Subject Access Request Team
Health Records Department
Gartnavel General Hospital
1053 Great Western Road
Glasgow
G12 0YN

NHS
Greater Glasgow and Clyde

MMA LEGAL
STOK, 43 - 59 PRINCES STREET,
STOCKPORT,
SK1 1RY

Date: **8TH MAY 2026**
Your Ref: **100112**
Our Ref: SAR/TEAM/TH
Enquiries to: Tracy Hunter
Direct Line: 0141 211 0667
Email: tracy.hunter3@nhs.scot

Dear Sir/Madam

Re: Subject Access Request under the General Data Protection Regulation

Patient: CATHERINE HONEYMAN **Date: 01.02.1949**

Thank you for your request received **21ST APRIL 2026** in which you seek a copy of your client's personal information.

Your request has been dealt with in line with our requirements under Article 15 of the General Data Protection Regulation and I now attach the following:

QUEEN ELIZABETH UNIVERSITY HOSPITAL - GARTNAVEL GENERAL HOSPITAL – NEW VICTORIA INFIRMARY HOSPITAL RECORDS

Please be aware that these health records have been reviewed by a clinician and any information identifying or provided by a third party has been removed.

We process personal information to enable us to provide healthcare services for patients; support and manage our employees; to carry out research and clinical trials; maintain our accounts and records and to carry out data matching under the national fraud initiative. We also use CCTV systems for crime prevention.

This personal information can be both clinical and non-clinical in nature and can include

- Patient health records, photographs or radiology images
- Video/telephone recordings, including CCTV images
- Witness statements

MANUAL PATIENT RECORDS

ALL HOSPITAL RECORDS HELD NHSGGC	☐		
ACS	☐		
BEATSON HOSPITAL	☐		
CANNIESBURN HOSPITAL	☐		
DENTAL HOSPITAL	☐		
GARTNAVEL GENERAL HOSPITAL	☐		
GLASGOW ROYAL INFIRMARY	☐		
INVERCLYDE ROYAL HOSPITAL	☐	MATERNITY	☐
NEW VICTORIA ACH	☐		
PRINCESS ROYAL MATERNITY	☐		
QUEEN ELIZABETH UNIVERSITY HOSPITAL	☐	MATERNITY	☐
ROYAL ALEXANDRA HOSPITAL	☐	MATERNITY	☐
ROYAL HOSPITAL FOR CHILDREN	☐		
STOBHILL HOSPITAL	☐		
VALE OF LEVEN	☐	MATERNITY	☐
WEST AMBULATORY CARE HOSPITAL	☐		
WESTERN INFIRMARY RECORDS	☐		

Including:

BADGERNET	☐
CAREVUE	☐
MEDICAL ILLUSTRATION	☐
METAVISION	☐
PHYSIOTHERAPY	☐
RADIOLOGY	☐
WEST MARC	☐
LABS	☐

Orthopaedic Codes

Emergency ☐ Elective ☐ MGH ☐ MBZ ☐ DM ☐ DBA ☐ DAS ☐ CRW ☐

PATIENT DETAILS

0102496145
HONEYMAN F
Catherine 01/02/1949
10 MELVILLE STREET
0/2
Glasgow, Lanarkshire
G41 2LN

GP NAME ADDRESS
Dr. G Marshall
Drs Mills & Marshall Practice
Gorbals Health Centre
45 Pine Place
Glasgow
G5 0BQ

DATE

Admission Other ward Other Hospital

Surgery RIGHT LEFT BILATERAL

Discharge TO Home Other Ward Other Hosp Irreg Died

FOLLOW-UP 1/52 10/7 2/52 4/52 6/52 None C'town

Injured Pedestrian Cyclist M/cycle Driver Passenger in Car HGV/PSV Van
Ice/snow Level surface Bed Chair Stair Ladder Scaffold Building Hole in ground
dent Hit by object Crush Glass Knife Hand tool Powered tool Hit by another

Hit Stationary object Cyclist M/cycle Car HGV/PSV Va
Assault Sharp Blunt Fight Bite Human Animal
Site Home Sport Public building Street Industrial

FRACTURE Open ☐ Closed ☐

AD

ont	Scalp S00.0	Orbit S00.1	Nose S00.3	Ear S00.4	Lip/Mouth S00.5	Multiple S00.7
n Wound	S01.0	S01.1	S01.2	S01.3	S01.5	S01.7

acture	Skull Vault S02.0	Base S02.1	Nose S02.2	Orbit S02.3	Malar S02.4	Jaw S02.6	Multiple S42.4

a-Cranial	Concussion S06.0
rain injury	Diffuse S06.3 Focal S06.2
aemorrhage	Epidural S06.4 Subdural S06.5 Subarachnoid S06.6

CK

rve Injury	Cord S14.0	Nerve root S14.2	Brachial Plexus S14.3	
racture	C1 S12.0	C2 S12.1	C3-C7 S12.3	Multiple S12.7
islocation Sprain	Facet Jt S13.1	Multiple S13.3	Whiplash S13.4	

EST, THORAX

Fracture	Vertebra S22.0	Sternum S22.1	Rib S22.2	Multiple ribs S22.4	Flail Chest S22.5
Nerve Injury	Spinal Cord S24.0		Nerve Root S23.2		

OULDER, UPPER ARM

nary OA	M19.01	Post trauma OA	M19.11
Sero +ve	M05.81	Sero -ve	M06.01
esive capsulitis	M75.0	Rotator cuff tear	M75.1
ingement syndrome	M75.4	Biceps tendinitis	M75.2
cifi dinitis	M75.3	Bursitis	M75.5
un dislocation	M24.41		

Contusion	S40.0					
Open Wound	Shoulder S41.0	Upper arm S41.1				
Fracture	Clavicle S42.0	Scapula S42.1	Humerus	Proximal S42.2	Shaft S42.3	Distal S42.4
Dislocation	Shoulder S43.0	A-C Joint S43.1	S-C Joint S43.2			
Sprain	Shoulder S43.4	A-C Joint S43.5	S-C Joint S43.6			
Nerve Injury	Ulnar S44.0	Median S44.1	Radial S44.2	Axillary S44.3	Musc.Cut S44.4	Multiple S44.7
Blood Vessel	Axillary S45.0	Brachial S45.1	Vein S45.3			
Muscle Tendon	Rotator Cuff S46.0	Biceps	Long head S46.1	Other S46.2	Triceps S46.3	Multiple S46.7
Traumatic Amputation	Shoulder S48.0	Upper arm S48.1	Crush S47.0			

LBOW, FOREARM

mary OA	M19.02	Post trauma OA	M19.12
Sero +ve	M05.82	Sero -ve	M06.02
dial epicondylitis	M77.0	Lateral epicondylitis	M77.1
rve Lesions	Ulnar G56.2	Median G56.1	Radial G56.3

Contusion	Elbow S50.0	Forearm S50.1					
Open Wound	Elbow S51.0	Forearm S51.8					
Fracture	Ulna	Upper S52.0	Shaft S52.2	Radius	Proximal S52.1	Shaft S52.3	Distal S52.5
	Radius & Ulna Shaft S52.4			Distal S52.6			
Dislocation	Radial Head S53.0	Elbow S53.1	Radial Collateral S53.2		Ulnar Collateral S53.3		
Sprain							
Nerve Injury	Ulnar S54.0	Median S54.1	Radial S54.2	Cutaneous S54.3	Multiple S54.7		
Blood Vessel	Ulnar Artery S55.0	Radial Artery S55.1					
Muscle Tendon	Flexor Thumb S56.0	Finger S56.1	Wrist S56.2	Extensor Thumb S56.3	Finger S56.4	Wrist S56.5	
Traumatic Amputation	Elbow S58.0	Forearm S58.1	Crush S57.8				

WRIST, HAND

Primary OA	M19.03	Post trauma OA	M19.13
R.A. Sero +ve	M05.83	Sero -ve	M06.03
Crepitant synovitis of wrist	M70.0	Wrist pain	M25.53
Triangular cartilage tear	M24.13	Wrist instability	M24.23
Chronic UCL thumb	M24.24	Carpal tunnel	G56.0
Other Nerve Lesions	Ulnar G56.2	Median G56.1	Radial G56.3
Trigger finger	M65.3	de Quervain	M65.4
Dupuytrens	M72.0		
Finger deformity	Acquired M20.0	Congenital Q68.1	

Contusion	Finger S60.0	Finger + Nail S60.1	Wrist & Hand S60.2			
Open Wound	Finger S61.0	Finger + Nail S61.1	Wrist & Hand S61.8			
Fracture	Scaphoid S62.0	Other Carpal S62.1	1st MC S62.2	Other MC S62.3	Thumb S62.5	Finger S62.6
Dislocation	Wrist Carpus S63.0	Finger thumb MCP/IP S63.1				
Ligament	Wrist S63.3	MCP/IP S63.4				
Nerve Injury	Ulnar S64.0	Median S64.1	Radial S64.2	Digital Thumb Finger S64.3	S64.4	Multiple S64.7
Blood Vessel	Ulnar S65.0	Radial S65.1	Palm Deep S65.3	Sup S65.2		
Muscle Tendon	Flexor Thumb S66.0	Finger S66.1	Extensor	Thumb S66.2	Finger S66.3	Intrinsic S66.5
Crush	Fingers S67.0	Wrist/Hand S67.8				
Traumatic Amputation	Thumb S68.0	One Finger S68.1	>1Finger S68.2	Hand S68.3	Wrist S68.4	

PREVIOUS SURGERY / INJURY

Infection	Prosthesis T84.5	ORIF T84.6	Surgical Wound T81.4	
Mechanical Failure	Fusion M96.0	Prosthesis T84.0	ORIF T84.1	
Fracture	Around implant M96.6	Malunion M84.0	Non-union M84.1	

INFECTION

Abscess L02.4 Cellulitis Toe or Finger L03.0 Limb L03.1
Lymphadenitis L04.3 Infected bursa M71.0

AMPUTATION

Diabetic IDDM E10.5 Non IDDM E11.5 P.V.D. I73.8
Stump Neuroma T87.3 Infection T87.4 Necrosis T87.5

OTHER ADMISSION CODE

Limb fitting Z44.1 Investigation Z13.9
Physio Z50.1 Social Z63.2 Fracture rehab Z54.4 Fracture follow-up Z09.

Surgery cancelled

Contra-indicated Z53.0 Patient decision Z53.2 Other reason Z53.8

DIAGNOSIS

PROCEDURE

COMMENTS

	M16.3	Post Perthes	M91.2
	M24.7	S.U.F.E	M93.0
matic AVN	M87.25	Idiopathic A.V.N.	M87.05
al Back Pain	M54.5	True sciatica	M51.1

Hallux valgus	M20.1	Hallux rigidus	M20.2
Hammer toe	M20.4	Other toe deformity	M20.5
Acquired deformity	M21.8	Acquired flat foot	M21.4
Morton's neuroma	G57.6	Peroneal drop foot	G57.3
Ingrowing toenail	L60.0	Onychogryphosis	L60.2

sion	Hip S70.0	Thigh - S70.1				
ound	Hip S71.0	Thigh S71.1	Multiple S71.7			
Femur	Shaft S72.3	Distal S72.4	Segmental S72.7			
Subcapital S72.0	Pertrochanteric S72.1	SubtrochantericS72.2				
S32.0	Sacrum S42.1	Ilium S32.3	Acetab S32.4	Pubis S32.5		
ion	Hip S73.0	Hip Prosthesis S73.0 & T84.0				
Cord S34.0	Nerve root S34. 2	Cauda equina S34.3	Sciatic S74.0	Femoral S74.1		
ssel	Femoral	Artery S75.0	Vein S75.1			
Hip S76.0	Quads S76.1	Adductor S76.2	Hamstrings S76.3			
Hip S77.1	Thigh S77.2					

Contusion	Ankle S90.0	Foot S90.3	Toe S90.1	Toe + Nail S90.2		
Open Wound	Ankle S91.0	Foot S91.3	Toe S91.1	Toe + Nail S91.2		
Fracture	Calcaneus S92.0	Talus S92.1	Tarsal S92.2	Metatarsal S92.3	1st Toe S92.4	Toe S92.5	Multiple S92.7
Dislocation Sprain	Ankle S93.0	Toe S93.1	Foot S93.3			
Nerve	Plantar Lateral S94.0	Medial S94.1	Deep peroneal S94.2			
Blood Vessel	Dorsal artery S95.0	Plantar artery S95.1				
Muscle/Tendon	Long flexor S96.0	Long extensor S96.1	Intrinsic S96.2			
Crush	Ankle S97.0	Toes S97.1				
Amputation	Ankle S98.0	One Toe S98.1	>2 Toes S98.2	Foot S98.3		

KNEE, LOWER LEG

OA	M17.1	Post trauma OA	M17.3
ro +ve	M05.66	Sero -ve	M06.06
Recurrent dislocation	M22.0	Recurrent subluxation	M22.1
Anterior Knee pain	M22.2	Chondromalacia	M22.4
ody	M23.4	Osteochondritis	M93.26

cus	Bucket handle	Anterior	Posterior	Discoid	Cyst
ial	M23.23	M23.31	M23.32	M23.13	M23.03
ral	M23.26	M23.34	M23.35	M23.16	M23.06

Contusion	Knee S80.0	Leg S80.1			
Open Wound	Knee S81.0	Leg S81.8	Multiple S81.7		
Fracture	Patella S82.0	Tibia Upper S82.1	Shaft S82.2	Distal S82.3	Fibula S82.4
Medial malleolus S82.5	Lateral malleolus S82.6	Bi/Tri malleolar S82.8			
Dislocation	Patella S83.0	Knee S83.1	Acute Meniscus S83.2		
Nerve Injury	Tibial S84.0	Peroneal S84.1			
Blood Vessel	Popliteal Artery S85.0	Vein S85.5	Tibial S85.1		
Muscle Tendon	Achilles tendon S86.0	Posterior S86.1	Anterior S86.2	Peroneal S86.3	
Crush	Knee S87.0	Leg S87.8			
Traumatic Amputation	Knee S88.0	Below knee S88.8			

ility	ACL	PCL	MCL	LCL	Multiple
te	S83.5		S83.4		S83.7
nic	M23.51	M23.52	M25.53	M23.54	M23.50

PROCEDURES

ELECTIVE

oplasty	Primary	Revision	Convert To	Excision
lip	W37.1	W37.3	W37.2	W57.4 Z84.3
nee	W41.1	W41.3	W41.2	W57.4 Z84.6
ented)	W40.1	W40.3	W40.2	
ulder				
emi	W50.1	W50.3	W50.2	
Cement	W49.1	W49.3	W49.2	W57.4 Z81..3
tal	W43.1 Z81..3	Revision W43.3 Z81.3		
ow	W43.1 Z81.5	Revision W43.3 Z81.5	W57.4 Z81.5	
ist	W44.1 Z82.1	Revision W44.3 Z82.1	W57.4 Z82.1	
CP	W44.1 Z83.2	No.		

od	Hip	Knee	Ankle	Subtalar	Triple	1st MTP	PIP toe
2-1	Z84.3	Z84.6	Z85.6	W04.3	W04.2	W59.3	W59.5
1st MCP Z83.1	Finger	PIP Z83.4 DIP Z83.5	Thumb IP Z83.3				
Wrist	Pin W62.1 Z82.1	Plate & graft W61.1 Z82.1					

scopy	Diagnostic	Menisectomy	Loose body	Biopsy	Lavage
ee	W87.9	W82.2	W85.1	W87.1	W85.2
gnostic W88.8	Loose body W86.1	Drilling W83.1	Shaving W83.3		
ilar cartilage W86.8	Plica W84.3	Fixation W83.2	Biopsy W88.1		
W84.8	Shoulder Z81.3	Elbow Z81.5	Wrist Z82.1	Knee Z84.6	

DER	Stabilisation	W77.1 Z81.3	A.C Jt W74.3 Z81.2
plasty	W08.5 Z68.2	Rotator Cuff T79.1	Distal clavicle W57.2Z81.2
V	Ulna nerve A67.1	Radial head excision W57.2 Z81.6	
is elbow	T83.2 Z55.2	Epicondylectomy W08.1 Z69.6	
Ganglion T59.1	Anchovy W56.2 Z82.3	Synovectomy W69.1 Z82.1	
screw W19.4 Z72.2	Ulnar head excision W08.5 Z71.6		
Trigger finger T72.3 Z56.3	de Quervain T72.3 Z55.8		
T59.2	Carpal tunnel A65.1	Fasciectomy T52.1 (Re-do T52.2)	
Soft tissue correction W02.4 Z89.6			
Morton's Neuroma A61.1 Z12.4	Ganglion T59.4		
olomy W15.1	Kellers W57.1	Fowlers W03.1	Stainsby W57.2 Z86.5

construction W74.2 Z84.6

rk removal	Diagnosis Z47.0	Procedure W28.3

TRAUMA

POP X48.1	MUA + POP W26.2	Closed reduction W66.9	IV Antibiotics X35.8	
N.O.F	Screws W24.1	DHS W19.1	Hemi W47.1 (Cement W46.1)	

IM Nail W19.2	Ex Fix W25.1	Plate	Shaft W20.1	Complex W20.4	Intra-articular W21.4
Percutaneous wires W24.8	ORIF + Screws W19.4	ORIF + Wires 19.6			
Ankle Fracture W20.5	Chondral # W21.3				

Humerus	Proximal Z69.3	Shaft Z69.4	Distal Z69.7		
Radius	Head Z70.1	Shaft Z70.3	Distal Z70.5	Ulna Z71.2	Olecranon Z71.1
Scaphoid Z72.2	MC1 Z73.3	2-5 Z 73.2	Phalanx Finger Z73.4	Thumb Z73.3	
Pelvis Z75.3	Acetabulum Z75.6				
Femur	Shaft Z76.4	Supracondylar Z76.5	Patella Z78.7		
Tibia	Condyle Z77.1	Shaft Z77.2	Distal Z77.5		
Talus Z79.1	Os calcis Z79.2	Navicular Z79.3	MT-1 Z80.1	2-5 Z80.2	

Skin	Suture S42.1	I + D S47.2	Debride S57.1	Graft S35.8
Amputation	Finger X08.3	Toe X11.2	Above knee X09.3	Below knee X09.5
Foreign body	Glass S44.4	Metal S44.2	Other S44.6	

Tendon/Muscle	Repair T67.6	Graft T68.5	Lysis T69. 1	Silastic T68.4
	Quads Z57.3	Patella Z58.7		
Flexor	Wrist Z55.1	FDS Z56.3	FDP Z56.4	FPL Z56.1	Thenar Z56.2
Extensor	Hand Z56.7	Wrist Z55. 2	Hypothenar Z56.5	Intrinsic Z56.6	

Nerve	A64.2	Fem Z10.1	Sciatic Z11.1	Popliteal Z12.1	Tib P Z12.2
	Ulna Z09.4	Radial Z09.3	Median Z09.2	Digital Z09.7	

Joint Primary Non arthroscopic

Aspiration	W90.1
EUA	W92.4
EUA + II	W92.3
Open biopsy Joint	W92.1
Open biopsy Synovium	W69.4
Loose body removal	W81.2
Incision Drainage	W81.3
Arthrotomy	W81.4
Synovectomy Total	W69.1
Sub-total	W69.2
Debridement	W71.3
Drilling of cartilage	W71.1

Shoulder Z81.4	A-C Jt Z81.2				
Elbow Z81.5	Radio/ulna Prox Z81.6 Distal Z81.7				
Wrist Z82.1	Intercarpal Z82.2				
Thumb CMC Z823	MCP Z83.1	IP Z83.3			
Finger	CMC Z82.4	MCP Z83.2	PIP Z83.4	DIP Z83.5	
Knee Z84.6	Ankle Z85.6				
Subtalar Z85. 3	Midtarsal Z86.1	Tarso-metatarsal Z86.3			
1st MTP Z86.4	MTP 2-5 Z86.5	IP Jt Z86.6			

SOUTHERN GENERAL HOSPITAL NHS TRUST

1

SURNAME (Block Letters)	FIRST NAME	UNIT No.
HONEYMAN	CATHERINE	940779

ADDRESS	OCCUPATION	SEX	DATE OF BIRTH
10 Melville Street. Glasgow 422-1580		F	1/2/49.

PHONE No. G41 2LN

NEXT OF KIN (Name and Address)

CHANGE OF ADDRESS

NAME AND ADDRESS OF OWN DOCTOR 531-8250

Dr G. Marshall Mills
Gorbals Health Centre
45 Pine Place
Glasgow G5 0BQ

PHONE No.

CHANGE OF ADDRESS

NAME AND ADDRESS OF OWN DOCTOR

BLOOD GROUP

SENSITIVITY

PHONE No.

UNIT CASE RECORDS

GENERAL	✓	ORTHOPAEDIC	
INSTITUTE		PODIATRY	
MATERNITY		PSYCHIATRIC	
SPINAL			

INDEX OF ATTENDANCES

Every NEW out-patient attendance, and EACH in-patient admission must be noted below

DATE	CLINIC / WARD	DOCTOR	DIAGNOSIS / OPERATION	CODED	DISCH. DATE
24-9-98	Ortho OP	MBZ	CS		
5.5.04	ORTHO OP	MILLER	DNA		
16-6-05	ORTHO OP	STEAD/NICOL			
23.11.05	WARD 1	STEAD	CANCELLED BY HOSPITAL		
11.12.05	WARD 6	STEAD	(2) T-I-C-R.		19/12/05
31-1-06	OP/HO				
29-5-07	OP/HO				
8-1-08	OP/HO	MOHAMMED			
23.1.09	ORTHO OP	Hullin			
27.1.10	WARD 6	Hullin	(1) TKR (2) Patella Resurfacing		3/2/10
26.2.10	OP/HO				
4.5.10	Ward 5	Hullin			
6/5/10	WARD	MARTIN	Post Op Knee Problem		14/5/10

CLINIC / WARD	DOCTOR	DIAGNOSIS / OPERATION	CODED	DISCH. DATE
	Hullin			
Ortho	Hullin			
WARD 3	Hullin			
Ortho	Hullin			
Ward 5	Hullin	ⓇSecond stage Knee replacement		1/7/11
Ortho	Hullin			
Ortho	Marlin			
Ortho	Hull.			
Ortho	Hullin			
Ortho	Hullin			

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR MARC BRANSBY-ZACHERY FRCS
Orthopaedic Hand & Upper Limb Service

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Direct Tel: 0141 201 1473

Our Ref: MB-Z/HAC
Enquiries To: Helen Carlisle

09/05/12

DR GRAEME G MARSHALL
GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ

Dear Dr

CATHERINE HONEYMAN DOB: 01/02/49 (SG00940779)
10 MELVILLE STREET, GLASGOW, G41 2LN

Many thanks for asking us to see this 63 year old lady today. She is well known to Mr Hullin having had a left knee replacement and numerous operations on the right and a revision on the right due to previous infection. She attends today with bilateral shoulder pain for several years, but she is struggling to cope. Due to her knee pain, she walks with 2 elbow crutches.

Catherine says she has pain night and day from her shoulders, the left is worse. She wakes at night with pain. She has pain with rest and activity and struggles with daily activities. She has pain in the upper part of both arms.

On examination, she is over weight, her neck is not tender with good movements. She is tender over both acromionae. Left active elevation is 100 with a little more passively, there is a bit more on the right. Impingement signs are negative. External rotation is reduced, worse on the left.

X-rays show bilateral glenohumeral changes, worse on the left.

I think with her pain, the only reasonable treatment is a shoulder replacement, however, due to her size and previous infections, I am not sure if she is a good candidate. We discussed the option of surgery today and she would like to consider things. I feel this is wise and she should see one of the surgeons for further assessment and management.

She is aware there is an increased risk with surgery. She will therefore attend Mr Martin's clinic in a few months.

Yours sincerely
Karen Shields
Extended Scope Practitioner

Hospital use Only	Clinic	Day Date	Time	Hospital No. 960779 G	GP112

REQUEST FOR OUT-PATIENT CONSULTATION
THE INFORMATION IN THIS SECTION MUST BE COMPLETED

Appointment Category: Routine ☐ Soon ☐ Urgent ☐

PARTICULARS OF PATIENT IN BLOCK LETTERS PLEASE

Hospital Southern General Date 4-2-98 CHI No.

Please arrange for this patient to attend the ORTHOPAEDIC clinic of Dr/Mr

Patient's Surname HONEYMAN Maiden Surname

First Names CATHERINE Single/Married/Widowed/Other

Address 10 MELVILLE ST Date of Birth 1-2-49

GLASGOW Patient's Occupation

Postal Code G41 2LN Contact telephone number

Has the patient attended hospital before? YES / NO If "YES" please state:

Name of Hospital

Year of attendance Hospital No. 960779

If the patient's name and/or address has/have changed since then please give details:

Can patient attend at short notice? YES / NO

If YES, minimum notice required days

Name, Address and Telephone number of MEDICAL / DENTAL PRACTITIONER

DR C. MILLS & DR G. MARSHALL
GORBALS HEALTH CENTRE
45 PINE PLACE
GLASGOW G5 0BQ
Tel: 0141 531 8250

Please use rubber stamp

49074

I would be grateful for your opinion and advice on the above named patient. A brief outline of history, symptoms and signs is given below:
Patient attended rheumatology not ortho

Dear Doctor

I would be grateful if you would see this lady who has attended the Orthopaedic Clinic in the past with golfer's elbow requiring hydrocortisone and lignocaine injection in 1994. She now complains of bilateral elbow pain and a very painful left thumb. The painful thumb is making it difficult for her to change gears and she is presently taking Tramadol 50mgs three hourly as required for general aches and pains and Traxam Gel as well as Lodine SR one at night. I have asked the physiotherapist to see her with a view to perhaps ultrasound however I would be grateful if you would see her and advise as to whether she requires another injection and also have a look at her thumb and advise on management.

Yours sincerely

Dr C Mills

Diagnosis / provisional diagnosis:

Present drug treatment and potential special hazards:

X-ray (women of childbearing age). Date of first day of L.M.P.

TRACKING SECTION 09 FEB 1998

Relevant X-rays available from: No. (if known)

Signature

355-2104

Printed for The Stationery Office Dd8456932 11/96

Oneek · SEC · gen or

E-mail Subject Line: Orthopaedics, - -, 0102496145, Honeyman, Catherine

Clinic	Day Date	Time	Hospital No. 940779
Consultant to complete:	Appointment category	Clinic Details	

Date: 07-Oct-2003 GP Urgency: Routine
Reason (if urgent): CHI **0102496145**

Please arrange for this patient to attend **Southern General Hospital, Orthopaedics, Orthopaedics, - -**

Surname **Honeyman** Title **Mrs**
Forename **Catherine** Date of birth **01/02/1949**
Address **10 Melville St□GLASGOW**

Tel **422-1580**

Post code **G41 2LN**
Previous name
" address

Previous hospital attendance Y/N
If Yes, please indicate year Year .
Unit number 940779
Referral checked by

Referring clinician: Dr C Mills
Gorbals Health Centre
45 Pine Place

0141 531 8250, fax: 0141 531 8248
Practice Number 49074

Dear Doctor

Thank you for seeing this woman who has bilateral knee pain in both knees and which are now giving way. On examination she had marked crepitus in both knees but no effusion. She does have a history of osteoarthritis and has attended the Rheumatology Clinic at the Southern but osteoarthritis was diagnosed in 1995. She was advised in 2001 that her weight was contributing to her joint pain and has managed to lose almost 2 stones in weight since that time. She is now 84kgs which is still overweight but despite her weight coming down her knee pain has worsened. I would be grateful for your advice on management now.

Yours sincerely

Dr C Mills

New
Routine
09 OCT 2003

H/O: injury (14J..) [Back]
15/04/1993 FH: * - breast (1243.)
15/04/1993 FH: Hypertension (12C1.)
15/04/1993 H/O: * breast (1424.)
15/07/1993 FH: Ischaemic heart dis. <60 (12C2.)
17/02/1994 FH: Ischaemic heart dis. >60 (12C3.)
06/06/1995 Other specified drug dependence NOS (E247z)
"patient suffered a back injury - on dyhydrocodeine - dependence"
01/01/1996 H/O: depression (1465.)
TRAMADOL SR tabs 200mg 1 tab bd
Omeprazole caps 20mg 1 tab mane
Fluoxetine caps 20mg 1 cap mane
Traxam gel 3% apply tid
ROFECOXIB 12.5mg 2 tabs mane

Honeyman, Catherine, 0102496145, 01/02/1949 - - Orthopaedics Southern General Hospital Routine
RR \\Gps49074serv1\Documents\Dr C Mills\Honeyman, Catherine 2003 10 07 #1.doc

Ex-smoker - amount unknown (05/03/99)
Less than 7 units/week (05/03/99)

LL OR/Sq/SR 940 779

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

Trauma and Orthopaedic Surgery C8
G General Referral

— **Consultant / receiving practitioner** and/or **specialty clinic**

Southern General Hospital

— **Hospital** and **hospital address**

Hospital unit no.: -

Email address: -

Urgency of referral: Routine

PATIENT DETAILS

Surname	Honeyman
Forename(s)	Catherine
Title	Mrs
Sex	Female
Date of birth	01-Feb-1949
CHI no.	0102496145

Patient's address

10 Melville St
GLASGOW
G41 2LN

Contact number(s)

Voice: 422-1580

REGISTERED GP DETAILS

Name	Dr G Marshall		
GMC code	3486557	GP code	G08095
Practice name	Gorbals Health Centre		
Practice code	49074		

Practice address

45 Pine Place

Contact number(s)

Voice: 0141 531 8250
Facsimile: 0141 531 8248

REFERRING PRACTITIONER DETAILS

Name	Dr G Marshall		
GMC code	3486557	GP code	G08095
Practice name	-		
Practice code	49074		

Practice address

Contact number(s)

-

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: Possible Knee Relacement

Comment: Dear Doctor

I would be grateful if you could see Catherine who has prove wide spread Osteoarthritis. This is particularly severe in her knees currently. Catherine wonders whether she would be suitable for knee replacement. I would be grateful if you could give you opinion on this.

Your sincerely

Dr G Marshall



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
Gastro-oesophageal reflux	-	-	-	01-Jan-1998
Neurotic depression reactive type	-	-	-	02-Dec-1996
Other specified drug dependence NOS	-	-	patient suffered a back injury - on dyhydrocodeine - dependence	06-Jun-1995
Benign breast cyst	-	-	-	01-Jan-1989
Osteoarthritis	-	-	-	01-Jan-1989
Fibrocystic disease of breast	-	-	-	01-Feb-1988

Past procedures

Description	Laterality	Modifier	Date performed
Refer for biochemical test	-	-	25-Nov-1999
Health ed. - diet	-	-	01-Jul-1994
Health ed. - exercise	-	-	01-Jul-1994
Health ed. - exercise	-	-	27-Jan-1994
Total cholecystectomy NEC	-	-	01-Apr-1992

Current and recent medication

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration
Fluoxetine	04.03.03.0	CAPS 20MG	1 Cap	mane	28-Jun-2004	-
TRAMADOL SR	00.00.00.0	TABS 200MG	1 TAB	BD	07-Oct-1999	-

Omeprazole	01.03.05.0	CAPS 20MG	1 TAB	MANE	09-Jan-1998	-
Flucloxacillin	05.01.01.2	CAPS 500MG	1 Cap	4 times daily cc	12-May-2005	-
Fusidic Acid	13.10.01.2	CREAM 2%	Apply	morning and night	12-May-2005	-

Clinical warnings

Lifestyle risks

Exercise status: Enjoys light exercise

Smoking status

Number per day
0 (never smoked tobacco)

Alcohol consumption

Units per day
1-2 (light drinker)

Additional relevant information

Administrative information

Preferred gender of consultant:No preference

Family conditions

Description	Modifier	Extension	Relation to patient
FH: Ischaemic heart dis. <60	-	-	-
FH: Ischaemic heart dis. >60	-	-	-
FH: Ischaemic heart dis. <60	-	-	-
FH: Hypertension	-	-	-

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

Attachments

REFERRAL TO

Trauma & Orthopaedic - Neck & Shoulder
GGC General Referral

— **Consultant / receiving practitioner** and/or **specialty clinic**

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

— **Hospital** and **hospital address**

Hospital location code.
G405H

Email address
-

Urgency of referral ROUTINE
Date of referral 13-Mar-2012 **Date sent** 14-Mar-2012

PATIENT DETAILS

Surname	Honeyman
Forename(s)	Catherine
Title	Mrs
Sex	Female
Date of birth	01-Feb-1949
CHI no.	0102496145
Area of Residence	-

Patient's address

10 Melville St
GLASGOW
G41 2LN

Contact number(s)
Voice: 422 1580

101003328547L Unique Care Pathway Number: 101003328547L

REGISTERED GP DETAILS

Name	Dr Graeme Marshall		
GMC code	3486557	GP code	08095
Practice name	Gorbals Health Centre		
Practice code	49074		

Practice address

Gorbals Health Centre
45 Pine Place
Glasgow
G5 0BQ

Contact number(s)
Voice: 0141 531 8250
Facsimile: 0141 531 8248

REFERRING GP DETAILS

Name	Dr. Graeme Marshall		
GMC code	3486557	GP code	08095
Practice name	Drs Mills & Marshall Practice (49074)		
Practice code	49074		

Practice address

Gorbals Health Centre
45 Pine Place
Glasgow
G5 0BQ

Contact number(s)
Voice: 0141 531 8250

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: Arthritis

Comment: Dear Doctor

I would be grateful if you would see Catherine who has severe pain probably secondary to arthritis in her left shoulder. I have X-rayed this which showed significant arthritis and I have injected her with corticosteroid & lidocaine which made little difference to her shoulder. Again she has been referred to physiotherapy which made little difference. Ordinary analgesia has almost no effect on her. She wishes an orthopaedic opinion to see if she requires surgery and I would be grateful if you could give your expert opinion.

Yours sincerely

Dr G Marshall

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history
Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Sciatica	-	12-Mar-2012	12-Mar-2012
Frozen shoulder	-	12-Mar-2012	12-Mar-2012
Vaginal bleeding	-	12-Mar-2012	12-Mar-2012
Osteoarthritis	-	22-Feb-2012	22-Feb-2012
Local infection skin/subcut tissue NOS	-	24-Oct-2011	24-Oct-2011
Ischaemic heart disease NOS	Disease: SPICE IHD,	14-May-2007	14-May-2007
Essential hypertension	Disease: SPICE Hypertension,	02-Nov-2005	02-Nov-2005
Gastro-oesophageal reflux	-	01-Jan-1998	01-Jan-1998
Neurotic depression reactive type	-	02-Dec-1996	02-Dec-1996
Other specified drug dependence NOS	patient suffered a back injury - on dyhydrocodeine - dependence	06-Jun-1995	06-Jun-1995
Osteoarthritis	-	01-Jan-1989	01-Jan-1989
Benign breast cyst	-	01-Jan-1989	01-Jan-1989
Fibrocystic disease of breast	-	01-Feb-1988	01-Feb-1988
H/O: injury	Back	01-Jan-1860	01-Jan-1860

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Endoscopic endometrial polypectomy	-	22-Dec-2011	22-Dec-2011
Diagnostic hysteroscopy	-	22-Dec-2011	22-Dec-2011
Skin wound swab taken	shin	24-Oct-2011	24-Oct-2011

Other total prosthetic replacement of knee joint (Right)	2nd stage	22-Jun-2011	22-Jun-2011
Revision of total knee replacement NEC	1st & 2nd Knee	20-May-2011	20-May-2011
Removal of prosthetic knee joint	-	27-Mar-2011	27-Mar-2011
Closed reduction of fracture of tibia and or fibula	undisplaced right distal tibia	14-Oct-2010	14-Oct-2010
Knee joint operations	Right Removal of patellar button	04-May-2010	04-May-2010
Primary total knee replacement NEC	Left	27-Jan-2010	27-Jan-2010
Depression screening using questions	:	06-Feb-2008	06-Feb-2008
Other total prosthetic replacement of knee joint	Right	12-Dec-2005	12-Dec-2005
Total cholecystectomy NEC	-	01-Apr-1992	01-Apr-1992

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Fluoxetine Hydrochloride Capsules 20 mg	56	56 CAPS	1 Cap In the morning	-	12-Mar-2012	12-Mar-2012
Glyceryl Trinitrate Cfc-free pump spray 400 micrograms/dose (200 dose)	2	2 spray	2 Puffs prn	-	23-Feb-2011	22-Feb-2012
Bendroflumethiazide Tablets 2.5 mg	56	56 TABS	1 Tab In the morning	-	23-Feb-2011	22-Feb-2012
Atenolol Tablets 25 mg	56	56 TABS	1 Tab In the morning	-	27-Apr-2011	22-Feb-2012
Omeprazole Capsules (Gastro-Resistant) 20 mg	56	56 CAPS	1 TAB In the morning	-	22-Jun-2011	22-Feb-2012
Tramadol Hydrochloride Capsules 50 mg	224	224 CAPS	4 Caps Twice daily	-	22-Jun-2011	22-Feb-2012
Aspirin Dispersible tablets 75 mg	56	56 TABS	1 Tab In the morning	-	11-Jul-2011	22-Feb-2012

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Tranexamic Acid Tablets 500 mg	24	24 TABLET	TWO TO BE TAKEN THREE TIMES A DAY FOR UP TO 4 DAYS	-	12-Mar-2012	12-Mar-2012
Dermol 500 Lotion	500	500 ml	TO BE USED TWICE A DAY	-	24-Oct-2011	24-Oct-2011
Cetirizine Hydrochloride Tablets 10 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	24-Oct-2011	24-Oct-2011
Simvastatin Tablets 40 mg	56	56 TABS	1 Tab At night	-	13-Jun-2011	30-Sep-2011
Fluoxetine Hydrochloride Capsules 20 mg	56	56 CAPS	1 Cap In the morning	-	13-Jun-2011	30-Sep-2011

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Ex smoker:		24-Oct-2011
Ex smoker:	Recorded through Combined Vaccination priority=2	27-May-2011
Ex smoker:	Disease: SPICE Basic Health Values, priority=2	20-Nov-2009
Ex smoker:	Recorded through Combined Vaccination priority=2	02-Dec-2008
Ex smoker:	: priority=2	06-Feb-2008
Teetotaller:		07-Dec-2011
Alcohol consumption, 4 units/week:		24-Oct-2011
Alcohol consumption:	28:units/week priority=2	06-Feb-2008
Alcohol consumption:		06-Feb-2008
Alcohol intake above recommended sensible limits:	: priority=2	06-Feb-2008

Declined referral to physical exercise programme:		07-Dec-2011
Exercise grading, 1:		24-Oct-2011
Declined referral to physical exercise programme:		24-Oct-2011
Exercise grading NOS, 1:		24-Oct-2011
Exercise grading:	3: priority=2	06-Feb-2008

Clinical warnings

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes
Patient will accept any site:Yes
Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Patient has disability or requires wheelchair access:No
Referred By:Referring GP
Electronic Attachment Present:No

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

SOUTHERN GENERAL HOSPITAL
NHS TRUST

3Y

MR M BRANSBY -ZACHARY FRCS
Orthopaedic Hand & Upper Limb Service

DOCTOR'S LETTER SHEET

UNIT NUMBER

Our ref: MB-Z/CC
Enquiries: Mrs Cant
Telephone: DIRECT LINE 0141 201 1473

24 December 1998

Dr Mills
Gorbals Health Centre
45 Pine Place
GLASGOW
G5 0BQ

Dear Dr Mills

CATHERINE HONEYMAN DOB 1.2.49
10 MELVILLE STREET, GLASGOW (UNIT NUMBER: 940779)

This patient failed to attend my clinic today and due to the great demand for clinic slots I have not sent a further appointment. It may be that symptoms have now settled. However, if this is not the case, please contact me and I will send a further appointment.

Yours sincerely

MARC BRANSBY-ZACHARY FRCS
Consultant Orthopaedic Surgeon

SOUTHERN GENERAL HOSPITAL
NHS TRUST

3Y

MR M BRANSBY -ZACHARY FRCS
Orthopaedic Hand & Upper Limb Service

DOCTOR'S LETTER SHEET

UNIT NUMBER

Our ref: MB-Z/CC
Enquiries: Mrs Cant
Telephone: DIRECT LINE 0141 201 1473

3 June 1999

Dr Mills
Gorbals Health Centre
45 Pine Place
GLASGOW
G5 0BQ

Dear Dr Mills

CATHERINE HONEYMAN DOB 1.2.49
10 MELVILLE STREET, GLASGOW (UNIT NUMBER: 940779)

Diagnosis: Polyarthritis but particularly left thumb CMC joint

Many thanks for referring this patient whom I saw today on behalf of Mr Bransby-Zachary. In your letter she was coming complaining of pain mainly in both arms and particularly the left hand but since that time she has developed aches and pains in nearly all the joints of her body, neck, shoulders, elbows, knees and hips also. We will just concentrate on the hands at this consultation. She finds particular problems with the left hand gripping items with pain at the base of the thumb. She feels her hands stiff and is tending to drop things occasionally. She has no particular history of numbness or paraesthesia in the hands.

Examining the lady she has reasonable range of neck movements. Shoulder and elbow movements seem to be satisfactory. In the hand she has full range of movement of the carpus and small joints of the hand. Rotational movements of the CMC joint of the left hand are very painful with crepitus and on the right less so. X-rays show early degenerative changes in the CMC joint of the left thumb. She also has degenerative changes in some of the other joints of the hand with some cyst formation and a couple of articular erosions.

From the point of view of her left thumb I think simple use of a splint for activity may well be all she requires at this stage. I have explained that further treatment is possible and it may become necessary later on.

I think in view of her rather generalised symptoms she would be best assessed by the Rheumatologists and I will ask them to have a look at her. She has been discharged from this clinic but should she run into difficulties we would be pleased to review her.

Yours sincerely

JAMES BIDWELL FRCS Ed (Orth)
Specialist Registrar V, Orthopaedics

MR M BRANSBY -ZACHARY FRCS
Orthopaedic Hand & Upper Limb Service

DOCTOR'S LETTER SHEET

UNIT NUMBER

Our ref: MB-Z/CC
Enquiries: Mrs Cant
Telephone: DIRECT LINE 0141 201 1473

3 June 1999

Dr Susan Fraser
Consultant Rheumatologist
SGH

Dear Dr Fraser

CATHERINE HONEYMAN DOB 1.2.49
10 MELVILLE STREET, GLASGOW G41 2LN (UNIT NUMBER: 940779)

I would be very grateful if you could see this lady in your clinic. She is complaining of worsening polyarthritis affecting most of her axial skeleton. We saw her on account of pains in her hands and she has some CMC degenerative joint disease at the base of the left thumb particularly but she also has evidence of joint changes in some of the other small joints of the thumb. There is a family history of arthritis but she is not sure of which kind. She and her GP seem to be having difficulty controlling her systemic symptoms with medication and we would be grateful for your input.

Yours sincerely

JAMES BIDWELL FRCS Ed (Orth)
Specialist Registrar V, Orthopaedics

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST
SOUTHERN GENERAL HOSPITAL
1345 GOVAN ROAD
GLASGOW
G51 4TF

5 May 2004

DIRECT LINE: 0141 201 1469

DR MARSHALL
GORBALS HEALTH CENTRE
45 PINE PLACE
GLASGOW
G5 0BQ

Dear DR MARSHALL,

CATHERINE HONEYMAN HOSP NO:SG00940779
10 MELVILLE STREET
DOB: 01/02/49
GLASGOW
G41 2LN

This patient did not attend my Clinic today. Due to the great demand for clinic slots I have not sent a further appointment. If the patient has telephoned and cancelled or postponed the appointment,this information has not been communicated to me and I apologise for the inconvenience.

However,if the patient has not contacted us, a further appointment will not be offered due to the demand for clinic appointments, unless re-referred.

Yours sincerely

MR MEEK
Consultant Orthopaedic Surgeon

DOCTOR'S LETTER SHEET

UNIT NUMBER

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR I W STEAD FRCS

Secretary: 0141 201 1469

IWS/CIH

16/06/05

Dr G Marshall
GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ

Dear Dr Marshall

CATHERINE HONEYMAN DOB: 01/02/49 (SG00940779)
10 MELVILLE STREET, GLASGOW, G41 2LN

I saw this lady in Mr Stead's Nurse Led OA Clinic this morning. She is complaining of pain in both knees, the right worse than the left.

Her Oxford knee score was 49/60.

X-rays taken today confirm medial compartment OA of both knees.

We had a long discussion about the risks and benefits of total knee joint replacement and Mrs Honeyman feels she would like to proceed with this. She also informed me that she is Jehovah's Witness.

I have placed her name on the Waiting List for a right total knee joint replacement.

Yours sincerely

SISTER F NICOL
Orthopaedic Nurse Specialist

DOCTOR'S LETTER SHEET

UNIT NUMBER

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR I W STEAD – FRCS
CONSULTANT

Secretary: 0141-201-1469

KO/CIH/940779

4 January 2006

Dr G Marshall
Surgery
45 Pine Place
GLASGOW G5 0BQ

Dear Dr Marshall

CHATHERINE HONEYMAN (01 2 49)
10 MELVILLE STREET G41 2LN

Your patient was admitted to the Orthopaedic Unit on 12 December 2005 as an elective admission. The diagnosis was:- OA – right knee.

The following procedures were carried out:- Right total knee replacement.

The discharge date was 19 December 2005 and follow up has been arranged for six weeks.

Yours sincerely

K OGUNWALE – FRCS
SHO 3 in Orthopaedics

South Glasgow
University Hospitals
Division

Southern General Hospital

1345 Govan Road
Glasgow G51 4TF
Telephone 0141-201-1100
Fax 0141-201-2999
www.nhsgg.org.uk

NHS
Greater
Glasgow

DEPARTMENT OF ORTHOPAEDIC SURGERY
DIRECT LINE: 0141 201 1137

07/03/06
CHI:0102496145

DR GRAEME G MARSHALL
GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ

Dear Dr Marshall

CATHERINE HONEYMAN DOB: 01/02/49 (SG00940779)
10 MELVILLE STREET, , GLASGOW, G41 2LN

This patient was seen at Mr Stead's Arthroplasty Clinic today.

It is now 3 months since right -knee replacement.

They are mobilising with 1 stick

The range of flexion was 95 degrees.

The wound was satisfactory.

Problems Identified: None noted

A follow-up appointment has been made for 9 - months

Yours sincerely

Fiona Nicol
Orthopaedic Nurse Specialist

Acute Services Division

Surgery and Anaesthetics Directorate

NHS
Greater Glasgow and Clyde

DEPARTMENT OF ORTHOPAEDIC SURGERY
DIRECT LINE: 0141 201 1137

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

29/05/07
CHI:0102496145

DR GRAEME G MARSHALL
GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ

Dear Dr Marshall

CATHERINE HONEYMAN DOB: 01/02/49 (SG00940779)
10 MELVILLE STREET, , GLASGOW, G41 2LN

This patient was seen at Mr Patil's Arthroplasty Clinic today.

It is now 18 months since right -knee replacement.

The range of flexion was 120 degrees.

The Oxford Knee Score was 46 Out of 60 (HIGHER score POORER outcome)

Medical Problems: None noted

Problems Identified: Persistant Pain

A follow-up appointment has been made for 2 - weeks

X-rays were assessed as Satisfactory -

In view of pain I have taken blood to check Mrs Honeyman's CRP, ESR and FBC to rule out infection as the cause of her pain. She will be reviewed at Mr Patil's clinic as above.

Yours sincerely

Fiona Nicol
Orthopaedic Nurse Specialist

Delivering better health

www.nhsggc.org.uk

40369

DOCTOR'S LETTER SHEET

UNIT NUMBER

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR SANJEEV PATIL
Orthopaedic Service

Our Ref: SP/CIH
Enquiries To: Secretary

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Direct Tel: 0141 201 2866

13/06/07

Dr G Marshall
GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ

Dear Dr Marshall

CATHERINE HONEYMAN DOB: 01/02/49 (SG00940779)
10 MELVILLE STREET, , GLASGOW, G41 2LN

I saw this lady in the Clinic today 18 months following her right total knee replacement. She has been ongoing pain with this, but check X-rays are satisfactory and infection screen is negative.

She has a good range of movement with no significant pain on examination.

I have arranged an Isotope bone scan for her as well as some physiotherapy to build up her poor quads bulk and we will see her for review with the result of the scan.

Yours sincerely

A BENNETT - FRCS
Orthopaedic Registrar

DOCTOR'S LETTER SHEET

UNIT NUMBER

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR SANJEEV PATIL
Orthopaedic Service

Our Ref: SP/MD
Enquiries To: Secretary

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Direct Tel: 0141 201 2866

25/07/07

DR GRAEME G MARSHALL
GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ

Dear Dr Marshall

CATHERINE HONEYMAN DOB: 01/02/49 (SG00940779)
10 MELVILLE STREET, , GLASGOW, G41 2LN

This lady was reviewed at the clinic a year and a half following a right total knee replacement. She has been left with a painful knee. So far all investigations have been negative for infection. The recent bone scan has shown evidence of inflammatory change in the medial aspect of the knee but no typical appearance of loosening. There is also increased uptake in her feet, shoulder and C-spine which are all consistent with degenerative pathology.

This lady also denies having any inflammatory joint disease.

So far all investigations have not conclusively shown any etiology to this lady's painful knee post TKR. I think we should watch and wait. I have in the first instance advised her to try anti-inflammatory medication with a proton pump inhibitor and see if this would make any difference to her pain.

We will see her in December of this year which will be 2 years post surgery, with an x-ray right knee AP lateral and skyline view on arrival.

Yours sincerely

K PERIASAMY
ORTHOPAEDIC REGISTRAR

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL
1345 GOVAN ROAD
GLASGOW
G51 4TF

5 December 2007

DIRECT LINE:

DR MARSHALL
GORBALS HEALTH CENTRE
45 PINE PLACE
GLASGOW
G5 0BQ

Dear DR MARSHALL,

CATHERINE HONEYMAN HOSP NO:SG00940779
10 MELVILLE STREET
DOB: 01/02/49
GLASGOW
G41 2LN

This patient did not attend my Clinic today. Due to the great demand for clinic slots I have not sent a further appointment. If the patient has telephoned and cancelled or postponed the appointment, this information has not been communicated to me and I apologise for the inconvenience.

However, if the patient has not contacted us, a further appointment will not be offered due to the demand for clinic appointments, unless re-referred.

Yours sincerely

MR PATIL
Orthopaedic Consultant

CHI No.0102496145

Acute Services Division

NHS
Greater Glasgow and Clyde

DEPARTMENT OF ORTHOPAEDIC SURGERY
DIRECT LINE: 0141 201 1137

08/01/08
CHI:0102496145

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

DR GRAEME G MARSHALL
GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ

Dear Dr Marshall

CATHERINE HONEYMAN DOB: 01/02/49 (SG00940779)
10 MELVILLE STREET, , GLASGOW, G41 2LN

This patient was seen at Mr Patil's Arthroplasty Clinic today.

It is now 2 years since right -knee replacement.

The range of flexion was 110 degrees.

The Oxford Knee Score was 42 Out of 60 (HIGHER score POORER outcome

Medical Problems: None noted

Problems Identified: Persistant Pain

A follow-up appointment has been made for 3 - weeks

X-rays were assessed as Satisfactory

Mrs Honeyman is still having a lot of pain from her knee despite all investigations being inconclusive. Mr Patil would like Mr Hullin's opinion and an appointment has been made for his clinic.

Yours sincerely

Fiona Nicol
Orthopaedic Nurse Specialist

DOCTOR'S LETTER SHEET

UNIT NUMBER

DEPARTMENT OF ORTHOPAEDIC SURGERY
SOUTHERN GENERAL HOSPITAL

MR. MICHAEL G. HULLIN MA MD FRCS
CONSULTANT ORTHOPAEDIC SURGEON

Our Ref: MGH/MN

Enquiries to: Margaret Nicol
Telephone: 0141 201 1357
E-mail: Margaret.nicol@sgh.scot.nhs.uk

Unit no: SG940779

13th February 2008

Dr. G. Marshall
Gorbals Health Centre
45 Pine Place
GLASGOW
G5 OBQ

Dear Dr. Marshall,

CATHERINE HONEYMAN – DOB 1.2.49
10 Melville Street, Glasgow, G41 3LN

Mrs. Honeyman was offered a return appointment at the orthopaedic clinic on 1st February 2008 which she failed to attend and no further appointment has been arranged. If Mrs Honeyman still requires to be seen, please re-refer her to the orthopaedic department.

Yours sincerely

Margaret M. Nicol
Orthopaedic Secretary

DOCTOR'S LETTER SHEET

UNIT NUMBER

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR MICHAEL HULLIN MA MD FRCS
ORTHOPAEDIC RETURNS CLINIC

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Direct Tel: 0141 201 1357

Our Ref: MGH/
Enquiries To: Margaret Nicol

Seen & Dict: 06/06/08
Typed: 16/06/08
CHI: 0102496145

DR Marshall
GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ

Dear Dr Marshall,

CATHERINE HONEYMAN DOB: 01/02/49 (SG00940779)
10 MELVILLE STREET, , GLASGOW, G41 2LN

This lady feels her anterior right knee pain is deteriorating 3 years following her right total knee replacement by Mr. Stead. X-rays do show she has an element of patella baha and elevation of the joint line but no evidence of loosening or obvious cause of her pain. Her left knee is giving her significant symptoms but the x-ray of this shows only some medial compartment changes. I had a long chat with her about the risks and benefits of surgery and explained there is only perhaps a 50% chance of improving her symptoms. She is quite keen to consider surgery and I have put her name on the waiting list for resurfacing right patella.

Yours sincerely

Michael G Hullin FRCS
Consultant Orthopaedic Surgeon

4/12/8
On waiting list
No further Appt.
D.

Run: 16/06/08-14:33 by NICOL,MARGARET

S.G.H./3Y
JMcC/71588

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL
1345 GOVAN ROAD
GLASGOW
G51 4TF

5 December 2008

DIRECT LINE: 0141 201-1357

DR MARSHALL
GORBALS HEALTH CENTRE
45 PINE PLACE
GLASGOW
G5 0BQ

Dear DR MARSHALL,

CATHERINE HONEYMAN HOSP NO:SG00940779
10 MELVILLE STREET
DOB: 01/02/49
GLASGOW
G41 2LN

This patient did not attend my Clinic today. Due to the great demand for clinic slots I have not sent a further appointment. If the patient has telephoned and cancelled or postponed the appointment, this information has not been communicated to me and I apologise for the inconvenience.

However, if the patient has not contacted us, a further appointment will not be offered due to the demand for clinic appointments, unless re-referred.

Yours sincerely

MR HULLIN
Consultant Orthopaedic Surgeon

CHI No.0102496145

SOUTH GLASGOW HOSPITALS
SOUTHERN GENERAL HOSPITAL

3Y

DOCTOR'S LETTER SHEET

UNIT NUMBER

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR MICHAEL HULLIN MA MD FRCS
ORTHOPAEDIC RETURNS CLINIC

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Direct Tel: 0141 201 1357

Our Ref: MGH/MN
Enquiries To: Margaret Nicol

Seen & Dict: 23/01/09
Typed: 11/02/09
CHI: 0102496145

DR Marshall
GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ

Dear Dr Marshall,

CATHERINE HONEYMAN DOB: 01/02/49 (SG00940779)
10 MELVILLE STREET, , GLASGOW, G41 2LN

This lady's left knee has deteriorated considerably since the last time and she has still got a lot of pain in the right knee. X-rays confirm degenerative changes in the left knee, the right knee is no change.

I discussed the options with her and put her name on the waiting list for a right knee patella resurfacing and a left total knee replacement.

Yours sincerely

Michael G Hullin FRCS
Consultant Orthopaedic Surgeon

0367709-SGH3Y

DOCTOR'S LETTER SHEET

UNIT NUMBER

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR MICHAEL HULLIN MA MD FRCS
ORTHOPAEDIC RETURNS CLINIC

Our Ref: MGH/KK
Enquiries To: Kathryn Kingsmore

Southern General Hospital
1345 Govan Road
Glasgow

Direct Tel: 0141 232 7912

Seen & Dict: 19/03/10
Typed: 25/03/10
CHI: 0102496145

DR GRAEME G MARSHALL
GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ

Dear Dr Marshall,

CATHERINE HONEYMAN DOB: 01/02/49 (SG00940779)
10 MELVILLE STREET, , GLASGOW, G41 2LN

This lady has returned to the clinic about 7 weeks following a right patella resurfacing (for previous LCS TKR 4 years ago) and left LCS TKR. She had some problems with the proximal end of her left knee wound opening up. This seems to have resolved. She has a full range of extension and can flex to 110 degrees in both knees. She is still using the crutches and I have advised her to wean herself of these. We will see her back in 6 weeks time.

Yours Sincerely

Alistair Brydone
Orthopaedic Registrar

0367709-SGH3Y

DOCTOR'S LETTER SHEET

UNIT NUMBER

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR MICHAEL HULLIN MA MD FRCS
FRACTURE CLINIC

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Direct Tel: 0141 232 7912

Our Ref: MGH/KK
Enquiries To: Kathryn Kingsmore

Seen & Dict: 04/06/10
Typed: 18/06/10
CHI: 0102496145

DR GRAEME G MARSHALL
GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ

Dear Dr Marshall,

CATHERINE HONEYMAN DOB: 01/02/49 (SG00940779)
10 MELVILLE STREET, , GLASGOW, G41 2LN

This lady has a lot of bruising and redness at the proximal part of her wound. Straight leg was intact and has flexion to about 90 degrees. She is still getting a lot of pain around the knee.

X-rays today show the patella is intact.

I have done an infection screen today and I will see her again in 2 weeks time.

Yours sincerely

Michael G Hullin FRCS
Consultant Orthopaedic Surgeon

0367709-SGH3Y

ARTMENT OF ORTHOPAEDIC SURGERY

MICHAEL HULLIN MA MD FRCS
HOPAEDIC RETURNS CLINIC

Ref: MGH/KK
uiries To: Kathryn Kingsmore

n & Dict: 25/06/10
Typed: 05/07/10
CHI: 0102496145

Southern General Hospital
1345 Govan Road
Glasgow

Direct Tel: 0141 232 7912

GRAEME G MARSHALL
:BALS HEALTH CENTRE
.SGOW
0

ır Dr Marshall,

HERINE HONEYMAN DOB: 01/02/49 (SG00940779)
MELVILLE STREET, , GLASGOW, G41 2LN

.s lady's CRP and ESR are normal. The wound is still quite inflamed and red and
s has pain on flexion against gravity. She is walking with 2 crutches. I have
/ised her to continue mobilising and I will see her again in 6 weeks time.

ırs sincerely

chael G Hullin FRCS
ısultant Orthopaedic Surgeon

DOCTOR'S LETTER SHEET

UNIT NUMBER

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR MICHAEL HULLIN MA MD FRCS
ORTHOPAEDIC RETURNS CLINIC

Southern General Hospital
1345 Govan Road
Glasgow

Direct Tel: 0141 232 7912

Our Ref: MGH/KK
Enquiries To: Kathryn Kingsmore

Seen & Dict: 06/08/10
Typed: 18/08/10
CHI: 0102496145

DR GRAEME G MARSHALL
GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ

Dear Dr Marshall,

CATHERINE HONEYMAN DOB: 01/02/49 (SG00940779)
10 MELVILLE STREET, , GLASGOW, G41 2LN

This lady is now 4 weeks since her lateral mallelous fracture. Her plaster has been removed today but she is still very tender. I have placed her back in a lightweight walking cast for a further 2 weeks. I will then see her again with the plaster off on arrival.

Yours sincerely

Michael G Hullin FRCS
Consultant Orthopaedic Surgeon

L©°1DIB

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR MICHAEL HULLIN MA MD FRCS
ORTHOPAEDIC RETURNS CLINIC

Southern General Hospital
1345 Govan Road
Glasgow

Direct Tel: 0141 232 7912

Our Ref: MGH/KK
Enquiries To: Kathryn Kingsmore

Seen & Dict: 27/08/10
Typed: 01/09/10
CHI: 0102496145

DR GRAEME G MARSHALL
GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ

Dear Dr Marshall,

CATHERINE HONEYMAN DOB: 01/02/49 (SG00940779)
10 MELVILLE STREET, , GLASGOW, G41 2LN

This lady was seen out of plaster with her ankle fracture. She is still very tender around the fracture site. X-rays shows the fracture line is still clearly visible. I have placed her back in a lightweight walking cast for a further 2 weeks. I will see her again in 2 weeks time with plaster off on arrival. She is also still getting quite significant knee pain.

Yours sincerely

Michael G Hullin FRCS
Consultant Orthopaedic Surgeon

DOCTOR'S LETTER SHEET

UNIT NUMBER

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

0141 201 1100

ORTHOPAEDIC DEPARTMENT

Typed: 02/09/10
CHI: 0102496145

DR GRAEME G MARSHALL
GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ

Dear Dr Marshall,

CATHERINE HONEYMAN DOB: 01/02/49 (SG00940779)
10 MELVILLE STREET, , GLASGOW, G41 2LN

Consultant: MIKE HULLIN

Admitted:

Discharged:

Diagnosis: INFECTED RIGHT TOTAL KNEE REPLACEMENT

Procedures: WASHOUT OF RIGHT TOTAL KNEE REPLACEMENT- 14/07/2010

Follow Up: DISCHARGED TO HOME WITH ORTHOPAEDIC FOLLOW UP ARRANGED

Yours sincerely

Mr Al-Fakayh
Orthopaedic Registrar

DOCTOR'S LETTER SHEET

UNIT NUMBER

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR MICHAEL HULLIN MA MD FRCS
ORTHOPAEDIC RETURNS CLINIC

Southern General Hospital
1345 Govan Road
Glasgow

Direct Tel: 0141 232 7912

Our Ref: MGH/KK
Enquiries To: Kathryn Kingsmore

Seen & Dict: 08/10/10
Typed: 21/10/10
CHI: 0102496145

DR GRAEME G MARSHALL
GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ

Dear Dr

CATHERINE HONEYMAN DOB: 01/02/49 (SG00940779)
10 MELVILLE STREET, , GLASGOW, G41 2LN

This lady is still getting a lot of pain in her right knee. She has pain on straight leg raising and flexion. There is no evidence of infection clinically today. However she has fallen and caused her wound to open up distally.

X-rays show the patella paja which could be possible loosing of the tibia component.

She is keen to consider further surgery. I have discussed the options of 1 and 2 stage revisions knee. I have done a full blood count, ESR and CRP today. we will see her again in 2 weeks time with results of this and further discussion.

Yours sincerely

Michael G Hullin FRCS
Consultant Orthopaedic Surgeon

0367709-SGH3Y

DOCTOR'S LETTER SHEET

UNIT NUMBER

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR MICHAEL HULLIN MA MD FRCS
ORTHOPAEDIC RETURNS CLINIC

Southern General Hospital
1345 Govan Road
Glasgow

Direct Tel: 0141 232 7912

Our Ref: MGH/KK
Enquiries To: Kathryn Kingsmore

Seen & Dict: 10/12/10
Typed: 24/12/10
CHI: 0102496145

DR GRAEME G MARSHALL
GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ

Dear Dr

CATHERINE HONEYMAN DOB: 01/02/49 (SG00940779)
10 MELVILLE STREET, , GLASGOW, G41 2LN

This lady was seen out of plaster today. She has minimal tenderness around the tibia but is still slightly tender over the fibula. X-rays today are satisfactory. I have put her in a light weight below knee walking cast and I will see her again in 6 weeks time with x-ray right ankle out of plaster on arrival.

Yours sincerely

Michael G Hullin FRCS
Consultant Orthopaedic Surgeon

0367709-SGH3Y

DOCTOR'S LETTER SHEET

UNIT NUMBER

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR MICHAEL HULLIN MA MD FRCS
ORTHOPAEDIC RETURNS CLINIC

Southern General Hospital
1345 Govan Road
Glasgow

Direct Tel: 0141 232 7912

Our Ref: MGH/HAC
Enquiries To: Kathryn Kingsmore

Seen & Dict: 19/01/11
Typed: 20/01/11
CHI: 0102496145

DR GRAEME G MARSHALL
GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ

Dear Dr Marshall

CATHERINE HONEYMAN DOB: 01/02/49 (SG00940779)
10 MELVILLE STREET, , GLASGOW, G41 2LN

This lady's fracture has healed and she can mobilise out of cast. We will see her in 4 weeks with x-rays left knee on arrival as it has been causing her pain and discomfort.

Yours sincerely

Michael G Hullin FRCS
Consultant Orthopaedic Surgeon

Run: 20/01/11-15:57 by CARLISLE,HELEN

0367709-SGH3Y

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL
1345 GOVAN ROAD
GLASGOW
G51 4TF

18 February 2011

DIRECT LINE: 0141 201-1357

DR MARSHALL
GORBALS HEALTH CENTRE
45 PINE PLACE
GLASGOW
G5 0BQ

Dear DR MARSHALL,

CATHERINE HONEYMAN HOSP NO:SG00940779
10 MELVILLE STREET
DOB: 01/02/49
GLASGOW
G41 2LN

This patient did not attend my Clinic today. Due to the great demand for clinic slots I have not sent a further appointment. If the patient has telephoned and cancelled or postponed the appointment, this information has not been communicated to me and I apologise for the inconvenience.

However, if the patient has not contacted us, a further appointment will not be offered due to the demand for clinic appointments, unless re-referred.

Yours sincerely

MR HULLIN
Consultant Orthopaedic Surgeon

CHI No:0102496145

South Glasgow University Hospitals Division

NHS Greater Glasgow

Consent to Donation of Residual Tissue for Medical Research and Training

Pat

SG00940779
CATHERINE HONEYMAN
10 MELVILLE STREET

GLASGOW 01/02/1949
G41 2LN CHI 0102496145

Date	8-11-05
Proposed Procedure (Block Capitals)	RTKR.

I agree to give any residual (left-over) tissue removed during my operation or treatment to the South Glasgow University Hospitals Division for medical research and teaching purposes. I agree that the tissue may be provided to a research institution or pharmaceutical company for regulated medical research. This work could help researchers understand disease, develop new diagnostic tests and produce better and safer drugs.

I understand that:

- You may remove tissue as part of my treatment. You will examine this, and use any residual material for medical research and teaching purposes. My doctor will not take more tissue than is needed for my care.
- You will make sure that all my donated tissue is anonymised (in other words I cannot be identified by the researcher).
- You may give some information from my medical records (that will not identify me) to the researcher.
- You will not sell my tissue but costs will be recovered on a non-profit making basis.
- I will not benefit financially or be entitled to a share of any profit that might arise from the research.
- It may be appropriate for genetic tests to be carried out in order to determine whether genetic makeup has any connection with disease.
- I will not receive results of any research carried out on my tissue.

Staff gave me a patient information leaflet on the use of residual tissue. I have had the opportunity to discuss the information with a qualified member of staff.

Patient's Name CATHERINE HONEYMAN	Patient's Signature Catherine Honeyman
Date 8-11-05	Date 8-11-05
Clinical Practitioner I W STEAD	Grade/Designation CONSULTANT

Copies to: Patient's Notes, Patient, Individual Taking Consent

South Glasgow University Hospitals Division, Southern General Hospital, 1345 Govan Road, Glasgow, G51 4TF

Version: 1 Date: July 2004

MI SGH .ORTHOPAEDICS.18811/051004

SOUTHERN GENERAL HOSPITAL
NHS TRUST

7

SG00940779
CATHERINE HONEYMAN
10 MELVILLE STREET

GLASGOW 01/02/1949
G41 2LN CHI 0102496145

CLINICAL NOTES

DATE	
23/4/5	Reviewed on ward pre-op knee replacement - consents in bay from usual Sx - One sup knee - present other leg as well - Discussed risk infection plan - postop Xr - discharge with bandages - review clinic 3/52

12-10-05

DePuy® DEPUY ORTHOPAEDICS,INC. P.O. BOX 988 WARSAW, IN 46581
REF 1294-05-510 LOT Z5FK64000
LCS® COMPLETE
RP INSERT
SZ STD+
MM 10

REF 129403050 LOT 1938472 2010 - 07
LCS Complete Primary • FEMORAL • Porocoat® STERILE R
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DePuy® DePuy Orthopaedics Inc. 700 Orthopaedic Drive Warsaw, IN 46580

REF 129432130 LOT 1977841 2010 - 10
DePuy MBT Tibial Tray • Porocoat® • 3 STERILE R
+E51312943213025
+$$3101017197784152
DePuy® DePuy Orthopaedics Inc. 700 Orthopaedic Drive Warsaw, IN 46580

DATE | CLINICAL NOTES (Continued)

12 12 05 **OPERATION NOTE:**

DIAGNOSIS: **OA – RIGHT KNEE**

OPERATION: **PRIMARY UNCEMENTED LCS RIGHT KNEE REPLACEMENT**

SURGEON: **MR STEAD/MR OGUNWALE**

ANAESTH: **DR O'CONNOR**

PROCEDURE:

Anaesthesia was administered in the Induction Room. Peripheral nerve blocks were inserted using Chirocaine. Prophylactic IV antibiotics were administered. The patient was wheeled into the Operating Room and positioned supine on the operating table. An above knee tourniquet was applied and an elastic isolation drape was below the tourniquet to prevent fluids from leaking under the tourniquet. Following 1-2 minutes of elevation the tourniquet was inflated to 300 mmHg. The leg was prepared in a standard method and draped.

The knee was exposed using a mid-line longitudinal skin incision and a medial para-patellar approach. Vastis tendon was split longitudinally. The patella was everted and the knee was flexed to 90 degs. Excess osteophytes and soft tissue were removed from the knee. The patella was debrided and denervated. Using the proximal tibial jigs with a 7 degree posterior slope jigs were centered and proximal tibial cut was made in neutral position. The diseased proximal tibial surface and menisci were removed. Attention was then turned to the distal femur. This was sized using the standard sizes. Using intra-articular referencing of the proximal tibial cut the anterior and posterior femoral cuts were made. The

DATE	
	flexion gap was measured and balanced. The distal femoral cut was
	then made and the extension gap was measured equal to the flexion
	gap and balanced. Using the finishing block the chamfur cuts were
	made and posterior femoral osteophtyes were removed.
	Attention was then turned back to the tibia which was sized and
	prepared using the proximal tibial jigs. The knee was then trialled
	using the standard LCS trials and checked for a full range of
	motion and balance in flexion and extension. Following this the
	trial implants were removed and the knee was thoroughly lavaged.
	Definitive LCS total knee implants were then implanted. The knee
	was once again checked for a full range of motion for balance and
	flexion and extension. Tracking of the patella was also checked.
	Following this the knee was once again lavaged. The extensor
	mechanism was repaired with one PDS Vicryl. Cutaneous tissue
	closed with a 2-0 Vicryl and skin closed with 2-0 Monocryl.
	Dressings and pressure bandage applied. The tourniquet was
	removed and circulation to the limb was checked.
	SIDE OPERATED:
	Right knee.
	FINDINGS:
	Compatible with tri-compartment OA.

SOUTHERN GENERAL HOSPITAL — ORTHOPAEDIC OPERATION NOTE

PATIENTS DETAILS: Name: CATHERINE HONEYMAN, DOB: 01/02/49
Unit No: SG00940779 CHI: 0102496145

PROCEDURE: TOTAL KNEE REPLACEMENT R/L/B: LEFT DATE: 28/0
SURGEON: CON.HULMI HULLIN,MIKE ANAESTHETIST:
ASSISTANT: STR.FRAMA FRAME,MARK

Anaesthetic: General Anaesthetic Antibiotic:

Components used:
Tibia: 3 Tibial Insert: 12.5 mm
Femur: STD+ Patella: was not resurfaced

Patella tracking: satisfactory
Lateral release: not performed

Supine position with lateral support. Routine prep and drape. Midline incision and knee joint exposed using a standard medial parapatellar approach. Significant degenerative disease noted. Patella everted and fat pad and osteophytes excised. Medial and lateral menisci excised followed by the ACL. Medial osteophytes excised and medial soft tissue release performed whilst protecting the MCL to balance the knee. Proximal tibial cut made using the extramedullary tibial guide aligned to the centre of the ankle joint whilst referencing from the medial tibial plateau (2mm).

Attention then paid to the femur which was sized as above. Intramedullary rod inserted and appropriate femoral block applied. Rotation set by inserting appropriate spacer block. Femoral block pinned in situ and anterior and posterior femoral cuts made using the saw capture guide. Using the intramedullary guide and the 5deg. valgus distal femoral cutting block the distal femoral cut was made. Flexion and extension gaps equal as above with satisfactory limb alignment. Appropriate femoral finishing block applied to complete preparation of the femur.

Tibial surface sized as above and prepared using the tibial tray. Trial components inserted as above. The knee joint was found to be stable through a full range of movement. Trial components removed. The knee was thoroughly lavaged and bone surfaces dried. The definitive components were then inserted as above. Wound lavaged with saline and chlorhexidine.

SECOND PROCEEDURE

RESURFACING OF RIGHT PATELLA.

TOURNIQUET 300MMHG
REUSED OLD MIDLINE INCISION SCAR
PARAPATELLAR APPROACH IN TO KNEE JOINT
SWABS TAKEN FOR MICRO
PATELLAR OSTEOPHYTES REMOVED.
USING PATELLAT DRILL GUIDE PATELLA PREPARED.
STD+ PATELLA USED AND IMPLANTED.
GOOD PATELLAR TRACKING.

IRRIGATED AND CLOSED IN LAYERS
SKIN WITH BIOSYN.

DRESSED WITH MEPORE WOOL AND CREP.

POST OP

BLOODS IN AM
XRAY BOTH KNEES IN 48HRS
MOBILISE AS ABLE
HOME WHEN SAFE
OPC IN 10 DAYS

Closure: Extensor mechanism:
Skin:
Post Op Instructions:

Fat:
Dressings applied

DOCTOR'S LETTER SHEET

UNIT NUMBER

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR MICHAEL HULLIN MA MD FRCS
ORTHOPAEDIC RETURNS CLINIC

Our Ref: MGH/KK
Enquiries To: Kathryn Kingsmore

Southern General Hospital
1345 Govan Road
Glasgow

Direct Tel: 0141 232 7912

Seen & Dict: 19/11/10
Typed: 02/12/10
CHI: 0102496145

DR GRAEME G MARSHALL
GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ

Dear Dr

CATHERINE HONEYMAN DOB: 01/02/49 (SG00940779)
10 MELVILLE STREET, , GLASGOW, G41 2LN

Unfortunately this lady's knee give way and she fell sustaining a fracture of his distal tibia and fibula. She is in a lightweight long leg cast.

X-rays taken 2 weeks ago show a satisfactory position.

I think she should remain in the cast for a further 3 weeks. We will see her again then with a x-ray out of plaster on arrival and ? for a light weight below knee walking cast at that stage.

Yours sincerely

Michael G Hullin FRCS
Consultant Orthopaedic Surgeon

0367709-SGH3Y

DOCTOR'S LETTER SHEET

UNIT NUMBER

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR MICHAEL HULLIN MA MD FRCS
ORTHOPAEDIC RETURNS CLINIC

Southern General Hospital
1345 Govan Road
Glasgow

Direct Tel: 0141 232 7912

Our Ref: MGH/KK
Enquiries To: Kathryn Kingsmore

Seen & Dict: 15/04/11
Typed: 06/05/11
CHI: 0102496145

DR GRAEME G MARSHALL
GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ

Dear Dr

CATHERINE HONEYMAN DOB: 01/02/49 (SG00940779)
10 MELVILLE STREET, , GLASGOW, G41 2LN

This lady's wounds have well healed. She is getting a lot of pain in the knee. I have placed her in a lightweight long leg cast today. I have repeated her blood tests and we will see her again in 2 weeks time.

Yours sincerely

Michael G Hullin FRCS
Consultant Orthopaedic Surgeon

Run: 06/05/11-10:20 by KINGSMORE,KATHRYN

0367709-SGH3Y

DOCTOR'S LETTER SHEET

UNIT NUMBER

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

0141 201 1100

ORTHOPAEDIC DEPARTMENT

Typed: 18/05/11
CHI: 0102496145

DR GRAEME G MARSHALL
GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ

Dear Dr

CATHERINE HONEYMAN DOB: 01/02/49 (SG00940779)
10 MELVILLE STREET, , GLASGOW, G41 2LN

Consultant: MIKE HULLIN

Admitted: 27/03/11

Discharged: 05/04/11

Diagnosis: RIGHT KNEE PAIN

Procedures: REMOVAL OF TOTAL KNEE REPLACEMENT

Follow Up: OUTPATIENT CLINIC

Yours sincerely

Sandesh Gulhane
Orthopaedic Registrar

DOCTOR'S LETTER SHEET

UNIT NUMBER

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR MICHAEL HULLIN MA MD FRCS
ORTHOPAEDIC RETURNS CLINIC

Southern General Hospital
1345 Govan Road
Glasgow

Our Ref: MGH/KK
Enquiries To: Kathryn Kingsmore

Direct Tel: 0141 232 7912

Seen & Dict: 20/05/11
Typed: 25/05/11
CHI: 0102496145

DR GRAEME G MARSHALL
GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ

Dear Dr

CATHERINE HONEYMAN DOB: 01/02/49 (SG00940779)
10 MELVILLE STREET, , GLASGOW, G41 2LN

DIAGNOSIS: 1st of 2 stage knee revision.

OUTCOME: Bloods, splint, and review at pre-assessment

I reviewed your patient in clinic today after the above operation. Her previously infected knee has been replaced with a spacer and we are waiting for the infection sub-side. We have taken bloods today to ensure this is the case. We have booked her previously at the end of June for her 2nd stage of two knee replacements. We will see her at pre-assessment with the results of the bloods.

Yours Sincerely

Mr S Gulhane
Orthopaedic Registrar

DOCTOR'S LETTER SHEET

UNIT NUMBER

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

0141 201 1100

ORTHOPAEDIC DEPARTMENT

Typed: 05/08/11
CHI: 0102496145

DR GRAEME G MARSHALL
GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ

Dear Dr

CATHERINE HONEYMAN DOB: 01/02/49 (SG00940779)
10 MELVILLE STREET, , GLASGOW, G41 2LN

Consultant: MIKE HULLIN

Admitted: 22/06/11

Discharged: 01/07/11

Diagnosis: RIGHT KNEE PAIN

Procedures: RIGHT 2ND STAGE TOTAL KNEE REPLACEMENT

Follow Up: OUTPATIENT CLINIC

Yours sincerely

Sandesh Gulhane
Orthopaedic Registrar

Run: 05/08/11-13:42 by KINGSMORE,KATHRYN

S.G.H./3B

SOUTH GLASGOW HOSPITALS
SOUTHERN GENERAL HOSPITAL

3Y

DOCTOR'S LETTER SHEET

UNIT NUMBER

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR MICHAEL HULLIN MA MD FRCS
ORTHOPAEDIC RETURNS CLINIC

Southern General Hospital
1345 Govan Road
Glasgow

Direct Tel: 0141 232 7912

Our Ref: MGH/MD
Enquiries To: Kathryn Kingsmore

Seen & Dict: 12/08/11
Typed: 22/08/11
CHI: 0102496145

DR GRAEME G MARSHALL
GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ

Dear Dr Marshall

CATHERINE HONEYMAN DOB: 01/02/49 (SG00940779)
10 MELVILLE STREET, , GLASGOW, G41 2LN

I reviewed this patient in Mr Hullin's Arthroplasty Clinic today. It is now 6 weeks since she has had a 2nd stage revision of her left knee replacement. She is mobilising with 2 sticks and can flex her knee to 105 degrees and is already quite pleased with the result although still having some pain as you would expect. Her wound has healed satisfactorily.

She will be reviewed back in Mr Hullin's Clinic in 10 months time with x-rays on arrival and she knows she can contact me in the interim should she have any worries about her knee replacement.

Yours sincerely

FIONA NICOL
CLINICAL NURSE SPECIALIST

Run: 22/08/11-17:01 by DOCHERTY,MARY

0367709-SGH3Y

CLINICAL NOTES

HOSPITALS
SG00940779
CATHERINE HONEYMAN
10 MELVILLE STREET
GLASGOW
G41 2LN 01/02/1949
CHI 0102496145

DATE

28.1.10 Theatre

REF FG29509B
LOT 366886
2011-10
Cardinal Health

S9050-001 1283152
LCS Tray C/2

S6550-008 1283250
Basic Orthopaedic Set

Customer: SOUTHERN - ORTHO THEATRE
Product: LCS Tray C/2

NHS Greater Glasgow Central Decontamination Unit Glasgow G22 5DT

S N S9050-001 Unit:1283152

STERILE 2010-01 2011-01

Store in dust free en... Do not use if package is...

S7945-017 1283339
Electric Power Pro

Customer: SOUTHERN - ORTHO THEATRE
Product: Light Handle

NHS Greater Glasgow Central Decontamination Unit Glasgow G22 5DT

S N I-042284-013 Unit:1283119

STERILE 2010-01 2011-01

S9038-001 1272594
LCS Patella Insl

(R) Patella resurfacing
(L) Total Knee Replacement - see Integrated Care Pathway.

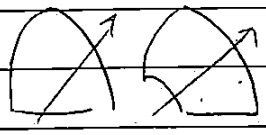
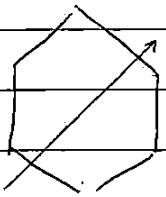
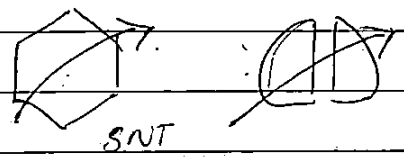
REF 1294-09-650 LOT 2783133 2013-12
LCS® Complete™
Metal Backed Patella
POROCOAT®
STD+
+H4411294096501I
+$$3131231278313316
DePuy DePuy Orthopaedics, Inc. Warsaw IN 46581

30/1/10 FYI Nights

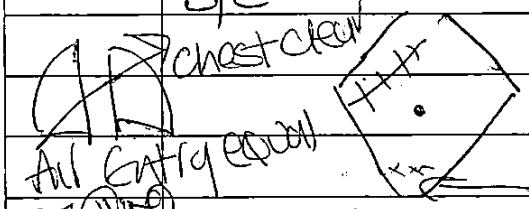
ATSP-? confusion.

Patient states that she does not sleep well away from home. ~~with~~ Patient has some urinary frequency no dysuria, ~~[illegible]~~, no abdo pain, ~~&~~ no cough; has had some white-yellow sputum. Not SOB

0367691-SGH7

DATE	CLINICAL NOTES (Continued)
OE/	107/68, HR 78, RR 16, Sat 96% on air apyrexial. Orientated in time, Place, Person. Pulse regular HS 1+11+0 no murmurs. °ankle oedema °calf tenderness.
	 chest clear, good AE. (N) breath sounds
	 soft non tender, bowel sounds present.
	Imp ?UTI.
	P (1) urine dip ± MSU. (2) regular obs. (3) antibiotic for UTI if urine positive. Shelly F1/1 #7510.
30.1.10	Surgical F41
	ATBP ve. ↑ inflammatory markers. Urine dip +ve for blood & protein. Obs stable (T) 36.3°C, HR 78, RR 15, Sats 97% on A, BP 107/65 Patient uncomplaining
	 SNT °masses. BS ✓ clear chest °added AE (L)=(R) HS 1+11+0 °added JVP ← wound: clean. slightly dehisced. °evidence of infection.
	WCC 14.5 today (↑)
	Plan: Start trimethoprim. Urine Culture. Teller F41 #7562

CLINICAL NOTES

DATE	
31.1.10	N/P review ask to see - constipated. Bowels have apparently not opened since last Tuesday 26/1/10. c/o lactulose 10mls BD & Senna 2tabs at night on 30/1/10. Patient states usual bowel pattern is every other day. At present report no particular abdominal discomfort ? flatus → "not sure" d/e  Abdomen soft non tender to palpation although slight discomfort. BS present although soft. has been commenced on Trimethoprim for UTI. Plan 1 encourage ↑ oral intake 2 change lactulose to movicol (1 sachet twice per day) N/s informed HMCCrone HMCCRONE ONP6 757

DATE	CLINICAL NOTES (Continued)
12/2/10	H&O obtained ATRP - C/o stomach upset this a.m. No N+V. Eats + drinks normally. No special point is affected by pain. On MSAJA - Diclofenac Obs (W) - dw calf pain/swelling. P/ Stop Diclofenac - Add Tramadol - R/v prn. Dr 753 H

DATE	CLINICAL NOTES
	Imp ?osteomyelitis / infection Plan • FBC UE / CRP/alb / Blood Cults taken. • Knee XR • Rel ortho @ 1235. Knee XR – ?patella resurfacing has slipped.

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION	SIGNATURE	GIVEN BY

DISCHARGE PRESCRIPTION PACKS

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	FREQUENCY	SIGNATURE	GIVEN BY

0141 422 1580

Southern General Hospital, Accident & Emergency Department, Glasgow G51 4TF
Tel Direct: 0141 201 1456/8 Switchboard: 0141 201 1100 Fax: 0141 201 2997

NAME: CATHERINE HONEYMAN — DATE: 18/04/10
AGE: 61 DOB: 01/02/49 — CONSULTANT: MALCOLM W.G GORDON — TIME: 1122
UNIT No.: S0000340779 — Account No: AE0031017/10 — CHI#: 0102496145

GP Name:	GRAEME G MARSHALL — GP Phone No: 0141 531 8250
REASON FOR VISIT:	RIGHT KNEE REPLACEMENT PROBLEMS
ALERTS:	(1) (2)
ALLERGIES:	(1) (2)
RELEVENT HISTORY:	
MEDICATIONS:	

TRIAGE CATEGORY: STANDARD — TRIAGE NURSE: ANNE DAVIDSON — TRIAGE TIME: 1136

TRANSCRIBED ANALGESIA :

OBSERVATION TEXT:

MR HULLIN PATIENT C/O RIGHT KNEE PAIN AND SWELLING, HAD RESURFACING OF KNEE 8/52

Enter/Edit Vital Signs

DATE	TIME	COMPLETED BY	DATE	TIME	COMPLETED BY
T	35.4		T		
HR			HR		
R			R		
BP			BP		
Sa02		ON	Sa02		ON
BG			BG		
PF			PF		
EPF					
E			E		
V			V		
M			M		

Visual Acuity

Left-6m	Right-6m

Correction Y/N	
Weight (kg)	
Breath Alcohol	
Pain Score	

HONEYMAN, Catherine
Attend: 18/04/10 1222 DOB: 01/02/1949 Sex: F
Ref: MR MW GORDON - SGH CASUALTY DEPARTMEN
XR Knee Rt

CRIS: 88599 E-12383490 ChiNo: 0102496145

DISCHARGE CODES: Please Circle
1. Admission 2. Discharge 3. Refer to GP 4. Transfer to other hospital (see below)
5. Died 6. Refer to O.P. Clinic (see below) 7. Irregular Discharge 8. D.O.A.

Discharge Date
Discharge Time

Ward No. (if admitted): WD 3 – ortho Boarder.
Transfer to Hospital
Consultant (if admitted)

Follow Up | Not arranged | Arranged | To be arranged

X-Ray & Other Reports to be filed on this side (if the patient is n eing admitted)

DO NOT WRITE HERE PLEASE !

DATE 18/4/10 CLINICAL NOTES

SEEN BY (DR) Mitchell TIME SEEN 1205

PC
R+ knee problem

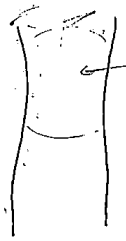
HPC
Had R+ TKR resurfacing approx 8/52 ago. RIU in clinic 4/52 ago, SB registrar. Since knee has become more swollen, bruised and painful.
Pain not controlled by tramadol and paracetamol.
Systemically well.
Recent sore throat.

PMH
HSP
Reflux

DH
Aspirin
Omeprazole
BFZ
Ruxetine
Paracetamol
Tramadol

NKDA

O/E
Temp 35⁴.



area of bruising / cellulitis
- supratatella effusion
- tender.

ROM 5° → 45° c pain
Able to SLR.

↑ temp to skin

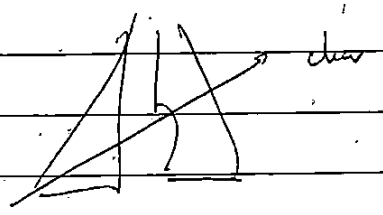
→

SOUTH GLASGOW HOSPITALS
SOUTHERN GENERAL HOSPITAL

7

CATHERINE HONEYMAN
SG00940779 01/02/49
10 MELVILLE STREET
GLASGOW G41 2LN
CHI: 0102496145 F

CLINICAL NOTES

DATE	
18/4/10.	(61) ↑ (R) knee ? infection
	(R) THR 4 yr ago patella resurfacing 8/52 ago under Mr Hulkes. Since op ↑ pain + swelling noted particularly last 1/52. Systemically well.
	- Xray - ? loosening of tibial component + patella component has moved distally
	PMH - ↑ BP Meds - Aspirin 75mg od Nbkt. GORD Omeprazole 20mg od Bilat THR Bendroflumethiazide Fluoxetine Paracetamol 1g qds Tramadol 50mg qds Atenolol O/E Apyrexial T 35.4 Simvastatin HR 82
	HS I + II + ø ↓ added CS JVP →  clear
	Abdo - SNT - BS ✓

0367691-SGH7

DATE | CLINICAL NOTES (Continued)

Ⓡ knee swollen ++
Skin discolouration ++ ? cellulitis
Warm to touch
No discharge from skin
Flexion to 45° ; unable to fully extend.
Unable due to swelling to detect effusion.

Imp - Chronically infected Ⓡ TKR ; loosening of metal components.

P/- OW Reg → Reg admission for theatre to aspirate knee
Bloods ✓
ECG ✓ NSR
Wait for Aspiration prior to Abx
Analgesia
NBM - fasted since 10am IV Fluids
Clerking Med ; GP / Husbands to bring in.

Hb 123 Na 140 Glu 5.8
WCC 6.1 K 4.8 CRP 4
plt 259 Ur 4.3
Cr 66

ORTHO ST R/V MR BRYSON

c/o pain, swelling + discolouration in R knee
Has swelling since surgery
pain has been for many years (months) prior to surgery & immediately after surgery but ↑ 1 week post op.

CATH. MONEYMAW.

CLINICAL NOTES

DATE	
	No systemic upset / pyrexia
	O/E: R knee grossly swollen discoloured - bruised ++ cellulitis Flexion: 15° – 100°.
	XR: L/S TKR i resurfacing (uncemented) Lucency under tibial tray (unchanged since original XR) Patellar resurfacing is loose. grossly
	IMP: Clinically not infected Symptoms due to dislodged patella resurfacing.
	ESP Clinic:
9/5/12	Several years history of (R)+(L) (L) > (R) Pain last few years Pain @ night Pain mod on mvmt Pain mainly upper shoulder USx
PMH:	General OA, previous multiple bilateral knee ops. Angina
DH:	tramadol (general aches) Bendrofluazide, aspirin, fluoxetine Atenolol. omeprazole

0367691-SGH7

DATE	CLINICAL NOTES (Continued)
9/5/12	63yr old, walks c cardies due to falls / muscle spasms
SH	attending Global HC (Mandy Leavy)
	Rtd WH Smith Sales Assistant, engaged knitting.
Obj,	Neck ✓ good mat
	tender cat acm (L) > (R)
	Ltd mob 120° (L) (R) ✓ bettern
	+ ER
	2+ pres wg in (L) I worked 2nd not too good

Emergency Department Nursing Documentation

Date/Time	

Once only prescriptions (including tetanus prophylaxis)

Date Given	Drug (Block Capitals)	Dose	Method of administration	Time of administration	Signature	Given by
5/5/10	VOLIEROL	50mg	PO			
5/5/10	PARACETAMOL	1g	PO			
5/5/10	CO-CODAMOL 8/500	2 tabs	PO	23:35		
5/5/10	TRAMA	50mg	IV	(Tony Silcox) 02:05		
5/5/10	MORPHINE	2mg	IV			
6/5/10	FLUCLOXACILLIN	1g	IV			
6/5/10	BENZYLPENICILLIN	1.2g	IV			

Discharge prescription packs

Date Given	Drug (Block Capitals)	Dose	Method of administration	Frequency	Signature	Given by

Southern General Hospital
Emergency Department

NHS Greater Glasgow and Clyde

Tel Direct: 0141 201 1456/8 — Switchboard: 0141 201 1100 — Fax: 0141 232 7500

NAME: CATHERINE HONEYMAN
AGE: 61 DOB: 01/02/49
UNIT No: SG00940779
CONSULTANT: NICOLA LITTLEWOOD
Account No: AE0036502/10
DATE: 05/05/10
TIME: 2246
CHI#: 0102496145

GP Name:	GRAEME G MARSHALL — GP Phone No: 0141 531 0250
REASON FOR VISIT:	POST OP KNEE PROBLEMS
ALERTS:	(1) (2)
ALLERGIES:	(1) NKDA (2)
RELEVENT HISTORY:	
MEDICATIONS:	

TRIAGE CATEGORY: STANDARD — TRIAGE NURSE: ANDY HANLON — TRIAGE TIME: 2308

TRANSCRIBED ANALGESIA :

OBSERVATION TEXT: Pt took (2) Zydol @ 2130pm .

PT PRESENTING WITH R KNEE POST OP PROBLEMS ? INFECTION, PT HAD KNEE OPERATED ON YESTERDAY WAS DISCHARGED THIS EVENING, SINCE DISCHARGE PT C/O INCREASED PAIN TO KNEE AND ALSO DRESSING SOAKING THROUGH WITH BLOOD AND SLOUGH, IN TRIAGE WOUND CLEANED, WOUND SLOUGHY WOUND SWAB TAKEN, WOUND COVERD WITH WOUND PADS AND A BANDAGE

CATHERINE HONEYMAN
SG00940779 01/02/49
CHI: 0102496145

Enter/Edit Vital Signs

DATE	TIME	COMPLETED BY
05/05/10	2323	NU.HANAN

Visual Acuity

DATE	TIME	COMPLETED BY	Left-6m	Right-6m

T	35.7		T			Correction Y/N
HR	89		HR			Weight (kg)
R	18		R			Breath Alcohol
BP	105/66		BP			Pain Score
Sa02	98	ON 21 %	Sat			
BG			BG			
PF			PF			
EPP						
B						
V						
M			M			

HONEYMAN, Catherine
Attend: 06/05/10 0250 DOB: 01/02/1949 Sex: F
Ref: DR NK LITTLEWOOD - SGH CASUALTY DEPARTM
XR Knee Rt

CRIS: 86569 E-12415251 ChiNo: 0102496145

DISCHARGE CODES:
1. Admission 2. D
5. Died 6. R

Ward No. (if admitted) 1 | Transfer to Hospital | Consultant (if admitted)

Outpatient clinic specialty | Admission or specialty clinic consultant

Clinic | AE | OP DVT | DME Falls | TIA | Medical | Surgical | First Seizure | Others Specify,

Please affix patient ID label here

Initial Assessment
Seen by (print): CRANCHAY
Time seen: 0055

Presenting Complaint

Post op. 1 day R patella resurfacing. Pain + swelling

History of Presenting Complaint

D/C today back within 6 hrs.
Swelling oozing + pain, erythema
Dislocated patella - patella has been reduced as well yesterday

Past Medical History

Depression
HT
COPD
OA

Systems Enquiry

CVS
RESP
GI
CNS/PNS
GU
Musculoskeletal

MEDICINES RECONCILIATION

Source of medication history: Patient ☐ Relative/ carer ☐ GP Surgery ☐ ECS ☐ d/c rx ☑
PODs ☐ Com. Pharmacist ☐ GP letter ☐ Rpt Presc ☐

Action on admission | **Action on discharge**

Name	Dose	Frequency	Stop	Amend	Hold	Continue as before
FLUOXETINE	20mg	OD				
ASPIRIN	75mg	OD				
BISOPROLOL/HYDROCHLORIDE	2.5mg	OD				
AMLODIPINE	2.5mg	OD				
OMEPRAZOLE	20mg	OD				
PARACETAMOL	1g	QID				
TRAMADOL	50-100mg	PRN 4hrly				

Allergies

None known ☑

Medication list

further clarification? Yes ☐ No ☐

Completed by: Designation: Date:

Drugs prescribed on admission checked and correct

Compliance aid? Yes ☐ No ☐

Comments: As per d/c Rx

Community Pharmacist

Reviewed by: S MCFARLANE (7385) Designation: Pharmacist Date: 10/5/10.

Social History

Smoking History: 0
Alcohol History: moderate
Other drug use?:

Home circumstances

Lives with daughter.

Affix patient ID label

General Examination

Temp:	RR:
Pulse	BG:
SpO2:	Weight:
BP:	Urinalysis:

Cardiovascular Examination

General Observations

In pain
obese
GCS 15

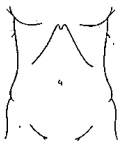
Respiratory Examination

clear



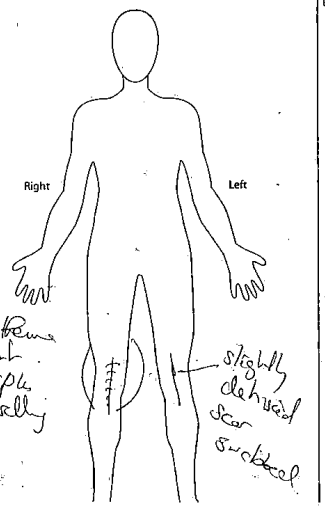
Abdominal Examination

Soft
Obese
Groin
BS —

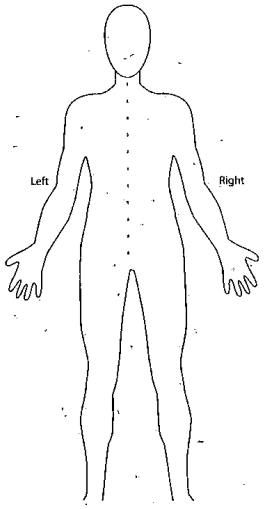


Neurological and Other Examination (eg. Vascular)

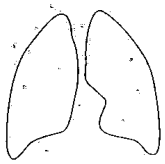
Front



Back



CXR:



Urinalysis:

ECG:

Differential Diagnosis/Problem List

Post op pain + swelling

SEWS ☐ 0-7

RED FLAG ☐ (Tick)

Done/completed	Immediate Management Plan
	IV access Bloods analgesia
	Swabs
	Review by Surgeons

Doctor Completing Initial Assessment

Name (print): CHARMAR Signature: Designation: SRD

Please affix patient ID label here

Secondary or Senior Focused Review

Seen by (print): [redacted]

Time seen:

4/5/10

GRAND ROUNDS

(61) F [redacted] F/C WO 5

Patient Bottom Removed 4/5/10.

Discharged 5/5/10

↑ Pain, Shivering, Diaphoresis

Not systemically unwell

AMH - PMP
Depression
COPD
OA

Meds - As per ARF

NKDA.

O/E - Alert + oriented

T 35.2
BP 105/66
HR 80
O2 sats 98% RA

CVS - HS RRR

RS/ clear

Done/ completed	Continuing Management Plan

Doctor Completing Initial Assessment

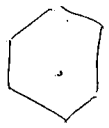
Signature: Designation: Page No.:

Senior Doctor Review

Seen by (print):

Time seen:

Abdo - soft
BS ✓



CRP 125
WCC 7.2

LFTs - Deranged.

(12) knee - swollen +++
Erythema ✓
Hot to touch
Painful on palpation
Fixed flexion 10° unable to fully extend
Flexion limited to 70°

Imp - Post Op Pain + Swelling
? Infected.

P/ Abx
Analgesia.
MSM ? not seen in ward - ? knee aspirate.
knee X-ray
Bloods ✓

Done/ completed	Continuing Management Plan
	Warfarin Bloods VS given LFT's.
	IV Abx
	Wound swab ✓

Signature: Designation: SHO Page No: 7555

Please affix patient ID label here

Continuation Sheet

Date/Time
6/5/10

WR Mr Martin
Day 2 Post-op.
Histology requested

O/E: - Wound clean
- Inflammatory markers - ↓
- Effusion - most likely post-op

Plan:-
Cont Abx
Recheck - bloods tomorrow
- Observe.
- Analgesia, Elevate legs
- Mobilise asable.

[illegible]
[illegible]
F42

6/5/10
09:15 am

F42 - Ortho
- D/W Bacteriologist, regarding dual aerobic/anaerobic done in theatre (04/05/10)
- No growth with now 2+0 days of incubation

[illegible]
[illegible]
F42

Date/Time

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL, 1345 GOVAN ROAD, GLASGOW G51 4TF
TEL: 0141 201 1100

DEPARTMENT OF ORTHOPAEDICS

WARD: S05 CONSULTANT: MR MIKE HULLIN
CONTACT TEL: 0141 201-1357

IMMEDIATE DISCHARGE LETTER

PATIENT: CATHERINE HONEYMAN
10 MELVILLE STREET
GLASGOW
G41 2LN

DOB: 01/02/49
UNIT NO: SG00940779
ACCT NO: IP0020908/10
CHI NO: 0102496145

GP: DR GRAEME G MARSHALL
GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ

DATE OF ADMISSION: 04/05/10
DATE OF DISCHARGE: 05/05/10

ADMISSION TYPE: ELECTIVE
DISCHARGE TO: HOME

REASON FOR ADMISSION: REV OF PATELLA RESURFACING RIGHT KNEE
MAIN DIAGNOSIS: DISLOCATED PATELLA

OTHER ACTIVE PROBLEMS: NONE

OPERATIONS/PROCEDURES/ TREATMENT: RMOVAL OF PATELLAR BUTTON RIGHT KNEE
RESULTS AWAITED: N
CURRENT MEDICATION: SEE PRESCRIPTION
DISCONTINUED DRUGS? N
COMMENT: NONE

ALLERGIES:
NONE

REVIEW? Y DETAILS: OUT PATIENT TIMESCALE: 2 WEEKS

FURTHER LETTER TO FOLLOW? Y DETAILS: FORMAL HOSPITAL LETTER

Highly Sensitive Document Y/N N Patient consent to share information Y/N Y

SIGNED: STR.REVVA REVANUR,VASANTHA
DESIGNATION: GPST
PAGE NUMBER: 7555

OPA- Wk Friday

Run: 05/05/10-11:55 by REVANUR,VASANTHA

Sedal Blood Results								
	Date:	6/5/10	8/5/10					
	Time:	08:16	09:00					
	Signature:							
Sodium	135 - 145	134	135					
Potassium	3.5 - 5.0	3.7	3.6					
Chloride	96 - 105	99	97					
Bicarbonate	24 - 29	20	24					
Urea	2.5 - 6.5	6.8	5.9					
Creatinine	55 - 120	91	77					
Glucose	3.5 - 5.5	8.8						
Magnesium	0.8 - 1.0							
Calcium	2.2 - 2.6							
Estimated GFR								
CRP	<10	125	238					
Cardiac Enzymes & Liver Function Tests	Normal Values							
Troponin	<0.04							
CK	<150							
Amylase	0 - 100							
Total Protein	60 - 80	67	69					
Albumin	35 - 50	35	39					
Globulins	20 - 35	32	30					
Total Bilirubin	0 - 20	12	23					
Alk Phos	90 - 350	216	223					
AST	0 - 40	349	228					
ALT	0 - 50	220	204					
Haematology & Clotting Screen	Normal Values							
White cell count	4.0 - 11.0	7.2	11.3					
Hb (sex dependent)	130 - 180	~~117~~ 116	122					
PCV	0.370 - 0.470							
MCV	76 - 100							
Platelet count	150 - 400	200	221					
Neutrophils	2.0 - 7.5							
Lymphocytes	1.5 - 4.0							
PT	10 - 13							
APTT	21 - 33							
INR	0.8 - 5.0							
Fibrogen	1.4 - 4.4							
Arterial Blood Gas	Normal Values							
H+	36 - 43							
PCO_2	4.5 - 6							
PO_2	10.5 - 13.5							
Base excess	+/- 2.5							
Bicarbonate	20 - 28							
FIO_2 (Inspired Oxygen)								
Saline								

...SITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL, 1345 GOVAN ROAD, GLASGOW G51 4TF
TEL: 0141 201 1100

WARD: S05 CONSULTANT: MR MIKE HULLIN DEPARTMENT OF ORTHOPAEDICS
CONTACT TEL: 0141 201-1357

IMMEDIATE DISCHARGE LETTER

PATIENT: CATHERINE HONEYMAN
10 MELVILLE STREET
GLASGOW
G41 2LN

DOB: 01/02/49 UNIT NO: SG00940779
ACCT NO: IP0020908/10
CHI NO: 0102496145
GP: DR GRAEME G MARSHALL

DISCHARGE MEDICATION

Time Required? Patient's own medication
Childproof Containers? Y
Patient's Weight (Kg):
Compliance Aid Required? N
Comment:

Medication	Form	Dose	Frequency	Duration
FLUOXETINE	OTAB	20 MG	OD	INDEFINITE

New Drug? N New Dose? N Comments:
Patient's Own Supply? Y Pharmacy Notes:
Supply:

Medication	Form	Dose	Frequency	Duration
BENDROFLUMETHIAZIDE	OTAB	2.5 MG	OD	INDEFINITE

New Drug? N New Dose? N Comments:
Patient's Own Supply? Y Pharmacy Notes:
Supply:

Medication	Form	Dose	Frequency	Duration
ASPIRIN	OTAB	75 MG	OD	INDEFINITE

New Drug? N New Dose? N Comments:
Patient's Own Supply? Y Pharmacy Notes:
Supply:

Medication	Form	Dose	Frequency	Duration
ATENOLOL	OTAB	25 MG	OD	INDEFINITE

New Drug? N New Dose? N Comments:
Patient's Own Supply? Y Pharmacy Notes:
Supply:

Medication	Form	Dose	Frequency	Duration
OMEPRAZOLE	OTAB	20 MG	OD	INDEFINITE

New Drug? N New Dose? N Comments:
Patient's Own Supply? Y Pharmacy Notes:
Supply:

Medication	Form	Dose	Frequency	Duration
PARACETAMOL	OTAB	1 GM	QDS	2 WEEKS

New Drug? Y New Dose? Y Comments:
Patient's Own Supply? N Pharmacy Notes:
Supply:

Medication	Form	Dose	Frequency	Duration
TRAMADOL	OTAB	50 TO 100 MG	AS REQUIRED	2 WEEKS

New Drug? Y New Dose? Y Comments:
Patient's Own Supply? N Pharmacy Notes:
Supply:

PHARMACY USE ONLY* DISPENSED BY: DATE: CHECKED BY:
CLINICAL PHARMACIST CHECK: COLLECTED BY:

Medicine received on ward by: Issued by:

Ward Nurse: Signature of Receipt:

Contact Number: 0505-0064 Date(Time): 05/05/10 (1155 Hours) Status: Draft

05/05/10-11:55 by REVANUR,VASANTHA

Emergency Department Nursing Documentation

Please affix patient ID label here

Initial Assessment
Seen by (print): CANAHAN
Time seen: 0055

Presenting Complaint

Post op 1 day R patella resurfacing Pain + Swelling

History of Presenting Complaint

D/C today back into 6 hrs.
- Swelling oozing + pain + erythema
Dislocated patella - patella button removed as well yesterday

Past Medical History

Depression
HT
GORD
OA

Systemic Enquiry

CVS

RESP

GI

CNS/PNS

GU

Musculoskeletal

MEDICATION RECONCILIATION

Source of medication history: Patient ☐ Relative/ carer ☐ GP Surgery ☐ ECS ☐ d/c rx ☑
PODs ☐ Com. Pharmacist ☐ GP letter ☐ Rpt Presc ☐

Pre-admission

Name	Dose	Frequency	Stop	Amend	Hold	Ward Round Orders
XARELTO	20mg	OD				
ASPIRIN	75mg	OD				
BENDROFLUMETHIAZIDE	2.5mg	OD				
ATENOLOL	25mg	OD				
OMEPRAZOLE	20mg	OD				
PARACETAMOL	1g	QID				
TRAMADOL	50-100mg	PRN 4-6°				

Allergies

None known ☐

Medication needs

further clarification?
Yes ☐ No ☐

Completed by: Designation: Date:

Drugs prescribed on admission checked and correct

Compliance aid? Yes ☐ No ☐

Comments: As per d/c Rx

Community Pharmacist

Reviewed by: S MCFARLANE (7765) Designation: Pharmacist Date: 10/5/10.

Social History

Smoking History: 0

Alcohol History: moderate

Other drug use?:

Home Circumstances

Lives with daughter

Affix patient ID label

General Examination	
Temp:	BR:
Pulse	BG:
SpO2:	Weight:
BP:	Urinalysis:

Cardiovascular Examination

General Observation

In pain
Obese
GCS 15

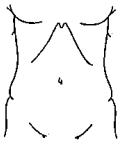
Respiratory Examination

clear



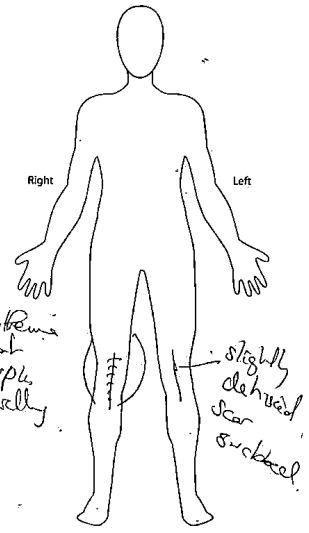
Abdominal Examination

Soft
Obese
Groin
BS —

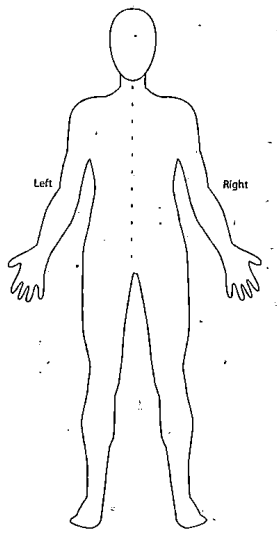


Neurological and Other Examination (e.g. Glasgow)

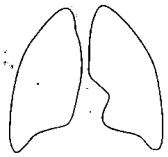
Front



Back



CXR:



Urinalysis:

ECG:

Differential Diagnosis/Problem List

Post op pain + swelling

SEWS ☐ 0-7

RED FLAG ☐ (Tick)

To Done / completed	Immediate Mangment Plans
	IV access Bloods analgesia
	Swabs
	Remi by Surgeons

Doctor Completing Initial Assessment

Name (print): CHAUHAN Signature: Designation: SR1

Page No.

Please affix patient ID label here

Secondary or Senior Focused Review
Seen by (print): HANNAH
Time seen:

4/5/10

ORTHO ADMITS

(61) F Fmlco D/C Wo 5
Patient Bottom Removed 4/5/10.
Discharged 5/5/10
4 Pain Shaving, Dressing
Not significantly unwell

PMH - PBP
Depression
Gout
OA

Meds - As Per Arf

NKDA.

O/E - Alert + oriented
T 35.2
BP 105/66
HR 80
O2 sats 98% Air

CVS - HS RRR
RS/ clear

Plan Completed	Continuing Management Plan

Doctor Completing Initial Assessment
Signature: Designation: Page No.:

Senior Doctor Review
Seen by (print):
Time seen:

Abdo - SNT
BS ✓



CRP 128
WCC 7.2
LFTs - Deranged

(12) knee - swollen +++
Erythema ✓
Hot to touch
Painful on palpation
Fixed flexion 10° unable to fully extend
Pleural limited to 20°

Imp - Post Op Pain + Swelling
? Infected.

P/ Abx
Analgesia
MSM initial seen in am - ? knee aspirate
knee Xray
Bloods ✓

Plan Completed	Continuing Management Plan
	Warnts Abdo VS gdn LFT's.
	IV Abx
	Wound swab ✓

Signature: Designation: SHO Page No: 7555

Please affix patient ID label here

Continuation Sheet

Date: Time

6/5/10

wd Mr Mistri
Day 2 Post-op.
History de-fracted

O:- Wound clean
- Inflammatory markers -ve
- Effusion - most likely post-op.

Plan:-
- Cont Abx.
- Recheck - bloods tomorrow.
- Observe.
- Analgesia, Elevate legs
- Mobilise - stable.

[illegible]
(R. DHEANJI)
F42

6/5/10
09:15 am

F42 - Addn
- D/w Bacteriologist, regarding final of wound.
done in theatre (04/05/10).
- No growth with more than 2 days of incubation.

[illegible]
(R. DHEANJI)
F42

Continuation Sheet

Date: Time

SOUTH GLASGOW HOSPITALS
SOUTHERN GENERAL HOSPITAL

7

Catherine Honeyman.

CLINICAL NOTES

DATE	
7/5/10	WR Mr Martin/Mr Meek. History revisited ↳ 4/5/10 → Removal of patella both (R) knee discharged 5/5/10; then re-admitted 2 hour later. Close observation yesterday Today continues to leak serous fluid ↳ ?less erythema -; remains swollen. Allow to eat today, repeat bloods incl CRP. Fast from midnight & Mr Meek will re-review mane ?for washout. R conlon FY2
7/5/10	Hb 112 WBC 8.4 Plt 217 CRP 449 Na 136 K+ 3.2 Cl 99 Bic 23 Ur 5.5 Cr 69
8/5/10	WR Mr Meek Apyrexic, obs stable Wound continues to leak serous fluid Encourage to bend knee Wound continues to improve Allow to eat & drink; does not need to fast Continue Abx.
8/5/10	Hb 106 WBC 7.6 Plt 227

0367691-SGH7

DATE	CLINICAL NOTES (Continued)
2/5/10	WR Mr Meek Less leaking, less erythema Able to flex to 90° Repeat bloods mane. Hb 111 CRP 324 Ur 4.0 WBC 6.6 Na 139 Cr 60 Plt 270 K+ 4.1
d5/10	WR meek. - continue IV abx - check bloods ane CRP - refer pain team (CWP 3578).
3/5/10.	Swab results (R) knee wound swab: 4/5/10. → No growth.
4/5/10	Knee tech must inspect CRP fitting. Contin Abs at present. Mark bloods / CRP Mangan
15th	SHO FBC, UE, CRP asked for tomorrow Plan: change on oral AB on Thursday 75 13

SOUTHERN GENERAL HOSPITAL

ORTHOPAEDIC OPERATION NOTE

PATIENTS DETAILS:

Name: CATHERINE HONEYMAN
DOB: 01/02/49
Unit No: SG00940779
CHI: 0102496145

DATE: 4/5/10

DIAGNOSIS:

OPERATION: REMOVAL PATELLA BUTTON RIGHT KNEE

SURGEON: HULLIN

ANAESTHETIST: KOPKA

PROCEDURE: THIGH TOURNIQUET
OLD SCAR INCISED
MEDIAL SOFT TISSUE ATTACHMENTS TO PATELLA HAD GIVEN WAY WITH LARGE EFFUSION RELEASED AFTER INCISING SUBCUTANEOUS TISSUES SWAB C+S
PATELLA BUTTON IDENTIFIED LOOSE IN KNEE
PATELLA INTACT BUT THIBN SHELL LYING LATERALLY
PATELLA NOT RPELACED
MEDIAL STRUCTURES DOUBLE BREASTED AND CLOSED IN 2 LAYERS

CLIPS TO SKIN

POST OP: MOBILISE AS FOR PRIMARY TKR

Dictated by:

SOUTH GLASGOW HOSPITALS
SOUTHERN GENERAL HOSPITAL

7

Catherine Honeyman
01/02/59

CLINICAL NOTES

DATE	
12/05/10	WR with consultant Normal checked. Continue IV for today. (oral from yesterday?) Bloods will be checked today Observation is stable. COCUM SHO 7513
13/05	SHO Obs. stable. Blood results satisfactory Start oral NAB. COCUM SHO 7513
14/05	SHO b/c today 1 prescribed — take home — 5 day NAB + 7 days analgesia. COCUM SHO 7513

691-SGH7

DATE	CLINICAL NOTES

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)

ATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION	SIGNATURE	GIVEN BY
13/07	MORPHINE	5mg	SC	0220		

DISCHARGE PRESCRIPTION PACKS

ATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	FREQUENCY	SIGNATURE	GIVEN BY

Southern General Hospital, Accident & Emergency Department, Glasgow G51 4TF
Tel Direct: 0141 201 1456/8 Switchboard: 0141 201 1100 Fax: 0141 201 2997

(3)

Affix Label

NAME: CATHERINE HONEYMAN DATE: 13/07/10
AGE: 61 DOB: 01/02/49 CONSULTANT: PETER DAVIS TIME: 2340
UNIT No: S0000940772 Account No: AE0058303/10 CHI#: 0102496145

GP Name:	GRAEME G MARSHALL GP Phone No: 0141 531 8250
REASON FOR VISIT:	KNEE PAIN
ALERTS:	(1) (2)
ALLERGIES/HISTORY	(1) NKDA (2)
RELEVENT HISTORY:	
MEDICATIONS:	
TRIAGE CATEGORY:	STANDARD TRIAGE NURSE: JANET HAIGH TRIAGE TIME: 2355
TIME FIRST ANALGESIA:	
TRANSCRIBED ANALGESIA:	

OBSERVATION TEXT:

SELF REFER, C/O PAIN AND SWELLING OF R KNEE , DOES ATTEND MR HULLIN, KNEE HOT TO TOUCH.

Enter/Edit Vital Signs

DATE	TIME	COMPLETED BY	DATE	TIME	COMPLETED BY
T	37.0		T		
HR			HR		
R			R		
BP			BP		
Sa02		ON 21 %	Sa02		ON
BG			BG		
PF			PF		
EPF					
E			E		
V			V		
M			M		

Visual Acuity: Left-6m | Right-6m

HONEYMAN, Catherine
Attend: 14/07/10 0242 DOB: 01/02/1949 Sex: F
Ref: DR PR DAVIS - SGH CASUALTY DEPARTMENT
XR Knee Rt
XR Ankle Rt

CRIS: 86589 E-25058705 ChiNo: 0102496145

(1)

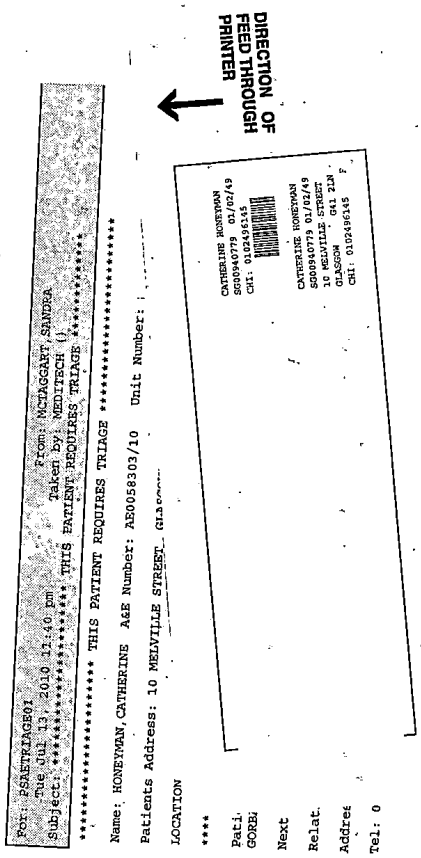
DISCHARGE CODES: Please Circle
1. Admission 2. Discharge 3. Refer to GP 4. Transfer to other hospital (see below)
5. Died 6. Refer to O.P. Clinic (see below) 7. Irregular Discharge 8. D.O.A.

Discharge Date:
Discharge Time:

Ward No. (If admitted): Ward 1
Transfer to Hospital:
Consultant (If admitted):

Follow Up: Not arranged / Arranged / To be arranged (Others Specify)

X-Ray & Other Reports to be filed on this side (if the patient is being admitted)



DATE	CLINICAL NOTES
	SEEN BY (DR) / TIME SEEN

13/07/2010 ON CALL ORTHOPSNO

Pt is Jehovah's Witness, not accepting blood products!

TKR (L) Jan 2010
(MR. NULLIN) (R) – 5 years ago; Jan/10; Mar/10
↳ readmitted after bleed of haematoma

(R) knee was swollen and painful since last op; last tonight knee pain it was more swollen and got excruciating pain. She felt sick, got nausea

pmh: HTN, Angina; 7/7 ago fell at home → right ankle # in Bridgelab.

med:
Nifedil 25mg OD
Simvastatin 40mg OD
Bendroflumethiazide 2.5mg OD
Tramadol 50mg x4 BD
Omeprazole 20mg
Fluoxetine 20mg OD
Aspirin 75mg OD
Nitrolingual spray PRN

allergy: NKDA

no bowel problems
no urinary symptoms

Neurology: GCS 15, (R) UPN

Chest: clear clear rhythmic heart sounds

Abdomen: soft no tenderness

(R) Right knee
swollen, redness, warm
externally painful
ROM: 20-30°
scar
redness

plan:
- admission under ortho. for IV Ab / analgesia / wash out?
  ↳ last wound swab: Staph. A.
- bloods
- ventilam, iv fluids
- duck x-ray along knee / ankle right side

CATHERINE HONEYMAN
SG00940779 01/02/49
CHI: 0102496145 F
Date____ Time____
Spec./Sig.____

CLINICAL NOTES

DATE	
16/07/10	MB2 ↑pain + swelling right knee TKR - 6yrs ago - patella revision Jan '10 - Excised April '10 ⇒ readmitted post op ē swelling ↑ pain felt to be haematoma ⇒ abx O/E today, swelling feels mainly prepatellar. erythematous tender CRP 12 WCC 13 Imp not definitely infected (P) Ask Mr Mohammed to review Keep posted at present
17/7/10	ATSP by MB2. Painful + swollen (R) TKR. Previous patella resurfacing followed by removal. Past few days ↑ pain and swelling over front of knee, unable to weight-bear due to recent (R) ankle fracture. O/E: (R) knee swollen ē prepatellar cellulitis and tenderness.

DATE | CLINICAL NOTES (Continued)

Able to flex to a 50-60°.
Generally tender.

Knee aspirated using aseptic technique through normal skin - medially. 35 mls of blood stained fluid obtained and sent for urgent Gram stain, microscopy + C&S.

In view of Temp of 36-9°C and CRP & WCC of 28/12/13 I think it would be appropriate to await Bacteriology prior to using out knee. If Bacteriology is +ve → Washout. If -ve Continue IV Antibiotics and treat as a Prepatella Bursitis and observe.

(CONSULTANT)

14/1/14 PM2

- Received call from Cons. Bacteriologist - Dr. Gallagher
- (L) knee aspirate shows numerous WCC and moderate amount of Gram +ve Staphylococcus
- Most likely to be to Staphylococcus

-D/w Dr Mr. Lonergan (Reg to Mr. Mohammed) - results noted,
- To keep patient fasted for washout in theatre later today
- No for IV Abx at present

(P-BRHAO)
PM 2.

Catherine Honeyman
[illegible]

CLINICAL NOTES

DATE

14/7/10 Lomax ST4 Ortho

Theatre Lomax / Mohammed

Washout & TKR

(4 jars) amounts of PVI

Debridement x2 washout (6L Saline + Chlorhexidine

Close in layers - leg PDS to tendon
1 vicryl to fat/scar
1 nylon to skin

Bulky knee POP applied - Chadwick ✓

Discussed with micro consultant
Advises - Flucloxacillin 2g qds
+ Gentamicin as per dose regimen

Lomax

DATE	CLINICAL NOTES (Continued)
4/7/10	NR Me: MBZ
08:50 am	- Day 1 Post - washout of (R) knee. - Below knee POP for present for (R) ankle #. - # 1 week all. - Pt/pts cast too tight around ankle region - Advised to elevate leg + re-assess cast at bedtime. - Pt is under Mr. Mohammed (P. BHATTI) PGY
5/7/10	FU2
09:20 am	Received call from Dr. Gallagher (Ears - Microbiologist) - Fluid from knee aspirate staph aureus which is sensitive to flucloxacillin. - To cont. on current regime of IV Abx (P. BHATTI) PGY2
5/7/10	FU2 - Pt c/o pain at top end of below knee cast - No distal neurovascular deficits - For trimming of cast under knee for comfort please. (P. BHATTI)
5/7/10	Plastol Rm. Below knee POP trimmed and padded D. DUMORE

Catherine Honeyman
DOS - 01/02/49
SG 00940779

CLINICAL NOTES

DATE	
15/7/10	Bloods CRP - (307) ↑. Na - 133 TRR - 89 Hb - 94 K - 3.2 Alb - 29 WCC - 8.0 Cl - 95 Urea - 22 Plt - 209 Bicarb - 25 ALP - 170 Urea - 5.1 AST - (106) Cr - 77 AST - (109) Gent level - 2.5 mg/l → dose is current dose. [signature] (F1 SHO) Bleep 12 In view of raised transaminases → to decrease dose of Flucloxacillin [signature] (F1 SHO) Bleep 12
16/07/10	MB2 Note above Continue antibiotics Will leave to on call team to review over weekend in case needs repeat bloods. Watch U&Es → [signature]
16/7/10 MH2	FH2 Rowan. Gent 2.7. → continue current dose 24 hrly.

DATE	CLINICAL NOTES (Continued)
20/7/10 0843	WR MR HULLIN Mobilising around ward. → mildly tender. Knee improving with antibiotics. Plan Continue mobilising Change cast to light weight Change to flucloxs. Home later today.
0 ' 10	Plaster Room Below Knee lightweight cast applied to (R) leg. Instructions given on cast care.

(11)

Southern General Hospital, Accident & Emergency Department, Glasgow G51 4TF
Tel Direct: 0141 201 1456/8 Switchboard: 0141 201 1100 Fax: 0141 201 2997

DATE	CLINICAL NOTES
27/3/11. 05.20	(62) + Referred patient A+E, ? septic joint. Background: TKR left " Patella resurfacing Right. } 2010 under Mr Hollin. Revision right patella - may 2010 Readmission May 2010. post-op haematoma + infection. Normally does daily pain, controlled c tramadol. Since 5pm 26/3/11, severe right knee pain. Unable to weightbear and very minimal movement. Systemically well. No Hx of injury. Joint erythema since 5pm. "feels like when I had haematoma". PMHx Angina Arthritis. DHx simvastatin 40mg atenolol 25mg tramadol 50mg aspirin 75mg bendrofluazide 2.5mg fluoxetine 20mg omeprazole 20mg Allergic - voltarol SHx lives c husband. Walks c crutches. o/e Alert. GCS 15/15. Temp 37.6. RR 17. Sats 99%. HR 113. BP 140/79. Right knee. cellulitis around scar. Hot joint. Very minimal movement. Peripheral pulses present. Cap refill. <2 secs. Neurologically intact.

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION	SIGNATURE	GIVEN BY
27/3/11	CO-CODAMOL 30/500	2/6	PO	05.20		KM

DISCHARGE PRESCRIPTION PACKS

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	FREQU	SIGNATURE	GIVEN BY

NAME: HONEYMAN, CATHERINE — DATE: 27/03/11 0523
AGE: 62 DOB: 01/02/49 — CONSULTANT: JASON LONG — TIME: 0523
UNIT No.: SG00540779 — Account No.: A80026431/11 — CHI#: 0102498145

GP Name:	GRAEME G MARSHALL — GP Phone No: 0141 531 8250
REASON FOR VISIT:	RIGHT KNEE PAIN
ALERTS:	(1) — (2)
ALLERGIES:	(1) NKDA — (2)
RELEVENT HISTORY:	
MEDICATIONS:	
TRIAGE CATEGORY:	STANDARD — TRIAGE NURSE: KIMBERLEY MACLEAN — TRIAGE TIME: 0526

TRANSCRIBED ANALGESIA :
OBSERVATION TEXT:
SELF REFERRAL - KNEE REPLACEMENT 6 YEARS AGO. SUDDEN ONSET OF LEG PAIN AND SWELLING AT 1700. NO MOI

UNABLE TO TRANSFER ONTO TROLLEY

Enter/Edit Vital Signs

DATE	TIME	COMPLETED BY	DATE	TIME	COMPLETED BY
T 37.6			T		
HR 113			HR		
R 17			R		
BP 140/79			BP		
Sa02 99%		ON 21 l	Sa02		ON l
BG			BG		
PF			PF		
EPF					
E			E		
V			V		
M			M		

Visual Acuity

Left-6m	Right-6m

Correction Y/N
Weight (kg)
Breath Alcohol
Pain Score

HONEYMAN, Catherine
Attend: 27/03/11 0523 DOB: 01/02/1949 Sex: F
Ref: DR JR LONG - SGH CASUALTY DEPARTMENT
XR Knee Rt

CRIS: 86569 E-25637365 ChiNo: 0102498145

(1)

DISCHARGE CODES: Please Circle — Referred ortho 0445
1. Admission 2. Discharge 3. Refer to GP 4. Transfer to other hospital (see below)
5. Died 6. Refer to O.P. Clinic (see below) 7. Irregular Discharge 8. D.O.A.

