PATIENT PROGRESS / COMMUNICATION SHEET

600065926A 03/07/1965
Berry, Deborah F
Flat 4,
366 West Granton Road,
Edinburgh,
EH5 1FE
CHI 0307651525
70573 LA MacDonald

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)
11.7.21	All over joint pain	
	① under [illegible] the [illegible]	
	to [illegible] [illegible] [illegible]	
	– [illegible]	
		DG Years ago (2007)
	C/O [illegible] [illegible]	
	bloodtest	
	–ve	
	Pain [illegible] [illegible]	
	↑ ē movement	
	Hands shoulders hips	
	DHx Painkillers	
	[illegible]	
	Tramadol	
	(Diclofenac – stopped)	
	Mirtazapine	
	[illegible]	
XR Hands	Duloxetine	[illegible]
?AP	Statin	
	Amlodipine	
	Perindopril	
	Sleep really [illegible] due to	
	pain	
	[illegible]	

File name: Progress Note and Communication Sheet v3.0 LOT104
Authorised: Jun 2019
Review: Jun 2022

PATIENT PROGRESS / COMMUNICATION SHEET	Addressograph, or Name DOB Unit No./CHI **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)
	No physio	
	Daily routine	
	– in house all day	
	crochet – but agony	
	Lives c̄ husband	
Contributes to:	Neuro-ablative	device
Nothing		
'Sedone'	in her? Au	
Cathedral	2010 ? ~~2009~~?	
Feeling!	In Australia	
	– Coming off c̄ here	

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Consent Form for a Colonoscopy (with Moviprep)

Name of procedure/investigation: **Colonoscopy**

Inspection of the colon using a flexible scope – with or without a biopsy and/or a polypectomy.

Please read the patient information leaflet for further details: **Colonoscopy with MOVIPREP version 3.1**

This procedure will involve: no morphine & NO fentanyl please

Intravenous analgesia ☐ Inhaled analgesia (Entonox) ☐ Sedation ☑ None ☐

Following a request for further information: Statement of the healthcare professional

With appropriate knowledge of the proposed procedure, I have explained the procedure to the patient, in particular:

The intended benefits of the procedure:

Bowel screening colonoscopy

The possible risks involved. I have discussed and listed below the significant, unavoidable and/or frequently occurring risks, including any risks that may be of specific concern to the patient:

Risks specific to colonoscopy are bleeding, perforation and missed pathology, infection, incomplete procedure, mould - a risk discussed. Pt has read booklet + is aware of risks.

The benefits and risks of alternative treatments that might be offered for this patient – including the option of no treatment: no investigations / CT colonoscopy

Any extra procedure(s) that might become necessary during this procedure

e.g. blood transfusion ☑ Other procedure (please state) ☐

Healthcare Professional's signature: E Baillie Print name and job title: ELE BAILLIE.	Date: 21/4/21

Statement of interpreter (where appropriate)

I have interpreted the information above to the patient/parent to the best of my ability and in a way in which I believe that she/ he they can understand

Signature:	Date:
Print name:	Or, telephone interpreter ID number:

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To the patient

You have the right to change your mind at any time, including after you have signed this consent form.

I have read and understood the information in the patient information leaflet.

I confirm that the risks, benefits and alternatives of this procedure have been discussed with me and that my questions have been answered to my satisfaction and understanding.

I wish to proceed with the planned procedure.

Signature: D. Berry Print name: D. BERRY	Date: 21/4/21

If signing for a child or young person *(delete if not applicable)*
I confirm that I am a person with parental responsibility for the patient named on this form:

Signature: Relationship to the patient:	Date:

If the patient is unable to sign but has indicated his/her consent, a witness should sign below:

Signature (Witness) Print name: Address:	Date:

Confirmation of Consent (where the procedure/treatment has been discussed in advance)

On behalf of the team treating the patient, I have confirmed with the patient that she/he has no further questions and wishes the treatment/procedure to go ahead.

Healthcare Professional's signature: E Baillie SN Print name and job title: ELE BAILLIE	Date: 21/4/21

Withdrawal of patient consent

The option of withdrawing consent has been discussed and agreed by the team treating the patient.

Signature: D Berry Print name: D. BERRY	Date: 21/4/21
Healthcare Professional's signature: E Baillie SN Print name and job title: ELE BAILLIE SN.	Date: 21/4/21

NHS Lothian

Addressograph or	Arrived in .....unit for procedure
F600065926A F 03/07/1965 Berry, Deborah F Flat 4, [illegible] 366 West Granton Road, Deborah Edinburgh, EH5 1FE [illegible] CHI 0307651525 70573 LA MacDonald CHI	Date: & time: GP Name Dr MacDonald Address Crewe Medical Centre EH5 2LH 01315525544
Tel. number 07955115357	Religion Nil. Ethnic Origin Caucasian
Next of Kin: Name/address Husband - James. Tel. number(s):home 07955100276. mobile	**Consultant:** **Proposed Procedure: with Sedation** Yes ☑ No ☐ ☑ Colonoscopy ..... ☐ Endoscopy ..... ☐ Flexible Sigmoidoscopy ..... ☐ Pouch Endoscopy ..... ☐ *Other* .....
ALLERGIES: Intolerance to Morphine, codeine + fentanyl. document if pt has no known allergies/sensitivities	**Other** ☐ ..... Proposed date: WGH 21/4/21 & time: 1330 Date confirmed by patient as suitable ☐

KEY TO INITIALS OF ALL STAFF COMPLETING THIS ICP

	Print name	Designation	Initials	Signature	date
1	Jill Crawford	CNS	JC		24/3/21
2	E VERBAILLIE	SN	EB	EVerbaillie	21/4/21
3	N MCDERMID	SN	NM	N McDermid	21/04/21
4	Samantha Mac	SN	SM	Mac	21-4-21
5	Sinead Ryan	STN	SR	Sinead Ryan	21/04/21
6	M MCINTYRE	SN	MCM	M McIntyre	21/04/21
7					
8					

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

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

c) **MOBILITY**: Wheelchair Y (N), Walking Aid (Y) N ☐. requires: Hoist ☐ elbow crutches
FALLS RISK ASSESSMENT REQUIRED Y / N

EJKM 760
8/3/21

d) **HOSPITAL TRANSPORT**: Required N ☑, Y ☐. If Yes, reason why .....
If Ordered date: Type Ref No.....

