taylor	Date of Birth	
Forenames	Richard	Age / Sex	10/06/1963 60 Yrs M
Address	42 Morvenside		
Postcode	EH14 2SJ	Telephone	0131 442 1596
Contact Address	McCrimmon, Natalie 42 Morvenside Edinburgh EH14 2SJ	Telephone H / W	0131 442 1596
Complaint	collapse	Allergies	

Attendances in last 12 months: 3 School :

Triage ? seizure in MH

General Practitioner

Address: CG Pigliacampo-Linley
Sighthill Green Medical Practi
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU
Telephone: 0131 202 5888

Date and Time of Attendance: 21/10/2023 16:44
Incident Date Time:
Mode of Arrival: Emergency Ambulance
Source of Referral: 999 Emergency

Initial Triage Assessment

Presenting Complaint	
History of Presenting Complaint	
Assessment	

Nursing Observations & Assessments

TEMP	°C	SCORE	MIN. FREQ		Blood Sugar		Pain Score		/10
HR		NEWS 0-1	Hourly		Peak Flow 1)		Analgesia Given	YES ☐	NO ☐
BP	/	NEWS 2-4	30mins Min		Peak Flow 2)		Fast Assessment	POS ☐	NEG ☐
SP02%	%	NEWS 5-7	15mins Min		Peak Flow 3)		Onset Time:		
RR		NEWS >7	10mins Min		Alcometer		Weight		Height
AVPU		Special Clinical Instructions							
O2 Therapy In Progress	Yes (= +2) No (= 0)	Please indicate any specific clinical observations to be continued or repeated once patient has left OPP							
NEWS SCORE									
Triaged By:	Print Name:			Signature:			Triage Time:		

Opp Care & Discharge Record

PVC Insertion - Please initial when complete

Handwash		Gloves	
CHD Skin Prep		Aseptic Insertion	
Dressing Labelled		Paperlite Bundle	
Reason for PVC Insertion:			

Blood Samples - Please tick all that apply

Routine		CRP	
Troponin		Coag	
Amylase		Tox Screen	
BTS		Other (Please state)	

Additional Investigations

ECG - Please tick
Required ☐ Done ☐

Urinalysis - Please tick
Required ☐ Done ☐

MSU Sent	Yes ☐	No ☐
HCG Consent	Yes ☐	No ☐
HCG Result	Yes ☐	No ☐

X-Rays - Please tick

CRX	Yes ☐	No ☐
CT Scan	Yes ☐	No ☐
Other (Please state)		

On Going Care Plan

Speciality Informed (write time)		Bed Required		Triaged To - Please tick			
Surg:	G.I:	Yes ☐	No ☐	Waiting Room		GP Out of Hours	
Vasc:	Stroke:	Transfer To: (Please tick if required)		Resus		Gynae Triage	
Medics:	Gynae:	WGH		HD		SMMP	
Ortho	Neuro:	S.B.H		IC		MIU	
Other (state Speciality)		Other (please state)		Exam		Other (Please state)	

"What Happens To The Patient?"

Clinical Notes

Think:- Other Sources of Information:

Family ☐ Carers ☐ SAS ☐ PRF ☐ EPR ☐ ECS ☐ KIS ☐ GP ☐ Patient Alerts ☐

Care Providers Name: _____ Signature: _____

NHS Lothian

PATIENT PROGRESS NOTES /COMMUNICATION SHEET

Name: 610119466W /E5501622 M TAYLOR Richard
DOB: 10-Jun-63 CHI: 100 663 1272
70911 CG Pigliacampo-Linley
42 Morvenside
EH14 2SJ
Unit No:

Ward/Clinical Area:

State Action/s taken After Exception Reporting
Each entry should be dated & timed

Date & Time	Progress notes / Problems Action Taken & Investigations Required	Signature (Print name & designation)
21/10 2050	Vital Signs updated NEWS 0	
21/10 23:11	pt in POD A, for neuro OBS OBS done NEWS of 0, (GCS 14) done by RN Shona.	

Authorised: Dec 2022
Review: Dec 2025

NHS
Lothian

PATIENT PROGRESS NOTES /COMMUNICATION SHEET	Addressograph, or Name DOB Unit No./CHI

Ward/Clinical Area:

State Action/s taken After Exception Reporting
Each entry should be dated & timed

Date & Time	Progress notes / Problems Action Taken & Investigations Required	Signature (Print name & designation)

Authorised: Dec 2022
Review: Dec 2025

10/10/2023 Incident Number: CR/01/2744

Patient Information		Date:	21/10/2023
RICHARD TAYLOR		Incident Number:	CR01/2744
Age/Gender:	60 years 4 months 11 days Old Male	Incident Type:	EMG
Address:	42 MORVENSIDE EDINBURGH EH142SJ	Incident Location:	O/S THE W WESTSIDE EDINBURG
DOB:	10/06/1963		
CHI:	1006631372		
Ethnicity:			

610119466W /E5501622 M
TAYLOR Richard
1[illegible] Jun-63 CHI: 100 663 1372
70911 CG Pigliacampo-Linley
42 M[illegible]rvenside
EH14 2SJ

Presenting Complaint

?COLLAPSE

Additional Comments

S/ 999 call to 60 YOM ?collapsed in bar. Ongoing hx of panic attacks ? Anxiety related attacks. New acute chest pain today. ?son describes dad as being extremely forgetful, more than usual. B/ similiar episodes prior which havent been investigated prev. Family adv first collapse. Limited medication taken re ecs. No hx of seizures / diabetes etc. A/ pt confused gcs14 lay supine on public house floor. Vacant episodes prior crew arrival. No alcohol or recreational drug use. Unknown if pt banged head during colapse. Acutely overwhelmed on crew arrival. Pt self mobilised to amb with assistance. 12 lead = nsr. All obs within normal limits. Slight blurred vision / headache and pain behind eyes. R/ c[illegible]eyed to neri further assessment. Calm and stable on route. Son with pt.

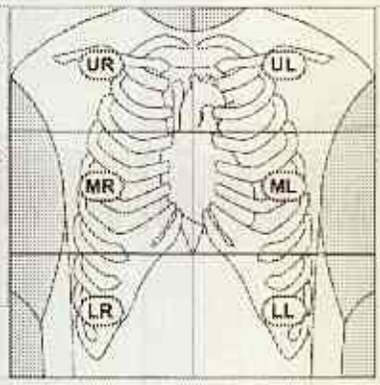
PATIENT ASSESSMENT

ACVPU	Acute Confusion		**<C>**	No
A	Clear			
B	**Breathing Adequately** Yes		**Respiratory Rate** 18	**SPO2** 98

Normal Percussion, Normal Breath Sounds, Normal Air Entry — UR

Normal Percussion, Normal Breath Sounds, Normal Air Entry — MR

Normal Percussion, Normal Breath Sounds, Normal Air Entry — LR



UL Normal Percussion, Normal Breath Sounds, Normal Air Entry

ML Normal Percussion, Normal Breath Sounds, Normal Air Entry

LL Normal Percussion, Normal Breath Sounds, Normal Air Entry

C	**Pulse Rate**	**BP**	**Cap Refill**	**ECG Rhythm**
	86	119/75	<=2 Secs	Sinus Rhythm
	Rhythm	**Arm**	**Central/Peripheral**	**ECG**
		Right		12 Lead

D	**GCS**	**Eyes**	**Voice**	**Motor**	**PEARL**
	14	Spontaneously (4)	Confused (4)	Obeys Commands (6)	Yes

E

NHS Lothian

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

Dr PC Leslie
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date: 27/02/2024

Emergency Discharge Summary

Patient	Richard Taylor 42 Morvenside Edinburgh EH14 2SJ	**CHI**	**1006631372**
		Date of Birth / Age	10/06/1963 (60 years)
		UHPI	610119466W
		A&E Attendance Number	E5618893
Attendance Date	26/02/2024	**Contact**	Taylor Arrices
Attendance Time	18:36		
Mode of Arrival	Emergency Ambulance		
Source of Referral	999 Emergency		
Discharge Date	26/02/2024		
Discharge To			

Dear Dr PC Leslie

Presentation: Seizure (fit), Fits T2- signs of meningism 1st reported seizures at 1720h lasted 3-4 mins had headache prior to event GCS15/15 PMH- brain hemorrhage NEWS 1 Bp-139/84-, HR-54, T-35.9 R. Manarang

CLINICAL NOTES:
Clinical note: 60 year old male

PMH
1) Probable dissociative attacks
2) Transient episode of altered awareness with no particular clinical pointers (28 December 2022)
2.1) MRI: old right putamen haemorrhagic lacune (2022)
3) Previous admission to hospital with confusion (August 2022)
4) Road traffic accident whilst smoking cannabis (January 2019)
5) Mental health problems
5.1) Recent review by Psychiatry for depression (2022) and Clinical Psychology (February 2023)
5.2) Episode of deliberate self-harm (2019)
6) Right lentiform nucleus cerebral haemorrhage (2004)
6.1) Presentation with frontal and right temporal headache with associated reduction in conscious level

PC Generlised seizure
HPC In his kitchen at home, partner present. Asked partner for paracetamol. No warning. Generalised tonic clonic seizure. Foaming at mouth. Took over 30 mins to recover from post ictal state. Witness account from partner. No similar previous episodes.
Patient has been feeling well today. Mild headache. Nil else.
Has been driving motorbike today.

No headache on initial consultation but then c/o headcahe after vomiting x 1.

O/E Well, alert, obs normal
No focal neuro deficit.
HS normal

ECG SR nil acute

CT head due to vomiting/ongoing headache - nil acute

IMP First seizure
Plan Home with first seizure advice.
Driving advice and inform DVLA
Bloods
First seizure clinic f/u

Yours Sincerely,

Dr Emma-Beth Wilson, Consultant

NHS Lothian
University Hospital Services

Department of Emergency Medicine

Dr. Dave McKeen ED Clinical Director
Ray Middlemiss ED Clinical Nurse Manager
The Royal Infirmary of Edinburgh
51 Little Frederick Crescent, Edinburgh, EH16 4SA
Tel: 0131 242 1300 Fax: 0131 242 1344

NHS Lothian

A/E no. E5618893
Previous no. E5501622
UHPI no. 610119466W
CHI no. 1006631372

Patient Information

Surname Taylor
Forenames Richard
Date of Birth 10/06/1963
Age 60 Yrs Sex M
Address 42 Morvenside
Postcode EH14 2SJ
Telephone
Contact Address Taylor, Arrices
Telephone H
W
Complaint seizure
Allergies
Attendances in last 12 months: 2 School

General Practitioner

Address PC Leslie
Sighhill Green Medical Practice
Sighhill Health Centre
Calder Road
Edinburgh
EH11 4AU
Telephone 0131 202 5888

Date and Time of Attendance 26/02/2024 18:36
Incident Date Time: 26/02/2024
Mode of Arrival Emergency Ambulance
Source of Referra 999 Emergency

Initial Triage Assessment

Presenting Complaint	
History of Presenting Complaint	
Assessment	

Nursing Observations & Assessments

TEMP	°C	SCORE	MIN FREQ		Blood Sugar		Pain Score	/ 10	
HR		NEWS 0-1	Hourly		Peak Flow 1)		Analgesia Given	YES ☐	NO ☐
BP	/	NEWS 2-4	30mins Min		Peak Flow 2)		Fast Assessment	POS ☐	NEG ☐
SPO2%	%	NEWS 5-7	15mins Min		Peak Flow 3)		Onset Time:		
RR		NEWS >7	10mins Min		Alcometer		Weight	Height	
AVPU		Special Clinical Instructions							
Therapy in Progress	Yes (= +2) No (= 0)	Please indicate any specific clinical observations to be continued or repeated once patient has left CPP							
NEWS SCORE									

Triaged By: Print Name: Signature: Triage Time:

Opp Care & Discharge Record

PVC Insertion - Please initial when complete

Handwash		Gloves	
CHD Skin Prep		Aseptic Insertion	
Dressing Labelled		Paperlite Bundle	
Reason for PVC Insertion:			

Blood Samples - Please tick all that apply

Routine		CRP	
Troponin		Coag	
Amylase		Tox Screen	
BTS		Other (Please state)	

Additional Investigations

ECG - Please tick
Required ☐ Done ☐
Urinalysis - Please tick
Required ☐ Done ☐
MSU Sent Yes ☐ No ☐
HCG Consent Yes ☐ No ☐
HCG Result Yes ☐ No ☐
X-Rays - Please tick
CRX Yes ☐ No ☐
CT Scan Yes ☐ No ☐
Other (Please state)

On Going Care Plan

Speciality Informed (circle one)		Bed Required		Triaged To - Please tick			
Surg:	G.I:	Yes ☐	No ☐	Waiting Room		GP Out of Hours	
Vasc:	Stroke:	Transfer To: (Please tick if required)		Resus		Gynae Triage	
Medics:	Gynae:	WGH		HD		SMMP	
Ortho:	Neuro:	SJH		IC		MIU	
Other (note Speciality)		Other (please state)		Exam		Other (Please state)	

"What Happens To The Patient?"

Clinical Notes

Think:- Other Sources of Information:

Family ☐ Carers ☐ SAS ☐ PRF ☐ EPR ☐ ECS ☐ KIS ☐ GP ☐ Patient Alerts ☐

Care Providers Name: _____ Signature: _____

Patient Information

RICHARD TAYLOR

Age/Gender: 60 years 5 months 16 days Old Male

Address: 42 MORVENSIDE EDINBURGH,EH14 2SJ

DOB: 10/06/1963

CHI:

Ethnicity:

Date:

Incident Number:

Incident Type:

Incident Location:

610119456W/E5618893 M
TAYLOR Richard
CHI: 100 663 1372
10-Jun-63
70911 PC Leslie
42 Morvenside
EH14 2SJ

Presenting Complaint

FIRST SEIZURE

Additional Comments

999 call for 60yom - pt partner has witnessed pt become vacant at approx 17:20 with pt then becoming stiff and rigid, partner lowered pt to floor where its reported pt eyes were rolling, he was unable to talk and foaming at the mouth. This lasted approx 3-4 mins and self terminated. Pt has hx of brain haemorrhage 10 years ago, pt recently been having episodes of collapse and migraines for 2/12 where pt has seen dr and attended hosp. Currently on no treatment/meds. Pt states he has not felt himself today and asked for paracetamol before seizure but pt unable to say what for [pt not had paracetamol as none at home]. o/a - pt post ictal on crews arrival, alert to crew but confused, well perfused. o/e - obs as recorded, airway patent with no oral trauma, 12ld ecg nsr - peaked t waves v2-v3, no head inj gcs 14 through assessment, pt still unsure whathas happened or remembers what he has done today [partner reporting he has been outon motorbike today and seemed himself for upto 30 mins before seizure, no incontinence, no obv inj/wounds, bm normal, no vomiting reported, perrla, c/o not feeling himself but unable to explain in what way, conveyed to nerl for further assessment, pt settled and sleepy - no furtyer seizures with crew.

PATIENT ASSESSMENT

ACVPU Alert <C> No

A Clear

B Breathing Adequately: Yes | Respiratory Rate: 28 | SPO2: 95 | Oxygen Given: No

C

Pulse Rate	BP	Cap Refill	ECG Rhythm
97	134/99	<=2 Secs	Sinus Rhythm

Rhythm	Arm	Central/Peripheral	ECG
Reg	Right	Peripheral	3 Lead12 Lead

D

GCS	Eyes	Voice	Motor	PEARL
14	Spontaneously (4)	Confused (4)	Obeys Commands (6)	Yes

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
18:32	76	18		96											E9886311
18:12	77	24	139/92	98		14	Alert								E9888733
18:01	97	28	134/99	98	<=2 Secs	14	Alert		36.3	6.1	Sinus Rhythm	0	0		E9888733

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
18:01	28 (3)	98 (0)		0	134 (0)	97 (1)	Alert (0)	36.3 (0)	4

HISTORY

AMPLE

Allergies: CODEINE/MORPHINE

Medication: Nil

Past Medical History: ANXIETY

Stroke: How Many:1
When:2014 [BRAIN HAEMORRHAGE]

Last Eaten	>4 Hours Ago
Events Prior	SITTING IN KITCHEN ON STOOL

Social History

Lives alone	No	Living With	PARTNER	Patient Occupation	HGV DRIVER

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

Safeguarding

Safeguarding Assessment	Adult >= 18	Safeguarding Category Of Risk	Low

MEDICAL

Convulsions

Convulsion	Epileptic	Seizure Terminated	Spontaneously	Blood Sugar Checked	Yes

Associated Factors	First Reported Convulsion
Individual Treatment Plan Present	No

CLOSE RECORD

Treatment On Scene	Non-Emergency

Conveyance

Transport To Hospital	Normal driving	Pre-Alert	No

INCIDENT LOG

Time Call Received	17:22	Allocated	17:42	Mobile	17:43
First Resource On Scene		Crew On Scene	17:55	Crew Left Scene	18:13
Crew At Hosp		Receiving Hospital	NEW EDINBURGH ROYAL INFIRMARY	Clear Time	

Crew ID	Crew Grade	Driver
E9886311	Ambulance Technician	YES
E9888733	Paramedic	NO

ED TROLLEY RAIL RISK ASSESMENT

610119466W /E5618893 M
TAYLOR Richard
10 Jun-63 CHI: 100 663 1372
70911 PC Leslie
42 Morvenside
EH14 2SJ

Please complete for ALL patients who are placed on Trolle
Emergency Department – circle most appropriate use of trolley rails

MENTAL STATE	USE OF TROLLEY RAILS	PLEASE TICK
PATIENT IS CONFUSED/DISORIENTATED OR IMMOBILE	USE TROLLEY RAILS WITH CARE *(PLACE WITHIN REACH OF CALL BELL; PLACE IN VISIBLE AREA IF NOT IN CUBICLE; CONSIDER 1:1; LOWER TROLLEY TO LOWEST HEIGHT)*	✓
PATIENT IS DROWSY	TROLLEY RAILS RECOMMENDED	
PATIENT IS UNCONSCIOUS	TROLLEY RAILS RECOMMENDED	
PATIENT IS ORIENTATED AND ALERT	TROLLEY RAILS NOT RECOMMENDED	

Would patient Like trolley rails used: YES/NO (please circle)

Other relevant information:

first seizure

clinic

Management of Adults with an Uncomplicated First Generalised Seizure

Inclusion Criteria	Patients >16 yrs; Clear history of first generalised seizure; Seizures related to drug or alcohol ingestion or withdrawal
Exclusion Criteria	Patients with non-epileptic attacks (e.g.syncope, panic attacks, pseudoseizures); Patients with known seizure or metabolic disorder; Seizures related to recent trauma or eclampsia

610119466W /E5618893 M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
70911 PC Leslie
42 Morvenside
EH14 2SJ

History Table

	✓ ✓
Witness History	✓
Type of seizure (generalised, partial)	Generalised
Previous history of seizures, febrile fits, birth trauma, meningitis, head injuries	PMH Haemorrhagic Stroke 2012
Family history of seizures	No
Possible precipitating events (alcohol, drugs, sleep deprivation)	No

Temperature	Pulse	Bp	BM	Breath Alcohol
36.7	76	134/89	6.1	Nil

GCS			Pupils				Limb movement			
15			Right		Left		R arm	L arm	R leg	L leg
E	M	V	Size	Reaction	Size	Reaction				
4	6	5	3	N	3	N	N	N	N	N

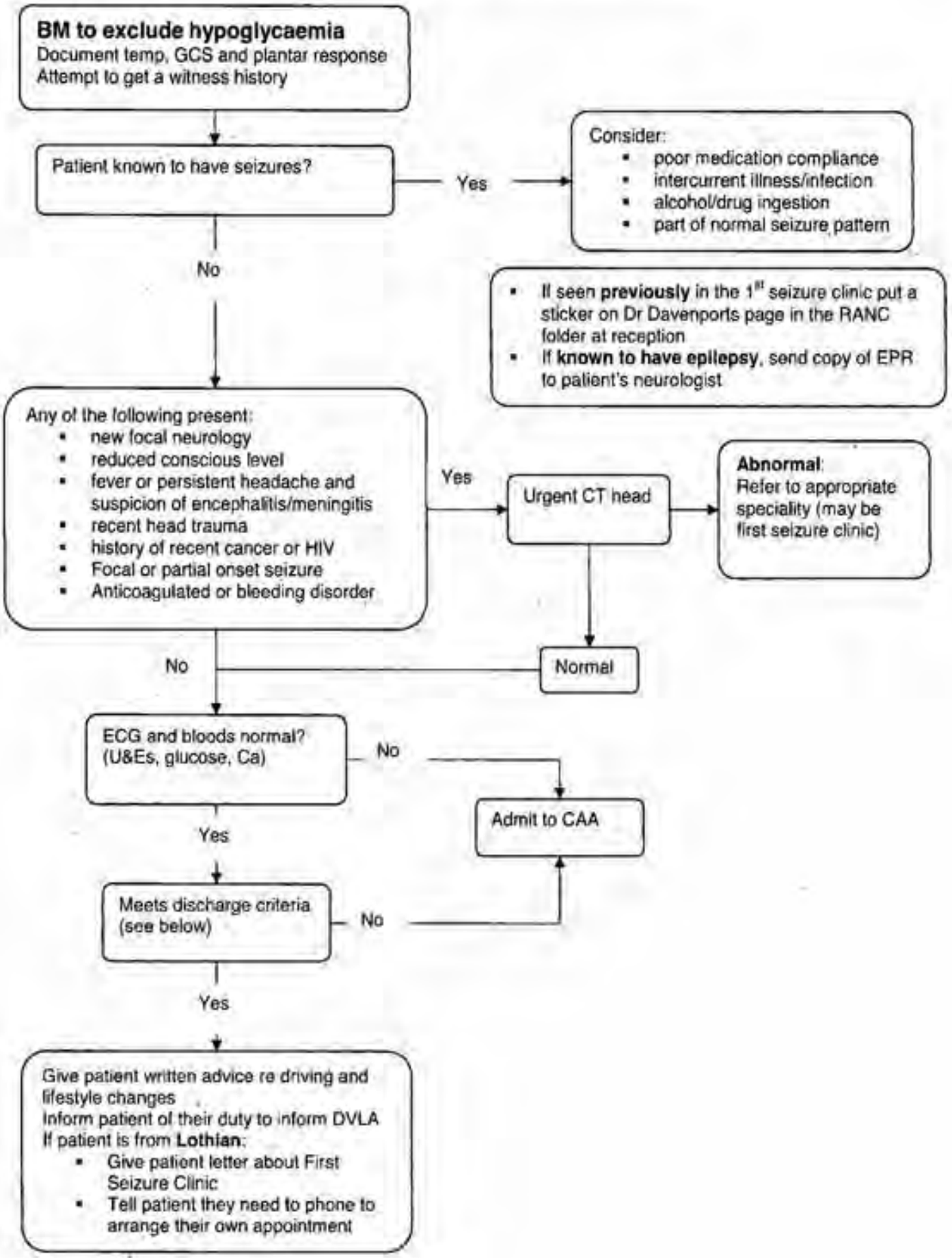
ECG	SR. NM Acute		
Urea	3.4	Hb	150
Creat	59	MCV	96
Na	140	WBC	16.4
K	3.9	Plt	312
CO2	26	Bil	17
Ca	2.36	GGT	
Alb	47	ALT	16
Gluc	6.0	Alk Phos	111
CT	Nil acute		

Indications for a CT scan prior to disposition:
- New focal neurology
- Reduced conscious level
- Fever or persistent headaches with suspicion of encephalitis/meningitis
- Recent head trauma
- History of recent cancer or HIV infection
- Patients with focal or partial onset seizures
- Patients whose follow up cannot be ensured
- Anticoagulation or bleeding diathesis

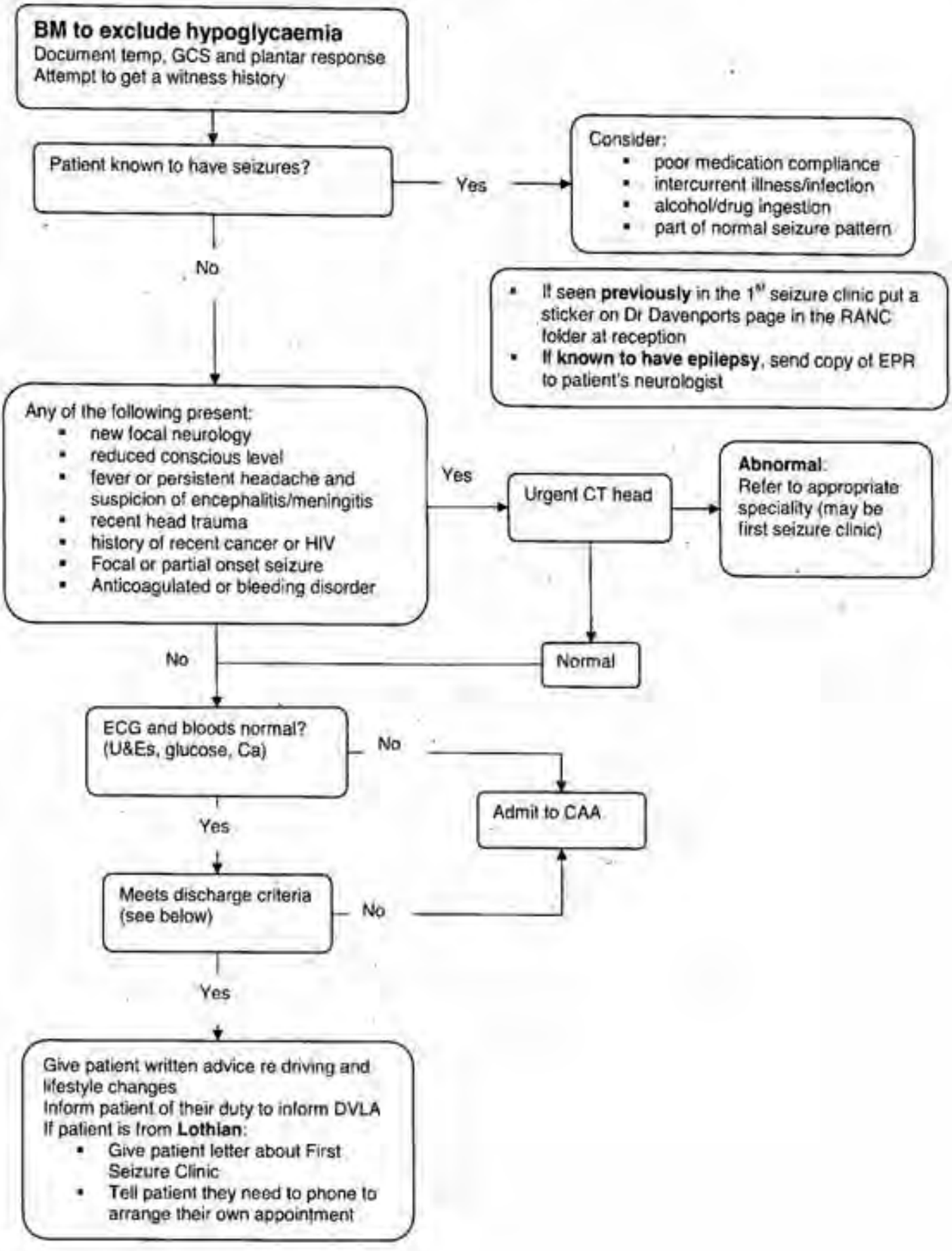
Discharge Table

	✓
Patient has a Lothian Postcode	✓
Patient has fully recovered with no persistent neurological symptoms/signs (including headache)	✓
Normal investigations and observations (including temperature)	✓
Patient has been given written advice about driving and lifestyle changes, and has been informed of their duty to inform the DVLA, if appropriate	✓
Patient has a responsible adult to stay with following discharge	✓
Patient will attend follow up	✓
Patient has been given First Seizure Clinic letter	✓
Patient informed they must make their own appointment for follow up	✓
Copies of all notes and investigations forwarded to the First Seizure Clinic	✓

Adult Seizure Protocol



Adult Seizure Protocol



Management of Adults with an Uncomplicated First Generalised Seizure

Inclusion Criteria	Patients >16 yrs; Clear history of first generalised seizure; Seizures related to drug or alcohol ingestion or withdrawal
Exclusion Criteria	Patients with non-epileptic attacks (e.g.syncope, panic attacks, pseudoseizures); Patients with known seizure or metabolic disorder; Seizures related to recent trauma or eclampsia

Name:
DoB:
Address

Tel no

History Table

	✓
Witness History	
Type of seizure (generalised, partial)	
Previous history of seizures, febrile fits, birth trauma, meningitis, head injuries	
Family history of seizures	
Possible precipitating events (alcohol, drugs, sleep deprivation)	

Temperature	Pulse	Bp	BM	Breath Alcohol

GCS			Pupils				Limb movement			
			Right		Left		R arm	L arm	R leg	L leg
E	M	V	Size	Reaction	Size	Reaction				

ECG			
Urea		Hb	
Creat		MCV	
Na		WBC	
K		Plt	
CO2		Bil	
Ca		GGT	
Alb		ALT	
Gluc		Alk Phos	
CT			

Indications for a CT scan prior to disposition:

- New focal neurology
- Reduced conscious level
- Fever or persistent headaches with suspicion of encephalitis/meningitis
- Recent head trauma
- History of recent cancer or HIV infection
- Patients with local or partial onset seizures
- Patients whose follow up cannot be ensured
- Anticoagulation or bleeding diathesis

Discharge Table

	✓
Patient has a Lothian Postcode	
Patient has fully recovered with no persistent neurological symptoms/signs (including headache)	
Normal investigations and observations (including temperature)	
Patient has been given written advice about driving and lifestyle changes, and has been informed of their duty to inform the DVLA, if appropriate	
Patient has a responsible adult to stay with following discharge	
Patient will attend follow up	
Patient has been given First Seizure Clinic letter	
Patient informed they must make their own appointment for follow up	
Copies of all notes and investigations forwarded to the First Seizure Clinic	

Patient ID sticker

DATE:

Dear

We think it is possible that you have had an epileptic seizure (fit) to account for your recent symptoms. We are therefore referring you to a specialist for a further opinion regarding the diagnosis, investigations and treatment if necessary.

To make your appointment, you need to telephone 0131 312 1552 between Monday-Friday 0900-1700. You should ask the receptionist to book you an appointment in the next available **First Seizure clinic** and we recommend that you have a pen and piece of paper handy to note the date, time and venue of your appointment. Clinics take place in the Department of Clinical Neurosciences at the **Royal Infirmary of Edinburgh**.

- If you would prefer a telephone consultation rather than come up to clinic, please advise the receptionist of this; they will note this and take your phone number. Please make sure you are available in a quiet place to take the call at the appointed time.
- If someone witnessed your collapse or funny turn, then please bring them with you to the clinic, or arrange for them to be contactable by phone, as the specialist may wish to speak to them.
- Please bring any prescription medications that you are taking with you, in their packaging, or a list of the medications and doses that you are taking.
- If you hold a driving licence, we advise that should you not drive until you have been seen in the clinic and this will be discussed further.

Doctor's name (printed):.....

Where applicable, the responsible hospital doctor should document in hospital records that patient has been given this letter.

Doctor's signature:.....

INFORMATION FOR PEOPLE WHO HAVE HAD A SINGLE SEIZURE

This page contains some information relevant to people who have had their first ever seizure (aka convulsion or fit). A single seizure is not the same as epilepsy, which is only diagnosed after two or more unprovoked epileptic seizures. Seizures may be provoked by a number of things, including sleep deprivation, drugs or alcohol, or disturbances in blood chemistry. Your specialist will advise you whether your seizure was thought to be provoked or not.

Tests

Most people will require tests after a seizure, which may include blood tests, a heart tracing (ECG), a brain wave tracing (EEG) and a brain scan. Not all people will require all these tests, your specialist will advise.

Treatment

Usually we do not recommend treatment after a single seizure, but there are occasional circumstances where this might be appropriate.

Driving

If you hold a UK driving licence (full or provisional), and have had a seizure (of any kind), you are legally obliged to inform the DVLA, and seek their guidance on your ability to drive; usually they will indicate that you must not drive until 6 months after your seizure. Further information is available from the DVLA:
http://www.direct.gov.uk/
Tel 0300 790 6806
email: eltd@dvla.gsi.gov.uk

What to do if you have another seizure

The risk of having a further seizure after the first one varies considerably, but overall is about 50% in the first year after your first seizure. If you have another seizure (or suspect you might have had), it is important that you inform your GP and/or specialist as this lead to changes in your treatment. First aid advice for carers is available at the websites listed below.

More information about seizures is available from:

EPILEPSY SCOTLAND
http://www.epilepsyscotland.org.uk/
Helpline: 0808 800 2200

EPILEPSY ACTION
http://www.epilepsy.org.uk/
0808 800 5050

NHS LOTHIAN
Emergency Department
Adult Majors
Prescription, Administration & Observation Record

NHS Lothian

Ricky

610119466W /E5618893 M
TAYLOR Richard
10-Jun-63 **CHI:** 100 663 1372
70911 PC Leslie
42 Morvenside
EH14 2SJ

The section below must be completed before any medicine is prescribed/given Likes to be known Ricky.

Previous Adverse Reactions	Weight kgs Actual / Estimate	Date
cocodamol. Morphine		26/2/24

Once Only Prescription

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber Sign & Print	Time Given	Issued by (Initials)	Checked by if applicable (Initials)
26/2/24	2100	ONDANSETRON	4mg	IV		2100		EW.
26/2/24	2130	PARACETAMOL	1g	P.		2105		
26/2/24	2230	CYCLIZINE	50mg	IV		2255		JE

Discharge Medication

Date & Time	Medicine (Approved Name)	Dose	Frequency	Route	Quantity	Duration	Prescriber Sign & Print	Issued by (Initials)	Checked by (Initials)

National Early Warning Score 2 (NEWS2) Chart

NEWS Key 0 1 2 3		Date																			
		Time:																			
A+B Respirations Breaths/min	≥25									3											
	21-24									2											
	18-20																				
	15-17	17		16																	
	12-14																				
	9-11									1											
	≤8									3											
A+B SpO_2 Scale 1 Oxygen saturation (%) Use Scale 1 if target range is 94-98%	≥96	98		98																	
	94-95									1											
	92-93									2											
	≤91									3											
SpO_2 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	≥97 on O_2									3											
	95-96 on O_2									2											
	93-94 on O_2									1											
	≥93 on air																				
	88-92																				
	86-87									1											
Tick box if using SpO_2 Scale 2 ☐	84-85									2											
Sign	≤83									3											
Air or Oxygen? Oxygen is a drug and prescribed by target range	A = Air	A		RA																	
	O^2 L/min or %									2											
	Device																				
C Blood Pressure mmHg Score uses Systolic BP only If manual BP mark as M	≥220									3											
	201-219																				
	181-200																				
	161-180																				
	141-160																				
	121-140	139		130																	
	111-120																				
	101-110									1											
	91-100									2											
	81-90	84																			
	71-80			77																	
	61-70									3											
	51-60																				
	≤50																				
C Pulse Beats/min Manual pulse	≥131									3											
	121-130									2											
	111-120																				
	101-110									1											
	91-100																				
	81-90																				
	71-80																				
	61-70			66		62															
	51-60	54																			
	41-50									1											
	31-40									3											
	≤30																				
D Consciousness Score for new onset of confusion (no score if chronic)	Alert	A		RA																	
	New Confusion									3											
	V																				
	P																				
	U																				
E Temperature °C	≥39.1°									2											
	38.1-39.0°									1											
	37.1-38.0°																				
	36.1-37.0°			36.6		8		6													
	35.1-36.0°	35		9						1											
	≤35.0°									3											
NEWS TOTAL		1		0		0															
Monitoring frequency		12H		2H		12															
Escalation of care Y/N		Y		N		N															
Blood Glucose reading or N/A		-		N/A		-															
Pain score (0-10)		-		0		0															
Initials		SO		CE																	

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.

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.**

Signs of Infection

- Temperature <36°c or >38°c
- Heart rate >90 beats pm
- Respiratory rate >20 breaths pm
- New confusion
- WCC <4 or >12
- Blood sugar >7.7 in non-diabetic

610119466W/E561E.9
TAYLOR Richard
10-Jun-63 **CHI:** 100 663 1372
70911 PC Leslie
42 Morvenside
EH14 2SJ

NEWS Total	Monitoring Frequency	Clinical Response
Total 0	Commence on 2 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
Total 1 - 4	Commence on 1 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
3 in one parameter *	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to Nurse In Charge (NIC) and Senior Medic
Total 5 - 6	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Total 7 or more	Commence on 15 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Special Instructions		

*or increase in NEWS score of 2

Conscious Level Chart to be completed when clinically indicated

		Date	
		Time	
GLASGOW COMA SCALE	Eyes Open	Spontaneously	4
		To speech	3
		To pain	2
		None	1
	Best Verbal Response	Orientated	5
		Confused	4
		Inappropriate words	3
		Incomprehensible sounds	2
		None	1
	Best Motor Response	Obey commands	6
		Localise to pain	5
		Flexion to pain	4
		Abnormal flexion	3
		Extension to pain	2
		None	1
		Total GCS Score	
Right Pupil		Size	
		Reaction	
Left Pupil		Size	
		Reaction	
LIMB MOVEMENT	ARMS	Normal power	
		Mild weakness	
		Severe weakness	
		Extension	
		No response	
	LEGS	Normal power	
		Mild weakness	
		Severe weakness	
		Extension	
		No response	
		Initials	

Eyes closed by swelling = C

Endotracheal tube or tracheostomy = T

Always record the best arm response

+ reacts
- no reaction
c. eye closed

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

Pupil Scale mm 1 2 3 4 5 6 7 8

IV Fluid Prescription

Time Prescribed	Fluid	Volume	Rate	Prescribers Signature	Time Started	Given by (Initials)	Checked by (Initials)	Time Finished

Fluid Balance

INPUT						OUTPUT				
	IV Fluids or SC Fluids IV Medication	**IV Line(s)**	**Oral Input**		**Input**		**Urine**		**Gastric**	
Time	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100ml	Running Total	Time	Volume	Running Total	Volume	Running Total

Drug Infusion

Drug Name:

	Time													
	Rate (ml/hr)													
	Volume in Syringe													
Pump No	Total amount Infused													

Drug Name:

	Time													
	Rate (ml/hr)													
	Volume in Syringe													
Pump No	Total amount Infused													

TAYLOR, RICHARD ID:1006631372 26-Feb-2024 21:11:52 NHS LOTHIAN-RIE_ED ROUTINE RECORD

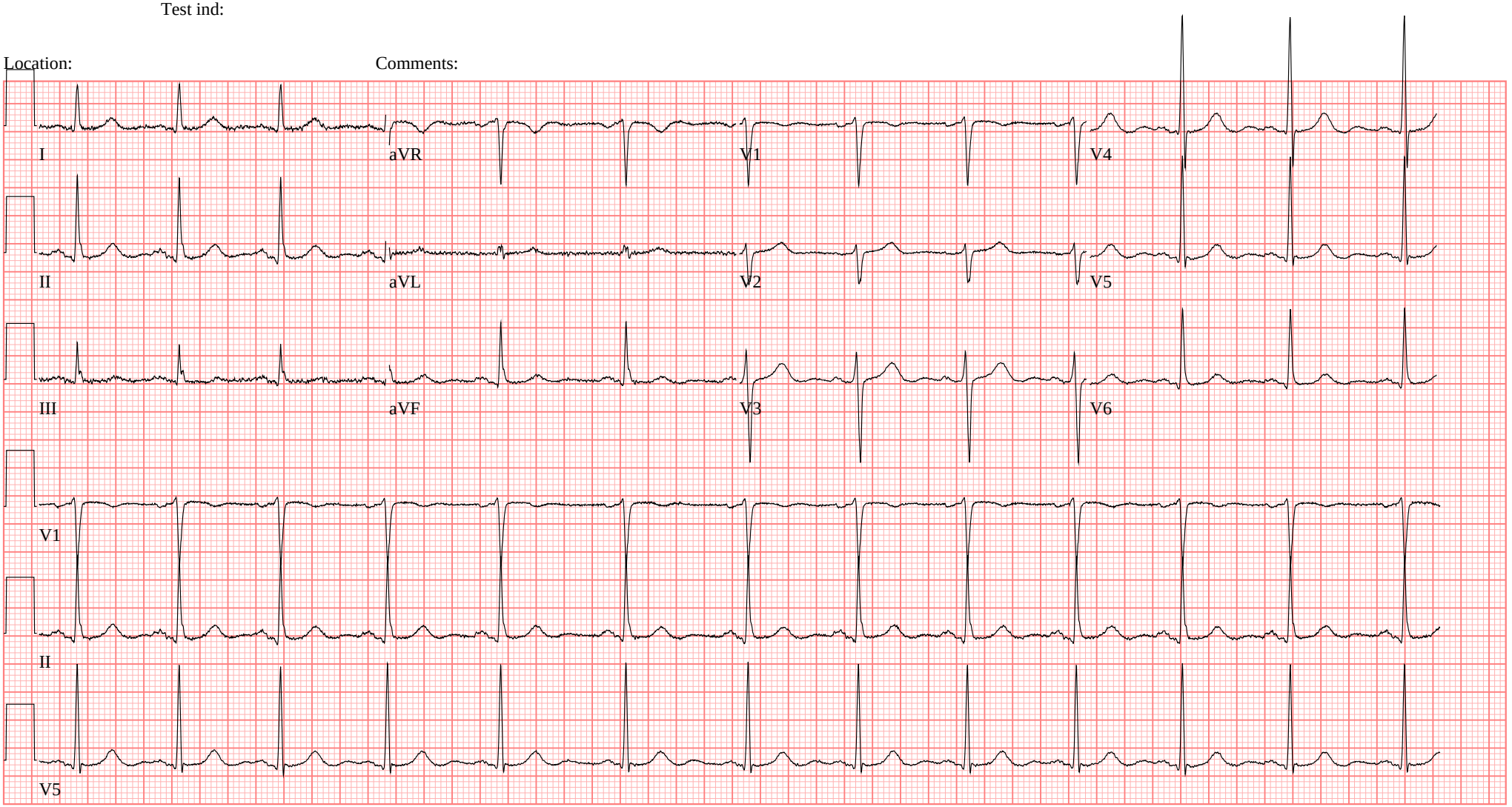
10-Jun-1963 (60 yr)
Male Unknown

Room:
Loc:40

Vent. rate	76	BPM
PR interval	146	ms
QRS duration	86	ms
QT/QTcB	390/438	ms
P-R-T axes	73 58	46

Technician:
Test ind:

Location: Comments:



25mm/s 10mm/mV 150Hz 10.1.3 12SL 243 CID: 38528

SID: 1008119 EID: 13 EDT: ORDER:

Patient Information

RICHARD TAYLOR

Age/Gender: 60Y Old Male
Address: 42 MORVENSIDE EDINBURGH,EH14 2SJ
DOB: 10/06/1963
CHI: 1006631372
Ethnicity:

Date: 03/06/2024
Incident Number: CR010979657
Incident Type: EMG
Incident Location: 42 MORVENSIDE EDINBURGH, EH14 2SJ

Scottish Ambulance Service

Presenting Complaint

60 YOM LOWER BACK PAIN

Additional Comments

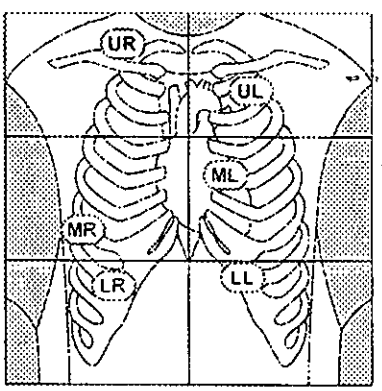
Pmhx- Gallbladder removed. Previous rib # to left hand side. P/c- 3/7 hx of bilateral lower back pain. Gp out to assess pt at home today. Arranged amb to attend and transport to WGH. O/a- Pt's partner greeted crew at the door. Pt standing upright in the kitchen. Appeared in obvious pain. O/e- Pt reports feeling sob due to pain stopping him from taking a deep breath. Chest auscultated- as recorded. Denies recent coughs or colds. Denies chest pain, tightness or palpitations. Reports pain as recorded on bodymap. Pt denies any trauma to the area. Last urine output was approx 1900 and was dark orange. Reports decreased fluid intake due to ongoing pain. Denies unilateral leg tenderness. Denies haemoptysis, coughs or colds. Drugs given to good effect. Settled during transport.

PATIENT ASSESSMENT

ACVPU Alert <C> No

A Clear

B Breathing Adequately: Yes | Respiratory Rate 24 | SPO2 100

Normal Breath Sounds	UR		UL	Normal Breath Sounds
Normal Breath Sounds	MR		ML	Normal Breath Sounds
Normal Breath Sounds	LR		LL	Normal Breath Sounds

C

Pulse Rate	BP	Cap Refill	ECG Rhythm
154	145/86	<=2 Secs	

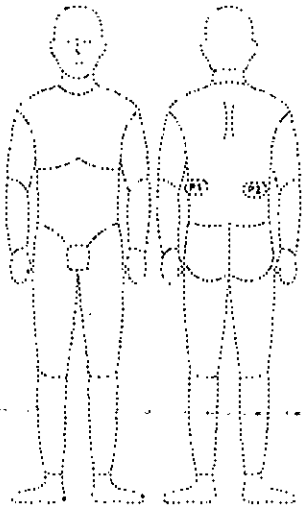
Rhythm	Arm	Central/Peripheral	ECG
Reg	Right	Peripheral	3 Lead

IV(R)
ACF

D

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

E



Pain

ID	Body Part	Pain Scale
P1	Back Body	10
P2	Back Body	10

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
20:25	83	18	158/101	99	<=2s	15	Alert		36.7	7.9					E0036838
20:07	93	18	167/111	98	<=2s	15	Alert								E0036838
19:40	154	24	145/86	100	<=2 Secs	15	Alert		36.7	7.9		5	5		E0036838

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
20:25	18 (0)	99 (0)		0	158 (0)	83 (0)	Alert (0)	36.7 (0)	0
19:40	24 (2)	100 (0)		0	145 (0)	154 (3)	Alert (0)	36.7 (0)	5

Drugs

Time	Drug	Desage	Units	Route	Drug Expiry Date	Pain Before	Pain After	CrewID
19:48	Saline flush	5	ml	IV	09/2023			E9887259
19:49	Paracetamol	1	g	IV	01/2026	10	8	E9887259
19:51	Saline flush	5	ml	IV	09/2023			E9887259

HISTORY

AMPLE

Allergies	MORPHINE
Medication	Omeprazole

Social History

Lives alone	No	Living With	CHILDREN	Patient Occupation	Does Not Work

Patients General Appearance	Normal
Patient Mobility	IBEX CHAIR TO AM8
Patient Communication	No Help Required
Patient Clinical Risk Factors	None Identified
Patient Enviromental Risk Factors	None Identified

SOCRATES

Site	BILATERAL LOWER BACK PAIN	Onset	SATURDAY, 03/06/2024
Character	Worsening	Radiates	No

NHS Lothian

610119466W /E5712000 M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
70911 PC Leslie
42 Morvenside
EH14 2SJ

Nursing Assessment Triage Form

Date: 3/6/24	Time of Triage:	20^{30}
Name of nurse completing triage (print name): Sarah & Caitlin		

Presentation:
back pain

Discriminator:
limp problem
~~– moderate pain~~

Triage category: severe pain
T3

History:
sudden onset back pain since saturday

Allergies:
check track
? opiates
gall bladder removal

Falls Risk Sticker

FALLS RISK? YES ☐ NO ☐ If YES, please affix a sticker above 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: __/__/__ inserted ambulance	
Nurse's signature: Print name:	Date: 3/6/24

154/99 90
96%
37.1

NHS Lothian

Medical Assessment Unit Admission Care Plan and Checklist	Addressograph, or Name: DOB: Hospital no/CHI:

Date/time	Progress Notes	Signature/print name

NURSING ADMISSION CHECKLIST

Standard Admission Procedures	**Initials**
Vital signs recorded YES ☐ NO ☐ N/A ☐	
NEWS 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**	Addressograph, or Name: DOB: Hospital no/CHI:

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					
Clinical Area					
Care Round Leader's Initials					
Review Frequency of Vital Signs & Cardiac Monitoring					
Vital Signs Frequency					
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)					
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					
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☐

NHS Lothian

Medical Assessment Unit Care Rounding Cont'd	Addressograph, or Name: DOB: Hospital no/CHI:

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	

Bristol Stool Chart

610119466W /E5712000 M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
70911 PC Leslie
42 Morvenside
EH14 2SJ

NHS Lothian

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 easily)	Type 6  Fluffy pieces with ragged edges, a mushy stool
Type 7  Watery, no solid pieces. **Entirely Liquid**	Reproduced with kind permission of Dr KW Keaton, Reader in Medicine at the University of Bristol.

Date	Time	Colour	Type	Amount	Blood	Mucous	Comments	Initials
5/6/24	1600	Brown	7	med	—	—	in toilet	NH
6/6/24	12:00	Brown	6/7	med	—	—	in toilet	NH

Ward: WM Site: WGH Date: 4/6/24

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

Name: 610119466W/E5712000 M TAYLOR Richard 10-Jun-63 CHI: 100 663 1372

DOB: 70911 PC Leslie 42 Morvenside EH14 2SJ

Unit no. / Cl

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	02:00	06:00	10:30	14:00	22:00	02:00	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)	/	N	N	N	N	N	N						
Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister	NS	NS	NS	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	N	Y	Y	Y	Y	Y						
Positioning (R) or (L) side (B) Back (C) Chair	B	B	B	B	B	B	B						
Mattress type / Cushion type	*please state type:*												
Elimination													
Do you need the toilet?	N	N	N	N	Y	N	I						
Is the patient continent of urine? (at time of Care Rounding)	Y	Y	Y	Y	Y	Y	Y						
Continence product changed/offered?	/	/	N	N	O	N	N						
Catheter care performed?	/	/	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	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	AS	WR	WR	W	W	W						
Fluid Balance Chart (if clinically indicated)	N	N	Y	Y	Y	Y	Y						
When did you last eat?	/	/	B	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	N	N						
Falls													
Appropriate Footwear?	Y	Y	Y	Y	Y	Y	Y						
Walking aid available(and within reach)	/	/	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?	/	/	N	/	/	/	/						
Glasses available for use? (if worn) Hearing aid available for use? (if worn)	/	/	N	/	N	N	N						
Requires close observation for commode, toilet, bathing or showering Y ☐ N ☑													
Pain													
Are you in pain?	Y	AS	Y	Y	Y	Y	Y						
Analgesia Given?	Y	AS			Y	Y	Y						
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	AS	Y	Y	Y	Y	Y						
Anything else I can do for you?	N	AS	N	N	Y	Y	Y						
Buzzer within easy reach	Y	Y	Y	Y	Y	Y	Y						

Personal Care *Type* Bath *(specify)* **Time Given** 1600

Initials – document at time of care delivery	JA	AR	[illegible]	[illegible]	SG	SG	SG						

Ward: MAU Site: RVH Date: 6/6/24

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 J MACAULAY J.MACAULAY

Addressograph, or

610119466W /E5712000 M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
70911 PC Leslie
42 Morvenside
EH14 2SJ

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	8:00	12:49	16:27	22:15	02:05	06:10						
	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	N	N	N	N						
	Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister	NS	NS	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	N	N						
	Positioning (R) or (L) side (B) Back (C) Chair	B	B	B	B	B	B						
	Mattress type / Cushion type	*please state type:*											
Elimination	Do you need the toilet?	N	Y	Y	Y	AS	AS						
	Is the patient continent of urine? (at time of Care Rounding)	Y	Y	Y	Y	AS	AS						
	Continence product changed/offered?	Y	Y	N	O	AS	AS						
	Catheter care performed?	N	N	N	NA	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	N	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	NR	AS	AS						
	Fluid Balance Chart (if clinically indicated)	N	N	N	Y	Y	Y						
	When did you last eat?	B	S	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)	N	N	N	N	AS	AS						
Falls	Appropriate Footwear?	Y	Y	Y	Y	AS	AS						
	Walking aid available(and within reach)	N	N	N	N	N	N						
	Area de-cluttered?	Y	Y	Y	Y	Y	Y						
	Chair and bed height assessed?	Y	Y	Y	Y	Y	Y						
	Falls alarm in use and attached?	N	N	N	N	N	N						
	Glasses available for use? (if worn) Hearing aid available for use? (if worn)	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N						
	Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐												
Pain	Are you in pain?	Y	Y	Y	Y	AS	AS						
	Analgesia Given?	Y	Y	Y	Y	AS	AS						
General	Peripheral Venous Cannula observed?	Y	Y	Y	Y	AS	AS						
	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	AS						
	Anything else I can do for you?	N	N	N	N	AS	AS						
	Buzzer within easy reach	Y	Y	Y	Y	AS	AS						
Initials – document at time of care delivery		AO	KO	AO	JM	JM	JM						

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

Ward RNH Beds Site NGH Date 06/06/24

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
610119466W /E5712000 M
Name TAYLOR Richard
10-Jun-63 **CHI:** 100 663 1372
DOB 70911 PC Leslie
42 Morvenside
EH14 2SJ
Unit no. / CH

Codes (Y) Yes, (N) No, (N/A) not applicable,(O) 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	08.00	12.00	13.30	18.30									
	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	/	/	/								
	Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister	NS	N	N	N								
	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	C	C								
	Mattress type / Cushion type	*please state type:*											
Elimination	Do you need the toilet?	N	T	I	T								
	Is the patient continent of urine? (at time of Care Rounding)	Y	Y	Y	Y								
	Continence product changed/offered?	REF	NA	NA	NA								
	Catheter care performed?	—	NA	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	WR	W	W	W								
	Fluid Balance Chart (if clinically indicated)	Y	NA	NA	NA								
	When did you last eat?	B	L	S	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)	N	NA	NA	NA								
	Area de-cluttered?	Y	Y	Y	Y								
	Chair and bed height assessed?	Y	Y	Y	Y								
	Falls alarm in use and attached?	—	✓	NA	NA								
	Glasses available for use? (if worn) Hearing aid available for use? (if worn)	Y N	Y N	Y N	Y N								
	Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐												
Pain	Are you in pain?	Y	N	Y	N								
	Analgesia Given?	Y	N	Y	Y								
General	Peripheral Venous Cannula observed?	NS	NA	NA	NA								
	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* REFUSED *(specify)* **Time Given** _____

Initials – document at time of care delivery	SC												

Ward:	Site:	Date:	Addressograph, or
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 DOB Unit no. / CHI

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													
	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												
	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?												
	Positioning (R) or (L) side (B) Back (C) Chair												
	Mattress type / Cushion type	*please state type:*											
Elimination	Do you need the toilet?												
	Is the patient continent of urine? (at time of Care Rounding)												
	Continence product changed/offered?												
	Catheter care performed?												
	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)												
	Bowel function monitored	Observe bowel function and update daily											
Food, Fluid & Nutrition	Would you like a drink? Ensure fluids are within easy reach												
	Fluid Balance Chart (if clinically indicated)												
	When did you last eat?												
	(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)												
Falls	Appropriate Footwear?												
	Walking aid available(and within reach)												
	Area de-cluttered?												
	Chair and bed height assessed?												
	Falls alarm in use and attached?												
	Glasses available for use? (if worn) Hearing aid available for use? (if worn)												
	Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐												
Pain	Are you in pain?												
	Analgesia Given?												
General	Peripheral Venous Cannula observed?												
	Observe for signs of inflammation/swelling at every CR session. **Bundle/VIP score to be updated daily**												
	Are you comfortable? Y/N												
	Anything else I can do for you?												
	Buzzer within easy reach												

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

Initials – document at time of care delivery													

NHS Lothian

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

Dr PC Leslie
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date: 25/06/2024

Emergency Discharge Summary

Patient	Richard Taylor 42 Morvenside Edinburgh EH14 2SJ	**CHI**	**1006631372**
		Date of Birth / Age	10/06/1963 (61 years)
		UHPI	610119466W
		A&E Attendance Number	E5731989
Attendance Date	24/06/2024	**Contact**	Taylor Arrices
Attendance Time	05:02		
Mode of Arrival	Emergency Ambulance		
Source of Referral	999 Emergency		
Discharge Date	24/06/2024		
Discharge To			

Dear Dr PC Leslie

Presentation: FACIAL INJURIES, recent problem, T4, Unwitnessed fall at approx 2200, found on ground by daughter at 2300. Unsure of what has happened. Laceration to top of head and L eye. Not bleeding. Recent T9 #, struggling with pain. Settled and sleeping with SAS

CLINICAL NOTES:
Clinical note: Lotte Smals, Clinical Fellow A&E

61M, BIBA, attends alone

PC/ ?collapse

HPC/
- Pt is very poor historian. Can't remember what happened, can't remember how he got in hospital. Only gives yes/no answers
- From SAS note: Pt returned home from playing dart with a friend at approx 22pm. Pt felt dizzy and nauseaus, ten vomited once. Pt tehn states he went to bed. Daughter found him lying on bedroom floor at approx 23pm, bleeding from injury to top of skull and left cheekbone. According to daughter, pt appears confused. Pt vomited while crew in attendance. Temp 38.2 with SAS.
- Pt hasn't taken any alcohol tonight. Has used cannabis. Does this every week.
- Pt has been struggeleing with pain from vertebrae #. He ran out of tramadol 2 days ago.
- Has otherwise been doing well over the past days he states, however pt appears a bit confused, so not very clear how thrustworthy this information is.

PMH/
06/2024 Presentation with T9 compression fracture, mild superior endplate fracture of L4 vertebra and Constipation
First ever generalised convulsion February 2024

1.1 CT head: established right putaminal lacune, no acute changes
Previous ?dissociative episodes
Right hemisphere intracranial haemorrhage 2004 with good recovery
Previous depression with deliberate self harm including stabbing 2019
Cholecystectomy 2018

SH/ States lives alone but daughter was visiting for the weekend. From other notes pt appears to have partner. Other notes states pt lives with son and daughter

OE/
NEWS 2: RR 18/min, sat 95%, BP 115/81, pulse 86bpm, temp 38.1
A: self-maintained, C-spine tender to palpation at level C4-5
B: No visible chest injury, normal auscultation, chest not tender to palpation
C: WWP, CR<2sec, abdomen soft but tender in right lower abdomen, pelvis/femur/humerus not tender
D: GCS15, alert, oriented to person and place and partially to time (knows it is june, but guesses it's 2021)
Pt has an dissociative episode while I examine him. He stares into the room with wide eyes and doesn't speak
Cranial nerves: PEARL, normval vision/visual fields/eye movements, normal speech and language, normal motor/sensor function of the face, m. trapezius 5/5, m. sternocleidomastoideus 5/5
E: 2 cm laceration to left temporal lobe, bruising around the left eye with mild tenderness over lower orbit

Ix/
- Bloods: WCC 15.5, normal U&E/LFT, Alk. Phos 141, trop 16
- ECG: NSR
- VBG: pH 7.42, Lac 1.0, Glu 6.8

Imp/ 61M with background of 1x seizure and dissociative episodes, now presents with:
- Fall with headinjury (amnesia for full event) ?seizure ?dissociative episode ?related to infection
- Vomiting (started BEFORE fall) and pyrexia ?gastro-enteritis

Plan d/w Dr. Tennyson (EM reg)/
- CT head and neck ordered
- CRP, amylase, Ca and albumin added on to bloods
- Analgesia (oramorph) for backpain
- Consider contacting daughter for further details about event last night

==========

ED SAS Maclachlan
Handed over to me this am
AW CT head and neck for facial injury and neck pain unkown cause
Spiked T so for CXR ?aspiration

Note LT lower back pain that is worse now - recent trx of tramadol and ralvo plasters - 1 - 2 weeks - took tramadol yesterday unsure how many - denies sedative SEs - pt denies ralvo at present

?Seizure ?trauma
See CT head and neck and can rv lower back
Analgesia pre scan

Collateral from partner

Note she lives with pt over weekend and away during week
Pt lives with her daughter / his step daughter Patches for back 2 - 3 weeks with pain
Went on tramadol a week ago and ran out over weekend

Panic attack yesterday - confusion and sweats and unsteady and panic

Friends took to darts and only lasted 10 mins - due to back pain

Home approx 1910
Daughter home 2200 and checked on him
In bed with head injury and blood on radiator - ,maybe trying to close curtains
Just mumbled to daughter nonsence - she called ambulance

Seen in first seizure clinic in Feb after presentation to this ED - no agent stated
Seen several years ago in SJH neurology June 23 - 'memory concern'

Course/ issues
1 - Back pain in lower thorax awiting XR ?acute on chronic injury - no neurology - refractory to oramorph and diazepam so far - previously under medics with compression #
2 - Spike T of 38.2 no clear source CXR ok ?aspiration ?discitis (CRP <1 so felt less liekly)
3 - Possible seizure - dw neurology and agree resonable to start an agent but no urgency - if stayig under medics will rv

Given above - admit medicine for analgesia, septc screen and neurolgy rv

Yours Sincerely,

Dr Lotte Smals, Doctor

NHS Lothian

ED/Medical Assessment Unit
Care Rounding

Nam
DOB:
Hospit

610119466W /E5731989 M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
70911 PC Leslie
42 Morvenside
EH14 2SJ

Care Rounding Frequency	1 2 3 (4) hourly *Circle os oppropriote* *Review frequency 12 hourly or if clinicol condition requires*								
Print Name of the Nurse Reviewing					Date		24/6/24		
Time of Round	1140	15:32							
Clinical Area	PodA	PODS							
Care Round Leader's Initials	[illegible]	AO							
Review Frequency of Vital Signs & Cardiac Monitoring									
Vital Signs Frequency (please sign) *signoture*	30m								
Cardiac Monitoring required?	Y☐ N☒	Y☐ N☒	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
Pain Management (refer to doctor if analgesia is required)									
Pain score (0 – 10)									
Analgesia provided	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
Medication									
Is person due any routine medication?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
Mobility									
Fully weight bearing	☐	☐	☐	☐	☐	☐	☐	☐	☐
Requires some assistance/uses walking aid	☐	☐	☐	☐	☐	☐	☐	☐	☐
Non weight bearing – needs full assistance	☐	☐	☐	☐	☐	☐	☐	☐	☐
Identified as at risk of falls	☐	☐	☐	☐	☐	☐	☐	☐	☐
Elimination									
Ask patient if they require the toilet	☐	☐	☐	☐	☐	☐	☐	☐	☐
Patient is self-caring and can walk to toilet	☐	☐	☐	☐	☐	☐	☐	☐	☐
Patient is incontinent and requires assistance	☐	☐	☐	☐	☐	☐	☐	☐	☐
Patient has catheter in situ – checks required	☐	☐	☐	☐	☐	☐	☐	☐	☐

NHS Lothian

Nutrition and Hydration									
Patient is self-caring	☐	☐	☐	☐	☐	☐	☐	☐	☐
Patient needs assistance with food/drink	☐	☐	☐	☐	☐	☐	☐	☐	☐
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☐	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☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐
Snack	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐
Catered meal	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐
Visual Skin Inspection									
Skin is healthy – no concerns	☐	☐	☐	☐	☐	☐	☐	☐	☐
Visible areas of redness	☐	☐	☐	☐	☐	☐	☐	☐	☐
Broken skin and evidence of ~~pressure ulcers~~ injury	☐	☐	☐	☐	☐	☐	☐	☐	☐
Is a Waterlow assessment required	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	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☐	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	Y☐ N☐								
Urinary catheter	☐	☐	☐	☐	☐	☐	☐	☐	☐
Catheter insertion bundle completed	Y☐ N☐								
Infusion device	☐	☐	☐	☐	☐	☐	☐	☐	☐
NG tube / PEG tube / Tracheotomy	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐
Vulnerable Person/cognitive impairment	Is a 4AT required Y☐ N☐								
Family Communication	Patient & relatives present, and have been made aware of any changes ☐								
Cubicle Tidy *Ensure area is tidy and free of abstructions*	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

WRITE, IMPRINT OR ATTACH LABEL

Surname: _____ CHI No: _____

Forenames: _____ Sex: ____

DoB: _____

Location: _____

NHS Lothian

Adapted Waterlow Pressure Area Risk Assessment Chart

Undertake and document risk assessment within 6 hours of admission or on first home visit. Reassess if there is a change in individual's condition and repeat regularly according to local protocol.

		Scoring			
Date:		24/2/24			
Initials:		AS			
Time:		1:50			
Sex					
• Male	(1)	(1)			
• Female	2				
Age					
• 14 – 49	1				
• 50 – 64	2	2			
• 65 – 74	3				
• 75 – 80	4				
• 81+	5				
Build/Weight for Height (BMI=weight in Kg/height in m²)					
• Average – BMI 20-24.9	0				
• Above average – BMI 25-29.9	1				
• Obese – BMI > 30	2				
• Below average – BMI < 20	3				
Continence					
• Complete/catheterised	0				
• Incontinent urine	1				
• Incontinent faeces	2				
• Doubly incontinent (urine & faeces)	3				
Skin Type - Visual Risks Area					
• Healthy	0				
• Tissue paper (thin/fragile)	1				
• Dry (appears flaky)	1				
• Oedematous (puffy)	1				
• Clammy (moist to touch/pyrexia)	1				
• Discoloured (bruising/mottled)	2	2			
• Broken (established ulcer)	3	injury			
Mobility					
• Fully mobile	0				
• Restless/fidgety	1				
• Apathetic (sedated/depressed/reluctant to move)	2				
• Restricted (restricted by severe pain or disease)	3				
• Bedbound (unconscious/unable to change position/traction)	4				
• Chair bound (unable to leave chair without assistance)	5				
Nutritional Element					
• Unplanned weight loss in past 3-6 months					
• < 5% Score 0, 5-10% Score 1, >10% Score 2	0-2				
• BMI >20 Score 0, BMI 18.5-20 Score 1, BMI < 18.5 Score 2	0-2				
• Patient/client acutely ill or no nutritional intake > 5 days	2				
Special Risks - Tissue Malnutrition					
• Multiple organ failure/terminal cachexia	8				
• Single organ failure e.g. cardiac, renal, respiratory	5				
• Peripheral vascular disease	5				
• Anaemia = Hb < 8	2				
• Smoking	1	1			
Special Risks - Neurological Deficit					
• Diabetes/MS/CVA/motor/sensory/paraplegia Max 6	4-6				
Special Risks - Surgery/Trauma					
• On table > 6 hours	6				
• Orthopaedic/below waist/spinal (up to 48 hours post op)	5				
• On table > 2 hours (up to 48 hours post op)	5				
Special Risks - Medication					
• Cytotoxic, anti-inflammatory, long term/high dose steroid Max 4	4				
TOTAL SCORE		6			

More than one score / category can be used:
10+ = 'At Risk'; 15+ = 'High Risk'; 20+ = 'Very High Risk'

p.t.o.

Adapted from tissueviabilityonline.com / version 2 November 2009

2

Date &Time	Score	Equipment in use	Comments	Signature
24/06/24	6	Trolley	In Pain	AO

NHS Lothian

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

Dr PC Leslie
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date: 22/08/2024

Emergency Discharge Summary

Patient	Richard Taylor 42 Morvenside Edinburgh EH14 2SJ	**CHI**	**1006631372**
		Date of Birth / Age	10/06/1963 (61 years)
		UHPI	610119466W
		A&E Attendance Number	E5785068
Attendance Date	20/08/2024	**Contact**	Taylor Arrices
Attendance Time	23:55		
Mode of Arrival	Emergency Ambulance		
Source of Referral	999 Emergency		
Discharge Date	21/08/2024		
Discharge To			

Dear Dr PC Leslie

Presentation: APPARENTLY DRUNK RECENT MILD PROBLEM T4 Patient found in the middle of a road intoxicated. Patient had written a suicide note and left at home and then went to pub. Well known to police and SAS for similar presentations. GCS 10. NEWS 1 (T 35.1.) J

CLINICAL NOTES:
Clinical note: RIE ED

61yo gentleman BIBA
No history from patient.
Ricky is reported by the SAS to have left the house tonight and gone to the local pub where he drunk a lot of alcohol. Reported suicidal ideation and wrote a suicide note at home. Found lying in the road intoxicated.
SAS report he is well known to themselves and the police with these presentations.

On arrival to A&E heavily intoxicated.
Normal observations.
On review at 3am - lying in bed, fast asleep.
Rouses to voice, unwilling to speak but shakes head and nods appropriately.
Admits to heavy alcohol use, denies pain, feels 'rubbish', wishes to sleep.
No detectable head injuries. PEARL.
Able to move all 4 limbs.
Abdomen SNT.
Strong smell of alcohol.

For repeat review when more sober and if ongoing suicidal ideation on concern then may need MHAS review.

Update - left for a cigarette and did not return.

Not answering mobile.
Requested welfare check with police as may need to come back for MHAS assessment.

H Cole ST5 ED

Yours Sincerely,

Harriet L Cole, Doctor

Patient Information

RICHARD TAYLOR

Age/Gender: 61 years 2 months 10 days Old Male
Address: 42 MORVENSIDE EDINBURGH,EH14 2SJ
DOB: 10/06/1963
CHI: 1006631372
Ethnicity:

Date: 20/08/2024
Incident Number: CR011229569
Incident Type: EMG
Incident Location: JUNCT WITH CLOVENSTONE RD WESTER HAILES RD WESTER HAILES EDINBURGH, EH14 3HR

610119466W/E5785068 M 10/06/1963
Taylor, Richard
42 Morvenside,
Edinburgh,
EH14 2SJ

CHI 1006631372 [redacted]
70911 PC Leslie

Presenting Complaint

SUICIDAL, COLLAPSE OUTSIDE INTOXICATED

Additional Comments

S- Back up to pru, red response - See epcf Police i/a. Pt left suicide note in house, went to pub to drink to excess and was found lying at bus stop by police. B- pt known for behaviour similar this evening. Police i/a confirmed this to be o be case. Often drink to excess and then states he wants to end his life. A- o/a police and pru i/a. Pt lying beside bus stop, responsive to pain, o/a A- clear, patent and self maintained. B- nil dib/sob, no verbal as intoxicated. C- no obvious concerns, D- GCS13, difficult to assess neurological state. E- nothing noted, no obvious issues apparent. Pt vomited multiple times in presence of police and pru before crew attended imp intoxicated, mental health issues Plan- convey to RIE for safeguarding and further assessment, Police followed crew to RIE in own car.

PATIENT ASSESSMENT

ACVPU <C>

A

B

C

D

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
23:52	86	16	156/120	100		13	Alert		35.4						E9884760

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
23:52	16 (0)	100 (0)		0	156 (0)	86 (0)	Alert (0)	35.4 (1)	1

HISTORY

AMPLE

Allergies CODEINE

Medication SEE ECS INCL LAMOTRIGINE

Last Eaten Unknown

CLOSE RECORD

Treatment On Scene Non-Emergency

Conveyance

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

INCIDENT LOG

Time Call Received	22:40	**Allocated**	23:00	**Mobile**	23:01
First Resource On Scene		**Crew On Scene**	23:22	**Crew Left Scene**	23:35
Crew At Hosp	23:53	**Receiving Hospital**	NEW EDINBURGH ROYAL INFIRMARY	**Clear Time**	

Crew ID **Crew Grade** **Driver**

E1021109	Paramedic	YES
E9884760	Ambulance Technician	NO

Patient Information

RICHARD TAYLOR

Age/Gender: 61 years 2 months 10 days Old Male

Address: 42 MORVENSIDE EDINBURGH EH14 2SJ

DOB: 10/06/1963

CHI: 1006631372

Ethnicity:

Date: 20/06/2024

Incident Number: CRD1229569

Incident Type: EMG

Incident Location: JUNCT WITH CLOVENSTONE ROAD WESTER HAILES ROAD WESTER HAILES EDINBURGH EH14 2HD

610119466W /E5785068 M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
70911 PC Leslie
42 Morvenside
EH14 2SJ

Presenting Complaint

SUICIDAL - LEFT NOTE - LYING IN MIDDLE OF ROAD

Additional Comments

c/a Ricky was lying on the floor by the bus stop, police i/a. Ricky was alert to pain, gcs 13 o/e Police advised that Ricky had been seen by a member of the public lying in the middle of Westerhailes Road. He had left a suicide note in his house and went to the local pub. Members of the public advised that he had drank a large amount of alcohol. Ricky has had multiple episodes of vomiting. Not c/o any pain. Rousable to painful stimuli. No known injuries. No evidence of overdose. Intoxicated. Family aware and advised by police he is attending hospital. All obs as recorded.

PATIENT ASSESSMENT

ACVPU Alert **<C>** No

A Clear

B Breathing Adequately: Yes | Respiratory Rate: 16 | SPO2: 95

Initial SPO2 On: Air

C

Pulse Rate	BP	Cap Refill	ECG Rhythm
1	172/117	<=2 Secs	Sinus Rhythm

Rhythm	Arm	Central/Peripheral	ECG
Reg	Right	Peripheral	3 Lead

D

GCS	Eyes	Voice	Motor	PEARL
12	To Pain (2)	Confused (4)	Obeys Commands (6)	Yes

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
22:55	1	16	172/117	95	<=2 Secs	12	Alert		35.4	4.9	Sinus Rhythm	4	4		E9883666

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
22:55	16 (0)	95 (1)		0	172 (0)	1 (3)	Alert (0)	35.4 (1)	5

HISTORY

AMPLE

Allergies CODEINE

Medication Lamotrigine, Ibuprofen, Alendronic acid, Naproxen, Paracetamol

Past Medical History MH

Last Eaten Unknown

Events Prior LEFT SUICIDE NOTE IN FLAT. FOUND LYING IN MIDDLE OF ROAD TRYING TO KILL HIMSELF

CLOSE RECORD

Treatment On Scene Non-Emergency

Non-Conveyance

I have Seen, Examined the patient and (the patient/parent/or guardian and) I have reached the following decision. Dealt with by other vehicle

INCIDENT LOG

Time Call Received	22:40	Allocated	22:40	Mobile	22:41
First Resource On Scene		Crew On Scene	22:46	Crew Left Scene	
Crew At Hosp		Receiving Hospital		Clear Time	

Crew ID	Crew Grade	Driver
E9583666	Paramedic	YES

NHS Lothian
University Hospital Services
Department of Emergency Medicine

Dr. Dave McKean ED Clinical Director
Ray Middlemiss ED Clinical Nurse Manager
The Royal Infirmary of Edinburgh
51 Little France Crescent, Edinburgh, EH16 4SA
Tel: 0131 242 1300 Fax: 0131 242 1344

NHS Lothian

A/E no.	E5785068
Previous no.	E5731989
UHPI no.	610119466W
CHI no.	1006631372

Patient Information

Surname	Taylor	Date of Birth	10/06/1963
Forenames	Richard	Age / Sex	61 Yrs / M
Address	42 Morvenside		
Postcode	EH14 2SJ	Telephone	
Contact Address	Taylor, Arrices	Telephone	H W
Complaint	suicidal / intoxicated	Allergies	

Attendances in last 12 months: 5 School :

General Practitioner

Address	PC Leslie Sighthill Green Medical Practi Sighthill Health Centre Calder Road Edinburgh EH11 4AU
Telephone	0131 202 5888

Date and Time of Attendance	20/08/2024 23:55
	Incident Date Time:
Mode of Arrival	Emergency Ambulance 999 Emergency
Source of Referral	

Initial Triage Assessment

Presenting Complaint	
History of Presenting Complaint	
Assessment	

Nursing Observations & Assessments

TEMP	°C	SCORE	MIN. FREQ	(please tick)	Blood Sugar		Pain Score		/ 10	
HR		NEWS 0-1	Hourly		Peak Flow 1)		Analgesia Given		YES ☐	NO ☐
BP	/	NEWS 2-4	30mins Min		Peak Flow 2)		Fast Assessment		POS ☐	NEG ☐
SP02%	%	NEWS 5-7	15mins Min		Peak Flow 3)		Onset Time:			
RR		NEWS >7	10mins Min		Alcometer		Weight		Height	
AVPU		Special Clinical Instructions								
On Therapy In Progress	Yes (= +2) No (= 0)	Please indicate any specific clinical observations to be continued or repeated once patient has left OPP								
NEWS SCORE										

Triaged By: Print Name: Signature: Triage Time:

Opp Care & Discharge Record

PVC Insertion - Please initial when complete

Handwash		Gloves	
CHD Skin Prep		Aseptic Insertion	
Dressing Labelled		Paperlite Bundle	
Reason for PVC Insertion:			

Blood Samples - Please tick all that apply

Routine		CRP	
Troponin		Coag	
Amylase		Tox Screen	
BTS		Other (Please state)	

Additional Investigations

ECG - Please tick

Required ☐ Done ☐

Urinalysis - Please tick

Required ☐ Done ☐

MSU Sent	Yes ☐	No ☐
HCG Consent	Yes ☐	No ☐
HCG Result	Yes ☐	No ☐

X-Rays - Please tick

CRX	Yes ☐	No ☐
CT Scan	Yes ☐	No ☐
Other (Please state)		

On Going Care Plan

Speciality Informed (enter time)

Surg:	G.I:		
Vasc:	Stroke:		
Medics:	Gynae:		
Ortho:	Neuro:		
Other (state Speciality)			

Bed Required

Yes ☐ No ☐

Transfer To: (Please tick if required)

WGH			
SJH			
Other (please state)			

Triaged To - Please tick

Waiting Room		GP Out of Hours	
Resus		Gynae Triage	
HD		SMMP	
IC		MIU	
Exam		Other (Please state)	

NHS Lothian
University Hospital Services
Department of Emergency Medicine

Dr. Dave McKean ED Clinical Director
Ray Middlemiss ED Clinical Nurse Manager
The Royal Infirmary of Edinburgh
51 Little France Crescent, Edinburgh, EH16 4SA
Tel: 0131 242 1300 Fax: 0131 242 1344

NHS Lothian

A/E no.	E5785068
Previous no.	E5731989
UHPI no.	610119466W
CHI no.	1006631372

Patient Information

Surname	Taylor	Date of Birth	10/06/1963
Forenames	Richard	Age / Sex	61 Yrs / M
Address	42 Morvenside		
Postcode	EH14 2SJ	Telephone	
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Complaint	suicidal / intoxicated	Allergies	

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	Incident Date Time:
Mode of Arrival	Emergency Ambulance 999 Emergency
Source of Referral	

Initial Triage Assessment

Presenting Complaint	
History of Presenting Complaint	
Assessment	

Nursing Observations & Assessments

TEMP	°C	SCORE	MIN. FREQ	(please tick)	Blood Sugar		Pain Score		/ 10	
HR		NEWS 0-1	Hourly		Peak Flow 1)		Analgesia Given		YES ☐	NO ☐
BP	/	NEWS 2-4	30mins Min		Peak Flow 2)		Fast Assessment		POS ☐	NEG ☐
SP02%	%	NEWS 5-7	15mins Min		Peak Flow 3)		Onset Time:			
RR		NEWS >7	10mins Min		Alcometer		Weight		Height	
AVPU		Special Clinical Instructions								
On Therapy In Progress	Yes (= +2) No (= 0)	Please indicate any specific clinical observations to be continued or repeated once patient has left OPP								
NEWS SCORE										

Triaged By: Print Name: Signature: Triage Time:

Opp Care & Discharge Record

PVC Insertion - Please initial when complete

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CHD Skin Prep		Aseptic Insertion	
Dressing Labelled		Paperlite Bundle	
Reason for PVC Insertion:			

Blood Samples - Please tick all that apply

Routine		CRP	
Troponin		Coag	
Amylase		Tox Screen	
BTS		Other (Please state)	

Additional Investigations

ECG - Please tick

Required ☐ Done ☐

Urinalysis - Please tick

Required ☐ Done ☐

MSU Sent	Yes ☐	No ☐
HCG Consent	Yes ☐	No ☐
HCG Result	Yes ☐	No ☐

X-Rays - Please tick

CRX	Yes ☐	No ☐
CT Scan	Yes ☐	No ☐
Other (Please state)		

On Going Care Plan

Speciality Informed (enter time)

Surg:	G.I:		
Vasc:	Stroke:		
Medics:	Gynae:		
Ortho:	Neuro:		
Other (state Speciality)			

Bed Required

Yes ☐ No ☐

Transfer To: (Please tick if required)

WGH			
SJH			
Other (please state)			

Triaged To - Please tick

Waiting Room		GP Out of Hours	
Resus		Gynae Triage	
HD		SMMP	
IC		MIU	
Exam		Other (Please state)	

"What Happens To The Patient?"

Clinical Notes

Think:- Other Sources of Information:

Family ☐ Carers ☐ SAS ☐ PRF ☐ EPR ☐ ECS ☐ KIS ☐ GP ☐ Patient Alerts ☐

Care Providers Name: _____ Signature: _____

NHS LOTHIAN
Emergency Department
Adult Majors
Prescription, Administration & Observation Record

NHS Lothian

610119466W /E5765068 M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
70911 PC Leslie
42 Morvenside
EH14 2SJ

The section below must be completed before any medicine is prescribed/given

Previous Adverse Reactions	Weight	Date
NKDA	kgs Actual / Estimate	20/21/8/24

Once Only Prescription

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber Sign & Print	Time Given	Issued by (Initials)	Checked by if applicable (Initials)

Discharge Medication

Date & Time	Medicine (Approved Name)	Dose	Frequency	Route	Quantity	Duration	Prescriber Sign & Print	Issued by (Initials)	Checked by (Initials)

National Early Warning Score 2 (NEWS2) Chart

NEWS Key 0 1 2 3																							
	Date:	21/4/17																					
	Time:	0335																					
A+B Respirations Breaths/min	≥25											3											
	21-24											2											
	18-20		18																				
	15-17	16																					
	12-14																						
	9-11											1											
	≤8											3											
A+B SpO$_2$ Scale 1 Oxygen saturation (%) Use Scale 1 if target range is 94-98%	≥96	98	99																				
	94-95											1											
	92-93											2											
	≤91											3											
SpO$_2$ 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	≥97 on O$_2$											3											
	95-96 on O$_2$											2											
	93-94 on O$_2$											1											
	≥93 on air																						
	88-92																						
	86-87											1											
	84-85											2											
	≤83											3											
Tick box if using SpO$_2$ Scale 2																							
Sign																							
Air or Oxygen? Oxygen is a drug and prescribed by target range	A = Air	✓	A																				
	O^2 L/min or %											2											
	Device																						
C Blood Pressure mmHg Score uses Systolic BP only If manual BP mark as M	≥220											3											
	201-219																						
	181-200	148																					
	161-180	^																					
	141-160																						
	121-140	1																					
	111-120	1																					
	101-110	V										1											
	91-100	80	96									2											
	81-90		1																				
	71-80																						
	61-70		64									3											
	51-60																						
	≤50																						
C Pulse Beats/min Manual pulse	≥131											3											
	121-130											2											
	111-120																						
	101-110											1											
	91-100																						
	81-90																						
	71-80	77	80																				
	61-70																						
	51-60																						
	41-50											1											
	31-40											3											
	≤30																						
D Consciousness Score for new onset of confusion (no score if chronic)	Alert	✓	A																				
	New Confusion											3											
	V																						
	P																						
	U																						
E Temperature °c	≥39.1°											2											
	38.1-39.0°											1											
	37.1-38.0°																						
	36.1-37.0°																						
	35.1-36.0°	35.1	35.7									1											
	≤35.0°											3											
NEWS TOTAL		1	3																				
Monitoring frequency		1°	1																				
Escalation of care Y/N		N	Y																				
Blood Glucose reading or N/A		4.9	/																				
Pain score (0-10)		0	0																				
Initials		JM	DR																				

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.

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.**

Signs of Infection

- Temperature <36°c or >38°c
- Heart rate >90 beats pm
- Respiratory rate >20 breaths pm
- New confusion
- WCC <4 or >12
- Blood sugar >7.7 in non-diabetic

Addressograph

Name:

DOB:

CHI:

NEWS Total	Monitoring Frequency	Clinical Response
Total 0	Commence on 2 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
Total 1 - 4	Commence on 1 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
3 in one parameter *	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to Nurse In Charge (NIC) and Senior Medic
Total 5 - 6	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Total 7 or more	Commence on 15 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Special Instructions		

*or increase in NEWS score of 2

Conscious Level Chart to be completed when clinically indicated

| | | |

IV Fluid Prescription

Time Prescribed	Fluid	Volume	Rate	Prescribers Signature	Time Started	Given by (Initials)	Checked by (Initials)	Time Finished

Fluid Balance

INPUT						OUTPUT				
	IV Fluids or SC Fluids IV Medication	IV Line(s)	Oral Input		Input		Urine		Gastric	
Time	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100ml	Running Total	Time	Volume	Running Total	Volume	Running Total

Drug Infusion

Drug Name:

	Time													
	Rate (ml/hr)													
	Volume in Syringe													
Pump No	Total amount Infused													

Drug Name:

	Time													
	Rate (ml/hr)													
	Volume in Syringe													
Pump No	Total amount Infused													

NHS Lothian

Western General Hospital
Crewe Road South
Edinburgh
EH4 2XU

Dr PC Leslie
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date: 06/12/2024

Emergency Discharge Summary

Patient	Richard Taylor 42 Morvenside Edinburgh EH14 2SJ	**CHI**	**1006631372**
		Date of Birth / Age	10/06/1963 (61 years)
		UHPI	610119466W
		A&E Attendance Number	E5884477
Attendance Date	03/12/2024	**Contact**	Taylor Arrices
Attendance Time	14:20		
Mode of Arrival	Private Transport		
Source of Referral	Flow Centre		
Discharge Date	04/12/2024		
Discharge To			

Dear Dr PC Leslie

Presentation: PC - BACK PAIN AND UTI SYMPTOMS HX - EPILEPTIC AND A T9 SPINAL # OBS - BP 146/79, HR 104, S 98, T 37, BM 8.6 ? UTI

CLINICAL NOTES:
Clinical note: WGH Trolleys
ST4 Geddie

PC
Confusion & back pain

HoPC
History mostly from partner

Woke up this morning confused +++ not sure where he was, Pain in back +++
Worse than normal, took tramadol no improvement
Struggling to walk and crying in pain
Called ambulance
Able to mobilise down the stairs with ambulance but writhing in pain

Passed urine in the department
Last seizure in April
No other illicit supstances

Family have reported these episodes before (note GF with him has been only dating him for 4 weeks)

PMH

First generalised convulsion (Feb 2024)
Previous probable dissociative attacks
Right hemisphere intracranial haemorrhage 2004 (with good recovery) - struc
Depression with DSH
Cholecystectomy
Backpain

Recreational drug use: cannabis

DH

Include ALL medications: recent acute, over the counter and recreational

Med Rec sources (minimum 2):

List of medicines on admission: Dose/Route/Frequency and a plan Continue/Stop/Withhold
Tramadol 50-100mg 4-6 hourly max QDS - c
Omeprazole 20mg OD - C
Ralvoplaster OD - C
Lamotrigine 125mg BD - C
Alendronic acid 70mg Weekly - C
Accrette D3 Once daily - C

O/E
Temp 37.5
HS pure
Chest clear
Tender mid- lumbar spine
Not orientated in time & place
Transferring from chair to chair
Sensation intact

Bloods: WCC 11.6, CRP 1

Impression:
Acute confusion & acute pain

Plan
XR thoraco-lumbar spine
Needs PR and full neuro once in bed
CT head - currently too agitated for this

XR lumbosacral - nil new , await report

Returned from dinner break and patient had attempted to leave - walking freely
Required Dr Gilmour to attend in order to bring patient back to trolleys
Patient does not have capacity and is detainable - he was coerced back by his partner with the promise that he would likely go home

Contacted MHO - will come and review for detention

Note partner mentioned that he hasn'thad any canabis in 3 days (normally spokes excess of 3 joints per day)

Impression: ? acute confusion in the context of canabis withdrawal.

Plan
MHO review for detention
AWI - completed
Can consider medication for agitation
Will need CT head

2000 MHO Assessment
- attended MAU - agrees with assessment
- Emergency detention completed

Discussion with psychiatry registrar on call
- 0.5mg haliperidol can be used for agistation up to 2mg
- Can use acute behavioural disturbance pathway if needed
- suggest urine tox screen

Catherine Geddie
ST4

Any queries please contact 0131 537 1728

Consultant On-Call - Dr Jeeyavudeen

Yours Sincerely,

Catherine Geddie, Doctor

610119466W /E5884477 M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
70911 PC Leslie
42 Morvenside
EH14 2SJ

ADULTS WITH INCAPACITY
(SCOTLAND) ACT 2000

Certificate of Incapacity under Section 47 of the Adults with Incapacity (Scotland) Act 2000

I CATHERINE GOODE (name)

of NGH (address)

*am the medical practitioner primarily responsible for the medical treatment of; or

*am a person who is *a dental practitioner/an ophthalmic optician/a registered nurse and who satisfies such requirements as are prescribed by the Adults with Incapacity (Requirements for Signing Medical Treatment Certificates) (Scotland) Regulations 2007 and who is primarily responsible for treatment of the kind in question of:

RICHARD TAYLOR (name)

of EH14 2SJ (address) DDMMYY (date of birth)

for whom the *guardian/welfare attorney/person appointed by intervention order/nearest relative/carer

is CLAIRE MCCRIMMON.

I have examined the patient named above on DDMMYY (date). I am of the opinion that *he/she is incapable within the meaning of the Adults with Incapacity (Scotland) Act 2000 ("the 2000 Act") in relation to a decision about the following medical treatment:

ACUTE BASIC MEDICAL CARE

because of (nature of incapacity) ACUTE CONFUSION

This incapacity is likely to continue for 1 months.

*I therefore consider it appropriate for the authority conferred by section 47(2) of the 2000 Act to subsist from: DDMMYY (date of examination) until DDMMYY, being a period which does not exceed one year from the *date of the examination on which this certificate is based/date of revocation of the certificate issued previously by me; or

*I am of the opinion that (a) *he/she is suffering from *a severe or profound learning disability/dementia/a severe neurological disorder; and (b) *what he/she is suffering from is unlikely to improve within the meaning of the Adults with Incapacity (Conditions and Circumstances Applicable to Three Year Medical Certificates) (Scotland) Regulations 2007/ YY and therefore consider it appropriate for the authority conferred by section 47(2) of the 2000 Act to subsist until:

DDMMYY being a period which does not exceed three years from the *date of the examination on which this certificate is based/date of revocation of the certificate issued previously by me.

The authority conferred by section 47(2) of the 2000 Act shall subsist for the period specified above or until such earlier date as this certificate is revoked.

In assessing the capacity of the patient, I have observed the principles set out in section 1 of the 2000 Act.

Signed [signature] Date DDMMYY

*delete as appropriate

Authorised: Dec 2022
Review: Dec 2025

NHS Lothian

Adults with Incapacity Treatment Plan	Addressograph, or Name: DOB: Hospital no/CHI:

I have examined the patient named above on: ___/___/___ (date) and consider that he ☐ /she ☐ needs to undergo procedures to safeguard or promote physical or mental health in relation to the treatment plan described below.
I have assessed his/her capacity to consent to treatment, in relation to each area of intervention.

Does the patient have Power of Attorney in place? YES ☐ NO ☐
If YES, name of POA:
Powers in place: Financial only ☐ Welfare only ☐ or Both ☐
Copy of documents requested on: ___/___/___

Disorder/Intervention (see Note A of AWI Code of Practice for Medical Practitioners – Annex 5)	**Capacity** **C = Capable** **I = Incapable**
1 Fundamental healthcare procedures (see Note B)	
2 Prevention and treatment of infection	
3 Prevention of Deep Venous Thrombosis	
4 AHP interventions	
5 Continuing management of existing long term conditions	
Please document any other interventions:	

I have consulted with the following people over this treatment plan and the patient's capacity (see Note C):

Name: Address:	Relationship to patient:

Healthcare Professional's signature: Print name: Designation:	Date: ___/___/___

Authorised: Dec 2022
Review: Dec 2025

NHS Lothian

610119466W M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
70911 PC Leslie
42 Morvenside
EH14 2SJ

Nursing Assessment Triage Form

Hospital no/CHI:

Date: 3/12/24 | Time of Triage:

Name of nurse completing triage (print name):

Presentation: Back pain.

Discriminator:
~~unable to walk~~
Sever pain -

Triage category:
3 Q

History:
T9##. Pain became much worse last night.
Taken Tramadol for pain. at 10:00 with no effect.

Allergies:

Falls Risk Sticker

FALLS RISK? YES ☐ NO ☐ If YES, please affix a sticker above 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:

Date: __/__/__

Approved: Sep 2023
Review: Sep 2026

NHS Lothian

Medical Assessment Unit Admission Care Plan and Checklist	Addressograph, or Name: DOB: Hospital no/CHI:

Date/time	Progress Notes	Signature/print name

NURSING ADMISSION CHECKLIST

Standard Admission Procedures	**Initials**
Vital signs recorded YES ☐ NO ☐ N/A ☐	
NEWS 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**	Addressograph, or Name: DOB: Hospital no/CHI:

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					
Clinical Area					
Care Round Leader's Initials					
Review Frequency of Vital Signs & Cardiac Monitoring					
Vital Signs Frequency					
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)					
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					
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☐

NHS Lothian

Medical Assessment Unit Care Rounding Cont'd	Addressograph, or Name: DOB: Hospital no/CHI:

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	

Rebecca

The Mental Health (Care and Treatment) (Scotland) Act 2003

Emergency Detention Certificate

DET1

Instructions

v7.1

The following form is to be used :
where it is necessary as a matter of urgency to detain the patient in hospital for the purpose of permitting a full assessment of the person's mental state; and where if the patient were not detained in hospital there would be a significant risk to either themselves or others.

There is no statutory requirement that you use this form but you are strongly recommended to do so. This form draws attention to some procedural requirements under the Mental Health (Care and Treatment) (Scotland) Act 2003. Failure to observe procedural requirements may invalidate the certificate.

If you are not completing this form electronically, please observe the following conventions, to ensure accuracy of information:

Write clearly within the boxes in BLOCK CAPITALS and in BLACK or BLUE ink

For example

Shade circles like this -> ●
Not like this -> ⊗ ✓

Where a text box has a reference number to the left, you can extend your response on plain paper where there is insufficient space in the box. Extension sheet(s) should be clearly labelled with Patient's name and CHI number, and each extended response should be labelled with the appropriate text box reference number.

Patient Details

610119466W M
TAYLOR Richard
10-Jun-63 **CHI:** 100 663 1372
70911 PC Leslie
42 Morvenside
EH14 2SJ

CHI number

Surname

First name(s)

Other / known as

that the patient would prefer to be known as.

Title: MR

DoB (dd / mm / yyyy): 10 / 06 / 1963

Gender: ✓ Male ○ Female ○ Prefers not to say ○ Not listed
If not listed, please specify

Patient's home address: 42 MORVENSIDE
EDINBURGH

Post code: EH14 2SJ *<< Please enter NF1 1AB if no fixed abode*

Medical Practitioner Details

Surname: GEDDIE

First name(s): CATHERINE

If you are an AMP, please indicate Yes ○ No ✓

An Approved Medical Practitioner (AMP) is a medical practitioner who has been approved under section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003 by a NHS Board or by the State Hospitals Board for Scotland as having special experience in the diagnosis and treatment of mental disorder.

Work Address: WESTERN GENERAL HOSPITAL
EDINBURGH

Postcode: EH4 2XU

Telephone No.: 0131 537 1495

Email: Catherine.geddie@nhs.scot

Please Note
This form must be sent to medical records, not just filed in case notes

PART 1 : CERTIFICATE — *To be completed by the Medical Practitioner*

Detention Criteria — *Boxes 1 - 6 must be completed*

As the medical practitioner named on page 1, I declare that I have examined the patient. I am granting this emergency detention certificate because I believe the patient meets the following criteria -

I consider it is likely, for the reasons stated below, that the patient has a mental disorder (see notes at foot).

1	*Describe your reasons for believing the patient may have mental disorder, e.g. they may have hallucinations, suicidal ideation, disorientation etc.*
	Acute confusion. Disoriented.

I consider it likely, for the reasons stated below, that because of this mental disorder, the patient's ability to make decisions about the provision of medical treatment for mental disorder is significantly impaired.

2	*Describe why you believe the patient has SIDMA (significantly impaired decision making ability) as a result of their mental disorder, e.g. that they have no insight into the fact that their hallucinations are part of a mental illness, that they cannot retain information due to memory problems, etc.*
	~~Disorientated in place + time~~ need to ~~does not know why he remained in hospital~~ Does not know he need to stay for assessment, not understanding Disorientated in place + time. Cannot retain information

I am satisfied, for the reasons stated below, that it is necessary as a matter of urgency to detain the patient in hospital for the purpose of determining what medical treatment for mental disorder the patient requires.

3	*Note the reason for urgency, e.g. that the patient is trying to leave at present, or stating that they are going to leave; also, e.g. that detention is necessary to assess what medical, social and nursing needs the patient has.*
	Brent trying to leave

Notes

As detailed in section 328 (2) of the Act, a person is not mentally disordered by reason only of any of the following: sexual orientation; sexual deviancy; transsexualism; transvestism; dependence on, or use of, alcohol or drugs; behaviour that causes, or is likely to cause, harassment, alarm or distress to any other person; acting as no prudent person would act.

PART 1 : CERTIFICATE (cont) — To be completed by the Medical Practitioner

Detention Criteria (cont) — ***Boxes 1 - 6 must be completed***

I am satisfied, for the reasons stated below, that if the patient were not detained in hospital there would be a significant risk -

- ✓ to the patient's health, safety or welfare
- ○ to the safety of any other person.

4	*Give evidence of the risk, e.g. 'has suicidal ideation', 'would not be aware of common dangers' etc., remembering to shade one or both of the circles above.*
	Acutely unwell with no formal diagnosis.

I am satisfied, for the reasons stated below, that making arrangements with a view to the granting of a short-term detention certificate would involve undesirable delay. Give details of efforts which were made with respect to granting a short-term detention certificate

5	*Would it take too long to get an AMP (Approved Medical Practitioner) to assess for STDC, how long would it have taken, why is this delay undesireble? What risks might be posed by waiting? Give details of attempts to get an AMP (phone number called, number of attempts, times of calls, length of wait for response). Delays relating to MHO attendance should be noted in box 7.*
	Urgent requirement.

Please give details of the alternatives which you considered to the granting of this certificate. Why is informal/voluntary care not appropriate ?

6	*Is there no safe alternative management plan other than involuntary inpatient hospital management? What other options have you considered?*
	Attempted conservative measures without success

PART 1 : CERTIFICATE (cont) — To be completed by the Medical Practitioner

MHO Consent

Complete A or B as appropriate

A I have consulted with the MHO named below, and he / she consents to the granting of this emergency detention certificate.

