NHS 24 FAX REPORT

NHS 24 ID:	Call ID: 12948853	**Site:**	Edinburgh
CHI #:	0104551062	**Caller Name:**	
Surname:	MCCORMACK	**Date/Time Call Received:**	31/03/2013 10:55
Forename:	HELEN		
DOB:	01/04/1955	**Date Call Completed:**	
Gender:	Female	**Time Call Completed:**	
Address:	16 Rowan Terrace	**Call Priority:**	CS2
	Blackburn	**Call Reason:**	PAINFUL FOOT 13HRS SEE A/V
	Bathgate	**Current Location:**	16 Rowan Terrace
			Blackburn
	West Lothian/EH47 7EQ		Bathgate
PH NO:	07778505335 (Return)		West Lothian/EH47 7EQ
		Special Directions:	
		Current PH NO:	07778505335 (Return)
Care Provider:	MACAULAY, D	**Care Provider Details:**	ASHGROVE HEALTH CENTRE BLACKBURN WEST LOTHIAN EH47 7LL Scotland

Temporary Resident: No

Referred To:

Recommended Action: Pt advised to go to A&E - For Information Only

CLINICAL SUMMARY

PAINFUL FOOT FOR 13HRS AND INJURY LAST NIGHT - WAS OUT WALKING. SLIGHT SWELLING, INJURED AREA PALER COLOUR THAN NORMAL. PATIENT TO ATTEND A & E ST JOHNS HOSPITAL ASAP.

PAST MEDICAL HISTORY

Referred Clinical Notes:

T:

P:

R:

BP: /

Print Name:

Signature:

NHS Lothian

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

Dr MacAulay
Ashgrove Group Practice
Ashgrove
Blackburn
West Lothian
EH47 7LL

Date: 31/03/2013

Emergency Discharge Summary

Patient	Helen McCormack 16 Rowan Terrace Blackburn Bathgate EH47 7EQ	**CHI**	**0104551062**
		Date of Birth / Age	01/04/1955 (57 years)
		UHPI	800130598V
		A&E Attendance Number	E2441125
Attendance Date	31/03/2013		
Attendance Time	12:12		
Mode of Arrival	Private Transport		
Source of Referral	Self Referral to A&E		
Discharge Date	31/03/2013		
Discharge To	GP Care - No Appt	**Final Triage**	7 - See and Treat
		Attendances in the last 12 months	1

Dear Dr MacAulay

Presentation:	r foot inj
Diagnosis:	STI ankle
Procedures:	None
Drugs given in A&E:	Diclofenac, Cocodamol/Codydramol

Discharge Drugs

Discharge Medication	Dose	Frequency	Duration	Additional Info

PC - foot injury
HPC -patient had eversion injury on ankle yesterday. Difficulty wweight bearing since. Effusion and bruising developed over later aspect of foot

O/E
Bruising andswelling to lateral midfoot
Tender over base 5th metatarsal
Limited ROM ankle

XR - no fracture

Im p -ankle sprain
Tubi grip and analgesia
Any queries please contact A&E Reception on 01506 523011

Yours Sincerely,

Dr Sophie Paton, Doctor

Emergency Medicine
NHS LOTHIAN UNIVERSITY HOSPITALS DIVISION

ST. JOHN'S HOSPITAL
Howden Road West
Livingston
EH54 6PP Tel: 01506 523000

NHS Lothian

A/E no. E2441125 OGH

Previous no. E717502

UHPI no: 800130598V
CHI no: 0104551062

PATIENT INFORMATION

Surname McCormack
Forename Helen
Date of Birth 01/04/1955
Age 57 Yrs Sex F

Address 16 Rowan Terrace
Blackburn
Bathgate, West Lothian
Postcode EH47 7EQ
Telephone 07778505335

Contact Garfoot, Mrs
Address 55 Rowan Street
Blackburn
Bathgate West Lothian
Telephone 01506 791636 W

Complaint foot inj
Allergies

Attendances in last 12 months: 0 School:

General Practitioner

Name
D MacAulay
Address
Ashgrove Group Practice
Ashgrove
West EH47 7LL
Telephone 01506 657130

Date and Time of Attendance
31/03/2013 12:12
Incident Date & Time: 30/03/2013 22:30
Mode of Arrival
Private Transport
Source of Referral
Self Referral to A&E

T	P	RR	BP	BM	SpO2	PEFR	Height	Weight	Alco

Initial Assessment 3 Wk c/o (R) ankle pain yesterday.
Swelling & tender 4th 5th MT.
Unable to WB
Refused pain relief

Signature Time 1230

Print Name S French Triage Cat. 3

Urinalysis	Leuc	Nit	Blood	Protein	Glucose	Ketones	SG	PH

Clinical Notes

Time seen	13
Alcohol	–
Investigations	Rx
Procedures	+
Drugs given in Dept.	Co DK
Diagnosis	14LQ

Diagnosis STJ ankle

Name (print) SFRENCH Signature

Clinical Notes Continued

Once Only Prescriptions

	Drug	Dose	Route	Prescribed By	Given By	Time
A	LOZUCAMOL 50/500	1 tabs	O			13
B	DICLOFENAC	50mg	O.			13
C						
D						
E						

Additional Nursing Notes

PMH

Meds

Allergies

Social History

Accompanied by

NHS Lothian

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

Dr Black
Ashgrove Group Practice
Blackburn Partnership Centre
Ashgrove
Blackburn
EH47 7LL

Date: 27/01/2021

Emergency Discharge Summary

Patient	Helen McCormack 121 Rowan Street Blackburn Bathgate EH47 7ED	**CHI**	**0104551062**
		Date of Birth / Age	01/04/1955 (65 years)
		UHPI	800130598V
		A&E Attendance Number	E4627265
Attendance Date	27/01/2021		
Attendance Time	09:56		
Mode of Arrival	Private Transport		
Source of Referral	Self Referral to A&E		
Discharge Date	27/01/2021		
Discharge To	GP Care - No Appt	**Final Triage**	3 - Urgent
		Attendances in the last 12 months	1

