Patient & GP Information

UHPI Number	600065926A
CHI Number	0307651525
Episode Number	E1402822
Surname/Forename	Berry, Deborah
Date of Birth	7/3/65
Sex	Female
Patient Address.	33 MACGINLAY TERRACE Edinburgh EH12 0BG
Registered GP	DW Binnie
GP Address.	Barclay Medical Practice East Craig,10 Bughtlin Market,East Craigs,Edinburgh EH12 8XP

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	Berry, Deborah
UHPI Number	600065926A

Episode Number	E1402822

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
A&E Notes Episode/Ref: E1402822 Dr Mhairi Sinclair 1/14/09 00:14	43 year old female.,,Mixed overdose about 8pm. Fluoxetine and tramadol - unspecified amounts.,Did it as fed up with doctor not helping her.,Has ME.,States wishes to die.,Previous overdose attempts.,Denies contact with psychiatric services in past but referred to CPN following overdose last year.,,PMH,Self harm,ITU admission with previous overdose,ME,,DH,Citalopram,Allergy - pontstan - hallucination,,O/E,Alert, orientated. Low volume voice.,HS pure.,Chest clear.,Abdo SNT. Bs normal.,ECG - sinus rhythm 86bpm, nil acute.,P96,BP 152/95,,Mixed overdose,,Plan,Admit CAA6,Bloods after midnight,Psych review mane

Directorate of
Accident and Emergency Medicine
LOTHIAN UNIVERSITY HOSPITALS NHS TRUST

THE ROYAL INFIRMARY OF EDINBURGH
51 Little France Crescent
Edinburgh EH16 4SU
Telephone:0131 242 1300
Fax: 0131 242 1344

NHS Lothian

A/E no: E1402822
Previous no. E1354102
JOB:
UHPI no: 600065926A
CHI no. 0307651525

PATIENT INFORMATION

Surname Sneddon
Forenames Deborah Frances
Date of Birth 03/07/1965
Age 43 Yrs Sex F

Address 11/4 Royston Mains Avenue
Edinburgh
Midlothian
Postcode EH5 1LE
Telephone 0131 552 9870

Contact Sneddon, Keiran
Address
Telephone H
W

Complaint overdose
Allergies

Attendances in last 12 months: 5 School:

General Practitioner

Name
CG Speight
Address
Crewe Medical Centre
135 Boswall Parkway
EH5 2LY
Telephone 0131 552 5544

Date and Time of Attendance
13/01/2009 21:56
Incident Date & Time:
Mode of Arrival
Emergency Ambulance
Source of Referral
999 Emergency

T	P	RR	BP	BM	SpO2	Peakflow	Urinalysis	Alcometer
36.9	107	17	152/95	6.0	96% (air)			

Nursing Assessment

Pain Assessment Score | Waterlow Score
Pain Score Review | Time | Triage Score
Signature | Time | Print Name

Clinical Notes Overdose ~ 8pm.

Fluoxetine } unable to specify amount
Tramadol
Recurrent overdoser - prev ITU stay
Not known to Ψ (referred to CPN following prev OD according to TRAK)
Has ME + feels fed up. Did it as stated not getting help from GP

PMH
ME

DH
Citalopram

SH
lives ? partner

Allergies - ponstan - hallucinations.

O/E Alert.
Conversing
P 92 BP 152/95
Chest clear

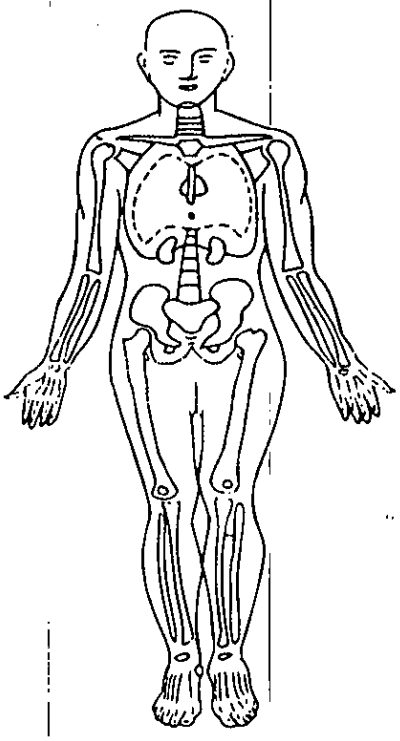
ECG - SR 86bpm
nil acute.

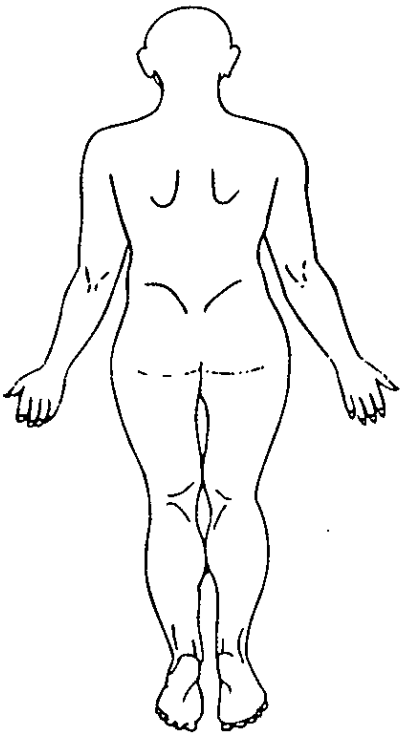
Admit CAA6, bloods ~ midnight, Ψ r/v

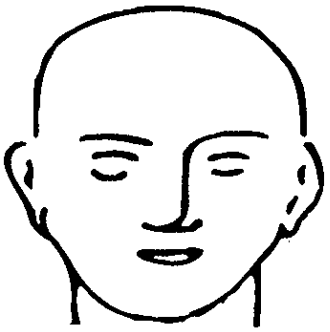
Diagnosis MIXED OVERDOSE

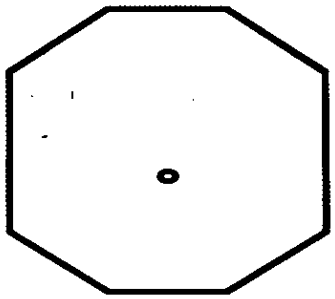
Doctor's Name (print) SINCLAIR Signature

Nursing Release				Clinical Notes Continued
Instruction/Health Education	Y	N	N/A	
Medication	Y	N	N/A	
Review				
X-rays	Y	N	N/A	
Clinic	Y	N	N/A	
Notes/X-rays	Y	N	N/A	
Walking Aids	Y	N	N/A	
Transport				
Self	Y	N	N/A	
Other	Y	N	N/A	
Amb ref no.....	Y	N	N/A	
Primary Care Ref.				
Safe Home	Y	N	N/A	
Crisis Care	Y	N	N/A	
District Nurse	Y	N	N/A	
GP	Y	N	N/A	
NoK/carer aware				
Documentation Complete	Y	N		
CSW signature				
RN signature				