An Integrated Care Pathway is intended as a guide to treatment & an aid to documenting patient's progress.
Clinicians are free to exercise their own professional judgements as appropriate.
Alterations to the care noted is recorded as a Variance ['VAR'] & explained in Variance section at the end.

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severity, frequency, duration, recent changes : what where how etc .

Patient to complete this Pre-Procedural Assessment

for information for the staff to know before the procedure

Clinical Assessment

Have you ever had any of the following:	No	Yes
1. Heart attack or Stroke	✓	
2. Angina / Chest Pains on exercise or at night.	✓	
3. Heart murmur	✓	
4. Heart Valve replacement	✓	
5. Do you have a Pacemaker	✓	
6. High Blood Pressure		✓
7. Asthma or Bronchitis		✓
8. Shortness of Breath SOBOE		✓
9. Diabetes	✓	
10. Epilepsy	✓	
11. Glaucoma	✓	
12. Could you be pregnant?	✓	
13. Do you use recreational drugs	✓	
14. Any noticeable weight loss over last 3-6 months?	✓	
15. Have you ever been contacted as 'at risk of CJD' (CreutzfeldJacob disease)for public health purposes?	✓	

Nurse comments in shaded areas

Just completed anti Bx

If YES: Insulin ☐, Diet ☐, or Tablets ☐

Nurse record of BM [redacted]

Non Smoker
Alcohol - none

Are you taking any of the following medication:	No	Yes
i) Clopidogrel	✓	
ii) Warfarin	✓	
iii) other anticoagulants (blood thinning drugs)	✓	
If yes, did you receive instructions about stopping?		

If YES: INR result

What were they?.....

CURRENT MEDICATIONS – including complementary medicines / vitamins etc *Tick if none* ☐

Drugs	dose	frequency	Drugs	dose	frequency
1 Duloxetine	✓		7 Amlodipine	✓	
2 Atorvastatin	✓		8		
3			9 Perindopril	✓	
4 Mirtazapine	✓		10		
5 Bisoprolol	✓		11 Tramadol	✓	
6 Omeprazole	✓		12 Diphenoxylate	✓	

* * **Staff –be aware that 'Allergies & Sensitivities' are to be noted on front cover** * *

Have you had previous operations (including what, where, dates etc) & were there any complications

Appendix 2007

Please list any other health problems

neuromodulation device

Chronic fatigue syndrome
Chronic back pain - Joint pain,

Would you like any information to be discussed in private YES ☐ NO ☐

Admitting Nurse initials ..EB..... date 21/4/21 time 1330

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PRE-PROCEDURE CHECKS

PRE-PROCEDURE ONCE-ONLY MEDICATIONS on 'Prescription Administration chart – p.7

CHECKLIST	WARD		Endoscopy		notes
Orientation to the ward/dept./unit	(Y)	N			
Patient identification checked & name band(s) applied	(Y)	N	(Y)	N	
ALLERGIES RE-CHECKED (same as on front cover)	(Y)	N	(Y)	N	morphine, codeine fentanyl.
Correct procedure	(Y)	N	(Y)	N	
Pre, Peri and Post procedure care explained	(Y)	N			
Explanation of withdrawing consent during procedure	(Y)	N	Y	N	
Ensure baseline obs & weight recorded (Obs chart pg 4)	(Y)	N			
Last food: date 20/4/21. time 0930.	(Y)	N	✓		
Last drink: date 21/4/21. time 1000.	(Y)	N	✓		
Bowel prep taken / phosphate enema given or N/A ☐	Y	N	(Y)	N	Moviprep
Taken routine drug therapy	(Y)	N			
Any limitations to movement identified: *If YES, Specify*	(Y)	N	Y	N	neuro Battery pack in button
Any other relevant issues identified:	✱ Backpain ✱				
Jewellery REMOVED/TAPED or N/A ☐	(Y)	N	Y	N	
Belongings secured	(Y)	N			
Hearing Aids in situ: L R or N/A ☑	Y	N	Y	N	
Dentures in situ: Top / Bottom / Full or N/A ☑	Y	N	Y	N	
Glasses sent with patient or N/A ☐	(Y)	N	Y	N	
Spare Stoma bag sent or N/A ☑	Y	N	Y	N	
Ask patients permission for presence of medical student / work experience student					
Consent signed	(Y)	N	(Y)	N	
Pre procedure Nurse check: initials* EB					date 21/4/21 time 1330
Endoscopy Nurse initials*					date 21/04/21 time 1520

intials can be used IF the staff member has signed in on the 'Initial table' on page one
otherwise, full name / print / designation is required.

Bowels
BO daily
occasional blood on paper
no abdo pain

FH- Mum - diverticular, ? malignancy. aged 60's.

