Legal Aspects Team
Health Records Department
Gartnavel General Hospital
1053 Great Western Road
Glasgow
G12 0YN

NHS
Greater Glasgow and Clyde

MMA Legal Ltd
23 Goodlass road
Building B
Speke Liverpool
L24 9HJ

Date: 14th July 2026
Your Ref: DSAR-20260625-8EC9B1
Our Ref: LAT/ACCESS/SB
Enquiries to: Samantha Barka
Direct Line: 0141 211 0151
Email: samantha.barka2@nhs.scot

Dear Sir/Madam

Re: Subject Access Request under the General Data Protection Regulation

Patient: BRIAN WHYTE **D.O.B: 31.03.1964**

Thank you for your request received 25th June 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
WEST AMBULATORY CARE HOSPITAL
NEW VICTORIA INFIRMARY

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
- Incident reports
- Complaints files

- Emails

The source of our data includes Patients, General Practitioners, Healthcare, Social and Welfare organisations, Legal representatives and Police forces.

We sometimes need to share the personal information we process with the individual themselves and also with other organisations as listed above. Where this is necessary we are required to comply with all aspects of the General Data Protection Regulation

Where these organisations are based outside Europe we take all appropriate safeguards to protect your information.

Health records are kept for a limited time and this is noted below for your information

- Adult general hospital records – six years after the date of last entry
- Maternity records – 25 years after the birth of the last child
- Children's and young people's records – until the child or young person's 25th birthday.
- Mental health records – 20 years after the date of the last contact

If you have any queries, please do not hesitate to contact us.

If you are unhappy with how your request has been dealt with please contact the NHSGGC Data Protection Officer. Their contact details are noted below:

Data Protection Officer
Information Governance Department
NHS GG&C – 2nd Floor
1 Smithhills Street
Paisley
PA1 1EB
Email: data.protection@ggc.scot.nhs.uk

Yours sincerely

Legal Aspects Team

ELECTRONIC 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 CARE AMBULATORY HOSPITAL	☑		
WESTERN INFIRMARY RECORDS	☐		

Including:

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

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name	
Address	3103646054 WHYTE M Brian 31/03/1964 FLAT 2-3 133 KINNELL AVE Glasgow, Lanarkshire
CHI No.	G52 3RT
DoB	

	Date	Ward
Admitted		
Transferred		
Transferred		

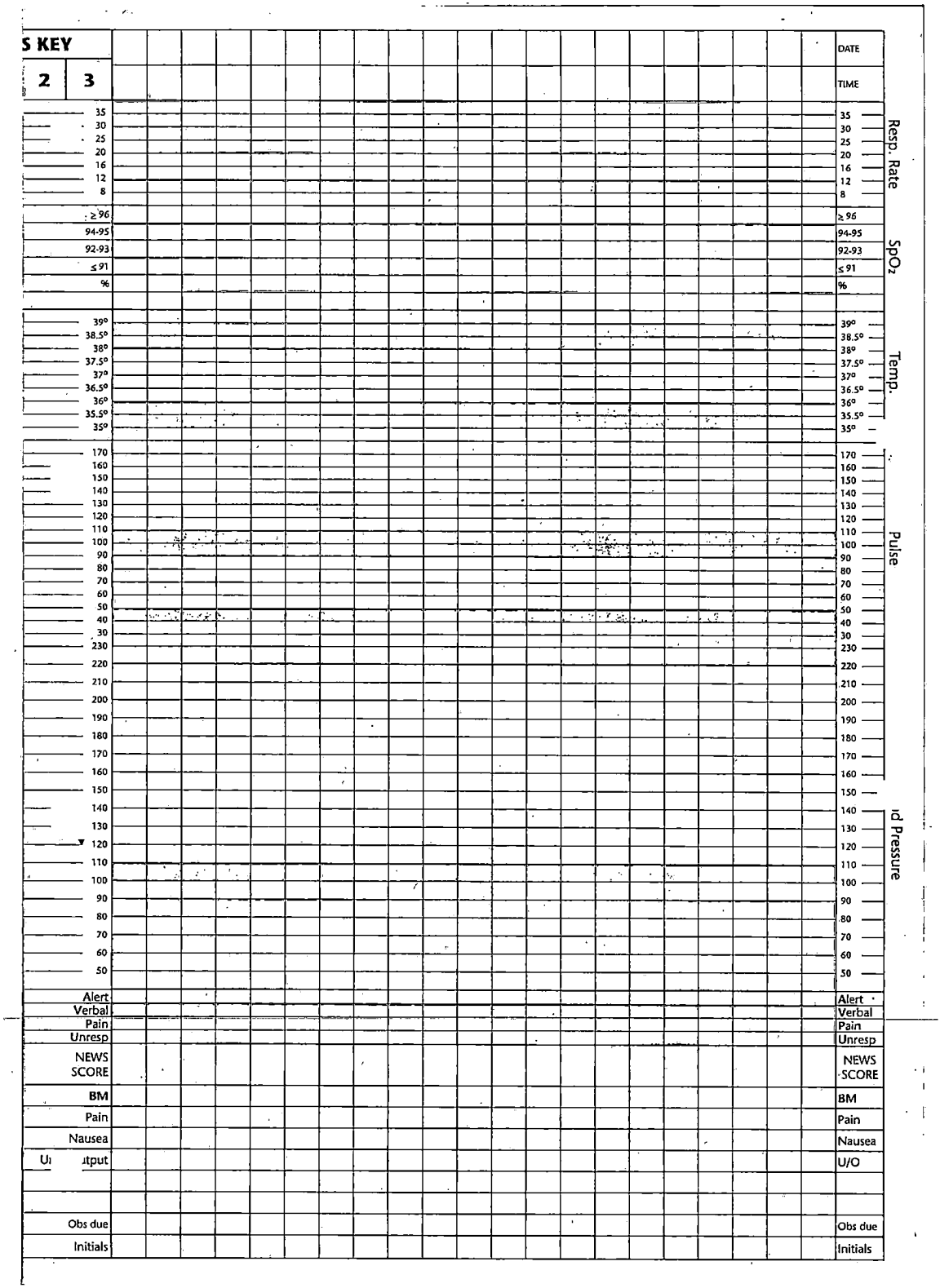
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.