Dear Dr Black

Presentation: Chest pain, chest pain 24hrs, lasting 5-10sec , central not radiating t35.5, sats 96%, HR96, BP141/87, RR18 Kbartscht 1001
Diagnosis: Musculoskeletal chest pain
Procedures: None
Drugs given in A&E: None
Discharge Drugs:

CLINICAL NOTES:
Clinical note: 65F - self presents to A&E

PC: chest pain

BG:
Previously investigated for chest pain at GP with ECGs

HPC:
1/7hx of intermittent chest pain which comes on at rest
- first noticed when out walking and spontaneously resolved without ceasing to walk
- has since noticed to come on intermittently at various points, mentions maybe 40+ episodes, lasting only 10-15 seconds and resolve spontaneously
- not all associated with exertion some coming on at rest which she describes as the worst ones
- has also noticed to be associated with some arm movements but not always

- no radiation of the pain or discomfort, no back pain, no arm pain
- no nausea, no vomiting, no abdo discomfort
No shortness of breath, no discomfort associated with breathing, no cough, no new swelling noticed
Otherwise feeling well, no known sick contacts
No trauma reported

Mx: nil
NKDA

SHx:
Current smoker
Drinks ~4cans alcohol daily
Primary carer for her brother

O/E
Alert, sitting up in cubicle, appears comfortable at rest
RR 18, SpO2 96%oa, HR 96, BP 141/87, Temp 35.8
HS I+II+0, bilatreal air entry no added sounds
No reproduceable pain on palpation of chest wall
Pain reproduced on abduction and flexion at the left shoulder above 100 degrees, felt worse just behind breast, no pain on other movements noted

INVESTIGATIONS
ECG: NSR rate 82, nil acute

IMPRESSION
1) Likely MSK
2) Cannot fully ruleout ACS given these maximal episodes reported at rest

PLAN
1) Bloods
2) CXR
3) Review

---
d/w Dr Datta (ED Cons) - would benefit from early referral to CP nurse, has cardiac RF

Call to SJH Chest Pain nurse
- no answer > message left on voicemail regarding referral

CXR: Normal cardiac, mediastinal and hilar contours. The lungs are markedly hyperinflated with attenuated pulmonary vascularity and lobe, flattened diaphragms,, suggesting emphysema/COPD, with no focal consolidation or collapse. No change from the previous radiograph of 03/01/2020.

Bloods:
FBC: 149 / 10.1 / 240
sCr 68, K 4, Na 142, Cholesterol 5.8
Troponin-I <1

IMPRESSIONS
1) MSK chest pain most in keeping

2) Possibly unstable angina given negative TnI and episodes of CP at rest
2) CXR suggestive of COPD/Emphysema with SpO2 96%oa

Phone cal from Dr Lattin (Cardiology Fellow)
- MSK more likely than angina given such a short history. Reassurred by negative TnI. Advised for patient to monitor and GP can refer to rapid access chest pain clinic if further concerns.

DISCHARGE PLAN
1) Analgesia if required
2) GP to please consider review regarding COPD given CXR findings
3) d/c from A&E with worsening advice and self monitoring instructions, smoking cessation advice given

Dr Michael Carvill
FY2 Emergency Medicine
SJH
Any queries please contact A&E Reception on 01506 523011

Yours Sincerely,

Dr Michael Carvill, Doctor

800130598V /E4627265 F
MCCORMACK Helen
01-Apr-55 **CHI:** 010 455 1062
78330 SK Black
121 Rowan Street West Lothian
EH47 7ED

SJH ED Nursing Care Plan

NHS Lothian

Admission Nurse Signature: .....

Admission Nurse Print Name: .....

Date: 27/1/21

Presenting History :	**DNAR in situ (please circle)** Yes No
CP.	

Date/ Time	Additional Nursing Progress Notes	Signature
11 00	News documented, ECG ✓ Sully FO	
@ 1200	Pt's observations due however pt has left department for 'fresh air' - awaiting presence.	

Section A Triage Procedures	**Initials**	**Section B Optional Nursing Procedures**			**Initials**
Vital signs recorded	✓	IV Cannula Inserted (please circle)	Yes	No	
Sews Score recorded	✓	ECG completed (please circle)	Yes	No	
BM Reading		CXR ordered (please circle)	Yes	No	
GCS assessed	✓	Falls / Risk Assessment	Required / Complete		NA Sully
Alcometer reading recorded		Swallow Assessment	Required / Complete		
Peak Flow reading recorded	✓	Waterlow Assessment	Required / Complete		
NameBand attached	✓	Frailty Concern (please circle)	Yes	No	
Section C Admission Procedures	**Initials**	**Section D Optional Nursing Requirements**			**Initials**
Relatives : (please circle) In ED / At Home / Not Aware	✓	Language Assistance requested (Please inform NIC if applicable)			NA Sully
Clothing & valuables (please tick) 1) Labelled 2) Documented		Vulnerable Adult Concern (Please inform NIC if applicable)			
Spectacles : (please circle) NA / In Situ / At home	✓	Child protection Concern (Enter on TRAK & inform NIC if applicable)			
Hearing Aid : (please circle) NA / In Situ / At home	✓	4AT test Score = (please enter only if clinically indicated)			

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

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

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

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

NHS Lothian

800130598V /E4627265 F
MCCORMACK Helen
01-Apr-55 **CHI:** 010 455 1062
78330 SK Black
121 Rowan Street West Lothian
EH47 7ED

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

Previous Adverse Reactions		Weight	Date
	NKDA	kgs Actual / Estimate	27/1/24

Once Only Prescription

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

Discharge Medication

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

National Early Warning Score 2 (NEWS2) Chart

| NEWS Key 0 1 2 3 | | |

NEWS of 5 or more?
Think Sepsis!