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Pre-, Peri-, Post-procedural observations

date 21/4/12

Ht (m) Wt(kg) 106 BMI	Time Hr : min	O/A 1410	1530	1545	1605	1615	RTW 1625	1655						
Oral Airway	or N/A ▯	SV	SV	SV	SV	SV	SV	SV						
Oxygen Therapy (L / Min)	or N/A ▯	RA	RA	ENT	ENT	RA	RA	RA						
Oxygen Saturation	or N/A ▯	97	98	99	99	94	95	97						
Respiration	or N/A ▯	16	14	14	12	12	13	14						
Sedation Score	or N/A ▯	0	0	0	0	0	0	0						
Pain Score	or N/A ▯ back pain	5	→	→	→ 5	5	0	0						
Nausea Score	or N/A ▯	0	0	4.5		0	0	0						
Procedure site checked	or N/A ▯	NA												
Blood Loss	or N/A ▯	0												
Blood sugar	or N/A ▯	NA												
Temp	or N/A ▯	36.6					36.1	36.2						

Chart (scale 200 / 150 / 100 / 50): 132, 145, 66, 66, 84, 72, 79, 73, 89, 85 [partly illegible]

SCORING SYSTEM
see table below

Pain: - use 0 – 10 scoring system

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
Assess. Using guidelines, Prescribe/give analgesia as Appropriate for the patient. REVIEW
6-10
Assess. Using guidelines, Prescribe/give analgesia as Appropriate for the patient. REVIEW

Blood Loss or N/A ▯
0 None
1 Slight
2 Heavy

[Record 'Drugs given' on table across]

Sedation		**Nausea**	
0	None, patient alert	0	None
1	Mild, occasionally drowsy, easy to rouse	1	Mild nausea, no treatment required
2	Moderate, frequently drowsy, easy to rouse	2	Nausea/vomiting helped by Rx
3	Severe, somnolent, difficult to rouse	3	Persistent nausea / vomiting despite Rx
S	Normal, sleep, stirs to light touch	S	Score S if sleeping normally

Endoscope label

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Dob CHI 0307651525
Unit 70573 LA MacDonald

PRESCRIPTION & ADMINISTRATION RECORD

Clinical area .....3.....

ONCE ONLY

Date	Time	Medicine (Approved name)	Dose	Route	Prescriber - sign + print	Time given	Given by
		OXYGEN	L	NASAL/ORAL			
21-4-21	1545	ENTONOX	50/50	inhale	JMiller	1545	

PERI-PROCEDURE CARE

time, initials

Cannula site (L) Hand Size 22g Skin Prep ☒ JM 15:30.
Handwash ☒ Gloves ☒ Aseptic Insertion ☒ Dressing labelled ☒
Difficulties/complication/deviation from standard technique Y (N) NB: 1x failed attempt.

BIOPSIES TAKEN OESOPHAGEAL ☐ GASTRIC ☐ DUODENAL ☐
CLO TEST ☐ COLON ☐ POLYP/S ☐ OTHER ☐ None

Oral Suction required Y ☐ or N/A ☒

Diathermy: none required ☒
Monopolar ☐, Bipolar ☐ site .....

Patient Nurse: initials* VO date 21/04/21
Endoscopy Nurse initials* SC date 21-4-21.

* initials if signed in on page 1 'Initials table'

POST-PROCEDURE:

Procedure performed Upper GI Endoscopy ☐ Colonoscopy ☒ Flexible Sigmoidoscopy ☐
ERCP ☐ Other (please specify) BS

PROCEDURE SUMMARY: procedure comfort mild ☒, moderate ☐, severe ☐

Bowel screening - normal scope

Follow-up required: N/A ☒, Yes ☐ If YES, *specify*
Please refer to discharge summary Y☐ N/A ☒

SPECIFIC INSTRUCTIONS TO STAFF POST-PROCEDURE

Patient can DRINK Y ☒ NO ☐ after 30 mins ☐
Patient can EAT Y ☒ NO ☐ after 30 mins ☐
Suitable for NURSE-LED DISCHARGE (YES) / NO

Endoscopist print J.Miller signature JMiller
designation STB date 21/4/21 time 16.10

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POST PROCEDURE and DISCHARGE CRITERIA

POST PROCEDURE			initials	Comment overleaf
1	Trolley lowered, bed rails in situ, buzzer given	Y, N/A	initials	
2	**Observations** recorded:			
	on return time 1625	Y, N/A	SR	
	at 30mins 1655	Y, N/A	SR	
	after 1 hour	Y, N/A	SR	

NOTE: Obs regime to follow is O_2 sats, TPR, BP Sedation, Pain & Nausea scores [recorded on pg 4]

DISCHARGE CRITERIA			initials	Comment overleaf
1.	Discharged by Endoscopist	Y, N/A	SR	
2.	Transport home arranged collection time: own	Y, N/A	SR	
3.	Vital signs stable & satisfactory	Y, N/A	initials	
4.	Alert & orientated (as on admission)	Y, N/A	SR	
5.	Pain controlled	Y, N/A	SR	
6.	Nausea controlled, no vomiting	Y, N/A	SR	
7.	Tolerating fluids/diet [If Throat Spray, drink at 30mins after receiving spray]	Y, N/A	SR	
8.	Mobilising as on admission	Y, N/A	SR	
9.	Patient told if further pathological specimens will be available, from whom and when	Y, N/A	SR	
10.	Discharge information given	Y, N/A	SR	
11.	Out Patient appointment given	Y, N/A	SR	
12.	IV cannula removed	Y, N/A	SR	
13.	Has passed urine	Y, N/A	SR	
14.	Identity bracelet removed	Y, N/A	SR	
15.	Collected by a responsible adult	Y, N/A	SR	
16.	Responsible adult at home for first 24h	Y, N/A	SR	
	Discharge Criteria met ? Yes ☑ No ☐* (record as variance)		SR	
	Patient discharged, or, back to Relative/Carer/Support person ☐ or N/A ☑		SR	
	Time patient left department 1715		SR	

If Overnight in hospital, record a Variance & start a new post-procedure care record.