| | | |


S KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
Blood Pressure
140
130
120
110
100
90
80
70
60
50
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Glasgow Coma Scale

Pupil size (mm): 1 2 3 4 5 6 7 8

AFFIX PATIENT ID

Neurological Observations

Date:																									
Time:																									
COMA SCALE	E Eyes open	Spontaneously	4																						Eyes closed by swelling = C
		To speech	3																						
		To pain	2																						
		None	1																						
	V Best Verbal response	Orientated	5																						Endotracheal tube or tracheostomy = T
		Confused	4																						
		Inappropriate words	3																						
		Incomprehensible sounds	2																						
		None	1																						
	M Best motor response	Obeys	6																						Usually record the best arm response
		Localises	5																						
		Flexion - withdrawal	4																						
		Flexion - abnormal	3																						
		Extension to pain	2																						
		None	1																						
	TOTAL SCORE																								
PUPILS	R	Size																							+ reacts – no reaction c. eyes closed
		Reaction																							
	L	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																							
		Spastic flexion																							
		Extension																							
		No response																							
	LEGS	Normal power																							
		Mild weakness																							
		Severe weakness																							
		Spastic flexion																							
		Extension																							
		No response																							

Pain Score

Ask the patient to rate his/her pain by choosing a number between 0 and 10. Use the diagram below to assist the patient. If patient's pain is chronic, use generic tool. If patient is unable to communicate, use observational tool.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Severe Pain			

Nausea and Vomiting	
0	= None
1	= Mild (*Not distressing – no retching/vomiting*)
2	= Moderate (*Troublesome – occasional retching/vomiting*)
3	= Severe (*Distressing – frequent retching/vomiting*)