Discharge Date
Discharge Time

Ward No. (if admitted) 3 — Transfer to Hospital — Consultant (if admitted)

Follow Up — Not arranged — Arranged — To be arranged

X-Ray & Other Reports to be filed on this side (if the patient is not being admitted)

DIRECTION OF FEED THROUGH PRINTER

For: PSHTRIAGE01 From: COMSKEY,GILLIAN
Sun Mar 27, 2011 3:23 am Taken By: WEDITECH 0
Subject: ********** THIS PATIENT REQUIRES TRIAGE **********

********** THIS PATIENT REQUIRES TRIAGE **********

Name: HONEYMAN,CATHERINE A&E Number:

Pa
LO
++
Pat
GOI
Nex
Rel
Add
Tel

HONEYMAN,CATHERINE
SG0094879J 01/02/49
10 MELVILLE STREET
GLASGOW G41 2LW F
CHI: 0102495145

DATE	27/3/11	CLINICAL NOTES	0730
SEEN BY (DR)	FERGUSON	TIME SEEN	

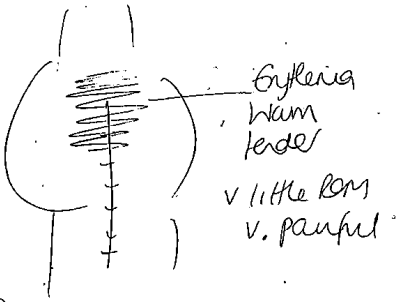
62 PC Painful (R) knee

PMH
Angina
Prev Inf (R) knee
TKR B/L
(R) knee 6 yrs ago.

HPC Pain (R) knee
since yesterday
Redness (R) knee
since yesterday
V. Painful to move
States unable to wb
No Syst features

NKDA

OE
(R) knee



No Calf swelling
No Calf tender
No Calf Erythema.

(P) Refer ⇒ ortho

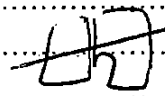
CLINICAL NOTES

DATE	
	Bloods today :- Hb 90 WBC 6·5 plts 227.
	(P) Gentrive – physio / OT. Check x-ray Observe wound Review if any concerns weight (91)
27/11	MR HULLIN Pt well over weekend. No acute issues. Obs stable, apyrexial. Wound inspected – some swelling but satisfactory. Plan – Recheck Hb today. – Mobilise Cltd FH2 SMITH 7559
7/6/11	FH2 SMITH Note Hb today (75). Pt is Jehovah's Witness + therefore not for transfusion. Currently asymptomatic. Plan – Commence iron supplements. – Recheck Hb tomorrow Cltd FH2 SMITH 7559.
28/6/11	MR GURHANE Pt well. Swelling in knee improving. Note low Hb yesterday. Recheck today. Commenced on iron supplements. Plan – Mobilise. Cltd FH2 SMITH 7559.
28/6/11	Bld s Hb (84) Na 140 WCC 6.5 K 3.6 Plts 294 Ur 8.7 C 67 Cltd FH2 SMITH 7559.

CLINICAL NOTES

Name CATHERINE HONEYMAN

Ward 5

DATE	
23/6/11	PM2 Review Reduced pain thro' mobs — post op planning 2nd stage revision (R) knee Pain controlled Smoking ++ PCA running Catheted ++ by catheter — eager pr removal Passed 90 mls clear urine last hr Troubled by thrush — feels that catheter irritating vulva ++ Obs — Stable + afebrile GE — Alert + comfortable RS 1+11+0  Chest clear Warm peripherally [ ] Abdo SNT BS quiet (P) Laxatives Catheter removal — monitr UO overnight Continue IV fluids while on PCA Bloods tomorrow X-ray 48 hrs ? Canesten if persistent vulval discomfort tomorrow Swab during catheter removal Review AM Usual = (PM2)
24/6/11 12 15	PM2 Review well otherwise Pain controlled Catheter removed with relief of vulval pain Nil bowel motion yet — on laxatives Not yet mobilising

Date		Signature	Print
5/4/11	WR FXZ.		
	=> Obs stable, apyrexial		
	=> Seen by Mr Hullin f IV → Oral switch ∴ Complete course of Abx f 6/52 Fludox & Rifampicin		
	=> (HI) today	FYZ 7585	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES

CATHERINE HONEYMAN

SG0094 0779.

Date	WR FY2	Signature	Print
4/4/11	- Changes over weekend.		
	- Obs stable		
	Samples from theatre (31/4/11)		
	- Swab/pus/fluid		
	→ all no growth.		
	Ⓟ Continue current Abx Rx,		
	Physio		
	MACKENZIE FY2.		
4/4/11	PHARMACY		
	PT. NOW PRESCRIBED TRAMADOL 100, q.i.d		
	MAY HAVE SEEN MAGGS TODAY. HOWEVER		
	I THINK THE INTENTION WAS TO STOP THE		
	OXYCONTIN AT THIS POINT (NOT STOPPED) - I		
	HAVE STOPPED OXYCONTIN ON CHART TODAY		
	D. MCCAMLEY		
	PHARMACIST		

DATE	CLINICAL NOTES (Continued)
28/3/11	FYI DONALD
1000	D/W Microbiologist Dr Cordina re: (R) knee aspirate result = Gram Staph. Aureus. On Fludoxacillin but await sensitivities to consider adding in a second agent.
	As joint is a prosthesis - will be difficult to eradicate organism - orthopaedic doctors to consider joint replacement.
	DONALD
	FYI #7577.
29/3/11	FYI DONALD
1200	D/W Microbiologist re: Staph aureus growth in joint aspirate
	Full sensitivities available
	(S) Fludoxacillin
	(S) to Rifampicin
	(S) to Fusidin.
	Advised to continue with IV fucloxacillin for 4-6 weeks and add in either Rifampicin or Fusidin orally for 4-6 wks: (600mg bd).
	D/W orthopaedic SHO who agrees to add Rifampicin. Watch LFTs with Rifampicin.
4/11	WR FYI
	~~Seen by MRS for the Mr Pehlis team.~~
	ERROR MACKENZIE
	DONALD
	FYI #7577.

[redacted]

HONEYMAN, CATHERINE
SG00940779 01/02/49
CHI: 0102496145 F
Date_____ Time_____
Spec./Sig._____

CLINICAL NOTES

DATE	
27/3/11	cont.
05.20.	Imp ? haematoma (on aspirin)
	cellulitis ? septic joint.
	Plan IV access
	Bloods.
	X-ray knee. - prosthesis present. Pre-patellar effusion.
	Obs. please.
	analgesia - co-codamol 30/500 1st.
	May require morphine.
	I am reluctant to attempt aspirate - as prosthetic joint.
	IV Abx for cellulitis.
	- flucloxacillin + gentamycin. BLEEP 7632
27/3/11.	DR WAQAS.
11:15a	- Knee aspirated under aseptic conditions by Mr. Meek / SHO
	- Microbiology rang to say that cultures of Staph aureus recommended that to be on Flucloxacillin IV 2g QDS
	- Mr. Meek adv. to first knee overnight for Tranexamic tomorrow for wash out.

CLINICAL NOTES

Name Catherine Honeyman

Ward 5

DATE

FH2 SMITH

29/6/11

Pt feeling well.
Pain improving. dwelling in (R) knee ↔
Mobility improving ± Physio. - walking ± sticks

Plan - Continue Physio
- (H) when safe.

Cl'd FH2 SMITH 7559

30/06/11 1010

FH2RN

Pt c/o ongoing pain in (R) knee
Nso vonvelling → same as alway not any worse
Waking well in physio

O/E bruising around (R) calf → soft non tender
(R) knee swollen
erythematous & hot to touch
good ROM

Imp → post op swelling

Plan → ~~continue~~ continue PT
encourage use of oramorph for pain
Bloods tomorrow
D/W Registrar re vonvelling ? further I.x

R Bagot FH2 #7052

01/07/11 1110

FH2RN
Pt feeling well

VCC 8.1 CRP 60 1088 Plt 351 18 ES (N)

Ongoing pain in (R) knee & swelling
R/V by Mr Cullhane → normal post op swelling
Obs stable

(D) Home today

R [illegible]

South Glasgow

HIGH DEPENDENCY UNIT

24 Hour Record

FLUID ADMINISTRATION

FLUID	VOL (ml)	ADDITIVE/AMT	RATE	PRESC SIGN	START TIME	GIVEN BY	CHECKED BY	BATCH NO.
0.9% NaCl	500	30mmol KCl	40	Fluids	0325	Jm		10L21E3B
HARTMANNS	500	———	40	Fluids	0845	AW		10K19 T4C

BLOOD RESULTS

TIME						TIME	2000					TIME		
Na 135 -145						Hb	100					PO_2		
K 3. 5-5.5						WCC	8.7					PCO_2		
Cl 98 -106						Plts	306					H^+		
CO_2 23-30						Pt						HCO_3		
Urea < 6.5						APTT						BE		
Creat < 120						Fib								

NUTRITION

Parenteral:			
Vol: / 24 hours			
Presc Sign:			
Batch	Given by	Checked by	Start time

Enteral: Type:			
Vol: / 20 hours			
Presc Sign:			
Batch	Given by	Checked by	Start time

Date: 31/3/11 Day No: POST	Surname: [redacted]
Date of Admission: 31/3/11	First Name: [redacted]
Consultant: ALLEN	D.O.B: 01/02/55 Unit No: [redacted]

Nasal Airway Size:
Tracheostomy:
Tube Type: Size:
Tube Last Changed:
DIAGNOSIS: 1ST REVISION (L) KNEE + INSERTION OF CEMENT SPACER.

Central Lines	Date of Insertion	Date of Change
1)		
2)		
Arterial Line Site:		
Urinary Catheter Size: —		

INVESTIGATIONS

HAEMATOLOGY	BIOCHEMISTRY	BACTERIOLOGY	DRUG LEVELS	X-RAY	ECG	OTHER

DAILY PLAN / WARD ROUND

RESPIRATORY	CVS	INTAKE/OUTPUT/NUTRITION	DRUGS	INITIAL

GENERAL CARE / COMMENTS

	INITIAL

Alarm Limits (a.m./p.m)	2000
B.P. (inv) 90-160	90-155
B.P. (non inv) 90-160	95-165
Sats 95-100	94-100
C.V.P. —	—
Resp 8-30	8-30
H.R. 60-160	60-100

08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 01 02 03 04 05 06 07 08
RESP
Mode
F_iO_2
Resp Rate
Peep
Air Entry L/R
Tracheal Suction
Oxygen Sat
Rhythm
CVS
Temp °C
•Periph (Black)
•Core (Green)
Pulse (Red)
BP
▲ cuff
^ artline
CVP
BLOOD GLUCOSE
DRUGS
FLUID INPUT
Cryst
Colloid
Blood
Drugs
Drugs
Oral/NG
TPN
Cummulative Total
FLUID OUTPUT/ DRAINAGE
Urine
Gastric
Air Entry:
✓ = Present
H = Harsh
Q = Quiet
D = Dull
↓ = Dull to base
W = Wheeze
CARE AND POSITION
PC = Position Changed M = Mouth
P = Physio
FLUID BALANCE
INTAKE
Blood
Crystalloid 2768
Colloid
Drugs 200
TPN
Oral/NG 2750
Total 5713
OUTPUT
Urine 680
Gastric
Other
Total 680
Balance
+VE 5033
Previous 24hr Balance

South Glasgow

HIGH DEPENDENCY UNIT
24 Hour Record

Date: 01/04/11 Day No: 1	Surname: HONEYMAN
Date of Admission: 31/03/11	First Name: CATHERINE
Consultant: HULLIN	D.O.B: 01/02/49 (62) Unit No: 00946779

Nasal Airway Size:	
Tracheostomy:	
Tube Type: Size:	
Tube Last Changed:	

DIAGNOSIS: 1ST REVISION (R) KNEE & INSERTION OF CEMENT SPACER.

Central Lines	Date of Insertion	Date of Change
1)		
2)		
Arterial Line Site (L) RAD	31/3/11	
Urinary Catheter Size: —		

FLUID ADMINISTRATION

FLUID	VOL (ml)	ADDITIVE/AMT	RATE	PRESC SIGN	START TIME	GIVEN BY	CHECKED BY	BATCH NO.
HARTMANN'S	500ml		5°	PBL				
HARTMANN'S	500ml		5°	PBL				
HARTMANN'S	500ml		6°	PBL				

INVESTIGATIONS

HAEMATOLOGY	BIOCHEMISTRY	BACTERIOLOGY	DRUG LEVELS	X-RAY	ECG	OTHER

DAILY PLAN / WARD ROUND

RESPIRATORY	CVS	INTAKE/OUTPUT/NUTRITION	DRUGS	INITIAL

BLOOD RESULTS

TIME						TIME						TIME		
Na 135-145	136					Hb	91					PO_2		
K 3.5-5.5	3.7					WCC	6.6					PCO2		
Cl 98-106	97					Plts	284					H^+		
CO_2 23-30	28					Pt						HCO_3		
Urea < 6.5	4.2					APTT						BE		
Creat < 120	75					Fib								

NUTRITION OP 438 Mg^{2+} 0.88

Parenteral:	Enteral: Type:
Vol: / 24 hours	Vol: / 20 hours
Please Sign:	Please Sign:

GENERAL CARE / COMMENTS

	INITIAL
Alarm Limits (a.m./p.m) ✓ B.P. (inv) 85 - 155 B.P. (non inv) 115 - 165 Sats 94 - 100 C.V.P. Resp 8 - 30	AME

	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07	08
RESP Mode		HNC		HNC																					
F_iO_2		4L		5L																					
Resp Rate		16		16																					
Peep																									
Air Entry L/R																								✓	
Tracheal Suction																									
Oxygen Sat		99%		98																					
Rhythm		ST		SR																					
CVS 40°		36.4		36.2																					
180																									
Temp °C 39°																									
•Periph (Black) 160																									
•Core (Green) 38°																									
Pulse (Red) 140																									
BP 37°		126		134																					
▲ cuff 120		^		^																					
^ artline 36°																									
100		92																							
35°		^																							
80				89																					
34°				✓																					
60				66																					
33°		53																							
40																									
CVP		(79)		(89)																					
BLOOD GLUCOSE																									
DRUGS																									
FLUID INPUT Cryst	125	125	125	125																					
Colloid																									
Blood																									
Drugs																									
Drugs																									
Oral/NG	200	150	150	300																					
TPN																									
Cummulative Total																									
FLUID OUTPUT/ DRAINAGE Urine	NUP	NUP	NUP																						
Gastric																									

Air Entry:
✓ = Present
H = Harsh
Q = Quiet
D = Dull
D↓ = Dull to base
W = Wheeze

CARE AND POSITION
PC = Position Changed M = Mouth
P = Physio

08	20
09	21
10	22
11	23
12	24
13	01
14	02
15	03
16	04
17	05
18	06
19	07

FLUID BALANCE

INTAKE

Blood	
Crystalloid	
Colloid	
Drugs	
TPN	
Oral/NG	
Total	

OUTPUT

Urine	
Gastric	
Other	
Total	

Balance

Previous 24hr Balance

[redacted]

SOUTHERN GENERAL HOSPITAL

ORTHOPAEDIC OPERATION NOTE

PATIENTS DETAILS:

Name: CATHERINE HONEYMAN
DOB: 01/02/49
Unit No: SG00940779
CHI: 0102496145

DATE: 31/3/11

DIAGNOSIS:

OPERATION: FIRST STAGE REVISION KNEE

SURGEON: HULLIN

ANAESTHETIST: HOSIE

PROCEDURE: THIGH TOURNIQUET
OLD SCAR INCISED
MEDIAL PARAPATELLA INCISION
100ML OF TURBID FLUID SENT FOR C+S
INFECTED MEMBRANE EXCISED
FEMORAL COMPONENT REMOVED EASILY
TIBIAL COMPONENT REMOVED AFTER POSTERIOR MOBILISATION

THOROUGH DEBRIDEMENT AND LAVAGE
DOUBLE MIX PALACOS CEMENT WITH 2 GM VANCOMYCIN

CLOSURE VICRYL CLIPS TO SKIN
KNEE IMMOBILISER

POST OP: CONTINUE IV ANTIBIOTICS OVER WEEKEND
MOBILISE AS ABLE WITH KNEE SPLINT
ANTIBIOTIVCS 6 WEEKS

Dictated by:

[redacted]

Patient Agreement to Investigation or Treatment

NHS Greater Glasgow and Clyde

CONSENT FORM

PATIENT DETAILS (OR PRE-PRINTED LABEL)

Hospital/Clinic/GP Practice ..... SGH .....

Patient's surname/family name : ..... Honeyman .....

Patient's first name(s): ..... Catherine .....

Date of Birth 01 / 07 / 1969 Gender: Male ☐ Female ☑

NHS/ CHI Number 010249 6145

pecial requirements (e.g. other language/communication method) .....

.....

Responsible practitioner: ..... Mr. Hullin .....

Job title: ..... Consultant .....

STATEMENT FOR PRACTITIONER

(to be filled in by practitioner with appropriate knowledge of proposed procedure- see guidance notes)

Describe proposed operation, investigation or other treatment.
Where appropriate specify site or side: (WRITTEN IN FULL)

Right. removal of total knee arthroplasty +/- cement spacer
+/- proceed

I have explained the procedure named on this form to the patient in terms which, in my judgement, are suited to their understanding. In particular, I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any significant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure (please specify major procedures above).

Signature of practitioner: .....

Name/Designation (Print) ..... Cochrane .....

STATEMENT TO BE COMPLETED BY PATIENT/PARENT*

(* parental responsibility for a minor without capacity)

You should read this form and the notes below carefully. If there is anything you do not understand ask the Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

I understand

- the procedure, important risks and appropriate alternatives which have been explained to me by the practitioner named on this form.
- that a practitioner other than the practitioner who has been providing treatment so far might carry out the procedure.
- that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to the medical treatment proposed, to safeguard or promote physical or mental health.
  That examination for the purpose of teaching will not be undertaken without my consent.

I have been told about additional procedures which may become necessary during treatment. I hav listed below **any procedures which I do NOT wish to be carried out without further discussion.**

I agree -

- to the administration of an anaesthetic or to sedation if required.
- to the procedure named on this form
- to the emergency administration of blood or blood products

Additionally you have to agree or disagree the following:-	**Agree**	**Disagree**
that information and/or images kept in records may be used anonymously for education, audit, and research with appropriate ethical approval, to nprove the quality of patient care.	☐	☐
that surplus tissue or other biological material not essential for my diagnosis or future treatment may be used for medical education and ethically approved medical research.	☐	☐

PATIENT REFUSAL FOR BLOOD PRODUCTS

Please sign here if you refuse to consent to the emergency administration of blood or blood products. Even if this results in death.

Signature: Catherine Hannigan ..... Date 31/3/11

Practitioner Signature: ..... Date 31/3/11

PATIENT/PARENT* AGREEMENT FOR TREATMENT

Signature: x Catherine Hannigan ..... Date 31/3/11

Name (Print): .....

DEPARTMENT OF ANAESTHESIA

SOUTH GLASGOW UNIVERSITY HOSPITALS

DIVISION

Name:	SG00940779
Address:	CATHERINE HONEYMAN 10 MELVILLE STREET
Unit No:	
Age:	GLASGOW 01/02/1949
Ward:	G41 2LN CHI 0102496145

Date: 24/10/05

Pre-medication: Temazepam 20mg. Lucc. 20mg

Time: 1045

Given by:

PRE-OPERATIVE NOTES

prev GA - lumpectomy 1989 * Jehovah's witness *

OA- neck, back, elbows

PMH HT

Current Medication:

tramadol
losec
Bendrofluazide
zorecal tabs

Allergies: NKA

Limit Blocks + PCA

ASA Grade: 1 (2) 3 4 5 E Airway ☐ Reflux ☑ ? cardiac tone

Hb: 141 wcc 7.3	Na: 141	Height (M): BMI 34	ECG: SR ischaemia
Platelets: 267	K: 4.1	Weight (Kg): 85	
Blood gp:	Cl: 100	Pre-op BP: 177/104*	CxR:
Xmatch:	U: 8.2 Cr: 81	Urinalysis:	

Operation Performed: (R) TKR

Anaesthetists: Seen by Henderson/O'Connor

Surgeons: Stead

POST-OPERATIVE INSTRUCTIONS AND NOTES

Oxygen:

Problems for Future Reference:

REGIONAL	AIRWAY	VENTILATION	IV SITES	POSITION
	☐ Oral/Nasal ☐ Mask ☐ Cuff ☐ Pack ☐ Phar. Airway Tube/LMA Size: Laryngoscopy Grade: 1 2 3 4	☐ Spontaneous V_t ☐ I P P V f Circuit Ventilator	Hand L R Forearm L R Internal Jugular L R Other L R Blood Warmer ☐	☐ Supine ☐ Lateral L/R ☐ Prone ☐ Lithotomy ☐ Other

Time																	

☐ Arterial line

SpO_2
FiO_2
$EtCO_2$
EtAA
Temp
Fluid

210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
20
10
0

CVP
Blood Loss
Urine Output

SpO_2
FiO_2
$EtCO_2$
EtAA
Temp
Fluid

210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
20
10
0

CVP
Blood Loss
Urine Output

mechanical respiration (ventilation), cardiopulmonary resuscitation (CPR), tube feeding (artificial nutrition or hydration), etc., but I accept basic palliative care–treatment for comfort.

✓ (b) **To Prolong Life.** That is, I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards but subject to my absolute refusal of blood and those blood components described herein, although I realise this means that I might be kept alive on machines for years in a hopeless condition.

—— (c) **Other.** [If you do not completely agree with either (a) or (b) above, initial here and write your own end-of-life instructions in the space provided.]——

(8) Other instructions: [Write any other health-care instructions here.]——

(9) (initial) [This clause applies only to women of child-bearing age.] If I am pregnant, and there is a reasonable chance that my unborn child could survive, I want my life to be prolonged for the sake of my unborn child. This is subject to the refusal of blood for myself and my unborn child as set out above. After any efforts to save my unborn child I direct that my doctors manage my care in harmony with the instructions in (7) and (8) above.[ii]

(10) If my health-care providers will not or cannot undertake a surgical operation, or administer any other form of medical treatment, without the use of blood or any blood products specifically prohibited by myself in this document, I direct my health-care providers to co-operate fully with the appointed representative(s) of the local Hospital Liaison Committee for Jehovah's Witnesses in discussing treatment options. Thereafter if a transfer is subsequently deemed necessary I direct that all my medical records, including a copy of this document, be transferred promptly to the other health-care provider to ensure that my health-care instructions herein will be respected.

(11) A copy of this document shall be as valid as the original. I ask that a copy of this document be made part of my permanent medical record. I have provided a copy of this document to my registered general practitioner.

(12) The provisions of this entire document are separable, so that the invalidity of one or more provisions shall not affect any others.

(13) **MY DECISION to refuse blood and choose non-blood management MUST BE RESPECTED EVEN IF MY LIFE OR HEALTH IS THREATENED by my refusal. Any attempt to administer blood contrary to my instructions will be a violation of my rights of bodily self-determination and personal autonomy, and accordingly will constitute an actionable trespass to my person.**[iii iv v vi]

(14) I understand and believe the full import of this document and verily aver that it accurately reflects my personal informed choice.[vii]

(15) SIGNED: Catherine Mowinson (Your signature) 29 · 11 · 05 (Date)

10 MELVILLE · ST (Address)

Pollokshields Glasgow G41 2LW

(16) STATEMENT OF WITNESSES: The person who signed this document (the principal) is known to me and voluntarily signed or voluntarily directed another to sign this document in my presence. The principal appears to be of sound mind and free from duress, fraud or undue influence. I am 18 years of age or older and I am not related to the principal by blood, marriage or adoption.

Signature of Witness 1	Signature of Witness 2
W. Scott	DAVID STONE
Print Name	Print Name
PAINTER.	TEACHER
Occupation or Profession	Occupation or Profession
77 Wallace Wynd	31 SECOND AVE
Home Address	Home Address
CHRISTIE, GLASGOW G72 8SE	KINGS PARK GLASGOW G44 4TD
0141 641 1283	0141 632 4609
Home Telephone	Home Telephone
0141 633 1777	01236 607034
Work Telephone	Work Telephone

i *In re T* [1992] 3 WLR 782, Donaldson MR at 787 D.

ii *St George's Healthcare NHS Trust v.S.; R. v. Collins and Others ex parte S.* [1998] 2 FLR 728.

iii BMA Code of Practice *Advance Statements About Medical Treatment* [April 1995] ¶¶ 2.2; 3.1; 13.5; 14.2.

iv *In re T* [1992] 3 WLR 782, Donaldson MR at 787 B.

v *Airedale National Health Service Trust v. Bland* [1993] 2 WLR 316, Lord Keith of Kinkel at 360 H–361 A.

vi *Airedale National Health Service Trust v. Bland* [1993] 2 WLR 316, Lord Goff of Chieveley at 367 E–368 A.

vii *re C* [1994] 1 FLR 31.

HEALTH-CARE ADVANCE DIRECTIVE

(1) I, CATHERINE HONEYMAN
Print your full name

born the 1st th day of 2 month, 19 49, am of sound mind and I voluntarily make this Health-Care Advance Directive. This document revokes any prior health-care advance directive and shall take effect upon my incapacity. It will remain in force unless and until specifically revoked in writing by me.

(2) I am one of Jehovah's Witnesses. On the basis of my firmly held religious convictions (founded on Bible directions such as at Acts 15:28, 29) and on the basis of my desire to avoid the numerous hazards and complications of blood transfusions, **I absolutely REFUSE allogeneic blood** (another person's blood); **the primary blood components red cells, white cells, platelets and/or plasma; and stored (predonated) autologous blood** (my own stored blood) **under any and all circumstances, no matter what the consequences. I also refuse to predonate any of my blood for storage and later reinfusion into me or anyone else.**

(3) The refusal in clause (2) above is not to be overridden by a purported consent of a spouse, relative or other person or body.

(4) **I request and will accept alternative non-blood medical management** to build up or conserve my own blood, to avoid or minimise blood loss, to replace lost circulatory volume, or to stop bleeding. Hence such volume expanders as dextran, saline solution, Ringer's solution modified fluid gelatin, hetastarch, and perflurochemicals; and oral or parenteral iron would be acceptable to me.

(5) Medical products: [Initial one of the three choices below.]

—— (a) I refuse all fractions derived from any primary component of blood.

✓ (b) I accept all fractions derived from any primary component of blood.

—— (c) I want to qualify either (5a) or (5b) above and my instructions are as follows:

(6) Medical procedures involving my own blood that do not involve storage of my blood for later infusion into me or someone else: [Initial one of the three choices(s) below.]

—— (a) I refuse any procedure involving the use of my blood during an operation or ongoing treatment.

—— (b) I accept any procedure involving the use of my blood during an operation or ongoing treatment.

✓ (c) I accept only the following procedures involving my blood:
CELL SALVAGE MACHINE

(7) With respect **to end-of-life decisions, I CHOOSE:** [Initial one of the three choices below.] (As to pregnancy see (9) overleaf.)

—— (a) NOT TO PROLONG LIFE. That is, if to a *reasonable degree of medical certainty my condition is considered hopeless.* (For example, if to a reasonable degree of medical certainty I have an incurable and irreversible condition that will result in my death within a relatively short time, or if I am unconscious and to a reasonable degree of medical certainty will not regain consciousness, or if I have brain damage or a brain disease that makes me unable to recognise people or communicate and to a reasonable degree of medical certainty my condition will not improve.) In such situations, I refuse

Britain

continued overleaf . . .

SOUTHERN GENERAL HOSPITAL NHS TRUST

PATIENT NAME (BLOCK CAPITALS) CATHERINE HONEYMAN DATE 23/11/05

UNIT NUMBER SG 00940779

TO BE COMPLETED BY MEDICAL OR DENTAL PRACTITIONER

I CONFIRM THAT I HAVE FULLY EXPLAINED: To the patient/ ~~parent~~* (*Delete as appropriate)

1. The nature and effect of the medical treatment required by the patient.
2. The possible risks attendant upon ~~his~~/her refusal to accept a blood transfusion as part of said medical treatment.

NAME (Physician) (BLOCK CAPITALS) I.W. STEAD DATE 23/11/05

SIGNATURE I.W. Stead

NAME (Witness) (BLOCK CAPITALS) O'GORMAN DATE 23/11/5

SIGNATURE

TO BE COMPLETED BY THE PATIENT / PARENT

I AM THE PATIENT / ~~PARENT~~* OF .....

I hereby give my consent to the administration of such medical treatment as the physician considers necessary, except that, although it has been explained to me that it may be necessary to administer to me / my ..... a blood transfusion as part of said necessary medical treatment, or even to preserve life, I hereby expressly withhold my consent to and forbid the administration to me / my ..... of a blood transfusion in any circumstance or for any reason whatsoever.

Accordingly absolve the physician ....., the Southern General Hospital NHS Trust Board, every member of the medical staff and any other member of staff concerned from all responsibility, and from any liability to me/ my ..... or to my estate or to my ..... estate or my dependants or my ..... dependants for any damage which may result from my refusal to consent to any such blood transfusion.

NAME (BLOCK CAPITALS) ..... DATE .....

SIGNATURE .....

NAME (Physician) (BLOCK CAPITALS) I.W. STEAD DATE 23/11/05

SIGNATURE I.W. Stead

NAME (Witness) (BLOCK CAPITALS) O'GORMAN DATE 23/11/5

SIGNATURE

INTRA-OPERATIVE CARE PLAN

TIME OF ARRIVAL IN ANAESTHETIC ROOM 0852

TIME OF ARRIVAL IN THEATRE 0930

THEATRE	ANAESTHETIST	ASSISTANT	ANAES. NURSE
Ortho 2	Mosie.		Alexander Nugent.

SURGEON	IST ASSISTANT	SCRUB NURSE	CIRCUL. NURSE
Hullin	Frame.	Scollin	Glaser.

I.V. INFUSIONS		ARTERIAL LINE		CVP-MONITORING	
COMMENCED	IN-SITU	COMMENCED	IN-SITU	COMMENCED	IN-SITU
✓					
AIRWAY MANAGEMENT		**SYRINGE/PCA PUMP**			
GENERAL ETT 8 ☑		COMMENCED	IN-SITU	COMMENCED	IN-SITU
LM ☐					
FM ☐					
SPINAL					
EPIDURAL		COMMENCED	IN-SITU	COMMENCED	IN-SITU
REGIONAL					
LOCAL					

POSITION	Supine	Prone	Lithotomy	Right Lateral	Left Lateral	Jack Knife	Other
RIGHT ARM	At Side		On Board		Across Chest		Other
LEFT ARM	At Side		On Board		Across Chest		Other
PATIENT PROTECTION SAFETY	Padding	Pillows		Gel Pad	Warming blanket		Other

TOURNIQUET		
Arm	Leg	Ankle
Right (R)TKR	Left	
Inflated 0928 Hrs	Pressure 300MM	
Deflated 1048 Hrs		

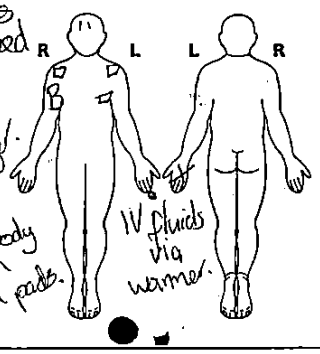
SWAB/NEEDLE/INSTRUMENT COUNT	
Correct	
Incorrect	
Appropriate Action Taken	

IMPLANTS	BATCH NO.	SERIAL NO.
(R) Patella 1106 300mmHg #11:50 - Right Lea		
REF 1294-09-650 LOT 2783133 2013-12		
LCS® Complete™ Metal Backed Patella		
POROCOAT® STD+		
DePuy Orthopaedics, Inc. Warsaw IN 46581		

SPECIMENS TAKEN

PATIENT MONITORING

PERIPHERAL IVI	X
IV CANNULAE	C
ECG ELECTRODES	□
C.V.P.	Z
ARTERIAL LINE	A
BP/MANUAL/AUTO	B
PULSE OXIMETER	•
DIATHERMY PLATE	Δ
SKIN CONDITION	S



POST OPERATIVE CARE PLAN

TIME OF ARRIVAL IN RECOVERY ROOM 1110

OPERATION GA + femoral + sciatic blocks: ~~RIGHT~~ LEFT TOTAL KNEE REPLACEMENT RIGHT KNEE RESURFACING

| | | | | |

POST OPERATIVE CARE PLAN

SPECIFIC PRE/INTRA & POST OPERATIVE COMPLICATIONS

COMPLICATION	ACTION TAKEN	OUTCOME
Pain 17:30	1g paracetamol given IV	

NURSING REPORT

Observations as charted overnight
Ht O2 via Hudson mask whilst on PCA
Analgesia as per Kardex and via PCA PCA
connected, prescribed 1:1:5, not required in recovery.
Further fluids prescribed.
C.S.M- satisfactory- toes warm to touch
perfusing well, can feel touch, can wiggle
toes, pedal pulses present.

Recovery discharge criteria - met

POST RECOVERY TRANSFER REPORT

CONSCIOUS LEVEL	OXYGEN	I.V. ACCESS	DRAINS	PAIN LEVEL
A). Unconscious B). Conscious/Drowsy C). Conscious/ Responsive D). Ventilated	A). Hudson Mask B). Nasal Canulae C). Other	A). Infusion Running B). Capped Can in SITU C). Discontinued	A). Patent B). Blocked C). Drainage in Mls D). Irrigation	A). Pain free B). Mild C). Moderate D). Severe
WOUND	**CVP MONITORING**	**ARTERIAL LINE**	**SYRINGE PCA PUMP**	**WATERLOW SCORE PLEASE SPECIFY AMOUNT**
A). Dry B). Slight Staining C). Heavy Staining	A). Commenced B). In Situ	A). Commenced B). In Situ	A). Commenced B). In Situ	A). 10+ At Risk B). 15+ High Risk C). 20+ Very High Risk

RECOVERY NURSES SIGNATURE Watson/Kitson

WARD NURSE SIGNATURE

SGH99 0099099 MG\080198

THEATRE CARE PLAN

Theatre:

NHS Greater Glasgow and Clyde

WARD NAMED NURSE	S/N Murray	DATE	28/01/10
PATIENT'S NAME	Catherine Hargyman	WARD	SIX
D.O.B.	01/02/49	UNIT NO.	SC 009940779

* Jehovahs Witness *

PROPOSED OPERATION (L) PKR & (R) Patella Resurface

BP - 122/74 P - 88 Temp - 36.5 Resps - 16 Sats - 97%

PRE-OPERATIVE CARE PLAN		
1. Obtain and record baseline vital signs	✓	✓
2. Note and record significant past medical history	✓	✓
3. Capped/loose teeth-number and position	1 upper cap	secure
4. Pre-op teaching carried out	✓	✓
5. Pre-op investigations carried out i.e. ECG, Bloods, X Rays	✓	✓
6. Skin shave and preparation required	N/A	N/A.
7. Remove make-up nail, varnish	Removed	✓
8. Remove prosthesis, dentures, hair pieces, lenses	Glasses - removed	✓
9. Jewellery - Tape rings (to be taped)	✓	4 rings taped.
10. Ensure patient has fasted (No less than 6 hours)	✓	Lucozade 5am.
11. Identification band	✓	✓
12. Empty bladder/catheter in situ	✓	✓
13. Naso-Gastric Tube	N/A	N/A.
14. Blood in Theatre Fridge		No.
15. Case Notes	✓	✓
Drugs kardex/charts	✓	✓
X Rays		on system
16. Theatre gown & cap	✓	✓
17. Premedication given	✓	✓
18. Consent form signed	✓	✓
19. Allergies	NKDA	none known
20. Waterlow Score	6	⇐

RELEVANT INFORMATION	Ward Nurse Sig	Theatre Nurse Sig
Backpain Lumpectomy - NAD - Vic 12-13 years ago. Hypertension GORD. Depression R Total Knee Replacement.		Alexander

NAMED NURSES

NAMED ANAESTHETIC NURSE SN Alexander / SN Nugent.

NAMED THEATRE NURSE SN Scollin.

NAMED RECOVERY NURSE

POST OPERATIVE CARE PLAN

TIME OF ARRIVAL IN RECOVERY ROOM

OPERATION

Catherine Honeyman

WOUND DRAINAGE	SKIN CLOSURE	DRESSING
LA INFILTRATION	**URINARY CATHETER**	**PACKS IN SITU**

CONSCIOUS LEVEL	AIRWAY	OXYGEN	I.V. ACCESS	DRAINS	WOUND
A). Unconscious B). Conscious/Drowsy C). Conscious/ Responsive D). Ventilated	A). Guedel B). E.T.T. C). Laryngeal Mask	A). Hudson Mask B). Nasal Canulae C). Other	A). Infusion Running B). Capped Can in SITU C). Discontinued	A). Patent B). Blocked C). Drainage in Mls D). Irrigation	A). Dry B). Slight Staining C). Heavy Staining

Continuation Sheet

TIME HOURS	MINS	0	5	10	15	20	25	30	45	60	75	90
RESPIRATORY FUNCTION												
Able to breath and cough	= 2	2	2	2								
Maintain own airway	= 1											
Airway needs support	= 0											
COLOUR												
Pink & Warm	= 2	2	2	2								
Pale, Dusky, Peripheral cyanosis	= 1											
Central Cyanosis, cold	= 0											
RECOVERY OF NEURO-MUSCULAR FUNCTION												
5 secs Head lift	= 2	2	2	2								
Moves limbs	= 1											
No move (Except Resp)	= 0											
CONSCIOUS LEVEL												
Responds to command	= 2	2	2	2								
Responds	= 1											
No Response	= 0											
BLOOD PRESSURE												
Within 30mmHg of Pre-op	= 2	125	128	129								
30-90 from Pre-op	= 1	68	76	64								
< 70mmHg	= 0											
O_2 SATURATION		95	97	97								
PULSE		75	74	76								
RESPIRATION RATE			12									
TEMPERATURE (If indicated)												

POST OPERATIVE CARE PLAN

SPECIFIC PRE/INTRA & POST OPERATIVE COMPLICATIONS

COMPLICATION	ACTION TAKEN	OUTCOME

URSING REPORT

POST RECOVERY TRANSFER REPORT

CONSCIOUS LEVEL	OXYGEN	I.V. ACCESS	DRAINS	PAIN LEVEL
A). Unconscious B). Conscious/Drowsy C). Conscious/ Responsive D). Ventilated	A). Hudson Mask B). Nasal Canulae C). Other	A). Infusion Running B). Capped Can in SITU C). Discontinued	A). Patent B). Blocked C). Drainage in Mls D). Irrigation	A). Pain free B). Mild C). Moderate D). Severe
WOUND	**CVP MONITORING**	**ARTERIAL LINE**	**SYRINGE PCA PUMP**	**WATERLOW SCORE PLEASE SPECIFY AMOUNT**
A). Dry B). Slight Staining C). Heavy Staining	A). Commenced B). In Situ	A). Commenced B). In Situ	A). Commenced B). In Situ	A). 10+ At Risk B). 15+ High Risk C). 20+ Very High Risk

RECOVERY NURSES SIGNATURE

WARD NURSE SIGNATURE

MG\080198 0069669 66

Acute Services Division

NHS
Greater Glasgow and Clyde

Pre-operative marking Checklist for Surgery that can be performed on either side of the body

The operating surgeon should mark the intended site of operation prior to the patient leaving the ward area and before any pre-medication is given.

Affix label or Patient's name: SG00940779 CATHERINE HONEYMAN Hospital No: 10 MELVILLE STREET, GLASGOW 01/02/1949 Date of Birth: G41 2LN CHI 0102496145	Date of procedure: 04/5/10 Proposed procedure: R. knee

Check 1 - Ward

To be checked by ward staff before patient goes to theatre.

• Check the patient's identity • The mark is inspected and confirmed against the patient's supporting documentation. • Check reliable imaging will accompany the patient to theatre	Signed: Print name: H. ANDERSON Ward: 5 Date: 04 / 05 / 10

Check 2 - Theatre/ Anaesthetic Room

To be checked by operating surgeon in the theatre department, prior to anaesthesia.

• The mark is inspected and checked against the patient's supporting documentation	Signed: Print name:

Check 3 - Theatre Nurse

The senior theatre nurse must ensure that the surgical, anaesthetic and theatre team involved in the intended operative procedure pause prior to commencement of surgery to verbally confirm the following points:

• Presence of the correct patient • Marking of the correct site • Procedure to be performed	Signed: Print name:

If an error is identified during the pre-operative checks, the surgeon in charge should assess the situation, review documentation and either return the patient to the ward or note and sign a decision to proceed at risk in the box below.

Signed	Date

POST OPERATIVE CARE PLAN

SPECIFIC PRE/INTRA & POST OPERATIVE COMPLICATIONS

COMPLICATION	ACTION TAKEN	OUTCOME
pain	IV paracetamol + IV Voltarol given intra-op	please cont. to observe.
jehovah's witness	Healthcare advance directive in notes	please communicate to appropriate staff
Pain score 7.	Morphine 2mg IVO Morphine 2mg IVO	10:45 } no change 10:47

NURSING REPORT

Chest pain - slightly breathless ? anxiety related - informed - atypical chest pain - ? had ECG in recovery - reviewed by anaesthetist pain appears to be settling with no intervention - on oxygen 2ltrs via nasal cannula @ 11:20 Intra-op in recovery IV fluids as charted Warm - dry - see above - Padded up - drug chart - cdas sink - sensitive informed pressure areas - satisfactory Discharge criteria met.

POST RECOVERY TRANSFER REPORT

CONSCIOUS LEVEL	OXYGEN	I.V. ACCESS	DRAINS	PAIN LEVEL
A). Unconscious B). Conscious/Drowsy C). Conscious/ Responsive D). Ventilated	A). Hudson Mask B). Nasal Canulae C). Other	A). Infusion Running B). Capped Can in SITU C). Discontinued	A). Patent B). Blocked C). Drainage in Mls D). Irrigation	A). Pain free B). Mild C). Moderate D). Severe see above
WOUND.	**CVP MONITORING**	**ARTERIAL LINE**	**SYRINGE PCA PUMP**	**WATERLOW SCORE PLEASE SPECIFY AMOUNT**
A). Dry B). Slight Staining C). Heavy Staining see dose	A). Commenced B). In Situ	A). Commenced B). In Situ	A). Commenced B). In Situ	A). 10+ At Risk B). 15+ High Risk C). 20+ Very High Risk

RECOVERY NURSES SIGNATURE Blacoe

0099099 MG\080198

THEATRE CARE PLAN

Theatre:

NHS Greater Glasgow and Clyde

WARD NAMED NURSE	**DATE**
PATIENT'S NAME [redacted]	**WARD** 5
D.O.B. 1/2/49	**UNIT NO.** SG 00[redacted]779

PROPOSED OPERATION

PRE-OPERATIVE CARE PLAN		
1. Obtain and record baseline vital signs	T 36.6 BP 120/80 P 80 RR 16	Temp 98% noted
2. Note and record significant past medical history	Noted	
3. Capped/loose teeth-number and position	Upper top secure.	Top capped
4. Pre-op teaching carried out	Anaesthetist aware	✓
5. Pre-op investigations carried out i.e. ECG, Bloods, X Rays		Bloods
6. Skin shave and preparation required	—	✓
7. Remove make-up nail, varnish	—	✓
8. Remove prosthesis, dentures, hair pieces, lenses	—	✓
9. Jewellery - Tape rings	Rings taped Time N/A.	✓ (L)+(R)
10. Ensure patient has fasted (No less than 6 hours)		✓ (Usted with
11. Identification band	—	✓
12. Empty bladder/catheter in situ	—	PU'd
13. Naso-Gastric Tube	N/A	✓
14. Blood in Theatre Fridge	G+R	G+S ?
15. Case Notes	—	✓
Drugs kardex/charts	✓	✓
X Rays	N/A CXR	PACS
16. Theatre gown & cap	—	✓
17. Premedication given	N/A Morphine	✓
18. Consent form signed	✓ See file	✓
19. Allergies	NKDA	N/K
20. Waterlow Score		
RELEVANT INFORMATION	**Ward Nurse Sig**	**Theatre Nurse Sig**

Ward staff confirmed no smoking in 12hrs

Drowsy in PACU. Morphine 2mg IV x2 given

NAMED NURSES

NAMED ANAESTHETIC NURSE SN STOAN

NAMED THEATRE NURSE SSN McALLISTER

INTRA-OPERATIVE CARE PLAN

TIME OF ARRIVAL IN ANAESTHETIC ROOM 0730

THEATRE	ANAESTHETIST	ASSISTANT	ANAES. NURSE
RGTHO2	KOPICA	/	SLOAN

TIME OF ARRIVAL IN THEATRE 0810

SURGEON	1ST ASSISTANT	SCRUB NURSE	CIRCUL. NURSE
HULLIN		MCALLISTER	HUNTER

I.V. INFUSIONS		ARTERIAL LINE		CVP-MONITORING	
COMMENCED	IN-SITU	COMMENCED	IN-SITU	COMMENCED	IN-SITU
✓ (L) 1025					
AIRWAY MANAGEMENT		**SYRINGE/PCA PUMP**			
GENERAL ETT ☐		COMMENCED	IN-SITU	COMMENCED	IN-SITU
LM ✓ ☐					
#4 FM ☐					
SPINAL					
EPIDURAL		COMMENCED	IN-SITU	COMMENCED	IN-SITU
REGIONAL					
LOCAL					

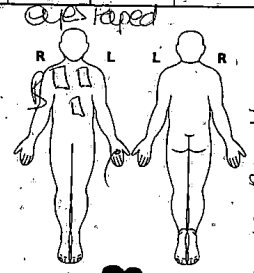
POSITION	Supine	Prone	Lithotomy	Right Lateral	Left Lateral	Jack Knife	Other
RIGHT ARM	At Side		On Board		Across Chest		Other
LEFT ARM	At Side		On Board		Across Chest		Other
PATIENT PROTECTION SAFETY	Padding	Pillows	Gel Pad	Warming blanket			Other

TOURNIQUET			
Arm	Leg	Ankle	
Right	Left		
Inflated Hrs	Pressure MM		
Deflated Hrs			

SWAB/NEEDLE/INSTRUMENT COUNT	
Correct	
Incorrect	
Appropriate Action Taken	

PATIENT MONITORING

PERIPHERAL IVI	X
IV CANNULAE	C
ECG ELECTRODES	☐
C.V.P.	Z
ARTERIAL LINE	A
BP/MANUAL/AUTO	B
PULSE OXIMETER	•
DIATHERMY PLATE	P
SKIN CONDITION	S



IMPLANTS	BATCH NO.	SERIAL NO.

SPECIMENS TAKEN

POST-OPERATIVE CARE PLAN

TIME OF ARRIVAL IN RECOVERY ROOM

HOSPITAL/CATHEDRAL
SOUTHERN GENERAL
10 NEWFIELDS STREET
GLASGOW G41 2AH
TEL: 01024561245

TIME	HOURS	MINS	0	5	10	15	20	25	30	45	60	75	90
RESPIRATORY FUNCTION													
Able to breath and cough		= 2	2										
Maintain own airway		= 1											
Airway needs support		= 0											
COLOUR													
Pink & Warm		= 2	2										
Pale, Dusky, Peripheral cyanosis		= 1											
Central Cyanosis, cold		= 0											
RECOVERY OF NEURO-MUSCULAR FUNCTION													
5 secs Head lift		= 2	2										
Moves limbs		= 1											
No move (Except Resp)		= 0											
CONSCIOUS LEVEL													
Responds to command		= 2	2										
Responds		= 1											
No Response		= 0											
BLOOD PRESSURE													
Within 30mmHg of Pre-op		= 2	106										
30-90 from Pre-op		= 1	64										
< 70mmHg		= 0											
O2 SATURATION			100										
PULSE			68										
RESPIRATION RATE			12										
TEMPERATURE (If indicated)			36.9										

CONSCIOUS LEVEL	AIRWAY	OXYGEN	I.V. ACCESS	DRAINS	WOUND
A). Unconscious	A). Guedel	A). Hudson Mask	A). Infusion Running	A). Patent	A). Dry
B). Conscious/Drowsy	B). E.T.T.	B). Nasal Cannulae	B). Capped Can in SITU	B). Blocked	B). Slight Staining
C). Conscious/ Responsive	C). Laryngeal Mask	C). Other	C). Discontinued	C). Drainage in Mls	C). Heavy Staining
D). Ventilated				D). Irrigation	

WOUND DRAINAGE	SKIN CLOSURE	DRESSING
LA INFILTRATION	URINARY CATHETER	PACKS IN SITU

POST OPERATIVE CARE PLAN

SPECIFIC PRE/INTRA & POST OPERATIVE COMPLICATIONS

COMPLICATION	ACTION TAKEN	OUTCOME
Chest pain -	IV Omeprazole 20mg daily	pain settled
	Tubac cannula	Left arm.
Knee pain	Morphine 10mg S/C @ 11:25	pain score ↓/4
Wound oozing	blue swabs / crepe applied	dressing

NURSING REPORT

POST RECOVERY TRANSFER REPORT

CONSCIOUS LEVEL	OXYGEN	I.V. ACCESS	DRAINS	PAIN LEVEL
A). Unconscious B). Conscious/Drowsy C). Conscious/ Responsive D). Ventilated	A). Hudson Mask B). Nasal Canulae C). Other	A). Infusion Running B). Capped Can in SITU C). Discontinued	A). Patent B). Blocked C). Drainage in Mls D). Irrigation	A). Pain free B). Mild C). Moderate D). Severe
WOUND	**CVP MONITORING**	**ARTERIAL LINE**	**SYRINGE PCA PUMP**	**WATERLOW SCORE PLEASE SPECIFY AMOUNT**
A). Dry B). Slight Staining C). Heavy Staining	A). Commenced B). In Situ	A). Commenced B). In Situ	A). Commenced B). In Situ	A). 10+ At Risk B). 15+ High Risk C). 20+ Very High Risk

RECOVERY NURSES SIGNATURE

0099099 MG\080198

POST OPERATIVE CARE PLAN

TIME OF ARRIVAL IN RECOVERY ROOM 1000

OPERATION

Lt: Removal patella Wiring (R) knee
Paracetamol 1g IV and Diclofenac 75mg slow-IV

WOUND DRAINAGE	SKIN CLOSURE	DRESSING
LA INFILTRATION	**URINARY CATHETER**	**PACKS IN SITU**
30ml 0.5% Chirocaine		

CONSCIOUS LEVEL	AIRWAY	OXYGEN	I.V. ACCESS	DRAINS	WOUND
A). Unconscious B). Conscious/Drowsy C). Conscious/ Responsive D). Ventilated	A). Guedel B). E.T.T. C). Laryngeal Mask Air	A). Hudson Mask B). Nasal Canulae C). Other	A). Infusion Running B). Capped Can in SITU C). Discontinued	A). Patent B). Blocked C). Drainage in Mls D). Irrigation	A). Dry B). Slight Staining C). Heavy Staining

TIME HOURS	MINS	0	5	10	15	20	25	30	45	60	75	90
RESPIRATORY FUNCTION												
Able to breath and cough	= 2	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maintain own airway	= 1											
Airway needs support	= 0											
COLOUR												
Pink & Warm	= 2	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pale, Dusky, Peripheral cyanosis	= 1											
Central Cyanosis, cold	= 0											
RECOVERY OF NEURO-MUSCULAR FUNCTION												
5 secs Head lift	= 2	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Moves limbs	= 1											
No move (Except Resp)	= 0											
CONSCIOUS LEVEL												
Responds to command	= 2	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Responds	= 1											
No Response	= 0											
BLOOD PRESSURE												
Within 30mmHg of Pre-op	= 2	120	29	127	120	125	110	112	102	109	116	106
30-90 from Pre-op	= 1	86	84	74	88	90	74	71	82	64	68	61
< 70mmHg	= 0											
O_2 SATURATION		99	100	100	100	100	100	100	99	100	100	100
PULSE		77	69	77	70	69	71	72	74	70	69	69
RESPIRATION RATE		15		12	9	10	11		11		10	
TEMPERATURE (if indicated)		37.0										

Post Operative Care

Time																			
SpO_2																			
O_2 L/min																			
Resp Rate																			
Airway																			
180																			
160																			
140																			
120																			
100																			
80																			
60																			
40																			
20																			
Temperature																			
CVP																			
Wound site																			
Affected limb pulse: +ve/-ve																			
Circulation Satisfactory:S Poor: P																			
Sensation +ve/-ve																			
Movement +ve/-ve																			
Sedation/Pain score																			
Nausea score																			

Time	Fluid in	Urine	Drain 1	Drain 2	Blood results / Drug given

Additional nursing comments

Waterlow Score [ ] **Intervention required:**

Discharge criteria met:	Discharged to:	Recovery Nurse name:	Ward Nurse name:
Yes ☐ NO ☐	Ward:	.....	.....
Comments:	HDU ☐ ITU ☐	Signature:	Signature:

VI MEDICAL ILLUSTRATION • ANAES • 1995/6.05 C 638 Cat. No. 0163149

South Glasgow Hospitals

ANAESTHETIC RECORD

JHH V4')

NHS Greater Glasgow and Clyde

Date: 03 / 05 / X

Pre-op instructions:

* TAKE OWN ATENOLOL &
OMEPRAZOLE !

Fast for: AM ~~Lunchtime~~ ~~PM~~ ~~List~~

Patient details

Name:

Unit No:

Address: SG00940779
CATHERINE HONEYMAN
10 MELVILLE STREET
GLASGOW
G41 2LN

DOB 01/02/1949
CHI 0102496145

Proposed operation: Rt. MAT Rt RK

Assessor: A KAPOOR

Ward: 5

Pre-op assessment

Previous G.A.'s: 081 ✓

CVS: HR BP / fluid TBP

Resp: CXR 14/7, 01/01/[illegible] TTA

Other (specify): Hg OK

GA Y, previous LMA + FNR.

Mo ✓ Mp ✓ (R) C1
L ✓ Pp ✓ (R) ANT on Omept.

Fasted:

Reflux:

Drugs:
Paroxetine
BB
ARB
STATIN
Atenolol
Omeprazole
Ty Mol
GTN

N.S.A.I.D's OK

Allergies:
NKDA

BMI:

Weight (kg): 91kg 160 cm

Airway:

Dentition:

Investigations

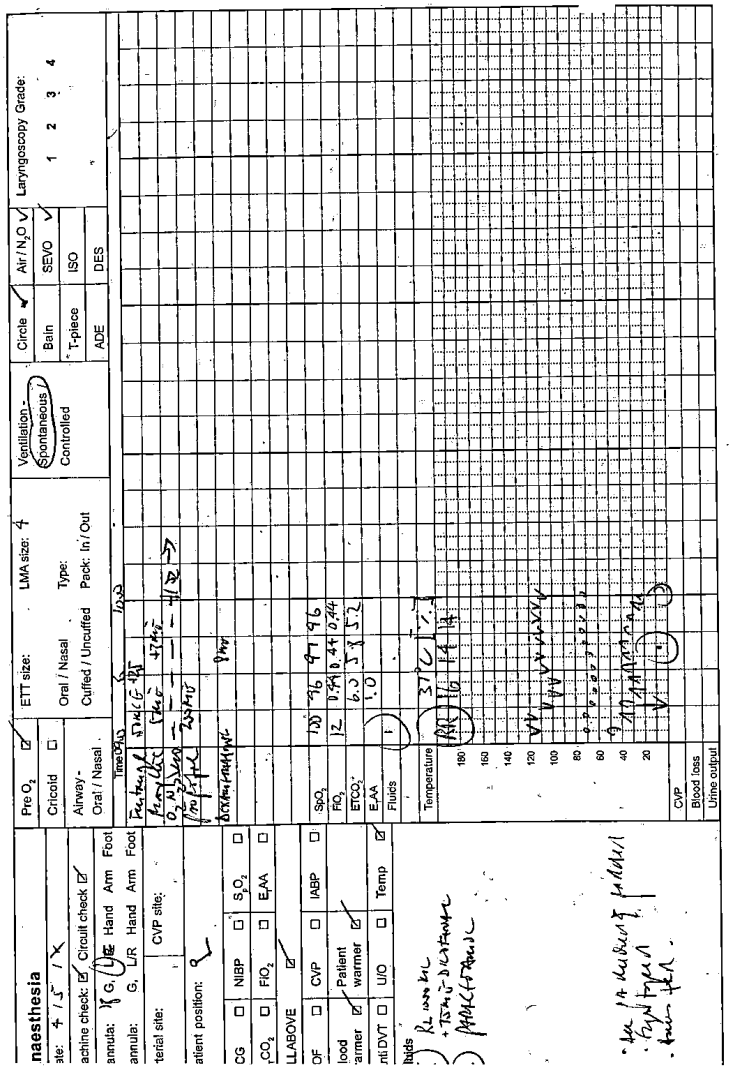
Na+: 138	Hb: 123	Others (specify):	
K+: 4.3	WCC: 6.4		
C1-:	Plts: 274		
HCO3-:	ECG: SR 44		
Urea: 6.9	CXR:		
Creat: 70	Glucose		

Urgency		A.S.A.
Elective	☑	1
Scheduled	☐	2
Urgent	☐	3
Emergency	☐	4
		5

Comments / ~~Warnings~~

Material risks explained ☐

GA + FNB. 1st, NT down, failure expl.



Regional Anaesthesia / Other Procedures / Comments

LA infiltration by surgeon

Operation Details Theatre: 02

Operation as proposed on page 1 ☑ Reversal given: Yes ☐ No ☐

Anaesthetist(s): A. Wojcik	Surgeon(s): MACLEAN
Named Consultant:	Discussed with Consultant: Yes ☐ No ☐

Post Operative Care

A. **Oxygen** 4 L/min OR % for hours OR SpO_2 % on air.

B. **Routine observations / postoperative care as per local protocol.**

C. **Appropriate DVT prophylaxis prescribed:** Yes ☑ N/A ☐

D. **Anti-emetic given:** Yes ☑ No ☐ **Drug given:**

E. **Analgesia:** CARAFX

I.V. Morphine as per Recovery Algorithm - Sign			OR	I.V. Fentanyl as per Recovery Algorithm - Sign		
2 mg bolus - Time:	Sign:	Witness:		40 µm bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:		40 µm bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:		40 µm bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:		40 µm bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:		40 µm bolus - Time:	Sign:	Witness:

F. **Post Operative fluids** fluid plt chart.

Fluid (additive)	Volume	Rate	Sign	Start	Lot No.	Initials
~~Marcaine~~	~~200~~	~~200~~	~~Mac~~			

Post operative notes / Comments

POST OPERATIVE CARE PLAN

SPECIFIC PRE/INTRA & POST OPERATIVE COMPLICATIONS

COMPLICATION	ACTION TAKEN	OUTCOME
Pain score 8/10 @ 17:15	2mg bolus of Morphine sulphate given from PCA	Pain not diminished.
Pain score 8/10 @ 17:23	2mg bolus of Morphine Sulphate from PCA given @ 17:23	Pain score rises to 10/10.
Pain score 10/10 @ 17:28	Anaesthetist Dr Harper given 3mg bolus of Morphine Sulphate.	Pain score still 10/10.
Pain score 10/10 @ 17:38	Dr Harper given 3mg bolus of Morphine Sulphate.	Pain score 7/10 @ 18:00. Pain score 5 or 6/10 @ 18:10

NURSING REPORT

- PCA connected to patient & explained.
- 4L O_2 whilst connected to PCA.
- Analgesia & anti-emetics prescribed on drugs kardex.
- Fluids prescribed on fluid prescription chart.
- Skin unmarked & pressure areas intact
- CSM good.

- Discharge criteria met.

POST RECOVERY TRANSFER REPORT

CONSCIOUS LEVEL	OXYGEN	I.V. ACCESS	DRAINS	PAIN LEVEL
A) Unconscious B) Conscious/Drowsy C) Conscious/ Responsive D) Ventilated	A) Hudson Mask B). Nasal Canulae C). Other 4L O_2	A) Infusion Running B). Capped Can in SITU C). Discontinued	A). Patent B). Blocked C). Drainage in Mls D). Irrigation	A). Pain free B). Mild C). Moderate D). Severe
WOUND	**CVP MONITORING**	**ARTERIAL LINE**	**SYRINGE PCA PUMP**	**WATERLOW SCORE PLEASE SPECIFY AMOUNT**
Staining Staining	A). Commenced B). In Situ	A). Commenced B). In Situ	A) Commenced B). In Situ	A). 10+ At Risk B) 15+ High Risk C). 20+ Very High Risk

ES SIGNATURE B. Flannagan (SN)

TURE

GH99 0000999 MG\080198

THEATRE CARE PLAN

Theatre:

NHS Greater Glasgow and Clyde

WARD NAMED P	DATE
PATIENT'S NAME	WARD
D.O.B	UNIT NO.

HOWIEMAN, CATHERINE
CHI 0104961485
Date of Birth
Sex F Age/Sex

PROPOSED OPERATION

BP 135/80 Pulse 80 Sats 98% Temp 36.6

PRE-OPERATIVE CARE PLAN		
1. Obtain and record baseline vital signs		
2. Note and record significant past medical history		
3. Capped/loose teeth-number and position		
4. Pre-op teaching carried out		
Pre-op investigations carried out i.e. ECG, Bloods, X Rays		
6. Skin shave and preparation required		
7. Remove make-up nail, varnish		
8. Remove prosthesis, dentures, hair pieces, lenses		
9. Jewellery - Tape rings		
10. Ensure patient has fasted (No less than 6 hours)	M.dnight	
11. Identification band	✓	
12. Empty bladder/catheter in situ	✓	
13. Naso-Gastric Tube	NR	
14. Blood in Theatre Fridge	NR	
15. Case Notes	✓	
Drugs kardex/charts	✓	
X Rays	✓	
16. Theatre gown & cap	✓	
17. Premedication given		
18. Consent form signed		
19. Allergies	NKDA	
20. Waterlow Score		
RELEVANT INFORMATION	**Ward Nurse Sig**	**Theatre Nurse Sig**

HTN,
Depression,
GORD, OA,

NAMED NURSES

NAMED ANAESTHETIC NURSE

NAMED THEATRE NURSE

NAMED RECOVERY NURSE

INTRA-OPERATIVE CARE PLAN

TIME OF ARRIVAL IN ANAESTHETIC ROOM ☐☐☐☐

THEATRE	ANAESTHETIST	ASSISTANT	ANAES. NURSE

TIME OF ARRIVAL IN THEATRE ☐☐☐☐

SURGEON	IST ASSISTANT	SCRUB NURSE	CIRCUL. NURSE

I.V. INFUSIONS		ARTERIAL LINE		CVP-MONITORING	
COMMENCED	IN-SITU	COMMENCED	IN-SITU	COMMENCED	IN-SITU

AIRWAY MANAGEMENT		SYRINGE/PCA PUMP			
		COMMENCED	IN-SITU	COMMENCED	IN-SITU
GENERAL ETT	☐				
LM	☐				
FM	☐				

SPINAL		COMMENCED	IN-SITU	COMMENCED	IN-SITU
EPIDURAL					
REGIONAL					
LOCAL					

POSITION	Supine	Prone	Lithotomy	Right Lateral	Left Lateral	Jack Knife	Other
RIGHT ARM	At Side		On Board		Across Chest		Other
LEFT ARM	At Side		On Board		Across Chest		Other
PATIENT PROTECTION SAFETY	Padding		Pillows	Gel Pad	Warming blanket		Other

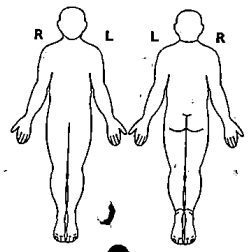
TOURNIQUET			SWAB/NEEDLE/INSTRUMENT COUNT	
Arm	Leg	Ankle	Correct	
Right	Left		Incorrect	
Inflated Hrs	Pressure	MM	Appropriate Action Taken	
Deflated Hrs				

IMPLANTS	BATCH NO.	SERIAL NO.

SPECIMENS TAKEN

PATIENT MONITORING

PERIPHERAL IVI	X
IV CANNULAE	C
ECG ELECTRODES	☐
C.V.P.	Z
ARTERIAL LINE	A
BP/MANUAL/AUTO	B
PULSE OXIMETER	•
DIATHERMY PLATE	Δ
SKIN CONDITION	S



POST OPERATIVE CARE PLAN

TIME OF ARRIVAL IN RECOVERY ROOM ☐☐☐☐

OPERATION

WOUND DRAINAGE / **SKIN CLOSURE** / **DRESSING**

LA INFILTRATION / **URINARY CATHETER** / **PACKS IN SITU**

CONSCIOUS LEVEL	AIRWAY	OXYGEN	I.V. ACCESS	DRAINS	WOUND
A). Unconscious B). Conscious/Drowsy C). Conscious/ Responsive D). Ventilated	A). Guedel B). E.T.T. C). Laryngeal Mask	A). Hudson Mask B). Nasal Canulae C). Other	A). Infusion Running B). Capped Can in SITU C). Discontinued	A). Patent B). Blocked C). Drainage in Mls D). Irrigation	A). Dry B). Slight Staining C). Heavy Staining

TIME														
RESPIRATORY FUNCTION	HOURS	0	5	10	15	20	25	30	45	60	75	90		
	MINS													
Able to breath and cough	= 2													
Maintain own airway	= 1													
Airway needs support	= 0													
COLOUR														
Pink & Warm	= 2													
Pale, Dusky, Peripheral cyanosis	= 1													
Central Cyanosis, cold	= 0													
RECOVERY OF NEURO-MUSCULAR FUNCTION														
5 secs Head lift	= 2													
moves limbs	= 1													
No move (Except Resp)	= 0													
CONSCIOUS LEVEL														
Responds to command	= 2													
Responds	= 1													
No Response	= 0													
BLOOD PRESSURE														
Within 30mmHg of Pre-op	= 2													
30-90 from Pre-op	= 1													
<70mmHg	= 0													
O2 SATURATION														
PULSE														
RESPIRATION RATE														
TEMPERATURE (If indicated)														

POST OPERATIVE CARE PLAN

SPECIFIC PRE/INTRA & POST OPERATIVE COMPLICATIONS

COMPLICATION	ACTION TAKEN	OUTCOME

NURSING REPORT

POST RECOVERY TRANSFER REPORT

CONSCIOUS LEVEL	OXYGEN	I.V. ACCESS	DRAINS	PAIN LEVEL
A). Unconscious B). Conscious/Drowsy C). Conscious/ Responsive D). Ventilated	A). Hudson Mask B). Nasal Canulae C). Other	A). Infusion Running B). Capped Can in SITU C). Discontinued	A). Patent B). Blocked C). Drainage in MIs D). Irrigation	A). Pain free B). Mild C). Moderate D). Severe
WOUND	**CVP MONITORING**	**ARTERIAL LINE**	**SYRINGE PCA PUMP**	**WATERLOW SCORE PLEASE SPECIFY AMOUNT**
A). Dry B). Slight Staining C). Heavy Staining	A). Commenced B). In Situ	A). Commenced B). In Situ	A). Commenced B). In Situ	A). 10+ At Risk B). 15+ High Risk C). 20+ Very High Risk

RECOVERY NURSES SIGNATURE

WARD NURSE SIGNATURE

0099099 MG\080198 69

THEATRE CARE PLAN

Theatre:

NHS Greater Glasgow and Clyde

WARD NAMED NURSE Rachel Sinkala	DATE 14/7/10
PATIENT'S NAME Catherine Honeyman	WARD 1
D.O.B. 01/02/49	UNIT NO. SG 0094/0779

PROPOSED OPERATION

PRE-OPERATIVE CARE PLAN		
1. Obtain and record baseline vital signs	T 36.2 P 75 R 17	BP 99/56 SpO2 97%
2. Note and record significant past medical history	✓	✓
3. Capped/loose teeth-number and position	✓	✓
4. Pre-op teaching carried out	✓	✓
5. Pre-op investigations carried out i.e. ECG, Bloods, X Rays	✓	✓
6. Skin shave and preparation required	✓	✓
7. Remove make-up nail, varnish	✓	✓
8. Remove prosthesis, dentures, hair pieces, lenses	✓	✓ own teeth
9. Jewellery - Tape rings	✓	✓
10. Ensure patient has fasted (No less than 6 hours)	FFMN	✓
11. Identification band	✓	✓
12. Empty bladder/catheter in situ	✓	✓
13. Naso-Gastric Tube	NA	—
14. Blood in Theatre Fridge Jehovahs Witness	No	Noted. + Form
15. Case Notes	✓	✓
Drugs kardex/charts	✓	✓
X Rays Pacs	✓	✓
16. Theatre gown & cap	✓	✓
17. Premedication given Nil ordered		—
18. Consent form signed	✗ NO	✓
19. Allergies NKDA		None Known
20. Waterlow Score	15	

RELEVANT INFORMATION

Angina, hypertension, bilat knee replacements, ? infected (R) knee

Ward Nurse Sig: (R)Dale

Theatre Nurse Sig: Eleggatt

NAMED NURSES

NAMED ANAESTHETIC NURSE S/N Eleggatt | SN Flannagan

NAMED THEATRE NURSE SN Hachlan

NAMED RECOVERY NURSE

INTRA-OPERATIVE CARE PLAN

TIME OF ARRIVAL IN ANAESTHETIC ROOM ☐☐☐☐

THEATRE	ANAESTHETIST	ASSISTANT	ANAES. NURSE

TIME OF ARRIVAL IN THEATRE ☐☐☐☐

SURGEON	IST ASSISTANT	SCRUB NURSE	CIRCUL. NURSE

I.V. INFUSIONS		ARTERIAL LINE		CVP-MONITORING	
COMMENCED	IN-SITU	COMMENCED	IN-SITU	COMMENCED	IN-SITU

AIRWAY MANAGEMENT	SYRINGE/PCA PUMP			
	COMMENCED	IN-SITU	COMMENCED	IN-SITU
GENERAL ETT ☐				
LM ☐				
FM ☐				

	COMMENCED	IN-SITU	COMMENCED	IN-SITU
SPINAL				
EPIDURAL				
REGIONAL				
LOCAL				

POSITION	Supine	Prone	Lithotomy	Right Lateral	Left Lateral	Jack Knife	Other
RIGHT ARM	At Side		On Board		Across Chest		Other
LEFT ARM	At Side		On Board		Across Chest		Other
PATIENT PROTECTION SAFETY	Padding		Pillows		Gel Pad	Warming blanket	Other

TOURNIQUET		
Arm	Leg	Ankle
Right	Left	
Inflated Hrs	Pressure	MM
Deflated Hrs		

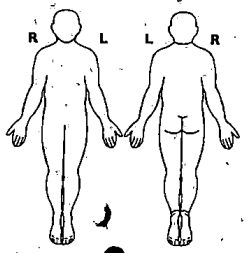
SWAB/NEEDLE/INSTRUMENT COUNT	
Correct	
Incorrect	
Appropriate Action Taken	

IMPLANTS	BATCH NO.	SERIAL NO.

SPECIMENS TAKEN

PATIENT MONITORING

PERIPHERAL IVI	X
IV CANNULAE	C
ECG ELECTRODES	☐
C.V.P.	Z
ARTERIAL LINE	A
BP/MANUAL/AUTO	B
PULSE OXIMETER	•
DIATHERMY PLATE	Δ
SKIN CONDITION	S



POST OPERATIVE CARE PLAN

TIME OF ARRIVAL IN RECOVERY ROOM ☐☐☐☐

OPERATION

WOUND DRAINAGE																		
SKIN CLOSURE																		
LA INFILTRATION																		
URINARY CATHETER																		
PACKS IN SITU																		
CONSCIOUS LEVEL	**AIRWAY**	**OXYGEN**	**I.V. ACCESS**	**DRAINS**	**WOUND DRESSING**													
A). Unconscious B). Conscious/Drowsy C). Conscious/ Responsive D). Ventilated	A). Guedel B). E.T.T. C). Laryngeal Mask	A). Hudson Mask B). Nasal Cannulae C). Other	A). Infusion Running B). Capped Can in SITU C). Discontinued	A). Patent B). Blocked C). Drainage in Mt. D). Irrigation	A). Dry B). Slight Staining C). Heavy Staining													

TIME	HOURS	MINS	0	5	10	15	20	25	30	45	60	75	90
RESPIRATORY FUNCTION													
Able to breath and cough		= 2											
Maintain own airway		= 1											
Airway needs support		= 0											
COLOUR													
Pink & Warm		= 2											
Pale, Dusky, Peripheral cyanosis		= 1											
Central Cyanosis, cold		= 0											
RECOVERY OF NEURO-MUSCULAR FUNCTION													
5 secs Head lift		= 2											
Moves limbs		= 1											
No move (Except Resp)		= 0											
CONSCIOUS LEVEL													
Responds to command		= 2											
Responds		= 1											
No Response		= 0											
BLOOD PRESSURE													
Within 30mmHg of Pre-op		= 2											
30-90 from Pre-op		= 1											
< 70mmHg		= 0											
O2 SATURATION													
PULSE													
RESPIRATION RATE													
TEMPERATURE (If indicated)													

POST OPERATIVE CARE PLAN

SPECIFIC PRE/INTRA & POST OPERATIVE COMPLICATIONS

COMPLICATION	ACTION TAKEN	OUTCOME
Pain score 8/10 @ 17:15	2mg bolus of Morphine sulphate given from PCA	Pain not diminished
Pain score 8/10 @ 17:23	2mg bolus of Morphine Sulphate from PCA given @ 17:23	Pain score risen to 10/10
Pain score 10/10 @ 17:28	Anaesthetist Dr Harper given 3mg bolus of Morphine Sulphate.	Pain score still 10/10.
Pain score 10/10 @ 17:38	Dr Harper given 3mg bolus of Morphine Sulphate.	Pain score 7/10 @ 18:00. Pain score 5 or 6/10 @ 18:10

NURSING REPORT

- PCA connected to patient & explained.
- 4L O2 whilst connected to PCA.
- Analgesia & anti-emetics prescribed on drugs kardex.
- Fluids prescribed on fluid prescription chart.
- Skin unmarked & pressure areas intact
- CSM good.

- Discharge criteria met.

POST RECOVERY TRANSFER REPORT

CONSCIOUS LEVEL	OXYGEN	I.V. ACCESS	DRAINS	PAIN LEVEL
A). Unconscious B). Conscious/Drowsy (C). Conscious/ Responsive D). Ventilated	(A). Hudson Mask B). Nasal Canulae C). Other 4L O2	(A). Infusion Running B). Capped Can in SITU C). Discontinued	A). Patent B). Blocked C). Drainage in Mls D). Irrigation	A). Pain free (B). Mild C). Moderate D). Severe
WOUND	**CVP MONITORING**	**ARTERIAL LINE**	**SYRINGE PCA PUMP**	**WATERLOW SCORE PLEASE SPECIFY AMOUNT**
(A). Dry B). Slight Staining C). Heavy Staining	A). Commenced B). In Situ	A). Commenced B). In Situ	(A). Commenced B). In Situ	A). 10+ At Risk (B). 15+ High Risk C). 20+ Very High Risk

RECOVERY NURSES SIGNATURE B. Flannagan (SN)

0099099 MG\080198 66

THEATRE CARE PLAN

Theatre:

NHS Greater Glasgow and Clyde

WARD NAMED NURSE Rachel Sinkala	**DATE** 14/7/10
PATIENT'S NAME Catherine Honeyman	**WARD** 1
D.O.B. 01/02/49	**UNIT NO.** SG 0094 0779

PROPOSED OPERATION

PRE-OPERATIVE CARE PLAN		
1. Obtain and record baseline vital signs	T 36² P 75 R 17	BP 92/56 SpO 97%
2. Note and record significant past medical history	✓	✓
3. Capped/loose teeth-number and position	✓	✓
4. Pre-op teaching carried out	✓	✓
5. Pre-op investigations carried out i.e. ECG, Bloods, X Rays	✓	✓
6. Skin shave and preparation required	✓	✓
7. Remove make-up nail, varnish	✓	✓
8. Remove prosthesis, dentures, hair pieces, lenses	✓	✓ own teeth
9. Jewellery - Tape rings	✓	✓
10. Ensure patient has fasted (No less than 6 hours)	FFMN	✓
11. Identification band	✓	✓
12. Empty bladder/catheter in situ	✓	✓
13. Naso-Gastric Tube	NA	—
14. Blood in Theatre Fridge Jehovahs Witness	No	Noted + Form
15. Case Notes	✓	✓
Drugs kardex/charts	✓	✓
X Rays Pacs	✓	✓
16. Theatre gown & cap	✓	✓
17. Premedication given Nil ordered		—
18. Consent form signed	✓ NO	✓
19. Allergies NKDA		None Known
20. Waterlow Score	15	
RELEVANT INFORMATION	**Ward Nurse Sig**	**Theatre Nurse Sig**
Angina, hypertension, bilat knee replacements, ? infected (R) knee	RDale	Eloggatt

NAMED NURSES

NAMED ANAESTHETIC NURSE S/N Eloggatt | SN Flannagan

NAMED THEATRE NURSE SN Maclean

TRA-OPERATIVE CARE PLAN

IME OF ARRIVAL IN ANAESTHETIC ROOM 1510

TIME OF ARRIVAL IN THEATRE 1528

THEATRE	ANAESTHETIST	ASSISTANT	ANAES. NURSE
Ortho 3	[illegible]	Dr McConnell	Leggatt

SURGEON	1ST ASSISTANT	SCRUB NURSE	CIRCUL. NURSE
Patric	Comax	SN MacNeill	NN Hunter

I.V. INFUSIONS		ARTERIAL LINE		CVP-MONITORING	
OMMENCED	IN-SITU	COMMENCED	IN-SITU	COMMENCED	IN-SITU
✓					

AIRWAY MANAGEMENT	SYRINGE/PCA PUMP			
GENERAL ETT Size 8.0 ✓	COMMENCED	IN-SITU	COMMENCED	IN-SITU
LM ☐				
FM ☐				

PINAL				
PIDURAL	COMMENCED	IN-SITU	COMMENCED	IN-SITU
EGIONAL				
OCAL				

POSITION	Supine	Prone	Lithotomy	Right Lateral	Left Lateral	Jack Knife	Other
RIGHT ARM	At Side		On Board		Across Chest		Other
LEFT ARM	At Side		On Board		Across Chest		Other
PATIENT PROTECTION SAFETY	Padding	Pillows		Gel Pad		Warming blanket	Other

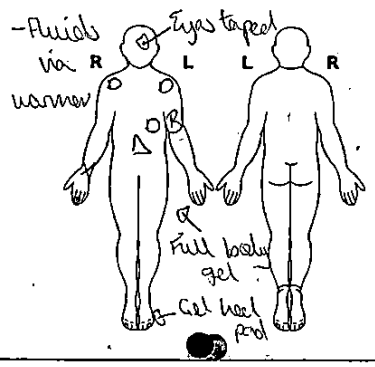
TOURNIQUET			SWAB/NEEDLE/INSTRUMENT COUNT	
Arm	Leg ✓	Ankle	Correct	
Right ✓	Left		Incorrect	
Inflated 15:35 Hrs	Pressure 300 MM		Appropriate Action Taken	
Deflated 16:30 Hrs				

IMPLANTS	BATCH NO.	SERIAL NO.

SPECIMENS TAKEN ① Fluid right knee ② Synovium right knee

TIENT MONITORING

PERIPHERAL IVI	X
IV CANNULAE	C
ECG ELECTRODES	☐
V.P.	Z
ARTERIAL LINE	A
BP/MANUAL/AUTO	B
PULSE OXIMETER	•
DIATHERMY PLATE	Δ
SKIN CONDITION	S



TIME	HOURS	MINS	10	15	20	25	30	45	60	75	90
RESPIRATORY FUNCTION											
Able to breath and cough											
Maintain own airway	= 2	2									
Airway needs support	= 1	2									
COLOUR	= 0										
Pink & Warm											
Pale, Dusky, Peripheral cyanosis	= 1	2									
Central Cyanosis, cold	= 2	2									
RECOVERY OF NEURO-MUSCULAR FUNCTION	= 0										
5 secs Head lift											
Moves limbs	= 2	2									
No move (Except Resp)	= 1	2									
CONSCIOUS LEVEL	= 0										
Responds to command											
Responds	= 2	2									
No Response	= 1	2									
BLOOD PRESSURE	= 0										
Within 30mmHg of Pre-op											
30-90 from Pre-op	= 2	113									
< 70mmHg	= 1	67	113								
O₂ SATURATION	= 0		64								
PULSE		79	88								
		93%	95%								
RESPIRATION RATE											

NURSING REPORT

POST RECOVERY TRANSFER REPORT

CONSCIOUS LEVEL	OXYGEN	I.V. ACCESS	DRAINS	PAIN LEVEL
A). Unconscious B). Conscious/Drowsy C). Conscious/ Responsive D). Ventilated	A). Hudson Mask B). Nasal Canulae C). Other	A). Infusion Running B). Capped Can in SITU C). Discontinued	A). Patent B). Blocked C). Drainage in Mls D). Irrigation	A). Pain free B). Mild C). Moderate D). Severe
WOUND	**CVP MONITORING**	**ARTERIAL LINE**	**SYRINGE PCA PUMP**	**WATERLOW SCORE PLEASE SPECIFY AMOUNT**
A). Dry B). Slight Staining C). Heavy Staining	A). Commenced B). In Situ	A). Commenced B). In Situ	A). Commenced B). In Situ	A). 10+ At Risk B). 15+ High Risk C). 20+ Very High Risk

RECOVERY NURSES SIGNATURE

H99 0099099 MC\080198

POST OPERATIVE CARE PLAN

TIME OF ARRIVAL IN RECOVERY ROOM 1655

OPERATION

GA:- Washout of right total knee replacement

WOUND DRAINAGE	SKIN CLOSURE	DRESSING
	2/0 Monocryl	Opsite knee Pack of pain-relief
LA INFILTRATION	**URINARY CATHETER**	**PACKS IN SITU**

CONSCIOUS LEVEL	AIRWAY	OXYGEN	I.V. ACCESS	DRAINS	WOUND
A). Unconscious B). Conscious/Drowsy C). Conscious/ Responsive D). Ventilated	A). Guedel B). E.T.T. C). Laryngeal Mask	A). Hudson Mask B). Nasal Canulae C). Other	A). Infusion Running B). Capped Can in SITU C). Discontinued	A). Patent B). Blocked C). Drainage in Mls D). Irrigation	A). Dry B). Slight Staining C). Heavy Staining

TIME HOURS	MINS	0	5	10	15	20	25	30	35/45	40/60	45/75	55/90
RESPIRATORY FUNCTION												
Able to breath and cough	= 2	2	2	2	2	2	2	2	2	2	2	2
Maintain own airway	= 1											
Airway needs support	= 0											
COLOUR												
Pink & Warm	= 2	2	2	2	2	2	2	2	2	2	2	2
Pale, Dusky, Peripheral cyanosis	= 1											
Central Cyanosis, cold	= 0											
RECOVERY OF NEURO-MUSCULAR FUNCTION												
5 secs Head lift	= 2	2	2	2	2	2	2	2	2	2	2	2
Moves limbs	= 1											
No move (Except Resp)	= 0											
CONSCIOUS LEVEL												
Responds to command	= 2	2	2	2	2	2	2	2	2	2	2	2
Responds	= 1											
No Response	= 0											
BLOOD PRESSURE												
Within 30mmHg of Pre-op	= 2	124	157	149	114	122	127	121	159	110	129	114
30-90 from Pre-op	= 1	61	72	73	71	71	73	67	60	60	64	63
< 70mmHg	= 0											
O_2 SATURATION		100%	100%	98%	99%	99%	100%	100%	100%	100%	100%	99%
PULSE		80	81	79	79	79	80	87	78	79	78	78
RESPIRATION RATE		18			18			16			12	
TEMPERATURE (If indicated)		36.6										

POST OPERATIVE CARE PLAN

SPECIFIC PRE/INTRA & POST OPERATIVE COMPLICATIONS

COMPLICATION	ACTION TAKEN	OUTCOME

NURSING REPORT

POST RECOVERY TRANSFER REPORT

CONSCIOUS LEVEL	OXYGEN	I.V. ACCESS	DRAINS	PAIN LEVEL
A). Unconscious B). Conscious/Drowsy C). Conscious/ Responsive D). Ventilated	A). Hudson Mask B). Nasal Canulae C). Other	A). Infusion Running B). Capped Can in SITU C). Discontinued	A). Patent B). Blocked C). Drainage in Mls D). Irrigation	A). Pain free B). Mild C). Moderate D). Severe
WOUND	**CVP MONITORING**	**ARTERIAL LINE**	**SYRINGE PCA PUMP**	**WATERLOW SCORE PLEASE SPECIFY AMOUNT**
A). Dry B). Slight Staining C). Heavy Staining	A). Commenced B). In Situ	A). Commenced B). In Situ	A). Commenced B). In Situ	A). 10+ At Risk B). 15+ High Risk C). 20+ Very High Risk

RECOVERY NURSES SIGNATURE

499 0099099 MG\080198

THEATRE CARE PLAN

Theatre:

NHS Greater Glasgow and Clyde

WARD NAMED P	HONEYMAN, CATHERINE		**DATE**
PATIENT'S NAM	SG00940779 01/02/49 CHI: 0102496145 F		**WARD**
D.O.B.	Date_____ Time ____ Spec./Sig._____		**UNIT NO.** /

PROPOSED OPERATION

BP 132/72 Pulse 80 Sats 98% Temp 36.4

PRE-OPERATIVE CARE PLAN		
1. Obtain and record baseline vital signs		
2. Note and record significant past medical history		
3. Capped/loose teeth-number and position		
4. Pre-op teaching carried out		
Pre-op investigations carried out i.e. ECG, Bloods, X Rays		
6. Skin shave and preparation required		
7. Remove make-up nail, varnish		
8. Remove prosthesis, dentures, hair pieces, lenses		
9. Jewellery - Tape rings		
10. Ensure patient has fasted (No less than 6 hours)	Midnight	
11. Identification band	✓	
12. Empty bladder/catheter in situ	✓	
13. Naso-Gastric Tube	NR	
14. Blood in Theatre Fridge	NR	
15. Case Notes	✓	
Drugs kardex/charts	✓	
X Rays	✓	
16. Theatre gown & cap	✓	
17. Premedication given		
18. Consent form signed		
19. Allergies	NKDA	
20. Waterlow Score		
RELEVANT INFORMATION	**Ward Nurse Sig**	**Theatre Nurse Sig**

HTN, Depression, GORD, OA,

NAMED NURSES

NAMED ANAESTHETIC NURSE

NAMED THEATRE NURSE

NAMED RECOVERY NURSE

INTRA-OPERATIVE CARE PLAN

TIME OF ARRIVAL IN ANAESTHETIC ROOM ☐☐☐☐

THEATRE	ANAESTHETIST	ASSISTANT	ANAES. NURSE

TIME OF ARRIVAL IN THEATRE ☐☐☐☐

SURGEON	1ST ASSISTANT	SCRUB NURSE	CIRCUL. NURSE

I.V. INFUSIONS		ARTERIAL LINE		CVP-MONITORING	
COMMENCED	IN-SITU	COMMENCED	IN-SITU	COMMENCED	IN-SITU

AIRWAY MANAGEMENT	SYRINGE/PCA PUMP			
GENERAL ETT ☐	COMMENCED	IN-SITU	COMMENCED	IN-SITU
LM ☐				
FM ☐				

SPINAL				
EPIDURAL	COMMENCED	IN-SITU	COMMENCED	IN-SITU
REGIONAL				
LOCAL				

POSITION	Supine	Prone	Lithotomy	Right Lateral	Left Lateral	Jack Knife	Other
RIGHT ARM	At Side		On Board		Across Chest		Other
LEFT ARM	At Side		On Board		Across Chest		Other
PATIENT PROTECTION SAFETY	Padding		Pillows	Gel Pad	Warming blanket		Other

TOURNIQUET		
Arm	Leg	Ankle
Right	Left	
Inflated Hrs	Pressure MM	
Deflated Hrs		

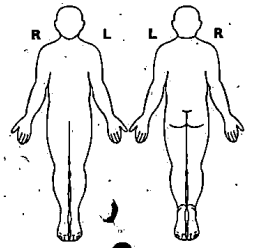
SWAB/NEEDLE/INSTRUMENT COUNT	
Correct	
Incorrect	
Appropriate Action Taken	

IMPLANTS	BATCH NO.	SERIAL NO.

SPECIMENS TAKEN

PATIENT MONITORING

PERIPHERAL IVI	X
IV CANNULAE	C
ECG ELECTRODES	☐
C.V.P.	Z
ARTERIAL LINE	A
BP/MANUAL/AUTO	B
PULSE OXIMETER	•
DIATHERMY PLATE	Δ
SKIN CONDITION	S



POST OPERATIVE CARE PLAN

TIME OF ARRIVAL IN RECOVERY ROOM ☐☐☐☐

OPERATION

WOUND DRAINAGE | **SKIN CLOSURE** | **DRESSING**

LA INFILTRATION | **URINARY CATHETER** | **PACKS IN SITU**

CONSCIOUS LEVEL	AIRWAY	OXYGEN	I.V. ACCESS	DRAINS	WOUND
A). Unconscious	A). Guedel	A). Hudson Mask	A). Infusion Running	A). Patent	A). Dry
B). Conscious/Drowsy	B). E.T.T.	B). Nasal Cannulae	B). Capped Can In SITU	B). Blocked	B). Slight Staining
C). Conscious/ Responsive	C). Laryngeal Mask	C). Other	C). Discontinued	C). Drainage in Mls	C). Heavy Staining
D). Ventilated				D). Irrigation	

TIME																		
HOURS																		
RESPIRATORY FUNCTION	MINS	0	5	10	15	20	25	30	45	60	75	90						
Able to breath and cough	= 2																	
Maintain own airway	= 1																	
Airway needs support	= 0																	
COLOUR																		
Pink & Warm	= 2																	
Pale, Dusky, Peripheral cyanosis	= 1																	
Central Cyanosis, cold	= 0																	
RECOVERY OF NEURO-MUSCULAR FUNCTION																		
5 secs Head lift	= 2																	
Moves limbs	= 1																	
No move (Except Resp)	= 0																	
CONSCIOUS LEVEL																		
Responds to command	= 2																	
Responds	= 1																	
No Response	= 0																	
BLOOD PRESSURE																		
Within 30mmHg of Pre-op	= 2																	
30-90 from Pre-op	= 1																	
< 70mmHg	= 0																	
02 SATURATION																		
PULSE																		
RESPIRATION RATE																		
TEMPERATURE (If Indicated)																		

Post Operative Care

Time																
SpO_2																
O_2 L/min																
Resp Rate																
Airway																
180																
160																
140																
120																
100																
80																
60																
40																
20																
Temperature																
CVP																
Wound site																
Affected limb pulse: +ve/-ve																
Circulation Satisfactory:S Poor: P																
Sensation +ve/-ve																
Movement +ve/-ve																
Sedation/Pain score																
Nausea score																

Time	Fluid in	Urine	Drain 1	Drain 2	Blood results / Drug given

Additional nursing comments

Waterlow Score ☐ **Intervention required:**

Discharge criteria met:	Discharged to:	Recovery Nurse name:	Ward Nurse name:
Yes ☐ NO ☐	Ward:	.....	.....
Comments:	HDU ☐ ITU ☐	Signature:	Signature: .....

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IC 638 Cat. No. 0163149

South Glasgow Hospitals

ANAESTHETIC RECORD

NHS Greater Glasgow and Clyde

Date: 14/7/10

Pre-op instructions:

Fast for: AM Lunchtime PM List

Patient details

Name: Catherine HONEYMAN

Unit No:.

Address:

DOB 1.2.49 61

Proposed operation:

Assessor: HARPER

Ward:

Pre-op assessment

Previous G.A.'s: TKR 5yrs ago (GAs) Patella ten. Jan 10 Exercise April 10

CVS: HR BP /

Resp: ↓ EF

Other (specify): Angina. — housing — occ'ly at rest. But worse recently.

JEHOVAH'S WITNESS

Fasted: H₂O pre. 11

Reflux: Omeprazole

°CNS / °EP

Drugs:
Atenolol
Statin
Bf
Tramadol
Omeprazole
Fluoxetine
Aspirin
GTN Spray

N.S.A.I.D's

Allergies: NKDA

BMI:

Weight (kg):

Airway:

Dentition: Crowned. (2) / /

Investigations

Na+: 136	Hb: 127	Others (specify):	
K+: 4.7	WCC: 13.9		
Cl-:	Plts: 291		
HCO3-:	ECG: ORL ESR 3		
Urea: 1.8	CXR:		
Creat: 76	Glucose		

Urgency		A.S.A.
Elective	☐	1
Scheduled	☐	2
Urgent	☐	3
Emergency	☐	4
		5

Comments / Warnings

CRP 12.

Material risks explained ☐

Anaesthesia

Date: 14/7/10

Machine check: ☐ Circuit check ☐

Cannula: 20 G, L/R (Hand) Arm Foot

Cannula: G, L/R Hand Arm Foot

Arterial site: | CVP site:

Patient position: Supine.

ECG ☐ | NIBP ☐ | S_pO_2 ☐

E_TCO_2 ☐ | FiO_2 ☐ | E_AA ☐

ALLABOVE ☐

TOF ☐ | CVP ☐ | IABP ☐

Blood warmer ☐ | Patient warmer ☐

Anti DVT ☐ | U/O ☐ | Temp ☐

Fluids

(1) RL 1000.

(2) RL 1000.

Pre O_2 ☐

Cricoid ☐

Airway - Oral / Nasal

ETT size: 6.0 | LMA size:

Oral / Nasal | Type:

Cuffed / Uncuffed | Pack: In / Out

Ventilation - Spontaneous / (Controlled)

(Circle) | (Air) / N_2O

Bain | (SEVO)

T-piece | ISO

ADE | DES

Laryngoscopy Grade: 1 (2) 3 4

Time	1500	1530	1600	1630
Propofol		150		
Alfentanil		1000		
Rocuronium		40		
Midazolam			5	5
Ephedrine	6	6		
Metaraminol	0.5			
Paracetamol				1g
Keppra				250
SpO_2		100	100 98	97 97
FiO_2		04	04 0.43	045 045
$ETCO_2$		5.5	4.6 4.3	4.3 4.3
E_AA		1.0	1.5 1.9	2.0 2.3
Fluids		(1)	(2)	(3)
TOF			2	4
Temperature				

160 140 120 100 80 60 40 20

CVP

Blood loss

Urine output

Regional Anaesthesia / L..... Procedures / Comments

Operation Details 1+D (R) infected knee ± washout

Theatre: Orbis 3

Operation as proposed on page 1 ☐ | Reversal given: Yes ☐ No ☐

Anaesthetist(s): Hargett/McConnell | Surgeon(s): Mohammad/Lomax

Named Consultant: | Discussed with Consultant: Yes ☐ No ☐

Post Operative Care

A. Oxygen 4 L/min **OR** % for (24) hours **OR SpO_2** % on air.

B. Routine observations / postoperative care as per local protocol.

C. Appropriate DVT prophylaxis prescribed: Yes ☐ N/A ☐

D. Anti-emetic given: Yes ☐ No ☐ Drug given:

E. Analgesia:

I.V. Morphine as per Recovery Algorithm - Sign

2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:

OR

I.V. Fentanyl as per Recovery Algorithm - Sign

40 µm bolus - Time:	Sign:	Witness:
40 µm bolus - Time:	Sign:	Witness:
40 µm bolus - Time:	Sign:	Witness:
40 µm bolus - Time:	Sign:	Witness:

F. Post Operative fluids:

Fluid (additive)	Volume	Rate	Sign	Start	Lot No.	Initials
		See chart.				

Post operative notes / Comments

SOUTHERN GENERAL HOSPITAL

OPERATION REPORT 8

Catherine Hanagman
SG0094077Q

SURGEONS: Lomax / Mohammed DATE: 14/7/10

OPERATION PERFORMED

Cemented R TKR

FINDINGS & PROCEDURE

Copious amount of pus in joint
Debridement
Lavage 6L Saline + Chlorhexidine
Close layers with PDS
1 Vicryl
1 Nylon to skin
Mepore, wool, crepe.
Post Belo knee applied for ankle
- check XR satis

Post op - Start Rocephin 2g qds + Gent as per micro advice

TISSUE SENT FOR PATHALOGICAL EXAMINATION

Signature.....

POST OPERATIVE CARE PLAN

SPECIFIC PRE/INTRA & POST OPERATIVE COMPLICATIONS

COMPLICATION	ACTION TAKEN	OUTCOME

NURSING REPORT

POST RECOVERY TRANSFER REPORT

CONSCIOUS LEVEL	OXYGEN	I.V. ACCESS	DRAINS	PAIN LEVEL
A). Unconscious B). Conscious/Drowsy C). Conscious/ Responsive D). Ventilated	A). Hudson Mask B). Nasal Canulae C). Other	A). Infusion Running B). Capped Can in SITU C). Discontinued	A). Patent B). Blocked C). Drainage in Mls D). Irrigation	A). Pain free B). Mild C). Moderate D). Severe
WOUND	**CVP MONITORING**	**ARTERIAL LINE**	**SYRINGE PCA PUMP**	**WATERLOW SCORE PLEASE SPECIFY AMOUNT**
A). Dry B). Slight Staining C). Heavy Staining	A). Commenced B). In Situ	A). Commenced B). In Situ	A). Commenced B). In Situ	A). 10+ At Risk B). 15+ High Risk C). 20+ Very High Risk

RECOVERY NURSES SIGNATURE

WARD NURSE SIGNATURE

H99 0099099 MG\080198

THEATRE CARE PLAN

NHS Greater Glasgow and Clyde

The

WA

PA SG0094077 9 DOB 7.2.49

D.C CHI:0102496145

DATE 28.3.11

WARD 3

UNIT NO.

PROPOSED OPERATION

PRE-OPERATIVE CARE PLAN		
1. Obtain and record baseline vital signs		
2. Note and record significant past medical history		
3. (Capped) loose teeth-number and position x1 top front	✓	
4. Pre-op teaching carried out		
5. Pre-op investigations carried out i.e. ECG, Bloods, X Rays		
6. Skin shave and preparation required		
7. Remove make-up nail, varnish	✓	
8. Remove prosthesis, dentures, hair pieces, lenses	NA	
9. Jewellery - Tape rings		
10. Ensure patient has fasted (No less than 6 hours)	✓ 12MN.	
11. Identification band	✓	
12. Empty bladder/catheter in situ	✓	
13. Naso-Gastric Tube	N/A	
14. Blood in Theatre Fridge	N/A	
15. Case Notes	A+E card,	
Drugs kardex/charts		
X Rays		
16. Theatre gown & cap	✓	
17. Premedication given		
18. Consent form signed	✓	
19. Allergies	None known.	
20. Waterlow Score	7	
RELEVANT INFORMATION	**Ward Nurse Sig**	**Theatre Nurse Sig**

NAMED NURSES

NAMED ANAESTHETIC NURSE

NAMED THEATRE NURSE

NAMED RECOVERY NURSE

INTRA-OPERATIVE CARE PLAN

TIME OF ARRIVAL IN ANAESTHETIC ROOM ☐☐☐☐

THEATRE	ANAESTHETIST	ASSISTANT	ANAES. NURSE

TIME OF ARRIVAL IN THEATRE ☐☐☐☐

SURGEON	1ST ASSISTANT	SCRUB NURSE	CIRCUL. NURSE

I.V. INFUSIONS

COMMENCED	IN-SITU

AIRWAY MANAGEMENT

GENERAL	ETT	☐
	LM	☐
	FM	☐
SPINAL		
EPIDURAL		
REGIONAL		
LOCAL		

ARTERIAL LINE

COMMENCED	IN-SITU

SYRINGE/PCA PUMP

COMMENCED	IN-SITU

COMMENCED	IN-SITU

CVP-MONITORING

COMMENCED	IN-SITU

COMMENCED	IN-SITU

COMMENCED	IN-SITU

PATIENT MONITORING

PERIPHERAL IVI	X
IV CANNULAE	C
ECG ELECTRODES	□
C.V.P.	Z
ARTERIAL LINE	A
BP/MANUAL/AUTO	B
PULSE OXIMETER	•
DIATHERMY PLATE	Δ
SKIN CONDITION	S

POSITION	Supine	Prone	Lithotomy	Right Lateral	Left Lateral	Jack Knife	Other
RIGHT ARM	At Side		On Board		Across Chest		Other
LEFT ARM	At Side		On Board		Across Chest		Other
PATIENT PROTECTION SAFETY	Padding		Pillows		Gel Pad	Warming Blanket	Other

TOURNIQUET				
Arm	•	Leg	•	Ankle •
Right	•		Left	•
Inflated	Hrs		Pressure	MM
Deflated	Hrs			

SWAB/NEEDLE/INSTRUMENT COUNT	
Correct	
Incorrect	

Appropriate Action Taken	

IMPLANTS	BATCH NO.	SERIAL NO.

SPECIMENS TAKEN

POST OPERATIVE CARE PLAN

TIME OF ARRIVAL IN RECOVERY ROOM ☐☐☐☐

OPERATION

WOUND DRAINAGE	SKIN CLOSURE	DRESSING
LA INFILTRATION	**URINARY CATHETER**	**PACKS IN SITU**

CONSCIOUS LEVEL	AIRWAY	OXYGEN	I.V. ACCESS	DRAINS	WOUND
A). Unconscious B). Conscious/Drowsy C). Conscious/ Responsive D). Ventilated	A). Guedel B). E.T.T. C). Laryngeal Mask	A). Hudson Mask B). Nasal Canulae C). Other	A). Infusion Running B). Capped Can in SITU C). Discontinued	A). Patent B). Blocked C). Drainage in Mls D). Irrigation	A). Dry B). Slight Staining C). Heavy Staining

TIME HOURS	MINS	0	5	10	15	20	25	30	45	60	75	90
RESPIRATORY FUNCTION												
Able to breath and cough	= 2											
Maintain own airway	= 1											
Airway needs support	= 0											
COLOUR												
Pink & Warm	= 2											
Pale, Dusky, Peripheral cyanosis	= 1											
Central Cyanosis, cold	= 0											
RECOVERY OF NEURO-MUSCULAR FUNCTION												
5 secs Head lift	= 2											
Moves limbs	= 1											
No move (Except Resp)	= 0											
CONSCIOUS LEVEL												
Responds to command	= 2											
Responds	= 1											
No Response	= 0											
BLOOD PRESSURE												
Within 30mmHg of Pre-op	= 2											
30-90 from Pre-op	= 1											
< 70mmHg	= 0											
O2 SATURATION												
PULSE												
RESPIRATION RATE												
TEMPERATURE (If indicated)												

Patient Agreement to Investigation or Treatment

NHS Greater Glasgow and Clyde

CONSENT FORM

PATIENT DETAILS (OR PRE-PRINTED LABEL)

Hospital/Clinic/GP Practice ..... GRI .....

Patient's surname/family name : ..... HONEYMAN .....

Patient's first name(s): ..... CATHERINE .....

Date of Birth 01/02/49 Gender: Male ☐ Female ☑

NHS/ CHI Number SC 946779

Special requirements (e.g. other language/communication method) .....

.....

Responsible practitioner: .....

Job title: .....

STATEMENT FOR PRACTITIONER

(to be filled in by practitioner with appropriate knowledge of proposed procedure- see guidance notes)

Describe proposed operation, investigation or other treatment.
Where appropriate specify site or side: (WRITTEN IN FULL)

Aspiration Rt knee
under L/A +/- proceed to
washout under GA

I have explained the procedure named on this form to the patient in terms which, in my judgement, are suited to their understanding. In particular, I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any significant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure (please specify major procedures above).

Signature of practitioner: .....

Name/Designation (Print) ..... O. Alfakeeh .....

Date 27/03/2011

STATEMENT TO BE COMPLETED BY PATIENT/PARENT*

(* parental responsibility for a minor without capacity)

You should read this form and the notes below carefully. If there is anything you do not understand ask the Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

I understand

- the procedure, important risks and appropriate alternatives which have been explained to me by the practitioner named on this form.
- that a practitioner other than the practitioner who has been providing treatment so far might carry out the procedure.
- that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to the medical treatment proposed, to safeguard or promote physical or mental health.
- That examination for the purpose of teaching will not be undertaken without my consent.

I have been told about additional procedures which may become necessary during treatment. I have listed below **any procedures which I do NOT wish to be carried out without further discussion.**

I agree -

- to the administration of an anaesthetic or to sedation if required.
- to the procedure named on this form
- to the emergency administration of blood or blood products

Additionally you have to agree or disagree the following:-	**Agree**	**Disagree**
that information and/or images kept in records may be used anonymously for education, audit, and research with appropriate ethical approval, to mprove the quality of patient care.	☐	☐
that surplus tissue or other biological material not essential for my diagnosis or future treatment may be used for medical education and ethically approved medical research.	☐	☐

PATIENT REFUSAL FOR BLOOD PRODUCTS

Please sign here if you refuse to consent to the emergency administration of blood or blood products. Even if this results in death.

Signature: ..... Date ...../...../.....

Practitioner Signature: ..... Date ...../...../.....

PATIENT/PARENT* AGREEMENT FOR TREATMENT

Signature: X Catherine Honeyman Date 27/3/2014

Name (Print): .....

Acute Services Division

NHS
Greater Glasgow and Clyde

Pre-operative marking Checklist for Surgery that can be performed on either side of the body

The operating surgeon should mark the intended site of operation prior to the patient leaving the ward area and before any pre-medication is given.

Affix lab Patient's Hospital Date of B SG00940779 HONEYMAN, CATHERINE 10 MELVILLE STREET GLASGOW 01/02/1949 G41 2LN CHI 0102496145	Date of procedure: 27/3/11 Proposed procedure: aspiration of Rt knee.

Check 1 - Ward

To be checked by ward staff before patient goes to theatre.

• Check the patient's identity • The mark is inspected and confirmed against the patient's supporting documentation. • Check reliable imaging will accompany the patient to theatre	Signed: Ahalid Print name: Alatrick Ward: 3 Date: 28 / 3 / 11

Check 2 - Theatre/ Anaesthetic Room

To be checked by operating surgeon in the theatre department, prior to anaesthesia.

• The mark is inspected and checked against the patient's supporting documentation	Signed: Print name:

Check 3 - Theatre Nurse

The senior theatre nurse must ensure that the surgical, anaesthetic and theatre team involved in the intended operative procedure pause prior to commencement of surgery to verbally confirm the following points:

• Presence of the correct patient • Marking of the correct site • Procedure to be performed	Signed: Print name:

If an error is identified during the pre-operative checks, the surgeon in charge should assess the situation, review documentation and either return the patient to the ward or note and sign a decision to proceed at risk in the box below.

Signed	Date

Pre-operative marking recommendations

The National Patient Safety Agency (NPSA) and the Royal College of Surgeons of England (RCSEng) strongly recommend pre-operative marking to indicate clearly the intended site for elective surgical procedures.

1. How to mark?

An indelible marker pen should be used. The mark should be clear such as an arrow that extends to, or near to, the incision site and remain visible after the application of skin preparation. It is desirable that the mark should also remain visible after the application of theatre drapes. Some procedures may require marking to assist with the surgery (plastic surgery) and therefore this may be more extensive.

2. Where to mark?

Surgical operations involving side (laterality) should be marked at, or near, the intended incision (some surgeons do not like the mark to be exactly where the actual incision will be). For digits on the hand and foot the mark should extend to the correct specific digit. Ascertain intended surgical site from reliable documentation and images.

3. Who makes the mark?

Marking should be undertaken by the operating surgeon, or nominated deputy, who will be present in the operating theatre at the time of the patient's procedure.

4. With whom?

The process of pre-operative marking of the intended site should involve the patient and/or family ıembers/significant others wherever possible.

5. Time and place

The surgical site should be marked on the ward or day care area prior to patient transfer to the operating theatre. Marking should take place before pre-medication.

6. Verify

The surgical site mark should subsequently be checked against reliable documentation to confirm it is (a) correctly located, and (b) still legible. This checking should occur at each transfer of the patient's care and end with a final verification prior to commencement of surgery. All team members should be involved in checking the mark.

SOUTHERN GENERAL HOSPITAL NHS TRUST

OPERATION REPORT 8

CATHERINE HONEYMAN
SG 940779
01/02/1949

SURGEONS: O. Al-Fakayh DATE: 27/3/11

OPERATION PERFORMED Aspiration & Right knee under L/A

FINDINGS & PROCEDURE Right knee prepared & draped. 10ml 1% lignocaine used
≈ 100 ml of haematoma drained.
Sample sent for G staing & C&S.
Mepore dressing

Postop)

- ✱ No Antibiotics, till further instructions from team ✱
- Chase specimen results.
- Bloods tomorrow (FBC, CRP)

OMAR

TISSUE SENT FOR PATHOLOGICAL EXAMINATION

Signature.....

POST OPERATIVE CARE PLAN

SPECIFIC PRE/INTRA & POST OPERATIVE COMPLICATIONS

COMPLICATION	ACTION TAKEN	OUTCOME

NURSING REPORT

POST RECOVERY TRANSFER REPORT

CONSCIOUS LEVEL	OXYGEN	I.V. ACCESS	DRAINS	PAIN LEVEL
A). Unconscious B). Conscious/Drowsy C). Conscious/ Responsive D). Ventilated	A). Hudson Mask B). Nasal Canulae C). Other	A). Infusion Running B). Capped Can in SITU C). Discontinued	A). Patent B). Blocked C). Drainage in Mls D). Irrigation	A). Pain free B). Mild C). Moderate D). Severe
WOUND	**CVP MONITORING**	**ARTERIAL LINE**	**SYRINGE PCA PUMP**	**WATERLOW SCORE PLEASE SPECIFY AMOUNT**
A). Dry B). Slight Staining C). Heavy Staining	A). Commenced B). In Situ	A). Commenced B). In Situ	A). Commenced B). In Situ	A). 10+ At Risk B). 15+ High Risk C). 20+ Very High Risk

RECOVERY NURSES SIGNATURE

WARD NURSE SIGNATURE

99 0099099 MG\080198

THEATRE CARE PLAN

Theatre:

NHS Greater Glasgow and Clyde

WARD NAMED NURSE	DATE 27/3/11
PATIENT'S NAME CATHERINE Honeyman	WARD 3
D.O.B. 1/2/49	UNIT NO. SS 00 94 07 79

PROPOSED OPERATION

PRE-OPERATIVE CARE PLAN		
1. Obtain and record baseline vital signs	BP 105/69 P 95 T 35.5 O2 98 resps 17	
2. Note and record significant past medical history		✓
3. Capped/loose teeth-number and position	crown / top front	✓
4. Pre-op teaching carried out	—	✓
5. Pre-op investigations carried out i.e. ECG, Bloods, X Rays		✓
6. Skin shave and preparation required	—	✓
7. Remove make-up nail, varnish	—	✓
8. Remove prosthesis, dentures, hair pieces, lenses	—	✓
9. Jewellery - Tape rings	—	✓
10. Ensure patient has fasted (No less than 6 hours)	0830 water/tea	✓
11. Identification band	✓	✓
12. Empty bladder/catheter in situ	✓	NO
13. Naso-Gastric Tube	NA	NO
14. Blood in Theatre Fridge	NA	NO
15. Case Notes	Consultant	✓
Drugs kardex/charts	✓	✓
X Rays	RIS	✓
16. Theatre gown & cap	✓	✓
17. Premedication given	—	NO
18. Consent form signed	✓	✓
19. Allergies	~~ACTAZ~~ voltarol	✓
20. Waterlow Score	<10	

RELEVANT INFORMATION	Ward Nurse Sig	Theatre Nurse Sig
angina arthritis		

NAMED NURSES

NAMED ANAESTHETIC NURSE O'Sullivan

NAMED THEATRE NURSE

TRA-OPERATIVE CARE PLAN

ME OF ARRIVAL IN ANAESTHETIC ROOM 1011 8

THEATRE	ANAESTHETIST	ASSISTANT	ANAES. NURSE
2nd			D Sullivan

TIME OF ARRIVAL IN THEATRE 1102

SURGEON	1ST ASSISTANT	SCRUB NURSE	CIRCUL. NURSE
Mr Keogh			Marshall

POSITION										
	Supine	Prone	Lithotomy	Right Lateral	Left Lateral	Jack Knife	Other
RIGHT ARM		At Side	On Board	Across Chest			Other
LEFT ARM		At Side	On Board	Across Chest			Other
PATIENT PROTECTION SAFETY		Padding	Pillows	Gel Pad	Warming blanket		Other

TOURNIQUET				
Arm	•	Leg	•	Ankle •
Right	•		Left	•
Inflated	Hrs		Pressure	MM
Deflated	Hrs			

SWAB/NEEDLE/INSTRUMENT COUNT	
Correct	
Incorrect	
Appropriate Action Taken	

IMPLANTS	BATCH NO.	SERIAL NO.

SPECIMENS TAKEN

I.V. INFUSIONS		ARTERIAL LINE		CVP-MONITORING	
COMMENCED	IN-SITU	COMMENCED	IN-SITU	COMMENCED	IN-SITU
	1829				

AIRWAY MANAGEMENT	SYRINGE/PCA PUMP		
	COMMENCED	IN-SITU	COMMENCED
GENERAL ETT ☐			
LM ☐			
FM ☐			

SPINAL			
EPIDURAL			
REGIONAL			
LOCAL			

PATIENT MONITORING

- PERIPHERAL IV — X
- IV CANNULAE — C
- ECG ELECTRODES — ☐
- C.V.P. — Z
- ARTERIAL LINE — A
- BP/MANUAL/AUTO — B
- PULSE OXIMETER — •
- DIATHERMY PLATE — Δ
- SKIN CONDITION — S

POST OPERATIVE CARE PLAN

TIME OF ARRIVAL IN RECOVERY ROOM ☐☐☐☐

OPERATION

LA: Aspiration of Right knee joint.

WOUND DRAINAGE	SKIN CLOSURE	DRESSING
		Allevyn
LA INFILTRATION	**URINARY CATHETER**	**PACKS IN SITU**
Xylocain 1% 20mls		1

CONSCIOUS LEVEL	AIRWAY	OXYGEN	I.V. ACCESS	DRAINS	WOUND
A). Unconscious	A). Guedel	A). Hudson Mask	A). Infusion Running	A). Patent	A). Dry
B). Conscious/Drowsy	B). E.T.T.	B). Nasal Canulae	B). Capped Can in SITU	B). Blocked	B). Slight Staining
C). Conscious/ Responsive	C). Laryngeal Mask	C). Other	C). Discontinued	C). Drainage in Mls	C). Heavy Staining
D). Ventilated				D). Irrigation	

TIME HOURS	MINS	0	5	10	15	20	25	30	45	60	75	90
RESPIRATORY FUNCTION												
Able to breath and cough	= 2											
Maintain own airway	= 1											
Airway needs support	= 0											
COLOUR												
Pink & Warm	= 2											
Pale, Dusky, Peripheral cyanosis	= 1											
Central Cyanosis, cold	= 0											
RECOVERY OF NEURO-MUSCULAR FUNCTION												
5 secs Head lift	= 2											
Moves limbs	= 1											
No move (Except Resp)	= 0											
CONSCIOUS LEVEL												
Responds to command	= 2											
Responds	= 1											
No Response	= 0											
BLOOD PRESSURE		108	102	103	102	107	105	107				
Within 30mmHg of Pre-op	= 2	69	60	71	41	58	58	15				
30-90 from Pre-op	= 1											
< 70mmHg	= 0											
O2 SATURATION		97	96	98	97	97	97	97				
PULSE		86	84	82	87	82	82	87				
RESPIRATION RATE												

Total - 6mg Morphine Bolus . 120mcg Fentanyl I.V .

POST OPERATIVE CARE PLAN

SPECIFIC PRE/INTRA & POST OPERATIVE COMPLICATIONS

COMPLICATION	ACTION TAKEN	OUTCOME
* Sats ↓ (88) @16[30]	Hudson mask removed +	O_2 titrated down @17[20]
Pain Score 5/10 @18[15]	Trauma mask applied	Hudson mask reapplied @17[45]
"Numb ach" described @17[05]	15L	sats 99-100% @18[05]
Pain on arrival into recovery (9/10)	• 2mg Morphine Bolus given @16[36]	• 1g Paracetamol given I.V @16[40] • 2mg Morphine given @17[36]
40mcg Fentanyl given I.V @17[16]	• 2mg Morphine Bolus given @16[51]	
	• 40mcg Fentanyl given @17[16].	
Nausea @16[40]	• 4mg Ondansetron given @16[45].	Nausea passed @17[15]
Jehovah's Witness - Healthcare advance directive in C/notes		Please check prior to prescribing IV fluids *

NURSING REPORT

- Blood Gas taken @ 16[30] - Anaesthetist reviewed results
- Hb to be checked @ 20[00] - monitor dressing
- On 4L/min oxygen via hudson mask whilst on PCA (*See above*)
- Post-op analgesia and anti-emetics prescribed as per Kardex
- I.V fluids running + prescribed
- Wound - Dressing Dry + intact @ 16[50] + 17[15]
- Monitor BP + U/O closely - further IV fluids after consideration of both (MAP'S)
- Arterial line insitu - transducing well in recovery
- CSM - satisfactory @ 17[30] Temp - Warm to touch Perfusion - satisfactory @ 17[30]
- For Supportive treatment for chest pain rather than blood if anaemic
- Post-op instructions in surgeons note

POST RECOVERY TRANSFER REPORT

CONSCIOUS LEVEL	OXYGEN	I.V. ACCESS	DRAINS	PAIN LEVEL
A). Unconscious B). Conscious/Drowsy C). Conscious/ Responsive D). Ventilated	A). Hudson Mask B). Nasal Canulae C). Other	A). Infusion Running B). Capped Can in SITU C). Discontinued	A). Patent B). Blocked C). Drainage in Mls D). Irrigation	A). Pain free B). Mild C). Moderate D). Severe
WOUND	**CVP MONITORING**	**ARTERIAL LINE**	**SYRINGE PCA PUMP**	**WATERLOW SCORE PLEASE SPECIFY AMOUNT**
A). Dry B). Slight Staining C). Heavy Staining	A). Commenced B). In Situ	A). Commenced B). In Situ	A). Commenced B). In Situ	A). 10+ At Risk B). 15+ High Risk C). 20+ Very High Risk 16

RECOVERY NURSES SIGNATURE M. M. R.

0099099 MG\080198

THEATRE CARE PLAN

Theatre:

* Patient is a Jehovah's Witness *

NHS Greater Glasgow and Clyde

WARD NAMED NURSE	DATE 31-3-14
PATIENT'S NAME Catherine Honeyman	WARD 2
D.O.B. 01-02-49	UNIT NO. 00940779

PROPOSED OPERATION

BP-133/79 - HR-109 Resp-16 SATS-98 RA

PRE-OPERATIVE CARE PLAN - Temp - 37.7		
1. Obtain and record baseline vital signs	✓	✓
2. Note and record significant past medical history	✓ @ site	✓ R/ lat knee
3. Capped/loose teeth-number and position	capped tooth	✓
4. Pre-op teaching carried out	✓	✓
5. Pre-op investigations carried out i.e. ECG, Bloods, X Rays	✓	✓
6. Skin shave and preparation required	✓	site marked
7. Remove make-up nail, varnish	none	no
8. Remove prosthesis, dentures, hair pieces, lenses	none	no
9. Jewellery - Tape rings	none	no
10. Ensure patient has fasted (No less than 6 hours)	Since PM	✓
11. Identification band	✓	✓
12. Empty bladder/catheter in situ	✓	✓
13. Naso-Gastric Tube	n/a	n/a
14. Blood in Theatre Fridge	n/a	no
15. Case Notes	✓	✓
Drugs kardex/charts	✓	✓
X Rays	on system	✓
16. Theatre gown & cap	✓	✓
17. Premedication given	none	no
18. Consent form signed	✓	✓
19. Allergies	NKDA	Nil known.
20. Waterlow Score	9	10
RELEVANT INFORMATION	**Ward Nurse Sig**	**Theatre Nurse Sig**

NAMED NURSES

NAMED ANAESTHETIC NURSE SN T. Buchanan

NAMED THEATRE NURSE

INTRA-OPERATIVE CARE PLAN

TIME OF ARRIVAL IN ANAESTHETIC ROOM 1438

THEATRE	ANAESTHETIST	ASSISTANT	ANAES. NURSE
Ortho 2	Hosie	Finn	Buchanan

TIME OF ARRIVAL IN THEATRE 1504

SURGEON	IST ASSISTANT	SCRUB NURSE	CIRCUL. NURSE
Hullin	Gulhane	Glover	Rowan

I.V. INFUSIONS		ARTERIAL LINE		CVP-MONITORING	
COMMENCED	IN-SITU	COMMENCED	IN-SITU	COMMENCED	IN-SITU
✓ 16g		✓ left radial			
AIRWAY MANAGEMENT		**SYRINGE/PCA PUMP**			
GENERAL ETT 8 ☑		COMMENCED	IN-SITU	COMMENCED	IN-SITU
LM ☐					
FM ☐					
SPINAL					
EPIDURAL		COMMENCED	IN-SITU	COMMENCED	IN-SITU
REGIONAL femoral + Sciatic ✓					
LOCAL					

POSITION	(Supine)	Prone	Lithotomy	Right Lateral	Left Lateral	Jack Knife	Other
RIGHT ARM	At Side		(On Board)		Across Chest		Other
LEFT ARM	At Side		(On Board)		Across Chest		Other
PATIENT PROTECTION SAFETY	(Padding)		(Pillows)		(Gel Pad)	(Warming blanket)	Other

TOURNIQUET		
Arm	(Leg)	Ankle
(Right)	Left	
Inflated 150 Hrs	Pressure 300. MM	
Deflated Hrs		

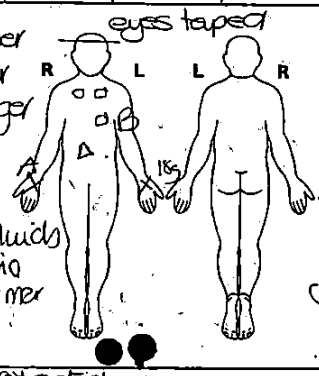
SWAB/NEEDLE/INSTRUMENT COUNT	
Correct	
Incorrect	
Appropriate Action Taken	

IMPLANTS	BATCH NO.	SERIAL NO.
Attach to patient's record 66017569 Palacos R+G 2x40 LOT 71934262 2014-10 Heraeus Medical GmbH, 61273 Wehrheim, Germany		

SPECIMENS TAKEN

PATIENT MONITORING

PERIPHERAL IVI	X
IV CANNULAE	C
ECG ELECTRODES	☐
C.V.P.	Z
ARTERIAL LINE	A
BP/MANUAL/AUTO	B
PULSE OXIMETER	•
DIATHERMY PLATE	Δ
SKIN CONDITION	S



Pressure areas :- protected

POST OPERATIVE CARE PLAN

TIME OF ARRIVAL IN RECOVERY ROOM ☐☐☐

OPERATION Continuation sheet (3 of 3)

HONEYMAN, CATHERINE
SGO0940779 01/02/49
CHI: 0102496145 F
Date Spec./Stg. Time

| | | | | |

POST OPERATIVE CARE PLAN

TIME OF ARRIVAL IN RECOVERY ROOM

OPERATION

HONEYMAN, CATHERINE
SG00940729 01/02/49
CHI: 0102490145 F
Date Time
Spec./Sig.

Continuation sheet (31/3/11)

WC

SKIN CLOSURE	DRESSING
LA INFILTRATION	URINARY CATHETER / PACKS IN SITU

CONSCIOUS LEVEL	AIRWAY	OXYGEN	I.V. ACCESS	DRAINS	WOUND
A). Unconscious B). Conscious/Drowsy C). Conscious/ Responsive D). Ventilated	A). Guedel B). E.T.T. C). Laryngeal Mask	A). Hudson Mask B). Nasal Canulae C). Other	A). Infusion Running B). Capped Can in SITU C). Discontinued	A). Patent B). Blocked C). Drainage in Mls D). Irrigation	A). Dry B). Slight Staining C). Heavy Staining

TIME HOURS	MINS	0	5	10	15	20	25	30	45	60	75	90
		17	30	35	40	17	45	50	55	60	65	70
RESPIRATORY FUNCTION												
Able to breath and cough	= 2	2	2	2	2	2	2	2	2	2		
Maintain own airway	= 1											
Airway needs support	= 0											
COLOUR												
Pink & Warm	= 2	2	2	2	2	2	2	2	2	2		
Pale, Dusky, Peripheral cyanosis	= 1											
Central Cyanosis, cold	= 0											
RECOVERY OF NEURO-MUSCULAR FUNCTION												
5 secs Head lift	= 2	2	2	2	2	2	2	2	2	2		
Moves limbs	= 1											
No move (Except Resp)	= 0											
CONSCIOUS LEVEL												
Responds to command	= 2	2	2	2	2	2	2	2	2	2		
Responds	= 1											
No Response	= 0											
BLOOD PRESSURE * Arterial line *		127	127	118	126	129	130	128	125	118		
Within 30mmHg of Pre-op	= 2	61	62	63	67	63	70	64	62	68		
30-90 from Pre-op	= 1											
< 70mmHg	= 0											
O2 SATURATION		100	96	100	100	100	100	100	100	100		
PULSE		80	74	74	80	71	70	70	71	78		
RESPIRATION RATE		14		14			13			12		
TEMPERATURE												

POST OPERATIVE CARE PLAN

TIME OF ARRIVAL IN RECOVERY ROOM 1630

OPERATION

GA Femoral & Sciatic nerve block. 1st stage revison right knee + insertion of cement spacer -
Arterial line insitu

WOUND DRAINAGE	SKIN CLOSURE	DRESSING
	Staples -	Tegaderm Pad, Wool & Crepe
LA INFILTRATION	URINARY CATHETER	PACKS IN SITU

CONSCIOUS LEVEL	AIRWAY	OXYGEN	I.V. ACCESS	DRAINS	WOUND
A). Unconscious (B). Conscious/Drowsy C). Conscious/ Responsive D). Ventilated	A). Guedel B). E.T.T. C). Laryngeal Mask	(A). Hudson Mask B). Nasal Canulae C). Other	(A). Infusion Running B). Capped Can in SITU C). Discontinued	A). Patent B). Blocked C). Drainage in Mls D). Irrigation	(A). Dry B). Slight Staining C). Heavy Staining

TIME HOURS	MINS	0	5	10	15	20	25	30	45	60	75	90
RESPIRATORY FUNCTION												
Able to breath and cough	= 2	2	2	2	2	2	2	2	2	2	2	2
Maintain own airway	= 1											
Airway needs support	= 0											
COLOUR												
Pink & Warm	= 2	2	2	2	2	2	2	2	2	2	2	2
Pale, Dusky, Peripheral cyanosis	= 1											
Central Cyanosis, cold	= 0											
RECOVERY OF NEURO-MUSCULAR FUNCTION												
5 secs Head lift	= 2	2	2	2	2	2	2	2	2	2	2	2
Moves limbs	= 1											
No move (Except Resp)	= 0											
CONSCIOUS LEVEL												
Responds to command	= 2	2	2	2	2	2	2	2	2	2	2	2
Responds	= 1											
No Response	= 0											
BLOOD PRESSURE * Arterial line *		151	165	154	116	149	143	145	147	142	138	126
Within 30mmHg of Pre-op	= 2	70	80	71	67	69	70	66	65	63	59	59
30-90 from Pre-op	= 1											
< 70mmHg	= 0											
O2 SATURATION		88	88	98	96	98	100	100	100	100	100	100
PULSE		85	85	82	85	81	77	76	75	70	75	75
RESPIRATION RATE				15			13		13		14	

Post Operative Care

Time																			
SpO_2																			
O_2 L/min																			
Resp Rate																			
Airway																			
180																			
160																			
140																			
120																			
100																			
80																			
60																			
40																			
20																			
Temperature																			
CVP																			
Wound site																			
Affected limb pulse: +ve/-ve																			
Circulation Satisfactory:S Poor: P																			
Sensation +ve/-ve																			
Movement +ve/-ve																			
Sedation/Pain score																			
Nausea score																			

Time	Fluid in	Urine	Drain 1	Drain 2	Blood results / Drug given

Additional nursing comments

Waterlow Score ☐ **Intervention required:**

Discharge criteria met:	Discharged to:	Recovery Nurse name:	Ward Nurse name:
Yes ☐ NO ☐	Ward:	.....	.....
Comments:	HDU ☐ ITU ☐	Signature:	Signature: .....

IC 638 Cat. No. 0163149 VI MEDICAL ILLUSTRATION • ANAES • 1985/6.05

South Glasgow Hospitals

ANAESTHETIC RECORD

NHS Greater Glasgow and Clyde

Date: 21/3/11

Pre-op instructions:
ECG please. - dust Fentanyl today.
Please report FBC + coag.

Fast for: AM Lunchtime PM List

Proposed operation: Revision @ knee.

Patient details
Name: [redacted]
Unit No: SG00940779
Address: HONEYMAN, CATHERINE
10 MELVILLE STREET
GLASGOW
G41 2LN
DOB: 01/02/1949
CHI 0102496145

Assessor: Dr Ian CTL
Ward: 2

Pre-op assessment

Previous G.A.'s: ① TKR 2010 Zoledronate + vomiting
② TKR 2007.

CVS: HR 109. BP 133/79.
- 1 wk of GTN recently - says BP's good.

Resp: SpO_2 %
T 37.7. Felt feverish earlier.
- Tightness in chest - 0700 today
- not like angina but dull ache with spray.
- ~ 5 minutes
- associated SOB. 5/10 severity.
- no cough
JEHOVAH'S Witness
- No blood or blood products.

Other (specify): + vomited at 0800.
Hypertension
Angina.

Fasted: Tuna at 0600. No food
Reflux: Indigestion. No reflux on omeprazole.