In a patient with a **NEWS of 5 or more** and a known infection, signs and symptoms of infection, or at risk of infection, think **'Could this be sepsis?'** and **escalate care immediately.**

Signs of Infection

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

800130598V /E4627265 F
MCCORMACK Helen
01-Apr-55 **CHI:** 010 455 1062
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NEWS Total	Monitoring Frequency	Clinical Response
Total 0	Commence on 2 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
Total 1 - 4	Commence on 1 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
3 in one parameter *	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to Nurse In Charge (NIC) and Senior Medic
Total 5 - 6	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Total 7 or more	Commence on 15 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic

Special Instructions

*or increase in NEWS score of 2

Conscious Level Chart to be completed when clinically indicated

| | | |

IV Fluid Prescription

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

Fluid Balance

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

Drug Infusion

Drug Name:

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

Drug Name:

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

NHS Lothian

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

Dr Parker
Ashgrove Group Practice
Blackburn Partnership Centre
Ashgrove
Blackburn
EH47 7LL

Date: 07/08/2023

Emergency Discharge Summary

Patient	Helen McCormack 121 Rowan Street Blackburn Bathgate EH47 7ED	**CHI**	**0104551062**
		Date of Birth / Age	01/04/1955 (68 years)
		UHPI	800130598V
		A&E Attendance Number	E5431843
Attendance Date	07/08/2023		
Attendance Time	12:13		
Mode of Arrival	Emergency Ambulance		
Source of Referral	999 Emergency		
Discharge Date	07/08/2023		
Discharge To		**Final Triage**	3 - Urgent
		Attendances in the last 12 months	1

Dear Dr Parker

Presentation: Chest pain, BIBA. Left sided chest pain, known angina, cough last few days. D+V. Has emphysema. T 37.4, HR 94, BP 119/75, Spo2 97%, RR , ECG done. FK 12:25 Note - initial troponin not processed, HAS NOW BEEN ADDED
Diagnosis: Non-specific chest pain
Procedures: None

CLINICAL NOTES:
Clinical note: 7/8/23 1605
PC: Chest pain

68 y o pt with BG:
- Depression
- Previous episodes of chest pain
DH: Citalopram
NKDA
SH: Smokes 5cpd and 5 joints cannabis per day. ET indefinite, but gets very SoB on slopes.

Pt presents following episode of chest pain that came on after she got out of bed at ~0930.
She has had D&V for a couple of days which she puts down to food poisoning. She ate a pizza that had been torn apart by a seagull.

Describes a tight pain in the left side of her chest, around the inferior ribs. This pain was "pretty bad." It did not radiate. It was a little worse when exerting herself. No nausea or vomiting. No SoB. No sweating. Pt was given 2

aspirin by a relative. She reports that the pain resolved completely with GTN from triage, and has been settled since. She is keen to go home.

Obs: NAD

OE
Appears very comfortable. Relatively frail. Speaking in full sentences.

HS I+II+0. HR~80 reg. WWP periph
Chest clear to auscultation. Fairly quiet AE to bases.
Abdo SNT

Bloods NAD including trop 8
CXR shows hyperinflated lungs

I: Reassuring initial results - needs repeat trop to r/o NSTEMI
Likely undiagnosed COPD

P: Repeat trop
Would benefit from GP input regarding breathing
Discussed smoking cessation and evidence of smoking-related damage to lungs - pt currently not interested in stopping.

1655

Repeat trop 7

Pt remains well

I: No concerning cause for pain identified
?Pain related to vomiting

P: Discussed reassuring results
Advised pt to attend own GP to discuss respiratory Sx
Advised to return if pain worsens, develops SoB, collapse
D/Ced with reassurance. Pt happy with explanation and advice.

Dr. Tom TRUDEAU
ED Specialty Doctor

Any queries please contact A&E Reception on 01506 523011

Yours Sincerely,

Dr Tom Trudeau, Doctor

NHS Lothian

Emergency Department SJH Care Rounding

(addressog

Name:

DOB:

Hospital

800130598V /E5431843 F
MCCORMACK Helen
01-Apr-55 CHI: 010 455 1062
78330 RH Parker
121 Rowan Street West Lothian
EH47 7ED

NURSING ADMISSION CHECKLIST

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

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

Presenting Complaint: Lt sided chest pain

Date/time	Progress Notes	Signature/print name
1/8/23	Pt awake on trolley, came in with chest pain, observation done Pt Hews 2. low blood pressure. no complains of pain currently. xray ordered and currently having xray done. No pain relief needed	