Surname: PLATTS

First name(s): CATHERINE

Appointed to act as a MHO by:

Local Authority: CITY OF EDINBURGH

eg Glasgow City, City of Edinburgh, Highland, Scottish Borders, etc (the word "Council" can be omitted)

MHO's work address and telephone number: EMERGENCY SOCIAL WORK
WAVERLEY COURT
8 EAST MARKET STREET 0131 553 8286

OR

B It was not practicable, for the reasons stated below, to gain the consent of a mental health officer to the granting of this certificate.

7	*Would it take too long for an MHO to attend? How long would it have taken and why would this constitute an undesirable delay? What risks might be posed by waiting? Give details of attempts to contact MHO (phone number called, number of attempts, times of calls, length of wait for response).*

Patient Pre-DetentionStatus, Transter / Admission to Hospital

Complete A or B as appropriate

A At the time of this certificate being granted this person was a patient in the following hospital.

Hospital:

OR

B At the time of this certificate being signed this patient was not in hospital.

Please state where the patient was when the certificate was granted (location/address) and provide details of transportation and accommodation arrangements which you have made with respect to transferring the patient to hospital.

8	*If applicable, you MUST provide these details. Usually escort is provided by the receiving hospital.*

PART 1 : CERTIFICATE (cont) — To be completed by the Medical Practitioner

Certification

✓ So far as I am able to ascertain, immediately before the medical examination was conducted, the patient was not detained in hospital under the authority of :

(a) an emergency detention certificate;

(b) a short-term detention certificate;

(c) an extension certificate;

(d) section 68 of the Act (extension of short-term detention pending determination of application for compulsory treatment order);

(e) a certificate granted under section 114(2) or 115(2) of the Act. (Compulsory treatment order: detention pending review or application for variation, or interim compulsory treatment order: detention pending further procedure).

(f) a certificate granted under section 113(5) of the Act (non-compliance with order).

✓ I have completed the section at the end of this form relating to the patient's ethnicity.

Date examination concluded 03 / 12 / 2024 AT 20 : 00 time (24 hr clock)

Date certificate granted (see notes) 03 / 12 / 2024 AT 20 : 20 time (24 hr clock)

By signing this certificate I confirm that I have no conflict of interest as defined in the regulations.

Signed by the medical practitioner Cleddie

The medical practitioner must now give this certificate to the managers of the hospital (e.g. the bed manager or the senior nursing page holder) in which the patient is to be detained. Failure to do so may invalidate the detention (see notes).

Notes

The emergency detention certificate must be granted:
i) before the end of the day if the examination was concluded by 8.00 pm; or
ii) within 4 hours if the examination concluded between 8.00pm and the end of the day.

If the patient is not in hospital immediately before the certificate is granted, the patient's detention in hospital under the authority of this certificate is only authorised if the certificate was given to the managers of the hospital before the patient was first admitted to hospital

If the patient is in hospital immediately before the certificate is granted, the medical practitioner shall as soon as practicable after granting the certificate, give the certificate to the managers of that hospital.

PART 2 — To be completed by the Hospital Managers

Admission Details

Shade as appropriate

○ The patient was a patient in the hospital detailed below when the certificate was granted. As a result the 72-hour period of detention began when the certificate was granted.

OR

○ The patient was not in hospital immediately before the certificate was granted. As a result, the 72-hour period of detention began when: the certificate was given to the managers of the hospital detailed below and the patient was admitted to the hospital under the authority of the certificate.

Hospital

Ward / clinic

Date detention began / / AT : time (24 hr clock)

Unless revoked, this authorisation to detain will expire on - / / AT : time (24 hr clock)

PART 2 — To be completed by the Hospital Managers

Record of Informing and Notifying — *Please ensure only current contact details are used*

The following were informed that the emergency detention certificate was granted within 12 hours of the hospital managers receiving the emergency detention certificate as specified under section 38(3)(a) of the Act.

O Patient's nearest relative

Full name and address of patient's nearest relative

Phone number (if known)

O Patient's named person (if they have one and if known)

Full name and address of the patient's named person

Phone number (if known)

O Any person who resides with the patient (if the patient's nearest relative does not reside with the patient)

Phone number (if known)

O Any guardian of the patient (if known)

Phone number (if known)

O Any welfare attorney of the patient (if known)

Phone number (if known)

It was considered appropriate by hospital managers to notify the following in writing of the circumstances (see notes below) within 7 days of receiving the emergency detention certificate as specified under section 38(3A) of the Act.

O Patient's nearest relative | O Any person who resides with the patient | O Patient's named person (if known)

O Any guardian of the patient (if known) | O Any welfare attorney of the patient (if known)

Where it was not practicable to gain the consent of the mental health officer for the granting of this certificate, the following will be sent a copy of this certificate (part 1 of this form) within 7 days of receiving the certificate:

O the local authority for the area in which the patient resides, OR

O if the patient's address is not known, the local authority for the area in which the hospital is situated

Local Authority

eg Glasgow City, City of Edinburgh, Highland, Scottish Borders, etc (the word "Council" can be omitted)

Completion Details

O The hospital managers have fulfilled their obligations under section 260 of the Act.

Completed by

Job title

Telephone No.

Signature

Date / /

A copy of this form should be sent to the Mental Welfare Commission as soon as practicable after receiving the certificate, and no later than 7 days after receiving the certificate.

Notes

The circumstances are:

- the reasons for granting the certificate;
- whether consent of a MHO was obtained to the granting of the certificate, and if not, the reasons why it was impracticable to consult the MHO;
- the alternatives to granting the certificate that were considered by the medical practitioner; and
- the reason for the medical practitioner determining that any such alternative(s) was/were inappropriate.

PATIENT ETHNICITY v7.1

The following information is requested to monitor the use of the Mental Health (Care & Treatment) (Scotland) Act 2003 across ethnic groups to ensure observance of equal opportunity requirements

Patient CHI Number 1 0 0 6 6 3 1 3 7 2

The patient describes his / her ethnic group as:

O Information not provided

A White	O Scottish	
	O Other British	
	O Irish	
	O Gypsy/ Traveller	
	O Polish	
	O Roma	
	O Showman/ Showwoman	
	O Any other white ethnic group, please describe	
B Mixed or multiple ethnic groups	O Any mixed or multiple ethnic groups, please describe	
C Asian, Scottish Asian or British Asian	O Pakistani, Scottish Pakistani or British Pakistani	
	O Indian, Scottish Indian or British Indian	
	O Bangladeshi, Scottish Bangladeshi or British Bangladeshi	
	O Chinese, Scottish Chinese or British Chinese	
	O Any other Asian, please describe	
D African, Scottish African or British African	O Please describe, for example Nigerian, Somali	
E Carribean or black	O Please describe, for example Scottish Carribean, Black Scottish	
F Other ethnic group	O Arab, Scottish Arab or British Arab	
	O Other, please describe, for example Sikh, Jewish	

610119466W M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
70911 PC Leslie
42 Morvenside
EH14 2SJ

CHI: 1006631372
Ethnicity:

Incident Number: CR011575166

Date: 03/12/2024
Incident Number: CR011575166
Incident Type: EMG
Incident Location: 15 DUMBEG PARK EDINBURGH, EH14 3JA

Scottish Ambulance Service

Presenting Complaint

?UTI

Additional Comments

999 call to 61yom S pt woke with worsening lower back pain. Lying on sofa unable to sit up due to pain. Has known T9# which is managed with tramadol but today feels much worse. Also c/o new pain around kidneys. Pt woke with new confusion, not knowing where he was or who his partner was. Able to give correct personal details. Partner states pt has been c/o passing urine more frequently in last couple of days. Pt being rather uncommunicative with crew due to being in pain/closing eyes to deal with pain. B pt normally fully mobile. Has cough which pt states is normal. Been living with partner for last month. A all obs as stated. Pale/sweaty. Lower back pain. T entonox to good effect. Pt able to sit, stand and self mobilise to ambulance down flight of stairs. R pt conveyed to wgh SDEC for further assessment. Pt happy with this plan. Partner travelled in ambulance.

PATIENT ASSESSMENT

ACVPU	Acute Confusion	<C>	No
A	Clear		

B

Breathing Adequately	Respiratory Rate	SPO2
Yes	20	95

Oxygen Given: No

C

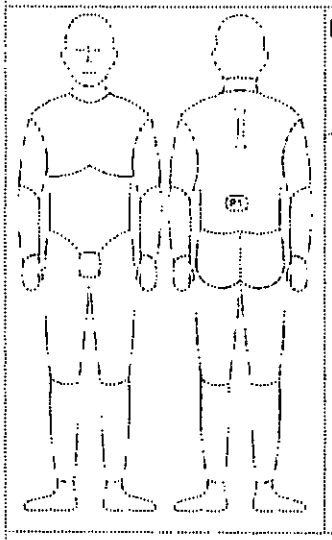
Pulse Rate	BP	Cap Refill	ECG Rhythm
18	146/79	<=2 Secs	Sinus Rhythm

Rhythm	Arm	Central/Peripheral	ECG
Reg	Right	Peripheral	3 Lead

D

GCS	Eyes	Voice	Motor	PEARL
14	Spontaneously (4)	Confused (4)	Obeys Commands (6)	

E



Pain

ID	Body Part	Pain Scale
P1	Back Body	8

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
13:56	92	18	144/76	96		14	Acute Confusion								E9884027
13:25	18	20	146/79	95	<=2 Secs	14	Acute Confusion		37	8.2	Sinus Rhythm				E9884027

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
13:25	20 (0)	95 (1)		0	146 (0)	18 (3)	Acute Confusion (3)	37 (0)	7

Drugs

Time	Drug	Dosage	Units	Route	Drug Expiry Date	Pain Before	Pain After	CrewID
13:15	Entonox		PRN	INH				E9884027
13:30	Entonox		PRN	INH				E9884027

HISTORY

AMPLE

Allergies	CODEINE
Medication	SEE TRAK/ECS
Past Medical History	Epilepsy, OSTEOPOROSIS, T9#
Last Eaten	>4 Hours Ago
Events Prior	AT FRIENDS HOUSE

Social History

Lives alone	No	Living With	SON	Patient Occupation	Does Not Work

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

SOCRATES

Site	LOWER BACK	Character	Constant, Worsening
Radiates	No	Associated Symptoms	Nausea
Exacerbating Or Relieving Symptoms	WORSE ON MOVEMENT/POSITIONING		

MEDICAL

CLOSE RECORD

Treatment On Scene	Non-Emergency

Conveyance

Transport To Hospital	Normal driving	Pre-Alert	No	Patient Accompanied By	PARTNER

INCIDENT LOG

Time Call Received	12:53	Allocated	12:52	Mobile	12:54
First Resource On Scene		Crew On Scene	12:57	Crew Left Scene	13:43
Crew At Hosp		Receiving Hospital	WESTERN GENERAL EDINBURGH	Clear Time	

Crew ID	Crew Grade	Driver
E9867058	Paramedic	YES

Inpatient Records

NHS Lothian

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

Dr Nickerson
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date: 11/09/2018

Inpatient Discharge Summary

Patient	Richard Taylor 42 Morvenside Edinburgh EH14 2SJ	**CHI** **Date of Birth / Age** **UHPI**	**1006631372** 10/06/1963 (55 years) 610119466W
Specialty	General Surgery	**Admission Date**	30/07/2018
Ward	Ward 106 RIE		
Consultant	Mr Richard JE Skipworth	**Discharge Date**	31/07/2018

Dear Dr Nickerson

Discharge Drugs

Discharge Medication	Dose	Frequency	Duration	Additional Info
Omeprazole Capsules	20 MG	ONCE DAILY	Long Term	Not supplied
Paracetamol Tablets	1000 MG	FOUR times daily	Long Term	Not supplied

Clinical Summary:
Mr Taylor presented with a recurrent attack of severe lower abdominal pain with nausea and vomiting. At the time of presentation his bilirubin was normal and his ALT was 123. He underwent a CT scan which showed no significant pathology. He was subsequently discharged home with no plans for further follow up.
Yours sincerely

ANDREW ROBERTSONLocum Consultant Surgeon to Mr RICHARD SKIPWORTH

Surname/Forename	Taylor, Richard
UHPI Number	610119466W

Episode Number	I0000337380

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0004513535 Professor Richard JE Skipworth 31/07/2018 12:44 Dr Katie Robinson	Dear Doctor,,,PRINCIPAL DIAGNOSIS/PROCEDURE, Abdominal Pain, diagnosis unclear,,TREATMENT,Mr Taylor presented to hospital w/ a hx of severe abdominal pain and associated N&V that started the morning he presented to hospital 30/07/18. He also mentioned that he has had foul smelling stool for the past months, no other bowel symptoms (no change of frequency or appearance).,He also mentioned similar episodes have happened previously but resolved w/out medical intervention.,,He was treated w/ appropiate analgesia, antiemetics and fluids.,,He was investigated w/ bloods, CXR and abdo CT. All were NAD.,CT report conclusion - Normal appendix and no significant diverticular disease.,,FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL, N/A,CHANGES TO DRUGS SINCE ADMISSION, N/A,ALLERGIES / ADVERSE DRUG REACTIONS,NKDA, ,SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS,Nil,,CHANGES TO DNACPR STATUS OR ANTICIPATORY CARE PLANNING ,Nil,,GP to please consider the following - thank you for your continued care of this patient, ,Should you need further information please contact - ward 106 RIE, ,Information contained in this letter has been discussed with the patient/carer.,,Yours sincerely....., ,Dr Katie Robinson, FY1,,This is an immediate discharge letter and a further letter may follow.

610119466W/E3915334 M 10/06/1963
Taylor, Richard
42 Morvenside,
Edinburgh,
EH14 2SJ

CHI 1006631372
70911 CB Nickerson

RIE ED Nursing Care Plan

Admission Nurse Signature.....

Admission Nurse Print Name.....

Date.....30/2/16.....

Presenting History :
Lower abdominal pain

Date/ Time	Progress Notes	Signature
30/2/16	Admitted patient to IC ; observations Stable as charted.	
0710	acuity review	
0735	NEWS 1. c/o pain - has had 16mg morphine with SAS Await N	
0915	NEWS 0. 10mg morphine given + anti-emetic. Await N	

Admission Standard Procedures	Initials	PRN Nursing Procedures	Initials
Vital signs recorded ✓		ECG completed	
NEWS Score recorded ✓		CXR ordered	
BM Reading ✓		Alcometer Reading Recorded	
GCS assessed ✓		DNAR in situ	
Acuity parameters set		LCP commenced / CP Aware	
Patient made comfortable ✓		Falls / Risk Assessment Require / Complete	
Name band Attached ✓		Swallow Assessment Required / Complete	
IV Cannula in Situ, Dated (please circle) Yes No		Waterlow Assessment Required / Complete	
Hearing Aid : (please circle) (NA) In Situ At home		Language Assistance requested (Please inform NIC if applicable)	
Spectacles : (please circle) (NA) In Situ At home		Vulnerable Adult Concern (Please Inform NIC if applicable)	
Relatives : (please circle) In ED At Home Not Aware		Child protection Concern (Enter on TRAK & inform NIC if applicable)	
Clothing & valuables (please tick) 1) Labelled 2) Documented		4AT test Score = (please enter only if clinically indicated)	

Care Provider must be informed of any clinical changes highlighted from Patient Screening

Time of Round	2040				
Clinical Area of ED	IC				
Initials of Care Round Leader	H				
Review frequency of Vital Signs & Cardiac Monitoring					
Vital signs frequency	1°				
Cardiac monitoring required	Y / (N)	Y / N	Y / N	Y / N	Y / N
Pain Management (Refer to CP for analgesia if required)					
Please note pain score (0-10 Score)	0				
Mobility					
Fully weight bearing	/				
Requires some assistance and / or uses walking aid					
Non Weight bearing and requires full assistance					
Elimination					
Ask patient if toilet is required					
Patient is Self Caring and can walk to toilet	/				
Patient is Incontinent and requires to be checked					
Patient has catheter in situ and requires to be checked					
Nutrition / Hydration					
Self Caring	/				
Patient requires assistance with feeding					
Patient is allowed fluids only					
Patient is NBM					
Patient has IVI in Situ					
Refreshments (Provided / Refused : Please indicate P / R)					
Drink		P / R	P / R	P / R	P / R
Snack	—	P / R	P / R	P / R	P / R
Catered Meal	—	P / R	P / R	P / R	P / R
Visual Skin Inspection					
Patient is healthy / no concerns	/				
Visible areas of redness					
Broken skin and evidence of Pressure Ulcers					
Invasive devices (please tick if in situ)					
PVC /Arterial Line / Central Line / PVC	X1				
Urinary Catheter / Chest Drain					
Infusion Device					
NG tube / PEG tube / Tracheostomy					
Other					
Family Communication (Please tick)					
Patient & Relatives present & made aware of any changes					
Cubicle Tidy (Please tick)	/				
Ensure area is tidy and free of obstruction					

Receiving Ward		ED Escort	
Nurse Name		Nurse Name	
Nurse Signature		Nurse Signature	
Date		Date	

Patient Name	CHI	Date of Birth	Age	GP	GP Practice	GP Practice Code
TAYLOR RICHARD	1006631372	10/06/1963	55	HENDRIE, RACHEL	Sighthill Green Medical Practice	70911

Allergies

Description	Date Recorded	Comments
No ECS data exists		

Sources: [1] ECS [ ] Patient's Drugs [ ] Referrer Kardex [ ] GP Practice [ ] TRAK
[ ] Patient [ ] Relative / Carer [ ] Referrer Letter [ ] Comm Pharmacy [ ] Other - Specify .....

Actions: C: Continue W: Withhold S: Stop

Acute Medication (including those greater than 30 days)

Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Source 1°	Source 2°	Source 3°	Action C	Action W	Action S	Comments
Diclofenac sodium 50mg gastro-resistant tablets	56 tablet	1 TABLET THREE TIMES A DAY			19/01/2018	1	✓				✓	Not taking
Co-codamol 30mg/500mg tablets	30 tablet	1-2 TABLETS UP TO FOUR TIMES DAILY			19/01/2018	1	✓				✓	Not taking

Repeat Medication

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Source 1°	Source 2°	Source 3°	Action C	Action W	Action S	Comments
GP practice	Omeprazole 20mg gastro-resistant capsules	56 capsule	1 CAPSULE DAILY AS NEEDED		15/06/2017	18/05/2018		1	✓		✓			Heartburn

Patient Name	CHI	Date of Birth	Age	GP	GP Practice	GP Practice Code
TAYLOR RICHARD	1006631372	10/06/1963	55	HENDRIE, RACHEL	Sighthill Green Medical Practice	70911

Compliance Device	Name and telephone number for community pharmacy

Completed by	Designation	Grade	Date	Time	Contact Number
Reviewed by	**Designation**	**Grade**	**Date**	**Time**	**Contact Number**

Key Information Summary

No KIS data recorded

610119466W /E3915334 M
TAYLOR Richard
10-Jun-63 CHI:100 663 1372
70911 CB Nickerson
42 Morvenside
EH14 2SJ

ADULT FLUID PRESCRIPTION CHART

NHS Lothian

Date 31/7/18 Sheet no

Ward 106

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***

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 /20mmol KCl	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 Lothian Guidance for Intravenous Fluid and Electrolyte prescribing (on Intranet)

610119466W/E3915334 M 10/06/1963
Taylor, Richard
42 Morvenside,
Edinburgh,
EH14 2SJ

CHI 1006631372
70911 CB Nickerson

ADULT FLUID PRESCRIPTION CHART

Date 30/7/18 | Sheet no

Ward

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?

Weight (kg)

Essential

Write in Maintenance requirements in next 24 hours:

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)
Plasmalyte	1000	IV	100	1400			

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

PLASMALYTE	500	IV	STAT			NICOLAS SIMPSON	YB
PLASMALYTE 148	1000	IV	100	2100		Kome	Charlton

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	Plasmalyte	100					/				
15.00		100					/				
16.00	Plasmalyte	500					/				
Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print											
17.00		100					/				
18.00		100					/				
19.00		100					/				
20.00							/				
21.00	Plasmalyte (1000)	100					145	145			
22.00		100					/				
23.00		100					/				
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 Lothian Guidance for Intravenous Fluid and Electrolyte prescribing (on Intranet)

Ward: 50a Site: RIE Date: 30/7/18

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 LHODA

Addressograph nr
610119466W/E3915334 M 10/06/1963 IS

Name: Taylor, Richard
42 Morvenside,
Edinburgh,
DOB: EH14 2SJ

CHI 1006631372

Unit no / C 70911 CB Nickerson

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	10[illegible]	RooHOO	18[illegible]05	2030	0130	0400	0430						
	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)		✓	/	NB	NS	N	N					
	Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister	H	H	/		N	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	N	N	N	Y	Y	Y					
	Positioning (R) or (L) side (B) Back (C) Chair	B	B	B	B	C	B	B					
	Mattress type / Cushion type	*please state type:*											
Elimination	Do you need the toilet?	N	N	N	N	N	N	N					
	Is the patient continent of urine? (at time of Care Rounding)	Y	Y	Y	Y	Y	Y	Y					
	Continence product changed/offered?	—	/	/	/	NA	NA	NA					
	Catheter care performed?	—	/	/	/	NA	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	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	W	W	W	W	W					
	Fluid Balance Chart (if clinically indicated)	N	N	N	/	N	N	N					
	When did you last eat?	29[illegible]	29[illegible]	29[illegible]	29[illegible]	29[illegible]	?	?					
	(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	Y					
	Walking aid available(and within reach)	—			Y	Y	Y	Y					
	Area de-cluttered?	Y			Y	Y	Y	Y					
	Chair and bed height assessed?	Y			Y	Y	Y	Y					
	Falls alarm in use and attached?	NA			NA	NA	NA	NA					
	Glasses available for use? (if worn)	N											
	Hearing aid available for use? (if worn)	NA			/	NA	NA	NA					
	Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐												
Pain	Are you in pain?	Y	N	N	R3	N	N	N					
	Analgesia Given?	Already Rx	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	AB	Y	Y	Y					
	Anything else I can do for you?	N	N	N	AB	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		HP	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]					

Ward: LIC Site: 06 Date: 31/7

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 Charlene

Addressograph no
610119466W /E3915334 M
Name TAYLOR Richard
10-Jun-63 CHI:100 663 1372
70911 CB Nickerson
42 Morvenside
DOB EH14 2SJ
Unit no

HS thian

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	08 20	245												
	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											
	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											
	Positioning (R) or (L) side (B) Back (C) Chair	B	C											
	Mattress type / Cushion type	*please state type:*												
Elimination	Do you need the toilet?	N	N											
	Is the patient continent of urine? (at time of Care Rounding)	Y	Y											
	Continence product changed/offered?	/	/											
	Catheter care performed?													
	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											
	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											
	Fluid Balance Chart (if clinically indicated)	N	N											
	When did you last eat?	29/7	L											
	(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											
Falls	Appropriate Footwear?	Y	Y											
	Walking aid available(and within reach)	N/A	/											
	Area de-cluttered?	Y	Y											
	Chair and bed height assessed?	Y	Y											
	Falls alarm in use and attached?	N/A	/											
	Glasses available for use? (if worn) Hearing aid available for use? (if worn)	N/A	/											
	Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐													
Pain	Are you in pain?	Y	N											
	Analgesia Given?	Y	N											
General	Peripheral Venous Cannula observed?	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											
	Anything else I can do for you?	N	N											
	Buzzer within easy reach	Y	Y											

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

Initials – document at time of care delivery	CW	CW												

Notes dest

PRESCRIPTION AND ADMINISTRATION RECORD

Standard Chart

NHS Lothian

Hospital/Ward: RIE Consultant: SKIPWORTH

Weight: Height:

If re-written, date:

DISCHARGE PRESCRIPTION

Date completed: Completed by:

610119486W /E3915334 M
TAYLOR Richard
10-Jun-63 CHI:100 663 1372
70911 CB Nickerson
42 Morvenside
EH14 2SJ



OTHER MEDICINE CHARTS IN USE		PREVIOUS ADVERSE REACTIONS This section must be completed before any medicine is given		Completed by (sign & print)	Date
Date	Type of Chart	None known ☑		BANERJEE	30/07/18
		Medicine / Agent	Description of reaction		

- 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'

ONCE ONLY

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber - Sign + Print	Time Given	Given By

Risk Factors for venous thromboembolism:

Age >70yrs	☐	Malignancy	☐
BMI>30 +	☐	Pregnancy/puerperium	☐
Poor Mobility	☐	Oestrogen Rx	☐
Surgery >1hr +	☐	Heart Failure	☐
Thrombotic states	☐	Severe COPD	☐
Previous DVT/PE	☐	Severe Infection	☐
Emergency admission	☐	+	+

☐ 1 factor: sc dalteparin 2,500u +
☐ >1 factor: sc dalteparin 5,000u & TEDS ☐ Vasc NO TEDS
+ (if weight less than 46kg / BMI less than 19, age greater than 70yrs: 2,500 dalteparin maximum. & TEDS if appropriate)
(if eGFR is less than 30; sc heparin 5,000u BD)

Name: Signature:
Date: Prescribed Rx: ☐

REGULAR THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

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

OXYGEN

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

PRESCRIPTION

Patient's Own Medicine

Date → 30 | 31 07 18

Time ↓ 07

Medicine (Approved Name): DALTEPARIN
For Use / Date
Dose: 5000 UNITS
Route: SC
Quantity
Notes/Indication for antibiotic
Start Date: 30/07
Stop Date
Prescriber - sign + print: [signature] BRANCH
Pharmacy

Time			
6			
8			
12			
14			
18			
22	CM		

Medicine (Approved Name): TEDS
For Use / Date
Dose
Route: TOP
Quantity
Notes/Indication for antibiotic: BOTH LEGS
Start Date: 30/07
Stop Date
Prescriber - sign + print: [signature] BRANCH
Pharmacy

Time			
6			
8			
12			
14			
18			
22			

Medicine (Approved Name): PARACETAMOL
For Use / Date
Dose: 1g
Route: PO
Quantity
Notes/Indication for antibiotic
Start Date: 30/07
Stop Date
Prescriber - sign + print: [signature] BRANCH
Pharmacy

Time			
6			
8	JW		
12			
14			
18	SEQUENCE		
22	CM		

Medicine (Approved Name): OMEPRAZOLE
For Use / Date
Dose: 20mg
Route: PO
Quantity
Notes/Indication for antibiotic: Pre-adm
Start Date: 30/07
Stop Date
Prescriber - sign + print: [signature] BRANCH
Pharmacy

Time			
6			
8	JW		
12			
14			
18			
22			

AS REQUIRED THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine													
Medicine (Approved Name)		For Use	Date	30/7											
CYCLIZINE			Time	1330											
Dose + frequency + max	Route	Quantity	Dose	50mg IM											
50mg TDS	PO/IM/IV		Initials	NP											
Indication + notes	Start Date	Date	Date												
	30/07/18		Time												
Prescriber - sign + print		Pharmacy	Dose												
DR BIANCHI			Initials												
Medicine (Approved Name)		For Use	Date	30/7											
ONDANSETRON			Time												
Dose + frequency + max	Route	Quantity	Dose												
4mg TDS	PO/IV		Initials												
Indication + notes	Start Date	Date	Date												
	30/07/18		Time												
Prescriber - sign + print		Pharmacy	Dose												
DR BIANCHI			Initials												
Medicine (Approved Name)		For Use	Date	30/7											
ORAMORPH			Time	2045											
Dose + frequency + max	Route	Quantity	Dose	10mg											
10mg 1°	PO		Initials	CM											
Indication + notes	Start Date	Date	Date												
	30/07/18		Time												
Prescriber - sign + print		Pharmacy	Dose												
DR BIANCHI			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												

REGULAR THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine	Date → / Time ↓															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															

TURN OVER →

Continuation

REGULAR THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine	Date → / Time ↓															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															

REGULAR THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine	Date → / Time ↓															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															

AS REQUIRED THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine												
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											

National Early Warning Score (NEWS) Chart

NHS Lothian

610119466W /E3915334 M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
70911 CB Nickerson
42 Morvenside
EH14 2SJ

Consultant: RJES Date chart commenced: 30/7/18

This is chart number 1 this admission

Weight: Actual kgs Estimated kgs

ASU: Ward:

Conscious Level Chart to be completed when clinically indicated

| GLASGOW COMA SCALE | | |

NEWS Key 0 1 2 3	Date: 30/7	31/7						
	Time: 10:00	14:00	18:00	20:00	00:00	10:00	15:15	
Respiratory Rate	≥25							
	21-24							
	12-20	18	16	16	16	14	16	18
	9-11							
	≤8							
Sp02	Chronic Hypoxia ≥88 / Default ≥96	96	94	98	95	94	95	98
Medical Signature required to use scale for patients with Chronic Hypoxia Sign	94-95							
	88-87 / 92-93							
	≤85 / ≤91							
	Unrecordable							
Inspired 02	% or litres		2 L/Min					
Temperature	≥39°							
	38°							
	37°		35.5		36.4			
	36°							
	≤35°							
NEWS SCORE uses Systolic BP	230							
	220							
	210							
	200							
	190							
	180							
	170							
	160	154	154					
	150							
	140							
If manual BP mark as M	130			134				
	120				124			
	110							
	100							
	90	92						
	80							
	70				72			
	60							
	50							
	Unrecordable							
Heart Rate	>140							
	130							
	120							
	110							
	100							
	90							
	80							
	70		53		69			
	60							
	50							
	40							
	30							
	Regular Y/N	Y	Y	Y	Y	Y	Y	Y
Conscious Level	Alert	A	A	A	A	A	A	A
	V / P / U							
	New Confusion							
Total NEWS score		0	2	3	2	1	1	
Urine output recorded Y/N								
Blood Glucose								
Frequency of Observations		4	4	2	2	6	6	
Structured Response Tool Y/N								
Escalation Y/N								
Pain score (0-10)				4		0		
Nausea score (0-3)				0		0		
Motor Block score (0-4)								
Circulation								
Sensation								
Movement								
Initials				CMM				

Date	Time
≥25	
21-24	
12-20	
9-11	
≤8	
Default ≥96 / Chronic Hypoxia ≥88	
94-95	
92-93 / 86-87	
≤91 / ≤85	
Unrecordable	
% or litres	
≥39°	
38°	
37°	
36°	
≤35°	
230	
220	
210	
200	
190	
180	
170	
160	
150	
140	
130	
120	
110	
100	
90	
80	
70	
60	
50	
Unrecordable	
>140	
130	
120	
110	
100	
90	
80	
70	
60	
50	
40	
30	
Regular Y/N	
Alert	
V / P / U	
New Confusion	
Total NEWS score	
Urine output recorded	
Blood Glucose	
Frequency of Obs	
SRT Y/N	
Escalation Y/N	
Pain score (0-10)	
Nausea score (0-3)	
Motor Block score (0-4)	
Circulation	
Sensation	
Movement	
Initials	

Patient Name:	CHI:

Special Instructions - to be completed by Medical Team

A total NEWS score 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**

NEWS Score	Frequency of Observations	Clinical Response
Total 0*	Minimum 12 hourly / 4 hourly in admission areas	• Continue routine NEWS monitoring with every set of observations.
Total 1 - 4*	Minimum 4 hourly Consider Structured Response Tool Consider Fluid Balance Chart	• Inform registered nurse • Registered nurse assessment using ABCDE • Review frequency of observations • Inform Nurse in Charge • **If ongoing concern, escalate to Medical Team**
Total 5 - 6* or 3 in one parameter	Increase frequency to a minimum of 1 hourly Start Structured Response Tool Start Fluid Balance Chart	• Registered nurse assessment • Inform Nurse in Charge • Escalate to Medical Team as per local escalation • Urgent medical assessment • Management plan to be discussed with Senior Trainee or above • Consider level of monitoring required in relation to clinical care
Total 7* or more	Continuous monitoring of vital signs Start Structured Response Tool Start Fluid Balance Chart	• Registered nurse to assess immediately • Inform Nurse in Charge • Request immediate assessment by Senior Trainee or above • Case to be discussed with supervising Consultant • If appropriate contact Critical Care for review

NEWS ≥4 Think Sepsis

Are any 2 or more SIRS criteria present?

RECOGNISE

Temperature	<36°c or >38°c
Pulse	>90 beats/min
White Cell Count	<4 or >12
Respiratory Rate	> 20 bpm
Mental State	New confusion
Blood Sugar	>7.7mmol/L in non-diabetic

and clinical suspicion of infection = SEPSIS

Apply Sepsis 6 within 1 hour

RESUSCITATE

1. Give oxygen to target saturation >94% (NB COPD 88%-92%)
2. IV fluids up to 20ml/kg
3. Take blood cultures
4. Measure lactate and FBC
5. Give IV antibiotics
6. Monitor urine output & start fluid chart

NHS Lothian

Royal Infirmary of Edinburgh
Emergency Department

Drug and Prescription Record

610119466W /E3915334 M
TAYLOR Richard
10-Jun-63 CHI:100 663 1372
70911 CB Nickerson
42 Morvenside
EH14 2SJ

Previous Adverse Reactions NICORD

Weight ____ kgs Actual / Estimate

Date 30/7/18

IV Fluid Prescription

Time Prescribed	Fluid	Volume	Duration	Prescribers Signature	Time Started	Given by (Initials)	Checked by (Initials)	Time Finished
0900	plasmalyte	1000	20	K NMP 109	0915	2Smith		

Fluid Balance

INPUT						OUTPUT				
	IV Fluids or SC Fluids IV Medication	IV Line(s)	Oral Input		Input		Urine		Gastric	
Time	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100ml	Running Total	Time	Volume	Running Total	Volume	Running Total

Drug Infusion

Drug Name:

	Time												
	Rate (ml/hr)												
	Volume in Syringe												
Pump No	Total amount Infused												

Drug Name:

	Time												
	Rate (ml/hr)												
	Volume in Syringe												
Pump No	Total amount Infused												

Once Only Prescription

Date	Time	Drug (Approved Name)	Dose	Route	Prescribers Signature	Time Given	Given by (Initials)	Checked by (Initials)
		Oxygen (NP/MASK/NRB)	%/L					
30/7/18	0845	Morphine 1-10mg	10mg	IV	K NMP 109	0915	2Smith	GM
30/7/18	0850	adenosine	4mg	IV	K NMP 109	0915	2Smith	
		16mg IV Morphine with SNS						

Discharge Medication to Take Away

Drug (Approved Name)	Dose	Frequency	Duration	Prescribers Signature	Given by (initials)	Checked by (initials)

NEWS Key	Date:	3/7				
0 1 2 3	Time:	0640	0710	0735	0910	0915
Blood Pressure					Post Morphine	
	128	127	134	↑	↑	
If manual BP mark as M			88	✓	✓	
Unrecordable						
Pulse Rate		66	57	61	•	•
Respiratory Rate		19	19	16	•	•
Temperature		36.9	36.2	35.1		
Sp02	Chronic Hypoxia ≥88	Default ≥96	96	98	98	98
		94-95				
	86-87	92-93	92			
	≤85	≤91				
	Unrecordable					
02	% or Litres		2L	2L		
Conscious Level	Alert		✓	A	A	A
	V P U					
	New Confusion					
Total NEWS SCORE			2	3	0	0
If NEWS >5 contact Senior Dr or Nurse In Charge						
If Escalated (Tick)						
Initials of person undertaking Obs			IH	IH	PS	PS

THINK SEPSIS

NEWS SCORE

SCORE MORE THAN 4

Are any of the following Present?	
Clinical signs of infection	
Plus 2 of these:	
Temperature <36°c or >38°c	
Heart rate >90 bpm	
Respiratory rate > 20bpm	
New confusion	
WCC <4 or >12	
Blood sugar > 7.7 in non-diabetic	

*If hypo tensive or raised lactate with above indicators discuss with Consultant

Start Sepsis 6 - complete within 1 hour	
Oxygen to achieve saturations >94% (NB COPD 88-92%)	
Measure lactate and FBC	
Blood cultures	
IV Antibiotics (start time _____)	
IV Fluids (up to 20ml/kg)	
Measure urine output and start fluid balance chart	

*please tick box i.e Yes or No (do not require time)

Neurological Observations

GLASGOW COMA SCALE

		Time:	0540
Eyes Open	Spontaneously	4	✓
	To speech	3	
	To pain	2	
	None	1	
Best Verbal Response	Orientated	5	✓
	Confused	4	
	Inappropriate words	3	
	Incomprehensible sounds	2	
	None	1	
Best Motor Response	Obey commands	6	✓
	Localise to pain	5	
	Flexion to pain	4	
	Abnormal flexion	3	
	Extension to pain	2	
	None	1	
Total GCS Score	14-15		15
	12-13		
	9-11		
	<8		

Endotracheal tube or tracheostomy = T

Always record the best arm response

Blood Sugar	Time:	0540
	>25	
	15-25	
	4-15	5.2
	<4	

Think Analgesia

Pain Score	Time:	
	Very Severe 9 - 10	
	Severe 6 - 8	
	Moderate 4 - 5	
	Mild 1 - 3	
	None 0	

NEWS Score	Structured Response	Escalation Plan
NEWS 0 - 1	Commence on 1hrly observations	Report to Area Co-ordinator if score increases
NEWS 2 - 4*	Commence on 30mins observations	Report to Area Co-ordinator if score increases
NEWS 5 - 7	Commence on 15mins observations and screen for Sepsis	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
NEWS >7	Commence on 10mins observations and screen for Sepsis	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
* score of 3 in one parameter	Commence on 30mins observations and screen for Sepsis	Report to Area Co-ordinator who must escalate to NIC and Senior Medic

Special Instructions

Right Pupil	Size		+ reacts - no reaction c. eye closed
	Reaction		
Left Pupil	Size		
	Reaction		
Initials of person taking GCS			

Pupil Scale mm

1 2 3 4 5 6 7 8

Patient Information		Incident Date:	30/07/2018
RICHARD TAYLOR		Incident Number:	CR004823295
Age/Gender:	55y Old Male		
Address:	42 MORVENSIDE EDINBURGH,EH14 2SJ	Incident Type:	EMG
DOB:	10/06/1963	Incident Location:	42 MORVENSIDE EDINBURGH, EH14 2SJ
CHI:	1006631372		
Ethnicity:			

Scottish Ambulance Service

Presenting Complaint

SEVERE ABDO [UMBILICAL] PAIN.

Additional Comments

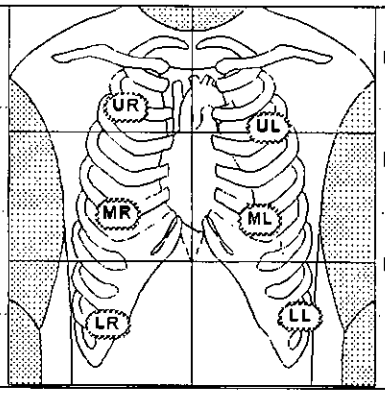
SAS ID : 0017442. O/E : PT WRITHING AROUND ON FLOOR IN DISTRESSED STATE DUE TO SEVERE UMBILICAL PAIN. PT STATES APS 8/10 [WHICH SAS CREW WOULD AGREE WITH ON INITIAL PRESENTATION]. ABDO SNT. NO MASSES, PALPABLE BILATERAL DORSALIS PEDIS. C/O NO FURTHER PAIN/SX. EVENTUALLY ADEQUATELY RESPONDED TO MORPHINE. NOTE : PT STATES SIMILAR TYPE PAIN, LOCATION AND SEVERITY OCCURRING X3 OVER PAST 2MTHS [LAST BEING 3WKS AGO], PT STATES DID NOT SEEK MEDICAL ATTENTION UNTIL TODAY.

PATIENT ASSESSMENT

AVPU	Alert		<C>	No
A	Clear			

B

Normal Breath Sounds	UR	UL	Normal Breath Sounds
Normal Breath Sounds	MR	ML	Wheeze
Normal Breath Sounds	LR	LL	Wheeze



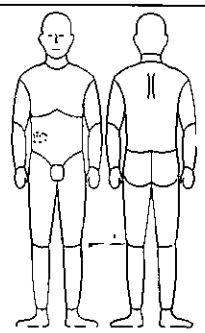
C

Pulse Rate	BP	Cap Refill	ECG Rhythm
71	115/84	<=2 Secs	Sinus Rhythm
Rhythm	**Arm**	**Central/Peripheral**	**ECG**
Reg	Left		12 Lead

D

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

E



Pain

ID	Body Part	Pain Scale
P1	Abdomen	8

Observations

Time	P	RR	BP	SpO2	CR	GCS	AVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
06:20	70	16	152/94	96	<=2s	15	Alert								E9888523
06:10	74	16	154/93	100	<=2s	15	Alert								E9888523
05:50	70	18	157/94	98	<=2s	15	Alert				12 LEAD : NSR				E9888523
05:35	72	20	115/84	100	<=2 Secs	15	Alert		36.3	5.6		4	4		E9888523

NEWS

Time	Clinical Risk	NEWS
06:20		0
06:10		0
05:50		0
05:35		0

Drugs

Time	Drug	Dosage	Units	Route	Drug Expiry Date	Pain Before	Pain After	CrewID
05:45	Morphine	2	mg	IV	01/2021	8	8	E0017442
05:48	Morphine	2	mg	IV	01/2021	8	8	E0017442
05:52	Morphine	2	mg	IV	01/2021	8	8	E0017442
05:55	Morphine	2	mg	IV	01/2021	8	7	E0017442
06:00	Morphine	2	mg	IV	01/2021	7	6	E0017442
06:03	Morphine	2	mg	IV	01/2021	6	6	E0017442
06:08	Morphine	2	mg	IV	01/2021	6	5	E0017442
06:10	Morphine	2	mg	IV	01/2021	5	4	E0017442

HISTORY

AMPLE

Allergies	None
Medication	PT STATES NIL.
Past Medical History	PT STATES NO SIGNIFICANT PMH.
Last Eaten	>4 Hours Ago
Events Prior	WOKEN FROM SLEEP AT 04:00HRS WITH ACUTE SEVERE UMBILICAL PAIN. VOMITED X2 APPROX 04:20HRS [PT UNABLE TO STATE IF NORMAL]. CALLED 999 AS NO LONGER ABLE TO TOLERATE PAIN.

CLOSE RECORD

Treatment On Scene	Emergency

Conveyance

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

INCIDENT LOG

Time Call Received	05:07	**Allocated**	05:15	**Mobile**	05:16
First Resource On Scene		**Crew On Scene**	05:30	**Crew Left Scene**	05:57
Crew At Hosp	06:38	**Receiving Hospital**	NEW EDINBURGH ROYAL INFIRMARY	**Clear Time**	

Crew ID	Crew Grade	Driver
E9888523	Ambulance Technician	YES
E0017442	Paramedic	NO

1006631372 30/07/2018 06:41:08 Taylor, Richard RIE (1)
Born 10/06/1963 Male Dept: Emergency Dept. (4>

Oper: Gildea

Rate 58 . Sinus bradycardia.....rate< 60

PR 142
QRSD 90
QT 402
QTc 395

--AXIS--
P 20
QRS 22
T 17

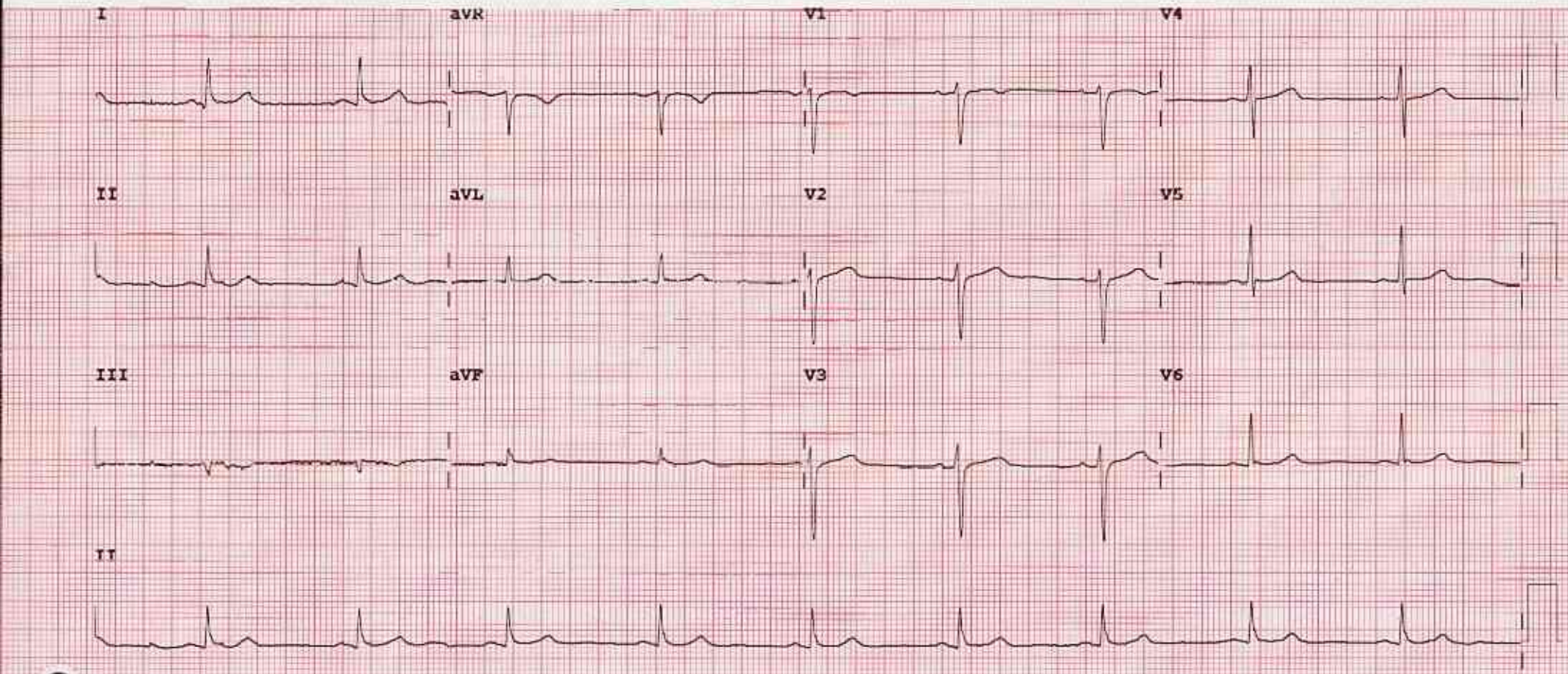
610119466W/E3915334 M 10/06/1963
Taylor, Richard
42 Morvenside,
Edinburgh,
EH14 2SJ

CHI 1006631372
70911 CB Nickerson

- OTHERWISE NORMAL ECG -

Review: .
Time: .
Actions: .

Unconfirmed Diagnosis



Dev: 350516 Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV F 50- 0.15-100 Hz PH100B BCL P?

MEDIGRAPHICS LTD

NHS Lothian

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

Dr Nickerson
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date: 02/10/2018

Inpatient Discharge Summary

Patient	Richard Taylor 42 Morvenside Edinburgh EH14 2SJ	**CHI** **Date of Birth / Age** **UHPI**	**1006631372** 10/06/1963 (55 years) 610119466W
Specialty	General Surgery	**Admission Date**	03/08/2018
Ward	Day Surgery Unit RIE		
Consultant	Mr Richard JE Skipworth	**Discharge Date**	06/08/2018

Dear Dr Nickerson

Clinical Summary:
This gentleman was admitted after attending the general surgery HOT clinic for an outpatient MRCP which demonstrated cholelithiasis and choledocholithiasis. He subsequently underwent laparoscopic cholecystectomy with intra-operative cholangiogram. Yours sincerely

Dr KIERAN PURCHASE FY2

Pictated 31/8/18

ROYAL INFIRMARY OF EDINBURGH

no. notes

IMMEDIATE DISCHARGE LETTER

IN CONFIDENCE

WHITE COPY - GIVEN TO PATIENT FOR DELIVERY TO GP PINK COPY - CASENOTES BLUE COPY - PHARMACY

NAME & ADDRESS OF GENERAL PRACTITIONER:

GP
Edrs ICP

SURNAME: Mr/Mr
FIRST NAME(S):
ADDRESS:

610119466W M
TAYLOR Richard
10-Jun-63 CHI:100 663 1372
70911 CB Nickerson
42 Morvenside
EH14 2SJ

BIRTH:

HOSPITAL: RIE | WARD/DEPT.: Gen Surg | CONSULTANT: Mr SKIPWORTH

DISCHARGE: Pt. bruised [illegible] no.

Your Patient { Attended / Was admitted } on _____ and was discharged on 06/08/18 { Home / To HOME }

PRINCIPAL DIAGNOSIS/OPERATION:

LAPAROSCOPIC CHOLECYSTECTOMY with INTRA-OP CHOLANGIOGRAM.

TREATMENT/COMMENTS:

DRUG SENSITIVITY NKDA.

DIAGNOSIS DISCUSSED	
G.P.	
Patient	✓
Next of Kin	

FOLLOW-UP Nil required. well

HOSPITAL
Further Review { Place Pt. All / Date / Time }

Further Investigations Pending:

G.P.
Further Treatment Advised: [illegible]

To attend G.P. Surgery	
Unable to attend Surgery	
Follow-up not required	✓

DOMICILIARY SUPPORT
Recommended:
Arranged by Hospital: N/A

MEDICATION ON DISCHARGE A 7 day supply will be dispensed unless otherwise requested.

	Medicine	Form	Dose	Administration Times	Additional Instructions	Quantity Supplied	Pharmacy Comments	Pharmacy Sig.
1	PARACETAMOL	TAB	1g		4-6hourly PRN max QDS			
2	DIHYDROCODEINE	TAB	30-60 mg		4-6hourly PRN max QDS			
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								

Prescribed by Dr K PURCHASE (FY2) Date: 6/8/18

Dispensed by: S. [illegible] Date: 6/8/18

Pharmacist check: _____ Date: _____

Final check by: [illegible] Date: 6/8/18.

LHB 2808

NN

106
B1

Department of General Surgery, Royal Infirmary of Edinburgh
Operation Record

Name:	**Mr Richard Taylor**	DoB:	10/6/1963	UHPI:	610119466W
				CHI:	1006631372
Consultant:	RICHARD SKIPWORTH	Ward:	106 → 054	Date of Op:	5/8/2018
Surgeon:	ALASTAIR HAYES	Assistant:			
Anaesthetist:		Anaesthetic:	General		
Urgency:	Emergency	Case:			

Operations

Site	Diagnosis	Operation	Code	Type
BILIARY TREE AND GALL BLADDER	**Gall stones and common bile duct stones**	**Laparoscopic cholecystectomy**	**101724**	
BILIARY TREE AND GALL BLADDER	**Gall stones acute symptoms**	**Laparoscopic cholecystectomy**	**100524**	

Operative Findings and Techniques

Operation note

Indications - GA - IV antibiotics administered. Right upper quadrant pain with deranged LFTs and 5mm CBD calculus on MRCP.

Procedure - who check list performed and patient undergone general anaesthetic, was prepped with Betadine and draped. Open cutdown at the umbilicus with 10mm port CO2 insufflation to 12mm mercury. 10mm epigastric port and 2 right upper quadrant 5mm ports inserted under lap control without incident. The gallbladder fundus was attempted and the gallbladder was needle decompressed and bile removed. The fundus of the gallbladder was successfully grasped and retracted up towards the right shoulder and adhesions to the greater omentum were taken down with targeted diathermy. The fundus of the gallbladder was identified and grasped to reveal Calot's triangle. The cystic artery was identified and isolated and the cystic duct was similarly identified and cleared of local adhesions and large windows were made in Calot's triangle between the cystic duct and cystic artery and the proximal one half of the gallbladder was mobilised off the gallbladder fossa. A large liga clip was placed at the proximal aspect of the cystic duct. The cystic duct was cut and cholangiogram performed which gave the appearance of a possible small calculus at the distal common bile duct right at the ampulla although this was questionable. Mr Skipworth attended theatre for senior opinion and 20mgs of IV Buscopan was given with a 40ml flush of saline down the cystic duct. Contrast was then injected down and cholangiogram this time was satisfactory with good tapering of common bile duct with flow of contrast into the duodenum and contrast displaying the right and left hepatic ducts. The cystic duct was then divided leaving 3 large liga clips on the cystic duct stump and one on the specimen side and 3 medium large liga clips were applied to the cystic artery leaving 2 in situ and divided between. The gallbladder was then dissected off the remainder of the liver bed and retrieved in a parachute bag through the epigastric port site and sent for routine histology. A saline irrigation was performed and suctioned out. A 20 French portex drain was sited at the right upper quadrant and secured with silk. J PDS was used to close the umbilical and epigastric port site sheath and 20mls 0.% chirocaine infiltrated to all four wounds. 4/0 monocryl to skin. Dressings.

Post op - patient to continue antibiotics until review on the ward round. Monitor drain output and fluid colour. DVT prophylaxis.

Mr ALASTAIR HAYES
Registrar to Mr RICHARD SKIPWORTH

06/08/2018

MRCP - 5mm CBD calculus, GB calculi JGT 267 B:L 38 ALT 255 ALP 252

Consent Form

Medical or Dental Investigation, Treatment or Operation

610119466W/E3917530 M 10/06/1963
Nai Taylor, Richard
42 Morvenside,
Edinburgh,
OO EH14 2SJ

CHI 1006631372
Unit 70911 CB Nickerson

NHS Lothian

To be completed by the medical, dental, nursing or paramedical practitioner. See notes overleaf

Type of operation, investigation or treatment for which written evidence of consent is considered appropriate

LAPAROSCOPIC +/- OPEN CHOLECYSTECTOMY +/- Bile duct exploration

Relevant written information outlining risks given to patient (tick box) **Yes** □ **No** □

I confirm I have explained to the patient and / or their parents or guardians in terms suited to their understanding, the proposed operation, investigation or treatment, including options available, and if relevant, the need for anaesthesia or sedation.

Signature ..... Date 04-08-2018
Name and Status of Practitioner ..... Mr A. HAMES

Reconfirmation of Consent on the day of admission:

Signature ..... Date .....
Name and Status of Practitioner .....

Medical Students

Tick relevant box	YES	NO
I agree to allow students to be present in theatre:		
I agree to be examined by a medical student whilst under general anaesthesia:		

To the patient (or Parent or Guardian if appropriate)

1. **Please read this form and the notes overleaf very carefully.**
2. **If there is anything that you don't understand about the explanation or if you want more information, you should ask the practitioner before signing.**
3. **Please check that all the information on the form is correct. If it is and you understand the explanation, then sign the form.**

I am the patient / parent / guardian (delete as necessary)
I agree - to what is proposed which has been explained to me by the practitioner above
I understand - that anaesthesia (general/regional/local) or sedation will be needed
- the procedure may not be done by the practitioner who has treated me so far
- any procedure in addition to the investigation or treatment described on this form will only be carried out if it is necessary and in my best interests and can be justified for medical reasons

I do not agree to the procedures below without having the opportunity to consider them first
.....
.....
.....

Signature ..... Name 04-08-2018 R. TAYLOR
Date .....

Note to all health practitioners (Doctors, Dentists, Nurses, Professions allied to Medicine)

A patient has an absolute legal right to grant or withhold consent prior to examination or treatment and should be given sufficient information, in a way that they can understand, about the proposed treatment and possible alternatives. Patients may refuse or withdraw consent at any time. The patient's consent to treatment should be recorded on this consent form (further guidance is given in the NHS Lothian Policy).

Note to Patients

The health practitioners are here to help you. He or she will explain the proposed treatment and what other alternatives exist. You can ask any questions and seek further information. You can also refuse treatment.

You should be provided with sufficient information to allow you to come to a decision as to whether to consent to the treatment proposed. The type of information you should receive should include:

I. Nature of your condition and proposed procedures, including degree of urgency
II. Benefits to be reasonably accepted of the procedure
III. Nature and probability of material (=significant) risks involved, including consideration of ratio of risks and benefits
IV. Inability of the practitioner to predict results
V. Irreversibility of the procedure, if that is the case
VI. The likely result of not having the proposed treatment or procedure
VII. Alternatives available, including their risks and benefits

You may ask for a relative, a friend or a nurse to be present. It is important that you understand all the information given to you. Please ask for clarity if something is not clear.

Your treatment may provide an important opportunity for training doctors, dentists, nurses and other health professionals. Such training is under the careful supervision of a senior doctor, dentist, nurse or other health professional.

You may decline to be involved in the formal training of medical, dental, nursing and other students without this adversely affecting your care and treatment. You must tell a senior doctor or nurse if you do not wish students to be involved in your care.

Medical Photography – I agree to the use of Medical Photography

Tick relevant box	**YES**	**NO**
For my medical records for the purpose of diagnosis and treatment		
For the purpose of teaching and education		
For the purpose of publication		
To be shown to other patients as an example		

RECOVERY ROOM* (→ WARD on day of surgery)

TIME IN: 1335 TIME OUT:

Discharge criteria met? Y ☐ N ☐

610119466W M
TAYLOR Richard
10-Jun-63 CHI:100 663 1372
70911 CB Nickerson
42 Morvenside
EH14 2SJ

Name:
Hospital N
Date of Bi

EVENTS

A Extubated
B PAC
C Sips of water
D
E
F
G
H

TIME	1340	1400	1415	1430	1455	1500	1515	1530	1545	1600	1615	1630	1655
Airway	ETT	ETT	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV
Oxygen Therapy	6L	6L	6L	4L	4L	4L	4L	4L	4L	4L	4L	4L	4L
S_pO_2	100	98	100	99	99	99	99	100	100	100	100	100	100
Respiration	6	14	11	11	9	9	9	8	8	16			
PAIN Severe 6-10													
PAIN Moderate 4-5				✓	✓	✓	✓	✓	✓	1			
PAIN Mild 1-3										✓			
PAIN None 0	U	U	0										
Nausea Score	U	U	0	0	0	0	0	0	0	0			
Sedation Score	U	U	1	0	0	0	0	0	0	0			
Urine Volume													
Wound Check													
Drains (1)	NIC			NIC		NIC							
Temperature	36.7												
SBP - v													
MAP - x													
DBP - ^													
Pulse - •													
Events				(A)		(B)	(C)						
Fluids													
Drugs	Morphine					3mg	2mg	3mg	2mg				
	paracetamol					1g							

200 / 150 / 100 / 50

PAIN SCORE
0 NONE. Continue to assess pain with every set of observations
1-3 MILD Continue to assess pain with every set of observations
4-5 MODERATE Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review
6-10 SEVERE Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review

NAUSEA SCORE
0 No Nausea
1 Nausea (consider anti-emetic)
2 Nausea/vomiting (administer anti-emetic)
3 Persistent nausea &/or vomiting (contact Dr.)

SEDATION SCORE
0 None, patient alert
1 Mild, occ drowsy, easy to rouse
2 Mod frequently drowsy, easy to rouse
3 Severe, somnolent, difficult to rouse
S Normal sleep, stirs to light touch
U Unconscious

RECOVERY COMMENTS

EBL Minimal

Lap Chole
Criteria discharge met @ 1455

NEWS = 2

Name (print) C SALIMU Signature

POST-OPERATIVE INSTRUCTIONS

Intravenous cannulae have been flushed ☑
Oxygen Overnight, to maintain SpO_2 > 94%.
Monitoring Routine
Fluids As charted ☑
Analgesia As charted ☑
Anti-emetics As charted ☑
Special Instructions (including expected return of power & sensation after RA):

Destination Day case ☐ Ward ☑ HDU ☐ ITU ☐

Name (print) A THOMSON Signature A Thomson
Contact No. 07968 281220

NHS LOTHIAN — ANAESTHESIA RECORD

Proposed operation: LAP. CHOLE + TRANSCYSTIC CBD EXPLORATION

610119466W /E3917530 M
TAYLOR Richard
10-Jun-63 CHI:100 663 1372
70911 CB Nickerson
42 Morvenside
EH14 2SJ

Date: 04/08/18 Side: —

NCEPOD: Ele ☐ Exp ☐ Urg ☑ Imm ☐

PRE-OP ASSESSMENT

Assessor: A. Goddard CONS ☐ SAS ☐ ST(CCT) ☑ CT__ ☐ Other ☐

Date: 04/08/18 Location: 108C Consent form signed and checked ☐

History / Examination (& see care pathway)

55 ♂ Biliary colic ∴ TLFTs.
MRCP: distal CBD calculus

PMH: ICH 2005 — nil residual

Resp/CVS.
Fit + well

HR 60.
BP 147/82
Weight (kg)
Height (m)

"Straining"
No N+V

Medications (including herbal)

omeprazole ✓

TEDS
Dalteparin
Paracetamol

Allergies & adverse reactions

NKDA ✓

ASA Grade

1 (2) 3 4 5 6 E

Airway Assessment

MO 3 MPZ
Subluxx A.
Recess
TMD > 6.5.

Teeth

ill crown - fixed

Previous Anaesthesia

Wrist ORIF (R) c graft

Uneventful Y ✓ N ☐ N/A ☐

Family History

Alcohol Nil.
Smoking 10cpd.
Drugs Ex-cannabis.
Reflux / GORD Not on PPI
Fasted ✓

Investigations

FBC Hb 151 WCC 7.4 Plt 223
U&E's / eGFR U/G 8.8 Na 141 K 4.6 Cr 84
G+S / e-Release / X-match Bld 38 / Ant 255 / Sec 267 Ant 252.
ECG
CXR

Information Given to Patient Dental damage. Sore throat. Extubation.

	Y	N	N/A
Intended anaesthetic technique discussed	✓	☐	
Regional / local anaesthetic technique discussed	✓	☐	☐
Risks of regional anaesthesia discussed:			☐
PDPH	☐	☐	☐
Failure	☐	☐	
Temporary nerve damage	☐	☐	
Permanent nerve damage	☐	☐	
Post-operative analgesia discussed	✓	☐	
Consent for PR drug administration	☐	☐	

Pre-op Instructions

	Y	N	N/A
Pre-medication prescribed on drug chart	☐	☐	☐
Give charted medication	☐	☐	☐
Omit anticoagulant	☐	☐	☐
Keep dentures in	☐	☐	☐

Fasting: Solids_____hrs Clear fluids_____hrs
(or state times)
Other:

Post-operative Remarks Happy to discuss concerns / questions

	Y	N
Uneventful anaesthetic	☐	☐

* Significant events
* Critical incident
* Warnings / Hazards

Name (print) Signature
Contact No

610119466W M
TAYLOR Richard
10-Jun-63 CHI:100 663 1372
70911 CB Nickerson
42 Morvenside
EH14 2SJ

Name:
Hospital
Date of E

ANAESTHETIST(S): A THOMSON
GRADE: CONS
SUPERVISING CONSULTANT INFORMED: Yes ☐ No ☐

OPERATION PERFORMED: LAP. CHOLE + IOC
LOCATION: TH. 17
SURGEON:

DATE: 5/8/18
START TIME:
END TIME:
TRAINED ASSISTANT PRESENT ☑

CONDUCT OF ANAESTHETIC

Induction
Pre O_2 ☑ RSI ☑ Cricoid ☑

FENTANYL 100 mcg
PROPOFOL 200 mg
SUX 150 mg

Maintenance

O_2 / AIR / SEVO

Reversal

NEO 2.5 / GLYCO 0.5

AIRWAY

Face Mask ☐
Oral Airway ☐
Nasal Airway ☐
LMA ☐
Type
Size
ETT ☑
Cuff ☑
Type
Size 8.0

Laryngoscopy grade (1) 2 3 4

BREATHING SYSTEM

Circuit UNIFLOW
Ventilator AESTIVA
Gas flow
Filter /Humidifier ☑
S.V. ☐
I.P.P.V. ☑
Throat Pack In ☐ Out ☐

Easy to hand ventilate Y ☐ N ☐ N/A ☐

VASCULAR ACCESS

Cannula(e)	Site
22G	R ACF (in situ)
16G	DRH

A – line ☐
CVP ☐

Ultrasound guidance Y ☐ N ☐

MONITORING

Machine checks
Anaesthetic room ☑
Theatre ☑

Monitor used MR

ECG	☑	P_{aw}	☑
S_pO_2	☑	Disconnect	☑
NIBP	☑	NMB	☑
F_iO_2	☑	Steth	☐
F_ECO_2	☑	Temp	☐
Agent	☑	Urine	☐
Anaesthetic depth			☐

POSITION

Patient / limb position: SUPINE

PROPHYLAXIS

		Y	N	N/A
Eye care	☑			
Pressure care	☑			
Fluid warmer	☐			
Warming blanket	☑			
DVT		☑	☐	☐
Antibiotics		☑	☐	☐
PONV		☑	☐	☐

REGIONAL TECHNIQUE

Type of block
Consent ☐
Awake ☐
Asleep ☐
Stimulator ☐
Ultrasound guidance ☐
Catheter ☐
Entry site
Needle used
Drugs given
Technique

Wound infiltration by surgeon.

EVENTS

A RSI
B STARS
C
D
E
F
G
H
I
J
K
L
M
N
O
P
Q
R
S
T
U
V

TIME	10:30	11:00	12:00	13:00	14:00
S_pO_2	99 100	100 100	100 100	100 100	100 100
F_ECO_2	4.5	3.9 4.3	4.5 4.7	4.9 4.7	4.7 5.3 5.7
F_iO_2	1.0 0.6	0.6 0.6	0.6 0.6	.6 .6	0.6 0.6
F_EAn	2.3	2.7 2.5	2.4 2.3	2.3 2.1	2.1 1.9 1.7
P_{aw}	16/4	22/4	23/4	2 14	
VT	500 x 13				
CVP					
Urine Output					
Blood loss					
Temperature					

SBP - v
MAP - x
DBP - ^
Pulse - •
200 / 150 / 100 / 50

Events	A			B													
Fluids	1					2											
MORPHINE	5	+	5									3					
ATRACURIUM	40					10			10			10					
CLONIDINE						100 mcg											
KETOROLAC						30											
[illegible]											20						
ONDANSETRON													A				
GENTAMICIN	200 mg																
AMOXICILLIN	1g																

FLUIDS

1 PL 148 1000
2 PL 148 1000
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18

TOTAL FLUIDS
TOTAL BLOOD LOSS
TOTAL URINE

Single Text Result

Printed on: 03/08/2018 at 1:50 pm

Surname:	Taylor, Rich[redacted]	**UHPI:**	610119466W	**CHI:**	1006631372
DOB:	10/06/1963				
Location:	Surgical Obs Inpatients	**Specialty:**	General Surgery	**Consultant:**	Mr Richard JE Skipworth

NHS Lothian

Order Name	Result Date Time
MRCP	03/08/2018 13:27

Result

Clinical details

MRCP
55 year old male RUQ pain AUSS: gallstones in gallbladder Deranged LFTs. ? stones in CBD

Report
The posterior sectoral duct inserts directly into the common hepatic duct shortly beyond the confluence of the right and left hepatic ducts.
The intra and extrahepatic biliary tree is non-dilated, the CBD measuring up to 5 mm, however a 5 mm filling defect is demonstrated within the distal CBD consistent with a ductal calculus. Several further gallstones are demonstrated at the gallbladder fundus. No pericholecystic inflammatory changes or fluid.

Unremarkable appearance of the liver, kidneys (right simple cyst noted), adrenal glands, pancreas and spleen. No upper abdominal lymph node enlargement.
Lung bases clear.

Opinion
Distal CBD calculus as described.

Dr S McLenachan
Consultant Radiologist
Suzanne.McLenachan@nhslothian.scot.nhs.uk

Bil 73
ALT 311
ALK 256
GGT 296

This list of patients' details is provided for its agreed purpose only. Please handle in accordance with the Caldicott principles and destroy this report immediately after use.

PLOT1371

NHS Lothian
University Hospital Services
Department of Emergency Medicine

Clinical Director Dr. Sara Robinson
Clinical Nurse Manager Mr. Chris Connolly
THE RDYAL INFIRMARY OF EDINBURGH
51 Little France Crescent, Edinburgh EH16 4SA
Tel: 0131 242 1300 • Fax: 0131 242 1344

NHS Lothian

A/E no. E3917530
Previous no. E3915334
UHPI no.
CHI no. 610119466W
CHI no. 1006631372

PATIENT INFORMATION

Surname Taylor
Forename Richard
Date of Birth 10/06/1963
Age Yrs Sex M

Address 42 Morvenside
Edinburgh

Postcode EH14 2SJ
Telephone 442 1596

Contact Taylor, Mrs
Address 20/4 Clovenstone Drive
Edinburgh
Midlothian EH14 3BD
Telephone 07792221250
W

Complaint SEVERE UPPER ABDO PAIN, DERANGED LFT'S, PAIN IS WO
Allergies

Attendances in last 12 months: 1 School:

General Practitioner

CB Nickerson
Address
Sighthill Green Medical Practice
Sighthill Health
EH11 4AU
Telephone 0131 537 7060

Date and Time of Attendance
01/08/2018 17:49
Incident Date & Time: 01/08/2018 16:24
Mode of Arrival
Private Transport
Source of Referral
Flow Centre

INITIAL ASSESSMENT

Presenting Complaint	
History of PC	Y M CB Nickerson Sighthill Green Medical Practice Sighthill Health
Assessment	442 1596 0131 537 7060

PAIN SCORE /10	ANALGESIA PRESCRIBED	YES NO	FAST + / -	ONSET TIME

Temp	HR	BP	RR	SPO2 %	AVPU	NEWS SCORE	ALC	PF (BEST OF 3)	BM
°C	SEVERE UPPER ABDO PAIN.			%					

Frequency of Observations (Please Tick)		Cardiac Monitoring (Please circle)	SPEICAL INSTRUCTIONS
Hourly		YES	
30 Minutes minimum			
15 Minutes minimum		NO	
10 Minutes minimum			

TRIAGED BY (SIGN)		TRIAGED BY (PRINT)	

PERIPHERAL VENOUS CANNULA INSERTION (Please circle all that applies)

DATE :		TIME :		STANDARD TECHNIQUE	
BLUE	PINK	LEFT	RIGHT	HANDWASH	GLOVES
GREEN	ORANGE	HAND	FOREARM	CHD SKIN PREP	ASEPTIC INSERTION
BROWN	GREY	ACF	FOOT	DRESSING LABELLED	
OPERATOR SIGNATURE					

BLOODS (Please tick)

ROUTINE		CRP	
TROPONIN		COAG	
AMYLASE		TOX SCREEN	
BTS		OTHER	

ADDITIONAL INVESTIGATIONS (Please indicate all that applies)

ECG	REQD	DONE	TIME DONE		X-RAYS CXR		OTHER
URINALYSIS	REQD	DONE	MSU SENT	YES / NO	HCG CONSENT	YES / NO	POS / NEG

ON-GOING CARE PLAN

SPECIALTY INFORMED	SURG	VASC	MEDICS	ORTHO	G.I	STROKE	GYNAE	OTHER

BED REQUIRED	YES	NO	TRIAGE CAT.	(Please Circle)	1	2	3	4	5	6	7
			TRIAGED TO	W/RM	RESUS	HDU	IC	EXAM			

"WHAT MATTERS TO THE PATIENT?"

THINK:- OTHER SOURCES OF INFORMATION:

FAMILY ☐ CARERS ☐ SAS PRF ☐ EPR ☐ ECS ☐ KIS ☐ GP ☐ PATIENT ALERTS ☐

Infection Screen

Have you been an in-patient in a hospital outwith Scotland in the past 12 months.

YES [ ] NO [ ]

Care Providers Name:..... Signature:.....

NHS Lothian - University Hospitals Division
Royal Infirmary of Edinburgh

Laparoscopic Cholecystectomy Integrated Care Pathway

Ac

610119466W M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
70911 CB Nickerson
42 Morvenside
EH14 2SJ

Key to Initials of ALL STAFF completing this ICP

Print name	Designation	Initials	Signature	Date
1. L GIBB	SN	LG	L GIBB	5/8/18
2. GRIFFIN	SN			5/8/18
3.				
4.				
5.				
6.				
7.				
8.				

A care pathway is intended as a guide to treatment and an aid to documenting patient's progress. Clinicians are free to exercise their own professional judgements as appropriate. However any alteratio to the practice identified within this care pathway should be noted as a variance.

Common Abbreviations Used

BMI	BODY MASS INDEX	LMP	LAST MENSTRUAL PERIOD
BP	BLOOD PRESSURE	NA	NOT APPLICABLE
CM	CENTIMETRES	NOK	NEXT OF KIN
ECG	ELECTROCARDIOGRAPH	OPD	OUT PATIENT DEPARTMENT
FBC	FULL BLOOD COUNT	P	PULSE
HRT	HORMONE REPLACEMENT THERAPY	R	RESPIRATIONS
I.V.	INTRAVENOUS	R/O	REMOVAL OF
KG	KILOGRAMS	T	TEMPERATURE
		U+E	UREA AND ELECTROLYTES

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Laparoscopic Cholecystectomy Integrated Care Pathway

610119466W M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
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CONSULTANT : .....

EXPECTED LENGTH OF STAY: Day case/23hr/Inpatient

DAY OF SURGERY PRE-OPERATIVE RECORD

CATEGORY	DATE 5/8/14	Initial	Var code
EDUCATION/ DISCHARGE PLANNING	Patient orientated to ward ✓ Pathway discussed ✓ Special needs assessed ✓ Remaining questions answered ✓	.....	.....
MEDICAL STAFF	Consent Form signed ✓ Surgeon- Review ✓ Anaesthetist- review ✓	.....	.....
MEDICATION	Patient has taken regular medication ☐ N/A Patient has discontinued appropriate medication ☐ N/A ✓ **Administer premedication** ☐ N/A ✓ **Allergies/sensitivities noted on pink perioperative record** **Red Bracelet insitu** ☐ Yes ☐ N/A NKDA	....	....
THROMBO EMBOLIC PROPHYLAXIS	**Prophylaxis to be prescribed:** minihep ☑ Flowtron boots ☑ Mobilise ☑ Other ☐	.....	.....
VITAL SIGNS (Chart)	(TPBP) Please record results on front page of **pink perioperative sheet**	.....	.....
PREPARATION FOR THEATRE	**Complete checklist in perioperative record**	.....	.....
FLUIDS/IV THERAPY (Chart)			
MOBILITY/ EXERCISES	Bedrest once premed given YES ☐ N/A ☐	.....	.....
ADMIN	Valuables Listed ☐ Not applicable ☐	.....	.....

SIGN/PRINTNAME: ..... Date/time.....

NHS Lothian- University Hospitals Division

Royal Infirmary of Edinburgh

610119466W M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
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Peri-operative Record

PREOPERATIVE CHECK LIST		Ward Initials		Theatre Initials	
		YES	NO	YES	NO
1.	Correct patient / correct procedure?	ML		TY	
2.	Bracelet in situ with name, date of birth, ward and unit number?	MC		TY	
3.	Teeth, dentures and crowns : In ☐ / Out ☐ Comments: Crowns Scar	ML		TY	
4.	Operation consent form signed?	ML		TY	
5.	Operation site marked if applicable?		ML		TY
6.	Prescribed pre-medication given?	ML		TY	
7.	Taken routine drug therapy? N/A		ML		TY
8.	Removed: make-up ☐ ~~contact lenses~~ ☐ ~~glasses~~ ☐ ~~hearing aid~~ ☐ ~~Jewellery (incl. body piercing items)~~ ☐ rings taped ☐ ~~hairclips~~ ☐			TY	
9.	Items **accompanying** patient to theatre: Metal RWrist/ Wigs ☐ hearing aids ☐ prosthesis ☐ glasses ☐ other.. L.Ankle	ML		TY	
10.	Has patient passed urine?	ML		TY	
11.	Urinalysis (if not recently tested at pre-admission ie<3mths) NAD ☐ protein ☐ glucose ☐ ketones ☐ blood ☐	—	—	—	—
12.	LMP:..... N/A ☐ Quickvue test ☐	—	—	—	—
13.	Dressed for theatre?	ML		TY	
14.	Anti-embolic stocking – N/A ☐, Yes ☐ ~~size~~	MC		TY	
15.	Waterlow score recorded				
16.	~~MRSA~~ ☐ ~~CPE~~ ☐ Any other infection risk ☐.....Nil		MC		TY
17.	Last food? Date 4/8 Time 2100	ML		TY	
18.	Last drink? Date 5/8 Time 0700 1/20	ML		TY	
19.	Documents accompanying patient All medical notes ☐ ICP ☐ X-rays ☐ Drug Chart ☐ Blood results ☐ Crossmatched ☐ Other ☐	ML		TY	

Ward Nurse SIGN/PRINTNAME: ML MCInnes .....Theatre Practitioner
SIGN/PRINT.....

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Royal Infirmary of Edinburgh

Laparoscopic Cholecystectomy

610119466W M
TAYLOR Richard
10-Jun-63 CHI:100 663 1372
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Intraoperative Care Record

Surgical Position SUPINE Initials: MEF	Equipment Used/Protection Eyes taped ☑ Flowtron Boots ☑ Heel pads ☐ Elbow supports ☐ Other BELT, LATERAL SUPPORT

Mobility Initials: MEF	Special Actions Taken INDEPENDENT - PRE-OP DEPENDENT POST-OP → PAT SLIDE + GUCHESTER
Diathermy Initials: MEF	Position RIGHT THIGH Problem/Action Taken
Skin Prep. Initials: MEF	Details IODINATED POVIDONE 10% H_2O
Skin Closure Initials:	Details 4/0 PROLENE/V ABSORBABLE SUTURE UNTIED
Dressings N/A ☐ Initials	Details Island dressing - mepore type -
Drains N/A ☐ Initials MEF	Details 2 soft passive drains
Catheters N/A ☑ Initials	Details Mls in Balloon
Specimens N/A ☐ Initials MEF	Details Gallbladder → path.
Packs N/A ☐ Initials	Details:

Comments

20 ml chirocaine - levobupivacaine 5mg/ml wound infiltration.

Print/sign C STIRLING / C5 3

NHS Lothian- University Hospitals Division
INTEGRATED CARE PATHWAY

Address
Name
Addres
DOB

610119466W M
TAYLOR Richard
10-Jun-63 CHI:100 663 1372
70911 CB Nickerson
42 Morvenside
EH14 2SJ

INTRAOPERATIVE COUNTS

	Initial Count	Intraoperative	Intraoperative	Intraoperative	Final Count
Correct (Signature)	Joan Lamb		Mcfarlane		Mcfarlane
Discrepancy And Action Taken					

Comments

Total Blood Loss minimal

Scrub Nurse

1. Print C Hinnie Sign C S

2. Print Sign

OPERATION SUMMARY (Surgeon or Deputy to complete)

Surgeon: A Hayes Assistants: Gill Stiles.

Operation Performed:

Laparoscopic cholecystectomy and cholangiogram

Postoperative Instructions:

1) Diet + fluid when awake
2) DVT prophylaxis
3) Caution Abx until ward review
4) Monitor drain fluid output volume + colour.

Please record any further information on "additional information sheet"

Follow-up required? Yes ☐, No ☒ - If Yes, specify when: /52

Signature/Print Surgeon.....

PLEASE RECORD VARIANCES AT END OF PATHWAY

NHS Lothian- University Hospitals Division	Addr Name Addı DOB	610119466W M TAYLOR Richard 10-Jun-63 CHI: 100 663 1372 70911 CB Nickerson 42 Morvenside EH14 2SJ
Laparoscopic Cholecystectomy		

FOR LABELS FROM PACKS/INSTRUMENTS USED FROM HSDU

Rotrak Pack Name Lothian - Laparoscopic Cat No RMT4487-REVG Lot No W431754 Date 2018 - 06 / Expiry: 2021 - 06 Rocialle, Wales Tel: +44 (0) 1443 471300 Fax: +44 (0) 1443 471301 www.rocialle.com	NEW GENERAL M.I.S O- A047439 2018/05/03 GS155 Edinburgh Royal Infirmary A/C No NOT USE IF D- 50 D.U. EDINBURGH 02 08	
	TELESCOPE OLYMPUS 30DEG/10MM O- A015845 018/08/03 S2680 dinburgh Royal Infirmary	
Lot: 14137449 GE Healthcare OMNIPAQUE™ 300 mg I/ml 50 ml		

NHS Lothian - University Hospitals Division
Royal Infirmary of Edinburgh

Laparoscopic Cholecystectomy Integrated Care Pathway

610119466W M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
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DAY OF SURGERY/ POST-OPERATIVE CARE

Return to ward @.....1600..... EXPECTED LENGTH OF STAY 12 ☐ 23hr ☐ 48hr ☐

CATEGORY	DATE 5/8/18		TIME	INITIAL	VAR. CODE
MEDICAL STAFF	Reviewed by Surgeon completed Discharge Summary page 20 Check Update all charts Complete discharge prescription		.....	.....	.....
MEDICATION	Check / administer regular medication	Rec E L	..... 1357 1500	..... CS M	....
PAIN MANAGEMENT	Record Pain Sedation Nausea Score	Rec E L	..... 1400 1500	..... CS M	....
	Administer analgesia / anti-emetic as prescribed	Rec E L	..... 1500	..... M	....
	Routine check of Pain score 30 min post analgesia	Rec E L	..... 1400 1500	..... CS M	....
VITAL SIGNS (CHART)	**TPR BP** monitored and evaluated Please tick and,on completion of each section, initial appropriate line. ½ hrly for 2 hours ☐ ☐ ☐ ☐		1500	M	.....
	Further observations as dictated by clinical need: ..... hourly for ..... hours ☐ ☐ .....hourly for .....hours ☐ ☐		....	....	....
	Oxygen administration .....4.....L/min via N/A ☐		1500	M	.....
TEST/INVESTIG (CHART					
FLUIDS/ IV THERAPY (CHART)	When patient able encourage fluids		1500	M	.....
	IV THERAPY AS CHARTED	Rec E L	1400	CS	....
DIET	When patient wishes - Resume **light** diet		.....	.....	.....
OUTPUT(Chart)	Passed urine post-op ☐ Yes ☐ No		.....	.....	.....
SPECIALTY OBSERVATION (chart)	NB blood loss in theatre CheckWound dressing intact-NAD+IV cannula	Rec E	1400	CS	....
	check-drain ☐ Yes ☐ N/A	L	.....	.....	.....
ACTIVITIES OF DAILY LIVING	On return to ward – provide assistance with basic hygiene Independent Hygiene / dressing Encourage mobilisation when able 1 hour post-operatively patient able to sit up in bed ☐ 2 hours post-operatively patient able to sit in high back chair at beside ☐		....	....	....
EDUCATION/ DISCHARGE PLANNING	Patient meets discharge criteria on day of surgery ☐ N/A Outpatient appointment actioned (if applicable) Issue / explain discharge information re wound care, activities GP letter issued	Ni	....	....	....
ADMIN	Complete discharge documentation Valuables returned ☐ Yes ☐ N/A Notify support services as appropriate i.e. Practice Nurse ☐ Yes ☐ N/A		....	....	....

WARD.....sign/print name

NHS Lothian - University Hospitals Division
Royal Infirmary of Edinburgh

Laparoscopic Cholecystectomy Integrated Care Pathway

610119466W M
TAYLOR Richard
10-Jun-63 CHI:100 663 1372
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42 Morvenside
EH14 2SJ

DAY OF SUR

Overnight admission

CATEGORY	DATE 6/8/18.		TIME	INITIAL	VAR. COD E
MEDICAL STAFF	Patient reviewed ☐ N/A				
MEDICATION	Check / administer regular medication	ND E	00:00		
PAIN MANAGEMENT	Record Pain Sedation Nausea Score	ND E	00:00		
	Administer analgesia / anti-emetic as prescribed	ND E	00:00		
	Routine check of Pain score 30 min post analgesia	ND E	00:00		
VITAL SIGNS (CHART)	**Monitor and evaluate TPR BP** as dictated by clinical need Please tick and, on completion of each section, initial appropriate line .....Hrly .....☐ .....hrly ☐ .....hrly ☐ .....hrly ☐ as per NEWS.		00:00		
	Oxygen administration .....1..... L/min via nasal cannula N/A ☐		00:00		
TEST/INVESTIG(CHART					
FLUIDS/ IV THERAPY (CHART)	When patient able encourage fluids		00:00		
	IV THERAPY AS CHARTED	ND E	N/A 00:00		
DIET(CHART)	When patient wishes - Resume **light** diet		00:00		
OUTPUT(Chart)	Passed urine post-op ☑ Yes ☐ No		00:00		
SPECIALTY OBSERVATION (chart)	Check Wound dressing intact-NAD IVCannula-NAD check-drain ☑ Yes ☐ N/A	ND E	00:00		
ACTIVITIES OF DAILY LIVING	On return to ward – provide assistance with basic hygiene Independent Hygiene / dressing Encourage mobilisation when able		00:00		
EDUCATION/ DISCHARGE PLANNING	Patient meets discharge criteria N/A ☐ Outpatient appointment actioned (if applicable) Issue / explain discharge information (eg wound care, activities, pain management) GP letter issued		00:00		
ADMIN	Complete discharge documentation Valuables returned ☑ Yes ☐ N/A Notify support services as appropriate i.e. Practice Nurse ☐ Yes ☑ N/A		00:00 00:00		

WARD..K.S.F./L.GRIFFIN...\...sign/print name

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Laparoscopic Cholecystectomy Integrated Care Pathway

610119466W M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
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Nurse Discharge Protocol

This protocol is designed to facilitate the smooth discharge of post-operative patients.

The Nurse in Charge may discharge patients who meet the discharge criteria.

For this to take place it is essential that all patients are seen by the surgeon post-operatively on the ward. He / she must complete a discharge summary / instructions and give authorisation for nurse discharge.

It is imperative that discharge drugs are prescribed at this point

If the patient does not meet the discharge criteria, the nurse will contact the appropriate member of the medical team to reassess the patient.

For those patients who insist on seeing a member of the medical staff before discharge, the nurse should be given a contact name / bleep number by the discharging surgeon.

I authorise Nurse Discharge from DSU if patient meets the stated Discharge Criteria.

Doctor's Discharge Summary:

Procedure:

Findings:

Instructions to patient:

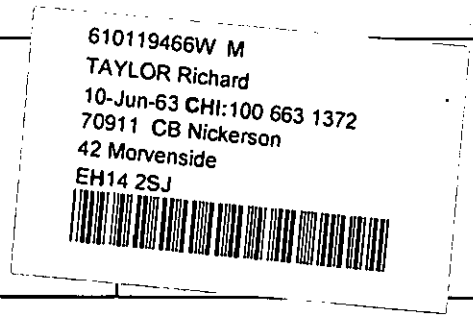
For Follow-up? No ☐, Yes ☐ - if Yes, no. of weeks: .....

Were Discharge drugs required to be prescribed? No ☐, Yes ☐

Signature of Doctor		**Print Name**
Date	**Time**	**Designation**
Contact name		**Bleep no.**

NHS Lothian -University Hospitals Division
Royal Infirmary of Edinburgh

Laparoscopic Cholecystectomy Integrated Care Pathway



DISCHARGE CRITERIA

DATE: _____

#	DISCHARGE CRITERIA	Yes	No	Comment or Variance code
1	Patient is 4h post anaesthesia	✓		*Refer to post-op Obs.*
2	Vital signs stable & satisfactory	✓		
3	Wound check satisfactory, dressings provided	✓		
4	Alert & orientated (as on admission)	✓		
5	Pain controlled	✓		
6	Nausea controlled, no vomiting	✓		
7	Tolerating fluids	✓		
8	Has passed urine	✓		
9	Normal mobilisation achieved	✓		
10	Discharge information given	✓		
11	Discharge drugs given with instructions	✓		
12	IV cannula removed	✓		
13	Ring tape: identity bracelet removed	✓		
14	Collected by a responsible adult	✓		
15	Responsible adult at home for first 24h	✓		
16	Patient issued with medical certificate	✓		

Was patient discharged as planned ie 1 On day of surgery? Yes ☐ No ☑

2 After one overnight stay Yes ☑ No ☐

If No, please record variance below. Commence new post-operative care record if indicated

Mr. Taylor ..... met the Discharge Criteria, & was discharged home from ward DSU

on (date): 6/8/18 at (time): 12.00

Accountable Nurse:

Signed S. K.

date: 6/8/18 time: 12:00

Printed: S. Reza Designation SIN

Patient offered next day phone call? Yes ☐, No ☑

Name of staff member to make call :

NHS Lothian-University Hospitals Division
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Laparoscopic Cholecystectomy Integrated Care Pathway

610119466W M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
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Date /Time	Additional Information	Signature/Designation Print Name
6/8/18	Nursing	
	Bleeped & spoke to FY1 doctor	
	for ~~jan~~ ERROR ET2 in regards	
	to getting Richard reviewed. FY1	
	reported team on ward round	
	just now & should be around	S/N.
	shortly	S. Ke S. Ke 11:15
6/8/18	Nursing	
12:00	Patient's drain removed &	
	d/c ERROR following review from	
	~~doctor~~ surgical team	S. Ke S. Reed S/N

NHS Lothian-University Hospitals Division Royal Infirmary of Edinburgh Laparoscopic Cholecystectomy Integrated Care Pathway	Addressograph

Additional Clinical Information **[not held elsewhere in the casenote]**

Additional information:

610119466W/E3917530 M 10/06/1963

Name: **Taylor, Richard**
42 Morvenside,
Edinburgh,
EH14 2SJ

Date of B

CHI No: **CHI** 1006631372
70911 CB Nickerson

NHS Lothian

Ward / Clinical Area

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)
5/8/18	Pt. boarded from ward 106.	
00.00	Pt. await Lap Chole tomorrow.	
	Pt. offered diet & fluid. Tea &	
	yogurt given. Pt. aware he is	
	fasting from mid-night. Pt.	
	can have clear fluids from	
	6am & then prescribed IV fluids.	
	Patient orientated to ward.	
	& Call bell place in reach	
	of pt. All medication given	
	as prescribed. + ——→	A GRIFFIN.

Patient Addressograph

Name:

Date of Birth:

CHI No:

NHS Lothian

Ward / Clinical Area

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)

WHO Surgical Safety Checklist

(adapted for General Surgery NHS Lothian)

Lothian

Last Name	610119466W M
First Name	TAYLOR Richard
Date of Birth	10-Jun-63 CHI: 100 663 1372
CHI Number	70911 CB Nickerson
	42 Morvenside
	EH14 2SJ

*DATE: 5/8/18

*THEATRE: 19

*SITE: RIE

*OPERATING/SUPERVISING CONSULTANT:

*PROCEDURE:

Please complete ALL boxes

SIGN IN (To be

Before commencement of anaesthesia

Member verbally confirms with the team:

	Yes	No	N/A
Patient confirmed his/her identity, site, procedure and consent	✓		
Correct operating table?	✓		
Surgical site/side marked		✓	
Are prophylactic antibiotics required?	✓		
Does the patient have a:			
Known Allergy?		✓	
Difficult airway/aspiration risk?	✓		
Complete case notes available?	✓		
Estimated blood loss > 500ml?		✓	
If yes, adequate IV access/fluid warming/cell salvage planned?			
Negative pregnancy test documented?			✓
Blood results available?	✓		
Group & Save available?	✓		
Patient temperature (°C)			
Patient diabetic?		✓	
If yes, BM (millimoles)			
Patient on Beta blockade?		✓	
If yes, Beta blockade given?			
If not given, state reason omitted:			

Name: A THOMSON

Signature: A Thomson

TIME OUT (To be read out loud)

Before start of surgical intervention

Member verbally confirms with the team:

	Yes	No	N/A
Team members introduce themselves by name and role	✓		
Correct patient?	✓		
Correct procedure/consent?	✓		
Correct site/side marked?			✓
Correct positioning?	✓		
Does the patient have a known allergy?		✓	
Essential imaging displayed	✓		
Has DVT prophylaxis been undertaken?			
TEDS	✓		
Calf compression	✓		
Heparin	✓		
Antibiotic prophylaxis administration complete?	Complete	Started ✓	N/A
Diathermy plate on	✓		
Extra/Specific Equipment required		✓	
Any anticipated difficulties expected by?	Yes	No	
Surgeon		✓	
Anaesthetist		✓	
Theatre Practitioner		✓	

Name: Lorna Young

Signature:

Please record any Problems identified overleaf

www.patientsafetyalliance.scot.nhs.uk/programme

SIGN OUT (To be read out loud)

Before patient leaves operating room

Member verbally confirms with the team:

	Yes	No	N/A
Has the operation/procedure summary been completed?	✓		
Have the post operative instructions been documented by:			
Surgeon	✓		
Anaesthetist	✓		
Theatre Practitioner	✓		
Have the specimens been labelled correctly (including patient name)?	✓		
Have blood tags been completed?			✓
Regular DVT prophylaxis prescribed?	✓		
Further antibiotic doses prescribed?	✓		
Cardiac medication prescribed?	✓		
Discharge medical analgesia prescribed?	✓		
Please ensure all *asterix boxes have been completed	✓		

Name: A Thomson

Signature:

RECOVERY AREA (On arrival:)

Patient temperature (°C): 36·7

Patient BM if diabetic (millimoles): N/A

Name: C SALMOND

Signature:

01011946GW/E391753U M 10/06/1963
Taylor, Richard
42 Morvenside,
Edinburgh,
EH14 2SJ

CHI 1006631372
70911 CB Nickerson
01011946GW/E391753U M 10/06/1963

ADULT FLUID PRESCRIPTION CHART

NHS Lothian

Date 3/8/18 | Sheet no 1

Ward SCP

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 seperate 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% Glucose	1000	IV	100	05.00		Fionn (IMP 140)	C. Osborne

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

Plasmalyte	1000	IV	500	1620	*	Fionn (IMP 141)	[illegible]

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 3/8/18
Name: Richard Taylor
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			Fasting				/				
01.00							/				
02.00							/				
03.00							/				
04.00							/				
05.00	0.18% NaCl + 4% Dex (1000)	100					/				
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 Lothian Guidance for Intravenous Fluid and Electrolyte prescribing (on Intranet)

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ADULT FLUID PRESCRIPTION CHART

NHS Lothian

Date 4/8/18 | Sheet no (1)

Ward 106

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)
0.18%NaCl/4%GLUCOSE +40mmol POTASSIUM	1000	IV	100	0780		K-PURCHASE FY2	GRIFFIN. LAGibb / GIBB

*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 4/8/18
Name: Richard Taylor
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	IVI Continued	100					/				
07.00		100					/				
08.00							/				
09.00							/				
10.00							/				
11.00	IVI Connected	100					/				
12.00		100					/				
Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print											
13.00		100					/				
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	Arrived to ward DSU from 106.						/				
22.00	Dug 750ml provided						/				
23.00	Tea	200ml.					/				
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 Lothian Guidance for Intravenous Fluid and Electrolyte prescribing (on Intranet)

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ADULT FLUID PRESCRIPTION CHART

NHS Lothian

Date 5/8/18 Sheet no 2

Ward DSU.

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?

Weight (kg) ~90 Essential

Write in Maintenance requirements in next 24 hours:

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% Glucose	1000	IV	85/hr			A Thompson	

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 5/8/18 Richard Taylor

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		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	0.18% NaCl / 4% Glucose + 40mmol KCl (1000)						/				
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			H2O (750)				/				
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	Yogurt · Jug H2O	750ml ·					/				
20.00	Tea	200ml ·					/				
21.00							/				
22.00							/				
23.00							/	700ml			
24.00							/				
01.00							/	(D/S continued.)			
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	

NOTE3 24 Hr Balance

Ward: SOU Site: RIE Date: 3/8/13

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 E EVANS

Addressograph, or

Taylor, Richard
42 Morvenside,
Edinburgh,
EH14 2SJ

CHI 1006631372
70911 CB Nickerson

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	2300	0200	0400	0600	08.10	10	13.20	16.05	2000	24	4
	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	H	H	H	H	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	N	N	N	N	I	I	I
Positioning (R) or (L) side (B) Back (C) Chair	B	B	R	R	B	B	B	B	B	B	B	
Mattress type / Cushion type	*please state type:* Pulsator											
Elimination — Do you need the toilet?	N	N	N	N	N	ind	I	ind	ind	I	I	I
Is the patient continent of urine? (at time of Care Rounding)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Continence product changed/offered?	—	—	—	—	NA	NA	N	NA	NA	NA	na	na
Catheter care performed?	—	—	—	—	NA	NA	N	NA	NA	NA	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	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	W	W	N	W	W	W	W	W	W	W
Fluid Balance Chart (if clinically indicated)	N/A	—	—	—	NA	NA	N	NA	NA	NA	na	na
When did you last eat?	31/8/13	1/8/13	-7	-7	S	B	B	B	B	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)	ind	ind	ind	ind	ind	ind	I	ind	ind	N	N	N
Falls — Appropriate Footwear?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Walking aid available(and within reach)	N/A	—	—	—	NA	NA	N	NA	NA	NA	na	na
Area de-cluttered?	Y	Y	Y	Y	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?	—	—	—	—	NA	NA	N	NA	NA	NA	na	na
Glasses available for use? (if worn) Hearing aid available for use? (if worn)	Y N/A	Y	Y	Y	Y NA	Y NA	Y N	Y NA	Y NA	Y	Y	Y
Requires close observation for commode, toilet, bathing or showering Y ☐ N ☑												
Pain — Are you in pain?	N	N	N	N	N	Y	Y	Y	Y	N	N	N
Analgesia Given?	N	N	N	N	N	N	N	N	N	N	N	N
General — Peripheral Venous Cannula observed?	N/K	—	NA	NA	NA	NA	N	NA	NA	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	Y	Y	Y	Y
Anything else I can do for you?	N	N	N	N	N	N	N	N	N	N	N	N
Buzzer within easy reach	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

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

Initials – document at time of care delivery	EE	EE	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	CO	[illegible]	[illegible]

Ward: 106 Site: RIE Date: 4/8/18

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 C.Osbome (OSBORNE)

Addressograph, or

610119466W /E3917530 M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
70911 CB Nickerson
42 Morvenside
EH14 2SJ

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	0755	1245	16 30	1945									
	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)			✓	✓ Jen									
Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister	H	H	ND	✓ Jen									
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	✓	2									
Positioning (R) or (L) side (B) Back (C) Chair	B	C	C	B									
Mattress type / Cushion type	*please state type:*												

Elimination

Do you need the toilet?	N	N	N	N									
Is the patient continent of urine? (at time of Care Rounding)	Y	Y	✓	Y									
Continence product changed/offered?			✓	N/A									
Catheter care performed?				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	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	FAST	FAST	✓	2									
Fluid Balance Chart (if clinically indicated)	Y	Y	✓	2									
When did you last eat?	FAST	FAST	✓										
(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	Y	✓	3									

Falls

Appropriate Footwear?	Y	Y	✓	Y									
Walking aid available(and within reach)	NA	✓	✓	N/A									
Area de-cluttered?	Y	Y	✓	Y									
Chair and bed height assessed?	Y	Y	✓	Y									
Falls alarm in use and attached?	NA	✓	✓	2									
Glasses available for use? (if worn) Hearing aid available for use? (if worn)	NA	✓	✓	2									
Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐													

Pain

Are you in pain?	Y	Y	✓	2									
Analgesia Given?	Y	Y	✓	N/A									

General

Peripheral Venous Cannula observed?	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									
Anything else I can do for you?	N	N	✓	N									
Buzzer within easy reach	Y	Y	✓	Y									

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

Initials – document at time of care delivery	OW	OW	✓	E									

PRESCRIPTION AND ADMINISTRATION RECORD

Standard Chart

NHS Lothian

Hospital/Ward: RIE Consultant: RICS.

