NHS
Ayrshire & Arran

University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE

MMA Legal Limited
Stok
43-59 Princes Street
Stockport
SK1 1RY

Date 27/07/2026
Our Ref EL\0902763334
Your Ref 100032
Enquires to Elaine
Telephone 01563 827076

E-mail subjectaccessrequest@aapct.scot.nhs.uk

Dear Sir/Madam

GDPR ACCESS TO HEALTH RECORDS REQUEST
RE: LEE JOHNSTONE – 12 WOODSIDE AVENUE, MAYBOLE, AYRSHIRE, KA19 7PP

I refer to your recent request for access to your client's medical records under the above Act.

I have now had the approval of the relevant Clinicians to provide you with a copy of the remaining notes and enclose herewith the relevant documents.

I would be grateful if you could return the tear-off slip confirming safe receipt of the documents.

Yours faithfully,

E. Lead

pp Mr R H Bryden
Head of Health Records Services

Please return to: **Health Records, University Hospital Crosshouse, Kilmarnock Road, Kilmarnock KA2 0BE**

I acknowledge receipt of the copies of medical records for:

LEE JOHNSTONE 0902763334

Signed: ---------- Date: ----------

Designation: ----------

Confidential - Clinical Information

Department of Respiratory Medicine
University Hospital Ayr
Dalmellington Road
Ayr
KA6 6DX

NHS Ayrshire & Arran

www.nhsaaa.net

Dr M Barr
Maybole Medical Practice
The Surgery, The Health Centre
6 High Street
Maybole
KA19 7BY

Our Ref:	MP/AM
Hospital No:	
Clinic Date:	10/10/2024
Date Dictated:	10/10/2024
Date Typed:	11/10/2024
Enquiries to	Andy McMath
Direct Line:	01292 617164
Ext. Number:	17164
Email:	

Dear Dr Barr,

LEE JOHNSTONE DOB: 09/02/1976 CHI No: 0902763334
12 WOODSIDE AVENUE, KIRKMICHAEL, MAYBOLE, AYRSHIRE, KA19 7PP

It was a pleasure to see Lee today in Dr Guhan's respiratory clinic.

He had been a patient on Station 8 in July due to a right upper lobe pneumonia. He still describes shortness of breath on exertion however does not report any cough, haemoptysis or night sweats. He does describe some worsening facial skin changes which are increasingly dry particularly along his nasal bridge, folds and back of his neck not relieved by any emollients or antihistamines.

On examination his saturations were 97% on room air and his chest was clear to auscultation. He is still vaping and smoking cigarettes however is actively trying to quit this.

His chest x-ray today in clinic showed that his right upper lobe consolidation had completely resolved. His bronchoscopy samples for AFB came back negative. I have commenced him on Fexofenadine to hopefully help with his allergic dermatitis and we have discharged him from clinic today.

Yours sincerely

Authorised on 14/10/2024 12:59:18 by Mithra Punniamoorthy.

Mithra Punniamoorthy
IMT2 in General Medicine
GMC No 7731132

INVESTING IN VOLUNTEERS

www.nhsaaa.net

STA0238

Write or attach label

CHI: 0902763334
Johnstone, Lee
12 WOODSIDE AVENUE
Maybole
KA19 7PP
09/02/1976
Dr M Barr
MRN: A100544212

DATE

10/10/24 1500 Weight - 97.4kg N/A LOUISE TAYLOR

Δ RUL pneumonia

SOBOE, ø cough ø haemoptysis ø night sweats
Worsening skin changes, dyspnoea + wheezy
not relieved by antihistamines

ø weight loss

O/E Chest clear Sats 97% RA

Calves SNT

SHx: vaping / cigarettes

CXR - resolving RUL consolidation

negative AFB, histopathology

Ⓟ - restart Fexofenadine

MEDICAL

Confidential - Clinical Information

Department of Respiratory Medicine
University Hospital Ayr
Dalmellington Road
Ayr
KA6 6DX

www.nhsaaa.net

NHS Ayrshire & Arran

Dr M Barr
Maybole Medical Practice
The Surgery, The Health Centre
6 High Street
Maybole
KA19 7BY

Our Ref:	AG/GM
Hospital No:	
Clinic Date:	03/08/2024
Date Dictated:	05/08/2024
Date Typed:	05/08/2024
Enquiries to	Andy McMath
Direct Line:	01292 617164
Ext. Number:	17164
Email:	@aapct.scot.nhs.uk

Dear Dr Barr,

LEE JOHNSTONE DOB: 09/02/1976 CHI No: 0902763334
12 WOODSIDE AVENUE, KIRKMICHAEL, MAYBOLE, AYRSHIRE, KA19 7PP

Mr Johnstone returned for review a week after he was discharged. He is feeling a lot better in himself and the chest x-ray certainly looked improved. Though initially we thought he could have TB we are starting to think he might just have had a rumbling community acquired pneumonia. He has a further review in place in about 6 week's time.

Yours sincerely

Authorised on 07/10/2024 16:29:22 by Anur Guhan.

Dr Anur Guhan
Consultant in Respiratory Medicine, GMC: 5161615

INVESTING IN VOLUNTEERS

University Hospital Ayr Dalmellington Road Ayr KA6 6DX Phone: 01292 610 555	Immediate Discharge Letter & Prescription

To:	Re:
Drs Sheward Partners The Surgery, The Health Centre 6 High Street Maybole KA19 7BY	LEE DAVID JOHNSTONE 12 WOODSIDE AVENUE , KIRKMICHAEL , MAYBOLE , AYRSHIRE , KA19 7PP DOB: 09/02/1976 Hosp. No.: 0902763334 CHI No.: 0902763334

Date of Admission: 20/06/2024
Mode of Admission: Emergency
Admission Reason:
Discharge Date: 27/06/2024

Ward: STATION 8-AYR
Consultant: DR ANUR GUHAN (Respiratory)
Follow Up:

Diagnoses suspected pulmonary TB (cavitating consolidating RUL)

( )

Secondary Diagnoses
RBBB
Asthma
guillian barre syndrome
bahvioral problems
accidental drug overdose

DR MABLE CAESAR DE TORRES (2024-06-27 13:03:32)

estigations

DR MABLE CAESAR DE TORRES (2024-06-27 13:09:41)

Clinical Progress 2 week history of cough with drenching night sweat, loss of appetite and weight loss associate with a wide spread rash on upper and lower extremities. nil recent ravel, nil fever or joint pain Xray showed right upper lobe cavitating consolidtation, managed for penumonia with levofloxacin. After respiratory review TB was supected, therefore levofloxacin was discontinued. (Levofloxacin has Mycobacterium cover)
Sputum AAFB was sent and he also Had a bronchoscopy which was normal, awaiting cytology and AAFB smear and culture.
Many thanks

DR MABLE CAESAR DE TORRES (2024-06-27 13:09:41)

Hospital follow up returning to see Dr guhan at clinic on Tuesday 02/07/2024 at 1pm station 12

DR MABLE CAESAR DE TORRES (2024-06-27 13:04:49)

Discharged by: DR MABLE CAESAR DE TORRES

Report generated on: 27/06/2024 20:00

University Hospital Ayr Dalmellington Road Ayr KA6 6DX Phone: 01292 610 555	Immediate Discharge Letter & Prescription

To:	Re:
Drs Sheward Partners The Surgery, The Health Centre 6 High Street Maybole KA19 7BY	LEE DAVID JOHNSTONE 12 WOODSIDE AVENUE , KIRKMICHAEL , MAYBOLE , AYRSHIRE , KA19 7PP DOB: 09/02/1976 Hosp. No.: 0902763334 CHI No.: 0902763334

Pharmacy nil changes

DR MABLE CAESAR DE TORRES (2024-06-27 13:04:49)

Allergy/Intolerance	Reaction
citalopram	Unknown

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

Drug	Dose	Route	Frequency	Note	GP to continu	POD	Days Supply
FEXOFENADINE 180 mg Tablets	**180 mg**	Oral	ONCE daily at 7am	7 x 180mg tablets supplied	No	N	7
PARACETAMOL 500 mg Tablets	**1000 mg**	Oral	FOUR times daily - 7am;1pm;6pm;10pm PRN FOR PAIN	32 x 500mg tablets supplied	No	N	7
ZEROBASE Cream	**1 Application**	Topical	PRN DRY SKIN		Yes	Y	

Discharged by: DR MABLE CAESAR DE TORRES

Report generated on: 27/06/2024 20:00

University Hospital Ayr Dalmellington Road Ayr KA6 6DX Phone: 01292 610 555	Immediate Discharge Letter & Prescription

To:	Re:
Drs Sheward Partners The Surgery, The Health Centre 6 High Street Maybole KA19 7BY	LEE DAVID JOHNSTONE 12 WOODSIDE AVENUE , KIRKMICHAEL , MAYBOLE , AYRSHIRE , KA19 7PP DOB: 09/02/1976 Hosp. No.: 0902763334 CHI No.: 0902763334

Additional Medicines Information:

Medicines discontinued or modified during admission (Medicines that patient was recorded as admitted on only)	
Drug	**Discontinued / Modified reason**
**** Warning - accuracy of information in this section is dependent on details entered by users of the HEPMA system.**** *****Information here may be incomplete and is for guidance only.*****	

Discharged by: DR MABLE CAESAR DE TORRES

Report generated on: 27/06/2024 20:00

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 101011122697P

REFERRAL LETTER

CHI:0902763334

MEDICAL IN CONFIDENCE

REFERRAL TO

Spinal R5A1
AA Back Pain

Musculoskeletal Triage and Treatment
NHS Ayrshire & Arran

Ethnic Origin	(White) Scottish
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	**Urgent**
Date of referral	01-Apr-2016
Date submitted	01-Apr-2016

PATIENT DETAILS

Surname	Johnstone
Forename(s)	Lee
Title	-
Sex	Male
Date of birth	09-Feb-1976
CHI no.	0902763334

Patient's address

55 Netherthird Road
Cumnock
KA18 3DH

Contact number(s)

Voice: 07802 683 249

REGISTERED GP DETAILS

Name	Dr Mutaz Amin		
GMC code	7020248	GP code	20133
Practice name	Tanyard Medical Practice (17305)		
Practice code	80171		

Practice address

Tanyard Medical Practice
2 Tanyard Cumnock

Contact number(s)

Voice: 01290 421157
Facsimile: 01290 425444

REFERRING PRACTITIONER DETAILS

Name	Dr. Mutaz Amin		
GMC code	7020248	GP code	20133
Practice name	Tanyard Medical Practice (80171)		
Practice code	80171		

Practice address

The Health Centre
2 Tanyard
Cumnock
KA18 1BF

Contact number(s)

Voice: 01290 421157

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: see below

Comment: Dear Colleague, Could you kindly review this patient who presented initially in January after falling on his bottom and developing lower back pain which has been persisting since the slip. He has been taking Co-Codamol 30/500 8 tablets daily and had to drop out of college because of the pain. He is also currently job seeking and is getting a sickline due to being debilitated by this back pain. He doesn't describe any particular red flag symptoms. The pain seems to be confined to the lower back and doesn't radiate down the legs. Certainly on examination he is tender across his lumbar spine with a slight reduction in his SLR due to the pain in his lumbar spine. I have started him on Naproxen and added Amitriptyline and advised him to replace Co-Codamol with Paracetamol where possible to avoid dependency. However I do think he would benefit from physio however with a view to ongoing pain and the fact that it is rather severe and affecting his ability to resume job seeking I would appreciate if he could be offered an urgent appointment to try and help his symptoms as I feel physio would be very valuable for this man. Many thanks. Yours sincerely, Dr Mutaz Amin.

Examinations and Investigations

Height:	167.5	-
Weight(kg):	95.8	-
BMI:	34.15	-
Current smoker:		17-Dec-2015
Teetotaller :	continues to have back pain which seems rather debilitating, seems to be confined to lower back, affecting ability to work, currently on ESA, requires sicklines, no red flag symptoms, tak- TRUNCATED	31-Mar-2016
Less than 30 mins/day of at least mod int physc act >=5 week:	7	17-Dec-2015

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Back pain, unspecified	-	-	-	02-Feb-2016	02-Feb-2016
Right bundle branch block	-	-	-	22-Dec-2007	22-Dec-2007
Asthma	-	-	-	16-Feb-2002	16-Feb-2002
[X]Post - traumatic stress disorder	-	-	-	02-Sep-2001	02-Sep-2001
Guillain-Barre syndrome	-	-	-	10-Apr-1995	10-Apr-1995
Alcohol dependence syndrome	-	-	-	28-Apr-1990	28-Apr-1990
[V]Behavioural problems	-	-	-	22-Nov-1984	22-Nov-1984
Closed fracture of femur, shaft or unspecified part (Right)	Mild	-	-	09-Aug-1983	09-Aug-1983

[X]Accidental drug overdose / other poisoning	-	Ingestion of Turps.	14-May-1977	14-May-1977

Past procedures

Description	Laterality	Modifier	Comments	Date performed	Recorded Date
Alcohol detoxification	-	-	-	14-Jul-2003	14-Jul-2003

Current medication (Active Repeat medication issued within the last 12 months)

No current medications recorded

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Naproxen Tablets 500 mg	1001010P0AAAEAE	56 TABLET	ONE TO BE TAKEN TWICE A DAY	-	31-Mar-2016	28 Days	31-Mar-2016
Omeprazole Capsules (Gastro-Resistant) 20 mg	0103050P0AAAGAG	28 CAPSULE	ONE TO BE TAKEN EACH DAY	-	31-Mar-2016	28 Days	31-Mar-2016
Amitriptyline Hydrochloride Tablets 10 mg	0403010B0AAAGAG	56 tablet	1-2 TABS AT NIGHT	-	31-Mar-2016	28 Days	31-Mar-2016
Co-Codamol 30/500 Tablets	0407010F0AAAHAH	224 tablet	TWO TO BE TAKEN FOUR TIMES A DAY WHEN REQUIRED	-	22-Feb-2016	72 Days	23-Mar-2016
Co-Codamol 30/500 Tablets	0407010F0AAAHAH	100 TABLET	TWO TO BE TAKEN FOUR TIMES A DAY WHEN REQUIRED	-	02-Feb-2016	12 Days	02-Feb-2016

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status	Alcohol consumption
Number per day	Units per day
? (not known)	? (not known)

Allergies

Description	Comment	Recorded Date
Adverse reaction to Citalopram hydrochloride	-	05-Oct-2004

Additional relevant information
Administrative information
Referred By:Registered GP

Social circumstances

Signature of referring doctor (or other professional) **Date**

Department of Urology
University Hospital Ayr
Dalmellington Road
Ayr
KA6 6DX
01292 610555

www.nhsaaa.net

NHS Ayrshire & Arran

Confidential - Clinical Information

Consultant – Mr G W Hollins

Dr G Paton
Dr Paton, Muduniri & Venkatachalapa
The Surgery, The Health Centre
6 High Street
Maybole
KA19 7BY

Our Ref:	GWH/LG./LAP
Hospital No:	A100544212
Clinic Date:	05/02/2016
Date Dictated:	05/02/2016
Date Typed:	09/02/2016
Enquiries to	Mrs Lisa Ponsford
Direct Line:	01292 614761
Ext. Number:	14761
Email:	Lisa.ponsford@aapct.scot..nhs.uk

Dear Dr Paton,

LEE JOHNSTONE DOB: 09/02/1976 CHI No: 0902763334
12 WOODSIDE AVENUE, KIRKMICHAEL, MAYBOLE, AYRSHIRE, KA19 7PP

Mr Johnstone walked out of clinic this morning. His appointment was 11.45 and he walked out about 1.00pm.

If he wishes to be seen again please do not hesitate to re-refer him but we will not be arranging a appointment for him.

Kind regards.

Yours sincerely

Authorised on 11/02/2016 12:20:26 by Louise Goodwin.

Louise Goodwin
Advanced Nurse Practitioner - Urology

Lee Johnstone
12 Woodside Avenue
Kirkmichael
Maybole
Ayrshire
KA19 7PP

INVESTING IN VOLUNTEERS

Confidential - Clinical Information

Consultant – Mr G W Hollins

Department of Urology
University Hospital Ayr
Dalmellington Road
Ayr
KA6 6DX
01292 610555

www.nhsaaa.net

NHS Ayrshire & Arran

Dr C Mudunuri
Dr Paton, Muduniri & Venkatachalapa
The Surgery, The Health Centre
6 High Street
Maybole
KA19 7BY

Our Ref:	GWH/LAP
Hospital No:	A100544212
Clinic Date:	02/10/2015
Date Dictated:	02/10/2015
Date Typed:	06/10/2015
Enquiries to	Mrs Lisa Ponsford
Direct Line:	01292 614761
Ext. Number:	14761
Email:	lisa.ponsford@aapct.scot.nhs.uk

Dear Dr Mudunuri,

LEE JOHNSTONE DOB: 09/02/1976 CHI No: 0902763334
12 WOODSIDE AVENUE, KIRKMICHAEL, MAYBOLE, AYRSHIRE, KA19 7PP

Thank you for referring this 39 year old man who was seen in the Urology Clinic this morning. For 2 to 3 years he has noticed lumps on both sides of his scrotum which have more recently been causing significant discomfort. He denies any lower urinary tract symptoms and has no previous history of scrotal problems. He has had no scrotal operations or vasectomy and denies any history of STDs.

His previous medical history includes Guillain-Barre Syndrome some 20 years although he has been left with no residual sequelae. He is on no regular medication, has no known allergies, smokes 3 cigarettes a day and rarely drinks alcohol.

Abdominal examination was unremarkable. Examination of his genitalia revealed tender epididymides with probable very small cysts which have been confirmed on ultrasound. Rectal examination revealed a small benign prostate with no sinister features.

I note the ultrasound findings although it would be more appropriate to consider clinical management of his symptoms. He is most likely to have chronic epididymal orchitis and I would be grateful if you would treat him with ofloxacin 400mg twice daily as per my handwritten note. His bloods to include tumour markers have been checked today and I will see him for further review in 3 months unless these indicate a reason to see him sooner. A follow up ultrasound will be organised at that time.

Kind regards.

Yours sincerely

Authorised on 09/10/2015 16:50:09 by JAIMIN BHATT.

G W HOLLINS
CONSULTANT UROLOGICAL SURGEON
GMC: 3242504

INVESTING IN VOLUNTEERS

Follow Up: Bloods
3 Month OP Review

CHI: 0902763334
Johnstone, Lee
12 Woodside Avenue
Maybole
KA19 7PP
09/02/1976
Dr G Paton
Date of Birth

STA1060

DATE
21/01/15

Co or Not Entered
C arity Not Entered

GLU Negative
PET Negative
SG 1.020
BLO Trace-Intact
pH 5.5
PRO Negative
N T Negative
LEU Trace

---

39 + 5

Scan imp. Patient unsure
2-3 w Gestation

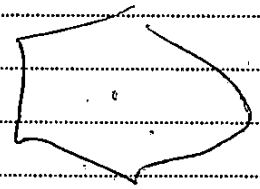
obs

discuss plan of care with STO

Pt's Gestation-Dates do not match
Pregnancy Scan

Pt to arrange scan when
known 3 days
antenatal booking

Ok



GP has arranged
NB U/S booking scan
advised

→ OF box
→ 2 3/7 Appointment letter

DATE

05/18/10

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 101009600271X

REFERRAL LETTER

CHI:0902763334

MEDICAL IN CONFIDENCE

REFERRAL TO

UrologyCB
AA Gen Ref - PMH Med & High

University Hospital Ayr
Dalmellington Road
Ayr
KA6 6DX

Ethnic Origin	-
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	14-Jul-2015
Date submitted	15-Jul-2015

PATIENT DETAILS

Surname	Johnstone
Forename(s)	Lee
Title	-
Sex	Male
Date of birth	09-Feb-1976
CHI no.	0902763334

Patient's address

12 Woodside Avenue
KIRKMICHAEL
MAYBOLE
KA19 7PP

Contact number(s)

Voice: 01655 750064

REGISTERED GP DETAILS

Name	Dr Gerald Paton		
GMC code	2597021	GP code	23612
Practice name	Dr Paton and Partners (16878)		
Practice code	80467		

Practice address

6 High Street
Maybole

Contact number(s)

Voice: 01655 882278
Facsimile: 01655 889616

REFERRING PRACTITIONER DETAILS

Name	Dr. Chaitanya Mudunuri		
GMC code	6056944	GP code	22454
Practice name	Dr Paton, Muduniri & Venkatachalapa (80467)		

Practice address

The Surgery
The Health Centre
6 High Street
Maybole
KA19 7BY

Practice code	80467	Contact number(s)
		Voice: 01655 882278

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: see letter

Comment: Many thanks for seeing 39 year old Mr Johnstone who presents with a history of swelling on the right side of his scrotum which has been present for a few months now. He had an initial ultrasound scan about 5 months ago which showed several simple epididymal cysts and a possible hypoechoic area within the right testes. He was advised review scanning in a few months time. Mr Johnstone has now had his review scan which stated the the hypoechoic area was no longer identified but there was an impression of a possible hypoechoic lesion measuring 5mm on the right testes and the appearance of which was uncertain. The radiologist has advised a urological referral to check suitable interval for a review scan. Mr Johnstone continues to have slight swelling of his right testes, he denies any associated pain. Given the ultrasound scan findings, I would be grateful for your opinion. Thank you

Examinations and Investigations

Height:	165	-
Weight(kg):	77.5	-
BMI:	28.47	-
Non-smoker :		10-Oct-2013
Alcohol intake above recommended sensible limits:	Disease: SPICE Basic Health Values, priority=2	28-Jan-2004
Enjoys light exercise:	Disease: SPICE Basic Health Values, priority=2	28-Jan-2004

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Epigastric hernia	-	-	Repaired priority=1	14-Sep-2009	14-Sep-2009
Epigastric hernia - irreducible	-	-	reduced surgically priority=1	21-Aug-2009	21-Aug-2009

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Omeprazole Capsules (Gastro-Resistant) 20 mg	0103050P0AAAGAG	56 capsule	ONE TO BE TAKEN EACH DAY	-	20-Oct-2014	-	20-Oct-2014

Recent medication (Any medication issued within last 90 days not shown above)

No recent medications recorded

Clinical warnings

Smoking status	Alcohol consumption
Number per day	Units per day
? (not known)	? (not known)

Lifestyle risks

Exercise status: Not Known

Additional relevant information

Administrative information

Referred By:Registered GP

Signature of referring doctor (or other professional) **Date**

MSK
Musculoskeletal Service

MSK DISCHARGE REPORT

NHS
Ayrshire
& Arran

Patient Name:	Lee Johnstone
Address:	12 Woodside Avenue, Maybole, Ayrshire, KA19 7PP
CHI:	0902763334
GP:	Dr G Paton
Consultant:	Mr J. Dearing
Referrer Source:	Mr J. Dearing
Referral Date:	25/11/2014
Start Date:	11/12/2014
Discharge Date:	31/12/2014
No. of treatments:	0
Discharge Reason:	Discharged patient DNA
Treatment Outcome:	
Therapist:	Fiona Maxton
Location:	MAYBOLE PHYSIOTHERAPY

Dear Dr G Paton

Diagnosis: Right Knee injury MRI NAD.

Actions for GP/Follow up recommendations: N/A.

Referred on to N/A.

Yours sincerely,
Authorised on 31/12/2014 12:12:22 by Fiona Maxton.
Fiona Maxton
31/12/2014

Mr Jonathan Dearing
Consultant Orthopaedic Surgeon
University Hospital Ayr
Dalmellington Road
Ayr
KA6 6DX

Confidential - Clinical Information

Department of Trauma and Orthopaedics
University Hospital Ayr
Dalmellington Road
Ayr
KA6 6DX
01292 610555
01292 614646
www.nhsaaa.net

NHS Ayrshire & Arran

Dr G Paton
Dr Paton, Muduniri & Venkatachalapa
The Surgery, The Health Centre
6 High Street
Maybole
KA19 7BY

Our Ref:	GH/CC
Hospital No:	
Clinic Date:	25/11/2014
Date Dictated:	25/11/2014
Date Typed:	26/11/2014
Enquiries to	Miss C Crawford
Direct Line:	
Ext. Number:	14068
Email:	Christine.Crawford@aaaht.scot.nhs.uk

Dear Dr Paton,

LEE JOHNSTONE DOB: 09/02/1976 CHI No: 0902763334
12 WOODSIDE AVENUE, MAYBOLE, AYRSHIRE, KA19 7PP

DIAGNOSIS: RIGHT KNEE INJURY
OUTCOME: DISCHARGED TO PHYSIOTHERAPY

I reviewed this 38 year old gentleman in the fracture clinic today. He had injured his knee in the summer and attended our knee clinic back in August. An MRI scan was organised which he has only had recently. This showed his ACL and MCL to be intact which were possibly differentials at the time of his last clinic. They show what appears to be an old injury of his medial meniscus as well. Mr Johnstone feels as though his symptoms have settled since his last clinic review and he no longer has any pain swelling or giving way in his leg.

On examination there was a mild effusion still present. He has a full ROM at his knee and he has a normal straight leg raise. His ACL, PCL and collateral ligaments all appear intact clinically and his meniscal tests are negative.

Given that Mr Johnstone symptoms have now improved and I have referred him for some formal physiotherapy to help with the strengthening of the muscles around his knee and I have not arranged any further formal follow-up but should he have any problems in the future we would be happy to see him.

Yours sincerely

Authorised on 27/11/2014 09:03:46 by Graeme Hopper.

Graeme Hopper
ST3 Trauma & Orthopaedics GMC: 7036915

INVESTING IN VOLUNTEERS

Confidential - Clinical Information

Department of Trauma and Orthopaedics
University Hospital Ayr
Dalmellington Road
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NHS Ayrshire & Arran

Dr G Paton
Dr Paton, Muduniri & Venkatachalapa
The Surgery, The Health Centre
6 High Street
Maybole
KA19 7BY

Our Ref: TW/CC
Hospital No:
Clinic Date: 05/08/2014
Date Dictated: 05/08/2014
Date Typed: 06/08/2014
Enquiries to Miss C Crawford
Direct Line:
Ext. Number: 14068
Email: Christine.Crawford@aaaht.scot.nhs.uk

Dear Dr Paton,

LEE JOHNSTONE DOB: 09/02/1976 CHI No: 0902763334
12 WOODSIDE AVENUE, MAYBOLE, AYRSHIRE, KA19 7PP

DIAGNOSIS: RIGHT KNEE ? GRADE II ACL INJURY WITH MEDIAL COLLATERAL LIGAMENT INJURY (27/07/14)

I reviewd this 38 year old gentleman in Mr Dearing's fracture clinic today who was playing five-a-side football on Astroturf when he twisted his knee on a stationary foot and heard a pop with immediate swelling. He discontinued with the game. He also speaks of a previous history of a femoral fracture.

On examination I note that there is no effusion of the knee and the extensor mechanism is intact. There is mid-substance tenderness of the MCL with grade II opening up of the medial aspect. The ACL has a grade II laxity with a definite endpoint. The PCL seems to be intact with no sag noted. There is no jointline tenderness. Extension is full and there is no restriction of extension to suggest a meniscal injury, McMurray's test is negative.

The splint which he had been wearing for two weeks had been taken off today and i have advised the patient to carry on with his normal activities as pain permits and he has been provided with Co-Codomol for pain relief.

An MRI scan has been arranged of his right knee and we will see him with the results of this.

Yours sincerely

Authorised on 08/08/2014 07:57:23 by Thisara Weerasuriya.

Thisara Weerasuriya, GMC No: 6072786
Speciality Doctor in Trauma & Orthopaedics

INVESTING IN VOLUNTEERS

University Hospital Ayr,
Dalmellington Road, Ayr,
KA6 6DX
Phone: 01292 610 555

Immediate Discharge Letter & Prescription

NHS Ayrshire & Arran

Date :03/05/2014 @ 12:14:08 (PROVISIONAL) *** Non-verified Orders Exist ***

To: Paton, Dr. G,
MAYBOLE HEALTH CENTRE,
6 HIGH STREET,
MAYBOLE,
KA19 7BY

Re: LEE DAVID JOHNSTONE
12 WOODSIDE AVENUE,MAYBOLE,AYRSHIRE,KA19 7PP
DOB: 09/02/1976
Hosp. No.: 0902763334
CHI No.: 0902763334

Date of Admission: 30/04/2014
Mode of Admission: Emergency Admission
Admission Reason:
Discharge Date: 02/05/2014

Ward: STATION 9-AYR
Consultant: DR KOFI OFUAFOR (Gastroenterology)
Follow-up:

Primary Diagnosis: alcohol excess
seizure ? drug/alcohol induced

Investigations: CXR: no lung pathology *last updated 02/05/2014; 4:04 pm by DR JOHN LEE*

Clinical Progress: was agitated and intoxicated on presentation
short stay in ICU
clinicl condition gradually improved
alcohol level was elevated on presentation
rest of bloods normal
GCS 15, no focal neuro signs
no changes to medications
if recurrent seizure, then advised to seek medical advice
obs stable, able for discharge *last updated 02/05/2014; 4:05 pm by DR JOHN LEE*

Results Awaited: awaiting magnesium and calcium results before discharge *last updated 02/05/2014; 4:05 pm by DR JOHN LEE*

Further patient/drug notes:

Allergy/Intolerance	Reaction
No Known Drug Allergies	

Allergy records are as recorded at time and date of printing

Drug	Dose	Route	Frequency	Days Supply	GP to continue
CYCLIZINE 50 mg Tablets	**50 mg**	Oral	THREE times daily - 7am;1pm;10pm	1	No
OMEPRAZOLE 20 mg Capsules	**20 mg**	Oral	ONCE daily at 7am	28	Yes
PARACETAMOL 500 mg Tablets	**1000 mg** PRN FOR PAIN	Oral	FOUR times daily - 7am;1pm;6pm;10pm	7	Yes

*** Non-verified Orders Exist ***

Additional Medicines Information:

Discharged by : DR JOHN LEE
Grade: Junior House Officer
Dispensed by:
Date:
Checked by:

Originally Printed: @ Revised: @

University Hospital Ayr,
Dalmellington Road, Ayr,
KA6 6DX
Phone: 01292 610 555

Immediate Discharge Letter & Prescription

NHS Ayrshire & Arran

To: Paton, Dr. G,
MAYBOLE HEALTH CENTRE,
6 HIGH STREET,
MAYBOLE,
KA19 7BY

Re: LEE DAVID JOHNSTONE
12 WOODSIDE AVENUE,MAYBOLE,AYRSHIRE,KA19 7PP

DOB: 09/02/1976
Hosp. No.: 0902763334
CHI No.: 0902763334

Medicines discontinued during admission (medicines that patient was recorded as admitted on only)

Drug	Date	Discontinued by	Discontinue reason

**** **Warning** - accuracy of information in this section is dependent on details entered by users of the HEPMA system.****
*****Information here may be incomplete and is for guidance only.*****

Discharged by : DR JOHN LEE **Dispensed by:** **Checked by:**

Grade: Junior House Officer **Date:**

Confidential - Clinical Information

Accident & Emergency Department
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
01563 521133
01563 827731
www.nhsayrshireandarran.com

NHS Ayrshire & Arran

Dr G Paton
The Surgery
Maybole Health Centre
6 High Street
Maybole
KA19 7BY

Our Ref:	CMG/sab
Hospital No:	
Clinic Date:	12/02/2013
Date Dictated:	12/02/2013
Date Typed:	14/02/2013
Enquiries to	Sharon Berry
Direct Line:	01563 827762
Ext. Number:	27762
Email:	sharon.berry@aaaht.scot.nhs.uk

Dear Dr Paton,

LEE JOHNSTONE DOB: 09/02/1976 CHI No: 0902763334
12 WOODSIDE AVENUE, MAYBOLE, AYRSHIRE, KA19 7PP

Diagnosis: Human bite to right thumb

This 36 year old gentleman failed to report for the Trauma Clinic today. No further review is proposed.

Yours sincerely

Authorised on 21/02/2013 22:13:59 by A C McGuffie.

Mr A C McGuffie MBChB, MRCP, FCEM
Consultant in Emergency Medicine
GMC: 3325960

INVESTING IN VOLUNTEERS

General Surgery
Consultant – Mr Michal Chudy
The Ayr Hospital
Dalmellington Road
AYR KA6 6DX

Admission	17.03.11
Discharge	17.03.11
Dictated	18.03.11
Typed	18.03.11
Our Ref:	MC/FS/100-544212
CHI No:	0902703334
Enquiries	Frances Scott
Direct Line	01292 614864
Fax:	01292 614537
e-mail:	frances.scott@aaaht.scot.nhs.uk

Dr G Paton
The Health Centre
6 High Street
MAYBOLE

Dear Dr Paton

LEE JOHNSTONE, 12 WOODSIDE AVENUE, KIRKMICHAEL : DOB 09.02.70

Diagnosis : Incisional hernia post sutured epigastric hernia repair
Procedure : Laparoscopic intraperitoneal onlay mesh repair of incisional hernia
Follow up : None planned

Lee Johnstone was admitted to the Day Surgery Unit at Ayr Hospital and underwent laparoscopic mesh repair of his incisional hernia. His procedure was carried out uneventfully; he made a quick recovery and was discharged home later the same day.

His port wounds were closed with absorbable sutures and they should not require any further attention. Arrangements were made for the District Nurse to review his wounds the following day.

Probable recovery time after this procedure is 10 days.

There are no plans for routine follow up but, if there are any problems, I would appreciate urgent referral back to us for early review.

Kind regards

Yours sincerely

Michal Chudy

MR MICHAL CHUDY
Consultant General & Laparoscopic Surgeon

INVESTING IN VOLUNTEERS

www.nhsayrshireandarran.com

JMcC/60802

Surgical

The Ayr Hospital
Dalmellington Road
Ayr KA6 7DX
Telephone: 01292 610555
Ext 14468
www.nhsayrshireandarran.com

NHS
Ayrshire & Arran

The Bruce Day Surgery Suite

A100-544212
JOHNSTONE LEE
12 WOODSIDE AVE
0902763334
KIRKMICHAEL
KA197PP 09/02/1976

PATON,G (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE M/S
Date of Birth .....

Dear Colleague

The above patient attended The Bruce Day Surgery Suite on ....17th March 2011.....

The procedure carried out was ....Incarcerated Femoral Repair.....
under ~~local~~ / general anaesthetic.

The patient was discharged home following this.

We would be grateful if you could:-

a) ~~Remove sutures in ..... days time.~~ observable.

b) Remove the theatre dressing in .....1..... days and dress thereafter as required.

c) Reduce the theatre dressing in 24 hours / ~~48 hours~~ / ~~72 hours~~.

d) ~~Dressing to remain intact until clinic appointment.~~

Comments ...District Nurse to review & redress wound 18/3/11
...please Appt to review if required...Discharged home
...on paracetamol & ciprofloxacin 500mg PRN.....

District Nurse visit requested by ansaphone / ~~telephone~~ on ....Callss - 8839762.....

~~Patient will contact surgery to make~~ an appointment with Practice Nurse.

The patient ~~has~~ / has not a review appointment.

A more detailed letter will follow.

Should you require further information please contact us on the above extension.

Yours sincerely, Asmeelyes.

General Surgery
Consultant – Mr Michal Chudy
The Ayr Hospital
Dalmellington Road
AYR KA6 6DX

Date dictated 11.03.11
Date typed 11.03.11
Our Ref: MC/FS/100-542212
CHI No: 0902763334

Dr G Paton
The Health Centre
6 High Street
MAYBOLE

Enquiries to: Frances Scott
Extension: 14864
Direct Line: 01292 614864
Fax: 01292 614537
e-mail: frances.scott@aaaht.scot.nhs.uk

Dear Dr Paton

LEE JOHNSTONE, 12 WOODSIDE AVENUE, KIRKMICHAEL : DOB 09.02.76

Lee Johnstone attended the Day Surgery Unit as planned, on 10th March 2011, for the elective laparoscopic mesh repair of his incisional hernia. Unfortunately, due to the overrunning of an earlier case on the theatre list, his procedure was cancelled due to lack of time.

His admission has been rescheduled for 17th March 2011.

Kind regards

Yours sincerely

MR MICHAL CHUDY
Consultant General & Laparoscopic Surgeon

INVESTING IN VOLUNTEERS

Cancellation of Procedure

Date 10.3.11

JOHNSTONE A100-544212
12 WOODSIDE AVE LEE

KIRKMICHAEL 0902763334
KA197PP 09/02/1976

PATON,G (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE M/S

- Procedure..... Hernia repair.....
- Speciality..... SURG / THEATRE NO.....
- Person authorising..... Chrissy.....
- Consultant..... Chrissy.....
- Reason for cancellation..... Rec'd outb.....
  ..... Reache time.....
- Patient admission time..... 11.30 am.....
- Time of discharge..... 4.50 pm.....
- Action taken..... To be re-appt.....
- .....
- Signature..... J Thomson SIN.....

Department of Vascular & General Surgery
The Ayr Hospital
Dalmellington Road
AYR.
KA6 6DX

☎ : 01292 610555

MR I McMILLAN
VASCULAR UNIT

Date Dictated: 02/02/2011
Date Typed: 03/02/2011
Our Ref IMCM/LM/100544212
CHI No.0902763334

Dr G Paton
Maybole Health Centre
6 High Street
Maybole

Enquiries to Mrs L McPike
Extension 01292 614855
Fax 01292 614609
E-mail lynn.mcpike@aaaht.scot.nhs.uk

Dear Dr Paton

LEE JOHNSTONE, 12 WOODSIDE AVENUE, KIRKMICHAEL (DOB: 09/02/1976)

This man attended with a view to repair of a recurrent epigastric hernia. The tissue was rather weak towards the zyphoid process and I gained the benefit of the opinion of Mr Chudy who has a specialist interest in this area.

At the end of the day it was felt that the best option for this gentleman was a laparoscopic repair of his hernia using mesh. The offer was made for him to wait until later in the day and perhaps gain a place on Mr Chudy's list of that day but he preferred to return home with a view to an arrangement being made at a later date.

Yours sincerely

IAIN McMILLAN
Consultant Vascular & General Surgeon

cc. Mr R Muir, Consultant Colorectal Surgeon, TAH

cc. Mr M Chudy, Consultant Surgeon, TAH

Department of Vascular & General Surgery
The Ayr Hospital
Dalmellington Road
AYR.
KA6 6DX

☎ : 01292 610555

MR I McMILLAN
VASCULAR UNIT

Date Dictated: 02/02/2011
Date Typed: 03/02/2011
Our Ref IMCM/LM/100544212
CHI No.0902763334

Dr G Paton
Maybole Health Centre
6 High Street
Maybole

Enquiries to Mrs L McPike
Extension 01292 614855
Fax 01292 614609
E-mail lynn.mcpike@aaaht.scot.nhs.uk

Dear Dr Paton

LEE JOHNSTONE, 12 WOODSIDE AVENUE, KIRKMICHAEL (DOB: 09/02/1976)

This man attended with a view to repair of a recurrent epigastric hernia. The tissue was rather weak towards the ~~zyphoid~~ process and I gained the benefit of the opinion of Mr Chudy who has a specialist interest in this area.

At the end of the day it was felt that the best option for this gentleman was a laparoscopic repair of his hernia using mesh. The offer was made for him to wait until later in the day and perhaps gain a place on Mr Chudy's list of that day but he preferred to return home with a view to an arrangement being made at a later date.

Yours sincerely

IAIN McMILLAN
Consultant Vascular & General Surgeon

cc. Mr R Muir, Consultant Colorectal Surgeon, TAH

cc. Mr M Chudy, Consultant Surgeon, TAH

Department of General Surgery
The Ayr Hospital
Dalmellington Road
AYR.
KA6 6DX

Tel: 01292 610555

Mr R Muir
Colorectal & General Surgery

Date Dictated: 30/11/2010
Date Typed: 02/12/2010
Date Admitted: 27/11/2010
Date Discharged: 29/11/2010

Our Ref RM/AC/100-544212
CHI number 0902763334

Enquiries to Miss Anne Carswell
Extension 14047
Fax 01292 614609
E-mail ann.carswell@aaaht.scot.nhs.uk

Dr Paton
Maybole Health Centre
6 High Street
MAYBOLE

Dear Dr Paton

RE: LEE JOHNSTONE, 12 WOODSIDE AVENUE, KIRKMICHAEL
DOB – 09/02/1976

Diagnosis: Recurrent Epigastric Hernia
Procedure: Nil
Management: Conservative
Follow-up: Day Case Epigastric Hernia Repair

This gentleman was admitted complaining of severe epigastric pain. He describes this as similar to the pain he had previously with his strangulated epigastric hernia. By the time I had seen him in the morning, things had settled and the pain largely resolved. He does have a recurrence of his epigastric hernia. This was fully reducible when reviewed by myself. We kept him for a further 24hrs and the pain did not return. I have discussed the options with him and think he would be best served by a further open repair with an insertion of a mesh. I have added his name to my waiting list to have this done.

Yours sincerely

Mr R Muir
Consultant in Colorectal & General Surgery

w/l – recurrent epigastric hernia repair

JMcC/60802

Surgical

Ayr Hospital,
Dalmellington Road, Ayr,
KA6 6DX
Phone: 01292 610 555

Immediate Discharge Letter & Prescription

NHS Ayrshire & Arran

Date

REPRINT *** Non-verified Orders Exist ***

To
JOHNSTONE A100-544212
LEE
12 WOODSIDE AVE
0902763334
KIRKMICHAEL
KA197PP 09/02/1976

PATON, G (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE
M/S

Re: LEE JOHNSTONE
12 WOODSIDE AVE,KIRKMICHAEL,KA19 7PP

DOB: 09/02/1976
Hosp. No.: 100544212
CHI No.:

Date of Admission: 27/11/2010
Mode of Admission: Planned Admission
Admission Reason: ABDOMINAL PAIN
Discharge Date: ~~26~~/11/2010
29

Ward: STATION 3-AYR
Consultant: MR ROBERT MUIR (Surgical)
Follow-up:

Primary Diagnosis:

Clinical Progress:

4 WEEK HISTORY OF EPIGASTRIC PAIN WORSENING TODAY WITH ASSOCIATED NAUSEA. PREVIOUS HERNIA REPAIR 4 MONTHS AGO. TENDER IN EPIGASTRIUM AND PERITONITIC. O/E SMALL RECURRANCE OF REDUCIBLE HERNIA WITH NO BOWEL INVOLEMENT.

PATIENT BLOODS NORMAL. IS STABLE FOR DISCAHRGE, DISCHARGED WITH SIMPLE ANALGESIA.

TO RETURN FOR ELECTIVE REPAIR, WILL BE ASSESSED AT OUTPATIENT CLINIC.

KIND REGARDS *last updated 28/11/2010;12:05 pm by DR CRAIG MITCHELL*

Further patient/drug notes:

Allergy/Intolerance	Reaction
No known drug allergies	

Allergy records are as recorded on the Ayr Hospital HEPMA system at time and date of printing (see above).

✓-AB 29/11/10.

Drug	Dose	Route	Frequency	Days Supply	GP to continue
CO-CODAMOL 30/500 Tablets ✓	**2 Tablet** PRN For pain	Oral	FOUR times daily - 7am;1pm;6pm;10pm 30 x 30/500	14	Yes
LACTULOSE Oral Solution ✓	**10 mL**	Oral	TWICE daily - 7am;10pm 500ml	28	Yes
OMEPRAZOLE 20 mg Capsules	**20 mg**	Oral	ONCE daily at 7am	Patients Own Supply	Yes

*** Non-verified Orders Exist ***

Additional Medicines Information:

Medicines discontinued during admission (medicines that patient was recorded as admitted on only)

Drug	Date	Discontinued by	Discontinue reason
None recorded			

**** **Warning** - accuracy of information in this section is dependent on details entered by users of the HEPMA system.****
*****Information here may be incomplete and is for guidance only.*****

Discharged by : DR CRAIG MITCHELL
Grade: Junior House Officer

Dispensed by: BCC **Checked by:** MDR
Date: 29/11

Originally Printed: 29/11/2010 @ 10:16

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 101001289952E

REFERRAL LETTER

CHI:0902763334

MEDICAL IN CONFIDENCE

REFERRAL TO

General Surgery (excl Vascular)C11
AA Gen Ref - PMH Med & High

Ayr Hospital
Dalmellington Road
Ayr
KA6 6DX

Ethnic Origin	-
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	22-Nov-2010
Date submitted	23-Nov-2010

PATIENT DETAILS

Surname	Johnstone
Forename(s)	Lee
Title	-
Sex	Male
Date of birth	09-Feb-1976
CHI no.	0902763334

Patient's address

12 Woodside Avenue
KIRKMICHAEL
KA19 7PP

Contact number(s)

Voice: 01655 750064

REGISTERED GP DETAILS

Name	Dr Gerald Paton		
GMC code	2597021	GP code	23612
Practice name	Dr Paton and Partners (16878)		
Practice code	80467		

Practice address

6 High Street
Maybole

Contact number(s)

Voice: 01655 882278
Facsimile: 01655 889616

REFERRING PRACTITIONER DETAILS

Name	Dr. Chaitanya Mudunuri		
GMC code	6056944	GP code	22454
Practice name	MAYBOLE HEALTH CENTRE (80467)		
Practice code	80467		

Practice address

6 HIGH STREET
MAYBOLE
AYRSHIRE
KA19 7BY

Contact number(s)

Voice: 01655 882278

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: see letter

Comment: Thirty four year old Mr Johnstone had a repair of epigastric hernia about a year ago. He presents with a 4 week history of swelling in the epigastric area. On examination, the swelling is reducable. My impression is that of recurrence of his epigastric hernia. I would be grateful if you could arrange to see Mr Johnstone back in your clinic for further assessment and surgical management of his epigastric hernia. Thank you

Examinations and Investigations

Height:	165	-
Weight(kg):	77.5	-
BMI:	28.47	-
Current smoker:	Disease: SPICE Basic Health Values, priority=2	16-Mar-2009
Alcohol intake above recommended sensible limits:	Disease: SPICE Basic Health Values, priority=2	28-Jan-2004
Enjoys light exercise:	Disease: SPICE Basic Health Values, priority=2	28-Jan-2004

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Epigastric hernia	-	-	Repaired priority=1	14-Sep-2009	14-Sep-2009
Epigastric hernia - irreducible	-	-	reduced surgically priority=1	21-Aug-2009	21-Aug-2009

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Omeprazole Capsules (Gastro-Resistant) 20 mg	0103050P0AAAGAG	56 CAPS	1 Cap In the morning	-	18-May-2010	-	18-Oct-2010
Tramadol Hydrochloride Capsules 50 mg	040702040AAAAAA	100 CAPS	1 Cap 4 times daily	-	18-May-2010	-	23-Sep-2010

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Diclofenac Sodium E/c tablets 50 mg	-	60 tablet	ONE TO BE TAKEN THREE TIMES A DAY	-	24-Aug-2010	42 Days	24-Aug-2010

WITH OR
AFTER FOOD

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status

Number per day
? (not known)

Alcohol consumption

Units per day
? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

Signature of referring doctor (or other professional) **Date**

AYR HOSPITAL
DALMELLINGTON ROAD
AYR, KA6 6DX
TEL: 01292 610 555 FAX: 01292614557

AB/GB/100-544212 CHI-0902763334

GENERAL MEDICINE – DR A COLLIER, CONSULTANT PHYSICIAN
STATION 7 DISCHARGE LETTER

DICTATED:	21/10/10	ADMITTED:	15/10/10
TYPED:	04/11/10	DISCHARGED:	15/10/10

Dr G Paton
Maybole Health Centre
6 High Street
Maybole

Dear Dr Paton,

Re: Lee Johnstone, 12 Woodside Avenue, Kirkmichael (09/02/1976)

Diagnosis: Musculoskeletal chest pain

Follow up: None

This 34 year old gentleman woke up with left sided chest pain, worse on movement of his left arm. I understand that he had been in Turkey 4 weeks prior with a description of some left leg swelling, but fortunately there was no evidence of DVT clinically and his D-dimers were negative. The description of his pain was musculoskeletal in nature and with a normal chest x-ray and ECG he was discharged without any plans for routine follow up.

Please note that I did not see this patient myself and it has been dictated entirely from the case notes. If you have any concerns please do not hesitate to contact us.

Many thanks,

Yours sincerely,

A BRECKENRIDGE
ST3 – GENERAL MEDICINE

A COLLIER
CONSULTANT PHYSICIAN

MEDICAL

Ayrshire & Arran
ACUTE HOSPITALS NHS TRUST

Immediate Discharge Summary

THE AYR HOSPITAL
DALMELLINGTON ROAD
AYR KA6 6DX

Telephone:
(01292) 610555
(01292) 265265

GP
Address

Patient Address: JOHNSTONE A100-544212
12 WOODSIDE AVE LEE
KIRKMICHAEL 0902763334
KA19 7PP

D.O.B: 09/02/1976

PATON, G (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE

Admission Date: 15/10/10
Admission Type: Emergency
Discharge Date: 15/10/10
Station: M/S
Consultant: Dr Collier

Diagnosis: Musculoskeletal chest pain

Summary: Admitted with left-sided chest pain, worse on deep inspiration on moving left arm. D-dimer was negative. Trop T also negative. Patient given analgesia and discharged home.

Operation:
Date:

Medication on Discharge

Medicine / Dressing BLOCK CAPITALS	Dose	Route	Time of Admin	Continue or Stop	Quantity & Strength	Pharmacy Notes
NUMBER OF DAYS SUPPLY IF MORE THAN 7						

PHARMACY USE ONLY

DATE	Dispensed by	Checked by

Further comments: (e.g. Histology, information given to patient regarding diagnosis....etc)

A consultant episode letter will / will not follow

Outpatient Appointment YES / NO

Distribution GP ☑ Pharmacy ☐ Casenotes ☐ District Nurse ☐ Patient Yes / No

Dr's Signature [signature] Print Name LAURA MACKIE Date 18/10/10

Heathfield Clinic
Heathfield Road
AYR KA8 9DZ
Tel:01292 610557 EXT.3504
Fax: 01292 288021

DEPARTMENT OF DERMATOLOGY

RAH/LH/544212/CHI-0902763334 Direct Line: 01292 666504

Clinic date: 02/07/2010	Date dictated: 02/07/10	Date typed: 09/07/10

Dr C.Mudunuri
The Health Centre
MAYBOLE

Dear Dr Mudunuri

LEE JOHNSTONE 12 WOODSIDE AVENUE KIRKMICHAEL (09/02/1976)

Diagnosis Inflamed mole right lower chest.

I saw this 34 year old patient at the clinic today. A longstanding mole on the right lower chest had recently become crusty; the crust has now fallen off; there are no symptoms.

Examination showed a 7 x 5 mm raised rough mid-brown hair bearing mole. Dermatoscopy was benign.

Overall this sounds like an inflammatory episode in a benign mole.

No action is required at present. The patient knows that if the symptoms recur then she should let you know and excision would be indicated at that point.

Kind regards.
Yours sincerely

R.A. Hardie
Consultant Dermatologist

Dermatology

Write or attach label

HC
CI
St JOHNSTONE
12 WOODSIDE AVE
Fc
Ar KIRKMICHAEL
KA197PP
∴ PATON,G (GP)
D 6 HIGH STREET
MAYBOLE

A100-544212
LEE

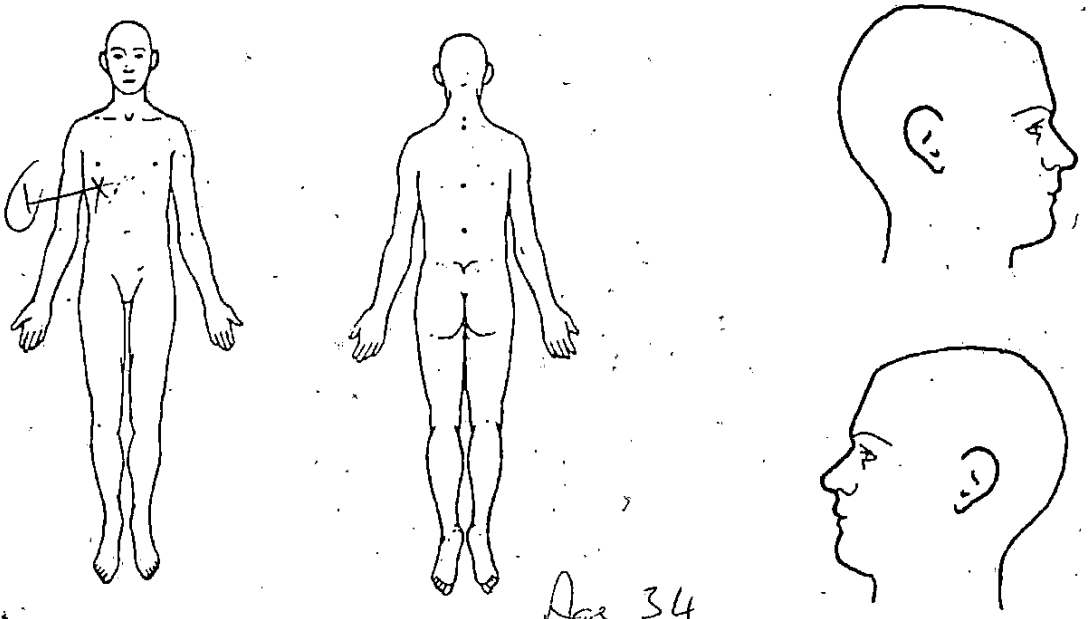
0902763334

09/02/1976

M/S

STA0128

DATE



2/7/16

Age 34

Mole (R) chest for yrs — recently developed crust which has now fallen off.

c/E 7x5 mm raised right mid thorax hair bearing mole
D'scopy = benign

D Inflammation in Mole

Re O @ present ; explain Symptoms resolved

Ref (HOUSE)

DERMATOLOGY

JMcC/81415

RST

Date Received: Fri 25/06/10
CHI: 0902763334 Hospital Number: A100544212

Permanent Flags

- ☐ GPWSI - GPWSI
- ☐ SR NICOL - SR NICOL COMMUNITY CLINIC
- ☐ SRJAMIESON - SR J HEATHFIELD CLINIC
- ☐ LESION - DR FOULDS MON AM CLINIC
- ☐ ONE STOP - DR DWYER ONE STOP FRI CLINIC
- ☐ ARRAN - DR FOULDS ARRAN CLINIC
- ☐ JOINT M/F - DR DWYER JOINT M/F THUR CLINIC

AYRSHIRE & ARRAN ACUTE HOSPITALS NHS TRUST
APPOINTMENTS
28 JUN 2010
RECEIVED

Hospital use only	Clinic	Day / Date	Time	Hospital No.
	HMROLE	2/7/10	425	

Transport required?

Unique Care Pathway Number: 1010006645830

REFERRAL LETTER

CHI:0902763334

MEDICAL IN CONFIDENCE

REFERRAL TO

DermatologyA7
AA Gen Ref - PMH Med & High

Heathfield Clinic
Heathfield Road
Ayr
KA8 9DZ

Ethnic Origin	-
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
of referral	24-Jun-2010
e submitted	25-Jun-2010

PATIENT DETAILS

Surname	Johnstone
Forename(s)	Lee
Title	-
Sex	Male
Date of birth	09-Feb-1976
CHI no.	0902763334

Patient's address

12 Woodside Avenue
KIRKMICHAEL
KA19 7PP

Contact number(s)

Voice: 01655 750064

REGISTERED GP DETAILS

Name	Dr Gerald Paton		
GMC code	2597021	GP code	23612
Practice name	Dr Paton and Partners (16878)		
Practice code	80467		

Practice address

6 High Street
Maybole

Contact number(s)

Voice: 01655 882278
Facsimile: 01655 889616

RRING PRACTITIONER DETAILS

me	Dr. Chaitanya Mudunuri
IC code	6056944 GP code 22454
ictice name	MAYBOLE HEALTH CENTRE (80467)
ictice code	80467

Practice address

6 HIGH STREET
MAYBOLE
AYRSHIRE
KA19 7BY

Contact number(s)

Voice: 01655 882278

AL INFORMATION

tory of presenting complaint / examination findings / investigation results

resenting complaint

Description: See below.

Comment: Many thanks for seeing 34 year old Mr Johnstone who presented with a mole on the right side of his chest. He reports a recent change in the colour of the mole.

On examination, Mr Johnstone has a 0.5cm fleshy mole which has variable colours. There is hair present over the mole and the margins appear irregular. My impression is that of a likely benign mole but given the irregular margins and variable colour we would be grateful if you could arrange to see Mr Johnstone in your clinic for a 2nd opinion with regards to this.

Thank you.

Examinations and Investigations

Height:	165
Weight(kg):	77.5
BMI:	28.47
Current smoker:	Disease: SPICE Basic Health Values, priority=2 16-Mar-2009 00:00
Alcohol intake above recommended sensible limits:	Disease: SPICE Basic Health Values, priority=2 28-Jan-2004 00:00
Enjoys light exercise:	Disease: SPICE Basic Health Values, priority=2 28-Jan-2004 00:00

son for referral

e type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Omeprazole Capsules (Gastro-Resistant) 20 mg	0103050P0AAAGAG	56 CAPS	1 Cap In the morning	-	19-Apr-2010	56 Days	27-May-2010
Tramadol Hydrochloride Capsules 50 mg	040702040AAAAAA	100 CAPS	1 Cap 4 times daily	-	10-May-2010	56 Days	14-Jun-2010

Recent medication (Any medication issued within last 90 days not shown above)

No recent medications recorded

nical warnings

style risks

Exercise status: Not Known

Smoking status: Number per day ? (not known)

Alcohol consumption: Units per day ? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

Signature of referring doctor (or other professional) **Date**

Department of General/Vascular Surgery,
The Ayr Hospital,
Dalmellington Road,
AYR.
KA6 6DX

☎ : 01292 610555

MR D WALLACE

Date Dictated: 28/08/2009
Date Typed: 31/08/2009
Date Admitted: 16/08/2009
Date Discharged: 18/08/2009

Our Ref DW/AB/100-544212
CHI number 0902763334

Enquiries to Miss A Bryden
Extension 14306
Fax 01292 616451
E-mail anne.bryden@aaaht.scot.nhs.uk

Dr G Paton
The Health Centre
6 High Street
Maybole

Dear Dr Paton

LEE JOHNSTONE 12 WOODSIDE AVENUE K IRKMICHAEL (DOB 09/02/1976)

DIAGNOSIS: Tender epigastric hernia

PROCEDURE: Repair

FOLLOW-UP: If required

COMPLICATIONS:

COMMENTS:
This young man was admitted with a tender epigastric hernia which was confirmed in theatre. However it was possible to reduce this back and primarily repair the defect with prolene sutures.

I have not organized out patient review but clearly if there were any concerns I would happily see him again. Mr. Johnstone has been warned not to stress his repair for the next six to eight weeks.

Yours sincerely

DAVID WALLACE
Consultant Vascular & General Surgeon

Clinical

Ayr Hospital,
Dalmellington Road, Ayr,
KA6 6DX
Phone: 01292 610 555

Immediate Discharge Letter & Prescription

NHS Ayrshire & Arran

Date : 18-Aug-2009 @ 11:27 REPRINT *** Non-verified Orders Exist ***

JOHNSTONE LEE A100-544212
12 WOODSIDE AVE
0902763334
KIRKMICHAEL
KA197PP 09/02/1976

Paton,G (GP)
Maybole Health Centre
6 High Street
Maybole

Re: LEE JOHNSTONE
12 WOODSIDE AVE,KIRKMICHAEL,KA19 7PP.
DOB: 09/02/1976
Hosp. No.: 100544212
CHI No.:

Date of Admission: 16/08/2009 M/S
Ward: STATION 2-AYR
Mode of Admission: Emergency Admission
Consultant: MR DAVID WALLACE (Surgical)
MR DAVID WALLACE (Surgical)
Admission Reason: EPIGASTRIC HERNIA.
Discharge Date: 18/08/2009
Follow-up:

Primary Diagnosis:

Investigations: MR. JOHNSTONE WAS ADMITTED TO STATION 2 OF AYR HOSPITAL ON THE 16TH OF AUGUST WITH AN EPIGASTRIC SWELLING OF 1/52 DURATION. THE MASS HAD BECOME ACUTLEY PAINFUL 2/7 BEFORE ADMISSION. THE MASS WAS IRREDUCIBLE (HAD BEEN SO SINCE ONSET). THE IMPRESSION WAS THAT OF AN EPIGASTRIC HERNIA, EXACERBATED BY WEIGHTLIFTING. THE HERNIA WAS REDUCED SURGICALLY ON THE 17TH OF AUGUST. THE PATIENT IS NOW FIT FOR DISCHARGE.

FORMAL DISCHARGE LETTER TO FOLLOW.

THANK YOU *last updated 18/08/2009;11:20 am by DR VIVIENNE BLACKHALL*

Further patient/drug notes:

Allergy/Intolerance	Reaction
No known drug allergies	

Allergy records are as recorded on the Ayr Hospital HEPMA system at time and date of printing (see above).

V.M.B. 18/8

Drug	Dose	Route	Frequency	Days Supply	GP to continue
PARACETAMOL 500 mg Tablets	**1000 mg** PRN	Oral For pain/pyrexia	FOUR times daily - 7am;1pm;6pm;10pm 500mg x 32.	7	No
TRAMADOL 50 mg Capsules	**50 mg** PRN	Oral For pain	FOUR times daily - 7am;1pm;6pm;10pm Supply 30 50mg x 30.	7	No

*** Non-verified Orders Exist ***

Additional Medicines Information:

Medicines discontinued during admission (medicines that patient was recorded as admitted on only)

Drug	Date	Discontinued by	Discontinue reason

None recorded

*** **Warning** - accuracy of information in this section is dependent on details entered by users of the HEPMA system.***
****Information here may be incomplete and is for guidance only.****

Discharged by : DR VIVIENNE BLACKHALL
Grade: Junior House Officer
Dispensed by: SM/NDS **Checked by:** C.M.H.
Date: 18/8/09

Originally Printed: 18/08/2009 @ 11:20

THE AYR HOSPITAL

NHS Ayrshire & Arran

DISTRICT NURSE REFERRAL FORM

Address: JOHNSTONE LEE
12 WOODSIDE AVE
KIRKMICHAEL
KA197PP

A100-544212
0902763334
09/02/1976

Paton,G (GP)
Maybole Health Centre
6 High Street
Maybole M/S

Consultant: MR WALLACE **Ward:** ST 2

D of A: 16/8/09 **D of D:** 18/8/09

Next of Kin: GEORGINA JOHNSTONE

Address: S/A

Tel No: 01655 750064

Diagnosis: EPIGASTRIC HERNIA

Treatment in Hospital:

REPAIR OF EPIGASTRIC HERNIA 17/8/09

Suggested Treatment on Discharge:

WOUND CHECK AS REQUIRED.

Patient/Family Awareness:

FULLY AWARE

Drug Therapy:

ANALGESIA

Services Required:

PRACTICE NURSE.

Ability Assessment:

INDEPENDENT

Additional Information:

Follow-up Appointment: NO FOLLOW UP

Ward Staff: [signature]

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

CHI:0902763334

MEDICAL IN CONFIDENCE

REFERRAL TO

General SurgeryC1
AA Gen Ref - PMH Med & High

Ayr Hospital

Ethnic Origin	-
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	24-Jul-2009
Date submitted	27-Jul-2009

PATIENT DETAILS

Surname	Johnstone
Forename(s)	Lee David
Title	-
Sex	Male
Date of birth	09-Feb-1976
CHI no.	0902763334

Patient's address

12 Woodside Avenue
KIRKMICHAEL
AYRSHIRE
KA19 7PP

Contact number(s)

Voice: 01655 750064

REGISTERED GP DETAILS

Name	Dr Gerald Paton		
GMC code	2597021	GP code	A23612
Practice name	Maybole Health Centre		
Practice code	80467		

Practice address

6 High Street Maybole

Contact number(s)

Voice: 01655 882278

REFERRING PRACTITIONER DETAILS

Name	Dr. Chaitanya Mudunuri		
GMC code	6056944	GP code	22454

Practice address

6 HIGH STREET
MAYBOLE

Practice name	MAYBOLE HEALTH CENTRE (80467)	AYRSHIRE KA19 7BY	
Practice code	80467	Contact number(s)	
		Voice: 01655 882278	

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: see letter

Comment: Many thanks for seeing 33 year old Mr Johnstone who presented with a swelling in his epigastric region. On examination, Mr Johnstone has a reducable swelling in the epigastric region which is non tender. My impression is that of a epigastric hernia. Mr Johnstone is keen for surgical repair of his hernia as he would like to join the Army and would need this repaired before joining. I would be grateful for your assessment and advice with regard to further management of Mr Johnstone's likely epigastric hernia. Thank you

Examinations and Investigations

Current smoker:	16-Mar-2009
Alcohol intake above recommended sensible limits:	28-Jan-2004
Enjoys light exercise:	28-Jan-2004

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Current medication (Active Repeat medication issued within the last 12 months)

No current medications recorded

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Omeprazole	01.03.05.0	CAPS 20MG	1 Cap	In the morning	22-Jul-2009	-	-

Clinical warnings

Smoking status

Alcohol consumption

Lifestyle risks

Exercise status: Not Known

Number per day ? (not known)

Units per day ? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

Signature of referring doctor (or other professional) **Date**

Accident and Emergency Department
Ayr Hospital
Dalmellington Road
Ayr, KA6 6DX

Tel: 01292 610555

Ref: MP/LB/100-544212
CHI number: 0902763334

Date Admitted:	22.12.07
Date Discharged:	22.12.07
Date Dictated:	10.01.08
Date Typed:	16.01.08

Enquiries to:	Louise Blades, A & E Secretary
Extension:	14578
Direct Dial:	01292 614578
Fax:	01292 288105
E-mail:	louise.blades@aaaht.scot.nhs.uk

Dr C Lau
6 High Street
Maybole

Dear Dr Lau

LEE JOHNSTONE, 16 MINNOCH CRESCENT, MAYBOLE
D.O.B: 09.02.1976

I reviewed Mr Johnstone in Accident and Emergency on the 22nd December 2007. He had a twelve hour history of severe epigastric pain and vomiting which contained specs of blood. Three days prior to this he had been having diarrhoea.

On examination he was apyrexial, bloods pressure was 162/96mmHg. Sats were 97% on air and pulse was 85 beats per minute which was regular. His chest was clear and his heart sounds were pure. There was some epigastric tenderness on abdominal examination, however his abdomen was soft and bowel sounds were present and normal.

Chest x-ray was clear, however ECG showed right bundle branch block.

In view of his epigastric tenderness, we checked his CK which was slightly elevated and his Troponins which came back as negative.

We treated him with IV Cyclizine and Buscopan and with fluid resuscitation. We were able to send him home after four hours' observation in our Observation Ward.

Yours sincerely

DR MOIRA PATERSON
FY2 IN ACCIDENT & EMERGENCY CARE

Day Surgery Unit
General Surgery
The Ayr Hospital
Dalmellington Road
AYR KA6 6DX

MR N A NUR

Date Attended: 01/11/2007
Date Typed: 15/11/2007

Our Ref: AP/CIK/100-544212
CHI No: 0902763334

Enquiries to: Helen Graham
Direct Line: 01292 614561
Fax: 01292 614641
e.mail: Helen.graham@aaaht.scot.nhs.uk

Dr Lau
The Surgery
The Health Centre
6 High Street
MAYBOLE

Dear Dr Lau

LEE JOHNSTONE 16 MINNOCH CRESCENT MAYBOLE (DOB 09.02.76)

Further to my letter of 01.11.07 this patient's histology is now to hand and I enclose a copy of the report for your information.

I have not arranged any further follow up for this patient but of course we would be quite glad to see him again if you thought it necessary.

Kind regards.

Yours sincerely

DR A PODDAR
SHO IN GENERAL SURGERY

enc

Surgical

DAY SURGERY UNIT
(General Surgery –Mr N A Nur)
The Ayr Hospital
Dalmellington Road
AYR KA6 6DX

Dr Lau
Maybole Health Centre
6 High Street
MAYBOLE

Date Attended	01.11.07
Date Dictated	01.11.07
Date Typed	02.11.07
Our Ref	AP/CIK/100-544212
CHI No	0902763334

Enquiries to:	Helen Graham
Direct Line:	01292 614561
Fax:	01292 614641
e.mail:	margaret.reid@aaaht.scot.nhs.uk

Dear Dr Lau

LEE JOHNSTONE 16 MINNOCH CRESCENT MAYBOLE (DOB 09.02.76)

This patient attended for removal of lesion on the upper outer aspect of the left thigh. This has been present for some years. Clinically it looked like a sebaceous cyst with a punctum.

This was excised under local anaesthetic today. The specimen was sent for Pathology, however, microscopically, it was a sebaceous cyst.

We have not arranged any routine follow-up, but the results will be forwarded to yourself.

Yours sincerely

DR A PODDAR
SHO IN GENERAL SURGERY

Surgical

Acute Hospitals NHS Trust

The Ayr Hospital
Dalmellington Road
Ayr KA6 6DX
Telephone: 01292 610555
Ext: 4468
www.show.scot.nhs.uk/aaaht

NHS
Ayrshire
& Arran

THE BRUCE DAY SURGERY SUITE

	JOHNSTONE A100-544212 L 16 MINNOCH CRESCENT LEE	
Surnar	MAYBOLE 0902763334 KA198DW	
Foren:	09/02/1976	
Addre	LAU, C (GP) MAYBOLE HEALTH CENTRE. 6 HIGH STREET MAYBOLE	
Ward or Dept.	M/S	

Dear Colleague

The above patient attended The Bruce Day Surgery Suite on _____

The procedure carried out was Excision of lesion of (L) Thigh. under local / general anaesthetic.

The patient was discharged home following this.

We would be grateful if you could:-

a) remove sutures in 10 days time. 12/11/07.

b) ~~remove the theatre dressing in _____ days and dress thereafter as required.~~

c) ~~reduce the theatre dressing in 24 hours / 48 hours / 72 hours.~~

d) ~~dressing to remain intact until clinic appointment~~

Comments _____

_____

_____

~~District Nurse visit requested by ansaphone / telephone on~~ _____

✓ Patient will contact surgery to make an appointment with Practice Nurse. Removal of Sutures 12/11/07.

The patient ~~has~~ / has not a review appointment.

A more detailed letter will follow.

Should you require further information please contact us on the above extension.

Yours sincerely,

Laura Adams

Awarded for excellence

DRS 036

The Ayr Hospital
Dalmellington Road
Ayr KA6 6DX
Telephone: 01292 610555 ☎ ext 14072

BF/CH/100-544212
Chi no.090276 3334

DEPARTMENT OF OTOLARYNGOLOGY

MISS E. M. SHANKS

Date of clinic : 26th November 2007
Date dictated : 26th November 2007
Date typed 30th November 2007

Dr E Steele
Health Centre
6 High Street
Maybole

Dear Dr Steele

LEE JOHNSTONE 16 MINNOCH CRESCENT MAYBOLE 9/2/76

I reviewed this patient in the out patient clinic. He was referred because of possible recurrence of thyroglossal cyst. The patient had an ultrasound scan which did not show any cyst or any other abnormality. The patient has not noted any further swelling.

Today on examination I was not able to palpate any swelling.

I have discharged the patient from the out patient clinic, but would be glad to see him again at your request.

Yours sincerely

MS B. FRUHSTORFER
FTSTA 3 in ENT SURGERY

Otolaryngology

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

CHI:0902763334

MEDICAL IN CONFIDENCE

REFERRAL TO

General SurgeryC1
AA Gen Ref - PMH Med & High

Ayr Hospital

Ethnic Origin	-
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	19-Sep-2007
Date submitted	19-Sep-2007

PATIENT DETAILS

Surname	Johnstone
Forename(s)	Lee David
Title	-
Sex	Male
Date of birth	09-Feb-1976
CHI no.	0902763334

Patient's address

16 Minnoch Crescent
MAYBOLE
AYRSHIRE
KA19 8DW

Contact number(s)

Voice: 01655 884283

REGISTERED GP DETAILS

Name	Dr Gerald Paton		
GMC code	2597021	GP code	A23612
Practice name	Maybole Health Centre		
Practice code	80467		

Practice address

6 High Street Maybole

Contact number(s)

Voice: 01655 882278

REFERRING PRACTITIONER DETAILS

Name	Dr Gerald Paton		
GMC code	2597021	GP code	A23612

Practice address

6 High Street Maybole

Practice name	Maybole Health Centre
Practice code	80467

Contact number(s)

Voice: 01655 882278

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: see letter

Comment: Dear Colleague Many thanks for seeing the above patient. He is a 31 year old man who presents with a small cystic lesion on the outer aspect of his (L) thigh. This is causing him some discomfort and he is keen for it to be removed. I would be grateful if you could see him with a view to arranging this for him. Kind regards

Examinations and Investigations

Current smoker:	22-Feb-2005
Alcohol intake above recommended sensible limits:	28-Jan-2004
Enjoys light exercise:	28-Jan-2004

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Lansoprazole	01.03.05.0	Gastro Resistant CAPS 15MG	1 Cap	Daily	11-Apr-2007	-	-

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Lansoprazole	01.03.05.0	CAPS 30MG	1 Cap	In the morning	19-Sep-2007	-	-

Clinical warnings

Smoking status

Alcohol consumption

Additional relevant information

Signature of referring doctor (or other professional) **Date**

The Ayr Hospital
Dalmellington Road
Ayr KA6 6DX
Telephone: 01292 610555 ☎ ext 14072

BF/CH/100-544212
Chi no.0902763334

DEPARTMENT OF OTOLARYNGOLOGY

MISS E. M. SHANKS

Date of clinic : 03rd September 2007
Date dictated : 03rd September 2007
Date typed 10th September 2007

Dr E Steele
Health Centre
6 High Street
Maybole

Dear Dr Steele

LEE JOHNSTONE 16 MINNOCH CRESCENT MAYBOLE 9/2/76

Thank you for referring this patient to our out patient clinic on. He had an excision of a thyroglossal cyst on 3 occasions most recently done by the general surgery in 1998 and 1999. In the past 12 months he has noticed some recurrence of the cyst which is fluctuating in size. He has no symptoms and he is fit and healthy otherwise.

On examination there was a scar over the laryngular prominence and also some hardening probably because of scar tissue. I could not find any distinct swelling.

I have arranged for an ultrasound scan of the neck. We will review the patient again after we have the result

Yours sincerely

MS B. FRUHSTORFER
FTSTA 3 in ENT SURGERY

JMcC/60803

Otolaryngology

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

CHI:0902763334

REFERRAL TO

Ear, Nose & Throat (ENT)C5 AA Gen Ref - PMH Med & High	
Ayr Hospital	

Ethnic Origin	-
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	26-Jun-2007
Date submitted	28-Jun-2007

PATIENT DETAILS

Surname	Johnstone
Forename(s)	Lee David
Title	-
Sex	Male
Date of birth	09-Feb-1976
CHI no.	0902763334

Patient's address

16 Minnoch Crescent
MAYBOLE
AYRSHIRE
KA19 8DW

Contact number(s)

Voice: 01655 884283

REGISTERED GP DETAILS

Name	Dr Gerald Paton		
GMC code	2597021	GP code	A23612
Practice name	Maybole Health Centre		
Practice code	80467		

Practice address

6 High Street Maybole

Contact number(s)

Voice: 01655 882278

REFERRING PRACTITIONER DETAILS

Name	Dr. Elizabeth Steele		
GMC code	1628757	GP code	23639

Practice address

6 HIGH STREET
MAYBOLE

Practice name	MAYBOLE HEALTH CENTRE (80467)	AYRSHIRE	
Practice code	80467	Contact number(s)	
		Voice: 01655882278	

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: Return of thyroglossal cyst.

Comment: This man has noticed a small pea sized cyst in the midline of his neck. He says it was much larger than this yesterday and on examination it is very mobile. He has had the removal of a thyroglossal cyst in 1982 and again in 1998 and 1999, the last 2 have been done by the General Surgeons. I would be grateful if you could see him on this occasion and see if you can help with the removal of this current one.

Examinations and Investigations

Current smoker:	22-Feb-2005
Alcohol intake above recommended sensible limits:	28-Jan-2004
Enjoys light exercise:	28-Jan-2004

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Lansoprazole	01.03.05.0	Gastro Resistant CAPS 15MG	1 Cap	Daily	11-Apr-2007	-	-

Recent medication (Any medication issued within last 90 days not shown above)

No recent medications recorded

Clinical warnings

Smoking status

Alcohol consumption

Additional relevant information

Signature of referring doctor (or other professional) **Date**

PATIENT SERVICES

Department of Neurology

Crosshouse Hospital
Crosshouse
Kilmarnock KA2 0BE
Telephone: 01563 521133
Fax: 01563 577976
www.show.scot.nhs.uk/aaaht

Our Ref: HR/BF/**A100-544212**
CHI: 0902763334
Direct Dial: 01563 577696 – Ext: 2696
Fax: 01563 577493

Date Dictated: 23.09.06 0 Neurology Clinic - WLI
Date Typed: 21.10.06

Dr Lau
The Health Centre
6 High Street
Maybole

Dear Dr Lau

Lee Johnstone, 09.02.1976., 16 Minnoch Crescent, Maybole, KA19 8DW

Your patient did not attend the extra WLI Neurology Clinic on 23.09.06. No further appointment will be sent unless we hear from yourself.

Yours sincerely

Dr H Rahman MBBS, MRCPI, MMSc
Consultant Neurologist

cc: Dr M Bell, Locum Consultant in A&E Care, The Ayr Hospital, Dalmellington Road, Ayr

Accident and Emergency Department
Ayr Hospital
Dalmellington Road
Ayr, KA6 6DX

Tel: 01292 610555

NHS
Ayrshire & Arran

REF: MB/LB/100-544212
CHI number: 0902763334

Date Dictated: 01.05.06
Date Typed: 09.05.06

Enquiries to: Mrs Louise Blades, A & E Secretary
Extension: 4578
Direct Dial: 01292 614578
Fax: 01292 288105
E-mail: louise.blades@aaaht.scot.nhs.uk

Dr O'Leary
Consultant Neurologist
The Ayr Hospital

Dear Dr O'Leary

LEE JOHNSTONE, 16 MINNOCH CRESCENT, MAYBOLE
D.O.B: 09.02.1976

As discussed by telephone with your Secretary, I would be grateful if you could arrange to review this gentleman with regard to what seems to be alcohol related seizures. He is currently not on any anti-Epileptic medication, and a CT scan performed during this admission for trauma was reported as normal.

Yours sincerely

DR MARK BELL
LOCUM CONSULTANT IN ACCIDENT AND EMERGENCY CARE

Routine new named
15-05-06

AYR HOSPITAL
16 MAY 2006
ADDED TO OUTPATIENTS WAITING LIST

STA 5000

Accident and Emergency Department
General Hospitals Division
Ayr Hospital
Dalmellington Road
Ayr, KA6 6DX

Tel: 01292 610555

NHS
Ayrshire & Arran

REF: MB/LB/100-544212
CHI number: 0902763334

Date Admitted:	30.04.06
Date Discharged:	01.05.06
Date Dictated:	01.05.06
Date Typed:	09.05.06

Enquiries to: Mrs Louise Blades, A & E Secretary
Extension: 4578
Direct Dial: 01292 614578
Fax: 01292 288105
E-mail: louise.blades@aaaht.scot.nhs.uk

Dr C Lau
6 High Street
Maybole

Dear Dr Lau

LEE JOHNSTONE, 16 MINNOCH CRESCENT, MAYBOLE
D.O.B: 09.02.1976

DIAGNOSES:
1. Soft tissue injuries from motor vehicle collision.
2. Acute and chronic alcohol excess.
3. Alcohol related seizures.

This 30 year old man was admitted for observation after being involved in a high velocity motor vehicle collision with a tree. He was the driver of the vehicle, and restrained, but has no recollection of events. An alcohol level on admission was 319mgs/dl. He was extricated from the vehicle by Paramedics who record two self limiting seizures at the scene.

A trauma series of x-rays was limited by Patient co-operation on admission, but did not show any acute abnormality.

A CT brain scan was also performed which was documented as normal.

Overnight observations were normal. A systematic review of injuries showed these to be essentially soft tissue in nature. There was a pronounced seat belt restraint mark. There was bruising and tenderness in the left flank. There were superficial scrapes and cuts to the limbs.

In view of the flank tenderness and some microscopic haematuria, an abdominal ultrasound scan was performed which was normal.

From previous Medical notes, I see that there was an admission in July 2003 with what seems to have been alcohol related seizures. A CT brain at that time was normal. The notes state that Mr Johnston is known to have had previous seizures, but absconded before his anti-epileptic Medication could be changed. Mr Johnston states he has never been on anti-Epileptic medication, and has had no previous seizures other than those in 2003. He has been driving ever since. There was Police Surgeon involvement in this case.

Continued/.....

RE: LEE JOHNSTONE

The Psychiatric Liaison Nurse reviewed Mr Johnstone with respect to his alcohol consumption, which appears to be of a binge pattern. He refused alcohol counselling at this time. Mr Johnstone has been advised not to drive and to inform the DVLA of these seizures. With respect to the seizures, I will ask Dr O'Leary to follow up on discharge.

Yours sincerely

DR MARK BELL
LOCUM CONSULTANT IN ACCIDENT AND EMERGENCY CARE

Cc Dr O'Leary, Consultant Neurologist, The Ayr Hospital

Psychiatric Liaison Service
Accident & Emergency Department
The Ayr Hospital
Dalmellington Road
Ayr, KA6 6DX
01292 610555

LB/MQ/100-549212 CHI: 0902763334

Date Assessed: 01.05.06
Date Dictated: 02.05.06
Date Typed: 08.05.06

Enquiries: Maureen Quinnell,
A&E/PLS Secretary
Extension: 4615
Direct Dial: 01292 614615
Fax: 01292 288105
E-mail: maureen.quinnell@aaaht.scot.nhs.uk

Dr Lau
Health Centre
Maybole

Dear Dr Lau

LEE JOHNSTONE, 16 MINNOCH CRESCENT, MAYBOLE
D.O.B: 09.02.76

This man was referred to the Psychiatric Liaison Service. I assessed him on 01.05.06 in the Observation Ward. I was asked to see him regarding his alcohol consumption post-admission as a driver of a car having hit a tree at speed. He was alcohol intoxicated, his alcohol level being 319 on admission. He states that he had been drinking all day on the Sunday and has no recollection of events leading to this crash. He believed he had two seizures , stating he has had previous alcohol related seizures.

He describes a history of consuming alcohol Fridays/Saturdays, approximately one litre of vodka per day. He states this is a reduction from him previously drinking every day approximately three days ago. He had attended Home Detox at that time via Linda Surgenor but had an unsuccessful detox and continued to drink although has reduced it to weekend bingeing only. He feels that his alcohol is not a problem and refused any further help with this at this time. His appetite and sleep pattern are okay and describes no cravings. He was advised that the amount of units he is consuming is obviously well above the legal amount. He was also advised that if charged by the Police today counselling may enforced as part of probation. He denied any forensic history and is currently unemployed.

In summary, this man appears to have a binge alcohol problem and I have advised him to attend Ayrshire Council on Alcohol but he refused this advice. He states that he plans to abstain as he is currently shocked by recent events. There is no evidence of acute mental illness today and he was discharged. If you require any further information please do not hesitate to contact me.

Yours sincerely

MRS LORNA BRUCE
PSYCHIATRIC LIAISON NURSE

Accident and Emergency Department
Ayr Hospital
Dalmellington Road
Ayr, KA6 6DX

Tel: 01292 610555

REF: MB/LB/100-544212
CHI number: 0902763334

Date Dictated: 01.05.06
Date Typed: 09.05.06

Enquiries to: Mrs Louise Blades, A & E Secretary
Extension: 4578
Direct Dial: 01292 614578
Fax: 01292 288105
E-mail: louise.blades@aaaht.scot.nhs.uk

Dr O'Leary
Consultant Neurologist
The Ayr Hospital

Dear Dr O'Leary

LEE JOHNSTONE, 16 MINNOCH CRESCENT, MAYBOLE
D.O.B: 09.02.1976

As discussed by telephone with your Secretary, I would be grateful if you could arrange to review this gentleman with regard to what seems to be alcohol related seizures. He is currently not on any anti-Epileptic medication, and a CT scan performed during this admission for trauma was reported as normal.

Yours sincerely

DR MARK BELL
LOCUM CONSULTANT IN ACCIDENT AND EMERGENCY CARE

Accident and Emergency Department
General Hospitals Division
Ayr Hospital
Dalmellington Road
Ayr, KA6 6DX

Tel: 01292 610555

REF: MB/LB/100-544212
CHI number: 0902763334

Date Admitted:	30.04.06
Date Discharged:	01.05.06
Date Dictated:	01.05.06
Date Typed:	09.05.06

Enquiries to: Mrs Louise Blades, A & E Secretary
Extension: 4578
Direct Dial: 01292 614578
Fax: 01292 288105
E-mail: louise.blades@aaaht.scot.nhs.uk

Dr C Lau
6 High Street
Maybole

Dear Dr Lau

LEE JOHNSTONE, 16 MINNOCH CRESCENT, MAYBOLE
D.O.B: 09.02.1976

DIAGNOSES:
1. Soft tissue injuries from motor vehicle collision.
2. Acute and chronic alcohol excess.
3. Alcohol related seizures.

This 30 year old man was admitted for observation after being involved in a high velocity motor vehicle collision with a tree. He was the driver of the vehicle, and restrained, but has no recollection of events. An alcohol level on admission was 319mgs/dl. He was extricated from the vehicle by Paramedics who record two self limiting seizures at the scene.

A trauma series of x-rays was limited by Patient co-operation on admission, but did not show any acute abnormality.

A CT brain scan was also performed which was documented as normal.

Overnight observations were normal. A systematic review of injuries showed these to be essentially soft tissue in nature. There was a pronounced seat belt restraint mark. There was bruising and tenderness in the left flank. There were superficial scrapes and cuts to the limbs.

In view of the flank tenderness and some microscopic haematuria, an abdominal ultrasound scan was performed which was normal.

From previous Medical notes, I see that there was an admission in July 2003 with what seems to have been alcohol related seizures. A CT brain at that time was normal. The notes state that Mr Johnston is known to have had previous seizures, but absconded before his anti-epileptic Medication could be changed. Mr Johnston states he has never been on anti-Epileptic medication, and has had no previous seizures other than those in 2003. He has been driving ever since. There was Police Surgeon involvement in this case.

Continued/.....

RE: LEE JOHNSTONE

The Psychiatric Liaison Nurse reviewed Mr Johnstone with respect to his alcohol consumption, which appears to be of a binge pattern. He refused alcohol counselling at this time. Mr Johnstone has been advised not to drive and to inform the DVLA of these seizures. With respect to the seizures, I will ask Dr O'Leary to follow up on discharge.

Yours sincerely

DR MARK BELL
LOCUM CONSULTANT IN ACCIDENT AND EMERGENCY CARE

Cc Dr O'Leary, Consultant Neurologist, The Ayr Hospital

STA0606

SKG/GS/100-544212

GENERAL MEDICINE - DR S K GHOSH

Date Admitted: 11.07.03
Date Discharged: 13.07.03

Date Dictated: 22.07.03
Date Typed: 04.08.03

Dr Lau
The Health Centre
6 High Street
MAYBOLE

Dear Dr Lau

LEE JOHNSTONE, 15A DRUMELLAN STREET, MAYBOLE (DOB 09.02.76)

DIAGNOSIS:
1. Epileptic fit
2. Alcoholism

Mr Johnstone with a history of alcohol over indulgence and previous epilepsy was admitted with repeated epileptic fit. Initially he was looked after by Dr Reynolds and I took over his care at the weekend. Inspite of adjusting his anti-epileptic drugs he was still having small fits. We did a CT scan of his brain which was normal and we tried to change his anti-epileptic drug. Inspite of all my advice Mr Johnstone decided to take his own discharge. He did not even wait for the prescription to be taken.

Yours sincerely

S K Ghosh
Consultant Physician

MEDICAL

Ayrshire & Arran
ACUTE HOSPITALS NHS TRUST

Telephone: (01292) 610555
Fax: (01292) 265265

Immediate Discharge Summary

GP
Address

Pa JOHNSTONE LEE A100-544212
Ad 15A DRUMELLAN STREET
MAYBOLE 0902763334
09/02/1976
D LAU, C (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE
M/S

Admission Date 11/7/03 Discharge Date 13/7/03 Station 7

Admission Type Emergency - Adt Referral. Consultant DR GHOSH

Diagnosis Admitted c seizures.

Summary History of alcohol excess. Had stopped drinking recently but then drank 5L cider which resulted in status epilepticus. Had diazepam but seizures continued, so IV phenytoin started. Self-discharged; opt up, pulled venflon out & walked out. No irregular discharge form completed.

Operation Date

Medication on Discharge

PHARMACY USE ONLY

Medicine / Dressing BLOCK CAPITALS	Dose	Route	Time of Admin	Continue or Stop	Quantity & Strength	Pharmacy Notes
NUMBER OF DAYS SUPPLY IF MORE THAN 7						

OWN MEDS

DATE	Dispensed by	Checked by

Further comments: (e.g. Histology, Information given to patient regarding diagnosis....etc)

A consultant episode letter *will / will not* follow

Outpatient Appointment *YES / NO*

Distribution GP ☑ Pharmacy ☐ Casenotes ☐ District Nurse ☐ Patient *Yes / No*

Dr's Signature V Winchester Print Name V. WINCHESTER Date 15/09/03

STEWART 13/8/01 1.40

Dr C Lau
Dr E C Wilson
Dr J Sheward

Appointments: 01655 882708
Prescriptions: 01655 883922
Fax: 01655 882977
Ref: 80491

Maybole Health Centre
6 High Street
MAYBOLE
KA19 7BY

Our ref: CL/ZG
Your ref: A100-544212

544212

4th July 2001

Mr G Stewart
Consultant Surgeon
Ayr Hospital
Dalmellington Road
AYR
KA6 6DX

Dear Mr Stewart

Lee Johnstone, 4c Whitefaulds Avenue, Maybole, KA19 8AS
DOB 09.02.1976 CHI 3334 No phone

This man has a recurrent thyroglossal cyst, which was excised in March 1982, February 1998 and November 1999. He failed to attend a follow up appointment to your clinic on the 24th January 2000. Unfortunately he still has a variable amount of discharge from the scar most days.

PMH – excision of thyroglossal cyst March 1982, February 1998 and November 1999, fracture of right femur 1983, Guillain-Barre syndrome May 1995, appendicectomy January 2000, burns to trunk genitals, arms and hands in chip pan fire June 2001.

DH – Nil

Allergies – Nil known

I would be most grateful if you would reassess him and your help in his future management.

Yours sincerely

Dr C Lau

CONSULTANTS INSTRUCTIONS TO APPOINTMENTS STAFF
CIRCLE PRIORITY
URGENT
SOON
ROUTINE 1340 13/8/01
INITIALS

RECEIVED
- 6 JUL 2001

Ayrshire & Arran
ACUTE HOSPITALS NHS TRUST

The Ayr Hospital
Dalmellington Road, Ayr KA6 6DX

Telephone: 01292 610555 Fax:

Your Ref:

Our Ref:

Station 2
27/6/01

Dear Doctor

Re: Lee Johnstone 4C Whitefaulds Ave Maybole DoB 09 02 1976

This 25 year old man has sustained a large burn over his chest, abdomen and both upper limbs when a chip-pan fell on him. This occurred at 01:50 this morning.

My registrar has discussed this patient with Mr. Taggart, who has suggested that he be transferred to your care as soon as possible.

His past medical history is as follows – appendicectomy and excision of thyroglossal cyst.

He is on no regular medications but is receiving morphine as required for his pain. He is currently receiving 3 hourly bags of Hartmann's solution.

Thank-you for taking over the care of this gentleman.

Yours sincerely

Andrew Harvey
JHO Station 2

ST/AB/100-544212

SURGICAL UNIT
MR I MCMILLAN

DATE ADMITTED: 02/01/2000
DATE DISCHARGED: 06/01/2000
DATE DICTATED: 11/01/2000
DATE TYPED: 12/01/2000

Dr C Lau
The Health Centre
6 High Street
Maybole

Dear Dr Lau

MR LEE JOHNSTONE 4C WHITEFAULDS AVENUE MAYBOLE (DOB 09/02/1976)

DIAGNOSIS: Appendicitis

PROCEDURE: Appendicectomy

COMPLICATIONS: Nil

COMMENTS

Follow-up – nil.

This 20 year old gentleman was admitted initially under the care of the Accident & Emergency physicians with abdominal pain of one days duration following some alcohol excess on hogmany. He was initially managed in the area observation ward, however when his pain did not settle he was transferred to the surgical team and over the next twelve hours his pain localised to the right iliac fossa. At operation a necrotic appendix wrapped in omentum was discovered and he underwent routine appendicectomy. He made a quick and uncomplicated recovery following this and was discharged once he had made a full recovery.

Yours sincerely

MR S TAYLOR FRCS
Senior House Officer III

SURGICAL

10.4

SOUTH AYRSHIRE HOSPITALS NHS TRUST

Immediate Discharge Summary

THE AYR HOSPITAL
DALMELLINGTON RD
AYR KA6 6DX
Telephone: (01292) 610555
Fax: (01292) 265265

GP Address: LAU, C (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE
KA19 7BY

Patient Address: LEE JOHNSTONE
4C WHITEFAULDS AVENUE
MAYBOLE
KA198AS

script number 100801

D.O.B: 09/02/1976
A100-544212

Admission Date: 02/01/00
Admission Type: EMERG ILLNESS
UK

Discharge Date: 06/01/00
Consultant: MCMILLAN, I
Station: S2

Diagnosis Summary:
ADMITTED WITH APPENDICITIS-
APPENDIX REMOVED
UNCOMPLICATED RECOVERY
COMFORTABLE ON DISCHARGE

Operation: Date:

Medication on Discharge

Medicine/Dressing BLOCK CAPITALS	Dose	Route	Time of Admin	Continue or Stop	Quantity & Strength	Pharmacy Notes
VOLTAROL	50mg	O	tid	5 DAYS	15 x 50mg.	
NUMBER OF DAYS SUPPLY IF MORE THAN 7						

PHARMACY USE ONLY

DATE	Dispensed by	Checked by
6/1/00	KS/EM.	RM

Further comments: (e.g. Histology, Information given to patient regarding diagnosis...etc.)

A consultant episode letter *will/will not* follow

Outpatient Appointment *Yes/No*

Distribution GP ☐ Pharmacy ☐ Casenotes ☐ District Nurse ☐ Patient *Yes/No*

Dr's Signature [signature] Print Name SMCILHINNEY Date 06/01/00

GS/JMM/AG533212

SURGICAL UNIT
MR G STEWART

DATE DICTATED:	29/11/99	DATE ADMITTED:	22/11/99
DATE TYPED:	29/11/99	DATE DISCHARGED:	25/11/99

Dr C Lau
The Health Centre
6 High Street
MAYBOLE

Dear Dr Lau

RE: LEE JOHNSTONE, 4C WHITEFAULDS AVENUE, MAYBOLE.
DOB 09/02/1976

DIAGNOSIS:
Recurrent thyroglossal cyst

PROCEDURE:
23/11/99 - Excision recurrent thyroglossal cyst

COMPLICATIONS:
Nil

COMMENTS:
This young man had an uneventful post-operative course. His histology is returned showing essentially reactive tissue and abscess formation. I suspect the lack of specific thyroglossal tissue is due to the degradation that follows recurrent procedures. I would hope that we will have solved this man's problems and I am sure you are aware time will tell. He will be reviewed in the Surgical Clinic in due course.

Best wishes.

Yours sincerely

GORDON STEWART MD FRCS
Consultant Surgeon

SURGICAL

Faxed @ 08:40 to P+O

SOUTH AYRSHIRE HOSPITALS NHS TRUST

Immediate Discharge Summary

THE AYR HOSPITAL
DALMELLINGTON RD
AYR KA6 6DX
Telephone: (01292) 610555
Fax: (01292) 265265

GP Address
LAU,C (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE
KA19 7BY

Patient Address
LEE JOHNSTONE
4C WHITEFAULDS AVENUE
MAYBOLE
KA198AS

D.O.B
09/02/1976
A100-544212

Admission Date 22/11/99
Admission Type WAITING LIST
Discharge Date 25/11/99
Consultant STEWART,G.
Station S2

Diagnosis
EXCISION THYROGLOSSAL CYST

Summary
ADMITTED FOR EXPLORATION WITH EXCISION OF THYROGLOSSAL CYST. UNCOMPLICATED PROCEDURE AND RECOVERY. PATIENT LEFT WARD BEFORE HE HAD RECIEVED FINAL DOSE OF AUGMENTIN. KIND REGARDS.

Operation
Date

Medication on Discharge

PHARMACY USE ONLY

Medicine/Dressing BLOCK CAPITALS	Dose	Route	Time of Admin	Continue or Stop	Quantity & Strength	Pharmacy Notes
No meds						
NUMBER OF DAYS SUPPLY IF MORE THAN 7					DATE / Dispensed by / Checked by	

Further comments: (e.g. Histology, Information given to patient regarding diagnosis... etc:)

A consultant episode letter *will/will not* follow
Outpatient Appointment *Yes/No*

Distribution GP ☑ Pharmacy ☐ Casenotes ☐ District Nurse ☐ Patient *Yes / No*

Dr's Signature V Goldie Print Name VICKI GOLDIE Date 25/11/99

GS/JMM/AG544212

SURGICAL UNIT - MR GORDON STEWART

Dictated: 18/08/99
Typed: 19/08/99

Mr Iain McMillan
Consultant Surgeon
The Ayr Hospital
AYR

Dear Iain

RE: LEE JOHNSTONE, 4C WHITEFAULDS AVENUE, MAYBOLE.
DOB 09/02/1976

Your patient's neck ultrasound did not show any obvious tract. I would therefore hope that he would not require a particularly major exploration on the next occasion and I will admit him in due course for his surgery.

Best wishes.

Yours sincerely

GORDON STEWART MD FRCS
Consultant Surgeon

Copy: Dr C Lau, The Health Centre, 6 High Street, Maybole.

SURGICAL

[redacted]

GS/JMM/AG544212

SURGICAL CLINIC
MR G STEWART

DATE OF CLINIC: 10/05/99
DATE DICTATED: 10/05/99
DATE TYPED: 11/05/99

Mr Iain McMillan
Consultant Surgeon
The Ayr Hospital
AYR

Dear Iain

RE: LEE JOHNSTONE, 4C WHITEFAULDS AVENUE, MAYBOLE.
DOB 09/02/1976

Thank you for referring this young man who as you say has a recurrent thyroglossal cyst. There seems little doubt that he will require this explored again. As part of this I have arranged for him to have some imaging including an ultrasound to see how well we can image the tract and once I have seen that will arrange for his further surgery.

Best wishes.

Yours sincerely

GORDON STEWART MD FRCS
Consultant Surgeon

Copy: Dr C Lau, The Health Centre, 6 High Street, Maybole.

Surgical

[redacted]

10/5/99 1.30

THE AYR HOSPITAL

DALMELLINGTON ROAD · AYR KA6 6DX
TELEPHONE: 01292 610555 FAX: 01292 288952

Our Ref: IMCM/AB/100-544212 Your Ref: If 'phoning please ask for:

544212

SURGICAL UNIT
MR I MCMILLAN

DATE DICTATED: 16/03/1999
DATE TYPED: 17/03/1999

RECEIVED
23 MAR 19
APPOINTMENTS OFFICE

Mr G Stewart
Consultant Surgeon
The Ayr Hospital
Dalmellington Road
Ayr

Dear Gordon

MR LEE JOHNSTONE 4C WHITEFAULDS AVENUE MAYBOLE (DOB 09/02/1976)

I would be grateful if you could undertake this young man's further management. He has a thyroglossal cyst. He had this explored as a child many years ago. More recently I explored his neck as he had a continuing discharge and bouts of inflammation.

Unfortunately it has recurred again and he now faces a third procedure. I am sure this is best undertaken by your good self.

Kind regards

Yours sincerely

I McMILLAN MD FRCS
Consultant Surgeon

CONSULTANTS INSTRUCTIONS TO ... STAFF
... PRIORITY
ROUTINE SURG MON
INITIALS

544
IMCM/AB/100-~~655~~212

SURGICAL UNIT
MR I MCMILLAN

DATE DICTATED: 16/03/1999
DATE TYPED: 17/03/1999

Mr G Stewart
Consultant Surgeon
The Ayr Hospital
Dalmellington Road
Ayr

Dear Gordon

MR LEE JOHNSTONE 4C WHITEFAULDS AVENUE MAYBOLE (DOB 09/02/1976)

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Unfortunately it has recurred again and he now faces a third procedure. I am sure this is best undertaken by your good self.

Kind regards

Yours sincerely

I McMILLAN MD FRCS
Consultant Surgeon

[redacted]

Surgical

[redacted]

IMCM/AB/100-544212

SURGICAL CLINIC
MR I MCMILLAN

DATE OF CLINIC: 15/03/1999
DATE DICTATED: 15/03/1999
DATE TYPED: 16/03/1999

Dr C Lau
The Health Centre
6 High Street
Maybole

Dear Dr Lau

MR LEE JOHNSTONE 4C WHITEFAULDS AVENUE MAYBOLE (DOB 09/02/1976)

This young man appears to have recurrence of his thyroglossal cyst. I think he will require surgery and I have referred him to my colleague Mr. Stewart who has a special interest in thyroid disorders.

Yours sincerely

I McMILLAN MD FRCS
Consultant Surgeon

Surgical

McMILLAN 15/3 1-40

S44212

Dr C Lau
Dr E Wilson
Dr J Sheward

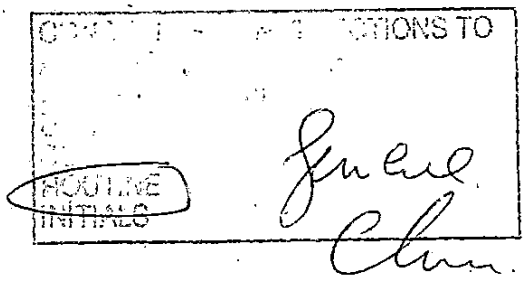
Tel: 01655 882708
01655 883922(prescription only)
Fax: 01655 882977

MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE

Our Ref CL/JT
Your Ref : The Ayr Hospital 100544212

09 February 1999

Mr I. McMillan
Consultant Surgeon
The Ayr Hospital
Dalmellington Road
AYR
KA6 6DX



Dear Mr McMillan

Re Lee Johnstone, 4C Whitefaulds Avenue, Maybole. KA19 8AS
Date of Birth 09.02.76 Chi No 3334

This man had exploration and excision of thryoglossal tract in February 1998. Unfortunately he has a residual cyst at the site of the scar. An ultrasound of scan of the neck was arranged. Mr Johnstone tells me that he never received the appointment for the ultrasound. Unfortunately the cyst is now getting bigger and has been tender on occasions. I have given him a seven day course of Coamoxiclav 1 tab tds.

PHH - Excision of thryoglossal cyst March 1982, Fracture of right femur 1983, Guillain Barre syndrome May 1995, excision of thryoglossal cyst February 1998.

Allergies - Nil known

DH - Coamoxiclav 1 tab tds.

I would be most grateful if you would see this man and for your help in his future management.

Yours sincerely

Dr C. Lau

RECEIVED
11 FEB 1999

Consultation and Management

IMCM/AB/100-544212

SURGICAL UNIT
MR I MCMILLAN

DATE DICTATED: 14/08/1998
DATE TYPED: 14/08/1998

Dr C Lau
The Health Centre
6 High Street
Maybole

Dear Dr Lau

MR LEE JOHNSTONE 16 MINNOCH CRESCENT MAYBOLE (DOB 09/02/1976)

This man recently failed to attend for the ultrasound examination that was scheduled to assess his neck further.

In the meantime no further appointment has been arranged but if he returns complaining of a problem we could always make the necessary arrangements.

Yours sincerely

I McMILLAN MD FRCS
Consultant Surgeon

Surgical

SOUTH AYRSHIRE HOSPITALS NHS TRUST

THE AYR HOSPITAL

Affix identification label or write

Surname JOHNSTONE Forename LEE HCR .....

Address .....

.....

DOB/CHI Number 9/2/76

GP MR MCMILLAN

Date 7/7

Dear Doctor

The above patient ~~cancelled~~/did not attend (delete as necessary) for an Out Patient appointment at the X-RAY ~~clinic~~/department today.

Tick appropriate box

☐ A further appointment has been arranged for .....

☑ No further appointment has been arranged

☐ Other specify

.....

.....

.....

Signed .....

gpdnatah
pl/ch/18.5.93

SB/AB/100-544212

SURGICAL CLINIC
MR I MCMILLAN

DATE OF CLINIC: 04/05/1998
DATE DICTATED: 04/05/1998
DATE TYPED: 06/05/1998

Dr C Lau
The Health Centre
6 High Street
Maybole

Dear Dr Lau

MR LEE JOHNSTONE 16 MINNOCH CRESCENT MAYBOLE (DOB 09/02/1976)

I reviewed your patient who had a thyroglossal cyst excised from his neck. Unfortunately for the past ten days he has had a discharge from the middle of the scar.

On examination he has a small area of infection in the scar which is discharging serous fluid. He says the discharge is more during the morning.

I have arranged for him to have an ultrasound scan of the neck and also advised him to contact you regarding a course of Augmentin. We will review him with the results of the scan.

Yours sincerely

S BALAJI
Senior House Officer III

U/S requested

Surgical

IMM/LW/100544212

GENERAL SURGERY
MR I McMILLAN

DATE OF ADMISSION: 26/02/98 DATE DICTATED: 26/03/98
DATE OF DISCHARGE: 28/02/98 DATE TYPED: 30/03/98

Dr Lau,
Health Centre
6 High Street,
MAYBOLE

Dear Dr Lau

LEE JOHNSTONE, 16 MINNOCH CRESCENT, MAYBOLE (DOB 9/2/76)

DIAGNOSIS: Thyroglossal cyst

PROCEDURE: Exploration of thyroglossal tract

As arranged this young man was admitted from our waiting list. We explored the area of his neck which proved to be a thyroglossal tract. He had, of course, undergone surgery for this many years ago when he was 3-4 years old.

On EXPLORATION we followed the tract to the upper reaches of the neck as it disappeared into the floor of the mouth.

The histology shows and inflamed sinus tract with no specific features.

I will see him again for review in the out-patient clinic in a few weeks time.

Yours sincerely

I McMILLAN MD FRCS
CONSULTANT SURGEON

Surgical

SOUTH AYRSHIRE HOSPITALS NHS TRUST

Immediate Discharge Summary

THE AYR HOSPITAL . DALMELLINGTON RD
AYR KA6 6DX
Telephone: (01292) 610555
Fax: (01292) 265265

GP Address: LAU, C (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE
KA19 7BY

Patient Address: LEE JOHNSTONE
16 MINNOCH CRESCENT
MAYBOLE
KA198DW

3.20

D.O.B. 09/02/1976

script number
0 5 7 4 1 7

A100-544212

Admission Date 26/02/98
Admission Type WAITING LIST

Discharge Date 28/02/98
Consultant MCMILLAN, I.

Station S2

Diagnosis Summary: EXPLORATIONLESION

Excision of thyroglossal cyst performed.
no post op complications.

Operation: 83.39-EXC LES SOFT TISSUE NEC

Date:

Medication on Discharge

Medicine/Dressing BLOCK CAPITALS	DOSE	ROUTE	TIME OF ADMIN	CONTINUE OR STOP	PHARMACY USE ONLY: Quantity & Strength	Pharmacy Notes
Paracetamol	1g	O	4-6° PRN	C	30x500mg	
NUMBER OF DAYS SUPPLY IF MORE THAN 7						

DATE 27/2/98 | Dispensed by | Checked by

Further comments: (e.g. Histology, Information given to patient regarding diagnosis...etc.)

A consultant episode letter *will/will not* follow.

Outpatient Appointment *yes/no*

Distribution: GP ☐ Pharmacy ☐ Casenotes ☐ District Nurse ☐ Patient *Yes/No*

Dr's Signature [signature] Print Name McMillan Date 27/2/98

IMCM/AB/100-544212

SURGICAL CLINIC
MR I MCMILLAN

DATE OF CLINIC: 18/08/1997
DATE DICTATED: 18/08/1997
DATE TYPED: 19/08/1997

Dr John Sheward
Maybole Health Centre
6 High Street
Maybole

Dear Dr Sheward

MR LEE JOHNSTONE 16 MINNOCH CRESCENT MAYBOLE (DOB 09/02/1976)

I saw Lee today at the surgical clinic. I think the next stage is to arrange for an ultrasound examination of his neck and I have now placed his name on the waiting list for exploration of the lesion which lies on the left side of the midline.

Yours sincerely

I McMILLAN MD FRCS
Consultant Surgeon

Surgical

112 McMillan 18/8/97 1:50

Dr C Lau
Dr E C Wilson
Dr J Sheward

Appointments: 01655 882708
Prescriptions: 01655 883922
Fax: 01655 882977
Ref: 80941

Maybole Health Centre
6 High Street
Maybole KA19 7BY

Our ref:JS/KMcP
Your ref:IMCM/AB/100-544212

01 July 1997

Mr McMillan
Consultant Surgeon
The Ayr Hospital
Dalmellington Road
AYR
KA6 6DX

544212

Dear Mr McMillan

Re: Lee Johnstone, 16 Minnoch Crescent, Maybole KA19 8DW
D.O.B. 09/02/76 Chi No: 3334

You have seen this young man before with a infected branchial/thyroglossal cyst on his neck and you were going to arrange to have this removed under general anaesthetic. Lee was in a young offenders institution and the surgery has not been done despite your referral to Falkirk.

I would be most grateful if you could put him back on your surgical list for removal or see him at out-patients with a view to the same.

Yours sincerely

Dr J Sheward

General Surgery Clinic

RECEIVED
03 JUL 1997

A100-544212
JOHNSTONE LEE
12 WOODSIDE AVE
0902763334
KIRKMICHAEL
KA197PP 09/02/1976
end Feb
PATON,G (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE M/S

Cancellation of Procedure

Date.....

A100-544212
JOHNSTONE LEE
12 WOODSIDE AVE
0902763334
KIRKMICHAEL
KA197PP 09/02/1976
PATON,G (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE M/S

- Procedure..Repair of Supraumbilic Hernia
- Speciality..Surg.../THEATRE NO..3.....
- Person authorising..Mr...McMurtrie.....
- Consultant...Mr...McMurtrie.....
- Reason for cancellation...Referred to Mr....
...Crosby.....
- Patient admission time....09.00.....
- Time of discharge...09.30.....
- Action taken....For appt. for Mr. Crosby's list
- .....
- Signature....Crosby.....

IMCM/AB/100-544212

SURGICAL UNIT
MR I MCMILLAN

DATE DICTATED: 21/01/1997
DATE TYPED: 21/01/1997

Mr R C Smith
Consultant Surgeon
Falkirk Royal Infirmary
Falkirk

Dear Mr Smith

MR LEE JOHNSTONE 16 MINNOCH CRESCENT MAYBOLE (DOB 09/02/1976)

I would be grateful if you could assess this young man. He was referred by one of the SHOs at Falkirk Royal Infirmary a Dr. Eatock, at which time he had attended Falkirk and District Royal Infirmary with a view to undergoing excision of a neck lump. I think he attended a local anaesthetic list and was declined as it was felt that the lesion represented a thyroglossal cyst. At that time he was within the Young Offenders Institute at Polmont but subsequently returned to Ayrshire hence the referral to myself.

He is now again detained in the Young Offenders Institution at Polmont and therefore I presume one of the surgeons at Falkirk Royal Infirmary would undertake his surgery although it is not clear from the letter received from Dr. Eatock which particular consultant was involved.

I would be grateful if you could arrange his further care at Falkirk.

Yours sincerely

I McMILLAN MD FRCS
Consultant Surgeon

Surgical

IMCM/AB/100-544212

SURGICAL UNIT
MR I MCMILLAN

DATE DICTATED: 30/12/1996
DATE TYPED: 30/12/1996

Dr C Lau
The Health Centre
6 High Street
Maybole

Dear Dr Lau

MR LEE JOHNSTONE 16 MINNOCH CRESCENT MAYBOLE (DOB 09/02/1976)

This young man is now an in-patient at a young offenders institution near Falkirk. I have therefore referred him back to one of the surgeons at Falkirk Royal Infirmary.

Yours sincerely

I McMILLAN MD FRCS
Consultant Surgeon

Surgical

IMCM/AB/100-544212

SURGICAL CLINIC
MR I MCMILLAN

DATE OF CLINIC: 02/12/1996
DATE DICTATED: 02/12/1996
DATE TYPED: 03/12/1996

Dr C Lau
The Health Centre
6 High Street
Maybole

Dear Dr Lau

MR LEE JOHNSTONE 16 MINNOCH CRESCENT MAYBOLE (DOB 09/02/1976)

Many thanks for asking me to see this young man at the surgical clinic. He has a infected indurated mass on his neck. At present it is difficult to assess it clinically but I gather it has been labelled as a thyroglossal cyst in the past. This may well be the case as it does move when he protrudes his tongue, however the subcutaneous tissues are so indurated at present that this clinical sign is difficult to interpret.

He requires removal of the lesion and I will arrange for this to be done under general anaesthesia in the near future.

Yours sincerely

I McMILLAN MD FRCS
Consultant Surgeon

Surgical

BST 25/11/96 MR MAMILLAN 544212 1/45
1.40

Dr C Lau
Dr E C Wilson
Dr J Sheward

Tel 0655-882708
0655-883922 (prescriptions only)
0655-882977 (fax only)
Ref No 80491

Maybole Health Centre
6 High Street
MAYBOLE
KA19 7BY

Our ref: CL./MM
Your ref:

30 October 1996

Surgical Clinic
The Ayr Hospital
Dalmellington Road
AYR
KA6 6DX

Dear Doctor,

re: Lee Johnstone 16 Minnoch Crescent Maybole KA19 8DW
Date of Birth 09.02.76 Telephone 01655 889536

This man recently joined my medical practice. He attended Falkirk Infirmary for excision of a lump in the neck as a day case. However, the operation was cancelled because that the lump was a left branchial cyst.

Past medical history - ~~nil of note~~. Guillain Barre Syndrome

Drug history - nil.

I would be most grateful for your assessment and your help in his future management.

Yours sincerely,

C Lau

Consultation & Management

CONSULTANTS INSTRUCTIONS TO APPOINTMENTS STAFF
CIRCLE PRIORITY
URGENT
SOON
(ROUTINE)
INITIALS.....

RECEIVED
- 1 NOV 1996

AM/SMcC/AG544212

ORTHOPAEDIC DEPARTMENT

MR A MUIRHEAD

Date Dictated : 4 August 1995
Date Typed : 7 August 1995

Mr Lee Johnstone
16 Minnoch Crescent
MAYBOLE

Dear Mr Johnstone

I understand that you have been unable to attend for an MRI test on 6.7.95 and 3.8.95. I presume your symptoms have improved and therefore no further appointment for an MRI scan has been requested.

Yours sincerely

A MUIRHEAD
CONSULTANT ORTHOPAEDIC SURGEON

Copy to Dr Lau, The Health Centre, 6 High Street, MAYBOLE

Orthopaedic

Southern General Hospital
NHS Trust

1345 Govan Road Glasgow G51 4TF
Tel 0141-201 1100 Fax 0141-201 2998

1820641
JOHNSTONE LEE
16 MINNOCK CRES M
MAYBOLE S
09/02/1976
KA19 8DW G.P.Prac.:0278

27.4.1995

Dear Colleague;

This 19 year old male was transferred from Ayr Hospital to this hospital because of inability to walk. The problem started with proximal muscle weakness since 3-4 weeks prior to admission. He had no incontinence at the time of admission. He had a swallowing problem and needed oxygen on arrival for a short time.
On physical examination his cranial nerves were intact. Tone and muscular power in the upper and lower limbs were markedly decreased (2 and 1 over 5 respectively). No deep tendon reflexes were found on examination. CT scan was normal and CSF showed increased protein content to 72. EMG showed severe segmental peripheral nerve demyelination highly suggestive of acute Guillain-Barre type. Lack of motor axonal degeneration was taken as a good prognostic sign.
A human immunoglobulin infusion was started at 400mg/kg/day for 5 days. The patient has improved and DTR are back. General muscular power also increased. FEV is normal and patient can swallow and breathe normally. His condition is improving but he needs few months to complete the recovery. Continuation of physiotherapy is strongly recommended.
Medications:

Lactulose	10ml PO BID
Senna	15mg PO PRN
Paracetamol	2 tablet PRN QID

Dr. M. Zarei
SHO in Neurology

DM/SMcC/AG544212

ORTHOPAEDIC DEPARTMENT

MR A MUIRHEAD

Date Attended : 10 April 1995
Date Dictated : 10 April 1995
Date Typed : 12 April 1995

Dr C Lau
The Health Centre
6 High Street
MAYBOLE

Dear Dr Lau

re : LEE JOHNSTONE, 16 MINNOCH CRESCENT, MAYBOLE DOB 9.2.76

Your patient was seen at the Orthopaedic Outpatient clinic today.

Please find overleaf a copy of my clinical findings made at the time of the examination.

Yours sincerely

D MENON
ORTHOPAEDIC REGISTRAR

Orthopaedic

SOUTHERN GENERAL HOSPITAL NHS TRUST

01287 **Discharge/Transfer Plan**

NAMED NURSE: L. McKAY

CONSULTANT: PROF. BEHAN.

NAME: LEE JOHNSTONE

ADDRESS: 16 MINNOCK CRES. MAYBOLE

PHONE No: 0655-88536 D.O.B.: 9/2/76

WARD: 62.

UNIT No: 1820641

ADMISSION DATE: 15/4/95

MALE/~~FEMALE~~: RELIGION: PROT.

NEXT OF KIN: MR + MRS JOHNSTONE

ADDRESS: A/A

PHONE No.: A/A

MAIN CARER: SELF

ADDRESS:

PHONE No:

PLANNED ~~DIS~~/TRANS DATE: 2/5/95

FINAL DIS/TRANS DATE:

ADDRESS: Hyr hosp - Station 8.

GP: DR LAW

ADDRESS: THE HEALTH CENTRE

PHONE No: MAYBOLE

COMMUNITY LIAISON SISTER: ~~YES~~/NO

NAME - CONTACT No: N/A

RELEVANT INFORMATION:

PATIENT HAS SEVERE WEAKNESS IN LOWER LIMBS - REQUIRES INTENSE PHYSIO.

HOME CIRCUMSTANCES:

TYPE OF HOME: SEMI

ANYONE AT HOME: MUM + DAD

ANY OTHER SERVICES: (prior to admission)

N/A

ILLNESS/~~PROGRESS~~ DISCUSSED WITH PATIENT/RELATIVE/~~CARER~~

FINAL DIAGNOSIS:

GUILLIAN BARRE SYNDROME.

DATE & SIGNATURE: 27/4/95

PATIENT ASSESSMENT/COMMENTS		DATE	SIGNATURE
MOBILITY	CANNOT WEIGHT BEAR - HAS BEEN UP TO SIT IN CHAIR +	27/4/95	CH2
PERSONAL HYGIENE DRESSING	HAS NORMAL \MILD WEAKNESS IN ARMS, SO REQUIRES ASSISTANCE WITH LOWER HALF.	27/4/95	CH2
CONTINENCE	FULLY CONTINENT	27/4/95	CH2
DIETARY REQUIREMENTS	NORMAL DIET - FREE FLUIDS.	27/4/95	CH2
COMMUNICATION	COMMUNICATES WELL	27/4/95	CH2
MENTAL STATE	GOOD - APART FROM BEING FED UP.	27/4/95	CH2
PRESSURE RISK/CONDITION OF SKIN	SKIN INTACT.	27/4/95	CH2
WOUND CARE	N/A		

CHECK LIST	COMMENTS	DATE	SIGNATURE
PATIENT INFORMED/~~DISCUSSION~~	✓	27/4/95	CH2
RELATIVES/CARER INFORMED	✓	27/4/95	SM
TRANSPORT ARRANGEMENTS	(STRETCHER) ambulance booked for Tuesday 2/5/95.		
COMMUNITY LIAISON SISTER	N/A		
SOCIAL SERVICES/WORKER			
HOME HELP	N/A	27/4/95	CH2
MEALS ON WHEELS	N/A	27/4/95	CH2
HOME SUPPORT/DAY CARE	N/A	27/4/95	CH2
DAY CENTRE	N/A	27/4/95	CH2
RESPITE CARE	N/A	27/4/95	CH2
DAY HOSPITAL REFERRAL	N/A	27/4/95	CH2
OUTPATIENT CLINIC APPOINTMENT	N/A	27/4/95	CH2
DISCHARGE MEDICATION: Ordered Received Explained	N/A	27/4/95	CH2
VALUABLES	AS LISTED.		CH2
KEY HOLDER HOUSING ADAPTATIONS/ PREPARATIONS	N/A		CH2

GHW/AB/694492A ext 4309

GENERAL SURGERY
MR G H WELCH

DATE ADMITTED :23/08/1993 **DATE DICTATED**:01/09/1993
DATE DISCHARGED:23/08/1993 **DATE TYPED** :02/09/1993

Dr C Lau
The Health Centre
6 High Street
Maybole

Dear Dr Lau

MR LEE JOHNSTONE 16 MINNOCH CRESCENT MAYBOLE (DOB 09/02/1976)

DIAGNOSIS:
Abdominal pain

PROCEDURE:
Nil

COMPLICATIONS:
Irregular discharge

COMMENTS:

Your patient was admitted as an emergency on the above date with abdominal pain. Examination was uneventful. Shortly after admission he took his own irregular discharge. No follow-up has been arranged.

Kind regards

GEORGE H WELCH MD FRCS
Consultant Surgeon

Surgical

GS/MW/694492A ext 4047

GENERAL SURGERY
MR G STEWART

DATE DICTATED:15/02/1993
DATE TYPED :16/02/1993

Dr C Lau
The Health Centre
6 High Street
Maybole

Dear Dr Lau

MR LEE JOHNSTONE 16 MINNOCH CRESCENT MAYBOLE (DOB 09/02/1976)

DATE OF ADMISSION:07/02/1993
DATE OF DISCHARGE:12/02/1993

DIAGNOSIS:
RTA - Motor bike. Abdominal pain.
Bruising left leg.

PROCEDURE:
08/02/1993 Ultra-sound of abdomen - no abnormality detected.

COMPLICATIONS:

INVESTIGATIONS:
COMMENTS:
Pain settled. Orthopaedic review.

Best wishes
Yours sincerely

GORDON STEWART MD FRCS
Consultant Surgeon

Surgical

South Ayrshire Hospitals NHS Trust IMMEDIATE DISCHARGE LETTER

Essential: Use Ball Point Pen and Pressure when completing this form **No** 5608

Dear Dr. LAU HOSPITAL AYR

ADDRESS WARD 3

DATE 10/02/93

Your Patient

(Use addressograph label, if available, on all Four copies)

Patient I CG6944\92

Name .... JOHNSTONE LEE
16 MINNOCH CRES
MAYBOLE

Address 09/02/1976 M/NK
DR LAU
THE HEALTH CENTRE, 6 HIGH STR
MAYBOLE

Date of Birth ../../.. Hospital No. .....

STA2101

Admitted on 07/02/93 in the care of Dr/Mr STEWART

was discharged on 10/02/93 with a diagnosis of no abdominal injury (although L/Q pain + U/S abdomen 9/2/93 normal) injury sustained to (L) leg - appears to be haematoma (seen by orthopaedic SHO 9/2/93)

KNOWN DRUG SENSITIVITY:

MEDICINE (IN BLOCK CAPITALS)	FORM	DOSE	ROUTE	FREQ./TIME OF ADMIN.	CONTINUE OR STOP*	Pharmacy Use Only: Quantity & Strength Dispensed	Pharmacy Notes
NUMBER OF DAYS SUPPLY IF MORE THAN 5							

DATE	Dispensed by	Checked by

* When the medication is to continue write CONT in the column indicated. When the medication is to stop write the date of the last full day on treatment and STOP. A follow-up appointment will/will not be made.

Other comments and treatments: .....

Detailed discharge letter will follow within two weeks.

Yours sincerely J Shakur Dr's Name (IN BLOCK CAPITALS) JOSEPHINE SHAKUR

Distribution of copies, after completion by Pharmacy:
WHITE—General Practitioner YELLOW—Medical Record BLUE—Patient PINK—Pharmacy

JLM/CM

ACCIDENT & EMERGENCY/SHORT STAY UNIT

DICTATED 16.12.92

21st December 1992

Dr Lau
Health Centre
Maybole

Dear Dr Lau

LEE JOHNSTON, 16 MINNOCH CRESCENT, MAYBOLE, DOB 9.2.76

EPISODE OF RECTAL BLEEDING

This young man attended A & E on 12.12.92 complaining that after passing a constipated stool he had had a small episode of rectal bleeding.

He was detained in the observation ward for surgical review. The Surgeons felt that this was a trivial episode and felt the patient could be safely discharged to your care.

Yours sincerely

LEO MURRAY FRCS MRCP MRCGP DA
CONSULTANT IN ACCIDENT & EMERGENCY CARE

SEAFIELD SICK CHILDREN'S HOSPITAL

DOCTOR'S LETTER

SURNAME (Block Letters) Mr Mrs Miss	FIRST NAMES (Block Letters)	UNIT NUMBER

COPY OF LETTER TO

SH/LMcC/44652

15 August 1983

Dr Brown
Health Centre
GIRVAN

Dear Dr Brown

LEE JOHNSTONE, 4 URNFIELD, GIRVAN, 9.2.76

This young boy was admitted from the Casualty Department on 4 July after he had sustained a closedfracture of the shaft of his right femur. This fracture was manipulated under GA and was treated in a Thomas splint. Post-manipulation X-rays were satisfactory. Lee's progress was satisfactory. He was out of the splint on 5 August, after he had considerable callus formation at the fracture site. He started mobilisation on 8 August and has made satisfactory progress. He was allowed home the next day and has an appointment to see us in 3 weeks. He has been walking independently.

Yours sincerely

S Hyder
Orthopaedic Registrar

Ayr Hospital EMERGENCY DEPARTMENT

NHS Ayrshire & Arran

A/E No: AYR-24-015165-1
Date & Time: 20 Jun 2024

CHI No: 0902763334

Lee JOHNSTONE

Duty Consultant: DR ALAN KRICHELL

Date of Birth: 09 Feb 1976
Age: 48 Years
Sex: M

GP:
LR Adams
Drs Sheward & Partners
The Surgery, The Health Centre
6 High Street
KA19 7BY
01655882708

Address:
12 WOODSIDE AVENUE
KIRKMICHAEL
MAYBOLE
AYRSHIRE
KA19 7PP

Marital Status: Single

Religion: None
Ethnicity: White Scottish

Next of Kin:

Attendances
Last 12mths: 1
Total: 28

Phone Numbers:
Home: 01655 750064
Mobile: 07864847180

Special Case: Alcohol Abuse

Accompanied by: Mother

Employer/School:
not employed
Not at School

Triage Time: 12:40 **Triage Nurse:** Cheryl Rowan **Triage Group:** Yellow

Resp Rate	O2 Sat%	PFR

Pulse	BP	E	M	V

Allergies: No Known Allergy

BMstix	NEWS	Temp	Weight

Visual Acuity
R:
L:

Pain Score Triage: 99

I give consent for details of my injury to be given to the Police.
Signed:.....

Triage details:
feeling unwell sudden onset of facial oedema/ widespread rash to body. scrotum odeamous.
Treatment
Had analgesia before attending A&E
Special Needs
Other Special Need
Clinical Frailty Score:
Re-assess in 15 30 60 minutes

Against Medical advice I decline the treatment offered. I know this may affect my recovery.
Signed: ..... Witness: ..... Witness: .....

Disch A+E clinic Paed Tr # Eye ENT Max Facial
Ward OP Ward IP.....

0902763334

Lee Johnstone CHI: 0902763334 A/E No: AYR-24-015165-1

Drug	Dose	Route	Time/ Freq	Prescriber's names	Prescriber's Signature	Quantity Given	Given By	Given Time
CHLORPHENAMINE	4mg	PO	STAT	[illegible]	[illegible]	4mg	DA	17:00
PREDNISOLONE	40mg	PO	STAT	[illegible]	[illegible]	40mg	DA	17:00
PEPTAC	20ml	PO	STAT	[illegible]	[illegible]	20ml	DA	17:00
AMOXICILLIN	1g	IV	STAT	[illegible]	[illegible]	1g	ICL	17:45
CLARITHROMYCIN	500mg	PO	STAT	[illegible]	[illegible]	500mg	ICL	17:45

Clinical Indication		IV Fluids / IV Drugs		Urgent access		Blood Products		Diagnostic Procedures	

Clean Field	Hand Hygiene	Skin antisepsis	No touch critical parts	Dated/ Timed	

PVC 1	Size		Site		Sign		PVC 2		Size		Site		Sign	

Clinician Name: Michael Lai **Date:** 2016 24

Grade: FY2 **Time:** 1555

48M - PC - Urticaria + generally unwell 2w + Swollen pen

Pt woke up c widespread urticaria - mixture of pain/itch intermittently.

Feeling generally unwell last 2w - sore throat that was improving past week but woke up today c ↑ pain. Says drooling past week but no issues swallowing liquids.

Green productive cough, malaise, ↓ eating/no food but reports drinks plenty of fluids - Felt wheezy past week.

Denies headache / CP - only on coughing / palps / N+V / LUTS.

Intermittent dizzyness + SOB. BO - no loose stools.

No hoarseness.

O/E: NEWS = 0 Does not look overtly unwell

RR Clear, no wheeze, no stridor

HS I+II +0

HR reg + strong ECG - NSR

Abdo SNT TWI V1-3

BS+

Calves SNT Concerned genital area - Penis appears swollen but able PV

(L) Scrotum testicle > (R) testicle = known cyst from USS 2015

Not overtly tender

PMHx: Opioid dependent Syndrome, asthma, PTSD, EBS, EtOH dependence (1990)

DHx: Reports only Buvidal once a month injection

NKDA

SHx: Unemployed
Smokes 5/pd = 20y
Denies alcohol / illicit subs
Fat + (F)

Dead – have you notified:	NOK?	GP?	Fiscal?	Police?	Letter?
ED Dr x-ray report:					

FY2

AYR HOSPITAL EMERGENCY DEPARTMENT

Name: Lee Johnstone **CHI No:** 0902763334
Address: 12 WOODSIDE AVENUE KIRKMICHAEL MAYBOLE AYRSHIRE KA19 7PP
Arrival Date/Time: 20 Jun 2024

Nurse Signature on initial assessment: _____ Print Name: _____

Triage Comments:	feeling unwell sudden onset of facial oedema/ widespread rash to body. scrotum odeamous.
Past Medical History	

DNACPR	Y	N/A	AWI	Y	N/A	Insulin	Y	N/A	On Anticoagulant?	Y	NA

Allergies	NKDA	Medications given by Paramedics	

Nursing Notes: Care taken over by

Date/Time	Name Printed	Signature
15:20 20/6	D. AGUILAR	
21/6/24 1025	Kylie Mansell	Kmansell

Name band in situ					Y	N	Patient prepared for exam & clothes bagged			Y	N
ECG	1st		2nd		Other		Valuables with patient:			Y	N
IV Access					Y	N	*If yes, please specify action taken*				
PVC Size/Colour:							Relative/Carer/Next of kin present:			Y	N
PVC Location:							Name: Georgina Johnstone Relation: Mother				
Inserted by:							Contact Number: 07826589742				
Blood samples	15:50				Y	N	Language, visual or hearing difficulty:			Y	N/A
Blood gases					Y	N	*If yes, please specify:*				
Blood cultures					Y	N	Interpreter required:			Y	N/A
PCR Test					Y	N	*If yes, please specify:*				
Radiology					Y	N	Package of Care?				

Screening tools Assessment	Date 20/6 Time 15:20		Date Time			Date Time		Date Time	
SEPSIS SCREEN	Y	N	Y	N	Adult Support & Protection	Y	N	Y	N
FAST Score	Y	N	Y	N	McKillop Tool	Y	N	Y	N
AAMAWS commenced	Y	N	Y	N	Child Protection/Wellbeing	Y	N	Y	N
Big Six (hip fracture	Y	N	Y	N					

Mobility	Bed Rest		Independent		Assistance/walking aid, specify:

If YES to any Falls Risk Assessment questions complete the safety intervention section. Repeat if the patient has a fall, is taking risks, has a change in condition/cognition.