Drugs:
Flucloxacillin 2g IV. qid
Enoxaparin 40mg s/c (Tod)
Simvastatin 40mg nocte
Atenolol 25mg od. Omeprazole 40mg od
Tramadol 50mg qid. Paracetamol 1g qid
Nifedipine 30mg od. RIVAROXABAN 10mg bd.
Ramipril 2.5mg od.
Fluoxetine 20mg od.
N.S.A.I.D's Aspirin

Allergies:
Diclofenac. Headaches + nausea.

BMI: 5'6"
Weight (kg): 151

Airway: Previous grade II intubation
MPL. Grade no. Moderate neck movement

Dentition: Good.

Investigations

23/3/11.

Na+: 137	Hb: 108	Others (specify):	
K+: 3.8	WCC: 8.1	TBR 67 ALT 19	
Cl-: 99	Plts: 195	Alb 29 ALT 70	
HCO3-: 25	ECG:	a/c 35 CRP 453	
Urea: 4.6	CXR:	8.1 19	
Creat: 78	Glucose	Mg 162	

Urgency

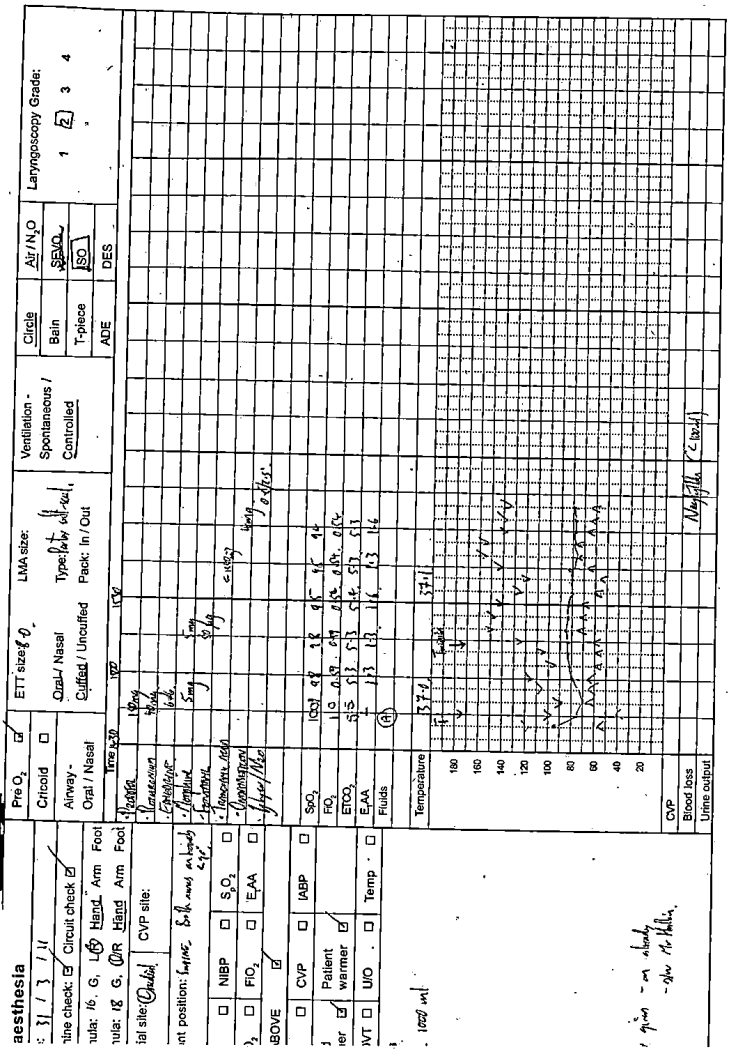
		A.S.A.
Elective	☐	1
Scheduled	☑	2
Urgent	☐	(3).
Emergency	☐	4
		5

Comments / Warnings

GA
+ FNB) Sciatic as
+ arterial line
+ Mon (bed available).

Explained risk of perioperative malignancy is submitted

Material risks explained ☐



Regional Anaesthesia / Other Procedures / Comments

(E) FNB, D Fenn.
Asleep. Sterile gloves. Chlorhexidine.
Lumbarsol + stimuplex 4" needle with nerve stimulator.
Twitches lost at 0.5mA.
~20mls x 0.25% chirocaine infiltrated with care.

(D) Sciatic NB D Fenn
Posterior approach. Sterile gloves + chlorhexidine.
6" needle stimuplex + nerve stimulator.
Twitches lost at 0.45mA.
~ 0.2% chirocaine ~20mls injected with care.

Operation Details

Theatre: Ortho.

Operation as proposed on page 1 ☐ Reversal given: Yes ☐ No ☐

Anaesthetist(s): Dr Howie. D Fenn	Surgeon(s): Mr Howie.
Named Consultant: ↑	Discussed with Consultant: Yes ☐ No ☐

Post Operative Care

A. **Oxygen** 4 L/min OR % for 24 hours via mask. OR SpO2 >95% on air.

B. **Routine observations / postoperative care as per local protocol.**

C. **Appropriate DVT prophylaxis precribed:** Yes ☐ N/A ☐

D. **Anti-emetic given:** Yes ☑ No ☐ **Drug given:** Ondansetron

E. **Analgesia:**

I.V. Morphine as per Recovery Algorithm - Sign		
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:

OR

I.V. Fentanyl as per Recovery Algorithm - Sign		
40 µm bolus - Time:	Sign:	Witness:
40 µm bolus - Time:	Sign:	Witness:
40 µm bolus - Time:	Sign:	Witness:
40 µm bolus - Time:	Sign:	Witness:
40 µm bolus - Time:	Sign:	Witness:

F. **Post Operative fluids** See chart

Fluid (additive)	Volume	Rate	Sign	Start	Lot No.	Initials

Spl's 88 intraarticular/epidural/sp.

Post operative notes / Comments

- Hbd.
- Monitor BP + u/o closely - Further IVF after consideration of bolus, aiming to keep MAP >65.
- 1000ml adult type fluid over 4hrs. - Check relevant medical directive prior to prescribing IVF's.
- Check Hb at 1000 tonight. Next for drawings in morning. 4th Intravenous.
- Supportive Rx for chest pain rather than blood if anaemic.

ABG's on ICU transfer made at 1645:
- EtHb 10.1
- Hct 29.6
- pCO_2 5.7
- pO_2 6.8
- HCO_3^- 26.6
- Lac 0.9

SOUTHERN GENERAL
SITU

Patient Sample Report

Patient

ID:	G00940779
Last Name:	HONEYMAN
First Name:	CATHERINE
Gender/Age:	Female, 62 years
Birth Date:	01.02.1949
Status:	ACCEPTED
Analyzed:	31.03.2011 16:39:06
Drawn:	31.03.2011
Sample Type	Arterial
Account Number:	
Order Number:	
Sample Number:	
Clinician:	TRAUMA MASK
Operator ID:	E FRASER

Analyzer

Model:	GEM® Premier 4000
Area:	SCHSITU
Name:	SITU
S/N:	06100195

Measured (37.0°C)		
cH	39.6	nmol/L
pCO_2	5.7	kPa
pO_2	↓ 6.8	kPa
Na^+	↓ 135	mmol/L
K^+	↓ 3.0	mmol/L
Cl^-	102	mmol/L
Glu	↑ 8.2	mmol/L
Lac	↓ 0.9	mmol/L
CO-Oximetry		
tHb	↓ 10.1	g/dL
O_2Hb	↓ 87.4	%
COHb	1.5	%
MetHb	0.8	%
HHb	↑ 10.3	%
sO_2	↓ 89.5	%
Derived		
BE(B)	1.5	mmol/L
HCO_3^-(c)	26.6	mmol/L
Operator Entered		
Temp	37.0	°C
O2 and Vent Settings		
FIO_2		%

↑↓ Outside Reference Range

POST OPERATIVE CARE PLAN

SPECIFIC PRE/INTRA & POST OPERATIVE COMPLICATIONS

COMPLICATION	ACTION TAKEN	OUTCOME
Sat 93-95% a 6Lts - anaesthetist informed		
→ 1200 Saturations now above 95% on 5L o2. →		
↳ hypotension - left side of chest - anaesthetist informed. - patient states not angina - new method epidural?		
↳ nausea - Ondasetron 4mg IV @ 1130.	→ Good Effect	

NURSING REPORT

- Patient had Ca + Bloods, On 6Lo2
- Observations As Charted.
- IV Fluids As Prescribed.
- Medication As On Kardex.
- Pressure Areas Intact.
- Wounds Dressing, Dry + Intact.
- * See Post-op instructions sheet
- Patient Settled + Orientated.
- Catheter Patent → Urine output.
- C.S.M.P.T Satisfactory → To Monitor.

POST RECOVERY TRANSFER REPORT

→ Discharge to ward alert

CONSCIOUS LEVEL	OXYGEN	I.V. ACCESS	DRAINS	PAIN LEVEL
A). Unconscious B). Conscious/Drowsy C). Conscious/ Responsive D). Ventilated	A). Hudson Mask B). Nasal Canulae C). Other	A). Infusion Running B). Capped Can in SITU C). Discontinued	A). Patent B). Blocked C). Drainage in Mls D). Irrigation	A). Pain free B). Mild C). Moderate D). Severe
WOUND	**CVP MONITORING**	**ARTERIAL LINE**	**SYRINGE PCA PUMP**	**WATERLOW SCORE PLEASE SPECIFY AMOUNT**
A). Dry B). Slight Staining C). Heavy Staining	A). Commenced B). In Situ	A). Commenced B). In Situ	A). Commenced B). In Situ	A). 10+ At Risk B). 15+ High Risk C). 20+ Very High Risk

RECOVERY NURSES SIGNATURE (1130) (RN) 1200 RN

0099099 MG\080198

THEATRE CARE PLAN

Theatre:

NHS Greater Glasgow and Clyde

WARD NAMED NURSE	HONEYMAN, CATHERINE SG00940779 01/02/49 CHI: 0102496145 F Date____ Time____ Spec./Sig.____	DATE	
PATIENT'S NAME		WARD	
D.O.B.		UNIT NO.	

PROPOSED OPERATION 2nd Stage Revision (R) Knee

PRE-OPERATIVE CARE PLAN		
1. Obtain and record baseline vital signs	BP 124/82 P 75. T 36.4	Sats 98
2. Note and record significant past medical history	SEE BELOW	✓
3. Capped/loose teeth-number and position	Sound.	✓
4. Pre-op teaching carried out	✓	✓
5. Pre-op investigations carried out i.e. ECG, Bloods, X Rays	✓	✓
6. Skin shave and preparation required	Yes.	✓
7. Remove make-up nail, varnish	Yes.	✓
8. Remove prosthesis, dentures, hair pieces, lenses	N/A.	✓
9. Jewellery - Tape rings	Rings removed	✓
10. Ensure patient has fasted (No less than 6 hours)	FFMN	✓
11. Identification band	Yes	✓
12. Empty bladder/~~catheter in situ~~	Yes.	✓
13. Naso-Gastric Tube	N/A	✓
14. Blood in Theatre Fridge	GIS	✓
15. Case Notes	✓	✓
Drugs kardex/charts	✓	✓
X Rays	System	✓
16. Theatre gown & cap	Yes.	✓
17. Premedication given	0730 2mg lorazepam	✓
18. Consent form signed	YES → ICP	✓
19. Allergies	NIL KNOWN	Nkda.
20. Waterlow Score	13.	Fleming
	Ward Nurse Sig	**Theatre Nurse Sig**

RELEVANT INFORMATION Angina
BIL KNEE REP.
REV. (R) KNEE
BIL. BREAST LUMPECTOMY

NAMED NURSES

NAMED ANAESTHETIC NURSE ODP. Fleming.

NAMED THEATRE NURSE

TRA-OPERATIVE CARE PLAN

ME OF ARRIVAL IN ANAESTHETIC ROOM 0845

TIME OF ARRIVAL IN THEATRE 0915

THEATRE	ANAESTHETIST	ASSISTANT	ANAES. NURSE
Ortho 2.	Hoole.		Fleming.

SURGEON	IST ASSISTANT	SCRUB NURSE	CIRCUL. NURSE
Hollin.	Al Fahayah Watson.	Rowan.	

I.V. INFUSIONS		ARTERIAL LINE		CVP-MONITORING	
OMMENCED	IN-SITU	COMMENCED	IN-SITU	COMMENCED	IN-SITU
✓					

AIRWAY MANAGEMENT	SYRINGE/PCA PUMP			
GENERAL ETT 8 ☑	COMMENCED	IN-SITU	COMMENCED	IN-SITU
LM ☐				
FM ☐				
PINAL				
PIDURAL	COMMENCED	IN-SITU	COMMENCED	IN-SITU
EGIONAL ✓ femoral + sciatic				
OCAL				

POSITION	Supine	Prone	Lithotomy	Right Lateral	Left Lateral	Jack Knife	Other
RIGHT ARM	At Side		On Board	Across Chest		Other	
LEFT ARM	At Side		On Board	Across Chest		Other	
PATIENT PROTECTION SAFETY	Padding		Pillows	Gel Pad	Warming blanket	Other	

covered c heated gel + pad

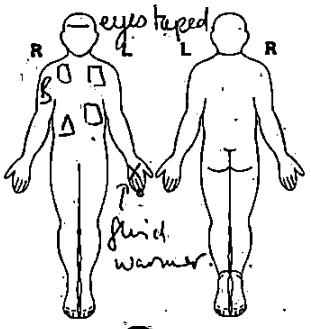
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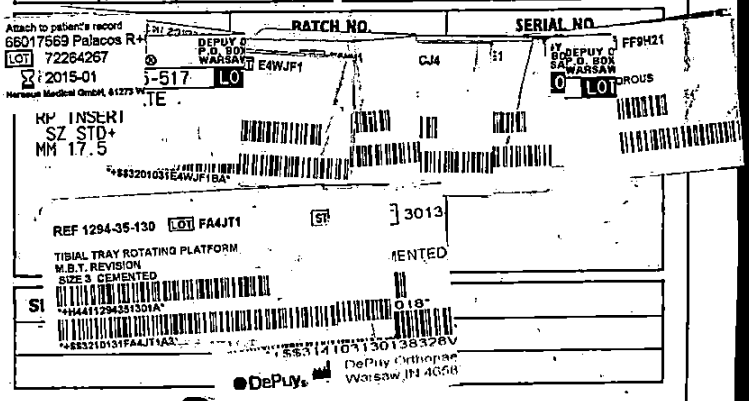
TOURNIQUET		
Arm	Leg ✓	Ankle
Right ✓	Left	
Inflated 0919 Hrs	Pressure 300 MM	
Deflated 1107 Hrs		

SWAB/NEEDLE/INSTRUMENT COUNT	
Correct	
Incorrect	
Appropriate Action Taken	

PATIENT MONITORING

- PERIPHERAL IVI — X
- IV CANNULAE — C
- ECG ELECTRODES — ☐
- C.V.P. — Z
- ARTERIAL LINE — A
- BP/MANUAL/AUTO — B
- PULSE OXIMETER — •
- DIATHERMY PLATE — Δ
- SKIN CONDITION — S





POST OPERATIVE CARE PLAN — TIME OF ARRIVAL IN RECOVERY ROOM 1125

OPERATION: GA + femoral + sciatic blocks - total knee revision - right knee.

WOUND DRAINAGE	SKIN CLOSURE	DRESSING
	Staples	sterile wool + crepe

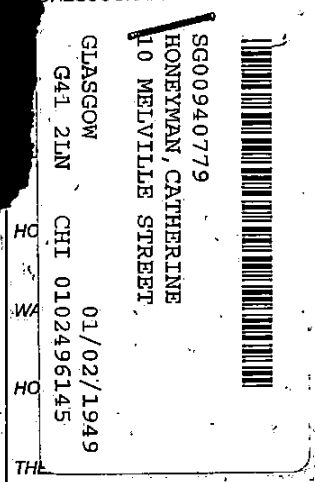
LA INFILTRATION	URINARY CATHETER	PACKS IN SITU
	Size 12	1

CONSCIOUS LEVEL	AIRWAY	OXYGEN	I.V. ACCESS	DRAINS	WOUND
A). Unconscious	A). Guedel	A). Hudson Mask	A). Infusion Running	A). Patent	A). Dry
B). Conscious/Drowsy	B). E.T.T.	B). Nasal Canulae	B). Capped Can in SITU	B). Blocked	B). Slight Staining
C). Conscious/ Responsive	C). Laryngeal Mask	C). Other	C). Discontinued	C). Drainage in Mls	C). Heavy Staining
D). Ventilated	Own.			D). Irrigation N/A	

TIME ~ HOURS	MINS	0	5	10	15	20	25	30	45	60	75	90
RESPIRATORY FUNCTION												
Able to breath and cough	= 2	2	2	2	2	2	2	2	2	2	2	2
Maintain own airway	= 1	1										
Airway needs support	= 0											
COLOUR												
Pink & Warm	= 2	2	2	2	2	2	2	2	2	2	2	2
Pale, Dusky, Peripheral cyanosis	= 1											
Central Cyanosis, cold	= 0											
RECOVERY OF NEURO-MUSCULAR FUNCTION												
5 secs Head lift	= 2	2	2	2	2	2	2	2	2	2	2	2
Moves limbs	= 1	1										
No move (Except Resp)	= 0											
CONSCIOUS LEVEL												
Responds to command	= 2	2	2	2	2	2	2	2	2	2	2	2
Responds	= 1	1										
No Response	= 0											
BLOOD PRESSURE												
Within 30mmHg of Pre-op	= 2	96	107	93	91	108	110	87	90	88	90	96
30-90 from Pre-op	= 1	90	96	96	95	95	95	91	91	94	95	98
< 70mmHg	= 0											
O2 SATURATION		94	94	94	96	97	96	97	98	97	98	98
PULSE		85	86	86	79	87	85	78	78	87	87	87
RESPIRATION RATE		17		15		12		14		12		14

Intraoperative Accountable Items Count Record

Date 23.6.11



COUNTS	Scrub Nurse(s) Print Name	Circulating Nurse(s) - Signature & Print name
PRE - OP SWAB COUNT CORRECT	AWATSON	K. ROWAN KR
PRE - OP INSTRUMENT COUNT CORRECT	AWATSON	K ROWAN KR
FINAL SWAB COUNT CORRECT	AWATSON	K. ROWAN KR
FINAL INSTRUMENT COUNT CORRECT	AWATSON	K. ROWAN KR
FINAL SWAB DISPATCH COUNT CORRECT	AWATSON	K ROWAN KR

SCRUB NURSE VERIFICATION - PLEASE SIGN ON PAGE UNDERNEATH.

I have reviewed this count sheet and can verify my count(s) correct

SCRUB NURSE 1- SIGNATURE - AWatson

SCRUB NURSE 2 SIGNATURE -
To be signed by replacement scrub nurse if applicable

HANDOVER COUNT IN EVENT OF REPLACEMENT OF SCRUB NURSE DURING PROCEDURE

	Outgoing Scrub Nurse - Print Name	Incoming Scrub Nurse - Print Name	Circulating Nurse(s) - Signature & Print name
OUTGOING COUNT *To be completed for permanent and temporary replacement*			
INCOMING COUNT *To be completed for temporary replacement*			

OPERATION

TALLY OF EACH ITEM USED - ADD ANY ITEMS SPECIFIC TO YOUR SPECIALITY

						ITEMS REMAINING IN SITU (Type & Number)
Swabs (2x2)	N/A	Tapes	N/A	LIGHT HANDLES	2	
Swabs (10x10)	10	Sloops/Slings	N/A	CHANNELM SPOON	1	
Abdominal packs	10	Bulldogs	N/A	SCREWS	8	
Sutures	4	Shods	N/A	COVES	2	
Blades	2	Tibbs Cannula	N/A			
IV needles	N/A	Ports	N/A			
Syringes	1	Staple Gun Inserts	N/A			
Discard-a-pad	1	Spears	N/A			
Diathermy pencil	1	Throat packs - Anae	N/A			
Diathermy tips	2	Throat packs - Scrub	N/A			
Scratch pad	N/A	Retrieval Bag (Bert)	N/A			
Reels	N/A	Digital Tourniquets	N/A			
Pattles	N/A	RCL Retractor	1			
Pledgelets	N/A	Pins	18			

DISCREPANCY IN COUNT - ACTIONS AND OUTCOME

COUNT IN WHICH DISCREPANCY OCCURRED

DETAILS

ACTIONS TAKEN AND OUTCOME (I.E. SWABS ISOLATED, SEARCH UNDERTAKEN, WOUND EXPLORED, X - RAY TAKEN) -

SCRUB NURSES SIGNATURE IF COUNT STILL INCORRECT FOLLOWING ALL POSSIBLE ACTIONS

SURGEONS SIGNATURE IF COUNT INCORRECT FOLLOWING ALL POSSIBLE ACTIONS

PLEASE INSERT TRACEABILITY STICKERS ON BACK OF COPY- TO STAY IN THEATRE.

Photocopy – 10-6-11.

HEALTH-CARE ADVANCE DIRECTIVE

(1) I, CATHERINE HONEYMAN
Print your full name
born the 1st th day of 2 month, 19 49, am of sound mind and I voluntarily make this Health-Care Advance Directive. This document revokes any prior health-care advance directive and shall take effect upon my incapacity. It will remain in force unless and until specifically revoked in writing by me.

(2) I am one of Jehovah's Witnesses. On the basis of my firmly held religious convictions (founded on Bible directions such as at Acts 15:28, 29) and on the basis of my desire to avoid the numerous hazards and complications of blood transfusions, **I absolutely REFUSE allogeneic blood** (another person's blood); **the primary blood components red cells, white cells, platelets and/or plasma; and stored (predonated) autologous blood** (my own stored blood) **under any and all circumstances, no matter what the consequences. I also refuse to predonate any of my blood for storage and later reinfusion into me or anyone else.**

(3) The refusal in clause (2) above is not to be overridden by a purported consent of a spouse, relative or other person or body.

I **request and will accept alternative non-blood medical management** to build up or conserve my own blood, to avoid or minimise blood loss, to replace lost circulatory volume, or to stop bleeding. Hence such volume expanders as dextran, saline solution, Ringer's solution modified fluid gelatin, hetastarch, and perflurochemicals; and oral or parenteral iron would be acceptable to me.

(5) Medical products: [Initial one of the three choices below.]

___ (a) I refuse all fractions derived from any primary component of blood.

✓ (b) I accept all fractions derived from any primary component of blood.

___ (c) I want to qualify either (5a) or (5b) above and my instructions are as follows:

(6) Medical procedures involving my own blood that do not involve storage of my blood for later infusion into me or someone else: [Initial one of the three choices(s) below.]

___ (a) I refuse any procedure involving the use of my blood during an operation or ongoing treatment.

___ (b) I accept any procedure involving the use of my blood during an operation or ongoing treatment.

✓ (c) I accept only the following procedures involving my blood:
CELL SALVAGE MACHINE

(7) With respect **to end-of-life decisions, I CHOOSE:** [Initial one of the three choices below.] (As to pregnancy see (9) overleaf.)

___ (a) NOT TO PROLONG LIFE. That is, if to a *reasonable degree of medical certainty my condition is considered hopeless.* (For example, if to a reasonable degree of medical certainty I have an incurable and irreversible condition that will result in my death within a relatively short time, or if I am unconscious and to a reasonable degree of medical certainty will not regain consciousness, or if I have brain damage or a brain disease that makes me unable to recognise people or communicate and to a reasonable degree of medical certainty my condition will not improve.) In such situations, I refuse

continued overleaf . . .

mechanical respiration (ventilation), cardiopulmonary resuscitation (CPR), tube feeding (artificial nutrition or hydration), etc., but I accept basic palliative care–treatment for comfort.

✓ (b) **TO PROLONG LIFE.** That is, I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards but subject to my absolute refusal of blood and those blood components described herein, although I realise this means that I might be kept alive on machines for years in a hopeless condition.

____ (c) **OTHER.** [If you do not completely agree with either (a) or (b) above, initial here and write your own end-of-life instructions in the space provided.]_____

(8) Other instructions: [Write any other health-care instructions here.]_____

(9) ____ (initial) [This clause applies only to women of child-bearing age.] If I am pregnant, and there is a reasonable chance that my unborn child could survive, I want my life to be prolonged for the sake of my unborn child. This is subject to the refusal of blood for myself and my unborn child as set out above. After any efforts to save my unborn child I direct that my doctors manage my care in harmony with the instructions in (7) and (8) above.[ii]

(10) If my health-care providers will not or cannot undertake a surgical operation, or administer any other form of medical treatment, without the use of blood or any blood products specifically prohibited by myself in this document, I direct my health-care providers to co-operate fully with the appointed representative(s) of the local Hospital Liaison Committee for Jehovah's Witnesses in discussing treatment options. Thereafter if a transfer is subsequently deemed necessary I direct that all my medical records, including a copy of this document, be transferred promptly to the other health-care provider to ensure that my health-care instructions herein will be respected.

(11) A copy of this document shall be as valid as the original. I ask that a copy of this document be made part of my permanent medical record. I have provided a copy of this document to my registered general practitioner.

(12) The provisions of this entire document are separable, so that the invalidity of one or more provisions shall not affect any others.

(13) **MY DECISION to refuse blood and choose non-blood management MUST BE RESPECTED EVEN IF MY LIFE OR HEALTH IS THREATENED by my refusal. Any attempt to administer blood contrary to my instructions will be a violation of my rights of bodily self-determination and personal autonomy, and accordingly will constitute an actionable trespass to my person.**[iii iv v vi]

(14) I understand and believe the full import of this document and verily aver that it accurately reflects my personal informed choice.[vii]

(15) SIGNED: Catherine Monaghan (Your signature) 22-11-05 (Date)

10 MELVILLE ST
(Address)

Pollokshields Glasgow G41 2LN

(16) STATEMENT OF WITNESSES: The person who signed this document (the principal) is known to me and voluntarily signed or voluntarily directed another to sign this document in my presence. The principal appears to be of sound mind and free from duress, fraud or undue influence. I am 18 years of age or older and I am not related to the principal by blood, marriage or adoption.

Signature of Witness 1	Signature of Witness 2
W. Scott	DAVID STONE
Print Name	Print Name
PARTNER.	TEACHER
Occupation or Profession	Occupation or Profession
77 WALLACE WYND	31 SECOND AVE
Home Address	Home Address
CHRISTIE ST GLASGOW G72 8SE	RINGS PARK GLASGOW G44 4TD
0141 641 1283	0141 632 4609
Home Telephone	Home Telephone
0141 633 1777	01236 607034
Work Telephone	Work Telephone

[i] *In re T* [1992] 3 WLR 782, Donaldson MR at 787 D.

[ii] *St George's Healthcare NHS Trust v.S.; R. v. Collins and Others ex parte S.* [1998] 2 FLR 728.

[iii] BMA Code of Practice *Advance Statements About Medical Treatment* [April 1995] ¶¶ 2.2; 3.1; 13.5; 14.2.

[iv] *In re T* [1992] 3 WLR 782, Donaldson MR at 787 B.

[v] *Airedale National Health Service Trust v. Bland* [1993] 2 WLR 316, Lord Keith of Kinkel at 360 H–361 A.

[vi] *Airedale National Health Service Trust v. Bland* [1993] 2 WLR 316, Lord Goff of Chieveley at 367 E–368 A.

[vii] *re C* [1994] 1 FLR 31.

Date: 10-6-11.

Dear Dr Marshall

Regarding: Patient's Blood Pressure.

SG00940779
HONEYMAN, CATHERINE
10 MELVILLE STREET

GLASGOW 01/02/1949
G41 2LN CHI 0102496145

This patient attended our Orthopaedic Pre-assessment clinic today. ~~He~~/she is due to be admitted on 22-6-11 for 2nd stage revision TKR.

At clinic today their blood pressure was elevated to 136/93

It would be a great help if the surgery practice nurse could check the patient's blood pressure on a couple of occasions before admission.

If the blood pressure does remain significantly above 190/90, it would clearly be safer to postpone their surgery until this has been controlled. Should this be necessary we would like to call a replacement patient so that the average time for surgery is kept as short as possible.

It would be helpful if you could let us know your findings at your earliest convenience. Please contact us on the below numbers.

Thank you for your co-operation in this matter.

Yours sincerely;

Orthopaedic Pre-assessment Clinic
Southern General Hospital
Glasgow

Tel: 0141 201 1156
Fax: 0141 201 1226.

Post Operative Care

Time																	
SpO_2																	
O_2 L/min																	
Resp Rate																	
Airway																	
180																	
160																	
140																	
120																	
100																	
80																	
60																	
40																	
20																	
Temperature																	
CVP																	
Wound site																	
Affected limb pulse: +ve/-ve																	
Circulation Satisfactory:S Poor: P																	
Sensation +ve/-ve																	
Movement +ve/-ve																	
Sedation/Pain score																	
Nausea score																	

Time	Fluid In	Urine	Drain 1	Drain 2	Blood results / Drug given

Additional nursing comments

Waterlow Score ☐ **Intervention required:**

Discharge criteria met:	Discharged to:	Recovery Nurse name:	Ward Nurse name:
Yes ☐ NO ☐	Ward:	.....	.....
Comments:	HDU ☐ ITU ☐	Signature:	Signature: .....

VI MEDICAL ILLUSTRATION • ANAES • 1985/6.05
Cat. No. 0163149
VIC 638

South Glasgow Hos s

NHS Greater Glasgow and Clyde

ANAESTHETIC RECORD

Date: 22/6/11.

Pre-op instructions: atenolol, omeprazole, ranitidine, lorazepam

Fast for: (AM) Lunchtime PM List

Patient
Name: [redacted]
Unit No: G00940779
Address: ONEYMAN, CATHERINE
0 MELVILLE STREET
LASGOW
G41 2LN
01/02/19
CHI 0102496145
DOB

Proposed operation: 2nd stage revision (R) knee jt replacement

Assessor: Dr Hosie

Ward: Ward 6

Pre-op assessment

Previous G.A.'s: uneventful CAS. in 2004 629

CVS: HR BP 140/90

Resp: non smoker.

Other (specify): Jehovas witness
angina last attack 2/52 ago
obese

Drugs: omeprazole, atenolol, BFZ, GTN, simvastatin, fluoxetine, aspirin, ranitidine 400mg

N.S.A.I.D's doesn't tolerate

Allergies: none known

Fasted:

Reflux: heartburn not on omeprazole

BMI:	48	Airway: MP 2, Grade 2 inhibitor ?Arthrod.	Dentition: 2.1
Weight (kg):	123.4		

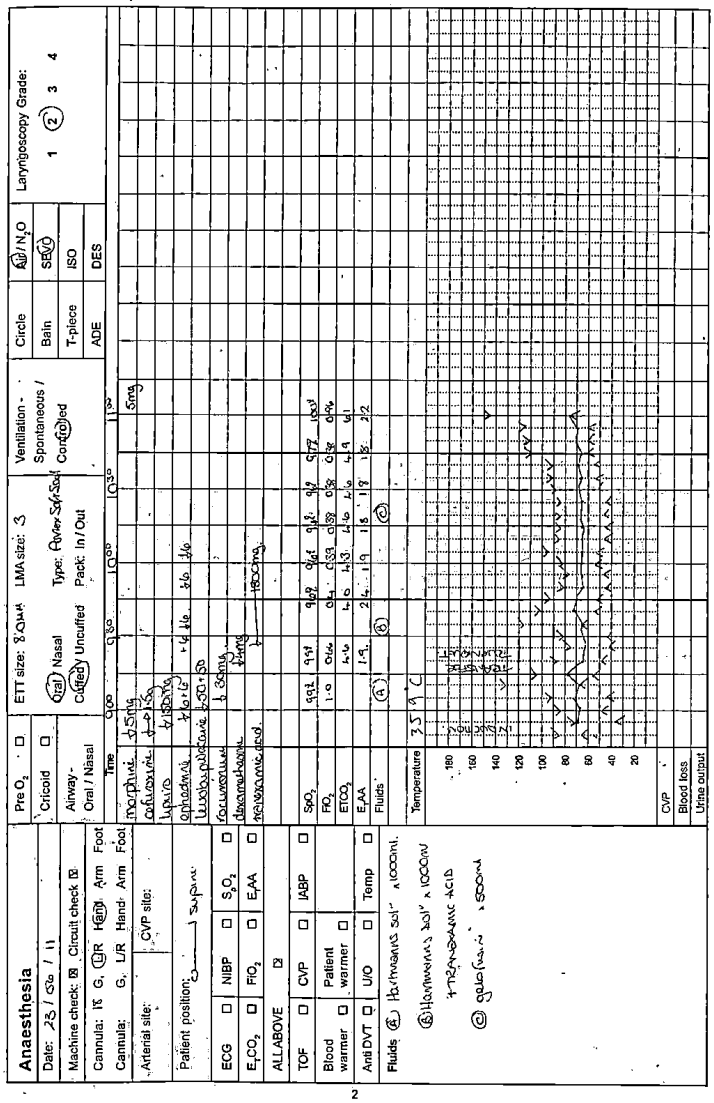
Investigations

Na+: 138	Hb: 129	Others (specify):	
K+: 3.5	WCC: 6.5		
Cl-: 96	Plts: 278		
HCO3-: 30	ECG:		
Urea: 5.2	CXR:		
Creat: 73	Glucose		

Urgency		A.S.A.
Elective	☐	1
Scheduled	☐	(2)
Urgent	☐	3
Emergency	☐	4
		5

Comments / Warnings Material risks explained ☑

makes GA/blocks.
not needing HDU bed because 4hrs.



Regional Anaesthesia / Other Procedures / Comments

① sciatic nerve block chlorhexidine spray 20g stimuplex needle 0.28mA. 20ml 0.25% levobupivacaine

② femoral nerve block chlorhexidine spray 22g stimiplexneedle 0.22mA. 20ml 0.25% levobupivacaine

Operation Details Theatre: SGH OATH02

Operation as proposed on page 1 ☐ Reversal given: Yes ☐ No ☐

Anaesthetist(s): Drs Hasia & Shazad	Surgeon(s): Mr Hullin & Mr Fadayomi
Named Consultant:	Discussed with Consultant: Yes ☐ No ☐

Post Operative Care

A. **Oxygen** 4L/min OR % for hours OR SpO_2 90% on air.

B. **Routine observations / postoperative care as per local protocol.**

C. **Appropriate DVT prophylaxis prescribed: Yes** ☒ **N/A** ☐

D. **Anti-emetic given: Yes** ☒ **No** ☐ **Drug given:** dexamethasone

E. **Analgesia:**

I.V. Morphine as per Recovery Algorithm - Sign		
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:

OR

I.V. Fentanyl as per Recovery Algorithm - Sign		
40 µm bolus - Time:	Sign:	Witness:
40 µm bolus - Time:	Sign:	Witness:
40 µm bolus - Time:	Sign:	Witness:
40 µm bolus - Time:	Sign:	Witness:
40 µm bolus - Time:	Sign:	Witness:

F. **Post Operative fluids**

Fluid (additive)	Volume	Rate	Sign	Start	Lot No.	Initials

Post operative notes / Comments

SOUTHERN GENERAL HOSPITAL

ORTHOPAEDIC OPERATION NOTE

PATIENTS DETAILS:

Name: CATHERINE HONEYMAN
DOB: 01/02/49
Unit No: SG00940779
CHI: 0102496145

DATE: 23/06/2011

DIAGNOSIS: PREVIOUS 1ST STAGE REVISION

OPERATION: 2ND STAGE REVISION RIGHT KNEE

SURGEON: M.HULLIN/O.AL-FAKAYH

ANAESTHETIST: DR.H.HOSIE

PROCEDURE: GA, I/V CEFUROXIME,SUPINE WITH LATERAL SUPPORT AND TOURNIQUET 300 MMGH.
STANDARD PREPARATION AND DRAPING.
ANTERIOR SKIN INCISION THROUGH OLD SCAR.
MEDIAL PARAPATELLAR APPROACH.BACTERIOLOGY SWAB SENT FOR STAINING.
CEMENT SPACER REMOVED. TIBIAL MEMBRANE SPECIMEN SENT FOR C&S.
DEBRIDEMENT AND WASHOUT OF KNEE.REVISION KNEE JIGS USED TO PREPARE TIBIA AND FEMUR.
FOLLOWING SIZES:
TIBIA: REVISION TRAY SIZE 3, TWO 5 MM AUGEMNTS USED,SLEEVE SIZE29MM, STEM SIZE 3*30 MM.
FEMUR: STD+ REVISION COMPONENT,STEM 13*60MM, TWO SIZE 5MM POSTERIOR AUGMENT AND ONE SIZE 5MM DISTAL AUGMENT. SIZE 17.5 MM INSERT.
TRIAL COMPONENTS OF THE ABOVE SIZES INSERTED, SATISFACTORY.
COMPONENTS REMOVED ,KNEE WASHED.
2 MIXES OF PALACOS WITH ANTIBIOTIC PREPARED AND INSERTED.FOLLOWED BY THE PROPER COMPONENTS WITH THE ABOVE SIZES.SATISFACTORY.
KNEE WASHED WITH CLEAR CHLORHEXIDINE. EXTENSOR MECHANISM CLOSED WITH NO. 1 VICRYL, 2/0 VICRYL FOR FAT AND CLIPS FOR SKIN.
MEPORE DRESSING WOOL AND CREPE BANDAGE.

POST OP: POSTOP BLOODS TOMORROW.
STANDARD DVT PROPHYLAXIS.
CHASE MICRO RESULTS OF SPECIMEN SENT FROM THEATRE.
POST OP KNEE X RAY 48 HOURS.
REHABILITATION AS PRIMARY TKR.

CATHERINE HONEYMAN

Dictated by: OMAR AL-FAKAYH

Pain Assessment & Management Guidelines

How to score pain: 0 (No Pain) — 10 (Worst Pain Imagineable)

Pain Score:		Action:
0	NONE	Continue to assess pain with every set of observations (must be at least daily).
1-3	MILD	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.
4-6	MODERATE	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.
7-10	SEVERE	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.

Guidelines

Cancer-related pain: Always score the worst pain in the last 24hours or since last assessment.

FOR PERSISTANT MODERATE PAIN (4 OR ABOVE) WHICH DISTRESSES THE PATIENT:

Use Cancer Pain Management Algorithm in Palliative Care Resource File. This is distributed to all wards and is also accessible on the intranet. If no improvement in pain score contact hospital palliative care team on **page 1266** at SGH and **page 5742** at VI.

Out of hours advice can be obtained from the Prince and Princess of Wales Hospice on **0141 420 6785.**

Acute pain: Score current pain on movement e.g. deep breathing

PERSISTENT SEVERE PAIN (7 OR ABOVE), WHICH DISTRESSES THE PATIENT:

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If no improvement in pain score contact CNS Pain Management on **page 1186/1157** at SGH and **page 3404/3101** at VI. On Call anaesthetist **page 1658** at SGH and **3004** at VI.

Measuring Sedation

The SEWS system uses the AVPU scoring system for conscious level. AVPU is an acronym for Alert, Verbal Pain, Unresponsive. The AVPU system relates to the previous sedation scale as follows:

Sedation	Descriptor	AVPU
0	Awake	A
1	Asleep, roused by speech	V
2	Physical stimulation (eg shaking) required to waken	P
3	Not roused by speech or shaking	U

Measuring Nausea

Is now recorded as 0 for no nausea or vomiting, N for nausea and V for vomiting
For persistent nausea and/or vomiting see clinical handbook or acute pain manual.

NB: Review Treatment Plan

If Temp>38 blood cultures ☐ other cultures ☐ Start antibiotic therapy if indicated

If Systolic BP<100 Review monitoring (cardiac/oximetry/urine output/invasive BP etc)
IV Access
Review patient/drug kardex. Consider fluid challenge ⟶ Definitive Therapy

Consider:

Hypovolaemia	Cardiac	Obstructive	Distributive
Dehydration	*Arryhthmia*	*PE*	*Sepsis*
Blood loss	*Pump failure*	*Tamponade*	*Anaphylaxis*

If Pulse>130 Review monitoring
IV Access
Review patient/ECG/electrolytes ⟶ Definitive Therapy

If O_2 sats <93% Review probe ? accurate
Review patient ⟶ prescribe oxygen on kardex if indicated.

If RR>24 Review patient/CXR +/- gases/PEF etc ⟶ Definitive Th

If responds to pain only

South Glasgow Hospitals
NHS Greater Glasgow and Clyde

EARLY WARNING SCORING SYSTEM (SEWS)
Patient Observation Chart

SG00940779
CATHERINE HONEYMAN
CHI:0102496145

Address 10 Melville Street
9w PATIENT
Hospital No. SG0094077 9
DOB 1/3/49

	Date	Ward	Consultant
Admitted	27/11/10	6	
Transferred			
Transferred			
Transferred			

This is Chart Number 1 during this admission

All seven parameters must be assessed with each set of observations to obtain an accurate SEWS score.
If a patient has abnormal vital signs please pay particular attention to scoring for urine output..

How to calculate SEWS Score

- Note whether observation falls in shaded "At Risk Zone". Score as per SEWS Key.
- Add points scored and record total "Sews Score" in bottom row of chart.
- Respiratory rate — Write numerical value in appropriate box
- Saturation Sp02 — Write numerical value in appropriate box
- Inspired Oxygen — If the patient's saturation is recorded on air please write A in appropriate box. If patient is on oxygen therapy, please document the amount in appropriate box.
- Temperature — Write numerical value in appropriate box
- Blood pressure — Write numerical values for systolic and diastolic pressure in appropriate box. Remember only the systolic value is considered for the SEWS Score.
- Heart rate — Write numerical value in appropriate box
- Neuro Response — Record patient's best response. If the patient is asleep or demonstrates new confusion, award the same score as verbal response.
- Urine Output. — Check that patient has voided urine recently. If yes write PU in box provided. If no write NPU in box provided.
- Urine Output — Check if the patient has passed the equivalent of or more than 30mls/hour for the last three consecutive hours. If yes score 0 in box provided. If no score 3 in box provided and add to total SEWS score.
- SEWS Score — Add up scores for all 7 parameters and write in box provided. If the patient merits an aggregate score of 0 please write 0 in the SEWS score box. Action as per guidelines below.

SEWS KEY

0	1	2	3

SEWS 0-1: Routine observations
SEWS 2-3: Hourly observations and inform nurse in charge
SEWS 4+: Contact PRHO immediately. SHO or more senior doctor must be informed by Junior Doctor. Please record action taken in Nursing Notes

FURTHER SEWS SCORE SHOULD BE CHECKED

- In the event of a sudden worrying ***Change***
- If there is a worsening ***Trend***
- If concerned the patient looks ***Unwell***

The frequency of SEWS scoring is determined by the previous SEWS Score. If the patient continually scores 0-1, the nurse caring for the patient should determine frequency of observations.

A full set of observations and SEWS score should still be carried out.

If SEWS continually 0-1 frequency of observations:

Date											

SEWS KEY

0	1	2	3

NAME _____ DOB _____

UNIT No. _____

| | | |

Pain Assessment & Management Guidelines

How to score pain: 0 (No Pain) — 10 (Worst Pain Imagineable)

Pain Score:		Action:
0	NONE	Continue to assess pain with every set of observations (must be at least daily).
1-3	MILD	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.
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Guidelines

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Out of hours advice can be obtained from the Prince and Princess of Wales Hospice on **0141 420 6785.**

Acute pain: Score current pain on movement e.g. deep breathing

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If no improvement in pain score contact CNS Pain Management on page **1186/1157** at SGH and page **3404/3101** at VI. On Call anaesthetist page **1658** at SGH and **3004** at VI.

Measuring Sedation

The SEWS system uses the AVPU scoring system for conscious level. AVPU is an acronym for Alert, Verbal Pain, Unresponsive. The AVPU system relates to the previous sedation scale as follows:

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Is now recorded as 0 for no nausea or vomiting, N for nausea and V for vomiting
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NB: Review Treatment Plan

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If Systolic BP<100 Review monitoring (cardiac/oximetry/urine output/invasive BP etc)
IV Access
Review patient/drug kardex. Consider fluid challenge ⟶ Definitive Therapy

Consider:

Hypovolaemia	Cardiac	Obstructive	Distributive
Dehydration	*Arryhthmia*	*PE*	*Sepsis*
Blood loss	*Pump failure*	*Tamponade*	*Anaphylaxis*

If Pulse>130 Review monitoring
IV Access
Review patient/ECG/electrolytes ⟶ Definitive Therapy

If O_2 sats <93% Review probe ? accurate
Review patient ⟶ prescribe oxygen on kardex if indicated.

If RR>24 Review patient/CXR +/- gases/PEF etc ⟶ Definitive Therapy

If responds to pain only or unresponsive Assess airway. BM GCS. consider neuro obs chart. review patient/kardex.

South Glasgow Hospitals

NHS Greater Glasgow and Clyde

STANDARDISED EARLY WARNING SCORING SYSTEM (SEWS)

Patient Observation Chart

Name Catherine Honeyman AFFIX PATIENT
Address
Hospital No. SC009405779 ID
DOB 1/12/49

	Date	Ward	Consultant
Admitted	18/4/10	3	
Transferred			
Transferred			
Transferred			

This is Chart Number ① during this admission

All seven parameters must be assessed with each set of observations to obtain an accurate SEWS score. If a patient has abnormal vital signs please pay particular attention to scoring for urine output.

How to calculate SEWS Score

- Note whether observation falls in shaded "At Risk Zone". Score as per SEWS Key.
- Add points scored and record total "Sews Score" in bottom row of chart.
- Respiratory rate — Write numerical value in appropriate box
- Saturation Sp02 — Write numerical value in appropriate box
- Inspired Oxygen — If the patient's saturation is recorded on air please write A in appropriate box. If patient is on oxygen therapy, please document the amount in appropriate box.
- Temperature — Write numerical value in appropriate box
- Blood pressure — Write numerical values for systolic and diastolic pressure in appropriate box. Remember only the systolic value is considered for the SEWS Score.
- Heart rate — Write numerical value in appropriate box
- Neuro Response — Record patient's best response. If the patient is asleep or demonstrates new confusion, award the same score as verbal response.
- Urine Output — Check that patient has voided urine recently. If yes write PU in box provided. If no write NPU in box provided.
- Urine Output — Check if the patient has passed the equivalent of or more than 30mls/hour for the last three consecutive hours. If yes score 0 in box provided. If no score 3 in box provided and add to total SEWS score.
- SEWS Score — Add up scores for all 7 parameters and write in box provided. If the patient merits an aggregate score of 0 please write 0 in the SEWS score box. Action as per guidelines below.

SEWS KEY

0	1	2	3

SEWS 0-1: Routine observations
SEWS 2-3: Hourly observations and inform nurse in charge
SEWS 4+: Contact PRHO immediately. SHO or more senior doctor must be informed by Junior Doctor. Please record action taken in Nursing Notes

FURTHER SEWS SCORE SHOULD BE CHECKED

- In the event of a sudden worrying *Change*
- If there is a worsening *Trend*
- If concerned the patient looks *Unwell*

The frequency of SEWS scoring is determined by the previous SEWS Score. If the patient continually scores 0-1, the nurse caring for the patient should determine frequency of observations.

A full set of observations and SEWS score should still be carried out.

If SEWS continually 0-1 frequency of observations:

Date												
Frequency	4hr											

SEWS KEY

0	1	2	3

NAME Catherine Honeyman DOB 11/2/69

UNIT No. 9407979

Date:		14	
Time:		1600	
RESP. RATE	36+		
	31-35		
	21-30		
	9-20	16	
	≤8		
SpO2 Numerical Value	93+	99	
	90-92		
	85-89		
	<85		
Inspired O2%	%	air	
TEMP.	39∞		
	38∞		
	37∞		
	36∞		
	35∞	35.8	
	34∞		
BLOOD PRESSURE	210		
	200		
	190		
	180		
	170		
	160	163	
	150	^	
	140		
	130		
	120		
	110		
SEWS SCORE uses Systolic BP	100		
	90		
	80	v	
	70	73	
	60		
	50		
	40		
	150		
	140		
	130		
	120		
	110		
HEART RATE	100		
	90		
	80	80	
	70		
	60		
	50		
	40		
	30		
	20		
NEURO RESPONSE	Alert	A	
	Verbal		
	Pain		
	Unresponsive		
URINE OUTPUT	PU/NPU: UO<30mls/hr (3 hrs +)	NV	
SEWS SCORE:	with all observations	1	
PAIN refer to guideline p4	Severe 7-10		
	Moderate 4-6		
	Mild 1-3		
	None 0	0	

SEWS KEY

0	1	2	3

Date:
Time:
36+
31-35
21-30
9-20
≤8
93+
90-92
85-89
<85
%
39∞
38∞
37∞
36∞
35∞
34∞
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
40
150
140
130
120
110
100
90
80
70
60
50
40
30
20
Alert
Verbal
Pain
Unresponsive
PU/NPU:
UO<30mls/hr
7-10
4-6
1-3
0
N/V

Pain Assessment & Management Guidelines

How to score pain: 0 — No Pain ... 10 — Worst Pain Imagineable

Pain Score:		Action:
0	NONE	Continue to assess pain with every set of observations (must be at least daily).
1-3	MILD	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.
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7-10	SEVERE	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.

Guidelines

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FOR PERSISTANT MODERATE PAIN (4 OR ABOVE) WHICH DISTRESSES THE PATIENT:

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Acute pain: Score current pain on movement e.g. deep breathing

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Measuring Nausea

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NB: Review Treatment Plan

If Temp>38 blood cultures ☐ other cultures ☐ Start antibiotic therapy if indicated

If Systolic BP<100 Review monitoring (cardiac/oximetry/urine output/invasive BP etc)
IV Access
Review patient/drug kardex. Consider fluid challenge ⟶ Definitive Therapy

Consider:

Hypovolaemia	Cardiac	Obstructive	Distributive
Dehydration	*Arryhthmia*	*PE*	*Sepsis*
Blood loss	*Pump failure*	*Tamponade*	*Anaphylaxis*

If Pulse>130 Review monitoring
IV Access
Review patient/ECG/electrolytes ⟶ Definitive Therapy

If O_2 sats <93% Review probe ? accurate
Review patient ⟶ prescribe oxygen on kardex if indicated.

If RR>24 Review patient/CXR +/- gases/PEF etc ⟶ Definitive Th

If responds to pain only

South Glasgow Hospitals

NHS Greater Glasgow and Clyde

STANDARDISED EARLY WARNING SCORING SYSTEM (SEWS)

Patient Observation Chart

Nam SG00940779
Addi CATHERINE HONEYMAN
01/02/1949
G41 2LN
Practice Code: 49074
CHI:0102496145
Hosp
DOB

	Date	Ward	Consultant
Admitted			
Transferred			
Transferred			
Transferred			

This is Chart Number_____during this admission

All seven parameters must be assessed with each set of observations to obtain an accurate SEWS score.
If a patient has abnormal vital signs please pay particular attention to scoring for urine output.

How to calculate SEWS Score

- Note whether observation falls in shaded "At Risk Zone". Score as per SEWS Key.
- Add points scored and record total "Sews Score" in bottom row of chart.
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FURTHER SEWS SCORE SHOULD BE CHECKED

- In the event of a sudden worrying *Change*
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- If concerned the patient looks *Unwell*

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A full set of observations and SEWS score should still be carried out.

If SEWS continually 0-1 frequency of observations:

Date												

SEWS KEY

0	1	2	3

NAME Catherine Honeyman DOB 1/2/69

UNIT No.

| | | |

Pain Assessment & Management Guidelines

How to score pain: 0 (No Pain) — 10 (Worst Pain Imagineable)

Pain Score:		Action:
0	NONE	Continue to assess pain with every set of observations (must be at least daily).
1-3	MILD	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.
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Guidelines

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Measuring Nausea

Is now recorded as 0 for no nausea or vomiting, N for nausea and V for vomiting
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NB: Review Treatment Plan

If Temp>38	blood cultures ☐	other cultures ☐	Start antibiotic therapy if indicated	
If Systolic BP<100	Review monitoring (cardiac/oximetry/urine output/invasive BP etc) IV Access Review patient/drug kardex. Consider fluid challenge ⟶ Definitive Therapy			
Consider:	Hypovolaemia *Dehydration* *Blood loss*	Cardiac *Arryhthmia* *Pump failure*	Obstructive *PE* *Tamponade*	Distributive *Sepsis* *Anaphylaxis*
If Pulse>130	Review monitoring IV Access Review patient/ECG/electrolytes ⟶ Definitive Therapy			
If O_2 sats <93%	Review probe ? accurate Review patient ⟶ prescribe oxygen on kardex if indicated.			
If RR>24	Review patient/CXR +/- gases/PEF etc ⟶ Definitive Therapy			
If responds to pain only or unresponsive	Assess airway, BM GCS, consider neuro obs chart, review patient/kardex.			

South Glasgow Hospitals

NHS Greater Glasgow and Clyde

STANDARDISED EARLY WARNING SCORING SYSTEM (SEWS)

Patient Observation Chart

Name

Address

AFFIX

CATHERINE HONEYMAN
9000940779 01/02/49 F
CHI: 0102496145
Date: Time:
Spec./Site:

Hospital No.

DOB

	Date	Ward	Consultant
Admitted			
Transferred			
Transferred			
Transferred			

This is Chart Number _____ during this admission

All seven parameters must be assessed with each set of observations to obtain an accurate SEWS score. If a patient has abnormal vital signs please pay particular attention to scoring for urine output.

How to calculate SEWS Score

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A full set of observations and SEWS score should still be carried out.

If SEWS continually 0-1 frequency of observations:

Date												
Frequency												

SEWS KEY

0	1	2	3

NAME Catherine Honeyman DOB 01/02/49

UNIT No.

Date:	
Time:	
RESP. RATE	36+ / 31-35 / 21-30 / 9-20 / ≤8
O2	93+
umerical Value	90-92 / 85-89 / <85
spired O2%	%
TEMP.	39∞ / 38∞ / 37∞ / 36∞ / 35∞ / 34∞
BLOOD PRESSURE	210 / 200 / 190 / 180 / 170 / 160 / 150 / 140 / 130 / 120 / 110 / 100 / 90 / 80 / 70 / 60 / 50 / 40
EWS SCORE	
ses Systolic	
P	
HEART RATE	150 / 140 / 130 / 120 / 110 / 100 / 90 / 80 / 70 / 60 / 50 / 40 / 30 / 20
NEURO RESPONSE	Alert / Verbal / Pain / Unresponsive
URINE OUTPUT	PU/NPU: / UO<30mls/hr (3 hrs+)
EWS SCORE:	with all observations
PAIN (refer to uideline 04)	Severe 7-10 / Moderate 4-6 / Mild 1-3

SEWS KEY

0	1	2	3

Date:

Time:

36+ / 31-35 / 21-30 / 9-20 / ≤8

93+ / 90-92 / 85-89 / <85 / %

39∞ / 38∞ / 37∞ / 36∞ / 35∞ / 34∞

210 / 200 / 190 / 180 / 170 / 160 / 150 / 140 / 130 / 120 / 110 / 100 / 90 / 80 / 70 / 60 / 50 / 40

150 / 140 / 130 / 120 / 110 / 100 / 90 / 80 / 70 / 60 / 50 / 40 / 30 / 20

Alert / Verbal / Pain / Unresponsive

PU/NPU:

UO<30mls/hr

7-10 / 4-6 / 1-3 / 0

Pain Assessment & Management Guidelines

How to score pain: 0 (No Pain) — 10 (Worst Pain Imagineable)

Pain Score:		Action:
0	NONE	Continue to assess pain with every set of observations (must be at least daily).
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Guidelines

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Out of hours advice can be obtained from the Prince and Princess of Wales Hospice on 0141 420 6785.

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PERSISTENT SEVERE PAIN (7 OR ABOVE), WHICH DISTRESSES THE PATIENT:

Use Acute Pain Manual - distributed to all Operating Theatres areas and Surgical wards throughout Division. Also accessible on Intranet (via anaesthetic department homepage)

If no improvement in pain score contact CNS Pain Management on page 1186/1157 at SGH and page 3404/3101 at VI. On Call anaesthetist page 1658 at SGH and 3004 at VI.

Measuring Sedation

The SEWS system uses the AVPU scoring system for conscious level. AVPU is an acronym for Alert, Verbal Pain, Unresponsive. The AVPU system relates to the previous sedation scale as follows:

Sedation	Descriptor	AVPU
0	Awake	A
1	Asleep, roused by speech	V
2	Physical stimulation (eg shaking) required to waken	P
3	Not roused by speech or shaking	U

Measuring Nausea

Is now recorded as 0 for no nausea or vomiting, N for nausea and V for vomiting
For persistent nausea and/or vomiting see clinical handbook or acute pain manual.

NB: Review Treatment Plan

If Temp>38 blood cultures ☐ other cultures ☐ Start antibiotic therapy if indicated

If Systolic BP<100 Review monitoring (cardiac/oximetry/urine output/invasive BP etc)
IV Access
Review patient/drug kardex. Consider fluid challenge ⟶ Definitive Therapy

Consider:	Hypovolaemia	Cardiac	Obstructive	Distributive
	Dehydration	*Arryhthmia*	*PE*	*Sepsis*
	Blood loss	*Pump failure*	*Tamponade*	*Anaphylaxis*

If Pulse>130 Review monitoring
IV Access
Review patient/ECG/electrolytes ⟶ Definitive Therapy

If O_2 sats <93% Review probe ? accurate
Review patient ⟶ prescribe oxygen on kardex if indicated.

If RR>24 Review patient/CXR +/- gases/PEF etc ⟶ Definitive Therapy

If responds to pain only or unresponsive Assess airway, BM GCS, consider neuro obs chart, review patient/kardex

South Glasgow Hospitals

NHS Greater Glasgow and Clyde

STANDARDISED EARLY WARNING SCORING SYSTEM (SEWS)

Patient Observation Chart

Name Catherine AFFIX PATIENT ID
Address
Hospital No.
DOB

	Date	Ward	Consultant
Admitted			
Transferred			
Transferred			
Transferred			

This is Chart Number_____during this admission

All seven parameters must be assessed with each set of observations to obtain an accurate SEWS score. If a patient has abnormal vital signs please pay particular attention to scoring for urine output.

How to calculate SEWS Score

- Note whether observation falls in shaded "At Risk Zone". Score as per SEWS Key.
- Add points scored and record total "Sews Score" in bottom row of chart.
- Respiratory rate — Write numerical value in appropriate box
- Saturation Sp02 — Write numerical value in appropriate box
- Inspired Oxygen — If the patient's saturation is recorded on air please write A in appropriate box. If patient is on oxygen therapy, please document the amount in appropriate box.
- Temperature — Write numerical value in appropriate box
- Blood pressure — Write numerical values for systolic and diastolic pressure in appropriate box. Remember only the systolic value is considered for the SEWS Score.
- Heart rate — Write numerical value in appropriate box
- Neuro Response — Record patient's best response. If the patient is asleep or demonstrates new confusion, award the same score as verbal response.
- Urine Output — Check that patient has voided urine recently. If yes write PU in box provided. If no write NPU in box provided.
- Urine Output — Check if the patient has passed the equivalent of or more than 30mls/hour for the last three consecutive hours. If yes score 0 in box provided. If no score 3 in box provided and add to total SEWS score.
- SEWS Score — Add up scores for all 7 parameters and write in box provided. If the patient merits an aggregate score of 0 please write 0 in the SEWS score box. Action as per guidelines below.

SEWS KEY

0	1	2	3

SEWS 0-1: Routine observations
SEWS 2-3: Hourly observations and inform nurse in charge
SEWS 4+: Contact PRHO immediately. SHO or more senior doctor must be informed by Junior Doctor. Please record action taken in Nursing Notes

FURTHER SEWS SCORE SHOULD BE CHECKED

- In the event of a sudden worrying ***Change***
- If there is a worsening ***Trend***
- If concerned the patient looks ***Unwell***

The frequency of SEWS scoring is determined by the previous SEWS Score. If the patient continually scores 0-1, the nurse caring for the patient should determine frequency of observations.

A full set of observations and SEWS score should still be carried out.

If SEWS continually 0-1 frequency of observations:

Date											
Frequency											

SEWS KEY

0	1	2	3

NAME _____ DOB _____

UNIT No. _____

SEWS KEY

0	1	2	3

Date:			Date:
Time:			Time:
RESP. RATE	36+		36+
	31-35		31-35
	21-30		21-30
	9-20		9-20
	≤8		≤8
SpO2	93+		93+
Numerical Value	90-92		90-92
	85-89		85-89
	<85		<85
Inspired O2%	%		%
TEMP.	39∞		39∞
	38∞		38∞
	37∞		37∞
	36∞		36∞
	35∞		35∞
	34∞		34∞
BLOOD PRESSURE	210		210
	200		200
	190		190
	180		180
	170		170
	160		160
	150		150
	140		140
	130		130
	120		120
SEWS SCORE uses Systolic BP	110		110
	100		100
	90		90
	80		80
	70		70
	60		60
	50		50
	40		40
	150		150
	140		140
	130		130
	120		120
	110		110
	100		100
HEART RATE	90		90
	80		80
	70		70
	60		60
	50		50
	40		40
	30		30
	20		20
NEURO RESPONSE	Alert		Alert
	Verbal		Verbal
	Pain		Pain
	Unresponsive		Unresponsive
URINE OUTPUT	PU/NPU:		PU/NPU:
	UO<30mls/hr (3 hrs +)		UO<30mls/hr
SEWS SCORE:	with all observations		
PAIN refer to guideline p4	Severe 7-10		7-10
	Moderate 4-6		4-6
	Mild 1-3		1-3
	None 0		0

Pain Assessment & Management Guidelines

How to score pain: 0 — 10 (No Pain — Worst Pain Imagineable)

Pain Score:		Action:
0	NONE	Continue to assess pain with every set of observations (must be at least daily).
1-3	MILD	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.
4-6	MODERATE	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.
7-10	SEVERE	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.

Guidelines

Cancer-related pain: Always score the worst pain in the last 24hours or since last assessment.

FOR PERSISTANT MODERATE PAIN (4 OR ABOVE) WHICH DISTRESSES THE PATIENT:
Use Cancer Pain Management Algorithm in Palliative Care Resource File. This is distributed to all wards and is also accessible on the intranet. If no improvement in pain score contact hospital palliative care team on **page 1266** at SGH and **page 5742** at VI.

Out of hours advice can be obtained from the Prince and Princess of Wales Hospice on **0141 420 6785.**

Acute pain: Score current pain on movement e.g. deep breathing

PERSISTENT SEVERE PAIN (7 OR ABOVE), WHICH DISTRESSES THE PATIENT:
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Measuring Sedation

The SEWS system uses the AVPU scoring system for conscious level. AVPU is an acronym for Alert, Verbal Pain, Unresponsive. The AVPU system relates to the previous sedation scale as follows:

Sedation	Descriptor	AVPU
0	Awake	A
1	Asleep, roused by speech	V
2	Physical stimulation (eg shaking) required to waken	P
3	Not roused by speech or shaking	U

Measuring Nausea

Is now recorded as 0 for no nausea or vomiting, N for nausea and V for vomiting
For persistent nausea and/or vomiting see clinical handbook or acute pain manual.

NB: Review Treatment Plan

If Temp>38 blood cultures ☐ other cultures ☐ Start antibiotic therapy if indicated

If Systolic BP<100 Review monitoring (cardiac/oximetry/urine output/invasive BP etc)
IV Access
Review patient/drug kardex. Consider fluid challenge ⟶ Definitive Therapy

Consider:

Hypovolaemia	Cardiac	Obstructive	Distributive
Dehydration	*Arryhthmia*	*PE*	*Sepsis*
Blood loss	*Pump failure*	*Tamponade*	*Anaphylaxis*

If Pulse>130 Review monitoring
IV Access
Review patient/ECG/electrolytes ⟶ Definitive Therapy

If O_2 sats <93% Review probe-? accurate
Review patient ⟶ prescribe oxygen on kardex if indicated.

If RR>24 Review patient/CXR +/- gases/PEF etc ⟶ Definitive Therapy

If responds to pain only or unresponsive Assess airway, BM GCS, consider neuro obs chart, review patient/kardex.

South Glasgow Hospitals

NHS Greater Glasgow and Clyde

STANDARDISED EARLY WARNING SCORING SYSTEM (SEWS)

Patient Observation Chart

Name
Address SG00940779
HONEYMAN, CATHERINE
10 MELVILLE STREET
GLASGOW 01/02/1949
Hospital G41 2LN CHI 0102496145
DOB

	Date	Ward	Consultant
Admitted	27/3/11	3	Hutin
Transferred			
Transferred			
Transferred			

This is Chart Number (1) during this admission

All seven parameters must be assessed with each set of observations to obtain an accurate SEWS score.
If a patient has abnormal vital signs please pay particular attention to scoring for urine output.

How to calculate SEWS Score

- Note whether observation falls in shaded "At Risk Zone". Score as per SEWS Key.
- Add points scored and record total "Sews Score" in bottom row of chart.
- Respiratory rate — Write numerical value in appropriate box
- Saturation Sp02 — Write numerical value in appropriate box
- Inspired Oxygen — If the patient's saturation is recorded on air please write A in appropriate box. If patient is on oxygen therapy, please document the amount in appropriate box.
- Temperature — Write numerical value in appropriate box
- Blood pressure — Write numerical values for systolic and diastolic pressure in appropriate box. Remember only the systolic value is considered for the SEWS Score.
- Heart rate — Write numerical value in appropriate box
- Neuro Response — Record patient's best response. If the patient is asleep or demonstrates new confusion, award the same score as verbal response.
- Urine Output — Check that patient has voided urine recently. If yes write PU in box provided. If no write NPU in box provided.
- Urine Output — Check if the patient has passed the equivalent of or more than 30mls/hour for the last three consecutive hours. If yes score 0 in box provided. If no score 3 in box provided and add to total SEWS score.
- SEWS Score — Add up scores for all 7 parameters and write in box provided. If the patient merits an aggregate score of 0 please write 0 in the SEWS score box. Action as per guidelines below.

SEWS KEY

0	1	2	3

SEWS 0-1: Routine observations
SEWS 2-3: Hourly observations and inform nurse in charge
SEWS 4+: Contact PRHO immediately. SHO or more senior doctor must be informed by Junior Doctor. Please record action taken in Nursing Notes

FURTHER SEWS SCORE SHOULD BE CHECKED

- In the event of a sudden worrying *Change*
- If there is a worsening *Trend*
- If concerned the patient looks *Unwell*

The frequency of SEWS scoring is determined by the previous SEWS Score. If the patient continually scores 0-1, the nurse caring for the patient should determine frequency of observations.

A full set of observations and SEWS score should still be carried out.

If SEWS continually 0-1 frequency of observations:

Date	2										
Frequency	4hr										

SEWS KEY

0	1	2	3

NAME Catherine Honeyman DOB 1/2/49.

UNIT No. 940779.

SEWS KEY

0	1	2	3

Date:

Time:

RESP. RATE

SpO2 Numerical Value

Inspired O2%

TEMP.

BLOOD PRESSURE

SEWS SCORE uses Systolic BP

HEART RATE

NEURO RESPONSE

URINE OUTPUT

SEWS SCORE:

PAIN refer to guideline p4

Severe	7-10
Moderate	4-6
Mild	1-3
None	0

RESP. RATE	36+ / 31-35 / 21-30 / 9-20 / ≤8
SpO2 Numerical Value	93+ / 90-92 / 85-89 / <85
Inspired O2%	%
TEMP.	39∞ / 38∞ / 37∞ / 36∞ / 35∞ / 34∞
BLOOD PRESSURE / SEWS SCORE uses Systolic BP	210 / 200 / 190 / 180 / 170 / 160 / 150 / 140 / 130 / 120 / 110 / 100 / 90 / 80 / 70 / 60 / 50 / 40
HEART RATE	150 / 140 / 130 / 120 / 110 / 100 / 90 / 80 / 70 / 60 / 50 / 40 / 30 / 20
NEURO RESPONSE	Alert / Verbal / Pain / Unresponsive
URINE OUTPUT	PU/NPU: / UO<30mls/hr (3 hrs +)
SEWS SCORE:	with all observations
PAIN refer to guideline p4	Severe 7-10 / Moderate 4-6 / Mild 1-3 / None 0

Pain Assessment & Management Guidelines

How to score pain: 0 (No Pain) — 10 (Worst Pain Imagineable)

Pain Score:		Action:
0	NONE	Continue to assess pain with every set of observations (must be at least daily).
1-3	MILD	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.
4-6	MODERATE	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.
7-10	SEVERE	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.

Guidelines

Cancer-related pain: Always score the worst pain in the last 24hours or since last assessment.

FOR PERSISTANT MODERATE PAIN (4 OR ABOVE) WHICH DISTRESSES THE PATIENT:

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Measuring Sedation

The SEWS system uses the AVPU scoring system for conscious level. AVPU is an acronym for Alert, Verbal Pain, Unresponsive. The AVPU system relates to the previous sedation scale as follows:

Sedation	Descriptor	AVPU
0	Awake	A
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Measuring Nausea

Is now recorded as 0 for no nausea or vomiting, N for nausea and V for vomiting
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NB: Review Treatment Plan

If Temp>38 blood cultures ☐ other cultures ☐ Start antibiotic therapy if indicated

If Systolic BP<100 Review monitoring (cardiac/oximetry/urine output/invasive BP etc)
IV Access
Review patient/drug kardex. Consider fluid challenge ⟶ Definitive Therapy

Consider:	Hypovolaemia	Cardiac	Obstructive	Distributive
	Dehydration	*Arryhthmia*	*PE*	*Sepsis*
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If Pulse>130 Review monitoring
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If O_2 sats <93% Review probe ? accurate
Review patient ⟶ prescribe oxygen on kardex if indicated.

If RR>24 Review patient/CXR +/- gases/PEF etc ⟶ Definitive The

If responds to pain only

South Glasgow Hospitals
STANDARDISED EARLY WARNING SCORING SYSTEM (SEWS)
Patient Observation Chart

NHS Greater Glasgow and Clyde

Name CATHERINE HONEYMAN
Address PATIENT
Hospital No. SC009[illegible]79
DOB 1/2/49

	Date	Ward	Consultant
Admitted			
Transferred			
Transferred			
Transferred			

This is Chart Number _____ during this admission

All seven parameters must be assessed with each set of observations to obtain an accurate SEWS score. If a patient has abnormal vital signs please pay particular attention to scoring for urine output.

How to calculate SEWS Score

- Note whether observation falls in shaded "At Risk Zone". Score as per SEWS Key.
- Add points scored and record total "Sews Score" in bottom row of chart.
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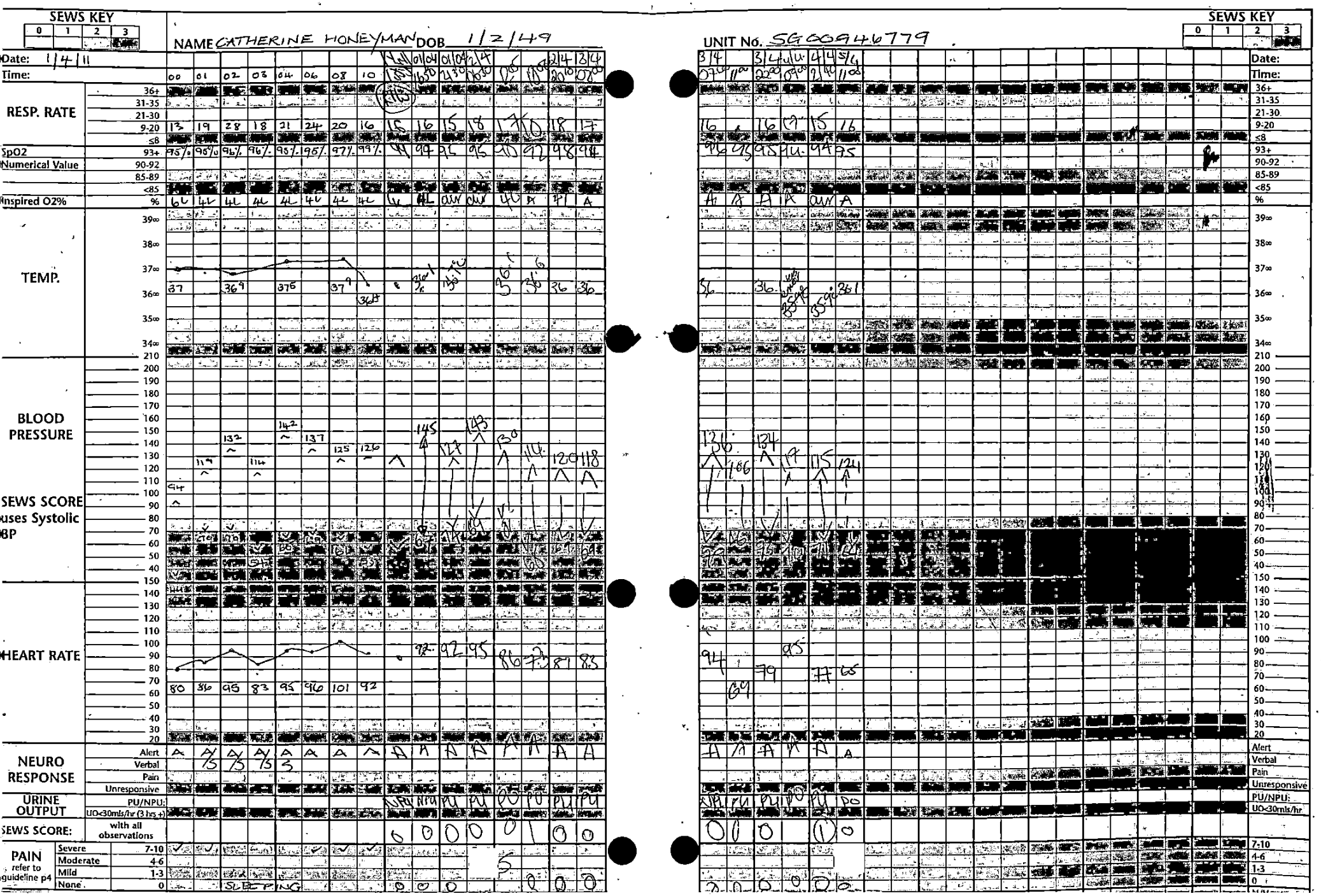
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- If concerned the patient looks ***Unwell***

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A full set of observations and SEWS score should still be carried out.

If SEWS continually 0-1 frequency of observations:

Date											


SEWS KEY
0 1 2 3
NAME CATHERINE HONEYMAN DOB 1/2/49
UNIT No. SG0094679
Date: 1/4/11
Time:
RESP. RATE
SpO2 Numerical Value
Inspired O2%
TEMP.
BLOOD PRESSURE
SEWS SCORE uses Systolic BP
HEART RATE
NEURO RESPONSE
Alert
Verbal
Pain
Unresponsive
URINE OUTPUT
PU/NPU:
UO<30mls/hr (3 hrs +)
SEWS SCORE: with all observations
PAIN refer to guideline p4
Severe 7-10
Moderate 4-6
Mild 1-3
None 0
SLEEPING

Pain Assessment & Management Guidelines

How to score pain: 0 — No Pain ... 10 — Worst Pain Imagineable

Pain Score:		Action:
0	NONE	Continue to assess pain with every set of observations (must be at least daily).
1-3	MILD	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.
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Measuring Nausea

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NB: Review Treatment Plan

If Temp>38 blood cultures ☐ other cultures ☐ Start antibiotic therapy if indicated

If Systolic BP<100 Review monitoring (cardiac/oximetry/urine output/invasive BP etc)
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Consider:	Hypovolaemia	Cardiac	Obstructive	Distributive
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	Blood loss	*Pump failure*	*Tamponade*	*Anaphylaxis*

If Pulse>130 Review monitoring
IV Access
Review patient/ECG/electrolytes ⟶ Definitive Therapy

If O_2 sats <93% Review probe ? accurate
Review patient ⟶ prescribe oxygen on kardex if indicated.

If RR>24 Review patient/CXR +/- gases/PEF etc ⟶ Definitive The

If responds to pain only

South Glasgow Hospitals

NHS Greater Glasgow and Clyde

STANDARDISED EARLY WARNING SCORING SYSTEM (SEWS)

Patient Observation Chart

Name
Address HONEYMAN, CATHERINE S0009460719 01/02/49 F CHI: 0102496145 Date Time Spec./Stg. AT
Hospital No. ID
DOB

	Date	Ward	Consultant
Admitted		5	Hutton
Transferred			
Transferred			
Transferred			

This is Chart Number 1 during this admission

All seven parameters must be assessed with each set of observations to obtain an accurate SEWS score.
If a patient has abnormal vital signs please pay particular attention to scoring for urine output.

How to calculate SEWS Score

- Note whether observation falls in shaded "At Risk Zone". Score as per SEWS Key.
- Add points scored and record total "Sews Score" in bottom row of chart.
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- Heart rate — Write numerical value in appropriate box
- Neuro Response — Record patient's best response. If the patient is asleep or demonstrates new confusion, award the same score as verbal response.
- Urine Output — Check that patient has voided urine recently. If yes write PU in box provided. If no write NPU in box provided.
- Urine Output — Check if the patient has passed the equivalent of or more than 30mls/hour for the last three consecutive hours. If yes score 0 in box provided. If no score 3 in box provided and add to total SEWS score.
- SEWS Score — Add up scores for all 7 parameters and write in box provided. If the patient merits an aggregate score of 0 please write 0 in the SEWS score box. Action as per guidelines below.

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0	1	2	3

SEWS 0-1: Routine observations
SEWS 2-3: Hourly observations and inform nurse in charge
SEWS 4+: Contact PRHO immediately. SHO or more senior doctor must be informed by Junior Doctor. Please record action taken in Nursing Notes

FURTHER SEWS SCORE SHOULD BE CHECKED

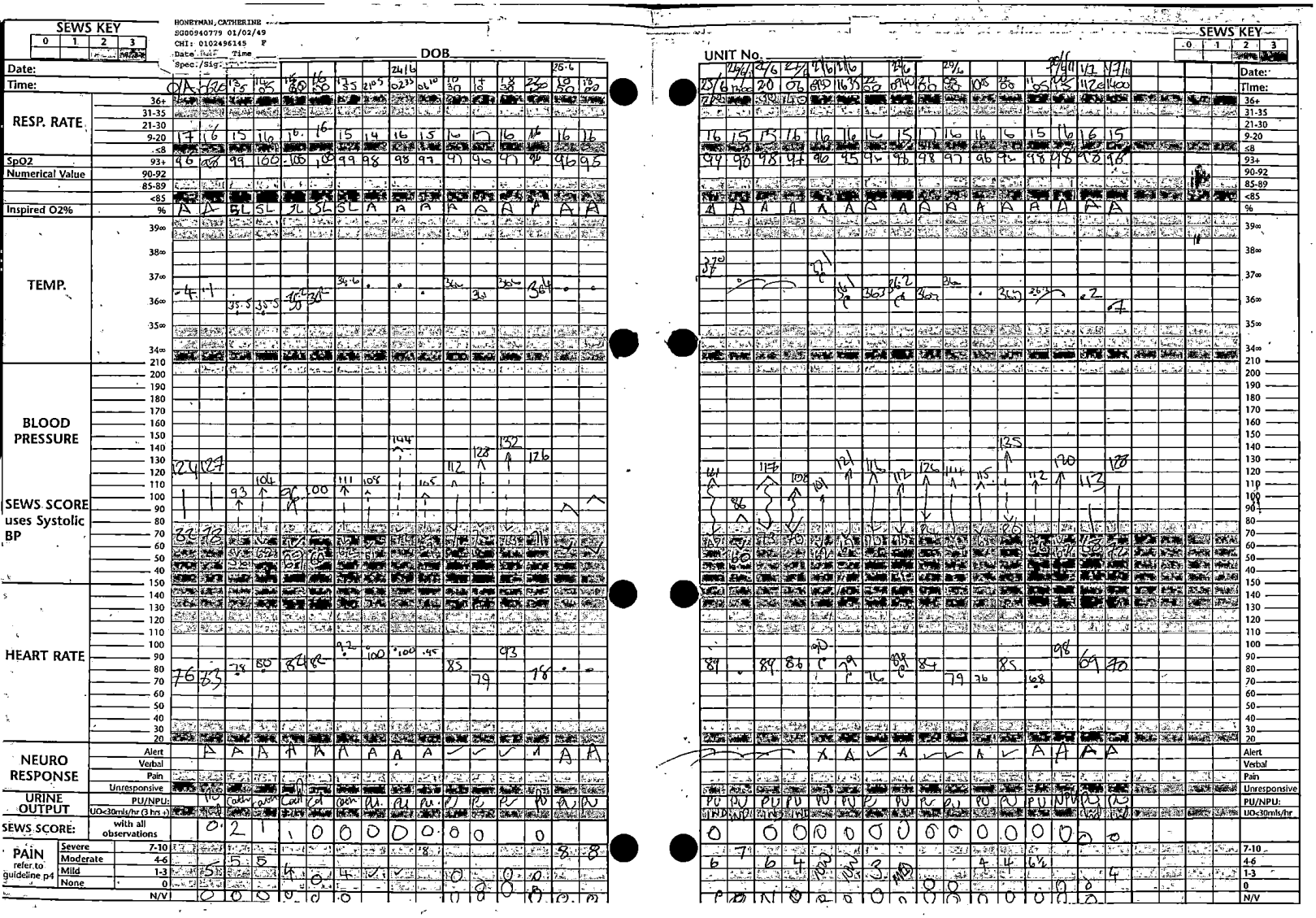
- In the event of a sudden worrying *Change*
- If there is a worsening *Trend*
- If concerned the patient looks *Unwell*

The frequency of SEWS scoring is determined by the previous SEWS Score. If the patient continually scores 0-1, the nurse caring for the patient should determine frequency of observations.

A full set of observations and SEWS score should still be carried out.

If SEWS continually 0-1 frequency of observations:

Date	2, VII	8/6	29/6									
	HD	4pm	4pm									


SEWS KEY
0 1 2 3
HONEYMAN, CATHERINE
SG00940779 01/02/49
CHI: 0102496145 F
DOB
UNIT No.
Date:
Time:
RESP. RATE
SpO2
Numerical Value
Inspired O2%
TEMP.
BLOOD PRESSURE
SEWS SCORE uses Systolic BP
HEART RATE
NEURO RESPONSE
Alert
Verbal
Pain
Unresponsive
URINE OUTPUT
PU/NPU:
UO<30ml/hr (3 hrs +)
SEWS SCORE:
with all observations
PAIN refer to guideline p4
Severe 7-10
Moderate 4-6
Mild 1-3
None 0
N/V

Female Caucasian

Loc: 48

[redacted]

PR interval 184 ms
QRS duration 86 ms
QT/QTc 402/448 ms
P-R-T axes 38 20 43

Normal Sinus Rhythm
Normal ECG

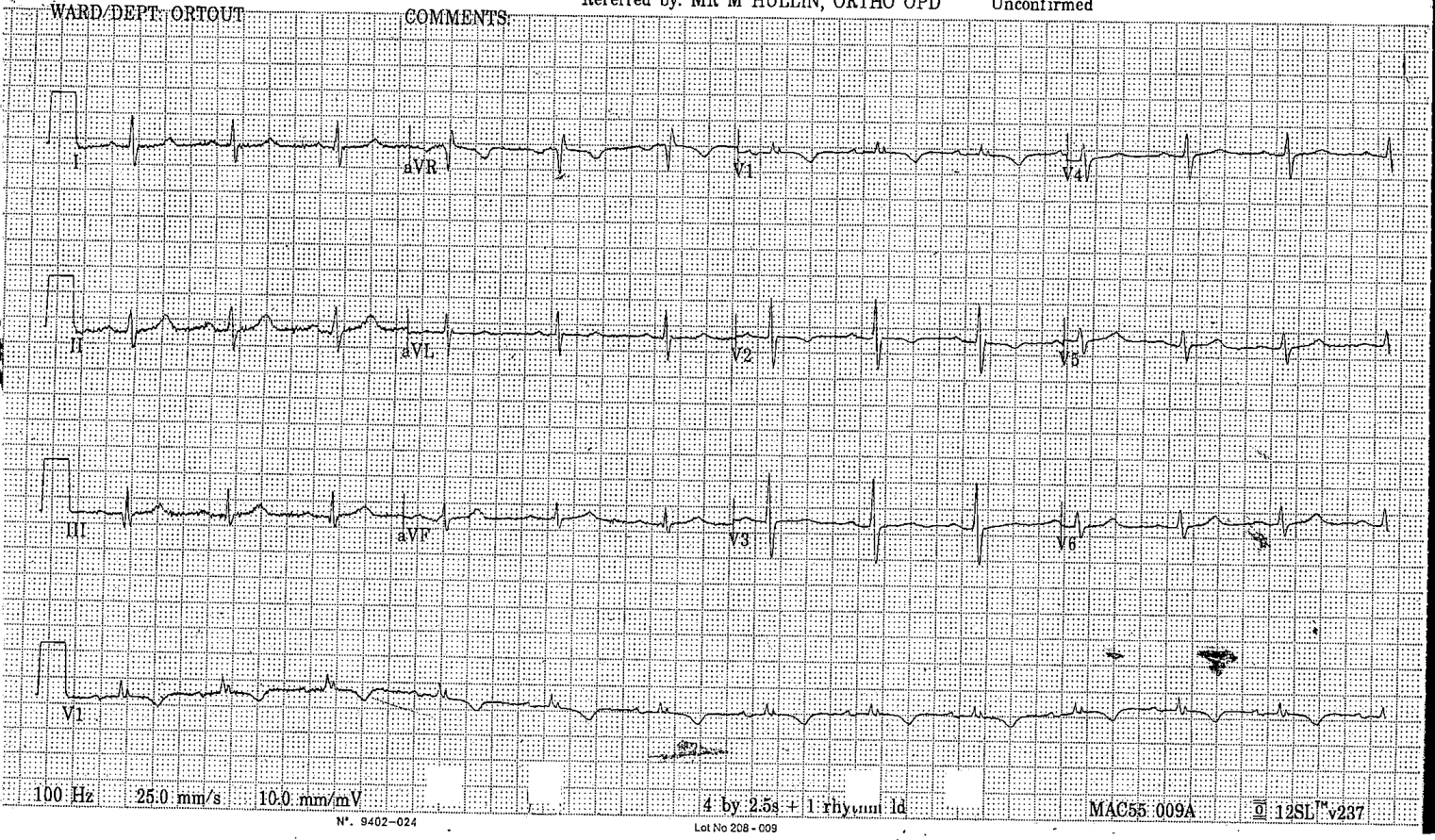
History: Unknown
Technician: CQ
Test ind: PRE OP

Referred by: MR M HULLIN, ORTHO OPD

Unconfirmed

WARD/DEPT: ORTOUT

COMMENTS:



100 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + 1 rhythm ld MAC55 009A 12SL™ v237

N°. 9402-024

Lot No 208 - 009

1-Feb-1949
Female Caucasian

Loc: 0

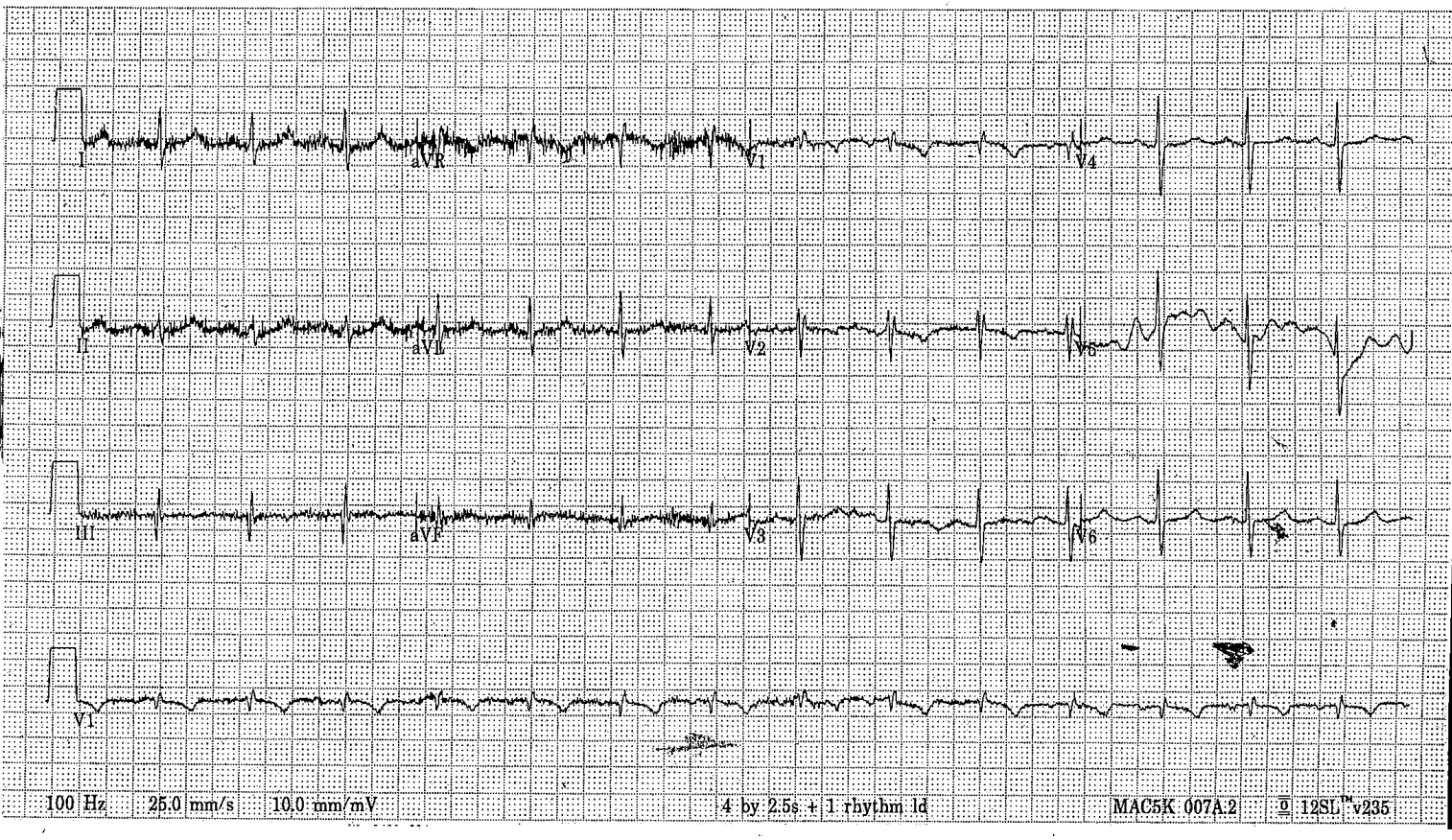
Technician:
Test ind:

Vent. rate	87	bpm
PR interval	152	ms
QRS duration	70	ms
QT/QTc	398/478	ms
P-R-T axes	12 -19 7	

Accelerated Junctional rhythm with fusion co[illegible]kes
[illegible]ferior infarct, age undetermined

Referred by:

Unconfirmed



100 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + 1 rhythm ld MAC5K 007A.2 12SL™ v235

HONEYMAN, CATHERINE ID: SG0094077[illegible] 16-Apr-2010 15:27:25 SOUTHERN GENERAL HOSPITAL

1-Feb-1949
Female Caucasian

Loc: 0

Vent. rate [illegible] bpm
PR interval
QRS duration 90 ms
QT/QTc 402/466 ms
P-R-T axes 92 5 13

Normal sinus rhythm
Normal ECG

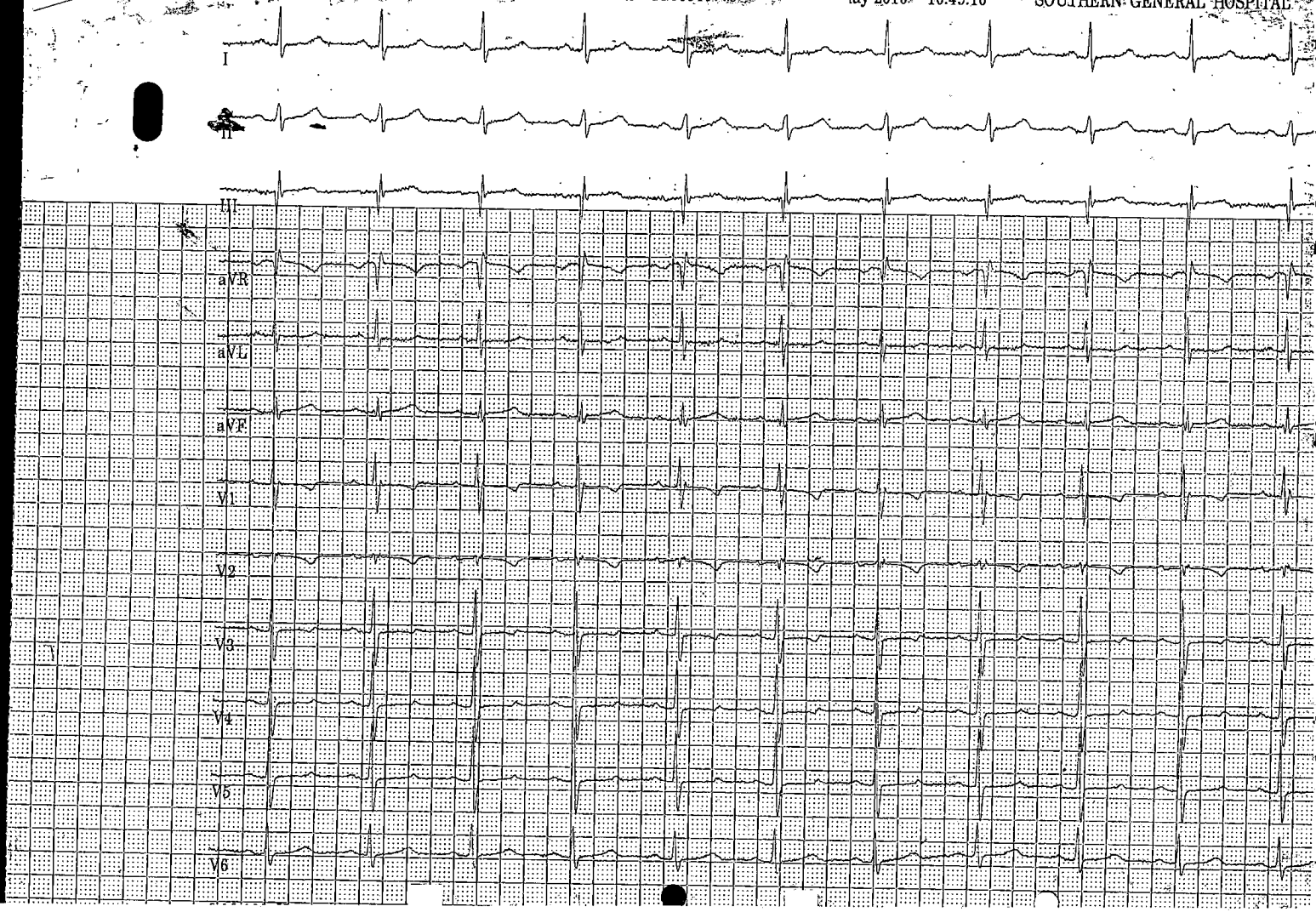
Technician:
Test ind:

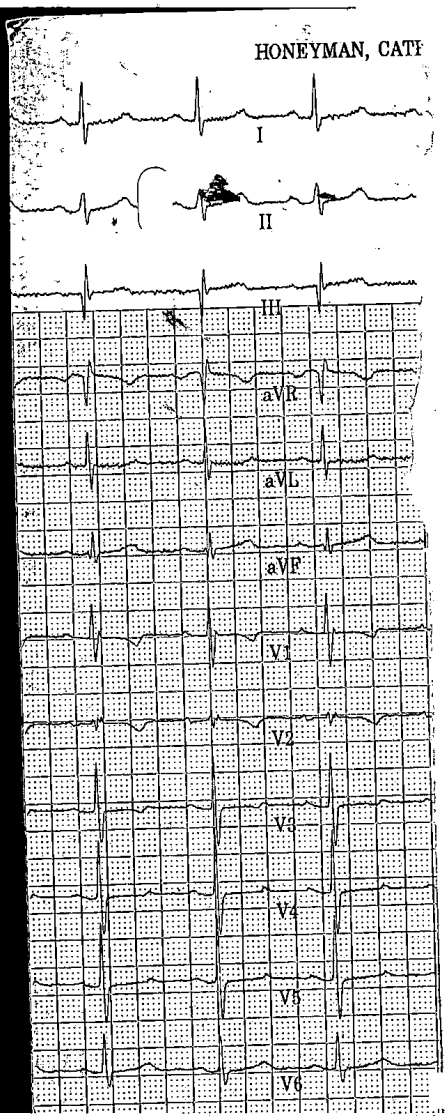
Referred by: --

Unconfirmed



HONEYMAN, CATHERINE ID: SG00940779 RHYTHM REPORT
ay-2010 10:49:16 SOUTHERN GENERAL HOSPITAL




HONEYMAN, CATH
I
II
III
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6

HONEYMAN, CATHERINE ID: SG00940779 4-May-2010 10:[illegible] SOUTHERN GENERAL HOSPITAL

Vent. rate 6[illegible] bpm
PR interval 192 ms
QRS duration 86 ms
QT/QTc 454/486 ms
P-R-T axes 30 2 46

Normal sinus rhythm
Septal infarct, age undetermined

Honeyman 4.

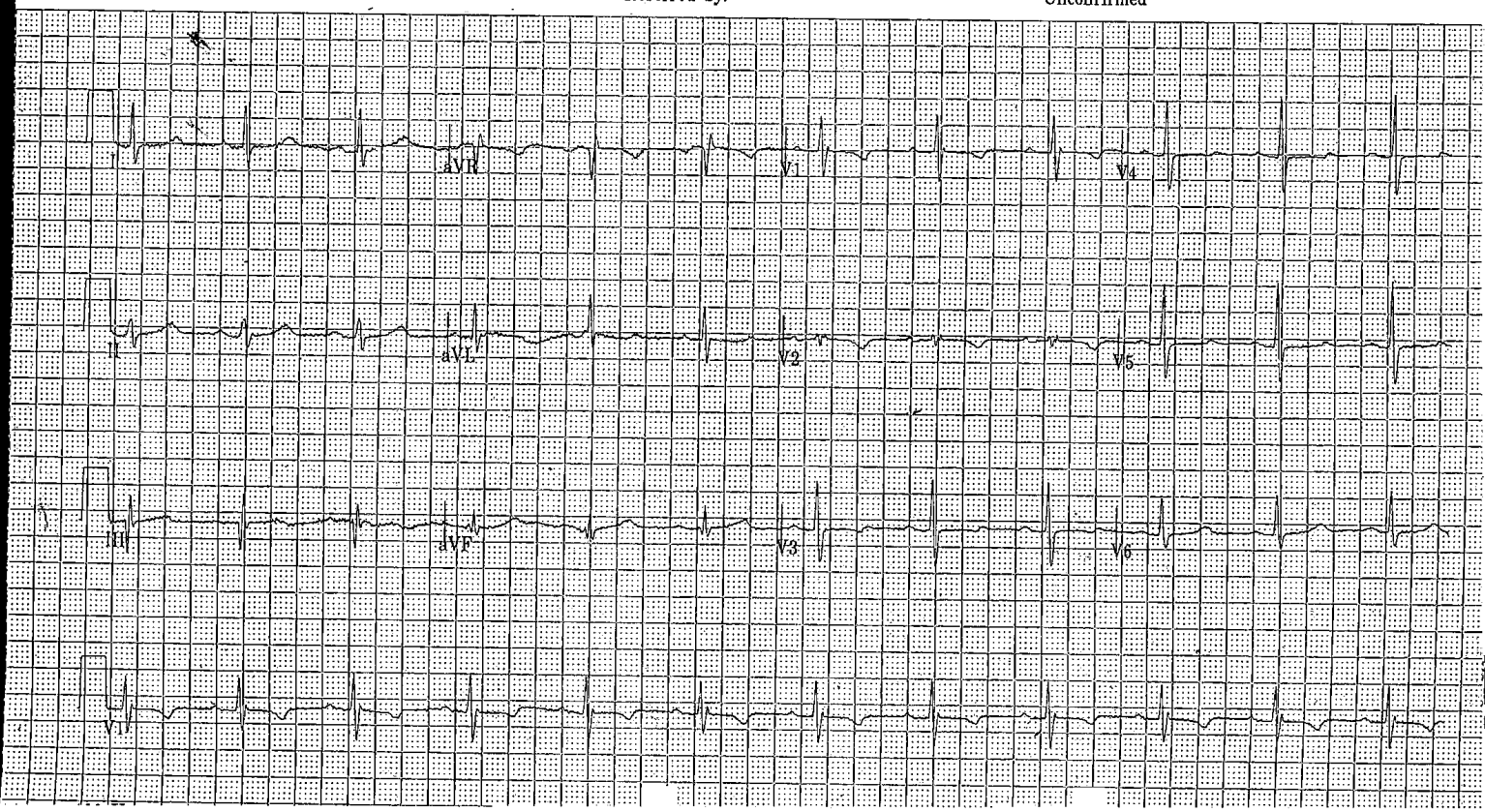
Loc: 0

[redacted]

Technician:
Test ind:

Referred by:

Unconfirmed



1-Feb-1949
Female Caucasian

Loc: 0

Vent. rate	76 bpm
PR interval	174 ms
QRS duration	100 ms
QT/QTc	426/479 ms
P-R-T axes	31 6 46

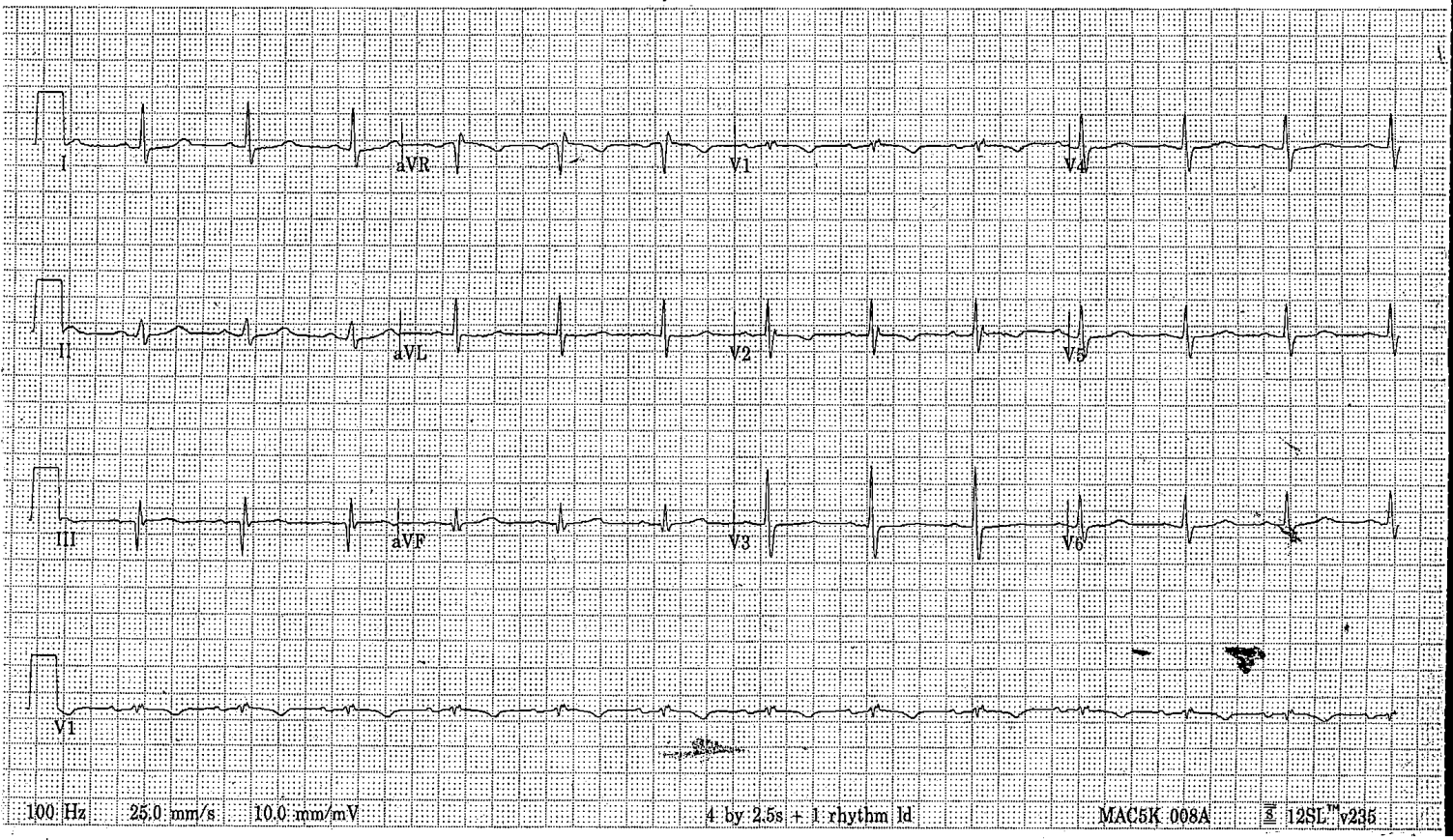
[redacted] Normal sinus rhythm
[redacted] Incomplete right bundle branch block

[redacted]

Technician: CATH
Test ind: PRE OP

Referred by: WARD 1

Unconfirmed



100 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + 1 rhythm ld MAC5K 008A S 12SL™v235

[redacted]

1-Feb-1949
Female Caucasian

Loc: 0

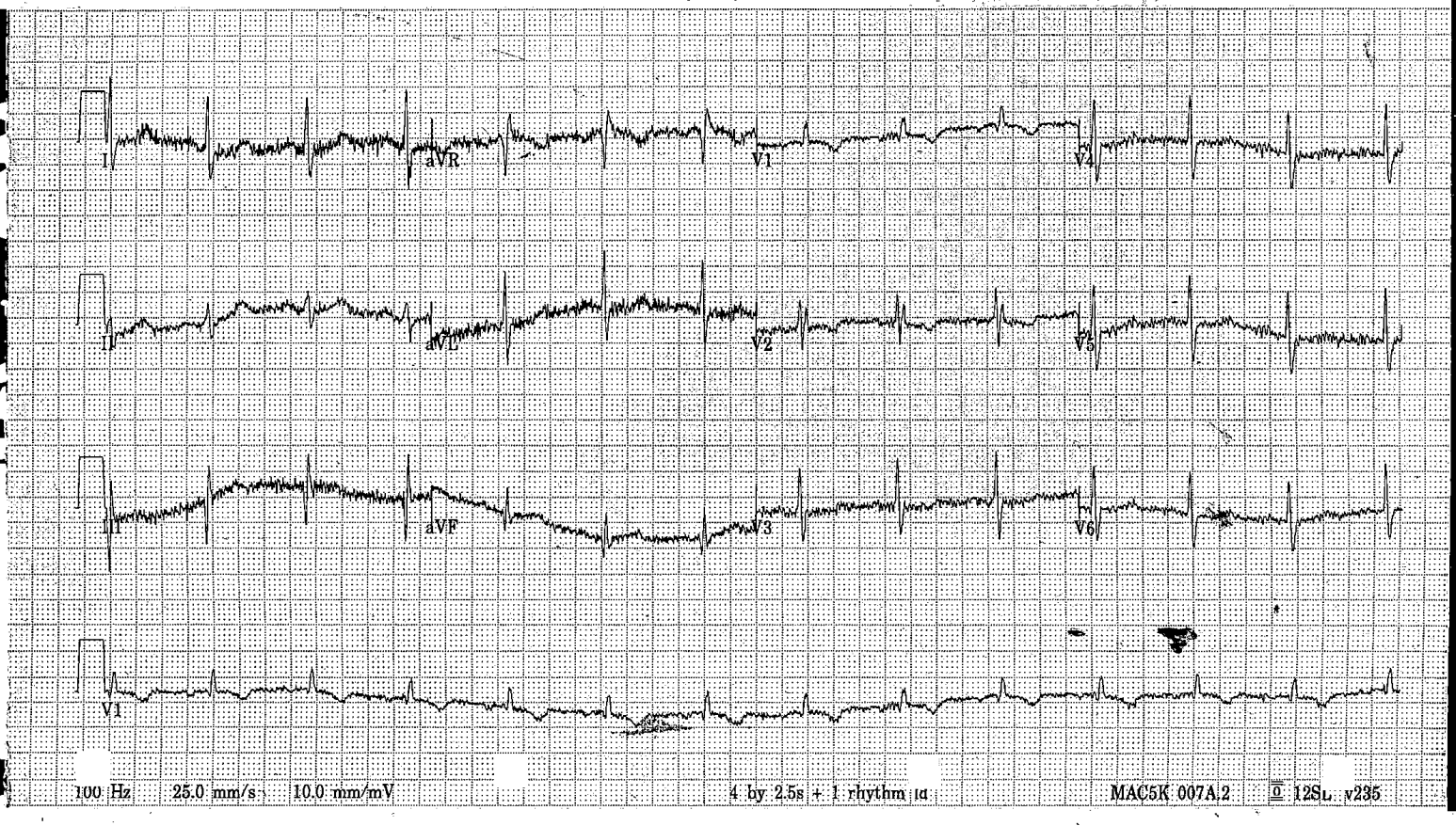
Vent. rate 79 bpm
PR interval 168 ms
QRS duration 88 ms
QT/QTc 394/451 ms
P-R-T axes 80 5 49

Accelerated Junctional rhythm
RSR' or QR pattern in V1 suggests right ventricular conduction delay
Nonspecific ST and T wave abnormality

Technician: SM
- Test ind: PREOP

Referred by: SM, FY2

Unconfirmed



100 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + 1 rhythm Id MAC5K 007A.2 12SL v235

1-Feb-1949
Female Caucasian

Loc: 0

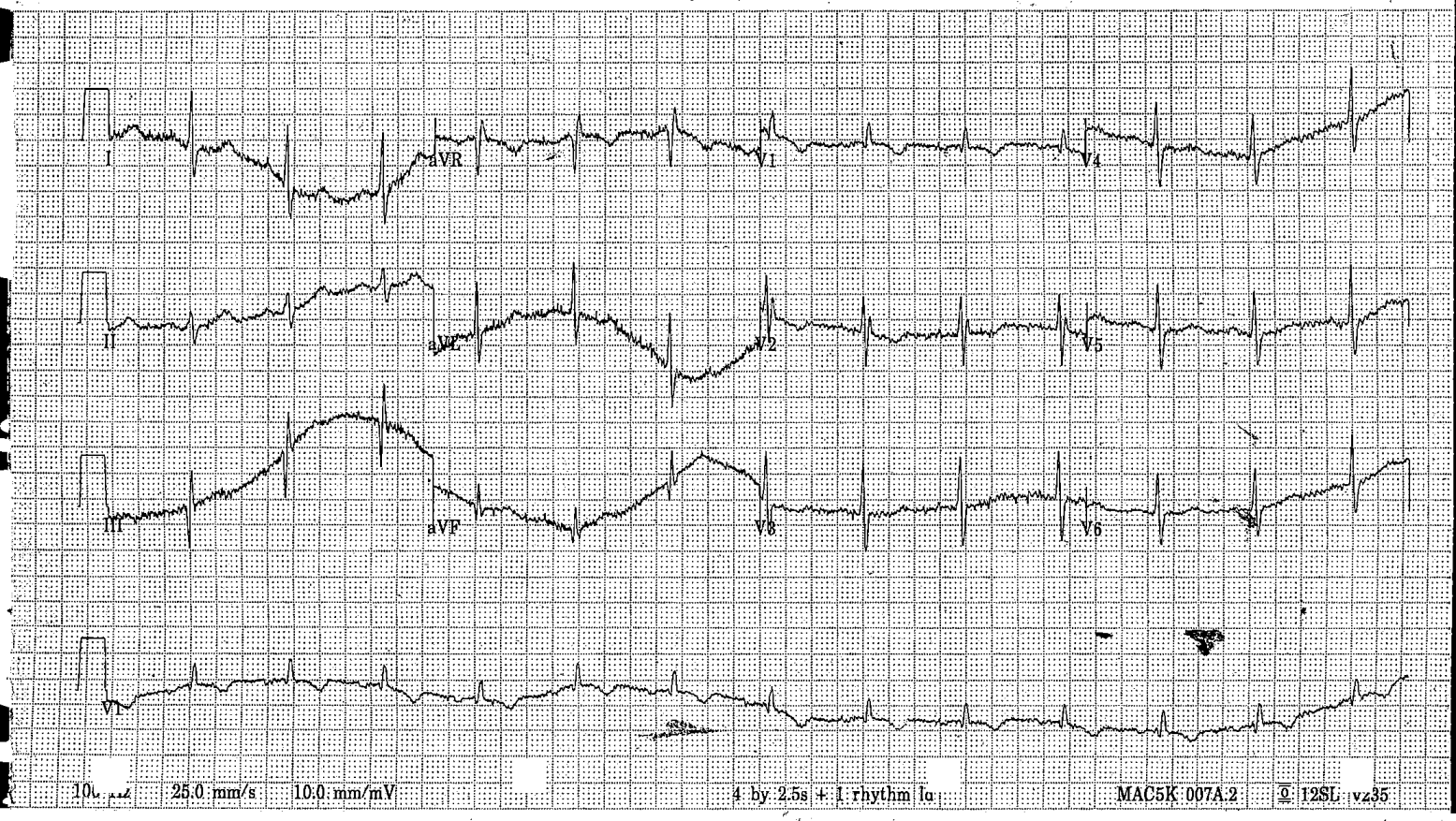
Vent. rate	80 bpm
PR interval	148 ms
QRS duration	96 ms
QT/QTc	426/491 ms
P-R-T axes	3 -4 73

Accelerated Junctional rhythm
Incomplete right bundle branch block
Nonspecific ST and T wave abnormality
Prolonged QT

Technician: SM
Test ind: PREOP

Referred by: SM, FY2

Unconfirmed



10.0 mm/mV 25.0 mm/s 10.0 mm/mV 4 by 2.5s + 1 rhythm la MAC5K 007A.2 12SL v235

1-Feb-1949
Female Caucasian

Loc: 301

[redacted]

Technician: 316
Test ind: PRE OP
Meds: PT IN CHAIR

Vent. rate	83 bpm
PR interval	182 ms
QRS duration	98 ms
QT/QTc	402/472 ms
P-R-T axes	53 99 61

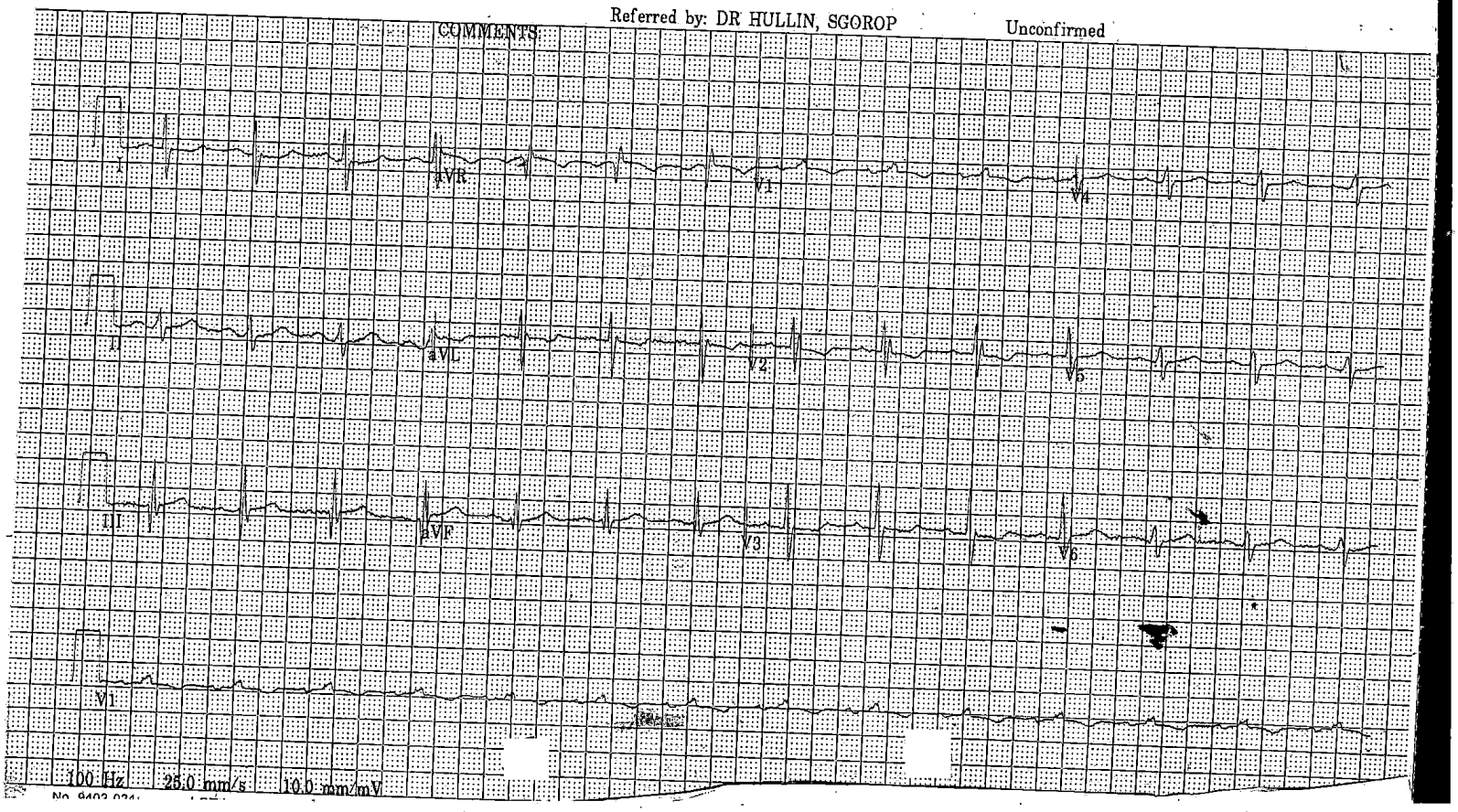
ormal sinus rhythm
ghtward axis
ncomplete right bundle branch block
Prolonged QT

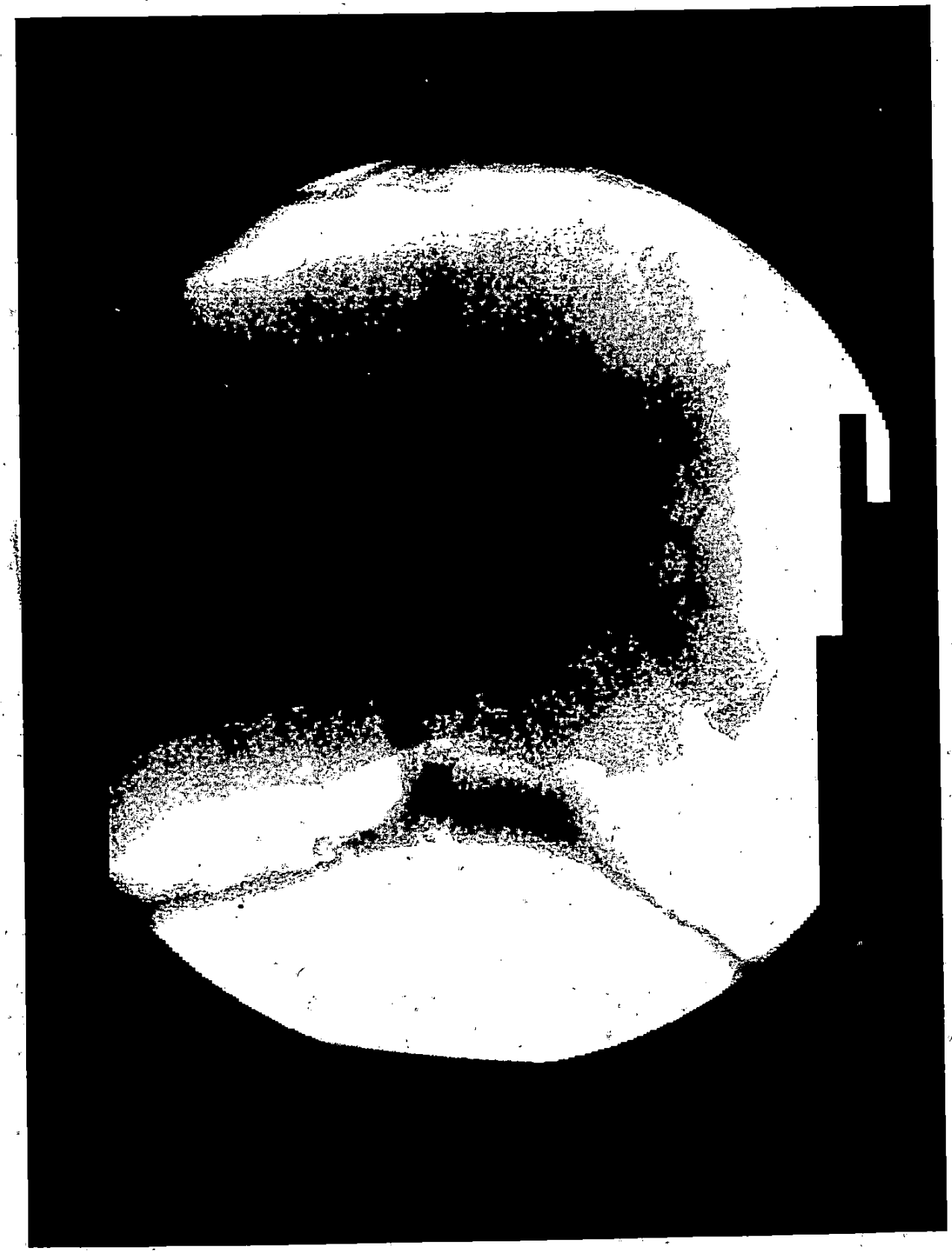
10-Jun-2011 12:45:24 SOUTHERN GENERAL HOSPITAL

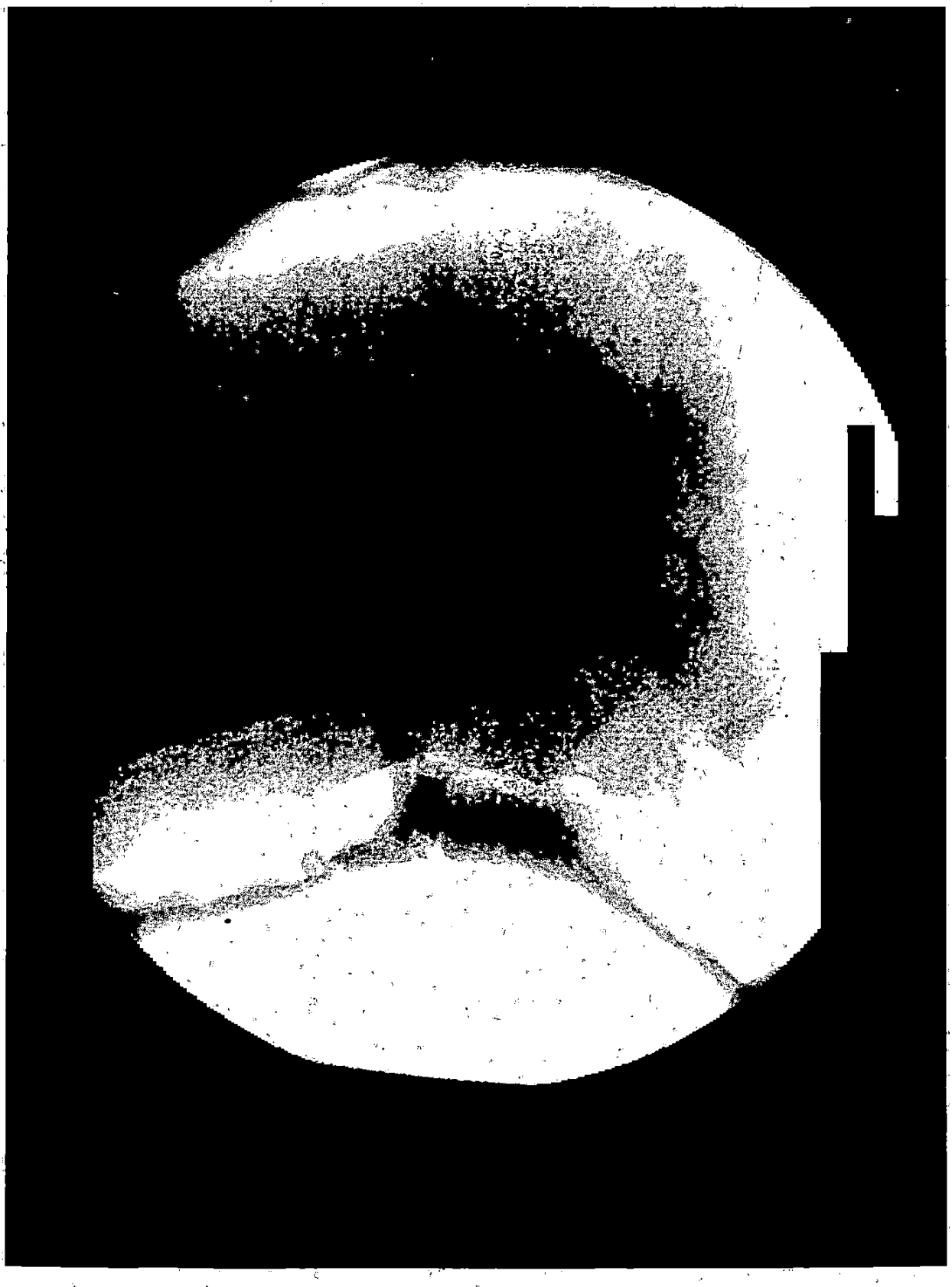
Referred by: DR HULLIN, SGOROP

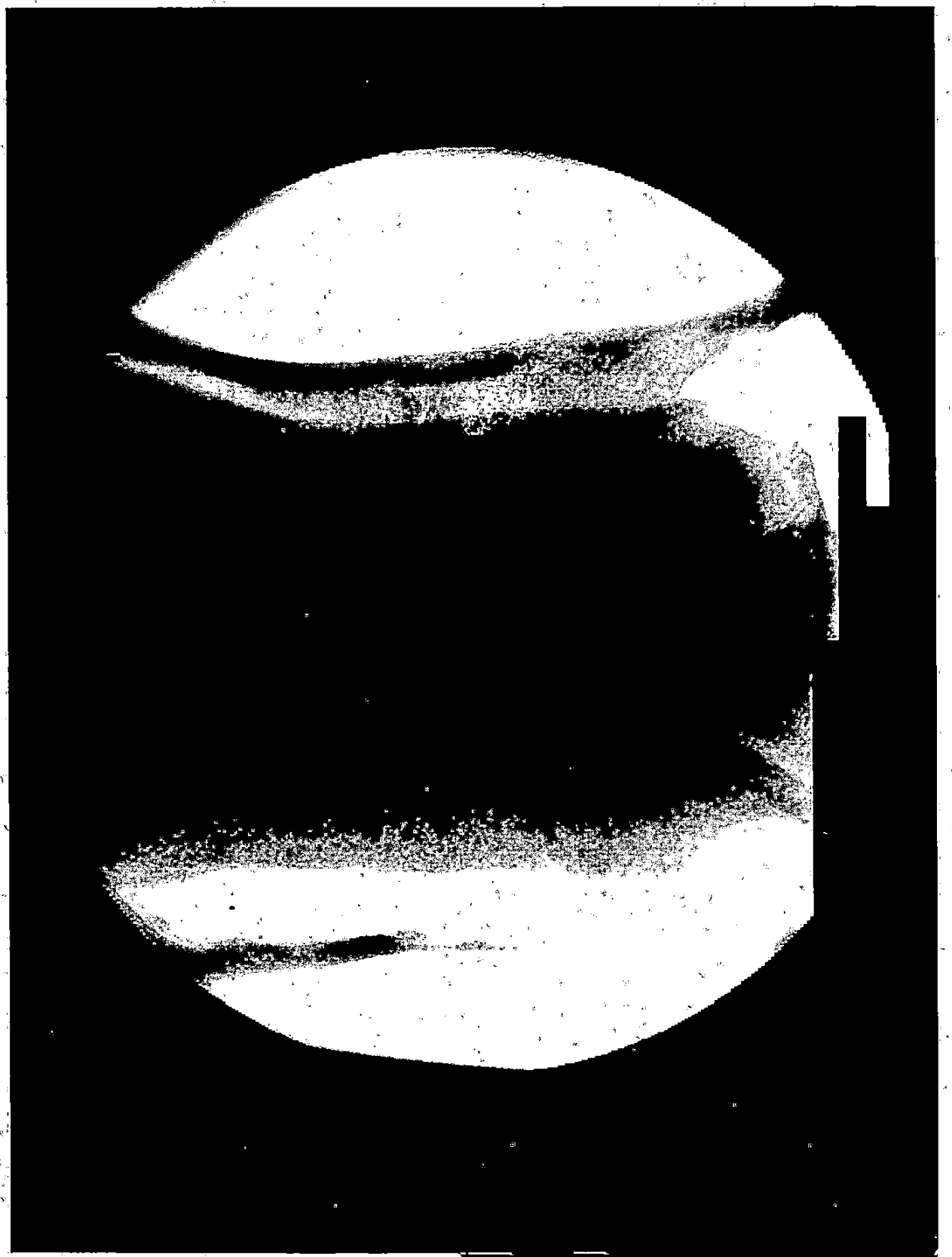
Unconfirmed

COMMENTS:









NHS Greater Glasgow and Clyde

Southern General Hospital

Diagnostic Imaging Repor

HONEYMAN, Catherine
10 Melville Street, , Glasgow, Lanarkshire, G41 2LN
Referrer: MR MG HULLIN - SGH WARD 6

DoB: **01/02/1949**
Chi No: **0102496145**
CRIS No: **86569**
Hosp No: **SG00940779**

VERIFIED Verified By: DR B MUCCI 02/02/10 1445.
Clinical History : Post op left knee replacement. Right patel post op check.