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

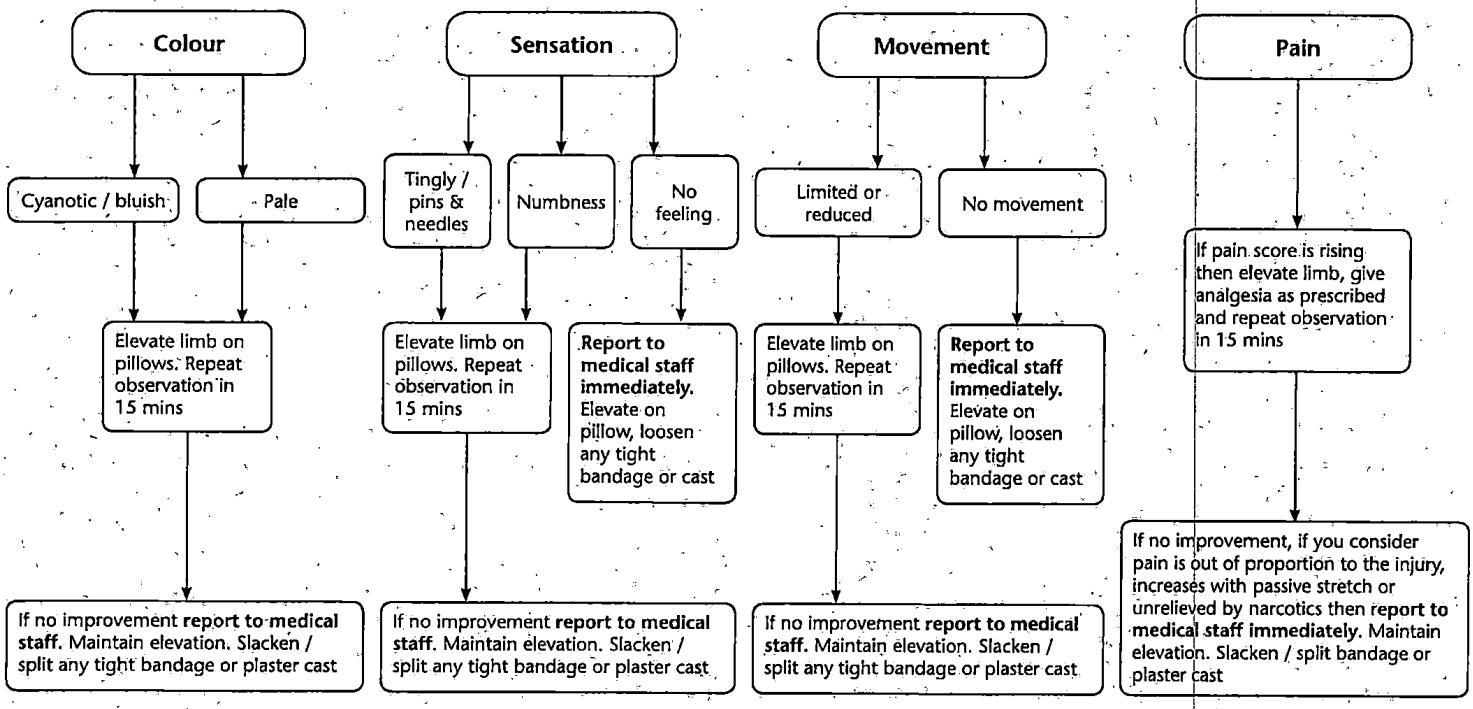
Neurovascular Assessment Chart

NHS Greater Glasgow and Clyde

Identification Label:	Consultant:
3103646054 WHYTE M Brian 31/03/1964 FLAT 2-3 133 KINNELL AVE Glasgow, Lanarkshire G52 3RT	Diagnosis / Injury / Operation (note any block): Area for Observation: LEFT / RIGHT (circle) If both limbs are affected use a separate chart for each limb

Date (every entry)		16/10/[illegible]									
Time (every entry)		1130	1220	1430							
Pain Score (1-10) Ask the patient to move fingers/hand/wrist or toes/foot. If unable then you should passively stretch the digits. Ask pt to score their pain level. See flow chart overleaf.		0	0	0							
Always compare with the unaffected limb											
Colour Observe colour of affected limb or digits	Normal for patient	✓	✓	✓							
	Cyanotic / bluish***										
	Pale***			✓							
Sensation Ask patient how the feeling is in the affected limb. Test all fingers or toes for feeling when you touch them and ask patient again.	Normal										
	Tingly / pins and needles ***	✓	✓								
	Numb ***										
	No feeling ***										
Movement As for pain score - ask patient to move fingers/hand/wrist or toes/foot. Assess the movement.	Normal range of movement										
	Limited or reduced movement ***	✓	✓	✓							
	No movement ***										
Initials (every entry)		M	M	M.							

***These may be signs of abnormalities, take appropriate action, follow algorithm. Document all actions taken in the space below


Colour
Cyanotic / bluish
Pale
Elevate limb on pillows. Repeat observation in 15 mins
If no improvement **report to medical staff.** Maintain elevation. Slacken / split any tight bandage or plaster cast
Sensation
Tingly / pins & needles
Numbness
No feeling
Elevate limb on pillows. Repeat observation in 15 mins
Report to medical staff immediately. Elevate on pillow, loosen any tight bandage or cast
If no improvement **report to medical staff.** Maintain elevation. Slacken / split any tight bandage or plaster cast
Movement
Limited or reduced
No movement
Elevate limb on pillows. Repeat observation in 15 mins
Report to medical staff immediately. Elevate on pillow, loosen any tight bandage or cast
If no improvement **report to medical staff.** Maintain elevation. Slacken / split any tight bandage or plaster cast
Pain
If pain score is rising then elevate limb, give analgesia as prescribed and repeat observation in 15 mins
If no improvement, if you consider pain is out of proportion to the injury, increases with passive stretch or unrelieved by narcotics then **report to medical staff immediately.** Maintain elevation. Slacken / split bandage or plaster cast