Falls risk Assessment	DATE 20/6 TIME 15:20		DATE TIME		**Safety interventions**	DATE TIME	DATE TIME
High risk of falling based on your clinical judgment?	Y	N	Y	N	Nonslip socks provided?	Y	Y
Fall in the last 6 months (including, this admission)?	Y	N	Y	N	Behaviour monitoring chart	Y	Y
Cognitive impairment/possible delirium?	Y	N	Y	N	Supervision required in bathroom/commode?	Y	Y
Risk taking/attempting to walk alone/unsteady?	Y	N	Y	N	Falls warning sign on whiteboard/symphony	Y	Y
Does the patient/their relative have a fear/anxiety about falling?	Y	N	Y	N	Bed in Visible area.....	Y	Y

Ayr Hospital Emergency Department

Name: Lee Johnstone **CHI No: 0902763334**

ED 4AT Delirium Assessment: Complete / update for all Patients over 65, anyone of any age, with a cognitive impairment/previous delirium, current hip fracture, acute illness or SQID positive (is your patient more confused or drowsy than normal?) GCS 15/15			N/A?
ALERTNESS: This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient, if asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating. Circle relevant number below			
Date			
Time			
Normal (fully alert, but not agitated, throughout assessment)	0	0	0
Mild sleepiness for <10 seconds after waking, then normal	0	0	0
Clearly abnormal	4	4	4
AMT4: Age, date of birth, place (name of the hospital or building), current year			
No Mistakes	0	0	0
One Mistake	1	1	1
Two or more mistakes	2	2	2
ATTENTION: Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "What is the month before December?" is permitted.			
Achieves 7 months or more correctly	0	0	0
Starts but scores <7 months / refuses to start	1	1	1
Untestable (cannot start because unwell, drowsy, inattentive)	2	2	2
ACUTE CHANGE OR FLUCTUATING COURSE: Evidence of significant change or fluctuation in: alertness, cognition, other mental function (e.g. paranoia, hallucinations) over the last 2 weeks and still evident in the last 24 hours.			
No	0	0	0
Yes	4	4	4
Total			
Signature			

4AT Score of 4 and above: Possible delirium +/- cognitive impairment (Complete the TIME bundle below)
4AT Score of 1-3: Possible cognitive impairment
4AT Score of 0: Delirium or severe cognitive impairment unlikely (but delirium still possible if [4AT] incomplete)

TIME BUNDLE: Complete the TIME bundle if the 4AT Score if 4 and above			
Date			
Time			
T	Think possible triggers for delirium. Use Codes: Y-Yes N-No NA- Not applicable		
	Is the patient in pain? (start pain chart, review analgesia)		
	Is the patient constipated or at risk of constipation? (Commence bowel chart and aperients)		
	Is the patient in urinary retention? (Palpate bladder/scan)		
	Is the patients' oral intake sufficient to prevent dehydration? (Encourage hourly fluids start FBC)		
	Could any drugs trigger delirium? (Doctor to review medication)		
	Blood sugar, high or low?		
	Is there a history of alcohol intake/drug abuse? (Intoxication or withdrawal, GMAWS/drug misuse)		
I	Investigate.		
	Record NEWS		
	Screen for infection (and consider urinalysis)		
	Take bloods and ensure ECG/appropriate imaging		
M	Management: Diagnose causes & initiate treatment		
	Document diagnosis of delirium		
	Document potential causes of delirium		
	Document treatment plan		
E	Engage and Explore.		
	If appropriate, explain diagnosis of delirium to patient/family/carers and provide delirium leaflet		
	Engage with patient/family/carers. ("What matters to me"/ "Getting to know me")		
	Does the patient have capacity to consent to care? (In no, complete AWI document)		
	Signature:		

Ayr Hospital Emergency Department

Name: Lee Johnstone **CHI No: 0902763334**

ED Care Round Checklist:
Frequency to be prescribed in relation to the patient's greatest need
To be completed by the member of staff delivering care. If unable to use the nurse call bell prescribe care and comfort at one hourly

Date/Time	Name	Designation	Signature	Circle frequency prescribed
20/6 15:20	D. AGUILAR	S.N		1 2 3 (4) 12
21/6 1020	Kylie Mansell	S/N.		1 2 3 (4) 12
				1 2 3 4 12

Use the following codes: **Y** – Yes **N** – No **NA** – not applicable **NT** – No Thanks
S – Sleeping **O** – Out of department **I** – Independent

	Date								
	Time	15:20	19:20	8??	1020				
	THINK DELIRIUM: Is the patient more confused or drowsy than normal? *(if yes escalate and update 4AT)*	N	N	N	N				
	PAIN: ASSESS AND ADDRESS . Is the patient distressed and/or in pain? *If yes inform nurse in charge*	0	0	N	N				
S	**SKIN INSPECTION** Pressure areas checked? (Y/N)	Y	Y	Y	Y				
	N normal briskly reactive (1-2 secs), **SR** slowly reactive (3-6 secs) **D** discoloured **U** pressure ulcer **M** moisture **E** excoriation	R	R	I	N				
	Cushion/heel protector appropriate: **Y**-Yes **N**- No Type	N	N/A	N	N				
K	**Keep moving** Has the patient changed position or walked?	Ys	Ys	Y	Y				
	Bed: **R**:right side **L**: left side **B**: back **I**: independent	I	I	I	I				
	Chair: **W/ST**: Assisted to walk/stand **I**: independent	I	I	I	I				
	Sliding Sheet used	/	/	I	N				
I	**Elimination**: Patient offered the toilet?	No I	No T	NT	N				
	I independent **A** assistance given **IC** incontinence (urine/faeces) **BO** Bowels open **C** Catheter	I	I	I	I				
N	**Food/Fluid and Nutrition** Fasting **F** Nil by mouth **NBM**	N	N	N	N				
	Drink taken	Y	Y	Y	Y				
	Food, snack or supplement taken	N	No	NT	N				
	Oral hygiene carried out	N	N	NT	N				
	Environmental check: is the nurse call bell to hand, area clutter free, belongings within reach	/	/	Y	Y				
	Is the trolley/bed at the lowest level	Y	Y	Y	Y				
	Information: is there anything I can help you with? Inform patient of return time	/	/	N	N				
	Escalation required to nurse in charge?	No	No	N	N				
	Move bed/trolley to visible area if taking risks	N/A	N/A	N	N				
	Patient stay > 12 hours? - Consider moving to a bed	N/A	N/A	Y	Y				
	If patient on bed, complete a bedrail risk assessment	N/A	N/A	NA	N				
	Initials	DA	DA	CL	KM				
	Designation	S.N	S.N	SN	S/N				

Ayr Hospital Emergency Department

Name: Lee Johnstone **CHI No: 0902763334**

Preliminary Pressure Ulcer Risk Assessment (PPURA), update daily:
Mobility: Patient requires assistance to mobilise/change position. Continence: Patient has continence issues which may/has compromise/d skin. Nutrition: Patient appears malnourished and/or unable to eat/drink. Skin: Patient has a pressure ulcer/skin is compromised (medical devices, neurological deficit, medication, co-morbidities)
If YES to any of above, activate care plan below.

Date	Time	Mobility		Continence		Nutrition		Skin		Sign
20/6/24	18:25	Y	(N)	Y	(N)	Y	(N)	Y	(N)	
		Y	N	Y	N	Y	N	Y	N	

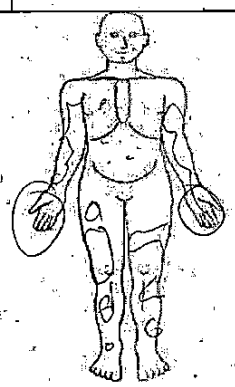
Pressure Prevention Care Plan

Patient is **at risk** of developing a pressure ulcer? Y [ ] N [✓]

Patient **has** a pressure ulcer? Y [ ] N [✓] **(If yes to either, initiate care plan below)**

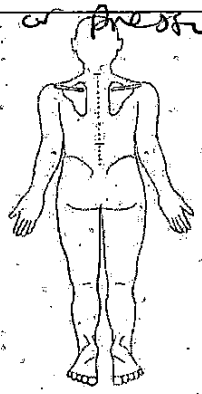
Date	Initial	Nursing intervention	Discontinued	Date/Time	Sign
		Ensure regular repositioning is carried out and documented on Care and Comfort round chart			
		The patient should not sit out of bed for longer than 2 hours without being repositioned (for acutely ill patients return to bed for a minimum of 1 hour)			
		Use sliding sheets to prevent shear and friction during movement in bed and record use in care round. Sliding sheets should not be left under the patient.			
		If the patient is incontinent use a PH balanced cleanser to clean and barrier products to protect as per: 'Scottish excoriation and moisture related skin damage tool'.			
		Move patient to bed with foam redistributing mattress. Initiate bedrail risk assessment and follow algorithm			
		Encourage a healthy, well-balanced diet and adequate fluid intake.			
		If the patient has a grade 2 or above pressure ulcer a wound assessment chart is required. Available from AthenA			
		Plan of care discussed and agreed with the patient as appropriate. Evaluate care in the nursing records.			

Date/Time	Location of ulcer	Grade of ulcer	Signature



Mobility aid
bedpads
Both our
two hands
legs
arms
oedematous

No broken skin or pressure ulcers



AYR HOSPITAL EMERGENCY DEPARTMENT

0902763334

HCR NO:	
CHI:	0902763334
Surname:	JOHNSTONE
Forename:	Lee
Sex/DoB/Age:	Male / 09 Feb 1976 / 48 Years
Address:	12 WOODSIDE AVENUE KIRKMICHAEL MAYBOLE KA19 7PP

I.V. Therapy and Prescription Sheet

	DATE	FLUID(USE BLOCK LETTERS) / ADDITIVE DRUG	Vol (ml) / Dose(mg)	Route of Admin.	Dur.of Admin*	SIGNATURE	Serial No. / Batch No.	Time Begun	Given By / Added By
A		0.9% NaCl	500ml	IV	4°		2400 4TAK	0200	CL
B									
C									
D									
E									
F									
G									
H									
I									
J									
K									
L									
M									
N									
O									

RATE OF FLOW (Drops/Min.) = VOL. OF FLUID (ml) X 15 / Duration (Mins.) (1ml = 15 drops)

6.62

Approximate Rate for 500ml: 1h = 120 Drops/min; 4hr = 30 Drops/min; 6h = 22 Drops/min; 8hr = 15 Drops/min

PLEASE FILL OUT FLUID BALANCE CHART OVERLEAF

AYR HOSPITAL EMERGENCY DEPARTMENT

0902763334

CHI: 0902763334

Fluid Intake and Output Chart

DATE						YESTERDAY'S BALANCE			
	INTAKE (ml)					OUTPUT(ml)			
	ORAL	INTRAVENOUS		OTHER		URINE	STOMACH	BOWEL	DRAINAGE
Time	Amount	Amount	Nature	Amount	Nature	Amount	Amount	Amount	Amount
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
1									
2									
3									
4									
5									
6									
7									
TOTAL						(a)	(b)	(c)	(d)

INTAKE =	ml	(e) Insensible loss* = OUTPUT (a + b + c + d)	ml
BALANCE =		ml	

*Average Adult = 600ml +100ml per each 0.5° C temperature elevation

Ayr Hospital Emergency Department

Name: Lee Johnstone **CHI No: 0902763334**

Nursing Notes

Date/Time		Signature
15:20	Patient has been place in majors (T) as he is now shortly due to be seen. He is accompanied by his NOK Mother Georgina.	DAGuinn
15:25	ECG completed by colleague	DAGuinn
	Bloods taken and sent for analysis by Dr reviewing patient	
17:00	Oral medications administered as prescribed on ED prescription.	DAGuinn
17:40	Abx administered as per prescription. NOK has now left and is aware of his plan of care.	D. AGuinn
19:25	Bed has been allocated. Patient informed, Observations done	D. AGUINN.
2100	First contact, news 0 2L O_2 NC applied at present as Spo^2 ↓ to 90% on RA. pt does not feel SOB. no complains — clang	
2300	news 0 resting settled at present. pillow given. fluids taken. — Clang	
2340	pt now on hospital bed — clang	
0210	IV Fluids ↓ no complaints. — clang blood cultures ↓ clang	
0525	news as charted. pt settled at present. — Clange	
0715	news 4 BP ↓ no tenths/ IV fluids prescribed. pt has had a settled night. — Clange	
1020	Assumed care of patient in cubicle 4. NEWS 2. Still awaiting medical bed. Breakfast taken —	K Mannell RGN

Ayr Hospital Emergency Department

Name: Lee Johnstone **CHI No: 0902763334**

Nursing Notes		
Date/Time		Signature
1035	Received call from ultrasound: To fast now until ultrasound	
	at abdomen this afternoon.	Kmanelli.
1500	Patient currently at ultrasound. Was unable to	
	give oral chlorphenamine due at midday due to	
	NBM.	Kmanelli.

MEDICAL CONTINUATION SHEET

CHI:	0902763334
Patient Name:	Lee Johnstone
DoB:	09 Feb 1976 48 Years
Address:	12 WOODSIDE AVENUE KIRKMICHAEL MAYBOLE AYRSHIRE KA19 7PP

VBG: pH 7.461 Lac 1.4
H^+ 34.6
pCO_2 6.22
HCO_3 31.2

DATE	
	M. Lai F92 ATE Cont-
20/6/24	
1620	O/E: Widespread erythema in upper limbs + lower limbs Reported some ? angioedema - could'nt see (L) eye but looks better - both eyes open - redness around eye.
	Throat - erythematous but no overt swelling or pus evident
	~~Plan~~ Denies recent sexual intercourse / discharge.
	Plan - ⊖ PVC + bloods + VBG ⊖ Sputum culture ⊖ Urine dip +/- MSSU ⊖ Flu + COVID PCR ⊖ CXR ~~⊖~~ ⊖ Chlorphenamine ⊖ D/w reg (Dr Kriebell) - ⊖ anti-histamine ⊖ Po pred ⊖ Pepto for gastric protection ⊖ Re-assess later - ? (H) ↓ better
1705	M. Lai F92 ATE Bloods - ~~Read~~
	ME F H

Lee Johnstone CHI: 0902763334

DATE		
	M. Lai PGY2 ATE	Bloods: U+E grossly (N)
2016/24		B Na 132 Cl 88
1705	CXR: RUL consolidation	Alb 31
		ALT 137
	Plan: ⊖ Tx for severe CAP	ALP 149
	↳ IV Amox +	AST 101
	PO Clari	Bili 9
	⊖ Reger + admit medics	Ca+, PO4, Mg+, Lac (N)
		CRP 424
		WCC 18.8
		Neut 17.0
		Lymph 1.0
		Hb 139
		Plat 586
		ML
		PGY2

Lee Johnstone CHI: 0902763334 A/E No: AYR-24-015165-1

Address: 12 WOODSIDE AVENUE KIRKMICHAEL MAYBOLE AYRSHIRE KA19 7PP

Arrival Date/Time: 20 Jun 2024

PAUSE for Discharge or Transfer **Destination**	Yes	NO	NA	Comments	Date & time	Sign
Relative/Carer informed of discharge/transfer Ambulatory Care	✓				20/6	
Has care package been confirmed/restarted						
Name band in place	✓				20/6	
Name band removed						
IV access patent and accessible	✓				20/6	
Cannula/invasive line removed						
Discharge medication issued and explained						
Transport arranged/available						
Follow up arranged						
Belongings with patient (i.e. valuables/own meds)	✓					
Notes complete	✓					
Pre discharge NEWS completed	✓					
Bed available	✓					
Handover given to forwarding ward	✓					20/06/2024
Kardex completed and fluids prescribed						
Resus equipment/sufficient oxygen/special equipment						
Grade 3 or above pressure ulcers referred to TVN						

Clinical Photography Request and Consent

Department of Medical Photography & AV Services • Tel: 01563 827478

NHS Ayrshire & Arran

Date..... MIM Job No .....

CH
Su
For
Ad
...
D.O

0902763334
JOHNSTONE Lee
2 WOODSIDE AVENUE, KIRKMICHAEL
KA19 7PP
DOB: 09/02/1976
AYR-24-015165-1

PATIENT LABEL

Consultant. SUPPORT ..... Dept ED

Diagnosis (PRINT) COP

Tick as required

☐ Photography ☐ Video/Audio ☐ 3D imaging

☐ Copy for Patient

Patient Email:

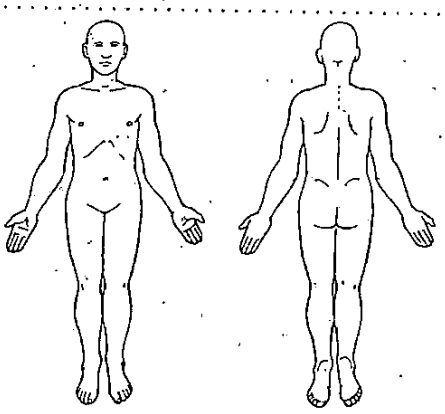
APPOINTMENT Date/time

Views required: Dermoscopy ☐

PRMS

LEGS

CHEST



☐ Chaperone required

Consent to clinical recording for medical records

I confirm that I have explained the purpose of the recording, how it will be used and how it will be stored, to the patient, who has given consent.

Healthcare professional's name:

☐ **A. Medical records only**

☐ Incapacity form

Consent to secondary use of personal data To be completed by patient or guardian

Only complete this section if recordings are required for secondary use as detailed below

Yes No

☐ ☑ **B. Teaching.** I consent to the recordings being used to teach medical, dental, nursing and healthcare staff and students.

Yes No

☐ ☐ **C. Publication.** I consent to being contacted if the recording is requested for publication.

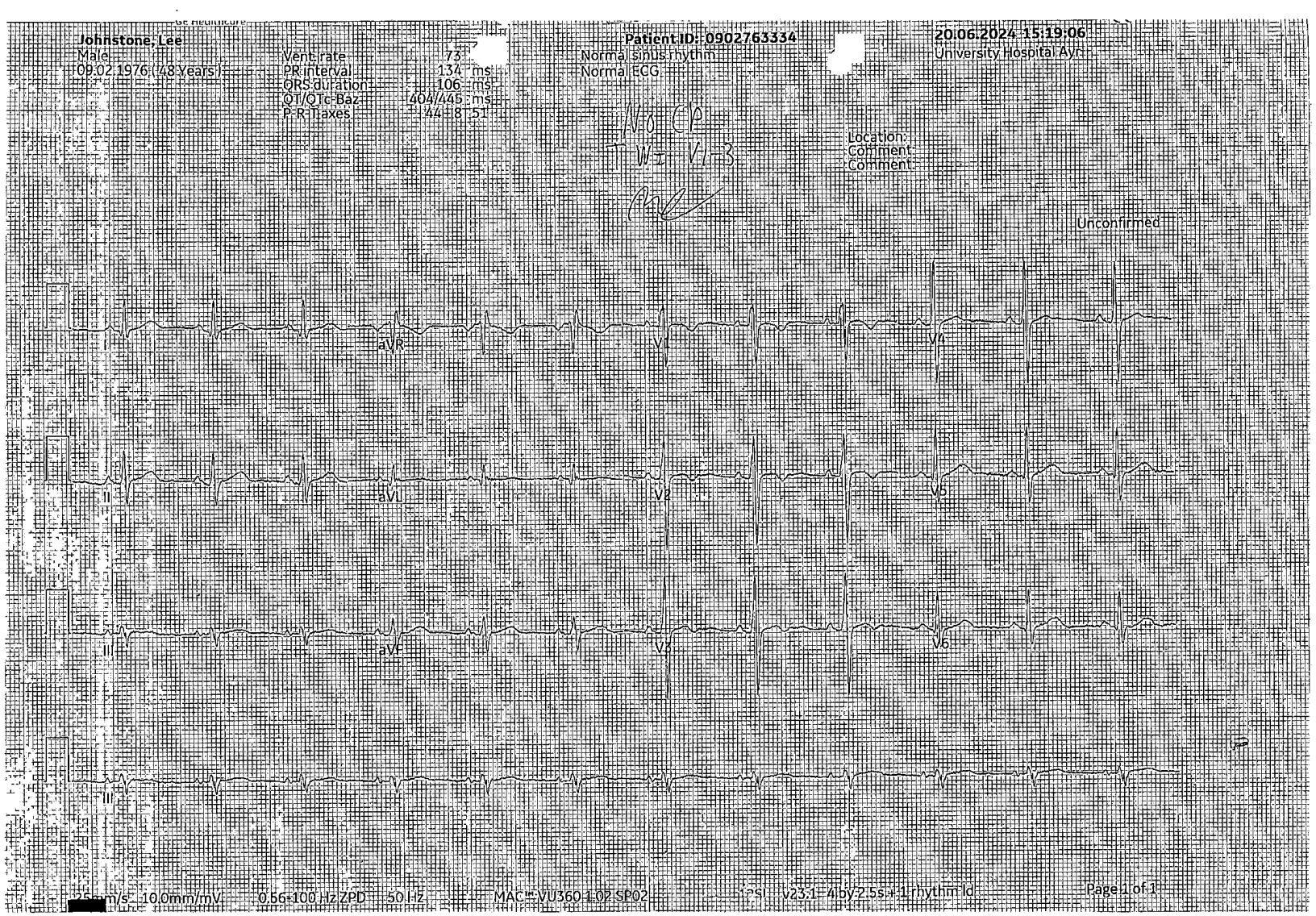
Yes No

☐ ☐ **D. Patient to patient.** I consent to the recordings being shown to other patients as an example of pre/post clinical/surgical procedures.

The level of consent to which you agree will not affect your treatment in any way. You can withdraw consent for secondary use by writing to Health Record Services, University Hospital Crosshouse, Kilmarnock, KA2 0BE

Signature of patient / guardian: L. J. JOHNSTONE Date: 21/06/24
(circle which is applicable)

NC23-00040


Johnstone, Lee
Male
09.02.1976 (48 years)
Patient ID: 0902763334
20.06.2024 15:19:06
University Hospital Ayr
Vent rate 73
PR interval 134 ms
QRS duration 106 ms
QT/QTc Baz 404/445 ms
P-R-T axes 44 8 51
Normal sinus rhythm
Normal ECG
Location:
Comment:
Comment:
Unconfirmed
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
II
25mm/s 10.0mm/mV 0.56-100 Hz ZPD 50 Hz
MAC™ VU360 1.02 SP02
Test v23.1 4 by 2.5s + 1 rhythm ld
Page 1 of 1

NHS Ayrshire & Arran

Acute Assessment Proforma

JOHNSTONE Lee
12 WOODSIDE AVENUE, KIRKMICHAEL
KA19 7PP
DOB: 09/02/1976
AYR-24-015165-1

Date: 20/06/24 Time: 18:42

Referral source: ED. Consultant: Dr. Swood.

Presenting Complaint and relevant History

49 year old male presented with wide spread rash on his upper and lower extremities. since last one week.

- c/o itching and pain associated with the rash.
- rash present around his eyes.
- no h/o recent travel, exposure,
- no h/o fever flu like symptoms, nausea, vomiting.
- no h/o joint pains.
- no h/o difficulty in swallowing.

Past Medical History

- Rt Bundle Branch Block.
- Heroin dependence
- Asthma
- Guillian-Barre syndrome.
- Behavioral problems.
- Accidental drug overdose / other poisoning.

Systems Enquiry

no h/o SOB, cough, loud noises from chest like stridor.

- no h/o chest pain, headache, heart racing, light headedness.
- no h/o calf tenderness.

- Dr does not know any known allergies.

Family History

no relevant family history.

Social History

Employment: not employed currently. Driving status: Yes

Lives with: Mother. Recent Travel: NO

Mobility: Functional Capacity: N

Family Support: Mother. Smoker: Yes 5 cig/day.

Home Care: Alcohol (units/wk): NO.

Staple Med Rec Here **Medication History and Multidisciplinary Medicines Reconciliation**

Must be started by the admitting Clinician and reviewed by the pharmacist within 24 hours

Please print ECS in the medicines reconciliation format and take medication history from the patient or relative & do medicines reconciliation and staple to this page. If not possible, use table below.

Allergies & Adverse reactions:

Medicines / Substance	Reaction
Citalopram	Adverse reaction

Details of Medicines obtained from							
PODs		ECS	✓	Nursing Home Chart		Recent IDL	
Patient	✓	GP Letter		Community Pharmacist			
Relative/Carer		Phone call to GP		Other (please specify)			

Medicine	Dose	Frequency	Continue	Amend	Suspend	Stop	Comments
Omeprazole	20mg	OD	✓	Pt states		doesn't take	
6/6/24 SUBOXONE injection	(BUPRENORPHINE	ME injection)				monthly	
32mg weekly starting 22/4/24 if tolerated							
Usual Hospital → 128mg monthly from May							
ESPRANOR discontinued.							

Are you satisfied this medication history is complete and accurate? YES ☐ NO ☐

If NO what further action is necessary (Contact GP etc.) ..... Tick when resolved ☐

Doctor/ANP signature ..... Date/Time ..... Beep No .....

Pharmacist Signature Marion Hamilton Date/Time 29/4/24 Beep No .....

GPhC 2080354

General Examination and Cognitive Assessment:

BP - Lying: 140/90 mmHg. Standing (1 min): (3 min): Pulse: 95 bpm.

Temp: 36.5°C RR: 16 SpO_2: 99 % on air or FiO_2: **NEWS:** 1

4AT score: 0 Is AWI needed? Yes/No Clinical Frailty Score:

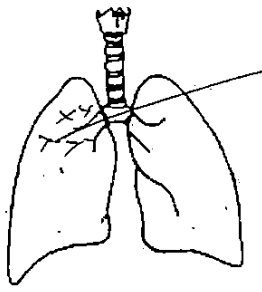
Other findings (Skin, Joints, Calves, etc.):

Cardiovascular Examination

Pulses: Regular Heart rate/rhythm: regular Heart sounds/Murmurs: S_1 (N) S_2 (N)

JVP: (N) Pedal oedema: (N) Heaves / Thrills: (N)

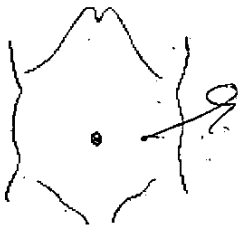
Respiratory Examination



Reduced air entry. no stridor no wheeze.

PEFR:

Abdominal Examination



soft non tender

Bowel sounds: (N)

PR exam:

Neurological Examination: GCS: 15/15 (E 4/4, M 6/6, V 5/5)

Gait: Cranial Nerves:

Meningism:

Cerebellar signs: Fundoscopy:

Local Examination

Generalised wide Spread eczema Seen on upper & lower extremities and around eyes.. Erythema Annulare Centrifugum.

	RUL	LUL	RLL	LLL
Pronator drift		-	-	-
Tone	+	+	+	+
Power	5/5	5/5	5/5	5/5
Reflexes	+	+	+	+
Sensation	+	+	+	+
Co-ordination	+	+	+	+
Plantar reflexes				

Investigations:

Relevant Bloods: FBC - WCC - 18.8
Neutro - 17.0
CRP - 424.
LFT - ALP - 149
ALT - 137
AST - 101

CXR: (RH) upper lobe consolidation.

ECG: (N)

ABGs: pH - 7.461 $cHCO_3$ - 31.2
Lac - 1.4

Urinalysis: Leucocytes Nitrites Protein Blood Glucose Ketones

Differential Diagnoses / Problem list & Treatment Plan

Imp: ? Community acquired pneumonia. (CURB65 - 0,)
? Angioedema.
? Uticaria.

plan:

1. IV antibiotics
2. IV fluids.
3. IV or oral steroids.
4. Antipyretics incase ↑ temp.
5. Blood cultures ☐
6. Anti-histamines, topical steroids for the rash.
7. PRN NEBS.
8. Continous monitoring of vitals.
9. Swabs sent for COVID PCR. and flu.
10. ? CTPA after d/w Consultant.
11. Incase of ↑ SOB, ↓ SpO_2, ↑ swelling or puffiness please immediately inform.

Medicine Reconciliation completed	☐	Is there an existing anticipatory care plan/KIS? Yes/No	
VTE Prophylaxis assessed & prescribed	☐	Treatment Escalation Plan (TEP) considered/filled	☐
Antibiotics as per microbiology policy	☐	DNACPR considered/documented ☐ Not Applicable	☐

Name & Grade (ID stamp): Dr: Kodali
Signature:
Page no.:

Location: UHA
Time: 19:42.

Is patient frail, sick and at risk of deterioration/dying? **Yes ☐ No ☐**

If **yes**, please discuss treatment escalation plan with patient and/or relative, and complete Treatment Escalation Plan (TEP)

TEP completed? Yes ☐ No ☐

DNACPR considered / completed? Yes ☐ No ☐ N/A ☐

Write or attach label

CHI No .....

Surname: .....

Forename: ..... Sex: .....

DOB:

Consultant Review: Date: Time: Location:

Shefqet Allan 20/6/2019 09:03 ED.

49 M 4c Pneumonia

Sepsis.

had rash ? itching Across body for 3/7 now improving.

No chest pain

No signs of meningeal irritation.

WCC 13.2

CRP 424

CXR R upper lobe pneumonia

ECG

Twave L

V1 V2 V3.

1a Abx for Pneumonia

Atypical Pneumonia

Screen Urin Legionella & Pneumococcal

Trop >60

Antihistamine for rash.

NEWS 4

SpO2 96%

BP (100/60)

- USD Abdomen
- Daily Bloods
- weekend R/V.

NS 132

- Oral Pred 2/7 only.

Baseline Trop.

Dermatology Mat

Medical Photography

Specialty Allocation:	**Discharge anticipated today:** Yes ☐ No ☒
Med. Rec. ☐ VTE prophylaxis ☒ AWI ☐	**EDD:** or <24hr 24-72 hrs >72 hrs
Consultant Signature:	
Name (ID Stamp):	

Write or attach label
CHI No 0902763334
Surname: JOHNSTONE
Forename: LEE Sex:
DOB: 9/2/76

Continuation

21/6/24 PHARMACIST
1220

Note Ailsa Hospital Addictions R - BUVIDAL monthly injection (BUPRENORPHINE)

2x weekly injections April
Started monthly injection May, last had 6/6/24.

Also antibiotics - CAP & LEVOFLOXACIN but not known to have PENICILLIN Allergy - will D/W medical team ?switch to alternative.

D/W Medical team - Chosen for Atypical cover

Mr [illegible]
Pharmacist
GPhC 2063358

16/24 D- Dr [illegible] (D- rabbit on call consultant)
40 -seen by Dr Dermatology
-referral from medicine/ED + seen in ED
- admitted yesterday - ? CAP.
has Complt - cough, fever + feeling generally unwell for 5-6/7.
awoke feels on (14/6/24) with widespread uncomfortable rash. Itchy + - Nose swollen slightly.
-admitted to ED 20/6/24 - given anti-histamine

Write or attach label

CHI No .....

Surname: .....

Forename: ..... Sex: .....

DOB: .....

Continuation

2/6/24 1340 + oral prednisolone
- rapid resolution / partial resolution of rash

- note - no new medications prior to onset of rash
- no new potential contact triggers
- no personal or significant history of dermatological disease

OE / - widespread urticated rash across trunk, discrete areas of erythema, raised edge + apparent vascular blood on edges
- the for dermatographism
- Mikolski sign -ve.
- no ano-mucosal/lesp involvement
- denies genital involvement - not examined

imp- acute urticaria + hx suggestive of angioedema
- likely reactive to recent illness
- raised CRP + low would not be explained by skin presentation
- no current evidence of TEN / SJS

Write or attach label

CHI No .....

Surname: .....

Forename: ..... Sex: .....

DOB: .....

Continuation

16/24 - Suggestions:

3460 - fexofenadine 180mg qds

- off licence dose per British association of dermatology urticaria guidelines

- regular lpm emollient eg zerobase

∴ I will arrange outpatient led dermatology follow up

- no formal derm r/v planned

- ongoing medical treatment per medical receiving team

LMDIS
DUFFY 6101076
ex 17079

21/6/24 1500 PHARMACIST

DIN Dr Shaygat - FEXOFENADINE 180mg 4x off license dose.
(BAD guidelines pr recommend this for chronic urticaria if inadequate response to standard dosed)

Try FEXOFENADINE 180mg 1x (licensed dose) & renew response.

ZELOSTASE added.

Marion Hamilton
Pharmacist
GPhC 2063358

Write or attach label

CHI No .....

Surname: .....

Forename: ..... Sex: .....

DOB: .....

Continuation

24/6/24

(h) Labs: pneumo

Afebrile

CRP 84 ← 424

WBC 13.4 → 18.8

→ Plan

- Await CT CAP Report
  Rpt Bloods
- possible Discharge after results
- Pulmonology referral for Bronchoscopy

Write or attach label

CHI No .....

Surname: .....

Forename: ..... Sex: .....

DOB: .....

Continuation

24/6/24 Graham

Thalley

(91) century RUL

Lesion

Extension

Unwell > 2 weeks

Cough

Bx extension

Drenching night sweats

Loss of appetite

Severe weight loss = 1½ stone in 2 weeks

△ TB nodes + bone Rx

CRP 400

NHS Ayrshire & Arran

Write or attach label
HCR No: 0902 763334
CHI No:
Surname: Johnston
Forename: Lee Sex:
Address:
Date of Birth:

DATE

Seen Rw with
Levofloxacin
Fully bilat
CAP ↓
However Levofloxacin has
anti TB cover.
Immunosuppression can be
due to partial treatment
due to Levofloxacin
I Think we need to actively
strive to R/O TB before treating
them as a simple CAP
R/O STOP All Abs
O Sputum x2, Mycobacterium + an
Wednesday AM AAFB

MEDICAL

DRS 6003

DATE

Breathing arranged for Wednesday 26/6/24

BD Qds

- Keep in
- Keep in side room
- Inform Infection Control Team
- Full Infection control measures until TB is R/O

Due explained Pt about + how has consent to stop antibiotics and investigate further to look for TB.

As he is an IP we can quickly establish control of his symptoms & they clear down

Co-ag pos plus HIV

Pt RBC/CRP/LFT/U+Es on 26/6/24

24/6/24

NHS Ayrshire & Arran

CHI: 0902763334
Johnstone, Lee
12 WOODSIDE AVENUE
Maybole
KA19 7PP
09/02/1976
Dr M Barr
Date of Birth:

DATE

20-6-24

Plan

(1) Bronchoscopy Scheduled tomorrow

(2) Sputum AFB result awaited

26/6/24 1:10pm

A Hosein - MT1

49 y.o. male

Cavitating RUL cancer

Had bronchoscopy this am. — Normal airway, RUL washings

PMHx - Asthma, GRS, Behavioral problems
Heroin dependence

Pt well post procedure

No current issues

NEWS-1 SpO_2-96%

A & Th.

Plan:-

(1) Chase Bronch + sputum AAFB + Th Cx

(2) Infection control precautions to cont.

(3) HIV pending Requested

A Hosein
765725

MEDICAL

DRS 6003

DATE

27/6/24

Galen

Suspend Pulm TB

Chest Sputum AAFB

Bronch results

cc HM Abs

for CAP

AYR HOSPITAL
EMERGENCY DEPARTMENT

NHS Ayrshire & Arran

A/E No: AYR-14-026067-1

CHI No: 0902763334

Date: 27 Jul 2014 **Time:** 05:16

Consultant: Dr Alastair Stevenson

GP
G PATON

THE SURGERY
THE HEALTH CENTRE
6 HIGH STREET
01655 882278
01655 882278

Incident Date: 27 Jul 2014
Incident Time: 05:16

Marital Status: Divorced

Sex: M

Ethnicity: Scottish

Religion: None

Attendances in last 12mths 4

Total Cross Site Attendances Count 24

Special case : Alcohol Abuse

Waterlow Score :

JOHNSTONE
Lee

Date of Birth: 09 Feb 1976 **Age:** 38 Years

Address:
12 WOODSIDE AVENUE
KIRKMICHAEL
MAYBOLE

KA19 7PP

Phone Numbers:
Home: 01655 750064

Employer/School
not employed Not at School

Next of Kin:
Georgina Johnstone
12 WOODSIDE AVENUE
KIRKMICHAEL
MAYBOLE
KA19 7PP

Mother
Home Tel: 01655750064

Accompanied By:
Other Person

Triage Time 05:22 **Triage Nurse** Tricia Smith **Triage Group** Green

Resp Rate **02 Sat%** **PFR**

Pulse **BP** /

E M V

Allergies: No Known Allergy

BMstix **Alcohol** **Temp** **Weight**

R L

Pain Score Triage 6

Pain Score Discharge

Triage details
Right knee injury/fell on astroturf. Pain over medial aspect of knee

Treatment
Had analgesia before attending A&E, Advice - verbal

Special Needs
Other Special Need

Re-assess in 15 30 60 minutes

Against Medical advice I decline the treatment offered. I know this may affect my recovery.

Signed.....Witness.....Witness.....

I Hereby Consent To My Self/Child Having

Signed.....

Disch A+E clinic Paed Tr. (Fracture Clinic) Eye ENT Max Facial Ward OP Ward IP

0902763334

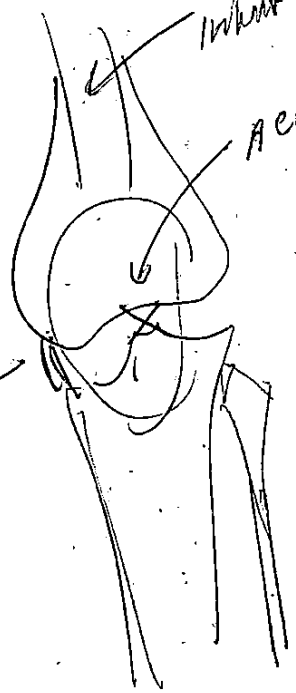
38 yo old

27/07/14 Sporting football injury

Ruptured tendon on stabilising foot

Heard a pop

Immediate swelling



Plan MRI of Right knee

O/P splint

Plan MRI scan

Forename: Lee Surname: JOHNSTONE Date : 27 Jul 2014 A/E No. AYR-14-026067-1

Drug	Dose	route	time/frequency	signature	quantity/given by
Diclofenac	50mg	PO	tds		Kaeleight
Co-codamol 8/500	2	PO	prn		Kaeleight

Clinical indication:
- IV fluids / IV drugs
- Urgent access
- Blood products
- Diagnostic Procedures
- Other

- Clean field
- Hand hygiene
- Skin antisepsis
- No touch critical parts
- Dressing dated/timed

PVC Insertion Bundle

	Size/Colour	Location	Initials
PVC1			
PVC2			

	Device	Flow Rate l/min	% O2 for Venturi	Target SpO2	Prescribed by	Stopped by	Started by
Oxygen							
Changed to							

DOCTOR / ENP: A SANDERSON 425360 Time:

Injured RIGHT knee at 5-a-side football tonight. Restricted extn. Then felt sweaty onto patella.

Unable to WB

No effusion

Mainly lateral knee pain

NVI distal sensory loss

No motor weakness

Closed injury

No previous knee injury / previous surgery

Dead - Have you notified :- NOK? ☐ GP? ☐ Fiscal? ☐ Police? ☐ Letter? ☐

I give consent for details of my injury to be given to the Police.

Signed.....

ED Dr Xray report

AYR-14-026067-1

Write or attach label

HCR Number:
CHI Number: 0902763334

Surname: Johnstone

Forename: Lee

Sex: Male

Address: 12 WOODSIDE AVENUE,
KIRKMICHAEL
MAYBOLE KA19 7PP

Date of Birth: 09 Feb 1976

MEDICAL CONTINUATION SHEET

DATE	
9/7/14	- Able to SLR - Tender over LCL - McMurray's ve pain. for OR Very small fluid within knee ACL: NO # No LOOSE BODY NO OSTEOCHONDRAL #S IMP: Likely meniscal inj LCL sprain TRACHEAL SPLINT OUTLINE ANALGESIA APPT FOR MR: DEARNOS NEURO CLINIC

RM

AYR HOSPITAL
EMERGENCY DEPARTMENT

NHS Ayrshire & Arran

A/E No: AYR-14-014500-1

CHI No: 0902763334

Date: 30 Apr 2014 **Time:** 19:49

Consultant: Dr Alastair Stevenson

GP
G PATON

THE SURGERY
THE HEALTH CENTRE
6 HIGH STREET
01655 882278
01655 882278

Incident Date: 30 Apr 2014
Incident Time: 19:49

Marital Status: Divorced

Sex: M

Ethnicity: Scottish

Religion: None

Attendances in last 12mths 2

Total Cross Site Attendances Count 22

Special case : Alcohol Abuse

Waterlow Score :

JOHNSTONE
Lee

Date of Birth: 09 Feb 1976 **Age:** 38 Years

Address:
12 WOODSIDE AVENUE
KIRKMICHAEL
MAYBOLE

KA19 7PP

Phone Numbers:
Home: 01655 750064

Employer/School
not employed Not at School

Next of Kin:
Georgina Johnstone
12 WOODSIDE AVENUE
KIRKMICHAEL
MAYBOLE
KA19 7PP

Mother
Home Tel: 01655750064

Accompanied By:
Police

Triage Time 19:52 **Triage Nurse** William Jamieson **Triage Group** Orange

Resp Rate **02 Sat%** **PFR**

Pulse **BP** /

E **M** **V**

Allergies: No Known Allergy

BMstix **Alcohol** **Temp** **Weight**

R L

Pain Score Triage 97

Pain Score Discharge

Triage details
999 stand by, intoxicated male under influence of drugs too. In company of police. Aggressive and agitated.

Treatment
ECG

Special Needs
NONE

Re-assess in 15 30 60 minutes

Against Medical advice I decline the treatment offered. I know this may affect my recovery.

Signed..... Witness..... Witness.....

I Hereby Consent To My Self/Child Having

Signed.....

Disch A+E clinic Paed Tr. Fracture Clinic Eye ENT Max Facial Ward OP Ward IP

0902763334

Forename: Lee Surname: JOHNSTONE Date: 30 Apr 2014 A/E No. AYR-14-014500-1

Drug	Dose	route	time/frequency	signature	quantity/given by
MIDAZOLAM	5mg	IV	20 00.		
MORPHINE	5mg	IV	20 15		
ANTIEMETICS	5mg + 5mg + 5mg		20 20		

Clinical indication:
- ☐ IV fluids / IV drugs
- ☐ Urgent access
- ☐ Blood products
- ☐ Diagnostic Procedures
- ☐ Other

- ☑ Clean field
- ☑ Hand hygiene
- ☐ Skin antisepsis
- ☐ No touch critical parts
- ☐ Dressing dated/timed

☑

PVC Insertion Bundle

	Size/Colour	Location	Initials
PVC1	Green	(R) Hand	MG S.A.S
PVC2	Green	(L) Hand	A.S.

	Device	Flow Rate l/min	% O2 for Venturi	Target SpO2	Prescribed by	Stopped by	Started by
Oxygen							
Changed to							

DOCTOR / ENP: ASTINGTON, Cons JM. 4412586. Time: 1950

PREF ARREST — Aggressive pt. Agitated / Restrained ? Not Sane

38 @

Has been hitting PCH — Smells strongly of EtOH

Unclear if drug ingestion. — no definite Hx.

Slumped in doorway

? recently split c girlfriend

Agitated + aggressive ++ c S.A.S.

focused aggression but not fully orientated

IV Diazepam 10mg from S.A.S. — no improvement

Restrained en route by 4 police + S.A.S.

PMH unclear — notes requested

c/o Speaking few words | screaming

No head injury. Appeared SBM 5.8. Temp (N)

No obvious injuries.

Hand-cuffed. Restrained by police.

Shaking head - Trying to bite. Unmanageable

IV access ? Rash / cuts / Cyanosis / GK / Paranoid Delusions

EtOH level sent.

Dead - Have you notified :- NOK? ☐ GP? ☐ Fiscal? ☐ Police? ☐ Letter? ☐

I give consent for details of my injury to be given to the Police.

Signed.....

Witness GCS — not accessible

ED Dr/Xray report

AYR-14-014500-1

CHI Number: 0902763334

NHS Ayrshire & Arran

Accident & Emergency Nursing Documentation Form

SITUATION

JOHNSTONE Lee
12 WOODSIDE AVENUE
KIRKMICHAEL
KA19 7PP

DOB: 09/02/1976

Date: 30 Apr 2014
Time: 19:49

Additional information for admission complaint:
999 stand by, intoxicated male under influence of drugs too. In company of police. Aggressive and agitated.

Receiving Nurse(s): L Jones (2030) ; J. Greer ; H. Campbell

BACKGROUND

Relevant PMH relating to presenting complaint:

Allergies: NKA
Warfarin: yes/no/unknown
Insulin: yes/no/unknown

Next of Kin details: (if difference from A&E Card)
Name:
Relationship:
Address:
Telephone no: (if diff from above)

With patient: Yes/No
To be contacted?
If yes-time contacted
If no - reason

Consent to displaying personal info: Yes No

ASSESSMENT

MEWS/PAWS score: 4
GCS: 12/15

Any medications given by paramedics
DIAZEPAM

Name band in situ: Y/N
Own medications Y/N
Belongings taken for safe-keeping: Y/N
Cognitive Impairment: Yes No

O2 therapy: yes/no Amount:

N/A

RECOMMENDATION

AYR-14-014500-1

CHI Number: 0902763334

Treatment plan/Nursing Notes:

Date & Time	Nursing Notes
30/4/14 1955	E.C.G. Y/N
	X-Ray Y/N CXR
	I.V. cannula in situ: Y/N
	Bloods Obtained: Y/N
	Commenced on pathway Y/N
	Waterlow Score if req'd :
	A- Patel
	B- Stalagmard
	C- Weak
	D- GCS 12/15
	E- Pt due to [illegible] of urine on arrival. Aggressive in police custody. Pre operative. WC
	Other Nursing Notes
1955	MIDAZOLAM 5MGS IV @ this time WC
2120	Further 5mg IV Midazolam given.
	Another 15mg IV Diazemuls given.
	Continues on IV fluids running stat.
	Portable CXR taken in Resus.
	Male Catheterisation using aseptic
	technique by S/N Campbell.
	NG tube passed by Anaethetist.
	Urine dipped - NAD.
	Tox screen negative.
	Intubated by Anaethetist @
	IV Propofol infusion commenced
	running 15mls/hr.
	For bed in ICU. Size 3 Guedel airway.
	Ready for transfer to ICU.
	J Greer/J. GREER SN

PTFE AquaFlate REF P310116
PTFE Coated Latex LOT 13IE39
Short/Medium-Term 2018-08
(up to 4 weeks use)
Standard, 2-way Foley
SIZE Ch. 16 (5.3mm) / 10ml
Teleflex Medical, IDA Business & Technology Park, Dublin Road, Athlone, Co. Westmeath, Ireland

Indication UNWELL
Residual Volume (ml)
Colour of Urine YELLOW
Easy Insertion? Y/N If No, why?
Name H CAMPBELL
Signed N Campbell
Date 30/4/14

2119 HC

Transferring Nurse Signature: _____ Receiving Nurse _____

Time of transfer: _____ Relatives aware yes/no

AYR-14-014500-1

Write or attach label

HCR Number:

CHI Number: 0902763334

Surname: Johnstone **Sex:** Male

Forename: Lee

Address: 12 WOODSIDE AVENUE,
KIRKMICHAEL
MAYBOLE KA19 7PP

Date of Birth: 09 Feb 1976

MEDICAL CONTINUATION SHEET

DATE	
	→ IV Midazolam 5mg — initially more settled — 5mg — ECG ✓. Consult ✓ subsequently awake aggressive / unmanageable agn. further sedation — 5mg Midazolam — 15mg increments in increments — still agitated ++ ↳ Anaesthetics called. → RSI, Intubated, Ventilated Propofol / Sux Uncomplicated Right sided. NGT — CXR Urinary Catheter ↳ ITU.

Consultant
4412586

Forename: Lee **Surname:** Johnstone



Date : 30 Apr 2014

DATE		

AYR-14-014500-1

Write or attach label

HCR No:
CHI No: 0902763334
Surname: Johnstone
Forename: Lee Sex: Male
Address: 12 WOODSIDE AVENUE, KIRKMICHAEL
MAYBOLE
PostCode: KA19 7PP
DOB: 09 Feb 1976

I.V. Therapy and Prescription Sheet

	DATE	FLUID (USE BLOCK LETTERS) ADDITIVE DRUG	Vol (ml) Dose (mg.)	Route of Admin.	Dur. of Admin.*	SIGNATURE	Serial No. Batch No.	Time Begun	Given By Added By
A	30/4/14	N.Saline (0.9%)	500ml	IV	stat				
B	30/4/14	N.Saline (0.9%)	1000ml	IV	stat				
C									
D									
E									
F									
G									
H									
I									
J									
K									
L									
M									
N									
O									

RATE OF FLOW (Drops/Min.)

VOL. OF FLUID (ml) x 15 / Duration (Mins.) (1ml = 15 drops)

Approximate Rate for 500ml

1hr = 120 Drops/min
4hr = 30 Drops/min
6hr = 22 Drops/min
8hr = 15 Drops/min

6.62

PLEASE FILL OUT FLUID BALANCE CHART OVERLEAF

CHI: 0902763334
Johnstone, Lee
12 Woodside Avenue
Maybole
KA19 7PP
09/02/1976
Dr G Paton

CHI No 0902763334

RT

Time 20:06 Date 30/04/2014

PATIENT AND INCIDENT DETAILS

Incident number	CR000277275.001
Name	LEE JOHNSTONE
Address	12 WOODSIDE AVE KIRKMICHEAL
Age	35 year(s)
Date of birth	09/02/1976
Gender	Male
Incident location	OS ON STREET 9 RIVERSIDE PLACE MAINHOLM AYR
Incident post code	KA8 0DY
Incident type	EMG
Call received	30/04/2014, 18:56
Call passed	30/04/2014, 18:57
Crew mobile	30/04/2014, 18:57
Crew at scene	30/04/2014, 19:02
Crew left scene	30/04/2014, 19:31
Patient at hospital	30/04/2014, 19:37
Receiving hospital and department	AYRH Ayr Hospital

PRIMARY SURVEY

RESPONSE

AVPU	Voice

AIRWAY

Airway assessment	Clear

BREATHING

Breathing rate	Fast
Respiratory rate	22

CIRCULATION

Pulse rate	Fast
Most peripheral pulse found	Radial
Cap refill rate	<2 secs
Skin colour	Flushed
Skin texture	Dry
Circulation treatment	IV cannula
Time of cannulation	19:08
PVC record completed	PVC record completed
Aseptic techniques followed	Aseptic techniques followed

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

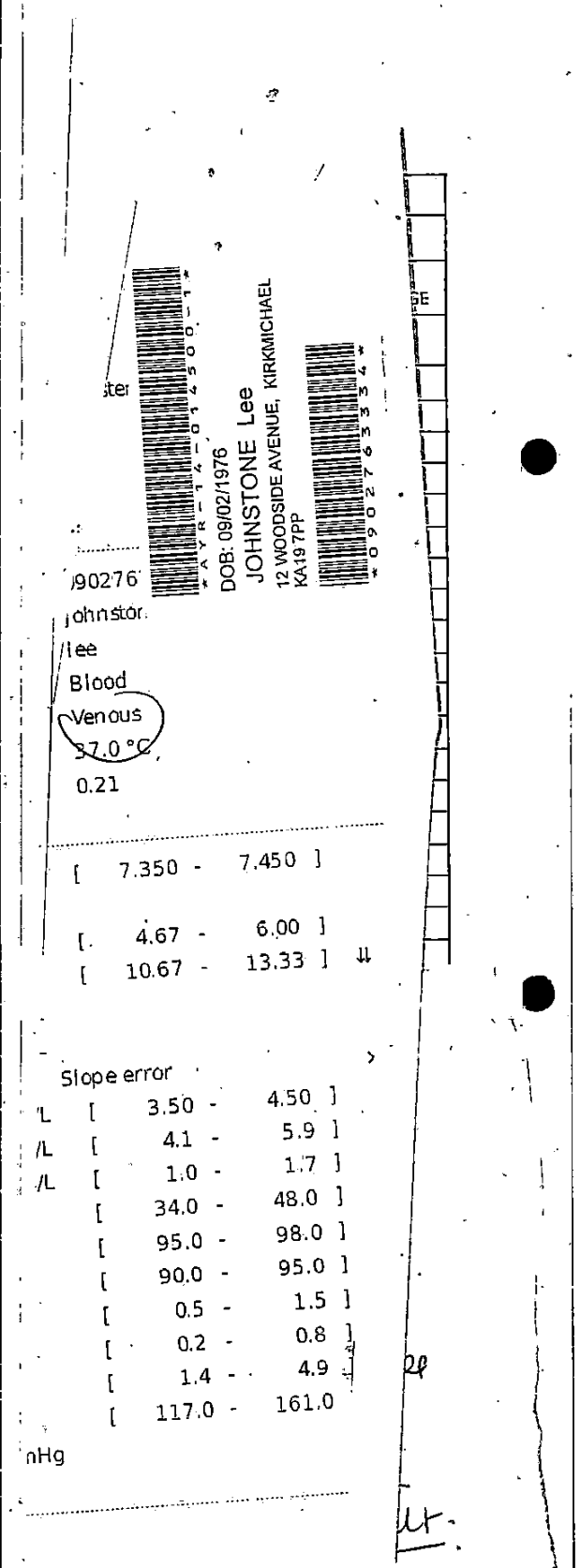
Dispatch code	32B03	Unknown Problem - Unknown Status/Other Codes N/A
Final code	12C01	Convulsions/Fitting, Focal fit (not alert)

GCS

Final GCS eye opening	Spontaneous
Final GCS verbal response	Confused
Final GCS motor response	Localised pain

VITAL SIGNS

Time hr : min	Pulse bpm	Pulse rhythm	Resp. rpm	BP mm Hg	Cap refill (secs)	Peak flow %	Blood sugar mmol/	Pain score	Temp °C	SpO2 %	GCS Total	NEWS	RTS	ECG	Sepsis



NHS Ayrshire & Arran

THE AYR HOSPITAL
INTENSIVE CARE UNIT
Admission Sheet

AYR-14-014500-1
DOB: 09/02/1976
JOHNSTONE Lee
12 WOODSIDE AVENUE, KIRKMICHAEL
KA19 7PP
0902763334

DATE

Clinical reason for admission: OD → agitated & confused state

Date: 30/4/14 Time: 2135. Source of admission: A&E

Referring consultant (not Anaes): Prasad Receiving anaesthetic consultant: Ryan

Summary of presenting problem: Brought in with police x4. Aggressive. Intoxicated. 10mg Nubain given in A&E + 15mg diazemuls. Variable GCS in A&E. Speaking & swearing at one point. No obvious injuries. Settled a little, but became aggressive & difficult to manage again. Handcuffed & 2 PCs remain restraining him when I arrived.

Past medical history: Known to A&E. Poss PSH & alcohol excess. Now alcohol issues.

Propofol 150mg Sux 100mg ETT tube, → Propofol infusion @ 15ml/hr + Atracurium 30mg bolus.

16G NGT – clear, then bilett.

Drugs: Allergies:

Clinical examination (general comments):

Temp 37.3

Central nervous system:

GCS = E = 1 M = 1 V = T Intubated (Y) N

GCS (Prior to sedation or GA) E = 1 M = 5 V = 2 Intubated Y (N)

Pupil signs: 3mm Rel reactive Any lateralising signs? No.

Respiratory system:

FiO2: 0.4 PaO2: PaCO2: BXS: [H+]:

SV / CPAP/ASB / NIV / (IPPV) → manual mode

Clear chest

DRS 5801

DATE

Cardiovascular system:

BP: 100/~~65~~ HR: 120 Rhythm: ST Perfusion: good

ECG - LONG QT

Renal system: clear urine - nil on urine testing for drugs.

Urea: Creat: Urine vols: Oliguria Y/(N) Anuria Y/(N)

Haematological system:

Hb: WCC: Plats: Coag:

Hepatic function:

Normal Y/N Bilirubin: INR: LFT's:

Gastrointestinal system:

Nutrition: Good/Adequate/Poor Albumin: Obese/(normal)/underweight

Sepsis markers: CRP: WCC: Pyrexial Y/N

Interventions: are the following in place or needed now or needed soon ?

Fragmin	Y/N/(Soon)	Antibiotics	Y/(N)/Soon
Ranitidine/PPI	(Y)/N/Soon	CXR — at OK — NG OK	(Y)/N/Soon
Arterial line	Y/N/Soon	Central line	Y/(N)/Soon
Sepsis Bundles	Y/(NA)	Line Cultures	Y/(N)/Soon
Glycaemic Control	Y/(N)/Soon	Urinary catheter	(Y)/N/Soon
Steroids needed?	Y/(N)	Nasogastric tube	(Y)/N/Soon
B-blockers replaced?	Y/(NA)	Lumbar puncture	Y/(N)/Soon

If the patient has Severe Sepsis or Septic Shock, please document Targets, cultures and antibiotics given, clearly in the ICU notes.

Bacteriology tests (list all)

Sputum Y/N Urine Y/N

Blood Cult Y/N Swabs Y/N

Impression: 38 year old man with probable intoxication due to alcohol. Blood results awaited

Treatment Plan (including sepsis targets): IPPV → weaning mode as able. Sedate & Propofol protocol. Reconsider investigation if decent recovery after period of sedation.

WHO of the surgical/medical team IS aware of this patient? 1001 holder

Admitting doctor (+ print) GMC Number

Shingstone LIVINGSTONE 3249283

I.C.U

NHS Ayrshire & Arran

DOB: 09/02/1976
JOHNSTONE Lee
12 WOODSIDE AVENUE, KIRKMICHAEL
KA19 7PP

I.C.U

DATE

30/4/14 2155 On moving Paramedic notes, there is a suspicion of having had 2x seizure-like episodes.
Will await blood results & then consider investigation pathway.

Shrimpstone
3249233

2400 From old notes: alcohol related seizures previously. Denied seizures at the time. Had been told not to drive, but states he may have ignored this as he has a driving licence at present.
Had laparoscopic epigastric hernia repair 3/11 — at that time on Omeprazole.

Bloods from admission — nil except alcohol level 339

Shrimpstone
3249233

01/05/14 09:15 Day 1. NR: AE/TS
Awake & communicating well. GCS: 15/15
Extubated x 1 & hr ago.
Rs: On O2 4L humidified. SaO2 100%.
Lungs: clear.
CVS: Stable.
Abd.
Urine output } NAD.
Neuro: Sober but does not remember events from last night.
Admits to seizures in the past but no investigations done.

DRS 5801

DATE

- apologetic for problems caused.

Plan: - for medical review regarding clinical.
- for D/c from ICU.

(SAW)

01/05/14

URID. [illegible]

IBT o/s

AKI. Investigation → [illegible]

AKI [illegible] 7339

[illegible]

↓

O/E [illegible]

Haemodynamically [illegible]

↓

- Urine O
- ABG Regular O
- Hourly wash O
- IV fluid O O

Δ Alcohol withdrawal → Toxicity [illegible]

Krishna Prasad
Consultant
Acute Medicine
GMC 5270 1/18

I.C.U

NHS Ayrshire & Arran

CHI: 0902763334
Johnstone, Lee
12 Woodside Avenue
Maybole
KA19 7PP
09/02/1976
Dr G Paton

DATE

Consultant CMR

2/2/14 38

LOR

OM Adm

PC

known to AHC with alcohol related issues

Brought in by police 30/1/14

Agitated

Aggressive

Given sedation (midazolam) - ITU

Extubated 1/2/14

Step down from ITU 2/2/14.

Persistent tachy 95

Mg^{2+} - WNL

Ca^{2+} - WNL

Bloods (T) LFT/U&E/FBC

MCV

LOR reviewed

NAD CT Head

Today

Not in bed

Gone downstairs

Sat [illegible]

History reviewed

Pt is now alert

Ambulant

Past drank alcohol for 5yrs

DRS 6003

MEDICAL

DATE

2/5/14 Drank 4 pints of beer + 1 shot of whiskey on 1/5/14 due to a party

Remembers nothing else.

PCW
safety belt / (N)

NKDA ⊗

[illegible] - Alcohol [illegible] intoxication ? seizure

Plan
Observe till tomorrow morning
If all well, then home
Parent/carer for parent
No further up

(G)
VSS
1020

3/5/14 ST3 MCDANIEL

1215. Hx noted
obs stable, apyrexial
feeling rested
(P) Home

[signature]
[illegible]/2014

(AU)

CROSSHOUSE HOSPITAL
EMERGENCY DEPARTMENT

0251

M'Guffie Tr 12/02

NHS Ayrshire & Arran

A/E No: XH-13-007363-1	CHI No: 0902763334
Date: 07 Feb 2013 Time: 23:51	Consultant: Dr Yvonne Moulds
GP Dr. GERALD G PATON THE SURGERY MAYBOLE HEALTH CENTRE 6 HIGH STREET MAYBOLE KA19 7BY	Incident Date: 07 Feb 2013 Incident Time: 23:51 Martial Status: Divorced Sex: M Ethnicity Scottish Religion None Attendances in last 12mths 1 Total Attendances Count 19
Next of Kin: Johnstone 12 WOODSIDE AVENUE KIRKMICHAEL MAYBOLE KA19 7PP Mother Home Tel: 01655750064	JOHNSTONE Lee Date of Birth: 09 Feb 1976 Age: 36 Years Address: 12 WOODSIDE AVENUE KIRKMICHAEL MAYBOLE KA19 7PP Phone Numbers: Home: 01655 750064
Accompanied By: Partner	Special case alc
	Employer/School not employed Not at School

Triage Time 23:53 **Triage Nurse** HEATHER MORTON **Triage Group** Green

Resp Rate 02 Sat% PFR Pulse BP E M V Allergies: **No Known Allergy** BMstix Alcohol Temp Weight Visual Acuity R L Pain Score (Triage) 7 Pain Score (Discharge)	**Triage details** Check human bite to right thumb and scratches to left ~~thumb~~ by ex wife **Treatment** **Declined analgesia at triage, NONE** **Special Needs** **NONE** Re-assess in 15 30 60 minutes

Against Medical advice I decline the treatment offered. I know this may affect my recovery.

Signed..... Witness..... Witness.....

I give consent for details of my injury to be given to the Police.

Signed.....

Disch A+E clinic Paed Tr. # eye ENT Max Facial Ward OP Ward IP

0902763354

A/E No. XH-13-007363-1

Drug	Dose	route	time/frequency	signature	quantity/given by
Paracetamol	1g	O	0135	PHD	HM
Ibuprofen	400mg	O	0135	PHD	
Augmentin 1/52	625mg	P	TDS 8	S	
Cocoamol 8/500 pr	2tabs	PO	QDS 4°	S	
Ibuprofen PR	400mg	PO	TDS 8	S	

PVC1	Size/Colour	Location	Initials	PVC2	Size/Colour	Location	Initials

	Device	Flow Rate l/min	%O2 for Venturi	Target SpO2	Prescribed by	Started by	Stopped by
Oxygen							
Changed to							

DOCTOR / ENP: Convoca ST7 Time: 0100

36 PMH → Camilla Bone SH / works on roads. NKDA

(R) hand dominant Thinks tetanus is up to date

In argument with ex wife this evening, bitten on (R) thumb

C/O pain ++ (R) thumb

Has scratched to (L) face

No other injury

Ex wife not known to have HIV / hepB / any BBV.

v/e well GCS 15

(R) thumb → tenderness over prox phalanx

No other bite mark bruising

e/o ++ tenderness over prox phalanx + 1st metacarpal

Distal sensation intact

Full power extensors but painful

limited flexion thumb due to pain

Reg Metacarpal block 4/4ml 2% lignocaine

wound explored → bone seen, tendon visible

but no joint seen, freely moving (I) Amox / Monday

→ wound washed + closed Analgesia

Wound dressing

IMV SpR → nad for closure, loosely in / stenosing only T dress

(I) oral abx

wound dressing

Wound review 8/7

Analgesia

CONVOCA ST7

(12) WA

AYR HOSPITAL
EMERGENCY DEPARTMENT

NHS Ayrshire & Arran

A/E No: AYR-10-040838-1

CHI No: 0902763334

Date: 27 Nov 2010 Time: 18:35

Consultant: Dr E Ofei

GP
G PATON

MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE

Incident Date: 27 Nov 2010
Incident Time: 18:35

JOHNSTONE
Lee

Marital Status: Divorced

Date of Birth: 09 Feb 1976 Age: 34 Years

Sex: M

Address:
12 WOODSIDE AVENUE
KIRKMICHAEL
MAYBOLE

KA19 7PP

Next of Kin:
Georgina Johnstone
12 WOODSIDE AVENUE
KIRKMICHAEL
MAYBOLE
KA19 7PP

Mother
Home Tel: 01655750064

Religion: Not Known

Previous Attendance Count: 17

Special case : Alcohol Abuse

Phone Numbers:
Home: 01655750064

Waterlow Score :

Employer/School
not employed

Accompanied By:
Partner

Triage Time 18:41 Triage Nurse Andy Seaton Triage Group Yellow

Resp Rate 02 Sat% PFR

Pulse BP / E M V

Triage details
abdo pain lt side - at site of previous hernia repair

Allergies: No Known Allergy

Treatment
NONE

BMstix Alcohol Temp Weight

Special Needs
NONE

R L

Pain Score Triage 8

Pain Score Discharge

Re-assess in 15 30 60 minutes

Against Medical advice I decline the treatment offered. I know this may affect my recovery.

Signed..... Witness..... Witness.....

I Hereby Consent To My Self/Child Having

ST3

Signed.....

Disch A+E clinic Paed Tr. Fracture Clinic Eye ENT Max Facial Ward OP Ward IP

AYR-10-040838-1

Forename: **Lee** Surname: **JOHNSTONE** Date : 27 Nov 2010 **A/E No.** AYR-10-040838-1

Drug	Dose	route	time/frequency	signature	quantity/given by
MORPHINE	5mg	IV	STAT		5mg
CYCLIZINE	50mg	~~Oral/IM~~ IV	STAT		MDU 2155
~~PARACETAMOL~~					
CO-CODAMOL	30/500	Oral	STAT		

DOCTOR / ENP: PARAMEDIC Time:

Surgically Expected → SDEC Referral

Clerk in the Emergency Dept Triage Nurse T. Not vomited; Not opened bowels since yesterday, not passed urine

No acute abdominal symptoms

O/E appeared, dehydrated

Sinus rhythm

Chest clear

Abdo soft
Tender in epigastrium
Guarding, RUQ
No rebound

Per Emergency Dept

IV access

Bloods

Refer to Surgical Team

Dead - Have you notified :- NOK? ☐ GP? ☐ Fiscal? ☐ Police? ☐ Letter? ☐

I give consent for details of my injury to be given to the Police.

Signed.....

ED Dr Xray report

3

Case Date: 27/11/2010 17:11 **Case Number:** 24581 **Case Type:** PCTC (Nurse Pract)

Patient Name: Lee Johnstone **Sex:** M **Date of Birth:** 09-Feb-1976 **Age:** 34 years

CHI Number: 0902763334

Current Address:
Guiltreehill Bungalow

Maybole

postcode

Contact Phone:
01655 750139

Case Origin: NHS24

Caller Name: Sarah

Home Address (if different):
12 Woodside Avenue Kirkmichael

KA19 7PP

Home Phone (if different):

Tel:

Own Doctor: Paton, Gerald
Surgery: Maybole H/C (Drs Paton
Case Priority: Within 2 Hours
PCC [ ] **Home Visit [ ]**
Rx NHS24: 16:42
Appointment: 18:00
Arrival time:

NHS24 **Triaged By:** (Nurse Advisor) (Ayrshire (& Arran))
Operator's Name: (Non-Clinical User) (Cardonald)

Triage Start: 16:46
Triage Finish: 17:07

Reported condition: CB - WORSENING HERNIA - 24 HOURS - SEE A/V

Allergies	Medications	Previous Medical History
NIL	AS PER ECS	ABDOMINAL HERNIA HERNIA REPAIR 14 MONTHS AGO

Clinical Summary:

Clinical summary created by: (Nurse Advisor) (Ayrshire (& Arran)) [27/11/2010 17:07:35]
ABDOMINAL PAIN FOR 1 DAY, WORSENING AND H/O ABDOMINAL HERNIA REPAIR 14 MONTHS AGO. SINCE YESTERDAY HERNIA HAS DOUBLED IN SIZE, UNABLE TO REDUCE, FEELS NAUSEATED, PAIN WORSE ON INSPIRATION, HERNIA IN SAME PLACE AS LAST TIME, SIMILAR PRESENTATION, WAS ADMITED AS EMERGENCY LAST TIME. ADVISE GP 2HRS - AYR PCEC AT 6PM WITH NP

Disposition: Contact GP Practice within 4 Hours (as soon as possible) **Outcome code:** PCC3

Reported Condition: **Operator:** **Receive Time:**

Latest Advice Details **Consulted by:** **Advice Begin:**
Advice End:

Latest Consultation Details **Consulted By:** **Cons. Begin:**
Cons. End:

do above - no vomiting, but no b.m. today

Examination Details: **Clinical Codes:**

T-37 Tender epigastrium, normal bowel sounds

Diagnosis: Some epigastric protrusion evident

Prescription Items:

Follow-up: Referred to duty surgical team, then hospital

Name of attending Gp/Nurse: Signature:

To receiving FYI for surgery
Apr Hospital

AYR-10-040838-1

CHI Number: 0902763334

NHS Ayrshire & Arran

Accident & Emergency Nursing Documentation Form

JOHNSTONE Lee DOB: 09/02/1976

12 WOODSIDE AVENUE

KIRKMICHAEL

KA19 7PP

Name of Receiving Nurse:

.....

Date of Admission: 27/11/10

Time of Admission:

Additional information for admission complaint:

abdo pain lt side - at site of previous hernia repair

Next of Kin: .....
(if different from A&E Card)

Address: .....

.....

.....

Tel No: .....

With Patient: Yes No

Contacted: Yes No

Reason for not contacting

.....

Time Contacted: .....

Name Band in situ:	Yes	No	
E.C.G	Yes	No	
X-Ray	Yes	No	ADMICKR
I.V. cannula in situ:	Yes	No	Cannula Chart ✓
Bloods Taken:	Yes	No	
Waterlow:	Yes	No	
Own medications with patient:	Yes	No	
Own belongings with patient:	Yes	No	
Patient undressed:	Yes	No	Nurse: .....
Belongings taken for safe-keeping:	Yes	No	Witness/Patient: .....

27/11/10

21:11	Reviewed by senior surgeon in department, For admission to ST3, Bed ready. Partner present. IV fluids, cannulated x ray as charted, Await MSU and Blood results. Megan Dunn SN (MKEGGS)

Write or attach label

HCR No: *AYR-10-040838-1*

CHI No: DOB: 09/02/1976

Surnam: JOHNSTONE Lee

Forena: 12 WOODSIDE AVENUE, KIRKMICHAEL

Addres: KA19 7PP

0902763334

Date o...

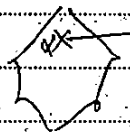
STA 0173

SURGICAL

DATE

27/11/10

2050 hr - 34y old ♂
- epigastric pain of 4/52 duration
- worse today
- crampy severe pain
- associated nausea
- no urinary complaint
- bowels opened normally yesterday. no abnormal bowel
Int Ventral hernia repaired mesh 14 months ago
- had 2 bottles of wine yesterday
O/E appeared T=37
-



→ Tender R.I.F ° Rebound
No cellulitis
No evidence of recurrence of hernia

BSS ✓

PR → empty rectum

Plan Imp R/O gastritis / Pancreatitis
R/O strangulated / incarcerated hernia

Con / Fluids / Pain Analgesia
A&E's. Lytes / Fbc / Coag
- Admit. NBM.

AES

JMcG/74031

DATE

28/11/10

Mr. Mun

He noted

Obs. OK

Pain ↓, better

reducible

↓ Small recurrence of hernia

NO bowel incarceration

Plan Eat & drink

analgesia

OP f/u clinic Repair ↓

29/11/10 Mr. Mun

abdominal pain settled

→ recurrence of ventral hernia

Exp recurrence of hernia

Plan on waiting list for

Repair of ventral hernia

(no mesh before)

[signature]

[illegible]

Write or attach label
DOB: 09/02/1976
JOHNSTONE Lee
12 WOODSIDE AVENUE, KIRKMICHAEL
KA19 7PP
0902763334
040838-1
Date of Birth

FYI Clerk In

STA 0173

DATE

27/11/10
8pm

PC Epigastric pain

HPC 4/52 hx of epigastric pain
Sudden onset severe epigastric pain started this morning, becoming increasingly worse.
Worse on movement
Severity 8/10

Associated vomiting
Not moved bowels today.

Previous abdominal hernia repair
14 months ago ? mesh repair.

No recent NSAID use

PMH Appendectomy
Abdominal hernia repair.

DH NKDA
Omeprazole 20mg OD

SH

S/E Neuro - Nil
CVS - Nil
Resp - Nil
Abdo - Nil
GU - Nil

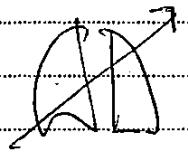
SURGICAL

DATE

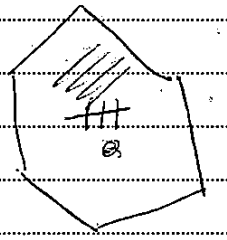
O/E BP 152/72 T 37 HR 85 RR 16 Sats 95%

CRT < 2 secs
HS I + II + 0
JVP ⊖
°ankle oedema

Equal a/e
Equal chest expansion



Abdo soft
Tender ++ in epigastrium
Peritonitic



No obvious masses
Slight protusion in abdomen upon sitting
°cough reflex +

PR → empty rectum

Imp / ? Incarcerated hernia
? Perf DU

Plan / Admit ST 3 ✓
Kardex ✓
CXR + AXR ✓
IV access + bloods (Done by A+E) ✓
Analgesia → 5mg IV Morphine
IV fluids
Antiemetics

AXR – faecal loading (L) side.
CXR – no free air under diaphragm
– raised (R) hemidiaphragm

* Will need senior r/w *

SCHAMPANEY
1153 FY1

AYR HOSPITAL
EMERGENCY DEPARTMENT

2

NHS Ayrshire & Arran

A/E No: AYR-10-035949-1

CHI No: 0902763334

Date: 15 Oct 2010 **Time:** 10:13

Consultant: Dr Sarah Learmonth

JOHNSTONE
Lee

GP
G PATON

MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE

Incident Date: 15 Oct 2010
Incident Time: 10:13

Marital Status: Divorced

Date of Birth: 09 Feb 1976 **Age:** 34 Years

Sex: M

Address:
12 WOODSIDE AVENUE
KIRKMICHAEL
MAYBOLE

KA19 7PP

Next of Kin:
Georgina Johnstone
12 WOODSIDE AVENUE
KIRKMICHAEL
MAYBOLE
KA19 7PP

Mother
Home Tel: 01655750064

Religion: Not Known

Previous Attendance Count: 16

Special case : Alcohol Abuse

Phone Numbers:
Home: 01655750064

Waterlow Score :

Employer/School
not employed

Accompanied By:
Mother

Triage Time 10:19 **Triage Nurse** Fiona Galloway **Triage Group** Orange

Resp Rate **02 Sat%** **PFR**

Pulse **BP** /

E **M** **V**

Allergies: No Known Allergy

BMstix **Alcohol** **Temp** **Weight**

R L

Pain Score Triage

Pain Score Discharge

Triage details
self presentation with central chest pain, no cardiac hx, worse on inspriation. mews 0 pts pain score 7/10.

Treatment
ECG, Advice - verbal

Special Needs
NONE

Re-assess in 15 30 60 minutes

Against Medical advice I decline the treatment offered. I know this may affect my recovery.

Signed.....Witness.....Witness.....

I Hereby Consent To My Self/Child Having

Signed.....

Disch A+E clinic Paed Tr. Fracture Clinic Eye ENT Max Facial Ward OP Ward IP

AYR-10-035949-1

Forename: Lee Surname: JOHNSTONE Date: 15 Oct 2010 A/E No. AYR-10-035949-1

Drug	Dose	route	time/frequency	signature	quantity/given by
PARACETAMOL	1g	O	11:30	DMcL	Glasgow 1200

DOCTOR / ENP: McCall (Cochran) Time: 11:20

34yr ♂ Woke from sleep c L sided chest pain (06:10)
Assoc c sweating + Pallor. No SOB
cough c black sputum 3/52 - since Holiday in Turkey (Th. Flight)
Pain worse on deep inspiration + cough + affected by posture. Also c/o bilat calf pain last wk.

PMHx: Guillian Barre - Age 18 Meds: Omeprazole
- Hernia NKDA
- Abscess in throat
FHx: no history of clots
Lives c partner + ? kids
Ex ETOH excess - Smoker 20 cpd.

O/E: Comfortable @ Rest Temp = 36.5
H.R = 85 BP = 156/96 R.R = 15 Sats = 99% A/
H1 - I + II + 0
CRT < 2secs
Calves = SNT
very mild @ basal crepts

PTO→

Dead - Have you notified :- NOK? ☐ GP? ☐ Fiscal? ☐ Police? ☐ Letter? ☐

I give consent for details of my injury to be given to the Police.
Signed.....

ED Dr Xray report

AYR-10-035949-1

Write or attach label

HCR Number:

CHI Number: 0902763334

Surname: Johnstone

Sex: Male

Forename: Lee

Address: 12 WOODSIDE AVENUE,
KIRKMICHAEL
MAYBOLE KA19 7PP

Date of Birth: 09 Feb 1976

MEDICAL CONTINUATION SHEET

DATE	
15/10/10	
cont'd	⊙ → SNT. ECG: S.R. n.T acute
	ABG: pH = 7.42 pCO_2 = 4.99 pO_2 = 10.71 HCO_3 = 24.1 } A:
	A/P: Pleuritic chest ± cough
	? LRTI + pleurisy
	? PE
	→ @ bloods inc. D-Dimers
	→ Rule Medics.

Forename: Lee **Surname:** Johnstone

AYR-10-035949-1

Date : 15 Oct 2010

DATE		

NHS Ayrshire & Arran

Acute Medicine Admission Proforma

WRITE OR ATTACH LABEL

HC
CH JOHNSTONE A100-544212
SU 12 WOODSIDE AVE LEE
FO 0902763334
AD KIRKMICHAEL 09/02/1976
KA197PP
PATON,G (GP)
DE 6 HIGH STREET M/S
MAYBOLE

Date: 15.10.2010 Time: 14:00

Referral source: A E Receiving Consultant:

Presenting Complaint 31 years old male

the patient wake up this morning by left sided chest pain ↑ by deep inspiration or moving his left arm away from the chest, pain is not increase by exercise. he has come from Turkey 4 weeks ago his swellen in his left leg immediately after come back resolve now has some productive cough with black coloured sputum no blood stain sputum or hemoptysis no fever no SOB

PMH

- appendicectomy
- excision cyst in the neck when she is 5
- gastritis

ACUTE MEDICINE

STA5225PS

Multidisciplinary Medicines Reconciliation

Must be started by admitting Clinician within 24 hours

Source of information (use at least two sources) (Tick)

Patient	☑	Emergency Care Summary	☐
Relative / Carer	☐	Nursing Home Chart	☐
Patient's Own Drugs	☐	Previous Discharge Letter	☐
GP Referral Letter	☐	Repeat Prescription	☐
GP Practice	☐	Other (please specify)	☐

Admission Medicines			Action Note: Unless otherwise indicated below, medicines should be continued on prescription sheet				
Name, Form, Route (specify if not oral)	Dose	Frequency eg 3X	Suspend	Amend	Stop	Comments (if medicine suspended, amended stopped or inaccurate)	Pharm initials if change
TRAMADOL	50mg	PRN					✓
OMEPRAZOLE	20mg	1x					LG

OTC / Herbal / Homeopathic / Illicit substances	Further information eg compliance aid, recent discontinued medicines

Adverse Reactions / Allergies None Known ☐ or

Medicines / Substance	Reaction

Are you satisfied this medication history is complete and accurate? YES ☐ NO ☐

If NO what further action is necessary (Contact GP etc) .....Tick when resolved ☐

Pharmacist review signature .....Date/Time 15/10/15 1405 Beep No 1260

(initial changes / additions above)

WRITE OR ATTACH LABEL

AYR-TD-035949-1

DOB: 09/02/1976

JOHNSTONE Lee

12 WOODSIDE AVENUE, KIRKMICHAEL
KA19 7PP

0902763334

FH

irritable

SH (include home circumstances; social support; functional status; occupational history)

Lives with new girl friend
divorced has 4 children

Alcohol (units /wk): Little

Smoker: (Yes) / No / Ex 20/day

Systemic Enquiry

epigastric discomfort

otherwise irritable

ACUTE MEDICINE

Examination: General Findings

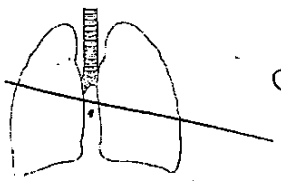
Temp: 36.1/2 P: 95 BP: 140/90 RR: 16 SaO_2: 98 FiO_2: (mask / NP)

Jaundice / Pallor / Clubbing / Cyanosis / LN

CVS

HS: normal JVP: not elevated Oedema: NO Pulses: 80/minute regular and palpable in lower limbs

RS



clear.

Abdo



apart from upper Abdominal scar from ~~dot~~ hernia repairs nothing else.

PR:

NS

AMT: /10 GCS: 15 /15 E: /4 M: /6 V: /5 Meningism?

(AMT: age, time, recall of address at end, hospital name, year, recognise 2 people, DOB, WW2, monarch, 20-1)

NAD

	RUL	LUL	RLL	LLL
Tone				
Power				
Coordination				
Reflexes				
Sensation				

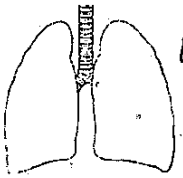
WRITE OR ATTACH LABEL

HCR 0902763334 A100-544212
CHI N JOHNSTONE LEE
Surna 12 WOODSIDE AVE
Forer KIRKMICHAEL
Addn KA197PP 09/02/1976
..... PATON,G (GP)
..... 6 HIGH STREET
MAYBOLE
Date of Birth ..... M/S

Initial investigations - Print out blood results and file with proforma. Transcribing results may lead to errors.

Blood Tests	Tick when taken	Comments	Blood Tests	Tick when taken	Comments
U+Es	☑		FBC	☐	
LFTs	☑		Coag screen	☐	
Bone Profile	☐		ESR	☐	
CRP	☑		D-Dimer	☑	
CK	☐		ABGs	☐ FiO_2?:	
cTnT	☑ 12h: Y / N				
Glucose	☐ Fasting: Y / N				
Lipids	☐ Fasting: Y / N				
TFTs	☐				

CXR: elevated right diaphragm?? when compare by old one otherwise normal.



ECGs: within normal Limits

URINALYSIS:

ABGs:

D. Dimer negative

Summary

as D Dimers is negative and his Hy is ok now may a case of pleurisy

Differential Diagnoses

- pleurisy
- PE unlikely. 4. Spain D. dimers negative
- musculoskeletal

ACUTE MEDICINE

Management Plan (List planned investigations on following page)

Co-abdominal pain ref
- carry on with his treatment.
- D-dimer - ve so Less likely to be PE or DVT.
- waiting for Troponin result if Normal.
consultant can decide to him To go home
- elevation of Rt diaphragm in new event he might need Abdominal ultrasound.

DVT / VTE prophylaxis (*see SIGN 62 for indications*)
Yes (dalteparin 5000 units daily) / No (why?:)

Patient informed of plan?

Relatives informed of plan? Name: Relationship:

Name: W. BICHARD N	Grade:	Page:
Signature:	Date:	Time:
Consultant:	Ward:	

Additional Notes (if insufficient space – use next page)

WRITE OR ATTACH LABEL

HCR N
CHI No
Surnam
Forenai
Addres
Date of

DOB: 09/02/1976
JOHNSTONE Lee
12 WOODSIDE AVENUE, KIRKMICHAEL
KA19 7PP

Additional Notes

15/10/10

Chest pain sounds musculoskeletal.

Not settled.

Denies any associated features.

Trop t at 6pm - if negative ~~discharge~~ discharge please

Agn

ACUTE MEDICINE

14

AYR HOSPITAL
EMERGENCY DEPARTMENT

NHS Ayrshire & Arran

A/E No: AYR-09-036605-1

CHI No: 0902763334

Date: 16 Aug 2009 **Time:** 15:02

Consultant: Dr TERESA HAND

JOHNSTONE
Lee

GP
G Paton
MAYBOLE HEALTH CENTRE
6 HIGH STREET

Incident Date: 16 Aug 2009
Incident Time: 15:02

Martial Status: Single

Date of Birh: 09 Feb 1976 **Age:** 33 Years

Sex: M

Address:
12 WOODSIDE AVENUE
KIRKMICHAEL
MAYBOLE

KA19 7PP

Next of Kin:
Georgina Johnstone
12 WOODSIDE AVENUE
KIRKMICHAEL
MAYBOLE
KA19 7PP

Mother
Home Tel: 01655750064

Religion: Not Known

Previous Attendance Count: 0

Phone Numbers:
Home: 01655750064

Employer/School
not employed

Accompanied By:
Mother

Special case

Triage Time 15:04 **Triage Nurse** Diane MacDonald **Triage Group** Yellow

Resp Rate **02 Sat%** **PFR**

Pulse **BP** /

E **M** **V**

Allergies: No Known Allergy

BMstix **Alcohol** **Temp** **Weight**

R L

Pain Score 5
Pain Score
Pain Score

Triage details
pt c/o abdo pain. known to have a hernia.

Treatment
Oxygen, NONE

Special Needs
NONE

Re-assess in 15 30 60 minutes

Against Medical advice I decline the treatment offered. I know this may affect my recovery.

Signed.....Witness.....Witness.....

I give consent for details of my injury to be given to the Police.

Signed.....

Disch A+E clinic Paed Tr. # eye ENT Max Facial Ward OP Ward IP

AYR-09-036605-1

A/E No. AYR-09-036605-1

Drug	Dose	route	time/frequency	signature	quantity/given by
CYCLIZINE	50mg	IV	1550		
MORPHINE	6mg	IV	1550		

DOCTOR / ~~ENP~~: Dr S Ahmad Locum SG Time: 1600.

33 years male. Walk in arrival. Self referral.

Accompanied by mum.

PC:

- Abdominal pain ⟶ 2/7 days.

Hx/ history of epigastric hernia for 3-4 months (20 to weight lifting)

Pain in upper abdomen/in hernia since yesterday. Pain and swelling has been increased over today. Also skin on the top of hernia looks red.

No Hx/ history of vomiting / Constipation. Opened bowel last night. Feels nauseous.

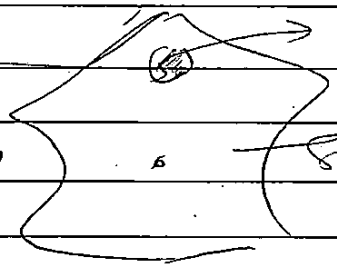
PMHx:
- Gastritis on omeprazole
- Appendicectomy / excision of cyst from throat in past
- Guillen Barre Syndrome ~~now~~ fully recovered.

NKDA

O/E GCS: 15/15, Alert

HR: B.P:

ABDOMEN:



- Chest: clear

Imp: Irreducible / Strangulated epigastric Hernia

Plan:

→ IV access / Blood

→ Analgesia

→ Referred to Surgical on-call team

Dr S Ahmad
Locum SG

AYR-09-036605-1

Write or attach label

HCR Number:

CHI Number: 0902763334

Surname: Johnstone **Sex:** Male

Forename: Lee

Address: 12 WOODSIDE AVENUE,
KIRKMICHAEL
MAYBOLE KA19 7PP

Date of Birth: 09 Feb 1976

Date : 16 Aug 2009

NURSING NOTES

DATE	
16/8. 15.08	Pt c/o Abdo pn. - known to have a Hernia - c/o nausea + pn + sore Obs stable.
15.30	brought to abicle 14, undressed into gown and auto trolley, NOK in cubicle awaiting Review by dr megaw SW
16.47	Reviewed by Surgeons, For admission to ST 2 Bed ready. megaw SW

Forename: Lee **Surname:** Johnstone



Date : 16 Aug 2009

DATE		

Write or attach label

AYR-09-036605-1

DOB: 09/02/1976

JOHNSTONE Lee
12 WOODSIDE AVENUE, KIRKMICHAEL
KA19 7PP

CHI*0902763334*

STA0172

SURGICAL

DATE

16/8/09

(33)M PC Epigastric swelling

Background
- Appendicectomy
- Excision of neck cyst aged 5? (? character)
- Guillen Barré

Currently
- 1/52 hx epigastric mass (always irreducible)
- Weight-lifter
- Progressively becoming tender during weightlifting ~~xxx~~ last 6/52 Dec 08 – April 09
- Attended AP who advised him to stop weightlifting
- Now 2/7 hx stabbing pain, constant over epigastric mass ° Colicky
- Associated inc. in size (double)
- Denies nausea or vomiting
- BLO yesterday morning → Normal
- NO LUTS → Although say he is not passing wind

SH
Smoker 10/day
ETOH 28 units/wk

DH NKDA
Nil

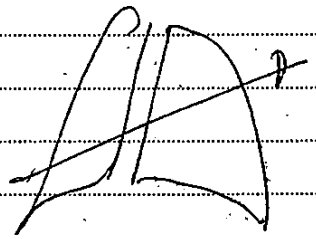
JMcC/74691

DATE

O/E Looks well

BP 140/70, HR 85, RR 16, Sats 97%

Resp

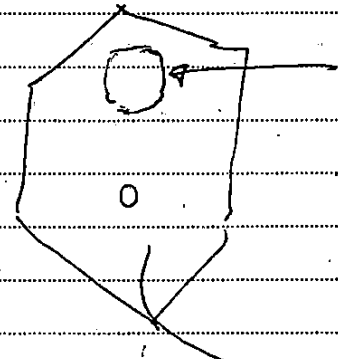


clear
good AE
bibasally

CV/

HS I + II + 0
0 pedal oedema

GI/



- mildly tender 3 x 4 cm
- smooth mass
- cannot get under it
- appears to be in plane of abdominal wall
- BS audible
- rest of abdomen SNT
- BS ✓

Imp: ? (Incarcerated) epigastric hernia

Plan
- Bloods
- Analgesia + antiemetic
- ? Abdominal Ultrasound

Obando ST1

Write or attach label

HCR No: .....

CHI No: .....

Surname: Lee

Forename: Johnstone Sex: .....

Address: .....

.....

Date of Birth .....

STA 0173

DATE

16/8/09

07:30

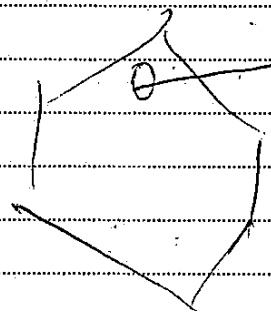
S/B Malpas

(33) presented with a lump in epigastrium. Tender lump for a day. Irreducible – pt says the lump was never reducible Has this for a year now

O/E

Apprehensive Obese male

P/A



Irreducible non Tender epigastric hernia

(P) ASA

Warn from Loan ? for lap hernia repair Pt

Malpas

SURGICAL

JMcC/74031

DATE

STATEMENT BY PATIENT

Against the advice of the Medical Officer responsible for my care, I have decided not to Accept/Continue the treatment offered. I have been advised by Doctor that my refusal may prejudice my improvement or recovery.

Date _____ Signed _____

Date _____ Witnessed by _____

Date _____ Medical Officer _____

CONSENT

I HEREBY CONSENT TO MY SELF/CHILD

HAVING:

I KNOW OF NO ALLERGY OR CONTRA INDICATION

Signed _____ Parent/Guardian

Date _____ Witness _____

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

J F M A M J J A S O N D

JOHNSTONE,LEE
16 MINNOCH CRESCENT
MAYBOLE

198DW
Tel. 01655 884283

Age: 31 Arr 22/12/07 at 11:32 A&E No: 07356-00076
DoB: 09.02.1976 MALE <1/24> Unit No: 100544212
Complaint : unwell
Assessment: epigastric pain, vomiting with specs of b
Triaged By: Bodle,Marianne at 11:35am Type : 03
Special Case : ALCOHOL PROBLEM?

Allergy : NIL

Referral Source : SELF REFERRAL
Employer/School :

G.P. : PATON,G (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE KA197BY
Tel. : 01655882278

Pain : Triage:
Review: _____
Dschrg: _____

OBS - RM 1

Obs ward whilst awaiting blood results

A&E Department, The Ayr Hospital, Ayr KA6 6DX 01292 610555 - A&E Direct Line 01292 614522 Fax 01292 288105

ALL PATIENTS	Seen by (name)	PATERSON	At (time)	13:35	patient in 12
ADMITTED PATIENTS	**Admitting Diagnosis**		**To Station**		

Notes - all personnel - please date and time. Triage notes and observations, allergies etc. on computer

22/12/17

31 year old man

Developed severe epigastric pain 7:30pm last night - had been drinking ~~m~~ more than usual last night
like a "lump" in his gullet in the epigastric region - started sudden ~~ex~~
No radiation of pain, constantly there but fluctuates in intensity
Made worse by vomiting / walking
Has been vomiting for past 12 hours
Occasional specks of blood in vomit
Had diarrhoea for past 3 days - no bowel movement since yesterday
Has had a cough for past 12 hours. Since this morning has been productive of yellow sputum. Has been feeling pyrexial / feverish
No SOB / chest pain / palpitations
No headache / dizziness

PMHx
Indigestion
Cyst removed from knee
Abscess removed from neck and throat

DHx
Lansoprazole

FHx
Dad had CABG

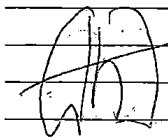
SHx
Ex smoker
Moderate alcohol intake. Has been drinking more than usual last night - bought

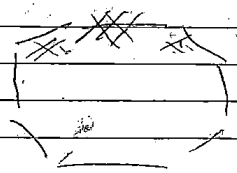
Dead - have you notified? NOK? ☐ GP? ☐ Fiscal? ☐ Police? ☐ Letter? ☐

DRUG PRESCRIPTION

DRUG	DOSE	ROUTE	DOCTORS SIGNATURE	GIVEN BY	TIME GIVEN
GAVISCON	10ml	PO	[signature]	[signature]	13.52
BUSCOPAN	20mg	IV	[signature]	[signature]	14.43
CYCLIZINE	50mg	IV	[signature]	[signature]	

O/E/ Temp/ 36.5°C PR 85
BP 162/96
Sats 97% on air
RR 18


Chest clear HS 1+11+0


Epigastric tenderness
Little tenderness over RUQ + LUQ

Imp – likely viral illness – DM on background of indigestion

Plan – IV access + Bloods (incl amylase)
– CXR – clear
– ECG – RBBB, nil else
– IVI saline – give bag of fluids
– Maxolone
– remain to obs to await blood results

[redacted]
FY1

17:30
Note checked OK
discussed with medical SHO on call – sounds GI in origin from history however should check troponin – if positive she will kindly review, if negative he can go home
Have added troponin to bloods from today

[redacted]
FY2

19:30
Troponin negative
Pt well – advised ie. bed rest, allowing illness to run its course, if continues indigestion – investigate as OP.
For home

[redacted]
FY2

Surname...	JOHNSTONE
Forenames	LEE
Address ...	16 MINNOCH CRESCENT MAYBOLE KA198DW
Ward or D	LAU, C (GP) MAYBOLE HEALTH CENTRE 6 HIGH STREET MAYBOLE

A100-544212
0902763334
09/02/1976
M/S

STA 0173

SURGICAL

DATE
1/5/06

10am:
Observation Ward Review

30♂
High velocity MVC ↓ Tree
Driver
Restrained
No recollection of events
Alcohol +++ / 319 mg/dl.
? Driving erratically
? FSP struggled for wheel to try to control car
Extricated by paramedics who record x2 GCS - limiting seizures.

Trauma series Pelvis (NGI) CXR/C-spine - inadequate but what is visible NAD
CT brain documented as NAD

Stable O/N in Obs Ward.

Primary Survey (N) Haemodynamically (N).
Secondary Survey:

Head/Face: No external signs injury
Neck: No tenderness, #s/#s.
Chest: Pronounced seat-belt mark.
Normal resps / sats
No clinical evidence pneumothorax
Abds: Bruising + tenderness (A) of flank
Otherwise SNT BS (N)
Pelvis: Stable, non-tender
Limbs: Scrapes + cuts; No significant injury

In view of microscopic haematuria + (L) flank pain a FAST scan/(L) renal scan (US) has been requested

1/5/06 cont'd

Independently ambulant. Gait (N).
TPCSR (N)
Rhomberg's (N) No pronator drift
CN II - XII (N)
PERL Preserved
No nystagmus No diplopia
Ophi fundi (N)
No papilloedema No haemorrhage.

Regarding seizures:
Dr Ghosh D/c letter (Admission 11-13/7/03)
Dx Alcohol related seizures (CT normal)
States had previous seizures + patient absconded before anti-epileptic medication could be changed.

Patient states that he has never been on antiepileptic medication and only ever had seizures in 2003.
He has been driving ever since.
→ Police surgeon involvement ✓
→ Advised to inform DVLA and not drive until Neurology assessment.
→ Letter to Dr O'Leary on D/c re follow up
→ LPN review re alcohol consumption

Ben
Loc Cons

1/5/06 Psych Liaison
Asked to see regards alcohol consumption.
Binge pattern Fri - Sun. - consumes up to 2 litres vodka other weeks XS Beer. Feels less of a problem than 3 yrs ago when drank every day. Attended Home detox at that time.
In since today. No recall of getting into car.
Plan - to abstain from alcohol.; refused alcohol counselling at this time. No acute mental illness
fit for d/c from Psych view.

Lorna
Psych

WRITE, IMPRINT OR ATTACH LABEL

Surname Johnstone HCR No.

Forenames Lee Sex

Address D.O.B. 9/2/76

Ward or Dept

STA0172

DATE

1/5/16

Backdiagn Abdo u/s

Normal liver, biliary tree, spleen, pancreas & kidneys

No free fluid or effusion

G Cunha

SURGICAL

DATE

Surname JOHNSTONE HCR No
Forenames Lee Sex
Address DOB

STA 0237 Ward or Department

DATE

30/4.

Driver of car.
-? restrained.
Hr tree or speed.
as being extracted from car, had 2 witnessed seizure.
- self terminating.
- very confused afterwards.

pt admitted to Resus had 1 or 2 pints demerol any drug injection.

A -
Neck - collar (Head hugger) Sp. board.
B - resp all clear.
C - P-160. brisk cap refill.
D - (A)

Re-in access:
- Bloods sent.
- IV fluids.

Xrays - C.spine, pelvis, ECK } nad.

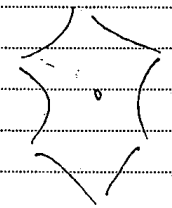
2° survey -
Head -.
PSLL
Cranial N. intact.
Rt Arm - full ROM
° tenderness
Lt Arm - full ROM.
° tenderness.
chest - abrasion over Rt anterior axis.
° pain on compression.

MEDICAL

JMcC/60557

DATE

Abdo



soft.

°tender at mcpoint.

pelvis - NAD.

legs - pes. ↑ tone.
bruise Rt shin.
°local tenderness.

top head - generally tender all over.
raised temperature noted.

Xrays → NAD.

In view of age, hx of fall head → ?ICH.

Admit ?ICH D/N.

wife seen → ?ICH

+ve breath test
- alcohol noted suspect.

SCOTTISH AMBULANCE SERVICE - PATIENT REPORT FORM

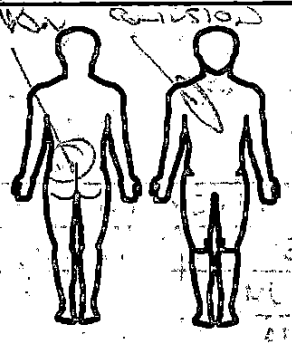
CCS INCIDENT No. 5W 172562 1 AB 1

Last Name: SOUTTER
First Name: LEE
Location: 8 ROSEBERY TERRACE
Age:
Sex: M
D of B: 09 02 76

Date: 30 04 06
Time of Call: 17 50
Time at Patient: 18 02
Time Left: 18 28
AMPDS Code: 29 D 06
AMPDS Revised:

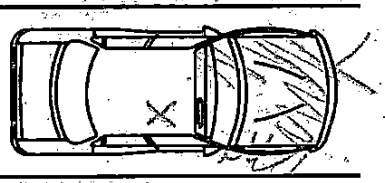
Airway Clear [X] Suction [ ] N/OPA [ ] ET [ ] LMA [ ] Successful? [ ] C-spine Injury [ ]
Breathing [X] Rate [X] BVM [ ] Ventilation [ ] Successful? [ ] Paralysis [ ] Fitting [ ]
Pulse [X] Rate [X] CPR [ ] IV/IO [X] Fluids [ ] Successful? [X] ECG: SR TACHY
Despite the above unable to
Clear airway [ ] Detect breathing [ ] Detect pulse [ ] [X]

Injury Site	Wound	#	Pain	Splint	Dressed
Head					
Neck					
Chest					
Abdomen					
Back			X	X	
R/Arm					
R/Leg					
L/Arm					
L/Leg					



RTA [X]
Trapped [ ]
Ejected [ ]
M/cyclist [ ]
Cyclist [ ]
Pedestrian [ ]
>20 min. Extricate [ ]

Temp. [ ] °C
PEFR [ ] %
B. Sugar [ ] mmol



Allergies:
Medication:
Assisted by and Name -
Doctor [1] Nurse [ ] Other [X]
POLICE + FIRE

Time	Pulse	Resp	BP	C/Refill	SpO2 %	GCS	Lpupil	Rpupil
1801	154	32		K	98	E4 V5 M6	C	C
				F S N				
				U A	F S N	E V M		

Time	Fluid/Drug/Gas	Dose	Unit	Route	Effect	Rhythm	No. Joules	Repeat	Result Rhythm
1802	DXTR	5	PC	IN	X				
1806	OXYG	100	PC	IN	X				

Condition at NAN hospital. Pulse [X] Breathing [X] Conscious [X] Time at Hospital 1823

History and Additional Information

THIS MALE WAS THE DRIVER OF A MEDIUM SALOON WHICH WAS HIT IN FRONT END ON HE IS COMPLAINING OF LOWER BACK PAIN VERY COMBATIVE STARTED FITTING IN CAR, WOULD NOT ALLOW BP CUFF OR ECGS CANNULATED ON SCENE FIT DIAZEPAM DRAWN BUT NOT USED DUE TO SHORT GRAND MAL DURATION, SMELLING OF ALCOHOL (IN CLUB RESCUE BOARD)

Working assessment: RTA
Diagnosis Code:

Crew Name 1: K MCGREGOR Grade: X
Crew Name 2: A CUTHBERTSON Grade: X

STATEMENT BY PATIENT

Against the advice of the Medical Officer responsible for my care, I have decided not to Accept/Continue the treatment offered. I have been advised by Doctor that my refusal may prejudice my improvement or recovery.

Date _____ Signed _____

Date _____ Witnessed by _____

Date _____ Medical Officer _____

CONSENT

I HEREBY CONSENT TO MY SELF/CHILD

HAVING:

I KNOW OF NO ALLERGY OR CONTRA INDICATION

Signed _____ Parent/ Guardian

Date _____ Witness _____

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z J F M A M J J A N D

JOHNSTONE,LEE
16 MINNOCH CRESCENT
MAYBOLE

KA198DW
Tel.

Age: 30 Arr 30/04/06 at 18:40 A&E No: 06120-00
DoB: 09.02.1976 MALE <1/24> Unit No: 100544212
Complaint : LOWER BACK PAIN
Assessment: RTA, DRIVER INTOXICATED
Triaged By: Jess,Fiona at 6:40pm Type : 2
Special Case : ALCOHOL PROBLEM?

Allergy : NIL

Referral Source : EMERGENCY SERVICES
Employer/School :

G.P. : LAU,C (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE KA197BY
Tel. : 01655882708

Pain : Triage: NA AU
Review: _____
Dschrg: _____

2

A&E Department, The Ayr Hospital, Ayr KA6 6DX 01292 610555 - A&E Direct Line 01292 614522 Fax 01292 288105

ALL PATIENTS	Seen by (name)	Kathleen Scrimgeour	At (time) 18:40	patient in
ADMITTED PATIENTS	**Admitting Diagnosis**		**To Station**	

Notes - all personnel - please date and time. Triage notes and observations, allergies etc. on computer

2/4/16 999 call - RTA 30 D-2
15:40 (Hx from SAS)
HPC (?) unrestrained driver RTA -
C.T fee head on
? LOC
motorway speed vehicle: Hyundai coupe
airbags did not deploy
Initially responded, GCS 15/15 found
clinical features c2 prior to arrival
admits ETOH, denies drugs

10/15 A - clear, trachea central

B - RR 24 Sat 100% RA
(CXR (L) = (R)
VBS

C - BP 140/80 P 140
⇒ IV access x2 sent for
Jack IVI bloods inc G+S
coag, Alcohol

D - GCS E 4 M 6 V 5 = 15/15
PERRL, dilated
pt agitated

E - T 38.3°C smell of ETOH ++
full immobilised
Exposure
chest: (+) abrasions/bruising
(R) upper chest wall

Stable, no surg emphysema
c2 =>

06120-00151 100544212
JOHNSTONE, LEE
16 MINNOCH CRESCENT
MAYBOLE
KA198DW 0902763334

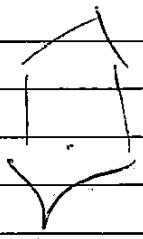
NOK? ☐ GP? ☐ Fiscal? ☐ Police? ☐ Letter? ☐

DoB 09/02/1976 Male

DRUG PRESCRIPTION

DRUG	DOSE	ROUTE	DOCTORS SIGNATURE	GIVEN BY	TIME GIVEN
metoclopramide	10mg	IV			1915

pelvis stable, no compression tenderness



all bloods FROG

leg roll: no obvious bruising / injuries
T-/L-spine tenderness

ECG 8 mins today 150/- ic

06120-00151 100544212
JOHNSTONE, LEE
16 MINNOCH CRESCENT
MAYBOLE
KA198DW 0902763334

DoB 09/02/1976 Male

SCOTTISH AMBULANCE SERVICE - PATIENT REPORT FORM

	CCS INCIDENT No.	A	A	/	N	N	N	N	N	N	/	N	N	N
Last Name	JOHNSON													
First Name	LEE													
Location	15 Drumgolanstown											Age		
	HYDE											Sex	M	F
										D of B	D	D	M	M	Y	Y

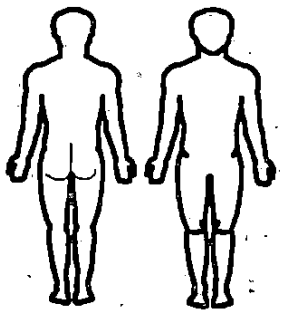
	D	D	M	M	Y	Y
Date						
Time of Call			0	0	4	7
Time at Patient			0	0	5	5
Time Left			0	1	4	1
AMPDS Code						
AMPDS Revised						

Airway Clear	X	Suction		N/OPA		ET		LMA		Successful ?	Y	C-spine Injury	Y
Breathing	X	Rate	F N S	BVM		Ventilation				Successful ?	Y	Paralysis	Y	Fitting	X
Pulse	X	Rate	F N S	CPR		IV/IO	X	Fluids		Successful ?	X	ECG			

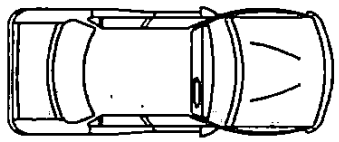
Despite the above unable to

Clear airway | Detect breathing | Detect pulse | A | V | P | U

Injury Site	Wound	#	Pain	Splint	Dressed
Head					
Neck					
Chest					
Abdomen					
Back					
R/Arm		X			
R/Leg					
L/Arm					
L/Leg					



RTA | Trapped | Ejected | M / cyclist | Cyclist | Pedestrian | >20 min. Extricate



Temp. °C

PEFR % B. Sugar mmol

Allergies NKA

1	2	3	4	5	6	7	8	9

Medication

Unknown

Assisted by and Name -

Doctor Y | Nurse Y | Other X

Parents

Time	Pulse	Resp	BP	C / Refill	SpO2 %	GCS	Lpupil	Rpupil
0159	112	26	SYS	DIA	FSN		E V M	S R	S R
0130			SYS	DIA	FSN		E V M	S R	S R
0145	138		SYS	DIA	FSN		E V M	S R	S R
0200	105		SYS	DIA	FSN	97	E V M	S R	S R

Time	Fluid/Drug/Gas	Dose	Unit	Route	Effect	Rhythm	No. Joules	Repeat	Result Rhythm
1015	Diaz	10	mg	IV	+ 0 -				
0145	Diaz	10	mg	IV	+ 0 -				
					+ 0 -				
					+ 0 -				

Condition at A&E hospital | Pulse Y | Breathing Y | Conscious Y | Time at Hospital 0203

History and Additional Information: Patient was overnight. Had 5 witnessed seizures by ambulance and at least 1 further 5 by his parents. Iv Diazepam given by Staff Nurse Jennifer Pyle nurse in charge for the 2nd lot of Diazepam. Each seizure lasts 10-20 seconds no previous history is on a detox programme which started on Monday. Refused O2 and SpO2 monitor. Possible #R wrist - unable to splint - patients wish.

Working assessment: seizures x 10 at least to Poss. #R wrist Diagnosis Code F C

Crew Name 1: WOOLE Grade A P T C

Crew Name 2: MCCORMICK Grade L P T C

SASPATIENT (9/2001)

STATEMENT BY PATIENT

Against the advice of the Medical Officer responsible for my care, I have decided not to Accept/Continue the treatment offered. I have been advised by Doctor that my refusal may prejudice my improvement or recovery.

Date ..... Signed .....

Date ..... Witnessed by .....

Date ..... Medical Officer .....

CONSENT

I HEREBY CONSENT TO MY SELF/CHILD

HAVING:

.....

.....

.....

I KNOW OF NO ALLERGY OR CONTRA INDICATION

.....

Parent/ Guardian

Signed .....

Date ..... Witness .....

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z J F M A M J J A S O N D

JOHNSTONE,LEE

15A DRUMELLAN STREET
MAYBOLE

Tel. 01655 882897

Age: 27 Arr 11/07/03 at 02:04 A&E No: 03192-00013
DoB: 09.02.1976 MALE <1/24> Unit No: 100544212
Complaint : SEIZURE
Assessment: seizures
Triaged By: Jamieson,William at 2:13am Type : 4
Special Case : Refer to Triage Screen

Allergy : Refer to Triage Screen

Referral Source : OTHER
Employer/School :

Pain : Triage:
Review: _____
Dschrg: _____

G.P. : LAU,C (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE KA197BY
Tel. : 01655882708

A&E Deparment, The Ayr Hospital, Ayr KA6 6DX 01292 610555 - A&E Direct line 01292 614522 Fax 01292 288105

ALL PATIENTS	Seen by (name)	PETRIE/LYLE	At (time)	2.13am
ADMITTED PATIENTS	**Admitting Diagnosis**		**To Station**	

patient in

Notes - all personnel - please date and time. Triage notes and observations, allergies etc. on computer.

(27) alcohol.
started Detox programme 5/7. on Librium.
has had 5L/ Ciders (his usual) today again
started drop @ home. - 5 episodes.
paramedics given him 2 lyr, Ringers. - 2 more
fingers on right
? R wrist injury.

PMH - Alcohol. Xs.
DH - Librium.
NKDA.

O/E. Agitated, intoxicated. Father present.
O_2 Sat 96% on air. Haemodynamically (N) T 37.5°C.
BM. 5.3.

Chest clear bilateral air entry. RR.
CVS: S1, S2 RRR no murmurs.

Abdo soft non tender.

GCS 15/15 but fluctuant fm. E 3 M 6 V 5 13/15.

Upwards. PERRL. No skull injury tenderness.

Keep all limbs normally. Plantars ↓↓.

IV access x 2.
Ringers. - no result.

Dead - have you notified? NOK? ☐ GP? ☐ Fiscal? ☐ Police? ☐ Letter? ☐

DRUG PRESCRIPTION

DRUG	DOSE	ROUTE	DOCTORS SIGNATURE	GIVEN BY	TIME GIVEN
PARACETAMOL	1g	IV		AP	
PARACETAMOL	1g	IV		AP	
PHENYTOIN	1250mg	IV infusion		AP	
PABRINEX	1 pair	IV infusion		AP	

in Hrds. Hoods.

Start Phantom. inform. acc. to SOP design. &

After Radiance.

RF: 10 — ... Trident symptomatic — more effected area

Sample QCS = 10/15

Refund. Reduced Rs: Skin symptoms — valid

Rs 16

ATTACH LABEL
S 03192-00013 100544212
F JOHNSTONE, LEE
A 15A DRUMELLAN STREET
MAYBOLE
DoB 09/02/1976 Male
STA0238

DATE

11/7/13
3[10]

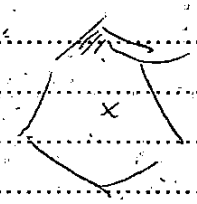
A&E Referral

Seizure.

Alcohol X.S.
Stopped drinking Monday but went back on
cider today → 5L
Having status epilepticus despite having had
1g Epilim diazepam in total
On IV phenytoin now + parent no longer phone
+ was able to say he had not taken
any illicit drugs just cider.
No prev Hx seizure.

On chlordiazepoxide (prescribed 8/7/13)

On Examination: BM 5.3
RR: pulse: regular Temp 37.5
HS1 → 2 BP 100/51
Chest: clear
Abdo:



Cerider - bites bear vomiting

New: PERL pupils and normal
Fundi ⓝ
No neck stiffness

Moves all 4 limbs on command, strength &
tone ⓝ
Reflexes present UL
knees + Solar
Ankles are not ass. just difficult to elicit
Plantars ↓↓

MEDICAL

DATE

Cl 1.9
Creat 90
Na 146
K 3.8
Cl 109
Bic 23.
Alb 224
Corr 45

Had one brief seizure witnessed by ATE Nurse (they have witnessed 6 in total)
Still on loading dose phenytoin - continue
If further fits requiring Rx ⇒ Lorazepam
If prolonged fit ⇒ DDx anaesthetics
Admit (T) ⇒ neuro-observations
Pabrinex IV
IV fluids
Urgent focal neurological signs CT in AM rather than now.
For maintenance dose phenytoin on Wed 7
11 Stevens

9/7/03

Does more liquid (has been getting through night)
Admits "registered alcoholic"
Drinking heavily since left sept - see Detox Team.
a focal neurol.
→ CIWA
IV phenytoin loon
CT brain - to excl haemorrhage (unlikely)

NM

Surnar	JOHNSTONE	A100-544212
Forena	15A DRUMELLAN STREET	LEE
Addre	MAYBOLE	0902763334
		09/02/1976
STA0237	Ward	LAU,C (GP) MAYBOLE HEALTH CENTRE 6 HIGH STREET MAYBOLE

DATE

M/S

12/7 bhll wareq seizw

CT heed

olocaeq higw (w)

acs - (w)

mueed breltht

Plan , chage r Phenytn 200 eq hd

Lact 1.burn

12/7 hed awn sn.

phyt. 300eq hd

12m

13/7 I am w.l Vy cmm wth

thr athm

I Phyt. 200eq hd

13/7 Mr. Johnston decided to self discharge himself despite advice given. Pulled the venflon out & walked out even without signing the discharge form.

Pharmp (Tooc)

(JHO)

MEDICAL

DATE

WRITE IMPRINT OR ATTACH LABEL

Surna
Fore JOHNSTONE LEE AG544212
Addr 16 MINNOCK CRESC
MAYBOLE
..... 09/02/1976 M/S
War DR LAU
THE HEALTH CENTRE, 6 HIGH ST
MAYBOLE

STA0173

SURGICAL

DATE

24/2/98

26/2/98 P.C. - AA for surgical explor^ of neck lumps

HPC - 2 year hx of midline neck lump
- 1cm in diameter,
- occasional dlc from lump
- occasionally painful on swallowing
- has noticed another small swelling just above initial one recently
- no symptoms of thyroid disease
- both lumps removed from neck when 3-4 years old

PMHx - i) guillaine Barré 5y~ 3years ago.

Drug hx - NKDA

Social hx - smokes ~ 10/day
- alcohol ~ 10 u/week
- lives in Irvine

SE - nil else of note

On Exam ~ - appears well
- no signs of thyroid disease

CVS - HR, 70 reg
BP
CVP ↔
HS1 HS2 O
no ankle oedema

Resp - CE - (N)
- percussion resonant
- air entry ✓
- BS vesicular
- no added sounds

DATE

C.V.T - abdo soft & non tender
- no masses / organomegaly
- BS ✓

CNS - grossly intact

Neck
- small mass
- mobile under skin
- non fluctuant
- moves on protrusion of tongue
- midline mass ~1cm in diameter
- firm on palpation
- erythematous scaly skin over it
- no movement on swallowing
- moves on protrusion of tongue

Imp - ? thyroglossal cysts

Plan - FBC ✓, U+Es, TFTs, GTS
- consent ✓

27/4/17 THEATRE - Mr McMillan / Dr Montgomery (anaesthetic)

Uneventful excision of thyroglossal cyst. Definite communication with floor of mouth.

Post-op - Analgesia
Home later today when fully recovered

(S Montgomery
SHO surgery)

AYRSHIRE AND ARRAN HEALTH BOARD

STA0173

WRITE, IMPRINT OR ATTACH LABEL

Surname JOHNSTONE HCR No.

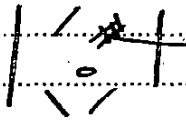
Forenames LEE Sex

Address D.O.B.

Ward or Dept. 3

DATE

9/2/93

Patient still c/o tenderness in LUQ.
And difficulty wt bearing (L) leg
O/E  remains tender in LUQ
OLICKS
BS ✓
abdomen soft
(L) leg – ? haematoma under skin – nil else.
pulses palpable
movement limited ± pain
Dlw Dr Boyle
Plan // 1) u/s scan of abdomen to exclude damage to spleen
2) Analgesia for pain relief (L) leg.
3) if u/s normal then → (H) ± analgesia
4) will request orthopaedic review (L) lower leg)

Thakur (JHO)

SURGICAL

9/2/93

Involved in AN RTA on 7/2/93
Complains of tenderness medial aspect of left leg
No abnormal sensation in the left leg
O/E – left leg
→ bruise in the middle 1/3 medial aspect
– tender on palpation
– mildly swollen
knee and ankle joint – NAD

Imp – ? haematoma

Xrays – for Review later – when available

9/2/93 – U/S
Renal liver, kidney, spleen
No free fluid

Thakur

DATE

9/2/93 Hb = 14.2
WCC = 6.1
plat = 169

Review by Mr Stewart mane ? home JS

10/2/93 C/O ↑ PAIN.
Seen by Mr KORSA
CXR & AXIOM FILMS.
NAD — No free air
No evidence perforation/intra-peritoneal bleed
No other abnormality. T. Finlayson

10/2/93 u/s abdomen - clear.
appears settled.
seen by Mr Kelly this morning
stop IV fluids.
mobilise
orthopaedic review ∴ Shakeur (GTH)
If settled → ⓗ later.

10.2.93 Thanks Orthopaedics
- Neurovascular function distal end Left Tibia 1/3
- ⓛ lower leg in the medial aspect.
- Tenderness on palpation
- Good range of ankle movements

X-Ray: No obvious evidence of # ∴ ? Suspicious line
Ankle joint intact

Plan: Tubigrip
Continue [illegible] = Rest + elevation
[illegible]
- # clinic

AYRSHIRE AND ARRAN HEALTH BOARD

STA0172

WRITE, IMPRINT OR ATTACH LABEL

Surname Johnstone HCR No.

Forenames Lee Sex

Address D.O.B.

Ward or Dept 3

SURGICAL

DATE

10/2/93 Called to see:
Vomited x2 after evening meal - solid food
Was scheduled to go home tonight.
CXR & U/S abdomen today - WNAD
P/E: LUQ tenderness extending to epigastrium & (L) lumbar area
BS ✓ °Lucks °mucs.
P = 80 reg. [redacted]

Plan: ① No food tonight
② Postpone discharge until further assessment tomorrow.
③ Observe.

C. Bala (SHO)

11/2/93 0130 - Called to see bef. of severe LUQ pain. Objectively doesn't seem to be distressed.
No guarding
Appendix cad
BP normal
No pallor/sweating.
Rate above observations — U/S and normal
Plan: Reassured
Review a.m.

C Bulloss (RMO)

11/2/93. Continues to feel nauseated + c/o LUQ pain. Mild haematemesis ("streak. blood") tested ⊕ blood.
N.b. This is not a new thing
Investigated at X-house (~18 months ago) for similar pain + haematemesis.
It is unclear as to Dx but spent 3/52 in hospital
O/E: Undistressed
Afebrile

DATE

mild tenderness in LUQ / Lumbar area.
no urinary / bowel symptoms
nil else to find.

D/W mr kelly - arrange endoscopy as in-patient or out patient.

J Stralow (J+D)

12.2.93 Casualty Room

Thai man ~~was~~ is unable to WB on (R) leg ? pain in (R) calf.

YET bruising post. medial calf. v. tender from knee ? ankle.

Gait ± pain Tenderness XR NBI.

Knee ° effusion

Imp ST bruising only

Rx Local OS ? encourage mobilise

See # cli 4/52

12/2/93. NBI today

Endoscopy to be arranged as outpatient

Patient informed.

Can go home after physiotherapy this afternoon.

J Stralow (J+D)

29/3/93

PATIENT

Surname	Forename C O R	Age	Date of Birth	Arr Date	Time	AE No
JOHNSTONE	KERR	17	9-2-76	23-8-93	00-20.	

Address	Sex	Religion	Date of Inc	Time
16 MINNOCH CRES MAYBOLE	M	PROT		

PC	Tel	Marital Status	Occupation/School	Type of Inc	Mode of Arr
	89536	S.		EMERG	~~A+E~~

GP

Name: DR LAU — Address:

Referred by: G.P. / Surg.

NEXT OF KIN

Name: ALISTAIR — Address: 317

Relat.: FATHER

Tel No.: A/A

Complaint: PAIN L/F.

Diagnosis: Acute abdo pain ? R/F ? Acute appendicitis

Examining Doctor: D. Mackay

Time:

Remarks for GP:

ACCIDENT & EMERGENCY DEPARTMENT

THE AYR HOSPITAL, DALMELLINGTON ROAD, AYR KA6 6DX Tel: (0292) 610555

THIS CARD IS CONFIDENTIAL – IT MUST NOT BE HANDLED BY PATIENTS OR UNAUTHORISED PERSONS

Pati: /

T 36.8 P

R BP

SaO BG

GCS TS

PFR

VAR VAL

URINE

TRIAGE NOTES

SEEN BY AMR AT 00·50

TO ROOM 15 AT 00·50

LFT - Surgeons Pain R.I.F.

NUMBER OF REVISITS 1 2 3 4 5 6 7 8 9 10

DRUG PRESCRIPTION

ALLERGIES

Drug	Dose	Route	Doctor's Signature	Given by	Time Given

CLINICAL NOTES

SIGNED

stigations

X-Ray	ECG	X/Match	Haem	Bio	Bact	Hist	Urine
1	2	3	4	5	6	7	8

edures

SWD	Suture	TT	POP	CPR	Return Appliance
1	2	3	4	5	6

Home	Police	Irr Disch	Did not wait	Return A/E on	Died	DOA
1	2	3	4	5	12	13

ome

Ortho Clinic on 7

Other Clinic 9 on

Police

Fiscal

NOK

District Nurse on 8

Admit to 10

Transfer to 11

Diagnosis:

	Pat Group	Diag	Anat Sit
(I)			
(II)			
(III)			
FD			

Research:

	1	2	3
A			
B			
C			

AYRSHIRE AND ARRAN HEALTH BOARD

STA0172

WRITE/IMPRINT OR ATTACH LABEL

Surname Johnstone HCR No.

Forenames Neil Sex

Address 6 D.O.B.

Ward or Dept

DATE

23/8/98

17 y old M presented c pain
1/7 two days after playing football. Last
night then shifting to RIF. The
pain settled down now. No dysuria.
N/V. appetite ok. Lower gastrointestinal troubles.
Past history of similar pain which settled
down conservatively.

O/E Pt looks well. Afebrile

Abdomen
Flat
No tenderness or
rebound tenderness
No guarding or rigidity
Intestinal sounds normal

Impression ? Muscular pain
?? Appendicitis
Advise observation

DATE

AYRSHIRE AND ARRAN HEALTH BOARD

STA0172

WRITE, IMPRINT OR ATTACH LABEL

Surname JOHNSTONE HCR No.

Forenames Lee Sex M

Address 16 MINNOCH CRES D.O.B 9/2/76

MAYBOLE

Ward or Dept STA 5

DATE

P/C – Abdo pain.

HPC – Started 10pm tonight in RIF as a 'ripping pain'
– Pain moved to RIF & over the next 1–2 hrs and became stabbing in nature. No relieving/aggravating factors.
– Pain referred to Groin.
– Vomiting + about 12.30 pm.
– Appetite unchanged
– Normal bowel movement ° Blood ° Mucus
–

PMH – RTA Feb 1993 # R femur
– 2 yrs ago bowel colic
– 7 yrs old operation to remove abscess in Neck
– ° MI/IJ/PM/Asthma/HBP/E/TB/REF

DH – No known allergies

SH – Smokes 10/day for 6 years
– Occasionally drinks alcohol
– Lives with mother & brother

FH – Nil of note

S/E – Resp: Cough & clear sputum. Wheeze on exertion
CVS: Nil of note
GUT: Nil of note
CNS: – Nil of note

DATE

O/E.

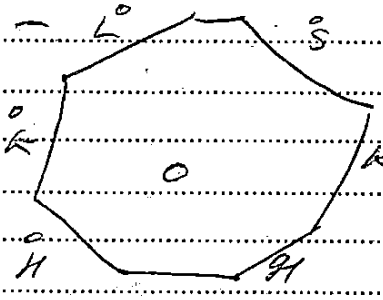
Talkative, Undistressed

J A C C O L

CVS – Pulse 72 Good vol, regular.
– JVP ⇔
– Apex undistressed °Thrills °Heaves
– HS I II + O
– BP

Resp – Chest clear.

Abdo – L S



Soft Tender, slightly in RIF

Non-masses.

BS ↓

PR – Faeces on Glove
→ No localising pain

CNS – Grossly intact

Inv – FBC, U&E, Glucose, AXR

Man – Admit to Ward 3.

D. Mackenzie

STA0173

A100-544212

Surname JOHNSTONE
Forenam LEE
Address 16 MINNOCK CRESC
MAYBOLE
LAU,C (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
Ward o. MAYBOLE

09/02/76

M/S

DATE

~~16/4/98~~

4.5.98

10.5.99

SURGICAL


DATE

JOHNSTONE A100-544212
Surn: LEE 09/02/76
Forer POSTCODE KA198AS
M
Addr Source of Referral
Ward Practice Code 80491

STA0172

DATE

AA for excision of thyroglossal cyst

HPC:- 2yr hx of known thyroglossal cyst.
Previous attempt at excision.
Discharges intermittently.
Pain when discharging
°symptoms of hypo/hyper — thyroidism
°stridor
°dysphagia.

PMHx Guillaine Barré syndrome 1995.
Had immunoglobulin and made full recovery.
NKDA's
N.I else.

Surgical - As before
°anaesthetic reaction

FHx N.I

DHx N.I

SHx Smokes 10/day
Social alcohol
Unemployed.

Sx:- N.I Note.

SURGICAL

DATE

O/E:- °JACCOZ
GCS 15/15

CVS

Pulse 64 +res
HS = 1+11+0

RS

RR = 10
Trachea ⊥
°nodes
Exp L-R = (N)
Ret L-R = (N)
Ax L-R = (N)

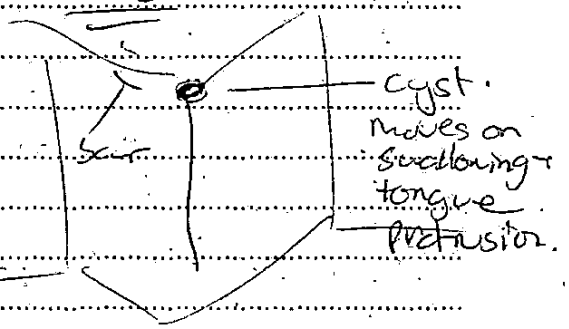
Neuro

Grossly intact.

Abdo

Soft
Non tender
°masses
°LKKS
BS ✓
°PR

Neck



Plan

1. FBC, U+E, GLUC, TFT, Ca^{2+} Coag. ✓
2. G+S on ward ✓
3. Consent ✓
4. Cardex ✓

27/11 Admitted to Ward — Greene H&P SHO #1044
Bloods done ✓
G+S

SH #1044.

Against the advice of the Medical Officer responsible for my care, I have decided not to Accept/Continue the treatment offered. I have been advised by Doctor that my refusal may prejudice my improvement or recovery.

Date ..... Signed .....

Date ..... Witnessed by .....

Date ..... Medical Officer .....

STATEMENT BY PATIENT

CONSENT

I HEREBY CONSENT TO MY SELF/CHILD

HAVING:

.....

.....

.....

I KNOW OF NO ALLERGY OR CONTRA INDICATION

.....

Signed ..... Parent/ Guardian

Date ..... Witness .....

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z J F M A M J J A S O N D

JOHNSTONE,LEE
4C WHITEFAULDS AVENUE
MAYBOLE

198AS
Tel. 884316

Age: 23 Arr 02/01/00 at 00:40 A&E No: 00002-00004
DoB: 09.02.76 MALE <1/24> Unit No: 100544212
Complaint : STOMACHE PAINS
Assessment: VOMITING.
Triaged By: Simpson,Kathy at 12:42am Type : 6
Special Case : Refer to Triage Screen

Allergy : NIL KNOWN

Referral Source : GP
Employer/School :

G.P. : LAU,C (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE KA197BY
Tel. : 01655882708

A&E Deparment, The Ayr Hospital, Ayr KA6 6DX 01292 610555 - A&E Direct line 01292 614522 Fax 01292 288105

ALL PATIENTS	Seen by (name)	GIBSON	At (time)	01.23.
ADMITTED PATIENTS	Admitting Diagnosis	Coffee ground vomits	To Station	OBS

patient in 7

⇒ IV access ✓
bldg (FBC U.S plain tube are on the fridge at Nurses station but not sent yet!.

IV Ranitidine
IV ~~xxxxx~~ fluids
+
Nil by mouth overnight.
Then oral fluids tomorrow morning
for more IV Ranitidine
on ward round tomorrow
then bland diet + home
after lunch, if remains
OK -

NB: If vomits any obvious fresh red blood, then to go to medical ward.

02.01.00 KSR
Still feeling rather achy
Vomited ~ 1hr ago. No blood fresh or otherwise

Plan: Repeat Ranitidine
- Give Maalox as well.
- Aims oral clear fluids if able to.
- Will review later this morning

Dr

02.01.00 Reviewed
1600 Still vomiting. Bowels ~~stuff~~ - no blood.
Do Lower dental pan
OE: 70 - 36.5°

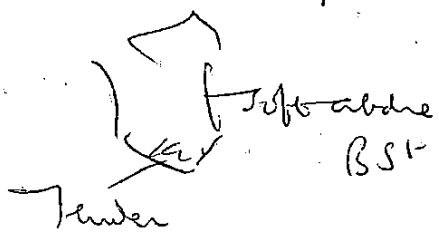
BSt.
IHOJ. Soft, ~~non~~ tender. No guarding / rebound tenderness
for discharge

Flow to Maxim
in Nothing Maybe
Can't we find
Allow free find take to
Review Colin tonight

20 40 Renewal

Severe lower abdo pain

OE:



Haem. Repeat FBC, UE, Amylase. Phys Surg.
Refer portal to Surgery.

Discussed with Mr. Scott Taylor (Surgical Reg).
He kindly agrees to see patient on the ward

Notes - all personnel - please date and time. Triage notes and observations, allergies etc. on computer.

2300 Temp 35.8°C

BP 162/92

HR 74. RR 16.

SaO2 97% on air.

"I've got severe stomach pains and I'm constantly sick".

Began ~ 19:00 hrs on 1/1/00.

Had drunk a lot of alcohol on 31/12/99 until ~ 2am on 1/1/00.

"Suspected" peptic ulcer — never proven.

"Dark brown stuff in my vomit" in the last 2 hrs — ? coffee grounds.

No fresh red blood noted.

No diarrhoea / melaena / fresh rectal blood.

Drug: NKA - On no medications.

O/E: fully conscious. Lungs — clear. Trachea central. HS I + II + nil.

NAD. BS present, although reduced on R.

Vomit tested → moderate blood (P.O.)

Dead - have you notified? NOK? ☐ GP? ☐ Fiscal? ☐ Police? ☐ Letter? ☐

DRUG PRESCRIPTION

DRUG	DOSE	ROUTE	DOCTORS SIGNATURE	GIVEN BY	TIME GIVEN
Ranitidine	50mg	IV	[illegible]	[illegible]	01:37

WRITE, IMPRINT OR ATTACH LABEL

Surname ... [illegible] JOHNSTONE No. ...

Forenames ... Lee ... Sex ...

Address ... D.O.B. ...

STA0173 Ward or Dept. ...

DATE

2/1/00

2200

23

Transfer from A+E Obs Ward

DSH Hx & appx GA pain / vomiting / ? colic

Sound vomiting 20/40 Abx x 5

No GGD No melena

Today started onset of colicky lower

abdo pain, ↑ freq. ↓ & ↓ amount

steady, no prev Hx

PMH. Gallstone Bowel Syndrome

Thyroidectomy

PR colic sound vomit

DH OMDA Smoks 10/d

Abx - 2 wk's

Ofh of non

Rob - Sam spleen x > 1/52

O/E Calm O/E Dehydration

P 72 reg

T 37.2

Soft

Resp/Exp Caudt ↓

Tender lower abdomen

& guarding

BS ↑

SURGICAL

DATE

CXR - NAD
ABG - NAD

Bloods awaited

→ D: Non specific low abd pain

Temp → Stat (2) for observ

[illegible]

3/1/00 Pain → (2) if → Theatre

[illegible]

5/1/00 D2 post-op
Doing ok
Temp 37.3
→ Continue IV ABs till tomorrow
Bloods am

[illegible]

WRITE, IMPRINT OR ATTACH LABEL

Surn JOHNSTONE A100-544212
Fore 4C WHITEFAULDS AVENU LEE
Add MAYBOLE 09/02/76
.... LAU,C (GP)
Wa MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE

STA0173

M/S

DATE	
24/1/00	DNA - NFA. GP notified

SURGICAL

DATE

Catheterisation:
Date 28.6.01 Time 0330
Type Lile Silicone
Batch/lot No
Size 14 Balloon 10ml
Residual 20ml
CSU
By Whom

Medical Officer .....

Witnessed by .....

Signed .....

ainst the advice of the Medical Officer responsible for care, I have decided not to Accept/Continue the atment offered. I have been advised by Doctor that my sal may prejudice my improvement or recovery.

I HEREBY CONSENT TO MY SELF/CHILD

HAVING:

CONSENT

ATEMENT BY PATIENT

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z J F M A M J J A S O N

JOHNSTONE,LEE

4C WHITEFAULDS AVENUE
MAYBOLE

KA198AS
Tel.

Age: 25 Arr 27/06/01 at 03:02 A&E No: 01178-00011
DoB: 09.02.1976 MALE <3/24> Unit No: 100544212
Complaint : BURNS FRONT OF BODY
Assessment: BURNS TO TRUNK,GENITALS,ARMS/HANDS
Triaged By: Smith,Mary at 3:05am Type : 4
Special Case : Refer to Triage Screen

Allergy : Refer to Triage Screen

Referral Source : OTHER
Employer/School :

G.P. : LAU,C (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE KA197BY
Tel. : 01655882708

A&E Department, The Ayr Hospital, Ayr KA6 6DX 01292 610555 - A&E Direct Line 01292 614522 Fax 01292 28810.