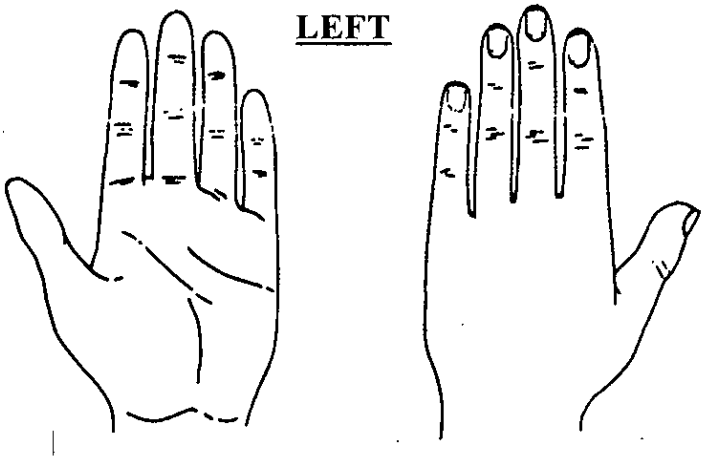




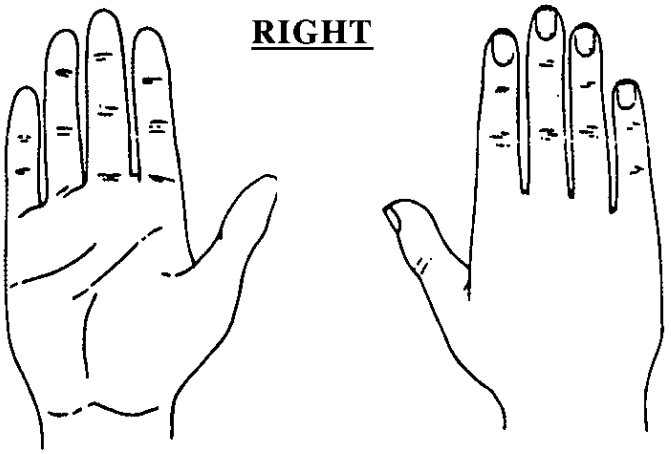




LEFT



RIGHT



Accident and Emergency Unit

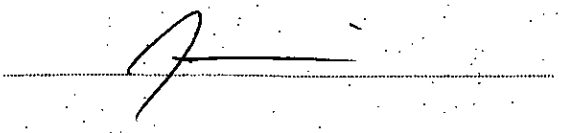
Nursing Care Plan

DEBORAH STROOD

Patient Addressograph Label

3/7/65

Admission Nurse Signature



Admission Care Guide

Mandatory Admission Tasks	Tick	Optional Admission Tasks	Tick
Undress patient		Connected to acuity	
Nurse on Sheet		12 Lead ECG	✓
Clothing bagged and labelled		Nurse X-Ray	
Vital Signs recorded (including pain score)		Analgesia	
Relatives informed		Valuables listed	

Pressure Care Guide

Build/Weight for Height		Appetite		Mobility		SCORE 1-10
Average	0	Average	0	Fully	0	
Above average	1	Poor	1	Restless/fidgety	1	LOW RISK
Obese	2	NG tube/fluids only	2	Apathetic	2	LIKELY TO BE SELF CARING AND INDEPENDENT IN
Below	3	NDM/anorexic	3	Restricted/inert	3	ALL OR MOST ASPECTS OF SCALE
				Traction	4	
				Chairbound	5	
Continence		**Tissue Malnutrition**		**Major Sugery/Trauma**		**SCORE 10-15**
Completely catheterised	0	Terminal cachexia	8		5	
Occasional incontinence	1	Cardiac failure	5	Orthopaedic – below waist		MODERATE RISK
Cath / incont of faeces	2	Peripheral disease	5	Spinal – on table over 2 hrs	5	NEEDS 2 HRLY PRESSURE CARE AND PRESSURE
Doubly incontinent	3	Anaemia	2			AREAS OBSERVED
		Smoking	1			
Skin Type: Visual Risk Area		**Neurological Deficit**		**Sex/Age**		**SCORE 15-20**
Healthy	0	Diabetes	4-6	Male	1	
Tissue paper	1	MS	4-6	Female	2	HIGH RISK
Dry	1	CVA	4-6	14-49	1	NEEDS 2 HRLY PRESSURE CARE
Oedematous	1	Motor sensory	4-6	50-64	2	AND POSITIONED ONTO A PRESSURE MATTRESS
Clammy	1	Paraplegia	4-6	65-74	3	CHART ANY VULNERABLE AREAS AND OBSERVE
Discoloured	2			75-80	4	
Broken/spot	3			81+	5	
Medication		**TOTAL SCORE**				**SCORE 20+**
Cytotoxics	4					VERY HIGH RISK
High doses of steriods	4					NEEDS 2 HRLY PRESSURE CARE
Anti-inflamatory	4					AND POSITIONED ONTO A PRESSURE MATTRESS.
						INFORM BED MANAGER IF ADMISSION IS REQUIRED
						AND CONTACT TISSUE VIABILITY SERVICE FOR
						FURTHER ADVICE.
						CONSIDER AIR MATTRESS

Continuous Nursing Care Record

Please note time and sign for any care delivered

NUTRITION	CONTINENCE	PRESSURE CARE

Time	Nursing Progress Notes	Signature
22:30	vitals ✓ BM ✓ GCS 15. awaits ECG / cubicle.	[illegible]
23:10	vitals rechecked. Appears very withdrawn. For bed	
	in CAAG. will be reviewed by psyche in	CALLSON
	am ——— SN	[illegible]

Nursing Care Rounds

Time of Round →							
Complete nursing documentation							
Review frequency of vital signs							
Inform patient & relatives of any change							

Nursing Release

Advice / Health Education	Y	N	N/A	Safe Home referral	Y	N	N/A
Medication	Y	N	N/A	Crisis care referral	Y	N	N/A
X-rays	Y	N	N/A	Ref. District Nurse	Y	N	N/A
Clinic appointment	Y	N	N/A	GP referral	Y	N	N/A
Notes	Y	N	N/A	NOK/Carer aware	Y	N	N/A
Transport with relatives	Y	N	N/A	Ambulance required	Y	N	N/A
Discharge Lounge	Y	N	N/A	SAS Reference No			

Discharge Nurse / Doctor Signature

E-Pacer PATIENT REPORT

Time	21:50	Date	13/01/2009

PATIENT AND INCIDENT DETAILS

Incident number	ED00234961 4 001
Name	DEBBIE SNEDDON
Age	0
Date of birth	03/07/1965
Gender	Female
Incident location	11/4, 11 4 ROYSTON MAINS AVENUE GRANTON EDINBURGH
Incident post code	EH5 1LE
Incident type	EMG
Call received	13/01/2009, 21 16
Call passed	13/01/2009, 21 17
Crew mobile	13/01/2009, 21 18
Crew at scene	13/01/2009, 21 21