VARIANCES: all staff to identify & record variances *further Variance Sheet are available*

note Variance code letter: A = patient, B = clinician, C = hospital system, D = external / community

Record of Variance

date	time	Description of issue	Reason	Action	Initials	Var. code
/	:					

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Multidisc **problems**

Time	ns required, etc + signature, print name & designation

[-]
[-]
[ ]
[-- WASH CYCLE PASSED --]
[ ]
[-]
[-]
[Cantel RapidAER]
[Serial No RAD063]
[-]
[Start 14h 08m]
[End 14h 30m]
[Date 21-04-2021]
[-]
[Cycle No 16880]
[-]
[Load Operator 60]
[Name Robert Dutton]
[-]
[Unload Operator 18]
[Name ronnie]
[-]
[-- Hookup --]
[CANTEL RAHD19]
[Serial No 000636]
[GS1]
[-]
[-- EndoScope --]
[OLYMPUS CF-HQ290L]
[Serial No 2953174]
[GS1]
[-]
[IMS Verify Enabled]
[-]
[Control Pass]
[IMS Verify Pass]
[-]
[Contact Time 5 Minutes]
[-]
[Last SO 21-04-2021 at 06h 14m]
[-]
[Suction Av Flow 1735 ml]
[Biopsy Av Flow 946 ml]
[Water Av Flow 203 ml]
[Air Av Flow 197 ml]
[Aux 1 Av Flow 173 ml]
[Aux 2 Not tested]
[RB Not tested]
[Leak Test Av Pres 203 mb]
[-]
[-- Conductivity --]
[Detergent 1587 uS]
[Disinfectant 1365 uS]
[Final Rinse 2 uS]
[-]
[-- Temperature --]
[Detergent 24.6 deg]
[Disinfectant 26.1 deg]
[Final Rinse 20.7 deg]
[-]
[-- Chemical Batch/Lot & Serial No --]
[Detergent 00052820/D000000309]
[Part B 00074420/B000001544]
[Part A 00001721/A000001219]
[-]

VARIAN **ırd variances** *further Variance Sheet are available*

Types of V Variance code letter where possible

A – patient ospital system, **D** – external / community

IRecord of

date	time	ion	Action	Initials	Var. code
/	:				
/	:				
/	:				
/	:				

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Multidisciplinary Progress notes / problems

Time	include action taken, investigations required, etc + signature, print name & designation
26/3/21	PAC completed. No issues with COVID criteria. PGD completed. Pt for sedation - husband will collect. Accepted 1st available appt 21/4/21 1330 WGH. DE.

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(adapted for Endoscopy Unit, WGH NHS Lothian)

NHS Lothian

DATE	21-4-21
ROOM	3
SITE	WGH
OPERATOR	MR Duff / MS J Mullay
PROCEDURE	Colonoscopy (BS)

Please complete ALL boxes

SIGN IN (To be read out loud) Pre-procedure	YES	NO
Member verbally confirms with the team:	(YES)	
All staff followed hand hygiene protocol?	☑	☐
Patient confirmed his/her identity, procedure and consent	☑	☐
Discussion with patient raising R. arm to withdraw consent during procedure	☑	☐
Correct case notes available?	☑	☐
Confirmed scope number and label match and scope within time limit	☑	☐
Confirm endoscopist & nurse checked medication	☐	N/A ☑ — entonox.
Confirm with endoscopist amount given	☐	N/A ☑
Initial or Signature:	SL	

SIGN OUT (To be read out loud) Post-procedure	YES	NO
Member verbally confirms with the team:	(YES)	
All staff followed hand hygiene protocol?	☑	☐
Have the specimens been labelled correctly	☐	N/A ☑
Is a follow up appointment required?	☐	N/A ☑
Patient follow up details placed in relevant sheet in secretary's office	☐	N/A ☑
Confirm amount medication being discarded	☐	N/A ☑
Initial or Signature:	SL	

Please record any issues identified

No issues

Bowel Screening "Scots Criteria" checklist

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DATE 24/3/21

Checklist completed by – SEB/JC/NB ☑

Criteria Assessment Checklist- 1st Telephone Call

	Please circle
Has the Patient had Symptoms suggestive of Covid 19 ?	YES (NO)
Has the Patient come in to close contact with a known or suspected case of Covid 19 ?	YES (NO)
Does the Patient s Occupation mean they are exposed to Covid 19 ?	YES (NO)
Has the Patient Travelled and Returned from outside the Country ?	YES (NO)
Is the Patient in a Shielded catagory ?	YES (NO)

If the patient answers "**YES**" to any of the above questions please give the appropriate advice outlined on the SCOTS Criteria Pathway ☐

Does the patient require a reassessment of the SCOTS Criteria in 14 days? YES ☐ NO ☑

Have any negative changes to health or medication occurred since the initial pre assessment call YES ☐ NO ☐

If the Patient reports any health or medication changes that may alter suitability for Colonoscopy at this time, please consult with Sheila/Jill or Dr Noble in the usual manner ☐

Outcome of Consult- Patient to Proceed to Colonoscopy ☐

Patient to Defer till Post Covid 19 ☐

If all the above questions are answered "**NO**" patients can be offered a DATE/TIME for colonoscopy ☑