ALL PATIENTS	Seen by (name)	MCMURTRIE	At (time)	0302hrs	patient in
ADMITTED PATIENTS	**Admitting Diagnosis**		**To Station**		RN

② - IV access - ① foot
IV fluids: 2½ L in so far
→ maintenance only.
Morphine 2mg IV so far.
U+E, CT, GM, CXR, ECG, coag ✓, G+S,
blood culture, alcohol
consented by S/N Connor (14:04)
→ output ~1L so far.
Cold water-soaked dressings to
cool burns.
Dressings after seen by surgeons.
- Kept surgeon, thank you
ATT ✓

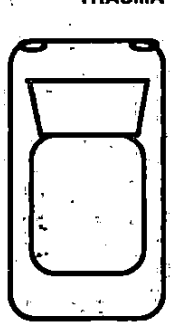
Connor SN

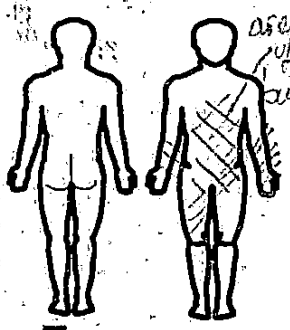
SCOTTISH AMBULANCE SERVICE — **PATIENT REPORT FORM** — INCIDENT No.

PATIENT NAME: LEE THOMPSON — SEX: M ✓ F
PATIENT ADDRESS: [illegible] — D.O.B.: [illegible]

TYPE OF INCIDENT: Trauma; Assault; Cardiac Arrest; Other Collapse; DSH; IHT; Obstetric; Other

TRAUMA INCIDENTS
RTA; Cyclist; M/Cyclist; Pedestrian; Ejected; Trapped; >20 mins. Extricate; Helmet Worn; Seat Belt Worn
Home; Work; Leisure; Burns; Drowning; Fall < 2 mtr.; Fall > 2 mtr.; Head Injury; Poisoning; Other





Damaged Area; Point of Impact; X Position of Patient; Damaged Area/ Burns%; # ? Fracture; X Laceration

INJURY / ILLNESS: Acute Abdo.; Breathlessness; Chest Pain; Other Cardiac; Convulsions; C.V.A.; DSH O/dose; Haemorrhage; Hypoglycaemia; Other ✓ Burns

PRIMARY SURVEY

Treatment prior to arrival	Y	N ✓
By whom		
Duration of treatment / CPR		
Airway — Clear ✓	Obstructed	
[illegible]hing	Y ✓	N
[illegible]lation - Pulse	Y ✓	N
Disability - Alert	Y ✓	N
Vocal Stimuli	Y	N
Pain Stimuli	Y	N
Unresponsive	Y	N
Vomited	Y	N ✓
Fitting	Y	N ✓
Knocked Out	Y	N ✓

INITIAL ACTIONS

Airway		
Pharyngeal Airway	Y	N
Tracheal Tube	Y	N
Laryngeal Mask	Y	N
Size		●
Successful ?	Y	N
Breathing		
O2 Flow rate	15 %	15/10
Mask Type	Hudson	
IPPV		
Circulation		Success
Cannulation — Size — Side — Site		full
1 — 14 — R — ACF	Y ✓	N
2	Y	N

A.M.P.L.E.
Allergies (See reverse for coding) NKA

1	2	3	4	5	6	7	8	9

Medication: [illegible]
Past Medical History: Keep; [illegible] health
Last Eaten: [illegible]
Events Preceding Incident: Chip pan [illegible] fell on [illegible]

OBSERVATIONS

Time	R.R.	SpO2 %	Pulse	Blood Pressure	Capillary Refill Norm	Capillary Refill Delay	Pupils Left Size (C N D)	Pupils Left React Y/N	Pupils Right Size (C N D)	Pupils Right React Y/N	Glasgow Coma Score E	M	V	Total
02:10	24	99	115	—	✓		D	Y	D	Y	4	6	5	15
02:30	24	96	123								4	6	5	15
02:50	22	95	117											

TREATMENTS

Time	Presenting Condition	Defib. (Joules)	Fluid / Drug	Batch / Box No.	Dose	Route	Result e.g. Pulse, Asys, VF, Other
02:15	Burns		Morphine	[illegible]	2mg	IV	
02:15	"		Hartmanns		500ml	IV	
02:15	"		Entonox via mask inhaled				running at arrival
			[illegible]				
							Monitor Only

COMMENTS / ADDITIONAL INFORMATION (Affix Rhythm Strip Here)
Patient moved a hot chip pan after use, slipped and poured the lot over his chest, abdo, groin, both arms & hands. On arrival patient was already in the shower trying to cool down, looked for a further period of time and then covered areas with burns dressings and cling film. Patient stable but still in a lot of pain on arrival

CREW 1	I/C Boyle	[illegible] Cormack
CREW 2		
MEDICAL STAFF	[illegible]	
INCIDENT LOCATION	[illegible]	

SIGNATURE (Crew 1 or 2): [illegible]

CONDITION ON ARRIVAL AT HOSPITAL
Conscious ✓ — Pulse ✓
Breathing ✓ — No Vital Signs

DESTINATION HOSPITAL: Aw

HOSPITAL USE ONLY

DATE OF CALL	07/07/06
TIME OF CALL	02:15
TREATMENT COMMENCED	02:30
TIME LEFT SCENE	04:00
TIME ARRIVED HOSPITAL	04:50

BLOOD RESULTS

A100

NAME: LEE JOHNSTONE ..... UNIT NO: 544212

DATE		27/6
TIME		0600
BIOCHEMISTRY	Normal Values	
Urea	2.5 - 7.5	4.7
Creatinine	50 - 125	96
Sodium	135 - 145	142
Potassium	3.5 - 5.5	4.0
Chloride	95 - 105	107
Bicarbonate	22 - 33	21
Glucose		4.1
Amylase	Up to 300 u/L	
Bilirubin	3 - 15 umol/L	
Alkaline Phosphatase	45 - 140 umol/L	
Total Protein	63 - 83 g/L	
Albumin	39 - 51 g/L	
Globulin		
Calcium (Ca)	2.2 - 2.6 mmol/L	
Corrected Ca	2.1 - 2.5 mmol/L	
Phosphate	0.8 - 1.3 mmol/L	
Zinc	14 - 18 umol/L	
Magnesium	0.7 - 1.1 mmol/L	
AST	10 - 40 u/L	
ALT	10 - 50 u/L	
LDH	250 - 540 u/L	
CK	Male 24 - 195 u/L	
	Female 24 - 170 u/L	
Paracetamol		
Salicylate	Up to 2.5 mmol/L	
Alcohol		
HAEMATOLOGY		
Hb	(m) 13-18 (f) 12-16	13.4
WCC	4.3 - 10.8 x 10^9	8
Platelets	150 - 350 x 10^9	112
Prothrombin and Control		
Thrombin / Control		
APPT / Control		
Fibrinogen		
Arterial Blood Gases		
PH	7.35 - 7.45	
PO2	80 - 100 mmHg	
PCO2	35 - 45 mmHg	
Base Excess	-2 - +2	
Standard Bicarbonate		
Saturation		
SVO2		
Digoxin Levels	1.3 - 2.6 mmol/L	
Gentamycin Levels	Peak 6 - 10mg/L	
	Trough <2.0 mg/L	
OTHER CRP	less	less 5
Alcohol		242

)1178-00011 100544212
JOHNSTONE, LEE
4C WHITEFAULDS AVENUE
MAYBOLE
KA198AS

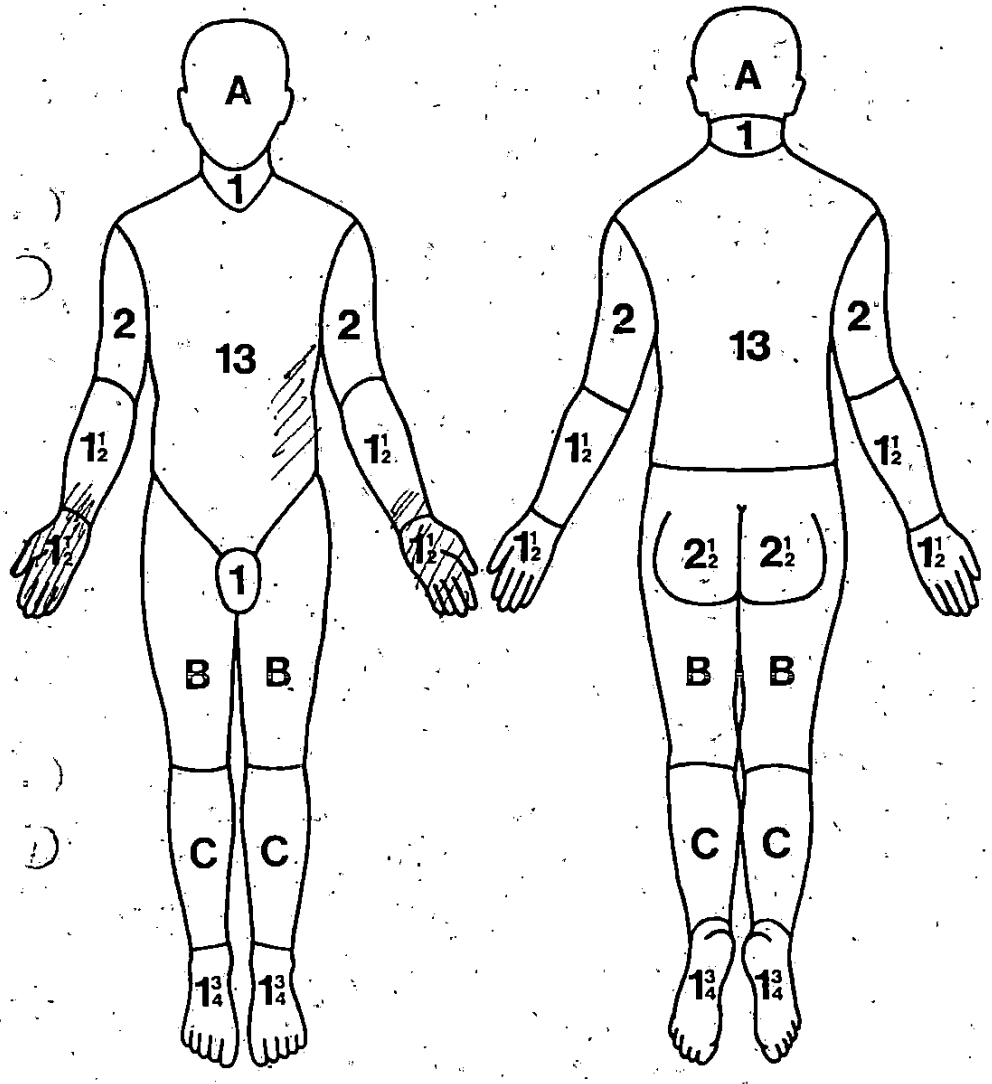
DoB 09/02/1976 Male

ESTIMATING SEVERITY OF BURN WOUND

_____WARD_____NUMBER_____DATE 27/6/07.

DMISSION WEIGHT_____

LUND AND BROWDER CHARTS



IGNORE SIMPLE ERYTHEMA

Partial thickness loss (PTL)

Full thickness loss (FTL)

REGION	% PTL	% FTL
HEAD		
NECK		
ANT.TRUNK	2	
POST.TRUNK		
RIGHT ARM	2	
LEFT ARM	2	
BUTTOCKS		
GENITALIA		
RIGHT LEG		
LEFT LEG		
TOTAL BURN	6	

RELATIVE PERCENTAGE OF BODY SURFACE AREA AFFECTED BY GROWTH

AREA	AGE 0	1	5	10	15	ADULT
A=½ OF HEAD	9½	8½	6½	5½	4½	3½
B=½ OF ONE THIGH	2¾	3¼	4	4½	4½	4¾
C=½ OF ONE LEG	2½	2½	2¾	3	3¼	3½

For further supplies of this pad or of Flamazine* Cream for the prevention and treatment of infection in burns contact Ingrebourne (04023) 49333 or your Smith & Nephew Pharmaceutical representative

*Trade mark

Smith+Nephew

WRITE, IMPRINT OR ATTACH LABEL

Surname LEE HCR No.

Forenames Johnstone Sex Male

Address D.O.B. 9-3-76

STA 0173 Ward or Dept

DATE

27-6-1

0430 Hrs

A+E Referral

H/o Superficial burn

He was using the Deep Fat Fryer
It slipped and spilled fat over his body.
at about 0150 Hrs.

0/E:- Pt is conscious and oriented
B.P :- 125/88 mmHg
Pulse 99/min.
Temp 37.3
O2 Sat 100% on air.
R.R : 17/min

Chest :- Equally moving on both sides
and air entry on both sides.

Burn area:- There is erythema of the trunk
involving the ant chest and abdomen
Erythema of left forearm and some
blisters and the wrist left side
some erythema of Rt forearm.

Imp :- Superficial burn 10%

Plan:-
Admission in Surgical Ward.
IV fluids
Analgesia
Fluorescein staining
catheterization.
Strict I/O
Vital signs

N. MAGBOOL

SURGICAL

WRITE, IMPRINT OR ATTACH LABEL

Surname.... JOHNSTONE
Forenames 4C WHITEFAULDS AVENU LEE
Address ... MAYBOLE
KA198AS
Ward or D LAU, C (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE

CHI No A100-544212
0902763334
09/02/1976
M/S

STA 0173

CLINICAL

DATE	
13/8/01	DNA
22.10.01	DNA
19/11/01	
25/2/02	edna
22/4/02	DNA-NFA

1/4/7 locals lost

(1) ant thigh lesion for years (2-3). discomfort. not discharging

o/e 3×4 cm lesion ant thigh

? sebaceous cyst / lipoma

(R) excise CA. for pathology

[illegible]

ACCIDENT & EMERGENCY DEPARTMENT

THE AYR HOSPITAL, DALMELLINGTON ROAD, AYR KA6 6DX Tel: (0292) 610555

Patient in

PATIENT	Surname Johnstone	Forename(s) Lee	Age 19	Date of Birth 9.2.76	Arr Date 7.4.95	Time 14.40	AE Number				
	Address 16 Minnoch Cres Mcgyboole		Sex Male	Religion Prot	Date of Inc 7.4.95	Time					
	PC	Tel 0655 884536	Marital Status Single	Occupation/School Sch	Type of Inc Other	Mode of Arrival Other					
GP	Name Dr Low	Address The Health Centre Mcgyboole			Referred by: How: To Self						
NEXT OF KIN	Name Mr & Mrs Johnstone Relat Mum + dad Tel No.	Address SIA.			Complaint Legs Pain						

Diagnosis complains of numbness in r foot and difficulty walking; he has difficulty walking when observed; he has no ankle jerk: reduced knee jerk; and sl sensory disturbance; he has pain at l 45 on coughing and abdominal lumbar spine xray; to orthopods. lm

Remarks for GP Ankle / Knee xrays L. M= Mrs Johnstone dict. 2dr.

Examining Doctor [illegible] Time 16.16

1 2 3 4

STATEMENT BY PATIENT

Against the advice of the Medical Officer responsible for my care, I have decided not to Accept/Continue the treatment offered. I have been advised by Doctor that my refusal may prejudice my improvement or recovery.

Date ..... Signed .....

Date ..... Witnessed by .....

Date ..... Medical Officer .....

CONSENT

I HEREBY CONSENT TO MY SELF/CHILD .....

HAVING: .....

.....

.....

I KNOW OF NO ALLERGY OR CONTRA INDICATION

Signed ..... Parent/ Guardian

Date ..... Witness .....

NURSING CARE .....

DISCHARGED AT ..... SIGNED .....

T 37.2 P 84

R 20 BP 128/66

BG ..... PFR .....

SaO ..... ON .....

T.T LESS THAN 10 YEARS?

VAR ..... VAL .....

URINE ....

TRIAGE NOTES

SEEN BY RS AT 16-44

TO ROOM 7 AT 16-44

Complaining of pain in both legs. Seen by GP Bloods taken on Wednesday 5th April.

NUMBER OF REVISITS 1 2 3 4 5 6 7 8 9 10

DRUG PRESCRIPTION

ALLERGIES

Drug	Dose	Route	Doctor's Signature	Given by	Time Given
CO-CO PROXAMOL	2 TABS	O			
NO BRUFEN	400	O			

CLINICAL NOTES

SIGNED .....

Investigations: X-Ray [1] ECG [2] X-Match [3] Haem [4] Bio [5] Bact [6] Hist [7] Urine [8]

Procedures: MUA [1] Suture [2] ETT [3] POP [4] CPR [5] Return Appliance [6]

Outcome: Home [1] Police [2] Irr Disch [3] Did not wait [4] Return A/E on [5] Died [12] DOA [13]

Ortho Clinic on [7] 10/4/95 Other Clinic [8] on

District Nurse on [9] Admit to [10] Transfer to [11]

Police ☐ Fiscal ☐ NOK ☐ GP ☐

Diagnosis:

	Pat Group	Diag	Anat Sit
(I)	U	S	11
(II)			
(III)			
FD			

Research:

Ambulance booked for

	1	2	3
A			
B			
C			
D			
E			

WRITE, IMPRINT OR ATTACH LABEL

Surname JOHNSTONE HCR No.

Forenames LEE Sex

Address D.O.B. 5/2/76

Ward/Dept 9

STA0213

DATE

7/4/95

— 15 yr. old boy developed pain in lower back region 1/52 ago when taping cycling.

- Since then has developed persistent ache aspect of (R) foot over 2/7.
- no urinary / bowel disturbance.
- feels is dragging leg when walks.

CE — Reflexes - 4/5 (R) 5/5 (L)

Reflexes - Patellas ✓ Ext soles

- Ankle jerks absent.
- Knee jerks ✓ (R) ✓ (L)
- B/T/S (R) = (L) = (N)

Sensation - ✓ (R) leg over S1 dermatome

Proprioception - (R) = (L) = (N).

SPINE - no spinal process tenderness

- SLR under at 75° relieved by knee flexion

JMP - ? S1 root compression

ORTHOPAEDIC

DATE

RPAH - DHx Mc Anomv. for analysis + RV in OPC.

NO DOWNER (OPD).

7/4/95. 1907.

Hx of Hx. - Coughed ~ 1/52 ago → sudden pain in low lumbar spine. Pain situated in back.
No radiation. No leg pain
Now has paraesthesia over dorsum of (R) foot.
Difficulty walking - ? dragging foot
Well otherwise. - Normal bladder & bowel symptoms.

O/E. Tender ~ L_5.

Power Quads R = L (N)
Hams R = L (N).
Dorsiflex 3/5 (R) (L) N.
Plantarflex 4/5 (R) (L) N.

Sensn ↓ L_5/S_1 (R) Leg.

Tone R = L (N).

Reflexes.

	Knee	Ankle	Plant
R	++	+	↓
L	++	+	↓

SLR (L) 90° (N) (R) 70° → (R) foot pain.

X-ray NAD.

Impr Prolapsed (R) L_5/S_1 disc. No leg pain but +ve neurological signs.

→ (D) tonight Review 2/4 HRMO. Needs discuss re OPEx

RSA 08

STA0213

WRITE, IMPRINT OR ATTACH LABEL

Surname..... HCR No.....

Forenames..... Sex .....

Address ..... D.O.B.....

54212

Ward/Dept .....

DATE

10.4.95

JOHNSTONE

Diagnosis - ? L5/S1 disc prolapse on the right side

HISTORY
This 19 year old boy presented on 7.4.95 to Casualty with low back pain radiating to his right knee with paraesthesia on the outer aspect of his right foot which he has had for about 2 weeks now. He also says that he finds that his leg is weak and he has to walk about with elbow crutches because of this. There is no bowel or bladder disturbance. There is no history of injury to the neck or back and no history of any fever.

EXAMINATION
On examination he walked with the aid of elbow crutches, his cranial nerves were normal on clinical examination. There was no weakness of the upper limbs. On examination of the right leg, straight leg raising was 70° and on the left it was 80°. There was weakness of dorsiflexion and plantar flexion of the right foot and sensory hypoaesthesia in the S1 dermatome on the right side. I was unable to elicit any of the deep tendon reflexes even on reinforcement. There was no neck tenderness, his lower back was tender in the L5/S1 area and above this as well.

X-rays of his back did not reveal anything abnormal.

TREATMENT
I think this young lad has prolapsed his right L5/S1 disc. I have referred him initially for an MRI scan and will review him again when this is available
AM/SMcC

ORTHOPÆDIC

AYRSHIRE AND ARRAN
HEALTH BOARD

STA0213

WRITE, IMPRINT OR ATTACH LABEL

Surname..... HCR No.....

Forenames..... Sex .....

Address ..... D.O.B.....

Ward/Dept.....

DATE

18.1.93 JOHNSTONE

HISTORY

Attended casualty on 15.1.93 with a history of falling and injuring his right wrist. The wrist was x-rayed. No bony injury was seen. He was provided with an elastic support. He returned back to casualty on 17.1.93 because of inability to use his hand and complaining of pain. It was noted that he had some swelling on the dorsum of his wrist and hand. No neuromuscular problem. A dorsi slab was applied.

EXAMINATION

When seen again at the clinic today the patient is quite comfortable. Continue with the slab. See in 2 weeks. Slab off on arrival.

SM.SJN

ORTHOPAEDIC

Left Ankle

LONGINGS: LISTED ☐ SAFE ☐ OTHER ☐

IRSING CARE

STATEMENT BY PATIENT

CONSENT

I HEREBY CONSENT TO MY SELF/CHILD HAVING:

I KNOW OF NO ALLERGY OR CONTRA INDICATION

Signed ..... Parent/ Guardian

Date ..... Witness

I have received advice of the Medical Officer responsible for care, I have decided not to Accept/Continue the atment offered. I have been advised by Doctor that my usal may prejudice my improvement or recovery.

e ..... Signed .....

e ..... Witnessed by .....

e ..... Medical Officer .....

PATIENT	Surname	Forename C	Age	Date of Birth	Arr Date	Time	AE Nu
	JOHNSTONE	LEE DAVID	16	9-2-76	15-1-93	23.40	109

	Address	Sex	Religion	Date of Inc	Time
	16, MINNOCH GDNS MAYBOLE	M	PROT	15-1-93	23.3

	PC	Tel	Marital Status	Occupation/School	Type of Inc	Mode of Arr
			S	U/E		Car

	Name	Address	Referred by
GP	DR LAU	MAYBOLE	Self

	Name	Address	Complaint
NEXT OF KIN	ALISTAIR JOHNSTON	16, MINNOCH GDNS	Inj. (R) Arm.
	Relat. FATHER	MAYBOLE	
	Tel No. 89536		

Diagnosis Inj (R) forearm

Examining Doctor

Time

Remarks for GP — NBI on XRay
- DTP
- BAS
Mdm

ACCIDENT & EMERGENCY DEPARTMENT

THE AYR HOSPITAL, DALMELLINGTON ROAD, AYR KA6 6DX Tel: (0292) 610555

THIS CARD IS CONFIDENTIAL – IT MUST NOT BE HANDLED BY PATIENTS OR UNAUTHORISED PERSONS.

Pati

SEEN BY KA AT 23.40

TRIAGE NOTES

T ..... P .....

R ..... BP .....

SaO ..... BG .....

GCS ..... TS .....

PFR ....

VAR ..... VAL .....

URINE ....

TO ROOM ..... AT .....

Fell down stairs from top to bottom: injury (R) arm & wrist.

NUMBER OF REVISITS 1 2 3 4 5 6 7 8 9 10

DRUG PRESCRIPTION

ALLERGIES

Drug	Dose	Route	Doctor's Signature	Given by	Time Given

CLINICAL NOTES

Fell down stairs
- Obvy injured arm
- ? ? ?

17/1/23 Rchmod : c/o severe pain — can sleep
@ IE wrist puffy
tender +ve distal radius - ulna
pulse ✓ sensation ✓

X ray (old films not available)
radial styloid

Ø brufen
Clinic review

T ..... P 110

R ..... BP 123/68

SaO 97 BG .....

GCS ..... TS .....

PFR ....

VAR ..... VAL .....

URINE ....

TRIAGE NOTES

SEEN BY JP AT 23.55

TO ROOM 4 AT 23.55

Bright red bloody ± bated motion. at 9pm felt light headed a



NUMBER OF REVISITS 1 2 3 4 5 6 7 8 9

DRUG PRESCRIPTION

ALLERGIES

Drug	Dose	Route	Doctor's Signature	Given by	Time Gi

CLINICAL NOTES

Went to toilet, was constipated & passed blood - saw blood in toilet pan - more than a cup full. not usually constipate no other history except some CIF pain

O/E. P.R. no stool. no blood or melaena. no pain abdo - some tenderness CVS normal/stable but still d

Surgical referral - b. to G.P.

Keep Stn 14.

SIGNED J Kennedy

Investigations: X-Ray 1 ✓ | ECG 2 | X-Match 3 | Haem 4 | Bio 5 | Bact 6 | Hist 7 | Urine 8

Procedures: SWO 1 ✓ | Suture 2 | TT 3 | POP 4 | CPR 5 | Return Appliance 6

Outcome: Home 1 ✓ | Police 2 | Trr Disch 3 | Did not wait 4 | Return A/E on 5 | Died 12 | DOA 13

Ortho Clinic on 7 | Other Clinic 8 | on | Police | Fiscal | NOK | GP

District Nurse on 9 | Admit to 10 Stn 14. | Transfer to 11

Diagnosis:

	Pat Group	Diag	Ana
(I)	4.	31	2
(II)			
(III)			
FD			

Research: 1 2 3

A

B

C

Ambulance booked for

ACCIDENT & EMERGENCY DEPARTMENT

THE AYR HOSPITAL, DALMELLINGTON ROAD, AYR KA6 6DX Tel: (0292) 610555

Patie

Remarks for GP

Diagnosis

Examining Doctor Johnson Time 0009

Complaint Fever. Bleeding

Referred by SELF

Address MAINSORE HEALTH CENTRE

NEXT OF KIN: Name ALISTAIR Relat. FATHER Tel No. Address 51A

G P: Name DR HAU

PATIENT: Surname JOHNSTONE Forename LEE C O R Age 4 Date of Birth 9/2/94 Religion RC Sex M Marital Status S Occupation/School MLE Type of Inc Mode of Arri

Address 16 MUNDHOUSE MAINSORE Tel 89556 PC

Art Date 12/12/92 Time 2355 AE Nu

ATEMENT BY PATIENT

ainst the advice of the Medical Officer responsible for care, I have decided not to Accept/Continue the atment offered. I have been advised by Doctor that my usal may prejudice my improvement or recovery.

le ..... Signed .....

te ..... Witnessed by .....

le ..... Medical Officer .....

CONSENT

I HEREBY CONSENT TO MY SELF/CHILD .....

HAVING: .....

.....

.....

I KNOW OF NO ALLERGY OR CONTRA INDICATION

Signed ..... Parent/ Guardian

Date ..... Witness .....

ELONGINGS: LISTED ☐ SAFE ☐ OTHER ☐

IRSING CARE .....

SCHARGED AT ..... SIGNED .....

T ..... P 92 145

R 20 ..... BP 86

SaO 96 ..... BG .....

GCS ..... TS .....

PFR ....

VAR ..... VAL .....

URINE N.A.D.

TRIAGE NOTES SEEN BY AT Toal AT 1555

TO ROOM Risus AT 1555

R.T.A. Motor cyclist passenger.
Injured ribs and (R) leg

104
107

NUMBER OF REVISITS 1 2 3 4 5 6 7 8 9 10

DRUG PRESCRIPTION ALLERGIES

Drug	Dose	Route	Doctor's Signature	Given by	Time Given

CLINICAL NOTES

Fit man, fasted, no drugs or allergies -
pillion passenger thrown off. alert when
found. aleart and bright here. complains
of l flank and neck. primary survey - neck
in collar, a ok. b ok c ok. IV access and
bloods off. film of neck and chest ok. secondary
survey shows teander l flank, but not over
ribs or l spine (rolled). abraded and tender
l calf. Unable to pu as vet. to xr for complete
neck series and l tib and fib and rv.lm.

TIB+FIB Xr

SIGNED .....

Investigations: X-Ray [1] ECG [2] X-Match [3] Haem [4] Bio [5] Bact [6] Hist [7] Urine [8]

Procedures: SWD [1] Suture [2] TT [3] POP [4] CPR [5] Return Appliance [6]

Outcome: Home [1] Police [2] Irr Disch [3] Did not wait [4] Return A/E on [5] Died [12] DOA [13]

Ortho Clinic on [7] Other Clinic [8] on

District Nurse on [9] Admit to [10] Transfer to [11]

Police
Fiscal
NOK
GP

Diagnosis:

	Pat Group	Diag	Anat Sit
(I)			
(II)			
(III)			
FD			

Research:

	1	2	3
A			
B			
C			

Ambulance booked for

SCHARGED AT ..... SIGNED .....

URSING CARE

ELONGINGS: LISTED ☐ SAFE ☐ OTHER ☐

STATEMENT BY PATIENT

gainst the advice of the Medical Officer responsible for
y care, I have decided not to Accept/Continue the
eatment offered. I have been advised by Doctor that my
efusal may prejudice my improvement or recovery.

ate ..... Signed .....

ate ..... Witnessed by .....

ate ..... Medical Officer .....

CONSENT

I HEREBY CONSENT TO MY SELF/CHILD

HAVING:

I KNOW OF NO ALLERGY OR CONTRA INDICATION

Signed ..... Parent/ Guardian

Date ..... Witness .....

PATIENT

Surname	Forename C O	Age	Date of Birth	Arr Date	Time	AE Numb
JOHNSTONE	LEE	16	09/02/1976	07/02/93	16:01	0028

Address	Sex	Religion	Date of Inc	Time
16 MINNOCH CRES MAYBOLE	MALE		07/02/93	-

PC	Tel 89536	Marital Status	Occupation/School	Type of Inc	Mode of Arrival
		SINGLE		R.T.A.	AMBULANC

GP

Name: LAU

Address: THE HEALTH CENTRE
6 HIGH STREET
MAYBOLE

Referred by:

NEXT OF KIN

Name: GEORGINA

Relat.

Tel No.

Address: S/A

Complaint: PAIN

Diagnosis: MUSCULOSKELETAL PAIN/STRAIN

Examining Doctor: [illegible]

Time: 1607

Remarks for GP: 12-7A

ACCIDENT & EMERGENCY DEPARTMENT

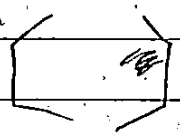
THE AYR HOSPITAL, DALMELLINGTON ROAD, AYR KA6 6DX Tel: (0292) 610555

THIS CARD IS CONFIDENTIAL – IT MUST NOT BE HANDLED BY PATIENTS OR UNAUTHORISED PERSONS

Patient i

7/2/93 Surgery thanks you
17 O7
RTA - motorbike pillion passenger
admitted to ICU via A&E pain.
Not c/o pain. haemodynamically stable
urine N/A

O/E well.

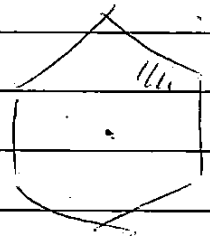


Tender. (B) flank + (D) renal angle.
° rebound.
BS ✓.

Imp. Soft tissue injury.
Observe will remain RTA.

MRaddy

8/2/93 22.5 am Still some abdo pain & nausea
° vomiting. Some diarrhoea.
still feels shaky.
O/E Pt well perfused.
Obs - N/A
Urine - clear.

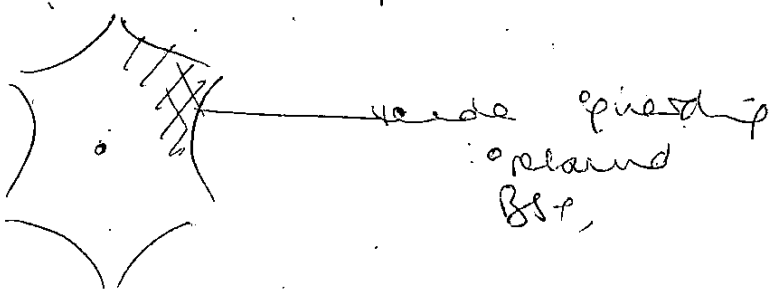


Tender (L) ~~flank~~ epigastrium & hypochondria
& posteriorly.
° rebound
BS ✓

→ Continue analgesia
& observe

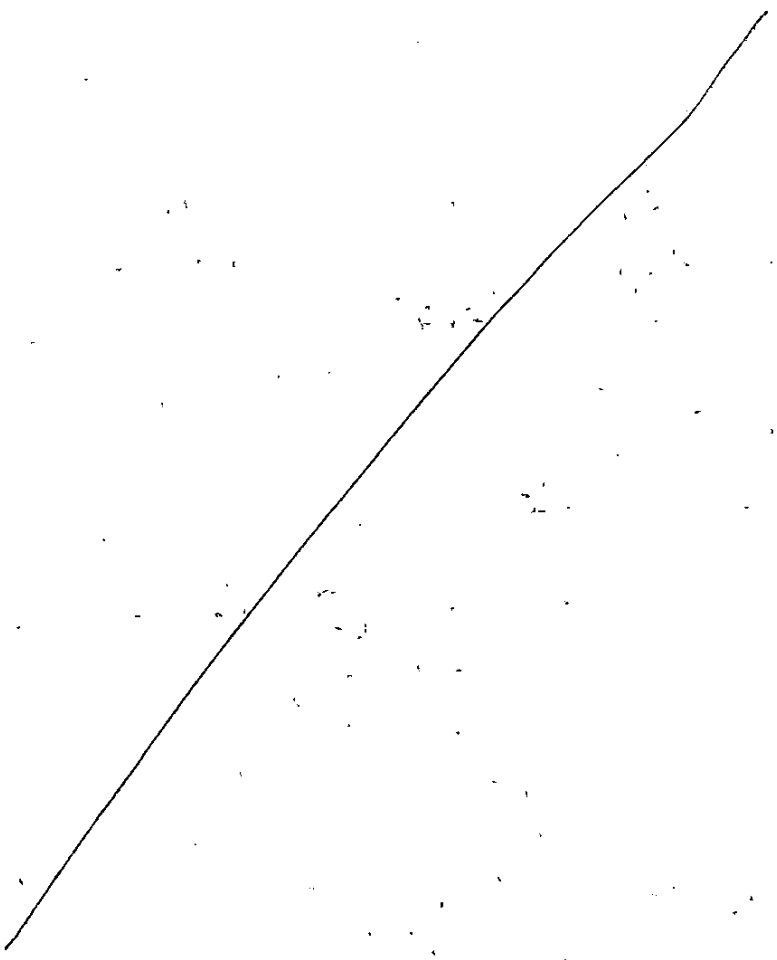
8/2/13. Still 70 diode par
Amplificateur.

P. 70



Plan fonctionnel recevoir

Anode



DIAGNOSIS ..... INDEX No. .....

..... X-RAY No. .....

SEAFIELD HOSPITAL, AYR KA7 4DW

ORTHOPAEDIC UNIT

UNDER CARE OF Mr Brown CLINIC .....

NAME Lee Johnstone DATE OF BIRTH .....

ADDRESS ..... AGE ON ADMISSION .....

.....

ADMITTED ..... REFD. BY .....

FILING ONLY — DO NOT USE THIS SPACE

DATE OF EXAM. SURGEON	
4.7.83	H: One hour ago this 7-year-old boy fell off his bike and injured his right leg. Not able to move right leg or weight bear. Pain in right femur. No head injury. No pain elsewhere. E: Bright and alert. Moving all limbs fully apart from right leg. No cyanosis, dyspnoea or jaundice. Right femur - swelling and slight deformity. Tender++ over mid-shaft. X-ray right femur - spiral fracture mid shaft with displacement. <u>Theatre - Dr Pavan</u> <u>GA - Dr Patel</u> Fracture mid shaft right femur manipulated and skin traction on Thomas splint applied. 5 lb of pull to splint.
6.7.83	Check X-ray of right femur satisfactory.
21.7.83	X-ray right femur - good alignment with early callus. Continue with splint.
4.8.83	Seen by Mr McNally. Repeat X-ray - large good callus.
5.8.83	Thomas splint removed. To have straight traction.
8.8.83	To start mobilisation.
9.8.83	Walking well. Home. See in 3 weeks.
29.8.83	E: Progress of right femur satisfactory. Full mobility of hips and knees. Walking with a careful gait. T: Reassured and discharged. (SH/LMcC)

Joe Jones one

[illegible]

[illegible] Fl: Ca[illegible] ago this [illegible] off his back and injured hi[illegible] right leg. Not able to move right [illegible] or walk. Pain i[illegible] right femur. No bone injury. No visible measures.
Fr: Brigi[illegible] and alert. Moving all limbs [illegible] part from right leg. No cyanosis, clubbing or jaundice. Right femur - swelling and slight deformity. Tenderness over mid-shaft. X-ray right femur - spiral fracture mid shaft with displacement.

Theatre - In ayer G. De Petel.

Fracture mid shaft right femur manipulated and skin traction on Thomas splint applied. 7 lb of wall to point.

5.7.83 Check X-ray of right femur satisfactory.

4.7.83 X-ray right femur - good alignment with early callus. Continue with splint.

[illegible].83 Seen [illegible] Mobility. Repeat X-ray - large mood callus.

5.8.83 Thomas splint removed. [illegible] Give straight traction, [illegible] out

8.8.83 To start mobilisation.

9.8.83 Walking well. Home. See in 3 weeks.

[illegible] Fr[illegible] o[illegible] [illegible] Mentor, [illegible] [illegible]
[illegible] Knee. K-Plate with 8 centre of rest.
[illegible] Knee [illegible] and dinobenzyl. [illegible]

AYRSHIRE AND ARRAN HEALTH BOARD

ANAESTHETIC RECORD

Name
Age
Hosp.
Ward
Unit No.

Proposed Procedure — Thomas splint

Elective / ~~Emergency~~ | WT | BP

Pre-operative Assessment

Recent Drug Therapy

Dentition | Allergies

X-ray | E.C.G.

Lab. Results

X. Matched | Units

Night Sedation | Date

Premedication | Date | Time

DRUGS GIVEN IN THEATRE

9:20: H

200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40

Anaesthetic Technique

Site of Injections
L/R Hand A/c Fossa Other

Site of Infusions
L/R Hand A/c Fossa Other

Oral/Nasal Airway

Cuffed/Uncuffed Oro/Naso Tracheal Tube

Tube Size Type

Throat Pack

Ventilation Spontaneous/I.P.P.V.

Ventilator Type

Local Analgesic

Spinal/Epidural/Catheter

Other

Fluids/Notes

Procedure Performed — ~~Thomas~~ - Thomas splint

Position on Table — splint (AP) for

Drains

Post-Op. Instructions

Sedation

Oxygen

Other

Surgeon — [signature]

Anaesthetist — [signature]

AYRSHIRE AND ARRAN HEALTH BOARD

SEAFIELD HOSPITAL

CONSENT FOR OPERATION

I, Alistair Johnston of 4, Urfield, Girvan

..... hereby consent to

*{ ~~undergo~~ / the submission of my } *{ child ..... Lee Johnston / ~~ward~~ }

the operation of manipulation of # (R) femur

the nature and purpose of which have been explained to me by

Dr./~~Mr.~~* E.M. HAMILTON

I also consent to such further or alternative operative measures as may be found necessary during the course of the above-mentioned operation and to the administration of general, local or other anaesthetics for any of these purposes.

No assurance has been given to me that the operation will be performed by any particular practitioner. (Not applicable to Section 1(2) patients.)

Date 4/7/83 Signed A Johnstone
(~~Patient~~/Parent/~~Guardian~~)*

I confirm that I have explained the nature and purpose of this operation to the ~~patient~~/parent/~~guardian~~.*

Date 4/7/83 Signed E M Hamilton
(Medical/~~Dental~~ Practitioner)*

*DELETE AS APPROPRIATE.

Any deletions, insertions or amendments to the form are to be made before the explanation is given and the form submitted for signature.

8 [illegible] 27.10

8/5 pmps admd

NURSING CARE

Date ..... Medical Officer .....

Date ..... Witnessed by .....

Date ..... Signed .....

Against the advice of the Medical Officer responsible for my care, I have decided not to Accept/Continue the treatment offered. I have been advised by Doctor that my refusal may prejudice my improvement or recovery.

STATEMENT BY PATIENT

Date ..... Witness .....

Signed ..... Parent/ Guardian

I KNOW OF NO ALLERGY OR CONTRA INDICATION

HAVING:

I HEREBY CONSENT TO MY SELF/CHILD

CONSENT

PATIENT

Surname	Forename C O R	Age	Date of Birth	Arr Date	Time	AE Numbe
JOHNSTONE	LEE	19	09/02/1976	10/04/95	20:30	0091

Address	Sex	Religion	Date of Inc	Time
16 MINNOCH CRES MAYBOLE	MALE	PROT	10/04/95	

PC	Tel	Marital Status	Occupation/School	Type of Inc	Mode of Arrival
KA19 8DW	0655889536	SINGLE	U/E	OTHER	AMBULANC

GP

Name	Address	Referred by: How: To
LAL	THE HEALTH CENTRE 6 HIGH ST MAYBOLE	

NEXT OF KIN

Name	Address	Complaint
PARENTS		PAIN LEGS
Relat.	S/A	
Tel No.		

Diagnosis ? G/Barre Syndrome

Examining Doctor GIBSON

Time 20.50.

Remarks for GP

1

2

3

4

ACCIDENT & EMERGENCY DEPARTMENT

THE AYR HOSPITAL, DALMELLINGTON ROAD, AYR KA6 6DX Tel: (0292) 610555

THIS CARD IS CONFIDENTIAL – IT MUST NOT BE HANDLED BY PATIENTS OR UNAUTHORISED PERSONS

Patient in 9

T ..... P 94

R\S ..... BP 149/75

BG 7.2 ..... PFR .....

SaO 95 ..... ON air .....

T.T LESS THAN 10 YEARS?

VAR ..... VAL .....

URINE ....

TRIAGE NOTES

SEEN BY HK AT 20.30 —

TO ROOM 9 AT 20.30

Felt drowsy tonight. Noloc but aware of sensation of about to black out. attended recently for numbness in rt foot referred to ortho + awaiting CT scan. C/o numbness. GCS 15/15. ECG.

NUMBER OF REVISITS 1 2 3 4 5 6 7 8 9 10

DRUG PRESCRIPTION

ALLERGIES

Drug	Dose	Route	Doctor's Signature	Given by	Time Given

CLINICAL NOTES

Attended Mr. Muirhead's clinic this morning → is going to get O.P. appmt sent for CT — ? of entire body from neck down.

Suddenly felt very weak in both lower limbs this evening and Thu limbs gave way → collapsed to ground Says he has had no feeling in (R) foot for ~ 3 wks — sudden onset Also pain in back of both lower limbs when sits up — relieved by lying flat — for ~ 3/52.

No micturition problems.

SIGNED (P10)

Investigations: X-Ray [1] ECG [2] X [2] X-Match [3] Haem [4] Bio [5] Bact [6] Hist [7] Urine [8]

Procedures: MUA [1] Suture [2] ETT [3] POP [4] CPR [5] Return Appliance [6]

Outcome: Home [1] Police [2] Inr Disch [3] Did not wait [4] Return A/E on [5] Died [12] DOA [13]

Ortho Clinic on [7] Other Clinic [8] on

District Nurse on [9] Admit to [10] 8 Transfer to [11]

Police Fiscal NOK GP

Diagnosis:

	Pat Group	Diag	Anat Sit
(I)			
(II)			
(III)			
FD			

Research:

Ambulance booked for

	1	2	3
A			
B			
C			
D			
E			

Problems walking for ~ 2/52 — his (R) foot has been dragging for 2/52, permanently.

Tonight, various new things happened:-

(1) developed difficulty swallowing — "his tongue feels too big for his mouth" and he feels that fluid is sticking at the back of his throat & he was dribbling liquids out both corners of mouth. Still managed to swallow food this evening — chips & gravy — which he has vomited back up twice since.

(2) This morning at Orthopaedic clinic, he noticed toes of (L) foot felt numb. Now it has spread to inner side of (L) foot, but not dorsum.

(3) When vomited this evening, "saw double" & felt light-headed.

(4) HAS NOT PASSED URINE SINCE 07.00 HRS THIS MORNING, & HAS HAD NO DESIRE TO DO SO.

Yesterday, he passed water more often than usual, more quantities too, and it seemed v "yellow" to him.

(5) "Tingling" in finger tips & hard — bilateral — which began ~ 18.30 This evening.

O/Es: Abdo soft - No bladder palpable / percussible. BS normal. Both femoral As present

(see contn sheet)

009124/95
JOHNSTONE LEE
16 MINNOCH CRES
MAYBOLE
KA198DW 0655889536
09/02/1976 MALE
N
TA0238

WRITE, IMPRINT OR ATTACH LABEL
Surname ..... HCR No. .....
Forenames ..... Sex .....
Address ..... D.O.B. .....
Ward or Dept. .....

DATE

10/4/95 weakness 2/5 (R) ~~upper~~ lower limb
Gibson 4+/5 (L) lower limb.
(contd.)

Plantars L = R = ↓

Absent knee jerks - bilateral
absent ankle jerks - bilateral.

Loss of pinprick sensation (R) foot - dorsum + sole.

Still has pinprick sensation (L) sole, as well as dorsum.

Normal pinprick sensation both upper limbs.

Good + symmetrical dorsalis pedis pulses both feet

⇒ Get in - patient notes: ? myelopathy

D/W Med. S.H.O. (Dr. Yoseph) ⇒ for urgent CT scan

IV fluids
Catheterise -
Cx spine XR

10/4/95 ORTHOPAEDICS

3/52 history of weakness (R) lower limb. No headache
Today (L) leg has parasthesiae and (R) upper limb weakness
Light touch sensation ↓ (R) L5 + S1 dermatomes
Position sensation ↓ (R) big toe

MEDICAL

DATE

Xrays cervical spine satis.

I suspect he has a CNS lesion, possibly a cerebral aneurysm to account for his symptoms and a medical opinion would be most helpful

Yours sincerely

10/4/95 19 yr M Consultant St. Elliot

A/E Ref

C/O Weakness lower limbs 2/52

Cold 1/12 ago.

Numbness, difficulty in walking 2/52

Pain lower lumbar made worse by coughing

NO headache. NO neck stiffness.

Weakness in lower limbs getting worse. Unable to walk now.

Sick today

Seen at orthop clinic (7/4/95) at the time ⇒ Impression ? (R) L5/S1 prolapse.

AND Hx of trauma

Diff swallowing

NOT passing urine / today

NO urge

Sys Rev

Drug Hx

nil else

Soc Hx

NKA

Unemployed

AYRSHIRE AND ARRAN HEALTH BOARD

STA0238

Cont

WRITE, IMPRINT OR ATTACH LABEL

Surname JOHNSTONE HCR No.

Forenames LEE Sex

Address D.O.B.

Ward or Dept.

DATE

10/4/95 Young man, afebrile Antecedents
NAD

Pulse rate 100/m
BP 128/66
RS Incr only
Chest clinically clear
Abdo soft non tender
No masses felt
CNS
Cranial NS 1 - 12 OK
Motor
Tone ↑ in upper, lower limbs
Reflexes sup Tr Bic ~~Knee~~ Ank Pl
R → →
L → →
Power 3/5 R upper limb 3/5 (R) lower limb 3/5 (L) upper & lower limbs
Sensation - NO SENSATION to L5 ↓ on (R) FOOT
Otherwise OK

Urea 5.2
Creat 72
Na 142
K 3.8
Ur 10.5
Bi C 26
Gluc 6.6

Hb 15.5 Fundoscopy NAD
WBC 7.3
Platelets 236 ? G/Barre Syndrome
INR 1.0
KCCT 34
TT 11
Fibrinogen 1.6

DVT Pro

MEDICAL

DATE

- FBC, ABG's
- U&E, coag screen — Catheterise
- LFTs, Bl. culture — I.V. fluids
- CT Brain
- ~~CTA Brain~~
- LP

CT Brain — A. Ivory

→ Reported as a normal scan.

1300 am

LP Unsuccessful as pt was uncooperative.

To be repeated in AM by the am

11/4/15 1907

'Ulcer' ~~Ulcer~~ 1/12 ago.

3/52 numbness feet
1/52 general weakness — No difficulty micturating

O/E Unremarkable.
Chest ✓ HS ✓ abdo ✓

Fundi - disc slightly pale
Cranials intact
Mild weakness arms, no reflexes. Sensation ✓
Postural weakness legs, no reflexes, plantars U/G
Patchy sensory loss R hand, otherwise (N).

AYRSHIRE AND ARRAN HEALTH BOARD

STA0238

WRITE, IMPRINT OR ATTACH LABEL

Surname ZORNOSDAE HCR No.

Forenames LEE Sex

Address D.O.B.

Ward or Dept.

DATE

Imm ?? GB.

For L.P. Routine Bloods.

Remove catheter, keep hydrated. CL

11/4/95

LUMBAR PUNCTURE

Uncomplicated procedure, aseptic technique.

Clear CSF → X/hoped for protein/glucose
cell count
C/S

W. Metcalfe

CSF RESULTS

WBC 0 PROTEIN 7 2.0

RBC 15

Gluc (N)

⇒ Probable antivaricella-Benzo

12/4/95

D/w Dr Duncan Watt (Dr Thomas on holiday).

for transfer there today (WA62) if bed available.

Slight deterioration today.

	RH	LH	RL	LL
Prox	2-3/5	3/5	4/5	4/5
Dist	3-4/5	3/5	4/5	4/5

monitor peak flows regularly.

Dr Bicknell

W. Metcalfe

12/4/95 CSF Protein 7 2 in keeping w/k GB. syndrome
I have explained diagnosis to Mr Johnstone
and discussed further management at SGH.
For transfer to SGH tomorrow am
Continue peak flow, VC monitoring.

SMO

MEDICAL

DATE

12/4/95 3.30pm — Felt acutely breathless & PBTR ↓ to 28 suddenly.
Evening E Ox
Feels better. PBTR now 50
→ "panicked", anxiety.

AT (SHO)

13/4/95 10.20pm — Dr. Murdoch / S.G.H. called regarding transfer:
→ pt. refused
→ keep eye on respiratory function
→ whenever we feel it's necessary, back in touch with him; will be happy to take him then. KL/JHO

pm — pt. wants to go home
17.15 — talked to girlfriend + pt.; explained disease again
— they are happy with him to go to the S.G.H, or to stay here dependent whether she can stay with him or not

KL/JHO

14/4/95 — Appears more weak today, especially legs.
Peeks like Duchenne.
Now agrees to go to SGH

For further DLW SGH
Respect Spirometry

WRITE, IMPRINT OR ATTACH LABEL

Surname JOHNSTONE HCR No.

Forenames Lee Sex

Address D.O.B.

Ward or Dept.

STA0237

DATE

4/5 ? Not re-assessed since Transfer
No motor lets in legs
Arms good but not full power
TED stockings
Can you ask Dr Mathiesen to advise ??
Referred to Dr Mathiesen who will assess other tomorrow or early next week
VOU

- transferred back from Southern Hospital
- Guillain-Barre Syndrome
- had infusion of human IgG

Hx PC feels he has much improved
now able to move arms again
no SOB, has not been incontinent
at any time, tends to constipation
slight leg discomfort / itching since
2 days

O/E alert & orientated, appears comfortable
CVS HR 90 regular
BP 120/60
no oedema
RS chest clear RR 18/min
Abdo soft, non-tender BS (+)
no "abdominal skin" reflexes
CNS PERRLA cranial nerves intact

upper limbs (R)=(L): Power 3-4/5
Reflexes: ⊘ NIL
Tone: slightly decreased

lower limbs (R)(L) Power 1/5
Reflexes NIL
Tone ↓↓

MEDICAL

DATE

→ can move arms
legs: very, very little movement
can't sit up but is able to
turn round

~~Bilateral sensory~~ Sensation: cotton wool
not felt both legs
D. Riggs (GHA)

4/8/95

I will arrange for transfer to rehab unit at ACH on Monday / next week - if transport can be arranged

Paul Matthews

SOUTH AYRSHIRE HOSPITALS
NHS TRUST

DIETETIC REQUISITION

PATIENT NAME JOHNSTONE, LEE	UNIT NUMBER 100-544212	ACCT. NUMBER 95122-00354
ADDRESS 16 MINNOCK CRESC MAYBOLE AYRSHIRE KA19 8DW Tel: 0655889536	DATE OF BIRTH 09/02/76 19Y	SEX M
	ADMISSION DATE 02/05/95	WARD/CLINIC S8 352-2 / 08A
	HEIGHT 0'0.0" / 0.0cm	WEIGHT 0lbs / 0.0kg
G.P. NAME/ADDRESS LAU, C (GP) MAYBOLE HEALTH CENTRE 6 HIGH STREET MAYBOLE KA19 7BY	B.M.I.	
	ALLERGIES	
CURRENT CONSULTANT ROSE, JAMES	DIAGNOSIS UK	
ORDER INSTRUCTIONS	ORDER DETAILS Prior: routine Req D/T: 02/05/95 07.26P Init: MM	
PRIMARY DIET 0010 NUTRITIONALLY COMPROMISED		
MODIFIERS		
RDER DEPT. Dietetics Ayr	ORDER PLACED 02/05/95 07.27pm	

DIETETICS

TREATMENT RECORD

DATE	WEIGHT	PROGRESS NOTES
3/5/95	Est 9½st	Transferred from Southern General Hosp 2/5/95 for rehab of Guillian Barrie Syndrome. Referred for HP diet + supps due to wt loss. Spoke c pt, says his appetite has improved over past couple of days. was on HP diet and F'sip drinks at SGH - only likes strawberry flavour. To commence HP diet + 3x E.Plus a day - Monitor + review.
		Liz Sillars SRD
		Senior Di

DATE	WEIGHT	PROGRESS NOTES
5/5/95		Reviewed, pt well, good appetite, taking up to 3 E. plus drinks a day, providing an extra 900 Kcals. Continue c HP diet + supps.
		L: 5/11/95 SRD

WRITE, IMPRINT OR ATTACH LABEL

Surname ..... HCR No. .....

For A100-544212

Add. JOHNSTONE LEE
16 MINNOCH CRESCENT
0902763334
MAYBOLE
KA198DW 09/02/1976

Wa

LAU,C (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE M/S

STA 0216

OTOLARYNGOLOGY

DATE	HISTORY
3/9/10	Excision of thyroglossal cyst on 3x occ 1982, 1990, 1999 ⇒ general surgeons hcs noted ↓ back cyclin for ~½ fluctuating in size no symptoms no infection fit locally

EXAMINATION

General

Nose

Mouth and Pharynx Throat

no obvious swelling

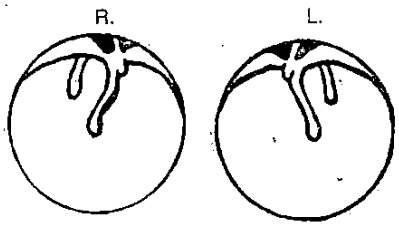
Post Nasal Space

Neck

scar + scarring

Larynx

Ears



TREATMENT

⇒ US neck

⇒ R/V aller results

JMCC/61654

DATE

26/11/07

USS => no gol
patient hasn't noted cg / chills
swelling
no swelling palpable
=> discharge

NHS Ayrshire & Arran

Endoscopy Checklist

Date 26/6/24

CHI: 0902763334
Johnstone, Lee
12 Woodside Avenue
Maybole
KA19 7PP
09/02/1976
Dr G Paton
Date of Birth .....

			Endoscopy staff check/comment
Procedure confirmed with Endoscopy Suite	Yes ☑	No ☐	
Jewellery removed	Yes ☑	No ☐	
Patient fasted	Yes ☑	No ☐	
Consent form signed	Yes ☐	No ☐	
PVC insitu **(right hand for ERCP)**	Yes ☐	No ☐	
ID Bracelet insitu	Yes ☑	No ☐	
Current medications / Mac and Map	Yes ☑	No ☐	
Case notes / records present	Yes ☑	No ☐	
Bowel prep	Yes ☐	No ☑	
Type:			
Last menstrual period Date:			
Warfarin therapy	Yes ☐	No ☑	
INR result (must be within **24 hrs**) Date taken:			
Metal prosthetic heart valve	Yes ☐	No ☑	
Implanted Cardiac Device	Yes ☐	No ☑	
Hip replacement /orthopaedic pins / plates	Yes ☐	No ☑	
Back / neck problems	Yes ☐	No ☑	
Diabetes	Yes ☐	No ☑	
If yes - tablet controlled	Yes ☐	No ☐	
GKI regime	Yes ☐	No ☑	
BM prior to transfer Time:			
Coag screen (ERCP patients only)	Yes ☐	No ☐	
Haemodynamically stable	Yes ☐	No ☐	
If no, please comment re IV regime etc			
Allergies:			
Medical history of note **(include any current infection control issues e.g. MRSA)**			
Ward staff Sign C Syme Print name Claire Syme Designation DCN Date 26/6/24			
Endoscopy Sign L Kennox Print name L Kennox Designation DCN Date 26/6/24			

NHS Ayrshire & Arran

INPATIENT ENDOSCOPY ADMISSION

CHI: 0902763334
Johnstone, Lee
12 WOODSIDE AVENUE
Maybole
KA19 7PP
09/02/1976
Dr M Barr
MRN: A100544212

Date: 26/8/24	**Ward:** St 8.
Procedure:	Bronchoscopy
Endoscopist:	Dr Gunan.
Endoscopy Nurses:	
Reason for Referral:	

PAST MEDICAL HISTORY: RE bundle branch block
Asthma
Guillan Barre syndrome
Behavioural problems
Heroin dependence - on buvidal inj

GLAUCOMA: YES ☐ NO ☑ **DIABETIC:** YES ☐ NO ☑ **TYPE:** **BM:**

ALLERGIES: YES ☑ NO ☐ Citalopram

MEDICATIONS:

ANTICOAGULANTS: YES ☐ NO ☑

ID Band in situ	Yes / No	Venflon in situ	Yes / No	Metal Implants	Yes / No
Case Notes	Yes / No	Fasted Food	Yes / No	Dentures/ Caps/Crowns	Yes / No
Consent	Yes / No	Fasted Fluids	Yes / No	Jewellery	Yes / No
MAC / MAP	Yes / No	Bowel Prep:	Yes / No	Glasses	Yes / No
ERCP LMP		ERCP Risks / Voltorol	Yes / No	Prosthesis	Yes / No

BASELINE OBSERVATIONS				
TIME:	SpO2: 99	HR: 69	BP: 109/69	TEMP:

Time Procedure Commenced:	09.35	**Time Procedure Completed:**	10.00

MEDICATIONS ADMINISTERED

Medication	Dose	Route	Time
Xylocaine	20 sprays.	oral	09.40
Midazolam	4mg	IV	09.40
Fentanyl			
Pethidine			
Buscopan			
NaCl Flush	4mls.	IV	09.40.
Oxygen	2l/02	nasal	09.40

Medication	Dose	Route	Time
lignocaine 1%	18mls.	per scope	09.45
Salbutamol.	1mg/1ml.	Inh	10.00.
= Total	5mg/5ml		

PERI / POST PROCEDURE OBSERVATIONS

TIME:	SpO2	Heart Rate	Blood Pressure
09.35	98% Air	58	/
09.40	99% - 2l/02.	67.	/
09.45	98% - 2l/02	70	/
10.00.	99% - 2l/02	73.	116/70.
10.10.	99% - Nil	67	103/57.

SPECIMENS TAKEN / SPECIMENS OBTAINED

Bronchial aspirate x2 RLL.
Await histology.

NURSING NOTES

Tolerated well, reassurance given. Observations stable as charted.
Pt intubated post procedure - as per Dr Guhan.
Pt alert post procedure - no c/o pain or discomfort. Observations remain stable + 2hr fast + FAST UNTIL: 12.00

DOCTORS FOLLOW ON INSTRUCTIONS

Dr Guhan Bronchoscopy report







DECONTAMINATION CHECKLIST

STERTRAX STICKER	YES	/	NO	
VALIDATION CHECK	YES	/	NO	
TRACEABILITY CHECK	YES	/	NO	
3 HOUR RULE CHECK	YES	/	NO	

Nurse 1 Signature: [signature] Nurse 2 Signature:

NHS
Ayrshire & Arran

CHI: 0902763334
Johnstone, Lee
12 WOODSIDE AVENUE
Maybole
KA19 7PP
09/02/1976
Dr M Barr
MRN: A100544212

Consent for Operation

PROCEDURE: Bronchoscopy and Lavage +/- Biopsy

PURPOSE OF PROCEDURE: Diagnosis of R lung shadow

SIDE OF PROCEDURE: LEFT / RIGHT / BOTH / (NOT APPLICABLE)

A. Statement of health professional

I confirm I am a health professional with an **appropriate knowledge of the proposed procedure** as specified in the Board's consent policy. I have explained the procedure to the patient. In particular, I have explained:

a) ☑ the proposed approach

b) ☑ the intended benefits of the procedure

c) ☑ the possible risks of the procedure (including those specific to the patient).

d) ☑ the benefits and risks of any alternative treatments (including no treatment) and any particular concerns of the patient.

e) any additional procedures that might become necessary during surgery. Commonly this would include:

☐ Blood transfusion ☐ Other procedure (please state)

NB. If blood transfusion is declined, please also complete a refusal of blood transfusion form.

I have provided an information leaflet to explain the benefits and risks of, and alternatives to the proposed treatment.

Yes ☑ Leaflet title: ...Bronchoscopy..... Leaflet version no.: ...6.07.....

No ☐ It is the health professional's responsibility to document the benefits, risks and alternatives explained to the patient.

.....As per TF 07.....

.....

.....

.....

.....

☑ In my view, this patient has capacity at this time to consent to this procedure.

Where the clinician has doubts about capacity, please refer to the consent policy for guidance on Adults with Incapacity, and section 47 certificate of incapacity.

Consultant or other responsible health professional

It is the responsibility of the doctor undertaking the procedure to personally seek patient consent. In the unusual event that this is not practical, the responsibility can be delegated to another professional, but that individual must be suitably trained and qualified, have sufficient knowledge of the proposed investigation or treatment, understand the risks involved and act in accordance with the Board's consent policy.

As the health professional explaining this procedure, please confirm:

☑ I am fully familiar with the procedure, its risks, benefits and alternatives.

Signed (health professional): ..... Date: 24/8/22

Name (PRINT): ..... Time (24 hr): 0915

Designation: ..... GMC/GDC/NMC number: .....

NHS
Ayrshire
& Arran

Consent for Operation

CHI: 0902763334
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Dr M Barr
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B. Consent of patient, parent or guardian

I understand the information given to me, including the risks, benefits and alternatives to this operation. The information has been discussed with me, and my questions have been answered in a way I could understand. I accept that the doctor has told me:

- ☑ my expected outcome and the risks of having the operation.
- ☑ the benefit this operation may bring to me, but also that this cannot be guaranteed even though performed with professional care.
- ☑ other relevant treatment options and their associated risks.
- ☑ that an appropriately qualified doctor, undergoing further training, may perform the operation.
- ☑ that I have the right to change my mind at any time before the operation, including after I have signed this form.

If an emergency occurs, I may require other procedures, but these will only be carried out to save my life or to prevent serious harm to my health. I have listed below any procedures that **I do not wish to be carried out without further discussion:**

☐ Blood transfusion ☐ Other procedure (please state)

.....

.....

NB. If blood transfusion is declined, please also complete a refusal of blood transfusion form.

I understand the benefits, risks and alternatives that have been explained to me, and I agree to the operation.

Signed (patient/parent/guardian): L. Johnstone Date: 26/6/24.

Name of patient/parent/guardian (PRINT): Lee Johnstone

Relationship to patient: .....

C. Confirmation of consent (for use on day before or day of surgery)

Confirmation of consent is only mandatory, when the original consent was signed by the patient >84 days before the date of the operation.

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

Consultant or other responsible health professional

Signed (health professional): ..... Date: .....

Name (PRINT): ..... Time (24 hr): .....

Designation: ..... GMC/GDC/NMC number: .....

Patient

Signed (patient/parent/guardian): ..... Date: .....

Name of patient/parent/guardian (PRINT): .....

Relationship to patient: .....

Procedure INCISIONAL HERNIA REPAIR

Consultant MR CHUDY / LAP MESH

Date 17/3/11

THE BRUCE DAY SURGERY SUITE

A100-544212
JOHNSTONE LEE
12 WOODSIDE AVE
0902763334
KIRKMICHAEL
KA197PP 09/02/1976
PATON, G (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE M/C

Prior to Admission - Review Results

X-rays available	Yes	No	N/A	Bloods	Yes	No	(N/A)
Casenotes available	(Yes)	No	N/A	ECG if over 45	Yes	No	(N/A)
Prescription request	Yes	No	N/A				

Comments

Signed K. M'C

On Admission

SATS 99% 02

Baseline obs BP 134/84 P 72 Allergies NKA

OMEPRAZOLE

Current Medication

Identity Bracelet (Yes)

Valuables

Signed K. M'C Named/Associate Nurse

Pre-op

Consent Signed	Yes	(No)		Seen by Anaesthetist	Yes	No	N/A
Theatre Gown - Time				Seen by Surgeon	Yes	No	N/A
Skin Shave	Yes	No	(N/A)				
Skin Shave - Checked	Yes	No	(N/A)	Urinalysis			
Operation site marked by surgeon	Yes	No					
Dentures	Yes	(No)	N/A				
Hearing Aid	Yes	(No)	N/A	Medication Prior to Theatre	(Yes)	No	
Nail Polish	Yes	(No)	N/A	ZANTAC AMITRIPTYLINE			

Signed K. M'C Named/Associate Nurse

To Theatre Time

Theatre

(GA) LA

Procedure

Surgeon MR CHUDY & MR VIASS

Anaesthetist DR ZHOOROWICZ

Operation site marked	(Yes)	No
Consent Signed	(Yes)	No
LA infiltration 20mls 0.5% CHIROCAINE	(Yes)	No
Voltorol Supps	Yes	(No)

Dressing MEPORE TO PORT SITES

Sutures / ~~Clips~~ ABSORBABLE

Review

Comments:

Signature Ritchie
Named/Associate Nurse/Practitioner

1st Stage Recovery

On entering recovery:-

Airway	Yes	No	Airway removed	Yes	No
Laryngeal Mask	Yes	No	Laryngeal mark removed	Yes	No
ETT	Yes	No	ETT removed	Yes	No

Special Instructions/comments:-

On leaving recovery:-

Patient responds to stimulus	Yes	No
Patient responds to speech	Yes	No
Patient understands simple commands	Yes	No
Patient is pain free	Yes	No
Vital signs satisfactory	Yes	No

Signed Named/Associate Nurse Time in Time out

DRUG	DOSE	METHOD	TIME	DR. SIG.	NURSES SIG.
					Mr Johnston NH

ADDRESSOGRAPH

2nd Stage Recovery

Wound Check	(Yes)	No
Fluids	(Yes)	No
Tea/Toast/Biscuit	(Yes)	No
Pain Free	Yes	No

Drug	Strength	Quantity Supplied	Directions	Date	Doctor's Signature
Paracetamol Tablets	500 mg	(16)	1-2 tablets 4-6 hrly when required for pain	17/3/11	
Co-codamol Tablets	30 / 500	10 20	1-2 tablets 4-6 hrly when required for pain		
Diclofenac Enteric coated Tablets	50mg	(9)	1 tablet 3 times daily	17/3/11	
Dispensed by Esmeralda				16:40	
				17/3/11.	

SC1384

Discharge Arrangements

District Nurse Arranged	(Y)	N	n/a
Practice Nurse Arranged	Y	(N)	n/a
Prescription Arranged	(Y)	N	n/a
Discharge Advice Given	Y	N	n/a
Review Appointment	Y	(N)	Date to be sent if required
Dressings Provided	(Y)	N	

Nursing Notes

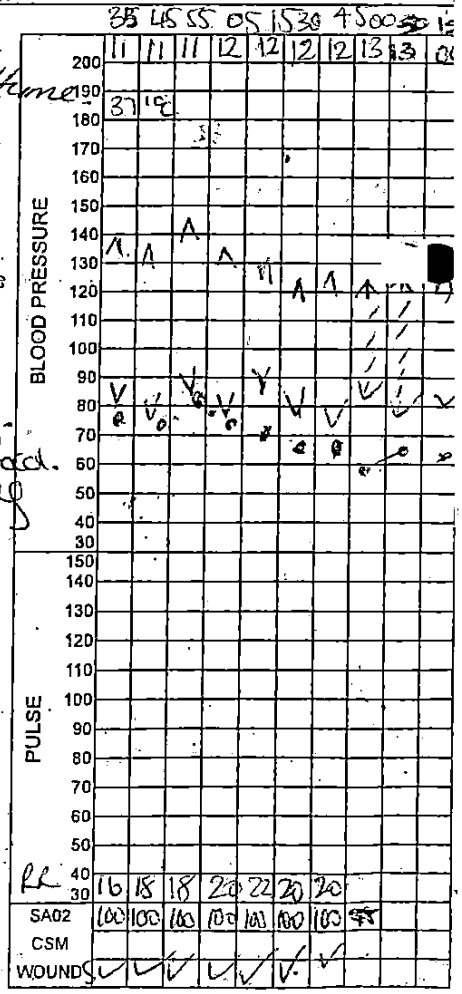
10[55] - Returned to ward, 10mg IV Morphine + 10mg Tramadol IV - 10mg IV cyclizine given - Mildly. Esmeralda
3[30]pm Mobilising. Obs okay. E+D. But Yo lower abdo pain
1g IV paracetamol given at 3[30]pm - 4th time
5[55]pm Pt can go home later if all well. S/B anaesthetist - can have tramadol 100mg PO prior to discharge (around 5[30]pm). Jo
16[40] - Wearing own clothes & fluids, passing urine spontaneously, mobilising. Wound dry & clean & intact & dressing. Esmeralda
17[30] Discharge advice & enclosures as per clinical protocol. written reports - Esmeralda

Signed.....Esmeralda.....
Named/Associate Nurse

Discharge Criteria

Stable Vital Signs	(Y)	N	N/A
Tolerating Diet & Fluids	(Y)	N	N/A
Mobilising	(Y)	N	N/A
Able to void Urine	(Y)	N	N/A
CSM of Limb Intact	(Y)	N	N/A GA
Wound Check	(Y)	N	N/A
Cannula Removed	(Y)	N	N/A
Collected by Responsible Adult	(Y)	N	N/A
Pain Free	(Y)	N	N/A

Signed.....Esmeralda.....
Named/Associate Nurse



CONSENT FOR OPERATION

STA1057

H	JOHNSTONE	A100-544212
G	12 WOODSIDE AVE	LEE
		0902763334
S	KIRKMICHAEL	
F	KA197PP	09/02/1976
A	PATON,G (GP)	
	MAYBOLE HEALTH CENTRE	
	6 HIGH STREET	
D	MAYBOLE	M/S

I .....of .....

.....hereby consent to

* undergo / the submission of my — * child / ward .....

the operation of laparoscopic mesh repair of incisional hern

the nature and purpose of which have been explained to me by

bleeding infection bowel injury open operation

Dr./Mr.* MICHAEL GAUDI

I also consent to such further of alternative operative measures as may be found necessary during the course of the above-mentioned operation and to the administration of general, local or other anaesthetics for any of these purposes.

No assurance has been given to me that the operation will be performed by any particular practitioner. (Not applicable to section 1 (2) patients.)

Date 17/3/11 Signed .....
(Patient/Parent/Guardian)

I confirm that I have explained the nature and purpose of this operation to the patient/parent/guardian.*

Date 17/3/11 Signed .....
(Medical/Dental Practitioner)*

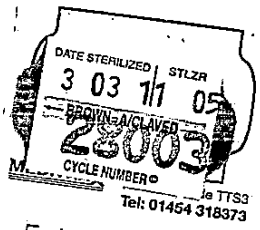
*DELETE AS APPROPRIATE

Note: This form is not to be used for any operation where there is a specific consent form with explanations.

Any deletions, insertions or amendments to the form are to be made before the explanation is given and the form submitted for signature.

JMcC/14329

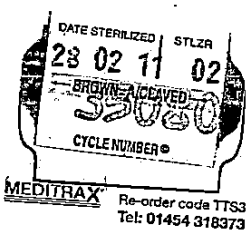
CONSENT FOR OPERATION



Endoeye Video
Laparoscope 30 Deg
AY01

STEAM
Dark = processed

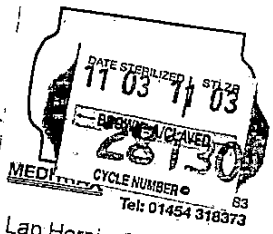
General
ACHU02040786



Endoeye Video
Laparoscope 0 Deg
AY05

STEAM
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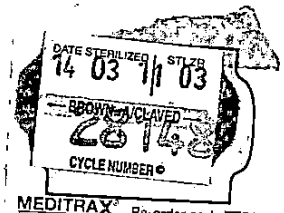
Urology
ACHU02039109



Lap Hernia Set Th2
AYR06

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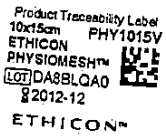
General
ACHU02044462

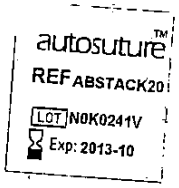


General Basic Set
Ayr 07

STEAM
Dark = processed

General
ACHU02045078





NHS AYRSHIRE and ARRAN
Pre operative, Correct Site and Patient verification.

3EL
A100-544212
JOHNSTONE LEE
12 WOODSIDE AVE
KIRKMICHAEL
KA197PP
0902763334
09/02/1976
PATON, G (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE

Station DSU Date 17/3/11 Theatre A2

Proposed Operation HERNIA REPAIR M/S

Prescribed Pre medication : Time Given ZANTAC PM → AM Fasted From: Time 6am TEA + MILK.

Identified Allergies: Specify. NKA

Check 1 Pre op Marking and Verification

Surgical Site Marking and Patient verification

- ☑ Check patient Identity
- ☑ Check all relevant documentation / results
- ☐ Images to ascertain intended surgical site
- ☑ Intended site marked with indelible pen
- ☐ Decision not to mark –**state reason below**

Signature confirming surgical check complete

Surgeon

In the event of this section being incomplete –Reception nurse to communicate with theatre staff to establish action to be taken

Signature .....

Print .....

Check 2-3 Surgical Site Marking and Patient verification	Station/DSU			Recpt./Recovery			Theatre		
	Yes	No	NA	Yes	No	NA	Yes	No	NA
Operation Site marked clearly		✓		✓			✓		
Case Notes/Drug Kardex	✓			✓			✓		
Identification Bracelet	✓			✓			✓		
Consent Form Signed		✓		✓			✓		
AWI Consent signed if applicable			✓			✓			✓
Patients labels included	✓			✓			✓		
Bone bank consent form signed			✓			✓			✓
X-Rays/Images	E-FILM			white			E FILM		
Pathology /Lab results			✓			✓			✓
Haemoglobin			✓			✓			✓
Blood x matched			✓			✓			✓
E.C.G. if applicable			✓			✓			✓
B.H.C.G.(pregnancy test if applicable)			✓			✓			✓
Urinalysis abnormalities			✓		✓				✓
Caps/Crowns/Loose teeth: Specify			✓		✓			✓	
Dentures removed			✓			✓			✓
Inhalers			✓		✓			✓	
Catheter in situ			✓		✓			✓	
Hearing aid			✓		✓			✓	
Rings /Body Piercing Taped			✓			✓			✓
Pre op shower			✓						
Skin prep carried out as instructed			✓						
Nail Polish /Jewellery/Make-up removed	✓								
Paper pants worn	✓								
Pad Tampon in situ			✓						
Other :Specify			✓						

Any other relevant information (e.g. high risks or changes to general health

LEA + MILK 6AM ✓

Station Nurse (signature) K.M.C. Print K. McGuire Designation S/N

Reception Nurse (signature) S. Hislop Print S. HISLOP Designation S/N

Anaesthetic Nurse (signature) J. Morrison Print J. MORRISON Designation ODP

NHS AYRSHIRE and ARRAN
Pre operative, Correct Site and Patient verification.

Check 4 **Surgical marking and patient verification Theatre:**	**Signature of Operating Surgeon or Senior member of Theatre team to confirm check was conducted.**	**Surgeon to complete and sign if discrepancy has been identified**
Surgical , Anaesthetic and Theatre team prior to commencement of surgery **should pause for verbal briefing to confirm the following** ☑ Correct Patient ☑ Consent form correct and signed by the patient and clinician ☑ Correct operation ☑ Operation site marked ☑ Availability of required image studies plus pathology results , especially those confirming malignancy	**Sign** J Morrison **Print** J. MORRISON **Designation** SOP **Time** 10.05 **Date** 17.3.11	**Nature of discrepancy** .... **Decision taken** .... **Sign** ..... **Print** ..... **Designation** ..... When there is a discrepancy, a senior member of staff will follow the adverse incident policy.

- If failure of any pre operative check occurs, the surgeon in charge must assess the situation and either return the patient to the ward /day care area or note and sign a decision to proceed at risk.
- If the patient is returned to the ward/day care area, a patient safety incident report form must be completed in line with local governance procedures.
- A senior member of staff must offer an explanation and apology
- If surgery is carried out at the incorrect site, a full root cause analysis of events is recommended.

NHS Ayrshire & Arran

The Bruce Day Surgery Suite

Admission for Surgery under General Anaesthetic
(to be completed on morning of admission)

Write or attach label

A100-544212
JOHNSTONE LEE
12 WOODSIDE AVE
0902763334
KIRKMICHAEL
KA197PP 09/02/1976
PATON,G (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE M/S

Has there been any change since we completed the Questionnaire? YES ☐ NO ☑

If yes, please give details:

Have you:

1. Had anything to eat in the last 6 hours? 6 am tea + toast YES ☐ NO ☐
2. Someone to collect you and remain with you for 24 hours? YES ☑ NO ☐
3. Had a cough, cold in the last 2 weeks? YES ☐ NO ☑
4. Taken any tablets or drugs? ZANTAC YES ☑ NO ☐

Please Remember for 24 Hours Following General Anaesthetic you should not:

1. Drive a vehicle or ride a motorcycle
2. Operate machinery
3. Drink alcohol or take sleeping tablets
4. Use a cooker
5. Sign important documents

I have answered the above questions honestly, and accurately and I have read and understood the above warnings.

Patient's Signature X

Witnesses Signature K. McIlvanney

Date 17/3/10

Anaesthetic Record

Elective	✓
Scheduled Urgent	
Urgent	
Emergency	

Proposed procedure: Lap. Nuclear heart

Consent form signed	Y / N
Incapacity form	Y / N
Fasted	Y / N

SASM Consultant:

Informed Y / N

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PATON, G (GP)
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6 HIGH STREET
MAYBOLE M/S

Preoperative assessment: Assessor: JS Date: 17/03/11 Location: DSU ASA Grade: 2

History

Previous GA uneventful

FH Ncl.

CVS Ncl. °I + II + O °angina °HT

Resp. good AE. Chest clear °Asthma °COPD °RTI

Reflux No, but often dyspeptic on reg. Omeprazole

Other

Examination

HR

BP

Weight

Height

BMI

Airway Assessment

Mallamp. II

Mouth opening good.

Teeth Ncl.

Smoking Ex (8 days)

Alcohol Y

Recreational Drugs N

Hb / WCC / Plats / Urea / Creat. / Na / K / ECG / CXR / OTHER

Recent Medication: Omeprazole

Allergies: None known

Discussed:		Regional Block: Complications discussed pre-operatively	
Fasting	✓	Failure	
Premed		Hypotension	
Induction		Headache	
Analgesia	✓	Numbness	
Suppositories		Nerve Damage	
Monitoring:		Patient agrees	Y / N
		Handout	Y / N

Premedication:

Fasting: Time

Light Breakfast

Fluids: Allow still juices / water till:

Usual medicines:

Give all:

Give only:

Give all except:

Drugs: Date: Time:

DS Rebecca

Given at / by:

Date: 17/03/11 Operation done: Ap. Location: Th 2 Start time: End time: Surgeon(s): MR Oudit

Anaesthetic assistant: Norraine Jaclyn. Anaesthetist(s): DR Zyd Rebecca Cons. Grade:

Remarks: Significant Events / Critical Incidents Hazard Warnings GNC Glo 597

Uneventful Y/N

Effect of Premed

ANAESTHETIC RECORD

JMcC/80163 STA0093

nitoring
G
BP
O_2
CO_2
Agent
N_2O
IT
mp.
ne Cath.
P
ots
id Warmer
rm Mattress
r Hugger

Machine Check
Anaesthetic room ☑
Theatre ☑

Circuit
Circle ☑ Bain ☐
Tpiece ☐ HME ☐

Ventilation
IPPV: Pressure Cont ☐
Volume Cont ☐
Spont Respiration ☐
Press Support ☐

Induction: Intravenous ☑ Gas ☐
Pre O_2 ☑ RSI ☐

Face Mask ☐
Airway: Oral ☑ Nasal ☐
LMA: Size..... Type.....
ETT: Size 9.0 Cuff ☑
Type PORTEX
Throat Pack In ☐ Out ☐

Laryngoscopy Grade 1
Laryngoscopy Notes

Position
Pressure Care ☑
Eye Care ☑
Thromboprophylaxis ☑
Antibiotic.....
Dose.....
Time.....

10⁰⁰ 15 30 45 11⁰⁰ 15 30 45 12⁰⁰

ne
PROPOFOL 200mg
FENTANYL 150mcg +200
ROCURONIUM 80mg
PARACETAMOL 1g —
ONDANSETRON 8mg
DICLOFENAC 75mg
MCOL / NEOST

220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30

extub. TH. 11.30

S_pO_2	100	99	99	98	99	99
$ETCO_2$		5.9	5.4	5.3	5.4	5.8
ET Agent		7.0	7.3	6.9	6.7	6.5
f_iO_2		.53	.50	.49	.049	.49

Blood Loss
Urine Output

Cannula	Site
A Line	
CVP	
Insertion Notes	

Regional Anaesthetic technique:

Spinal	☐	Full aseptic	☐
Epidural	☐	Entry site:	
N. Block	☐	Needle used:	
Wound Inf.	☐	Catheter: Y/N	

Anaesthetic / Recovery

Fluid In

Infusion 1	Vol

Infusion 2	Vol

Events Key

Total	
Blood Loss	
Urine Output	

Time | Recovery

Postoperative instructions | Reviewed by

Routine monitoring & care ☑

O_2 4 l/min for .....hrs ☐

Humidified O_2 % as required to maintain O_2 Sat > 95% ☐

Morphine 1mg/ml iv up to 10mg as required for pain in recovery (YES) Signed ..... No

Ondansetron 4mg iv in recovery if required for nausea YES Signed .....

~~iv fluids as charted~~ ☐ Special instructions

Drug therapy as charted ☑

NOTES

DATE	
	P.O | p.o. PARACETAMOL 1g (4-6° 4g/24hrs.)
	PRN 4h | p.o (DSU) TRAMADOL 100mg (8° dose 5 doses)
	1h | i.m CYCLIZINE 50mg (8° 150mg/24hr before Tramadol.)
	Dr. [illegible]
	Cons. Anaesth.
	6101592

RECOVERY ROOM INSTRUCTIONS

JOHNSTONE A100-5442
LEE 09/02/19
Postcode KA197PP
CHI M 09027633
Referral Source 10
Practice Code 80467

DATE: 17-3-11 ANAESTHETIST: Dr Zydorowicz

SURGEON: Mr Chudy. ANAESTHETIC: general.

OPERATION: laparascopic repair of incisional hernia.

THEATRE NO: 2 TIME ENTERED RECOVERY 1133

CONDITION ON ENTERING RECOVERY Asleep

AIRWAY: ○ **I.V. FLUIDS:** ○

LARYNGEAL MASK: ○ PERIPHERAL:

E.T.T.: ○

P.P.V.: ○

ARTERIAL LINE ○

CVP ○

NASO-GASTRIC ○

OXYGEN THERAPY: 4L/min.

DRAINS ○	**CATHETERS:** ○	**PACKS:** ○	**STOMAS:** ○	**DRESSINGS:**
CHEST	URINARY	ABDOMINAL	ILEOSTOMY	
SHIRLEY	SUPRA PUBIC	RECTAL	COLOSTOMY	
PORTEX	URETERIC	VAGINAL		
CORRUGATED	IRRIGATION		**POP:** ○	
SUCTION				

DRUGS GIVEN IN RECOVERY: CONTROLLED IN RED

1. cyclizine 50mg I.V. at 1145cm
2. Tramadol 100mgs I.V. at 1150cm.
3. morphine 3mgs I.V. at 1215cm
4. morphine 3mgs I.V. at 1225cm
5. morphine 2mgs I.V. at 1230cm
6. morphine 2mgs I.V. at 1240cm
7.
8.
9.
10.

CONDITIONS ON LEAVING RECOVERY:

PATIENT RESPONDS TO STIMULUS ✓

PATIENT RESPONDS TO SPEECH ✓

PATIENT UNDERSTANDS SIMPLE COMMANDS ✓

PATIENT IS PAIN FREE – improving

TIME LEFT RECOVERY 1250

NURSING NOTES:

NURSE SIGNATURE G. Morrison

JOHNSTONE LEE A100-544212
12 WOODSIDE AVE
0902763334
KIRKMICHAEL
KA197PP 09/02/1976

PATON,G (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE M/S

STA0215

OPERATION

DATE	SURGEON	ANAESTHETIST
17/3/11	MICHAEL CAVOY	BARBARA ZYDOROWICZ

ASSISTANT

DAVID VASS

OPERATION PERFORMED

~~ENDOSC~~ LAPAROSCOPIC MESH REPAIR OF

DESCRIPTION OF PROCEDURE INCISIONAL HERNIA POST SUTURED EPIGASTRIC REPAIR

Product Traceability Label
10cm x 5cm PHY1015V
ETHICON PHYSIOMESH™
LOT DA8BLQA0
2012-12
ETHICON™

autosuture™
REF ABSTACK20
LOT N0K0241V
Exp:2013-10

(1) 

1 Excel optical gnome
2,3 5 m poly

(2) 1 cm ø epigastric defect

(3) posterior sheath exposed (3 x 15 cm)
Absorbatack
no bleeding, desiccated
pors removed on vision

(4) monocryl 3-0 sheps

DRAINS ..... PACKS.....

SPECIAL INSTRUCTIONS TO WARD

(1) can eat
home tonight if well

Signature .....

JMcC/74602

Procedure REPAIR of DIAPHRAGMATIC HERNIA

Consultant MR McMILLAN

Date 27/1/11

JOHNSTONE A100-544212
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MAYBOLE

THE BRUCE DAY SURGERY SUITE

Prior to Admission - Review Results

X-rays available	Yes	(No)	N/A
Casenotes available	(Yes)	No	N/A
Prescription request	(Yes)	No	N/A

Comments

Bloods	(Yes)	No	N/A
ECG if over 45	Yes	(No)	N/A

Signed J. Gemmell.

On Admission

Spo2 - 98%. Temp - 36.9

Baseline obs BP 135/92 P 98 Allergies NKA

Current Medication Omeprazole 20mg.

Identity Bracelet (Yes)

Valuables None

Signed J. Gemmell Named/Associate Nurse

Pre-op

Consent Signed	Yes	No	
Theatre Gown - Time			
Skin Shave	Yes	No	N/A
Skin Shave - Checked	Yes	No	N/A
Operation site marked by surgeon	Yes	No	
Dentures	Yes	(No)	N/A
Hearing Aid	Yes	(No)	N/A
Nail Polish	Yes	No	(N/A)

Seen by Anaesthetist	Yes	No	N/A
Seen by Surgeon	Yes	No	N/A
Urinalysis			

Medication Prior to Theatre (Yes) No

Solpadol 08.20am, Ranitidine 150mg.

Signed J. Gemmell Named/Associate Nurse

To Theatre Time

Theatre

GA LA

Procedure

Surgeon

Anaesthetist

Operation site marked	Yes	No
Consent Signed	Yes	No
LA infiltration	Yes	No
Voltorol Supps	Yes	No

Dressing

Sutures / Clips

Review

Comments:

Signature
Named/Associate Nurse/Practitioner

1st Stage Recovery

On entering recovery:-

Airway	Yes	No	Airway removed	Yes	No
Laryngeal Mask	Yes	No	Laryngeal mark removed	Yes	No
ETT	Yes	No	ETT removed	Yes	No

On leaving recovery:-

Patient responds to stimulus	Yes	No
Patient responds to speech	Yes	No
Patient understands simple commands	Yes	No
Patient is pain free	Yes	No
Vital signs satisfactory	Yes	No

Special Instructions/comments:-

Signed Named/Associate Nurse Time in Time out

NHS Ayrshire & Arran

Write or attach label

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Pre-operative Assessment

Previous MRSA Y ☑ N ☐
MRSA +ve Y ☐ N ☐

H. 01655 750064.
M. 07540988547

Screening form to be completed for all admissions

Marital Status: DIVORCED.
Religion *(if patient wishes to state)*: PROTESTANT.
Occupation: UNEMPLOYED.
Hobbies / Interests: WEIGHT TRAINING.

1st Contact Details:
Name: GEORGINA JOHNSTONE
Relationship: MOTHER.
Address: A/A.

To be given information on condition? Yes ☑ No ☐

Home: A/A.
Work:
Mobile: 0782 658 9742.
Contactable Day ☑ Night ☑
Aware of admission Y ☑ N ☐

2nd Contact Details:
Name: SARAH SPIERS
Relationship: GIRLFRIEND.
Address: CULTREE BUNGALOW BOURTREHILL NR KIRKMICHAEL.

To be given information on condition? Yes ☑ No ☐

Home:
Work:
Mobile: 078305 37593.
Contactable Day ☑ Night ☑
Aware of admission Y ☑ N ☐

Planned operation: EPIGASTRIC HERNIA REPAIR

MR MOIR. Consultant: Anaesthetist:
Date of Admission: Date of Surgery:
Time of Admission: Estimated Date of Discharge:

Surgically suitable for:- *(surgeon to complete)*
Day Surgery ☐ 23 Hour ☐ Same day admission ☐ In Patient ☐

Anaesthetically suitable for:-
Day Surgery ☐ 23 Hour ☐ Same day admission ☐ In Patient ☑

Operation performed:

Observations at pre-operative assessment

BP: 139 / 93	HR: 95. Reg/Irreg	Temp: 37°C.	Resps: 14.	SaO2: 96. %
Height: 1.67 m	Weight: 95.6 kg	BMI: 34.3. *If < 19 refer to dietitian*	Urinalysis: NAD.	

Day surgery patients only

Will you have a responsible adult (aged 18 or over) to take you home by car or taxi? *(public transport is not acceptable)* Y ☐ N ☐
Will you have a responsible adult (aged 18 or over) to stay with you for 24 hours post-op? Y ☐ N ☐
Do you have access to a telephone? Y ☐ N ☐
Do you live within a 1 hour car journey of the hospital? Y ☐ N ☐
Day surgery patients only Accept ☐ Reject ☐

PATIENT'S SIGNATURE:

Assessment Nurse Name: Lynne Bird
Sign: Lynne Bird Date: 16/12/10.

STA4231

Lives:-

Alone ☐
With elderly/infirm partner ☐
With healthy partner/family ☑
Identify carer/s .....
Does carer require additional support ☐
Details .....
.....
No of dependants.....
Who is caring for dependants? .....
.....
Nursing home ☐
Residential care ☐
Home care services ☐ No.
Community nursing service ☐
Services aware of admission ☐

Type of House: SEMI DETACHED

Stairs inside ☑ How many? 12
Stairs outside ☑ How many? 1 STEP
Toilet Upstairs ☑ Downstairs ☑
Bedroom Upstairs ☑ Downstairs ☐

Personal Hygiene

Independent ☑
Requires assistance ☐
Able to dress independently ☐
Requires assistance ☐

Nutrition *(Please record details on problem identification page)*

No special requirements ☑
Therapeutic diet *(state)* .....
Requires Cultural / Ethnic Diet *(state)* .....
(If special diet required, inform Dietitian at pre-op stage)
Loss of appetite ☐
Nausea / Vomiting ☐
Referral to dietician: Clinic ☐ Ward ☐
Dysphagia *(Consider referral to SALT for assessment)*
IF BMI < 19 Refer to Dietitian ensuring Dietitian is aware that patient has just attended pre-op and date of admission if known. The patient will be sent the first available appt.

NUTRITION RISK SCORE TO BE COMPLETED ON ADMISSION TO WARD

Elimination

Bowel function: Frequency: DAILY
No problems ☑ Constipation ☐
Loose stools ☐ Blood / Mucus / Pus ☐
If constipated, advise to seek advice from pharmacist about commencing / increasing stool softener / laxative before hospital admission

Urinary function:

No problems ☑ Frequency ☐
Urgency ☐ Dribbling ☐
Hesitancy ☐ Incontinence ☐
Nocturia ☐ Catheter ☐

Skin

Skin intact ☑ Broken ☐
Psoriasis ☐ Eczema ☐
Rash ☐ Wound/Ulcer ☐
If wound/ulcer, please swab for C/S & MRSA

Podiatry ..... No.
.....

Dentures: **Own teeth** ☑
Upper ☐ Lower ☐
Caps / Crowns ☐ Full ☐
Partial ☐ Bridge ☐

Body piercings:
Site/s: EARS TONGUE.
Advised to remove before surgery? ☑

Prostheses: ☐ No

Mobility:

Independent ☑
Stick(s) ☐ Frame ☐
Wheelchair ☐ Hoist ☐

Communication

Communicates effectively ☑
Impaired speech ☐ Visual aids ☐
Learning Difficulty ☐
Please undertake LD Assessment
Primary language English Y ☑ N ☐
If no state .....
Interpreter Arranged ☐ TBA ☐
Ability to understand written communication *e.g. Dyslexia*
.....
.....
Dysphasia ☐

Hearing

Normal ☑ Dull ☐
Hearing aid Left ☐ Right ☐ Bilateral ☐

Visual impairment

Wears glasses ☐ Contact lenses ☐

Emotional state

Alert /Orientated ☑ Confused ☐
Mildly anxious ☐ Highly anxious / distressed ☐

Sleep

No problems ☑ Hours per night: 9HRS
Medication required ☐

Discharge planning

Own transport ☑ **Hospital transport** ☐
Patient has keys ☐
Complex ☐ Straightforward ☐
Discharge co-ordinator informed Y ☐ N ☐

Burns - trunk, genitals, arms, hands etc.

Previous medical and surgical history **(please list what, when and where)** 2003 Alcohol excess - one seizure
Oct 2010 - musculoskeleval chest pain ~~Epilepsy~~ ?alcohol related.
Appendicectomy 2000 Guillain-Barre syndrome, 1995 - Not ventilated.
Abdominal hernia repair Aug 2009
excision thyroglossal cyst ~~x~~ 3 on 3 occasions.

Have you had?	Yes	No	Comments
1. A general anaesthetic (GA)?	✓		
2. Complications with previous GA? *(please list all relevant details)*		✓	
3. Has anyone in your family ever had a problem with an anaesthetic? *(please document all relevant information)*		✓	
4. Any hospital admissions in the past year?	✓		Dec '10.
5. Are you taking any drugs, tablets or medication including herbal, clopidogrel, warfarin, recreational drugs? *(please list)*			Patient's medication stored in ward Y ☐ N ☐

Name	Dose	Frequency	Name	Dose	Frequency
Omeprazole	20mg T-TT	Od			

H.R.T.? Y ☐ N ☐ Name .....
O.C.P.? Y ☐ N ☐ Name .....
L.M.P. .....

Advise patient re continuation / stopping medication prior to surgery.

No recreation drugs for 24 hrs pre-op.

6. Smoke? Y ☑ N ☐ How many per day? 10 Want to stop? Y ☐ N ☐
Information given re smoking cessation service / contact numbers? Y ☐ N ☐ Trying to stop.

7. Drink alcohol? Y ☐ N ☑ Alcohol screening score *(see additional form)* Rarely.
Offer referral to Alcohol Liaison Nurse if indicated. Accepted Y ☐ N ☐ Referred Y ☐ N ☐
Inform patient to have no alcohol for 24 hours pre-operatively.

8. Are you allergic to anything? Y ☐ N ☑
Please specify source of allergy and type of reaction e.g. rash, swelling, sickness, diarrhoea, collapse, other

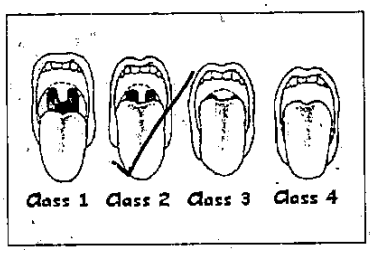
Source of Allergy	Type of Reaction	Other allergies (specify)	Type of Reaction
Medication (specify): NKDA.			
Elastoplast Y ☐ N ☑			
Latex Y ☐ N ☑			
Fruits / Nuts Y ☐ N ☑			

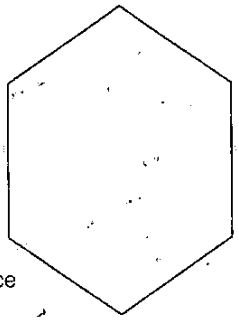
Have you ever suffered from:	Yes	No	Details
Cardiovascular / Respiratory			
9. M.I. (heart attack) or Angioplasty? *(If in past 6 months, not suitable for DSU)* *(Ask about exercise tolerance)*	✓		Chest pain Oct '10 ?musculoskeletal.
10. Angina / chest pain / heart murmur / stents / pacemaker? *(Ask about exercise tolerance)*		✓	
11. Palpitations?		✓	
12. Hypertension?		✓	
13. Rheumatic fever? + / - swollen ankles?		✓	
14. Blood clot / thrombosis / embolus / DVT?		✓	
15. Claudication / peripheral neuropathy?		✓	
16. Blood disorders/bruising/bleeding/anaemia?		✓	
17. Asthma/wheeze/breathlessness? *(Ask about exercise tolerance)*		✓	
18. C.O.P.D. / TB? *(Ask about exercise tolerance)*		✓	
19. Cough / sputum?		✓	
Central Nervous System			
20. C.V.A. / T.I.A.? *(stroke / mini-stroke)*		✓	
21. Epilepsy / fits / seizures / convulsions?	✓		x1 yrs ago ?alcohol related.
22. Fainting / dizzy spells?		✓	
Gastro-Intestinal			
23. Heartburn / indigestion / gastric reflux? How many pillows do you sleep with?	✓		occasionally On meds.
24. Hiatus hernia?		✓	
25. Liver problems / jaundice / hepatitis / biliary?	✓		slight damage due to previous alcohol over use.
26. Bowel disorders?		✓	
Renal / Genito-Urinary / musculo-skeletal / other			
27. Kidney / urinary problems?		✓	
28. Muscle disease or progressive weakness?		✓	
29. Arthritis or joint problems?		✓	
30. Diabetes?		✓	
31. Thyroid problems?		✓	
32. Any other serious illnesses? *(please list)*			

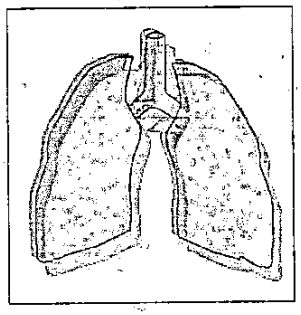
Clinical Examination

Cardiovascular	Respiratory
Heart rate / regularity	Chest expansion
JVP	Percussion
Carotid Bruits	Breath sounds
Heart sounds / Murmurs	Trachea
Peripheral Oedema	Finger clubbing

Surgical Examination







Modified Mallampati's classification of pharyngeal appearance

Neck movement
Full range of movement ☑
Difficult ☐
Mouth opening Good ☑ Poor ☐

Dentition
Own teeth ☑ Loose teeth ☐
Dentures ☐ Full ☐ Partial ☐
Upper ☐ Lower ☐

Body piercings ☑
State site/s Ears, tongue.

Caps / Crowns / Bridge / Braces ☐
State site/s .....

Advise to remove prior to surgery. ☑

Further comments:

.....

.....

.....

.....

.....Continue over if necessary

Medical Staff Name *(print)* .....Designation.....

Signature .....Page no. .....Date .....

Investigations

Investigation	Requested (Date)	Reviewed by	Date reviewed	Repeated (Date)	Reviewed by	Date reviewed
FBC	16/12	AB	16/12			
Group & Save						
X Match						
Urea & Electrolytes	16/12	AB	16/12			
LFT	16/12	AB	16/12			
TFT						
Blood Glucose	16/12	AB	16/12			
BM						
HbA1C						
INR						
Coag						
CXR						
PEFR		1 / 2 / 3			1 / 2 / 3	
Spirometry						
ECG						
Urinalysis	16/12					
MSSU/CSU						
Pregnancy Test						
Sputum						
MRSA	16/12 x3 N.T.P.					
Audio/Tymps						
Photography						
Other						

Problem identification

To be completed at end of assessment and thereafter

Problem	Action Taken	Sign	Date	Outcome	Sign	Date

Medicines issued at pre-operative assessment as per PGD (patient group direction)

Ranitidine ☐ Sign:..... Other ☐ .....(state) Sign: .....

Picolax ☐ Sign:..... Other ☐ .....(state) Sign: .....

Information given:

Written ☑ Visiting times ☑

Verbal ☑ No smoking policy ☑

Fasting ☐ Other ☐ State .....

Evaluation and Progress of Care

1	Basic care and hygiene	4	Mobility	7	Wound Care	10	Special Needs
2	Nutrition	5	Observations	8	Specimens & Investigation	11	Communication
3	Elimination	6	Technical Care	9	Sleep	12	Other relevant information

Date	Time	No	Evaluation and progress of care	Inits
			Seen by: Nurse ☑ Pharmacist ☐ Physiotherapist ☐ Occupational therapist ☐ Bone Bank Nurse ☐ Anaesthetist ☐ SHO / JHO ☐ Consultant ☐ Other (state) ☐	
16/12/10			Seen in poa. To have routine bloods, swabs. Nad found to have been mrsa + in nose swab 1/12/10. Has not been told or put on any treatment. Secretary contacted to inform Mr Muir. Lyme. Repeat swabs done today in pre op. (Bid)	

Evaluation and Progress of Care

1	Basic care and hygiene	4	Mobility	7	Wound Care	10	Special Needs
2	Nutrition	5	Observations	8	Specimens & Investigation	11	Communication
3	Elimination	6	Technical Care	9	Sleep	12	Other relevant information

Date	Time	No	Evaluation and progress of care	Inits
22/12/10	11AM		MRSA PRE OP SCREEN POSITIVE, & PT PREVIOUSLY POSITIVE	NR
			CHG DIRECTIONS GIVEN. BACTROBAN NASAL OINTMENT AND	
			STERISOFT SOAP WASH FOR 5 DAYS PRESCRIBED, &	
			PT TO COLLECT FROM CLINIC.	
6/12/11		11	Attended for 2nd MRSA screen	HS
		8		
13/12/11		11	Attended for 3rd MRSA screen	HD
		8		

CONSENT FOR OPERATION

STA1057

A100-544212
JOHNSTONE LEE
12 WOODSIDE AVE
0902763334
KIRKMICHAEL
KA197PP 09/02/1976
PATON,G (GP)
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6 HIGH STREET
MAYBOLE M/S

I .....of .....

.....hereby consent to

* undergo / the submission of my — * child / ward .....

the operation of laparoscopic mesh repair of incisional

the nature and purpose of which have been explained to me by

epigastric hernia, bleed, infection, bowel injury

Dr./Mr. Mitchell Laing open extirpation

I also consent to such further of alternative operative measures as may be found necessary during the course of the above-mentioned operation and to the administration of general, local or other anaesthetics for any of these purposes.

No assurance has been given to me that the operation will be performed by any particular practitioner. (Not applicable to section 1 (2) patients.)

Date 10/3/14 Signed .....
(Patient/Parent/Guardian)

I confirm that I have explained the nature and purpose of this operation to the patient/parent/guardian.*

Date 10/3/14 Signed .....
(Medical/Dental Practitioner)*

*DELETE AS APPROPRIATE

Note: This form is not to be used for any operation where there is a specific consent form with explanations.

Any deletions, insertions or amendments to the form are to be made before the explanation is given and the form submitted for signature.

JMcC/74329

CONSENT FOR OPERATION

NHS Ayrshire & Arran

The Bruce Day Surgery Suite

Admission for Surgery under General Anaesthetic
(to be completed on morning of admission)

Write or attach label

HCR No: A100-544212
JOHNSTONE LEE
12 WOODSIDE AVE
0902763334
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09/02/1976
PATON,G (GP)
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MAYBOLE
M/S

Has there been any change since we completed the Questionnaire? YES ☐ NO ☑

If yes, please give details:

Have you:

1. Had anything to eat in the last 6 hours? YES ☐ NO ☑
2. Someone to collect you and remain with you for 24 hours? YES ☑ NO ☐
3. Had a cough, cold in the last 2 weeks? YES ☐ NO ☑
4. Taken any tablets or drugs? Solpadol - 08.20am. Ranitidine 150mg. YES ☐ NO ☐

Please Remember for 24 Hours Following General Anaesthetic you should not:

1. Drive a vehicle or ride a motorcycle
2. Operate machinery
3. Drink alcohol or take sleeping tablets
4. Use a cooker
5. Sign important documents

I have answered the above questions honestly, and accurately and I have read and understood the above warnings.

Patient's Signature L. Johnstone

Witnesses Signature J. Fremmell

Date 10/03/11.

NHS AYRSHIRE and ARRAN
Pre operative, Correct Site and Patient verification.

A100-544212 L
JOHNSTONE LEE
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PATON, G (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE M/S

Station DSU Date 10/03/11 Theatre A2

Proposed Operation Repair of diaphragmatic hernia / GA

Prescribed Pre medication : Time Given 07.15 Ranitidine 150 Fasted From: Time 06.15

Identified Allergies: Specify NKA

Check 1 Pre op Marking and Verification

Surgical Site Marking and Patient verification

- ☑ Check patient Identity
- ☑ Check all relevant documentation / results
- ☐ Images to ascertain intended surgical site
- ☑ Intended site marked with indelible pen
- ☐ Decision not to mark –**state reason below**

Signature confirming surgical check complete

Surgeon

In the event of this section being incomplete –Reception nurse to communicate with theatre staff to establish action to be taken

Signature .....

Print .....

Check 2-3 Surgical Site Marking and Patient verification	Station/DSU			Recpt./Recovery			Theatre		
	Yes	No	NA	Yes	No	NA	Yes	No	NA
Operation Site marked clearly									
Case Notes/Drug Kardex	✓			✓					
Identification Bracelet	✓			✓					
Consent Form Signed	✓			✓					
AWI Consent signed if applicable			✓			✓			
Patients labels included	✓			✓					
Bone bank consent form signed			✓			✓			
X-Rays/Images		✓			✓				
Pathology /Lab results	✓			✓					
Haemoglobin	✓			✓					
Blood x matched		✓			✓				
E.C.G. if applicable		✓	✓		✓				
B.H.C.G.(pregnancy test if applicable)			✓			✓			
Urinalysis abnormalities		✓			✓				
Caps/Crowns/Loose teeth: Specify		✓			✓				
Dentures removed		✓			✓				
Inhalers		✓			✓				
Catheter in situ		✓			✓				
Hearing aid		✓			✓				
Rings /Body Piercing Taped		✓			✓				
Pre op shower	✓								
Skin prep carried out as instructed	✓								
Nail Polish /Jewellery/Make-up removed	✓								
Paper pants worn	✓								
Pad Tampon in situ			✓						
Other :Specify TED STOCKINGS									

Any other relevant information (e.g. high risks or changes to general health

.....

Station Nurse (signature) ..... Print J. GEMMELL Designation S/N

Reception Nurse (signature) A. D'AGOSTINO Print A. D'AGOSTINO Designation S/N

Anaesthetic Nurse (signature) ..... Print ..... Designation .....

NHS Ayrshire & Arran

ALCOHOL SCREENING PRE-OPERATIVE ASSESSMENT FORM

WRITE OR ATTACH LABEL

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To be completed by pre-op assessment team with patient

Date of pre operative assessment 16 / 12 / 10

Questions	0	1	2	3	4
A. How often do you have a drink Containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week
B. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 or 8	10 or more
C. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
D. How often during the last year have you failed to do what was normally expected of you because of your drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
E. Has a relative or friend or doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the past year		Yes during the past year

1. Alcohol screening score **Only record if score is 5 or above** **Score** Rarely

Only continue if score is 5 or above

2. Was this discussed with patient? ☐ Yes ☐ No ☐ Don't know

3. Was patient offered referral to alcohol liaison services? ☐ Yes ☐ No ☐ Don't know

4. Did patient accept offer of referral? ☐ Yes ☐ No ☐ Don't know
If patient refused please indicate why?

a. Don't feel I have a problem ☐

b. I am already receiving treatment/help at present ☐

If patient indicates they are receiving help please use following line to give their comment on the help/support used .....

c. I don't feel this is a priority for me at present ☐

d. Yes, I drink but I don't want to change anything ☐

e. There is nothing that can be done to help me ☐

f. Other. Please specify ☐ .....

5. Was patient given a Self Help Pack? ☐ Yes ☐ No ☐ Patient refused

JMcC/71937

CONSENT FOR OPERATION

STA1057

		A100-544212
HC	JOHNSTONE	LEE
	12 WOODSIDE AVE	
CH		0902763334
Sur	KIRKMICHAEL	
For	KA197PP	09/02/1976
	Paton, G (GP)	
Add	Maybole Health Centre	
	6 High Street	
	Maybole	M/S
Date of Birth		

I ..... of .....

..... hereby consent to

* undergo / the submission of my — * child ..... / ward

the operation of Open repair of epigastric hernia

the nature and purpose of which have been explained to me by

Dr./Mr.* D Malpani

I also consent to such further of alternative operative measures as may be found necessary during the course of the above-mentioned operation and to the administration of general, local or other anaesthetics for any of these purposes.

No assurance has been given to me that the operation will be performed by any particular practitioner. (Not applicable to section 1 (2) patients.)

Date 17/8/09 Signed ..... (Patient/Parent/Guardian)

I confirm that I have explained the nature and purpose of this operation to the patient/parent/guardian.*

Date 17/8/09 Signed Deepak Malpani (Medical/Dental Practitioner)*

*DELETE AS APPROPRIATE

Note: This form is not to be used for any operation where there is a specific consent form with explanations.

Any deletions, insertions or amendments to the form are to be made before the explanation is given and the form submitted for signature.

JMcC/74329

CONSENT FOR OPERATION

Patient Portion MEDITRAX®
DATE STERILIZED STLZR
10 08 08 01
BROWN=AUCLAVED
CYCLE NUMBER
ACH TSSU IRVINE
STORE IN A CLEAN, DRY AREA
OPEN AT POINT OF USE ONLY
In accordance with Article 12
Laryngoscope Blade (Mac 4)TH
AYR24 (S099524)
Ayr Th Supps
10/08/2009 10/08/2010 ACHUH1705177

DATE STERILIZED STLZR
14 08 08 02
BROWN=AUCLAVED
CYCLE NUMBER
MEDITRAX® Re-order code TTS3
Tel: 01454 318373
General Basic Set
Ayr 36
Dark = processed
General
ACHU01796854

7 332430 852564
Mölnlycke Health Care AB
Hernia
REF 97004694-01
2013-04
LOT 09059321

A100-544212 EL

JOHNSTONE LEE
12 WOODSIDE AVE
0902763334
KIRKMICHAEL
KA197PP 09/02/1976
Paton,G (GP)
Maybole Health Centre
6 High Street
Maybole M/S

RSHIRE and ARRAN
erative, Correct Site and Patient verification.

on 2 Date 17/8/09 Theatre 3

pposed Operation Open repair of epigastric hernia

rescribed Pre medication : Time Given nov Fasted From: Time last night

dentified Allergies: Specify none known

Check 1 Pre op Marking and Verification

Surgical Site Marking and Patient verification

- ☑ Check patient Identity
- ☐ Check all relevant documentation / results
- ☐ Images to ascertain intended surgical site
- ☐ Intended site marked with indelible pen
- ☑ Decision not to mark –**state reason below**

Abdominal surgery

Signature confirming surgical check complete

Surgeon

In the event of this section being incomplete –Reception nurse to communicate with theatre staff to establish action to be taken

Signature ....
Print D. Halpin

Check 2-3 Surgical Site Marking and Patient verification	Station			Recpt./Recovery			Theatre		
	Yes	No	NA	Yes	No	NA	Yes	No	NA
Operation Site marked clearly	✓			✓			✓		
Case Notes/Drug Kardex	✓			✓			✓		
Consent Form Signed	✓			✓			✓		
AWI Consent signed if applicable			✓			✓			✓
Bone bank consent form signed			✓			✓			✓
Identification Bracelet	✓			✓			✓		
Patients labels included	✓			✓			✓		
X-Rays/Images	✓			E/m			✓		
Pathology /Lab results	✓			✓			✓		
Haemoglobin 13·8 17/8/09				✓			✓		
Blood x matched		✓			✓			✓	
E.C.G. if applicable		✓			✓			✓	
Pregnancy test if applicable			✓			✓			✓
Urinalysis abnormalities documented	✓						✓		
Caps/Crowns/Loose teeth: Specify		✓			✓			✓	
Dentures removed			✓			✓			✓
Inhalers		✓			✓			✓	
Catheter in situ		✓			✓			✓	
Hearing aid		✓			✓			✓	
Rings /Body Piercing Taped Removed.			✓		✓			✓	
Pre op shower	✓								
Skin prep carried out as instructed			✓						
Nail Polish /Jewellery/Make-up removed	✓								
Paper pants worn		✓							
Pad/Tampon in situ			✓						
Other :Specify			✓						

Any other relevant information (e.g. high risks or changes to general health

Station Nurse (signature) ..... Print LMENZIES Designation RGN
Reception Nurse (signature) ..... Print Sinclair Designation RGN
Anaesthetic Nurse (signature) ..... Print SINCLAIR Designation RGN

IS AYRSHIRE and ARRAN
e operative, Correct Site and Patient verification.

Check 4 Surgical marking and patient verification Theatre:	Signature of Operating Surgeon or Senior member of Theatre team to confirm check was conducted.	Surgeon to complete and sign if discrepancy has been identified
Surgical , Anaesthetic and Theatre team prior to commencement of surgery **should pause for verbal briefing to confirm the following** ☑ Correct Patient ☑ Consent form correct and signed by the patient and clinician ☑ Correct operation ☑ Operation site marked ☑ Availability of required image studies plus pathology results especially those confirming malignancy	Sign ..... Print S. WARD Designation DCN Time 15.25 Date 17/8/09	**Nature of discrepancy** .... **Decision taken** .... **Sign** ..... **Print** ..... **Designation** ..... When there is a discrepancy, a senior member of staff will follow the adverse incident policy.

- If failure of any pre operative check occurs, the surgeon in charge must assess the situation and either return the patient to the ward /day care area or note and sign a decision to proceed at risk.
- If the patient is returned to the ward/day care area, a patient safety incident report form must be completed in line with local governance procedures.
- A senior member of staff must offer an explanation and apology
- If surgery is carried out at the incorrect site, a full root cause analysis of events is recommended.

Anaesthetic Record

Elective	
Scheduled Urgent	
Urgent	✓
Emergency	

Proposed procedure: Reduction + open suture repair incarcerated epigastric hernia

Consent form signed (Y) / N

Incapacity form Y / (N)

Fasted (Y) / N

SASM Consultant:

Informed Y / N

A100-544212

JOHNSTONE LEE

12 WOODSIDE AVE

0902763334

KIRKMICHAEL

KA197PP 09/02/1976

Adv Paton, G (GP)
Maybole Health Centre
6 High Street
Maybole M/S

Preoperative assessment: Assessor: Not performed Date: Location: ASA Grade:

History

Previous GA

FH

CVS

Resp.

Reflux

Other

B/G - Appendicectomy
Guillen Barré ~15yrs ago.

Examination

HR

BP

Weight

Height

BMI

Airway Assessment

Mouth opening

Teeth

Smoking 10cpd

Alcohol 28units/wk

Recreational Drugs

Hb / WCC / Plats / Urea / Creat. / Na / K / ECG / CXR / OTHER

Recent Medication: Nil

Allergies: NKDA

Discussed:		Regional Block: Complications discussed pre-operatively	
Fasting	☐	Failure	☐
Premed	☐	Hypotension	☐
Induction	☐	Headache	☐
Analgesia	☐	Numbness	☐
Suppositories	☐	Nerve Damage.	☐
Monitoring:	☐	Patient agrees Y / N	
		Handout Y / N	

Premedication:

Fasting: Time

Light Breakfast

Fluids: Allow still juices / water till:

Usual medicines:

Give all:

Give only:

Give all except:

Drugs: Date: Time:

Given at / by:

Date: 17/8/09 Operation done: Location: Th 2 Start time: End time: Surgeon(s):

Anaesthetic assistant:

Anaesthetist(s): Dr Whylie (SAS) Dr Livingston (ST2)

Grade:

Remarks: Significant Events / Critical Incidents Hazard Warnings

Uneventful Y/N

Effect of Premed

JMcC/80193 STA0093

Monitoring	
ECG	✓
NIBP	✓
SpO_2	✓
$ETCO_2$	✓
ET Agent	✓
F_iO_2	✓
NMT	
Temp.	
Urine Cath.	
CVP	
IBP	
Boots	
Fluid Warmer	
Warm Mattress	
Bair Hugger	

Machine Check

Anaesthetic room ☐

Theatre ☐

Circuit

Circle ☑ Bain ☐

Tpiece ☐ HME ☐

Ventilation

IPPV: Pressure Cont ☐

Volume Cont ☐

Spont Respiration ☐

Press Support ☐

Induction: Intravenous ☐ Gas ☐

Pre O_2 ☐ RSI ☐

Face Mask ☑

Airway: Oral ☐ Nasal ☐

LMA: Size..... Type.....

ETT: Size 8½ Cuff ☑

Type Portex

Throat Pack In ☐ Out ☐

Laryngoscopy Grade.....

Laryngoscopy Notes

Position

Pressure Care ☑

Eye Care. ☑

Thromboprophylaxis ☐

Antibiotic Ceftriaxone

Dose 2g

Time .....

Time	15:00	*	15:30	*	16:00	*	16:30	*	17:00
Ceftriaxone 2g									
Rocuronium	7mg		3mg		2mg				
Propofol	220mg								
Morphine	10mg								
Midazolam	2mg								
Neostigmine / Glycopyrrolate					2×0mg				
Paracetamol					1g				

O_2 ☐

N_2O ☐

Air ☐

Sev ☐

Des ☐

Iso ☐

Halo ☐

Others ☐

220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30

SpO_2		100	100	100	100
$ETCO_2$		5.4	5.6	5.8	5.5
ET Agent					
F_iO_2					

Blood Loss

Urine Output

Cannula	Site
green x 2	(R) hand
A Line	
CVP	
Insertion Notes	

Regional Anaesthetic technique:

Spinal	☐	Full aseptic	☐
Epidural	☐	Entry site:	
N. Block	☐	Needle used:	
Wound Inf.	☐	Catheter: Y/N	

Anaesthetic / Recovery

Fluid In

Infusion 1	Vol
① Hartmann's	1000ml

Time

Recovery

Postoperative instructions

Reviewed by

Routine monitoring & care ☑

O_2 4 l/min for 1/4 hrs ☐

Humidified O_2, % as required to maintain O_2 Sat > 95% ☐

Morphine 1mg/ml iv up to 10mg as required for pain in recovery (YES) Signed AML

Ondansetron 4mg iv in recovery if required for nausea (YES) Signed AML

iv fluids as charted ☐ Special instructions

Drug therapy as charted ☐

NOTES

DATE	

HC	JOHNSTONE A100-544212
CH	12 WOODSIDE AVE LEE
St	KIRKMICHAEL 0902763334
Fc	KA197PP 09/02/1976
Ac	Paton,G (GP)
..	Maybole Health Centre
Da	6 High Street Maybole M/S

STA0215

DATE

SURGEON

Mr LEITCH.

ANAESTHETIST

~~Mr CAROLSEC~~
~~(Anaesthetist)~~
DR WYCE

ASSISTANT

Mr CAROLSEC (med student)

OPERATION PERFORMED

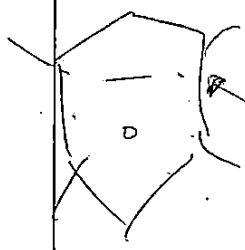
REDUCTION + OPEN SUTURE REPAIR
OF INCARCERATED EPIGASTRIC HERNIA.

DESCRIPTION OF PROCEDURE

GA.

Transverse incision over hernia.
Omentum incarcerated in sac.
Sac dissected around then reduced into
abdo cavity.
Iam defect in rectus.
→ 4 x No 1 prolene sutures
→ good closure

3x 2/0 vicryl to close s/c space
3/0 monocryl to skin.



20 ml 0.5% chivacaine to wound edges

Small dressing over to LUQ
→ superficial 5ml 0.5%
chivacaine infiltrated.

DRAINS ..... PACKS .....

SPECIAL INSTRUCTIONS TO WARD

Nil per oral + drink.
No antibiotics.
(F) Mane if not for surg

Signature .....

R LEITCH
STS #1310

OPERATION

JMcC/74602

JOHNSTONE LEE A100-544212
12 WOODSIDE AVE
0902763334
KIRKMICHAEL KA197PP 09/02/1976
Paton,G (GP)
Maybole Health Centre
6 High Street
Maybole M/S

RECOVERY ROOM INSTRU

DATE: 17/8/09 ANAESTHETIST: Dr Wylie

SURGEON: Mr Leitch. ANAESTHETIC: GA + local infiltration towards.

OPERATION: reduction + open suture repair incarcerated epigastric hernia.

THEATRE No.: 2. TIME ENTERED RECOVERY 1631

CONDITION ON ENTERING RECOVERY sleepy, breathing spontaneously

AIRWAY: maintained-

LARYNGEAL MASK:

E.T.T.:

I.P.P.V.

ARTERIAL LINE:

I.V. FLUIDS:

PERIPHERAL: IV fluids discontinued

CENTRAL:

OXYGEN THERAPY: 4L/min via Hudson mask

DRAINS:	CATHETERS:	PACKS:	POP
CHEST	URINARY	ABDOMINAL	CPM MACHINE
SHIRLEY	SUPRA PUBIC	RECTAL	
YATES	URETERIC	VAGINAL	
CORRUGATED	IRRIGATION	NASAL	
SOLCOTRANS		AURAL	
SUCTION			

blue swabs legs down towards

STOMAS:

ILEOSTOMY:

COLOSTOMY:

DRUGS GIVEN IN RECOVERY: CONTROLLED IN RED

1. Morphine sulphate 2mg IV given 17⁰⁰ SE
2. 2mgs IV Morphine Sulphate given @ 17.13 RSpn
3. 2mgs IV Morphine Sulphate given @ 17.18 RSpn
4. 2mgs IV Morphine Sulphate given @ 17.25 RSpn
5. morphine sulphate 2mg IV given 1735 SE

CONDITIONS ON LEAVING RECOVERY:

PATIENT RESPONDS TO STIMULUS ✓

PATIENT RESPONDS TO SPEECH ✓

PATIENT UNDERSTANDS SIMPLE COMMANDS ✓

PATIENT IS PAIN FREE comfortable

TIME LEFT RECOVERY 1744

SPECIAL INSTRUCTIONS/COMMENTS:

Satisfactory post op observations:
can eat + drink.
no antibiotics
home tomorrow if not too sore

NURSE SIGNATURE: S Reid

LEE
JOHNSTONE

Hospital No: 100-544212

01.11.07 DR PODDAR DR PODDAR

Removal of left upper thigh skin lesion

Area was cleaned and draped. A total of 15mls of Lignocaine 1% of Adrenaline was injected into the lesion. A looped local incision was made and the lesion was removed, unfortunately, not intact as some of the sebum was leaking. All the contents were removed and sent for Pathology. The subcutaneous layer was closed with Vicryl and the skin was closed with 4/0 Ethilon and a total of 5 interrupted sutures, which should be removed in 10 days' time. Pathology results will be forwarded to the GP.

Procedure EXC LESION (L) THIGH

Consultant MR McMILLAN

Date 1/11/07

A100-544212
JOHNSTONE LEE
16 MINNOCH CRESCENT
0902763334
MAYBOLE 09/02/1976
KA198DW
LAU, C (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE M/S

THE BRUCE DAY SURGERY SUITE

Prior to Admission - Review Results

X-rays available	Yes	(No)	N/A	Bloods	Yes	No	(N/A)
Casenotes available	(Yes)	No	N/A	ECG if over 45	Yes	No	(N/A)
Prescription request	(Yes)	No	N/A				

Comments mum will pick pt up

Signed Claire Webb

On Admission

Baseline obs BP 143/81 P 86 Allergies NKDA Current Medication Zoton 30mgs

Identity Bracelet (Yes)

Valuables

Signed Claire Webb Named/Associate Nurse

Pre-op

Consent Signed	Yes	No		Seen by Anaesthetist	Yes	No	N/A
Theatre Gown - Time				Seen by Surgeon	Yes	No	N/A
Skin Shave	Yes	No	(N/A)				
Skin Shave - Checked	Yes	No	(N/A)	Urinalysis			
Operation site marked	Yes	No					
Dentures	Yes	No	(N/A)				
Hearing Aid	Yes	No	(N/A)	Medication Prior to Theatre	(Yes)	No	
Nail Polish	Yes	No	(N/A)	Zoton			

Signed Claire Webb Named/Associate Nurse

To Theatre Time

Theatre

GA (LA) 1% Lidocaine Adrenaline 1:200,000

Procedure excision lesion left thigh.

Surgeon MR PODDAR

Anaesthetist Surgeon

Operation site marked	(Yes)	No
Consent Signed	(Yes)	No
LA infiltration AS ABOVE	(Yes)	No
Voltorol Supps	Yes	(No)

Dressing Steri-strips, Mepore

Sutures / Clips Non-Absorbable Sutures

Review N.O.S - 10 DAYS TIME.

Comments:

Signature

Named/Associate Nurse/Practitioner

1st Stage Recovery

On entering recovery:-

						On leaving recovery:-		
Airway	Yes	No	Airway removed	Yes	No	Patient responds to stimulus	Yes	No
Laryngeal Mask	Yes	No	Laryngeal mark removed	Yes	No	Patient responds to speech	Yes	No
ETT	Yes	No	ETT removed	Yes	No	Patient understands simple commands	Yes	
						Patient is pain free	Yes	No
						Vital signs satisfactory	Yes	No

Special Instructions/comments:-

Signed Named/Associate Nurse Time in Time out

DRS 030 498

DRUG	DOSE	METHOD	TIME	DR. SIG.	NURSES SIG.

ADDRESSOGRAPH

2nd Stage Recovery

Wound Check (Yes) No

Fluids (Yes) No

Tea/Toast/Biscuit Yes (No)

Pain Free (Yes) No

Referred to Physio Y N (n/a)
Asess mobility

Flow Study
Bladder Scan N/A

Discharge Arrangements

District Nurse Arranged	Y	N	(n/a)	Suture Removal Date 10days
Practice Nurse Arranged	(Y)	N	n/a by patient	
Prescription Arranged	(Y)	N	n/a	
Discharge Advice Given	(Y)	N	n/a	
Review Appointment	Y	(N)	Date.....	
Dressings Provided	(Y)	N	...Mepore...	

Nursing Notes

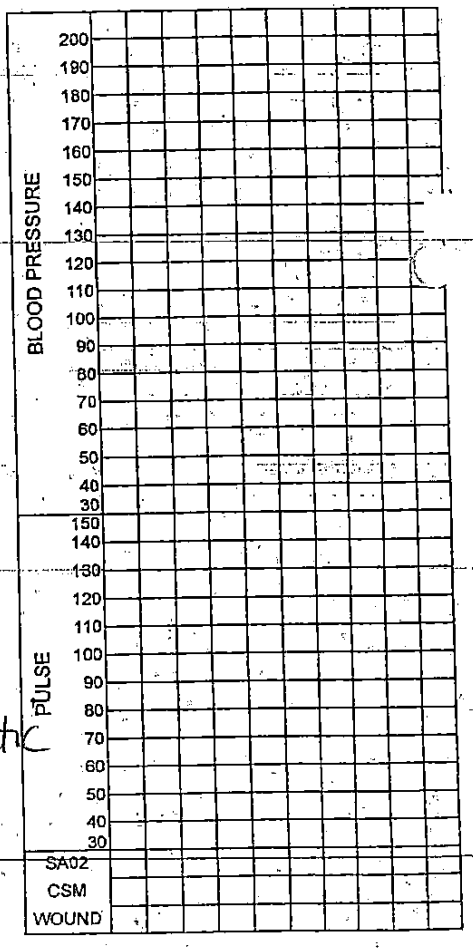
15. Uncomplicated discharge, relevant information given. e-Adams

Signed.....
Named/Associate Nurse

Discharge Criteria

Stable Vital Signs	Y	N	N/A	
Tolerating Diet & Fluids	Y	N	N/A	
Mobilising	Y	N	N/A	
Able to void Urine	Y	N	N/A	local
CSM of Limb Intact	Y	N	N/A	Anaesthetic
Wound Check	(Y)	N	N/A	
Cannula Removed	Y	N	N/A	
Collected by Responsible Adult	Y	N	N/A	
Pain Free	Y	N	N/A	

Signed Lauren Adams
Named/Associate Nurse



CONSENT FOR PROCEDURE

STA1058

Sur JOHNSTONE A100-544212
For 16 MINNOCH CRESCENT LEE
MAYBOLE 0902763334
Adc KA198DW 09/02/1976
LAU,C (GP)
Wa MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE M/S

I .....of .....

.....hereby consent to

* undergo / the submission of my * child..... / ward

the procedure of ..... Removal of lesion upper outer (L) thigh LA....

the nature and purpose of which have been explained to me by

Dr./Mr.* .....

I also consent to such further or alternative operative measures as may be found necessary during the course of the above-mentioned procedure and to the administration of general, local or other anaesthetics for any of these purposes.

No assurance has been given to me that the operation will be performed by any particular practitioner. (Not applicable to section 1 (2) patients.)

Date 1/11/7 Signed X - .....
(Patient/Parent/Guardian)*

I confirm that I have explained the nature and purpose of this procedure to the patient/parent/guardian.*

Date 1/11/7 Signed .....
(Medical/Dental Practitioner)*

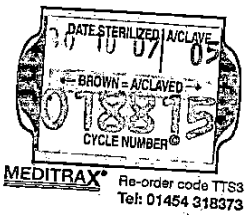
*DELETE AS APPROPRIATE

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JMcC/34724

CONSENT FOR PROCEDURE



MEDITRAX® Re-order code TTS3
Tel: 01454 318373

Plastic Surgery Set
Ayr DSU 33

STEAM
Dark = processed

General
ACHU01470036

NHS Ayrshire & Arran

A100-544212 EL
Surna JOHNSTONE LEE
Foren 16 MINNOCH CRESCENT 0902763334
Addre MAYBOLE 09/02/1976
KA198DW
Ward o LAU,C (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE M/S

Day Surgery
Discharge Prescription

Surgical Procedure exc lesion (L) thigh.

PLEASE DISPENSE

1. Paracetamol 500mg

Sig: 2 tablets to be taken 4-6 hourly as required for pain. Up to a maximum of 8 tablets in 24 hours.

Mitte: 24

OR

2. Co-codamol 30/500 (Codeine Phosphate 30mg, Paracetamol 500mg)

Sig: 1-2 tablets to be taken 4-6 hourly as required for pain. Up to a maximum of 8 tablets in 24 hours.

Mitte: 8 tablets

OR

3. Co-codamol 30/500 (Codeine Phosphate 30mg, Paracetamol 500mg)

Sig: 1-2 tablets to be taken 4-6 hourly as required for pain, Up to a maximum of 8 tablets in 24 hours.

Mitte: 20 tablets

PLEASE DELETE AS APPROPRIATE

4. Any other medications:

DRS0029

Doctor's Name:

Signed: Date: 1/11/7

CONSENT FOR OPERATION

STA1057

A100-544212

Surnam JOHNSTONE LEE
Forenar 4C WHITEFAULDS AVENU 09/02/76
Address MAYBOLE
LAU,C (GP)
MAYBOLE HEALTH CENTRE
Ward or 6 HIGH STREET M/S
MAYBOLE

I LEE JOHNSTONE of .....

..... hereby consent to

* undergo / the submission of my — * child / ward

the operation of APPENDICECTOMY

the nature and purpose of which have been explained to me by

Dr./Mr.* MCILHINNEY

I also consent to such further or alternative operative measures as may be found necessary during the course of the above-mentioned operation and to the administration of general, local or other anaesthetics for any of these purposes.

No assurance has been given to me that the operation will be performed by any particular practitioner. (Not applicable to Section 1 (2) patients.)

Date 3/1/0 Signed L Johnstone
(Patient/Parent/Guardian)*

I confirm that I have explained the nature and purpose of this operation to the patient/parent/guardian.*

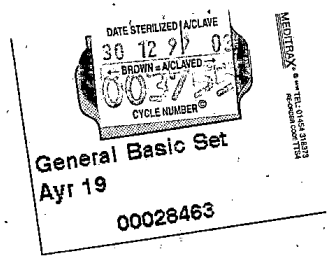
Date 3/1/0 Signed .....
(Medical/Dental Practitioner)*

*DELETE AS APPROPRIATE

Note: This form is not to be used for any operation where there is a specific consent form with explanations.

Any deletions, insertions or amendments to the form are to be made before the explanation is given and the form submitted for signature.

CONSENT FOR OPERATION


DATE STERILIZED / AUCLAVE
30 12 96 03
BROWN = AUCLAVED
CYCLE NUMBER
MEDITRAX
General Basic Set
Ayr 19
00028463

Anaesthetic Record

Proposed procedure: STA 0093

A/P/endicectomy.

Elective	
Scheduled urgent	
Urgent	
Emergency	
Consultant Informed	

WRITE, IMPRINT OR ATTACH LABEL

Surname Johnstone HCR No.

Forenames LEE Sex

Address WC whitefaulds maybole D.O.B 09/02/76

Ward or Dept. 8

Preoperative assessment: ASA: B.P.

Excision of thyroglossal cyst °FH

°RMH

Weight

Dentition °NCT.

Hb

Biochem

Urea

Creat

Na

Cl

K

HCO_3

ECG

CXR

Recent drug therapy: SMOKER 4 days.

NIL.