PRIMARY SURVEY

RESPONSE	
AVPU	Alert
AIRWAY	
Airway assessment	Clear
BREATHING	
Breathing rate	Normal
Respiratory rate	20
CIRCULATION	
Pulse rate	Fast
Most peripheral pulse found	Radial
Cap refill rate	>2 secs
Skin colour	Pale
Skin texture	Dry
C-SPINE INJURY	
Suspicion of CSI	No evidence of C spine injury
PATIENT CONSENT	
Patient consent	Treatment benefits explained, Risks of condition explained, Risk of refusal explained, Capacity to understand risks and treatment

AMPDS

Dispatch code	23C06I	Overdose / Poisoning, Unknown Status - Intentional
Final code	23C04	Overdose/Poisoning, Antidepressants (Tricyclic)

GCS

Final GCS eye opening	Spontaneous
Final GCS verbal response	Orientated
Final GCS motor response	Obeys commands

VITAL SIGNS

Time hr : min	Pulse bpm	Resp. rpm	BP mm Hg	Cap refill (secs)	Peak flow %	Blood sugar mmol / l	Temp °C	SpO2 %	GCS Total	RTS	ECG	Pain score
21:36	120	20	166 / 98	<2 secs	-	-	-	99	15	7.550	-	-

EYES AND PUPIL SIZE AND REACTION

	Left	Right
Pupil size	Normal	Normal
Pupil reaction	Normal	Normal

AMPLE

Other allergies	PONSTAN
Medication	CITALIPRAM
Past history	ME, DEPRESSION, O/D
Last eaten	>5 hrs
Events prior	HAS TAKEN AN INENTIONAL O/D OF PROZAC (50 TABLETS) AND ZYDOL (8 TABLETS) AT APPROX 19:45 THIS EVENING NO ALCOHOL. WASHED DOWN WITH RED BULL. FEELS UNABLE TO COPE WITH M.E AND LACK OF HELP WITH CONDITION.

PATIENT HANDOVER

On arrival at scene	Seated
Scene removal	Walking
Transportation	Seated
Care delivery at hospital	Chair
Time of handover	21:55

FINAL OBSERVATION AND COMMENTS

O/A POLICE I A O/E CALM, LUCID, APPEARS DEPRESSED OBS UN NORMAL RANGES OTHER THN TACHYCARDIA. HAS NOT VOMITED DOES NOT WANT TO TRAVEL BUT FACED ARREST OTHERWISE GP: BOSWALL PARKWAY MEDICAL NOK: KIERAN SNEDDON (SON) SAME ADDRESS	
Report ID	143ae89a-32e7-40eb-a506-f6ffabb72d7c

NHS Lothian

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

Dr SC Duerden
Crewe Medical Centre
135 Boswall Parkway
Edinburgh
EH5 2LY

Date: 11/04/2022

Emergency Discharge Summary

Patient	Deborah Berry 190 PILTON AVENUE Edinburgh EH5 2LG	**CHI** **Date of Birth / Age** **UHPI** **A&E Attendance Number**	**0307651525** 03/07/1965 (56 years) 600065926A E4995648
Attendance Date	08/04/2022	**Contact**	Sneddon Keiran
Attendance Time	11:55		
Mode of Arrival	Emergency Ambulance		
Source of Referral	999 Emergency		
Discharge Date	08/04/2022		
Discharge To			

Dear Dr SC Duerden

Presentation: ? Cauda equina

CLINICAL NOTES:
Clinical note: PC: Lumbar back pain

HPC: Yesterday at 2:30pm was picking up 3kg puppy from crate, as she was standing she felt a twinge in her back
Continued on with day taking paracetamol
This morning got up and pain was exponentially worse, mobilised to bathroom
Was experiencing difficulty fully voiding bladder and feels like she wasn't emptying properly
Struggled to get up from the toilet seat due to pain and crawled back to bed
Pain is bilateral across back and spasmodic
Pain radiates into both legs and right groin
Describes paraesthesia in both legs, worse in feet and in saddle region
No saddle anaesthesia
No bowel or bladder incontinence

Prev horse riding accident 7 years ago, which results in several lumbar herniated discs
She has problems with chronic lumbar back pain, radiaiting into both legs, however this is significantly worse

PMH:
- HTN
- Herniated lumbar discs with neuromodulation device in situ: known to the pain services
- Prev ICU admission following OD

Medication:
- Perindopril

- Amlodipine
- Duloxetine
- Atorvastatin
- Atenolol
- Mirtazapine
- Omeprazole

SH: Lives with husband. Normally mobilises independently, however sometimes uses sticks.

O/E: Looks well
A - Patent
B - Sats 98% on air, RR 16
C - WWP, HR 80, BP 141/80
D - GCS 15
- Power 5/5
- Sensation reduced to light touch bilaterally, more on right in L4/5, S1 distribution
- Reflexes ++ in knees bilaterally
- Antalgic and slow gait
E - T 36.3, Abdomen SNT

Post void bladder scan = 14ml

Plan
1. MRI - changed to CT lumbar (due to neuromodulation device)
2. Analgesia

CT scan: No evidence of cauda equina. Patient has a spinal nerve stimulator which is non MRI compatible. CT performed instead.
At L2/3, left subarticular protrusion likely compresses the left L3 roots.
At L4/5, the disc bulges broadly and a right subarticular protrusion likely compresses the right L5 roots.
At L5/S1, left subarticular protrusion likely compresses the left S1 roots.
Discs at other levels imaged are unremarkable.
No bony abnormality. Alignment is satisfactory.

Pt encouraged to mobilise with analgesia
D/C home, patient is going to make GP appt for ongoing pain management
It sounds like her pain issues are somewhat longstanding and she would perhaps benefit from pain team input

Yours Sincerely,

Dr Hannah Crane, Doctor

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. E4995648
Previous no. E1402822
UHPI no. 600065926A
CHI no. 0307651525

Patient Information

Surname Berry
Forename(s) Deborah Frances
Date of Birth 03/07/1965
Age 56 Yrs Sex F
Address 190 PILTON AVENUE
Postcode EH5 2LG
Telephone
Contact Sneddon, Keiran
Address
Telephone H
W
Complaint? Cauda equina
Allergies VARIOUS. SEE CHART.
Attendances in last 12 months: 0 School :

General Practitioner

SC Duerden
Crewe Medical Centre
135 Boswall Parkway
Address Edinburgh
EH5 2LY
0131 552 5544
Telephone

Date and Time of Attendance 08/04/2022 11:55
Incident Date/Time: 08/04/2022
Mode of Arrival Emergency Ambulance
Source of Referral 999 Emergency

Initial Triage Assessment

Presenting Complaint	LUMBAR BACK PAIN. MARKED BACK PAIN SINCE YESTERDAY AFTER LIFTING DOG. WORSE TODAY, CAN'T MOBILISE.
History of Presenting Complaint	
Assessment	SADDLE PARAESTHESIA NO INCONTINENCE. DIFFICULTY PASSING ?CAUDA EQUINA HAS SPINAL NEUROSTIMULATOR.