Egfr > 30 and PGD/ prescription completed for Bowel Preparation ☑

DATE of colon appt	DATE to be called	Place patient label here

PRE COLONOSCOPY

SCOTS Criteria call 3 days prior to Colonoscopy completed by SEB/JC/NB/JS/NT ☐

	Please circle
Has the Patient had Symptoms suggestive of Covid 19 ?	YES NO
Has the Patient come in to close contact with a known or suspected case of Covid 19 ?	YES NO

Any questions answered "YES" Patient should be transferred to speak to SEB/JC/NB ☐

Colonoscopy to be cancelled due to Symptoms or Contact and appropriate advice given to patient

YES ☐

Patient to be re assessed using SCOTS Criteria in 14 days? YES ☐

Both questions answered "NO" Patient to proceed with Colonoscopy YES ☐

POST COLONOSCOPY

SCOTS Criteria call 7 days POST Colonoscopy completed by ☐

	Please circle
Has the Patient had Symptoms suggestive of Covid 19 develop since their Colonoscopy ?	YES NO

SCOTS Criteria call 14 days POST Colonoscopy completed by ☐

	Please circle
Has the Patient had Symptoms suggestive of Covid 19 develop since their Colonoscopy ?	YES NO

This checklist must be completed by the nurse completing the Patient Group Direction for the oral bowel cleansing agent moviprep and must be filed in the

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ressograph
name.....
..... Date of Birth .....
.....
.....

If any of the following apply refer to authorised prescriber.

	Please circle
Congestive cardiac failure	YES (NO)
Ileus	YES (NO)
Ileo anal pouch	YES (NO)
Renal impairment or dialysis	YES (NO)
Pregnancy	YES (NO)
Known or suspected gastrointestinal obstruction or perforation	YES (NO)
GI ulceration	YES (NO)
Disorders of gastric emptying e.g. gastroparesis	YES (NO)
Toxic megacolon	YES (NO)
Acute surgical abdominal conditions e.g appendicitis	YES (NO)
Severe acute inflammatory bowel disease	YES (NO)
Dehydration	YES (NO)
Toxic colitis	YES (NO)
Known hypersensitivity to any ingredient	YES (NO)
Impaired consciousness	YES (NO)
Known previous adverse reaction, allergy or sensitivity	YES (NO)
Ileostomy	YES (NO)
Phenylketonuria	YES (NO)
G6PD deficiency	YES (NO)
Impaired gag reflex, or with a tendency to aspiration or regurgitation	YES (NO)
Under 18 years of age	YES (NO)
eGFR <30mls/min/1.73m2	YES (NO)

Renal function must have been checked in the last 3 months.

eGFR=.....76.....ml/min/1.73m2 Date of result 08/03/2021

eGFR > 30mls/min/1.73m2 – proceed with Moviprep
eGFR < 30mls/min – refer to authorised prescriber

REVIEW MEDICATIONS – *circle whether patient taking any of the following medication.*		
Non steroidal anti-inflammatory drugs (e.g. Ibuprofen, diclofenac)	Y	N
Diuretics (e.g. Furosemide, bendroflumethazide)	Y	N
Iron preparations (e.g. ferrous sulphate)	Y	N
Warfarin, clopidogrel	Y	N
Oral contraceptives	Y	N
Oral anti-diabetic drugs	Y	N
Insulin	Y	N

If **YES** to any of the above – advise as per PGD advice. Refer to authorised prescriber if in doubt.

Instructions provided to the patient

VERBALLY YES NO

Patient information booklet sent YES NO

NAME and SIGNATURE of NURSE completing checklist. Name Jill Crawford

Signature

Date 26/3/21

Moviprep pack details:

Batch Number 7760081

Expiry Date 30.5.23

Comments

Entonox Administration Sheet

The protocol must be available and adhered to at all times during the self-administration of Entonox. A prescription chart must be completed unless administered under a PGD.

600065926A F 03/07/1965
Berry, Deborah F
Flat 4,
366 West Granton Road,
Edinburgh,
EH5 1FE
CHI 0307651525
70573 LA MacDonald

Date: 21-4-21

Time: 15 30

Procedure: Colonoscopy (BS)

Prescription chart completed by: [signature]

Duration of self-administration	Pulse	Respiratory Rate	O_2 Saturations
Start: 15 45	66	14	99
Finish:			

Checklist for contraindications
(if yes to any question seek advice from medical staff)

Head injury or altered GCS	YES/ (NO)
Maxillofacial injury	YES/ (NO)
Alcohol intoxication	YES/ (NO)
Pneumothorax or chest trauma	YES/ (NO)
Respiratory Problems SOBOE	(YES)/ NO
Recent decompression illness or recent dive (within 24 hr)	YES/ (NO)
First sixteen weeks of pregnancy	YES/ (NO)
Middle ear occlusion	YES/ (NO)
Infection (see decontamination guidance)	YES/ (NO)
Vitamin B12 deficiency	YES/ (NO)

* Pt recently furnished course of antibiotics for Bronchitis but Mr Duff happy to go ahead with Entonox —— Sleaa S.N

THE SKIN CANCER SCREENING CLINIC

NHS Lothian
DEPARTMENT OF DERMATOLOGY
Lauriston Building,
Lauriston Place, Edinburgh EH3 9HA

NEW TUMOUR PATIENT

600065926A F 03/07/1965
Berry, Deborah F
190 PILTON AVENUE,
Edinburgh,
EH5 2LG

CHI 0307651525
70573 SC Duerden

Date: 1/10/21 Consultant: [illegible]

Skin Type: 1 2 3 4 5 6

Immunosuppression: No Yes

Screening Examination: (Full) Upper half Patient declined

No.	Diagnosis	Location	Size	Management	Description / Comments
1	flat seb k x 2	(R) ext knee		reassure	4mm flat [illegible] smooth
2					brown macule [illegible]
3					smaller lesion adjacent
4					NO SCC
5					