Allergies: NKDA

Premedication:

Fasting: MIDNIGHT Time

Full Breakfast

Light Breakfast

Fluids: Allow still juices/water till:

Usual medicines:

Give all

Give only:

Drugs: Date Time

Given at / by

ANAESTHETIC RECORD

Monitoring	
ECG	✓
NIBP	✓
S_pO_2	✓
$ETCO_2$	✓
ET Agent	✓
f_iO_2	✓
NMT	
Temp	
Urine cath.	
CVP	
IBP	
Boots	
Fluid warmer	
Warm mattress	

Anaesthetic technique

Injection: R(E) 16G DUH Infusion(s) Right - Left - IV FLUIDS

Induction PreO₂ ☐ Cricoid ✓ Inhalation ☐ IV ✓

Airway Oral ☐ Nasal ☐ LMA ☐ Size

Intubation Oral ✓ Nasal ☐ Cuff ✓ Size 9.0 Type MAC

Laryngoscopy Grade 1 Laryngoscopy notes:

Spray ☐ Pack ☐ Respiration Spont ☐ IPPV ✓

Ventilator: Ohmeda ✓ Circuit: Circle ✓ Bain ☐ T piece ☐

Position: ⊖ @ ARM OUT

Pressure care:

Local Anaesthetic technique

Spinal ☐

Epidural ☐

N. Block ✓

Wound Inf ✓ 20ml 0.5% BUPIVACAINE + PLAIN

Date: 3/1/00. Operation: AS ABOVE

Anaesthetist(s) JAMIESON.

Anaesthetic Nurse: MONTGOMERY.

Surgeon(s)

Notes

Effect of premed:

Time	15:00	15:30	16:00
FENTANYL	100mg		
PROPOFOL	200mg		
SUX	100mg		
ROCURONIUM	30mg		
MORPHINE	5mg	2.5mg	
ZOFRAN	4mg		
CEFUROXIME	1.5g		
FLAGYL	500mg		
N,O/O,/SEVO			

220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30

S_pO_2	95	99	99	99	99
$ETCO_2$	4.6	4.4	4.5	5.0	4.8
ET Agent	1.8	1.7	2.15	2.1	2.2
f_iO_2	0.75	0.72	0.69	0.67	0.67

IV FLUIDS ① ② ③

	Fluid In				Fluid Out	
	Infusion 1	Vol.	Infusion 2	Vol.	Urine	Blood
①	HARTMANNS	1000.	-			
②	N.SALINE	500.				
③	5% DEXTROSE	500	-			

Time

Recovery

Drugs & Events

220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30

S_pO_2

Resp Rate

Sed Score

Pain Score

O_2L/min

40
39
38
37
36
35
34
33
32

TEMPERATURE

Postoperative Instructions

Reviewed By

Routine Care ☑

O_2 4 l/min till awake ☑

O_2:

Morphine 1mg/ml IV up to 10mg as required for pain in recovery (Yes) Signed ...

Analgesia as prescribed.

IV fluids as charted until eating + drinking normally.

DATE	

100 54622

Write—Imprint or attach Label

Surname JOHNSTONE HCR No.

Forenames LEE Sex

D.of B.

Address

Ward/Dept.

STA0215

DATE | SURGEON Mr S. Taylor | ANAESTHETIST

ASSISTANT

/

OPERATION PERFORMED

Appendicectomy

DESCRIPTION OF PROCEDURE

Cef & Flag pre-op

Grid iron incision

① Abdomen opened
Small fluid → swab

② Appendix - gangrenous
pelvic
wrapped in omentum

→ omentum dissected off

Mesoappendix ligated & divided
appendix base crushed & excised
stump diathermied & buried
washout 300 mls saline
Closure - loops & vicryl
clips → skin

DRAINS..... PACKS.....

SPECIAL INSTRUCTIONS TO WARD

Continue IV Antibiotics Metronidazole
3 days

Signature.....

OPERATION

RECOVERY ROOM INSTRUCTIONS

A100544212
KEE JOHNSTONE

DATE: 03/01/00
ANAESTHETIST: DR JAMIESON ~~ADDRESSOGRAPH:~~
SURGEON: MR TAYLOR
ANAESTHETIC: G.A. + INFILTRATION.
OPERATION: APPENDICECTOMY
THEATRE No.: 1
TIME ENTERED RECOVERY 1615

CONDITION ON ENTERING RECOVERY Breathing spont. SaO_2 99%

AIRWAY: Clear
LARYNGEAL MASK:
E.T.T.:
I.P.P.V.
ARTERIAL LINE:

I.V. FLUIDS: AS prescribed
PERIPHERAL: left hand
CENTRAL:

OXYGEN THERAPY: 4Lts in recovery.

DRAINS:	**CATHETERS:**	**PACKS:**	
CHEST	URINARY	ABDOMINAL	POP
SHIRLEY	SUPRA PUBIC	RECTAL	CPM MACHINE
YATES	URETERIC	VAGINAL	
CORRUGATED	IRRIGATION	NASAL	
SOLCOTRANS		AURAL	
SUCTION			

STOMAS:
ILEOSTOMY:
COLOSTOMY:

DRUGS GIVEN IN RECOVERY: CONTROLLED IN RED
1. IM MORPHINE SULPHATE 10mgs GIVEN AT 16[TH] HRS W
2.
3.
4.

#IM Morphine 10mgs intraoperatively *

CONDITIONS ON LEAVING RECOVERY:

PATIENT RESPONDS TO STIMULUS Yes
PATIENT RESPONDS TO SPEECH Yes
PATIENT UNDERSTANDS SIMPLE COMMANDS Yes
PATIENT IS PAIN FREE Yes

SPECIAL INSTRUCTIONS/COMMENTS:

① Satisfactory recovery.
② See anaesthetic chart.
③ Wound intact.

TIME LEFT RECOVERY 1700

NURSE SIGNATURE: .....

ST D/L R

THE AYR HOSPITAL

OPERATION NOTE

SURNAME : JOHNSTONE
FORENAME : LEE

UNIT NO. : AG544212

STATION : 2

DATE : 23/11/99
SURGEON : MR CHONG/STEWART
ASSISTANT :
ANAESTHETIST : GENERAL ANAESTHETIC - DR MCKENZIE

OPERATION : EXCISION RECURRENT HYPOGLOSSAL CYST

SECOND :

PROCEDURE :

FINDINGS :

A fairly significant recurrent hypoglossal cyst with a small sinus tract. The sinus tract and the hypoglossal cyst were excised up to the hyoid bone. A fairly significant left lateral extension of the cyst extended as far as the left submandibular gland.

Complete excision of the whole recurrent cyst was achieved. Haemostasis was achieved.

Closure with subcuticular Prolene. Suction drain x 1.

Post-op management Augmentin IV x 3 and then Augmentin for ten days post-operatively.

GS/JMM
24/11/99 GS

SOUTH AYRSHIRE HOSPITALS NHS TRUST

ANAESTHETIC RECORD

STA 4009

A100-544212

Surname JOHNSTONE LEE
Forenam 4C WHITEFAULDS AVENU
Address: MAYBOLE 09/02/76
LAU,C (GP)
Ward or D MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE

M/S

PROPOSED PROCEDURE Nasal Neck cyst | EMERGENCY | Wt. | BP

PRE-OPERATIVE ASSESSMENT ASA

Fit

RECENT DRUG THERAPY	ALLERGIES	FASTING	PREMEDICATION DATE TIME
	Nil	12 M/N ☐ Light b/fast ☐ Clear Fluids (2H pre op) ☐	TIME INIT.

MONITORING

ECG ☑
BP ☑
PULSE ☑
O_2 ☑
CO_2 ☑
CVP ☐
TEMP ☐
NMT ☐
CFM ☐

ANAESTHETIC TECHNIQUE

INJECTION R (L) 20 g INFUSION(S) R L

INDUCTION	PRE O_2 ☑	CRICOID ☐	INHAL ☐	IV ☑		
AIRWAY	ORAL ☐	NASAL ☐	LM ☑	SIZE 5		
INTUBATION	ORAL ☐	NASAL ☐	CUFF ☐	SIZE	TYPE	
	SPRAY ☐	PACK ☐				
RESPIRATION	SPONT ☐	IPPV ☐	VENTILATOR	VENTILATION		
POSITION ON TABLE	SUPINE ☐			V_T		
	LITH ☐			P_{AW}		
	TREND ☐			F		
	PRONE ☐					
	OTHER ☐					

LOCAL ANAESTHESIA

SPINAL ☐
EPIDURAL ☐
NERVE BLOCK ☐

DRUGS GIVEN wound – Bupivacaine with adrenaline

INDUCTION

fentanyl 75mcg
Propofol 200 mg

DATE OF OP.	OPERATION PERFORMED	SURGEON	ANAESTHETIST
23/11/at		Stewart/Chong	Mackenzie / AMcNAR

POST OP. INSTRUCTIONS

ANALGESIA
O_2 4L/min until awake
FLUIDS
OTHER

NOTES/COMMENTS

ANAESTHETIC RECORD

FLUIDS IN DRIP 1	VOL.
① Hartmanns	1000

FLUIDS IN DRIP 2	VOL.
TOTALS IN	
TOTALS OUT	

Fentanyl 33m 1.2g

Enzymeth

O2 Inhalers

Blood/Plasma Bottle numbers

Blood Pressure:- V Λ

Pulse Rate:- ●

240 220 200 180 160 140 120 100 80 60 40 20

SpO_2		97	98	99
FiO_2		0.42	0.34	0.35
E_{Taa}		2.0	1.9	2.0
Temp Ecm		6.2	6.7	6.0
CVP				
Blood Loss				
Urine				

RECOVERY ROOM INSTRUCTIONS

A100-544212

ABEL
CR No.:
ex:
O.B.:

JOHNSTONE LEE
4C WHITEFAULDS AVENU
MAYBOLE
KA198AS

S.2.

DATE: 23-11-99
SURGEON: Mr. Stewart
OPERATION: Excision thyroglossal cyst. +HA INFILTRATION + ADRENALINE
THEATRE No.: 3

ANAESTHETIST: Dr Mackenzie
ANAESTHETIC: General
TIME ENTERED RECOVERY: 12 20

CONDITION ON ENTERING RECOVERY

Breathing Spont

AIRWAY: O
LARYNGEAL MASK: ✓ removed
E.T.T.: O
I.P.P.V. O
ARTERIAL LINE O

I.V. FLUIDS:
PERIPHERAL: ✓ Discont. after present bag
CENTRAL: O

OXYGEN THERAPY: 4L/min

DRAINS:	**CATHETERS:** O	**PACKS:** O	POP O
CHEST	URINARY	ABDOMINAL	CPM MACHINE O
SHIRLEY	SUPRA PUBIC	RECTAL	
YATES	URETERIC	VAGINAL	
CORRUGATED	IRRIGATION	NASAL	
SOLCOTRANS		AURAL	
SUCTION ✓ X 1			

STOMAS: O
ILEOSTOMY:
COLOSTOMY:

DRUGS GIVEN IN RECOVERY: CONTROLLED IN RED
1. Papaveretum 15.4mgs I.M. at 12.40 p.m.
2.
3.
4.

CONDITION ON LEAVING RECOVERY

PATIENT RESPONDS TO STIMULUS ✓
PATIENT RESPONDS TO SPEECH ✓
PATIENT UNDERSTANDS SIMPLE COMMANDS
PATIENT IS PAIN FREE Not quite yet

TIME LEFT RECOVERY: 13 10

SPECIAL INSTRUCTIONS/COMMENTS:
Routine Care

NURSE SIGNATURE: D. Morrison

CONSENT FOR OPERATION

STA1057

A100-544212

Surname JOHNSTONE
Forenames LEE
Address 4C WHITEFAULDS AVENU
MAYBOLE
LAU,C (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
Ward or MAYBOLE

09/02/76

M/S

I LEE JOHNSTONE of .....

..... hereby consent to

* undergo / the submission of my * child / ward .....

the operation of EXCISION OF THYROGLOSSAL CYST

the nature and purpose of which have been explained to me by

Dr./~~Mr.~~* GRAEME ITHER

I also consent to such further or alternative operative measures as may be found necessary during the course of the above-mentioned operation and to the administration of general, local or other anaesthetics for any of these purposes.

No assurance has been given to me that the operation will be performed by any particular practitioner. (Not applicable to Section 1 (2) patients).)

Date X 12/11/99 Signed X Lee Johnstone
(Patient/Parent/Guardian)*

I confirm that I have explained the nature and purpose of this operation to the patient/parent/guardian.*

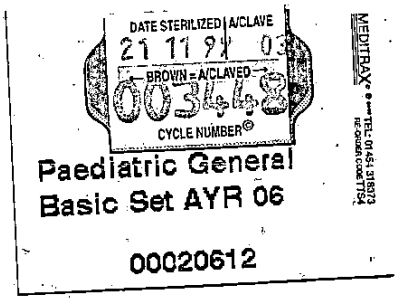
Date 12/11/99 Signed C Hatt
(Medical/Dental Practitioner)*

*DELETE AS APPROPRIATE

Note: This form is not to be used for any operation where there is a specific consent form with explanations.

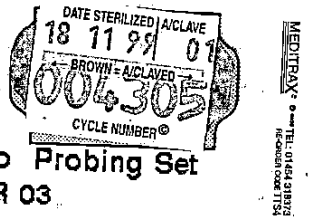
Any deletions, insertions or amendments to the form are to be made before the explanation is given and the form submitted for signature.

CONSENT FOR OPERATION



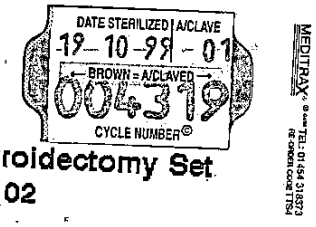
Paediatric General
Basic Set AYR 06

00020612



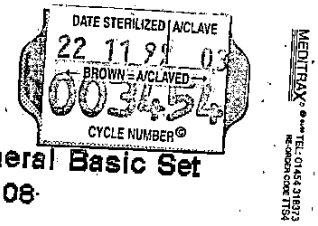
Swo Probing Set
AYR 03

00019903



Thyroidectomy Set
Ayr 02

00020189



General Basic Set
Ayr 08

00020715

THE AYR HOSPITAL

OPERATION NOTE

NAME:	Lee Johnstone
UNIT NO:	100544212
DOB:	9/2/76
DATE:	27/02/98

SURGEON: Mr I McMillan

ANAESTHETIST: Dr Ryan

The decision was placed to remove the infected material which lay in a superficial level. This led down to a sinus tract which was explored to the floor of the mouth. At this level it was ligated and divided. Closure of the wound with 20 vicryl, and clips to skin.

CONSENT FOR OPERATION

STA1057

A100-544212 EL

S JOHNSTONE LEE
F 16 MINNOCH CRESCENT
A MAYBOLE 09/02/76
LAU,C (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
W MAYBOLE

I No:
B.:
M/S

I Lee Johnstone of 16 Minnoch Cres.
..... hereby consent to

* undergo / ~~the submission of my~~ * child / ward .....

the operation of explor^n of midline neck lumps

the nature and purpose of which have been explained to me by

Dr. ~~[illegible]~~* Claire McDonnell

I also consent to such further or alternative operative measures as may be found necessary during the course of the above-mentioned operation and to the administration of general, local or other anaesthetics for any of these purposes.

No assurance has been given to me that the operation will be performed by any particular practitioner. (Not applicable to Section 1 (2) patients).)

Date 26/2/98 Signed X. lee Johnstone
(Patient/~~Parent/Guardian~~)*

I confirm that I have explained the nature and purpose of this operation to the patient/ ~~parent/guardian.~~*

Date 26/2/98 Signed emcdougall
(Medical/~~Dental~~ Practitioner)*

*DELETE AS APPROPRIATE

Note: This form is not to be used for any operation where there is a specific consent form with explanations.

Any deletions, insertions or amendments to the form are to be made before the explanation is given and the form submitted for signature.

CONSENT for OPERATION

Anaesthetic Record

Elective	✓
Scheduled urgent	
Urgent	
Emergency	
Consultant Informed	

A100-544212
Surnan JOHNSTONE LEE
Forena 16 MINNOCH CRESCENT
Addres MAYBOLE 09/02/76
LAU, C (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE M/S

Proposed procedure:
Expl. midline lesion of neck

Preoperative assessment:
ASA: 2
B.P.
Guillain Barré Syndrome 3yrs ago → full recovery
Smokes 10
Thomas splint
(R-A)

Weight
Dentition

Hb
Biochem
Urea
Creat
Na
Cl
K
HCO_3 awaited
ECG
CXR

Recent drug therapy: Nil

Allergies: Nil

Premedication:
Fasting: Time
Full Breakfast
Light Breakfast
Fluids: Allow still juices/water till:

Usual medicines:
Give all
Give only:

Drugs: Date 27/2/98 Time 0500
TEMAZEPAM 20MG
RANITIDINE 150MG
Oral
Given at / by

Monitoring	
ECG	✓
NIBP	✓
S_pO_2	✓
$ETCO_2$	✓
ET Agent	✓
F_iO_2	✓
NMT	
Temp	
Urine cath.	
CVP	
IBP	
Boots	
Fluid warmer	
Warm mattress	

Anaesthetic technique
Injection: R/L for induction 20V
Infusion(s) Right - Left -
Induction PreO₂ ☐ Cricoid ☐ Inhalation ☐ IV ☐
Airway Oral ☐ Nasal ☐ LMA ☑ Size 4
Intubation Oral ☐ Nasal ☐ Cuff ☐ Size ____ Type ____
Laryngoscopy Grade ☐ Laryngoscopy notes:
No problem ↑ LMA.

Spray ☐ Pack ☐ Respiration Spont ☑ IPPV ☐
Ventilator: Ohmeda ☐ Circuit: Circle ☑ Bain ☐ T piece ☐
Position: Supine
Pressure care:

Local Anaesthetic technique
Spinal ☐
Epidural ☐
N. Block ☐
Wound Inf ☐

Date: 27/2/98 Operation: Expl. thyroglossal cyst.
Anaesthetist(s) Ryan
Anaesthetic Nurse: Gillian / Joan.
Surgeon(s) McMillan.

Notes

Effect of premed: Calm

ANAESTHETIC RECORD

STA 0093

e 0900 30 1000

DAZ 2
DDL 100
sfofol 160
D/OL
DFL
roxicam 20

220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30

S_pO_2	98	98
$ETCO_2$	61	59
Agent	1.4	1.1
O_2	36	34
N_2O	57	61

Fluid In				Fluid Out		
Infusion 1	Vol.	Infusion 2	Vol.		Urine	Blood

Time

Recovery

Drugs & Events

220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30

40
39
38
37
36
35
34
33
32

S_pO_2

Resp Rate

Sed Score

Pain Score

O_2L/min

Postoperative Instructions

Reviewed By

Routine Care ☐

O_2 4 l/min till awake ☑

O_2: If S_{aO_2} < 94% on air give O_2 postop on ward.

Morphine 1mg/ml IV up to 10mg as required for pain in recovery (Yes) Signed .....

DATE	

A100-544212

JOHNSTONE LEE
16 MINNOCH CRESCENT
MAYBOLE
LAU, C (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE

09/02/76

M/S

RECOVERY ROOM INSTRUCTI

DATE: 27.02-97. ANAESTHETIST: DR Lynn

SURGEON: MR Macmillan ANAESTHETIC: GM

OPERATION: Excision of thyroglossal cyst.

THEATRE No.: 2. TIME ENTERED RECOVERY 0940

CONDITION ON ENTERING RECOVERY Breathing spont via LMA - Sat 99%

AIRWAY:

LARYNGEAL MASK: ✓ Extubated at

E.T.T.:

I.P.P.V.

ARTERIAL LINE:

I.V. FLUIDS:

PERIPHERAL:

CENTRAL:

OXYGEN THERAPY: 4l/min until fully awake

DRAINS:

CHEST
SHIRLEY
YATES
CORRUGATED
SOLCOTRANS
SUCTION

CATHETERS:

URINARY
SUPRA PUBIC
URETERIC
IRRIGATION

PACKS:

ABDOMINAL
RECTAL
VAGINAL
NASAL
AURAL

POP
CPM MACHINE

STOMAS:

ILEOSTOMY:
COLOSTOMY:

DRUGS GIVEN IN RECOVERY: CONTROLLED IN RED

1.
2.
3.
4.

CONDITIONS ON LEAVING RECOVERY:

PATIENT RESPONDS TO STIMULUS ✓
PATIENT RESPONDS TO SPEECH ✓
PATIENT UNDERSTANDS SIMPLE COMMANDS
PATIENT IS PAIN FREE ✓

TIME LEFT RECOVERY 1010

SPECIAL INSTRUCTIONS/COMMENTS:

1. Analgesia - Karvex

NURSE SIGNATURE: .....

Endoscopy Department, The Ayr Hospital

BRONCHOSCOPY REPORT

Name:	**Lee JOHNSTONE (M)**	Address:	**12 Woodside Avenue**
Date of birth:	**09/02/1976**		**Kirkmichael**
CHI No:	**0902763334**		**Maybole**
Case note no.:	**0902763334**		**AyrshireKA19 7PP**

GP: **Drs Wilson & Partners**
The Surgery, The Health Centre
6 High Street
Maybole
KA19 7BY

Procedure date: **26th June 2024**
Status: **Outpatient/NHS**
Hospital: **Ayr Hospital**
Referring Cons: **Dr Guhan (Medicine)**

Clinical details
RIGHT UPPER LOBE CAVITATING PNEUMONIA.

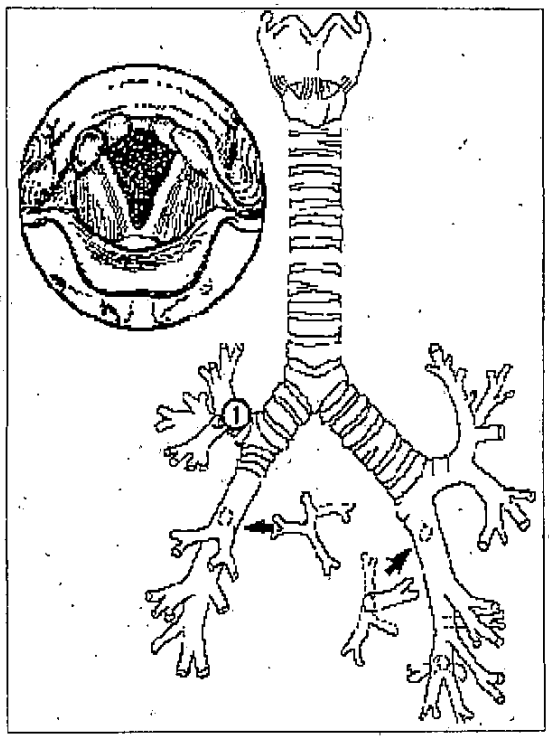
Indications
Suspected Tb.

Consultant/Endoscopist
Dr Anur Guhan
Dr S Dissanayaka
Amanda Hosein

Instrument
2100333 via mouth

Report
Site 1: Right upper lobe bronchus
Descriptions:
Excessive secretions: purulent
Notes:
Well tolerated procedure. No endobronchial abnormalities. Some purulent looking secretions noted in RUL bronchus. Washings taken for Microbiology including AAFB and culture.as well as for cytology
Normal bronchoscopy

Sedation and anaesthesia
Midazolam (IV) 4 mgs
Lido\Lignocaine spray was used
Lido\Lignocaine 1% to larynx via scope 16 mls
Nasal cannulae 4 L min-1



Dr Anur Guhan

Endoscopy Department, The Ayr Hospital

BRONCHOSCOPY REPORT

Name:	**Lee JOHNSTONE (M)**	Address:	**12 Woodside Avenue**
Date of birth:	**09/02/1976**		**Kirkmichael**
CHI No:	**0902763334**		**Maybole**
Case note no.:	**0902763334**		**AyrshireKA19 7PP**

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KA19 7BY

Procedure date: **26th June 2024**
Status: **Outpatient/NHS**
Hospital: **Ayr Hospital**
Referring Cons: **Dr Guhan (Medicine)**

Clinical details
RIGHT UPPER LOBE CAVITATING PNEUMONIA.

Consultant/Endosc
Dr Anur
Dr S Dissar
Amanda

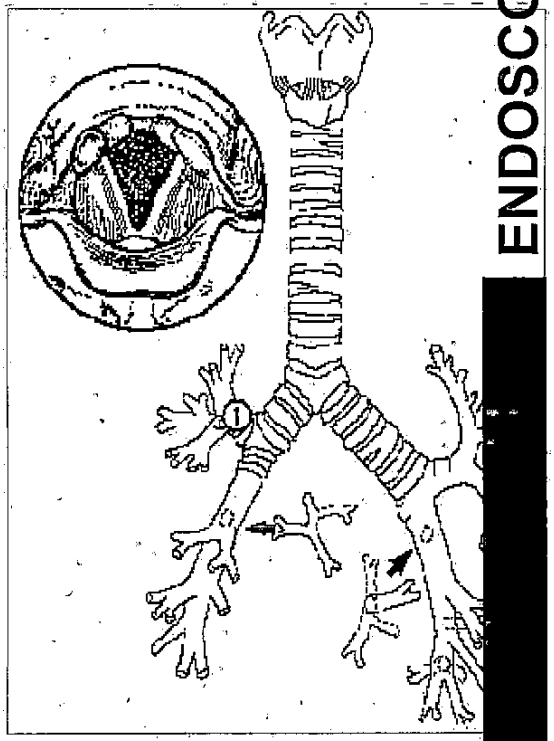
Indications
Suspected Tb.

Instrument
2100333 via m

Report

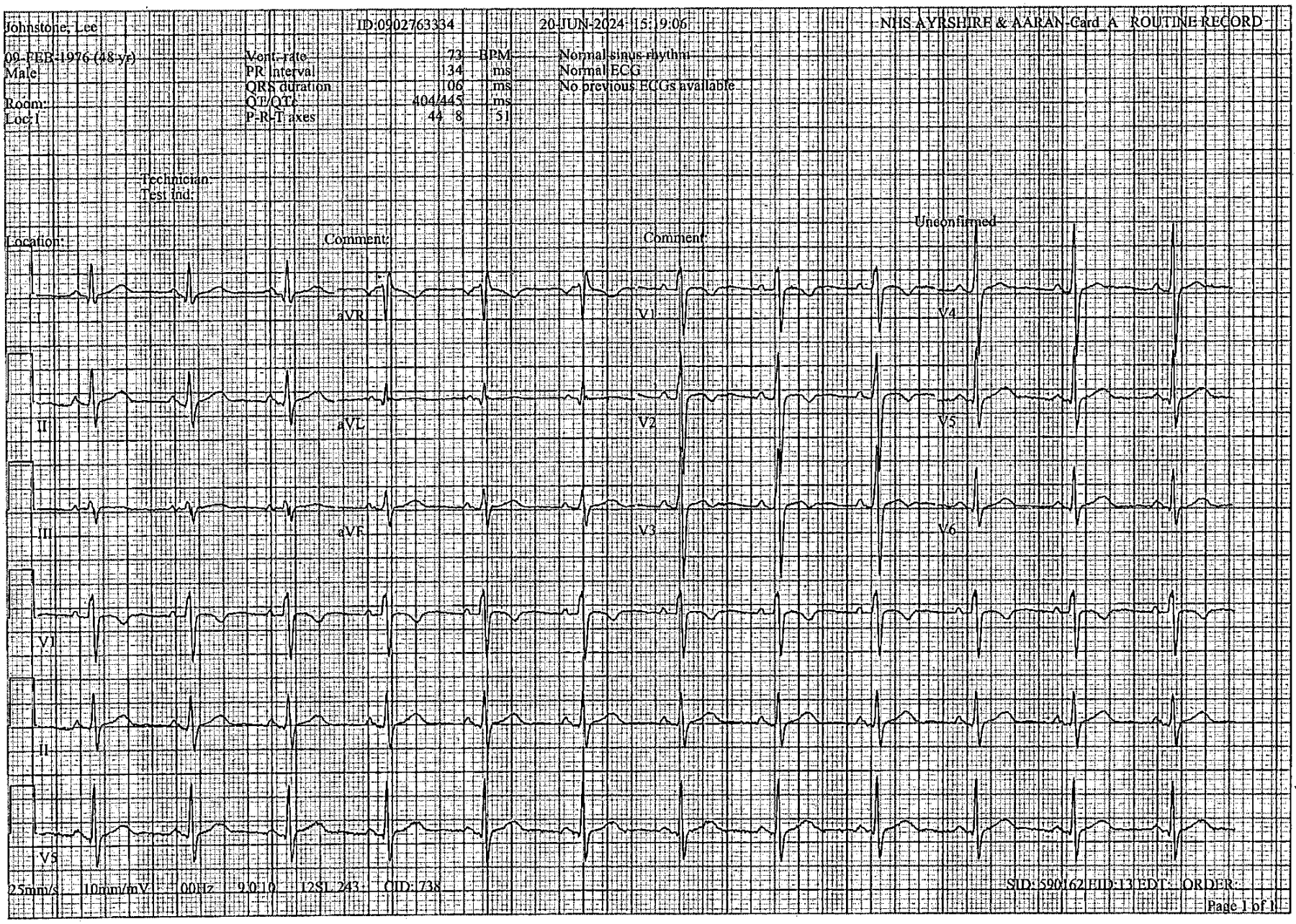
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Site 1: Right upper lobe bronchus
Descriptions:
Excessive secretions: purulent
Notes:
Well tolerated procedure. No endobronchial abnormalities. Some purulent looking secretions noted in RUL bronchus. Washings taken for Microbiology including AAFB and culture as well as for cytology
Normal bronchoscopy



ENDOSCOPY SUITE

Dr Anur Guhan


Johnstone, Lee
ID:0902763334
20-JUN-2024 15:19:06
NHS AYRSHIRE & ARAN Card A ROUTINE RECORD
09-FEB-1976 (48 yr)
Male
Room:
Loc:I
Vent. rate 73 BPM
PR interval 134 ms
QRS duration 106 ms
QT/QTc 404/445 ms
P-R-T axes 44 8 51
Normal sinus rhythm
Normal ECG
No previous ECGs available
Technician:
Test ind:
Location:
Comment:
Comment:
Unconfirmed
I
II
III
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6
V1
II
V5
25mm/s 10mm/mV 00Hz 9.0.10 I2SL 243 CID: 738
SID: 590162 EID: 13 EDT ORDER:
Page 1 of 1

NON GYNAE CYTOLOGY

Patient ID	0902763334:OHCP	**Patient Name**	JOHNSTONE, Lee
Sex	Male	**Date Of Birth**	09-Feb-1976
Responsible Doctor	Dr Anur Guhan	**Observation Date**	26-Jun-2024 10:00
Hospital	Ayr Hosp Station 8	**Modified**	26-Jun-2024 10:00
Document Status	Final		

Non Gynae Report Final

CLINICAL HISTORY

RUL shadow? Malignancy.

MACROSCOPY

'Bronchial Wash from RUL: 8 ml colourless/cloudy yellow fluid is received. (A). A cell block has been prepared and subsequently processed as specimen B.

MICROSCOPY (A and B)

Microscopy of the ThinPrep (specimen A) shows a cellular specimen with numerous background squames and thick clusters of possible inflammatory cells. Scattered respiratory epithelial cells present. Given the amount of inflammation the changes in the cells has been considered of reactive nature. Microscopy of the cell block (specimen B) shows a degenerated specimen comprising of inflammatory cells with focal bacterial colonies.

No viable epithelial element identified in immunocytochemistry with AE1/3.
No organisms identified in Gram stain.
No fungi identified in Periodic Acid-Schiff diastase stain.

The cytological features are in keeping with inflammation . Please correlate with microbiology. The absence of any viable epithelial element no further cytological assessment possible in this specimen.

Reporting pathologist 1 Final

Dr A Mukhopadhyay

Authorised by: Final

05/07/2024 17:11 Arunima Mukhopadhyay

XR Chest

Patient ID	0902763334:OHCP	**Patient Name**	JOHNSTONE, Lee
Sex	Male	**Date Of Birth**	09-Feb-1976
Performed	10-Oct-2024 15:14	**Order Number**	A105113581301
Ordering Provider	Dr Anur Guhan	**Status**	Final

General

Final

: Patient Name: Lee, Johnstone
: Patient Address: 12 WOODSIDE AVENUE, KA19 7PP
: DOB: 09/02/1976
: Patient ID: 0902763334
: Accession Number: A105113581301
: Referring Cons: Anur Guhan (Cons)
: Referring Dept: Ayr Suite G
: Visit Type: OP
: Site: University Hospital Ayr

: 51135813 10/10/2024 XR Chest

: –

: Clinical Indications
: Previous pneumonia with consolidation on CXR, repeat film to ensure resolving changes

: Report

: Comparison is made with previous x-ray dated 02/07/2024.

: The previously noted right apical consolidation has significantly improved, however there is still a small area of apical opacification/residual atelectasis.

: Cardiomediastinal contours are within normal limits. The pleural spaces remain clear. Visualised bony thorax appears intact.

: Hewitt, Lorna (Reporting Radiographer, RA71218)

: Reported by: Lorna Hewitt (Radiographer)
Reported By: Lorna Hewitt
Released By: Lorna Hewitt

XR Chest

Patient ID	0902763334:OHCP	**Patient Name**	JOHNSTONE, Lee
Sex	Male	**Date Of Birth**	09-Feb-1976
Performed	02-Jul-2024 14:21	**Order Number**	A105104709201
Ordering Provider	Dr Anur Guhan	**Status**	Final

General

Final

: Patient Name: Lee, Johnstone
: Patient Address: 12 WOODSIDE AVENUE, KA19 7PP
: DOB: 09/02/1976
: Patient ID: 0902763334
: Accession Number: A105104709201
: Referring Cons: Anur Guhan (Cons)
: Referring Dept: Ayr Station 12 (OP Area)
: Visit Type: IP
: Site: University Hospital Ayr

: 51047092 02/07/2024 XR Chest

: Clinical Indications
: Cavitating RUZ consolidation - TB suspected but not proven- Soutum and Bronchial wash negative for AAFB. Improved with IV levofloxacin that was started in the CAU prior to shift to station 8. Levoflox has mycobacterial cover- so there remains the possibiloity of partial treatment - CXR today for interime assessment pleas

: Report
: When compared to 20/06/24, there has been some improvement in the right apical consolidation though this has not fully resolved.

: Henderson, S (Con Radiologist 7039117)

: Reported by: Dr Steven Henderson (Radiologist)
Reported By:Steven Henderson
Released By:Steven Henderson

CT Chest

Patient ID	0902763334:OHCP	**Patient Name**	JOHNSTONE, Lee
Sex	Male	**Date Of Birth**	09-Feb-1976
Performed	24-Jun-2024 10:18	**Order Number**	A105103980101
Ordering Provider	Haider (Cons)	**Status**	Final

General

Final

: Patient Name: Lee, Johnstone
: Patient Address: 12 WOODSIDE AVENUE, KA19 7PP
: DOB: 09/02/1976
: Patient ID: 0902763334
: Accession Number: A105103980101
: Referring Cons: Syed Nayab Haider (Cons)
: Referring Dept: Ayr CAU (IP)
: Visit Type: IP
: Site: University Hospital Ayr

: 51039801 24/06/2024 CT Chest Contrast
: –

: Clinical Indications
: Urgent CT Chest. NMR 9. On behalf of Dr Haider. Pt presents with right upper lobe pneumonia. Wheeze. Dyspnoea. Ex smoker, heroin use. CT chest to assess for malignancy please.

: Report

: Portal venous acquisition. Reference is made to our previous radiograph performed on 20/06/2024.

: Dense consolidation demonstrated within the right upper lobe. Areas of lower attenuation with locules of gas predominantly demonstrated at the apical regions of this consolidation may suggest developing cavitation.

: No further consolidative changes demonstrated throughout the remaining lungs.

: Minor centrilobular emphysema with apical predominance.

: No size-significant intrathoracic nodules. Mildly prominent subcentimetre lymph nodes demonstrated within the mediastinum is likely reactive to right upper lobe consolidation.

: Minor coronary artery calcification.

: Likely simple liver cyst. Simple renal cyst within the left kidney.

: Otherwise, normal appearance to the partially visualised upper abdominal organs.

CT Chest

Patient ID	0902763334:OHCP	**Patient Name**	JOHNSTONE, Lee
Sex	Male	**Date Of Birth**	09-Feb-1976
Performed	24-Jun-2024 10:18	**Order Number**	A105103980101
Ordering Provider	Haider (Cons)	**Status**	Final

:
: Minor degenerative changes of spine. No aggressive lytic bony lesion demonstrated.
:
:
:
: Opinion:
:
: Dense consolidation demonstrated in the right upper lobe with features of early cavitation. No convincing evidence of malignancy. There is likely to be significant ongoing lung injury in the context of cavitation. CT follow-up to exclude underlying tumour in 2-3 months would seem wise.
:
:
: Kwek, Adriel Ju Wen (Rad.Registrar, 7597317)
:
: Reported by: Adriel Kwek (Reg) (Registrar), Iain Cameron (Radiologist)
Reported By:Adriel Kwek (Reg)
Released By:Iain Cameron

US Abdomen

Patient ID	0902763334:OHCP	**Patient Name**	JOHNSTONE, Lee
Sex	Male	**Date Of Birth**	09-Feb-1976
Performed	21-Jun-2024 14:54	**Order Number**	A105103868101
Ordering Provider	Shafqat (Cons)	**Status**	Final

General

Final

: Patient Name: Lee, Johnstone
: Patient Address: 12 WOODSIDE AVENUE, KA19 7PP
: DOB: 09/02/1976
: Patient ID: 0902763334
: Accession Number: A105103868101
: Referring Cons: Muhammad Shafqat (Cons)
: Referring Dept: Ayr CAU (Pre-Arrivals)
: Visit Type: IP
: Site: University Hospital Ayr

: 51038681 21/06/2024 US Abdomen

: Clinical Indications
: NMR9 TR on behalf of Dr Shafqat: Presents with (R) atypical pneumonia. Derranged LFTs and rash. Need US to assess liver parenchymal

: Report

: The liver, galbladder, biliary tree, right kidney and spleen appear normal.

: There is a 21mm simple medullary cyst within the left kidney.

: The pancreas and aorta were obscured therefore not examined.

: No free fluid.

: Connelly, K (Sonographer RA48026)

: Reported by: Karen Connelly (Reporting Sonographer)
Reported By:Karen Connelly
Released By:Karen Connelly

Patient ID	0902763334:OHCP	**Patient Name**	JOHNSTONE, Lee
Sex	Male	**Date Of Birth**	09-Feb-1976
Performed	02-Nov-2014 14:53	**Order Number**	A103291747501
Ordering Provider	Cooper.S (Con Radiologist)	**Status**	Final

MR Final

: 02 November 2014, 14:53:00
: 02 November 2014, 15:30:00
:
: RADIOLOGY REPORT
: CHI NUMBER: 0902763334 Examination Number: 32917475 Examination Date: 02/11/2014
: Name: JOHNSTONE, LEE DOB: 09/02/1976
: Address: 12 WOODSIDE AVENUE, MAYBOLE, KIRKMICHAEL, KA19 7PP -- CC: -
: Referring Department / Location: AYR SUITE H
:
:
:
:
:
: Referring Consultant: Dearing.Jon
: Date Dictated: 03/11/2014 Typed by: None
: Examination: MRI Knee Rt
:
: Clinical Indication
:
: tWISTING INJURY TO RIGHT KNEE ON STATIONARY FOOT
: ? ACL RUPTURE
: ?MCL TEAR
: ?MEDIAL MENISCAL INJURY
:
:
: Report:
: The anterior cruciate ligament and the medial collateral ligament are both intact with no abnormality identified.
: There is a small cleft in the cortex of the weight bearing articular surface of the medial femoral condyle with irregularity of both the overlying articular cartilage and the superior articular surface of the posterior horn of the medial meniscus. This appears longstanding and may even be congenital.
: The medial meniscus and the lateral meniscus appear otherwise normal.
: The posterior cruciate the lateral collateral ligaments and patellar tendon appear normal.
: No other osteochondral or soft tissue abnormality identified.
:
:
: Dictating Radiologist / Clinical Specialist Cooper.S (Con Radiologist)
:
: Verified by: Cooper.S (Con Radiologist)
Reported By: Cooper.S (Con Radiologist)
Released By: Cooper.S (Con Radiologist)
Released On: 03/11/2014 14:42

Department of Radiology

UNIVERSITY HOSPITAL AYR
Medical Imaging Department
Dalmellington Road
AYR
KA6 6DX

NHS Ayrshire & Arran

544212
c/f

RADIOLOGY REPORT

CHI NUMBER: 0902763334 **Examination Number:** 32670887 **Examination Date: 30/04/2014**

Name: Johnstone, Lee DOB: 09/02/1976

Address: 12 Woodside Avenue, , Maybole, KA19 7PP -- **CC:** -

Referring Department / Location: Ayr A&E

Referring Consultant: Stevenson.Alastair

Date Dictated: 06/05/2014 **Typed by:** (Medica) Dr Peter Holland

Examination: XR Chest

Clinical Indication

post intubation. NG tube. check position. ?aspiration

Report:

The ETT and nasogastric tube both satisfactory positions.

Normal heart size. The hilar and mediastinal outlines are within normal limits. There is no focal active lung pathology

Dictating Radiologist / Clinical Specialist **(Medica) Dr Peter Holland**

Verified by: (Medica) Dr Peter Holland

SCAN		REVIEW	
DATE RECEIVED IN A & E			
-7 MAY 2014			
MED STAFF ACTION	TO WARD (9)	RECALL	SCAN

741111

The Ayr Hospital
Medical Imaging Department
Dalmellington Road
Ayr
KA6 6DX

NHS Ayrshire & Arran

RADIOLOGY REPORT

CHI NUMBER: 0902763334 **Examination Number:** 31024941 **Examination Date:** 27/11/2010
Name: JOHNSTONE, LEE **DOB:** 09/02/1976
Address: 12 WOODSIDE AVENUE, MAYBOLE, KIRKMICHAEL, KA19 7PP -- **CC:** -
Referring Department / Location: Ayr A&E

Referring Consultant: Muir.Robbie

Date Dictated: 30/11/2010 **Typed by:** Dr D Horton

Examination: XR Chest, XR Abdomen

Clinical Indication:

abdominal hernia repair 14months ago. now presented with severe epigastric pain with nausea. peritonitic on examination in epigastrium.

Report:

Chest:

Heart size and mediastinal contours are within normal limits, allowing for respiratory phase. Lungs are clear of active disease. There is probably eventration of the right hemidiaphragm. No free gas under the diaphragm.

Abdomen:

Bowel gas pattern is unremarkable. No obstruction or perforation.

Dictating Radiologist / Clinical Specialist **Dr D Horton (Medica)**

Verified by: Dr D Horton (Medica)

Department of Radiology

The Ayr Hospital
Medical Imaging Department
Dalmellington Road
Ayr
KA6 6DX

NHS Ayrshire & Arran

544212

OL

Bleeches 21/10

RADIOLOGY REPORT

CHI NUMBER: 0902763334 **Examination Number:** 30974430 **Examination Date:** 15/10/2010

Name: **JOHNSTONE, LEE DOB: 09/02/1976**

Address: 12 WOODSIDE AVENUE, MAYBOLE, KIRKMICHAEL, KA19 7PP -- **CC:** -

Referring Department / Location: Ayr A&E

Referring Consultant: Learmonth.Sarah

Date Dictated: 18/10/2010 **Typed by:** DR A Katti (Medica0

Examination: XR Chest

Clinical Indication:

Pleuritic L.sided chest pain, recent travel, cough with black sputum.

Report:
Xray Chest:

No active lung pathology noted. Normal cardiac and mediastinal contour.

Dictating Radiologist / Clinical Specialist **Dr A Katti (Medica0**

Verified by: Dr A Katti (Medica0

SR 20/10

19 OCT 2010

CHI NUMBER: 0902763334 **Examination Number:** 30974430 **Examination Date:** 15/10/2010
Name: **LEE JOHNSTONE** **DOB:** 09/02/1976
0902763334

A1005446212

MR WALLACE
DIL 19-8-09

Department of Radiology

The Ayr Hospital
Medical Imaging Department
Dalmellington Road
Ayr
KA6 6DX

NHS
Ayrshire & Arran

RADIOLOGY REPORT

CHI NUMBER: 0902763334 **Examination Number:** 30488470 **Examination Date:** 16/08/2009

Name: JOHNSTONE, LEE DOB: 09/02/1976

Address: 16 MINNOCH CRESCENT, , MAYBOLE, KA198DW -- **CC:** -

Referring Department / Location: AYR STATION 2

Referring Consultant: Wallace.David

Date Dictated: 18/08/2009 **Typed by:** Dr D Horton

Examination: XR Abdomen

Clinical Indication:

Know epigastric hernia. Now tenderness ++++ and associated nausea.

Report:

Abdomen:

Bowel gas pattern unremarkable. No obstruction or perforation.

Dictating Radiologist / Clinical Specialist . Dr D Horton (Medica)

Verified by: Dr D Horton (Medica)

CHI NUMBER: 0902763334 **Examination Number:** 30488470 **Examination Date:** 16/08/2009
Name: LEE JOHNSTONE DOB: 09/02/1976
0902763334

RADIOLOGY

STA0169

14	F	ELOW
13	F	ELOW
12	F	ELOW
11	P	ELOW
10	P	ELOW
9	P	ELOW
8	P	ELOW
7	P	ELOW
6	P	ELOW
5	P	ELOW
4	P	ELOW
3	P	ELOW
2	P	ELOW

RADIOLOGY REPORT

Name: JOHNSTONE,LEE
16 MINNOCH CRESCENT ,
MAYBOLE
Sex: M DOB: 09/02/76
Location: OPG
Unit #: A100544212 CHI 0902763334

Ayr Hospital

Current Cons: SHANKS,E.M.
Requesting Dr: SHANKS,E.M.
CROSSHOUSE HOS
Exam Date/Time: 08/10/07 1436

Chk-in #	Order	Code	Exam
961176	0001	2690	US Neck

Examination performed and reported by Ultrasonographer.

HISTORY: ?Recurrence of thyroglosal cyst.

The patient was unable to palpate a lump today.
No cystic area or other abnormality demonstrated in the region demonstrated by the patient.

Reported By: Laura McGibbon

Typed By: SB 10/10/07 1239

✓ EMS
For Clin appt
✓ NM 26/11/07

AYRSHIRE and ARRAN ACUTE HOSPITALS NHS TRUST

PATHOLOGY DEPARTMENT - CROSSHOUSE HOSPITAL

HISTOPATHOLOGY REPORT

Laboratory No.: **P.07.017354**

Name:	LEE JOHNSTONE	Hospital No:	AY100544212	Date Taken:	01/11/2007
D.O.B.:	09/02/1976	Sender:	Mr I McMillan	Date Recvd:	02/11/2007
Patient ID:	0902763334	Source:	Ayr Hospital Day Surgery Unit		

CLINICAL HISTORY

Cinically sebaceous cyst from left thigh.

EXCISION LESION LEFT THIGH

A 25 x 8mm skin ellipse with underlying tissue up to 25mm, including a ruptured cyst with soft pale contents. The surface bears an eccentric depression, 2 x 2mm. On sectioning, there is a thin-walled cyst measuring 14mm maximum diameter.

MICROSCOPY REPORT:

Sections show skin with an underlying ruptured cyst. This contains keratin and is lined by keratinising squamous epithelium. The appearances are of an epidermoid cyst.

Reported By: **Dr E R Nairn**

Trimmed by: B.M.S. - Zoe Cole

Date Printed: **12/11/2007** MEN

This Report to: Mr I McMillan Ayr Hospital Day Surgery Unit

AYRSHIRE and ARRAN ACUTE HOSPITALS NHS TRUST

PATHOLOGY DEPARTMENT - CROSSHOUSE HOSPITAL

HISTOPATHOLOGY REPORT Laboratory No.: **P.99.015385**

NAME:	**LEE JOHNSTONE**	HOSPITAL NO:	**AY100544212**	DATE	**23/11/1999**
D.O.B.:	**09/02/1976**	SENDER:	**Mr G Stewart**	DATE RECVD:	**23/11/1999**
PATIENT NO:	**0902763334**	SOURCE:	**Ayr Hospital Station 2**		

? RECURRENT THYROGLOSSAL CYST

Irregular fragment of fibrous tissue 30 x 10 mm.

MICROSCOPY REPORT

Microscopy shows skin and associated subcutaneous tissue. There is a small dermal abscess and several small reactive lymph nodes. No sinus track is identified.
(ref 2831/98)

Taken in by: Pathologist - **Dr M R Adamson**

Reported By: **Dr M R Adamson** Date Printed: **26/11/1999**

This Report to: Mr G Stewart Ayr Hospital Station 2

AYRSHIRE and ARRAN ACUTE HOSPITALS NHS TRUST

PATHOLOGY DEPARTMENT - CROSSHOUSE HOSPITAL

HISTOPATHOLOGY REPORT Laboratory No.: **P.00.000013**

NAME:	LEE JOHNSTONE	HOSPITAL	AY100544212	DATE	03/01/2000
D.O.B. :	09/02/1976	SENDER:	Mr A L Forster	DATE RECVD:	04/01/2000
PATIENT NO:	0902763334	SOURCE:	Ayr Hospital Station 2		

APPENDIX

57mm inflamed appendix.

MICROSCOPY REPORT

Microscopy shows acute appendicitis with peritonitis.

Taken in by: M R Adamson

Reported By: Dr M R Adamson Date Printed: 05/01/2000

MEN

This Report to: Mr A L Forster Ayr Hospital Station 2

NHS
Ayrshire & Arran

CHI: 0902763334
Johnstone, Lee
12 WOODSIDE AVENUE
Maybole
KA19 7PP
09/02/1976
Dr M Barr
MRN: A100544212
Date of Birth

PATIENT PROFILE

Please complete below when patient is admitted or transferred to your clinical area

	Admission		Transfer 1		Transfer 2		Transfer 3	
Hospital	AYR		Ayr					
Ward	CAU		St8.					
Consultant	Dr Sword.		Dr Sword					
Date / Time	21/6/24	1545	26/6/24	0800				
Relative Informed	(Yes)	No	(Yes)	No	Yes	No	Yes	No
ID Band in situ	(Yes)	No	Yes	(No)	Yes	No	Yes	No
CRA Completed *	Yes	No	(Yes)	No	Yes	No	Yes	No
Completed By - Signature	Lewis							

The Patient Profile can be used for patients with ongoing regular treatment i.e. for a course of therapy or weekly blood transfusion, however if there is a gap of more than 6 weeks since last attendance update lifestyle assessment (P6)

*If the patient is readmitted or transferred between hospitals an additional MRSA/CRA (P 1 1 must be completed. Additional forms can be obtained from the infection control AthenA site.

This profile can also be used for readmission within 3 days. Please remember to review earlier risk assessments.

Patient's Property – Where possible send belongings home with family

You are asked to keep belongings/valuables to a minimum whilst in hospital. You are responsible for property belonging to you not handed over for safe custody. This includes cash, spectacles, hearing aids, dentures and other personal items and valuables. Valuables should be sent home at first opportunity or given to the nurse if this is not possible.

Signature of Patient / Significant Other:..... Date:.....

Property handed over for Safe Keeping: Yes ☐ No ☐

Date taken to Cashier: ..... Cash & Valuables Ref No:.....

Property handed over for safe keeping

PLACE VALUABLES STICKER HERE

Date Returned:

Personal Details

Prefers to be known as: Lee.	Age: 49
Receiving Consultant: Dr Sward	Allocated Consultant:
From where: ED	Accompanied by: nurse + mum.
Emergency ☐ Elective ☐	Patient Contact Number:
Occupation: unemployed.	

Reason for Admission: feeling unwell sudden onset of facial oedema/ widespread rash to body. Scrotum oedamous.

Patient and/or Carers Accounts

Next of Kin/First/Contact/Significant other		Second contact/significant other	
Name: Georgie Jonstone		Name:	
Address:		Address:	
Relationship to patient:	mum.	Relationship to patient:	
Contact No(s) Home:		Contact No(s) Home:	
Mobile:	07826 589742.	Mobile:	
Aware of Admission	Yes ☑ No ☐	Aware of Admission	Yes ☐ No ☐
Contact Overnight	Yes ☑ No ☐	Contact Overnight	Yes ☐ No ☐

Patient gives consent to share information with whom?

Spiritual or religious needs

Do you have any spiritual or religious needs whilst in hospital? (please state) Yes ☐ No ☑	Specify needs or cultural practices that place limitations on the patients care (please state)
Do you wish your details to be passed to the hospital chaplaincy service? Yes ☐ No ☑	

Home Circumstances on admission

Do you live alone?	Yes ☐ No ☑	**Living arrangements**	
With dependent partner?	Yes ☐ No ☑	Type of house	T ↓ stairs
With independent partner/family?	Yes ☑ No ☐	Sheltered Housing	Yes ☐ No ☐
Do you have a carer?	Yes ☐ No ☑	How many steps at entrance?	1
Family ☐ Private ☐ Local Authority ☐		How many stairs inside?	13
Does carer require additional support? (Consider referral to social work)	Yes ☐ No ☑	Toilet	Upstairs ☐ Downstairs ☑
		Bedrooms	Upstairs ☑ Downstairs ☐
		Bannister	Yes ☑ No ☐

Personal Details

Are you a carer? Yes ☐ No ☑ Please specify Children ☐ Elderly relative ☐ Other ☐ ....
Who is caring for them currently?

Family	☐	Social Worker	☐	Neighbour	☐	Nursing Home	☐
Respite Centre	☐	Other ☐					

Community Services in use:		Frequency	Informed of Admission	Informed by/Comments
Home Care provided	Yes ☐ No ☑		Yes ☐ No ☐	
Community Alarm	Yes ☐ No ☑		Yes ☐ No ☐	
Day Hospital	Yes ☐ No ☑		Yes ☐ No ☐	
Community Nurse	Yes ☑ No ☐	monthly inject	Yes ☐ No ☐	
Community Mental Health Nurse	Yes ☐ No ☑		Yes ☐ No ☐	
Learning Disability Nurse	Yes ☐ No ☑		Yes ☐ No ☐	
Visited by Specialist Nurse	Yes ☐ No ☑		Yes ☐ No ☐	Please specify
Does the patient have an ACP?	Yes ☐ No ☑	Ensure it is visible in notes		

Previous Medical History

Details	Dates
Rt Bundle Branch Block	
Asthma	
Guillain-Barre Syndrome	
Behavioural problems	
Accidental drug overdose/other poisoning	
Heroin dependence - on buvidal injection	

Medications

Is the patient prescribed regular medications?	Yes ☐ No ☐	Have they brought them in?	Yes ☐ No ☐
Retained in the ward?	Yes ☐ No ☐	Given to relatives?	Yes ☐ No ☐

Is patient on any high risk medications? Please tick the box below

Epilepsy	Asthma	Insulin	Anticoagulation	Controlled drugs	Any others note below

Pre-Admission Status Independent ☐ Prompting required ☐ Assistance required ☐

Drug Allergies	**Other Allergies/including food** None Known ☐
~~Known~~: citalopram.	none.

Informed Consent and Capacity

While undertaking the patient's clinical assessment, if you have any concerns regarding the patient's capacity and ability to make healthcare decisions refer to medical staff for **assessment and treatment plan** under the Adults With Incapacity (Scotland) Act 2000 and document your actions within the nursing notes. Refer to the Consent policy for further guidance.

Relatives and carers cannot make decisions for patients except in certain circumstances where they hold Welfare Guardianship or Power of Attorney extending to health care decisions under the Adults With Incapacity (Scotland) Act 2000.

Advanced Statement	Yes ☐ No ☑	Guardianship details	Yes ☐ No ☐	Please note name
Power of Attorney details	Yes ☐ No ☑	Financial ☐ Please note name	Welfare ☐ Please note name	
"Getting to know me" in use	Yes ☐ No ☑	If yes to any of the above obtain a copy of the relevant document		

Adult Support and Protection – 3 point criteria **Please see ASP toolkit**

If you have a concern about an adult who you believe is or may be at risk of harm complete an ASP/Concern referral. **ASP / Concern referral submitted Yes ☐ No ☐ Date** _____

Referral information can be found on ward ASP folder or AthenA Adult Support and Protection site

4AT		Circle score		
To be completed on all patients over 65 or if appropriate or if the patient has suspected delirium Ask the patient the following questions: (4AT)		1st Assess Date	2nd Assess Date	3rd Assess Date
Alertness	Normal (fully alert, but not agitated, throughout assessment)	0	0	0
	Mild Sleepiness for< 10 seconds after waking then normal	0	0	0
	Clearly abnormal	4	4	4
AMT4	Age, Date of Birth, place (name of the hospital or building) , current year			
	No mistake	0	0	0
	1 mistake	1	1	1
	2 mistakes or untestable	2	2	2
Attention	Instruct patient to list months in reverse order starting at December			
	Lists 7> correctly	0	0	0
	Starts but lists <7 or refuses to start	1	1	1
	Untestable (cannot start became unwell, drowsy or inattentive)	2	2	2
Acute Change or fluctuating course	evidence of significant change or fluctuation in mental status within the last 2 weeks and still persisting in the last 24 hours			
	No	0	0	0
	Yes	4	4	4
	Total			
	Sign			

If 4AT > 4 commence TIME bundle. **Please reassess if there is a change in clinical condition.**

If no 4AT carried out please state reason here..... < 65 yrs .....

Driving Status	Do you Drive? Yes ☑ No ☐	
Alcohol Use	Units per week 0	
	Suitable for alcohol brief intervention?	Yes ☐ No ☑ NA ☐
	Currently in Treatment	Yes ☐ No ☑ NA ☐
	Refer to alcohol liaison team?	Yes ☐ No ☑ NA ☐
Substance misuse	Substance misuse issues? If yes, give details: None.	Yes ☐ No ☑ NA ☐
	Currently in treatment	Yes ☐ No ☑ NA ☐
	Refer to substance misuse	Yes ☐ No ☑ NA ☐

Personal Details

Lifestyle Assessments

Communicating : **Interpreter required** Yes ☐ No ☐

Any specific needs	What's your normal?	How is it now?	Comments
Speaking	no issues	no change	
Reading	reading glasses	no change	
Writing	no issues	no change	
Vision (please specify if glasses/contact lenses are worn)	reading glasses	no change	
Hearing (please specify if hearing aids are worn and if in patient possession)	no issues	no change	

Breathing	What's your normal?	How is it now?	Do you suspect the patient has a respiratory infection? isolate with appropriate precautions and refer to IPC site on Athena
Do you normally have any issues breathing?	no issues	SOB	

Equipment / aids - tick all that apply:
Inhalers ☐ oxygen-concentrator ☐ cylinder ☐ nebulisers ☐ tracheostomy ☐

Do you smoke? Yes ☐ No ☐ If so how many? .....

Patient wishes nicotine replacement therapy? Yes ☐ No ☐

Refer All smokers to **"Quit your way"** for discussion about smoking management whilst in hospital (Ask patients permission) Date referred..... sign.....

Mobility	What is your normal?	How is it now?	Comments
Bed Transfers	indep	AO1	
Chair Transfers	indep	AO1	
Balance	indep. no issues	unsteady	
Walking Any issues with foot health affecting mobility	indep.	AO1	

Oral Care

If the answer to any of the questions below is **'yes'**, please complete an Oral Hygiene Care Plan

Does the patient need assistance carrying out their basic oral care?	Yes ☐ No ☑
Does the patient need assistance in caring for their denture?	Yes ☐ No ☑
Is the patient suffering from mouth pain?	Yes ☐ No ☑

Comments

Lifestyle Assessments continued

Eating and Drinking		If yes what support is required?
Support required for eating/drinking	Yes ☐ No ☑	
Equipment required to support eating/drinking **Please state what equipment required**	Yes ☐ No ☑	
Is Patient on nutritional supplements / enteral feed at home Yes ☐ No ☐		Type: ↓ appetite.
Likes: not fussy Dislikes: fish		Modified fluid consistency Level: N
		Modified diet consistency Level: N
Swallowing ability impaired Yes* ☐ No ☑ *If Yes, date referred to SLT: Name of referrer: Signature of referrer:		Consent to therapeutic diet (Cultural, ethnic, religious requirements) Yes ☐ No ☑
		Therapeutic diet details:

Eliminating	What is your normal	How is it now?	Do you suspect the patient has infective diarrhoea? Send a sample and isolate patient.
Normal bowel habit. When did your bowels last move?	no issues. 19/6/24.	no change	
Any problems passing urine?	no issues.	no change	

Does the patient have a urinary catheter in situ Yes ☐ No ☑ Date of catheter insertion.....

Long term catheter Yes ☐ No ☑ Date due changed

If yes, apply the Catheter Care Bundle

Complete continence assessment if required ☐
Refer to Adult Continence Assessment Pathway algorithm

Urinalysis Results. Please circle where appropriate

NAD ☐	Protein Trace + ++ +++ ++++	Blood Trace + ++ +++	Glucose Trace + ++ +++ ++++	Leucocytes + ++ +++	Nitrates -ve +ve

Only send for culture if suspected;

UTI ☐ **Sepsis** ☐ **MSSU Sent** ☐ **CSU Sent** ☐

Date Last Menstrual Period (if appropriate) Pregnancy Test (if appropriate) +ve ☐ - ve ☐

Glucometer reading result

Personal Cleansing and Dressing	What is your normal	How is it now?	Comments
What type of assistance is required by the patient? **(please consider patient preferences)**	Indep.	Indep.	

Person Centred Care:

To promote person-centred care our focus is changing from asking 'What's the matter with you "' to asking "What matters to you'.

We can do this by reliably covering the five 'Must do with me' elements of care with patients and/or their families and carers. This will help to ensure all of the interactions between people using our services and the staff delivering them is person-centred and are characterised by listening, dignity, compassion and respect.

The information required for the following 5 Must Do questions can be captured during your conversations with the patient and their families. There may be no need for you to ask these questions directly but gather that information during the admission process and record below

'MUST DO WITH ME'

1 What matters to you?

Your personal goals and the things that are important to you have been discussed and form the basis of your care or treatment.

Getting home

2 Who matters to you?

We have asked you about the people that matter most in your life and we have given you the opportunity to involve them in the way that you choose

Family

3 What information do you need?

We have provided you with understandable full information and supported you to make decisions that take account of your personal goals and the things that are important to you.

Keep me informed

4 Nothing about me without me.

You will always be given the opportunity to be involved in discussions. All information exchanges and communication between professionals or between different services or supports are transparent and always provide you with the opportunity either to be present or to contribute to the process.

5 Personalised contact

Multi – Disciplinary Discharge Plan (Continued)

Referrals for support when patient goes home			
	Date of referral	Initials	Comments
Intermediate Care Team			
Dietician			
SLT			
Physio			
OT			
Community Nurse			
Podiatry			
Other			

Please share discharge plan on transfer

Signature of transferring nurse.....

Signature of receiving nurse.....

Date.....

Please use the following section to record all further discharge planning information.

Date	Time	All Care and communication relating to Discharge	Initials
27/6/24	–	own transport.	
		Medications ✓	
		Cannula removed	
		to attend MDU on Tuesday at	
		1pm ——— CSyms	

Infection Prevention and Control Clinical Risk Assessment (CRA): Multi-Drug Resistant Organism (MDRO Admission Screening)

Hospital + Ward/Dept: 8

Admission date: 26/6/17 Time: 1105

CPE Clinical Risk Assessment (on admission)

Date of Screen:_____ Time:_____ Print Name:_____ (Staff Member)

		(Y/N)
1.	**Patient has history of CPE colonisation or infection at any time in the past** (confirm by checking PMS for ALERTS and confirm by asking the patient if there is no record on system)	N
2.	**In the past 12 months** (this will most often require asking the patient): • **Patient has been an inpatient outside Scotland** • **Patient has received holiday dialysis outside Scotland** • **Patient has been close contact of someone with CPE**	N N N

If **YES**, patient should be managed as a CPE positive case + **must** be placed in a single room, and the case discussed with IPCT

If **YES**, to any, patient is at increased risk of CPE colonisation, + **must** be placed in a single room and the case discussed with IPCT

Discussed with patient and provided information leaflet ☐

1. PATIENT PLACEMENT (Single Room)

Date_____ Signature_____

AND

2. SAMPLES FOR TESTING (refer to CPE policy)

Rectal swab (or stool sample) ☐
AND
Wound swab, if present ☐
AND
Invasive device site swab, if present (exc urinary catheter site) ☐
AND
CSU if catheterised ☐

Date_____ Signature_____

MRSA Clinical Risk Assessment

Date of Screen:_____ Time:_____ Signature:_____

		(Y/N)
1.	**Patient has history of MRSA colonisation or infection at any time in the past** (confirm by checking PMS for ALERTS and confirm by asking the patient if there is no record on the system)	N
2.	**Patient admitted from somewhere other than home e.g. another hospital, care home** (confirm by checking admission documentation / PMS)	N
3.	**Patient has wound / ulcer or invasive device present before admission** (may require physical inspection)	N

If **YES**, to any, patient is at increased risk of MRSA colonisation

If **NO** to all **AND** patient is in high impact speciality*

Discussed with patient and provided them with leaflet ☐

1. PATIENT PLACEMENT (refer to MRSA Policy)

Single Room ☐

If placement not possible as per policy, undertake risk assessment and document reasons below:

_____

_____

2. SAMPLES FOR TESTING

Nasal + perineal ☐
AND
Wound/skin break swab, if Present ☐
AND
Invasive device site swab, if present (exc urinary catheter site) ☐
AND
CSU if catheterised ☐

Date_____ Signature_____

**High impact specialties refers to:*
Intensive care, Orthopaedics, Renal Medicine, Vascular Surgery
Note: If the patient is transferred to UHC or UHA from any NHS A&A Hospital, an additional CRA must be carried out. Additional forms can be obtained from the IPC AthenA site.

If further advice is required contact the Infection Prevention & Control Team (ext 25765) or the on call Consultant Microbiologist (via switchboard)

Nutritional Screening Malnutrition Universal Screening Tool (MUST)

Food Fluid and Nutrition

Step 1 Measure height and weight to get a BMI score
Step 2 Note percentage unplanned weight loss and score
Step 3 Establish acute disease effect and score
Step 4 Add scored from steps 1, 2 and 3 together to obtain overall risk of malnutrition
Step 5 Commence the care plan appropriate to the risk category

Screening Results

Please indicate if measurements are Measured (M), Reported (R) or Estimated (E)
Please Refer to BMI graph on ward

Date	21·6·24				
Time	2200				
Ward	CAU				
Height in metres (M)or(R)or(E)	5ft 6 m (E)	m ( )			
Current weight in Kg (M)or(R)or(E)	78.1 Kg (M)	Kg ( )	Kg ( )	Kg ( )	Kg ( )
BMI	27.8				
Is patient within obese category?	NO				
Usual weight (Kg)	83.8 Kg (R)				
Signature	AM				
MUST					
Step 1: BMI Score >20 (>30 = Obese) 0 18.5 - 20 1 < 18.5 2	0				
Step 2: Weight Loss Score Unplanned weight loss in past 3-6 months. <5% 0 5 - 10% 1 >10% 2	0				
Step 3: Acute Disease Effect Score If patient is acutely ill **and** there has been or is likely to be no nutritional intake for>5 days Score 2..... Not applicable Score 0.....	0				
Step 4: Overall Risk of Malnutrition Total:	LOW				
Step 5:	[redacted]	1 = Medium Risk	[redacted]		

N.B. When completing step 2, always compare the most recent weight with the usual weight and not the previous week's weight.

PLEASE RECORD REASON FOR WEIGHTS NOT BEING RECORDED

Date	Reason	Initials

Malnutrition Universal Screening Tool

('MUST') Multidisciplinary Care Plan

(FFN)

Patient Problem	
Nutritional screening has identified the patient as being	Low ☐ **Medium** ☐ High ☐ risk of malnutrition
Patient identified as having other nutritional problems	e.g. obesity, chewing certain foods (please specify)

Goal
To meet patients nutritional and fluid requirements

Date	Time	Initial	Planned Nursing Interventions/Support	End Date	Initial
21/6	1620	KL	[redacted]		
			Assistance required (specify) e.g. helping, prompting, cutting up food, opening packets:-		
			Individual / therapeutic dietary requirements (specify) e.g. likes/dislikes religious/ethical/cultural:-		
			Modified eating equipment (specify) e.g. cutlery.		
			Assist patient to select appropriate meals from menu card.		
			Ensure fresh drinking water is offered regularly and available at all times, where clinically appropriate.		
			Consider patients positioning and support oral hygiene, if required.		
			Ensure patients nutritional needs recorded on nutrition board.		
			Monitoring and review care plan **repeat screening weekly** (Monthly continuing care).		
			This care plan has been discussed and agreed with the patient as appropriate.		
			Medium Risk Care Plan (complete low risk section also)		
			Commence food chart for a minimum of 3 days. Only discontinue if/when dietary intake is adequate.		
			If intake is insufficient, offer patient milk to drink with / and between meals and suitable additional snacks.		
			Record accurate fluid intake / output on fluid balance chart until established that oral intake is adequate. If intake per 24 hours is inadequate consider IV/SC fluids.		
			Provide "Food First" nutrition information leaflet to patient/carer/relative		
			RED TRAY Yes ☐ No ☐ **RED JUG** Yes ☐ No ☐		
			[redacted]		
			Refer to Dietitian, ensuring the MUST score is included.		
			Discontinue food chart only when advised by Dietitian.		
			Administer and monitor enteral feed via NG/PEG route as per local guidelines.		

Please record any Therapeutic/Special Diet/Fluids/Oral supplements

Diet / supplement	Date commenced	Comments	Date discontinued

If on oral nutritional supplements, please commence on supplement monitoring chart. Ensure dietary needs are reflected on the patient's bed board and ward nutritional information board.

Daily Preliminary Pressure Ulcer Risk Assessment (PPURA)

(unless full waterlow required)

Points to consider

- Use within 6 hours of admission to care area
- People who are overweight may not be well nourished
- Please sign after each check

Date 21/6/24 **Time** 1620		
Mobility		
Patient is fully mobile without equipment/assistance	Yes ☐ No ☑	
Continence		
Patient is fully continent	Yes ☑ No ☐	**If *No*, to any questions undertake Waterlow Assessment and apply SSKIN bundle as indicated.**
Nutrition		
Patient appears to be well nourished and able to eat and drink	Yes ☑ No ☐	
Skin		**If all answers Yes, complete a daily PPURA below.**
Skin is healthy and intact **Assess condition of skin, any wounds/lesions/stomas**	Yes ☑ No ☐	

Use daily if the person is identified to be "not at risk"

Mobility	Person is fully mobile without equipment/assistance
Continence	Person is fully continent
Nutrition	Person appears well nourished and able to eat and drink
Skin	Persons pressure areas are healthy, with no signs of redness, discolouration, including bruising or ulceration

Record your answer in the grid below **Y** – Yes or **N** – No
If the answer is **Yes** to all statements use this chart daily
If the answer is **No** to any questions undertake Waterlow Assessment and apply SSKIN bundle as indicated.

Date	Time	Mobility	Continence	Nutrition	Skin Inspected	Is a full pressure ulcer risk assessment required?	Signature
21/6/24	1620	N	Y	Y	Y	N	Kiera

Risk Assessment

N/M.

Adapted Waterlow Pressure Area – Risk Assessment

More than one score can be used in each section. Complete assessment according to PPURA or if there is a change in individuals condition. Reassess score as per protocol.

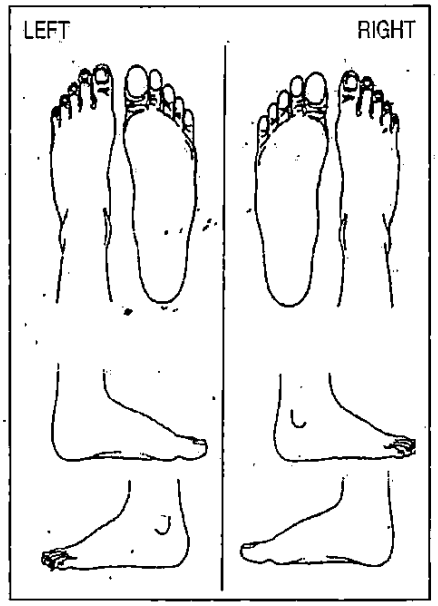
<10 Low Risk - Reassess weekly
15+ High Risk - Reassesson alternate days
10+ At Risk - Reassess twice weekly
20+ Very High Risk - Assess daily

	Date	20/6											
	Time	1500											
Sex													
Male 1 Female 2		1											
Age													
14 - 49	1	1											
50 - 64	2												
65 - 74	3												
75 - 80	4												
81+	5												
Build/Weight for Height (BMI=weight in Kg/height in m²)													
Average - BMI 20-24.9	0	0											
Above average - BMI 25-29.9	1												
Obese - BMI > 30	2												
Below average - BMI < 20	3												
Continence													
Complete/catheterised	0	0											
Urinary Incontinence	1												
Faecal incontinence	2												
Urinary and faecaly incontinent	3												
Skin Type - Visual Risks Area													
Healthy	0	0											
Tissue paper (thin/fragile)	1												
Dry (appears flaky)	1												
Oedamatous (puffy)	1												
Clammy (moist to touch) pyrexia	1												
Discoloured/Bruising/Grade 1	2												
Broken (established ulcer) Grade 2 - 4	3												
Mobility													
Fully mobile	0												
Restless/fidgety	1												
Apathetic (sedated/depressed/reluctant to move)	2	2											
Restricted (restricted by severe pain or disease)	3												
Bedbound (unconscious/unable to change position/traction)	4												
Chair bound (unable to leave chair without assistance)	5												
Nutritional Element													
Unplanned weight loss in past 3-6 months		0											
< 5% Score **0**, 5-10% Score **1**, >10% Score **2**	0-2												
BMI >20 Score **0**, BMI 18.5-20 Score **1**, BMI < 18.5 score2	0-2												
Patient/ client acutely ill or no nutritional intake > 5 days	2												
Special Risks - Tissue Malnutrition													
Multiple organ failure/terminal cachexia	8	0											
Single organ failure e.g. cardiac, renal, respiratory	5												
Peripheral vascular disease	5												
Anaemia = Hb < 8	2												
Smoking	1												
Special Risks - Neurological Deficit													
Diabetes/MS/CVA/motor/sensory/paraplegia *Max 6*	4-6	0											
Special Risks - Surgery/Trauma													
On table > 2 hours (up to 48 hours post op)	5	0											
On table for up to 6 hours (up to 48 hours post op) provided 5 the rate of recovery is normal)													
Orthopedic/below waist/spinal	8	0											
Special Risks – Medication													
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*													
	Total	4											
	Initials	CS											

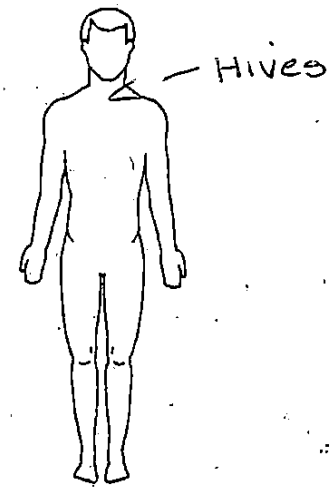
Pressure Ulcer Record

Indicate by circling, numbering and dating all pressure damage on diagrams, then complete box below.

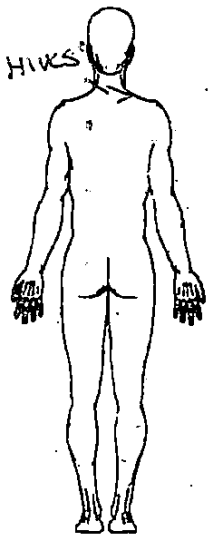
Initiate SSKIN care plan/wound assessment chart



Anterior view



Posterior view



Date	Number of Ulcer	Location of Ulcer	Grade of Ulcer	Datix – Insert reference (grade 2-4 and suspected deep tissue injury	Logged on Safety Cross (Grade 1-4)	Signature	Print Name

Scottish Adapted European Pressure Ulcer Advisory Panel (EDUAP)-Pressure Ulcer Grading Tool 2014

GRADE 1 Intact skin with non blanchable redness, usually over a bony prominence. Darker skin tones may not have visible blanching but the colour may differ from the surrounding skin. The area may be painful, firmer, softer, warmer or cooler than the surrounding tissue.

GRADE 2 Loss of epidermis/dermis presenting as a shallow open ulcer with red/pink wound bed without slough or bruising. May also present as a blister.

GRADE 3 Subcutaneous fat may be visible but bone tendon or muscle is not visible or palpable. Slough may be present but does not obscure the depth of tissue loss. Often includes undermining or tunnelling

GRADE 4 Extensive destruction with exposed or palpable bone, tendon or muscle. Slough may be present but does not obscure the depth of tissue loss. Often includes undermining or tunneling

DEEP TISSUE INJURY – Epidermis is intact but the area appears purple or maroon or is a blood filled blister over a dark wound bed. Over time the skin will degrade and develop into deeper tissue loss.

UNGRADABLE - Full thickness skin loss where the depth of the ulcer is completely obscured by slough/necrosis. Until enough slough or necrotic tissue is removed to expose the base of the wound the true depth cannot be determined. It may be a grade 3 or 4 once debrided

All acquired pressure ulcers graded 2 - 4 and suspected deep tissue damage, must be reported via Datix. Refer to podiatry for at risk feet and foot wounds using "CPR for Feet" Criteria.

Falls for All Bundle

Falls for All Bundle - 5 Questions	Ward	Ward	Ward	Ward	Ward	Ward
	CAU.	8				
Date	21/6/24	26/6/24				
Time	1625	12^{00}				
a. Has the patient fallen in the last 6 months – including during this admission?	Y / (N)	Y / (N)	Y / N	Y / N	Y / N	Y / N
b. Does that patient have cognitive impairment or possible delirium?	Y / (N)	Y / (N)	Y / N	Y / N	Y / N	Y / N
c. Does that patient attempt to walk alone although unsteady or unsafe?	Y / (N)	Y / (N)	Y / N	Y / N	Y / N	Y / N
d. Does the patient or their relative/s have fear or anxiety, Re-falling?	Y / (N)	Y / (N)	Y / N	Y / N	Y / N	Y / N
e. Based on your clinical judgment, is this patient at high risk of falling?	Y / (N)	Y / (N)	Y / N	Y / N	Y / N	Y / N
Staff initial	ICL.					

- **If yes to any of the above, the patient is deemed as a vulnerable patient and should be commenced on the falls bundle within the care and comfort rounding chart.**
- **A slips trip and falls care plan should be completed and individualised as appropriate.**
- **Evaluate using (F) within nursing notes**

Falls for All Bundle - 5 Questions	Ward	Ward	Ward	Ward	Ward	Ward
Date						
Time						
a. Has the patient fallen in the last 6 months – including during this admission?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
b. Does that patient have cognitive impairment or possible delirium?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
c. Does that patient attempt to walk alone although unsteady or unsafe?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
d. Does the patient or their relative/s have fear or anxiety, Re falling?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
e. Based on your clinical judgment, is this patient at high risk of falling?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Staff initial						

- **If yes to any of the above, the patient is deemed as a vulnerable patient and should be commenced on the falls bundle within the care and comfort rounding chart.**
- **A slips trip and falls care plan should be completed and individualised as appropriate.**
- **Evaluate using (F) within nursing notes**

Moving and Handling

Patient Risk Assessment

All Patients:

- Independently A hoist **must** be used if assistance is required from the floor
- Sliding aids **must** be used bed to trolley/bed unless the patient transfers
- A hoist **must** be used for bathing unless independently mobile
- **Hoists are for lifting patients and must not be used for transport between rooms**

Special Alerts: **Date:**	21/6/24					
Overweight / Obese (BMI definition)						
Very tall (>185cm in height)						
Restricted use of limbs						
Poor standing ability						
Sedation or lethargy						
Irrational behaviour / confusion						
Unable to co-operate						
Acute pain						

Assessment of Risk:

Low Risk: Independently mobile / supervision only required. Aids required should be specified in care plan

Moderate Risk: Requires physical assistance from one or more handlers. Is able to stand or partially bear weight and has no more than one special alert.

High Risk: (a) Is unable to bear weight and requires assistance.
(b) 2 or more special alerts present and requires assistance.

Aids, equipment and a minimum of 2 handlers recommended to move a patient.

Date:	21/6/24	26/6/24				
LOW RISK	✓	✓				
MODERATE RISK						
HIGH RISK						
Assessor's Initials		Q				

If a hoist or standing aid is required please specify:

Sling type:		**Size:**		**Manufacturer:**	

Additional Comments:

Moving and Handling Care Plan (MH)

Date:	21/6	26/6/24				
1. Moving in bed: a) Independent	a) ✓	✓				
b) Handlers and sliding sheets required to move in bed - specify number of handlers in grid	b)					
c) Specify any additional equipment required in grid	c)					
2. Sitting to Standing: a) Independent	a) sup	✓				
b) Requires assistance from sit/stand to sit? Specify number of handlers in grid	b)					
c) Also requires aids. Specify equipment in grid	c)					
4. Transfers: (chair / wheelchair / commode / toilet / bed) a) Independent or with minimal supervision	a) sup.	✓				
b) Assistance required from handlers specify number of handlers in grid.	b)					
c) Equipment required - specify equipment in grid	c)					
4. Adjusting Clothing a) Independent or minimal supervision	a) ✓	✓				
b) Can use support/grab rails while assistance is given with clothing	b)					
c) Requires support from Handler(s) while another assists with clothing	c)					
d) Requires equipment, specify equipment in grid	d)					
5. Repositioning in chair / wheelchair: a) Independent or minimal supervision	a) ✓	✓				
b) Assistance from handler(s), specify number in grid	b)					
c) Specify other aids or equipment required in grid	c)					
6. Mobilising:	Documented in Mobility Care Plan					
Assessors initials	KL -	CS				

If it is decided to stand, transfer or mobilise a patient requiring assistance of more than 2 handlers, without equipment, a detailed assessment outlining the decision making process must be documented in the mobility care plan.

Date & Time	Initial Medical/ANP presentation and management plan	Initials
21/6/24 1635	Imp: ? Community acquired pneumonia (CURB65-0) ? Angioedema ? Urticaria	
	Plan: 1) IV antibiotics 2) IV fluids 3) IV or oral steroids 4) Antipyretics mcare ↑temp 5) Blood cultures ☑ 6) Anti histamines, topical steroids for rash 7) PRN NERS 8) Continuous monitoring of vitals 9) Swabs sent for covid, PCR and flu 10) ? CTPA after d/w consultant 11) Incase of ↑RR, ↓SpO2, ↑ swelling or puffiness please immediately inform	
	Seen by consultant: Imp/ (R) upper lobe pneumonia Sepsis plan/ IV abx Screen for urine legionella ☑ antihistimines uss abdomen. daily bloods ☑ weekend renew oral prednisilone baseline trop medical photography dermatology renew. CRP = 424.	

Ward ..CAU.....

Date & Time	Care Plan Code	Record of **all** care. Including Ward round / MDT and Relative communication	Initials
21/6/24	N	NEWS 2 due to 2L O2 requirement.	
1700	M.	Independent with supervision	
	CP	Able to express any needs.	
	EM	Settled at present.	AK
21/06/24 2340	MDT	Seen by dermatology	
		∧ acute urticaria and history suggestive of angio oedema, likely reactive to recent illness.	
		↑CRP would not be explained by skin presentation.	
		plan/-fexofenadine 180mg ̈qds	
		-Regular / PRN emollient eg zerobase	
		-dermatology follow up.	
		-on-going medical treatment as per medical team.	
		Pharmacy then d/w dr Shafquat renewed fexofenadine : patient to get fexofenadine 180mg 1x daily and monitor response.	SG
22/06/24 0450	(N)	NEWS 0 ; obs as charted.	
		Medication given as prescribed	
	(EM)	patient slept well overnight.	SG
		paged medics ? IVF.	SG
22/06/24 0630	(N)	NEWS remains 0.	
		medics never clarified IVF for patient despite being paged a few times overnight.	
	(EM)	patient appear to have slept well overnight, nil new concerns noted.	SG
1130	N	Current news of 0 as charted	KM

Ward Care Notes

Ward ..... CAU .....

Date & Time	Care Plan Code	Record of all care. Including Ward round / MDT and Relative communication	Initials
	D	Independent with a shower this morning	Knc.
	P	All medications given as charted.	Knc
	fN	Breakfast taken this morning	Knc
	I	PCR obtained & Sent.	Knc
18.30.	PIC	PIC intact & flush.	Knc
	N	News currently 0 as charted.	Knc
	fm	patient Settled through the day, visitor in this afternoon	Knc
23/6/24		News charted	
01.00		(I) mobile.	
		Medication as per wellsky.	
		N.I. new concerns.	Knc
		Appears settled at present &	
11.00	(M)	News as charted	in
	(P)	medication given as charted	in
	(fN)	normal diet, normal fluid. Needs encouragement with oral fluids	in
	(PIC)	cannula intact	in
	(E)	passing urine.	in
	(D)	Independent with washing and dressing	in
	(M)	Independent with mobility	in
	(PA)	patient independent with mobility status pressure areas intact- patient has a rash all over his body patient has been seen by dermatology. patient is for a follow up with dermatology	in
23.06.24	WR	DR. HAINER R/V.	
1120		for CT chest ☐ / rpt bloods ☐	

Ward .....

Date & Time	Care Plan Code	Record of **all** care. Including Ward round / MDT and Relative communication	Initials
1145	(N)	NEWS (2). patients BP was low paged F4E. Advised to keep an eye on BP and encourage oral fluids	[illegible]
1300	(N)	news as charted	[illegible]
	(P)	medication given as charted	[illegible]
	(FFN)	eating and drinking	[illegible]
1800	(N)	news as charted	[illegible]
	(P)	no meds at tea-time	[illegible]
	(FFN)	eating and drinking	[illegible]
		patient is going for CT chest contrast. ?r/o malignancy. It will be 24/6/24.	[illegible]
	(EN)	settled at time of writing.	[illegible]
24/6/24 0220		Vital signs stable as per NEWS. Patient states feels skin condition i.e. redness & rash have significantly improved. Diet and fluids thus prior to settling. Independently mobile around room. PCR (-ve).	FMcA
24/06/24 1015	N	NEWS - 0, RR 16. TEMP 36.1. HR 51 BP 112/49, O2 SATS (RA) 97%.	
	M	PT COMPLETELY INDEPENDENTLY MOBILISES.	
	E	INDEPENDENT TO BATHROOM FOR PU/BO.	
	D	INDEPENDENT E PERSONAL CARE & DRESSING.	
	FFN	NORMAL DIET & FLUIDS - GOOD DAILY INTAKE.	
	P	NO C/O PAIN, MEDICATIONS GIVEN AS PXD AND CHARTED AS PER HEPMA.	

Ward Care Notes

Ward ..... CAU .....

Date & Time	Care Plan Code	Record of all care. Including Ward round / MDT and Relative communication	Initials
24/06/24 (CONTD)	1	FOR DAILY BLOODS ☑	
		URINE FOR LEGIONELLA TO BE SENT ☑	
		CT CHEST ☑	
		ABDO U/S ☐	
	P.A.	PT STATES PRESSURE AREAS INTACT,	
		P/C WAS ALL OVER BODY RASH -	
		SEEN BY DERMATOLOGY RV & FURTHER	
		FOLLOW-UP PLANNED.	
	CP	PT CHATS & RESPONDS APPROPRIATELY	SJN
	EM	PT SETTLED AT PRESENT.	KL
24/6/24		S/B Dr Haider.	
1145.		CRP improved 424 → 84.	
		~~WCC~~ 18.8 → 13.4	
		~~MPE: bloods~~ ☐	
		c/w CT CAP	
		~~Cancer report~~	
		? (H) if bloods & CT okay	
1509		bloods improved	
		~~again~~ - CRP 60's.	
		CT result - dense consolidation RUL, features of early cavitation. no convincing evidence of malignancy. will need CT follow up to exclude underlying tumour in 2-3 months D/w Dr Haider - rev to resp. as in patient	

Ward CAU

Date & Time	Care Plan Code	Record of **all** care. Including Ward round / MDT and Relative communication	Initials
24/6/24 1635		seen by Dr Guhan:	
		ΔTB ⇒ to R/O TB before treating as Simple CAP	
		Plan: STOP all abx	
		- Sputum [redacted] & DD	
		- Bronchoscopy Weds	
		- inform infection control ✓	
		- Bloods ✓	
		- Pt aware of ?TB diagnosis, aware to stay in room	
	MDT	- phoned infection control to make aware of Possible diagnosis, ppe Precautions in place - only face fitted masks in room.	
		- 1x Sputum sample collected	
1750	N	NEWS 0 obs as charted	
	FFN	good diet + fluid intake	CJ.
25/6/24	N	obs as charted	
0850	E/M	mobile around room. nil elimination issues	
	CP	can make needs known	
	CF	no enquires made	
	P	nil complaints	
	PVC	Remains intact	
	FFN	not anx at present infection control precautions continue to be worn	DF
25/6/24 09:55	N	News 1 obs as charted - ↓ temp 35.6	SS
	F FN	Good diet and fluid intake	SS
	O	Pt washed (showered) independantly	SS
	P	No c/o of pain	

Ward Care Notes

Ward .... CAU - UME .....

Date & Time	Care Plan Code	Record of **all** care. Including Ward round / MDT and Relative communication	Initials
25/6/24 09:55	PRC	PVC remains in situ ~~~~	SS
	CP	Pt happy to communicate with staff and make any needs known	SS
	COI	Barrier nursing continued due to ? TB. / / / / / /	SS
25/6/24 1105	WR	Dr Haider △ ? TB.	
		Plan: - for bronchoscopy tomorrow - chase AAFB results ☐	LW
1330	Meds	DALTAPARIN given as prescribed.	
	FFN	patient has maintained oral and dietry intake throughout the day	
	CM	Patient has remained independent with toileting	
	E	No complaints of pain ✓ and patient remains settled	DP
26/06/24 0030	N	observations charted. NEWS 1 due to BP 109/62.	
	M	mobilising independently around room.	
	P	No complaints given.	
	EM	settled at time of writing.	CT
0540	N	observations charted - NEWS 0	
		Patient has had a settled night. slept well.	
		Sputum pots given for further	

Ward Care Notes

Ward ... CAU - UME .....

Date & Time	Care plan Code	Record of **all** care. Including Ward round / MDT and Relative communication	Initials
cont		samples required for AAFB.	CH
24/6/24		AAFB sputum samples ☑☑☐	
0750		Morning meds given	
		Pt for mask to ST 8	
26/6/24	-	Admitted to ST8 this am,	
		Relused skin unspecified, states	
		pressure areas intact. and	
		rash ~~is~~ reduced.	
		attended bronchoscopy ✓	
		Reviewed by medics. await	
		AAFB results. resp RN	
		tomorrow.	
		Managed quiet and mods well —	CS
2310	B/N	Obs as charted. NEWS 0	SW
	E/M	Ind and self caring	SW
	P	Pt requested analgesia for	
		sore throat & chest. Paracetamol	
		prx as first line but dihydrocodeine	
		if needed.	SW
	Pd	Nursed on hybrid ~~mattress~~	
		mattress and ind with	
		positional changes	SW
	EM	Settled at time of writing	SW
27/6/24	N	observations stable.	
	D	An Independent	
	E.	Reports no issues.	
	FN	Quiet and meds taken	
		well	

Ward Care Notes

NHS Ayrshire & Arran

NHS Ayrshire & Arran Care and Comfort Round



CHI: 0902763334
Johnstone, Lee
12 Woodside Avenue
Maybole
KA19 7PP
09/02/1976
Dr G Paton

Registered Nurse responsible for patient should prescribe frequency as per patient's greatest need, to provide individualised person centred care.
Escalate any concerns to Staff Nurse responsible for patient.
Min 12hrly *only* if patient independent with ADLs
Weigh Patient every 7 days Recorded Weight

Date/Time	Name	Designation	Initials	Circle prescribed hourly frequency
				1hr 2 hr 3hr 4hr (12hr)
				1hr 2 hr 3hr 4hr 12hr

Date/Time of Care Rounding	1/1/22	25	26/6	26/6	27/6										
24 hr format (0000 -2400)	0800	2150	0600	0210	0900										

Generic Codes : Y- Yes N – No NA-not applicable NT – No Thanks S – Sleeping O – Off ward I - Independent

Pressure area care should take place at a maximum of 4 hourly intervals – Consider if pain relief required prior to moving

Pressure Ulcer Care If new grade ≥2 PU identified, complete DATIX	Skin Inspection completed?	Y	N	NT	NT	NT									
	Skin checked under devices?	Y	–	–	–	–									
	Area of skin damage codes *if multiple document on reverse*	**RHL** - Right Heel **LHL** - Left Heel		**RHP** - Right Hip **LHP** – Left Hip		**C**- Coccyx **B** – Buttocks		**SP** – Spine **OT** – Other		**O** – Occiput (back of head) **M**- Multiple		**N** – None			
	Area of skin damage	C	–	–	–	–									
	Condition of Skin Record Codes	**SR** – Slowly Reactive (3-6secs) **D** –Discolouration **U**- Pressure Ulcer **M** – Moisture **E**- Excoriation **N** – Normal Briskly Reactive (1-2 secs)													
	Condition of Skin	SR	–	–	–	–									
	Skin Surface pressure relieving equipment in use codes	**HA** - Hybrid activated **HNA** - Hybrid not activated				**C** – Chair Cushion **PB**– Prolevo boots				**OM** – Other (document on reverse) **HS** – Heel Safe Pad					
	Skin Surface pressure relieving equipment in use	HNA	–	HNA	HNA	HNA									
	Keep Moving - Record change of patient position	**R** – Right Side **L** – Left Side **B** – Back **C**-Chair to Stand **BC**-Bed to chair **I** – Independent **Recommend 30 degree lateral tilt and use of sliding sheets**													
	Record change of position	R	I	I	I	I									
	Sliding sheet used	Y	–	–	–	–									
Personal Hygiene		**I** – Independent **A** – Assistance given **B** - Basin **S**- Shower **BB** – Bed bath **FI**- Full immersion bath													
	Personal Hygiene	BB	I	I	I	I									
Elimination	Patient toilet facility codes	**I** – Independent **A** – Assistance given **BP**- Bed Pan **C**- Commode **NA** – Not applicable													
	Offer patient toilet facility	A	I	I	I	I									
	Continence Codes	**IU** – Incontinent Urine **IF** – Incontinent Faeces **UC** - Urinary Catheter **S** – Stoma **PU** – Passed Urine **BO** – Bowels open **NA** – Not applicable													
	Bowels open/ passed urine?	IU	–	I	I										
	Bristol Stool Score (if known)	NA	–	N	N										
	Barrier product applied?	Y	–	D	D										
	Document skin care intervention and barrier product used in evaluation section on reverse														
Food Fluid and Nutrition	Has appropriate assistance with eating and drinking been provided?	Y	Y	Y	Y										
	Nutritional Supplements given and encouraged	Y	N	N	N										
	Fluid is within easy reach and refreshed and offered	Y	Y	Y	Y										
	ensure FFN given is appropriate level ***Update Nutritional Intake Record Chart & Fluid Intake/Output chart if applicable**														
	Oral hygiene carried out (12hrly) (Increase to 2hrly if NBM)	Y	–	I	I										
Falls If HLS required, complete appropriate documentation	Is the nurse call buzzer working and within reach of the patient?	Y	Y	Y	Y										
	If unable to use buzzer, commence 1 hourly care and comfort round														
	How many bed rails in use?	2	0	0	0										
	Trolley/bed at lowest level	Y	Y	Y	Y										
	HLS Codes	**S** – Standard **CO** - Cohort **CT** Constant (provide meaningful activity)													
	Level of Higher Level Supervision in place	CO	S	S	S										
	Is the patient more confused, drowsy or agitated? Think Delirium	N	N	N	N										
	Encourage to mobilise (ie marching feet, sit to stand)	Y	Y	Y	Y										
	Walking aid within reach Aid in use.....	NA	NA	NA	N										
	Ensure environment free of any trip hazards	Y	Y	Y	Y										
	Escalate all concerns	Y	NA	NA	NA										
	Completed by (Initial)	KP	KP	JM	JM										

Does the patient require a PVC? Consider DRIFT!

Diagnostics	Resus	IV meds	Fluids	Transfusion
Does the patient require a PVC for diagnostic purposes eg CT Scan?	Is the patient at risk of a cardiac or respiratory arrest that may require resuscitation?	Does the patient require IV medication? **(Can this be switched to the oral route?)**	Does the patient require IV Fluids? **(Are they now able to receive sufficient fluids by the oral route?)**	Does the patient require transfusion of any blood products?

Patient meets 1 or more requirements of DRIFT

Yes (PVC required)	No (PVC not required)
• Complete Insertion sticker • Maintain PVC daily	• Encourage diet and fluids where appropriate

PVC In

PVC Insertion Bundle

Name Lee Johnstone CHI 0907763334

Date 26/6/24 Time 0850

Insertion Site R Hand Colour Blue

Inserted by L Lennox Grob Designation DCN

If the inse wn:

Date inserte

By (designa

Site.....

1st attempt ☑ 2nd attempt ☐ 3rd attempt ☐

Insertion Criteria (circle those that apply)

Diagnostics Resus (IV meds) Fluids Transfusion

Clean Field ☑ Hand Hygiene ☑

Skin asepsis ☑ Non touch technique ☑

Maintenance Bundle (please circle all that applies e.g. Ⓓ R I F T)

Hand hygiene must be performed before & after all procedures. Prior to access, the hub must be scrubbed with 2% CHG & 70% IPA (Clinell wipe)

Day	Date	Patient requires a PVC because: (see above)	The PVC dressing appears:	Phlebitis Score: (see below)	The PVC was:	Initials	Ward
1	...../...../.....	D R I F T	Intact / Not Intact And Replaced		Left Insitu / Removed		
2	...../...../.....	D R I F T	Intact / Not Intact And Replaced		Left Insitu / Removed		
3	...../...../.....	D R I F T	Intact / Not Intact And Replaced		Left Insitu / Removed		
4	...../...../.....	D R I F T	Intact / Not Intact And Replaced		Left Insitu / Removed		
5	...../...../.....	D R I F T	Intact / Not Intact And Replaced		Left Insitu / Removed		

NB If the PVC site is inflamed, please remove and obtain a swab (charcoal swab)

If a new PVC is required, please commence a new bundle

Continue over page

Phlebitis Score					
IV site healthy	0	Observe	Pain/Redness/Swelling/Tracking/Pyrexia (not all symptoms require to be present)	1	Remove/Resite/Review/ Consider treatment

NEWS 2 Key | 1 | 2 | 3

Ward/Department			CAU	CAU	CAU	CAU	CAU	CAU	CAU	CAU	CAU	CAU	CAU	CAU	CAU		8	8	8	8								
Date		1/11	24/6	24/6	24/6	24/6	24/6	25/6	25/6	25/6	25/6	25/6	25/6	26/6	26/6		26/6	26/6	26/6	27/6								
Time		11:00	05:46	08:00	12:00	16:50	20:20	20:40	05:44	08:00	12:50	20:00	05:30	07:30			12:20	14:50	20:35	08:23								
A + B Respirations Breaths/min	≥25															3												
	21-24															2												
	12-20	•	•	16	17	•	•		=	18	18	16	•	17		0	•	•	•	•								
	9-11															1												
	≤8															3												
A + B SpO2 Scale 1 Oxygen saturation (%)	≥96	97	98	97	97	98	98		97	97	97	96	97	96		0	97	96	96	97								
	94-95															1												
	92-93															2												
	≤91															3												
SpO2 Scale 2 Oxygen saturation (%) Use Scale 2 if target range is 88-92% e.g. in chronic hypercapnic respiratory failure	≥97 on O2															3												
	95-96% on O2															2												
	93-94% on O2															1												
	≥93 on air															0												
	88-92															0												
Only use scale 2 under direction of qualified clinician	86-87															1												
	84-85															2												
	≤83															3												
Air or oxygen?	Air (A) or O2 device*	A	n	A	A	A	A	A	A	A	A	A	A	A		0	A	A	A	A								
	O2 L/min 2															2												
C Blood Pressure mmHg (Score uses systolic BP only)	≥220															3												
	201–219															0												
	181–200															0												
	161–180															0												
	141–160					185										0												
	121–140	↑							122							0												
	111–120		^	112	111		111			116		109	113	100		0		^	^	^								
	101–110									^		^	^	^		1	^											
	91–100										98					2												
	81–90										^					3												
	71–80	↓														3												
	61–70				64				65							3												
	51–60									53	53					3												
	≤50			49												3												
C Pulse Beats / min	≥131															3												
	121-130															2												
	111-120															2												
	101-110															1												
	91-100															1												
	81-90															0												
	71-80	•				69										0												
	61-70				67	64				71	66	77				0	6	6										

Affix Patient ID

Abbreviations for recording oxygen device

A	Room Air
N	Nasal Cannulae
SM	Simple Mask
V	Venturi Mask and % eg. V24
NIV	Non Invasive Ventilation
IV	Invasive Ventilation
T	Tracheostomy
CP	CPAP Mask
HFN	High Flow Nasal Oxygen
NEB	Nebuliser
RM	Reservoir Mask (Emergency use only)

	51-60			51					×	55	56		58		0																		
	41-50														1																		
	31-40														3																		
	≤30														3																		
D Any changes in neuro response, complete GCS. Immediate medical review. Check Blood Glucose. Complete 4AT*.	A Alert	•	A	A	A	A	A	A	A	A	A	A	O	X	0	J	O																
	C New Confusion														3																		
	V Verbal														3																		
	P Pain														3																		
	U Unresponsive														3																		
E Temperature	≥39														2																		
	38.1-39.0														1																		
	37.1-38.0														0																		
	36.1-37.0	•	36.1	36.3	36.4	36	×	35.6	36.1	36.5	36.6	36.4			0	0	0																
	35.1-36.0														1																		
	≤35.0														3																		
NEWS Total		0	0	0	0	0	1	0	0	1	2	1	0	1		0	0	0	0														
Blood glucose		7.0	-	-	-	-	-	-	-	-	-	-	-						1														
Pain / function score		OA	0	0A	0A	0A	0A	OA	0	0	0	0A	0A	0A					1														
Time Pt last passed urine		10.20	AM	PU	PU	PU	I	I	PU	I	I	I	I	I					I														
Fluid balance chart indicated Y/N		N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					N														
GCS Indicated Y/N		N	N	N	N	N	N	N	N	N	N	N	N	N					N														
Time NEWS due		23.00	0940	1200	1600	2000	8°		3-6	8°	4°	8°	0400	1130					12°														
Escalation of care, Y/N		N	N	N	N	N	N	N	N	N	N	N	N	N					N														
Initials		AB	A	KM	KM	CJ	AF	LR	KM	SS	SS	LH	GT	MJ		CD	SJW	SJW	CS														

*if 4AT>4 commence TIME bundle.

Pain Score
Ask the patient to rate his/her pain by using numerical scale 0 to 10. Use the chart below to assist the patient. If the patient is unable to communicate, use alternative pain scoring tools.

No Pain	Mild Pain			Moderate Pain			Severe Pain			
0	1	2	3	4	5	6	7	8	9	10

Pain Function Score	
A	No limitations, activity unrestricted by pain or settles quickly
B	Mild limitations, mild activity restrictions
C	Moderate limitations, attempts but reluctant to continue because of pain. **Seek Advice**
D	Severe limitations, unable to or refuse to perform because of pain. **Urgent Review Required**

NHS Ayrshire & Arran

NHS Ayrshire & Arran Care and Comfort Round

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KA19 7PP
09/02/1976
Dr M Barr
MRN: A100544212

Registered Nurse responsible for patient should prescribe frequency as per patient's greatest need, to provide individualised person centred care.
Escalate any concerns to Staff Nurse responsible for patient.
Min 12hrly *only* if patient independent with ADLs
Weigh Patient every 7 days Recorded Weight

Date/Time	Name		Designation	Initials	Circle prescribed hourly frequency
21.6.22	Annie Marshall		NT		1hr 2 hr 3hr 4hr 12hr
22/6/22	Thom				1hr 2hr 3hr 4hr 12hr

Date/Time of Care Rounding 24 hr format (0000 -2400)															
	1/1/22	21.6	22/6	2000	0200	0400	0600	0800	2316	2316	2316	24/6	24/6	24/6	25/6
	0800	2200	0000	0200	0400	0600	0800	0830	2039	23	23	09.00	12.30	10.00	

Generic Codes: **Y**- Yes **N** – No **NA**-not applicable **NT** – No Thanks **S** – Sleeping **O** – Off ward **I** - Independent

Pressure area care should take place at a maximum of 4 hourly intervals – Consider if pain relief required prior to moving

Pressure Ulcer Care – If new grade ≥2 PU identified complete DATIX															
Skin Inspection completed?	Y	NT	NT	NO	S	NO	NS	OT	OT			NT	NT	NT	
Skin checked under devices?	Y		N												
Area of skin damage codes *if multiple document on reverse*	**RHL** - Right Heel **LHL** - Left Heel		**RHP** - Right Hip **LHP** – Left Hip			**C**- Coccyx **B** – Buttocks		**SP** – Spine **OT** – Other		**O** – Occiput (back of head) **M**- Multiple		**N** – None			
Area of skin damage	C		N OT												
Condition of Skin Record Codes	**SR** – Slowly Reactive (3-6secs) **D** –Discolouration **U**- Pressure Ulcer **M** – Moisture **E**- Excoriation **N** – Normal Briskly Reactive (1-2 secs)							OT Chest							
Condition of Skin	SR		N OT												
Skin Surface pressure relieving equipment in use codes	**HA** - Hybrid activated **HNA** - Hybrid not activated					**C** – Chair Cushion **PB**– Prolevo boots				**OM** – Other (document on reverse) **HS** – Heel Safe Pad					
Skin Surface pressure relieving equipment in use	HNA	HNA	HNA	HNA				HNA	HNA	HNA	HNA	HNA	HNA	HNA	
Keep Moving - Record change of patient position	**R** – Right Side **L** – Left Side **B** – Back **C**-Chair to Stand **BC**-Bed to chair **I** – Independent **Recommend 30 degree lateral tilt and use of sliding sheets**														
Record change of position	R	I	I	I	I	I	I	I	I	I	I	I	I	I	
Sliding sheet used	Y		N					NA	NA	NA			NA		

Personal Hygiene															
Personal Hygiene	**I** – Independent **A** – Assistance given **B** – Basin **S**- Shower **BB** – Bed bath **FI**- Full immersion bath														
	BB	I	I					I	I	I	I	I	S		

Elimination															
Patient toilet facility codes	**I** – Independent **A** – Assistance given **BP**- Bed Pan **C**- Commode **NA** – Not applicable														
Offer patient toilet facility	A	I	I					I	I	I	I	I	I	I	
Continence Codes	**IU** – Incontinent Urine **IF** – Incontinent Faeces **UC** - Urinary Catheter **S** – Stoma **PU** – Passed Urine **BO** – Bowels open **NA** – Not applicable														
Bowels open/ passed urine?	IU	PU	I	PU											
Bristol Stool Score (if known)	NA		-												
Barrier product applied?	Y		-												

Document skin care intervention and barrier product used in evaluation section on reverse

Food Fluid and Nutrition															
Has appropriate assistance with eating and drinking been provided?	Y	Y	Y					Y	Y	Y	Y	Y	Y	Y	
Nutritional Supplements given and encouraged	Y	N	N						Y	Y	Y	-		N	
Fluid is within easy reach and refreshed and offered	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	

ensure FFN given is appropriate level **Update Nutritional Intake Record Chart & Fluid Intake/Output chart if applicable**

Falls – If HLS required, complete appropriate documentation															
Oral hygiene carried out (12hrly) (Increase to 2hrly if NBM)	Y		I						I	I	I	I	I		
Is the nurse call buzzer working and within reach of the patient?	Y	Y	Y	Y	Y	Y			Y	Y	Y	Y	Y	Y	

If unable to use buzzer, commence 1 hourly care and comfort round

How many bed rails in use?	2	0	0	0	0	0		0	0	0	0	0	0	0	
Trolley/bed at lowest level	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
HLS Codes	**S** – Standard **CO** – Cohort **CT** Constant (provide meaningful activity)														
Level of Higher Level Supervision in place	CO	S	S	S	S	S	S	S	S	S	S	S	S	S	
Is the patient more confused, drowsy or agitated? Think Delirium	N	N	N	N	N/S	N	N	N	N	N	N	N	N	N	
Encourage to mobilise (ie marching feet, sit to stand)	Y	I	I	Y		1	I	I		I		Y	Y	Y	
Walking aid within reach Aid in use.....	NA		I	NA	NA	NA		NA	NE	NE		NA	NA	NA	
Ensure environment free of any trip hazards	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	
Escalate all concerns	Y		N					NA	NA	NA		NA	NA	N	
Completed by (Initial)	KP	KM	LG					FM			KM			SS	

Daily Evaluation of HCSW Care Delivery & Escalation Record

Date	Evaluation and Escalation Record	Name
01/01/22	*Example* – Identified Concern – Slowly reactive area at coccyx	
0800	Escalated to SN. Positional change nursed on alternate side (30 degree tilt) hybrid mattress activated, barrier cream	
	applied. Personal Hygiene attended to using Senset foam, incontinence products replaced. Request for care	K.Perry
	rounding frequency to be increased to 3 hourly. Assisted wash given.	HCSW
22/12/2022	Patient has areas of rash on body previously normal - some areas reduced now normal. Zerobase given to apply on itchy areas.	

Does the patient require a PVC? Consider DRIFT!

Diagnostics	Resus	IV meds	Fluids	Transfusion
Does the patient require a PVC for diagnostic purposes eg CT Scan?	Is the patient at risk of a cardiac or respiratory arrest that may require resuscitation?	Does the patient require IV medication? **(Can this be switched to the oral route?)**	Does the patient require IV Fluids? **(Are they now able to receive sufficient fluids by the oral route?)**	Does the patient require transfusion of any blood products?

Patient meets 1 or more requirements of DRIFT

Yes (PVC required)	No (PVC not required)
• Complete Insertion sticker • Maintain PVC daily	• Encourage diet and fluids where appropriate

PVC Insertion I

Pl
If n

CHI: 0902763334
Johnstone, Lee
12 WOODSIDE AVENUE
Maybole
KA19 7PP
09/02/1976
Dr M Barr
MRN: A100544212

If the insertion sticker is unavailable please complete the following, if known:

Date inserted 21/6/24

By (designation) ED Ward CAU

Site lower arm Colour Green

Maintenance Bundle (please circle all that applies e.g. D R I F T)

Hand hygiene must be performed before & after all procedures. Prior to access, the hub must be scrubbed with 2% CHG & 70% IPA (Clinell wipe)

Day	Date	Patient requires a PVC because: (see above)	The PVC dressing appears:	Phlebitis Score: (see below)	The PVC was:	Initials	Ward
1	21/6/24	D R I F T	Intact / Not Intact And Replaced		Left Insitu / Removed	KMC	CAU
2 D/S	23/6/24	D R I F T	Intact / Not Intact And Replaced	0	Left Insitu / Removed	LM	CAU
3	...../...../.....	D R I F T	Intact / Not Intact And Replaced		Left Insitu / Removed		
4	...../...../.....	D R I F T	Intact / Not Intact And Replaced		Left Insitu / Removed		
5	25/6/24	D R I F T	Intact / Not Intact And Replaced	0	Left Insitu / Removed	AF	CAU

NB If the PVC site is inflamed, please remove and obtain a swab (charcoal swab)

If a new PVC is required, please commence a new bundle

Continue over page

Phlebitis Score					
IV site healthy	0	Observe	Pain/Redness/Swelling/Tracking/Pyrexia (not all symptoms require to be present)	1	Remove/Resite/Review/ Consider treatment

Maintenance Bundle (please circle all that applies e.g. (D) R I F T)

Hand hygiene must be performed before & after all procedures. Prior to access, the hub must be scrubbed with 2% CHG & 70% IPA (Clinell wipe)

Day	Date	Patient requires a PVC because: (see above)	The PVC dressing appears:	Phlebitis Score: (see below)	The PVC was:	Initials	Ward
6	...../...../.....	D R I F T	Intact / Not Intact And Replaced		Left Insitu / Removed		
7	...../...../.....	D R I F T	Intact / Not Intact And Replaced		Left Insitu / Removed		
8	...../...../.....	D R I F T	Intact / Not Intact And Replaced		Left Insitu / Removed		
9	...../...../.....	D R I F T	Intact / Not Intact And Replaced		Left Insitu / Removed		
10	...../...../.....	D R I F T	Intact / Not Intact And Replaced		Left Insitu / Removed		
11	...../...../.....	D R I F T	Intact / Not Intact And Replaced		Left Insitu / Removed		
12	...../...../.....	D R I F T	Intact / Not Intact And Replaced		Left Insitu / Removed		
13	...../...../.....	D R I F T	Intact / Not Intact And Replaced		Left Insitu / Removed		
14	...../...../.....	D R I F T	Intact / Not Intact And Replaced		Left Insitu / Removed		

NB If the PVC site is inflamed, please remove and obtain a swab (charcoal swab)

If a new PVC is required, please commence a new bundle

Phlebitis Score					
IV site healthy	0	Observe	Pain/Redness/Swelling/Tracking/Pyrexia (not all symptoms require to be present)	1	Remove/Resite/Review/ Consider treatment

NEWS 2 Key | 1 | 2 | 3

Ward/Department			ED	ED	EPAED	EPAED	EPAED	CDU	EDU	EDU	CDU	ED	FD	FED		CAU	CAU	CAU	CAU	CAU	CAU	CAU	CAU	CAU	CAU	CAU
Date		1/11	20/6	20/6	20/6	20/6	20/6	21/6	21/6	21/6	21/6	21/6	21/6	21/6		21/6	21/6	22/6	22/6	22/6	23/6	23/6	23/6	23/6	23/6	23/6	23/6
Time		11.00	2400	1110	2100	2205	2342	0134	0400	0525	0710	0950	1216	1510		1900	2200	0600	0845	1700	2000	0400	1400	1800	2000	2200	0000

A + B Respirations Breaths/min	≥25														3												
	21-24														2												
	12-20	•	•	•			•	•	•	•	•	•	16	16	0	15	14	16	14	14	•	•	•	•	•	•	•
	9-11														1												
	≤8														3												
A + B SpO2 Scale 1 Oxygen saturation (%)	≥96	97	99	100		99	99	96	96	96	96	97	99	96	0	99	97	97	98	96	96	96	97	98	98	98	
	94-95				95										1												
	92-93														2												
	≤91														3												
SpO2 Scale 2 Oxygen saturation (%) Use Scale 2 if target range is 88-92% e.g. in chronic hypercapnic respiratory failure	≥97 on O2														3												
	95-96% on O2														2												
	93-94% on O2														1												
	≥93 on air														0												
	88-92														0												
Only use scale 2 under direction of qualified clinician	86-87														1												
	84-85														2												
	≤83														3												
Air or oxygen?	Air (A) or O2 device	A			NC	NC	NC		NC	NC	NC	NC	NC	NC	0	NC	RA	RA	RA	A							
	O2 L/min 2				2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2	2L											
C Blood Pressure mmHg (Score uses systolic BP only)	≥220														3												
	201–219														0												
	181–200														0												
	161–180														0												
	141–160													183	0												
	121–140							105	110						0	128	126		132	110							
	111–120												102		0			170									
	101–110													86	1												
	91–100												79	88	2												
	81–90														3												
	71–80														3		62		79								
	61–70														3	69		64		61							
	51–60							56							3												
	≤50														3												
C Pulse Beats / min	≥131														3												
	121-130														2												
	111-120														2												
	101-110														1												
	91-100		6												1												
	81-90														0												
	71-80	•													0				76								
	61-70										68	86			0					63				63	62		
	51-60														0	55	54	56					59				
	41-50														0												

Abbreviations for recording oxygen device

- A Room Air
- N Nasal Cannulae
- SM Simple Mask
- V Venturi Mask and % eg. V24
- NIV Non Invasive Ventilation
- IV Invasive Ventilation
- T Tracheostomy
- CP CPAP Mask
- HFN High Flow Nasal Oxygen
- NEB Nebuliser
- RM Reservoir Mask (Emergency use only)

JOHNSTONE Lee
12 WOODSIDE AVENUE, KIRKMICHAEL
KA19 7PP
DOB: 09/02/1976

| | | |

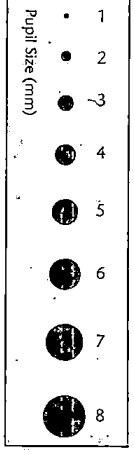
Glasgow Coma Scale

Date:			11/1	RA																											
Time:			11.00	12 47																											
Eyes Open	Spontaneous	4	•																												
	To speech	3																													
	To pain	2																													
	None	1																													
Best Verbal Response	Orientated	5	•																												
	Confused	4																													
	Inapp. words	3																													
	Incomp. sounds	2																													
	None	1	•																												
Best motor response	Obeys commands	6	•																												
	Localise pain	5																													
	Withdrawal to pain	4																													
	Abnorm. flexion to pain	3																													
	Extension to pain	2																													
	None	1																													
GCS TOTAL			15																												
PUPILS	R	Size	3																												
		Reaction	+																												
	L	Size	3																												
		Reaction	+																												
LIMB MOVEMENT	ARMS	Normal power	•																												
		Mild weakness																													
		Severe weakness																													
		Abnormal flexion																													
		Extension																													
		No response																													
	LEGS	Normal power	•																												
		Mild weakness																													
		Severe weakness																													
		Extension																													
		No response																													
Initials			AB	CA																											

Pupil Reaction and size

s = sluggish
+ = reaction
- = no reaction

Pupil Size (mm)



I	Identify self/area/patient.
S	Situation - what is your concern?
B	Background - relevant Hx/reason for admission.
A	Assessment - A-E findings/NEWS2 score.
R	Recommendation - what do you need & when.

NEWS > 5 THINK SEPSIS Apply SEPSIS 6 within 1 hour

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

NEWS 2 Key | 1 | 2 | 3

Ward/Department			ED	ED																							
Date			1/11	2/6	2/6																						
Time			11.00	1500	1730																						
A + B Respirations Breaths/min	≥25														3												
	21-24														2												
	12-20	•	18	19											0												
	9-11														1												
	≤8														3												
A + B SpO2 Scale 1 Oxygen saturation (%)	≥96		97	96	96										0												
	94-95														1												
	92-93														2												
	≤91														3												
SpO2 Scale 2 (†) Oxygen saturation (%) Use Scale 2 if target range is 88-92% e.g. in chronic hypercapnic respiratory failure	≥97 on O2														3												
	95-96% on O2														2												
	93-94% on O2														1												
	≥93 on air														0												
	88-92														0												
Only use scale 2 under direction of qualified clinician	86-87														1												
	84-85														2												
	≤83														3												
Air or oxygen?	Air (A) or O2 device		A	RA	RA										0												
	O2 L/min 2														2												
C Blood Pressure mmHg (Score uses systolic BP only)	≥220														3												
	201–219														0												
	181–200														0												
	161–180														0												
	141-160			159											0												
	121-140	↑			124										0												
	111-120														0												
	101–110														1												
	91–100														2												
	81–90														3												
	71–80	↓	83	93											3												
	61–70														3												
	51–60														3												
	≤50														3												
C Pulse Beats / min	≥131														3												
	121-130														2												
	111-120														2												
	101-110														1												
	91-100			92											1												
	81-90														0												
	71-80	•		94											0												
	61-70														0												

Abbreviations for recording oxygen device

A	Room Air
N	Nasal Cannulae
SM	Simple Mask
V	Venturi Mask and % eg. V24
NIV	Non-Invasive Ventilation
IV	Invasive Ventilation
T	Tracheostomy
CP	CPAP Mask
HFN	High Flow Nasal Oxygen
NEB	Nebuliser
RM	Reservoir Mask

Emergency

JOHNSTONE Lee
12 WOODSIDE AVENUE KIRKMICHAEL
KA19 7PP
DOB: 09/02/1976
CHI: 0902761337

[redacted]	71-80	0		74												0															
	61-70															0															
	51-60															0															
	41-50															1															
	31-40															3															
	≤30															3															
D [redacted] Any changes in neuro response, complete GCS. Immediate medical review. Check Blood Glucose. Complete 4AT*.	A Alert	0	F	A												0															
	C New Confusion															3															
	V Verbal															3															
	P Pain															3															
	U Unresponsive															3															
E Temperature	≥39															2															
	38.1-39.0															1															
	37.1-38.0															0															
	36.1-37.0	●	36.1	36.2												0															
	35.1-36.0															1															
	≤35.0															3															
NEWS Total		0	1	0																											
Blood glucose		7.0																													
Pain / function score		OA	0	0																											
Time Pt last passed urine		10.20	14:14																												
Fluid balance chart indicated Y/N		N	N	N																											
GCS indicated Y/N		N	15/15	15/15																											
Time NEWS due		23.00	1°	2°																											
Escalation of care Y/N		N	N	N																											
Initials		AB	AB	AB																											

Reservoir Mask (Emergency use only)

*if 4AT≥4 commence TIME bundle.

Pain Score

Ask the patient to rate his/her pain by using numerical scale 0 to 10. Use the chart below to assist the patient. If the patient is unable to communicate, use alternative pain scoring tools.

No Pain	Mild Pain			Moderate Pain			Severe Pain			
0	1	2	3	4	5	6	7	8	9	10

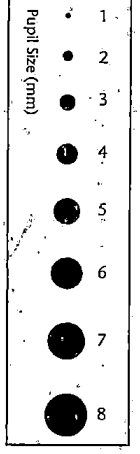
Pain Function Score	
A	No limitations, activity unrestricted by pain or settles quickly
B	Mild limitations, mild activity restrictions
C	Moderate limitations, attempts but reluctant to continue because of pain. **Seek Advice**
D	Severe limitations, unable to or refuse to perform because of pain. **Urgent Review Required**

Glasgow Coma Scale

Date:		11/1																												
Time:		11.00	15:20																											
Eyes Open	Spontaneous	4	✓																											
	To speech	3																												
	To pain	2																												
	None	1																												
Best Verbal Response	Orientated	5	✓																											
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	Extension to pain	2																												
	None	1																												
GCS TOTAL			15/15																											
PUPILS R	Size																													
	Reaction																													
PUPILS L	Size																													
	Reaction																													
LIMB MOVEMENT ARMS	Normal power		N/L																											
	Mild weakness																													
	Severe weakness																													
	Abnormal flexion																													
	Extension																													
	No response																													
LIMB MOVEMENT LEGS	Normal power		N/L																											
	Mild weakness																													
	Severe weakness																													
	Extension																													
	No response																													
Initials		AB	DA																											

Pupil Reaction and size

s = sluggish
+ = reaction
- = no reaction



I	Identify self/area/patient.
S	Situation - what is your concern?
B	Background - relevant Hx/reason for admission.
A	Assessment - A-E findings/NEWS2 score.
R	Recommendation - what do you need & when.

NEWS > 5 THINK SEPSIS Apply SEPSIS 6 within 1 hour

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

SHEET No. .....

MEDICINE PRESCRIPTION SHEET

Key: O ORAL; IM INTRAMUSCULAR; IV INTRAVENOUS; SC SUBCUTANEOUS; SL SUBLINGUAL; ID INTRADERMAL; INH INHALATION; NEB NEBULISED; PR PER RECTUM; PV PER VAGINA; IT INTRATHECAL

Write, Imr
HCR No:
CHI No: CHI: 0902763334
Surname: Johnstone, Lee
Forename: 12 Woodside Avenue
Address: Maybole
..... KA19 7PP
Date of Bi 09/02/1976
MEDIC Dr G Paton

..... KNOWN SENSITIVITY nil known
..... 1. 2.
..... SUSPECTED ADVERSE REACTION
..... MEDICINE | ADVERSE EFFECT
..... 1.
..... 2.

..... ITALS)

PHARM.	Date Commenced	APPROVED NAME OF MEDICINE	DOSE	TIMES OF ADMINISTRATION 6am	8am	10am	12md	2pm	6pm	8pm	10pm	12mn	OTHER		ROUTE (See Key)	OTHER INSTRUCTIONS	DOCTOR'S SIGNATURE	DISCONTINUED DATE	INITIAL
ED	A 30/4/14	PROPOFOL	ad. chartad												IV		Shinpstone		
ED	B 30/4/14	ALFENTANIL	ad. chartad												IV		Shinpstone		
ED	C 30/4/14	OMEPRAZOLE	20mg		✓										IV		Shinpstone		
ED	D 30/4/14	CHLORHEXIDINE	1 appl.	✓			✓		✓			✓			oral		Shinpstone		
ED	E 30/4/14	DALTEPARIN	25MU in.									✓			sc		Shinpstone		
ED	F 01/5/14	PARACETAMOL	2 Amp.		✓			✓				✓			IV		KS		
	G																		
	H																		
	I																		
	J																		
	K																		
	L																		
	M																		
	N																		
	O																		
	P																		
	R																		
	S																		
	T																		
	V																		

STA0235

SHEET No .. CHI: 0902763334
Nam Johnstone, Lee
Age 12 Woodside Avenue
Cons Maybole
Hosp KA19 7PP
09/02/1976
Dr G Paton

MEDICINE RECORDING SHEET

Enter code in box and initial when medicine is taken.

If medicine refused record (A) If patient unable to swallow record A

If patient absent record A If medicine not available record A

Date	6 a.m	8 a.m	10 a.m	12 m.d	2 p.m	6 p.m	8 p.m	10 p.m	12 m.n	Other Administrations
31/12/13									D E	
	Init.								A	
1/1/14	D	C			F					
	Init.	MS			MS					
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

Date	6 a.m	8 a.m	10 a.m	12 m.d	2 p.m	6 p.m	8 p.m	10 p.m	12 m.n	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

STA 0236

NHS Ayrshire & Arran

Adult Peripheral Vascular Cannula Insertion and Maintenance Bundle

CHI: 0902763334
Johnstone, Lee
12 Woodside Avenue
Maybole
KA19 7PP
09/02/1976
Dr G Paton

A&E / Theatre — Yes ☑ No ☐ | **Date / Time** inserted 30/4/2014 | Date due for removal _____ | Insertion site Gauge / Colour Dorsal Green | Inserted by Signature ?

Clinical Indication — IV Fluids / IV Drugs ☐ | Urgent Access ☑ | Interventional Procedures ☐ | Other _____

Insertion Criteria — Clean field used ☐ | Hand hygiene ☐ | Skin Asepsis ☐ | Dressing dated, timed & numbered ☐ | Non touch technique used ☐

PVC 1	1. Has the PVC been used in past 24hrs	2. Absence of inflammation and/or extravasation	3. The cannula dressing is intact	4. The cannula has been inserted <72hrs	5. Hand hygiene before & after all procedures	If answer no to any of criteria 1-5 and PVC left insitu – document rationale for decision in comments	Initial
Day 1 1/5/14	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Left in situ ☑ Removed ☐	MJ
Day 2 2/5/14	Yes ☐ No ☑	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☑	AHC
Day 3 .../.../....	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Cannulas should be removed after 72 hours and should only be left insitu in exceptional circumstances. Close observation essential - document reason							
Day 4 .../.../....	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 .../.../....	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

Date removed _____ Reason for removal _____ Reason in >72hrs _____

Date & Time	PVC No.	Comments	Signature

Adult Peripheral Intravenous Cannula Monitoring and Recording Sheet

A&E / Theatre — Yes ☑ No ☐ | **Date / Time** inserted 30/4/14 : | Date due for removal _____ | Insertion site R hand | Gauge / Colour Green | Inserted by 2 | Signature _____

Clinical Criteria IV Fluids/IV Drugs ☐ Urgent Access ☑ Interventional Procedures ☐ Other _____

Insertion Criteria Clean field used ☐ Hand Hygiene ☐ Skin Asepsis ☐ Dressing dated, timed & numbered ☐ Non touch technique used ☐

PVC 2	1 Has the PVC been used in past 24hrs	2 Absence of inflammation and/ or extravasation	3 The cannula dressing is intact	4 The cannula has been inserted <72hrs	5 Hand hygiene before & after all procedures	If answer no to any of criteria 1-5 and PVC left insitu – document rationale for decision in comments	Initial
Day 1 1../5./14	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Left in situ ☑ Removed ☐	MJ
Day 2 2../5../14	Yes ☐ No ☑	Yes ☐ No ☑	Yes ☐ No ☑	Yes ☐ No ☑	Yes ☐ No ☐	Left in situ ☐ Removed ☑	OH
Day 3 .../.../....	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Cannulas should be removed after 72 hours and should only be left insitu in exceptional circumstances. Close observation essential.							
Day 4 .../.../....	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 .../.../....	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

Date removed _____ Reason for removal _____ Reason in >72hrs _____

A&E / Theatre — Yes ☐ No ☐ | **Date / Time** inserted / / : | Date due for removal _____ | Insertion site _____ | Gauge / Colour _____ | Inserted by _____ | Signature _____

Clinical Criteria IV Fluids/IV Drugs ☐ Urgent Access ☐ Interventional Procedures ☐ Other _____

Insertion Criteria Clean field used ☐ Hand Hygiene ☐ Skin Asepsis ☐ Dressing dated, timed & numbered ☐ Non touch technique used ☐

PVC 3	1 Has the PVC been used in past 24hrs	2 Absence of inflammation and/ or extravasation	3 The cannula dressing is intact	4 The cannula has been inserted <72hrs	5 Hand hygiene before & after all procedures	If answer no to any of criteria 1-5 and PVC left insitu – document rationale for decision in comments	Initial
Day 1 .../.../....	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 2 .../.../....	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 .../.../....	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Cannulas should be removed after 72 hours and should only be left insitu in exceptional circumstances. Close observation essential.							
Day 4 .../.../....	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 .../.../....	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

Date removed _____ Reason for removal _____ Reason in >72hrs _____

NHS
Ayrshire & Arran

PATIENT PROFILE

Admission Transfer	Destination 1	Destination 2	Destination 3
Hospital	AAK		
Ward	ICU		
Transfer Date / Time	30.04.14 2145		
Relative informed?	Yes		
Completed By – Initials	[illegible]		

The Patient Profile can be used for patients with repeated admissions i.e. for a course of therapy. However if a gap of more than 6 weeks since last admission repeat lifestyle risk assessment. If greater than 12 week, complete a new profile.

safe

VALUABLES

HERE

Name: Lee Johnstone

CHI number: 0902763334

Date: 30:04:2014

Clinical Team Signatures

All staff completing the documentation **must** complete this section

Name (BLOCK CAPS)	Designation	Ward/ Page No	Signature	Initials
EMMA LIVINGSTON	DCN	ICU		
Mhairi Stevenson	SN	ICU		
Lynn Stewart	S/N	ST9		
SARAH HARRIS	STAFF NURSE	ST 9		

CN – Charge Nurse; **DCN** – Deputy Charge Nurse; **SN** – Staff Nurse; **EN** – Enrolled Nurse; **HCA** – Health Care Assistant; **STN** – Student Nurse; **AHP** – Allied Health Professional

Abbreviations

This abbreviation list has been approved for ICPS Hospital Wards for Records and Record Keeping for Registered Nurses, Midwives and Specialist Community Public Health Nurses.

There are blank spaces incorporated and each clinical speciality can write their own relevant abbreviations in full below, and therefore can be included within the record.

A&E	Accident and Emergency	**HDU**	High Dependency Unit
BM	Blood Glucose Monitoring	**BMI**	Body Mass Index
IM	Intramuscular	**BP**	Blood Pressure
INR	International Normolised Ratio	**ICU**	Intensive Care Unit
CCU	Coronary Care Unit	**IV**	Intravenous
C DIFF	Clostridium Difficile	**CHI**	Community Health Index
MUST	Malnutrition Universal Screening Tool	**CPR**	Cardio Pulmonary Resuscitation
RSA	Methicillin Resistant Staphylococcus Aureus	**CVA**	Cerebral Vascular Accident
O2	Oxygen	**CVC**	Central Venous Catheter
PEG	Percutaneous Endoscopic Gastrostomy	**DOB**	Date of Birth
PMH	Past Medical History	**ECG**	Electrocardiogram
PVC	Peripheral Vascular Catheter	**GP**	General Practitioner
SBAR	Situation Background Assessment Recommendations	**HAI**	Healthcare Associated Infection
H@N	Hospital At Night	**SP02**	Saturation of Peripheral Oxygen
PICC	Peripherally Inserted Central Catheter	**CSU**	Catheter Specimen of Urine
MSSU	Mid Stream Speciment of Urine	**ERT**	Emergency Response Team
MEWS	Modified Early Warning Score	**CSW**	Clinical Support Worker
ANP	Advanced Nurse Practioner	**CDU**	Clinical Decisions Unit
	Myocardial Infarction	**CABG**	Coronary Artery Bypass Graft
MRI	Magnetic Resonance Imaging	**CKD**	Chronic Kidney Disease
CT	Computerised Tomography	**COPD**	Chronic Obstructive Pulmonary Disease
ERCP	Endoscopic Retrograde Cholangiopancreatography	**NAD**	No abnormalities Detected

Personal Details

Prefers to be addressed as:	Age: 38 years
Receiving Consultant:	Allocated Consultant:
Admission date: 30:04:2014	Time: 2145
From where: A&E	Accompanied by: Anaesthetist & nurse
Emergency ☑ Elective ☐	Patient's telephone number:

H
C
S
F
A
...
D

CHI: 0902763334
Johnstone, Lee
12 Woodside Avenue
Maybole
KA19 7PP
09/02/1976
Dr G Paton

GP name and address:

.....
.....
.....

Consent to share information: Yes ☐ No ☐ If yes with whom? .....
Any exceptions? .....

First contact/significant other

Name: Georgia Johnstone
Address: 12 Woodside Ave Kirkmichael

Relationship to patient:
Contact No(s) Home: 01655 750264
Mobile:
Aware of admission Yes ☐ No ☐
Contact overnight Yes ☐ No ☐

Second contact/significant other

Name:
Address:

Relationship to patient:
Contact No(s) Home:
Mobile:
Aware of admission Yes ☐ No ☐
Contact overnight Yes ☐ No ☐

Reason for Admission/provisional diagnosis

Fatal collapse, variable GCS in A&E & became aggressive

Specific Alerts

Has patient had any **previous history of MRSA** colonisation or MRSA infection at any time in the past?
Yes ☑ No ☐ Don't know ☐

Is patient currently **resident in a care home or institutional setting** i.e. prison, homeless, hotel or **transferred from another hospital?**
Yes ☐ No ☑ Don't know ☐

Does the patient **have a wound/ulcer or indwelling medical device** which was present before admission to this hospital?
Yes ☐ No ☑ Don't know ☐

If Yes:

- Screen nose and perineum (& wound or device where applicable),
- Manage patient as if MRSA positive (isolate if possible)

If No or Don't know: Patient is likely to be at low risk of MRSA & can be managed as normal in accordance with the Infection Control Policy.