XR Knee Lt :
XR Knee Rt :

Positions appear good.

NHS Greater Glasgow & Clyde
SGH 401 Cat 5290802

Ref. Src: Southern General Hospital, 1345 Govan Road, Glasgow, G51 4TF
Exams: XR Knee Lt,XR Knee Rt
Exam Date: 01/02/10 Event: E-12203312

089(
JMcC/715

NHS Greater Glasgow and Clyde

Southern General Hospital

Diagnostic Imaging Report

HONEYMAN, Catherine **01/02/1949** **CHI: 0102496145**
10 Melville Street, Glasgow, Lanarkshire, G41 2LN Hosp: SG00940779
Source: **SGH ORTHO OUTPATIENT** **Age: 58yr Sex: F** **CRIS: 86569**
Ref: **MR SANJEEV PATIL** **TRAUMA & ORTHOPAEDIC SURGERY*** **Event: E-2776389**

25/7

INJECTION + IMAGING 30 BONE, EARLY/LATE
Reported by: Dr B MUCCI (Cons). Verified
Clinical History : 8 months post knee replacement, ongoing pain ? inflammation.

INJECTION + IMAGING 30 :

BONE, EARLY/LATE :
Early phase acquisition over the knees shows increase uptake around the prosthesis particularly the medial side of both the femoral and tibial components. Also in the early phase is some increased uptake medially in the opposite (left) knee consistent with inflammatory change here. Distribution on the late acquisition is similar. Elsewhere in the skeleton there are other areas of late increased uptake including the feet, the shoulders and cervical spine, these appearances may all be degenerative. Overall

reater Glasgow & Clyde
Cat 5290802

Patient's Name: Catherine Honeyman

D.o.B.:

Unit number: SG0094O779

Ward:

Use addressograph label

South Glasgow Hospitals

24 Hour Fluid Balance Chart

NHS Greater Glasgow and Clyde

Instructions

* Theatre

Date: 28/1/10 | Previous 24 hour fluid balance - Intake: | Output:

	Intake					Output		
Time	IV infusions	Volume	Enteral / Oral	Volume	Running Total	Urine	Drains (D), Vomit (V) Aspirate (A) etc.	Running Total
01								
02								
03								
04								
06								
07								
08								
09 *	Hartmann's	1000		~~1000~~	1000			
10 *	Gelofusine	500		~~1500~~	~~500~~			
*	Hartmans	1000			2500			
11 *	NaCl	500 + diclofenac 75mg			3000			
12 *	Hartmann's	1000	500 aissuaded	0	3500			
13	Paracetamol Hartmans	100 500			3600			
14								
16								
17	Dextrose 5% 500	5100			4600			
18								
19								
20								
21			Tea	200	4800	IV ?		
22			Water	500	4800			
23								
24	Dextrose	500			5300			
	Individual Totals:							
				Total Intake:			Total Output:	

Final Fluid Balance +/-

atient's N

.o.B.: SG00940779

CATHERINE HONEYMAN

nit numl 10 MELVILLE STREET

'ard: GLASGOW 01/02/1949

G41 2LN CHI 0102496145

South Glasgow Hospitals

24 Hour Fluid Balance Chart

NHS Greater Glasgow and Clyde

Instructions

Date:

Previous 24 hour fluid balance - Intake: Output:

Time	Intake					Output		
	IV infusions	Volume	Enteral / Oral	Volume	Running Total	Urine	Drains (D), Vomit (V) Aspirate (A) etc	Running Total
01								
02								
03								
04								
0!								
06								
07								
08								
09								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
	Individual Totals:							
				Total Intake:			**Total Output:**	
al Fluid Balance +/-								

atient's Name: CATHERINE HONEYMAN

.o.B.: 01/01/49

nit number: SG 940779

/ard: 5

Use addressograph label

South Glasgow Hospitals

24 Hour Fluid Balance Chart

NHS Greater Glasgow and Clyde

Instructions

Date: 04:05:10 | Previous 24 hour fluid balance - Intake: | Output:

	Intake					Output		
Time	IV Infusions	Volume	Enteral / Oral	Volume	Running Total	Urine	Drains (D), Vomit (V) Aspirate (A) etc	Running Total
01								
02								
03								
04								
05								
06								
07								
08								
09	HARTMANNS	1000						
10	Volterol 75g							
11	PCA Morphine 1g	100						
12	Hartmanns	1000						
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
	Individual Totals:							
				Total Intake:			Total Output:	

Final Fluid Balance +/-

Patient's Name: _____

D.o.B.: _____

Unit number: _____

Ward: _____

Use addressograph label

South Glasgow Hospitals

24 Hour Fluid Balance Chart

NHS Greater Glasgow and Clyde

Instructions

Date:

Previous 24 hour fluid balance - Intake: Output:

	Intake					**Output**		
Time	IV infusions	Volume	Enteral / Oral	Volume	Running Total	Urine	Drains (D), Vomit (V) Aspirate (A) etc	Running Total
01								
02								
03								
04								
06								
07								
08								
09								
10								
11								
12								
13								
14								
16								
17								
18								
19								
20								
21								
22								
23								
24								
	Individual Totals:							
				Total Intake:			**Total Output:**	

inal Fluid Balance +/-

atient's Name: Catherine Honeyman

.o.B.: 01/02/1949

nit number: SG0094077G.

/ard: 1

Use addressograph label

South Glasgow Hospitals

24 Hour Fluid Balance Chart

NHS Greater Glasgow and Clyde

Instructions

* Theatre *

Date: 14.7.10 | **Previous 24 hour fluid balance -** Intake: Output:

	Intake					Output		
Time	IV infusions	Volume	Enteral / Oral	Volume	Running Total	Urine	Drains (D) Vomit (V) Aspirate (A) etc	Running Total
01								
02								
03 34	IVF	500			500			
04						300		300
05								
06								
07						200		500
08								
09								
10								
11								
12								
13								
14								
20	Hartmanns	1,000ml			1,500ml			
*25	1g IV Paracetamol	100ml			1,600ml			
*30 16	Hartmanns	1,000ml						
17					-300 1,300			
18								
19						300		800
20								
21			TEA	200	1500			
22 30	Saline/Ivraft N Saline	100 500			1600 2100			
23			TEA	100	2200			
24						PU		
	Individual Totals:							
				Total Intake:			**Total Output:**	800+

Final Fluid Balance +/-

Patient's Name: Catherine Horayman

D.o.B.: 01-02-1945

Unit number:

Ward: 1

Use addressograph label

South Glasgow Hospitals

24 Hour Fluid Balance Chart

NHS Greater Glasgow and Clyde

Instructions

Date: 16/07/D

Previous 24 hour fluid balance - Intake: Output:

	Intake					Output		
Time	IV infusions	Volume	Enteral/Oral	Volume	Running Total	Urine	Drains (D), Vomit (V), Aspirate (A) etc	Running Total
01	c/f N Saline	400			400			
02								
03								
04						300		300
06								
07	N Saline ~~100~~	100			500			
08								
09								
10	~~5%~~ Dex	500			1000			
11								
12								
13								
14								
16								
17								
18								
19								
20								
21								
22								
23								
24								
	Individual Totals:							
				Total Intake:			**Total Output:**	

Final Fluid Balance +/-

atient's Name: CATHERINE HONEYMAN

.o.B.: 1/2/49

nit number: SG0094677 9

/ard: SHDU / ND 2

Use addressograph label

South Glasgow Hospitals

24 Hour Fluid Balance Chart

NHS Greater Glasgow and Clyde

Instructions

Date: 1/4/11

Previous 24 hour fluid balance - Intake: Output:

	Intake					Output		
Time	IV infusions	Volume	Enteral / Oral	Volume	Running Total	Urine	Drains (D), Vomit (V), Aspirate (A) etc	Running Total
01		125		600	725			
02		125			850			
03		125			975			
04		125			1100			1
05		125			1225			
06		125		300	1650	400		400
07		142			1792			
08		125		150	2067			
09		125	BFAST	200	2392	NUP		400
10		125	WATER	150	2667			
11		125				NUP		400
12		125	LUNCH	800	2967			
13								
14								
15								
16								
17						500		900
18								
19								
20								
21								
22								
23								
24								
	Individual Totals:							
				Total Intake:			Total Output:	

Final Fluid Balance +/-

Patient's Name: CATHERINE HONEYMAN

D.o.B.: 1/2/49

Unit number: SC0094679

Ward: TWO

Use addressograph label

South Glasgow Hospitals

24 Hour Fluid Balance Chart

NHS Greater Glasgow and Clyde

Instructions

Date: 2/4/4 | **Previous 24 hour fluid balance -** Intake: Output:

	Intake					Output		
Time	IV infusions	Volume	Enteral / Oral	Volume	Running Total	Urine	Drains (D), Vomit (V) Aspirate (A) etc	Running Total
01								
02								
03								
04								
06								
07	IVAB's	100		15	100			
08			Breakfast.	150	250			
09								
10								
11								
12			lunch	150	400			
13	IVAB's				500			
14								
16								
17								
18								
19								
20			MILK	250	750			
21								
22			MILK	250	1000			
23								
24								
	Individual Totals:							
				Total Intake:			**Total Output:**	
al Fluid Balance	+/-							

368571-SGH 27A

VIMI • NURSING • 5710

SOUTHE

SG00940779
CATHERINE HONEYMAN
10 MELVILLE STREET
GLASGOW
G41 2LN

01/02/1949
CHI 0102496145

I.V. THERAPY PRESCRIPTION SHEET

NAME:

WARD: 6

UNIT No.:

D.O.B.:

DATE			IVE	VOLUME OR DOSE	TIMING	DOCTORS SIGNATURE		BATCH No.	NURSES SIGNATURE			
						ORDERED BY	CANCELLED BY		DATE	TIME	GIVEN BY	CHECKED BY
12/12/05		A 0.9% NaCl		500ml	4°			05116S	12/12	1400		
14/12/05		B 5% Dextrose		500 ml	8°			05129J	12/12	2350		
		C (N) Saline		500	6°			05J03F	13.12	0415	JF	
		D										
		E										
		F										
		G										
		H										
		I										
		J										
		K										
		L										
		M										
		N										
		O										
		P										
		Q										
		R										

DATE	ADVERSE REACTION	STOP FLUID/BLOOD/ADDITIVE	RECORD BATCH No. BELOW

SGH 27C

RN GENERAL HOSPITAL

I.V. THERAPY PRESCRIPTION SHEET

NAME: WARD: UNIT No.: D.O.B.:

DATE	TIME		FLUID / BLOOD	ADDITIVE	VOLUME OR DOSE	TIMING	DOCTORS SIGNATURE		BATCH No.	NURSES SIGNATURE			
							ORDERED BY	CANCELLED BY		DATE	TIME	GIVEN BY	CHECKED BY
		A											
		B											
		C											
		D											
		E											
		F											
		G											
		H											
		I											
		J											
		K											
		L											
		M											
		N											
		O											
		P											
		Q											
		R											

DATE	ADVERSE REACTION	STOP FLUID/BLOOD/ADDITIVE	RECORD BATCH No. BELOW

SOUTHERN GENERAL HOSPITAL — **I.V. THERAPY PRESCRIPTION SHEET**

NAME: Catherine Honeyman WARD: Six. UNIT No.: SG0094049 D.O.B.: 01.02.49

DATE	TIME		FLUID / BLOOD	ADDITIVE	VOLUME OR DOSE	TIMING	DOCTORS SIGNATURE		BATCH No.	NURSES SIGNATURE			
							ORDERED BY	CANCELLED BY		DATE	TIME	GIVEN BY	CHECKED BY
		A	Hartmanns sol"		1000	Th	Heatherthorne		09L22BC	28.1.10	9.10	HH	
		B	gelofusin		500	Th			9823 H41	28.1.10	9.30	HH	
		C	Hartmanns sol"		1000	Th	Heatherthorne		09L22BC	28.1.10	9.55	HH	
		D	NaCl 0.9%	DICLOFENAC 75mg	500	8L	Heatherthorne		09G29T5R	28.1.10	11.00	HH	
		E	Hartmanns sol"		1000	Th	Heatherthorne		09L22BC	28.1.10	7.40	HH	
		F	5% glucose		500	4hrs			091 11E1N	28/1/10	16.30	CM.	
		G	5% glucose		500	6hrs	Heatherthorne		09G13E1S	28/1/10	23.50	[illegible]	
		H	NaCl 0.9%		500	6hrs							
		I	5% glucose		500	6hrs							
		J											
		K											
		L											
		M											
		N											
		O											
		P											
		Q											
		R											

DATE	ADVERSE REACTION	STOP FLUID/BLOOD/ADDITIVE	RECORD BATCH No. BELOW

SOUTHERN GENERAL HOSPITAL — **I.V. THERAPY PRESCRIPTION SHEET**

NAME: WARD: UNIT No.: D.O.B.:

DATE	TIME		FLUID / BLOOD	ADDITIVE	VOLUME OR DOSE	TIMING	DOCTORS SIGNATURE		BATCH No.	NURSES SIGNATURE			
							ORDERED BY	CANCELLED BY		DATE	TIME	GIVEN BY	CHECKED BY
		A											
		B											
		C											
		D											
		E											
		F											
		G											
		H											
		I											
		J											
		K											
		L											
		M											
		N											
		O											
		P											
		Q											
		R											

DATE	ADVERSE REACTION	STOP FLUID/BLOOD/ADDITIVE	RECORD BATCH No. BELOW

0368104-SGH 27C

SOUTHERN GENERAL HOSPITAL — **I.V. THERAPY PRESCRIPTION SHEET**

NAME: CATHERINE HONEY WAN WARD: UNIT No.: SG-00940779 D.O.B.:

DATE	TIME		FLUID / BLOOD	ADDITIVE	VOLUME OR DOSE	TIMING	DOCTORS SIGNATURE		BATCH No.	NURSES SIGNATURE			
							ORDERED BY	CANCELLED BY		DATE	TIME	GIVEN BY	CHECKED BY
18/4/10		A	0.9% NaCl		500	4°	A						
		B											
		C											
		D											
		E											
		F											
		G											
		H											
		I											
		J											
		K											
		L											
		M											
		N											
		O											
		P											
		Q											
		R											

DATE	ADVERSE REACTION	STOP FLUID/BLOOD/ADDITIVE	RECORD BATCH No. BELOW

SOUTHERN GENERAL HOSPITAL — **I.V. THERAPY PRESCRIPTION SHEET**

NAME: WARD: UNIT No.: D.O.B.:

DATE	TIME		FLUID / BLOOD	ADDITIVE	VOLUME OR DOSE	TIMING	DOCTORS SIGNATURE		BATCH No	NURSES SIGNATURE			
							ORDERED BY	CANCELLED BY		DATE	TIME	GIVEN BY	CHECKED BY
		A											
		B											
		C											
		D											
		E											
		F											
		G											
		H											
		I											
		J											
		K											
		L											
		M											
		N											
		O											
		P											
		Q											
		R											

DATE	ADVERSE REACTION	STOP FLUID/BLOOD/ADDITIVE	RECORD BATCH No. BELOW

I.V. THERAPY PRESCRIPTION SHEET

SG00940779
CATHERINE HONEYMAN
10 MELVILLE STREET

GLASGOW 01/02/1949
G41 2LN CHI 0102496145

WARD: ONC UNIT No.: D.O.B.:

			ADDITIVE	VOLUME OR DOSE	TIMING	DOCTORS SIGNATURE		BATCH No	NURSES SIGNATURE			
						ORDERED BY	CANCELLED BY		DATE	TIME	GIVEN BY	CHECKED BY
4/5/10		A	RINGERS	1000 ml	6°	[illegible]		10C12BR	4/5/10	1005	RS	VB
		B										
		C										
		D										
		E										
		F										
		G										
		H										
		I										
		J										
		K										
		L										
		M										
		N										
		O										
		P										
		Q										
		R										

DATE	ADVERSE REACTION	STOP FLUID/BLOOD/ADDITIVE	RECORD BATCH No. BELOW

SOUTHERN GENERAL HOSPITAL

I.V. THERAPY PRESCRIPTION SHEET

NAME: WARD: UNIT No.: D.O.B.:

DATE	TIME		FLUID / BLOOD	ADDITIVE	VOLUME OR DOSE	TIMING	DOCTORS SIGNATURE		BATCH No.	NURSES SIGNATURE			
							ORDERED BY	CANCELLED BY		DATE	TIME	GIVEN BY	CHECKED BY
		A											
		B											
		C											
		D											
		E											
		F											
		G											
		H											
		I											
		J											
		K											
		L											
		M											
		N											
		O											
		P											
		Q											
		R											

DATE	ADVERSE REACTION	STOP FLUID/BLOOD/ADDITIVE	RECORD BATCH No. BELOW

0368104-SGH 27C

SOUTHERN GENERAL HOSPITAL — **I.V. THERAPY PRESCRIPTION SHEET**

NAME: Catherine Honeyman WARD: 1 UNIT No.: D.O.B.: 01/02/53

DATE	TIME		FLUID / BLOOD	ADDITIVE	VOLUME OR DOSE	TIMING	DOCTORS SIGNATURE		BATCH No.	NURSES SIGNATURE			
							ORDERED BY	CANCELLED BY		DATE	TIME	GIVEN BY	CHECKED BY
13/09		A	N. Saline	—	500ml	6°	[illegible]		10D21T5X	14/9	0345	[illegible]	
14/9		B	N. Saline	—	500	6°	[illegible]		10D21T5Y		2230	[illegible]	
17/10		C	5% dextrose	—	500	6°	[illegible]		10C13E1N		1000	[illegible]	
		D											
		E											
		F											
		G											
		H											
		I											
		J											
		K											
		L											
		M											
		N											
		O											
		P											
		Q											
		R											

DATE	ADVERSE REACTION	STOP FLUID/BLOOD/ADDITIVE	RECORD BATCH No. BELOW

SOUTHERN GENERAL HOSPITAL — **I.V. THERAPY PRESCRIPTION SHEET**

NAME: WARD: UNIT No.: D.O.B.:

DATE	TIME		FLUID / BLOOD	ADDITIVE	VOLUME OR DOSE	TIMING	DOCTORS SIGNATURE		BATCH No.	NURSES SIGNATURE			
							ORDERED BY	CANCELLED BY		DATE	TIME	GIVEN BY	CHECKED BY
		A											
		B											
		C											
		D											
		E											
		F											
		G											
		H											
		I											
		J											
		K											
		L											
		M											
		N											
		O											
		P											
		Q											
		R											

DATE	ADVERSE REACTION	STOP FLUID/BLOOD/ADDITIVE	RECORD BATCH No. BELOW

0368104-SGH 27C

SG00940779
HONEYMAN, CATHERINE
PATIENT 10 MELVILLE STREET
GLASGOW 01/02/1949
G41 2LN CHI 0102496145

.TANT

DIAGNOSIS/OPERATION

DATE	WC	Neut	Hb	Plt	Na	K	Bic	U	Cr	Bili	Al P	AsT	AlT	Alb	CRP	Amy	Others
27/3/11	12.1	10.1	133	254	134	4.0	23	7.3	83	10	155	18	28	40	97		Alb c 10.4 Coag (N)
29/3/11	8.1	6.3	108	195	135	3.9	26	5.4	94	16	170	38	102	32	445		

Patient's Name: _____

D.O.B.: _____

Unit number: _____

Ward: 2

HONEYMAN, CATHERINE
SG00940779 01/02/49
CHI: 0102496145 F
Date_____ Time ____
Spec./Sig._____

Use addressograph label

South Glasgow Hospitals

24 Hour Fluid Balance Chart

NHS Greater Glasgow and Clyde

Instructions

*Theatre

Date: 31.3.11

Previous 24 hour fluid balance - Intake: Output:

	Intake					Output		
Time	IV infusions	Volume	Enteral / Oral	Volume	Running Total	Urine	Drains (D) Vomit (V) Aspirate (A) etc	Running Total
01								
02								
03								
04								
06								
07								
08								
09								
10								
11								
12								
13								
14								
*	Hartmanns	1000mls						
16								
17	Hartmanns	500mls						
18								
19								
20								
21								
22								
23								
24								
	Individual Totals:							
				Total Intake			Total Output:	

Final Fluid Balance +/-

Patient's Name: _____

D.o.B.: _____

Unit number: _____

Ward: _____

Use addressograph label

South Glasgow Hospitals

24 Hour Fluid Balance Chart

NHS Greater Glasgow and Clyde

Instructions

Date:

Previous 24 hour fluid balance - Intake: Output:

	Intake					Output		
Time	IV infusions	Volume	Enteral / Oral	Volume	Running Total	Urine	Drains (D), Vomit (V) Aspirate (A) etc	Running Total
01								
02								
03								
04								
06								
07								
08								
09								
10								
11								
12								
13								
14								
16								
17								
18								
19								
20								
21								
22								
23								
24								
	Individual Totals:							
				Total Intake:			**Total Output:**	

Final Fluid Balance +/-

SOUTHERN GENERAL HOSPITAL — **I.V. THERAPY PRESCRIPTION SHEET**

NAME: Catherine Honeyman WARD: SHDU UNIT No.: S6009407 79 D.O.B.: 1/2/49.

DATE	TIME		FLUID / BLOOD	ADDITIVE	VOLUME OR DOSE	TIMING	DOCTORS SIGNATURE		BATCH No.	NURSES SIGNATURE			
							ORDERED BY	CANCELLED BY		DATE	TIME	GIVEN BY	CHECKED BY
31/3/11	Post-op.	A	Hartmann's		500 ml	4°	JZ		10521 T&G	31/3/11	~~1600~~ 1600	PS	[illegible]
31/3/11	Post-op	B	Hartmann's		500 ml	4°	JZ		10TA1T44	31/3/11	2315	[illegible]	-
		C											
		D											
		E											
		F											
		G											
		H											
		I											
		J											
		K											
		L											
		M											
		N											
		O											
		P											
		Q											
		R											

DATE	ADVERSE REACTION	STOP FLUID/BLOOD/ADDITIVE	RECORD BATCH No. BELOW

DATE	TIME	RESP RATE	PAIN SCORE	SED SCORE	NAUSEA SCORE	RATE	AMOUNT IN SYRINGE	TOTALISER AMOUNT	SIGNATURES

PAIN SCORE

S	Sleeping
0	No pain
1	Mild pain
2	Moderate pain
3	Severe pain

SEDATION SCORE

S	Sleep normal
0	None - patient alert
1	Mildly sedated, Easily awakes to verbal stimuli
2	Moderately drowsy, Awakes to vebal stimuli
3	Severe - somnolent, Difficult to awake to verbal stimulation

NAUSEA : :E

0	None
1	Mild, No treatment needed
2	Nausea and Vomiting, Helped by treatment
3	Nausea, Persistant despite treatment

DATE	TIME	RESP RATE	PAIN SCORE	SED SCORE	NAUSEA SCORE	RATE	AMOUNT IN SYRINGE	TOTALISER AMOUNT	SIGNATURES

DATE	TIME	RESP RATE	PAIN SCORE	SED SCORE	NAUSEA SCORE	RATE	AMOUNT IN SYRINGE	TOT. ...R AMOUNT	SIGNATURES

PAIN SCORE

S	Sleeping
0	No pain
1	Mild pain
2	Moderate pain
3	Severe pain

SEDATION SCORE

S	Sleep normal
0	None - patient alert
1	Mildly sedated, Easily awakes to verbal stimuli
2	Moderately drowsy, Awakes to vebal stimuli
3	Severe - somnolent, Difficult to awake to verbal stimulation

NAUSEA SCC

0	None
1	Mild, No treatment needed
2	Nausea and Vomiting, Helped by treatment
3	Nausea, Persistant despite treatment

DATE	TIME	RESP RATE	PAIN SCORE	SED SCORE	NAUSEA SCORE	RATE	AMOUNT IN SYRINGE	TOTALISER AMOUNT	SIGNATURES
12/12/05	12:25				Pump	set-up	50ml	0	Expires
	13:45	16	1/2	0	0	—	43ml	6ml	
12/12	14:15	16	1/2	0	0	—	34	15	
12/12	15:00	15	1/2	0	0	—	29	20	
12/12	15:15	15	0/1	0	0	—	26	23	
12/12/05	17:00	15	1	0	0		22	27	SK
12/12/05	18:00	16	2	0	0		20	29	SK
	20:30	16	2	0	0		20	29	
	21:30	16	2	0	0		20	29	
	23:00	16	2	0	0	RCA	18	31	
	00:00	16	1	0	0	RCA	14	32	
	01:00	14	S	S	S	PCA	12	37	SK
	02:00	14	1	0	0	PCA	9	41	SK
	03:00	12	0	0	0	PCA	7	44	SK
04:30	04:00	11	0	0	0	PCA	3	48	
13/12/05	PCA	Removed	50mls	Morphine	Sulphate.		47ml	1	
	06:00	12	0	0	0	PCA	49mls	1mg	
	09:00	13	0	0	0	PCA	42	14	SK
	Pump	discontinued			42mls	discarded		NO/SL	

DATE	TIME	RESP RATE	N SCORE	SED SCORE	NAUSEA SCORE	RATE	AMOUNT IN SYRINGE	TOTALISER AMOUNT	SIGNATURES

Date	Time	Resp rate	Pain score	Sed score	Nausea score	Rate	Amount in syringe	Totaliser amount	Signatures

Pain Score

0		10
No pain		Worst pain imaginable

S	Sleeping

Sedation Score

A	Awake
V	Asleep roused by speech
P	Physical stimulation (e.g. shaking) when required to waken
U	Not roused by speech or shaking

Nausea Score

N	Nausea
V	Vomiting

Date	Time	Resp rate	Pain score	Sed score	Nausea score	Rate	Amount in syringe	Totaliser amount	Signatures
28/1/10	1010	—	—	—	—	Set up	48ml	0	[illegible] RS
28/1/10	1300		connected				48mls	0	[illegible]
	1430	12		A	0	PCA	47ml S	1	[illegible]
	1515	13	7	A	0	PCA	47ml S	1	[illegible]
	1615	14	2	A	0	PCA	44	4	[illegible]
	1715	14	2	A	0	PCA	40	8	[illegible]
[illegible]	[illegible]	14	8	A	0	PCA			[illegible]
28/1/10	2350	13	7	A	0	PCA	37	11	[illegible]
29/1/10	0100	14	4	A	0	PCA	34	14	[illegible]
	0200	14	5	A	0	PCA	32	16	[illegible]
	0300	14		A	0	PCA	28	20	[illegible]
	0400	14		A	0	PCA	25	23	[illegible]
	0500	14	7	A	0	PCA	23	25	[illegible]
	0600	14	7	A	0	PCA	20	28	[illegible]
	0700	Vomiton	resolved						[illegible]
	0900	awaiting	Surgeon	to	be	reviewed			[illegible]
	0900	15	5	0	0	11	15mls	34.99	[illegible]
PCA	discontinued	at	patients	request	11am	29			[illegible]

Date	Time	Resp rate	Pain score	Sed score	Nausea score	Rate	Amount in syringe	Totaliser amount	Signatures

Date	Time	Resp rate	Pain score	Sed score	Nausea score	Rate	Amount in syringe	Totaliser amount	Signatures
14-7-10	16 10					2ml/hr		0	

Pain Score

0	10
No pain	Worst pain imaginable

S	Sleeping

Sedation Score

A	Awake
V	Asleep roused by speech
P	Physical stimulation (e.g. shaking) when required to waken
U	Not roused by speech or shaking

Nausea Score

N	Nausea
V	Vomiting

Date	Time	Resp rate	Pain score	Sed score	Nausea score	Rate	Amount in syringe	Totaliser amount	Signatures
14/7/10	1615					Up	48ml	0	[illegible]
14/7/10	1700					Up after	48ml	0	[illegible] B Flanagan
14/7/10	18:10	12	5	0	0	Bol	31ml	18 mls	B.F.
Turn to side	1830	14	0	0	0	PCA	31	18	[illegible]
	19.20	15	0	0	0	PCA	31	18	[illegible]
	2040	16	6	A	0	PCA	22	26	LMJ
	2130	14	5	A	0	PCA	20	28	LMJ
	2230	14	4	A	0	PCA	18	30	LMJ
	MN	16	4	A	0	PCA	13	35	LMJ
15/7	0100	14	3	A	0	PCA	12	36	LMJ
	0200	15	3	A	0	PCA	7	41	[illegible]
	0330	16	5	A	0	PCA	4	44	LMJ
	0500	PCA pump refilled					50	0	LMJ [illegible]
	0600	16	6	A	0	PCA	48	3	LMJ
	0700	16	7	A	0	PCA	47	4	LMJ
	0830	14	5	A	0	PCA	42	9	[illegible]
	1000	15	5	A	0	PCA	41	10	[illegible]
	1100	15	5	A	0	PCA	39	11	[illegible]
	1200	16	4	A	0	PCA	37	13	[illegible]
	1300	16	3	A	0	PCA	36	14	[illegible]
18/7	1315	PCA	discontinued			36 mls discarded			[illegible]

Date	Time	Resp rate	Pain score	Sed score	Nausea score	Rate	Amount in syringe	Totaliser amount	Signatures

Date	Time	Resp rate	Pain score	Sed score	Nausea score	Rate	Amount in syringe	Totaliser amount	...tures

Pain Score

0	10
No pain	Worst pain imaginable

S	Sleeping

Sedation Score

A	Awake
V	Asleep roused by speech
P	Physical stimulation (e.g. shaking) when required to waken
U	Not roused by speech or shaking

Nausea Score

N	Nausea
V	Vomiting

Date	Time	Resp rate	Pain score	Sed score	Nausea score	Rate	Amount in syringe	Totaliser amount	Signatures
31/3/11	1540	PCA	SET		OA		47	—	
31/3/11	1635	PCA	connected				47ml	0ml	
31/3/11	1730	14	10	A	N/A	—	36ml/s	11ml	
31/3/11	1815	13	5-6	A	N/A	—	28ml/s	19ml	
	1830	13	6-9	A	0	PCA	2-6	2.1-66	
	1845	12	5-10	A	0	PCA	25	2g	
	2000	22	7-5/10	A	0	PCA	16ml/s	31mg	
	2100	15	5/10	A	0	PCA	10 ml/s	37mg	
	2215	New		Syringe		PCA	51	0	
	2300	13	5	V	0	PCA	48	3	
	0000	12	5	V	5	PCA	48	3	
	0100	15	7/10	A	0	PCA	44	7	
	0200	16	8/10	A	0	PCA	35	16	
	0300	17	5	V	5	PCA	33	18	
	0400	21	8/10	A	0	PCA	29	22	
	0500	21	10/10	A	0	PCA	26	25	
	0600	16	8/10	A	0	PCA	15	36	
	0700	19	8/10	A	0	PCA	12	40	
1/4/11	0805	15	10/10	A	0	PCA	8	41.77	
	0900	17	10/10	A	0	PCA	3	47	
	0945	New	Syringe				50	0	
	10.00	19	9/10	A	0	PCA	50	1-25	
	1100	19	10/10	A	0	PCA	45	6.25	
	12	PCA	off	as	no	ventilation		insitu	
	1330	PCA	9/10	A	0	PCA	37	14	
	1400	16	9	A	0	PCA	36	15	
	1500	16	6	A	0	PCA	28	23	
	1700	16	4	A	0	PCA	21	30	
	1800	16	3	A	0	PCA	19	32	
	1900	16	3	A	0	PCA	14	37	
	2215	New	Syringe			PCA	50	0	
	2300	18	5	A	0	PCA	45	5ml	
	0000	16	4	A	0	11	43	7mls	
	0100	14	3	V	0	11	41	9	
	0200	16	2	A	0	11	40	10ml	

Date	Time	Resp rate	in score	Sed score	Nausea score	Rate	Amount in syringe	Totaliser amount	Signatures
01/04/11	0300	16	—	A	0	PCA	39	11	
	0400	16	—	0	0	PCA	38	12	
	0500	15	4	A	0	PCA	38	12	
	0600	18	9	A	N	PCA	34	16	
	0700	16	4	A	0	11	30	20	
	1100	15	0	A	0	PCA	27	25	
	1200	16	5	A	0	PCA	23	28	
	1315	15	3	A	0		15	37	

Date	Time	Resp rate	Pain score	Sed score	Nausea score	Rate	Amount in syringe	Totaliser amount	Signatures

Pain Score

0	10
No pain	Worst pain imaginable

S	Sleeping

Sedation Score

A	Awake
V	Asleep roused by speech
P	Physical stimulation (e.g. shaking) when required to waken
U	Not roused by speech or shaking

Nausea Score

N	Nausea
V	Vomiting

Date	Time	Resp rate	Pain score	Sed score	Nausea score	Rate	Amount in syringe	Totaliser amount	Signatures
23/6/11	1040	PCA	SET	UP	—	—	48mls	—	Belle / MM MM
23/6/11	1145	PCA	Connected	—	—	—	48mls	—	MM TR
23/6/11	1205	17	S	V	—	PCA	48mls	0mls	[illegible]
23/6/11	1250	14	A	A	—	PCA	46mls	2mls	[illegible]
25/6/11	1310	15	O	A	O	PCA	43mls	5mls	[illegible] / CS
23/6/11	1410	16	S	A	O	PCA	40mls	8mls	CS
	1508	15	4	A	O	PCA	36	12	[illegible]
	1600	16	O	A	O	PCA	30	12	[illegible]
	1700	15	O	A	O	PCA	30	18	[illegible]
	1800	15	O	A	O	PCA	29	19	[illegible]
	1900	16	O	A	O	PCA	28	20	[illegible]
	2100	15	6	A	O	"	24	24	L.C
	2200	16	6	A	O	"	18	30	L.C
	2300	16	6	A	O	"	15	33	L.C
24/6/11	0000	16	6	A	O	"	12	36	L.C
	0100	15	S	S	S	"	8	40	L.C
	0200	16	S	S	S	"	4	44	L.C
	0305	PCA	Renewed			"	51	0	L.C [illegible]
	0400	16	S	S	S	"	48	3	L.C
	0500	15	4	A	O	"	44	7	L.C
	0600	16	8	A	O	"	41	10	L.C
	0700	15	8	A	O	"	35	16	L.C
	0900	Discontinued					5mls d	iscarded	

Date	Time	Resp rate	Pain score	Sed score	Nausea score	Rate	Amount in syringe	Totaliser amount	Signatures

Patient Agreement to Investigation or Treatment

NHS Greater Glasgow and Clyde

CONSENT FORM

PATIENT DETAILS (OR PRE-PRINTED LABEL)

SG00940779
CATHERINE HONEYMAN
10 MELVILLE STREET
GLASGOW 01/02/1949
G41 2LN CHI 0102496145

Hospital/Clinic/GP Practice .....

Patient's surname/family name :.....

Patient's first name(s): .....

Date of Birth___/____/_____ Gender: Male ☐ Female ☐

NHS/ CHI Number _____

Special requirements (e.g. other language/communication method) .....

.....

Responsible practitioner: .....

Job title: .....

STATEMENT FOR PRACTITIONER

(to be filled in by practitioner with appropriate knowledge of proposed procedure-see guidance notes)

Describe proposed operation, investigation or other treatment.
Where appropriate specify site or side: (WRITTEN IN FULL)

Removal of patella button RIGHT Knee

I have explained the procedure named on this form to the patient in terms which, in my judgement, are suited to their understanding. In particular, I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any significant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure (please specify major procedures above).

Signature of practitioner: .....

Name/Designation (Print) .....

Date 23/4/10

STATEMENT TO BE COMPLETED BY PATIENT/PARENT*

(* parental responsibility for a minor without capacity)

You should read this form and the notes below carefully. If there is anything you do not understand ask the Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

I understand

- the procedure, important risks and appropriate alternatives which have been explained to me by the practitioner named on this form.
- that a practitioner other than the practitioner who has been providing treatment so far might carry out the procedure.
- that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to the medical treatment proposed, to safeguard or promote physical or mental health.
- That examination for the purpose of teaching will not be undertaken without my consent.

I have been told about additional procedures which may become necessary during treatment. I have listed below **any procedures which I do NOT wish to be carried out without further discussion.**

I agree -

- to the administration of an anaesthetic or to sedation if required.
- to the procedure named on this form
- to the emergency administration of blood or blood products

Additionally you have to agree or disagree the following:-	**Agree**	**Disagree**
that information and/or images kept in records may be used anonymously r education, audit, and research with appropriate ethical approval, to improve the quality of patient care.	☐	☐
that surplus tissue or other biological material not essential for my diagnosis or future treatment may be used for medical education and ethically approved medical research.	☐	☐

PATIENT REFUSAL FOR BLOOD PRODUCTS

Please sign here if you refuse to consent to the emergency administration of blood or blood products. Even if this results in death.

Signature: ..... Date ...../...../.....

Practitioner Signature: ..... Date ...../...../.....

PATIENT/PARENT* AGREEMENT FOR TREATMENT

Signature: Catherine Monaghan Date 23/6/10

Name (Print): .....

Patient's Name:
D.o.B.:
Unit number:
Ward:

HONEYMAN, CATHERINE
SG00940779 01/02/49
CHI: 0102496145 F
Date Time
Spec./Sig.

Use addressograph label

South Glasgow Hospitals

24 Hour Fluid Balance Chart

NH
Greater Cl and Cly

Instructions

Date: 23/6/11 Previous 24 hour fluid balance - Intake: Output:

Time	Intake: IV infusions	Volume	Enteral / Oral	Volume	Running Total	Output: Urine	Drains (D), Vomit (V) Aspirate (A) etc	Running
01								
02								
3								
04								
05								
06								
07								
08								
09	Hartmanns	1000mls			1000mls			
10	Hartmann's	1000mls			2000mls			
11	Gelofusine	500mls			2,500mls.			
12	5% Dextrose	500mls				60mls.		60
						90mls		150
14						100		250
15						200		450
16			WATER	150	3150	200 Catheter removed		650
17	5% DEXTROSE	500	DINNER	400	3950	Patient request		750
18			WATER	100	4050			
19								
20			TEA	250	4300	700		1450
21								
22								
23								
24						300		1750
	Individual Totals:							
				Total Intake:	4300		**Total Output:**	1750

nal Fluid Balance +/-

Patient's Name:

D.o.B:

Unit Number:

Ward:

Use addressograph label

South Glasgow Hospitals

24 Hour Fluid Balance Chart

NHS Greater Glasgow and Clyde

Instructions

Date: 24/6/11 | Previous 24 hour fluid balance - | Intake: 4300 | Output: 50

	Intake					Output		
Time	IV infusions	Volume	Enteral / Oral	Volume	Running Total	Urine	Drains (D), Vomit (V) Aspirate (A) etc	Running Total
01								
02								
						500		500
04	Hartmanns	500						
05								
06								
07								
08			Breakfast	300	300			
09								
10			Late	500	800			
11								
12			Lunch	300	1100			
			Milk	200	1300			
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
	Individual Totals:							
				Total Intake:			**Total Output:**	

Total Fluid Balance +/-

ORTHOPAEDIC OUTPATIENTS DEPARTMENT
SOUTHERN GENERAL HOSPITAL NHS
1345 GOVAN ROAD
GLASGOW
G51 4TF

17 April 2012 CHI NUMBER: 0102496145

CATHERINE HONEYMAN
10 MELVILLE STREET
GLASGOW
G41 2LN

Dear CATHERINE HONEYMAN Hospital Number SG00940779

OUTPATIENT APPOINTMENT
ORTHOPAEDIC DEPARTMENT ZONE 7 BUILDING U

An appointment has been made for you to attend the Orthopaedic Physiotherapy clinic on:

Wednesday 09/05/12 at 3:00 pm

If for any reason you are unable to keep this appointment, please inform the Appointments office on: 0141 201-1462 for return appointments and 0141 201 1430/1432 for new appointments.
Email SGHappointments@ggt.scot.nhs.uk
*If contacting us by email you should include the following information:
Your Name
Your Chi Number
Consultants Name
Date and time of your appointment
Reason: eg: Unable to attend and require a further appointment.
For security purposes, please do not include any clinical information in you email.

Yours sincerely

Mr Gordon Crossan
Appointments Co-ordinator

SOUTHERN GENERAL HOSPITAL — **I.V. THERAPY PRESCRIPTION SHEET**

NAME: Catherine Honeyman WARD: 5 UNIT No.: SG 0094 0779 D.O.B.: 01/02/1949

DATE	TIME		FLUID / BLOOD	ADDITIVE	VOLUME OR DOSE	TIMING	DOCTORS SIGNATURE		BATCH No.	NURSES SIGNATURE			
							ORDERED BY	CANCELLED BY		DATE	TIME	GIVEN BY	CHEC BY
23/6/11		A	5% D/W		500ml	4°	Bhatyal		09(MEIN	23/6/11	1255		RS
23/6/11		B	5% D/W		500ml	4°	Bhatyal		10L03E04	23/6/11	1710		
23/6/11		C	Humans		500	4°			11D14T4H	24/6/11	0430	L. Connolly	
23/6/11		D	Humans		500	4°							
		E											
		F											
		G											
		H											
		I											
		J											
		K											
		L											
		M											
		N											
		O											
		P											
		Q											
		R											

DATE | ADVERSE REACTION | STOP FLUID/BLOOD/ADDITIVE | RECORD BATCH N BELOW

0368104-SGH 27C

South Glasgow University Hospitals Division
REFUSAL OF BLOOD TRANSFUSION FORM
(Suitable for Jehovah Witnesses)

NHS Greater Glasgow

This form is to be used for patients refusing blood or blood products in any circumstances.

Where a specific procedure is proposed, this form should be used in conjunction with the *'Consent to Anaesthesia, Operation or Treatment"* form.
For further information with regard to issues of consent and blood transfusion see '*Jehovah Witness Blood Transfusion Policy'.*

Name .... HONEYMAN,CATHERINE SG00940779 01/02/49 CHI: 0102496145 F ..... C. HONEYMAN

DOB .... Date_____ Time ____ Spec./Sig._____

Unit Number ..... Date 14-7-2010

Note for guidance of Doctors and Patients overleaf.

TO BE COMPLETED BY THE PATIENT I accept cell salvage CH.

I refuse consent to treatment with blood or the following blood transfusion products *(please tick those that apply)*:

- ☑ Red blood cells
- ☑ Coagulation factors from donated blood
- ☑ Platelets
- ☐ Other (specify).....

- I understand that my refusal to consent to receive blood or these blood products as part of medical treatment may be life threatening.
- It is my expressed wish that blood and the blood products that I have indicated must be withheld even in circumstances where they might prevent permanent injury or death.
- I understand that this refusal does not preclude my right to later change my position with regard to such consent should I wish to do so.

Name CATHERINE HONEYMAN (BLOCK CAPITALS) Signature Catherine Honeyman

TO BE COMPLETED BY MEDICAL PRACTITIONER

I confirm that I have explained to the patient the risks of withholding the above blood transfusion products in relation to the proposed medical treatment in as far as I am able to predict them.

I understand that this does not preclude the patient changing his/her decision at a later date.

Name C. L HARPER (BLOCK CAPITALS) Signature .....

NOTES OF GUIDANCE

Medical Practitioner

The Doctor completing this form should be suitably qualified and experienced to explain the consequences of the patient's refusal for blood or blood products in relation to the patient's condition and proposed treatment. This should ideally be the consultant in charge or the practitioner who is operating or supervising the treatment.

Information must be given in a way the patient can understand with important risks and possible alternatives explained. He/she should be given sufficient time to consider the issues and have the opportunity to ask questions.

Where the treatment requires an anaesthetic, (especially where blood loss is likely to be an issue), it is advisable to discuss this with the consultant anaesthetist involved in the case at the earliest opportunity to ensure optimal care.

In all adult cases, advanced directives carry the weight of law in conscious and unconscious patients.

The patient can withdraw this declaration to refuse blood or blood products at any time following completion of this form. If this occurs it is recommended that the patient's wishes are witnessed by another Health Professional and documented clearly in the medical notes.

Where the patient is under 16 years it is advisable to refer to the relevant sections of the Hospital Policies for Jehovah Witness (part 3) and Consent (part 2) and seek any further advice as may considered appropriate in the circumstances.

Please refer to Jehovah Witness Blood Transfusion Policy for further information and guidance.

Patient Agreement to Investigation or Treatment

NHS Greater Glasgow and Clyde

CONSENT FORM

PATIENT DETAILS (OR PRE-PRINTED LABEL)

Hospital/Clinic/GP Practice .....

HONEYMAN,CATHERINE
SG00940779 01/02/49
CHI: 0102496145 F
Date_____ Time ____
Spec./Sig._____

Patient's surname/family name :.....

Patient's first name(s):.....

Date of Birth___/___/_____ Gender: Male ☐ Female ☐

NHS/ CHI Number _____

Special requirements (e.g. other language/communication method) .....

.....

Responsible practitioner: Mohammed

Job title: Consultant

STATEMENT FOR PRACTITIONER

(to be filled in by practitioner with appropriate knowledge of proposed procedure- see guidance notes)

Describe proposed operation, investigation or other treatment.
Where appropriate specify site or side: (WRITTEN IN FULL)

Washout & right TKR

I have explained the procedure named on this form to the patient in terms which, in my judgement, are suited to their understanding. In particular, I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any significant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure (please specify major procedures above).

An information leaflet/tape has been provided.

☐ ..... (title)

Signature of practitioner: .....

Name/Designation (Print) .....

Date 14/7/10

Patient Agreement to Investigation or Treatment

NHS Greater Glasgow and Clyde

CONSENT FORM

PATIENT DETAILS (OR PRE-PRINTED LABEL)

Hospital/Clinic/GP Practice SG00940779

Patient's surname/family name :. HONEYMAN, CATHERINE

Patient's first name(s): ..... 10 MELVILLE STREET GLASGOW G41 2LN

01/02/1949

CHI 0102496145

Date of Birth____/____/_____ Gender: Male ☐ Female ☐

NHS/ CHI Number _____

Special requirements (e.g. other language/communication method) .....

.....

Responsible practitioner: .....

Job title: .....

STATEMENT FOR PRACTITIONER

(to be filled in by practitioner with appropriate knowledge of proposed procedure- see guidance notes)

Describe proposed operation, investigation or other treatment.
Where appropriate specify site or side: (WRITTEN IN FULL)

2nd Stage revision RIGHT Knee

I have explained the procedure named on this form to the patient in terms which, in my judgement, are suited to their understanding. In particular, I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any significant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure (please specify major procedures above).

Signature of practitioner: .....

Name/Designation (Print) .....

Date 10/6/11

00526

STATEMENT TO BE COMPLETED BY PATIENT/PARENT*

(* parental responsibility for a minor without capacity)

You should read this form and the notes below carefully. If there is anything you do not understand ask the Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

I understand

- the procedure, important risks and appropriate alternatives which have been explained to me by the practitioner named on this form.
- that a practitioner other than the practitioner who has been providing treatment so far might carry out the procedure.
- that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to the medical treatment proposed, to safeguard or promote physical or mental health.

I have been told about additional procedures which may become necessary during treatment. I have listed below **any procedures which I do NOT wish to be carried out without further discussion.**

I agree -

- to the administration of an anaesthetic or to sedation if required.
- to the procedure named on this form
- that the examination for the purposes of teaching will not be undertaken without my consent
- to the emergency administration of blood or blood products

Please sign here if you refuse to consent to the emergency administration of blood or blood products.

Signature ..... Date ...../...../.....

Additionally you have to agree or disagree the following:-	**Agree**	**Disagree**
that information and/or images kept in records may be used anonymously for education, audit, and research with appropriate ethical approval, to improve the quality of patient care.	☐	☐
that surplus tissue not essential for my diagnosis or future treatment may be used for medical education and ethically approved medical research.	☐	☐

PATIENT AGREEMENT FOR TREATMENT

Signature: ..... Date ...../...../.....

Name (Print): .....

CONFIRMATION OF CONSENT

(to be completed when patient is admitted for procedure if form signed in advance)

I confirm that I have no further questions and wish the procedure to go ahead.

Signature: X Catherine Abernyan Print name.....

Date ...../...../.....

00526

STATEMENT TO BE COMPLETED BY PATIENT/PARENT*

(* parental responsibility for a minor without capacity)

You should read this form and the notes below carefully. If there is anything you do not understand ask the Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

I understand

- the procedure, important risks and appropriate alternatives which have been explained to me by the practitioner named on this form.
- that a practitioner other than the practitioner who has been providing treatment so far might carry out the procedure.
- that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to the medical treatment proposed, to safeguard or promote physical or mental health.
- That examination for the purpose of teaching will not be undertaken without my consent.

I have been told about additional procedures which may become necessary during treatment. I have ;ted below **any procedures which I do NOT wish to be carried out without further discussion.**

I agree -

- to the administration of an anaesthetic or to sedation if required.
- to the procedure named on this form
- to the emergency administration of blood or blood products

Additionally you have to agree or disagree the following:-	**Agree**	**Disagree**
that information and/or images kept in records may be used anonymously for education, audit, and research with appropriate ethical approval, to improve the quality of patient care.	☐	☐
that surplus tissue or other biological material not essential for my diagnosis or ıture treatment may be used for medical education and ethically approved medical research.	☐	☐

PATIENT REFUSAL FOR BLOOD PRODUCTS

Please sign here if you refuse to consent to the emergency administration of blood or blood products. Even if this results in death.

Signature: Catherine Honeyman Date 10/6/11

Practitioner Signature: [signature] Date 10/6/11

PATIENT/PARENT* AGREEMENT FOR TREATMENT

Signature: Catherine Honeyman Date 10/6/11

Name (Print): .....

ORTHOPAEDIC DEPARTMENT SOUTHERN GENERAL

Name: Catherine Honeymoon Unit No SG0094077 9

Date:	7/5/10	8/5/10	9/5/10	10/5/10	12/05							
Time												
WCC 4-11	8·4	7·6	6·6	5·8	6.0							
Hb M13-18 F11.5-16.5	112	106	111	95	93							
Plat 150-400	217	227	270	259	325							
Amy <100												
CRP<10	449	469	324	187	99							
Na 135-145	136	136	139	138	140							
K 3.5-5.0	3·2	3·4	4·1	4·4	3.1							
Cl 97-107	99	99	100	101	102							
Bic 23-30	23	26	23	26	28							
Urea 2.5-8.0	5·5	4·5	4·0	4·1	4.4							
Creat 40-130	69	63	60	59	62							

ORTHOPAEDIC DEPARTMENT SOUTHERN GENERAL

Name: CATHERINE HONEYMAN Unit No SG 0094079

Date:	14/7/10	16/7/10	19/7/10										
Time													
WCC 4-11	13.9	6.7	5.2										
Hb M13-18 F11.5-16.5	127	97	103										
Plat 150-400	291	214	301										
Amy <100													
CRP<10	12	315	40										
Na 135-145	136	139	141										
K 3.5-5.0	4.7	3.3	4.7										
Cl 97-107	95	99	101										
Bic 23-30	26	28	28										
Urea 2.5-8.0	7.8	3.6	4.7										
Creat 40-130	78	69	76										

PT - 11 Ciem 2.7 Gen 5.9

APTT - 31

Alb - 3.4

Gluc 3.0-5.5												
Bili 3-22		8	6									
AST 12-48		38	26									
ALT 3-55		112	66									
Alk Phos 80-280		161	255									
G-GT 5-50												
Prot 62-82		60	65									
Albumin 35-55		29	32									
Globulin 22-33												
INR												
Ortho Bloods												
Adj Ca 2.2-2.6												
Ca 2.2-2.6												
PO4 0.7-1.4												
Vit D												

GENTAMICIN/VANCOMYCIN ADMINISTRATION RECORDING CHART

Patient's name: Catherine Honeyman **Weight:** **Date of birth:** 01.02.49 **Unit no:**

Date	Drug	Dose	Time started	Time stopped	Given by	Blood sample date / time	Concentration (mg/L)
15/7	GENTAMYCIN	320mg	00.30	01.30	HMoller		
16/7	GENTAMYCIN	320mg	00.10	01.00	HMSlle		
17/7	GENTAMYCIN	320mg	00.50	01.40	HMull		
17/7	Gentamycin	320mg	00.30	01.30	J.King		
18/7	Gentamicin	320mg	23.00		JKing		
19/7/10	Gentamicin	WITHOLD.				19/7/10 0840	

SOUTHERN GENERAL HOSPITAL

BIOCHEMISTRY DEPARTMENT

A

REMOVE THIS STRIP & AFFIX REPORT - TOP EDGE TO LINE ABOVE 12

BIOCHEMISTRY DEPARTMENT SOUTH GLASGOW ☎ (0141) 201 1681 NHS Greater Glasgow and Clyde A

Name **HONEYMAN CATHERINE** CHI Number **0102496145** Location **Ward 5 SGH**

Unit No. **SG00940779** Lab Number R,11.1208271.D Consultant **Mr.M.G.Hullin**

D.O.B. **01.02.49** Sex **F** Received 24.06.11 at 11:37 Prov. Diagnosis

Withdrawal		Na 135–145	K 3.5–5.0	Cl 98–108	HCO_3 23–30	Urea 2.5–7.0	Creat 40–130	eGFR	Glucose	*	CRP <10	Amylase <100	Magnesium 0.70–1.00	Urate 0.15–0.35
Date	Time	mmol/L					umol/L	mL/min	mmol/L		mg/L	U/L	mmol/L	
05.04.11	09:00	137	4.3	95	29	4.4	71	>60			85			
15.04.11	12:45										21			
06.05.11	20:00										9			
20.05.11	11:00	140	4.0	99	29	5.1	69	>60			10			
10.06.11	12:00	138	3.5	96	30	5.2	73	>60			4			
24.06.11	10:20	137	3.7	100	24	3.7	67	>60			114			

Withdrawal		T.Protein 60–80	Albumin 32–45	Globulins 23–38	Bilirubin <20	Alk. Phos. 35–135	AST <40	ALT <50	GGT <40	CK <170	Calcium	Adj Ca 2.10–2.60	Phosphate 0.70–1.40
Date	Time	g/L			umol/L	U/L					mmol/L		
14.10.10	20:20	85	45	40	7	164	28	27					
27.03.11	05:20	74	40	34	10	155	18	28					
28.03.11	08:00	75	39	36	35	216	168	208					
29.03.11	10:00	65	32	33	16	170	38	102					
30.03.11	09:00	64	29	35	11	162	19	70					
24.06.11	10:20												

* Fasting: Y = Yes, N = No

CPA Accredited Medical Laboratory Reference No: 2923

Report authorised by Computer validation

Run No: 641 Issued 24.06.11 at 13:53 Specimen type: **Blood**

BIOCHEMISTRY DEPARTMENT

SOUTH GLASGOW ☎ (0141) 201 1681 NHS Greater Glasgow and Clyde **A**

Name **HONEYMAN CATHERINE** CHI Number **0102496145** Location **H.D.U., SGH**

Unit No. **SG00940779** Lab Number **R,11.1111304.Y** Consultant **Mr.M.G.Hullin**

D.O.B. **01.02.49** Sex **F** Received **01.04.11** at **10:16** Prov. Diagnosis

Withdrawal		Na	K	Cl	HCO3	Urea	Creat	eGFR	Glucose	*	CRP	Amylase	Magnesium	Urate
		135–145	3.5–5.0	98–108	23–30	2.5–7.0	40–130				<10	<100	0.70–1.00	0.15–0.35
Date	Time	mmol/L					umol/L	mL/min	mmol/L		mg/L	U/L	mmol/L	
14.10.10	20:20	141	3.8	95	24	4.4	73	>60	7.3	Y	9			
27.03.11	05:20	134	4.0	96	23	7.3	83	>60	10.4	N	57			
28.03.11	08:00	135	3.6	96	22	5.7	103	47			424			
29.03.11	10:00	135	2.9	95	26	5.4	94	52			445			
30.03.11	09:00	137	3.8	99	25	4.6	78	>60			453			
01.04.11	08:00	138	3.7	97	25	4.2	75	>60			438		0.83	

Withdrawal		T.Protein	Albumin	Globulins	Bilirubin	Alk. Phos.	AST	ALT	GGT	CK	Calcium	Adj Ca	Phosphate
		60–80	32–45	23–38	<20	35–135	<40	<50	<40	<170		2.10–2.60	0.70–1.40
Date	Time	g/L			umol/L	U/L					mmol/L		
14.10.10	20:20	85	45	40	7	164	28	27					
27.03.11	05:20	74	40	34	10	155	18	28					
28.03.11	08:00	75	39	36	35	216	168	208					
29.03.11	10:00	65	32	33	16	170	38	102					
30.03.11	09:00	64	29	35	11	162	19	70					
01.04.11	08:00												

* Fasting: Y = Yes, N = No

CPA Accredited Medical Laboratory Reference No: 2923

Report authorised by Computer validation

Run No: 586 Issued 01.04.11 at 11:41 Specimen type: Blood

BIOCHEMISTRY DEPARTMENT

SOUTH GLASGOW ☎ (0141) 201 1681 NHS Greater Glasgow and Clyde **A**

Name **HONEYMAN CATHERINE** CHI Number **0102496145** Location **Ward 5 SGH**

Unit No. **SG00940779** Lab Number **R,11.1210140.S** Consultant **Mr.M.G.Hullin**

D.O.B. **01.02.49** Sex **F** Received **27.06.11** at **11:16** Prov. Diagnosis

Withdrawal		Na	K	Cl	HCO3	Urea	Creat	eGFR	Glucose	*	CRP	Amylase	Magnesium	Urate
		135–145	3.5–5.0	98–108	23–30	2.5–7.0	40–130				<10	<100	0.70–1.00	0.15–0.35
Date	Time	mmol/L					umol/L	mL/min	mmol/L		mg/L	U/L	mmol/L	
15.04.11	12:45										21			
06.05.11	20:00										9			
20.05.11	11:00	140	4.0	99	29	5.1	69	>60			10			
10.06.11	12:00	138	3.6	96	30	5.2	73	>60			14			
24.06.11	10:20	137	3.7	100	24	3.7	67	>60			114			
27.06.11	09:00	139	3.7	98	29	3.6	66	>60						

Withdrawal		T.Protein	Albumin	Globulins	Bilirubin	Alk. Phos.	AST	ALT	GGT	CK	Calcium	Adj Ca	Phosphate
		60–80	32–45	23–38	<20	35–135	<40	<50	<40	<170		2.10–2.60	0.70–1.40
Date	Time	g/L			umol/L	U/L					mmol/L		
14.10.10	20:20	85	45	40	7	164	28	27					
27.03.11	05:20	74	40	34	10	155	18	28					
28.03.11	08:00	75	39	36	35	216	168	208					
29.03.11	10:00	65	32	33	16	170	38	102					
30.03.11	09:00	64	29	35	11	162	19	70					
27.06.11	09:00												

* Fasting: Y = Yes, N = No

CPA Accredited Medical Laboratory Reference No: 2923

Report authorised by Computer validation

Run No: 681 Issued 27.06.11 at 12:37 Specimen type: Blood

BIOCHEMISTRY DEPARTMENT

SOUTH GLASGOW ☎ (0141) 201 1681 NHS Greater Glasgow and Clyde **A**

Name **HONEYMAN CATHERINE** CHI Number **0102496145** Location **Ward 3 SGH**

Unit No. **SG00940779** Lab Number **R,11.1108171.J** Consultant **Mr.M.G.Hullin**

D.O.B. **01.02.49** Sex **F** Received **30.03.11** at **10:09** Prov. Diagnosis

Withdrawal		Na	K	Cl	HCO3	Urea	Creat	eGFR	Glucose	*	CRP	Amylase	Magnesium	Urate
		135–145	3.5–5.0	98–108	23–30	2.5–7.0	40–130				<10	<100	0.70–1.00	0.15–0.35
Date	Time	mmol/L					umol/L	mL/min	mmol/L		mg/L	U/L	mmol/L	
08.10.10	12:00										3			
14.10.10	20:20	141	3.8	95	24	4.4	73	>60	7.3	Y	9			
27.03.11	05:20	134	4.0	96	23	7.3	83	>60	10.4	N	57			
28.03.11	08:00	135	3.6	96	22	5.7	103	47			424			
29.03.11	10:00	135	2.9	95	26	5.4	94	52			445			
30.03.11	09:00	137	3.8	99	25	4.6	78	>60			453			

Withdrawal		T.Protein	Albumin	Globulins	Bilirubin	Alk. Phos.	AST	ALT	GGT	CK	Calcium	Adj Ca	Phosphate
		60–80	32–45	23–38	<20	35–135	<40	<50	<40	<170		2.10–2.60	0.70–1.40
Date	Time	g/L			umol/L	U/L					mmol/L		
19.07.10	08:40	65	32	33	6	255	26	66					
14.10.10	20:20	85	45	40	7	164	28	27					
27.03.11	05:20	74	40	34	10	155	18	28					
28.03.11	08:00	75	39	36	35	216	168	208					
29.03.11	10:00	65	32	33	16	170	38	102					
30.03.11	09:00	64	29	35	11	162	19	70					

* Fasting: Y = Yes, N = No

CPA

BIOCHEMISTRY DEPARTMENT

SOUTH GLASGOW ☎ (0141) 201 1681 NHS Greater Glasgow and Clyde **A**

Name **HONEYMAN CATHERINE** CHI Number **0102496145** Location **Ward 2 SGH**

Unit No. **SG00940779** Lab Number **R,11.1114785.T** Consultant **Mr.M.G.Hullin**

D.O.B. **01.02.49** Sex **F** Received **05.04.11** at **10:12** Prov. Diagnosis

Withdrawal		Na	K	Cl	HCO3	Urea	Creat	eGFR	Glucose	*	CRP	Amylase	Magnesium	Urate
		135–145	3.5–5.0	98–108	23–30	2.5–7.0	40–130				<10	<100	0.70–1.00	0.15–0.35
Date	Time	mmol/L					umol/L	mL/min	mmol/L		mg/L	U/L	mmol/L	
28.03.11	08:00	135	3.6	96	22	5.7	103	47			424			
29.03.11	10:00	135	2.9	95	26	5.4	94	52			445			
30.03.11	09:00	137	3.8	99	25	4.6	78	>60			453			
01.04.11	08:00	138	3.7	97	25	4.2	75	>60			438		0.83	
05.04.11	09:00	137	4.3	95	29	4.4	77	>60			256			
											95			

Withdrawal		T.Protein	Albumin	Globulins	Bilirubin	Alk. Phos.	AST	ALT	GGT	CK	Calcium	Adj Ca	Phosphate
		60–80	32–45	23–38	<20	35–135	<40	<50	<40	<170		2.10–2.60	0.70–1.40
Date	Time	g/L			umol/L			U/L			mmol/L		
14.10.10	20:20	85	45	40	7	164	28	27					
27.03.11	05:20	74	40	34	10	155	18	28					
28.03.11	08:00	75	39	36	35	216	168	208					
29.03.11	10:00	65	32	33	16	170	38	102					
30.03.11	09:00	64	29	35	11	162	19	70					
05.04.11	09:00												

* Fasting: Y = Yes, N = No

BIOCHEMISTRY DEPARTMENT SOUTH GLASGOW 141) 201 1681 NHS A

Name HONEYMAN CATHERINE | CHI Number 0102496145 | Location Ward 1 SGH
Unit No. SG00940779 | Lab Number R,10.1149997.F | Consultant Mr.David.Martin
D.O.B. 01.02.49 Sex F | Received 07.05.10 at 10:07 | Prov. Diagnosis Not stated

Withdrawal		Na 135–145	K 3.5–5.0	Cl 98–108	HCO3 23–30	Urea 2.5–7.0	Creat 40–130	eGFR	Glucose	*	CRP <10	Amylase <100	Magnesium 0.70–1.00	Urate 0.15–0.35
Date	Time	mmol/L					umol/L	mL/min	mmol/L		mg/L	U/L	mmol/L	
03.02.10	10:10	141	4.2	105	27	6.9	93	53						
16.04.10	12:20	140	4.8	102	24	4.3	66	>60	5.8	N	4.1			
23.04.10	10:45	138	4.3	99	26	6.9	70	>60						
06.05.10	01:12	134	3.7	99	20	6.9	91	55	6.8	N	125			
06.05.10	08:40	135	3.6	97	24	5.9	77	>60			238			
07.05.10	09:10	136	3.2	99	23	5.5	69	>60			449			

Withdrawal		T.Protein 60–80	Albumin 32–45	Globulins 23–38	Bilirubin <20	Alk. Phos. 35–135	AST <40	ALT <50	GGT <40	CK <170	Calcium	Adj Ca 2.10–2.60	Phosphate 0.70–1.40
Date	Time	g/L			umol/L	U/L					mmol/L		
06.02.08	14:00	73	44	29	9	111	51	48	83				
12.02.08	08:00	64	37	27	9	100	36	46					
31.01.10	12:30	57	29	28	29	166	35	103					
06.05.10	01:12	67	35	32	12	216	349	220					
06.05.10	08:40	69	39	30	23	223	228	204					
07.05.10	09:10	65	34	31	12	197	61	111					

* Fasting: Y = Yes, N = No

CPA Accredited Medical Laboratory Reference No: 2923

Report authorised by Frank Finlay
Run No: 120 Issued 07.05.10 at 14:01 Specimen type: Blood

BIOCHEMISTRY DEPARTMENT SOUTH GLASGOW (0141) 201 1681 NHS A

Name HONEYMAN CATHERINE | CHI Number 0102496145 | Location Ward 1 SGH
Unit No. SG00940779 | Lab Number R,10.1235035.A | Consultant Dr.S.Patil
D.O.B. 01.02.49 Sex F | Received 19.07.10 at 10:17 | Prov. Diagnosis INFECTED KNEE

Withdrawal		Na 135–145	K 3.5–5.0	Cl 98–108	HCO3 23–30	Urea 2.5–7.0	Creat 40–130	eGFR	Glucose	*	CRP <10	Amylase <100	Magnesium 0.70–1.00	Urate 0.15–0.35
Date	Time	mmol/L					umol/L	mL/min	mmol/L		mg/L	U/L	mmol/L	
13.05.10	09:00	139	4.6	102	28	4.2	60	>60			80			
04.06.10	11:23										6			
14.07.10	02:20	136	4.7	95	26	7.8	76	>60			12			
15.07.10	09:15	133	3.21	95	25	5.1	77	>60			307			
16.07.10	08:10	139	3.3	99	28	3.6	69	>60			315			
19.07.10	08:40	141	4.72	101	28	4.7	76	>60			40			

Withdrawal		T.Protein 60–80	Albumin 32–45	Globulins 23–38	Bilirubin <20	Alk. Phos. 35–135	AST <40	ALT <50	GGT <40	CK <170	Calcium	Adj Ca 2.10–2.60	Phosphate 0.70–1.40
Date	Time	g/L			umol/L	U/L					mmol/L		
06.05.10	01:12	67	35	32	12	216	349	220					
06.05.10	08:40	69	39	30	23	223	228	204					
07.05.10	09:10	65	34	31	12	197	61	111					
16.07.10	09:15	57	29	28	22	170	108	160					
16.07.10	08:10	60	29	31	8	161	38	112					
19.07.10	08:40	65	32	33	6	255	28	66					

* Fasting: Y = Yes, N = No

CPA Accredited Medical Laboratory Reference No: 2923

Report authorised by Computer validation
Run No: 133 Issued 19.07.10 at 11:35 Specimen type: Blood

BIOCHEMISTRY DEPARTMENT SOUTH GLASGOW (0141) 201 1681 NHS A

Name HONEYMAN CATHERINE | CHI Number 0102496145 | Location Ward 6 SGH
Unit No. SG00940779 | Lab Number R,10.1038350.T | Consultant Mr.M.G.Hullin
D.O.B. 01.02.49 Sex F | Received 03.02.10 at 11:25 | Prov. Diagnosis Post op

Withdrawal		Na 135–145	K 3.5–5.0	Cl 98–108	HCO3 23–30	Urea 2.5–7.0	Creat 40–130	eGFR	Glucose	*	CRP <10	Amylase <100	Magnesium 0.70–1.00	Urate 0.15–0.35
Date	Time	mmol/L					umol/L	mL/min	mmol/L		mg/L	U/L	mmol/L	
30.01.10	10:30	134	4.1	97	22	7.3	127	37						
31.01.10	10:00	133	4.8	100	23	10.7	130	36						
31.01.10	12:30	129	4.3	97	21	10.8	131	35			446			
01.02.10	11:00	130	4.1	97	22	13.2	143	32						
02.02.10	11:00	133	4.0	99	23	12.7	135	35			417			
03.02.10	10:10	141	4.2	105	27	6.9	93	53						

Withdrawal		T.Protein 60–80	Albumin 32–45	Globulins 23–38	Bilirubin <20	Alk. Phos. 35–135	AST <40	ALT <50	GGT <40	CK <170	Calcium	Adj Ca 2.10–2.60	Phosphate 0.70–1.40
Date	Time	g/L			umol/L	U/L					mmol/L		
19.10.07	16:00	73	46	27	7	96	29	34					
06.02.08	14:00	73	44	29	9	111	51	48	83				
12.02.08	08:00	64	37	27	9	100	36	46					
31.01.10	12:30	57	29	28	29	166	35	103					
03.02.10	10:10												

* Fasting: Y = Yes, N = No

CPA

BIOCHEMISTRY DEPARTMENT SOUTH GLASGOW (0141) 201 1681 NHS A

Name HONEYMAN CATHERINE | CHI Number 0102496145 | Location Ward 1 SGH
Unit No. SG00940779 | Lab Number R,10.1156979.H | Consultant Mr.David.Martin
D.O.B. 01.02.49 Sex F | Received 13.05.10 at 10:16 | Prov. Diagnosis KNEE INFECTION

Withdrawal		Na 135–145	K 3.5–5.0	Cl 98–108	HCO3 23–30	Urea 2.5–7.0	Creat 40–130	eGFR	Glucose	*	CRP <10	Amylase <100	Magnesium 0.70–1.00	Urate 0.15–0.35
Date	Time	mmol/L					umol/L	mL/min	mmol/L		mg/L	U/L	mmol/L	
07.05.10	09:10	136	3.2	99	23	5.5	69	>60			449			
08.05.10	10:00	136	3.4	99	26	4.5	63	>60			469			
09.05.10	08:40	139	4.1	100	23	4.0	60	>60			324			
10.05.10	08:10	138	4.4	101	26	4.1	59	>60			187			
12.05.10	11:30	140	4.1	102	28	4.4	62	>60			99			
13.05.10	09:00	139	4.6	102	28	4.2	60	>60			80			

Withdrawal		T.Protein 60–80	Albumin 32–45	Globulins 23–38	Bilirubin <20	Alk. Phos. 35–135	AST <40	ALT <50	GGT <40	CK <170	Calcium	Adj Ca 2.10–2.60	Phosphate 0.70–1.40
Date	Time	g/L			umol/L	U/L					mmol/L		
12.02.08	08:00	64	37	27	9	100	36	46					
31.01.10	12:30	57	29	28	29	166	35	103					
06.05.10	01:12	67	35	32	12	216	349	220					
06.05.10	08:40	69	39	30	23	223	228	204					
07.05.10	09:10	65	34	31	12	197	61	111					
13.05.10	09:00												

* Fasting: Y = Yes, N = No

CPA Accredited Medical Laboratory

SOUTHERN GENERAL HOSPITAL

BIOCHEMISTRY DEPARTMENT

A

REMOVE THIS STRIP & AFFIX REPORT - TOP EDGE TO LINE ABOVE	12
REMOVE THIS STRIP & AFFIX REPORT - TOP EDGE TO LINE ABOVE	11
REMOVE THIS STRIP & AFFIX REPORT - TOP EDGE TO LINE ABOVE	10
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REMOVE THIS STRIP & AFFIX REPORT - TOP EDGE TO LINE ABOVE	7
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REMOVE THIS STRIP & AFFIX REPORT - TOP EDGE TO LINE ABOVE	3
REMOVE THIS STRIP & AFFIX REPORT - TOP EDGE TO LINE ABOVE	2

LIFT TAB AND PEEL STRIP FROM THIS SIDE

BIOCHEMISTRY DEPARTMENT

SOUTH GLASGOW UNIVERSITY HOSPITALS

A

Name HONEYMAN CATHERINE Sex F D.O.B. 01.02.49 Location Ward 5 SGH

CHI Number 0102496145 Consultant Mr Ian Stead Hosp. Number SG00940779

Prov. Diagnosis Received 19.12.05 10:24 Lab. Number R.05.1220665.G

Withdrawal		Na 135-145	K 3.5-5.0	Cl 97-107	HCO3 23-30	Urea 2.5-7.0	Creat 40-130	Glucose 3.5 - 6.0 Fasting	Amylase <100	Magnesium 0.70-1.00	Urate F: 0.15-0.36 M: 0.21-0.44	Ser. Osm. 275-295	Ur. Osm.
Date	Time	mmol/L					µmol/L	mmol/L	U/L	mmol/L		mmol/kg	
22.11.99	16:00	136	4.0	105	23	7.0	70						
08.11.05	12:10	141	4.1	100	27	8.2	81						
13.12.05	11:00	138	3.2	99	28	3.6	70						
19.12.05	09:25	142	4.0	102	33	4.3	77						

Withdrawal		T.Protein 62-82	Albumin 36-49	Globulins 20-35	Bilirubin <20	Alk. Phos. 60-260	AST <40	ALT <40	γ-GT F<30, M<50	CK F<170, M<210	Calcium	Adj. Ca 2.15-2.60	Phosphate 0.70-1.40
Date	Time	g/L			µmol/L			U/L			mmol/L		
22.11.99	16:00	77	48	29	4	235	29	38			2.46		1.15
19.12.05	09:25												

Run No: 291

Report authorised by Maggie Snedden

BIOCHEMISTRY PARTMENT SOUTH GLASGOW ☎ (0141) 201 1681

NHS Greater Glasgow and Clyde

A

Name HONEYMAN CATHERINE CHI Number 0102496145 Location Ward 6 SGH

Unit No. SG00940779 Lab Number R,10.1036700.S Consultant Mr.M.G.Hullin

D.O.B. 01.02.49 Sex F Received 02.02.10 at 12:23 Prov. Diagnosis post left tkr

Withdrawal		Na 135-145	K 3.5-5.0	Cl 98-108	HCO3 23-30	Urea 2.5-7.0	Creat 40-130	eGFR	Glucose	*	CRP <10	Amylase <100	Magnesium 0.70-1.00	Urate 0.15-0.35
Date	Time	mmol/L					umol/L	mL/min	mmol/L		mg/L	U/L	mmol/L	
29.01.10	10:55	138	4.1	102	23	3.4	74	>60						
30.01.10	10:30	134	4.1	97	22	7.3	127	37						
31.01.10	10:00	133	4.8	100	23	10.7	130	36						
31.01.10	12:30	129	4.3	97	21	10.8	131	36			446			
01.02.10	11:00	130	4.1	97	22	13.2	143	32						
02.02.10	11:00	133	4.0	99	23	12.7	135	35			417			

Withdrawal		T.Protein 60-80	Albumin 32-45	Globulins 23-38	Bilirubin <20	Alk. Phos. 35-135	AST <40	ALT <50	GGT <40	CK <170	Calcium	Adj Ca 2.10-2.60	Phosphate 0.70-1.40
Date	Time	g/L			umol/L	U/L					mmol/L		
19.10.07	16:00	73	46	27	7	96	29	34					
06.02.08	14:00	73	44	29	9	111	51	48	83				
12.02.08	08:00	64	37	27	9	100	36	46					
31.01.10	12:30	57	29	28	29	166	35	103					
02.02.10	11:00												

* Fasting: Y = Yes, N = No

CPA Accredited Medical Laboratory Reference No: 2923

Report authorised by Computer validation

Run No: 149 Issued 02.02.10 at 13:30 Specimen type: Blood

BIOCHEMISTRY DEPARTMENT SOUTH GLASGOW ☎ (0141) 201 1681

NHS Greater Glasgow and Clyde

A

Name HONEYMAN CATHERINE CHI Number 0102496145 Location Orthopaedic OPD, SGH

Unit No. SG00940779 Lab Number R,10.1014763.L Consultant Mr.M.G.Hullin

D.O.B. 01.02.49 Sex F Received 15.01.10 at 13:25 Prov. Diagnosis Osteoarthritis

Withdrawal		Na 135-145	K 3.5-5.0	Cl 98-108	HCO3 23-30	Urea 2.5-7.0	Creat 40-130	eGFR	Glucose	*	CRP <10	Amylase <100	Magnesium 0.70-1.00	Urate 0.15-0.35
Date	Time	mmol/L					umol/L	mL/min	mmol/L		mg/L	U/L	mmol/L	
29.05.07	09:00													
19.10.07	16:00	138	3.8	99	22	7.2	76	>60	5.0	N	2			
06.02.08	14:00	141	4.0	103	22	7.6	74	>60	6.3	N				
11.02.08	08:00	136	4.0	101	22	8.0	77	>60	6.7	N		34		
12.02.08	08:00	139	3.3	101	26	6.9	84	>60			1			
15.01.10	11:00	140	4.1	102	24	6.2	77	>60			2	27		

Withdrawal		T.Protein 60-80	Albumin 32-45	Globulins 23-38	Bilirubin <20	Alk. Phos. 35-135	AST <40	ALT <50	GGT <40	CK <170	Calcium	Adj Ca 2.10-2.60	Phosphate 0.70-1.40
Date	Time	g/L			umol/L	U/L					mmol/L		
19.10.07	16:00	73	46	27	7	96	29	34					
06.02.08	14:00	73	44	29	9	111	51	48	83				
12.02.08	08:00	64	37	27	9	100	36	46					
15.01.10	11:00												

Time of sample collection estimated

* Fasting: Y = Yes, N = No

CPA

BACTERIOLOGY DEPARTMENT

SGH 115A

BACTERIOLOGY DEPARTMENT
TEL: 0141 201 1703/4/5

SOUTHERN GENERAL HOSPITAL GLASGOW

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Dr.N.Littlewood
Ward: Acc / Emergency SGH
Specimen: SWAB.WOUND.Leg

Unit No.: SG00940779 CHI No.: 0102496147
D.O.B. 01.02.49 Sex: F
Report to: Acc / Emergency SGH
Date collected: 06.05.10
Date received: 07.05.10

W1

REPORT:

Microscopy:-

Antibiotic	Organism 1. 2. 3.
Erythromycin	S
Flucloxacillin	S
Penicillin	S

Cultures:-

36502/10

1. Staphylococcus aureus heavy growth
2.
3.

Comment:-

S=Sensitive I=Intermediate R=Resistant

Prof.A Leanord 10.05.10

LAB.NO. R,10.0004691

SGH 115A

BACTERIOLOGY DEPARTMENT
TEL: 0141 201 1703/4/5

SOUTHERN GENERAL HOSPITAL GLASGOW

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Mr.M.G.Hullin
Ward: Orthopaedic OPD, SGH
Specimen: SWAB MRSA nasal

Unit No.: SG00940779 CHI No.: 0102496145
D.O.B. 01.02.49 Sex: F
Report to: Orthopaedic OPD, SGH
Date collected: 23.04.10
Date received: 23.04.10

REPORT:

Microscopy:-

Culture:-
METHICILLIN RESISTANT Staph aureus NOT ISOLATED

Comment:-

MONTY MCLEAN 24.04.10

LAB.NO. M,10.001248

[redacted]

GH 115A

BACTERIOLOGY DEPARTMENT
TEL: 0141 201 1703/4/5

SOUTHERN GENERAL HOSPITAL GLASGOW

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Mr.M.G.Hullin
Ward: Orthopaedic OPD, SGH
Specimen: SWAB MRSA groin

Unit No.: SG00940779 CHI No.: 0102496145
D.O.B. 01.02.49 Sex: F
Report to: Orthopaedic OPD, SGH
Date collected: 23.04.10
Date received: 23.04.10

REPORT:

Microscopy:-

Cultures:-
METHICILLIN RESISTANT Staph aureus NOT ISOLATED

Comments:-

MONTY MCLEAN 24.04.10

LAB.NO. M,10.0012482

SGH 115A

BACTERIOLOGY DEPARTMENT
TEL: 0141 201 1703/4/5

SOUTHERN GENERAL HOSPITAL GLASGOW

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Mr.M.W.G.Gordon
Ward: Acc / Emergency SGH
Specimen: BLOOD CULTURE

Unit No.: SG00940779 CHI No.: 0102496145
D.O.B. 01.02.49 Sex: F
Report to: Acc / Emergency SGH
Date collected: 18.04.10
Date received: 19.04.10

WS

REPORT:

Culture:-
BLOOD CULTURE:NO GROWTH AFTER 48 HOURS. INCUBATION CONTINUES

Comments:-

Colin Gordon 21.04.10

Lab.No. B.10.000301

SOUTHERN GENERAL HOSPITAL GLASGOW

...OLOGY DEPARTMENT
...0141 201 1703/4/5

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Mr.M.G.Hullin
Ward: Ward 6 SGH
Specimen: SWAB WOUND knee

Unit No.: SG00940779 CHI No.: 0102496145
D.O.B. 01.02.49 Sex: F
Report to: Ward 6 SGH
Date collected: 03.02.10
Date received: 03.02.10

REPORT:

Microscopy:-

Antibiotic	Organism 1. 2. 3.
Erythromycin	S
Flucloxacillin	S
Penicillin	S

Culture:-

1. Staphylococcus aureus heavy growth
2.
3.

Comment:-

S=Sensitive I=Intermediate R=Resistan

Prof.A Leanord 05.02.10

LAB.NO. R,10.0001223

6)

SGH 115A

BACTERIOLOGY DEPARTMENT
TEL: 0141 201 1703/4/5

SOUTHERN GENERAL HOSPITAL GLASGOW

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Mr.M.G.Hullin
Ward: Ward 6 SGH
Specimen: URINE mid stream

Unit No.: SG00940779
D.O.B. 01.02.49
Report to: Ward 6 SGH
Date collected: 01.02.10
Date received: 01.02.10

CHI No.: 0102496145
Sex: F

REPORT:

Microscopy:- W.B.C. SCANTY
R.B.C. INSIGNIFICANT NUMBER

Culture:-
NO SIGNIFICANT BACTERIURIA

Comment:-
URINE NOT CULTURED.

MONTY MCLEAN 01.02.10

LAB.NO. U.10.0005636

SGH 115A

BACTERIOLOGY DEPARTMENT
TEL: 0141 201 1703/4/5

SOUTHERN GENERAL HOSPITAL GLASGOW

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Mr.M.G.Hullin
Ward: Ward 6 SGH
Specimen: SWAB WOUND right knee

SG00940779
Unit No: 01.02.49
D.O.B. Ward 6 SGH
Report to: 28.01.10
Date collected: 28.01.10
Date received:

CHI No.: 0102496145
Sex: F

REPORT:

Microscopy:-

Culture:-
NO GROWTH

Comment:-

Sylvia Rennie 30.01.10

LAB.NO. R,10.0000995

SGH 115A

BACTERIOLOGY DEPARTMENT
TEL: 0141 201 1703/4/5

SOUTHERN GENERAL HOSPITAL GLASGOW

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Mr.M.G.Hullin
Ward: Orthopaedic OPD, SGH
Specimen: SWAB MRSA groin

Unit No.: SG00940779 CHI No.: 0102496145
D.O.B. 01.02.49 Sex: F
Report to: Orthopaedic OPD, SGH
Date collected: 15.01.10
Date received: 15.01.10

REPORT:

Microscopy:-

Culture:-
METHICILLIN RESISTANT Staph aureus NOT ISOLATED

Comment:-

Ronnie Mcfarla 16.01.10

LAB.NO. M,10.0001488

487

023

SGH 115A

BACTERIOLOGY DEPARTMENT

TEL: 0141 201 1703/4/5

SOUTHERN GENERAL HOSPITAL GLASGOW

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Mr.M.G.Hullin
Ward: Orthopaedic OPD, SGH
Specimen: SWAB MRSA nasal

Unit No.: S600940779 CHI No.: 0102496145
D.O.B. 01.02.49 Sex: F
Report to: Orthopaedic OPD, SGH
Date collected: 15.01.10
Date received: 15.01.10

REPORT:

Microscopy:-

Culture:-
METHICILLIN RESISTANT Staph aureus NOT ISOLATED

Comment:-

Ronnie Mcfarla 16.01.10

LAB.NO. M,10.000148

SGH 115A

BACTERIOLOGY DEPARTMENT **SOUTHERN GENERAL HOSPITAL** GLASGOW

TEL: 0141 201 1703/4/5

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Mr.M.G.Hullin
Ward: Orthopaedic OPD, SGH
Specimen: URINE mid stream

Unit No.: SG00940779 CHI No.: 010249614
D.O.B. 01.02.49 Sex: F
Report to: Orthopaedic OPD, SGH
Date collected: 15.01.10
Date received: 15.01.10

REPORT:

Microscopy:- W.B.C. ABSENT
R.B.C. INSIGNIFICANT NUMBER

Culture:-
NO SIGNIFICANT BACTERIURIA

Comment:-
URINE NOT CULTURED

MONTY MCLEAN 15.01.10 LAB.NO. U;10.00023

BACTERIOLOGY DEPARTMENT

SOUTHERN GENERAL HOSPITAL GLASGOW

15A
BACTERIOLOGY DEPARTMENT
TEL: 0141 201 1703/4/5

CHI No.: 0102496145

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Mr.D.Meek
Ward: Ward 3 SGH
Specimen: FLUID knee right

Unit No.: SG00940779
D.O.B. 01.02.49
Sex: F
Report to: Ward 3 SGH
Date collected: 27.03.11 11:05
Date received: 27.03.11 11:20

REPORT: FINAL REPORT

Microscopy:-
" B.C. NUMEROUS
DERATE GRAM POSITIVE COCCI

Antibiotic	Organism 1.
Erythromycin	S
Flucloxacillin	S
Fusidic Acid	S
Penicillin	S
Rifampicin	S

Culture:-

1. Staphylococcus aureus growth
2.
3.

S=Sensitive I=Intermediate R=Resistant

Comment:-

LAB.NO.R,11.0075855

Authorised by Prof.A Leanord 29.03.11 11:59

SGH 115A

BACTERIOLOGY DEPARTMENT
TEL: 0141 201 1703/4/5

SOUTHERN GENERAL HOSPITAL GLASGOW

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Mr.M.G.Hullin
Ward: Ward 3 SGH
Specimen: SWAB MRSA nasal

Unit No.: SG00940779
D.O.B. 01.02.49
Report to: Ward 3 SGH
Date collected: 27.03.11
Date received: 27.03.11

CHI No.: 0102496145
Sex: F

REPORT: FINAL REPORT

Microscopy:-

Culture:-
METHICILLIN RESISTANT Staph aureus NOT ISOLATED

Comment:-

Autherised by Mathew Noble 28.03.11 10:51

LAB.NO.M,11.0010403

SGH 115A

BACTERIOLOGY DEPARTMENT
TEL: 0141 201 1703/4/5

SOUTHERN GENERAL HOSPITAL GLASGOW

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Mr.M.Branzby-Zachary
Ward: Ward 1 SGH
Specimen: TISSUE knee right

Unit No.: SG00940779
D.O.B. 01.02.49
Report to: Ward 1 SGH
Date collected: 14.07.10
Date received: 15.07.10

CHI No.: 0102496145
Sex: F

REPORT:

Microscopy:-
W.B.C. SCANTY
NO ORGANISMS SEEN

Antibiotic	Organism 1. 2. 3.
Erythromycin	S
Flucloxacillin	S
Gentamicin	S
Penicillin	S

Culture:-

1. Staphylococcus aureus light growth
2.
3.

Comment:-

S=Sensitive I=Intermediate R=Resistant

CB

Dr.P.Redding 19.07.10

LAB.NO. R,10.0007286

SGH.115A

BACTERIOLOGY DEPARTMENT
TEL: 0141 201 1703/4/5

SOUTHERN GENERAL HOSPITAL GLASGOW

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Dr.S.Patil
Ward: Ward 1 SGH
Specimen: VENOUS BLOOD

Unit No.: SG00940779 CHI No.: 0102496145
D.O.B. 01.02.49 Sex: F
Report to: Ward 1 SGH
Date collected: 19.07.10 08:40
Date received: 19.07.10 11:08

REPORT:

Antibiotic Assay:-

GENTAMICIN ASSAY TROUGH LEVEL: 5.9 mg/l

Comment:-

STEVEN HALLEY / 19.07.10

Lab.No. S,10.0009754

SGH 115A

BACTERIOLOGY DEPARTMENT
TEL: 0141 201 1703/4/5

SOUTHERN GENERAL HOSPITAL GLASGOW

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Mr.M.Branzby-Zachary
Ward: Ward 1 SGH
Specimen: PUS knee right

Unit No.: SG00940779
D.O.B. 01.02.49
Report to: Ward 1 SGH
Date collected: 14.07.10
Date received: 15.07.10

CHI No.: 0102496145
Sex: F

REPORT:

Microscopy:-
W.B.C. NUMEROUS
SCANTY GRAM POSITIVE COCCI

Antibiotic	Organism 1. 2. 3.
Erythromycin	S
Flucloxacillin	S
Penicillin	S

Culture:-

1. Staphylococcus aureus moderate growth
2.
3.

Comment:-

S=Sensitive I=Intermediate R=Resistant

CB

Batchelor 17.07.10

LAB.NO. R,10.0007277

SGH 115A

BACTERIOLOGY DEPARTMENT
TEL: 0141 201 1703/4/5

SOUTHERN GENERAL HOSPITAL GLASGOW

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Dr.S.Patil
Ward: Ward 1 SGH
Specimen: VENOUS BLOOD

Unit No.: SG00940779 CHI No.: 0102496145
D.O.B. 01.02.49 Sex: F
Report to: Ward 1 SGH
Date collected: 16.07.10 08:40
Date received: 16.07.10 11:04

REPORT:

Antibiotic Assay:-

GENTAMICIN ASSAY PEAK LEVEL: 2.7 mg/l

Comment:-

M.MURRAY 16.07.10 Lab.No. S,10.0009651

076934
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021543
09599
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SGH 115A

BACTERIOLOGY DEPARTMENT
TEL: 0141 201 1703/4/5

SOUTHERN GENERAL HOSPITAL GLASGOW

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Dr.S.Patil
Ward: Ward 1 SGH
Specimen: FLUID knee right synovial

Unit No.: SG00940779
D.O.B. 01.02.49
Report to: Ward 1 SGH
Date collected: 14.07.10
Date received: 14.07.10

CHI No.: 0102496145
Sex: F

REPORT:

Microscopy:-
W.B.C. NUMEROUS.
MODERATE GRAM POSITIVE COCCI

Culture:-

1. Staphylococcus aureus heavy growth
2.
3.

Antibiotic	Organism 1. 2. 3.
Erythromycin	S
Flucloxacillin	S
Fusidic Acid	S
Gentamicin	S
Penicillin	S
Rifampicin	S

Comment:-
Microscopy result phoned 14/07/10
Result phoned 15/07/10

S=Sensitive I=Intermediate R=Resistan

Dr Chloe Keane 16.07.10

LAB.NO. R,10.0076934

SGH 115A

BACTERIOLOGY DEPARTMENT
TEL: 0141 201 1703/4/5

SOUTHERN GENERAL HOSPITAL GLASGOW

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Mr.M.Branzby-Zachary
Ward: Ward 1 SGH
Specimen: SWAB MRSA nasal

Unit No.: SG00940779
D.O.B. 01.02.49
Report to: Ward 1 SGH
Date collected: 14.07.10
Date received: 14.07.10

CHI No.: 0102496145
Sex: F

REPORT:

Microscopy:-

Culture:-
METHICILLIN RESISTANT Staph aureus NOT ISOLATED

Comment:-

Sylvia Rennie 15.07.10

LAB.NO. M,10.0021542

SGH 115A

BACTERIOLOGY DEPARTMENT

TEL: 0141 201 1703/4/5

SOUTHERN GENERAL HOSPITAL GLASGOW

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Mr.M.Branzby-Zachary
Ward: Ward 1 SGH
Specimen: SWAB MRSA groin

Unit No.: SG00940779
D.O.B. 01.02.49
Report to: Ward 1 SGH
Date collected: 14.07.10
Date received: 14.07.10

CHI No.: 0102496145
Sex: F

REPORT:

Microscopy:-

Culture:-
METHICILLIN RESISTANT Staph aureus NOT ISOLATED

Comment:-

Sylvia Rennie 15.07.10

LAB.NO. M,10.0021543

SGH 115A

BACTERIOLOGY DEPARTMENT
TEL: 0141 201 1703/4/5

SOUTHERN GENERAL HOSPITAL GLASGOW

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Dr.S.Patil
Ward: Ward 1 SGH
Specimen: VENOUS BLOOD

Unit No.: SG00940779 CHI No.: 0102496145
D.O.B. 01.02.49 Sex: F
Report to: Ward 1 SGH
Date collected: 15.07.10 09:15
Date received: 15.07.10 11:47

REPORT:

Antibiotic Assay:-

GENTAMICIN ASSAY PEAK LEVEL: 2.5 mg/l

Comment:-

M.MURRAY 15.07.10 Lab.No. S,10.0009595

SGH 115A

BACTERIOLOGY DEPARTMENT **SOUTHERN GENERAL HOSPITAL** GLASGOW

TEL: 0141 201 1703/4/5

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Mr.David.Martin
Ward: Ward 1 SGH
Specimen: SWAB WOUND knee

Unit No.: SG00940779 CHI No.: 0102496145
D.O.B. 01.02.49 Sex: F
Report to: Ward 1 SGH
Date collected: 08.05.10
Date received: 08.05.10

REPORT:

Microscopy:-

Culture:-
1. Staphylococcus aureus heavy growth
2.
3.

Antibiotic	Organism 1. 2. 3
Erythromycin	S
Flucloxacillin	S
Penicillin	S

Comment:-

S=Sensitive I=Intermediate R=Resista

Prof.A Leanord 11.05.10

LAB.NO. R,10.000474

JB-24336/6

FORM 0389186 SGH 284

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BIOCHEMISTRY DEPARTMENT

SOUTH GLASGOW ☎ (0141) 201 1681 NHS Greater Glasgow and Clyde **A**

Name **HONEYMAN CATHERINE** CHI Number **0102496145** Location **Ward 5 SGH**

Unit No. **SG00940779** Lab Number R,11.1216456.H Consultant **Mr.M.G.Hullin**

D.O.B. **01.02.49** Sex **F** Received 01.07.11 at 11:12 Prov. Diagnosis

Withdrawal		Na 135–145	K 3.5–5.0	Cl 98–108	HCO3 23–30	Urea 2.5–7.0	Creat 40–130	eGFR	Glucose	*	CRP <10	Amylase <100	Magnesium 0.70–1.00	Urate 0.15–0.35
Date	Time	mmol/L					umol/L	mL/min	mmol/L		mg/L	U/L	mmol/L	
20.05.11	11:00	140	4.0	99	29	5.1	69	>60			10			
10.06.11	12:00	138	3.5	96	30	5.2	73	>60			4			
24.06.11	10:20	137	3.7	100	24	3.7	67	>60			114			
27.06.11	09:00	139	3.7	98	29	3.6	66	>60						
28.06.11	10:10	140	3.6	100	26	3.7	67	>60						
01.07.11	09:50	136	4.0	97	27	4.2	79	>60			60			

Withdrawal		T.Protein 60–80	Albumin 32–45	Globulins 23–38	Bilirubin <20	Alk. Phos. 35–135	AST <40	ALT <50	GGT <40	CK <170	Calcium	Adj Ca 2.10–2.60	Phosphate 0.70–1.40
Date	Time	g/L			umol/L	U/L					mmol/L		
14.10.10	20:20	85	45	40	7	164	28	27					
27.03.11	05:20	74	40	34	10	155	18	28					
28.03.11	08:00	75	39	36	35	216	168	208					
29.03.11	10:00	65	32	33	16	170	38	102					
30.03.11	09:00	64	29	35	11	162	19	70					
01.07.11	09:50												

* Fasting: Y = Yes, N = No

CPA Accredited Medical Laboratory Reference No: 2923

Report authorised by Computer validation

Run No: 751 Issued 01.07.11 at 12:15 Specimen type: Blood

BIOCHEMISTRY DEPARTMENT

SOUTH GLASGOW ☎ (0141) 201 1681 NHS Greater Glasgow and Clyde **A**

Name **HONEYMAN CATHERINE** CHI Number **0102496145** Location **Ward 5 SGH**

Unit No. **SG00940779** Leb Number R,11.1211627.V Consultant **Mr.M.G.Hullin**

D.O.B. **01.02.49** Sex **F** Received 28.06.11 at 11:16 Prov. Diagnosis Not stated

Withdrawal		Na	K	Cl	HCO_3	Urea	Creat	eGFR	Glucose	*	CRP	Amylase	Magnesium	Urate
		135–145	3.5–5.0	98–108	23–30	2.5–7.0	40–130				<10	<100	0.70–1.00	0.15–0.35
Date	Time	mmol/L					umol/L	mL/min	mmol/L		mg/L	U/L	mmol/L	
06.05.11	20:00										9			
20.05.11	11:00	140	4.0	99	29	5.1	69	>60			10			
10.06.11	12:00	138	3.5	96	30	5.2	73	>60			4			
24.06.11	10:20	137	3.7	100	24	3.7	67	>60			114			
27.06.11	09:00	139	3.7	98	29	3.6	66	>60						
28.06.11	10:10	140	3.6	100	26	3.7	67	>60						

Withdrawal		T.Protein	Albumin	Globulins	Bilirubin	Alk. Phos.	AST	ALT	GGT	CK	Calcium	Adj Ca	Phosphate
		60–80	32–45	23–38	<20	35–135	<40	<50	<40	<170		2.10–2.60	0.70–1.40
Date	Time	g/L			umol/L	U/L					mmol/L		
14.10.10	20:20	85	45	40	7	164	28	27					
27.03.11	05:20	74	40	34	10	155	18	28					
28.03.11	08:00	75	39	36	35	216	168	208					
29.03.11	10:00	65	32	33	16	170	38	102					
30.03.11	09:00	64	29	35	11	162	19	70					
28.06.11	10:10												

* Fasting: Y = Yes, N = No

CPA
Accredited Medical Laboratory
Reference No: 2923

Report authorised by Computer validation

Run No: 694 Issued 28.06.11 at 12:14 Specimen type: **Blood**

BACTERIOLOGY DEPARTMENT

SGH.115A

BACTERIOLOGY DEPARTMENT
TEL: 0141 201 1703/4/5

SOUTHERN GENERAL HOSPITAL GLASGOW

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Mr.M.G.Mullin
Ward: Ward 5 SGH
Specimen: TISSUE membrane tibia

Unit No: SG00940779
D.O.B. 01.02.49
Report to: Ward 5 SGH
Date collected: 23.06.11
Date received: 23.06.11

CHI No.: 0102496145
Sex: F

REPORT: FINAL REPORT
Senders ref. no.

Microscopy:-
W.B.C.ABSENT
NO ORGANISMS SEEN

Culture:-
NO GROWTH AFTER PROLONGED INCUBATION.

Comment:-

Authorised by Julie Keith 30.06.11 11:49

LAB.NO.R,11.0004305

SGH 115A

BACTERIOLOGY DEPARTMENT
TEL: 0141 201 1703/4/5

SOUTHERN GENERAL HOSPITAL GLASGOW

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Mr.M.S.McClin
Ward: Ward 6 SGH
Specimen: TISSUE membrane lit..

Unit No.: 2000944779 CHI No.: 0102494145
D.O.B. [illegible] Sex: F
Report to: Ward 6 SGH
Date collected: 22.06.11
Date received: 23.06.11

REPORT: INTERIM REPORT - Further report to follow
Senders ref. no.
Microscopy:-
W.B.C.ABSENT
NO ORGANISMS SEEN

Culture:-
NO GROWTH

Comments:-

Authorised by: J.DUNCAN 28.06.11 10:27

LAB.NO.R,11.0006305

SGH 115A

BACTERIOLOGY DEPARTMENT
TEL: 0141 201 1703/4/5

SOUTHERN GENERAL HOSPITAL GLASGOW

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Mr.M.G.Mullin
Ward: Ward 5 SGH
Specimen: SWAB WOUND right knee

Unit No.: S0079407?S CHI No.: 0102496145
D.O.B. 01.02.49 Sex: F
Report to: Ward 5 SGH
Date collected: 25.06.11
Date received: 25.06.11

REPORT: FINAL REPORT

Microscopy:-

Culture:-
NO GROWTH

Comment:-

Authorised by: S.GUTHRIE 25.06.11 10:22

LAB.NO.R.11.0002236

SGH:115A

BACTERIOLOGY DEPARTMENT
TEL: 0141 201 1703/4/5

SOUTHERN GENERAL HOSPITAL GLASGOW

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Mr.M.G.Hullin
Ward: Ward 5 SGH
Specimen: SWAB vaginal

Unit No.: SG00940779
D.O.B. 01.02.49
Report to: Ward 5 SGH
Date collected: 23.06.11
Date received: 24.06.11

CHI No.: 0102496145
Sex: F

REPORT: FINAL REPORT

Microscopy:-
TRICHOMONAS VAGINALIS NOT DETECTED

Culture:-
COMMENSALS ONLY ISOLATED.

Comments:-

Date authorised[illegible] Lead Consultant 27.06.11 11:30

LAB.NO.G.11.0005999

SGH 115A

BACTERIOLOGY DEPARTMENT
TEL: 0141 201 1703/4/5

SOUTHERN GENERAL HOSPITAL GLASGOW

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Mr.M.G.Hullin
Ward: Orthopaedic OPD, SGH
Specimen: SWAB MRSA nasal

Unit No.: SG00940779 CHI No.: 0102496145
D.O.B.: 01.02.49 Sex: F
Report to: Orthopaedic OPD, SGH
Date collected: 10.06.11
Date received: 10.06.11

REPORT: FINAL REPORT

Microscopy:-

Culture:-
METHICILLIN RESISTANT Staph aureus NOT ISOLATED

Comments:-

Authorised by D. Germanni 11.06.11 11:26

LAB.NO.M.11.0019383

SGH 115A

BACTERIOLOGY DEPARTMENT
TEL: 0141 201 1703/4/5

SOUTHERN GENERAL HOSPITAL GLASGOW

Name:	HONEYMAN CATHERINE	Unit No.:	SG00940779 CHI No.: 0102496145
Address:	10 MELVILLE STREET	D.O.B.	01.02.49 Sex: F
Consultant/GP:	Mr.M.G.Mullin	Report to:	Orthopaedic OPD, SGH
Ward:	Orthopaedic OPD, SGH	Date collected:	10.06.11
Specimen:	SWAB MRSA groin	Date received:	10.06.11

REPORT: FINAL REPORT

Microscopy:-

Cultures:-
METHICILLIN RESISTANT Staph aureus NOT ISOLATED

Comments:-

Authorised by D. Sermanni 11.06.11 11:26 LAB.NO.M,11.001938

SOUTHERN GENERAL HOSPITAL GLASGOW

SGH 516A
BACTERIOLOGY DEPARTMENT
TEL 0141 201 1703/4/5

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Mr.M.G.Hullin
Ward: H.D.U., SGH
Specimen: TISSUE right knee

Unit No.: SG00940779
D.O.B. 01.02.49
Report to: H.D.U., SGH
Date collected: 31.03.11
Date received: 01.04.11

CHI No.: 0102496145
Sex: F

REPORT: INTERIM REPORT - Further report to follow
Senders ref. no.

Microscopy:-
W.B.C.MODERATE
NO ORGANISMS SEEN

Culture:-
NO GROWTH

Comment:-

Authorised by MOIRA BENNET 04.04.11 09:47

LAB.NO.R,11.0003369

3

BACTERIOLOGY DEPARTMENT SOUTHERN GENERAL HOSPITAL GLASGOW
TEL 0141 201 1703/4/5

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Mr.M.G.Hullin
Ward: H.D.U., SGH
Specimen: SWAB WOUND right knee

Unit No.: SG00940779 CHI No.: 0102496l4
D.O.B. 01.02.49 Sex: F
Report to: H.D.U., SGH
Date collected: 31.03.11
Date received: 01.04.11

REPORT: FINAL REPORT

Microscopy:-

Culture:-
NO GROWTH

Comment:-

Authorised by J.GUTHRIE 03.04.11 10:29 LAB.NO.R,11.000336

SGH 115A

BACTERIOLOGY DEPARTMENT
TEL: 0141 201 1703/4/5

SOUTHERN GENERAL HOSPITAL GLASGOW

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Mr.M.G.Hullin
Ward: H.D.U., SGH
Specimen: PUS right knee

Unit No.: SG00940779
D.O.B. 01.02.49
Report to: H.D.U., SGH
Date collected: 31.03.11
Date received: 01.04.11

CHI No.: 0102496145
Sex: F

REPORT: INTERIM REPORT - Further report to follow

Microscopy:-
W.B.C. NUMEROUS
NO ORGANISMS SEEN

Culture:-
NO GROWTH

Comment:-

Authorised by J.GUTHRIE 03.04.11 10:30

LAB.NO.R,11.0003368

SOUTHERN GENERAL HOSPITAL GLASGOW

SGH 115A

BACTERIOLOGY DEPARTMENT

TEL: 0141 201 1703/4/5

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Mr.M.G.Hullin
Ward: H.D.U.: SGH
Specimen: SWAB MRSA nasal

Unit No.: SG00940779 CHI No.: 0102496145
D.O.B. 01.02.49 Sex: F
Report to: H.D.U., SGH
Date collected: 31.03.11
Date received: 01.04.11

REPORT: FINAL REPORT

Microscopy:-

Culture:-
METHICILLIN RESISTANT Staph aureus NOT ISOLATED

Comment:-

LAB.NO.M,11.0011010

Autherised by D. Germanni 02.04.11 10:11

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CTERIOLOGY DEPARTMENT

TEL: 0141 201 1703/4/5

SOUTHERN GENERAL HOSPITAL GLASGOW

Name: HONEYMAN CATHERINE
Address: 10 MELVILLE STREET
Consultant/GP: Mr.M.G.Hullin
Ward: H.D.U., SGH
Specimen: SWAB MRSA groin

Unit No.: SG00940779
D.O.B. 01.02.49
Report to: H.D.U., SGH
Date collected: 31.03.11
Date received: 01.04.11

CHI No.: 0102496145
Sex: F

REPORT: FINAL REPORT

Microscopy:-

Culture:-
METHICILLIN RESISTANT Staph aureus NOT ISOLATED

Comment:-

LAB.NO.M.11.0011

erised by D. Sermanni 02.04.11 10:11

MOUNT SHEET

SOUTHERN GENERAL HAEMATOLOGY DEPARTMENT

SURNAME	FORENAMES	SEX	D.O.B.	HOSP. No.
HONEYMAN	CATHERINE	F	01.02.49	SG00940779

DOCTOR	WARD, HOSPITAL OR G.P. ADDRESS	
Mr.David.Martin	Ward 1 SGH	Run : 4411

REPORT

DATE OF REPORT	MACHINE DIFF.	NEUT	LYMPH	MONO	EOSIN	BASO	AUTHORISED BY		
06-May-10	X10⁹/L	9.7	0.69	0.73	0.13	0.03	Ian Myles		
DATE OF SAMPLE	LAB. No.	W.B.C. X10⁹/L	PLAT. X10⁹/L	R.B.C. X10¹²/L	Hb g/L	P.C.V. L/L	M.C.V. fL	M.C.H. pg	RETIC X10⁹/L
6-May-10	3108235	11.3	221	4.38	122	0.385	88	27.9	

SOUTHERN GENERAL HAEMATOLOGY DEPARTMENT

SURNAME	FORENAMES	SEX	D.O.B.	HOSP. No.
HONEYMAN	CATHERINE	F	01.02.49	SG0094[illegible]779

DOCTOR	WARD, HOSPITAL OR G.P. ADDRESS	
Dr.N.Littlewood	Ward 1 SGH	Run : 4405

REPORT

DATE OF REPORT	MACHINE DIFF.	NEUT	LYMPH	MONO	EOSIN	BASO	AUTHORISED BY		
06-May-10	X10⁹/L	6.1	0.72	0.37	0.06	0.01	Andrew Walker		
DATE OF SAMPLE	LAB. No.	W.B.C. X10⁹/L	PLAT. X10⁹/L	R.B.C. X10¹²/L	Hb g/L	P.C.V. L/L	M.C.V. fL	M.C.H. pg	RETIC X10⁹/L
6-May-10	3108111	7.2	200	4.17	116	0.367	88	27.8	

SOUTHERN GENERAL HAEMATOLOGY DEPARTMENT

SURNAME	FORENAMES	SEX	D.O.B.	HOSP. No.
HONEYMAN	CATHERINE	F	01.02.49	SG0094 0779
DOCTOR	WARD, HOSPITAL OR G.P. ADDRESS			Run : 4405
Dr.N.Littlewood	Ward 1 SGH			

REPORT

DATE OF REPORT	MACHINE DIFF.	NEUT	LYMPH	MONO	EOSIN	BASO	AUTHORISED BY		
06-May-10	X10⁹/L	6.1	0.72	0.37	0.06	0.01	Andrew Walker		
DATE OF SAMPLE	LAB. No.	W.B.C. X10⁹/L	PLAT. X10⁹/L	R.B.C. X10¹²/L	Hb g/L	P.C.V. L/L	M.C.V. fL	M.C.H. pg	RETIC X10⁹/L
6-May-10	3108111	7.2	200	4.17	116	0.367	88	27.8	

SOUTHERN GENERAL HAEMATOLOGY DEPARTMENT

SURNAME	FORENAMES	SEX	D.O.B.	HOSP No.
HONEYMAN	CATHERINE	F	01.02.49	SG00940779

DOCTOR	WARD, HOSPITAL OR G.P. ADDRESS	
M.r, M.G. Hullin	Orthopaedic OPD, SGH	Run : 4164

REPORT

DATE OF REPORT	MACHINE DIFF.	NEUT	LYMPH	MONO	EOSIN	BASO	AUTHORISED BY		
23-Apr-10	X10⁹/L	3.3	2.29	0.57	0.32	0.01	Steven Greig		
DATE OF SAMPLE	LAB. No.	W.B.C. X10⁹/L	PLAT. X10⁹/L	R.B.C. X10¹²/L	Hb g/L	P.C.V. L/L	M.C.V. fL	M.C.H. pg	RETIC X10⁹/L
23-Apr-10	3097210	6.4	274	4.44	123	0.390	88	27.7	

SOUTHERN GENERAL HAEMATOLOGY DEPARTMENT

SURNAME	FORENAMES	SEX	D.O.B.	HOSP. No.
HONEYMAN	CATHERINE	F	01.02.49	SG00940779

DOCTOR	WARD, HOSPITAL OR G.P. ADDRESS	
Mr.M.W.G.Gordon	Acc / Emergency SGH	Run : 4057

REPORT

21/4/10

DATE OF REPORT	MACHINE DIFF.	NEUT	LYMPH	MONO	EOSIN	BASO	AUTHORISED BY		
19-Apr-10	X10⁹/L	3.8	1.59	0.45	0.29	0.01	Scott Wright		
DATE OF SAMPLE	LAB: No.	W.B.C. X10⁹/L	PLAT. X10⁹/L	R.B.C. X10¹²/L	Hb g/L	P.C.V. L/L	M.C.V. fL	M.C.H. pg	RETIC X10⁹/L
18-Apr-10	3092616	6.1	259	4.54	123	0.393	87	27.1	

SOUTHERN GENERAL HAEMATOLOGY DEPARTMENT

SURNAME	FORENAMES	SEX	D.O.B.	HOSP. No.
HONEYMAN	CATHERINE	F	01.02.49	S6009940779
DOCTOR	WARD, HOSPITAL OR G.P. ADDRESS			
Mr.M.G.Hullin	Ward 6 SGH			Run : 2821

REPORT

DATE OF REPORT	MACHINE DIFF.	NEUT	LYMPH	MONO	EOSIN	BASO	AUTHORISED BY		
02-Feb-10	X10⁹/L	5.3	0.94	1.12	0.40	0.02	Andrew Walker		
DATE OF SAMPLE	LAB. No.	W.B.C. X10⁹/L	PLAT. X10⁹/L	R.B.C. X10¹²/L	Hb g/L	P.C.V. L/L	M.C.V. fL	M.C.H. pg	RETIC X10⁹/L
2-Feb-10	3026542	7.7	261	3.13	89	0.270	86	28.4	

SOUTHERN GENERAL HAEMATOLOGY DEPARTMENT

SURNAME	FORENAMES	SEX	D.O.B.	HOSP No.
HONEYMAN	CATHERINE	F	01.02.49	SG0094077 9
DOCTOR	WARD, HOSPITAL OR G.P. ADDRESS			
Mr.M.G.Hullin	Ward 6 SGH.			Run : 2793

REPORT

DATE OF REPORT	MACHINE DIFF.	NEUT	LYMPH	MONO	EOSIN	BASO	AUTHORISED BY-		
01-Feb-10	X10⁹/L	5.0	0.71	0.53	0.33	0.00	Lorna Willis		
DATE OF SAMPLE	LAB. No.	W.B.C. X10⁹/L	PLAT. X10⁹/L	R.B.C. X10¹²/L	Hb g/L	P.C.V. L/L	M.C.V. fL	M.C.H. pg	RETIC X10⁹/L
31-Jan-10	3025322	6.6	171	3.30	93	0.286	87	28.2	

SOUTHERN GENERAL HAEMATOLOGY DEPARTMENT

SURNAME	FORENAMES	SEX	D.O.B.	HOSP No.
HONEYMAN	CATHERINE	F	01.02.49	SG0040779
DOCTOR: Mr.M.G.Hullin	WARD, HOSPITAL OR G.P. ADDRESS: Ward 6 SGH			Run : 2782

REPORT

DATE OF REPORT	MACHINE DIFF.	NEUT	LYMPH	MONO	EOSIN	BASO	AUTHORISED BY		
30-Jan-10	X10⁹/L	11.7	1.33	0.94	0.52	0.02	Joanne Melvin		
DATE OF SAMPLE	LAB. No.	W.B.C. X10⁹/L	PLAT. X10⁹/L	R.B.C. X10¹²/L	Hb g/L	P.C.V. L/L	M.C.V. fL	M.C.H. pg	RETIC X10⁹/L
30-Jan-10	3024862	14.5	223	3.80	109	0.335	88	28.7	

SOUTHERN GENERAL HAEMATOLOGY DEPARTMENT

SURNAME	FORENAMES	SEX	D.O.B.	HOSP No.
HONEYMAN	CATHERINE	F	01.02.49	SN0040779
DOCTOR	WARD, HOSPITAL OR G.P. ADDRESS			
Mr.M.G.Hullin	Ward 6 SGH.			
REPORT				Run : 2758

DATE OF REPORT	MACHINE DIFF.	NEUT	LYMPH	MONO	EOSIN	BASO	AUTHORISED BY		
29-Jan-10	X10⁹/L	4.2	0.97	0.64	0.33	0.01	Joanne Melvin		
DATE OF SAMPLE	LAB. No.	W.B.C. X10⁹/L	PLAT. X10⁹/L	R.B.C. X10¹²/L	Hb g/L	P.C.V. L/L	M.C.V. fL	M.C.H. pg	RETIC X10⁹/L
29-Jan-10	3023905	6.1	217	3.96	112	0.347	88	28.3	

SOUTHERN GENERAL HAEMATOLOGY DEPARTMENT

SURNAME	FORENAMES	SEX	D.O.B.	HOSP. No.
HONEYMAN	CATHERINE	F	01.02.49	SG00940779
CTOR .M.G.Hullin	WARD, HOSPITAL OR G.P. ADDRESS Orthopaedic OPD, SGH			Run : 2541

REPORT

DATE OF REPORT	MACHINE DIFF.	NEUT	LYMPH	MONO	EOSIN	BASO	AUTHORISED BY		
15-Jan-10	X10⁹/L	3.9	1.97	0.60	0.86	0.02	Shimshare Singh		
DATE OF SAMPLE	LAB. No.	W.B.C. X10⁹/L	PLAT. X10⁹/L	R.B.C. X10¹²/L	Hb g/L	P.C.V. L/L	M.C.V. fL	M.C.H. pg	RETIC X10⁹/L
15-Jan-10	3011354	7.4	254	4.63	136	0.410	89	29.4	

SOUTHERN GENERAL HAEMATOLOGY DEPARTMENT

SURNAME	FORENAMES	SEX	D.O.B.	HOSP. No.
HONEYMAN	CATHERINE	F	01.02.49	SG00940779

DOCTOR	WARD, HOSPITAL OR G.P. ADDRESS	
Mr Ian Stead	Ward 5 SGH	Run : 2725

REPORT

6

DATE OF REPORT	MACHINE DIFF.	NEUT	LYMPH	MONO	EOSIN	BASO	AUTHORISED BY		
13-Dec-05	X10⁹/L	4.3	0.97	0.66	0.01	0.01	SEAN ALEXANDER		
DATE OF SAMPLE	LAB. No.	W.B.C. X10⁹/L	PLAT. X10⁹/L	R.B.C. X10¹²/L	Hb g/L	P.C.V. L/L	M.C.V. fL	M.C.H. pg	RETIC X10⁹/L
13-Dec-05	206847	5.9	173.	3.43	106	0.314	92	30.9	

SOUTHERN GENERAL HAEMATOLOGY DEPARTMENT

SURNAME	FORENAMES	SEX	D.O.B.	HOSP. No.
HONEYMAN	CATHERINE	F	01.02.49	SG00940779

DOCTOR	WARD, HOSPITAL OR G.P. ADDRESS	
Mr Ian Stead	Ward 5 SGH	Run : 2814

REPORT

DATE OF REPORT	MACHINE DIFF.	NEUT	LYMPH	MONO	EOSIN	BASO	AUTHORISED BY		
19-Dec-05	X10⁹/L	2.9	1.34	0.47	0.11	0.01	Ross Gilbert.		
DATE OF SAMPLE	LAB. No.	W.B.C. X10⁹/L	PLAT. X10⁹/L	R.B.C. X10¹²/L	Hb g/L	P.C.V. L/L	M.C.V. fL	M.C.H. pg	RETIC X10⁹/L
19-Dec-05	210126	4.9	267	3.30	98	0.313	95	29.7	

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RM 0369174 SGH 286

JB-24336/2

SOUTH GLASGOW HOSPITALS - HAEMATOLOGY DEPARTMENT

SURNAME	FORENAME	SEX	HOSP. No.	D.O.B.
HONEYMAN	CATHERINE	U	SG00940779	01.02.49

MEDICAL OFFICER	WARD / HOSPITAL	C.H.I. NUMBER
Dr.S.Patil	Ward 1 SGH	0102496145

Haemoglobin	103	g/l		White Blood Count		6.2	x10⁹/l	(4.0-11.0)
Red Cell Count	3.68	x10¹²/l		Neutrophils		2.9	x10⁹/l	(2.0-7.5)
Haematocrit	0.327	l/l		Lymphocytes		1.6	x10⁹/l	(1.5-4.0)
MCV	88.9	fl	(78.0-99.0)	Monocytes		0.5	x10⁹/l	(0.2-0.8)
MCH	28.0	pg	(27.0-32.0)	Eosinophils		0.2	x10⁹/l	(0.0-0.4)
Platelets	301	x10⁹/l	(150-400)	Basophils		0.0	x10⁹/l	(0.0-0.1)

Lab No:	Spec:	Collected:	Received:	Reported:	Author
H.10.3171052.7	Blood	19.07.10 08:40	19.07.10 10:20	19.07.10 11:49	

SOUTH GLASGOW HOSPITALS - HAEMATOLOGY DEPARTMENT

SURNAME	FORENAME	SEX	HOSP. No.	D.O.B.
HONEYMAN	CATHERINE	F	SG00940779	01.02.49

MEDICAL OFFICER	WARD / HOSPITAL	C.H.I. NUMBER
Dr.Jason.Long	Acc / Emergency SGH	0102496145

Haemoglobin	133	g/l	(115-165)	White Blood Count	H	12.1	x10⁹/l	(4.0-11.0)
Red Cell Count	4.58	x10¹²/l	(3.80-5.80)	Neutrophils	H	10.1	x10⁹/l	(2.0-7.5)
Haematocrit	0.397	l/l	(0.330-0.470)	Lymphocytes	L	0.7	x10⁹/l	(1.5-4.0)
MCV	86.7	fl	(78.0-99.0)	Monocytes	H	1.2	x10⁹/l	(0.2-0.8)
MCH	29.0	pg	(27.0-32.0)	Eosinophils		0.0	x10⁹/l	(0.0-0.4)
Platelets	264	x10⁹/l	(150-400)	Basophils		0.0	x10⁹/l	(0.0-0.1)

Lab No:	Spec:	Collected:	Received:	Reported:	Authorised by:	Work done:
H.11.3067498.D	Blood	27.03.11 06:19	27.03.11 06:19	27.03.11 09:03	YWEB	FBC

SOUTH GLASGOW HOSPITALS - HAEMATOLOGY DEPARTMENT

SURNAME	FORENAME	SEX	HOSP. No.	D.O.B.
HONEYMAN	CATHERINE	U	SG00940779	01.02.49

MEDICAL OFFICER	WARD / HOSPITAL	C.H.I. NUMBER
Dr.S.Patil	Ward 1 SGH	0102496145

Haemoglobin	94	g/l		White Blood Count		8.0	x10⁹/l	(4.0-11.0)
Red Cell Count	3.40	x10¹²/l		Neutrophils		6.4	x10⁹/l	(2.0-7.5)
Haematocrit	0.305	l/l		Lymphocytes	L	1.0	x10⁹/l	(1.5-4.0)
MCV	89.7	fl	(78.0-99.0)	Monocytes		0.5	x10⁹/l	(0.2-0.8)
MCH	27.6	pg	(27.0-32.0)	Eosinophils		0.1	x10⁹/l	(0.0-0.4)
Platelets	200	x10⁹/l	(150-400)	Basophils		0.0	x10⁹/l	(0.0-0.1)

Lab No:	Spec:	Collected:	Received:	Reported:	Auth
[illegible]	[illegible]	15.07.10 09:15	15.07.10 12:09	15.07.10 12:27	KDU

SOUTH GLASGOW HOSPITALS - HAEMATOLOGY DEPARTMENT

SURNAME	FORENAME	SEX	HOSP. No.	D.O.B.
HONEYMAN	CATHERINE	F	SG00940779	01.02.49

MEDICAL OFFICER	WARD / HOSPITAL	C.H.I. NUMBER
Dr.Jason.Long	Acc / Emergency SGH	0102496145

Prothrombin Time	12	secs	(9-12)
PT Ratio	1.0		(0.8-1.1)
APTT	30	secs	(25-37)
APTT Ratio	1.0		(0.8-1.2)
Fibrinogen	3.3	g/l	(2.0-4.1)

CS. : APTTr Therapeutic Range for I.V Heparin (1.9 - 2.6)

Lab No:	Spec:	Collected:	Received:	Reported:	Authorised by:	Work done:
H.11.3067499.S	Blood	27.03.11 06:16	27.03.11 06:16	27.03.11 09:09		CS

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SOUTH GLASGOW HOSPITALS - HAEMATOLOGY DEPARTMENT

SURNAME	FORENAME	SEX	HOSP. No.	D.O.B.
HONEYMAN	CATHERINE	U	SG00940779	01.02.49
MEDICAL OFFICER	**WARD / HOSPITAL**			**C.H.I. NUMBER**
Mr.P.Davis	Acc / Emergency SGH			0102496145

Haemoglobin	127	g/l		White Blood Count	H	13.9	$x10^9/l$	(4.0-11.0)
Red Cell Count	4.50	$x10^{12}/l$		Neutrophils	H	12.2	$x10^9/l$	(2.0-7.5)
Haematocrit	0.396	l/l		Lymphocytes	L	0.9	$x10^9/l$	(1.5-4.0)
MCV	88.0	fl	(78.0-99.0)	Monocytes		0.7	$x10^9/l$	(0.2-0.8)
MCH	28.2	pg	(27.0-32.0)	Eosinophils		0.1	$x10^9/l$	(0.0-0.4)
Platelets	291	$x10^9/l$	(150-400)	Basophils		0.0	$x10^9/l$	(0.0-0.1)

Lab No:	Spec:	Collected:	Received:	Reported:	Auth
H,10.3167193.V	Blood	14.07.10 07:00	14.07.10 07:38	14.07.10 08:51	RWA

SOUTH GLASGOW HOSPITALS - HAEMATOLOGY DEPARTMENT

SURNAME	FORENAME	SEX	HOSP. No.	D.O.B.
HONEYMAN	CATHERINE	U	SG00940779	01.02.49
MEDICAL OFFICER	**WARD / HOSPITAL**			**C.H.I. NUMBER**
Mr.P.Davis	Acc / Emergency SGH			0102496145

Prothrombin Time	11	secs	(9-12)
PT Ratio	1.0		(0.8-1.1)
APTT	31	secs	(25-37)
APTT Ratio	1.0		(0.8-1.2)
Fibrinogen	3.4	g/l	(2.0-4.1)

CS : APTTr Therapeutic Range for I.V Heparin (1.9 - 2.6)

Lab No:	Spec:	Collected:	Received:	Reported:	Auth
H,10.3167194.R	Blood	14.07.10 07:30	14.07.10 07:38	14.07.10 09:05	

SOUTHERN GENERAL HAEMATOLOGY DEPARTMENT

SURNAME	FORENAMES	SEX	D.O.B.	HOSP. No.
HONEYMAN	CATHERINE	F	01.02.49	SG00940779

DOCTOR	WARD, HOSPITAL OR G.P. ADDRESS
Mr.David.Martin	Ward 1 SGH

REPORT

Run : 4572

DATE OF REPORT	MACHINE DIFF.	NEUT	LYMPH	MONO	EOSIN	BASO	AUTHORISED BY
13-May-10	X10⁹/L	4.8	1.40	0.63	0.22	0.02	Ian Myles

DATE OF SAMPLE	LAB. No.	W.B.C. X10⁹/L	PLAT. X10⁹/L	R.B.C. X10¹²/L	Hb g/L	P.C.V. L/L	M.C.V. fL	M.C.H. pg	RETIC X10⁹/L
13-May-10	3115210	7.1	385	3.77	104	0.335	89	27.6	

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SOUTHERN GENERAL HAEMATOLOGY DEPARTMENT

SURNAME	FORENAMES	SEX	D.O.B.	HOSP. No.
HONEYMAN	CATHERINE	F	01.02.49	SG00940779

DOCTOR	WARD, HOSPITAL OR G.P. ADDRESS	
Mr.David.Martin	Ward 1 SGH	Run : 4535

REPORT

DATE OF REPORT	MACHINE DIFF.	NEUT	LYMPH	MONO	EOSIN	BASO	AUTHORISED BY		
12-May-10	X10⁹/L	3.9	1.22	0.65	0.23	0.02	Shimshare Singh		
DATE OF SAMPLE	LAB. No.	W.B.C. X10⁹/L	PLAT. X10⁹/L	R.B.C. X10¹²/L	Hb g/L	P.C.V. L/L	M.C.V. fL	M.C.H. pg	RETIC X10⁹/L
12-May-10	3114241	6.0	325	3.42	93	0.301	88	27.2	

SOUTHERN GENERAL HAEMATOLOGY DEPARTMENT

SURNAME	FORENAMES	SEX	D.O.B.	HOSP. No.
HONEYMAN	CATHERINE	F	01.02.49	SG00940779

DOCTOR	WARD, HOSPITAL OR G.P. ADDRESS	
Mr.David.Martin	Ward 1 SGH	Run : 4486

REPORT

DATE OF REPORT	MACHINE.DIFF.	NEUT	LYMPH	MONO	EOSIN	BASO	AUTHORISED BY		
10-May-10	X10⁹/L	3.7	1.11	0.80	0.18	0.01	Steve Milroy		
DATE OF SAMPLE	LAB. No.	W.B.C. X10⁹/L	PLAT. X10⁹/L	R.B.C. X10¹²/L	Hb g/L	P.C.V. L/L	M.C.V. fL	M.C.H. pg	RETIC X10⁹/L
10-May-10	3112068	5.8	259	3.45	95	0.306	89	27.5	

SOUTHERN GENERAL HAEMATOLOGY DEPARTMENT

SURNAME	FORENAMES	SEX	D.O.B.	HOSP No.
HONEYMAN	CATHERINE	F	01.02.49	SG0940779
DOCTOR	WARD, HOSPITAL OR G.P. ADDRESS			
Mr.David.Martin	Ward 1 SGH			Run : 4481