NHS
Lothian

Date/time	Progress Notes	Signature/print name

NHS Lothian

CARE ROUNDING

HOURLY FREQUENCY	☐ 1	☐ 2	☐ 3	☐ 4

Review frequency every 12 hours or if the patient's clinical condition requires

Print name of nurse reviewing: Date: / /

Time of Round	0557				
Clinical Area	14				
Care Round Leader's Initials					
Review Frequency of Vital Signs & Cardiac Monitoring					
Vital Signs Frequency	0				
Cardiac Monitoring required?	☐Y ☒N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Pain score (0-10)	-	-	-	-	-
Analgesia provided	☐Y ☒N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Is the person due any routine medication?	☐Y ☒N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Mobility - tick one option per care rounding					
Fully weight bearing	☐	☐	☐	☐	☐
Requires some assistance/uses walking aid	☐	☐	☐	☐	☐
Non weight bearing- needs full assistance	☐	☐	☐	☐	☐
Identified as at risk of falls	☐	☐	☐	☐	☐
Ask patient if they require the toilet	☐	☐	☐	☐	☐
Patient is self-caring and can walk to toilet	☒	☐	☐	☐	☐
Patient has issues with incontinence - assist with personal care as needed	☐Reviewed	☐Reviewed	☐Reviewed	☐Reviewed	☐Reviewed
Personal care	☐Given	☐Given	☐Given	☐Given	☐Given
Personal care	☒Not required	☐Not required	☐Not required	☐Not required	☐Not required
Patient has catheter in situ- assist patient as needed (THINK FLUID BALANCE CHART)	☐Patent & draining?	☐Patent & draining?	☐Patent & draining?	☐Patent & draining?	☐Patent & draining?
Personal care	☐Offered	☐Offered	☐Offered	☐Offered	☐Offered
Personal care	☐Given	☐Given	☐Given	☐Given	☐Given
Personal care	☒Declined/Not required	☐Declined/Not required	☐Declined/Not required	☐Declined/Not required	☐Declined/Not required
Nutrition and Hydration (tick one option) *THINK SWALLOW					
Patient is self-caring (ensure nutrition and hydration needs are still being met)	☒	☐	☐	☐	☐
Patient needs assistance with feeding/drinks and have been given help	☐	☐	☐	☐	☐
Patient for fluids only- ensure signage appropriate above bed/trolley	☐	☐	☐	☐	☐
Patient is NBM* (are background fluids required? Review signage is appropriate above the bed/trolley)	☐	☐	☐	☐	☐
Patient has IVI in situ	☐	☐	☐	☐	☐
Fluid balance chart updated?	☐Y ☐N ☒N/A	☐Y ☐N ☐N/A	☐Y ☐N ☐N/A	☐Y ☐N ☐N/A	☐Y ☐N ☐N/A
Refreshments - Provided (P) Declined (D)					
Drink	☐P ☒D	☐P ☐D	☐P ☐D	☐P ☐D	☐P ☐D
Snack	☐P ☐D	☐P ☐D	☐P ☐D	☐P ☐D	☐P ☐D
Catered meal	☐P ☐D	☐P ☐D	☐P ☐D	☐P ☐D	☐P ☐D

NHS Lothian

Emergency Department Care Rounding

(addressograph, or handwritten)

Name:

DOB:

Hospital no/CHI:

CARE ROUNDING					
Time of Round	357				
Clinical Area	14				
Care Round Leader's Initials	R				
Review Frequency of Vital signs and Cardiac Monitoring					
Vital signs frequency monitoring	12				
Visual Skin Inspection - tick one option per care rounding					
Patient is healthy - no concerns	✓				
Visible areas of redness					
Broken skin and evidence of pressure ulcers					
Is a Waterlow assessment required (AND COMPLETED)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Is pressure relieving equipment/mattress required?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Invasive Devices - please circle device used and tick if device in situ					
PVC/PVC insertion bundle completed	☐	☐	☐	☐	☐
Urinary catheter/catheter insertion bundle completed	☐	☐	☐	☐	☐
Infusion device	☐	☐	☐	☐	☐
NG tube / PEG tube / Tracheotomy	☐	☐	☐	☐	☐
Other:					
Vulnerable person/cognitive impairment					
Is a 4AT required?	✓ ☐ Y		☐ N		
Family Communication					
Patient and relatives present, and have been made aware	✓				
Cubicle Tidy					
Ensure area is tidy and free of obstructions	✓				

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

Patient Information

HELEN MCORMACK

Age/Gender:	68y Old Female
Address:	121 ROWAN STREET BLACKBURN BATHGATE.EH47 7ED
DOB:	01/04/1955
CHI:	
Ethnicity:	White Scottish

Date:	07/08/2023
Incident Number:	CR010065861
Incident Type:	EMG
Incident Location:	121 ROWAN STREET BLACKBURN BATHGATE, EH47 7ED

Scottish Ambulance Service

Presenting Complaint

LEFT SIDED RIB / CHEST PAIN

Additional Comments

O/a pt was complaining of leftsided rib/chest pain that was a sudden onset at 0930 hrs when at rest and pt thought this was the start of an angina attack as pt has had the same symptoms before and this was put down very mild angina and not given and meds to take pt has a non productive cough that's pt had for a few days and also had d/v due to eating a pizza lefts out an sea gulls got to it o/e full set of obs carried out and 12 lead ecg done pt chest sounds clear pt is a person that doesn't like to be fussed over and as she has never had pain like this before her daughter contacted the chemist for advice and they told her to phone 999

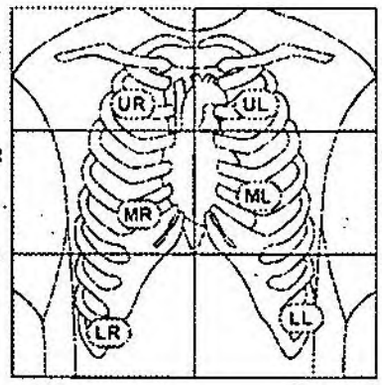
PATIENT ASSESSMENT

ACVPU Alert <C> No

A Clear

B Breathing Adequately: Yes — Chest Signs/Sounds: Cough

Respiratory Rate: 18 — SPO2: 99

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

C

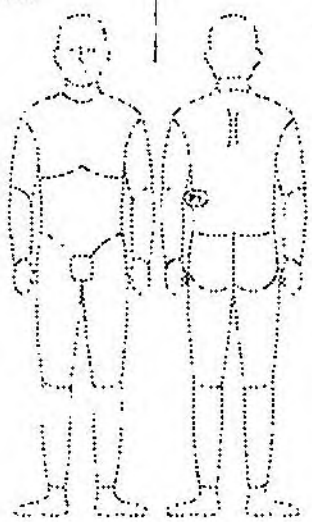
Pulse Rate	BP	Cap Refill	ECG Rhythm
104	102/76	>2 Secs	Sinus Tachy