Weight: Height:

If re-written, date:

DISCHARGE PRESCRIPTION

Date completed: Completed by:

Name of Patient: 610119466W/E3917530 M 10/06/1963
Taylor, Richard
42 Morvenside,
Edinburgh,
EH14 2SJ

CHI Number:

D.O.B.

CHI 1006631372

70911 CB Nickerson

OTHER MEDICINE CHARTS IN USE		PREVIOUS ADVERSE REACTIONS This section must be completed before any medicine is given		Completed by (sign & print)	Date
Date	Type of Chart	None known ☑			
		Medicine / Agent	Description of reaction		

- 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'

ONCE ONLY

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber - Sign + Print	Time Given	Given By
5/8/18	IN RECOVERY	MORPHINE titrate to	10mg	IV	A Thomson	2mg @ 1440 2mg @ 1417 2mg @ 1420 2mg @ 1442	SB
5/8/18	IN RECOVERY	MORPHINE titrate to	10mg	IV	A Thomson	2mg @ 1455	NF/CS

Risk Factors for venous thromboembolism:

Age >70yrs	☐	Malignancy	☐
BMI>30	☐	Pregnancy/puerperium	☐
Poor Mobility	☐	Oestrogen Rx	☐
Surgery >1hr	☐	Heart Failure	☐
Thrombotic states	☐	Severe COPD	☐
Previous DVT/PE	☐	Severe Infection	☐
Emergency admission	☐		

☐ 1 factor: sc dalteparin 2,500u
☑ >1 factor: sc dalteparin 5,000u & TEDS ☐ Vasc NO TEDS
(if weight less than 46kg / BMI less than19, age greater than 70yrs: 2,500 dalteparin maximum. & TEDS if appropriate)
(if eGFR is less than 30: sc heparin 5,000u BD)

Name: Signature:
Date: Prescribed Rx: ☐

REGULAR THERAPY

610119466W M
TAYLOR Richard
10-Jun-63 CHI:100 663 1372
70911 CB Nickerson
42 Morvenside
EH14 2SJ

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

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

PRESCRIPTION

Patient's Own Medicine

Date → 3/8/18 | 4/8/18 | 5/8/18 | 6/8/18

Time ↓ | 6 | 8 | 12 | 14 | 18 | 22

Medicine (Approved Name): Paracetamol
Dose: 1g | Route: Oral | For Use Date | Quantity
Notes/Indication for antibiotic: Pain relief | Start Date: 2/8/18 | Stop Date
Prescriber - sign + print: A. Barrett-Voss F1 | Pharmacy
Times given: 8 (B, JW, LG), 12 (B), 14 (B, JW, CO), 18 (JW, DW), 22 (CO)

Medicine (Approved Name): Dalteparin
Dose: 5000 units | Route: SIC | For Use Date | Quantity
Notes/Indication for antibiotic: VTE Prophylaxis | Start Date: 2/8/18 | Stop Date
Prescriber - sign + print: A. Barrett-Voss | Pharmacy
Times given: 22 (CO)

Medicine (Approved Name): TEOS
Dose: 1 App | Route: TOP | For Use Date | Quantity
Notes/Indication for antibiotic: VTE Prophylaxis | Start Date: 2/8/18 | Stop Date
Prescriber - sign + print: A. Barrett-Voss | Pharmacy
Times given: 22

Medicine (Approved Name):
Dose | Route | For Use Date | Quantity
Notes/Indication for antibiotic | Start Date | Stop Date
Prescriber - sign + print | Pharmacy

REGULAR THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine	Date → / Time ↓														
Medicine (Approved Name)		For Use / Date	6														
Dose	Route	Quantity	8														
			12														
Notes/Indication for antibiotic	Start Date	Stop Date	14														
Prescriber - sign + print		Pharmacy	18														
			22														
Medicine (Approved Name)		For Use / Date	6														
Dose	Route	Quantity	8														
			12														
Notes/Indication for antibiotic	Start Date	Stop Date	14														
Prescriber - sign + print		Pharmacy	18														
			22														
Medicine (Approved Name)		For Use / Date	6														
Dose	Route	Quantity	8														
			12														
Notes/Indication for antibiotic	Start Date	Stop Date	14														
Prescriber - sign + print		Pharmacy	18														
			22														
Medicine (Approved Name)		For Use / Date	6														
Dose	Route	Quantity	8														
			12														
Notes/Indication for antibiotic	Start Date	Stop Date	14														
Prescriber - sign + print		Pharmacy	18														
			22														
Medicine (Approved Name)		For Use / Date	6														
Dose	Route	Quantity	8														
			12														
Notes/Indication for antibiotic	Start Date	Stop Date	14														
Prescriber - sign + print		Pharmacy	18														
			22														
Medicine (Approved Name)		For Use / Date	6														
Dose	Route	Quantity	8														
			12														
Notes/Indication for antibiotic	Start Date	Stop Date	14														
Prescriber - sign + print		Pharmacy	18														
			22														
Medicine (Approved Name)		For Use / Date	6														
Dose	Route	Quantity	8														
			12														
Notes/Indication for antibiotic	Start Date	Stop Date	14														
Prescriber - sign + print		Pharmacy	18														
			22														

TURN OVER →

AS REQUIRED THERAPY

610119466W M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
70911. CB Nickerson
42 Morvenside
EH14 2SJ



PRESCRIPTION		Patient's Own Medicine												
Medicine (Approved Name)		For Use	Date	2/16	2/16	4/8/18	4/8	4/8	5/8	5/8/18	4/8/18			
Codeine			Time	8.30	12.30	22.25	0755	21.30	07[10]	15[illegible]	9.30			
Dose + frequency + max	Route	Quantity	Dose	60mg	60mg	60mg	60/0	60mg	60mg	60mg	30mg			
30-60mg, 4°, 240mg/d	oral		Initials	[illegible]	[illegible]	CO	JW	[illegible]	[illegible]	[illegible]	[illegible]			
Indication + notes	Start Date	Date	Date											
Pain relief	2/8/18		Time											
Prescriber - sign + print		Pharmacy	Dose											
A. Barrett-Vares			Initials											
Medicine (Approved Name)		For Use	Date	2/16/18										
Buscopan			Time	16.20										
Dose + frequency + max	Route	Quantity	Dose	20mg										
20mg 6° QDS	Oral		Initials	[illegible]										
Indication + notes	Start Date	Date	Date											
Pain/colic	2/8/18		Time											
Prescriber - sign + print		Pharmacy	Dose											
A. Barrett-Vares			Initials											
Medicine (Approved Name)		For Use	Date											
Omeprazole			Time											
Dose + frequency + max	Route	Quantity	Dose											
20mg OD	Oral		Initials											
Indication + notes	Start Date	Date	Date											
As per ECS	2/8/18		Time											
Prescriber - sign + print		Pharmacy	Dose											
A. Barrett-Vares			Initials											
Medicine (Approved Name)		For Use	Date	2/8/18	6/8/18									
ORAMORPH			Time	13.30	09.[illegible]									
Dose + frequency + max	Route	Quantity	Dose	10mg	10mg									
10mg 1°	P.O.		Initials	[illegible]	[illegible]									
Indication + notes	Start Date	Date	Date											
Analgesia	2/08		Time											
Prescriber - sign + print		Pharmacy	Dose											
Joe Francisco			Initials											
Medicine (Approved Name)		For Use	Date											
PRIAN ONDANSETRON			Time											
Dose + frequency + max	Route	Quantity	Dose											
4mg / 8hrly	IV / IM		Initials											
Indication + notes	Start Date	Date	Date											
PRN: NAUSEA	5/8/18		Time											
Prescriber - sign + print		Pharmacy	Dose											
A Thornton			Initials											
Medicine (Approved Name)		For Use	Date	5/8/18										
CYCLIZINE			Time	1600										
Dose + frequency + max	Route	Quantity	Dose	50mg										
50mg / 8hrly	IV / IM		Initials	[illegible]										
Indication + notes	Start Date	Date	Date											
PRN: NAUSEA	5/8/18		Time											
Prescriber - sign + print		Pharmacy	Dose											
A Thornton			Initials											

REGULAR THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine	Date → / Time ↓															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															

AS REQUIRED THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine												
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											

Royal Infirmary of Edinburgh
Emergency Department

Drug and Prescription Record

NHS Lothian

Addressograph
01011946W/E391/S30 M 10/06/1963
Taylor, Richard
42 Morvenside,
Edinburgh,
EH14 2SJ

CHI 1006631372
70911 CB Nickerson

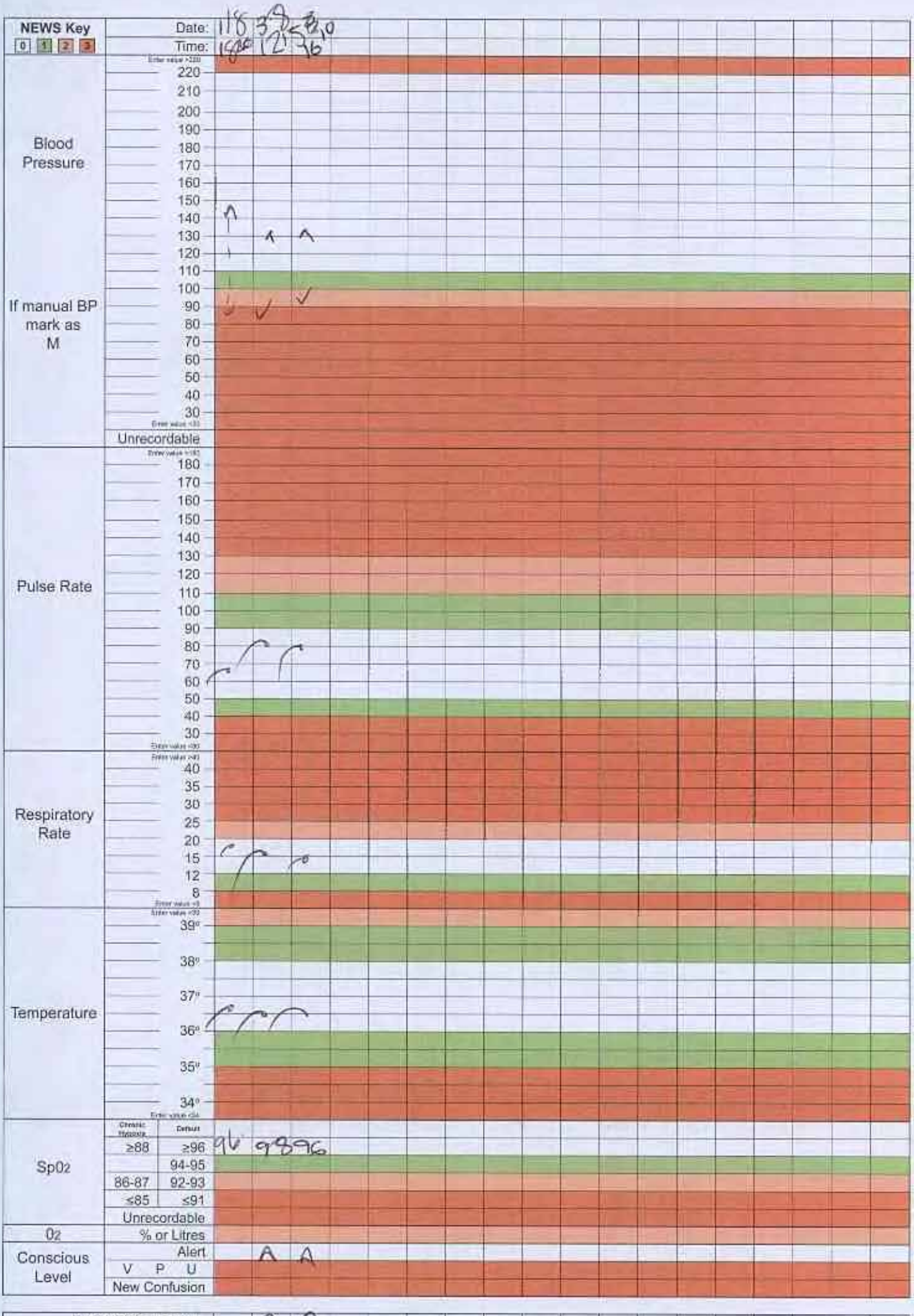
Previous Adverse Reactions	Weight kgs Actual / Estimate	Date
NKOA		1/8/18

Once Only Prescription

Date	Time	Drug (Approved Name)	Dose	Route	Prescribers Signature	Time Given	Given by (Initials)	Checked by (Initials)
		Oxygen (NP/MASK/NRB)	%/L					
1/8/18	23:25	CO-CODAMOL	2 TABS 30/500mg	ORAL	DONACHIE	2330	EE	
1/8/18	23:25	HYOSCINE BUTYLBROMIDE	20mg	ORAL	Donachie			

Discharge Medication to Take Away

Drug (Approved Name)	Dose	Frequency	Duration	Prescribers Signature	Given by (initials)	Checked by (initials)


NEWS Key
0 1 2 3
Date:
Time:
Blood Pressure
If manual BP mark as M
Unrecordable
Pulse Rate
Respiratory Rate
Temperature
Sp02
Chronic Hypoxia
Default
≥88
≥96
94-95
86-87
92-93
≤85
≤91
Unrecordable
02
% or Litres
Conscious Level
Alert
V P U
New Confusion
Total NEWS SCORE
If NEWS >5 contact Senior Dr or Nurse In Charge
If Escalated (Tick)
Initials of person undertaking Obs

THINK SEPSIS

NEWS SCORE

SCORE MORE THAN 4

Are any of the following Present?	
Clinical signs of infection	

Plus 2 of these:	
Temperature <36°c or >38°c	
Heart rate >90 bpm	
Respiratory rate > 20bpm	
New confusion	
WCC <4 or >12	
Blood sugar > 7.7 in non-diabetic	

*if hypo tensive or raised lactate with above indicators discuss with Consultant

Start Sepsis 6 - complete within 1 hour	
Oxygen to achieve saturations >94% (NB COPD 88-92%)	
Measure lactate and FBC	
Blood cultures	
IV Antibiotics (start time _____)	
IV Fluids (up to 20ml/kg)	
Measure urine output and start fluid balance chart	

*please tick box i.e Yes or No (do not require time)

Neurological Observations

GLASGOW COMA SCALE			Time								
Eyes Open	Spontaneously	4								
	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	14-15									
	12-13									
	9-11									
	<8									

		Time:						
Blood Sugar		>25						
		15-25						
		4-15						
		<4						

Think Analgesia

		Time:						
Pain Score	Very Severe	9 -10						
	Severe	6 - 8						
	Moderate	4 - 5						
	Mild	1 - 3						
	None	0						

NEWS Score	Structured Response	Escalation Plan
NEWS 0 - 1	Commence on 1hrly observations	Report to Area Co-ordinator if score increases
NEWS 2 - 4*	Commence on 30mins observations	Report to Area Co-ordinator if score increases
NEWS 5 - 7	Commence on 15mins observations and screen for Sepsis	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
NEWS >7	Commence on 10mins observations and screen for Sepsis	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
* score of 3 in one parameter	Commence on 30mins observations and screen for Sepsis	Report to Area Co-ordinator who must escalate to NIC and Senior Medic

Special Instructions

Right Pupil	Size								+ reacts - no reaction c: eye closed
	Reaction								
Left Pupil	Size								
	Reaction								
Initials of person taking GCS									

Pupil Scale mm



IV Fluid Prescription

Time Prescribed	Fluid	Volume	Duration	Prescribers Signature	Time Started	Given by (Initials)	Checked by (Initials)	Time Finished

Fluid Balance

INPUT						OUTPUT				
	IV Fluids or SC Fluids IV Medication	**IV Line(s)**	**Oral Input**		**Input**		**Urine**		**Gastric**	
Time	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100ml	Running Total	Time	Volume	Running Total	Volume	Running Total

Drug Infusion

Drug Name:

	Time													
	Rate (ml/hr)													
	Volume in Syringe													
Pump No	Total amount Infused													

Drug Name:

	Time													
	Rate (ml/hr)													
	Volume in Syringe													
Pump No	Total amount Infused													

National Early Warning Score (NEWS) Chart

NHS Lothian

[illegible] M 10/06/1965
Taylor, Richard
42 Morvenside,
N Edinburgh,
EH14 2SJ
D
CHI 1006631372
C 70911 CB Nickerson

Consultant: RJES (1) Date chart commenced: 1/8/18

This is chart number (1) this admission

Weight: Actual kgs Estimated kgs

ASU: Ward: S@4

Conscious Level Chart to be completed when clinically indicated

| GLASGOW COMA SCALE | | |

NEWS Key 0 1 2 3	Date:	1/3/18	2/3					3/3	4/3					5/3/18											Date
	Time:	2300	0200	0600	1000	1400	1800	2000	0000	0400	0800	1200	1600	1945	2130	0930	1300	1455	1800	1530	1630	1800	2030	0330	0630	1100	Time
Respiratory Rate	≥25																										≥25
	21-24																										21-24
	12-20	14	16	16	18		18	18	14	16	15	16	16	16	16					14	13	12	13	16	16	16	18	16	12-20
	9-11																										9-11
	≤8																										≤8
Sp02	Chronic Hypoxia	Default																									Default	Chronic Hypoxia
	≥88	≥96	98	96	95	96	5	a°	97	96	98	98	95	96	97	100				99	99%	99%	100	97	97	96	≥96	≥88
Medical Signature required to use scale for patients with Chronic Hypoxia		94-95																									94-95	
	86-87	92-93																									92-93	86-87
	≤85	≤91																									≤91	≤85
Sign	Unrecordable																										Unrecordable	
Inspired 02	% or litres																			4L	4L	4L	4L	4L	2L	2L	2L	% or litres
Temperature	≥39°																										≥39°
	38°																										38°
	37°							36.8																			37°
	36°																										36°
	≤35°																										≤35°
NEWS SCORE uses Systolic BP	230																										230
	220																										220
	210																										210
	200																										200
	190																										190
	180																										180
	170																										170
	160																										160
	150																										150
	140																										140
If manual BP mark as M	130																										130
	120																										120
	110																										110
	100																										100
	90																										90
	80																										80
	70																										70
	60																										60
	50																										50
	Unrecordable																										Unrecordable
Heart Rate	>140																										>140
	130																										130
	120																										120
	110																										110
	100																										100
	90																										90
	80							78																			80
	70																										70
	60																										60
	50																										50
	40																										40
	30																										30
	Regular Y/N	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y						Y	Y	Y	Y	Y	Y	Y		Regular Y/N
Conscious Level	Alert	A	A	A	A		A	✓	✓	✓	✓	A	A	A						A	A	A	A	A	A	A		Alert
	V / P / U																											V / P / U
	New Confusion																											New Confusion
Total NEWS score		0	0	(1)	0		0	0	0	0	1	0	0	2		2	3	2		2	2	2	1		0		**Total NEWS score**
Urine output recorded Y/N				Y			NA	NA				Y															Urine output recorded
Blood Glucose				5.5			NA	NA				2.1															Blood Glucose
Frequency of Observations		4'	4'	4'			4'	4'				4'															Frequency of Obs.
Structured Response Tool Y/N				N			N	N				N															SRT Y/N
Escalation Y/N				N			N	N				N															Escalation Y/N
Pain score (0-10)							0	0																			Pain score (0 10)
Nausea score (0-3)							0	0																			Nausea score (0-3)
Motor Block score (0-4)																											Motor Block score (0-4)
Circulation																											Circulation
Sensation																											Sensation
Movement																											Movement
Initials																											Initials

Patient Name:	CHI:

Special Instructions - to be completed by Medical Team

A total NEWS score 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**

NEWS Score	Frequency of Observations	Clinical Response
Total 0*	**Minimum 12 hourly / 4 hourly in admission areas**	• Continue routine NEWS monitoring with every set of observations.
Total 1 - 4*	**Minimum 4 hourly** Consider Structured Response Tool Consider Fluid Balance Chart	• Inform registered nurse • Registered nurse assessment using ABCDE • Review frequency of observations • Inform Nurse in Charge • **If ongoing concern, escalate to Medical Team**
Total 5 - 6* or 3 in one parameter	**Increase frequency to a minimum of 1 hourly** Start Structured Response Tool Start Fluid Balance Chart	• Registered nurse assessment • Inform Nurse in Charge • Escalate to Medical Team as per local escalation • Urgent medical assessment • Management plan to be discussed with Senior Trainee or above • Consider level of monitoring required in relation to clinical care
Total 7* or more	**Continuous monitoring of vital signs** Start Structured Response Tool Start Fluid Balance Chart	• Registered nurse to assess immediately • Inform Nurse in Charge • Request immediate assessment by Senior Trainee or above • Case to be discussed with supervising Consultant • If appropriate contact Critical Care for review

NEWS ≥4 Think Sepsis

Are any 2 or more SIRS criteria present?

RECOGNISE

Temperature	<36°c or >38°c
Pulse	>90 beats/min
White Cell Count	<4 or >12
Respiratory Rate	> 20 bpm
Mental State	New confusion
Blood Sugar	>7.7mmol/L in non-diabetic

and clinical suspicion of infection = SEPSIS

Apply Sepsis 6 within 1 hour

RESUSCITATE

1. Give oxygen to target saturation >94% (NB COPD 88%-92%)
2. IV fluids up to 20ml/kg
3. Take blood cultures
4. Measure lactate and FBC
5. Give IV antibiotics
6. Monitor urine output & start fluid chart

NHS Lothian

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

Dr Nickerson
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date: 12/11/2018

Inpatient Discharge Summary

Patient	Richard Taylor 42 Morvenside Edinburgh EH14 2SJ	**CHI** **Date of Birth / Age** **UHPI**	**1006631372** 10/06/1963 (55 years) 610119466W
Specialty	General Surgery	**Admission Date**	01/11/2018
Ward	Surgical Obs Inpatients		
Consultant	Mr S Paterson-Brown	**Discharge Date**	01/11/2018

Dear Dr Nickerson

Dear Doctor,

PRINCIPAL DIAGNOSIS/PROCEDURE

Non-specific abdominal pain

Mr Taylor attended Surgeons overnight 31/10/18 with sudden onset acute upper abdominal pain. No associated symptoms with pain - denied dysuria, nausea, vomiting or change to bowel habit, afebrile. History of recent cholecystectomy under Mr Skipworth August 2018. Bloods showed mild derangement of LFTs with slight rise in Amylase. CT abdomen/pelvis found no acute surgical cause for symptoms and following a brief period of observation, Mr Taylor felt well enough to return home. Worsening statement given, no surgical follow up indicated.

TREATMENT
1. Observations - NEWS 0 on discharge
2. Blood analysis - WCC 11.3, Bil 23, ALT 59, AlkP131, Amylase 162.
3. CTAP: nil acute surgical cause identified. Mild bibasal atelectasis - no respiratory symptoms.
4. Senior review - Consultant Surgeon Mr Paterson-Brown.

FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL

N/A

CHANGES TO DRUGS SINCE ADMISSION

N/A

ALLERGIES / ADVERSE DRUG REACTIONS

N.K.D.A.

SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS

N/A

CHANGES TO DNACPR STATUS OR ANTICIPATORY CARE PLANNING

N/A

GP to please consider the following; nil at this time, thank you.

Should you need further information please contact Mr Paterson-Brown's General Surgery ET1 team at RIE on 0131 536 1000.

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

Yours sincerely.....

Staff Signature..... Print Name.....Angela Macnamara.....

Designation.....SNP..... Date.....1/11/18..... Time.....20:00.....

Patient/Carer Signature.....

This is an immediate discharge letter and a further letter may follow.

610119466W /E3993022 M
TAYLOR Richard
10-Jun-63 CHI:100 663 1372
70911 CB Nickerson
42 Morvenside
EH14 2SJ

RIE ED Nursing Care Plan

Admission Nurse Signature SB

Admission Nurse Print Name BURN

Date 1/4/18

Presenting History :
ABDO PAIN

Date/ Time	Progress Notes	Signature
04 15	Allocated cubicle awaiting RN.	SB.

Admission Standard Procedures	Initials	PRN Nursing Procedures	Initials
Vital signs recorded	✓	ECG completed	
Sews Score recorded	✓	CXR ordered	
BM Reading	✓	Alcometer Reading Recorded	
GCS assessed	✓	DNAR in situ	
Acuity parameters set	✓	LCP commenced / CP Aware	
Patient made comfortable	✓	Falls / Risk Assessment Require / Complete	
Name band Attached	✓	Swallow Assessment Required / Complete	
IV Cannula in Situ. Dated (please circle) Yes No		Waterlow Assessment Required / Complete	
Hearing Aid : (please circle) NA In Situ At home		Language Assistance requested (Please inform NIC if applicable)	
Spectacles : (please circle) NA In Situ At home		Vulnerable Adult Concern (Please inform NIC if applicable)	
Relatives : (please circle) In ED At Home Not Aware		Child protection Concern (Enter on TRAK & inform NIC if applicable)	
Clothing & valuables (please tick) 1) Labelled 2) Documented		4AT test Score = (please enter only if clinically indicated)	

Care Provider must be informed of any clinical changes highlighted from Patient Screening

Time of Round	O/A				
Clinical Area of ED					
Initials of Care Round Leader					
Review frequency of Vital Signs & Cardiac Monitoring					
Vital signs frequency					
Cardiac monitoring required	Y / N	Y / N	Y / N	Y / N	Y / N
Pain Management (Refer to CP for analgesia if required)					
Please note pain score (0-10 Score)					
Mobility					
Fully weight bearing					
Requires some assistance and / or uses walking aid					
Non Weight bearing and requires full assistance					
Elimination					
Ask patient if toilet is required					
Patient is Self Caring and can walk to toilet					
Patient is Incontinent and requires to be checked					
Patient has catheter in situ and requires to be checked					
Nutrition / Hydration					
Self Caring					
Patient requires assistance with feeding					
Patient is allowed fluids only					
Patient is NBM					
Patient has IVI in Situ					
Refreshments (Provided / Refused : Please indicate P / R)					
Drink		P / R	P / R	P / R	P / R
Snack		P / R	P / R	P / R	P / R
Catered Meal		P / R	P / R	P / R	P / R
Visual Skin Inspection					
Patient is healthy / no concerns					
Visible areas of redness					
Broken skin and evidence of Pressure Ulcers					
Invasive devices (please tick if in situ)					
PVC /Arterial Line / Central Line / PVC					
Urinary Catheter / Chest Drain					
Infusion Device					
NG tube / PEG tube / Tracheostomy					
Other					
Family Communication (Please tick)					
Patient & Relatives present & made aware of any changes					
Cubicle Tidy (Please tick)					
Ensure area is tidy and free of obstruction					

Receiving Ward		ED Escort	
Nurse Name		Nurse Name	
Nurse Signature		Nurse Signature	
Date		Date	

Emergency Department (ED)
Royal Infirmary of Edinburgh

NHS Lothian

] and Valuables Document

610119466W /E3993022 M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
70911 CB Nickerson
42 Morvenside
EH14 2SJ

Name:
Date of
CHI:

Patient Addressograph

Date of Admission: 1 / 11 / 18

Date of Transfer: ... / ... / ...

Outer Wear	Tick	Cut (tick)
Trousers/Skirt		
Shirt/Top		
T-Shirt		
Coat		
Other		
Jersey/Cardigan		
Shoes		
Underwear		
Vest/Bra		
Pants		
Socks/Tights		
Thermals		
Underskirt		
Nightwear		
Dressing Gown		
Nightclothes		
Slippers		
Toiletries		
Dentures Removed	Yes No N/A	
Patients Own Medication	Yes No N/A	
Meds in Green Bag	Yes No N/A	

Patient Valuables	
Purse/Wallet	
Bank Cards	
Other ID Cards	
Keys	
Mobile Phone	
Cash: Notes	
Coins	
Total Cash	
Jewellery	
Given to Patient: Y / N	Locked in ED Safe Y / N
Valuables Receipt No.	
Signed by Ward: Y / N	

I am willing to take responsibility for my own belongings and do not wish staff to document them on my behalf/Clothing returned to patient on discharge*

Signed ..... (Patient)

Name of ED Nurse: R Taylor (PRINT)

Signature of ED Nurse: .....

Name of ED Nurse (2): ..... (PRINT)

Signature of ED Nurse (2): .....

Name of Receiving Ward Nurse: ..... (PRINT)

Signature of Receiving Ward Nurse: .....

*Delete as appropriate

Date Authorised: December 2012 Review Date: December 2015

LOT 132

Ward: Sou. Site: RIE Date: 8/11/18

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 B Bellamy

610119466W/E3993022 M 10/06/1963
Taylor, Richard
Nr 42 Morvenside,
Edinburgh,
Dr EH14 2SJ

CHI 1006631372
Ur 70911- CB Nickerson

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. 0630	6³⁰	08	10	12									
	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	Y									
	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?	N	N	N	N									
	Is the patient continent of urine? (at time of Care Rounding)	Y	Y	Y	Y									
	Continence product changed/offered?	NA	-	-	-									
	Catheter care performed?	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	N	Fast	Fast	SIP									
	Fluid Balance Chart (if clinically indicated)	N	Y	Y	Y									
	When did you last eat?	30/19	30	10:30	10:30	N								
	(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)	N	NA	NA	-									
	Area de-cluttered?	Y	Y	Y	Y									
	Chair and bed height assessed?	Y	Y	Y	Y									
	Falls alarm in use and attached?	N	NA	NA	-									
	Glasses available for use? (if worn)	Y	N	N	N									
	Hearing aid available for use? (if worn)	Y	NA	NA	NA									
	Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐													
Pain	Are you in pain?	Y	N	N	N									
	Analgesia Given?	N	N	N	N									
General	Peripheral Venous Cannula observed?	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									
	Anything else I can do for you?	Y	N	N	N									
	Buzzer within easy reach	Y	Y	Y	Y									

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

Initials – document at time of care delivery														
	M	LO	K	Ka										

Ward:	Site:	Date:	Addressograph, or Name DOB Unit no. / CHI	NHS Lothian

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

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														
	08.00 am ← 24 hour period → 07.00 am													
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	Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister													
	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?													
	Positioning (R) or (L) side (B) Back (C) Chair													
	Mattress type / Cushion type	*please state type:*												
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	Is the patient continent of urine? (at time of Care Rounding)													
	Continence product changed/offered?													
	Catheter care performed?													
	Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact													
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Food, Fluid & Nutrition	Would you like a drink? Ensure fluids are within easy reach													
	Fluid Balance Chart (if clinically indicated)													
	When did you last eat?													
	(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)													
Falls	Appropriate Footwear?													
	Walking aid available(and within reach)													
	Area de-cluttered?													
	Chair and bed height assessed?													
	Falls alarm in use and attached?													
	Glasses available for use? (if worn) Hearing aid available for use? (if worn)													
	Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐													
Pain	Are you in pain?													
	Analgesia Given?													
General	Peripheral Venous Cannula observed?													
	Observe for signs of inflammation/swelling at every CR session. **Bundle/VIP score to be updated daily**													
	Are you comfortable? Y/N													
	Anything else I can do for you?													
	Buzzer within easy reach													

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

Initials – document at time of care delivery													

610119466W/E3993022 M 10/06/1963
Taylor, Richard
42 Morvenside,
Edinburgh,
EH14 2SJ

CHI 1006631372
70911 CB Nickerson

ADULT FLUID PRESCRIPTION CHART

Date 1/11/18 Sheet no

Ward SOU

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?

Weight (kg)

Essential

Write in Maintenance requirements in next 24 hours:

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%							

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

PLASMALYTE 148	500	IV	STAT	18[illegible]		G CHAPMAN	YM
PLASMALYTE	500	IV	1.0	0800		4001 eHOCT	M
PLASMALYTE	1000	IV	~~200~~ 500ml	0820		eHOCT eHOCT	M

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 1/11/18

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							/		500 ml		
07.00	Plasmalyte	Start 500 ml/hr.					/		200 ml		
08.00	(500) ml						/				
09.00		500					/				
10.00	PLASMALYTE (100)						/				
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 Lothi Guidance for Intravenous Fluid and Electrolyte pr ribing (on Intranet)

PRESCRIPTION AND ADMINISTRATION RECORD

Standard Chart

NHS Lothian

Hospital/Ward: Sa. Consultant: SPB

Weight: Height:

If re-written, date:

DISCHARGE PRESCRIPTION

Date completed: Completed by:

Name of Patient: 6101119466W/E3993022 M 10/06/1963
Taylor, Richard
42 Morvenside,
Edinburgh,
EH14 2SJ

CHI Number:

D.O.B.

CHI 1006631372

70911 CB Nickerson

OTHER MEDICINE CHARTS IN USE		PREVIOUS ADVERSE REACTIONS This section must be completed before any medicine is given		Completed by (sign & print)	Date
Date	Type of Chart	None known ☑			01/10/18
		Medicine / Agent	Description of reaction		

- **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'

ONCE ONLY

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber - Sign + Print	Time Given	Given By

REGULAR THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

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

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

PRESCRIPTION

Patient's Own Medicine

Date →

Time ↓

Medicine (Approved Name): TEDS
Dose: 1 part
Route: Top
Notes/Indication for antibiotic:
Start Date: 1/11
Stop Date:
Prescriber - sign + print:
For Use / Date:
Quantity:
Pharmacy:

Medicine (Approved Name): Dalteparin
Dose: 5000 units
Route: SC
Notes/Indication for antibiotic:
Start Date: 1/11
Stop Date:
Prescriber - sign + print:
For Use / Date:
Quantity:
Pharmacy:

Medicine (Approved Name): Omeprazole
Dose: 20mg
Route: ORAL
Notes/Indication for antibiotic:
Start Date: 1/11
Stop Date:
Prescriber - sign + print:
For Use / Date:
Quantity:
Pharmacy:

Medicine (Approved Name):
Dose:
Route:
Notes/Indication for antibiotic:
Start Date:
Stop Date:
Prescriber - sign + print:
For Use / Date:
Quantity:
Pharmacy:

Time	Medicine 1	Medicine 2	Medicine 3	Medicine 4
6				
8				
12				
14				
18				
22				

AS REQUIRED THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine												
Medicine (Approved Name) ORAMORPH		For Use	Date	1/11/16										
			Time	1020										
Dose + frequency + max 10mg/10	Route ORAL	Quantity	Dose	10mg PO										
			Initials	MP										
Indication + notes	Start Date 31/10	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name) Cyclizine		For Use	Date											
			Time											
Dose + frequency + max 50mg/8hrs	Route IV/IM/PO	Quantity	Dose											
			Initials											
Indication + notes	Start Date 31/10	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											

REGULAR THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine	Date → / Time ↓															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															

REGULAR THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine	Date → / Time ↓															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
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Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															

TURN OVER →

AS REQUIRED THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine												
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
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			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											

THINK SEPSIS

NEWS SCORE

SCORE MORE THAN 4

Are any of the following Present?	
Clinical signs of infection	

Plus 2 of these:	
Temperature <36°c or >38°c	
Heart rate >90 bpm	
Respiratory rate > 20bpm	
New confusion	
WCC <4 or >12	
Blood sugar > 7.7 in non-diabetic	

*If hypo tensive or raised lactate with above indicators discuss with Consultant

Start Sepsis 6 - complete within 1 hour	
Oxygen to achieve saturations >94% (NB COPD 88-92%)	
Measure lactate and FBC	
Blood cultures	
IV Antibiotics (start time _____)	
IV Fluids (up to 20ml/kg)	
Measure urine output and start fluid balance chart	

*please tick box i.e Yes or No (do not require time)

Neurological Observations

GLASGOW COMA SCALE

			Time:					
Eyes Open	Spontaneously	4	4					
	To speech	3						
	To pain	2						
	None	1						
Best Verbal Response	Orientated	5	5					
	Confused	4						
	Inappropriate words	3						
	Incomprehensible sounds	2						
	None	1						
Best Motor Response	Obey commands	6	6					
	Localise to pain	5						
	Flexion to pain	4						
	Abnormal flexion	3						
	Extension to pain	2						
	None	1						
Total GCS Score	14-15		15					
	12-13							
	9-11							
	<8							

Endotracheal tube or tracheostomy = T

Always record the best arm response

		Time:					
Blood Sugar	>25						
	15-25						
	4-15						
	<4						

Think Analgesia

		Time:					
Pain Score	Very Severe 9 -10	10					
	Severe 6 - 8						
	Moderate 4 - 5						
	Mild 1 - 3						
	None 0						

NEWS Score	Structured Response	Escalation Plan
NEWS 0 - 1	Commence on 1hrly observations	Report to Area Co-ordinator if score increases
NEWS 2 - 4*	Commence on 30mins observations	Report to Area Co-ordinator if score increases
NEWS 5 - 7	Commence on 15mins observations and screen for Sepsis	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
NEWS >7	Commence on 10mins observations and screen for Sepsis	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
* score of 3 in one parameter	Commence on 30mins observations and screen for Sepsis	Report to Area Co-ordinator who must escalate to NIC and Senior Medic

Special Instructions

Right Pupil	Size								+ reacts - no reaction c. eye closed
	Reaction								
Left Pupil	Size								
	Reaction								
Initials of person taking GCS									

Pupil Scale mm



IV Fluid Prescription

Time Prescribed	Fluid	Volume	Duration	Prescribers Signature	Time Started	Given by (Initials)	Checked by (Initials)	Time Finished

Fluid Balance

INPUT						OUTPUT				
	IV Fluids or SC Fluids IV Medication	IV Line(s)	Oral Input		Input		Urine		Gastric	
Time	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100ml	Running Total	Time	Volume	Running Total	Volume	Running Total

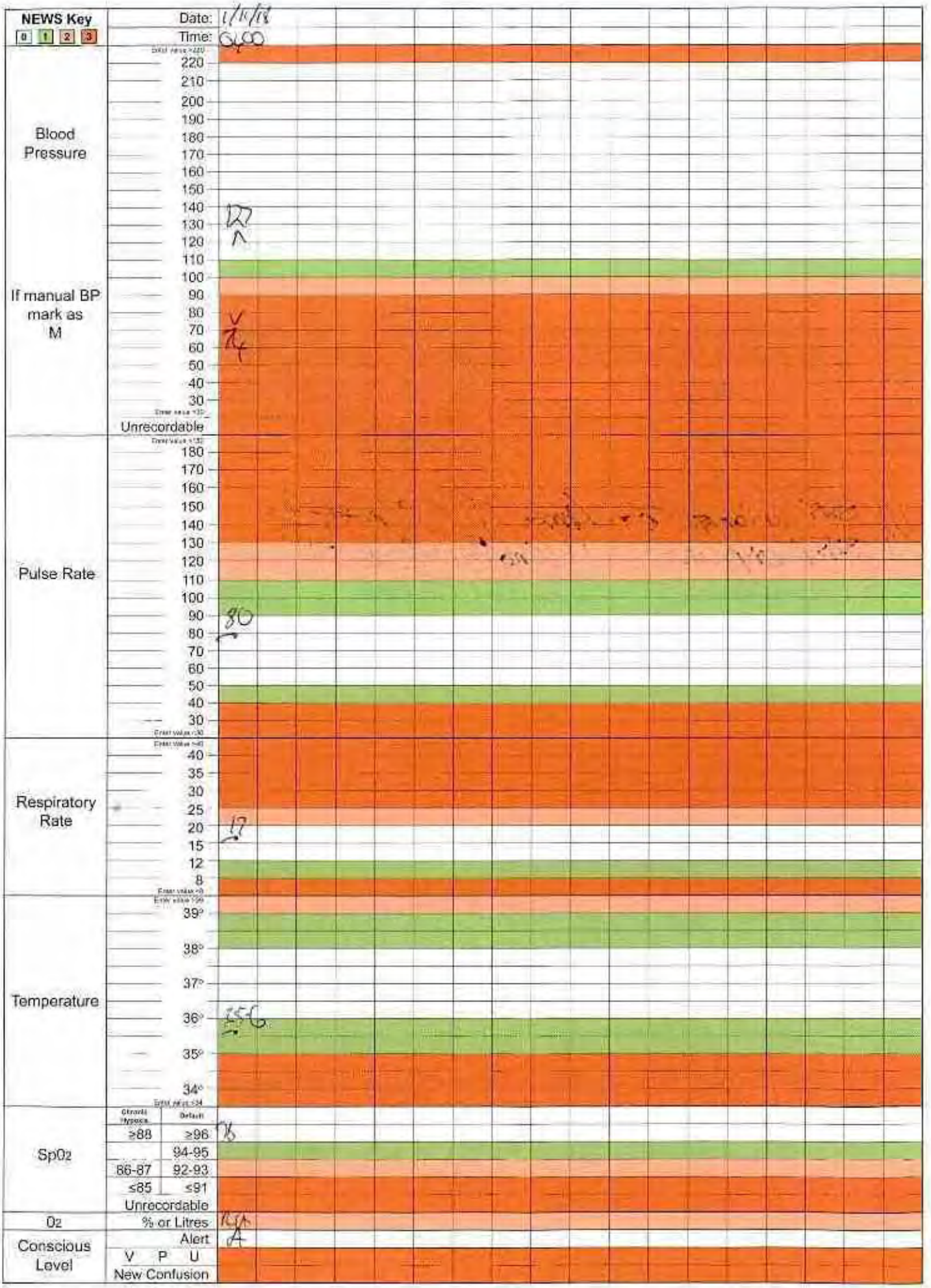
Drug Infusion

Drug Name:

	Time													
	Rate (ml/hr)													
	Volume in Syringe													
Pump No	Total amount Infused													

Drug Name:

	Time													
	Rate (ml/hr)													
	Volume in Syringe													
Pump No	Total amount Infused													


NEWS Key
0 1 2 3
Date: 1/11/18
Time: 0400
Blood Pressure
If manual BP mark as M
Unrecordable
Pulse Rate
Respiratory Rate
Temperature
SpO2
Hypoxic
Default
≥88
≥96
94-95
86-87
92-93
≤85
≤91
Unrecordable
O2
% or Litres
Conscious Level
Alert
V P U
New Confusion
Total NEWS SCORE
If NEWS >5 contact Senior Dr or Nurse In Charge
If Escalated (Tick)
Initials of person undertaking Obs

Royal Infirmary of Edinburgh
Emergency Department

Drug and Prescription Record

6I0119466W/E3993022 M 10/06/1963
Taylor, Richard
42 Morvenside,
Edinburgh,
EH14 2SJ

CHI 1006631372
70911 CB Nickerson

NHS Lothian

Previous Adverse Reactions		Weight	Date
	NKDA	kgs Actual / Estimate	1/11/17

Once Only Prescription

Date	Time	Drug (Approved Name)	Dose	Route	Prescribers Signature	Time Given	Given by (Initials)	Checked by (Initials)
		Oxygen (NP/MASK/NRB)	% / L					
1/11	0345	CHLORPHENIRAMINE	1-10 mg	PO		Vomit	N/K given	
1/11	0345	Ondansetron	4mg	IV		0405	CT	PG
1/11	0345	Morphine (10)	1-10mg	IV		0405	CT	PG
1/11	07°°	CYCLIZINE	50mg	IM		given by night shift		

Discharge Medication to Take Away

Drug (Approved Name)	Dose	Frequency	Duration	Prescribers Signature	Given by (initials)	Checked by (initials)

NEWS Key 0 1 2 3	Date: 1/11/18																								Date
	Time: 0625																								Time
Respiratory Rate	≥25																								≥25
	21-24																								21-24
	12-20	18	18																						12-20
	9-11																								9-11
	≤8																								≤8
Sp02	Chronic Hypoxia ≥88	Default ≥96	96	96																					Default ≥96 / Chronic Hypoxia ≥88
		94-95																							94-95
Medical Signature required to use scale for patients with Chronic Hypoxia Sign	86-87	92-93																							92-93 / 86-87
	≤85	≤91																							≤91 / ≤85
	Unrecordable																								Unrecordable
Inspired 02	% or litres		2L																						% or litres
Temperature	≥39°																								≥39°
	38°																								38°
	37°																								37°
	36°																								36°
	≤35°	35.8																							≤35°
NEWS SCORE uses Systolic BP	230																								230
	220																								220
	210																								210
	200																								200
	190																								190
	180																								180
	170																								170
	160																								160
	150																								150
	140																								140
If manual BP mark as M	130	123																							130
	120																								120
	110																								110
	100																								100
	90																								90
	80	81																							80
	70																								70
	60																								60
	50																								50
	Unrecordable																								Unrecordable
Heart Rate	>140																								>140
	130																								130
	120																								120
	110																								110
	100																								100
	90																								90
	80																								80
	70	70																							70
	60																								60
	50																								50
	40																								40
	30																								30
	Regular Y/N	Y	Y																						Regular Y/N
Conscious Level	Alert	A	A																						Alert
	V / P / U																								V / P / U
	New Confusion																								New Confusion
Total NEWS score		3	0																						Total NEWS score
Urine output recorded Y/N																									Urine output recorded
Blood Glucose																									Blood Glucose
Frequency of Observations																									Froquency of Obs.
Structured Response Tool Y/N																									SRT Y/N
Escalation Y/N																									Escalation Y/N
Pain score (0-10)		7	2																						Pain score (0-10)
Nausea score (0-3)		1	0																						Nausea score (0-3)
Motor Block score (0-4)																									Motor Block score (0-4)
Circulation																									Circulation
Sensation																									Sensation
Movement																									Movement
Initials		katie																							Initials

Patient Name:	CHI:

Special Instructions - to be completed by Medical Team

A total NEWS score 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**

NEWS Score	Frequency of Observations	Clinical Response
Total 0*	Minimum 12 hourly / 4 hourly in admission areas	• Continue routine NEWS monitoring with every set of observations.
Total 1 - 4*	Minimum 4 hourly Consider Structured Response Tool Consider Fluid Balance Chart	• Inform registered nurse • Registered nurse assessment using ABCDE • Review frequency of observations • Inform Nurse in Charge • **If ongoing concern, escalate to Medical Team**
Total 5 - 6* or 3 in one parameter	Increase frequency to a minimum of 1 hourly Start Structured Response Tool Start Fluid Balance Chart	• Registered nurse assessment • Inform Nurse in Charge • Escalate to Medical Team as per local escalation • Urgent medical assessment • Management plan to be discussed with Senior Trainee or above • Consider level of monitoring required in relation to clinical care
Total 7* or more	Continuous monitoring of vital signs Start Structured Response Tool Start Fluid Balance Chart	• Registered nurse to assess immediately • Inform Nurse in Charge • Request immediate assessment by Senior Trainee or above • Case to be discussed with supervising Consultant • If appropriate contact Critical Care for review

NEWS ≥4 Think Sepsis

Are any 2 or more SIRS criteria present?

RECOGNISE

Temperature	<36°c or >38°c
Pulse	>90 beats/min
White Cell Count	<4 or >12
Respiratory Rate	> 20 bpm
Mental State	New confusion
Blood Sugar	>7.7mmol/L in non-diabetic

and clinical suspicion of infection = SEPSIS

Apply Sepsis 6 within 1 hour

RESUSCITATE

1. Give oxygen to target saturation >94% (NB COPD 88%-92%)
2. IV fluids up to 20ml/kg
3. Take blood cultures
4. Measure lactate and FBC
5. Give IV antibiotics
6. Monitor urine output & start fluid chart

Continuation

National Early Warning Score (NEWS) Chart

NHS Lothian

610119466W/E3993022 M 10/06/1963
Taylor, Richard
42 Morvenside,
Edinburgh,
EH14 2SJ

CHI 1006631372
70911 CB Nickerson

Consultant: Date chart commenced: 1/11/18

This is chart number this admission

Weight: Actual 87 kgs Estimated kgs

ASU: 5"11 Ward:

Conscious Level Chart to be completed when clinically indicated

GLASGOW COMA SCALE			
		Date	
		Time	
Eyes Open		Spontaneously	4
		To speech	3
		To pain	2
		None	1
Best Verbal Response		Orientated	5
		Confused	4
		Inappropriate words	3
		Incomprehensible sounds	2
		None	1
Best Motor Response		Obey commands	6
		Localise to pain	5
		Flexion to pain	4
		Abnormal flexion	3
		Extension to pain	2
		None	1
		Total GCS Score	
		Size	
Right Pupil		Reaction	
		Size	
Left Pupil		Reaction	
MOVEMENT ARMS		Normal power	
		Mild weakness	
		Severe weakness	
		Extension	
		No response	
LEGS		Normal power	
		Mild weakness	
		Severe weakness	
		Extension	
		No response	
		Initials	

Endotracheal tube or tracheostomy = T

Always record the best arm response

+ reacts
- no reaction
c- eye closed

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

Pupil Scale mm 1 2 3 4 5 6 7 8

REMEMBER
- **Record all observations** on NEWS chart
- **Document any** deterioration in the notes - remember the Structured Response Tool
- **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 • SpO2 • Accessory muscle use • Noises +/- percussion, palpation & auscultation • Position / posture	→ Administer prescribed Oxygen to maintain saturations 94%-98% (NB COPD 88%-92%) → Monitor SpO2 / 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 Assessment and Management Guidelines

Cancer-related pain: Always score worst pain in the last 24 hours or since last assessment: refer to 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	PALLIATIVE
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 0-3	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 2016 Date of Publication - April 2016 Review Date - April 2017 LOT367

National Early Warning Score (NEWS) Chart

NHS Lothian

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Ref: MPS NHS Lothian 2016 Date of Publication - April 2016 Review Date - April 2017 LOT367

610119466W/E3993022 M 10/06/1963
Taylor, Richard
42 Morvenside,
Edinburgh,
EH14 2SJ

CHI 1006631372
70911 CB Nickerson

Incident Date:	01/11/2018
Incident Number:	PA005047136
Incident Type:	EMG
Incident Location:	42 MORVENSIDE EDINBURGH, EH14 2SJ

Scottish Ambulance Service

Presenting Complaint

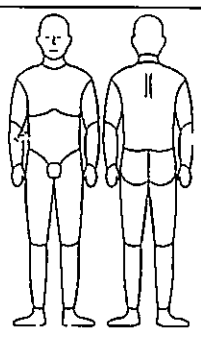
ABDO PAIN

Additional Comments

O/A: PT ALERT OBVIOUS DISTRESS. HPC: PT HAS BEEN WOKEN FROM SLEEP WITH SUDDEN ONSET OF ABDO PAIN. DESCRIBES IT AS SIMMILAR TO GALL STONES BUT IN DIFFRENT POSITION AND HAS HAO GALL BLADER REMOVED. TRIED OWN PAIN KILLERS WITH NO RELIEF. NO LOOSE STOOLS OR CONSTIPATION NO VOMITING. WAS WELL TODAY. O/E: GCS 15 A/O. BREATHING NORMAL. GOOD REGULAR RADIAL PULSE. PALE IN COLOR. ABDO FIRM TENDER OVER RIGHT LOWER. BOWEL SOUNDS PRESENT. PT IN FETAL POSITION. OBS AS RECORDED. TX: MORPHINE FOR PAIN. PLAN: FOR A&E REVIEW.

PATIENT ASSESSMENT

AVPU	Alert	<C>	No	
A	Clear			
B				
C	Pulse Rate	BP	Cap Refill	ECG Rhythm
	90	151/107	<=2 Secs	
	Rhythm	Arm	Central/Peripheral	ECG
	Reg	Right	Peripherel	
	IV(L)			
	ACF			
D	GCS	Eyes	Voice	Motor / PEARL
	15	Spontaneously (4)	Orientated (5)	Obeys Commands (6)
E				



Pain

ID	Body Part	Pain Scale
P1	Abdomen	10

Observations

Time	P	RR	BP	SpO2	CR	GCS	AVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
03:10	70	18	148/97	99	<=2s	15	Alert								E1008080
03:00	70	18	149/94	99	<=2s	15	Alert								E1008080
02:50	86	20	124/73	99	<=2s	15	Alert								E1008080
02:40	90	20	151/107	96	<=2 Secs	15	Alert		36.5	7.7					E1008080

NEWS

Time	Clinical Risk	NEWS
03:10		0
03:00		0
02:50		0
02:40		0

Drugs

Time	Drug	Dosage	Units	Route	Drug Expiry Date	Pain Before	Pain After	CrewID

02:50	Morphine	5	mg	IV	05/2021	10	8	E1008080
02:50	Saline flush	5	ml	IV	12/2019			E1008080
02:55	Morphine	5	mg	IV	05/2021	8	7	E1008080
02:55	Saline flush	5	ml	IV	12/2019			E1008080

HISTORY

AMPLE

Allergies	None
Medication	OMEPRAZOLE
Past Medical History	GALL BLADER SURGERY, ACID REFLUX
Events Prior	SUDDEN ONSET OF ABDO PAIN AT 01:30

Social History

Lives alone	No	**Living With**	PARTNER	**Patient Occupation**	Does Not Work
Patients General Appesrance	Normal				
Patient Mobility	Fully Mobile				
Patient Communication	No Help Required				
Patient Clinical Risk Factors	None Identified				
Patient Enviromental Risk Factors	None Identified				

SOCRATES

Site	RIGHT SIDE OF ABDO	**Onset**	AT REST, 01/11/2018, 01:30
Character	SHARP CRAMPING	**Radiates**	No
Associated Symptoms	Nausea	**Timing**	NIL
Exacerbating Or Relieving Symptoms	NIL	**Severity**	10/10

MEDICAL

CLOSE RECORD

Treatment On Scene	Non Emergency

Conveyance

Trsnsport To Hospital	Normal driving	**Pre Alert**	No

INCIDENT LOG

Time Call Received	02:10	**Allocated**	02:13	**Mobile**	02:13
First Resource On Scene		**Crew On Scene**	02:32	**Crew Left Scene**	
Crew At Hosp		**Receiving Hospital**		**Clear Time**	

Crew ID	Crew Grade	Driver
E1008080	Paramedic	YES

NHS Lothian

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

Dr Perks
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date: 08/03/2019

Inpatient Discharge Summary

Patient	Richard Taylor 42 Morvenside Edinburgh EH14 2SJ	**CHI** **Date of Birth / Age** **UHPI**	**1006631372** 10/06/1963 (55 years) 610119466W
Specialty	General Surgery	**Admission Date**	30/01/2019
Ward	Surgical Obs Inpatients		
Consultant	Mr PJ Lamb	**Discharge Date**	30/01/2019

Dear Dr Perks

Clinical Summary:
Diagnosis - Stab to abdominal wall (did not penetrate into abdominal cavity).
Surgical follow up - None.
Management - Conservative.
The above-named 55-year old gentleman was admitted to the surgical observations unit having stabbed his abdominal wall as a self-inflicted injury whilst intoxicated.
The handle of the blade was impressively sticking out of his abdominal wall when he was reviewed by the trauma team in resus and his abdomen was soft and he underwent a CT scan which appeared to show that the blade did not penetrate through the abdominal wall. Accordingly, it was removed in A&E and the wound cleaned with some Betadine.
He had a thorough review by the psychiatry team and he was going to review his Mirtazapine in the community with the GP and was going to consider abstaining from alcohol.
Two clips were put in the skin wound which will need to be removed and he will make an appointment with the GP practice nurse for this but there is no need for any surgical follow up.
Yours sincerely

Mr ALASTAIR HAYESRegistrar to Mr PETER LAMB

NHS Lothian

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

General Surgery

Dr Hendrie
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date: 09/10/2020

Inpatient Discharge Summary

Patient	Richard Taylor 42 Morvenside Edinburgh EH14 2SJ	**CHI** **Date of Birth / Age** **UHPI**	**1006631372** 10/06/1963 (57 years) 610119466W
Ward	Ward 106 RIE	**Admission Date**	16/09/2020
Consultant	Dr Sarah C Thomasset	**Discharge Date**	18/09/2020

Dear Dr Hendrie

Clinical Summary:
This 57-year-old gentleman was admitted on the 16th of September 2020, with upper abdominal pain and deranged liver function tests (bilirubin 11, ALT 115, ALP 185). His amylase was normal. History of a cholecystectomy in August 2018 was noted and an MRCP was arranged. It did not show any evidence of retained stones or biliary dilatation. An incidental 4.5cm renal cyst was also commented on along with a small hiatus hernia. Mr Taylor self discharged on the 18th of September 2020, and no routine follow-up is planned.
Kind regards.
Yours sincerely

Miss SARAH THOMASSETConsultant Surgeon

University Hospitals Division

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

NHS Lothian

ET/ST

Department of General Surgery

Dr Hendrie
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date First Created : 18/09/2020
Date Authorised :
Date/Time Printed : 22/09/2020 10:53
Our Ref : 610119466W
CHI : 1006631372

Patient:	Richard Taylor 42 Morvenside Edinburgh EH14 2SJ	**UHPI:** **Date of Birth:**	610119466W 10/06/1963
Ward:	Ward 106 RIE		
Consultant:	Dr Sarah C Thomasset	**Admission Date:** **Discharge Date:**	16/09/2020 18/09/2020

OPERATION/PROCEDURE(S):
Nil

UNDERLYING DIAGNOSIS: Acute on Chronic Pancreatitis

TYPE OF ADMISSION: Emergency

CHANGES TO MEDICATIONS SINCE ADMISSION (relative to ECS):
Started: Nil
Stopped: Nil
Changed: Nil
Withheld: Nil

ALLERGIES / ADVERSE DRUG REACTIONS:
NKDA / Specify

Discharge prescription checked against ECS med rec: Yes
FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL: Nil

ACTION REQUIRED FROM GP: Nil

Dear Doctor,

Mr Taylor presented to the RIE on 16/09/20 with epigastric pain radiating through to his back. MRCP on 17/09/20 showed:

General Surgery

Prof OJ Garden
Ms TE Gillias
Professor SJ Wigmore
Mr S Paterson-Brown
Professor RW Parks
Mr JJC Casey
Mr JJ Powell
Mr GW Couper
Mr GGP Browning
Mr B Tulloh
Mr A de Beaux
Mr C Deans
Mr P Lamb
Mr R Ravindran
Miss A Paisley
Mr E Harrison
Mr O Mole
Mr G Oniscu
Miss A Adair
Mr I Currie
Mr R Skipworth
Mr S McKechnia
Mr A Sutherland
Mr D Damaskos
Mr J Terrace
Miss S Thomasset
Mr A Healey

For enquiries:
0131 242 1000

Hepatobiliary Team:-
0131 242 3661/2

Upper GI:
0131 242 3620
0131 242 3667

Thyroid:
0131 242 3663

Oncology Consultant WGH:
Dr Lucy Wall
0131 537 3916

Inpatient Discharge Summary

Previous cholecystectomy. No biliary dilatation. CBD measures 7 mm. No ductal filling defects demonstrated.
Incomplete pancreas divisum. No pancreatic duct dilatation. Grossly normal liver parenchyma and pancreas.
4.5 cm right renal cyst. Otherwise normal appearance of both kidneys and spleen.
Small hiatus hernia. No upper abdominal lymph node enlargement.

Mr Taylor was informed his pancreatitis is not caused by gallstones and is likely caused by excess alcohol.
He self-discharged on 18/09/20.

SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS/DNACPR STATUS/ ANTCIPATORY CARE PLANNING:
Nil

Should you need further information please contact: Miss Thomasset and Team

Thank you for your ongoing care of this patient.

Yours sincerely,

Anushka Srinivas FY1
Department of General Surgery, Royal Infirmary of Edinburgh

This is an immediate discharge letter and a further letter may follow.

Inpatient Discharge Summary

Continuation

Ward:	Site:	Date:	Addressograph, or Name DOB Unit no. / CHI	NHS Lothian

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

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													
	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													
	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?													
	Positioning (R) or (L) side (B) Back (C) Chair													
	Mattress type / Cushion type	*please state type:*												
Elimination	Do you need the toilet?													
	Is the patient continent of urine? (at time of Care Rounding)													
	Continence product changed/offered?													
	Catheter care performed?													
	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)													
	Bowel function monitored	Observe bowel function and update daily												
Food, Fluid & Nutrition	Would you like a drink? Ensure fluids are within easy reach													
	Fluid Balance Chart (if clinically indicated)													
	When did you last eat?													
	(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)													
Falls	Appropriate Footwear?													
	Walking aid available(and within reach)													
	Area de-cluttered?													
	Chair and bed height assessed?													
	Falls alarm in use and attached?													
	Glasses available for use? (if worn) Hearing aid available for use? (if worn)													
	Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐													
Pain	Are you in pain?													
	Analgesia Given?													
General	Peripheral Venous Cannula observed?													
	Observe for signs of inflammation/swelling at every CR session. **Bundle/VIP score to be updated daily**													
	Are you comfortable? Y/N													
	Anything else I can do for you?													
	Buzzer within easy reach													

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

Initials – document at time of care delivery													

Ward:	Site:	Date:	Addressograph, or Name DOB Unit no. / CHI	NHS Lothian

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Falls	Appropriate Footwear?													
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	Chair and bed height assessed?													
	Falls alarm in use and attached?													
	Glasses available for use? (if worn) Hearing aid available for use? (if worn)													
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Pain	Are you in pain?													
	Analgesia Given?													
General	Peripheral Venous Cannula observed?													
	Observe for signs of inflammation/swelling at every CR session. **Bundle/VIP score to be updated daily**													
	Are you comfortable? Y/N													
	Anything else I can do for you?													
	Buzzer within easy reach													

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

Initials – document at time of care delivery													

PRESCRIPTION AND ADMINISTRATION RECORD

Standard Chart

NHS Lothian

Hospital/Ward: SOU Consultant: MISS S THOMASSET

Weight: Height:

If re-written, date:

DISCHARGE PRESCRIPTION

Date completed: 17/9/20 Completed by:

Name: 610119466W /E4537756 M
TAYLOR Richard

CHI No: 10-Jun-63 CHI: 100 663 1372

D.O.B. 70911 R Hendrie
42 Morvenside
EH14 2SJ

OTHER MEDICINE CHARTS IN USE		PREVIOUS ADVERSE REACTIONS This section must be completed before any medicine is given		Completed by (sign & print)	Date
Date	Type of Chart	None known ☑			
		Medicine / Agent	Description of reaction		

- 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'

ONCE ONLY

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber - Sign + Print	Time Given	Given By
17/09/20	10:00	MORPHINE	10mg	S/C	[signature]	0945	[signature]

REGULAR THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

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

OXYGEN

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

PRESCRIPTION

Patient's Own Medicine

Date → 17/9 | 2/9/20

Time ↓

Medicine (Approved Name): DALTEPARIN
Dose: 5000 UNITS
Route: SC
Notes/Indication for antibiotic:
Start Date: 17/9
Stop Date:
Prescriber - sign + print: M Mehta
For Use / Date:
Quantity:
Pharmacy:
Times: 6, 8, 12, 14, (18), (22)
Given: 1 | JM

Medicine (Approved Name): TEDS
Dose: 1 pair
Route: TOP
Notes/Indication for antibiotic:
Start Date: 17/9
Stop Date:
Prescriber - sign + print: M Mehta
For Use / Date:
Quantity:
Pharmacy:
Times: 6, 8, 12, 14, (18), 22

Medicine (Approved Name): OMEPRAZOLE
Dose: 20 mg
Route: ORAL
Notes/Indication for antibiotic: 1 dose from 20mg OD please R/V on d/c
Start Date: 17/9
Stop Date:
Prescriber - sign + print: M. Mehta
For Use / Date:
Quantity:
Pharmacy:
Times: 6, (8), 12, 14, 18, 22
Given: JM | JM

Medicine (Approved Name): FLUOXETINE
Dose: 20mg
Route: ORAL
Notes/Indication for antibiotic:
Start Date: 17/9
Stop Date:
Prescriber - sign + print: M Mehta
For Use / Date:
Quantity:
Pharmacy:
Times: 6, (8), 12, 14, 18, 22

REGULAR THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine	Date → / Time ↓	17/9	18/9	19/9	20/9
Medicine (Approved Name): PARACETAMOL		For Use / Date	6				
Dose: 1g	Route: ORAL	Quantity	8	4	4	4	
Notes/Indication for antibiotic: DISPERSIBLE	Start Date: 17/9	Stop Date	12	2	1		
Prescriber - sign + print: M Mehta		Pharmacy	14				
			18	3			
			22	BD			
Medicine (Approved Name): CODEINE		For Use / Date	6				
Dose: 30mg	Route: ORAL	Quantity	8	1	1		
Notes/Indication for antibiotic:	Start Date: 17/9	Stop Date	12	2	1		
Prescriber - sign + print: M Mehta		Pharmacy	14				
			18	3			
			22	BD			
Medicine (Approved Name):		For Use / Date	6				
Dose:	Route:	Quantity	8				
Notes/Indication for antibiotic:	Start Date:	Stop Date	12				
Prescriber - sign + print:		Pharmacy	14				
			18				
			22				
Medicine (Approved Name):		For Use / Date	6				
Dose:	Route:	Quantity	8				
Notes/Indication for antibiotic:	Start Date:	Stop Date	12				
Prescriber - sign + print:		Pharmacy	14				
			18				
			22				
Medicine (Approved Name):		For Use / Date	6				
Dose:	Route:	Quantity	8				
Notes/Indication for antibiotic:	Start Date:	Stop Date	12				
Prescriber - sign + print:		Pharmacy	14				
			18				
			22				
Medicine (Approved Name):		For Use / Date	6				
Dose:	Route:	Quantity	8				
Notes/Indication for antibiotic:	Start Date:	Stop Date	12				
Prescriber - sign + print:		Pharmacy	14				
			18				
			22				
Medicine (Approved Name):		For Use / Date	6				
Dose:	Route:	Quantity	8				
Notes/Indication for antibiotic:	Start Date:	Stop Date	12				
Prescriber - sign + print:		Pharmacy	14				
			18				
			22				

AS REQUIRED THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine												
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											

REGULAR THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine	Date → / Time ↓															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															

TURN OVER →

AS REQUIRED THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine													
Medicine (Approved Name)		For Use	Date	17/9	17/9	17/9									
1) ORAMORPH			Time	08/10	08/10	1100									
Dose + frequency + max	Route	Quantity	Dose	10/90	10/90	10/90									
10mg 2°	ORAL		Initials	LWP	LWP	LWP									
Indication + notes	Start Date	Date	Date												
pain	17/9		Time												
Prescriber - sign + print		Pharmacy	Dose												
M. Mehta.			Initials												
Medicine (Approved Name)		For Use	Date												
CYCLIZINE			Time												
Dose + frequency + max	Route	Quantity	Dose												
50mg 6-8° max TDS	ORAL/ IM		Initials												
Indication + notes	Start Date	Date	Date												
nausea/vomits	17/9		Time												
Prescriber - sign + print		Pharmacy	Dose												
M. Mehta			Initials												
Medicine (Approved Name)		For Use	Date	17/9											
ONDANSETRON			Time	1450											
Dose + frequency + max	Route	Quantity	Dose	4mg											
4mg 6-8° max TDS	ORAL/ IV		Initials	SHIV											
Indication + notes	Start Date	Date	Date												
nausea/vomits	17/9		Time												
Prescriber - sign + print		Pharmacy	Dose												
M. Mehta.			Initials												
Medicine (Approved Name)		For Use	Date	17/9											
2) MORPHINE			Time	1455											
Dose + frequency + max	Route	Quantity	Dose	5mg											
5mg 2-4HRLY	S/C		Initials	SHIV											
Indication + notes	Start Date	Date	Date												
PAIN	17/09/20		Time												
Prescriber - sign + print		Pharmacy	Dose												
A. SRINIVAS			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												

NHS LOTHIAN
Emergency Department
Adult Majors
Prescription, Administration & Observation Record

NHS Lothian

610119466W /E4537756 M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
70911 R Hendrie
42 Morvenside
EH14 2SJ

The section below must be completed before any medicine is prescribed/given

Previous Adverse Reactions		Weight kgs Actual / Estimate	Date
	NKDA		16/4/20

Once Only Prescription

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber Sign & Print	Time Given	Issued by (Initials)	Checked by if applicable (Initials)
16/4/20	2205	Paracetamol	1g	O	Hunter G.S	22⁰⁶	MH	
	BD							

Discharge Medication

Date & Time	Medicine (Approved Name)	Dose	Frequency	Route	Quantity	Duration	Prescriber Sign & Print	Issued by (Initials)	Checked by (Initials)

National Early Warning Score 2 (NEWS2) Chart

| NEWS Key 0 1 2 3 | | |

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.**

Signs of Infection

- Temperature <36°c or >38°c
- Heart rate >90 beats pm
- Respiratory rate >20 breaths pm
- New confusion
- WCC <4 or >12
- Blood sugar >7.7 in non-diabetic

Addressograph

Name:

DOB:

CHI:

NEWS Total	Monitoring Frequency	Clinical Response
Total 0	Commence on 2 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
Total 1 - 4	Commence on 1 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
3 in one parameter *	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to Nurse In Charge (NIC) and Senior Medic
Total 5 - 6	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Total 7 or more	Commence on 15 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Special Instructions		

*or increase in NEWS score of 2

Conscious Level Chart to be completed when clinically indicated

| | | |

IV Fluid Prescription

Time Prescribed	Fluid	Volume	Rate	Prescribers Signature	Time Started	Given by (Initials)	Checked by (Initials)	Time Finished

Fluid Balance

INPUT						OUTPUT				
	IV Fluids or SC Fluids IV Medication	**IV Line(s)**	**Oral Input**		**Input**		**Urine**		**Gastric**	
Time	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100ml	Running Total	Time	Volume	Running Total	Volume	Running Total

Drug Infusion

Drug Name:

	Time													
	Rate (ml/hr)													
	Volume in Syringe													
Pump No	Total amount Infused													

Drug Name:

	Time													
	Rate (ml/hr)													
	Volume in Syringe													
Pump No	Total amount Infused													

Addressograph

Name:

DOB:

CHI:

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 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

Date / Time																	
Circulation																	
Sensation																	
Movement																	

NEWS Key	Date:	16/9/20		18/9													Date
0 1 2 3	Time:	2230	0400	0535	1800	1550	1500	1400	0545	1000							Time
A+B Respirations Breaths/min	≥25															3	≥25
	21-24															2	21-24
	18-20	18	18	17	18	18	18		15	17							18-20
	15-17																15-17
	12-14																12-14
	9-11															1	9-11
	≤8															3	≤8
A+B SpO_2 Scale 1 Oxygen saturation (%) Use Scale 1 if target range is 94-98%	≥96	98	98	96	99	96	96	96	96	98							≥96
	94-95															1	94-95
	92-93															2	92-93
	≤91															3	≤91
SpO_2 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	≥97 on O_2															3	≥97 on O_2
	95-96 on O_2															2	95-96 on O_2
	93-94 on O_2															1	93-94 on O_2
	≥93 on air																≥93 on air
	88-92																88-92
	86-87															1	86-87
	84-85															2	84-85
Tick box if using SpO_2 Scale 2 Sign:	≤83															3	≤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
	O^2 L/min or %															2	O^2 L/min or %
	Device																Device
C Blood Pressure mmHg Score uses Systolic BP only If manual BP mark as M	≥220															3	≥220
	201-219																201-219
	181-200																181-200
	161-180																161-180
	141-160		127		142	121	122	126	145								141-160
	121-140	135		124						123							121-140
	111-120																111-120
	101-110															1	101-110
	91-100															2	91-100
	81-90																81-90
	71-80																71-80
	61-70															3	61-70
	51-60																51-60
	≤50																≤50
C Pulse Beats/min Manual pulse	≥131															3	≥131
	121-130															2	121-130
	111-120																111-120
	101-110																101-110
	91-100															1	91-100
	81-90																81-90
	71-80	74			71												71-80
	61-70		69			66	64	53	67	65							61-70
	51-60																51-60
	41-50															1	41-50
	31-40															2	31-40
	≤30															3	≤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															3	New Confusion
	V																V
	P																P
	U																U
E Temperature °c	≥39.1°															2	≥39.1°
	38.1-39.0°															1	38.1-39.0°
	37.1-38.0°																37.1-38.0°
	36.1-37.0°	36.2	36.5		36.4	36.0	37.2	36.1	36.0								36.1-37.0°
	35.1-36.0°															1	35.1-36.0°
	≤35.0°															3	≤35.0°
NEWS TOTAL		0	0	0	3	0	2	0	0	0							**Total**
Monitoring frequency			4	6	12	12		12	12	1							Monitoring
Escalation of care Y/N			N	N	N	N		N	N	N							Escalation
Initials		KA	KA														Initials
Urine output recorded Y/N					NA	NA		NA	NA	NA							Urine output
Blood Glucose level or N/A				2	NA	NA		NA	NA	NA							Blood Glucose
Pain score (0-10)		8		0	0	0		0	0	0							Pain
Nausea score (0-3)		0		0	0	0		0	0	0							Nausea
Motor Block score (0-4) or N/A				NA	NA	NA		NA	NA	NA							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

National Early Warning Score 2 (NEWS2) Chart

NHS Lothian

610119466W /E4537756 M
TAYLOR Richard
10-Jun-63 **CHI:** 100 663 1372
70911 R Hendrie
42 Morvenside
EH14 2SJ

Date chart commenced: 16/9/20

This is chart number 1 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

| GLASGOW COMA SCALE | | |

E4537756
E4067977
610119466W

Dr R Hendrie

Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Taylor
Richard

42 Morvenside
Edinburgh

EH14 2SJ 0131 442 1596

10/06/1963

Unknown 57 Male

16/09/2020 17:46

Private Transport

Self Referral to
A&E

CLINICAL NOTES:
Clinical note: 57 year old gentleman

PC: Abdominal pain

3/7 history of gradual onset right sided abdominal pain associated with vomiting. Pain came on gradually but now reportedly severe however appears to have spasmodic bursts where the pain is more significant. Reportedly opened bowels yesterday and they were normal. States that he hasn't passed urine in 724 hours. Denies any urinary frequency or dysuria prior to this. Not taken any analgesia for fear that tablets will make the pain worse. Denies any changes to genital region-no testicualr swelling.

PMH:

Previous cholecystectomy
Previous trauma to abdomen-stabbing
MH problems

O/E

Temp-36.4 HR-90 BP-124/80 RR-16 SpO-99%
Abdomen soft, diffusely tender but no gurading and not tender over any specific point. No peritonism. No renal angle tenderness. No palpable bladder.
Urinalysis-Negative

Impression/?Biliary sludge

Plan/

Bloods .
If bloods are normal senior will review ?discharge
Patient offered oral analgesia but declined as he thinks this will make the symptoms worse, I do not think IV is appropriate at this stage

Update

-Bloods show CRP of 38 and raised ALT and Alk phos. Conatced surgeons who will review in department.

GPST 2

Gillian E Souter Doctor

no notes

E4537756
E4067977
610119466W

Dr R Hendrie

Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Taylor
Richard

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EH14 2SJ 0131 442 1596

10/06/1963
Unknown 57 Male

16/09/2020 17:46

[redacted]vate Transport

Self Referral to
A&E

General Surgery R/V Reg A Hayes / SHO M Mehta

Thanks for referral.

57M
3/7 abdominal pain + vomiting
describes central abdominal pain, radiating to back
intermittent episodes of similar pain over the last 4/52

BNO in 3/7 - feels this is because he has not been eating

PMHx:
[redacted]allstone disease - MRCP 2018 showed ductal stone, cholecystectomy 2018 with IOC
[redacted]artburn
[redacted]st operation - bike accident
Ankle operation - bike accident

SHx:
does not drink alcohol
does not take herbal/alternative medicine

→ Karen - friend
07851393461
Glasses

O/E
Apyrexial
Abdomen soft.
Tender in epigastrium.

IMP
?retained ductal stone
?SBO
?gastritis

PLAN:
1) PPI + antiemetics + analgesia
2) IV fluids
3) AXR ?SBO
- if no distended SB loops then MRCP
- if distended SB loops present then CT-AP

E4537756

E4067977

610119466W

Dr R Hendrie

Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Taylor
Richard

42 Morvenside
Edinburgh

EH14 2SJ 0131 442 1596

10/06/1963

Unknown 57 Male

16/09/2020 17:46

[redacted]ate Transport

Self Referral to
A&E

4) Admit surgical obs

M Mehta FY2

Gillian E Souter Doctor

[redacted]

Patient Addressograph Label

RIE ED Nursing Care Plan

Admission Nurse Signature.....

Admission Nurse Print Name.....

Date 16-9-20

Presenting History :

Abdo pain

Date/ Time	Progress Notes	Signature
18:50 2205	Patient waiting to be assessed in the A CVS NEWS 0. SCI 11. Pain 9/10. Seen analgesia & Refused took 4g paracetamol. Declined analgesia at first.	

Admission Standard Procedures	Initials	PRN Nursing Procedures	Initials
Vital signs recorded	✓	ECG completed	
Sews Score recorded	N/A	CXR ordered	
BM Reading	N/A	Alcometer Reading Recorded	
GCS assessed	N/A	DNAR in situ	
Acuity parameters set	N/A	LCP commenced / CP Aware	
Patient made comfortable	✓	Falls / Risk Assessment Require / Complete	
Name band Attached	✓	Swallow Assessment Required / Complete	
IV Cannula in Situ. Dated (please circle) Yes No	✓	Waterlow Assessment Required / Complete	
Hearing Aid (please circle) NA In Situ At home	✓	Language Assistance requested (Please inform NIC if applicable)	
Spectacles (please circle) NA In Situ At home	✓	Vulnerable Adult Concern (Please Inform NIC if applicable)	
Relatives (please circle) In ED At Home Not Aware		Child protection Concern (Enter on TRAK & inform NIC if applicable)	
Clothing & valuables (please tick) 1) Labelled 2) Documented		4AT test Score = (please enter only if clinically indicated)	

Care Provider must be informed of any clinical changes highlighted from Patient Screening

Time of Round	1200	2200			
Clinical Area of ED	A	A			
Initials of Care Round Leader	AJ	LW			
Review frequency of Vital Signs & Cardiac Monitoring					
Vital signs frequency		2			
Cardiac monitoring required	Y / N	Y / (N)	Y / N	Y / N	Y / N
Pain Management (Refer to CP for analgesia if required)					
Please note pain score (0-10 Score)	8/10	9			
Mobility					
Fully weight bearing	✓	–			
Requires some assistance and / or uses walking aid					
Non Weight bearing and requires full assistance					
Elimination					SI
Ask patient if toilet is required	✓				
Patient is Self Caring and can walk to toilet					
Patient is Incontinent and requires to be checked					
Patient has catheter in situ and requires to be checked				\	
Nutrition / Hydration					
Self Caring	✓	–			
Patient requires assistance with feeding					
Patient is allowed fluids only					
Patient is NBM					
Patient has IVI in Situ					
Refreshments (Provided / Refused : Please indicate P / R)					
Drink		P / (R)	P / R	P / R	P / R
Snack		P / R	P / R	P / R	P / R
Catered Meal		P / R	P / R	P / R	P / R
Visual Skin Inspection					
Patient is healthy / no concerns	✓	–			
Visible areas of redness					
Broken skin and evidence of Pressure Ulcers					
Invasive devices (please tick if in situ)	\				
PVC /Arterial Line / Central Line / PVC	-				
Urinary Catheter / Chest Drain	-				
Infusion Device	-				
NG tube / PEG tube / Tracheostomy	/				
Other	\				
Family Communication (Please tick)					
Patient & Relatives present & made aware of any changes	✓	–			
Cubicle Tidy (Please tick)					
Ensure area is tidy and free of obstruction	✓	–			

Receiving Ward		ED Escort	
Nurse Name		Nurse Name	
Nurse Signature		Nurse Signature	
Date		Date	

810119466W /E4537756 M
TAYLOR Richard
10-Jun-63 CHI: 100 653 1372
70911 R Hendrie
42 Morvenside
EH14 2SJ

General Surgery SB

S

SITUATION: Patient Name and CHI

Date 17/9/20 Location RIE – SAU

Consultant Miss. Thomasset

Presenting complaint, clinical symptoms: 3/7 Right sided Abdo pain associated with Vomiting

B

BACKGROUND:

Allergies: NKDA Relevant patient history: Prev. cholecystectomy
Prev. trauma to Abdominal stabbing.

Social History /POC Indep. Mobility Fully Mobile

A

ASSESSMENT: Most recent vital signs @02:15

Temp 36.1 HR 69 RR 18 BP 117/80 SaO2 98 % on RA O2

NEWS 0

Neuro Obs GCS:

Deranged Bloods CRP-38, Alk. phos-185, ALT-115, Urea-7.6

Lactate: N/A

Frailty Score: Referral Y/N

Infection Risk/Trak Alert Inform ward if cubicle required.

R

RECOMMENDATIONS: ?. gastritis, ?. retained distal stone

Differential Diagnosis ~~?. pancreatitis~~, ?. gastritis ? gastritis ?. SBO

Actions required **PRIOR** to admission to ward.

IV FLUIDS ☑ **IV ABX** ☐ **NBM** ☐ **D+F** ☑ **CF** ☐ **FF** ☐

ANALGESIA ☑ **Gent level@** __:__

Scan Results/Plan:

?. CT ?. MRCP – depending on AXR.
For MRCP

Is DNACPR form in place: Y (N)

ADULT FLUID PRESCRIPTION CHART

NHS Lothian

Name	Date	Sheet no
RICHARD TAYLOR	17/9/20	
Date of Birth 10/06/63	Ward SOU	
CHI/Unit No 1006631372		

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)
Plasmalyte 148	1000	IV	250			H Mehta	
0.18% NaCl / 4% dextrose + 20mmol KCl	1000	IV	100	0600		A SRINIVAS	

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		250					/				
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 Lothian Guidance for Intravenous Fluid and Electrolyte prescribing (on Intranet)

N 610119466W /E4537756 M
TAYLOR Richard
10-Jun-53 CHI: 100 663 1372
70911 R Hendrie
42 Morvenside
D EH14 2SJ
C

ADULT FLUID PRESCRIPTION CHART

NHS Lothian

Date 17/9/2020 | Sheet no

Ward 106

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% dextrose +20mmol KCl	1000	IV	100			R J A BRUNIVAL	

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	Continue	250					/				
07.00		250					/				
08.00		250					/				
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 Lothian Guidance for Intravenous Fluid and Electrolyte prescribing (on Intranet)

ADULT FLUID PRESCRIPTION CHART

NHS Lothian

Name Richard Taylor

Date of Birth 10/6/63

CHI/Unit No

Date 18/9/20 | Sheet no

Ward 106

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

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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___/___/___

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 Lothian Guidance for Intravenous Fluid and Electrolyte prescribing (on Intranet)

Ward: S04 Site: RIE Date: 16/9/20

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 Ret

610119466W /E4537756 M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
70911 R Hendrie
42 Morvenside
EH14 2SJ

Unit no. / CHI

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	22:30	00:30	02:30																				
	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	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																			
	Positioning (R) or (L) side (B) Back (C) Chair	C	B	B																			
	Mattress type / Cushion type	*please state type:*																					
Elimination	Do you need the toilet?	Y	N	N																			
	Is the patient continent of urine? (at time of Care Rounding)	Y	Y	Y																			
	Continence product changed/offered?	NA	—	—																			
	Catheter care performed?	No	—	—																			
	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																			
	Bowel function monitored	Observe bowel function and update daily																					
Food, Fluid & Nutrition	Would you like a drink? Ensure fluids are within easy reach	SIPS	SIPS	SIPS																			
	Fluid Balance Chart (if clinically indicated)	NA	NA	N																			
	When did you last eat?	14/9	14/9	14/9																			
	(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)	Lves	Nothing																				
Falls	Appropriate Footwear?	Y	Y	Y																			
	Walking aid available(and within reach)	NA	NA	NA																			
	Area de-cluttered?	Y	Y	Y																			
	Chair and bed height assessed?	Y	Y	Y																			
	Falls alarm in use and attached?	No	NA	NA																			
	Glasses available for use? (if worn)	Y	Y	Y																			
	Hearing aid available for use? (if worn)	NA	NA	NA																			
	Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐																						
Pain	Are you in pain?	Y	Y	Y																			
	Analgesia Given?	M	Ref	Ref																			
General	Peripheral Venous Cannula observed?	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																			
	Anything else I can do for you?	N	N	N																			
	Buzzer within easy reach	Y	Y	Y																			

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

Initials – document at time of care delivery	Ret	LM	LM																				

Ward: 10 Site: RIE Date: 17/9/2020

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

Addressograph, or

Name RICHARD TAYLOR

DOB 10/6/63

Unit no. / CHI 1372

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	08.10	10.30	16.00	17.45	19.30	21.15	23.45						
	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	NS	H	H	H	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	I	Y	Y	Y	Y						
Positioning (R) or (L) side (B) Back (C) Chair	B	B	B	R	B	B	B						
Mattress type / Cushion type	*please state type:* Pentaflex												
Elimination — Do you need the toilet?	N	N	I	N	N	I	I						
Is the patient continent of urine? (at time of Care Rounding)	Y	Y	Y	Y	Y	Y	Y						
Continence product changed/offered?	N	N	N/A	N	—	NB							
Catheter care performed?	NA	NA	NA	NA	—	NB	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	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	W	W	N	D	W						
Fluid Balance Chart (if clinically indicated)	N	N	N	N	Y	B	Y						
When did you last eat?	B	S	L	D	D	B	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	B	E						
Falls — Appropriate Footwear?	Y	Y	Y	Y	Y	B	E						
Walking aid available(and within reach)	N	N	N	N	N	B	NA						
Area de-cluttered?	Y	Y	Y	Y	Y	B	Y						
Chair and bed height assessed?	N	N	N	N	N	B	Y						
Falls alarm in use and attached?	N	N	N	N	N	B	NA						
Glasses available for use? (if worn) Hearing aid available for use? (if worn)	N	N	N	N	N	B	NA						
Requires close observation for commode, toilet, bathing or showering Y ☐ N ☑													
Pain — Are you in pain?	N	N	N	N	N	B	N						
Analgesia Given?	N	N	N	N	NA	B	N						
General — Peripheral Venous Cannula observed?	Y	Y	Y	Y	Y	B	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	B	Y						
Anything else I can do for you?	N	N	N	N	N	B	N						
Buzzer within easy reach	Y	Y	Y	Y	Y	B	Y						

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

Initials — document at time of care delivery

Ward: LOb Site: RIE Date: 18/9/20

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 Crosson

Addressograph or

Name Richard Taylor

DOB 10/6/63

Unit no / CHI

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		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																					
	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																					
	Positioning (R) or (L) side (B) Back (C) Chair	C																					
	Mattress type / Cushion type	*please state type:*																					
Elimination	Do you need the toilet?	D																					
	Is the patient continent of urine? (at time of Care Rounding)	Y																					
	Continence product changed/offered?	-																					
	Catheter care performed?	-																					
	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																					
	Bowel function monitored	Observe bowel function and update daily																					
Food, Fluid & Nutrition	Would you like a drink? Ensure fluids are within easy reach	Y																					
	Fluid Balance Chart (if clinically indicated)	Y																					
	When did you last eat?	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)	H																					
Falls	Appropriate Footwear?	H																					
	Walking aid available(and within reach)	H																					
	Area de-cluttered?	Y																					
	Chair and bed height assessed?	Y																					
	Falls alarm in use and attached?	-																					
	Glasses available for use? (if worn) Hearing aid available for use? (if worn)	/																					
	Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐																						
Pain	Are you in pain?	Y																					
	Analgesia Given?	Y																					
General	Peripheral Venous Cannula observed?	Y																					
	Observe for signs of inflammation/swelling at every CR session. **Bundle/VIP score to be updated daily**																						
	Are you comfortable? Y/N	Y																					
	Anything else I can do for you?	Y																					
	Buzzer within easy reach	Y																					

Personal Care Type Shaved (specify) **Time Given** 08.00

Initials – document at time of care delivery	MC																						

Clinitek Status®

Serial Number:
302691

Patient:

Multistix® 10 SG
Test date 16-09-202
Time 7:04P
Test number 961
Color Not Entere
Clarity Not Entere

GLU	Negative
BIL	Small
KET	Trace
SG	1.025
BLO	Negative
pH	5.5
PRO	30 mg/dL
URO	0.2 E.U./dL
NIT	Negative
LEU	Negative

NHS Lothian

Western General Hospital
Crewe Road South
Edinburgh
EH4 2XU

General Medicine

Dr Leslie
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date: 17/07/2024

Inpatient Discharge Summary

Patient	Richard Taylor 42 Morvenside Edinburgh EH14 2SJ	**CHI** **Date of Birth / Age** **UHPI**	**1006631372** 10/06/1963 (61 years) 610119466W
Ward	WGH MAU Base 1	**Admission Date**	04/06/2024
Consultant	Dr William J Newman	**Discharge Date**	06/06/2024

Dear Dr Leslie

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

Discharge Drugs:

Morphine (MST Continus) 10mg modified-release tablets			
Dose	Route	Frequency	To Continue
10 mg	Oral	Twice daily at 0700 & 2000	Yes
Notes: Please supply 14 TABLETS (FOURTEEN TABLETS)			
Omeprazole 20mg gastro-resistant capsules			
Dose	Route	Frequency	To Continue
20 mg	Oral	Once daily at 0700	Yes
Notes:			
Paracetamol 500mg caplets			
Dose	Route	Frequency	To Continue
1000 mg	Oral	Four times daily at 0700, 1200, 1800 & 2200	No
Notes:			
Sennosides 7.5mg tablets			
Dose	Route	Frequency	To Continue
15 mg	Oral	Once daily at 2200	No
Notes:			

PRINCIPAL DIAGNOSIS/PROCEDURE:

T9 compression fracture
mild superior endplate fracture of L4 vertebra
Constipation

TREATMENT

Mr Taylor presented on 04/06/24 with back pain. His AXR some faecal loading on right side and he was started on laxatives. He had a CT scan which showed a compression fracture of T9 vertebral body. He was discussed with neurosurgery who suggested analgesia, bed rest and further MRI imaging.

His MRI scan showed the following:
Moderate T9 compression fracture, with features suggestive of a benign / insufficiency fracture. Further mild superior endplate fracture of L4 vertebra is also consistent with a benign / insufficiency fracture. In the absence of a history of trauma, further evaluation with DEXA scan is recommended to assess bone density.

A DEXA bone scan has been requested to investigate his compression fracture . He has been started on regular paracetamol and Morphine (MST Continus) for pain relief.

FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL: OP DEXA bone scan

CHANGES TO DRUGS SINCE ADMISSION:
Started:
Morphine (MST Continus) 10mg modified-release tablets BD
Paracetamol 1g QDS
Sennosides 15 mg OD

ALLERGIES / ADVERSE DRUG REACTIONS: As per ECS

SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS: Nil

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

GP to please consider the following: Nil

Should you need further information please contact: MAU WGH

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

Yours sincerely
Nizami Rahman FY1

ADDITIONAL CONSULTANT COMMENT- please note the attached drug list and notes are unchanged from the immediate letter that you should already have had.

Consultant comment Final Discharge Letter

I have nothing further to add to the immediate discharge letter. Please, do not hesitate to contact me if you require

any further information.

Yours sincerely,

e-signed and verified by Dr Newman

Dr William Newman
Consultant in Respiratory and General Medicine

Any queries please contact 0131 537 1707

Day Surgery Centre
St John's Hospital, Howden Road West,
Livingston, West Lothian, EH54 6PP.
Phone: 01506 524105
www.nhslothian.scot.nhs.uk

NHS Lothian

Discharge Letter

610119466W /E5074856 M
TAYLOR Richard
10-Jun-63 **CHI:** 100 663 1372
70911 R Hendrie
42 Morvenside
EH14 2SJ

M / F

Consultant: .....
Operator: .....
GP: .....

Dear Doctor,

Your patient underwent the following operation or investigation and will be discharged today.

Operation / Investigation: CT Head

Findings / Results: - NAD ACUTE INTRACRANIAL PATHOLOGY

Further treatment is planned as follows: -
- SHOULD AVOID DRIVING FOR 24 HRS AFTER INJECTION

Removal of sutures: -

Follow up arrangements: -

Sickness absence form has been issued for: days / weeks

DISCHARGE Prescription	Dose / Timing / Route	No. of days	Prescriber: Sign / Name	Dispenser: Sign / Name	Checked by
Paracetamol 500mg	Two tablets every 6 hours PRN				
Ibuprofen 400mg	One tablet every 6 hours PRN				
Dihydrocodeine 30mg	One tablet every 6 hours PRN				

CONTROLLED Drug Prescription (delete those not required)	Dose	Frequency	Total Quantity Supplied in figures & words	Prescribers Signature & Name	Pharmacy Disp/check
Tramadol 50mg capsules	ONE or TWO capsules	4 hourly PRN Max 400mg daily	..... capsules ..... capsules		
Morphine sulphate 10mg MR tablets	.....mg .....tabs	Twice daily	..... tablets ..... tablets		
Morphine sulphate 10mg/5ml oral solution	.....mg	..... Hourly PRN Max.....times daily	..... millilitres ..... millilitres		

Signature: ..... Date: 4-1-16

Name: ANNA JAMES Phone. no: 1405

Top copy (White) Patient's copy Second copy (Yellow) GP's copy Third copy (Blue) Pharmacy copy

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

General Medicine

Dr Hendrie
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date: 28/10/2022

Inpatient Discharge Summary

Patient	Richard Taylor 42 Morvenside Edinburgh EH14 2SJ	**CHI** **Date of Birth / Age** **UHPI**	**1006631372** 10/06/1963 (59 years) 610119466W
Ward	SJH Medical Assessment Unit	**Admission Date**	25/08/2022
Consultant	Dr Maria Corretge	**Discharge Date**	25/08/2022

Dear Dr Hendrie

FINAL DISCHARGE SUMMARY

DIAGNOSES:
Transient global amnesia
Migraine
Previous intracranial haemorrhage
Self-harm and depression
Cannabis use
Nasal polyps discovered during CT head

This 59-year-old patient was looked after by Dr Wilson. He had been feeling unwell for 48 hours prior to his attendance to A&E. He then started to feel confused and had a new headache. He admitted to having been smoking cannabis and having some family stress recently.

Unfortunately, I do not have details in the notes of the type of confusion he was suffering from but he is described as vacant, very sweaty and then drowsy.

Investigations were normal and the patient returned to normal demeanor after 24 hours observation and was discharged home with a tentative diagnosis of transient global amnesia.

I cannot comment on any other possible diagnosis when I met the patient in person and I am only relying on notes. Given that his CT head no acute find I would not think there is any further investigations required at this stage. We have not organised follow-up for Mr Taylor.

With many thanks.

Yours sincerely

e-signed

Dr Maria Corretge
Consultant MOE

MC/AM
160922
131022

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

General Medicine

Dr Hendrie
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date: 25/08/2022

Inpatient Discharge Summary

Patient	Richard Taylor 42 Morvenside Edinburgh EH14 2SJ	**CHI** **Date of Birth / Age** **UHPI**	**1006631372** 10/06/1963 (59 years) 610119466W
Ward	SJH Medical Assessment Unit	**Admission Date**	25/08/2022
Consultant	Dr Maria Corretge	**Discharge Date**	

Dear Dr Hendrie

PRINCIPAL DIAGNOSIS/PROCEDURE
?TGA

Richard Taylor is a 59 year old man who was admitted to SJH on the 24/8/22 in an acute confusional state. He w had word finding difficulties and could not remember his own birthday. A CT head was normal along with blood tests. He was afebrile. He improved and was orientated the following day. He is fit for discharge today.

TREATMENT
Nil

FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL
Nil

CHANGES TO DRUGS SINCE ADMISSION
Nil

GP to please consider the following...nil, thank you

Should you need further information please contact...SJH, MAU

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

Yours sincerely
K Burgess

Locum

This is an immediate discharge letter and a further letter may follow.

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

NHS Lothian

Department of General Medicine

Dr Hendrie
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date First Created : 16/09/2022
Date Authorised :
Date/Time Printed : 13/10/2022 15:33
Our Ref : 610119466W
CHI : 1006631372

Patient:	Richard Taylor 42 Morvenside Edinburgh EH14 2SJ	**UHPI:** **Date of Birth:**	610119466W 10/06/1963
Ward:	SJH Medical Assessment Unit		
Consultant:	Dr Maria Corretge	**Admission Date:** **Discharge Date:**	25/08/2022 25/08/2022

FINAL DISCHARGE SUMMARY

DIAGNOSES:
Transient global amnesia
Migraine
Previous intracranial haemorrhage
Self-harm and depression
Cannabis use
Nasal polyps discovered during CT head

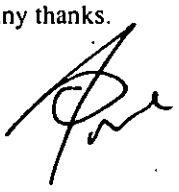
This 59-year-old patient was looked after by Dr Wilson. He had been feeling unwell for 48 hours prior to his attendance to A&E. He then started to feel confused and had a new headache. He admitted to having been smoking cannabis and having some family stress recently.

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Investigations were normal and the patient returned to normal demeanor after 24 hours observation and was discharged home with a tentative diagnosis of transient global amnesia.

I cannot comment on any other possible diagnosis when I met the patient in person and I am only relying on notes. Given that his CT head no acute find I would not think there is any further investigations required at this stage. We have not organised follow-up for Mr Taylor.

With many thanks.



Acute Consultants
Dr A Harmouche
Enquiries to Secretary
Tel: 01508 523025
Dr E W Williams
Dr R M Noh
Enquiries to Secretaries
Tel: 01508 585082
Tel: 01508 585080
Cardiology Consultants
Dr A G Japp
Dr C Stirrat
Enquiries to Secretary
Tel: 01508 523853
Dr C Scally
Enquiries to Secretary
Tel: 01506 523869
Diabetes & Endocrinology Consultants
Dr K A Adamson
Dr R Wright
Enquiries to Secretary
Tel: 01508 523838
Dr R M Noh
Dr E Fotejnopoulou
Enquiries to Secretary
Tel: 01506 523855
Dr L Van Look
Enquiries to Secretary
Tel: 01506 585093
Gastroenterology Consultants
Dr K Dabos
Dr H R Gillett
Dr C J Goddard
Enquiries to Secretary
Tel: 01508 523880
Dr S Minnis-Lyons
Enquiries to Secretary
Tel: 01506 585092
Medicine of the Elderly Consultants
Dr M McMurray
Dr J A Wilson
Dr M Corretge
Enquiries to Secretary
Tel: 01506 523841
Dr L Munang
Enquiries to Secretary
Tel: 01508 523844
Dr A Barugh
Dr S G Ramsay
Dr J H W Rimer
Enquiries to Secretary
Tel: 01506 523846
Respiratory Consultants
Dr F Boellert
Dr R Dickinson
Dr G Martin
Dr D O Noble
Dr F O'Brien
Dr T Plant
Enquiries to Secretaries
Tel: 01508 523838

Tel: 01506 523623
Tel: 01506 523830
Tel: 01506 523644

Yours sincerely

Dr Maria Corretge
Consultant MOE

MC/AM
160922
131022

Document Scanned into CHI System on 13/10/2022

Leaving Against Advice

Addressograph

Name RICHARD TAYLOR

DOB 10-06-1968.