Nursing Observations & Assessments

TEMP	36.3 °C	SCORE	MIN. FREQ	(please tick)	Blood Sugar	6.9 mmols	Pain Score	/10		
HR	80	NEWS 0-1	Hourly		Peak Flow 1)		Analgesia Given	YES ☐	NO ☐	
BP	141/68	NEWS 2-4	30mins Min		Peak Flow 2)		Fast Assessment	POS ☐	NEG ☐	
SP02%	98 %	NEWS 5-7	15mins Min		Peak Flow 3)		Onset Time:			
RR	16	NEWS >7	10mins Min		Alcometer		Weight		Height	
AVPU	A	Special Clinical Instructions			HAS TAKEN TRAMADOL & DIAZEPAM.					
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: [illegible] Signature: Triage Time: 1230.

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 Specialty)			

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 ☐

56 ♀

PMH: HTN
came off here 7 years
neuromodulation device
in situ
known bulging disc

meds: perindopril
amlodipine
duloxetine
atorva
aten
mirt
omep

yesterday noticed bump in back ~ 2:30pm
pain in back

lifting puppy ~ 3kg

bilateral pain radiating into L groin
radiating into back legs to feet
bilateral paraesthesia

difficulty voiding
unable to fully void
no weakness
pins and needles in saddle region

taken PR + paracetamol
pain in legs worse

husband at home
not working
non smoker
sometimes uses crutches

256 ml

Care Providers Name: _____ Signature: _____

6000659260/B490563Y * 03/07/1965
Berry, Deborah F
190 PILTON AVENUE
Edinburgh,
EH5 2LG

CHI 0307651525
70573 SC Duerden

RIE ED Nursing Care Plan

Admission Nurse Signature.....

Admission Nurse Print Name.....

Date. 08/04/22

Presenting History :

Date/ Time	Progress Notes	Signature
08/04/22 15⁰⁰	Pt on trolley in rod A, settled on comfortable bed 2 ↓ SpO2, GCS 15. Diazepam given as charted.	EL

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	1500				
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	

Patient Information		Date:	08/04/2022
DEBORAH BERRY		Incident Number:	CR008541597
Age/Gender:	56y Old Female		
Address:	190 PILTON AVENUE EDINBURGH,EH5 2LG	Incident Type:	EMG
DOB:	03/07/1965	Incident Location:	190 PILTON AVENUE EDINBURGH, EH5 2LG
CHI:			
Ethnicity:			

600065926A/E4995648 F 03/07/1965
Terry, Deborah F
190 PILTON AVENUE,
Edinburgh.
EH5 2LG
CHI:0307651525
70573 SC Duerden

Presenting Complaint

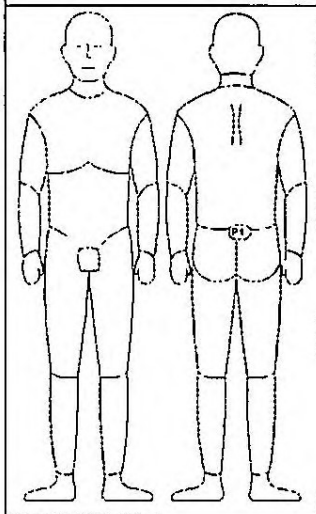
SCIATICA

Additional Comments

O/A pt lying in bed after mobilising to the toilet. A clear. B RR16, sats 97% on RA. C HR and BP norm. Cap <2. D BM and Temp norm. GCS15. Perrl, 3mm. E Lumbar pain. Sciatica. No inco. Internal sciatica neurostimulator which does work. Paraesthesia. Pt used Entonox to good effect. Pt allergic to morphine. Crew called CCP 3824. CCP unable to remote script, however does have penthrox if needed. Crew called GP. GP would not allow IV Diazepam. GP scripted 6mg tablets x 2. Pt took 6mg at 1030hrs, then 1105hrs. At 1045hrs pt helped up to toilet then onto trolley, see 1100hrs obs. Crew unable to scoop pt due to angles/doorways in pts house. Unable to immobilise pt due to pts positioning. NoK James Berry, husband, 07955 100 276, on scene. GP Crewe Med Cen. ?Lumbar nerve pain ?Cauda Equina

PATIENT ASSESSMENT

ACVPU	Alert	<C>	No		
A	Clear				
B	Breathing Adequately: Yes	Respiratory Rate: 16	SPO2: 97		
C	Pulse Rate	BP	Cap Refill	ECG Rhythm	
	80	139/89	<=2 Secs		
	Rhythm	Arm	Central/Peripheral	ECG	
	Reg	Left	Peripheral	3 Lead	
D	GCS	Eyes	Voice	Motor	PEARL
	15	Spontaneously (4)	Orientated (5)	Obeys Commands (6)	Yes
E					



Pain

ID	Body Part	Pain Scale
P1	Right Buttock	7

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
12:10	80	16	141/68	98	<=2s	15	Alert								E9883630
11:50	75	18	137/66	96	<=2s	15	Alert								E9883630
11:00	96	22	155/99	100	<=2s	15	Alert								E9883630
09:50	80	16	139/89	97	<=2s	15	Alert		36.3	6.9					E9883630

09:35		15	Alert		E9883630

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
09:50	16 (0)	97 (0)		0	139 (0)	80 (0)	Alert (0)	36.3 (0)	0

Drugs

Time	Drug	Dosage	Units	Route	Drug Expiry Date	Pain Before	Pain After	CrewID
09:50	Entonox		PRN	INH		7		E9883630
10:30	Diazepam	6	mg	OR				E9883630
10:40	Tramadol pts own	100	mg	OR				E9883630
11:05	Diazepam	6	mg	OR				E9883630

HISTORY

AMPLE

Allergies	MORPHINE, ENDONE, PHENTANYL, CODEINE, PANADIENE FORTE, PONSTAN, LATEX, AMITRIPTYLINE
Medication	Dihydrocodeine, Tramadol, Atorvastatin, Mirtazapine, Atenolol, Duloxetine, Esomeprazole, Perindopril erbumine + Amlodipine
Past Medical History	SPINAL CORD NEUROSTIMULATION, LUMBAR 3 5 AND SACRAL 1 ISSUES AFTER FALLING OFF A HORSE IN 2015
Last Eaten	>4 Hours Ago
Events Prior	PT LIFTING DOG INTO CRATE, TWINGE ON BACK, ON THURSDAY. PT WAS STILL MOBILISING. PT TOOK SCRIPTED DIHYROCODEINE AND TRAMADOL. PT GOT UP AT 0815HRS WENT TO TOILET. PT MOBILISED BACK TO BED. PT CALLED NHS24, EMG AMBO.