Rhythm	Arm	Central/Peripheral	ECG
Reg	Right	Peripheral	12 Lead

D

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

E



Pain

ID	Body Part	Pain Scale
P1	Back Body	4

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
11:46	96	18	106/73	99	>2s	15	Alert		36.5	4.9	Sinus Rhythm				E1013203
11:41	92	18	102/76	99	>2 Secs	15	Alert		36.5	4.9	Sinus Rhythm				E1013203

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
11:46	18 (0)	99 (0)		0	106 (1)	96 (1)	Alert (0)	36.5 (0)	2
11:41	18 (0)	99 (0)		0	102 (1)	92 (1)	Alert (0)	36.5 (0)	2

HISTORY

AMPLE

Allergies	None
Medication	Citalopram
Past Medical History	Angina. EMPHYSEMA ANXIETY
Last Eaten	>4 Hours Ago
Events Prior	SUDDEN ONSET LEFTSIDED RIB PAIN

Social History

Lives alone	Yes	Patient Occupation	Does Not Work

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

SOCRATES

Site	LEFTSIDE RIB PAIN	Onset	WHEN AT REST, 07/08/2023, 09:30
Character	ACHE, Intermittent	Radiates	Yes, PT MIDDLE OF HER BACK
Exacerbating Or Relieving Symptoms	NONE	Severity	MILD

NHS LOTHIAN
Emergency Department

NHS Lothian

Adult Majors

Prescription, Administration & Observation Record

800130598V /E5431843 F
MCCORMACK Helen
01-Apr-55 **CHI:** 010 455 1062
78330 RH Parker
121 Rowan Street West Lothian
EH47 7ED

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

Previous Adverse Reactions		Weight	Date
	NKDA	kgs Actual / Estimate	

Once Only Prescription

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber Sign & Print	Time Given	Issued by (Initials)	Checked by if applicable (Initials)
7/8/23	12:33	GTN	2 Spray	Sublingual	TH	1235		

Discharge Medication

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

National Early Warning Score 2 (NEWS2) Chart

NEWS Key 0 1 2 3		Date:	12/8	13/8	16/8																
		Time:	0830		1615																
A+B Respirations Breaths/min		≥25									3										
		21-24									2										
		18-20																			
		15-17	16	15	19																
		12-14																			
		9-11									1										
		≤8									3										
A+B SpO_2 Scale 1 Oxygen saturation (%) Use Scale 1 if target range is 94-98%		≥96	91	96	95																
		94-95									1										
		92-93									2										
		≤91									3										
SpO_2 Scale 2* Oxygen saturation (%) Use Scale 2 if target range is 88-92% eg. in hypercapnic respiratory failure * **ONLY** use Scale 2 under the direction of a qualified clinician		≥97 on O_2									3										
		95-96 on O_2									2										
		93-94 on O_2									1										
		≥93 on air																			
		88-92																			
		86-87									1										
Tick box if using SpO_2 Scale 2 ☐		84-85									2										
Sign:		≤83									3										
Air or Oxygen? Oxygen is a drug and prescribed by target range		A = Air	A	A	A																
		O^2 L/min or %									2										
		Device																			
C Blood Pressure mmHg Score uses Systolic BP only If manual BP mark as M		≥220									3										
		201-219																			
		181-200																			
		161-180																			
		141-160																			
		121-140																			
		111-120																			
		101-110			135						1										
		91-100	99	99							2										
		81-90																			
		71-80																			
		61-70		65	66						3										
		51-60	50																		
		≤50																			
C Pulse Beats/min Manual pulse		≥131									3										
		121-130																			
		111-120									2										
		101-110																			
		91-100									1										
		81-90	86																		
		71-80			75																
		61-70																			
		51-60																			
		41-50									1										
		31-40									3										
		≤30																			
D Consciousness Score for new onset of confusion (no score if chronic)		Alert	A	A	A																
		New Confusion									3										
		V																			
		P																			
		U																			
E Temperature °c		≥39.1°									2										
		38.1-39.0°									1										
		37.1-38.0°		37.4	37.7																
		36.1-37.0°	37																		
		35.1-36.0°									1										
		≤35.0°									3										
NEWS TOTAL			2	2	2																
Monitoring frequency			C	1	12																
Escalation of care Y/N			Y	N	N/A																
Blood Glucose reading or N/A			/	/	/																
Pain score (0-10)			0	0	0																
Initials				JF																	

Reproduced from: Royal College of Physicians. *National Early Warning Score (NEWS) 2: Standardising the assessment of acute-illness severity in the NHS*. Updated report of a working party. London: RCP, 2017.

NEWS of 5 or more?
Think Sepsis!

In a patient with a **NEWS** of **5 or more** and a known infection, signs and symptoms of infection, or at risk of infection, think **'Could this be sepsis?'** and **escalate care immediately.**

Signs of Infection

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

Addressograph

Name:

DOB:

CHI:

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

*or increase in NEWS score of 2

Conscious Level Chart to be completed when clinically indicated

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

Pupil Scale mm 1 2 3 4 5 6 7 8

IV Fluid Prescription

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

Fluid Balance

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

Drug Infusion

Drug Name:

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

Drug Name:

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

NHS Lothian

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

Dr RH Parker
Ashgrove Group Practice
Blackburn Partnership Centre
Ashgrove
Blackburn
EH47 7LL

Date: 19/06/2024

Emergency Discharge Summary

Patient	Helen McCormack 121 Rowan Street Blackburn Bathgate West Lothian EH47 7ED	**CHI**	**0104551062**
		Date of Birth / Age	01/04/1955 (69 years)
		UHPI	800130598V
		A&E Attendance Number	E5725832
Attendance Date	17/06/2024	**Contact**	Garfoot Jane-Sarah 55 Rowan Street Blackburn Bathgate West Lothian EH47 7DZ 07597895067
Attendance Time	17:13		
Mode of Arrival	Emergency Ambulance		
Source of Referral	999 Emergency		
Discharge Date	18/06/2024		
Discharge To			