Unit No./CH

NHS Lothian

a) This is to certify that I am taking my own discharge from this hospital, against the advice of the Medical Staff.

Signature ..... Date 25th.

b) This is to certify that I am taking (patient's name) ..... away from this hospital on my own responsibility and against the advice of the Medical Staff.

Signature ..... Date.....

Relationship .....

Delete a) or b) as necessary

WLT593

TAYLOR, RICHARD ID:1006631372 24-Aug-2022 20:42:53 NHS LOTHIAN-SJHA&E ROUTINE RECORD

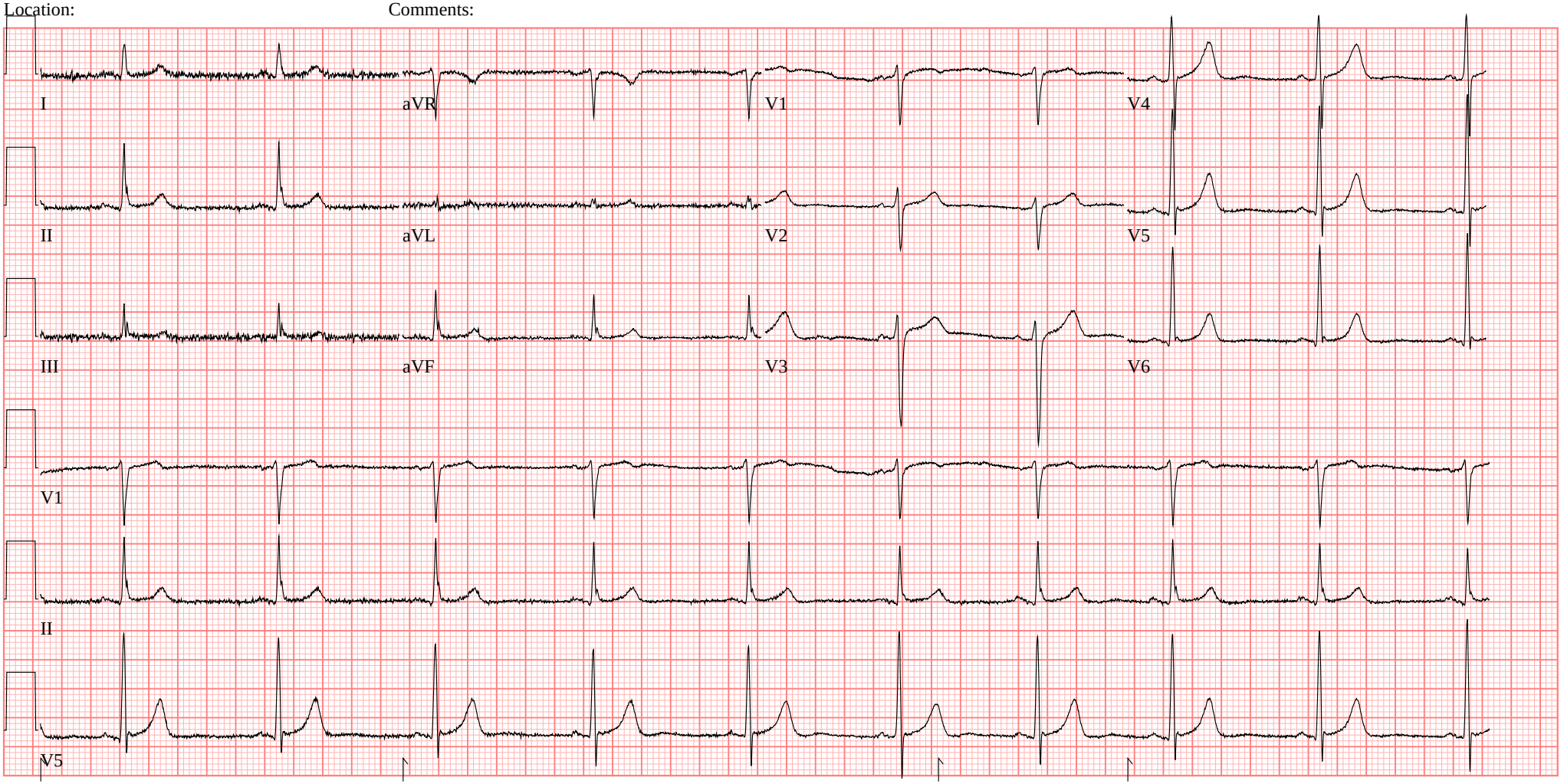
10-Jun-1963 (59 yr)
Male Unknown

Room:
Loc:230

Vent. rate	58	BPM
PR interval	116	ms
QRS duration	82	ms
QT/QTcB	392/384	ms
P-R-T axes	44 58	37

Technician:
Test ind:

Location: Comments:



25mm/s 10mm/mV 150Hz 10.1.3 12SL 243 CID: 25108

SID: 1008119 EID: 13 EDT: ORDER:

TAYLOR, RICHARD ID:1006631372 24-Aug-2022 19:15:09 NHS LOTHIAN-SJHA&E ROUTINE RECORD

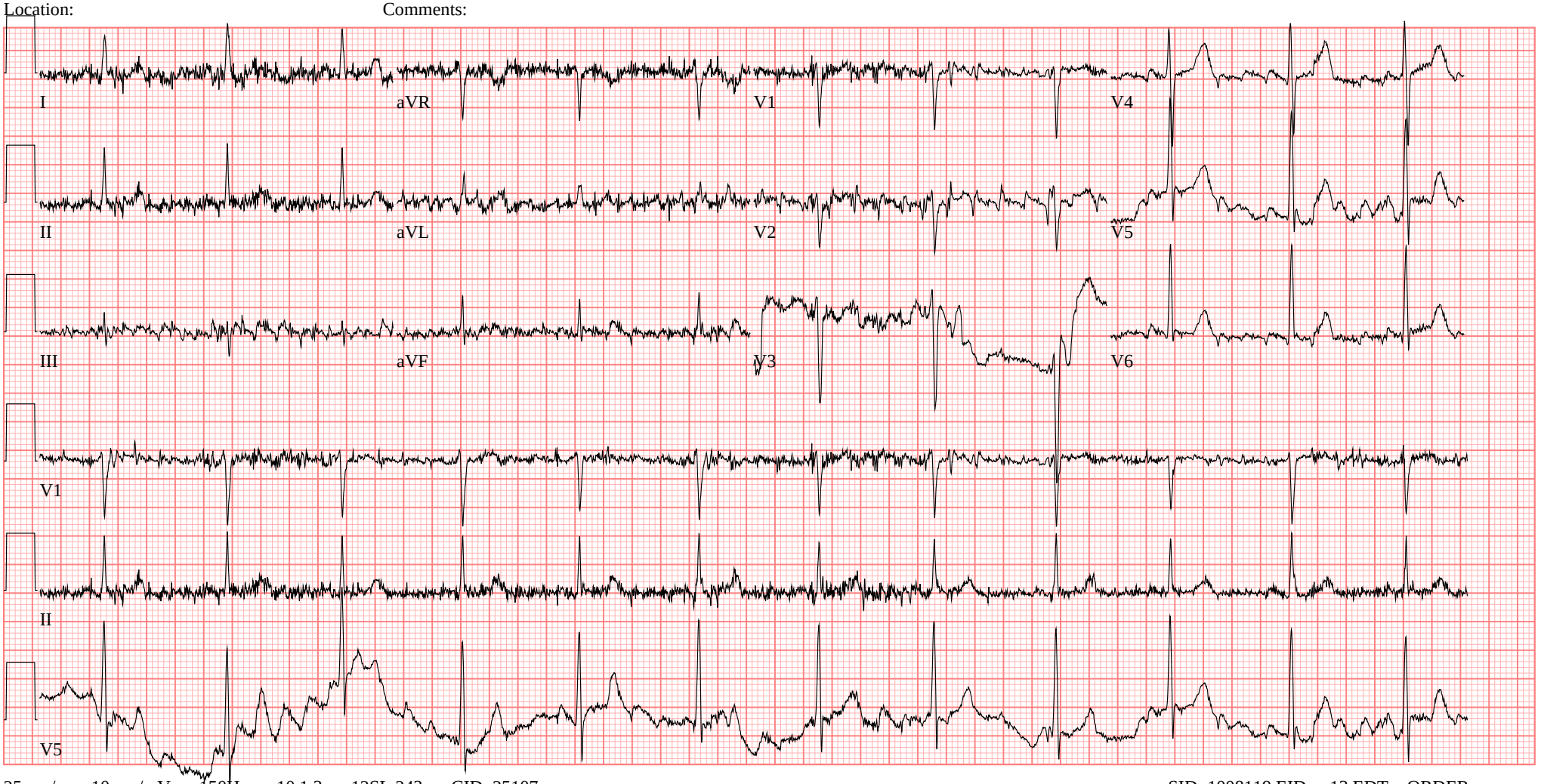
10-Jun-1963 (59 yr)
Male Unknown

Room:
Loc:230

Vent. rate	72	BPM
PR interval	*	ms
QRS duration	78	ms
QT/QTcB	362/396	ms
P-R-T axes	* 34	28

Technician:
Test ind:

Location: Comments:



25mm/s 10mm/mV 150Hz 10.1.3 12SL 243 CID: 25107

SID: 1008119 EID: 13 EDT: ORDER:

ICH
self harm
depression

codein
morph ef

A&E TO MAU HANDOVER

A&E NURSE

PATIENTS NAME: Richard Taylor (59) 2/

Time in A&E dept?	1645 19
Presenting complaint?	confusion anxious vasovagal ? LVF ? Infection (T)
NEWs>7, who is escorting patients? Should be nurse	0 ? LP
GCS<8 needs nurse escort?	N
Swallow assessment within 4 hrs?	NA
DNACPR STATUS	NA
Any history of violence & aggression?	NO
PVC Bundle! Is Venflon inserted? Details on trak	cannula NA
Prescribed drugs given?	para
• Any history of diarrhoea? Family? • Poct test done? • Pcr sent?	
Has patient got a wrist band.	PCC neg

Time of admission 00:20

OBS @ 00:25

T - 37.2 PR - 54 RR - A SPO2 - 95 % RA

BP - 139/88

HA - 0

NOBMO - PROPOFOL

DUST - NDF

PVC

Sacral Bruising.

Analg - Morphine / Codein

Lothian University Hospitals NHS Trust

ADULT UNITARY PATIENT RECORD

ADMITTING HOSPITAL: St John's Hospital at Howden

TYPE OF ADMISSION: Emergency

PRESENTING COMPLAINTS/REASON FOR ADMISSION

1 Chest pain, Confusion / reattend from last night patient got scred and left dept Temp 36.5 hr 64 bp 152/84 rr 18 sats 95% gcs 14 PE
2 ARL
3
4

Patient wishes to be known as:

NAME & ADDRESS (PATIENT LABEL)

Hospital No: 610119466W F/M: M
DOB: 10/06/1963 Age: 59

Name: Richard Taylor
Address: 42 Morvenside

Edinburgh

EH14 2SJ
Telephone No: 0131 442 1596

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

	ADMISSION WARD	DESTINATION WARD - 1st	DESTINATION WARD - 2nd
Ward No.	SJHMAU		
Admission Date	25/08/2022		
Admission Time to Ward	00:25		
Admitting Nurse			
Consultant	Dr Maria Corretgc		

G.P.Details: 6134660/70911 70911/4
R Hendrie
Sighthill Green Medical Practi

EH11 4AU
Tel No: 0131 202 5888

NEXT OF KIN
RELATIONSHIP
Address:

Contact No.

FIRST CONTACT
RELATIONSHIP
Address:

Contact No.

Patients Relative / Next of Kin Present on Admission Y/N
IO:
Date & Time of Notification: Signature:

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

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

Please document rationale for change in the progess notes.

Name
610119466W M 10/06/1963
Taylor, Richard
42 Morvenside,
Edinburgh,
EH14 2SJ

CHI 1006631372
70911 R Hendric

Date started	Ward/Bed
25/8/22	212
Box No.	Diagnosis
3492	Vaso vagal

Time	Rate	Rhythm	Comments
0030	64	SR	
0100	65	SR	
0200	55	SR	
0300	48	SB	
0400	60	SR	
0500	59	SB	
0600	64	SR	
0700	52	SB	
0830	61	SR	
0930	ECG leads off		
1000	98	SR	
1100	64	SR	

Time	Rate	Rhythm	Comments

Patient Name/ CHI:

Indication (circle or write):
Other indication:

Date/Time started and by:
Timeframe for review:

Date/Time stopped and by:



Guidelines for telemetry at SJH

These should not supersede clinical judgement.

Patients should have clearly documented escalation plan, agreed by senior medical staff before telemetry is considered.

RED- Telemetry is essential. Ongoing monitoring until underlying cause effectively treated.

AMBER- Telemetry is strongly recommended. 24-48h then review.

GREEN- Telemetry is desirable. 24h then review.

These lists are not exhaustive. There are other indications where telemetry may be required:

When giving certain medications: ie flecainide, IV amiodarone, adenosine, inotropes.

In cases of overdose - consultant specific guidelines. Beta blockers, Tricyclic antidepressants and most antipsychotics.

- Unexplained syncope or with suspected cardiac cause
- Within 24 hours post STEMI/ NSTEMI
- Myocarditis
- Asymptomatic Sick Sinus syndrome
- Asymptomatic complete heart block

- Patients with documented long QT interval (>440 ms for males >460 ms for females)
- Patients with new pacemaker until check complete
- Patient with ICD suspected to have received therapies- until interrogation
- Syncope with severe aortic stenosis
- Patients with aortic valve endocarditis and significant or worsening 1st degree Heart Block
- Atrial fibrillation /flutter with haemodynamic compromise

v1 - Designed by Dr. Jacob Flapan, review by Dr. Colin Stirrat (Consultant Cardiologist)

Ward: MAU Site: SJH Date: 25/8/22

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

Addressograph, or

NHS

Name **Taylor, Richard**
42 Morvenside,
Edinburgh,
EH14 2SJ

DOB

Unit no. / C **CHI** 1006631372
70911 R Hendrie

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	08 30	04 30	08 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)	N	N	✓
	Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister PE Stage	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?	/	I	I
	Positioning (R) or (L) side (B) Back (C) Chair	B	B	C
	Mattress type / Cushion type	*please state type:* Soft form		
Elimination	Do you need the toilet?	I	I	I
	Is the patient continent of urine? (at time of Care Rounding)	Y	Y	Y
	Continence product changed/offered?	NA	NA	/
	Catheter 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
	Bowel function monitored	Observe bowel function and update daily		
Food, Fluid & Nutrition	Would you like a drink? Ensure fluids are within easy reach	W I	W I	W I
	Fluid Balance Chart (if clinically indicated)	N	N	N
	When did you last eat?	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
Falls	Appropriate Footwear?	Y	Y	Y
	Walking aid available(and within reach)	NA	NA	/
	Area de-cluttered?	Y	Y	Y
	Chair and bed height assessed?	Y	Y	Y
	Falls alarm in use and attached?	N	N	N
	Glasses available for use? (if worn) Hearing aid available for use? (if worn)	N	N	N
	Requires close observation for commode, toilet, bathing or showering	Y ☐	N ☐	✓
Pain	Are you in pain?	N	N	N
	Analgesia Given?	N	N	N
General	Peripheral Venous Cannula observed?	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
	Anything else I can do for you?	N	N	N
	Buzzer within easy reach	Y	Y	Y

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

Initials – document at time of care delivery	SN	SN																						

Ward:	Site:	Date:	Addressograph, or
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.			Name
1hrly 2 hrly 3 hrly _____hrly (please circle/complete)			DOB
Print name and sign _____			Unit no. / CHI

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		
	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	
	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?	
	Positioning (R) or (L) side (B) Back (C) Chair	
	Mattress type / Cushion type	*please state type:*
Elimination	Do you need the toilet?	
	Is the patient continent of urine? (at time of Care Rounding)	
	Continence product changed/offered?	
	Catheter care performed?	
	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)	
	Bowel function monitored	Observe bowel function and update daily
Food, Fluid & Nutrition	Would you like a drink? Ensure fluids are within easy reach	
	Fluid Balance Chart (if clinically indicated)	
	When did you last eat?	
	(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)	
Falls	Appropriate Footwear?	
	Walking aid available(and within reach)	
	Area de-cluttered?	
	Chair and bed height assessed?	
	Falls alarm in use and attached?	
	Glasses available for use? (if worn) Hearing aid available for use? (if worn)	
	Requires close observation for commode, toilet, bathing or showering	Y ☐ N ☐
Pain	Are you in pain?	
	Analgesia Given?	
General	Peripheral Venous Cannula observed?	
	Observe for signs of inflammation/swelling at every CR session. **Bundle/VIP score to be updated daily**	
	Are you comfortable? Y/N	
	Anything else I can do for you?	
	Buzzer within easy reach	

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

Initials – document at time of care delivery

610119466W /E5120401 M
TAYLOR Richard
10-Jun-63 **CHI:** 100 663 1372
70911 R Hendrie
42 Morvenside
EH14 2SJ

SJH ED Nursing Care Plan

Admission Nurse Signature: .....

Admission Nurse Print Name: JODIE BULL

Date: 24/08/22

NHS Lothian

Presenting History :	**DNAR in situ (please circle)** **Yes** **No**
ACUTE CONFUSION.	

Date/ Time	Additional Nursing Progress Notes	Signature
24/08/22	Pt settled into cubicle. Telemetry connected. TJ attempted ECG. Will try again. Name band in situ. Partner present. NEWS - 0.	
14:00	Observations updated	
16:25	patient outside for cigarette with partner	
16:50	Pt Refused dinner but accepted caramel shortcake	
1930.	Patient shaking vigourously. Very confused + breathless. Visibly sweating. Unable to obtain BP. ECG obtained. Partner states he normally passes out. Dr reviewing.	
21[00]	Pt c/o Chest pain. ECG x 2 taken + checked by dr. Dr rvd pt and has prescribed analgesia. Telemetry insitu	LMcTeith
22[00]	Pt settled. NEWS 0. Denies pain. Await med bed	LMcTeith
00[00]	Repeated obs, NEWS 0. Advised by reg to commence 4° obs. Relative updated by Pt. Denies pain. Has been outside for cigarette.	LMcTeith

Section A Triage Procedures	**Initials**	**Section B Optional Nursing Procedures**			**Initials**
Vital signs recorded	JS.	IV Cannula Inserted (please circle)	(Yes)	No	JS
Sews Score recorded		ECG completed (please circle)	(Yes)	No	JS.
BM Reading		CXR ordered (please circle)	Yes	No	
GCS assessed	JS.	Falls / Risk Assessment	Required / Complete		
Alcometer reading recorded		Swallow Assessment	Required / Complete		
Peak Flow reading recorded		Waterlow Assessment	Required / Complete		
NameBand attached	JS.	Frailty Concern (please circle)	Yes	No	

Section C Admission Procedures	**Initials**	**Section D Optional Nursing Requirements**	**Initials**
Relatives : (please circle) (In ED) At Home Not Aware		Language Assistance requested (Please inform NIC if applicable)	
Clothing & valuables (please tick) 1) Labelled 2) Documented		Vulnerable Adult Concern (Please Inform NIC if applicable)	
Spectacles : (please circle) (NA) In Situ At home		Child protection Concern (Enter on TRAK & inform NIC if applicable)	
Hearing Aid : (please circle) (NA) In Situ At home		4AT test Score = (please enter only if clinically indicated)	

Care Provider must be informed of any clinical changes highlighted from Patient Screening

Time of Round	O/A	14.00	21[m]	60[m]	
Clinical Area of ED			M3	M3	
Initials of Care Round Leader					
Review frequency of Vital Signs & Cardiac Monitoring					
Vital signs frequency		1	1	4	
Cardiac monitoring required	Y / N	Y / (N)	(Y) / N	(Y) / N	Y / N
Pain Management (Refer to CP for analgesia if required)					
Please note pain score (0-10 Score)			8	0	
Mobility					
Fully weight bearing		✓	✓	✓	
Requires some assistance and / or uses walking aid					
Non Weight bearing and requires full assistance					
Elimination					
Ask patient if toilet is required					
Patient is Self Caring and can walk to toilet		✓	✓	✓	
Patient is Incontinent and requires to be checked					
Patient has catheter in situ and requires to be checked					
Nutrition / Hydration					
Self Caring		✓	✓	✓	
Patient requires assistance with feeding					
Patient is allowed fluids only					
Patient is NBM					
Patient has IVI in Situ					
Refreshments (Provided / Refused - Please indicate P / R)					
Drink		P / R	(P) / R	(P) / R	P / R
Snack		P / R	P / R	P / (R)	P / R
Catered Meal		P / R	P / R	P / (R)	P / R
Visual Skin Inspection					
Patient is healthy / no concerns		✓	✓	✓	
Visible areas of redness					
Broken skin and evidence of Pressure Ulcers					
Invasive devices (please tick if in situ)					
PVC /Arterial Line / Central Line / PVC			✓	✓	
Urinary Catheter / Chest Drain					
Infusion Device					
NG tube / PEG tube / Tracheostomy					
Other					
Family Communication (Please tick)					
Patient & Relatives present & made aware of any changes			✓	✓	
Cubicle Tidy (Please tick)					
Ensure area is tidy and free of obstruction		✓	✓	✓	

Receiving Ward		ED Escort	
Nurse Name		Nurse Name	
Nurse Signature		Nurse Signature	
Date		Date	

Day 2

NHS LOTHIAN
Emergency Department
Adult Majors
Prescription, Administration & Observation Record

NHS Lothian

610119466W /E5120401 M
TAYLOR Richard
10-Jun-63 **CHI:** 100 663 1372
70911 R Hendrie
42 Morvenside
EH14 2SJ

The section below must be completed before any medicine is prescribed/given

Previous Adverse Reactions	Weight	Date
Coedine Morphine.	kgs Actual / Estimate	24/08/12.

Once Only Prescription

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber Sign & Print	Time Given	Issued by (Initials)	Checked by if applicable (Initials)
24/8	2100	PARACETAMOL	1g	PO		2055	UM	

Discharge Medication

Date & Time	Medicine (Approved Name)	Dose	Frequency	Route	Quantity	Duration	Prescriber Sign & Print	Issued by (Initials)	Checked by (Initials)

National Early Warning Score 2 (NEWS2) Chart

| NEWS Key 0 1 2 3 | | |

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.**

Signs of Infection

- Temperature <36°c or >38°c
- Heart rate >90 beats pm
- Respiratory rate >20 breaths pm
- New confusion
- WCC <4 or >12
- Blood sugar >7.7 in non-diabetic

610119466W /E5120401 M
TAYLOR Richard
10-Jun-63 **CHI:** 100 663 1372
70911 R Hendrie
42 Morvenside
EH14 2SJ

NEWS Total	Monitoring Frequency	Clinical Response
Total 0	Commence on 2 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
Total 1 - 4	Commence on 1 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
3 in one parameter *	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to Nurse In Charge (NIC) and Senior Medic
Total 5 - 6	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Total 7 or more	Commence on 15 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Special Instructions		

*For increase in NEWS score of 2

Conscious Level Chart to be completed when clinically indicated

| | | |

IV Fluid Prescription

Time Prescribed	Fluid	Volume	Rate	Prescribers Signature	Time Started	Given by (Initials)	Checked by (Initials)	Time Finished

Fluid Balance

INPUT						OUTPUT				
	IV Fluids or SC Fluids IV Medication	IV Line(s)	Oral Input		Input		Urine		Gastric	
Time	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100ml	Running Total	Time	Volume	Running Total	Volume	Running Total

Drug Infusion

Drug Name:

	Time													
	Rate (ml/hr)													
	Volume in Syringe													
Pump No	Total amount Infused													

Drug Name:

	Time													
	Rate (ml/hr)													
	Volume in Syringe													
Pump No	Total amount Infused													

National Early Warning Score 2 (NEWS2) Chart

NHS Lothian

610119466W /E5120401 M
Nam TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
DO' 70911 R Hendrie
42 Morvenside
EH14 2SJ
CH

Date chart commenced:

This is chart number of this admission

Conscious Level Chart to be completed when clinically indicated

| | | |

Addressograph

Name:

DOB:

CHI:

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		Date:																										Date
0 1 2 3		Time:																										Time
A+B Respirations Breaths/min	≥25																											≥25
	21-24																											21-24
	18-20																											18-20
	15-17	17	16	16																								15-17
	12-14																											12-14
	9-11																											9-11
	≤8																											≤8
A+B SpO_2 Scale 1 Oxygen saturation (%) Use Scale 1 if target range is 94-98%	≥96	98	96	98																								≥96
	94-95																											94-95
	92-93																											92-93
	≤91																											≤91
SpO_2 Scale 2* Oxygen saturation (%) Use Scale 2 if target range is 88-92% eg. in hypercapnic respiratory failure	≥97 on O_2																											≥97 on O_2
	95-96 on O_2																											95-96 on O_2
	93-94 on O_2																											93-94 on O_2
* ONLY use Scale 2 under the direction of a qualified clinician	≥93 on air																											≥93 on air
	88-92																											88-92
	86-87																											86-87
Tick box if using SpO_2 Scale 2	84-85																											84-85
Sign:	≤83																											≤83
Air or Oxygen? Oxygen is a drug and prescribed by target range	A = Air	A	A	A																								A = Air
	O^2 L/min or %																											O^2 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	135	125	A																								121-140
	111-120																											111-120
	101-110																											101-110
	91-100																											91-100
	81-90	88	V	23	V																							81-90
	71-80																											71-80
	61-70																											61-70
	51-60																											51-60
	≤50																											≤50
C Pulse Beats/min Manual pulse	≥131																											≥131
	121-130																											121-130
	111-120																											111-120
	101-110																											101-110
	91-100																											91-100
	81-90																											81-90
	71-80	54	56																									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	Y	Y	U																								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	36.6	C																								37.1-38.0°
	36.1-37.0°																											36.1-37.0°
	35.1-36.0°																											35.1-36.0°
	≤35.0°																											≤35.0°
NEWS TOTAL		5	0	0																								**Total**
Monitoring frequency		4	4	12																								Monitoring
Escalation of care Y/N		N	N	N																								Escalation
Initials		GH	SB	NB																								Initials
Urine output recorded Y/N		Y	N	N																								Urine output
Blood Glucose level or N/A			20	20																								Blood Glucose
Pain score (0-10)		0	0	0																								Pain
Nausea score (0-3)		0	0	0																								Nausea
Motor Block score (0-4) or N/A		0	NA	NA																								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.

GE Healthcare

TAYLOR, RICHARD
Male
10.06.1963 (59 Years)

Vent. rate	72	BPM
PR interval	*	ms
QRS duration	78	ms
QT/QTc-Baz	362/396	ms
P-R-T axes	* 34	28

Patient ID: 1006631372
Accelerated Junctional rhythm
Abnormal ECG

24.08.2022 07:15:09 PM
St John's Hospital

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

GE Healthcare

REF 2047721-001

PRINTED IN UK

TAYLOR, RICHARD
Male
10.06.1963 (59 Years)

Patient ID: 1006631372

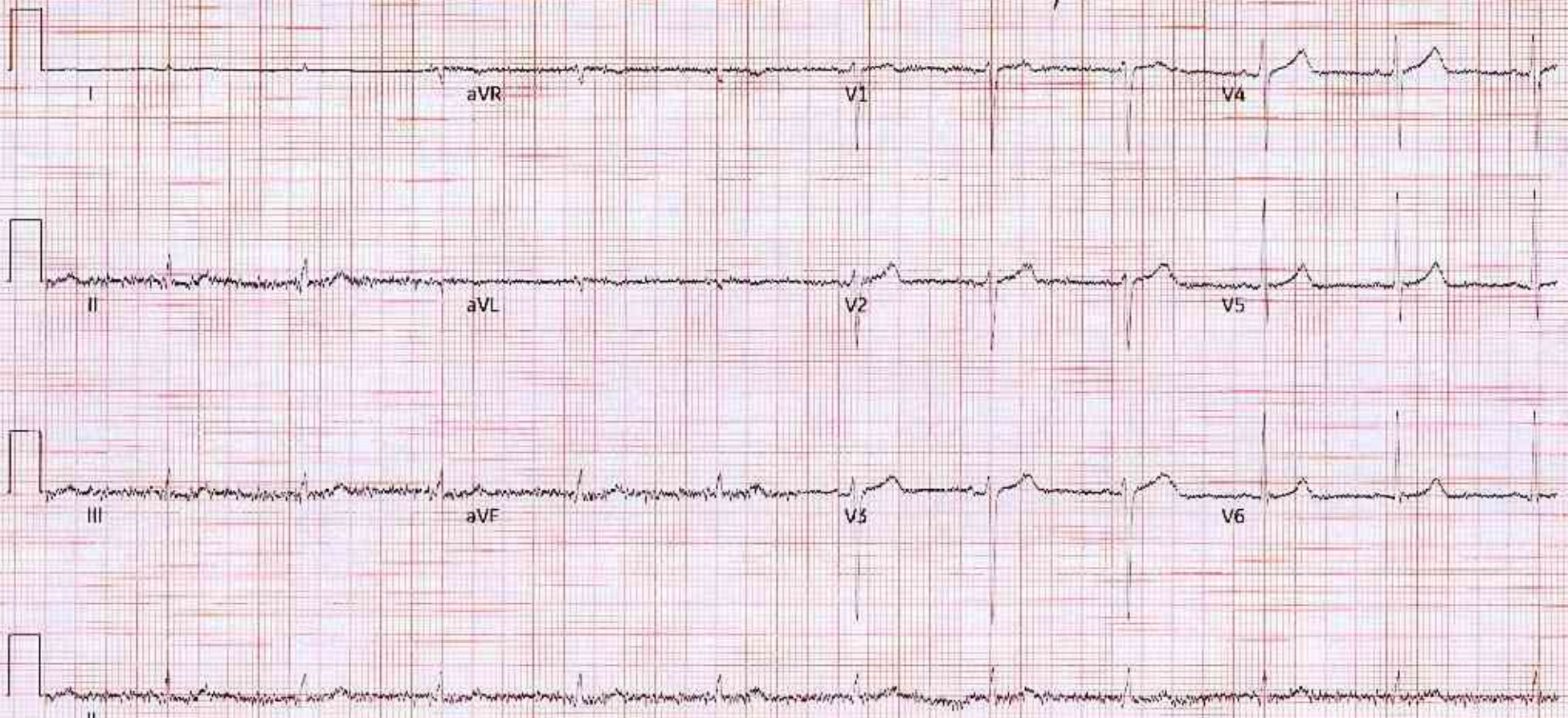
24.08.2022 10:37:39 AM
St John's Hospital

Vent. rate	66	BPM
PR interval	120	ms
QRS duration	78	ms
QT/QTc-Baz	388/406	ms
P-R-T axes	20 79	56

Normal sinus rhythm
Low voltage QRS
Borderline ECG

Location:
Comments:

Unconfirmed



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

GE Healthcare REF 2104772-00 CE PRINTED IN UK

TAYLOR, RICHARD
Male
10.06.1963 (59 Years)

Vent. rate	58	BPM
PR interval	116	ms
QRS duration	82	ms
QT/QTc-Baz	392/384	ms
P-R-T axes	44 58	37

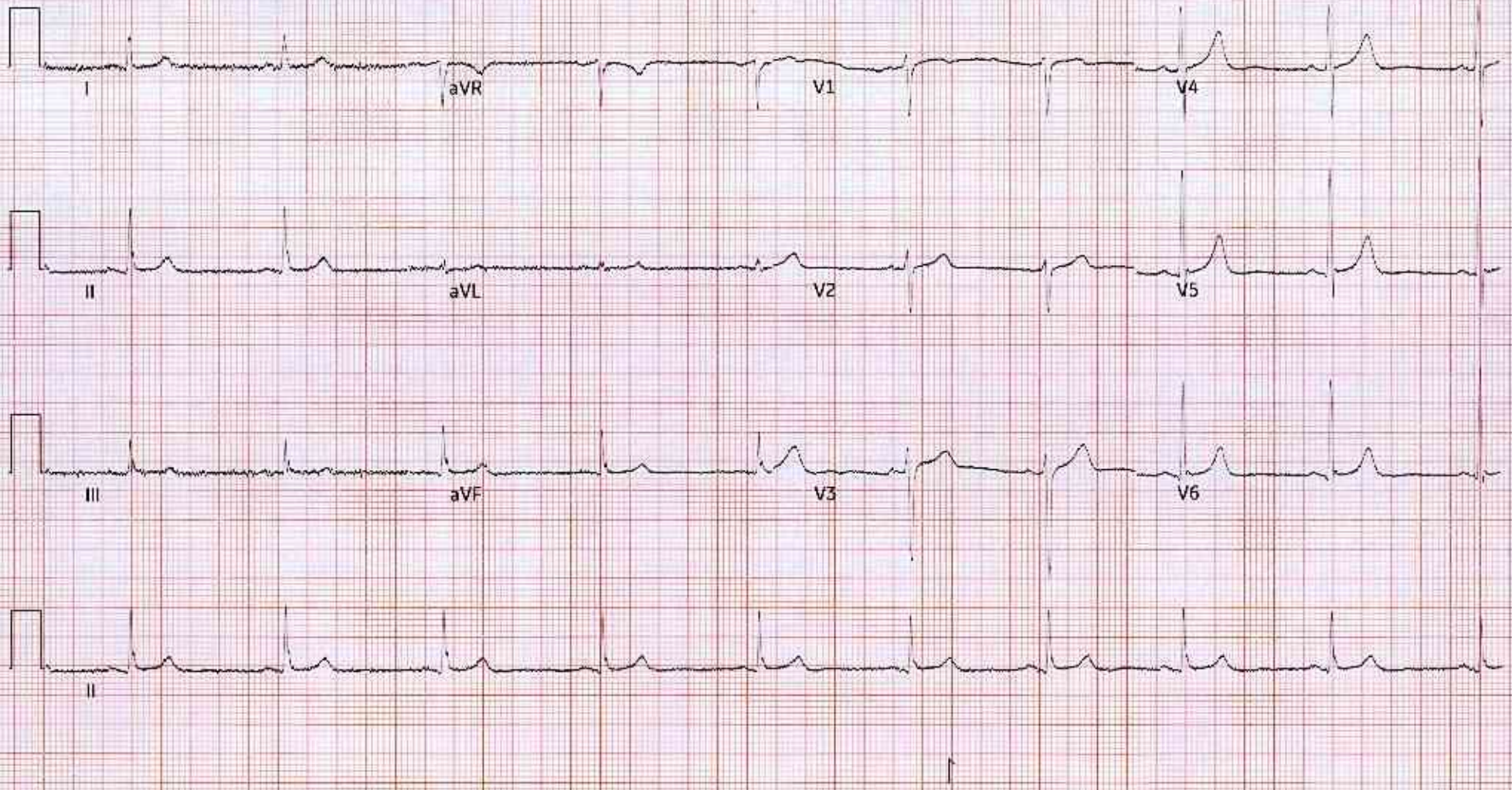
Patient ID: 1006631372
Sinus bradycardia
Otherwise normal ECG

24.08.2022 20:42:53
St John's Hospital

sinus brady

Location:
Comments:

Unconfirmed



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

TAYLOR, RICHARD ID:1006631372 24-Aug-2022 10:37:39 NHS LOTHIAN-SJHA&E ROUTINE RECORD

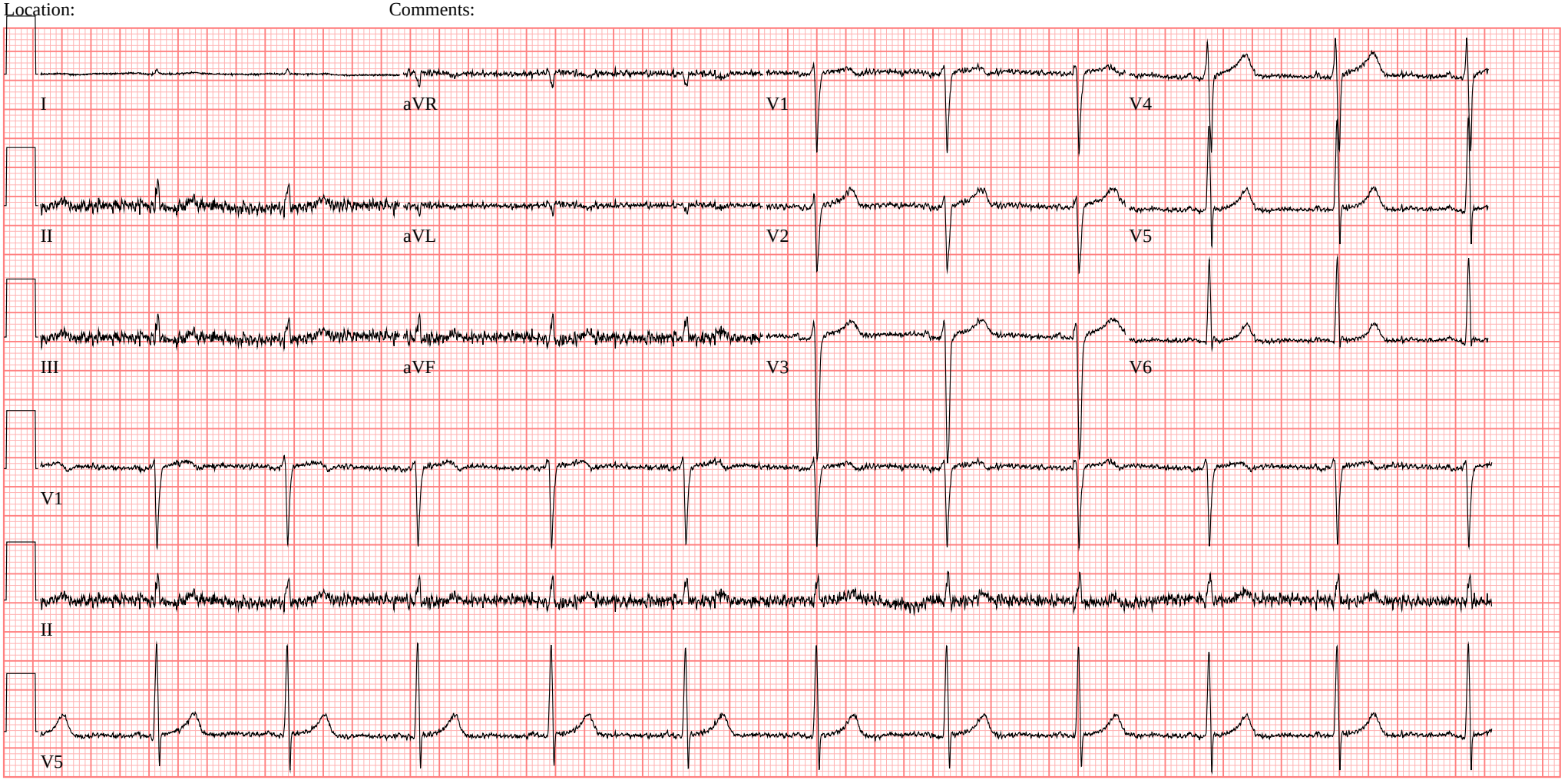
10-Jun-1963 (59 yr)
Male Unknown

Room:
Loc:230

Vent. rate	66	BPM
PR interval	120	ms
QRS duration	78	ms
QT/QTcB	388/406	ms
P-R-T axes	20 79	56

Technician:
Test ind:

Location: Comments:



25mm/s 10mm/mV 150Hz 10.1.3 12SL 243 CID: 25107 SID: 1008119 EID: 13 EDT: ORDER:

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

General Medicine

Dr Hendrie
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date: 30/12/2022

Inpatient Discharge Summary

Patient	Richard Taylor 42 Morvenside Edinburgh EH14 2SJ	**CHI** **Date of Birth / Age** **UHPI**	**1006631372** 10/06/1963 (59 years) 610119466W
Ward	SJH Medical Assessment Unit	**Admission Date**	29/12/2022
Consultant	Dr Rebecca S Dickinson	**Discharge Date**	

Dear Dr Hendrie

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

Discharge Drugs:

Omeprazole 20mg gastro-resistant capsules			
Dose	Route	Frequency	To Continue
20 mg	Oral	PRN OD if required	Yes
Notes:			
Paracetamol 500mg caplets			
Dose	Route	Frequency	To Continue
1000 mg	Oral	Four times daily at 0700, 1200, 1800 & 2200	Yes
Notes:			

PRINCIPAL DIAGNOSIS
Epsodes of confusion and amnesia with unclear cause

TREATMENT
Mr Taylor was admitted on 29/12 following left sided facial dropp and right sided werakness with urinary incontinence. He has a bg of intracerebral bleed 10 years ago and has had 4 episodes of amnesia over the last 4 months. He has been advised to self report to the DVLA and will be follow ed up with neurology as an outpatient.

FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL

outpatient follow up in the neurology clinic

CHANGES TO DRUGS SINCE ADMISSION
nil

ALLERGIES / ADVERSE DRUG REACTIONS
nil

SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS
nil

CHANGES TO DNACPR STATUS / DETAILS OF TREATMENT ESCALATION PLAN
nil

Should you need further information please contact...SJH MAU

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

Yours sincerely.....

Rachel Kelly FY1

This is an immediate discharge letter and a further letter may follow.

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

NHS Lothian

Rebecca
NO SJH

Department of General Medicine

Dr Hendrie
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date First Created : 30/12/2022
Date Authorised :
Date/Time Printed : 30/12/2022 17:00
Our Ref : 610119466W
CHI : 1006631372

Patient:	Richard Taylor 42 Morvenside Edinburgh EH14 2SJ	**UHPI:**	610119466W
		Date of Birth:	10/06/1963
Ward:	SJH Medical Assessment Unit		
Consultant:	Dr Rebecca S Dickinson	**Admission Date:**	29/12/2022
		Discharge Date:	30/12/2022

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

Omeprazole 20mg gastro-resistant capsules				
Dose	Route	Frequency	Days Supply	To Continue
20 mg	Oral	PRN OD if required	7	Y
Notes:				

Paracetamol 500mg caplets				
Dose	Route	Frequency	Days Supply	To Continue
1000 mg	Oral	Four times daily at 0700, 1200, 1800 & 2200	7	Y
Notes:				

Prescribed By ..... Date 30/12/22 **Print Name**.....
Dispensed By ..... Date..... **Print Name**.....
Final Check ..... Date..... **Print Name**.....
Verified By ..... Date..... **Print Name**.....

PRINCIPAL DIAGNOSIS
Epsodes of confusion and amnesia with unclear cause

TREATMENT
Mr Taylor was admitted on 29/12 following left sided facial dropp and right sided werakness with urinary incontinence. He has a bg of intracerebral bleed 10 years ago and has had 4 episodes

Inpatient Discharge Summary

Acute Consultants
Dr A Harmouche
Enquiries to Secretary
Tel: 01506 523025
Dr E W Williams
Dr R M Noh
Enquiries to Secretaries
Tel: 01506 585082
Tel: 01508 585080
Cardiology Consultants
Dr A G Japp
Dr C Stirral
Enquiries to Secretary
Tel: 01508 523853
Dr C Scally
Enquiries to Secretary
Tel: 01506 523869
Diabetes & Endocrinology Consultants
Dr K A Adamson
Dr R Wright
Enquiries to Secretary
Tel: 01506 523838
Dr R M Noh
Dr E Foteinopoulou
Enquiries to Secretary
Tel: 01506 523855
Dr L Van Look
Enquiries to Secretary
Tel: 01508 585093
Gastroenterology Consultants
Dr K Dabos
Dr H R Gillett
Dr C J Goddard
Enquiries to Secretary
Tel: 01506 523880
Dr S Minnis-Lyons
Enquiries to Secretary
Tel: 01506 585092
Medicine of the Elderly Consultants
Dr M McMurray
Dr J A Wilson
Dr M Corretge
Enquiries to Secretary
Tel: 01506 523841
Dr L Munang
Enquiries to Secretary
Tel: 01506 523844
Dr A Barugh
Dr S G Ramsay
Dr J H W Rimer
Enquiries to Secretary
Tel: 01506 523846
Respiratory Consultants
Dr F Boellert
Dr R Dickinson
Dr G Martin
Dr D D Noble
Dr F D'Brien
Dr T Plant
Enquiries to Secretaries
Tel: 01506 523836

Tel: 01506 523623
Tel: 01506 523830
Tel: 01506 523844

of amnesia over the last 4 months. He has been advised to self report to the DVLA and will be follow ed up with neurology as an outpatient.

FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL
outpatient follow up in the neurology clinic

CHANGES TO DRUGS SINCE ADMISSION
nil

ALLERGIES / ADVERSE DRUG REACTIONS
nil

SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS
nil

CHANGES TO DNACPR STATUS / DETAILS OF TREATMENT ESCALATION PLAN
nil

Should you need further information please contact...SJH MAU

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

Yours sincerely.....

Rachel Kelly FY1

This is an immediate discharge letter and a further letter may follow.

Archive Copy Not to be Photocopied

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

General Medicine

Dr Hendrie
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date: 25/01/2023

Inpatient Discharge Summary

Patient	Richard Taylor 42 Morvenside Edinburgh EH14 2SJ	**CHI** **Date of Birth / Age** **UHPI**	**1006631372** 10/06/1963 (59 years) 610119466W
Ward	SJH Medical Assessment Unit	**Admission Date**	29/12/2022
Consultant	Dr Rebecca S Dickinson	**Discharge Date**	30/12/2022

Dear Dr Hendrie

FINAL DISCHARGE SUMMARY

Dear Doctor,

I have nothing further to add to the Immediate Discharge Letter which you should already have received.

Yours sincerely,

E-signed

Dr Rebecca Dickinson
Consultant Respiratory Physician

RD/MH

Dict: 13.01.23
Typed: 25.01.23

PRINCIPAL DIAGNOSIS
Epsodes of confusion and amnesia with unclear cause

TREATMENT

Mr Taylor was admitted on 29/12 following left sided facial dropp and right sided werakness with urinary incontinence. He has a bg of intracerebral bleed 10 years ago and has had 4 episodes of amnesia over the last 4 months. He has been advised to self report to the DVLA and will be follow ed up with neurology as an outpatient.

FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL
outpatient follow up in the neurology clinic

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nil

ALLERGIES / ADVERSE DRUG REACTIONS
nil

SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS
nil

CHANGES TO DNACPR STATUS / DETAILS OF TREATMENT ESCALATION PLAN
nil

Should you need further information please contact...SJH MAU

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

Yours sincerely.....

Rachel Kelly FY1

This is an immediate discharge letter and a further letter may follow.

The Royal Infirmary of Edinburgh

Safety Questionnaire for **MRI** scanning

Surname TAYLOR First name RICHARD

Date-of-Birth 10/06/1963 Weight _____

Have you had a **CT or MRI** scan before?	(Yes)	No
Have you had any operations on your **HEAD**?	Yes	(No)
Have you had any operations on your **SPINE**?	Yes	(No)
Have you had any operations on your **CHEST or HEART**?	Yes	(No)
Have you had any operations involving the use of **METALLIC CLIPS, PINS or PLATES**? (L) ankle	(Yes)	No
Do you have a **Cardiac Pacemaker**?	Yes	(No)
Do you have an **Aneurysm Clip**?	Yes	(No)
Do you have a **Cochlear implant**?	Yes	(No)
Have you ever worked with metal?	Yes	(No)
Is there any possibility that you could have **metal in your eye**?	Yes	(No)
Have you ever had a shrapnel or bullet injury?	Yes	(No)
Are you wearing a **CARDIAC / HRT / NICOTINE** patch?	Yes	(No)
Do you suffer from any allergies?	Yes	(No)

LADIES:

Is there any possibility that you may be pregnant?	~~Yes~~	No N/A
Are you breast-feeding?	Yes	~~No~~

ALL metal worn or carried on your person is to be removed.
Pens, Spectacles, Keys, Money, Jewellery, Watches, Hairgrips, Dentures, Scissors, Credit Cards, Hearing Aids, Bra, Surgical Supports, etc.

Do not sign this form yet. A radiographer will go through the form with you and explain the MRI scan procedure.

I understand the procedure of a MRI examination. I also understand the above questions.

I give permission for the use of an intravenous contrast agent if it is deemed necessary.

Patient's Signature: _____ Date: _____

RDA Signature: _____ Date: _____

Radiographer Signature: _____ Date: _____

PTO

Continuation

REGULAR THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine	Date → / Time ↓															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber – sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber – sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber – sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber – sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber – sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber – sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber – sign + print		Pharmacy	18															
			22															

REGULAR THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine	Date → / Time ↓															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber – sign + print		Pharmacy	18															
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Prescriber – sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber – sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber – sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber – sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber – sign + print		Pharmacy	18															
			22															

AS REQUIRED THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine												
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
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Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											

Ward: MAU Site: Date: 29/12/11

Addressograph or

610119466W /E5237225 M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
70911 R Hendrie
42 Morvenside
EH14 2SJ

NHS Lothian

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 _____

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	1008	2308	0508	0808									
	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	Y	Y	Y									
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	Y	Y	Y									
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?	N	N	N	N									
Is the patient continent of urine? (at time of Care Rounding)	Y	Y	Y	Y									
Continence product changed/offered?	N	N	N	N									
Catheter care performed?	NA	NA	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)	N	N	N	N									
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									
Fluid Balance Chart (if clinically indicated)	N	N	N	N									
When did you last eat?	S	S	S	S									
(B) Breakfast (L) Lunch (D) Dinner (S)Snack (NBM) Nil by Mouth (A) Assistance Update Food Chart if required													
Falls — Oral Hygiene Performed (ref to risk assessment)	I	I	I	I									
Appropriate Footwear?	Y	Y	Y	Y									
Walking aid available(and within reach)	NA	NA	NA	NA									
Area de-cluttered?	Y	Y	Y	Y									
Chair and bed height assessed?	Y	Y	Y	Y									
Falls alarm in use and attached?	NA	NA	NA	NA									
Glasses available for use? (if worn) Hearing aid available for use? (if worn)	NA	NA	NA	NA									
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?	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									
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	MOM		OM										

Ward: MDU Site: STH Date: 30/12/22

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

Addressograph, or
610119466W M 10/06/1963
Name Taylor, Richard
42 Morvenside,
Edinburgh,
EH14 2SJ
DOB
CHI 1006631372
Unit no. 70911 R Hendrie

IS ian

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

	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
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	I	I
Positioning (R) or (L) side (B) Back (C) Chair	C	B	C
Mattress type / Cushion type	*please state type:*		
Elimination			
Do you need the toilet?	I	I	I
Is the patient continent of urine? (at time of Care Rounding)	Y	Y	Y
Continence product changed/offered?	—	—	—
Catheter care performed?	—	—	—
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
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
Fluid Balance Chart (if clinically indicated)	N	N	N
When did you last eat?	B	L	L
(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	I
Falls			
Appropriate Footwear?	Y	Y	Y
Walking aid available(and within reach)	—	—	—
Area de-cluttered?	Y	Y	Y
Chair and bed height assessed?	Y	Y	Y
Falls alarm in use and attached?	—	—	—
Glasses available for use? (if worn) Hearing aid available for use? (if worn)	—	—	—
Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐			
Pain			
Are you in pain?	N	N	N
Analgesia Given?	N	N	N
General			
Peripheral Venous Cannula observed?	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
Anything else I can do for you?	N	N	N
Buzzer within easy reach	Y	Y	Y

Personal Care *Type* Shower *(specify)* **Time Given** 8:20 (1)

Initials – document at time of care delivery			
		GS	GS

Patient Addressograph

Name: RICHARD TAYLOR

D.o.B.: 10/6/1963.

CHI Number:

SJH ED Nursing Care Plan

Admission Nurse Signature: A Fielding

Admission Nurse Print Name: A Fielding

Date: 28/12/22

NHS Lothian

Presenting History :	DNAR in situ (please circle) Yes No
R sided facial droop / weakness. Collapse.	

Date/ Time	Additional Nursing Progress Notes	Signature
28/12/22	Pt brought through to RAU from triage - NEWS 3 dad	
1630	to note confusion. IV access obtained ECG R axis	
	and very gurgly voice. Changed into gown as had	
	been incontinent. BM 6.1. Swallow Ax passed ☑	AFielding
1656	Pt appears like he is regurgitating, choking / drooling and	
	feeling very cold. Temp checked in both axs and 37.1°	AF
1705	Pt started to appear grey, sweating profusely, feeling	
	very unwell, escalated to medics. ED consultant now	
	reviewing.	AFielding
1910	Observations updated IV flush running	
0830	Pt declined offer of breakfast. Drank providing	NM
@1215	Obs done, IV aciclavir given. To run over 2 hours.	LA
12.20	Pt encouraged to order lunch but declined offer	NM

Section A Triage Procedures	Initials	Section B Optional Nursing Procedures			Initials
Vital signs recorded		IV Cannula Inserted (please circle)	Yes	No	
Sews Score recorded		ECG completed (please circle)	Yes	No	
BM Reading		CXR ordered (please circle)	Yes	No	
GCS assessed		Falls / Risk Assessment	Required / Complete		
Alcometer reading recorded		Swallow Assessment	Required / Complete		
Peak Flow reading recorded		Waterlow Assessment	Required / Complete		
NameBand attached		Frailty Concern (please circle)	Yes	No	

Section C Admission Procedures	Initials	Section D Optional Nursing Requirements	Initials
Relatives : (please circle) In ED At Home Not Aware		Language Assistance requested (Please inform NIC if applicable)	
Clothing & valuables (please tick) 1) Labelled 2) Documented		Vulnerable Adult Concern (Please inform NIC if applicable)	
Spectacles : (please circle) NA In Situ At home		Child protection Concern (Enter on TRAK & inform NIC if applicable)	
Hearing Aid : (please circle) NA In Situ At home		4AT test Score = (please enter only if clinically indicated)	

Care Provider must be informed of any clinical changes highlighted from Patient Screening

Time of Round	O/A				
Clinical Area of ED					
Initials of Care Round Leader					
Review frequency of Vital Signs & Cardiac Monitoring					
Vital signs frequency					
Cardiac monitoring required	Y / N	Y / N	Y / N	Y / N	Y / N
Pain Management (Refer to CP for analgesia if required)					
Please note pain score (0-10 Score)					
Mobility					
Fully weight bearing					
Requires some assistance and / or uses walking aid					
Non Weight bearing and requires full assistance					
Elimination					
Ask patient if toilet is required					
Patient is Self Caring and can walk to toilet					
Patient is Incontinent and requires to be checked					
Patient has catheter in situ and requires to be checked					
Nutrition / Hydration					
Self Caring					
Patient requires assistance with feeding					
Patient is allowed fluids only					
Patient is NBM					
Patient has IVI in Situ					
Refreshments (Provided / Refused : Please indicate P / R)					
Drink		P / R	P / R	P / R	P / R
Snack		P / R	P / R	P / R	P / R
Catered Meal		P / R	P / R	P / R	P / R
Visual Skin Inspection					
Patient is healthy / no concerns					
Visible areas of redness					
Broken skin and evidence of Pressure Ulcers					
Invasive devices (please tick if in situ)					
PVC /Arterial Line / Central Line / PVC					
Urinary Catheter / Chest Drain					
Infusion Device					
NG tube / PEG tube / Tracheostomy					
Other					
Family Communication (Please tick)					
Patient & Relatives present & made aware of any changes					
Cubicle Tidy (Please tick)					
Ensure area is tidy and free of obstruction					

Receiving Ward		ED Escort	
Nurse Name		Nurse Name	
Nurse Signature		Nurse Signature	
Date		Date	

NHS LOTHIAN
Emergency Department
Adult Majors
Prescription, Administration & Observation Record

NHS Lothian

Addressograph
Name: RICHARD TAYLOR
DOB: 10/6/1963.
CHI: 1372.

The section below must be completed before any medicine is prescribed/given

Previous Adverse Reactions	Weight	Date
co-codamol, morphine → stomach irritation	kgs Actual / Estimate	28/11/22

Once Only Prescription

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber Sign & Print	Time Given	Issued by (Initials)	Checked by if applicable (Initials)
28/12	1645	Paracetamol	1g	PO	A Hilditch PAD 3764	1645	AF	
28/12	1605	Ibuprofen	400mg	PO	A Hilditch 367	1605	AF	
28/12	1640	ONDANSETRON	10mg	oral		17:40		
28/12	1640	ONDANSETRON	4mg	IV				
28/12	1640	METOCLOPRAMIDE	10mg	IV		18:50		
28/12/22	1950	SUMATRIPTAN	50mg	ORAL		1950		
29.12	11:30	AMOXICLAV	625mg	oral		11:30	LA	
29/12/22		PARACETAMOL	1g	oral		11:30	LA	
29/12/22	11:35	ACICLOVIR	750mg	IV		12.10	LA	CT.

Discharge Medication

Date & Time	Medicine (Approved Name)	Dose	Frequency	Route	Quantity	Duration	Prescriber Sign & Print	Issued by (Initials)	Checked by (Initials)

National Early Warning Score 2 (NEWS2) Chart

NEWS Key 0 1 2 3																	
	Date:	28/12															
	Time:	16:20	16:37	19:00	18:10	19:10	21:40	22:30	23:45	00:40	03:30	06:00	08:50	10:15	12:15		
A+B Respirations Breaths/min	≥25															3	
	21-24			24	22											2	
	18-20	18	20			20		20	18	18							
	15-17										17	16	17	17	17		
	12-14																
	9-11															1	
	≤8															3	
A+B SpO_2 Scale 1 Oxygen saturation (%) Use Scale 1 if target range is 94-98%	≥96	96%	98%	100%	96	98				96	96		98		96		
	94-95						95		94			94		94		1	
	92-93							93		93						2	
	≤91															3	
SpO_2 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	≥97 on O_2															3	
	95-96 on O_2															2	
	93-94 on O_2															1	
	≥93 on air																
	88-92																
	86-87															1	
	84-85															2	
Tick box if using SpO_2 Scale 2 Sign	≤83															3	
Air or Oxygen? Oxygen is a drug and prescribed by target range	A = Air	A	A	A	A	A	A	(A)	A	A	A	A	A	(A)	(A)		
	O_2 L/min or %															2	
	Device																
C Blood Pressure mmHg Score uses Systolic BP only If manual BP mark as M	≥220															3	
	201-219																
	181-200				169												
	161-180			145													
	141-160	139	130					126					146				
	121-140					129											
	111-120																
	101-110															1	
	91-100															2	
	81-90	96			89								92				
	71-80		84	76		83		80									
	61-70															3	
	51-60																
	≤50																
C Pulse Beats/min Manual pulse	≥131															3	
	121-130																
	111-120															2	
	101-110																
	91-100															1	
	81-90	74		83		89							75				
	71-80		64		74												
	61-70																
	51-60																
	41-50															1	
	31-40															3	
	≤30																
D Consciousness Score for new onset of confusion (no score if chronic)	Alert	✓							A	A	A	A	A	(A)	(A)		
	New Confusion	✓	✓	✓	✓	✓	✓	•								3	
	V																
	P																
	U																
E Temperature °C	≥39.1°															2	
	38.1-39.0°															1	
	37.1-38.0°		37.1	⊙		37.2							37.1				
	36.1-37.0°	•			36.7			•	•	•	•	•	•	•	•		
	35.1-36.0°															1	
	≤35.0°															3	
NEWS TOTAL		03	3	5	2	3		5	1	0	0	1	0	1	0		
Monitoring frequency		30'	30'	30'	1°	1°		1°	1°	2°	2°	2°	1°	2°	2°		
Escalation of care Y/N		N	N	N	N			N	N	N							
Blood Glucose reading or N/A		6.1			NA							NA					
Pain score (0-10)		03							2		0	0	0	0	0		
Initials		AJ	AF	AF	GMC				DG	DG	DS	DG	NM	AA	AA		

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.

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.**

Signs of Infection

- Temperature <36°c or >38°c
- Heart rate >90 beats pm
- Respiratory rate >20 breaths pm
- New confusion
- WCC <4 or >12
- Blood sugar >7.7 in non-diabetic

Addressograph

Name: Richard Taylor

DOB:

CHI:

NEWS Total	Monitoring Frequency	Clinical Response
Total 0	Commence on 2 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
Total 1 - 4	Commence on 1 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
3 in one parameter *	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to Nurse In Charge (NIC) and Senior Medic
Total 5 - 6	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Total 7 or more	Commence on 15 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic

Special Instructions

*or increase in NEWS score of 2

Conscious Level Chart to be completed when clinically indicated

| | | |

IV Fluid Prescription

Time Prescribed	Fluid	Volume	Rate	Prescribers Signature	Time Started	Given by (Initials)	Checked by (Initials)	Time Finished
02/10/22	PLASMALYTE	500ml	IV 1°		12:15			

Fluid Balance

	INPUT					OUTPUT				
	IV Fluids or SC Fluids IV Medication	IV Line(s)	Oral Input		Input		Urine		Gastric	
Time	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100ml	Running Total	Time	Volume	Running Total	Volume	Running Total

Drug Infusion

Drug Name: Aciclovir

	Time	12:15													
	Rate (ml/hr)	180													
	Volume in Syringe	280													
Pump No	Total amount Infused	0													

Drug Name:

	Time														
	Rate (ml/hr)														
	Volume in Syringe														
Pump No	Total amount Infused														

Haemograph

610119466W /E6237225 M
TAYLOR Richard
10-Jun-63 **CHI:** 100 663 1372
70911 R Hendrie
42 Morvenside
EH14 2SJ

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 patient 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 severity

| | | |

National Early Warning Score 2 (NEWS2) Chart

NHS Lothian

610119466W /E5237225 M
TAYLOR Richard
10-Jun-63 **CHI:** 100 663 1372
70911 R Hendrie
42 Morvenside
EH14 2SJ

Date chart commenced:

This is chart number of this admission

Conscious Level Chart to be completed when clinically indicated

| | | |

Lothian University Hospitals NHS Trust

ADULT UNITARY PATIENT RECORD

ADMITTING HOSPITAL: St John's Hospital at Howden

TYPE OF ADMISSION: Emergency

PRESENTING COMPLAINTS/REASON FOR ADMISSION

1 Confusion, memory loss/vomiting
2
3
4

Patient wishes to be known as:

NAME & ADDRESS (PATIENT LABEL)

Hospital No: 610119466W F/M: M
DOB: 10/06/1963 Age: 59

Name: Richard Taylor
Address: 42 Morvenside

Edinburgh

EH14 2SJ
Telephone No: 0131 442 1596

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

	ADMISSION WARD	DESTINATION WARD - 1st	DESTINATION WARD - 2nd
Ward No.	SJHMAU		
Admission Date	29/12/2022		
Admission Time to Ward	15:44		
Admitting Nurse			
Consultant	Dr Rebecca S Dickinson		

G.P.Details: 613466/70911 70911/4
R Hendrie
Sighthill Green Medical Practi

EH11 4AU
Tel No: 0131 202 5888

NEXT OF KIN
RELATIONSHIP
Address:

Contact No.

FIRST CONTACT
RELATIONSHIP
Address:

Contact No.

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

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

	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
University Hospital Services
Department of Emergency Medicine

ST. JOHN'S HOSPITAL
Howden Road West, Livingston
EH54 6PP Tel: 01506 523000

NHS Lothian

A/E no. 32
Previous no.
UHPI no.
CHI no.

PATIENT INFORMATION

Surnan 810119466W/E5237225 M
Forena TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
Addre: 70911 R Hendrie
42 Morvenside
EH14 2SJ
Postco

Date of Birth 10/06/1963
Age Sex M

Telephone 07593330473

Contact Address

Telephone H 07554-735550
W Natalie

Complaint memory loss + vomiting.

Allergies

General Practitioner

Address SIGHTHILL HEALTH CENTRE.

Telephone

Date and Time of Attendance 28/12/22 @ 15:34

Mode of Arrival PR

Source of Referral (S)

Temp	Pulse Rate	BP	RR	Sats O_2/air	BM	PF best	Alcometer	GCS	SEWS
36.9	73	158/96	20	98% RA				/15 e_v_m_	

Presenting Complaint: 6am - 2:30pm, No memory.

History of Presenting Complaint: wet (incont) R side Droop new -

Assessment:

Triaged no.: 1 2 3 4 7 *(circle)* Senior Doctor Informed? Y / N time.....

BLOODS Routine ☐ Troponin ☐ Amylase ☐ TOX ☐ Other ☐ _____ Bloods Done ☐ _____

time due..... (time of QD.....)

PVC Started (time).....

EC Required ☐ Done ☐ Time.....

X-RAYS CXR ☐ Other ☐ _____

URINALYSIS Required ☐ Done ☐ HCG: + / - *(circle)* MSU Sent: Y / N

PAIN SCORE ___/10 Analgesia ☐ Time.....

Peripheral Venous Cannula Insertion *Complete all sections*

Date:..... Time:..... Operator:.....

Size		Position		Standard technique	
Blue	☐	LEFT	☐	Handwash	☐
Pink	☐	RIGHT	☐	Gloves	☐
Green	☐	Hand	☐	CHD skin prep	☐
Orange	☐	Forearm	☐	Aseptic insertion	☐
Brown	☐	ACF	☐	Needle free port	☐
Grey	☐	Foot	☐	Dressing labelled	☐

Difficulties/complications/deviation from standard technique:

Operator Signature:.....

Are any 2 of the following present:

1. temp >383 or <36 ☐
2. HR > 90 ☐
3. RR > 20 ☐
4. WCC > 12 or < 4 ☐
5. BM > 7 (+ not diabetic) ☐
6. age > 70 ☐
7. signs of infection ☐

>2 → think sepsis and triage up start Sepsis 6

FAST + / - *(circle)* Onset Time:.....

Stroke Test

Speciality Informed ☐ time..... Speciality:.....

Time of Triage:.....

Triaged by: *(sign)*.....

(print).....

Clinician: *(sign)*.....

(print).....

Clinical Notes

Care Providers Name:..... Signature:.....

413.

A&E TO MAU HANDOVER

A&E NURSE

PATIENTS NAME: Richard Taylor 59

Time in A&E dept?	
Presenting complaint?	Confusion - when driving Q - NIL - Stroke Review -
NEWs>7, who is escorting patients? Should be nurse	? encephalitis - LP ☐ MSU ☐ News 0 ? toxigdoxy
GCS<8 needs nurse escort?	14
Swallow assessment within 4 hrs?	
DNACPR STATUS	✓
Any history of violence & aggression?	—
PVC Bundle! Is Venflon inserted? Details on trak	PIVC.
Prescribed drugs given?	Aciclovir ✓ IV fluid paracetamol / bourhan oramph.
• Any history of diarrhoea? Family? • Poct test done? • Pcr sent?	No infections.
Has patient got a wrist band.	

R. T

Mdb - no issues - ind

Cont - no issues - ind.

Skin - no issues - intact + healthy

F+F - no issues - normal diet + fluids

Plc

G - Rhand

28/12/22

4AT

Goals

Get home

normal

Drivers license + kids + wife

ST6 Medicine Ricchetti

28/12/2022.
2330.

Richard
~~Robert~~ Taylor
10/6/83 1372.

PC. confusion
bilirally left facial droop + R sided weakness. - resolved.

HPC. Recurrent episodes of strange behaviours + confusion. prev. thought to be atypical presentations of transient global amnesia. cluster of symptoms across episodes: headache, diaphoresis, abdominal pain + odd behaviour.
DAY. - found confused, driving own car in circles, transient drop in GCS + limb jerking (not stereotypical).
no recollection of events

~~PMH~~ Hx -
? transient global amnesia.
Intracranial haemorrage
Depression
gallstones.

Bloods Unremarkable

SHx ⇒ HGV driver

Cannabis smoker.

OE: I+II+O
nil focal neurology
correctly oriented

FHx: nil reg.

imp: unclear. neurology ? partial seizures ? migraine.
not safe to drive.

(P)
- admit for neurology review emailed referral.
-? MRI brain.

Richard Taylor DOB 10/6/63

28/12/22 18:00

PC/ confusion

HPC/ 59 male

HGV driver

TRAK down so Hx relied on partner

intracerebral bleed 10 years ago- currently not on any medications

4 episodes of what was thought to be transient global amnesia over last 4 months- with disorientation of time/ person/ place and intermittent sweats and headaches

No medical follow up

Partner got a call from patient's employer today as patient was confused, driving his own car in circles as unable to recall how to get home

Partner found patient confused- unware of name, place, DOB

Self presented? Left sided facial droop and right sided weakness at at triage, and urinary incontinence- weakness resolved.

Currently only complaint is global headache despite paracetamol and ibuprofen, initermittent transient drop in GCS lasting 20 seconds with associating sinus bradycardia (80bpm drops to 40 bpm), jerking all 4 limbs but not rhythmic/seizure like, and profused sweating with paroxysmal worsening of headache

Able to recall names, and place, but nothing else

No recall of events since waking this morning

PMH/ as above

DH/ nil. ? morphine an d codeine in last admission causing stomach aches- but agrees to take some oramorph

SH/ cannabis use in the past

O/E

Sweating

Ob stable otherwise

Pupils small 2mm symmetrical and reactive to light

during the moment of unresponsiveness non responsive to trapezius squeeze , with eyes deviated to right but work up in an exaggerated jump

Able to self transfer to CT table no obvious weakness, no pronator drift

HS i+ii

Chest clear

SNT abdomen

Intermittent drop of SaO2 to 91% no relating to drop in conscious level, improves with deep breathing

IMP/ All these symptoms are very strange. Originally I questioned if these were functional in origin but patient does look very unwell and I cannot explain the diffuse sweating and transient bradycardia. ? Seizure related.

P1) with him being HGV driver and monthly recurrence- I think admission with neurology input is warranted. Currently not being treated as TIA/ stroke

2) CTH and bloods already done- report pending

3) refer medics

ATSP approx 19:00 as sweating ++ again with vomiting (slightly pink and blood stained). Headache worse. Seems less confused. States gets headache every few weeks, no further details offered, denies photophoebia/ auro with these headaches.

CTH head: old right putamen lacunar infarct. no new intracranial pathology

WCC 16.9 UE LFT normal ranges

I am not convinced that this is migraine, but trial of sumatriptan, IV metoclopramide and IVF

may help.

Review later.

19:30 Patient rolling around in trolley screaming with abdominal pain, stating this was due to medications given. Oramorph was approx 1 hour ago and patient had large vomit not that long ago. The only other medications given since was metoclopramide. Want to self discharge.

Explained that I cannot think of alternative analgesia for him at the moment, but trial of sumatriptan.

Encourage to stay in hospital as a neurology opinion would be really useful for him with his frequent attendance with these symptoms, and I shall review him again re: analgesia need in 1 hour.

Review 20:30

Patient now comfortable and sleeping

SNT abdomen

His wife states that the confusion, jerking, sweating followed by abdominal pain seems to be the pattern of his presentation.

I have explained to her that and I do not have a clear explanation of his symptoms, but encourage him to be admitted for neurology review.

Patient Name	CHI	Date of Birth	Age	GP	GP Practice	GP Practice Code
TAYLOR RICHARD	1006631372	10/08/1963	59	HENDRIE, RACHEL	Sighthill Green Medical Practice	70911

Allergies

Description	Date Recorded	Comments
No ECS data exists		

Sources: [1] ECS [ ] Patient's Drugs [ ] Referrer Kardex [ ] GP Practice [2] TRAK
[3] Patient [ ] Relative / Carer [ ] Referrer Letter [ ] Comm Pharmacy [ ] Other - Specify .....

Actions: C: Continue W: Withhold S: Stop

Acute Medication (including those greater than 30 days)

Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Source 1P	Source 2P	Source 3P	Action C	Action W	Action S	Comments
Venlafaxine 150mg modified-release tablets	14 tablet	WEEK SEVEN ONWARDS: 1 CAPSULE ONCE DAILY		31/08/2022	31/08/2022	1		3			✓	not taking
Venlafaxine 37.5mg modified-release capsules	28 capsule	WEEK ONE AND TWO AND WEEKS FIVE AND SIX: TAKE ONE CAPSULE EACH MORNING		31/08/2022	31/08/2022	1		3			✓	
Venlafaxine 75mg modified-release tablets	28 tablet	WEEK THREE TO SIX: 1 CAPSULE ONCE DAILY		31/08/2022	31/08/2022	1		3			✓	

Repeat Medication

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Source 1P	Source 2P	Source 3P	Action C	Action W	Action S	Comments
GP practice	Omeprazole 20mg gastro-resistant capsules	56 capsule	1 CAPSULE DAILY AS NEEDED		15/06/2017	03/06/2020		1	2		✓			

Patient Name	CHI	Date birth	Age	GP	GP Practice	GP Practice Code
TAYLOR RICHARD	1006631372	10/[illegible]J63	59	HENDRIE, RACHEL	S[illegible]ill Green Medical Practice	70911

Repeat Medication

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Source 1*	Source 2*	Source 3*	Action C	Action W	Action S	Comments

Compliance Device	Name and telephone number for community pharmacy

Completed by	Designation	Grade	Date	Time	Contact Number
S-KOUDELKA		F1	29/12/22	22:47	3993
Reviewed by	**Designation**	**Grade**	**Date**	**Time**	**Contact Number**

Patient Name	CHI	Date of Birth	Age	GP	GP Practice	GP Practice Code
TAYLOR RICHARD	1006631372	10/06/1963	59	HENDRIE, RACHEL	Sighthill Green Medical Practice	70911

Key Information Summary

(Extract of selected information - additional information may be available in the full KIS report)

Is there a DNACPR Form in Place?

Is there a CYPADM Form in Place? No

Medical History

Date Recorded	Diagnosis
03/06/1963	[X]Intentional self-harm
10/06/1963	[X]Int self hang/strang/suffoc
20/07/1973	Bell's (facial) palsy
21/11/1977	Post-concussion syndrome
18/09/1978	Personality disorders
02/05/1981	Head injury
31/07/1981	[X]Intentional self-harm
30/09/1981	Head injury
01/10/1981	[X]Intentional self-harm
24/11/1981	Head injury
05/02/1982	[X]Intentional self-harm
30/03/1982	Motor vehicle traffic acid.NOS
30/05/1982	Inj.?acc-cutting/stabbing
14/12/1982	[X]Overdose - deliberate
11/11/1986	[X]Intentional self-harm
27/04/1987	[X]Intentional self-harm
14/05/1987	Motor vehicle traffic acid.NOS
28/06/1987	#Ankle
23/07/1987	[X]Overdose - deliberate
04/08/1987	[X]Overdose - deliberate
04/08/1987	[X]Intentional self-harm
06/08/1987	[X]Intentional self-harm
18/08/1987	[X]Depressive episode
01/09/1989	Removal int fixation dev NEC
02/04/1994	Fracture of radius NOS
05/07/1994	Removal int fixation dev NEC
02/01/1997	[X]Intentional self-harm
28/01/1997	Fusion of joint NEC
24/02/1997	[X]Intentional self-harm
26/05/1998	Viral illness
02/01/1999	[X]Intentional self-harm
27/09/2000	Motor vehicle traffic acid.NOS
13/11/2004	Intracerebral haemorrhage
13/11/2004	Endotracheal intubation
11/08/2009	Nondependent cannabis abuse
20/11/2009	Renal impairment
06/09/2011	Stress at home
15/06/2017	Vasectomy NEC

Patient Name	CHI	Date of Birth	Age	GP	GP Practice	GP Practice Code
TAYLOR RICHARD	1006631372	10/06/1963	59	HENDRIE, RACHEL	Sighthill Green Medical Practice	70911

Anticipatory Care Plan
No data recorded

No OCR

4/3

Patient Name	CHI	Date of Birth	Age	GP	GP Practice	GP Practice Code
TAYLOR RICHARD	1006831372	10/06/1963	59	HENDRIE, RACHEL	Sighhill Green Medical Practice	70911

Allergies

Description	Date Received	Comments
	No ECS data exists	
NKDA		

Source: [1] ECS [2] Patient [ ] Patient's Drugs [ ] Relative / Carer [ ] Referrer Kardex [ ] Referrer Letter [ ] GP Practice [ ] Comm Pharmacy [ ] TRAK [ ] Other - Specify _____

Actions: C: Continue W: Withhold S: Stop

Acute Medication (including those greater than 30 days)

Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Source 1*	Source 2*	Source 3*	Action C	Action W	Action S	Comments
Venlafaxine 150mg modified-release tablets	14 tablet	WEEK SEVEN ONWARDS: 1 CAPSULE ONCE DAILY		31/08/2022	31/08/2022	1						NOT
Venlafaxine 37.5mg modified-release capsules	28 capsule	WEEK ONE AND TWO AND WEEKS FIVE AND SIX: TAKE ONE CAPSULE EACH MORNING		31/08/2022	31/08/2022	1						
Venlafaxine 75mg modified-release tablets	28 tablet	WEEK THREE TO SIX: 1 CAPSULE ONCE DAILY		31/08/2022	31/08/2022	1						

Repeat Medication

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Source 1*	Source 2*	Source 3*	Action C	Action W	Action S	Comments
GP practice	Omeprazole 20mg gastro-resistant capsules	56 capsule	1 CAPSULE DAILY AS NEEDED		15/09/2017	03/09/2020		1						NOT

no req

Patient Name	CHI	Date of Birth	Age	GP	GP Practice	GP Practice Code
TAYLOR RICHARD	1006831372	10/06/1963	59	HENDRIE, RACHEL	Sighhill Green Medical Practice	70911

Repeat Medication

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Source 1*	Source 2*	Source 3*	Action C	Action W	Action S	Comments

Compliance Device	Name and telephone number for community pharmacy

Constructed by	Designation	Grade	Date	Time	Contact Number
RD	Pharmacy Tech		29/12/22		
Reviewed by	**Designation**	**Grade**	**Date**	**Time**	**Contact Number**

Paracet 1g QDS
Ceftriaxone 2g IV OD
Aciclovir 750mg TDS IV

Patient Name	CHI	Date of Birth	Age	GP	GP Practice	GP Practice Code
TAYLOR RICHARD	1006631372	10/06/1963	59	HENDRIE, RACHEL	Sighhill Green Medical Practice	70911

Key Information Summary

(Excision of selected information - additional information may be available in the full KIS report)

Is there a DNACPR Form in Place?

Is there a CYPADM Form in Place? No

Medical History

Date Recorded	Diagnosis
03/06/1963	[X]Intentional self-harm
10/06/1963	[X]Int self hang/strang/suffoc
20/07/1973	Bell's (facial) palsy
21/11/1977	Post-concussion syndrome
18/09/1978	Personality disorders
02/05/1981	Head injury
31/07/1981	[X]Intentional self-harm
30/09/1981	Head injury
01/10/1981	[X]Intentional self-harm
24/11/1981	Head injury
05/02/1982	[X]Intentional self-harm
30/03/1982	Motor vehicle traffic accid NOS
30/05/1982	Inj face-cutting/stabbing
14/12/1982	[X]Overdose - deliberate
11/11/1986	[X]Intentional self-harm
27/04/1987	[X]Intentional self-harm
14/05/1987	Motor vehicle traffic accid NOS
28/06/1987	#Ankle
23/07/1987	[X]Overdose - deliberate
04/08/1987	[X]Overdose - deliberate
04/08/1987	[X]Intentional self-harm
06/08/1987	[X]Intentional self-harm
18/08/1987	[X]Depressive episode
01/09/1989	Removal int fixation dev NEC
02/04/1994	Fracture of radius NOS
05/07/1994	Removal int fixation dev NEC
02/01/1997	[X]Intentional self-harm
28/01/1997	Fusion of joint NEC
24/02/1997	[X]Intentional self-harm
26/05/1998	Viral illness
02/01/1999	[X]Intentional self-harm
27/09/2000	Motor vehicle traffic accid NOS
13/11/2004	Intracerebral haemorrhage
13/11/2004	Endotracheal intubation
11/08/2009	Nondependent cannabis abuse
26/11/2009	Renal impairment
09/09/2011	Stress at home
15/06/2017	Vasectomy NEC

Patient Name	CHI	Date of Birth	Age	GP	GP Practice	GP Practice Code
TAYLOR RICHARD	1006631372	10/06/1963	59	HENDRIE, RACHEL	Sighhill Green Medical Practice	70911

Anticipatory Care Plan

No data recorded

NHS Lothian

ED/Medical Assessment Unit
Care Rounding

Name: 610119466W /E5237225 M
TAYLOR Richard
DOB: 10-Jun-63 CHI: 100 663 1372
70911 R Hendrie
42 Morvenside
Hosp: EH14 2SJ

Care Rounding Frequency	1 2 3 (4) hourly *Circle as appropriate* *Review frequency 12 hourly or if clinical condition requires*								
Print Name of the Nurse Reviewing	[illegible]			Date			29 / 12 / 22		
Time of Round	0915								
Clinical Area	AE								
Care Round Leader's Initials	[illegible]								
Review Frequency of Vital Signs & Cardiac Monitoring									
Vital Signs Frequency (please sign) *signature*	4°								
Cardiac Monitoring required?	YO NO	YO NO	YO NO	YO NO	YO NO	YO NO	YO NO	YO NO	YO NO
Pain Management (refer to doctor if analgesia is required)									
Pain score (0 – 10)	0								
Analgesia provided.	YO NO	YO NO	YO NO	YO NO	YO NO	YO NO	YO NO	YO NO	YO NO
Medication									
Is person due any routine medication?	YO NO	YO NO	YO NO	YO NO	YO NO	YO NO	YO NO	YO NO	YO NO
Mobility									
Fully weight bearing	☑	☐	☐	☐	☐	☐	☐	☐	☐
Requires some assistance/uses walking aid	☐	☐	☐	☐	☐	☐	☐	☐	☐
Non weight bearing – needs full assistance	☐	☐	☐	☐	☐	☐	☐	☐	☐
Identified as at risk of falls	☐	☐	☐	☐	☐	☐	☐	☐	☐
Elimination									
Ask patient if they require the toilet	☑	☐	☐	☐	☐	☐	☐	☐	☐
Patient is self-caring and can walk to toilet	☐	☐	☐	☐	☐	☐	☐	☐	☐
Patient is incontinent and requires assistance	☐	☐	☐	☐	☐	☐	☐	☐	☐
Patient has catheter in situ – checks required	☐	☐	☐	☐	☐	☐	☐	☐	☐

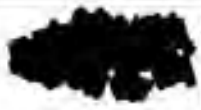
NHS Lothian

Nutrition and Hydration									
Patient is self-caring	☐	☐	☐	☐	☐	☐	☐	☐	☐
Patient needs assistance with food/drink	☐	☐	☐	☐	☐	☐	☐	☐	☐
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☐	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☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐
Snack	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐
Catered meal	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐
Visual Skin Inspection									
Skin 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☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
Is pressure relieving equipment/mattress required?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	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	Y☐ N☐								
Urinary catheter	☐	☐	☐	☐	☐	☐	☐	☐	☐
Catheter insertion bundle completed	Y☐ N☐								
Infusion device	☐	☐	☐	☐	☐	☐	☐	☐	☐
NG tube / PEG tube / Tracheotomy	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐	☐
Vulnerable Person/cognitive impairment	Is a 4AT required Y☐ N☐								
Family Communication	Patient & 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/ED Escort's signature:			Date:		/ /		

Bristol Stool Chart

Name 610119466W /E5237225 M
TAYLOR Richard
DOB 10-Jun-63 CHI: 100 663 1372
Unit No. 70911 R Hendrie
42 Morvenside
EH14 2SJ

NHS Lothian

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 easily)	Type 6  Fluffy pieces with ragged edges, a mushy stool
Type 7  Watery, no solid pieces. **Entirely Liquid**	Reproduced by kind permission of Dr KW Heaton, Reader in Medicine at the University of Bristol

Date	Time	Colour	Type	Amount	Blood	Mucous	Comments	Initials
29/12	BNO						n/shift	OM
30/12		0930	NBO					IL

PRESCRIPTION AND ADMINISTRATION RECORD

Standard Chart

NHS Lothian

Hospital/Ward:	Consultant: M.C
Weight:	Height:
If re-written, date:	
DISCHARGE PRESCRIPTION	
Date completed:	Completed by:

Name of Patient: RICHARD TAYLOR

CHI Number: 1006631372

D.O.B.

(Attach printed label here)

OTHER MEDICINE CHARTS IN USE		PREVIOUS ADVERSE REACTIONS This section must be completed before any medicine is given		Completed by (sign & print)	Date
Date	Type of Chart	None known ☐			
		Medicine / Agent	Description of reaction		

- 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'

ONCE ONLY

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber - Sign + Print	Time Given -	Given By

REGULAR THERAPY

Name of Patient:

CHI Number:

D.O.B.

(Attach printed label here)

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

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

PRESCRIPTION

Patient's Own Medicine

Date → 29/12

Time ↓

Medicine (Approved Name): CEFTRIAXONE

Dose: 2g | Route: IV | For Use / Date | Quantity

Notes/Indication for antibiotic | Start Date: 29/12 | Stop Date

Prescriber - sign + print: R.M.C | Pharmacy

Time																			
6																			
8																			
(12)																			
14																			
18																			
22																			

Medicine (Approved Name): ACICLOVIR

Dose: 750mg | Route: IV | For Use / Date | Quantity

Notes/Indication for antibiotic: ? encephalitis | Start Date: 29.12.22 | Stop Date

Prescriber - sign + print | Pharmacy

Time																			
6																			
(8)		X																	
(12)		X																	
14																			
(18)		/																	
22																			

Medicine (Approved Name): PARACETAMOL

Dose: 1g | Route: oral | For Use / Date | Quantity

Notes/Indication for antibiotic | Start Date: 29.12.22 | Stop Date

Prescriber - sign + print: R. Cameron | Pharmacy

Time																			
6																			
(8)																			
(12)																			
14																			
(18)																			
22		X																	

Medicine (Approved Name):

Dose | Route | For Use / Date | Quantity

Notes/Indication for antibiotic | Start Date | Stop Date

Prescriber - sign + print | Pharmacy

Time																			
6																			
8																			
12																			
14																			
18																			
22																			

AS REQUIRED THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine												
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											

REGULAR THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine	Date → / Time ↓																	
Medicine (Approved Name)		For Use / Date	6																	
Dose	Route	Quantity	8																	
			12																	
Notes/Indication for antibiotic	Start Date	Stop Date	14																	
Prescriber - sign + print		Pharmacy	18																	
			22																	
Medicine (Approved Name)		For Use / Date	6																	
Dose	Route	Quantity	8																	
			12																	
Notes/Indication for antibiotic	Start Date	Stop Date	14																	
Prescriber - sign + print		Pharmacy	18																	
			22																	
Medicine (Approved Name)		For Use / Date	6																	
Dose	Route	Quantity	8																	
			12																	
Notes/Indication for antibiotic	Start Date	Stop Date	14																	
Prescriber - sign + print		Pharmacy	18																	
			22																	
Medicine (Approved Name)		For Use / Date	6																	
Dose	Route	Quantity	8																	
			12																	
Notes/Indication for antibiotic	Start Date	Stop Date	14																	
Prescriber - sign + print		Pharmacy	18																	
			22																	
Medicine (Approved Name)		For Use / Date	6																	
Dose	Route	Quantity	8																	
			12																	
Notes/Indication for antibiotic	Start Date	Stop Date	14																	
Prescriber - sign + print		Pharmacy	18																	
			22																	
Medicine (Approved Name)		For Use / Date	6																	
Dose	Route	Quantity	8																	
			12																	
Notes/Indication for antibiotic	Start Date	Stop Date	14																	
Prescriber - sign + print		Pharmacy	18																	
			22																	

TURN OVER →

GE Healthcare

Taylor, Richard
Male
10.06.1963 (59 Years)

Vent. rate	61	BPM
PR interval	138	ms
QRS duration	84	ms
QT/QTc-Baz	384/386	ms
P-R-T axes	29 23 19	

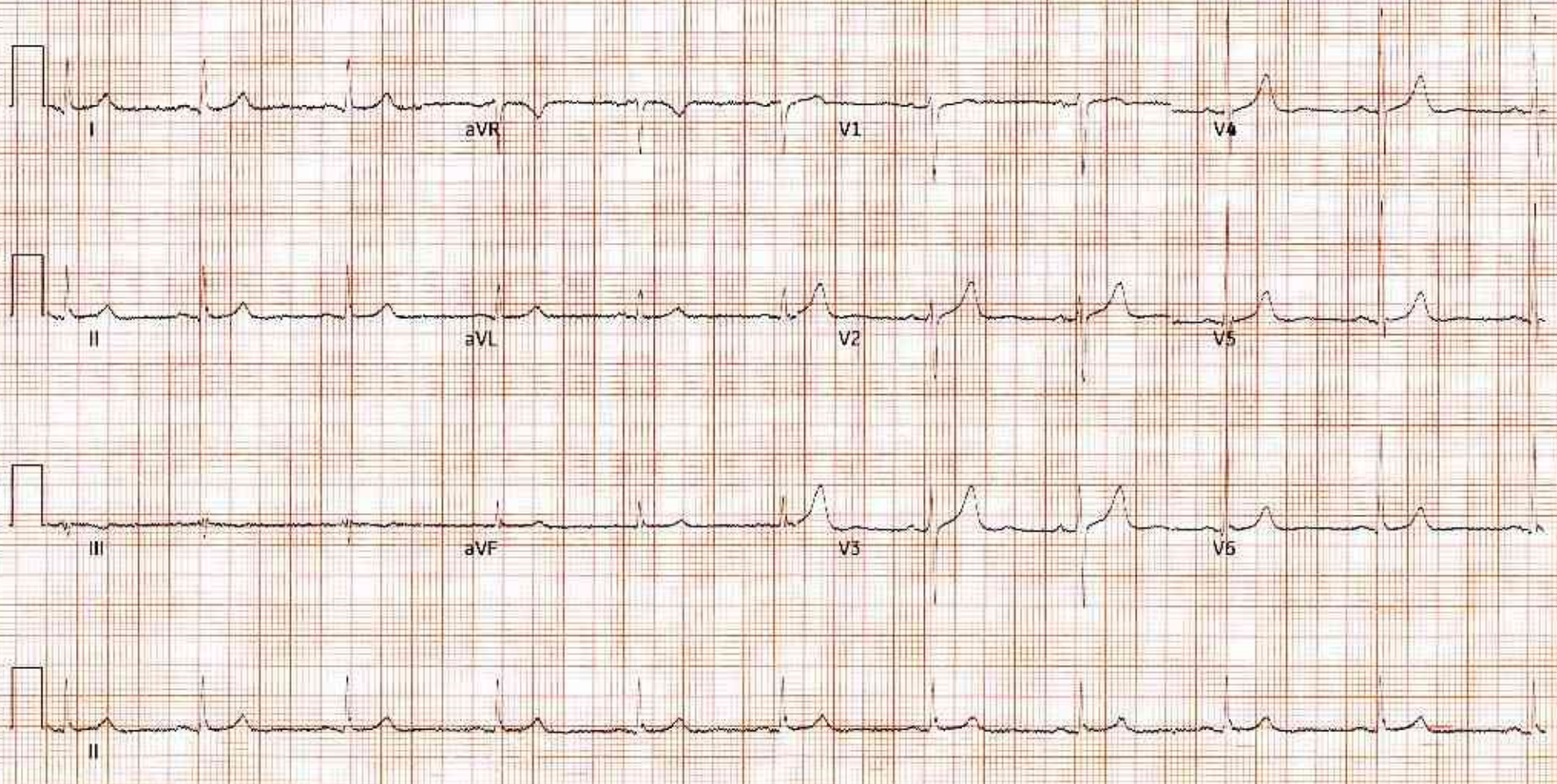
Patient ID: 10061963

Normal sinus rhythm
Normal ECG

28.12.2022 15:49:17
St John's Hospital

Location:
Comments:

Unconfirmed



25mm/s 10.0mm/mV 0.56-100 Hz ZPD 50 Hz MAC* VU360 1.02 SP01 12SL v23.1 2.5s + 1 rhythm ld

GE Healthcare

Taylor, Richard

Patient ID: 0000000000

28.12.2022 17:27:14

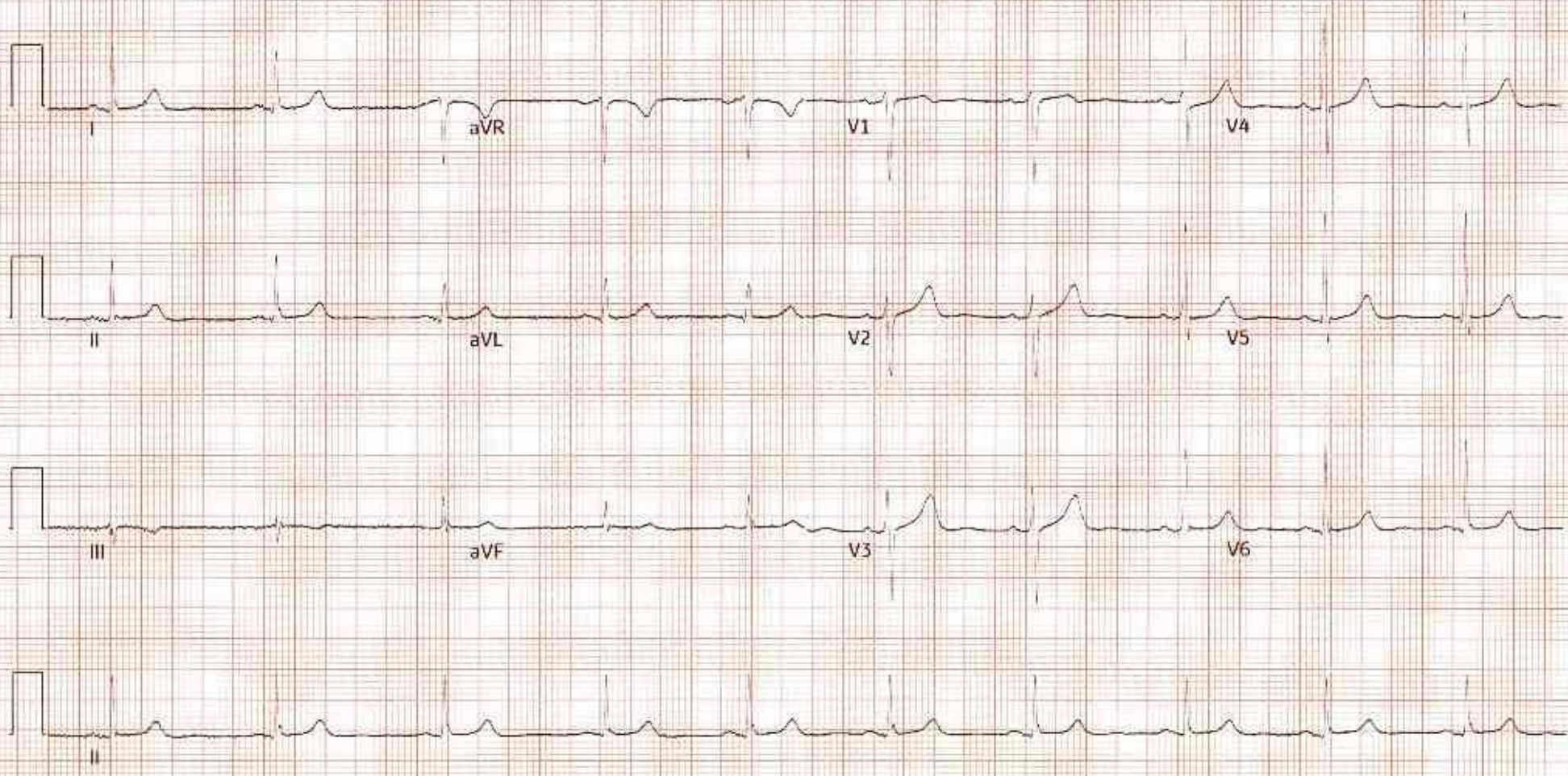
St John's Hospital

Vent. rate	60
PR interval	138
QRS duration	86
QT/QTc-Baz	410/410 ms
P-R-T axes	41 21 20

Normal sinus rhythm
Normal ECG

Location:
Comments:

Unconfirmed



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

GE Healthcare
REF 2104772-001
PRINTED IN UK

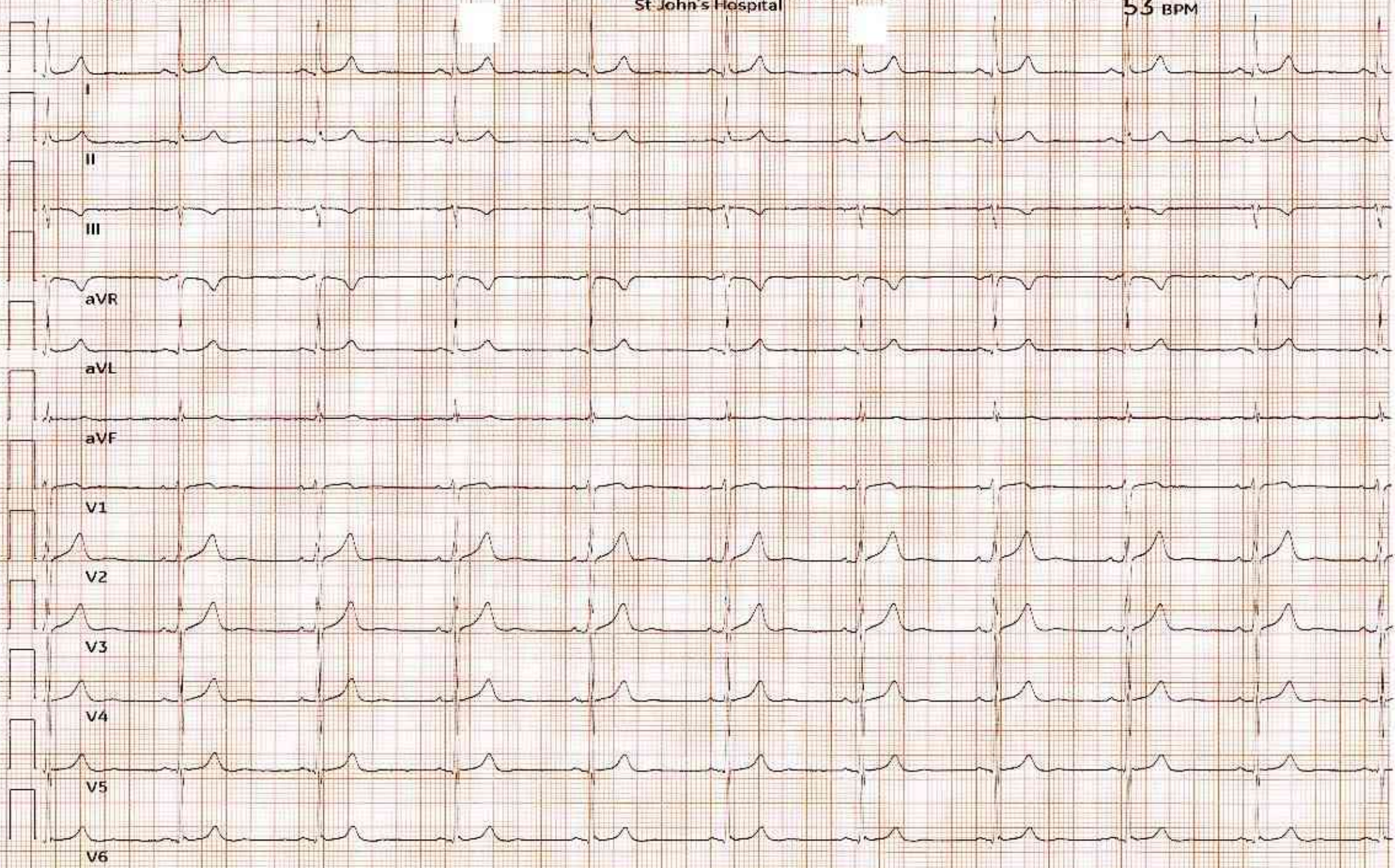
Taylor, Richard

Patient ID: 0000000000

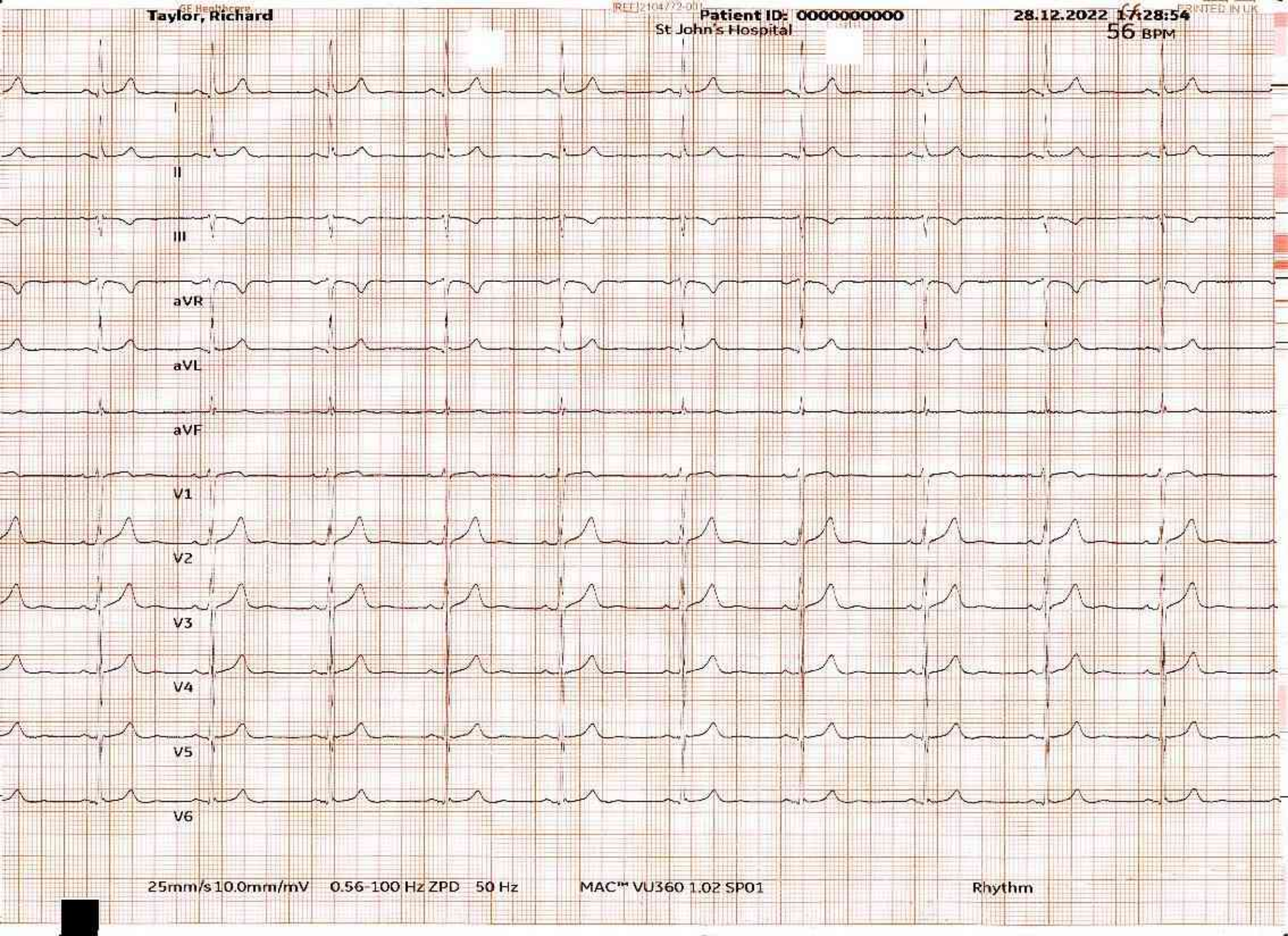
St John's Hospital

28.12.2022 17:28:41

53 BPM



25mm/s 10.0mm/mV 0.56-100 Hz ZPD 50 Hz MAC™ VU360 1.02 SP01 Rhythm


Taylor, Richard
Patient ID: 0000000000
St John's Hospital
28.12.2022 17:28:54
56 BPM
I
II
III
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6
25mm/s 10.0mm/mV 0.56-100 Hz ZPD 50 Hz
MAC™ VU360 1.02 SP01
Rhythm

NHS Lothian

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

General Medicine

Dr Leslie
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date: 26/06/2024

Inpatient Discharge Summary

Patient	Richard Taylor 42 Morvenside Edinburgh EH14 2SJ	**CHI** **Date of Birth / Age** **UHPI**	**1006631372** 10/06/1963 (61 years) 610119466W
Ward	AMU Bay 8	**Admission Date**	24/06/2024
Consultant	Dr James W Dear	**Discharge Date**	25/06/2024

Dear Dr Leslie

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

Discharge Drugs:

Lamotrigine 25mg tablets			
Dose	Route	Frequency	To Continue
25 mg	Oral	Once daily at 0700 for 14 day(s)	Yes
Notes:			

RIE ACUTE MEDICINE DISCHARGE LETTER

For patients who have had less than 4 medication changes during their admission: ONLY new medicines, or those that have been changed during this admission are prescribed in this IDL.
All other medicines should be continued as before.