REPORT

DATE OF REPORT	MACHINE DIFF.	NEUT	LYMPH	MONO	EOSIN	BASO	AUTHORISED BY		
09-May-10	X10⁹/L	4.2	1.29	0.85	0.19	0.01	Shimshare Singh		
DATE OF SAMPLE	LAB. No.	W.B.C. X10⁹/L	PLAT. X10⁹/L	R.B.C. X10¹²/L	Hb g/L	P.C.V. L/L	M.C.V. fL	M.C.H. pg	RETIC X10⁹/L
9-May-10	3111727	6.6	270	4.02	111	0.351	87	27.6	

SOUTHERN GENERAL HAEMATOLOGY DEPARTMENT

SURNAME	FORENAMES	SEX	D.O.B.	HOSP. No.
HONEYMAN	CATHERINE	F	01.02.49	SG00940779

DOCTOR	WARD, HOSPITAL OR G.P. ADDRESS	
Mr.David.Martin	Ward 1 SGH	Run : 4445

REPORT

DATE OF REPORT	MACHINE DIFF.	NEUT	LYMPH	MONO	EOSIN	BASO	AUTHORISED BY		
07-May-10	X10⁹/L	6.6	0.82	0.87	0.10	0.01	Ian Myles		
DATE OF SAMPLE	LAB. No.	W.B.C. X10⁹/L	PLAT. X10⁹/L	R.B.C. X10¹²/L	Hb g/L	P.C.V. L/L	M.C.V. fL	M.C.H. pg	RETIC X10⁹/L
7-May-10	3109410	8.4	217	3.98	112	0.348	87	28.1	

SOUTH GLASGOW HOSPITALS - HAEMATOLOGY DEPARTMENT

SURNAME	FORENAME	SEX	HOSP. No.	D.O.B.
HONEYMAN	CATHERINE	F	SG00940779	01.02.49
MEDICAL OFFICER	**WARD / HOSPITAL**			**C.H.I. NUMBER**
Mr.M.G.Hullin	Ward 5 SGH			0102496145

Haemoglobin	L 75	g/l	(115-165)	White Blood Count	5.7	x10⁹/l	(4.0-11.0)
Red Cell Count	L 2.63	x10¹²/l	(3.80-5.80)	Neutrophils	3.5	x10⁹/l	(2.0-7.5)
Haematocrit	L 0.235	l/l	(0.330-0.470)	Lymphocytes	1.5	x10⁹/l	(1.5-4.0)
MCV	89.4	fl	(78.0-99.0)	Monocytes	0.4	x10⁹/l	(0.2-0.8)
MCH	28.5	pg	(27.0-32.0)	Eosinophils	0.3	x10⁹/l	(0.0-0.4)
Platelets	244	x10⁹/l	(150-400)	Basophils	0.0	x10⁹/l	(0.0-0.1)

Lab No:	Spec:	Collected:	Received:	Reported:	Authorised by:	Work done:
H.11.3137202.T	Blood	27.06.11 09:45	27.06.11 11:13	27.06.11 12:09		FBC

SOUTH GLASGOW HOSPITALS - HAEMATOLOGY DEPARTMENT

SURNAME	FORENAME	SEX	HOSP. No.	D.O.B.
HONEYMAN	CATHERINE	F	SG00940779	01.02.49
MEDICAL OFFICER	**WARD / HOSPITAL**			**C.H.I. NUMBER**
Mr.M.G.Hullin	Ward 5 SGH			0102496145

Haemoglobin	L 84	g/l	(115-165)	White Blood Count	6.6	x10⁹/l	(4.0-11.0)
Red Cell Count	L 3.04	x10¹²/l	(3.80-5.80)	Neutrophils	4.3	x10⁹/l	(2.0-7.5)
Haematocrit	L 0.272	l/l	(0.330-0.470)	Lymphocytes	1.3	x10⁹/l	(1.5-4.0)
MCV	89.5	fl	(78.0-99.0)	Monocytes	0.5	x10⁹/l	(0.2-0.8)
MCH	27.6	pg	(27.0-32.0)	Eosinophils	0.4	x10⁹/l	(0.0-0.4)
Platelets	294	x10⁹/l	(150-400)	Basophils	0.0	x10⁹/l	(0.0-0.1)

Lab No:	Spec:	Collected:	Received:	Reported:	Authorised by:	Work done:
L.3138146.A	Blood	28.06.11 10:10	28.06.11 11:21	28.06.11 11:53		FBC

SOUTH GLASGOW HOSPITALS - HAEMATOLOGY DEPARTMENT

SURNAME	FORENAME	SEX	HOSP. No.	D.O.B.
HONEYMAN	CATHERINE	F	SG00940779	01.02.49
MEDICAL OFFICER	**WARD / HOSPITAL**			**C.H.I. NUMBER**
Mr.M.G.Hullin	Ward 5 SGH			0102496145

Haemoglobin	L 90	g/l	(115-165)	White Blood Count	6.5	x10⁹/l	(4.0-11.0)
Red Cell Count	L 3.12	x10¹²/l	(3.80-5.80)	Neutrophils	4.4	x10⁹/l	(2.0-7.5)
Haematocrit	L 0.277	l/l	(0.330-0.470)	Lymphocytes	L 1.0	x10⁹/l	(1.5-4.0)
MCV	88.8	fl	(78.0-99.0)	Monocytes	H 0.9	x10⁹/l	(0.2-0.8)
MCH	28.8	pg	(27.0-32.0)	Eosinophils	0.1	x10⁹/l	(0.0-0.4)
Platelets	227	x10⁹/l	(150-400)	Basophils	0.0	x10⁹/l	(0.0-0.1)

Lab No:	Spec:	Collected:	Received:	Reported:	Authorised by:	Work done:
H.11.3135687.E	Blood	24.06.11 10:20	24.06.11 11:37	24.06.11 12:19		FBC

SOUTH GLASGOW HOSPITALS - HAEMATOLOGY DEPARTMENT

SURNAME	FORENAME	SEX	HOSP. No.	D.O.B.
HONEYMAN	CATHERINE	F	SG00940779	01.02.49
MEDICAL OFFICER	**WARD / HOSPITAL**			**C.H.I. NUMBER**
Mr.M.G.Hullin	Ward 5 SGH			0102496145

Haemoglobin	L 88	g/l	(115-165)	White Blood Count	8.	x10⁹/l	(4.0-11.0)
Red Cell Count	L 3.20	x10¹²/l	(3.80-5.80)	Neutrophils	5.6	x10⁹/l	(2.0-7.5)
Haematocrit	L 0.291	l/l	(0.330-0.470)	Lymphocytes	L 1.6	x10⁹/l	(1.5-4.0)
MCV	90.9	fl	(78.0-99.0)	Monocytes	0.6	x10⁹/l	(0.2-0.8)
MCH	27.5	pg	(27.0-32.0)	Eosinophils	0.4	x10⁹/l	(0.0-0.4)
Platelets	351	x10⁹/l	(150-400)	Basophils	0.0	x10⁹/l	(0.0-0.1)

Spec:	Collected:	Received:	Reported:	Authorised by:	Work done:
Blood	01.07.11 09:50				

SOUTH GLASGOW HOSPITALS - HAEMATOLOGY DEPARTMENT

SURNAME	FORENAME	SEX	HOSP. No.	D.O.B.
YMAN	CATHERINE	F	SG00940779	01.02.49
MEDICAL OFFICER	WARD / HOSPITAL			C.H.I. NUMBER
L.G.Hullin	Ward 2 SGH			0102496145

moglobin	L 88	g/l	(115-165)	White Blood Count	5.4	x10⁹/l	(4.0-11.0)
d Cell Count	L 3.17	x10¹²/l	(3.80-5.80)	Neutrophils	4.0	x10⁹/l	(2.0-7.5)
ematocrit	L 0.277	l/l	(0.330-0.470)	Lymphocytes	L 0.7	x10⁹/l	(1.5-4.0)
CV	87.4	fl	(78.0-99.0)	Monocytes	0.5	x10⁹/l	(0.2-0.8)
CH	27.8	pg	(27.0-32.0)	Eosinophils	0.2	x10⁹/l	(0.0-0.4)
Platelets	383	x10⁹/l	(150-400)	Basophils	0.0	x10⁹/l	(0.0-0.1)

Lab No:	Spec:	Collected:	Received:	Reported:	Authorised by:	Work done:
H,11.3073119.E	Blood	03.04.11 08:40	03.04.11 10:58	03.04.11 11:23	IF	FBC

SOUTH GLASGOW HOSPITALS - HAEMATOLOGY DEPARTMENT

SURNAME	FORENAME	SEX	HOSP. No.	D.O.B.
HONEYMAN	CATHERINE	F	SG00940779	01.02.49
MEDICAL OFFICER	WARD / HOSPITAL			C.H.I. NUMBER
Mr.M.G.Hullin	Orthopaedic OPD, SGH			0102496145

Haemoglobin	129	g/l	(115-165)	White Blood Count	6.5	x10⁹/l	(4.0-11.0)
Red Cell Count	4.35	x10¹²/l	(3.80-5.80)	Neutrophils	4.0	x10⁹/l	(2.0-7.5)
Haematocrit	0.386	l/l	(0.330-0.470)	Lymphocytes	1.9	x10⁹/l	(1.5-4.0)
MCV	88.7	fl	(78.0-99.0)	Monocytes	0.4	x10⁹/l	(0.2-0.8)
MCH	29.7	pg	(27.0-32.0)	Eosinophils	0.2	x10⁹/l	(0.0-0.4)
Platelets	288	x10⁹/l	(150-400)	Basophils	0.0	x10⁹/l	(0.0-0.1)
ESR	9	mm/hr	(1-12)				

Lab No:	Spec:	Collected:	Received:	Reported:	Authorised by:	Work done:
H,11.3124585.X	Blood	10.06.11 13:11	10.06.11 13:11	10.06.11 14:49		ESR,FBC

SOUTH GLASGOW HOSPITALS - HAEMATOLOGY DEPARTMENT

SURNAME	FORENAME	SEX	HOSP. No.	D.O.B.
MAN	CATHERINE	F	SG00940779	01.02.49
MEDICAL OFFICER	WARD / HOSPITAL			C.H.I. NUMBER
.G.Hullin	H.D.U., SGH			0102496145

moglobin	L 91	g/l	(115-165)	White Blood Count	6.4	x10⁹/l	(4.0-11.0)
d Cell Count	L 3.31	x10¹²/l	(3.80-5.80)	Neutrophils	4.3	x10⁹/l	(2.0-7.5)
ematocrit	L 0.289	l/l	(0.330-0.470)	Lymphocytes	L 1.0	x10⁹/l	(1.5-4.0)
CV	87.3	fl	(78.0-99.0)	Monocytes	H 1.0	x10⁹/l	(0.2-0.8)
CH	27.5	pg	(27.0-32.0)	Eosinophils	0.1	x10⁹/l	(0.0-0.4)
Platelets	284	x10⁹/l	(150-400)	Basophils	0.0	x10⁹/l	(0.0-0.1)

Lab No:	Spec:	Collected:	Received:	Reported:	Authorised by:	Work done:
H,11.3071835.D	Blood	01.04.11 06:00	01.04.11 10:38	01.04.11 12:13	MARB	FBC

SOUTH GLASGOW HOSPITALS - HAEMATOLOGY DEPARTMENT

SURNAME	FORENAME	SEX	HOSP. No.	D.O.B.
HONEYMAN	CATHERINE	F	SG00940779	01.02.49
MEDICAL OFFICER	WARD / HOSPITAL			C.H.I. NUMBER
Mr.M.G.Hullin	Ward 2 SGH			0102496145

Haemoglobin	L 101	g/l	(115-165)	White Blood Count	7.0	x10⁹/l	(4.0-11.0)
Red Cell Count	L 3.67	x10¹²/l	(3.80-5.80)	Neutrophils	5.1	x10⁹/l	(2.0-7.5)
Haematocrit	L 0.323	l/l	(0.330-0.470)	Lymphocytes	L 1.0	x10⁹/l	(1.5-4.0)
MCV	88.0	fl	(78.0-99.0)	Monocytes	0.6	x10⁹/l	(0.2-0.8)
MCH	27.5	pg	(27.0-32.0)	Eosinophils	0.2	x10⁹/l	(0.0-0.4)
Platelets	H 509	x10⁹/l	(150-400)	Basophils	0.0	x10⁹/l	(0.0-0.1)

Lab No:	Spec:	Collected:	Received:	Reported:	Authorised by:	Work done:
H,11.3074459.T	Blood	05.04.11 09:15				

SOUTH GLASGOW HOSPITALS - HAEMATOLOGY DEPARTMENT

SURNAME	FORENAME	SEX	HOSP. No.	D.O.B.
HONEYMAN	CATHERINE	F	SG00940779	01.02.49
MEDICAL OFFICER	**WARD / HOSPITAL**			**C.H.I. NUMBER**
Mr.M.G.Hullin	Ward 3 SGH			0102496145

Haemoglobin	L 108	g/l	(115-165)	White Blood Count	8.1	x10⁹/l	(4.0-11.0)
Red Cell Count	3.87	x10¹²/l	(3.80-5.80)	Neutrophils	6.3	x10⁹/l	(2.0-7.5)
Haematocrit	0.338	l/l	(0.330-0.470)	Lymphocytes	L 0.9	x10⁹/l	(1.5-4.0)
MCV	87.3	fl	(78.0-99.0)	Monocytes	0.8	x10⁹/l	(0.2-0.8)
MCH	27.9	pg	(27.0-32.0)	Eosinophils	0.1	x10⁹/l	(0.0-0.4)
Platelets	195	x10⁹/l	(150-400)	Basophils	0.0	x10⁹/l	(0.0-0.1)

Lab No:	Spec:	Collected:	Received:	Reported:	Authorised by:	Work done:
H,11.3068989.M	Blood	29.03.11	29.03.11 11:52	29.03.11 13:06	TMYL	FBC

SOUTH GLASGOW HOSPITALS - HAEMATOLOGY DEPARTMENT

SURNAME	FORENAME	SEX	HOSP. No.	D.O.B.
HONEYMAN	CATHERINE	F	SG00940779	01.02.49
MEDICAL OFFICER	**WARD / HOSPITAL**			**C.H.I. NUMBER**
Mr.M.G.Hullin	Ward 2 SGH			0102496145

Prothrombin Time	12	secs	(9-12)					
PT Ratio	1.0		(0.8-1.1)					
APTT	33	secs	(25-37)					
APTT Ratio	1.1		(0.8-1.2)					
Fibrinogen	H 10.2	g/l	(2.0-4.1)					

CS : APTTr Therapeutic Range for I.V Heparin (1.9 - 2.6)

Lab No:	Spec:	Collected:	Received:	Reported:	Authorised by:	Work done:
H,11.3071109.R	Blood	31.03.11 11:00	31.03.11 13:23	31.03.11 16:08	STMIL	CS

SOUTH GLASGOW HOSPITALS - HAEMATOLOGY DEPARTMENT

SURNAME	FORENAME	SEX	HOSP. No.	D.O.B.
HONEYMAN	CATHERINE	F	SG00940779	01.02.49
MEDICAL OFFICER	**WARD / HOSPITAL**			**C.H.I. NUMBER**
Mr.M.G.Hullin	Ward 3 SGH			0102496145

Haemoglobin	130	g/l	(115-165)	White Blood Count	H 12.9	x10⁹/l	(4.0-11.0)
Red Cell Count	4.47	x10¹²/l	(3.80-5.80)	Neutrophils	H 10.1	x10⁹/l	(2.0-7.5)
Haematocrit	0.401	l/l	(0.330-0.470)	Lymphocytes	1.7	x10⁹/l	(1.5-4.0)
MCV	89.7	fl	(78.0-99.0)	Monocytes	H 1.0	x10⁹/l	(0.2-0.8)
MCH	29.1	pg	(27.0-32.0)	Eosinophils	0.1	x10⁹/l	(0.0-0.4)
Platelets	258	x10⁹/l	(150-400)	Basophils	0.0	x10⁹/l	(0.0-0.1)

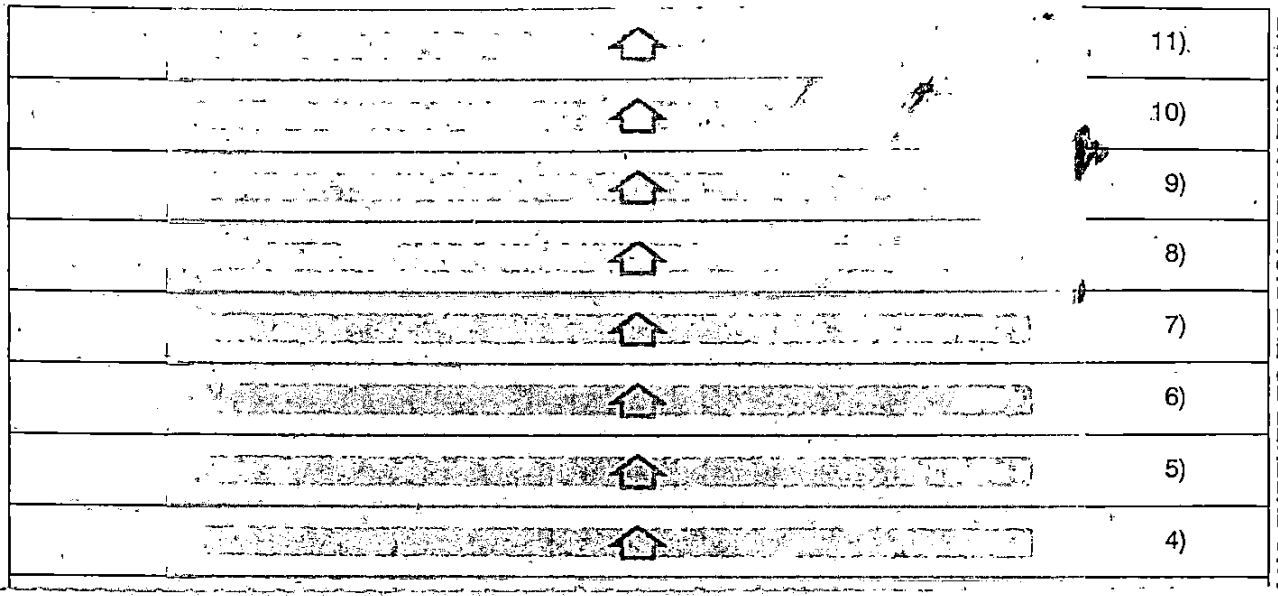
SOUTH GLASGOW HOSPITALS - HAEMATOLOGY DEPARTMENT

SURNAME	FORENAME	SEX	HOSP. No.	D.O.B.
HONEYMAN	CATHERINE	F	SG00940779	01.02.49
MEDICAL OFFICER	**WARD / HOSPITAL**			**C.H.I. NUMBER**
Mr.M.G.Hullin	Ward 2 SGH			0102496145

Haemoglobin	L 111	g/l	(115-165)	White Blood Count	9.1	x10⁹/l	(4.0-11.0)
Red Cell Count	3.93	x10¹²/l	(3.80-5.80)	Neutrophils	6.6	x10⁹/l	(2.0-7.5)
Haematocrit	0.339	l/l	(0.330-0.470)	Lymphocytes	L 1.2	x10⁹/l	(1.5-4.0)
MCV	86.3	fl	(78.0-99.0)	Monocytes	H 1.2	x10⁹/l	(0.2-0.8)
MCH	28.2	pg	(27.0-32.0)	Eosinophils	0.1	x10⁹/l	(0.0-0.4)
Platelets	309	x10⁹/l	(150-400)	Basophils	0.0	x10⁹/l	(0.0-0.1)

Lab No:	Spec:	Collected:	Received:

BLOOD TRANSFUSION



SOUTH GLASGOW HOSPITALS - BLOOD TRANSFUSION DEPARTMENT

SGH285(Rev. 03/08)

SURNAME	FORENAME	SEX	HOSP. No.	D.O.B.
HONEYMAN	CATHERINE	Female	SG00940779	01-Feb-1949

MEDICAL OFFICER	WARD / HOSPITAL	C.H.I. NUMBER
Mr.M.G.Hullin	ORTHO OP	0102496145

BLOOD GROUP	Rh	ANTIBODY SCREEN
O	POS	Negative

REMEMBER THE FINAL NAMEBAND CHECK FOR EVERY UNIT

LABORATORY NUMBER R,11.0016175.N

EXPIRY DATE	PRODUCT CODE	DONOR GROUP	COMPATIBLE PACK Nos.	TO BE COMPLETED BY NURSE / MED. OFF. SET UP BY · DATE / TIME	CHECKED BY	REACTION

"THIS BLOOD WILL BE DERESERVED" AT 9.00 am ON.....

PLASMA RETAINED
ZERO TOLERANCE POLICY ON SAMPLE LABELLING EFFECTIVE 05.10.09

SPECIMEN RECEIVED: DATE 10-Jul-11 TIME 13:08 DATE OF TEST 10-Jun-11 AUTHORISED BY RP

SPECIMEN RECEIVED: DATE 14-Jul-10 TIME 07:39 DATE OF TEST 14-Jul-10 AUTHORISED BY MW

SPECIMEN RECEIVED: DATE ..... TIME ..... DATE OF TEST ..... AUTHORISED BY .....

FORM

JB-24336/8

SOUTH GLASGOW HOSPITALS - BLOOD TRANSFUSION DEPARTMENT

SGH285(Rev..03/08)

SURNAME	FORENAME	SEX	HOSP. No.	D.O.B.
HONEYMAN	CATHERINE	Female	SG00940779	01-Feb-1949

MEDICAL OFFICER	WARD / HOSPITAL	C.H.I. NUMBER
Mr.P.Davis	Ward 1 SGH	0102496[illegible]

BLOOD GROUP	Rh	ANTIBODY SCREEN
O	POS	Negative

REMEMBER THE FINAL NAMEBAND CHECK FOR EVERY UNIT

LABORATORY NUMBER: R.10.0021117.D

EXPIRY DATE	PRODUCT CODE	DONOR GROUP	COMPATIBLE PACK Nos.	TO BE COMPLETED BY NURSE / MED. OFF. SET UP BY	DATE / TIME	CHECKED BY	REACTION

"THIS BLOOD WILL BE DERESERVED" AT 9.00 am ON.....

PLASMA RETAINED

ZERO TOLERANCE POLICY ON SAMPLE LABELLING EFFECTIVE 05.10.09

SPECIMEN RECEIVED: DATE 14-Jul-10 TIME 07:39 DATE OF TEST 14-Jul-10 AUTHORISED BY MO

SPECIMEN RECEIVED: DATE ..... TIME ..... DATE OF TEST ..... AUTHORISED BY .....

FORM

SOUTH GLASGOW HOSPITALS - BLOOD TRANSFUSION DEPARTMENT

SGH285(Rev. 03/08)

SURNAME	FORENAME	SEX	HOSP. No.	D.O.B.
HONEYMAN	CATHERINE	Female	SG00940779	01-Feb-1948

MEDICAL OFFICER	WARD / HOSPITAL	C.H.I. NUMBER
Mr.M.G.Hullin	Orthopaedic OPD, SGH	0102496145

BLOOD GROUP	Rh	ANTIBODY SCREEN
O	POS	Negative

REMEMBER THE FINAL NAMEBAND CHECK FOR EVERY UNIT

LABORATORY NUMBER: R,10.0012215.H

EXPIRY DATE	PRODUCT CODE	DONOR GROUP	COMPATIBLE PACK Nos.	TO BE COMPLETED BY NURSE / MED. OFF. SET UP BY	DATE / TIME	CHECKED BY	REACTION

"THIS BLOOD WILL BE DERESERVED". AT 9.00 am ON.....

PLASMA RETAINED

ZERO TOLERANCE POLICY ON SAMPLE LABELLING EFFECTIVE 05.10.09

SPECIMEN RECEIVED: DATE 23-Apr-10 TIME 11:19 DATE OF TEST 23-Apr-10 AUTHORISED BY .....

FORM

SURGICAL HIGH DEPENDENCY LINE CHANGE CHART

NAME :- CATHERINE CONSTANCE

WEEK COMMENCING : 31/3/11

DISPOSABLE ITEM	DATE 31/3/11	DATE 1/4/11	DATE	DATE	DATE	DATE	DATE
CENTRAL LINE (7DAYS) Date inserted –							
C.V.P. TRANSDUCER (4 DAYS)							
ARTERIAL LINE (7 DAYS) Date inserted –	~	1					
ARTERIAL LINE TRANSDUCER (4 DAYS)	~	1					
ALARIS GIVING SET (4 DAYS)	~	1					
ALARIS SECONDARY SET (4 DAYS)	N	1					
ENTERAL FEEDING SET (24 HRS)							
URINARY CATHETER (as per manufacturers instructions) Date inserted -							

1/4/11

FINE BORE N.G. (as per manufacturers instructions) Date inserted –							
CATHERTER BAG (5 DAYS) CHEST DRAIN (as per manufacturers instructions) Date inserted- 3							
P.C.A. LINE (24 HRS)	~	1					
SUB CUT CANNULA (3 DAYS)							
VENFLON (3 DAYS)	~	1					
TRACHEAL TUBE (7 DAYS or as per manufacturers Instructions Date inserted –							
RESPIFLO OXYGEN SET (5 DAYS)	~	1					
NEBULISER CIRCUIT (7 DAYS)							
WIDE BORE N.G. TUBE (10 DAYS) Date inserted-							
BIONECTORS VENFLON (7 DAYS/ 100 USES)	~	1					
BIONECTORS CENTRAL LINE (7 days /100 uses							

S SITUATION	B BACKGROUND	A ASSESSMENT	R RECOMMENDATION
NAME:- CATHERINE HONEYMAN **AGE:-** 62 **CONSULTANT:-** MR HULLIN **DATE OF TRANSFER:-** 31.1.11	**RELEVANT HISTORY:-** LONGSTANDING HX. R KNEE PAIN PREVIOUS:- R KNEE REPLACEMENT / WASHOUTS	**RESPIRATORY :-** STABLE **CARDIO:-** STABLE **BLOOD RESULTS:-** TODAYS BLOODS TAKEN. NO RESULT AS YET **INTAKE:-** SATISFACTORY	**PLAN OF CARE :-** ROUTINE DAILY BLOODS
DIAGNOSIS:- ~~1ST STAGE~~ REVISION (R) KNEE HAEMATOMA / INFECTION	**MEDICATIONS:-** & LOSEC SIMVASTATIN ATENOLOL TRAMADOL ASPIRIN FLUOXETINE **ALLERGIES:-** VOLTAROL	**OUTPUT:-** POOR - BUT DOESN'T FEEL UNCOMFORTABLE, Pu'd 60am. **PAIN:-** PCA / ORAL PAIN SCORE HIGH **NEURO:-** CHATTY, SLIGHTLY SEDATED AT TIMES DUE TO MORPHINE PCA **MOBILITY:-** ~~BEDREST~~ TODAY BUT MAY MOBILISE 1/c CAMP SPLINT.	**PLANNED INVESTIGATIONS:-**
SURGERY:- 1ST STAGE REVISION (R) KNEE + CEM. SPACER INSERTED (1)	**RECENT OBSERVATIONS:-** ON SEWS & HDU CHART **SEWS SCORE :-** 2	**TISSUE VIABILITY:-** SKIN SATISFACTORY **WOUND CARE:-** LEFT INTACT, AS INSTRUCTED BY MGH **DRAINS:-** NIL **LINES:-**	**RELATIVES:-** HUSBAND AWARE OF PLANNED TRANSFER.

CATHERINE HOWDYSHELL
DOB 10/04/1979
01-02-49
Affix Address Label

Adult Intravenous (IV) Cannulation Care Plan

NHS Greater Glasgow and Clyde

Potential Complications of IV Cannulation

1. Redness, pain or inflammation at insertion site due to phlebitis or local infection
2. Local oedema due to infiltration
3. Bloodstream infection
4. Extravasation

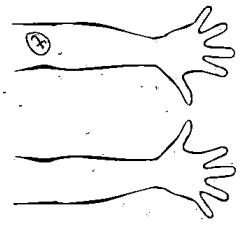
Required Interventions

The interventions below are required to minimise the above complications. Those highlighted in bold are necessary to assist in compliance with the Healthcare Protection Scotland (HPS) Peripheral Vascular Catheter (PVC) Care Bundle.

1. **Hand hygiene must be performed before and after IV cannula insertion or manipulation is undertaken.**
2. Decontaminate the patients' skin for at least 30 seconds and allow to dry before inserting the IV cannula. Non-sterile gloves must be worn and the insertion site should never be directly touched.
3. **Document the date, time**, gauge and **site of IV cannula insertion below.** Use the date strip contained within the IV dressing to label the date of insertion on the cannula dressing.
4. Assess and document the reasons for insertion and removal of IV cannulae below. **The IV cannula site and ongoing clinical need should be assessed at least once per shift and must be documented in the Monitoring and Recording Chart overleaf.** When the IV cannula is not in use, maintain patency by flushing with 0.9% sodium chloride every 24 hours.
5. **The IV cannula should be changed every 72 hours or immediately if indicated by VIP score of 2 or more. If the patient has poor venous access, a risk assessment should be carried out using VIP scoring tool overleaf. If score is less than or equal to 1 then the decision can be documented by nursing staff in the chart overleaf to retain cannula up to a maximum of 96 hours. If the cannula has to remain in situ for longer than this, then this decision must be made and documented by medical staff.**
6. **Check IV cannula dressing is dry and intact and that site of insertion can be easily observed. Replace dressing immediately if indicated and document procedure overleaf.**
7. Ensure IV cannula has a needle-free access system with integrated extension. This must be decontaminated for at least 30 seconds and allowed to dry before and after use.
8. If there has been a breach in aseptic technique during insertion (e.g. cannula was inserted during an emergency) then the cannula must be replaced within 24 hours of insertion *. If the cannula has to remain insitu for longer than this, then this decision must be documented overleaf.

Cannula Insertion Site

Please mark successful cannulation with a number e.g. ① and failed cannulation with an Ⓕ



Other Site Used _____

Insertion Reason Codes

Emergency IV Access = E
Routine IV Access = R
Radiological Procedure = RP
Nil by Mouth = NBM
Chemotherapy = C
IV Fluids / IV Medicine Administration = IV
Blood = B
Other (Please state)

Removal Reason Codes

Not Required = NR
Phlebitis = P
Infiltration = I
Extravasation = E
Other (Please state)

Cannula Number	Date and Time	Inserted by (print name)	Insertion Reason Code	Gauge	Was aseptic technique breached?	Removed by (print name)	Date and Time	Removal Reason Code
①	01-04-11	[illegible]	W	20	Yes*/No			
					Yes*/No			
					Yes*/No			
					Yes*/No			

Modified VIP (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phlebitis **OBSERVE CANNULA**
One of the following is evident: • Slight pain or redness near IV site	1	Possible first signs **OBSERVE CANNULA**
Two of the following are evident: • Pain • Erythema • Swelling	2	Early stages of phlebitis **RESITE CANNULA**
All of the following are evident: • Pain along the path of the cannula • Erythema • Induration	3	Mid-stage phlebitis **RESITE CANNULA and SEEK FURTHER ADVICE**
All of the following are evident and extensive: • Pain along the path of cannula • Erythema • Induration • Palpable venous cord	4	Advanced stage of phlebitis or start of thrombophlebitis **RESITE CANNULA and SEEK FURTHER ADVICE**
All of the following are evident and extensive: • Pain along path of cannula • Erythema • Induration • Pyrexia • Palpable venous cord	5	Advanced thrombophlebitis **RESITE CANNULA and SEEK FURTHER ADVICE**

IV Cannula Monitoring & Recording Chart

(Based on the HPS PVC Care Bundle)

Cannula Number	Date and Time	Appropriate Hand Hygiene Undertaken?	Has cannula been in situ for 72 hours?	Continuing Clinical Indication	VIP Score	IV Dressing Dry and Intact?	Comments / Action Taken	Initials
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		

SG00940779
HONEYMAN, CATHERINE
10 MELVILLE STREET

GLASGOW 01/02/1949
G41 2LN CHI 0102496145

Adult Intravenous (IV) Cannulation Care Plan

NHS Greater Glasgow and Clyde

Potential Complications of IV Cannulation

1. Redness, pain or inflammation at insertion site due to phlebitis or local infection
2. Local oedema due to infiltration
3. Bloodstream infection
4. Extravasation

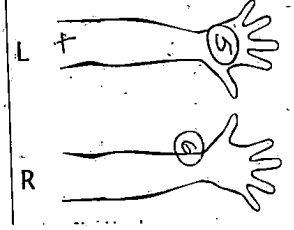
Required Interventions

The interventions below are required to minimise the above complications. Those highlighted in bold are necessary to assist in compliance with the Healthcare Improvement Scotland (HIS) Peripheral Vascular Catheter (PVC) Care Bundle.

1. **Hand hygiene must be performed before and after IV cannula insertion or manipulation is undertaken.**
2. Decontaminate the patients' skin for at least 30 seconds and allow to dry before inserting the IV cannula. Non-sterile gloves must be worn and the insertion site should never be directly touched.
3. **Document the date, time**, gauge and **site of IV cannula insertion below.** Use the date strip contained within the IV dressing to label the date of insertion on the cannula dressing.
4. Assess and document the reasons for insertion and removal of IV cannulae below. **The IV cannula site and ongoing clinical need should be assessed at least once per shift and must be documented in the Monitoring and Recording Chart overleaf.** When the IV cannula is not in use, maintain patency by flushing with 0.9% sodium chloride every 24 hours.
5. **The IV cannula should be changed every 72 hours or immediately if indicated by VIP score of 2 or more. If the patient has poor venous access, a risk assessment should be carried out using VIP scoring tool overleaf. If score is less than or equal to 1 then the decision can be documented by nursing staff in the chart overleaf to retain cannula up to a maximum of 96 hours. If the cannula has to remain in situ for longer than this, then this decision must be made and documented by medical staff.**
6. **Check IV cannula dressing is dry and intact and that site of insertion can be easily observed. Replace dressing immediately if indicated and document procedure overleaf.**
7. Ensure IV cannula has a needle-free access system with integrated extension. This must be decontaminated for at least 30 seconds and allowed to dry before and after use.
8. If there has been a breach in aseptic technique during insertion (e.g. cannula was inserted during an emergency) then the cannula must be replaced within 24 hours of insertion *. If the cannula has to remain insitu for longer than this, then this decision must be documented overleaf.

Cannula Insertion Site

Please mark successful cannulation with a number e.g. ① and failed cannulation with an Ⓕ



Insertion Reason Codes

Emergency IV Access = E
Routine IV Access = R
Radiological Procedure = RP
Nil by Mouth = NBM
Chemotherapy = C
IV Fluids / IV Medicine Administration = IV
Blood = B
Other (Please state)

Removal Reason Code

Not Required = NR
Phlebitis = P
Infiltration = I
Extravasation = E
Other (Please state)

Cannula Number	Date and Time	Inserted by (print name)	Insertion Reason Code	Gauge	Was aseptic technique breached?	Removed by (print name)	Date and Time	Removal Reason Code
	27/3/10	A+E	E	Green	Yes*/No			
(2)	28.3.11	FYI			Yes*/No			
(3)	31/3/10	CSW	IV	20G	Yes*/No			
(4)	2/4/	EC	R	Green	Yes*/No			

Modified VIP (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phlebitis **OBSERVE CANNULA**
One of the following is evident: • Slight pain or redness near IV site	1	Possible first signs **OBSERVE CANNULA**
Two of the following are evident: • Pain • Erythema • Swelling	2	Early stages of phlebitis **RESITE CANNULA**
All of the following are evident: • Pain along the path of the cannula • Erythema • Induration	3	Mid-stage phlebitis **RESITE CANNULA and SEEK FURTHER ADVICE**
All of the following are evident and extensive: • Pain along the path of cannula • Erythema • Induration • Palpable venous cord	4	Advanced stage of phlebitis or start of thrombophlebitis **RESITE CANNULA and SEEK FURTHER ADVICE**
All of the following are evident and extensive: • Pain along path of cannula • Erythema • Induration • Pyrexia • Palpable venous cord	5	Advanced thrombophlebitis **RESITE CANNULA and SEEK FURTHER ADVICE**

IV Cannula Monitoring & Recording Chart

(Based on the HPS PVC Care Bundle)

Cannula Number	Date and Time	Appropriate Hand Hygiene Undertaken?	Has cannula been insitu for 72 hours?	Continuing Clinical Indication	VIP Score	IV Dressing Dry and Intact?	Comments / Action Taken	Initials
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
(2)	30·3·11	Yes / No*	Yes* / (No)	(Yes) / No*	0	(Yes) / No*		NR
(5) + (6)	31/3/11 09.00	(Yes) / No*	Yes* / (No)	(Yes) / No*	0	(Yes) / No*		
5 + 6	31/3/11 23.05	(Yes) / No*	Yes* / (No)	(Yes) / No*	0	(Yes) / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		

dar Code 81117

SURGICAL HIGH DEPENDENCY UNIT - S.G.H

PATIENT CARE PLAN

NAME: Catherine Honeyman

UNIT NUMBER: S6000940779

D.O.B: 01/02/49

CONSULTANT: Mr Hullin

DATE OF ADMISSION: 31/03/11

REASON FOR ADMISSION/ DIAGNOSIS:

First stage revision R) knee

I. RESPIRATORY

	TICK APPLICABLE	DATE & INITIAL
a. Maintaining $SpO^2 \geq 94\%$ on air		
b. Maintaining $SpO^2 \geq 94\% \leq 40\%$	✓	31/3/11 CM
c. Maintaining $SpO^2 \geq 94\% > 40\%$		
d. High flow $O^2 \geq 98\%$ or CPAP or BIRD		
e. Specific care plan applicable		

SPECIFICS OF CARE

DATE	ASSESS, PLAN, IMPLEMENT & EVALUATE

2. CARDIOVASCULAR

	TICK APPLICABLE	DATE & INITIAL
a. N.I.B.P, pulse and ECG monitoring	✓	31/03/11 EM
b. Invasive BP monitoring via arterial line	✓	31/03/11 EM
c. CVP monitoring via central line		
d. Invasive BP & CVP monitoring		
e. Requiring inotropic support		
f. Specific care plan applicable		

SPECIFICS OF CARE

DATE	ASSESS, PLAN, IMPLEMENT & EVALUATE

3. ELECTROLYTE/HAEMATOLOGY/MICROBIOLOGY

	TICK APPLICABLE	DATE & INITIAL
a. Within normal parameters		
b. Biochemistry imbalance requiring monitoring ± correction	✓	
c. Haematology imbalance requiring monitoring ± correction	✓	
d. Positive microbiology culture requiring monitoring ± intervention		
e. Drug level monitoring		
f. Specific care plan applicable		

SPECIFICS OF CARE

DATE	ASSESS, PLAN, IMPLEMENT & EVALUATE
31/3/11	FBC +o be checked tonight

4. NUTRITION/ HYDRATION

	TICK APPLICABLE	DATE & INITIAL
a. Free fluids ± oral diet	✓	3/3/11 EM
b. I.V fluids ± ~~restricted oral intake~~	✓	3/3/11 EM
c. Entral feeding via fine bore naso-gastric tube. (Secured at cms)		
d. Parenteral nutrition via peripheral or central access.		
e. MUST - Nutrition Profile	✓	3/3/11 EM
f. Specific care plan applicable		

SPECIFICS OF CARE

DATE	ASSESS, PLAN, IMPLEMENT & EVALUATE

5A. ELIMINATION

	TICK APPLICABLE	DATE & INITIAL
a. Normal bladder function	✓	31/08/11 EM
b. Urinary catheter with hourly volumes		
c. Oliguric/anuric ±intervension		
d. Polyguria ± intervension		
e. Urostomy		
f. Specific care plan applicable		

SPECIFICS OF CARE

DATE	ASSESS, PLAN, IMPLEMENT & EVALUATE

5B. ELIMINATION

	TICK APPLICABLE	DATE & INITIAL
a. Normal bowel function	✓	31/03/11 EM
b. Constipated ± intervention		
c. Loose stools ± infective cause		
d. Colostomy/ileostomy		
e. Specific care plan applicable		

SPECIFICS OF CARE

DATE	ASSESS, PLAN, IMPLEMENT & EVALUATE

6A. PAIN

	TICK APPLICABLE	DATE & INITIAL
a. No pain		
b. Mild pain	✓	3/3/11 EM
c. Moderate pain		
d. Severe pain		
e. Specific care plan applicable		

SPECIFICS OF CARE

DATE	ASSESS, PLAN, IMPLEMENT & EVALUATE

6B. PAIN

	TICK APPLICABLE	DATE & INITIAL
a. Oral analgesia	✓	3/3/11 EM
b. S/C ± IV analgesia		
c. P.C.A	✓	3/3/11 EM
d. Epidural		
e. Specific care plan applicable		

SPECIFICS OF CARE

DATE	ASSESS, PLAN, IMPLEMENT & EVALUATE

7. SEDATION

	TICK APPLICABLE	DATE & INITIAL
a. None (alert & orientated)		
b. Associated post-op sedation ±intervention	✓	31/3/11 EM
c. Associated analgesic sedation ± intervention		
d. Requiring sedation		
e. Specific care plan applicable		

SPECIFICS OF CARE

DATE	ASSESS, PLAN, IMPLEMENT & EVALUATE

8. NEUROLOGICAL

	TICK APPLICABLE	DATE & INITIAL
a. Alert & Orientated	✓	3/3/11 EM
b. Recognised altered neurological state		
c. Requires APVU & GCS assessment		
d. Specific care plan applicable		

SPECIFICS OF CARE

DATE	ASSESS, PLAN, IMPLEMENT & EVALUATE

9. COMMUNICATION

	TICK APPLICABLE	DATE & INITIAL
a. Communicates verbally	✓	31/3/11 EM
b. Communicates non-verbally		
c. Identified communication barrier		
d. Specific care plan applicable		

SPECIFICS OF CARE

DATE	ASSESS, PLAN, IMPLEMENT & EVALUATE

10. MOBILITY

	TICK APPLICABLE	DATE & INITIAL
a. Mobile with minimal assistance		
b. Mobile with assistance ± equipment aids		
c. Maximum assistance required ± use of hoist		
d. Bed rest	✓	31/3/11 EM
e. Cannard Fall Risk assessment	✓	31/3/11 EM
f. Specific care plan applicable		

SPECIFICS OF CARE

DATE	ASSESS, PLAN, IMPLEMENT & EVALUATE

11. TISSUE VIABILITY

	TICK APPLICABLE	DATE & INITIAL
a. Waterlow score implemented	✓	31/3/11 em
b. Pressure areas clean & intact	✓	31/3/11 em
c. Blanching or non-blanching hyperaemia		
d. Discoloured/Broken area requiring frequent positional turns ± therapy mattress		
e. Requires therapy aid		
f. Specific care plan applicable		

SPECIFICS OF CARE

DATE	ASSESS, PLAN, IMPLEMENT & EVALUATE

12. WOUND CARE

	TICK APPLICABLE	DATE & INITIAL
a. No wound		
b. Uncomplicated wound	✓	31/3/11 RM
c. Complicated wound ± Wound Assessment Chart		
d. Tissue viability Nurse assessment required		
e. Infection suspected		
f. Specific care plan applicable		

SPECIFICS OF CARE

DATE	ASSESS, PLAN, IMPLEMENT & EVALUATE

13. DRAINS

	TICK APPLICABLE	DATE & INITIAL
a. No drains	✓	3/3/11 EM
b. Wide-bore nasogastric tube ± low wall suction. (100-150mmHg)		
c. Wound drain(s) insitu		
d. Chest drain(s) insitu ± low wall suction (100-150mmHg)		
e. Specific care plan applicable		

SPECIFICS OF CARE

DATE	ASSESS, PLAN, IMPLEMENT & EVALUATE

14. LINE MANAGEMENT

	TICK APPLICABLE	DATE & INITIAL
a. Peripheral access	✓	3/3/11 Em
b. Central line insitu		
c. Hickman line / Nutricath insitu		
d. Arterial line insitu	✓	3/3/11 Em
e. Specific care plan applicable		

SPECIFICS OF CARE

DATE	ASSESS, PLAN, IMPLEMENT & EVALUATE

15. PERSONAL HYGIENE

	TICK APPLICABLE	DATE & INITIAL
a. Minimal assistance required with: bed-bathing or showering		
b. Maximum assistance required with: bed-bathing or showering	✓	31/3/11 GM
c. Independent with mouth care/eye care		
d. Requires nurse assisted mouth care/eye care.		
e. Specific care plan applicable		

SPECIFICS OF CARE

DATE	ASSESS, PLAN, IMPLEMENT & EVALUATE

16. RELATIVES

	TICK APPLICABLE	DATE & INITIAL
a. Updated on current condition and treatment daily and as requested.	✓	31/3/11 EM
b. Relative communication notes commenced.		
c. Relatives updated by Medical staff.		

SPECIFICS OF CARE

DATE	ASSESS, PLAN, IMPLEMENT & EVALUATE

SPECIFICS OF CARE - CONTINUED

DATE	ASSESS, PLAN, IMPLEMENT & EVALUATE

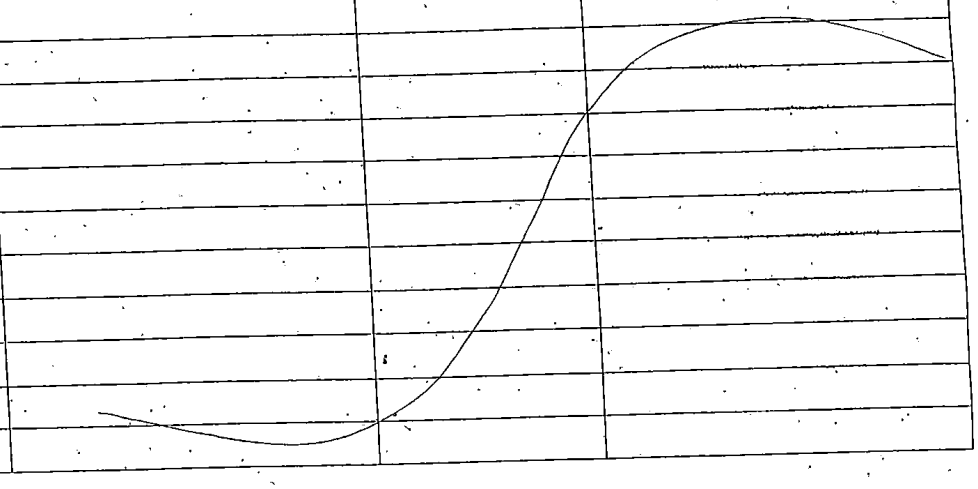
SPECIFICS OF CARE - CONTINUED

DATE	ASSESS, PLAN, IMPLEMENT & EVALUATE

FINE BORE NASO-GASTRIC TUBE CHART

FEED COMMENCEMENT CHART

DATE & TIME	PH NG POSITION	DATE & TIME	PH NG POSITION



QP1

NAME CATHERINE HONEYMAN UNIT NO. 00940779

GENERAL COMMENTS

DATE & TIME	DAY NO	COMMENTS	SIGNATURE
11.5	PA	To be consented by Mr Stead on admission.	
		This lady is a Jehovahs witness and needs to complete "refusal to blood transfusion" form with Mr Stead.	
		Hypertensive at clinic, will attend GP to have BP checked.	S/N E. Tweed
11.5	PA	BP reading from GP - 177/83 168/74	
		Commenced on bendrofluazide 2.5mg daily.	S/N E. Thomlinson
11.5	PA	BP today at practice nurse 168/110.	
		Anaesthetist to be informed of BP reading	S/N E. Thomlinson
3.12.		Recovery Room staff Reporting stable	
		Cardiovascular Case stable IV Ceftriaxone	
		Oximetry, full pain Oramide Box Analgesia as charted	
		CSM - Satisfactory Pressure areas checked and correct	
		Observations as charted.	
		Waterlow score 16 - Patient	
		Pain eased off - Tym 8 in the Sapiroy to 415 at 1415	
		Discharge criteria - Met.	
		Paired Fibrin tubes - centrifuging	
		Wound drain - at 1415 - Still dry est 15-15	
12-05	1	R/A Reported adequate. Vapl received + Histed	
		Analgesic adequate pain free.	

South Glasgow University Hospitals Division

Southern General Hosp

TISSUE DONATION

YES ☑

NO ☐

Greater Glasgow

ALERT NOTICE

NO BLOOD PRODUCTS ~~ALLERGIC TO~~.

-JEHOVAHS WITNESS.

INTEGRATED CARE PATHWAY

Primary Knee Replacement

SG00940779
CATHERINE HONEYMAN
10 MELVILLE STREET

GLASGOW 01/02/1949
G4I 2LN CHI 0102496145

(56)

CONSULTANT
MR Stead

NAMED NURSE

PROPOSED SURGERY

Diagnosis: OA ☐ RA ☐ Servo +ve ☐
Post Trauma ☐ Servo -ve ☐
Other _____

Left ☐ Right ☑ Bilateral ☐

DEPARTMENT *of* ORTHOPAEDICS

PATIENT DETAILS

DATE 8.11.5

PREFERRED NAME Cathie
AGE 56
PATIENT'S TEL NO. 0141 422 1580

RELIGION Jehovahs Witness
CLERGY VISIT REQUESTED YES ☐ NO ☑
OCCUPATION —

NEXT OF KIN Raymond Honeyman
ADDRESS s/A

RELATIONSHIP husband
TEL. DAY: s/A NIGHT:

OTHER CONTACT
ADDRESS

RELATIONSHIP
TEL. DAY: NIGHT:

GP NAME Dr G. Marshall
TEL NO.

ADDRESS Pine Place
Gorbals HLC

MOBILITY

COMMUNITY	☑	HOUSEBOUND	☐
UNAIDED	☐	CRUTCHES	☐
1 STICK	☑	ZIMMER	☐
2 STICKS	☐	WHEELCHAIR	☐

HOUSING	YES	NO
STEPS OUTSIDE	☐	☑
STEPS INSIDE	☐	☑
STEPS TO TOILET	☐	☑

SOCIAL CIRCUMSTANCES

LIVES ALONE ☐ INFIRM/ELDERLY PARTNER ☐ HEALTHY PARTNER ☐ LIVES WITH FAMILY ☑

	NO	YES
RECEIVES SUPPORT	☑	☐
REQUIRES SUPPORT	☑	☐
Confirm additional support organised	☐	☐
TRANSPORT ORGANISED	☐	☐
Admission	☐	☐
Discharge	☐	☐
SIGNIFICANT VISUAL IMPAIRMENT	☑	☐
SIGNIFICANT DEAFNESS	☑	☐
ALCOHOL	☐	☑
SMOKING	☑	☐
NORMAL DIET	☐	☑

	M	T	W	T	F	S	S
DISTRICT NURSE							
HOME HELP							
DAY CENTRE							
MEALS ON WHEELS							
FAMILY VISIT							
OTHER							

4 = current support
• = required support

Alert notification ☐
Units per day moderate
No. per day
Dietitian informed if no ☐

(If no, tick appropriate) Diabetic ☐ Religious ☐ Low Fat ☐ Vegetarian/Vegan ☐

ADDITIONAL INFORMATION

OCCUPATIONAL THERAPY

	DRESSING	WASHING	FEEDING	HYGIENE	BED	CHAIR	TOILET	BATH
INDEPENDENT	✓	✓	✓	✓	✓	✓	✓	✓ difficulties
AIDS/ ASSISTANCE								
UNABLE								

AIDS IN SITU

AIDS REQUIRED FOR DISCHARGE

High Chair ☐	Perching Stool ☐	Shoe Horn ☐	Helping Hand ☐	Sock Aid ☐	Tights Aid ☐	
Bath Board ☐	Shower Board ☑	Bath Seat ☐	Trolley ☐	Mowbray ☐	Dressing Stick ☐	
Toilet Seat ☐	C.O.T. Referral Sent ☐	Other				

2" ☐ 4" ☐ 6" ☐

SIGNED [signature] (OT)

NAME Catherine Honeyman
UNIT NO. 00960779

PRE-OPERATIVE ASSESSMENT

DATE 8.11.05

PREVIOUS GA NO ☐ YES ☑
sob after endoscopy
IF YES: VIC
Complication ☐
Within 3 Months ☐
Family History of Problem ☐

CHEST PROBLEMS NO ☑ YES ☐
IF YES:
Bronchitis ☐
OPD Chest Clinic ☐
Productive Cough ☐
Asthma In-patient Treatment in Last Year ☐

MI Date _____ NO ☑ YES ☐

HYPERTENSION NO ☐ YES ☑

BLEEDING TENDENCY NO ☑ YES ☐
Treatment ☐

BOWEL PROBLEMS NO ☑ YES ☐
IF YES:
Constipation ☐
Diarrhoea ☐

URINARY SYMPTOMS NO ☑ YES ☐
IF YES:
Haematuria ☐
Dysuria ☐
Nocturia > 2x ☐
Urgency ☐

ALLERGIES NO ☑ YES ☐
IF YES: Food/Pollen ☐ Antibiotics ☐
Other Drug
Rash ☐ Sickness ☐
Diarrhoea ☐ Swelling ☐
Collapse ☐ Flat ☐

ALLERGY NOTIFICATION (Signed)

ANGINA NO ☑ YES ☐
IF YES:
Occasionally ☐ At Rest ☐
Once per Week ☐ Climbing Stairs ☐
Once per Day ☐ In Cold Air ☐
With Anxiety ☐

PALPITATIONS NO ☐ YES ☑
IF YES:
Exercise ☐ Coffee ☐
Excitement ☑ Stress No Predisposing Factor ☐

SHORTNESS OF BREATH NO ☐ YES ☑
IF YES:
At Rest ☐ Flight of Stairs ☑
In the House ☐ At Night Lying Flat ☐
Level Walking ☐

ANKLE SWELLING NO ☑ YES ☐
IF YES:
Occasionally ☐ All the Time ☐
At Night ☐

DIABETES NO ☑ YES ☑ 4
IF YES:
Diet ☐ Insulin ☐
Oral ☐
Drug/Dose

FITS/EPILEPSY NO ☑ YES ☐
IF YES:
Rarely ☐ Blackouts ☐
A few per month ☐ < 3 Months Ago ☐
Treatment ☐ Seen GP ☐

HIATUS HERNIA NO ☑ YES ☑
Heartburn Lying Flat ☑

CVA Date _____ NO ☑ YES ☐
IF YES: SIDE L ☐ R ☐

PAST MEDICAL HISTORY
Kidney infection - 2wks ago
lumpectomy - VIC x 3 - all ⊖.

★ JEHOVAH'S WITNESS ★
- not for blood products
★ ★

SIGNED RM Kerr (OLN/Reg)

NAME CATHERINE HONEYMAN UNIT NO. 00940779

DRUG HISTORY

STEROIDS/METHOTREXATE/WARFARIN — NO ☑ YES ☐ DRUG
IF YES: Dose / Frequency

CURRENT DRUGS	DOSE	FREQUENCY
Zydol SR	200mgs	B.D.
Losec	20 mgs	T.I.D.
hendrofluazide	2.5mgs	x 1 a.m.
zenecal tabs for weight loss		1 tab with b/fast

SIGNED (OLN/Reg/SHO)

EXAMINATION

PULSE 88 Irregular NO ☑ YES ☐
BLOOD PRESSURE 177/104 Diastolic >90 Systolic >190 INFORM ANAESTHETIST
ABNORMAL URINALYSIS NO ☑ YES ☐ IF YES: Glucose ☐ Protein ☐ Blood ☐
HEIGHT 1.58 m WEIGHT 85 kilos
BODYMASS INDEX 34 WATERLOW 6
TED STOCKING SIZE C-
ABNORMAL CHEST PERCUSSION NO ☑ YES ☐
ABNORMAL CHEST SOUNDS NO ☑ YES ☐
ABNORMAL HEART SOUNDS NO ☑ YES ☐
ABDOMINAL MASSES NO ☑ YES ☐
DISTAL PULSES NO ☐ YES ☑ DISTAL OEDEMA NO ☑ YES ☐

KNEE JOINT	LEFT	RIGHT
QUADS WASTING	NO ☑ YES ☐	NO ☑ YES ☐
SYNOVITIS	NO ☑ YES ☐	NO ☑ YES ☐
EFFUSION	NO ☑ YES ☐	NO ☑ YES ☐
SIGNATURE OF SURGEON		
NURSING	☑ S/N E. Thomlinson (Sig)	
PHYSIOTHERAPY	☑ Briana Rae SWET (Sig)	

	LEFT	RIGHT
DEFORMITY	NO ☑ YES ☐	NO ☑ YES ☐
If Yes:	FIXED	FIXED
VARUS	° NO ☑ YES ☐	° NO ☑ YES ☐
VALGUS	° NO ☑ YES ☐	° NO ☑ YES ☐
FLEXION 105	° NO ☑ YES ☐	° NO ☑ YES ☐

NAME Catherine Honeyman UNIT NO. 00940779

INVESTIGATION — RESULT

FBC	☑	Hb 141 g/L WCC 7.3 x10⁹/L
G + R	☑	
MSU	☐	
U & E	NO ☐ YES ☑	Na 141 (135-145) K 4.1 (3.5-5.0) Cl 106 (101-111) TCO² (23-30 mmol/L)
CXR	NO ☑ YES ☐	Urea 5.2 (2.5-7.5) Creatine 81 (40-130)
ECG	NO ☐ YES ☑	

OTHER SIGNED (OLN/REG/SHO)

ANAESTHETIC ASSESSMENT

Jehovah's Witness
WARD VISIT ☑ OPD ☐ DATE 12/9/05
PROSTHESIS; TEETH; CROWNS — Please mark crowns, loose teeth etc
AIRWAY ASSESSMENT
ASA SCORE 1 ☐ 2 ☑ 3 ☐ 4 ☐ 5 ☐
OTHER TEST ORDERED
SURGERY DEFERRED NO ☑ YES ☐ Hop - after - controlled ↑ BM!
IF YES, ACTION TAKEN
Refer GP ☐ Letter Sent ☐ W/L Deferred ☐
Await test result ☐ Reassess ☐
DATE
PREMED PRESCRIBED NO ☐ YES ☐ SIGNED (Anaesthetist)

UPPER / LOWER

ADMISSION - DAY 0

DATE
BP — PULSE — TEMP — RESPS —
PATIENT PATHWAY ☐ LIFTING ☐
TED Stockings fitted ☐ IDENTIFICATION ☐
WATERLOW SCORE ☐ INFECTION RISK SCORE ☐
SIGNATURE

DRUGS

TIME & SIG.	TIME & SIG.	TIME & SIG.

CONSENT TO ANAESTHESIA, OPERATION, INVESTIGATION OR TREATMENT

NOTES OF GUIDANCE

1. **DOCTORS**

A patient has the right to grant or withhold consent prior to examination, investigation, treatment or operation. The Doctor must give the patient sufficient information, in a way which he/she can understand, about the proposed procedure, any significant side-effects and the possible alternatives. The Doctor must give the patient enough time to read this sheet and ask any questions relating to it or their treatment. The patient must be allowed to decide whether he or she will agree to the procedure and they may refuse or withdraw consent to a procedure at any time. The patient's consent to a procedure should be recorded.

1.1. The patient must give written consent to be examined by students during any procedure for which consent is required. (See below).

2. **PATIENTS**

2.1. The Doctor is here to help you. He or she will explain the procedure, which you are entitled to refuse. You can ask any questions and ask for more information.

2.2. You may ask for a relative or friend or a nurse to be present while the Doctor explains the procedure and asks you to sign this sheet.

2.3. Students need to learn how to examine patients and to see how procedures are done. This is important for the future of health services. You may be asked to give consent to be examined by students during the procedure. It is up to you to decide whether you give your consent or not but whatever you decide, it will not affect your treatment.

TO BE COMPLETED BY THE MEDICAL PRACTITIONER

PROPOSED PROCEDURE RIGHT TOTAL KNEE REPLACEMENT

I HAVE FULLY EXPLAINED: To the patient/parent/guardian/next of kin* (*Delete as appropriate)

1. The procedure named on this form
2. Appropriate alternatives which are available
3. Significant side-effects which may result from the procedure. Including Deep Vein Thrombosis, Pulmonary Embolism, Infection, Stiffness, Dislocation and Longevity of Implant.

NAME (BLOCK CAPITALS) N STEAD **SIGNATURE** [signature]

TO BE COMPLETED BY THE PATIENT

You should read this form carefully. If there is anything you do not understand ask the Doctor for an explanation. If the information is correct and you understand the procedure you should sign the form.

I AM The patient/parent/guardian/next of kin* (*Delete as appropriate).

I UNDERSTAND
- The procedure which has been explained to me by the Doctor named on this form.
- The procedure may not be carried out by the Doctor who has been treating me so far.
- That any procedure in addition to that named on this form will only be carried out if necessary and in my best interests and can be justified for medical reasons.

I AGREE
- To the administration of an anaesthetic or sedation if required.
- To the procedure named on this form.
- That examination for the purposes of teaching will not be undertaken without my permission.

I AGREE/ DO NOT AGREE*
- To the involvement of a student at the procedure named.
- To the examination by a student during the procedure named under the supervision of the Senior Medical Officer undertaking this procedure.

SIGNATURE Catherine Honeyman
Patient/Parent/Guardian/Next of Kin* (BLOCK CAPITALS)

NAME CATHERINE HONEYMAN **UNIT NO** 00944779

OPERATION DETAILS

TOURNIQUET	YES ☐ NO ☐	STANDARD PREPARATION	YES ☐ NO ☐
MIDLINE SKIN INCISION	YES ☐ NO ☐	MEDIAL PARAPATELLAR	YES ☐ NO ☐
UNCEMENTED LCS	YES ☐ NO ☐	PATELLAR DEBRIDED ONLY	YES ☐ NO ☐

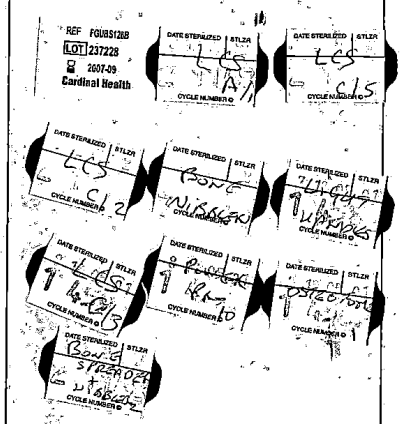
IMPLANTS USED

DePuy® DEPUY ORTHOPAEDICS,INC. P.O. BOX 988 WARSAW, IN 46581
REF 1294-05-510 LOT Z5FK64000
LCS® COMPLETE
RP INSERT
SZ STD+
MM 10

REF 129403050 LOT 1938472 2010 - 07
LCS Complete Primary • FEMORAL • Porocoat® STERILE R
STD +
RIGHT
DePuy® DePuy Orthopaedics Inc. 700 Orthopaedic Drive Warsaw, IN 46580

REF 129432130 LOT 1977841 2010 - 10
DePuy MBT Tibial Tray • Porocoat® • 3 STERILE R
DePuy® DePuy Orthopaedics Inc. 700 Orthopaedic Drive Warsaw, IN 46580

INSTRUMENTS USED



INSTRUMENTS USED MILESTONE ☐	OTHER ☐	RANGE OF MOVEMENT ON TABLE ____ TO ____ Degrees	
STANDARD CLOSURE	YES ☐ NO ☐	ROUTINE POST-OP	YES ☐ NO ☐
FULL CORRECTION OF DEFORMITY	YES ☐ NO ☐	STANDARD DRAINS	YES ☐ NO ☐
Residual Deformity		IF NOT TO ANY QUESTION RECORD VARIANCE	

T30

KNEE REPLACEMENT

DATE 12.12.05

RIGHT ☑ LEFT ☐ BILATERAL ☐

PRE-OPERATIVE CHECK

Ward Nurse JJ/SDow

Theatre Nurse

Pressure Care ☑ Eye Care ☑

Diathermy Abdo ☒ Thigh ☑

Tourniquet Up 1185

Down ____ Pressure 300

SIGNED

SWAB COUNT CORRECT ☐

Scrub Nurse

Circulating Nurse

Surgeon Stead

Assistant

Anaesthetist Jacobs

Assistant O'Connor

Anaesthetic Nurse Ruskin

Scrub Nurse Hughes

Circulation Nurse Bobby

Recovery Nurse

Named Nurse

POST-OP CHECK ☐

Recovery Nurse

Ward Nurse

IV Site Right Left

Hand ☐ ☑

Wrist ☐ ☐

Central ☐ ☐

Size 16G

Spinal ☐ Block ☑

Site femoral & sciatic

Drug L-bupivacaine

Volume 5ml : 19mg

Needle

AIRWAY

Laryngeal Mask ☑

Orotracheal ☐

Nasotracheal ☐

Size #3

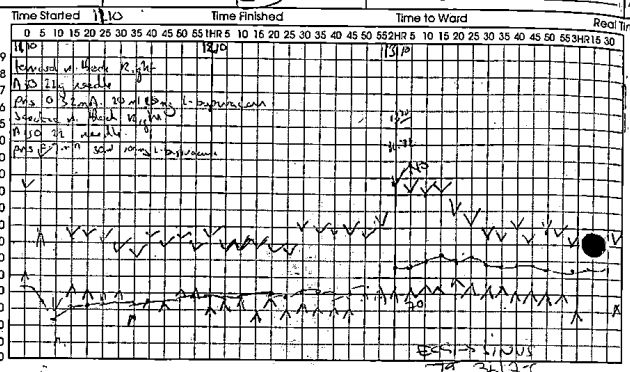
VENTILATION

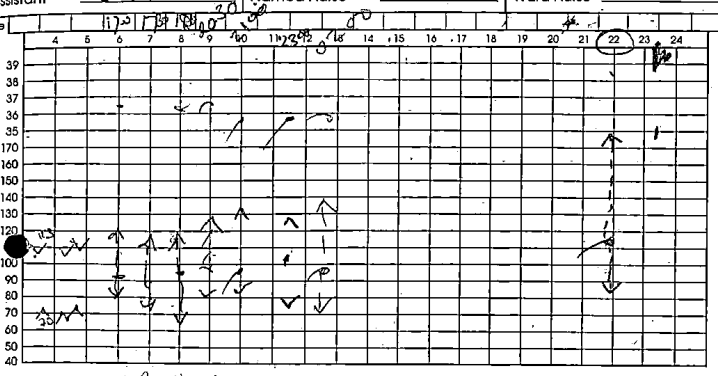
Spontaneous ☑

IPPV ☐

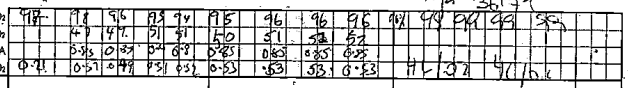
Gases O2/N2O/ISO

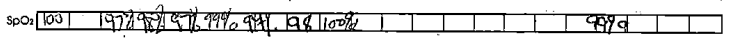
Time Started 1110 Time Finished Time to Ward Real Time





SpO2 / EtCO2 / EtAA / FiO2



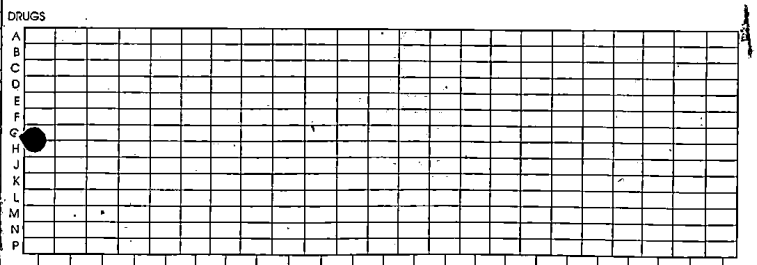


DRUGS/GASES

Propofol mg	150		
Fentanyl mcg	50	+25	
Metaraminol mg	0.5		
Ceftriaxone gm	1g IS		
Morphine mg	5		
Ibuprofen mg		5	

KARNOFSKY

DRUGS



EPIDURAL 0.25% Bupivacaine

MORPHINE 60ml 1mg/ml PUMP NO. ____ VOLUME REMAINING

Resps	Pos clo	SEE	PACU 1	PACU 2
Sedation	Dr. to keep Sat. 95% at least until 8am	16	15	15
Pain	Analgesia - na PCA.	0	0	0
Nausea/Vomit	Fluids not started	112	112	011
Sensory Level	Roosting Stay & more placed	0	0	0
Motor Block		—	—	—
Circulation/Leg Power		—	—	—

RECORD FLUID + START/STOP TIME

IV In	Hartmanns 1000	NaCl 1000		
Oral In				
Blood Out				
Fluid Out				

TOTAL 570 500

BALANCE

NAME Catherine Honeyman DATE 13.12.05 UNIT NO.

DAY 1

	6	10	2	6	10	(2)
TEMP						
PULSE						
	98%	99%	97%	99%	97%	98%

							24 HOUR TOTAL
IV Fluid							
Oral Fluid					150		
Blood Loss							
Fluids Out	Fluid	Fluid	Fluid		450	300	
						BALANCE	

DRUGS	8	12	2	6	10	(2)
A						
B						
C						
D						
E						
F						
G						
H						
J						
K						
L						
M						
N						
P						
OTHER TIMES						

Hb 10.6
Waterlow

PUMP Volume Left

	R	L
SLR	(N)	
Lag		10
Flex		30

error c.lcw

Resps
Sedation
Pain
Nausea/Vomit
Sensory Level
Motor Block
Circulation

POST OPERATIVE OUTCOMES				
MEDICAL	YES ☐ NO ☐		O.T.	YES ☐ NO ☐
NURSING	YES ☐ NO ☐		PATIENT	YES ☐ NO ☐
PHYSIO	YES ☑ NO ☐	Lorraine Rae		

NAME Catherine Honeyman DATE 14-12-05 UNIT NO. 940779

DAY 2

	6	10	2	6	10	(2)
TEMP						
PULSE						
	99%	96·1	96%	99%	97%	

							24 HOUR TOTAL
IV Fluid							
Oral Fluid							
Blood Loss							
Fluids Out							
						BALANCE	

DRUGS	8	12	2	6	10	(2)
A						
B						
C						
D						
E						
F						
G						
H						
J						
K						
L						
M						
N						
P						
OTHER TIMES						

CHECK X-RAY ORDERED
Date
Signature

PUMP Volume Left

	R	L
SLR	(N)	
Lag		10
Flex		45

error c.lcw

Resps
Sedation
Pain
Nausea/Vomit
Sensory Level
Motor Block
Circulation

POST OPERATIVE OUTCOMES				
MEDICAL	YES ☐ NO ☐		O.T.	YES ☐ NO ☐
NURSING	YES ☐ NO ☐		PATIENT	YES ☐ NO ☐
PHYSIO	YES ☑ NO ☐	Lorraine Rae		

	DAY 3	DAY 4	DAY 5	DAY 6
Date	15/12/05	16/12/05	17/12/05	18/12/05
6 10 2 6 10 (2)	1000			

TEMP 39 38 37 36 35 160 150 140 130 120 110 100 PULSE 90 80 70 60

DRUGS 8 12 2 6 10 2 | 8 12 2 6 10 2 | 8 12 2 6 10 2 | 8 12 2 6 10 2

A B C D E F G H J K L M N P

OTHER TIMES SIG

PAIN 3 2 1 0

Waterlow Score

DISCHARGE CRITERIA MET

MEDICAL Day ___ Sig ___ PHYSIO Day ___ Sig ___

NURSING Day ___ Sig ___ O.T. Day ___ Sig ___

	DAY 3				DAY 4				DAY 5				DAY 6			
	RIGHT		LEFT		RIGHT		LEFT		RIGHT		LEFT		RIGHT		LEFT	
SLR	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Lag																
Flex	60°								60							

POST OPERATIVE OUTCOMES

	DAY 3	DAY 4	DAY 5	DAY 6
MEDICAL	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
NURSING	YES ☑ NO ☐ Jones	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
PHYSIO	YES ☑ NO ☐ L. Kay	YES ☐ NO ☐	YES ☑ NO ☐ Rutchins	YES ☐ NO ☐
OT	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
PATIENT	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐

	DAY 7	DAY 8	DAY 9	DAY 10
Date				
6 10 2 6 10 (2)				

TEMP 39 38 37 36 35 160 150 140 130 120 110 100 PULSE 90 80 70 60

DRUGS 8 12 2 6 10 2 | 8 12 2 6 10 2 | 8 12 2 6 10 2 | 8 12 2 6 10 2

A B C D E F G H J K L M N P

OTHER TIMES SIG

PAIN 3 2 1 0

Waterlow Score

Hb

DISCHARGE DOCUMENTS COMPLETED

MEDICAL Day ___ Sig ___ PHARM. Day ___ Sig ___ O.T. Day ___ Sig ___

NURSING Day ___ Sig ___ PHYSIO Day ___ Sig ___

DISCHARGE DATE

	DAY 7				DAY 8				DAY 9				DAY 10			
	RIGHT		LEFT		RIGHT		LEFT		RIGHT		LEFT		RIGHT		LEFT	
SLR	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Lag																
Flex	0-85°															

POST OPERATIVE OUTCOMES

	DAY 7	DAY 8	DAY 9	DAY 10
MEDICAL	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
NURSING	YES ☑ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
PHYSIO	YES ☑ NO ☐ L. Kay	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
OT	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
PATIENT	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐

VARIANCES

NAME _____

UNIT NO. _____

DATE & TIME	DAY NO	TYPE	PROBLEM	ACTION	OUTCOME	SIGNATURE & DESIGNATION

❶ PATIENT/FAMILY ❷ CLINICAL STAFF ❸ HOSPITAL/SYSTEM ❹ COMMUNITY/OTHER AGENCIES ❺ PATIENT CONDITION

VARIANCES

NAME _____

UNIT NO. _____

DATE & TIME	DAY NO	TYPE	PROBLEM	ACTION	OUTCOME	SIGNATURE & DESIGNATION

❶ PATIENT/FAMILY ❷ CLINICAL STAFF ❸ HOSPITAL/SYSTEM ❹ COMMUNITY/OTHER AGENCIES ❺ PATIENT CONDITION

GENERAL COMMENTS

NAME Catherine Hodgkinson UNIT NO.

DATE & TIME	DAY NO	COMMENTS	SIGNATURE
14/12/05	01:30	ATSP re knee pain	
		-Total knee replacement 12/12	
		-Pt states knee very sore, not controlled by current analgesia	
		O/E ABS stable, apyrexial	
		R knee swollen, erythema + bruising, tender to touch	
		-Requires ↑ analgesia - N/S to discuss with anaesthest re PCA	AHS BLEEPER LOCUM F41
14-12-05	0600	Seen by Anaesthatist approx 0130 who recommended Tramadol and sub cutaneous morphine as analgesia due to patients poor venous Tramadol at 2200 HRS on 13TH had been omitted as Zydol prescribed and I intended to check BNF re Zydol. Save explained to patient. Tramadol 200mg given at 0200 along with scripted subcutaneous 10mg Morphine 0200	
		Patient requested analgesia approx 0345 saying her knee was just as painfull + then changed her mind saying that the morphine was making her hallucinate. Cup of tea given.	
		Effect of analgesia difficult to assess as patient is very nervous.	
		Patient asking overnight re infection in her knee. Bruising coming out - no signs of infection. Observations satisfactory, apyrexial. Seen by DC for reassurance.	
		Secredol 10mg given at 2230, 2350, 0105	AMVey

GENERAL COMMENTS

NAME Catherine Hamilton UNIT NO. 1004011

DATE & TIME	DAY NO	COMMENTS	SIGNATURE
14/12/05	2	Physio S/ agreed to tx. % pain ++ (R) knee O, lie → sit ī ✓ AOI, STS ī AOL, T/F ī mnt & AOI % pain ++ (R) L.L ✓ foot clearance (R) + (L) R/ bed exs + gait re-ed A/ ROM poor °/RQ, °/LR, Pain+: P/ Rush bed exs + gait	CLAIRE EAG
16/12/05	(4)	OT/ S/ Pt consented to Rx. O/ Transfer Ax conducted: - Chair - (I) on/off, Bed - (I) in/out, Toilet - (I) on/off standard toilet, Bath - (I) in/out ī bathboard in situ Pt awaiting bath this am P/ Conduct OAx.	SNRI SROT Lauraschmith
17/12/05	(5)	PT (S) pt consents to tx, pt jolted knee last night getting up to toilet during night. (O) pt sitting in bed. Lie → sit indep sts indep, indep ī sticks (A) stair practice, r/v bed exs (P) ↑ knee pain due to pain++ (P), ↑ ROM, ? d/c mon	
19.12.05		Discharge analgesia discussed with pain control team & ward patient. For discharge home on Tramadol + Paracetamol. Carleen is happy with this decision	SMcLean (SEPT) 9 Jack

GENERAL COMMENTS

NAME Catherine Honeyman UNIT NO. 5600440

DATE & TIME	DAY NO	COMMENTS	SIGNATURE
18/12/05 1100		Settled Morning, washed at bedside with basin independently. Right Knee wound cleansed and redressed with Mepore. patient stated Right knee is stiff, sore, and sensation on skin at sides is decrease. advised that this may be due to swelling and a result of the strain caused by partial fall on early Saturday 17/12/05 morning, encouraged to Continue physio exercises and will be reviewed by physio's on Monday 19/12/05 observations Satisfactory, hypertensive at 169/93 this is Normal for patient, no further complaints offered	[illegible] Staff Nurse
19/12/05 0630		Seroxedol 30 mgs given once overnight with good effect	
19/12/05 PT		S. Keen for home Q Mobile (I) c 2 x w/s + 3pt gait, Mauri (I) K/C gait re-ed, Bed exs & managing stairs. Would benefit from further PT due to lack of motivation & Refer to OPPT @ Govanhill. D/C	Elaine Rae Staff Nurse

SOUTH GLASGOW UNIVERSITY HOSPITALS DIVISION

PATIENT MOVING AND HANDLING RISK ASSESSMENT

NHS Greater Glasgow

Patient's Name: Catherine Honeyman	If patient is totally independent, tick here and go to date box
Named Nurse:	

BODY BUILD

Obese		Tall	
Above average		Medium	
Average		Short	
Below Average		Weight:	

RISK OF FALLS High | Low

Problems with comprehension, behaviour, co-operation (specify)

Handling constraints,e.g. disability, weakness, pain, skin lesions infusions (specify)

INTO BATH OR SHOWER

HANDLING AID		WHICH BATH	
Hoist (Specify)		Parker	
Shower chair		Variable height	
		Standard	
		Any	

ASSISTANCE | SUPERVISION | INDEPENDENT

Staff required:

TRANSFERS (including to/from: bed, wheelchair, commode, toilet)

HOIST		MANUAL SUPPORT
Which hoist?		Staff required:
Sling type?		Specify support given
Sling size?		

ASSISTANCE | SUPERVISION | INDEPENDENT

Additional Information

TOILETING

HOIST		MANUAL SUPPORT
Which hoist?		Staff required:
Sling type?		Specify support given
Sling size?		

ASSISTANCE | SUPERVISION | INDEPENDENT

Additional Information

WALKING

NO WALKING		ASSISTANCE
Staff required:		
Walking Aid		

SUPERVISION | INDEPENDENT

Distance walked / additional information

MOVE UP/DOWN BED

HOIST		MANUAL SUPPORT
Which hoist?		Sliding aid
Sling type?		Rope ladder
Sling size?		Hand blocks
		Monkey poles

ASSISTANCE | SUPERVISION | INDEPENDENT

Additional Information (include details of any therapy beds used)

Staff required:

SIT UP OVER SIDE OF BED

Rope ladder | Sliding aid | ASSISTANCE | SUPERVISION | INDEPENDENT

MOVE ON/OFF BED PAN

Hoist | Roll Patient | Patient bridges | Monkey pole | Not used

TRANSFER TO/FROM TROLLEY (or bed etc)

Sliding aid (rigid) | Sliding aid (fabric) | Transfer aid (specify) | Staff required (specify) | INDEPENDENT

Date assessed:	Assessors signature:

Date reviewed									
Assessors signature									

THERAPEUTIC HANDLING INSTRUCTIONS

Date	Instruction	Therapist's Name

SG00940779
CATHERINE HONEYMAN
10 MELVILLE STREET

GLASGOW 01/02/1949
G41 2LN CHI 0102496145

th Glasgow University Hospitals NHS Trust

essure Ulcer Risk Assessment Record

NHS Greater Glasgow

dified Waterlow Risk Assessment

Initials	ET	MK														
Date	8/11/5	12														
Date: ~ 8 - 1 1 - 5	Number	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Body weight for height:																
Average 0 Above average 1		2	2													
Obese 2 Below 3																
Continence:																
Completely / Catheterised 0 Occasionally incontinent 1		0	0													
Catheterised / Incontinent of faeces 2 Doubly incontinent 3																
Skin type - Visual risk areas:																
Healthy 0																
Tissue paper/Dry 1																
Oedematous/Clammy (temp. raised) 1																
Discoloured 2																
Broken spot 3		0	0													
Mobility:																
Fully 0 Restless/Fidgety 1		0	3													
Apathetic 2 Restricted 3																
Inert/Traction 4 Chairbound 5																
Sex/Age:																
Male/Female 1/2 14-49 1		4	4													
50-64 2 65-74 3																
75-80 4 80+ 5																
Appetite:																
Average 0 Poor 1		0	2													
N.G. tubes/fluids only 2 NBM / Anorexic 3																
Special risks - Tissue malunitrition:																
e.g. Terminal cachexia 8																
Cardiac failure 5																
Peripheral vascular disease 5																
Anaemia 2																
Smoking 1		0	0													
Neurological deficit:																
e.g. Diabetes, MS, CVA, Motor-sensory paraplegia 4-6		0	0													
Major surgery /trauma:																
Orthopaedic; Below waist; Spinal 5		0	5													
On table > 2 hours 5																
Medication:																
Cytotoxics; Highdose steroids; Anti-inflamatory 4		0	0													
TOTAL SCORE:		6	16													

Score as follows: <10 = Low risk; 10-14 = At risk; 15-19 = High risk; 20+ = Very high risk.

Refer to Pressure Ulcer Prevention Guidelines (GGHB) for action.

South Glasgow University Hospitals Division

NHS Greater Glasgow

Part II Discharge Letter / Transfer Plan

- [x] Southern General Hospital 0141 201 1100
- [ ] Victoria Infirmary 0141 201 6000
- [ ] Mansionhouse Unit 0141 201 6101

Name: CATHERINE HONEYMAN

Address: 10 MELVILLE ST.
GLASGOW

Unit number: 009L077 D.O.B. 1.2.45

Telephone: 0141 422 1580

Next of kin: RAYMOND HONEYMAN

Relationship: HUSBAND

Address: AS ABOVE

Telephone:

Named Nurse: S. KERR

Consultant: MR STEAD

Ward: C

Telephone: 0141/ 201 1639

Admission date: 11.12.05

Planned discharge/transfer date: 14.12.05

Final discharge/transfer date: 14.12.05

Discharge address: HOME

G.P.: DR MARSHALL

Address: PARK PLACE
GOVAN H/C

Telephone:

Community Services Arranged

Service: DISTRICT NURSE

Contact number:

Service details: Wound dressing.

Service:

Contact number:

Service details:

Additional/Transfer Information

Patient Assessment/Comments

Mobility: Independent with 2 sticks

Personal hygiene/Dressing: Independant

Continence: No problems.

Dietary requirements: Normal Diet

Communication / Swallowing: No problems.

Mental state: Alert & Orientated.

Skin condition/Waterlow Score: Pressure areas intact
Waterlow = 11

Wound care: S/c Steristrips to close - No ends to be clipped.
Prepare to cast

Special Instructions for Patient e.g. Exercise , Diet, Wounds, Others

Others/Follow-up arrangements

Progress discussed with patient: Yes ☑ No ☐

Progress discussed with relative/carer: Yes ☐ No ☐

This information has been fully discussed with Patient/Carer.

Date and signature of Nurse: 19.12.05 [signature]

Date and signature of Patient/Carer:

Diagnosis:

(2) Knee Replacement
12.12.05

se/Midwife Administration by Protocol - Authorised Nurses/Midwives Only

(Maximum number of doses as per protocol)

ing: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed by a doctor.

DOCTOR'S DECLARATION (if required by Local Protocol)

prise nurse/midwife administration of the medicines included in the nurse/midwife administration

ol No.(s) ..... with the following exceptions: _____

ure: _____ Date: _____

DRUG	DOSE	ROUTE	TIME	SIGNATURE OF NURSE	GIVEN BY	TIME GIVEN

Notes for Users

FOR DOCTORS:

1. Sign your name clearly against each prescription.
2. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date appropriate boxes.
3. If an existing prescription is to be modified, delete existing prescription as described and re-write new instructions in a new section.
4. Use approved names in BLOCK LETTERS and use metric doses as follows:
   Milligram = **mg** Gram = **g**
   Millilitre = **ml** Microgram: **to be written in full.**
   Fractions of a milligram should be written in micro grams. A zero should be written in front of a decimal point where there is no other figure, e.g. 0.5ml **not** .5ml.
5. Method of administration should be abbreviated as follows:

Intravenous	= **IV**	Oral	= **O**
Subcutaneous	= **SC**	Per rectum	= **PR**
Inhalations	= **INH**	Topical	= **TOP**
Sublingual	= **SL**	Nasogastric	= **NG**
Intramuscular	= **IM**	Vaginal	= **PV**
Intradermal	= **ID**		

FOR NURSES:

1. The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.
2. Ensure entry is made on administration record each time drug is given. Initial in relevant date column and time row.
3. Check that all drugs prescribed at a certain time are administered.
4. If drug is not administered, enter reason in appropriate box using the undernoted coding system.

Codes for Non-Administration of Drugs

atient refused
rug not available
il by mouth/fasting
atient unavailable

(7) Patient asleep
(8) Time varied on doctor's instructions
(9) Dose withheld on doctor's instructions
(10) Nausea/vomiting
(11) Unable to swallow
(12) No intravenous access
(13) Patient Self-Administration of Medicine
(14) Other - Record in nursing notes
(15) Prescription clarification required

Ver 6, 01/2002

PRESCRIPTION FORM

Hospital Name: SSH

PATIENT DETAILS

[redacted]

eight: _____

940779
ERINE HONEYMAN
ELY[redacted] STREET

eight: _____

GOW 01/02/1949
1 2LN CHI 0102496145

urface area: _____

Date of writing discharge prescription: __/__/__

of Admission: __/__/__

Ward: S

ultant Name: Mr Stead

and time this form prepared: __/__/__ Time: _____

Sheet No .....

2nd Prescription in use Yes or NO

DRUG SENSITIVITIES

☆ NOT FOR BLOOD PRODUCTS ☆

T Risk on Admission (SIGN Guideline)

gh ☐ Moderate ☐ Low ☐

ssessed by: Date: __/__/__

OTHER CHARTS IN USE

sulin ☐
CA and other infusions ☐
nticoagulants: Heparin ☐ Oral ☐
pical: ☐

TPN: ☐
Enteral Nutrition: ☐
Oxygen Therapy: ☐
Other:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF DOCTOR	GIVEN BY	TIME GIVEN
12/12	Temazepam	20mg	O	1000	R. Lennox	[redacted]	1000
12/12	Lasix	20mg	O	1000	R. Lennox	[redacted]	1000
12/12	CEFTRIAXONE	1.5gm	IV		[redacted]	[redacted]	1120
11/12/05	Dexamethasone	5mg	IV		[redacted]	[redacted]	1120
13/12/05	RANITIDINE	150mg	IV	1400	[redacted]	[redacted]	1400
13/12	MORPHINE	10mg	S/C	1030	[redacted]	ND/SK	1030
13/12	MORPHINE	10mg	S/C		[redacted]	ND/SK	11.45

PATIENT'S NAME:

ADMINISTRATION

Parenteral Drugs: Regular Prescription

DATE →

MONTH →

A DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

B DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

C DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

D DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

Parenteral Drugs: Regular Prescription

DATE →

MONTH →

E DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

F DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

G DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

H DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent or double dosing is avoided.

Note: To discontinue a prescription, initial and date appropriate boxes and draw a diagonal line through section

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE / MONTH

J DRUG: Aspirin
DOSE: 75mg | ROUTE: O | DATE: 8/11 | STOPPED DATE: | INITIALS:
SIGNATURE OF DOCTOR:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: for 35 days post-op
FOR DOCTORS USE ONLY

K DRUG: ~~zydol SR~~
DOSE: 200mg | ROUTE: O | DATE: 8/11 | STOPPED DATE: 14/12 | INITIALS: SH
SIGNATURE OF DOCTOR:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
FOR DOCTORS USE ONLY

L DRUG: Duepragolo
DOSE: 20mg | ROUTE: O | DATE: 8/11 | STOPPED DATE: | INITIALS:
SIGNATURE OF DOCTOR:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
FOR DOCTORS USE ONLY

M DRUG: Ramiprilo
DOSE: 2.5mg | ROUTE: O | DATE: 8/11 | STOPPED DATE: | INITIALS:
SIGNATURE OF DOCTOR:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
FOR DOCTORS USE ONLY

Oral and Other Drugs: Regular Prescriptions

DATE / MONTH

N DRUG: ~~Cocodamol 30/500~~
DOSE: 2 | ROUTE: PO | DATE: 13/12/12 | STOPPED DATE: 14/12 | INITIALS:
SIGNATURE OF DOCTOR:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
FOR DOCTORS USE ONLY

P DRUG: ~~FLUOXETINE~~
DOSE: 20mg | ROUTE: O | DATE: 13/12 | STOPPED DATE: | INITIALS:
SIGNATURE OF DOCTOR:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
FOR DOCTORS USE ONLY

R DRUG: FLUOXETINE
DOSE: 20mg | ROUTE: O | DATE: 14/12 | STOPPED DATE: | INITIALS:
SIGNATURE OF DOCTOR:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
FOR DOCTORS USE ONLY

S DRUG: PARACETAMOL
DOSE: 1g | ROUTE: O | DATE: 14/12 | STOPPED DATE: | INITIALS:
SIGNATURE OF DOCTOR:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
FOR DOCTORS USE ONLY

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Note: To discontinue a prescription, initial and date appropriate boxes and draw a diagonal line through section

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE → 14 15 16 17 18 19

MONTH → 12 12 12 12 12 12

T DRUG: TRIMADOL

DOSE: 100mg | ROUTE: O | DATE: 14/12 | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

	14	15	16	17	18	19
Other time						
0700-0900		BE	NO	NO	SK	SK
1200-1400	SK	BE	NO	SK	SK	
1600-1800	SK	DE	NO	SK		
2200-2400	JK	M	M	AS		
Other time						

V DRUG: SANDO-K

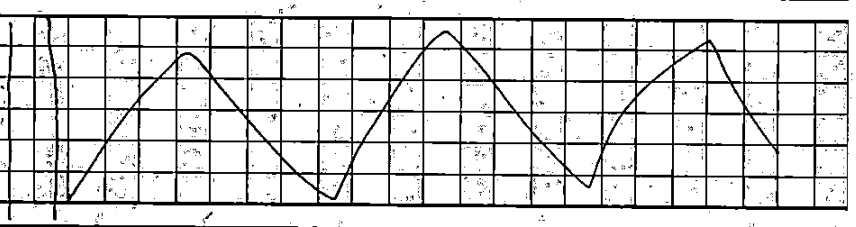
DOSE: 2 tabs | ROUTE: O | DATE: 14/12 | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: 2 DAYS ONLY

FOR DOCTORS USE ONLY

Other time						
0700-0900			NO			
1200-1400			NO			
1600-1800						
2200-2400			MLH			
Other time						



W DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

X DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

Oral and Other Drugs: Regular Prescriptions

DATE →

MONTH →

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent or double dosing is avoided.

Note: To discontinue a prescription, initial and date appropriate boxes and draw a diagonal line through section

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE / MONTH

J DRUG: Aspirin — DOSE: 75mg — ROUTE: O — DATE: 8/11 — STOPPED DATE: — INITIALS: — SIGNATURE OF DOCTOR: — ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: 8 for 35 days post-op

K DRUG: ~~zydol SR~~ — DOSE: 200mg — ROUTE: O — DATE: 8/11 — STOPPED DATE: 14/12 — INITIALS: SH — SIGNATURE OF DOCTOR: — ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

L DRUG: Omeprazole — DOSE: 20mg — ROUTE: O — DATE: 8/11 — STOPPED DATE: — INITIALS: — SIGNATURE OF DOCTOR: — ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

M DRUG: Bendroflumazide — DOSE: 2.5mg — ROUTE: O — DATE: 8/11 — STOPPED DATE: — INITIALS: — SIGNATURE OF DOCTOR: — ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

FOR DOCTORS USE ONLY

Oral and Other Drugs: Regular Prescriptions

DATE / MONTH

N DRUG: Cocodamol 30/500 — DOSE: 2 tabs — ROUTE: PO — DATE: 13/12/00 — STOPPED DATE: 14/12 — INITIALS: — SIGNATURE OF DOCTOR: — ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

P DRUG: ~~FLUOXETINE~~ — DOSE: 20mg — ROUTE: O — DATE: 13/12 — STOPPED DATE: — INITIALS: — SIGNATURE OF DOCTOR: — ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

R DRUG: FLUOXETINE — DOSE: 20mg — ROUTE: O — DATE: 14/12 — STOPPED DATE: — INITIALS: — SIGNATURE OF DOCTOR: — ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

S DRUG: PARACETAMOL — DOSE: 1g — ROUTE: O — DATE: 14/12 — STOPPED DATE: — INITIALS: — SIGNATURE OF DOCTOR: — ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

FOR DOCTORS USE ONLY

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PATIENT'S NAME:

ADMINISTRATION

Parenteral Drugs: Regular Prescription

DATE →

MONTH →

Other time

0700-0900

1200-1400

1600-1800

2200-2400

Other time

A

DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

B

DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

C

DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

D

DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

Parenteral Drugs: Regular Prescription

DATE →

MONTH →

Other time

0700-0900

1200-1400

1600-1800

2200-2400

Other time

E

DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

F

DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

G

DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

H

DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

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SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL, 1345 GOVAN ROAD, GLASGOW G51 4TF
TEL: 0141 201 1100

DEPARTMENT OF ORTHOPAEDICS

WARD: S05 CONSULTANT: MR IAN STEAD
CONTACT TEL: 0141 201 1469

IMMEDIATE DISCHARGE LETTER

PATIENT: CATHERINE HONEYMAN
10 MELVILLE STREET
GLASGOW
G41 2LN

DOB: 01/02/49 UNIT NO: SG00940779
ACCT NO: IP0058969/05
CHI NO: 0102496145

GP: DR GRAEME G MARSHALL
GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ

DATE OF ADMISSION: 12/12/05
DATE OF DISCHARGE: 16/12/05

ADMISSION TYPE: ELECTIVE
DISCHARGE TO: HOME

REASON FOR ADMISSION: R - TKR
MAIN DIAGNOSIS: RIGHT TKR

OTHER ACTIVE PROBLEMS: NIL

OPERATIONS/PROCEDURES/ TREATMENT: AS ABOVE
RESULTS AWAITED: N
CURRENT MEDICATION: SEE PRESCRIPTION
COMMENT: NIL

ALLERGIES:
NIL

REVIEW? Y DETAILS: OP CLNIC TIMESCALE: 6 WEEKS

URTHER LETTER TO FOLLOW? Y DETAILS: TO FOLLOW

SIGNED: SHO.STELA STEVENSON,LAURA
ESIGNATION: SENIOR HOUSE OFFICER
AGE NUMBER: 2558

un: 16/12/05-14:07 by BOYLE,ALISON

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL, 1345 GOVAN ROAD, GLASGOW G51 4TF
TEL: 0141 201 1100

DEPARTMENT OF ORTHOPAEDICS

WARD: S05 **CONSULTANT: MR IAN STEAD**
CONTACT TEL: 0141 201 1469 ***IMMEDIATE DISCHARGE LETTER***

PATIENT: CATHERINE HONEYMAN DOB: 01/02/49 UNIT NO: SG00940779
10 MELVILLE STREET ACCT NO: IP0058969/05
GLASGOW CHI NO: 0102496145
G41 2LN GP: DR GRAEME G MARSHALL

D I S C H A R G E M E D I C A T I O N

Time Required? Routine - within 4 hours Childproof Containers? Y
Compliance Aid Required? N
Patient's Weight (Kg): Comment:

Medication	Form	Dose	Frequency	Duration
ASPIRIN	OTAB	150MG	IN THE MORNING	6 WEEKS

New Drug? N New Dose? Y Comments: 6 WEEKS POST OP THEN NORMAL DOSE
Patient's Own Supply? N Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration
OMEPRAZOLE	OTAB	20MG	IN THE MORNING	INDEFINITE

New Drug? N New Dose? N Comments:
Patient's Own Supply? N Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration
BENDROFLUAZIDE	OTAB	2.5MG	IN THE MORNING	INDEFINITE

New Drug? N New Dose? N Comments:
Patient's Own Supply? N Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration
FLUOXETINE	OTAB	20MG	IN THE MORNING	INDEFINITE

New Drug? N New Dose? N Comments: N
Patient's Own Supply? N Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration
PARACETAMOL	OTAB	1G	4 TIMES A DAY	INDEFINITE

New Drug? N New Dose? N Comments:
Patient's Own Supply? N Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration
TRAMADOL	OTAB	100MG	4 TIMES A DAY	10 DAYS

New Drug? N New Dose? N Comments:
Patient's Own Supply? N Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration

New Drug? New Dose? Comments:
Patient's Own Supply? Pharmacy Notes: Supply:

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL, 1345 GOVAN ROAD, GLASGOW G51 4TF
TEL: 0141 201 1100

DEPARTMENT OF ORTHOPAEDICS

WARD: S05 CONSULTANT: MR IAN STEAD
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IMMEDIATE DISCHARGE LETTER

PATIENT: CATHERINE HONEYMAN
10 MELVILLE STREET
GLASGOW
G41 2LN

DOB: 01/02/49 UNIT NO: SG00940779
ACCT NO: IP0058969/05
CHI NO: 0102496145
GP: DR GRAEME G MARSHALL

Medication	Form	Dose	Frequency	Duration
New Drug? New Dose? Comments:				
Patient's Own Supply? Pharmacy Notes:			Supply:	

Medication	Form	Dose	Frequency	Duration
New Drug? New Dose? Comments:				
Patient's Own Supply? Pharmacy Notes:			Supply:	

Medication	Form	Dose	Frequency	Duration
New Drug? New Dose? Comments:				
Patient's Own Supply? Pharmacy Notes:			Supply:	

Medication	Form	Dose	Frequency	Duration
New Drug? New Dose? Comments:				
Patient's Own Supply? Pharmacy Notes:			Supply:	

Medication	Form	Dose	Frequency	Duration
New Drug? New Dose? Comments:				
Patient's Own Supply? Pharmacy Notes:			Supply:	

Medication	Form	Dose	Frequency	Duration
New Drug? New Dose? Comments:				
Patient's Own Supply? Pharmacy Notes:			Supply:	

Medication	Form	Dose	Frequency	Duration
New Drug? New Dose? Comments:				
Patient's Own Supply? Pharmacy Notes:			Supply:	

PHARMACY USE ONLY DISPENSED BY: DATE: CHECKED BY:
CLINICAL PHARMACIST CHECK: COLLECTED BY: _____

Medicine received on ward by: _____ Issued by: _____

Named Nurse: _____ Signature of Receipt: _____

Report Number: 1612-0032 Date(Time): 16/12/05 (1025 Hours) Status: Signed

NAME _____ UNIT NO. _____

GENERAL COMMENTS

DATE & TIME	DAY NO	COMMENTS	SIGNATURE
15-1-10		Elective Pre assessment today. RD	
22-1-10		Admitted to ward 6 for theatre tomorrow. Patient settled. To have tea and toast in the morning. OStone	
25-1-10		Observations as charted. Medication administered as per Wardex. Mobilising to toilet independently. Pain well controlled. Dressings taken down. Staples intact. To remain on S/C care. Physiotherapy & Occupational therapy to begin on S/C care. Thromboprophylaxis & Vooms water TED.	
26.1.10		(a) Fem Bilateral femoral and sciatic nerve blocks. Chlorhexidine spray. (b) Fem 22g Stimuplex @ femoral 0.4ml x 0.4%mA x 22g (c) Sciatic 0.35mA x 20g (d) Anaesthesia nerve stimulator 20g Stimuplex needle 0.5mA. All 10ml x 0.375% bupivacaine plain/Hospira (Hospira/Cons Area)	
14:00		Patient returned from theatre after receiving a left total knee replacement and right knee resurfacing under a G.A. Femoral and sciatic blocks. 1g paracetamol given IV post op in recovery and PCA in situ, 1mg with a 5minute lockout. Hughes O2 therapy via the hudsen mask while on PCA. IV fluids also prescribed.	
		C.S.M satisfactory and dressings dry and in tact, apart from used and crepe used. Observations satisfactory. Patient drowsy and slightly confused since returning for theatre, is uncomplaining at pain. s/N Mulvey.	

BE AWARE
THIS PATIENT IS ON
BETA BLOCKERS

ALERT NOTICE
Please Check
for PCD
Cascades

Acute Services Division

Southern General Hospital

Greater Glasgow and Clyde

#Jehovahs Wit Hosp

Integrated Care Pathway

Primary Knee Replacement

(R) Patella Resurfacing.

SG00940779
CATHERINE HONEYMAN
10 MELVILLE STREET

GLASGOW 01/02/1949
G41 2LN CHI 0102496145

60

CONSULTANT
Mr Hullin

NAMED NURSE
SN Slow 24

PROPOSED SURGERY

Diagnosis: OA ☐ RA Servo +ve ☐
Post Trauma ☐ Servo -ve ☐
Other _____

Left ☐ Right ☑ Bilateral ☐

Department of Orthopaedics

PATIENT DETAILS

DATE

PREFERRED NAME

RELIGION Seventh Adventist

AGE 60

CLERGY VISIT REQUESTED YES ☐ NO ☐

PATIENT'S TEL NO. 0141 422 1580

OCCUPATION

NEXT OF KIN Raymond Hannan

OTHER CONTACT

ADDRESS Sim

ADDRESS

RELATIONSHIP Husband

RELATIONSHIP

TEL. DAY: Sim NIGHT:

TEL. DAY: NIGHT:

GP NAME Dr marshall

ADDRESS Scotts M.C.

TEL NO. 531 8250

45 Pine Drive

MOBILITY

COMMUNITY	☐	HOUSEBOUND	☐	HOUSING	YES	NO
UNAIDED	☐	CRUTCHES	☐	STEPS OUTSIDE x 5no	☑	☐
1 STICK	☑	ZIMMER	☐	STEPS INSIDE	☐	☐
2 STICKS	☐	WHEELCHAIR	☐	STEPS TO TOILET	☐	☑

SOCIAL CIRCUMSTANCES

LIVES ALONE ☐ INFIRM/ELDERLY PARTNER ☐ HEALTHY PARTNER ☐ LIVES WITH FAMILY ☑

	NO	YES
RECEIVES SUPPORT	☑	☐
REQUIRES SUPPORT	☑	☐
Confirm additional support organised	☑	☐
TRANSPORT ORGANISED	☐	☑ own transport
Admission	☐	☑
Discharge	☐	☑
SIGNIFICANT VISUAL IMPAIRMENT	☐	☑ wears glasses
SIGNIFICANT DEAFNESS	☑	☐ Alert notification ☐
ALCOHOL	☐	☑ Units per day Socially
SMOKING	☑	☐ No. per day
NORMAL DIET	☐	☑ Dietitian informed if no ☐

	M	T	W	T	F	S	S
DISTRICT NURSE							
HOME HELP							
DAY CENTRE							
MEALS ON WHEELS							
FAMILY VISIT							
OTHER							

4 = current support
* = required support

(If no, tick appropriate) Diabetic ☐ Religious ☐ Low Fat ☐ Vegetarian/Vegan ☐

ADDITIONAL INFORMATION

OCCUPATIONAL THERAPY

	DRESSING	WASHING	FEEDING	HYGIENE	BED	CHAIR	TOILET	BATH
INDEPENDENT	✓	✓	✓	✓		✓	Has Bathroom	Has Shower
AIDS/ ASSISTANCE					✓			
UNABLE								

AIDS IN SITU Nil - to be assessed in hospital

AIDS REQUIRED FOR DISCHARGE

High Chair	☐	Perching Stool	☐	Shoe Horn	☐	Helping Hand	☐
Bath Board	☐	Shower Board	☐	Bath Seat	☐	Trolley	☐
Toilet Seat	☐	C.O.T. Referral Sent	☐	Other			

Sock Aid ☐ Tights Aid ☐
Mowbray ☐ Dressing Stick ☐

2" ☐ 4" ☐ 6" ☐

SIGNED _____ (OT)

NAME

UNIT NO.

PRE-OPERATIVE ASSESSMENT

DATE

	NO	YES
PREVIOUS GA	☐	☑
IF YES: Reluctance	Complication	☐
	Within 3 Months	☐
	Family History of Problem	☐
CHEST PROBLEMS	☑	☐
IF YES:	Bronchitis	☐
	OPD Chest Clinic	☐
	Productive Cough	☐
	Asthma In-patient Treatment in Last Year	☐
MI Date _____	☑	☐
HYPERTENSION on medication	☐	☑
BLEEDING TENDENCY on aspirin	☐	☑
Treatment	☐	☐
BOWEL PROBLEMS	☑	☐
IF YES:	Constipation	☐
	Diarrhoea	☐
URINARY SYMPTOMS	☑	☐
IF YES:	Haematuria	☐
	Dysuria	☐
	Nocturia > 2x	☐
	Urgency	☐
ALLERGIES	☑	☐
IF YES: Food/Pollen ☐	Antibiotics	☐
Other Drug		
Rash ☐	Sickness	☐
Diarrhoea ☐	Swelling	☐
Collapse ☐	Flat	☐

ALLERGY NOTIFICATION : _____ (Signed)

	NO	YES
ANGINA	☐	☑
IF YES: Occasionally	☑	At Rest ☑
Once per Week	☐	Climbing Stairs ☐
Once per Day	☐	In Cold Air ☐
		With Anxiety ☑
PALPITATIONS	☐	☑
IF YES: Exercise	☐	Coffee ☐
Excitement	☑	No Predisposing Factor ☐
SHORTNESS OF BREATH	☐	☑
IF YES: At Rest	☐	Flight of Stairs ☑
In the House	☐	At Night Lying Flat ☐
Level Walking	☐	
ANKLE SWELLING	☑	☐
IF YES: Occasionally	☐	All the Time ☐
At Night	☐	
DIABETES	☑	☐
IF YES: Diet	☐	Insulin ☐
Oral	☐	
Drug/Dose		
FITS/EPILEPSY	☑	☐
IF YES: Rarely	☐	Blackouts ☐
A few per month	☐	< 3 Months Ago ☐
Treatment	☐	Seen GP ☐
HIATUS HERNIA	☐	☑
		Heartburn Lying Flat ☐
CVA Date _____	☑	☐
IF YES: SIDE	L ☐	R ☐

PAST MEDICAL HISTORY - 09. - GORD.
- Back Pain - Cholecystectomy 92.
- Hysterectomy
- x3 Lumpectomy - NAD - Dec 12-13.45 exp.
- Depression

SIGNED _____ (OLN/Reg)

NAME _____ UNIT NO. _____

DRUG HISTORY

STEROIDS/METHOTREXATE/WARFARIN — NO ☐ YES ☑ DRUG Oramorph.

IF YES: ☐ ☐ Dose / Frequency

CURRENT DRUGS	DOSE	FREQUENCY
Ranitidine	2.5ml	OD AM.
Aspirin	75mg	OD AM.
Simvastatin	40mg	OD AM.
Atenolol	25mg	OD AM.
Fluoxetine	40 20mg	OD AM.
Tramadol	50mg	P.R.N.
Omeprazole	20mg	OD AM.
C.T.N 50mg		P.R.N
Yang Baby - Urdu medication		

SIGNED _____ (OLN/Reg/SHO)

EXAMINATION

PULSE 79. Irregular NO ☑ YES ☐ — BLOOD PRESSURE 137 / 85 Diastolic >90 Systolic >190 INFORM ANAESTHETIST

ABNORMAL URINALYSIS NO ☐ YES ☑ — HEIGHT 1.53 m WEIGHT 93.6 Kilos

IF YES: Glucose ☐ Protein ☑ Blood ☑ — BODYMASS INDEX 39 WATERLOW 6

TED STOCKING SIZE _____

ABNORMAL CHEST PERCUSSION NO ☑ YES ☐ _____

ABNORMAL CHEST SOUNDS NO ☑ YES ☐ _____

ABNORMAL HEART SOUNDS NO ☑ YES ☐ _____ 7573 1440

ABDOMINAL MASSES NO ☑ YES ☐ _____

DISTAL PULSES Regular NO ☐ YES ☑ — DISTAL OEDEMA NO ☑ YES ☐

KNEE JOINT

	LEFT		RIGHT			LEFT		RIGHT	
	NO	YES	NO	YES		NO	YES	NO	YES
QUADS WASTING	☐	☐	☐	☐	DEFORMITY	☐	☐	☐	☐
SYNOVITIS	☐	☐	☐	☐	If Yes:	FIXED		FIXED	
EFFUSION	☐	☐	☐	☐	VARUS	NO ☐ YES ☐		NO ☐ YES ☐	
					VALGUS	NO ☐ YES ☐		NO ☐ YES ☐	
					FLEXION	NO ☐ YES ☐		NO ☐ YES ☐	
					MAXIMUM FLEXION				

SIGNATURE OF SURGEON _____

NURSING ☑ _____ (Sig)

PHYSIOTHERAPY ☑ WATSON (Sig)

NAME _____ UNIT NO. _____

INVESTIGATION — RESULT

FBC ☐ Hb 136 g/L WCC 7.4 x10⁹/L

X-MATCH 3 UNITS ☐

MSU ☐

U&E NO ☐ YES ☒ — Na 140 (135-145) K 4.1 (3.5-5.0) Cl 102 (101-111) CO2 24 (23-30 mmol/L)

CXR NO ☐ YES ☐ — Urea 6.2 (2.5-7.5) Creatine 77 (40-130)

ECG NO ☐ YES ☒ normal.

OTHER _____ SIGNED _____ (OLN/REG/SHO)

ANAESTHETIC ASSESSMENT

WARD VISIT ☐ OPD ☑ DATE 15.1.10.

PROSTHESIS; TEETH; CROWNS 3i MPI — Please mark crowns, loose teeth etc

AIRWAY ASSESSMENT neck ↓.

ASA SCORE 1 ☐ 2 ☑ 3 ☐ 4 ☐ 5 ☐

OTHER TEST ORDERED _____

SURGERY DEFERRED NO ☑ YES ☐ — ↑BP hiatus hernia. obese. behaves witness

IF YES, ACTION TAKEN

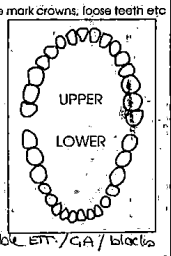
Refer GP ☐ / Letter Sent ☐ W/L Deferred ☐

Await test result ☐ Reassess ☐ in vivo ophth. → probable ETT/GA/blocks

DATE _____ paracetamol knee replacement morphine PCA.

PREMED PRESCRIBED NO ☐ YES ☑ check Hb → decide on procedure

BMI 39 SIGNED _____ (Anaesthetist)



ADMISSION - DAY 0

DATE _____

BP ____ PULSE ____ TEMP ____ RESPS ____

PATIENT PATHWAY ☐ LIFTING ☐

TED Stockings fitted ☐ IDENTIFICATION ☐

WATERLOW SCORE ☐ INFECTION RISK SCORE ☐

SIGNATURE _____

DRUGS

TIME & SIG.	TIME & SIG.	TIME & SIG.

CONSENT ☐ LIMB MARKED ☐

DRUGS PRESCRIBED ☐

CONSENT TO ANAESTHESIA, OPERATION, INVESTIGATION OR TREATMENT

NOTES OF GUIDANCE

1. **DOCTORS**

A patient has the right to grant or withhold consent prior to examination, investigation, treatment or operation. The Doctor must give the patient sufficient information, in a way which he/she can understand, about the proposed procedure, any significant side-effects and the possible alternatives. The Doctor must give the patient enough time to read this sheet and ask any questions relating to it or their treatment. The patient must be allowed to decide whether he or she will agree to the procedure and they may refuse or withdraw consent to a procedure at any time. The patient's consent to a procedure should be recorded.

1.1. The patient must give written consent to be examined by students during any procedure for which consent is required. (See below).

2. **PATIENTS**

2.1. The Doctor is here to help you. He or she will explain the procedure, which you are entitled to refuse. You can ask any questions and ask for more information.

2.2. You may ask for a relative or friend or a nurse to be present while the Doctor explains the procedure and asks you to sign this sheet.

2.3. Students need to learn how to examine patients and to see how procedures are done. This is important for the future of health services. You may be asked to give consent to be examined by students during the procedure. It is up to you to decide whether you give your consent or not but whatever you decide, it will not affect your treatment.

TO BE COMPLETED BY THE MEDICAL PRACTITIONER

PROPOSED PROCEDURE LEFT Total Knee Replacement Possibly Revision Required

I HAVE FULLY EXPLAINED: To the patient/parent/guardian/next of kin* (*Delete as appropriate)

1. The procedure named on this form
2. Appropriate alternatives which are available
3. Significant side-effects which may result from the procedure. Including Deep Vein Thrombosis, Pulmonary Embolism, Infection, Stiffness, Dislocation and Longevity of Implant.

NAME (BLOCK CAPITALS) [illegible] **SIGNATURE** [signature]

TO BE COMPLETED BY THE PATIENT

You should read this form carefully. If there is anything you do not understand ask the Doctor for an explanation. If the information is correct and you understand the procedure you should sign the form.

I AM The patient/parent/guardian/next of kin* (*Delete as appropriate)

I UNDERSTAND
- The procedure which has been explained to me by the Doctor named on this form.
- The procedure may not be carried out by the Doctor who has been treating me so far.
- That any procedure in addition to that named on this form will only be carried out if necessary and in my best interests and can be justified for medical reasons.

I AGREE
- To the administration of an anaesthetic or sedation if required.
- To the procedure named on this form.
- That examination for the purposes of teaching will not be undertaken without my permission.

I AGREE/ DO NOT AGREE*
- To the involvement of a student at the procedure named.
- To the examination by a student during the procedure named under the supervision of the Senior Medical Officer undertaking this procedure.

SIGNATURE Catherine Montgomery

Patient/Parent/Guardian/Next of Kin* (BLOCK CAPITALS)

NAME **UNIT NO.**

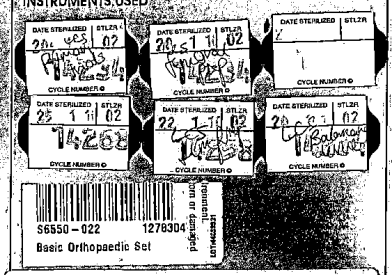
OPERATION DETAILS

TOURN QUET	YES ☐ NO ☐	STANDARD PREPARATION	YES ☐ NO ☐
MIDLINE SKIN INCISION	YES ☐ NO ☐	MEDIAL PARAPATELLAR	YES ☐ NO ☐
UNCEMENTED LCS	YES ☐ NO ☐	PATELLAR DEBRIDED ONLY	YES ☐ NO ☐

IMPLANTS USED



INSTRUMENTS USED



INSTRUMENTS USED MILESTONE ☐ OTHER ☐		RANGE OF MOVEMENT ON TABLE _____ TO _____ Degrees	
STANDARD CLOSURE	YES ☐ NO ☐	ROUTINE POST-OP	YES ☐ NO ☐
FULL CORRECTION OF DEFORMITY	YES ☐ NO ☐	STANDARD DRAINS	YES ☐ NO ☐
Residual Deformity		IF NOT TO ANY QUESTION	

KNEE REPLACEMENT

DATE 28th January 2010

RIGHT ☐ LEFT ☐ BILATERAL ☒

PRE-OPERATIVE CHECK

Ward Nurse _____

Theatre Nurse _____

Pressure Care ☐ Eye Care ☐

Diathermy Abdo ☐ Thigh ☐

Tourniquet Up 925 (L)

Down _____ Pressure 300

SIGNED _____

SWAB COUNT CORRECT ☐

Scrub Nurse _____

Circulating Nurse _____

Surgeon Mr Frame (L)

Assistant Mr Hutton (L)

Anaesthetist Dr Horse

Assistant _____

Anaesthetic Nurse _____

Scrub Nurse _____

Circulation Nurse _____

Recovery Nurse _____

Named Nurse _____

POST-OP CHECK ☐

Recovery Nurse _____

Ward Nurse _____

IV Site Right Left

Hand ☐ ☒

Wrist ☐ ☐

Central ☐ ☐

Size 16g venflon

Spinal ☐ Block ☒

Site femoral/sciatic

Drug levobup. 0.375%

Volume 10/10/10/10

Needle 21/22g

AIRWAY see comments

Laryngeal Mask ☐

Orotracheal 8

Nasotracheal ☐

Size 8.0mm Ashley Shiley

VENTILATION

Spontaneous ☐

IPPV ☒

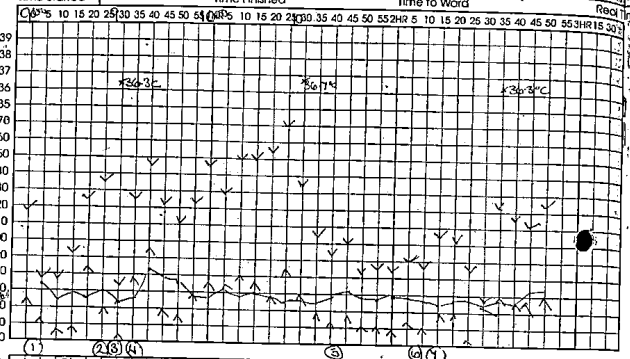
Gases O2/air/iso

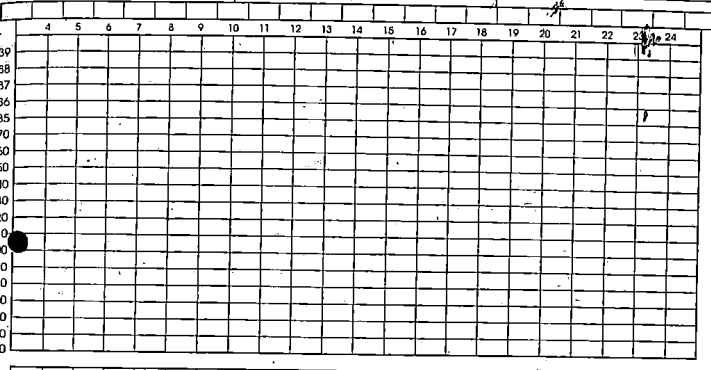
Time Started 900

Time Finished

Time to Ward

Real Time





SpO2	98	96	96	97	97	96	97	98	97	97	97			
EtCO2	5.5	4.6	5.6	4.9	4.8	4.9	6.2	4.9	4.8	4.8	4.7			
EtAA	1.0	1.1	1.1	1.1	1.2	1.2	1.1	1.1	1.1	1.0	0.8			
FiO2	1.0	0.58	0.48	0.45	0.45	0.45	0.44	0.62	0.44	0.46	1.0			

SpO2

DRUGS/GASES

gentamicin 160mg

fluclocacillin 2g

morphine 5mg 5mg 5mg

lipuro 150mg

levobupivacaine 10 to 150mg

vecuronium 8mg

ephedrine 6mg 6mg 6mg

lignocaine via laryngoscope 40mg

(1) induction
(2) transfer to theatre
(3) tourniquet (L) up
(4) incision (L)
(5) tourniquet down (L)
(6) tourniquet up (R)
(7) incision (R)

DRUGS

A
B
C
D
E
F
G
H
J
K
L
M
N
P

EPIDURAL 0.25% Bupivacaine

MORPHINE 60ml 1mg/ml PUMP NO. _____

VOLUME REMAINING

Resps
Sedation
Pain
Nausea/Vomit
Sensory Level
Motor Block
Circulation/Leg Power

RECORD FLUID + START/STOP TIME

IV In (A) 1000 (B) 500 (C) 1000

Oral In

Blood Out

Fluid Out

TOTAL

BALANCE

NAME _____ DATE _____ UNIT NO. _____

DAY 1

	6	10	2	6	10	(2)
TEMP 39						
38						
37						
36						
35						
160						
150						
140						
130						
120						
110						
100						
PULSE 90						
80						
70						
60						
50						
40						

							24 HOUR TOTAL
IV Fluid							
Oral Fluid							
Blood Loss							
Fluids Out							
							BALANCE

DRUGS	8	12	2	6	10	(2)	Hb
A							
B							Waterlow
C							
D							
E							
F							
G							
H							
J							
K							
L							
M							
N							
P							
OTHER TIMES							

PUMP
Volume Left

		R	L
Resps			
Sedation			
Pain			
Nausea/Vomit			
Sensory Level			
Motor Block			
Circulation			
	SLR Y N		
	Lag		
	Flex		

POST OPERATIVE OUTCOMES

MEDICAL	YES ☐ NO ☐ _____	O.T.	YES ☐ NO ☐ _____
NURSING	YES ☐ NO ☐ _____	PATIENT	YES ☐ NO ☐ _____
PHYSIO	YES ☐ NO ☐ _____		

NAME _____ DATE _____ UNIT NO. _____

DAY 2

	6	10	2	6	10	(2)
TEMP 39						
38						
37						
36						
35						
160						
150						
140						
130						
120						
110						
100						
PULSE 90						
80						
70						
60						
50						
40						

							24 HOUR TOTAL
IV Fluid							
Oral Fluid							
Blood Loss							
Fluids Out							
							BALANCE

DRUGS	8	12	2	6	10	(2)
A						
B						
C						
D						
E						
F						
G						
H						
J						
K						
L						
M						
N						
P						
OTHER TIMES						

CHECK X-RAY ORDERED
Date _____
Signature _____

PUMP
Volume Left

		R	L
Resps			
Sedation			
Pain			
Nausea/Vomit			
Sensory Level			
Motor Block			
Circulation			
	SLR Y N		
	Lag		
	Flex		

POST OPERATIVE OUTCOMES

MEDICAL	YES ☐ NO ☐ _____	O.T.	YES ☐ NO ☐ _____
NURSING	YES ☐ NO ☐ _____	PATIENT	YES ☐ NO ☐ _____
PHYSIO	YES ☐ NO ☐ _____		

	DAY 3	DAY 4	DAY 5	DAY 6
Date				
6 10 2 6 10 (2)				
TEMP 39				
38				
37				
36				
35				
160				
150				
140				
130				
120				
110				
100				
PULSE 90				
80				
70				
60				

DRUGS	8 12 2 6 10 2	8 12 2 6 10 2	8 12 2 6 10 2	8 12 2 6 10 2
A				
B				
C				
D				
E				
F				
G				
H				
J				
K				
L				
M				
N				
P				
OTHER TIMES SIG				

PAIN				
3				
2				
1				
0				

Waterlow Score

DISCHARGE CRITERIA MET

MEDICAL Day___ Sig___ PHYSIO Day___ Sig___

NURSING Day___ Sig___ O.T. Day___ Sig___

	DAY 3				DAY 4				DAY 5				DAY 6			
	RIGHT		LEFT		RIGHT		LEFT		RIGHT		LEFT		RIGHT		LEFT	
SLR	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Lag																
Flex																

POST OPERATIVE OUTCOMES

MEDICAL	YES ☐ NO☐	YES ☐ NO☐	YES ☐ NO☐	YES ☐ NO☐
NURSING	YES ☐ NO☐	YES ☐ NO☐	YES ☐ NO☐	YES ☐ NO☐
PHYSIO	YES ☐ NO☐	YES ☐ NO☐	YES ☐ NO☐	YES ☐ NO☐
OT	YES ☐ NO☐	YES ☐ NO☐	YES ☐ NO☐	YES ☐ NO☐
PATIENT	YES ☐ NO☐			

	DAY 7	DAY 8	DAY 9	DAY 10
Date				
6 10 2 6 10 (2)				
TEMP 39				
38				
37				
36				
35				
160				
150				
140				
130				
120				
110				
100				
PULSE 90				
80				
70				
60				

DRUGS	8 12 2 6 10 2	8 12 2 6 10 2	8 12 2 6 10 2	8 12 2 6 10 2
A				
B				
C				
D				
E				
F				
G				
H				
J				
K				
L				
M				
N				
P				
OTHER TIMES SIG				

PAIN				
3				
2				
1				
0				

Waterlow Score

Hb

DISCHARGE DOCUMENTS COMPLETED

MEDICAL Day___ Sig___ PHARM. Day___ Sig___

NURSING Day___ Sig___ PHYSIO Day___ Sig___

DISCHARGE DATE

O.T. Day___ Sig___

	DAY 7				DAY 8				DAY 9				DAY 10			
	RIGHT		LEFT		RIGHT		LEFT		RIGHT		LEFT		RIGHT		LEFT	
SLR	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Lag																
Flex																

POST OPERATIVE OUTCOMES

MEDICAL	YES ☐ NO☐	YES ☐ NO☐	YES ☐ NO☐	YES ☐ NO☐
NURSING	YES ☐ NO☐	YES ☐ NO☐	YES ☐ NO☐	YES ☐ NO☐
PHYSIO	YES ☐ NO☐	YES ☐ NO☐	YES ☐ NO☐	YES ☐ NO☐
OT	YES ☐ NO☐	YES ☐ NO☐	YES ☐ NO☐	YES ☐ NO☐
PATIENT	YES ☐ NO☐			

DATE & TIME	DAY NO	TYPE	PROBLEM	ACTION	OUTCOME	SIGNATURE & DESIGNATION

VARIANCES

NAME

UNIT NO.

1 PATIENT/FAMILY 2 CLINICAL STAFF 3 HOSPITAL/SYSTEM 4 COMMUNITY/OTHER AGENCIES 5 PATIENT CONDITION

DATE & TIME	DAY NO	TYPE	PROBLEM	ACTION	OUTCOME	SIGNATURE & DESIGNATION

VARIANCES

NAME

UNIT NO.