SOCRATES

Site	LUMBAR 2/3 PAIN	Onset	TWISTING, 07/04/2022, 15:00
Character	NERVE PAIN, Constant, Worsening	Radiates	Yes, L2 SCIATIA L3 GROIN
Associated Symptoms	Nausea	Timing	SINCE 0815HRS
Exacerbating Or Relieving Symptoms	LYING DOWN	Severity	PS7, PS10 ON MOVEMENT PS4 ON ENTONOX

MEDICAL

CLOSE RECORD

Treatment On Scene	Emergency

Conveyance

Transport To Hospital	Normal driving	Pre Alert	No

INCIDENT LOG

Time Call Received	09:19	Allocated	09:21	Mobile	09:22
First Resource On Scene		Crew On Scene	09:33	Crew Left Scene	11:11
Crew At Hosp	11:53	Receiving Hospital	NEW EDINBURGH ROYAL INFIRMARY	Clear Time	

Crew ID	Crew Grade	Driver
E1021087	Paramedic	YES
E9883630	Student Technician Level 4	NO

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

NHS Lothian

[illegible]graph
[illegible]5926A/E4995648 F 03/07/1[illegible]55
Berry, Deborah F
19[illegible]ILTON AVENUE,
Edinburgh,
EH5 2LG

CHI 0307651525
[illegible]/0523 SC Duerden

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

Previous Adverse Reactions	Weight	Date
FENTANYL CODEINE MORPHINE	kgs Actual / Estimate	8/4/22

Once Only Prescription

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber Sign & Print	Time Given	Issued by (Initials)	Checked by if applicable (Initials)
8/4	1235	PARACETAMOL	1G	ORAL		1245	CF	
4	"	DIHYDROCODEINE	30MG	ORAL	LOTHIAN.	1245	CF	
08/04	1435	DIAZEPAM	5 mg	oral		1510	CF	
08/04	1735	DIHYDROCODEINE	30mg	oral		1810	CM	
		Paracetamol	1G	oral		1810	CM	
08/04	2010	Diazepam	5 mg	oral		2015	NM	

Discharge Medication

Date & Time	Medicine (Approved Name)	Dose	Frequency	Route	Quantity	Duration	Prescriber Sign & Print	Issued by (Initials)	Checked by (Initials)
08/04	DIAZEPAM	5 mg	x4	oral	20 tabs	5 day		HC	NM

National Early Warning Score 2 (NEWS2) Chart

NEWS Key: 0 1 2 3

Parameter	Range	8/4 1230	8/4 1500	8/4 1730	8/4 1950	Score
A+B Respirations Breaths/min	≥25					3
	21-24					2
	18-20	16	☐	18		
	15-17					
	12-14				14	
	9-11					1
	≤8					3
A+B SpO₂ Scale 1 Oxygen saturation (%) Use Scale 1 if target range is 96-98%	≥96	98			97	
	94-95					1
	92-93		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
* ONLY use Scale 2 under the direction of a qualified clinician	≥93 on air					
	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	A	A	
	O² L/min or %					2
	Device					
C Blood Pressure mmHg Score uses Systolic BP only	≥220					3
	201-219					
	181-200					
	161-180		164			
	141-160	141				
	121-140			135	135	
If manual BP mark as M	111-120					
	101-110					1
	91-100					2
	81-90			81		3
	71-80				76	3
	61-70					3
	51-60	65	62			3
	≤50					3
C Pulse Beats/min	≥131					3
	121-130					2
	111-120					2
	101-110					1
	91-100				99	1
Manual pulse	81-90	80		87		
	71-80					
	61-70		68			
	51-60					
	41-50					1
	31-40					3
	≤30					3
D Consciousness Score for new onset of confusion (no score if chronic)	Alert	A	A	A	A	
	New Confusion					3
	V					3
	P					3
	U					3
E Temperature °C	≥39.1°					2
	38.1-39.0°					1
	37.1-38.0°	36.3				
	36.1-37.0°		36.6	36.5	36.5	
	35.1-36.0°					1
	≤35.0°					3
NEWS TOTAL		0	2	2	1	
Monitoring frequency		2°	1°	1	1	
Escalation of care Y/N			N	N	N	
Blood Glucose reading or N/A		6.9	/	—	—	
Pain score (0-10)			0	—	—	
Initials		KL	[illegible]	HM	[illegible]	

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	3/4	
		Time	15:00	
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	
		Extens on to pain	2	
		None	1	
		Total GCS Score		
	Right Pupil	Size		+ reacts - no reaction c. eye closed
		Reaction		
	Left Pupil	Size		
		Reaction		
LIMB MOVEMENT	ARMS	Normal power	✓	Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness		
		Severe weakness		
		Extension		
		No response		
	LEGS	Normal power	✓	
		Mild weakness		
		Severe weakness		
		Extension		
		No response		
		Initials		

Pupil Scale mm 1 2 3 4 5 6 7 8

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

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

Dr J Cooney
Crewe Medical Centre
135 Boswall Parkway
Edinburgh
EH5 2LY

Date: 08/11/2024

Emergency Discharge Summary

Patient	Deborah Berry 190 Pilton Avenue Edinburgh EH5 2LG	**CHI**	**0307651525**
		Date of Birth / Age	03/07/1965 (59 years)
		UHPI	600065926A
		A&E Attendance Number	E5859247
Attendance Date	06/11/2024	**Contact**	Sneddon Keiran
Attendance Time	19:01		
Mode of Arrival	Private Transport		
Source of Referral	NHS 24		
Discharge Date	07/11/2024		
Discharge To			

Dear Dr J Cooney

Presentation: Back pain; neuro deficit >24hr; t3 Atraumatic lower back pain, onset 2/52 ago. Worsening past 2/7. Down left leg. 3x episodes urinary incontinence. Independent with stick. Hx: gastric bypass Sept '24 NEWS: 1. 95% S Overweel S worsening back

CLINICAL NOTES:
Clinical note: RIE ED
Daanyal Afzal CF

PC - Back pain

HPC -
2 week history of worsening lower back pain
no preceeding injury or strenuous activity
pain is in the lower back mainly on the left, described as burning and tight, it travels down into her left leg to her knee
She has been struggling to mobilise due to the pain
Patients back pain flares usually last 10 days but this has lasted longer and is more severe
over the last 2 days she has not been able to get to the toilet in time and had been incontinent on a couple of occasions but she has the sensaiton of her bladder filling and needing to go to the toilet
no perianal lumbness
no bilateral shooting leg pains

I note patient is on waiting list for chronic pain team

PMH -
Back pain since falling off horse in 2015, has a neuromodulator in her spine from 2017
gastric band surgery Sept 2024

coronary artery disease

SH - lives with husband, housebound, walks with crutch

DH - as per ECS

Allergies - fentanyl (vomiting), codeine and morphine (itch)