Medicines reconciled against ECS/other sources? Yes

CHANGES TO DRUGS SINCE ADMISSION (relative to ECS)

Stopped: Nil
Started:
Week 1&2: Lamotrigine, 25mg once daily

Week 3&4: Lamotrigine, 25mg twice daily
Week 5&6: Lamotrigine, 50mg twice daily
Week 7&8: Lamotrigine, 75mg twice daily
Week 9&10: Lamotrigine, 100mg twice daily
Week 11 onwards: Lamotrigine, 125mg twice daily
Changed: Nil
Withheld: Nil

ALLERGIES / ADVERSE DRUG REACTIONS:Codeine

PHARMACIST CHECK: Name: Date: Time:

NURSING CHECK:
Patients own medication / controlled drugs returned to patient YES / NO / NA

Signature.....
Patients own medication / controlled drugs removed with consent YES / NO / NA

Signature.....

Due to diagnosis of Epilepsy, the DVLA must be informed by yourself immediately.

1. What is my diagnosis?
You have been diagnosed with epilepsy. This is a condition that affects the brain and causes seizures. Seizures are when there is a change in the electrical activity of the brain that can cause a range of symptoms such as losing awareness, uncontrollable shaking and jerking, suddenly becoming stiff and collapsing.

The Neurology team advised that you start an anti-seizure medication called Lamotrigine. An adjustment plan has been arranged and is at the top of this letter. Some of the side effects of Lamotrigine include insomnia, and skin reaction and requires careful dose titration. Any changes to skin should be reported to GP/NHS24 urgently.

Furthermore, you have been advised that you must inform the DVLA of your diagnosis of epilepsy and in general, seizures need to be under control for minimum of 1 year.

The Neurology team have also discussed with you the risk of fatal accidents with patients with epilepsy. These might occur being in deep water such as baths or swimming pools or at elevation such as working on rooftops. We would advise caution in such circumstances and be cautious with heavy machinery.

Our Neurology team will write with further information and refer you to our Epilepsy Specialist Nurses.

Please note that the first 2 weeks of Lamotrigine has been prescribed and the schedule is added to this letter.

2. What tests have I had and what were the results from these tests?
- CT scan Head - No acute intracranial findings.
- CT Scan Spine - No acute cervical spine injury.
- Chest X-Ray Normal.

3. Do I need to see my GP after discharge? If so, why and when?
Yes, please see your GP for your prescription changes for Lamotrigine within 2 weeks. Unless skin changes caused

by Lamotrigine.

DIAGNOSIS:
Epilepsy

Mr Taylor was admitted to RIE on 25/06/24 following a seizure. Sudden onset of loss of consciousness, unwitnessed.

Amnesiatic over event and reports confusion afterwards. Facial and scalp lacerations noted. No tongue biting but has bit lower lip. Biochemistry compatible with seizure.

Lamotrigine titration schedule planned by Neurology team as documented. Explained the need to inform DVLA of diagnosis.

ACTION REQUIRED IN COMMUITY:
GP to please arrange Lamotrigine prescriptions with titration plan noted above. The first two weeks have been prescribed and provided. Many thanks.

HOSPITAL FOLLOW-UP ARRANGED:
Follow-Up with Dr Urwin, Neurology Department.

CHANGES MADE TO CARE ARRANGEMENTS/ TREATMENT ESCALATION PLAN: Nil

---

OUTSTANDING RESULTS / INVESTIGATIONS: Nil

PLEASE CC THIS LETTER TO:
Dr Urwin, Consultant Neurologist, Neurology, DCN, 50 Little France Crescent, Edinburgh Bioquarter, EH16 4TJ

Sent 26/06/24

Yours sincerely,

Ben Rankine
Trainee ANP
Acute and General Medicine, Royal Infirmary of Edinburgh

Addition by Mahnoor Shah, FY1 Acute and General Medicine, Royal Infirmary of Edinburgh.

FINAL DISCHARGE LETTER
Authorising consultant: Date:

For further information contact:
Acute and General Medicine Secretaries
Phone: 0131 242 1440

E-mail: RIEacutemedicine@nhslothian.scot.nhs.uk

NHS Lothian
University Hospital Services

Department of Emergency Medicine

Dr. Dave McKean EO Clinical Director
Ray Middlemiss EO Clinical Nurse Manager
The Royal Infirmary of Edinburgh
51 Little France Crescent, Edinburgh, EH16 4SA
Tel: 0131 242 1300 Fax: 0131 242 1344

NHS Lothian

A/E no. E5731989
Previous no. E5712000
UHPI no. 610119466W
CHI no. 1006631372

Patient Information

Surname	Taylor	Date of Birth	
Forenames	Richard	Age / Sex	10/06/1963 61 Yrs M
Address	42 Morvenside		
Postcode	EH14 2SJ	Telephone	
Contact Address	Taylor, Arrices	Telephone H / W	
Complaint	head injury	Allergies	

Attendances in last 12 months: 4 School :

General Practitioner

Address: PC Leslie
Sighthill Green Medical Practi
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU
Telephone: 0131 202 5888

Date and Time of Attendance: 24/06/2024 05:02
Incident Date Time:
Mode of Arrival: 24/06/2024
Emergency Ambulance
Source of Referral: 999 Emergency

Initial Triage Assessment

610119466W M 10/06/1963
Taylor, Richard
42 Morvenside,
Edinburgh,
EH14 2SJ

CHI 1006631372
70911 PC Leslie

Presenting Complaint	
History of Presenting Complaint	
Assessment	

Nursing Observations & Assessments

TEMP	°C	SCORE	MIN. FREQ	(please tick)	Blood Sugar	mmols	Pain Score	/ 10	
HR		NEWS 0-1	Hourly		Peak Flow 1)		Analgesia Given	YES ☐	NO ☐
BP	/	NEWS 2-4	30mins Min		Peak Flow 2)		Fast Assessment	POS ☐	NEG ☐
SPO2%	%	NEWS 5-7	15mins Min		Peak Flow 3)		Onset Time:		
RR		NEWS >7	10mins Min		Alcometer		Weight	Height	
°U		Special Clinical Instructions							
O2 Therapy In Progress	Yes (= +2) No (= 0)	Please indicate any specific clinical observations to be continued or repeated once patient has left OPP							
NEWS SCORE									

Triaged By: Print Name: Signature: Triage Time:

Opp Care & Discharge Record

PVC Insertion - Please initial when complete

Handwash		Gloves	
CHD Skin Prep		Aseptic Insertion	
Dressing Labelled		Paperlite Bundle	
Reason for PVC Insertion:			

Blood Samples - Please tick all that apply

Routine		CRP	
Troponin		Coag	
Amylase		Tox Screen	
BTS		Other (Please state)	

Additional Investigations

ECG - Please tick
Required ☐ Done ☐

Urinalysis - Please tick
Required ☐ Done ☐

MSU Sent Yes ☐ No ☐
HCG Consent Yes ☐ No ☐
HCG Result Yes ☐ No ☐

X-Rays - Please tick

CRX	Yes ☐	No ☐	
CT Scan	Yes ☐	No ☐	
Other (Please state)			

On Going Care Plan

Speciality Informed (enter time)		Bed Required		Triaged To - Please tick			
Surg:	G.I:	Yes ☐	No ☐	Waiting Room		GP Out of Hours	
Vasc:	Stroke:	Transfer To: (Please tick if required)		Resus		Gynae Triage	
Medics:	Gynae:	WGH		HD		SMMP	
Ortho:	Neuro:	SJH		IC		MIU	
Other (state Speciality)		Other (please state)		Exam		Other (Please state)	

"What Happens To The Patient?"

Clinical Notes

Think:- Other Sources of Information:

Family ☐ Carers ☐ SAS ☐ PRF ☐ EPR ☐ ECS ☐ KIS ☐ GP ☐ Patient Alerts ☐

Care Providers Name: _____ Signature: _____

NHS Lothian

610119466W /E5731989 M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
70911 PC Leslie
42 Morvenside
EH14 2SJ

PATIENT PROGRESS NOTES /COMMUNICATION SHEET

Ward/Clinical Area:

State Action/s taken After Exception Reporting
Each entry should be dated & timed

Date & Time	Progress notes / Problems Action Taken & Investigations Required	Signature (Print name & designation)
09.00	Patient in POD A, AIW to be seen	P
24/06/24	Nursing patient in pod A at present NEWS 0 as charted pain score 8 - analgesia provided Await CT results.	
11.05	news as charted - R	P Flannery Staff Nurse
13.10	NEWS IS 1, Pain score 8, Pulse 101 escalated to RN Amy	AD CSW
1520	Under care of pod O. AMU bed allocated treatment administered as prescribed. States pain 8/10, however sleeping well between interventions. NEWS 0 - BP 116/74, HR 77.	

Authorised: Dec 2022
Review: Dec 2025

Ward: AM4 & Site: Date: 25/6/24

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

610119466W M 10/06/1963
Name **Taylor, Richard**
42 Morvenside,
DOB Edinburgh,
EH14 2SJ

Unit n CHI 1006631372
70911 PC Leslie

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	1044	12										
	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	N/S	N/S										
	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										
	Positioning (R) or (L) side (B) Back (C) Chair	L	Y										
	Mattress type / Cushion type	*please state type:*											
Elimination	Do you need the toilet?	I	I										
	Is the patient continent of urine? (at time of Care Rounding)	Y	Y										
	Continence product changed/offered?	N	N										
	Catheter care performed?	ND											
	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										
	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										
	Fluid Balance Chart (if clinically indicated)	N	N										
	When did you last eat?	B	L										
	(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										
Falls	Appropriate Footwear?	Y	Y										
	Walking aid available(and within reach)	Y	Y										
	Area de-cluttered?	Y	Y										
	Chair and bed height assessed?	Y	Y										
	Falls alarm in use and attached?	N	N										
	Glasses available for use? (if worn) Hearing aid available for use? (if worn)	Y	Y										
	Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐												
Pain	Are you in pain?	Y	Y										
	Analgesia Given?	N	N										
General	Peripheral Venous Cannula observed?	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										
	Anything else I can do for you?	N	N										
	Buzzer within easy reach	Y	Y										

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

Initials – document at time of care delivery													

Ward:	Site:	Date:	Addressograph, or Name DOB Unit no. / CHI

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 _____

NHS Lothian

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

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	If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan												
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	Positioning (R) or (L) side (B) Back (C) Chair												
	Mattress type / Cushion type	*please state type:*											
Elimination	Do you need the toilet?												
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	Continence product changed/offered?												
	Catheter care performed?												
	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)												
	Bowel function monitored	Observe bowel function and update daily											
Food, Fluid & Nutrition	Would you like a drink? Ensure fluids are within easy reach												
	Fluid Balance Chart (if clinically indicated)												
	When did you last eat?												
	(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)												
Falls	Appropriate Footwear?												
	Walking aid available(and within reach)												
	Area de-cluttered?												
	Chair and bed height assessed?												
	Falls alarm in use and attached?												
	Glasses available for use? (if worn) Hearing aid available for use? (if worn)												
	Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐												
Pain	Are you in pain?												
	Analgesia Given?												
General	Peripheral Venous Cannula observed?												
	Observe for signs of inflammation/swelling at every CR session. **Bundle/VIP score to be updated daily**												
	Are you comfortable? Y/N												
	Anything else I can do for you?												
	Buzzer within easy reach												

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

Initials – document at time of care delivery													

PRESCRIPTION AND ADMINISTRATION RECORD

including the Warfarin Chart

NHS Lothian

Hospital/Ward:	Consultant:
Weight:	Height:
If re-written, date:	
DISCHARGE PRESCRIPTION	
Date completed:	Completed by:

610119466W /E5731989 M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
70911 PC Leslie
42 Morvenside
EH14 2SJ

OTHER MEDICINE CHARTS IN USE		PREVIOUS ADVERSE REACTIONS This section must be completed before any medicine is given		Completed by (sign & print)	Date
Date	Type of Chart	None known *(tick box)* ☐			
		Medicine / Agent / Food / Other	Description of reaction		
			CODEINE		

Risk assessment for Venous Thromboembolism (VTE) has been completed ☐

Outcome: No action required ☐ TEDS ☐ LMWH/heparin (please prescribe) ☐

- **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'

ONCE ONLY

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber - Sign + Print	Time Given	Given By
2006	1415	OMEPRAZOLE	20mg	ORAL		1455	

REGULAR THERAPY

610119466W /E5731989 M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
70911 PC Leslie
42 Morvenside
EH14 2SJ

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

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

PRESCRIPTION

Patient's Own Medicine

Date → / Time ↓

Medicine (Approved Name): OMEPRAZOLE
For Use / Date
Dose: 20 mg
Route: ORAL
Quantity
Notes/Indication for antibiotic:
Start Date: 24.06.24
Stop Date
Prescriber - sign + print:
Pharmacy

Medicine (Approved Name): NAPROXEN 500 mg
For Use / Date
Dose: x 1
Route: PEG
Quantity
Notes/Indication for antibiotic: ON FOR 12 HOURS OFF FOR 12 HOURS
Start Date: 24.06.24
Stop Date
Prescriber - sign + print:
Pharmacy

Medicine (Approved Name): PARACETAMOL
For Use / Date
Dose: 1g
Route: ORAL
Quantity
Notes/Indication for antibiotic:
Start Date: 24.06.24
Stop Date
Prescriber - sign + print:
Pharmacy

Medicine (Approved Name):
For Use / Date
Dose:
Route:
Quantity
Notes/Indication for antibiotic:
Start Date:
Stop Date
Prescriber - sign + print:
Pharmacy

Time	Date: 24.06.24																			
6																				
8	X																			
12																				
14																				
18																				
22																				
6																				
8																				
12																				
14																				
18																				
22																				
6																				
8	X																			
12	X																			
14																				
18																				
22																				
6																				
8																				
12																				
14																				
18																				
22																				

REGULAR THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine	Date → / Time ↓															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															

TURN OVER →

AS REQUIRED THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine												
Medicine (Approved Name) DIHYDROCODEINE		For Use	Date	24/6										
			Time	1455										
Dose + frequency + max 30-60 mg	Route ORAL	Quantity	Dose	60mg										
			Initials											
Indication + notes up to 240mg a day	Start Date 24/06/24	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											
Medicine (Approved Name)		For Use	Date											
			Time											
Dose + frequency + max	Route	Quantity	Dose											
			Initials											
Indication + notes	Start Date	Date	Date											
			Time											
Prescriber - sign + print		Pharmacy	Dose											
			Initials											

REGULAR THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine	Date → / Time ↓															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
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Prescriber - sign + print		Pharmacy	18															
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Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
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Prescriber - sign + print		Pharmacy	18															
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Medicine (Approved Name)		For Use / Date	6															
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Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

WARFARIN CHART

Recommended target INRs and indications:

- INR 2-2.5 for prophylaxis of DVT including surgery on high risk patients.
- INR 2.5 for treatment of DVT and PE (or for recurrence in patients no longer receiving warfarin), AF, cardioversion, dilated cardiomyopathy, mural thrombus following MI, and for rheumatic mitral valve disease.
- INR 3.5 for recurrent DVT and PE (in patients currently receiving warfarin) and mechanical prosthetic heart valves.

Indication	Target INR	Duration of treatment	Signature	Date

Yellow anticoagulant booklet completed and issued:

Signature Date

Date	INR	Warfarin Dose	Prescriber - sign + print	Administered by

National Early Warning Score 2 (NEWS2) Chart

NEWS Key 0 1 2 3		Date:	24/6						
		Time:	05:15	09:30	09:30	11:00	15:15	15:20	
A+B Respirations Breaths/min	≥25								3
	21-24								2
	18-20		20						
	15-17			18	18	16	16	15	
	12-14								
	9-11								1
	≤8								3
A+B SpO₂ Scale 1 Oxygen saturation (%) Use Scale 1 if target range is 94-98%	≥96		98		96	96	100	97	
	94-95			95					1
	92-93								2
	≤91								3
SpO₂ Scale 2* Oxygen saturation (%) Use Scale 2 if target range is 88-92% eg. in hypercapnic respiratory failure	≥97 on O₂								3
	95-96 on O₂								2
	93-94 on O₂								1
	≥93 on air								
* ONLY use Scale 2 under the direction of a qualified clinician	88-92								
	86-87								1
Tick box if using SpO₂ Scale 2 ☐	84-85								2
Sign	≤83								3
Air or Oxygen? Oxygen is a drug and prescribed by target range	A = Air		A		A	B	A	A	
	O² L/min or %								2
	Device								
C Blood Pressure mmHg Score uses Systolic BP only If manual BP mark as M	≥220								3
	201-219								
	181-200								
	161-180		141						
	141-160								
	121-140				A3		128		
	111-120			115	114			116	
	101-110							A	1
	91-100								2
	81-90		89	81	72				
	71-80					72	78		
	61-70								3
	51-60								
	≤50								
C Pulse Beats/min Manual pulse	≥131								3
	121-130								2
	111-120		116				105		
	101-110								1
	91-100								
	81-90			86	79	78		A	
	71-80								
	61-70								
	51-60								
	41-50								1
	31-40								3
	≤30								
D Consciousness Score for new onset of confusion (no score if chronic)	Alert		A	A	A	A	A	A	
	New Confusion								
	V								3
	P								
	U								
E Temperature °c	≥39.1°								2
	38.1-39.0°			38.1					1
	37.1-38.0°		37.7		37.1				
	36.1-37.0°					36.9		36.7	
	35.1-36.0°								1
	≤35.0°								3
NEWS TOTAL			2	2	0	0	1	0	
Monitoring frequency			1		1	2	1	1	
Escalation of care Y/N			N		N	Y	N	N	
Blood Glucose reading or N/A									
Pain score (0-10)									
Initials				LS	RF	RF	AB		

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.**

Signs of Infection

- Temperature <36°c or >38°c
- Heart rate >90 beats pm
- Respiratory rate >20 breaths pm
- New confusion
- WCC <4 or >12
- Bl... betic

610119466W /E5731989 M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
70911 PC Leslie
42 Morvenside
EH14 2SJ

610119466W /E5731989 M
TAYLOR Richard
63 CHI: 10... 3 127...
...slie

NEWS Total	Monitorin	Clinical Response
Total 0	Commence on 2 ho	a Co-ordinator if score increases to 5 or more
Total 1 - 4	Commence on 1 ho... ...vations	...rt to Area Co-ordinator if score increases to 5 or more
3 in one parameter *	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to Nurse In Charge (NIC) and Senior Medic
Total 5 - 6	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Total 7 or more	Commence on 15 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Special Instructions		

*or increase in NEWS score of 2

Conscious Level Chart to be completed when clinically indicated

| | | | | | | | | |

IV I Prescription

Time Prescribed	Fluid	Volume	Rate	Prescribers Signature	Time Started	Given by (Initials)	Checked by (Initials)	Time Finished

Fluid Balance

INPUT						OUTPUT				
	IV Fluids or SC Fluids IV Medication	IV Line(s)	Oral Input		Input		Urine		Gastric	
Time	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100ml	Running Total	Time	Volume	Running Total	Volume	Running Total

Drug Infusion

Drug Name:

	Time												
	Rate (ml/hr)												
	Volume in Syringe												
Pump No	Total amount Infused												

Drug Name:

	Time												
	Rate (ml/hr)												
	Volume in Syringe												
Pump No	Total amount Infused												

NHS LOTHIAN
Emergency Department
Adult Majors
Prescription, Administration & Observation Record

NHS Lothian

Addressograph
610119466W /E5731989 M
TAYLOR Richard
10-Jun-63 CHI: 100 663 1372
70911 PC Leslie
42 Morvenside
EH14 2SJ

The section below must be completed before any medicine is prescribed/given

Previous Adverse Reactions	Weight kgs Actual / Estimate	Date
codeine		24/6/24.

Once Only Prescription

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber Sign & Print	Time Given	Issued by (Initials)	Checked by if applicable (Initials)
24/6	5[50]	oramorph	5mg	PO		0553	AY	
24/6	7[45]	oramorph	5mg	PO		0805	RF	
24/06 24	0830	~~PARACETAMOL~~						
24/06 24	0830							
24/06 24	1115	DIAZEPAM	5mg	ORAL		1120	RF	
24/06 24	1115	PARACETAMOL	1g	ORAL		1120	RF	
24/6/24	1320	~~CODE~~ CODEINE	60mg	oral			NOT GIVEN	

see kardex 1115 24/06/24

Discharge Medication

Date & Time	Medicine (Approved Name)	Dose	Frequency	Route	Quantity	Duration	Prescriber Sign & Print	Issued by (Initials)	Checked by (Initials)

Incident Number: 610119466W M 10/06/1963

Patient Information

RICHARD TAYLOR

Age/Gender: 61Y Old Male

Address: 42 MORVENSIDE EDINBURGH,EH14 2SJ

DOB: 10/06/1963

CHI: 1006631372

Ethnicity: White Scottish

Date:

Incident Nu

Incident Ty

Incident Lo

Taylor, Richard
42 Morvenside,
Edinburgh,
EH14 2SJ

CHI 1006631372

70911 PC Leslie

Scottish Ambulance Service

Presenting Complaint

HEAD INJURY FOLLOWING COLLAPSE

Additional Comments

999 call for 61 yom with a head injury following collapse at home. HxPc - pt returned home from playing darts with a friend at approx 22:00. Pt felt dizzy and nauseous, then vomited once. Pt then states he went to bed. Pt daughter has then found pt lying on bedroom floor at approx 23:00, bleeding from injury to top of skull and left cheekbone. Blood on radiator and floor (<50ml). Pt states he does not remember falling or collapse, daughter states he appears confused. O/a pt daughter let crew into property. Pt upstairs in bed, sleeping but alert once awake. Pt gcs 15 with palpable radial pulse. Pt unsure how he sustained injuries, unknown loc. Pt confirms recent diagnosis of t9 vertebrae #, now rx'd tramadol. Pt been struggling with pain 2/7, not arranged repeat rx of tramadol and ran out 2/7. Pt vomited while crew in attendance. Pt able to mobilise independently, walked downstairs with crew in attendance. O/e pt pyrexic and initial tachypnoea, pt appears distressed. Once pt is calm, rr returns to normal. Other obs within normal parameters for pt. Ecg nsr. Head to toe reveals approx 3cm laceration to pt head, not suitable for ooh wound care. Further 2cm laceration to left cheek bone, alongside significant bruising and swelling. Pt not c/o headache or blurred vision, still feels dizzy. Pupils pearl +ve. Pt not rx'd anticoagulants. Pt c/o chronic pain in thoracic spine. Pt partner on the phone states pt unable to have morphine without diazepam (?). Pt given oral paracetamol for analgesia. Pt confused but states he has ongoing issues with his memory. Pt daughter agrees, unknown cause. Pt urine darker than usual but not been drinking much fluids, also Pt states no smell or burning sensation when passing urine. Recent issues with constipation (following rx tramadol) but already prescribed laxative. Crew recommend hosp attendance for wound care, pt happy to attend. Pt walked down 2 flights of stairs and into ambulance. Pt stable on route to hosp, head injury ? Loc.

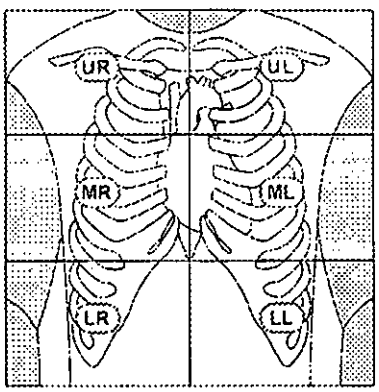
PATIENT ASSESSMENT

ACVPU Alert <C> No

A Clear

B Breathing Adequately: Yes | Respiratory Rate: 22 | SPO2: 100

Oxygen Given: No

Normal Percussion, Normal Breath Sounds, Normal Air Entry	UR		UL	Normal Percussion, Normal Breath Sounds, Normal Air Entry
Normal Percussion, Normal Breath Sounds, Normal Air Entry	MR		ML	Normal Percussion, Normal Breath Sounds, Normal Air Entry
Normal Percussion, Normal Breath Sounds, Normal Air Entry	LR		LL	Normal Percussion, Normal Breath Sounds, Normal Air Entry

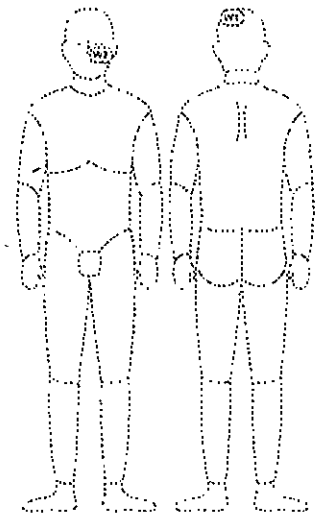
C

Pulse Rate	BP	Cap Refill	ECG Rhythm
101	136/94	<=2 Secs	Sinus Rhythm
Rhythm	**Arm**	**Central/Peripheral**	**ECG**
Reg	Right	Peripheral	3 Lead

D

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

E



Wounds

ID	Body Part	Wounds	Treatments
W1	Back Head	Laceration	Irrigation, Swabs
W2	Head	Laceration, Bruising, Swelling	None

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
03:48	92	18	141/89	100	<=2s	15	Alert				Sinus Rhythm				E9888190
03:03	101	22	136/94	100	<=2 Secs	15	Alert		38.2	8.8	Sinus Rhythm	4	4		E9888190

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
03:03	22 (2)	100 (0)		0	136 (0)	101 (1)	Alert (0)	38.2 (1)	4

Drugs

Time	Drug	Dosage	Units	Route	Drug Expiry Date	Pain Before	Pain After	CrewID
03:55	Paracetamol	1	g	OR	04/2028	10	10	E9888190

HISTORY

AMPLE

Allergies	None
Medication	Tramadol, Paracetamol, Omeprazole
Past Medical History	T9 VERTEBRAE #
Last Eaten	>4 Hours Ago

Social History

Lives alone	No	Living With	DAUGHTER	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 Environmental 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	23:32	Allocated	02:40	Mobile	02:45
First Resource On Scene		Crew On Scene	02:52	Crew Left Scene	04:34
Crew At Hosp		Receiving Hospital	NEW EDINBURGH ROYAL INFIRMARY	Clear Time	

Crew ID	Crew Grade	Driver
E9888190	Paramedic	YES

TAYLOR, RICHARD ID:1006631372 24-Jun-2024 05:23:30 NHS LOTHIAN-RIE_ED ROUTINE RECORD

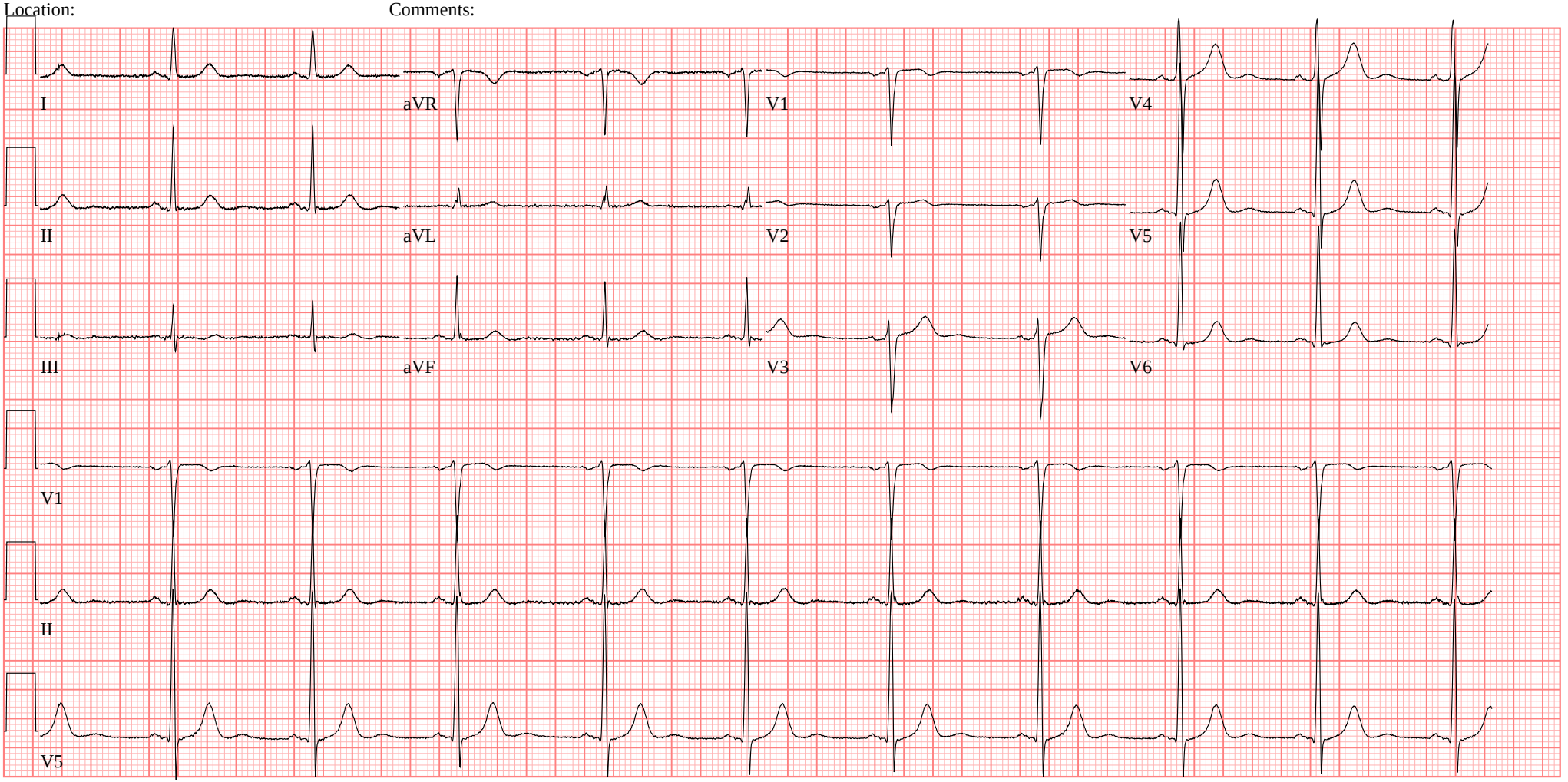
10-Jun-1963 (61 yr)
Male Unknown

Room:
Loc:40

Vent. rate	61	BPM
PR interval	122	ms
QRS duration	90	ms
QT/QTcB	394/396	ms
P-R-T axes	56 51	38

Technician:
Test ind:

Location: Comments:



25mm/s 10mm/mV 150Hz 10.1.3 12SL 243 CID: 38524

SID: 1008119 EID: 13 EDT: ORDER:

Clinical Notes

Patient & GP Information

UHPI Number	610119466W
CHI Number	1006631372
Episode Number	I0000337380
Surname/Forename	Taylor, Richard
Date of Birth	10/06/1963
Sex	Male
Patient Address.	Flat 1 3 Clovenstone CloseEdinburgh EH14 3FA
Registered GP	M Green
GP Address.	Sighthill Green Medical Practice,Sighthill Health Centre,Calder Road,Edinburgh EH11 4AU

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Patient & GP Information

610119466W	610119466W
1006631372	1006631372
I0000337381	I0000337382
Taylor, Richard	Taylor, Richard
10/06/1963	10/06/1963
Male	Male
Flat 1 3 Clovenstone CloseEdinburgh EH14 3FA	Flat 1 3 Clovenstone CloseEdinburgh EH14 3FA
M Green	M Green
Sighthill Green Medical Practice,Sighthill Health Centre,Calder Road,Edinburgh EH11 4AU	Sighthill Green Medical Practice,Sighthill Health Centre,Calder Road,Edinburgh EH11 4AU

Patient & GP Information

610119466W	610119466W
1006631372	1006631372
I0000337383	I0001882204
Taylor, Richard	Taylor, Richard
10/06/1963	10/06/1963
Male	Male
Flat 1 3 Clovenstone CloseEdinburgh EH14 3FA	Flat 1 3 Clovenstone CloseEdinburgh EH14 3FA
M Green	M Green
Sighthill Green Medical Practice,Sighthill Health Centre,Calder Road,Edinburgh EH11 4AU	Sighthill Green Medical Practice,Sighthill Health Centre,Calder Road,Edinburgh EH11 4AU

Patient & GP Information

610119466W	610119466W
1006631372	1006631372
I0004513535	I0004515812
Taylor, Richard	Taylor, Richard
10/06/1963	10/06/1963
Male	Male
Flat 1 3 Clovenstone CloseEdinburgh EH14 3FA	Flat 1 3 Clovenstone CloseEdinburgh EH14 3FA
M Green	M Green
Sighthill Green Medical Practice,Sighthill Health Centre,Calder Road,Edinburgh EH11 4AU	Sighthill Green Medical Practice,Sighthill Health Centre,Calder Road,Edinburgh EH11 4AU

Patient & GP Information

610119466W	610119466W
1006631372	1006631372
I0004517172	I0004576063
Taylor, Richard	Taylor, Richard
10/06/1963	10/06/1963
Male	Male
Flat 1 3 Clovenstone CloseEdinburgh EH14 3FA	Flat 1 3 Clovenstone CloseEdinburgh EH14 3FA
M Green	M Green
Sighthill Green Medical Practice,Sighthill Health Centre,Calder Road,Edinburgh EH11 4AU	Sighthill Green Medical Practice,Sighthill Health Centre,Calder Road,Edinburgh EH11 4AU

Patient & GP Information

610119466W	610119466W
1006631372	1006631372
I0004635176	I0005013293
Taylor, Richard	Taylor, Richard
10/06/1963	10/06/1963
Male	Male
Flat 1 3 Clovenstone CloseEdinburgh EH14 3FA	Flat 1 3 Clovenstone CloseEdinburgh EH14 3FA
M Green	M Green
Sighthill Green Medical Practice,Sighthill Health Centre,Calder Road,Edinburgh EH11 4AU	Sighthill Green Medical Practice,Sighthill Health Centre,Calder Road,Edinburgh EH11 4AU

Patient & GP Information

610119466W	610119466W
1006631372	1006631372
I0005468443	I0005501168
Taylor, Richard	Taylor, Richard
10/06/1963	10/06/1963
Male	Male
Flat 1 3 Clovenstone CloseEdinburgh EH14 3FA	Flat 1 3 Clovenstone CloseEdinburgh EH14 3FA
M Green	M Green
Sighthill Green Medical Practice,Sighthill Health Centre,Calder Road,Edinburgh EH11 4AU	Sighthill Green Medical Practice,Sighthill Health Centre,Calder Road,Edinburgh EH11 4AU

Patient & GP Information

610119466W	610119466W
1006631372	1006631372
I0005581540	I0005940304
Taylor, Richard	Taylor, Richard
10/06/1963	10/06/1963
Male	Male
Flat 1 3 Clovenstone CloseEdinburgh EH14 3FA	Flat 1 3 Clovenstone CloseEdinburgh EH14 3FA
M Green	M Green
Sighthill Green Medical Practice,Sighthill Health Centre,Calder Road,Edinburgh EH11 4AU	Sighthill Green Medical Practice,Sighthill Health Centre,Calder Road,Edinburgh EH11 4AU

Patient & GP Information

610119466W
1006631372
I0005954444
Taylor, Richard
10/06/1963
Male
Flat 1 3 Clovenstone CloseEdinburgh EH14 3FA
M Green
Sighthill Green Medical Practice,Sighthill Health Centre,Calder Road,Edinburgh EH11 4AU

Surname/Forename	Taylor, Richard
UHPI Number	610119466W

Episode Number	I0000337380

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Clerking Episode/Ref: I0004513535 Eleonora Bianchi 30/07/2018 10:38 Eleonora Bianchi	HISTORY:,,Presenting complaint,» Lower abdominal pain ,,History of presenting complaint,» Awoke this morning with lower abdominal pain at 5am, 8/10 severity. Sharp in nature, constant with waves of intensity. No radiation. Breathing in and movement makes pain worse.,Associated with N&V - x2 episode, foodstuff no blood noted. 1x episode of vomiting during consultation. ,Does not feel abdomen has been any more bloated than usual.,,Bowels last opened yesterday - no changes in habit. Passing wind. ,No urinary symptoms ,,Happened x3 prior to this - same pain in same place - 4wks ago was last episode. Resolved spontaneously after 1-2hours - not been investigated about this,,Bloods: ALT 123, otherwise unremarkable. Lactate not taken.,CXR: unremarkable, ,SYSTEMATIC ENQUIRY:, ,CVS / Heart Failure » No chest pain ,RS » Nil ,Abdominal » As above ,GU (inc LMP /Pregnancy) » N/A ,Neurology » Nil ,Musculoskeletal » Nil,Previous GA » Yes,Adverse effects » Nil ,,PAST MEDICAL HISTORY:,,Heartburn,Wrist operation - bike accident,Ankle operation - bike accident,,FAMILY HISTORY:,,Nil ,,LIFESTYLE CHOICES:,,Smokes: 10/day for 40 years: 20 pack years ,ETOH: Nil ,No current recreational drug use, used to smoke cannabis ,,HOME SUPPORT:,,Lives with wife and 5 children (1-12 year olds),Lives with house with stairs,Mobilise independently ,House husband,,ALLERGIES:,,Nil known,,MEDICATIONS/PHARMACEUTICAL CARE ISSUES:,- Omeprazole 20mg OD long-term for heartburn,No other medicatons on admission,,PHYSICAL EXAMINATION:,,General / ENT ,» Evidently uncomfortable but talking in full sentenes. Evident tattoos all over.,- no jaundice, no pallor,NEWS: 0,,Cardiovascular System ,» WWP, CR<2s, pulse regular, HS I+II+0; warm, well perfused,- pulse regular;,- peripheral pulses present, no peripheral edema , ,Respiratory System ,»good air entry, equal and bilateral; clear,,Abdomen / Gastrointestinal / Genito-urinary system ,» pt experiences pain and difficulty puffing out/sucking in abdomen,- bowel sounds present,- voluntary guarding, tenderness++ lower abdomen, rebound tenderness present ,- rosving negative ,- no hernias,,Central nervous system / Locomotor system ,» Tone/Power Normal 5/5,,Conscious Level (AVPU) » A,Glasgow Coma Scale » 15,,IMPRESSION/ DIFFERENTIAL DIAGNOSIS:,,Non-specific abdominal pain,,INITIAL MANAGEMENT PLAN:,,- Lactate to be added to bloods,- Abdo x-ray,- Analgesia and antiemetic,,

Surname/Forename	Taylor, Richard
UHPI Number	610119466W

Episode Number	I0000337380

Note Details	Clinical Notes
Ward Round Episode/Ref: I0004513535 Professor Richard JE Skipworth 30/07/2018 16:19 Dr Katie Robinson	WR SKIPWORTH,,Feeling the same,Ongoing pain,,NEWS2 - hypotension,,PLAN,- bolus fluid,- await CTAP,- NS to check has PU,,FY1 K Robinson

Surname/Forename	Taylor, Richard
UHPI Number	610119466W

Episode Number	I0000337380

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0004513535 Nurse 30/07/2018 17:39 Zoe Blair	Nursing- Richard is settled and comfortable within 106. Still fasting awaiting CTAP [ ]. States he is struggling to pass urine at 4pm- Had stat IVI and maintance IVI. Will monitor for urine output. May need IDC if not passed. News stable.

Surname/Forename	Taylor, Richard
UHPI Number	610119466W

Episode Number	I0000337380

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0004513535 Professor Richard JE Skipworth 31/07/2018 11:32 Dr Katie Robinson	CT Report,Unable to compare study to previous imaging.,,No free intra-abdominal fluid or gas.,,Unremarkable appearance of the liver, gallbladder, pancreas, spleen, adrenals and kidneys. Simple right lower pole cortical cyst. The bladder is virtually empty.,,No gross lesion of the non-prepped colon. No significant diverticular disease. Unremarkable appendix and terminal ileum. Unremarkable small bowel appearance.,,No size significant abdominal or retrocrural lymph nodes.,,Within the limits of this study, the origins of the coeliac axis and SMA appear patent.,,The visualised lung bases are clear.,,No destructive bony abnormality. Degenerative osteophytosis at the right iliac crest.,,Opinion:,,Normal appendix and no significant diverticular disease.,,

Surname/Forename	Taylor, Richard
UHPI Number	610119466W

Episode Number	I0000337380

Note Details	Clinical Notes
Pharmaceutical Care Issues Episode/Ref: I0004513535 30/07/2018 11:11 Eleonora Bianchi	- Omeprazole 20mg OD long-term for heartburn,No other medicatons on admission

Surname/Forename	Taylor, Richard
UHPI Number	610119466W

Episode Number	I0000337380

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0004513535 Professor Richard JE Skipworth 31/07/2018 12:44 Dr Katie Robinson	Dear Doctor,,,PRINCIPAL DIAGNOSIS/PROCEDURE, Abdominal Pain, diagnosis unclear,,TREATMENT,Mr Taylor presented to hospital w/ a hx of severe abdominal pain and associated N&V that started the morning he presented to hospital 30/07/18. He also mentioned that he has had foul smelling stool for the past months, no other bowel symptoms (no change of frequency or appearance).,He also mentioned similar episodes have happened previously but resolved w/out medical intervention.,,He was treated w/ appropiate analgesia, antiemetics and fluids.,,He was investigated w/ bloods, CXR and abdo CT. All were NAD.,CT report conclusion - Normal appendix and no significant diverticular disease.,,FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL, N/A,CHANGES TO DRUGS SINCE ADMISSION, N/A,ALLERGIES / ADVERSE DRUG REACTIONS,NKDA, ,SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS,Nil,,CHANGES TO DNACPR STATUS OR ANTICIPATORY CARE PLANNING ,Nil,,GP to please consider the following - thank you for your continued care of this patient, ,Should you need further information please contact - ward 106 RIE, ,Information contained in this letter has been discussed with the patient/carer.,,Yours sincerely....., ,Dr Katie Robinson, FY1,,This is an immediate discharge letter and a further letter may follow.

Surname/Forename	Taylor, Richard
UHPI Number	610119466W

Episode Number	I0000337380

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0004513535 Nurse 31/07/2018 18:44 Therese Ferguson	Self discharged this pm,Patient contacted and he is happy and feeling well at home,Letter posted to home address

Surname/Forename	Taylor, Richard
UHPI Number	610119466W

Episode Number	I0000337380

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0004513535 Professor Richard JE Skipworth 04/09/2018 15:44 Karen Ann Bell	Clinical Summary:,Mr Taylor presented with a recurrent attack of severe lower abdominal pain with nausea and vomiting. At the time of presentation his bilirubin was normal and his ALT was 123. He underwent a CT scan which showed no significant pathology. He was subsequently discharged home with no plans for further follow up. ,Yours sincerely,,,,,ANDREW ROBERTSONLocum Consultant Surgeon to Mr RICHARD SKIPWORTH,

Surname/Forename	Taylor, Richard
UHPI Number	610119466W

Episode Number	I0000337380

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0004513535 Nurse 30/07/2018 11:31 Rhoda Turbela	Admitted patient to SOU, alert and orientated, NEWS 0, awating to be reviewed. IVI continued.,Rhoda Pagotaisidro- S/N

Surname/Forename	Taylor, Richard
UHPI Number	610119466W

Episode Number	I0000337380

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0004513535 Professor Richard JE Skipworth 30/07/2018 11:45 Eleonora Bianchi	W/R Mr Skipworth,,History revisited - lower abdominal pain. 4th episode of lower abdominal pain associated with N&V,,No changes in bowel habit, passing wind,No urinary syptoms,,CXR reviewed,Bloods unremakable,,Plan:,- Urine dip ,- Lactate has been added,- CT Abdomen Pelvis ? dierticulitis ?appendiits,,FY1 EBianchi 5244

Surname/Forename	Taylor, Richard
UHPI Number	610119466W

Episode Number	I0000337380

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0004513535 Nurse 30/07/2018 14:39 Rhoda Turbela	Patient is transferred to ward 106, hand over given, IVI continued ,still for CT scan.,Rhoda Pagotaisidro- S/N

Surname/Forename	Taylor, Richard
UHPI Number	610119466W

Episode Number	I0000337380

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0004515812 Nurse 01/08/2018 23:27 Emma Evans	1/8/18 23:30,Nursing, Patient admitted to SOU from GP with deranged LFTs and abdo pain. Liver screen completed. Tolerating D&F. For review and AUSS mane.,Staff Nurse Emma Evans

Surname/Forename	Taylor, Richard
UHPI Number	610119466W

Episode Number	I0000337380

Note Details	Clinical Notes
Ward Round Episode/Ref: I0004515812 Professor Richard JE Skipworth 02/08/2018 08:25 Claire B McNaull (NMR)	Date : 02/08/2018,Ward Round Lead : Mr Richard JE Skipworth,Team : ET1,,DIAGNOSIS / PROCEDURE : Re attends with upper abdominal pain ,DAILY UPDATE : Previous admission attended with lower abdominal pain with derrnaged LFTS, patient self discharged. CT A/P - no cause for pain ,,Now worsening LFT's ,,O/E ,derranged LFT's worsening ,tender in RUQ ,MANAGEMENT PLAN : 1. AUSS + MRCP ,2. Pm review ,,30 day re-admission : No,30 day re-operation : No,NEWS Score : 1,Results reviewed : Yes,IVI fluids : Reviewed ,Nutrition reviewed : Oral,VTE risk assessed, reviewed : Yes,Adequate analgesia : Yes,Antibiotics status : Not applicable,Estimated discharge date : 02/08/2018,

Surname/Forename	Taylor, Richard
UHPI Number	610119466W

Episode Number	I0000337380

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0004515812 Professor Richard JE Skipworth 02/08/2018 14:32 Dr Jennifer L Hendry	FY2 Hendry- PM review ,,Mr Taylor reports ongoing RUQ abdominal pain that is not really improving, remains 5/6 in severity. Reports pain is worse when walking. Has been feeling nauseated but no vomiting. Has been able to drink around 750mls so far today but has not eaten since breakfast - had piece of toast and made him feel more unwell. ,Not opened bowels today, not feeling feverish. Reports urine was very dark in colour. ,,Obs: NEWS 0 ,,O/E: Some discomfort when moving around bed ,WWP ,CRT <2s,dry mucous membranes ,Abdomen soft, tenderness in RUQ and epigastrium with voluntary guarding. Bowel sounds positive ,,Plan:,1) Await USS abdomen

Surname/Forename	Taylor, Richard
UHPI Number	610119466W

Episode Number	I0000337380

Note Details	Clinical Notes
Ward Round Episode/Ref: I0004515812 Professor Richard JE Skipworth 02/08/2018 15:59 Dr Louise Symons	Date : 02/08/2018,Team : ET1,,DIAGNOSIS / PROCEDURE : Re attends with upper abdominal pain ,DAILY UPDATE : Abdominal pain ongoing,,USS: Gallstones within gallbladder, no ductal dilatation. No evidence of acute cholecystitis. ,MANAGEMENT PLAN : 1. MRCP,2. Can be HOT clinic ,3. LFTs mane,,30 day re-admission : No,30 day re-operation : No,NEWS Score : 0,Results reviewed : Yes,IVI fluids : Not indicated,Nutrition reviewed : Not applicable,VTE risk assessed, reviewed : Yes,Adequate analgesia : Yes,Antibiotics status : Not applicable,Estimated discharge date : 04/08/2018,,,

Surname/Forename	Taylor, Richard
UHPI Number	610119466W

Episode Number	I0000337380

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0004515812 Nurse 02/08/2018 16:34 Betty Manoj	patient discharged and went home.and coming back tomarow morning. for mrcp. feeling well.news 0

Surname/Forename	Taylor, Richard
UHPI Number	610119466W

Episode Number	I0000337380

Note Details	Clinical Notes
Ward Round Episode/Ref: I0004517172 Professor Richard JE Skipworth 04/08/2018 16:49 Kieran Purchase	WR Mr Skipworth (Cons),,Theatre not going to happen today.,Patient can eat again today.,,Plan:,1) Fast from midnight for likely theatre.

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0004517172 Professor Richard JE Skipworth 05/08/2018 08:49 Dr Giles Lewis-Morgan	wr,,news 0,Pain moderate today,,For surgery at 10 am today

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0004517172 Professor Richard JE Skipworth 05/08/2018 16:35 Dr Giles Lewis-Morgan	WR ,,NEWS 3 4L O2, low temp,doing well post-op,,Plan:,Early bloods tomorrow

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0004517172 Professor Richard JE Skipworth 06/08/2018 12:00 Kieran Purchase	Date : 06/08/2018,Ward Round Lead : Mr Richard JE Skipworth,,,Ward Round Note : .,Patient feels better. Pain managed by simple analgesia.,,Abdomen SNT,,Plan:,1) Drain out today,2) Home today,3) Repeat LFTs with GP in 1-2 weeks,,UPDATE:,Discharge letter intially completed without repeat LFT information. I rang DSU and spoke to the nurse looking after this patient who kindly agreed to add-on this information to the letter.,

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Note Details	Clinical Notes
Operation Note Episode/Ref: I0004517172 Professor Richard JE Skipworth 06/08/2018 12:05 Karen Ann Bell	Name: Mr Richard Taylor DoB: 10/6/1963 UHPI: 610119466W , CHI: 1006631372 ,Consultant: RICHARD SKIPWORTH Ward: 106 Date of Op: 5/8/2018 ,Surgeon: ALASTAIR HAYES Assistant: ,Anaesthetist: Anaesthetic: General ,Urgency: Emergency Case: ,,Operations,Site Diagnosis Operation Code Type ,BILIARY TREE AND GALL BLADDER Gall stones and common bile duct stones Laparoscopic cholecystectomy 101724 ,BILIARY TREE AND GALL BLADDER Gall stones acute symptoms Laparoscopic cholecystectomy 100524 ,,Operative Findings and Techniques,Operation note,Indications - GA - IV antibiotics administered. Right upper quadrant pain with deranged LFTs and 5mm CBD calculus on MRCP.,Procedure - who check list performed and patient undergone general anaesthetic, was prepped with Betadine and draped. Open cutdown at the umbilicus with 10mm port CO2 insufflation to 12mm mercury. 10mm epigastric port and 2 right upper quadrant 5mm ports inserted under lap control without incident. The gallbladder fundus was attempted and the gallbladder was needle decompressed and bile removed. The fundus of the gallbladder was successfully grasped and retracted up towards the right shoulder and adhesions to the greater omentum were taken down with targeted diathermy. The fundus of the gallbladder was identified and grasped to reveal Calot's triangle. The cystic artery was identified and isolated and the cystic duct was similarly identified and cleared of local adhesions and large windows were made in Calot's triangle between the cystic duct and cystic artery and the proximal one half of the gallbladder was mobilised off the gallbladder fossa. A large liga clip was placed at the proximal aspect of the cystic duct. The cystic duct was cut and cholangiogram performed which gave the appearance of a possible small calculus at the distal common bile duct right at the ampulla although this was questionable. Mr Skipworth attended theatre for senior opinion and 20mgs of IV Buscopan was given with a 40ml flush of saline down the cystic duct. Contrast was then injected down and cholangiogram this time was satisfactory with good tapering of common bile duct with flow of contrast into the duodenum and contrast displaying the right and left hepatic ducts. The cystic duct was then divided leaving 3 large liga clips on the cystic duct stump and one on the specimen side and 3 medium large liga clips were applied to the cystic artery leaving 2 in situ and divided between. The gallbladder was then dissected off the remainder of the liver bed and retrieved in a parachute bag through the epigastric port site and sent for routine histology. A saline irrigation was performed and suctioned out. A 20 French portex drain was sited at the right upper quadrant and secured with silk. J PDS was used to close the umbilical and epigastric port site sheath and 20mls 0.% chirocaine infiltrated to all four wounds. 4/0 monocryl to skin. Dressings. ,Post op - patient to continue antibiotics until review on the ward round. Monitor drain output and fluid colour. DVT prophylaxis. ,,,,,Mr ALASTAIR HAYES,Registrar to Mr RICHARD SKIPWORTH,

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Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0004517172 Professor Richard JE Skipworth 13/09/2018 16:17 Karen Ann Bell	Clinical Summary:,This gentleman was admitted after attending the general surgery HOT clinic for an outpatient MRCP which demonstrated cholelithiasis and choledocholithiasis. He subsequently underwent laparoscopic cholecystectomy with intra-operative cholangiogram. Yours sincerely,,,,,Dr KIERAN PURCHASE FY2,

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0004517172 Nurse 03/08/2018 15:59 Tracey Wither	03.08.2018 nursing,Pt admitted to SOU from clinic. Risk asessment completed, cannula inserted and bloods taken. NEWS of 0. For transfer to ward 106 base c,,Tracey Wither,staff nurse

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0004517172 Nurse 03/08/2018 16:21 Tracey Wither	03.08.2018 nursing,,Pt transferred to ward 106, handover given on transfer. NEWS of 0 prior to move.,,Staff Nurse,Tracey wither

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0004517172 Nurse 04/08/2018 04:32 Chelsea Osborne	Richard has slept well. Observations stable. No complaints of Pain. IV Fluids running. Independent overnight. Awaiting Theatre. No concerns at present.

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0004517172 Nurse 04/08/2018 14:08 Jennifer Watson	Richard has been settled today. Checklisted, consented and dressed for theatre. Awaiting lap chole. Fasting and connected to IVI. Currently sleeping, NEWs stable. No issues at present

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0004576063 Nurse 01/11/2018 16:11 Rhoda Turbela	Patient discharged home,, cannula removed. Awaiting fro lift to go home. ,Staff Nurse

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Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0004576063 Mr S Paterson-Brown 01/11/2018 20:02 Angela Macnamara	Dear Doctor, ,,PRINCIPAL DIAGNOSIS/PROCEDURE,,Non-specific abdominal pain,,Mr Taylor attended Surgeons overnight 31/10/18 with sudden onset acute upper abdominal pain. No associated symptoms with pain - denied dysuria, nausea, vomiting or change to bowel habit, afebrile. History of recent cholecystectomy under Mr Skipworth August 2018. Bloods showed mild derangement of LFTs with slight rise in Amylase. CT abdomen/pelvis found no acute surgical cause for symptoms and following a brief period of observation, Mr Taylor felt well enough to return home. Worsening statement given, no surgical follow up indicated. , ,TREATMENT,1. Observations - NEWS 0 on discharge,2. Blood analysis - WCC 11.3, Bil 23, ALT 59, AlkP131, Amylase 162.,3. CTAP: nil acute surgical cause identified. Mild bibasal atelectasis - no respiratory symptoms.,4. Senior review - Consultant Surgeon Mr Paterson-Brown. , ,FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL,,N/A, ,CHANGES TO DRUGS SINCE ADMISSION,,N/A ,,ALLERGIES / ADVERSE DRUG REACTIONS,,N.K.D.A., ,SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS,,N/A,,CHANGES TO DNACPR STATUS OR ANTICIPATORY CARE PLANNING ,,N/A,,GP to please consider the following; nil at this time, thank you., ,Should you need further information please contact Mr Paterson-Brown's General Surgery ET1 team at RIE on 0131 536 1000., ,Information contained in this letter has been discussed with the patient/carer.,,Yours sincerely....., ,Staff Signature..... Print Name.....Angela Macnamara.....,,Designation.....SNP..... Date.....1/11/18..... Time..... 20:00.....,,Patient/Carer Signature....., ,This is an immediate discharge letter and a further letter may follow.

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0004576063 Nurse 01/11/2018 06:39 Betty Manoj	All nursing admission completed.alert and oriented. awaiting Snr R/V

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0004576063 Mr S Paterson-Brown 01/11/2018 07:29 Dr Christopher Holt	ET1 Nights WR - Robertson,,Constant abdo pain, similar to previous pain before cholecystectomy in August ,LFTs derranged, WCC 11, CRP <1, afebrile ,,OE abdo tender RIF, soft ,,?appendicitis however no raised inflammatory markers,,Plan:,1.NBM,2. Observe this morning ,,,ET1 Nights FY1, Chris Holt, 5244

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0004576063 Mr S Paterson-Brown 01/11/2018 08:23 Jack Vojak	Date : 01/11/2018,Team : ET1,,DIAGNOSIS / PROCEDURE : Acue onset sudden abdominal pain,DAILY UPDATE : Bowel habit-normal,previous cholecystectomyy,,Bloods-,raised liver enzymes,WCC 1.3,Amylase 162,,,O/E,abdomen soft,tender epigastrium ,tender R side abdomen,Tender lower abdomen ,,,NEWS-3,temp 35.8,o2 requirement,,Imression:,divertiulitis,appendicitis,adhesions,MANAGEMENT PLAN : Plan:,CTAP,,30 day re-admission : No,30 day re-operation : No,NEWS Score : 3,Results reviewed : Yes,IVI fluids : Re-started,Nutrition reviewed : Yes,VTE risk assessed, reviewed : Yes,Adequate analgesia : Yes,Antibiotics status : Not applicable,Estimated discharge date : 02/11/2018,

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Note Details	Clinical Notes
Clerking Episode/Ref: I0004576063 Dr Jack Vojak 01/11/2018 09:16 Jack Vojak	HISTORY:,,Presenting complaint,»severe abdominal pain,,History of presenting complaint,»acute onset abdominal pain,nil clear precipitating factors,associated vomitting ,no diarrhoea,BO yesterday,No urinary symptoms,Nobody else has had similar symptoms,,Previous Laparoscopic Cholecystectomy under Mr SKipworth 2/12 ago,, ,SYSTEMATIC ENQUIRY:, ,CVS / Heart Failure »NIL,RS »NIL,Abdominal »as above ,GU (inc LMP / Pregnancy) »NIL,Neurology »NIL,Musculoskeletal »NIL,Previous GA »yes,Adverse effects »no,,PAST MEDICAL HISTORY:,,Cholecystectomy 2018,Heartburn,Wrist operation - bike accident,Ankle operation - bike accident,,FAMILY HISTORY:,,Nil ,,LIFESTYLE CHOICES:,,Smokes: 10/day for 40 years: 20 pack years stopped 2/12 ago,ETOH: Nil currently, stopped 14 years ago,No current recreational drug use, used to smoke cannabis ,,HOME SUPPORT:,,Lives with partner and 5 children ,,ALLERGIES:,,Nil known,,PHYSICAL EXAMINATION:,,General / ENT ,»Patient remains still on the trolley. WWP,,Cardiovascular System ,»HS 1 2 0, CRT > 2,, ,Respiratory System ,»hest clear equal air entry bilaterally,,Abdomen / Gastrointestinal / Genito-urinary system ,»Port scars healing well from lap chole 2/12 ago. Abdomen non distended. Soft, with voluntary guarding globally. Maximal tenderness RIF. Rovsings -ve.,,Central nervous system / Locomotor system ,»moving all 4 limbs,,Conscious Level (AVPU) »A,Glasgow Coma Scale »15,,IMPRESSION/DIFFERENTIAL DIAGNOSIS:,,appendictis ,SBO,adhesions,,Cholecystitis,,INITIAL MANAGEMENT PLAN:,,CTAP,fluids,,

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0004576063 Mr S Paterson-Brown 01/11/2018 10:43 Jack Vojak	Progress Note:,Note CT findings with thanks,-Small focus of calcification in the uncinate process raises possibility of chronic pancreatitis but is not typical.,-Mild consolidation/atelectasis at both lung bases.,-No evidence of appendicitis,-No evidence of obstruction,-No evidence of adhesions,,Vojak F1

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0004635176 Nurse 30/01/2019 13:45 Nicola Clark	Nursing - Patient discharged from SOU in police custody. Cannula's removed. Nil voiced concerns at time of writing.,,Nicola Clark,S/N

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Note Details	Clinical Notes
Specialty Review Episode/Ref: I0004635176 Vikki Argent 30/01/2019 14:35 Vikki Argent	ST5 Argent Liaison Psychiatry,,Attended Surgical Ward to review Richard following Dr Craig's assessment of Richard, and further discussion and review of his notes.,,Richard appeared slightly tired but engaged well in the review. ,,Some history revisited - Richard reported his mood had been 'up and down' over the last few weeks, and he identified that he had been struggling to come to terms with his wife separating with him, which has been compounded by continuing to live in the same property as her with their 5 children (all primary school age and under). He said that everytime she goes out, he knows what she might be doing (with her new partner) and finds this very difficult.,,He could recall that yesterday, as usual, he had got up and prepared the children for nursery and school, taken them and then went out for a walk in the afternoon to 'clear my head'. He then came back, picked up the children, gave them their tea and then had gone to a friend's house. He did not recall what time he left there, but thought it was late, and could recall feeling drunk. He estimated he had had 'a few' jack daniels and coke (2-3) but that they had contained a lot of coke as it 'didn't take much'. He said that he hadn't really consumed alcohol for about 14 years but said it had been nice to have a few drinks and think about other things rather than his current situation. He was not sure whether he then got into his car and drove home, or if he got into his car at a separate time. He said he could not recall driving, or the accident, and said the next thing he remembers was waking up in hospital. He also had no recollection of stabbing his abdomen or being at home. He denied using any illicit substances.,,He thought he might have done it because thoughts of self-harm/suicide had been on his mind recently, including stabbing himself. He said that yesterday he had not had such thoughts and had enjoyed his evening so wasn't clear why this had happened at this time. He said he had not done anything to harm himself since his presentation to MHAS a few weeks ago despite continuing to have thoughts of doing so, and wondered whether thinking of his children stopped him from doing anything. He viewed his children as a positive feature in his life and said that if it weren't for them (he has 16 children) he would probably be dead now.,,He denied any ongoing thoughts to harm himself or end his life. He said he just wanted to get home to his children. He was aware that following discharge from hospital he would be going to the Police station, and this was in relation to his car crash. He said he hoped to get home after this and he would have to deal with the consequences. He anticipated this incident overnight could have implications for any future employment as he has a licence to drive lorries and has previously worked as a lorry driver. He is currently unemployed and plays a significant role in his children's care.,,Objectively he appeared low in mood and there was some reactivity to his affect. He made good eye contact. He spoke softly but had a normal rate and rhythm to his speech. There was no formal thought disorder. Richard has made a number of appointments to follow-up on his mental health, including starting mirtazapine 15mg 3 days ago with his GP, and reported he planned to continue to engage with his planned contact.,,Imp: Act of ?self-harm/suicide attempt in the context of intoxication with alcohol and significant psychosocial stressors (marriage break-up),,Plan,Go Psych,Has follow up appointments arranged with MHAS, GP and Rivers Centre (he could not remember the dates but said they are on his calendar at home),He will continue mirtazapine 15mg and have this reviewed with his GP,Advice given re: abstaining from alcohol - Richard informed me he had no intention of drinking again,Crisis numbers provided, as well as information about edspace to consider options for counselling

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Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0004635176 Mr PJ Lamb 28/02/2019 10:26 Janice Pirie	Clinical Summary:,Diagnosis - Stab to abdominal wall (did not penetrate into abdominal cavity).,Surgical follow up - None.,Management - Conservative.,The above-named 55-year old gentleman was admitted to the surgical observations unit having stabbed his abdominal wall as a self-inflicted injury whilst intoxicated. ,The handle of the blade was impressively sticking out of his abdominal wall when he was reviewed by the trauma team in resus and his abdomen was soft and he underwent a CT scan which appeared to show that the blade did not penetrate through the abdominal wall. Accordingly, it was removed in A&E and the wound cleaned with some Betadine.,He had a thorough review by the psychiatry team and he was going to review his Mirtazapine in the community with the GP and was going to consider abstaining from alcohol.,Two clips were put in the skin wound which will need to be removed and he will make an appointment with the GP practice nurse for this but there is no need for any surgical follow up.,Yours sincerely,,,,,Mr ALASTAIR HAYESRegistrar to Mr PETER LAMB,

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0004635176 Nurse 30/01/2019 05:14 Alison Carrick	30/1/19 05:12 Nursing:,,Pt admitted to SOIP from A&E following a stab wound to abdomen,NEWS 1 on admission,Patient very drowsy on admisson- one word answers and refusing to open his eyes to cooperate,,In police custody,Awaiting clerk in, kardex and senior r/v,For rpt bloods following IVI,,Alison Carrick SN

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Note Details	Clinical Notes
Clerking Episode/Ref: I0004635176 Dr Sam Skillcorn 30/01/2019 05:39 Dr Sam Skillcorn	HISTORY:,,Presenting complaint,» abdominal stab wound,,History of presenting complaint,» No history available from patient as drowsy/uncooperative. History taken from A&E note below.,,Reported to have been smoking cannabis while driving car, unknwn speed although police report significant damage to vehicle. Car veered off road, passenger side vs barier. Patient self-extricated and left scene. Returned home drank alcohol ++ and smoked further cannabis. Self-inflicted stab wound to left side of abdomen with straight edged kitchen knife. ,Found by wife/family.,Very agitated/aggressie with SAS requiring midazolam for safe transfer to hospital, ,,,PAST MEDICAL HISTORY:,,Cholecystectomy 2018,Heartburn,Wrist operation - bike accident,Ankle operation - bike accident,,FAMILY HISTORY:,,Nil ,,LIFESTYLE CHOICES:,,Smokes: 10/day for 40 years: 20 pack years stopped 2/12 ago, ,,HOME SUPPORT:,,Lives with ?partner,,ALLERGIES:,,Nil known,,PHYSICAL EXAMINATION:,,General / ENT ,» asleep, difficult to rouse,,Cardiovascular System ,» HSI+II, strong regular radial pulse. Not tachycardic., ,Respiratory System ,» chest clear anteriorly, good air entry,,Abdomen / Gastrointestinal / Genito-urinary system ,» Knife removed by surgical reg earlier. Wound site dressed, not examined. Abdomen difficult to examine due to positioning in bed.,,Central nervous system / Locomotor system ,» Drowsy, occasional single words/noises. Moving limbs independently. Not following commands.,,IMPRESSION/DIFFERENTIAL DIAGNOSIS:,,Wound : lac / incised / bite : abdomen,,INITIAL MANAGEMENT PLAN:,,1. Fast IV fluids given CK 10 000,2. Monitor,3. Repeat bloods later after fluids,4. Consider home mane if well,,

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0004635176 Mr PJ Lamb 30/01/2019 08:44 Dr Alastair John Hayes	Surgical Nights - A.Hayes ST6,Entered in retrospect.,Self inflicted stab to RIF abdominal wall with knife insitu on arrival at A&E. Seemingly this occured after a car crash. Allegedly under influence of alcohol and drugs.,Haemodynamically stable. Blade at very oblique angle suggestive of subcutaenous/ extra-peritoneal injury only.,CT confirmed injury appears to be superficial only.,Knife removed in A&E by myself, wound irrigated with saline-Betadine. x2 skin clips.,Plan: Diet and fluids, IV fluids + recheck CK and renal function. ,Discharge with Police later today.

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0004635176 Mr PJ Lamb 30/01/2019 09:18 Alison Forsyth (NMR)	Date : 30/01/2019,Ward Round Lead : Mr PJ Lamb,Team : ET1,,DIAGNOSIS / PROCEDURE : Self inflicted stab wound last night,DAILY UPDATE : Well this am,,D&F,,Wound intact,MANAGEMENT PLAN : Psych review,Home once reviewed,,30 day re-admission : No,30 day re-operation : No,NEWS Score : 1,Results reviewed : Yes,IVI fluids : Reviewed ,Nutrition reviewed : Oral,VTE risk assessed, reviewed : Yes,Adequate analgesia : Yes,Antibiotics status : Not applicable,Estimated discharge date : 31/01/2019,

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Note Details	Clinical Notes
Specialty Review Episode/Ref: I0004635176 Vikki Argent 30/01/2019 12:17 Dr Hollie Craig	Hollie Craig Liaison Psychiatry FY1,,Impression: Self inflicted abdo wound while intoxicated. Suicidal thoughts however no plans. ,,Plan: ,- Will refer children to social services,- Registrar Dr Argent will review ,,Referred following self inflicted abdominal wound following a car accident. ,,Richard initially did not recall the events of yesterday, however on further questioning and taking him through the day chronologically he remembered going to a friend's house to drink (whiskey) and driving home while intoxicated. He became distracted by something out the window and crashed into a barrier. He does not recall hitting any pedestrians or other cars. He then left the car, went home, and then does not rememeber anything else. He does not recall stabbing himself in the abdomen or what his motivations for this might have been, and he does not remember coming to hospital. It is noted on TRAK that he was smoking cannabis however he denies this. ,,His mood has been deteriorating since he seperated from his ex-wife just before Christmas. She was seeing another man and is reportedly pregnant with his baby. Richard has found this extremely depressing and presented very soon after wth lacerations to his arms which were with suicidal intent. They still live in the same house and are arguing frequently. He is sleeping very poorly, has low appetite, reduced concentration, although he does still find enjoyment in his usual activities. ,,He was recently started on mirtazapine by his GP who he has follow up with in two weeks. He describes suicidal thoughts but has no plans for self-harm or suicide. He has had previous episodes of self harm as a teenager in relation to abuse from his mother. When asked if he would kill or harm himeslf if he went home today he denied this. ,,He lives with his ex-wife and their 5 children, however I see on TRAK he has 16 children altogether. It is unclear if the children were present during this incident, police will refer him to social services however we will also submit a second report. ,,He had previously been abstinent from alcohol for 14 years, although denied this was for alcohol excess and says he just 'didn't enjoy it'. He recently started drinking again following discovering his wife's infidelity. ,,MSE: Richard is a heavily tattooed middle aged man with police present at his hospital bed. He was keen to engage and made good eye contact. He initially claimed he did not recall the events of yesterday however on further questioning was able to discuss driving while intoxicated. His speech was normal in rate rhythm and volume. He describes his mood as low, although appeared reactive. No formal thought disorder, has ongoing suicidal thoughts but no plans for suicide or self harm. No evidence of abnormal perceptions and not responding to any unseen stimuli. Describes himself as confused although oriented to time, place and person, 4AT negative. Good insight although claiming to not remember the stabbing. ,,H.Craig FY1 ,,,Edit: 30/01/19 12:35 ,,Referral made to social work, police referral should follow later today

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005013293 Nurse 18/09/2020 01:22 Emma King	Richard has been settled tonight and mobilising well around bedspace. Has complained of no pain and observations stable with NEWS 0 at start of night. Refused pain killers and daltaparin tonight despite encouragement. No further issues at present.

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005013293 Miss Sarah C Thomasset 18/09/2020 08:46 Dr Anushka Srinivas	WR AM ETB,Miss Thomasset,,Admitted 16/09 with ?retained stone,,Issues,- cholecystectomy + IOC 2018,,Today,- More settled today, still no appetite and some nausea,- MRCP normal,,NEWS 0,,O/E,Abdo soft, generally tender,,Plan,1. Eat and drink, analgesia,2. Repeat bloods today,3. Home today if bloods normal,,A Srinivas FY1 5685

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Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0005013293 Miss Sarah C Thomasset 18/09/2020 18:28 Dr Anushka Srinivas	OPERATION/PROCEDURE(S): ,Nil,,UNDERLYING DIAGNOSIS: Acute on Chronic Pancreatitis,,TYPE OF ADMISSION: Emergency,,CHANGES TO MEDICATIONS SINCE ADMISSION (relative to ECS):,Started: Nil ,Stopped: Nil,Changed: Nil ,Withheld: Nil,,ALLERGIES / ADVERSE DRUG REACTIONS:,NKDA / Specify,,Discharge prescription checked against ECS med rec: Yes,FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL: Nil,,ACTION REQUIRED FROM GP: Nil,_____,,Dear Doctor,,Mr Taylor presented to the RIE on 16/09/20 with epigastric pain radiating through to his back. ,MRCP on 17/09/20 showed:,Previous cholecystectomy. No biliary dilatation. CBD measures 7 mm. No ductal filling defects demonstrated.,Incomplete pancreas divisum. No pancreatic duct dilatation. Grossly normal liver parenchyma and pancreas.,4.5 cm right renal cyst. Otherwise normal appearance of both kidneys and spleen. ,Small hiatus hernia. No upper abdominal lymph node enlargement.,,Mr Taylor was informed his pancreatitis is not caused by gallstones and is likely caused by excess alcohol. ,He self-discharged on 18/09/20., ,SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS/ DNACPR STATUS/ANTCIPATORY CARE PLANNING:,Nil,,Should you need further information please contact: Miss Thomasset and Team, ,Thank you for your ongoing care of this patient.,,Yours sincerely,,,,Anushka Srinivas FY1,Department of General Surgery, Royal Infirmary of Edinburgh, ,This is an immediate discharge letter and a further letter may follow.,

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005013293 Nurse 18/09/2020 18:44 Margaret Crossan	Patient left the ward today before nurse staff were able to discharge according to ward protocol. He asked nurse staff how long it would be before discharge? He was informed we were waiting on letter from doctors. He was seen leaving the ward with his belongings by staff nusre crossan shortly after this. Cannula had been removeds prior to this. There are no concerns about Mr Taylor leaving as he was medically fit for discharge and not requiring any medications other than routine analgesia.

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005013293 Nurse 16/09/2020 22:54 Leah McKean	Nursing,Admitted to SOU observations stable ,Richard appears to be in pain however has declined analgesia,Awaiting clerking and kardex from medical staff,Leah McKean SN

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Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0005013293 Miss Sarah C Thomasset 30/09/2020 08:08 Nicola Downs	Clinical Summary:,This 57-year-old gentleman was admitted on the 16th of September 2020, with upper abdominal pain and deranged liver function tests (bilirubin 11, ALT 115, ALP 185). His amylase was normal. History of a cholecystectomy in August 2018 was noted and an MRCP was arranged. It did not show any evidence of retained stones or biliary dilatation. An incidental 4.5cm renal cyst was also commented on along with a small hiatus hernia. Mr Taylor self discharged on the 18th of September 2020, and no routine follow-up is planned.,Kind regards.,Yours sincerely,,,,,Miss SARAH THOMASSETConsultant Surgeon,

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Note Details	Clinical Notes
Pharmaceutical Care Issues Episode/Ref: I0005013293 17/09/2020 02:36 Dr Anna Boyer	Phar: 3,Med Rec completed: Y,Sources used (min.of 2): ECS - to conf with patient,Outstanding Med Rec issues:,Outstanding/ ongoing care issues:,1. Abdo pain - for MRCP - rx'd for s/c morphine,2. VTE - Dalteparin ,Changes to medication:,Discharge/Compliance information: ,,No longer taking fluoxetine,No OTC/ supplements/ alternative medicine

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Note Details	Clinical Notes
Clerking Episode/Ref: I0005013293 Anna Victoria Boyer 17/09/2020 02:36 Dr Anna Boyer	HISTORY:,,Presenting Complaint ,» Abdominal pain,,History of presenting complaint,4/7 hx abdominal pain - generalised. Sudden onset. Constant. No radiation. No obvious exacerbating/ relieving factors. States pain is similar to pain from gallstones prior to cholecystectomy. Nauseous & vomiting first few days. Last ate 2-3 days ago. Not drinking much water. ,Dysphagia»,Indigestion»,Vomiting»In first few days,Anorexia» Yes in past few days. Reduced appetite past 2 years linked to relationship/ family difficulties,Weight loss» Yes, several stone past few years, intentional,Change in bowel habit»Very little past few days - not eating,Constipation»No,Diarrhoea»No,PR bleeding»No,Abdominal pain», ,Systematic Enquiry:, ,CVS / Heart Failure »No CP, no SOB,RS »No SOB,GI»,GU (inc LMP / Pregnancy),Neurology »Some quite severe headaches past few days, radiating to neck. No current neck stiffness, reports some in past few days. No photophobia. No focal neurology reported. Note PMH brain haemorrhage (presented with headache, photophobia & LOC, required ITU admission). ,Musculoskeletal »,Previous GA »Yes,Adverse effects »No,Urinalysis »,Results,MSU sent,BHCG »,PID/Chlamydia » ,,PAST MEDICAL HISTORY:,,Cholecystectomy 2018,Heartburn,Brain haemorrhage 9 years ago.,Wrist operation - bike accident,Ankle operation - bike accident,,FAMILY HISTORY:,,Nil ,,LIFESTYLE CHOICES:,,Smokes: 10/day for 40 years: 20 pack years stopped a few days ago,Does not drink alcohol, previous social drinker, ,,HOME SUPPORT:,,Lives alone,,ALLERGIES:,,Nil known,,MEDICATIONS/PHARMACEUTICAL CARE ISSUES:,,No longer taking fluoxetine,No OTC/ supplements/ alternative medicine,,PHYSICAL EXAMINATION:,,General (including skin & ENT) ,»Appears comfortable at rest,,Cardiovascular System ,»Warm & well-perfused peripherally. HS 1+2+0. No peripheral oedema., ,Respiratory System ,»Chest clear,,Abdomen / Gastrointestinal / Genito-urinary system ,Distension» No,Scars» Lap chole,Stoma» No,Visible mass»No ,Localised tenderness» Tender throughout, worst centrally/ LIF ,Diffused peritonitis» Abdomen soft,Localised peritonitis» Guarding in LIF,Palpable mass» No,Organomegaly» No,Hernia» No,Aneurysm»No ,Ascites» No,Bowel sounds»Present ,PR» ,,Central nervous system / Locomotor system ,»Grossly normal. Moving all 4 limbs,,Tone»,Power »,Reflexes »,Sensation »,Coordination »,,Conscious Level (AVPU) »A,Glasgow Coma Scale » 15,,IMPRESSION/DIFFERENTIAL DIAGNOSIS:,,Non-specific abdominal pain,,INITIAL MANAGEMENT PLAN:,,Analgesia & antiemetics as required,IV fluids,AXR,MRCP requested following senior review,,

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005013293 Miss Sarah C Thomasset 17/09/2020 08:47 Dr Anushka Srinivas	WR AM ETA,Miss Thomasset,,Admitted 16/09 with ?retained stone,,Issues,- cholecystectomy + IOC 2018,,Today,- in a lot of pain with vomiting,- generalised abdo pain,- has had fevers in the past 2 days,,O/E,abdo generally tender,NEWS 3 (RR),,Plan,1. MRCP,2. Pain relief ,,A Srinivas FY1 5243

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005013293 Nurse 17/09/2020 15:25 Jennifer Gilchrist	Richard has had a couple of episodes of extreme pain today. This morning following a shower was rolling about the bed and floorshouting out. PRN oramorph given with nil apprent effect, stat subcut morphine then given and appeared to settled. NEWS 3 at this point, due to resp rate as was hyperventilating. ,NEWS this afternoon score 0. Went for MRCP this afternoon, awaiting results. ,Radiographer phoned to report Richard had 2 x large vomits whilst in the department. On RTW gave PRN anti-emetic and further subcut morphine. Appears comfortable at present. NEWS 2 due to temp 35.8, HR 48. ,Will continue to monitor and await formal report and plan.

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005501168 Dr Maria Corretge 25/08/2022 05:46 Simimol Philip	Deterioration and Escalation Obs are stable as charted.

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005501168 Dr Maria Corretge 25/08/2022 10:32 Dr Kieran Burgess	PTWR Dr Wilson 59y old M PMH of previous ICH, depression Cannabis smoker Admitted with confusion ?cause Bloods- midly elevated WCC and eGFR off baseline. CRP<1 Review: Feeling well today Now alert and orientated Recalled admission events- can recall feeling out of sorts and confused. Now normal. Afebrile overnight Neuro exam normal HS normal Imp ?TGA Plan Repeat bloods today - FBC, U+E, CRP Aim home if bloods ok Burgess Locum MG

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005501168 Nurse 25/08/2022 12:09 Shonna Carlin	settled day observations stable as charted independent with personal hygien around ward and to toilet medication given as prescribed for discharge home providing own transport offering no complaints

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Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0005501168 Dr Maria Corretge 25/08/2022 12:41 Dr Kieran Burgess	PRINCIPAL DIAGNOSIS/PROCEDURE ?TGA Richard Taylor is a 59 year old man who was admitted to SJH on the 24/8/22 in an acute confusional state. He w had word finding difficulties and could not remember his own birthday. A CT head was normal along with blood tests. He was afebrile. He improved and was orientated the following day. He is fit for discharge today. TREATMENT Nil FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL Nil CHANGES TO DRUGS SINCE ADMISSION Nil GP to please consider the following...nil, thank you Should you need further information please contact...SJH, MAU Information contained in this letter has been discussed with the patient/carer. Yours sincerely K Burgess Locum This is an immediate discharge letter and a further letter may follow.

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Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0005501168 Dr Maria Corretge 16/09/2022 11:51	FINAL DISCHARGE SUMMARY DIAGNOSES: Transient global amnesia Migraine Previous intracranial haemorrhage Self-harm and depression Cannabis use Nasal polyps discovered during CT head This 59-year-old patient was looked after by Dr Wilson. He had been feeling unwell for 48 hours prior to his attendance to A&E. He then started to feel confused and had a new headache. He admitted to having been smoking cannabis and having some family stress recently. Unfortunately, I do not have details in the notes of the type of confusion he was suffering from but he is described as vacant, very sweaty and then drowsy. Investigations were normal and the patient returned to normal demeanor after 24 hours observation and was discharged home with a tentative diagnosis of transient global amnesia. I cannot comment on any other possible diagnosis when I met the patient in person and I am only relying on notes. Given that his CT head no acute find I would not think there is any further investigations required at this stage. We have not organised follow-up for Mr Taylor. With many thanks. Yours sincerely e-signed Dr Maria Corretge Consultant MOE MC/AM 160922 131022

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005581540 Dr Rebecca S Dickinson 30/12/2022 00:30 Briony McIntyre	HOSPITAL at NIGHT / WEEKEND Type of Request: Task Assigned To: Briony McIntyre Time Seen: No data entered Problem/Request: Venflon Outcome: 20g inserted into right hand, pvc bundle completed.

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Note Details	Clinical Notes
Specialty Review Episode/Ref: I0005581540 Dr Rebecca S Dickinson 30/12/2022 15:08 Dr Neshika E Samarasekera	Neurology Complex hx with episode of altered awareness with no clinical pointers to cause, and at least one previous episode of confusion. Interpersonal stress because of breakdown of relationship 3-4 yrs ago with no access to kids Partner may have witnessed a previous episode but she was not present, and couldn't get collateral hx from her because she was looking after their kids. HGV driver - i said to him that he couldn't drive pending further investigations and that he was legally obliged to inform the DVLA. He sounded rather reluctant to do so and was clearly upset by this. He asked whether the episode could be related to stress/emotional upset (what he calls astroprojection) , although i think he is describing dissociation. I said this could be a factor but he doesn't recall dissociation occurring actually at the time of the event. I will arrange f/up in the neuro clinic. he can go home. i think encephalitis is unlikely.

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Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0005581540 Dr Rebecca S Dickinson 30/12/2022 16:57 Dr Rachel Kelly	PRINCIPAL DIAGNOSIS Epsodes of confusion and amnesia with unclear cause TREATMENT Mr Taylor was admitted on 29/12 following left sided facial dropp and right sided werakness with urinary incontinence. He has a bg of intracerebral bleed 10 years ago and has had 4 episodes of amnesia over the last 4 months. He has been advised to self report to the DVLA and will be follow ed up with neurology as an outpatient. FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL outpatient follow up in the neurology clinic CHANGES TO DRUGS SINCE ADMISSION nil ALLERGIES / ADVERSE DRUG REACTIONS nil SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS nil CHANGES TO DNACPR STATUS / DETAILS OF TREATMENT ESCALATION PLAN nil Should you need further information please contact...SJH MAU Information contained in this letter has been discussed with the patient/carer. Yours sincerely..... Rachel Kelly FY1 This is an immediate discharge letter and a further letter may follow.

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Note Details	Clinical Notes
Outpatient Clinic Letter Episode/Ref: I0005581540 Dr Neshika E Samarasekera 09/01/2023 11:49 Jacqueline Ross	DATE OF NEUROLOGY REVIEW: 30/12/2022 PROBLEMS: 1) Transient episode of altered awareness with no particular clinical pointers (28 December 2022) 1.1) MRI head: old right putamen haemorrhagic lacune (2022) 2) Previous admission to hospital with confusion (August 2022) 3) Road traffic accident whilst smoking cannabis (January 2019) 4) Mental health problems 4.1) Recent review by Psychiatry for depression (August 2022) 4.2) Episode of deliberate self-harm (2019) 5) Right lentiform nucleus intracerebral haemorrhage (2004) 5.1) Presentation with frontal and right temporal headache with associated reduction in conscious level I was asked to review this 59-year old right handed HGV driver and met him on the Medical Admissions Unit on 30 December. He was alone and I was unable to obtain collateral history from his partner who was at home looking after their children. He had been referred to Neurology because of an episode of altered awareness which occurred on 28 December. Mr Taylor could not recall anything about this episode. He was at work. His partner received a call from Mr Taylor's employer reporting that he seemed confused, driving his car around in circles and unable to recall how to get home. His partner attended to him and found him confused, unaware of his name, date of birth or place. Initially he was noted to have a left sided facial droop and possible weakness of his right arm although since has since resolved. He had also been incontinent of urine. Blood tests showed a neutrophilia. Mr Taylor does not recall anything about the event itself or his stay in the Emergency Department. He does however recall events on the Medical Admissions Unit. Reviewing his electronic record, I note that he presented in August with an episode of confusion. He had been smoking cannabis. He self-presented to the Emergency Department and then seemed to self-discharge because he was confused about 'what was happening'. He had been found by his partner slumped on his couch at home although he was unable to recollect what had happened. I note that there is a family history of myocardial infarction in his father (late fifties). His father subsequently had a stroke in his seventies. Mr Taylor lives with his girlfriend. He works as an HGV driver. He smokes cannabis but does not use any other illicit drugs. He told me today that he does not drink any alcohol although I note from previous entries on his electronic record that there were concerns about excess alcohol in the past. I explained to him that he has had a transient episode of confusion with no clear clinical pointers regarding what this was. In view of this I do not think he should drive pending investigations and I think he is legally obliged to inform the DVLA. He seemed rather reluctant to do so. Given that I was unable to obtain collateral history today I will recall him to the Neurology Clinic for repeat assessment. He specifically asked about whether the episodes could be related to interpersonal stress. I understand that he has had a difficult time following the break up of his relationship with his ex-wife and he no longer has any contact with their five children. Although he does not recall dissociation in the context of this recent event, he has had dissociative symptoms in the past. This may be relevant. Yours sincerely Electronically checked DR NESHIKA SAMARASEKERA Consultant Neurologist Secretary: Jacki Ross (01506 523827) Dictated: 30/12/2022 Typed: 09/01/2023

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Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0005581540 Dr Rebecca S Dickinson 25/01/2023 16:53 Maryam Habibollahi	FINAL DISCHARGE SUMMARY Dear Doctor, I have nothing further to add to the Immediate Discharge Letter which you should already have received. Yours sincerely, E-signed Dr Rebecca Dickinson Consultant Respiratory Physician RD/MH Dict: 13.01.23 Typed: 25.01.23 PRINCIPAL DIAGNOSIS Epsodes of confusion and amnesia with unclear cause TREATMENT Mr Taylor was admitted on 29/12 following left sided facial dropp and right sided werakness with urinary incontinence. He has a bg of intracerebral bleed 10 years ago and has had 4 episodes of amnesia over the last 4 months. He has been advised to self report to the DVLA and will be follow ed up with neurology as an outpatient. FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL outpatient follow up in the neurology clinic CHANGES TO DRUGS SINCE ADMISSION nil ALLERGIES / ADVERSE DRUG REACTIONS nil SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS nil CHANGES TO DNACPR STATUS / DETAILS OF TREATMENT ESCALATION PLAN nil Should you need further information please contact...SJH MAU Information contained in this letter has been discussed with the patient/carer. Yours sincerely..... Rachel Kelly FY1 This is an immediate discharge letter and a further letter may follow.

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005581540 Dr Rebecca S Dickinson 30/12/2022 02:54 Margaret Mcsherry	Person-Centred Care Richard has a settled night, no concerns at present. Deterioration and Escalation news score 1, no further concerns at present Pressure Area Care Skin intact, patient independtly relieving pressure areas. Falls patient independent with mobility, monitor when mobilising as ? seizures. Bladder and Bowel Function Richard is independent with toileting Medicine Management Richard took medicaiton as per hepna with no conerns. Pain Management Richard took regular paracetomol, no pain has been expressed at present. Infection Prevention and Control New PVC inserted 29/12/22, no further concerns at present Food Fluid and Nutrition Paitent eating and drinking, no further concerns at present Altered Stage of Cognition Richard is alert and oreintated, no further concerns at present Vulnerable Person Rihard has been settled, no conerns presented at present.

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0005581540 Dr Rebecca S Dickinson 30/12/2022 10:00 Dr Rachel Kelly	Cons WR Dr Dickinson Issues: found driving in circles and not orientated to TPP 4 episodes in last month bG Currently: sitting up in chair, alert and conversive Orientated to TPP doesnt recall ever having any memory problems or people being worried about him feels alot better this am ?focal seizures - ?cerebral irritation doesnt drink alcohol MRI Head - Opinion: Old haemorrhagic right putamen lacunar event. No acute intracranial pathology. explained to patient sometimes scar tissue from previous bleed can cause irritation and lead to seizures Plan: neurology review

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005581540 Nurse 30/12/2022 11:03 Karen Glenny	Settled morning, diet and fluids tolerated Observations stable at this time Meds given as per hepma Awaiting neuro r/v

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Note Details	Clinical Notes
Pharmaceutical Care Issues Episode/Ref: I0005581540 30/12/2022 11:30 Rachel Clarke	Phar:T RC 30/12/22 Med Rec completed: Y Sources used (min.of 2): ECS, patient NKDA, no OTC Referral code: B.1 Venlafaxine prescribed on acute ECS (08/22), not prescribed on hepma - patient states he no longer takes this B.1 Omeprazole prn prescribed on ECS (2020), not prescribed on hepma - patient states he no longer takes this Changes to medication: 1. Paracetamol 1g QDS, Ceftriaxone 2g IV OD and Aciclovir 750mg TDS IV started on hepma Discharge/Compliance information: Patient denies any regular medicines so will need all new on discharge

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005940304 Dr Johanna Hofer 04/06/2024 05:20 Julia Farkas	Person-Centred Care Richard arrived to the ward around 2am. He settled quickly, and slept through the night Deterioration and Escalation NEWS stable as charted For full escalation Pressure Area Care Richard is able to relieve his pressure areas independently, no issue reported Mobility Due to his pain, Richard needs minimal assistance to mobilise/ADLs. Normaly fully independent. Bladder and Bowel Function Voids independently, uses bottles/ward toilet. No bowel movement during the night Pain Management Analgesia administered by RN as per Hepma. After arriving to the ward, no further complaint of pain Infection Prevention and Control Pink PVC in right ACF Food Fluid and Nutrition Normal F+D Altered Stage of Cognition Alert and oriented Discharge Planning No discharge plan so far

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005940304 Nurse 05/06/2024 03:05 Rachel Cruse	Patient settled overnight, complaining of ongoing pain. Pain increased overnight, HAN team contacted for analgesia review. Medication as per HEPMA. Observations as charted, NEWS stable. Patient remains independent with ADLs. Will continue to monitor.