1 PATIENT/FAMILY 2 CLINICAL STAFF 3 HOSPITAL/SYSTEM 4 COMMUNITY/OTHER AGENCIES 5 PATIENT CONDITION

SOUTHERN GENERAL HOSPITAL

DEPARTMENT: ORTHO

NAME Catherine Honeyman UNIT NO SG0094044 WARD: 6

DATE	PROB. NO	NURSING NOTES/EVALUATION	SIGNATURE
29/1/10	0730	Ventlon resited & PCA pump recommenced. PCA being used frequently Morcalcon administered as per kardex IV fluids running. Passing urine spontaneously Wound dry & intact Very labile to settle.	
		- Ventlon reissued again PCA pump stopped	
		- Patient took down own bandages - informed that this should have been carried out by staff. Opsite strained	
	0745	Informed by staff nurse that patient states that PCA pump has not been connected. Informed SN Sinclair that patient advised me that ventlon leaking at 7.00am. Removed ventlon. Discussed removal of ventlon with patient - patient appears to have forgot whole conversation stating that ventlon wasn't taken out by night staff @ 7.00am.	
29/1/10	13.20	Very unsettled morning. Patient restless removed her own bandages and opened theatre dressings Wound on (R) knee dehissed approx 5cm. Steristrips applied and both knees redressed and patient informed of increased risk of infection if she tampers with dressings. Oxycontin 10mg given as per kardex Diet and fluids taken well Patients behaviour appear bizarre pain team informed ? oxycontin / norm. Will observe throughout the day. Up to mobilise and transfer with Zimmer: Bed to chair. Removed her own ventlon for the second time this morning. Obs satisfactory as charted.	
		Pain review - MS Honeyman has been acting a little strangely and I am unclear if this is related to her analgesia however she is sore and requesting oxynorm	

0369438-SGH 306A

SOUTHERN GENERAL HOSPITAL

DEPARTMENT:

NAME: Cathrine Honeyman UNIT NO. WARD: 6

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
		If this odd behaviour continues please consider reducing oxycontin to 10mg BD.	S Mavis
30/1/10	05.10	Patient appears very confused, behaving very strange possibly related to analgesia please have reviewed by pain team or doctor Patient unsettled early evening walking up the ward with only a sheet around her. Patient thought this was acceptable behaviour MSU to be sent. blood and protein in urine, doctor sounded chest all clear. Patient finally settled later on evening no complaints offered	J. Kinsey
	Cont	Obs stable Sews 0	
	12.10	Patient vomited 100mls semi solid food. Felt nauseated AM. 3m Buscopem	
31/1/10	1350	Observations satisfactory / Hypotensive - Tolerated small amount of diet - Medication administered as per Kardex Oxycontin reduced 10mg BD. Observe for further confusion - Patient alert & orientated today - no signs of confusion or hallucinating. - WC ↑ 14.1 : MSU taken twice for ~~for~~ ~~tolerated~~ protein & Blood. MSU sent Written up for trimethoprim. Given PM - Mobility: With crutches independently to toilet. Stair practice 31/1/10 - Wound: Taken down, wound debrided & cleansed with normasol - steristrips applied & wound pads & opsite to cover Wound requires to be reviewed by Dr on Monday - Passing urine spontaneously - Bowels inactive Bowels not active since Tuesday (phone reported) written up for senna & lactulose - Independent in washing & dressing - D - discharge home	

SOUTHERN GENERAL HOSPITAL

DEPARTMENT: Orthopaedics

NAME Catherine Honeyman UNIT NO. SG0094077 9 WARD: Six

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
31/1/10	0535	Patient has been mobilising independently on sticks, passing urine spontaneously. Observations as charted - patient has been hypotensive overnight. Has been taking fluid and has increased slightly. Trimethaprim continues. No episodes of vomitting. Medication taken as per kardex. Settled night	Adams
	1735	Patient mobilising independently on Elbow crutches. Independent with ADLs. Patient drinking fluids regularly. Remains hypotensive as charted. Patient reviewed by nurse practitioner re: constipation - patient c/o nausea and abdominal pains. Prescribed movicol BD. No bowel movement today	[illegible]
1/2/10	0500	Patient has slept for short periods. Feeling uncomfortable with no bowel movements. Senna given. F41 reviewed overnight and re-wrote lactulose. Patient vomitted once over night, 4mg ondansetron given. Remains hypotensive overnight however asymptomatic. Medication taken as per kardex. Please ask day shift doctors about inactive bowels	Adams
1/2/10	1130	Pain review - Oxycontin discontinued - prescribed tramadol 50mg OD as step down analgesia.	SMorris
	1800	Went for chest x-Ray, Hb 93 - Still constipated, laxatives increased, bowels started to move. Independent with elbow crutches. Diclofenac withheld, Patient feels she has irritated stomach when on them. Has own transport. Hopefully home tomorrow. Discharge medication done.	[illegible]

SGH 306A

SOUTHERN GENERAL HOSPITAL

DEPARTMENT: Ortho

NAME: Catherine Monaghan UNIT NO. 940779 WARD: 6

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
22/02/10	04.00	Slept for short periods overnight.	
		Mobilising around the ward ~~for~~ independently	
		with elbow crutches.	
		Wound to left knee re-dressed and	
		steristrips applied. Wound pad and	
		opsite dressings applied. Wound was	
		leaking +++, is now dry and intact	
		Ted stockings in situ.	
		Possibly for discharge home tomorrow.	
		Observations stable.	Cllinway
	1500	Independant with washing and dressing.	
		Dressing renewed to Right knee - dry.	
		left Knee, leaking. Mr Fraune to	
		review not for home until knee	
		reviewed	yorklark
	1600	Seen by Mr Fraune, looked at wound	
		observe wound meanwhile, gap present	
		wound swab obtained: Aquacel and	
		opsite applied. Advised to not touch	
		wound at all. Mr Hullin to review	
		tomorrow.	yorklark
23/02/10	05.10	Slept for long periods overnight.	
		Mobilising around ward independently	
		with elbow crutches.	
		Dressings to both legs dry and intact.	
		Wounds to be reviewed by Mr Hullin	
		today. Awaiting results of swab that	
		was taken from left knee.	
		Aim is for discharge home today.	
		Observations satisfactory.	Cllinway
	1330	Wound reviewed by Mr Hullin - patient	
		can be discharged home today	
		with district nurses dressing wound	
		District nurse referral picked up by	
		district nurse liaison OPD a week on	shildwyk
		Friday.	
	1600	Discharge medication given and explained	
		Daughter collected patient. Opd 10days	
		Mr Hullins clinic	yorklark

NHS
Greater Glasgow and Clyde

NATVNS
SCOTLAND

SG00940779
CATHERINE HONEYMAN
10 MELVILLE STREET

GLASGOW 01/02/1949
G41 2LN CHI 0102496145

ADAPTED WATERLOW PRESSURE AREA RISK ASSESSMENT CHART

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

Complete assessment on admission/1st visit, if there is a change in individuals condition and repeat regularly according to local protocol

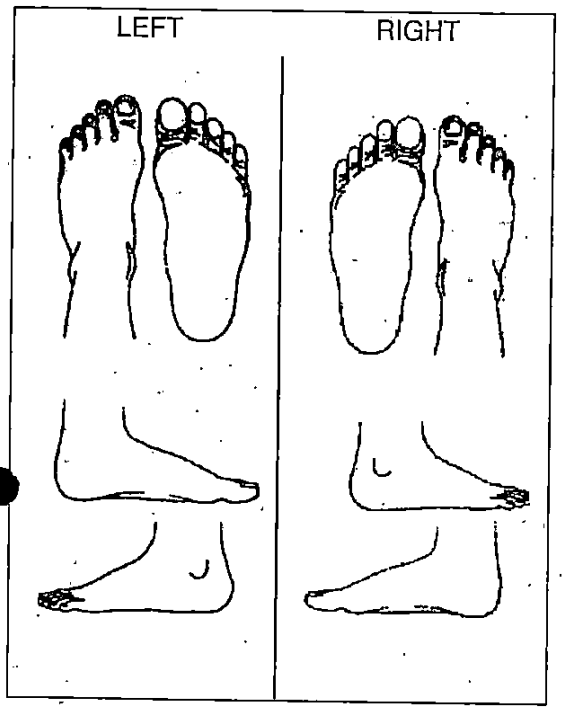
Sex										
Male	1									
Female	2	2	2	2						
Age										
14 -49	1									
50 -64	2	2	2	2						
65 - 74	3									
75 - 80	4									
81+	5									
Build/Weight for Height (BMI=weight in Kg/height in m²)										
Average - BMI 20-24.9	0									
Above average - BMI 25-29.9	1									
Obese - BMI > 30	2	2	1	2						
Below average - BMI < 20	3									
Continence										
Complete/catheterised	0	0	0	0						
Incontinent urine	1									
Incontinent faeces	2									
Doubly incontinent (urine & faeces)	3									
Skin Type - Visual Risks Area										
Healthy	0	0	0	0						
Tissue paper (thin/fragile)	1									
Dry (appears flaky)	1									
Oedematous (puffy)	1									
Clammy (moist to touch)/pyrexia	1									
Discoloured (bruising/mottled)	2									
Broken (established ulcer)	3									
Mobility										
Fully mobile	0	0	0	0						
Restless/fidgety	1									
Apathetic (sedated/depressed/reluctant to move)	2									
Restricted (restricted by sever pain or disease)	3									
Bedbound (unconscious/unable to change position/traction)	4									
Chairbound (unable to leave chair without assistance)	5									
Nutritional Element										
Unplanned weight loss in past 3-6 months										
<5% Score **0**, 5-10% Score **1**, >10% Score **2**	0-2	0	0	0						
BMI > 20 Score **0**, BMI 18.5-20 Score **1**, BMI < 18.5 Score **2**	0-2									
Patient acutely ill or no nutritional intake > 5 days	2									
Special Risks - Tissue Malnutrition										
Multiple organ failure/terminal cachexia	8									
Single organ failure e.g. cardiac, renal, respiratory	5									
Peripheral vascular disease	5									
Anaemia = Hb < 8	2									
Smoking	1	0	0	0						
Special Risks - Neurological Deficit										
Diabetes/MS/CVA/motor/sensory/paraplegia *Max 6*	4-6	0	0	0						
Special Risks - Surgery/Trauma										
On table > 6 hours	8									
Orthopaedic/below waist/spinal (up to 48 hours post op)	5									
On table > 2 hours (up to 48 hours post op)	5	0	0	0						
Special Risks - Medication										
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*	4	0	0	0						
Total Score		6	5	6						
Date		15/1	21/1/10	31/1/10						
Initials		MC	SC	AT						
Time		1300	2150	1140						

83826

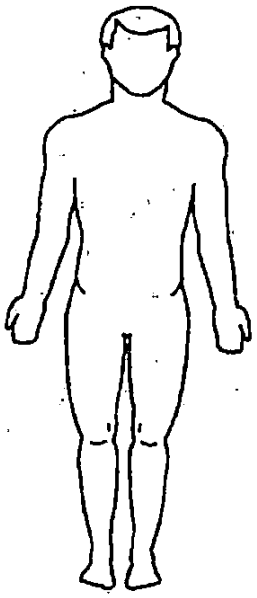
Ensure plan of care is implemented / reviewed for all identified areas of concern.

PRESSURE ULCER RECORD

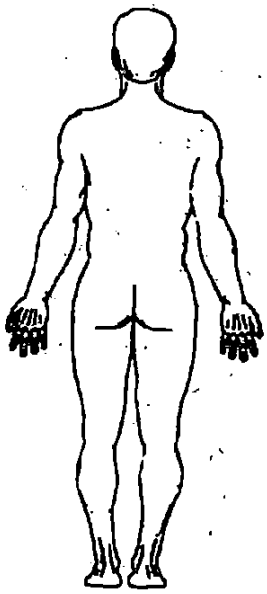
Indicate by circling and numbering all pressure damage on diagrams, then complete box below. Indicate care plan/wound assessment chart.



Anterior view



Posterior view



SCOTTISH ADAPTED EPUAP PRESSURE ULCER GRADING TOOL

GRADE 1 Non-blanchable erythema of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness may also be used as indicators, particularly on individuals with darker skin.

GRADE 2 Partial thickness skin loss involving epidermis, dermis or both. The ulcer is superficial and presents clinically as an abrasion or blister.

GRADE 3 Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia.

GRADE 4 Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss.

DATE	NUMBER OF ULCER(S)	LOCATION OF ULCER(S)	GRADE OF ULCER(S)	LOCATION OF ULCER(S)

Pressure Ulcers may deteriorate from Grade 1 to Grade 4, but can not be reversed and should be documented as a healing grade of pressure ulcer, eg healing grade 4.

ASGOW HOSPITALS
HANDLING RISK ASSESSMENT

NHS Greater Glasgow and Clyde

SG00940779
CATHERINE HONEYMAN
10 MELVILLE STREET
GLASGOW 01/02/1949
G41 2LN CHI 0102496145

Patient's Nam
Named Nurs

If patient is totally independent, tick here and go to date box ✓

BODY BUILD

Obese		Tall	
Above average		Medium	
Average		Short	
Below Average		Weight:	

RISK OF FALLS High | Low

Problems with comprehension, behaviour, co-operation (specify)

Handling constraints,e.g. disability, weakness, pain, skin lesions infusions (specify)

INTO BATH OR SHOWER

HANDLING AID		WHICH BATH	
Hoist (Specify)		Parker	
Shower chair		Variable height	
		Standard	
		Any	

ASSISTANCE | SUPERVISION | INDEPENDENT

Staff required:

TRANSFERS (including to/from: bed, wheelchair, commode, toilet)

HOIST		MANUAL SUPPORT
Which hoist?		Staff required:
Sling type?		Specify support given
Sling size?		

ASSISTANCE | SUPERVISION | INDEPENDENT

Additional information

TOILETING

HOIST		MANUAL SUPPORT
Which hoist?		Staff required:
Sling type?		Specify support given
Sling size?		

ASSISTANCE | SUPERVISION | INDEPENDENT

Additional information

WALKING

NO WALKING		ASSISTANCE	
Staff required:			
Walking Aid			

SUPERVISION | INDEPENDENT

Distance walked / additional information

MOVE UP/DOWN BED

HOIST		MANUAL SUPPORT	
Which hoist?		Sliding aid	
Sling type?		Rope ladder	
Sling size?		Hand blocks	
		Monkey poles	

ASSISTANCE | SUPERVISION | INDEPENDENT

Additional information (include details of any therapy beds used)

Staff required:

SIT UP OVER SIDE OF BED

Rope ladder | Sliding aid | ASSISTANCE | SUPERVISION | INDEPENDENT

MOVE ON/OFF BED PAN

Hoist | Roll Patient | Patient bridges | Monkey pole | Not used

TRANSFER TO/FROM TROLLEY (or bed etc)

Sliding aid (rigid) | Sliding aid (fabric) | Transfer aid (specify) | Staff required (specify) | INDEPENDENT

Date assessed: 21/11/10 | Assessors signature:

Date reviewed									
Assessors signature									

THERAPEUTIC HANDLING INSTRUCTIONS

Date	Instruction	Therapist's Name

INTO BATH OR SHOWER

HANDLING AID		WHICH BATH	
Hoist (Specify)		Parker	
Shower chair		Variable height	
		Standard	
		Any	

ASSISTANCE		SUPERVISION		INDEPENDENT	
Staff required:					

TRANSFERS (including to/from: bed, wheelchair, commode, toilet)

HOIST	
Which hoist?	
Sling type?	
Sling size?	

MANUAL SUPPORT
Staff required:
Specify support given

ASSISTANCE		SUPERVISION		INDEPENDENT	
Additional Information					

TOILETING

HOIST	
Which hoist?	
Sling type?	
Sling size?	

MANUAL SUPPORT
Staff required:
Specify support given

ASSISTANCE		SUPERVISION		INDEPENDENT	
Additional Information					

WALKING

NO WALKING		ASSISTANCE		SUPERVISION		INDEPENDENT	
Staff required:				Distance walked / additional information			
Walking Aid							

MOVE UP/DOWN BED

HOIST	
Which hoist?	
Sling type?	
Sling size?	

MANUAL SUPPORT	
Sliding aid	
Rope ladder	
Hand blocks	
Monkey poles	

ASSISTANCE		SUPERVISION		INDEPENDENT	
Additional information (include details of any therapy beds used)					
Staff required:					

SIT UP OVER SIDE OF BED

Rope ladder		Sliding aid		ASSISTANCE		SUPERVISION		INDEPENDENT	

MOVE ON/OFF BED PAN

Hoist		Roll Patient		Patient bridges		Monkey pole		Not used	

TRANSFER TO/FROM TROLLEY (or bed etc)

Sliding aid (rigid)		Sliding aid (fabric)		Transfer aid (specify)		Staff required (specify)		INDEPENDENT	

Date assessed:	Assessors signature:

Date reviewed									
Assessors signature									

THERAPEUTIC HANDLING INSTRUCTIONS

Date	Instruction	Therapist's Name

Glossary of terms used in risk assessment

SIGHT DEFICIT means patient cannot see well even when wearing glasses or is registered blind.

HEARING DEFICIT means person has hearing problems even with a hearing aid or has hearing problems and does not wear a hearing aid.

BALANCE DEFICIT means person is unable to stand without the support of another person or a walking frame.

MEDICINES FOR SOME MENTAL ILLNESSES include Chlorpromazine (Largactil), Risperidone (Risperdal), Lithium (Camcolit or Priadel), Haloperidol, Chloral hydrate (Welldorm), Clomethiazole (Heminevin), antidepressants.

BLOOD PRESSURE TABLETS include Captopril, atenolol and many others.

WATER TABLETS (DIURETICS) are such as Bendroflumethiazide, Furosemide and Co-amilofruse.

SLEEPING TABLETS include medicines such as Diazepam, Temazepam, Nitrazepam, Chlordiazepoxide and Zopiclone (Zimovane).

INABILITY TO CO-OPERATE includes failure to use walking aids or putting themselves in situations with a high risk of falling (usually due to mental impairment).

RESTRICTED MOBILITY means the person requires supervision and/or help to walk (i.e. is not safe to walk alone even with an aid.

HESITANT IN INITIATING MOVEMENT means difficulty in starting to walk.

POOR TRANSFER means the person requires help and is not safe to do the following alone - get in or out of bed, on or off a chair, move from chair to standing.

Cat. No. 41328

VI MEDICAL ILLUSTRATION • DME • 10469

Hospital / Department SGH

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

SG00940779
Patient name CATHERINE HONEYMAN
01/02/1949
Ward: G41 2LN
Practice Code: 49074
CHI number: CHI:0102496145 Unit/Hospital number .....

Contents

1. Canard Falls Risk Assessment Scoring Form
2. Falls Assessment Care Plan
3. Glossary of terms used in risk assessment

Notes: Risk assessment should be completed within 24 hours of admission.

Assessment Wards: Risk assessment and care plan should be reviewed weekly.

Continuing Care Wards: Mobile and 'at risk' patients should have risk assessment and care plan reviewed monthly.

Cannard Falls Risk Assessment

(Must be completed within 24 hours)

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						DATE 27/1/16	DATE	DATE	DATE	DATE	DATE	DATE
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			1						
Sex	Male 1	Female 2				2						
Age	60-70 1	71-80 2	81+ 1			1						
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0		1						
Medication type **	Drugs for mental illness 1	Blood pressure / water tablets 1	Sleeping tablets 1	None of these 0		2						
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	0						
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed bound 1		1						
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		1						
				TOTAL SCORE		7						
				ACTION(S) TAKEN Enter action code(s)		1,2,17						
SCORE 2 - 8 = LOW, 9 – 12 = MEDIUM, 13+ = HIGH RISK				NURSE SIGNATURE								

** If you are in any doubt about whether a person's medicine belongs to one of the types listed ask the person or carer or please phone the number on the medicine container and ask the community or hospital pharmacist.

* Please see back page for clarification

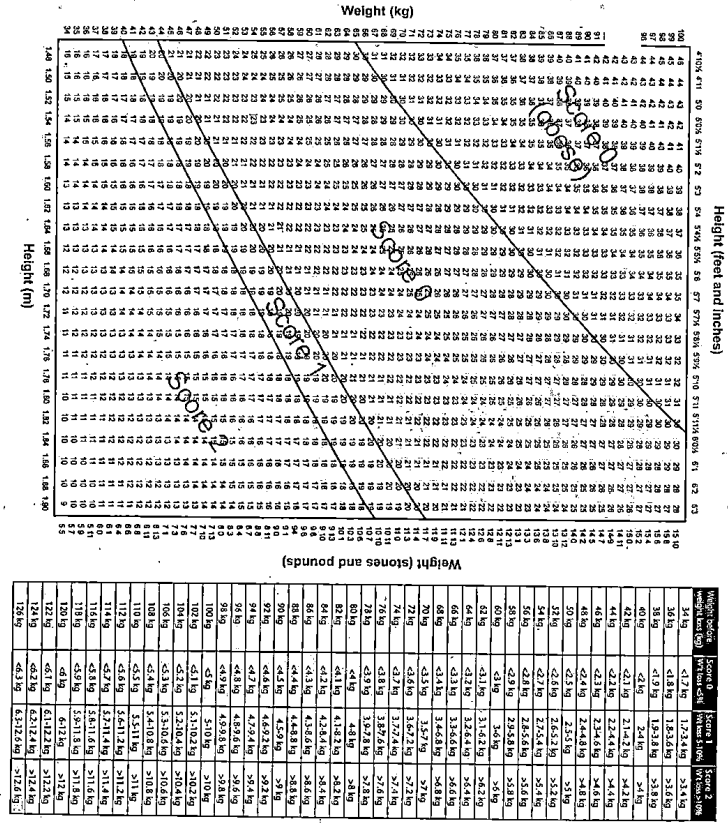
Falls Assessment Care Plan

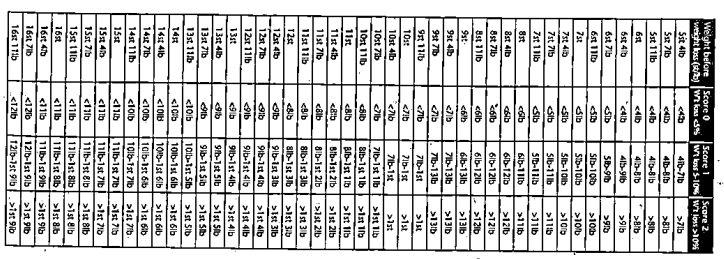
Please tick all applicable nursing interventions

	NURSING INTERVENTIONS	DATE	DATE	DATE	DATE	DATE	DATE	DATE
Action code	LOW, MODERATE AND HIGH RISK							
1	Prevention and general safety precautions discussed with patient and family.	27/1/16						
	MODERATE AND HIGH RISK							
2	Move to more observable area of ward to optimise supervision.							
3	Refer to Physiotherapist.	27/1/16						
4	Refer to Occupational Therapist.							
5	Patient requires footwear or podiatry referral. (Date referred:)							
6	Commence continence assessment							
7	Monitor lying and standing BP and pulse.							
8	Request medication review.							
9	Select suitable seating (refer to policy).							
10	Non-slip mat on chair/floor following advice of OT.							
11	Bed rails/bumpers to be used (refer to policy).							
12	Falls map in use for seven days.							
13	Bed/chair monitor in use.							
14	If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.							
15	Patient to be nursed on mattress on the floor (refer to policy.)							
16	Patient requires one to one nursing care.							
17	Other interventions. (buzzer @ ward)	27/1/16						
	HIGH RISK ONLY (Score of 13 or over)							
18	Provide hip protectors to patients being discharged to care homes/longterm NHS facilities							
	SIGNATURE							

Review Cannard score weekly / monthly as per policy.

Enter action code(s) selected in action taken section on Falls Risk Assessment.





Weight (kg)	Score 0 kg/m²	Score 1 kg/m²	Score 2 kg/m²	Score 3 kg/m²
34 kg	<17 kg	17-18.4 kg	18.5-20 kg	>20 kg
36 kg	<17.9 kg	18-19.4 kg	19.5-21 kg	>21 kg
38 kg	<18.9 kg	19-20.4 kg	20.5-22 kg	>22 kg
40 kg	<19.9 kg	20-21.4 kg	21.5-23 kg	>23 kg
42 kg	<20.9 kg	21-22.4 kg	22.5-24 kg	>24 kg
44 kg	<21.9 kg	22-23.4 kg	23.5-25 kg	>25 kg
46 kg	<22.9 kg	23-24.4 kg	24.5-26 kg	>26 kg
48 kg	<23.9 kg	24-25.4 kg	25.5-27 kg	>27 kg
50 kg	<24.9 kg	25-26.4 kg	26.5-28 kg	>28 kg
52 kg	<25.9 kg	26-27.4 kg	27.5-29 kg	>29 kg
54 kg	<26.9 kg	27-28.4 kg	28.5-30 kg	>30 kg
56 kg	<27.9 kg	28-29.4 kg	29.5-31 kg	>31 kg
58 kg	<28.9 kg	29-30.4 kg	30.5-32 kg	>32 kg
60 kg	<29.9 kg	30-31.4 kg	31.5-33 kg	>33 kg
62 kg	<30.9 kg	31-32.4 kg	32.5-34 kg	>34 kg
64 kg	<31.9 kg	32-33.4 kg	33.5-35 kg	>35 kg
66 kg	<32.9 kg	33-34.4 kg	34.5-36 kg	>36 kg
68 kg	<33.9 kg	34-35.4 kg	35.5-37 kg	>37 kg
70 kg	<34.9 kg	35-36.4 kg	36.5-38 kg	>38 kg
72 kg	<35.9 kg	36-37.4 kg	37.5-39 kg	>39 kg
74 kg	<36.9 kg	37-38.4 kg	38.5-40 kg	>40 kg
76 kg	<37.9 kg	38-39.4 kg	39.5-41 kg	>41 kg
78 kg	<38.9 kg	39-40.4 kg	40.5-42 kg	>42 kg
80 kg	<39.9 kg	40-41.4 kg	41.5-43 kg	>43 kg
82 kg	<40.9 kg	41-42.4 kg	42.5-44 kg	>44 kg
84 kg	<41.9 kg	42-43.4 kg	43.5-45 kg	>45 kg
86 kg	<42.9 kg	43-44.4 kg	44.5-46 kg	>46 kg
88 kg	<43.9 kg	44-45.4 kg	45.5-47 kg	>47 kg
90 kg	<44.9 kg	45-46.4 kg	46.5-48 kg	>48 kg
92 kg	<45.9 kg	46-47.4 kg	47.5-49 kg	>49 kg
94 kg	<46.9 kg	47-48.4 kg	48.5-50 kg	>50 kg
96 kg	<47.9 kg	48-49.4 kg	49.5-51 kg	>51 kg
98 kg	<48.9 kg	49-50.4 kg	50.5-52 kg	>52 kg
100 kg	<49 kg	50-51.4 kg	51.5-53 kg	>53 kg
102 kg	<50 kg	51-52.4 kg	52.5-54 kg	>54 kg
104 kg	<51 kg	52-53.4 kg	53.5-55 kg	>55 kg
106 kg	<52 kg	53-54.4 kg	54.5-56 kg	>56 kg
108 kg	<53 kg	54-55.4 kg	55.5-57 kg	>57 kg
110 kg	<54 kg	55-56.4 kg	56.5-58 kg	>58 kg
112 kg	<55 kg	56-57.4 kg	57.5-59 kg	>59 kg
114 kg	<55.9 kg	57-58.4 kg	58.5-60 kg	>60 kg
116 kg	<56.9 kg	58-59.4 kg	59.5-61 kg	>61 kg
118 kg	<57.9 kg	59-60.4 kg	60.5-62 kg	>62 kg
120 kg	<58.9 kg	60-61.4 kg	61.5-63 kg	>63 kg
122 kg	<59.9 kg	61-62.4 kg	62.5-64 kg	>64 kg
124 kg	<60.9 kg	62-63.4 kg	63.5-65 kg	>65 kg
126 kg	<61.9 kg	63-64.4 kg	64.5-66 kg	>66 kg

Weight (stones and pounds)	Score 0	Score 1	Score 2	Score 3
5st 4lb	<5st	5st-5st 7lb	5st 8lb-5st 13lb	>5st 13lb
5st 7lb	<5st 3lb	5st 3lb-5st 10lb	5st 11lb-6st 2lb	>6st 2lb
5st 11lb	<5st 7lb	5st 7lb-6st 1lb	6st 2lb-6st 6lb	>6st 6lb
6st	<5st 10lb	5st 10lb-6st 4lb	6st 5lb-6st 10lb	>6st 10lb
6st 4lb	<6st	6st-6st 7lb	6st 8lb-6st 13lb	>6st 13lb
6st 7lb	<6st 3lb	6st 3lb-6st 10lb	6st 11lb-7st 2lb	>7st 2lb
6st 11lb	<6st 7lb	6st 7lb-7st 1lb	7st 2lb-7st 6lb	>7st 6lb
7st	<6st 10lb	6st 10lb-7st 4lb	7st 5lb-7st 10lb	>7st 10lb
7st 4lb	<7st	7st-7st 7lb	7st 8lb-7st 13lb	>7st 13lb
7st 7lb	<7st 3lb	7st 3lb-7st 10lb	7st 11lb-8st 2lb	>8st 2lb
7st 11lb	<7st 7lb	7st 7lb-8st 1lb	8st 2lb-8st 6lb	>8st 6lb
8st	<7st 10lb	7st 10lb-8st 4lb	8st 5lb-8st 10lb	>8st 10lb
8st 4lb	<8st	8st-8st 7lb	8st 8lb-8st 13lb	>8st 13lb
8st 7lb	<8st 3lb	8st 3lb-8st 10lb	8st 11lb-9st 2lb	>9st 2lb
8st 11lb	<8st 7lb	8st 7lb-9st 1lb	9st 2lb-9st 6lb	>9st 6lb
9st	<8st 10lb	8st 10lb-9st 4lb	9st 5lb-9st 10lb	>9st 10lb
9st 4lb	<9st	9st-9st 7lb	9st 8lb-9st 13lb	>9st 13lb
9st 7lb	<9st 3lb	9st 3lb-9st 10lb	9st 11lb-10st 2lb	>10st 2lb
9st 11lb	<9st 7lb	9st 7lb-10st 1lb	10st 2lb-10st 6lb	>10st 6lb
10st	<9st 10lb	9st 10lb-10st 4lb	10st 5lb-10st 10lb	>10st 10lb
10st 4lb	<10st	10st-10st 7lb	10st 8lb-10st 13lb	>10st 13lb
10st 7lb	<10st 3lb	10st 3lb-10st 10lb	10st 11lb-11st 2lb	>11st 2lb
10st 11lb	<10st 7lb	10st 7lb-11st 1lb	11st 2lb-11st 6lb	>11st 6lb
11st	<10st 10lb	10st 10lb-11st 4lb	11st 5lb-11st 10lb	>11st 10lb
11st 4lb	<11st	11st-11st 7lb	11st 8lb-11st 13lb	>11st 13lb
11st 7lb	<11st 3lb	11st 3lb-11st 10lb	11st 11lb-12st 2lb	>12st 2lb
11st 11lb	<11st 7lb	11st 7lb-12st 1lb	12st 2lb-12st 6lb	>12st 6lb
12st	<11st 10lb	11st 10lb-12st 4lb	12st 5lb-12st 10lb	>12st 10lb
12st 4lb	<12st	12st-12st 7lb	12st 8lb-12st 13lb	>12st 13lb
12st 7lb	<12st 3lb	12st 3lb-12st 10lb	12st 11lb-13st 2lb	>13st 2lb
12st 11lb	<12st 7lb	12st 7lb-13st 1lb	13st 2lb-13st 6lb	>13st 6lb
13st	<12st 10lb	12st 10lb-13st 4lb	13st 5lb-13st 10lb	>13st 10lb
13st 4lb	<13st	13st-13st 7lb	13st 8lb-13st 13lb	>13st 13lb
13st 7lb	<13st 3lb	13st 3lb-13st 10lb	13st 11lb-14st 2lb	>14st 2lb
13st 11lb	<13st 7lb	13st 7lb-14st 1lb	14st 2lb-14st 6lb	>14st 6lb
14st	<13st 10lb	13st 10lb-14st 4lb	14st 5lb-14st 10lb	>14st 10lb
14st 4lb	<14st	14st-14st 7lb	14st 8lb-14st 13lb	>14st 13lb
14st 7lb	<14st 3lb	14st 3lb-14st 10lb	14st 11lb-15st 2lb	>15st 2lb
14st 11lb	<14st 7lb	14st 7lb-15st 1lb	15st 2lb-15st 6lb	>15st 6lb
15st	<14st 10lb	14st 10lb-15st 4lb	15st 5lb-15st 10lb	>15st 10lb
15st 4lb	<15st	15st-15st 7lb	15st 8lb-15st 13lb	>15st 13lb
15st 7lb	<15st 3lb	15st 3lb-15st 10lb	15st 11lb-16st 2lb	>16st 2lb
15st 11lb	<15st 7lb	15st 7lb-16st 1lb	16st 2lb-16st 6lb	>16st 6lb
16st	<15st 10lb	15st 10lb-16st 4lb	16st 5lb-16st 10lb	>16st 10lb
16st 4lb	<16st	16st-16st 7lb	16st 8lb-16st 13lb	>16st 13lb
16st 7lb	<16st 3lb	16st 3lb-16st 10lb	16st 11lb-17st 2lb	>17st 2lb
16st 11lb	<16st 7lb	16st 7lb-17st 1lb	17st 2lb-17st 6lb	>17st 6lb

STORES ORDER CODE 41850

VI MEDICAL ILLUSTRATION • NUTRITION & DIET • 13264401.00.08

Nutrition Profile

NHS Greater Glasgow and Clyde

Name:	Date of admission: 27 / 1 / 10
Address: SG00940779 CATHERINE HONEYMAN 10 MELVILLE-STREET GLASGOW G41 2LN	Time:
DoB: 01/02/1949	HOSPITAL:
CHI number: CHI 0102496145	Ward:
Affix patient data label	

To be recorded within 24 hours of admission*

Height: 5ft 3½ m/ft Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Weight: 148lb 10 kg/stones Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Recent unplanned weight loss: Yes ☐ No ☑

If 'Yes' how much?: kg/stones. Over what period of time?: weeks/months

Is there evidence of recent weight loss?

No ☐ Loose clothing ☐ History of reduced food intake/appetite ☐ Swallowing problem ☐

Eating and drinking likes and dislikes (including appetite and/or NBM status):

Normal diet & fluids

Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☐

Please state:

Are there any contributing factors that may affect food intake such as **physical** (e.g. swallowing difficulties), **physiological** (e.g. nausea), **psychological** (e.g. dementia), **social** or **environmental**? Yes ☐ No ☐

Please specify all factors:

Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☐

Please state:

Profile completed by: Name (PRINT): J. McKay Signature: J. McKay Date: 27/1/10

NOTE: This is ADMISSION DATA - please refer to changes in Care Plan.

* Quality Improvement Scotland (2003). Food, Fluids and Nutritional Care in Hospitals Edinburgh QIS

Malnutrition Universal Screening Tool ('MUST')

Date	11/10									
Initials	MH									
Height (see page 1) 5ft 3½	Weight 16st 10									
Oedema or ascites present Y/N	N									
BMI	30									

'MUST'

Step 1: BMI Score (refer to chart on page 4)										
>20 (>30 = Obese) 0										
18.5 - 20 1	0									
<18.5 2										
Step 2: Weight Loss Score										
Unplanned weight loss in past 3-6 months:										
<5% 0										
5-10% 1	0									
>10% 2										
Step 3: Acute Disease Effect Score										
If patient is acutely ill **and** there has been or is likely to be no or virtually no food intake for > 5 days..... Score 2										
Not applicable ..... Score 0	0									
Step 4: Overall Risk of Malnutrition Total:	0									

Step 5: Management Guidelines

Score of Overall Risk of Malnutrition	Action Required
0	**LOW RISK** - *Routine Clinical Care* • Repeat screening. Hospital Acute .....Weekly Hospital Rehabilitation .....Monthly
1	**MEDIUM RISK** - *Observe* • Document dietary intake for 3 days on a Food Record Chart. • If no improvement in intake: - Encourage oral intake. - Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Repeat screening weekly.
2 or more	**HIGH RISK** - *Treat** • Refer to Dietitian and document food intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Monitor and review Care Plan weekly. * Unless detrimental or no benefit is expected from nutritional support e.g. imminent death

Management Plan

FOR ALL PATIENTS

- Provide help and advice on food choices and eating and drinking when necessary.
- Treat underlying conditions and initiate appropriate treatment to relieve symptoms that affect nutritional intake e.g. nausea, vomiting, constipation, diarrhoea and/or pain.
- Refer to dietitian if any specialist advice is required.
- Complete nursing checklist for swallowing difficulties if appropriate.
- Use a recognised system to identify when equipment or asssistance is required at mealtimes (e.g. red mats, coloured napkins).

Referral Services

Dietitian	Date: / /	Outcome:
Speech and Language Therapy	Date: / /	Outcome:
Occupational Therapy	Date: / /	Outcome:
Dental Service	Date: / /	Outcome:

Multidisciplinary Nutrition Care Plan

Date	Overall Risk	Action	Review date	Name (PRINT) Signature/Designation
7/11/10	0	Reweigh in 1 week	7/12	[illegible]

Physiotherapy Walking Aid Issue Form

(Please refer to guidelines for completion)

NHS Greater Glasgow and Clyde

atient Details (label)

ame: Catherine Honeyman

ddress: 10 Melville St

ost code: G41 2LD Tel No: 0141 422 1580

OB / CHI No: 010296 6145

Walking Aid Details

Make: Coopers

Model/Code No: 8302c

Batch/Lot No:

Manufacturer Date:

Patient Weight: _____ (if applicable)

lking Aid(s) issued: Stick(s) ☐ Crutch(es) ☑ Zimmer ☐ Mobilator ☐ Delta ☐ 4 wheeled walker ☐

er: *(please state)* _____ New aid ☑ Recycled aid ☐

eck List	Y	N/A
he aid clean, in accordance with the recommended infection control procedure?	✓	
ll ferrules in good condition?	✓	
all wheels secure and able to rotate freely?		✓
there any dents / bends in the metal supports?		✓
there any splinters / cracks in wooden walking sticks?		✓
the aid been adjusted to the correct height?	✓	
ne legs and handles of correct height, aligned correctly and secured?		✓
ne brakes in good working order?		✓
ere appropriate has the patient been taught how to use the aid correctly		
- indoors	✓	
- outdoors / kerbs / slopes	✓	
- stairs	✓	
e patient safe to use the aid independently? co nts?	✓	
the appropriate walking aid leaflet been provided to the patient?	✓	

sion following issue of walking aid	Yes	No	N/A
harged	✓		
ysiotherapy ongoing?			✓
ther assessment / rehab required? If Yes please state service referred to:			✓
referral completed (if appropriate):			✓

aration:

firm the walking aid(s) provided to the above named is deemed safe and suitable at the date of issue.

Name: [illegible] Grade/Role: SW

ature: [signature] Date: 3/2/10

MIS 189331

NAME: CATHERINE HONEYMAN UNIT NO. SG0094077P

GENERAL COMMENTS

C+I: 0102496145

2

DATE & TIME	DAY NO	COMMENTS	SIGNATURE
29.12.10	DISCONT A	Pt's BETHANCHE GUIDE BAZAAR AT PRESENT ?	
		HER CC DUE TO MEDS. NOT LISTENING TO	
		INSTRUCTIONS VERY WELL ADVISED TO BLAZE PAIN	
		MIS TO MOBILISE	
	P	2/1 v MS ABLE PROGRESS MOBILITY CNT. ex's	A little sore
29.01.10	PT S.	Pt FOUND MOBILISING (I)'LY AROUND BAY.	
		ADVISED NOT TO OVER DO IT. P. 2/1 v MANE	A little sore
29/1/10. 2.45pm	OT	S: Pt attended self, reviewed role and attained consent for OT assist.	
		O: Pt found mobilising (I) around ward. PT (Rina Little) advised pt not to overdo it. Mobilised to toilet c WZF c close supervision. Toilet: pt not keen to attempt toilet t/f Rx as did not want to place hands on to toilet seat: OT advised that toilet t/f could be undertaken via OT desire if the preferred. But: Struggled to lift legs onto bed - required MOI to t/f legs onto bed.	
		A: for toilet t/f, OT Rx. and further bed t/f practice.	Pt declined Mattress discharge needed OT
		P: Continue OT Rx.	
30.1.10.	PT	S/ agreeable for Rx, uncomplaining.	
		O ROM (L) F 90° (R) F 80	
		E 0° E 0°	
		QUADS (R) static quads ✓ (L) st.q. ✓	
		SLR ✓ SLR ✓	
		IRQ ✓ IRQ ✓	
		o/t → stand (I)	
		mobile (I) c WZF	
		Rx · review of bed ex's	
		progressed to R FC' safe + (I) c some.	

MED ILL SCH: ORTHOPAEDICS: 161657250304

DATE & TIME	DAY NO	COMMENTS	SIGNATURE
29.01.10	POT S.	Pt TRYING TO GET OUT OF BED. NIS REPORT	
		Pt WOKE UP IN MIDDLE OF NIGHT TOOK COMPRESSION	
		BANDAGES OFF + STARTED APPLYING FAKE TAN +	
		MAKE-UP. ? HER NORMAL OR DUE TO CANCER.	
		CONSENT TO Rx. ROUTINE INSTRUCTION.	
	O	HIGH SITTING IN BED. PCA DISCONNECTED	
		OBS STABLE. CHEST CLEAR	
	Rx	~~BED EXS // KNEES/ANKLES // GOOD BILAT~~ (ERROR) FL	
		C: INTACT. BILAT. S: (L) DULL LAT REFLECT. (R) INTACT	
		M: ANKLE FULL BILAT. HIP/KNEE: RESTRICTED BILAT.	
		RESISTED DF/PF S/S. BILAT.	
	Rx	BED EXS 1. TOES/ANKLE BILAT // NO PROBLEMS	
		2. SG'S BILAT // GOOD CONTRACTION BILAT.	
		3. AROM: (R) 0 - 90° (L) 0 - 10° C/O PAIN	
		4. IRG (R) GOOD CONTROL °LACK (L) UNABLE	
		5. SLR (R) °LACK °LAG (L) UNABLE	
		// R's (L) LEG STARTED TO BLEED AFTER SG'S	
		UNABLE TO COMPT EXS C/O PAIN.	
	Rx	LTS: AM. SITTING: (R) 90° FLEXT (L) 40° FLEXT	
		STS // MANAGED WELL FROM RAISED BED REQUIRE	
		V.P FOR HAND POSITION	
	Rx	GAIT RE-ED 3M E WRF + AT.	
		// STEP-TO (L) FOR STEP HEIGHT. BILAT	
		SAFE E SUPT	FL EEE SGP

D ILL SCH. ORTHOPAEDICS.1.G1 65/250304

GENERAL COMMENTS

DATE & TIME	DAY NO	COMMENTS	SIGNATURE
30-1-10		A managing well, (L) knee locking +++ ∴	
cont		- rct taken to ward	
		P rtv tomorrow for stairs + d/c thereafter	
		NO f/up required.	RWatt - KWATSON GNR PT
30-1-10	OT	① Attempted to Ax pt c toilet & DAX. However pt was back on way to toilet so Ax abandoned.	
		② Independently mobile c E/C. States she struggles c both Dressing h/h & toilet t/f ∴ requires further OT Ax.	
		Ⓐ Unable to progress at present due to pts current issue c sickness	
		Ⓟ Try to see later. Lunch just arrived on ward and OT requires to travel over to see pts at VIC. ∴ Inform n/s if unable to see today and shall require Ax on Mon.	Jacqueline Bird
2/31/1/10 ~~31/10~~	PT	S/Consents to Ax/Rx. c/o LBP → long standing + tired today discussed LBP ? agg c qpt ↑bed time, reviewed - funds as able.	
		O/- STS Ⓘ E2xBC	
		- gait E2xBC - step to → two pattern, tends overstride - recip pattern → steady t/o except x1 → pF dorsiflexed	
		- knee AROM + quads FSA to yesterday + running.	Gemma Ramos Senior PT

GENERAL COMMENTS — NAME _____ UNIT NO. _____

DATE & TIME	NO	COMMENTS	SIGNATURE
31/1/10	PT	O/ steps c rail c/c → safety technique steady to	
		R/V ① upstairs - education c/c → steady to, encouragement + slow pace, don't overstride	
		② steps c 2 ft b x2 // good technique, prompts 1st time.	
		A/ safety c/c rail steps c 2 c/c's. safe for D/C, happy c plans	Emma Taylor (Senior PT)
		P/ D/C PT.	
1/2/2010 10.20 am	S:	Unable to attempt DPA and toilet t/f Rm. as pt reporting feeling nauseous and fatigued. Nursing staff reported that pt has c/o being constipated.	
	O:	Re-attempt later.	Michael Nettleton
	A:		Michael Nettleton (OT)
1/2/2010 2-30 pm	S:	Agreeable to attempt Rm. Feeling better now.	
	O:	Toilet t/f Rm: Managed c/o stiff c slight assist. Prompting given re. placing of hands to t/f on toilet. Managed physically - would benefit from further practice to improve confidence. Dressing Rm: Managed to doff and re-don trousers (E) (E) donning shoes.	
	A:	Benefit from further toilet t/f practice. Both t/f Rm as able. Progressing well.	Michael Nettleton
	P:	Continue c Rm.	Michael Nettleton (OT)
2/2/2010 10.30 am	S:	Attempted to conduct toilet t/f Rm, however unable as pt stated wound has been feeling tight and has been re-dressed. pt c/c pain ++ in both knees.	
	O:	O.T. advised N/S - advised that wound to be monitored and aim for	

DJE 01.02.2010

ILL SCH. ORTHOPAEDICS 16165/250304

NAME Cpt. Keane Wing Man. UNIT NO. 5 of 5 Pgs

GENERAL COMMENTS

DATE & TIME	DAY NO	COMMENTS	SIGNATURE
2/2/2010	O:	d/c Coumadin.	Melissa Mattes
2/2/2010	P:	Re-consult letter.	Melissa Mattes
2/2/2010		Consult faxed.	Melissa Mattes
3/2/2010	S:	Remarks & Pt Re: Pt reported feeling fatigued. Date & Time: Afternoon of Pt. Pt's vitals taken (A) Patient left the Infirmary Area Supervisor Pt's bedding in C.C.Q. upon d/c. Pt to wear shoes upon d/c.	
2-15 pm.	O:	Treatment: Pt's vitals within normal limits. Pt's wife picked up Pt. Pt to be discharged by Dr. Pt's name on d/c.	
	P:	d/c from ER.	Melissa Mattes

MED ILL SGH. ORTHOPAEDICS.16165/250984

Acute Services Division

Part 2 Discharge Letter / Transfer Plan

NHS Greater Glasgow and Clyde

- ☐ Glasgow Royal Infirmary 0141 211 4000
- ☐ Stobhill Hospital 0141 201 3000
- ☐ Western Infirmary 0141 211 2000
- ☑ Southern General Hospital 0141 201 1100
- ☐ Victoria Infirmary 0141 201 6000
- ☐ Mansionhouse Unit 0141 201 6101
- ☐ Gartnavel General Hospital 0141 211 3000
- ☐ Blawarthill Hospital 0141 211 9000
- ☐ Drumchapel Hospital 0141 211 6000
- ☐ Lightburn Hospital 0141 211 1500
- ☐ Vale of Leven Hospital 01389 754 121
- ☐ Royal Alexandra Hospital 887 9111
- ☐ Inverclyde Royal Hospital 01475 633777
- ☐ Other:

Name: CATHERINE HONEYMAN

Address: 16 MELVILLE STREET
GLASGOW. G41 2LN

Discharge Address: N/A

CHI number: 0103461645

Unit number: 0094077 D.O.B. 1/2/1945

Telephone:

Next of kin: Raymond Honeyman

Relationship: S/A

Address:

Telephone:

Ward: 6

Telephone: 0141/ 2011 1641

Admission date: 27/ 1/ 10

Final discharge/transfer date: 3/ 2/ 10

Named Nurse: C. SLOWEY.

Consultant: MR HALLIN

G.P.: DR MARSHALL

Address: GORBALS HEALTH
CENTRE

Telephone: 531 8250

Post Discharge Services Arranged (e.g. District Nurse, CPN, Day Hospital, Home Care)
State package requested and time of first visit.

Service: D/N	Service:
Contact number:	Contact number:
Service details:	Service details:

Additional/Transfer Information (including equipment/adaptions)

Patient Assessment/Comments

Mobility: ELBOW CRUTCHES

Personal hygiene/Dressing: INDEPENDANT.

Continence: Catheter in situ: Yes ☐ No ☑
Type: Size:
Date of change:

Continence details: CONTINENT.

Dietary requirements: NORMAL DIET

Communication / Swallowing: NO PROBLEM.

Mental state: ALERT ORIENTATED

Skin condition/Waterlow Score: LOW RISK

Wound care/Stoma care: SLC sutures

Aquacel + opsite (L) (R) Knee - opsite

Special Instructions for Patient (e.g. Exercise, Diet, Wounds, Others)

Others/Follow-up arrangements

10 days

Progress discussed with patient: Yes ☑ No ☐

Progress discussed with relative/carer: Yes ☐ No ☐

This information has been fully discussed with Patient/Carer.

Date and signature of Nurse: Yourcare

Date and signature of Patient/Carer:

Diagnosis:

(L) KNEE REPLACEMENT

(R) KNEE PATELLA RESURFACE.

28-1-10

Acute Services Division

Disch[redacted]

NHS Greater Glasgow and Clyde

Patient's na[redacted]

Unit numb SG00940779
CATHERINE HONEYMAN
CHI numbe 10 MELVILLE STREET
GLASGOW 01/02/1949
G41 2LN CHI 0102496145

Ward: 6

Discharge destination: Home

Estimated Discharge Date (1) 1/12/10.

Estimated Discharge Date (2) 2/[illegible]/10

Final date of discharge : 3/12/10

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓		YL	
Relative/carer informed	✓		YL	
Others informed: Care Home		—		
Transport arranged				
Own transport (preferred option)	✓		YL	Daughter collected.
Ambulance-1 man/ 2 man am/pm		—		
Other: Flight, Air ambulance etc.		—		
Discharge medication				
Discharge prescription completed	✓		YL	
Compliance aids e.g. Dossette Box (involve pharmacist)		—		
Medication received	✓		YL	
Medication explained to patient and/or relative/carer	✓		YL	
Own medication returned to patient	✓		YL	
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)	✓		YL	aquacel, opsite.
Informed of discharge				
Social work/ Other agencies/Home help		—		
Physiotherapist		—		
Occupational Therapist		—		
Dietician		—		
Speech and Language Therapist		—		
Clinical Nurse specialist e.g. Care Home Liaison		—		
Liaison/ District Nurse/ Practice Nurse	✓		YL	for wound dressing.
Other discharge items				
Access arrangements (e.g. keys, door entry)	✓		YL	
Patients clothing available for day of discharge	✓		YL	
Valuables e.g. cashier		—		
Intravenous cannula removed	✓		YL	
Equipment ordered (inc. walking aids) in place for discharge	✓		YL	
Part 2 Discharge letter - Required	✓		YL	
- Completed	✓		YL	
Out patient clinic appointment e.g. Anticoagulation clinic				
Arranged / To follow				6/7 mr Hullins clinic or next friday.
If unknown at time of discharge state reason				
Additional information / leaflets / factsheets				

Time of Discharge: 1600

Nurse's signature: Y Lovelace — Designation S/N — Date: 3/12/10

FORM NUMBER 0005752

Nurse/Midwife Administration by Protocol - Authorised Nurses/Midwives Only

(Maximum number of doses as per protocol)

Warning: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed by a doctor.

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the nurse/midwife administration protocol No.(s) ..... with the following exceptions: _____

Signature: _____ Date: _____

DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF NURSE	GIVEN BY	TIME GIVEN

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).
2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).
3. Sign your full name clearly against each prescription entry.
4. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes.
5. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.
6. The following metric unit abbreviations must be used –

Milligram = mg — Gram = g
Millilitre = ml — Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

7. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - Intrathecal must be written in full.

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.
2. Insert initials in the relevant date column and time row each time a drug is administered.
3. Check that all drugs prescribed at a certain time have been administered.
4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

(3) Patient refused
(4) Drug not available
(5) Nil by mouth/fasting
(6) Patient unavailable
(7) Patient asleep
(8) Time varied on doctor's instructions
(9) Dose withheld on doctor's instructions
(10) Nausea/vomiting
(11) Unable to swallow
(12) No intravenous access
(13) Patient Self-Administration of Medicine
(14) Other - Record in nursing notes
(15) Prescription clarification required

Cat No.00548 Ver 8, 01/2009

PRESCRIPTION FORM

Hospital Name: .....

PATIENT DETAILS

SG00940779
CATHERINE HONEYMAN
10 MELVILLE STREET
GLASGOW
G4 N CHI 0102496145
01/02/1949

Height: 1.53
Weight: 93.6
Surface area:
Date of writing discharge prescription: __/__/__
Ward: Six.

Date of Admission: 27/1/10
Consultant Name: Hullin

Date and time this form prepared: 5/1/10 Time: 11[00]
Sheet No 1
2nd Prescription in use Yes or NO

DRUG SENSITIVITIES

none known

VT Risk on Admission (SIGN Guideline)
High ☒ Moderate ☐ Low ☐
Assessed by: H+I Date: 15/1/10

OTHER CHARTS IN USE

Insulin ☐
PCA and other infusions ☒
Anticoagulants: Heparin ☐ Oral ☐
Topical: ☐
TPN: ☐
Enteral Nutrition: ☐
Oxygen Therapy: ☐
Other:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF PRESCRIBER	GIVEN BY	TIME GIVEN
28.1.10	ATENELOL	25mg	O	0830	HoolieHosie	CAWright	0810
28.1.10	OMEPRAZOLE	20mg	O	0830	HoolieHosie	CAWright	0810
28.1.10	LORAZEPAM with 10ml water.	2mg	O	TDP	HoolieHosie	CAWright	0810
28.1.10	TEA AND TOAST	150ml	O	0830	HoolieHosie	NOT GIVEN	CAWright
28.1.10	PARACETAMOL	1g	O/IV	Recovery	HoolieHosie	LW	1730
28.1.10	FENTANYL by algorithm	Hourly	IV	Recovery	HoolieHosie		
28.1.10	DIAZEPAM	10mg	IV	Recovery	HoolieHosie	LW	12[00]

PATIENT'S NAME: Catherine HONEYMAN

Parenteral Drugs: Regular Prescription

ADMINISTRATION

DATE → 28 29 30 31 1 2
MONTH → 1 1 1 1 12 2

A DRUG: CLEXANE
DOSE: 40mg | ROUTE: S/C | DATE: 0/A | STOPPED DATE:
SIGNATURE OF PRESCRIBER: [signature] | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800 ✓ PSW OK TAKEN
2200-2400
Other time

B DRUG: MORPHINE
DOSE: 1mg/ml | ROUTE: IV | DATE: 28-1-10 | STOPPED DATE:
SIGNATURE OF PRESCRIBER: Heather Hosie | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: see PCA chart
FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

C DRUG
DOSE | ROUTE | DATE | STOPPED DATE:
SIGNATURE OF PRESCRIBER | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

D DRUG
DOSE | ROUTE | DATE | STOPPED DATE:
SIGNATURE OF PRESCRIBER | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

E DRUG
DOSE | ROUTE | DATE | STOPPED DATE:
SIGNATURE OF PRESCRIBER | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

F DRUG
DOSE | ROUTE | DATE | STOPPED DATE:
SIGNATURE OF PRESCRIBER | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

G DRUG
DOSE | ROUTE | DATE | STOPPED DATE:
SIGNATURE OF PRESCRIBER | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

H DRUG
DOSE | ROUTE | DATE | STOPPED DATE:
SIGNATURE OF PRESCRIBER | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

Note: To discontinue a prescription, initial and date appropriat... and draw a diagonal line through...

This Regular Drug Prescription is required by law to ensure that all medicines are prescribed correctly and that unintentional omission or double dosing is avoided.

PATIENT'S NAME: Catherine HONEYMAN

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE: 27 28 29 30 31 1 2 3
MONTH: 1 1 1 1 1 2 2 2

J DRUG: BENDROFLUMETHIAZIDE
DOSE: 2.5mg | ROUTE: PO | DATE: 0/A | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER: MLyD
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY
Other time / 0700-0900 ✓ / 1200-1400 / 1600-1800 / 2200-2400 / Other time
0700-0900: 9 AD MK MK MK MK

K DRUG: ASPIRIN
DOSE: 75mg | ROUTE: PO | DATE: 0/A | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER: MLyD
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: omit while on diclofenac
FOR PRESCRIBERS USE ONLY
Other time / 0700-0900 ✓ / 1200-1400 / 1600-1800 / 2200-2400 / Other time
0700-0900: 9 AD MK MK MK MK

L DRUG: SIMVASTATIN
DOSE: 40mg | ROUTE: PO | DATE: 0/A | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER: MLyD
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY
Other time / 0700-0900 / 1200-1400 / 1600-1800 / 2200-2400 ✓ / Other time
2200-2400: MK AK NA NA CF

M DRUG: ATENOLOL
DOSE: 25mg | ROUTE: PO | DATE: 0/A | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER: MLyD
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY
Other time / 0700-0900 ✓ / 1200-1400 / 1600-1800 / 2200-2400 / Other time
0700-0900: AD AD MK MK MK MK MK

Oral and Other Drugs: Regular Prescriptions

DATE: 28 29 30 31 1 2 3
MONTH: 1 1 1 1 2 2 2

N DRUG: FLUOXETINE
DOSE: 20mg | ROUTE: PO | DATE: 0/A | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER: MLyD
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY
Other time / 0700-0900 ✓ / 1200-1400 / 1600-1800 / 2200-2400 / Other time
0700-0900: 9 AD MK MK MK MK MK

P DRUG: OMEPRAZOLE
DOSE: 20mg | ROUTE: PO | DATE: 0/A | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER: MLyD
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY
Other time / 0700-0900 ✓ / 1200-1400 / 1600-1800 / 2200-2400 / Other time
0700-0900: AD AD MK MK MK MK MK

R DRUG: ~~OXYCODONE~~ OXYCONTIN
DOSE: 20mg | ROUTE: O | DATE: 29.1.10 | STOPPED DATE: 30.1.10 | INITIALS: CF
SIGNATURE OF PRESCRIBER: Hollie Hosie
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: Review on 1.2.10
FOR PRESCRIBERS USE ONLY
Other time / 0700-0900 ✓ / 1200-1400 / 1600-1800 ✓ / 2200-2400 / Other time
0700-0900: AD
1600-1800: 25

S DRUG: PARACETAMOL
DOSE: 1g | ROUTE: O | DATE: 28.1.10 | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER: Hollie Hosie
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY
Other time / 0700-0900 ✓ / 1200-1400 ✓ / 1600-1800 / 2200-2400 / Other time
0700-0900: AD MK MK MK MK MK
1200-1400: IW AK MK MK MK MK MK
1600-1800: CW CW MK MK MK MK
2200-2400: MK SK NA NA CF

Note: To discontinue a prescription, initial and date appropriate boxes and draw a diagonal line through section

Please check the prescription and administration record at each administration round to ensure that inadvertent omission or double dosing is avoided.

PATIENT'S NAME: Catherine HONEYMAN

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE / MONTH

T DRUG: DICLOFENAC
DOSE: 50mg | ROUTE: O | DATE: 28.1.10 | STOPPED DATE: 2/2/10
SIGNATURE OF PRESCRIBER: Hooton Hosie | INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: Post op with food
FOR PRESCRIBERS USE ONLY

V DRUG: Lactulose
DOSE: 10mls | ROUTE: O | DATE: 30/1/10 | STOPPED DATE:
SIGNATURE OF PRESCRIBER: HMCCrorie | INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
FOR PRESCRIBERS USE ONLY

W DRUG: SENNA
DOSE: 2 TABS | ROUTE: O | DATE: 30/1/10 | STOPPED DATE:
SIGNATURE OF PRESCRIBER: HMCCrorie | INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
FOR PRESCRIBERS USE ONLY

X DRUG: OXYCONTIN
DOSE: 10mg | ROUTE: O | DATE: 30/1/10 | STOPPED DATE: 1/4/10
SIGNATURE OF PRESCRIBER: | INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
FOR PRESCRIBERS USE ONLY

Oral and Other Drugs: Regular Prescriptions

DATE / MONTH

Y DRUG: TRIMETHOPRIM
DOSE: 200mg | ROUTE: O | DATE: 30/1/10 | STOPPED DATE:
SIGNATURE OF PRESCRIBER: | INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
FOR PRESCRIBERS USE ONLY

AA DRUG: MOVICOL
DOSE: 1 SACHET | ROUTE: O | DATE: 30/1/10 | STOPPED DATE:
SIGNATURE OF PRESCRIBER: HMCCrorie | INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
FOR PRESCRIBERS USE ONLY

BB DRUG: LACTULOSE
DOSE: 10ml | ROUTE: oral | DATE: 1/2/10 | STOPPED DATE:
SIGNATURE OF PRESCRIBER: | INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
FOR PRESCRIBERS USE ONLY

CC DRUG: TRAMADOL
DOSE: 50mg | ROUTE: O | DATE: 1/2/10 | STOPPED DATE:
SIGNATURE OF PRESCRIBER: | INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
FOR PRESCRIBERS USE ONLY

Note: To discontinue a prescription, initial and date appropriate boxes and draw a diagonal line through section

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

GTN SPRAY

DOSE	ROUTE	INDICATION	STOPPED	INITIALS:
2 puffs	SL	ANGINA		
SIGNATURE OF PRESCRIBER	MAX.FREQUENCY		DATE:	
	PRN		8/11	

TIME

DOSE

GIVEN BY

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE →

MONTH →

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

Oral and Other Drugs: Regular Prescriptions

DATE →

MONTH →

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

LL DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Note: To discontinue a prescription, initial and [illegible] boxes and draw a diagonal line through section

SOUTHERN GENERAL HOSPITAL

DEPARTMENT: Orthopaedics

NAME Catherine Honeyman UNIT NO. WARD:

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
6/5/10	03:30	Admitted to ward via A+E presenting with a swollen and painful (R) knee. Fasting for ? theatre. Observations stable as charted. Wound swabbed in A+E. Wound leaking ++	M Travis RGN
	Cont	Commenced on IVAB	J. King (S)
6/5/10	1915	Wound leaking ++. Dressed with wound pads and mepore. Fasted till lunch, Mr Martin reviewed patient expressed haematoma from wound. Remained fasting and reviewed by Mr Martin at evening meal and no longer fasting. Tolerated dinner. IVAB continues. Required senexdal twice today. Observations stable. Wound remains swollen and red	J Adams
7/5/10	0600	Continues on IVAB. Venflon rested, not had settled night. Sats's O. wound continue to leek +++, no complaints appeard.	(S) J. King
	16:00	Seen by Mr Martin, fasting discontinued Please fast overnight for ? theatre tomorrow. Continued on IV ABS	Skmk Adams
		Wound swabbed and redressed several times with wound pads and opsites. Observations stables	J Adams (S)
8/5/10	06:00	Patient has slept very little overnight. Refused to go to bed last night choosing to try and sleep in armchair. Dressing to right knee remains dry and intact. Analgesia and IV antibiotics given as prescribed. Fasting from midnight for ? theatre today.	M Rose
8/5/10	11:00 W/C	Reviewed by MR meek Plan is to continue on IVAB's and daily check CRP and progress. No need to fast meantime.	Meek (S)

0369438-SGH 306A

SOUTHERN GENERAL HOSPITAL

DEPARTMENT: Orthopaedics

NAME: Cathrin Maregmen. UNIT NO. WARD: One

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
3/5/10		Wound leaking ++. Wound pads and opsite x 3 to cover. New verflan requested	Mark. SW (6)
4/5/10	0630	Settled and slept well. IV antibiotics and medication given as prescribed. Patient mobilised to toilet x 2 overnight using elbow crutches.	Hope (5)
	1600	Independent with her personal hygiene. Eating + drinking well. Mobile with 2 EC indep. Seen by Mr Meek who advised to continue with the same treatment. Leakage less now. Continues on IVAB.	Kelly
		Wound still leaking. Wound Changed + wound pad + opsite applied.	Kelly
3/5/10	0600	Finally settled to bed at around 3.30 am. Sevredol 10mg given x 2 for pain. Mobilising using elbow crutches. IV antibiotics given as prescribed.	Hope (5)
	1445	PS/B Mr Meek and Mr Martin (E) knee wound redressed with wound pads and opsite. Bliste noted to (R) forefoot. which remains intact at present. Bloods checked today. For referral to pain team. No growth shown in (E) knee swab. Patient refused wash and mobilise.	Steve P S/N.
5/5/10	0630	Fairly Settled evening. Sevredol given with good effect. Slept very little IVAB's continue as charted. Wound intact overnight. Using commode overnight.	Mark
	10AM	Physiotherapy Review: Pt (I) mobile c 2 Elbow crutches on ward level. ⇒ No Physiotherapy intervention required @ present. (R) A/V on stairs prior to D/C.	(SCPT) DAVIS BOYLE.

SOUTHERN GENERAL HOSPITAL

DEPARTMENT: Orthopaedics

NAME: CATHERINE HONEYMAN UNIT NO. S9009460779 WARD: one

DATE	PROB. NO	NURSING NOTES/EVALUATION	SIGNATURE
11/5/10	14[30]	Independent with hygiene needs. Continues on IVABS until Thurs. Mobilising with elbow crutches will require stair practice prior to discharge. right knee dressing is stained by remains intact Observations stable as charted. No complaints expressed.	Olawop S/N
12/5/10	0500	Patient showered independently last night. Ventlon pt out - rested at 0800 - pt on HAN at 2130. IVABS given as prescribed following the dressing to R knee renewed following shower - aquand pads and opsite. Wound remains swollen, erythemic with moderate serous exudate volumes. Patient has requested sevredol for breakthrough pain x 1 over night. Passing urine on commode overnight. Patient slightly tachycardic at 2200 - 104. Patient complaining of pain at time. Will review @ 0600	SNHeeg
0645		Obs stable this am. SEWS 0; FS Pube 76	SNHeeg
	1900	Independent with her personal hygiene. Eating + drinking well. Obs satisfactory. Mobile with FC indep. Reviewed at ward round, adv to continue IVAB till Friday when shall be reviewed + maybe changed to oral then discharge. Wound redressed with wound pads + opsite	Help
13/5/10	06[00]	Settled and slept well. IV antibiotics given as prescribed. Mobilising with elbow crutches. Analgesia given as prescribed.	MRee
13/5/10		Independent with hygiene needs. Mobilising around ward with crutches.	Cout

0369438-SGH 306A

SOUTHERN GENERAL HOSPITAL

DEPARTMENT: Orthopaedics

NAME: Catherine Traynor UNIT NO. S4009407T9 WARD: ward

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
13/5/10		WR – To go on to oral antibiotics today and home tomorrow if bloods improving – then return to Mr Hullins' clinic next week.	[illegible] SN
14/5/10	0600	Settled and slept well. Mobilising well using elbow crutches. Medication given as prescribed. Offering no complaints	[illegible] SN
	10am	Physiotherapy: Pt (I) mobile ± 2E/C on ward level + stairs ⇒ °Physiotherapy/mobility issues post i.v. D/C	[illegible] SPT Maria Boyle
14/5/10	1900	Reviewed by Mr Hullin. Plan is for discharge D home today on oral antib's for discharge. OPA 1/52 Mr Hullins clinic. District nurse referral made for R/O Sutures and wound check.	[illegible]

SOUTHERN GENERAL HOSPITAL

INVESTIGATION INSTRUCTION SHEET

NAME: Catherine Honeyman UNIT NO: WARD:

DATE		DATE	INITIALS
19/5/10	(R) knee wound swab - NO GROWTH		CS

DATE		DATE		DATE		DATE		DATE		DATE	

0369451-SGH307

NHS
Greater Glasgow and Clyde

NATVNS
SCOTLAND

WRITE, IMPRINT OR ATTACH LABEL
Surname Honeyman CHI No .....
Forenames Catherine Sex F
DoB .....
Location .....

ADAPTED WATERLOW PRESSURE AREA RISK ASSESSMENT CHART

More than one score/category can be used: **10+= 'At Risk': 15+= 'High Risk': 20+= 'Very High Risk'**
Complete assessment on admission/1st visit, if there is a change in individuals condition and repeat regularly according to local protocol

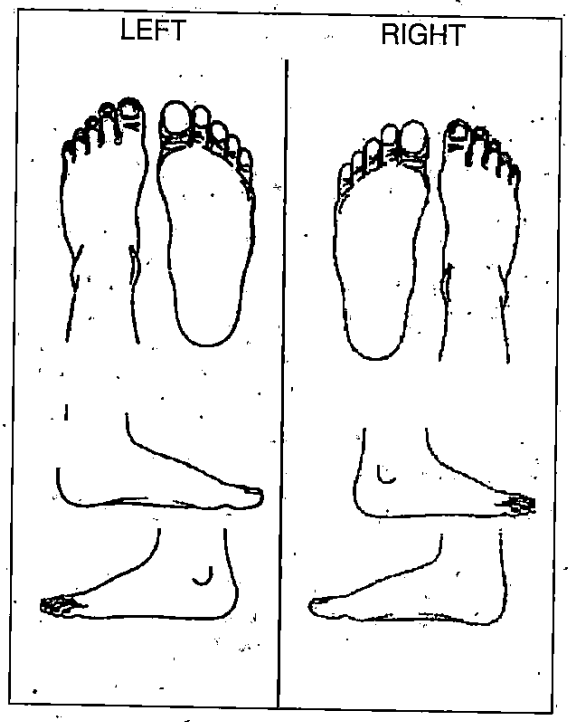
Sex										
Male	1									
Female	2	2	2	2						
Age										
14 -49	1									
50 -64	2	2	2	2						
65 - 74	3									
75 - 80	4									
81+	5									
Build/Weight for Height (BMI=weight in Kg/height in m²)										
Average - BMI 20-24.9	0	0	0	0						
Above average - BMI 25-29.9	1									
Obese - BMI > 30	2									
Below average - BMI < 20	3									
Continence										
Complete/catheterised	0	0	0	0						
Incontinent urine	1									
Incontinent faeces	2									
Doubly incontinent (urine & faeces)	3									
Skin Type - Visual Risks Area										
Healthy	0	0	0	0						
Tissue paper (thin/fragile)	1									
Dry (appears flaky)	1									
Oedematous (puffy)	1									
Clammy (moist to touch)/pyrexia	1									
Discoloured (bruising/mottled)	2									
Broken (established ulcer)	3									
Mobility										
Fully mobile	0		0	0						
Restless/fidgety	1									
Apathetic (sedated/depressed/reluctant to move)	2									
Restricted (restricted by sever pain or disease)	3	3								
Bedbound (unconscious/unable to change position/traction)	4									
Chairbound (unable to leave chair without assistance)	5									
Nutritional Element										
Unplanned weight loss in past 3-6 months		0	0	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 Score **2**	0-2									
Patient acutely ill or no nutritional intake > 5 days	2									
Special Risks - Tissue Malnutrition										
Multiple organ failure/terminal cachexia	8									
Single organ failure e.g. cardiac, renal, respiratory	5									
Peripheral vascular disease	5									
Anaemia = Hb < 8	2									
Smoking	1	0	0	0						
Special Risks - Neurological Deficit										
Diabetes/MS/CVA/motor/sensory/paraplegia *Max 6*	4-6	0	0	0						
Special Risks - Surgery/Trauma										
On table > 6 hours	8									
Orthopaedic/below waist/spinal (up to 48 hours post op)	5									
On table > 2 hours (up to 48 hours post op)	5		0	0						
Special Risks - Medication										
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*	4		0	0						
Total Score			2	4						
Date			7/5	11/5						
Initials		(7)	NA	SS						
Time			1130	12						

83826

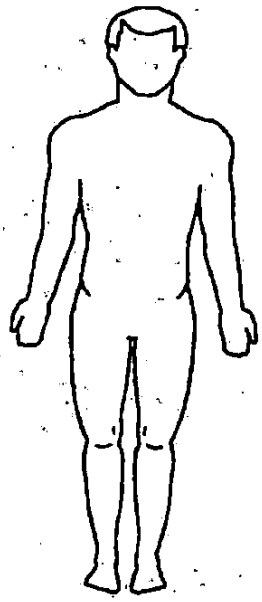
Ensure plan of care is implemented / reviewed for all identified areas of concern.

PRESSURE ULCER RECORD

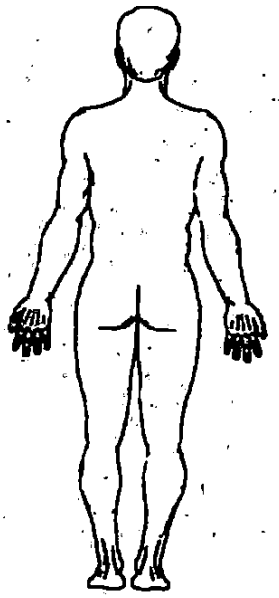
Indicate by circling and numbering all pressure damage on diagrams, then complete box below. Indicate care plan/wound assessment chart.



Anterior view



Posterior view



SCOTTISH ADAPTED EPUAP PRESSURE ULCER GRADING TOOL

GRADE 1 Non-blanchable erythema of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness may also be used as indicators, particularly on individuals with darker skin.

GRADE 2 Partial thickness skin loss involving epidermis, dermis or both. The ulcer is superficial and presents clinically as an abrasion or blister.

DE 3 Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia.

GRADE 4 Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss.

DATE	NUMBER OF ULCER(S)	LOCATION OF ULCER(S)	GRADE OF ULCER(S)	LOCATION OF ULCER(S)

Pressure Ulcers may deteriorate from Grade 1 to Grade 4, but can not be reversed and should be documented as a healing grade of pressure ulcer, eg healing grade 4.

Cannard Falls Risk Assessment

Glossary of terms used in risk assessment

SIGHT DEFICIT means patient cannot see well even when wearing glasses or is registered blind.

HEARING DEFICIT means person has hearing problems even with a hearing aid or has hearing problems and does not wear a hearing aid.

BALANCE DEFICIT means person is unable to stand without the support of another person or a walking frame.

MEDICINES FOR SOME MENTAL ILLNESSES include Chlorpromazine (Largactil), Risperidone (Risperdal), Lithium (Camcolit or Priadel), Haloperidol, Chloral hydrate (Welldorm), Clomethiazole (Heminevin), antidepressants.

BLOOD PRESSURE TABLETS include Captopril, atenolol and many others.

WATER TABLETS (DIURETICS) are such as Bendroflumethiazide, Furosemide and Co-amilofruse.

SLEEPING TABLETS include medicines such as Diazepam, Temazepam, Nitrazepam, Chlordiazepoxide and Zopiclone (Zimovane).

INABILITY TO CO-OPERATE includes failure to use walking aids or putting themselves in situations with a high risk of falling (usually due to mental impairment).

RESTRICTED MOBILITY means the person requires supervision and/or help to walk (i.e. is not safe to walk alone even with an aid.

HESITANT IN INITIATING MOVEMENT means difficulty in starting to walk.

POOR TRANSFER means the person requires help and is not safe to do the following alone - get in or out of bed, on or off a chair, move from chair to standing.

Acute Services Division

Hospital / Department

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

Patient name: Catherine Honeyman

Ward: 1

CHI number: ..... Unit/Hospital number .....

Contents

1. Canard Falls Risk Assessment Scoring Form
2. Falls Assessment Care Plan
3. Glossary of terms used in risk assessment

Notes: Risk assessment should be completed within 24 hours of admission.

Assessment Wards: Risk assessment and care plan should be reviewed weekly.

Continuing Care Wards: Mobile and 'at risk' patients should have risk assessment and care plan reviewed monthly.

Cannard Falls Risk Assessment

(Must be completed within 24 hours)

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						DATE 6/5/10	DATE	DATE	DATE	DATE	DATE	DATE
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			0.						
Sex	Male 1	Female 2				2.						
Age	60-70 (1)	71-80 2	81+ 1			1.						
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None (0)		0.						
Medication type **	Drugs for mental illness 1	Blood pressure / water tablets (1)	Sleeping tablets 1	None of these 0		1.						
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	0.						
Mobility	Fully mobile 1	Uses aids (2)	Restricted* 3	Bed bound 1		2.						
Gait	Steady 1	Hesitant in initiating movement* (1)	Poor transfer* 3	Unsteady 3		1						
				TOTAL SCORE		7						
				ACTION(S) TAKEN Enter action code(s)		(1)						
SCORE 2 - 8 = LOW, 9 - 12 = MEDIUM, 13+ = HIGH RISK				NURSE SIGNATURE		KE						

** If you are in any doubt about whether a person's medicine belongs to one of the types listed ask the person or carer or please phone the number on the medicine container and ask the community or hospital pharmacist.

* Please see back page for clarification

Falls Assessment Care Plan

Please tick all applicable nursing interventions

tion code	NURSING INTERVENTIONS	DATE 6/5	DATE	DATE	DATE	DATE	DATE	DATE
	LOW, MODERATE AND HIGH RISK							
1	Prevention and general safety precautions discussed with patient and family.	KE						
	MODERATE AND HIGH RISK							
2	Move to more observable area of ward to optimise supervision.							
3	Refer to Physiotherapist.							
4	Refer to Occupational Therapist.							
5	Patient requires footwear or podiatry referral. (Date referred:)							
6	Commence continence assessment							
7	Monitor lying and standing BP and pulse.							
8	Request medication review.							
9	Select suitable seating (refer to policy).							
10	Non-slip mat on chair/floor following advice of OT.							
11	Bed rails/bumpers to be used (refer to policy).							
12	Falls map in use for seven days.							
13	Bed/chair monitor in use.							
14	If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.							
15	Patient to be nursed on mattress on the floor (refer to policy.)							
16	Patient requires one to one nursing care.							
17	Other interventions.							
	HIGH RISK ONLY (Score of 13 or over)							
18	Provide hip protectors to patients being discharged to care homes/longterm NHS facilities							
	SIGNATURE							

Review Cannard score weekly / monthly as per policy.

Enter action code(s) selected in action taken section on Falls Risk Assessment.

Acute Services Division

Part 2 Discharge Letter / Transfer Plan

NHS Greater Glasgow and Clyde

- ☐ Glasgow Royal Infirmary 0141 211 4000
- ☐ Stobhill Hospital 0141 201 3000
- ☐ Western Infirmary 0141 211 2000
- ☑ Southern General Hospital 0141 201 1100
- ☐ Victoria Infirmary 0141 201 6000
- ☐ Mansionhouse Unit 0141 201 6101
- ☐ Gartnavel General Hospital 0141 211 3000
- ☐ Blawarthill Hospital 0141 211 9000
- ☐ Drumchapel Hospital 0141 211 6000
- ☐ Lightburn Hospital 0141 211 1500
- ☐ Vale of Leven Hospital 01389 754 121
- ☐ Royal Alexandra Hospital 887 9111
- ☐ Inverclyde Royal Hospital 01475 633777
- ☐ Other:

Name: Catherine Honeyman

Address: 10 Melville Street
Glasgow, G41 2LN

Discharge Address:

CHI number:

Unit number: 940779 D.O.B. 1/2/49

Telephone:

Next of kin: Raymond Honeyman

Relationship: Husband

Address:

Telephone: 0788 7621326

Ward: one

Telephone: 0141/201 1163 1

Admission date: 6/5/10

Final discharge/transfer date: 14/5/10

Named Nurse: S.N. Clarkson

Consultant: Mr. Hullin

G.P.: Dr Morrice

Address:

Telephone:

Post Discharge Services Arranged (e.g. District Nurse, CPN, Day Hospital, Home Care)
State package requested and time of first visit.

Service: 53/8250	Service: Wound check
Contact number: 53/8210	Contact number: Staples on 18th
Service details:	Service details:

Additional/Transfer Information (including equipment/adaptions)

HTN
Depression
GORD
OA

Patient Assessment/Comments

Mobility: [illegible]

Personal hygiene/Dressing: Independant

Continence: Catheter in situ: Yes ☐ No ☐
Type: Size:
Date of change:

Continence details: Intact

Dietary requirements: Normal

Communication / Swallowing: No Problems

Mental state: Lucid

Skin condition/Waterlow Score:
(R) knee wound. Swollen Red. Small area discharge.

Wound care/Stoma care: STAPLES TO KNEE FOR REMOVAL 18th MAY
Opsite to wound on knee. Mepore to (R) foot blister

Special Instructions for Patient (e.g. Exercise , Diet, Wounds, Others)

Wound check please 16th MAY
R/O Staples from knee (R) on 18th
Opsite dressing

Mepore dressing to (R) forefoot blister.

Others/Follow-up arrangements

Wound check please 16/5/10
AS ABOVE
OPA MR NULLINS CLINIC 21/5/10

Progress discussed with patient: Yes ☐ No ☐
Progress discussed with relative/carer: Yes ☐ No ☐

This information has been fully discussed with Patient/Carer.
Date and signature of Nurse: [signature]

Date and signature of Patient/Carer:

Diagnosis:
R Patella
Repair
4/5/10

TOP COPY TO - Patient; OTHER COPIES TO - G.P.; District Nurse; Case Notes

SURGICAL DIRECTORATES: PATIENT CARE PLAN

NAME: Catherine Honeyman UNIT NO:

D.O.B: WARD: 1 DATE OF ADMISSION:

ate Commenced Signature	PERSONAL HYGIENE/DRESSING	Tick	Date Discontinued & Signature
KE 6/5	Independent		
	Bedbath		
	Shower		
	Immersion Bath		
	Basin		
	Assistance Required: No of Staff:		
	Oral Hygiene: Independent Assistance Required:		
	MOBILISATION		
	Independent		
	Assistance Required: No of Staff:		
KE 6/5	Aids Used: Walking Stick: x 2		
	Zimmer:		
	Elbow Crutches:		
	Wheelchair:		
	Other:		
	EATING & DRINKING		
	Normal Diet:		
	Special Diet:		
	Light Diet:		
	Assistance to Eat & Drink:		
	Fluids Only:		
	Dietary Supplements:		
	Parental/Entral Nutrition:		
	Nasogastric Tube:		
KE 6/5	Fasting: From: 12 MN 6/5/10 To:		
	Light Early Breakfast: Time:		
	ELIMINATIONS		
KE 6/5	Independent:		
	Assistance to Toilet: No of Staff:		
	Urinary Catheter:		
	Suprapubic Catheter:		
	Ileal Conduit:		
	Colostomy:		

e Commenced ignature	SPECIAL NEEDS/MAINTAIN PERSONAL SAFETY	Tick	Date Discontinued & Signature
	Cotsides:		
	Visually Impaired: Removal Hazards		
	TECHNICAL CARE		
KE 6/5	Venflon Insitu: Green (R) hand		
	IV Infusion:		
	Check Site:		
	Subcutaneous Cannula Insitu:		
	Oxygen: Mask:		
	Rate:		
	Length of Time:		
	OBSERVATIONS		
KE	BP: 4°		
KE	Pulse: 4°		
KE	Temperature: 4°		
KE	Saturations: 4°		
	Fluid Balance:		
	Glucose Monitoring:		
	C.S.M. (Fingers: R L) (Toes R L)		
	Vascular Observations:		
	Stool Chart:		
	PAR Scoring:		
	Head Injury Observations:		
	WOUND CARE/OTHER CARE		
	Pressure Area Care:		
	Check: Hourly		
	Pressure Cushion:		
	Therapy Mattress:		
	Avant Guard Bed:		
	Wound Assessment Chart:		
	PAIN ASSESSMENT CHART		
	Patient Moving & Handling Risk Assessment		
	MISCELLANEOUS		
	Ted Stockings: Size:		

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

Patient's name: Catherine Honeyman	Ward: one
Unit number: 940799	Discharge destination: Home
CHI number:	Estimated Discharge Date (1) 14/5/10
	Estimated Discharge Date (2) / /
Apply addressograph label	Final date of discharge : / /

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓		ek	
Relative/carer informed		✓		
Others informed: Care Home		✓		
Transport arranged				
Own transport (preferred option)	✓		ek	
Ambulance-1 man/ 2 man am/pm				
Other: Flight, Air ambulance etc.				
Discharge medication				
Discharge prescription completed	✓		ek	
Compliance aids e.g. Dossette Box (involve pharmacist)		✓		
Medication received		✓		
Medication explained to patient and/or relative/carer		✓		
Own medication returned to patient		✓		
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)		✓		
Informed of discharge				
Social work/ Other agencies/Home help		✓		
Physiotherapist		✓		
Occupational Therapist		✓		
Dietician		✓		
Speech and Language Therapist		✓		
Clinical Nurse specialist e.g. Care Home Liaison		✓		
~~Liaison~~/ District Nurse/~~Practice Nurse~~	✓		ek	
Other discharge items				
Access arrangements (e.g. keys, door entry)		✓		
Patients clothing available for day of discharge		✓		
Valuables e.g. cashier		✓		
Intravenous cannula removed		✓		
Equipment ordered (inc. walking aids) in place for discharge		✓		
Part 2 Discharge letter - Required		✓		
- Completed	✓		ek	
Out patient clinic appointment e.g. Anticoagulation clinic				
~~Arranged~~ / ~~To follow~~	✓		ek	1/52 Fridays MR Hallida
If unknown at time of discharge state reason				
Additional information / leaflets / factsheets				

Time of Discharge: 17:00		
Nurse's signature: C Ralston	Designation: Staff Nurse	Date: 14/5/10

Nurse/Midwife Administration by Protocol - Authorised Nurses/Midwives Only

(Maximum number of doses as per protocol)

Warning: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed by a doctor.

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the nurse/midwife administration protocol No.(s) ..... with the following exceptions: _____

Signature: _____ Date: _____

DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF NURSE	GIVEN BY	TIME GIVEN

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).
2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).
3. Sign your full name clearly against each prescription entry.
4. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes.
5. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.
6. The following metric unit abbreviations must be used –

Milligram = mg	Gram = g
Millilitre = ml	Millimoles = mmol

Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

7. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - Intrathecal **must be written in full.**

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.
2. Insert initials in the relevant date column and time row each time a drug is administered.
3. Check that all drugs prescribed at a certain time have been administered.
4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

(3) Patient refused	(7) Patient asleep	(11) Unable to swallow	(14) Other - Record in nursing notes
(4) Drug not available	(8) Time varied on doctor's instructions	(12) No intravenous access	(15) Prescription clarification required
(5) Nil by mouth/fasting	(9) Dose withheld on doctor's instructions	(13) Patient Self-Administration of Medicine	
(6) Patient unavailable	(10) Nausea/vomiting		

Cat No.00548 Ver 8, 01/2009

PRESCRIPTION FORM

Hospital Name: .....

PATIENT DETAILS

Name: CATHERINE HONEYMAN

CHI No: SG00940779 01/02/49
CHI: 0102496145 F
Date____ Time____
Ht Spec./Sig._____

Height:

Weight:

Surface area:

DOB:

Date of writing discharge prescription: __/__/__

Date of Admission: 6/5/10

Ward:

Consultant Name: MR

Date and time this form prepared: __/__/__ Time: _____

Sheet No .....

2nd Prescription in use Yes or NO

DRUG SENSITIVITIES

Nil

DVT Risk on Admission (SIGN Guideline)

High ☐ Moderate ☐ Low ☐

Assessed by: Date: __/__/__

OTHER CHARTS IN USE

Insulin ☐

PCA and other infusions ☐

Anticoagulants: Heparin ☐ Oral ☐

Topical: ☐

TPN: ☐

Enteral Nutrition: ☐

Oxygen Therapy: ☐

Other:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF PRESCRIBER	GIVEN BY	TIME GIVEN
6/5/10	Furosemide	1g	IV	03:00		Klaire	04:00
6/5/10	Benzylpenicillin	1.2g	IV	03:00		Klaire	05:00

PATIENT'S NAME:

ADMINISTRATION

Parenteral Drugs: Regular Prescription

DATE → 6 7 8 9 10 11 12 13

MONTH → 5 5 5 5 5 5 5 5

A DRUG ceftriaxone

DOSE 40g | ROUTE sc | DATE 6/5/13 | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

B DRUG flucloxacillin

DOSE 1g | ROUTE IV | DATE 6/5/13 | STOPPED DATE: 13/5

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

C DRUG benzylpenicillin

DOSE 1.2g | ROUTE IV | DATE 6/5/13 | STOPPED DATE: 13/5

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

D DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Parenteral Drugs: Regular Prescription

DATE →

MONTH →

E DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

F DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

G DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

H DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

n or double dosing is avoided.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent

Note: To discontinue a prescription, initial and date appropriate boxes and draw a diagonal line through section

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE: 6 7 8 9 10 11 12 13 14
MONTH: 6 5 5 5 5 5 5 5 5

J DRUG: FLUOXETINE
DOSE: 20mg | ROUTE: ORAL | DATE: 6/5/15 | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

K DRUG: BISOPROLOL/HYDROCHLOROTHIAZIDE
DOSE: 2.5mg | ROUTE: ORAL | DATE: 6/5/15 | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

L DRUG: ASPIRIN
DOSE: 75mg | ROUTE: ORAL | DATE: 6/5/15 | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

M DRUG: ATENOLOL
DOSE: 25mg | ROUTE: ORAL | DATE: 6/5/15 | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

Oral and Other Drugs: Regular Prescriptions

DATE: 6 7 8 9 10 11 12 13 14
MONTH: 5 5 5 5 5 5 5 5 5

N DRUG: OMEPRAZOLE
DOSE: 20mg | ROUTE: ORAL | DATE: 6/5/15 | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

P DRUG: PARACETAMOL
DOSE: 1g | ROUTE: ORAL | DATE: 6/5/15 | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

R DRUG: TRAMADOL
DOSE: 50mg | ROUTE: ORAL | DATE: 6/5/15 | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

S DRUG: Slow K
DOSE: 2 tablets | ROUTE: PO | DATE: 7/5/15 | STOPPED DATE: 11/5 | INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: DURATION
FOR PRESCRIBERS USE ONLY
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent or double dosing is avoided.

Note: To discontinue a prescription, initial and date appropriate boxes and draw a diagonal line through section

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE → 13 14
MONTH → 5 5

T DRUG: Flucloxacillin
DOSE: 500mg | ROUTE: PO | DATE: 13/5 | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY

Other time	0700-0900	1200-1400	1600-1800	2200-2400	Other time
	✓	✓	✓	✓	
		RA	RA	MP	

V DRUG: Penicillin V
DOSE: 500mg | ROUTE: PO | DATE: 13/5 | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY

Other time	0700-0900	1200-1400	1600-1800	2200-2400	Other time
	✓	✓	✓	✓	
		RA	RA	MP	

W DRUG
DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY

X DRUG
DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY

Oral and Other Drugs: Regular Prescriptions

DATE →
MONTH →

Y DRUG
DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY

AA DRUG
DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY

BB DRUG
DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY

CC DRUG
DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

Note: To discontinue a prescription, initial and date appropriate boxes and draw a diagonal line through section

Completeness of this medication record should be checked by a second person to ensure that inadvertent omission or double dosing is avoided.

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

Oral and Other Drugs: Regular Prescriptions

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

LL DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent [illegible] of double dosing is avoided.

Note: To discontinue a prescription, initial and date appropriate boxes and draw a diagonal line through [illegible]

PATIENT'S NAME:

All Routes: As Required Prescriptions

ADMINISTRATION

MM DRUG: Simeticone | DOSE: 10 mg | ROUTE: oral | INDICATION: gas | STOPPED DATE: | INITIALS: | SIGNATURE OF PRESCRIBER: | MAX.FREQUENCY: 2° | DATE: 6/5/10 | ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

| | | |

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL, 1345 GOVAN ROAD, GLASGOW G51 4TF
TEL: 0141 201 1100

WARD: S01 CONSULTANT: MR DAVID MARTIN *DEPARTMENT OF ORTHOPAEDICS*
CONTACT TEL: *IMMEDIATE DISCHARGE LETTER*

PATIENT: CATHERINE HONEYMAN
10 MELVILLE STREET
GLASGOW
G41 2LN

DOB: 01/02/49 UNIT NO: SG00940779
ACCT NO: IP0023782/10
CHI NO: 0102496145
GP: DR GRAEME G MARSHALL
GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ

DATE OF ADMISSION: 06/05/10
DATE OF DISCHARGE: 14/05/10

ADMISSION TYPE: EMERGENCY
DISCHARGE TO: HOME

REASON FOR ADMISSION: POST OP KNEE PROBLEMS
MAIN DIAGNOSIS: AS ABOVE (WOUND LEAKAGE,SWOLLEN KNEE)

OTHER ACTIVE PROBLEMS: NIL

'ERATIONS/PROCEDURES/ TREATMENT: IV THAN ORAL AB TREATMENT,MOBILISTAION
RESULTS AWAITED: N
CURRENT MEDICATION: SEE PRESCRIPTION
DISCONTINUED DRUGS? N
COMMENT: CONTINUE ORAL AB, ANALGESIA

ALLERGIES: . NKDA
. NIL

REVIEW? Y DETAILS: OUT PATIENT TIMESCALE: 6/52 AFTER KNEE OP

FURTHER LETTER TO FOLLOW? Y DETAILS: FORMAL HOSPITAL LETTER

Highly Sensitive Document Y/N N Patient consent to share information Y/N Y

SIGNED: STR.VORTI VOROS,TIBOR
DESIGNATION: SHO
NUMBER: 7513

Run: 14/05/10-13:51 by VOROS,TIBOR

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL, 1345 GOVAN ROAD, GLASGOW G51 4TF
TEL: 0141 201 1100

DEPARTMENT OF ORTHOPAEDICS

WARD: S01 **CONSULTANT: MR DAVID MARTIN**
CONTACT TEL: ***IMMEDIATE DISCHARGE LETTER***

PATIENT: CATHERINE HONEYMAN
10 MELVILLE STREET
GLASGOW
G41 2LN

DOB: 01/02/49 UNIT NO: SG00940779
ACCT NO: IP0023782/10
CHI NO: 0102496145
GP: DR GRAEME G MARSHALL

DISCHARGE MEDICATION

Time Required? Routine - within 4 hours
Childproof Containers? Y
Compliance Aid Required? N
Patient's Weight (Kg):
Comment:

Medication	Form	Dose	Frequency	Duration
FLUOXETINE	OCAP	20MG	IN THE MORNING	INDEFINITE
New Drug? N New Dose? N	Comments:			
Patient's Own Supply? Y	Pharmacy Notes:		Supply:	

Medication	Form	Dose	Frequency	Duration
BENDROFLUMETHIAZIDE	OCAP	2.5MG	IN THE MORNING	INDEFINITE
New Drug? N New Dose? N	Comments:			
Patient's Own Supply? Y	Pharmacy Notes:		Supply:	

Medication	Form	Dose	Frequency	Duration
ASPIRIN	OCAP	75 MG	IN THE MORNING	INDEFINITE
New Drug? N New Dose? N	Comments:			
Patient's Own Supply? Y	Pharmacy Notes:		Supply:	

Medication	Form	Dose	Frequency	Duration
ATENOLOL	OCAP	25MG	IN THE MORNING	INDEFINITE
New Drug? N New Dose? N	Comments:			
Patient's Own Supply? Y	Pharmacy Notes:		Supply:	

Medication	Form	Dose	Frequency	Duration
OMEPRAZOLE	OCAP	20MG	IN THE MORNING	INDEFINITE
New Drug? N New Dose? N	Comments:			
Patient's Own Supply? Y	Pharmacy Notes:		Supply:	

Medication	Form	Dose	Frequency	Duration
PARACETAMOL	OCAP	1000MG	EVERY 6 HOURS	7 DAYS
New Drug? Y New Dose? Y	Comments:			
Patient's Own Supply? N	Pharmacy Notes:		Supply:	

Medication	Form	Dose	Frequency	Duration
TRAMADOL	OCAP	50MG	EVERY 6 HOURS	7 DAYS
New Drug? Y New Dose? Y	Comments:			
Patient's Own Supply? N	Pharmacy Notes:		Supply:	

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL, 1345 GOVAN ROAD, GLASGOW G51 4TF
TEL: 0141 201 1100

DEPARTMENT OF ORTHOPAEDICS

WARD: S01 CONSULTANT: MR DAVID MARTIN
CONTACT TEL:

IMMEDIATE DISCHARGE LETTER

PATIENT: CATHERINE HONEYMAN
10 MELVILLE STREET
GLASGOW
G41 2LN

DOB: 01/02/49 UNIT NO: SG00940779
ACCT NO: IP0023782/10
CHI NO: 0102496145
GP: DR GRAEME G MARSHALL

Medication	Form	Dose	Frequency	Duration
FLUCLOXACILLIN	OCAP	500MG	EVERY 6 HOURS	5 DAYS

New Drug? Y New Dose? Y Comments:
Patient's Own Supply? N Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration
PENICILLIN V	OCAP	500MG	EVERY 6 HOURS	5 DAYS

New Drug? Y New Dose? Y Comments:
Patient's Own Supply? N Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration

New Drug? New Dose? Comments:
Patient's Own Supply? Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration

New Drug? New Dose? Comments:
Patient's Own Supply? Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration

New Drug? New Dose? Comments:
Patient's Own Supply? Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration

New Drug? New Dose? Comments:
Patient's Own Supply? Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration

New Drug? New Dose? Comments:
Patient's Own Supply? Pharmacy Notes: Supply:

PHARMACY USE ONLY DISPENSED BY: DATE: CHECKED BY:
CLINICAL PHARMACIST CHECK: COLLECTED BY: _____

Medicine received on ward by: _____ Issued by: _____

Named Nurse: _____ Signature of Receipt: _____

Report Number: 1405-0171 Date(Time): 14/05/10 (1351 Hours) Status: Draft

SOUTHERN GENERAL HOSPITAL
PATIENTS PROFILE

WARD / DEPT: 1	NAMED NURSE:
CONSULTANT: MBZ	REFERRAL: Self
DATE: 13.7.10	TIME: 2340
PATIENTS NAME: Catherine Honeyman	
UNIT NUMBER: SG0094077 9	
PREFERS TO BE CALLED:	
ADDRESS: 10 Melville St Glasgow G41 2LN	
TELEPHONE NUMBER: 0141- 221- 580	

AGE: 61	D.O.B.: 1.2.49	SEX: F	MARITAL STATUS: Married
OCCUPATION: MARRIED			
RELIGION:	CLERGY / OTHER:	CONTACT REQUIRED:	CONTACTED:

REASON FOR ADMISSION:

Right knee infection

14/7/10 washout (R) knee replacement under GA
POP to (R) ankle

VIOUS HEALTH HISTORY:

HTN
Angina

KNOWN ALLERGIES:

NKDA

SGH 308

PATIENTS PROFILE (cont'd)

MEDICATION ON ADMISSION:

Atenolol 25
Simvastatin 40
Bendroflumethiazide 2.5
Tramadol 50
Omeprazole 20mg
Fluoxetine 20
Aspirin 75
GTN Spray

PATIENTS PRECEPTION OF CURRENT HEALTH STATUS:

Fully aware

RELATIVES PRECEPTIONS OF PATIENTS HEALTH STATUS:

Fully aware

EMERGENCY CONTACT NAME: RAYMOND HONEYMAN

NEXT OF KIN: RAYMOND HONEYMAN

RELATIONSHIP: HUSBAND

ADDRESS: SIA

TELEPHONE NUMBER (DAY): SIA | TELEPHONE NUMBER (NIGHT):

OTHER RELEVANT CONTACT:

G.P.'s NAME: Dr Marshall

G.P.'s ADDRESS: Garbeds HIC

G.P.'s TELEPHONE NUMBER: 0141 531 8250

Patient / Relative spoken to by	DATE	TIME	DOCTOR	NURSE
	14-7-10	0330		

VALUABLES: DISPOSAL / HOME / WARD / CASHIER'S OFFICE

CLOTHING: DISPOSAL / HOME / WARD / CASHIER'S OFFICE

NURSES SIGNATURE:

SOUTHERN GENERAL HOSPITAL
NURSING ASSESSMENT

PATIENTS NAME: Catherine Hanegan.	UNIT No.:	WARD: 1

GENERAL ASSESSMENT ON ADMISSION:

Well kempt lady.

SOCIAL / HOME BACKGROUND (INCLUDING PROBLEMS RELATED TO ADMISSION):

lives with husband and daughter

Non Smoker.

Occasional alcohol.

BLOOD PRESSURE:	120/44	WEIGHT:	
PULSE:	84	HEIGHT:	
RESPIRATIONS:	18	URINALYSIS:	NAD
TEMPERATURE:	36.2	WATERLOW SCORE:	

SGH 310

NURSING ASSESSMENT (ASSESSMENT OF ACTIVITIES OF DAILY LIVING)

MAINTAINING A SAFE ENVIRONMENT, COMMUNICATING, BREATHING, EATING AND DRINKING, ELIMINATING, PERSONAL CLEANSING AND DRESSING, CONTROLLING BODY TEMPERATURE, MOBILISING, WORKING AND PLAYING, EXPRESSING SEXUALITY, SLEEPING, DYING.

Manages safe environment

Communicates well.

No problems breathing

Normal diet and fluids.

No problems with elimination.

Manages own personal hygiene

Normal body temperature.

Been in wheelchair last 1/52 prior to that using crutches

Lives with husband and daughter.

NKT discussed.

Sleeps well.

NKT discussed.

NURSES SIGNATURE:

SOUTHERN GENERAL HOSPITAL

DEPARTMENT: Ortho

NAME: Catherine Hargnon UNIT NO. WARD: 1

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
14.7.10	0330	Patient admitted to ward via A+E Orientated to ward and buzzer system. Observations stable. Admitted with right knee infection. Solvedol 10g given at 0330 — and Paracetamol 1g given. Plan: Bloods ☐ Analgesia ✓ Washout ☐ IVFT ✓ XR knee ✓ Review XR this am ☐ IV abx this am ☐ r/v today ☐ IVF running as charted. Passed wide MSSU - NAD. Solvedol 10g given at 0610 — stopt for theatre period.	
	0900	Patient still to have IV abx	
(TH)	19-35	Returned from theatre after having washout to right knee replacement under General anaesthetic. POP applied to right ankle in theatre. Patient has ## to ankle. Substance 1152 weeks ago. Analgesia via PCA Morphine 1mg/1ml. 5 minute lock out. 4 Bolus given in recovery for pain. Solvedol also prescribed. oxygen therapy 4 litres via hudson/MAT IV Cannula in situ as prescribed Observations on return B/P 116/66. P80 T36.4 R.16. So2 98%. Wound intact and dry no staining Knee aspirated prior to theatre result should positive for Gram cocci. Has not passed urine.	
	1900	Passed 300ml urine	

0369438-SGH 306A

SOUTHERN GENERAL HOSPITAL

DEPARTMENT: Orthopaedics

NAME: Catherine Honeyman UNIT NO. 5900914C79 WARD: ave

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
15.07.10	0420	Has not slept much overnight but states this is her normal. Vs Observations have remained stable & satisfactory, SEWS 0. Morphine PCA remains in situ and used effectively, pain score 3-6	
		I.V. fluids still in progress, but is tolerating oral fluids & had night clear last night. Voiding urine spontaneously, good volumes, using bedpan.	
		On IV flucloxacillin & gentamycin. CSM of toes (R) foot satisfactory.	LMULLENS SNLMuller
	0700	Observations 37.6° this am, other obs satisfactory	LMUK
	1845	Patient required minimal assistance to wash and dress this morning. Patient able to transfer from bed to chair / commode, unable to weightbear at present. Patient complained that plaster cast to (R) below knee was tight, patient attended plaster room this afternoon for application of a new cast, symptoms now relieved. Cent levels were taken at 0910 am. Remains on IVAB, dose reduced from 2g flucloxacillin to 1g, see drugs Kardex. (R) leg bleeding, doctor aware, wound pad and further bandages applied as advised. Patient settled at present with no complaints.	
		Gentamycin level checked by FY1 and dose given as Kardex. Observations satisfactory. Patient insisted on trying to walk to toilet with crutches, and would have fallen if not for assistance from HCA	JPaton SN(5)
07.10	0500	settled night, slept better. Observations satisfactory. Zolpidem 10mg this am	LMULLENS SNLMuller
	2000	Patient refused wash although being asked on numerous occasions. To continue as WARS. Commenced on sando K	

SOUTHERN GENERAL HOSPITAL

DEPARTMENT: ORTHO

NAME: CATHERINE HONEYMAN UNIT NO. SG0094077 9 WARD: 1

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
17.07.10.	0545	observations satisfactory. Right upper thigh noted	
(3)		to be red, area marked and observe if any	
		change. FYI has seen patient.	
		Wound dressing removed and wound inspected,	
		still some blood oozing from wound. Knee	
		remains swollen which patient states ~~it~~ is	
		her usual and feels less hot than usual.	
		~~Continues on IV fludox~~. Wound cleaned	
		with saline, tegaderm and wool + crepe	
		applied. csm of toes satisfactory	
		Continues on IV fluclocaillin + gentamycin	
		using commode to P.U. NBO since	LMiller
		Monday. Temperature normal	SNLMullen
	2000	Assistance given with hygiene	
		needs.	
		Wound s/B Dr Brydone and	
		redressed with wound pads	
		and mepore.	
		Continues on IV fludox 1g.	
		Diet and fluids taken.	
		Analgesia effective for pain	
18/7/10	06.20	Patient continues on IVAB	
		small amount of blood oozing	
		from wound, patient states	
		really pained, Seuredol 10mg	
		given with good effected	
		patient settled slept well	(5)
		commode given at bedside	J. King
	1130	Independent normal.	
		Dressing left intact – no further	
		leakage.	
		Wantibiotic therapy continues	
		Observations satisfactory	SNLDough
	1855hrs	c/o mouth ulcers and dry cracked lips.	
		Given yellow paraffin for lips and	
		Chlorhexadine mouthwash for mouth ulcers	
19/7/10	06.10	Continues on IVAB, bedpan	
		given at bedside. New ~~pant~~	
		Venflon sited (R) arm. Settled	(5)
		slept well. no complaints offered	J. King
	1230	Independent with personal hygiene	
		IV antibiotics continue as prescribed	

0369438-SGH 306A

SOUTHERN GENERAL HOSPITAL

DEPARTMENT:

NAME: UNIT NO. WARD:

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
		Dressing left intact for review on ward round tomorrow.	s/n Akbright
	1900	Patient to have ward reviewed on ward round tomorrow.	
		Offering no complaints. Mobilising well with elbow crutches.	Mbpa(5)
07/10	05.00	Settled and slept well overnight.	
		IV Flucloxacillin administered.	
		IV Gentamicin witheld due to levels being too high. To receive night time dose tonight and levels to be done tomorrow.	
		Mobilising around ward with elbow crutches. Dressing intact.	
		Observations satisfactory.	allunay
	1430	Washed independantly	
		Seen by Mr Hallin	
		To have lightweight cast applied & check x-ray done.	
		Warmed satisfactory	
		IV AB discontinued commenced on oral.	
		Can be discharged home tonight and come back FRIDAY 30th July to Mr Hallins clinic	s/n Akbright
	1600	Independent with her personal hygiene. Obs satisfactory. Seen at ward round adv- home today after changing the POP to a below knee LDC on the right ankle. Same done. Part 2 completed for district nurse to remove sutures on Monday 26/7/10. Pt will be reviewed in the clinic a wk on Friday. Wound redressed with wound pad and primer pore.	RNelg

SOUTHERN GENERAL HOSPITAL

INVESTIGATION INSTRUCTION SHEET

NAME: Catherine Hogan UNIT NO: WARD: 1

DATE		DATE	INITIALS
14.7.10	MRSA Screen.	14.7.10	
"	MSOU - NAD	"	

DATE		DATE		DATE		DATE		DATE		DATE	

0369451-SGH307

NHS
Greater Glasgow and Clyde

NATVNS
SCOTLAND

WRITE, IMPRINT OR ATTACH LABEL
Surname Hanaghan CHI No .....
Forenames Peggy Sex .....
DoB .....
Location .....

ADAPTED WATERLOW PRESSURE AREA RISK ASSESSMENT CHART

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

Complete assessment on admission/1st visit, if there is a change in individuals condition and repeat regularly according to local protocol

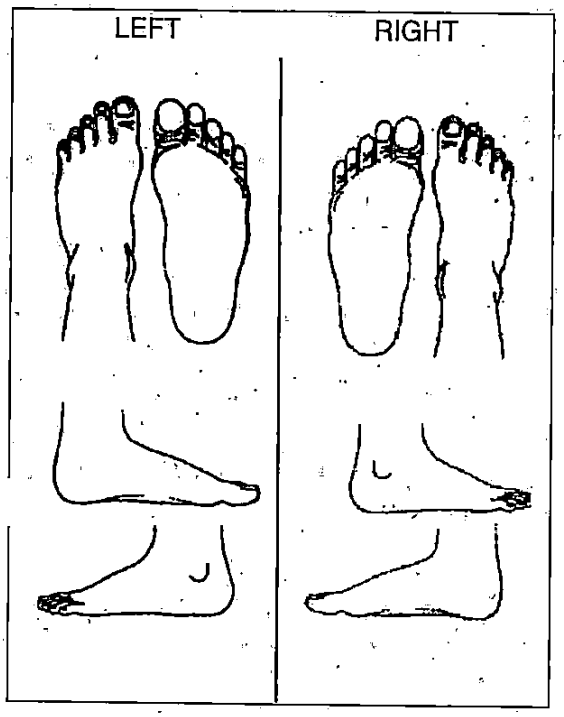
Sex									
Male	1								
Female	2	2	2	2	2	2	2		
Age									
14 -49	1								
50 -64	2	2	2	2	2	2	2		
65 - 74	3								
75 - 80	4								
81+	5								
Build/Weight for Height (BMI=weight in Kg/height in m²)									
Average - BMI 20-24.9	0								
Above average - BMI 25-29.9	1	1	1	1	1	1	1		
Obese - BMI > 30	2								
Below average - BMI < 20	3								
Continence									
Complete/catheterised	0	0	0	0	0	0			
Incontinent urine	1								
Incontinent faeces	2								
Doubly incontinent (urine & faeces)	3								
Skin Type - Visual Risks Area									
Healthy	0			0	0	0			
Tissue paper (thin/fragile)	1								
Dry (appears flaky)	1								
Oedematous (puffy)	1								
Clammy (moist to touch)/pyrexia	1								
Discoloured (bruising/mottled)	2								
Broken (established ulcer)	3	3	3		3	3	3		
Mobility									
Fully mobile	0				0	0	0		
Restless/fidgety	1								
Apathetic (sedated/depressed/reluctant to move)	2								
Restricted (restricted by sever pain or disease)	3	3	3	3					
Bedbound (unconscious/unable to change position/traction)	4								
Chairbound (unable to leave chair without assistance)	5								
Nutritional Element									
Unplanned weight loss in past 3-6 months									
<5% Score **0**, 5-10% Score **1**, >10% Score **2**	0-2	0	0	0	0	0	0		
BMI > 20 Score **0**, BMI 18.5-20 Score **1**, BMI < 18.5 Score **2**	0-2								
Patient acutely ill or no nutritional intake > 5 days	2								
Special Risks - Tissue Malnutrition									
Multiple organ failure/terminal cachexia	8								
Single organ failure e.g. cardiac, renal, respiratory	5								
Peripheral vascular disease	5								
Anaemia = Hb < 8	2								
Smoking	1			0					
Special Risks - Neurological Deficit									
Diabetes/MS/CVA/motor/sensory/paraplegia *Max 6*	4-6		0	0					
Special Risks - Surgery/Trauma									
On table > 6 hours	8								
Orthopaedic/below waist/spinal (up to 48 hours post op)	5								
On table > 2 hours (up to 48 hours post op)	5		0	0					
Special Risks - Medication									
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*	4	4	4	8	4	4	4		
Total Score		15	15	8	12	12	12		
Date		14/7	18/7	16/7	18/7	19/7	20/7		
Initials		[illegible]	BH	UM	AK	AK	PD		
Time		0700	1200	0900	1730	1030	1730		

83826

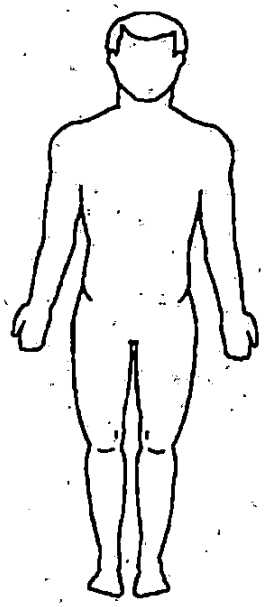
Ensure plan of care is implemented / reviewed for all identified areas of concern.

PRESSURE ULCER RECORD

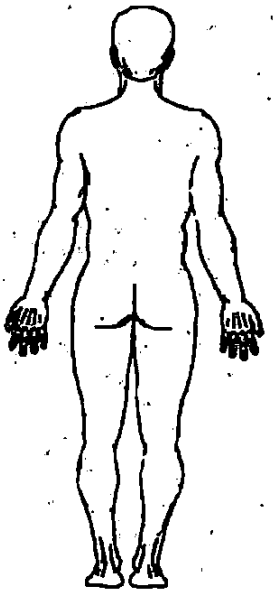
Indicate by circling and numbering all pressure damage on diagrams, then complete box below. Indicate care plan/wound assessment chart.



Anterior view



Posterior view



SCOTTISH ADAPTED EPUAP PRESSURE ULCER GRADING TOOL

GRADE 1 Non-blanchable erythema of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness may also be used as indicators, particularly on individuals with darker skin.

GRADE 2 Partial thickness skin loss involving epidermis, dermis or both. The ulcer is superficial and presents clinically as an abrasion or blister.

GRADE 3 Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia.

GRADE 4 Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss.

DATE	NUMBER OF ULCER(S)	LOCATION OF ULCER(S)	GRADE OF ULCER(S)	LOCATION OF ULCER(S)

Pressure Ulcers may deteriorate from Grade 1 to Grade 4, but can not be reversed and should be documented as a healing grade of pressure ulcer, eg healing grade 4.

SOUTH GLASGOW HOSPITALS
PATIENT MOVING AND HANDLING RISK ASSESSMENT

NHS Greater Glasgow and Clyde

Patient's Name: Catherine Humphries	If patient is totally independent, tick here and go to date box	
Named Nurse:		

BODY BUILD

Obese		Tall	
Above average		Medium	
Average		Short	
Below Average		Weight:	

RISK OF FALLS: High ✓ | Low

Problems with comprehension, behaviour, co-operation (specify)

Handling constraints e.g. disability, weakness, pain, skin lesions infusions (specify) w/chair 1/52 previous fracture

INTO BATH OR SHOWER

HANDLING AID		WHICH BATH	
Hoist (Specify)		Parker	
Shower chair		Variable height	
		Standard	
		Any	

ASSISTANCE		SUPERVISION		INDEPENDENT	
Staff required:					

TRANSFERS (including to/from: bed, wheelchair, commode, toilet)

HOIST		MANUAL SUPPORT
Which hoist?		Staff required:
Sling type?		Specify support given
Sling size?		

ASSISTANCE		SUPERVISION		INDEPENDENT	
Additional Information					

TOILETING

HOIST		MANUAL SUPPORT
Which hoist?		Staff required:
Sling type?		Specify support given
Sling size?		

ASSISTANCE		SUPERVISION		INDEPENDENT	
Additional Information					

WALKING

NO WALKING		ASSISTANCE		SUPERVISION		INDEPENDENT	
Staff required:				Distance walked / additional information			
Walking Aid							

MOVE UP/DOWN BED

HOIST		MANUAL SUPPORT	
Which hoist?		Sliding aid	
Sling type?		Rope ladder	
Sling size?		Hand blocks	
		Monkey poles	

ASSISTANCE		SUPERVISION		INDEPENDENT	
Additional Information (include details of any therapy beds used)					
Staff required:					

SIT UP OVER SIDE OF BED

Rope ladder		Sliding aid		ASSISTANCE		SUPERVISION		INDEPENDENT	

MOVE ON/OFF BED PAN

Hoist		Roll Patient		Patient bridges		Monkey pole		Not used	

TRANSFER TO/FROM TROLLEY (or bed etc)

Sliding aid (rigid)		Sliding aid (fabric)		Transfer aid (specify)	Staff required (specify)		INDEPENDENT	

Date assessed:	Assessors signature:								
Date reviewed									
Assessors signature									

THERAPEUTIC HANDLING INSTRUCTIONS

Date	Instruction	Therapist's Name

INTO BATH OR SHOWER

HANDLING AID		WHICH BATH	
Hoist (Specify)		Parker	
Shower chair		Variable height	
		Standard	
		Any	

ASSISTANCE		SUPERVISION		INDEPENDENT	
Staff required:					

TRANSFERS (including to/from: bed, wheelchair, commode, toilet)

HOIST		MANUAL SUPPORT
Which hoist?		Staff required:
Sling type?		Specify support given
Sling size?		

ASSISTANCE		SUPERVISION		INDEPENDENT	
Additional information					

TOILETING

HOIST		MANUAL SUPPORT
Which hoist?		Staff required:
Sling type?		Specify support given
Sling size?		

ASSISTANCE		SUPERVISION		INDEPENDENT	
Additional information					

WALKING

NO WALKING		ASSISTANCE		SUPERVISION		INDEPENDENT	
Staff required:				Distance walked / additional information			
Walking Aid							

MOVE UP/DOWN BED

HOIST		MANUAL SUPPORT	
Which hoist?		Sliding aid	
Sling type?		Rope ladder	
Sling size?		Hand blocks	
		Monkey poles	

ASSISTANCE		SUPERVISION		INDEPENDENT	
Additional information (include details of any therapy beds used)					
Staff required:					

SIT UP OVER SIDE OF BED

Rope ladder		Sliding aid		ASSISTANCE		SUPERVISION		INDEPENDENT	

MOVE ON/OFF BED PAN

Hoist		Roll Patient		Patient bridges		Monkey pole		Not used	

TRANSFER TO/FROM TROLLEY (or bed etc)

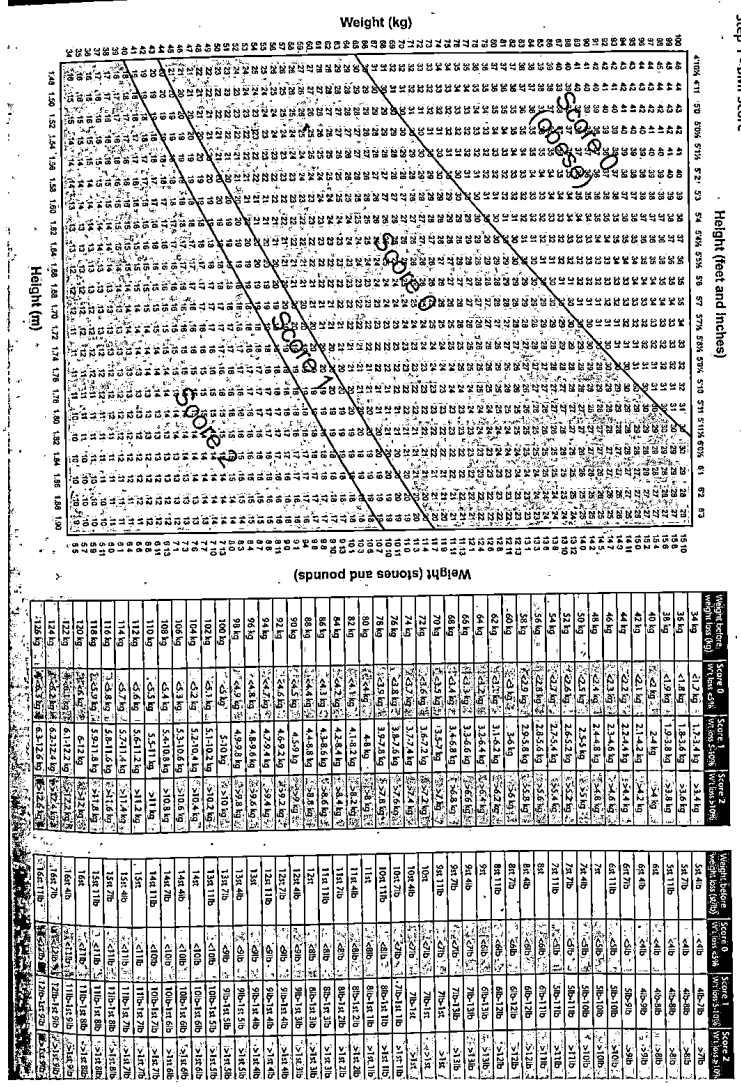
Sliding aid (rigid)		Sliding aid (fabric)		Transfer aid (specify)	Staff required (specify)		INDEPENDENT	

e assessed:	Assessors signature:

Date reviewed									
Assessors signature									

THERAPEUTIC HANDLING INSTRUCTIONS

Date	Instruction	Therapist's Name



NHS Greater Glasgow and Clyde

Nutrition Profile

Name: CATHERINE HONEYMAN	Date of admission: 14/7/10
Address: 10 MELVILLE ST. G41 2LN	Time: 2340
DoB: 1.2.44	HOSPITAL: SGH
CHI number: 0102496145	Ward: 1
Affix patient data label	

To be recorded within 24 hours of admission*

Height: 5ft 4in. ~~cm~~/ft Actual ☐ Patient/ ~~carer reported~~ ☐ ~~Alternative measurement~~ ☐

Weight: 148 - 2 1/3 ~~kg~~/stones Actual ☐ Patient/ ~~carer reported~~ ☐ ~~Alternative measurement~~ ☐

Recent unplanned weight loss: Yes ☐ No ☒

If 'Yes' how much?: kg/stones. Over what period of time?: weeks/months

Is there evidence of recent weight loss?

No ☐ Loose clothing ☐ History of reduced food intake/appetite ☐ Swallowing problem ☒

Eating and drinking likes and dislikes (including appetite and/or NBM status):

Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☒

Please state:

Are there any contributing factors that may affect food intake such as **physical** (e.g. swallowing difficulties), **physiological** (e.g. nausea), **psychological** (e.g. dementia), **social or environmental**? Yes ☐ No ☒

Please specify all factors:

Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☒

Please state:

Profile completed by: Name (PRINT): AMACRI Signature:

NOTE: This is ADMISSION DATA - please refer to changes in Care Plan.

Scottish Intercollegiate Guidelines Network (2003). Food, Fluids and Nutritional Care in Hospitals Edinburgh SIG

Malnutrition Universal Screening Tool ('MUST')

Date	14/7/10									
Initials										
Height (see page 1) 5ft 4in / Weight	145 kg									
Oedema or ascites present Y/N	N									
BMI	34									

'MUST'

Step 1: BMI Score (refer to chart on page 4)										
>20 (>30 = Obese) 0	0									
18.5 - 20 1										
<18.5 2										
Step 2: Weight Loss Score										
Unplanned weight loss in past 3-6 months:										
<5% 0	0									
5-10% 1										
>10% 2										
Step 3: Acute Disease Effect Score										
If patient is acutely ill and there has been or is likely to be no or virtually no food intake for > 5 days..... Score 2	0									
Not applicable ..... Score 0										
Step 4: Overall Risk of Malnutrition Total:	0									

Step 5: Management Guidelines

Score of Overall Risk of Malnutrition	Action Required
0	LOW RISK - *Routine Clinical Care* • Repeat screening. Hospital Acute .....Weekly Hospital Rehabilitation.....Monthly
1	MEDIUM RISK - *Observe* • Document dietary intake for 3 days on a Food Record Chart. • If no improvement in intake: - Encourage oral intake. - Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Repeat screening weekly.
2 or more	HIGH RISK - *Treat** • Refer to Dietitian and document food intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Monitor and review Care Plan weekly. * Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

Management Plan

FOR ALL PATIENTS

- Provide help and advice on food choices and eating and drinking when necessary.
- Treat underlying conditions and initiate appropriate treatment to relieve symptoms that affect nutritional intake e.g. nausea, vomiting, constipation, diarrhoea and/or pain.
- Refer to dietitian if any specialist advice is required.
- Complete nursing checklist for swallowing difficulties if appropriate.
- Use a recognised system to identify when equipment or asssistance is required at mealtimes (e.g. [illegible] mats, coloured napkins).

Referral Services

Dietitian	Date: / /	Outcome:
Speech and Language Therapy	Date: / /	Outcome:
Occupational Therapy	Date: / /	Outcome:
Dental Service	Date: / /	Outcome:

Multidisciplinary Nutrition Care Plan

Date	Overall Risk	Action	Review date	Name (PRINT) Signature/Designation

NHS Greater Glasgow and Clyde

SOUTH GLASGOW PHYSIOTHERAPY SERVICE
ORTHOPAEDIC FRONT SHEET/ASSESSMENT FORM

Unit No: SG0094079
Surname: Honeyman
First Name: Catherine
Address: 10 Melville St
Glasgow
G41 2LN
DOB: 01/02/49
CHI: 0102496195

Ward: 1
Consultant: MBZ
Admission Date: 13.07.10
Date referred: 16.07.10
Tel No: 0141 221 580
Occupation: /
Age: 61

Patient consent ☑

PC	® Knee injection (Woohart 14.07.10).
HPC	↑ pain + swelling ® knee
PMH	® TKR 2010 ® Ankle # 06.07.10 HTN Angina ® TKR (5 yr ago) - re-admitted post op -> haematoma.
DH	See Kardex.
SH	lives c husband. Step into house.
	Previous mobility: c/c 2° # ankle.

Problem List and Goals

	Date	Problem	Goal	Active/ Resolved	Date
1	16/07/10	↓ mob	① T/F to chair		
2			① c F/C NWB		
3					
4					

Discharge Date:
Follow-up physiotherapy:

Date: 16.07.10
PRINT: SONYA BETTS

Physiotherapist signature:
Designation: SCPT.

Date	Details	Signature
	Catherine Honeyman (H) 0102496145.	
16.07.10	S, Consents to Ax + Rx. # ® ankle ~ 1/7 ago. To be NWB pr 6/52. Prior to admission was using attendant propelled w/c round home as struggling to NWB. Does has self propelling chair which she will use on D/C. Also reluctant to hop on ® 2° recent TKR Jan 2010.	
	O, T/F bed → chair 90° + 180° Ⓘ. NWB on ®.	
	Rx, • T/F px	
	A, T/F Ⓘ. Req Ax mob short dist NWB to ensure can get to toilet. Requiring touchy 2° verbal position, as reaching on E/C.	(SCPT) Sonya Betts
	P, Review + Ax mob.	
19/07/10	Pt has been mobilising to toilet ~ 2 x c/c PWB ® LL. Pt was supposed to be NWB. D/W Mr Carter, ~~pt reports~~ Mr Carter reports pt can carry on as she wishes to do her own thing. Refused PT input today. ↑ for (H) tomorrow. Stair pr prior to D/C. RCW — Mal — Aust MASA Senior	
20/07/10	S, Consents to Ax + Rx.	
	O, Gait ~ Ⓘ c E/C's PWB. step to gait leading c ® Stairs ~ Ⓘ c 2 x E/C. • rail single step ascent + descent c good foot placement	
	Rx, • Mobilise ad ~ 40m • Stair px x 3	
	A, Steady t/o	(SCPT) Sonya Betts
	P, D/C	

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

Patient's name: Catherine Honeyman	Ward: 1
Unit number: SG0094O779	Discharge destination: Home
CHI number: 0102496146	Estimated Discharge Date (1) 20/7/10
	Estimated Discharge Date (2) 20/7/10
Apply addressograph label	Final date of discharge : 20/7/10

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓			
Relative/carer informed	✓			
Others informed: Care Home		✓		
Transport arranged				
Own transport (preferred option)	✓			
Ambulance-1 man/ 2 man am/pm		✓		
Other: Flight, Air ambulance etc.		✓		
Discharge medication				
Discharge prescription completed	✓			
Compliance aids e.g. Dossette Box (involve pharmacist)		✓		
Medication received		✓		
Medication explained to patient and/or relative/carer	✓			
Own medication returned to patient	✓			
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)	✓			
Informed of discharge				
Social work/ Other agencies/Home help		✓		
Physiotherapist		✓		
Occupational Therapist		✓		
Dietician		✓		
Speech and Language Therapist		✓		
Clinical Nurse specialist e.g. Care Home Liaison		✓		
Liaison/ (District Nurse)/Practice Nurse		✓		For RAS on 26/7/10
Other discharge items				
Access arrangements (e.g. keys, door entry)	✓			
Patients clothing available for day of discharge	✓			
Valuables e.g. cashier		✓		
Intravenous cannula removed	✓			
Equipment ordered (inc. walking aids) in place for discharge		✓		
Part 2 Discharge letter - Required	✓			
- Completed	✓			
Out patient clinic appointment e.g. Anticoagulation clinic				
Arranged / (To follow)	✓			Rpt 1/52 Fridays
If unknown at time of discharge state reason		✓		
Additional information / leaflets / factsheets				

Time of Discharge: 1600			
Nurse's signature: [signature]	Designation: SSN	Date: 20/7/10	

Acute Services Division

Part 2 Discharge Letter / Transfer Plan

NHS Greater Glasgow and Clyde

- ☐ Glasgow Royal Infirmary 0141 211 4000
- ☐ Stobhill Hospital 0141 201 3000
- ☐ Western Infirmary 0141 211 2000
- ☒ Southern General Hospital 0141 201 1100
- ☐ Victoria Infirmary 0141 201 6000
- ☐ Mansionhouse Unit 0141 201 6101
- ☐ Gartnavel General Hospital 0141 211 3000
- ☐ Blawarthill Hospital 0141 211 9000
- ☐ Drumchapel Hospital 0141 211 6000
- ☐ Lightburn Hospital 0141 211 1500
- ☐ Vale of Leven Hospital 01389 754 121
- ☐ Royal Alexandra Hospital 887 9111
- ☐ Inverclyde Royal Hospital 01475 633777
- ☐ Other:

Name: Catherine Honeyman

Address: 10 Melville ct

Glasgow G41 2LN

Discharge Address: AA

CHI number: 0102496146

Unit number: SG 0596077 D.O.B. 01/02/46

Telephone: 0141 221 5580

Next of kin: Mr Raymond Honeyman

Relationship: Husband

Address: AA

Telephone: AA

Ward: 1

Telephone: 0141/ 201 / 1631

Admission date: 13/07/10

Final discharge/transfer date: 20/07/10

Named Nurse: Rachel Sinclair

Consultant: Mr Hullin

G.P.: Dr Marshall

Address: Garbals HC

Telephone: 0141 531 2254

Post Discharge Services Arranged (e.g. District Nurse, CPN, Day Hospital, Home Care)
State package requested and time of first visit.

Service: District nurse	Service:
Contact number:	Contact number:
Service details: Wound dressing and ROS	Service details:

Additional/Transfer Information (including equipment/adaptions)

District nurses to remove stitches on Monday 26/07/10

Patient Assessment/Comments

Mobility: Independent with aid

Personal hygiene/Dressing: Independent

Continence: Catheter in situ: Yes ☐ No ☑
Type: Size:
Date of change:

Continence details: Continent of both

Dietary requirements: Normal diet

Communication / Swallowing: No problems

Mental state: Alert and orientated

Skin condition/Waterlow Score: PA intact

Wound care/Stoma care: Daily district nurse wound dressing for ROS on Monday 21/07/16. Has a light weight below knee cast on (R) leg.

Special Instructions for Patient (e.g. Exercise, Diet, Wounds, Others)

Sutures to be removed from right knee on 28/7/16 by the District Nurse

Others/Follow-up arrangements Review Fri 29 July in the clinic

Progress discussed with patient: Yes ☑ No ☐
Progress discussed with relative/carer: Yes ☑ No ☐

This information has been fully discussed with Patient/Carer.

Date and signature of Nurse:

Date and signature of Patient/Carer:

Diagnosis: Right knee avulsed fracture on 14/7/16 + POP applied to (R) ankle.

TOP COPY TO - Patient; OTHER COPIES TO - G.P.; District Nurse; Case Notes.

Nurse/Midwife Administration by Protocol - Authorised Nurses/Midwives Only

(Maximum number of doses as per protocol)

Warning: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed by a doctor.