Background / Relevant Medical History / Other Issues

6/12
rough

Checklist For Patients Requiring Surgery	
Clinical Photography	
Drug Allergies / Intolerances	
Infection Risk (Hepatitis / HIV)	
Implantable Electric Devices	
Anticoagulants / Antiplatelets	
Capacity / Consent Issues	

Outcome: (Discharge)

Surgical List
☐ Same day
☐ Booked list
☐ Mohs surgery

Follow-up

Refer to

Assessor Name: [illegible]

Grade: Cons

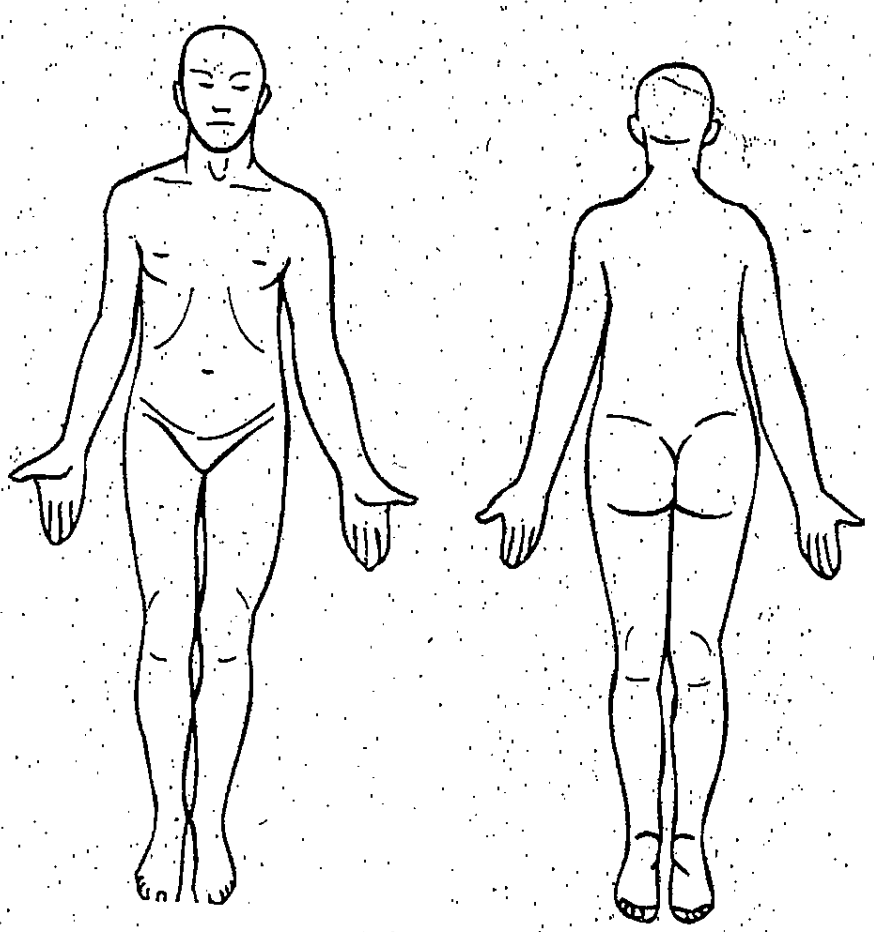
Chaperone (if required)

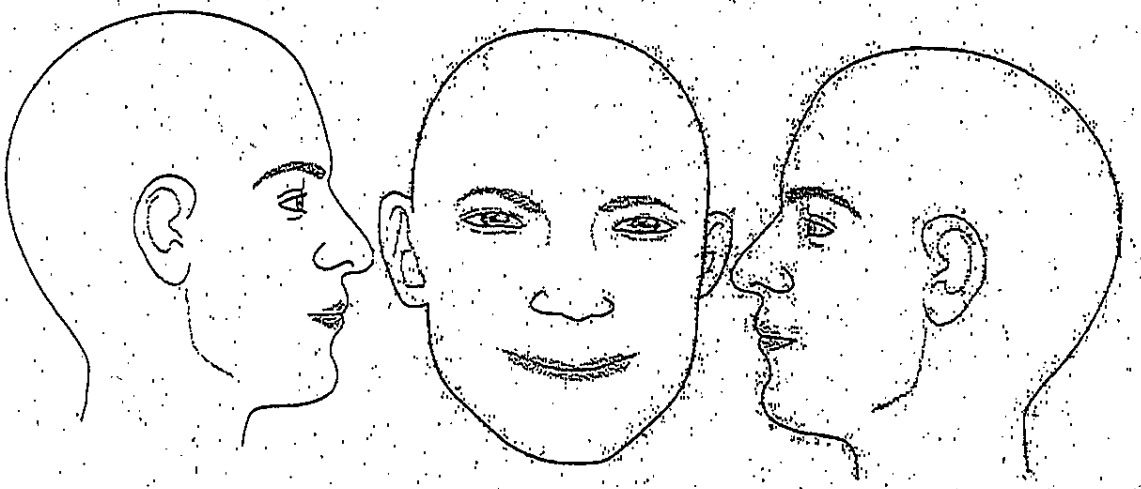
THE SKIN CANCER SCREENING CLINIC

NHS Lothian

DEPARTMENT OF DERMATOLOGY
Lauriston Building,
Lauriston Place, Edinburgh EH3 9HA

SKIN MAP





NHS Lothian

Immediate Outpatient Letter

Serial number 735780

IN CONFIDENCE

Hospital : WGH Department : Cardiology Consultant : Henderson

Name and address of General Practitioner	Mr/Mrs/Miss	Unit No.:
Dr Dalgleish Crewe Medical GP.	Surname:	Date of Birth:
	First Name:	
	Address:	
	Weight (where applicable)	

Your patient attended the clinic on: 20/03/23

Recommendations/comments:

Follow-up advice: To attend hospital for further review in 4 months.