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005940304 Dr Johanna Hofer 05/06/2024 03:16 Kerina Robb	HOSPITAL at NIGHT / WEEKEND Type of Request: COORDINATOR Advice Assigned To: Kerina Robb Time Seen: No data entered Problem/Request: T9# Pain ++ Outcome: Has 2.5mg Oramorph prescribed PRN - has only had one dose (0115) Advised to give another dose now, and a further dose more frequently, and if pain remains uncontrolled, to re-escalate for dose increase

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005940304 Dr Helen M Hare 05/06/2024 09:29 Dr Helen M Hare	Handed over to inform patient of CT result re:unstable fracture and to discuss with orthopaedics. Informed Richard of need to immobilise. He is struggling with pain despite QDS oral morphine 10mg. I have increased his PRN dose (2.5mg to 5mg) and frequency in order to allow us to manage his pain. He should have a PRN dose of cyclizine now to avoid the need to vomit whilst back unstable. On reviewing imaging report on Trak, the clinical note which states this is unstable has been superceded by an updated formal consulant report which states : There is a compression fracture of T9 vertebral body with some gas in the intervertebral disc above and below. Whilst this fracture was not present on CT scan of December 2023 there are features which suggests it is subacute rather than hyperacute. Equally, there is no suggestion of osteoporosis therefore an underlying cause of this fracture should be sought, and malignancy excluded. An MRI scan in due course would help. If there is no neurology, immobilisation may be over cautious. Needs new neurology exam then I will discuss with orthopaedics. - Given concerns re potential instablity directed by orthopaedic registrar to neurosurgical registrar. H Hare ACCS4

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005940304 Dr Helen M Hare 05/06/2024 10:19 Dr Helen M Hare	Neurology examination Examination limited by back pain; further 5mg morphine given 0945 (had 10mg <1h prior) with limited effect. Upper limb Normal tone upper limbs. Power limited by pain- 5/5 hand grip and elbow flexion. Lower limb Tone increased bilaterally- appears voluntary secondary to pain Power 5/5 hip flexion Patellar and ankle jerks brisk but symmetrical Babinski absent bilaterally- marked callous. Normal sensation right leg. Left leg absent sharp and soft sensation to lateral and anterior thigh- L3/L4/L5 distribution but doesn't feel strictly dermatomal given distribution of loss on medial thigh. Impression Sensory changes more in keeping with meralgia paraesthetica or similar cutaneous nerve problem. No changes associated with area of lesion (T9)

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005940304 Dr Helen M Hare 05/06/2024 10:44 Dr Helen M Hare	Telephone call with Mr Mustafa El Sheik, Neurosurgical Registrar on Call. Case history discussed and Mr El Sheik reviewed images. Impression Fracture does not appear unstable therefore should be for bed rest (for pain reasons) rather than immobilsation- specifically does not need to be log rolled. At present no explanation for fracture in an otherwise well relatively young patient. Recommendations 1)Bed rest 2)Analgesia 3)Further imaging required; an MRI whole spine with contrast (to look for source of infection; there is some gas visible on CT which is suggestive of this, and infection would also explain fracture) 4) If MRI normal aim to sit up and then when able, for standing xray of spine. If there is no kyphosis then could have a TLSO brace (thoracic-lumbar-sacral orthosis). 5) Myeloma screen 6) Osteoporosis screen 7) Rediscuss with neurosurgery should Mr Taylor develop neurology or once MR results back. H Hare ACCS4

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005940304 Dr Johanna Hofer 05/06/2024 11:00 Dr Erin Brown	WR Hofer Issues 1. T9 # 2. Constipation Note discussion with neurology today - thanks Explained findings of a fracture and requiring futher investigation of cause Visibly in a lot of pain, has not been utilising PRNs PLAN As per Neuro - MRI whole spine with contrast ?infection Myeloma screen Osteoporosis screen Rediscuss with neuro once MRI done Longtec 10 BD (to have a stat now) Encouraged to use PRN Diazepam 5mg TDS (stat now)

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005940304 Dr Helen M Hare 05/06/2024 11:13 Dr Helen M Hare	Discussed MRI with Dr Alastair Mckenzie, Duty Radiology Consultant He feels infection low on the differential (vacuum effect/gas can be result of vertebral collapse) so they will likely do plain MR in first instance and consider second set of sequences if images indicate need for this. Nevertheless MR reasonable for investigation of osteoporosis/neoplastic causes of fracture. TB clinically unlikely. He is not sure if there is capacity in MRI to scan today but will scan as soon as possible. I asked about transfer onto scanner given Medical team concern re instability and risk of paralysis. Having reviewed the images himself he is did not feel there was a need for spinal brace etc; 'will likely use same precautions as you are using on ward'. He will ask the MRI radiographers to contact ward regarding pragmatics of the scan. H Hare ACCS4

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005940304 Dr William J Newman 05/06/2024 16:35 Nicole Hibberd	Written by Student Nurse - Rachael Ayres from dayshift on 04/06/24 Person-Centred Care Introduced myself to richard this morning. He has been sleepy throughout the day. Had his scan this morning. Deterioration and Escalation FOR RESUS Self ventilating on room air. NEWS2 score 0. Pressure Area Care Independent with pressure area care. skin intact. Mobility Independent with minimum supervision with mobilising to and from the toilet. Bladder and Bowel Function Indpendent with urine bottles for toiletting. Medicine Management Medications given as prescribed on hepma. Laxido sachets x4 prepared in full jug of water. Pain Management Richard has been scoring a 9 for his pain today. PRN oral morphine has been given as and when required. Discharge Planning continue with on going care

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005940304 Dr William J Newman 05/06/2024 16:51 Nicole Hibberd	Person-Centred Care Richard has enjoyed a visit from his family today. Was unsettled this morning due to severe back pain in the AM after medical examiniation. Pain has since settled. Deterioration and Escalation Observations stable NEWS of 0. FOr full esculation. Pressure Area Care Richard independently releaves own pressure areas. Mobility Richard has been informed he is to be bed rest. However has been up multiple times to attend to toilet. Is aware of the risk of being up and mobilising. Bladder and Bowel Function Independent with toileting. Has been asked to use bottles throughout day. Medicine Management Medications given as per HEPMA. Pain Management Was in alot of pain this morning. PRN orymorth given and regular paracetomol and ibroprofen given as charted for pain. Has been started on longtec. Infection Prevention and Control PVC insitu. Food Fluid and Nutrition Has had good nutritional intake today. Normal diet and fluids. Altered Stage of Cognition Alert and orientated.

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005940304 Dr William J Newman 05/06/2024 21:15 Dr Amy Oakes	Written in retrospect due to clinical activities - seen with Dr Kim Russell ATSP re back pain and 'crunch' BG of T9 fracture On arrival, clearly very sore, sat upright in bed with back support, explained he moved in bed heard and felt a 'crunch' and has been very sore since Neuro exam 5/5 power in upper limbs Sensation intact 5/5 power in lower limbs Normal reflexes in lower limb No changes in sensation in lower limbs Was given stat of 5mg of oromorph - pain improved D/W Dr Newman who advised the following - MRI spine tomorrow as normal neurology - Bedrest - Analgesia Has been more settled following analgesia Dr Oakes

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005940304 Dr William J Newman 06/06/2024 00:41 Lucy McKEnzie	Person-Centred Care Richard has been settled since start of the shift, no issues to note Deterioration and Escalation news as per trak, currently 2 Pressure Area Care richard is independent with pressure area care in bed, not seen skin overnight Mobility richard usually mobilises independently, however due to spine compression fracture is curretnly bedrest. richard was trying to walk to the toilet at start of the shift, has been made aware on different occations that he is on bedrest, and told to buzz when needing a bottle to pass urine Bladder and Bowel Function richard passes urine spontanously, currently using bottles in bed, not had bowel movement overnight. Medicine Management medication administered as per hepma, no issues Pain Management richard has been complaining of pain through night, PRN analgesia provided Food Fluid and Nutrition NDF

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0005940304 Dr William J Newman 06/06/2024 10:23 Dr Mohammad Rahman	WR Dr Newman Issues 1. T9 # 2. Constipation NEWS 1 MRI Spine Opinion: Moderate T9 compression fracture, with features suggestive of a benign / insufficiency fracture. Further mild superior endplate fracture of L4 vertebra is also consistent with a benign / insufficiency fracture. In the absence of a history of trauma, further evaluation with DEXA scan is recommended to assess bone density. Today Scan results with Richard Xmas time he was pushed with great force was jumped on Pain came on suddenly on saturday whilist in bed No recent eppileptic seizures Weight loss No alochol excess No IV drug use Pain controlled to some extent Bowels active Plan Analgesia Dexa bone scan Nizami Rahman FY1

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005940304 Dr William J Newman 06/06/2024 14:23 Nicole Hibberd	Person-Centred Care Richard independently had a wash this morning. Deterioration and Escalation Observations stable NEWS of 0. Pressure Area Care Richard is independent with pressure area care. Mobility Has been independently mobising to toilet today. Bladder and Bowel Function Independent to toilet. Voding freely. Reports of type 6/7 bowel movement today. Medicine Management Medications given as per HEPMA. Pain Management Regular pain releif given as charted on hepma. Has not needed any further PRNs today. Infection Prevention and Control PVC insitu. Food Fluid and Nutrition Had had good fluid and nutritional intake today. Normal diet and fluids. Altered Stage of Cognition Alert and orientated.

Surname/Forename	Taylor, Richard
UHPI Number	610119466W

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Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0005940304 Dr William J Newman 06/06/2024 16:35 Dr Mohammad Rahman	PRINCIPAL DIAGNOSIS/PROCEDURE: T9 compression fracture mild superior endplate fracture of L4 vertebra Constipation TREATMENT Mr Taylor presented on 04/06/24 with back pain. His AXR some faecal loading on right side and he was started on laxatives. He had a CT scan which showed a compression fracture of T9 vertebral body. He was discussed with neurosurgery who suggested analgesia, bed rest and further MRI imaging. His MRI scan showed the following: Moderate T9 compression fracture, with features suggestive of a benign / insufficiency fracture. Further mild superior endplate fracture of L4 vertebra is also consistent with a benign / insufficiency fracture. In the absence of a history of trauma, further evaluation with DEXA scan is recommended to assess bone density. A DEXA bone scan has been requested to investigate his compression fracture . He has been started on regular paracetamol and Morphine (MST Continus) for pain relief. FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL: OP DEXA bone scan CHANGES TO DRUGS SINCE ADMISSION: Started: Morphine (MST Continus) 10mg modified-release tablets BD Paracetamol 1g QDS Sennosides 15 mg OD ALLERGIES / ADVERSE DRUG REACTIONS: As per ECS SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS: Nil CHANGES TO DNACPR STATUS / DETAILS OF TREATMENT ESCALATION PLAN: Nil GP to please consider the following: Nil Should you need further information please contact: MAU WGH Information contained in this letter has been discussed with the patient/carer. Yours sincerely Nizami Rahman FY1 ADDITIONAL CONSULTANT COMMENT- please note the attached drug list and notes are unchanged from the immediate letter that you should already have had. Consultant comment – Final Discharge Letter I have nothing further to add to the immediate discharge letter. Please, do not hesitate to contact me if you require any further information. Yours sincerely, e-signed and verified by Dr Newman Dr William Newman Consultant in Respiratory and General Medicine Any queries please contact 0131 537 1707

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Note Details	Clinical Notes
Outpatient Clinic Letter Episode/Ref: I0005940304 Dr William J Newman 22/07/2024 14:42 Stefanos Parcharidis	I note since I last saw Mr Taylor that he has been diagnosed with epilepsy. His bone scan has confirmed he has osteoporosis in his lumbar spine. The recommendation is to start vitamin D/calcium as well as Alendronic acid. I will ask the patient to contact you about starting these medications. Of note his renal function and calcium were normal when last checked and his Alk. Phos mildly raised at 129. If he has issues tolerating these medications then the Rheumatologists have recommended contacting themselves. It is also recommended he have a repeat bone scan in 5 years to assess response. Yours sincerely, e-signed and verified by Dr Newman Dr William Newman Consultant in Respiratory and General Medicine Dictated: 22/07/2024 Typed: 22/07/2024 (SP) Any queries please contact 0131 537 1707

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Note Details	Clinical Notes
Outpatient Clinic Letter Episode/Ref: I0005940304 Dr William J Newman 22/07/2024 14:43 Stefanos Parcharidis	Thank you for attending for your recent bone scan. This has confirmed that your bones are thinner than normal. This is called osteoporosis. This puts you at risk of further fractures and to try and prevent this we would recommend you start some medications. I would be grateful if you could contact your GP about starting these. Lifestyle advice including remaining active, not smoking and drinking alcohol within recommended limits also applies. Yours sincerely, e-signed and verified by Dr Newman Dr William Newman Consultant in Respiratory and General Medicine Dictated: 22/07/2024 Typed: 22/07/2024 (SP) c.c. Sighthill Green Medical Practice, Sighthill Health Centre, Calder Road, Edinburgh, EH11 4AU Any queries please contact 0131 537 1707 - posted

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0005940304 Dr Johanna Hofer 04/06/2024 10:20 Dr Mohammad Rahman	POST TAKE WARD ROUND Dr Hofer Issues Abdominal pain -Right sided faecal loading - Chaperoned by colorectal - no abnormailities AXR: Right sided faecal loading with noted bowel gas but does not appear significantly dilated - does not look like an obstruction ECG:NSR with artefact Bloods: Unremarkable NEWS 1 Today: Ongoing abdominal pain since saturday morning suddenly No bowel movement Passing wind No nausea/vomiting Weight loss - uncertain how much No fever No recent travel Not eating OE: Pulse regular No peripheral oedema Lower abdominal + right sided tenderness + BS present Chest clear Palpable pedal pulses Cons impression: Constipation -Right sided faecal loading as per AXR Plan: Urine dip Bladder scan Macrogol Abdominal US for AAA exclusion ECG seen: y VTE prophylaxis: y/n/na if not, why not? After excluding AAA AWI required? No Escalation/DNACPR discussed/documented? Full escalation Nizami Rahman FY1

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005940304 Dr Johanna Hofer 04/06/2024 17:02 Dr Johanna Hofer	pm review Hofer note partially visualised T9 fracture plan to complete CT imaging distally discussed result with patient, he denies any trauma, no idea how he could have injured his back advised to lie flat on his back for now asks for increased pain control- suggest Oramorph 10mg prn will hand over to evening cons

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005940304 Dr Johanna Hofer 04/06/2024 20:05 Dr James Peter Bott	***This is a provisional report only. Please check the consultant verified report on TRAK to ensure no changes. The verified report supersedes this report.*** Clinical History Incompletely imaged T9 vertebral body fracture on CTAP. Has right sided abdominal pain radiating to back. Further scan for complete imaging of thoracic spine and any underlying cause. No evidence of trauma in history. 8325482 04/06/2024 CT Chest Noncontrast study. Comparison with previous CT abdomen dated 04/06/2024, and CT pulmonary trauma dated 19/12/2023. New wedge compression fracture of T9 vertebral body, affecting the anterior and middle columns. The fracture line extends posteriorly into the vertebral canal, and laterally to the left costovertebral joint. There is no significant retropulsion of bony fragments into the vertebral canal. Given this is 2 column fracture, this is considered unstable. The posterior elements are unaffected. Associated vacuum effect noted within the T8/T9 and T9/T10 intervertebral discs. No significant paravertebral collection demonstrated. Benign appearing bony lesion in the T8 vertebral body. Old left T10 rib fractures. No concerning bony abnormalities demonstrated. Minor bilateral basal atelectasis. The lungs are otherwise clear. No concerning pulmonary nodularity or size significant thoracic lymph nodes. No pleural or pericardial effusions. Coronary artery and aortic valve calcification noted. The imaged solid upper abdominal viscera are unremarkable. Opinion: Two column wedge compression fracture of the T9 vertebral body. This is considered unstable. Immobilisation and a spinal surgical opinion is advised. ---- Dr James Bott. GMC: 7493766 Radiology Registrar

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005954444 Dr James W Dear 24/06/2024 16:58 Sarah Finlayson	Person-Centred Care Richard has been admitted to AMU 8 Deterioration and Escalation NEWS 0 Mobility Independently mobile a bit unsteady but thinks this is due to lying down for a while Pain Management Complaining of back pain states this is ongoing issue Food Fluid and Nutrition Normal diet and fluids Altered Stage of Cognition Alert and orientated

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0005954444 Dr James W Dear 25/06/2024 10:13 Dr Joseph Faulkner	WR Prof Dear 61M presenting 24/6 with unwitnessed fall, head injury and disorientation Issues: 1) Likely 2nd presentation seizure --> Previous Convulsive seizure in Feb 2024, diagnoised in clinic in March --> No AEDs, No further Seizures, CT-B Negative, awaiting IP Neuro review today. --> ESBP 144-->123, not symptomatic of his Today: NEWS = 0 Bloods improved, WCC 15-->9 CRP <1.0

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Note Details	Clinical Notes
Specialty Review Episode/Ref: I0005954444 Dr Iain Alexander Maltman 25/06/2024 10:26 Dr Iain Alexander Maltman	Dr Urwin/Dr Maltman Neurology Review Thank you for referral 61 year old gentleman Past Medical History First generalised convulsion (Feb 2024) Previous probable dissociative attacks Right hemisphere intracranial haemorrhage 2004 (with good recovery) Depression with DSH Cholecystectomy Backpain Recreational drug use: cannabis Driving: G1DL Drug History - as per ECS Omeprazole, 20mg once daily Ralvo 700mg plaster, once daily Tramadol, 50mg up to QDS Investigations CT head: No acute intracranial imaging. Old putaman haemorrhagic infarct on previous imaging Bloods: WCC 15.5, CRP 1, lactate 1.0, glucose 6.8 Progress History revisited: Sudden onset of loss of consciousness, unwitnessed. Amnesiatic over event and reports confusion afterwards. Facial and scalp lacerations noted. No tongue biting but has bit lower lip. Biochemistry compatible with seizure. Explained that given previous diagnosis from Dr Davenport, in conjunction with this episode, means that Mr Taylor now has a diagnosis of epilepsy. Explained that sleep deprivation, tramadol likely triggering factors. Previous bleed in the brain likely predisposing factor Advice Explained that we would recommend starting an anti-seizure medication. Mr Taylor is in agreement. Explained that lamotrigine would be first line option, in particular helpful given mental health background. Explained side effects can include insomnia, skin reaction and requires careful dose titration. Any changes to skin should be reported to GP/NHS24 urgently. Explained that DVLA must be informed of diagnosis of epilepsy and in general, seizures need to be under control for minimum of 1 year. Please copy this into IDL Explained risk of SUDEP and safety information Explained we will write letter with information and refer to Epilepsy Specialist Nurses Follow up with Dr Urwin Please ensure first 2 weeks lamotrigine prescribed and copy below schedule into discharge letter. I have written up initial dose on Hepma We would suggest codeine as alternative short term opioid for back pain, avoid long term use due to risk of escalating doses/long term harm Diagnosis Epilepsy Lamotrigine Initiation schedule Week 1&2: Lamotrigine, 25mg once daily Week 3&4: Lamotrigine, 25mg twice daily Week 5&6: Lamotrigine, 50mg twice daily Week 7&8: Lamotrigine, 75mg twice daily Week 9&10: Lamotrigine, 100mg twice daily Week 11 onwards: Lamotrigine, 125mg twice daily

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Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0005954444 Dr James W Dear 25/06/2024 13:22 Benjamin Rankine	RIE ACUTE MEDICINE DISCHARGE LETTER For patients who have had less than 4 medication changes during their admission: ONLY new medicines, or those that have been changed during this admission are prescribed in this IDL. All other medicines should be continued as before. _____ Medicines reconciled against ECS/other sources? Yes CHANGES TO DRUGS SINCE ADMISSION (relative to ECS) Stopped: Nil Started: Week 1&2: Lamotrigine, 25mg once daily Week 3&4: Lamotrigine, 25mg twice daily Week 5&6: Lamotrigine, 50mg twice daily Week 7&8: Lamotrigine, 75mg twice daily Week 9&10: Lamotrigine, 100mg twice daily Week 11 onwards: Lamotrigine, 125mg twice daily Changed: Nil Withheld: Nil ALLERGIES / ADVERSE DRUG REACTIONS: Codeine PHARMACIST CHECK: Name: Date: Time: _____ NURSING CHECK: Patient's own medication / controlled drugs returned to patient YES / NO / NA Signature..... Patient's own medication / controlled drugs removed with consent YES / NO / NA Signature..... _____ Due to diagnosis of Epilepsy, the DVLA must be informed by yourself immediately. 1. What is my diagnosis? You have been diagnosed with epilepsy. This is a condition that affects the brain and causes seizures. Seizures are when there is a change in the electrical activity of the brain that can cause a range of symptoms such as losing awareness, uncontrollable shaking and jerking, suddenly becoming stiff and collapsing. The Neurology team advised that you start an anti-seizure medication called Lamotrigine. An adjustment plan has been arranged and is at the top of this letter. Some of the side effects of Lamotrigine include insomnia, and skin reaction and requires careful dose titration. Any changes to skin should be reported to GP/NHS24 urgently. Furthermore, you have been advised that you must inform the DVLA of your diagnosis of epilepsy and in general, seizures need to be under control for minimum of 1 year. The Neurology team have also discussed with you the risk of fatal accidents with patients with epilepsy. These might occur being in deep water such as baths or swimming pools or at elevation such as working on rooftops. We would advise caution in such circumstances and be cautious with heavy machinery. Our Neurology team will write with further information and refer you to our Epilepsy Specialist Nurses. Please note that the first 2 weeks of Lamotrigine has been prescribed and the schedule is added to this letter. 2. What tests have I had and what were the results from these tests? - CT scan Head - No acute intracranial findings. - CT Scan Spine - No acute cervical spine injury. - Chest X-Ray – Normal.

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Note Details	Clinical Notes
	3. Do I need to see my GP after discharge? If so, why and when? Yes, please see your GP for your prescription changes for Lamotrigine within 2 weeks. Unless skin changes caused by Lamotrigine. _____ DIAGNOSIS: Epilepsy Mr Taylor was admitted to RIE on 25/06/24 following a seizure. Sudden onset of loss of consciousness, unwitnessed. Amnesiatic over event and reports confusion afterwards. Facial and scalp lacerations noted. No tongue biting but has bit lower lip. Biochemistry compatible with seizure. Lamotrigine titration schedule planned by Neurology team as documented. Explained the need to inform DVLA of diagnosis. ACTION REQUIRED IN COMMUITY: GP to please arrange Lamotrigine prescriptions with titration plan noted above. The first two weeks have been prescribed and provided. Many thanks. HOSPITAL FOLLOW-UP ARRANGED: Follow-Up with Dr Urwin, Neurology Department. CHANGES MADE TO CARE ARRANGEMENTS/ TREATMENT ESCALATION PLAN: Nil _____ OUTSTANDING RESULTS / INVESTIGATIONS: Nil PLEASE CC THIS LETTER TO: Dr Urwin, Consultant Neurologist, Neurology, DCN, 50 Little France Crescent, Edinburgh Bioquarter, EH16 4TJ Sent 26/06/24 Yours sincerely, Ben Rankine Trainee ANP Acute and General Medicine, Royal Infirmary of Edinburgh Addition by Mahnoor Shah, FY1 Acute and General Medicine, Royal Infirmary of Edinburgh. _____ FINAL DISCHARGE LETTER Authorising consultant: Date: _____ For further information contact: Acute and General Medicine Secretaries Phone: 0131 242 1440 E-mail: RIEacutemedicine@nhslothian.scot.nhs.uk _____

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005954444 Dr James W Dear 25/06/2024 14:40 Lauren Dickson (Nursing Student)	No seizure activity today. Independent. Observations stable. Awaiting D/C letter. PVC removed.

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Note Details	Clinical Notes
Pharmaceutical Care Issues Episode/Ref: I0005954444 25/06/2024 16:52 Lydia M Skipsey	Phar:D Med Rec completed: Y/N Sources used (min.of 2): Referral code: Outstanding Med Rec issues: Outstanding/ ongoing care issues: Changes to medication: - new lamotrigine ordered on ips Discharge/Compliance information:

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005954444 Nurse 25/06/2024 19:22 Lorraine Daniels	Nurse: patient discharged home with lamotrigine regime. Explained to patient and his relative who will help him with fortnightly changes as specified in discharge letter. All belongings returned to him. Relative providing transport home.

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Note Details	Clinical Notes
Specialty Review Episode/Ref: I0005954444 Dr James W Dear 24/06/2024 18:26 Dr Joseph Faulkner	AMU ADMISSION REVIEW Summary of ED/Interface presentation: Went home from friends home yesterday evening after feeling dizzy and unwell. Vomited once. Found on floor one hour later by his step daughter with bleeding from head and appearing confused. Cannot recall this event Two head injuries, laceration to left cheek and top of head CT-B nil acute Was confused at the time, has been slowly improving Last memory was still at his friends home, first memory is within AMU Oriented to place and person, but unable to recall age or current month. Would normally know this. No focal neurology, CNs intact No meningism/photophobia Note previous Tonic clonic seizure in Feb Has been taking Tramadol since a T9 compression fracture this month Not taken since 2 days prior to fall. No clear evidence of cardiogenic fall ECG sinus, rate 61, nil ischaemic Trop of 16 at around 0535 (6h post fall) Lying BP 144/85 --> Standing 123/84, denies symptoms of this. Pyrexial at 38.2 in ED No clear source identified No cough, chest clear, CXR NAD No rashes, muscle aches or sore throat No Urinary symptoms. Nausea and vomiting abated. No lower GI symptoms Treatment given in ED: • Medication:oramorph 5mg x2 diazepam 5mg Codene 50mg paracetamol 1g • Fluids: Nil PMHx: 06/2024 Presentation with T9 compression fracture, mild superior endplate fracture of L4 vertebra and Constipation First ever generalised convulsion February 2024 1.1 CT head: established right putaminal lacune, no acute changes Previous ?dissociative episodes Right hemisphere intracranial haemorrhage 2004 with good recovery Previous depression with deliberate self harm including stabbing 2019 Cholecystectomy 2018 SHx (driving if relevant): Lives with girlfriend No alcohol Mobilises independantly NEWS: 0 Bloods: Hb 149 MCV 94 WCC 15.5 CRP 1 Renal function stable Br 11 ALT 13 ALP 141 Amylase 65 Trop 16 at 0535 ECG: NSR rate 61

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Note Details	Clinical Notes
	Radiology: CT-B Small longstanding lacune in the right lentiform nucleus Streak artefact degrades images, particularly of the posterior fossa. CT Neck No acute cervical spine injury. Mild cervical degenerative change, as demonstrated on recent MRI. CXR Normal cardiomediastinal contours. Lungs and pleura are clear with normal pulmonary vascularity. XR Thoracic Spine = T9 compression # as previous XR Lumbar spine = No obvious fracture Medicine: • Is medicine reconciliation complete: Y • ALLERGY: NKDA • Is VTE risk assessed and prescribed: Y Problem lists: Diagnosis is not fully clear, although change over time may help to clarify the likely cause of his fall. Most likely further convulsive seizure, given two separate head injuries on two aspects of head --> ?Tramadol as a trigger --> Pyrexial suggests potential infective driver --> Post ictal period does seem prolonged for this --> This would be second seizure since February, suggesting need for AED going forward Potentially a postural drop with concussion Isolated Pyrexia of uncertain significance Plan: Monitor for further pyrexia Repeat bloods tomorrow Monitor for seizures overnight Review cognitive status in the morning Plan discussed with Prof Dear Name and designation: J Faulkner CDF AMU Bays 1, 2, 3, 7 - Bleep 2241 AMU Bays 4, 5, 6, 8 - Bleep 2112

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Note Details	Clinical Notes
Consultant Review Episode/Ref: I0005954444 Dr James W Dear 24/06/2024 18:55 Dr James W Dear	Prof Dear Summary First fit 3/2024 diagnosed by Dr Davenport. No treatment started. Tramadol prescribed recently (strongly associated with seizures even in therapeutic doses) Now presents with unwitnessed collapse head injury confusion post episode WCC increased with normal CRP. Has aspects consistent with second seizure. Neurology input would be helpful regarding starting anti-epileptic (note previous depression and self harm) Stop tramadol - seizures and not a good analgesic. Use oramorph tonight.

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005954444 Nurse 25/06/2024 03:08 Catherine Rensner	Nursing Richard has been settled overnight. NEWS stable. Mobilising independently. No further seizure activity noted overnight. No complaints of pain or discomfort. No new concerns at time of writing.

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Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0000337381 Dr AW Patrick 26/05/1998	DIAGNOSIS: 1. GENERAL MALAISE , 2. NAUSEA AND VOMITING, 3. ? SYSTEMIC VIRAL ILLNESS , 4. ? UTI,,HISTORY: Five to Six day history of mild generalized headache and vague colicky general abdominal pains associated fever, sweating and shivering. Mild Shortness of breath. Vomiting for the two days prior to admission and not keeping much food or fluid down. No diarrhoea. Reported a very poor appetite although this had improved by admission. There were no other specific symptoms of note. ,,PAST MEDICAL HISTORY: I note his past history of Tetanus as a child. Previous fractures and manic depressive illness. ,,SOCIAL HISTORY: I note he smokes 5 cigarettes per day and drinks approximately 4 to 5 units of alcohol per week. ,,EXAMINATION: Extensive tattoo's, No J,A,C,C,L. Apyrexial. Well perfused. Pulse was 80 per minute regular. Blood pressure was 135/70. Heart sounds pure. No peripheral oedema. Peripheral pulse were present but no arterial bruits and chest was clear and abdomen was soft with mild tenderness on deep palpation. No masses or organomegally. Normal bowel sounds. Neurological examination - no neck stiffness or photophobia, no focal neurological signs. Urinalysis - NAD other than a couple of ++ of Ketones. ,,INVESTIGATIONS/PROCEDURES: White count 7.1, haemoglobin 169, platelets 193, glucose 5.1, U's and E's normal. Chest X-ray unremarkable. ,,CLINICAL COURSE: Intravenous fluids were given and the patient symptoms rapidly resolved. He remained pyrexial overnight. He was reviewed by Dr Patrick in the morning after admission when he was feeling generally quite well. It was felt that this illness probably represented a systemic viral illness. The patient was discharged to complete a 5 days course of Augmentin initiated by his G.P. in case there was an underlying urinary tract infection. There has been no growth on MSU. ,,DRUGS ON DISCHARGE: 1. Augmentin 365 mgs tds ,,FOLLOW UP ARRANGEMENTS: Nil,,Yours sincerely ,,,,,,DR LUIS FERRANDO ,SENIOR HOUSE OFFICER ,,,,,,LF/GPB,,,,,,

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Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0000337383 Dr ML Watson 13/11/2004	Diagnosis:,,1. Severe headache,2. Intra-cerebral haemorrhage,3. Coma,,Management in ICU:,,1. Mechanical ventilation,2. Lumbar puncture,,Mr Taylor was admitted to the Royal Infirmary of Edinburgh from home with sudden headache and photophobia. He was initially GCS 15 but declined to GCS 3 and underwent endotracheal intubation and mechanical ventilation. A CT scan showed intra-cerebral blood in the right lentiform nucleus. His conscious level then improved and subsequently declined but a further CT scan showed no new changes and the Neurosurgical opinion was that no intervention was required. He was admitted to the Intensive Care Unit where his conscious level gradually recovered over the next few hours and he was able to be weaned from the ventilator. ,,A lumbar puncture was performed which showed no xanthochromia or evidence of infection and he was transferred to the Medical Wards for further investigation of his continuing headache but with no clear neurological abnormality. Clearly there is the possibility that he is at risk of further vascular events.,,A further summary will follow in due course.,,,,,Yours sincerely,,,,,,,DR S MACKENZIE,Consultant in Anaesthesia and Intensive Care,,,,cc Dr M Watson, Consultant Physician, RIE, File,

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Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0000337383 Dr ML Watson 13/11/2004	DISCHARGED AGAINST MEDICAL ADVICE ON 17 NOVEMBER 2004,,DIAGNOSIS:,Focal Right Lentiform Nucleus Haematoma - ?Cause ,,PRESENTING HISTORY:,This 41 year old man was admitted with a frontal and right temporal headache. He had earlier taken Solpadol at home for the above. He also complained of photophobia and an episode of vomiting prior to presenting to A&E. His initial GCS was 15/15. As he was taken to have a CT Head scan done his GCS dropped to 3/15 and he had to be intubated. He has a history of a head injury about two years ago with a right-sided weakness which has completely resolved. This was following a motorbike accident.,,INVESTIGATIONS:,Hb 150. WCC 14.8. Platelets 276.,Urea 3.6. Creatinine 98. Sodium 143. Potassium 3.7. TCO2 23.,Glucose 5.4.,Coagulation Profile - normal.,Urine for toxic screen - positive for amphetamines,,CLINICAL COURSE:,Mr Taylor was transferred to the Intensive Care Unit where a CT Brain done showed a small 7 mm x 5 mm right lentiform nucleus haematoma with no evidence of subarachnoid haemorrhage. He self-extubated but subsequently his GCS dropped again and he had to be reintubated. A repeat CT Head showed no change. He was transferred up to Ward 207 once his overall condition had improved. He, however, complained of a persistent headache. He had a lumbar puncture done which showed no organisms, no xanthochromia, protein 0.63, glucose 3.2. His symptoms settled with IV hydration. He was seen by the Neurology Team previously who suggested that beside a LP (note results) he should have an EEG done to rule out seizures, and this has been requested as an O/P. He had an MRI Head done which showed a haematoma centred on the right lentiform nucleus as before with no evidence of an underlying mass or lesion but it was not possible to categorically exclude an underlying cavernoma as a cause for bleed although there were no positive features for this. It was suggested that Mr Taylor be referred to the Stroke Physicians. His case and MRI findings were subsequently discussed with the Stroke Team and it was felt that he had no neurological deficit he would not need to be seen in the Stroke Clinic.,,AS this gentleman does not have a history of hypertension, diabetes, no symptoms suggestive of vasculitis the exact cause for the focal bleed was not known. However, decided to discharge himself, against medical advice, before a definite plan of action was made.,,DRUGS ON DISCHARGE:,None.,,FOLLOW-UP:,The scan findings are to be discussed with the Neurology and Radiology Teams and further investigations, if thought necessary, to be decided based on the above. We will inform you if he needs any kind of further intervention based outcome of the above discussion. ,In the meantime this man was advised to avoid driving for one month.,GP - If possible could you kindly perform an ESR as he decided to discharge himself prior to this being done.,,Yours sincerely,,,,,Dr Anil Vijayan,SHO to Dr Bateman

Clinic Letters

University Hospitals Division

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

Surgical Ambulatory Care

Dr Green
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date First Created: 03/08/2018
Date/Time Printed: 11/05/2026 09:43
Our Ref: 610119466W
CHI: 1006631372

Patient:	Mr Richard Taylor Flat 1 3 Clovenstone Close Edinburgh EH14 3FA	**UHPI:** **Date of Birth:**	610119466W 10/06/1963
Specialty:	Surgical Ambulatory Care	**Consultant:**	Professor Richard JE Skipworth

HOT Clinic (Mr Skipworth)

This 55 year old gentleman was asked to return to the HOT clinic for an MRCP after presenting with RUQ pain and deranged LFTs. MRCP today confirms gallstones in his gallbladder and as distal CBD calculus. LFTs 2 days ago - Bil 73 ALT 311 Alk Phos 256 GGT 296. Richard remains in considerable pain and discomfort and is troubles with nausea and vomiting when eating and drinking. We have explained treatment options to Richard and he has elected to be admitted for a lap chole and CBD exploration. Admitted from clinic, for IVI, NBM from midnight and analgesia. Bloods also rechecked.

A Forsyth
ANP

Mental Health Assessment Service (MHAS)

Dr Green
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date First Created: 21/01/2019
Date/Time Printed: 11/05/2026 09:43
Our Ref: 610119466W
CHI: 1006631372

Patient:	Mr Richard Taylor Flat 1 3 Clovenstone Close Edinburgh EH14 3FA	**UHPI:** **Date of Birth:**	610119466W 10/06/1963
Specialty:	Mental Health Assessment Service (MHAS)	**Consultant:**	Gary Cleghorn

Taylor Richard 10/06/1963 55 Yrs Male CHI: 1006631372

Follow up appointment at MHAS on the 21st Of January at 11am with Louise Munro. Was reviewed by MHAS at the Infirmary on the 19th following an episode of self harm. Asked to return today for further assessment purposes and to offer support following incident on Saturday.

Richard presented as arranged at MHAS, looking much less distressed. Has gone to the Crisis Centre on Saturday as agreed but reports only stayed there for a short time as he was worrying about his children and felt he wanted to return home to them. Two of his sons had called him whilst at the crisis centre offering support. Had returned home and appears to have spoken things over with his wife which Richard felt was positive. Now feeling "a bit better" in terms of suicidality , feels he has a supportive family and that his children are the only positive driver in his life currently so feels he would not act on suicidal thoughts due to his children.

Reports history of using poor coping mechanisms to deal with stress. Previously self harmed significantly around sixteen years ago following previous marriage break up, states he required surgery in St John's. Reports as a teenager was an inpatient within Hearthill hospital in Shotts due to self harming, states he was in for around one month. Discussed triggering factors at this time, Richard disclosed as a young child until a teenager he was physically abused by his mother, Richard extremely tearful when discussing this, since the abuse has used self harming to deal with "emotional pain", states it is the only coping mechanism he knows and turns to self harm in an effort to deal with stress. Further disclosed as a young boy he was subject to sexual abuse for a period by his mothers neighbour, states he has never disclosed this before. Reports most of his adult life he has regular nightmares and flashbacks relating to the physical and sexual abuse. Feels over the years his sleep as been disturbed due to nightmares.

One of three siblings has no contact with his brother but has regular contact with his sister whom is supportive. Has sixteen children, his eldest in a Nurse and she has been supporting her father since Saturdays incident. States in the longer term he and his wife will separate, Richard has decided to move out and is going to attend the housing office this week. His wife has told him she is now in

Mental Health Assessment Service (MHAS)

Dr Green
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date First Created: 21/01/2019
Date/Time Printed: 11/05/2026 09:43
Our Ref: 610119466W
CHI: 1006631372

a relationship with another man whom she is planning on having loner relationship with. Richard feels now he is starting to accept this and is hopeful he can build a life for him and his family once they separate.

Casually dressed, good evidence of self care, tearful at times, pleasant in all interactions, speech normal, able to give more of a history than when last saw due to circumstances, reports sleep remains poor, has had little diet since Friday, mood - subjectively "ok" objectively more reactive in affect, no current thoughts to end his life, cites his family as a protective factor, nil psychosis, nil formal thought disorder, alert and oriented to time and place, describes previous traumatic events as a young boy and as a teenager of both physical and sexual abuse. History of nightmares and flashbacks of traumatic event, history of poor coping mechanism.

Risk

Denies any thoughts to end his life, cites his family as a protective factor for him, future plans evident. No indication of any mood disorder or any psychotic illness.

Imp
Self harm in the context of situational crisis.

Discharge MHAS
Made aware of the Rivers Centre and drop in facility regarding possible trauma symptoms
Aware of crisis services including MHAS

Lothian NHS Board

Rivers Centre for Traumatic Stress
1st Floor
Fountainbridge Library Building
137 Dundee Street
Edinburgh EH11 1BG

Telephone 0131 451 7400

www.nhslothian.scot.nhs.uk

Date 26 February 2019

Our Ref RT / CHI: 1006631372

Private & Confidential

Dr Smith
SW CMHT
Cambridge Street House
5 Cambridge Street
Edinburgh
EH1 2DY

Dear Dr Smith

Re: Richard Taylor, 42 Morvenside, Edinburgh, EH14 2SJ

I would be grateful if you would consider seeing this man for psychiatric assessment.

Richard self-referred to the Rivers Centre and was seen for a brief triage appointment. He told me that he recently split up from his partner as he discovered she was pregnant with another man's child just before Christmas. On 30th Jan there was an incident when he had been drinking and then drove his car and had an accident. He also stabbed himself in the abdomen. (Please see the A&E notes on TRAK.)

Richard is currently staying with a friend as he is not allowed to go to his house due to his bail conditions. He is not allowed contact with ex wife or his children so has not seen his children for over 3 weeks and this is impacting on them as well as him. He said he has a social worker and is due to meet with them this week – Elspeth Holden at Drumbrae. This may be the social worker for children as they are currently on the child protection register.

Richard reported a trauma history of abuse from his mother when he was a child but he did not go into details about this. In terms of his symptoms, Richard explained that he has always been very up and down emotionally. He is not sleeping well, is tearful and has no appetite. He said he has always self harmed. He cuts his arms, has taken an overdose and has also attempted to hang himself. His self harming is worse depending on what is going on his life, but he feels that it all stems from his relationship with his mother. Richard has vivid memories of child hood that come into his head and he tries to switch back off from the memories. Spending time with his children helps with this. The memories are usually triggered by something and he feels that they are as clear as day. He wants to be able to talk about them to be able to get rid of them. Richard said he struggles to get to sleep and to stay asleep. He said he can go several days without any sleep but is not aware of any dreams. He

currently feels very low and anxious and says some of this is due to missing his children.

Day to day Richard has been visiting his older children from previous relationships. They have been very supportive of him and are concerned about him so have encouraged him to seek help. His oldest daughters are 38and 36 and are both nurses. They both have children so he feels better when he sees grandchildren.

Richard feels that his present difficulties are all linked to both the past and present and he feels that he is losing everything again and feels trapped inside himself. He said he has never had the opportunity to talk about what happened to him when he was a child. He feels that he now needs to do something as he cannot keep on the way he has been and he wants to address his self-harming behaviours. He currently takes mirtazepine but does not feel that they are working. His GP has advised that if this was the case then he to go back to increase the dose.

I discussed his case with the Rivers Team and the feeling was that Richard needs a full psychiatric assessment to consider the most appropriate diagnosis for this man given his repeated self-harming behaviour. I would be grateful if you would consider seeing him.

Kind regards.

Yours sincerely,

Heather Hillen
Psychological Therapist

Copy: Dr Knickerson, Sighthill Medical Practice, Green Practice.
Richard Taylor, 42 Morvenside, Edinburgh, EH14 2SJ

South West Edinburgh
Adult Mental Health Services

PRIMARY CARE MENTAL HEALTH TEAM
(Referrals Co-ordinator)
Cambridge Street House
5 Cambridge Street
Edinburgh EH1 2DY
T: 0131 537 8665

NHS Lothian

Heather Hillen
Psychological Therapist
Rivers Centre
1st Floor
Fountainbridge Library Building
137 Dundee Street
Edinburgh

Date 01.04.19
Your Ref
Our Ref WP/LK-037415
CHI Number 1006631372

Enquiries to Lorraine King,
Referrals Co-ordinator
Extension 48665
Direct Line 0131537 8665

Dear Heather,

Re: Richard Taylor, 42 Morvenside, Edinburgh, EH14 2SJ, DOB: 10.06.63

Thank you for referring Mr Taylor who your saw at the advice clinic with a history of trauma and current self harming behaviour. You asked for a psychiatric assessment from our team. We reviewed your referral and do not feel that a psychiatric assessment is the appropriate next step at this time. We recommend that he has a further psychological assessment with your department to determine the correct course of treatment going forward.

Accordingly we have not arranged an appointment at present.

Yours sincerely,

South West Primary Care Mental Health Team

Cc: Dr Nickerson, Sighthill Green Medical Practice

Lothian NHS Board

Rivers Centre for Traumatic Stress
1st Floor
Fountainbridge Library Building
137 Dundee Street
Edinburgh EH11 1BG

Telephone 0131 451 7400

www.nhslothian.scot.nhs.uk

NHS Lothian

PRIVATE & CONFIDENTIAL
Mr R Taylor
42 Morvenside
Edinburgh
EH14 2SJ

Date 8 August 2019
Your Ref
Our Ref KL/1006631372

Dear Richard

Thank you for coming to the assessment appointment at the Rivers Centre on 1 August 2019.

I'm writing to summarise the plan we discussed. I fed back that I thought you were suffering from Depression, which is very understandable after what you've been through. You stopped Mirtazapine as it didn't help. I feel it would be worth having a trial of another anti-depressant called Fluoxetine and am making this suggestion to your GP. The main side effects with Fluoxetine are a bit of tummy upset which usually settles after a week to 10 days. Some people do get more anxious, and a small number have an increase in thoughts of self harm and suicide. If this happens it is important you seek support and you may need to stop it. You can contact your GP but also you are aware of the out of hours services like MHAS, the Crisis Centre and the Samaritans.

As well as medication I am referring you for individual psychological therapy with the South West Edinburgh sector team. You told me you want to try to understand how you have been affected by difficult experiences in your past and how this relates to how you are in relationships. You appeared really thoughtful about this and I think you would benefit from individual psychological therapy to help with this.

I have also referred you to Roslyn Taylor, one of the Specialist Link Workers at the Rivers Centre. She will meet you to give advice about working towards getting access to your children and also to see if she can suggest any community resources that would reduce your social isolation.

Our Values Into Action

disability confident EMPLOYER

Headquarters
Waverley Gate
2-4 Waterloo Place
Edinburgh EH1 3EG

Chair Brian G. Houston
Chief Executive Tim Davison
Lothian NHS Board is the common name of Lothian Health Board

Please get in touch if there is anything in this letter that isn't clear or you want to discuss.

Best wishes

Dr. Katharine Logan
Consultant Psychiatrist in Psychotherapy
Rivers Centre

c. Dr R Hendrie, Sighthill Green Medical Practice, EH11 4AU

Lothian NHS Board

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1st Floor
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PRIVATE & CONFIDENTIAL

Date 8 August 2019
Your Ref
Our Ref KL/1006631372

Referral Coordinator
South West Mental Health Team
Cambridge Street

Dear colleague

Richard Taylor 1006631372
42 Morvenside, Edinburgh EH14 2SJ
Diagnosis
Depressive Episode
Recurrent self harm

Medication

Stopped Mirtazapine (?dose) as he felt it had no benefit. Reports no other history of anti-depressant use.
Omeprazole

Plan:

Referral to South West sector team for psychological therapy.
Suggest further trial of anti-depressant medication with Fluoxetine commencing at 20 mg daily
Referral to Rivers Centre Specialist Link Worker for:
Advice about working towards getting access to his children and secondly, information and sign posting about community resources he could engage with to reduce his social isolation, including any supports specifically for those with a history of being in care
I mentioned the option of him contacting the Scottish Child Abuse Inquiry
He is aware of crisis services

This 56 year old man attended the Rivers Centre advice clinic on 19 February 2019 and I saw him for an assessment on 1 August 2019. He gave the following history.

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2-4 Waterloo Place
Edinburgh EH1 3EG

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Richard's wife told him she wanted to separate in mid December 2018 and around new year she said she was pregnant with another man's child. He hoped they could co-parent their 5 children (ages 13, 12, 6, 5 and 2) amicably but on 30 January, after a row with his wife, and some alcohol, his car skidded into a barrier. He returned to the family home and stabbed himself in the abdomen, knowingly in front of his wife, but he didn't know his 5 year old son was also in the room. He was tearful when describing recurrent intrusive images of his son's face and greatly regrets exposing his son to this. He said he wanted to die at the time due to the fear of losing his family. After hospital treatment he was charged and required to stay away from his wife and children, and his children were placed on the Child Protection Register (CPR). He stayed with a friend and contact with his children did resume. The children have been removed from the CPR but his wife has not allowed him to see them since she moved out of the family home in April. He says she is saying his mental health problems will stop him getting access to the children. His wife and the children have moved in with her new partner. He doesn't know where they are living. Social Worker Elspeth Holden at Drumbrae was involved when the children were on the child protection register but he doesn't think there is current SW involvement.

Background

He was born in Leith. He has been told his mum didn't want a boy and his aunt looked after him for the first few years of his life. He has an older sister and a younger brother. He described his mum as unkind and cruel, and said she singled him out for punishment for minor things. She repeatedly locked him in a cupboard and hit him with a belt for minor things like not making his bed properly. His dad was a positive figure but he was in the Army so away from home a lot. He wasn't hit when his dad was around home. He had some friends at Primary School but remembers a lot of bullying around the end of Primary School, but couldn't remember what this was about. He described sexual abuse by a male neighbour between the ages of 5 and 8. He thinks he tries to block this out. When he meets friends from Primary School they have reminded him that he used to take his trousers down at school. This reminds him about the neighbour getting him to take off his clothes and engage in sexual touching. His parents split up when he was about 8. His dad took him and his brother to live in Wester Hailes, while his sister stayed with their mum. This meant he was away from the sexual abuse and the abuse from mum. However he said his emotions were all over the place and he became 'anti everything'. He was self harming with cutting and ODs from age 10, attempted to hang himself and stole cars. He had several admissions to psychiatric hospitals from age 10 and was expelled from school at age 12. He spent time in children's homes and said he was abused by the boss of one of these homes. He couldn't remember the name of the man or the home.

He has had a series of relationships producing 16 children but not lasting, and has been married 3 times. The first marriage was in 1980 and lasted 7 years. He said previous partners had denied him access to his children. He said this wasn't for a specific reason and said none of the older children had been at risk or on the CPR. He said he got his education in Prison doing a Higher in Art and Design, and training in sign writing and in painting and decorating. He did this work for years and then moved on to being a driver and got his HGV licence. He described himself as a good worker. He stopped work a few years ago to help his wife look after the children. The recently ended relationship lasted for 15 years, although they split for a period when she got involved with someone else. Richard took her back and they had the 3 younger children. He described giving up going out, having friends, being very involved with childcare and doing what she wanted. He feels he was a good dad, things were stable and going well and now his world has been shattered. He wouldn't want to get re-involved with his wife but just wants to see the children and be amicable with his wife for the sake of the children.

Current Symptoms

He was intermittently tearful and described his mood as persistently low over the past couple of months. He feels sad due to missing his children and says he doesn't feel angry. He struggles to get to sleep, usually falling asleep about 4 am and then sleeps fitfully. He has dreams about the children, which are not distressing. He has reported nightmares and daytime intrusions about past abuse in the past but doesn't have these currently. He reported poor appetite with significant weight loss, going from a 34 to 30 inch trouser waist since the start of the year. He described poor concentration and poor motivation. He has ongoing thoughts about harming himself but he hasn't acted on these since the self stabbing at the end of January.

Currently he is ruminating about his children, feeling sad, thinking about what he has lost, wondering why his relationships keep ending and whether it is related to his past experiences. He does report a recurrent distressing intrusive image of his son's face when his son saw him stab himself. He doesn't describe current hyper arousal or avoidance symptoms.

He reports being in contact, and good relationships, with his 11 older children from previous relationships. They have been very supportive of him and are concerned about him and have encouraged him to seek help. His oldest daughters are 38 and 36 and are both nurses with children. He feels better when he sees grandchildren. His sister is supportive but he is not in touch with his brother. He isn't working currently and he is living alone in the family .

He feels he cleans rather compulsively but he has little motivation for anything else.

Psychiatric and Medical History

RIE, MHAS and Crisis Centre after self harm January 2019
Reports admissions related to self harm (cutting arms, taking ODs, attempting hanging) to REH secure unit then Hartwood Hospital and child secure units from age 10. Remembers hating being locked in as it reminded him of being locked in a cupboard by his mum at home. He remembers being injected with medication and Chlorpromazine causing side effects which sound like dystonia.

Self harm requiring surgery at St. John's after previous marriage break up around 2003. Self harm increases with increased distress. He feels it relates to emotions related to how he was treated as a child. At times he feels he wants to end his life, at other times self harm gives him a feeling of relief which may relate to the familiarity of punishment. He spoke about negative and self blaming thinking such as believing his mum hit him or relationships end because he is bad or has failed and self harming can be linked to a feeling he needs to punish himself.

Cholecystectomy 2018

Longstanding Cannabis use, currently most days, which he feels helps him sleep. He doesn't feel he's ever been dependent on alcohol and hasn't used alcohol since the self stabbing.

He was on a prescription for Diazepam in the past. He hasn't used heroin or injected drugs.

Forensic History

He had a number of prison sentences as a young man, most recently for 2 years, coming out in 1995. Charges included car theft and also attempted murder, when he used a weapon to assault a man who had threatened his wife and daughter. He said he got 2 years instead of 8 as he had been provoked.

Summary

Richard is a 56 year old man with a long history of self harm which seems related to difficulty managing his emotions following disrupted early attachments and childhood experiences of invalidation and abuse. He reports having a series of relationships,

producing 16 children, with things being quite stable over recent years in a 15 year relationship. However he has been struggling greatly since this relationship ended at the end of last year. In particular he is struggling as he has no current contact with his youngest 5 children.

He currently presents as depressed and isolated, although he does have support from his older children. He wants to try to understand how he has been affected by his past experiences and if his experiences are related to his pattern of relationship breakdowns. I think he would benefit from individual psychological therapy with a focus on formulation. I would also suggest he has a trial of Fluoxetine 20 mg, although I suspect resuming contact with his children will have more impact than any medication. I will also ask my Specialist Link Worker colleagues to see him.

Yours sincerely

DR KATHARINE LOGAN
Consultant Psychiatrist in Psychotherapy
Rivers Centre

c. Dr R Hendrie, Sighthill Green Medical Practice, EH11 4AU

South West Primary Care Mental Health
Dr Cooper – Consultant Psychiatrist
Dr Smith – Consultant Psychiatrist
Dr O'Connor- Speciality Doctor

Cambridge Street House
5 Cambridge Street
Edinburgh EH1 2DY

Tel: 0131 537 8650
Fax: 0131 537 8655

NHS Lothian

Mr Richard Taylor
42 Morvenside
Westburn
Edinburgh
EH14 2SJ

Date: 20.11.19
Ref: DC/LK
CHI No: 1006631372

Enquires to: 0131 537 8673

Direct Line:
Extension:

Dear Mr Taylor,

Your GP has referred you to the South West Community Mental Health Team and we would like to offer you the following outpatient appointment with Dr Cooper, Consultant Psychiatrist and David Curran, CPN, on:

Friday, 29th November 2019 at 3.00pm

in

Sighthill Health Centre, 380 Calder Road, Edinburgh, EH11 4AU

If you need to change your appointment please phone us as soon as possible on 0131 537 8673.

On arrival, you should report to the receptionist with this letter.

Yours sincerely

Appointments Officer

If you need support, the following services may help:

Breathing Space	0800 83 85 87 (6pm – 2am / 24 hrs at weekend)
Mental Health Assessment Service	0131 537 6000 (24 hours)
NHS 24	111 (24 hours)
Samaritans	116 123 (24 hours)
Saneline	08457678000 (6pm – 11pm)
Edinburgh Crisis Centre	0808 801 0414 (24 hours)

South West Community Mental Health Team

Dr D Cooper, Consultant Psychiatrist
Dr S Smith, Consultant Psychiatrist
Dr S Gilfillan, Consultant Psychiatrist

Dr M O'Connor, Specialty Doctor in Psychiatry

Cambridge Street House
5 Cambridge Street
Edinburgh EH1 2DY

Tel: 0131 537 8650 / 8673

Dr Hendrie
Sighthill Green Medical Practice
Calder Road
Edinburgh
EH11 4AU

Date: 02/03/20
CHI: 1006631372

Enquiries: Pamela McDonald
Direct Line: 0131 537 8650

Dr Hendrie

Re: Richard Taylor (CHI: 1006631372), 42 Morvenside, Edinburgh EH14 2SJ

Unfortunately Mr Taylor did not attend his appointment on the 12 February 2020. He has missed a few appointments with me now and I am discharging him at the current time. Please feel free to discuss with me.

Kind regards.

Yours sincerely

Dr Deborah Cooper
Consultant Psychiatrist

South West Community Mental Health Team

Dr D Cooper, Consultant Psychiatrist
Dr S Smith, Consultant Psychiatrist

Dr M O'Connor, Specialty Doctor in Psychiatry
Dr M I Thomas, Specialty Doctor in Psychiatry

Cambridge Street House
5 Cambridge Street
Edinburgh EH1 2DY

Tel: 0131 537 8650 / 8673

Date: 16/05/2022
Our Ref: HO/AR
CHI: 1006631372

Enquiries to: (Secretary)
Direct Line: 0131 537 8693

Dr R Hendrie
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Dear Dr Hendrie

Re: Richard Taylor / d.o.b. 10.06.1963

Mr Taylor did not attend his appointment today (11/05/2022).

He was referred for a long history of depressive episodes, overdose and self harm necessitating review.

After discussion with Dr Deborah Cooper, Consultant Psychiatrist we have decided to discharge Mr Taylor from our service today.

Should he require further review, please re-refer him back to our service and we will add him to the waiting list.

Yours sincerely and best wishes,

Dr Halima Okewole
FY2 to Dr Deborah Cooper, Consultant Psychiatrist

Adult Mental Health SW OPD

Dr Green
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date First Created: 03/08/2022
Date/Time Printed: 11/05/2026 09:43
Our Ref: 610119466W
CHI: 1006631372

Patient:	Mr Richard Taylor Flat 1 3 Clovenstone Close Edinburgh EH14 3FA	**UHPI:** **Date of Birth:**	610119466W 10/06/1963
Specialty:	Adult Mental Health SW OPD	**Consultant:**	Dr Deborah J Cooper

Psychiatric diagnosis:
1. Depression

Current psychiatric medication:
Nil.

Plan as discussed with Dr Deborah Cooper, Consultant Psychiatrist:
1. GP to start Venlafaxine now at 37.5mg then increase this by 37.5mg every two weeks up to 150mg. Before any further increase please check his blood pressure.
2. Mr Taylor to opt back into psychology.
3. Copy letter to Mr Taylor but Dr Cooper explained that his clinic letter for his information.

Presenting complaint:
Poor mental health.

History of presenting complaint:
Mr Taylor explained that most of his poor mental health began around three and a half years ago in 2019 after his wife phoned him to tell him that their marriage was ending and that she had been cheating on him. He then reported that two weeks later she told him that she was pregnant with the new partner's child. Upon hearing this, Mr Taylor, who had been sober he says for about 15 years, drank a bottle of Jack Daniels and took the car out for a ride. He reports crashing the car and making his way back home upon which he stabbed himself in the stomach in front of his wife and unknowingly his young child, Rio.

He says that he has not seen his children in the last three and a half years. He has five children with the ex-partner and he says that she has changed their names and says that he is not allowed to come in contact with any of the children. Richard has 11 other children and one of the older children is in contact with the five children from the ex-partner and has been keeping Richard informed of their wellbeing and progress.

Adult Mental Health SW OPD

Dr Green
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
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Date First Created: 03/08/2022
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Our Ref: 610119466W
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He says ever since this has happened, he has really struggled mentally especially around Christmas and birthdays where he finds himself crying, anxious and agitated. He says he still lives in the house he shared with his ex-partner and children, and there are a lot of memories in the house which often serve as a trigger for his low mood and depression. He says he was married to his ex-partner for 15 years and denies any violence towards the ex-partner or children. He says the five children with his ex-partner are his youngest children and as such he feels especially affected by their absence as he was fairly close with them when they used to live together.

He denies any further suicide attempts since the episode that occurred around Christmas time three and a half years ago, although he says that when his mood is very low and he starts to have flashback memories of his children, he finds that he can get really upset and can't stop himself from thinking about self harm which he thinks would be a release for him from his pain.

He says the low mood has affected his weight, for example he used to be a 34 waist however this dropped down to 28 over the period of his low mood. He says that his weight has now been improving because his older children, who were very worried about him, have made a concerted effort to ensure that he is eating well and looking after himself better. He also says that the thoughts of his older children not having him around serves as a protective factor and motivation for him to stay alive. Additionally he finds that he has been occupying himself more by spending time with his other children, ie he leaves the house early in the morning and arrives back very late at night and it is only sometimes during this period of being at home alone that he gets the flashback memories of his younger children.

He says that initially when his ex-partner left him, he went on a big spending spree and got himself into some debt. However he is now making headway into repaying this debt. He says that he is looking to sell the house that he shared with his ex-partner as "there are too many memories in this house" and additionally he is trying to downsize again due to the cost of the house.

He says overall that he finds it very hard to eat and has poor sleep. He says that he has been using cannabis which has helped him to improve his sleep and now he gets about six hours a night when he does take the cannabis.

He also disclosed that he feels very guilty because he worries that he has traumatised his young son, Rio, as Rio saw him stab himself during the episode described earlier in this letter.

Past psychiatric history:
He reports having an admission around 14 years old and thinks he might have been sectioned.

Past medical history:

Adult Mental Health SW OPD

Dr Green
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date First Created: 03/08/2022
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Nil of note.

Medication history:
NKDA.
1. Omeprazole
2. Fluoxetine; the GP started him on this medication initially however Mr Taylor reports that he stopped this about a year ago. He says that he was on it for a few months but did not see any benefit.

Personal and social history:
Mr Taylor says that he has suffered with mental health issues since he was a child. He reports being physically and mentally abused by his mother. He says his mother was "hard headed". He has not spoken to her in many years.

He says his dad was in the Army so was away a lot however "dad was cool, top man". He says his dad had ideas and probably knew that he was being abused by his mother as he had bruises or welts on his body as a child, however dad "was too scared to say anything". His dad didn't like confrontation although he would often think "grow a set dad". He has one older sister and one younger brother who he reports were not abused by his mother. He says that at one point his older sister would join in with his mum in abusing him. He says he has no contact with his sister or brother presently.

He reports being in and out of many homes when he was a younger child. Presently his son stays with him and has done so for the last six months (one of his older children).

Family history:
He was told by his maternal grandmother that his mother had postnatal depression after she had given birth to him. His maternal grandmother says that the mum wanted a girl but that she had Richard instead. His maternal grandmother also told him that his mother "detested him". He recalls looking up the meaning of the word detest and being significantly hurt by this. Otherwise he denies any other family history of mental health.

Drug and alcohol history:
He is not previously a big drinker and except for the episode where he drank a bottle of Jack Daniels after finding out about his wife, he says that alcohol rarely appeals to him. He also says he has not drank alcohol since that night. He uses cannabis on most nights essentially to help him sleep.

Forensic history:
Nil of note.

Adult Mental Health SW OPD

Dr Green
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Sighthill Health Centre
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EH11 4AU

Date First Created: 03/08/2022
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Mental state examination:

Appearance and behaviour:
Mr Taylor was dressed in a black vest and a scarf on his head. He had multiple tattoos. He did not appear significantly overweight and he was well kempt.

In terms of his behaviour we were able to develop a good rapport and he was engaged in the conversation. He was able to maintain eye contact and had a relaxed facial expression and body language. He had no psychomotor activity or retardation. He also had no abnormal movements or postures.

Speech:
Mr Taylor had a good rate, quantity, tone, volume, fluency and rhythm of speech.

Mood and affect:
Subjectively Mr Taylor describes his mood as significantly low. Objectively he did appear low in mood. His affect was reactive. His affect had a good range and mobility and a normal intensity. His affect was congruent with his mood.

Thought, form and content:
Mr Taylor had no evidence of a formal thought disorder. In terms of his thought content he exhibited suicidal thoughts however he had no immediate plans to action any of these.

Perception and cognition:
Mr Taylor did not exhibit any abnormal perceptions. His cognition appeared intact.

Insight and judgement:
Mr Taylor had good insight into his presentation and could pinpoint the trigger for his deterioration in his mental health. He also had good judgement with regards to keeping himself safe and his motivation for not committing suicide.

Risks:
To self - Mr Taylor has significantly harmed himself in the past.
Risk to other or from others - None could be identified.

Summary:
Mr Taylor is a 59 year old man who presents with persistent low mood following the ending of a relationship in a negative way with his ex-partner of 15 years. He attempted suicide three and a half years ago after discovering that his wife had been cheating on him and was now pregnant with the new partner's child.

Adult Mental Health SW OPD

Dr Green
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date First Created: 03/08/2022
Date/Time Printed: 11/05/2026 09:43
Our Ref: 610119466W
CHI: 1006631372

As a result of this suicide attempt, the Court issued that he could not see his five children that he had with his ex-partner and had no contact with them. He has really struggled with this distance and as such his mood has remained persistently low and he has been having persistent thoughts of suicide and self harm.

Dr Cooper explained the side effects to expect with Venlafaxine. Mr Taylor is happy to follow the plan as detailed above.

Yours sincerely and best wishes,

Electronically checked by Dr Cooper

Dr Halima Okewole
FY2 to Dr Deborah Cooper, Consultant Psychiatrist

Orthopaedic Trauma Triage Clinic

Dr Green
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
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EH11 4AU

Date First Created: 13/10/2022
Date/Time Printed: 11/05/2026 09:43
Our Ref: 610119466W
CHI: 1006631372

Patient:	Mr Richard Taylor Flat 1 3 Clovenstone Close Edinburgh EH14 3FA	**UHPI:** **Date of Birth:**	610119466W 10/06/1963
Specialty:	Orthopaedic Trauma Triage Clinic	**Consultant:**	

This Patient's Emergency Departments records and x-rays were reviewed at the Trauma Triage Clinic by Mr J F Keating on 13/10/2022 and the following was determined:

Date of injury: 12/10/2022
Mechanism of injury: Other
Clinical note :

Diagnosis: Undisplaced proximal phalangeal fracture right ring finger.

History: This 59 year old man presented on 12/10/22 following an injury on the same day to his right ring finger. Radiographs indicate a completely undisplaced fracture of the base of the ring finger proximal phalanx which looks entirely stable and requires no specific treatment. I have discharge him from the TTC.

The management plan is for Discharge. No further intervention required. Self management as per ED leaflet
Kind regards

Mr J F Keating
Consultant Orthopaedic & Trauma Surgeon
Royal Infirmary of Edinburgh

Contact No: 0131 242 3436

Adult Mental Health SW OPD

Dr Green
Sighthill Green Medical Practice
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EH11 4AU

Date First Created: 04/01/2023
Date/Time Printed: 11/05/2026 09:43
Our Ref: 610119466W
CHI: 1006631372

Patient:	Mr Richard Taylor Flat 1 3 Clovenstone Close Edinburgh EH14 3FA	**UHPI:** **Date of Birth:**	610119466W 10/06/1963
Specialty:	Adult Mental Health SW OPD	**Consultant:**	Dr Deborah J Cooper

Unfortunately Mr Taylor did not attend his appointment on the 4thNovember. He did not attend any further psychology appointments which were organised. I am going to discharge him at the current time but if he is committed to engaging he can always be referred back.

Yours sincerely

electronically signed

Dr Deborah J
Cooper
Consultant Psychiatrist

dc/em

University Hospitals Division

St John's Hospital at Howden
Howden West
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West Lothian
EH54 6PP

General Medicine

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Date First Created: 09/01/2023
Date/Time Printed: 11/05/2026 09:42
Our Ref: 610119466W
CHI: 1006631372

Patient:	Mr Richard Taylor Flat 1 3 Clovenstone Close Edinburgh EH14 3FA	**UHPI:** **Date of Birth:**	610119466W 10/06/1963
Specialty:	General Medicine	**Consultant:**	Dr Rebecca S Dickinson

DATE OF NEUROLOGY REVIEW:30/12/2022

PROBLEMS:
1) Transient episode of altered awareness with no particular clinical pointers (28 December 2022)
1.1) MRI head: old right putamen haemorrhagic lacune (2022)
2) Previous admission to hospital with confusion (August 2022)
3) Road traffic accident whilst smoking cannabis (January 2019)
4) Mental health problems
4.1) Recent review by Psychiatry for depression (August 2022)
4.2) Episode of deliberate self-harm (2019)
5) Right lentiform nucleus intracerebral haemorrhage (2004)
5.1) Presentation with frontal and right temporal headache with associated reduction in conscious level

I was asked to review this 59-year old right handed HGV driver and met him on the Medical Admissions Unit on 30 December. He was alone and I was unable to obtain collateral history from his partner who was at home looking after their children.

He had been referred to Neurology because of an episode of altered awareness which occurred on 28 December. Mr Taylor could not recall anything about this episode. He was at work. His partner received a call from Mr Taylor's employer reporting that he seemed confused, driving his car around in circles and unable to recall how to get home. His partner attended to him and found him confused, unaware of his name, date of birth or place. Initially he was noted to have a left sided facial droop and possible weakness of his right arm although since has since resolved. He had also been incontinent of urine. Blood tests showed a neutrophilia. Mr Taylor does not recall anything about the event itself or his stay in the Emergency Department. He does however recall events on the Medical Admissions Unit.

Reviewing his electronic record, I note that he presented in August with an episode of confusion. He had been smoking cannabis. He self-presented to the Emergency Department and then seemed to self-discharge because he was confused about 'what was happening'. He had been found by his partner slumped on his couch at home although he was unable to recollect what had happened.

University Hospitals Division

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Date First Created: 09/01/2023
Date/Time Printed: 11/05/2026 09:42
Our Ref: 610119466W
CHI: 1006631372

I note that there is a family history of myocardial infarction in his father (late fifties). His father subsequently had a stroke in his seventies. Mr Taylor lives with his girlfriend. He works as an HGV driver. He smokes cannabis but does not use any other illicit drugs. He told me today that he does not drink any alcohol although I note from previous entries on his electronic record that there were concerns about excess alcohol in the past.

I explained to him that he has had a transient episode of confusion with no clear clinical pointers regarding what this was. In view of this I do not think he should drive pending investigations and I think he is legally obliged to inform the DVLA. He seemed rather reluctant to do so. Given that I was unable to obtain collateral history today I will recall him to the Neurology Clinic for repeat assessment. He specifically asked about whether the episodes could be related to interpersonal stress. I understand that he has had a difficult time following the break up of his relationship with his ex-wife and he no longer has any contact with their five children. Although he does not recall dissociation in the context of this recent event, he has had dissociative symptoms in the past. This may be relevant.

Yours sincerely

Electronically checked

DR NESHIKA SAMARASEKERA
Consultant Neurologist

Secretary: Jacki Ross (01506 523827) Dictated: 30/12/2022 Typed: 09/01/2023

Psychological Therapy Edin NW

Dr Green
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date First Created: 28/02/2023
Date/Time Printed: 11/05/2026 09:43
Our Ref: 610119466W
CHI: 1006631372

Patient:	Mr Richard Taylor Flat 1 3 Clovenstone Close Edinburgh EH14 3FA	**UHPI:** **Date of Birth:**	610119466W 10/06/1963
Specialty:	Psychological Therapy Edin NW	**Consultant:**	Judith Leicht

I apologise for the delay in sending this letter. I am writing to inform you that I have discharged Richard from my case load. The decision was based on poor attendance in line with our attendance policy. Richard has attended three out of ten scheduled appointments offered to him between 17/11/2021 and 25/08/22.

The following was all I was able to glean during our three appointments.

During assessment Richard disclosed long-standing mental health difficulties. He has as a history of repeated incarceration and admission to psychiatric hospitals. Additionally, he reported being married three times and having 16 children ranging in age from 5 to 42 years old. Richard also reported a challenging relationship with his ex-partner, with whom he shares five children. In 2015, his ex-partner left him for someone else and informed him of her pregnancy with her new partner. Richard disclosed that he subsequently stabbed himself in the stomach in front of his three year old son. This incident resulted in social service involvement and his children being placed on the child protection register. He reported attending meetings to demonstrate that he does not pose any risk to his children. Richard explained that his ex-wife had prohibited him from seeing them on the premise that they do not wish to see him. He disclosed that he is currently undergoing a divorce, emphasising that his children are of utmost importance to him and constitute a vital aspect of his life.

In terms of his upbringing, Richard disclosed a difficult upbringing marked by emotional and physical abuse inflicted by his mother, who he believes, would have preferred a daughter. He also reported concealing his injuries at school.

Richard disclosed that he was subjected to CSA perpetrated by a neighbour at the age of eight, which lasted for a period of 2-3 years. He shared that he had not previously disclosed this information to anyone. He further reported that the abuse took place during

Psychological Therapy Edin NW

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Date First Created: 28/02/2023
Date/Time Printed: 11/05/2026 09:43
Our Ref: 610119466W
CHI: 1006631372

periods when his father, who served in the army, was away. Richard expressed a desire to start therapy and move forward with his life, gain self-understanding, improve his social confidence and overall well-being.

As noted above, due to repeated missed appointments, I have no other option but to discharge Richard from our service.

Should you wish to discuss this case any further, please do not hesitate to contact me.

Yours sincerely,

Judith Leicht

Registered Counselling Psychologist

University Hospitals Division

St John's Hospital at Howden
Howden West
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West Lothian
EH54 6PP

Neurology

Dr Green
Sighthill Green Medical Practice
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Date First Created: 20/06/2023
Date/Time Printed: 11/05/2026 09:42
Our Ref: 610119466W
CHI: 1006631372

Patient:	Mr Richard Taylor Flat 1 3 Clovenstone Close Edinburgh EH14 3FA	**UHPI:** **Date of Birth:**	610119466W 10/06/1963
Specialty:	Neurology	**Consultant:**	Dr Neshika E Samarasekera

PROBLEMS:

1) Subjective memory complaints typically in association with headache - probable migraine with possible dissociative amnesia
2) Transient episode of altered awareness with no particular clinical pointers (28 December 2022)
2.1) MRI: old right putamen haemorrhagic lacune (2022)
3) Previous admission to hospital with confusion (August 2022)
4) Road traffic accident whilst smoking cannabis (January 2019)
5) Mental health problems
5.1) Recent review by Psychiatry for depression (2022) and Clinical Psychology (February 2023)
5.2) Episode of deliberate self-harm (2019)
6) Right lentiform nucleus cerebral haemorrhage (2004)
6.1) Presentation with frontal and right temporal headache with associated reduction in conscious level

Thank you for referring this 60-year old right handed HGV driver back to the Neurology Clinic who I previously met as an inpatient on 30 December. I apologise for the delay in receiving this letter. The original dictation seems to have gone awry so I am dictating the notes on this consultation from memory.

I met Mr Taylor with his partner. He had been referred back because of memory concerns. Since we met in December, he has not had any further similar episodes of loss of awareness. However Mr Taylor and his partner reported episodes of 'confusion' typically associated with headache. The headaches were severe with photophobia. He would then tend to sit quietly and sometimes would have amnesia for autobiographical information - for example asking his partner what his name was. There was no repetitive questioning in keeping with transient global amnesia and no markers of seizures.

He is still continuing to work intermittently in a job which involves driving HGVs. He mentioned today that he smokes cannabis daily to aid his sleep. There is no other illicit drug use and he does not drink any alcohol. It became apparent during the consultation that his complex social situation (including lack of access to some of his children with a former partner) is a considerable source of stress and upset for him.

University Hospitals Division

St John's Hospital at Howden
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Neurology

Dr Green
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EH11 4AU

Date First Created: 20/06/2023
Date/Time Printed: 11/05/2026 09:42
Our Ref: 610119466W
CHI: 1006631372

I would have completed a MoCA today but he mentioned today to me that he had attended your practice last week and had been able to complete a MoCA scoring 29/30. Today, unprompted, he recalled the five words comprising the memory domain of the MoCA without difficulty. His fundi were normal.

This gentleman reports episodes of confusion/amnesia in the context of severe headache suggestive of migraine. I did wonder, given the retrograde amnesia with loss of autobiographical information, whether this was dissociative. He was uncertain today how frequent his headaches are so I have encouraged him to keep a headache diary and suggested to him that if he was having at least two disabling episodes per month, it would be worth considering a trial of migraine prophylaxis. First-line options would typically be Propranolol or Amitriptyline although given his history of prior mental health problems, we would need to consider the risks of either medication in overdose and I said to him today that both medications would be dangerous in the context of an overdose.

Regarding the episode in December 2022, this was a transient episode of altered awareness with no particular clinical pointers. At the time, I recommended that he should inform the DVLA and refrain from driving which unfortunately does not seem to have happened. I said to him once again today that there is a legal obligation to inform the DVLA.

I have not arranged any further neurology follow-up at the current time but happy to provide further input should the need arise.

Yours sincerely

E-signed

DR NESHIKA SAMARASEKERA
Consultant Neurologist

c.c. Richard Taylor

Secretary: Jacki Ross (01506 523827) Dictated: 20/06/2023 Typed: 21/06/2023

Unsolicited Referral

Dr Green
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date First Created: 01/09/2023
Date/Time Printed: 11/05/2026 09:43
Our Ref: 610119466W
CHI: 1006631372

Patient:	Mr Richard Taylor Flat 1 3 Clovenstone Close Edinburgh EH14 3FA	**UHPI:** **Date of Birth:**	610119466W 10/06/1963
Specialty:	Unsolicited Referral	**Consultant:**	

DNA letter - 31.08.23
This gentleman was referred with 3 episodes of PR bleeding, failed to attend for his out-patient appointment today. It appears he has not engaged with the qFIT testing. I have not arranged further review but if you have any ongoing concerns and he is willing to attend, please do not hesitate to contact us.
Yours sincerely

Mr CHINNA REDDY
Consultant Surgeon

University Hospitals Division

St John's Hospital at Howden
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Neurology

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Date First Created: 17/11/2023
Date/Time Printed: 11/05/2026 09:42
Our Ref: 610119466W
CHI: 1006631372

Patient:	Mr Richard Taylor Flat 1 3 Clovenstone Close Edinburgh EH14 3FA	**UHPI:** **Date of Birth:**	610119466W 10/06/1963
Specialty:	Neurology	**Consultant:**	Dr Neshika E Samarasekera

PROBLEMS:

1) Probable dissociative attacks
2) Transient episode of altered awareness with no particular clinical pointers (28 December 2022)
2.1) MRI: old right putamen haemorrhagic lacune (2022)
3) Previous admission to hospital with confusion (August 2022)
4) Road traffic accident whilst smoking cannabis (January 2019)
5) Mental health problems
5.1) Recent review by Psychiatry for depression (2022) and Clinical Psychology (February 2023)
5.2) Episode of deliberate self-harm (2019)
6) Right lentiform nucleus cerebral haemorrhage (2004)
6.1) Presentation with frontal and right temporal headache with associated reduction in conscious level

I met up with Mr Taylor once again in the Neurology Clinic today. He had been referred back because of ongoing collapses.

Mr Taylor attended alone today. He acknowledged that he had not been eating and sleeping well recently and attributed this to some anxieties about his personal life. The ED report from 22 October when he presented following a collapse mentions concerns about relationship difficulties but he does not think that there are any significant relationship issues with his partner. He felt that his headaches had generally improved though on some occasions he can become muddled - he reports trying to do something at home that he may have already done before.

I discussed the collapses that had been mentioned in the ED clerking from 22 October. Initially he said that he did not think he was having collapses but later acknowledged that he was. He was happy for me to speak to his partner, Natalie, and video called her during the consultation. She described them associated with background levels of anxiety - in particular concerns about their finances and about his children who do not live with him. She describes a rising feeling of panic and him telling her that 'he cannot breathe'. She thinks they are worse if he uses certain forms of analgesia such as Morphine. If the episodes are very severe, she describes confusion but I could not work out in exactly which way he could become confused. His partner said that she helps him to slow his breathing down so that the episode does not become more severe. I could not elicit any history suggestive of seizures from sleep.

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
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Neurology

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Sighthill Health Centre
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Edinburgh
EH11 4AU

Date First Created: 17/11/2023
Date/Time Printed: 11/05/2026 09:42
Our Ref: 610119466W
CHI: 1006631372

I do not think we have evidence that these episodes are epileptic seizures and I suspect that these are dissociative attacks related to anxiety. After he left the consultation, I noticed that the ED clerking mentioned Mr Taylor using street Tramadol for pain. This could be contributing to his reports of confusion. Tramadol can also be associated with epileptic seizures although the description of the events is not in keeping with epilepsy.

I showed him the DVLA guidance today for dissociative attacks. For Group 2 licences he must inform the DVLA and licensing may be reconsidered once episodes have been controlled for at least three months with no relevant mental health issues. Because his background mental health problems are a likely factor for the dissociative attacks, he was agreeable today to be referred back to counselling psychology (he previously met Judith Leicht in February but was discharged after he missed a couple of appointments). He assures me that he will attend today. He told me that he had received a form from the DVLA and will complete this. I said to him that has a legal obligation to inform the DVLA.

No further follow-up has been arranged at the current time.

Yours sincerely

E-signed

DR NESHIKA SAMARASEKERA
Consultant Neurologist

c.c. Richard Taylor
c.c. Judith Leicht, Registered Counselling Psychologist, Craigroyston Clinic, 1B Pennywell Road, Edinburgh EH4 4PH

Secretary: Jacki Ross (01506 523827) Dictated: 17/11/2023 Typed: 29/11/2023

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Neurology

Dr Green
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date First Created: 29/11/2023
Date/Time Printed: 11/05/2026 09:45
Our Ref: 610119466W
CHI: 1006631372

Patient:	Mr Richard Taylor Flat 1 3 Clovenstone Close Edinburgh EH14 3FA	**UHPI:** **Date of Birth:**	610119466W 10/06/1963
Specialty:	Neurology	**Consultant:**	Dr Neshika E Samarasekera

I wonder whether you might be able to consider offering this gentleman a further appointment. I think he is having dissociative attacks in relation to his mental health problems. He previously missed a few appointments in your clinic but has assured me that he will attend.

Many thanks for considering this.

Yours sincerely

E-signed

DR NESHIKA SAMARASEKERA
Consultant Neurologist

Enc: copy clinic letter 17/11/2023

Secretary: Jacki Ross (01506 523827) Dictated: 17/11/2023 Typed: 29/11/2023

University Hospitals Division

Western General Hospital
Crewe Road South
Edinburgh
EH4 2XU

Colorectal General Surgery

Dr Green
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date First Created: 19/12/2023
Date/Time Printed: 11/05/2026 09:45
Our Ref: 610119466W
CHI: 1006631372

Patient:	Mr Richard Taylor Flat 1 3 Clovenstone Close Edinburgh EH14 3FA	**UHPI:**	610119466W
		Date of Birth:	10/06/1963
Specialty:	Colorectal General Surgery	**Consultant:**	Dr Danielle R Collins

Many thanks for referring this 60-year old gentleman who was complaining of PR bleeding. Since your referral his bleeding has completely subsided. I note he has a qFIT test that is undetectable and he is not anaemic with a normal transferrin.

I offered to examine him but he declined an abdominal and rectal examination.

He is not keen for any intervention at present as his symptoms have settled. Therefore I am discharging him back to your care. Please do re-refer him should his symptoms recur.

Kind regards,

Yours sincerely

Miss DANIELLE COLLINS
Consultant Colorectal Surgeon

DRC/AIT
Dictated 18.12.2023

University Hospitals Division

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

Neurology

Dr Green
Sighthill Green Medical Practice
Sighthill Health Centre
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Edinburgh
EH11 4AU

Date First Created: 05/03/2024
Date/Time Printed: 11/05/2026 09:45
Our Ref: 610119466W
CHI: 1006631372

Patient:	Mr Richard Taylor Flat 1 3 Clovenstone Close Edinburgh EH14 3FA	**UHPI:** **Date of Birth:**	610119466W 10/06/1963
Specialty:	Neurology	**Consultant:**	Dr RJ Davenport

Dictated: 4 March 2024
Typed: 5 March 2024

Diagnosis:
1 First ever generalised convulsion February 2024
1.1 CT head: established right putaminal lacune, no acute changes
2 Previous ?dissociative episodes
3 Right hemisphere intracranial haemorrhage 2004 with good recovery
4 Previous depression with deliberate self harm including stabbing 2019
5 Cholecystectomy 2018

Current medication: Nil

History:

Further to Mr Taylor's acute presentation tot he ED on 26.2.24, I met him with his partner in the first seizure clinic. He is 60, right-handed, in receipt of universal credit, and lives on this own. He has eight sons and eight daughters between the ages of six and 43. We discussed what happened on 26.2.24, he can remember no warning at all, he remembers being in the kitchen and his next recollection was of being in hospital. Apart from a sore neck, he had not sustained any injuries. His partner said they were sitting on stools, he briefly zoned out between 10 to 15 seconds, then his face began to contort, he started to bubble saliva, and then became increasingly tonic, initially his arms flexed and then extended, there was no significant clonic phase, but he remained unrousable until after the paramedics had arrived. They have been together for about two years, and she has never seen anything like this, and in particular she was quite clear this was entirely different from the previous symptoms that have been interpreted as dissociative attacks.

He smokes up to 20 cigarettes per day, drinks little alcohol, uses cannabis but no other drugs, and has a driving licence (I think probably Groups 1 and 2).

University Hospitals Division

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Neurology

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Date First Created: 05/03/2024
Date/Time Printed: 11/05/2026 09:45
Our Ref: 610119466W
CHI: 1006631372

Impression:

I reviewed the electronic record, and much of the past history is summarised above. In August 2022 he presented to the ED with fluctuating confusion and some amnesia, his partner then found him slumped on his couch at home, and when he got to the ED, he collapsed in the waiting room, and was described as clammy and pale with significant bradycardia, before gradually recovering. He was admitted to hospital, a CT head was described as normal (although he has had a longstanding right hemisphere abnormality since the ICH in 2004), and this was labelled as a possible episode of transient global amnesia, although it does not sound typical for TGA to me. In December 2022 he presented with further confusion, and it was recorded that he had had recurrent episodes when he would become acutely disorientated in association with headache. He met Dr Samarasekera for the first time in January 2023, and she was uncertain initially, she reassessed him in June 2023, and thought migraine probably explained some of his symptoms with possible dissociative amnesia. In October 2023, he was in the ED again having had a collapse once again in the waiting room, associated with significant agitation. There was some emotional upset around the time, and some features suggestive of presyncope/syncope. Dr Samarasekera reviewed him again in November 2023, and thought these were probably dissociative attacks.

In the context, it seems important to consider whether the previous episodes, diagnosed as dissociative/ migraine attacks might have represented epilepsy, but I think this is unlikely and it is clear that what happened recently was entirely different. I think therefore the correct diagnosis is a first ever generalised convulsion, and I do not think at the moment there are grounds for starting an antiseizure medication (I appreciate that he has an abnormal brain scan, which can increase the risk of recurrence, although a putaminal lacune I would not regard as a typically epileptogenic lesion). In short, I think nothing further needs to be done at the moment and I hope that he remains well, and we discussed this. Finally, we discussed driving, he knows that he must not drive and has already been in contact with the DVLA. Whether they will wish him to be off for six or 12 months I am unsure, it may depend on their interpretation of the background, and I have encouraged him to forward a copy of this letter to them to help their deliberations.

With kind regards

Yours sincerely

authorised to send by
Dr Richard Davenport
Consultant Neurologist
Email: richard.davenport@nhs.scot

Tel: 0131-312 0691

University Hospitals Division

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Date First Created:	05/03/2024
Date/Time Printed:	11/05/2026 09:45
Our Ref:	610119466W
CHI:	1006631372

Appts: 0131-312 1552

cc: Richard Taylor
Dr Nesh Samarasekera, Consultant Neurologist, SJH

University Hospitals Division

Western General Hospital
Crewe Road South
Edinburgh
EH4 2XU

General Medicine

Dr Green
Sighthill Green Medical Practice
Sighthill Health Centre
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EH11 4AU

Date First Created: 22/07/2024
Date/Time Printed: 11/05/2026 09:45
Our Ref: 610119466W
CHI: 1006631372

Patient:	Mr Richard Taylor Flat 1 3 Clovenstone Close Edinburgh EH14 3FA	**UHPI:** **Date of Birth:**	610119466W 10/06/1963
Specialty:	General Medicine	**Consultant:**	Dr William J Newman

I note since I last saw Mr Taylor that he has been diagnosed with epilepsy. His bone scanhas confirmed he has osteoporosis in his lumbar spine. The recommendation is to start vitamin D/calcium as well as Alendronic acid.

I will ask the patient to contact you about starting these medications. Of note his renal function and calcium were normal when last checked and his Alk. Phos mildly raised at 129.

If he has issues tolerating these medications then the Rheumatologists have recommended contacting themselves. It is also recommended he have a repeat bone scan in 5 years to assess response.

Yours sincerely,

e-signed and verified by Dr Newman

Dr William Newman
Consultant in Respiratory and General Medicine

Dictated: 22/07/2024
Typed: 22/07/2024 (SP)

Any queries please contact 0131 537 1707

University Hospitals Division

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Crewe Road South
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General Medicine

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Date First Created: 22/07/2024
Date/Time Printed: 11/05/2026 09:45
Our Ref: 610119466W
CHI: 1006631372

Patient:	Mr Richard Taylor Flat 1 3 Clovenstone Close Edinburgh EH14 3FA	**UHPI:**	610119466W
		Date of Birth:	10/06/1963
Specialty:	General Medicine	**Consultant:**	Dr William J Newman

Thank you for attending for your recent bone scan. This has confirmed that your bones are thinner than normal. This is called osteoporosis. This puts you at risk of further fractures and to try and prevent this we would recommend you start some medications. I would be grateful if you could contact your GP about starting these.

Lifestyle advice including remaining active, not smoking and drinking alcohol within recommended limits also applies.

Yours sincerely,

e-signed and verified by Dr Newman

Dr William Newman
Consultant in Respiratory and General Medicine

Dictated: 22/07/2024
Typed: 22/07/2024 (SP)

c.c. Sighthill Green Medical Practice, Sighthill Health Centre, Calder Road, Edinburgh, EH11 4AU

Any queries please contact 0131 537 1707 - posted

University Hospitals Division

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Neurology

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Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date First Created: 30/12/2024
Date/Time Printed: 11/05/2026 09:45
Our Ref: 610119466W
CHI: 1006631372

Patient:	Mr Richard Taylor Flat 1 3 Clovenstone Close Edinburgh EH14 3FA	**UHPI:** **Date of Birth:**	610119466W 10/06/1963
Specialty:	Neurology	**Consultant:**	Neurology Advice Clinic

Dictated: 17/12/2024
Typed: 23/12/2024

I expected to meet Richard Taylor in clinic today for his scheduled appointment, but he did not attend. If there has been some administrative problem, or if Mr Taylor would like to make another appointment, he should get in touch with the appointments department on the telephone number below and we can then reschedule this.
I also attempted to phone Mr Taylor on his mobile from the clinic, but the phone rang out to voicemail.

Yours sincerely

Electronically signed

Dr Patrick Urwin
Consultant Neurologist

Correspondence address:
Department of Clinical Neurosciences
Clinical Offices, 2nd Floor
50 Little France Crescent
Edinburgh Bio Quarter
Edinburgh
EH16 4TJ

Secretary: Susan Reynols - Tel: 0131 312 0693
Appointments: 0131 312 1552

CC: Patient

University Hospitals Division

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

Neurology

Dr Green
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date First Created: 12/02/2025
Date/Time Printed: 11/05/2026 09:45
Our Ref: 610119466W
CHI: 1006631372

Patient:	Mr Richard Taylor Flat 1 3 Clovenstone Close Edinburgh EH14 3FA	**UHPI:** **Date of Birth:**	610119466W 10/06/1963
Specialty:	Neurology	**Consultant:**	Dr RJ Davenport

Date dictated: 12/02/2025
Date typed: 13/02/2025

Diagnosis:
1. Epilepsy
1.1 Diagnosed in July 2024

Current anti-seizure medication:
Lamotrigine 125mg morning and night (GP to correct me if this is wrong)

Recommendations:
1. Richard has had no further seizures and so we have not adjusted his medication today. He seems to have been seizure-free since June 2024.
2. We have discussed triggers including misuse of alcohol or drugs and we have also talked around the small risk of a fatal outcome from a seizure. He understands that this is a rare occurrence and that the main thing is if he were to have any return of seizures he must alert us to this on 0131 312 0717 and that taking his medication is the most important thing to try and prevent the seizures.
3. He has stopped taking cannabis and he is trying to cut down on his smoking.

I reviewed Richard in the Epilepsy Nurse Led clinic today. He is doing well and he has not had any further seizures. He is taking his health very seriously and he is trying to get fit which I have encouraged and also cut back on cannabis use and he no longer drinks. If he would like any further information he can reach out to us but I will send him information leaflets pertaining to the issues we have discussed today including safety and compliance and why people may develop epilepsy. He understands that sometimes we know why people develop epilepsy and in some cases we cannot be sure and in his case it is difficult. We, broadly speaking, have two camps of people who have epilepsy;one is that a group of people who have a structural cause that can be spotted on MRI and the other group are a group who have likely genetic predisposition towards seizures. I note he had a normal CT scan in December 2024. I also note a normal MRI scan in 2022.

University Hospitals Division

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Date First Created: 12/02/2025
Date/Time Printed: 11/05/2026 09:45
Our Ref: 610119466W
CHI: 1006631372

As I say we will see him back in clinic in six months time. If he were to have any problems in the soon period he should let us know on 0131 312 0717.

With kindest regards.

Yours sincerely

Yvonne Leavy RGN, MSC, Epileptology
Epilepsy Nurse Specialist

e-signed

Epilepsy Specialist Nurse Service: 0131 312 0717
Secretary: Alexandra Gellert
Typed by: Caren Lovatt

cc Richard Taylor
cc Dr Patrick Urwin, Consultant Neurologist, DCN, RIE (For Information Only)

Essential Scanning Sheet

This sheet should only be used for essential patient information not currently captured electronically (e.g. diagrams).

NHS Lothian

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PATIENT PROGRESS / COMMUNICATION SHEET

Name 610119466W M 10/06/1963
Taylor, Richard
DOB 42 Morvenside,
Edinburgh,
EH14 2SJ

Unit No CHI 1006631372

Clinical Area: Out Patients Department: 70911 PC Leslie

State Action/s taken After Exception Reporting
Each entry should be dated & timed

Date & Time	Progress notes / Problems Action Taken & Investigations Required	Signature (Print name & designation)
18/02/25	Lamotrigine 125mg BD No SE ? June 2024	
	Triggers discussed. Off cannabis for 7/52 Lemi Sleep / 1st Aid discussed. Trying to STOP SMOKING DRIVING HEALTH ALCOHOL discussed.	
	6/12	

Authorised: Nov 2022
Review: Nov 2025

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NHS Lothian

Essential Scanning Sheet

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PATIENT PROGRESS / COMMUNICATION SHEET	Addressograph, or Name DOB Unit No./CHI

Clinical Area: Out Patients Department:

State Action/s taken After Exception Reporting
Each entry should be dated & timed

Date & Time	Progress notes / Problems Action Taken & Investigations Required	Signature (Print name & designation)

Authorised: Nov 2022
Review: Nov 2025

University Hospitals Division

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

Neurology

Dr Green
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date First Created: 20/05/2025
Date/Time Printed: 11/05/2026 09:45
Our Ref: 610119466W
CHI: 1006631372

Patient:	Mr Richard Taylor Flat 1 3 Clovenstone Close Edinburgh EH14 3FA	**UHPI:** **Date of Birth:**	610119466W 10/06/1963
Specialty:	Neurology	**Consultant:**	Dr Patrick JM Urwin

Dictated: 20/05/2025
Typed: 21/05/2025

Diagnosis: Epilepsy diagnosed July 2024

Current Medications: Lamotrigine 125 mg twice daily

Follow-up: None planned but patient to phone the epilepsy nurses if he were to have further seizures.

I reviewed Richard Taylor in my general neurology clinic. I am really pleased to hear that he has not had any further seizures since commencing Lamotrigine. He is tolerating the 125 mg twice daily dose well without side effects. Six months ago, he elected to come off cannabis. This has been a huge positive step in terms of his overall health and well-being, as well as a financially good step. He is very motivated to return to his driving (normal licence) and motor bike riding and I reminded him if he can reach a whole year seizure free with his diagnosis of epilepsy, then I would be supportive of his return to driving; he still needs to go through the necessary forms with the DVLA. Usually they would then write to me with a form. It can take me a little bit of time to complete this form so I would encourage him to carry on with the process pending his one year date. His last seizure was on 24/06/24. Mr Taylor did previously hold an HGV licence. The HGV driving restrictions are much more stringent, and he may not be able to recover his HGV licence.

So long as he remains on medication, I would suggest in the context of a structurally abnormal brain, it would be worth persevering for at least 5 years of seizure freedom before we were to even contemplate whether or not he wished for a medication reduction. Medication reduction at that stage would prevent him from driving through the medication reduction, for a period off medication, and if he were to have a further seizure this would further delay returning to driving. Most patients at that point prefer to continue on their antiseizure medication, but if Mr Taylor wished to have discussions about this he could be referred back in to the epilepsy nurses if he was not still under review.

University Hospitals Division

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

Neurology

Dr Green
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Sighthill Health Centre
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Edinburgh
EH11 4AU

Date First Created: 20/05/2025
Date/Time Printed: 11/05/2026 09:45
Our Ref: 610119466W
CHI: 1006631372

He has contact details for the epilepsy nurses and should let us know if he has further seizures but so long as things remain well I would not follow him up at this stage.

Yours sincerely

Electronically signed

Dr Patrick Urwin
Consultant Neurologist

Correspondence address:
Department of Clinical Neurosciences
Clinical Offices, 2nd Floor
50 Little France Crescent
Edinburgh Bio Quarter
Edinburgh
EH16 4TJ

Secretary: Susan Reynols - Tel: 0131 312 0693
Appointments: 0131 312 1549 / 0131 312 1537

CC: Patient

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Plastic Surgery

Dr Green
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date First Created: 16/07/2025
Date/Time Printed: 11/05/2026 09:45
Our Ref: 610119466W
CHI: 1006631372

Patient:	Mr Richard Taylor Flat 1 3 Clovenstone Close Edinburgh EH14 3FA	**UHPI:**	610119466W
		Date of Birth:	10/06/1963
Specialty:	Plastic Surgery	**Consultant:**	Mrs DM Davidson (ELCH)

Diagnosis:
Probable left carpal tunnel syndrome, currently quiescent.

Thank you for referring this right handed 62-year-old gentleman, whose hobbies include art. For the past year he has been greatly troubled by nocturnal paraesthesia affecting all the digits of the left hand. Nocturnal splinting exacerbated the problem. However, a few months ago he received an injection from into the carpal tunnel from yourselves, and this has resolved his symptoms.

Medical history includes epilepsy, previous right wrist fusion, lower back pain. He does not take any blood thinners. He has no allergies.

Symptoms are very suggestive of carpal tunnel syndrome, but as things are quiet I have not arranged any intervention at present. Should symptoms recur, he will let my secretary know, and we will consider nerve conduction studies +/- surgical decompression.

Thank you for the referral.

Kind regards
Yours sincerely

Mrs Dominique Davidson FRCS (Plast) DPhil
Consultant Plastic & Hand Surgeon

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Plastic Surgery

Dr Green
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date First Created: 09/09/2025
Date/Time Printed: 11/05/2026 09:45
Our Ref: 610119466W
CHI: 1006631372

Patient:	Mr Richard Taylor Flat 1 3 Clovenstone Close Edinburgh EH14 3FA	**UHPI:** **Date of Birth:**	610119466W 10/06/1963
Specialty:	Plastic Surgery	**Consultant:**	Mrs DM Davidson (ELCH)

Diagnosis:
Probable left carpal tunnel syndrome, currently quiescent.

Thank you for referring this right handed 62-year-old gentleman, whose hobbies include art. For the past year he has been greatly troubled by nocturnal paraesthesia affecting all the digits of the left hand. Nocturnal splinting exacerbated the problem. However, a few months ago he received an injection from into the carpal tunnel from yourselves, and this has resolved his symptoms.

Medical history includes epilepsy, previous right wrist fusion, lower back pain. He does not take any blood thinners. He has no allergies.

Symptoms are very suggestive of carpal tunnel syndrome, but as things are quiet I have not arranged any intervention at present. Should symptoms recur, he will let my secretary know, and we will consider nerve conduction studies +/- surgical decompression.

Thank you for the referral.

Kind regards
Yours sincerely

Mrs Dominique Davidson FRCS (Plast) DPhil
Consultant Plastic & Hand Surgeon

Patient has been in touch to report marked recurrence of his hand paraesthesia and we have agreed to onward referal for nerve conductions studies to clarify diagnosis and level of severity.