Dear Dr RH Parker

Presentation: Back pain, severe pain T2 lifting wheelie bin which fell over and landed on legs. Removed from legs instantly. C/O lower back pain, no neurological sx. News1 N Smart

CLINICAL NOTES:
Clinical note: 69F

Pulling a wheelie bin backwards down a step - fell backward with the bin landing on top of her.
Hit a concrete floor and complained of immediate pain in back
No other complaints

PMH
DH

OE ABC NAD - chest clear, abdo soft
GCS 15
No HI
Neck - no pain, no BT, FROM - cleared clinically
2 survey - log rolled - BT L3-5, Perianal sensation intact
UL NAD, FROM, no BT
LL NAD, FROM, no BT

Neuro - LL - No neurological deficit

Plain XR - L3 anterior wedge fracture
L4 - body fratture

For nursing flat
For CT L spine noted multiple lumbar spine #s - L4 involves 2 colums with 3mm retropulsion of fragment

M REED
ED CONSULTANT

Comment from neurosurgery
Thank you for the referral. Low-impact trauma with insufficiency fractures. No spinal precautions required. Recommend metabolic screen for osteoporosis in primary care. No admission indicated.

Asked nursing staff to mobilise patient - if fails admit AMU as an osteporotic compression # as per protocol
Managed on feet and still keen for home
Discharge with oramorph and advised ot FU with GP re bone protection etc

Yours Sincerely,

Professor Matthew J Reed , Consultant

NHS Lothian

ED/Medical Assessment Unit
Care Rounding

Nam
DOB:
Hospi

800130598V /E5725832 F
MCCORMACK Helen
01-Apr-55 CHI: 010 455 1062
78330 RH Parker
121 Rowan Street West Lothian
ED

Care Rounding Frequency	1 2 3 4 hourly *Circle as appropriate* *Review frequency 12 hourly or if clinical condition requires*				Date					
								17/6/24		
Print Name of the Nurse Reviewing										
Time of Round	23 LS									
Clinical Area	B1									
Care Round Leader's Initials	CS									
Review Frequency of Vital Signs & Cardiac Monitoring										
Vital Signs Frequency (please sign)										
signature										
Cardiac Monitoring required?	Y☐ N☑	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	
Pain Management (refer to doctor if analgesia is required)										
Pain score (0 – 10)	0									
Analgesia provided	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	
Medication										
Is person due any routine medication?	Y☐ N☑	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	
Mobility										
Fully weight bearing	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Requires some assistance/uses walking aid use Commode	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Non weight bearing – needs full assistance	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Identified as at risk of falls	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Elimination										
Ask patient if they require the toilet	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Patient is self-caring and can walk to toilet	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Patient is incontinent and requires assistance	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Patient has catheter in situ – checks required	☐	☐	☐	☐	☐	☐	☐	☐	☐	

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Nutrition and hydration									
Patient is self-caring	☑	☐	☐	☐	☐	☐	☐	☐	☐
Patient needs assistance with food/drink	☐	☐	☐	☐	☐	☐	☐	☐	☐
Patient is only allowed fluids	☐	☐	☐	☐	☐	☐	☐	☐	☐
Patient is NBM	☐	☐	☐	☐	☐	☐	☐	☐	☐
Patient has IVI in situ	☐	☐	☐	☐	☐	☐	☐	☐	☐
Fluid Balance Chart Updated	Y☐ N☐ N/A☐	Y☐ N☐ N/A☐	Y☐ N☐ N/A☐	Y☐ N☐ N/A☐	Y☐ N☐ N/A☐	Y☐ N☐ N/A☐	Y☐ N☐ N/A☐	Y☐ N☐ N/A☐	Y☐ N☐ N/A☐
Refreshments – Provided (P) / Refused (R)									
Drink	P☐ R☑	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐
Snack	P☐ R☑	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐
Catered meal	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐
Visual Skin Inspection									
Skin is healthy – no concerns noted	☐	☐	☐	☐	☐	☐	☐	☐	☐
Visible areas of redness	☐	☐	☐	☐	☐	☐	☐	☐	☐
Broken skin and evidence of pressure ulcers	☐	☐	☐	☐	☐	☐	☐	☐	☐
Is a Waterlow assessment required	Y☑ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
Is pressure relieving equipment/mattress required?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
Invasive Devices – please circle device used and tick if device in situ									
PVC	☐	☐	☐	☐	☐	☐	☐	☐	☐
PVC insertion bundle completed	Y☐ N☐								
Urinary catheter	☐	☐	☐	☐	☐	☐	☐	☐	☐
Catheter insertion bundle completed	Y☐ N☐								
Infusion device	☐	☐	☐	☐	☐	☐	☐	☐	☐
NG tube / PEG tube / Tracheotomy	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐	☐
Vulnerable Person/cognitive Impairment	Is a 4AT required Y☐ N☐								
Family Communication	Patient & relatives present, and have been made aware of any changes ☐								
Cubicle Tidy *Ensure area is tidy and free of obstructions*	☑	☐	☐	☐	☐	☐	☐	☐	☐