Nose	Perineum	Other:	Date: 1.5.14
☑	☑	Urine	Sign:

Other infectious conditions Yes ☐ No ☑
Specify:

Allergies

Drug allergies:
Other allergies (food, latex, etc)

None known ☑

Observations on admission

Glucometer Reading	Last Menstrual Period (if appropriate)	Pregnancy Test (if appropriate)

Urinalysis: NAD ☐ Protein + ++ +++ ++++ Blood + ++ +++ Glucose + ++ +++ ++++
Leucocytes + ++ +++ Nitrates + Other .....
MSSU (mid stream sample of urine) collected? Yes ☐ No ☐ Date .....

Previous medical, surgical and mental health history
(including operations, treatments and investigations with the corresponding dates)

Details	Date
Alcohol related seizures	
Prev. alcohol excess	
Appendicectomy	
Guillain-barre syndrome 1995	
Epigastric hernia repair 2010	

	Ward	Yes	Ward	Yes	Ward	Yes
ID band in situ						

	Ward			Ward			Ward		
Verbal ward information given to patient and / or relatives:	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
Call buzzer									
Toilets / Bathroom									
Explained Protected Mealtimes									
Drug Rounds / Purple Aprons									
Visiting times / policy									
Infection control / hand hygiene									
Fire alarm procedure									
Valuables									
Smoking									
Patient Discharge Booklet given									
Other.....									

Patient's Property

You are advised to restrict to a minimum the amount of property, including cash and other valuables, brought into hospital. You are advised to hand to the nurse in charge of your admission any articles you wish to be kept in safe custody as soon as possible. You will be issued with a receipt. You are responsible for property belonging to you not handed over for safe custody. This includes cash, spectacles, hearing aids, dentures and other personal items and valuables.

Anything handed over for safe keeping will not be kept indefinitely in the ward safe but will be sent to the cashier's office.

Signature of Patient / Significant Other:..... Date .....

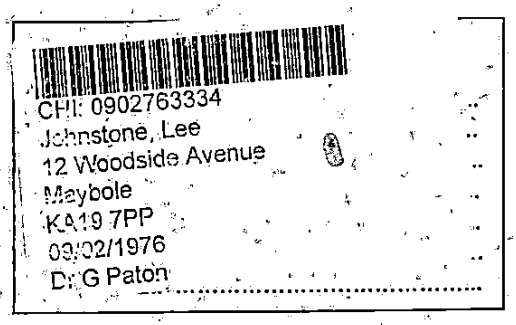
Property Handed Over For Safe Keeping: Yes ☐ No ☐ Sticker on front page ☐

Date Taken to Cashier: ..... Cash & Valuables Ref No: ..... Date Returned: .....

Initials of Nurse: ..... Date: 01.05.2014

NHS Ayrshire & Arran

Nurse Evaluation



Date & Time	Care No	Evaluation	Signature
30/04/14	2230	Patient admitted from A&E following being found unresponsive and then having fluctuating GCS intubated in A&E on SIMV, FiO_2 0.6 V_T 520mls rate 15bpm. Air entry equal to right side and quiet to left side, copious mucoid secretions obtained on tracheal suction and copious secretions orally and nasally Maintaining in sinus tachycardia, apyrexial O_2 sats 95-100% Foley catheter very good IV crystalloids running at 125mls/hour IV infusions running as:- propofol 20mls/hour and alfentanyl 2mls/hour Pressure areas intact. NG tube on free drainage. Patients mother now aware of his admission and will phone again in the morning	
01/05/14	0600	Remains on SIMV, FiO_2 0.4 PEEP 3. mucoid secretions obtained on tracheal suction, but less than when first admitted Observations remain stable. Foley catheter volumes ≥80mls	

Date & Time	Care No	Evaluation	Signature
10514	08[00] (cont.)	IV crystalloids running at 100mls/hour Sedation was increased to propofol 25ml/hour and alfentanil 2ml/hour as patient woke and going for his ET tube 400 mls emptied from NG tube drainage bag. Pressure areas intact. Patient stable and settled at time of reporting.	
1/5/14 1330	(2)	Hemodynamically Stable, borderline pyrexia infectious markers within normal limits.	ms
	(3)	Saturations in high nineties on room air, a/e clear to all lung fields.	ms
	(4)	Taking good amount of diet and fluids.	ms
1/5/14 1730		Settled since transfer to station 9.	
	✓	observation as charted	
02/05/14 0230	V	MEWS 0	SH
		Independent to front door for ciggarettes	SH
	P	No complaints of pain	SH
	I	Settled and appears to have slept well	SH
2/5/14 1650	✓	observations as charted	
	P	Paracetamol given for pain.	
	—	Seen by Dr Ofuafor, for discharge home tomorrow if remains seizure free	CM C
03/05/14 0400	V	Observations as charted MEWS 0	SH
	P	No complaints of pain	SH
	I	Settled and appears to have slept well.	SH
3/5/	1520	Patient discharged home as planned	

Family & Carer Communication Sheet

Write or attach label

CHI: 0902763334
Johnstone, Lee
12 Woodside Avenue
Maybole
KA19 7PP
09/02/1976
Dr G Paton

Date & Time	Communication and significant information discussed with patient / family / carers. This may include relevant telephone communication	Initials
1/5/14	ASKED BY MR JOHNSTONE TO phone HIS	
	Lawyer as HE HAS A COURT Appearance Today	
	I Telephoned STEVEN maxwell ON 265024	
	BUT ~~STEVENS~~ ~~mum~~ MR JOHNSTONES MOTHER HAD	S/N.
	ALready CONTACTED THEM.	G.Ly
1/5/14	Patient and mum, updated by Dr Pienaar	M.S.

Date & Time	Communication and significant information discussed with patient / family / carers. This may include relevant telephone communication.	Initials

NHS Ayrshire & Arran

MEWS CHART
(with Neuro - Observations)

AYR-14-014500-1
DOB: 09/02/1976
JOHNSTONE Lee
12 WOODSIDE AVENUE, KIRKMICHAEL
KA19 7PP
0902763334

DATE	30/4	30/4	4/5	5/5	7/5/14	21/5	22/5/14	3/5
TIME (24 hour clock)	0/A	2045	16.30	2145	1355	2100	1020	
Temperature		37.1						
BLOOD PRESSURE	165	132/176						
HEART RATE	101	72						
Respiratory Rate	25	28	18	19	17	19	18	
O_2	A	15L	A	A	A	A	A	
Saturation	92	98	100	99%	98	99%	100	
MEWS SCORE for EACH of the INDIVIDUAL OBSERVATIONS								
Temperature (°C)	0	0	0	0	0	0	0	

O_2	A	15c	A	A	A	n																									
Saturation	92	98	100	99%	98	99%	100																								

MEWS SCORE for EACH of the INDIVIDUAL OBSERVATIONS

Temperature (°C)	0	0	0	0	0	0	0																								
BP (Systolic)	0	0	0	0	0	0	0																								
Heart Rate	3	2	0	0	0	0	0																								
Respiratory Rate	1	3	0	0	0	0	0																								
SpO_2	0	0	0	0	0	0	0																								
Urine Output	0	0	0	0	0	0	0																								
CNS	0	1	0	0	0	0	0																								

MEWS SCORE - TOTALS

Record the total MEWS scores for each set of observations this way

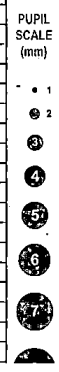
6		0																													
5																															
4																															
3																															
2																															
1																															
0																															

Sedation Score	0	1	0	0	0	0	0																								
Pain Score (On Movement)	0	0	0	0	0	0	0																								
Nausea Score	0	0	0	0	0	0	0																								

Eyes Open	Spontaneously	4																													
	To speech	3	o	X																											
	To pain	2																													
	None	1																													
Best Verbal Response	Orientated	5																													
	Confused	4																													
	Inaprop. words	3																													
	Incomp. sounds	2		X																											
	None	1																													
Best Motor Response	Obeys commands	6		X																											
	Localise pain	5																													
	Withdrawl to pain	4																													
	Abnormal flexion to pain	3																													
	Extension to pain	2																													
	None	1	12	11																											
GCS TOTAL																															

PUPILS	R	Size	4																												
		Reaction	+																												
	L	Size	4																												
		Reaction	+																												
LIMB MOVEMENT	ARMS	Normal power	0	RL																											
		Mild weakness																													
		Severe weakness																													
		Spastic flexion																													
		Extension																													
		No response																													
	LEGS	Normal power	0	RL																											
		Mild weakness																													
		Severe weakness																													
		Extension																													

PUPIL SCALE (mm)



4202

Multi-Disciplinary Discharge Plan

CHI: 0902763334
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Dr G Paton

Multi-Disciplinary Referrals

Discuss with patient and obtain patient consent for referrals.
Record referrals made or contact details for staff outwith Hospital if not on admission information.

Referral			First Seen	
Date	**Initials**	**Service referred to**	**Date**	**Initials**

Discharge requirements		Completion date	Initials
	Discharge medicines ordered dispensed by ward	3/5/14	US
	Patients own medication returned N/K		
	Check patients medication with patient / carer before discharge ✓	3/5/14	US
	7 day supply of dressings, continence aids, catheters or stoma products (new patients must be given a 7 day supply and refer to district nurse for re-assessment)		
	Supplements: new patients must be given a 7 day supply		
	Written advice / information on self-care and lifestyle including diet		
	Cannula removed (Y) N N/A	3/5/14	US
	Follow-up arrangements given Y N N/A		
	If patient not for resuscitation, compete DNACPR discharge plan		
Alert Note: Any changes made to discharge date must be communicated to patient / relative / carer and all services involved ☐ Re-inform all services involved when new date is established ☐			
	Discuss and agree discharge date with patient / relative / carer and all members of multi-disciplinary team		
	Discuss and document all discharge plans with patient and / or relative / carer and services	3/5/14	US

Patient Seen by medical staff
Can be discharged home as planned
& Steven

Medicine Prescription Sheet

Patient JOHNSTONE, LEE DAVID
Address 12 WOODSIDE AVENUE
MAYBOLE
AYRSHIRE
KA19 7PP

Hospital Number 0902763334
CHI Number 0902763334
Date of Birth 09/02/1976
Ward STATION 9-AYR
Consultant DR KOFI OFUAFOR

Allergy	Reaction
No Known Drug Allergies	

Date Printed: 03/05/2014 15:38
User Name: NU2064

	Date Started	Date Stopped, Suspended or Resumed	Approved Name of Medicine	Dose	Frequency	Route	Other Instructions	Last EPA dose given	Prescriber / Verified by:
A	02/05/2014		OMEPRAZOLE 20 mg Capsules	20 mg	07:00	Oral		03/05/2014 at 08:31:00	MISS EMMA DE COURCY / MISS EMMA DE COURCY
C	02/05/2014		PARACETAMOL 500 mg Tablets	1000 mg	07:00 13:00 18:00 22:00 PRN	Oral	FOR PAIN	1000 mg on 02/05/2014 at 14:00:00	DR TANVIR ABASS
D	03/05/2014		Either CYCLIZINE 50 mg Tablets	50 mg	07:00 13:00 22:00 PRN	Oral	FOR NAUSEA		
E	03/05/2014		Or CYCLIZINE 50 mg in 1 mL Injection	50 mg	07:00 13:00 22:00 PRN	Intramuscular	FOR NAUSEA		
F	03/05/2014		Or CYCLIZINE 50 mg in 1 mL Injection	50 mg	07:00 13:00 22:00 PRN	Intravenous Bolus Injection	FOR NAUSEA		DR JAY MALONEY
G	03/05/2014		Either ONDANSETRON 4 mg Tablets	4 mg	every 8 hours PRN	Oral	NAUSEA		
H	03/05/2014		Or ONDANSETRON 4 mg in 2mL Injection	4 mg	every 8 hours PRN	Intravenous Slow Bolus	NAUSEA		
I	03/05/2014		Or ONDANSETRON 4 mg in 2mL Injection	4 mg	every 8 hours PRN	Intramuscular	NAUSEA		DR JAY MALONEY

Read report carefully. Pay particular attention to the Date Stopped, Suspended or Resumed column

NHS AYRSHIRE & ARRAN

HOSPITAL Ayr M 07803

PATIENT'S CASH AND VALUABLES FORM

1. Patient's Name Lee Johnstone (Surname first in BLOCK CAPITALS) Ward ICU
   Address 12 WOODSIDE AVENUE Date of Admission 30.04.14
   KIRKMICHAEL
   KA19 7PP

2. Cash: £ 18.51
   Other valuables (including cheque & stamps)
   1 MOTOROLA MOBILE PHONE
   1 BLACK WALLET
   1 YELLOW METAL BRACELET
   1 HOUSE KEY
   CARDS:- 2 DRIVING LICENCES (2 different names)
   2 POST OFFICE CARD ACCOUNT
   Bank/ Building Society Book? Y / N Balance on Date of Arrival
   Pension Book? Y / N Date of First Usable Voucher
   Signature of Nurse [signature] Rank [illegible]
   Signature of Patient/Witness [signature]

3. Articles given into safekeeping of relatives
   Signature of Relative Relationship
   Signature of Witness Date

4. Received in Cashier's Office by:
   Signature
   Designation Date
   No. of Official Receipt for cash etc Envelope No. (valuables only)

5. Received by Patient on Discharge:
   Received from Cashier the Cash and Valuables recorded at item 2 above.
   Signature [signature] Date 1/5/14
   Witness M Stirling Date 1/5/14

Note: NHS Ayrshire & Arran cannot accept responsibility for property of any kind (including money) which is retained by patients.

NHS AYRSHIRE & ARRAN

HOSPITAL Ayr M 11323

RECORD OF CLOTHING BROUGHT TO WARD (MALE PATIENTS)

Ward IOU Name of Patient Lee Johnstone

Date 30.04.14

Description	Number of Articles
COAT	
HAT/CAP	1
JACKET	
WAISTCOAT	
TROUSERS Jeans	1
CARDIGAN	
PULLOVERS Hoodie	1
TIES	
SCARF	
SHIRT	1
VEST	
PANTS	1
SOCKS	1
SHOES/BOOTS Trainers	1
SLIPPERS	
HANDKERCHIEFS	
PYJAMAS	
DRESSING GOWNS	
DENTURES	
PURSE	
MONEY	
CASE	
KEYS	
GLASSES	
WATCH WRIST/POCKET	
RINGS	
TOILET BAG/CONTENTS	
_____	
_____	

Signature of Nurse [signature] Date 30.04.14

Signature of Witness [signature] Date .....

I certify that the above is a correct record of articles brought into the hospital by me. I also understand that any of the above articles retained in my possession are held on my own responsibility.

Patient's Signature .....

* Certified that the above articles of clothing have been removed from the ward.

Signature of Relative .....

*Received the above mentioned articles on discharge from hospital.

Signature of Patient ..... Date .....

**Delete as appropriate*

Note: NHS Ayrshire & Arran cannot accept responsibility for property of any kind (including money) which is retained by patients.

Goals of Care



CHI: 0902763334
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Date & Time	Ward Round Instructions	EDD	Initials	Date & Time	Ward Round Instructions	EDD	Initials
30/4/14	Patient admitted						
2215	from A&E						
	To keep isolated						
	& ventilated						
	overnight for						
	? lumbar puncture						
	later						
1/5/14	Alcohol Liaison						
1330	referral ☐						
	Parkinex ☐						
	Ward ☐		MS.				

Lifestyle / Risk Assessment

Patient sedated & ventilated

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Dr G Paton

Lifestyle/Risk Assessment	Initial assessment Date: / /	Subsequent assessment Date: / /
Communicating	**Problems/Risk**	**Problems/Risk**
1. Any specific communication needs – Speaking ☐ Reading ☐ Writing ☐ Glasses ☐ Contact Lenses ☐ Hearing aid – Left ☐ with Patient ☐ Hearing aid – Right ☐ with Patient ☐		
Breathing	**Problems/Risk**	**Problems/Risk**
Factors influencing breathing – rate, depth, cough, breathlessness. Smoker YES / NO Referral to Smoking cessation offered YES / NO 1. Equipment/aids – circle all that apply: Inhalers / oxygen – concentrater/cylinder / nebulisers / tracheostomy	Needs:	Needs:
Mobilising	**Problems/Risk**	**Problems/Risk**
Does the patient have a reduced functional ability? YES/NO Walking Aids ☐ Pain ☐ Poor Balance ☐ Uncoordinated movements ☐ Medication ☐ Falls History ☐ Cognitive Impairment ☐ Sensory Problems ☐ Is patient at risk from falling from bed? YES / NO If YES, refer to algorithm.	Needs: Is the patient at risk of falls? YES / NO (If yes apply the falls care *bundle*) Nurse Initials _____	Needs: Is the patient at risk of falls? YES / NO (If yes apply the falls care *bundle*) Nurse Initials _____

Patient sedated & ventilated on admission

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	Initial assessment Date: / /	Subsequent assessment Date: / /
Personal Cleansing & dressing	**Problems/Risk**	**Problems/Risk**
Is Patient independent: YES / NO What type of assistance is required by the patient (please consider patient preferences)	Needs: Does the patient require help? YES / NO (If yes apply the personal care bundle) Nurse Initials ___	Needs: Does the patient require help? YES / NO (If yes apply the personal care bundle) Nurse Initials ___
(Adapted PPURA) Skin Integrity	**Problems/Risk**	**Problems/Risk**
Assess condition of skin, any wounds / lesions / stomas **Date** ___ ___ **Time** ___ ___ **Mobility** Patient is fully mobile without equipment/assistance YES / NO **Continence** Patient is fully continent YES / NO **Nutrition** Patient appears well nourished and able to eat and drink YES / NO	Needs: If **No** to any apply the skin bundle. Nurse Initials ___	Needs: If **No** to any apply the skin bundle. Nurse Initials ___
Spiritual or religious needs	**Problems/Risk**	**Problems/Risk**
Religion? Do you have any spiritual or religious needs whilst in hospital? (please state) Would you mind if your details were passed to the hospital Chaplain service? YES / NO Specify needs or cultural practices that place limitations on the patients care (Please state)	Needs	Needs

Nutritional Care

CHI: 0902763334
Johnstone, Lee
12 Woodside Avenue
Maybole
KA19 7PP
09/02/1976
Dr G Paton

Date / Time	30:04:14 2200
Oedema/ Ascites?	~~YES~~ (NO)
Height (M)	1·67 est.
Stadiometer ☐ Self reported height (if reliable) ☐ By Carer ☐	
Current Weight (kg)	95 est.
Actual Measured ☐ Self reported weight (if reliable) ☐ By Carer ☐	
Corrected weight (kg)	
BMI	
Is patient obese?	~~YES~~ / NO Patient Informed? YES / NO
Usual weight (kg)	
Variance	

Malnutrition Universal Screening Tool (MUST) Calculator

STEP 1
BMI Score
(from Ready Reckoner)

BMI kg/m²	Score
Greater than 20 (>30 obese)	= 0
18.5 – 20	= 1
Less than 18.5	= 2

STEP 2
Weight Loss Score
(from Ready Reckoner)

Unplanned weight loss in past 3 – 6 months (this includes obese patients)

%	Score
Less than 5	= 0
5 – 10	= 1
Greater than 10	= 2

STEP 3
Acute disease

If patient is acutely ill and there has been or is likely to be no nutritional intake for more than 5 days

Score 2

Score 0 if not applicable

0 | 0 | 0

STEP 4
(Add step 1, 2 and 3 together to give overall risk of malnutrition ('MUST' Score)

0

STEP 5
Implement Nutritional Care Bundle for Patients at risk

Date	Oedema / Ascites Yes / No	Current Weight	Corrected Weight	Measured	BMI	Step 1 Score	Step 2 Score	Step 3 Score	Step 4 Total Score	Dietetic Referral Yes / No	Date for Review	Initials
				☐								
				☐								
				☐								
				☐								
				☐								
				☐								

Multidisciplinary Medicines Reconciliation Form

CHI: 0902763334
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09/02/1976
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Patient	☐	Emergency care summary	☐
Relative / Carer	☐	Nursing home chart	☐
Patient's own drugs	☐	Previous discharge letter	☐
GP referral letter	☐	Repeat prescription slip	☐
GP practice	☐	Other (please state)	☐ .....

Admission Medicines			Action (Note: Unless otherwise indicated below medicine should be continued on prescription sheet)				
Name, Form, Route (specify if not oral)	Dose	Frequency	Suspend	Amend	Stop	Comments (if medicine suspended, amended, stopped or inaccurate)	Pharm initials if change
[illegible]	20mg						

Are the patients medications stored in the ward?	Yes	No	Initials
Have the medications been returned to the relatives?	Yes	No	Initials

Over the counter / herbal / homeopathic / illicit substances	Further information e.g. compliance aid, recent discounted medicines	

Signature..... Print name.....Designation.....

NHS Ayrshire & Arran

The Ayr Hospital
Intensive Care Unit

Todays Date 01:05:14 No. of ICU Days 1

Date of Admission to ICU 30:04:14

Reason for Admission Fluctuating GCS

Nature of Surgery ..... No.Of Post Op Days 1

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VENTILATION	HANDOVER CHECKS	DAY- please sign	NIGHT-please sign
Tube Type: ET Tube	Ventilator Alarms		
Tube Size: 8.5	Monitor Alarms		
No. of days: 1	Bedside Equipment	M. Stevenson	
Ventilator No: 13055	Renal Prescription	~	
Space: ONE			

Administration Sets	Time due changed	Signature
Feeding Line (1)		
Crystalloids (3)	21:45	
Drugs (1)		
Propofol	2200	
Alfentanil		

Disposables	Days in use	Date due Changed	Signature
1 + Filter (1)	1	01514	
Nebuliser/MDI (1)			
Trachcare (3)	1	030514	Removed
EtCo2 (3)	1	030514	
Vent Tubing (7)	1	070514	
O² Mask: (1)			
Respiflo (2)			
Bi-Pap Mask (7)			
CPAP Circuit (2)			
Nasal High Flow (7)			
Chest Drain Bottle (2)			
Octopus (7)	1	070514	
Bionector (7)	1	070514	
Flexiseal (28)			Removed
Urometer (7)	1	070514	
Urinary Catheter (28)	1	280514	

GLASGOW COMA SCALE X2/shift			TIME
COMA SCALE	Eyes open	Spontaneously	Eyes closed by swelling = C
		To speech	
		To pain	
		None	
	Best verbal response	Orientated	Endotracheal tube or tracheostom = T
		Confused	
		Inappropriate words	
		Incomprehensible sounds	
		None	
	Best Motor response	Obey commands	Usually the best arm response recorded
		Localised pain	
		Withdrawal to pain	
		Abnormal flexion to pain	
		Extension to pain	
		None	
LIMB MOVEMENT	ARMS	Normal power	Record right (R)) and left (L) separately i there is a difference between th two sides
		Mild weakness	
		Severe weakness	
		Spastic flexion	
		Extension	
		No response	
	LEGS	Normal power	
		Mild weakness	
		Severe weakness	
		Extension	
		No response	
PUPILS	Right	Size	+ Reacts -no reacti c eye clos
		Reaction	
	Left	Size	
		Reaction	

Pupil Size in mm

1 2 3 4 5 6 7 8



ICU/HDU | CRITICAL CARE SKIN INSPECTION | AYR HOSPITAL

Frequency of care: Aim for 2 hourly

Moving & Handling Aids: Sliding Sheet
Other Pressure Relieving Aids: _____
Type of Mattress: Soft foam mattress

ASSESS AND DOCUMENT INTEGRITY OF PATIENTS SKIN WITHIN 2 HOURS OF ADMISSION: YES ( ) NO ( ) IF NOT DOCUMENT WHY.

Time (use 24 hour clock)	0900											
SURFACE												
Pressure relieving equipment working? Y/N	WIA											
SKIN INSPECTION												
Tick if pressure areas checked	Record N if no damage R for redness. D for discolouration. U for existing pressure ulcer. E for excoriation, SC for self care											
All pressure areas checked												
Evidence of pressure related damage? If Y Record action on evaluation chart												
KEEP MOVING (positional change)												
SL = Skin Loading (if unable to turn), A = Absent, R = Refused, D = Deviation												
Bed R=Right L=Left B=Back P=Prone												
Chair Stand/Redistribute Pressure	Chair											
INCONTINENCE												
Urine Y/N												
Bowels Y/N												
MEDICAL DEVICES LIKELY TO CAUSE PRESSURE (Tick those checked)												
ET tube (corners of mouth, back of neck)												
Nasogastric tube (nostrils)												
O2 Saturation Pleth (alternate site)												
NIV Mask (nose, chin, forehead)												
O2 mask (tops of ears)												
Bowel management system												
Urinary catheter												
Other:												
Nurses Initials												

NB: Document any reasons for deviation from 2 hourly care or necessary action taken overleaf in the evaluation box.

WL/2013

SKIN INSPECTION EVALUATION PAGE

DATE & TIME	EVALUATION	ACTION TAKEN	INITIALS
DAYSHIFT	Patient Status Skin intact		
NIGHTSHIFT			

IF ULCER NOTED TO BE GRADE 3 OR 4 REFER TO TISSUE VIABILITY. FILL OUT WOUND ASSESSMENT CHART IF PATIENT HAS PRESSURE ULCER GRADE 2 OR ABOVE.

NB: SKIN DAMAGE DETERMINED AS A RESULT OF INCONTINENCE AND/OR MOISTURE ALONE SHOULD NOT BE RECORDED AS A PRESSURE ULCER.

IDENTIFIED CARE NEEDS

NO.	Daily Plan of Care	SIGNATURE	NO.	Daily Plan of Care	SIGNATURE
1	SKIN INSPECTION		8		
2	MASE CARE		9		
3	RESPIRATORY CARE		10		
4	NUTRITION/HYDRATION CARE		11		
5	PVC Maintenance bundle	M Stevenson	12		
6			13		
7			14		

PLAN OF CARE/BUNDLES AVAILABLE in ICU/HDU

CRITICAL CARE SKIN INSPECTION
MASE
RESPIRATORY CARE
NUTRITION/HYDRATION CARE
PVC MAINTENANCE BUNDLE

ARTERIAL LINE MAINTENANCE BUNDLE
CVAD MAINTENANCE BUNDLE
CAUTI PREVENTION BUNDLE
PAIN CARE PLAN
RENAL CARE PLAN (CRRT, AKI)

VASOACTIVE DRUGS
VAP BUNDLE
SEVERE SEPSIS CARE BUNDLE
COGNITIVE IMPAIRMENT
FALLS PREVENTION BUNDLE

NHS Ayrshire & Arran

NAME: Mrs Johnstone

24 Hour Fluid Balance

INPUT (mls)								IN		OUT	OUTPUT (mls)						
Time HRS	Oral/Naso Gastric	BLOOD PLASMA	I.V. (1)	I.V. (2) TPN	Infusion Pumps	I.V. Drugs	Hourly Total	Cumulative Total	Balance (mls)	Cumulative Total	Hourly Total	URINE	Gastric Aspirate				Time Hrs
08			100		22		122	122		555	555	55	500				08
09	100+200					100	400	522		585	030	30	7				09
10	200		100				300	822	+197	625	40	40					10
11																	11
12	200						200	1022									12
13	200						200	1222		825	200	200					13
14																	14
15																	15
16																	16
17																	17
18																	18
19																	19
20																	20
21																	21
22																	22
23																	23
24																	24
01																	01
02																	02
03																	03
04																	04
05																	05
06																	06
07																	07
								Total In	Balance	Total Out		Insensible loss					

NHS Ayrshire & Arran

Name Lee Johnson

Date 01:05:2014

Extubated 0830

Observations Recording Chart

TIME			08⁰⁰	09⁰⁰	10⁰⁰	11⁰⁰	12⁰⁰	13⁰⁰	14⁰⁰	15⁰⁰	16⁰⁰	17⁰⁰	18⁰⁰	19⁰⁰	20⁰⁰	21⁰⁰	22⁰⁰	23⁰⁰	24⁰⁰	01⁰⁰	02⁰⁰	03⁰⁰	04⁰⁰	05⁰⁰	06⁰⁰	07⁰⁰
MODE			SIMV	Hum	R/A																					
INSPIRED O2			0.4	0.4	~~0.35~~																					
P Insp	P High																									
CPAP OR PEEP	P Low		3																							
SUPPORT or ASSIST	T High		10																							
PEAK PRESSURE	T Low		20																							
SET VT			520																							
SET RATE (SIMV / CMV)			15																							
SET MV																										
MEASURE EXP VT			525																							
MV			6.2																							
MEASURED RATE			15																							
SPONT RATE				8	15		17		18																	
VT																										
MV																										
Length of ET tube @ lips																										
I : E RATIO			1:2																							
CUFF PRESSURE/VOLUME			31																							
AIR ENTRY:	APICES		F																							
R . L	BASES		F																							
SUCTION:	ET																									
	ORAL																									
ABG'S	H+																									
	PO^2																									
	PCO^2																									
	HCO^3																									
	BASE EXCESS																									
	Potassium																									
	Lactate																									
	Hb																									
TEMP	39	240	36.8				37.5		37.8																	
	38	230																								

| | | |

NHS Ayrshire & Arran

The Ayr Hospital
Intensive Care Unit

Todays Date 30:04:14 ..... No. of ICU Days: Admission

Date of Admission to ICU 30:04:14 .....

Reason for Admission: Awaiting CCS .....

Nature of Surgery — ..... No.Of Post Op Days: Adm

Write or attach label

HCF
CHI CHI: 0902763334
Surr Johnstone, Lee
Fore 12 Woodside Avenue
Add Maybole
..... KA19 7PP
Date 09/02/1976
Dr G Paton

VENTILATION	HANDOVER CHECKS	DAY- please sign	NIGHT-please sign
Tube Type: ET Tube	Ventilator Alarms		
Tube Size: 8.5	Monitor Alarms		
No. of days: 0	Bedside Equipment		
Ventilator No: 13055	Renal Prescription		
Space: ONE			

Administration Sets	Time due changed	Signature
Feeding Line (1)		
Crystalloids (3)	21⁴⁵	
Drugs (1)		
Propofol	22⁰⁰	
Alfentanil	22⁰⁰	

Disposables	Days in use	Date due Changed	Signature
+ Filter (1)	0		
Nebuliser/MDI (1)			
Trachcare (3)			
EtCo2 (3)	0		
Vent Tubing (7)			
O² Mask: (1)			
Respiflo (2)			
Bi-Pap Mask (7)			
CPAP Circuit (2)			
Nasal High Flow (7)			
Chest Drain Bottle (2)			
Octopus (7)	0		
Bionector (7)	0		
Flexiseal (28)			
Urometer (7)	0		
Urinary Catheter (28)	0		

GLASGOW COMA SCALE X2/shift			22⁰⁰	03				TIME
COMA SCALE	Eyes open	Spontaneously						Eyes closed by swelling = C
		To speech						
		To pain						
		None						
	Best verbal response	Orientated						Endotracheal tube or tracheostom = T
		Confused						
		Inappropriate words						
		Incomprehensible sounds						
		None	T	T				
	Best Motor response	Obey commands						Usually the best arm response recorded
		Localised pain						
		Withdrawal to pain						
		Abnormal flexion to pain						
		Extension to pain						
		None						
LIMB MOVEMENT	ARMS	Normal power						Record right (R)) and left (L) separately i there is a difference between th two sides
		Mild weakness						
		Severe weakness						
		Spastic flexion						
		Extension						
		No response						
	LEGS	Normal power						
		Mild weakness						
		Severe weakness						
		Extension						
		No response	*					
PUPILS	Right	Size	4	3				+ Reacts -no reacti c eye clos
		Reaction	+	+				
	Left	Size	4	3				
		Reaction	+	+				

Pupil Size in mm

1 2 3 4 5 6 7 8



ICU/HDU | CRITICAL CARE SKIN INSPECTION | AYR HOSPITAL

Frequency of care: Aim for 2 hourly

Moving & Handling Aids: Sliding Sheet
Other Pressure Relieving Aids: Sofflon
Type of Mattress: Basic care bed

ASSESS AND DOCUMENT INTEGRITY OF PATIENTS SKIN WITHIN 2 HOURS OF ADMISSION: YES ( ) NO ( ) IF NOT DOCUMENT WHY.

Time (use 24 hour clock)	22[illegible]	00[illegible]	04[illegible]									
SURFACE												
Pressure relieving equipment working? Y/N	Yes	Yes	Yes									
SKIN INSPECTION												
Tick if pressure areas checked	Record N if no damage R for redness. D for discolouration. U for existing pressure ulcer. E for excoriation, SC for self care											
All pressure areas checked	✓	✓	✓									
Evidence of pressure related damage? If Y Record action on evaluation chart	N	N	N									
KEEP MOVING (positional change)												
SL = Skin Loading (if unable to turn), A = Absent, R = Refused, D = Deviation												
Bed R=Right L=Left B=Back P=Prone	B	L	B									
Chair Stand/Redistribute Pressure	-	-	-									
INCONTINENCE												
Urine Y/N	N	N	N									
Bowels Y/N	N	N	N									
MEDICAL DEVICES LIKELY TO CAUSE PRESSURE (Tick those checked)												
ET tube (corners of mouth, back of neck)	✓	✓	✓									
Nasogastric tube (nostrils)	✓	✓	✓									
O2 Saturation Pleth (alternate site)	✓	✓	✓									
NIV Mask (nose, chin, forehead)												
O2 mask (tops of ears)												
Bowel management system												
Urinary catheter	✓	✓	✓									
Other:												
Nurses Initials	[illegible]	[illegible]	[illegible]									

NB: Document any reasons for deviation from 2 hourly care or any necessary action taken overleaf in the evaluation box.

WL/2013

NHS Ayrshire & Arran Name Lee Johnstone Date 30:04:14

Observations Recording Chart

TIME	06⁰⁰	09⁰⁰	10⁰⁰	11⁰⁰	12⁰⁰	13⁰⁰	14⁰⁰	15⁰⁰	16⁰⁰	17⁰⁰	18⁰⁰	19⁰⁰	20⁰⁰	21⁰⁰	22⁰⁰	23⁰⁰	24⁰⁰	01⁰⁰	02⁰⁰	03⁰⁰	04⁰⁰	05⁰⁰	06⁰⁰	07⁰⁰
MODE															SIMV									
INSPIRED O2															0·6			0·4						
P insp / P High																								
CPAP OR PEEP / P Low															5			3						
SUPPORT or ASSIST / T High															10									
PEAK PRESSURE / T Low															28	22	20	19	18	19	18	18	18	19
SET VT															520									
SET RATE (SIMV / CMV)															15									
SET MV																								
MEASURE EXP VT															603	522	521	527	523	517	518	517	520	522
MV															7·0	5·9	5·8	6·1	6·2	6·1	6·4	6·1	6·9	6·18
MEASURED RATE															15	15	15	15	15	15	15	15	15	15
SPONT RATE																								
VT																								
MV																								
Length of ET tube @ lips															20									
I : E RATIO															1:2·1									
CUFF PRESSURE/VOLUME															100	32								
AIR ENTRY: APICES																FQ		FQ				FF		
R . L BASES																FQ		FQ				QQ		
SUCTION: ET																3M			3M		2M			
ORAL															✓	✓		✓	✓		✓			
ABG'S H+																								
PO²																								
PCO²																								
HCO³																								
BASE EXCESS																								
Potassium																								
Lactate																								
Hb																								
TEMP 39 240															37·5		36·4		36·5			37·9		
36 230																								

| | | |

NHS Ayrshire & Arran ..AME:_____

24 Hour Fluid Balance

	INPUT (mls)							IN		OUT	OUTPUT (mls)						
Time HRS	Oral/Naso Gastric	BLOOD PLASMA	I.V. (1)	I.V. (2) TPN	Infusion Pumps	I.V. Drugs	Hourly Total	Cumulative Total	Balance (mls)	Cumulative Total	Hourly Total	URINE	Gastric Aspirate				Time Hrs
08																	08
09																	09
10																	10
11																	11
12																	12
13																	13
14																	14
15																	15
16																	16
17																	17
18																	18
19																	19
20																	20
21																	21
22	~~485~~		125		15		140	140		500	500	500					22
23			125		17		147	287		760	260	260					23
24			125		17		142	429		860	100	100					24
01			125		17		142	571		960	100	100					01
02			100		17		117	688	-372	1060	100	100					02
03			100		17		117	805		1260	200	200					03
04			100		27		127	932		1340	80	80					04
05			100		27		127	1059		1440	100	100					05
06			100		27		127	1186		1500		60					06
07			100		27		127	1313	-247	1560	60	60					07
												Insensible loss					
								Total In	Balance	Total Out							
									-247								

I.V. Therapy

Prescription Chart

CH
Sur CHI: 0902763334
For Johnstone, Lee
Add 12 Woodside Avenue
Maybole
..... KA19 7PP
Date 09/02/1976
Dr G Paton

	Date	FLUID (USE BLOCK LETTERS) ADDITIVE DRUG	Vol (ml) Dose (mg)	Route of Admin.	Dur of Admin.	Signature	Serial No. Batch No.	Time Begun	Given by Added by
A	1/5/14	Hartmanns	500	IV	5L	SL	14B2 5TLHH	0145	A
B	"	Hartmanns	500	IV	5L	SL	14B2 5TLHH	0645	AL
D									
E									
F									
G									
H									
I									
J									
K									
L									
M									
N									
O									

NHS Ayrshire & Arran

ICU/HDU

Blood Results

CHI: 0902763334
Johnstone, Lee
12 Woodside Avenue
Maybole
KA19 7PP
09/02/1976
Dr G Paton

	Date	30/4/14	1/5/14						
	Time	2000	0900						
Biochemistry	**Normal values**								
Urea	2.5-7.5	2.2	3.1						
Creatinine	50-125	91	86						
Sodium	135-145	136	141						
Potassium	3.5-5.5	4.2	3.5						
Chloride	95-105	100	104						
Bicarbonate	22-33		22						
Glucose	3.3-5.5		3.4						
Amylase	70-100								
Bilirubin	3-15	6							
Alk. Phosphate	45-140	85							
Total Protein	63-83	77							
Albumin	39-51	47							
Globulin	16-37	30							
Calcium	2.2-2.6								
Cor. Calcium	2.1-2.5								
Phosphate	0.8-1.3								
Zinc	14-16								
Magnesium	0.7-1.1								
AST	10-40	23							
ALT	10-50	23							
LDH	250-540								
CK	M: 24-195 F: 24-170	173							
CRP	2-10	<5	5						
Digoxin	0.5-2.0								
Troponin	<0.03								
Phenytion	10-20								
Gentamycin	Per protocol								
Vancomycin	Per protocol								
Theophylline	10-20								
Paracetamol		<7							
Haematology									
HB	11.5-16.4	154	140						
WCC	4.0-11.5	8.4	9.1						
Platelets	100-500	267	218						
Fibrinogen	150-400	3.35	2.78						
PT time	9-13	11	11						
APTT	25-33	22	23						
INR									
Alcohol	mg/dl	339							

NHS Ayrshire & Arran

ICU/HDU

Bacteriology

CHI: 0902763334
Johnstone, Lee
12 Woodside Avenue
Maybole
KA19 7PP
09/02/1976
Dr G Paton

Date	Specimen Type	Source	Date	Results	Action
01/5/14	MRSA SCREEN	NOSE PERINEUM URINE			

NB – if patient has loose stools, please refer to Bristol Stool Chart

ANTI-EMBOLIC STOCKINGS CHECKLIST

Once per shift the patients legs to be checked to ensure that stockings are fitted correctly (no wrinkles) and that there is no pain or discomfort.

Date 01.4.14 Patient leg measurements 38cm Size of stocking applied medium

Sign when completed

Date	Day Shift	Night Shift	Removed for 30 mins/day	Fresh stockings every 3rd day

CHI: 0902763334
Johnstone, Lee
12 Woodside Avenue
Maybole
KA19 7PP
09/02/1976
Dr G Paton

CONTRAINDICATIONS TO WEARING ANTI-EMBOLIC STOCKINGS

	Yes
Peripheral Vascular Disease	
Diabetic peripheral neuropathy	
Cellulitis	
Arterial Graft	
Extreme leg deformity of misshapen leg (preventing correct fit)	
Fragile skin; dermatitis; skin lesions; skin grafts; gangrene	
Foot ulceration	
Known allergy to stockings	
If patient refuses to wear stockings	
Intermittent claudication	
Trophic skin changes (cold, pale, shiny hairless legs	
Acute stroke	
Cardiac failure/pulmonary oedema	

If patient is on noradrenaline, stockings should be removed.

(SIGN guidelines 2012; NICE guidelines 2010; All Walés Tissue Viability Forum 2009; Walker and Lamont 2007).

If answer to any of the above contraindication do not apply anti-embolic stockings.

Patient given stockings Yes ~~No~~ Date 1.5.14 Time 0010

Signature L Livingstone

CHI: 0902763334
Johnstone, Lee
12 Woodside Avenue
Maybole
KA19 7PP
09/02/1976
Dr G Paton

NASOGASTRIC TUBE POSITION CONFIRMATION RE

The position of the nasogastric tube should be checked:

- Following initial insertion (please use placement checklist to record this)
- Before administering each feed
- Before giving medications
- Any new or unexplained respiratory symptoms or if oxygen saturations decrease
- At least once daily during continuous feeds
- Following episodes of vomiting, retching or coughing spasms
- When there is suggestion of tube displacement

If you are not able to confirm that the tube is in the stomach it should be removed and reinserted. This should be documented on the nasogastric tube placement bedside checklist.

DATE	01/09/14	4/5/14					
TIME	0010	2200					
Ph							
EXTERNAL TUBE LENGTH	36cm	Removed					
CHECKED BY	[signature]	MS					
DATE							
TIME							
Ph							
EXTERNAL TUBE LENGTH							
CHECKED BY							

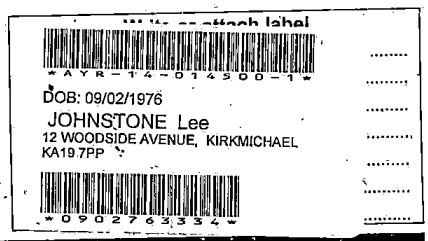
HIGH RISK INFUSION THERAPY CHART

NHS AYRSHIRE & ARRAN

SHEET NUMBER: .....

PATIENT WEIGHT: .....

ALLERGIES: .....



1 MEDICINE AND DILUTION DETAILS (to be completed by PRESCRIBER before start of therapy) Consult Pharmacy prior to prescribing additives

MEDICINE	Total Amount of Drug (mg)	Diluent	Total Volume (mls)	Drug Concentration (mg / ml)	Route of Administration	Prescriber's Signature
1. ALFENTANIL	30mg	N. SALINE	30mls	1mg/ml	IV	S Livingstone
Additive 1						
Additive 2						

2 DOSE AND FLOW RATE DETAILS (to be completed by PRESCRIBER)

	Date	Start Time	Dose or Range to be Administered (Dose / Weight / Time)	Required Flow Rate Setting or Range (mls / hour - mm / time)	If Range, Actual Flow Rate to be commenced (mls / hour - mm / time)	Prescriber's Signature
Initial rate	30/4/14	22.00.		0-3ml/hr	2ml/hr	S Livingstone
New rate						
New rate						
New rate						
New rate						
New rate						

3 PREPARATION / PRODUCT DETAILS (where a pre-prepared solution is available, the batch number should be recorded under the *Drug* section below)

	Date	Time	Prepared by	Checked by	Batch Number Drug(s)	Batch Number Diluent
Initial Preparation	30/4/14	2205			3430346	1431472B

4 MONITORING AND DEVICE SELECTION (To be completed by Nurse / Prescriber before start of therapy)

Infusion Device Selected	ALARIS
Serial / Equipment Number	12248

Replacement 2											2 GCS	
Replacement 3											3 Rural Secretary	
Replacement 4											4	

5 ADMINISTRATION CHECK (To be completed in full by Nursing Staff) — **HOURLY**

6 START / STOP / RATE CHANGE CHECK The reason for the alteration must always be recorded

Date	Time Infusion Checked or Stopped	Total Volume Infused	Volume Remaining (Approximate)	Actual Rate Setting	Check by	Time Infusion Started / Restarted	Rate Setting	Started / Restarted	Checked by	10 minute check	Reason for change in rate / stop. Comments
30/4/14						2200	2ml		EC		Prescription + 0.9% bolus
	2300	2.1dml	20ml	2ml	AL						
01/05/14	0000	4.67ml	24ml	2ml	AL						
	0100	6.67ml	22ml	2ml	AL						
	0200	8.63ml	20ml	2ml	AL	0215	1.5ml	AL	SG		rate ↓
	0300	10.3	19ml	2ml	AL	0315	2.0ml	AL	MM4P		rate ↑
	0400	13.1ml	16ml	2ml	AL						
	0500	14.8	15	2ml	AL						
	0615	17.3	12	2ml							
	0700	18.8	10	2ml							
	0800	21.1	8	2ml	MS	0800	1.5	MS			
						0825	off	MS			

STA3013

Time

RECORDING CHART

AYR-14-014500-1

DOB: 09/02/1976

JOHNSTONE Lee
12 WOODSIDE AVENUE, KIRKMICHAEL
KA19 7PP

0902763334

SHEET NUMBER: .....

PATIENT WEIGHT: .....

ALLERGIES: .....

1 MEDICINE AND DILUTION DETAILS (to be completed by PRESCRIBER before start of therapy) Consult Pharmacy prior to prescribing additives

MEDICINE	Total Amount of Drug (mg)	Diluent	Total Volume (mls)	Drug Concentration (mg / ml)	Route of Administration	Prescriber's Signature
1 PROPOFOL	1000mg	None	100mls	10mg per ml	IV	Johnstone
Additive 1						
Additive 2						

2 DOSE AND FLOW RATE DETAILS (to be completed by PRESCRIBER)

	Date	Start Time	Dose or Range to be Administered (Dose / Weight / Time)	Required Flow Rate Setting or Range (mls / hour - mm / time)	If Range, Actual Flow Rate to be commenced (mls / hour - mm / time)	Prescriber's Signature
Initial rate	30/4/14	2100	0.3mg - 4.0mg per kg per hour	0 - 40mls per hour. (Maximum rate per hour: - 50kg= 20ml, 60kg= 24ml, 70kg= 28ml, 80kg= 32ml, 90kg=36ml, 100kg= 40ml)	15ml/h	Johnstone
New rate						
New rate						
New rate						
New rate						
New rate						

3 PREPARATION / PRODUCT DETAILS (where a pre-prepared solution is available, the batch number should be recorded under the *Drug* section below)

	Date	Time	Prepared by	Checked by	Batch Number Drug(s)	Batch Number Diluent
Initial Preparation						
Replacement 1						
Replacement 2						
Replacement 3						
Replacement 4						

4 MONITORING AND DEVICE SELECTION (To be completed by Nurse / Prescriber before start of therapy)

Infusion Device Selected	COLLEAGUE 3
Serial / Equipment Number	20081
Monitoring Requirements	1 BP
	2 SATS
	3 Pupil reaction
	4

5 ADMINISTRATION CHECK — HOURLY — 6 START / STOP / RATE CHANGE CHECK – The reason for the alteration

New rate.

3 PREPARATION / PRODUCT DETAILS (Where a pre-prepared solution is available, the batch number should be recorded under the *Drug* section below)

	Date	Time	Prepared by	Checked by	Batch Number Drug(s)	Batch Number Diluent
Initial Preparation						
Replacement 1						
Replacement 2						
Replacement 3						
Replacement 4						

4 MONITORING AND DEVICE SELECTION (To be completed by Nurse / Prescriber before start of therapy).

Infusion Device Selected	COLLEAGUE 3
Serial / Equipment Number	20081
Monitoring Requirements 1.	BP
2	SATS
3	Pupil reaction
4	

5 ADMINISTRATION CHECK (To be completed in full by Nursing Staff) — **HOURLY**

6 START / STOP / RATE CHANGE CHECK - The reasons for the alteration must always be recorded.

Date	Time Infusion Checked or Stopped	Total Volume Infused	Volume Remaining (Approximate)	Actual Rate Setting	Check by	Time Infusion Started / Restarted	Rate Setting	Started / Restarted by	Checked by	10 minute check	Reason for change in rate / stop. Comments
30/4/14			80			2150	15ml/h		EC		NEW PRESCRIPTION.
	2215	8.6	71.5	20ml		2220	120		EC.		
	2300	26.7ml	53.1ml	20ml	AL						
01/5/14	0010	47ml	33.1ml	20ml	AL	0030	15ml	AL	MMP		rate ↓
	0100	64ml	16.1ml	15ml	AL						
	0200	78.8ml	1.3ml	15ml	AL	0215	15ml	AL	SD		16G NBI 18 new bottle.
	0230	103	103	error							
	0310	84	15	15ml	h	0317	125ml	H	AL		2ml loaded
	0400	35ml	65.2ml	25ml	AL						
	0500	43.5	56	25ml	H						
	0615	87.6	125	25ml							
	0700	6	94.1	25ml		0645	25ml				NEW BOTTLE
	0800	33.8	66.3	25ml	MS.	0800	120ml	MS.			
						0825	OFF	MS.			

NHS Ayrshire & Arran

Estimated Discharge Date:

Refer to Multidisciplinary discharge plan

Actual Discharge Date:

IN-PATIENT ADULT ADMISSION / DISCHARGE BOOKLET

Property handed over for safe keeping

PLACE STICKER HERE

Name: _____

CHI number: _____

Date: _____

PERSONAL DETAILS

Personal Details

GP (name & address) .....

.....

.....

.....

Patient's Age .....

Write or attach label

HCR No: .....
CHI No: .....
Surname: .....
Forename: ..... Sex: .....
Address: .....
.....
Date of Birth: .....

SPECIFIC ALERT

Previous known – MRSA Yes ☐ No ☐
or - Extended Spectrum
Beta Lactamases (ESBL) Yes ☐ No ☐
Other infectious condition? Yes ☐ No ☐
specify.....

Allergies (food, latex, other)
.....
.....
None known ☑

DRUG ALLERGY / SENSITIVITY YES/NO

Drug name:	Symptoms experienced:
Nil	

Prefers to be addressed as:	Receiving Consultant:	Allocated Consultant:	
LEE	MR MUIR		Emergency ☑ Elective ☐

Admission Date 27/4/10 Time 2130

Ward/Dept (1) S53 (2) ..... (3) .....

Date of transfer...../...../.....

From where	Accompanied by
Home	Nurse/Porter

Do you have a religion? Yes ☑ No ☐

Would you like to be visited by the hospital Chaplin? Yes ☐ No ☑

Reason for admission (including patient account)

Recent Hernia Repair 2009 thought hernia had returned

Provisional diagnosis

First Contact / Significant Other

Name: Mrs Johnstone

Address: S/A

.....

.....

Relationship to patient:

Contact No(s): Home: 01655 750664
Mobile:

Aware of Admission?: Yes ☑ No ☐
Contact Overnight?: Yes ☑ No ☐

Overnight Contact No: .....

Second Contact / Significant Other

Name: .....

Address: .....

.....

.....

Relationship to patient:

Contact No(s): Home: .....
Mobile: .....

Aware of Admission?: Yes ☐ No ☐
Contact Overnight?: Yes ☐ No ☐

Overnight Contact No: .....

Consent to share information: (Yes) / No

If yes with whom? Mother

Any exceptions?

What information are the above aware of? All relevant

Who can messages be left with? Mother

Write or attach label

HCR No:
CHI No:
Surname:
Forename: Sex:
Address:
Date of Birth:

PERSONAL DETAILS

Observations on admission / General Appearance

Temp	Pulse	BP	Resps	O^2 Sats	Pallor	Conscious Level	Glucometer Reading	Last Menstrual Period (If Appropriate)	Pregnancy Test (If Appropriate)
36.6	74	150/76	16	95		Alert			

Urinalysis: Protein ☐ Blood ☐ Glucose ☐ Other ☐ NAD

MSSU (mid stream sample of urine) collected? Yes ☐ No ☐

Previous medical, surgical and mental health history (including operations, treatments and investigations with the corresponding dates)

Details	Date if applicable
Cysts.	
Hernia Repair 09	
Appendix	
Guillian Barre Syndrome	
Previous #.	

PERSONAL DETAILS

Record of specimens, procedures, surgery & investigations since admission	Initials	Date	Patient aware of results?	Initials	Date

Medication used at home (including herbal / over the counter)

For patient's current medication please refer to the Multi-disciplinary Medicines Reconciliation Form if available. If not present complete below:

Drug	Dose	Frequency	Route
Omeprazole	20mg	mane	oral

PERSONAL DETAILS

Write or attach label
HCR No:
CHI No:
Surname:
Forename: ..... Sex: .....
Address:
.....
Date of Birth: .....

Home Circumstances

Contact the hospital Social Work Dept to obtain Single Shared Assessment (SSA1) if appropriate.

Requested ☐ No SSA1 available ☐ Name of Social Worker/Contact .....

Do you have a carer? Yes ☐ No ☐

Do you live:-

Alone ☐
With elderly / infirm partner ☐
With healthy partner / family ☑
Does carer require additional support ☐
(Consider referral to social work) ☐

Are you a carer Yes ☐ No ☐

Who for:

Children ☐
Elderly relative ☐
Other ☐

Please specify: .....

Who is caring for them currently? Please detail .....

.....

Family ☐ Social Worker ☐
Nursing Home ☐ Neighbour ☐
Respite Centre ☐

Describe Family Living Arrangements:

lives with mother

Terraced

Type of House (circle):

Steps at entrance ☐ How many? 0
Stairs inside ☑ How many? 14
Toilet: Upstairs ☑ Downstairs ☑
Bedroom: Upstairs ☑ Downstairs ☐

Community Services in Use	Frequency	Informed of Admission	Informed By/Comments
Home Care Yes ☐ No ☐		Yes ☐ No ☐	
Meals on Wheels Yes ☐ No ☐		Yes ☐ No ☐	
Sheltered Housing Yes ☐ No ☐		Yes ☐ No ☐	
Day Hospital Yes ☐ No ☑	N/A	Yes ☐ No ☐	
Community Nurse Yes ☐ No ☐		Yes ☐ No ☐	
Visited by Specialist Nurse Yes ☐ No ☐ Specify.....		Yes ☐ No ☐	
SPARRA Yes ☐ No ☐		Yes ☐ No ☐	

If Yes, contact Case Manager Name..... Contact Number.....

Discharge

Will personal transport be available for discharge: Yes ☐ No ☐ Patient has keys: Yes ☐ No ☐

Predicted discharge: Complex ☐ Straight forward ☐

Discharge co-ordinator informed Yes ☑ No ☐

Initials of Nurse..... Date 27/11/10

PERSONAL DETAILS

Admission Checklist

	Yes	No	N/A
ID band in situ	✓		

Verbal ward Information given to patient and/or relatives:	Yes	No	N/A
Call buzzer	✓		
Toilets / Bathroom	✓		
Mealtimes	✓		
Visiting times/policy	✓		
Infection control / hand hygiene	✓		
Fire alarm procedure			
Valuables			
Smoking	✓		
Other.....			

Patient information leaflets given as applicable:	Yes	No	N/A
Ward information			
Nutritional Care			
Tissue Viability			
Continence			
Falls / Bedrails			

Other (specify) Date given

_____ _____ ☐

_____ _____ ☐

_____ _____ ☐

Patient's Property

You are advised to restrict to a minimum amount of property, including cash and other valuables, brought into hospital and to hand to the nurse in charge of your admission, as soon as possible, any articles you wish to be kept in safe custody for which a receipt will be given to you. You are responsible for property belonging to you not handed over for safe custody.

Anything handed over for safe keeping will not be kept indefinately in the ward safe but will be sent to the cashier's office. This includes cash, spectacles, hearing aids, dentures and other personal items and valuables.

Signature of Patient / Significant Other [signature] Date 27/11/10

Property Handed Over For Safe Keeping: Yes ☐ No ☑ Sticker on front page ☐

Date Taken to Cashier:..... Cash & Valuables Ref No:..... Date Returned:.....

Initials of Nurse [initials] Date 27/4/10

Lifestyle Assessment

Write or attach label
HCR No:
CHI No:
Surname:
Forename: ..... Sex: .....
Address:
Date of Birth:

Communicating	Yes	No	Problems / needs
Are there any specific communication needs? e.g. Impaired speech, impaired hearing, registered blind, language barrier, dyslexia, learning difficulty. (Complete learning disability assessment if appropriate)	☐	☑	
Interpreter required	☐	☑	
Wears glasses / contact lens	☐	☑	
Hearing aid R / L / Bi lateral (if private aid or glasses, refer to patient property notice)	☐	☑	

Breathing	Yes	No	Problems / needs
Normal rate/rhythm	☑	☐	
Cough	☐	☑	
Breathlessness	☐	☑	
Equipment used e.g. inhalers etc	☐	☑	
Home oxygen/nebulisers used	☐	☑	
Airway e.g. tracheostomy	☐	☑	
Smoker	☑	☐	10 per day

Please ensure smoking algorithm is completed for smokers and patients trying to stop.

Controlling body temperature	Yes	No	Problems / needs
Apyrexial on admission	☑	☐	
Do they feel the cold	☐	☑	
Night sweats	☐	☑	

Eating & drinking	Yes	No	Problems / needs
Any known food allergies	☐	☑	
Recent appetite normal	☑	☐	
Swallowing ability impaired	☐	☑	(if YES consider referral to SALT)
Nausea/vomiting	☐	☑	
Special dietary needs, e.g. therapeutic diet, ethnic, cultural & religious considerations, nutritional supplements	☐	☑	
Feeding aids/assistance required	☐	☑	
Nutritional Care in Hospital leaflet given	☐	☑	(All patients must be given this leaflet)
Does patient have any food preferences? (likes/dislikes)	☐	☑	
Specify: Eating.....	Drinking.....		
Does the patient consent to following a therapeutic diet	☐	☑	Nurses Initials.....
Alcohol intake (>50units consider referral to Alcohol liaison team): Referral made Yes ☐ No ☐ Date.....			
Date / time last alcohol drink taken and amount : weekend - 30-40 cans			

Mobilising	Yes	No	Problems / needs
Independent walking ability	☑	☐	.....
Aids needed	☐	☑	.....
Falls history	☐	☑	.....
Bed rest restrictions	☐	☑	.....
Podiatry problems	☐	☑	.....
Limiting factors e.g. pain	☐	☑	.....

Eliminating	Yes	No	Problems / needs
Normal Bowel activity	☑	☐	daily
Normal Bladder activity	☑	☐	.....

Please ensure continence assessment is completed if required.

Personal cleansing & dressing	Yes	No	Problems / needs
Independent	☑	☐	.....
Requires assistance e.g. showering, hair washing,oral care	☐	☑	.....
Use of dressing aids	☐	☐	.....

Specify:.....

.....

Please complete oral assessment tool if required.

Condition of skin - assess any wounds / lesions / stomas ....

Religious or cultural requirements that impact on patients' personal care ☐ ☑ .....

Is an OT referral needed? ☐ ☑ .....

Working & recreation	Yes	No	Problems / needs
Currently in occupation	☒	☑	Unemployed
Hobbies	☑	☐	Gym
Impact of illness on work or recreation?	☐	☑	.....

Sleeping	Yes	No	Problems / needs
Usual pattern	☑	☐	.....
Sedation used	☐	☑	.....
What helps			.....

Personal awareness	Yes	No	Problems / needs
Possible altered body image	☐	☑	.....
Privacy/modesty issues	☐	☑	.....
Impact of illness on family / partner - attitude / support issues	☐	☑	.....
Worries regarding emotional problems/ dying	☐	☑	.....

Write or attach label
HCR No: .....
CHI No: .....
Surname: .....
Forename: ..... Sex: .....
Address: .....
.....
Date of Birth: .....

State of mind	Yes	No	Problems / needs
Orientated to time and place	☑	☐	.....
Signs of anxiety / confusion: Confused ☐ Mildly anxious ☐ Highly anxious/distressed ☐			
no anxiety			
Any current or previous psychological or psychiatric history? (e.g. depression, self harm)	☐	☑	.....
Undergoing any current treatment/therapy If yes, name of	☐	☑	.....
Consultant/CPN.....			.....
History of dementia	☐	☑	.....
Memory problems	☐	☑	.....
Any phobias	☐	☑	.....

If this patient has a known cancer, please consider using the Distress Thermometer. For information contact Psychosocial Oncology on (01294) 323552

Spiritual or religious needs	Yes	No	needs
Does the patient wish to state their religion?	☑	☐	
Specify: Protestant			
Any specific religious needs/practices that place limitations on the patient's care? (refer to religions and cultures manual)	☐	☑	....

Initials of Nurse ..... Date 27/11/10

Assessment of this patient may highlight the need for referral to other disciplines. Discuss with the patient and obtain the patient's verbal consent. This should be recorded on the multidisciplinary discharge pages.

Patient Screening & Risk Assessment

After completing the patient's lifestyle assessment decide which risk assessments your patient needs.

Tick the box to confirm assessment tool activated.

Write or attach label
HCR No: .....
CHI No: .....
Surname: .....
Forename: ..... Sex: .....
Address: .....
.....
Date of Birth: .....

YES	N/A		
☑	☐	**Pressure Area Care – Waterlow**	**mandatory**
☐	☑	**Falls**	**over 65 / history of falls**
☑	☐	**Bedrails**	**mandatory**
☑	☐	**Moving and Handling**	**mandatory**
☑	☐	**MUST**	**mandatory**
☑	☐	**MRSA**	**mandatory**
☐	☐	**Oral Care**	
☐	☐	**Continence**	
☑	☐	**Smoking**	

All appropriate assessments **must** be undertaken for every patient.

You may use your professional judgement to decide which assessment tools are most relevant to your patient. It is not necessary to complete all risk assessments for every patient.

In exceptional circumstances your professional judgement may decide that this patient is exempt from a particular mandatory assessment. You must clearly document the reason for this decision.

Initials of Nurse DMF ..... Date: 27/11/10 .....

NHS Ayrshire & Arran

Pressure Prevention Care Plan

Patient Problem / Need					
Patient has a Waterlow score of.....5.....and is at risk of developing pressure ulcers					
Patient has a pressure ulcer(s) grade.....low Risk.....					
Goal					
Patient's skin will remain intact					
To promote healing of ulcer and prevent infection					
Date	**Time**	**Init's**	**Planned Nursing Intervention**		
27/11	22⁰⁴	DH	Calculate and record the Waterlow score on admission and recalculate as the patient's condition changes and on a regular basis		
27/11	22⁰⁴	DH	Inspect the patient's skin especially over bony prominences on admission and at regular intervals and document findings • Skin condition on admission.....		
			Select pressure reducing equipment according to patient need • ..... • ..... • ..... •		
			When in bed encourage and facilitate position changes using 30 degree tilt (indicate frequency below) •		
			The patient should not sit out of bed for longer than 2 hours without being repositioned (for acutely ill patients return to bed for a minimum of 1 hour)		
			Use sliding sheets to prevent shear and friction during movement in bed (Sliding sheets should not be left under the patient)		
			Initiate a skin inspection and repositioning chart according to identified risk		
			When the patient is incontinent refer to the skin care guideline Encourage a healthy, well balanced diet and adequate fluid intake		
			If the patient has a grade 2 or above pressure ulcer a wound assessment chart is required		
			This care plan has been discussed and agreed with the patient as appropriate.		

Moving & Handling Patient Risk Assessment

All Patients:

A hoist is for lifting patients and must not be used for transporting between rooms.
A mechanical aid **must** be used for bathing unless independently mobile.
A mechanical aid **must** be used if assistance is required from the floor.
Sliding aids should be used bed to trolley/bed (specify number of handlers)

Special Alerts: Date:	27/11/10				
Overweight / Obese (BMI definition)					
Restricted use of limbs					
Poor standing ability					
Sedation of lethargy					
Irrational behaviour / confusion					
Unable to co-operate					
Acute pain	✓				
Recent surgery					

Additional Comments:

Sling specification	Type	Size

Assessment of Risk:

Low Risk: Independently mobile / supervision only required. Aids required should be specified in care plan.

Moderate Risk: Requires physical assistance from one or more handlers. Is able to stand or partially bear weight and has no more than one special alert.

High Risk: a) Is unable to bear weight and requires assistance.
b) 2 or more special alerts present and requires assistance.

Aids, equipment and a minimum of 2 handlers recommended to move a patient.

Specify Level of Risk

Date:	27/11/10					
Low risk	✓					
Moderate risk						
High risk						
Assessors Initials	DH					

If the patient is independently mobile and self caring, there is no requirement to complete the following pages.

NHS Ayrshire & Arran

Nutritional Screening 'Malnutrition Universal Screening Tool' ('MUST')

To be completed within **24 hours** of admission

Step 1: Measure height and weight to get a BMI score.
Step 2: Note percentage unplanned weight loss and score.
Step 3: Establish acute disease effect and score.
Step 4: Add scores from steps 1, 2 and 3 together to obtain risk of malnutrition.
Step 5: Follow the management guidance appropriate to the risk category and commence the corresponding care plan.

Screening Results

Please indicate if measurements are Measured (M), Reported (R), or Estimated (E)

Date / Time	5T3.				
Ward	27/11/10				
Height 5'6. M( ) R( ) E( )	1.676.m				
Current weight (Kg) 14 2.	89.8Kg ( )	Kg ( )	Kg ( )	Kg ( )	Kg ( )
BMI	32				
Is patient within obese category?	(Y)/N	Y/N	Y/N	Y/N	Y/N
Usual weight (Kg)	89.8 Kg				
Signature					
MUST					
Step 1: BMI Score > 20 (> 30 = Obese).....0 18.5 - 20.....1 < 18.5.....2	0				
Step 2: Weight Loss Score Unplanned weight loss in past 3-6 months: < 5%.....0 5-10% .....1 > 10%.....3	0				
Step 3: Acute Disease Effect Score If patient is acutely ill and there has been or is likely to be no nutritional intake for > 5 days.....2 Not applicable 0	0				
Step 4: Overall Risk of Malnutrition Total:	0				
Step 5:	0 = Low Risk	1 = Medium Risk	2 or more = High Risk		

Referrals	Date Referred	Signature
Dietitian		
Speech & Language Therapy		
Occupational Therapy		
Nutritional Support Team		
Dental Service		

Write or attach label

HCR No: .....
CHI No: .....
Surname: .....
Forename: ..... Sex: .....
Address: .....
.....
Date of Birth: .....

NHS Ayrshire & Arran

Malnutrition Universal Screening Tool (MUST) Multidisciplinary Care Plan

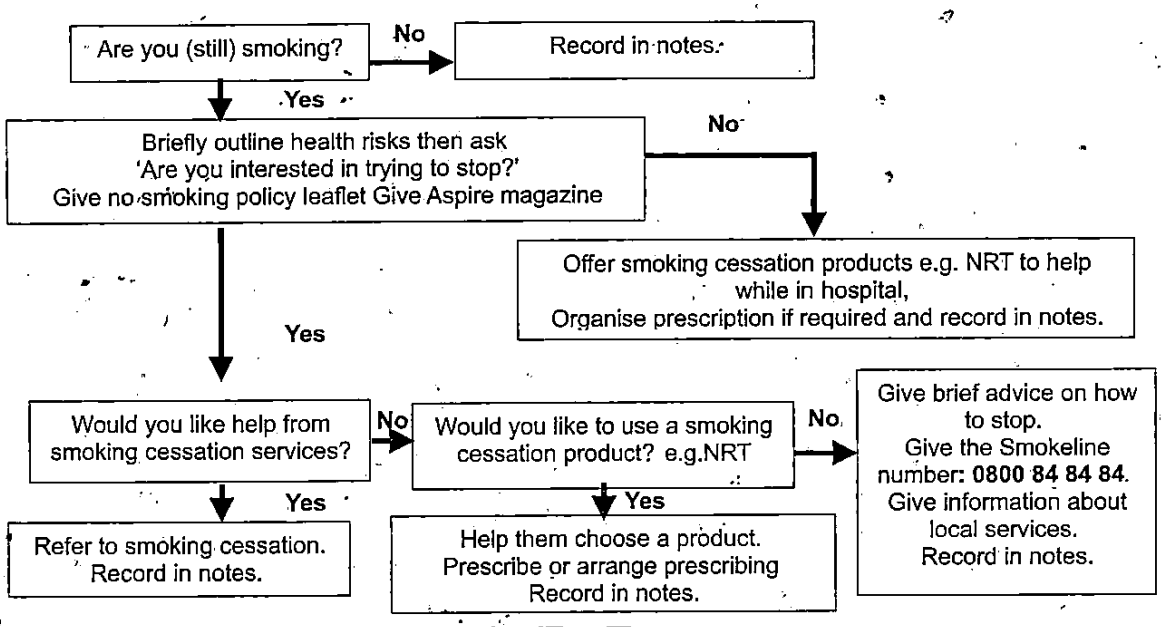
Patient Problem/Need							
Nutritional screening has identified patient as being at	Low		Medium		High		risk of malnutrition

Goal
To meet patients nutritional and fluid requirements. To prevent weight loss and promote weight gain, as appropriate.
For Low Risk patients consider interventions in the **green** section of the care plan as appropriate.
For Medium Risk patients follow interventions in the **green and** yellow sections of the care plan.
For High Risk patients follow interventions in the **green,** yellow **and red** sections of the care plan.
Allied Health Professionals: consider interventions appropriate for speciality on the reverse of the form.

Date	Time	Intls		Planned Nursing Interventions	Discontinued Date/Time	Intls
27/11	22[04]	DH.		**Low Risk Care Plan -**		
27/11	22[04]	DH		Monitor and review care plan and **repeat screening weekly** or monthly if in continuing care.		
27/11	22[04]	DH		Consider individual and/or therapeutic dietary requirements.		
27/11	22[04]	DH		Assist patient to select appropriate meals from menu card.		
27/11	22[04]	DH		Provide encouragement and assistance with eating and drinking as required.		
27/11	22[04]	DH		Ensure fresh drinking water is offered regularly and available at all times, where clinically appropriate.		
27/11	22[04]	DH		Consider patient's positioning and support oral hygiene, if required		
27/11	22[04]	DH		This care plan has been discussed and agreed with the patient as appropriate.		
27/11	22[04]	DH				
				Medium Risk Care Plan		
				Commence food chart for a minimum of 3 days. Only discontinue if/when dietary intake is adequate.		
				If intake is insufficient, offer patient full cream milk or suitable alternative to drink with and between meals and suitable additional snacks.		
				Record accurate fluid intake/output on fluid balance chart until established that oral intake is adequate. If intake per 24hrs is inadequate, consider IV/SC fluids.		
				Monitor and review care plan and **repeat screening weekly**		
				High Risk Care Plan		
				Refer to Dietitian, ensuring the 'MUST' score is included.		
				Monitor and review care plan and **repeat screening weekly**		
				Discontinue food chart only when advised by Dietitian		

NHS Ayrshire & Arran

Algorithm for smoking



Referral made: Yes ☐ No ☐ Date.....

Smoking Disclaimer

Section 1 - for patient disclaimer

I.....(print name) have been provided with information regarding the smoking ban in NHS wards / departments introduced via the Smoking, Health and Social Care Act 2005. I have read and understood this information. I have been advised against leaving the ward / department. In particular I understand that my decision will affect the medical attention I receive and that NHS Ayrshire & Arran cannot provide medical attention to me while I am absent from the ward / department. I therefore accept that the staff cannot be responsible for my care whilst I am absent from the ward.

Witness Name ..... D. HEPBURN .....

Witness Signature .....

Signed ..... Y.L. Smoke .....

Date 27/4/10 ..... Time 21:35 .....

Section 2 - for escort disclaimer

To be completed by adult escort where patient is dependant upon assistance to leave the ward to smoke against medical / nursing advice.

I.....(print name) will escort.....(patient) as he / she leaves the ward / department to smoke. I have been advised of the risks to the patient of being absent from the ward / department. I acknowledge that the patient and I have both been advised against this course of action. In particular I understand that NHS Ayrshire & Arran cannot provide medical care and attention while he / she is absent from the ward / department. I agree to take responsibility for the patient while he / she is absent from the ward / department.

Witness Name .....

Witness Signature .....

Signed .....

Date.....Time .....

An escort disclaimer form should be completed for each new escort during the patients hospital stay and filed with the nursing notes.

Summary problem list

List the nursing problems/needs identified in the patient assessment. Commence appropriate care plans for the identified problems/needs or implement an individual/specialist care plan for specific problems. Allocate the appropriate care plan code next to the problem. Add any new problems as they arise e.g. post-operative care.

Problems / needs identified	Care plan / chart (Code)	Date achieved / Discontinued	Initials
Pt admitted with			
Epigastric Pain	A.		Dm

Evaluation of patient care

Registered staff must countersign entries made by students and nursing assistants who have not yet been deemed competent in the delegated skill of record keeping.

Write or attach label

HCR No: .....
CHI No: .....
Surname: .....
Forename: ..... Sex: .....
Address: .....
.....
Date of Birth: .....

Date & Time	Careplan Code	Evaluation of Patient's Care	Initials
27/11	A-	Pt admitted Epigastric Pain	
		Plan :- IV fluids	
		NBM	
		Bloods	
		Urinalysis - NAD	
		SIB by Senior ? Gastritis	
		? Pancreatitis.	
		AXR has shown right basal	
		loading. Observe overnight.	
28/11/10	A	SIB MW Muir. ? has recurrence of	
		hernia. Can eat and drink as tolerated.	
		If OK home later. Observations satisfactory	
		News 0. Mobile No other problems.	
29.11.10	A.	Settled and slept well.	JK -
29/11	A.	Seen by Mr Muir - for	
		discharge home. On w/l	
		for hernia repair	JH
		Meds ✓ Map ✓ Letter → GP ✓	

EVALUATION OF CARE

NHS Ayrshire & Arran

MEWS CHART
(with Neuro - Observations)

Write or attach label

HCR No:

CHI No:

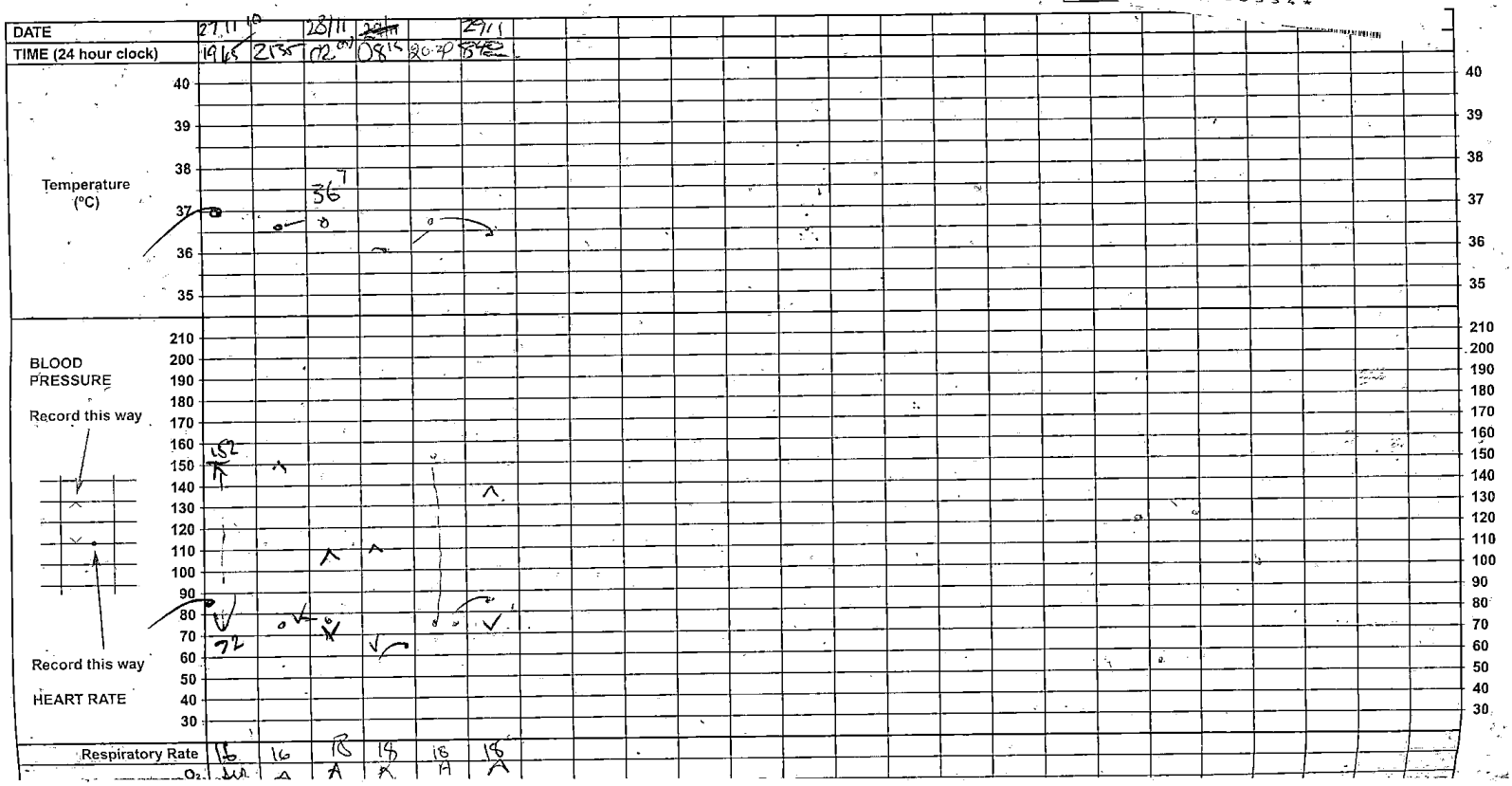
DOB: 09/02/1976

Surnam JOHNSTONE Lee

Forena

Addres 12 WOODSIDE AVENUE, KIRKMICHAEL KA19 7PP

Date



O_2 Saturation	95	95	96	96	97	96																				

MEWS SCORE for EACH of the INDIVIDUAL OBSERVATIONS																										
Temperature (°C)	0	0	0	0	0	0																				
BP (Systolic)	0	0	0	0	0	0																				
Heart Rate	0	0	0	0	0	0																				
Respiratory Rate	0	0	0	0	0	0																				
SpO_2	0	0	0	0	0	0																				
Urine Output	0	0	0	0	0	0																				
CNS	0	0	0	0	0	0																				

MEWS SCORE - TOTALS																										
Record the total MEWS scores for each set of observations this way	6																									
	5																									
	4																									
	3																									
	2																									
	1																									
	0																									

Sedation Score	0	0	0	0	0	0																				
Pain Score (On Movement)	0	2	2	0	0	0																				
Nausea Score	0	0	0	0	0	0																				

C Eyes Open	Spontaneously	4																								
	To speech	3																								
	To pain	2																								
	None	1																								
A Best Verbal Response	Orientated	5																								
	Confused	4																								
	Inaprop. words	3																								
	Incomp. sounds	2																								
	None	1																								
C Best Motor Response	Obeys commands	6																								
	Localise pain	5																								
	Withdrawl to pain	4																								
	Abnormal flexion to pain	3																								
	Extension to pain	2																								
	None	1																								
	GCS TOTAL																									
PUPILS	R Size																									
	R Reaction																									
	L Size																									
	L Reaction																									
LIMB MOVEMENTS ARMS	Normal power																									
	Mild weakness																									
	Severe weakness																									
	Spastic flexion																									
	Extension																									
	No response																									
LEGS	Normal power																									
	Mild weakness																									
	Severe weakness																									
	Extension																									
	No response																									

PUPIL SCALE (mm)

1 2 3 4 5 6 7 8

AYR-10-040838-1

I.V. Therapy and Prescription Sheet

Write or attach label.

HCR No:
CHI No: 0902763334
Surname: Johnstone
Forename: Lee Sex: Male
Address: 12 WOODSIDE AVENUE, KIRKMICHAEL
MAYBOLE
PostCode: KA19 7PP
DOB: 09 Feb 1976

	DATE	FLUID (USE BLOCK LETTERS) ADDITIVE DRUG	Vol (ml) Dose (mg.)	Route of Admin.	Dur. of Admin.*	SIGNATURE	Serial No. Batch No.	Time Begun	Given By Added By
A	27/11/10	(N) Saline	500	IV	1°	[signature]	10304 T4G	2055	MK
B	27/11/10	5% Dextrose	500	IV	4°	[signature]	1017 EOP	21 40	DM
C	27/11/10	(N) Saline	500	IV	4°	[signature]	10907 T4A	01 40	D
D	27/11/10	NaCl 0.9%	500	IV	4°	A.G	10V 07T4A	05 50	D
E	27/11/10	NaCl 0.9%	500	IV	4°	A.G			
F	27/11/10	Dextrose 5%	500	IV	4°	A.G.			
G									
H									
I									
J									
K									
L									
M									
N									
O									

RATE OF FLOW
(Drops/Min.)

VOL. OF FLUID (ml) x 15
Duration (Mins.)
(1ml = 15 drops)

Approximate Rate for 500ml
1hr = 120 Drops/min
4hr = 30 Drops/min
6hr = 22 Drops/min
8hr = 15 Drops/min

6.62

Fluid Intake and Output Chart

FAN0386

Write or attach label

HCR No: .....

CHI No: .....

Surname: .....

Forename: ..... Sex: .....

Address: .....

.....

Date of Birth .....

DATE 27/11/0						YESTERDAY'S BALANCE			
INTAKE (ml)						**OUTPUT (ml)**			
	ORAL	INTRAVENOUS		OTHER		URINE	STOMACH	BOWEL	DRAINAGE
Time	Amount	Amount	Nature	Amount	Nature	Amount	Amount	Amount	Amount
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20[55]		500	N/Saline						
21[40]		500	Dextrose						
22									
23									
24									
1									
2		500	N/Saline						
3									
4									
5									
6		500	N/Saline						
7									
TOTAL						(a)	(b)	(c)	(d)

JMcC/74024

INTAKE =	ml	(e) Insensible loss* = **OUTPUT =** (a + b + c + d)	ml

BALANCE = (Intake minus output)	ml

* Average Adult = 600 ml + 100 ml per each 0.5°C temperature elevation.

Medicine Prescription Sheet

Patient JOHNSTONE, LEE
Address 12 WOODSIDE AVE
KIRKMICHAEL
KA19 7PP

Hospital Number **100544212**
CHI Number
Date of Birth **09/02/1976**
Ward STATION 3-AYR
Consultant MR ROBERT MUIR

Allergy	Reaction
No known drug allergies	

Date Printed: 29/11/2010 11:49
User Name: NU0420

	Date Started	Date Stopped, Suspended or	Approved Name of Medicine	Dose	Frequency	Route	Other Instructions	Last EPA dose given	Prescriber Verified by:
A	28/11/2010		OMEPRAZOLE 20 mg Capsules	**20 mg**	07:00	Oral			DR AMY GORDON
B	28/11/2010		PARACETAMOL 500 mg Tablets	**1000 mg**	07:00 13:00 18:00 22:00	Oral			DR SONIA CHAMPANE
D	28/11/2010		TRAMADOL 50 mg Capsules	**50 mg**	07:00 13:00 18:00 22:00 PRN	Oral	For pain		DR SONIA CHAMPANE
E	28/11/2010		SENNA 7.5 mg Tablets	**15 mg**	22:00 PRN	Oral	FOR CONSTIPATION	15 mg on 28/11/2010 at 21:31:00	DR CRAIG MITCHELL
F	28/11/2010		LACTULOSE Oral Solution	**10 mL**	07:00 22:00 PRN	Oral	FOR CONSTIPATION	10 mL on 29/11/2010 at 08:08:00	DR CRAIG MITCHELL

Read report carefully. Pay particular attention to the Date Stopped, Suspended or Resumed column

NHS Ayrshire & Arran

Estimated Discharge Date: 16/10/10.

Refer to Multidisciplinary discharge plan

Actual Discharge Date:

IN-PATIENT ADULT ADMISSION / DISCHARGE BOOKLET

Property handed over for safe keeping

PLACE STICKER HERE

Name: _____

CHI number: _____

Date: _____

PERSONAL DETAILS

Personal Details

GP (name & address) .....

.....

.....

.....

Patient's Age 34

Write or attach label

A100-544212
JOHNSTONE LEE
12 WOODSIDE AVE
0902763334
KIRKMICHAEL KA197PP
09/02/1976
PATON,G (GP)
6 HIGH STREET
MAYBOLE
M/S

SPECIFIC ALERT

Previous known – MRSA Yes ☐ No ☑

or - Extended Spectrum Beta Lactamases (ESBL) Yes ☐ No ☑

Other infectious condition? Yes ☐ No ☑

specify.....

Allergies (food, latex, other)

.....

.....

None known ☑

DRUG ALLERGY / SENSITIVITY YES/NO

Drug name:	Symptoms experienced:

Prefers to be addressed as:

Receiving Consultant: Dr Colvin

Allocated Consultant:

Emergency ☑ Elective ☐

Admission Date 16/10/10 Time 1243

Ward/Dept (1) 7 (2)..... (3).....

Date of transfer...../...../.....

From where: A&E Dept

Accompanied by: Sister Porter

Do you have a religion? Yes ☑ No ☐

Would you like to be visited by the hospital Chaplin? Yes ☐ No ☐

Reason for admission (including patient account)

Chest pain
Developed chest pain at 6.30am. – Wakened him from sleep.

Provisional diagnosis

First Contact / Significant Other

Name: Georgina Johnstone

Address: S/A

.....

.....

Relationship to patient: Mother

Contact No(s): Home: 01655.750064
Mobile:

Aware of Admission?: Yes ☑ No ☐
Contact Overnight?: Yes ☑ No ☐

Overnight Contact No:.....

Second Contact / Significant Other

Name:.....

Address:.....

.....

.....

Relationship to patient:

Contact No(s): Home:.....
Mobile:.....

Aware of Admission?: Yes ☐ No ☐
Contact Overnight?: Yes ☐ No ☐

Overnight Contact No:.....

PERSONAL DETAILS

Consent to share information: (Yes) / No

If yes with whom? Mother

Any exceptions?

What information are the above aware of?

Who can messages be left with?

JOHNSTONE LEE A100-544212
12 WOODSIDE AVE
KIRKMICHAEL 0902763334
KA197PP 09/02/1976
PATON,G (GP)
6 HIGH STREET
MAYBOLE
Date of Birth: M/S

Observations on admission / General Appearance

Temp	Pulse	BP	Resps	O^2 Sats	Pallor	Conscious Level	Glucometer Reading	Last Menstrual Period (If Appropriate)	Pregnancy Test (If Appropriate)
35.9	78	136/72	18	98- RA	good colour	Alert			

Urinalysis: Protein ☐ Blood ☐ Glucose ☐ Other ☐

MSSU (mid stream sample of urine) collected? Yes ☐ No ☐

Previous medical, surgical and mental health history (including operations, treatments and investigations with the corresponding dates)

Details	Date if applicable
Heartburn	

PERSONAL DETAILS

Record of specimens, procedures, surgery & investigations since admission	Initials	Date	Patient aware of results?	Initials	Date

Medication used at home (including herbal / over the counter)

- For patient's current medication please refer to the Multi-disciplinary Medicines Reconciliation Form if available. If not present complete below:

Drug	Dose	Frequency	Route
omeprazole	20mg	daily	O

PERSONAL DETAILS

JOHNSTONE A100-544212
12 WOODSIDE AVE LEE
KIRKMICHAEL 0902763334
KA197PP 09/02/1976
PATON,G (GP)
6 HIGH STREET
MAYBOLE M/S
Date of Birth: .....

Home Circumstances

Contact the hospital Social Work Dept to obtain Single Shared Assessment (SSA1) if appropriate.
Requested ☐ No SSA1 available ☐ Name of Social Worker/Contact .....

Do you have a carer? Yes ☐ No ☑

Do you live:-

- Alone ☐
- With elderly / infirm partner ☐
- With healthy partner / family ☑
- Does carer require additional support ☐
- (Consider referral to social work) ☐

Are you a carer Yes ☐ No ☐

Who for:

- Children ☐
- Elderly relative ☐
- Other ☐

Please specify: .....

Who is caring for them currently? Please detail .....

.....

Family ☐ Social Worker ☐
Nursing Home ☐ Neighbour ☐
Respite Centre ☐

Describe Family Living Arrangements:

lives with mother.

Type of House (circle):

Steps at entrance ☐ How many? .....
Stairs inside ☑ How many? .....
Toilet: Upstairs ☑ Downstairs ☐
Bedroom: Upstairs ☑ Downstairs ☐

Community Services in Use		Frequency	Informed of Admission	Informed By/Comments
Home Care	Yes ☐ No ☑		Yes ☐ No ☐	
Meals on Wheels	Yes ☐ No ☑		Yes ☐ No ☐	
Sheltered Housing	Yes ☐ No ☑		Yes ☐ No ☐	
Day Hospital	Yes ☐ No ☑		Yes ☐ No ☐	
Community Nurse	Yes ☐ No ☑		Yes ☐ No ☐	
Visited by Specialist Nurse Yes ☐ No ☐ Specify.....			Yes ☐ No ☐	
SPARRA	Yes ☐ No ☐		Yes ☐ No ☐	

If Yes, contact Case Manager Name..... Contact Number.....

Discharge

Will personal transport be available for discharge: Yes ☑ No ☐ Patient has keys: Yes ☐ No ☑
Predicted discharge: Complex ☐ Straight forward ☑
Discharge co-ordinator informed Yes ☐ No ☐

Initials of Nurse..... Date..... 15/10/10

PERSONAL DETAILS

Admission Checklist

	Yes	No	N/A
ID band in situ	✓		

Verbal ward Information given to patient and/or relatives:	Yes	No	N/A
Call buzzer	✓		
Toilets / Bathroom	✓		
Mealtimes	✓		
Visiting times/policy	✓		
Infection control / hand hygiene	✓		
Fire alarm procedure	✓		
Valuables			✓
Smoking			✓
Other.....			

Patient information leaflets given as applicable:	Yes	No	N/A
Ward information			
Nutritional Care			
Tissue Viability			
Continence			
Falls / Bedrails			

Other (specify) Date given

_____ _____ ☐

_____ _____ ☐

_____ _____ ☐

Patient's Property

You are advised to restrict to a minimum amount of property, including cash and other valuables, brought into hospital and to hand to the nurse in charge of your admission, as soon as possible, any articles you wish to be kept in safe custody for which a receipt will be given to you. You are responsible for property belonging to you not handed over for safe custody.

Anything handed over for safe keeping will not be kept indefinately in the ward safe but will be sent to the cashier's office. This includes cash, spectacles, hearing aids, dentures and other personal items and valuables.

Signature of Patient / Significant Other ..X L Dantao..... Date .....

Property Handed Over For Safe Keeping: Yes ☐ No ☐ Sticker on front page ☐

Date Taken to Cashier:..... Cash & Valuables Ref No:..... Date Returned:.....

Initials of Nurse..... Date..18/10/10

Lifestyle Assessment

JOHNSTONE A100-544212
12 WOODSIDE AVE LEE
KIRKMICHAEL 0902763334
KA197PP
PATON,G (GP) 09/02/1976
6 HIGH STREET
MAYBOLE
Date of Birth ..... M/S

Communicating	Yes	No	Problems / needs
Are there any specific communication needs? e.g. Impaired speech, impaired hearing, registered blind, language barrier, dyslexia, learning difficulty. (Complete learning disability assessment if appropriate)	☐	☑	
Interpreter required	☐	☑	
Wears glasses / contact lens	☐	☑	
Hearing aid R / L / Bi lateral (if private aid or glasses, refer to patient property notice)	☐	☑	

Breathing	Yes	No	Problems / needs
Normal rate/rhythm	☑	☐	
Cough	☐	☑	
Breathlessness	☐	☑	
Equipment used e.g. inhalers etc	☐	☑	
Home oxygen/nebulisers used	☐	☑	
Airway e.g. tracheostomy	☐	☑	
Smoker	☐	☑	ex smoker - stopped 1 week ago

Please ensure smoking algorithm is completed for smokers and patients trying to stop.

Controlling body temperature	Yes	No	Problems / needs
Apyrexial on admission	☑	☐	
Do they feel the cold	☐	☑	
Night sweats	☐	☑	

Eating & drinking	Yes	No	Problems / needs
Any known food allergies	☐	☑	
Recent appetite normal	☑	☐	
Swallowing ability impaired	☐	☑	(if YES consider referral to SALT)
Nausea/vomiting	☐	☑	
Special dietary needs, e.g. therapeutic diet, ethnic, cultural & religious considerations, nutritional supplements	☐	☑	
Feeding aids/assistance required	☐	☑	
Nutritional Care in Hospital leaflet given	☐	☑	(All patients must be given this leaflet)

Does patient have any food preferences? (likes/dislikes) ☐ ☑
Specify: Eating... Dislikes Shellfish... Drinking... Tea with milk.
Does the patient consent to following a therapeutic diet ☐ ☐ Nurses Initials.....
Alcohol intake (>50units consider referral to Alcohol liaison team): Referral made Yes ☐ No ☐ Date.....
Date / time last alcohol drink taken and amount : Social alcohol - only at weekends

Mobilising	Yes	No	Problems / needs
Independent walking ability	☑	☐	.....
Aids needed	☐	☑	.....
Falls history	☐	☑	.....
Bed rest restrictions	☐	☑	.....
Podiatry problems	☐	☑	.....
Limiting factors e.g. pain	☐	☑	.....

Eliminating	Yes	No	Problems / needs
Normal Bowel activity	☐	☑	.....
Normal Bladder activity	☐	☑	.....

Please ensure continence assessment is completed if required.

Personal cleansing & dressing	Yes	No	Problems / needs
Independent	☑	☐	.....
Requires assistance e.g. showering, hair washing,oral care	☐	☑	.....
Use of dressing aids	☐	☑	.....

Specify:.....

.....

Please complete oral assessment tool if required.

Condition of skin - assess any wounds / lesions / stomas — Intact

Religious or cultural requirements that impact on patients' personal care	☐	☑	.....
Is an OT referral needed?	☐	☑	.....

Working & recreation	Yes	No	Problems / needs
Currently in occupation	☐	☑	unemployed
Hobbies	☑	☐	gym, football
Impact of illness on work or recreation?	☐	☑	.....

Sleeping	Yes	No	Problems / needs
Usual pattern	☑	☐	.....
Sedation used	☐	☑	.....
What helps			.....

Personal awareness	Yes	No	Problems / needs
Possible altered body image	☐	☑	.....
Privacy/modesty issues	☐	☑	.....
Impact of illness on family / partner - attitude / support issues	☐	☑	.....
Worries regarding emotional problems/ dying	☐	☑	.....

JOHNSTONE
12 WOODSIDE AVE
KIRKMICHAEL
KA197PP
PATON,G (GP)
6 HIGH STREET
MAYBOLE
Date of Birth: .....

A100-544212
LEE
0902763334
09/02/1976
M/S

State of mind	Yes	No	Problems / needs
Orientated to time and place	☑	☐	.....
Signs of anxiety / confusion: Confused ☐ Mildly anxious ☐ Highly anxious/distressed ☐			
Any current or previous psychological or psychiatric history? (e.g. depression, self harm)	☐	☑	.....
Undergoing any current treatment/therapy If yes, name of Consultant/CPN.....	☐	☑	.....
History of dementia	☐	☑	.....
Memory problems	☐	☑	.....
Any phobias	☐	☑	.....

If this patient has a known cancer, please consider using the Distress Thermometer. For information contact Psychosocial Oncology on (01294) 323552

Spiritual or religious needs	Yes	No	needs
Does the patient wish to state their religion?	☑	☐	
Specify:			Protestant
Any specific religious needs/practices that place limitations on the patient's care? (refer to religions and cultures manual)	☐	☑	.....

Initials of Nurse..... JH Green .....

Date..... 10/10/10 .....

Assessment of this patient may highlight the need for referral to other disciplines. Discuss with the patient and obtain the patient's verbal consent. This should be recorded on the multidisciplinary discharge pages.

Patient Screening & Risk Assessment

Write or attach label

JOHNSTONE LEE
12 WOODSIDE AVE
KIRKMICHAEL
KA197PP
PATON,G (GP)
6 HIGH STREET
MAYBOLE

A100-544212
0902763334
09/02/1976
M/S

After completing the patient's lifestyle assessment decide which risk assessments your patient needs.

Tick the box to confirm assessment tool activated.

YES	N/A		
☑	☐	**Pressure Area Care – Waterlow**	**mandatory**
☐	☑	**Falls**	**over 65 / history of falls**
☑	☐	**Bedrails**	**mandatory**
☐	☑	**Moving and Handling**	**mandatory**
☐	☐	**MUST**	**mandatory**
☑	☐	**MRSA**	**mandatory**
☐	☐	**Oral Care**	
☐	☐	**Continence**	
☐	☐	**Smoking**	

All appropriate assessments **must** be undertaken for every patient.

You may use your professional judgement to decide which assessment tools are most relevant to your patient. It is not necessary to complete all risk assessments for every patient.

In exceptional circumstances your professional judgement may decide that this patient is exempt from a particular mandatory assessment. You must clearly document the reason for this decision.

Initials of Nurse ..... Date: 18/10/10.

Summary problem list

List the nursing problems/needs identified in the patient assessment. Commence appropriate care plans for the identified problems/needs or implement an individual/specialist care plan for specific problems. Allocate the appropriate care plan code next to the problem. Add any new problems as they arise e.g. post-operative care.

Problems / needs identified	Care plan / chart (Code)	Date achieved / Discontinued	Initials
Chest Pain	1.		

Care Plans and Monitoring Charts

Record of care plans and monitoring charts implemented for the patient. List additional specific care plans and monitoring charts and allocate each with a number.

JOHNSTONE A100-544212
12 WOODSIDE AVE LEE
KIRKMICHAEL 0902763334
KA197PP
PATON,G (GP) 09/02/1976
6 HIGH STREET
MAYBOLE
Date of Birth..... M/S

Code	Care plan / monitoring chart	Code	Additional specific care plans / monitoring charts
A	Admitted as an emergency	(1)	Chest Pain Pathway
B	Breathing	2	
C	Catheter	3	
D	Cleansing and dressing	4	
E	Elimination	5	
F	Falls	6	
G	Bedrails	7	
H	Mobilising	8	
J	Communication	9	
K	Pre-operative	10	
L	Post-operative	11	
M	Wound Management	12	
N	Pressure area care	13	
O	Oral hygiene	14	
P	Pain management	15	
R	MUST - Eating & Drinking	16	
S	Emotional well being / Anxiety	17	
T	MRSA	18	
V	MEWS chart	19	
W	Fluid balance chart	20	
X	Peripheral Vascular Cannula chart	21	

CARE PLAN

Evaluation of patient care

Registered staff must countersign entries made by students and nursing assistants who have not yet been deemed competent in the delegated skill of record keeping.

H' JOHNSTONE A100-544212
C 12 WOODSIDE AVE LEE
S KIRKMICHAEL 0902763334
F KA197PP
PATON,G (GP) 09/02/1976
6 HIGH STREET
MAYBOLE
Date of Birth..... M/S

Date & Time	Careplan Code	Evaluation of Patient's Care	Initials
16/10/0 1230	1.	admitted after having chest pain and ~~sweat~~. episode of dyspnoea @ 6.30am. o/a well looking, pain free, colour good. obs stable, 1 lead ECG carried out o/a to ward, (not done on A+E). on NEWS 0. Taking diet / fluids.	JHyett
		Ltd Plan - OD: Imer - neg. for Miscarriage 1800. u/j - neg ? Haem.	JHeir
16/10/0	1910	Hopt - neg. Pain free. obs stable. Discharged home.	JHyett

EVALUATION OF CARE

Patient / Family / Carer Communication Sheet

Write or attach label

JOHNSTONE A100-544212
12 WOODSIDE AVE LEE
KIRKMICHAEL 0902763334
KA197PP
PATON,G (GP) 09/02/1976
6 HIGH STREET
MAYBOLE

Date & Time	Communication and significant information discussed with patient / family / carers. This may include relevant telephone communication.	M/S...ials
15/10/10	NOK aware of admission.	JGiel
O/A.		

Multi-Disciplinary Discharge Plan

label

A100-544212
LEE
JOHNSTONE
12 WOODSIDE AVE
0902763334
Sex:
KIRKMICHAEL
KA197PP
PATON,G (GP)
6 HIGH STREET
MAYBOLE
09/02/1976
M/S

DISCHARGE PLANNING

	Discharge Requirements	Completion date	Initials
	Discharge Medicines ordered		
	Patients own medication returned		
	Check patients medication with patient / carer before discharge		
	7 day supply of dressings, continence aids, catheters or stoma products. (new patients must be given a 7 day supply and refer to district nurse for re-assessment)		
	Nutritional Supplements: New patients must be given a 7 day supply		
	Written advice / information on self-care and lifestyle including diet		
5/9/5	Cannula removed Y N N/A		
	Follow-up arrangement given Y N N/A		
	If patient not for resuscitation, complete DNAR discharge plan		
	If patient requires specialist interventions (e.g. home oxygen therapy) complete specialist discharge plan. Specify		

Discharge Arrangements:- Require a **minimum of 24 hrs notice** (those needing enteral feeding will require longer)

Alert Note: Any changes made to discharge date must be communicated to patient / relative / carer and all services involved ☐

Re-inform all services involved when new date is established ☐

	Discuss and agree discharge date with patient / relative / carer and all members of multi-disciplinary team		
	Discuss and document all discharge plans with patient and / or relative / carer and services		

Transport

Those able to make their own transport arrangements should be encouraged to do so

	Own ☐ Ambulance ☐ am ☐ pm Reference No:		

Equipment Needs - Note: that which is **essential** for discharge will be provided on discharge

	Equipment Type	Arranged By	Expected Delivery Date	Delivery Confirmed
	Physio (specify)			
	OT (specify)			
	Commode			
	Hospital Bed			
	Pressure Mattress			
	Wheelchair			
	Oxygen Cylinder and / or Concentrator			
	Enteral Feeding Equipment			
	Other (specify)			

Multi-Disciplinary Discharge Plan

Date & Time	REASON FOR EDD CHANGE	Initials

Date & Time	COMMUNICATION / EVALUATION	Initials
16/10/10	Discharged home. No follow up	

NHS Ayrshire & Arran

A&E/Station 7 Non-Traumatic Chest Pain Pathway Care Plan

Care Plan Code:

A100-544212
LEE
JOHNSTONE
12 WOODSIDE AVE
0902763334
KIRKMICHAEL
KA197PP
09/02/1976
PATON,G (GP)
6 HIGH STREET
M/S
MAYBOLE

Patient Problem/Need
Patient identified as suitable for management on Category 3 Non-Traumatic Chest Pain Pathway

Goal
To ascertain cause of chest pain & as per pathway

Date	Time	Init's	Planned Nursing Interventions	Discontinued Date/Time	Init's
16/10/10	1240	JL	Introduce patient to named nurse and orientate to ward environment. Give information on condition and treatment to alleviate anxiety. Ensure patient ID Bracelet in situ with corresponding CHI number.		
"	"	JL	Liase with medical staff to ensure patient fits criteria for pathway management and appropriate documentation completed.		
"	"	JL	Check full set of observations a minimum of 4 hourly including heart rate, temperature, respirations, sPo2 & MEWS score, alerting medical staff to any abnormalities or deterioration to patient. Give prescribed oxygen.		
"	"	JL	Patient to have admission ECG, ECG at 1 Hour & 12 Hours. 1 Hour ECG due 11.30 16/10/10. Completed at 12.40.		
"	"	JL	12 Hour ECG due 1830. Completed at 1802.		
"	"	JL	Ensure medical staff informed of any changes to ECG & liaise with CCU for advice.		
"	"	JL	Cannulate & record site, size, date & time for removal as per PVC Policy. Ensure all bloods as per pathway taken inc FBC, U&E's, Glucose & lipids. 12 Hour Troponin due 16.30 Result <0.03		
"	"	JL	Administer any medications prescribed observing & documenting response. Inform medical staff immediately of adverse effects.		

16/10/	1240		Administer anti-coagulation therapy as prescribed, observe for signs of bleeding.		
			Maintain bedrest until condition stable, then gently mobilise according to patient's condition. Identify moving & handling risks and waterlow recommendations.		
			Offer diet & fluids as tolerated adhering to MUST assessment tool for recommendations.		
			If further episode of pain, obtain ECG & administer medication as prescribed which may including oxygen, GTN spray, Suscard Buccal, Opitae's & anti emetics on each occassion.		
			If evidence of ongoing pain & ECG Changes consider transfer to Coronary Care Unit-discuss with medical staff/coronary care unit.		
			Ensure Geleijnse et al score completed. In patient ETT/Out patient ETT/Myocardial perfusion imaging/No ETT **(delete as appropriate).** Ensure Pre ETT assessment completed prior to transfer to cardiac dept.		
			This care plan has been discussed and agreed with the patient and / or relatives as appropriate		

NHS Ayrshire & Arran

A100-544212

, JOHNSTONE LEE
12 WOODSIDE AVE
0902763334
KIRKMICHAEL
KA197PP 09/02/1976
PATON,G (GP)
6 HIGH STREET
MAYBOLE M/S
Address
Date of Birth

Adult Peripheral Intravenous Cannula Monitoring and Recording Sheet

All peripheral IV cannula should be resited every 72 hours.
Refer to Infection Control manual for further information.
All new cannula insertions must be recorded on the table below.

Cannula Code	Cannula Size / Colour	Cannula Location	Date Inserted	Date Due Removed	Comments	Signature/ Designation
A	Green	(R) arm	15/10/10		Inserted in A+E	C/N
B						
C						
D						
E						
F						

All patients with peripherally inserted intravascular cannula must have the insertion site CHECKED AT LEAST DAILY for signs of infection/phlebitis and this observation documented. Heparin flushes must NOT be administered routinely and only when prescribed.

Cannulas should be flushed as per Patient Group Direction for the administration of flushes. Summary guide and frequency of flush administration:

- All sodium chloride 0.9% flushes must be administered by aseptic technique and recorded on either drug prescription chart or on electronic prescribing system by the administering staff nurse trained in IV administration.
- Pre, between & post IV medication administration as determined by prescribed IV medication.
- Every 8 hours to maintain patency, where no continuous infusion is in place or the patient is not receiving IV medication at least 8 hourly.

In exceptional circumstances it may be necessary for a cannula to remain in situ for longer than 72 hours. In this instance the rationale for this must be recorded in the patient's care plan and care and maintenance of the cannula and site is of the highest standard.

Check the patient's cannula site against the 5 criteria and tick the appropriate yes/no box. You must date, time and sign on each occasion that a cannula is checked.

Cannula Code	Date	Time	1 Has the cannula been used in the past 24 hours?	2 Absence of inflammation and/or extra vasation?	3 The cannula dressing is intact?	4 The cannula has been inserted for <72 hrs? *	5 Hand hygiene before and after all procedures?	If answer is NO to any of the 5 criteria the cannula must be removed. **What has been done?**	Sign and print name and designation
A	16/10/10	1900	Yes ☑	Yes ☐	Yes ☑	Yes ☐	Yes ☑	**Cannula left in situ** ☐	
			No ☐	No ☐	No ☐	No ☐	No ☐	**Cannula removed** ☑ Prior to discharge	

			No ☐	No ☐	No ☐	No ☐	No ☐	Cannula removed	

Cannula Code	Date	Time	1 Has the cannula been used in the past 24 hours?	2 Absence of inflammation and/or extra vasation?	3 The cannula dressing is intact?	4 The cannula has been inserted for <72 hrs? *	5 Hand hygiene before and after all procedures?	If answer is NO to any of the 5 criteria the cannula must be removed. **What has been done?**	Sign and print name and designation
			Yes ☐	Yes ☐	Yes ☐	Yes ☐	Yes ☐	**Cannula left in situ** ☐	
			No ☐	No ☐	No ☐	No ☐	No ☐	**Cannula removed** ☐	
Cannula Code	Date	Time	1 Has the cannula been used in the past 24 hours?	2 Absence of inflammation and/or extra vasation?	3 The cannula dressing is intact?	4 The cannula has been inserted for <72 hrs? *	5 Hand hygiene before and after all procedures?	If answer is NO to any of the 5 criteria the cannula must be removed. **What has been done?**	Sign and print name and designation
			Yes ☐	Yes ☐	Yes ☐	Yes ☐	Yes ☐	**Cannula left in situ** ☐	
			No ☐	No ☐	No ☐	No ☐	No ☐	**Cannula removed** ☐	
Cannula Code	Date	Time	1 Has the cannula been used in the past 24 hours?	2 Absence of inflammation and/or extra vasation?	3 The cannula dressing is intact?	4 The cannula has been inserted for <72 hrs? *	5 Hand hygiene before and after all procedures?	If answer is NO to any of the 5 criteria the cannula must be removed. **What has been done?**	Sign and print name and designation
			Yes ☐	Yes ☐	Yes ☐	Yes ☐	Yes ☐	**Cannula left in situ** ☐	
			No ☐	No ☐	No ☐	No ☐	No ☐	**Cannula removed** ☐	
Cannula Code	Date	Time	1 Has the cannula been used in the past 24 hours?	2 Absence of inflammation and/or extra vasation?	3 The cannula dressing is intact?	4 The cannula has been inserted for <72 hrs? *	5 Hand hygiene before and after all procedures?	If answer is NO to any of the 5 criteria the cannula must be removed. **What has been done?**	Sign and print name and designation
			Yes ☐	Yes ☐	Yes ☐	Yes ☐	Yes ☐	**Cannula left in situ** ☐	
			No ☐	No ☐	No ☐	No ☐	No ☐	**Cannula removed** ☐	
Cannula Code	Date	Time	1 Has the cannula been used in the past 24 hours?	2 Absence of inflammation and/or extra vasation?	3 The cannula dressing is intact?	4 The cannula has been inserted for <72 hrs?	5 Hand hygiene before and after all procedures?	If answer is NO to any of the 5 criteria the cannula must be removed. **What has been done?**	Sign and print name and designation
			Yes ☐	Yes ☐	Yes ☐	Yes ☐	Yes ☐	**Cannula left in situ** ☐	

NHS Ayrshire & Arran

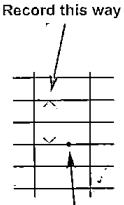
MEWS CHART

(with Neuro - Observations)

HCR N
CHI Nc
Surnar JOHNSTONE Lee
Forena 12 WOODSIDE AVENUE, KIRKMICHAEL
Addres KA19 7PP
DOB: 09/02/1976
Date of Birth

DATE	15/10		15/10	15/10
TIME (24 hour clock)	1015	1150	1350	1830
Temperature (°C)				
Bm 7.5				
BLOOD PRESSURE	158			
HEART RATE	95			
Respiratory Rate	13	17	15	16
O_2	RA	RA	RA	RA
Saturation	97%	98%	98%	96%

Record this way



Record this way

Respiratory Rate	15		18	16
O_2	A	A	RA	RA
Saturation	99	96	98	98

MEWS SCORE for EACH of the INDIVIDUAL OBSERVATIONS

Temperature (°C)	0	0	0	0
BP (Systolic)	0	0	0	0
Heart Rate	0	0	0	0
Respiratory Rate	0	0	0	0
SpO_2	0	0	0	0
Urine Output	0	0	0	0
CNS	0	0	0	0

MEWS SCORE - TOTALS

Record the total MEWS scores for each set of observations this way



6				
5				
4				
3				
2				
1				
0	0	0	0	0

Sedation Score	0	0	0	0
Pain Score (On Movement)	0	0	0	0
Nausea Score	0	0	0	0

Eyes Open	Spontaneously	4	4	4		
	To speech	3				
	To pain	2				
	None	1				
Best Verbal Response	Orientated	5	5	5		
	Confused	4				
	Inaprop. words	3				
	Incomp. sounds	2				
	None	1				
Best Motor Response	Obeys commands	6	6	6		
	Localise pain	5				
	Withdrawl to pain	4				
	Abnormal flexion to pain	3				
	Extension to pain	2				
	None	1				
GCS TOTAL			15	15		
PUPILS	R Size		NA	NA		
	R Reaction					
	L Size					
	L Reaction					
LIMB MOVEMENT ARMS	Normal power			N		
	Mild weakness					
	Severe weakness					
	Spastic flexion					
	Extension					
	No response					
LEGS	Normal power					
	Mild weakness					
	Severe weakness					
	Extension					

PUPIL SCALI (mm)

AYR-10-035949-1

CHI Number: 0902763334

NHS Ayrshire & Arran

Accident & Emergency Nursing Documentation Form

JOHNSTONE Lee

DOB: 09/02/1976

12 WOODSIDE AVENUE

KIRKMICHAEL

KA19 7PP

Date of Admission: 15/10/10

Time of Admission:

Name of Receiving Nurse:

GJ Gallagher & Christine

Additional information for admission complaint:

self presentation with central chest pain, no cardiac hx, worse on inspriation. mews 0 pts pain score 7/10.

Next of Kin: Mum

(if different from A&E Card)

With Patient: (Yes) No

Contacted: Yes No

Address: .....

Reason for not contacting

.....

.....

.....

Time Contacted: .....

Tel No: .....

Name Band in situ:	(Yes)	No	
E.C.G	(Yes)	No	
X-Ray	Yes	No	
I.V. cannula in situ:	Yes	No	Cannula Chart ☐
Bloods Taken:	Yes	No	
Waterlow:	Yes	No	
Own medications with patient:	Yes	(No)	
Own belongings with patient:	Yes	(No)	
Patient undressed:	(Yes)	No	Nurse: .....
Belongings taken for safe-keeping:	Yes	(No)	Witness/Patient: .....

CHI Number: 0902763334

15/10/10

1020/ Self presentation with central chest pain,

- no cardiac hx.
- worse on inspiration
- news 0. ECG
- Pt's pain score 7/10.
- Mum into cub.

Kellaher SN.

1154 News 0. Pt clo chest pain on inspiration Dr McColl informed. 1g paracetemol given. Admit ST 7 via CXR. SN Ellaghers

Write or attach label

DOB: 09/02/1976

JOHNSTONE Lee
12 WOODSIDE AVENUE, KIRKMICHAEL
KA19 7PP

NHS
Ayrshire
& Arran

Patient Services
Patient Profile

SPECIFIC ALERT

NHS Ayrshire & Arran

Write or attach label

H *AYR-09-036605-1*

C

S JOHNSTONE Lee DOB: 09/02/1976

F 12 WOODSIDE AVENUE, KIRKMICHAEL KA19 7PP

A *CHI-0902763334*

Date of Birth

Previous MRSA Yes ☐ No ☑

MRSA +ve Yes ☐ No ☐

Typre of Admission: Emergency / Elective

Screening form to be completed for all admissions

PREFERS TO BE ADDRESSED AS:

Receiving Consultant: Mr Wallace.

Allocated Consultant:

Date of admission: 16/08/09

Time: 17.05 hrs

From Where: A/E.

Religion (if stated): Prot.

Accompanied by: Nurse.

Age: 33 yrs

Estimated discharge date: 20/08/09.

Patients telephone number: 01655 750064.

Reason for Admission (Include patient's own account)

Epigastric hernia

First Contact / Significant Other

Name: Georgina Johnstone

Relationship: Mother.

Address: S/A.

To be given information on condition? Yes ☑ No ☐

Contact No(s): As before.

Aware of Admission: Yes ☑ No ☐

Contactable Overnight if Required Yes ☑ No ☐

Second Contact / Significant Other

Name:

Relationship:

Address:

To be given information on condition? Yes ☐ No ☐

Contact No(s):

Aware of Admission: Yes ☐ No ☐

Contactable Overnight if Required Yes ☐ No ☐

PREVIOUS MEDICAL AND SURGICAL HISTORY

Appendicectomy.
Excision of cyst (neck) aged 5.
Excision of cyst LV upper outer leg.
Guillen Barré.
Gastritis

Medication used at home (including herbal / over the counter)

Drug	Dose
Omeprazole	20mg BD

* for more entries see opposite

ALLERGIES (Including food allergies/Latex Allergy)

NKDA.

Stored in ward: Yes ☐ No ☐

Returned to patient: Yes ☐ No ☐

Other (State): Yes ☐ No ☐

Conformance Aid in use*: Yes ☐ No ☐
(If yes, inform pharmacist)

Date:.....Sign:.....

RECORD OF INVESTIGATION, PROCEDURES AND SURGERY

Date	Procedure / Surgery	Patient Aware of Result	Initials
16/8.	Bloods. IV access. Analgesia/Antiemetic.		

OBSERVATIONS ON ADMISSION

General Appearance

Temperature	Pulse	BP	Respiration	O2 Saturation	Colour	Conscious Level	GR	LMP	BHCG
36.3	84	140/70	16	97	Perfused	Alert			

Urinalysis: NAD

Midstream urine sent for C & S Yes ☐ No ☐

Date:

ADMISSION ASSESSMENT

Has a Single Shared Assessment been completed/commenced for this patient? Yes ☐ No ☐

Home Circumstances

Lives:-

Alone ☐

Identify carer/s

With elderly/infirm partner ☐

With healthy partner/family ☑

Does carer require additional support ☐

(Consider referral to social work)

Does patient have any dependants Yes ☐ No ☐

Details:.....

.....

Who is caring for dependants

Nursing home ☐

Residential care ☐

Describe Family Living Arrangements:

Type of House (circle): House

Stairs at entrance ☐ How many? _____

Stairs inside ☐ How many? _____

Toilet: Upstairs ☐ Downstairs ☑

Bedroom: Upstairs ☑ Downstairs ☐

COMMUNITY SERVICES IN USE		Frequency	Informed of Admission	Informed By/Comments
Home Care	Yes ☐ No ☐		Yes ☐ No ☐	
Meals on Wheels	Yes ☐ No ☐		Yes ☐ No ☐	
Sheltered Housing	Yes ☐ No ☐		Yes ☐ No ☐	
Visited by Specialist Nurse	Yes ☐ No ☐		Yes ☐ No ☐	
District Nurse	Yes ☐ No ☐		Yes ☐ No ☐	
Day Hospital	Yes ☐ No ☐		Yes ☐ No ☐	

DISCHARGE

Will Personal Transport be Available for Discharge: Yes ☐ No ☐ Patient has keys: Yes ☑ No ☐

Predicted Discharge Complex ☐ Straight forward ☑ Discharge co-ordinator informed Yes ☐ No ☐

PATIENT'S PROPERTY

Property Retained by Patient:.....

I understand articles/valuables (e.g. jewellery, money, spectacles, hearing aids, personal items) retained by me are my own responsibility.

Signature of Patient/Significant Other:..... Date:.....

Property Handed Over for Safe Keeping Yes ☐ No ☐

Date Taken to Safe: Cash and Valuables Ref. No:..... Date Returned:.....

Signature of Admitting- nurse: L McClinton Date: 16/8/09

Print Name	Initials	DES	Signature	Print Name	Initials	DES	Signature
L McCLINTON	LMC	SN	L McClinton				

DES - Designation SR - Sister SN - Staff Nurse EN - Enrolled Nurse STN - Student Nurse HCA - Health Care Assistant

NHS
Ayrshire & Arran

Patient Services - Hospitals

Activities of Living Assessment

Write or attach label

HCR No: .....

CHI No: .....

Surname: .....

Forename: ..... Sex: .....

Address: .....

.....

Date of Birth .....

MAINTAINING A SAFE ENVIRONMENT

Orientated to Time and Place	Yes	☑	No	☐
Known Dementia	Yes	☐	No	☑
Skin Intact	Yes	☐	No	☑
Podiatry problems	Yes	☐	No	☑
Waterlow Assessment:	Completed	☑	To be completed	☐
Wound	Yes	☐	No	☑
Pain Present	Yes	☑	No	☐
Pain Score	5			

PROBLEMS / NEEDS

BREATHING

Rate/Rhythm/Character/Cough:

Patient Colour:

Smoker Yes ☑ No ☐

(If YES, please undertake assessment)

Number Per Day: 10 per day.

Home Oxygen in Use Yes ☐ No ☑

Home Nebulisers in Use Yes ☐ No ☑

PROBLEMS / NEEDS

CONTROLLING BODY TEMPERATURE

Apyrexial on Admission Yes ☑ No ☐

PROBLEMS / NEEDS

EATING AND DRINKING

Height: 5ft 6ins. Weight: 148st.

Dentures: Upper ☐ Lower ☐ Partial ☐

Caps / Crowns ☐ Bridge ☐

Mouth Assessment:

Recent Appetite:

Nausea / Vomiting: Nausea.

Weight: Steady ☐ Loss ☑ Gain ☐

Eating Likes/Dislikes:

Theraputic Diet:

Alcohol Intake: 28 units per week.

(Alcohol consumption greater that 50 units per week – consider referral to alcohol liaison team)

Physical Difficulties When Eating and Drinking, e.g. Dysphagia, Visual Impairment:

(Consider referral to SALT)

Equipment requirements:

Cultural/Ethnic/Religious Requirements: e.g. halal, kosher food

PROBLEMS / NEEDS

intended.

MOBILISING

(Posture/Gait/Mobility)

Independent Yes ☑ No ☐

Aids Required Yes ☐ No ☐

Specify :

If Assistance Required Specify

Usual Level of Physical Activity

Limiting Factors, e.g. Pain

PROBLEMS / NEEDS

ELIMINATING

Normal Bowel Activity: Daily

Suggested Aperients taken Yes ☐ No ☐ N/A ☐

Last Bowel Motion: 15/08/07

Constipation ☐ Loose stools ☐

Blood / Mucus / Pus ☐ Incontinent ☐

Normal urinary function: No concerns

Urgency ☐ Frequency ☐ Dribbling ☐

Hesitancy ☐ Nocturia ☐ Incontinent ☐

Continence Products in Use Yes ☐ No ☐

(If yes State Type/Amount)

If bladder or bowel incontinence is a problem, has assessment

been completed by Continence Nurse? Yes ☐ No ☑

Catheterised Yes ☐ No ☑

Stoma Yes ☐ No ☑

Specifics:

Cultural/Religious Needs:

PROBLEMS / NEEDS

COMMUNICATION

Impaired Hearing Yes ☐ No ☑

Hearing Aid Left ☐ Right ☐ Bilateral ☐

Impaired Vision ☐ Glasses ☐ Contact Lenses ☐

Impaired Speech ☐ Visual Aids ☐

Learning Difficulties Yes ☐ No ☑

(If Yes,Please Undertake LD Assessment)

Primary Language English: Yes ☑ No ☐

If no, state:

Interpreter Required: Yes ☐ No ☑

Patient's Ability to Understand Written Communication, e.g. Dyslexia:

Patient's Personal Feelings Regarding Eye Contact:

Religious or Cultural Requirements that Place Limitations on the Patient's Care

PROBLEMS / NEEDS

PERSONAL CLEANSING AND DRESSING

Independent Yes ☑ No ☐

Assistance Required With:

Religious or Cultural Requirements:

Patient's Personal Feeling Regarding Touch:

Use of Dressing Aids (State):

PROBLEMS / NEEDS

WORKING AND RECREATION

Occupation: Unemployed.

Hobbies: weightlifting.

Impact of Illness on Work and Recreation:

PROBLEMS / NEEDS

SLEEPING

Usual Pattern/Routine: Sleeps well.

What helps?

No of Pillows:

PROBLEMS / NEEDS

EXPRESSING SEXUALITY

Possible Altered Body Image: Yes ☐ No ☑

Privacy/Modesty Issues:

PROBLEMS / NEEDS

SPIRITUAL OR RELIGIOUS NEEDS

Does the Patient Wish to State-Their Religion: PROT.

Visit Required from Own Minister/Priest or Faith Representative. Yes ☐ No ☐

(If Yes, Please Contact Chaplaincy Team)

Describe Any Specific Religious Needs/Practices:

(Please Refer to Religions and Cultures Manual)

Signs of Spiritual Distress, e.g. Loss of Meaning and Purpose in Life:

Need to Revisit Spiritual Needs Yes ☐ No ☐

PROBLEMS / NEEDS

DYING / EMOTIONAL PROBLEMS/NEEDS

Patient's Mood: Bright.

Confused ☐ Mildly anxious ☐ Highly anxious/distressed ☐

Worries Regarding Admission:

Impact of Illness on Family/Significant Other:

Signature of Admitting Nurse: [signature]

PROBLEMS / NEEDS

Date: 16/8/09

Write or attach label

AYR-09-036605-1

DOB: 09/02/1976

JOHNSTONE Lee

12 WOODSIDE AVENUE, KIRKMICHAEL

KA19 7PP

CHI-0902763334

Date of Birth.....

NURSING NOTES

DATE	
16/8/09.	Pt via casualty with epigastric hernia.
	S/B M/S Obsds - Bloods ✓ Analgesia ✓ Antiemetic ✓
	IV access ✓ Orientated to ward environment. LMcC.
22⁰⁰	S/B Mr Wallace - attended for abdo x-ray.
	~~NBM~~ to fast from 0am
	? for lap repair of hernia — R Cameron
17/8/09	0030 - Very settled night. Appears to have slept well.
	Oral analgesia given as charted — R Cameron
17.8.9	Self showered in prep for
(10⁵⁵ am)	theatre. S/b Mr Wallace.
	for hernia repair today.
	Consent ✓ Anaesthetist ✓.
	IV para given for pain.
	Obs charted.
	TEDS given — L Lorenzo
(18²⁰ pm)	Returned from theatre.
	Comfortable. Obs charted.
	— (LMcC)
18/8/09	0540.
	Has now passed urine. Observations
	within normal limits
	Settled with oral analgesia
	Wound intact — R Cameron

DATE	
	18/8/09 11⁴⁵ AM - SELF CARING TODAY, SEEN BY MR ~~HAIR~~ MALPANI, FOR DISCHARGE HOME. TODAY, NO FOLLOW UP. PRACTICE NURSE TO CHECK WOUND. OBSERVATIONS SATISFACTORY.

NHS Ayrshire & Arran

Write or attach label

Practice Code 80487

H .....

C JOHNSTONE A100-544212
12 WOODSIDE AVE LEE .....

S 0902763334 .....

F KIRKMICHAEL
KA197PP 09/02/1976 .....

A Paton,G (GP) .....
Maybole Health Centre
6 High Street

Date of Birth 2 M/a .....

Multi-disciplinary Discharge Plan

Estimated Discharge Date ..... 20/08/09 .....

Medically fit Date .....

Ready for Discharge Date .....

Actual discharge date ..... Time.....

All entries must be dated and timed, name and designation (sign and print)

Identified Problem:
Needs assessment to facilitate discharge following in-patient stay

Goal / Aim:
To ensure planned safe timeous discharge

Nursing Interventions

Date Time		Completion date	Signature
16/8/09 17:30	**Clarify patients admission details are complete, which will identify appropriate referrals to the MDT.** **Refer to appendix multidisciplinary roles and responsibilities.**	16/8/09	LMcC

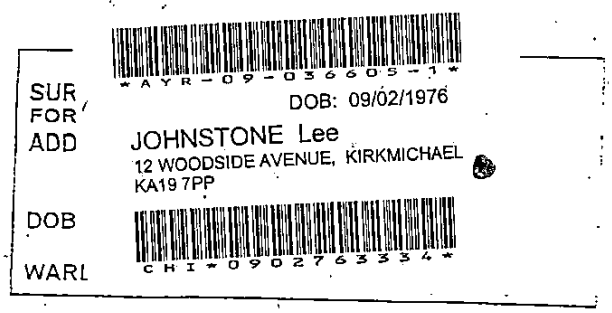
Multi-Disciplinary Referrals. Discuss with patient and obtain patients consent for referrals.

Record referrals made or contact details for staff outwith Hospital if not on admission information

Referral			First Seen	
Date	Sign		Date	Sign
		Physiotherapist		
		Occupational Therapist		
		Dietitian		
		SALT		
		Pharmacist Does Patient have a medication concordance / compliance aid? Y N If Y refer to ward clinical pharmacist		
		Specialist Nurse		
		District Nurse		
		Social Worker		
		Home Care Organiser		
		Discharge Co-ordinator		
		Podiatrist		
		Other e.g. Mental Health Team, Psychologist (Specify):		

Multi-Disciplinary Interventions

	Has the patient been assessed as requiring a home visit Y N N/A If so Record date..... And ensure patient has clothes and house keys		



ASSESSEMENT OF RISK OF DEEP VENOUS THROMBOSIS (DVT)

Score 1 point for each risk factor

Risk Factors

Age 40 years plus ☐
Smoker ☑
Obesity ☐
History of DVT/PE ☐
Congestive Cardiac Failure ☐
Thrombophilia ☐
Malignancy ☐
Surgery lasting >30 Mins ☐
Laparoscopic Procedure ☐
Inflammatory Bowel Disease ☐
Contraceptive Pill /HRT ☐
Pregnancy ☐
Post – Partum (<6 weeks) ☐
Sepsis ☐

Total Risk Factor Score [1]

Large Teds Supplied

Please follow guidance below depending on Total Risk Score.

0 – Low Risk – Anti – Thrombotic stockings and early mobilisation

1-2-Moderate Risk – Anti – Thrombotic stockings and low dose Dalteparin

2+ High Risk – Anti Thrombotic stockings and high dose Dalteparin

Contra – Indications for Dalteparin

Bleeding Disorder ☐
Severe liver disease ☐
On oral anti – coagulants ☐
With therapeutic INR ☐
History of Haemorrhagic ☐
Stroke ☐
Active G1 bleed ☐
Heparin allergy ☐

If guidance not followed please explain reasons why.

A&A Logo

Maybole

M/S

JOHNSTONE A100-544212
12 WOODSIDE AVE LEE
KIRKMICHAEL 0902763334
KA197PP 09/02/1976

Paton,G (GP)
Maybole Health Centre
6 High Street
Maybole

Smoking Disclaimer draft 4

Ward SC2
Date 16/8/09
Time 1925

Section 1 - for patient signature

I have been provided with information regarding the smoking ban in NHS wards / departments introduced via the Smoking, health and social care act 2005. I have been advised against leaving the ward to smoke and understand that there are risks associated with this. I therefore absolve staff of responsibility for my care whilst I am absent from the ward.

signed... L Johnstone

Witness name... L Jamieson
Witness signature... L Jamieson

Section 2 - for escort signature

To be completed by adult escort where patient is dependant upon assistance to leave the ward to smoke against medical / nursing advice.

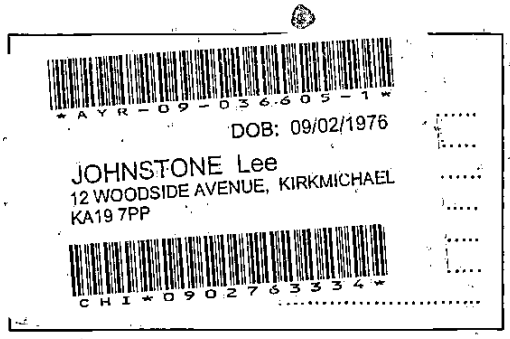
I (adult's name.....) having been made aware of the implications of the smoking, health and social care act 2005, take responsibility for above patient whilst s/he is absent from the ward to smoke. I understand that staff cannot provide care whilst the patient is not present on the ward.

signed.....

Witness name.....
Witness signature.....

Please file this form in nursing notes ensuring circumstances are fully documented.

NHS Ayrshire & Arran



Pressure Sore Risk Assessment Tool
Waterlow Pressure Sore Risk Assessment

SCORE		
<10	Low risk	Re-assess weekly or if condition changes
10+	At risk	Re-assess twice weekly or if condition changes
15+	High Risk	Re-assess on alternate days
20+	Very high risk	Assess daily

Waterlow Risk Assessment		Initials	LMcC													
		Date	16/8													
Body weight for height		No.	1	2	3	4	5	6	7	8	9	10	11	12	13	14
	Average	0														
	Above average	1	0													
	Obese	2														
	Below average	3														
Continence																
	Completely catheterised	0														
	Occasionally Incontinent	1	0													
	Cath. Incontinence of Faeces	2														
	Doubly Incontinent	3														
Skin Type: Visual Risk Areas																
	Healthy	0														
	Tissue Paper/Dry	1	6													
	Oedematous/Clammy (temp)	1														
	Discoloured	2														
	Broken Spot	3														
Mobility																
	Fully	0														
	Restless/Figity	1	0													
	Apathetic	2														
	Restricted	3														
	Inert/Traction	4														
	Chairbound	5														
Age/Sex																
	Male/Female	1/2	1													
	14 – 49	1														
	50 – 64	2	1													
	65 – 74	3														
	75 - 80	4														
	80+	5														
Appetite																
	Average	0														
	Poor	1	0													
	NG Tubes/Fluids only	2														
	nbm - Anorexic	3														
Special Risks – Tissue Malnutrition																
	eg Terminal Cachexia	8														
	Cardiac failure	5														
	Peripheral Vascular Disease	5	1													
	Anaemia	2														
	Smoking	1														
Neurological Deficit																
	eg Diabetes. MS, CVA															
	Motor-sensory Paralegia	4-6														
Major Surgery/Trauma																
	Orthopaedic Below waist, Spinal	5														
	On table >2 hours	5														
Medication																
	Cylotoxics, Highdose Steriods	4														
	Anti-inflammatory															
		Total Score	3													

Date	Waterlow Score	Comments (eg treatment, mattress, etc.)	Date of next assessment due	Signed
(Admission)	5	Self caring + fully mobile	23/8/09	LMcC

NHS Ayrshire & Arran

Moving/Handling Assessment

Admission Date 16/8/09

Write or attach label

H Maybole M/S .....
C JOHNSTONE A100-544212 .....
12 WOODSIDE AVE LEE .....
S .....
I KIRKMICHAEL 0902763334 .....
KA197PP .....
09/02/1976 .....
Paton, G (GP) .....
Maybole Health Centre .....
6 High Street .....
Maybole .....
Date of Birth: .....