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Plastic Surgery

Dr Green
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date First Created:	09/09/2025
Date/Time Printed:	11/05/2026 09:45
Our Ref:	610119466W
CHI:	1006631372

Urgent technician NCS referral

East Lothian Community Hospit
Alderston Road
Haddington
EH41 3PF

NHS Lothian

09 SEP 2025

GS

Dr Green
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date First Created 09/09/2025
Date Authorised
Date/Time Printed 09/09/2025 14:48
Our Ref 610119466W
CHI 1006631372

Patient:	Mr Richard Taylor Flat 1 3 Clovenstone Close Edinburgh EH14 3FA	**UHPI:**	610119466W
		Date of Birth:	10/06/1963
		Attendance Date:	15/07/2025
Clinic Code:	SJHPL - DDHSELCH PM		
Specialty:	Plastic Surgery		
Consultant:	Mrs DM Davidson (ELCH)		

Outpatient Clinic Letter

Dear Dr Green,

Diagnosis:
Probable left carpal tunnel syndrome, currently quiescent.

Thank you for referring this right handed 62-year-old gentleman, whose hobbies include art. For the past year he has been greatly troubled by nocturnal paraesthesia affecting all the digits of the left hand. Nocturnal splinting exacerbated the problem. However, a few months ago he received an injection from into the carpal tunnel from yourselves, and this has resolved his symptoms.

Medical history includes epilepsy, previous right wrist fusion, lower back pain. He does not take any blood thinners. He has no allergies.

Symptoms are very suggestive of carpal tunnel syndrome, but as things are quiet I have not arranged any intervention at present. Should symptoms recur, he will let my secretary know, and we will consider nerve conduction studies +/- surgical decompression.

Thank you for the referral.

Kind regards
Yours sincerely

East Lothian Community Hospit
Alderston Road
Haddington
EH41 3PF

NHS Lothian

Cont'd... **Ref:** 610119466W **Patient Name:** Mr Richard Taylor

Mrs Dominique Davidson FRCS (Plast) DPhil
Consultant Plastic & Hand Surgeon

Patient has been in touch to report marked recurrence of his hand paraesthesia and we have agreed to onward referal for nerve conductions studies to clarify diagnosis and level of severity.

Urgent technician NCS referral

Department of Clinical Neurophysiology OPD15

DCN RIE
Little France
Edinburgh
EH16 4TJ

Tel 0131 312 1510

Nerve Conduction Study Report

Full Name: Richard TAYLOR **Gender:** Male
CHI No: 100663172 **Date of Birth:** 6/10/1963

Visit Date: 10/20/2025 9:08 AM
Age: 62 Years
Clinical Physiologist: FB
Physician: Mrs DM Davidson
Referring Hospital: ELCH
W Number: W0161255
Height: 1.74 m

Physiologist Only Hand Clinic

This patient has been seen at a clinical physiologist led upper limb nerve entrapment clinic. Upper limb nerve conduction studies have been performed by one of our clinical physiologists. The results have been reviewed and reported by me. I have not seen the patient clinically, therefore any interpretation of these results should be done in the appropriate clinical context.

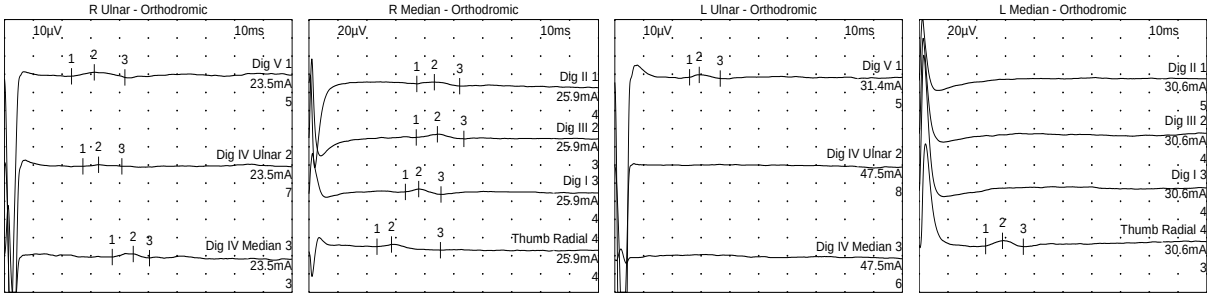
Opinion
Right mild (grade 2) carpal tunnel syndrome
Left severe (grade 4) carpal tunnel syndrome
No evidence of an ulnar neuropathy at the elbows

Dr Fahad Shaikh BSc (Hons), MBChB, MRCGP, MRCP(UK), FRCP Edin
GMC: 6128592
Consultant Clinical Neurophysiologist
EV

Sensory NCS

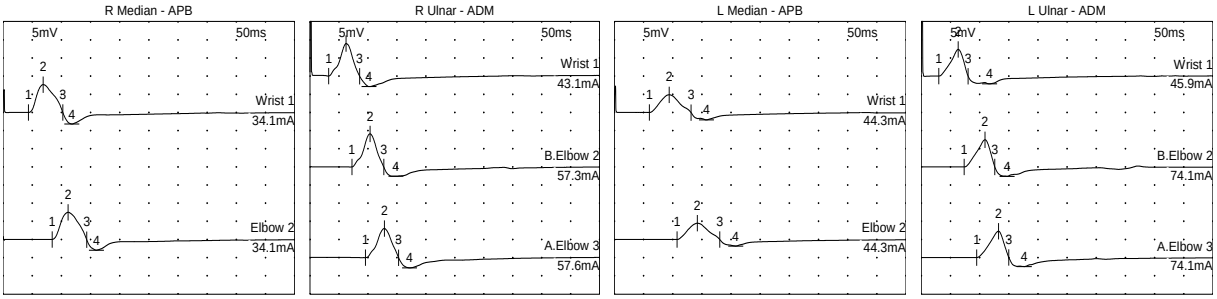
Nerve / Sites	Lat. 2 ms	Onset Lat ms	NP Amp µV	PP Amp µV	Distance mm	Vel. m/s	Temp. °C
R Median - Orthodromic							
Dig II	4.33	3.73	1.9	4.4	140	37.5	33
Dig III	4.44	3.71	3.5	5.2	140	37.8	
Dig I	3.79	3.33	3.1	6.1	120	36.0	
Thumb Radial	2.85	2.35	2.5	6.3	120	51.0	
L Median - Orthodromic							
Dig II	NR	NR	NR	NR			33
Dig III	NR	NR	NR	NR			
Dig I	NR	NR	NR	NR			
Thumb Radial	2.90	2.31	6.0	6.7	120	51.9	
R Ulnar - Orthodromic							

Nerve / Sites	Lat. 2 ms	Onset Lat ms	NP Amp µV	PP Amp µV	Distance mm	Vel. m/s	Temp. °C
Dig V	3.13	2.33	2.3	2.9	120	51.4	33
Dig IV Ulnar	3.27	2.73	0.94	0.94	140	51.3	
Dig IV Median	4.48	3.75	1.7	2.3	140	37.3	
L Ulnar - Orthodromic							
Dig V	2.94	2.60	1.4	2.1	130	49.9	33
Dig IV Ulnar	NR	NR	NR	NR			
Dig IV Median	NR	NR	NR	NR			



Motor NCS

Nerve / Sites	Muscle	Latency ms	Amplitude mV	Amp % %	P-P Amp mV	Duration ms	Segments	Distance mm	Lat Diff ms	Velocity m/s	Temp. °C
R Median - APB											
Wrist	APB	4.33	7.7	103	10.9	5.92	Wrist - APB	70			33
Elbow	APB	8.42	7.5	100	10.5	5.92	Elbow - Wrist	190	4.08	47	
L Median - APB											
Wrist	APB	6.00	4.9	109	7.0	7.15	Wrist - APB	70			33
Elbow	APB	10.75	4.5	100	6.4	7.31	Elbow - Wrist	190	4.75	40	
R Ulnar - ADM											
Wrist	ADM	3.21	9.0	100	11.9	5.35	Wrist - ADM				33
B.Elbow	ADM	7.23	9.1	101	11.7	5.52	B.Elbow - Wrist	200	4.02	50	
A.Elbow	ADM	9.56	8.1	89.7	10.9	5.73	A.Elbow - B.Elbow	120	2.33	51	
L Ulnar - ADM											
Wrist	ADM	3.00	7.4	100	9.5	5.02	Wrist - ADM				33
B.Elbow	ADM	7.35	7.5	101	10.1	5.25	B.Elbow - Wrist	240	4.35	55	
A.Elbow	ADM	9.48	7.3	98.4	9.8	5.52	A.Elbow - B.Elbow	120	2.12	56	



University Hospitals Division

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

Neurology

Dr Green
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date First Created: 04/02/2026
Date/Time Printed: 11/05/2026 09:45
Our Ref: 610119466W
CHI: 1006631372

Patient:	Mr Richard Taylor Flat 1 3 Clovenstone Close Edinburgh EH14 3FA	**UHPI:**	610119466W
		Date of Birth:	10/06/1963
Specialty:	Neurology	**Consultant:**	YC Leavy

Dictated 03/02/26 -; Typed 06/02/26 (AG)

Diagnosis:
1. Focal epilepsy
1.1 Diagnosed in July 2024

Current anti-seizure medication:
Lamotrigine 125mg morning and night

Recommendation:
1. Richard is doing extremely well. He has not had any seizures since June 2024. He looks extremely well and seems to be on top of some of the triggers that were causing his seizures to break through in the past. He will remain on his anti-seizure medication for the current time and if he does want any discussions around this in the future he should simply come back to us on 0131 312 0717.

For the time being, we will discharge him from clinic as he is doing so well. We would suggest he continue on his anti-seizure medication for the foreseeable future. If you would like to contact us for him to reviewed in the future simply contact us via neurology ref or on 0131 312 0717.

With kindest regards

Yours sincerely

Yvonne Leavy
OBE, RGN, MSC, Epileptology, Independent Prescriber
Advanced Epilepsy Specialist Nurse NHS Lothian

e-signed

Epilepsy Specialist Nurse Service: 0131 312 0717

University Hospitals Division

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Neurology

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Date First Created:	04/02/2026
Date/Time Printed:	11/05/2026 09:45
Our Ref:	610119466W
CHI:	1006631372

Secretary: Alexandra Gellert

CC: Dr Patrick Urwin, Consultant Neurologist, DCN, Royal Infirmary of Edinburgh

Dear Patrick,
This gentleman is now seizures free since June 2024. Therefore, we will discharge him from epilepsy nurse led follow-up and he knows to contact us should he have any breakthrough seizures.
With kindest regards
Yvonne Leavy

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NHS Lothian

Essential Scanning Sheet

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PATIENT PROGRESS NOTES /COMMUNICATION SHEET

610119466W M 10/06/1963
Taylor, Richard
Nan Flat 1,
3 Clovenstone Close,
Edinburgh,
DO EH14 3FA
CHI 1006631372
70911 M Green
Unit No./CHI

Hospital ☐ **OPD** ☐ **Ward** ☐ **Clinical area**

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

Date and Time	Progress notes / Problems Action Taken and Investigations Required	Signature (Print name & designation)
03/02/26	No seizure	
	Lamotrigine 125mg BD	
	No seizures since June 24th 2024.	Yeary COHen
	DC.	

Authorised: Nov 2022
Review: Nov 2025

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PATIENT PROGRESS NOTES /COMMUNICATION SHEET	Addressograph, or Name DOB Unit No./CHI

Hospital	☐ OPD	☐ Ward	☐ Clinical area

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

Date and Time	Progress notes / Problems Action Taken and Investigations Required	Signature (Print name designation)

Authorised: Nov 2022
Review: Nov 2025

Referrals

NHS Lothian - Referral Letter

Referral To	Western General Hospital Neuroradiology L Neuroradiology
Urgency of referral	Routine
Date of referral	11/04/2013
Date submitted	16/04/2013

PATIENT DETAILS

CHI number:	1006631372
Name:	MR RICHARD TAYLOR
Date of birth:	10/06/1963
Sex:	Male

Contact Details

20-4 CLOVENSTONE DRIVE
EDINBURGH
EH14 3BD

Voice (Home) : 4421596

REFERRING PRACTITIONER DETAILS

Name:	Dr. Christopher Nickerson (GMC: 2620444)
Practice:	Sighthill Green Medical Practice (70911)
Phone:	Voice : 0131 537 7060

Practice address

Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

CLINICAL INFORMATION

Reason for Referral: MRI Lumbar Spine

Main Referral Text: I would be grateful if you could consider this 66 year old man for an MRI scan of his back. He has a long history of back pain going back to 1986 when he was first diagnosed with sciatica.

His current exacerbation started 10 weeks ago with pain initially localised to his right lumbar spine and paravertebral region but is now radiating to his right lateral thigh with associated numbness affecting the anterior lateral aspect of his leg below the knee.

He has no bladder or bowel problems and his knee reflex is slightly reduced compared to the left leg but there is no weakness in dorsiflexion or plantar flexion of the feet.

I wonder whether he has a disc prolapse affecting L4/5 on the right side and would welcome your help in imaging this area to confirm this diagnosis.

Thank you for your help.

Investigations

Description	Result	Date
Cardiac Pacemaker :	No	
Intracranial Surgery / Aneurysm Clip :	No	
Cochlear Implants :	No	
Ferrous metal in the body/orbits :	No	
Could the patient be pregnant? :	No	

Additional information

Smoking history (Encounters):Current smoker	Date recorded:29-Dec-2012
Alcohol history (Encounters):Trivial drinker - <1u/day	Date recorded:31-Jan-2011
Exercise history (Encounters):Enjoys light exercise	Date recorded:11-Aug-2009
Patient Weight in Kilograms:86	
Patient Height in Metres:1.8	

NHS Lothian - Referral Letter

Referral To	Princess Alexandra Eye Pavillion Ophthalmology L Basic SIGN Referral
Urgency of referral	Routine
Date of referral	07/11/2014
Date submitted	13/11/2014
UCPN	101008198695W

PATIENT DETAILS

CHI number:	1006631372
Name:	MR RICHARD TAYLOR
Date of birth:	10/06/1963
Sex:	Male

Contact Details

20-4 CLOVENSTONE DRIVE
EDINBURGH
EH14 3BD

Voice (Home) : 4421596

REFERRING PRACTITIONER DETAILS

Name:	Dr. Christopher Nickerson (GMC: 2620444)
Practice:	Sighthill Green Medical Practice (70911)
Phone:	Voice : 0131 537 7060

Practice address

Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

CLINICAL INFORMATION

Reason for Referral: -

Main Referral Text: I would be grateful if you could see this 51 year old man who has a 4mm skin tag effecting his right lower eyelid nearer the medial end of the eyelid. This is causing the patient some irritation and he would like this removed. I would be grateful if you could see him at your minor procedures clinic with a view to assessment and removal of this skin tag.

Thank you for your help.

Yours sincerely

Pre-existing conditions (High & Medium Priority)

Description	Modifier	Extension	Start Date	Date Recorded
Stress at home	New event		06/09/2011	06/09/2011
Renal impairment		DATE_RECORDED=05/05/2011	20/11/2009	20/11/2009
Intracerebral haemorrhage		Discharged against medical advice on the 17.11.04	13/11/2004	13/11/2004
Motor vehicle traffic acid.NOS		Crashed motorbike into car at 50 mph	27/09/2000	27/09/2000
[X]Intentional self-harm		Bites to both arms plus hitting his head off cell wall	02/01/1999	02/01/1999
Viral illness		Admitted.	26/05/1998	26/05/1998
[X]Intentional self-harm		left wrist laceration.	24/02/1997	24/02/1997
[X]Intentional self-harm		Opened up old wound on his right arm with his teeth	02/01/1997	02/01/1997
Fracture of radius NOS		Right ; ORIF	02/04/1994	02/04/1994
[X]Depressive episode	First ever		18/08/1987	18/08/1987
[X]Intentional self-harm		Laceration to left forearm with razor blade	06/08/1987	06/08/1987
[X]Overdose - deliberate		Valium	04/08/1987	04/08/1987
[X]Intentional self-harm		Slashed wrists	04/08/1987	04/08/1987
[X]Overdose - deliberate		Chlomethiazole	23/07/1987	23/07/1987
#Ankle		Left ; ORIF	28/06/1987	28/06/1987
Motor vehicle traffic acid.NOS		Crashed motorbike into a wall	14/05/1987	14/05/1987
[X]Intentional self-harm		Laceration to brachial artery - Repaired	27/04/1987	27/04/1987
[X]Intentional self-harm		Lacerations to left forearm with razor blade	11/11/1986	11/11/1986
[X]Overdose - deliberate		Warfarin, Ampicillin, Betahistine.	14/12/1982	14/12/1982
Inj.?acc-cutting/stabbing		Superficial wound on right calf - Stabbed by wife	30/05/1982	30/05/1982

Motor vehicle traffic acid.NOS	Came off motorbike	30/03/1982	30/03/1982
[X]Intentional self-harm	Slashed left elbow	05/02/1982	05/02/1982
Head injury	+ large scalp laceration	24/11/1981	24/11/1981
[X]Intentional self-harm	Stabbed dorsum of left forearm with knife	01/10/1981	01/10/1981
Head injury		30/09/1981	30/09/1981
[X]Intentional self-harm	Set fire to house	31/07/1981	31/07/1981
Head injury	+ scalp laceration	02/05/1981	02/05/1981
Personality disorders	Psychopathic Type	18/09/1978	18/09/1978
Post-concussion syndrome		21/11/1977	21/11/1977
Bell's (facial) palsy		20/07/1973	20/07/1973
[X]Int self hang/strang/suffoc	Failed	10/06/1963	10/06/1963
[X]Intentional self-harm	Right ; Forearm Laceration	03/06/1963	03/06/1963

Past procedures (High and Medium Priority)

Procedure	Comment	Modifier	Date Performed	Date Recorded
Endotracheal intubation	+ ventilation - Intubated twice due to declining GCS		13/11/2004	13/11/2004
Fusion of joint NEC	Right ; Wrist.		28/01/1997	28/01/1997
Removal int fixation dev NEC	Right ; Wrist.		05/07/1994	05/07/1994
Removal int fixation dev NEC	Left ; Ankle.		01/09/1989	01/09/1989

Additional information

Smoking history (Encounters):Cigarette smoker Date recorded:29-Dec-2012
Alcohol history (Encounters):Trivial drinker - <1u/day Date recorded:31-Jan-2011
Exercise history (Encounters):Enjoys light exercise Date recorded:11-Aug-2009
Patient Weight in Kilograms:86
Patient Height in Metres:1.8

Richard taylor
10/6/63
42 Merseyside.

1/8/18.

Surgical Reg
Assistant
CAA
NMC

Dear Doctor.

Thank for seeing this 55y old man who was seen on 30/7/18. Pain in Epigastric + RUQ. MRI showed LFTs. ⊕ CT Scan. Referral letter said didn't want for letter & no details and not a Sci Store. After 2x Bacon rolls last night Pain came on again with eating +++. graded 10/10. Vomited but little blood. Was taken daily but not been drinking to fluids + Pain return. Passed 1 Hard Stool today.

BS Active
tender - RUQ.
BP 180/101
Pulse 97
Sats 98%
Apyrexial.

AMA
Meds
} attached

Lap RUQ Pain. ? Biliary Colic
? Cancer.

Thanks for reviewing. If LFTs Worsen. need further Imaging / IX.

Many Thanks

Dr Matt Brown

NHS Lothian SCI Store - Patient Result Report

Report ID: H8238847M **Sample Collected:** 31/07/2018 11:13:00

Patient

Patient Name	CHI	Date Of Birth	Age	GP	GP Practice	Consultant Ward/Location
RICHARD W TAYLOR	1006631372	10/06/1963	55	HENDRIE, RACHEL	Sighthill Green Medical Practice	

Report Details

Report Requestor	Requestor Location	ReportIdentifier	Discipline	Referral Source
Skipworth, Mr Richard JE	(RIE106) RIE Ward 106	HB238847M	Clinical Biochemistry RIE	N/A
Sample Type	**Sample Collected**	**Sample Received**	**Processed Into Store**	**Status**
Blood	31/07/2018 11:13:00	31/07/2018 13:04:00	31/07/2018 14:53:41	Active

Report

Liver function tests

Description	Value	Range	Unit	Normalcy Notes
Bilirubin	**37**	**3 - 21**	**umol/L**	**R**
ALT	**171**	**10 - 50**	**U/L**	**R**
Alk.Phos	**146**	**40 - 125**	**U/L**	**R**

Urea and electrolytes

Description	Value	Range	Unit	Normalcy Notes
Urea	6.4	2.5 - 6.6	mmol/L	
Creatinine	87	64 - 111	umol/L	
Sodium	140	135 - 145	mmol/L	
Potassium	4.0	3.6 - 5	mmol/L	
eGFR (/1.73m2)	>60			

Serum C reactive protein level

Description	Value	Range	Unit	Normalcy Notes
C-Reactive Prot	**6**	**0 - 5**	**mg/L**	**R** (BCRP)

Test Comments

(BCRP) Please note that CRP takes three days to achieve peak
(8CRP) levels and also has a long half life. Testing once
(BCRP) every 3 days is recommended to detect significant
(BCRP) changes in CRP.

Sample Comments

5243 robinson

Requestor Comments

sepsis..

Printed By: Matthew Brown on 01/08/2018 16:03:27

ℝ Home Visit Summary (Send to printer)

Address and Contact Details

Richard Taylor 10/06/1963 Male NHS: S685/8/63/736 CHI: 1006631372
No data recorded.
42 Morvenside Westburn Edinburgh EH14 2SJ
Telephone - home 442 1596
Richard Taylor 10/06/1963 Male NHS: S685/8/63/736 CHI: 1006631372

610119466W/E39I7530 M 10/06/1963
Taylor, Richard
42 Morvenside,
Edinburgh,
EH14 2SJ

CHI 1006631372
70911 CB Nickerson

Significant PMH

15/06/2017 Vasectomy NEC
06/09/2011 Stress at home Dr Chris Nickerson
20/11/2009 Renal impairment DATE_RECORDED=05/05/2011 Dr . .
13/11/2004 Intracerebral haemorrhage Discharged against medical advice on the 17.11.04 Dr . .
13/11/2004 Endotracheal intubation + ventilation - Intubated twice due to declining GCS Dr . .
27/09/2000 Motor vehicle traffic acid.NOS Crashed motorbike into car at 50 mph Dr . .
02/01/1999 [X]Intentional self-harm Bites to both arms plus hitting his head off cell wall Dr . .
26/05/1998 Viral illness Admitted. Dr . .
24/02/1997 [X]Intentional self-harm left wrist laceration. Dr . .
28/01/1997 Fusion of joint NEC Right ; Wrist. Dr . .
02/01/1997 [X]Intentional self-harm Opened up old wound on his right arm with his teeth Dr . .
05/07/1994 Removal int fixation dev NEC Right ; Wrist. Dr . .
02/04/1994 Fracture of radius NOS Right ; ORIF Dr . .
01/09/1989 Removal int fixation dev NEC Left ; Ankle. Dr . .
18/08/1987 [X]Depressive episode
06/08/1987 [X]Intentional self-harm Laceration to left forearm with razor blade Dr . .
04/08/1987 [X]Intentional self-harm Slashed wrists Dr . .
04/08/1987 [X]Overdose - deliberate Valium Dr . .
23/07/1987 [X]Overdose - deliberate Chlomethiazole Dr . .
28/06/1987 #Ankle Left ; ORIF Dr . .
14/05/1987 Motor vehicle traffic acid.NOS Crashed motorbike into a wall Dr . .
27/04/1987 [X]Intentional self-harm Laceration to brachial artery - Repaired Dr . .
11/11/1986 [X]Intentional self-harm Lacerations to left forearm with razor blade Dr . .
14/12/1982 [X]Overdose - deliberate Warfarin, Ampicillin, Betahistine. Dr . .
30/05/1982 Inj.?acc-cutting/stabbing Superficial wound on right calf - Stabbed by wife Dr . .
30/03/1982 Motor vehicle traffic acid.NOS Came off motorbike Dr . .
05/02/1982 [X]Intentional self-harm Slashed left elbow Dr . .
24/11/1981 Head injury + large scalp laceration Dr . .
01/10/1981 [X]Intentional self-harm Stabbed dorsum of left forearm with knife Dr . .
30/09/1981 Head injury Dr . .
31/07/1981 [X]Intentional self-harm Set fire to house Dr . .
02/05/1981 Head injury + scalp laceration Dr . .
18/09/1978 Personality disorders Psychopathic Type Dr . .
21/11/1977 Post-concussion syndrome Dr . .
20/07/1973 Bell's (facial) palsy Dr . .
10/06/1963 [X]Int self hang/strang/suffoc Failed Dr . .
03/06/1963 [X]Intentional self-harm Right ; Forearm Laceration Dr . .

Last 6 Surgery , Home or Telephone Consultations

01/08/2018 Surgery consultation Dr Matt Brown
01/08/2018 Buscopan 10mg tablets (Sanofi) Supply: (56) tablet 1 -2 TABS UPTO FOUR TIMES A DAY Dr Matt Brown
01/08/2018 Consultation Abdo pain not settled since diacharge. Had pain graded 10+ /10 last night after eating then sick after. Not been able to eat today. Had CT scan at hospital and no gall stones or biliary dilation but LFts were deranged with alp 146 ALT 171 and Bil 37.
Tende rin RUQ on exam BP 181/101 pulse 97 sats 98%
apyrrexial.
Imp ?? biliary colic ? dyspepsia. as pain worsen and been unable to eat today ask Surgical assessment to reassess. MB Dr Matt Brown
18/05/2018 Administration Mr David Ramage
18/05/2018 issue 6 Omeprazole 20mg gastro-resistant capsules Supply: (56) capsule 1 CAPSULE DAILY AS NEEDED Dr Tony Harrison
09/04/2018 Administration Miss Anne Spence
09/04/2018 issue 5 Omeprazole 20mg gastro-resistant capsules Supply: (56) capsule 1 CAPSULE DAILY AS NEEDED Dr Tony Harrison
23/02/2018 Administration Miss Maureen Miller
23/02/2018 issue 4 Omeprazole 20mg gastro-resistant capsules Supply: (56) capsule 1 CAPSULE DAILY AS NEEDED Dr Tony Harrison
19/01/2018 Surgery consultation Dr Tony Harrison
19/01/2018 Consultation LOW BACK PAIN 2/7 LOW lumbr orse movt no urinary probs /leg pain o/e slr 90/90 abdo soft power n MECH PAIN ADV RE EXCERSISES phuysio no rev as nedded Dr Tony Harrison
19/01/2018 Request for Laboratory test requested
Remote Test request from ICE system: NHS Lothian Ice
Clinical Information: poor libido
Priority: non-urgent,
Ordered from: Biochemistry, No samples collected
Test: Creat & Electolytes, Status: Requested, Updated: 19/01/2018
Test: Cholesterol, Status: Requested, Updated: 19/01/2018
Test: LFTs, Status: Requested, Updated: 19/01/2018
Test: Testosterone, Status: Requested, Updated: 19/01/2018
Ordered from: Haematology, No samples collected
Test: FBC, Status: Requested, Updated: 19/01/2018
Ordered from: Biochemistry Yellow, No samples collected
Test: Random Glucose, Status: Requested, Updated: 19/01/2018 Dr Tony Harrison
19/01/2018 Co-codamol 30mg/500mg tablets Supply: (30) tablet 1-2 TABLETS UP TO FOUR TIMES DAILY Dr Tony Harrison
19/01/2018 Diclofenac sodium 50mg gastro-resistant tablets Supply: (56) tablet 1 TABLET THREE TIMES A DAY Dr Tony Harrison
17/01/2018 Administration Miss Maureen Miller
17/01/2018 issue 3 Omeprazole 20mg gastro-resistant capsules Supply: (56) capsule 1 CAPSULE DAILY AS NEEDED Dr Tony Harrison

Current Repeat Masters

Repeat Omeprazole 20mg gastro-resistant capsules Last issued: 18/05/2018 Issued: 6 maximum 12 allowed Supply: (56) capsule 1 CAPSULE DAILY AS NEEDED Dr Tony Harrison

Acutes in Last 3 Months

No data recorded.

Allergies and Intolerances

No data recorded.
No data recorded.

Prevention

05/11/2014 12:56.00 BP 120 / 80 taken Sitting Cuff: Standard recall due: O/E - blood pressure reading Dr Chris Nickerson
29/12/2012 10:52.00 BP 132 / 90 taken Sitting Cuff: Standard recall due: O/E - blood pressure reading
26/01/2011 BP 129 / 82 recall due: O/E - BP reading normal ACTION=Repeat after an Interval : PROTOCOL=B P Screening$$ Dr Practice Nurse
15/06/2017 Smoker Cigarettes: 20 Cigarette smoker Dr Tony Harrison
31/01/2011 Current drinker Trivial drinker - <1u/day Dr . .
11/08/2009 Weight: 86 kgs BMI: 26.5 O/E - weight ACTION=Repeat after an Interval : PROTOCOL=Weight$$ Ms Keepwell Nurse
11/08/2009 Height: 1.8 metres O/E - height ACTION=Repeat after an Interval : PROTOCOL=Height$$ Ms Keepwell Nurse

NHS Lothian - Referral Letter

Referral To	Western General Hospital General Surgery - Colorectal L GI - Colorectal
Urgency of referral	Urgent
Date of referral	14/01/2019
Date submitted	17/01/2019
UCPN	101017788794T

PATIENT DETAILS

CHI number:	1006631372
Name:	MR RICHARD TAYLOR
Date of birth:	10/06/1963
Sex:	Male

Contact Details

42 MORVENSIDE WESTBURN
EDINBURGH
EH14 2SJ

Voice (Home) : 442 1596

REFERRING PRACTITIONER DETAILS

Name:	Dr. Gruffydd Perks (GMC: 7421062)
Practice:	Sighthill Green Medical Practice (70911)
Phone:	Voice : 0131 537 7060

Practice address

Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

CLINICAL INFORMATION

Reason for Referral: 1. BLOOD IN STOOL;

Main Referral Text: I would be grateful if you could see this 55 year male. He has had 1 episode of fresh blood in the stool, and 1 episode of dark stool. This is on a background of change in bowel habit. He noticed a lot of blood in the pan yesterday after defecating. He does not have any rectal or anal pain, pain on defecating or wiping. Previously he opened his bowels daily, more recently his bowels have been opening every 3 - 4 days and harder in nature. There is no unexplained weight loss or loss of appetite. He does not have any abdominal pain either.

On examination his observations were normal, his abdomen is soft, no masses were felt. PR exam - no anal fissure was noted. No masses felt in the rectum.

Given his age, a history of fresh blood, dark stool and change in bowel habit, I would be grateful if you could review this gentleman.

Kind regards

Investigations

Description	Result	Date
Age :	More than 55 years	
Duration of symptoms :	Less than 1 month	
Suspicion of Bowel Cancer :	Yes	
Altered Bowel Habit - Constipation :	true	
Bleeding PR :	Fresh Rectal bleeding	
Obstructive Symptoms :	None	
Hb result :	Result normal	
Is the patient fit/co-operative to go 'direct to test' :	Yes	
eGFR >30 :	Yes	

Pre-existing conditions (High & Medium Priority)

Description	Modifier	Extension	Start Date	Date Recorded
Gallstones	New event		03/08/2018	03/08/2018
Abdominal pain			30/07/2018	30/07/2018
Stress at home	New event		06/09/2011	06/09/2011
Renal impairment		DATE_RECORDED=05/05/2011	20/11/2009	20/11/2009
Intracerebral haemorrhage		Discharged against medical advice on the 17.11.04	13/11/2004	13/11/2004

Motor vehicle traffic acid.NOS		Crashed motorbike into car at 50 mph	27/09/2000	27/09/2000
[X]Intentional self-harm		Bites to both arms plus hitting his head off cell wall	02/01/1999	02/01/1999
Viral illness		Admitted.	26/05/1998	26/05/1998
[X]Intentional self-harm		left wrist laceration.	24/02/1997	24/02/1997
[X]Intentional self-harm		Opened up old wound on his right arm with his teeth	02/01/1997	02/01/1997
Fracture of radius NOS		Right ; ORIF	02/04/1994	02/04/1994
[X]Depressive episode	First ever		18/08/1987	18/08/1987
[X]Intentional self-harm		Laceration to left forearm with razor blade	06/08/1987	06/08/1987
[X]Overdose - deliberate		Valium	04/08/1987	04/08/1987
[X]Intentional self-harm		Slashed wrists	04/08/1987	04/08/1987
[X]Overdose - deliberate		Chlomethiazole	23/07/1987	23/07/1987
#Ankle		Left ; ORIF	28/06/1987	28/06/1987
Motor vehicle traffic acid.NOS		Crashed motorbike into a wall	14/05/1987	14/05/1987
[X]Intentional self-harm		Laceration to brachial artery - Repaired	27/04/1987	27/04/1987
[X]Intentional self-harm		Lacerations to left forearm with razor blade	11/11/1986	11/11/1986
[X]Overdose - deliberate		Warfarin, Ampicillin, Betahistine.	14/12/1982	14/12/1982
Inj.?acc-cutting/stabbing		Superficial wound on right calf - Stabbed by wife	30/05/1982	30/05/1982
Motor vehicle traffic acid.NOS		Came off motorbike	30/03/1982	30/03/1982
[X]Intentional self-harm		Slashed left elbow	05/02/1982	05/02/1982
Head injury		+ large scalp laceration	24/11/1981	24/11/1981
[X]Intentional self-harm		Stabbed dorsum of left forearm with knife	01/10/1981	01/10/1981
Head injury			30/09/1981	30/09/1981
[X]Intentional self-harm		Set fire to house	31/07/1981	31/07/1981
Head injury		+ scalp laceration	02/05/1981	02/05/1981
Personality disorders		Psychopathic Type	18/09/1978	18/09/1978
Post-concussion syndrome			21/11/1977	21/11/1977
Bell's (facial) palsy			20/07/1973	20/07/1973
[X]Int self hang/strang/suffoc		Failed	10/06/1963	10/06/1963
[X]Intentional self-harm		Right ; Forearm Laceration	03/06/1963	03/06/1963

Past procedures (High and Medium Priority)

Procedure	Comment	Modifier	Date Performed	Date Recorded
Laparoscopic cholecystectomy		New event	06/08/2018	06/08/2018
Vasectomy NEC		New event	15/06/2017	15/06/2017
Endotracheal intubation	+ ventilation - Intubated twice due to declining GCS		13/11/2004	13/11/2004
Fusion of joint NEC	Right ; Wrist.		28/01/1997	28/01/1997
Removal int fixation dev NEC	Right ; Wrist.		05/07/1994	05/07/1994
Removal int fixation dev NEC	Left ; Ankle.		01/09/1989	01/09/1989

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	1 CAPSULE DAILY AS NEEDED		15/06/2017		30/11/2018

Additional information

Smoking history (Encounters):Cigarette smoker Date recorded:15-Jun-2017
Alcohol history (Encounters):Trivial drinker - <1u/day Date recorded:31-Jan-2011
Exercise history (Encounters):Enjoys light exercise Date recorded:11-Aug-2009
Patient Weight in Kilograms:86
Patient Height in Metres:1.8

NHS Lothian - Referral Letter

Referral To	Mental Health Edinburgh - Adult Psychiatry (South West) L Edinburgh Adult Psychiatry
Urgency of referral	Urgent
Date of referral	15/11/2019
Date submitted	18/11/2019
UCPN	101020055773Q

PATIENT DETAILS

CHI number:	1006631372
Name:	MR RICHARD TAYLOR
Date of birth:	10/06/1963
Sex:	Male

Contact Details

42 MORVENSIDE WESTBURN
EDINBURGH
EH14 2SJ

Voice (Home) : 442 1596
Voice (Mobile) : 07593330473

REFERRING PRACTITIONER DETAILS

Name:	VICKY WALKER (MENTAL HEALTH AND ADDICTIONS PRACTICE NURSE) (GMC: -)
Practice:	Sighthill Health Centre
Phone:	Voice : 01315377060

Practice address

380 CALDER ROAD
EDINBURGH
EH11 4AU

CLINICAL INFORMATION

Reason for Referral: FAO DEBORAH COOPER

Main Referral Text:

Dear Dr Cooper,

I would appreciate your assessment of this gentleman who has a long history of depressive episodes, overdose and deliberate self harm. In January of this year Richard was involved in a road traffic accident where he was driving after consuming alcohol and cannabis. He left the car returned home and then stabbed himself in the abdomen and was found by his ex-partner and their 5 year old child. His contact with services has been well documented there after and ultimately he was assessed by Dr Logan at the Rivers Centre in August. At this point he had stopped taking his Mirtazepine as he did not feel it was helping and she suggested a trial of Fluoxetine 20mg and also a referral to Sector Psychological Therapy. As you are aware the waiting time for this service is lengthy and so he has not therefore been seen by secondary care since this time. I met with Richard in September and initiated the Fluoxetine. Initially he did not take it and by this point he reported that his mood was so low that he felt unable to leave his home to attend the chemist. I therefore arranged for the pharmacy to deliver his medication to his home hoping to get him established and feeling well enough to engage better with services. Unfortunately Richards mental state has continued to deteriorate and he failed to attend a couple of appointments with myself for further review. He was however engaging with a community link worker, Calum Barrie, who was accompanying him to PIP assessment and helping him fill out forms.

After failing to attend an appointment with myself on the 7 November 2019 I noticed that Calum had recorded that he felt there had been a deterioration in Richards mental state and that during an appointment with him he spoke about fixated thoughts of suicide and his children. Becoming increasingly concerned I attempted to contact Richard on numerous occasions but was unsuccessful. Given his history I felt that he was at risk so contacted the Police to perform a welfare check. The Police were able to gain access to Richard at home and reported back to our reception staff that he was well, reception staff spoke to Richard and arranged an appointment with him on 14 November 2019. On realising this I felt that it was important that a health professional spoke to Richard and therefore arranged for our duty doctor to attend his home on 12 November 2019. Richard was either not in or failed to answer his door.

Calum had reported that he had been very concerned about Richard at his last contact with him as he stated that Richard was not eating or drinking, not washing or cleaning his house which was unlike him. He spoke repeatedly of thoughts of suicide and how much he misses his children, who he has not had contact with since April. Calum also reported that Richard was not leaving his home unless accompanied by Calum and even while in his home was isolating to just one room as he felt afraid. On attending his house on the 12 November Dr Hendrie noted that all his curtains and blinds were closed.

Richard did attend his appointment on the 14 November and was by myself and Dr Aulmann. He presented with multiple layers of clothes and was unshaven. He had attended the surgery by walking from his home alone. He was difficult to engage in conversation, paused prior to answering questions which he done monosyllabically. He was struggling to hold back tears and appeared anxious and guarded as he was fiddling with his hands which remained in his pockets throughout his appointment. He agreed that his mood had deteriorated and admitted to having suicidal thoughts, although clearly stated he has no plan at this time. He stated that he just wants to see his boy. He admitted he has not been eating or drinking and said he had not had

anything to eat on that day (the appointment was at 2pm) and that he had only had a cup of tea the previous day. He then stated that he had not been eating or drinking for about a year. He was orientated to time, place and person and there was no visible evidence of dehydration or malnourishment, although he was difficult to fully assess. He was not malodorous and there was no evidence of psychologic symptoms and he did not report any psychotic symptoms to us. He did not report any illicit drug or alcohol use but again it is difficult to exclude due to his poor interaction.

Given his history and poor ability to interact we felt it would be beneficial for further assessment at MHAS. Initially Richard agreed to attend MHAS and we were in the middle of arranging transport when unfortunately Richard left the building and although we tried to find him we were unable to. It was quite difficult to assess Richards level of illness during our consultation, however both myself and Dr Aulmann did not feel it would appropriate to attempt to proceed with a detention as, although Richard does have suicidal thoughts, he did state he has no plan to act on these at the time of consultation and although he is clearly neglecting his needs to some extent there was little evidence that this was to a level that would warrant detention under the Mental Health Act. I do however feel that Richard is quite unwell at present and would benefit from further assessment. I have asked Calum Barrie, his link support worker, to encourage Richard to attend MHAS at there next contact and I will send out an appointment for further assessment at the practice. I realise that Richard has been assessed in secondary care and it was felt that psychological therapy was the most appropriate treatment for him, however I feel that given the deterioration in his mood it would now be appropriate for further psychiatric assessment.

I would appreciate any advice you could offer in the meantime and hope you will be able to see Richard as soon as possible.

Please do not hesitate to contact me should you wish to discuss this further or require any further information.

Yours sincerely

Pre-existing conditions (High & Medium Priority)

Description	Modifier	Extension	Start Date	Date Recorded
[X]Depressive episode	New event		08/08/2019	08/08/2019
Injury - self-inflicted		stab wound to abdomen post RTA while smoking canabis	30/01/2019	30/01/2019
Gallstones	New event		03/08/2018	03/08/2018
Abdominal pain			30/07/2018	30/07/2018
Stress at home	New event		06/09/2011	06/09/2011
Renal impairment		DATE_RECORDED=05/05/2011	20/11/2009	20/11/2009
Nondependent cannabis abuse	New event	Smoked for 30 years	11/08/2009	11/08/2009
Intracerebral haemorrhage		Discharged against medical advice on the 17.11.04	13/11/2004	13/11/2004
Motor vehicle traffic acid.NOS		Crashed motorbike into car at 50 mph	27/09/2000	27/09/2000
[X]Intentional self-harm		Bites to both arms plus hitting his head off cell wall	02/01/1999	02/01/1999
Viral illness		Admitted.	26/05/1998	26/05/1998
[X]Intentional self-harm		left wrist laceration.	24/02/1997	24/02/1997
[X]Intentional self-harm		Opened up old wound on his right arm with his teeth	02/01/1997	02/01/1997
Fracture of radius NOS		Right ; ORIF	02/04/1994	02/04/1994
[X]Depressive episode	First ever		18/08/1987	18/08/1987
[X]Intentional self-harm		Laceration to left forearm with razor blade	06/08/1987	06/08/1987
[X]Overdose - deliberate		Valium	04/08/1987	04/08/1987
[X]Intentional self-harm		Slashed wrists	04/08/1987	04/08/1987
[X]Overdose - deliberate		Chlomethiazole	23/07/1987	23/07/1987
#Ankle		Left ; ORIF	28/06/1987	28/06/1987
Motor vehicle traffic acid.NOS		Crashed motorbike into a wall	14/05/1987	14/05/1987
[X]Intentional self-harm		Laceration to brachial artery - Repaired	27/04/1987	27/04/1987
[X]Intentional self-harm		Lacerations to left forearm with razor blade	11/11/1986	11/11/1986
[X]Overdose - deliberate		Warfarin, Ampicillin, Betahistine.	14/12/1982	14/12/1982
Inj.?acc-cutting/stabbing		Superficial wound on right calf - Stabbed by wife	30/05/1982	30/05/1982
Motor vehicle traffic acid.NOS		Came off motorbike	30/03/1982	30/03/1982
[X]Intentional self-harm		Slashed left elbow	05/02/1982	05/02/1982
Head injury		+ large scalp laceration	24/11/1981	24/11/1981
[X]Intentional self-harm		Stabbed dorsum of left forearm with knife	01/10/1981	01/10/1981
Head injury			30/09/1981	30/09/1981
[X]Intentional self-harm		Set fire to house	31/07/1981	31/07/1981
Head injury		+ scalp laceration	02/05/1981	02/05/1981
Personality disorders		Psychopathic Type	18/09/1978	18/09/1978
Post-concussion syndrome			21/11/1977	21/11/1977
Bell's (facial) palsy			20/07/1973	20/07/1973

[X]Int self hang/strang/suffoc	Failed	10/06/1963	10/06/1963
[X]Intentional self-harm	Right ; Forearm Laceration	03/06/1963	03/06/1963

Past procedures (High and Medium Priority)

Procedure	Comment	Modifier	Date Performed	Date Recorded
Mental health assessment		Continuing	26/02/2019	26/02/2019
Mental health assessment	self harm, sexual abuse as a child, situational crisis	New event	21/01/2019	21/01/2019
Laparoscopic cholecystectomy		New event	06/08/2018	06/08/2018
Vasectomy NEC		New event	15/06/2017	15/06/2017
Endotracheal intubation	+ ventilation - Intubated twice due to declining GCS		13/11/2004	13/11/2004
Fusion of joint NEC	Right ; Wrist.		28/01/1997	28/01/1997
Removal int fixation dev NEC	Right ; Wrist.		05/07/1994	05/07/1994
Removal int fixation dev NEC	Left ; Ankle.		01/09/1989	01/09/1989

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	1 CAPSULE DAILY AS NEEDED		15/06/2017		09/09/2019

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Fluoxetine 20mg capsules	capsule	1 TABLET DAILY DISPENSE WEEKLY		07/11/2019		07/11/2019
Fluoxetine 20mg capsules	capsule	1 TABLET DAILY DISPENSE WEEKLY		30/09/2019		30/09/2019
Fluoxetine 20mg capsules	capsule	1 TABLET DAILY DISPENSE WEEKLY		09/09/2019		09/09/2019

Additional information

Smoking history (Encounters):Cigarette smoker Date recorded:22-Jan-2019
Alcohol history (Encounters):Trivial drinker - <1u/day Date recorded:31-Jan-2011
Exercise history (Encounters):Enjoys light exercise Date recorded:11-Aug-2009
Patient Weight in Kilograms:87.5
Patient Height in Metres:1.8
Patient BMI:27
Patient Blood Pressure (Systolic):120
Patient Blood Pressure (Diastolic):84

NHS Lothian - Referral Letter

Referral To	Mental Health Edinburgh - Adult Psychiatry (South West) LI Edinburgh Adult Psychiatry
Urgency of referral	Routine
Date of referral	06/10/2021
Date submitted	06/10/2021
UCPN	101024531678D

PATIENT DETAILS

CHI number:	1006631372
Name:	MR RICHARD TAYLOR
Date of birth:	10/06/1963
Sex:	Male

Contact Details

42 MORVENSIDE WESTBURN
EDINBURGH
EH14 2SJ

Voice (Mobile) : 07593330473

REFERRING PRACTITIONER DETAILS

Name:	Dr. Corinne Aitken (GMC: 4634612)
Practice:	Sighthill Green Medical Practice (70911)
Phone:	Voice : 0131 537 7060

Practice address

Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

CLINICAL INFORMATION

Reason for Referral: Long history of depressive episodes, overdose and self harm

Main Referral Text:

Dear Colleague,

I would be grateful if this gentleman could be offered an appointment in clinic. He was originally referred in November 2019 and I attach a copy of his referral letter at that time which details his problems. He has a long history of depressive episodes, overdose and self harm and in January 2019 he had a self inflicted stab wound to his abdomen following a split with his ex-partner. This has led to him losing contact with his ex-partner but also with his 5 children from that relationship. He didn't keep appointments with you following that referral as these were scheduled during Covid pandemic and he was nervous about attending. He has been back in touch to say he would like to seek some help and has requested referral back to your clinic. He continues to report low in mood. He reports constant thoughts of suicide that he reports are chronic but denied any active plans. He is still living in the same house as the incident in which he stabbed himself and where he lived with his ex-partner and he says that he has got constant memories and these keep flashing back at him.

He has been re-started on Fluoxetine and I would be grateful if he could be added to the waiting list for review.

Many thanks.

Yours sincerely,
Dr Corinne Aitken
GP

Pre-existing conditions (High & Medium Priority)

Description	Modifier	Extension	Start Date	Date Recorded
Abdominal pain	New event	Admitted	16/09/2020	16/09/2020
[X]Depressive episode	New event		08/08/2019	08/08/2019
Injury - self-inflicted		stab wound to abdomen post RTA while smoking canabis	30/01/2019	30/01/2019
Gallstones	New event		03/08/2018	03/08/2018
Abdominal pain			30/07/2018	30/07/2018
Stress at home	New event		06/09/2011	06/09/2011

Renal impairment		DATE_RECORDED=05/05/2011	20/11/2009	20/11/2009
Nondependent cannabis abuse	New event	Smoked for 30 years	11/08/2009	11/08/2009
Intracerebral haemorrhage		Discharged against medical advice on the 17.11.04	13/11/2004	13/11/2004
Motor vehicle traffic acid.NOS		Crashed motorbike into car at 50 mph	27/09/2000	27/09/2000
[X]Intentional self-harm		Bites to both arms plus hitting his head off cell wall	02/01/1999	02/01/1999
Viral illness		Admitted.	26/05/1998	26/05/1998
[X]Intentional self-harm		left wrist laceration.	24/02/1997	24/02/1997
[X]Intentional self-harm		Opened up old wound on his right arm with his teeth	02/01/1997	02/01/1997
Fracture of radius NOS		Right ; ORIF	02/04/1994	02/04/1994
[X]Depressive episode	First ever		18/08/1987	18/08/1987
[X]Intentional self-harm		Laceration to left forearm with razor blade	06/08/1987	06/08/1987
[X]Overdose - deliberate		Valium	04/08/1987	04/08/1987
[X]Intentional self-harm		Slashed wrists	04/08/1987	04/08/1987
[X]Overdose - deliberate		Chlomethiazole	23/07/1987	23/07/1987
#Ankle		Left ; ORIF	28/06/1987	28/06/1987
Motor vehicle traffic acid.NOS		Crashed motorbike into a wall	14/05/1987	14/05/1987
[X]Intentional self-harm		Laceration to brachial artery - Repaired	27/04/1987	27/04/1987
[X]Intentional self-harm		Lacerations to left forearm with razor blade	11/11/1986	11/11/1986
[X]Overdose - deliberate		Warfarin, Ampicillin, Betahistine.	14/12/1982	14/12/1982
Inj.?acc-cutting/stabbing		Superficial wound on right calf - Stabbed by wife	30/05/1982	30/05/1982
Motor vehicle traffic acid.NOS		Came off motorbike	30/03/1982	30/03/1982
[X]Intentional self-harm		Slashed left elbow	05/02/1982	05/02/1982
Head injury		+ large scalp laceration	24/11/1981	24/11/1981
[X]Intentional self-harm		Stabbed dorsum of left forearm with knife	01/10/1981	01/10/1981
Head injury			30/09/1981	30/09/1981
[X]Intentional self-harm		Set fire to house	31/07/1981	31/07/1981
Head injury		+ scalp laceration	02/05/1981	02/05/1981
Personality disorders		Psychopathic Type	18/09/1978	18/09/1978
Post-concussion syndrome			21/11/1977	21/11/1977
Bell's (facial) palsy			20/07/1973	20/07/1973
[X]Int self hang/strang/suffoc		Failed	10/06/1963	10/06/1963
[X]Intentional self-harm		Right ; Forearm Laceration	03/06/1963	03/06/1963

Past procedures (High and Medium Priority)

Procedure	Comment	Modifier	Date Performed	Date Recorded
Mental health assessment		Continuing	26/02/2019	26/02/2019
Mental health assessment	self harm, sexual abuse as a child, situational crisis	New event	21/01/2019	21/01/2019
Laparoscopic cholecystectomy		New event	06/08/2018	06/08/2018
Vasectomy NEC		New event	15/06/2017	15/06/2017
Endotracheal intubation	+ ventilation - Intubated twice due to declining GCS		13/11/2004	13/11/2004
Fusion of joint NEC	Right ; Wrist.		28/01/1997	28/01/1997
Removal int fixation dev NEC	Right ; Wrist.		05/07/1994	05/07/1994
Removal int fixation dev NEC	Left ; Ankle.		01/09/1989	01/09/1989

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Fluoxetine 20mg capsules	capsule	1 TABLET DAILY DISPENSE WEEKLY		05/10/2021		05/10/2021

Additional information

Patient Weight in Kilograms:87.1
Patient Height in Metres:1.79
Patient BMI:27.1
Patient Blood Pressure (Systolic):135
Patient Blood Pressure (Diastolic):90
Smoking history (Screening):Cigarette smoker Date Recorded:07-Jul-2021
Smoking history (Encounters):Cigarette smoker Date Recorded:07-Jul-2021

Alcohol history (Screening):Trivial drinker - <1u/day	Date Recorded:31-Jan-2011
Alcohol history (Encounters):Trivial drinker - <1u/day	Date Recorded:31-Jan-2011
Exercise history (Screening):Enjoys light exercise	Date Recorded:11-Aug-2009
Exercise history (Encounters):Enjoys light exercise	Date Recorded:11-Aug-2009

NHS Lothian - Referral Letter

Referral To	Mental Health Edinburgh - Adult Psychiatry (South West) L Edinburgh Adult Psychiatry
Urgency of referral	Urgent
Date of referral	15/11/2019
Date submitted	18/11/2019
UCPN	101020055773Q

PATIENT DETAILS

CHI number:	1006631372
Name:	MR RICHARD TAYLOR
Date of birth:	10/06/1963
Sex:	Male

Contact Details

42 MORVENSIDE WESTBURN
EDINBURGH
EH14 2SJ

Voice(Home) : 442 1596
Voice(Mobile) : 07593330473

REFERRING PRACTITIONER DETAILS

Name:	VICKY WALKER (MENTAL HEALTH AND ADDICTIONS PRACTICE NURSE) (GMC: -)
Practice:	Sighthill Health Centre
Phone:	Voice : 01315377060

Practice address

380 CALDER ROAD
EDINBURGH
EH11 4AU

CLINICAL INFORMATION

Reason for Referral: FAO DEBORAH COOPER

Main Referral Text:

Dear Dr Cooper,

I would appreciate your assessment of this gentleman who has a long history of depressive episodes, overdose and deliberate self harm. In January of this year Richard was involved in a road traffic accident where he was driving after consuming alcohol and cannabis. He left the car returned home and then stabbed himself in the abdomen and was found by his ex-partner and their 5 year old child. His contact with services has been well documented there after and ultimately he was assessed by Dr Logan at the Rivers Centre in August. At this point he had stopped taking his Mirtazepine as he did not feel it was helping and she suggested a trial of Fluoxetine 20mg and also a referral to Sector Psychological Therapy. As you are aware the waiting time for this service is lengthy and so he has not therefore been seen by secondary care since this time. I met with Richard in September and initiated the Fluoxetine. Initially he did not take it and by this point he reported that his mood was so low that he felt unable to leave his home to attend the chemist. I therefore arranged for the pharmacy to deliver his medication to his home hoping to get him established and feeling well enough to engage better with services. Unfortunately Richards mental state has continued to deteriorate and he failed to attend a couple of appointments with myself for further review. He was however engaging with a community link worker, Calum Barrie, who was accompanying him to PIP assessment and helping him fill out forms.

After failing to attend an appointment with myself on the 7 November 2019 I noticed that Calum had recorded that he felt there had been a deterioration in Richards mental state and that during an appointment with him he spoke about fixated thoughts of suicide and his children. Becoming increasingly concerned I attempted to contact Richard on numerous occasions but was unsuccessful. Given his history I felt that he was at risk so contacted the Police to perform a welfare check. The Police were able to gain access to Richard at home and reported back to our reception staff that he was well, reception staff spoke to Richard and arranged an appointment with him on 14 November 2019. On realising this I felt that it was important that a health professional spoke to Richard and therefore arranged for our duty doctor to attend his home on 12 November 2019. Richard was either not in or failed to answer his door.

Calum had reported that he had been very concerned about Richard at his last contact with him as he stated that Richard was not eating or drinking, not washing or cleaning his house which was unlike him. He spoke repeatedly of thoughts of suicide and how much he misses his children, who he has not had contact with since April. Calum also reported that Richard was not leaving his home unless accompanied by Calum and even while in his home was isolating to just one room as he felt afraid. On attending his house on the 12 November Dr Hendrie noted that all his curtains and blinds were closed.

Richard did attend his appointment on the 14 November and was by myself and Dr Aulmann. He presented with multiple layers of clothes and was unshaven. He had attended the surgery by walking from his home alone. He was difficult to engage in conversation, paused prior to answering questions which he done monosyllabically. He was struggling to hold back tears and appeared anxious and guarded as he was fiddling with his hands which remained in his pockets throughout his appointment. He agreed that his mood had deteriorated and admitted to having suicidal thoughts, although clearly stated he has no plan at this time. He stated that he just wants to see his boy. He admitted he has not been eating or drinking and said he had not had

anything to eat on that day (the appointment was at 2pm) and that he had only had a cup of tea the previous day. He then stated that he had not been eating or drinking for about a year. He was orientated to time, place and person and there was no visible evidence of dehydration or malnourishment, although he was difficult to fully assess. He was not malodorous and there was no evidence of psychologic symptoms and he did not report any psychotic symptoms to us. He did not report any illicit drug or alcohol use but again it is difficult to exclude due to his poor interaction.

Given his history and poor ability to interact we felt it would be beneficial for further assessment at MHAS. Initially Richard agreed to attend MHAS and we were in the middle of arranging transport when unfortunately Richard left the building and although we tried to find him we were unable to. It was quite difficult to assess Richards level of illness during our consultation, however both myself and Dr Aulmann did not feel it would appropriate to attempt to proceed with a detention as, although Richard does have suicidal thoughts, he did state he has no plan to act on these at the time of consultation and although he is clearly neglecting his needs to some extent there was little evidence that this was to a level that would warrant detention under the Mental Health Act. I do however feel that Richard is quite unwell at present and would benefit from further assessment. I have asked Calum Barrie, his link support worker, to encourage Richard to attend MHAS at there next contact and I will send out an appointment for further assessment at the practice. I realise that Richard has been assessed in secondary care and it was felt that psychological therapy was the most appropriate treatment for him, however I feel that given the deterioration in his mood it would now be appropriate for further psychiatric assessment.

I would appreciate any advice you could offer in the meantime and hope you will be able to see Richard as soon as possible.

Please do not hesitate to contact me should you wish to discuss this further or require any further information.

Yours sincerely

Pre-existing conditions (High & Medium Priority)

Description	Modifier	Extension	Start Date	Date Recorded
[X]Depressive episode	New event		08/08/2019	08/08/2019
Injury - self-inflicted		stab wound to abdomen post RTA while smoking canabis	30/01/2019	30/01/2019
Gallstones	New event		03/08/2018	03/08/2018
Abdominal pain			30/07/2018	30/07/2018
Stress at home	New event		06/09/2011	06/09/2011
Renal impairment		DATE_RECORDED=05/05/2011	20/11/2009	20/11/2009
Nondependent cannabis abuse	New event	Smoked for 30 years	11/08/2009	11/08/2009
Intracerebral haemorrhage		Discharged against medical advice on the 17.11.04	13/11/2004	13/11/2004
Motor vehicle traffic acid.NOS		Crashed motorbike into car at 50 mph	27/09/2000	27/09/2000
[X]Intentional self-harm		Bites to both arms plus hitting his head off cell wall	02/01/1999	02/01/1999
Viral illness		Admitted.	26/05/1998	26/05/1998
[X]Intentional self-harm		left wrist laceration.	24/02/1997	24/02/1997
[X]Intentional self-harm		Opened up old wound on his right arm with his teeth	02/01/1997	02/01/1997
Fracture of radius NOS		Right ; ORIF	02/04/1994	02/04/1994
[X]Depressive episode	First ever		18/08/1987	18/08/1987
[X]Intentional self-harm		Laceration to left forearm with razor blade	06/08/1987	06/08/1987
[X]Overdose - deliberate		Valium	04/08/1987	04/08/1987
[X]Intentional self-harm		Slashed wrists	04/08/1987	04/08/1987
[X]Overdose - deliberate		Chlomethiazole	23/07/1987	23/07/1987
#Ankle		Left ; ORIF	28/06/1987	28/06/1987
Motor vehicle traffic acid.NOS		Crashed motorbike into a wall	14/05/1987	14/05/1987
[X]Intentional self-harm		Laceration to brachial artery - Repaired	27/04/1987	27/04/1987
[X]Intentional self-harm		Lacerations to left forearm with razor blade	11/11/1986	11/11/1986
[X]Overdose - deliberate		Warfarin, Ampicillin, Betahistine.	14/12/1982	14/12/1982
Inj.?acc-cutting/stabbing		Superficial wound on right calf - Stabbed by wife	30/05/1982	30/05/1982
Motor vehicle traffic acid.NOS		Came off motorbike	30/03/1982	30/03/1982
[X]Intentional self-harm		Slashed left elbow	05/02/1982	05/02/1982
Head injury		+ large scalp laceration	24/11/1981	24/11/1981
[X]Intentional self-harm		Stabbed dorsum of left forearm with knife	01/10/1981	01/10/1981
Head injury			30/09/1981	30/09/1981
[X]Intentional self-harm		Set fire to house	31/07/1981	31/07/1981
Head injury		+ scalp laceration	02/05/1981	02/05/1981
Personality disorders		Psychopathic Type	18/09/1978	18/09/1978
Post-concussion syndrome			21/11/1977	21/11/1977
Bell's (facial) palsy			20/07/1973	20/07/1973

[X]Int self hang/strang/suffoc	Failed	10/06/1963	10/06/1963
[X]Intentional self-harm	Right ; Forearm Laceration	03/06/1963	03/06/1963

Past procedures (High and Medium Priority)

Procedure	Comment	Modifier	Date Performed	Date Recorded
Mental health assessment		Continuing	26/02/2019	26/02/2019
Mental health assessment	self harm, sexual abuse as a child, situational crisis	New event	21/01/2019	21/01/2019
Laparoscopic cholecystectomy		New event	06/08/2018	06/08/2018
Vasectomy NEC		New event	15/06/2017	15/06/2017
Endotracheal intubation	+ ventilation - Intubated twice due to declining GCS		13/11/2004	13/11/2004
Fusion of joint NEC	Right ; Wrist.		28/01/1997	28/01/1997
Removal int fixation dev NEC	Right ; Wrist.		05/07/1994	05/07/1994
Removal int fixation dev NEC	Left ; Ankle.		01/09/1989	01/09/1989

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	1 CAPSULE DAILY AS NEEDED		15/06/2017		09/09/2019

Recent medication(Any medication issued within last 90 days not shown above)

Drug name	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Fluoxetine 20mg capsules	capsule	1 TABLET DAILY DISPENSE WEEKLY		07/11/2019		07/11/2019
Fluoxetine 20mg capsules	capsule	1 TABLET DAILY DISPENSE WEEKLY		30/09/2019		30/09/2019
Fluoxetine 20mg capsules	capsule	1 TABLET DAILY DISPENSE WEEKLY		09/09/2019		09/09/2019

Additional information

Smoking history (Encounters):Cigarette smoker	Date recorded:22-Jan-2019
Alcohol history (Encounters):Trivial drinker - <1u/day	Date recorded:31-Jan-2011
Exercise history (Encounters):Enjoys light exercise	Date recorded:11-Aug-2009

Patient Weight in Kilograms:87.5
Patient Height in Metres:1.8
Patient BMI:27
Patient Blood Pressure (Systolic):120
Patient Blood Pressure (Diastolic):84

NHS Lothian - Referral Letter

Referral To	St John's Hospital Neurology LI Basic Sign Referral
Urgency of referral	Urgent
Date of referral	05/05/2023
Date submitted	05/05/2023
UCPN	101029511278F

PATIENT DETAILS

CHI number:	1006631372
Name:	MR RICHARD TAYLOR
Date of birth:	10/06/1963
Sex:	Male

Contact Details

42 MORVENSIDE WESTBURN
EDINBURGH
EH14 2SJ

Voice (Mobile) : 07593330473

REFERRING PRACTITIONER DETAILS

Name:	Dr. Colette Pigliacampo-Linley (GMC: 7460882)
Practice:	Sighthill Green Medical Practice (70911)
Phone:	Voice : 0131 202 5888

Practice address

Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

CLINICAL INFORMATION

Reason for Referral:	FAO Dr Samarasekera
Main Referral Text:	Thank you for seeing this patient. He was seen by yourself in December when he was admitted with an episode of amnesia ?cause. And was due neurology follow up in clinic which he failed to attend. He called today asking to be re-referred to clinic and is keen to be seen by neurology. He feels he has ongoing issues with his memory. Many thanks, Dr Colette Linley GPST 3

Pre-existing conditions (High & Medium Priority)

Description	Modifier	Extension	Start Date	Date Recorded
Confusion		- Amnesia, abdominal pain, profuse sweating, looks unwell, ? cause, for neuro opinion.admitted, St Johns	28/12/2022	28/12/2022
Fall - accidental		# ring finger	12/10/2022	12/10/2022
Transient global amnesia		migraine nasal polyps cannabis use	25/08/2022	25/08/2022
Confusion		A&E st Johns, CT, head, normal, discharged 25/8	24/08/2022	24/08/2022
Confusion		self discharged.	23/08/2022	23/08/2022
Renal colic	New event		03/07/2022	03/07/2022
Abdominal pain	New event	Admitted	16/09/2020	16/09/2020
[X]Depressive episode	New event		08/08/2019	08/08/2019
Injury - self-inflicted		stab wound to abdomen post RTA while smoking canabis	30/01/2019	30/01/2019
Gallstones	New event		03/08/2018	03/08/2018
Abdominal pain			30/07/2018	30/07/2018
Stress at home	New event		06/09/2011	06/09/2011
Renal impairment		DATE_RECORDED=05/05/2011	20/11/2009	20/11/2009
Nondependent cannabis abuse	New event	Smoked for 30 years	11/08/2009	11/08/2009
Intracerebral haemorrhage		Discharged against medical advice on the 17.11.04	13/11/2004	13/11/2004

Motor vehicle traffic acid.NOS		Crashed motorbike into car at 50 mph	27/09/2000	27/09/2000
[X]Intentional self-harm		Bites to both arms plus hitting his head off cell wall	02/01/1999	02/01/1999
Viral illness		Admitted.	26/05/1998	26/05/1998
[X]Intentional self-harm		left wrist laceration.	24/02/1997	24/02/1997
[X]Intentional self-harm		Opened up old wound on his right arm with his teeth	02/01/1997	02/01/1997
Fracture of radius NOS		Right ; ORIF	02/04/1994	02/04/1994
[X]Depressive episode	First ever		18/08/1987	18/08/1987
[X]Intentional self-harm		Laceration to left forearm with razor blade	06/08/1987	06/08/1987
[X]Overdose - deliberate		Valium	04/08/1987	04/08/1987
[X]Intentional self-harm		Slashed wrists	04/08/1987	04/08/1987
[X]Overdose - deliberate		Chlomethiazole	23/07/1987	23/07/1987
#Ankle		Left ; ORIF	28/06/1987	28/06/1987
Motor vehicle traffic acid.NOS		Crashed motorbike into a wall	14/05/1987	14/05/1987
[X]Intentional self-harm		Laceration to brachial artery - Repaired	27/04/1987	27/04/1987
[X]Intentional self-harm		Lacerations to left forearm with razor blade	11/11/1986	11/11/1986
[X]Overdose - deliberate		Warfarin, Ampicillin, Betahistine.	14/12/1982	14/12/1982
Inj.?acc-cutting/stabbing		Superficial wound on right calf - Stabbed by wife	30/05/1982	30/05/1982
Motor vehicle traffic acid.NOS		Came off motorbike	30/03/1982	30/03/1982
[X]Intentional self-harm		Slashed left elbow	05/02/1982	05/02/1982
Head injury		+ large scalp laceration	24/11/1981	24/11/1981
[X]Intentional self-harm		Stabbed dorsum of left forearm with knife	01/10/1981	01/10/1981
Head injury			30/09/1981	30/09/1981
[X]Intentional self-harm		Set fire to house	31/07/1981	31/07/1981
Head injury		+ scalp laceration	02/05/1981	02/05/1981
Personality disorders		Psychopathic Type	18/09/1978	18/09/1978
Post-concussion syndrome			21/11/1977	21/11/1977
Bell's (facial) palsy			20/07/1973	20/07/1973
[X]Int self hang/strang/suffoc		Failed	10/06/1963	10/06/1963
[X]Intentional self-harm		Right ; Forearm Laceration	03/06/1963	03/06/1963

Past procedures (High and Medium Priority)

Procedure	Comment	Modifier	Date Performed	Date Recorded
Mental health review	- A&E unscheduled, thinking about stabbing himself, in police custody, currently not under arrest		11/12/2022	11/12/2022
Mental health assessment		Continuing	26/02/2019	26/02/2019
Mental health assessment	self harm, sexual abuse as a child, situational crisis	New event	21/01/2019	21/01/2019
Laparoscopic cholecystectomy		New event	06/08/2018	06/08/2018
Vasectomy NEC		New event	15/06/2017	15/06/2017
Endotracheal intubation	+ ventilation - Intubated twice due to declining GCS		13/11/2004	13/11/2004
Fusion of joint NEC	Right ; Wrist.		28/01/1997	28/01/1997
Removal int fixation dev NEC	Right ; Wrist.		05/07/1994	05/07/1994
Removal int fixation dev NEC	Left ; Ankle.		01/09/1989	01/09/1989

Additional information

Patient Weight in Kilograms:87

Patient Height in Metres:1.79

Patient BMI:27.1

Patient Blood Pressure (Systolic):134

Patient Blood Pressure (Diastolic):86

Smoking history (Screening):Cigarette smoker Date Recorded:07-Jul-2021

Smoking history (Encounters):Cigarette smoker	Date Recorded:07-Jul-2021
Alcohol history (Screening):Trivial drinker - <1u/day	Date Recorded:31-Jan-2011
Alcohol history (Encounters):Trivial drinker - <1u/day	Date Recorded:31-Jan-2011
Exercise history (Screening):Enjoys light exercise	Date Recorded:11-Aug-2009
Exercise history (Encounters):Enjoys light exercise	Date Recorded:11-Aug-2009

NHS Lothian - Imaging Request

Please note that this request will become invalid if the patient does not attend within 30 days of this request

Referral To	Lauriston Buildings Clinical Radiology L Radiology Walk in
Urgency of referral	Urgent - Suspected Cancer
Date of referral	15/05/2023
Date submitted	15/05/2023
UCPN	1010295779022

PATIENT DETAILS

CHI number:	1006631372
Name:	MR RICHARD TAYLOR
Date of birth:	10/06/1963
Sex:	Male

Contact Details

42 MORVENSIDE WESTBURN
EDINBURGH
EH14 2SJ

Voice (Mobile) : 07593330473

REFERRING PRACTITIONER DETAILS

Name:	Dr. Colette Pigliacampo-Linley (GMC: 7460882)
Practice:	Sighthill Green Medical Practice (70911)
Phone:	Voice : 0131 202 5888

Practice address

Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

INVESTIGATION REQUESTED

Test Requested: Chest

Reason for Request: smoker, weight loss, chronic cough., chest clear ?cancer

CLINICAL INFORMATION

Investigations

Description	Result	Date
Chronic Cough :	true	
Suspected :	Malignancy	
Could the patient be pregnant? :	Blank	

Signature of requesting doctor **Designation** **Date**

Radiology Walk In is available Monday to Friday as follows:

Lauriston Building	8:30am - 4:00pm
Leith Community Treatment Centre	8:30am - 4:00pm
Midlothian Community Hospital	9:15am - 12:30pm
East Lothian Community Hospital (Roodlands)	8:30am - 4:00pm
Royal Hospital for Sick Children - **Children Only**	9:00am - 4:30pm (Except public holidays)
Royal Infirmary of Edinburgh	9:00am - 4:30pm
St John's Hospital	8:30am - 5:00pm
Western General Hospital	8:00am - 5:00pm (Main xray Department)

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	12/06/2023
Date submitted	12/06/2023
UCPN	101029857045B

PATIENT DETAILS

CHI number:	1006631372
Name:	MR RICHARD TAYLOR
Date of birth:	10/06/1963
Sex:	Male

Contact Details

42 MORVENSIDE WESTBURN
EDINBURGH
EH14 2SJ

Voice (Mobile) : 07593330473

REFERRING PRACTITIONER DETAILS

Name:	Dr. Colette Pigliacampo-Linley (GMC: 7460882)
Practice:	Sighthill Green Medical Practice (70911)
Phone:	Voice : 0131 202 5888

Practice address

Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

CLINICAL INFORMATION

Reason for Referral:	Pr bleed, low iron
Main Referral Text:	Thank you for considering this patient for qfit testing. He has presented with weight loss ?cause, and says his waist has decreased by around 6 inches unintentionally. He says over the past 6 months he has had 3 episodes of PR bleeding with blood mixed in with stool. he has no abdominal pain. examination is unremarkable ioncluding PR examination. bloods show normal hb, but low iron of 8 (although normal transferrin). I wonder if he would benefit from qfit testing? Many thanks, Dr Colette Linley GPST 3

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	
Repeated PR bleeding without an obvious anal cause :	true	
Any blood mixed with the stool :	true	
Abdominal pain with weight loss (also consider upper GI cancer) :	true	
Unexplained iron deficiency anaemia :	true	
FBC :	done	
eGFR>30 :	Yes	
Liver function blood tests :	done	
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
Confusion		- Amnesia, abdominal pain, profuse sweating, looks unwell, ? cause, for neuro opinion.admitted, St Johns	28/12/2022	28/12/2022
Fall - accidental		# ring finger	12/10/2022	12/10/2022
Transient global amnesia		migraine nasal polyps cannabis use	25/08/2022	25/08/2022
Confusion		A&E st Johns, CT, head, normal, discharged 25/8	24/08/2022	24/08/2022
Confusion		self discharged.	23/08/2022	23/08/2022
Renal colic	New event		03/07/2022	03/07/2022

Abdominal pain	New event	Admitted	16/09/2020	16/09/2020
[X]Depressive episode	New event		08/08/2019	08/08/2019
Injury - self-inflicted		stab wound to abdomen post RTA while smoking canabis	30/01/2019	30/01/2019
Gallstones	New event		03/08/2018	03/08/2018
Abdominal pain			30/07/2018	30/07/2018
Stress at home	New event		06/09/2011	06/09/2011
Renal impairment		DATE_RECORDED=05/05/2011	20/11/2009	20/11/2009
Nondependent cannabis abuse	New event	Smoked for 30 years	11/08/2009	11/08/2009
Intracerebral haemorrhage		Discharged against medical advice on the 17.11.04	13/11/2004	13/11/2004
Motor vehicle traffic acid.NOS		Crashed motorbike into car at 50 mph	27/09/2000	27/09/2000
[X]Intentional self-harm		Bites to both arms plus hitting his head off cell wall	02/01/1999	02/01/1999
Viral illness		Admitted.	26/05/1998	26/05/1998
[X]Intentional self-harm		left wrist laceration.	24/02/1997	24/02/1997
[X]Intentional self-harm		Opened up old wound on his right arm with his teeth	02/01/1997	02/01/1997
Fracture of radius NOS		Right ; ORIF	02/04/1994	02/04/1994
[X]Depressive episode	First ever		18/08/1987	18/08/1987
[X]Intentional self-harm		Laceration to left forearm with razor blade	06/08/1987	06/08/1987
[X]Overdose - deliberate		Valium	04/08/1987	04/08/1987
[X]Intentional self-harm		Slashed wrists	04/08/1987	04/08/1987
[X]Overdose - deliberate		Chlomethiazole	23/07/1987	23/07/1987
#Ankle		Left ; ORIF	28/06/1987	28/06/1987
Motor vehicle traffic acid.NOS		Crashed motorbike into a wall	14/05/1987	14/05/1987
[X]Intentional self-harm		Laceration to brachial artery - Repaired	27/04/1987	27/04/1987
[X]Intentional self-harm		Lacerations to left forearm with razor blade	11/11/1986	11/11/1986
[X]Overdose - deliberate		Warfarin, Ampicillin, Betahistine.	14/12/1982	14/12/1982
Inj.?acc-cutting/stabbing		Superficial wound on right calf - Stabbed by wife	30/05/1982	30/05/1982
Motor vehicle traffic acid.NOS		Came off motorbike	30/03/1982	30/03/1982
[X]Intentional self-harm		Slashed left elbow	05/02/1982	05/02/1982
Head injury		+ large scalp laceration	24/11/1981	24/11/1981
[X]Intentional self-harm		Stabbed dorsum of left forearm with knife	01/10/1981	01/10/1981
Head injury			30/09/1981	30/09/1981
[X]Intentional self-harm		Set fire to house	31/07/1981	31/07/1981
Head injury		+ scalp laceration	02/05/1981	02/05/1981
Personality disorders		Psychopathic Type	18/09/1978	18/09/1978
Post-concussion syndrome			21/11/1977	21/11/1977
Bell's (facial) palsy			20/07/1973	20/07/1973
[X]Int self hang/strang/suffoc		Failed	10/06/1963	10/06/1963
[X]Intentional self-harm		Right ; Forearm Laceration	03/06/1963	03/06/1963

Past procedures (High and Medium Priority)

Procedure	Comment	Modifier	Date Performed	Date Recorded
Mental health review	- A&E unscheduled, thinking about stabbing himself, in police custody, currently not under arrest		11/12/2022	11/12/2022
Mental health assessment		Continuing	26/02/2019	26/02/2019
Mental health assessment	self harm, sexual abuse as a child, situational crisis	New event	21/01/2019	21/01/2019
Laparoscopic cholecystectomy		New event	06/08/2018	06/08/2018
Vasectomy NEC		New event	15/06/2017	15/06/2017

Endotracheal intubation	+ ventilation - Intubated twice due to declining GCS	13/11/2004	13/11/2004
Fusion of joint NEC	Right ; Wrist.	28/01/1997	28/01/1997
Removal int fixation dev NEC	Right ; Wrist.	05/07/1994	05/07/1994
Removal int fixation dev NEC	Left ; Ankle.	01/09/1989	01/09/1989

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	1 CAPSULE DAILY AS NEEDED		15/06/2017		12/06/2023

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Ferrous fumarate 210mg tablets	tablet	1 TABLET(S) ONCE A DAY FOR 3 [more]		12/06/2023		12/06/2023
Folic acid 5mg tablets	tablet	1 TABLET ONCE A DAY FOR 4 MON[more]		12/06/2023		12/06/2023
Omeprazole 20mg gastro-resistant capsules	capsule	1 CAPSULE DAILY AS NEEDED		15/06/2017		12/06/2023

Additional information

Patient Weight in Kilograms:84
Patient Height in Metres:1.79
Patient BMI:26.2
Patient Blood Pressure (Systolic):134
Patient Blood Pressure (Diastolic):86

Smoking history (Screening):Cigarette smoker	Date Recorded:07-Jul-2021
Smoking history (Encounters):Cigarette smoker	Date Recorded:07-Jul-2021
Alcohol history (Screening):Trivial drinker - <1u/day	Date Recorded:31-Jan-2011
Alcohol history (Encounters):Trivial drinker - <1u/day	Date Recorded:31-Jan-2011
Exercise history (Screening):Enjoys light exercise	Date Recorded:11-Aug-2009
Exercise history (Encounters):Enjoys light exercise	Date Recorded:11-Aug-2009

NHS Lothian - Referral Letter

Referral To	St John's Hospital Neurology LI Basic Sign Referral
Urgency of referral	Urgent
Date of referral	31/10/2023
Date submitted	31/10/2023
UCPN	101031215396T

PATIENT DETAILS

CHI number:	1006631372
Name:	MR RICHARD TAYLOR
Date of birth:	10/06/1963
Sex:	Male

Contact Details

42 MORVENSIDE WESTBURN
EDINBURGH
EH14 2SJ

Voice (Mobile) : 07593330473

REFERRING PRACTITIONER DETAILS

Name:	Dr . Rachel Gillett (GMC: 7488404)
Practice:	Sighthill Green Medical Practice (70911)
Phone:	Voice : 0131 202 5888

Practice address

Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

CLINICAL INFORMATION

Reason for Referral: FAO Dr Samarasekera

Main Referral Text:

Dear Dr Samarasekera,

I wondered if you would kindly review Mr Taylor again. He saw you back in June in regards to headaches with associated confusion/memory loss. This was felt to be due to migraine but he did not attend for review with a GP following this. He has recently been seen in A+E in relation to multiple collapses (see attached letters) and again has been told not to drive but without much of a plan going forward (one of my colleagues has informed the DVLA after multiple efforts from various parties to encourage him to do this himself). Him and his partner feel all of this is potentially related to anxiety, which may well be the case, but in the context of his complex background, these collapses and the occupational/social impact, I would appreciate your review and advice on further investigation / management.

Kind Regards,
Dr Rachel Gillett
GPST3

Pre-existing conditions (High & Medium Priority)

Description	Modifier	Extension	Start Date	Date Recorded
Confusion		- Amnesia, abdominal pain, profuse sweating, looks unwell, ? cause, for neuro opinion.admitted, St Johns	28/12/2022	28/12/2022
Fall - accidental		# ring finger	12/10/2022	12/10/2022
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Exercise history (Encounters):Enjoys light exercise Date Recorded:11-Aug-2009

NHS Lothian

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

Dr CG Pigliacampo-Linley
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date: 22/10/2023

Emergency Discharge Summary

Patient	Richard Taylor 42 Morvenside Edinburgh EH14 2SJ	**CHI**	**1006631372**
		Date of Birth / Age	10/06/1963 (60 years)
		UHPI	610119466W
		A&E Attendance Number	E5501622
Attendance Date	21/10/2023	**Contact**	Taylor Arrices
Attendance Time	16:44		
Mode of Arrival	Emergency Ambulance		
Source of Referral	999 Emergency		
Discharge Date	22/10/2023		
Discharge To			

Dear Dr CG Pigliacampo-Linley

Presentation: Fainting episode, Collapse. T2. New neurological deficit <24 hours. Witnessed collapse ?seizure activity 4pm approx. New confusion today intermittently. C/O headache. PMH: Anxiety related collapses previously. NEWS 0. C Valente CN collapse.

CLINICAL NOTES:

Clinical note: O Hawkes CDF

I initially planned to review this gentleman as he was up-triaged having had a collapse in the waiting room

Has been on a cardiac monitor since

Since became increasingly agitated and got up, tore off leads and walked out of the department

Did not respond to verbal de-escalation.

Stormed out of department and onto road accompanied by son and daughter, who tell me has been having regular collapses every few days or so
Has been increasingly confused and disorientated

Son and daughter have since brought back to dpeartment
Very agitated
When asked where he is, says 'just here'
Was mobilising around department looking for phone
Had a further collapse in pod C

On my arrival, seated in chair, unresponsive to voice
Pale, breathing, no concerns about airway compromise
WWP pulse regular HS I+II+0
Lasted approx 30s, then came round suddenly
Able to trnasfer to trolley, very unsteady on feet

Complaining of severe posteroir headache
Tells me similar to previous stroke

Asking to go home as wants to go back to work on Monday
Tells me works as a HGV driver
I have told him strongly that he cannot drive whilst having unexplained collapses and must inform the DVLA - legal duty to do so
I note has previously been told not to drive following neurology review

VBG following collapse is reassuring - pH 7.4 lactate 0.9 BM 7

Accepting of some oral diazepam
I have ahnded over to night team for more formal review and assessment
Son and daughter currently with pt - contact numbers on trak if absconds again
Now settled and sleepig

Above discussed with Dr Kerslake, ED Cons

Yours Sincerely,

Olivia Hawkes, Doctor

NHS Lothian

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

Dr CG Pigliacampo-Linley
Sighthill Green Medical Practice
Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

Date: 22/10/2023

Emergency Discharge Summary

Patient	Richard Taylor 42 Morvenside Edinburgh EH14 2SJ	**CHI**	**1006631372**
		Date of Birth / Age	10/06/1963 (60 years)
		UHPI	610119466W
		A&E Attendance Number	E5501622
Attendance Date	21/10/2023	**Contact**	Taylor Arrices
Attendance Time	16:44		
Mode of Arrival	Emergency Ambulance		
Source of Referral	999 Emergency		
Discharge Date	22/10/2023		
Discharge To			

Dear Dr CG Pigliacampo-Linley

Presentation: Fainting episode, Collapse. T2. New neurological deficit <24 hours. Witnessed collapse ?seizure activity 4pm approx. New confusion today intermittently. C/O headache. PMH: Anxiety related collapses previously. NEWS 0. C Valente CN collapse.

CLINICAL NOTES:

Clinical note: 60M ?seizures

SAS: Called for collpase in pub

GCS 14 on rrival

Family report chest pain, forgetfullness, vacant episodes

Seen with son (lives with him) and daughter present. Multiple complaints.

Headache started yesterday AM
Otherwise normal throughout day. Became upset in evening due to relationship problems
Went to bed
Woke up this AM- son says was forgetful. Can have periods of forgetfullness that resolve spontaneously
Went to go to work- headache too sore so went later
Went to pub approx 1700
From family friend at pub: looked sweaty/pale, collapsed at pub, unable to be woken up, SAS called
In ED- became agitated and wanted to leave.
Collapse as documented by Dr Hawkes, with thanks

Over last couple of weeks:
Headache
- Occipital, constant, gradual onset
- Nil worsening/relieving. Not tried anaglesia. States very severe, can keep him up at night
- Painful eyes associated with this
- No other visual change/neurological change

Collapses- from family
- Feels generally unwell prior- unable to explain further
- Collapses to floor with fine tremor of all limbs, unresponsive
- No urinary/bowel incontience
- Lasts 30 secs before can sometimes reoccur.
- Aware has been told not to drive previously- son states he went back to driving when had fewer collapses.
- Has been happening 4-5 tmes/day last couple of days

Chest pain
- Central chest pain, at rest and on walking, no radiation
- Lasts 5 hours at time. No associated symptoms
- Taking street tramadol for pain
- Happening daily

PR bleeding
- Unable to say time frame
- Fresh blood on wiping and darker in pan, not mixed with stool. No maleana

- Not seen GP- although I note has been referred to colorectal and DNAd multiple appointments/FIT testing
- No other change in bowel habit

PMHx
Previous stroke - but no functional residual deficit according to partner
Previous interaction with neurology at end of last year
1) Subjective memory complaints typically in association with headache - probable migraine with possible dissociative amnesia
2) Transient episode of altered awareness with no particular clinical pointers (28 December 2022)
2.1) MRI: old right putamen haemorrhagic lacune (2022)
3) Previous admission to hospital with confusion (August 2022)
4) Road traffic accident whilst smoking cannabis (January 2019)
5) Mental health problems
5.1) Recent review by Psychiatry for depression (2022) and Clinical Psychology (February 2023)
5.2) Episode of deliberate self-harm (2019)
6) Right lentiform nucleus cerebral haemorrhage (2004)
6.1) Presentation with frontal and right temporal headache with associated reduction in conscious level

FHx
Dad dementia

DHx
ADR: morphine, coedine
Nil reg

SHx
At hoem with son and daughter
Smokes pack/day. 1 oz cannabis/week
Nil alcohol. Denies IVDU

O/E
NEWS 0

A: Patent
B: Clear bilateral A/E
C: HS 1+2+0 reg WWP
D: SNT BS present
E: Calves SNT
CN II-XII intact, PEARL
Tone, power and sensation intact all limbs
Reflexes all ellicted, planters downgoinig

Imp
Collapse ?cause
- Has brain pathology that would predepose to seizures, but observed episode not typical
Chronic headaches
- ?migraine vs tramadol overuse
- No red flags

Ix
ECG: NSR 61bpm, nil acute
Bloods- unremarkable

Discussed with family and pt here to r/o emergency issues and to plan appropriate f/u Ix
In agreement- state pt is "stoical" in issues with engaging with healthcare
Explained first fit clinic would provide a good opportunity to Ix symptoms
Son asking if appointments can be addressed to him- explained pt has capacity to engage as he chooses

Advised due to category 2 license we have legal obligation to infrom DVLA about driving.
Explained diagnosis and control of episodes could allow license to re-instated
Pt became very angry at this- states he has to work to support his 16 children.
Stormed out of ED, refused to sign self discharge form. Appears to understand risks and has capacity. Cannula removed, highlighted to family can represent at any time.

K Hill EM ST1

Yours Sincerely,

Dr Kirsty Hill, Doctor

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	31/10/2023
Date submitted	31/10/2023
UCPN	101031215546U

PATIENT DETAILS

CHI number:	1006631372
Name:	MR RICHARD TAYLOR
Date of birth:	10/06/1963
Sex:	Male

Contact Details

42 MORVENSIDE WESTBURN
EDINBURGH
EH14 2SJ

Voice (Mobile) : 07593330473

REFERRING PRACTITIONER DETAILS

Name:	Dr . Rachel Gillett (GMC: 7488404)
Practice:	Sighthill Green Medical Practice (70911)
Phone:	Voice : 0131 202 5888

Practice address

Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

CLINICAL INFORMATION

Reason for Referral: Re-referral PR Bleed, low iron

Main Referral Text: My colleague Dr Pigliacampo-Linley referred Mr Taylor back in June (see below) but he did not return his qFIT tests. He has not presented to the GP since then and does report some improvement in rectal bleeding but symptoms on the whole are unchanged. I have arranged some repeat bloods for him but after explanation of the purpose of the qFIT tests, he understands the importance and says he would like to complete them. I wonder if he could be sent repeat tests?

Main Referral Text: Thank you for considering this patient for qfit testing. He has presented with weight loss ?cause, and says his waist has decreased by around 6 inches unintentionally. He says over the past 6 months he has had 3 episodes of PR bleeding with blood mixed in with stool. he has no abdominal pain. examination is unremarkable including PR examination. bloods show normal hb, but low iron of 8 (although normal transferrin). I wonder if he would benefit from qfit testing? Many thanks, Dr Colette Linley GPST 3

Kind Regards,
Dr Rachel Gillett
GPST3

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	
Repeated PR bleeding without an obvious anal cause :	true	
Any blood mixed with the stool :	true	
Abdominal pain with weight loss (also consider upper GI cancer) :	true	
Unexplained iron deficiency anaemia :	true	
FBC :	done	
eGFR>30 :	Yes	
Liver function blood tests :	done	
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

Confusion		- Amnesia, abdominal pain, profuse sweating, looks unwell, ? cause, for neuro opinion.admitted, St Johns	28/12/2022	28/12/2022
Fall - accidental		# ring finger	12/10/2022	12/10/2022
Transient global amnesia		migraine nasal polyps cannabis use	25/08/2022	25/08/2022
Confusion		A&E st Johns, CT, head, normal, discharged 25/8	24/08/2022	24/08/2022
Confusion		self discharged.	23/08/2022	23/08/2022
Renal colic	New event		03/07/2022	03/07/2022
Abdominal pain	New event	Admitted	16/09/2020	16/09/2020
[X]Depressive episode	New event		08/08/2019	08/08/2019
Injury - self-inflicted		stab wound to abdomen post RTA while smoking canabis	30/01/2019	30/01/2019
Gallstones	New event		03/08/2018	03/08/2018
Abdominal pain			30/07/2018	30/07/2018
Stress at home	New event		06/09/2011	06/09/2011
Renal impairment		DATE_RECORDED=05/05/2011	20/11/2009	20/11/2009
Nondependent cannabis abuse	New event	Smoked for 30 years	11/08/2009	11/08/2009
Intracerebral haemorrhage		Discharged against medical advice on the 17.11.04	13/11/2004	13/11/2004
Motor vehicle traffic acid.NOS		Crashed motorbike into car at 50 mph	27/09/2000	27/09/2000
[X]Intentional self-harm		Bites to both arms plus hitting his head off cell wall	02/01/1999	02/01/1999
Viral illness		Admitted.	26/05/1998	26/05/1998
[X]Intentional self-harm		left wrist laceration.	24/02/1997	24/02/1997
[X]Intentional self-harm		Opened up old wound on his right arm with his teeth	02/01/1997	02/01/1997
Fracture of radius NOS		Right ; ORIF	02/04/1994	02/04/1994
[X]Depressive episode	First ever		18/08/1987	18/08/1987
[X]Intentional self-harm		Laceration to left forearm with razor blade	06/08/1987	06/08/1987
[X]Overdose - deliberate		Valium	04/08/1987	04/08/1987
[X]Intentional self-harm		Slashed wrists	04/08/1987	04/08/1987
[X]Overdose - deliberate		Chlomethiazole	23/07/1987	23/07/1987
#Ankle		Left ; ORIF	28/06/1987	28/06/1987
Motor vehicle traffic acid.NOS		Crashed motorbike into a wall	14/05/1987	14/05/1987
[X]Intentional self-harm		Laceration to brachial artery - Repaired	27/04/1987	27/04/1987
[X]Intentional self-harm		Lacerations to left forearm with razor blade	11/11/1986	11/11/1986
[X]Overdose - deliberate		Warfarin, Ampicillin, Betahistine.	14/12/1982	14/12/1982
Inj.?acc-cutting/stabbing		Superficial wound on right calf - Stabbed by wife	30/05/1982	30/05/1982
Motor vehicle traffic acid.NOS		Came off motorbike	30/03/1982	30/03/1982
[X]Intentional self-harm		Slashed left elbow	05/02/1982	05/02/1982
Head injury		+ large scalp laceration	24/11/1981	24/11/1981
[X]Intentional self-harm		Stabbed dorsum of left forearm with knife	01/10/1981	01/10/1981
Head injury			30/09/1981	30/09/1981
[X]Intentional self-harm		Set fire to house	31/07/1981	31/07/1981
Head injury		+ scalp laceration	02/05/1981	02/05/1981
Personality disorders		Psychopathic Type	18/09/1978	18/09/1978
Post-concussion syndrome			21/11/1977	21/11/1977
Bell's (facial) palsy			20/07/1973	20/07/1973
[X]Int self hang/strang/suffoc		Failed	10/06/1963	10/06/1963
[X]Intentional self-harm		Right ; Forearm Laceration	03/06/1963	03/06/1963

Past procedures (High and Medium Priority)

Procedure	Comment	Modifier	Date Performed	Date Recorded

Mental health review	- A&E unscheduled, thinking about stabbing himself, in police custody, currently not under arrest		11/12/2022	11/12/2022
Mental health assessment		Continuing	26/02/2019	26/02/2019
Mental health assessment	self harm, sexual abuse as a child, situational crisis	New event	21/01/2019	21/01/2019
Laparoscopic cholecystectomy		New event	06/08/2018	06/08/2018
Vasectomy NEC		New event	15/06/2017	15/06/2017
Endotracheal intubation	+ ventilation - Intubated twice due to declining GCS		13/11/2004	13/11/2004
Fusion of joint NEC	Right ; Wrist.		28/01/1997	28/01/1997
Removal int fixation dev NEC	Right ; Wrist.		05/07/1994	05/07/1994
Removal int fixation dev NEC	Left ; Ankle.		01/09/1989	01/09/1989

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	1 CAPSULE DAILY AS NEEDED		15/06/2017		12/06/2023

Additional information

Patient Weight in Kilograms:84
Patient Height in Metres:1.79
Patient BMI:26.2
Patient Blood Pressure (Systolic):134
Patient Blood Pressure (Diastolic):86
Smoking history (Screening):Cigarette smoker Date Recorded:07-Jul-2021
Smoking history (Encounters):Cigarette smoker Date Recorded:07-Jul-2021
Alcohol history (Screening):Trivial drinker - <1u/day Date Recorded:31-Jan-2011
Alcohol history (Encounters):Trivial drinker - <1u/day Date Recorded:31-Jan-2011
Exercise history (Screening):Enjoys light exercise Date Recorded:11-Aug-2009
Exercise history (Encounters):Enjoys light exercise Date Recorded:11-Aug-2009

Radiology Request Form

Thursday please

NHS Lothian

Produced By: Dr Helen M Hare
Run on: 05/06/2024 10:49:51

UHPI	610119466W	**DOB**	10/06/63
Name	**Taylor, Richard**	**CHI No**	1008631372
Address	42 Morvenside	**Sex**	Male
		Visit No	48917966
	Edinburgh	**Episode No**	10005940304
	EH14 2SJ	**Episode Type**	I
Order Location	WGH MAU Base 1 + MAUB1/R02-09	**Consultant**	Dr Johanna Hofer

Order Item	Order Status	Request Date	Priority	Requested By	Mob	Hot Report	Preferred Radiologist	Auth By	Appt Date	Appt Time
MRI Spine Whole	Ord	05/06/2024	Routine	Dr Helen M Hare				6.6.24	10.00. (10.15)	

RADIOLOGY REQUEST INFORMATION

Clinical Details for Radiology	**Presents with acute back pain, no trauma history. CT (abdo pelvis then confirmed on chest) shows T9 compression fracture and gas. No neurology in T9 dermatome but some L3/4 loss of sensation. Following discussion with neurosurgery, please can we have an MRI whole spine with contrast to further characterise fracture and specifically to assess for infection or malignancy which might have lead to fracture?**
Method of Transportation	**Bed**
Nurse Escort Required	**No**
Previous History of Contrast Reactions	**Unknown**
Does the patient have a programmable device or stimulator?	**No**
Does the patient have any of the following implants: Cardiac Pacemaker; Cerebral Aneurysm Clip; Cochlear Implant; Heart Valves or Stents?	**No**
Has the patient EVER had metal in their eyes	**No**
What is the Patients eGFR	**Over 30**
If the eGFR is <30 and contrast is required, do you feel the benefits of this investigation outweigh the increased risks of NSF?	**Not Relevant**
Please enter then name and grade of most senior clinician involved in the above decision.	**Mr Mustafa El Sheik, neurosurgical registrar**

MRI whole spine inc STIR.
Axials [redacted] @ T9.
review on table > contrast.
AMH

GENERAL INFORMATION

Requestor Name and Bleep / Contact Number / Alternative Contact Details / Ward Phone No	**H Hare 8760**
Please confirm that this is the correct patient for the examination requested.	**Yes**
Does the Patient have any of the following - MRSA, VRE, HEP C? Is this a future date / follow up / surveillance examination? If Yes, please provide expected dates in the Clinical Details section.	

please note ward treating = spinal precautions

Appt Letter Sent		Arrival Time		Previous X-Rays	
Justified		ID Checked		Radiographer	
Exposure / Dose		Screening Time		Room	
Films Rejected	35x43 / 24x30	Reject Reasons		Contrast Details	

Radiology Request Form

Produced By: Dr Helen M Hare
Run on: 05/06/2024 10:49:51

NHS Lothian

18x24 ☐ ☐

Notes

NHS Lothian MRI Patient Screening Questionnaire and Consent Form

NHS Lothian

SURNAME Taylor FIRST NAME Richard

DATE OF BIRTH 10/06/1963 CHI 1006631372

HEIGHT 5'11 WEIGHT ?12/13 stone

ADDRESS 42 morningside HOME TEL 07593330473

	Question	Yes	No
1.	Do you have a **CARDIAC PACEMAKER** or artificial **HEART VALVE**?		✓
2.	Have you **ever** had any operations on your **CHEST, HEART, HEAD** or **EYES**?		✓
3.	Do you have an **ANEURYSM CLIP, COCHLEAR IMPLANT** or **SHUNT**?		✓
4.	Have you **ever** in your life had an accident with metal, where **metal fragments** have gone into your **eyes** or body?		✓
5.	Are you wearing a **glucose monitoring sensor** (Libre) or a **MEDICAL patch** e.g. Pain, Cardiac, HRT, Nicotine, Fentanyl		✓
6.	**LADIES**: Could you be pregnant? Or are you breast-feeding?		
	If you answer YES to any of the questions 1-6 please contact the MRI department.		
7.	Have you **ever** had any surgery? gallbladder, left ankle.	✓	
8.	Have you had any surgery in the last **2 months**?		✓
9.	Do you have a **HEART CONDITION** or **KIDNEY DISORDER**?		✓
10.	Are you currently **EPILEPTIC** or **DIABETIC**? (2 seizures in past 2 months)	✓	✓
11.	Are you wearing **DENTURES, DENTAL PLATE, CONTACT LENSES** or **HEARING AID**?		✓
12.	Do you have any tattoos or piercings?	✓	
13.	Do you have any metallic, electronic or foreign metallic objects in or attached to your body other than those mentioned above? ankle.	✓	

I UNDERSTAND THE MRI EXAMINATION. I ALSO UNDERSTAND THE ABOVE QUESTIONS AND GIVE PERMISSION FOR THE USE OF INTRAVENOUS CONTRAST AGENT IF IT IS DEEMED NECESSARY.