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

WRITE, IMPRINT OR ATTACH LABEL

Surname: _____ CHI No: _____

Forenames: _____ Sex: ____

DoB: _____

Location: _____

NHS Lothian

Adapted Waterlow Pressure Area Risk Assessment Chart

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

		Scoring			
Date:		17/6/12			
Initials:		CS 2215			
Time:					
Sex					
• Male	1				
• Female	2	2			
Age					
• 14–49	1				
• 50–64	2				
• 65–74	3	3			
• 75–80	4				
• 81+	5				
Build/Weight for Height (BMI=weight in Kg/height in m²)					
• Average – BMI 20-24.9	0				
• Above average – BMI 25-29.9	1				
• Obese – BMI > 30	2				
• Below average – BMI < 20	3	3			
Continence					
• Complete/catheterised	0				
• Incontinent urine	1				
• Incontinent faeces	2				
• Doubly incontinent (urine & faeces)	3				
Skin Type - Visual Risks Area					
• Healthy	0				
• Tissue paper (thin/fragile)	1	1			
• Dry (appears flaky)	1				
• Oedematous (puffy)	1				
• Clammy (moist to touch/pyrexia)	2				
• Discoloured (bruising/mottled)	3				
• Broken (established ulcer)	4				
Mobility					
• Fully mobile	0				
• Restless/fidgety	1				
• Apathetic (sedated/depressed/reluctant to move)	2				
• Restricted (restricted by severe pain or disease)	3	3			
• Bedbound (unconscious/unable to change position/traction)	4				
• Chair bound (unable to leave chair without assistance)	5				
Nutritional Element					
• Unplanned weight loss in past 3-6 months					
• < 5% Score 0, 5-10% Score 1, >10% Score 2	0-2				
• BMI >20 Score 0, BMI 18.5-20 Score 1, BMI < 18.5 Score 2	0-2				
• Patient/client acutely ill or no nutritional intake > 5 days	2				
Special Risks - Tissue Malnutrition					
• Multiple organ failure/terminal cachexia	8				
• Single organ failure e.g. cardiac, renal, respiratory	5				
• Peripheral vascular disease	5				
• Anaemia = Hb < 8	2	1			
• Smoking	1				
Special Risks - Neurological Deficit					
• Diabetes/MS/CVA/motor/sensory/paraplegia Max 6	4-6				
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				
Special Risks - Medication					
• Cytotoxic, anti-inflammatory, long term/high dose steroid Max 4	4				
TOTAL SCORE		12			

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

p.t.o.

2

Adapted from tissueviabilityonline.com / version 2 November 2009

Date &Time	Score	Equipment in use	Comments	Signature
7/6/24	12	Trolley		ecb

NHS Lothian
University Hospital Services
Department of Emergency Medicine

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

NHS Lothian

A/E no.	E5725832
Previous no.	E5431843
UHPI no.	800130598V
CHI no.	0104551062

Patient Information

Surname	McCormack	Date of Birth	
Forenames	Helen	Age / Sex	01/04/1955
		69 Yrs	F
Address	121 Rowan Street Blackburn Bathgate, West Lothian		
Postcode	EH47 7ED	Telephone	07597895067
Contact Address	Garfoot, Jane-Sarah 55 Rowan Street Blackburn Bathgate EH47 7DZ	Telephone H W	
Complaint	fall	Allergies	

Attendances in last 12 months: 1 School :

General Practitioner

Address: RH Parker
Ashgrove Group Practice
Blackburn Partnership Centre
Ashgrove
Blackburn
EH47 7LJ
Telephone: 01506 657130

Date and Time of Attendance: 17/06/2024 17:13
Incident Date Time: 17/06/2024
Mode of Arrival: Emergency Ambulance
Source of Referral: 999 Emergency

Initial Triage Assessment

Presenting Complaint	
History of Presenting Complaint	
Assessment	

Nursing Observations & Assessments

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

Triaged By: Print Name: Signature: Triage Time:

Opp Care & Discharge Record

PVC Insertion - Please initial when complete

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

Blood Samples - Please tick all that apply

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

Additional Investigations

ECG - Please tick: Required ☐ Done ☐

Urinalysis - Please tick: Required ☐ Done ☐

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

X-Rays - Please tick

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

On Going Care Plan

Speciality Informed (enter time)

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

Bed Required: Yes ☐ No ☐

Transfer To: (Please tick if required)

WGH			
SJH			
Other (please state)			

Triaged To - Please tick

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

"What Happens To The Patient?"

Clinical Notes

Think:- Other Sources of Information:

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

Care Providers Name: _____ Signature: _____

L4 vwbl # L5

6/17/2024 Incident Number: CR011025113

Patient Information

HELEN MCCORMACK

Age/Gender: 69 years 2 months 18 days Old Female

Address: 121 ROWAN STREET BLACKBURN EH47 7ED

DOB: 01/04/1955

CHI: 0104551062

Ethnicity:

Date: 17/06/2024

Incident Number: CR011025113

Incident Type: EMG

Incident Location: ON THE PAVEMENT O/S 42 REDHOUSE PLACE BLACKBURN BATHGATE. EH47 7PY

Scottish Ambulance Service

Presenting Complaint

FALL

Additional Comments

999 call for 69yof fallen backwards while trying to pull bin up steps, injuring lower back. Pt tripped over step, has full recall of events, denies any head/chest/abdo injuries. C/o pain in lower back and left hip. o/a pt lying on left side, alert, no iwob, well perfused. o/e pt c/o 9/10 lumbar spine pain radiating across back to flanks. Denies and numbness/pain/pins and needles in legs. Chest clear, equal rise and fall of chest, no sob, no signs of chest wall injury. Abdo soft non-tender. Left hip pain on palpation - pain free once lying on back, normal flexion and extension of joint. No pelvic or long bone pain. No signs of head inj. Obs as documented. pt fully immobilised. 10mg iv morphine and entenox administered - pain improved to 4/10. 4mg iv ondansetron administered. pt transported to eri a/e