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the nurse/midwife administration protocol No.(s) ..... with the following exceptions: _____

Signature: _____ Date: _____

DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF NURSE	GIVEN BY	TIME GIVEN

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).
2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).
3. Sign your full name clearly against each prescription entry.
4. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes.
5. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.
6. The following metric unit abbreviations must be used –

Milligram = mg — Gram = g
Millilitre = ml — Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

7. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - Intrathecal **must be written in full.**

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.
2. Insert initials in the relevant date column and time row each time a drug is administered.
3. Check that all drugs prescribed at a certain time have been administered.
4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

(3) Patient refused
(4) Drug not available
(5) Nil by mouth/fasting
(6) Patient unavailable
(7) Patient asleep
(8) Time varied on doctor's instructions
(9) Dose withheld on doctor's instructions
(10) Nausea/vomiting
(11) Unable to swallow
(12) No intravenous access
(13) Patient Self-Administration of Medicine
(14) Other - Record in nursing notes
(15) Prescription clarification required

Cat No.00548 Ver 5.01/2009

PRESCRIPTION FORM

Hospital Name: .....

PATIENT DETAILS

Name: Catherine Honeyman
Height:
CHI No:
Weight:
Hospital Number: -0096O779
Surface area:
D 01/02/59
Date of writing discharge prescription: __/__/__
Date of Admission: 13/07/2016
Ward: 1
Consultant Name: MR. MBZ (MR. MULLA)
Date and time this form prepared: __/__/__ Time:
Sheet No .....
2nd Prescription in use Yes or NO

DRUG SENSITIVITIES

NKDA

DVT Risk on Admission (SIGN Guideline)
High ☐ Moderate ☐ Low ☐
Assessed by: Date: __/__/__

OTHER CHARTS IN USE

Insulin ☐
PCA and other infusions ☐
Anticoagulants: Heparin ☐ Oral ☐
Topical: ☐
TPN: ☐
Enteral Nutrition: ☐
Oxygen Therapy: ☐
Other:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF PRESCRIBER	GIVEN BY	TIME GIVEN
14/7/16	Morphine	2MG	IV	1300			
	As per protocol						

PATIENT'S NAME:

ADMINISTRATION

Parenteral Drugs: Regular Prescription

DATE: 14 15 16 17 18 19 20
MONTH: 07 07 07 07 7 7 7

A DRUG: Flucloxacillin
DOSE: 1g | ROUTE: IV | DATE: 14/7/07 | STOPPED DATE: | STOPPED INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY

Other time / 0700-0900 / 1200-1400 / 1600-1800 / 2200-2400 / Other time

B DRUG: Benzylpenicillin
DOSE: 1.2g | ROUTE: IV | DATE: 14/7/07 | STOPPED DATE: | STOPPED INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY

C DRUG: Clexane
DOSE: 40mg | ROUTE: S/C | DATE: 14/7/10 | STOPPED DATE: | STOPPED INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY

1600-1800: ✓ BP BP BP BP BP BP

D DRUG: Morphine PCA 1mg/ml
DOSE: Bolus | ROUTE: IV | DATE: 14/7/10 | STOPPED DATE: | STOPPED INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: Bolus 1mg 6hrly 15mm L.O
FOR PRESCRIBERS USE ONLY

0700-0900: 85 EM MA
1200-1400: EM
2200-2400: EM

Parenteral Drugs: Regular Prescription

DATE: 14 15 16 17 18 19 20
MONTH: 07 07 07 07 7 7 7

E DRUG: Flucloxacillin
DOSE: 2g | ROUTE: IV | DATE: 14/7 | STOPPED DATE: 15/7 | STOPPED INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY

0700-0900: EM
1200-1400: EM
1600-1800: BP
2200-2400: EM

F DRUG: Gentamicin
DOSE: 320mg | ROUTE: IV | DATE: 14/7 | STOPPED DATE: 15/7/07 | STOPPED INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: EVERY 24 HOURS
FOR PRESCRIBERS USE ONLY

Other time / 0700-0900 / 1200-1400 / 1600-1800 / 2200-2400 / Other time

2200-2400: LM LM LM LM LM LM (9)

G DRUG: FLUCLOXACILLIN
DOSE: 1g | ROUTE: IV | DATE: 15/7/07 | STOPPED DATE: 15/7/07 | STOPPED INITIALS: CD
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY

0700-0900: LM LM LM EM BP
1200-1400: BP BP BP BP BP
1600-1800: BP BP BP BP BP
2200-2400: LM LM LM LM LM

H DRUG
DOSE | ROUTE | DATE | STOPPED DATE: | STOPPED INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent or double dosing is avoided.

Note: To discontinue a prescription, initial and date appropriate boxes and draw a diagonal line through section

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE → 14 15 16 17 18 19 20
MONTH → 7 07 07 07 7 7 7

J DRUG: Atenolol
DOSE: 25mg | ROUTE: po | DATE: 13/7/07 | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY

Other time
0700-0900 ✓ — ✓ ✓ ✓ ✓ ✓ ✓ ✓
1200-1400
1600-1800
2200-2400 ✓ — LM JL JK CT
Other time

K DRUG: Simvastatin
DOSE: 40mg | ROUTE: po | DATE: 13/7/07 | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY

Other time
0700-0900 ✓ — (14) ✓ ✓
1200-1400
1600-1800
2200-2400 ✓ — LM JL JK CT
Other time

L DRUG: Bendrofluazide
DOSE: 2.5mg | ROUTE: po | DATE: 13/7/07 | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY

Other time
0700-0900 ✓ — ✓ ✓ ✓ ✓ ✓ ✓ ✓
1200-1400
1600-1800
2200-2400
Other time

M DRUG: Tramadol
DOSE: 100mg | ROUTE: po | DATE: 13/7/07 | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY

Other time
0700-0900 ✓ — ✓ ✓ ✓ ✓ ✓ ✓ ✓
1200-1400
1600-1800 ✓
2200-2400 — LM LM JL JK CT
Other time

Oral and Other Drugs: Regular Prescriptions

DATE → 14 15 16 17 18 19 20
MONTH → 7 07 07 07 7 7 7

N DRUG: Omeprazole
DOSE: 20mg | ROUTE: po | DATE: 13/7/07 | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY

Other time
0700-0900 ✓ — ✓ ✓ ✓ ✓ ✓ ✓ ✓
1200-1400
1600-1800
2200-2400
Other time

P DRUG: Fluoxetine
DOSE: 20mg | ROUTE: po | DATE: 13/7/07 | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY

Other time
0700-0900 ✓ — ✓ ✓ ✓ ✓ ✓ ✓ ✓
1200-1400
1600-1800
2200-2400
Other time

R DRUG: Nitrazepam
DOSE: 7.5mg | ROUTE: po | DATE: 13/7/07 | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY

Other time
0700-0900 ✓ — ✓ ✓ ✓ ✓ ✓ ✓ ✓
1200-1400
1600-1800
2200-2400
Other time

S DRUG: Paracetamol
DOSE: 1000mg | ROUTE: po | DATE: 13/7/07 | STOPPED DATE: | INITIALS:
SIGNATURE OF PRESCRIBER:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY

Other time
0700-0900 ✓ — ✓ ✓ ✓ ✓ ✓ ✓ ✓
1200-1400 ✓ — (5) ✓ ✓ ✓ ✓ ✓ ✓
1600-1800 ✓ — (11) ✓ ✓ ✓ ✓ ✓ ✓
2200-2400 — LM LM LM JL JK CT
Other time 03:00 am — (11)

Note: To discontinue a prescription, initial and date

This 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE → 16 17 18 19 20

MONTH → 07 07 7 7 7

T DRUG: SANDO K

DOSE: TWO | ROUTE: PO | DATE: 16/7/10 | STOPPED DATE: 20/7/10

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: FOR 3 DAYS ONLY

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

0700-0900: X

1200-1400: X

2200-2400: LM JC

FOR PRESCRIBERS USE ONLY

V DRUG: FLUCLOXACILLIN

DOSE: 1G | ROUTE: PO | DATE: 20/7/10 | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

1600-1800: X

2200-2400: X

Other time: X

FOR PRESCRIBERS USE ONLY

W DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

FOR PRESCRIBERS USE ONLY

X DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

FOR PRESCRIBERS USE ONLY

Oral and Other Drugs: Regular Prescriptions

DATE →

MONTH →

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

FOR PRESCRIBERS USE ONLY

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

FOR PRESCRIBERS USE ONLY

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

FOR PRESCRIBERS USE ONLY

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

FOR PRESCRIBERS USE ONLY

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent d... or double dosing is avoided.

Note: To discontinue a prescription, initial and date appropriate boxes and draw a diagonal line Above ...

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE

MONTH

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Oral and Other Drugs: Regular Prescriptions

DATE

MONTH

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

LL DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent ... or double dosing is avoided.

Note: To discontinue a prescription, initial and date appropriate boxes and draw a diagonal line through section

PATIENT'S NAME:

All Routes: As Required Prescriptions

ADMINISTRATION

MM DRUG: Nitrolingual spray — STOPPED DATE: / INITIALS:
DOSE: 1 spray | ROUTE: SL | INDICATION: For angina
SIGNATURE OF PRESCRIBER: [signature] | MAX.FREQUENCY: PRN | DATE: 11/07
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

DATE	
TIME	
DOSE	
GIVEN BY	

NN DRUG: Ondansetron — STOPPED DATE: / INITIALS:
DOSE: 1 mg | ROUTE: IV | INDICATION: For nausea
SIGNATURE OF PRESCRIBER: [signature] | MAX.FREQUENCY: PRN | DATE: 11/07
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

DATE	
TIME	
DOSE	
GIVEN BY	

PP DRUG: Seroquel — STOPPED DATE: / INITIALS:
DOSE: 1 mg | ROUTE: PO | INDICATION: For pain
SIGNATURE OF PRESCRIBER: [signature] | MAX.FREQUENCY: 2° | DATE: 11/07
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: Withhold while on PCA

| | | |

South Glasgow Hospitals
Southern General Hospital, Glasgow G51 4TF. Tel. 0141 201 1100

Part I Discharge Letter and Medicine Prescription for **Confidential** Ref No: 144800

NHS Greater Glasgow and Clyde

VIMI • DISCHARGE • 2725 SGH

Dear Doctor .....
Surgery .....

Fix ID label to all 4 copies

Patient: CATHERINE HONEYMAN
Address: 10 MELVILLE STREET
GLASGOW
G41 2LN.
DOB: 1 / 2 / 49 Unit no: SG 00940779
Weight ..... CHI no: 0102496145

Ward ..... Tel .....
Consultant: Mr Hullin
Specialty: Orthopaed.
Named Nurse: .....
Admission date: 14 / 7 / 10
Mode of admission .....
Source of admission .....
Discharge date: 20 / 7 / 10

Follow-up arrangements
Clinic appointment made:
Yes ☐ No ☐ To follow ☐
Clinic name .....
Date ... / ... / ...
Non-childproof containers required: Yes ☐ No ☐
Medicine compliance aids required: Yes ☐ No ☐
Specify: .....

Reason for admission, treatment, diagnosis, investigations, operations, complications:
Patient admitted with post op pain + swelling of (R) knee (previous TKR). Joint aspirated + subsequently washout in theatre. Patient treated with IV antibiotics and discharged home with oral antibiotic course.

Other information:

MEDICINE	Dosage form	Dose	Times for administration: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 8	pm 10	Other times	Recommended duration of treatment after discharge	New Drug	New Dose	Number of days supply	Dispensing Details (Pharmacy only)
FLUCLOXACILLIN	ORAL	1g		✓		✓	✓		✓							10	
PARACETAMOL	ORAL	1g		✓		✓		✓		✓						7	
TRAMADOL	ORAL	100mg		✓						✓						7	

Medicines discontinued	Reason (if known) e.g. side effects

Clinical Pharmacy check:
All known drug sensitivity / adverse reactions:

Dispensed by: ..... Date: ... / ... / ...
Checked by: .....

WARD USE ONLY
Med. rec. on ward by: .....
Issued by: [signature] Date: 20 / 7 / 10
Signature of recipient: X

Doctor's name: Graeme Bannan Signature: [signature] Date 20 / 7 / 10
Doctor's grade: SHO Pager number: .....

Number of prescription sheets at discharge: .....

White copy - G.P.; Pink copy - Case Notes; Blue copy - Pharmacy; White copy - Patient.

If you have any problems after discharge, please contact the Ward or your G.P.

Affix Address Label

Adult Intravenous (IV) Cannulation Care Plan

NHS Greater Glasgow and Clyde

Potential Complications of IV Cannulation

1. Redness, pain or inflammation at insertion site due to phlebitis or local infection.
2. Local oedema due to infiltration
3. Bloodstream infection
4. Extravasation

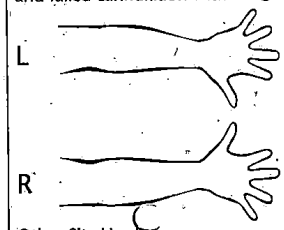
Required Interventions

The interventions below are required to minimise the above complications. Those highlighted in bold are necessary to assist in compliance with the Health Protection Scotland (HPS) Peripheral Vascular Catheter (PVC) Care Bundle

1. **Hand hygiene must be performed before and after IV cannula insertion or manipulation is undertaken.**
2. Decontaminate the patients' skin for at least 30 seconds and allow to dry before inserting the IV cannula. Non-sterile gloves must be worn and the insertion site should never be directly touched.
3. **Document the date, time,** gauge and **site of IV cannula insertion below.** Use the date strip contained within the IV dressing to label the date of insertion on the cannula dressing.
4. Assess and document the reasons for insertion and removal of IV cannulae below. **The IV cannula site and ongoing clinical need should be assessed at least once per shift and must be documented in the Monitoring and Recording Chart overleaf.** When the IV cannula is not in use, maintain patency by flushing with 0.9% sodium chloride every 24 hours.
5. **The IV cannula should be changed every 72 hours or immediately if indicated by VIP score of 2 or more. If the patient has poor venous access, a risk assessment should be carried out using VIP scoring tool overleaf. If score is less than or equal to 1 then the decision can be documented by nursing staff in the chart overleaf to retain cannula up to a maximum of 96 hours. If the cannula has to remain in situ for longer than this, then this decision must be made and documented by medical staff.**
6. **Check IV cannula dressing is dry and intact and that site of insertion can be easily observed. Replace dressing immediately if indicated and document procedure overleaf.**
7. Ensure IV cannula has a needle-free access system with integrated extension. This must be decontaminated for at least 30 seconds and allowed to dry before and after use.
8. If there has been a breach in aseptic technique during insertion (e.g. cannula was inserted during an emergency) then the cannula must be replaced within 24 hours of insertion *. If the cannula has to remain insitu for longer than this, then this decision must be documented overleaf.

Cannula Insertion Site

Please mark successful cannulation with a number e.g. ①
and failed cannulation with an Ⓕ



Other Site Used _____

Insertion Reason Codes

Emergency IV Access = E
Routine IV Access = R
Radiological Procedure = RP
Nil by Mouth = NBM
Chemotherapy = C
IV Fluids / IV Medicine Administration = IV
Blood = B
Other (Please state)

Removal Reason Codes

Not Required = NR
Phlebitis = P
Infiltration = I
Extravasation = E
Other (Please state)

Cannula Number	Date and Time	Inserted by (print name)	Insertion Reason Code	Gauge	Was aseptic technique breached?	Removed by (print name)	Date and Time	Removal Reason Code
					Yes*/No			
					Yes*/No			
					Yes*/No			
					Yes*/No			

Mod	VIP (Visual Infusion Phlebitis) Score	
IV site appears healthy	0	No phlebitis **OBSERVE CANNULA**
One of the following is evident: • Slight pain or redness near IV site	1	Possible first signs **OBSERVE CANNULA**
Two of the following are evident: • Pain • Erythema • Swelling	2	Early stages of phlebitis **RESITE CANNULA**
All of the following are evident: • Pain along the path of the cannula • Erythema • Induration	3	Mid-stage phlebitis **RESITE CANNULA and SEEK FURTHER ADVICE**
All of the following are evident and extensive: • Pain along the path of cannula • Erythema • Induration • Palpable venous cord	4	Advanced stage of phlebitis or start of thrombophlebitis **RESITE CANNULA and SEEK FURTHER ADVICE**
All of the following are evident and extensive: • Pain along path of cannula • Erythema • Induration • Pyrexia • Palpable venous cord	5	Advanced thrombophlebitis **RESITE CANNULA and SEEK FURTHER ADVICE**

IV Cannula Monitoring & Recording Chart

(Based on the HPS PVC Care Bundle)

Cannula Number	Date and time	Appropriate Hand Hygiene Undertaken?	Has cannula been in situ for 72 hours?	Continuing Clinical Indication	VIP Score	IV Dressing Dry and Intact?	Comments / Action Taken	Initials
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

Patient's name: Catherine Honeyman	Ward: 3
Unit number:	Discharge destination: Home
CHI number: 5900940779	**Estimated Discharge Date** (1) 31/12/11
Apply addressograph label	**Estimated Discharge Date** (2) / /
	Final date of discharge : / /

Checklist	Yes	N/A	Initials	Comments
Patient informed				
Relative/carer informed				
Others informed: Care Home				
Transport arranged				
Own transport (preferred option)				
Ambulance-1 man/ 2 man am/pm				
Other: Flight, Air ambulance etc.				
Discharge medication				
Discharge prescription completed				
Compliance aids e.g. Dossette Box (involve pharmacist)				
Medication received				
Medication explained to patient and/or relative/carer				
Own medication returned to patient				
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)				
Informed of discharge				
Social work/ Other agencies/Home help				
Physiotherapist				
Occupational Therapist				
Dietician				
Speech and Language Therapist				
Clinical Nurse specialist e.g. Care Home Liaison				
Liaison/ District Nurse/Practice Nurse				
Other discharge items				
Access arrangements (e.g. keys, door entry)				
Patients clothing available for day of discharge				
Valuables e.g. cashier				
Intravenous cannula removed				
Equipment ordered (inc. walking aids) in place for discharge				
Part 2 Discharge letter - Required				
- Completed				
Out patient clinic appointment e.g. Anticoagulation clinic				
Arranged / To follow				
If unknown at time of discharge state reason				
Additional information / leaflets / factsheets				
Time of Discharge:				
Nurse's signature:	Designation:			Date: / /

FORM NUMBER 0005752

SOUTHERN GENERAL HOSPITAL

INVESTIGATION INSTRUCTION SHEET

NAME: Catherine Honeyman UNIT NO: 940779 WARD: 3

DATE		DATE	INITIALS
	CRP 57		
	Na 134 Chlor 96 Gluc 10·4.		
	WCC 10·1 Hb 133 Plat 254.		
	MRSA Swab ✓.		
27/3/11	WCC 12 ↑ Hb 133 Plt 254		
	CRP 57↑ Sod 134↓ K 4·0 Chl 96 bicb 23		
	Urea 7·3 Creat 83 ALP 155 other LFTs (N)		
28/3/11	MRSA nasal swab negative		
	WCC (12·9) Hb 130 Plts 258		
	CRP (421) GFR (17)		
	Cl (96) Bic (22) other UTEs (N)		
	Bili (35) ALP (214) AST (168) ALT (208) other LFTs (N).		LB
30·3·11	U+E (N) CRP (↑453) EGFR 760		
	LFTs ~~Alb~~ Alb ↓ 29 Alk Phos ↑ 162 ALTrans ↑ 70		
	FBC - insufficient sample		

DATE		DATE		DATE		DATE		DATE		DATE	

0369451-SGH307

SUR SG00940779
HONEYMAN, CATHERINE
10 MELVILLE STREET
GLASGOW 01/02/1949
D.O G41 2LN CHI 0102496145

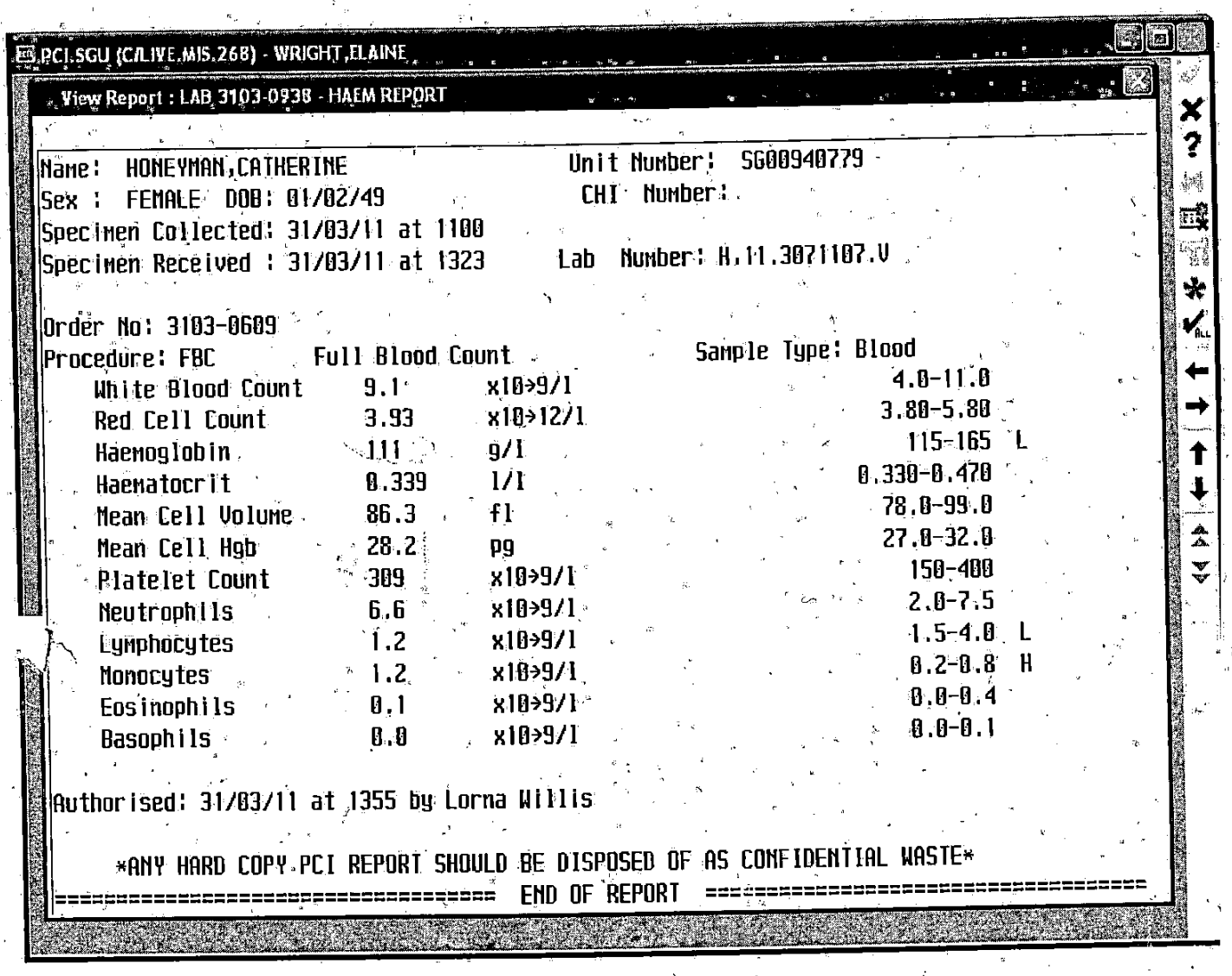
: PATIENT CARE PLAN

Name:_____ Unit No:_____

Date of Admission:_____

Date Commenced & Signature	PERSONAL HYGIENE/DRESSING	Tick	Date Discontinued & Signature
27/3/11	Independent		
CS	Bedbath		
	Shower	HT	
	Immersion Bath		
30.3	Basin	✓	
~~30.3~~	Assistance Required: Number of staff :		
27.3	Oral Hygiene: Independent: Assistance Required:	✓	
	MOBILISATION		
27/3/11	Independent		
CS	Assistance Required:		
29/3	Number of staff : X1 ☐ Helper ✓		
	Aids Used:		
	Walking Stick		
	Zimmer		
	Elbow Crutches X 2	✓	
	Wheelchair		
	Other:		
	EATING & DRINKING		
27/3/11 CS	Normal Diet:	✓	
	Special Diet:		
	Light Diet:		
	Assistance to Eat & Drink:		
	Fluids Only:		
	Dietary Supplements:		
	Parental/Entral Nutrition:		
	Nasogastric Tube:		
	Fasting from: to:		
	Light Early Breakfast: Time:		
	ELIMINATIONS		
27/3/11 CS	Independent:		
	Assistance to Toilet: commode No of Staff: X 1	✓	
	Urinary Catheter:		
	Suprapubic Catheter:		
	Ileal Conduit:		
	Colostomy:		

Date Commenced & Signature	SPECIAL NEEDS/MAINTAIN PERSONAL SAFETY	Tick	Date Discontinued & Signature
	Cotsides	✓	
	Visually Impaired: Removal Hazards		
	TECHNICAL CARE		
27/3/11 CS	Venflon Insitu:	✓	
	IV Infusion:		
	Check Site:		
	Subcutaneous Cannula Insitu:		
	Oxygen: Mask:		
	Rate:		
	Length of Time:		
	OBSERVATIONS		
27/3/11 CS	BP:	✓	
	Pulse:	✓	
	Temperature:	✓	
	Saturations:	✓	
	Fluid Balance:		
	Glucose Monitoring:		
	C.S.M (Fingers:R L)(Toes R L)		
	Vascular Observations:		
	Stool Chart:		
	PAR Scoring:		
	Head Injury Observations:		
	WOUND CARE/OTHERCARE		
27/3/11 CS	Pressure Area Care:		
	Check: ___ Hourly		
	Pressure Cushion:		
	Therapy Mattress:		
	Avant Guard Bed:		
	Wound Assessment Chart:		
	PAIN ASSESSMENT CHART		
28/3/11 CS	Patient Moving & Handling Risk Assessment	✓	
	MISCELLANEOUS		
27/3/11 CS	Ted Stockings: Size:		



PCI.SGU (C/LIVE.MIS.268) - WRIGHT,ELAINE

View Report : LAB 3103-0938 - HAEM REPORT

Name: HONEYMAN,CATHERINE Unit Number: SG00940779
Sex : FEMALE DOB: 01/02/49 CHI Number:
Specimen Collected: 31/03/11 at 1100
Specimen Received : 31/03/11 at 1323 Lab Number: H.11.3071107.V

Order No: 3103-0609
Procedure: FBC Full Blood Count Sample Type: Blood

White Blood Count	9.1	x10→9/l	4.0-11.0	
Red Cell Count	3.93	x10→12/l	3.80-5.80	
Haemoglobin	111	g/l	115-165	L
Haematocrit	0.339	l/l	0.330-0.470	
Mean Cell Volume	86.3	fl	78.0-99.0	
Mean Cell Hgb	28.2	pg	27.0-32.0	
Platelet Count	309	x10→9/l	150-400	
Neutrophils	6.6	x10→9/l	2.0-7.5	
Lymphocytes	1.2	x10→9/l	1.5-4.0	L
Monocytes	1.2	x10→9/l	0.2-0.8	H
Eosinophils	0.1	x10→9/l	0.0-0.4	
Basophils	0.0	x10→9/l	0.0-0.1	

Authorised: 31/03/11 at 1355 by Lorna Willis

ANY HARD COPY PCI REPORT SHOULD BE DISPOSED OF AS CONFIDENTIAL WASTE

========== END OF REPORT ==========

Cannard Falls Risk Assessment

Glossary of terms used in risk assessment

SIGHT DEFICIT means patient cannot see well even when wearing glasses or is registered blind.

HEARING DEFICIT means person has hearing problems even with a hearing aid or has hearing problems and does not wear a hearing aid.

BALANCE DEFICIT means person is unable to stand without the support of another person or a walking frame.

MEDICINES FOR SOME MENTAL ILLNESSES include Chlorpromazine (Largactil), Risperidone (Risperdal), Lithium (Camcolit or Priadel), Haloperidol, Chloral hydrate (Welldorm), Clomethiazole (Heminevrin), antidepressants, Diazepam, Lorazepam and Amitriptyline.

CARDIOVASCULAR SYSTEM MEDICATION all antihypertensive medication and inotropes including Captopril, atenolol and many others.

WATER TABLETS (DIURETICS) are such as Bendroflumethiazide, Furosemide and Co-amilofruse.

SEDATIVES / ANALGESIA AT NIGHT include medicines such as Diazepam, Temazepam, Nitrazepam, Chlordiazepoxide and Zopiclone (Zimovane) Morphine PCA, Fentanyl, Tramadol and Oxycontin.

INABILITY TO CO-OPERATE includes failure to use walking aids or putting themselves in situations with a high risk of falling (usually due to mental impairment).

RESTRICTED MOBILITY means the person requires supervision and/or help to walk (i.e. is not safe to walk alone even with an aid).

HESITANT IN INITIATING MOVEMENT means difficulty in starting to walk.

POOR TRANSFER means the person requires help and is not safe to do the following alone - get in or out of bed, on or off a chair, move from chair to standing.

Acute Services Division

Hospital / Department: Shaw

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

Patient name:	SG0094077 9 HONEYMAN, CATHERINE 01/02/1949
Ward:	G41, 2LN
CHI number:	Practice Code: 49074 CHI 0102496145 Unit/Hospital number

Contents

1. Canard Falls Risk Assessment Scoring Form
2. Falls Assessment Care Plan
3. Glossary of terms used in risk assessment

Notes: Risk assessment should be completed within 24 hours of admission to each ward.

Assessment Wards: Risk assessment and care plan should be reviewed weekly.

Continuing Care Wards: Risk assessment and care plan reviewed monthly.

Referral Criteria for Hospital Falls Prevention Co-ordinator

1. Cannard score of 18+.
2. Second or subsequent fall
3. Significant Injury caused by a fall. (Significant Injury defined as any fracture, significant bruising or laceration to head or body.)

The patient should be referred with any of the above criteria.

General Safety Precautions

- Ensure patient has buzzer to hand
- Check patient has the manual dexterity and cognitive ability to operate buzzer
- Place personal items within easy reach
- Keep the bed in lowest position possible (use low bed if available)
- DO NOT leave patients with cognitive impairment unattended on commodes, in toilets, baths and showers.
- Patients with poor mobility, who are known not to ask for assistance, should not be left unattended on commodes, toilets, baths and showers.
- If noted that mobility / transfers are unsafe refer to physio / OT for assessment
- If patient wears glasses, ensure they are clean
- Ensure patient's footwear is adequate
- Lock wheels on all wheelchairs, beds, commodes and trolleys when in use
- Provide adequate lighting at night
- Request medication review if appropriate
- Clean up spills immediately
- Orientate patient to the ward environment

Cannard Falls Risk Assessment

(Must be completed within 24 hours of admission to each ward)

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0									
Sex	Male 1	Female 2										
Age	13-59 0	60-70 1	71-80 2	81+ 1								
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0								
Medication type**	Drugs for mental illness 1	Blood pressure / water tablets 1	Sleeping tablets 1	None of these 0								
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1							
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed / chair-bound/ wheel-chair 1								
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3								
				TOTAL SCORE								
				ACTION(S) TAKEN Enter action code(s) from Care Plan below								
SCORE 13+ = HIGH RISK If patient unconscious score as N/A until patient status improves.				NURSE SIGNATURE								

Please see back page for glossary of terms relating to the assessment above.

Falls Assessment Care Plan

Please tick all applicable nursing interventions

Action code	NURSING INTERVENTIONS	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:
1	Falls prevention and general safety precautions discussed with patient and family.							
	Move to more observable area of ward to optimise supervision.							
	Advise patient they may experience dizziness when they mobilise initially.							
4	Requires assistance with mobilisation.							
5	Observe trip hazard due to invasive lines, drains and catheters.							
6	Do not leave the patient unattended when using commode, toilet, in shower or the bathroom area.							
7	If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.							
8	Monitor lying and standing / sitting BP and pulse.							
9	A. Patient requires footwear or podiatry referral. (Date referred: / requested :) B. Request family / carer to provide suitable footwear.							
10	Commence continence assessment, follow Local Guidelines.							
11	Refer to Occupational Therapist.							
12	Select suitable seating (refer to policy).							
13	Non slip mat on chair /floor following advice from therapists.							
14	Refer to Physiotherapist.							
15	Review Transfer techniques.							
16	Request medication review.							
17	Bed/chair monitor in use.							
18	Falls map in use for seven days for patient who has second or subsequent falls.							
19	Bed rails/bumpers to be used (refer to policy).							
20	Patient requires low bed / mattress on the floor (refer to policy.)							
21	Patient requires one to one nursing care.							
22	Refer to Hospital Falls Prevention Co-ordinator (see criteria on front cover).							
23	Other interventions.							

Review Cannard score weekly / monthly as per policy. Enter action code(s) selected in action taken section on Falls Risk Assessment page above.

SOUTH GLASGOW HOSPITALS DIVISION — SOUTHERN GENERAL HOSPITAL

NURSING PROFILE

Name: CATHERINE HONEYMAN — Unit No: SG00940779 — Acct No: IP0016709/11

Address: 10 MELVILLE STREET
GLASGOW
G41 2LN
Tel: 0414221580

Consultant: HULLIN,MIKE

DOB: 01/02/49 Age: 62
CHI: 0102496145
Rel:

Ward: S03
Date: 27/03/11
Time: 0645

Marital Status: MAR

Next of Kin: HONEYMAN,RAYMOND
Address: 10 MELVILLE STREET
GLASGOW
Tel: 0414221580
Relationship: HUS

GP: MARSHALL, GRAEME G
Practice Address: GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ
Tel: 0141 531 8250

Other Contact:
Tel: Relationship:

REASON FOR ADMISSION:- RIGHT KNEE PAIN

SHORT SUMMARY:- LONGSTANDING HX OF PAIN IN R KNEE, INCREASING IN SEVERITY, NOW UNABLE TO WEIGHTBEAR.JOINT ERYTHEMATOUS, CELLULITIC AROUND SCAR. HAD LTKR AND R PATELLA RESURFACING 2010, REVISION R PATELLA MAY 2010 THEN READMITTED WITH HAEMATOMA AND INFECTION

PAST MEDICAL HISTORY

- AS ABOVE
- ANGINA
- ARTHRITIS
-
-
-

MEDICATIONS ON ADMISSION

1) SIMVASTATIN
2) ATENOLOL
3) TRAMADOL
4) ASPIRIN
5) BENDROFLUAZIDE
- FLUOXETINE
LOSEC

********** Allergies **********

NKDA

VOLTAROL

ESTIMATED DATE OF DISCHARGE:

(T) 31/3/11 1ST STAGE REVISION
(R) KNEE I/C INSERTION OF CEMENT SPACER.

Name: CATHERINE HONEYMAN Unit No: SG0094077 9 Acct No: IP0016709/11

GENERAL ASSESSMENT

> IN PAIN, HAD COCODAMOL IN CASUALTY, REQUIRED MORPHINE ON ARRIVAL TO WARD. ASSISTED WITH TRANSFER.

SOCIAL/HOME BACKGROUND

> LIVES WITH HUSBAND AND DAUGHTER. NON SMOKER, SELDOM ALCOHOL. DOESNT GET OUT MUCH, SCARED OF FALLING.

RELATIVES AWARE OF ADM Y/N?:- Y Comment:

ACTIVITIES OF DAILY LIVING

MAINTAINING SAFE ENVIRONMENT: Risk of Falls
Requires Supervision

COMMUNICATING: Communicates Freely

BREATHING: Can Maintain Airway

EATING/DRINKING: Good Appetite

ELIMINATING: Normal Bowel Function
Normal Bladder Function

CLEANSING/DRESSING: Assistance

TEMPERATURE: Apyrexial

MOBILISING: Risk of Falls
Walking Aid(See Note) - elbow crutches

WORKING/PLAYING: Housebound
Not Active Socially

SLEEPING: Good Sleep Pattern

DYING: Not Appropriate Discuss

SOUTH GLASGOW HOSPITALS DIVISI : SOUTHERN GENERAL HOSPITAL

N RSING PROFILE

Name: CATHERINE HONEYMAN Unit No: SG00940779 Acct No: IP0016709/11

SKIN CONDITION: IN BROKEN

Does patient smoke? N
Does patient want to stop smok g NOW?
Has patient been referred to op Smoking Service'?

BP:143/81 mmHG Pulse: 11 /min Resp: 16 /min SpO2: 96 % Temp: 36 C
Weight:95 Kg Height:5 ft.4 in / Metric: cm BM: BMI: 35
Waterlow Score: 8 Urinalys :

Highly Sensi Document Y/N Patient consent to share information Y/N Y

Completed By (Sign):

Completed by: CLARE SANTIAGO on/at 27/03/11 0646 Report Number: 2703-0005

SOUTHERN GENERAL HOSPITAL

DEPARTMENT:

NAME: Catherine Honeyman . UNIT NO. 940779 , WARD: 3

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
27/3/11	0730	Admitted as per profile Orientated to ward and staff Commenced on IV abiotics - given fluclox. dose, still for gentamicin Knee not aspirated in A+E, hot and fiery - apyrexial. Tachycardic at 115 sews 2. For reveiw by Mr Hullin today Reviewed by Mr Meek, attended Theatre for aspiration of R Knee under Local. Allowed diet and fluid. Given cyclizine and s/c morphine 5mg @ 1130 for pain relief. Vomitted a moderate amount of bile and water brash. Assisted with personal hygiene. Unable to weight bear on R leg. Vague at times. Obs post-op BP 104/69 P78 T36 R17 sats 95% on air. IV abiotics discontinued. Earlier used a bed pan but able to transfer to commode using elbow crutches	J Sweeney
	1330.	To fast from midnight for Theatre tomorrow for further exploration. Re-commenced on IV Flucloxacillin 2gm settled evening. Transferring to commode independently Passing Jane Diet + fluids taken IV antibiotics continue sews 0 Fast 12mn for theatre Paracetamol 1g and Tramadol 50mg for pain.	J Sweeney Abalid
28/3/11	0400	IV flucloxacillin 2gr at 10pm. Tramadol and paracetamol for pain at 10pm with little effect, therefore given oramorph 10mg @ midnight with better effect. Slept for short periods only. Transferring to commode with little assistance. Knee remains swollen. Obs satisfactory Fasting from midnight ? theatre again. Oramorph 10mg repeated @ 0330hrs	

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SOUTHERN GENERAL HOSPITAL

DEPARTMENT: Surgical

NAME: C. Honeyman UNIT NO. WARD: 3

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
29/3/11		Datix completed. Cannot full assessment rescored. Patient advised to use commode at bedside. Independent with personal hygiene. Managing diet & fluids well. Passing urine spontaneously Bowels Paracetamol + Tramadol effective for pain. Observations satisfactory. (R) Knee remains swollen, red reducing slowly. Wound cleansed & dry dressing applied. Patient applying talcum to wound - discouraged from doing so. J/S MW Mullin for continue on IV Flucloxacillin till sensitivities available from microbiology - then to convert to oral antibiotics and aim for home.	CMcF
	2200	Venflon rested and IV antibiotics as prescribed. Commenced on oral rifampacin. Sens O Knee unchanged Using commode - transferring with supervision. Diet + fluids taken commenced on Rifampacin.	RatclF
30/3/11	0500	IV antibiotics given Slept for short periods, disorientated at times Up to commode for toilet. Knee remains swollen Paracetamol and tramadol for pain. Not washed this morning. Will have later on. Feeling tired and sore Continues on IV antibiotics - Rifampicin 600mg orally Knee remains swollen / painful Transferring to commode - passing urine. Sens O Diet + fluids taken Paracetamol 1G and tramadol 50mg for pain. Not reviewed today Washed and oral hygiene attended to	RatclF Patrick

SOUTHERN GENERAL HOSPITAL

DEPARTMENT: C. Care

NAME: Catherine Henderson UNIT NO. SC0095078 WARD: Scal

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
3/3/14	30	Transferred from recovery Morning: Post surgical revision of (R) knee I/C insertion of cement spacer. Pain issues in recovery: given 6mg bolus of IV morphine in dilution & 1mg via morphine PCA. also given next 120mg of Ketorolac IV in recovery. Experiencing apnoea in knee - note good sensation and movement in toes colour also satisfactory. Note ABG's in recovery: pO_2 ↓ 6.8 Sp_2O_2 88% - ∴ connected on a venturi next @ 15L, known on return to unit on 6L via face mask. S_pO_2 ≥ 97% O_2 changed to 6L via M. S_pO_2 ≥ 96% RR: 23 bpm, good cough ECG: S.R HR: 77 bpm BP: 137/68 (92). Apyrexial - colour pink/warm in face Spinal insertion to (R) knee - no evidence of leaking fluid through dressings limbs satisfactory: Serum/Serum not seen. Nursed on a bed for now returning morphine PCA visit: 1mg/5ml bolus Pain score 5-6/10 on return: encouraged to use PCA more effectively does appear drowsy, but rousing & conversation: observe for evidence of	

SOUTHERN GENERAL HOSPITAL

DEPARTMENT: Critical Care.

NAME: Catherine Honeyman. UNIT NO. 5900940779 WARD: SHOU

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
01/04/11	0600	Lines: Arterial line to left radial artery patent and secure, good waveform, good blood return. 2 x peripheral line VIP score 0 1x left hand not in use 1x right hand patent and in use for IV fluids and pca.	
		Pain regular paracetamol as prescribed morphine pca insitu 1mg/1ml with 5 min lockout, using small amounts, pain score 8-5. 1x override @ 0505.	
		Hygiene freshen up and oral hygiene conducted prior to settling.	J M Meeken (F. MEEKEN)
		Relatives no contact overnight.	
1/4/11	10^{20}	Pain review - Continue PCA today. Oxycontin 10mg BD to commence today. When PCA discontinued oramorph 10mg prescribed for breakthrough pain.	S Morris
WR	10^{30}	Reviewed by Mr Hullin wound to be left intact. Splint can be off when in bed but MUST BE ON when mobilising - no restrictions to weight bearing status when up.	AM CARRON.
	1120.	RESPIRATORY:-	
		O2 continues between 4-6L via nasal cannula (humidified).	
		sats 99-100%. Chest	
		appears clear.	
	CVS:	systolic: 120 - 126	
		diastolic 58 - 53.	
		Map 79.	
		Temp 36^4.	
		NEUR/SED/COM:	
		Appears slightly sedated due to analgesia. Chatty when awake. No hallucinations this am.	
		NUTRITION/HYDRATION	AM CARRON.

0369438-SGH-J06A

SOUTHERN GENERAL HOSPITAL

DEPARTMENT: Ortho

NAME: Catherine Honeyman UNIT NO. SG 09/67/79 WARD: 2

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
02/04/11	0455	Unsettled night, unable to find comfortable position in bed. Morphine PCA remains in situ, all other medications given as per Kardex. Observations satisfactory - SEWS 0. SpO_2 96% on air, passing urine spontaneously, using bedpan, patient feels unable to mobilise onto commode. Patient tearful at times, reassurance offered, Camp splint remains in situ, dressing dry and intact. —— Oxynorm given as per kardex for review in 3 days. Bandage insitu as per instruction. PCA refilled.	KBKIRD. SNO
	1830	Assisted wash given. Remained in bed today. Observations Stable. PCA discontinued as oramorph. Attempts a IVABS. Dressing remains intact. Hb 91 at 0400 tomorrow. Ferrous fumarate. On enquarter BD. Sat 91 o/A 2L O_2 via nasal cannula.	
3/4/11	N/D	Patients observations satisfactory SEWS=0. All medication administered as prescribed including IVAB. Patient unhappy prior to sleeping due to being uncomfortable in bed. Patient requested an electric bed for better comfort. No electric bed available, patient unhappy about this. Oramorph given twice overnight with good effect. Eating and drinking well. Passing urine via bedpan spontaneously. Settled evening, sleeping for long periods of time.	
	1430	Washed with minimum assistance. IVAB's continue as prescribed. Transferring from bed to chair	

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NHS
Greater Glasgow and Clyde

NATVNS
SCOTLAND

WRITE, IMPRINT OR ATTACH LABEL
Surname Honeyman CHI No 0102496145
Forenames Catherine Sex F
DoB 01/02/49
Location SHDU

DAILY REPOSITIONING & SKIN INSPECTION CHART

DATE 31/03/11

- Inspect skin for evidence of change
- Reassess at every positional change and document below
- Reposition the person to reduce the risk of further damage, eg using the 30 degree tilt
- Use manual handling aids to minimise risk of friction and shear
- Individuals on any form of pressure redistribution equipment still require skin inspection and regular repositioning
- Provide suitable seating including pressure redistribution cushions, if required, encourage repositioning/mobilisation where possible
- Acutely ill people are seated out for no longer than 2 hours and returned to bed for no less than 1 hour

(Reference: Best Practice Statement-Prevention & Management of Pressure Ulcers-March 2009)

TIME	REPOSITIONING (USING CODES) FROM	TO	SKIN INSPECTION COMMENTS	ACTION TAKEN	SIGNATURE
Eg: 08:00	L	U	Left Hip Non-Blanching	Reassess at next positional change	
1830	Admitted from theatre		Heels in tact sacrum not seen	reassess	EM
2100	B	rolled B	heels intact sacrum pink intact	reassess	JM
2300	B	bedpan B	"	reassess	JM
01/04/11 0200	moving around bed independently				JM
0800	"	"	"		AMC
1000	turned: sacrum satisfactory, heels satisfactory			reassess	both AMC

Code: L = LEFT, R = RIGHT, B = BACK, P = PRONE (FRONT), M = MOBILISED, U = UP TO SIT

NHS
Greater Glasgow and Clyde

NATVNS
SCOTLAND

WRITE, I

Surname SG00940779
HONEYMAN, CATHERINE
Forenam 10 MELVILLE STREET
DoB ..... GLASGOW 01/02/1949
Location G41 2LN CHI 0102496145

ADAPTED WATERLOW PRESSURE AREA RISK ASSESSMENT CHART

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

Complete assessment on admission/1st visit, if there is a change in individuals condition and repeat regularly according to local protocol

Sex										
Male	1									
Female	2	2	2	2						
Age										
14 -49	1									
50 -64	2	2	2	2						
65 - 74	3									
75 - 80	4									
81+	5									
Build/Weight for Height (BMI=weight in Kg/height in m²)										
Average - BMI 20-24.9	0									
Above average - BMI 25-29.9	1									
Obese - BMI > 30	2		2	2						
Below average - BMI < 20	3									
Continence										
Complete/catheterised	0	0	0	0						
Incontinent urine	1									
Incontinent faeces	2									
Doubly incontinent (urine & faeces)	3									
Skin Type - Visual Risks Area										
Healthy	0	0	0	0						
Tissue paper (thin/fragile)	1									
Dry (appears flaky)	1									
Oedematous (puffy)	1									
Clammy (moist to touch)/pyrexia	1									
Discoloured (bruising/mottled)	2									
Broken (established ulcer)	3									
Mobility										
Fully mobile	0									
Restless/fidgety	1									
Apathetic (sedated/depressed/reluctant to move)	2									
Restricted (restricted by sever pain or disease)	3	3	3							
Bedbound (unconscious/unable to change position/traction)	4									
Chairbound (unable to leave chair without assistance)	5			5						
Nutritional Element										
Unplanned weight loss in past 3-6 months										
<5% Score **0**, 5-10% Score **1**, >10% Score **2**	0-2	0		0						
BMI > 20 Score **0**, BMI 18.5-20 Score **1**, BMI < 18.5 Score **2**	0-2									
Patient acutely ill or no nutritional intake > 5 days	2									
Special Risks - Tissue Malnutrition										
Multiple organ failure/terminal cachexia	8									
Single organ failure e.g. cardiac, renal, respiratory	5									
Peripheral vascular disease	5									
Anaemia = Hb < 8	2									
Smoking	1	0	0	0						
Special Risks - Neurological Deficit										
Diabetes/MS/CVA/motor/sensory/paraplegia *Max 6*	4-6	0		0						
Special Risks - Surgery/Trauma										
On table > 6 hours	8									
Orthopaedic/below waist/spinal (up to 48 hours post op)	5			5						
On table > 2 hours (up to 48 hours post op)	5	0								
Special Risks - Medication										
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*	4	0		0						
Total Score		7	9	10						
Date		27/5	30.5	31/5						
initials		CS	AR	MM						
Time		0930	11am	1704						

83826

Ensure plan of care is implemented / reviewed for all identified areas of concern.

NHS
Greater Glasgow and Clyde

NATVNS
SCOTLAND

WRITE, IMPRINT OR ATTACH LABEL
Surname Honeyman CHI No
Forenames Catherine Sex F
DoB
Location TWO, SCH

ADAPTED WATERLOW PRESSURE AREA RISK ASSESSMENT CHART

More than one score/category can be used: **10+= 'At Risk': 15+= 'High Risk': 20+= 'Very High Risk'**
Complete assessment on admission/1st visit, if there is a change in individuals condition and repeat regularly according to local protocol

Sex										
Male	1									
Female	2	2	2	2						
Age										
14 -49	1									
50 -64	2	2	2	2						
65 - 74	3									
75 - 80	4									
81+	5									
Build/Weight for Height (BMI=weight in Kg/height in m²)										
Average - BMI 20-24.9	0									
Above average - BMI 25-29.9	1									
Obese - BMI > 30	2	2	2	2						
Below average - BMI < 20	3									
Continence										
Complete/catheterised	0	0		0						
Incontinent urine	1									
Incontinent faeces	2									
Doubly incontinent (urine & faeces)	3									
Skin Type - Visual Risks Area										
Healthy	0	0		0						
Tissue paper (thin/fragile)	1									
Dry (appears flaky)	1									
Oedematous (puffy)	1									
Clammy (moist to touch)/pyrexia	1									
Discoloured (bruising/mottled)	2									
Broken (established ulcer)	3									
Mobility										
Fully mobile	0									
Restless/fidgety	1									
Apathetic (sedated/depressed/reluctant to move)	2									
Restricted (restricted by sever pain or disease)	3									
Bedbound (unconscious/unable to change position/traction)	4	4	4	4						
Chairbound (unable to leave chair without assistance)	5									
Nutritional Element										
Unplanned weight loss in past 3-6 months										
<5% Score **0**, 5-10% Score **1**, >10% Score **2**	0-2									
BMI > 20 Score **0**, BMI 18.5-20 Score **1**, BMI < 18.5 Score **2**	0-2									
Patient acutely ill or no nutritional intake > 5 days	2	0		0						
Special Risks - Tissue Malnutrition										
Multiple organ failure/terminal cachexia	8									
Single organ failure e.g. cardiac, renal, respiratory	5									
Peripheral vascular disease	5									
Anaemia = Hb < 8	2									
Smoking	1	0		0						
Special Risks - Neurological Deficit										
Diabetes/MS/CVA/motor/sensory/paraplegia *Max 6*	4-6	0		0						
Special Risks - Surgery/Trauma										
On table > 6 hours	8									
Orthopaedic/below waist/spinal (up to 48 hours post op)	5									
On table > 2 hours (up to 48 hours post op)	5	0		0						
Special Risks - Medication										
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*	4	0		0						
Total Score		10	10	10						
Date		3/4	4/4	5/4						
initials		DP	SS	SK						
Time		0800	0900	1100						

83826

Ensure plan of care is implemented / reviewed for all identified areas of concern.

SOUTH GLASGOW HOSPITALS
PATIENT MOVING AND HANDLING RISK ASSESSMENT

NHS Greater Glasgow and Clyde

Patient's Name: Catherine Harlyman

If patient is totally independent, tick here and go to date box

Named Nurse:

BODY BUILD

Obese		Tall	
Above average	✓	Medium	✓
Average		Short	
Below Average		Weight:	

Problems with comprehension, behaviour, co-operation (specify)

Handling constraints,e.g. disability, weakness, pain, skin lesions infusions (specify)

RISK OF FALLS: High ✓ Low

INTO BATH OR SHOWER

HANDLING AID		WHICH BATH	
Hoist (Specify)	✓	Parker	
Shower chair		Variable height	
		Standard	
		Any	✓

ASSISTANCE | SUPERVISION ✓ | INDEPENDENT

Staff required: X 1

TRANSFERS (including to/from: bed, wheelchair, commode, toilet)

HOIST		MANUAL SUPPORT
Which hoist?		Staff required: X 1
Sling type?		Specify support given
Sling size?		

ASSISTANCE | SUPERVISION ✓ | INDEPENDENT

Additional information

X 1

TOILETING

HOIST		MANUAL SUPPORT
Which hoist?		Staff required: X 1
Sling type?		Specify support given
Sling size?		

ASSISTANCE | SUPERVISION ✓ | INDEPENDENT

Additional information

a commode at bedside

WALKING

NO WALKING		ASSISTANCE	✓	SUPERVISION	INDEPENDENT
Staff required:				Distance walked / additional information	
Walking Aid					

MOVE UP/DOWN BED

HOIST		MANUAL SUPPORT	
Which hoist?		Sliding aid	
Sling type?		Rope ladder	
Sling size?		Hand blocks	
		Monkey poles	

ASSISTANCE | SUPERVISION | INDEPENDENT ✓

Additional information (include details of any therapy beds used)

Staff required:

SIT UP OVER SIDE OF BED

Rope ladder		Sliding aid		ASSISTANCE		SUPERVISION ✓	INDEPENDENT ✓

MOVE ON/OFF BED PAN

Hoist		Roll Patient		Patient bridges	✓	Monkey pole	Not used

TRANSFER TO/FROM TROLLEY (or bed etc)

Sliding aid (rigid)		Sliding aid (fabric)		Transfer aid (specify)		Staff required (specify) X 1	INDEPENDENT

Date assessed: 27/3/11 Assessors signature:

Date reviewed	30/3								
Assessors signature	N								

THERAPEUTIC HANDLING INSTRUCTIONS

Date	Instruction	Therapist's Name

SOUTH GLASGOW HOSPITALS
PATIENT MOVING AND HANDLING RISK ASSESSMENT

NHS Greater Glasgow and Clyde

Patient's Name: Catherine Honeyman

If patient is totally independent, tick here and go to date box

Named Nurse: S/N J PATON

BODY BUILD

Obese		Tall	✓
Above average		Medium	
Average		Short	
Below Average		Weight:	

Problems with comprehension, behaviour, co-operation (specify): None

Handling constraints.e.g. disability, weakness, pain, skin lesions infusions (specify): Pain

RISK OF FALLS High ☐ Low ✓

INTO BATH OR SHOWER

HANDLING AID		WHICH BATH	
Hoist (Specify)		Parker	
Shower chair		Variable height	
		Standard	
		Any	

ASSISTANCE ☐ SUPERVISION ☐ INDEPENDENT ☐

Staff required:

Not at present.

TRANSFERS (including to/from: bed, wheelchair, commode, toilet)

HOIST		MANUAL SUPPORT
Which hoist?		Staff required:
Sling type?		Specify support given
Sling size?		

ASSISTANCE ☐ SUPERVISION ✓ INDERENDENT ☐

Additional Information: Patient bridges. Using bedpans at present

TOILETING

HOIST		MANUAL SUPPORT
Which hoist?		Staff required:
Sling type?		Specify support given
Sling size?		

ASSISTANCE ☐ SUPERVISION ✓ INDEPENDENT ☐

Additional Information: Bedpans

WALKING

NO WALKING ✓ ASSISTANCE ☐

Staff required:

Walking Aid

SUPERVISION ☐ INDEPENDENT ☐

Distance walked / additional information

MOVE UP/DOWN BED

HOIST		MANUAL SUPPORT	
Which hoist?		Sliding aid	
Sling type?		Rope ladder	
Sling size?		Hand blocks	
		Monkey poles	

ASSISTANCE ☐ SUPERVISION ☐ INDEPENDENT ✓

Additional information (include details of any therapy beds used)

Staff required:

SIT UP OVER SIDE OF BED

Rope ladder ☐ Sliding aid ☐ ASSISTANCE ☐ SUPERVISION ✓ INDEPENDENT ☐

MOVE ON/OFF BED PAN

Hoist ☐ Roll Patient ☐ Patient bridges ☐ Monkey pole ✓ Not used ☐

TRANSFER TO/FROM TROLLEY (or bed etc)

Sliding aid (rigid) ✓ Sliding aid (fabric) ☐ Transfer aid (specify) ☐ Staff required (specify) ☐ INDEPENDENT ☐

Date assessed: 3/4/11 Assessors signature: J Paton

Date reviewed								
Assessors signature								

THERAPEUTIC HANDLING INSTRUCTIONS

Date	Instruction	Therapist's Name

SOUTHERN GENERAL HOSPITAL

DEPARTMENT:

NAME: Catherine Honeyman UNIT NO. WARD: TWO

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
1/4/11	N/S	Observations satisfactory SEWS = 0. Medication as prescribed including IVAB. Passing urine spontaneously via bedpan, good volumes. Independent ↑ pressure area care overnight. Settled evening.	J Paton S/N (5)
1/4/11	15⁰⁰.	Patient assisted with minimal assistance. IVAB continue as per kardex. Compliant remains in situ; mobilising from bed to chair. Dressing reviewed. Wound cleansed and redressed with tegaderm to area. Wound remains clean and dry with no complaints offered. Pain relief given as per kardex. All other medications given as per kardex. Passing urine spontaneously via bedpan, good volumes. Observations satisfactory SEWS=0. Returned to bed early this afternoon and remains in bed at time of writing — S/B Pain nurse on kardex ↑ c/o nausea x1 ondansetron 4mg given with effect. NR S/B Mr Hillin to chase samples taken in theatre	Diane O'Connor S/N. Diane O'Connor S/N.
2/4/11	N/D	Observations satisfactory SEWS = 0. All medication administered as prescribed including IVAB. Transferring well using Zimmer frame to use commode. Passing urine spontaneously. Settled and slept well overnight, offering no complaints.	J Paton S/N (5)
	18.30	Patient discharged as per check list meds given and explained to patient. O/P appointment 1 wk Fri 11/4/11	

SOUTHERN GENERAL HOSPITAL

DEPARTMENT: CRITICAL CARE

NAME: CATHERINE HOLEYMAN UNIT NO. SG 00946779 · WARD: SHDU ·

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
31.4.11	Cont	IV fluids @ 125mls/hr.	
		Diet & fluids tolerated well.	
		Has not passed urine since 0600, does not feel the "need to go" yet, no discomfort from bladder/ abdomen.	
		ELIMINATION:- No bowel movement as yet.	
		WOUND:-	
		Left intact as instructed by Mr Hullin.	
		Camp splint off for short time while in bed.	
		TISSUE VIABILITY:-	
		Moving around bed freely skin intact. Nursedon soft form mattress.	
		PAIN:-	
		Morphine PCA, using well but still uncomfortable.	
		Commenced on oral oxycontin & paracetamol.	
		Reviewed by pain team.	
		RELATIVES:	
		Husband phoned, informed of planned transfer to Ward 2, and spoke to Catherine.	AM'CARRON SN
	12⁰⁰	Arterial line removed.	
		Ventlon dislodged - FYI.	
		aware - awaiting insertion of new ventlon.	AM'CARRON SN
	12⁴⁰	Ventlon resited PJ'd 350.	AM'CARRON
1.4.11	17⁴⁵	Returned from SHDU, alert and orientated, Morphine PCA IV x 2 in situ IVT x 1 intact commenced oxycontin BD Dressing not to be reviewed today Consultant instructed Camaplin IV site. No yesterday IVT 40 ml today Observations as per chart	
	P30	Observations stable P.A. A&I IVT x 1 continues	

SOUTHERN GENERAL HOSPITAL

DEPARTMENT: Critical Care

NAME: Catherine Honeyman UNIT NO. SG0094077 9 WARD: SHDU

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
		over - sedation.	
		IV access x 2 : V-10 sense	
		O. aware, tire, x. x. A.	
		- IV clinics in progress	
		@ 83 c/c. Ext c wt	
		as able. Chest xs @ 2000	
		Commence IV antibiotics	
		are marked. Urine	
		as able with free syringe	
		For antibiotics for trough	SSN
		6/52 : s. MRSA swabs ✓	[illegible]
		No wound cultures :	[illegible]
		nc passed urine yet	
1/04/11	0600	Respiration O2 sats 95-96 % on 6 l/hrs via humidified nasal cannula, nil cough expectorate RR - 13-24. O2 ↓ 4 l/hrs	
		CVS HR SR - rate - 80-96.	
		invasive blood pressure monitored 1 hrly	
		systolic - 142 - 94.	
		dystolic - 70 - 44.	
		map - 62 - 90	
		temp - 36.7 - 37.9	
		Neuro/sed / Comms appears sedated from opiods, orientated to time place and person, communicating needs verbally. visual hallucinations at times overnight.	
		Bloods fbc checked @ 2000 hrs - HB - 100 WCC 8.7 plts 306.	
		Nutrition / Hydration - tolerating oral diet and fluids when awake, IV abs as charted, oral medications as charted, IV fluids running 125 - 83 mls/hr.	
		Elimination bowels inactive, nil nausea/ vomit, passing urine spontaneously into urinals 680 mls passed overnight.	
		Wound dressing to right knee appears dry and intact, splint remains insitu	
		Tissue Viability / Mobility - remains on bedrest, nursed on softform mattress heels and elbows intact, sacrum pink but intact, regular positional changes given, plus patient moving around - independently.	

SOUTHERN GENERAL HOSPITAL

DEPARTMENT:

NAME: Carth Honeyman. UNIT NO. WARD: 8 2

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
2/3/11	1900	Settled evening	
		Diet & fluids enjoyed.	
		Passing urine spontaneously using commode	
		Bowels inactive for 5-6 days - pt denies any discomfort.	
		Remains on bedrest. Continues on IV fludoxacillin	
		Given paracetamol and tramadol for pain with poor effect only - given oramorph 10mg @ 1755 with better effect.	caw/pn
	2000	Patient for transfer to ward 2. Patient & family aware of transfer. Handover given.	caw
3/11	N/P	Patient transferred to ward 2 as planned	
		IVAB 2g fluclox as per kardex	
		Verplan reviewed. Patient transferring using ZLF and supervision. Oral antibiotic	
		rifampicin as prescribed. Oramorph required	
		for breakthrough - For repeat bloods and ? washout if required.	[illegible] 5/10
3/3/11	1645	SR anaesthetist for ECG, patient stated	
		had chest pain on left side this am	
		RV to review same requested ? theatre	
		for washout, ? maybe cancelled to	
		be reviewed	[illegible]
	1700	Attending theatre ? NOM P/O.	[illegible]

SOUTHERN GENERAL HOSPITAL

DEPARTMENT:

NAME: UNIT NO. WARD:

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
		Temp 37° - Paracetamol 1gr @ 0640.	
		Basin to wash at bedside	
		Independent with personal and oral hygiene.	
		Right knee remains very swollen	
		Transferring independently to commode	
		Seen by Mr Hullin - not for theatre today continue IV antibiotics	
		Flucloxacillin 500mg Q.I.D.	
		Ventolin to be restitled	
		Microbiology contacted FYI - aspirate growing Staph aureus - await sensitivity	
		SHO contacted re further management	
		sees O	
		Taking diet + fluids. Passing urine	
		Taking paracetamol 1G and tramadol 50mg for pain	
28/3/11	2000	Settled afternoon. Uncomplaining	
		Continues on 2gm IV Flucloxacillin	
		Mobile between bed + commode.	
		Observations satisfactory	
		Taking diet + fluids well	
		(R) knee remains swollen but less inflammed	
		Paracetol 1gm and Tramadol 50g effective for pain.	
		Theatre cancelled meantime, await bacteriologist advice re - knee aspirate growing staph aureus.	
		Intravenous antibiotics given as prescribed	
29/3/11	0600	Slept for short periods. Paracetamol + tramadol for	
		right knee remains swollen	
		Temp 37.8 - paracetamol 1g at 0630	
29/3/11	0800	Patient up mobilising to toilet using elbow crutches, stopped when coming out of toilet - reviewed by orthopaedic doctors - no apparent injury.	

Cannard Falls Risk Assessment

Glossary of terms used in risk assessment

SIGHT DEFICIT means patient cannot see well even when wearing glasses or is registered blind.

HEARING DEFICIT means person has hearing problems even with a hearing aid or has hearing problems and does not wear a hearing aid.

BALANCE DEFICIT means person is unable to stand without the support of another person or a walking frame.

MEDICINES FOR SOME MENTAL ILLNESSES include Chlorpromazine (Largactil), Risperidone (Risperdal), Lithium (Camcolit or Priadel), Haloperidol, Chloral hydrate (Welldorm), Clomethiazole (Heminevrin), antidepressants, Diazepam, Lorazepam and Amitriptyline.

CARDIOVASCULAR SYSTEM MEDICATION all antihypertensive medication and inotropes including Captopril, atenolol and many others.

WATER TABLETS (DIURETICS) are such as Bendroflumethiazide, Furosemide and Co-amilofruse.

SEDATIVES / ANALGESIA AT NIGHT include medicines such as Diazepam, Temazepam, Nitrazepam, Chlordiazepoxide and Zopiclone (Zimovane) Morphine PCA, Fentanyl, Tramadol and Oxycontin.

INABILITY TO CO-OPERATE includes failure to use walking aids or putting themselves in situations with a high risk of falling (usually due to mental impairment).

RESTRICTED MOBILITY means the person requires supervision and/or help to walk (i.e. is not safe to walk alone even with an aid).

HESITANT IN INITIATING MOVEMENT means difficulty in starting to walk.

POOR TRANSFER means the person requires help and is not safe to do the following alone - get in or out of bed, on or off a chair, move from chair to standing.

Acute Services Division

Critical Care, High Dependency, Coronary Care

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

Patient name: Catherine Honeyman

Ward: Shaw

CHI number: ..... Unit/Hospital number 5600940779

Contents

1. Canard Falls Risk Assessment Scoring Form
2. Falls Assessment Care Plan
3. Glossary of terms used in risk assessment

Notes: Risk assessment should be completed within 24 hours of admission to each ward.

Assessment Wards: Risk assessment and care plan should be reviewed weekly.

Continuing Care Wards: Risk assessment and care plan reviewed monthly.

Referral Criteria for Hospital Falls Prevention Co-ordinator

1. Canard score of 18+.
2. Second or subsequent fall
3. Significant Injury caused by a fall. (Significant Injury defined as any fracture, significant bruising or laceration to head or body.)

The patient should be referred with any of the above criteria.

General Safety Precautions

- Ensure patient has buzzer to hand
- Check patient has the manual dexterity and cognitive ability to operate buzzer
- Place personal items within easy reach
- Keep the bed in lowest position possible (use low bed if available)
- DO NOT leave patients with cognitive or mobility problems unattended on commodes, in toilets, baths or showers
- If noted that mobility / transfers are unsafe refer to physio / OT for assessment
- If patient wears glasses, ensure they are clean
- Ensure patient's footwear is adequate
- Lock wheels on all wheelchairs, beds, commodes and trolleys when in use
- Provide adequate lighting at night
- Request medication review if appropriate
- Clean up spills immediately
- Orientate patient t ward environment

Cannard Falls Risk Assessment

(Must be completed within 24 hours of admission to ward)

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						Date: 31/03/11 Ward: SHAU	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:
History of falls in the last 6 months	At home 1	In ward/ unit 2	None 0			0						
Sex	Male 1	Female 2				2						
Age	13-59 0	60-70 1	71-80 2	81+ 1		1						
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0		0						
Medication type	Medication for mental illness & drug / alcohol withdrawal 1	Drugs for CVS Support Medication 1	Sedatives / Analgesia / Night sedation 1	None of these 0		1						
Medical history	Cardiovascular Disease / Diabetes1	Confusion 1	Fits/ spasms 1	Incontinent 1	Inability to cooperate* 1	✓						
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed bound/ wheelchair 1		1						
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		N/A						
				TOTAL SCORE		5						
				ACTION(S) TAKEN Enter action code(s) from Care Plan below		1, 2, 3, 5 11, 15						
SCORE 13+ = HIGH RISK If patient unconscious score as N/A until patient status improves.				NURSE SIGNATURE								

Please see back page for glossary of terms relating to the assessment above.

Falls Assessment Care Plan

Please tick all applicable nursing interventions

	NURSING INTERVENTIONS	Date: 31/03/11 Ward: SHAU	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:
Action code								
1	Prevention and general safety precautions discussed with patient and family.	✓						
2	Move to more observable area of ward to optimise supervision.	✓						
3	Advise patient they may experience dizziness when they mobilise initially.	✓						
4	Two nurses to assist mobilisation if patient recovering from epidural.							
5	Observe trip hazard due to invasive lines, drains and catheters.	✓						
6	Do not leave patient unattended when using commode. toilet or shower.							
7	If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.							
8	Monitor lying and standing/ sitting BP and pulse.							
9	A. Patient requires footwear or podiatry referral. (Date referred: / requested :) B. Request family / carer to provide suitable footwear.							
10	Commence continence assessment, refer to chart if appropriate.							
11	Refer to Physiotherapist.	✓						
12	Request medication review.							
13	Select suitable seating (refer to policy).							
14	Review Transfer techniques.							
15	Bed rails/bumpers to be used (refer to policy).	✓						
16	Falls map in use for seven days for patients who have had second or subsequent falls.							
17	Bed/chair monitor in use.							
18	Patient requires low bed / mattress on the floor (refer to policy).							
19	Patient requires one to one nursing care.							
20	Refer to Hospital Falls Prevention Co-ordinator (see criteria on front cover).							
21	Other interventions. buzzer	✓						
	SIGNATURE							

Review Cannard score weekly / monthly as per policy. Enter action code(s) selected in action taken section on Falls Risk Assessment.

SOUTH GLASGOW HOSPITALS DIVISION — SOUTHERN GENERAL HOSPITAL

NURSING PROFILE

Name: CATHERINE HONEYMAN Unit No: SG00940779 Acct No: IP0016709/11

Address: 10 MELVILLE STREET
GLASGOW
G41 2LN
Tel: 0414221580

Consultant: HULLIN,MIKE
DOB: 01/02/49 Age: 62
CHI: 0102496145
Rel:

Ward: S03
Date: 27/03/11
Time: 0645
Marital Status: MAR

Next of Kin: HONEYMAN,RAYMOND
Address: 10 MELVILLE STREET
GLASGOW
Tel: 0414221580
Relationship: HUS

GP: MARSHALL, GRAEME G
Practice Address: GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ
Tel: 0141 531 8250

Other Contact:
Tel: Relationship:

REASON FOR ADMISSION:- RIGHT KNEE PAIN

SHORT SUMMARY:- LONGSTANDING HX OF PAIN IN R KNEE, INCREASING IN SEVERITY, NOW UNABLE TO WEIGHTBEAR.JOINT ERYTHEMATOUS, CELLULITIC AROUND SCAR. HAD LTKR AND R PATELLA RESURFACING 2010, REVISION R PATELLA MAY 2010 THEN READMITTED WITH HAEMATOMA AND INFECTION

PAST MEDICAL HISTORY

- AS ABOVE
- ANGINA
- ARTHRITIS
-
-
-

MEDICATIONS ON ADMISSION

1) SIMVASTATIN
2) ATENOLOL
3) TRAMADOL
4) ASPIRIN
5) BENDROFLUAZIDE
- FLUOXETINE
LOSEC

Allergies

NKDA
VOLTAROL

ESTIMATED DATE OF DISCHARGE:

(T) 31/3/11 1ST STAGE REVISION
(R) KNEE I/C INSERTION OF CEMENT SPACER.

GENERAL ASSESSMENT

> IN PAIN, HAD COCODAMOL IN CASUALTY, REQUIRED MORPHINE ON ARRIVAL TO WARD. ASSISTED WITH TRANSFER.

SOCIAL/HOME BACKGROUND

> LIVES WITH HUSBAND AND DAUGHTER. NON SMOKER, SELDOM ALCOHOL. DOESNT GET OUT MUCH, SCARED OF FALLING.

RELATIVES AWARE OF ADM Y/N?:- Y Comment:

ACTIVITIES OF DAILY LIVING

MAINTAINING SAFE ENVIRONMENT: Risk of Falls
Requires Supervision

COMMUNICATING: Communicates Freely

BREATHING: Can Maintain Airway

EATING/DRINKING: Good Appetite

ELIMINATING: Normal Bowel Function
Normal Bladder Function

CLEANSING/DRESSING: Assistance

TEMPERATURE: Apyrexial

MOBILISING: Risk of Falls
Walking Aid(See Note) - elbow crutches

WORKING/PLAYING: Housebound
Non Active Socially

SLEEPING: Good Sleep Pattern

DYING: Not Appropriate Discuss

SOUTH GLASGOW HOSPITALS DIVISI | SOUTHERN GENERAL HOSPITAL

N[illegible]RSING PROFILE

Name: CATHERINE HONEYMAN | Unit No: SG00940779 | Acct No: IP0016709/11

SKIN CONDITION: IN BROKEN

Does patient smoke? N
Does patient want to stop smok[illegible]g NOW?
Has patient been referred to '[illegible]op Smoking Service'?

BP:143/81 mmHG Pulse: 11[illegible] min Resp: 16 /min SpO2: 96 % Temp: 36 C
Weight:95 Kg Height:5 ft.4 [illegible]n / Metric: cm BM: BMI: 35
Waterlow Score: 8 Urinal[illegible]:

Highly Sens[illegible]mment Y/[illegible] Patient consent to share information Y/N Y

Completed By (Sign): [signature]

Completed by: CL[illegible]E SANTIAG on/at 27/03/11 0646 Report Number: 2703-0005

SOUTHERN GENERAL HOSPITAL

DEPARTMENT:

NAME: Catherine Honeyman . UNIT NO. 940779 , WARD: 3

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
27/3/11	0730	Admitted as per profile	
		Oreintated to ward and staff	
		Commenced on IV abiotics - given fluclox dose, still for gentamicin	
		Knee not aspirated in A+E, hot and fiery - apyrexial. Tachycardic at 115 Sews 2	
		For review by Mr Hullin today	
		Reviewed by Mr Meek, attended Theatre for aspiration of ® Knee under local. Allowed diet and fluid. Given cyclizine and s/c morphine 5mg @ 1130 for pain relief.	
		Vomitted a moderate amount of bile and water brash.	
		Assisted with personal hygiene.	
		Unable to weight bear on ® leg	
		Vague at times.	
		Obs post-op BP 104/69 P78 T36 R17 Sats 95% on air.	
		IV abiotics discontinued.	J Sweeney
		Earlier used a bed pan but able to transfer to commode using elbow crutches	
	1330.	To fast from midnight for Theatre tomorrow for further exploration. Re-commenced on IV Flucloxacillin 2gm	J Sweeney
		Settled evening. Transferring to commode independently Passing urine Diet + fluids taken IV antibiotics continue Sews 0	
		Fast 12mn for theatre Paracetamol 1g and Tramadol 50mg for pain.	Alalil
28/3/11	0400	IV fluclocacillin 2gr at 10pm.	
		Tramadol and paracetamol for pain at 10pm with little effect, therefore given oramorph 10mg @ midnight with better effect.	
		Slept for short periods only.	
		Transferring to commode with little assistance. Knee remains swollen.	
		Obs satisfactory	
		Fasting from midnight ?theatre again.	
		Oramorph 10mg repeated @ 0330hrs	

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SOUTHERN GENERAL HOSPITAL

DEPARTMENT:

NAME: UNIT NO. WARD:

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
		Temp 37°. - Paracetamol 1gr @ 0640.	
		Basin to wash at bedside	
		Independent with personal and oral hygiene.	
		Right knee remains very swollen	
		Transferring independently to commode	
		seen by Mr Hullin ↓ rst for	
		Heal ↑ today continue IV antibiotics	
		Flucloxacillin 500mg Q.I.D.	
		Venflon to be restitled ✓	
		Microbiology contacted F.Y.I - aspirate	
		growing staph aureus - await sensitivity	
		SHO contacted re further management	
		swiss O	
		Taking diet + fluids. Passing urine	
		Taking paracetamol 1g and Tramadol 50mg	
		for pain	
28/3/11	2000	Settled afternoon. Uncomplaining	
		Continues on 2gm IV Flucloxacillin	
		Mobile between bed & commode.	
		Observations satisfactory	
		Taking diet + fluids well	
		(R) knee remains swollen but less	
		inflammed	
		Paracetamol 1gm and Tramadol 50g	
		effective for pain.	
		Theatre cancelled meantime,	
		await bacteriologist advice	
		re - knee aspirate growing	
		staph aureus.	
		Intravenous antibiotics given	
		as prescribed	
29/3/11	0600	stay in short pyjamas.	
		Paracetamol & tramadol in	
		regular knee remains swollen	
		Temp 37.8 - paracetamol 1g at 0600	
29/3/11	0800	Patient up mobilising to toilet using	
		elbow crutches, stopped when	
		coming out of toilet - reviewed	
		by orthopaedic doctors - no	
		apparent injury.	

SOUTHERN GENERAL HOSPITAL

DEPARTMENT: Surgical

NAME: C. Honeymen UNIT NO. WARD: 3

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
29/3/11		Datix completed. Cannard full assessment rescored. Patient advised to use commode at bedside. Independent with personal hygiene. Managing diet & fluids well. Passing urine spontaneously. Bowels. Paracetamol + Tramadol effective for pain. Observations satisfactory. (2) Knee remains swollen, red reducing slowly. Wound cleansed & dry dressing applied. Patient applying talcum to wound - discourage from doing so. Dr MW Mullin to continue on IV Flucloxacillin till sensitivities available from microbiology - then to convert to oral antibiotics and aim for home.	Rstaff
	2000	Venflon rested and IV antibiotics as prescribed. Commenced on oral rifampacin. Sats 0 Knee unchanged. Using commode - transferring with supervision. Diet + fluids taken commenced on oral Rifampacin.	Rstaff
30/3/11	0500	IV antibiotics given. Slept for short periods, disorientated at times. Up to commode for toilet. Knee remains swollen. Paracetamol and tramadol for pain.	
		Not washed this morning. Will have later on. Feeling tired and sore. Continues on IV antibiotics - Rifampicin 600mg orally. Knee remains swollen / painful. Transferring to commode - passing urine. Sats 0 Diet + fluids taken. Paracetamol 1G and tramadol 50mg for pain. Not reviewed today.	Rstaff
		Washed and oral hygiene attended to	Pstaff

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SOUTHERN GENERAL HOSPITAL

DEPARTMENT:

NAME: Carth Honeyman. UNIT NO. WARD: 8 2

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
30/3/11	1900	Settled evening Diet & fluids enjoyed. Passing urine spontaneously using commode Bowels inactive for 5-6 days - pt denies any discomfort. Remains on bedrest. Continues on IV fludoxacillin Given paracetamol and tramadol for pain with poor effect. only - given oramorph 10mg @ 1755 with better effect.	caw
	2000	Patient for transfer to ward 2. Patient & family aware of transfer. Handover given.	caw
31/3/11	NP	Patient transferred to ward 2 as planned IVAB 2g flucloxacillin as per kardex Venflon resited. Patient transferring using ZLF and supervision. Oral antibiotic rifampicin as prescribed. Oramorph required for breakthrough. For repeat bloods and ? washout if required.	[illegible] 5/10
3/4/11	1000	SR anaesthetist for ECG, patient stated had chest pain and used GTN spray. Pt also stated same happened in theatre for washout, maybe cancelled to be reviewed	[illegible]
	1400	Attending theatre ? NOK PO	[illegible]

SOUTHERN GENERAL HOSPITAL

DEPARTMENT: C - CARE

NAME: CATHERINE HENDERSON UNIT NO. SC0094079 WARD: SCAL

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
3/3/94	30	Transferred from theatre following Left knee revision of (R) knee I/C insertion of cement spacer. Pain issues in recovery. given 6mg bolus of IV morphine in dilution & 1mg/hr via morphine PCA. also given next 120mg of Ketogel IV in recovery. Experiencing spasms in knee - note good sensation and movement in toes colour also satisfactory. Note ABG's in recovery: PO_2 6.8 S_pO_2 88% - ∴ connected on a 4 litre mask @ 15L, however on return to unit on 6L via face mask. S_pO_2 97% O_2 changed to 6L NC. S_pO_2 96% RR: 23 bpm, good cough ECG: S.R HR: 72 bpm BP: 137/68 (92). Apyrexial - colour Thrombex in toes Splint intact to (R) knee - no evidence of bleeding through dressings Neuro satisfactory: Serum/Sodium not seen. Nursed on a 30° Fowlers position morphine PCA instituted. 2mg/5ml bolus. Pain score 5-6/10 on return: encouraged to use PCA more effectively Does appear drowsy, but breathing & conversation: observe for evidence of	

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SOUTHERN GENERAL HOSPITAL

DEPARTMENT: Critical Care

NAME: Catherine Honeyman UNIT NO. 5900940779 WARD: SHDU

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
		~~ore - sedation.~~	
		~~IV access x 2 : VIP score~~	
		~~O. Arterial line x.1.A.~~	
		~~IV lines in progress~~	
		~~@ 83 c/c. Foley cath~~	
		~~in situ. Clear urine @ 20ml~~	
		~~Continue IV antibiotics~~	
		~~are checked. Ventilator~~	
		~~in situ with tube taping~~	
		~~for antibiotics for chest~~	SSN
		~~6/52 : 5 MRSA swabs ✓~~	M. Angel
		~~No urinary catheter~~	M. Scrip
		~~not passed urine yet~~	
01/04/11	0600	Respiration O2 sats 95-96 % on 6 l/hrs via humidified nasal cannula, ~~wet~~ cough expectorate RR - 13-24. O2 ↓ 4 l/hrs	
		CVS HR SR - rate - 80-96.	
		invasive blood pressure monitored 1 hrly	
		systolic - 142 - 94.	
		dystolic - 70 - 44.	
		map - 62 - 90	
		temp - 36.7 - 37.9	
		Neuro/sed / Comms appears sedated from opiods, orientated to time place and person, communicating needs verbally. visual hallucinations at times overnight.	
		Bloods fbc checked @ 2000 hrs - HB - 100 WCC 8.7 plts 306.	
		Nutrition / Hydration - tolerating oral diet and fluids when awake, IVabs as charted, oral medications as charted, IV fluids running 125 - 83 mls/hr.	
		Elimination bowels inactive, ~~wet~~ nausea/ vomit, passing urine spontaneously into urinals 680 mls passed overnight.	
		Wound dressing to right knee appears dry and intact, splint remains insitu	
		Tissue Viability / Mobility - remains on bedrest, nursed on softform mattress heels and elbows intact, sacrum pink but intact, regular postional changes given, plus patient moving around independently.	

SOUTHERN GENERAL HOSPITAL

DEPARTMENT: Critical Care.

NAME: Catherine Honeyman. UNIT NO. 5900940779 WARD: SHAW

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
01/04/11	0600	Lines: Arterial line to left radial artery patent and secure, good waveform, good blood return. 2 x peripheral line VIP score 0 1x left hand not in use 1x right hand patent and in use for IV fluids and pca.	
		Pain: regular paracetamol as prescribed morphine pca insitu 1mg/1ml with 5min lockout, using small amounts, painscore 0-3. 1x override @ 0505.	
		Hygiene: freshen up and oral hygiene conducted prior to settling.	JM Meeken (F. MEEKEN)
		Relatives: no contact overnight.	
1/4/11	10^{20}	Pain review - Continue PCA today: Oxycontin 10mg BD to commence today. When PCA discontinued oramorph 10mg prescribed for breakthrough pain.	S Morris
WR	10^{30}	Reviewed by Mr Hullin wound to be left intact. Splint can be off when in bed but MUST BE ON when mobilising - no restrictions to weight bearing status when up.	AN CARRON
	1120.	RESPIRATORY:-	
		O2 continues between 4-6L via nasal cannula (humidified).	
		sats 99-100%. Chest	
		appears clear.	
	CVS:	systolic: 120 - 126	
		diastolic 58 - 53.	
		Map 79.	
		Temp 36^4.	
		NEUR NEUR/SED/COM:	
		Appears slightly sedated due to analgesia. Chatty when awake. No hallucinations this am.	
		NUTRITION/HYDRATION	

SOUTHERN GENERAL HOSPITAL

DEPARTMENT: CRITICAL CARE

NAME: CATHERINE HOLEYMAN UNIT NO. SG 00946779 · WARD: SHDU ·

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
31.4.11	Cont	IV fluids @ 125mls/hr.	
		Diet & fluids tolerated well.	
		Has not passed urine since 0600, does not feel the "need to go" yet, no discomfort from bladder/ abdomen.	
		ELIMINATION:- No bowel movement as yet.	
		WOUND:-	
		Left intact as instructed by Mr Hullin.	
		Camp splint off for short time while in bed.	
		TISSUE VIABILITY:-	
		Moving around bed freely skin intact. Nursedon soft foam mattress.	
		PAIN:-	
		Morphine PCA, using well but still uncomfortable.	
		Commenced on oral Oxycontin & paracetamol.	
		Reviewed by pain team.	
		RELATIVES:	
		Husband phoned, informed of planned transfer to Ward 2, and spoke to Catherine. AM'CARRON SN	
	12⁰⁰	Arterial line removed.	
		Ventlon dislodged - FYI aware - awaiting insertion of new ventlon. AM'CARRON SN	
	1240	Ventlon resited Pu'd 350.	
1.4.11	1345	Returned from SHDU, alert and orientated, Morphine PCA 1ml @ 1hr lock out, commenced oxycontin BD Dressing not to be removed today Camp splint in situ. No vomiting Ice Pack x 1 Observations as per chart	
	1730	Observations stable P.A. A.V.P.U. continues	

SOUTHERN GENERAL HOSPITAL

DEPARTMENT: Ortho

NAME: Catherine McNeyman UNIT NO. SGA 091677H WARD: 2

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
02/04/11	0455	Unsettled night, unable to find comfortable position in bed. Morphine PCA remains in situ, all other medications given as per Kardex. Observations satisfactory - SEWS 0. SpO_2 96% on air, passing urine spontaneously, using bedpan, patient feels unable to mobilise onto commode. Patient tearful at times, reassurance offered, 'Camp splint remains in situ, dressing dry and intact. Oxynorm given as per kardex for review in 3 days. Bandage insitu as per instruction. PCA refilled.	KBAIRD. SLO
	1830	Assisted wash given. Remained in bed today. Observations stable. PCA discontinued on oramorph. Continues on IVABS. Dressing remains intact. Hb 91 on oral ferrous fumerate. On oxycontin BD. Sat 91 o/A 2c O_2 via nasal cannula.	
3/4/11	N/D	Patients observations satisfactory SEWS=0. All medication administered as prescribed including IVAB. Patient unhappy prior to sleeping due to being uncomfortable in bed. Patient requested an electric bed for better comfort. No electric bed available, patient unhappy about this. Oramorph given twice overnight with good effect. Eating and drinking well. Passing urine via bedpan spontaneously. Settled evening, sleeping for long periods of time.	
	1430	Washed with minimum assistance. IVAB's continue as prescribed. Transferred from bed to chair.	(5)

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SOUTHERN GENERAL HOSPITAL

DEPARTMENT:

NAME: Catherine Honeyman UNIT NO. WARD: TWO

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
7/4/11	N/S	Observations satisfactory SEWS=0. Medication as prescribed including IVAB. Passing urine spontaneously via bedpan, good volumes. Independent t pressure area care overnight. Settled evening.	J Paton SN (5)
1/4/11	15[00]	Patient rested with minimal assistance. IV AB continue as per kardex. Complaint remains in site, mobilising from bed to chair. Dressing reduced. Wound cleansed and redressed with tegaderm to area. Wound remains clean and dry with no complaints offered. Pain relief given as per kardex. All other medications given as per kardex. Passing urine spontaneously via bedpan, good volumes. Observations satisfactory SEWS=0. Returned to bed early this afternoon and remains in bed at time of writing — S/B Pain nurse as kardex c/o nausea x1 antiemetic given with effect. n/v. S/B Mr Hullin to chase samples taken in theatre	[illegible] S/N. [illegible] S/N
8/4/11	N/D	Observations satisfactory SEWS=0. All medication administered as prescribed including IVAB. Transferring well using Zimmer frame to the commode. Passing urine spontaneously. Settled and slept well overnight, offering no complaints.	J Paton SN (5)
	8.30	Patient discharged as per check list meds given and explained to patient O/P appointment 1 wk Fri 11/4/11	

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Greater Glasgow and Clyde

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Surname Honeyman CHI No 0102496145
Forenames Catherine Sex F
DoB 01/02/49
Location SHOU

DAILY REPOSITIONING & SKIN INSPECTION CHART

DATE 31/03/11

- Inspect skin for evidence of change
- Reassess at every positional change and document below
- Reposition the person to reduce the risk of further damage, eg using the 30 degree tilt
- Use manual handling aids to minimise risk of friction and shear
- Individuals on any form of pressure redistribution equipment still require skin inspection and regular repositioning
- Provide suitable seating including pressure redistribution cushions, if required, encourage repositioning/mobilisation where possible
- Acutely ill people are seated out for no longer than 2 hours and returned to bed for no less than 1 hour

(Reference: Best Practice Statement-Prevention & Management of Pressure Ulcers-March 2009)

TIME	REPOSITIONING (USING CODES) FROM	TO	SKIN INSPECTION COMMENTS	ACTION TAKEN	SIGNATURE
Eg: 08:00	L	U	Left Hip Non-Blanching	Reassess at next positional change	
1830	Admitted from theatre		Heels in tact sacrum not seen	reassess	EM
2100	B	rolled B	heels intact sacrum pink intact	reassess	JM
2300	B	bedpan B	"	reassess	JM
01/04/11 0200	moving around bed independently				JM
0800	"	"	"		AMC
1000	turned, sacrum satisfactory, heels satisfactory			reassess	both AMC

83824

Code: L = LEFT, R = RIGHT, B = BACK, P = PRONE (FRONT), M = MOBILISED, U = UP TO SIT

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Surname ..... CHI No .....

Forenames ..... Sex .....

DoB .....

Location .....

DAILY REPOSITIONING & SKIN INSPECTION CHART

DATE _____

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- Reassess at every positional change and document below
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NATVNS
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WRITE, I

Surname SG00940779
HONEYMAN, CATHERINE
Forenam 10 MELVILLE STREET
DoB ..... GLASGOW 01/02/1949
Location G41 2LN CHI 0102496145

ADAPTED WATERLOW PRESSURE AREA RISK ASSESSMENT CHART

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

Complete assessment on admission/1st visit, if there is a change in individuals condition and repeat regularly according to local protocol

Sex										
Male	1									
Female	2	2	2	2						
Age										
14 -49	1									
50 -64	2	2	2	2						
65 - 74	3									
75 - 80	4									
81+	5									
Build/Weight for Height (BMI=weight in Kg/height in m²)										
Average - BMI 20-24.9	0									
Above average - BMI 25-29.9	1									
Obese - BMI > 30	2		2	2						
Below average - BMI < 20	3									
Continence										
Complete/catheterised	0	0	0	0						
Incontinent urine	1									
Incontinent faeces	2									
Doubly incontinent (urine & faeces)	3									
Skin Type - Visual Risks Area										
Healthy	0	0	0	0						
Tissue paper (thin/fragile)	1									
Dry (appears flaky)	1									
Oedematous (puffy)	1									
Clammy (moist to touch)/pyrexia	1									
Discoloured (bruising/mottled)	2									
Broken (established ulcer)	3									
Mobility										
Fully mobile	0									
Restless/fidgety	1									
Apathetic (sedated/depressed/reluctant to move)	2									
Restricted (restricted by sever pain or disease)	3	3	3							
Bedbound (unconscious/unable to change position/traction)	4									
Chairbound (unable to leave chair without assistance)	5			5						
Nutritional Element										
Unplanned weight loss in past 3-6 months										
<5% Score **0**, 5-10% Score **1**, >10% Score **2**	0-2	0		0						
BMI > 20 Score **0**, BMI 18.5-20 Score **1**, BMI < 18.5 Score **2**	0-2									
Patient acutely ill or no nutritional intake > 5 days	2									
Special Risks - Tissue Malnutrition										
Multiple organ failure/terminal cachexia	8									
Single organ failure e.g. cardiac, renal, respiratory	5									
Peripheral vascular disease	5									
Anaemia = Hb < 8	2									
Smoking	1	0	0	0						
Special Risks - Neurological Deficit										
Diabetes/MS/CVA/motor/sensory/paraplegia *Max 6*	4-6	0		0						
Special Risks - Surgery/Trauma										
On table > 6 hours	8									
Orthopaedic/below waist/spinal (up to 48 hours post op)	5			5						
On table > 2 hours (up to 48 hours post op)	5	0								
Special Risks - Medication										
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*	4	0		0						
Total Score		1	9	10						
Date		27/3	30-3	31/3						
initials		S	AR	MM						
Time		0050	11am	1700						

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Ensure plan of care is implemented / reviewed for all identified areas of concern.

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WRITE, IMPRINT OR ATTACH LABEL
Surname Honeyman CHI No
Forenames Catherine Sex F
DoB
Location TWO, SCH

ADAPTED WATERLOW PRESSURE AREA RISK ASSESSMENT CHART

More than one score/category can be used: **10+= 'At Risk': 15+= 'High Risk': 20+= 'Very High Risk'**
Complete assessment on admission/1st visit, if there is a change in individuals condition and repeat regularly according to local protocol

Sex										
Male	1									
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14 -49	1									
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Build/Weight for Height (BMI=weight in Kg/height in m²)										
Average - BMI 20-24.9	0									
Above average - BMI 25-29.9	1									
Obese - BMI > 30	2	2	2	2						
Below average - BMI < 20	3									
Continence										
Complete/catheterised	0	0		0						
Incontinent urine	1									
Incontinent faeces	2									
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Skin Type - Visual Risks Area										
Healthy	0	0		0						
Tissue paper (thin/fragile)	1									
Dry (appears flaky)	1									
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<5% Score **0**, 5-10% Score **1**; >10% Score **2**	0-2									
BMI > 20 Score **0**, BMI 18.5-20 Score **1**, BMI < 18.5 Score **2**	0-2									
Patient acutely ill or no nutritional intake > 5 days	2	0		0						
Special Risks - Tissue Malnutrition										
Multiple organ failure/terminal cachexia	8									
Single organ failure e.g. cardiac, renal, respiratory	5									
Peripheral vascular disease	5									
Anaemia = Hb < 8	2									
Smoking	1	0		0						
Special Risks - Neurological Deficit										
Diabetes/MS/CVA/motor/sensory/paraplegia *Max 6*	4-6	0		0						
Special Risks - Surgery/Trauma										
On table > 6 hours	8									
Orthopaedic/below waist/spinal (up to 48 hours post op)	5									
On table > 2 hours (up to 48 hours post op)	5	0		0						
Special Risks - Medication										
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*	4	0		0						
Total Score		10	10	10						
Date		13/4	14/4	15/4						
Initials		DP	LS	SE						
Time		0600	0900	1100						

83826

Ensure plan of care is implemented / reviewed for all identified areas of concern.

SOUTH GLASGOW HOSPITALS
PATIENT MOVING AND HANDLING RISK ASSESSMENT

NHS Greater Glasgow and Clyde

Patient's Name: Catherine Harleyman	If patient is totally independent, tick here and go to date box
Named Nurse:	

BODY BUILD

Obese		Tall	
Above average	✓	Medium	✓
Average		Short	
Below Average		Weight:	

RISK OF FALLS High ✓ Low

Problems with comprehension, behaviour, co-operation (specify)

Handling constraints,e.g. disability, weakness, pain, skin lesions infusions (specify)

INTO BATH OR SHOWER

HANDLING AID		WHICH BATH	
Hoist (Specify)	✓	Parker	
Shower chair		Variable height	
		Standard	
		Any	✓

ASSISTANCE | ✓ SUPERVISION | | INDEPENDENT |

Staff required: X 1

TRANSFERS (including to/from: bed, wheelchair, commode, toilet)

HOIST		MANUAL SUPPORT	
Which hoist?		Staff required:	X 1
Sling type?		Specify support given	
Sling size?			

ASSISTANCE | ✓ SUPERVISION | | INDEPENDENT |

Additional Information

X 1

TOILETING

HOIST		MANUAL SUPPORT	
Which hoist?		Staff required:	X 1
Sling type?		Specify support given	
Sling size?			

ASSISTANCE | ✓ SUPERVISION | | INDEPENDENT |

Additional Information

Commode at bedside

WALKING

NO WALKING		ASSISTANCE	✓	SUPERVISION		INDEPENDENT	

Staff required:

Walking Aid

Distance walked / additional information

MOVE UP/DOWN BED

HOIST		MANUAL SUPPORT	
Which hoist?		Sliding aid	
Sling type?		Rope ladder	
Sling size?		Hand blocks	
		Monkey poles	

ASSISTANCE | SUPERVISION | ✓ INDEPENDENT ✓

Additional Information (include details of any therapy beds used)

Staff required:

SIT UP OVER SIDE OF BED

Rope ladder		Sliding aid		ASSISTANCE		SUPERVISION	✓	INDEPENDENT	✓

MOVE ON/OFF BED PAN

Hoist		Roll Patient	✓	Patient bridges		Monkey pole		Not used	

TRANSFER TO/FROM TROLLEY (or bed etc)

Sliding aid (rigid)		Sliding aid (fabric)		Transfer aid (specify)	Staff required (specify)	X 1	INDEPENDENT	

Date assessed: 27/3/11 Assessors signature:

Date reviewed	30/3							
Assessors signature	N							

THERAPEUTIC HANDLING INSTRUCTIONS

Date	Instruction	Therapist's Name

INTO BATH OR SHOWER

HANDLING AID		WHICH BATH		ASSISTANCE		SUPERVISION		INDEPENDENT	
Hoist (Specify)		Parker		Staff required:					
Shower chair		Variable height							
		Standard							
		Any							

TRANSFERS (including to/from: bed, wheelchair, commode, toilet)

HOIST		MANUAL SUPPORT	ASSISTANCE		SUPERVISION		INDEPENDENT	
Which hoist?		Staff required:	Additional Information					
Sling type?		Specify support given						
Sling size?								

TOILETING

HOIST		MANUAL SUPPORT	ASSISTANCE		SUPERVISION		INDEPENDENT	
Which hoist?		Staff required:	Additional Information					
Sling type?		Specify support given						
Sling size?								

WALKING

NO WALKING		ASSISTANCE		SUPERVISION		INDEPENDENT	
Staff required:				Distance walked / additional information			
Walking Aid							

MOVE UP/DOWN BED

HOIST		MANUAL SUPPORT		ASSISTANCE		SUPERVISION		INDEPENDENT	
Which hoist?		Sliding aid		Additional information (include details of any therapy beds used)					
Sling type?		Rope ladder		Staff required:					
Sling size?		Hand blocks							
		Monkey poles							

SIT UP OVER SIDE OF BED

Rope ladder		Sliding aid		ASSISTANCE		SUPERVISION		INDEPENDENT	

MOVE ON/OFF BED PAN

Hoist		Roll Patient		Patient bridges		Monkey pole		Not used	

TRANSFER TO/FROM TROLLEY (or bed etc)

Sliding aid (rigid)		Sliding aid (fabric)		Transfer aid (specify)	Staff required (specify)		INDEPENDENT	

ate assessed:	Assessors signature:

Date reviewed									
Assessors signature									

THERAPEUTIC HANDLING INSTRUCTIONS

Date	Instruction	Therapist's Name

SOUTH GLASGOW HOSPITALS
PATIENT MOVING AND HANDLING RISK ASSESSMENT

NHS Greater Glasgow and Clyde

Patient's Name: Catherine Honeyman

If patient is totally independent, tick here and go to date box

Named Nurse: S/N J PATON

BODY BUILD

Obese		Tall	
Above average		Medium	✓
Average	✓	Short	
Below Average		Weight:	

RISK OF FALLS: High | | Low | ✓

Problems with comprehension, behaviour, co-operation (specify): None

Handling constraints e.g. disability, weakness, pain, skin lesions infusions (specify): Pain

INTO BATH OR SHOWER

HANDLING AID		WHICH BATH	
Hoist (Specify)		Parker	
Shower chair		Variable height	
		Standard	
		Any	

ASSISTANCE | SUPERVISION | INDEPENDENT

Staff required:

Not at present.

TRANSFERS (including to/from: bed, wheelchair, commode, toilet)

HOIST		MANUAL SUPPORT
Which hoist?		Staff required:
Sling type?		Specify support given
Sling size?		

ASSISTANCE | SUPERVISION ✓ | INDERENDENT

Additional Information: Patient bridges. Using bedpans at present

TOILETING

HOIST		MANUAL SUPPORT
Which hoist?		Staff required:
Sling type?		Specify support given
Sling size?		

ASSISTANCE | SUPERVISION ✓ | INDEPENDENT

Additional Information: Bedpans

WALKING

NO WALKING	✓	ASSISTANCE	
Staff required:			
Walking Aid			

SUPERVISION | INDEPENDENT

Distance walked / additional information

MOVE UP/DOWN BED

HOIST		MANUAL SUPPORT	
Which hoist?		Sliding aid	
Sling type?		Rope ladder	
Sling size?		Hand blocks	
		Monkey poles	

ASSISTANCE | SUPERVISION | INDEPENDENT ✓

Additional Information (include details of any therapy beds used)

Staff required:

SIT UP OVER SIDE OF BED

Rope ladder | Sliding aid | ASSISTANCE | SUPERVISION ✓ | INDEPENDENT

MOVE ON/OFF BED PAN

Hoist | Roll Patient | Patient bridges | Monkey pole ✓ | Not used

TRANSFER TO/FROM TROLLEY (or bed etc)

Sliding aid (rigid) ✓ | Sliding aid (fabric) | Transfer aid (specify) | Staff required (specify) | INDEPENDENT

Date assessed: 3/4/11 | Assessors signature: JPaton

Date reviewed								
Assessors signature								

THERAPEUTIC HANDLING INSTRUCTIONS

Date	Instruction	Therapist's Name

INTO BATH OR SHOWER

HANDLING AID		WHICH BATH	
Hoist (Specify)		Parker	
Shower chair		Variable height	
		Standard	
		Any	

ASSISTANCE		SUPERVISION		INDEPENDENT	
Staff required:					

TRANSFERS (including to/from: bed, wheelchair, commode, toilet)

HOIST	
Which hoist?	
Sling type?	
Sling size?	

MANUAL SUPPORT
Staff required:
Specify support given

ASSISTANCE		SUPERVISION		INDEPENDENT	
Additional Information					

TOILETING

HOIST	
Which hoist?	
Sling type?	
Sling size?	

MANUAL SUPPORT
Staff required:
Specify support given

ASSISTANCE		SUPERVISION		INDEPENDENT	
Additional Information					

WALKING

NO WALKING		ASSISTANCE		SUPERVISION		INDEPENDENT	
Staff required:							
Walking Aid							

Distance walked / additional information

MOVE UP/DOWN BED

HOIST	
Which hoist?	
Sling type?	
Sling size?	

MANUAL SUPPORT	
Sliding aid	
Rope ladder	
Hand blocks	
Monkey poles	

ASSISTANCE		SUPERVISION		INDEPENDENT	

Additional Information (include details of any therapy beds used)

Staff required:

SIT UP OVER SIDE OF BED

Rope ladder		Sliding aid		ASSISTANCE		SUPERVISION		INDEPENDENT	

MOVE ON/OFF BED PAN

Hoist		Roll Patient		Patient bridges		Monkey pole		Not used	

TRANSFER TO/FROM TROLLEY (or bed etc)

Sliding aid (rigid)		Sliding aid (fabric)		Transfer aid (specify)		Staff required (specify)		INDEPENDENT	

Date assessed:

Assessors signature:

Date reviewed									
Assessors signature									

THERAPEUTIC HANDLING INSTRUCTIONS

Date	Instruction	Therapist's Name

Cannard Falls Risk Assessment

Glossary of terms used in risk assessment

SIGHT DEFICIT means patient cannot see well even when wearing glasses or is registered blind.

HEARING DEFICIT means person has hearing problems even with a hearing aid or has hearing problems and does not wear a hearing aid.

BALANCE DEFICIT means person is unable to stand without the support of another person or a walking frame.

MEDICINES FOR SOME MENTAL ILLNESSES include Chlorpromazine (Largactil), Risperidone (Risperdal), Lithium (Camcolit or Priadel), Haloperidol, Chloral hydrate (Welldorm), Clomethiazole (Heminevrin), antidepressants, Diazepam, Lorazepam and Amitriptyline.

CARDIOVASCULAR SYSTEM MEDICATION all antihypertensive medication and inotropes including Captopril, atenolol and many others.

WATER TABLETS (DIURETICS) are such as Bendroflumethiazide, Furosemide and Co-amilofruse.

SEDATIVES / ANALGESIA AT NIGHT include medicines such as Diazepam, Temazepam, Nitrazepam, Chlordiazepoxide and Zopiclone (Zimovane) Morphine PCA, Fentanyl, Tramadol and Oxcycontin.

INABILITY TO CO-OPERATE includes failure to use walking aids or putting themselves in situations with a high risk of falling (usually due to mental impairment).

RESTRICTED MOBILITY means the person requires supervision and/or help to walk (i.e. is not safe to walk alone even with an aid).

HESITANT IN INITIATING MOVEMENT means difficulty in starting to walk.

POOR TRANSFER means the person requires help and is not safe to do the following alone - get in or out of bed, on or off a chair, move from chair to standing.

Acute Services Division

Hospital / Department: SGH Surgical

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

Patient name: SG00940779
HONEYMAN, CATHERINE
Ward: 10 MELVILLE STREET
GLASGOW 01/02/1949
CHI number: G41 2LN CHI 0102496145 Unit/Hospital number

Contents

1. Canard Falls Risk Assessment Scoring Form
2. Falls Assessment Care Plan
3. Glossary of terms used in risk assessment

Notes: Risk assessment should be completed within 24 hours of admission to each ward.

Assessment Wards: Risk assessment and care plan should be reviewed weekly.

Continuing Care Wards: Risk assessment and care plan reviewed monthly.

Referral Criteria for Hospital Falls Prevention Co-ordinator

1. Cannard score of 18+.
2. Second or subsequent fall
3. Significant Injury caused by a fall. (Significant Injury defined as any fracture, significant bruising or laceration to head or body.)

The patient should be referred with any of the above criteria.

General Safety Precautions

- Ensure patient has buzzer to hand
- Check patient has the manual dexterity and cognitive ability to operate buzzer
- Place personal items within easy reach
- Keep the bed in lowest position possible (use low bed if available)
- DO NOT leave patients with cognitive impairment unattended on commodes, in toilets, baths and showers.
- Patients with poor mobility, who are known not to ask for assistance, should not be left unattended on commodes, toilets, baths and showers.
- If noted that mobility / transfers are unsafe refer to physio / OT for assessment
- If patient wears glasses, ensure they are clean
- Ensure patient's footwear is adequate
- Lock wheels on all wheelchairs, beds, commodes and trolleys when in use
- Provide adequate lighting at night
- Request medication review if appropriate
- Clean up spills immediately
- Orientate patient to the ward environment

Cannard Falls Risk Assessment

(Must be completed within 24 hours of admission to each ward)

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						Date: 27/3 Ward: 3	Date: 29/3 Ward: 3	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			0	2					
Sex	Male 1	Female 2				2	2					
Age	13-59 0	60-70 1	71-80 2	81+ 1		1	1					
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0		2	2					
Medication type	Drugs for mental illness 1	Blood pressure / water tablets 1	Sleeping tablets 1	None of these 0		1	1					
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	0	0					
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed / chair-bound/ wheel-chair 1		2	2					
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		1	1					
				TOTAL SCORE		9	11					
				ACTION(S) TAKEN Enter action code(s) from Care Plan below		1,12	1,2,					
SCORE 13+ = HIGH RISK If patient unconscious score as N/A until patient status improves.				NURSE SIGNATURE								

Please see back page for glossary of terms relating to the assessment above.

Falls Assessment Care Plan

Please tick all applicable nursing interventions

Action code	NURSING INTERVENTIONS	Date: 27/3 Ward: [illegible]	Date: 29/3 Ward: [illegible]	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:
1	Falls prevention and general safety precautions discussed with patient and family.	✓	✓					
2	Move to more observable area of ward to optimise supervision.	✓	✓					
3	Advise patient they may experience dizziness when they mobilise initially.							
4	Requires assistance with mobilisation.	✓	✓					
5	Observe trip hazard due to invasive lines, drains and catheters.							
6	Do not leave the patient unattended when using commode, toilet, in shower or the bathroom area.							
7	If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.							
8	Monitor lying and standing / sitting BP and pulse.							
9	A. Patient requires footwear or podiatry referral. (Date referred: / requested :) B. Request family / carer to provide suitable footwear.							
10	Commence continence assessment, follow Local Guidelines.							
11	Refer to Occupational Therapist.							
12	Select suitable seating (refer to policy).							
13	Non slip mat on chair /floor following advice from therapists.							
14	Refer to Physiotherapist.							
15	Review Transfer techniques.							
16	Request medication review.							
17	Bed/chair monitor in use.							
18	Falls map in use for seven days for patient who has second or subsequent falls.							
19	Bed rails/bumpers to be used (refer to policy).							
20	Patient requires low bed / mattress on the floor (refer to policy.)							
21	Patient requires one to one nursing care.							
22	Refer to Hospital Falls Prevention Co-ordinator (see criteria on front cover).							
23	Other interventions.							

Review Cannard score weekly / monthly as per policy. Enter action code(s) selected in action taken section on Falls Risk Assessment page above.

Cannard Falls Risk Assessment

Glossary of terms used in risk assessment

SIGHT DEFICIT means patient cannot see well even when wearing glasses or is registered blind.

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HESITANT IN INITIATING MOVEMENT means difficulty in starting to walk.

POOR TRANSFER means the person requires help and is not safe to do the following alone - get in or out of bed, on or off a chair, move from chair to standing.

Acute Services Division

Hospital / Department SGH

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

Patient name: Catherine Honeyman

Ward: 2

CHI number: ..... Unit/Hospital number SA0696467?9

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- If noted that mobility / transfers are unsafe refer to physio / OT for assessment
- If patient wears glasses, ensure they are clean
- Ensure patient's footwear is adequate
- Lock wheels on all wheelchairs, beds, commodes and trolleys when in use
- Provide adequate lighting at night
- Request medication review if appropriate
- Clean up spills immediately
- Orientate patient to the ward environment

Cannard Falls Risk Assessment

(Must be completed within 24 hours of admission to each ward)

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						Date: 4/4 Ward: 2	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			0						
Sex	Male 1	Female 2				2						
Age	13-59 0	60-70 1	71-80 2	81+ 1		1						
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0		0						
Medication type**	Drugs for mental illness 1	Blood pressure / water tablets 1	Sleeping tablets 1	None of these 0		0						
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1							
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed / chair-bound/ wheel-chair 1		3						
C	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		✓						
				TOTAL SCORE		6						
				ACTION(S) TAKEN* Enter action code(s) from Care Plan below*		1						
SCORE 13+ = HIGH RISK If patient unconscious score as N/A until patient status improves.				NURSE SIGNATURE								

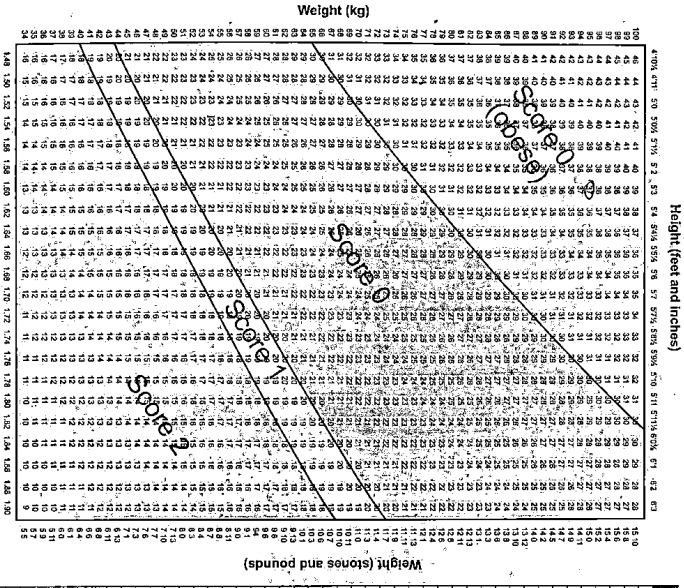
Please see back page for glossary of terms relating to the assessment above.

Falls Assessment Care Plan

Please tick all applicable nursing interventions

	NURSING INTERVENTIONS	Date: 4/4 Ward: 9	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:
Action code								
	Falls prevention and general safety precautions discussed with patient and family.	✓						
2	Move to more observable area of ward to optimise supervision.							
3	Advise patient they may experience dizziness when they mobilise initially.							
4	Requires assistance with mobilisation.							
5	Observe trip hazard due to invasive lines, drains and catheters.							
6	Do not leave the patient unattended when using commode, toilet, in shower or the bathroom area.							
7	If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.							
8	Monitor lying and standing / sitting BP and pulse.							
9	A. Patient requires footwear or podiatry referral. (Date referred: / requested :) B. Request family / carer to provide suitable footwear.							
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15	Review Transfer techniques.							
16	Request medication review.							
17	Bed/chair monitor in use.							
18	Falls map in use for seven days for patient who has second or subsequent falls.							
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20	Patient requires low bed / mattress on the floor (refer to policy.)							
21	Patient requires one to one nursing care.							
22	Refer to Hospital Falls Prevention Co-ordinator (see criteria on front cover).							
23	Other interventions.							

Review Cannard score weekly / monthly as per policy. Enter action code(s) selected in action taken section on Falls Risk Assessment page above.



Step 1 - BMI Score

Step 2 - Weight Loss Score

Weight before weight loss (kg)	Score 0 Wt loss <5%	Score 1 Wt loss 5-10%	Score 2 Wt loss >10%
54 kg	<1.7kg	1.7-3.4 kg	>3.4 kg
56 kg	<1.8 kg	1.8-3.6 kg	>3.6 kg
58 kg	<1.9 kg	1.9-3.8 kg	>3.8 kg
60 kg	<2 kg	2-4 kg	>4 kg
62 kg	<2.1 kg	2.1-4.2 kg	>4.2 kg
64 kg	<2.2 kg	2.2-4.4 kg	>4.4 kg
66 kg	<2.3 kg	2.3-4.6 kg	>4.6 kg
68 kg	<2.4 kg	2.4-4.8 kg	>4.8 kg
70 kg	<2.5 kg	2.5-5 kg	>5 kg
72 kg	<2.6 kg	2.6-5.2 kg	>5.2 kg
74 kg	<2.8 kg	2.8-5.6 kg	>5.6 kg
76 kg	<2.9 kg	2.9-5.8 kg	>5.8 kg
78 kg	<3 kg	3-6 kg	>6 kg
80 kg	<3.1 kg	3.1-6.2 kg	>6.2 kg
82 kg	<3.2 kg	3.2-6.4 kg	>6.4 kg
84 kg	<3.3 kg	3.3-6.6 kg	>6.6 kg
86 kg	<3.4 kg	3.4-6.8 kg	>6.8 kg
88 kg	<3.5 kg	3.5-7 kg	>7 kg
90 kg	<3.6 kg	3.6-7.2 kg	>7.2 kg
92 kg	<3.7 kg	3.7-7.4 kg	>7.4 kg
94 kg	<3.8 kg	3.8-7.6 kg	>7.6 kg
96 kg	<3.9 kg	3.9-7.8 kg	>7.8 kg
98 kg	<4 kg	4-8 kg	>8 kg
100 kg	<4 kg	4-8 kg	>8 kg
102 kg	<4.1 kg	4.1-8.2 kg	>8.2 kg
104 kg	<4.2 kg	4.2-8.4 kg	>8.4 kg
106 kg	<4.3 kg	4.3-8.6 kg	>8.6 kg
108 kg	<4.4 kg	4.4-8.8 kg	>8.8 kg
110 kg	<4.5 kg	4.5-9 kg	>9 kg
112 kg	<4.6 kg	4.6-9.2 kg	>9.2 kg
114 kg	<4.7 kg	4.7-9.4 kg	>9.4 kg
116 kg	<4.8 kg	4.8-9.6 kg	>9.6 kg
118 kg	<4.9 kg	4.9-9.8 kg	>9.8 kg
120 kg	<5 kg	5-10 kg	>10 kg
122 kg	<5.1 kg	5.1-10.2 kg	>10.2 kg
124 kg	<5.2 kg	5.2-10.4 kg	>10.4 kg
126 kg	<5.3 kg	5.3-10.6 kg	>10.6 kg

Weight before weight loss (st/lb)	Score 0 Wt loss <5%	Score 1 Wt loss 5-10%	Score 2 Wt loss >10%
8st 4lb	<8lb	8lb-1st 0lb	>1st 0lb
8st 7lb	<8lb	8lb-1st 1lb	>1st 1lb
8st 11lb	<9lb	9lb-1st 2lb	>1st 2lb
9st	<9lb	9lb-1st 3lb	>1st 3lb
9st 4lb	<9lb	9lb-1st 4lb	>1st 4lb
9st 7lb	<9lb	9lb-1st 5lb	>1st 5lb
9st 11lb	<10lb	10lb-1st 6lb	>1st 6lb
10st	<10lb	10lb-1st 7lb	>1st 7lb
10st 4lb	<10lb	10lb-1st 8lb	>1st 8lb
10st 7lb	<10lb	10lb-1st 9lb	>1st 9lb
10st 11lb	<11lb	11lb-1st 10lb	>1st 10lb
11st	<11lb	11lb-1st 11lb	>1st 11lb
11st 4lb	<11lb	11lb-2st	>2st
11st 7lb	<11lb	11lb-2st 1lb	>2st 1lb
11st 11lb	<12lb	12lb-2st 2lb	>2st 2lb
12st	<12lb	12lb-2st 3lb	>2st 3lb
12st 4lb	<12lb	12lb-2st 4lb	>2st 4lb
12st 7lb	<13lb	13lb-2st 5lb	>2st 5lb
12st 11lb	<13lb	13lb-2st 6lb	>2st 6lb
13st	<13lb	13lb-2st 7lb	>2st 7lb
13st 4lb	<13lb	13lb-2st 8lb	>2st 8lb
13st 7lb	<14lb	14lb-2st 9lb	>2st 9lb
13st 11lb	<14lb	14lb-2st 10lb	>2st 10lb
14st	<14lb	14lb-2st 11lb	>2st 11lb
14st 4lb	<14lb	14lb-3st	>3st
14st 7lb	<14lb	14lb-3st 1lb	>3st 1lb
14st 11lb	<15lb	15lb-3st 2lb	>3st 2lb
15st	<15lb	15lb-3st 3lb	>3st 3lb
15st 4lb	<15lb	15lb-3st 4lb	>3st 4lb
15st 7lb	<15lb	15lb-3st 5lb	>3st 5lb
15st 11lb	<16lb	16lb-3st 6lb	>3st 6lb
16st	<16lb	16lb-3st 7lb	>3st 7lb
16st 4lb	<16lb	16lb-3st 8lb	>3st 8lb
16st 7lb	<17lb	17lb-3st 9lb	>3st 9lb
16st 11lb	<17lb	17lb-3st 10lb	>3st 10lb

Nutrition Profile

NHS Greater Glasgow and Clyde

Name:	Date of admission: 27/3/11
Address: SG00940779 HONEYMAN, CATHERINE 10 MELVILLE STREET	Time: ~~09~~ 0930
DoB: GLASGOW 01/02/1949 G41 2LN CHI: 0102496145	HOSPITAL: SGH
CHI number:	Ward: 3
Affix patient data label	

To be recorded within 24 hours of admission*

Height: 5'6 in/ft Actual ☐ Patient/ carer reported ☑ Alternative measurement ☐

Weight: 15 kg/stones Actual ☐ Patient/ carer reported ☑ Alternative measurement ☐

Recent unplanned weight loss: Yes ☐ No ☑

If 'Yes' how much?: kg/stones. Over what period of time?: weeks/months

Is there evidence of recent weight loss?
No ☑ Loose clothing ☐ History of reduced food intake/appetite ☐ Swallowing problem ☐

Eating and drinking likes and dislikes (including appetite and/or NBM status):
Good appetite, no food allergies

Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☑
Please state:

Are there any contributing factors that may affect food intake such as **physical** (e.g. swallowing difficulties), **physiological** (e.g. nausea), **psychological** (e.g. dementia), **social or environmental**? Yes ☐ No ☑
Please specify all factors:

Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☑
Please state:

Profile completed by: Name (PRINT): CSANTIAGO Signature: Date: 27/3/11

NOTE: This is ADMISSION DATA - please refer to changes in Care Plan.

* Quality Improvement Scotland (2003). Food, Fluids and Nutritional Care in Hospitals Edinburgh QIS

Malnutrition Universal Screening Tool ('MUST')

Date	27/3									
Initials	CS									
Height (see page 1) 5'4" Weight	96									
Oedema or ascites present Y/N	N									
BMI	37									

'MUST'

Step 1: BMI Score (refer to chart on page 4)									
>20 (>30 = Obese) 0	0								
18.5 - 20 1									
<18.5 2									
Step 2: Weight Loss Score									
Unplanned weight loss in past 3-6 months:									
<5% 0	0								
5-10% 1									
>10% 2									
Step 3: Acute Disease Effect Score									
If patient is acutely ill and there has been or is likely to be no or virtually no food intake for > 5 days..... Score 2	0								
Not applicable..... Score 0									
Step 4: Overall Risk of Malnutrition Total:	0								

Step 5: Management Guidelines

Score of Overall Risk of Malnutrition	Action Required
(0)	**LOW RISK** - *Routine Clinical Care* • Repeat screening. Hospital Acute .....Weekly Hospital Rehabilitation .....Monthly
1	**MEDIUM RISK** - *Observe* • Document dietary intake for 3 days on a Food Record Chart. • If no improvement in intake: - Encourage oral intake. - Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Repeat screening weekly.
2 or more	**HIGH RISK** - *Treat** • Refer to Dietitian and document food intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Monitor and review Care Plan weekly. * Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

Management Plan

FOR ALL PATIENTS

- Provide help and advice on food choices and eating and drinking when necessary.
- Treat underlying conditions and initiate appropriate treatment to relieve symptoms that affect nutritional intake e.g. nausea, vomiting, constipation, diarrhoea and/or pain.
- Refer to dietitian if any specialist advice is required.
- Complete nursing checklist for swallowing difficulties if appropriate.
- Use a recognised system to identify when equipment or assistance is required at mealtimes (e.g. red mats, coloured napkins).

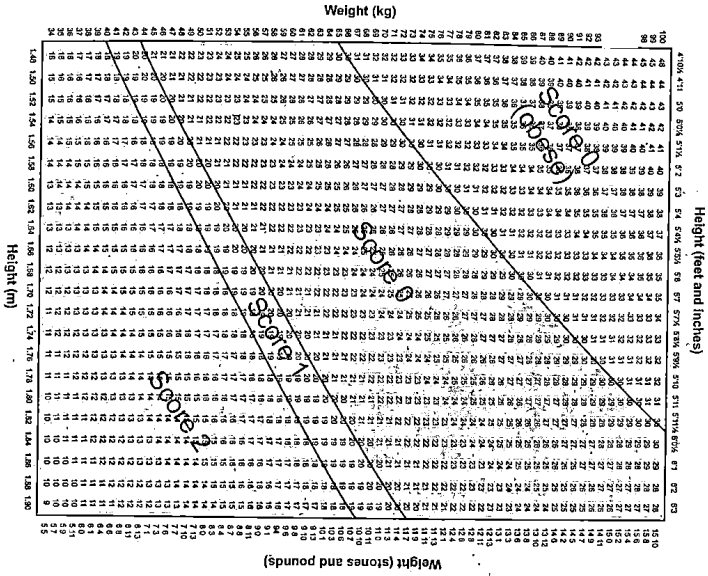
Referral Services

Dietitian	Date: / /	Outcome:
Speech and Language Therapy	Date: / /	Outcome:
Occupational Therapy	Date: / /	Outcome:
Dental Service	Date: / /	Outcome:

Multidisciplinary Nutrition Care Plan

Date	Overall Risk	Action	Review date	Name (PRINT) Signature/Designation
27/3	0	Review 1/7	3/4	Mark Warrick

N.B. Ensure discharge plan includes most recent 'MUST' score and any necessary follow-up requirements.



Step 1 - BMI Score

Step 2 - Weight Loss Score

Weight before weight loss (kg)	Score 0 (<5% loss)	Score 1 (5%-10% loss)	Score 2 (>10% loss)
34kg	<1.7kg	1.7-3.4kg	>3.4kg
35kg	<1.8kg	1.8-3.5kg	>3.5kg
36kg	<1.8kg	1.8-3.6kg	>3.6kg
37kg	<1.9kg	1.9-3.7kg	>3.7kg
38kg	<1.9kg	1.9-3.8kg	>3.8kg
39kg	<1.9kg	1.9-3.9kg	>3.9kg
40kg	<2kg	2-4kg	>4kg
41kg	<2.1kg	2.1-4.1kg	>4.1kg
42kg	<2.1kg	2.1-4.2kg	>4.2kg
43kg	<2.2kg	2.2-4.3kg	>4.3kg
44kg	<2.2kg	2.2-4.4kg	>4.4kg
45kg	<2.2kg	2.2-4.5kg	>4.5kg
46kg	<2.3kg	2.3-4.6kg	>4.6kg
47kg	<2.3kg	2.3-4.7kg	>4.7kg
48kg	<2.4kg	2.4-4.8kg	>4.8kg
49kg	<2.4kg	2.4-4.9kg	>4.9kg
50kg	<2.5kg	2.5-5kg	>5kg
51kg	<2.5kg	2.5-5.1kg	>5.1kg
52kg	<2.6kg	2.6-5.2kg	>5.2kg
53kg	<2.6kg	2.6-5.3kg	>5.3kg
54kg	<2.7kg	2.7-5.4kg	>5.4kg
55kg	<2.8kg	2.8-5.5kg	>5.5kg
56kg	<2.8kg	2.8-5.6kg	>5.6kg
57kg	<2.9kg	2.9-5.7kg	>5.7kg
58kg	<2.9kg	2.9-5.8kg	>5.8kg
59kg	<2.9kg	2.9-5.9kg	>5.9kg
60kg	<3kg	3-6kg	>6kg
61kg	<3kg	3-6.1kg	>6.1kg
62kg	<3.1kg	3.1-6.2kg	>6.2kg
63kg	<3.2kg	3.2-6.4kg	>6.4kg
64kg	<3.2kg	3.2-6.4kg	>6.4kg
65kg	<3.3kg	3.3-6.6kg	>6.6kg
66kg	<3.3kg	3.3-6.6kg	>6.6kg
67kg	<3.4kg	3.4-6.8kg	>6.8kg
68kg	<3.4kg	3.4-6.8kg	>6.8kg
69kg	<3.5kg	3.5-7kg	>7kg
70kg	<3.5kg	3.5-7kg	>7kg
71kg	<3.6kg	3.6-7.2kg	>7.2kg
72kg	<3.6kg	3.6-7.2kg	>7.2kg
73kg	<3.7kg	3.7-7.4kg	>7.4kg
74kg	<3.7kg	3.7-7.4kg	>7.4kg
75kg	<3.8kg	3.8-7.6kg	>7.6kg
76kg	<3.8kg	3.8-7.6kg	>7.6kg
77kg	<3.9kg	3.9-7.8kg	>7.8kg
78kg	<3.9kg	3.9-7.8kg	>7.8kg
79kg	<3.9kg	3.9-7.9kg	>7.9kg
80kg	<4kg	4-8kg	>8kg
81kg	<4kg	4-8.1kg	>8.1kg
82kg	<4.1kg	4.1-8.2kg	>8.2kg
83kg	<4.2kg	4.2-8.4kg	>8.4kg
84kg	<4.2kg	4.2-8.4kg	>8.4kg
85kg	<4.3kg	4.3-8.6kg	>8.6kg
86kg	<4.3kg	4.3-8.6kg	>8.6kg
87kg	<4.4kg	4.4-8.8kg	>8.8kg
88kg	<4.4kg	4.4-8.8kg	>8.8kg
89kg	<4.5kg	4.5-9kg	>9kg
90kg	<4.5kg	4.5-9kg	>9kg
91kg	<4.6kg	4.6-9.2kg	>9.2kg
92kg	<4.6kg	4.6-9.2kg	>9.2kg
93kg	<4.7kg	4.7-9.4kg	>9.4kg
94kg	<4.7kg	4.7-9.4kg	>9.4kg
95kg	<4.8kg	4.8-9.6kg	>9.6kg
96kg	<4.8kg	4.8-9.6kg	>9.6kg
97kg	<4.9kg	4.9-9.8kg	>9.8kg
98kg	<4.9kg	4.9-9.8kg	>9.8kg
99kg	<5kg	5-10kg	>10kg
100kg	<5kg	5-10kg	>10kg
101kg	<5.1kg	5.1-10.2kg	>10.2kg
102kg	<5.1kg	5.1-10.2kg	>10.2kg
103kg	<5.2kg	5.2-10.4kg	>10.4kg
104kg	<5.2kg	5.2-10.4kg	>10.4kg
105kg	<5.3kg	5.3-10.6kg	>10.6kg
106kg	<5.3kg	5.3-10.6kg	>10.6kg
107kg	<5.4kg	5.4-10.8kg	>10.8kg
108kg	<5.4kg	5.4-10.8kg	>10.8kg
109kg	<5.5kg	5.5-11kg	>11kg
110kg	<5.5kg	5.5-11kg	>11kg
111kg	<5.6kg	5.6-11.2kg	>11.2kg
112kg	<5.6kg	5.6-11.2kg	>11.2kg
113kg	<5.7kg	5.7-11.4kg	>11.4kg
114kg	<5.7kg	5.7-11.4kg	>11.4kg
115kg	<5.8kg	5.8-11.6kg	>11.6kg
116kg	<5.8kg	5.8-11.6kg	>11.6kg
117kg	<5.9kg	5.9-11.8kg	>11.8kg
118kg	<5.9kg	5.9-11.8kg	>11.8kg
119kg	<6kg	6-12kg	>12kg
120kg	<6kg	6-12kg	>12kg
121kg	<6.1kg	6.1-12.2kg	>12.2kg
122kg	<6.1kg	6.1-12.2kg	>12.2kg
123kg	<6.2kg	6.2-12.4kg	>12.4kg
124kg	<6.2kg	6.2-12.4kg	>12.4kg
125kg	<6.3kg	6.3-12.6kg	>12.6kg
126kg	<6.3kg	6.3-12.6kg	>12.6kg

Weight before weight loss (stones)	Score 0 (<5% loss)	Score 1 (5%-10% loss)	Score 2 (>10% loss)
5st 4lb	<7lb	7lb-14lb	>14lb
5st 7lb	<7lb	7lb-14lb	>14lb
5st 11lb	<7lb	7lb-14lb	>14lb
6st	<7lb	7lb-14lb	>14lb
6st 4lb	<7lb	7lb-14lb	>14lb
6st 7lb	<7lb	7lb-14lb	>14lb
6st 11lb	<7lb	7lb-14lb	>14lb
7st	<7lb	7lb-14lb	>14lb
7st 4lb	<7lb	7lb-14lb	>14lb
7st 7lb	<7lb	7lb-14lb	>14lb
7st 11lb	<7lb	7lb-14lb	>14lb
8st	<7lb	7lb-14lb	>14lb
8st 4lb	<7lb	7lb-14lb	>14lb
8st 7lb	<7lb	7lb-14lb	>14lb
8st 11lb	<7lb	7lb-14lb	>14lb
9st	<7lb	7lb-14lb	>14lb
9st 4lb	<7lb	7lb-14lb	>14lb
9st 7lb	<7lb	7lb-14lb	>14lb
9st 11lb	<7lb	7lb-14lb	>14lb
10st	<7lb	7lb-14lb	>14lb
10st 4lb	<7lb	7lb-14lb	>14lb
10st 7lb	<7lb	7lb-14lb	>14lb
10st 11lb	<8lb	8lb-14lb	>14lb
11st	<8lb	8lb-14lb	>14lb
11st 4lb	<8lb	8lb-14lb	>14lb
11st 7lb	<8lb	8lb-14lb	>14lb
11st 11lb	<8lb	8lb-14lb	>14lb
12st	<8lb	8lb-14lb	>14lb
12st 4lb	<9lb	9lb-14lb	>14lb
12st 7lb	<9lb	9lb-14lb	>14lb
12st 11lb	<9lb	9lb-14lb	>14lb
13st	<9lb	9lb-14lb	>14lb
13st 4lb	<9lb	9lb-14lb	>14lb
13st 7lb	<9lb	9lb-14lb	>14lb
13st 11lb	<9lb	9lb-14lb	>14lb
14st	<9lb	9lb-14lb	>14lb
14st 4lb	<9lb	9lb-14lb	>14lb
14st 7lb	<10lb	10lb-14lb	>14lb
14st 11lb	<10lb	10lb-14lb	>14lb
15st	<10lb	10lb-14lb	>14lb
15st 4lb	<11lb	11lb-14lb	>14lb
15st 7lb	<11lb	11lb-14lb	>14lb
15st 11lb	<11lb	11lb-14lb	>14lb
16st	<11lb	11lb-14lb	>14lb
16st 4lb	<11lb	11lb-14lb	>14lb
16st 7lb	<12lb	12lb-14lb	>14lb
16st 11lb	<12lb	12lb-14lb	>14lb

STORES ORDER CODE 41850

NHS Greater Glasgow and Clyde

Nutrition Profile

Name: Catherine Honeyman	Date of admission: / /
Address:	Time:
	HOSPITAL:
DoB:	Ward:
CHI number:	
Affix patient data label	

To be recorded within 24 hours of admission*

Height: 5·4 m/ft Actual ☐ Patient/ carer reported ☑ Alternative measurement ☐

Weight: 14.10 kg/stones Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Recent unplanned weight loss: Yes ☐ No ☑

If 'Yes' how much?: kg/stones. Over what period of time?: weeks/months

Is there evidence of recent weight loss?