I CONFIRM I HAVE REMOVED ALL METAL FROM MY PERSON.

SIGNATURE ..... DATE 6.6.24

(Or signature of responsible adult)

RADIOGRAPHER..... DATE.....

NHS Lothian MRI Patient Screening Questionnaire and Consent Form

NHS Lothian

To be completed by Hospital Staff

GADOLINIUM

GIVEN BY_____ AMOUNT GIVEN_____

Lot No: _____ EXPIRY DATE_____

COMPLICATIONS_____

SODIUM CHLORIDE

AMOUNT GIVEN_____ Lot No:_____

EXPIRY DATE_____

CONSENT FOR THE ADMINISTRATION OF HYOSCINE BUTYLBROMIDE (BUSCOPAN)

20 mg/ml to be administered intra-venously if no contraindications:

Myasthenia Gravis (muscle weakness)	Yes	No
Megacolon	Yes	No
Narrow angle glaucoma	Yes	No
Tachycardia	Yes	No
Prostatic enlargement with urinary retention	Yes	No
Paralytic Ileus (inactive gut)	Yes	No
Mechanical stenosis in the GI tract (blockage)	Yes	No
Pregnancy	Yes	No
Breastfeeding	Yes	No
Known sensitivity to Hyoscine Butylbromide or any of its components	Yes	No

The reason for the administration of Hyoscine Butylbromide and potential side effects have been explained to me, and I consent to its administration

Patient's Signature: _____

Administered by: _____ Date: _____

Vial checked by: _____

NHS Lothian - Referral Letter

Referral To	Princess Alexandra Eye Pavilion Ophthalmology - Request for Information LI Ophthamology Additional inf
Urgency of referral	Routine
Date of referral	05/02/2025
Date submitted	05/02/2025
UCPN	101035509834G

PATIENT DETAILS

CHI number:	1006631372
Name:	MR RICHARD TAYLOR
Date of birth:	10/06/1963
Sex:	Male

Contact Details

42 MORVENSIDE WESTBURN
EDINBURGH
EH14 2SJ

Voice (Mobile) : 07593330473
E-mail : rtclan2019@outlook.com

REFERRING PRACTITIONER DETAILS

Name:	Dr. Rachel Hendrie (GMC: 6134660)
Practice:	Sighthill Green Medical Practice (70911)
Phone:	Voice : 0131 202 5888

Practice address

Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

CLINICAL INFORMATION

Reason for Referral:	Additional Information Required
Main Referral Text:	Dear colleague, this patient has been referred to your service and further information is requested. Please find below PMH and medications. Many thanks.

Pre-existing conditions (High & Medium Priority)

Description	Modifier	Extension	Start Date	Date Recorded
Osteoporosis	New event		05/08/2024	05/08/2024
Constipation			04/06/2024	04/06/2024
Epileptic seizures - tonic			26/02/2024	26/02/2024
Closed fracture rib		left 10th rib	19/12/2023	19/12/2023
Collapse - symptom	New event	?cause (Cat 2 licence duty to inform DVLA)	22/10/2023	22/10/2023
Confusion		- Amnesia, abdominal pain, profuse sweating, looks unwell, ? cause, for neuro opinion.admitted, St Johns	28/12/2022	28/12/2022
Fall - accidental		# ring finger	12/10/2022	12/10/2022
Transient global amnesia		migraine nasal polyps cannabis use	25/08/2022	25/08/2022
Confusion		A&E st Johns, CT, head, normal, discharged 25/8	24/08/2022	24/08/2022
Confusion		self discharged.	23/08/2022	23/08/2022
Renal colic	New event		03/07/2022	03/07/2022
Abdominal pain	New event	Admitted	16/09/2020	16/09/2020
[X]Depressive episode	New event		08/08/2019	08/08/2019
Injury - self-inflicted		stab wound to abdomen post RTA while smoking canabis	30/01/2019	30/01/2019
Gallstones	New event		03/08/2018	03/08/2018
Abdominal pain			30/07/2018	30/07/2018

Stress at home	New event		06/09/2011	06/09/2011
Renal impairment		DATE_RECORDED=05/05/2011	20/11/2009	20/11/2009
Nondependent cannabis abuse	New event	Smoked for 30 years	11/08/2009	11/08/2009
Intracerebral haemorrhage		Discharged against medical advice on the 17.11.04	13/11/2004	13/11/2004
Motor vehicle traffic acid.NOS		Crashed motorbike into car at 50 mph	27/09/2000	27/09/2000
[X]Intentional self-harm		Bites to both arms plus hitting his head off cell wall	02/01/1999	02/01/1999
Viral illness		Admitted.	26/05/1998	26/05/1998
[X]Intentional self-harm		left wrist laceration.	24/02/1997	24/02/1997
[X]Intentional self-harm		Opened up old wound on his right arm with his teeth	02/01/1997	02/01/1997
Fracture of radius NOS		Right ; ORIF	02/04/1994	02/04/1994
[X]Depressive episode	First ever		18/08/1987	18/08/1987
[X]Intentional self-harm		Laceration to left forearm with razor blade	06/08/1987	06/08/1987
[X]Overdose - deliberate		Valium	04/08/1987	04/08/1987
[X]Intentional self-harm		Slashed wrists	04/08/1987	04/08/1987
[X]Overdose - deliberate		Chlomethiazole	23/07/1987	23/07/1987
#Ankle		Left ; ORIF	28/06/1987	28/06/1987
Motor vehicle traffic acid.NOS		Crashed motorbike into a wall	14/05/1987	14/05/1987
[X]Intentional self-harm		Laceration to brachial artery - Repaired	27/04/1987	27/04/1987
[X]Intentional self-harm		Lacerations to left forearm with razor blade	11/11/1986	11/11/1986
[X]Overdose - deliberate		Warfarin, Ampicillin, Betahistine.	14/12/1982	14/12/1982
Inj.?acc-cutting/stabbing		Superficial wound on right calf - Stabbed by wife	30/05/1982	30/05/1982
Motor vehicle traffic acid.NOS		Came off motorbike	30/03/1982	30/03/1982
[X]Intentional self-harm		Slashed left elbow	05/02/1982	05/02/1982
Head injury		+ large scalp laceration	24/11/1981	24/11/1981
[X]Intentional self-harm		Stabbed dorsum of left forearm with knife	01/10/1981	01/10/1981
Head injury			30/09/1981	30/09/1981
[X]Intentional self-harm		Set fire to house	31/07/1981	31/07/1981
Head injury		+ scalp laceration	02/05/1981	02/05/1981
Personality disorders		Psychopathic Type	18/09/1978	18/09/1978
Post-concussion syndrome			21/11/1977	21/11/1977
Bell's (facial) palsy			20/07/1973	20/07/1973
[X]Int self hang/strang/suffoc		Failed	10/06/1963	10/06/1963
[X]Intentional self-harm		Right ; Forearm Laceration	03/06/1963	03/06/1963

Past procedures (High and Medium Priority)

Procedure	Comment	Modifier	Date Performed	Date Recorded
Mental health review	- A&E unscheduled, thinking about stabbing himself, in police custody, currently not under arrest		11/12/2022	11/12/2022
Mental health assessment		Continuing	26/02/2019	26/02/2019
Mental health assessment	self harm, sexual abuse as a child, situational crisis	New event	21/01/2019	21/01/2019
Laparoscopic cholecystectomy		New event	06/08/2018	06/08/2018
Vasectomy NEC		New event	15/06/2017	15/06/2017
Endotracheal intubation	+ ventilation - Intubated twice due to declining GCS		13/11/2004	13/11/2004
Fusion of joint NEC	Right ; Wrist.		28/01/1997	28/01/1997
Removal int fixation dev NEC	Right ; Wrist.		05/07/1994	05/07/1994
Removal int fixation dev NEC	Left ; Ankle.		01/09/1989	01/09/1989

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	1 CAPSULE DAILY AS NEEDED		15/06/2017		29/01/2025
Accrete D3 One a Day 1000mg/880unit chewable tablets (Thornton & Ross Ltd)	tablet	TAKE ONE TABLET ONCE A DAY		06/08/2024		13/12/2024
Alendronic acid 70mg tablets	tablet	TAKE ONE TABLET ONCE WEEKLY. [more]		06/08/2024		13/12/2024
Lamotrigine 100mg tablets	tablet	1 TWICE A DAY (TOTAL 125MG BD)		28/06/2024		28/01/2025
Lamotrigine 25mg tablets	tablet	1 TWICE A DAY (TOTAL 125MG BD)		28/06/2024		28/01/2025

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Dihydrocodeine 30mg tablets	tablet	I TABLET UP TO FOUR TIMES A D[more]		30/01/2025		30/01/2025
Dihydrocodeine 30mg tablets	tablet	I TABLET UP TO FOUR TIMES A DAY		29/01/2025		29/01/2025
Dihydrocodeine 30mg tablets	tablet	I TABLET UP TO FOUR TIMES A DAY		21/01/2025		21/01/2025
Dihydrocodeine 30mg tablets	tablet	I TABLET UP TO FOUR TIMES A DAY		07/01/2025		07/01/2025
Ibuprofen 5% gel	gram	APPLY THREE TIMES DAILY TO TH[more]		30/12/2024		30/12/2024
Dihydrocodeine 30mg tablets	tablet	I TABLET UP TO FOUR TIMES A DAY		30/12/2024		30/12/2024
Omeprazole 20mg gastro-resistant capsules	capsule	1 CAPSULE DAILY AS NEEDED		15/06/2017		18/12/2024
Dihydrocodeine 30mg tablets	tablet	I TABLET UP TO FOUR TIMES A DAY		18/12/2024		18/12/2024
Dihydrocodeine 30mg tablets	tablet	I TABLET UP TO FOUR TIMES A DAY		06/12/2024		06/12/2024
Tramadol 50mg capsules	capsule	ONE OR TWO CAPSULE TO BE TAKE[more]		26/11/2024		26/11/2024
Tramadol 50mg capsules	capsule	ONE OR TWO CAPSULE TO BE TAKE[more]		07/11/2024		07/11/2024

Additional information

Patient Weight in Kilograms:84
Patient Height in Metres:1.79
Patient BMI:26.2
Patient Blood Pressure (Systolic):134
Patient Blood Pressure (Diastolic):86
Smoking history (Screening):Cigarette smoker Date Recorded:07-Jul-2021
Smoking history (Encounters):Cigarette smoker Date Recorded:07-Jul-2021
Alcohol history (Screening):Trivial drinker - <1u/day Date Recorded:31-Jan-2011
Alcohol history (Encounters):Trivial drinker - <1u/day Date Recorded:31-Jan-2011
Exercise history (Screening):Enjoys light exercise Date Recorded:11-Aug-2009
Exercise history (Encounters):Enjoys light exercise Date Recorded:11-Aug-2009

Direct Referral To Hospital Eye Service
General

101035494983Z
Unique Care Pathway Number: 101035494983Z

Urgency of referral
Urgent

HOSPITAL / LOCATION CODE S316H | **HOSPITAL** Princess Alexandra Eye Pavilion

Patient Surname	**Patient Forename**	**Title**	**Optometrist Details**
TAYLOR	RICHARD	Mr	Neil Maclennan Jack Brown Eyecare (11075) WESTSIDE PLAZA WESTER HAILES SHOPPING CENTRE EDINBURGH EH14 2SW 0131-442-2333

DOB	1963-06-10	**CHI**	1006631372	**SEX**	M
Address	42 MORVENSIDE WESTBURN EDINBURGH				
Postcode	EH14 2SJ	**Tel No**	07593330473		
Ethnicity	Scottish				
Location Code:	11075	**HCP Code**	01-36729	**Date of Referral:**	2025-02-04

Patient History & Details

Incidental finding of new 2.5+mm anisocoria L>R on review of LE corneal abrasion. New since 15/09/23, not noticed by px until pointed out during today's examination. Definitively new, anisocoria is marked while being absent from all prior records. Appears broadly equal in all light conditions. No h/a. Diplopia appreciated on laevoversions, none in primary position. Colour vision normal, C-45 screening fields full, range of EOM movements full and smooth. VA stable from prev. Pupillary reactions present D&C in both eyes, with LE appearing more sluggish than RE. Given the marked and recent nature of the findings of anisocoria and diplopia, I would appreciate neuro-ophthalmological opinion as to underlying cause and any required intervention. Many thanks.

Patient Symptomatic	No
Previous Attendance at HES	No
If Yes ? Date	
If Yes ? Location	

Armed Forces Personnel, Immediate families and veterans

Translator Required	No
If Yes ? Language	

Diagnosis	Neurological New anisiocoria and diplopia.	**Treatment**	Neuro-ophthalmological assessment in the first instance.

Ocular Examination - External/Internal

Right	**Left**
Direct and SL volk reveals- External: Healthy lids, conj white Cornea: Clear A/C: quiet, open, VHG4, no cells or flare Lens: Clear Vitreous Clear Vessels smooth 2:3 C:D 0.40 Disc and macula healthy/stable	Direct and SL volk reveals- External: G2.5 conj red, trace G1 inf stain Cornea: Clear A/C: quiet, open, VHG4, no cells or flare Lens: Clear Vitreous CLear Vessels smooth 2:3 C:D 0.40 Disc and macula healthy/stable

Applanation No **Tonometry**	**R** 11 mmhg	**L** 10 mmhg	**Relative Afferent Pupillary Defect**	-	**Fields Attached** -

Vision	Sph	Cyl	Axis	VA	PH VA	Add	NVA
R	-	-	-	6/9	-	-	-
L	-	-	-	6/9	-	-	-
						Images Attached	No

GP informed of referral? Yes **Patient sent to casualty:** No **Hospital telephoned:** No Patient **consents** to GP being contacted for further information.	**GP**	RACHEL HENDRIE **GP Code:** S4052 **GMC Code:** 6134660
	GP Practice	**Practice Code:** 70911 Sighthill Green Medical Practice Sighthill Health Centre Calder Road Edinburgh EH11 4AU

NHS Lothian - Referral Letter

Referral To	St John's Hospital Plastic Surgery - Hands Service LI Carpal Tunnel
Urgency of referral	Routine
Date of referral	24/02/2025
Date submitted	24/02/2025
UCPN	101035696023J

PATIENT DETAILS

CHI number:	1006631372
Name:	MR RICHARD TAYLOR
Date of birth:	10/06/1963
Sex:	Male

Contact Details

42 MORVENSIDE WESTBURN
EDINBURGH
EH14 2SJ

Voice (Mobile) : 07593330473
E-mail : rtclan2019@outlook.com

REFERRING PRACTITIONER DETAILS

Name:	Dr. Michael Green (GMC: 7561389)
Practice:	Sighthill Green Medical Practice (70911)
Phone:	Voice : 0131 202 5888

Practice address

Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

CLINICAL INFORMATION

Reason for Referral: CTS symptom desptie brace/DHC/amitript affecting QOL

Main Referral Text:

Dear hand surgeon,

I'd be grateful if you could see this gentleman who is on 120 mg of DHC due to a vertebral fracture. Plus, amitriptyline 50 mg. Despite this, unfortunately, he still suffers from quite significant palmar pain on the left hand with characteristic median nerve distribution pain, and pins and needles, with poor sleep patterns amd constant needs to shake his hand to relief the pain .

Unfortunately, Symptoms ongoing > 6 weeks and despite brace/DHC/amitriptyline getting significant sleep loss and pain, regularly shaking hand to relief this.

Yours sincerely,
Dr Michael Green

Examinations and Investigations

Description	Result	Date
Do symptoms regularly occur at night/early morning? :	Yes	
Are symptoms predominantly in thumb/index/middle finger? :	Yes	
Do symptoms regularly occur during the daytime? :	Yes	
Is there permanent altered sensation? :	Yes	
Does the patient shake their hands to try to relieve symptoms? :	Yes	
Is the patient diabetic? :	No	
Is Phalen's sign positive? (see RefHelp for description) :	No	
Past history of neck problems? :	No	
Is Tinel's sign positive? (see RefHelp for description) :	Yes	
Has the patient tried a wrist splint for at least 6 weeks? :	Yes	
Is there any thumb weakness or wasting? :	No	
Are there other symptoms not compatible with carpal tunnel? (Please explain below) :	No	

Pre-existing conditions (High & Medium Priority)

Description	Modifier	Extension	Start Date	Date Recorded
Osteoporosis	New event		05/08/2024	05/08/2024

Constipation			04/06/2024	04/06/2024
Epileptic seizures - tonic			26/02/2024	26/02/2024
Closed fracture rib		left 10th rib	19/12/2023	19/12/2023
Collapse - symptom	New event	?cause (Cat 2 licence duty to inform DVLA)	22/10/2023	22/10/2023
Confusion		- Amnesia, abdominal pain, profuse sweating, looks unwell, ? cause, for neuro opinion.admitted, St Johns	28/12/2022	28/12/2022
Fall - accidental		# ring finger	12/10/2022	12/10/2022
Transient global amnesia		migraine nasal polyps cannabis use	25/08/2022	25/08/2022
Confusion		A&E st Johns, CT, head, normal, discharged 25/8	24/08/2022	24/08/2022
Confusion		self discharged.	23/08/2022	23/08/2022
Renal colic	New event		03/07/2022	03/07/2022
Abdominal pain	New event	Admitted	16/09/2020	16/09/2020
[X]Depressive episode	New event		08/08/2019	08/08/2019
Injury - self-inflicted		stab wound to abdomen post RTA while smoking canabis	30/01/2019	30/01/2019
Gallstones	New event		03/08/2018	03/08/2018
Abdominal pain			30/07/2018	30/07/2018
Stress at home	New event		06/09/2011	06/09/2011
Renal impairment		DATE_RECORDED=05/05/2011	20/11/2009	20/11/2009
Nondependent cannabis abuse	New event	Smoked for 30 years	11/08/2009	11/08/2009
Intracerebral haemorrhage		Discharged against medical advice on the 17.11.04	13/11/2004	13/11/2004
Motor vehicle traffic acid.NOS		Crashed motorbike into car at 50 mph	27/09/2000	27/09/2000
[X]Intentional self-harm		Bites to both arms plus hitting his head off cell wall	02/01/1999	02/01/1999
Viral illness		Admitted.	26/05/1998	26/05/1998
[X]Intentional self-harm		left wrist laceration.	24/02/1997	24/02/1997
[X]Intentional self-harm		Opened up old wound on his right arm with his teeth	02/01/1997	02/01/1997
Fracture of radius NOS		Right ; ORIF	02/04/1994	02/04/1994
[X]Depressive episode	First ever		18/08/1987	18/08/1987
[X]Intentional self-harm		Laceration to left forearm with razor blade	06/08/1987	06/08/1987
[X]Overdose - deliberate		Valium	04/08/1987	04/08/1987
[X]Intentional self-harm		Slashed wrists	04/08/1987	04/08/1987
[X]Overdose - deliberate		Chlomethiazole	23/07/1987	23/07/1987
#Ankle		Left ; ORIF	28/06/1987	28/06/1987
Motor vehicle traffic acid.NOS		Crashed motorbike into a wall	14/05/1987	14/05/1987
[X]Intentional self-harm		Laceration to brachial artery - Repaired	27/04/1987	27/04/1987
[X]Intentional self-harm		Lacerations to left forearm with razor blade	11/11/1986	11/11/1986
[X]Overdose - deliberate		Warfarin, Ampicillin, Betahistine.	14/12/1982	14/12/1982
Inj.?acc-cutting/stabbing		Superficial wound on right calf - Stabbed by wife	30/05/1982	30/05/1982
Motor vehicle traffic acid.NOS		Came off motorbike	30/03/1982	30/03/1982
[X]Intentional self-harm		Slashed left elbow	05/02/1982	05/02/1982
Head injury		+ large scalp laceration	24/11/1981	24/11/1981
[X]Intentional self-harm		Stabbed dorsum of left forearm with knife	01/10/1981	01/10/1981
Head injury			30/09/1981	30/09/1981
[X]Intentional self-harm		Set fire to house	31/07/1981	31/07/1981
Head injury		+ scalp laceration	02/05/1981	02/05/1981
Personality disorders		Psychopathic Type	18/09/1978	18/09/1978
Post-concussion syndrome			21/11/1977	21/11/1977
Bell's (facial) palsy			20/07/1973	20/07/1973
[X]Int self hang/strang/suffoc		Failed	10/06/1963	10/06/1963

[X]Intentional self-harm	Right ; Forearm Laceration	03/06/1963	03/06/1963

Past procedures (High and Medium Priority)

Procedure	Comment	Modifier	Date Performed	Date Recorded
Mental health review	- A&E unscheduled, thinking about stabbing himself, in police custody, currently not under arrest		11/12/2022	11/12/2022
Mental health assessment		Continuing	26/02/2019	26/02/2019
Mental health assessment	self harm, sexual abuse as a child, situational crisis	New event	21/01/2019	21/01/2019
Laparoscopic cholecystectomy		New event	06/08/2018	06/08/2018
Vasectomy NEC		New event	15/06/2017	15/06/2017
Endotracheal intubation	+ ventilation - Intubated twice due to declining GCS		13/11/2004	13/11/2004
Fusion of joint NEC	Right ; Wrist.		28/01/1997	28/01/1997
Removal int fixation dev NEC	Right ; Wrist.		05/07/1994	05/07/1994
Removal int fixation dev NEC	Left ; Ankle.		01/09/1989	01/09/1989

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	1 CAPSULE DAILY AS NEEDED		15/06/2017		29/01/2025
Accrete D3 One a Day 1000mg/880unit chewable tablets (Thornton & Ross Ltd)	tablet	TAKE ONE TABLET ONCE A DAY		06/08/2024		13/12/2024
Alendronic acid 70mg tablets	tablet	TAKE ONE TABLET ONCE WEEKLY. [more]		06/08/2024		13/12/2024
Lamotrigine 100mg tablets	tablet	1 TWICE A DAY (TOTAL 125MG BD)		28/06/2024		28/01/2025
Lamotrigine 25mg tablets	tablet	1 TWICE A DAY (TOTAL 125MG BD)		28/06/2024		28/01/2025

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Morphine sulfate 10mg/5ml oral solution	ml	2MG(1.25ML) UP TO 4 TIMES A DAY		24/02/2025		24/02/2025
Dihydrocodeine 30mg tablets	tablet	I TABLET UP TO FOUR TIMES A D[more]		21/02/2025		21/02/2025
Ibuprofen 5% gel	gram	APPLY THREE TIMES DAILY TO TH[more]		17/02/2025		17/02/2025
Amitriptyline 10mg tablets	tablet	1 OR 2 TABLETS AT NIGHT		17/02/2025		17/02/2025
Dihydrocodeine 30mg tablets	tablet	I TABLET UP TO FOUR TIMES A D[more]		30/01/2025		30/01/2025
Dihydrocodeine 30mg tablets	tablet	I TABLET UP TO FOUR TIMES A DAY		29/01/2025		29/01/2025
Dihydrocodeine 30mg tablets	tablet	I TABLET UP TO FOUR TIMES A DAY		21/01/2025		21/01/2025
Dihydrocodeine 30mg tablets	tablet	I TABLET UP TO FOUR TIMES A DAY		07/01/2025		07/01/2025
Ibuprofen 5% gel	gram	APPLY THREE TIMES DAILY TO TH[more]		30/12/2024		30/12/2024
Dihydrocodeine 30mg tablets	tablet	I TABLET UP TO FOUR TIMES A DAY		30/12/2024		30/12/2024
Omeprazole 20mg gastro-resistant capsules	capsule	1 CAPSULE DAILY AS NEEDED		15/06/2017		18/12/2024

Dihydrocodeine 30mg tablets	tablet	I TABLET UP TO FOUR TIMES A DAY	18/12/2024	18/12/2024
Dihydrocodeine 30mg tablets	tablet	I TABLET UP TO FOUR TIMES A DAY	06/12/2024	06/12/2024
Tramadol 50mg capsules	capsule	ONE OR TWO CAPSULE TO BE TAKE[more]	26/11/2024	26/11/2024

Additional information

Patient Weight in Kilograms:84
Patient Height in Metres:1.79
Patient BMI:26.2
Patient Blood Pressure (Systolic):134
Patient Blood Pressure (Diastolic):86

Smoking history (Screening):Cigarette smoker	Date Recorded:07-Jul-2021
Smoking history (Encounters):Cigarette smoker	Date Recorded:07-Jul-2021
Alcohol history (Screening):Trivial drinker - <1u/day	Date Recorded:31-Jan-2011
Alcohol history (Encounters):Trivial drinker - <1u/day	Date Recorded:31-Jan-2011
Exercise history (Screening):Enjoys light exercise	Date Recorded:11-Aug-2009
Exercise history (Encounters):Enjoys light exercise	Date Recorded:11-Aug-2009

NHS Lothian - Referral Letter

Referral To	Princess Alexandra Eye Pavilion Ophthalmology - Request for Information LI Ophthamology Additional inf
Urgency of referral	Routine
Date of referral	15/12/2025
Date submitted	15/12/2025
UCPN	101038521652K

PATIENT DETAILS

CHI number:	1006631372
Name:	MR RICHARD TAYLOR
Date of birth:	10/06/1963
Sex:	Male

Contact Details

3-1 CLOVENSTONE CLOSE
EDINBURGH
EH14 1FA

Voice (Home) : 0759 333 0473
Voice (Mobile) : 07593330473
E-mail : rtclan2019@outlook.com

REFERRING PRACTITIONER DETAILS

Name:	Dr. Emma Rotheram (GMC: 7553159)
Practice:	Sighthill Green Medical Practice (70911)
Phone:	Voice : 0131 202 5888

Practice address

Sighthill Health Centre
Calder Road
Edinburgh
EH11 4AU

CLINICAL INFORMATION

Reason for Referral: Additional Information Required

Main Referral Text: Dear Colleague

This patient has been referred to your service and further information is requested.

Please find below PMH and medications as per note.

Kind Regards

Dr Emma Rotheram
GP

Pre-existing conditions (High & Medium Priority)

Description	Modifier	Extension	Start Date	Date Recorded
Osteoporosis	New event		05/08/2024	05/08/2024
Constipation			04/06/2024	04/06/2024
Epileptic seizures - tonic			26/02/2024	26/02/2024
Closed fracture rib		left 10th rib	19/12/2023	19/12/2023
Collapse - symptom	New event	?cause (Cat 2 licence duty to inform DVLA)	22/10/2023	22/10/2023
Confusion		- Amnesia, abdominal pain, profuse sweating, looks unwell, ? cause, for neuro opinion.admitted, St Johns	28/12/2022	28/12/2022
Fall - accidental		# ring finger	12/10/2022	12/10/2022
Transient global amnesia		migraine nasal polyps cannabis use	25/08/2022	25/08/2022
Confusion		A&E st Johns, CT, head, normal, discharged 25/8	24/08/2022	24/08/2022
Confusion		self discharged.	23/08/2022	23/08/2022
Renal colic	New event		03/07/2022	03/07/2022
Abdominal pain	New event	Admitted	16/09/2020	16/09/2020
[X]Depressive episode	New event		08/08/2019	08/08/2019

Injury - self-inflicted		stab wound to abdomen post RTA while smoking canabis	30/01/2019	30/01/2019
Gallstones	New event		03/08/2018	03/08/2018
Abdominal pain			30/07/2018	30/07/2018
Stress at home	New event		06/09/2011	06/09/2011
Renal impairment		DATE_RECORDED=05/05/2011	20/11/2009	20/11/2009
Nondependent cannabis abuse	New event	Smoked for 30 years	11/08/2009	11/08/2009
Intracerebral haemorrhage		Discharged against medical advice on the 17.11.04	13/11/2004	13/11/2004
Motor vehicle traffic acid.NOS		Crashed motorbike into car at 50 mph	27/09/2000	27/09/2000
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[X]Intentional self-harm		Opened up old wound on his right arm with his teeth	02/01/1997	02/01/1997
Fracture of radius NOS		Right ; ORIF	02/04/1994	02/04/1994
[X]Depressive episode	First ever		18/08/1987	18/08/1987
[X]Intentional self-harm		Laceration to left forearm with razor blade	06/08/1987	06/08/1987
[X]Overdose - deliberate		Valium	04/08/1987	04/08/1987
[X]Intentional self-harm		Slashed wrists	04/08/1987	04/08/1987
[X]Overdose - deliberate		Chlomethiazole	23/07/1987	23/07/1987
#Ankle		Left ; ORIF	28/06/1987	28/06/1987
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Inj.?acc-cutting/stabbing		Superficial wound on right calf - Stabbed by wife	30/05/1982	30/05/1982
Motor vehicle traffic acid.NOS		Came off motorbike	30/03/1982	30/03/1982
[X]Intentional self-harm		Slashed left elbow	05/02/1982	05/02/1982
Head injury		+ large scalp laceration	24/11/1981	24/11/1981
[X]Intentional self-harm		Stabbed dorsum of left forearm with knife	01/10/1981	01/10/1981
Head injury			30/09/1981	30/09/1981
[X]Intentional self-harm		Set fire to house	31/07/1981	31/07/1981
Head injury		+ scalp laceration	02/05/1981	02/05/1981
Personality disorders		Psychopathic Type	18/09/1978	18/09/1978
Post-concussion syndrome			21/11/1977	21/11/1977
Bell's (facial) palsy			20/07/1973	20/07/1973
[X]Int self hang/strang/suffoc		Failed	10/06/1963	10/06/1963
[X]Intentional self-harm		Right ; Forearm Laceration	03/06/1963	03/06/1963

Past procedures (High and Medium Priority)

Procedure	Comment	Modifier	Date Performed	Date Recorded
Mental health review	- A&E unscheduled, thinking about stabbing himself, in police custody, currently not under arrest		11/12/2022	11/12/2022
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Mental health assessment	self harm, sexual abuse as a child, situational crisis	New event	21/01/2019	21/01/2019
Laparoscopic cholecystectomy		New event	06/08/2018	06/08/2018
Vasectomy NEC		New event	15/06/2017	15/06/2017
Endotracheal intubation	+ ventilation - Intubated twice due to declining GCS		13/11/2004	13/11/2004
Fusion of joint NEC	Right ; Wrist.		28/01/1997	28/01/1997
Removal int fixation dev NEC	Right ; Wrist.		05/07/1994	05/07/1994

Removal int fixation dev NEC	Left ; Ankle.	01/09/1989	01/09/1989

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Ibuprofen 5% gel	gram	APPLY THREE TIMES DAILY TO TH[more]		11/03/2025		11/11/2025
Lamotrigine 25mg tablets	tablet	1 TWICE A DAY (TOTAL 125MG BD)		28/06/2024		11/11/2025
Lamotrigine 100mg tablets	tablet	1 TWICE A DAY (TOTAL 125MG BD)		28/06/2024		11/11/2025
Accrete D3 One a Day 1000mg/880unit chewable tablets (Thornton & Ross Ltd)	tablet	TAKE ONE TABLET ONCE A DAY		06/08/2024		20/10/2025
Omeprazole 20mg gastro-resistant capsules	capsule	1 CAPSULE DAILY AS NEEDED		15/06/2017		11/11/2025
Dihydrocodeine 30mg tablets	tablet	I TABLET UP TO FOUR TIMES A D[more]		10/10/2025		04/12/2025

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Ibuprofen 10% gel	gram	APPLY THREE TIMES DAILY TO TH[more]		26/09/2025		26/09/2025
Omeprazole 20mg gastro-resistant capsules	capsule	1 CAPSULE DAILY AS NEEDED		15/06/2017		20/10/2025
Accrete D3 One a Day 1000mg/880unit chewable tablets (Thornton & Ross Ltd)	tablet	TAKE ONE TABLET ONCE A DAY		06/08/2024		20/10/2025
Lamotrigine 25mg tablets	tablet	1 TWICE A DAY (TOTAL 125MG BD)		28/06/2024		20/10/2025
Lamotrigine 100mg tablets	tablet	1 TWICE A DAY (TOTAL 125MG BD)		28/06/2024		20/10/2025

Additional information

Patient Weight in Kilograms:84
Patient Height in Metres:1.79
Patient BMI:26.2
Patient Blood Pressure (Systolic):134
Patient Blood Pressure (Diastolic):86
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Smoking history (Encounters):Cigarette smoker Date Recorded:07-Jul-2021
Alcohol history (Screening):Trivial drinker - <1u/day Date Recorded:31-Jan-2011
Alcohol history (Encounters):Trivial drinker - <1u/day Date Recorded:31-Jan-2011
Exercise history (Screening):Enjoys light exercise Date Recorded:11-Aug-2009
Exercise history (Encounters):Enjoys light exercise Date Recorded:11-Aug-2009

Direct Referral To Hospital Eye Service
Cataract

1010384519735
Unique Care Pathway Number: 1010384519735

Urgency of referral
Routine

HOSPITAL / LOCATION CODE S316H | **HOSPITAL** Princess Alexandra Eye Pavilion

Patient Surname	**Patient Forename**	**Title**	**Optometrist Details**
TAYLOR	RICHARD	Mr	Neil Maclennan Jack Brown Eyecare (11075) WESTSIDE PLAZA WESTER HAILES SHOPPING CENTRE EDINBURGH EH14 2SW 0131-442-2333

DOB	1963-06-10	**CHI**	1006631372	**SEX**	M
Address	FLAT 3 1 CLOVENSTONE CLOSE EDINBURGH				
Postcode	EH14 3FA	**Tel No**	07593330473		
Ethnicity	Scottish				
Location Code:	11075	**HCP Code**	Optometrist	**Date of Referral:**	2025-12-05

Patient History & Details

Aware of general visual deterioration at all distances. 1-2 instances of fleeting horizontal diplopia in June of this year. Large myopic shift and visual reduction in LE: dense cataract evident. Small L. XOT evident at near. No h/a. 1.0mm L>R anisocoria evident, equivalent in all light conditions, reactions normal direct + consensual. Risks/benefits/wait times/processes discussed - keen to be considered for LE cataract surgery only at this time. Importance of attendance emphasised. Many thanks for your time.

Patient Symptomatic	Yes
Previous Attendance at HES	No
If Yes ? Date	
If Yes ? Location	
Armed Forces Personnel, Immediate families and veterans	
Translator Required	No
If Yes ? Language	

Lifestyle affected	Yes	**AMD Present**	Yes
Wants surgery	Yes		
Cataract Leaflet Given	-		

Date of Last Eye Test 2023-09-15 **Acuity at Last Eye Test** **Right** 6/9 **Left** 6/9

Right	**Ocular Examination - External/Internal**	**Left**
Direct and SL volk reveals- External: Healthy lids, conj white Cornea: Clear A/C: quiet, open, VH4 Lens: G1 NS Vitreous: Clear Disc: Round, healthy colour, 0.4 mod/deep, defined Vessels: Healthy 2:3 Macula: Mild drusen Fundus: Healthy, flat FIXATION OK		Direct and SL volk reveals- External: Healthy lids, conj white Cornea: Clear A/C: quiet, open, VH4 Lens: G2.5 NS + PSCC + blue dot Vitreous: Clear Disc: Round, healthy colour, 0.4 mod, defined Vessels: Healthy 2:3 Macula: Clear Fundus: Healthy, flat FIXATION OK

Applanation No				**Relative Afferent Pupillary Defect**	No
Tonometry	**R** 19 mmhg	**L** 16 mmhg		**Fields Attached**	No

Vision	**Sph**	**Cyl**	**Axis**	**VA**	**PH VA**	**Add**	**NVA**

R	+1.25	-1.00	90	6/9	-	2.25	N5
L	-4.00	-2.25	20	6/18	6/12	2.25	N36

GP informed of referral? No Patient **consents** to GP being contacted for further information.	**GP**	RACHEL HENDRIE **GP Code:** S4052 **GMC Code:** 6134660
	GP Practice	**Practice Code:** 70911 Sighthill Green Medical Practice Sighthill Health Centre Calder Road Edinburgh EH11 4AU


OD(R) 45
05/12/2025
OS(L) 45
05/1

Radiology Reports

The Royal Infirmary of Edinburgh

Radiology Report

Patient Name:	Taylor Richard	**Report Date:**	20-Jan-2015 12:18
Patient ID:	1006631372	**Accession No.:**	S310004367032
Patient Birth Date:	10-Jun-1963	**Report Status:**	F
Referring Physician:	EJ6 Dr Edward James	**Reason For Study:**	

Clinical details

sudden onset bilateral posterior rib pain. Increasing SOB. Unable to take a deep breath. ? pneumothorax

Report
CHEST
Normal heart and mediastinal contours. The lungs are clear. No pneumothorax. No rib fractures are seen. There is slight elevation of the right hemidiaphragm with associated linear atelectasis at the left lung base.

GR/AR

Reported by :

2nd Report by :

Verified by : *Dr Gillian Ritchie*

Produced by Carestream Health PACS

The Royal Infirmary of Edinburgh

Radiology Report

Patient Name:	Taylor Richard	**Report Date:**	28-Dec-2014 11:53
Patient ID:	1006631372	**Accession No.:**	S310004367043
Patient Birth Date:	10-Jun-1963	**Report Status:**	F
Referring Physician:	CLM1 Dr Claire L Stewart	**Reason For Study:**	

Clinical details
Sudden onset bilateral posterior lower rib/flank pain. Trace blood in urine. ? renal colic

Report

Non-contrast scan.

No renal, ureteric or bladder calculus. No dilatation of either collecting system. Normal appearance of the unenhanced kidneys, noting a right lower pole simple cyst.

Normal appearance of the unenhanced upper abdominal solid organs. No abdominal or pelvic enlarged lymph nodes, free fluid or pneumoperitoneum. The unprepared and unenhanced small and large bowel are unremarkable.

Lung bases clear. Normal scan skeleton.

Opinion:
No renal, ureteric or bladder calculus.
No other cause for abdominal pain identified.

Reported by Dr F Macleod
Checked by Dr G McKillop

Reported by :

2nd Report by :

Verified by : *Dr Fiona MacLeod*

Produced by Carestream Health PACS

The Royal Infirmary of Edinburgh

Radiology Report

Patient Name:	Taylor Richard	**Report Date:**	24-Oct-2018 10:59
Patient ID:	1006631372	**Accession No.:**	S310007956825
Patient Birth Date:	10-Jun-1963	**Report Status:**	F
Referring Physician:	AH295 Alison M Herron	**Reason For Study:**	

Clinical details

XR Chest
sudden onset lower abdo pain, requiring 26mgs morphine, tender below umbilicus, need to exclude perforation please, upright at 0925

Report

Chronic scarring in the left base. No free gas.

Reported by Dr F Perks, Consultant Radiologist, RIE
fperks@nhs.net
01312423800

Reported by :

2nd Report by :

Verified by : *Dr Fergus J Perks*

The Royal Infirmary of Edinburgh

Radiology Report

Patient Name:	Taylor Richard	**Report Date:**	31-Jul-2018 10:59
Patient ID:	1006631372	**Accession No.:**	S310007957891
Patient Birth Date:	10-Jun-1963	**Report Status:**	F
Referring Physician:	EB149 Eleonora Bianchi	**Reason For Study:**	

Clinical details

CT Abdomen/Pelvis With Contrast
55yo M with 4th episode of severe lower abdominal pain associated with ongoing N\T\V. Bloods unremarkable. ? diverticulitis ?appendicitis

Report
Unable to compare study to previous imaging.

No free intra-abdominal fluid or gas.

Unremarkable appearance of the liver, gallbladder, pancreas, spleen, adrenals and kidneys. Simple right lower pole cortical cyst. The bladder is virtually empty.

No gross lesion of the non-prepped colon. No significant diverticular disease. Unremarkable appendix and terminal ileum. Unremarkable small bowel appearance.

No size significant abdominal or retrocrural lymph nodes.

Within the limits of this study, the origins of the coeliac axis and SMA appear patent.

The visualised lung bases are clear.

No destructive bony abnormality. Degenerative osteophytosis at the right iliac crest.

Opinion:

Normal appendix and no significant diverticular disease.

Reported by Dr. J. Wylie, Radiology Registrar, JRW3
Checked by Dr. McLaughlin, Consultant Radiologist

Reported by :

2nd Report by :

Verified by : *Dr Jonathan R Wylie*

Produced by Carestream Health PACS

The Royal Infirmary of Edinburgh

Radiology Report

Patient Name:	Taylor Richard	**Report Date:**	31-Jul-2018 10:59
Patient ID:	1006631372	**Accession No.:**	S310007957891
Patient Birth Date:	10-Jun-1963	**Report Status:**	F
Referring Physician:	EB149 Eleonora Bianchi	**Reason For Study:**	

Clinical details

CT Abdomen/Pelvis With Contrast
55yo M with 4th episode of severe lower abdominal pain associated with ongoing N\T\V. Bloods unremarkable. ? diverticulitis ?appendicitis

Report
Unable to compare study to previous imaging.

No free intra-abdominal fluid or gas.

Unremarkable appearance of the liver, gallbladder, pancreas, spleen, adrenals and kidneys. Simple right lower pole cortical cyst. The bladder is virtually empty.

No gross lesion of the non-prepped colon. No significant diverticular disease. Unremarkable appendix and terminal ileum. Unremarkable small bowel appearance.

No size significant abdominal or retrocrural lymph nodes.

Within the limits of this study, the origins of the coeliac axis and SMA appear patent.

The visualised lung bases are clear.

No destructive bony abnormality. Degenerative osteophytosis at the right iliac crest.

Opinion:

Normal appendix and no significant diverticular disease.

Reported by Dr. J. Wylie, Radiology Registrar, JRW3
Checked by Dr. McLaughlin, Consultant Radiologist

Reported by :

2nd Report by :

Verified by : *Dr Jonathan R Wylie*

Produced by Carestream Health PACS

The Royal Infirmary of Edinburgh

Radiology Report

Patient Name:	Taylor Richard	**Report Date:**	02-Aug-2018 14:55
Patient ID:	1006631372	**Accession No.:**	S310007966747
Patient Birth Date:	10-Jun-1963	**Report Status:**	F
Referring Physician:	MD139 Matthew Donachie	**Reason For Study:**	

Clinical details
US Abdomen
55M presented with severe upper abdo pain. Worsening deranged LFTs (Bili 73, ALT 311, Alk Phos 256, GGT 296). CT abdo/pelvis NAD. USS abdo please ?GB or liver pathology. Thanks.

Report
Gallstones within the gallbladder neck with debris in the gallbladder. No pericholecystic fluid or gallbladder wall thickening.No CBD dilatation.
Normal and uniform echotexture in the liver. Normal portal vein flow. No splenomegaly.
No gross pancreatic mass.
Normal appearance of the kidneys other than a simple right renal cyst.

Conclusion:
Gallstones within the gallbladder. No ultrasound signs of acute cholecystitis.
No ductal dilatation.

Reported by Mark Macmillan ST3 radiology

Reported by :

2nd Report by :

Verified by : *Mark MacMillan*

Produced by Carestream Health PACS

The Royal Infirmary of Edinburgh

Radiology Report

Patient Name:	Taylor Richard	**Report Date:**	03-Aug-2018 13:27
Patient ID:	1006631372	**Accession No.:**	S310007969736
Patient Birth Date:	10-Jun-1963	**Report Status:**	F
Referring Physician:	JLH5 Dr Jennifer L Hendry	**Reason For Study:**	

Clinical details

MRCP
55 year old male RUQ pain AUSS: gallstones in gallbladder Deranged LFTs. ? stones in CBD

Report
The posterior sectoral duct inserts directly into the common hepatic duct shortly beyond the confluence of the right and left hepatic ducts.
The intra and extrahepatic biliary tree is non-dilated, the CBD measuring up to 5 mm, however a 5 mm filling defect is demonstrated within the distal CBD consistent with a ductal calculus. Several further gallstones are demonstrated at the gallbladder fundus. No pericholecystic inflammatory changes or fluid.

Unremarkable appearance of the liver, kidneys (right simple cyst noted), adrenal glands, pancreas and spleen.
No upper abdominal lymph node enlargement.
Lung bases clear.

Opinion
Distal CBD calculus as described.

Dr S McLenachan
Consultant Radiologist
Suzanne.McLenachan@nhslothian.scot.nhs.uk

Reported by :

2nd Report by :

Verified by : *Dr Suzanne L McLenachan*

Produced by Carestream Health PACS

- **Patient Name:** *Taylor Richard*
- **Patient ID:** *610119466W*
- **Issuer of Patient ID:** *LPID_S1*
- **Patient Birth Date:** *10-Jun-1963*
- **Accession No.:** *S310007974544*
- **Reason for study:**
- **Report Date:** *05-Aug-2018 13:43.05*
- **Report Status:** *F*

Non Standard Report Issued: No report required

Radiologist : *Dr.*

The Royal Infirmary of Edinburgh

Radiology Report

Patient Name:	Taylor Richard	**Report Date:**	02-Oct-2018 11:01
Patient ID:	1006631372	**Accession No.:**	S310008132075
Patient Birth Date:	10-Jun-1963	**Report Status:**	F
Referring Physician:		**Reason For Study:**	

Clinical details

XR Thumb Lt
cut to thumb with saw tonight. unasure of how deep wound is. BT to distal 5th phalange. ?bony involvement

Report
LEFT THUMB
Slight irregularity to the cortex of the medial aspect of the distal phalanx.

Kim Jameson
Advanced Practitioner Radiographer.
This report was generated using speech recognition software.

Reported by :

2nd Report by :

Verified by : *Kim Jameson*

Produced by Carestream Health PACS

The Royal Infirmary of Edinburgh

Radiology Report

Patient Name:	Taylor Richard	**Report Date:**	01-Nov-2018 10:09
Patient ID:	1006631372	**Accession No.:**	S310008213300
Patient Birth Date:	10-Jun-1963	**Report Status:**	F
Referring Physician:	JV12 Jack Vojak	**Reason For Study:**	

Clinical details

CT Abdomen/Pelvis With Contrast
55 year old man presents with acute onset abdominal pain, Maximal in RIF. Previous cholecystitis .Deranged LFT's, WCC 11. ? appendicitis/diverticulitis/adhesions

Report
Venous phase scan of the abdomen and pelvis. Comparison with previous CT on 31/7/18.

Cholecystectomy noted. No focal liver lesion. No significant biliary tree dilatation. Portal vein is patent.
Pancreas enhances normally throughout. Small focus of calcification in the uncinate process raises possibility of chronic pancreatitis but is not typical.
The spleen, adrenal glands and kidneys are unremarkable.

Normal appearance of the appendix. The bowel is unprepared and non-distended, but no obvious focal colonic lesion seen. No evidence of diverticulitis. No small bowel dilatation.

No size significant lymphadenopathy or free fluid.

Mild consolidation/atelectasis at both lung bases, which was not present on the previous CT.
No concerning bony lesions.

Opinion
Mild bibasal consolidation/atelectasis. No acute intra-abdominal abnormality identified.

Dr Neil Masson, Consultant Radiologist RIE
neil.masson@nhslothian.scot.nhs.uk

Reported by :

2nd Report by :

Verified by : *Dr Neil M Masson*

The Royal Infirmary of Edinburgh

Radiology Report

Patient Name:	Taylor Richard	**Report Date:**	30-Jan-2019 11:36
Patient ID:	1006631372	**Accession No.:**	S310008454664
Patient Birth Date:	10-Jun-1963	**Report Status:**	F
Referring Physician:	RA112 Dr Ross Archibald	**Reason For Study:**	

Medic 1 Enhanced Trauma - D/W Radiologist. 55M. Out driving tonight under the influence of cannabis. Crashed car. Got pout of car and walked home. Consumed further cannabis and alcohol. Self-inflicted stab wound to abdomen. ?Inrta-abdominal haemorrhage

CT Whole Body Scan (Trauma)

Head

No evidence of intracranial injury.
The neuroparenchymal volume, grey white matter differentiation and CSF configuration are normal.
Mucosal sinus disease and possible small frontal sinus mucocele.
Unremarkable skull and extracranial soft tissues otherwise and no fracture.

Neck

Patent airway.
Anterior wedge configuration CV 6 of indeterminate duration, but no acute features, as at CV2.
Normal alignment with no fracture or dislocation otherwise.
Unremarkable soft tissues.

Chest

No evidence of thoracic trauma. Bilateral atelectasis and mild bullous changes.
Major vascular structures are normal. No pneumothorax or pneumomediastinum.
No acute fractures.

Abdomen

The penetrating knife enters the subcutaneous fat of the right flank, piercing the oblique muscles but not the right transverse abdominis muscle. No intraabdominal injury, no free fluid or free gas.
Solid abdominal viscera and unprepped bowel are unremarkable. No vascular injury.
Cholecystectomy noted. No enlarged lymph nodes.
No fracture.

Opinion:

Superficial penetrating injury, with no intra-abdominal extension.

Reported by Dr A Nania, Radiology Registrar (AN66)
Checked by Dr T Fitzgerald, Radiology Consultant

Reported by :

2nd Report by :

Verified by : *Dr Alberto Nania*

Produced by Carestream Health PACS

The Royal Infirmary of Edinburgh

Radiology Report

Patient Name:	Taylor Richard	**Report Date:**	17-Sep-2020 07:29
Patient ID:	1006631372	**Accession No.:**	S310010015958
Patient Birth Date:	10-Jun-1963	**Report Status:**	F
Referring Physician:	MM348 Maithili Mehta	**Reason For Study:**	

Report

Clinical History
57M 3/7 worsening abdo pain + vomiting. CRP 38 with normal WCC. AXR please ?obstruction or pseudoobstruction

5095829 16/09/2020 XR Abdomen

Nonspecific bowel gas pattern. Previous cholecystectomy.

Prof John Murchison. GMC: 2958301
Consultant Radiologist. john.murchison@luht.scot.nhs.uk

Reported by : *Prof John Murchison*

2nd Report by :

Verified by : *Prof John Murchison*

Produced by Carestream Health PACS

The Royal Infirmary of Edinburgh

Radiology Report

Patient Name:	Taylor Richard	**Report Date:**	17-Sep-2020 16:26
Patient ID:	1006631372	**Accession No.:**	S310010016052
Patient Birth Date:	10-Jun-1963	**Report Status:**	F
Referring Physician:	MM348 Maithili Mehta	**Reason For Study:**	

Report

Clinical History
57M 3days abdominal pain+vomits. Apyrexial. WCC 9, CRP 38, Bili 11, ALT 115, ALP 185, Amy normal. Has had previous cholecystectomy with IOC in 2018. Given newly deranged LFTs and abdo pain in context of normal AXR most likely explanation is felt to be a retained ductal stone. MRCP would be appreciated to clarify.

5095899 17/09/2020 MRCP

Reference made to CT dated 30/01/2019. Volume images are degraded by motion.

Previous cholecystectomy. No biliary dilatation. CBD measures 7 mm. No ductal filling defects demonstrated.

Incomplete pancreas divisum. No pancreatic duct dilatation. Grossly normal liver parenchyma and pancreas.

4.5 cm right renal cyst. Otherwise normal appearance of both kidneys and spleen.
Small hiatus hernia. No upper abdominal lymph node enlargement.

Opinion:
Within limits of motion, no ductal filling defects demonstrated. No biliary dilatation.

Dr Lily Lei. GMC: 7411634
Radiology Registrar (FRCR). lily.lei@nhslothian.scot.nhs.uk

Checked by Dr S. McLaughlin, Consultant Radiologist

Reported by : *Dr Siobhan McLaughlin*

2nd Report by :

Verified by : *Dr. Lily Lei*

NHS Lothian - Radiology

Radiology Report

Patient Name:	Taylor, Richard (Mr)	**Report Date:**	04/07/2022 11:03:00
Patient ID:	1006631372	**Accession No.:**	S300011885573
Patient Birth Date:	10/06/1963	**Report Status:**	A
Referring Physician:	HD203 Hannah Douglas	**Reason For Study:**	

Report

Clinical History
for in hours 4/7 morning at per ctkub pathway please, 59 yo male, 2-3 day hx of right sided / flank severe spasming pain, some stinging on urine, normal bloods and urine, ?renal stone

04/07/2022 CT KUB

Unenhanced study. Reference to previous 30/01/2019.
Cholecystectomy noted.

No hydronephrosis or hydroureter. No renal or urinary tract calculi.

Bilateral simple renal cysts, enlarged from previous.

Normal unenhanced adrenals, spleen and liver. Unremarkable unprepared, partially collapsed bowel.
A few small foci of calcification within the pancreas, suggesting chronic pancreatitis.

Mild bibasal atelectasis and bullous change.

Opinion:
No renal or urinary tract calculi.
No other cause for pain seen.

Dr Robert Cronshaw. GMC 7659196
Radiology Registrar. NHS Lothian

Verified by Dr Brush Consultant Radiologist

Reported by :

2nd Report by :

Verified by :

Produced by Carestream Health PACS

NHS Lothian - Radiology

Radiology Report

Patient Name:	Taylor, Richard (Mr)	**Report Date:**	23/08/2022 16:16:00
Patient ID:	1006631372	**Accession No.:**	S300012033945
Patient Birth Date:	10/06/1963	**Report Status:**	A
Referring Physician:	TT8 Tina Tennant	**Reason For Study:**	

Report

Clinical History
Sudden onset confusion this morning, relapsing and remitting collapse in ED waiting room, left sided facial droop ?Stroke ? encephalitis

6725205 23/08/2022 CT Head

No acute infarct, bleed, space occupying lesion or extra-axial collection. Ventricles and basal cisterns within normal limits. No significant skull vault or base of skull abnormality. Soft tissue polyps within the left within the antrum.

Dr Domenyk Brown. GMC: 4403432
Consultant Radiologist.

Reported by :

2nd Report by :

Verified by :

Produced by Carestream Health PACS

NHS Lothian - Radiology

Radiology Report

Patient Name:	Taylor, Richard (Mr)	**Report Date:**	24/08/2022 07:33:00
Patient ID:	1006631372	**Accession No.:**	S300012034465
Patient Birth Date:	10/06/1963	**Report Status:**	D
Referring Physician:	LI18 Dr Laura Irvine	**Reason For Study:**	

Report

Clinical History
epigastric pain ?perforated DU erect cxr please

6725610 23/08/2022 XR Chest

AP erect lordotic radiograph.
Normal cardiac, mediastinal and hilar contours.
The lungs are clear with normal pulmonary vascularity.
No free subphrenic gas.

Dr Colin Turnbull. GMC: 1327812
Consultant Radiologist.

Reported by :

2nd Report by :

Verified by :

Produced by Carestream Health PACS

NHS Lothian - Radiology

Radiology Report

Patient Name:	Taylor, Richard (Mr)	**Report Date:**	13/10/2022 11:21:00
Patient ID:	1006631372	**Accession No.:**	S300012189272
Patient Birth Date:	10/06/1963	**Report Status:**	D
Referring Physician:	Unknown	**Reason For Study:**	

Report

Clinical History
fall onto han from standing - wirst fused previously. felt crunch in middle and ring fingers. unable to move. sensation altered. bony tender

6847483 12/10/2022 XR Hand Rt

Established radio-scapho-lunate arthrodesis and united fracture of the fifth metacarpal.
Oblique, nondisplaced fracture of the base of the proximal phalanx of the right ring finger.
There is also an intra-articular avulsion fracture of the radial cortex of the proximal phalanx of the index finger, of uncertain age.
No other acute bony injury.

Dr Rachel Blacow. GMC: 7582278
Radiology Registrar

Checked by Dr Colin Turnbull, Consultant Radiologist.

Reported by :

2nd Report by :

Verified by :

Produced by Carestream Health PACS

- **Patient Name:** *Taylor Richard*
- **Patient ID:** *610119466W*
- **Issuer of Patient ID:** *LPID_S1*
- **Patient Birth Date:** *10-Jun-1963*
- **Accession No.:** *S300012423421*
- **Reason for study:**
- **Report Date:** *29-Dec-2022 12:14.00*
- **Report Status:** *A*

Report

Clinical History
clinical details interpreted by administration staff. sudden onset confusion episodic today, new R facial droop onset ? 14.30 ? stroke

7031358 29/12/2022 CT Head

Comparison with CT dated 23/08/2022.

No intracranial haemorrhage or acute territorial infarct. No extra-axial collections. No hyperdense vessels. Old right putamen lacunar infarct. Ventricles and basal cisterns are unremarkable. Normal posterior fossa and cranio-cervical junction. Polyps in the left maxillary sinus. Mastoid air cells are clear. Skull is intact.

Opinion: No acute intracranial pathology.

Dr Alex Coupland. GMC 7078878
Radiology Registrar.

Checked by Dr Stephen Glancy. GMC: 3587805
Consultant Radiologist.

Radiologist : *Dr.*

NHS Lothian - Radiology

Radiology Report

Patient Name:	Taylor, Richard (Mr)	**Report Date:**	29/12/2022 11:53:00
Patient ID:	1006631372	**Accession No.:**	S300012423194
Patient Birth Date:	10/06/1963	**Report Status:**	A
Referring Physician:	AKMC11 Dr Antonia Karus-Mcelvogue	**Reason For Study:**	

Report

Clinical History
rigoring, sweating +++ chest clear

7031176 29/12/2022 XR Chest

Normal heart and mediastinal contours. No significant lung or pleural abnormality has been demonstrated. The visible thoracic skeletal structures appear unremarkable.

Dr Alastair Matthews. GMC: 3581287
Consultant Radiologist.

Reported by :

2nd Report by :

Verified by :

Produced by Carestream Health PACS

NHS Lothian - Radiology

Radiology Report

Patient Name:	Taylor, Richard (Mr)	**Report Date:**	29/12/2022 15:59:00
Patient ID:	1006631372	**Accession No.:**	S300012421229
Patient Birth Date:	10/06/1963	**Report Status:**	D
Referring Physician:	GR225 Giuseppe Ricchetti	**Reason For Study:**	

Report

Clinical History
several admissions with confusion, headache, ?transient amnesia followed by abdominal pain. previous intracranial bleed.

7029678 29/12/2022 MRI Head

Non-contrast MRI head. Reference made to prior CT 28/12/2022.

Findings:
Old haemorrhagic right putamen lacunar infarct. Otherwise no signal or structural abnormality.
No acute infarct or small vessel disease. No space occupying lesion.
No abnormal diffusion restriction.
Normal CSF configuration.
Normal major vascular signal voids.
Normal included bones and extracranial structures. Left maxillary sinus mucous retention cyst.

Opinion:
Old haemorrhagic right putamen lacunar event. No acute intracranial pathology.

Reported by: Dr Hwee Fang Lim, ST5 radiology registrar (Hw176)

Checked by: Dr Marialena Gregoriades, Consultant Radiologist

Reported by :

2nd Report by :

Verified by :

NHS Lothian - Radiology

Radiology Report

Patient Name:	Taylor, Richard (Mr)	**Report Date:**	19/06/2023 11:39:00
Patient ID:	1006631372	**Accession No.:**	S310012846822
Patient Birth Date:	10/06/1963	**Report Status:**	A
Referring Physician:	PW13 Pauline Watson	**Reason For Study:**	

Report

Clinical History
smoker, weight loss, chronic cough., chest clear ?cancer / Chest

7364413 30/05/2023 XR Chest

Heart and mediastinal contours normal.
Lungs clear.

Prof John Murchison. GMC: 2958301
Consultant Radiologist.

Reported by :

2nd Report by :

Verified by :

NHS Lothian - Radiology

Radiology Report

Patient Name:	Taylor, Richard (Mr)	**Report Date:**	26/08/2023 08:36:00
Patient ID:	1006631372	**Accession No.:**	S300013177030
Patient Birth Date:	10/06/1963	**Report Status:**	A
Referring Physician:	Unknown	**Reason For Study:**	

Report

Clinical History
Reduced GCS. head injury fallen down ~5 steps. ?LOC at time then aggressive. Alcohol and cannabis involved

7621729 26/08/2023 CT Head

Reference December 2022
No intracranial haemorrhage, mass lesion or large vessel infarct. No hydrocephalus. No concerning abnormality of bony vault or extracranial soft tissues.

Comment:
No acute intracranial pathology

Dr Simon Jackson. GMC: 4114479
Consultant Radiologist.

Reported by :

2nd Report by :

Verified by :

Produced by Carestream Health PACS

NHS Lothian - Radiology

Radiology Report

Patient Name:	Taylor, Richard (Mr)	**Report Date:**	27/02/2024 09:09:00
Patient ID:	1006631372	**Accession No.:**	S310013757649
Patient Birth Date:	10/06/1963	**Report Status:**	D
Referring Physician:	EBW Dr Emma-Beth Wilson	**Reason For Study:**	

Report

Clinical History
60 year old male attends following a generalised seizure. 1st seizure. PMH Right lentiform nucleus cerebral haemorrhage (2004). ? headache prior to seizure. Now has a headache. ? ICH

8075617 26/02/2024 CT Head
Unenhanced images. Comparison made to CT 19/12/2023.

No evidence of acute intracranial haemorrhage.

Old infarcts in the right lentiform nucleus, as before. Otherwise normal appearances of the brain parenchyma. No space-occupying lesion. Normal CSF spaces. Normal midline structures and craniocervical junction.

No significant incidental bone or soft tissue findings.

Conclusion: No acute intracranial findings.

Dr Rory Thompson. GMC: 747635
Radiology Registrar

Reported by :

2nd Report by :

Verified by :

Produced by Carestream Health PACS

NHS Lothian - Radiology

Radiology Report

Patient Name:	Taylor, Richard (Mr)	**Report Date:**	04/06/2024 17:32:00
Patient ID:	1006631372	**Accession No.:**	S110014072045
Patient Birth Date:	10/06/1963	**Report Status:**	D
Referring Physician:	DC152 Dr Despoina Chasapi	**Reason For Study:**	

Report

*** THIS REPORT CONTAINS AN ADDENDUM ***

Sacroiliac joints appear unremarkable.

Dr Alastair Matthews. GMC: 3581287
Consultant Radiologist.

Clinical History
Acute onset bilateral flank/lumbar spine pain down to sacrum, since Saturday morning. Severity 10/10. Inflammatory markers normal and no clinical/biochemical features of infection. ?fracture

8322446 04/06/2024 XR Lumbar Spine and S.I. Joints

Normal vertebral alignment. Disc spaces are preserved. No fracture or destructive lesion demonstrated.

Dr Alastair Matthews. GMC: 3581287
Consultant Radiologist.

Reported by :

2nd Report by :

Verified by :

Produced by Carestream Health PACS

NHS Lothian - Radiology

Radiology Report

Patient Name:	Taylor, Richard (Mr)	**Report Date:**	04/06/2024 11:16:00
Patient ID:	1006631372	**Accession No.:**	S110014072058
Patient Birth Date:	10/06/1963	**Report Status:**	D
Referring Physician:	DC152 Dr Despoina Chasapi	**Reason For Study:**	

Report

Clinical History
Bilateral severe flank pain, bowel gas ++ on lumbar x ray, for AXR ?bowel dilatation ?obstruction or perforation

8322450 04/06/2024 XR Abdomen

Faecal loading of the ascending colon. No plain radiographic evidence of obstruction, perforation, colitis or toxic megacolon.
Cholecystectomy clips.
No destructive bony abnormality.

Dr Matthew Tse GMC: 7474641
Radiology Consultant.

Reported by :

2nd Report by :

Verified by :

Produced by Carestream Health PACS

NHS Lothian - Radiology

Radiology Report

Patient Name:	Taylor, Richard (Mr)	**Report Date:**	04/06/2024 16:37:00
Patient ID:	1006631372	**Accession No.:**	S110014075395
Patient Birth Date:	10/06/1963	**Report Status:**	A
Referring Physician:	EB226 Dr Erin Brown	**Reason For Study:**	

Report

Clinical History
60yo male with severe back pain radiating to abdomen. No previous imaging of aorta. Please to investigate for aortic dimensions to rule out AAA

8325086 04/06/2024 CT Abdomen/Pelvis With Contrast

Comparison to CT 19/12/2023.

No free gas, free fluid or intra-abdominal collection.

Normal liver parenchyma. Postcholecystectomy biliary duct dilatation. Simple renal cysts bilaterally. No hydronephrosis. Punctate calcifications at the pancreatic head as before may reflect previous pancreatitis. No other pancreatic abnormality or CT features to suggest acute pancreatitis. Normal adrenal glands and spleen.

Normal calibre aorta with nonocclusive diffuse aortic atheroma. The major mesenteric vessels appear patent allowing for contrast timing. Patent portal venous system.

The unprepared bowel is grossly unremarkable.

Minor lung base atelectasis.

T9 vertebral body fracture - only partially imaged at edge of volume. No further bony abnormality.

Opinion:
Incompletely imaged T9 vertebral body fracture may account for the patient's pain.
Normal calibre, though atheromatous aorta.

___
Dr Alastair McKenzie. GMC 7329062
Radiology Consultant.

Reported by :

2nd Report by :

Verified by :

Produced by Carestream Health PACS

NHS Lothian - Radiology

Radiology Report

Patient Name:	Taylor, Richard (Mr)	**Report Date:**	04/06/2024 20:35:00
Patient ID:	1006631372	**Accession No.:**	S110014075909
Patient Birth Date:	10/06/1963	**Report Status:**	A
Referring Physician:	MEUHR1 Dr Mohammad Ehsan-Ul-Haque Rahman	**Reason For Study:**	

Report

Please see the full report for some changes from the provisional report issued at time of scan.

Clinical History
Incompletely imaged T9 vertebral body fracture on CTAP. Has right sided abdominal pain radiating to back. Further scan for complete imaging of thoracic spine and any underlying cause. No evidence of trauma in history.

8325482 04/06/2024 CT Chest

Noncontrast study.
Comparison with previous CT abdomen dated 04/06/2024, and CT pulmonary trauma dated 19/12/2023.

New wedge compression fracture of T9 vertebral body, affecting the anterior and middle columns.
The fracture line extends posteriorly into the vertebral canal, and laterally to the left costovertebral joint.
There is no significant retropulsion of bony fragments into the vertebral canal.
Given this is 2 column fracture, this is considered unstable.
The posterior elements are unaffected.

Associated vacuum effect noted within the T8/T9 and T9/T10 intervertebral discs.
No significant paravertebral collection demonstrated.

Benign appearing bony lesion in the T8 vertebral body.
Old left T10 rib fractures.
No concerning bony abnormalities demonstrated.

Minor bilateral basal atelectasis. The lungs are otherwise clear.
No concerning pulmonary nodularity or size significant thoracic lymph nodes.
No pleural or pericardial effusions.
Coronary artery and aortic valve calcification noted.
The imaged solid upper abdominal viscera are unremarkable.

Opinion:
Two column wedge compression fracture of the T9 vertebral body.
This is considered unstable. Immobilisation and a spinal surgical opinion is advised.

Dr James Bott. GMC: 7493766
Radiology Registrar

Checked by Dr J Taylor, Consultant Radiologist, WGH at 20:30 on 4/6/24 . change from report issued at time of scan.

There is a compression fracture of T9 vertebral body with some gas in the intervertebral disc above and below. Whilst this fracture was not present on CT scan of December 2023 there are features which suggests it is subacute rather than hyperacute. Equally, there is no suggestion of osteoporosis therefore an underlying cause of this fracture should be sought, and malignancy excluded. An MRI scan in due course would help. If there is no

neurology, immobilisation may be over cautious.

4635723 john.taylor@nhslothian.scot.nhs.uk

Reported by :

2nd Report by :

Verified by :

Produced by Carestream Health PACS

NHS Lothian - Radiology

Radiology Report

Patient Name:	Taylor, Richard (Mr)	**Report Date:**	06/06/2024 11:14:00
Patient ID:	1006631372	**Accession No.:**	S110014077719
Patient Birth Date:	10/06/1963	**Report Status:**	A
Referring Physician:	HH36 Dr Helen M Hare	**Reason For Study:**	

Report

Clinical History
Presents with acute back pain, no trauma history. CT (abdo pelvis then confirmed on chest) shows T9 compression fracture and gas. No neurology in T9 dermatome but some L3/4 loss of sensation. Following discussion with neurosurgery, please can we have an MRI whole spine with contrast to further characterise fracture and specifically to assess for infection or malignancy which might have lead to fracture?

8326858 06/06/2024 MRI Spine Whole

Reference made to CT scan dated 04/06/2024. Motion artefacts degrade the images.

Moderate compression fracture of T9 vertebra with low T1 and high STIR signal in keeping with underlying marrow oedema. No evidence of bone destruction on MRI. Of note gas was present in the intervertebral discs above and below the level of the fracture which is against a diagnosis of discitis. No evidence of abnormal enhancement of the intervertebral discs or epidural spaces. Appearances are therefore considered to represent a benign / insufficiency fracture. In a male patient of this age, further
investigation with a DEXA scan is recommended to assess the bone density.

Subtle superior endplate compression fracture of L4 vertebra is also noted without underlying bony abnormality.

Rest of the bone marrow signal is normal.

Multilevel degenerative changes of the cervical spine.

Within the limitations of motion artefacts, normal spinal cord and cauda equina. Spinal canal is patent. Neural exit foramina are also patent.

Opinion: Moderate T9 compression fracture, with features suggestive of a benign / insufficiency fracture. Further mild superior endplate fracture of L4 vertebra is also consistent with a benign / insufficiency fracture. In the absence of a history of trauma, further evaluation with DEXA scan is recommended to assess bone density.

Dr Deepak Subedi. GMC: 6041891
Consultant Radiologist.

Reported by :

2nd Report by :

Verified by :

NHS Lothian - Radiology

Radiology Report

Patient Name:	Taylor, Richard (Mr)	**Report Date:**	24/06/2024 16:09:00
Patient ID:	1006631372	**Accession No.:**	S310014136153
Patient Birth Date:	10/06/1963	**Report Status:**	D
Referring Physician:	DM106 Dr David Maclachlan	**Reason For Study:**	

Report

Clinical History
61M pw ?head injury and new fever loss of memory - ?aspiration

8382726 24/06/2024 XR Chest

Comparison with priors, most recent dated 30/05/2023.

AP erect projection.

Normal cardiomediastinal contours.
Lungs and pleura are clear with normal pulmonary vascularity.
No significant skeletal abnormality.

Dr Andreas Karamitros. GMC: 7687113
Radiology Registrar
Verified by Dr M. Jones
Consultant Radiologist

Reported by :

2nd Report by :

Verified by :

Produced by Carestream Health PACS

NHS Lothian - Radiology

Radiology Report

Patient Name:	Taylor, Richard (Mr)	**Report Date:**	24/06/2024 09:46:00
Patient ID:	1006631372	**Accession No.:**	S310014136020
Patient Birth Date:	10/06/1963	**Report Status:**	A
Referring Physician:	LDMS6 Dr Lotte Smals	**Reason For Study:**	

Report

Clinical History
61M found on the floor next to bed. Pt can't recall any of the events from before the fall or the arrival of ambulance. Has a background of dissociative episodes and 1 seizure. Also somewhat confused. Not anticoagulated. ? intracranial bleed Tenderness over C4-5 on examination?#

8382647 24/06/2024 CT Head
Comparison: 26/2/2024, 26/8/2023, 29/12/2022.

Findings:
Streak artefact degrades images, particularly of the posterior fossa.
No haemorrhage, space-occupying lesion or collection.
Small longstanding lacune in the right lentiform nucleus. Grey-white matter differentiation is otherwise preserved.
Normal parenchymal volume and configuration of CSF spaces.
Metallic foreign body within the oral cavity, presumed tongue piercing. Mild ethmoid and paranasal sinus mucosal thickening. Otherwise unremarkable imaged soft tissues and bones.

8382648 24/06/2024 CT Spine Cervical
Comparison: MRI 06/06/2024. CT 19/12/2023.

Findings:
Patient imaged to the level of T6 vertebral body.
No acute cervical spine injury. Normal vertebral body height and alignment are preserved. Normal facet joint alignment.
Mild cervical degenerative change, as demonstrated on recent MRI.
Unremarkable unenhanced soft tissues of the neck.
Unremarkable lung apices.

Opinion:
No acute intracranial findings.
No acute cervical spine injury.

__
Dr Eilidh Dempster
Radiology Registrar.

Reported by :

2nd Report by :

Verified by :

NHS Lothian - Radiology

Radiology Report

Patient Name:	Taylor, Richard (Mr)	**Report Date:**	25/06/2024 13:45:00
Patient ID:	1006631372	**Accession No.:**	S310014136666
Patient Birth Date:	10/06/1963	**Report Status:**	D
Referring Physician:	LF30 Lynsey Frame	**Reason For Study:**	

Report

Clinical History

61M pw ?seizure - known T9 # as well as L4 # - now CO pain in lower thoracic spine despite oramoprh and ? post seizure ?further height loss
8383518 24/06/2024 XR Thoracic Spine

No acute fracture.
Further vertebral body height loss of T9 wedge compression fracture when compared to priors, which now appears to be grade 3. Minor adjacent paravertebral soft tissue swelling.
Vertebral body heights are otherwise maintained. Spinal alignment and intervertebral disc spaces are preserved.

61M pw ?seizure / ?trauma - head injuries acute on chronic lower back pain - tender generally ?#
8383153 24/06/2024 XR Lumbar Spine
Reference made to previous CT scan dated 04/06/2024.

No acute fracture.
L4 superior endplate infraction as noted on previous MRI scan dated 06/06/2024.
Vertebral body heights are otherwise maintained. Intervertebral disc spaces and spinal alignment are preserved.
The sacroiliac joints are normal.

Siobhan Hibbs. HCPC: RA68941
Reporting Radiographer.

Verified by:
Marie Gibson. HCPC:RA37992
Consultant Radiographer

Reported by :

2nd Report by :

Verified by :

Produced by Carestream Health PACS

NHS Lothian - Radiology

Radiology Report

Patient Name:	Taylor, Richard (Mr)	**Report Date:**	25/06/2024 13:45:00
Patient ID:	1006631372	**Accession No.:**	S310014137164
Patient Birth Date:	10/06/1963	**Report Status:**	D
Referring Physician:	DM106 Dr David Maclachlan	**Reason For Study:**	

Report

Clinical History

61M pw ?seizure - known T9 # as well as L4 # - now CO pain in lower thoracic spine despite oramoprh and ? post seizure ?further height loss
8383518 24/06/2024 XR Thoracic Spine

No acute fracture.
Further vertebral body height loss of T9 wedge compression fracture when compared to priors, which now appears to be grade 3. Minor adjacent paravertebral soft tissue swelling.
Vertebral body heights are otherwise maintained. Spinal alignment and intervertebral disc spaces are preserved.

61M pw ?seizure / ?trauma - head injuries acute on chronic lower back pain - tender generally ?#
8383153 24/06/2024 XR Lumbar Spine
Reference made to previous CT scan dated 04/06/2024.

No acute fracture.
L4 superior endplate infraction as noted on previous MRI scan dated 06/06/2024.
Vertebral body heights are otherwise maintained. Intervertebral disc spaces and spinal alignment are preserved.
The sacroiliac joints are normal.

Siobhan Hibbs. HCPC: RA68941
Reporting Radiographer.

Verified by:
Marie Gibson. HCPC:RA37992
Consultant Radiographer

Reported by :

2nd Report by :

Verified by :

Produced by Carestream Health PACS

Order Summary for **Taylor Richard 610119466W**

Patient Name	**Taylor Richard**
Accession Number	**S110014084325**
Gender	**M**

Procedure

Scheduled Date	**04-Jul-2024**
Procedure Code	**DEXAS**

Clinical Info

Examination	
Indication	
Infection Risk	
Referring Clinician	
Consultant	
Speciality	
Allergy	

Post Exam Documentation Info

Red Dot	
Room Used	
Contrast reaction	
Reaction information	
Operator	
Exams/Operator Comments	
Justified By	
Justification Comment	
Projections Sent	
Dose information	
Contrast	
Contrast Volume	

Clinical Question From Order Comms

Clinical Question

NHS Lothian - Radiology

Radiology Report

Patient Name:	Taylor, Richard (Mr)	**Report Date:**	04/12/2024 08:25:00
Patient ID:	1006631372	**Accession No.:**	S110014648876
Patient Birth Date:	10/06/1963	**Report Status:**	A
Referring Physician:	CG206 Catherine Geddie	**Reason For Study:**	

Report

Clinical History
61 year old admitted with Acute on chronic back pain. Known osteoporosis with fragility fractures. ? further fractures. Tender ++ over thoracic and lumbar spine

8783069 03/12/2024 XR Thoraco-Lumbar Spine

Comparison made with previous thoracic and lumbar spine radiographs dated 24/06/2024.
No new vertebral fractures.
Static appearance of this severe anterior wedge compression fracture of vertebral body of T9.
Minor compression of the superior endplate of L4, also unchanged.
Moderate thoracic kyphosis centred at T9, otherwise normal vertebral alignment is maintained.
Minor spondylotic changes throughout, as before.

Sarah Carrigan. HCPC: RA67003
Reporting Radiographer.

Reported by :

2nd Report by :

Verified by :

Produced by Carestream Health PACS

NHS Lothian - Radiology

Radiology Report

Patient Name:	Taylor, Richard (Mr)	**Report Date:**	04/12/2024 09:17:00
Patient ID:	1006631372	**Accession No.:**	S110014649155
Patient Birth Date:	10/06/1963	**Report Status:**	A
Referring Physician:	CG206 Catherine Geddie	**Reason For Study:**	

Report

Clinical History
61 year old admitted with acute confusion with previous haemorrhagic stroke. ? bleed?

8783291 03/12/2024 CT Head

Unenhanced CT head.
Comparison is made to previous CT head dated 24/06/2024.

No intracranial haemorrhage or infarct.
No space-occupying lesion or collection.
Chronic lacunar infarcts within the right basal ganglia. Otherwise normal appearances of the brain parenchyma for patient's age.
The ventricles and basal cisterns are patent.
Normal skull and mastoid air cells. Mucosal thickening of the paranasal sinuses.
Normal orbits and extracranial soft tissues.

Opinion:
No acute intracranial abnormality.

Dr Olivia Anderson. GMC: 7590913
Radiology Registrar

Checked by Dr S Jackson
Consultant Radiologist

Reported by :

2nd Report by :

Verified by :

Case Notes

Lothian NHS Board

Rivers Centre for Traumatic Stress
1st Floor
Fountainbridge Library Building
137 Dundee Street
Edinburgh EH11 1BG

Telephone 0131 451 7400

www.nhslothian.scot.nhs.uk

NHS Lothian

Private & Confidential

Date 26 February 2019

Our Ref RT / CHI: 1006631372

Dr Smith
SW CMHT
Cambridge Street House
5 Cambridge Street
Edinburgh
EH1 2DY

Dear Dr Smith

Re: Richard Taylor, 42 Morvenside, Edinburgh, EH14 2SJ

I would be grateful if you would consider seeing this man for psychiatric assessment.

Richard self-referred to the Rivers Centre and was seen for a brief triage appointment. He told me that he recently split up from his partner as he discovered she was pregnant with another man's child just before Christmas. On 30th Jan there was an incident when he had been drinking and then drove his car and had an accident. He also stabbed himself in the abdomen. (Please see the A&E notes on TRAK.)

Richard is currently staying with a friend as he is not allowed to go to his house due to his bail conditions. He is not allowed contact with ex wife or his children so has not seen his children for over 3 weeks and this is impacting on them as well as him. He said he has a social worker and is due to meet with them this week – Elspeth Holden at Drumbrae. This may be the social worker for children as they are currently on the child protection register.

Richard reported a trauma history of abuse from his mother when he was a child but he did not go into details about this. In terms of his symptoms, Richard explained that he has always been very up and down emotionally. He is not sleeping well, is tearful and has no appetite. He said he has always self harmed. He cuts his arms, has taken an overdose and has also attempted to hang himself. His self harming is worse depending on what is going on his life, but he feels that it all stems from his relationship with his mother. Richard has vivid memories of child hood that come into his head and he tries to switch back off from the memories. Spending time with his children helps with this. The memories are usually triggered by something and he feels that they are as clear as day. He wants to be able to talk about them to be able to get rid of them. Richard said he struggles to get to sleep and to stay asleep. He said he can go several days without any sleep but is not aware of any dreams. He

South West Edinburgh
Adult Mental Health Services

PRIMARY CARE MENTAL HEALTH TEAM
(Referrals Co-ordinator)
Cambridge Street House
5 Cambridge Street
Edinburgh EH1 2DY
T: 0131 537 8665

NHS Lothian

Heather Hillen
Psychological Therapist
Rivers Centre
1st Floor
Fountainbridge Library Building
137 Dundee Street
Edinburgh

Date	01.04.19
Your Ref	
Our Ref	WP/LK-037415
CHI Number	1006631372
Enquiries to	Lorraine King, Referrals Co-ordinator
Extension	48665
Direct Line	0131537 8665

Dear Heather,

Re: Richard Taylor, 42 Morvenside, Edinburgh, EH14 2SJ, DOB: 10.06.63

Thank you for referring Mr Taylor who your saw at the advice clinic with a history of trauma and current self harming behaviour. You asked for a psychiatric assessment from our team. We reviewed your referral and do not feel that a psychiatric assessment is the appropriate next step at this time. We recommend that he has a further psychological assessment with your department to determine the correct course of treatment going forward.

Accordingly we have not arranged an appointment at present.

Yours sincerely,

South West Primary Care Mental Health Team

Cc: Dr Nickerson, Sighthill Green Medical Practice

037415 LP

NHS Lothian - Referral Letter

Referral To	Mental Health Edinburgh - Adult Psychiatry (South West) L Edinburgh Adult Psychiatry
Urgency of referral	Urgent
Date of referral	15/11/2019
Date submitted	18/11/2019
UCPN	101020055773Q

Psychiatry Dr Cooper

AT initial with SW Psychology (Ed 7/11/19

PATIENT DETAILS

CHI number:	1006631372
Name:	MR RICHARD TAYLOR
Date of birth:	10/06/1963
Sex:	Male

Contact Details

42 MORVENSIDE WESTBURN
EDINBURGH
EH14 2SJ

Voice (Home) : 442 1596
Voice (Mobile) : 07593330473

REFERRING PRACTITIONER DETAILS

Name:	VICKY WALKER (MENTAL HEALTH AND ADDICTIONS PRACTICE NURSE) (GMC: -)
Practice:	Sighthill Health Centre
Phone:	Voice : 01315377060

Practice address

380 CALDER ROAD
EDINBURGH
EH11 4AU

19/11/19 2pm with Sighthill David at Fridge 3pm at David with her mum

CLINICAL INFORMATION

Reason for Referral: FAO DEBORAH COOPER

Main Referral Text:

Dear Dr Cooper,

I would appreciate your assessment of this gentleman who has a long history of depressive episodes, overdose and deliberate self harm. In January of this year Richard was involved in a road traffic accident where he was driving after consuming alcohol and cannabis. He left the car returned home and then stabbed himself in the abdomen and was found by his ex-partner and their 5 year old child. His contact with services has been well documented there after and ultimately he was assessed by Dr Logan at the Rivers Centre in August. At this point he had stopped taking his Mirtazepine as he did not feel it was helping and she suggested a trial of Fluoxetine 20mg and also a referral to Sector Psychological Therapy. As you are aware the waiting time for this service is lengthy and so he has not therefore been seen by secondary care since this time. I met with Richard in September and initiated the Fluoxetine. Initially he did not take it and by this point he reported that his mood was so low that he felt unable to leave his home to attend the chemist. I therefore arranged for the pharmacy to deliver his medication to his home hoping to get him established and feeling well enough to engage better with services. Unfortunately Richards mental state has continued to deteriorate and he failed to attend a couple of appointments with myself for further review. He was however engaging with a community link worker, Calum Barrie, who was accompanying him to PIP assessment and helping him fill out forms.

After failing to attend an appointment with myself on the 7 November 2019 I noticed that Calum had recorded that he felt there had been a deterioration in Richards mental state and that during an appointment with him he spoke about fixated thoughts of suicide and his children. Becoming increasingly concerned I attempted to contact Richard on numerous occasions but was unsuccessful. Given his history I felt that he was at risk so contacted the Police to perform a welfare check. The Police were able to gain access to Richard at home and reported back to our reception staff that he was well, reception staff spoke to Richard and arranged an appointment with him on 14 November 2019. On realising this I felt that it was important that a health professional spoke to Richard and therefore arranged for our duty doctor to attend his home on 12 November 2019. Richard was either not in or failed to answer his door.

Calum had reported that he had been very concerned about Richard at his last contact with him as he stated that

Richard was not eating or drinking, not washing or cleaning his house which was unlike him. He spoke repeatedly of thoughts of suicide and how much he misses his children, who he has not had contact with since April. Calum also reported that Richard was not leaving his home unless accompanied by Calum and even while in his home was isolating to just one room as he felt afraid. On attending his house on the 12 November Dr Hendrie noted that all his curtains and blinds were closed.

Richard did attend his appointment on the 14 November and was by myself and Dr Aulmann. He presented with multiple layers of clothes and was unshaven. He had attended the surgery by walking from his home alone. He was difficult to engage in conversation, paused prior to answering questions which he done monosyllabically. He was struggling to hold back tears and appeared anxious and guarded as he was fiddling with his hands which remained in his pockets throughout his appointment. He agreed that his mood had deteriorated and admitted to having suicidal thoughts, although clearly stated he has no plan at this time. He stated that he just wants to see his boy. He admitted he has not been eating or drinking and said he had not had anything to eat on that day (the appointment was at 2pm) and that he had only had a cup of tea the previous day. He then stated that he had not been eating or drinking for about a year. He was orientated to time, place and person and there was no visible evidence of dehydration or malnourishment, although he was difficult to fully assess. He was not malodorous and there was no evidence of psychologic symptoms and he did not report any psychotic symptoms to us. He did not report any illicit drug or alcohol use but again it is difficult to exclude due to his poor interaction.

Given his history and poor ability to interact we felt it would be beneficial for further assessment at MHAS. Initially Richard agreed to attend MHAS and we were in the middle of arranging transport when unfortunately Richard left the building and although we tried to find him we were unable to. It was quite difficult to assess Richards level of illness during our consultation, however both myself and Dr Aulmann did not feel it would appropriate to attempt to proceed with a detention as, although Richard does have suicidal thoughts, he did state he has no plan to act on these at the time of consultation and although he is clearly neglecting his needs to some extent there was little evidence that this was to a level that would warrant detention under the Mental Health Act. I do however feel that Richard is quite unwell at present and would benefit from further assessment. I have asked Calum Barrie, his link support worker, to encourage Richard to attend MHAS at there next contact and I will send out an appointment for further assessment at the practice. I realise that Richard has been assessed in secondary care and it was felt that psychological therapy was the most appropriate treatment for him, however I feel that given the deterioration in his mood it would now be appropriate for further psychiatric assessment.

I would appreciate any advice you could offer in the meantime and hope you will be able to see Richard as soon as possible.

Please do not hesitate to contact me should you wish to discuss this further or require any further information.

Yours sincerely

Pre-existing conditions (High & Medium Priority)

Description	Modifier	Extension	Start Date	Date Recorded
[X]Depressive episode	New event		08/08/2019	08/08/2019
Injury - self-inflicted		stab wound to abdomen post RTA while smoking canabis	30/01/2019	30/01/2019
Gallstones	New event		03/08/2018	03/08/2018
Abdominal pain			30/07/2018	30/07/2018
Stress at home	New event		06/09/2011	06/09/2011
Renal impairment		DATE_RECORDED=05/05/2011	20/11/2009	20/11/2009
Nondependent cannabis abuse	New event	Smoked for 30 years	11/08/2009	11/08/2009
Intracerebral haemorrhage		Discharged against medical advice on the 17.11.04	13/11/2004	13/11/2004
Motor vehicle traffic acid.NOS		Crashed motorbike into car at 50 mph	27/09/2000	27/09/2000
[X]Intentional self-harm		Bites to both arms plus hitting his head off cell wall	02/01/1999	02/01/1999
Viral illness		Admitted.	26/05/1998	26/05/1998
[X]Intentional self-harm		left wrist laceration.	24/02/1997	24/02/1997
[X]Intentional self-harm		Opened up old wound on his right arm with his teeth	02/01/1997	02/01/1997
Fracture of radius NOS		Right ; ORIF	02/04/1994	02/04/1994

[X]Depressive episode	First ever		18/08/1987	18/08/1987
[X]Intentional self-harm		Laceration to left forearm with razor blade	06/08/1987	06/08/1987
[X]Overdose - deliberate		Valium	04/08/1987	04/08/1987
[X]Intentional self-harm		Slashed wrists	04/08/1987	04/08/1987
[X]Overdose - deliberate		Chlomethiazole	23/07/1987	23/07/1987
#Ankle		Left ; ORIF	28/06/1987	28/06/1987
Motor vehicle traffic acid.NOS		Crashed motorbike into a wall	14/05/1987	14/05/1987
[X]Intentional self-harm		Laceration to brachial artery - Repaired	27/04/1987	27/04/1987
[X]Intentional self-harm		Lacerations to left forearm with razor blade	11/11/1986	11/11/1986
[X]Overdose - deliberate		Warfarin, Ampicillin, Betahistine.	14/12/1982	14/12/1982
Inj.?acc-cutting/stabbing		Superficial wound on right calf - Stabbed by wife	30/05/1982	30/05/1982
Motor vehicle traffic acid.NOS		Came off motorbike	30/03/1982	30/03/1982
[X]Intentional self-harm		Slashed left elbow	05/02/1982	05/02/1982
Head injury		+ large scalp laceration	24/11/1981	24/11/1981
[X]Intentional self-harm		Stabbed dorsum of left forearm with knife	01/10/1981	01/10/1981
Head injury			30/09/1981	30/09/1981
[X]Intentional self-harm		Set fire to house	31/07/1981	31/07/1981
Head injury		+ scalp laceration	02/05/1981	02/05/1981
Personality disorders		Psychopathic Type	18/09/1978	18/09/1978
Post-concussion syndrome			21/11/1977	21/11/1977
Bell's (facial) palsy			20/07/1973	20/07/1973
[X]Int self hang/strang/suffoc		Failed	10/06/1963	10/06/1963
[X]Intentional self-harm		Right ; Forearm Laceration	03/06/1963	03/06/1963

Past procedures (High and Medium Priority)

Procedure	Comment	Modifier	Date Performed	Date Recorded
Mental health assessment		Continuing	26/02/2019	26/02/2019
Mental health assessment	self harm, sexual abuse as a child, situational crisis	New event	21/01/2019	21/01/2019
Laparoscopic cholecystectomy		New event	06/08/2018	06/08/2018
Vasectomy NEC		New event	15/06/2017	15/06/2017
Endotracheal intubation	+ ventilation - Intubated twice due to declining GCS		13/11/2004	13/11/2004
Fusion of joint NEC	Right ; Wrist.		28/01/1997	28/01/1997
Removal int fixation dev NEC	Right ; Wrist.		05/07/1994	05/07/1994
Removal int fixation dev NEC	Left ; Ankle.		01/09/1989	01/09/1989

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	1 CAPSULE DAILY AS NEEDED		15/06/2017		09/09/2019

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date

Fluoxetine 20mg capsules	capsule	1 TABLET DAILY DISPENSE WEEKLY	07/11/2019	07/11/2019
Fluoxetine 20mg capsules	capsule	1 TABLET DAILY DISPENSE WEEKLY	30/09/2019	30/09/2019
Fluoxetine 20mg capsules	capsule	1 TABLET DAILY DISPENSE WEEKLY	09/09/2019	09/09/2019

Additional information

Smoking history (Encounters):Cigarette smoker Date recorded:22-Jan-2019
Alcohol history (Encounters):Trivial drinker - <1u/day Date recorded:31-Jan-2011
Exercise history (Encounters):Enjoys light exercise Date recorded:11-Aug-2009
Patient Weight in Kilograms:87.5
Patient Height in Metres:1.8
Patient BMI:27
Patient Blood Pressure (Systolic):120
Patient Blood Pressure (Diastolic):84

South West Primary Care Mental Health
Dr Cooper – Consultant Psychiatrist
Dr Smith – Consultant Psychiatrist
Dr O'Connor- Speciality Doctor

Cambridge Street House
5 Cambridge Street
Edinburgh EH1 2DY

Tel: 0131 537 8650
Fax: 0131 537 8655

NHS Lothian

Mr Richard Taylor
42 Morvenside
Westburn
Edinburgh
EH14 2SJ

Date: 20.11.19
Ref: DC/LK
CHI No: 1006631372

Enquires to: 0131 537 8673

Direct Line:
Extension:

Dear Mr Taylor,

Your GP has referred you to the South West Community Mental Health Team and we would like to offer you the following outpatient appointment with Dr Cooper, Consultant Psychiatrist and David Curran, CPN, on:

Friday, 29th November 2019 at 3.00pm

in

Sighthill Health Centre, 380 Calder Road, Edinburgh, EH11 4AU

If you need to change your appointment please phone us as soon as possible on 0131 537 8673.

On arrival, you should report to the receptionist with this letter.

Yours sincerely

Appointments Officer

If you need support, the following services may help:

Breathing Space	0800 83 85 87 (6pm – 2am / 24 hrs at weekend)
Mental Health Assessment Service	0131 537 6000 (24 hours)
NHS 24	111 (24 hours)
Samaritans	116 123 (24 hours)
Saneline	08457678000 (6pm – 11pm)
Edinburgh Crisis Centre	0808 801 0414 (24 hours)

PATIENT PROGRESS / COMMUNICATION SHEET

Nar 610119466W M 10/06/1963
Taylor, Richard
42 Morvenside,
DOE Edinburgh,
EH14 2SJ

Unit **CHI** 1006631372
70911 G Perks

NHS Lothian

Ward/Clinical Area:

State Action/s taken After Exception Reporting
Each entry should be dated & timed

Date & Time	Progress notes / Problems Action Taken & Investigations Required	Signature (Print name & designation)
20/7/22 0900	PC Mental health 59M → 2019 : HPC 3-5yrs ago, wife left. She phoned him telling him she had been cheating and was pregnant w new partner's child. Hasn't seen 5 kids for the last 3-5yrs. Ex-Wife has changed their names [to his], she says he's not allowed to contact the kids stabbed himself in the stomach when she told him the news Birthdays/Christmas upset him a lot - crying anxious Was married to her for 15yrs : no violence towards the ex wife/kids : no has 16 kids, 11 total - good relationship w other 11 children/mothers Current 5 are the youngest 2 weeks before Christmas after she told him she didn't love him anymore told him she was pregnant Sober for 15yrs, drank bottle of Jack Daniels, drink driving, crashed the car then went back home stabbed himself. At the time, not relieved he turned to court told him he had to stay away from kids/wife. no further suicide attempts but has had thoughts When he gets really upset or can't stop himself, he finds his best release is self harm. Has lost weight - 34 weight → 28 lowest, because his older kids were worried about..	

PATIENT PROGRESS / COMMUNICATION SHEET

Name 6101194666W M 10/06/1963
Taylor, Richard
DOB 42 Morvenside, Edinburgh, EH14 2SJ

Unit No./ **CHI** 1006631372
70911 G Perks

Ward/Clinical Area:

State Action/s taken After Exception Reporting
Each entry should be dated & timed

Date & Time	Progress notes / Problems Action Taken & Investigations Required	Signature (Print name & designation)
20/7/22 0980	Getting flashbacks memories of his kids + what they have done Occupying himself w his other kids, leaves early in the morning, comes back late @ night Got himself into debt after his wife kept up excessive spending, buying drugs. But is now making headway into this Looking to sell the house as too many memories in his current house - Hard to eat / sleep. - ½ of cannabis, 6 hours sleep. His son Ro saw himself himself and he's upset he traumatised himself his kid "Lighting the candle this 11th anyday" Hope the picture outside of his kids is helping him as a protective factor Past Psych Manic Depressive as a child. Hardwood mental hospital @ 14yrs. old. +? Satanic PHx nil notable health ? mum post natal depression after mum had him mum wanted a girl but had him "maternal grandmother told him 'mum detests him" he looked this up and was hurt by it + other son from earlier relationships has been in custody of younger children of that's also he's been telling him what's happening w the younger kids	

PATIENT PROGRESS / COMMUNICATION SHEET

Name: 610119466W M 10/06/1963
Taylor, Richard
DOB: 42 Morvenside, Edinburgh, EH14 2SJ

Unit No./CHI: **CHI** 1006631372
70911 G Perks

Ward/Clinical Area:

State Action/s taken After Exception Reporting
Each entry should be dated & timed

Date & Time	Progress notes / Problems Action Taken & Investigations Required	Signature (Print name & designation)
Social Hx. 20/11/20 0900	~~Past Psych~~ Has had mental health issues since he was a child. Can't hold a relationship. Placed in approved, better w/ Betts. Was physical + mentally abused by his mum. Dad ~~was~~ is in the army so away a lot - "Dad was not top man" 1 older sister, 1 younger brother - not abused. S-Sys ~~sexually~~ abused by a man who lived in the flats. Dad had ~~does~~ as he had bruises/welts on his body as a child but Dad "too scared to say anything" Just like the expression "grow a set Ted" Mum ~~not~~ was "head-headed". Not spoken to her in years - w/ Sister joined ~~him~~ in his mum at one point - no control of sister/brother. His children are very important to him. Suicide attempts as a child - cut wrists, ODs. admitted to REH as a young boy "used IO" there for a while. going in and out of homes when he was younger. Son stays w him p. the last 6 months. DH + Alcohol - not previously a big drinker, alcohol doesn't agree to him. no alcohol since that night. Connebrs use - most nights, a couple of spliffs, helps to sleep. DH Omeprazole / Allergies - nkda Fluoxetine - on it for a few months stopped at least a year ago.	

610119466W M 10/-
Taylor, Richard
42 Morvenside,
Edinburgh,
EH14 2SJ

Name

DOB

CHI 1006631372
70911 G Perks

Unit No./CHI

NHS Lothian

PATIENT PROGRESS / COMMUNICATION SHEET

Ward/Clinical Area:

State Action/s taken After Exception Reporting
Each entry should be dated & timed

Date & Time	Progress notes / Problems Action Taken & Investigations Required	Signature (Print name & designation)
25/7/22 0900	Plan (1) Verbal consent obtained 37.5mg then up to 75mg od 67.5mg every 2 weeks up to 150mg if BP not increasing more than this check BP.	
	(2) Opt back in to psychology	
	(3) cc-letter to Mr Taylor but doctor Cooper explained his letter is not a court report	
	(4) Email Judith to let her know he wants to opt in	
Should be on stop suboxone	MSE Appearance: dressed in vest + shorts. Covered in tattoos.	