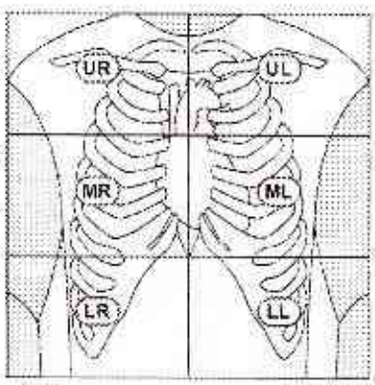
PATIENT ASSESSMENT

ACVPU Alert **<C>** No

A Clear

B **Breathing Adequately** Yes **Respiratory Rate** 20 **SPO2** 100

Oxygen Given No

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

C

Pulse Rate	BP	Cap Refill	ECG Rhythm
85	158/83	<=2 Secs	Sinus Rhythm

Rhythm	Arm	Central/Peripheral	ECG
Reg	Right		3 Lead

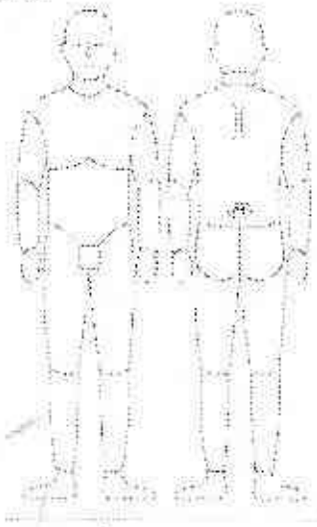
IV(R)

ACF

D

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

E



Pain

ID	Body Part	Pain Scale
P1	Back Body	9

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
17:00	74	18	142/87	94	<=2s	15	Alert		37.1		Sinus Rhythm				E1013769
16:30	80	20	134/95	94	<=2s	15	Alert		37.1		Sinus Rhythm				E1013769
16:15	90	20	166/84	95	<=2s	15	Alert		37.1		Sinus Rhythm				E1013769
15:55	85	20	158/93	100	<=2 Secs	15	Alert		37.1	5.9	Sinus Rhythm				E1013769

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
17:00	18 (0)		94 (0)	0	142 (0)	74 (0)	Alert (0)	37.1 (0)	0
16:30	20 (0)		94 (0)	0	134 (0)	80 (0)	Alert (0)	37.1 (0)	0
16:15	20 (0)	95 (1)		0	166 (0)	90 (0)	Alert (0)	37.1 (0)	1
15:55	20 (0)		100 (0)	0	158 (0)	85 (0)	Alert (0)	37.1 (0)	0

Drugs

Time	Drug	Dossge	Units	Route	Drug Expiry Date	Pain Before	Pain After	CrewID
15:55	Entonox		PRN	INH		9	7	E1013769
16:07	Ondansetron	4	mg	IV	11/2026			E1013769
16:10	Morphine	5	mg	IV	09/2026	9	6	E1013769
16:20	Morphine	5	mg	IV	09/2026	6	4	E1013769

HISTORY

AMPLE

Allergies	None
Medication	Citalopram
Past Medical History	COPD
Last Eaten	Unknown
Events Prior	69YOF FALLEN - BACK INJURY

Social History

Lives alone	Yes	Patient Occupation	Retired

Patients General Appearance	Normal
Patient Mobility	Fully Mobile
Patient Communication	No Help Required
Patient Clinical Risk Factors	Smoker

CLOSE RECORD

Treatment On Scene	Non-Emergency

Conveyance

Transport To Hospital	Emergency (Blue)	Pre-Alert	Yes	Patient Accompanied By	DAUGHTER

INCIDENT LOG

Time Call Received	15:29	Allocated	15:33	Mobile	15:35
First Resource On Scene		Crew On Scene	15:44	Crew Left Scene	16:42
Crew At Hosp		Receiving Hospital	NEW EDINBURGH ROYAL INFIRMARY	Clear Time	

Crew ID	Crew Grade	Driver
E9882130	Ambulance Technician	YES
E1013769	Paramedic	NO

RIE ED Pre-Alert

Keep original with notes

Patient details/sticker

Date: Time: Call sign: 367C

Age: 69 M ☐ F ☑

MEDICAL

Medical complaint:

TRAUMA

Time of incident: __ : __

Mechanism:
fall
standing

Injuries:
Back pain

STROKE

Onset time: __ : __

On waking? Y ☐ N ☐

Symptoms:

HELIPAD? S&R ☐ SAS ☐ Number of patients: Expected by:

Any infectious disease or decontamination concerns? Y ☐ N ☐

RR: 20
SpO2: 94
HR: 80
BP: 134/95

GCS: 15
BM:
Temp:
Rhythm:

Treatment:

Mechanical CPR: Y ☐ N ☐

Intubated: Y ☐ N ☐

ETA: 10 mins

Name:

PREPARATION Senior Doctor/NIC informed ☐

Trauma Team: ED ☐ Enhanced ☐ Code Red ☐

Stroke Team informed ☐ Radiology informed ☐ E-CPR Team informed ☐

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

NHS Lothian

Addressograph

800130598V /E5725832 F
MCCORMACK Helen
01-Apr-55 CHI: 010 455 1062
78330 RH Parker
121 Rowan Street West Lothian
EH47 7ED

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

Previous Adverse Reactions	Weight	Date
NKDA	kgs Actual / Estimate	17/6/24

Once Only Prescription

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber Sign & Print	Time Given	Issued by (Initials)	Checked by if applicable (Initials)
17/6	1945	Morphine (1-5mg) 5mg slow		IV		2000	PM	
17/6	2113	ONDANSETRON	4mg	IV		2140	BR	RCN

Discharge Medication

Date & Time	Medicine (Approved Name)	Dose	Frequency	Route	Quantity	Duration	Prescriber Sign & Print	Issued by (Initials)	Checked by (Initials)
0055	ONDANSETRON	4mg	BDS	ORAL		1 bottle		CE	

National Early Warning Score 2 (NEWS2) Chart

| NEWS Key 0 1 2 3 | | |

NEWS of 5 or more?
Think Sepsis!

In a patient with a **NEWS** of **5 or more** and a known infection, signs and symptoms of infection, or at risk of infection, think **'Could this be sepsis?'** and **escalate care immediately.**

Signs of Infection

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

Addressograph

Name:

DOB:

CHI:

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

*or increase in NEWS score of 2

Conscious Level Chart to be completed when clinically indicated

| | | |

IV Fluid Prescription

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

Fluid Balance

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

Drug Infusion

Drug Name:

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

Drug Name:

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