O/E:
Looks well
walking without crutch after analgesia
power 5 in hip flexion, knee extention/flexion, ankle dorsi and plantar flexion bilateraly
power 4 in hip extention bilaterally
reduced sensation in L5/S1 distribution on left leg
knee jerk brisk bilaterally but slightly more on right

Imp - flare of chronic back pain

Plan:
DW C.Evans ED Reg - for pre and post-void bladder scan and if normal can be discharged with analgesia
advised patient to engage with physiotherapy

DA CF

---

pre-void bladder scan 76mls
post -void bladder scan 1ml

discharged home with analgesia and worsening advice

Yours Sincerely,

Dr Mohammad D Afzal, Doctor

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. E5859247
Previous no. E5825688
UHPI no. 600065926A
CHI no. 0307651525

Patient Information

Surname	Berry	Date of Birth	
Forenames	Deborah Frances	Age / Sex	03/07/1965 59 Yrs F
Address	190 Pilton Avenue		
Postcode	EH5 2LG	Telephone	07955115357
Contact Address	Sneddon, Keiran	Telephone H / W	
Complaint	S worsening back pain B has chri nic back pain	Allergies	

Attendances in last 12 months: 1 School :

General Practitioner

Address: J Cooney, Crewe Medical Centre, 135 Boswall Parkway, Edinburgh, EH5 2LY
Telephone: 0131 552 5544

Date and Time of Attendance: 06/11/2024 19:01
Mode of Arrival: Incident Date Time: 06/11/2024 17:32
Source of Referral: Private Transport NHS 24

Initial Triage Assessment

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 ☐
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)	

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)	

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)		

"What Happens To The Patient?"

Clinical Notes

Think:- Other Sources of Information:

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

BLADDER SCAN - PRE 76ml - POST 1ML @ 01:25

Care Providers Name: _____ Signature: _____

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

NHS Lothian

6

600065926A /E5859247 F
BERRY Deborah
03-Jul-65 **CHI:** 030 765 1525
70573 J Cooney
190 Pilton Avenue
EH5 2LG

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

Previous Adverse Reactions	Weight	Date
Fentoxyl, codeine, morphine (itch). (itch) (itch)	kgs Actual / Estimate	6/11/24.

Once Only Prescription

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber Sign & Print	Time Given	Issued by (Initials)	Checked by if applicable (Initials)
6/11	2245	Paracetamol	1g	PO		2251	HW	
7/11	2245	Oramorph	10mg	PO		2256	HW	

Discharge Medication

Date & Time	Medicine (Approved Name)	Dose	Frequency	Route	Quantity	Duration	Prescriber Sign & Print	Issued by (Initials)	Checked by (Initials)
0129 7/11	Oramorph	5mg	4° max 6 doses per day	PO		7 days.		DA	RM

National Early Warning Score 2 (NEWS2) Chart

NEWS Key: 0 1 2 3				Score
	Date:	6/11/24		
	Time:	1930	2227	
A+B Respirations Breaths/min	≥25			3
	21-24			2
	18-20			
	15-17	15	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			
	94-95	95	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	≥97 on O_2			3
	95-96 on O_2			2
	93-94 on O_2			1
	≥93 on air			
* ONLY use Scale 2 under the direction of a qualified clinician	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 to target range	A = Air	A	A	
	O^2 L/min or %			2
	Device			
C Blood Pressure mmHg Score uses Systolic BP only	≥220			3
	201-219			
	181-200			
	161-180			
	141-160			
	121-140	127	130	
If manual BP mark as M	111-120	^	^	
	101-110	|		1
	91-100			2
	81-90	v	v 84	
	71-80	86		
	61-70			3
	51-60			
	≤50			
C Pulse Beats/min	≥131			3
	121-130			2
	111-120			
	101-110			1
	91-100			
Manual pulse	81-90	88	85	
	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	
	New Confusion			
	V			3
	P			
	U			
E Temperature °C	≥39.1°			2
	38.1-39.0°			1
	37.1-38.0°			
	36.1-37.0°	36.9	37.0	
	35.1-36.0°			1
	≤35.0°			3
NEWS TOTAL		1	1	
Monitoring frequency		1	1	
Escalation of care Y/N		N	N	
Blood Glucose reading or N/A			/	
Pain score (0-10)			8	
Initials		SO	KW	

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
		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													

NHS Lothian

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

Dr J Cooney
Crewe Medical Centre
135 Boswall Parkway
Edinburgh
EH5 2LY

Date: 24/06/2025

Emergency Discharge Summary

Patient	Deborah Berry 33 MacGinlay Terrace Edinburgh EH12 0BG	**CHI**	**0307651525**
		Date of Birth / Age	03/07/1965 (59 years)
		UHPI	600065926A
		A&E Attendance Number	E6075019
Attendance Date	23/06/2025	**Contact**	Sneddon Keiran
Attendance Time	14:06		
Mode of Arrival	Emergency Ambulance		
Source of Referral	999 Emergency		
Discharge Date	23/06/2025		
Discharge To			

Dear Dr J Cooney

Presentation: fall, lac to head and finger

PC: 59 year old female BIBA to MIU with head injury and left middle finger injury.

PMH: Fibromyalgia, lumbar disc bulge, HTN
PSH: Rotator cuff repair to left shoulder, anterior and posterior vaginal wall repair, gastric bypass, breast reduction and tummy tuck.
MEds: Amlodipine, atorvastatine, bisoprolol, duloxetine, mirtazepine, coversil
Allergies: Morphine - itchy/chesty
SH: Lives with husband, non-smoker, no alcohol.

HPC: Tripped on a folded up piece of carpet, hit head against concrete. Wound to forehead and injury to left middle finger. Denies LOC/vomiting/blurred or double vision.

O/E:
- Appears well.
- Able to mobilise independently.
- Observations: T 36.5, HR 83, SpO2 96%, BP 133/84, RR 15, alert throughout examination.

Head injury:
- 3cm longitudinal laceration to forehead, closed by SAS crew, appears well opposed, wound not re-opened in MIU.
- CN II-XII intact
- PERLA 2+, FROEM.
- No c-spine tenderness.
- GROM in neck.
- GCS 15/15

- Power/tone/sensation/reflexes normal to upper and lower limbs.
- Normal gait.
- No battles signs, boggy haematoma or bilateral periorbital bruising.
- TMs clear, no haemotympanum.

Left middle finger:
- Bruising along length of digit, generalised tenderness.
- GROM n digit but limited slightly by swelling and pain.
- Sensation intact to distal tip, CRT < 2secs.

X-ray left middle finger: No acute bony injury

Imp: Head injury with wound and bruising to left middle finger.