To attend GP surgery Y / N

Follow-up required Y / N

Medication: The following medicines are recommended. Only those items that must be initiated immediately have been provided from the hospital pharmacy, as indicated under the 'Quantity to be provided' section.

Pharmacy use:

Medicine and Form	Dose	Administration Times					Additional Instructions (including length of treatment course)	Quantity to be provided *	LJF **	Dispensed/ Issued by:	Checked by:
1. GTN Spray	2 puffs		PRN								
2.											
3.											
4.											
5.											
6.											

N.B. * A 14 day supply should be provided from the hospital if required unless a shorter or longer course is appropriate.

** Tick the box if the medicine is not on the Lothian Joint Formulary, and include an explanatory note for non-Formulary medicines under Recommendations/comments.

Prescribed by : _____ (sign) Date : 20/03/23

R TURNER (print)

Contact for advice : _____ Tel/bleep no. : 8102

WHITE COPY - TO PHARMACY *PINK COPY - G.P.* *BLUE COPY - CASENOTES*

RIE 334

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.	E5825688
Previous no.	E4995648
UHPI no.	600065926A
CHI no.	0307651525

Patient Information

Surname	Berry	Date of Birth	
Forenames	Deborah Frances	Age / Sex	59 Yrs / F
Address	190 Pilton Avenue		03/07/1965
Postcode	EH5 2LG	Telephone	07955115357
Contact Address	Sneddon, Keiran	Telephone	H W
Complaint	PC- GASTRIC BYPASS SURGERY DONE IN TURKEY LAST WEE	Allergies	

Attendances in last 12 months: 0 School :

General Practitioner

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

Date and Time of Attendance	02/10/2024 11:49
	Incident Date Time:
Mode of Arrival	02/10/2024 10:07
	Private Transport
Source of Referral	Flow Centre

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									
O 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				Blood Samples - Please tick all that apply				Additional Investigations		
Handwash		Gloves		Routine		CRP		ECG - Please tick		
CHD Skin Prep		Aseptic Insertion		Troponin		Coag		Required ☐ Done ☐		
Dressing Labelled		Paperlite Bundle		Amylase		Tox Screen		Urinalysis - Please tick		
Reason for PVC Insertion:				BTS		Other (Please state)		Required ☐ Done ☐		
On Going Care Plan								MSU Sent	Yes ☐	No ☐
Speciality Informed (enter time)		Bed Required		Triaged To - Please tick				HCG Consent	Yes ☐	No ☐
Surg:	G.I:	Yes ☐	No ☐	Waiting Room		GP Out of Hours		HCG Result	Yes ☐	No ☐
Vasc:	Stroke:	Transfer To: (Please tick if required)		Resus		Gynae Triage		X-Rays - Please tick		
Medics:	Gynae:	WGH		HD		SMMP		CRX	Yes ☐	No ☐
Ortho:	Neuro:	SJH		IC		MIU		CT Scan	Yes ☐	No ☐
Other (state Specialty)		Other (please state)		Exam		Other (Please state)		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

600065926A /E5825688 F
BERRY Deborah
03-Jul-65 CHI: 030 765 1525
70573 J Cooney
190 Pilton Avenue
EH5 2LG

General Surgery SBAR

S — SITUATION:

Patient Name and CHI:

Date 2/10/24 Location SOU

Consultant ...Mr....Arthur.....Zanellato.....

Presenting complaint, clinical symptoms:...Abdo....pain..).gastric.....

...Sleeve....in....Turkey.....25/09.....

B — BACKGROUND:

Allergies: MORPHINE, FENTANYL Relevant patient history....CAD.....

...Angina...ME.....

Social History /POC .....Mobility.....Ind sem assist

NAD WHEELCHAIR

A — ASSESSMENT:

Most recent vital signs @: 01:45

Temp. 18 HR 83 RR 18 BP 137/77 SaO2 94 % on NA O2

NEWS 1

Neuro Obs GCS:

Deranged Bloods: CRP 39

Lactate:.....

Infection Risk/Trak Alert..... ? CRE. Inform ward if cubicle required.

R — RECOMMENDATIONS:

Differential Diagnosis..... ? Perf or infection

Current Care:

IV FLUIDS ☒ **IV ABX** ☒ **NBM** ☐ **D+F** ☑ **CF** ☐ **FF** ☐

ANALGESIA ☑ **Gent level@** __:__

Scan Results/Plan: CT/AP ☑ – no perf or concerning

Is DNACPR form in place: Y/N

SBAR COMPLETED BY:

Designation, Sign & Print: [signature] Z. Oxley (85)

Ward: COU Site: RIE Date: 2/10/24

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 Daniel Amoni

600065926A /E5825688 F
Name BERRY Deborah
03-Jul-65 CHI: 030 765 1525
DOB 70573 J Cooney
190 Pilton Avenue
EH5 2LG
Unit no. /C