No ☑ Loose clothing ☐ History of reduced food intake/appetite ☐ Swallowing problem ☐

Eating and drinking likes and dislikes (including appetite and/or NBM status):

Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☑

Please state:

Are there any contributing factors that may affect food intake such as physical (e.g. swallowing difficulties), physiological (e.g. nausea), psychological (e.g. dementia), social or environmental? Yes ☐ No ☑

Please specify all factors:

Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☑

Please state:

Profile completed by: Name (PRINT): ANNE DOUGLAS Signature: Anne Douglas Date: 4/4/11

NOTE: This is ADMISSION DATA - please refer to changes in Care Plan.

* Quality Improvement Scotland (2003). Food, Fluids and Nutritional Care in Hospitals Edinburgh QIS

Malnutrition Universal Screening Tool ('MUST')

Date	4/4									
Initials	MP									
Height (see page 1) 5.4 / Weight	14 10									
Oedema or ascites present Y/N	N									
BMI	30									
'MUST'										
Step 1: BMI Score (refer to chart on page 4) >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 or virtually no food intake for > 5 days..... Score 2 Not applicable ..... Score 0	0									
Step 4: Overall Risk of Malnutrition Total:	0									

Step 5: Management Guidelines

Score of Overall Risk of Malnutrition	Action Required
0	LOW RISK - *Routine Clinical Care* • Repeat screening. Hospital Acute ..... 1 .....Weekly Hospital Rehabilitation .....Monthly
1	MEDIUM RISK - *Observe* • Document dietary intake for 3 days on a Food Record Chart. • If no improvement in intake: - Encourage oral intake. - Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Repeat screening weekly.
2 or more	HIGH RISK - *Treat** • Refer to Dietitian and document food intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Monitor and review Care Plan weekly. * Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

Management Plan

FOR ALL PATIENTS

- Provide help and advice on food choices and eating and drinking when necessary.
- Treat underlying conditions and initiate appropriate treatment to relieve symptoms that affect nutritional intake e.g. nausea, vomiting, constipation, diarrhoea and/or pain.
- Refer to dietitian if any specialist advice is required.
- Complete nursing checklist for swallowing difficulties if appropriate.
- Use a recognised system to identify when equipment or asssistance is required at mealtimes (e.g. rad mats, coloured napkins).

Referral Services

Dietitian	Date: / /	Outcome:
Speech and Language Therapy	Date: / /	Outcome:
Occupational Therapy	Date: / /	Outcome:
Dental Service	Date: / /	Outcome:

Multidisciplinary Nutrition Care Plan

Date	Overall Risk	Action	Review date	Name (PRINT) Signature/Designation
4/4	0	Nil required – review 11/52	11/4	Clin Dietn

NHS Greater Glasgow and Clyde

SOUTH GLASGOW PHYSIOTHERAPY SERVICE
ORTHOPAEDIC FRONT SHEET/ASSESSMENT FORM

Unit No: SG 0094 0779
Surname: Honeyman.
First Name: Catherine.
Address: 10 melville st.
Glasgow G41 2LN.

DOB: 01/02/49.
CHI: 0102 49 6145.

Ward: 2
Consultant: Hislop
Admission Date: 27/3/11
Date referred: 04/04/11
Tel No: 427 1580
Occupation:
Age: 62

Patient consent ☐:

PC	® knee 1st stage rev → to mob WB as able (31/03/11)
HPC	↑ pain, joint erythemarous, cellulitic around scar. ® patella resurfacing 2010. Readmitted c haematoma & infection.
PMH	Angina, OA.
DH	simvastatin, atenolol, tramadol, aspirin, bendroflumazide fluoxetine, losec.
SH	Lives c husband & daughter. non smoker, seldom alcohol Housebound
	Previous mobility: mob c aids ~ 1 yr.

Problem List and Goals

	Date	Problem	Goal	Active/ Resolved	Date
1					
2					
3					
4					

Discharge Date:
Follow-up physiotherapy:

Date: 04/04/11

Physiotherapist signature:

PRINT: Alisa Masa

Designation: Senior PT

Catherine Honeyman (2) SA0094077 9

Date	Details	Signature
04/04/11	S, Consent Ax/Rx	
	O, lying → sit (I)	
	sit → stand (I)	
	Gait - mob i WRF ↓ SIV i (P) camp splint in situ.	
	- 3 point step to gait	
	- leaning heavily through LLS	
	- steady R/A	
	Rx, Gait px i WRF	
	A, Pt safe to mob (I)	
	P, Progress mob i WRF. CO2 mob Ax/Rx > MAS > SENIOR PT	
05/04/11	S, Consent Ax/Rx. Pt for DC (H) today on oral abx	
	O, sit → stand (I)	
	Gait - mob (I) i 2x elc i no issues	
	- 3 point step to gait	
	- good step length ↓ poor clearance	
	- steady throughout	
	Stair - 12 steps i rail ↓ elc	
	- good. Poor placement, safe ↓ (I)	
	Rx, (1) Gait px i 2x elc (I)	
	(2) Stair px i rail ↓ elc	
	A, Pt mob (I) i 2x elc ↓ managed stair safely ↓ (I)	
	No further PT issues	
	P, DC PT. CO2 mob Ax/Rx) MAS) SENIOR PT	

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

Warning: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed by a doctor.

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).
2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).
3. Print & Sign your full name clearly against each prescription entry.
4. Time should be recorded in 24hr format e.g. 0600, 1800.
5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.
6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.
7. The following metric unit abbreviations must be used –

Milligram = mg — Gram = g
Millilitre = ml — Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

8. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - **intrathecal must be written in full.**

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.
2. Insert initials in the relevant date column and time row each time a drug is administered.
3. Check that all drugs prescribed at a certain time have been administered.
4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

(3) Patient refused	(7) Patient asleep	(11) Unable to swallow
(4) Drug not available	(8) Time varied on doctor's instructions	(12) No intravenous access
(5) Nil by mouth/fasting	(9) Dose withheld on doctor's instructions	(13) Patient Self-Administration of Medicine
(6) Patient unavailable	(10) Nausea/vomiting	(14) Other - Record in nursing notes
		(15) Prescription clarification required

Cat. No. 40999 Ver 4, 09/2010

MEDICINE PRESCRIPTION FORM

Hospital Name: .....

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐
Date _____ Name (Print) _____
Discharge Prescription Prepared & Reconciled YES ☐
Date _____ Name (Print) _____

Date and time this form prepared:	Sheet No	2nd Prescription in use
__/__/__ Time: _____	.....	YES ☐ NO ☐

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the symptomatic relief policy & local protocol:

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name _____ Tel No. _____
Address _____
Compliance Aid Details _____
Patient consent to share discharge information Y/N
Print & Sign _____

PATIENT DETAILS

HONEYMAN, CATHERINE
SG00940779 01/02/49
CHI: 0102496145

Ho
DC

	Height:
	Weight:
	Surface area:
Date of Admission: __/__/__	
Consultant Name:	Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
27/3/11	FLUCLOXACILLIN	2g	IV	06.00	BMR		0630
27/3/11	Paracetamol	1gram	IV	1600	0.Finn		1600
31.3.11	FENTANYL by algorithm	40mcg	IV	recovery	Hoolahan	040mcg	17[10]
						240mcg	17[20]
						340mcg	17[30]

DATE 27 28 29 30 31 1 2 3 4 5

MONTH 3 3 3 3 3 4 4 4 4 4

RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)

IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N

ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N

SIGNATURE OF ASSESSOR

ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N

Parenteral Drugs : Regular Prescription

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

A BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☒

DRUG Clexane

DOSE 40mg | ROUTE s/c | DATE 27/3/11 | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

B BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION

DRUG Flucloxacillin

DOSE 2g | ROUTE IV | DATE 27/3/11 | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

C BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☒

DRUG Gentamycin

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

REVIEW THE NEED FOR IV ANTIBIOTIC DAILY. SWITCH TO ORAL THERAPY AS SOON AS POSSIBLE (SEE IVOST POLICY)

Parenteral Drugs: Regular Prescription

DATE 27 28 29 30 31 01 2 3 4 5

MONTH 3 3 3 3 3 04 4 4 4 4

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

D BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG FLUCLOXACILLIN

DOSE 2 gm | ROUTE IV | DATE 27/3 | STOPPED DATE: 3/4 | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

ON MICROBIOLOGY ADVICE

E BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG Morphine. PCA.

DOSE As per chart | ROUTE IV | DATE 31/3 | STOPPED DATE: 4/4 | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

F BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

G BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Name Catherine Honeyman.

CHI No 0102496145.

Drug Allergies / Sensitivities None Known ☐ Yes ☒ (provide details below)

~~Ventolol~~.

Oral and Other Drugs: Regular Prescription

POD

DATE / MONTH: 28 28 29 30 31 1 2 3 4 5 / 3 3 3 3 3 4 4 4 4 4

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

H — BEFORE ADMISSION ☒ — NEW DOSE ☐ — NEW MEDICATION ☒

DRUG: Simvastatin
DOSE: 40mg | ROUTE: PO | DATE: 27/3/11 | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

J — BEFORE ADMISSION ☒ — NEW DOSE ☐ — NEW MEDICATION ☐

DRUG: Atenolol
DOSE: 25mg | ROUTE: Po | DATE: 27/3/11 | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

K — BEFORE ADMISSION ☒ — NEW DOSE ☐ — MEI —

DRUG: Tramadol
DOSE: 00mg | ROUTE: Po | DATE: 27/3/11 | STOPPED DATE: 31/3 | STOPPED INITIALS: DF
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

L — BEFORE ADMISSION ☒ — NEW DOSE ☐ — NEW MEDICATION ☐

DRUG: Aspirin
DOSE: 75mg | ROUTE: PO | DATE: 27/3/11 | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE / MONTH: 28 28 29 30 31 1 2 3 4 5 / 3 3 3 3 3 4 4 4 4 4

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

M — BEFORE ADMISSION ☒ — NEW [illegible] — NEW MEDICATION ☐

DRUG: Bendroflumethiazide
DOSE: 2.5mg | ROUTE: PO | DATE: 27/3/11 | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

N — BEFORE ADMISSION ☒ — NEW DOSE ☐ — NEW MEDICATION ☐

DRUG: Fluoxetine
DOSE: 20mg | ROUTE: Po | DATE: 27/3/11 | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

P — BEFORE ADMISSION ☒ — NEW DOSE ☐ — NEW MEDICATION ☐

DRUG: Omeprazole
DOSE: 20mg | ROUTE: Po | DATE: 27/3/11 | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

R — BEFORE ADMISSION ☐ — NEW DOSE ☐ — NEW MEDICATION ☐

DRUG: PARACETAMOL
DOSE: 1Gm | ROUTE: PO | DATE: 27/3/11 | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

0600 0800

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Name: Catherine Honeyman.
CHI No: 0102496145.

Drug ~~Allergies~~ Sensitivities: None Known ☐ Yes ☒ (provide details below)
Voltaol.

Oral and Other Drugs: Regular Prescription

S — DRUG: RIFAMPICIN
DOSE: 600mg | ROUTE: ORAL | DATE: 29/3/11 | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN): DONALD
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: FOR 4-6 WEEKS TOTAL. WATCH LFTs
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☑

T — DRUG: FERROUS SULPHATE
DOSE: 2 tablets | ROUTE: O | DATE: 31.3.11 | STOPPED DATE: 1/4/11 | STOPPED INITIALS: DM
PRESCRIBER (PRINT & SIGN): Hazlehurst
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: CHANGED TO FUMARATE (SEE BELOW)
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

V — DRUG: OXYCONTIN
DOSE: 10mg | ROUTE: ORAL | DATE: 31/3/11 | STOPPED DATE: 1/4/11 | STOPPED INITIALS: DM
PRESCRIBER (PRINT & SIGN): DAWSON
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: R/V m 4/4/11
BEFORE ADMISSION ☐ | NEW DOSE ☑ | MEI ☐

W — DRUG: FERROUS FUMARATE
DOSE: 2x 210mg | ROUTE: ORAL | DATE: 1/4/11 | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN): DUNCOMBE JP
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: 420mg tid
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DATE: 29 30 31 1 2 3 4 5
MONTH: 3 3 3 4 4 4 4 4
Other time / 0700-0900 / 1200-1400 / 1600-1800 / 2200-2400 / Other time

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

X — DRUG: TRAMADOL
DOSE: 100mg | ROUTE: O | DATE: 4/4/11 | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN): SMORRIS (NIP)
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐

Y — DRUG: FLUCLOXACILLIN
DOSE: 1g | ROUTE: O | DATE: 5/4 | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

AA — DRUG:
DOSE: | ROUTE: | DATE: | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

BB — DRUG:
DOSE: | ROUTE: | DATE: | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DATE: 4 5
MONTH: 4 4
Other time / 0700-0900 / 1200-1400 / 1600-1800 / 2200-2400 / Other time

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Name: Catherine Honeyman.
[redacted]: 0102496145.

Drug Allergies / Sensitivities — None Known ☐ Yes ☒ (provide details below)
Voltarol.

Oral and Other Drugs: Regular Prescription

DATE / MONTH

| | | |

All Routes: As Required Prescriptions

LL — DRUG: Morphine — STOPPED DATE: — INITIALS:
DOSE: 5mg | ROUTE: s/c | INDICATION: Pain | PRESCRIBER (PRINT & SIGN): [redacted] | MAX.FREQ.: 2° | DATE: 27/3/11
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☒

DATE	TIME	DOSE	GIVEN BY
27/3	1800	5mg	[redacted]
27/3	2200	5mg	[redacted]
28/3	0200	5mg	[redacted]
28/3	0600	5mg	[redacted]
28/3	1000	5mg	[redacted]
28/3	1400	5mg	[redacted]

MM — DRUG: Cyclizine — STOPPED DATE: — INITIALS:
DOSE: 50mg | ROUTE: PO/IV | INDICATION: N+V | PRESCRIBER (PRINT & SIGN): [redacted] | MAX.FREQ.: TID | DATE: 27/3/11
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☒

DATE	TIME	DOSE	GIVEN BY
27/3	1800	50mg	[redacted]

NN — DRUG: ORAMORPH — STOPPED DATE: 31/3/11 — INITIALS: DP
DOSE: 5-10ml | ROUTE: PO | INDICATION: ↑↑ pain | PRESCRIBER (PRINT & SIGN): [redacted] | MAX.FREQ.: 2-4hrly | DATE: 31/3/11
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DATE	TIME	DOSE	GIVEN BY
27/3	2400	10mg	[redacted]
28/3	0325	10mg	[redacted]
28/3	0730	10mg	[redacted]
28/3	1755	10mg	[redacted]

PP — DRUG: ONDANSETRON — STOPPED DATE: — INITIALS:
DOSE: 4mg | ROUTE: IV/O | INDICATION: Nausea | PRESCRIBER (PRINT & SIGN): [redacted] RINN | MAX.FREQ.: 8° | DATE: 31/3/11
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DATE	TIME	DOSE	GIVEN BY
31/3	1645	4mg	[redacted]

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Patient's Own Medicine — For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

RR — DRUG: ORAMORPH — STOPPED DATE: — INITIALS:
DOSE: 5-10mg | ROUTE: O | INDICATION: PAIN | PRESCRIBER (PRINT & SIGN): [redacted] RINN | MAX.FREQ.: 2° | DATE: 31/3/11
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: FOR BREAKTHROUGH PAIN WHEN PCA STOPPED
BEFORE ADMISSION ☐ NEW [illegible] NEW MEDICATION ☐

DATE	TIME	DOSE	GIVEN BY
24/3	1700	10mg	[redacted]
24/3	2130	10mg	[redacted]
25/3	0330	10mg	[redacted]
25/3	0755	10mg	[redacted]
25/3	1300	10mg	[redacted]
25/3	2200	10mg	[redacted]
25/3	2420	10mg	[redacted]

SS — DRUG: PIRITON — STOPPED DATE: — INITIALS:
DOSE: 4mg | ROUTE: O/I/V | INDICATION: Itch | PRESCRIBER (PRINT & SIGN): [redacted] | MAX.FREQ.: TID | DATE: 31/3/11
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DATE	TIME	DOSE	GIVEN BY
31/3	2030	4mg	[redacted]

TT — DRUG: GAVISCON — STOPPED DATE: — INITIALS:
DOSE: 15ml | ROUTE: O | INDICATION: Indigestion | PRESCRIBER (PRINT & SIGN): HMC Crolie [redacted] PRN | MAX.FREQ.: [illegible] | DATE: 31/3/11
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DATE	TIME	DOSE	GIVEN BY
5/6	0900	15ml	[redacted]

VV — DRUG: — STOPPED DATE: — INITIALS:
DOSE: | ROUTE: | INDICATION: | PRESCRIBER (PRINT & SIGN): | MAX.FREQ.: | DATE:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DATE	TIME	DOSE	GIVEN BY

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Name: Catherine Honeyman.
CHI No: 0102496145.

Drug Allergies / Sensitivities — None Known ☐ Yes ☒ (provide details below)
~~Codeine~~.

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

Patient's name: Catherine Honeyman	Ward: 2
Unit number: SG-00940779	Discharge destination: Home.
CHI number: 0102496145	Estimated Discharge Date (1) 5/4/11
	Estimated Discharge Date (2) / /
Apply addressograph label	Final date of discharge: 5/4/11

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓			
Relative/carer informed	✓			
Others informed: Care Home		✓		
Transport arranged				
Own transport (preferred option)	✓			
Ambulance-1 man/ 2 man am/pm		✓		
Other: Flight, Air ambulance etc.		✓		
Discharge medication				
Discharge prescription completed	✓			
Compliance aids e.g. Dossette Box (involve pharmacist)		✓		
Medication received	✓			
Medication explained to patient and/or relative/carer	✓			
Own medication returned to patient		✓		
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)	✓			
Informed of discharge				
Social work/ Other agencies/Home help		✓		
Physiotherapist		✓		
Occupational Therapist		✓		
Dietician		✓		
Speech and Language Therapist		✓		
Clinical Nurse specialist e.g. Care Home Liaison		✓		
Liaison/ District Nurse/Practice Nurse		✓		
Other discharge items				
Access arrangements (e.g. keys, door entry)	✓			
Patients clothing available for day of discharge	✓			
Valuables e.g. cashier		✓		
Intravenous cannula removed	✓			
Equipment ordered (inc. walking aids) in place for discharge				
Part 2 Discharge letter - Required	✓			District Nurse
- Completed	✓			
Out patient clinic appointment e.g. Anticoagulation clinic				
~~Arranged~~ / To follow	✓			
If unknown at time of discharge state reason		✓		
Additional information / leaflets / factsheets		✓		

Time of Discharge: 16.30		
Nurse's signature:	Designation: Home	Date: 5/4/11

FORM NUMBER 0005752

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL, 1345 GOVAN ROAD, GLASGOW G51 4TF
TEL: 0141 201 1100

DEPARTMENT OF ORTHOPAEDICS

WARD: S02 **CONSULTANT: MR MIKE HULLIN**
CONTACT TEL: 0141 201-1357 ***IMMEDIATE DISCHARGE LETTER***

PATIENT: CATHERINE HONEYMAN
10 MELVILLE STREET
GLASGOW
G41 2LN

DOB: 01/02/49 UNIT NO: SG00940779
ACCT NO: IP0016709/11
CHI NO: 0102496145

GP: DR GRAEME G MARSHALL
GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ

DATE OF ADMISSION: 27/03/11
ADMISSION TYPE: EMERGENCY DATE OF DISCHARGE: 05/04/11
DISCHARGE TO: HOME

REASON FOR ADMISSION: RIGHT KNEE PAIN
MAIN DIAGNOSIS: INFECTED R TKR, TAKEN FOR 1ST STAGE REVISION FOR 6/52 ORAL ABX THEN FURTHER REVIEW BY MR HULLIN WITH VIEW TO 2ND STAGE REVISION
OTHER ACTIVE PROBLEMS: NIL

OPERATIONS/PROCEDURES/ TREATMENT: AS ABOVE
RESULTS AWAITED: N
CURRENT MEDICATION: SEE PRESCRIPTION
DISCONTINUED DRUGS? N
COMMENT:

ALLERGIES: . NKDA
. NKDA

REVIEW? Y DETAILS: MR HULLIN RETURN CLINIC TIMESCALE: 6/52

FURTHER LETTER TO FOLLOW? Y DETAILS: FORMAL HOSPITAL LETTER

Highly Sensitive Document Y/N N Patient consent to share information Y/N Y

SIGNED: FY2.REIJA REID,JAMES
DESIGNATION: FOUNDATION DR YEAR 2
PAGE NUMBER: 7555

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL, 1345 GOVAN ROAD, GLASGOW G51 4TF
TEL: 0141 201 1100

DEPARTMENT OF ORTHOPAEDICS

WARD: S02 CONSULTANT: MR MIKE HULLIN
CONTACT TEL: 0141 201-1357 *IMMEDIATE DISCHARGE LETTER*

PATIENT: CATHERINE HONEYMAN
10 MELVILLE STREET
GLASGOW
G41 2LN

DOB: 01/02/49 UNIT NO: SG00940779
ACCT NO: IP0016709/11
CHI NO: 0102496145
GP: DR GRAEME G MARSHALL

DISCHARGE MEDICATION

Time Required? As Per Date of Discharge
Childproof Containers? Y
Compliance Aid Required? N
Patient's Weight (Kg):
Comment:

Medication	Form	Dose	Frequency	Duration
SIMVASTATIN	OTAB	40MG	NOCTE	INDEFINITE

New Drug? N New Dose? N Comments:
Patient's Own Supply? Y Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration
TENOLOL	OTAB	25MG	IN THE MORNING	INDEFINITE

New Drug? N New Dose? N Comments:
Patient's Own Supply? Y Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration
ASPIRIN	OTAB	150MG	IN THE MORNING	6/52

New Drug? N New Dose? Y Comments: 6/52 FOR DVT PROPHYLAXIS THEN BACK TO 75MG OD
Patient's Own Supply? N Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration
BENDROFLUMETHIAZIDE	OTAB	2.5MG	IN THE MORNING	INDEFINITE

New Drug? N New Dose? N Comments:
Patient's Own Supply? Y Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration
FLUOXETINE	OCAP	20MG	IN THE MORNING	INDEFINITE

New Drug? N New Dose? N Comments:
Patient's Own Supply? Y Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration
OMEPRAZOLE	OCAP	20MG	IN THE MORNING	INDEFINITE

New Drug? N New Dose? N Comments:
Patient's Own Supply? Y Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration
PARACETAMOL	OTAB	1G	4 TIMES A DAY	7 DAYS

New Drug? Y New Dose? Y Comments:
Patient's Own Supply? N Pharmacy Notes: Supply:

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL, 1345 GOVAN ROAD, GLASGOW G51 4TF
TEL: 0141 201 1100

DEPARTMENT OF ORTHOPAEDICS

WARD: S02 CONSULTANT: MR MIKE HULLIN
CONTACT TEL: 0141 201-1357

IMMEDIATE DISCHARGE LETTER

PATIENT: CATHERINE HONEYMAN
10 MELVILLE STREET
GLASGOW
G41 2LN

DOB: 01/02/49
UNIT NO: SG00940779
ACCT NO: IP0016709/11
CHI NO: 0102496145
GP: DR GRAEME G MARSHALL

Medication	Form	Dose	Frequency	Duration
RIFAMPICIN	OCAP	600MG	MORNING AND NIGHT	5 WEEKS

New Drug? Y New Dose? Y Comments:
Patient's Own Supply? N Pharmacy Notes: 25-DAY SUPPLY - GP SUPPLY REST Supply:

Medication	Form	Dose	Frequency	Duration
FLUCLOXACILLIN	OCAP	1G	4 TIMES A DAY	5 WEEKS

New Drug? Y New Dose? Y Comments:
Patient's Own Supply? N Pharmacy Notes: 2-WEEK SUPPLY - GP SUPPLY REST Supply:

edication	Form	Dose	Frequency	Duration
FERROUS FUMARATE	OTAB	420MG	3 TIMES A DAY	INDEFINITE

New Drug? Y New Dose? Y Comments: PC: GP REVIEW DOSE IN 3 MONTHS
Patient's Own Supply? N Pharmacy Notes: GP PLEASE MONITOR HAEMATINICS Supply:

Medication	Form	Dose	Frequency	Duration
TRAMADOL	OCAP	100MG	4 TIMES A DAY	INDEFINITE

New Drug? Y New Dose? Y Comments:
Patient's Own Supply? N Pharmacy Notes: INC RISK OF CNS TOX WITH SSRI Supply:

Medication	Form	Dose	Frequency	Duration

New Drug? New Dose? Comments:
Patient's Own Supply? Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration

New Drug? New Dose? Comments:
Patient's Own Supply? Pharmacy Notes: Supply:

edication	Form	Dose	Frequency	Duration

New Drug? New Dose? Comments:
Patient's Own Supply? Pharmacy Notes: Supply:

PHARMACY USE ONLY DISPENSED BY: DATE: CHECKED BY:
CLINICAL PHARMACIST CHECK: COLLECTED BY: _____

Medicine received on ward by: _____ Issued by: N Dooley/A

Named Nurse: _____ Signature of Receipt: _____

Report Number: 0504-0033 Date(Time): 05/04/11 (1010 Hours) Status: Signed

Acute Services Division

Part 2 Discharge Letter / Transfer Plan

NHS Greater Glasgow and Clyde

- ☐ Glasgow Royal Infirmary 0141 211 4000
- ☐ Stobhill Hospital 0141 201 3000
- ☐ Western Infirmary 0141 211 2000
- ☑ Southern General Hospital 0141 201 1100
- ☐ Victoria Infirmary 0141 201 6000
- ☐ Mansionhouse Unit 0141 201 6101
- ☐ Gartnavel General Hospital 0141 211 3000
- ☐ Blawarthill Hospital 0141 211 9000
- ☐ Drumchapel Hospital 0141 211 6000
- ☐ Lightburn Hospital 0141 211 1500
- ☐ Vale of Leven Hospital 01389 754 121
- ☐ Royal Alexandra Hospital 887 9111
- ☐ Inverclyde Royal Hospital 01475 633777
- ☐ Other:

Name: Catherine Honeyman

Address: 10 Melville Street

Glasgow

Discharge Address: N/A

CHI number: 0102496145

Unit number: [redacted] D.O.B. 1/2/69

Telephone: 0141 221 560

Next of kin: Raymond Honeyman

Relationship: 10 Melville Street

Address: Glasgow

Telephone: N/A.

Ward: 2

Telephone: 0141/ 201 1165

Admission date: 27/3/11

Final discharge/transfer date: 5/4/11

Named Nurse:

Consultant: Mr Hullin

G.P.: Dr Marshall

Address: Gorbals Health Centre

Telephone: 5318250

Post Discharge Services Arranged (e.g. District Nurse, CPN, Day Hospital, Home Care)
State package requested and time of first visit.

Service: DN	Service:
Contact number:	Contact number:
Service details: Clips to wound ~~Wound review & clips to wound~~	Service details:

Additional/Transfer Information (including equipment/adaptions)

1st stage reconstruction (knee) & insertion of cement spacer. Clips to wounds ~~will be removed~~ by district. Please remove on 11/4/11

Patient Assessment/Comments

Mobility:
Cramp Sphincters

Personal hygiene/Dressing:
independent

Continence: Catheter in situ: Yes ☐ No ☐
Type: Size:
Date of change:

Continence details:

Dietary requirements:
no problems

mmunication / Swallowing:
no problems

Mental state:
alert

Skin condition/Waterlow Score:
intact

Wound care/Stoma care:
See additional info

Special Instructions for Patient (e.g. Exercise , Diet, Wounds, Others)

Others/Follow-up arrangements
OPA 15/6/11

Progress discussed with patient: Yes☐ No☐
Progress discussed with relative/carer: Yes☐ No☐

This information has been fully discussed with Patient/Carer.

Date and signature of Nurse:

Date and signature of Patient/Carer:

Diagnosis:
31/3/11. 1st Stage
Carcinoma (R) Knee
W/C infiltration of
Cancellous Space.

HONEYMAN, CATHERINE
SG00940779 01/02/49
CHI: 0102496145 F
Date _____ Time _____
Spec./Sig. _____

UNIT NO. 9

COMMENTS

DATE & TIME	DAY NO	COMMENTS	SIGNATURE
10-6-11	PA	Attended today - for admission	
		BMI: 48. Ward, theatre and anaesthetist	
		all informed by e-mail. Dr. Hosie also	
		advised of patient's medical history and	
		bleed transfusion status ie. not for	
		transfusion.	
23/6/11	1600	Patient has had a settled night sleep	
		Patient has been Marked, Consented	
		and Seen by anaethetist.	
		O/E - med Stockinet for OT.	DMcNally
	1250	Returned from theatre following right	
		second stage knee replacement; under GA	
		femoral and Sciatic block. Stapled to	
		close, sterile wool and crepe to dress.	
		Wound dry and intact. O² 5l through hudson	
		mask. Sats were sitting 93% - 95% in	
		recovery however have rose and stayed	
		stable above 95% on return. Experienced	
		chest tightness to left side, anaesthetist	
		informed tightness settled spontaneously.	
		Also experienced nausea with ondansetron 4mg	
		IV given to good effect. IV fluids running	
		with further fluids prescribed. Pressure	
		areas intact CVI satisfactory.	

ATTACH ALERT NOTIFICATION HERE IF REQUIRED

Health Care / Advance Directive
105 - No Transfusion
= cell salvage only

Acute Services Division

Southern General Hospital

NHS Greater Glasgow and Clyde

This patient is on beta blockers
Please complete a SPSP form postop
and return to Ward Clerkess

Integrated Care Pathway

(R) ~~Primary~~ 2nd Stage Knee Replacement

SG00940779
HONEYMAN, CATHERINE
10 MELVILLE STREET
GLASGOW 01/02/1949
G41 2LN CHI 0102496145

CONSULTANT: Hollis

NAMED NURSE: T. Brown

PROPOSED SURGERY

Diagnosis: OA ☐ RA Servo +ve ☐
Post Trauma ☐ Servo -ve ☐
Other _____

Left ☐ Right ☑ Bilateral ☐

Department of Orthopaedics

PATIENT DETAILS

DATE 10-6-11

PREFERRED NAME Cathy.
AGE 62.
PATIENT'S TEL NO. 422-1580, 07977209 369.

RELIGION Jehovahs Witness.
CLERGY VISIT REQUESTED YES ☐ NO ☐
OCCUPATION retired.

NEXT OF KIN Raymond.
ADDRESS 5/A.

RELATIONSHIP husband
TEL. DAY: 07887871326 NIGHT:

OTHER CONTACT
ADDRESS

RELATIONSHIP
TEL. DAY: NIGHT:

GP NAME Dr. Marshall.
TEL NO. 531-8250

ADDRESS Pine Place
Corbals H.C.

MOBILITY

COMMUNITY ☐ HOUSEBOUND ☐
UNAIDED ☐ CRUTCHES ☐
1 STICK ☐ ZIMMER ☐
2 STICKS ☐ WHEELCHAIR ☑ see below.

HOUSING	YES	NO
STEPS OUTSIDE	ground floor flat.	☑
STEPS INSIDE		☑
STEPS TO TOILET		☑

SOCIAL CIRCUMSTANCES

LIVES ALONE ☐ INFIRM/ELDERLY PARTNER ☐ HEALTHY PARTNER ☐ LIVES WITH FAMILY ☑ ☐

	NO	YES	
RECEIVES SUPPORT	☑	☐	
REQUIRES SUPPORT	☑	☐	
Confirm additional support organised	☑	☐	
TRANSPORT ORGANISED	☐	☑	pt will arrange
Admission	☐	☑	
Discharge	☐	☑	
SIGNIFICANT VISUAL IMPAIRMENT	☑	☐	reading/driving specs.
SIGNIFICANT DEAFNESS	☑	☐	Alert notification ☐
ALCOHOL	☐	☑	Units per ~~day~~ wk 4-5
SMOKING	☑	☐	No. per day
NORMAL DIET	☐	☑	Dietitian informed If no ☐

(If no, tick appropriate) Diabetic ☐ Religious ☐ Low Fat ☐ Vegetarian/Vegan ☐

	M	T	W	T	F	S	S
DISTRICT NURSE							
HOME HELP							
DAY CENTRE							
MEALS ON WHEELS							
FAMILY VISIT							
OTHER							

4 = current support
* = required support

ADDITIONAL INFORMATION

Out only in car with driver.

OCCUPATIONAL THERAPY

	DRESSING	WASHING	FEEDING	HYGIENE	BED	CHAIR	TOILET	BATH
INDEPENDENT								
AIDS/ ASSISTANCE								

DISCHARGE
Perching Stool ☐ Shoe Horn ☐ Helping Hand ☐ Sock Aid ☐ Tights Aid ☐
Shower Board ☐ Bath Seat ☐ Trolley ☐ Mowbray ☐ Dressing Stick ☐
O.T. Referral Sent ☐ Other

SIGNED _____

NAME Catherine Honeyman. UNIT NO. 940779.

PRE-OPERATIVE ASSESSMENT

DATE 10-6-11

	NO	YES	
PREVIOUS GA	☐	☑	
IF YES: Complication		☐	
Within 3 Months		☐	
Family History of Problem		☐	
CHEST PROBLEMS	☑	☐	
IF YES: Bronchitis		☐	
OPD Chest Clinic		☐	
Productive Cough		☐	
Asthma In-patient Treatment in Last Year		☐	
MI Date _____	☑	☐	
HYPERTENSION	☐	☑	
BLEEDING TENDENCY	☑	☐	
Treatment	☐	☐	
BOWEL PROBLEMS	☑	☐	
IF YES: Constipation		☐	
Diarrhoea		☐	
URINARY SYMPTOMS	☑	☐	
IF YES: Haematuria		☐	
Dysuria		☐	
Nocturia > 2x		☐	
Urgency		☐	
ALLERGIES	☑	☐	
IF YES: Food/Pollen ☐	Antibiotics ☐		
Other Drug _____			
Rash ☐	Sickness ☐		
Diarrhoea ☐	Swelling ☐		
Collapse ☐	Flat ☐		
ALLERGY NOTIFICATION _____ (Signed)			

	NO	YES	
ANGINA	☐	☑	
IF YES: Occasionally ☑ usual.	At Rest ☑		
Once per Week ☐	Climbing Stairs ☐		
Once per Day ☐	Cold Air ☐		
	With Anxiety ☐		
Past 3 mths.			
PALPITATIONS ? anxiety.	☐	☑	
IF YES: Exercise ☐	Coffee ☐		
Excitement ☐	No Predisposing Factor ☐		
SHORTNESS OF BREATH ? anxiety.	☐	☑	
IF YES: At Rest ☐	Flight of Stairs ☐		
In the House ☐	At Night Lying Flat ☐		
Level Walking ☐			
ANKLE SWELLING	☐	☑	
IF YES: Occasionally ☐	All the Time ☑		
At Night ☐	(R) only slight		
DIABETES	☑	☐	
IF YES: Diet ☐	Insulin ☐		
Oral ☐			
Drug/Dose _____			
FITS/EPILEPSY	☑	☐	
IF YES: Rarely ☐	Blackouts ☐		
A few per month ☐	< 3 Months Ago ☐		
Treatment ☐	Seen GP ☐		
HIATUS HERNIA	☐	☑	
	Heartburn Lying Flat ☑		
CVA Date _____	☑	☐	
IF YES: SIDE	L ☐	R ☐	

PAST MEDICAL HISTORY Angina. Ischaenic Heart Disease.
(R) TKR. '05. SGH
(L) TKR. '10 SGH.
(R) Knee surgery - related to problems with TKR. SGH
Chalurnatectomy '95 V.I. SIGNED M McLaughlin. (OLN/R&O)

NAME Catherine Monaghan UNIT NO.

DRUG HISTORY

STEROIDS/METHOTREXATE/WARFARIN NO ☑ YES ☐ DRUG

IF YES: ☐ ☐ Dose / Frequency

CURRENT DRUGS	DOSE	FREQUENCY
GTN.	x2-3 puffs.	daily over 5/7.
Simvastatin.	~~25~~ 40mg	nght.
Atenolol	25mg	am.
Tramadol Hydrochloride	50mg x4	BD.
Aspirin Dispersible.	75mg.	am.
Bendroflumethiazide	2.5mg.	am.
Fluoxetine.	20mg.	am.
Omeprazole	20mg.	am.

SIGNED MMclaghan (OLN/Reg/SHO)

EXAMINATION

PULSE 80. Irregular NO ☑ YES ☐

BLOOD PRESSURE 136/93. Diastolic >90 Systolic >190 INFORM ANAESTHETIST

ABNORMAL URINALYSIS NO ☑ YES ☐

IF YES: Pt unable to provide urine @ P.A. Glucose ☐ Protein ☐ Blood ☐

HEIGHT 1.61 m WEIGHT 123.4 kilos

BODYMASS INDEX 48. WATERLOW 1

TED STOCKING SIZE

ABNORMAL CHEST PERCUSSION NO ☑ YES ☐

ABNORMAL CHEST SOUNDS NO ☑ YES ☐

ABNORMAL HEART SOUNDS NO ☑ YES ☐

ABDOMINAL MASSES NO ☑ YES ☐

DISTAL PULSES NO ☐ YES ☑ DISTAL OEDEMA NO ☑ YES ☐

KNEE JOINT

	LEFT		RIGHT	
	NO	YES	NO	YES
QUADS WASTING	☐	☐	☐	☐
SYNOVITIS	☐	☐	☐	☐
EFFUSION	☐	☐	☐	☐
DEFORMITY	☐	☐	☐	☐
If Yes:	FIXED		FIXED	
VARUS	° NO ☐ YES ☐		° NO ☐ YES ☐	
VALGUS	° NO ☐ YES ☐		° NO ☐ YES ☐	
FLEXION	° NO ☐ YES ☐		° NO ☐ YES ☐	
MAXIMUM FLEXION	°		°	

SIGNATURE OF SURGEON

NURSING ☑ MMclaghan (Sig)

PHYSIOTHERAPY ☐ (Sig)

O.T. ☐ (Sig)

NAME UNIT NO. 960779

INVESTIGATION — RESULT

FBC ☑ Hb g/L WCC x10⁹/L

~~X MATCH 3 UNITS~~ Group & Retain ☑

MSU ☐

U & E: NO ☐ YES ☑ Na (135-145) K (3.5-5.0) Cl (101-111) TCO^2 (23-30 mmol/L)

CXR NO ☑ YES ☐ Urea (2.5-7.5) Creatine (40-130)

ECG NO ☐ YES ☑

OTHER MRSH screen ESR, CRP. SIGNED MMclaghan (OLN/REG/SHO)

ANAESTHETIC ASSESSMENT

WARD VISIT ☐ OPD ☐ DATE

PROSTHESIS; TEETH; CROWNS

AIRWAY ASSESSMENT

ASA SCORE 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

OTHER TEST ORDERED

SURGERY DEFERRED NO ☐ YES ☐

IF YES, ACTION TAKEN

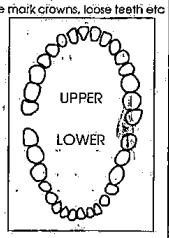
Refer GP ☐ Letter Sent ☐ W/L Deferred ☐

Await test result ☐ Reassess ☐

DATE

PREMED PRESCRIBED NO ☐ YES ☐ SIGNED (Anaesthetist)

Please mark crowns, loose teeth etc



ADMISSION - DAY 0

DATE

BP PULSE TEMP RESPS

PATIENT PATHWAY ☐ LIFTING ☐

TED Stockings fitted ☐ IDENTIFICATION ☐

WATERLOW SCORE ☐ INFECTION RISK SCORE ☐

SIGNATURE

DRUGS

TIME & SIG.	TIME & SIG.	TIME & SIG.

CONSENT ☐ LIMB MARKED ☐

DRUGS PRESCRIBED ☐

SIGNED (Operating Surgeon)

CONSENT TO ANAESTHESIA, OPERATION, INVESTIGATION OR TREATMENT

NOTES OF GUIDANCE

1. **DOCTORS**

A patient has the right to grant or withhold consent prior to examination, investigation, treatment or operation. The Doctor must give the patient sufficient information, in a way which he/she can understand, about the proposed procedure, any significant side-effects and the possible alternatives. The Doctor must give the patient enough time to read this sheet and ask any questions relating to it or their treatment. The patient must be allowed to decide whether he or she will agree to the procedure and they may refuse or withdraw consent to a procedure at any time. The patient's consent to a procedure should be recorded.

1.1. The patient must give written consent to be examined by students during any procedure for which consent is required. (See below).

2. **PATIENTS**

2.1. The Doctor is here to help you. He or she will explain the procedure, which you are entitled to refuse. You can ask any questions and ask for more information.

2.2. You may ask for a relative or friend or a nurse to be present while the Doctor explains the procedure and asks you to sign this sheet.

2.3. Students need to learn how to examine patients and to see how procedures are done. This is important for the future of health services. You may be asked to give consent to be examined by students during the procedure. It is up to you to decide whether you give your consent or not but whatever you decide, it will not affect your treatment.

TO BE COMPLETED BY THE MEDICAL PRACTITIONER

PROPOSED PROCEDURE: Revision 2nd Stage Right Knee

I HAVE FULLY EXPLAINED: To the patient/parent/guardian/next of kin* (*Delete as appropriate)

1. The procedure named on this form
2. Appropriate alternatives which are available
3. Significant side-effects which may result from the procedure. Including Deep Vein Thrombosis, Pulmonary Embolism, Infection, Stiffness, Dislocation and Longevity of Implant.

NAME (BLOCK CAPITALS) [signature] SIGNATURE [signature]

TO BE COMPLETED BY THE PATIENT

You should read this form carefully. If there is anything you do not understand ask the Doctor for an explanation. If the information is correct and you understand the procedure you should sign the form.

I AM — The patient/parent/guardian/next of kin* (*Delete as appropriate)

I UNDERSTAND
- The procedure which has been explained to me by the Doctor named on this form.
- The procedure may not be carried out by the Doctor who has been treating me so far.
- That any procedure in addition to that named on this form will only be carried out if necessary and in my best interests and can be justified for medical reasons.

I AGREE
- To the administration of an anaesthetic or sedation if required.
- To the procedure named on this form.
- That examination for the purposes of teaching will not be undertaken without my permission.

I AGREE/ DO NOT AGREE*
- To the involvement of a student at the procedure named.
- To the examination by a student during the procedure named under the supervision of the Senior Medical Officer undertaking this procedure.

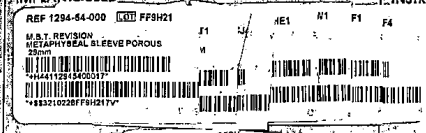
SIGNATURE [signature]
Patient/Parent/Guardian/Next of Kin* (BLOCK CAPITALS)

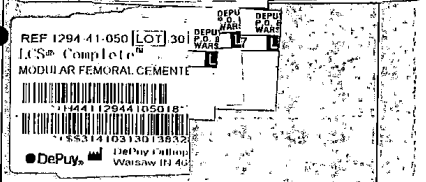
NAME: _____ UNIT NO. _____

OPERATION DETAILS

TOURNIQUET	YES ☐ NO ☐	STANDARD PREPARATION	YES ☐ NO ☐
MIDLINE SKIN INCISION	YES ☐ NO ☐	MEDIAL PARAPATELLAR	YES ☐ NO ☐
UNCEMENTED LCS	YES ☐ NO ☐	PATELLAR DEBRIDED ONLY	YES ☐ NO ☐

IMPLANTS USED





INSTRUMENTS USED

INSTRUMENTS USED	MILESTONE ☐ OTHER ☐	RANGE OF MOVEMENT ON TABLE	_____ TO _____ Degrees
STANDARD CLOSURE	YES ☐ NO ☐	ROUTINE POST-OP	YES ☐ NO ☐
FULL CORRECTION OF DEFORMITY	YES ☐ NO ☐	STANDARD DRAINS	YES ☐ NO ☐
Residual Deformity _____ Degrees Plane _____		IF NOT TO ANY QUESTION RECORD VARIANCE	

NAME _____ UNIT NO. _____

OPERATION DETAILS

TOURNIQUET	YES ☐	NO ☐	STANDARD PREPARATION	YES ☐	NO ☐
MIDLINE SKIN INCISION	YES ☐	NO ☐	MEDIAL PARAPATELLAR	YES ☐	NO ☐
UNCEMENTED LCS	YES ☐	NO ☐	PATELLAR DEBRIDED ONLY	YES ☐	NO ☐

IMPLANTS USED

2021-02

1

DePuy Orthopaedics, Inc.
700 Orthopaedic Drive
Warsaw IN 46582
1-800-366-8143

REF 1294-35-130 LOT FA4JT1

TIBIAL TRAY ROTATING PLATFORM
M.B.T. REVISION
SIZE 3 CEMENTED

+H4411294351301A

+$$3210131FA4JT1A3

-IE1 N1 F1 F4

2014-10

DePuy®

REF 1294-56-130 L

M.B.T.
STEP WEDGE
SZ 3
5 MM

INSTRUMENTS USED

INSTRUMENTS USED
MILESTONE ☐ OTHER ☐

RANGE OF MOVEMENT ON TABLE
_____ TO _____ Degrees

STANDARD CLOSURE	YES ☐	NO ☐	ROUTINE POST-OP	YES ☐	NO ☐
FULL CORRECTION OF DEFORMITY	YES ☐	NO ☐	STANDARD DRAINS	YES ☐	NO ☐

Residual Deformity
_____ Degrees Plane _____

IF NOT TO ANY QUESTION RECORD VARIANCE

NAME _____ UNIT NO. _____

OPERATION DETAILS

TOURNIQUET	YES ☐ NO ☐	STANDARD PREPARATION	YES ☐ NO ☐
MIDLINE SKIN INCISION	YES ☐ NO ☐	MEDIAL PARAPATELLAR	YES ☐ NO ☐
UNCEMENTED LCS	YES ☐ NO ☐	PATELLAR DEBRIDED ONLY	YES ☐ NO ☐

PLANTS USED

E R 2021-01

QTY 1

DePuy Orthopaedics, Inc. 700 Orthopaedic Drive Warsaw, IN 46582 1-800-366-8143

REF 86-6402 LOT E66CJ... HE1 M1 F1 F4
P.F.C.® SIGMA®
MODULAR STEM CEMENTED
13mm x 60mm
+H44186640218
+S$3201231E66CJ48S

LTHOPAEDICS,INC.
988
, IN 46581
DW9H11000

DePuy®
REF 1294-56-130 L7 L
M.B.T.
STEP WEDGE
SZ 3
5 MM

INSTRUMENTS USED

INSTRUMENTS USED MILESTONE ☐ OTHER ☐	RANGE OF MOVEMENT ON TABLE _____ TO _____ Degrees
STANDARD CLOSURE YES ☐ NO ☐	ROUTINE POST-OP YES ☐ NO ☐
FULL CORRECTION OF DEFORMITY YES ☐ NO ☐ Residual Deformity _____ Degrees Plane _____	STANDARD DRAINS YES ☐ NO ☐ **IF NOT TO ANY QUESTION RECORD VARIANCE**

ATTACH ALERT

NAME _____ UNIT NO. _____

OPERATION DETAILS

TOURNIQUET	YES ☐	NO ☐	STANDARD PREPARATION	YES ☐	NO ☐
MIDLINE SKIN INCISION	YES ☐	NO ☐	MEDIAL PARAPATELLAR	YES ☐	NO ☐
UNCEMENTED LCS	YES ☐	NO ☐	PATELLAR DEBRIDED ONLY	YES ☐	NO ☐

IMPLANTS USED



INSTRUMENTS USED

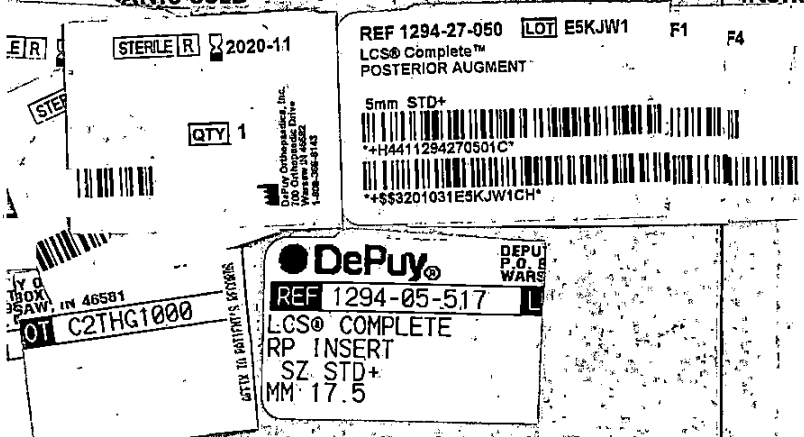
INSTRUMENTS USED MILESTONE ☐ OTHER ☐	RANGE OF MOVEMENT ON TABLE _____ TO _____ Degrees
STANDARD CLOSURE YES ☐ NO ☐	ROUTINE POST-OP YES ☐ NO ☐
FULL CORRECTION OF DEFORMITY YES ☐ NO ☐ Residual Deformity _____ Degrees Plane _____	STANDARD DRAINS YES ☐ NO ☐ **IF NOT TO ANY QUESTION RECORD VARIANCE**

NAME _____ UNIT NO. _____

OPERATION DETAILS

TOURNIQUET	YES ☐ NO ☐	STANDARD PREPARATION	YES ☐ NO ☐
MIDLINE SKIN INCISION	YES ☐ NO ☐	MEDIAL PARAPATELLAR	YES ☐ NO ☐
UNCEMENTED LCS	YES ☐ NO ☐	PATELLAR DEBRIDED ONLY	YES ☐ NO ☐

IMPLANTS USED



INSTRUMENTS USED

INSTRUMENTS USED MILESTONE ☐ OTHER ☐	RANGE OF MOVEMENT ON TABLE _____ TO _____ Degrees
STANDARD CLOSURE YES ☐ NO ☐	ROUTINE POST-OP YES ☐ NO ☐
FULL CORRECTION OF DEFORMITY YES ☐ NO ☐ Residual Deformity _____ Degrees Plane _____	STANDARD DRAINS YES ☐ NO ☐ **IF NOT TO ANY QUESTION RECORD VARIANCE**

NAME _____ UNIT NO. _____

OPERATION DETAILS

TOURNIQUET	YES ☐	NO ☐	STANDARD PREPARATION	YES ☐	NO ☐
MIDLINE SKIN INCISION	YES ☐	NO ☐	MEDIAL PARAPATELLAR	YES ☐	NO ☐
UNCEMENTED LCS	YES ☐	NO ☐	PATELLAR DEBRIDED ONLY	YES ☐	NO ☐

IMPLANTS USED



INSTRUMENTS USED

INSTRUMENTS USED

MILESTONE ☐ OTHER ☐

STANDARD CLOSURE YES ☐ NO ☐

FULL CORRECTION OF DEFORMITY YES ☐ NO ☐

Residual Deformity _____ Degrees Plane _____

RANGE OF MOVEMENT ON TABLE

_____ TO _____ Degrees

ROUTINE POST-OP YES ☐ NO ☐

STANDARD DRAINS YES ☐ NO ☐

IF NOT TO ANY QUESTION RECORD VARIANCE

KNEE REPLACEMENT

RIGHT ☐ LEFT ☐ BILATERAL ☐

PRE-OPERATIVE CHECK

Ward Nurse _____

Theatre Nurse _____

DATE

Pressure Care ☐ Eye Care ☐

Diathermy Abdo ☐ Thigh ☐

Tourniquet Up _____

Down _____ Pressure _____

SIGNED _____

SWAB COUNT CORRECT ☐

Scrub Nurse _____

Circulating Nurse _____

Surgeon _____

Assistant _____

Anaesthetist _____

Assistant _____

Anaesthetic Nurse _____

Scrub Nurse _____

Circulation Nurse _____

Recovery Nurse _____

Named Nurse _____

POST-OP CHECK ☐

Recovery Nurse _____

Ward Nurse _____

IV Site Right Left

Hand ☐ ☐

Wrist ☐ ☐

Central ☐ ☐

Size _____

Spinal ☐ Block ☐

Site _____

Drug _____

Volume _____

Needle _____

AIRWAY

Laryngeal Mask ☐

Orotracheal ☐

Nasotracheal ☐

Size _____

VENTILATION

Spontaneous ☐

IPPV ☐

Gases _____

Time Started | Time Finished | Time to Ward | Recd Time

0 5 10 15 20 25 30 35 40 45 50 55 1HR 5 10 15 20 25 30 35 40 45 50 55 2HR 5 10 15 20 25 30 35 40 45 50 55 3HR 15 30

4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24

39 38 37 36 35 170 160 150 140 130 120 110 100 90 80 70 60 50 40

SpO2

EtCO2

EtAA

FiO2

DRUGS/GASES

DRUGS

A B C D E F G H J K L M N P

EPIDURAL 0.25% Bupivacaine

MORPHINE 60ml 1mg/ml PUMP NO. _____ VOLUME REMAINING

Resps

Sedation

Pain

Nausea/Vomit

Sensory Level

Motor Block

Circulation/Leg Power

RECORD FLUID + START/STOP TIME

IV In

Oral In

Blood Out

Fluid Out

TOTAL

BALANCE

NAME _____ DATE _____ UNIT NO. _____

DAY 1

	6	10	2	6	10	(2)
TEMP 39						
38						
37						
36						
35						
160						
150						
140						
130						
120						
110						
100						
PULSE 90						
80						
70						
60						
50						
40						

							24 HOUR TOTAL
IV Fluid							
Oral Fluid							
Blood Loss							
Fluids Out							
						BALANCE	

DRUGS	8	12	2	6	10	(2)	Hb
A							
B							Waterlow
C							
D							
E							
F							
G							
H							
J							
K							
L							
M							
N							
P							
OTHER TIMES							

PUMP
Volume Left

		R	L
Resps			
Sedation			
Pain			
Nausea/Vomit			
Sensory Level			
Motor Block			
Circulation			
	SLR Y N		
	Lag		
	Flex		

POST OPERATIVE OUTCOMES

MEDICAL	YES ☐ NO ☐	O.T.	YES ☐ NO ☐
NURSING	YES ☐ NO ☐	PATIENT	YES ☐ NO ☐
PHYSIO	YES ☐ NO ☐		

NAME _____ DATE _____ UNIT NO. _____

DAY 2

	6	10	2	6	10	(2)
TEMP 39						
38						
37						
36						
35						
160						
150						
140						
130						
120						
110						
100						
PULSE 90						
80						
70						
60						
50						
40						

							24 HOUR TOTAL
IV Fluid							
Oral Fluid							
Blood Loss							
Fluids Out							
						BALANCE	

DRUGS	8	12	2	6	10	(2)
A						
B						
C						
D						
E						
F						
G						
H						
J						
K						
L						
M						
N						
P						
OTHER TIMES						

CHECK X-RAY ORDERED
Date
Signature

PUMP
Volume Left

		R	L
Resps			
Sedation			
Pain			
Nausea/Vomit			
Sensory Level			
Motor Block			
Circulation			
	SLR Y N		
	Lag		
	Flex		

POST OPERATIVE OUTCOMES

MEDICAL	YES ☐ NO ☐	O.T.	YES ☐ NO ☐
NURSING	YES ☐ NO ☐	PATIENT	YES ☐ NO ☐
PHYSIO	YES ☐ NO ☐		

	DAY 3	DAY 4	DAY 5	DAY 6
Date				
	6 10 2 6 10 (2)	6 10 2 6 10 (2)	6 10 2 6 10 (2)	6 10 2 6 10 (2)
TEMP 39				
38				
37				
36				
35				
160				
150				
140				
130				
120				
110				
100				
PULSE 90				
80				
70				
60				

DRUGS	8 12 2 6 10 2	8 12 2 6 10 2	8 12 2 6 10 2	8 12 2 6 10 2
A				
B				
C				
D				
E				
F				
G				
H				
J				
K				
L				
M				
N				
P				
OTHER TIMES SIG				

PAIN				
3				
2				
1				
0				

Waterlow Score

DISCHARGE CRITERIA MET

MEDICAL Day___ Sig ___ PHYSIO Day___ Sig ___

NURSING Day___ Sig ___ O.T. Day___ Sig ___

	DAY 3				DAY 4				DAY 5				DAY 6			
	RIGHT		LEFT		RIGHT		LEFT		RIGHT		LEFT		RIGHT		LEFT	
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
SLR																
Lag																
Flex																

POST OPERATIVE OUTCOMES

MEDICAL	YES ☐ NO ☐ ___	YES ☐ NO ☐ ___	YES ☐ NO ☐ ___	YES ☐ NO ☐
NURSING	YES ☐ NO ☐ ___	YES ☐ NO ☐ ___	YES ☐ NO ☐ ___	YES ☐ NO ☐
PHYSIO	YES ☐ NO ☐ ___	YES ☐ NO ☐ ___	YES ☐ NO ☐ ___	YES ☐ NO ☐
OT	YES ☐ NO ☐ ___	YES ☐ NO ☐ ___	YES ☐ NO ☐ ___	YES ☐ NO ☐
PATIENT	YES ☐ NO ☐	YES ☐ NO ☐ ___	YES ☐ NO ☐ ___	YES ☐ NO ☐

	DAY 7	DAY 8	DAY 9	DAY 10
Date				
	6 10 2 6 10 (2)	6 10 2 6 10 (2)	6 10 2 6 10 (2)	6 10 2 6 10 (2)
TEMP 39				
38				
37				
36				
35				
160				
150				
140				
130				
120				
110				
100				
PULSE 90				
80				
70				
60				

DRUGS	8 12 2 6 10 2	8 12 2 6 10 2	8 12 2 6 10 2	8 12 2 6 10 2
A				
B				
C				
D				
E				
F				
G				
H				
J				
K				
L				
M				
N				
P				
OTHER TIMES SIG				

PAIN				
3				
2				
1				
0				

Waterlow Score

Hb

DISCHARGE DOCUMENTS COMPLETED

MEDICAL Day___ Sig ___ PHARM. Day___ Sig ___ O.T. Day___ Sig ___

NURSING Day___ Sig ___ PHYSIO Day___ Sig ___

DISCHARGE DATE

	DAY 7				DAY 8				DAY 9				DAY 10			
	RIGHT		LEFT		RIGHT		LEFT		RIGHT		LEFT		RIGHT		LEFT	
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
SLR																
Lag																
Flex																

POST OPERATIVE OUTCOMES

MEDICAL	YES ☐ NO ☐ ___	YES ☐ NO ☐ ___	YES ☐ NO ☐ ___	YES ☐ NO ☐ ___
NURSING	YES ☐ NO ☐ ___	YES ☐ NO ☐ ___	YES ☐ NO ☐ ___	YES ☐ NO ☐ ___
PHYSIO	YES ☐ NO ☐ ___	YES ☐ NO ☐ ___	YES ☐ NO ☐ ___	YES ☐ NO ☐ ___
OT	YES ☐ NO ☐ ___	YES ☐ NO ☐ ___	YES ☐ NO ☐ ___	YES ☐ NO ☐ ___
PATIENT	YES ☐ NO ☐ ___	YES ☐ NO ☐ ___	YES ☐ NO ☐ ___	YES ☐ NO ☐ ___

VARIANCES

NAME _____ UNIT NO. _____

DATE & TIME	DAY NO	TYPE	PROBLEM	ACTION	OUTCOME	SIGNATURE & DESIGNATION

1 PATIENT/FAMILY 2 CLINICAL STAFF 3 HOSPITAL/SYSTEM 4 COMMUNITY/OTHER AGENCIES 5 PATIENT CONDITION

VARIANCES

NAME _____ UNIT NO. _____

DATE & TIME	DAY NO	TYPE	PROBLEM	ACTION	OUTCOME	SIGNATURE & DESIGNATION

1 PATIENT/FAMILY 2 CLINICAL STAFF 3 HOSPITAL/SYSTEM 4 COMMUNITY/OTHER AGENCIES 5 PATIENT CONDITION

HONEYMAN, CATHERINE
SG00940779 01/02/49
CHI: 0102496145 F
Date _____ Time ____
Spec./Sig. _____

SOUTHERN GENERAL HOSPITAL

UNIT NO. WARD: 05

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
T4	cont.	for standard DVT prophylaxis. And to chase micro results of specimen sent from theatre. for FBC tommorow. Check Xray in 2 days. catheter insitu, for hourly volumes.	C. Sivell (JHN)
	1800	Catheter removed at patients request as it was causing discomfort. FY2 had been informed and spoke with patient, advised to remove catheter and take vaginal swab ? thrush. Swab obtained observe urinary output. IV fluids continue using PCA Mumm, YJ Lam	
24/6/11	N/S	Unsettled night - did not sleep. Observations Stable. Continues to use PCA. Dressing reduced this morning as complaining very tight. Wound leaking +++ - re-padded. p/v via bedpan. For check bloods & xray today.	L. Comrie
	1500	Condition satisfactory. Assisted with hygiene needs this morning Independent with positional changes Seen by physio - transferring with Zimmer and supervision into Wheelchair. Tolerating diet & fluids well Passing urine spontaneously Bowels inactive Morphine PCA and Crystalloid discontinued Oramorph prescribed as required Wound dressing intact Vital signs stable Apyrexial WCC 6.5 Hb 90 Plt 227 CRP 114 · U&E normal Awaiting results of vaginal Swab Attended for chest xray	
25/6/11	0600	Settled for short periods overnight - oramorph given for breakthrough pain Voiced concern that leg was infected due	

0369438-SGH 306A

SOUTHERN GENERAL HOSPITAL

DEPARTMENT:

NAME: UNIT NO. WARD:

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
25/6/11	0600 cont	to the swelling and bruising following Surgery and some ## blisters. explained this was normal after Surgery but would get registra to review in morning. Observations Satisfactory Post Op HB 90 medical staff to be informed. Cold pack given for Swelling passing urine Spontaneously, HB 90 observations satisfactory.	YeBeau (S)
	1530	Has complained of excessive pain this morning and has had regular analgesia and breakthrough. Mobilised short distance only with physio with aid of 2 zimmers. Leg remains swollen and bruised. Mildly hypotensive.	
26/6/11	0630	Slept for short spells only, up to commode frequently, passing good volumes, Urinalysis - NAD. Oramorph given for breakthrough c good effect. Vital signs all within normal parameters - SEWS 0.	
	1500	Tired this afternoon but has managed to mobilise with physio and aid of elbow crutches this morning. Continues to feel a high level of pain at times but has managed though oxycontin was reduced to 10mg this morning. Has had occasional oramorph	
27/6/11	0630	Slept for short spells only. Pain score 5-7, oramorph x 2 c good effect. Vital signs all within normal parameters. SEWS 0. Mobilising well c E/C.S to and from toilet. For Hb check this am	
	11.45	Patient settled, observations stable. Haematology results:	
		WCC 5.7, Hb 75, Plts 246 — FYI informed.	GMS
	1600	Patient to be commenced on Fumas Fmerade 210mg	
		T.I.D.	GMS
	1830	Patient settled, observations stable. Ecchymotic small wounds.	
		Patients R knee remains swollen - Mr Hillis	

SOUTHERN GENERAL HOSPITAL

DEPARTMENT: Ortho

NAME: Catherine Honeyman UNIT NO. WARD: 5

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
		uncovered. Patient given exercises to do by physio: new complaint of pain in thigh area. Discussed with patient that this will probably be due to exercise and that muscle needs building/strengthening in order to help aid mobilisation. Patient mobile in wheelchair to toilet to PU. Dr Khan physio.	AH (S)
28/06/11	0100	Condition satisfactory Mobile to toilet with wheelchair Transferring from bed to chair with Zimmer Tolerating oral fluids overnight Passing urine spontaneously Bowels inactive Wound dressing intact (R) leg swollen ++ - has been seen by Mr Hullin who is not concerned Pain well controlled Vital signs stable Apyrexial ? for check blood today	Tailer
	05[00]	Slept for short spells overnight Mobile to toilet in wheelchair No change to leg oedema No other complaints offered	
28/6/11	1100	Patient settled today, observations stable. Seen by physio: to perform exercises / stretches for leg / knee Wound redressed – wound looking healthy with slight leakage noted. Cleaned with normasol and Tegaderm applied. Steps to close.	AH (S)
28/06/11	15[30]	Minimal assistance required with personal care this morning. Observations stable, dressing stained but intact. Passing urine, bowels inactive. Patient requires maximum encouragement to mobilise around ward.	
29/06/11	06[00]	Condition unchanged Mobile to toilet with wheelchair Reluctant to use crutches Tolerating oral fluids overnight Passing urine spontaneously Bowels inactive Wound dressing intact	

SOUTHERN GENERAL HOSPITAL

DEPARTMENT:

NAME: UNIT NO. WARD:

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
		Staning	
		Vital signs stable Apyrexial	
		? would benefit from referral	
		to DART and start aming more ??? Plan	
	16:30	Encouraged mobility today.	
		Wound redressed had been	
		leaking slightly ? for home tomorrow	
		dosed at 16:00 Satisfactory.	
		Has own transport if discharged	
		HB 84.	
2 6/11	05[00]	Condition fair	
		Reluctant to mobilise due to pain	
		and swelling in leg.	
		Commode given at bedside.	
		Passing urine spontaneously	
		Bowels incont.	
		Routine meds as per kardex.	
		Required Oramorph for pain with	
		effect.	
		Wound dressing intact with minimal	
		staining. Leg swollen and	
		tender to touch - ? requires review	
		prior to discharge.	
		Pat 2 request for discharge.	
		Patient has own transport.	
		Meds to be ordered.	
		? requires DART for further rehab	
		Vital signs Stable Apyrexial	
	06[00]	Settled and slept for long spells	
20/06/11	16[00]	Patient independent with personal care this morning. Observations stable, wound dressing stained, but intact. Leg remains swollen and hot to touch. Reviewed by ward SHO, awaiting review by Reg to confirm ultrasound. Patient requires full encouragement to mobilise. Does not require DART referral, will follow up with physios as outpatient.	
1/7/11	0545	Settled and slept well overnight. Observations satisfactory. Oramorph 10mg given for pain relief x 1. Awaiting Registrar to review patient.	

SOUTHERN GENERAL HOSPITAL

DEPARTMENT: Ortho

NAME: Catherine Honeyman UNIT NO. WARD: 5

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
	→	regarding swollen leg - ? to have ultrasound today. D/C letter done.	
1/7/14	1615	patient washed and dressed independently D/C from physio D/C from O.T wound re-dressed with tegaderm, dry and intact on discharge. part 2 form completed, explained and given to patient. D/C script and medication completed, explained and given to patient. obs stable pain score low to moderate, seen by pain team Discharged home with 6x10mg of Severadol tablets. passing good volumes of urine. HB 88 patient discharged home. ——	Lyndall

MED TIL SCH. ORTHOPAEDICS 1/6165/250304

NAME CATHERINE HONEYMAN

GENERAL COMMENTS

UNIT NO. SG0094077T

DATE & TIME	DAY NO	COMMENTS	SIGNATURE
24.6.11	PT	S 117 post-op 2nd stage revision (R) knee	
		To be treated as primary TKR.	
		Patient consenting.	
		O lying in bed. Sats 99% on air CSM ✓	
		Knee Exs: SQ ✓ SLR 40 lag IRQ ✓ 40 lag ROM 20-70	
		Bed T/fers (I) STS (I)	
		Gait re-ed c WZF c close supvn ~12m	
		- 3 point pattern	
		- good step length	
		Rx knee exs; t/fers, gait re-ed	
		Ax keen for Rx, mobilising well, however, struggling slightly c exs	SWALLACE
		P Continue to ↑ROM; ↓lag; ↑walking distance	SCPT
25.06.11	PT	S, Consents to Ax. + Rx. c/o pain++ around posterior fossa area.	
9.45am.		O, (R) knee - swollen+ colour ✓ hot to touch.	
		Gait - c c WZF + Aol Step to pattern Antalgic+	
		↓ WB through (R) LL. ↓ (R) knee E in stance	
		Rx, • Mobilised ∞ 8m	
		• Discussed analgesia + swelling c D/S // breakthrough analgesia given	
		• Enc circ ex's. TAG's.	
		A, Limited by pain. Req further gait px.	(SCPT)
		P, Progress mob.	Sonya Betts
25/6/11	(S)	A agreed to OT intervention. Reports nil equipment at home. Declined d/ax reports managing (I) c lower garments.	

CATHERINE HONEYMAN

MED ILL SGH. ORTHOPAEDICS. 10161/250304

DATE & TIME	DAY NO	COMMENTS	SIGNATURE
	(0)	out of bed. (I), mobilised ↓ WZF → toilet.	
		Mobilised to toilet ↓ WZF. OT demonstrated safe technique on/off toilet. Pt unable to transfer safely on/off 16" regular AOT. Pt then reported had a fall at the weekend (E) side but unsure when demonstrating on par technique, ? old fracture (dislocated shoulder previously in car accident). Ax ↓ FSTF. Pt.	
		(I) ↓ FSTF on/off toilet. Mobilised back to bed (I) transferred into bed.	
	(A)	Benefit from FSTF (I) and safety for discharge	
	(P)	order FSTF and discharge OT.	ANCUNNING
26/6/11.		PHYSIO. S/. Consent to Rx Ax. Still painful today.	
		Has not slept well.	
		O/ Knee ~10° ext	
		Lie to sit indp	
		sit → stand indp	
		Mob ⊂ WZF ~ 20m to toilet - step to gait	
		Rx↓ gait need	
		A: Improved pain yesterday	
		P/ R↓v manip Progress to WBS/ECs.	LITTLEWOOD (PHYSIO)
27.6.11	OT.	S/ Consenting to Rx - Has not been doing many knee exercises	
		O/ AROM - (R) Knee = -10° - 70° on sliding board.	
		Knee (R) SLR ~ 35° lag	CHARLES (RMO)

GENERAL COMMENTS

NAME

UNIT NO.

CATHERINE HONEYMAN

MED ILL SGH, ORTHOPAEDICS.16165729304

DATE & TIME	DAY NO	COMMENTS	SIGNATURE
29.6.11	PT	SH Consenting to Rx. Has been exercising more regularly.	
		OH ® Knee = ~5° lack (improved)	
		= ~15°-20° lag (improved)	
		AH ROM + Power improving	
		RH RLW of Exercises	
		Exc IRCR	
		PH RLW Gait - try w/sticks	
29.6.11	PT	SH Consenting to Rx.	
		Keen to mobilise	
		OH Gait ē 2 w/sticks - Improved control of ® LL	
		3 pt step through pattern	
		Good WT bearing through LL's	
		AH Improved once again	
		RH Gait read - Mod ~10m ē 2 w/sticks	
		PH RLW homework	
		Stair practice	
30.6.11	PT	SH Consenting to Rx. C/O ® Knee pain today.	
		OH ® Knee ROM - ISCR	
		Gait ē 2 w/sticks - Mod well. 3pt step through	
		Stairs ↓ + ↑ 2 steps ē ease	
		RH Gait RLW	
		Stair practice	
		PH D/C ē follow up @ SCH	

GENERAL COMMENTS

NAME

UNIT NO.

ITHERNE HONEYMAN

DATE & TIME	DAY NO	COMMENTS	SIGNATURE
27.6.11	PT	STS = (I) LTS = (I)	
		Cant c WBP + sup° - Poor control of (R) knee - held in flex° during stance phase	
		Cant c 2 W/Sticks - Unable - Attempting to take too much weight through sticks	
		All (R) LL weak - too weak for W/Sticks	
		R/V IRQD / SQD	
		Attempted SLR	
		Cant RW	
		P/V RW Ex's	
		RW Cant	
28.6.11	PT	S/V Consenting to Rx. Appears more receptive to information	
		O/V (R) LL ext° ex - Has been swinging leg rather than controlled ext°.	
		AROM - ISQD	
		Cant - ISQD	
		All ↑ up sitting ∴ ens to rest LL on block to extend knee	
		R/V (R) Knee F/E	
		IRQD	
		Cant RW	
		O/V RW Power	
		Progress gait as able	

JENNY CERRUTI

NAME

GENERAL COMMENTS

UNIT NO.

MED ILL SCH. ORTHOPAEDICS. 16165/250304

NHS
Greater Glasgow and Clyde

NATVNS
SCOTLAND

SG00940779
HONEYMAN, CATHERINE
10 MELVILLE STREET

GLASGOW 01/02/1949
G41 2LN CHI 0102496145

ADAPTED WATERLOW PRESSURE AREA RISK ASSESSMENT CHART

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

Complete assessment on admission/1st visit, if there is a change in individuals condition and repeat regularly according to local protocol

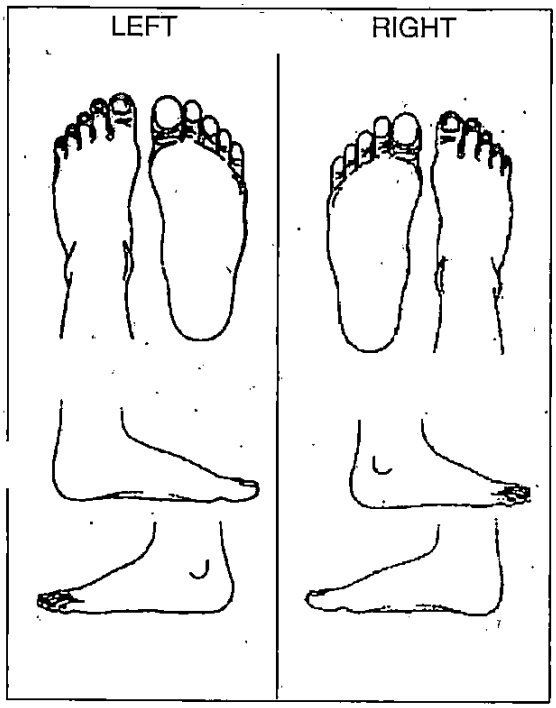
Sex									
Male	1								
Female	2	2	2	2	2	2	2	2	
Age									
14 -49	1								
50 -64 (62)	2	2	2	2	2	2	2	2	
65 - 74	3								
75 - 80	4								
81+	5								
Build/Weight for Height (BMI=weight in Kg/height in m²)									
Average - BMI 20-24.9	0								
Above average - BMI 25-29.9	1								
Obese - BMI > 30	2	~~2~~ 0	2	2	2	2	2	2	
Below average - BMI < 20	3								
Continence									
Complete/catheterised	0	0	0	0	0	0	0	0	
Incontinent urine	1								
Incontinent faeces	2								
Doubly incontinent (urine & faeces)	3								
Skin Type - Visual Risks Area									
Healthy	0	0							
Tissue paper (thin/fragile)	1								
Dry (appears flaky)	1						1		
Oedematous (puffy)	1							1	
Clammy (moist to touch)/pyrexia	1					2	2	2	
Discoloured (bruising/mottled)	2		2	2	2				
Broken (established ulcer)	3								
Mobility									
Fully mobile	0								
Restless/fidgety	1								
Apathetic (sedated/depressed/reluctant to move)	2						2		
Restricted (restricted by sever pain or disease)	3				3			3	
Bedbound (unconscious/unable to change position/traction)	4			4		4	3		
Chairbound (unable to leave chair without assistance)	5	5	5						
Nutritional Element									
Unplanned weight loss in past 3-6 months									
<5% Score **0**, 5-10% Score **1**, >10% Score **2**	0-2					0	0	0	
BMI > 20 Score **0**, BMI 18.5-20 Score **1**, BMI < 18.5 Score **2**	0-2								
Patient acutely ill or no nutritional intake > 5 days	2		0	0	0				
Special Risks - Tissue Malnutrition									
Multiple organ failure/terminal cachexia	8								
Single organ failure e.g. cardiac, renal, respiratory	5								
Peripheral vascular disease	5					0	0		
Anaemia = Hb < 8	2								
Smoking	1	0	0	0	0		-	0	
Special Risks - Neurological Deficit									
Diabetes/MS/CVA/motor/sensory/paraplegia *Max 6*	4-6	0	0	0	0	0	0	0	
Special Risks - Surgery/Trauma									
On table > 6 hours	8								
Orthopaedic/below waist/spinal (up to 48 hours post op)	5		0	0	0	0	0		
On table > 2 hours (up to 48 hours post op)	5							0	
Special Risks - Medication									
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*	4	0	0	0	0	0	0	0	
Total Score		11	13	12	11	12	14	12	
Date		10-6-16	21/6	25/6	26/6	27/6	29/6	30/6	1
initials		Mdcl	SN	DW	DW	LF	LF	WM	
Time		PM	SN	NLD	NLD	23:00	23:00	1305	

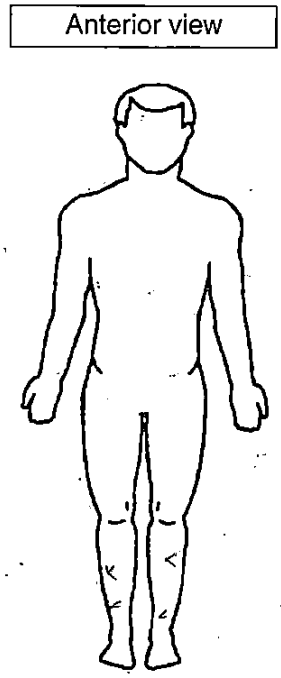
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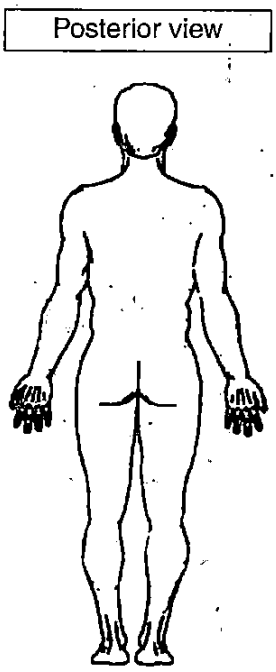
Ensure plan of care is implemented / reviewed for all identified areas of concern.

PRESSURE ULCER RECORD

Indicate by circling and numbering all pressure damage on diagrams, then complete box below. Indicate care plan/wound assessment chart.







SCOTTISH ADAPTED EPUAP PRESSURE ULCER GRADING TOOL

GRADE 1 Non-blanchable erythema of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness may also be used as indicators, particularly on individuals with darker skin.

GRADE 2 Partial thickness skin loss involving epidermis, dermis or both. The ulcer is superficial and presents clinically as an abrasion or blister.

GRADE 3 Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia.

GRADE 4 Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss.

DATE	NUMBER OF ULCER(S)	LOCATION OF ULCER(S)	GRADE OF ULCER(S)	LOCATION OF ULCER(S)
22/6/11		Pressure areas	intact.	
		sores on both legs on	admission	
		G.P. + Surgeon aware - Sn		
26/6/11	0	Pressure areas intact, Nursed on alternate		
		sides, repose in situ		Sn DeO
27/06/11	0	Pressure areas	satisfactory. Independent	
		with positional changes	Pt also	

Pressure Ulcers may deteriorate from Grade 1 to Grade 4, but can not be reversed and should be documented as a healing grade of pressure ulcer, eg healing grade 4.

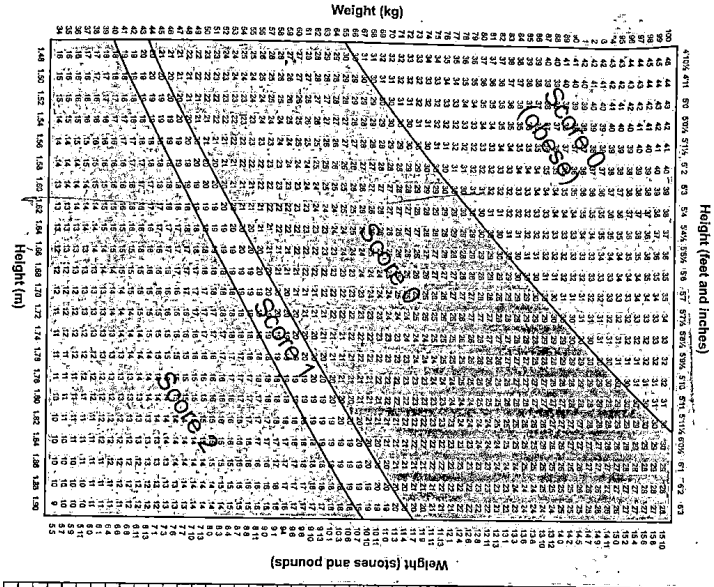
SURGICAL DIRECTORATES: PATIENT CARE PLAN

Name: Catherine Honeyman Unit No: SG0940779

D.O.B: 01/02/49 Ward: 5 Date of Admission: 22/06/11

Date Commenced & Signature	PERSONAL HYGIENE/DRESSING	Tick	Date Discontinued & Signature
	Independent		
	Bedbath		
	Shower		
	Immersion Bath		
	Basin		
27/06/11 LF	Assistance Required: Number of staff : X1	✓	
27/06/11 LF	Oral Hygiene: Independent: ✓ Assistance Required:	✓	
	MOBILISATION		
	Independent		
27/06/11 LF	Assistance Required: Number of staff : X1	✓	
	Aids Used:		
	Walking Stick		
	Zimmer		
	Elbow Crutches		
27/06/11 LF	Wheelchair	✓	
	Other:		
	EATING & DRINKING		
27/06/11 LF	Normal Diet:	✓	
	Special Diet:		
	Light Diet:		
	Assistance to Eat & Drink:		
	Fluids Only:		
	Dietary Supplements:		
	Parental/Entral Nutrition:		
	Nasogastric Tube:		
	Fasting from: to:		
	Light Early Breakfast: Time:		
	ELIMINATIONS		
27/06/11 LF	Independent:	✓	
	Assistance to Toilet: No of Staff:		
	Urinary Catheter:		
	Suprapubic Catheter:		
	Ileal Conduit:		
	Colostomy:		

Date Commenced & Signature	SPECIAL NEEDS/MAINTAIN PERSONAL SAFETY	Tick	Date Discontinued & Signature
	Cotsides		
	Visually Impaired: Removal Hazards		
	TECHNICAL CARE		
	Venflon Insitu:		
	IV Infusion:		
	Check Site:		
	Subcutaneous Cannula Insitu:		
	Oxygen: Mask:		
	Rate:		
	Length of Time:		
	OBSERVATIONS		
27/06/11 LE	BP: BD	✓	
27/06/11 LE	Pulse: BD	✓	
27/06/11 LE	Temperature: BD	✓	
27/06/11 LE	Saturations: BD	✓	
	Fluid Balance:		
	Glucose Monitoring:		
	C.S.M (Fingers:R L)(Toes R L)		
	Vascular Observations:		
	Stool Chart:		
	PAR Scoring:		
	Head Injury Observations:		
	WOUND CARE/OTHERCARE		
27/06/11 LE	Pressure Area Care:	✓	
	Check: Hourly		
	Pressure Cushion:		
	Therapy Mattress:		
	Avant Guard Bed:		
	Wound Assessment Chart:		
	PAIN ASSESSMENT CHART		
27/06/11 LE	Patient Moving & Handling Risk Assessment	✓	
	MISCELLANEOUS		
	Ted Stockings: Size:		



Step 1 - BMI Score

Weight (stones and pounds)

Step 2 - Weight Loss Score

NHS
Greater Glasgow and Clyde

Nutrition Profile

Name:	Date of admission: 22/6/11
Address: SG00940779 HONEYMAN, CATHERINE 10 MELVILLE STREET GLASGOW	Time:
DoB: 01/02/1949 G41 2LN CHI 0102496145	HOSPITAL: SGH
CHI number:	Ward: 5
Affix patient data label	

To be recorded within 24 hours of admission*

Height: 1·61 (m)/ft Actual ☐ Patient/ carer reported ☑ Alternative measurement ☐

Weight: 123·4 (kg)/stones Actual ☐ Patient/ carer reported ☑ Alternative measurement ☐

Recent unplanned weight loss: Yes ☐ No ☐

If 'Yes' how much?: kg/stones. Over what period of time?: weeks/months

Is there evidence of recent weight loss?

No ☑ Loose clothing ☐ History of reduced food intake/appetite ☐ Swallowing problem ☐

Eating and drinking likes and dislikes (including appetite and/or N&M status):

Good appetite NO

Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☑

Please state: Normal diet and fluids

Are there any contributing factors that may affect food intake such as physical (e.g. swallowing difficulties), physiological (e.g. nausea), psychological (e.g. dementia), social or environmental? Yes ☐ No ☑

Please specify all factors:

No food allergies

Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☑

Please state: Independent

Profile completed by: Name (PRINT): S MCINALLY Signature: SMcInally Date: 22/6/11

NOTE: This is ADMISSION DATA - please refer to changes in Care Plan.

* Quality Improvement Scotland (2003). Food, Fluids and Nutritional Care in Hospitals Edinburgh QIS

Malnutrition Universal Screening Tool ('MUST')

Date	22/6/17									
Initials	SM									
Height (see page 1) 161 / Weight	63									
Oedema or ascites present Y/N	N									
BMI	38+									
'MUST'										
Step 1: BMI Score (refer to chart on page 4)										
>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 or virtually no food intake for > 5 days..... Score 2 Not applicable ..... Score 0	0									
Step 4: Overall Risk of Malnutrition Total:	0									

Step 5: Management Guidelines

Score of Overall Risk of Malnutrition	Action Required
0	**LOW RISK** - *Routine Clinical Care* • Repeat screening. Hospital Acute ..... Weekly Hospital Rehabilitation ..... Monthly
1	**MEDIUM RISK** - *Observe* • Document dietary intake for 3 days on a Food Record Chart. • If no improvement in intake: - Encourage oral intake. - Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Repeat screening weekly.
2 or more	**HIGH RISK** - *Treat** • Refer to Dietitian and document food intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Monitor and review Care Plan weekly. * Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

Management Plan

FOR ALL PATIENTS

- Provide help and advice on food choices and eating and drinking when necessary.
- Treat underlying conditions and initiate appropriate treatment to relieve symptoms that affect nutritional intake e.g. nausea, vomiting, constipation, diarrhoea and/or pain.
- Refer to dietitian if any specialist advice is required.
- Complete nursing checklist for swallowing difficulties if appropriate.
- Use a recognised system to identify when equipment or asssistance is required at mealtimes (e.g. red mats, coloured napkins).

Referral Services

Dietitian	Date: / /	Outcome:
Speech and Language Therapy	Date: / /	Outcome:
Occupational Therapy	Date: / /	Outcome:
Dental Service	Date: / /	Outcome:

Multidisciplinary Nutrition Care Plan

Date	Overall Risk	Action	Review date	Name (PRINT) Signature/Designation
22/6/17		BMI 38+, MUST Score 0	Y52	Dr Kelly

N.B. Ensure discharge plan includes most recent 'MUST' score and any necessary follow-up requirements.

mechanical respiration (ventilation), cardiopulmonary resuscitation (CPR), tube feeding (artificial nutrition or hydration), etc., but I accept basic palliative care–treatment for comfort.

✓ (b) TO PROLONG LIFE. That is, I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards but subject to my absolute refusal of blood and those blood components described herein, although I realise this means that I might be kept alive on machines for years in a hopeless condition.

___ (c) OTHER. [If you do not completely agree with either (a) or (b) above, initial here and write your own end-of-life instructions in the space provided.]___

(8) Other instructions: [Write any other health-care instructions here.]___

(9) ___ (initial) [This clause applies only to women of child-bearing age.] If I am pregnant, and there is a reasonable chance that my unborn child could survive, I want my life to be prolonged for the sake of my unborn child. This is subject to the refusal of blood for myself and my unborn child as set out above. After any efforts to save my unborn child I direct that my doctors manage my care in harmony with the instructions in (7) and (8) above.[ii]

(10) If my health-care providers will not or cannot undertake a surgical operation, or administer any other form of medical treatment, without the use of blood or any blood products specifically prohibited by myself in this document, I direct my health-care providers to co-operate fully with the appointed representative(s) of the local Hospital Liaison Committee for Jehovah's Witnesses in discussing treatment options. Thereafter if a transfer is subsequently deemed necessary I direct that all my medical records, including a copy of this document, be transferred promptly to the other health-care provider to ensure that my health-care instructions herein will be respected.

(11) A copy of this document shall be as valid as the original. I ask that a copy of this document be made part of my permanent medical record. I have provided a copy of this document to my registered general practitioner.

(12) The provisions of this entire document are separable, so that the invalidity of one or more provisions shall not affect any others.

(13) **MY DECISION to refuse blood and choose non-blood management MUST BE RESPECTED EVEN IF MY LIFE OR HEALTH IS THREATENED by my refusal. Any attempt to administer blood contrary to my instructions will be a violation of my rights of bodily self-determination and personal autonomy, and accordingly will constitute an actionable trespass to my person.**[iii iv v vi]

(14) I understand and believe the full import of this document and verily aver that it accurately reflects my personal informed choice.[vii]

(15) SIGNED: Catherine Mowynan, 22 · 11 · 05
Your signature — Date

10 MELVILLE ST
Address

Pollokshields Glasgow G41 2LN

(16) STATEMENT OF WITNESSES: The person who signed this document (the principal) is known to me and voluntarily signed or voluntarily directed another to sign this document in my presence. The principal appears to be of sound mind and free from duress, fraud or undue influence. I am 18 years of age or older and I am not related to the principal by blood, marriage or adoption.

Witness 1	Witness 2
Signature of Witness 1	Signature of Witness 2
W. Scott	DAVID STONE.
Print Name	Print Name
PAINTER.	TEACHER
Occupation or Profession	Occupation or Profession
77 Wallace Wynd	31 SECOND AVE
Home Address	Home Address
CUMBERNAULD G68 9SE	KINGS PARK GLASGOW G44 4TD
0141 641 1283	@ 0141 632 4609
Home Telephone	Home Telephone
0141 633 1333	01236 607034
Work Telephone	Work Telephone

i *In re T* [1992] 3 WLR 782, Donaldson MR at 787 D.
ii *St George's Healthcare NHS Trust v.S.; R. v. Collins and Others ex parte S.* [1998] 2 FLR 728.
iii BMA Code of Practice *Advance Statements About Medical Treatment* [April 1995] ¶¶ 2.2; 3.1; 13.5; 14.2.
iv *In re T* [1992] 3 WLR 782, Donaldson MR at 787 B.
v *Airedale National Health Service Trust v. Bland* [1993] 2 WLR 316, Lord Keith of Kinkel at 360 H–361 A.
vi *Airedale National Health Service Trust v. Bland* [1993] 2 WLR 316, Lord Goff of Chieveley at 367 E–368 A.
vii *re C* [1994] 1 FLR 31.

HEALTH-CARE ADVANCE DIRECTIVE

(1) I, CATHERINE · HONEYMAN
Print your full name
born the 1st th day of 9 month, 19 49, am of sound mind and I voluntarily make this Health-Care Advance Directive. This document revokes any prior health-care advance directive and shall take effect upon my incapacity. It will remain in force unless and until specifically revoked in writing by me.

(2) I am one of Jehovah's Witnesses. On the basis of my firmly held religious convictions (founded on Bible directions such as at Acts 15:28, 29) and on the basis of my desire to avoid the numerous hazards and complications of blood transfusions, **I absolutely REFUSE allogeneic blood** (another person's blood); **the primary blood components red cells, white cells, platelets and/or plasma; and stored (predonated) autologous blood** (my own stored blood) **under any and all circumstances, no matter what the consequences. I also refuse to predonate any of my blood for storage and later reinfusion into me or anyone else.**

(3) The refusal in clause (2) above is not to be overridden by a purported consent of a spouse, relative or other person or body.

I request and will accept alternative non-blood medical management to build up or conserve my own blood, to avoid or minimise blood loss, to replace lost circulatory volume, or to stop bleeding. Hence such volume expanders as dextran, saline solution, Ringer's solution modified fluid gelatin, hetastarch, and perflurochemicals; and oral or parenteral iron would be acceptable to me.

(5) Medical products: [Initial one of the three choices below.]

___ (a) I refuse all fractions derived from any primary component of blood.

✓ (b) I accept all fractions derived from any primary component of blood.

___ (c) I want to qualify either (5a) or (5b) above and my instructions are as follows:

(6) Medical procedures involving my own blood that do not involve storage of my blood for later infusion into me or someone else: [Initial one of the three choices(s) below.]

___ (a) I refuse any procedure involving the use of my blood during an operation or ongoing treatment.

___ (b) I accept any procedure involving the use of my blood during an operation or ongoing treatment.

✓ (c) I accept only the following procedures involving my blood:
CELL SALVAGE MACHINE

(7) With respect **to end-of-life decisions, I CHOOSE:** [Initial one of the three choices below.] (As to pregnancy see (9) overleaf.)

___ (a) NOT TO PROLONG LIFE. That is, if to a *reasonable degree of medical certainty my condition is considered hopeless.* (For example, if to a reasonable degree of medical certainty I have an incurable and irreversible condition that will result in my death within a relatively short time, or if I am unconscious and to a reasonable degree of medical certainty will not regain consciousness, or if I have brain damage or a brain disease that makes me unable to recognise people or communicate and to a reasonable degree of medical certainty my condition will not improve.) In such situations, I refuse

Cannard Falls Risk Assessment

Glossary of terms used in risk assessment

SIGHT DEFICIT means patient cannot see well even when wearing glasses or is registered blind.

HEARING DEFICIT means person has hearing problems even with a hearing aid or has hearing problems and does not wear a hearing aid.

BALANCE DEFICIT means person is unable to stand without the support of another person or a walking frame.

MEDICINES FOR SOME MENTAL ILLNESSES include Chlorpromazine (Largactil), Risperidone (Risperdal), Lithium (Camcolit or Priadel), Haloperidol, Chloral hydrate (Welldorm), Clomethiazole (Heminevrin), antidepressants, Diazepam, Lorazepam and Amitriptyline.

CARDIOVASCULAR SYSTEM MEDICATION all antihypertensive medication and inotropes including Captopril, atenolol and many others.

WATER TABLETS (DIURETICS) are such as Bendroflumethiazide, Furosemide and Co-amilofruse.

SEDATIVES / ANALGESIA AT NIGHT include medicines such as Diazepam, Temazepam, Nitrazepam, Chlordiazepoxide and Zopiclone (Zimovane) Morphine PCA, Fentanyl, Tramadol and Oxycontin.

INABILITY TO CO-OPERATE includes failure to use walking aids or putting themselves in situations with a high risk of falling (usually due to mental impairment).

RESTRICTED MOBILITY means the person requires supervision and/or help to walk (i.e. is not safe to walk alone even with an aid).

HESITANT IN INITIATING MOVEMENT means difficulty in starting to walk.

POOR TRANSFER means the person requires help and is not safe to do the following alone - get in or out of bed, on or off a chair, move from chair to standing.

Acute Services Division

Hospital / Department SGH Ortho

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

Patient name: [redacted]

Ward: 5

G00940779
ONEYMAN, CATHERINE
0 MELVILLE STREET
GLASGOW
G41 2LN

CHI number: CHI 0102496145 01/02/1945 Unit/Hospital number

Contents

1. Canard Falls Risk Assessment Scoring Form
2. Falls Assessment Care Plan
3. Glossary of terms used in risk assessment

Notes: Risk assessment should be completed within 24 hours of admission to each ward.

Assessment Wards: Risk assessment and care plan should be reviewed weekly.

Continuing Care Wards: Risk assessment and care plan reviewed monthly.

Referral Criteria for Hospital Falls Prevention Co-ordinator

1. Cannard score of 18+.
2. Second or subsequent fall
3. Significant injury caused by a fall. (Significant injury defined as any fracture, significant bruising or laceration to head or body.)

The patient should be referred with any of the above criteria.

General Safety Precautions

- Ensure patient has buzzer to hand
- Check patient has the manual dexterity and cognitive ability to operate buzzer
- Place personal items within easy reach
- Keep the bed in lowest position possible (use low bed if available)
- DO NOT leave patients with cognitive impairment unattended on commodes, in toilets, baths and showers.
- Patients with poor mobility, who are known not to ask for assistance; should not be left unattended on commodes, toilets, baths and showers.
- If noted that mobility / transfers are unsafe refer to physio / OT for assessment
- If patient wears glasses, ensure they are clean
- Ensure patient's footwear is adequate
- Lock wheels on all wheelchairs, beds, commodes and trolleys when in use
- Provide adequate lighting at night
- Request medication review if appropriate
- Clean up spills immediately
- Orientate patient to the ward environment

Cannard Falls Risk Assessment

(Must be completed within 24 hours of admission to each ward)

22/6/4

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						Date: / Ward: 5	Date 24/6 / Ward: 5	Date 27/6 / Ward: 5	Date 29/6 / Ward: 5	Date: / Ward:	Date: / Ward:	Date: / Ward:
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			0	0	0	0			
Sex	Male 1	Female 2				2	2	2	2			
Age	13-59 0	60-70 1 (62)	71-80 2	81+ 1		1	1	1	1			
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0		0	2	2	2			
Medication type	Drugs for mental illness 1	Blood pressure / water tablets 1	Sleeping tablets 1	None of these 0		1	1	1	1			
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	0	0	0	0			
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed / chair-bound/ wheel-chair 1		3 wheel chair	3	5	5			
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		1	3	3	3			
				TOTAL SCORE		8	12	14	13			
				ACTION(S) TAKEN (Enter action code(s) from Care Plan below)			see below	see below	see below			
SCORE 13 = HIGH RISK If patient unconscious score as N/A until patient status improves				NURSE SIGNATURE								

Please see back page for glossary of terms relating to the assessment above.

Falls Assessment Care Plan

Please tick all applicable nursing interventions

22/6/4

Action code	NURSING INTERVENTIONS	Date: / Ward: 5	Date 24/6 / Ward: 5	Date 27/6 / Ward: 5	Date 29/6 / Ward: 5	Date: / Ward:	Date: / Ward:	Date: / Ward:
1	Falls prevention and general safety precautions discussed with patient and family.	✓	✓	✓	✓			
	Move to more observable area of ward to optimise supervision.	✗	✗	✗	✗			
3	Advise patient they may experience dizziness when they mobilise initially.	✗	✗	✗	✗			
4	Requires assistance with mobilisation.	✓	✓	✓	✓			
5	Observe trip hazard due to invasive lines, drains and catheters.	✗	✗	✗	✗			
6	Do not leave the patient unattended when using commode, toilet, in shower or the bathroom area.	✗	✗	✗	✗			
7	If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.	✗	✗	✗	✗			
8	Monitor lying and standing / sitting BP and pulse.	✗	✗	✗	✗			
9	A. Patient requires footwear or podiatry referral. (Date referred: / requested :) B. Request family / carer to provide suitable footwear.	✗	✗	✗	✗			
10	Commence continence assessment, follow Local Guidelines.	✓	✗	✗	✗			
11	Refer to Occupational Therapist.	✓	✓	✓	✓			
12	Select suitable seating (refer to policy).	✓	✓	✓	✓			
13	Non slip mat on chair /floor following advice from therapists.	✗	✗	✗	✗			
14	Refer to Physiotherapist.	✓	✓	✓	✓			
15	Review Transfer techniques.	✓	✓	✓	✓			
16	Request medication review.	✗	✗	✗	✗			
17	Bed/chair monitor in use.	✓	✗	✗	✗			
18	Falls map in use for seven days for patient who has second or subsequent falls.	✓	✗	✗	✗			
19	Bed rails/bumpers to be used (refer to policy).	✓	✗	✗	✗			
20	Patient requires low bed / mattress on the floor (refer to policy.)	✓	✗	✗	✗			
21	Patient requires one to one nursing care.	✓	✗	✗	✗			
22	Refer to Hospital Falls Prevention Co-ordinator (see criteria on front cover).	✓	✗	✗	✗			
23	Other interventions. (3+22a)	✓	✓	✓	✓			
		✓						

Review Cannard score weekly / monthly as per policy. Enter action code(s) selected in action taken section on Falls Risk Assessment page above.

Acute Services Division

Part 2 Discharge Letter / Transfer Plan

NHS Greater Glasgow and Clyde

- ☐ Glasgow Royal Infirmary 0141 211 4000
- ☐ Stobhill Hospital 0141 201 3000
- ☐ Western Infirmary 0141 211 2000
- ☒ Southern General Hospital 0141 201 1100
- ☐ Victoria Infirmary 0141 201 6000
- ☐ Mansionhouse Unit 0141 201 6101
- ☐ Gartnavel General Hospital 0141 211 3000
- ☐ Blawarthill Hospital 0141 211 9000
- ☐ Drumchapel Hospital 0141 211 6000
- ☐ Lightburn Hospital 0141 211 1500
- ☐ Vale of Leven Hospital 01389 754 121
- ☐ Royal Alexandra Hospital 887 9111
- ☐ Inverclyde Royal Hospital 01475 633777
- ☐ Other:

Name: Catherine Honeyman

Address: 10 Melville Street
Glasgow, G41 2LN

Discharge Address: SIA.

CHI number: 0102 49 6145

Unit number: SGOOL 40779 D.O.B 01/02/49

Telephone: 07873671326

Next of kin: Raymond

Relationship: HUSBAND

Address: SIA

Telephone: 422 - 1586

Ward: 5 ortho

Telephone: 0141 201 1639

Admission date: 22/6/11

Final discharge/transfer date: 1/7/11

Named Nurse: T Brown

Consultant: Mr Nixlin

G.P.: Dr Mitchell

Address: Pine Place
Garbals Medical
Centre

Telephone: 571 8330

Post Discharge Services Arranged (e.g. District Nurse, CPN, Day Hospital, Home Care)
State package requested and time of first visit.

Service: District nurse	Service: N/A
Contact number: 531 8250	Contact number:
Service details: removal of staples + wound check Monday 4/7/11	Service details:

Additional/Transfer Information (including equipment/adaptions)

PMH Angina

3x Lumpectomy - breast - bilateral

(R) TKR

(L) TKR

(R) knee surgery

cholecystectomy

Patient Assessment/Comments

Mobility: Unaccomp/independent c/o 2 sticks

Personal hygiene/Dressing: Independent

Continence: Catheter in situ: Yes ☐ No ☑
Type: Size:
Date of change:

Continence details: continent

Dietary requirements: normal no problems

Communication / Swallowing: normal no problems

Mental state: normal - no problems

Skin condition/Waterlow Score: pressure areas intact

Wound care/Stoma care: wound re-dressed with tegaderm on 1/7/11 - intact on discharge.

Special Instructions for Patient (e.g. Exercise , Diet, Wounds, Others)

strict rules to remove staples and shower from on 4/7/11 please.

Others/Follow-up arrangements

Patient to attend follow up clinic 6 weeks post op. appointment details will be sent to discharge address.

Progress discussed with patient: Yes ☐ No ☐
Progress discussed with relative/carer: Yes ☐ No ☐

This Information has been fully discussed with Patient/Carer.

Date and signature of Nurse:

Diagnosis: 23/6/11
(R) 2nd Stage
Knee replacement

urse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

arning: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed by a doctor.

TE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).
2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).
3. Print & Sign your full name clearly against each prescription entry.
4. Time should be recorded in 24hr format e.g. 0600, 1800.
5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.
6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.
7. The following metric unit abbreviations must be used –

Milligram = mg — Gram = g
Millilitre = ml — Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

8. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - intrathecal **must be written in full.**

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.
2. Insert initials in the relevant date column and time row each time a drug is administered.
3. Check that all drugs prescribed at a certain time have been administered.
4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

Patient refused	(7) Patient asleep	(11) Unable to swallow	(14) Other - Record in nursing notes
Drug not available	(8) Time varied on doctor's instructions	(12) No intravenous access	(15) Prescription clarification required
Nil by mouth/fasting	(9) Dose withheld on doctor's instructions	(13) Patient Self-Administration of Medicine	
Patient unavailable	(10) Nausea/vomiting		

Cat. No. 40995 Ver 4, 09/2010

MEDICINE **PRESCRIPTION FORM** Hospital Name: SGH

MEDICINES RECONCILIATION

dicl econciled on Admission YES ☐
e _____ Name (Print) _____
charge Prescription Prepared & Reconciled YES ☐
e _____ Name (Print) _____

and time this form prepared:	Sheet No	2nd Prescription in use
/__/__ Time: _____	.....	YES ☐ NO ☐

CTOR'S DECLARATION (if required by Local Protocol)

thorise nurse/midwife administration of the medicines included ie symptomatic relief policy & local protocol:

_____

the following exceptions: _____

t & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

me _____ Tel No. _____
dress _____
mpliance Aid Details _____
tient consent to share discharge information Y/N
nt & Sign _____

PATIENT DETAILS

spital Number:	Height: 1.61m
IB:	Weight: 123.4 kgs
	Surface area:
te of Admission: 22/6/11	
nsultant Name:	Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
23.6.11	PLEASE GIVE (K) AMO (2)		O	730	Hoolie Hosie HOSIE		
23.6.11	PARACETAMOL with	1g	O	730	Hoolie Hosie HOSIE	GM	0730
23.6.11	LORAZEPAM 100ml	2mg	O	730	Hoolie Hosie HOSIE	GM	0730
	weeks						
23.6.11	CEFTRIAXIME	1.5g	IV	900	Hoolie Hosie HOSIE	HH	0900
23.6.11	FENTANYL bydaglgath	45mcg	IV	0900	Hoolie Hosie HOSIE		
29/6	CLEXANE	60mg	S/C	1800			1800

This patient is on beta blockers
Please complete a SPSP form postop
and return to Ward Clerkess

	DATE	28	24	25	26	27	28	29
	MONTH	6	6	6	6	6	6	6

RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HF

IS DRUG THROMBOPROPHYLAXIS INDICATED? (Y) N

ARE ANTIEMBOLISM STOCKINGS INDICATED? Y (N)

SIGNATURE OF ASSESSOR Hayley Hosie

ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N

Parenteral Drugs : Regular Prescription

A DRUG Clexane

DOSE 40mg | ROUTE S/C | DATE 22/6/11 | STOPPED DATE: 29/6 | INITIALS: CS

PRESCRIBER (PRINT & SIGN) [signature] | ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

Other time 0700-0900 1200-1400 1600-1800 2200-2400 Other time

B DRUG MORPHINE

DOSE 1mg/ml | ROUTE IV | DATE 22.6.11 | STOPPED DATE: 22/6 | INITIALS: CS

PRESCRIBER (PRINT & SIGN) Hayley Hosie HOSIE | ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY please go PCA crav

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☒

Other time 0700-0900 1200-1400 1600-1800 2200-2400 Other time

C DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN) | ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☒

Other time 0700-0900 1200-1400 1600-1800 2200-2400 Other time

Patient Own Medicine | For Use Y/N | Qty: | Date: | Assessed | Ordered from Pharmacy

REVIEW THE NEED FOR IV ANTIBIOTIC DAILY. SWITCH TO ORAL THERAPY AS SOON AS POSSIBLE (SEE IVOST POLICY)

Parenteral Drugs: Regular Prescription

DATE → MONTH →

D DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN) | ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

Other time 0700-0900 1200-1400 1600-1800 2200-2400 Other time

E DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN) | ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

Other time 0700-0900 1200-1400 1600-1800 2200-2400 Other time

F DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN) | ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

Other time 0700-0900 1200-1400 1600-1800 2200-2400 Other time

G DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN) | ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

Other time 0700-0900 1200-1400 1600-1800 2200-2400 Other time

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

HONEYMAN, CATHERINE
10 MELVILLE STREET
GLASGOW
Name 01/02/1949
CHI No 341 2LN CHI 0102496145

Drug Allergies / Sensitivities None Known ☐ Yes ☐ (provide details below

NKDA

Oral and Other Drugs: Regular Prescription

DATE: 22 23 24 25 26 27 28 29 30 1
MONTH: 6 6 6 06 6 6 6 6 6 7

H DRUG: GTN SPRAY
DOSE: 2-3 puffs | ROUTE: INH | DATE: 13/6/11 | STOPPED: DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: To be used as req. Sometimes she uses it regularly

J DRUG: SIMVASTATIN
DOSE: 40mg. | ROUTE: PO | DATE: 13/6/11 | STOPPED: DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
2200-2400: LW LC AB EB EB XN XN

K DRUG: ATENOLOL
DOSE: 25mg | ROUTE: PO | DATE: 13/6/11 | STOPPED: DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
0700-0900: AM LL FB Marion Nelson

L DRUG: TRAMADOL 14CO
DOSE: 50mg | ROUTE: PO | DATE: 13/6/11 | STOPPED: DATE: 22/6 | INITIALS: SV
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
2200-2400: ✓

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by | Ordered from Pharm

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE: 23 24 25 26 27 28 29 30 1
MONTH: 6 6 06 6 6 6 6 6 7

M DRUG: ASPIRIN
DOSE: 75mg | ROUTE: PO | DATE: 13/6/11 | STOPPED: DATE: 29/6 | INITIALS: SW
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
0700-0900: 9 9 FB Marion

N DRUG: BENDROFLUMETHA 2.5mg
DOSE: 2.5mg | ROUTE: PO | DATE: 13/6/11 | STOPPED: DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
0700-0900: ✓ 9 LF FB Marion Nelson

P DRUG: FLUOXETINE
DOSE: 20mg | ROUTE: PO | DATE: 13/6/11 | STOPPED: DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
0700-0900: 9 LF FB Marion Nelson

R DRUG: OMEPRAZOLE
DOSE: 20mg | ROUTE: PO | DATE: 13/6/11 | STOPPED: DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
0700-0900: AM LF FB Marion Nelson

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Name: IONEYMAN, CATHERINE
10 MELVILLE STREET
GLASGOW 01/02/1949
G41 2LN CHI No 0102496145

Drug Allergies / Sensitivities None Known ☐ Yes ☐ (provide details below)

NKDA

Oral and Other Drugs: Regular Prescription

DATE: 22 23 24 25 26 27 28 29 30 1
MONTH: 6 6 6 06 6 6 6 6 6 7

S — DRUG: TRAMADOL
DOSE: 200mg | ROUTE: PO | DATE: 22/6/11 | STOPPED DATE: 23.6.11 | INITIALS: HH
PRESCRIBER (PRINT & SIGN): [illegible]
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: As directed from prescription
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

T — DRUG: OXYCONTIN
DOSE: 20mg | ROUTE: O | DATE: 23.6.11 | STOPPED DATE: 27/6 | INITIALS: CH
PRESCRIBER (PRINT & SIGN): HOSIE
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: for 4 doses until 26.6.11.
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☒

V — DRUG: PARACETAMOL
DOSE: 1g | ROUTE: O | DATE: 23.6.11 | STOPPED DATE: 27/6 | INITIALS: CH
PRESCRIBER (PRINT & SIGN): HOSIE
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☒

W — DRUG: OXYCONTIN
DOSE: 10mg | ROUTE: O | DATE: 26.6.11 | STOPPED DATE: 27/6 | INITIALS: CH
PRESCRIBER (PRINT & SIGN): HOSIE
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: from 26.6.
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☒

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reaso

Oral and Other Drugs: Regular Prescription

DATE: 23 24 25 26 27 28 29 30 1
MONTH: 6 6 06 6 6 6 6 6 7

X — DRUG: LACTULOSE
DOSE: 10 mls | ROUTE: PO | DATE: 23/6 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): [illegible] (CURTIS)
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

Y — DRUG: SENNA
DOSE: X 2 TABS | ROUTE: PO | DATE: 23/6 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): [illegible] (CURTIS)
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

AA — DRUG: Co-codamol 30/500
DOSE: 2 tabs | ROUTE: PO | DATE: 27/6/11 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): [illegible]
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

BB — DRUG: Ferrous Fumarate
DOSE: 210mg | ROUTE: PO | DATE: 27/6/11 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): [illegible]
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

[redacted] HONEYMAN, CATHERINE
[redacted] MELVILLE STREET
Name [redacted] GLASGOW 01/02/1949
[redacted] 341 2LN CHI 0102496145
CHI No

Drug Allergies / Sensitivities — None Known ☐ Yes ☐ (provide details belo

NKDA

Oral and Other Drugs: Regular Prescription

DATE / MONTH: 29 30 1 7

CC DRUG: ASPIRIN

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DOSE: 150mg | ROUTE: PO | DATE: 29/6 | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN): [signature]

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

0700-0900: X [signature]

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE / MONTH

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

HONEYMAN, CATHERINE
10 MELVILLE STREET
GLASGOW
341 2LN

Name 01/02/1949

CHI No CHI 0102496145

Drug Allergies / Sensitivities None Known ☐ Yes ☐ (provide details bel

NKDA

All Routes: As Required Prescriptions

LL
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐
DRUG: ORAMORPH
DOSE: 5-10mg | ROUTE: PO | INDICATION: ↑↑ pain
PRESCRIBER (PRINT & SIGN): [signature] | MAX.FREQ.: 2-2° | DATE: 13/6/11
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
STOPPED DATE: | INITIALS:

MM
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐
DRUG: ONDANSETRON
DOSE: 4mg | ROUTE: PO | INDICATION: N+V
PRESCRIBER (PRINT & SIGN): [signature] | MAX.FREQ.: TDS | DATE: 13/6/11
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
STOPPED DATE: | INITIALS:

NN
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☒
DRUG: BUCCASTEM
DOSE: 3-6mg | ROUTE: BUCCAL | INDICATION: post operative
PRESCRIBER (PRINT & SIGN): HOSIE HOSIE HOSIE | MAX.FREQ.: 12hr | DATE: 23/6/11
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: maximum 12mg/24hrs
STOPPED DATE: | INITIALS:

PP
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐
DRUG:
DOSE: | ROUTE: | INDICATION:
PRESCRIBER (PRINT & SIGN): | MAX.FREQ.: | DATE:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
STOPPED DATE: | INITIALS:

DATE	21/6 24/6 24/6 25/6 25/6 25/6 26/6 26/6 26/6 27/6 27/6 28/6 28/6 29/6 29/6 30/6 30/6 1/7
TIME	08 20 20 08 10 16 20 01 08 08 08 11 08 17 12 03 20 11 15 01
DOSE	10 20 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10
GIVEN BY	D JH IBM N MO JH IM D JH D JH JH JH JH JH JH JH

Note: To discontinue a prescription, initial and date appropriate boxes; draw a diagonal line through section & record reason

RR
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐
DRUG:
DOSE: | ROUTE: | INDICATION:
PRESCRIBER (PRINT & SIGN): | MAX.FREQ.: | DATE:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
STOPPED DATE: | INITIALS:

SS
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐
DRUG:
DOSE: | ROUTE: | INDICATION:
PRESCRIBER (PRINT & SIGN): | MAX.FREQ.: | DATE:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
STOPPED DATE: | INITIALS:

TT
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐
DRUG:
DOSE: | ROUTE: | INDICATION:
PRESCRIBER (PRINT & SIGN): | MAX.FREQ.: | DATE:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
STOPPED DATE: | INITIALS:

VV
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐
DRUG:
DOSE: | ROUTE: | INDICATION:
PRESCRIBER (PRINT & SIGN): | MAX.FREQ.: | DATE:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
STOPPED DATE: | INITIALS:

DATE	
TIME	
DOSE	
GIVEN BY	

Patient's own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

3G00940779
HONEYMAN, CATHERINE
10 MELVILLE STREET

Name: GLASGOW 01/02/1949

CHI No: G41 2LN CHI 0102496145

Drug Allergies / Sensitivities: None Known ☐ Yes ☐ (provide details below)

NKDA

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL, 1345 GOVAN ROAD, GLASGOW G51 4TF
TEL: 0141 201 1100

DEPARTMENT OF ORTHOPAEDICS

WARD: S05 **CONSULTANT: MR MIKE HULLIN**
CONTACT TEL: 0141 201-1357 *IMMEDIATE DISCHARGE LETTER*

PATIENT: CATHERINE HONEYMAN
10 MELVILLE STREET
GLASGOW
G41 2LN

DOB: 01/02/49 UNIT NO: SG00940779
ACCT NO: IP0028639/11
CHI NO: 0102496145

GP: DR GRAEME G MARSHALL
GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ

DATE OF ADMISSION: 22/06/11
ADMISSION TYPE: ELECTIVE
DISCHARGE TO: HOME
DATE OF DISCHARGE: 01/07/11

REASON FOR ADMISSION: RIGHT 2ND STAGE REVISION KNEE
MAIN DIAGNOSIS: REVISION RIGHT KNEE

OTHER ACTIVE PROBLEMS: IHD
ANGINA
'ERATIONS/PROCEDURES/ TREATMENT: RIGHT 2ND STAGE KNEE REVISION
RESULTS AWAITED: N
CURRENT MEDICATION: SEE PRESCRIPTION
DISCONTINUED DRUGS? N
COMMENT: FOLLOW UP IN 6/52

ALLERGIES: NKDA

REVIEW? N DETAILS: TIMESCALE:

FURTHER LETTER TO FOLLOW? Y DETAILS: FORMAL HOSPITAL LETTER

Highly Sensitive Document Y/N N Patient consent to share information Y/N Y

SIGNED: FY2.BOYRO BOYD,ROSALYN
DESIGNATION: FOUNDATION DR YEAR 2
E NUMBER: 7082

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL, 1345 GOVAN ROAD, GLASGOW G51 4TF
TEL: 0141 201 1100

DEPARTMENT OF ORTHOPAEDICS

WARD: S05 **CONSULTANT: MR MIKE HULLIN**
CONTACT TEL: 0141 201-1357

IMMEDIATE DISCHARGE LETTER

PATIENT: CATHERINE HONEYMAN
10 MELVILLE STREET
GLASGOW
G41 2LN

DOB: 01/02/49 UNIT NO: SG00940779
ACCT NO: IP0028639/11
CHI NO: 0102496145
GP: DR GRAEME G MARSHALL

D I S C H A R G E M E D I C A T I O N

Time Required? As Per Date of Discharge
Childproof Containers? Y
Compliance Aid Required? N
Patient's Weight (Kg):
Comment:

Medication	Form	Dose	Frequency	Duration
COCODAMOL 30/500	OTAB	2 TABS	4 TIMES A DAY	7 DAYS

New Drug? Y New Dose? Y Comments:
Patient's Own Supply? N Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration
FERROUS FUMARATE	OTAB	210MG	3 TIMES A DAY	REVIEW

New Drug? Y New Dose? Y Comments:
Patient's Own Supply? N Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration
ASPIRIN	OTAB	150MG	IN THE MORNING	6 WEEKS

New Drug? Y New Dose? Y Comments: GP PLEASE REVIEW ASPIRIN DOSE AFTER 6 WEEKS
Patient's Own Supply? N Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration

New Drug? New Dose? Comments:
Patient's Own Supply? Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration

New Drug? New Dose? Comments:
Patient's Own Supply? Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration

New Drug? New Dose? Comments:
Patient's Own Supply? Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration

New Drug? New Dose? Comments:
Patient's Own Supply? Pharmacy Notes: Supply:

PHARMACY USE ONLY DISPENSED BY: DATE: CHECKED BY:
CLINICAL PHARMACIST CHECK: COLLECTED BY: _____

Medicine received on ward by: _____ Issued by: SM / CS

Named Nurse: _____ Signature of Receipt: C Honeyman

Report Number: 3006-0266 Date(Time): 30/06/11 (1635 Hours) Status: Signed

South Glasgow Hospitals
Southern General Hospital, Glasgow G51 4TF. Tel. 0141 201 1100

Part 1 Discharge Letter and Medicine Prescription Form - Confidential

Ref No: 164648

NHS Greater Glasgow and Clyde

VIMI • DISCHARGE • 2725 SGH

Dear Doctor .....
Surgery .....

Fix ID label to all 4 copies

Patient: [illegible]
Address: [illegible]
[illegible]
[illegible]
DOB: [illegible] Unit no: [illegible]
Weight ..... CHI no: [illegible]

Ward: [illegible] Tel: .....
Consultant: [illegible]
Specialty [illegible]
Named Nurse: .....
Admission date: [illegible]
Mode of admission [illegible]
Source of admission .....
Discharge date: [illegible]

Follow-up arrangements
Clinic appointment made:
Yes ☐ No ☐ To follow ☐
Clinic name .....
Date ...../...../.....
Non-childproof containers required: Yes ☐ No ☐
Medicine compliance aids required: Yes ☐ No ☐
Specify: .....

Reason for admission, treatment, diagnosis, investigations, operations, complications:

[illegible] renal failure [illegible]

Other information

60
1/7 2.10 [illegible]

MEDICINE	Dosage form	Dose	Times for administration: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 8	pm 10	Other times	Recommended duration of treatment after discharge	New Drug	New Dose	Number of days supply	Dispensing Details (Pharmacy only)
[illegible]	[illegible]	[illegible]	PRN			[illegible]								[illegible]			
Please supply	[illegible]	[illegible]				[illegible]							Supplied	[illegible]			

Medicines discontinued	Reason (if known) e.g. side effects

Clinical Pharmacy check: MD
All known drug sensitivity / adverse reactions:

Dispensed by: [illegible] Date: ...../...../.....
Checked by:

WARD USE ONLY
Med. rec. on ward by: .....
Issued by: [illegible] Date: 1/7/11
Signature of recipient: C Honeyman

Doctor s name: [illegible] Signature: [illegible] Date [illegible]
Doctor s grade: [illegible] Pager number: [illegible]

Number of prescription sheets at discharge: 3

White copy - G.P.; Pink copy - Case Notes; Blue copy - Pharmacy; White copy - Patient. 3345156

If you have any problems after discharge, please contact the Ward or your G.P.

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL, 1345 GOVAN ROAD, GLASGOW G51 4TF
TEL: 0141 201 1100

SENT TO PHARMACY

DEPARTMENT OF ORTHOPAEDICS

WARD: S05 CONSULTANT: MR MIKE HULLIN
CONTACT TEL: 0141 201-1357

IMMEDIATE DISCHARGE LETTER

PATIENT: CATHERINE HONEYMAN
10 MELVILLE STREET
GLASGOW
G41 2LN

DOB: 01/02/49

UNIT NO: SG00940779
ACCT NO: IP0028639/11
CHI NO: 0102496145

GP: DR GRAEME G MARSHALL
GORBALS HEALTH CENTRE
GLASGOW
G5 0BQ

DATE OF ADMISSION: 22/06/11
DATE OF DISCHARGE: 01/07/11

ADMISSION TYPE: ELECTIVE
DISCHARGE TO: HOME

REASON FOR ADMISSION: RIGHT 2ND STAGE REVISION KNEE
MAIN DIAGNOSIS: REVISION RIGHT KNEE

OTHER ACTIVE PROBLEMS: IHD
ANGINA
OPERATIONS/PROCEDURES/ TREATMENT: RIGHT 2ND STAGE KNEE REVISION
RESULTS AWAITED: N
CURRENT MEDICATION: SEE PRESCRIPTION
DISCONTINUED DRUGS? N
COMMENT: FOLLOW UP IN 6/52

ALLERGIES: NKDA

REVIEW? N DETAILS: TIMESCALE:

FURTHER LETTER TO FOLLOW? Y DETAILS: FORMAL HOSPITAL LETTER

Highly Sensitive Document Y/N N Patient consent to share information Y/N Y

SIGNED: FY2.BOYRO BOYD,ROSALYN
DESIGNATION: FOUNDATION DR YEAR 2
PAGE NUMBER: 7082

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL, 1345 GOVAN ROAD, GLASGOW G51 4TF
TEL: 0141 201 1100

DEPARTMENT OF ORTHOPAEDICS

WARD: S05 CONSULTANT: MR MIKE HULLIN
CONTACT TEL: 0141 201-1357

IMMEDIATE DISCHARGE LETTER

PATIENT: CATHERINE HONEYMAN
10 MELVILLE STREET
GLASGOW
G41 2LN

DOB: 01/02/49 UNIT NO: SG00940779
ACCT NO: IP0028639/11
CHI NO: 0102496145
GP: DR GRAEME G MARSHALL

DISCHARGE MEDICATION

Time Required? As Per Date of Discharge
Childproof Containers? Y
Compliance Aid Required? N
Patient's Weight (Kg):
Comment:

Medication	Form	Dose	Frequency	Duration
COCODAMOL 30/500	OTAB	2 TABS	4 TIMES A DAY	7 DAYS

New Drug? Y New Dose? Y Comments:
Patient's Own Supply? N Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration
FERROUS FUMARATE	OTAB	210MG	3 TIMES A DAY	REVIEW

New Drug? Y New Dose? Y Comments:
Patient's Own Supply? N Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration
ASPIRIN	OTAB	150MG	IN THE MORNING	6 WEEKS

New Drug? Y New Dose? Y Comments:
Patient's Own Supply? N Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration

New Drug? New Dose? Comments:
Patient's Own Supply? Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration

New Drug? New Dose? Comments:
Patient's Own Supply? Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration

New Drug? New Dose? Comments:
Patient's Own Supply? Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration

New Drug? New Dose? Comments:
Patient's Own Supply? Pharmacy Notes: Supply:

PHARMACY USE ONLY DISPENSED BY: DATE: CHECKED BY:
CLINICAL PHARMACIST CHECK: COLLECTED BY: _____

Medicine received on ward by: _____ Issued by: _____

Named Nurse: _____ Signature of Receipt: C Honeyman

Report Number: 3006-0266 Date(Time): 30/06/11 (1635 Hours) Status: Draft