Assessment Categories		Tick as appropriate							
			1	2	3	4	5	6	7
	AMBULATION	**DATE**	16/8						
1	Walks independently		✓						
2	Needs supervision								
3	Needs 1/2 people to assist (specify)								
4	Uses walking aid type:								
5	Unable to walk								
6	Other / Specify:								
	BED TRANSFERS								
1	Manages in/out independently								
2	Needs supervision		✓						
3	Needs 1/2 people to assist (specify)								
4	Needs mechanical assist (specify)								
5	On bedrest								
6	Needs 1/2/3 people to change position Specify number:								
7	May be at risk of falling/attempting to get out of bed - needs supervision								
8	Other / Specify:								
	ARMCHAIR								
1	Transfers independently in/out chair		✓						
2	Needs supervision								
3	Needs 1/2 people to assist (specify)								
4	Needs specific seating due to disability Specify:								
5	At risk of falling / may attempt to rise from chair unaided - needs supervision								
6	Other / Specify:								

NHS Ayrshire & Arran

AYR-09-036605-1
DOB: 09/02/1976
JOHNSTONE Lee
12 WOODSIDE AVENUE, KIRKMICHAEL
KA19 7PP
CH1-0902763334

Nutritional Screening 'Malnutrition Universal Screening Tool' ('MUST')

To be Completed within 24 Hours of Admission

Step 1: Measure height and weight to get a BMI score.

Step 2: Note percentage unplanned weight loss and score.

Step 3: Establish acute disease effect and score.

Step 4: Add scores from steps 1, 2 and 3 together to obtain overall risk of malnutrition.

Step 5: Follow the management guidance appropriate to the risk category and commence the corresponding care plan.

Screening Results

Please indicate if measurements are Measured (M), Reported (R) or Estimated (E)

Date	16/8/09				
Ward	8R2				
Height (metres) M( ) R(✓) E( )	1.67 m				
Current weight (Kg)	88.9 Kg ( )	Kg ( )	Kg ( )	Kg ( )	Kg ( )
BMI	32				
Is patient within obese category?	No				
Usual Weight (Kg)	92 Kg				
Signature	[signature]				
'MUST'					
Step 1: BMI Score > 20 (> 30 = Obese) ..... 0 18.5 – 20 ..... 1 < 18.5 2	0				
Step 2: Weight Loss Score Unplanned weight loss in past 3-6 months: < 5% ..... 0 5-10% ..... 1 >10% 2	0				
Step 3: Acute Disease Effect Score If patient is acutely ill **and** there has been or is likely to be no nutritional intake for > 5 days.....Score 2 Not applicable ..... Score 0	0				
Step 4: Overall Risk of Malnutrition Total:	0				
Step 5:	0 = Low Risk	1 = Medium Risk	2 or more = High Risk		

Referrals	Date Referred	Signature
Dietitian		
Speech and Language Therapy		
Occupational Therapy		
Nutritional Support Team		
Dental Service		

NHS Ayrshire & Arran

Malnutrition Universal Screening Tool (MUST) Multidisciplinary Care Plan

H JOHNSTONE A100-544212
12 WOODSIDE AVE LEE
C
S KIRKMICHAEL 0902763334
F KA197PP 09/02/1976
Paton, G (GP)
Maybole Health Centre
6 High Street
Maybole

Patient Problem/Need							
Nutritional screening has identified patient as being at	Low	☑	Medium		High	☐	risk of malnutrition

Goal
To meet patients nutritional and fluid requirements. To prevent weight loss and promote weight gain, as appropriate.
For Low Risk patients consider interventions in the **green** section of the care plan as appropriate.
For Medium Risk patients follow interventions in the **green and** sections of the care plan.
For High Risk patients follow interventions in the **green,** **and red** sections of the care plan.
Allied Health Professionals: consider interventions appropriate for speciality on the reverse of the form.

Date	Time	Intls		Planned Nursing Interventions	Discontinued Date/Time	Intls
				Low Risk Care Plan -		
18/09	80			Monitor and review care plan and **repeat screening weekly** or monthly if in continuing care.		
18/	17 KS	Lm ac		Consider individual and/or therapeutic dietary requirements.		
				Assist patient to select appropriate meals from menu card.		
16/				Provide encouragement and assistance with eating and drinking as required.		
				Ensure fresh drinking water is offered regularly and available at all times, where clinically appropriate.		
				Consider patient's positioning and support oral hygiene, if required		
				This care plan has been discussed and agreed with the patient as appropriate.		
				Medium Risk Care Plan		
				Commence food chart for a minimum of 3 days. Only discontinue if/when dietary intake is adequate.		
				If intake is insufficient, offer patient full cream milk or suitable alternative to drink with and between meals and suitable additional snacks.		
				Record accurate fluid intake/output on fluid balance chart until established that oral intake is adequate. If intake per 24hrs is inadequate, consider IV/SC fluids.		
				Monitor and review care plan and **repeat screening weekly**		
				High Risk Care Plan		
				Refer to Dietitian, ensuring the 'MUST' score is included.		
				Monitor and review care plan and **repeat screening weekly**		
				Discontinue food chart only when advised by Dietitian		

NHS Ayrshire & Arran

MEWS CHART
(with Neuro - Observations)

HCI DOB: 09/02/1976
CHI JOHNSTONE Lee
Surn 12 WOODSIDE AVENUE, KIRKMICHAEL
Fore KA19 7PP
Addr
Date of birth

DATE	16/8												17/8			
TIME (24 hour clock)	1520	2000	1000	1623	1633	1643	1653	0102	0115	0130	0140	1820	2000	0108	1000	
Temperature (°C)																
BLOOD PRESSURE																
Respiratory Rate	16	16	17	22	19	17	18	17	18	17	17	16	16	16	16	
O_2 Saturation	97	97	97	100	100	100	100	100	100	100	100	97	97	97	97	

O_2 Saturation	N 99	A 96	A 97	A 100	A 100	A 100		N 100	A 100	A 100	A 100	A 97	A 98	A 97													

MEWS SCORE for EACH of the INDIVIDUAL OBSERVATIONS

Temperature (°C)	0	0		0	0	0	0	0	0	0	0	0	0	0													
BP (Systolic)	0	0		0	0	0	0	0	0	0	0	0	0	0													
Heart Rate	0	0		0	0	0	0	0	0	0	0	0	0	0													
Respiratory Rate	0	0		1	0	0	0	0	0	0	0	0	0	0													
SpO_2	0	0		0	0	0	0	0	0	-	0	0	0	0													
Urine Output	0	0		0	0	0	0	0	0	-	0	0	0	0													
GNS	0	0		1	1	1	2	2	-	-	0	0	0	0													

MEWS SCORE = TOTALS

Record the total MEWS scores for each set of observations this way

6																											
5				5																							
4				4																							
3																											
2																											
1																											
0	0	0		0																							

Sedation Score	0	0	0	1	1	1	1	1	0	0	0	0	0	0	0												
Pain Score (On Movement)	3	1	1	0	0	0	1	1	2	2	0	0	0	0	1												
Nausea Score	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0												

C Eyes Open	Spontaneously	4																									
	To speech	3																									
	To pain	2																									
	None	1																									
A Best Verbal Response	Orientated	5																									
	Confused	4																									
	Inaprop. words	3																									
	Incomp. sounds	2																									
S	None	1																									
C Best Motor Response	Obeys commands	6																									
	Localise pain	5																									
	Withdrawl to pain	4																									
	Abnormal flexion to pain	3																									
	Extension to pain	2																									
M	None	1																									
	GCS TOTAL																										
PUPILS	R Size																										
	R Reaction																										
	L Size																										
	L Reaction																										
LIMB MOVEMENTS ARMS	Normal power																										
	Mild weakness																										
	Severe weakness																										
	Spastic flexion																										
	Extension																										
	No response																										
LEGS	Normal power																										
	Mild weakness																										
	Severe weakness																										
	Extension																										
	No response																										

PUPIL SCALE (mm)

1 2 3 4 5 6 7 8

STA4002

VIC082075

NHS Ayrshire & Arran

Adult Peripheral Intravenous Cannula Monitoring and Recording Sheet

All peripheral IV cannula should be resited every 72 hours.
Refer to Infection Control manual for further information.
All new cannula insertions must be recorded on the table below.

HCR	JOHNSTONE LEE	A100-544212	
CHI	12 WOODSIDE AVE		
Surr	KIRKMICHAEL	0902763334	
Fore	KA197PP	09/02/1976	
Add	Paton, G (GP)		
	Maybole Health Centre		
Dat	6 High Street		

Cannula Code	Cannula Size / Colour	Cannula Location	Date Inserted	Date Due Removed	Comments	Signature/ Designation
A	GREEN	RT HAND	16/08/09	19/08/09	Inserted in A/E	LM°Clatta SN
B						
C						
D						
E						
F						

All patients with peripherally inserted intravascular cannula must have the insertion site CHECKED AT LEAST DAILY for signs of infection/phlebitis and this observation documented. Heparin flushes must NOT be administered routinely and only when prescribed.

Cannulas should be flushed as per Patient Group Direction for the administration of flushes. Summary guide and frequency of flush administration:

- All sodium chloride 0.9% flushes must be administered by aseptic technique and recorded on either drug prescription chart or on electronic prescribing system by the administering staff nurse trained in IV administration.
- Pre, between & post IV medication administration as determined by prescribed IV medication.
- Every 8 hours to maintain patency, where no continuous infusion is in place or the patient is not receiving IV medication at least 8 hourly.

In exceptional circumstances it may be necessary for a cannula to remain in situ for longer than 72 hours. In this instance the rationale for this must be recorded in the patient's care plan and care and maintenance of the cannula and site is of the highest standard.

Check the patient's cannula site against the 5 criteria and tick the appropriate yes/no box. You must date, time and sign on each occasion that a cannula is checked.

Cannula Code	Date	Time	1 Has the cannula been used in the past 24 hours?	2 Absence of inflammation and/or extra vasation?	3 The cannula dressing is intact?	4 The cannula has been inserted for <72 hrs? *	5 Hand hygiene before and after all procedures?	If answer is NO to any of the 5 criteria the cannula must be removed. **What has been done?**	Sign and print name and designation
			Yes ☐	Yes ☐	Yes ☐	Yes ☐	Yes ☐	**Cannula left in situ** ☐	
			No ☐	No ☐	No ☐	No ☐	No ☐	**Cannula removed** ☐	

Medicine Prescription Sheet

Address 12 WOODSIDE AVE
KIRKMICHAEL
KA19 7PP

CHI Number
Date of Birth 09/02/1976
Ward STATION 2-AYR
Consultant MR DAVID WALLACE

Allergy	Reaction
No known allergies	

Date Printed: 18/08/2009 13:08
User Name: NU1017

	Date Started	Date Stopped, Suspended or Resumed	Approved Name of Medicine	Dose	Frequency	Route	Other Instructions	Last EPA dose given	Prescriber / Verified by:
B	16/08/2009		**Either CYCLIZINE 50 mg Tablets**	**50 mg**	07:00 13:00 22:00 PRN	Oral	For nausea and vomitting		
C	16/08/2009		**Or CYCLIZINE 50mg in 1ml Injection**	**50 mg**	07:00 13:00 22:00 PRN	IM	For nausea and vomitting		DR DANIELLE GIBSON
D	16/08/2009		TRAMADOL 50 mg Capsules	**50 mg**	07:00 13:00 18:00 22:00 PRN	Oral	For pain	50 mg on 18/08/2009 at 07:58:00	DR DANIELLE GIBSON
E	16/08/2009		**Either PARACETAMOL 500 mg Tablets**	**1000 mg**	07:00 13:00 18:00 22:00 PRN	Oral	For pain/pyrexia	1000 mg on 17/08/2009 at 21:24:00	
F	16/08/2009		**Or PARACETAMOL 500mg Suppositories**	**1000 mg**	07:00 13:00 18:00 22:00 PRN	Rectally	For pain/pyrexia		
G	16/08/2009		**Or PARACETAMOL 1000 mg in 100ml Intravenous Infusion**	**1000 mg**	07:00 13:00 18:00 22:00 PRN	IV Int	For pain/pyrexia	1000 mg on 17/08/2009 at 08:51:00	DR DANIELLE GIBSON

Read report carefully. Pay particular attention to the Date Stopped, Suspended or Resumed column

Medication Administration Profile

Patient: JOHNSTONE, LEE
Hospital No: 100544212
Date Of Birth: 9-Feb-1976
Allergies: No known drug allergies

Weight: kg
Height: cm
Body Surface: sq m

Date of Report: 18-Aug-2009 at 13:10
Type of Report: Since Admission
Requested By: NU1017
Current Status: On Ward STATION 2-AYR
Under the Care of: MR DAVID WALLACE
Admitted On: 16-Aug-2009

Episode History:
Consultant: MR DAVID WALLACE from 16-Aug-2009 17:15
Transfer History:
Admitted to Ward: STATION 2-AYR on 16-Aug-2009 at 17:15

Key: ! - denotes unverified order at the time of charting or administration. * - denotes charting was overridden. ? - denotes witnessable administration not witnessed. [@@] - denotes patient was/is on Short Term Leave. [+] - Order Notes exist <MOD> - Order Modified <DIS> - Order Discontinued <STOPPED> - Order Stopped <SUS> - Order Suspended <RES> - Order Resumed

DRUG DOSE,ROUTE & FREQUENCY/INTERVAL/RATE *VERIFIER*	16-Aug-2009 Sunday	17-Aug-2009 Monday	18-Aug-2009 Tuesday				
CYCLIZINE 50 mg Tablets OR 50 mg Oral 3X PRN For nausea and vomitting DR DANIELLE GIBSON Start Date/Time 16-Aug-2009 18:43							
CYCLIZINE 50mg in 1ml Injection 50 mg IM 3X PRN For nausea and vomitting DR DANIELLE GIBSON Start Date/Time 16-Aug-2009 18:43							
TRAMADOL 50 mg Capsules 50 mg Oral 4X PRN For pain DR DANIELLE GIBSON Start Date/Time 16-Aug-2009 18:44	! 21:10 NU1803	! 21:24 NU1803	! 07:58 NU1017				
PARACETAMOL 500 mg Tablets OR 1000 mg Oral 4X PRN For pain/pyrexia DR DANIELLE GIBSON Start Date/Time 16-Aug-2009 18:44	! 21:10 NU1803	! 21:24 NU1803					
PARACETAMOL 500mg Suppositories OR 1000 mg Rectally 4X PRN For pain/pyreixa DR DANIELLE GIBSON Start Date/Time 16-Aug-2009 18:44							
PARACETAMOL 1000 mg in 100ml Intravenous In 1000 mg IV Int 4X PRN For pain/pyrexia DR DANIELLE GIBSON Start Date/Time 16-Aug-2009 18:44		! 08:51 NU2092					

Surname	07356-00076 100544212
Forename	JOHNSTONE, LEE
Address	16 MINNOCH CRESCENT
	MAYBOLE
	KA198DW 0902763334
	DoB 09/02/1976 Male
Ward or Dep	

NHS
Ayrshire & Arran

Patient Services
Patient Profile

STA4205

SPECIFIC ALERT

NHS Ayrshire & Arran

Su 07356-00076 100544212
Fo JOHNSTONE, LEE
16 MINNOCH CRESCENT
MAYBOLE
Ad KA198DW 0902763334
DoB 09/02/1976 Male
Ward or Department

Previous MRSA Yes ☐ No ☐
MRSA +ve Yes ☐ No ☐
Screening form to be completed for all admissions

Typre of Admission (Emergency) / Elective

PREFERS TO BE ADDRESSED AS:	Receiving Consultant	Allocated Consultant:

Date of admission: 22/12/07	Time: 1500
From Where: A/E	Religion (if stated):
Accompanied by: MUM, DAD + SON	Age: 30
Estimated discharge date: 22/12/07	Patients telephone number:

Reason for Admission (Include patient's own account)

D+V
AWAITING BLOOD RESULTS

First Contact / Significant Other

Name: GEORGINA
Address: JOHNSTONE
Relationship: MOTHER
To be given information on condition? Yes ☐ No ☐
Contact No(s): 01655 889669
Aware of Admission: Yes ☑ No ☐
Contactable Overnight if Required Yes ☑ No ☐

Second Contact / Significant Other

Name:
Address:
Relationship:
To be given information on condition? Yes ☐ No ☐
Contact No(s):
Aware of Admission: Yes ☐ No ☐
Contactable Overnight if Required Yes ☐ No ☐

PREVIOUS MEDICAL AND SURGICAL HISTORY

INDIGESTION
? ALCOHOL

Medication used at home
(including herbal / over the counter)

Drug	Dose
LANSOPRAZOLE	
* for more entries see opposite	

ALLERGIES (Including food allergies/Latex Allergy)

NKDA

Stored in ward: Yes ☐ No ☐
Returned to patient: Yes ☐ No ☐
Other (State): Yes ☐ No ☐
Conformance Aid in use*: Yes ☐ No ☐
(If yes, inform pharmacist)
Date:.....Sign:.....

RECORD OF INVESTIGATION, PROCEDURES AND SURGERY

Date	Procedure / Surgery	Patient Aware of Result	Initials
22/12	BLOODS		
	CXR		

OBSERVATIONS ON ADMISSION

General Appearance

Temperature	Pulse	BP	Respiration	O2 Saturation	Colour	Conscious Level	GR	LMP	BHCG
36.5	75	160/95	17	98		15/15			

Urinalysis:

Midstream urine sent for C & S Yes ☐ No ☐

Date:

ADMISSION ASSESSMENT

Has a Single Shared Assessment been completed/commenced for this patient? Yes ☐ No ☐

Home Circumstances

Lives:-

Alone ☐

Identify carer/s

With elderly/infirm partner ☐

With healthy partner/family ☐

Does carer require additional support ☐

(Consider referral to social work)

Does patient have any dependants Yes ☐ No ☐

Details:.....

.....

Who is caring for dependants

Nursing home ☐

Residential care ☐

Describe Family Living Arrangements:

LIVES WITH MUM + DAD

Type of House (circle):

Stairs at entrance ☐ How many? _____

Stairs inside ☐ How many? _____

Toilet: Upstairs ☐ Downstairs ☐

Bedroom: Upstairs ☐ Downstairs ☐

COMMUNITY SERVICES IN USE		Frequency	Informed of Admission	Informed By/Comments
Home Care	Yes ☐ No ☐		Yes ☐ No ☐	
Meals on Wheels	Yes ☐ No ☐		Yes ☐ No ☐	
Sheltered Housing	Yes ☐ No ☐		Yes ☐ No ☐	
Visited by Specialist Nurse	Yes ☐ No ☐		Yes ☐ No ☐	
District Nurse	Yes ☐ No ☐		Yes ☐ No ☐	
Day Hospital	Yes ☐ No ☐		Yes ☐ No ☐	

DISCHARGE

Will Personal Transport be Available for Discharge: Yes ☑ No ☐ Patient has keys: Yes ☑ No ☐

Predicted Discharge Complex ☐ Straight forward ☐ Discharge co-ordinator informed Yes ☐ No ☐

PATIENT'S PROPERTY

Property Retained by Patient:.....

I understand articles/valuables (e.g. jewellery, money, spectacles, hearing aids, personal items) retained by me are my own responsibility.

Signature of Patient/Significant Other:..... Date:.....

Property Handed Over for Safe Keeping Yes ☐ No ☐

Date Taken to Safe: Cash and Valuables Ref. No:..... Date Returned:.....

Signature of Admitting- nurse:..... Date:.....

Print Name	Initials	DES	Signature	Print Name	Initials	DES	Signature
E HOGGS	EH						

DES - Designation SR - Sister SN - Staff Nurse EN - Enrolled Nurse STN - Student Nurse HCA - Health Care Assistant

NHS
Ayrshire & Arran

Patient Services - Hospitals

Activities of Living Assessment

07356-00076 100544212
Su JOHNSTONE, LEE
16 MINNOCH CRESCENT
Fc MAYBOLE
A KA198DW
0902763334
DoB 09/02/1976 Male
Ward or Department .....

MAINTAINING A SAFE ENVIRONMENT

Orientated to Time and Place	Yes	☑	No	☐
Known Dementia	Yes	☐	No	☑
Skin Intact	Yes	☑	No	☐
Podiatry problems	Yes	☐	No	☑
Waterlow Assessment:	Completed	☐	To be completed	☐
Wound	Yes	☐	No	☐
Pain Present	Yes	☑	No	☐
Pain Score				

PROBLEMS / NEEDS

BREATHING

Rate/Rhythm/Character/Cough: 17/MW
Patient Colour: PINK
Smoker Yes ☐ No ☑
(If YES, please undertake assessment)
Number Per Day:
Home Oxygen in Use Yes ☐ No ☐
Home Nebulisers in Use Yes ☐ No ☐

PROBLEMS / NEEDS

CONTROLLING BODY TEMPERATURE

Apyrexial on Admission Yes ☑ No ☐

PROBLEMS / NEEDS

EATING AND DRINKING

Height: 5'6" Weight:
Dentures: Upper ☐ Lower ☐ Partial ☐
Caps / Crowns ☐ Bridge ☐
Mouth Assessment:
Recent Appetite:
Nausea / Vomiting:
Weight: Steady ☐ Loss ☐ Gain ☐
Eating Likes/Dislikes:

Theraputic Diet:
Alcohol Intake:
(Alcohol consumption greater that 50 units per week – consider referral to alcohol liaison team)
Physical Difficulties When Eating and Drinking, e.g. Dysphagia, Visual Impairment:
(Consider referral to SALT)

Equipment requirements:

Cultural/Ethnic/Religious Requirements: e.g. halal, kosher food

PROBLEMS / NEEDS

NAUSEAS - REG ANTIEMETICS AT PRESENT

MOBILISING

(Posture/Gait/Mobility)

Independent Yes ☑ No ☐

Aids Required Yes ☐ No ☑

Specify :

If Assistance Required Specify

Usual Level of Physical Activity

Limiting Factors, e.g. Pain

PROBLEMS / NEEDS

INDEPENDANT

ELIMINATING

Normal Bowel Activity:

Suggested Aperients taken Yes ☐ No ☐ N/A ☐

Last Bowel Motion:

Constipation ☐ Loose stools ☐

Blood / Mucus / Pus ☐ Incontinent ☐

Normal urinary function:

Urgency ☐ Frequency ☐ Dribbling ☐

Hesitancy ☐ Nocturia ☐ Incontinent ☐

Continence Products in Use Yes ☐ No ☐

(If yes State Type/Amount)

If bladder or bowel incontinence is a problem, has assessment been completed by Continence Nurse? Yes ☐ No ☐

Catheterised Yes ☐ No ☐

Stoma Yes ☐ No ☐

Specifics:

Cultural/Religious Needs:

PROBLEMS / NEEDS

D+V OVER PAST 3 DAYS

COMMUNICATION

Impaired Hearing Yes ☐ No ☑

Hearing Aid Left ☐ Right ☐ Bilateral ☐

Impaired Vision ☐ Glasses ☐ Contact Lenses ☐

Impaired Speech ☐ Visual Aids ☐

Learning Difficulties Yes ☐ No ☑

(If Yes,Please Undertake LD Assessment)

Primary Language English: Yes ☑ No ☐

If no, state:

Interpreter Required: Yes ☐ No ☑

Patient's Ability to Understand Written Communication, e.g. Dyslexia:

Patient's Personal Feelings Regarding Eye Contact:

Religious or Cultural Requirements that Place Limitations on the Patient's Care

PROBLEMS / NEEDS

PERSONAL CLEANSING AND DRESSING	PROBLEMS / NEEDS
Independent Yes ☑ No ☐ Assistance Required With: Religious or Cultural Requirements: Patient's Personal Feeling Regarding Touch: Use of Dressing Aids (State):	INDEPENDANT

WORKING AND RECREATION	PROBLEMS / NEEDS
Occupation: Hobbies: Impact of Illness on Work and Recreation:	

SLEEPING	PROBLEMS / NEEDS
Usual Pattern/Routine: What helps? No of Pillows:	

EXPRESSING SEXUALITY	PROBLEMS / NEEDS
Possible Altered Body Image: Yes ☐ No ☐ Privacy/Modesty Issues:	

SPIRITUAL OR RELIGIOUS NEEDS	PROBLEMS / NEEDS
Does the Patient Wish to State Their Religion: Visit Required from Own Minister/Priest or Faith Representative. Yes ☐ No ☐ *(If Yes, Please Contact Chaplaincy Team)* Describe Any Specific Religious Needs/Practices; *(Please Refer to Religions and Cultures Manual)* Signs of Spiritual Distress, e.g. Loss of Meaning and Purpose in Life: Need to Revisit Spiritual Needs Yes ☐ No ☐	

DYING / EMOTIONAL PROBLEMS/NEEDS	PROBLEMS / NEEDS
Patient's Mood: Confused ☐ Mildly anxious ☐ Highly anxious/distressed ☐ Worries Regarding Admission: Impact of Illness on Family/Significant Other: Signature of Admitting Nurse: [signature]	Date 22/12/07

JMcC/64847

FAN12

NURSING NOTES

Surname 07356-00076 100544212
JOHNSTONE, LEE
Forename 16 MINNOCH CRESCENT
MAYBOLE
KA198DW
Address 0902763334
DoB 09/02/1976 Male
Ward/Dept.

DATE	
	HAS HAD DIARRHOEA OVER PAST 3 DAYS
22/12/07	EPIGASTRIC PAIN + VOMITING SINCE LAST
1500	NIGHT. CYCLIZINE, BUSCOPAN + GAVISCON
	GIVEN IN A/E. LIKELY VIRAL ILLNESS
	TO REMAIN W OBS AWAITING BLOOD
	RESULTS. OBSERVATIONS ON ARRIVAL
	WITHIN NORMAL LIMITS AS CHARTED
	IVF IN PROGRESS. NAUSEA SCORE
	REDUCED. FAMILY PRESENT [signature]
1730	FOR REPEAT MORNING BLOOD TEST - 1ST
	ONE HAEMOLYSED. TRIED TO DRINK
	SOME WATER - VOMITED AGAIN. IVF
	CONTINUED. OBSERVATIONS SATISFACTORY
1945	TROPONIN -VE, PATIENT FEELING BETTER
	DISCHARGED HOME TO CARE OF PARENTS
	VENFLON REMOVED [signature]

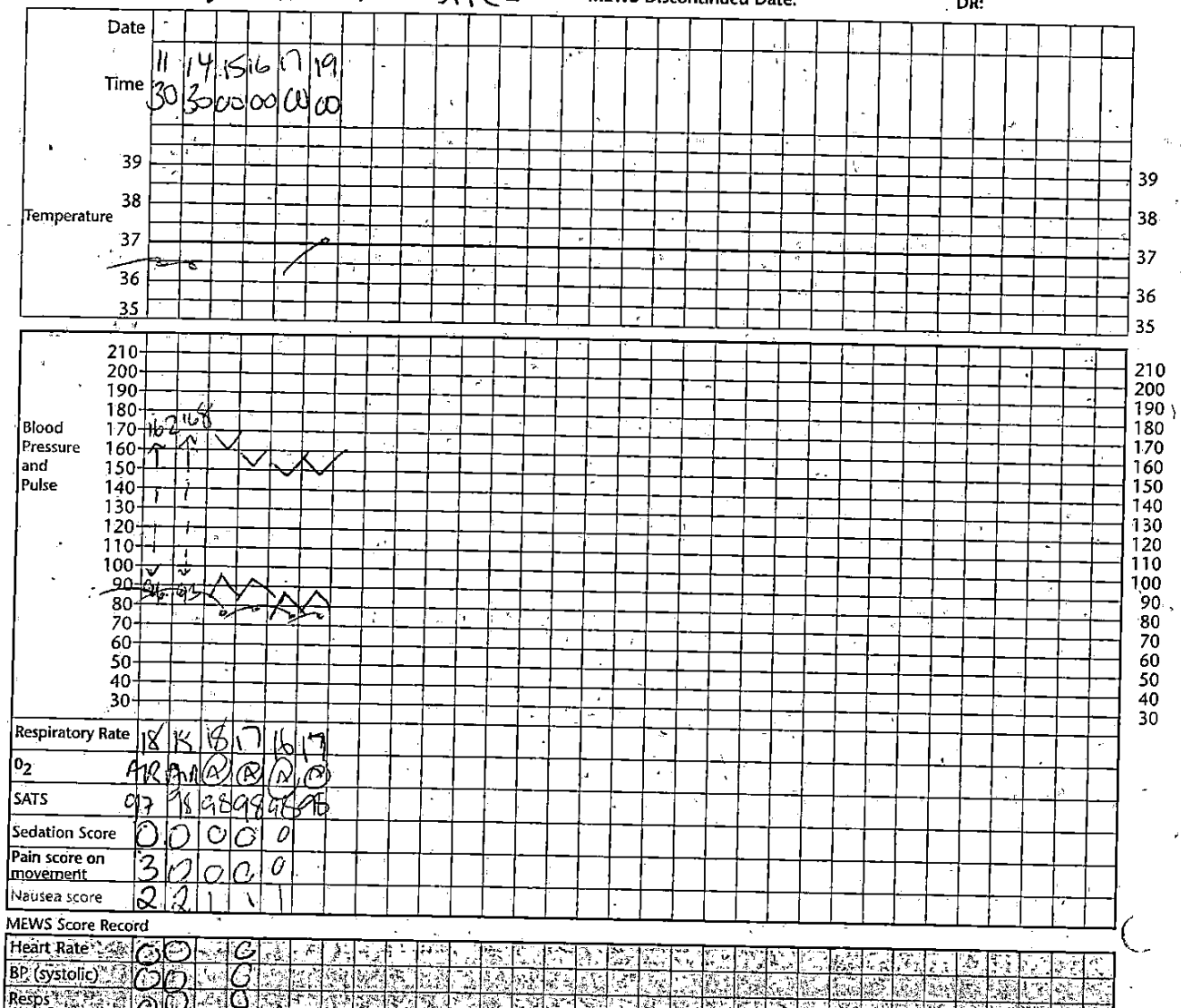
NHS Ayrshire & Arran

TPR, BP, Pain, Sedation, Nausea & Mews Chart

If MEWS Discontinued, record reason in medical notes

Surr .....
Fore 07356-00076 100544212
JOHNSTONE, LEE
16 MINNOCH CRESCENT
Add MAYBOLE
KA198DW 0902763334
War DoB 09/02/1976 Male

Commencement date: 22/12/07 Ward: A+E MEWS Discontinued Date: DR:



MEWS Score Record

| | | |

A1005442(2)

Surname JOHNSTONE Hosp. No.

Forenames LEE Sex

DoB

Address 16 MINNOCH CRESCENT
MAYBOLE KA19 8QN

Ward/Dept.

I.V. Therapy Prescription Sheet

FAN 0886

	DATE	FLUID (USE BLOCK LETTERS) / ADDITIVE DRUG	Vol (ml.) / Dose (mg.)	Route of Admin.	Dur. of Admin.*	SIGNATURE	Serial No. Batch No.	Time Begun	Given By / Added By
A	22/12/1	SALINE 0.9%	500ml	IV	4°	Mordrake	09H23E1A 07/2010	14.40	MBoodle
B		SALINE 0.9%	500	IV	4°	Mordrake	07H23 E1A 07/10	1815	EHOOD
C									
D									
E									
F									
G									
H									
I									
J									
K									
L									
M									
N									
O									

JMcC/60651

RATE OF FLOW (Drops/Min.) = VOL. OF FLUID (ml) x 15 / Duration (Mins.) (1ml = 15 drops)

Approximate Rate for 500 ml.

1 hr. = 120 Drops/min. 6 hr. = 22 Drops/min.
4 hr. = 30 Drops/min. 8 hr. = 15 Drops/min.

6.62

ACCIDENT AND EMERGENCY NURSING DOCUMENTATION FORM

This form is to be completed by nursing staff of the A&E Department and must contain details of all patients who have the potential to be admitted to the Ayr Hospital via the Accident and Emergency Department.

Date: 22/12/07 Time: 14.30

Patient Sticker

07356-00076 100544212
JOHNSTONE, LEE
16 MINNOCH CRESCENT
MAYBOLE
KA198DW 0902763334

Tel N
DoB 09/02/1976 Male

Named Nurse: M Boodle

Associate Nurse: J. Gourley

Admission Complaint: Self Referal
Epigastric pain + vomiting
currently on Lansoprazole

Have you entered the patients observations in the computer? Yes: ☐ No: ☑

Does Patient Require Cardiac Monitoring (in dept): Yes ☑ No: ☐

IV Cannula in situ: Yes ☑ No: ☐

Waterlow Score: ☐ N/A

Intervention:

1 2 3 4 5 6 7 8 9 10
No Pain Most Pain

Pain Score: ☑ 2/10

Analgesia given: Yes ☐ No: ☐

Effect of Analgesia: 1 2 3 4 5 6 7 8 9 10

Name Band: Yes: ☑ No: ☐

Allergies: N.K.D.A

Own Medications with patient: Yes: ☐ No: ☑

Catheter sticker attached to notes: Yes: ☐ No: ☐

Next of Kin: Georgina. Johnstone
16 Minnoch Cres

Tel No: 01655 889669

With Patient: Yes: ☐ No: ☐

Contacted: Yes: ☐ No: ☑

If Contacted, specify time:

Explanation of medical/nursing care to patient/relative: Yes: ☑ No: ☐

Offered refreshments (if allowed): Yes: ☐ No: ☐

If yes, indicate what refreshments were given

Please check, bag and label patients belongings.

Nurse to sign and obtain signature from witness

M Boodle
Nurse Signature

Witness Signature

Please ask patient/relative to sign below to verify ownership of own possessions

Patient/Relative Signature

Time decision made to admit to ward: 14.30

Reason for any delay in transferring to ward:

Admitted: obs St ☐ Time ☐ 14.30

Patients being discharge home. State reason:

Patient Notes: ☐ X-Rays: ☑ Belongings: ☑

Named Nurse/Associate Nurse Discharge Signature:
M Boodle Time: 22/12/07
PTO for Additional Notes:

DRS5083

Additional Nursing Notes:

C/A ↑o epigastric pain + vomiting 1/7 - currently on Lansoprazole. Alcohol excess last night

-observations

avail ate Dr MBoddle

14.30 S/B ATE Dr

IV Access/blds

ECG

CXR

Admit obs awaiting bld results

IM commenced MBoddle

IV Cyclizine

Signature: _____

NHS Ayrshire & Arran

Nursing Assessment Form

Station/Ward: observation ward

Date of Admission: 30-4-06 Time: 23:00

Type of admission: *Emergency* / ~~*Elective*~~

From where: A+E
Accompanied by:

Named Nurse: nursing staff

Surname: JOHNSTONE
Forenames: LEE
A100-544212
16 MINNOCH CRESCENT
0902763334
MAYBOLE
KA198DW
09/02/1976

Address:

GP: LAU,C (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE
M/S

Age: 30 Religion:

~~Married~~/Single/~~Widow~~/~~Divorced~~

Reason for admission:
RTA x 2 Seizures at Scene
Alcohol on board

Patient account of illness:
Car hit tree at speed.

Planned procedure or treatment
Expected:
Actual (1) neuro obs Date 30-4-06
(2) Date

Previous health problems
Guillain Barre Syndrome

Medication used before admission
nil

Stored in the ward Yes ☐ No ☐
Returned to patient/relative Yes ☐ No ☐

Next of Kin: Gorgie Johnstone
Aware of admission Yes ☑ No ☐
Relationship: mum
Address: as above

Home phone No. 01655 889669
Work phone No.
Alternative next of kin:
Relationship:
Address:

Phone No.
Special visiting needs:
Seen by Minister/Priest

Allergies:
nil

Patients Property

(1) Property retained by patient.

I understand any articles/valuables retained in my possession are held on my own responsibility. Including jewelery.

Signature of patient:

Date:

(2) Property handed over for safekeeping.

Date taken for safekeeping:

Cash and valuables Ref. No.:

Date property returned:

STA 4073

Needs Assessment

Home circumstances

Occupation: unemployed

Living alone Yes ☐ No ☑ With whom?

Identify carer(s): mum

Community Services (details where appropriate)

Home help Yes ☐ No ☑

District Nurse Yes ☐ No ☑

Meals on Wheels Yes ☐ No ☑

Attend day hospital Yes ☐ No ☑

Sheltered Housing Yes ☐ No ☑

Nursing Home Yes ☐ No ☑

Other _____

Relatives agreed to notify service providers ? Yes ☐ No ☐

Nurse to notify service providers? Yes ☐ No ☐

Date notified _____

Housing (details where appropriate)

Type of house: House

Steps at entrance Yes ☐ No ☑ How many?

Stairs Yes ☐ No ☑

Bedroom up stairs Yes ☐ No ☑

Toilet upstairs Yes ☐ No ☑

Mobilising

Independent Yes ☑ No ☐

Assistance of _____

Sleeping

Pattern no problems

What helps

Communicating

Vision: any problems Yes ☐ No ☑

Spectacles Yes ☐ No ☐

Hearing: any problems Yes ☐ No ☑

Speech dificulty Yes ☐ No ☑

Oriented time/place Yes ☑ No ☐

General Appearance / Condition

Good

Skin Inspection (where appropriate)

Dentures Yes ☐ No ☑

Upper Lower Partial Crowns

General Observation on admission

BP **T** **P** **R**

BM: Peak flow:

Waterlow: Nutrition:

Handling & Moving: MSU: Yes ☐ No ☐

Urinalysis:

Height: Weight:

MRSA Screen: Yes ☐ No ☐

Any prosthesis? Yes ☐ No ☐

Smoker **Yes** ☑ **No** ☐

Amount:

Alcohol intake amount:

Eating and Drinking

Special diet Yes ☐ No ☑

Type of diet _____

Cleansing and Dressing

Self caring Yes ☑ No ☐

Assistance with _____

Wound dressing Yes ☐ No ☑

Elimination

Bladder: any problems Yes ☐ No ☑

Bowel: any problems Yes ☐ No ☑

Admitting Nurse Signature: H-Allinson

Discharge

Will personal transport be available for discharge?

Yes ☐ No ☐

Predicted Discharge

Complex ☐ Uncomplicated ☑

FAN1286

Surname JOHNSTONE
Forename LEE
16 MINNOCH CRESCENT
MAYBOLE
KA198DW
Address

A100-544212
0902763334
09/02/1976
M/S

LAU, C (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE

NURSING NOTES

DATE	
	Lee admitted to the observations
30.4.06	ward this evening after being
	involved in RTA: Lee had been
	drinking alcohol and was the
	driver of the car. At Sc
	Lee had two witnessed Seizures,
	CT of head performed - NAD Spoke
	with medics but to be admitted
	to observation ward for neuro
	obs overnight. Mum informed of
	accident and came in to visit
	about 11.45pm. Al-Allinson
00.45	Analgesia given at 00.45 hrs. Complainin
	of back pain and pain on passing
	urine, urine tested +++ Blood in
	urine. Dr Madden informed.
01.45	patient still. Complaining of pain in
	back, xrays re-checked two tylex
	given.
07.00	Settled and Slept for short period
	tylex tablets helped with back
	pain but did not take the pain
	away completely. neuro obs contin
	GCS 15/15. Passing urine well.
	Al-Allinson
	PTO

DATE	
1130	S/b Dr Bell, Por ultrasound of kidneys and repeat urinalysis. Mobilising around ward. (L) venflon removed by patient. Breakfast tolerated. FJes
1155	urinalysis trace of blood FT.
1425	(R) Venflon removed, Ultrasound of kidneys normal. Review with Nurse regarding alcohol misuse. Head injury advice sheet given. Discharge with mother. FT

I.V. Therapy Prescription Sheet

FAN 0886

Surn
Fore
Addr

06120-00151 100544212
JOHNSTONE, LEE
16 MINNOCH CRESCENT
MAYBOLE
KA198DW 0902763334

DoB 09/02/1976 Male

Ward/Dept.

	DATE	FLUID (USE BLOCK LETTERS) / ADDITIVE DRUG	Vol (ml.) / Dose (mg.)	Route of Admin.	Dur. of Admin.*	SIGNATURE	Serial No. Batch No.	Time Begun	Given By / Added By
A	30/4/06	Normasol	1000	IV	stat		TL2112 05	1845	HJ
B	30/4/06	Normasol	1000	IV	stat		TL2120	1850	HJ
C		Saline	500	IV	2		063 69	19:0	
D									
E									
F									
G									
H									
I									
J									
K									
L									
M									
N									
O									

JMcC/80551

RATE OF FLOW (Drops/Min.) = VOL. OF FLUID (ml) x 15 / Duration (Mins.) (1ml = 15 drops)

6.62

Approximate Rate for 500 ml.

1 hr. = 120 Drops/min. 6 hr. = 22 Drops/min.
4 hr. = 30 Drops/min. 8 hr. = 15 Drops/min.

I.V. Therapy Prescription Sheet

Surname..... Hosp. No. .....

Forenames..... Sex .....

..... DoB .....

Address.....

.....

Ward/Dept. .....

FAN 0886

	DATE	FLUID (USE BLOCK LETTERS) / ADDITIVE DRUG	Vol (ml.) / Dose (mg.)	Route of Admin.	Dur. of Admin.*	SIGNATURE	Serial No. Batch No.	Time Begun	Given By / Added By
A									
B									
C									
D									
E									
F									
G									
H									
I									
J									
K									
L									
M									
N									
O									

TE OF FLOW

ops/Min.)

2

= VOL. OF FLUID (ml) x 15 / Duration (Mins.) (1ml = 15 drops)

Approximate Rate for 500 ml.

1 hr. = 120 Drops/min. 6 hr. = 22 Drops/min.
4 hr. = 30 Drops/min. 8 hr. = 15 Drops/min.

SHEET No. .....

MEDICINE PRESCRIPTION SHEET

Key: O ORAL | SL SUBLINGUAL | PR PER RECTUM | IM INTRAMUSCULAR | ID INTRADERMAL | PV PER VAGINA | IV INTRAVENOUS | INH INHALATION | IT INTRATHECAL | SC SUBCUTANEOUS | NEB NEBULISED

Write A100-544212
Surna JOHNSTONE LEE
Forer 16 MINNOCH CRESCENT
0902763334
MAYBOLE
.... KA198DW 09/02/1976
Addre LAU, C (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE M/S
nent .....

KNOWN SENSITIVITY

1.	2.

SUSPECTED ADVERSE REACTION

MEDICINE	ADVERSE EFFECT
1.	
2.	

MEDICINES TO BE GIVEN REGULARLY (BLOCK CAPITALS)

PHARM.	Date Commenced	APPROVED NAME OF MEDICINE	DOSE	TIMES OF ADMINISTRATION 6am	8am	10am	12md	2pm	6pm	8pm	10pm	12mn	OTHER	ROUTE (See Key)	OTHER INSTRUCTIONS	DOCTOR'S SIGNATURE	DISCONTINUED DATE	DISCONTINUED INITIAL
A	30.4.6	PARACETAMOL	1g			4-6			hly							G. Fraser		
B	30.4.6	IBUPROFEN	400mg			4-6			hly							G Fraser		
C	30.4.6	Tylex	2 tabs			4-6			hly					O				
D																		
E																		
F																		
G																		
H																		
I																		
J																		
K																		
L																		
M																		
N																		
O																		
P																		
R																		
S																		
T																		
V																		

JMcC/60995

STA 0235

MEDICINES TO BE GIVEN ONCE (BLOCK CAPITALS)

PHARM.	TO BE GIVEN		APPROVED NAME OF MEDICINE	DOSE	ROUTE (See Key)	DOCTOR'S SIGNATURE	GIVEN BY	TIME GIVEN
	DATE	TIME						

A100:544212

SHEET

JOHNSTONE LEE

16 MINNOCH CRESCENT

MAYBOLE
KA198DW

MEDICINE RECORDING SHEET

Enter code in box and initial when medicine is taken.

If medicine refused record (A) If patient unable to swallow record A

If patient absent record A If medicine not available record A

Date	6 a.m	8 a.m	10 a.m	12 m.d	2 p.m	6 p.m	8 p.m	10 p.m	12 m.n	Other Administrations
1-5-06		B C								A+B @ 00.45 C @ 01.40
	Init.	[illegible]								
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

Date	6 a.m	8 a.m	10 a.m	12 m.d	2 p.m	6 p.m	8 p.m	10 p.m	12 m.n	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

SHEET No .....

Name .....

Age .....

Consultant .....

Hospital .....

MEDICINE RECORDING SHEET

Enter code in box and initial when medicine is taken.

If medicine refused record (A) If patient unable to swallow record A

If patient absent record A If medicine not available record A

Date	6 a.m	8 a.m	10 a.m	12 m.d	2 p.m	6 p.m	8 p.m	10 p.m	12 m.n	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

Date	6 a.m	8 a.m	10 a.m	12 m.d.	2 p.m	6 p.m	8 p.m.	10 p.m.	12 m.n	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

06120-00151 100544212
JOHNSTONE, LEE
16 MINNOCH CRESCENT
MAYBOLE
KA198DW 0902763334

DoB 09/02/1976 Male

OBSERVATION CHART

FAN

DATE 30/4/06

TIME 18:45 19:00 19:30 19:55 20:15 20:45 21:00 21:25 21:30 22:30 23:30 00:30 02:30 03:30 04:30 06:30 07:30 08:30 11:30

COMA SCALE

Eyes open	Spontaneously
	To speech
	To pain
	None
Best verbal response	Orientated
	Confused
	Inappropriate words
	Incomprehensible sounds
	None
Best motor response	Obey commands
	Localise pain
	Withdrawal to pain
	Abnormal flexion to pain
	Extension to pain
	None

Eyes closed by swelling = C

Endotracheal tube or tracheostomy = T

Usually recorded the best arm response

SpO2 99 99 99 100 95 95 96 95 98 98 98 96 97 98 98 96 96 100

O2 15 15 10 10 A A A A A A A A A A A A A A

Temperature °C

38·3 36·1 36·5

Blood pressure and Pulse rate

Respiration

BM 32 32

Pupil scale mm

PUPILS

right	Size	5 5 6 6 4 4 4 4 4 4 4 3 3 3 3 3 3 3
	Reaction	+ + + + + + + + + + + + + + + + + +
left	Size	5 5 6 6 4 4 4 4 4 4 4 3 3 3 3 3 3 3
	Reaction	+ + A + + + + + + + + + + + + + +

+ reacts
– no reaction
c. eye closed

LIMB MOVEMENT

ARMS	Normal power
	Mild weakness
	Severe weakness
	Spastic flexion
	Extension
	No response
LEGS	Normal power
	Mild weakness
	Severe weakness
	Extension
	No response

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

FILING – DO NOT USE THIS SPACE

Ayrshire & Arran Acute Hospitals NHS Trust

Nursing Assessment Form

Station/~~Ward~~: 11/7/03

Date of Admission: Time: 04·00

Type of admission: *Emergency* / ~~*Elective*~~

From where: A/E

Accompanied by: S/N & PORTER.

Named Nurse:

JOHNSTONE LEE A100-544212 No.
15A DRUMELLAN STREET
MAYBOLE 0902763334
09/02/1976
LAU, C (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE M/S

Age: 27YR. **Religion:** PROTESTAN

~~Married~~/~~Single~~/~~Widow~~/Divorced

Reason for admission:

ALCOHOL RELATED SEIZURES.

Patient account of illness:

ON DETOX PROGRAME
TOOK 5 LITRES CIDER TODAY

Planned procedure or treatment

Expected: CXR ECG BLOODS

Actual (1) NEURO OBS. CT BRAIN ☑ Date
~~IV PHENYTOIN~~

(2) PABRINEX 1+2 Date
IV FLUIDS

Next of Kin: MR ALISTAIR JOHNSTONE

Aware of admission Yes ☐ No ☐

Relationship:

Address: 16 MINNOCH CRES
MAYBOLE

Home phone No. 01655889669

Work phone No.

Alternative next of kin:

Relationship:

Address:

Phone No.

Special visiting needs:

Seen by Minister/Priest

Previous health problems

ALCOHOL PROBLEMS.
GYANNE BARRY SYNDROME

Allergies: NKDA.

Medication used before admission

CHLORDIAZIPOXIDE 10MG

DIAZEMULS 20 MG IV
PHENYTOIN 1250 MG IV
PABRINEX 1+2 IV
GIVEN IN A/E.

Stored in the ward Yes ☑ No ☐

Returned to patient/relative Yes ☐ No ☐

Patients Property

(1) Property retained by patient.

I understand any articles/valuables retained in my possession are held on my own responsibility. Including jewelery.

Signature of patient: CLOTHING DOCUMENTED

Date: 11/7/03

(2) Property handed over for safekeeping.

Date taken for safekeeping:

Cash and valuables Ref. No.:

Date property returned:

Needs Assessment

Home circumstances

Occupation: UNEMPLOYED

Living alone Yes ☐ No ☑ With whom?

Identify carer(s): FIANCE :

LINDA STURGEON CPN. - 886980

Community Services (details where appropriate)

Home help Yes ☐ No ☑

District Nurse Yes ☐ No ☑

Meals on Wheels Yes ☐ No ☑

Attend day hospital Yes ☐ No ☑

Sheltered Housing Yes ☐ No ☑

Nursing Home Yes ☐ No ☑

Other _____

Relatives agreed to notify service providers ? Yes ☐ No ☐

Nurse to notify service providers? Yes ☐ No ☐

Date notified _____

Housing (details where appropriate)

Type of house: 1ST FLOOR FLAT.

Steps at entrance Yes ☑ No ☐ How many? 14

Stairs Yes ☐ No ☑

Bedroom up stairs Yes ☐ No ☑

Toilet upstairs Yes ☐ No ☑

Mobilising

Independent Yes ☑ No ☐

Assistance of _____

Sleeping VERY POOR SLEEP

Pattern PATTERN.

What helps

Communicating

Vision: any problems Yes ☐ No ☑

Spectacles Yes ☐ No ☑

Hearing: any problems Yes ☐ No ☑

Speech dificulty Yes ☐ No ☑

Oriented time/place Yes ☑ No ☐

General Appearance / Condition

ABLE TO CONVERSE. HAVING INTERMITTENT SEIZURES. O/A TO WARD.

Skin Inspection (where appropriate)

GRAZE TO PALM OF RIGHT HAND ? # (R) HAND

Dentures Yes ☐ No ☑

Upper Lower Partial Crowns

General Observation on admission

BP 115 T 35.8 P 94 R

BM: 5.5.5 Peak flow:

Waterlow: 9 Nutrition: 2

Handling & Moving: MSU: Yes ☐ No ☐

Urinalysis:

Height: Weight:

MRSA Screen: Yes ☐ No ☐

Any prosthesis? Yes ☐ No ☐

Smoker Yes ☑ No ☐

Amount: 4 / 5 CPD.

Alcohol intake amount: 5 LITRES CIDER PER DAY OR 1 BTL VODKA PER DAY

Eating and Drinking

Special diet Yes ☐ No ☑

Type of diet _____

Cleansing and Dressing

Self caring Yes ☑ No ☐

Assistance with _____

Wound dressing Yes ☐ No ☑

Elimination

Bladder: any problems Yes ☑ No ☐

NOTICED BLOOD

Bowel: any problems Yes ☐ No ☑

Admitting Nurse Signature: S. Hudspith

Discharge

Will personal transport be available for discharge?

Yes ☑ No ☐

Predicted Discharge

Complex ☐ Uncomplicated ☑

Ayrshire and Arran Acute Hospitals Trust

Pressure Sore Risk Assessment Tool

Waterlow Pressure Sore Risk Assessment

SCORE		
<10	Low risk	Re-assess weekly or if condition changes
10+	At risk	Re-assess twice weekly or if condition changes
15+	High risk	Re-assess on alternate days
20+	Very high risk	Assess daily

ATTACH LABEL

JOHNSTONE LEE
A100-544212
15A DRUMELLAN STREET
MAYBOLE
0902763334
09/02/1976

LAU, C (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE

M/S

Waterlow Risk Assessment		Initials	1	2	3	4	5	6	7	8	9	10	11	12	13	14
		Date	SH													
Body weight for height	**No.**															
Average	0		0													
Above average	1															
Obese	2															
Below average	3															
Continence																
Completely Catheterised	0		0													
Occasionally Incontinent	1															
Cath. Incontinence of Faeces	2															
Doubly Incontinent	3															
Skin Type: Visual Risk Areas																
Healthy	0															
Tissue Paper/Dry	1															
Oedematous/Clammy (temp)	1															
Discoloured	2															
Broken Spot	3		3													
Mobility																
Fully	0															
Restless/Figity	1															
Apathetic	2															
Restricted	3		3													
Inert/Traction	4															
Chairbound	5															
Age/Sex																
Male/Female	1/2		1													
14 - 49	1		1													
50 - 64	2															
65 - 74	3															
75 - 80	4															
80+	5															
Appetite																
Average	0		0													
Poor	1															
NG Tubes/Fluids only	2															
nbm - Anorexic	3															
Special Risks - Tissue Malutrition																
eg Terminal Cachexia	8															
Cardiac failure	5															
Peripheral Vascular Disease	5															
Anaemia	2															
Smoking	1		1													
Neurological Deficit																
eg Diabetes. MS, CVA																
Motor-sensory Paralegia	4-6		–													
Major Surgery/Trauma																
Orthopaedic Below waist, Spinal	5		–													
On table>2 hours	5															
Medication																
Cytotoxics, Highdose Steroids	4		–													
Anti-inflammatory																
	Total Score		9													

Date 11/7/03	Waterlow Score	Comments (eg treatment, mattress etc)	Date next assessment due	Signed
(Admission)	9	ABLE TO INITIATE POSITIONAL		
		CHANGES SOFT FORM		
		MATTRESS IN SITU	13/7/03	SH.

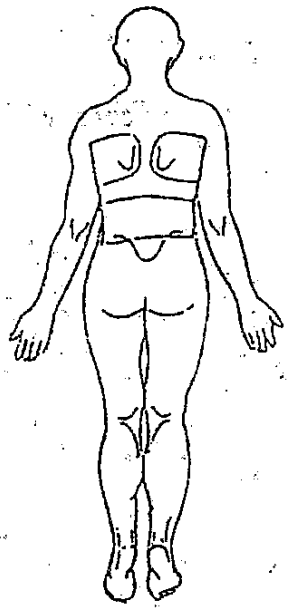
Reference:
Waterlow: A risk assessment card. (1985). Waterlow J. Vol 81 pp48 - 55.

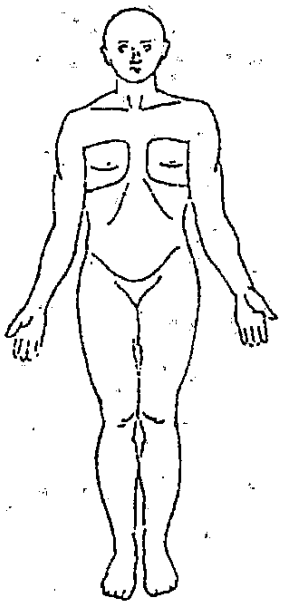
Pressure Sore Site and Treatment Plan

Indicate on the diagram the site(s) of any pressure sores.

Site Codes

PM1	Occipital
PM2	Scapula
PM3	Elbows
PM4	Vertebrae
PM5	Sacrum
PM6	Buttocks
PM7	Heels
PM8	Malleoli
PM9	Other





Date	Site/Code	Stage	Treatment	Comments	Signed

Classification

Stage 0 - Blanching hyperaemia - the skin is intact but momentary finger pressure onto the site of erythema, following a prolonged period of pressure on the skin causes the skin to blanch.

Stage I - Non-blanching hyperaemia - the erythema remains when light finger pressure is applied. The area stays red more than 5 minutes after the relief of pressure indicating there is some damage to the micro-circulation.

Stage II - Partial thickness skin loss involving epidermis and/or dermis. The sore is superficial and presents clinically as an abrasion, blister or shallow crater.

Stage III - Full thickness skin loss involving damage to subcutaneous tissue that may extend down to, but not through, underlying fascia. The sore presents clinically as a deep crater with or without undermining of adjacent tissue.

Stage IV - Full thickness skin loss with extensive, tissue necrosis or damage to muscle, bone or supporting structures (eg tendon or joint capsule). Note: Undermining and sinus tracts may also be associated with Stage IV pressure sores.

Acute Hospitals Trust

Moving & Handling
Patient Risk Assessment

A100-544212 BEL
JOHNSTONE LEE
15A DRUMELLAN STREET
0902763334
MAYBOLE
09/02/1976
LAU,C (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE M/S

All Patients:

Sliding aids should be used bed to trolley/bed (unless independent) with minimum 3 handlers.
Specify number of handlers:
A hoist **must** be used if assistance is required from the floor.
A hoist **must** be used for bathing unless independently mobile.
Hoists are for lifting patients and must not be used for transport between rooms.

Special Alerts: Date:	11/7/03				
Overweight/obese (BMI definition)					
Restricted use of limbs					
Poor standing ability					
Sedation or lethargy	✓				
Irrational behaviour/confusion					
Unable to co-operate					
Acute pain					
Recent surgery					

Additional Comments:

Special Alerts:

Low Risk: Independently mobile/supervision only required. Aids required should be specified in care plan.

Moderate Risk: Requires physical assistance from one or more handlers. Is able to stand or partially bear weight and has no more than one special alert.

High Risk:
a) Is able to bear weight and requires assistance.
b) 2 or more special alerts present.

Aids, equipment and a minimum of 2 handlers recommended to move a patient

Specify Level of Risk

Date:	11/7/03					
LOW RISK	✓					
MODERATE RISK						
HIGH RISK						
Assessors Initials	S H					

Moving and Handling Care Plan

Date:	11/7/03					
1. Lying to sitting in bed:						
a) Handlers required to insert and pull sliding sheets. *Specify number in grid:*	a)					
b) Can sit with assistance from 1 or 2 handlers (rotation). *Specify number in grid:*	b) 1 ✓					
c) Equipment required:	c)					
2. Sitting to Standing:						
a) 1 handler assists from the side with oblique hold on the patient's back.	a) ✓					
b) 2 handlers assist from the side with oblique hold on the patient's back.	b)					
c) 1 handler assists from the side and 1 from the front.	c)					
d) Aids required:	d)					
3. Mobilising:						
a) Does not mobilise.	a)					
b) Mobilises independently.	b)					
c) Support required from side by 1 handler.	c) ✓					
d) Support from side by 2 handlers.	d)					
e) Requires to be followed by staff member and wheelchair when mobilising.	e)					
d) Aids required:	f)					
4. Transfers:(chair / wheelchair / commode / toilet / bed)						
a) Walking transfer with assistance of 1 handler.	a) ✓					
b) Walking transfer with assistance of 2 handlers.	b)					
c) Assistance of 1 handler and equipment.	c)					
d) Assistance of 2 handlers and equipment. *Specify equipment:*	d)					
5. Adjusting Clothing:						
a) Can use support / grabrails while assistance is given with clothing.	a)					
b) Requires support from 1 handler while another assists with clothing.	b) ✓					
c) Requires 2 handlers and equipment.	c)					
6. Repositioning in chair / wheelchair:						
a) Tilt and slide.	a)					
b) One way sliding sheet *Specify number of handlers in grid.*	b)					
c) *Specify Aids and equipment:*	c)					
Assessors Initials	SH					

03192-00013 100544212
JOHNSTONE, LEE
15A DRUMELLAN STREET
MAYBOLE

DoB 09/02/1976 Male

OBSERVATION CHART

FILING ONLY – DO NOT USE THIS SPACE

DATE 11/0
TIME 02

COMA SCALE

- Eyes open: Spontaneously / To speech / To pain / None
- Best verbal response: Oriented / Confused / Inappropriate words / Incomprehensible sounds / None
- Best motor response: Obey commands / Localise pain / Withdrawal to pain / Abnormal flexion to pain / Extension to pain / None

Eyes closed by swelling = C

Endotracheal tube or tracheostomy = T

Usually recorded the best arm response

Pupil scale mm

Blood pressure and Pulse rate

Respiration

Temperature °C

PUPILS

- right: Size / Reaction
- left: Size / Reaction

+ reacts
– no reaction
c. eye closed

LIMB MOVEMENT

ARMS: Normal power / Mild weakness / Severe weakness / Spastic flexion / Extension / No response

LEGS: Normal power / Mild weakness / Severe weakness / Extension / No response

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

Seizure chart.

DATE	
	4:30am on transfer to ward tonic clonic seizure lasting 30 seconds - spontaneously resolved
	4:40am Tonic clonic seizure lasting 40 seconds - spontaneously resolved
	4:45am Tonic clonic seizure lasting 1 minute - spontaneously resolved
	4:50 am Tonic clonic seizure lasting 40 seconds spontaneously resolved.
	5:10 am legs & arms twitching 20 seconds spontaneously resolved
11/7	8:50 am legs + arms twitching, lasting 20 secs spontaneously resolved
	9:05 am Tonic clonic seizure lasting 20 secs spontaneously resolved
	0922 Tonic/clonic - lasted 20 secs. resolved spontaneously
	11:45 Tonic/clonic - lasted 20 secs spontaneously resolved
	12:00 Tonic/clonic - lasted 20 secs spontaneously resolved
	13:10 Tonic/clonic - lasted 20 secs - spontaneously resolved
	14:30 tonic/clonic - lasted 20 secs (spont resol
	15:30 tonic/clonic - lasted 30 secs given diazemuls 10mg further IV 10mg diazemuls given prior to CT brain
	6pm tonic/clonic - lasted 1 min resolved spont

WRITE, IMPRINT OR ATTACH LABEL

Surname ..... HCR No. .....

Forenames ..... Sex .....

Address ..... D.O.B. .....

STA0238 Ward or Dept. .....

DATE	
7.40p.	Tonic/clonic seizure lasting 35 secs. Given 10mg Diazemuls
10.10p	Arms and legs twitching lasting 20 secs. - resolved spontaneously.
12/7/03 05.15	Tonic clonic seizure lasting 1 minute resolved spontaneously
1135 am	Tonic clonic seizure lasting 30 seconds resolved with 5mg IV Diazemuls
1625	Tonic clonic seizure lasting approx 30 secs resolved spontaneously
2100	Seizure
13/7/03 0410	Seizure

MEDICAL

~~AYRSHIRE & ARRAN ROYAL INFIRMARY~~
NHS TRUST

RECORDING CHART

03192-00013 100544212
JOHNSTONE, LEE
15A DRUMELLAN STREET
MAYBOLE

DoB 09/02/1976 Male

SHEET NUMBER:

PATIENT WEIGHT:

ALLERGIES:

1 PRESCRIPTION AND DILUTION DETAILS (to be completed by PRESCRIBER before start of therapy). Consult Pharmacy prior to prescribing additives

MEDICINE	Total Amount of Drug (mg)	Diluent	Total Volume (mls)	Drug Concentration (mg/ml)	Route of Administration	Prescriber's Signature
1 Phenytoin	100 mg	0.9% Saline	100mg	1mg/ml.	IV	[signature]
Additive 1						
Additive 2						

2 DOSE AND FLOW RATE DETAILS (to be completed by PRESCRIBER)

	Date	Start Time	Dose or Range to be Administered (Dose/Weight/Time)	Required Flow Rate/Setting or Range (mls/hour - mm/time)	If Range, Actual Flow Rate to be Commenced (mls/hour - mm/time)	Prescriber's Signature
Initial rate	11/7/13.			400 mls/hour		[signature]
New rate						
New rate						
New rate						
New rate						
New rate						

3 PREPARATION/PRODUCT DETAILS (Where ready prepared solution is available the batch number should be recorded under the Drug section below)

	Date	Time	Prepared by	Checked by	Batch Number Drug(s)	Batch Number Diluent
Initial Preparation						
Replacement						
Replacement 2						
Replacement 3						
Replacement 4						

4 MONITORING AND DEVICE SELECTION (to be completed by Nurse/Prescriber before start of therapy)

Infusion Device Selected	BAXTER
Serial/Equipment Number	XH33380
Monitoring Requirements 1	pump check
2	BP + pulse
3	venflon site
4	

PRESCRIPTION CHANGES: Any changes must be signed by the prescriber. The reason for the alteration must be recorded.

3	PREPARATION/PRODUCT DETAILS (Where a prepared solution is available, the batch number should be recorded under the Drug/Solution Below)					
	Date	Time	Prepared by	Checked by	Batch Number Drug(s)	Batch Number Diluent
Initial Preparation						
Replacement 1						
Replacement 2						
Replacement 3						
Replacement 4						

4	MONITORING AND DEVICE SELECTION (to be completed by Nurse/Prescriber before start of therapy)	
Infusion Device Selected		BAXTER
Serial/Equipment Number		XH33380
Monitoring Requirements	1	pump check
	2	BP + pulse
	3	insertion site
	4	

5	ADMINISTRATION CHECK (to be completed in full by Nursing Staff)				HOURLY	6	START/STOP/RATE CHANGE CHECK - The reason for the alteration must always be recorded					
Date	Time Infusion Checked or Stopped	Total Volume Infused	Volume Remaining (Approximate)	Actual Rate Setting	Check By	Time Infusion Started/ Restarted	Rate Setting	Started/ Restarted by	Checked by	10 minute check	Reason for change in rate/stop. Comments.
11/7/03	0815	0	100mls	400ml/hr	SL	0815	400ml/hr	SL	PD	SL	
	0830	100	—	400ml/hr	ET						infusion complete
	1405	0	100mls	400ml/hr	SL	1405	400ml/hr	SL			new bag
	1430	100mls	0	400ml/hr	SL						complete
11/7/03	2200	0mls	100mls	100ml/hr	MG	2300	100ml/hr	MG			NEW INFUSION
12/7/03	0810	0mls	100mls	200ml/hr	RL	0810	200ml/hr	RL	MM		NEW infusion

Name: 03192-00015
(use address) JOHNSTONE, LEE
Address: 15A DRUMELLAN STREET
MAYBOLE
D.O.B.:
Station: DoB 09/02/1976 Male

NHS TRUST

RECORDING CHART

SHEET NUMBER: 1
PATIENT WEIGHT:
ALLERGIES:

1 MEDICINE AND DILUTION DETAILS (to be completed by DOCTOR before start of therapy) - Consult Pharmacy prior to prescribing additives

MEDICINE	Total Amount of Drug (mg)	Diluent	Total Volume (mls)	Drug Concentration (mg/ml)	Route	Normal Therapeutic Range (dose/weight/time)	Dose Rate Range for Patient (Flow Rate/Time)	Doctor's Signature
1. PHENYTOIN.	1250mg	N Saline	500 mls		IV.	15mg/kg	500mls/2hours	
Additive 1								
Additive 2								

2 DOSE AND FLOW RATE DETAILS (to be completed by DOCTOR and PERSON ADMINISTERING)

	Date	Start Time	Dose (Range) (Dose/Weight/Time)	Required Flow Rate Setting (Range) (mls/hour - mm/time)	If Range, Actual Flow Rate Commenced (mls/hour - mm/time)	Doctor's Signature	Batch Number if Prepack	Set By	Checked By	5 minutes	15 minutes
Initial rate											
New rate											
New rate											
New rate											
New rate											
New rate											

3 PREPARATION DETAILS (to be completed by person/s preparing solution if required. Not if ready-made solution used)

	Date	Time	Prepared by	Checked by	Batch Number Drug(s)	Batch Number Diluent
Initial Preparation						
Replacement 1						
Replacement 2						
Replacement 3						
Replacement 4						

4 MONITORING AND DEVICE SELECTION (To be completed by Nurse/Doctor before start of therapy)

Infusion Device Selected		BAXTER
Serial/Equipment Number		AH 1560
Monitoring Requirements	1	BP
	2	P
	3	R/R
	4	SpO2

5 ADMINISTRATION CHECK (To be completed initially by Nursing Staff) — HOURLY

6 START/STOP/RATE CHANGE CHECK (To be completed by Nursing Staff as required) - The reason for the alteration must always be recorded.

Date | Time Infusion

3 PREPARATION DETAILS (to be completed by [redacted] preparing solution if required. Not if ready made solution used)

	Date	Time	Prepared by	Checked by	Batch Number Drug(s)	Batch Number Diluent
Initial Preparation						
Replacement 1						
Replacement 2						
Replacement 3						
Replacement 4						

4 MONITORING AND DEVICE SELECTION (To be completed by Nurse/D[redacted] before start of therapy)

Infusion Device Selected	BAXTER
Serial/Equipment Number	AH 1560
Monitoring Requirements 1	BP
2	P
3	R/R
4	SpO2

5 ADMINISTRATION CHECK (To be completed in full by Nursing Staff) HOURLY

6 START/STOP/RATE CHANGE CHECK (To be completed by Nursing Staff as required) The reason for the alteration must always be recorded.

Date	Time Infusion Checked or Stopped	Total Volume Infused	Volume Remaining (Approximate)	Actual Rate Setting	Checked By	Time Infusion Restarted	Rate Setting	Restarted by	Checked by	5 minutes	15 minutes	Reason for change in rate/stop. Comments
Administered in A&E not completed (recording chart)												

Name: ..... (use addressograp JOHNSTONE, LEE

Address: ..... 15A DRUMELLAN STREET MAYBOLE

D.O.B.: ..... DoB 09/02/1976 Male

Station: .....

NHS TRUST

RECORDING CHART

SHEET NUMBER: 2

PATIENT WEIGHT: .....

ALLERGIES: .....

1 MEDICINE AND DILUTION DETAILS (to be completed by DOCTOR before start of therapy) Consult Pharmacy prior to prescribing additives

MEDICINE	Total Amount of Drug (mg)	Diluent	Total Volume (mls)	Drug Concentration (mg/ml)	Route	Normal Therapeutic Range (dose/weight/time)	Dose Rate Range for Patient (Flow Rate/Time)	Doctor's Signature
1 PABRINEX 1+2	1+2	N Saline	100 mls		IV		100mls/hour	
Additive 1								
Additive 2								

2 DOSE AND FLOW RATE DETAILS (to be completed by DOCTOR and PERSON ADMINISTERING)

	Date	Start Time	Dose (Range) (Dose/Weight/Time)	Required Flow Rate Setting (Range) (mls/hour - mm/time)	If Range, Actual Flow Rate Commenced (mls/hour - mm/time)	Doctor's Signature	Batch Number if Prepack	Set By	Checked By	5 minutes	15 minutes
Initial rate											
New rate											
New rate											
New rate											
New rate											
New rate											

3 PREPARATION DETAILS (to be completed by person preparing solution if required. Not if ready made solution used)

	Date	Time	Prepared by	Checked by	Batch Number Drug(s)	Batch Number Diluent
Initial Preparation						
Replacement 1						
Replacement 2						
Replacement 3						
Replacement 4						

4 MONITORING AND DEVICE SELECTION (To be completed by Nurse/Doctor before start of therapy)

Infusion Device Selected		BAXTER
Serial/Equipment Number		AH1560
Monitoring Requirements	1	BP
	2	P
	3	R/R
	4	SpO2

5 ADMINISTRATION CHECK (to be completed in full by Nursing Staff) HOURLY

Date	Time Infusion Started	Total Volume to be Infused	Volume Remaining	Actual Rate	Checked

6 START/STOP/RATE CHANGE CHECKS (To be completed by Nursing Staff as required). The reason for the alteration must always be recorded.

Time	Rate Setting	Restarted	Checked	5	15	Reason for change in rate/stop

Medication Administration Profile

Requested By: NU0032

Date of Report: 13-Jul-2003 at 11:30 Type of Report: Since Admission

Patient: **JOHNSTONE, LEE** Hospital No: 100544212

Date Of Birth: 9-Feb-1976 Weight: kg Height: cm Body Surface: sq m

Allergies:

Current Status: On Ward STATION 7-AYR Under the Care of: DR PETER REYNOLDS

Admitted On: 11-Jul-2003 Patient Note(s) exist

Episode History:

Consultant: DR PETER REYNOLDS from 11-Jul-2003 04:49

Transfer History:

Admitted to Ward: STATION 7-AYR On 11-Jul-2003 at 04:49

Key: ! - denotes unverified order at the time of charting or administration. [+] - Order Notes exist
<> - denotes charted time.
? - denotes the witness has questioned this administration.
* - denotes charting was overridden.
[@@] - denotes patient was/is on Short Term Leave.
Note : Explicit Charting, PRN and Variable Continuous Infusion times are administration times. Others refer to the time the administration was charted.

DOSE,ROUTE & FREQUENCY/INTERVAL/RATE PRESCRIBER START DATE/TIME	11-Jul-2003 Friday	12-Jul-2003 Saturday	13-Jul-2003 Sunday				
PHENYTOIN 250 mg in 5ml Injection 100 mg IV Int 6H DR FIONA BURTON 11-Jul-2003 08:00 Stop Date/Time: 11-Jul-2003 08:01	! 08:18 NU0947 <MODIFIED> DR1436						
PHENYTOIN 250 mg in 5ml Injection 100 mg IV Int 2X7/13 DR KURUP PRIYESH 11-Jul-2003 13:00 Stop Date/Time: 12-Jul-2003 09:11	13:58 NU0947	08:34 NU1149 <DISCONT> DR1436					
PABRINEX High Potency Intravenous Injection 1 x 2 Ampoules IV Slow 8H DR FIONA BURTON 11-Jul-2003 08:00 Stop Date/Time: 13-Jul-2003 09:45	! 08:43 NU0947 21:38 NU0965	<05:43> [Withheld] NU0965 08:34 NU1149 17:55 NU1149	00:53 NU0965 <08:57> [IV Access] NU0975 <DISCONT> DR1436				
PHENYTOIN 250 mg in 5ml Injection 150 mg IV Int 1X22 DR KURUP PRIYESH 11-Jul-2003 22:00 Stop Date/Time: 12-Jul-2003 09:11		01:41 NU0965 <DISCONT> DR1436					
CHLORDIAZEPOXIDE 5 mg Capsules 20 mg Oral 4X DR KURUP PRIYESH 11-Jul-2003 18:00 Stop Date/Time: 12-Jul-2003 13:01	! 21:13 NU0965 ! <21:13> [Withheld] NU0965	! 08:02 NU1149 ! 12:44 NU0105 <STOPPED>					
CHLORDIAZEPOXIDE 5 mg Capsules 15 mg Oral 4X DR KURUP PRIYESH 12-Jul-2003 18:00 Stop Date/Time: 13-Jul-2003 13:01		! 17:59 NU1149 ! 21:37 NU0965	! 08:57 NU0975 <STOPPED>				
CHLORDIAZEPOXIDE 5 mg Capsules 10 mg Oral 4X DR KURUP PRIYESH 13-Jul-2003 18:00 Stop Date/Time: 14-Jul-2003 13:01				<STOPPED>			

Medication Administration Profile

Requested By: NU0032
Date of Report: 13-Jul-2003 at 11:30
Patient: **JOHNSTONE, LEE**
Date Of Birth: 9-Feb-1976 Weight: kg Height: cm Body Surface: sq m
Allergies:

Type of Report: Since Admission
Hospital No: 100544212

Current Status: On Ward STATION 7-AYR
Admitted On: 11-Jul-2003

Under the Care of: DR PETER REYNOLDS
Patient Note(s) exist

Key: ! - denotes unverified order at the time of charting or administration. [+] - Order Notes exist
<> - denotes charted time.
? - denotes the witness has questioned this administration.
* - denotes charting was overridden.
[@@] - denotes patient was/is on Short Term Leave.
Note : Explicit Charting, PRN and Variable Continuous Infusion times are administration times. Others refer to the time the administration was charted.

DRUG DOSE,ROUTE & FREQUENCY/INTERVAL/RATE PRESCRIBER START DATE/TIME	11-Jul-2003 Friday	12-Jul-2003 Saturday	13-Jul-2003 Sunday				
CHLORDIAZEPOXIDE 5 mg Capsules 1 Oral 3X DR KURUP PRIYESH 14-Jul-2003 22:00 Stop Date/Time: 15-Jul-2003 13:01					<STOPPED>		
CHLORDIAZEPOXIDE 5 mg Capsules 10 mg Oral 4X DR KURUP PRIYESH 15-Jul-2003 18:00 Stop Date/Time: 16-Jul-2003 13:01						<STOPPED>	
CHLORDIAZEPOXIDE 5 mg Capsules 10 mg Oral 3X DR KURUP PRIYESH 16-Jul-2003 22:00 Stop Date/Time: 17-Jul-2003 13:01							<STOPPED>
CHLORDIAZEPOXIDE 5 mg Capsules 10 mg Oral 2X DR KURUP PRIYESH 17-Jul-2003 22:00 Stop Date/Time: 18-Jul-2003 07:01							
PHENYTOIN (Epanutin) 300 mg Capsules 300 mg Oral 2X7/20 DR KURUP PRIYESH 12-Jul-2003 20:00 Stop Date/Time: 13-Jul-2003 07:01		! 21:37 NU0965	! 08:57 NU0975 <MODIFIED DR1203				
PHENYTOIN (Epanutin) 300 mg Capsules 300 mg Oral 2X7/20 DR CLAIRE COPELAND 13-Jul-2003 20:00							
PHENYTOIN (Epanutin) 300 mg Capsules 300 mg Oral STAT DR KURUP PRIYESH 12-Jul-2003 17:30 Stop Date/Time: 12-Jul-2003 17:30		! 17:59 NU1149 <STOPPED>					
PHENYTOIN 250 mg in 5ml Injection 300 mg IV Cont Variable Rate DR FIONA BURTON 11-Jul-2003 07:57 Stop Date/Time: 11-Jul-2003 07:58	<DISCONT> DR1430						

Medication Administration Profile

Requested By: NU0032
Date of Report: 13-Jul-2003 at 11:30
Patient: **JOHNSTONE, LEE**
Date Of Birth: 9-Feb-1976 Weight: kg Height: cm Body Surface: sq m
Allergies:

Type of Report: Since Admission
Hospital No: 100544212

Current Status: On Ward STATION 7-AYR
Admitted On: 11-Jul-2003

Under the Care of: DR PETER REYNOLDS
Patient Note(s) exist

Patient Notes

Note to appear when Charting — **NOT GIVEN DOSE OF PABRINEX AT MIDNIGHT A**

Added by: NURSE MELANIE GIBSON on 12-Jul-2003 at 05:44

NOT GIVEN DOSE OF PABRINEX AT MIDNIGHT AS PRESCRIBED AS 1ST DOSE GIVEN AT 10PM

Note to Pharmacist — ***CARE PLAN**

Added by: MRS ALISON FOSTER on 11-Jul-2003 at 12:24
Prior versions of this note exist.
Last Changed by: MRS ALISON FOSTER on 11-Jul-2003 at 14:04

Admitted with alcohol induced seizures

PMH
Guillain Barre Syndrome May 95

DH
Was on chlordiazepoxide prescribed 8/7/03

Bloods
10/7 U=1.9, Creat=90, k=3.8 Alcohol = 225

Care Issues
1. 10/7 Received loading dose of 1250mg Phenytoin then prescribed 350mg iv in divided doses - to take levels after 24 hours as a guide and adjust dose accordingly. Still fitting 11/7 am. Spoke to Kris 11/7 pm and asked hm to check phenytoin levels - AF
2.* Prescribed iv Pabrinex - to change to oral vitamins when oral intake appropriate - AF

Medicine Prescription Sheet

Address 15A DRUMELLAN STREET
MAYBOLE
KA19 8DS

Date of [illegible] 9/2/1976
Ward STATION 7-AYR
Consultant DR PETER REYNOLDS

13/7/2003
11:43

Allergies _____

P		Date Started	Approved Name of Medicine	Dose	Frequency		Route	Other Instructions	Last EPA dose given	Prescriber	Date Stopped
	A	11/7/2	PABRINEX High Potency Intravenous Injection	1 x 2 Ampoules	every 8 hours		IV Slow			DR FIONA BURTON	Stopped 13/7/2003
	B	12/7/2	CHLORDIAZEPOXIDE 5 mg Capsules	15 mg	07 13 18 22		Oral			DR KURUP PRIYESH	Stopped 13/7/2003
	C	13/7/2	CHLORDIAZEPOXIDE 5 mg Capsules	10 mg	07 13 18 22		Oral			DR KURUP PRIYESH	Stopped 14/7/2003
	D	14/7/2	CHLORDIAZEPOXIDE 5 mg Capsules	10 mg	07 13 22		Oral			DR KURUP PRIYESH	Stopped 15/7/2003
	E	15/7/2	CHLORDIAZEPOXIDE 5 mg Capsules	5 mg	07 13 18 22		Oral			DR KURUP PRIYESH	Stopped 16/7/2003
	F	16/7/2	CHLORDIAZEPOXIDE 5 mg Capsules	5 mg	07 13 22		Oral			DR KURUP PRIYESH	Stopped 17/7/2003
	G	17/7/2	CHLORDIAZEPOXIDE 5 mg Capsules	5 mg	07 22		Oral			DR KURUP PRIYESH	Stopped 18/7/2003
	H	18/7/2	CHLORDIAZEPOXIDE 5 mg Capsules	5 mg	22		Oral			DR KURUP PRIYESH	Stopped 18/7/2003
	I	12/7/2	PHENYTOIN (Epanutin) 300 mg Capsules	300 mg	07 20		Oral			DR KURUP PRIYESH	Stopped 13/7/2003

Read report carefully. Pay particular attention to the Dose, Frequency and Date Stopped columns

L

NURSING ASSESSMENT

01178-00011 100544212
JOHNSTONE, LEE
4C WHITEFAULDS AVENUE
MAYBOLE
KA198AS

DoB 09/02/1976 Male

Date of admission: 270601 Time: 0600
Type of admission: EMERGENCY
Accompanied by: NURSING STAFF & PORTER
From where: A & E.
PATIENT'S OCCUPATION: U/EMPLOYED
MARITAL STATUS: DIVORCED
Dependants - children 1 Boy Ages: 20months
- others

Living alone?
(1) NO - with whom? 1/c Fiancée
(2) YES - any supportive help?

RELIGION: CofS
Seen by Minister/Priest

NEXT OF KIN: Diane mConnichie
Relationship: Fiancée
Address: S/A

Home phone no.: 01655 884440.
Work phone no.:
ALTERNATIVE NEXT OF KIN:
Relationship:
Address:

Phone no.:

REASON FOR THIS ADMISSION
BURNS

PATIENT'S ACCOUNT OF ILLNESS
Making Chips went to move pan & it slipped off work top over body & arms.

SPECIAL VISITING NEEDS
NONE

PREVIOUS HEALTH PROBLEMS
Guillaine Barré Syndrome 1995
Cyst on neck - recurrant
Appendix surgery Jan 2000
Femur following R.T.A 1992.

SPECIAL NEEDS AT HOME
- housing
- social NONE
- other

DRUGS USED BEFORE ADMISSION
NONE

ALLERGIES
NIL KNOWN

TAKEN FOR SAFEKEEPING RETURNED

Property checked YES NO
Valuables in hospital safe YES NO

NURSING ASSESSMENT

1. **Capable of self care** (YES) NO Usually

2. **Communicating**
   Vision - any problems? None
   - spectacles?
   - contact lenses?
   Hearing - any problems? None
   - hearing aid?
   - battery type?
   Speech difficulty YES (NO)

3. **Mobility** - (independent?)
   - with assistance?
   - remarks.

4. **Eating and drinking**
   - appetite? good
   - special diet? none
   - dislikes?
   - assistance needed YES (NO)

5. **Personal cleaning and dressing**
   (- independent?) usually
   - with assistance?
   - remarks.

6. **Bladder and Bowels** - any problems? None
   - special needs?

7. **Sleeping** - pattern Good.
   - what helps?

8. **Recreational interests**

9. **Other relevant information**

Smoker - 10 @ day
Social alcohol.

GENERAL APPEARANCE/CONDITION

Fit. Generally Healthy
young male I/C burns
In some pain on t/fer.
Polite and well mannered.

GENERAL OBSERVATIONS

T 37.2 P 112 R 18 B/P 165/55.
Height: 5ft 6 Weight: 10st Norton score:
Urine: 7/6s
SKIN INSPECTION Burns
ORAL INSPECTION own teeth
Condition of mouth: dry
Condition of teeth:
Dentures: Upper Lower Partial
Crown:
Any problems?

DISCHARGE/FUTURE PLANS	Date ordered	Date given	Sign
Education of condition/ limitations/ rehabilitation (a) Patient			
(b) Relatives			
Discharge medications			
Warfarin Steroid/ Tetanus card			
Transport home			
Out-patient appointment			
Walking stick/crutches			
Dressings:			
Other:			
Community nursing			
Home help			
Meals on wheels			
Social worker			
Physiotherapy			
Occupational Therapy			
Speech Therapy			
Geriatric waiting list			
Sheltered housing			
Other:			

01178-00011 100544212
JOHNSTONE, LEE
4C WHITEFAULDS AVENUE
MAYBOLE
KA198AS

DoB 09/02/1976 Male

No.....
.....
B.....
.....
HDU

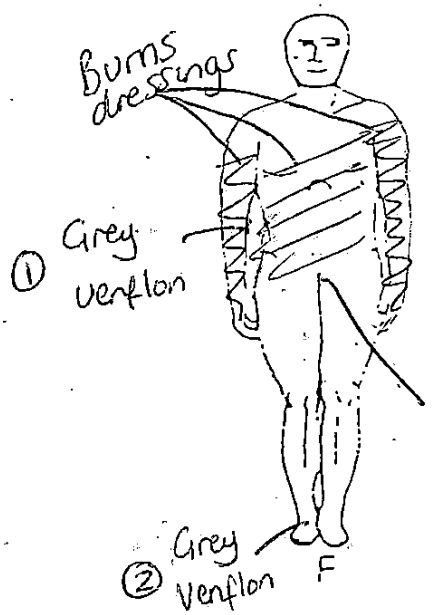
AYR Hospital
STA0481

INVESTIGATION INSTRUCTION SHEET

DATE	INVESTIGATION REQUIRED
270601 0600	Emergency admission via A&E following incident of burns caused by chip pan. Area burned on abdomen, groins, both arms and hand. All dressed in A & E 1/c tulle and pads. Urinary cath on 1° vols. IV access insitu but not for fluids as according to burns regime has had all the fluids he requires for the next 12hrs c/o 2lmin O_2 via nasal prong. In a fair amount of pain on admission 10mg IV Morphine given 1/c effect. Obs satisfactory Taking free oral fluids. Admitted under the care of the surgeons and to be reviewed in morning for ? burns unit.
1145	s/b Mr El-Banna - Flamazine to be rubbed into burned areas - then left exposed to air. To recommence iv fluids to maintain an output of 50ml/hr Can stop fluids again if this is achieved by drinking. MT

DATE	WEIGHT	DATE	WEIGHT	DATE	WEIGHT	DATE	WEIGHT	DATE	WEIGHT	DATE	WEIGHT

SOUTH AYRSHIRE HOSPITALS NES TRUST
INFECTION INVESTIGATIONS



01178-00011 100544212
JOHNSTONE, LEE
4C WHITEFAULDS AVENUE
MAYBOLE
KA198AS

DoB 09/02/1976 Male

Lines

Date of Insertion	Date of Removal
27060① Grey Venflon	
② Grey Venflon	
Catheter	
Urometer	
Burns dressings	

Date	Specimen	Results

Ayrshire & Arran Acute Hospitals NHS Trust

Nursing Assessment Form

Station/Ward: Two

Date of Admission: 2/1/00 Time: 10.30 pm

Type of admission: (Emergency) / Elective

From where: Obs ward.

Accompanied by: Porter.

Named Nurse:

Surname: Johnstone Hosp. No. 544212

Forenames: Lee Sex: M

DoB: 9/2/76

Address: 4C Whitefaulds Ave
Maybole

GP: DR LAU - MAYBOLE

Age: 23 Religion:

Married/Single/Widow/Divorced

Reason for admission:

Vomiting - ? haematemesis

Abdo pain

Patient account of illness:

Severe stomach pains & constantly vomiting since 7pm 1/1/00 - Admitted to obs

Planned procedure or treatment

Expected:

Actual (1)_____ Date_____

(2)_____ Date_____

Previous health problems

Exc of thyroglossal cyst

femur - RTA

Guillane Barre Syndrome

Medication used before admission

No medications

Stored in the ward Yes ☐ No ☐

Returned to patient/relative Yes ☐ No ☐

Next of Kin: Mrs Johnstone

Aware of admission Yes ☑ No ☐

Relationship: Mother

Address: 16 Minnoch Cres
Maybole

Home phone No. 01655 - 889669

Work phone No.

Alternative next of kin: DIANE McCONNECHIE

Relationship: FIANCE

Address: A/A

Phone No. 884316

Special visiting needs:

Seen by Minister/Priest

Allergies:

None known

Patients Property

(1) Property retained by patient.

I understand any articles/valuables retained in my possession are held on my own responsibility. Including jewelery.

Signature of patient:_____

Date:_____

(2) Property handed over for safekeeping.

Date taken for safekeeping:_____

Cash and valuables Ref. No.:_____

Date property returned:_____

Needs Assessment

Home circumstances

Occupation:

Living alone Yes ☐ No ☑ With whom? with fiance

Identify carer(s):

Community Services (details where appropriate)

Home help Yes ☐ No ☐

District Nurse Yes ☐ No ☐

Meals on Wheels Yes ☐ No ☐

Attend day hospital Yes ☐ No ☐

Sheltered Housing Yes ☐ No ☐

Nursing Home Yes ☐ No ☐

} N/A

Other

Relatives agreed to notify service providers ? Yes ☐ No ☐

Nurse to notify service providers? Yes ☐ No ☐

Date notified

Housing (details where appropriate)

Type of house:

Steps at entrance Yes ☐ No ☐ How many?

Stairs Yes ☐ No ☐

Bedroom up stairs Yes ☐ No ☐

Toilet upstairs Yes ☐ No ☐

} N/A

Mobilising

Independent Yes ☑ No ☐

Assistance of

Sleeping

Pattern ✓

What helps

Communicating

Vision: any problems Yes ☐ No ☑

Spectacles Yes ☐ No ☑

Hearing: any problems Yes ☐ No ☑

Speech dificulty Yes ☐ No ☑

Oriented time/place Yes ☑ No ☐

General Appearance / Condition

Medium build

Skin Inspection (where appropriate)

appears intact

Dentures Yes ☐ No ☐

Upper Lower Partial Crowns

General Observation on admission

BP 150/75 T 36.3 P 88 R 19

BM: Peak flow:

Waterlow: Nutrition:

Handling & Moving: MSU: Yes ☐ No ☐

Urinalysis:

Height: Weight:

MRSA Screen: Yes ☐ No ☐

Any prosthesis? Yes ☐ No ☐

Smoker **Yes** ☑ **No** ☐

Amount: 10/day

Alcohol intake amount: – weekends

Eating and Drinking

Special diet Yes ☐ No ☑

Type of diet

Cleansing and Dressing

Self caring Yes ☑ No ☐

Assistance with

Wound dressing Yes ☐ No ☐

Elimination

Bladder: any problems Yes ☐ No ☑

Bowel: any problems Yes ☐ No ☑

Admitting Nurse Signature:

Discharge

Will personal transport be available for discharge?

Yes ☐ No ☐

Predicted Discharge

Complex ☐ Uncomplicated ☐

Multidisciplinary Discharge Summary

Ayrshire & Arran Acute Hospitals NHS Trust

Sheet 1

Date of Admission 2 1 00

Addressograph here

Anticipated Date of Discharge

Type of Discharge: Complex ☐ Uncomplicated ☑

Station/Ward ST 2

Consultant Mr Forster

Named Nurse s/w Philbi

Station/Ward Phone No. 4288

Date declared medically fit

Date Patient/Relative informed of Discharge

Actual Date and Time of Discharge _____ am/pm

Reason for Delay on Discharge: Deterioration of medical condition ☐ Transport ☐ Social ☐

Other (please specify) _____

Patient Information		Signature	Comments
In patient book received	Yes / No		
Patient informed of Diagnosis	Yes / No		
Family informed of Diagnosis	Yes / No		
Patient vocalises understanding	Yes / No		
Information leaflets provided State topic/title:			

Transport Home

Date arranged for _____ Time _____ am/pm Own ☐ Ambulance ☐ Ref _____

Special Requirements _____

Post Discharge Service Arranged (please tick)

District Nurse ☐ Social Work Dept. ☐ Day Hospital ☐

Meals on Wheels ☐ Home Help ☐ Other (please state) _____

		Date	Signature	Comments
Medications ordered	Yes / No / NA			
Dressings ordered	Yes / No / NA			
Own Medications returned	Yes / No / NA			
Valuables checked/returned	Yes / No / NA			
Venflon removed	Yes / No / NA			
Follow up appointment	Yes / No / NA			
OPD Transport arranged	Yes / No / NA			
GP Letter faxed	Yes / No / NA			
House keys available	Yes / No / NA			

The information contained in this discharge summary has been fully explained and discussed with me.

Signed _____ Date _____ (Patient or Carer's Signature)

Discharging Nurse's Signature _____ Date _____

Discharge Destination _____ Accompanied by _____

A copy of this Discharge Summary has been given to (tick)

☐ Patient ☐ GP ☐ District Nurse ☐ Other (state)

If you have any problems after discharge, please contact your General Practitioner

Ayrshire and Arran Acute Hospitals NHS Trust

GP - Dr Law

THE AYR HOSPITAL

DISTRICT NURSE REFERRAL FORM

01655 882211

Addressograph

LEE JOHNSTONE
4c Whitefaulds Ave
Maybole
DoB - 9/2/76

D of A: 2/1/00 D of D: 6/1/00

Next of Kin: Mrs Johnstone

Address: 16 Minnoch Cres

Tel No: Maybole

Consultant: Mr McMillan Ward: 52

Diagnosis: 01655, 889669

Treatment in Hospital:

Appendicectomy carried out on 31/1/00

Suggested Treatment on Discharge:

Wound check please
and removal of clips - 11/1/00

Patient/Family Awareness:

aware district nurse will visit

Drug Therapy:

Voltarol

Services Required:

District Nurse

Ability Assessment:

fully mobile
Wound Sound

Additional Information:

Follow-up Appointment: No follow up

Ward Staff: JCraig

SOUTH AYRSHIRE HOSPITALS NHS TRUST

Discharge Plan Print

Printed on 06.01.00 at 12:18 pm

Name : LEE JOHNSTONE (A100544212)

Address : 4C WHITEFAULDS AVENUE
MAYBOLE
AYRSHIRE
KA19 8AS

NHS No. :
Religion : PROTESTANT
D.o.B. : 09 Feb 76 (23yrs) Sex : Male

Ward : Station 2 Surgical (S2)
Consultant : DR GIBSON,F.M. (81)
Specialty : GENERAL SURGERY (GS)
Originator : DIANE CANAVAN
Named Nurse:

GP Name : LAU,C (GP)

Address :

Admission Date : 02 Jan 00

Planned Discharge Date : 06 Jan 00 at 12:18

Dependency as at 13:00 on 06 Jan 00 : 1

Problems	Actions	Completed By	Date	Time
1. Requirements for Discharge	1. Informed of discharge date	DIANE CANAVAN	06.01.00	12:18
	2. In receipt of discharge medications	DIANE CANAVAN	06.01.00	12:18
Nurse Id: DIANE CANAVAN	3. Own transport arrangements made	DIANE CANAVAN	06.01.00	12:18

End of printout

SOUTH AYRSHIRE HOSPITALS NHS TRUST

Summary Care Plan for LEE JOHNSTONE (A100544212)

Printed on 06.01.00 at 12:17 pm

Start date : 02.01.00 Start time : 01:00
End date : 06.01.00 End time : 13:00

Name : LEE JOHNSTONE (A100544212)

Address : 4C WHITEFAULDS AVENUE
MAYBOLE
AYRSHIRE
KA19 8AS

NHS No. :
Religion : PROTESTANT
D.o.B. : 09 Feb 76 (23yrs) Sex : Male

Ward : Station 2 Surgical (S2)
Consultant : DR GIBSON,F.M. (81)
Specialty : GENERAL SURGERY (GS)
Originator : DIANE CANAVAN
ed Nurse:

GP Name : LAU,C (GP)

Address :

Admission Date : 02 Jan 00

Dependency as at 13:00 on 06 Jan 00 : 1

Admission history :

Date	Time	Ward	Specialty	Consultant
02.01.00	00:00	Observation Ward	ACCIDENT/EMERGENCY	DR GIBSON,F.M.
02.01.00	22:28	Station 2 Surgical	GENERAL SURGERY	DR GIBSON,F.M.

PROBLEMS/NEEDS/EXPECTED OUTCOMES	EVALUATIONS
1. Pt experiencing pain 1.1 Alleviate pain/assist determination/treatment caus	06.01.00 13:00 Achieved pain now settling,oral analgesia given on discharge Nurse id : DIANE CANAVAN
	04.01.00 21:00 Carry care forward, review on 06.01.00 at 20:00 oral analgesia given for wound/abdominal pain,observing meantime Nurse id : DIANE CANAVAN
	03.01.00 06:00 Carry care forward, review on 05.01.00 at 20:00 im analgesia as prescribed with effect at this time Nurse id : DIANE CANAVAN

Start date : 02.01.00 Start time : 01:00
End date : 06.01.00 End time : 13:00

PROBLEMS/NEEDS/EXPECTED OUTCOMES	EVALUATIONS
2. Patient Suffering From Nausea/Vomiting 2.1 To determine cause alleviate/symptoms	06.01.00 13:00 Achieved Nurse id : DIANE CANAVAN
	04.01.00 21:00 Carry care forward, review on 06.01.00 at 20:00 no complaints of nausea/vomiting today Nurse id : DIANE CANAVAN
	03.01.00 06:00 Carry care forward, review on 05.01.00 at 20:00 no vomiting overnight Nurse id : DIANE CANAVAN
Patient receiving Intra-venous Fluids 3.1 Patient will safely undergo administration of IV f	06.01.00 13:00 Achieved Nurse id : DIANE CANAVAN
	04.01.00 21:00 Carry care forward, review on 06.01.00 at 20:00 iv fluids continue as charted Nurse id : DIANE CANAVAN
	03.01.00 06:00 Carry care forward, review on 05.01.00 at 20:00 iv fluids as charted overnight Nurse id : DIANE CANAVAN

eneral Comments

5.01.00 06:00 IV running very slowly despite flushing by doctor.Obs stable Nurse ID : YVONNE GIVENS
4.01.00 14:00 c/o some pain this am. analgesia as prescribed with effect. Nurse ID : KEVIN MCMAHON
07:00 iv cont,i/m analgesia as charted,passing urine. Nurse ID : ANGELA SMITH
3.01.00 20:00 c/o some pain following theatre, morphine 10mg im given as Rx. Nurse ID : KEVIN MCMAHON

printout

Surname..... HCR No.....
Forenames..... Sex .....
Address ..... D.O.B.....
.....
Ward/Dept. .....

..... Hospital
STA0481

INVESTIGATION INSTRUCTION SHEET

DATE	INVESTIGATION REQUIRED	DATE	INVESTIGATION REQUIRED
2/1/00	Admitted from obs ward		
	NBM & IV fluids & Review in am		
3/1/00	for Theatre, appendicectomy		
	T & PR paracetamol given with good effect		
	commenced on IV Cef/ met. Um		
5/1	Seen by Mr McMulla		
	allowed diet		
	continued IV antibiotics		
	today, ? home tomorrow		
6/1	Seen by Mr Taylor		
	allowed home - no		
	follow up.		

DATE	WEIGHT	DATE	WEIGHT	DATE	WEIGHT	DATE	WEIGHT	DATE	WEIGHT	DATE	WEIGH

FAN1286

Sur 00002-00004 100544212
JOHNSTONE, LEE
For 4C WHITEFAULDS AVENUE
MAYBOLE
.... KA198AS

Ad DoB 09/02/76 Male

Ward/Dept. OBS

NURSING NOTES

DATE	0200
2/1/00	Admitted following vomiting - Haemchmesis - had been drinking 31/12 → 01/00. Has had Ranitidine and to be repeated mane IV. For IV fluids + observation. - NIL BY mouth overnight + ~~bbb~~ clear fluids in mane. If vomits fresh blood overnight to be referred to Medical
0630hours.	Vomit x 2 - Bile stained fluid. IVI continues Maxalon 10mg IVI at 0530 with some effect. BO x 2 - normal colour - obs as charted.. nil Pain noted.
02/1/00	Pt seen by Dr - given Ranitadine 50mg I.V. To commence ~~of~~ on fluids this AM, however continued to vomit any water that he drank. Tried a ½ slice toast for lunch. I.V.I continues, though very positional. Pt still % abdo pain.
14.30	Pt, now not vomitted for ø 2-3hrs. IVI stop
1600	% Low abdo pain - vomited ++ bile. Dr Ofei informed.
1620	Pt reviewed - given IV Maxalon 10mgs + IV Morphine 10 mgs at 1630. To continue with IV fluids
1930	Abdo pain settled. No further vomitting. Has not taken any diet or oral fluids. IV fluids continue. Vital signs stable

DATE	
20.45	I.V. Ranitidine 50 mgs given. Bloods taken. Abdominal X-Rays. Refer Surgeons.
22.10.	Seen by Surgeons Transfer ST 2 S. Hanna

Ayrshire & Arran Acute Hospitals NHS Trust

Pressure Sore Risk Assessment Tool

Waterlow Pressure Sore Risk Assessment

WRITE, IMPRINT OR ATTACH LABEL

Surname Johnstone Hosp. No.

Forenames Sex

Address DoB

Ward or Dept.

Build/weight for height		Skin type Visual risk areas		Sex Age		Special risks	
Average	0	Healthy	0	Male	1	Tissue Malnutrition	8
Above average	1	Tissue paper	1	Female	2	Eg Terminal cachexia	
Obese	2	Dry	1	14 - 49	1	Cardiac failure	5
Below average	3	Oedematous	1	50 - 64	2	Peripheral Vascular Disease	
		Clammy (temp)	2	65 - 74	3	Anaemia	5
		Discolour	2	75 - 80	4	Smoking	2
		Broken / Spot	3	81+	5		1
Continence		**Mobility**		**Appetite**		**Neurological Deficit**	
Complete / Catheterised	0	Fully	0	Average	0	Eg Diabetes, MS, CVA	4-6
Occasion incont.	1	Restless / Fidgety	1	Poor	1	Motor / Sensory	
Cath / incont. of faeces	2	Apathetic	2	N.G. tube/fluids		Paraplegia	
Doubly incont.	3	Restricted	3	only	2		
		Inert / Traction	4	NBM/Anorexic	3		
		Chairbound	5				

SCORE		
<10	Low risk	Re-assess weekly or if condition changes
10+	At risk	Re-assess twice weekly or if condition changes
15+	High risk	Re-assess on alternate days
20+	Very high risk	Assess daily

Major Surgery / Trauma	
Orthopaedic -	
Below waist, spinal	**5**
On table >2 hour	**5**
Medication	
Cytotoxics	4
High dose Steroids	
Anti-inflammatory	

Date	Waterlow Score	Comments (eg treatment, mattress, etc.)	Date next assessment due	Signed
(Admission)			twice	
2/1/00	4	Encourage mobility	weekly	DC

DRS 096 998

Ayrshire & Arran Acute Hospitals NHS Trust

Patient Handling Assessment Chart

WRITE, IMPRINT OR ATTACH LABEL

Surname Johnstone Hosp. No.

Forenames Sex

Address DoB

Ward or Dept.

SEVERAL SCORES MAY BE RINGED FROM EACH SECTION - ADD TOTAL

PHYSICAL ASSESSMENT A		MENTAL ASSESSMENT B		ENVIRONMENT C	
Above 8 stone	3	Unable to respond to instructions	5	Spacious, well designed toilet, sitting bed areas	0
Overweight / Obese	5	Confused / Demented	2	Restricted space	3
Limited use of limbs	3	Irrational behaviour	5	Poor lighting	1
Sitting balance affected	5	Deaf	1	Poor floor conditions	1
Standing balance affected	10	Poor eyesight	1	Needs isolation	1
Able to stand partially	5	Lethargic	2		
Unable to weight-bear	10				
TOTAL SCORE A		**TOTAL SCORE B**		**TOTAL SCORE C**	

STAFF CAPACITY D		SPECIAL RISK E		SCORE EVALUATION	
Some staff untrained in handling techniques	2	Pain	5	0 - 20 Low risk	
Specialist advice required	2	Surgery	5		
Staff pregnant / health problems	5	Spinal injuries	5	21 - 30 medium risk	
Uniform restrictions	1	Pressure sores	3		
		Diminished sensory areas	3	Over 30 High risk (may need mechanical assistance)	
		Heavy sedation	5		
TOTAL SCORE D		**TOTAL SCORE E**			

Date	A	B	C	D	E	Total	Signature
2/1/00	3	0	0	7	5	15	J Cannon

Ayrshire & Arran Acute Hospitals NHS Trust

Moving/Handling Assessment

WRITE, IMPRINT OR ATTACH LABEL

Surname Johnstone Hosp. No.

Forenames Sex

Address DoB

Ward or Dept.

Admission Date

Assessment Categories		Tick as appropriate							
			1	2	3	4	5	6	7
	AMBULATION	**DATE**	2/1						
1	Walks independently		✓						
2	Needs supervision								
3	Needs 1/2 people to assist (specify)								
4	Uses walking aid type:								
5	Unable to walk								
6	Other / Specify:								
	BED TRANSFERS								
1	Manages in/out independently		✓						
2	Needs supervision								
3	Needs 1/2 people to assist (specify)								
4	Needs mechanical assist (specify)								
5	On bedrest								
6	Needs 1/2/3 people to change position Specify number:								
7	May be at risk of falling/attempting to get out of bed - needs supervision								
8	Other / Specify:								
	ARMCHAIR								
1	Transfers independently in/out chair		✓						
2	Needs supervision								
3	Needs 1/2 people to assist (specify)								
4	Needs specific seating due to disability Specify:								
5	At risk of falling / may attempt to rise from chair unaided - needs supervision								
6	Other / Specify:								

DRS 107 998

Ayrshire & Arran Acute Hospitals NHS Trust

NUTRITION RISK SCORE

To be completed ***within the first 24 hours*** of admission.

Please circle the relevant score from each section (only select **ONE** score from each section).

Select the highest score that applies.

WRITE, IMPRINT OR ATTACH LABEL

Surname Johnstone HCR No.

Forenames Sex

Address DoB

Ward or Dept

Ward: T20

Date of Admission: 2/1/00

Height:

Weight (kg)
BMI = height ^{2}(m)
(or refer to BMI chart)

WEIGHT LOSS (in last 3 months)	**0** No weight loss	**1** 0-3Kg Weight loss	**2** >3-6Kg Weight loss	**3** >6Kg Weight loss
B.M.I	**0** >20	**1** 18 or 19	**2** 15 - 17	**3** <15
APPETITE	**0** Good appetite - manages most of 3 meals/day		**2** Poor appetite. poor intake - leaving >1/2 meals.	**3** Appetite Nil or virtually nil. Unable to eat NBM. (no food for > meals)
ABILITY TO EAT / RETAIN FOOD	**0** No difficulties eating. Independent. No diarrhoea or vomiting.	**1** Problems feeding (needs aides). Regurgitation/ vomiting/mild diarrhoea.	**2** Swallowing difficulties chewing/denture problems. Slow to feed. Moderate V+/ or D. Needs help with feeding.	**3** Unable to take food orally. Complete Dysphagia. Severe vomiting +/or diarrhoea.
STRESS	**0** No stress factor.	**1** **MILD** Minor surgery. Minor infection.	**2** **MODERATE** Chronic disease. Major surgery/ infection. Fractures. Pressure sores. CVA. Inflammatory bowel disease. Other GI disease.	**3** **SEVERE** Multiple injuries. Multiple fractures. Multiple deep pressure sores. Severe sepsis Carcinoma/Malignant disease.

SCORE ON ADMISSION 0

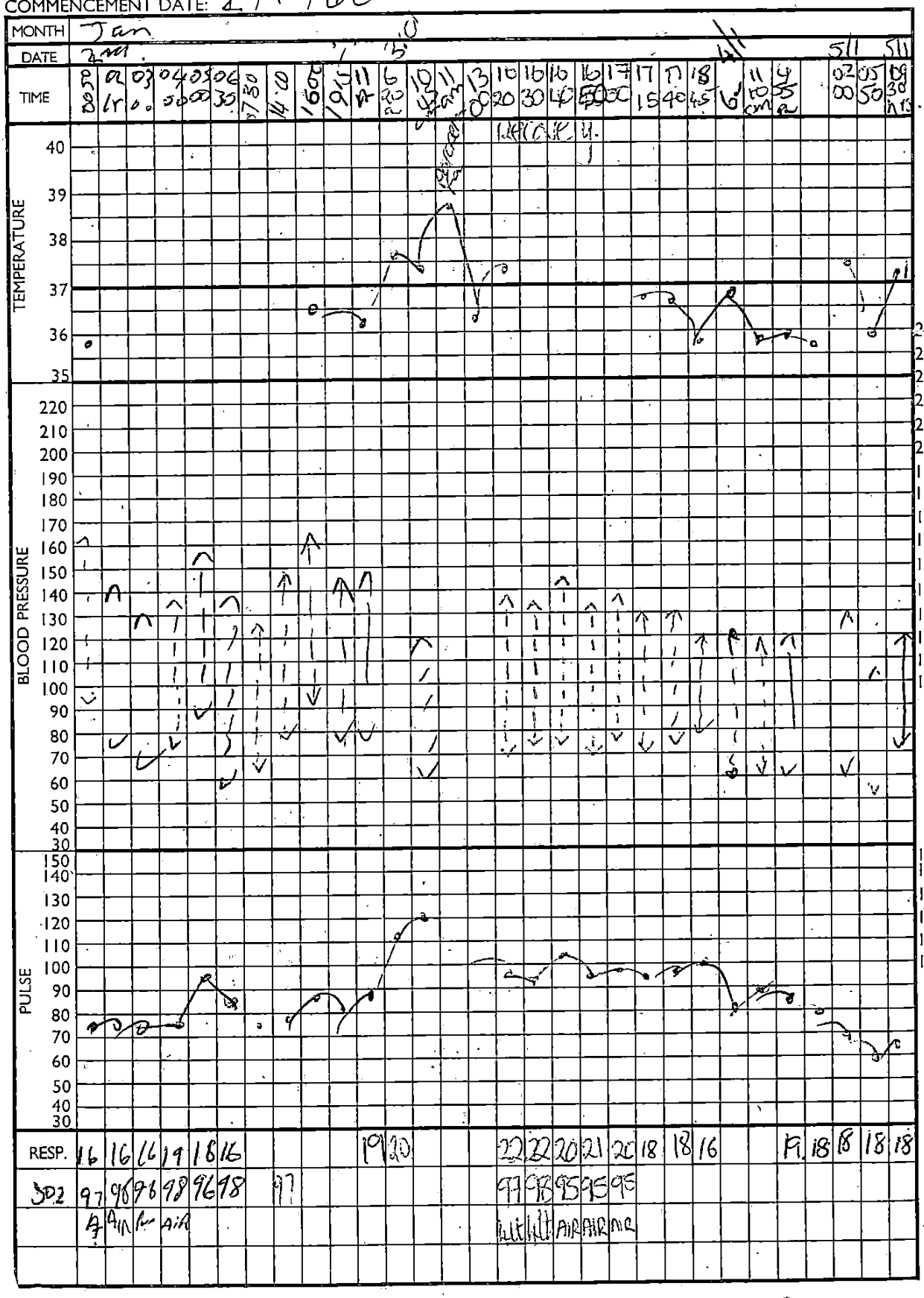
Surnai 00002-00004 100544212
JOHNSTONE, LEE
Foren: 4C WHITEFAULDS AVENUE
MAYBOLE
KA198AS
Addres DoB 09/02/76 Male

T.P.R & B.P. CHART

FAN0486

Ward/Dept. OBS

COMMENCEMENT DATE: 2/1/00



Surname ..... Hosp. No. .....

Forenames ..... Sex .....

..... D.O.B. .....

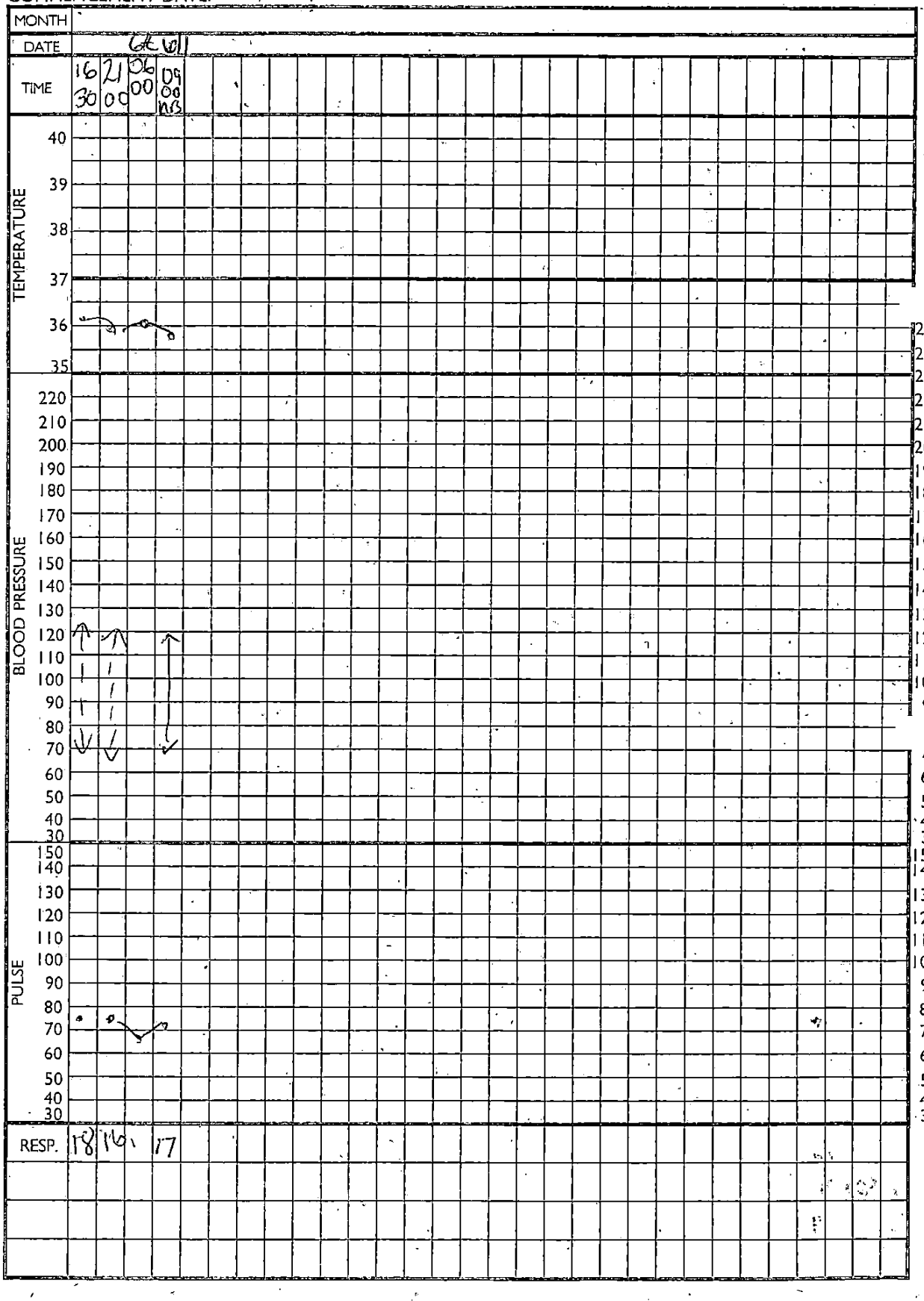
Address .....

.....

FAN0486 Ward/Dept. .....

T.P.R & B.P. CHART

COMMENCEMENT DATE: / /



Fluid Intake and Output Chart

Surname Johnston Hosp. No. ⊙

Forenames Lee Sex M

D.O.B. 09/02/70

Address 4 C Whitefields Ave Mayfield

FAN0386 Ward/Dept. STR

DATE 4/1/00 YESTERDAY'S BALANCE +3400

	INTAKE (ml)					OUTPUT (ml)			
	ORAL	INTRAVENOUS		OTHER		URINE	STOMACH	BOWEL	DRAINAGE
Time	Amount	Amount	Nature	Amount	Nature	Amount	Amount	Amount	Amount
8	50 CF	400	N/Saline + 20mls.			500			
9									
10									
11									
12	50	300	Ivdrugs						
1		500	Dextrose						
14	100					450			
15	100								
16	150								
17		200	Ivdrugs						
18	150								
19		500	Dextrose 3rd bag						
20	150					900			
21	100								
22						400			
23									
1		250	Iv Drugs			500			
2						300			
3									
4									
5		50	NSaline						
6		ven flo. dislodged				Toilet			
7									
TOTAL	850	2200				(a) +2950	(b)	(c)	(d)

INTAKE =	3050	ml	(e) Insensible loss* = 700 OUTPUT = (a + b + c + d)	+3650	ml
BALANCE = (Intake minus output)	−600	ml			

* Average Adult = 600 ml + 100 ml per each 0.5°C temperature elevation.

Surname Johnstone Hosp. No. .....

Forenames ..... Sex .....

..... D.O.B. .....

Address .....

.....

FAN0386 Ward/Dept. .....

Fluid Intake and Output Chart

DATE 3/1/99

YESTERDAY'S BALANCE

	INTAKE (ml)					OUTPUT (ml)			
	ORAL	INTRAVENOUS		OTHER		URINE	STOMACH	BOWEL	DRAINAGE
Time	Amount	Amount	Nature	Amount	Nature	Amount	Amount	Amount	Amount
8	NBM			100	Zantac		200		
9	↓					200	Bile		
10									
11		500	NSaline	200	Cefime	Toilet			
12	↓		20KCl						
13									
14		100	Caf						
15		100	Flagyl						
16		1000	(in Hrtte)						
17									
18		500	5% Dext						
19									
20									
21									
22		200	ceftriaxone						
23		500	Sod+20KCl						
24									
1									
2		500	N/Saline						
3									
4						200			
5									
6		1000	Mann						
7			+20KCl						
TOTAL		4600		300		(a) 400	(b) 200	(c)	(d)

INTAKE = 4900 ml

(e) Insensible loss* = 900

OUTPUT = 1500 ml

(a + b + c + d)

BALANCE = +3400 ml

(Intake minus output)

* Average Adult = 600 ml + 100 ml per each 0.5°C temperature elevation.

Surname JOHNSTONE Hosp. No. A100-544212

Forenames LEE Sex M

D.O.B. 09.02.76

Address 4C WHITEFALDS AVE

MAYBOLE

Ward/Dept. STN 2

I.V. Therapy Prescription Sheet

FAN 0886

	DATE	FLUID (USE BLOCK LETTERS) / ADDITIVE DRUG	Vol (ml.) / Dose (mg.)	Route of Admin.	Dur. of Admin.*	SIGNATURE	Serial No. / Batch No.	Time Begun	Given By / Added By
A	4/1	5% Dex + 20 mmol KCl	500	IV	4			7p	DC
B	4/1	N Saline	500	IV	4		41K 2418C	0505	YG
C	4/1	5% Dex	500	IV	4				
D	4/1	(N) Saline + 20 mmol KCl	500	IV	4				
E	4/1	5% Dex	500	IV	4				
F	4/1	(N) Saline	500	IV	4				
G	4/1	5% Dex + 20 mmol KCl	500	IV	4				
H									
I									
J									
K									
L									
M									
N									
O									

ATE OF FLOW = VOL. OF FLUID (ml) x 15 / Duration (Mins.) (1ml = 15 drops)

rops/Min.)

Approximate Rate for 500 ml.

1 hr. = 120 Drops/min. 6 hr. = 22 Drops/min.

4 hr. = 30 Drops/min. 8 hr. = 15 Drops/min.

62

I.V. Therapy Prescription Sheet

FAN 0886

Surname 00002-00004 100544212
Forenam JOHNSTONE, LEE
4C WHITEFAULDS AVENUE
MAYBOLE
KA198AS
Address DoB 09/02/76 Male

Ward/Dept. OBS

	DATE	FLUID (USE BLOCK LETTERS) / ADDITIVE DRUG	Vol (ml.) / Dose (mg.)	Route of Admin.	Dur. of Admin.*	SIGNATURE	Serial No. Batch No.	Time Begun	Given By / Added By
A	2/1/00	N. Saline	500	IV	Start		99K 24BG	0215	
B	2/1/00	N. Saline	500	IV	Start		99K 24BG	0300	
C	2/00	Dextrose	500	IV	3		99K 09BA	0455	
D		N. Saline	500	IV	3		99K 24BG	0800	
E	2/1/00	Dextrose	500	IV	3		99K 098X	14.00	
F		Dextrose 5%	500	IV	3			1820	
G	2/1/00	N. SALINE	500	IV	2°			1610	
H	2/1/00	5% Dextrose	500	IV	4°		99K 098X	11.30 pm	
I	2/1/00	5% Dextrose +20 mmol KCl	500	IV	4°			3.15 am	
J	2/1/00	N Saline 20mmol KCl	500	IV	4°		99K1 CBJ	11.40 am	
K	3/1	5% Dex	500	IV	4°		99K 098X	1805	
L	"	5% Dex 20mmol KCl	500	IV	4°		995 87BW	11 pm	
M	"	N SALINE	500	IV	4°		99K 24BG	2 am	
N	"	N SALINE 20mmol KCl	500	IV	4°		99K OBJ	5.30 am	
O	4/1	5% Dextrose	500	IV	4°			12d	

RATE OF FLOW (Drops/Min.) = VOL. OF FLUID (ml) x 15 / Duration (Mins.) (1ml = 15 drops)

Approximate Rate for 500 ml.
1 hr. = 120 Drops/min. 6 hr. = 22 Drops/min.
4 hr. = 30 Drops/min. 8 hr. = 15 Drops/min.

6.62

Surname Johnstone Hosp. No. .....

Forenames ..... Sex .....

..... D.O.B. .....

Address .....

.....

FAN0386 Ward/Dept. .....

Fluid Intake and Output Chart

DATE 2/1/00

YESTERDAY'S BALANCE

	INTAKE (ml)					OUTPUT (ml)			
	ORAL	INTRAVENOUS		OTHER		URINE	STOMACH	BOWEL	DRAINAGE
Time	Amount	Amount	Nature	Amount	Nature	Amount	Amount	Amount	Amount
8	NBM	500	N/Saline						
9									
10									
11									
12									
13									
14		500	Dex5%						
15									
16		500	N/Saline						
17									
18		500	Dex5%			0			
19									
20									
21									
22		Admitted to ST2.							
23		500	DEX5%						
24						600			
1									
2									
3		500	Dex5% 2Amp KCl			600			
4									
5									
6									
7									
TOTAL		3000				(a) 1200+	(b)	(c)	(d)

INTAKE = 3000 ml

(e) Insensible loss* = 600

OUTPUT = (a + b + c + d) 1800+ ml

BALANCE = (Intake minus output) ml

* Average Adult = 600 ml + 100 ml per each 0.5°C temperature elevation.

Surname Johnston Hosp. No. .....

Forenames Lee Sex .....

..... D.O.B. .....

Address .....

.....

FAN0386 Ward/Dept. .....

Fluid Intake and Output Chart

DATE 1/1/00 YESTERDAY'S BALANCE

	INTAKE (ml)					OUTPUT (ml)			
	ORAL	INTRAVENOUS		OTHER		URINE	STOMACH	BOWEL	DRAINAGE
Time	Amount	Amount	Nature	Amount	Nature	Amount	Amount	Amount	Amount
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20			Commenced @ 2100						
21									
22									
23									
24									
1									
2		500	NACL 0.9%						
3		500	NACL 0.9%						
4		500	Dextr 5%				25	(tarry)	
5							150	(tarry)	
6									
7									
TOTAL						(a)	(b)	(c)	(d)

INTAKE =	ml	(e) Insensible loss* = **OUTPUT** = (a + b + c + d)	ml
BALANCE = (Intake minus output)	ml		

* Average Adult = 600 ml + 100 ml per each 0.5°C temperature elevation.

SHEET No. .....

MEDICINE PRESCRIPTION SHEET

KEY: O ORAL; IM INTRAMUSCULAR; IV INTRAVENOUS; SC SUBCUTANEOUS; SL SUBLINGUAL; ID INTRADERMAL; INH INHALATION; NEB NEBULISED; PR PER RECTUM; PV PER VAGINA; IT INTRATHECAL

Write, Impr 00002-00004 100544212
Surname ... JOHNSTONE, LEE
Forenames MAYBOLE
..... KA198AS
Address ....
..... DoB 09/02/76 Male

KNOWN SENSITIVITY

1.	2.

SUSPECTED ADVERSE REACTION

MEDICINE	ADVERSE EFFECT
1.	
2.	

MEDICINES TO BE GIVEN REGULARLY (BLOCK CAPITALS)

PHARM.	Date Commenced	APPROVED NAME OF MEDICINE	DOSE	TIMES OF ADMINISTRATION: 6 am	8 am	10 am	12 md	2 pm	6 pm	8 pm	10 pm	12 mn	OTHER	ROUTE (see key)	OTHER INSTRUCTIONS	DOCTOR'S SIGNATURE	DISCONTINUED: DATE	INITIAL
	A 2/1/00	Ranitidine	50mg							✓				IV			6/1	
	B 2/1/00	Morphine	10mg				4 – 6°			PRN				IM			3/1	
	C 2/1/00	Maxalon	10mg				6 – 8°			PRN				IM				
	D 3/1/00	Cefuroxime	750mg											IV				
	E 3/1/00	Metronidazole	500mg											IV			3/1	
	F 3/1/00	Paracetamol	1g					6° PRN						PR	4 tds 1 day more			
	3/1/00	Valtrex	500mg											O				
	H																	
	I																	
	J																	
	K																	
	L																	
	M																	
	N																	
	O																	
	P																	
	R																	
	S																	
	T																	
	V																	

STA 0235

MEDICINES TO BE GIVEN ONCE (BLOCK CAPITALS)

PHARM.	TO BE GIVEN DATE	TO BE GIVEN TIME	APPROVED NAME OF MEDICINE	DOSE	ROUTE (see key)	DOCTOR'S SIGNATURE	GIVEN BY	TIME GIVEN
	2.1.00	0530	MAXOLON	10mg	I/V	P Parry	P Parry	0530
	02-01-00	1600	MAXALON	10mg	IV	Dr	Dr	1600
	02-01-00	1620	MORPHINE	10mg	IV	Dr	Dr	1620
	3/1/00	7pm	Morphine	10mg	im	R Walker	KMM/PP.	1905

SHEET No.....

Name .... JOHNSTONE, LEE
4C WHITEFAULDS AVENUE
MAYBOLE
KA198AS

Age .....

Consultar DoB 09/02/76 Male

Hospital..

MEDICINE RECORDING SHEET

Enter code in box and initial when medicine is taken.
If medicine refused record (A) If patient unable to swallow record A
If patient absent record A If medicine not available record A

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
3/1/00		A			D E			E G D A		
	Init.	LM			JP			IKMM		
4/1/00		G A D E			G	D E		A G D E		
	Init.	IKMM			IKMM	NC		PC		
5/1/00		A G B E		E D A	G	D E		G		
	Init.	NC		R	PO	SG.		SG.		
6/1/00		A B E								
	Init.	NC								
	Init.									
	Init.									
	Init.									

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

SHEET No.....

MEDICINE RECORDING SHEET

Name .....

Age .....

Consultant .....

Hospital.....

Enter code in box and initial when medicine is taken.

If medicine refused record (A) If patient unable to swallow record A

If patient absent record A If medicine not available record A

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

Ayrshire & Arran Acute Hospitals NHS Trust

Nursing Assessment Form

Station/Ward: A+E ODU

Date of Admission: 2/1/00 Time: 0200

Type of admission: (Emergency) Elective

From where: A+E

Accompanied by: NURSE

Named Nurse:

Surnai 00002-00004 100544212

Foren: JOHNSTONE, LEE

Addre: 4C WHITEFAULDS AVENUE
MAYBOLE
KA198AS

GP:

DoB 09/02/76 Male

Age: 23 Religion:

Married/Single/Widow/Divorced

Reason for admission:

VOMITING
HAEMATEMISIS

Patient account of illness:

Planned procedure or treatment

Expected:

Actual (1)_____ Date_____

(2)_____ Date_____

Previous health problems

Medication used before admission

NONE

Stored in the ward Yes ☐ No ☐

Returned to patient/relative Yes ☐ No ☐

Next of Kin: Mrs JOHNSTONE

Aware of admission Yes ☐ No ☐

Relationship: MUM

Address: 16 MINNOCH CRES
MAYBOLE

Home phone No. 01655 889669

Work phone No.

Alternative next of kin: DIANE McCONNECHIE

Relationship: FIANCE

Address: N/A

Phone No. 881316

Special visiting needs:

Seen by Minister/Priest

Allergies:

Patients Property

(1) Property retained by patient.

I understand any articles/valuables retained in my possession are held on my own responsibility. Including jewelery.

Signature of patient:_____

Date:_____

(2) Property handed over for safekeeping.

Date taken for safekeeping:_____

Cash and valuables Ref. No.:_____

Date property returned:_____

Needs Assessment

Home circumstances

Occupation:

Living alone Yes ☐ No ☐ With whom?

Identify carer(s):

Community Services (details where appropriate)

Home help Yes ☐ No ☐

District Nurse Yes ☐ No ☐

Meals on Wheels Yes ☐ No ☐

Attend day hospital Yes ☐ No ☐

Sheltered Housing Yes ☐ No ☐

Nursing Home Yes ☐ No ☐

Other _____

Relatives agreed to notify service providers ? Yes ☐ No ☐

Nurse to notify service providers? Yes ☐ No ☐

Date notified _____

Housing (details where appropriate)

Type of house:

Steps at entrance Yes ☐ No ☐ How many?

Stairs Yes ☐ No ☐

Bedroom up stairs Yes ☐ No ☐

Toilet upstairs Yes ☐ No ☐

Mobilising

Independent Yes ☐ No ☐

Assistance of _____

Sleeping

Pattern

What helps

Communicating

Vision: any problems Yes ☐ No ☐

Spectacles Yes ☐ No ☐

Hearing: any problems Yes ☐ No ☐

Speech dificulty Yes ☐ No ☐

Oriented time/place Yes ☐ No ☐

General Appearance / Condition

Skin Inspection (where appropriate)

Dentures Yes ☐ No ☐

Upper Lower Partial Crowns

General Observation on admission

BP **T** **P** **R**

BM: Peak flow:

Waterlow: Nutrition:

Handling & Moving: MSU: Yes ☐ No ☐

Urinalysis:

Height: Weight:

MRSA Screen: Yes ☐ No ☐

Any prosthesis? Yes ☐ No ☐

Smoker **Yes** ☐ **No** ☐

Amount:

Alcohol intake amount:

Eating and Drinking

Special diet Yes ☐ No ☐

Type of diet _____

Cleansing and Dressing

Self caring Yes ☐ No ☐

Assistance with _____

Wound dressing Yes ☐ No ☐

Elimination

Bladder: any problems Yes ☐ No ☐

Bowel: any problems Yes ☐ No ☐

Admitting Nurse Signature: _____

Discharge

Will personal transport be available for discharge?

Yes ☐ No ☐

Predicted Discharge

Complex ☐ Uncomplicated ☐

Ayrshire & Arran Acute Hospitals NHS Trust

Nursing Assessment Form

Station/Ward: 5th 2

Date of Admission: 22/11/99 Time: 10am

Type of admission: *Emergency / Elective*

From where: Home

Accompanied by: Parents

Named Nurse:

Su A100-544212
JOHNSTONE LEE
Fo 4C WHITEFAULDS AVENU
MAYBOLE 09/02/76
LAU,C (GP)
Ad MAYBOLE HEALTH CENTRE
6 HIGH STREET
GP MAYBOLE M/S

Age: **Religion:** Protestant

Married/Single/Widow/Divorced

Reason for admission:

Removal of epidermoid cyst

Patient account of illness:

Cyst discharges frequently.

Planned procedure or treatment

Expected:

Actual (1)_____ Date_____

(2)_____ Date_____

Previous health problems

Guillain Barré Syndrome 1995.

Next of Kin: Miss Diane McConnach

Aware of admission Yes ☑ No ☐

Relationship: Fiance

Address: Same Address.

Home phone No. 01655 884316

Work phone No.

Alternative next of kin:

Relationship:

Address:

Phone No.

Special visiting needs:

Seen by Minister/Priest

Allergies:

None known.

Medication used before admission

Stored in the ward Yes ☐ No ☐

Returned to patient/relative Yes ☐ No ☐

Patients Property

(1) Property retained by patient.

I understand any articles/valuables retained in my possession are held on my own responsibility. Including jewelery.

Signature of patient:_____

Date:_____

(2) Property handed over for safekeeping.

Date taken for safekeeping:_____

Cash and valuables Ref. No.:_____

Date property returned:_____

Needs Assessment

Home circumstances

Occupation: Unemployed

Living alone Yes ☐ No ☑ With whom? fiance.

Identify carer(s):

Community Services (details where appropriate)

Home help Yes ☐ No ☑

District Nurse Yes ☐ No ☑

Meals on Wheels Yes ☐ No ☑

Attend day hospital Yes ☐ No ☑

Sheltered Housing Yes ☐ No ☑

Nursing Home Yes ☐ No ☑

Other

Relatives agreed to notify service providers ? Yes ☐ No ☐

Nurse to notify service providers? Yes ☐ No ☐

Date notified

Housing (details where appropriate)

Type of house: Flat

Steps at entrance Yes ☐ No ☑ How many?

Stairs Yes ☐ No ☑

Bedroom up stairs Yes ☐ No ☑

Toilet upstairs Yes ☐ No ☑

Mobilising

Independent Yes ☑ No ☐

Assistance of

Sleeping

Pattern Good sleep pattern

What helps

Communicating

Vision: any problems Yes ☐ No ☑

Spectacles Yes ☐ No ☑

Hearing: any problems Yes ☐ No ☑

Speech dificulty Yes ☐ No ☑

Oriented time/place Yes ☑ No ☐

General Appearance / Condition

Appears fit and healthy.

Skin Inspection (where appropriate)

Small discharging area under chin

Dentures Yes ☐ No ☑

Upper Lower Partial Crowns

General Observation on admission

BP 110/60 T 36.2 P 66 R 16

BM: Peak flow:

Waterlow: Nutrition:

Handling & Moving: MSU: Yes ☐ No ☐

Urinalysis:

Height: 5' 6" Weight: 10st 9lbs.

MRSA Screen: Yes ☐ No ☐

Any prosthesis? Yes ☐ No ☐

Smoker **Yes** ☑ **No** ☐

Amount: 7-8 per day.

Alcohol intake amount: Occassional

Eating and Drinking

Special diet Yes ☐ No ☑

Type of diet

Cleansing and Dressing

Self caring Yes ☑ No ☐

Assistance with

Wound dressing Yes ☐ No ☐

Elimination

Bladder: any problems Yes ☐ No ☑

Bowel: any problems Yes ☐ No ☑

Admitting Nurse Signature: KA Clubbs

Discharge

Will personal transport be available for discharge?