Plan:
- Wound left as closed by SAS, wound appears to be well opposed with no boggyness felt on palpation around the wound.
- Advised to keep finger moving to help with stiffness/swelling.
- Head injury advice given, both written and verbal
- Worsening advice

ENP S Ritchie

Yours Sincerely,

Sarah Ritchie, Nurse Practitioner

600065926A/E6075019 F 03/07/1965
Berry, Deborah F
33 MacGinlay Terrace,
Edinburgh,
EH12 0BG

CHI 0307651525
70573 J Cooney

DEBORAH BERRY

Age/Gender:	**59Y, Female**	**Incident Date:**	**23/06/2025 11:19:00**
DOB:	**03/07/1965**	**ePCR Number:**	**6-2-230625-111917**
Address:	**33 MACGINLAY TERRACE EDINBURGH EH12 0BG**	**Incident Number:**	**CR012177837**
CHI Number:	**0307651525**	**Incident Type:**	**EMG**
Ethnicity:	**-**	**Incident Location:**	**33 MACGINLAY TERRACE EDINBURGH, EH12 0BG**

PATIENT INFO

Capacity Assessed

	Deemed to have Capacity

Clinical Assessment

Consent Decision:	**Consent Gained**

Treatments

Consent Decision:	**Consent Gained**

ADDITIONAL COMMENTS

Presenting Complaint:	**Fall, laceration to head and ? finger #**	

Timestamp	Additional Comment	Crew Name
23/06/2025 13:58:00	PC - 3Rd party call to 999 for this 59 YOF following a fall at home and laceration to the head.OA - PT was sitting on her chair, she was well perfused and able to speak in full sentences, she is oriented to place and time.OE - Allergic to morphine, All obs as below and unremarkable, crew steri stripped head and bandaged. There was no TLOC, did feel nauseous but was not sick, was dizzy on standing, some blurred vision and confusion now resolved. HXPC- Had mechanical fall in home and landed face first on concrete floor.PMHX - Recent surgery in Turkey 28th May, Fibromyalgia, arthritis, bulging discs.SHX - Lives with husband Jim.TX - Nil by crew, PT has not had daily meds but had 1 gm paracetamol 11:05.Careplan - Convey to ERI minor injuries for further assessment.	-

ACVPU

Options:	**Alert**

CATASTROPHIC HAEMORRHAGE

Catastrophic Haemorrhage:	**No**

AIRWAY

Assessment:	**Clear**

BREATHING

Breathing Adequately:	**Yes**	**Initial Respiratory Rate:**	**18**
Initial SpO2:	**98**	**Initial SpO2 On Air:**	**Yes**
Oxygen Given:		**No**	

CIRCULATION

Pulse Rate:	**87**	**Rhythm:**	**Reg**
Most Distal Pulse Found:	**Radial**	**Cap Refill:**	**<=2 Secs**
Central Peripheral:	**Peripheral**	**Arm:**	**Right**
Systolic Pressure:	**142**	**Diastolic Pressure:**	**80**

Skin

Appearance:	**Normal**	**Skin Texture:**	**Dry**
Skin Temperature:		**Warm**	

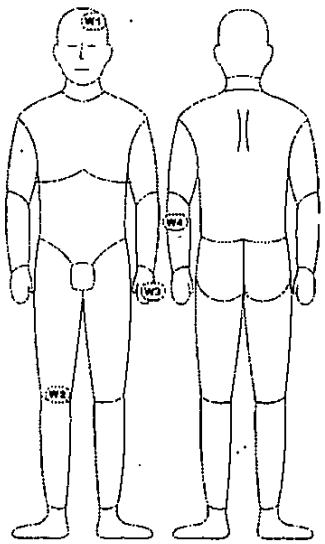
DISABILITY

Eyes

Left Pupil Size (Mm):	**4**	**Right Pupil Size (Mm):**	**4**

EXAMINATION

Assessment Graphic



Wounds Table

ID	Body Part	Wounds	Treatment
W1	Head	Laceration, Swelling, Haematoma	Steristrips
W2	Right Upper Leg	Abrasion	-
W3	Left Hand	Bruising, Swelling	-
W4	Back Left Lower Arm	Abrasion	-

OBSERVATIONS

Observations Assessment

Timestamp	Pulse	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	Temp	BM	ECG	P(L|R)	PEF	Crew
23/06/2025 12:35	87	18	142/80	98	<=2 Secs	15	Alert		36.3			4|4		E9883659
23/06/2025 12:51	75	18	141/82	98	<=2 Secs	15	Alert							E9883659

GCS

Timestamp	Eyes Value	Eyes Score	Voice Value	Voice Score	Motor Value	Motor Score	Final Score
23/06/2025 12:35	Spontaneously	4	Orientated	5	Obeys Commands	6	15
23/06/2025 12:51	Spontaneously	4	Orientated	5	Obeys Commands	6	15

NEWS Score

Timestamp	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
23/06/2025 12:35	18 (0)	98 (0)	-	0	142 (0)	87 (0)	Alert (0)	36.3 (0)	0

AMPLE

Drugs:	**Morphine**

Medication

Medication:	**Atorovastatin, Amlodipine, Duloxetine, Mirtezipine, Dihydrocodien, Bisoprolol, Aspirin.**

Heart Disease

Disorders:	**Hypertension**

Last Eaten

Last Eaten:	**>4 Hours Ago**

SOCIAL HISTORY

General Appearance:	**Normal**

Occupation

Status:	**Does Not Work**

Living Arrangement

Lives Alone:	**No**

Mobility	
Patient Mobility:	**Fully Mobile**
Communication	
Communication Requirements:	**No Help Required**
Clinical Risks	
Factors:	**None Identified**
Environmental Risks	
Factors:	**Loose Carpets**
SOCRATES	
Site	
Site:	**Laceration to the forehead, abrasion to left knee and right elbow. bruising to left wriet and middle finger.**
Onset	
Onset: **Following a fall.**	**Date/Time:** **23/06/2025 10:50**
Cherecter	
State:	**Improving**
Radiates	
Radiates:	**No**
Associated Symptoms	
Symptoms:	**Nausea, Dizziness**
Severity	
Severity:	**4/10**
ADULT MAJOR TRAUMA TOOL	
Trauma Outcome	
Recommendation **TU**	**Recommendation Response** **Yes**
CLOSE REPORT	
Clinical Response Feedback	
On-Scene Clinicel Findings	**Non Emergency**
CONVEYANCE	
Transport To Hospital **Normel Driving**	**Pre-Alert** **No**
Destination Hospital	**NEW EDINBURGH ROYAL INFIRMARY**
INCIDENT INFORMATION	
Dispatch	
Dispatch Code **ICHY**	**Dispatch Deacription** **Integrated Clinical Hub Yellow**