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											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											
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	B											
Mattress type / Cushion type	*please state type:*											
Elimination												
Do you need the toilet?	Y											
Is the patient continent of urine? (at time of Care Rounding)	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)	N											
Bowel function monitored	Observe bowel function and update daily											
Food, Fluid & Nutrition												
Would you like a drink? Ensure fluids are within easy reach	N											
Fluid Balance Chart (if clinically indicated)	N/A											
When did you last eat?	01/10											
(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											
Falls												
Appropriate Footwear?	Y											
Walking aid available(and within reach)	N/A											
Area de-cluttered?	Y											
Chair and bed height assessed?	Y											
Falls alarm in use and attached?	N/A											
Glasses available for use? (if worn) Hearing aid available for use? (if worn)	Y N/A											
Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐												
Pain												
Are you in pain?	N											
Analgesia Given?	N											
General												
Peripheral Venous Cannula observed?	N											
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?	N											
Buzzer within easy reach	Y											
Personal Care *Type* _____ *(specify)* **Time Given** _____												
Initials – document at time of care delivery	DM											

Ward: 106 Site: RLE Date: 3.10.24

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 Eleanor O'HARKIN

Addressograph, or

600065926A /E5825688 F...
BERRY Deborah
03-Jul-65 CHI: 030 765 1525
70573 J Cooney
190 Pilton Avenue
EH5 2LG

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	0230	0435										
	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)	AS	AS										
Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister	NS	NS										
Vulnerable areas? (circle areas of damage)	Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other.....											

If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan

Have you changed position since last CR?	I	I										
Positioning (R) or (L) side (B) Back (C) Chair	L	B										
Mattress type / Cushion type	*please state type:* Pentaflex											

Elimination

Do you need the toilet?	AS	AS										
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	AS	AS										
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)	AS	AS										

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?	AS	AS										
Analgesia Given?	↓	↓										
Peripheral Venous Cannula observed?	↓	↓										

General

Observe for signs of inflammation/swelling at every CR session. **Bundle/VIP score to be updated daily**

Are you comfortable? Y/N	AS	AS										
Anything else I can do for you?	↓	↓										
Buzzer within easy reach	↓	↓										

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

Initials – document at time of care delivery	MK	MK										

Ward: L06 Site: R1F Date: 3/10/26

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 K Islam

Addressograph or

600065926A /E5825688 F

Name BERRY Deborah

DOB 03-Jul-65 CHI: 030 765 1525

70573 J Cooney
190 Pilton Avenue
EH5 2LG

Unit

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	0805	1315										
	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	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									
	Positioning (R) or (L) side (B) Back (C) Chair	B	R									
	Mattress type / Cushion type	*please state type:* PENTAFLEX										
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?	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									
	Bowel function monitored	Observe bowel function and update daily										
Food, Fluid & Nutrition	Would you like a drink? Ensure fluids are within easy reach	N	N									
	Fluid Balance Chart (if clinically indicated)	Y	Y									
	When did you last eat? liquid diet	LS	LD									
	(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	Y									
	Area de-cluttered?	Y	Y									
	Chair and bed height assessed?	Y	Y									
	Falls alarm in use and attached?	NA	NA									
	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?	N	N									
	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	KI	DR										

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													

600065926A /E5825688 F
BERRY Deborah
03-Jul-65 **CHI:** 030 765 1525
70573 J Cooney
190 Pilton Avenue
EH5 2LG

ADULT FLUID PRESCRIPTION CHART

NHS Lothian

Date 21/10/24 | Sheet no 1

Ward 30U

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 / RIC	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	Plasmalyte Gooo	85					/				
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)

Na 600065926A /E5825688 F
BERRY Deborah
03-Jul-65 CHI: 030 765 1525
70573 J Cooney
Da 190 Pilton Avenue
EH5 2LG
Ch

ADULT FLUID PRESCRIPTION CHART

NHS Lothian

Date 3/10/24 | 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 3 / 10 / 24

ADULT FLUID BALANCE CHART

Name: _____ **Total Input Goal:** _____ ml in 24hr

CHI/Unit No. **Today's PEG/NG Feed:** _____ ml/24hr **TPN** _____ ml/24hr **Fluid Restriction:** _____ ml in 24hr

	IV FLUIDS or SC FLUIDS IV MEDICATION	Line 1	ORAL INPUT		ENTERAL: NG/ PEG / RIG	TPN/Other Line 2	URINE		GASTRIC	DRAIN 1	DRAIN 2 OTHER
	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100 ml	Volume	Volume	Volume	Running Total	Volume	Volume	Volume
06.00	Plasmalyte	95					/				
07.00		95	Water	100			/				
08.00		95	Coffee	200			/				
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)

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

NHS Lothian

600065926A /E5825688 F
BERRY Deborah
03-Jul-65 **CHI:** 030 765 1525
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190 Pilton Avenue
EH5 2LG

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

Previous Adverse Reactions	Weight	Date
Morphine, Fentanyl	kgs Actual / Estimate	02/10/24

Once Only Prescription

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber Sign & Print	Time Given	Issued by (Initials)	Checked by if applicable (Initials)
		Dihydrocodeine	30mg	Oral	[signature] F Ion	2130	[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:	02/10																					
	Time:	1206																					
A+B Respirations Breaths/min	≥25										3												
	21-24										2												
	18-20																						
	15-17	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	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												
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																					
	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																					
	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	96									1												
	81-90																						
	71-80																						
	61-70																						
	51-60																						
	41-50										1												
	31-40										2												
	≤30										3												
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°	37.2																					
	36.1-37.0°																						
	35.1-36.0°										1												
	≤35.0°										3												
NEWS TOTAL		1																					
Monitoring frequency		1																					
Escalation of care Y/N		Y																					
Blood Glucose reading or N/A		N/A																					
Pain score (0-10)		5																					
Initials		SN																					

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 .f 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
17:10	Plasmalyte	1000ml	85	[signature] KT	19:20	[illegible]		

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													