Yes ☑ No ☐

Predicted Discharge

Complex ☐ Uncomplicated ☑

Multidisciplinary Discharge Summary

Ayrshire & Arran Acute Hospitals NHS Trust

A100-544212
JOHNSTONE LEE
4C WHITEFAULDS AVENU
MAYBOLE 09/02/76
LAU,C (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET M/S
MAYBOLE

Date of Admission 24/11/99

Anticipated Date of Discharge 25/11/99

Type of Discharge: Complex ☐ Uncomplicated ☑

Date declared medically fit 25/11/99

Date Patient/Relative informed of Discharge ☐☐☐

Actual Date and Time of Discharge ☐☐☐ ____ am/pm

Station/Ward ____

Consultant ____

Named Nurse ____

Station/Ward Phone No. ST - 2

Reason for Delay on Discharge: Deterioration of medical condition ☐ Transport ☐ Social ☐

Other (please specify) ____

Patient Information		Signature	Comments
In patient book received	Yes / No		
Patient informed of Diagnosis	Yes / No		
Family informed of Diagnosis	Yes / No		
Patient vocalises understanding	Yes / No		
Information leaflets provided State topic/title: ____			

Transport Home

Date arranged for ____ Time ____ am/pm Own ☐ Ambulance ☐ Ref ____

Special Requirements ____

Post Discharge Service Arranged *(please tick)*

District Nurse ☐ Social Work Dept. ☐ Day Hospital ☐

Meals on Wheels ☐ Home Help ☐ Other (please state) ____

		Date	Signature	Comments
Medications ordered	(Yes) / No / NA	25/11		
Dressings ordered	Yes / No / (NA)			
Own Medications returned	Yes / No / (NA)			
Valuables checked/returned	Yes / No / (NA)			
Venflon removed	(Yes) / No / NA	25/11		
Follow up appointment	(Yes) / No / (NA)			
OPD Transport arranged	Yes / No / (NA)			
GP Letter faxed	(Yes) / No / NA	25/11		
House keys available	(Yes) / No / NA	25/11		

LEFT BEFORE SIGNING

The information contained in this discharge summary has been fully explained and discussed with me.

Signed ____ Date ____ (Patient or Carer's Signature)

Discharging Nurse's Signature ____ Date ____

Discharge Destination Home Accompanied by ____

A copy of this Discharge Summary has been given to (tick)

☐ Patient ☐ GP ☐ District Nurse ☐ Other (state)

If you have any problems after discharge, please contact your General Practitioner

SOUTH AYRSHIRE HOSPITALS NHS TRUST

Front Assessment Print

Printed on 25.11.99 at 8:59 am

Name	: LEE JOHNSTONE (A100544212)	GP Name	: LAU,C (GP)
Address	: 4C WHITEFAULDS AVENUE MAYBOLE AYRSHIRE KA19 8AS	Address	: -
NHS No.	:		
Religion	: PROTESTANT	Admission Date	: 22 Nov 99
D.o.B.	: 09 Feb 76 (23yrs) Sex : Male		
Ward	: Station 2 Surgical (S2)	Planned Discharge Date	: -
Consultant	: MR STEWART,G. (4)		
Specialty	: GENERAL SURGERY (GS)	Dependency as at 09:00 on 25 Nov 99	: 2
Originator	: CATHY CURTIS		
Named Nurse:			

: Station 2 Surgical — Assessment sheet : Initial Assessment Sheet

SION DETAILS: Time of Admission : [10:00] Type of Admission : [Elective]
Reason for Admission : [For removal of epyglossal cyst]

Previous Medical History : [Guillam Barre Syndrome 1995] Next of Kin informed of admission : [Yes]

MEDICATION DETAIL: Current Medication : [_____]
[_____] [_____]
[_____] [_____]
Is patient able to self medicate : [Yes] Own tablets brought into hospital : [_] Retained on ward : [_]

Sent to Pharmacy for destruction : [_] Sent home with relatives/carers : [_] Mental status : [Alert/Orientated]
If other please state: : [_____]

SOCIAL HISTORY:Does patient live alone : [No] If no with whom does the patient live : [With fiance] Type of housing : [Flat]
If other please state : [_____]

Care ? : [Independant]
nity Services (prior to admission) : [_____]
[_____] [_____]
[_____] [_____]
[_____]
Frequency of services : [_____]

MOBILITY ASSESSMENT : [Unlimited] Walking aids/Equipment : [_____]

SENSORY ASSESS:Hearing : [No problems] Hearing aids with patient : [_] Sight : [No problems]

Speech: Able to communicate : [Yes] If no,state problem : [_____]
[_____]

Ward : Station 2 Surgical

Assessment sheet : Initial Assessment Sheet

Teeth : [Own teeth] SKIN INSPECTION ASSESSMENT : [Skin intact] Pressure sore identified : [No]
Grade of pressure sore : [_____] Waterlowe Score : [4]
Pressure Sore Assessment Completed : [Yes] If no, why not : [_____]
[_____]

Nutritional Assessment Completed : [Yes] If no, why not : [_____]
[_____]

RISK ASSESSMENT :Audiologist : [_____]
Dietitian : [_____]
[_____]
Occupational Therapist : [_____]
[_____]

Pharmacist : [_____]
_____] [_____]
[_____]
Physiotherapist : [_____]
_____] [_____]
_____]
Podiatry : [_____]
_____] [_____]

URSE SPECIALIST :Breast Care : [_____]
_____] [_____]
Cardiac Rehabilitation : [_____]
_____] [_____]
Continence : [_____]
_____]

Diabetes : [_____]
_____]
Respiratory Care : [_____]
_____]
MacMillan Service : [_____]
[_____]

Pediatric : [_____]
_____] [_____]
Palliative Care : [_____]
_____]
Stoma Care : [_____]
_____]

Ward : Station 2 Surgical

Assessment sheet : Initial Assessment Sheet

Social Worker : [_____]
[_____] [_____]
[_____]
Speech and Language Therapist : [_____]
[_____]

Referrals requested from: : [_____]
[_____] [_____]
[_____] [_____]
[_____] Date referrals made : [_____]

OBSERVATIONS: Temperature,Pulse,Resps : [T36.2 P66 R16] Blood Pressure : [110/60]
Urinalysis : [_____] Height : [5'6"]
Weight : [10st 4lbs]

Is patient a smoker : [Yes] How many a day : [7-8] Any alcohol intake : [Yes] How many units per week : [occassional]

Information obtained from : [Patient]
If no information obtained:state why : [_____]
Patient informed of Diagnosis/Treatment : [Yes] Relatives informed/Diagnosis/Treatment : [_]

Written information supplied : [No] If no, why not : [none available]
State topic literature relates to : [_____]
[_____] [_____]

State Pt's perception of diagnosis : [Patient appears fully aware of diagnosis and] [proposed procedure]
Type of Discharge : [Uncomplicated]

nd of printout

SOUTH AYRSHIRE HOSPITALS NHS TRUST

Care Plan Print

Printed on 25.11.1999 at 8:59 am

ame : LEE JOHNSTONE (A100544212)

ddress : 4C WHITEFAULDS AVENUE
MAYBOLE
AYRSHIRE
KA19 8AS

HS No. :
eligion : PROTESTANT
.o.B. : 09 Feb 76 (23yrs) Sex : Male

ard : Station 2 Surgical (S2)
onsultant : MR STEWART,G. (4)
pecialty : GENERAL SURGERY (GS)
urrent Care Plan Originator : CATHY CURTIS
med Nurse:

GP Name : LAU,C (GP)

Address :

Admission Date : 22 Nov 99

Planned Discharge Date :

Dependency as at 09:00 on 25 Nov 99 : 2

ROBLEM/NEED	ACTION
Immediate Post-Operative Care - for ion og epiglossyl cyst 23/11/99	
pected Outcome:	Nurse Pt on side
1 Safe recovery from	Maintain clear airway
aesthesia/surgery	Oxygen therapy as prescribed
	Record vital signs 1/2 hrly
aluation:	Record vital signs 1 hrly
st reviewed on 25.11.1999 for 09:00	Record vital signs 2 hrly
hieved on 25.11.1999	Record vital signs 4 hrly
	Continuous cardiac monitoring
b dr for home today	Contniuous Sa02 monitoring using pleth
	Inform Dr of any abnormalities
rse ID : FIONA FERGUSON	Observe peripheral perfusion
	Observe wound for leakage 1 hrly
	Observe wound for leakage 2 hrly
	Observe wound for leakage 4 hrly
	Give prescribed IV fluids
	Assess level of pain 2-4 hrly
	Give prescribed analgesia/note effect
	Observe Pt for non verbal signs of pain

of printout

A100-544212

Surname JOHNSTONE LEE

Forenam 4C WHITEFAULDS AVENU

MAYBOLE 09/02/76

Address. LAU,C (GP)

MAYBOLE HEALTH CENTRE

6 HIGH STREET

Ward/De MAYBOLE M/S

.....Hospital

STA0481

INVESTIGATION INSTRUCTION SHEET

DATE	INVESTIGATION REQUIRED	DATE	INVESTIGATION REQUIRED
24/11	S/B mr Chang. Drain		
	to be removed ✓ SW		

DATE	WEIGHT	DATE	WEIGHT	DATE	WEIGHT	DATE	WEIGHT	DATE	WEIGHT	DATE	WEIGHT

Ayrshire & Arran Acute Hospitals NHS Trust

Pressure Sore Risk Assessment Tool

WR[illegible] PRINT OR ATTACH LABEL

A100-544212
Surname JOHNSTONE
Forename LEE
Address 4C WHITEFAULDS AVENU
MAYBOLE
09/02/76
LAU,C (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
Ward or Dept. MAYBOLE M/S

Waterlow Pressure Sore Risk Assessment

Build/weight for height		Skin type Visual risk areas		Sex Age		Special risks	
Average	(0)	Healthy	(0)	Male	(1)	Tissue Malnutrition	8
Above average	1	Tissue paper	1	Female	2	Eg Terminal cachexia	
Obese	2	Dry	1	14 - 49	(1)	Cardiac failure	5
Below average	3	Oedematous	1	50 - 64	2	Peripheral Vascular Disease	
		Clammy (temp)	2	65 - 74	3	Anaemia	5
		Discolour	2	75 - 80	4	Smoking	(2)
		Broken / Spot	3	81+	5		1

Continence		Mobility		Appetite		Neurological Deficit	
Complete / Catheterised	(0)	Fully	(0)	Average	0	Eg Diabetes, MS, CVA	4-6
Occasion incont.	1	Restless / Fidgety	1	Poor	1	Motor / Sensory	
Cath / incont. of faeces	2	Apathetic	2	N.G. tube/fluids		Paraplegia	
Doubly incont.	3	Restricted	3	only	2		
		Inert / Traction	4	NBM/Anorexic	3		
		Chairbound	5				

SCORE		
<10	Low risk	Re-assess weekly or if condition changes
10+	At risk	Re-assess twice weekly or if condition changes
15+	High risk	Re-assess on alternate days
20+	Very high risk	Assess daily

Major Surgery / Trauma	
Orthopaedic -	
Below waist, spinal	**5**
On table >2 hour	**5**

Medication	
Cytotoxics	4
High dose Steroids	
Anti-inflammatory	

Date	Waterlow Score	Comments (eg treatment, mattress, etc.)	Date next assessment due	Signed
(Admission)	4			ICE

DRS 096 998

Ayrshire & Arran Acute Hospitals NHS Trust

Patient Handling Assessment Chart

WF [illegible] OR ATTACH LABEL

JOHNSTONE LEE
Surname 4C WHITEFAULDS AVENU
Forenam MAYBOLE
LAU,C (GP)
Address MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE
Ward or Dept. _____

A100-544212
09/02/76
M/S

SEVERAL SCORES MAY BE RINGED FROM EACH SECTION - ADD TOTAL

PHYSICAL ASSESSMENT A		MENTAL ASSESSMENT B		ENVIRONMENT C	
Above 8 stone	(3)	Unable to respond to instructions	5	Spacious, well designed toilet, sitting bed areas	0
Overweight / Obese	5	Confused / Demented	2	Restricted space	3
Limited use of limbs	3	Irrational behaviour	5	Poor lighting	1
Sitting balance affected	5	Deaf	1	Poor floor conditions	1
Standing balance affected	10	Poor eyesight	1	Needs isolation	1
Able to stand partially	5	Lethargic	2		
Unable to weight-bear	10				
TOTAL SCORE A	3	**TOTAL SCORE B**	0	**TOTAL SCORE C**	0

STAFF CAPACITY D		SPECIAL RISK E		SCORE EVALUATION	
Some staff untrained in handling techniques	2	Pain	5	0 - 20 Low risk	
Specialist advice required	2	Surgery	5		
Staff pregnant / health problems	5	Spinal injuries	5	21 - 30 medium risk	
Uniform restrictions	1	Pressure sores	3		
		Diminished sensory areas	3	Over 30 High risk (may need mechanical assistance)	
		Heavy sedation	5		
TOTAL SCORE D	0	**TOTAL SCORE E**	5		

Date	A	B	C	D	E	Total	Signature
	3	0	0	0	5	8	DAuts

DRS 110 998

Ayrshire & Arran Acute Hospitals NHS Trust

Moving/Handling Assessment

V ABEL

A100-544212

JOHNSTONE LEE

Surnar 4C WHITEFAULDS AVENU

Forenc MAYBOLE 09/02/76

LAU,C (GP)

Addre: MAYBOLE HEALTH CENTRE

6 HIGH STREET

MAYBOLE

M/S

Admission Date _____

Ward or Dept. _____

Assessment Categories		Tick as appropriate							
			1	2	3	4	5	6	7
	AMBULATION	**DATE**	RT						
1	Walks independently		✓						
2	Needs supervision								
3	Needs 1/2 people to assist (specify)								
4	Uses walking aid type:								
5	Unable to walk								
6	Other / Specify:								
	BED TRANSFERS		✓						
1	Manages in/out independently								
2	Needs supervision								
3	Needs 1/2 people to assist (specify)								
4	Needs mechanical assist (specify)								
5	On bedrest								
6	Needs 1/2/3 people to change position Specify number:								
7	May be at risk of falling/attempting to get out of bed - needs supervision								
8	Other / Specify:								
	ARMCHAIR								
1	Transfers independently in/out chair		✓						
2	Needs supervision								
3	Needs 1/2 people to assist (specify)								
4	Needs specific seating due to disability Specify:								
5	At risk of falling / may attempt to rise from chair unaided - needs supervision								
6	Other / Specify:								

DRS 107 998

Ayrshire & Arran Acute Hospitals NHS Trust

NUTRITION RISK SCORE

To be completed ***within the first 24 hours*** of admission.

Please circle the relevant score from each section (only select **ONE** score from each section).

Select the highest score that applies.

A100-544212

Surname JOHNSTONE LEE

Forenam 4C WHITEFAULDS AVENU

Address MAYBOLE 09/02/76

LAU,C (GP)

MAYBOLE HEALTH CENTRE

6 HIGH STREET

MAYBOLE M/S

Ward or Dept

Ward: 5m 2

Date of Admission: 22/11/99

Height:

Weight (kg)
BMI = height ^{2}(m)
(or refer to BMI chart)

WEIGHT LOSS (in last 3 months)	(0) No weight loss	1 0-3Kg Weight loss	2 >3-6Kg Weight loss	3 >6Kg Weight loss
B.M.I	(0) >20	1 18 or 19	2 15 - 17	3 <15
APPETITE	(0) Good appetite - manages most of 3 meals/day		2 Poor appetite. poor intake - leaving >1/2 meals.	3 Appetite Nil or virtually nil. Unable to eat NBM. (no food for > meals)
ABILITY TO EAT / RETAIN FOOD	0 No difficulties eating. Independent. No diarrhoea or vomiting.	1 Problems feeding (needs aides). Regurgitation/ vomiting/mild diarrhoea.	2 Swallowing difficulties chewing/denture problems. Slow to feed. Moderate V+/ or D. Needs help with feeding.	3 Unable to take food orally. Complete Dysphagia. Severe vomiting +/or diarrhoea.
STRESS	0 No stress factor.	1 **MILD** Minor surgery. Minor infection.	(2) **MODERATE** Chronic disease. Major surgery/ infection. Fractures. Pressure sores. CVA. Inflammatory bowel disease. Other GI disease.	3 **SEVERE** Multiple injuries. Multiple fractures. Multiple deep pressure sores. Severe sepsis Carcinoma/Malignant disease.

SCORE ON ADMISSION 2

DRS 115 998

SCORE	0-3 LOW RISK	4-5 NEEDS MONITORING	6-15 HIGH RISK
ACTION TO BE TAKEN	• No action necessary • Check weight weekly	• Check weight weekly. • Encourage with eating and drinking • Refer to Dieitians for supplements if required • Repeat score weekly and refer to Dietitian if no improvement	• Refer to Dietitian +/or Nutrition Support Team

ACTION TAKEN No action necessary.

Nurse signature K.A. Curtis

REPEATED ASSESSMENTS

DATE	SCORE	WEIGHT	ACTION TAKEN	NURSE SIGNATURE

T.P.R & B.P. CHART

Surname JOHNSTONE A100-544212
Forename: LEE
4C WHITEFAULDS AVENU
MAYBOLE 09/02/76
LAU,C (GP)
Address.. MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE M/S
FAN0486 Ward/Dept.

COMMENCEMENT DATE: / /

MONTH November 98

DATE 23 23 24

TIME 8 20 12 32 12 42 12 50 12 0 13 14 00 4 pm 21 22 10 16 00 nd.

TEMPERATURE 40 39 38 37 36 35

BLOOD PRESSURE 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30

PULSE 150 140 130 120 110 100 90 80 70 60 50 40 30

RESP.		18	18	18	17	16	16		10
SO_2		100	99	99	100	100	100		100
Wound		✓	✓	✓	✓	✓	✓		✓
drain		✓	✓	✓	✓	✓	✓		✓

SOUTH AYRSHIRE HOSPITALS NHS TRUST

Patient's addressograph

A100-544212
JOHNSTONE LEE
4C WHITEFAULDS AVENU
MAYBOLE 09/02/76
LAU,C (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE M/S

PHARMACEUTICAL SERVICES

MEDICATION ON ADMISSION -
(Have you checked all available sources - Previous notes, GP Letter, Own medication?)

Outstanding Care Issues -

Biochemistry and Bloods on admission -

Associated Pharmaceutical Care Issues -

Care Issues -	Action -	Output/Outcome -		Initials
1. Thromboprophylaxis assessed	Nil			
2. Pain Relief	Co Proxamol ✓		24/2	
3. Augmentin IV ✓	3 doses BD Stop 3pm 24/2/99 Nore Left			

SHEET No. .....

MEDICINE PRESCRIPTION SHEET

KEY: O ORAL; IM INTRAMUSCULAR; IV INTRAVENOUS; SC SUBCUTANEOUS; SL SUBLINGUAL; ID INTRADERMAL; INH INHALATION; NEB NEBULISED; PR PER RECTUM; PV PER VAGINA; IT INTRATHECAL

A100-544212

Write JOHNSTONE LEE
Surna 4C WHITEFAULDS AVENU
Foren MAYBOLE 09/02/76
..... LAU,C (GP)
Addre MAYBOLE HEALTH CENTRE
6 HIGH STREET
..... MAYBOLE M/S

KNOWN SENSITIVITY

1.	2.

SUSPECTED ADVERSE REACTION

MEDICINE	ADVERSE EFFECT
1.	
2.	

MEDICINES TO BE GIVEN REGULARLY (BLOCK CAPITALS)

Code STA0235

PHARM.	Date Commenced	APPROVED NAME OF MEDICINE	DOSE	TIMES OF ADMINISTRATION: 6 am	8 am	10 am	12 md	2 pm	6 pm	8 pm	10 pm	12 mn	OTHER	ROUTE (see key)	OTHER INSTRUCTIONS	DOCTOR'S SIGNATURE	DISCONTINUED: DATE	INITIAL
STOP 2	23/11	AUGMENTIN	1.2g		✓			✓			✓			IV	3 DOSES	[signature]		
B	23/11	CODAFAMOL	2tabs	PRN			4-6°		PRN					O	MAX 8 tabs/day	[signature]		
C																		
D																		
E																		
F																		
G																		
H																		
I																		
J																		
K																		
L																		
M																		
N																		
O																		
P																		
R																		
S																		
T																		
V																		

MEDICINES TO BE GIVEN ONCE (BLOCK CAPITALS)

PHARM.	TO BE GIVEN DATE	TO BE GIVEN TIME	APPROVED NAME OF MEDICINE	DOSE	ROUTE (see key)	DOCTOR'S SIGNATURE	GIVEN BY	TIME GIVEN
	23-4-99	12[30]	PARACETAMOL	15:4g	PR	[signature]	LM RD	1240

SHEET N

MEDICINE RECORDING SHEET

A100-544212
JOHNSTONE LEE
4C WHITEFAULDS AVENU
MAYBOLE 09/02/76
LAU, C (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE M/S

Enter code in box and initial when medicine is taken.
If medicine refused record (A) If patient unable to swallow record A
If patient absent record A If medicine not available record A

Date	6a.m.	10p.m.	12m.n.	Other Administrations
23/11/69		A		
Init.		LMO		
24/11/69		A		
Init.		EH		
Init.				
Init.				
Init.				
Init.				
Init.				

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
Init.										
Init.										
Init.										
Init.										
Init.										
Init.										
Init.										

SHEET No .....

MEDICINE RECORDING SHEET

Name .....

Age .....

Consultant .....

Hospital .....

Enter code in box and initial when medicine is taken.

If medicine refused record Ⓐ

If patient unable to swallow record A

If patient absent record A

If medicine not available record A

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

NURSING ASSESSMENT

22y

Forenames Johnstone Sex Lee

D.O.B. 09/02/76

Address 4C Whitefaulds Ave
Maybole

FAN0986 Ward/Dept. 9

Date of admission: 26/02/98 Time: 10.30

Type of admission: W.L.

Accompanied by: Father

From where: Home

PATIENT'S OCCUPATION:

MARITAL STATUS: Single

Dependants - children Ages:

- others

Living alone?

(1) NO - with whom? Fiancee

(2) YES - any supportive help?

RELIGION: Protestant

Seen by Minister/Priest

NEXT OF KIN: Alistair Johnston

Relationship: Father

Address: 16 Minnoch Crescent
Maybole

Home phone no.: 01655 889536

Work phone no.:

ALTERNATIVE NEXT OF KIN: Diane McCord

Relationship: Fiancée

Address: 4C Whitefaulds Ave
Maybole

Phone no.:

REASON FOR THIS ADMISSION

Removal of Cyst on Neck

PATIENT'S ACCOUNT OF ILLNESS

For removal of cyst on neck — same cyst removed age 7y/s

SPECIAL VISITING NEEDS

No

PREVIOUS HEALTH PROBLEMS

(R) shaft Femur 1983 → RTA
Bowel Colic
Op. for cyst on neck age 7y/s
Guillian Barrie Syndrome 1995

SPECIAL NEEDS AT HOME

- housing
- social House
- other

DRUGS USED BEFORE ADMISSION

None

ALLERGIES

None known

TAKEN FOR SAFEKEEPING RETURNED

Property checked (YES) NO

Valuables in hospital safe YES (NO)

NURSING ASSESSMENT

1. **Capable of self care** (YES / NO)

2. **Communicating**
   Vision - any problems? No
   - spectacles? No
   - contact lenses?
   Hearing - any problems? No
   - hearing aid?
   - battery type?
   Speech difficulty (YES / NO)

3. **Mobility** - independent? ✓
   - with assistance?
   - remarks.

4. **Eating and drinking**
   - appetite? Satisfactory
   - special diet? No
   - dislikes?
   - assistance needed (YES / NO)

5. **Personal cleaning and dressing**
   - independent? ✓
   - with assistance?
   - remarks.

6. **Bladder and Bowels** - any problems? No
   - special needs?

7. **Sleeping** - pattern Satisfactory
   - what helps?

8. **Recreational interests**

9. **Other relevant information**
   Smoker 10 day.
   alcohol weekends.

GENERAL APPEARANCE/CONDITION

GENERAL OBSERVATIONS
T 36.7 P 80 R 16 B/P 130/90.

Height: Weight: Norton score:

Urine:

SKIN INSPECTION

ORAL INSPECTION
Condition of mouth:
Condition of teeth:

Dentures: Upper Lower Partial

Crown:

Any problems?

DISCHARGE/FUTURE PLANS	Date ordered	Date given	Sign
Education of condition/ limitations/ rehabilitation (a) Patient (b) Relatives			
Discharge medications			
Warfarin Steroid/ Tetanus card			
Transport home			
Out-patient appointment			
Walking stick/crutches			
Dressings:			
Other:			
Community nursing			
Home help			
Meals on wheels			
Social worker			
Physiotherapy			
Occupational Therapy			
Speech Therapy			
Geriatric waiting list			
Sheltered housing			
Other:			

SOUTH AYRSHIRE HOSPITALS NHS TRUST

Front Assessment Print

Printed on 28.02.98 at 10:15 am

Name : LEE JOHNSTONE (A100544212)

Address : 16 MINNOCH CRESCENT
MAYBOLE
AYRSHIRE
KA19 8DW

NHS No. :
Religion : PROTESTANT
D.o.B. : 09 Feb 76 (22yrs) Sex : Male

Ward : Station 2 Surgical (S2)
Consultant : DR MCMILLAN,I. (145)
Specialty : GENERAL SURGERY (GS)
Originator : KERRY BAIRD
Named Nurse:

GP Name : LAU,C (GP)

Address : MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE
KA19 7BY

Admission Date : 26 Feb 98

Planned Discharge Date : -

Dependency as at 11:00 on 28 Feb 98 : 1

==========

: Station 2 Surgical

Assessment sheet : Initial Assessment Sheet

ADMISSION DETAILS: Time of Admission : [10:30] Type of Admission : [Waiting List]
Reason for Admission : [Removal of cyst on neck.]

Previous Medical History : [# R Shaft of femur 1983 - RTA] [Bowel Colic] [Op for cyst on neck age 7yrs.]
[Guillian Barrie Syndrome 1995.] Next of Kin informed of admission : [Yes]

MEDICATION DETAIL: Current Medication : [None] Is patient able to self medicate : [Yes] Own tablets brought into hospital : [No]
Retained on ward : [No]

Sent to Pharmacy for destruction : [No] Sent home with relatives/carers : [No] Mental status : [Alert/Orientated]
If other please state: : [_____]

SOCIAL HISTORY:Does patient live alone : [No] If no with whom does the patient live : [Lives with Fiancee]
Type of housing : [House] If other please state : [_____]

Self Care ? : [Independant]
Community Services (prior to admission) : [_____]
[_____] [_____]
[_____] [_____]
[_____]
Frequency of services : [_____]

MOBILITY ASSESSMENT : [Unlimited] Walking aids/Equipment : [_____]

SENSORY ASSESS:Hearing : [No problems] Hearing aids with patient : [No] Sight : [No problems]

Speech: Able to communicate : [Yes] If no,state problem : [_____]
[_____]

Teeth : [Own teeth] SKIN INSPECTION ASSESSMENT : [Skin intact] Pressure sore identified : [No]
Grade of pressure sore : [_____] Waterlowe Score : [5]
Pressure Sore Assessment Completed : [Yes] If no, why not : [_____]
_____]

Nutritional Assessment Completed : [No] If no, why not : [_____]
_____]

RISK ASSESSMENT :Audiologist : [_____]
Dietitian : [_____]
_____]
Occupational Therapist : [_____]
_____]

Pharmacist : [_____]
_____] [_____]
_____]
Physiotherapist : [_____]
_____] [_____]
_____]
Podiatry : [_____]
_____] [_____]

NURSE SPECIALIST :Breast Care : [_____]
_____] [_____]
Cardiac Rehabilitation : [_____]
_____] [_____]
Continence : [_____]
_____]

Diabetes : [_____]
_____]
Respiratory Care : [_____]
_____]
Pallan Service : [_____]
_____]

Paediatric : [_____]
_____] [_____]
Palliative Care : [_____]
_____]
Stoma Care : [_____]
_____]

Social Worker : [_____]
[_____] [_____]
[_____]
Speech and Language Therapist : [_____]
[_____]

Referrals requested from: : [_____]
[_____] [_____]
[_____] [_____]
[_____] Date referrals made : [_____]

OBSERVATIONS: Temperature,Pulse,Resps : [T 35.7 P80 rr16] Blood Pressure : [130/90]
Urinalysis : [_____] Height : [_____]
Weight : [_____]

tient a smoker : [Yes] How many a day : [10 day] Any alcohol intake : [Yes] How many units per week : [weekends only.]

Information obtained from : [Patient]
If no information obtained:state why : [_____]
Patient informed of Diagnosis/Treatment : [Yes] Relatives informed/Diagnosis/Treatment : [Yes]

Written information supplied : [No] If no, why not : [None available]
State topic literature relates to : [_____]
[_____] [_____]

State Pt's perception of diagnosis : [Fully aware] Type of Discharge : [Uncomplicated]

nd of printout

SOUTH AYRSHIRE HOSPITALS NHS TRUST

Front Assessment Print

Printed on 28.02.98 at 10:15 am

Name : LEE JOHNSTONE (A100544212)

Address : 16 MINNOCH CRESCENT
MAYBOLE
AYRSHIRE
KA19 8DW

NHS No. :
Religion : PROTESTANT
D.o.B. : 09 Feb 76 (22yrs) Sex : Male

Ward : Station 2 Surgical (S2)
Consultant : DR MCMILLAN,I. (145)
Specialty : GENERAL SURGERY (GS)
Originator : KERRY BAIRD
Named Nurse:

GP Name : LAU,C (GP)

Address : MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE
KA19 7BY

Admission Date : 26 Feb 98

Planned Discharge Date : -

Dependency as at 11:00 on 28 Feb 98 : 1

==========

: Station 2 Surgical

Assessment sheet : Initial Assessment Sheet

ADMISSION DETAILS: Time of Admission : [10:30] Type of Admission : [Waiting List]
Reason for Admission : [Removal of cyst on neck.]

Previous Medical History : [# R Shaft of femur 1983 - RTA] [Bowel Colic] [Op for cyst on neck age 7yrs.]
[Guillian Barrie Syndrome 1995.] Next of Kin informed of admission : [Yes]

MEDICATION DETAIL: Current Medication : [None] Is patient able to self medicate : [Yes] Own tablets brought into hospital : [No]
Retained on ward : [No]

Sent to Pharmacy for destruction : [No] Sent home with relatives/carers : [No] Mental status : [Alert/Orientated]
If other please state: : [_____]

SOCIAL HISTORY:Does patient live alone : [No] If no with whom does the patient live : [Lives with Fiancee]
Type of housing : [House] If other please state : [_____]

Self Care ? : [Independant]
C nity Services (prior to admission) : [_____]
[_____] [_____]
[_____] [_____]
[_____]
Frequency of services : [_____]

MOBILITY ASSESSMENT : [Unlimited] Walking aids/Equipment : [_____]

SENSORY ASSESS:Hearing : [No problems] Hearing aids with patient : [No] Sight : [No problems]

Speech: Able to communicate : [Yes] If no,state problem : [_____]
[_____]

ocial Worker : [_____]
_____] [_____]
_____]
peech and Language Therapist : [_____]
_____]

eferrals requested from: : [_____]
_____] [_____]
_____] [_____]
_____] Date referrals made : [_____]

BSERVATIONS: Temperature,Pulse,Resps : [T 35.7 P80 rr16] Blood Pressure : [130/90]
rinalysis : [_____] Height : [_____]
eight : [_____]

s' tient a smoker : [Yes] How many a day : [10 day] Any alcohol intake : [Yes] How many units per week : [weekends only.]

nformation obtained from : [Patient]
f no information obtained:state why : [_____]
atient informed of Diagnosis/Treatment : [Yes] Relatives informed/Diagnosis/Treatment : [Yes]

ritten information supplied : [No] If no, why not : [None available]
:ate topic literature relates to : [_____]
_____] [_____]

:ate Pt's perception of diagnosis : [Fully aware] Type of Discharge : [Uncomplicated]

of printout

SOUTH AYRSHIRE HOSPITALS NHS TRUST

Care Plan Print

Printed on 28.02.1998 at 10:15 am

Name : LEE JOHNSTONE (A100544212)

Address : 16 MINNOCH CRESCENT
MAYBOLE
AYRSHIRE
KA19 8DW

NHS No. :
Religion : PROTESTANT
D.o.B. : 09 Feb 76 (22yrs) Sex : Male

Ward : Station 2 Surgical (S2)
Consultant : DR MCMILLAN,I. (145)
Specialty : GENERAL SURGERY (GS)
Current Care Plan Originator : KERRY BAIRD
Named Nurse:

GP Name : LAU,C (GP)

Address : MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE
KA19 7BY

Admission Date : 26 Feb 98

Planned Discharge Date : -

Dependency as at 11:00 on 28 Feb 98 : 1

'em	Action
1. Care of Surgical Wound/Drain - excision of cyst to neck	Daily aseptic wound/drain care Ensure prevention of contamination Ensure correct hand washing technique Prepare/explain procedure to patient Cleanse wound/drain with appropriate soltn Observe wound/drain for signs of infection Collect wound swab for OC&S Apply appropriate dressing to wound/drain Report any abnormalities to Dr
Expected Outcome: Wound will heal fully/free of infection	
Evaluation: Last reviewed on 28.02.1998 for 11:00 Achieved on 28.02.1998	
clips insitu. district nurse to attend at home	
Nurse ID : ROBERTA MCCOLM	

End of printout

SOUTH AYRSHIRE HOSPITALS NHS TRUST

Summary Discharge Plan

Printed on 28.02.98 at 10:15 am

Name	: LEE JOHNSTONE (A100544212)	GP Name	: LAU,C (GP)
Address	: 16 MINNOCH CRESCENT MAYBOLE AYRSHIRE KA19 8DW	Address	: MAYBOLE HEALTH CENTRE 6 HIGH STREET MAYBOLE KA19 7BY
NHS No.	:		
Religion	: PROTESTANT	Admission Date	: 26 Feb 98
D.o.B.	: 09 Feb 76 (22yrs) Sex : Male		
Ward	: Station 2 Surgical (S2)	Planned Discharge Date	: -
Consultant	: DR MCMILLAN,T. (145)		
Specialty	: GENERAL SURGERY (GS)	Dependency as at 11:00 on 28 Feb 98	: 1
Originator	: ALISON MARSHALL		
Named Nurse:			

/Actions

1. Requirements for Discharge

Informed of discharge date	Completed on 28.02.1998 at 10:11
Aware of all follow up care(please state)	Completed on 28.02.1998 at 10:11
Own transport arrangements made	Completed on 28.02.1998 at 10:11

End of printout

SOUTH AYRSHIRE HOSPITALS NHS TRUST

Discharge Plan Print

Printed on 28.02.98 at 10:15 am

Name : LEE JOHNSTONE (A100544212)

Address : 16 MINNOCH CRESCENT
MAYBOLE
AYRSHIRE
KA19 8DW

NHS No. :
Religion : PROTESTANT
D.o.B. : 09 Feb 76 (22yrs) Sex : Male

Ward : Station 2 Surgical (S2)
Consultant : DR MCMILLAN,I. (145)
Specialty : GENERAL SURGERY (GS)
Originator : ALISON MARSHALL
Named Nurse:

GP Name : LAU,C (GP)

Address : MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE
KA19 7BY

Admission Date : 26 Feb 98

Planned Discharge Date : -

Dependency as at 11:00 on 28 Feb 98 : 1

	Actions	Completed By	Date	Time
1. Requirements for Discharge	1. Informed of discharge date	ROBERTA MCCOLM	28.02.98	10:11
	2. Aware of all follow up care(please state)	ROBERTA MCCOLM	28.02.98	10:11
Nurse Id: ALISON MARSHALL	3. Own transport arrangements made	ROBERTA MCCOLM	28.02.98	10:11

End of printout

A100-544212

JOHNSTONE LEE
16 MINNOCH CRESCENT
MAYBOLE 09/02/76
LAU,C (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE M/S

Surname
Forename
Address

.....Hospital

STA0481

Ward/Dep....

INVESTIGATION INSTRUCTION SHEET

DATE	INVESTIGATION REQUIRED	DATE	INVESTIGATION REQUIRED
26-27 2 98	Fasted for theatre		

DATE	WEIGHT	DATE	WEIGHT	DATE	WEIGHT	DATE	WEIGHT	DATE	WEIGHT	DATE	WEIGHT

A100-544212

Surname JOHNSTONE LEE

Forename MAYBOLE 09/02/76

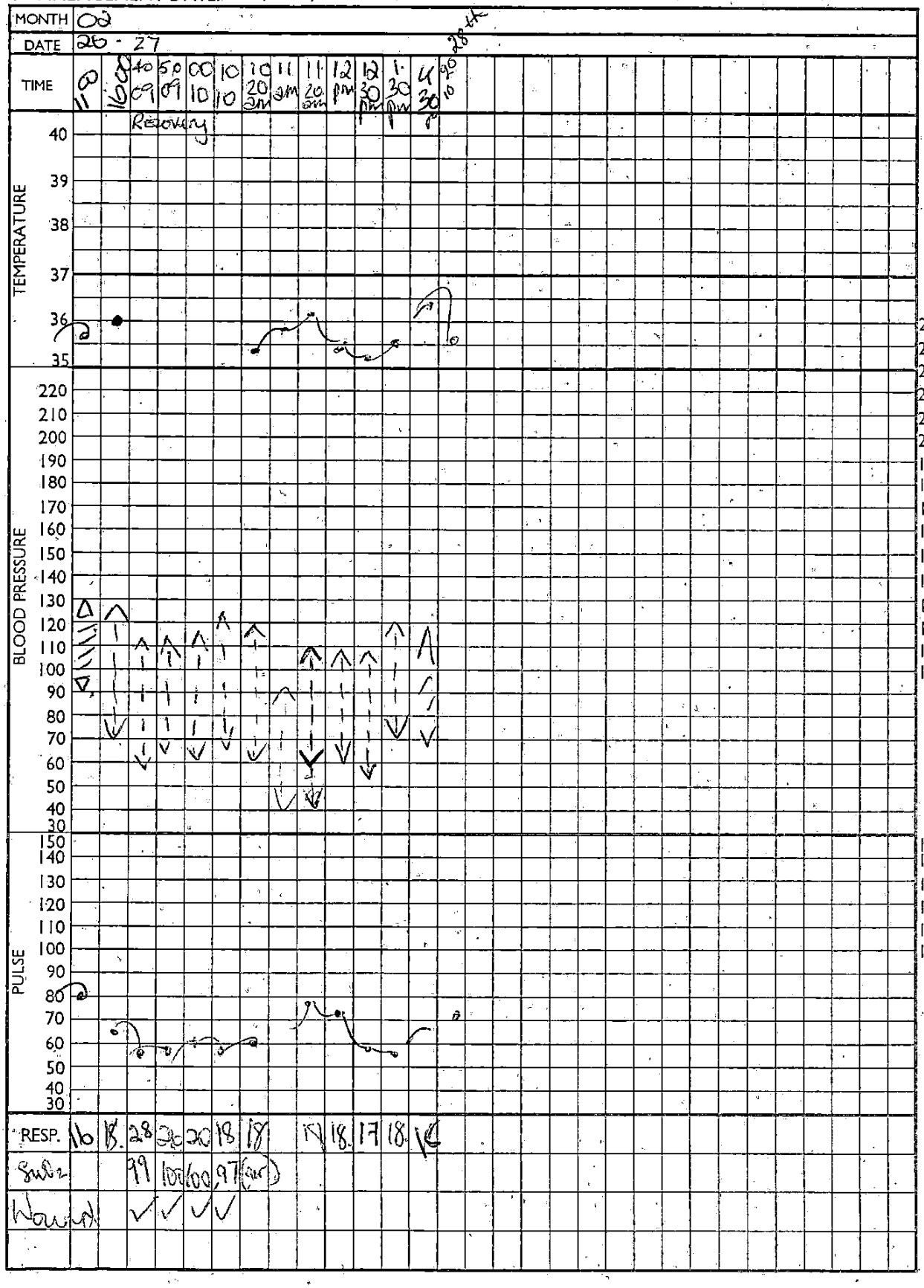
LAU, C (GP)
MAYBOLE HEALTH CENTRE

Address 6 HIGH STREET
MAYBOLE M/S

T.P.R & B.P. CHART

COMMENCEMENT DATE: 26 / 02 / 98

FAN0486 Ward/Dept.



Surname Johnstone Hosp. No. A100 54421

Forenames Lee Sex M

D.O.B.

Address

FAN0386 Ward/Dept.

Fluid Intake and Output Chart

DATE						YESTERDAY'S BALANCE			
	INTAKE (ml)					OUTPUT (ml)			
	ORAL	INTRAVENOUS		OTHER		URINE	STOMACH	BOWEL	DRAINAGE
Time	Amount	Amount	Nature	Amount	Nature	Amount	Amount	Amount	Amount
8									
9									
10									
11									
12									
13						50ml			
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
1									
2									
3									
4									
5									
6									
7									
TOTAL						(a)	(b)	(c)	(d)

INTAKE =	ml	(e) Insensible loss* = **OUTPUT =** (a + b + c + d)	ml
BALANCE = (Intake minus output)	ml		

* Average Adult = 600 ml + 100 ml per each 0.5°C temperature elevation.

SHEET No. .....

MEDICINE PRESCRIPTION SHEET

KEY: O ORAL; IM INTRAMUSCULAR; IV INTRAVENOUS; SC SUBCUTANEOUS; SL SUBLINGUAL; ID INTRADERMAL; INH INHALATION; NEB NEBULISED; PR PER RECTUM; PV PER VAGINA; IT INTRATHECAL

A100-544212

JOHNSTONE LEE
16 MINNOCH CRESCENT
MAYBOLE
LAU, C. (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE

09/02/76

CR No. .....
Sex .....
D.o.B. .....
M/S /Dept. .....

KNOWN SENSITIVITY	
1.	2.

SUSPECTED ADVERSE REACTION	
MEDICINE	ADVERSE EFFECT
1.	
2.	

MEDICINES TO BE GIVEN REGULARLY (BLOCK CAPITALS)

Code STA0235

PHARM.	Date Commenced	APPROVED NAME OF MEDICINE	DOSE	TIMES OF ADMINISTRATION										OTHER		ROUTE (see key)	OTHER INSTRUCTIONS	DOCTOR'S SIGNATURE	DISCONTINUED	
				6 am	8 am	10 am	12 md	2 pm	6 pm	8 pm	10 pm	12 mn							DATE	INITIAL
A	27/2/98	MORPHINE	10MG													IM	3h for pain	D A Hyde		
B	27/2	STEMETIL	12.5MG													IM	6h for nausea	D A Hyde		
C	27/2	PARACETAMOL	1G													O	6h for pain	D A Hyde		
D																				
E																				
F																				
G																				
H																				
I																				
J																				
K																				
L																				
M																				
N																				
O																				
P																				
R																				
S																				
T																				
V																				

SHEET No .....

MEDICINE RECORDING SHEET

Name Lee Johnstone

Age .....

Consultant Dr Bicknell

Hospital AyR

Enter code in box and initial when medicine is taken.

If medicine refused record (A) If patient unable to swallow record A

If patient absent record A If medicine not available record A

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
11/4/95								B		A (A) 7pm CP
								11p		
	Init.							Dr		
12/4/95		B								Bat 11.15pm
	Init.	Dr								VP
13/4/95										A A B at (A) at 8.45 11pm 3.15 pm SPH
	Init.									LP AT CS
14/4/95		A		B						B at 8pm RB
	Init.	BM		RT						
15/4/95				B						
	Init.			BM						
	Init.									
	Init.									
	Init.									

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

X52 failed + phoned

South Ayrshire Hospitals National Health Service Trust

THE AYR HOSPITAL

883921

DISTRICT NURSE REFERRAL FORM

Addressog: A100-544212
JOHNSTONE LEE
16 MINNOCH CRESCENT
MAYBOLE 09/02/76
LAU, C (GP)
MAYBOLE HEALTH CENTRE
6 HIGH STREET
MAYBOLE M/S

Consultant:

D of A: 26/2/98 D of D: 28/2/98

Next of Kin: MR A JOHNSTONE

Address: 16 MINNOCH CRESCENT

Tel No: MAYBOLE 01655 889536

Diagnosis:

Treatment in Hospital:

EXCISION of THYROGLOSSAL CYST 27/2/98
CLIPS TO WOUND

Suggested Treatment on Discharge:

WOUND ASSESSMENT
REMOVAL of CLIPS APPROX. 6/3/98

Patient/Family Awareness:

AWARE

Drug Therapy:

PARACETAMOL

Services Required:

DISTRICT NURSE

Ability Assessment:

Additional Information:

Follow-up Appointment: 4/52 O/P/A MR McMILLANS CLINIC

Ward Staff:

NURSING ASSESSMENT

Surname: Johnstone Hosp. No.
Forenames: Lee Sex: M
D.O.B. 9/2/76
Address: 16 Minnoch Crescent Maybole
FAN 0986 Ward/Dept: 8

Date of admission: 11/4/95 Time: 1.45am.
Type of admission: Emergency.
Accompanied by: S/n & Porter.
From where: A+E Dept.
PATIENT'S OCCUPATION: Unemployed.
MARITAL STATUS: Single.
Dependants - children Ages:
- others

Living alone?
(1) NO - with whom? ✓ with parents.
(2) YES - any supportive help?

RELIGION: Prot.
Seen by Minister/Priest

NEXT OF KIN: Mr & Mrs Johnstone.
Relationship: Parents.
Address: 16. Minnoch Crescent. Maybole.
Home phone no.: 0655 889536.
Work phone no.: Wellkelly House
ALTERNATIVE NEXT OF KIN: Mrs McMillan
Relationship: gran.
Address: * Parents both out at work during day - phone gran
Phone no.: 0655 882762.

REASON FOR THIS ADMISSION
Difficulty walking.
Weakness lower limbs.

PATIENT'S ACCOUNT OF ILLNESS
Has had weakness of (R) leg for past 3 weeks. and has now developed weakness and sensory loss of both feet.

PREVIOUS HEALTH PROBLEMS
Was investigated by orthopaedic staff 4 days ago.

SPECIAL VISITING NEEDS

SPECIAL NEEDS AT HOME
- housing
- social
- other

DRUGS USED BEFORE ADMISSION
Co proxamol
Brufen.

ALLERGIES
None known.

TAKEN FOR SAFEKEEPING RETURNED

Property checked YES NO
Valuables in hospital safe YES NO

NURSING ASSESSMENT

1. **Capable of self care** YES ✓ NO

2. **Communicating**
   - Vision - any problems? none.
   - spectacles?
   - contact lenses?
   - Hearing - any problems? none -
   - hearing aid?
   - battery type?
   - Speech difficulty YES NO ✓

3. **Mobility** - independent? ✓ normally
   - with assistance?
   - remarks.

4. **Eating and drinking**
   - appetite? fair
   - special diet?
   - dislikes?
   - assistance needed YES NO ✓

5. **Personal cleaning and dressing**
   - independent? ✓ normally.
   - with assistance?
   - remarks.

6. **Bladder and Bowels** - any problems? usually none.
   - special needs? but required to be catheterised 2/2.

7. **Sleeping** - pattern
   - what helps? good.

8. **Recreational interests**

9. **Other relevant information**

GENERAL APPEARANCE/CONDITION

Well looking man. but has some difficulty moving around bed

GENERAL OBSERVATIONS

T 36.8 P 88 R 20 B/P 132/70.

Height: Weight: Norton score:

Urine: PH 6.0. 5.9 - 1000 + blood + bilirubin.

SKIN INSPECTION intact.

ORAL INSPECTION clean - dry

Condition of mouth:

Condition of teeth:

Dentures: Upper Lower Partial

Crown:

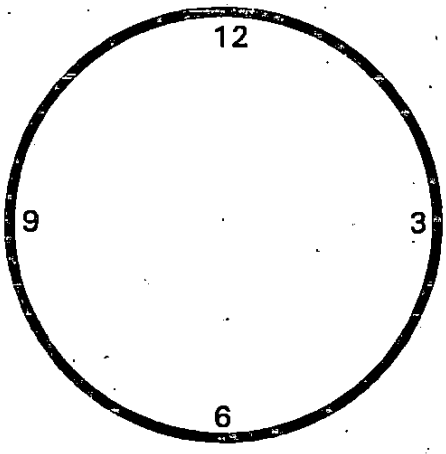
Any problems?

DISCHARGE/FUTURE PLANS	Date ordered	Date given	Sign
Education of condition/ limitations/ rehabilitation			
(a) Patient			
(b) Relatives			
Discharge medications			
Warfarin Steroid/ Tetanus card			
Transport home			
Out-patient appointment			
Walking stick/crutches			
Dressings:			
Other:			
Community nursing			
Home help			
Meals on wheels			
Social worker			
Physiotherapy			
Occupational Therapy			
Speech Therapy			
Geriatric waiting list			
Sheltered housing			
Other:			

Code STA0485

Mr L: Johnstone.

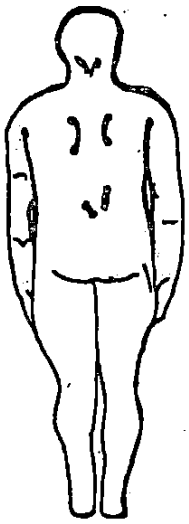
POSITIONAL CLOCK



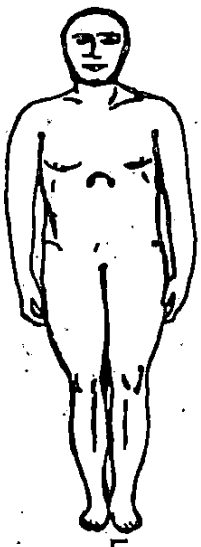
Encourage position, change regularly.

Pressure Area Information

Norton Scale Rating : 11 AT RISK



B



F

Surname ..... HCR No. .....

Forenames ..... Sex .....

Address ..... D.O.B .....

.....

Ward or Dept .....

START DATE			A.M.				P.M.				
			6	8	10	12	2	6	8	10	12
A											
B											
C											
D											
E											
F											
G											
H											
I											
J											
K											
L											
M											
N											
O											
P											
Q											
R											
S											

Activity of Daily Living

STA0938

WRITE, IMPRINT OR ATTACH LABEL

Surname: Johnstone HCR No:

Forenames: Lee Sex: M

Address: D.O.B.: 9/2/76

Ward or Dept: F

Assessment Date

MAINTAINING A SAFE ENVIRONMENT	Patient / Nurse Call System advised.
BEHAVIOUR	No problems.
COMMUNICATION	No problems.
BREATHING	No problems.
EATING/DRINKING	No problems.
ELIMINATING	Required catheterisation on admission. Because of urinary retention.
PERSONAL CLEANLINESS/ DRESSING	Bed bath / Assist ward

CONTROL OF BODY TEMPERATURE	4 hourly T.P.R - and BP. Neurological obs.
MOBILISING	Bed-rest.
WORKING AND PLAYING	
EXPRESSING SEXUALITY	Ensure privacy
SLEEPING	No problems.
FINANCE	Not discussed.
DYING	Not discussed.

FAN01E

NURSING CARE PLAN

Surname Johnstone Hosp. No.
Forenames Shea Sex M
D.O.B. 9/2/76
Address
Ward/Dept. 8

Date	Patient's Problem Identified Need	Aim of Nursing Care—Nursing Action	Review Date	AIM Met	AIM Not Met	Signature
11/4/95	Investigation of weakness of leg + arm weakness in legs + Arms ? Guillane Barrie Syndrome	Aim TO find Cause of leg + arm weakness				Rhan
		1) 1hrly B/P and T.P.R.	8/4/95			
		2) 2hrly peek Flows unless deterioration then hrly	8/4/95			
		3) Explain lumbar puncture	11/4/95	✓		Rhan
		4) ensure observation carried out ½ hrly then 1hrly after lumbar puncture	11/4/95	✓	✓	Rhan
		5) Ensure aseptic technique used.	11/4/95	✓		Rhan
		6) Explain what Guillane Barrie Syndrome is	11/4/95			
		7) Answer any question that Lee & wishes to ask	12/4/95			

FAN0186

NURSING CARE PLAN

Surname ..... Hosp. No. .....

Forenames ..... Sex .....

..... D.O.B. .....

Address .....

.....

Ward/Dept. .....

Date	Patient's Problem Identified Need	Aim of Nursing Care—Nursing Action	Review Date	AIM		Signature
				Met	Not Met	

FAN1286

Surname Johnstone Hosp. No.

Forenames Lee Sex M

D.O.B. 9/2/76

Address

Ward/Dept. 8L

NURSING NOTES

DATE	
11/4/95	Ward E/A at 1.30am via A&E Dept. Developed weakness of lower limbs 3 weekends - attended orthopaedic dept last week - who said patient had disc problems, but over past 24 hours - this has developed sensory loss to both lower limbs and has been unable to pass urine. Catheterised in A&E Dept. C.T. scan performed - negative. Lumbar puncture attempted but unsuccessful - to be rescheduled this am. C/O loosing all limbs but lower limbs weaker. IV fluids in progress. Has slept for very spells. Neurological obs as charted. Bladder drainage satis. Jhyce
7-30 10pm	settled, Complained of headache this morning but settled. S/B Dr Bicknell lumbar puncture Carried out observation satisfactory For vital Capacity test, to have peak flow RMcm
	Observations satisfactory, has passed urine MMcNulty
9 30 p	C/O symptoms increasing, reviewed by Dr Nixon continue treatment NBM. on pulse oximetry. (MMcN)
12/4/95	10-7am. Complained of back pain - quite upset. Seen by Dr - DF118 30mg orally at 11p.m and settled and slept well. IV fluids running behind time. Observations as charted. Passing urine well - Jhyce Loosing all limbs although legs weak.

DATE	
7-3[10]pm.	Assisted wash given remains slightly more breathless. peak flows being checked 2hrly for transfer to Glasgow Southern general Hospital Ward 62 Ambulance arranged To have Vital Capacity checked again this afternoon.
2-10[10]PM	Became extremely breathless at 3[30]pm. PEFR 280 - doctor informed. O2 therapy at 5L given - PEFR now 500. Lee expressed concern about going to SGH tomorrow, saying he did not wish to go, Dr Hartmann spoke to Lee, and said that Dr Metcalfe would speak to him tomorrow morning. Peak flows remain good - as charted.
13/4/95	10pm - 7am A bit anxious this evening, spoken to by nurse, has agreed to go to Glasgow. Slept for long spells. M. Boyd
7-3[10]PM	Lee informed nursing staff that he did not wish to go to SGH. Spoken to by nursing staff, Dr Metcalfe, Dr Nixon, Dr Hartmann and Dr Gemmell but still refused to go. Southern general telephoned re: decision. Immersion bath given this morning. O2 therapy at 5L taken as required PEFR's remain good
2-10[10]pm	Continues on Oxygen therapy PEFR's remain good. observations as charted still refusing to go to Southern general.

FAN1286

Surname JOHNSTONE Hosp. No. .....

Forenames LEE Sex M

D.O.B. 9/2/76

Address 16 MINNOCH CRES
MAYBOLE

Ward/Dept. St. 8

NURSING NOTES

DATE	
	unless his girlfriend can go with him
	weakness in arms more marked. A Nixon
nocte 14/4/95	Condition as before. Girlfriend stayed overnight. Appeared comfortable. Complaining of back pain. DF118 given 11pm. Settled thereafter. C Boyle
7-3pm	Analgesia given as charted bathed up sitting in parker knoll chair marked weakness in all limbs finding swallowing difficult PEFR 02 record observation as charted to have vital capacity re-checked today C Nixon
2-10pm	Pt as above vital capacity has not been re-checked PEFR as charted. Appeared really upset at times. DF 118 given at 8pm with good effect. He has decided to go to the Southern General tomorrow. Please arrange amb bed. Phone SGeneral
15/4/95	10pm - 7am Settled and slept for long spells. Position changed as desired - M Boyd
12mo.	DF118 at midday for pain. S Milligan
1:30pm.	Transferred to SGH. Ward 62. Relatives aware, Ward 62 informed. M Maclean

DATE	

Surname Johnstone Hosp. No.

Forenames Lee Sex M

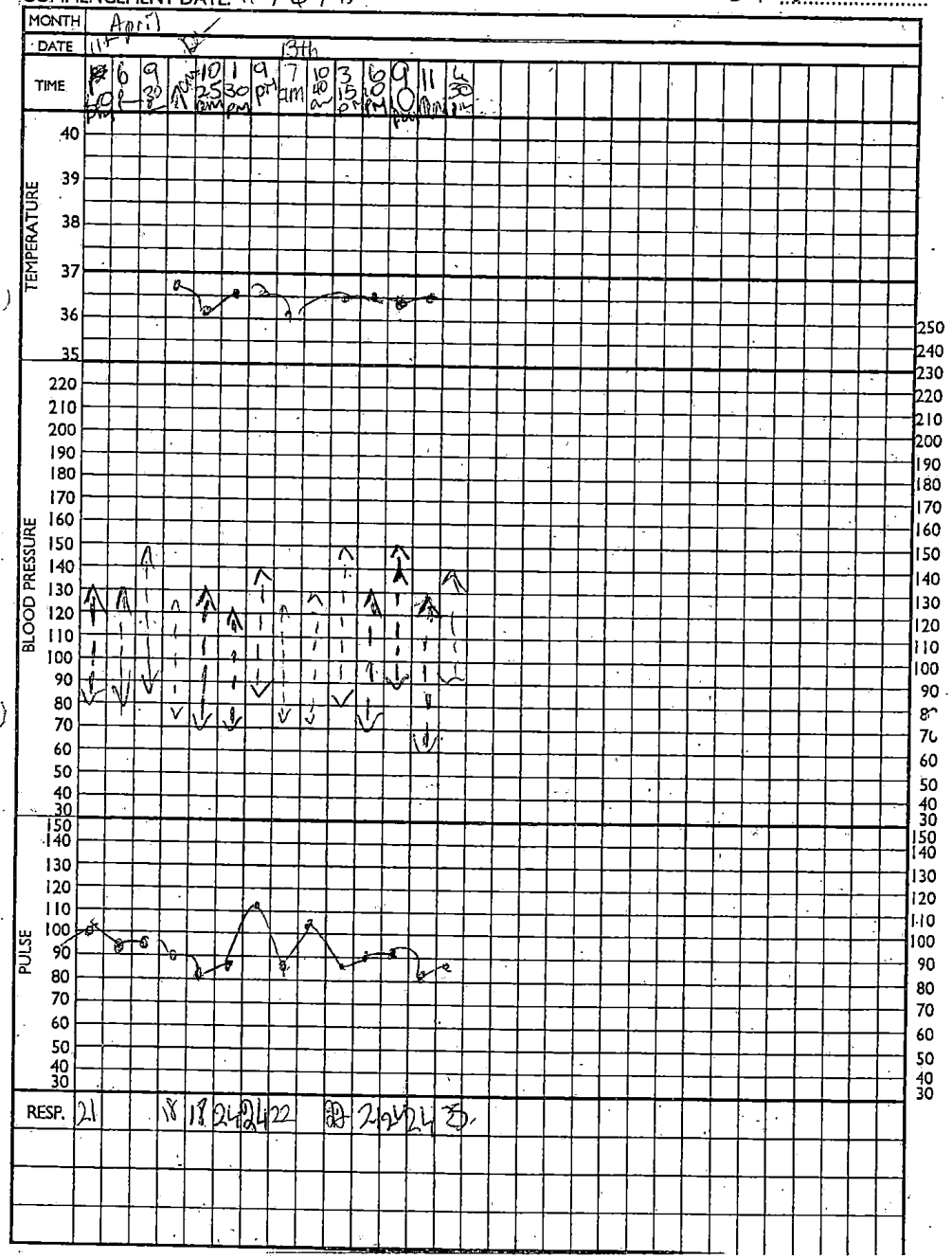
D.O.B. 9/2/76

Address

FAN0486 Ward/~~Dept~~ 8

T.P.R & B.P. CHART

COMMENCEMENT DATE: 11/4/95



Surname ..... Hosp. No. .....

Forenames ..... Sex .....

..... D.O.B. .....

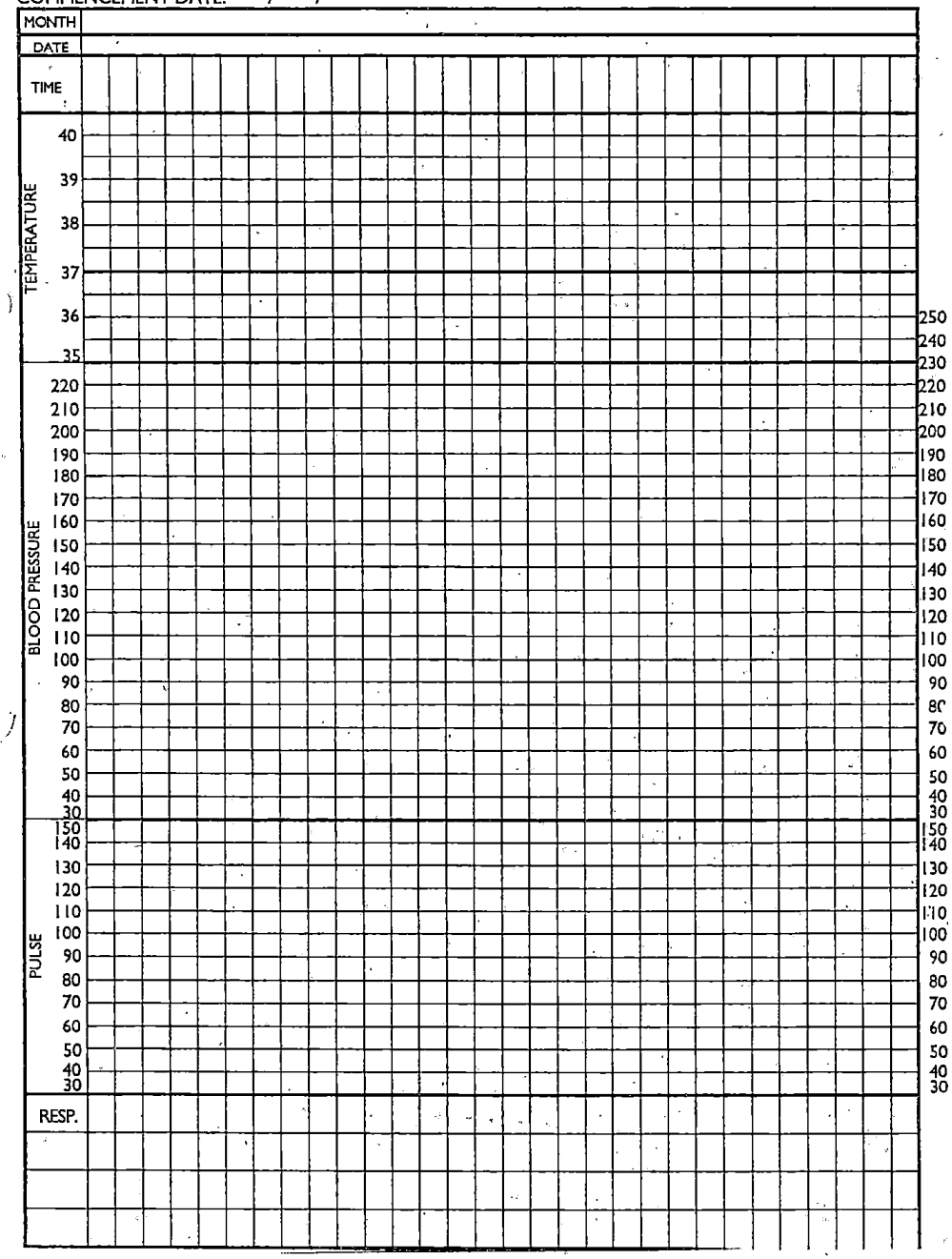
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.....

FAN0486 Ward/Dept. .....

T.P.R & B.P. CHART

COMMENCEMENT DATE: / /



PEAK FLOW RATE

NAME:										
DATE:	12/4/95	13/4	13/4.	14/4						
DRUGS:										

6 10 2 6 10 6 10 2 6 10 6 10 2 6 10 6 10 2 6 10 6 10 2 6 10 6 10 2 6 10 6 10 2 6 10 6 10 2 6 10 6 10 2 6 10 6 10 2 6 10 6 10 2 6 10 6

AM AM

500
400
300
200
100

4PM 12 HS 2p 3:30PM 4:30PM 6pm 7pm 3pm 6PM 9PM 11PM 1AM 8PM 5PM

AN5/86

AYRSHIRE AND ARRAN HEALTH BOARD

NEUROLOGICAL OBSERVATION CHART

009124/95
JOHNSTONE LEE
16 MINNOCH CRES
MAYBOLE

Ward/Dept.

KA198DW 0655889536
09/02/1976 MALE

| | | | DATE | 10/4/14 | | |

AYRSHIRE AND ARRAN.
HEALTH BOARD

NEUROLOGICAL OBSERVATION CHART

Surname ..... Hosp. No. .....
Forenames ..... Sex .....
..... D. O. B. .....
Address .....
Ward/Dept. .....

			DATE	DATE
			TIME	TIME
COMA SCALE	Eyes open		Spontaneously	Eyes closed by swelling = C
			To speech	
			To pain	
			None	
	Best verbal response		Orientated	Endotracheal tube or tracheostomy = T
			Confused	
			Inappropriate words	
			Incomprehensible sounds	
			None	
	Best motor response		Obey commands	Normally the best arm response should be recorded
			Localise pain	
			Flexion to pain	
			Extension to pain	
			None	
Pupil scale (m.m.)	1		240	40
			230	
			220	39
	2		210	38
			200	37
	3		190	36
			180	35 Temperature
			170	34 °C
	4	Blood	160	33
		Pressure	150	32
		and	140	31
	5	Pulse	130	30
		Rate	120	
			110	
	6		100	
			90	
	7		80	
			70	
			60	
	8		50	
			40	
			30	
		Respiration	20	
			10	
PUPILS		Right	Size	+ reacts
			Reaction	— no reaction
		Left	Size	c. eye closed
			Reaction	
LIMB MOVEMENT	ARMS		Normal power	Record Right (R) and Left (L) separately if there is a difference between the two sides
			Mild weakness	
			Severe weakness	
			Spastic flexion	
			Extension	
			No response	
	LEGS		Normal power	
			Mild weakness	
			Severe weakness	
			Spastic flexion	
			Extension	
			No response	

FAN0886

Surname JOHNSTONE Hosp. No.

Forenames LEE Sex

D.O.B.

Address

Ward/Dept. 8

I.V. Therapy Prescription Sheet

	DATE	FLUID (USE BLOCK LETTERS) / ADDITIVE DRUG	Vol. (ml) / Dose (mg)	Route of Admin.	Dur. of Admin.*	SIGNATURE	Serial No. Batch No.	Time Begun	Given By / Added By
A	11/4/95	(N) Saline	500	IV	4h	Piper	95B266N	2.30	
B	11/4/95	5% Glucose	500	IV	4h	Piper	95B88 B8N	3.50 pm	SM
C	11/4/95	5% Glucose	500	IV	4h	Piper	9582 8B8	8.20 PM	SM
D	11/4/95	N. SALINE	500	IV	6h				
E									
F									
G									
H									
I									
J									
K									
L									
M									
N									
O									

RATE OF FLOW (Drops/Min.) = VOL. OF FLUID (ml) x 15 / Duration (Mins.) (1ml = 15 drops)

Approximate Rate for 500 ml.

1 hr. = 120 Drops/min. 6 hr. = 22 Drops/min.
4 hr. = 30 Drops/min. 8 hr. = 15 Drops/min.

3.62

FAN0886

Surname ..... Hosp. No. .....

Forenames ..... Sex .....

..... D.O.B. .....

Address .....

.....

Ward/Dept. .....

I.V. Therapy Prescription Sheet

	DATE	FLUID (USE BLOCK LETTERS) / ADDITIVE DRUG	Vol. (ml) / Dose (mg)	Route of Admin.	Dur. of Admin.*	SIGNATURE	Serial No. Batch No.	Time Begun	Given By / Added By
A									
B									
C									
D									
E									
F									
G									
H									
I									
J									
K									
L									
M									
N									
O									

RATE OF FLOW (Drops/Min.) = **VOL. OF FLUID (ml) x 15** / Duration (Mins.) (1ml = 15 drops)

Approximate Rate for 500 ml.

1 hr. = 120 Drops/min.
4 hr. = 30 Drops/min.
6 hr. = 22 Drops/min.
8 hr. = 15 Drops/min.

6.62

AYRSHIRE and ARRAN HEALTH BOARD

.....Hospital

STA0436

Surname Johnston Ⓓ HCR No.....

Forenames Lee Sex M

Address ..... D.O.B.....

.....

Ward/Dept. .....

Date	Quantity (in 24 hours)	Reaction	Sp. Gr.	Albumen	Blood	Sugar	Bile	Uro-Bilino-gen	Ketones	Other Abnormalities
11/4/95		6	1020	–	+	–	+	–	–	

URINE INVESTIGATION

Date	Quantity (in 24 hours)	Reaction	Sp. Gr.	Albumen	Blood	Sugar	Bile	Uro-Bilino-gen	Ketones	Other Abnormalities

Fluid Intake and Output Chart

Surname Johnstone Hosp. No.

Forenames Lee Sex M

D.O.B.

Address

FAN0386 Ward/Dept 4-

DATE 11/4/95

YESTERDAY'S BALANCE

	INTAKE (ml)					OUTPUT (ml)			
	ORAL	INTRAVENOUS		OTHER		URINE	STOMACH	BOWEL	DRAINAGE
Time	Amount	Amount	Nature	Amount	Nature	Amount	Amount	Amount	Amount
8									
9									
10									
11									
12									
13									
14									
15									
16		500	Dextrose						
17									
18									
19									
20		500	Dextrose.						
21									
22									
23	150 -					200.			
24									
1									
2									
3									
4									
5									
6									
7									
TOTAL						(a)	(b)	(c)	(d)

INTAKE =	ml	(e) Insensible loss* = **OUTPUT =** (a + b + c + d)	ml

BALANCE = (Intake minus output)	ml

* Average Adult = 600 ml + 100 ml per each 0.5°C temperature elevation.

Fluid Intake and Output Chart

Surname Johnstone Hosp. No. .....
Forenames Lee Sex M
..... D.O.B. 9/2/76
Address .....
.....
FAN0386 Ward/Dept. 8

DATE 10/4/95 YESTERDAY'S BALANCE

	INTAKE (ml)					OUTPUT (ml)			
	ORAL	INTRAVENOUS		OTHER		URINE	STOMACH	BOWEL	DRAINAGE
Time	Amount	Amount	Nature	Amount	Nature	Amount	Amount	Amount	Amount
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
1									
2		500	N/Saline 0.9%						
3									
4									
5									
6									
7									
TOTAL						(a)	(b)	(c)	(d)

INTAKE =	ml	(e) Insensible loss* = **OUTPUT =** (a + b + c + d)	ml
BALANCE = (Intake minus output)	ml		

* Average Adult = 600 ml + 100 ml per each 0.5°C temperature elevation.

AYRSHIRE AND ARRAN HEALTH BOARD

NURSING ASSESSMENT

Surname Johnstone Hosp. No.
Forenames Lee Sex M
D.O.B. 9.2.76.
Address 16, Minnoch Cres.
Maybole
FAN 0986 Ward/Dept. St 3

Date of admission: 23/8/93. Time: 2-30am
Type of admission: Emer.
Accompanied by: Girlfriend + Porter.
From where: A/E.
PATIENT'S OCCUPATION:
MARITAL STATUS: Single
Dependants - children Ages:
- others

Living alone?
(1) NO - with whom? Family
(2) YES - any supportive help?

RELIGION: Prot
Seen by Minister/Priest

NEXT OF KIN: Alistair.
Relationship: Father.
Address: S/A.
Home phone no.: Maybole 895536.
Work phone no.:
ALTERNATIVE NEXT OF KIN:
Relationship:
Address:
Phone no.:

REASON FOR THIS ADMISSION
Abdominal Pain

PATIENT'S ACCOUNT OF ILLNESS
Pain started 8pm getting worse

SPECIAL VISITING NEEDS

PREVIOUS HEALTH PROBLEMS
R-TA. - Feb 93.
Bowel Colic - 2yrs ago.

SPECIAL NEEDS AT HOME
- housing
- social
- other

DRUGS USED BEFORE ADMISSION

ALLERGIES
Nil known.

TAKEN FOR SAFEKEEPING RETURNED

Property checked YES NO
Valuables in hospital safe YES NO

NURSING ASSESSMENT

1. **Capable of self care** YES ~~NO~~

2. **Communicating**
   Vision - any problems? No
   - spectacles?
   - contact lenses?
   Hearing - any problems? NO
   - hearing aid?
   - battery type?
   Speech difficulty ~~YES~~ NO

3. **Mobility** - independent? Fully
   - with assistance?
   - remarks.

4. **Eating and drinking**
   - appetite? Good
   - special diet? No
   - dislikes?
   - assistance needed ~~YES~~ NO

5. **Personal cleaning and dressing**
   - independent? Fully
   - with assistance?
   - remarks.

6. **Bladder and Bowels** - any problems? Normal
   - special needs?

7. **Sleeping** - pattern Normal
   - what helps?

8. **Recreational interests**
   Football

9. **Other relevant information**
   Smokes 10 a day
   Occassionally takes alcohol

GENERAL APPEARANCE/CONDITION

GENERAL OBSERVATIONS
T 36.5 P 68 R 20 B/P 140/90

Height: Weight: Norton score:

Urine:

SKIN INSPECTION

ORAL INSPECTION
Condition of mouth:
Condition of teeth:

Dentures: Upper Lower Partial

Crown:

Any problems?

DISCHARGE/FUTURE PLANS	Date ordered	Date given	Sign
Education of condition/ limitations/ rehabilitation (a) Patient (b) Relatives			
Discharge medications			
Warfarin Steroid/ Tetanus card			
Transport home			
Out-patient appointment			
Walking stick/crutches			
Dressings:			
Other:			
Community nursing			
Home help			
Meals on wheels			
Social worker			
Physiotherapy			
Occupational Therapy			
Speech Therapy			
Geriatric waiting list			
Sheltered housing			
Other:			

FAN1286

AYRSHIRE AND ARRAN HEALTH BOARD

NURSING NOTES

Surname Johnstone Hosp. No.

Forenames Lee Sex M

D.O.B. 9.2.76

Address 16, Minnoch Cres

Maybole

Ward/Dept. St 3

DATE	
23.8.93	Emergency admission via Casualty with a history of Abdominal Pain. On admission, observations satisfactory. Not unduly distressed. Seen by Dr to remain nil by mouth meantime, I.V. infusion commenced 4 hrly. A. Hull.
	Patient unkeen to stay in ward. States pain has settled. Took irregular discharge at 4.30am. A. Hull.

DATE

AYRSHIRE AND ARRAN HEALTH BOARD

T.P.R & B.P. CHART

Surname Johnstone Hosp. No. 0

Forenames LEE Sex M

D.O.B. 9.2.76

Address 16 Minnoch Cres

Mayhole.

FAN0486 Ward/Dept. St 3

COMMENCEMENT DATE: 23/8/93

| | | |

AYRSHIRE AND ARRAN HEALTH BOARD

T.P.R & B.P. CHART

Surname ..... Hosp. No. .....

Forenames ..... Sex .....

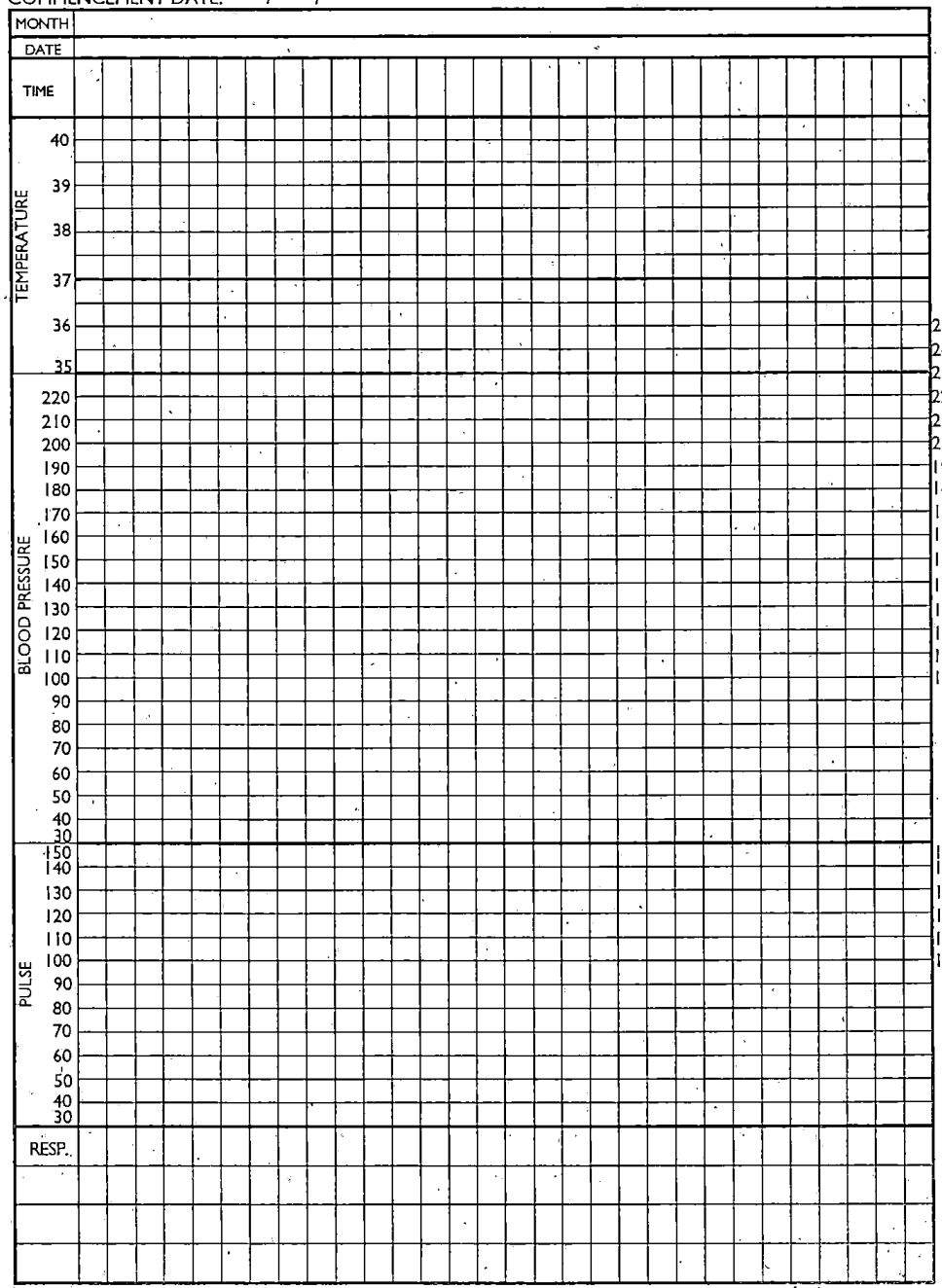
..... D.O.B. .....

Address .....

.....

FAN0486 Ward/Dept. .....

COMMENCEMENT DATE: / /



FANO886

AYRSHIRE AND ARRAN HEALTH BOARD

Surname ..... Hosp. No. .....

Forenames ..... Sex .....

..... D. O. B. .....

Address .....

.....

Ward/Dept. .....

I.V. Therapy Prescription Sheet

	DATE	FLUID (USE BLOCK LETTERS) / ADDITIVE DRUG	Vol. (ml) / Dose (mg)	Route of Admin.	Dur. of Admin.*	SIGNATURE	Serial No. Batch No.	Time Begun	Given By / Added By
A	23/8/93	5% Dextrose	500	IV	4h	D Mackenzie	93F038N	3.10 AM	A Hull
B	23/8/93	5% Dextrose	500	IV	4h	D Mackenzie			
C	23/8/93	0.9% NaCl +20mmol KCl	500	IV	4h	D Mackenzie			
D									
E									
F									
G									
H									
I									
J									
K									
L									
M									
N									
O									

RATE OF FLOW (Drops/Min.) = VOL. OF FLUID (ml) x 15 / Duration (Mins.) (1ml = 15 drops)

6.62

Approximate Rate for 500 ml.

1 hr. = 120 Drops/min.
4 hr. = 30 Drops/min.
6 hr. = 22 Drops/min.
8 hr. = 15 Drops/min.

AYRSHIRE AND ARRAN HEALTH BOARD

Surname ..... Hosp. No. .....

Forenames ..... Sex .....

..... D. O. B. .....

Address .....

.....

Ward/Dept. .....

I.V. Therapy Prescription Sheet

	DATE	FLUID (USE BLOCK LETTERS) / ADDITIVE DRUG	Vol. (ml) / Dose (mg)	Route of Admin.	Dur. of Admin.*	SIGNATURE	Serial No. Batch No.	Time Begun	Given By / Added By
A									
B									
C									
D									
E									
F									
G									
H									
I									
J									
K									
L									
M									
N									
O									

RATE OF FLOW (Drops/Min.) = VOL. OF FLUID (ml) x 15 / Duration (Mins.) (1ml = 15 drops)

.62

Approximate Rate for 500 ml.

1 hr. = 120 Drops/min.
4 hr. = 30 Drops/min.
6 hr. = 22 Drops/min.
8 hr. = 15 Drops/min.

AYRSHIRE AND ARRAN HEALTH BOARD

NURSING ASSESSMENT

Dr Lau (17) (Rogers)

Surname JOHNSTON Hosp. No. A

Forenames LEE Sex MALE

D.O.B. 9.2.76

Address 16 MINNOCH CRESCENT
MAYBOLE

FAN 0986 Ward/Dept. ST WK 3

Date of admission: 7-2-93 Time: 5.30PM

Type of admission: EMERGENCY

Accompanied by: STAFF NURSE & PORTER

From where: ACCIDENT & EMERGENCY

PATIENT'S OCCUPATION:

MARITAL STATUS: SINGLE.

Dependants - children Ages:

- others

Living alone?

(1) NO - with whom?

(2) YES - any supportive help?

RELIGION:

Seen by Minister/Priest

NEXT OF KIN: GEORGINA JOHNSTONE

Relationship: MOTHER

Address: 16 MINNOCH CRESCENT

Home phone no.: 89536

Work phone no.:

ALTERNATIVE NEXT OF KIN:

Relationship:

Address:

Phone no.:

REASON FOR THIS ADMISSION

(A) FLANK & NECK PAIN POST MOTORCYCLE ACCIDENT.
? soft tissue internal injury.

PATIENT'S ACCOUNT OF ILLNESS

AWARE.

RT WRIST.

SPECIAL VISITING NEEDS

PREVIOUS HEALTH PROBLEMS

SPECIAL NEEDS AT HOME

- housing
- social
- other

DRUGS USED BEFORE ADMISSION

ALLERGIES

TAKEN FOR SAFEKEEPING RETURNED

Property checked YES NO

Valuables in hospital safe YES NO

NURSING ASSESSMENT

1. **Capable of self care** YES ~~NO~~
2. **Communicating**
   Vision - any problems?
   - spectacles?
   - contact lenses?
   Hearing - any problems?
   - hearing aid?
   - battery type?
   Speech difficulty YES NO
3. **Mobility** - independent? Funny
   - with assistance?
   - remarks.
4. **Eating and drinking**
   - appetite?
   - special diet?
   - dislikes?
   - assistance needed YES NO
5. **Personal cleaning and dressing**
   - independent? Funny.
   - with assistance?
   - remarks.
6. **Bladder and Bowels** - any problems?
   - special needs?
7. **Sleeping** - pattern
   - what helps?
8. **Recreational interests**
9. **Other relevant information**

GENERAL APPEARANCE/CONDITION
Young Boy. Appears to have slight discomfort in neck on admission.

ST 3 abdominal pain

GENERAL OBSERVATIONS
T 36.7 P 80 R 18 B/P 120/60

Height: Weight: Norton score:

Urine: 1015 SG Ph 7. NAD

SKIN INSPECTION

ORAL INSPECTION
Condition of mouth:
Condition of teeth:

Dentures: Upper Lower Partial

Crown:

Any problems?

DISCHARGE/FUTURE PLANS	Date ordered	Date given	Sign
Education of condition/ limitations/ rehabilitation (a) Patient (b) Relatives			
Discharge medications			
Warfarin Steroid/ Tetanus card			
Transport home			
Out-patient appointment			
Walking stick/crutches			
Dressings:			
Other:			
Community nursing			
Home help			
Meals on wheels			
Social worker			
Physiotherapy			
Occupational Therapy			
Speech Therapy			
Geriatric waiting list			
Sheltered housing			
Other:			

FAN0186

AYRSHIRE AND ARRAN HEALTH BOARD

NURSING CARE PLAN

Surname Johnstone Hosp. No. .....

Forenames LEE Sex .....

..... D.O.B. .....

Address .....

.....

Ward/Dept. .....

Date	Patient's Problem Identified Need	Aim of Nursing Care–Nursing Action	Review Date	AIM Met	AIM Not Met	Signature
9/3/93	Abdominal Pain	Aim / To alleviate pain and ensure patient comfort				
		Action / 1/ Observe pain for site duration and intensity of pain.				
		2/ Give analgesia as prescribed and note for effect.				
		3/ Nil by mouth meantime				
		4/ I.V. infusion Commenced as prescribed				
		5/ Ultrasound arranged				

FAN0186

AYRSHIRE AND ARRAN HEALTH BOARD

NURSING CARE PLAN

Surname ..... Hosp. No. .....

Forenames ..... Sex .....

..... D.O.B. .....

Address .....

.....

Ward/Dept. .....

Date	Patient's Problem Identified Need	Aim of Nursing Care—Nursing Action	Review Date	AIM		Signature
				Met	Not Met	

FAN1286

AYRSHIRE AND ARRAN HEALTH BOARD

Surname JOHNSTONE Hosp. No. .....
Forenames LEE Sex MALE
..... D.O.B. 9.2.76
Address 16 MINNOCH CRESCENT
MAYBOLE
Ward/Dept. 16 STB

NURSING NOTES

DATE	
8.9.7:298 @ 1730	Admitted via Accident and Emergency department of 17 year old boy who was pillion passenger on a motorbike involved in an accident. Thrown clear. Complaining of neck and flank pain Seen by surgeons no action taken admitted to short stay for overnight observation — J Patrick
pm	Settled well into ward, taking fluids and diet well — J Patrick
9.2-93	Slept for short spells only
10-	(L) sided abdominal pain persists, Dr informed 2 co-prox ē effect. Observations stable. Taking diet + fluids NM
AM	Seen by Doctor McDonald this morning to be transferred to Station 3. for further investigations into persistant pain. ? ultra sound. — J Patrick
pm	Tranferred from short stay. settled unto ward. complaining of discomfort in abdomen & leg
8/9.293	Analgesia for pain @ 10pm. Complained of nausea & discomfort. Dr. informed, patient settled without further treatment.
	BP 90/58 this am
7a 2p	Settled man O. Up is shower. Dull abdominal ache persists. C/O pain in front lt. leg - knee & ankle - bears weight bearing. Analgesia given as prescribed. Remains rested for rest

DATE	
	Seen by orthopaedic registrar re: leg will be reviewed later To X-ray for ultra-sound.
	I.V. infusion commenced. c/o nausea following diet. A. Hall
9/10-2-93	c/o discomfort, S/B Dr. Korsah, I/V fluids cont'd 4hrly. Repeat Abdo/Chest X-rays taken. To remain N.B.M. meantime. For further investigation. J Blair
7am-2pm	Seen by Dr + Physiotherapist. For discharge home tonight. A Hall
pm.	S/B orthopaedic doctor this p.m. To be reviewed at fracture clinic on Friday at 1025am. Lee is aware of this. Adams
5.30pm	Lee has vomited x 2 this pm. - possibly "fizzy drinks". c/o abdominal discomfort. Seen by R. Shot for discharge tonight. Results only to be on C. Parents informed. E Ward
10/11-2-93	Vomited small amount of ? blood streaked fluid, +ve for blood on testing. continues to complain of left sided abdominal discomfort.
130 am	Complaining of left sided abdominal pain more severe than earlier. Observations within normal limits. Examined by Dr. Rees, no guarding, continue to observe, reassured. Complained of feeling hot, temperature 36°C, requested fan. Settled to sleep. J. M'Clements
7am-3pm	Still complaining of abdominal Pain (L) sided and vomiting. Seen by Dr. To remain in ward overnight and to

FAN1286

AYRSHIRE AND ARRAN HEALTH BOARD

Surname Johnston Hosp. No.
Forenames LEE Sex
D.O.B.
Address
Ward/Dept.

NURSING NOTES

DATE	
	have endoscopy arranged as an outpatient. A. Hull.
3pm 10pm	Settled night. Feeling nauseated tonight. Observations satisfactory. Clear fluids tolerated. Please fast from midnight. E Ward
11/12.2.93	Settled night. Fasted from 12 midnight in preparation for endoscopy. J. McClement
AM.	ambulant on crutches. Seen by Mr Large at orthopaedic clinic. No fracture seen. Referral made to physio re ultrasound treatment of bruising. Repeat clinic appointment 1/12 time.
4pm.	Seen by Mr Stewart for review in surgical clinic in 8 weeks. appointment made. Discharged home. A. Hull.

DATE

AYRSHIRE and ARRAN HEALTH BOARD

AYR Hospital

STA0481

Surname Johnstone HCR No.

Forename Lee Sex

Address D.O.B.

Ward/Dept ST3

INVESTIGATION INSTRUCTION SHEET

DATE	INVESTIGATION REQUIRED	DATE	INVESTIGATION REQUIRED
	baseline obs ✓		
	MSU ✓		
	Ward spec ✓		
9/2.	ultrasound ☑		
	Orthopaedic Opinion ☑		
11/2.	Seen by Dr KELLY		
?	Home - Tom.		
	FRACTURE Clinic FRI. 10.25AM		
	ENDOSCOPY AS OPA.		

DATE	WEIGHT	DATE	WEIGHT	DATE	WEIGHT	DATE	WEIGHT	DATE	WEIGHT	DATE	WEIGHT

DATE	INVESTIGATION REQUIRED	DATE	INVESTIGATION REQUIRED

AYRSHIRE AND ARRAN HEALTH BOARD

T.P.R & B.P. CHART

Surname JOHNSTONE Hosp. No. .....

Forenames LEE Sex .....

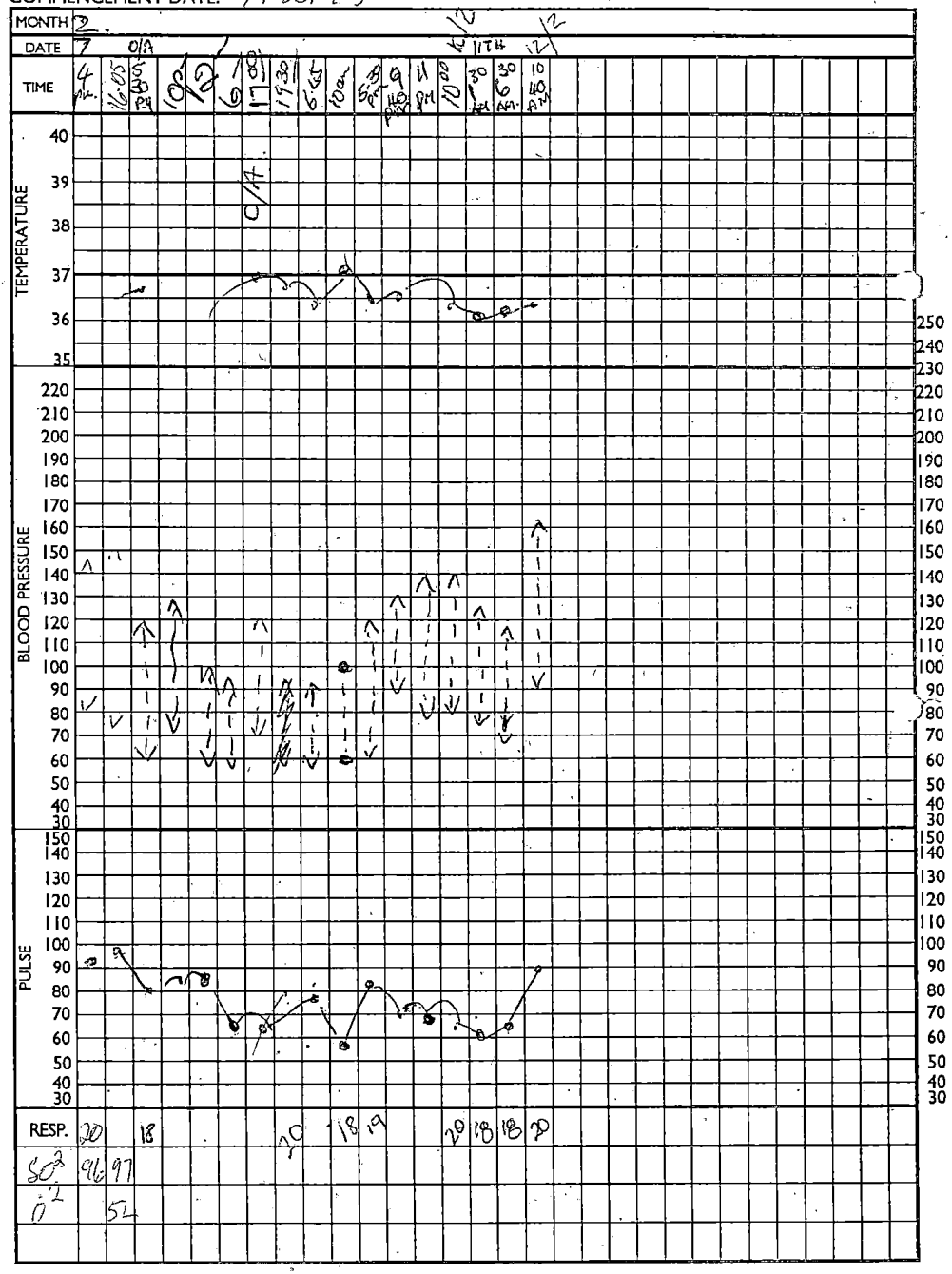
..... D.O.B. .....

Address .....

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FAN0486 Ward/Dept. .....

COMMENCEMENT DATE: 7/2/93



AYRSHIRE AND ARRAN HEALTH BOARD

T.P.R & B.P. CHART

Surname ..... Hosp. No. .....

Forenames ..... Sex .....

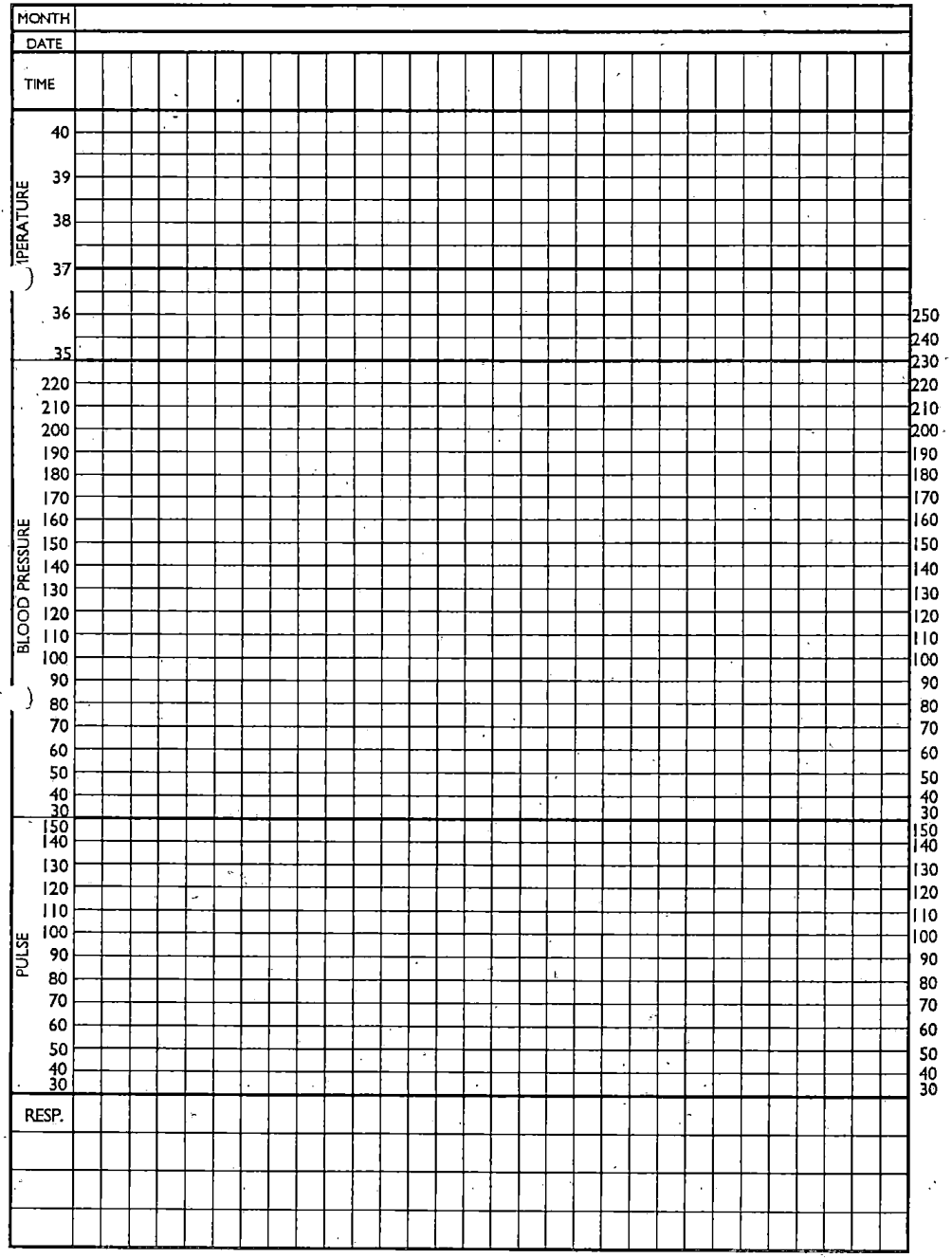
..... D.O.B. .....

Address .....

.....

FAN0486 Ward/Dept. .....

COMMENCEMENT DATE: / /



AN 3/86

AYRSHIRE AND ARRAN HEALTH BOARD

Fluid Intake and Output Chart

Surname Johnstone Hosp. No.

Forenames Lee Sex

D. O. B.

Address

Ward/Dept. ST3

DATE 9/2/93. YESTERDAY'S BALANCE

	INTAKE (ml)					OUTPUT (ml)			
	ORAL	INTRAVENOUS		OTHER		URINE	STOMACH	BOWEL	DRAINAGE
Time	Amount	Amount	Nature	Amount	Nature	Amount	Amount	Amount	Amount
8									
9									
10									
11									
12									
13									
14						100			
15									
16									
17		500	N|SAL.						
18									
19									
20						To			
21									
22		~~500~~	~~5% Dex~~			L			
23						KT			
24		500	5% DEX.						
1									
2									
3									
4		500	N|SALINE						
5									
6									
7									
TOTAL		1500				(a) 7	(b)	(c)	(d)

INTAKE = 1500 ml

(e) Insensible loss* = 600

OUTPUT = (a + b + c + d) ml

BALANCE = (Intake minus output) ml

* Average Adult = 600 ml + 100 ml per each 0·5°C temperature elevation.

AYRSHIRE AND ARRAN HEALTH BOARD

Fluid Intake and Output Chart

Surname Johnston Hosp. No. .....

Forenames Lee Sex .....

..... D. O. B. .....

Address .....

.....

Ward/Dept. St 3

DATE	10·2·93					YESTERDAY'S BALANCE			
	INTAKE (ml)					OUTPUT (ml)			
	ORAL	INTRAVENOUS		OTHER		URINE	STOMACH	BOWEL	DRAINAGE
Time	Amount	Amount	Nature	Amount	Nature	Amount	Amount	Amount	Amount
8		500	5% Dex						
9									
10						900			
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
1									
2									
3									
4									
5									
6									
7									
TOTAL						(a)	(b)	(c)	(d)

INTAKE =	ml	(e) Insensible loss* = **OUTPUT =** (a + b + c + d)	ml
BALANCE = (Intake minus output)	ml		

* Average Adult = 600 ml + 100 ml per each 0·5°C temperature elevation.

FANO886

AYRSHIRE AND ARRAN HEALTH BOARD

Surname Johnstone Hosp. No. [redacted]

Forenames Lee Sex

D. O. B.

Address

Ward/Dept. 5B

I.V. Therapy Prescription Sheet

	DATE	FLUID (USE BLOCK LETTERS) / ADDITIVE DRUG	Vol. (ml) / Dose (mg)	Route of Admin.	Dur. of Admin.*	SIGNATURE	Serial No. Batch No.	Time Begun	Given By / Added By
A	9/2/93	(N) saline	500	IV	4 Hrs	J Shalaw.	92K 25BS	5-10 pm	A.H
B	9/2/93	5% Dextrose.	500	IV	4 Hrs	J Shalaw.	9200 2BM	~~10-30~~ 12a/n	JH2
C	9/2/93	(N) saline	500	IV	4 Hrs	J Shalaw.	92K 25BS	4.15 am	JH
D		5% Dextrose	500	IV	4	P. Korsah	90K0 2BM.	7.20 AM	AH
E		5% Dextrose	500	IV	4	P. Korsah			
F									
G									
H									
I									
J									
K									
L									
M									
N									
O									

RATE OF FLOW (Drops/Min.) = VOL. OF FLUID (ml) x 15 / Duration (Mins.) (1ml = 15 drops)

6.62

Approximate Rate for 500 ml.

1 hr. = 120 Drops/min. 6 hr. = 22 Drops/min.
4 hr. = 30 Drops/min. 8 hr. = 15 Drops/min.

AYRSHIRE AND ARRAN HEALTH BOARD

Surname ..... Hosp. No. .....

Forenames ..... Sex .....

..... D. O. B. .....

Address .....

.....

Ward/Dept. .....

I.V. Therapy Prescription Sheet

	DATE	FLUID (USE BLOCK LETTERS) / ADDITIVE DRUG	Vol. (ml) / Dose (mg)	Route of Admin.	Dur. of Admin.*	SIGNATURE	Serial No. Batch No.	Time Begun	Given By / Added By
A									
B									
C									
D									
E									
F									
G									
H									
I									
J									
K									
L									
M									
N									
O									

RATE OF FLOW (Drops/Min.) = VOL. OF FLUID (ml) x 15 / Duration (Mins.) (1ml = 15 drops)

6.62

Approximate Rate for 500 ml.

1 hr. = 120 Drops/min. 6 hr. = 22 Drops/min.
4 hr. = 30 Drops/min. 8 hr. = 15 Drops/min.

SHEET No. .....

MEDICINE PRESCRIPTION SHEET

KEY: O ORAL; IM INTRAMUSCULAR; IV INTRAVENOUS; SC SUBCUTANEOUS; SL SUBLINGUAL; ID INTRADERMAL; INH INHALATION; NEB NEBULISED; PR PER RECTUM; PV PER VAGINA; IT INTRATHECAL

Write, Imprint, or attach label

Surname JOHNSTONE HCR No. .....

Forenames LEE Sex .....

..... D.o.B. .....

Address .....

..... Ward/Dept. .....

KNOWN SENSITIVITY

1. 2.

SUSPECTED ADVERSE REACTION

MEDICINE	ADVERSE EFFECT
1.	
2.	

MEDICINES TO BE GIVEN REGULARLY (BLOCK CAPITALS)

Code STA0236

PHARM.	Date Commenced	APPROVED NAME OF MEDICINE	DOSE	TIMES OF ADMINISTRATION: 6 am	8 am	10 am	12 md	2 pm	6 pm	8 pm	10 pm	12 mn	OTHER		ROUTE (see key)	OTHER INSTRUCTIONS	DOCTOR'S SIGNATURE	DISCONTINUED: DATE	INITIALS
A	8/2/93	CO-PROXAMOL	1-2 cap				4-6 hrly								O	* max 8 daily			
B	11/2/93	METOCLOPRAMIDE	10 mg	4-6	hrly		as	req'd	for	nausea/	vomiting				O				
C																			
D																			
E																			
F																			
G																			
H																			
I																			
J																			
K																			
L																			
M																			
N																			
O																			
P																			
R																			
S																			
T																			
V																			

MEDICINES TO BE GIVEN ONCE (BLOCK CAPITALS)

PHARM.	TO BE GIVEN		APPROVED NAME OF MEDICINE	DOSE	ROUTE (see key)	DOCTOR'S SIGNATURE	GIVEN BY	TIME GIVEN
	DATE	TIME						

SHEET No .....

MEDICINE RECORDING SHEET

Name .....

Age .....

Consultant .....

Hospital .....

Enter code in box and initial when medicine is taken.

If medicine refused record (A) If patient unable to swallow record A

If patient absent record A If medicine not available record X

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
7/2/93								A		
	Init.							AMH		
8/2/93		A						A		Aat 2.30 AMH
	Init.	AP						AD.		
9/2/93			a 10.20							
	Init.		EE.							
10/3/93										Actl/Cary (JP)
	Init.									
11/3/93										A 1/25 RBM (JP)
	Init.									
	Init.									
	Init.									
	Init.									

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

SHEET No .....

MEDICINE RECORDING SHEET

Name .....

Age .....

Consultant .....

Hospital .....

Enter code in box and initial when medicine is taken.

If medicine refused record (A) If patient unable to swallow record A

If patient absent record A If medicine not available record A

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

AYRSHIRE AND ARRAN HEALTH BOARD

NURSING ASSESSMENT

Surname Johnstone Hosp. No. [redacted]
Forenames Lee Sex Male
D.O.B. 9/2/76
Address 16 Monash Cres
Maybole
FAN 0986 Ward/Dept. SN4

Date of admission: 13/12/92 Time: 12-30
Type of admission: Emergency
Accompanied by: Friend.
From where: Home.
PATIENT'S OCCUPATION:
MARITAL STATUS: Single.
Dependants - children Ages:
- others

iving alone?
(1) NO - with whom? Mum & Dad
(2) YES - any supportive help?

RELIGION: Prot.
Seen by Minister/Priest

NEXT OF KIN: ALISTAIR
Relationship: Father.
Address: S/A
Home phone no.:
Work phone no.:
ALTERNATIVE NEXT OF KIN:
Relationship:
Address:
Phone no.:

REASON FOR THIS ADMISSION
Rectal Bleeding.

PATIENT'S ACCOUNT OF ILLNESS

SPECIAL VISITING NEEDS

PREVIOUS HEALTH PROBLEMS
None # Leg.
Abscess throat.

SPECIAL NEEDS AT HOME
- housing
- social
- other

DRUGS USED BEFORE ADMISSION
None.

ALLERGIES
None known.

TAKEN FOR SAFEKEEPING RETURNED

Property checked YES NO
Valuables in hospital safe YES NO

NURSING ASSESSMENT

1. **Capable of self care** YES ✓ NO

2. **Communicating**
   Vision - any problems? None.
   - spectacles?
   - contact lenses?
   Hearing - any problems? None
   - hearing aid?
   - battery type?
   Speech difficulty YES NO ✓

3. **Mobility** - independent? ✓
   - with assistance?
   - remarks.

4. **Eating and drinking**
   - appetite?
   - special diet?
   - dislikes?
   - assistance needed YES NO

5. **Personal cleaning and dressing**
   - independent? ✓
   - with assistance?
   - remarks.

6. **Bladder and Bowels** - any problems? Rectal Bleeding.
   - special needs?

7. **Sleeping** - pattern
   - what helps?

8. **Recreational interests**

9. **Other relevant information**

GENERAL APPEARANCE/CONDITION

GENERAL OBSERVATIONS

T P R B/P

Height: Weight: Norton score:

Urine:

SKIN INSPECTION

ORAL INSPECTION

Condition of mouth:
Condition of teeth:

Dentures: Upper Lower Partial)

Crown:

Any problems?

DISCHARGE/FUTURE PLANS	Date ordered	Date given	Sign
Education of condition/ limitations/ rehabilitation (a) Patient (b) Relatives			
Discharge medications			
Warfarin Steroid/ Tetanus card			
Transport home			
Out-patient appointment			
Walking stick/crutches			
Dressings:			
Other:			
Community nursing			
Home help			
Meals on wheels			
Social worker			
Physiotherapy			
Occupational Therapy			
Speech Therapy			
Geriatric waiting list			
Sheltered housing			
Other:			

FAN1286

AYRSHIRE AND ARRAN HEALTH BOARD

Surname Johnstone Hosp. No.
Forenames Lee Sex Male
D.O.B. 9/2/76
Address 16 Minnoch Cres
Maybole
Ward/Dept. ST

NURSING NOTES

DATE	
13/12/92	Admitted for observation after having rectal bleeding. To be referred to G.P. Feeling sick and dizzy. Has been drinking - litre or more of cider. Abdo. Vomited small amount. Settled & slept well No further bleeding Rolly
11am	Seen by Dr Madden, discharged home with referral back to G.P re: rectal bleeding. No further bleeding noted this morning. S Leask

DATE	

Inpatient prescription & administration record for JOHNSTONE, Lee David (CHI: 0902763334).

NHS Ayrshire & Arran
02:02
28/06/24

Patient Demographics

JOHNSTONE, Lee David (CHI: 0902763334)
DOB: 09/02/1976
12 Woodside Avenue, Kirkmichael,
Maybole,
Ayrshire,
KA19 7PP

GP details

Barr, Dr. M,
Maybole Health Centre,
6 High Street,
Maybole,
KA19 7BY

Admitted: 20/06/2024 17:21:00
Discharged: 27/06/2024

Transfer history

Admission	2024-06-20 1	ACAU PRE-ADMIT
Transfer	2024-06-21 1	ACAU INPATIENT
Transfer	2024-06-26 0	STATION 8-AYR

Responsible Consultant history

Dr David Sword	20/06/24	17:21
Dr Syed Navab Haider	24/06/24	10:59
Dr David Sword	26/06/24	08:25
Dr Anur Guhan	27/06/24	09:26

Current recorded allergy (reaction): citalopram (Unknown)

Regular Medication Orders

CHLORPHENAMINE 4 mg Tablets (CHLORPHENIRAMINE)

20/06/24 22:00 4 mg FOUR times daily - 7am;1pm;6pm;10pm (Oral) — DR DHANUSH KODALI

20/06/24	22:00	20/06/2024	21:51	NURSE CHLOE LONGAIR
21/06/24	07:00	21/06/2024	06:07	NURSE CHLOE LONGAIR
21/06/24	13:00	Drug discontinued		MRS MARION HAMILTON (PIP)

Discontinued on: 21/06/2024 15:06 by: MRS MARION HAMILTON (PIP) . Reason: Formulation/Route Change

DALTEPARIN 5000 units in 0.2mL Pre-Filled Syringe

21/06/24 12:00 5,000 unit ONCE daily at midday (Subcutaneous Bolus Injection) — NURSE ALLAN JOHNSTONE (NIP)

21/06/24	12:00	21/06/2024	14:59	NURSE KYLIE MANSELL
22/06/24	12:00	22/06/2024	12:15	NURSE KIRSTY MCLATCHIE
23/06/24	12:00	23/06/2024	12:51	NURSE LESLEY MCNEILL
24/06/24	12:00	24/06/2024	12:50	NURSE CAROL JACK
25/06/24	12:00	25/06/2024	12:40	NURSE SHAUNGH GALLACHER
26/06/24	12:00	26/06/2024	12:37	NURSE HOPE DRYSDALE/ NURSE CLAIRE SYME
27/06/24	12:00	27/06/2024	12:31	NURSE HOPE DRYSDALE/ NURSE CLAIRE SYME

FEXOFENADINE 180 mg Tablets

22/06/24 07:00 180 mg ONCE daily at 7am (Oral) — MRS MARION HAMILTON (PIP)

22/06/24	07:00	22/06/2024	08:52	NURSE KIRSTY MCLATCHIE
23/06/24	07:00	23/06/2024	09:05	NURSE LESLEY MCNEILL
24/06/24	07:00	24/06/2024	08:11	NURSE CAROL JACK
25/06/24	07:00	25/06/2024	09:11	NURSE SHAUNGH GALLACHER
26/06/24	07:00	26/06/2024	07:40	NURSE LYLE MCGHEE/ NURSE GREGAR WOODHEAD
27/06/24	07:00	27/06/2024	08:26	NURSE CLAIRE SYME

21/06/24 15:06 180 mg (Oral) — MRS MARION HAMILTON (PIP)

21/06/24	15:06	21/06/2024	16:28	NURSE KIRSTY LEWIS

HYDROCORTISONE 1 % Ointment

21/06/24 07:00 1 Application ONCE daily at 7am (Topical) for 5 day(s) — DR DHANUSH KODALI

21/06/24	07:00	Unavailable Medicine		NURSE CHLOE LONGAIR

Discontinued on: 21/06/2024 15:06 by: MRS MARION HAMILTON (PIP) . Reason: Course Complete

LEVOFLOXACIN 500 mg Tablets

21/06/24 07:00 500 mg TWICE daily at 7am and 7pm (Oral) for 5 day(s) — DR DHANUSH KODALI

21/06/24	07:00	21/06/2024	06:21	NURSE CHLOE LONGAIR
21/06/24	19:00	21/06/2024	21:32	NURSE SHAUNGH GALLACHER
22/06/24	07:00	22/06/2024	08:50	NURSE KIRSTY MCLATCHIE

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LEVOFLOXACIN 500 mg Tablets *(Continued)*

22/06/24	19:00	22/06/2024	22:31	NURSE STEPHANIE THOMSON
23/06/24	07:00	23/06/2024	09:05	NURSE LESLEY MCNEILL
23/06/24	19:00	23/06/2024	21:28	NURSE FIONA MIDDLETON
24/06/24	07:00	24/06/2024	08:11	NURSE CAROL JACK

Discontinued on: 24/06/2024 15:54 by: DR MUCHEN JIANG . Reason: Course Complete

OMEPRAZOLE 20 mg Capsules

☒ 21/06/24 07:00 20 mg ONCE daily at 7am (Oral) — DR DHANUSH KODALI

21/06/24	07:00	21/06/2024	06:07	NURSE CHLOE LONGAIR

Discontinued on: 21/06/2024 12:17 by: MRS MARION HAMILTON (PIP) . Reason: Prescribed in error

PREDNISOLONE 5 mg Tablets

☒ 22/06/24 07:00 20 mg ONCE daily at 7am (Oral) for 4 day(s) — NURSE ALLAN JOHNSTONE (NIP)

22/06/24	07:00	22/06/2024	08:51	NURSE KIRSTY MCLATCHIE
23/06/24	07:00	23/06/2024	09:06	NURSE LESLEY MCNEILL
24/06/24	07:00	24/06/2024	08:11	NURSE CAROL JACK
25/06/24	07:00	25/06/2024	09:09	NURSE SHAUNGH GALLACHER

PREDNISOLONE 20 mg Tablets

☒ 21/06/24 07:00 40 mg ONCE daily at 7am (Oral) for 5 day(s) — DR DHANUSH KODALI

21/06/24	07:00	21/06/2024	06:07	NURSE CHLOE LONGAIR

Discontinued on: 21/06/2024 09:17 by: NURSE ALLAN JOHNSTONE (NIP) . Reason: Discontinued due to conflict

As Required Medication Orders

DIHYDROCODEINE 30 mg Tablets as required

☒ 26/06/24 22:09 30 mg FOUR times daily - 7am;1pm;6pm;10pm (Oral) FOR PAIN — DR EIMEAR O'CONNELL

PARACETAMOL 500 mg Tablets as required

☒ 26/06/24 22:03 1,000 mg FOUR times daily - 7am;1pm;6pm;10pm (Oral) FOR PAIN — DR EIMEAR O'CONNELL

1,000.00	26/06/2024	22:13	NURSE SHARON WILSON

SODIUM CHLORIDE 0.9 % (2.5mL) Nebuliser Solution as required

☒ 20/06/24 20:43 1 Single Dose Unit FOUR times daily - 7am;1pm;6pm;10pm (Nebulised) FOR SOB — DR DHANUSH KODALI

Discontinued on: 26/06/2024 09:07 by: DR SAGARA DISSANAYAKA . Reason: Diagnosis Changed

ZEROBASE Cream as required

☒ 21/06/24 15:07 1 Application (Topical) DRY SKIN — MRS MARION HAMILTON (PIP)

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Patient level notes

Note to Pharmacist added by **MRS MARION HAMILTON (PIP)** on 21/06/2024 at 11:56

Title: Care Plan CAU

PC: Widespread rash - 1/52 itching and pain
PMH: RBBB, Asthma, Gullian-Barre syndrome, behaviorial problems, Accidential OD, Heroin dependence
Meds: Nil regular only monthly Buvidal inj - started April for initial 2 doses and had 2nd monthly injection 6/6/24

Issues:
*1. VTE prophylaxis - Rx note abnormal LFTs, PT high, APTT normal - monitor. For Abdo USS MH 21/6
Continues - PT now normal, plts ok. LCC 25/6
2. CAP:
Antibiotics - Rx levo ? Why not pen allergic - will d/w medic ? switch to PO amox Levo to cover atypicals MH 21/6
Steroids - Pred reduced to 20mg (think more for rash)
Nebs - no home nebs
Abx stopped - to r/o TB. LCC 25/6
*3. Rash - Antihistamines, topical steroid. Derm review - fexofenadine 180mg 4x as per BAD guidelines however they are for chronic urticaria and 4x dose when standard dose inadequate. D/W Dr Shafqat and Rx 180mg 1x for now and review resopnse MH 21/6
*4. NB above re Buvidal - review if remains inpatient. Due 6/7/24. LCC 25/6

DISCHARGE
Discussed with medical team station 8, patient for 7 day further course of fexofenadine. Patient confirms has next appointment scheduled for Buvidal injection on 08/07/2024. KR27/6

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Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Assessed 20th May 2026 at 10:00

Summary of contact/details
Lee attended Maybole health centre this morning for joint prescriber review appt with writer and Dr Wilson. Lee presented as well kempt and appropriately dressed for the weather, his speech was normal in rate tone and rhythm and good rapport established, no evidence of intoxication or withdrawal noted at this time. Overall Lee acknowledged feelings much less anxious and attributes this to keeping himself occupied, less isolated and having more social contacts with old friends. Reports ongoing compensation claim from Kerlaw Childrens home claim, Dr Wilson awaiting request to release records re same. Lee Reports no illicit drug use, and has no plans or intentions of use. Denies any alcohol use. Reports ongoing stability on 96mg Buvidal no current plans to reduce although happy to continue to discuss this. There are no changes to his physical or mental state at time. Reports of having a good diet/ fluid intake and no concerns re sleep. No immediate concerns at this time. With consent, writer administered 96mg Buvidal injection subcutaneously into his left arm, as per his prescription. Nil concerns were raised during administration. There was nil sign of any pain, discomfort or any adverse reaction evident. EXP 04/28 LOT C0048D PC 07350068620416 SN not printed on box Next planned Buvidal injection 13:30pm on the 17/06/26 at Maybole HC. Lee is aware that he can contact START in the meantime should he require any additional support. No further issues or concerns raised by Lee at time of appointment.

Assessed 22nd Apr 2026 at 13:43

Summary of contact/details
Lee attended planned Buvidal Clinic this afternoon, ASW M.Wallace also present. With consent, writer administered 96mg Buvidal injection subcutaneously into his right arm, as per his prescription. Nil concerns were raised during administration. There was nil sign of any pain, discomfort or any adverse reaction evident. EXP 10/27 LOT B0290U PC 07350068620416 SN not printed on box Lee presented as well kempt and appropriately dressed, speech normal in rate tone and rhythm and good rapport established, no evidence of intoxication or withdrawal noted at this time. Lee continues to present as bright in affect and feeling the benefits of keeping himself busy in the week and overall improvements to his routine. Lee is hopeful to return to work and has set himself a goal to achieving this in the next year. Lee Reports no illicit drug use, and has no plans or intentions of use/laps. Denies any alcohol use. Reports ongoing stability on 96mg Buvidal no current plans to reduce although happy to continue to discuss this.

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

There are no changes to his physical or mental state at time. Mood has improved due to the change in the weather, stated mood has lifted as he enjoys being out and about walking when the weather is nice.
No immediate concerns at this time.

Next planned Buvidal injection 13:30pm on the 20/05/26 at Maybole HC. Lee is aware that he can contact START in the meantime should he require any additional support. No further issues or concerns raised by Lee at time of appointment.

Assessed 25th Mar 2026 at 13:30

Summary of contact/details	

Lee attended planned Buvidal Clinic this afternoon, C/N L Clarke also present.

With consent, writer administered 96mg Buvidal injection subcutaneously into his left arm, as per his prescription. Nil concerns were raised during administration. There was nil sign of any pain, discomfort or any adverse reaction evident.
EXP 10/27
LOT B0290U
PC 07350068620416
SN not printed on box

Lee presented as well kempt and appropriately dressed, speech normal in rate tone and rhythm and good rapport established, no evidence of intoxication or withdrawal noted at this time.
Lee continues to present as bright in affect and feeling the benefits of keeping himself busy in the week and overall improvements to his routine. Lee reports to have met a female friend and has been spending more time with her over the last 3 weeks which he is enjoying but 'taking it slow'. Reports ongoing compensation claim from Kerlaw Childrens home claim.

Lee Reports no illicit drug use, and has no plans or intentions of use/laps. Denies any alcohol use. Reports ongoing stability on 96mg Buvidal no current plans to reduce although happy to continue to discuss this.

There are no changes to his physical or mental state at time. Reports of having a good diet/ fluid intake and no concerns re sleep.

No immediate concerns at this time.

Next planned Buvidal injection 13:30pm on the 22/04/26 at Maybole HC. Lee is aware that he can contact START in the meantime should he require any additional support. No further issues or concerns raised by Lee at time of appointment.

Assessed 25th Feb 2026 at 13:37

Summary of contact/details	

Lee attended planned Buvidal Clinic this afternoon, ASW S.Kerr also present.

With consent, writer administered 96mg Buvidal injection subcutaneously into his right arm, as per his prescription. Nil concerns were raised during administration. There was nil sign of any pain, discomfort or any adverse reaction evident.
EXP 10/27
LOT B0290S
PC 07350068620416
SN not printed on box

Lee presented as well kempt and appropriately dressed, speech normal in rate tone and rhythm and good rapport established, no

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

evidence of intoxication or withdrawal noted at this time.
Lee continues to present as bright in affect and feeling the benefits of keeping himself busy in the week and overall improvements to his routine. Lee has been keeping himself busy by working on his car, reports that he is getting it ready for summertime as he enjoys attending the annual car shows, over in Aran.

Lee Reports no illicit drug use, and has no plans or intentions of use/laps. Denies any alcohol use. Reports ongoing stability on 96mg Buvidal, and wished to remain on current dose, however is happy to look at further reduction in the next year and has set himself a personal goal to do so, as Lee is hopeful to return back to work next year.

There are no changes to his physical or mental state at time. Reports of having a good diet/ fluid intake and no concerns re sleep.

o immediate concerns at this time.

Next planned Buvidal injection 13:30pm on the 25/03/26 at Maybole HC. Lee is aware that he can contact START in the meantime should he require any additional support. No further issues or concerns raised by Lee at time of appointment.

Assessed 28th Jan 2026 at 13:30

Summary of contact/details	

Lee attended planned Buvidal Clinic this afternoon, ASW Ma Wallace also present.
Buvidal 96mg administer to left arm by writer without concern.

EXP 10/27
LOT B0290S
PC 07350068620416
SN not printed on box

Lee presented as well kempt and appropriately dressed, speech normal in rate tone and rhythm and good rapport established, no idence of intoxication or withdrawal noted at this time.

Lee continues to present as bright in affect and feeling the benefits of keeping himself busy in the week and overall improvements to her routine. Enjoying working on his car.

Lee spoke of having contact with a service regards compensation from previous abuse while in Kerelaw children's home, reports to have given writer and Dr Wilson's details and reports they will likely get in contact with START to confirm some details. Lee has given consent to share this. Lee reports to feel able to manage any potential upset this may bring in relation to past trauma.

Lee reports to remain abstinent from illicit substances and stability on Buvidal.

No immediate concerns at this time.

next planned contact below

Assessed 21st Jan 2026 at 13:30

Summary of contact/details	

Lee attended Maybole HC this afternoon as planned for Buvidal administration.
On collecting prescription pharmacy advised they do not have prescription dated 31st Dec, it would appear when prescription issue arouse on 24/12/25 due prescription being administered early due to festive period, the prescription for 31st Dec that should

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

have covered todays injection has been destroyed. Current script dated 28th Jan.
Explained situation to Lee who was very understanding and accepting of situation and agreed to return next week Wed 28th Jan.

Assessed 24th Dec 2025 at 09:30

Summary of contact/details	

Lee attended planned Buvidal Clinic this morning, ASW M Wallace also present.

Due to pending festive period and bank holidays, agreed with ANP I Morrison for Lee to have his Buvidal 7 x days early.

On collecting prescription from the pharmacy it was made aware that the date on current prescription was dated for 31st Dec and pharmacy would not dispensing.
Discussed with ANP A Glass and completed urgent prescription to be delivered to Maybole pharmacy.
Lee was unable to return to Maybole later in the day but agreed to return to Ailsa hospital this afternoon at 2pm for administration.

Buvidal 96mg administer to right arm without concern.

EXP 10/27
LOT B0290H
PC 07350068620416
SN not printed on box

Lee presented as well kempt and appropriately dressed, speech normal in rate tone and rhythm and good rapport established, no evidence of intoxication or withdrawal noted at this time. Reports he continues to experience stability on dose, at present wishes to remain on current dose and will further review in January. Lee denies any alcohol or drug use.

Lee repots to have plans for a quiet christmas as his mum is working however is looking forward to the peace and quiet. Reports to have plans to visit his auntie for new year which he is looking forward to.
Lee reports he continues to occupy himself by modernising a car he has been working on which is supporting him to isolate himself less.
Lee reports good nutritional intake and no real changes re his physical health although reports having a cold.
No immediate concerns at this time.

Lee is aware he can contact START she he require additional input inbetween Buvidal appts. At present, he reports to be happy with the frequency of contact.
next Buvidal due in 4 weeks, Wed 21st Jan

Assessed 3rd Dec 2025 at 14:00

Summary of contact/details	

Lee attended planned Buvidal Clinic this afternoon, S/n K McIlroy also present.
Buvidal 96mg administer to left arm by S/N McIlroy without concern.

EXP 10/27
LOT B0290H
PC 07350068620416
SN not printed on box

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Lee presented as well kempt and appropriately dressed, speech normal in rate tone and rhythm and good rapport established, no evidence of intoxication or withdrawal noted at this time.

Compared to previous contact, Lee appeared much brighter in affect, and acknowledged himself feeling better without himself. Recognises this has been directly impacted by Lee isolating himself less and has been occupying himself more effectively by working on his car which he has been enjoying doing. Reports no further panic attacks and general feels less anxious and paranoid about going out. Lee reports his motivation has been to get back to work and felt he was in a 'rut' with no plans to return to work. Recognises he is still a while off being fit for work but feels he is now moving in the right direction.

Lee denies any thoughts of harming himself or ending his life. Identifies his mother as protective factor.

ee spoke about his limited plans for Christmas due to his mother working, and plans to get a take away.

Lee reports to remain abstinent from illicit substances and stability on Buvidal. Spoke of reduction in dose as discussed with Dr Wilson at recent prescriber review, Lee is keen to reduce to 64mg in January however will discuss more and agree plan at next appt.

No immediate concerns at this time.

Advised Lee due to festive period he will be given next Buvidal 7 days early which he was accepting of.

next planned contact below

Assessed 27th Nov 2025 at 17:34

Summary of contact	

Diagnosis: ICD11 6c43.2 Opioid Dependence

ychiatric Medication: Buvidal 96mg monthly through START

No regular GP medications ongoing (ECS checked today, though appeared to have been last updated in August and Lee reports no ongoing medications)

Recommendations/Plan: Repeat OPC 4-6 months
START CPN, Abbie Rennie

Community Addictions Worker, Keri McNeil and I reviewed Lee at the Maybole Health Centre Addictions Out-patient Clinic on 27th November 2025. He presented as well kempt with no suggestion of intoxication or withdrawal from any substance. He looked physically well and appeared relaxed and low but reactive in mood. There was no suggestion of active symptomatology of major affective or psychotic disorder and he did not report recent thoughts of self-harm/suicide or of harming others.

Addictions Stability and Addictions Medications
Lee reports continued stability from the addictions viewpoint, denying recent illicit drug or alcohol use. He describes feeling stable from the Opioid perspective on his current Buvidal dose with no recent withdrawal symptoms. He was keen to continue on this dose currently, and spoke about a goal to consider reducing and ultimately detoxifying from same in the New Year. We have discussed that this can be considered with his CPN between appointments here and we would be happy to support this when he feels ready.

Mental Health
Lee reported a clear improvement in his mental health since my last review in July. He feels he is coming to terms with the death

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) **undefined** Male **CHI Number** 0902763334

History for Summary of contact/details

From 27/05/1926 **Until** 27/05/2026

of his father in April as well as earlier bereavements.

2/ LEE JOHNSTONE 12 WOODSIDE AVENUE, KIRKMICHAEL, MAYBOLE, AYRSHIRE, KA19 7PP
CHI No: 0902763334

He feels his mood has gradually improved in recent months, though notes some continued day-to-day fluctuation consistent with the longer-term pattern (his description being suggestive of a degree of emotional dysregulation rather than major mood disorder). He notes a marked improvement in his previously described generalised and social anxiety (which is said to have included 2 episodes of more intense feelings of panic in public places at that time), and states he is now getting out on a regular basis without difficulty and is enjoying this. He seemed to have a good understanding that his anxiety over the summer was likely worsened by his behaviour at that time in that through isolating himself at home this had been further undermining his confidence.

He describes his sleep as having improved significantly since my last appointment and reported no difficulties with his appetite. He stated to have tried the Mirtazapine after I suggested this at the last appointment, but disliked this and was clear he would prefer to remain off antidepressants currently (there seemed no immediate indication for these today).

We gave general advice that he continue to engage with positive activities and psychosocial supports. He is aware of the availability of low intensity structured psychological supports around anxiety and confidence building through START and that he can engage with this through his CPN if he wishes. He did not indicate a wish for this today. He was clear he also did not wish particular bereavement supports.

Physical Health and Social Circumstances
He describes generally stable physical health and his previous skin complaints are said to have resolved. He continues to live with his mother and describes an ongoing supportive relationship. She has apparently undergone a knee replacement and is said to be doing well. He is hopeful of returning to work sometime in the coming months and states he has a job offer available through friends. He continues to have no contact with his daughter (this continuing to be blocked by his ex-partner) and continues to consider a legal challenge around this, but states he prefers to focus on optimising his mental health currently to build his confidence to consider such a process. He states he continues to hold a driving licence but is not driving and was able to recount the DVLA legal requirements with his dependence diagnosis that he requires to follow before returning to driving as was detailed previously to him at the clinic.

Assessed 27th Nov 2025 at 16:35

Summary of contact/details	
Lee attended joint prescriber review with Dr. Wilson. Please see full assessment of appointment by prescriber Dr. Wilson on 27/11. Lee presented well, no signs of intoxication evident. Lee advised that he wishes to reduce to 64mg on Buvidal injection after the new year. Plan - writer will update key worker CN Abbie Rennie of contact.	

Assessed 5th Nov 2025 at 14:00

Summary of contact/details	
Lee attended planned Buvidal Clinic this afternoon, ASW S Kerr also present. Buvidal 96mg administer to right arm by writer without concern. EXP 10/27	

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

LOT B0290H
PC 07350068620416
SN not printed on box

Lee presented as well kempt and appropriately dressed, speech normal in rate tone and rhythm and good rapport established, no evidence of intoxication or withdrawal noted at this time. Lee notably sweating today, however claims this is not in relation to withdrawals and has been a long standing anxiety symptoms.

Lee appeared brighter in affect to previous contacts and reports to have had no more 'panic attacks' however feels this may be as a result of him isolating himself and not being triggered by anxiety. Spoke to Lee, as pre previous contacts, about support available to Lee in the community to combat this which he was accepting of, however at this time feels he is unable to give it his ill attention/focus and would like to revisit this in the new year.

Lee denies any thoughts of harming himself or ending his life. Identifies his mother as protective factor.

Lee is aware he can contact writer should he change his mind regards additional support he can contact writer.

Lee reports to remain abstinent from illicit substances and stability on Buvidal.

Lee reports very limited structure/routine to his day and spends his time at home with his mum, who is returning to work after a knee replacement. Lee watches TV and cleans the house to occupy himself.

No immediate concerns at this time.

next planned contact below

Assessed 8th Oct 2025 at 14:00

Summary of contact/details

Lee attended planned Buvidal Clinic this afternoon, ASW Ma Wallace also present.
Buvidal 96mg administer to left arm by writer without concern.

EXP 04/27
LOT B0176Y
PC 07350068620416
SN not printed on box

Lee presented as well kempt and appropriately dressed, speech normal in rate tone and rhythm and good rapport established, no evidence of intoxication or withdrawal noted at this time. Lee appeared flat in affect which she acknowledged. Lee reports to have had a 'panic attack' in Aldi on Sunday which resulted in him being incontinent of urine. Lee unable to identify any triggers regards this, however reports to have heard some kind of 'ringing' in his head. Lee reports this is the 2nd time this has happened, last time in July while on the bus however was not incontinent using this time. Spoke with Lee about what was previously agreed with Dr Wilson regards Low intensity psychological therapies however Lee feels at present he does not feel ready to engage in this as is rarely leaving the house as does not feel able to or want to. Writer agreed to discuss this further next month and in the mean time post him out some self help guides for managing worry and stress.

Lee is aware he can contact writer should he change his mind regards additional support he can contact writer.

Lee reports to remain abstinent from illicit substances and stability on Buvidal.

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

No immediate concerns at this time.

next planned contact below

Assessed 10th Sep 2025 at 14:00

Summary of contact/details	

Lee attended his planned buvidal appointment on time at Maybole health centre.

Lee presented well kempt with good engagement, polite and pleasant manner and good eye contact, rapport easily developed.