Incident Log

Status Time	Status	Callsign	Reason	Hospital
10:56:08	Call Received Time	EDC3490		
11:22:08	Mobile	EDC3490		
10:58:08	Call Received Time	EDC4085		
11:55:55	Mobile	EDC4085		
12:30:53	At Scene	EDC4085		
13:17:10	Leave Scene	EDC4085		NEW EDINBURGH ROYAL INFIRMARY
13:47:30	At Hospital	EDC4085		

CREW INFORMATION

Additional Crew

Crew ID	Crew Grade
E9883659	Ambulance Technician (AT)
E9881208	Ambulance Paramedic (AP)

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. E6075019
Previous no. E5949754
UHPI no. 600065926A
CHI no. 0307651525

Patient Information

Surname Berry
Forenames Deborah Frances
Address 33 MacGinlay Terrace
Postcode EH12 0BG
Contact Address Sneddon, Keiran
Complaint fall, lac to head and finger
Attendances in last 12 months: 3 School :

Date of Birth 03/07/1965
Age 59 Yrs Sex F
Telephone 07955115357
Telephone H
W
Allergies Morphine itchy/sweaty

General Practitioner

J Cooney
Crewe Medical Centre
135 Boswall Parkway
Edinburgh
EH5 2LY
Address
Telephone 0131 552 5544

Date and Time of Attendance 23/06/2025 14:06
Incident Date Time:
Mode of Arrival Emergency Ambulance
999 Emergency
Source of Referral

Initial Triage Assessment

Presenting Complaint	
History of Presenting Complaint	tripped over carpet, head hit on concrete = wound.
Assessment	L middle finger analgesia ✓ Xray ✓

Nursing Observations & Assessments

TEMP	36.5°C	SCORE	MIN. FREQ	(please tick)	Blood Sugar	mmols	Pain Score	/ 10	
HR	83	NEWS 0-1	Hourly		Peak Flow 1)		Analgesia Given	YES ☐	NO ☐
BP	133/84	NEWS 2-4	30mins Min		Peak Flow 2)		Fast Assessment	POS ☐	NEG ☐
SP02%	96 %	NEWS 5-7	15mins Min		Peak Flow 3)		Onset Time:		
RR	15	NEWS >7	10mins Min		Alcometer		Weight		Height
AVPU	A	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 OPP							
NEWS SCORE									

PMH - atorvastatin, amlodipine, cozaar, codeine, duloxetine, mirtazipine, bicoprilol
- fibromyalgia, disc bulge, arthritis.

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 ☐

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 Specialty)		Other (please state)		Exam		Other (Please state)	

X-Rays - Please tick

CRX	Yes ☐	No ☐
CT Scan	Yes ☐	No ☐
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 ☐

PMH: (R) rotator cuff repair, ant/post vaginal repair, gastric bypass, breast reduction, IT, HTN.

meds: Amlodipine, atorva, bisoprolol, dulaxetine, nitrazepine, Cavedilol.

Sx: lives c husb, ø Sm, ø alc.

Care Providers Name: _____ Signature: _____

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

NHS Lothian

600065926A/E6075019 F 03/07/1965
Berry, Deborah F
33 MacGinlay Terrace,
Edinburgh,
EH12 0BG

CHI 0307651525

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

Previous Adverse Reactions	Weight	Date
Morphine	70 kgs (Actual / Estimate)	23/06/25

Once Only Prescription

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber Sign & Print	Time Given	Issued by (Initials)	Checked by if applicable (Initials)
23/06/25	1615	paracetamol	1g	PO	S Pottle RGN 370A	1615	SP	

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

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.**

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

Neurological Observations

		Date							
		Time							
GLASGOW COMA SCALE	Eyes Open	Spontaneously	4						Eyes closed by swelling = C
		To speech	3						
		To pain	2						
		None	1						
	Best Verbal Response	Orientated	5						Endotracheal tube or tracheostomy = T
		Confused	4						
		Inappropriate words	3						
		Incomprehensible sounds	2						
		None	1						
	Best Motor Response	Obey commands	6						Always record the best arm response
		Localise to pain	5						
		Flexion to pain	4						
		Abnormal flexion	3						
		Extension to pain	2						
		None	1						
		Total GCS Score							
	Right Pupil	Size							+ reacts - no reaction c. eye closed
		Reaction							
	Left Pupil	Size							
		Reaction							
LIMB MOVEMENT	ARMS	Normal power							Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness							
		Severe weakness							
		Extension							
		No response							
	LEGS	Normal power							
		Mild weakness							
		Severe weakness							
		Extension							
		No response							
		Initials							

Pupil Scale mm

1 • 2 • 3 • 4 • 5 • 6 • 7 • 8 •

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.	E5949754
Previous no.	E5859247
UHPI no.	600065926A
CHI no.	0307651525

Patient Information

Surname	Berry	Date of Birth	
Forenames	Deborah Frances	Age / Sex	03/07/1965
		59 Yrs	F
Address	190 Pilton Avenue		
Postcode	EH5 2LG	Telephone	07955115357
Contact Address	Sneddon, Keiran	Telephone	H W
Complaint	R Sided Earache and Discharge	Allergies	

Attendances in last 12 months: 2 School :

General Practitioner

Address: J Cooney, Crewe Medical Centre, 135 Boswall Parkway, Edinburgh, EH5 2LY
Telephone: 0131 552 5544

Date and Time of Attendance: 14/02/2025 19:09
Mode of Arrival: Incident Date Time: Private Transport
Source of Referral: Self Referral to A&E

Initial Triage Assessment

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 ☐	
SP02%	%	NEWS 5-7	15mins Min		Peak Flow 3)		Onset Time:			
RR		NEWS >7	10mins Min		Alcometer		Weight		Height	
AVPU		Special Clinical Instructions								
Ox 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)	

"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

NHS Lothian

Adult Majors

Prescription, Administration & Observation Record

600065926A /E5949754 F
BERRY Deborah
03-Jul-65 **CHI:** 030 765 1525
70573 J Cooney
190 Pilton Avenue
EH5 2LG

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

Previous Adverse Reactions		Weight _____ kgs Actual / Estimate	Date 14.2.25

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:	14.2.25																				
	Time:	2010																				
A+B Respirations Breaths/min	≥25										3											
	21-24										2											
	18-20	18																				
	15-17																					
	12-14																					
	9-11										1											
	≤8										3											
A+B SpO_2 Scale 1 Oxygen saturation (%) Use Scale 1 if target range is 94-96%	≥96	97																				
	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																					
	161-180																					
	141-160																					
	121-140	133																				
	111-120																					
	101-110										1											
	91-100										2											
	81-90																					
	71-80	79																				
	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																					
	71-80																					
	61-70	64																				
	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°	37.0																				
	35.1-36.0°										1											
	≤35.0°										3											
NEWS TOTAL		0																				
Monitoring frequency		2																				
Escalation of care Y/N		N																				
Blood Glucose reading or N/A																						
Pain score (0-10)		MOD																				
Initials		PC																				

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		
	LEGS	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													