Lee reported his mood as a 5 on an ascending mood scale out of 10 highlighting that he is "not good but not terrible" stating he is under stress linking same to his fathers passing and his cousin completion of suicide along with his mother not keeping well, Writer asked if Lee felt he required further support however declined stating he is "just getting to that age" where family members are getting older. Writer advised Lee of bereavement services however Lee identified he feels fine and does not feel he requires same. Affect appeared mood congruent, euthymic and stable with nil concerns regarding mental state observed. Future planning evident regarding reducing from buvidal, excited regarding reduction plan hoping to reduce again in January next year and then be off of a buvidal prescription by summer next year.

Nil evidence of intoxication, sedation or withdrawal, reported no illicit substance use and that he is 14 months "clean".

Writer administered 96mg buvidal subcutaneous injection into Lees right arm with nil ill effect observed or disclosed.
EXP: 04-2027
LOT: B0176M
PC: 07350068620416

Nil issues regarding physical or social concerns disclosed apart from feeling like he is becoming more reclusive however advised he feels at peace at home.

Writer has appointed (see below) and provided and appointment card.

Assessed 27th Aug 2025 at 14:00

Summary of contact/details	

Writer previously agreed with Lee and Dr Wilson to offer additional input for Tier 2 psychological therapies to help manage anxiety and emotional distress. Lee has failed to attend last 2 appts for additional support. Writer to further discuss with Lee suitability for this at next Buvidal appt.

Assessed 13th Aug 2025 at 14:00

Summary of contact/details	

Lee attended planned Buvidal Clinic this afternoon, ASW S Harper alongside St/N R Rinaldi
Buvidal 96mg administer to left arm this afternoon by St/N Roxanne without concern.
EXP 04/27
LOT B0176M
PC 07350068620416
SN not printed on box

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Lee presented as well kempt and appropriately dressed, speech normal in rate tone and rhythm and good rapport established, no evidence of intoxication or withdrawal noted at this time. Lee was noted to be profusely sweating however was a very hot day and Lee reports he was struggling with the heat.

Lee reports to remain abstinent from illicit substances and stability on Buvidal.
Lee reports since commencement on Mirtazapine 15mg following recent prescriber review, Lee has noted some improvement in his mental state, particularly his mood, however noted to be experiencing nightmares as a side effect, however happy to 'suffer' these if they were to continue to life his mood.

Lee acknowledged needing to cancel his last appt with writer for review to explore 'managing your worries' work. Reports his mother to be havng treatment for district nurse following her knee replacement and was unable to leave her alone, however was keen for another appt to be arranged which writer agreed too.

Lee has been effectively occupying his time mainly spending time with his mother supporting her following recent surgery.
Lee reports no changes or concerns to his physical or mental state and described being mainly well.

No immediate concerns at this time.

Next buvidal Wed 10th Sept 2pm

next planned contact below

Assessed 6th Aug 2025 at 14:30

Summary of contact/details	
Additional appt made for Lee for this afternoon as planned following prescriber review, Lee made contact ahead of planned appt to cancel as his mother was getting out of hospital and he wanted to be there for her. Next planned appt for Buvidal below	

Assessed 18th Jul 2025 at 09:30

Summary of contact/details	
Lee attended joint prescriber review with Dr Wilson and writer this morning at Maybole health centre, engaged well throughout, appropriately dressed, speech normal in rate tone and rhythm and good rapport established, no evidence of intoxication noted. As discussed at previous review, Lee struggling with low mood and poor sleep, following discussion Dr Wilson agreed to recommend to GP commencement of Mirtazapine 15mg and writer to deliver 1:1 low intensity psychological therapies , 'managing your worries' which he is keen to engage in. No obvious changes or concerns re physical health. Lee remains abstinent from illicit substances and stable on Buvidal, no plans to make changes to dose at present. Next planned contact below	

Assessed 18th Jul 2025 at 08:27

Summary of contact	
Diagnosis: ICD-11 6C43.2 Opioid Dependence Possible Depressive Episode Current Medication: Buvidal 96mg monthly through START No regular GP medications ongoing (ECS checked today)	

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

As per handwritten note issued to Lee today, many thanks for commencing Mirtazapine 15mg nocte through the practice for treatment of low mood/anxiety/sleep disturbance.

Follow-Up: 1. Repeat OPC 3-4 months (Maybole Health Centre).
2. START CPN, Abbie Rennie (including low intensity structured psychological support / Decider Skills).

CPN Rennie and I reviewed Lee at the Maybole Health Centre Addictions Outpatient Clinic on 18th July 2025. Lee presented as well kempt with no suggestion of intoxication or withdrawal from any substance. His overall skin condition remained visibly better than had been the case last Autumn, but he did show us some erythematous areas which he plans to discuss at the community pharmacy/practice and states have worsened in recent weeks. He appeared low but reactive in mood and more anxious that I have seen him previously. There was no suggestion of active symptomatology of major psychotic disorder and he did not report recent thoughts of self-harm/suicide or of harming others.

Additions Stability and Addictions Medications
Lee reports continuing to feel stable from the addiction view point and denied recent illicit drug or alcohol use. He reports no recent opioid withdrawal symptoms. The reduction in his Buvidal appears to have made little difference to his complaints around sleep (as detailed below) and I think this is likely better explained by his current wider mental state than any particular side effect of this medication. He wishes to continue on the current Buvidal dose.

Mental Health
After having noted an improvement in his mental health at the last appointment in March, he today described a view that his mood has worsened and his anxiety levels increased since then. The death of his father in April (leaving him ruminating on their limited contact and with some sense of regret at not having connected more with his father prior to his death) and the ongoing lack of contact with his daughter (as below) sound to have been possible precipitants for this deterioration.

He describes general low mood in recent months, with ongoing initial insomnia and problematic anxiety. He describes a level of both generalised and social anxiety, and states he is spending much of his time indoors due to this. He recognises this is unhelpful and spoke of a goal to build his routine back up.

He had previously stated he did not wish to consider structured psychological support and previously opted against continuing Mirtazapine after a month's trial of this. Today he was keen to look at both antidepressant medication and talking therapies. We discussed first line antidepressant options, including Mirtazapine and Sertraline. We noted potential risks and benefits, in particular the possibility of metabolic changes with Mirtazapine. This is a concern for Lee as he states he has gained weight over the last one to two years, but on balance he was clear he preferred a sedating antidepressant and has had contact with individuals who have found Mirtazapine beneficial. Ultimately therefore he opted for Mirtazapine but Sertraline would be an option should he look to reconsider this.

We discussed that the beneficial effect of antidepressants are likely to be partial at best and that engagement with structured psychological work would be expected to be of more benefit. Lee seemed much more open to this today and CPN Rennie will introduce same as above.

Physical Health and Social Circumstances
He describes generally stable physical health, though problematic widespread itch with areas of erythema is re-emerging in recent weeks. He states he plans to discuss this as above.

He continues to reside at his mother's home and described a close relationship with no immediate plan to seek his own tenancy. He is in receipt of state benefits and is hopeful of returning to work when he feels physically well (not currently in employment but states his qualifications make him desirable for employers). He remains single. He describes an unstructured and purposeless routine. We have encouraged him to take steps to address this. He reports he is not driving following our previous discussions

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

around the DVLA and recalled the information around this. He reported no outstanding forensic issues.

He describes wider supportive family nearby. His mother is awaiting a knee replacement. His ex-partner reportedly continues to deny him access to his young daughter. He spoke with some upset about this and the fact that he has not seen his daughter for four years (now aged eight). He is considering seeking legal advice on this

Assessed 16th Jul 2025 at 16:12

Summary of contact/details	

Staff nurse Abbie and student nurse Tanya were present at this review.

ɜe attended his review today, and engaged well. Lee appeared appropriately dressed, and did not seem unkempt.
Lee received his buvidal, there were no issues.
Lee shared that he has OCD to the extent where he has a shower three times daily and constantly ensuring everything in his home is clean and in there places. Lee reported concerns about his sweating, attributing this to his weight, or the medication. Abbie discussed Lee getting support for his OCD.

Plan
Support will be looked into for Lee's OCD.

Buvidal 96gm
Expired 01 - 2027
Lot B0013R
PC 07350068620416
SN AEBS5NREKKRXX69

Assessed 16th Jul 2025 at 14:00

ɯmmary of contact/details	

Lee attended planned Buvidal Clinic this afternoon, ASW A Woodcock also present, alongside St/N T Frew
Buvidal 96mg administer to right arm this afternoon by St/N Tanya without concern.
EXP 01/27
LOT B0013R
PC 07350068620416
SN AEBS5NREKKRXX69

Lee presented as well kempt and appropriately dressed, speech normal in rate tone and rhythm and good rapport established, no evidence of intoxication or withdrawal noted at this time.
Lee reports to remain abstinent from illicit substances and stability on Buvidal.
Lee reports low mood an increased anxiety, reports mainly isolating himself in his bedroom at home and reports poor sleep. Lee reports increased sweating which was evident today.
Lee is keen to explore some anxiety management work however struggles to commit to this. Writer offered 1:1 slow paced tier 2 'managing your worries' work which he plans to think about. Reports to have an appt with Dr wilson and writer on Friday and plans to discuss things further then.
Lee has been effectively occupying his time and is enjoying the nice weather. Reports he plans to look into returning back to work in the coming months.
Lee reports no changes or concerns to his physical or mental state and described being mainly well.

Lee is happy with current frequency of contact, monthly for Buvidal injection and review however is aware should he require

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

additional input this can bee arranged.

No immediate concerns at this time.

Assessed 18th Jun 2025 at 14:24

Summary of contact/details
Lee attended planned Buvidal Clinic this afternoon, Buvidal 96mg administer to left arm after discussion re rotation of injection sites and happy to try in his arm. EXP 01/27 LOT B0103D PC 07350068620416 SN 249PY8VMCMREKSS Lee presented as well kempt and appropriately dressed, speech normal in rate tone and rhythm and good rapport established, no evidence of intoxication or withdrawal noted at this time. Lee reports to remain abstinent from illicit substances and alcohol. Lee reports to remain stable to 96mg and hopes to reduce dose further at the end of the year. Lee has been effectively occupying his time and is enjoying the nice weather. Reports he plans to look into returning back to work in the coming months. Lee reports no changes or concerns to his phsyical or mental state and described being mainly well. Lee is happy with current frequency of contact, monthly for Buvidal injection and review however is aware should he require additional input this can be arranged. No immediate concerns at this time.

Assessed 21st May 2025 at 14:00

Summary of contact/details
Lee attended planned Buvidal Clinic this afternoon, Buvidal 96mg administer to right abdo this afternoon by writer without concern. EXP 01/27 LOT B0013R PC 07350068620416 SN AEGM3WS6MX3XX23 Lee presented as well kempt and appropriately dressed, speech normal in rate tone and rhythm and good rapport established, no evidence of intoxication or withdrawal noted at this time. Lee reports to remain abstinent from illicit substances, despite some thoughts of same following the sudden passing of his father. Lee spoke about distraction techniques and reflection on how far he has come to be helpful in changing these thoughts/acting on impulses. Lee reports to remain stable to 96mg and hopes to reduce dose further at the end of the year. Lee has been effectively occupying his time and is enjoying the nice weather. Reports he plans to look into returning back to work in the coming months. Lee reports no changes or concerns to his phsyical or mental state and described being mainly well. Lee is happy with current frequency of contact, monthly for Buvidal injection and review however is aware should he require

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

additional input this can bee arranged.

No immediate concerns at this time.

Assessed 23rd Apr 2025 at 14:00

Summary of contact/details	

Lee attended today's appointment for administration of his Opioid Substitute Treatment as planned. Lee reported being entirely stabile on his OST with no illicit substance use reported or evident. He denied any use of Heroin or opiates, denied any cannabis or alcohol use in recent months.
''e spoke of the recent death of his father suddenly and attendance at his creation on the 22/4/25. He was appropriately upset nd appeared to be managing this well however he had been estranged from him for over 15 years and had regrets regarding this.
He is prescribed Buvidal (Buprenorphine Depot) 96mg every 28 days by subcutaneous injection.
This was administered into his left abdomen as requested and administered by writer today, the 23rd April 2025.
Lee had no adverse reaction to Buvidal depot injection after administration and observations.
Buvidal (Buprenorphine Depot) 96mg
EXP – 01/2027
LOT – B0013R
Pc – 07350068620416
SN – VADR4P847D5P9SF
Next due on the 21st May 2025

Assessed 26th Mar 2025 at 14:19

Summary of contact/details	

Lee attended Maybole Health Centre today for scheduled monthly Buvidal Depot administration.
96mg Buvidal administered into Right Abdo by Charge Nurse Louise Steele and witnessed by Assistant Community Drug Worker Keri McNeil

LOT: B0013R
EXP: 01/27

Lee offered no new concerns today, this was his first reduced dose of 96mg at Lee's request in order to try and resolve his sleep difficulties.
Lee presented well, he engaged appropriately, speech was of regular rate and tone and there was no indication or report of deteriorating mental / physical health.
Lee was reminded that he can contact START in between his monthly appointment's should he have any additional care or support needs. - Lee was welcoming of same.

Assessed 21st Mar 2025 at 14:43

Summary of contact/details	

Writer received email from prescriber Dr. Wilson advising that prescription to reduce Buvidal injection from 128mg to 96mg, however prescription change unable to be processed at this time, however will be completed next week. Therefore writer was instructed to advise Lee that on 26/03 he will be administered 128mg, from this Lee will be administered 96mg

Plan - writer will make team aware.
Writer will continue to make contact with lee.

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) **undefined** Male **CHI Number** 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Assessed 20th Mar 2025 at 16:09

Summary of contact	

Thank you for attending your 20th March 2025 Maybole Health Centre Addictions Out-patient Clinic appointment.

We agreed at the appointment that I would write to you to provide you with the DVLA forms so that you can notify the DVLA, as a driver, of your dependence diagnosis and treatment through the START team.

We discussed that you are considering returning to driving and we discussed that in order to legally do this you require to first notify the DVLA of your addictions diagnosis and then await their confirmation of your medical fitness to drive before resuming driving. Please find attached the DVLA DG1 form to allow you to make this disclosure.

We discussed that you cannot legally return to driving until you have made this disclosure and receive the DVLA response, and that if healthcare professionals become aware that you have returned to driving without following this guidance we may have a responsibility at that time to notify the DVLA direct of your treatment through our service (as discussed, there is no indication for healthcare staff to do this currently in your case).

Assessed 20th Mar 2025 at 16:06

Summary of contact	

Diagnosis: ICD11 6c43.2 Opioid Dependence

Psychiatric Medication: Buvidal 128mg monthly prescribed / administered through START (voluntary reduction now planned to 96mg monthly)
No regular GP medications reported (Lee reports preferring to stay off antidepressants today)

Recommendations/Plan: Repeat OPC 3-4 months (Maybole Health Centre)
START Community Addictions Worker, Keri McNeil

Keri McNeil and I reviewed Lee at the Maybole Health Centre Addictions Out-patient Clinic on 20th March 2025. Lee presented as well kempt with no suggestion of intoxication or withdrawal from any substance. His skin condition appeared markedly improved since my last appointment. He appeared relaxed and bright in mood. There was no suggestion of active symptomatology of major affective or psychotic disorder and he did not report recent thoughts of self-harm/suicide or of harming others.

Addictions Stability and Addictions Medications
Lee reports feeling stable from the addictions viewpoint and denied recent illicit drug or alcohol use. He reports no ongoing opiate withdrawal symptoms with his current Buvidal prescription. He continues to describe difficulty sleeping (initial insomnia), the onset of which coincided with commencement of Buprenorphine, but also appeared to follow on from his various changes in routine (loss of employment which included nightshift, breakdown of relationship) in the months preceding the commencement of Buprenorphine.

We discussed today that this sleep issue may be related to the adjustment to Buprenorphine and the heightened emotional clarity with this compared to Methadone or other Opioids and ultimately we agreed to reduce Lee's Buvidal dose to 96mg from his next prescription.

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) **undefined** Male **CHI Number** 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

We would expect no particular adverse effects from this reduction and are obviously hopeful that a lower dose may reduce any adverse effects from the Buprenorphine. We will keep this under review.

Mental Health
Lee describes his overall mental health as much improved in recent months. He described better coming to terms with his new social situation / routine in this time and also noted that his more recent physical health improvement following pneumonia last year is likely to have contributed to this mental health improvement. He continues to report some variation in mood and some days where he feels more low than others, but describes these as becoming less frequent and overall was very positive today. He reported good appetite.

He describes a trial of Mirtazapine 15mg through the Practice for a month from December. He states this benefitted his sleep on ıe first night, but not thereafter and he felt no change with sleep or mood after the first month and had not collected this again thereafter. He was clear he did not wish to return to antidepressants and there seemed no obvious indication for these today. He was not seeking additional support around his mental health currently and spoke positively about taking steps to introduce more structure and purpose to his routine in the coming months which he felt would be the most useful adaptations he can make.

Physical Health and Social Circumstances
Lee reports his breathing and overall physical health has much improved since my last clinic review. The allergic dermatitis he was diagnosed with following his pneumonia is also said to be markedly improved and was visibly better today. He describes a goal to lose weight in the coming months and spoke about a plan to begin attending the gym.

He continues to reside at his mother's home and described a close relationship with no immediate plan to seek his own tenancy today. He reports having separated from a short-term partner in the last year and was positive about this. He continues to have no contact with his longer-term ex-partner in Cumnock and as a result no current contact with his young daughter, Harper. He described considering taking legal action to try to enable contact. He is not currently working and states a plan to continue his physical and mental health recuperation over the coming months while aiming to return to work towards the end of this year. He states he has various standing job offers. He reports he is considering returning to driving (I understand from his account that his driving license was suspended by the DVLA following his previously disclosing substance dependence). I have advised him today f the legal requirement to disclose this dependence and his current treatment at this time to the DVLA and awaiting their esponse prior to returning to drive. I have since followed this up with a letter to him and have sent him the DVLA driver notification forms with this. He was expecting same following the appointment and has stated he will follow this guidance. He reports no outstanding forensic issues.

Assessed 20th Mar 2025 at 15:30

Summary of contact/details	
Lee attended joint prescriber review with Dr. Wilson. Lee presented well, no signs of intoxication evident. Lee requested to reduce Buvidal from 128mg to 96mg due to experiencing sleep issues. Dr. Wilson agreed with same and will generate prescription. Lee is due for monthly Buvidal injection on 26/03. Appointment card provided of appointment. No other changes to prescribed medication. Lee will be appointed in 3/4 months time by prescriber. Please see full appointment details by prescriber Dr. Wilson on 20/03.	

Assessed 26th Feb 2025 at 14:00

Summary of contact/details	

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Lee attended his planned appointment with ANP Glass (in absence of keyworker C/N Rennie) and ASDW McNeil at Maybole Health Centre for his monthly buvidal injection.
Lee was dressed casually, he presented very well kempt and groomed and there was no evidence of any intoxication. Lee was bright and chatty throughout the appointment and engaged well.
Lee denies any illicit substance or alcohol use and he reports to feel stable on his prescribed buvidal. Lee described the transfer over to buvidal as a "lifesaver and gamechanger" for him. Lee stated he will never o back to drug use.
Lee advised that his mental health has greatly improved, he reports his mood to be bright which showed today and he reports to be eating and sleeping well. Lee stated that he feels ready to go back to work and is keen to do so however would like to speak with Dr Wilson first to gather his opinion. Writer advised that she was sure Dr Wilson would be supportive of this. Lee reports to have discontinued his antidepressant medication as he does not feel he requires this and he is sleeping well now.
Lee continues to live with his mother who he described as a good support to him. Lee has a family holiday planned later this year which he is looking forward too.
lee denies any other issues.
lee was administered his monthly 128mg buvidal injection into his left side abdomen with no ill effect.
EXP: 12/2026
LOT: B0039A
PC: 07350068620423
SN: HHKRFSRY97V101M

Next date for administration and review planned and agreed for 26th March 2025.

Assessed 29th Jan 2025 at 14:00

Summary of contact/details	

Lee attended his planned monthly buvidal appointment on time at Maybole Health Centre at 2:00pm. Lee appeared well kempt, groomed and dressed appropriately for the current climate. Lee engaged well during the appointment actively engaging in conversation, was polite in manner with good eye contact and good rapport. Lee's speech was normal in rate, tone and volume.

Lee reported that his mental health is "not perfect but better" highlighting his sleep has improved, Lees observable affect was bright in demeanour and he visibly appeared to be well, nil physical health concerns.

Lee reported that he has stopped taking his 15mg mirtazapine prescribed for sleep stating that he only received a month's prescription of same. C/N Glass advised that mirtazapine is usually prescribed for a month and then a review occurs with his GP for subsequent prescription, Lee appeared not aware of same and stated he would contact his GP and pharmacy.

Nil evidence of intoxication, lee reported no use of illicit substances or alcohol. Lee discussed reducing his buvidal prescription down from 128mg to 96mg as well as returning to work however he detailed he would discuss this with Dr Wilson at his upcoming appointment.

Writer administered the monthly 128mg Buvidal subcutaneous injection into Lee's right abdomen with no adverse reactions or irritations observed or stated by Lee.

EXP: 12-2026
LOT: B0039A
PC: 07350068620423
SN: 47MCYE1MAY6DDG8

Lee is aware of his next monthly Buvidal appointment on 26/02/2025 at 2:00pm, Lee is aware he can contact the service if needed. No further issues or concerns raised by Lee at the appointment.

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Assessed 30th Dec 2024 at 14:00

Summary of contact/details	

Lee attended his planned appointment at Girvan Community Hospital for administration of his monthly buvidal injection and review. S/N Williams was also present. Lee was dressed casually, he presented very well kempt and groomed, made good eye contact and his speech was normal in rate, rhythm and tone. There was no evidence of any intoxication from Lee, he was bright and chatty throughout.
Lee reports to be feeling really well. Lee reports to have spent a nice Christmas with his family.
Lee advising that his GP has issued him with a sleeping tablet, when asked for further details, he reports being prescribed mirtazapine 15mg daily. C/N Glass explained medication and again went over good sleep hygiene. Lee then reported that his sleep pattern had been getting better however when it was poor he suffered with low mood the following day. Lee reported that he picked up his prescription on Saturday 28th December and after taking his medication that night he had the best sleep ever. Lee then reported that he did not intend to take his medication every night and only when required. C/N Glass discussed same and encouraged Lee to take his medication as prescribed for therapeutic effect. Lee accepting of same. Lee denies any other physical or mental health issues. Lee spoke of plans to get back to work in the New Year.
Lee denies any illicit substance or alcohol use and reports to feel stable on prescribed buvidal. Lee advised that he hopes to take a reduction in his buvidal in the New Year. Lee declining of a copy of nyoxid as has an in date copy at home.

Lee was administered his monthly 128mg buvidal injection into his left side abdomen with no ill effect.
EXP: 12/2026
LOT: B0039A
PC: 07350068620423
SN: AFATWPY5PTXA5FK

Lee was advised that due to changes within the service his new keyworker will be C/N Abbie Rennie who would be joining the Carrick Team in January. Lee accepting of same. Lee's next buvidal appointment has been arranged for Wednesday 29th January 2025 at 2pm.

Assessed 2nd Dec 2024 at 14:00

Summary of contact/details	

Lee attended his planned appointment with C/N Glass at Maybole Health Centre for administration of his monthly buvidal injection. S/N Williams was also present. Lee was dressed casually, he presented well kempt and groomed, made good eye contact and his speech was normal in rate, rhythm and volume. There was no evidence of any intoxication. Lee appeared bright in mood and was chatty throughout.
Lee explaining that he has been feeling a lot better both mentally and physically and was a lot more upbeat today. Lee reports to be eating well, he reports to be getting out and about a bit more and he also reports to have booked a family holiday to Turkey for next year for 10 days which he is looking forward too. Lee reports to have bumped into his 7 year old daughter Harper Lee in town the other day and feels this has also brightened his mood after he had the chance to speak to her for a bit.
Lee denies any illicit substance or alcohol use. Lee reports to feel stable on his prescribed buvidal. Lee advised that he did not feel any benefit from zopiclone previously prescribed as a 7 day course for sleep, he reports that the medication made him feel groggy and is not for him. Lee advised that his sleep has slowly been improving. Lee is in receipt of nyoxid.

Lee was administered his monthly 128mg buvidal injection into his right side abdomen by S/N Williams with no ill effect.
EXP: 09/2026
LOT: A0183K
PC: 07350068620423
SN: 2C75F306RKK0D7B

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Next appointment planned and agreed for 30th December 2024. Lee aware to contact C/N Glass in the meantime should he require any additional help or support.

Assessed 4th Nov 2024 at 14:00

Summary of contact/details

Lee attended his planned appointment with C/N Glass at Maybole Health Centre for administration of his monthly buvidal injection. St/N Emma Hamilton was also present. Lee was dressed casually, he presented well kempt and groomed, he gave good eye contact and engaged well during the review. There was no evidence of any intoxication.
Lee denies any illicit substance or alcohol use. Lee reports that he remains unemployed, does not feel ready to look for other employment yet and is spending all his time at home with his family. Lee reports that his mother is a good support. Lee reports to be feeling better physically although reports main concern being unable to sleep, Lee feels that his lack of sleep is his main cause of his low mood and anxiety during the day, he also spoke about feeling irritable and feeling bad that he has been snappy with his mother. Lee has asked C/N Glass to speak to Dr Wilson on his behalf to request a short prescription of medication to help him sleep. Lee explaining that he feels that his sleep has been affected since he transferred over to buvidal earlier in the year, alongside this, Lee is currently unemployed after a period of illness a few months ago and giving up work, when Lee was employed he stated that he worked nightshifts constantly and therefore it appears a mixture of factors have knocked his sleep pattern off. Lee reports that he is often still awake at 5am and although he gets up in the morning, with no current structure to his day he often nods off and naps around 11am. C/N Glass provided good sleep hygiene advice and encouraged Lee to go to bed and get up at the same time each night/day. C/N Glass also agreed to discuss with Dr Wilson. Lee denies any other physical health concerns, he reports to be eating well. Lee denies any thoughts, plans or intent to self harm or commit suicide. Lee did speak for a bit about feelings of guilt around the car accident he was in last year where he was driving and slipped on ice and his workmate has been left paralysed.
Lee was administered his monthly 128mg buvidal injection into his left side abdomen with no ill effect.
EXP: 09/2026
LOT: A0183A
PC: 07350068620423
SN: X03H7CNP8MG4W32

Next due date and appointment agreed 2/12/2024. 2pm

Assessed 7th Oct 2024 at 14:00

Summary of contact/details

Lee attended his planned monthly Buvidal appointment at Maybole Health centre on time, Lee appeared well kempt and engaged well throughout the appointment with good eye contact. Lee was appropriate in rate, tone and volume of speech. No observable signs of intoxication or withdrawal, Lee reported he felt stable on his medication and has been abstinent from illicit substances for 6 months. Lee accepted a NYXOID naloxone kit.

Lee detailed that his mood was low and that he has not been leaving his house often. When CN Glass asked about sleep and diet, Lee replied that he has had poor sleep not being able to sleep at night and napping throughout the day, CN Glass advised not sleeping throughout the day in order to not create a bad sleeping habit. Lee stated no issue with diet. Lee denied any thought plan or intent to complete suicide highlighting his mother as a protective factor. Lee reported that he had not attended the tier 2 low level psychological intervention however did not go into further detail and stated he plans to contact his GP regarding his mood.

CN Glass administered the 128 mg Buvidal subcutaneous injection into Lee's right abdomen with no adverse reactions or irritations observed by staff or stated by Lee.

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

EXP: 09-2026
LOT: A0183A
PC: 07350068620423
SN: BPWDNN6NA06K3NY

Lee is aware of next monthly Buvidal appointment on 04/11/2024, Lee is aware he can contact the service if needed. No further issues or concerns raised at appointment.

Assessed 25th Sep 2024 at 10:45

Summary of contact/details	

ier 2 clinic, 2nd offered initial appt, Lee failed to attend without prior warning.
Lee to be discharged from Tier 2 at this time, writer to advise keyworker C/N A Glass of same.

Assessed 18th Sep 2024 at 16:45

Summary of contact	

You have been referred to the Tier 2 Clinic by Angela Glass/Dr Wilson.

An appointment has been arranged for you on:

Date Wednesday 25 September 2024

Time 10:45 am

Venue Ayrshire Council on Alcohol, 24 Fullarton Street, Ayr

If you are unable to attend this appointment, please call the above number to re-arrange.

Assessed 18th Sep 2024 at 10:45

Summary of contact/details	

Tier 2 clinic, managing your worries, session 1
Lee failed to attend without prior warning.
2nd appt offered Wed 25th sept, should Lee fail to attend 2nd offered appt he will be discharged from Tier 2. Key worker updated.

Assessed 9th Sep 2024 at 15:00

Summary of contact/details	

Lee attended his appointment at Maybole Health Centre today with writer and st/n K Woods to receive his monthly Buvidal injection. Lee was slightly flat in his presentation. He engaged well in conversation throughout the appointment however did make comment that he is really struggling with his mental health. His speech was appropriate in rate, volume and tone. There were no signs noted in regards to intoxication or signs of withdrawals.

Lee reported that he is really struggling with his mental health currently however has plan in place with his key worker and prescriber for support around this. Lee denied any illicit substance or alcohol use. He reports to feel stable on his Buvidal injection, not noticing it was a week over due.

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

St/n Woods administered 128mg Buvidal injection was administered to his left abdomen as per his request and prescription. No adverse reactions or irritations noted following administration.

EXP: 07-2026
LOT: A0183A
PC: 07350068620423
SN: XYVSYR2R4DT4187

Lee's next dose is due in 4 weeks time (07/10/2024). Writer advised Lee will be sent appointment letter close to date. Lee is aware he can contact the service in the meantime if needed. No further concerns or risks identified at this time.

Assessed 6th Sep 2024 at 16:00

Summary of contact/details	

You have been referred to the Tier 2 Clinic by Angela Glass/Dr Wilson.

An appointment has been arranged for you on:

Date Wednesday 18 September 2024

Time 10:45 am

Venue Ayrshire Council on Alcohol, 24 Fullarton Street, Ayr

If you are unable to attend this appointment, please call the above number to re-arrange.

Assessed 27th Aug 2024 at 11:00

Summary of contact/details	

Lee attended his planned appointment with Dr Wilson and C/N Glass at Dr Wilson's joint clinic/prescriber review within Girvan Community Hospital.
Writer will discuss and complete referral to low intensity clinic within service for support for Lee's mental health which he had reported to have dipped alongside his physical health over the last few months.
See Dr Wilson's clinic entry for further details.

Assessed 27th Aug 2024 at 10:36

Summary of contact	

Diagnosis: F11.2 Opioid Dependence Syndrome

Psychiatric Medication: Buvidal 128mg monthly prescribed and administered through START
No regular GP medications reported (unable to access ECS today to confirm)

Recommendations/Plan: Repeat OPC 3-4 months (Maybole Health Centre)
START CPN, Angela Glass

CPN Glass and I reviewed Lee at the Girvan Hospital Addictions Out-patient Clinic on 27th August 2024. Lee presented as well kempt with no suggestion of intoxication or withdrawal from any substance. Skin irritation was visible on his head and face. He appeared relaxed and low, but reactive in mood, appearing less bright overall than at his previous clinic appointment. There was

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

no suggestion of active symptomatology of major affective or psychotic disorder and he did not report recent thoughts of self-harm/suicide or of harming others.

Addictions Stability and Addictions Medications
Lee completed transfer from Methadone to Espranor, and thereafter Buvidal, in April of this year. He reports no Opiate withdrawal symptoms subsequently and describes abstinence from all un-prescribed substances and alcohol since this transfer. He seemed pleased with the effect of Buvidal on his addictions stability and stated he wished to continue with this.

He seemed to be describing heightened emotional clarity since this transfer. We discussed that this may be related to the direct effect of Buprenorphine, and may also be related to the fact he is no longer using sedating illicit substances alongside his prescribed Opiate replacement therapy. We highlighted that this is common during the initial stages of Buprenorphine treatment nd discussed mental health supports (as below) which may assist.

Mental Health
Lee reports a general sense that he is struggling with his mental health currently. He seemed to be describing an understandably difficult adjustment to changes in his life circumstances over the last year (specifically, the breakdown of his long-term relationship and subsequent lack of contact with his young daughter and stepchildren, his lapse to unprescribed substance use and now re-establishment of abstinence, the recent deterioration in his physical health, the loss of his employment, the adjustment to his new living circumstances with his mother, concern around his mother's physical health). He described a deterioration in his sleep in recent months (broken sleep). He reported good appetite. He described a general lowering of mood, though did report being able to concentrate on and enjoy activities of interest.

Our overall impression was that Lee was not presenting as significantly depressed. We discussed options for treatment and support for his understandable difficult emotions. We discussed that antidepressants may offer some benefit, but would be unlikely to cure his difficulties and he was clear he did not wish to consider antidepressants currently. He seemed more keen for psychological approaches and CPN Glass will link him with our T2 low intensity psychological interventions clinic as a starting point. He is aware to contact us on an early basis in the event of any deterioration in his mental health meantime.

hysical Health and Social Circumstances
ee reports a deterioration in his physical health in spring of this year. In June he underwent a several day acute medical admission in Ayr Hospital with a pneumonia and ?suspected TB. He reports improved respiratory functioning subsequently with no ongoing treatment and states to have a respiratory out-patient clinic follow up appointment in September. He noted while in hospital developing a widespread skin irritation which was relieved with antihistamines at that time. He states he discontinued antihistamines several weeks ago and the skin condition is now returning. We suggested he discuss this at the community pharmacy in the first instance and consider attending his GP, both of which he said he would do. I note that his hospital discharge correspondence listed both Guillain Barre Syndrome and possible substance overdose as secondary diagnoses (Lee has repeatedly denied drug use at that time). He reports gaining weight in recent months and seemed pleased by this.

Lee continues to reside at his mother's home and seemed to have no immediate plan to seek his own tenancy today. His mother is said to have recently undergone an operation so Lee's aunt is also temporarily staying for support and his mother is now said to be making a good recovery. Lee reports being off sick from work for several months and states he does not feel physically ready to return and therefore has now handed in his notice and is in the process of obtaining state benefits. Clearly this is a difficult adjustment for him.

He reports his ex-partner in Cumnock has cut off all contact with him and he therefore no longer has current contact with his young daughter, Harper who has entered primary 3. He discussed a plan to challenge this once he feels more physically fit. He did not report immediate forensic issues and continues to report that his driving licence is suspended by the DVLA following his previously disclosing substance dependence.

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Assessed 5th Aug 2024 at 15:00

Summary of contact/details
Lee attended his planned appointment with writer C/N Glass at Girvan Community Hospital for administration of his monthly buvidal injection. C/N Clarke was also present. Lee was dressed casually, he presented well kempt and groomed and he appeared bright and chatty throughout. There was no signs of any intoxication. Lee denies any illicit substance or alcohol use and reports to feel stable on his prescribed OST buvidal. Lee reports to be in receipt of nyoxid. Lee spoke of recent hospital admission with pneumonia and reports to be recovering from same and feeling a lot better. Lee advised that he is still off work on sick leave. Lee reports to feel well mentally. Lee advised that he is no longer in a relationship but feels this to be a positive aspect in his life as his ex-partner had continued to use drugs. Lee reports good family support. Lee was administered his monthly 128mg buvidal injection into his right side abdomen with no ill effect. EXP: 09/2026 LOT: A0183A PC: 07350068620423 SN: XMYCTM6C85SHETY No concerns next due date: 02/09/24.

Assessed 8th Jul 2024 at 15:00

Summary of contact/details
Lee attended his appointment at Maybole Health Centre today with writer to receive his monthly Buvidal injection. Lee was bright and friendly with writer. He engaged well in conversation throughout the appointment. His speech was appropriate in rate, volume and tone. There were no signs noted in regards to intoxication or signs of withdrawals. Lee reported that he was in hospital for a while the previous week due to possible pneumonia and respiratory issues. He reported to be feeling better however writer could still hear Lee was struggling from a chesty cough. Lee denied having any other concerns regarding his physical health, he explained that he is currently off work which is helping with his recovery. Lee denied any concerns regarding his mental health. Lee denied any illicit substance use and reports to be feeling stable on his prescription. Lee is keen to talk about reducing his Buvidal dose, writer encouraged Lee to discuss this with his key worker (CN Angela Glass) at his next appointment. 128mg Buvidal injection was administered to his left abdomen as per his request and prescription. No adverse reactions or irritations noted following administration. EXP: 07-2026 LOT: A0166A PC: 07350068620423 SN: FEEMX026X4XC4FA Lee's next dose is due in 4 weeks time (05/08/2024). Writer advised Lee will be sent appointment letter close to date. Lee is aware he can contact the service in the meantime if needed. No further concerns or risks identified at this time.

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Assessed 28th Jun 2024 at 13:19

Summary of contact/details	
HOSPITAL DISCHARGE Correspondence received via clinical email to advise that Lee was discharged from Ayr Hospital General Medicine on 27/06 KW emailed and aware	

ıssessed 21st Jun 2024 at 10:19

ɔummary of contact/details	
Duty Correspondence via clinical mail reports Lee attended ED on 20/6/24 and was later admitted to hospital the same day. Unwell adult feeling unwell sudden onset of facial oedema/ widespread rash to body. scrotum odeamous. KW emailed	

Assessed 10th Jun 2024 at 15:00

Summary of contact/details	
I confirm the previous entry recorded by ST/N McClure is an accurate reflection of the event.	

Assessed 10th Jun 2024 at 15:00

Summary of contact/details	
ɛe attended his appointment today at Maybole Health Center for his monthly Buvidal 128mg injection with C/N Angela Glass, ST/N Valerie McClure was also in attendance. As Lee's prescription was held at Girvan pharmacy instead of Maybole pharmacy, C/N Angela Glass apologized about the mix up and advised Lee that she would have to go and collect his Buvidal injection from Girvan and asked Lee if he could come back at 4pm. Lee appeared to be disgruntled by this, and stated that he was already a week late in getting his injection and was going to Birmingham to work tomorrow so needed it done today. Lee also stated that he was not happy as he had not been receiving appointment letters, getting phone calls or been drug screened. C/N Angela Glass advised Lee that she had checked that all appointment letters had been sent and it may have been lost in post. C/N Angela Glass also advised Lee that she could carry out a drug screen during this appointment. Lee consented to providing a urine drug analysis screen, which tested positive for his prescribed Buprenorphine and the line for opioids appeared to be extremely faint. However, Lee could not provide much urine for said screen. Lee returned at 4pm as arranged. He was well-kempt in presentation and dressed appropriately for the weather. Lee engaged well throughout his appointment and his speech was appropriate in rate, volume and tone. There were no visible signs of withdrawals or intoxication in presentation at time of writing. Lee denied any illicit substance use and reported that he was keeping well. Lee also reported that he has been working away a lot and requested that his prescription be changed to Maybole pharmacy as the Maybole Clinic appointment suits him best at present. C/N Angela Glass agreed to same and has advised Girvan pharmacy that his prescription will be getting transferred to Maybole pharmacy. In regards to his OST, Lee reported that he feels the Buvidal 128mg injection is working well for him and he wishes to continue on his current dose. ST/N Valerie McClure administered Lee's monthly 128mg Buvidal injection to the right side of his abdomen. No visible side effects or reactions were reported at time if writing.	

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male · CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

EXP: 07-2026
LOT: A0166A
PC: 07350068620423
SN: W10KTB0CN9F5YGK

Lee's next Buvidal injection is due on 8/7/2024. No other issues or risks were identified at time of writing. Lee is aware that he can contact START if required in the mean time.

Assessed 3rd Jun 2024 at 14:30

Summary of contact/details	
Lee failed to attend planned appointment with writer at Maybole Health Centre today for administration of his monthly buvidal injection. Writer contacted Lee on phone to enquire if he had forgotten. Lee reports to be in Dundee working this week and not back till end of week thinking his injection was next week. Stated that he did not receive letter. Appointment rearranged for next week.	

Assessed 8th May 2024 at 16:00

Summary of contact/details	
Lee attended for his appointment to receive his first monthly Buvidal injection at Maybole Health Centre. Lee was bright and reactive in affect. His speech was appropriate in rate, volume and tone with no concerns regarding intoxication or signs of withdrawals. Lee reported that he could not stay long for his appointment as he was running late for his dentist appointment. Lee reported that he has been feeling great since commencing on the Buvidal injection. Lee denied any alcohol or illicit substance use since commencing on his Buvidal injections. He reports to feel stable and denied experiencing any withdrawal symptoms. Writer administered 32mg weekly Buvidal injection to Lee's right abdomen as per his request and prescription. There was no adverse reaction or irritation noted following administration. There was a little blood following injection administered however this cleared quickly and Lee denied any lasting pain. EXP: 05-2026 LOT: A0093H PC: 07350068620423 SN: A3DDMFPAR1KP5FT Lee's next dose in due in 4 weeks time (05/06/24) at Maybole Health Centre. Lee is aware he can contact the service in the meantime if needed. No further concerns or risks identified at this time.	

Assessed 29th Apr 2024 at 14:31

Summary of contact/details	
I confirm that the previous entry recorded by ST/N McClure is an accurate reflection of the event.	

Assessed 29th Apr 2024 at 14:30

Summary of contact/details	

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Lee attended his weekly Buvidal Clinic appointment today as arranged with C/N Angela Glass, ST/N Valerie McClure was also in attendance. Lee was dressed casually but well kempt today and his mood appeared bright. Lee's speech tone, rate and volume were appropriate and he engaged well throughout his appointment. Lee did not display any signs of intoxication or withdrawals at time of writing. Lee reported that he was feeling great today and stated that he felt Buvidal was working well for him and he had more energy. In regards to side effects Lee reported that he had been having strange dreams but nothing alarming and that had been waking during the night. C/N Angela Glass advised Lee that these were common side effects of Buvidal and should settle with time, C/N Angela Glass gave Lee the patient information leaflet from his Buvidal 32mg to read at home. Lee reported he was in a hurry today as he had a dental appointment straight after this appointment today.

C/N Angela Glass administered Lee's Buvidal 32mg weekly injection today to his RIGHT abdomen. There were no sign effects identified or reported at time of writing.

EXP: 12-2025
LOT: A0012AA
PC: 07350068620393
SN: 933NT4K8E489DMX

Lee's next appointment has been made for 8/5/24 at 4pm for his monthly Buvidal injection. Lee is aware how to contact the service if required in the mean time. No other concerns or risks were identified at time of writing.

Assessed 22nd Apr 2024 at 16:00

Summary of contact/details	

Lee attended for his appointment to receive his first Buvidal injection at Maybole Health Centre. Lee was due to receive his injection the previous Friday (19/04/24) however had taken his dose of Espranor that morning. Lee was bright and reactive in affect. His speech was appropriate in rate, volume and tone with no concerns regarding intoxication or signs of withdrawals.

Writer spoke with Lee's community pharmacy who reported that Lee had not collected his Friday Espranor as it was on hold and s last collection was on the Tuesday where he was given 3 days worth of 16mg Espranor. When discussed with Lee he appeared confused stating he had more that 3 days in his box where he keeps his medication, he explained that this may of been mixed in with his ex partners medication or he may of had extra without knowing. Lee denied having any Espranor today and denied any opiate or other illicit substance use.

Lee spoke briefly about his new job stating he has to give 12 weeks notice, in the meantime he would like to attend Maybole Pharmacy for his Buvidal injection. Once he starts his new job he may have to move to the Girvan Buvidal clinic whilst he is working away for his training.

Writer administered 32mg weekly Buvidal injection to Lee's left abdomen as per his request and prescription. There was no adverse reaction or irritation noted following administration.

EXP: 12-2025
LOT: A0012AA
PC: 07350068620393
SN: 92AA0NP3DWCX53R

Lee's next dose in due in a weeks time (29/04/24) at Maybole Health Centre. Lee is aware he can contact the service in the meantime if needed. No further concerns or risks identified at this time.

Assessed 19th Apr 2024 at 10:30

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) **undefined** Male **CHI Number** 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Summary of contact/details	
Lee attended his appointment today at Girvan community Hospital with writer and ACDW Keri McNeil to receive his first dose of the weekly Buvidal injection. Lee stated that he had taken 16 mg of Espranor this morning before his appointment. He stated that he was unaware that he was not supposed to take this medication. Writer advised that due to Lee taking his Espranor this morning he was unable to receive his first monthly dose of Buvidal. Lee was frustrated about this however understanding of the situation. Write rearranged his appointment for Monday afternoon at Maybole Health Centre where he will receive his first dose. Lee is aware he is not take any Espranor on this day and writer will ensure pharmacy do not dispense any further medication. New appointment arranged for Monday (22/04/24). Lee is aware he can contact the service in the meantime if needed. No further concerns or risks identified at this time.	

Assessed 10th Apr 2024 at 16:29

Summary of contact/details	
Lee attended arranged joint appointment with SN Laura Clarke. Laura discussed the plan moving from Espranor to Buvidal injection at length, Lee understanding of same. Lee stated that he had a mouth abscess, therefore consumed 1 Solpadol tablet, Lee stated that he has been feeling withdrawal, however has been feeling unwell due to abscess within his mouth. Lee stated that he has a dentist appointment arranged for later this pm. Discussed the risk of consuming opiates/codeine medication whilst prescribed Espranor medication and the risk of precipitated withdrawal. Lee understating of same. Urine drug screen undertaken, urine drug screen positive for Bup and Opiates. Lee stated that he has not smoked heroin since commencing on Espranor medication. Lee stated that he has now registered with Maybole Health centre. Lee stated that he will be starting new employment in 3/4 weeks for initial 6/8 weeks training. Discussed with prescriber Dr. Wilson. It was agreed that Lee will be started on weekly Buvidal injection on - 19/04 32mg (weekly) - 26/04 32mg (weekly) - 03/05 128mg (Monthly) Dr. Wilson generated prescriptions. It was agreed that Espranor medication will continue until Buvidal has been administered. Contacted Maybole pharmacy, Pharmacy aware to withhold dispensing of Espranor medication on 19/04. Lee to attended Girvan community Hospital on 19/04 at 10:30am - 26/04 10:30am - 03/05 10:30am. Lee has been advised of Buvidal clinic appointments.	

Assessed 10th Apr 2024 at 09:50

Summary of contact	
Following my recent clinic letter, Lee is now established on prescription Espranor through the START team. At Lee's request, following keyworker update review on 10th April, he is undergoing a planned to transfer to Buvidal which will be prescribed and administered through our service. (Since this letter was dictated, he commenced Buvidal 32mg weekly on 22nd April, and if his first 2 doses are received and tolerated this will move to 128mg monthly from early May. His Espranor has therefore now been discontinued. We will let you know if this plan changes).	

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

This is at the upper end of recommended Buvidal initiation doses on transfer from Espranor 16mg daily at Lee's request, with this starting dose being consistent with SIGN recommendations around Buvidal. His treatment plan remains otherwise as detailed in my last clinic letter.

Assessed 4th Apr 2024 at 10:40

Summary of contact/details	

Writer telephoned Lee, Lee stated that he has not used any illicit substances since being commenced on Espranor medication. Lee stated that he is concordant with prescribed Espranor medication. Writer discussed with Maybole Pharmacy. pharmacy reports no concerns when Lee attends for dispensing.

eview appointment with SN Laura Clarke on 10/04 at 1:30pm within Maybole health centre to discuss Buvidal injection further nd discuss plan moving forward.

Plan - Review appointment with SN Laura Clarke on 10/04 at 1:30pm within Maybole health centre

Assessed 21st Mar 2024 at 13:58

Summary of contact/details	

Writer telephoned Lee, Lee advised that he did not present at pharmacy since 13/03 for prescribed 40mls Methadone as pharmacy advised that his prescription was on hold. Lee was last dispensed methadone on 13/03, however did not present after this. Pharmacy advised they dispensed 29 tablets from prescription of micro dosing at once. Lee advised that he is still continuing the plan of micro dosing and consuming as prescribed. Pharmacy have Espranor prescription within pharmacy, Writer advised to discard methadone prescription, stop sheet submitted. Review appointment arranged for today at 3pm within Milan suite, Lee happy to continue with Espranor plan without Methadone prescription. Lee still very keen to be commenced to 16mg Espranor, with further plan of Buvidal injection.

Lee presented within Milan for arranged review appointment.
ine drug screen positive for prescribed Bup.
ositive for opiates and benzo.
lee stated that he smoked half a bag of heroin 2 days ago. Lee is fully aware of the risk of consuming opiates whilst prescribed Espranor medication and effects from same. Lee advised that he felt slight withdrawals, writer advised that using opiate based substances whilst prescribed Espranor medication can induce precipitated withdrawal . Lee advised that he would not consume and opiate based medications in the future.
Lee advised that when his methadone medication was on hold and did not receive his 40mls dose whilst micro dosing he felt in withdrawal, therefore consumed prescription grade 5mg Diazepam. Writer advised that drug use would need to be discontinued if planning on continuing with micro dosing pan following Buvidal injection. Lee aware of risks of illicit substances whilst prescribed Espranor medication.

Cows score undertaken - scoring 7.

Discussed with prescriber Dr. Wilson, it was advised that Lee can continue on micro dosing as planned without methadone prescription. Writer contacted Maybole pharmacy. Pharmacy advised that they have second week of Espranor prescription within pharmacy and happy to dispense this from 22/03. From this lee will attend pharmacy again on 28/03 and receive one day dose of 16mg Espranor, attending on 29/03 16mg twice weekly dispense. After this, writer will discuss plan for Buvidal injection with prescriber and team.

Writer will contact lee the morning of 22/03 to undertake further Cows screening. Lee aware of same.

Assessed 19th Mar 2024 at 16:23

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Summary of contact/details	
Writer visited Lee's address in Kirkmichael however Lee was not home but his mother advised that Lee was at his partner's and writer asked that Lee make contact with service as messages have been left for Lee to contact. Writer shall pass information to his named worker to clarify his address that he is residing at.	

Assessed 19th Mar 2024 at 13:10

Summary of contact/details	
UNSUCCESSFUL CONTACT Writer attempted to call Lee, no answer, voice message left. Pharmacy advised they have had no contact with Lee since 4.55pm on 15/03/24 when dispensing was refused. Lee has now missed 5 days Methadone today being day 6.	

Assessed 18th Mar 2024 at 11:58

Summary of contact/details	
PHARMACY CONTACT Lee failed to attend for Methadone 14/03 and turned up at 4.55pm on the 15/03 and wasn't dispensed to. Lee has now missed 4 days of his 40ml Methadone. Attempts to call Lee last week were unsuccessful. Pharmacy have raised a few concerns recently since having reconnected with his ex partner. Lee commenced micro dosing on 12/04 collecting all the required medication at this time. Pharmacy discussed his plan and provided a check sheet. Lee presented 13/03 unsure of what he should be doing. He hadn't taken his first dose at this point. Pharmacy again went through the plan. Prescriber emailed for advice. Prescriber advised that once contact with Lee has been established a discussion would require to take place regarding plan going forward with regards to OST. Lee will be advised of options to allow him to make an informed decision. Contact attempted to Lee, voice message left	

Assessed 15th Mar 2024 at 10:07

Summary of contact/details	
PHARMACY CONTACT Phone contact received from Lucy at Maybole Pharmacy to advise that Lee failed to attend the pharmacy yesterday to collect his prescribed 40ml of Methadone. Lee has recently commenced on micro dosing to allow him to change to Espranor with a view to commencing Buvidal. Lee collected 2 week Buprenorphine prescription on 12/03. Several attempts have been made to contact Lee to discuss his agreed plan due to Lee voicing some confusion to pharmacy earlier in the week. Writer discussed pharmacy contact with Dr Wilson who advised that pharmacy to hold todays prescription until Lee makes contact with START. Should Lee fail to attend pharmacy today no methadone to be dispensed over the weekend and Lee to be encouraged to contact START on Monday. Pharmacy made aware of plan. Writer attempted to call Lee however no answer from mobile, voice message left.	

Assessed 14th Mar 2024 at 14:18

Summary of contact/details	
PHONE CONTACT 2.15PM- Writer attempted to call Lee following commencement of micro dosing on 12/03. No answer at this time from either	

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

number on Carepartner.

3pm- Further contact attempted by S/N Laura Clarke. No answer, voice message left.

Assessed 13th Mar 2024 at 14:12

Summary of contact/details	
ATTEMPTED PHONE CONTACT Writer attempted to call Lee following commencement of micro dosing yesterday. No answer from number on system. Writer will ttempt further contact.	

Assessed 8th Mar 2024 at 12:27

Summary of contact.	
Email sent to Pharmacy on behalf of Dr Wilson on 08/03/2024 uploaded.	

Assessed 8th Mar 2024 at 12:11

Summary of contact/details	
Lee attended arranged joint prescriber review with Dr. Wilson to discuss OST options. It was agreed that Lee would commence on micro dosing Espranor with methadone medication. Lee advised that he would feels happy with micro dosing plan due to his working commitments. Lee will commence micro dosing programme (MDP) from methadone to Espranor on 12/03 for 13 days, following this will be commenced on Buvidal injection. Dr. Wilson sent email to pharmacy to advise of induction chart of micro dosing. Lee is aware of the risk of using opiate based substances whilst prescribed Espranor medication. ine drug screen undertaken, urine drug screen positive for prescribed methadone medication. ositive for Opiates, THC, Benzo. Lee stated that he was unable to fall asleep after his nightshift last weekend therefore consumes 4/5 street diazepam. Lee stated that he smoked 1 bag of heroin after his work to aid sleep. Writer discussed sleep hygiene at length. Writer advised the risk surrounding illicit substances whilst prescribed OST and with the plan on micro dosing. PLAN: Espranor micro-dosing programme (MDP) to commence from 12/4/23: - Lee's Methadone to currently remain at 40mls daily, surprised, - 7 day MDP from 12/3/24 - 19/3/24 (dispensed on 12/3/24). 7 day Espranor MDP from 19/3/24 - 25/3/24 (dispensed on 19/3/24) - routine Espranor 16mg prescription, TWPU from 26/3/24 - methadone prescription to stop 25/3/24. Lee is fully aware of regime, and provided with Micro dosing Induction Chart. Discussed plan with Maybole pharmacy, Pharmacy happy with same. Dr. Wilson sent clinical email to pharmacy with Micro dosing Induction Chart. Girvan/Maybole team aware of plan. It was agreed that ASW Siobhan Kerr will contact Lee on 13/03 - 15/03 and 19/03 on writers absence. Writer will arrange home visit once returned from annual leave. Buvidal clinic will be discussed in 2 weeks time.	

Assessed 8th Mar 2024 at 11:25

Summary of contact	

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Diagnosis: F11.2 Opioid Dependence Syndrome

Psychiatric Medication: Methadone 40mg by daily supervised dispense (update 4/4/24: Methadone now discontinued at patient request in the weeks since this appointment).
Buprenorphine Microdosing induction commenced through START from 12th March (and as at 4/4/24 Lee is now established on Espranor 16mg daily by twice weekly dispense through START, with plan to transfer to Buvidal depot Buprenorphine injection in next 1-2 weeks).
No regular GP medications reported (unable to access ECS today to confirm).

Recommendations/Plan: Repeat OPC 3-4 months (Maybole Health Centre, Friday appointment around work commitment)
START keyworker, Keri McNeil

Apologies for the delay in this letter.

Community Addictions Worker, Keri McNeil and I met with Lee at Ailsa Hospital Addictions Psychiatry Out-patient Clinic on the morning of 8th March 2024. The appointment was arranged earlier than planned at Lee's request as he wished to discuss options for transfer from Methadone to Buprenorphine.

Lee's presentation today was entirely unchanged from that described in my January 2024 assessment letter. His mental state was again unchanged, and he reported no immediate changes in his mental health, physical health, or social circumstances.

2/ LEE JOHNSTONE 12 WOODSIDE AVENUE, KIRKMICHAEL, MAYBOLE, AYRSHIRE, KA19 7PP
CHI No: 0902763334

He reports that his Methadone prescription has supported him to manage Opiate withdrawals to the extent that he has now halved his inhaled Heroin use (now smoking small quantities once rather than twice daily). But he feels the Methadone effect is wearing off around 12 hours post-dose, leading to withdrawal symptoms which are making it difficult for him to discontinue Heroin at the current Methadone dose. He continues to report struggling to attend the pharmacy daily around his work commitments and does not feel this is sustainable in the long-term. Therefore he had reached the conclusion that he wished to work towards transfer to the Buvidal depot Buprenorphine injection rather than seeking further Methadone dose increases.

Urine drug screen today was positive for Methadone and Opiates as expected, and also for Cannabis (occasional use reported) and Benzodiazepines (one off use of 4 unprescribed tablets to help with sleep on one occasion after finishing nightshift one week ago, no other unprescribed substance or alcohol use reported). Harm reduction advice was given and Lee reports a plan to maintain abstinence from unprescribed Benzodiazepines from now.

We discussed options for transfer to Buprenorphine. We discussed our more general (and licensed) recommendation for reduction to 30mg of Methadone then no Opiate replacement dose for one day followed by initiation of Buprenorphine when in Opiate withdrawal. We also discussed our new Microdosing transfer option which, while unlicensed, offers a more gradual transition to Buprenorphine alongside Methadone which can then be discontinued. We discussed the pros and cons of both approaches, and the logistics of taking both generic Buprenorphine and Espranor for the Microdosing transfer.

Lee understands the risks of heightened emotional clarity, the partial agonist blocking effect of Buprenorphine for Opioid analgesics and the risk of precipitated withdrawal, and the logistics and potential risks and benefits thereafter of transfer to Buvidal.

There seemed to be no contraindication to Buprenorphine Microdosing initiation which was Lee's preferred option. Similarly, there seems no contraindication to Buvidal if treatment dose Espranor is then tolerated for a few days so our team will look at supporting him through the process and transfer provided he tolerates this. We will keep you updated on this as above.

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Lee seemed pleased with this outcome, whilst also leaving with our local Buprenorphine Microdosing initiation patient information sheet and dose chart, plus our wider Opiate Replacement Therapy leaflet which contains information on Espranor and Buvidal more generally.

Assessed 7th Mar 2024 at 12:56

Summary of contact/details	

Discussed with prescriber Dr. Wilson regarding Lee's starting on Espranor medication with the view of transferring to Buvidal. Appointment arranged for 08/03 at 9:30am within Milan Suite.

Writer has attempted to call Lee on several occasions, however voicemail answered, voicemail left to contact service. Maybole pharmacy contacted to advise Lee to contact service.

Assessed 6th Mar 2024 at 16:21

Summary of contact/details	

40mls methadone, daily supervised.
Dispensed from Maybole Pharmacy.
prescriber - Dr. Wilson.

Lee is requesting to be transferred to Buvidal, however advised that he would need to be commenced on Espranor medication for a few weeks before Buvidal injection.
Writer will discuss with prescriber with plan moving forward.
Lee report's no GP medications.

Lee advised that his brother passed away 6 years ago, therefore started to misuse heroin in order to cope. Lee advised that his relationship with his partner is a good support. Lee reports no concerns regarding his mental health at this time. Lee advised that he works full time and this occupies most of his time. Lee advised that he wishes to change to Espranor medication with the view of starting Buvidal injection due to his work commitments. Writer will discuss with prescriber and arrange a pan moving forward.
Lee reports no history of , or risk of, deliberate self-injury or suicide.
Nor any history of antidepressant or other psychiatric treatment.
Lee reports no thought, plan or intent of self harm at time of assessment. Outreach numbers provided.
Historical - Lee disclosed 1 x previous self harm incident when his brother died 16 x years ago. Lee self harmed on his arms with a razor. No further attempts since. No current self harming thoughts/feelings.
Lee reports no thought, plan or intent of suicide at time of assessment. Outreach numbers provided.
Historical - Lee disclosed 1 x previous suicide attempt. He informed that he attempted to hang himself 16 x years ago when his brother died suddenly. He stated that the rope snapped. No further attempts made since. He reported feeling remorseful following this. No current suicidal ideation.

Lee has 1 child and 4 step children. They all live with their mother [redacted]
[redacted] (260/9/05)
[redacted] (24/07/06)
[redacted] (dob unknown at this time)
[redacted] (30/6/14),
And his daughter [redacted] (07/03/17).

No current social work involvement.
Lee and [redacted] separated, occasional contact with children due to work commitments.

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) **undefined** Male **CHI Number** 0902763334

History for Summary of contact/details

From 27/05/1926 **Until** 27/05/2026

No current issues raised at time of writing.

Lee has a history of prison sentences, including 2 years and 10 months for serious assault. Last sentence was in 2014. No issues noted during appointment. Reports no outstanding warrants, charges or arrests.

Lee is currently prescribed methadone 40ml daily supervised pick up. Planning to commence Espranor once prescriber review undertaken, Following transition he will be commencing Buvidal.
Lee stated that this will be more suitable for his work as he has been working away from home more often.
Lee advised that he is smoking 1 bag of heroin in the morning, however is aware he is unable to consume any opiate based medication whilst prescribed Espranor medication, aware of risks of same. Harm reduction advise given. IEP services advised. Declined BBV.

Lee sustained a back injury years ago which he used to manage with Solpadol 30/500mg tablets however stopped medication when he was started on a methadone prescription. No other physical health issues raised at this time and not on any other medication.

Lee advised that he has a supportive relationship with his family and partner. Lee works full time and this occupies most of his day. currently working full time away from home during the week, Lee stated that he usually doesn't work on a Friday, staying at his mothers tenancy. Lee is in full time employed. No housing and or financial issues raised at this time.

Plan - Discussed with prescriber Dr. Wilson regarding transfer to Espranor medication.
Prescriber appointment to be organised initially before transition.
Writer will discuss with team nurses re; buvidal.
Lee to discontinue use of heroin occasionally.
Lee is aware of the risk of using opiate based substances when prescribed Espranor medication.

Assessed 1st Mar 2024 at 16:22

Summary of contact/details	
Lee did not attend home visit appointment, note posted through letterbox requesting Lee to contact service. Lee contacted service and advised that he was within his tenancy at the time, however could not hear the door bell. Plan - Home visit appointment arranged for 06/03 at 2pm.	

Assessed 22nd Feb 2024 at 11:36

Summary of contact/details	
Lee returned writers call, Lee advised that he had been working and was unable to answer writers call. Home visit appointment confirmed for 01/03 at 1:30pm/2pm	

Assessed 15th Feb 2024 at 12:59

Summary of contact/details	
Writer telephoned Lee, however voicemail answered, voicemail left to contact service. Writer telephoned Well Pharmacy, pharmacy advised that Lee has been attending daily for dispensing, no concerns regarding presentation. Writer has requested pharmacy to leave note for Lee to contact service as soon as possible.	

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Writer has sent appointment letter to Lee's home address.

Plan - writer will continue to make contact.

Assessed 9th Feb 2024 at 13:38

Summary of contact/details	
Writer telephoned Lee for follow up, however no answer, voicemail left to contact service. Writer will send appointments letter to Lee home address. Plan- Appt letter to be sent to Lee home address. Lee has requested appointments after 2pm due to work commitments.	

Assessed 31st Jan 2024 at 16:31

Summary of contact/details	
Writer attempted to make further contact with Lee for MAC Review to ascertain how he is getting on with his ORT prescription. Unable to make contact as phone is ringing out on both attempts. Writer contacted pharmacy requesting they ask Lee to contact START Duty Team tomorrow for review. Pharmacy reported Lee has been attending for pick up and no concerns raised.	

Assessed 30th Jan 2024 at 15:56

Summary of contact/details	
Writer attempted to call Lee for MAC Review and to see how he was getting on with new ORT medication but received no answer. Writer contacted pharmacy who reports no concerns with his appearance or attendance.	

Assessed 26th Jan 2024 at 10:19

Summary of contact/details	
AC Review Telephone call with Lee for review after MAC appointment. Lee reports to be experiencing symptoms of withdrawal but is aware that this is normal. Lee reports no side effects from the medication and was advised of the importance of attending the pharmacy. Lee reports he will be attending.	

Assessed 25th Jan 2024 at 12:36

Summary of contact	
Discharge letter sent to GP.	

Assessed 24th Jan 2024 at 16:26

Summary of contact/details	
Lee attended MAC Boswell House today for the purpose of assessment for suitability for OST. Dr Wilson and Dr. Geraldine Scullin (ST4) were also present. Lee was dressed casually and well kempt today. Maintained good eye contact with rapport easily established. His speech was appropriate in rate, rhythm and volume with no evidence of formal though disorder. He did not appear intoxicated during this conversation. Lee has requested to be commenced on Methadone medication as his choice of ORT should he be suitable however indicated in future he will be keen to transfer to Espranor.	

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Lee previously open to East Ayrshire addiction services however has now moved from East to South. Last dispensed dose from East was December 2023 and this was due to struggling to attend pharmacy as he works full time.

Reports no G.P prescribed medication, Plans to transfer to Maybole surgery from Cumnock.

Substance Use
Urine Drug Screen was positive for Opiates only
Naloxone accepted
Lee declined BBV testing
ASW Margaret-Ann will contact tomorrow 25/01/2024
Lee reports to smoke heroin however did not disclose quantity. He denied any other illicit substance use or any IV use.

Mental Health
Lee reports his mood fluctuates at this time. He states his recent relationship separation and ashamed of using heroin has impacted on his mood.
Lee denied any current self-harm thoughts, plans or intent.

Children
Lee has 1 x child and 4 x step children. They all live with their mother, [redacted] and at present Lee has no contact with children.
[redacted] (260/9/05)
[redacted] (24/07/06)
[redacted] (dob unknown at this time)
[redacted] (30/6/14),
And their daughter [redacted] (07/03/17).

Lee has declared his involvement with addiction services to DVLA.

Forensic
Reports no current or outstanding charges

Physical
No concerns and reports no allergies.

Plan
Lee will be contacted by ASW Margaret-Ann Wallace to review 25/01/2024
Lee to attend Toll pharmacy after 2pm to be commenced on 30ml Methadone 24/01/2024
Lee to be titrated to 40ml Saturday 27/01/2024
ASW will review Lee by telephone until she is allocated key worker.
Lee is aware she will be allocated a key worker (TBC) who will review and carry out assessment.

Lee works mostly nightshift and requested any calls be after 2.30pm. He is off every Friday.

Assessed 24th Jan 2024 at 14:38

Summary of contact	
Diagnosis:	F11.2 Opioid Dependence Syndrome
Psychiatric Medication:	Methadone 30mg by daily supervised dispense recommencing through START from 24th January, increasing to 40mg daily from 27th January with further dose titrations as indicated thereafter.

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

No regular GP medications reported (unable to access ECS today to confirm).

Recommendations/Plan: Repeat OPC 3-4 months (Maybole Health Centre, Friday appointment around work commitment) START keyworker, Tamie Kelly (will be transferred area keyworker in the coming days)

Community Addictions Worker Tamie Kelly, Psychiatry ST4 Dr Scullin, and I met with Lee at the Boswell House Addictions Medication Access Clinic on the morning of 24th January 2024. Lee had contacted our service in the preceding days requesting recommencement of Opiate therapy and this appointment was arranged to assess suitability for same.

Lee today presented as well kempt and wearing clothing branded with his employer's logo. There was no suggestion of intoxication or withdrawal from any substance. He appeared relaxed and bright in mood and there was no suggestion of active symptomatology of major affective or psychotic disorder. He did not report recent thoughts of self-harm/suicide or of harming others and appeared future focused.

Addictions Stability and Addictions Medications
Lee has been well known to the East Ayrshire Community Addictions Team previously, having been prescribed Methadone through that service on an ongoing basis from 2018 up to around 2 weeks ago.
2/ LEE JOHNSTONE 12 WOODSIDE AVENUE, KIRKMICHAEL, MAYBOLE, AYRSHIRE, KA19 7PP
CHI No: 0902763334

The records suggest he recently disengaged from contact with that service and today he reports having missed Methadone dose collection relatively frequently due to work commitments in recent years and finding it difficult to maintain this prescription as a result. As he is now living in South Ayrshire, this is the first START contact with him.

Lee reports feeling stable and abstinent from unprescribed Opiates for a long period when prescribed 50mg Methadone. Because of missed doses his Methadone dose has been frequently reduced in recent months and he describes struggling with Opiate withdrawals at the standard safe recommencement dose of 30mg. He reports smoking small quantities of Heroin twice daily at the current time to manage Opiate withdrawals and denies other recent illicit drug or alcohol use. He denies IV drug use at any time, and his earlier substance background is as detailed in Dr Kessavalou's January 2018 East CAT initial addictions assessment clinic letter. Urine drug screen today was positive for Opiates but negative for other tested substances.

We outlined prescribing options for Lee today and emphasised the potential benefits of Buprenorphine for him (in terms of more rapid titration to therapeutic dosing, reduced sedative effects, option of transfer to depot injection). Ultimately, he preferred the familiarity of recommencing Methadone, but is aware that Buprenorphine is an option and also that transfer from Methadone to Buprenorphine can now potentially be simplified through our Buprenorphine micro-dosing induction. He understands the risks and benefits of Methadone and is in possession of a Naloxone kit. We agreed that we would look to reduce his dispensing once he has stabilised at dose on an early basis and it is likely that I would move him straight to twice weekly supervised dispense following a clear drug screen once stable as an initial step given his work commitments.

Mental Health
Lee reports variable mood presently, attributing this to his current illicit Opiate use and social stressors, and was not describing features suggestive of active mental illness. He reports no previous specialist Mental Health Service input outwith addictions and the available records seem to support this. There has been a past account of self-laceration and an attempted hanging some 16 years ago following the death of his brother and he is aware of how to seek help in the event of a crisis. There seemed no indication to consider psychotropic medication today.

Physical Health and Social Circumstances
Lee reports generally stable physical health. He reports chronic lower back pain following previous injury (describes his first Opiate / Opioid as prescribed Co-codamol linked to this some years ago before moving onto Heroin) but states he generally now manages with this. There are no recent liver function tests available on the clinical portal system. He reports no known drug allergies.

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) **undefined** Male **CHI Number** 0902763334

History for Summary of contact/details

From 27/05/1926 **Until** 27/05/2026

Lee reports he is currently employed as a supervisor working for a company fitting and maintaining air conditioning systems. He reports this does not involve heavy machinery operation or work in dangerous environments. He describes enjoying this work, though notes that he can be required to travel across the country for this at short notice. He states his employer is not aware of his addictions background and he would not voluntarily disclose this.
There seemed no indication from his account to breach his confidentiality around this today.
3/ LEE JOHNSTONE 12 WOODSIDE AVENUE, KIRKMICHAEL, MAYBOLE, AYRSHIRE, KA19 7PP
CHI No: 0902763334

He reports his driving licence was revoked after previous disclosure of substance dependence and he hopes to reapply for this after a year abstinent from illicit substances (we discussed the legal requirements in detail today and he insists he is following these).

Lee has recently moved into his mother's home in Kirkmichael, after separating from his partner with whom he had been residing in Cumnock. He states his lapse to Heroin use was the trigger for the relationship breakdown though he remains on good terms with his ex-partner. His 4 stepchildren and his daughter continue to reside with this ex-partner and though he has no contact with the family currently he plans to resume this once stable from an addictions perspective (children's age range 2-18). There is no current Childcare Social Work input reported. Forensic history is said to include previous conviction for serious assault and previous prison sentences (last 2014) with no recent or outstanding criminal charges reported.

Assessed 24th Jan 2024 at 13:35

Summary of contact/details	

Lee attended planned MAC appointment this afternoon at Boswell House.
All contact details checked and verified.
Lee declined BBV testing
Naloxone supplied
UDS undertaken and positive for - Opiates

Plan- see ACAW for more info
Lee to commence 30ml Methadone 24/1/24
ASW to contact Lee 25/1/24 for review
Following review and regular attendance at pharmacy, Lee to be titrated to 40ml Methadone 27/1/24.

Assessed 22nd Jan 2024 at 15:48

Summary of contact/details	

Lee contacted service wishing to self refer having relocated from Cumnock to Kirkmichael.

He reports his relationship has ended and he has returned to his mothers home where he plans to remain for the foreseeable.

Lees prescription with East was discontinued on 04/01/24 following non collection/engagement. Previously 30ml Methadone, 50ml in the past but reduced due to non collection.
Lee currently reporting use of heroin only £50 daily smoked.
He is keen to recommence on OST and looking to explore Methadone and Espranor.
Works full time and so relaxed dispensing would benefit in future - encouraged to consider Espranor for Buvidal.
Aware there will be a process for any relaxed dispensing.
Pharmacy in Maybole (9 Hight street) happy to dispense - Confirmed by writer today - Lee had attended himself on Sat.

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Lee denied any physical or mental health concerns, no significant concerns noted on previous ARAF.
No other prescribed medications.
Lee will register at local GP.

Lee reports two children although previous ARAF notes conflicting info - to be clarified at assessment.

No financial issues, works full time.
No housing issues, living with own mother - supportive.
Denies driving, Advised and aware of DVLA responsibility.

Plan:
IAC appointment scheduled for 24/01/24 9.45am Boswell House
Update RADAR for Lee to be Dx - at Lee's request - he advised he did not intend to contact RADAR.
New pharmacy identified at 9 High Street Maybole.
MAC staff emailed.
Lee aware of assessment process.
Email sent to RADAR KW Katrina Skimming.
Writer called RADAR also.

Assessed 16th Jan 2024 at 16:59

Summary of contact/details	
CN K McSkimming attempted to call Lee however straight to voicemail, message left. Await contact.	

Assessed 11th Jan 2024 at 11:26

Summary of contact	
EE JOHNSTONE HI 0902763334 Prescribed by addiction services: nil due to non engagement Lee did not attend for his appointment with writer at Cumnock health centre on the 11th January 2024 I will see Lee again face to face at my next available appointment ,he will have regular key worker input in the . Lee does not have good engagement with our service which i will discuss with his key worker as it is important that he attends his appointments .I will discuss attendance with Lee as i could offer him an evening clinic if this would suit him better . Lee is not on a prescription with our service due to his non-engagement and will now be monitored by our twelve week engagement process . Should you wish to discuss this patient further please do make contact Joanne Goldie Community Addictions Advanced Nurse Practitioner North West Kilmarnock Area Centre 01563574237	

Assessed 4th Jan 2024 at 13:59

Summary of contact/details	
Lee not attending pharmacy , stop sheet completed Lee to contact service to get restarted.	

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Assessed 27th Dec 2023 at 16:24

Summary of contact/details
DUTY - pharmacist called stating that Lee was in chemist. writer asked pharmacist to take number and writer will call Lee with appointment. writer advised pharmacist not to dispense medication until Lee has been reviewed by duty. Attempted to call number that Lee had given pharmacist. No answer. attempted to call back pharmacy but Lee had left already. Police Scotland aware that Lee is safe and well. Await contact from Lee to arrange appointment to be reviewed.

Assessed 27th Dec 2023 at 15:41

Summary of contact/details
DUTY - Writer telephoned police Scotland to carry out welfare check. incident number 2911271223. Duty will follow up tomorrow if no contact made.

Assessed 27th Dec 2023 at 09:47

Summary of contact/details
DUTY- pharmacy report that Lee has missed 4 days of medication. writer telephoned Lee, no answer. generic voicemail left asking Lee to contact duty.

Assessed 30th Nov 2023 at 12:05

Summary of contact
LEE JOHNSTONE CHI 0902763334 Prescribed by addiction services 30mg methadone (daily dispense) Writer attempted to call Lee today the 30th November 2023 for a review of his care but he did not answer, writer has left a message for Lee to contact writer . I will see Lee again face to face at my next available appointemt, but he will have regular key worker input in the interm. Lee does not have good engagement with our service which i will discuss with his key worker as it is important that he attends her appointments . I do note that Lee works full time and this may be the reason for him not being available. I have asked for his prescription to be withheld at his next key worker review I will discuss attendance with Lee as i could offer him an evening clinic if this would suit him better . Should you wish to discuss this patient further please do make contact Joanne Goldie Community Addictions Advanced Nurse Practitioner North West Kilmarnock Area Centre 01563574237

Assessed 23rd Nov 2023 at 13:22

Summary of contact/details
CN K McSkimming attempted to call Lee however no answer. Writer wanted to offer appointment to discuss micro-dosing. Voicemail left await contact.

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Assessed 24th Oct 2023 at 11:08

Summary of contact/details	
Lee failed to attend arranged appointment with CN K McSkimming for review and potential increase in his prescription. Await contact from Lee.	

Assessed 18th Oct 2023 at 15:00

Summary of contact/details	
ee attended his arranged appointment with CN K McSkimming. SN E Houston also present during. Lee was dressed in his work clothes, reported that he was working tonight. Engaged well in brief conversation. Normal speech, tone and rate. He did not appear under the influence. Lee requesting to go back on to methadone prescription. Discussed espranor/buvidla however declined this at this time. Lee reported smoking 2-3 bags of heroin daily. Denied any other use. Urine drug screen undertaken, tested positive for opiates and EDDP only. Lee was recommenced onto his methadone prescription 30ml daily supervised. Further appointment arranged for Tuesday 24th October, 09:30am at Auchinleck Health Centre.	

Assessed 6th Oct 2023 at 14:57

Summary of contact/details	
Lee failed to attend his arranged appointment with CN K McSkimming to be recommenced on to methadone prescription.	

Assessed 2nd Oct 2023 at 11:36

ummary of contact/details	
DUTY CONTACT: Lee contacted Addiction services today to request he is restarted on his prescription writer returned Lee's phone call to advise that his key worker, Katrina McSkimming will return to work tomorrow and she will be notified to contact him this week to arrange this otherwise Lee would need to attend NWAC to be seen and restarted. Lee advised he is happy to wait for Katrina to make contact with him.	

Assessed 28th Sep 2023 at 15:01

Summary of contact/details	
Phone Call - DUTY Lee contacted Duty, reports has been working away and didn't realize it was a bank holiday last week and his script has been stopped he also had the police at his door last night doing a welfare check he would like to have his script restarted and apologized as he didn't realize they would stop the script Writer spoke with Lee over the phone, no concerns at time of call. Lee agreed to attend NWAC for a review/ restarted appointment: *29/09/2023 at 10am, NWAC* to see Duty.	

Assessed 27th Sep 2023 at 14:51

Summary of contact/details	

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Duty correspondence recieved from Maybole pharmacy stating Lee had not attended the pharmacy ince Friday the 22nd September. Several attempts to contact Lee on numbers on care partner with no answer. Welfare check placed incident number: 20762709.

Assessed 16th Aug 2023 at 15:25

Summary of contact/details	
Lee failed to attend his arranged appointment with CN K McSkimming at Cumnock Health Centre. Further appointment to be scheduled.	

Assessed 20th Jul 2023 at 13:30

Summary of contact	
LEE JOHNSTONE CHI 0902763334 Prescribed by addiction services 50mg methadone (daily dispense) Writer attempted to call Lee today the 20th July 2023 for a review of his care but he did not answer, writer has left a message for Lee to contact writer . I will see Lee again face to face at my next available appointemt, but he will have regular key worker input in the interm. Lee does not have good engagement with our service which i will discuss with his key worker as it is important that he attends her appointments . I do note that Lee works full time and this may be the reason for him not being available. I will discuss this with Lee as i could offer him an evening clinic if this would suit him better . Should you wish to discuss this patient further please do make contact Joanne Goldie Community Addictions Advanced Nurse Practitioner North West Kilmarnock Area Centre 01563574237	

Assessed 29th Jun 2023 at 16:27

Summary of contact/details	
"Lee Johnstone (09/02/1976)phoned asking if you could call him back on 07864847180". CN K McSkimming attempted to call Lee however straight to voicemail. Left voicemail, await contact.	

Assessed 21st Jun 2023 at 13:54

Summary of contact/details	
Lee attended his arranged appointment with CN K McSkimming at Cumnock Health Centre. Lee presented clean and tidy. Maintained good eye contact. Normal speech, tone and rate. Lee did not appear under the influence. Lee reported that he has relapsed and is currently smoking 2 x bags of heroin daily. Also reported buying illicit methadone on Monday, roughly 50ml. Lee requesting to go back on to methadone prescription. Urine drug screen undertaken, tested positive for opiates and EDDP only. Lee reported that since his relasped his mental health has deteriroated, mood fluctauting frequently. Not on any medication. No	

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

immediate concerns noted at this time. No suicidal ideation.

Plan:
Lee was commenced back on to methadone prescription.
Starting on 30ml daily and increased by 10ml every 3rd day until 50ml.
Lee is on nightshift next week so he has to contact writer next week for review when available.
Naloxone offered however declined at this time.
Lee is aware that he can contact the service if he feels he needs support.

Assessed 31st May 2023 at 13:40

ummary of contact/details	
CN K McSkimming attempted to call Lee however no answer, voicemail left. If no contact writer will send an engagement letter out.	

Assessed 17th May 2023 at 10:36

Summary of contact/details	
CN K McSkimming returned call to Lee however no answer, voicemail left. Await contact.	

Assessed 20th Apr 2023 at 09:14

Summary of contact	

LEE JOHNSTONE
Summary of contact

Lee Johnstone
HI 0902763334
Diagnosis: F11.2 Opioid Dependence Syndrome, currently on substitute treatment and stable

Psychiatric Medication:
Prescribed by Addictions Services: buvidal long acting injectible 96mg monthy depot
Prescribed by General Practitioner: None ,

I had a prearranged appointment with Mr Johnstone on the 20/04/23 at Cumnock Health Centre, but he did not attend . I also tried to call him the same day on a couple of occasions but he did not answer . I will re appoint Mr Johnstone in 3 months time, i know he is busy working away and does have regular contact with his key worker but if you have any questions in relation to this patient please do contact me, i will also highlight his non- attendance to his key worker and the importance of him also attending his prescriber appointments . Yours Sincerely

Joanne Goldie
Advanced Nurse Practitioner in Substance Misuse
North West Kilmarnock Area Centre
01563574237less

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

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Uploaded document

Not recorded

Assessed 31st Mar 2023 at 14:57

Summary of contact/details	
Lee failed to attend planned telephone appointment. Await contact from Lee.	

Assessed 24th Mar 2023 at 09:59

Summary of contact/details	
CN K McSkimming telephoned Lee however no answer. Voicemail left, await contact. Lee's prescription remains held at pharmacy. Writer attempted to call Lee's partner's number on the system however it is invalid.	

Assessed 23rd Mar 2023 at 13:59

Summary of contact/details	
CN K McSkimming attempted to call Lee several times for day 1 espranor however Lee did not answer. Voicemail was left but no response. Writer has held his pharmacy asking him to make contact with writer.	

Assessed 24th Feb 2023 at 14:04

Summary of contact/details	
Appointment letter being sent out for Friday 10th March, 11am at Cumnock Health Centre with CN K McSkimming.	

Assessed 14th Feb 2023 at 11:28

Summary of contact/details	
CN K McSkimming telephoned Lee to arranged appointment to update risk assessment for transferring to the South team however Lee informed that he wishes to remain within the East team. He informed that he is now back with his partner [redacted] and he is mainly at her house. Agreed that writer would send out an appointment for a couple of weeks time. Lee informed that he is off work on Fridays and asked if the letter be sent to his mother's address. 12 Woodside Avenue, Kirkmichael, KA19 7PP. Lee also enquired about commencing Buvidal. This to be discussed at appointment.	

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Assessed 12th Jan 2023 at 10:25

Summary of contact	

Summary of contact

Lee Johnstone
CHI 0902763334
Diagnosis: F11.2 Opioid Dependence Syndrome, currently on substitute treatment

Psychiatric Medication:
Prescribed by Addictions Services: Methadone 30 mls daily (on a weekly pick up)
Prescribed by General Practitioner: None

I had a prearranged appointment with Mr Johnstone on the 12/01/23 over the phone at Cumnock Health Centre, but he did not attend . I also tried to call him the same day on a couple of occasions but he did not answer . I will re appoint Mr Johnstone in 3 months time, but if you have any questions in relation to this patient please do contact me, i will also highlight his non-attendance to his key worker. I know that Lee is in employment and this may also be the reason for him not attending . Yours Sincerely

Joanne Goldie
Advanced Nurse Practitioner in Substance Misuse
North West Kilmarnock Area Centre
01563574237

Assessed 6th Oct 2022 at 10:04

Summary of contact	

Summary of contact

Lee Johnstone
CHI 0902763334
Diagnosis: F11.2 Opioid Dependence Syndrome, currently on substitute treatment

Psychiatric Medication:
Prescribed by Addictions Services: Methadone 30 mls daily (on a weekly pick up)
Prescribed by General Practitioner: None

I had a prearranged appointment with Mr Johnstone on the 6th October 2022 at Cumnock Health Centre, but he did not attend . I also tried to call him the same day on a couple of occasions but he did not answer . I will re appoint Mr Johnstone in 3 months time, but if you have any questions in relation to this patient please do contact me . Yours Sincerely

Joanne Goldie
Advanced Nurse Practitioner in Substance Misuse
North West Kilmarnock Area Centre
01563574237

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Assessed 11th Aug 2022 at 10:25

Summary of contact	

Summary of contact
Diagnosis: F11.2 Opioid Dependence Syndrome, currently on substitute treatment

Psychiatric Medication:
Prescribed by Addictions Services: Methadone 30 mls daily (on a weekly pick up)
Prescribed by General Practitioner: None

I had a prearranged appointment with Mr Johnstone on the 11th August 2022 .

SUBSTANCE MISUSE
Lee has been stable on his ORT for quite sometime . Lee has not used any illicit substances for over a year. Lee is looking to switch from methadone to espranor and then onto buvidal long acting injection. I have discussed this with his key worker who is in the process of transferring Lee to the south addiction team as he is now residing in this area and this plan for treatment will be passed to them.

MENTAL HEALTH
Lee presented as well he voiced no suicidal nor homicidal ideation and no evidence of psychosis was detected today . Lee currently works and is hoping to go to the oil rigs for a promotion.

If Lee is not transferred as requested I will re appoint Mr Johnstone in 2 months time, but if you have any questions in relation to this patient please do contact me . Yours Sincerely

Joanne Goldie
Advanced Nurse Practitioner in Substance Misuse
North West Kilmarnock Area Centre
01563574237

Assessed 19th Jul 2022 at 11:01

Summary of contact/details	

Writer received the following email whilst on annual leave, "Can you call Lee Johnston on your return please; he would like to start buvidal asap please 09/02/1976".
Writer attempted to call Lee however no answer, voicemail left. Await contact.

Assessed 1st Jul 2022 at 16:16

Summary of contact/details	

New address is 12 Woodside Avenue, Kirkmichael, KA19 7PP.

Assessed 1st Jul 2022 at 16:12

Summary of contact/details	

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Lee failed to attend his arranged appointment with writer. Writer telephoned Lee, he reported that he moved in with his mother in South Ayrshire last year and has been asking to move on to espranor for a while. Writer asked him to find a pharmacy in South Ayrshire for him change pharmacy. Advised that he would be a transfer of care. Writer to call Lee on return to work.

Assessed 9th Jun 2022 at 10:33

Summary of contact	

Summary of contact
Diagnosis: F11.2 Opioid Dependence Syndrome, currently on substitute treatment

sychiatric Medication:
Prescribed by Addictions Services: Methadone 30 mls daily (on a weekly pick up)
Prescribed by General Practitioner: None

I had a prearranged appointment with Mr Johnstone on the 9th June at Cumnock Health Centre, but he did not attend . I also tried to call him the same day on a couple of occasions but he did not answer . I will re appoint Mr Johnstone in 3 months time, but if you have any questions in relation to this patient please do contact me . Yours Sincerely

Joanne Goldie
Advanced Nurse Practitioner in Substance Misuse
North West Kilmarnock Area Centre
01563574237

Assessed 18th Mar 2022 at 15:56

Summary of contact/details	

Writer attempted to call Lee today with no success writer was not given the option to leave a message . Writer will continue to try make contact

Assessed 4th Feb 2022 at 21:43

Summary of contact/details	

Lee failed to attend an appointment with writer today at Cumnock health centre another appointment will be sent out

Assessed 8th Dec 2021 at 10:01

Summary of contact/details	

Lee called writer to advis4e that he needed a holiday px for working away . Writer liaised with prescriber who agreed . At time of call Lee voiced no suicidal nor homicidal ideation and no evidence of psychosis was detected over the phone . Writer will send an appointment out for Lee in January . Lee happy with plan

Assessed 20th Oct 2021 at 12:10

Summary of contact/details	

Writer attempted to call Lee today but he did not pick up the phone . Writer will continue to try to make contact with Lee

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Assessed 15th Sep 2021 at 14:18

Summary of contact/details	
Writer contacted Lee who is still split from his wife . Lee is staying with his mum in kirkmichael but did not want to move service as he has applied for a house in Cumnock to be nearer kids . Lee stated he has not used any illicit substances for months and is looming to reduce of his methadone with the hope of going onto espranor . Writer stated she would arrange this starting with 2mg reductions of his ORT . Lee happy with this plan . At time of call Lee voiced no suicidal nor homicidal ideation and no evidence of psychosis was detected over the phone . Writer will contact lee again in a few weeks time to see how he is doing	

Assessed 10th Aug 2021 at 10:10

Summary of contact	
Lee was appointed for a telephone consultation with me on 10th August 2021 but was not contactable. He continues to remain on Methadone 50mls daily. I will re-appoint him in due course. Yours sincerely Authorised on 13/09/2021 09:47:45 by Karthik Kessavalou.	

Assessed 21st Jul 2021 at 13:30

Summary of contact/details	
Writer spoke with Lee and Lee had stated he was doing well apart from splitting up with his wife and moving in with his mum . Writer advised lee to contact the homeless team and writer would also send them a message for housing . Lee stated he still speaks with his wife and everything is amicable . Lee is looking to get a house in Cumnock . Lee stated he is doing well on his ORT and did not need any changes to medication . Lee has asked for a bus pass form and writer will see that this is sent out to his wifes address at his request . At time of call Lee voiced no suicidal nor homicidal ideation and no signs of psychosis was detected over the phone . Writer will contact Lee in a few weeks time	

Assessed 21st Jul 2021 at 12:11

Summary of contact/details	
Writer has tried to call Lee but he did not answer the phone . Writer will continue to make contact a message was left for Lee to contact writer	

Assessed 17th Mar 2021 at 16:10

Summary of contact/details	
Writer spoke with Lee today to see how he was doing and if he was wanting any more reductions . Lee stated he would like to stick at 50mls for time being as he had really struggled with previous reductions. Lee also asked if writer could change his pharmacy to townhead in Cumnock and writer has done this . Lee was not intoxicated at time of call he voiced no suicidal nor homicidal ideation and no evidence of psychosis was detected over the phone . Lee has been doing really well of late and has not used any illicit substances for months and months . Writer will call Lee to see how he is doing in a few weeks time .	

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Assessed 19th Feb 2021 at 12:33

Summary of contact	

Diagnosis: F11.2 Opioid Dependence Syndrome, currently on substitute treatment

Psychiatric Medication:
Prescribed by Addictions Services: Methadone 50mls daily (on a weekly pick up)
Prescribed by General Practitioner: None

Recommendations/Plan:
No changes to medication
2 Out-patient / Telephone consultation in 6 months' time
3 Key Worker contact in the interim

I spoke to Lee on 19th February 2021 for a telephone consultation. He remains stable on the current dose of Methadone and he denied taking any illicit drugs. His mental health remains stable. He did not report any suicidal or homicidal ideations. He has been decorating his house and laying new carpets. He is taking the necessary Covid19 safety precautions.

Follow up arrangements are as above.

Yours sincerely

Authorised on 23/03/2021 14:35:03 by Karthik Kessavalou.

Dr K Kessavalou
Consultant Psychiatrist in Addictions

sessed 11th Feb 2021 at 13:39

Summary of contact/details	
Writer has tried to contacy Lee again today as well as call his pharmacy who stated they will ask Lee to call in to the Bentinck centre with his new number as both numbers we have on the system are not working again . Pharmacy have no concerns with regards Lees presentation	

Assessed 10th Feb 2021 at 14:46

Summary of contact/details	
Writer tried to contact lee for an update but could not get an answer . Writer then called new Cumnock pharmacy who staed that Lee presents there as well weekly with no concerns with regards his presentation . Writer has asked that they pass on the message to Lee to contact the Bentinck centre to update his numbers	

Assessed 14th Dec 2020 at 12:08

Summary of contact	
Lee was appointed for telephone consultation with me on 14th December 2020. However, I have only managed to leave a voice mail.	

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

He remains on Methadone 50mls daily (on a weekly pick up).

I will re-appoint him in due course.

Assessed 6th Nov 2020 at 12:12

Summary of contact/details	
Writer spoke to Lee who stated he has been reducing on his methadone too quickly and he was really close to lapsing . Lee has lost two important people in his life only just recently and feels he needs to have his methadone at 50mls for the time being as he cannot cope with the withdrawals plus his recent loss. Writer ststed she would speak to prescriber about getting an increase for lee . At time of call Lee voiced no suicidal nr homicidal ideation and no evidence of psychosis was detected over the phone . Writer will call Lee again in a few weeks to see how he is doing	

Assessed 3rd Nov 2020 at 08:29

Summary of contact	
Mr Rankin was appointed for a telephone consultation on 3rd November 2020 but unfortunately was not contactable. He is currently on Methadone 120mls daily and Diazepam 12mgs daily. I will re-appoint him in due course.	

Assessed 20th Oct 2020 at 08:27

Summary of contact	
I contacted Lee by telephone on 20th October 2020 on the two numbers we have for him but unfortunately it was not possible to connect the call. He is currently on Methadone 30mls daily. I will re-appoint him in 2 months' time.	

Assessed 9th Oct 2020 at 16:43

Summary of contact/details	
Writer has tried to call lee several times today with no reply a message was left on his answer machine	

Assessed 12th Jun 2020 at 12:50

Summary of contact/details	
Writer attempted to make contact with Lee today but attempt was unsuccessful . Writer will attempt contact again next week	

Assessed 3rd Mar 2020 at 19:34

Summary of contact/details	
Lee attended joint review with writer and prescriber at Cumnock health centre PLAN Lee was supposed to be on regular reductions but these had stopped in November Writer will recommence 5ml reductions of methadone monthly Lee will go onto to espranor in the near future	

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Lee will be reviewed again in three months

A detailed letter will follow

Assessed 3rd Mar 2020 at 16:42

Summary of contact

Diagnosis: F11.2 – Opioid Dependence Syndrome, currently on substitute treatment

Psychiatric Medication: Prescribed by Addiction Services
Methadone 65mls daily

Prescribed by General Practitioner
Omeprazole 20mg

Recommendations/Plan:

1) At his request, we will start reducing his Methadone by 5mls every four weeks.
2) Out-patient review in three to four months time.

I reviewed Lee in my out-patient clinic at Cumnock Health Centre on 3 March 2020. This was a joint appointment along with his Key Worker Joanne Goldie, Addictions CPN. Lee remains stable on the current dose of Methadone and denied any recent illicit drug intake. He was requesting regular reductions in Methadone at the rate above. He continues to look for jobs. We have discussed the availability of Buprenorphine Oral Lyophilisate (Espranor) tablets for potential transfer from Methadone to Espranor and gradual reductions.

On mental state examination, he was casually dressed and well kempt. He maintained good eye contact. His affect was reactive. He was euthymic. He denied any suicidal or homicidal ideas. There was no evidence of psychosis.

Follow-up arrangements are as above.

Assessed 31st Jan 2020 at 16:23

Summary of contact/details

Writer went out to see lee at home. Lee his wife and children were present . Lee was well kempt he maintained good eye contact throughout and his mood was euthymic. Lee and his wife are going to a wedding tomorrow and are looking forward to a night away. Lee continues on reductions of 5 mls monthly and did not have any effects or withdrawals from his last reductionand is now at 65mls weekly dispensing. Lee provided a urine drug screen which was positive for methadone. Writer and lee spoke about his future and lee would like to go onto espranor once he gets to 30mls. Writer agreed that this is a good idea . Lee also starts employment soon labouring and is looking forward to this . At the time of appointment Lee voiced no suicidal nor homicidal ideation and no evidence of psychosis was noted . Writer will send lee an appointment for 3 months time . Lee happy with same

Assessed 11th Nov 2019 at 13:16

Summary of contact/details

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Writer went out to see Lee at home his wife was present. Lee was a lot happier today and he had stated to writer that he and his wife had went away for the weekend and they had a great time. Lee is currently on a reduction of his methadone and hopes to be going onto suboxone once he reached 30ml . Writer commends lee on how well he has done. Lee states that he just wants to get back to work and off of methadone as he works with machinery. Lee is reducing by 5mls and did say that he felt withdrawal from this especially in his legs which felt sore. Writer suggested they could go slower with reductions to 2ml . Lee said he will see how he goes and if it gets too much then he will ask the Bentinck centre to let writer know. Lee provided a urine drug screen which was positive for EDDP . At the time of appointment Lee was well kempt he voiced no suicidal nor homicidal ideation and no evidence of psychosis was noted . Writer will see Lee after Christmas in a joint clinic with Dr Kessavalou Lee happy with same

Assessed 8th Oct 2019 at 11:49

Summary of contact

Diagnosis: F11.2 – Opioid Dependence Syndrome, currently on substitute treatment

Psychiatric Medication: Prescribed by Addiction Services
Methadone 70mls daily on a weekly pick up

Prescribed by General Practitioner
None

Recommendations/Plan:

1) At his request, I will reduce his Methadone to 65mls daily.
2) Out-patient review in four months time.
3) Key Worker review in the interim.

I reviewed Lee in my out-patient clinic at Cumnock Health Centre on 8 October 2019. He remains stable on the current dose of Methadone and was requesting reductions in his Methadone. He is hoping to come off Methadone sometime next year. He is stable mentally and did not report any recent change to his physical health either.

On mental state examination, he was casually dressed and well kempt. He maintained good eye contact. His affect was reactive. He was euthymic. He denied any suicidal or homicidal ideas. There was no evidence of psychosis.

Follow-up arrangements are as above.

Assessed 30th Sep 2019 at 16:47

Summary of contact/details

Writer arrived at Lees home address as planned. Lee was upstairs on arrival but his wife was sitting down stairs writer had asked how his wife was and she had replied fine Lee does not go out he just sits upstairs all day . Lee then came down stairs and was keen to give a urine screen as he had stated he had been needing the toilet for ages. Lees urine screen was positive for methadone. This is now lees third or fourth clean screen and is doing really well. Writer had asked Lee about starting reductions and Lee keen for this to happen to allow him to go onto suboxone. Lee was adamant that he wants off methadone but his wife thought it was too soon as he is only just became stable. Writer suggested waiting until after Christmas then to start 2ml reductions monthly, both seem happy with this. Lee is looking forward to a holiday he has planned for his birthday and his wifes birthday in the next few months. Lee continues on 70ml weekly dispensing and is doing well on same. At time of appointment Lees mood was fairly euthymic he engaged well in conversation and made good eye contact throughout . Lee voiced no suicidal nor homicidal ideation and no evidence of psychosis was noted another appointment was made for November to discuss reductions and suboxone detox going forward.

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Assessed 19th Jul 2019 at 13:21

Summary of contact/details	
Writer went out to see Lee at home . It was going to be a quick visit as all the children were in the home as the schools were off. Lee was looking well and had stated he is doing great and will never go back the way . Writer asked lee if he could provide a urine drug screen which was positive for methadone Mentally he feels stable and did not report of any problems. On mental state examination, he was casually dressed and well kempt. He maintained good eye contact. His affect was reactive. He was euthymic. He denied any suicidal or homicidal ideas. There was no evidence of psychosis. Lee prescription will now be changed to weekly dispensing. Writer will go out and see lee in 6 weeks time .	

..ssessed 4th Jun 2019 at 08:44

Summary of contact	
Diagnosis: F11.2 – Opioid Dependence Syndrome, currently on substitute treatment Psychiatric Medication: Prescribed by Addiction Services Methadone 70mls daily (on a three times weekly pick up) Prescribed by General Practitioner None Recommendations/Plan: 1) I have agreed to reduce his Methadone to 65mls daily from the next prescription run. 2) Out-patient review in four months time. 3) Key Worker review in the interim. I reviewed Lee in my out-patient clinic at Cumnock Health Centre on 4 June 2019. Since the increase in his Methadone in January, e has not required to take any unprescribed Opioids. He was asking for reductions in his Methadone and has agreed to make a one-off reduction of 5mls prior to looking at regular reductions. I have discussed with him about the use of Suboxone over longer than the standard detox, in particular if he gets into employment. He is a ground worker and tends to work on the roads a lot. I also discussed with him about Naltrexone for relapse prevention. Mentally he feels stable and did not report of any problems. On mental state examination, he was casually dressed and well kempt. He maintained good eye contact. His affect was reactive. He was euthymic. He denied any suicidal or homicidal ideas. There was no evidence of psychosis. Follow-up arrangements are as above.	

Assessed 3rd May 2019 at 15:05

Summary of contact/details	
Writer attended appointment with Lee at his home address. Lee was well kempt, but casually dressed . Lee was complaining that he had put on a lot of weight due to sitting about, writer encouraged him to get back into his fitness and when he starts working again he will feel a little better. Lee was laughing and joking with writer and his mood was fairly euthymic. Lee was not intoxicated he spoke within normal rate and rhythm and was not agitated. Lee showed no signs of psychosis nor any suicidal nor homicidal ideation was evident. Lee provided a urine drug screen which was positive for methadone. Lee decided he is at the best he has ever felt and would like to look for part time work. Writer stated she would look for him as well as this is a really positive step in his	

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

recovery. Lee seemed happy with this and is due to go on holiday in the summer for a week with his wife. Lee happy with everything that is going on in his life just now and knows to stay clear of any pain killers containing opiates. Writer will go out and see lee again in 4 weeks time

Assessed 17th Jan 2019 at 10:22

Summary of contact/details	
Writer went out to see Lee at home. Lee has recently had a titration of 10ml due to his coming off his prescribed codine tablets. Lee had claimed to be struggling and was using his codine to top up his methadone. Lee now understands as he has had a rise of 10ml he no longer needs the codine tablets . Writer will come out agin in 6 weeks time to give the codine a chance of being out his system to then re test him . Apart from this lee is doing well, he is looking forward to a night soon at the menzies hotel in irvine with his wife. Lee was well kempt in presentation he conversed well made good eye contact throughout . Lee voiced no suicidal nor homicidal ideation and showed no signs of psychosis . An appointment was made for 6 weeks time.	

Assessed 8th Jan 2019 at 10:14

Summary of contact	
Diagnosis: 1. F11.2 Opioid Dependence Syndrome, currently on substitute treatment Psychiatric Medication: Prescribed by Addiction Services Methadone 60mls daily Prescribed by General Practitioner (as per patient) Solpadol 30/500mgs as required, up to eight tablets a day – GP TO KINDLY STOP THIS Recommendations/Plan: 1. I have agreed to increase his Methadone to 70mls daily. 2. GP to kindly stop Solpadol prescription. 3. Outpatient review in three months times. 4. Keyworker review in the interim. I reviewed Lee in my outpatient clinic at Cumnock Health Centre on 8th January 2019. Since the last outpatient review he admitted to nocturnal withdrawal symptoms and has intermittently used Solpadol. He has not used any Solpadol for over four weeks now and he continues to describe nocturnal and early morning withdrawals. It was agreed to increase his Methadone to 70mls daily and request his GP to stop the as required Solpadol prescription. His mental health remains stable. On examination, he was casually dressed and well kempt. He maintained good eye contact. His affect was reactive. He appeared to be in mild withdrawals. He was euthymic. He denied any suicidal or homicidal ideas. There was no evidence of psychosis. Follow up arrangements are as above.	

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Assessed 3rd Oct 2018 at 14:36

Summary of contact/details	
Writer went out to see Lee at home. Lee was looking well and was well kempt in appearance. Lee made good eye contact, he conversed well (within normal rate and rhythm) and his mood was fairly euthymic throughout the assessment . Lee was asked to provide a urine drug screen which was positive for opiates (prescribed solpadol) and methadone. Writer suggested that Lee go back to his GP for another opiate free analgesic for his back pain. Writer stated that solpadol is not the best medication for him as he is a recovering heroin addict and taking this medication only aggravates his addiction and could make him subsequently relapse. Lee agreed and will go and see his GP this week to review the same. Writer suggested that they work towards a goal of opiate free drug screens on his next appointment with the progression to twice weekly pick up. Lee seemed quite determined to ow be opiate free on every drug screen. Writer made an appointment to see Lee in 4 weeks.	

Assessed 21st Aug 2018 at 12:26

Summary of contact	

LEE JOHNSTONE 3 HOLMBURN AVENUE, CUMNOCK, AYRSHIRE, KA18 3DF
CHI No: 0902763334

Diagnosis: F11.2 – Opioid Dependence Syndrome, currently on substitute treatment

Psychiatric Medication: Prescribed by Addiction Services
Methadone 60mls daily (on a three time weekly pick up)

Prescribed by General Practitioner (as per patient)
None

Recommendations/Plan:
1) No changes to medication
2) Out-patient review in four months time
3) Key worker review in the interim

I reviewed Lee in my out-patient clinic at Cumnock Health Centre on 21 August 2018.

He continues to remain stable on the current dose of Methadone and has not taken any unprescribed medication/drugs for approximately seven months now. His mood remains stable and he denied any depressive or anxiety symptoms. I was pleased to hear that he is starting his new job a week after the appointment.

On examination, he was casually dressed and well kempt. He maintained good eye contact. His affect was reactive. He was euthymic. He denied any suicidal or homicidal ideas. There was no evidence of psychosis.

I briefly discussed the DVLA regulations on the diagnosis of Opioid Dependence and his current treatment on Methadone substitute treatment. I have strongly encouraged him to notify the DVLA about this. Other follow-up arrangements are as above.

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Assessed 14th Aug 2018 at 16:30

Summary of contact/details	
Writer went out to see Lee at home. Lee was looking well kempt and had been out doing his garden. Lee discussed how he will never go back the way and that he felt great now . Lee discussed his goal of going onto suboxone, writer said this would take some time as he is still on quite a high dose but some thing they can work towards. Lee conversed well throughout appointment, he made good eyecontact. Lee had no evidence of psychosis and had no suicidal nor homicidal ideation. Lee provided a urine drug screen positive for prescribed opiates and methadone. A further appointment was made for 5 weeks time	

Assessed 6th Jul 2018 at 12:58

Summary of contact/details	
Writer called Lees GP just to confirm that lee is on a prescription for solpadol as Lee has been testing positive for opiates on some drug screens. Lee can now have his dispensing relaxed.	

Assessed 4th Jul 2018 at 15:25

Summary of contact/details	
Writer went out to visit Lee at home. Lee said he has been doing well but would like his prescription relaxed. Writer asked him for a drug screen and Lee tested positive for opiates. Lee had claimed that this was solpadol as he had toothache. Writer said she will contact the doctor to make sure this is prescribed and then she has no problem relaxing his dispensing. Writer had asked if there was anything else he would like to discuss, but Lee had said no he actually feels brilliant just now. Lee was well kempt in presentation, his mood was euthymic and his speech was normal rate and rhythm. Lee did not display any suicidal ideation he had no evidence of psychosis and he maintained good eye contact throughout. Writer will call Lee with regards to his relaxed dispensing tomorrow. A further appointment was made for a months time.	

Assessed 30th May 2018 at 14:07

Summary of contact/details	
Writer went out as part of a first visit to see Lee. However Lee was just leaving to take his wee one to school. Lee had explained to writer that C.N King had just been out last week and done a urine test which was positive for methadone only. A further appointment was made for 5 weeks time.	

Assessed 23rd May 2018 at 13:35

Summary of contact/details	
the writer visits Lee 1.35pm - Lee and his partner [redacted] and their daughter are outside in the garden enjoying the sunshine. The writer asks [redacted] about her ongoing health issues, and she is pleased to report good progress. Lee invites the writer into the family home. Lee appears well , and reports 5 weeks abstinence from heroin, the writer provides positive feedback. Lee kindly provides a sample of urine which screens positive methadone only. The writer explains that he is leaving his post and that this is the last appointment he will have with Lee before his care and treatment are transferred to a new keyworker. Lee and the writer reflect on their therapeutic work and Lee's progress - Lee and the writer wish each other well for the future.	

Assessed 24th Apr 2018 at 13:20

Summary of contact/details	

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

writer visits Lee, his partner [redacted] and their daughter are present also.
[redacted] reports all is well, she continues to liaise with Health Services in relation to her health issues.
The writer invites Lee to share about how he is coping with his partner's issues - Lee reports he is eating and sleeping well, able to cope with his partner's situation - with support.
Lee wishes his prescription methadone dispensing relaxed -
Lee kindly provides a sample of urine which screens positive methadone and morphine - the writer advises Lee that, therefore, his dispensing cannot be relaxed - Lee states he has absolutely no idea why his drug screen would be positive opiates.
Agreement next home visit 23/5/18 at 1.30pm, drug screen to be carried out

Assessed 18th Apr 2018 at 11:40

ummary of contact/details	
writer returns call from Lee 11.40am, agreement reschedule next appointment to 23/4/18 1pm	

Assessed 17th Apr 2018 at 16:19

Summary of contact/details	

Dear Dr Mitchell

LEE JOHNSTONE 3 HOLMBURN AVENUE, CUMNOCK, AYRSHIRE, KA18 3DF
CHI No: 0902763334

Diagnosis:

1. F11.2 Opioid Dependence Syndrome, currently on substitute treatment

Psychiatric Medication:

Prescribed by Addiction Services
Methadone 60mls daily supervised

Prescribed by General Practitioner (as per patient)
None

Recommendations/Plan:

1. No changes to medication.
2. Outpatient review in four months time.
3. Keyworker review in the interim.

I reviewed Lee in my outpatient clinic at Cumnock Health Centre on 17th April 2018.

I was pleased to hear that he is completely stable on the current dose of Methadone and has not taken any unprescribed medications/drugs for approximately nine weeks now. He reports good sleep and massive improvements in mood symptoms. He is positive about his future and is back in the family home looking after his one year old daughter. He reflected on positive changes in his life since he was initiated on Methadone. We have agreed not to make any changes at this stage.

Continued...

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Page 2
10th May 2018
Dr Mitchell, Re: Lee Johnstone

On examination, he was casually dressed and well kempt. He maintained good eye contact. His affect was reactive. He was euthymic. He denied any suicidal or homicidal ideas. There was no evidence of psychosis.

Follow up arrangements are as above.

Yours sincerely

Assessed 10th Apr 2018 at 15:47

Summary of contact/details	
Social Worker Kirsty Pope calls the writer who reports on Lee's progress and engagement in treatment	

Assessed 28th Mar 2018 at 15:25

Summary of contact/details	
the writer visits Lee 3.25pm - Lee shares that he is very well. Lee's partner [redacted] and their young daughter are present for only a brief period before they leave to collect another child from school. Lee shares about his recovery, the improvements in his life, the family recovering, being close to each other, and enjoying normal family functioning. Lee shares about taking on board the writer's challenge in relation to his responsibility to support [redacted] with her serious health issue - they await confirmation of medical plans . Preparing for crisis, large and small, is explored - The writer stresses to Lee the benefit of seeking support as and when required. Agreement next home visit 20/4/18 at 3pm The writer confirms Lee's medication will increase with 10/4/18 - Lee reports no issues with maintaining abstinence from heroin / opiates	

Assessed 26th Mar 2018 at 12:11

Summary of contact/details	
Dr. Gaze in agreement with proposed 10mg methadone prescription increase Writer advises pharmacist of New Cumnock chemist of the change due to commence 10/4/18, to be delivered in prescription run	

Assessed 14th Mar 2018 at 11:30

Summary of contact/details	
The writer visits Lee 11.30am - Lee reports that he has not misused heroin during past weeks - he had consumed some solpadol tablets to relieve pain, but decided against this due to the potential escalation of problems developing with them - he has thrown out his stock of tablets, and plans to request his GP discontinue the repeat prescription.	

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Lee kindly provides a sample of urine which screens positive methadone only. The writer opens discussion with Lee about the option of increasing his methadone dosage - exploring Lee's resistance to this option, and the potential benefits of another increase.
Lee wishes an increase in methadone, the writer agreeable to advocating for this to the prescriber at the earliest opportunity.
Lee's self-worth and esteem deficits are explored.
Lee shares about the impact of his parents separating, and the factors associated. And the devastating impact of his brother's passing.
The writer, once again, suggests Lee start writing a thoughts and feelings diary to aid therapeutic process.
The cyclical and non-linear nature of the personal recovery process is discussed.
Lee reports anxieties in relation to constipation - the writer explains this is a pretty routine complaint of individuals receiving methadone, encouraging him to discuss the ailment with the pharmacist who may be able to offer a treatment for relief.

[redacted]present with a couple of the children - the writer offers his thoughts in relation to [redacted] recently been diagnosed with a serious physical condition which will require much input and treatmenbt in coming months.
The writer encourages Lee to express his thoughts and feelings in relation to this whole issue.

Agreement next home visit 28/3/18 at 4pm

Assessed 6th Mar 2018 at 12:45

Summary of contact/details	
due to adverse weather this morning the writer unable to visit Lee as planned 10am - writer calls Lee 12.45pm - Lee shares that he has not been doping so well, although he remains a little vague about drug intake over and above prescription methadone, states only misusing prescription solpadol - Lee shares that last Friday his partner had a diagnosis of cervical cancer , Lee states he is "devastated" - the writer offers feedback in relation to Lee not using this as a justification not to continue addressing drug issues. Lee unable to acept the offer of a home visit this afternoon - agreement writer to visit Wednesday 14/3/18 at 11am	

sessed 20th Feb 2018 at 09:25

Summary of contact/details	
the writer visits Lee 10.25am [redacted] joins discussion. Lee reports that Saturday he hadlapsed and smoked a bag of heroin. Lee describes that he and partner [redacted] were increasingly stressed about their home wifi not yet being fitted, the kids were apparently disturbed by this and proving stressful Lee had shouted at the kids, [redacted]had chastised him , Lee had justified the situation and associated stress to source and use heroin. Discussion explores the build up the the lapse, alternative strategies to cope with such stress and situations, Lee's issues with anger. Lee shares that he is motivated to change, the writer suggests that such incidents can be very useful learning opportunities. The writer offers a description associating stress with lapses - Lee shares that he regretted using heroin Lee again mentions going to the gym - when asked he can identify no barriers to doing this, except financial limits. Agreement next home visit 6/3/18 at 10am	

Assessed 13th Feb 2018 at 10:15

Summary of contact/details	
the writer visits Lee 10.15am, offering apologies for being later than scheduled. Lee appears bright and fresh, he is extremely pleased to report that he has been able to abstain from illicit substances the past three days - he does not feel the need for an increase in his prescription methadone at this time. Lee's partner, [redacted] herself appears less stressed , she expresses her relief that Lee is getting on track with his goals. [redacted]	

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

is caring for her baby daughter.

Lee shares that he and [redacted] greatly enjoyed their weekend away at a hotel - he is happy that it brought them closer together. They plan another hotel stay at the end of next month.
Lee shares about ongoing plans to continue decorating the family home, now he does not need to focus on sourcing drugs each day, and as the result of this has the necessary funds.
And Lee has plans for returning to work, including approaching an employer he previously worked for, and another.

The writer opens discussion about family recovery, and thought patterns associated with addiction.
The writer encourages Lee to remain open and honest about his experiences, thoughts and feelings in early recovery.

Lee accepts the writer's offer of a drive to New Cumnock chemist - this provides more time for discussion focussing on recovery outcomes and minimising the risk of relapse, exploring relapse thought patterns and strategies to challenge them.

Agreement next home visit 20/2/18 at 10.30am

Assessed 7th Feb 2018 at 11:32

Summary of contact/details	
Alert The writer had approaches Dr. Kessavalou Monday 5/2/18 - it had been agreed that Lee's prescription methadone be increased from 40mg to 50mg commencing 8/2/18. And that he be provided with a holiday prescription, for supervised dispensing 9/2/18 with two take home doses. e-prescription change sheet emailed to Isobel Hyslop for processing. Writer contacts the pharmacist of New Cumnock to advise	

Assessed 7th Feb 2018 at 09:37

Summary of contact/details	
the writer returns a call from Lee 9.35am - Lee explains he is still struggling, and notices his prescription methadone has not yet been increased - the writer offers apologies for this, explaining that he was unable to process prescriptions on Monday as is usual due to other issues with prescriptions, and that it is his intention to attend to his prescription today. Lee expresses appreciation	

Assessed 2nd Feb 2018 at 09:30

Summary of contact/details	
The writer visits Lee 9.30am - Lee's partner [redacted] and a daughter and son are present also. Lee reports much improvement in his well being , with a reduction in his intake of heroin, reportedly smoking a bag of heroin per day now. Lee kindly provides a sample of urine screens positive methadone and opiate. The writer is to approach Dr. Kessavalou and advocate Lee's prescription methadone be increased from 40mg to 50mg at the earliest convenience. The writer is also to discuss the holiday prescription assisting Lee and [redacted] to stay in a hotel in Irvine (a birthday present from his mother) next weekend - writer to advocate Lee be provided with two days take home methadone [redacted] to take care of these doses (as she does on Saturdays with Sunday's take home dose.) The writer explains the function of methadone, therapeutic dosing, and gently challenges Lee's fears of being on too high a dose making it more difficult to detox off.	

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

The writer opens discussion with Lee about the recovery process, how it can be expected to progress, addressing issues as they organically arise. Lee expresses how he wishes he had sought support years ago.
Agreement next home visit 13/2/18 at 9.30am

Assessed 29th Jan 2018 at 10:28

Summary of contact/details	

The writer returns a call from Lee 10.28am - Lee shares that he is still uncomfortable and not receiving enough prescription methadone. Lee reports smoking a reduced amount of heroin yesterday , two bags, not the 4 or 5 he has been using of recent - the writer suggests this may very well be the main reason for his discomfort.
The writer explains to Lee that methadone titration necessarily takes some time. The writer voice a level of empathy with Lee's situation and experience, suggesting that his difficulties can serve as motivation to not relapse once he is medically stable.
Agreement to meet as already scheduled Friday.

Assessed 26th Jan 2018 at 10:43

Summary of contact/details	

the writer is delivering Lee's replacement prescription to New Cumnock Lloyds chemist - Lee is just coming out of the chemist after recieving his 30mg methadone - the writer expresses his surprise that Lee had not waited, as agreed, until 10am , when the prescription would have arrived and he would have received 40mg methadone. Lee expresses his disappointment.

The writer phones Lee 10.40am to see if he is ok - Lee explains eh had simply forgotten about the plan to present at the chemist 10am - discussion explores how early recovery can be quite an anxious time, where it takes time to create a manageability in daily life.
It transpires that Lee was confused about the date of going away to the hotel for the weekend - it is on 6/2/18, not tomorrow.
Lee shares that plans for the weekend include taking the kids to the cinema

sessed 25th Jan 2018 at 16:12

Summary of contact/details	

Dr Kessavalou returns the writer's call and is agreeable to Lee's methadone increasing from 30mg to 40mg tomorrow.
Prescription change sheet forwarded by email to Isobel Hyslop at Bentinck Centre , ready for processing.
Writer contacts the pharmacist of New Cumnock Lloyds, she is kindly agreeable to arranging the prescription , which the writer states he will deliver tomorrow morning.
Writer confirms this all with Lee, Lee expresses appreciation

Assessed 25th Jan 2018 at 14:25

Summary of contact/details	

The writer visits Lee 2.25pm, one of the children is sleeping in the living room, Lee's partner [redacted] not at home - Lee wishes to disclose that at the last appointment his report of not using heroin since commencing prescription methadone was incorrect - he continues to smoke four or five bags of the drug per day.
Lee shares that his partner was seriously unhappy about this, and with particular regard to Lee being unable to report accurately which would mean he could not be assessed correctly and therefore not receive appropriate interventions and medical treatment.
The writer suggests Lee has the opportunity to learn much from this.
Lee shares that his rationale for not reporting accurately was fear of "losing his children," the writer conveys that neither he nor Social Work colleagues have voiced concern over Lee's (and his partner's) childrens' wellbeing and care.
Lee states that Social Worker Kirsty Pope intends to visit Monday 29/1/18. The writer advises of his expectation that Kirsty will

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

approach the writer following this to discuss Lee's care plan and progress.
urine sample screens positive methadone and opiate.

Lee shares that his mother gave him and his partner a couple of nights stay in a five star hotel in Irvine this weekend.

Lee is currently receiving 30mg methadone prescription - Lee kindly povides a sample of urine which screens positive methadone and opiate - writer states his intention to discuss Lee's prescription with the prescriber, advocating for an increase at the earliest opportunity, very probably to occur Tuesday.

Agreement next home visit 2/2/18 at 9.30am

writer awaits return call from Dr.Kessavalou to discuss prescription

Assessed 18th Jan 2018 at 09:35

Summary of contact/details	

The writer visits Lee 9.45am, fortunately before he walks too far from his home - Lee states he was going out as he expected the writer to not make it due to adverse weather conditions.
Lee invites the writer into the family home - his partner [redacted] and a couple of their sons are in the living room - all appear well, [redacted] reports much improvement in Lee since he commenced prescription methadone.
Lee reports he is very well, comfortable and not experiencing any opiate withdrawal symptoms - he is very happy with the improvement in his situation. Discussion explores Lee's plans to look for employment in the next couple of months, after his methadone dispensing has been relaxed.
Lee mentions that his plan is to remain on methadone only a short period - the writer conveys caution, suggesting Lee may benefit from settling into the treatment, and not being haty, as impatientce can lead to relapse, to be discussed further.
The writer suggests Lee start recording thoughts and feelings in a diary form , to provide material for therapeutic work, and as a tool for increasing self-awareness.
Lee kindly urine screens positive methadone, opiate and thc - Lee states, when advised, that he was not aware to not consume co-codamol whilst receiving opiate-replacement therapy. He reports taking 6 tablets a few days ago to relieve a headache.

Agreement next home visit 25/1/18 at 3pm

Health Visitor Kirsty MacLeod approaches the writer in Tanyard Health Centre , 11.15am - Kirsty reports that she had discussed Lee's family's case with Social Work Children & Families who had advised her that the writer had not contacted them following Lee's Addictions Service assessment on 21/12/17 - the writer reads from Care Partner records clearly indicating that the writer had approached the service and discussed issues with Social Worker Amy Scobie on 22/12/18.
Of note , Kirsty also said that Lee's partner had expressed anxiety in relation to the writer being in contact with her and discussing the family's case - Kirsty had discussed this with [redacted] at a home visit yesterday - the writer expresses his surprise insomuch as [redacted] had previously been quite open about the need for cross-agency communication.
Kirsty to approach Social Work colleagues again to discuss.

Assessed 17th Jan 2018 at 10:22

Summary of contact/details	

writer in telephone contact with Health Visitor Kirsty MacLeaod - advising her of his assessment of the family situation in the light of Lee's substance misuse and recently being commenced on prescription methadone.
Kirsty expresses surprise that Social Work colleagues had not contacted her after the writer had approached them.
Agreement between writer and Kirsty that there are no specific concerns in relation to the family, and that Lee's partner [redacted] appears clearly to provide adequate protective factor

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

Assessed 15th Jan 2018 at 13:41

Summary of contact/details	
writer tries to phone Lee 1.40pm his phone appears out-of-operation. Writer decides to call Lee's partner [redacted] she is kindly to advise Lee of the writer's plan to visit Thursday 18/1/18 at 9.30am	

Assessed 12th Jan 2018 at 10:03

Summary of contact/details	
he writer receives an email 10.03 reporting that Lee's partner had phoned Bentinck Centre to state Lee was accompanying her to ospital today and hence needs to cancel the writer's 1pm home visit. Another appointment to be offered at the earliest opportunity	

Assessed 10th Jan 2018 at 10:34

Summary of contact/details	

Letter sent to GP Dr Mitchell, Tanyard Medical Practice on 22/2/2018.

I saw Mr Johnstone at my outpatient clinic at Bentick Centre on 10th January 2018. This appointment was arranged for suitability of opioid substitute treatment.

Substance and misuse history
Mr Johnstone advised me that he has experimented with hash and benzodiazepines when he was around 22yrs old. This happened after his brother died suddenly and he was struggling to cope with this and at the same time his relationship broke down and he ended up taking heroin. His heroin use gradually escalated and within months he started to use daily, an average use of around of four to five bags of heroin every day. He also lost his job as a hygiene operator approximately four weeks back. He has always smoked heroin and denied any intravenous use. He denied significant use of any other illicit drugs or alcohol. He wants to stop taking heroin because of its impact on finances and his relationship.

Background history
He denied any childhood trauma and admitted that he was in a care home for a few years. He is currently in a relationship over the last three years and has one daughter age 10months and four stepsons aged 12yrs, 11yrs, 6yrs and 3yrs. He is keen to stop taking illicit drugs as he is keen to remain in the family home.

He denied any chronic medical problems other than the chronic pain related to a few injuries he sustained when someone tried to stab him. He doesn't take amitriptlyne every night but admits getting pain relief from solpodol. He denied any non drug allergies.

He denied any significant past psychiatric history. He has never been prescribed anti depressants. He denied a history of self harm or any suicidal attempts.

On mental state examination
On mental state examination, he was casually dressed and well kempt. He maintained good eye contact. His affect was reactive. He appeared to be in mild withdrawal. He denied any suicidal or homicidal ideas. There was no evidence of psychosis.

Discussion and plan
We discussed the treatment options available in Ayrshire for opioid dependence both in terms of detox and maintenance treatment. It was agreed he would benefit from methadone substitute treatment at this stage. I discussed the DVLA regulations

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) undefined Male CHI Number 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

around his diagnosis and proposed methadone treatment. He is currently not driving and does not have a driving license.

Follow up arrangements are as above.

Assessed 5th Jan 2018 at 14:03

Summary of contact/details	
the writer receives an email confirming Lee's medical appointment is at Bentinck Centre 10/1/18 at 9.45am. Writer phones Lee 2.03pm - advising him of this , and of the location of the Centre. Lee expresses much appreciation, stating he simply cannot wait to commence prescription methadone. The writer advises Lee of the three days of methadone building up in his system , and the related risk of overdose - Lee states his intention to stop using heroin the day he commences methadone. Agreement to meet home visit as previously scheduled 12/1/18 at 1pm	

Assessed 3rd Jan 2018 at 10:15

Summary of contact/details	
the writer visits Lee 10.15am - Lee returns home 10 minutes later, he explains he had needed to source and use some heroin. During the 10 minutes waiting the writer is in the company of Lee's partner [redacted] and two of their sons. The sons appear bright and well, they interact freely with their mother (and father when he arrives) and the writer. The home environment is warm and cared for. [redacted] reports that Social Worker Amy Scobie had been in contact - [redacted] accepting of the Social Work Department's responsibilities to act in such circumstances and assess the family situation, a home visit expected in the next few days [redacted] shares that she had previously formed a professional relationship with Amy's colleague Kirsty Pope - whilst in a previous relationship. Amy had directed that Lee not to be in charge of the children for the time being - [redacted] cousing is helping out when she is at work. Lee arrives - [redacted] non-verbals , not looking toward Lee much at all, not joining his discussion, indicate to the writer the strain in their relationship. Lee reports no changes in his situation, he speaks about his motivation to stop using heroin for his family, with the use of prescription methadone which he plans to be only a short-term intervention. The writer suggests the term of treatment may be reviewed once Lee has stabilised on methadone and had the space to continue therapeutic work. Lee kindly provides a sample of urine which screens positive opiate only Agreement next home visit Friday 12/1/18 at 1pm - Lee and [redacted] aware the writer is available anytime during working hours.	

Assessed 22nd Dec 2017 at 13:56

Summary of contact/details	
writer tries to contact Lee to discuss his unscheduled home visit this morning, and liaison with Social Services - his phone would appear to be switched off at 1.55pm	

Assessed 22nd Dec 2017 at 10:35

Summary of contact/details	

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) **undefined** Male **CHI Number** 0902763334

History for Summary of contact/details

From 27/05/1926 Until 27/05/2026

the writer decides the best way forward is to visit Lee's family home, 10.35am - explain his plans to liaise with Social Work Children & Families colleagues.

Lee is not at home, his partner [redacted] tries on several occasions to contact him and request he return home.
The writer explains he is duty bound to liaise with Social Work colleagues. [redacted] shares that she had explained this to Lee , she fully expected this - in fact [redacted] and the family have previously had Social Work input when she was living with her four children's father who also had drug issues.

[redacted] explains that she is under increasing pressure over the past couple of months, with Lee's drug misuse.
[redacted] describes working five days per week, 2pm-10pm - when Lee is in charge of looking after the children.
The writer thanks [redacted] for her attitude toward his visit - one of acceptance.
Charlene expects contact from Social Work colleagues today.
Agreement to reschedule next home visit Wednesday 3/1/18, from 2pm to 10am - so as [redacted] can be present.

Writer approaches Amy Scobie, Social Worker on Duty today in Rothesay House, 10.50am - describing the pertinent points from yesterday's assessment and today's visit. Amy plans to contact [redacted] this morning - ongoing liaison planned

Assessed 21st Dec 2017 at 16:20

Summary of contact/details	

Health Visitor Helen MacIntosh kindly returns the writer's call 4.20pm - the writer explains his assessment appointment with Lee this morning, in relation to his (and his partner's) children.
Helen sees from recent records that her colleague, (and named nurse) Kirsty MacLeod, has visited the family home , and no concerns have been raised.

The writer states his intention to visit the family home (decision after further reflection following this morning's appointment) - ongoing liaison with Health Visitor colleagues planed also

sessed 21st Dec 2017 at 11:47

Summary of contact/details	

Activity record 21/12/2017 sent to HC Tanyard on 13/02/2018.

Assessed 21st Dec 2017 at 10:40

Summary of contact/details	

Lee attends new assessment appointment, Cumnock health centre 10.40am.

Lee and the writer meet for the first time.

CHILDREN AND SITUATION

Lee lives with his partner of three years, [redacted]
They live with [redacted] four children and their own child ;

[redacted] (26/9/05)
[redacted] (24/7/06)
[redacted]n (dob unknown at this time)

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) **undefined** Male , **CHI Number** 0902763334

History for Summary of contact/details

From 27/05/1926 **Until** 27/05/2026

[redacted] (30/6/14),
And their daughter [redacted] (7/3/17)

It is clear that Lee is currently in crisis : he resigned from his job last week , simply unable to cope with carrying on. His partner has issued Lee with an ultimatum – he either addresses his issues or needs to leave the family home.

The writer plans the next appointment as a home visit and will assess the home situation, with potentially a referral to Children & Families Social Work colleagues.

The writer plans to discuss the family with School Nurse Nuala Corrigan, and Health Visitor Helen Macintosh – and has emailed both of them requesting contact.

Lee shares that he had a good upbringing, but being a "nuisance" at school led to him being taken into the care of children's homes aged 12 – 16 years.

Lee reports no childhood or adult traumas.

Lee shares that he receives much support from his mother who lives fairly nearby.

SUBSTANCE MISUSE

Lee reports that he started to misuse substances aged 12 years old - during the next few years he would experiment and regularly misuse alcohol, lsd, mushrooms, cocaine and amphetamine.

In his 20's Lee would progress and regularly misuse illicit benzodiazepines – he reports most recent intake of diazepam 2 months ago.

Lee shares that he had occasionally smoked heroin prior to six years ago – six years ago his brother sadly passed , and Lee started to smoke the drug regularly as a way of coping.
Lee reports current smoking of four to six bags of heroin per day.
Since he has stopped working Lee understandably expects it to be more difficult to be able to afford to sustain this level of intake.
Lee fears that in the near future he may revert to intravenous injecting to cope with having reduced amounts of heroin – he states he has never injected previously.

Lee smokes marijuana ("weed") regularly each day.

Lee reports that he sustained a back injury 8 months ago, and has received GP repeat prescriptions of solpadol 30mg/500mg and amitryptiline (2x10mg) for relief of pain.
Lee admits to consuming more than the prescribed 2 tablets four times daily in the event he is unable to source heroin – up to 20 tablets at a time.
The writer advises Lee , later in discussion, that it is likely he would be asked to stop taking the solpadol if he is commenced on methadone prescription.

Lee kindly provides a sample of urine which screens positive opiates and thc only.

Lee kindly accepts offer of basic life support and naloxone training, and being provided with a naloxone kit.

Treatment options are explored in discussion – Lee feels he would benefit best from medium-term methadone , granting him space for therapeutic treatment.

Care Partner

Johnstone, Lee (Mr)

Date of Birth 09-Feb-1976 (50y) **undefined** Male **CHI Number** 0902763334

History for Summary of contact/details

From 27/05/1926 **Until** 27/05/2026

MENTAL HEALTH / RISK

As previously mentioned, Lee's brother passed away 6 years ago, and Le started to misuse heroin in order to cope – it would be expected that this unresolved issue would become very apparent in Lee's early recovery – therapeutic work regarding this issue is planned, along with specialist referral if this becomes necessary.

Lee reports no history of , or risk of, deliberate self-injury or suicide.

Nor any history of antidepressant or other psychiatric treatment.

FORENSIC / RISK

Lee reports that he has served a number of prison sentences – the longest sentence being 2 years 10 months for serious assault, his most recent being served in 2014 – Lee shares that he has not been committing crime since he got together with his partner. Nil pending.

PHYSICAL HEALTH

Lee reports that a blood borne virus test 2014 showed negative results.

PLAN

- Request medical appointment for consideration of commencement on prescription methadone
- Therapeutic work focussing on issues associated with chronic substance misuse
- Including bereavement issue
- The writer is to liaise with School Nurse and Health Visitor colleagues with regard to assessing the children Lee lives with. The writer is to visit the family home, and assess the home situation, with the option of referral to Children & Families Social Work colleagues being considered.

Agreement next appointment, home visit 3/1/18 at 2pm

Assessed 21st Dec 2017 at 10:36

Summary of contact/details	
Activity record dated 21/12/2017 sent to Tanyard MP on 13/02/2018.	

Assessed 1st May 2006 at 15:06

Summary of contact/details	
-Referred for assessment of alcohol comsumption. Post admission as driver of a car having hit a tree at speed. Alcohol level on admission 319. States had been drinking all day and has no recollection of events. Believes had 2 seizures and that they are alcohol related. Hx of alcohol dependence. Previously drank daily 3 years ago. Had unsuccessful home detox via linda Surgenor. States now only drink binge pattern on Friday/ Saturday, consuming 1 bottle of vodka each day. Doesnt see as a problem but plans to abstain due to the shock he has had with this accident. refused any counselling but advised may be enforced to attend via courts. no evidence of mental illness. PLAN - Discharged to GP. Refused ACA.	