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

3103646054 WHYTE M Brian 31/03/1964 FLAT 2-3 133 KINNELL AVE Glasgow, Lanarkshire G52 3RT	Hospital: GGH Ward: 2A	**Points to consider:** • **Use within 6 hrs of admission to care area** • **Re-assess daily and more frequently if a person's condition changes**

1 **Pressure Damage**	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY Active Care to avoid further damage occurring and complete the pressure ulcer interventional plan overleaf.

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2 Mobility	Does the person require assistance to mobilise?
3 Continence	Does the person have continence issues with urine and/or faeces?
4 Nutrition	Does the person appear malnourished and/or unable to eat or drink?
5 Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?
6 Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY Active Care interventions and complete the pressure ulcer interventional plan overleaf.

If NO to all statements, continue Active Care Prescribing as assessed for individual need and re-assess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
16/10/19	08:00	N	N	N	Y	N	Y	3 hrly	Em.
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	

Complete prevention of pressure ulcer interventional plan overleaf for all patients with redness/pressure damage and for those at risk.

Prevention of Pressure Ulcer Inter[illegible]ntional Plan

NHS Greater Glasgow and Clyde

3103646054
WHYTE M
Brian 31/03/1964
FLAT 2-3
133 KINNELL AVE
Glasgow, Lanarkshire
G52 3RT

Aim: To incorporate effective pressure ulcer prevention strategies to reduce/eliminate potential for pressure ulcer development.

Outcome: To prevent pressure ulcer development through establishment of effecting work practices in line with SSKINS bundle.

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCONTINENCE / MOISTURE	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of initial plan: 9AM 16/10/19	Check: • Pressure areas 3 hourly. • Skin under medical devices 3 hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition 3 hourly in bed and chair. • Overnight patient / carer has agreed to repositioning 3 hourly • Specify any manual handling equipment used:	• Skin care to be carried out 3 hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree plan with patient / family/ carer YES ☑ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	E M Date discontinued:
Date Reviewed:	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition ____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out ____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐	Date discontinued:
Date Reviewed:	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition ____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out ____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐	Date discontinued:

P[illegible]ient) Moving and Handling Assessment Form

3103646054 M
WHYTE 31/03/1964
Brian
FLAT 2-3
133 KINNELL AVE
Glasgow, Lanarkshire G52 3RT

Person's Name:	Named Nurse:	Person is totally independent (tick here and go to date box)
		✓

1. Gen[illegible]

Weight	Height
Kg	cm
BMI	

Problems with comprehension, behaviour, co-operation (specify):

Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):

Risk of Falls: Yes ☐ No ☐

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist ☐	Standaid ☐	Walking Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
Model		Aid Type	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist ☐	Standaid ☐	Walking Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information:	

4. Move on / off bed pan

Hoist ☐	Manoeuvre ☐	Assistance ☐	Supervision ☐	N / A ☐
See No 2 Sit to Stand Transfers for details	Roll patient ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information:	
	Monkey pole ☐			
	Independent bridging ☐			

5. Move up / down bed

Hoist ☐	Handling Aids ☐	Assistance ☐	Supervision ☐	Independent ☐
See No 2 Sit to Stand Transfers for details	Sliding sheets ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information:	
	Monkey pole ☐			
	Rope ladder ☐			

6. Lateral Transfer to / from trolley / bed

Hoist ☐	Handling Aids ☐	Assistance ☐	Supervision ☐	Independent ☐
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify) ☐			

7. Sit up over side of bed

Bed Rest ☐	Assistance ☐	Supervision ☐	Independent ☐
	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment ☐	Handling Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
Shower ☐	Shower chair ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath ☐	Shower trolley ☐			
Bed bath ☐	Bathing hoist (eg Atenti) ☐			

9. Walking

No Walking ☐	Walking Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
	see 'sit to stand transfers'	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	☐ / Forward slash	☐ X Where a forward slash exists, add a back slash to make a cross	☐ * Where a slash or cross exists add slashes to make a star
Date Assessed:	16/10/17		
Assessor's signature:	[signature]		
Proposed Review date:	2 days		

Continuation Sheet

1. General Information (Only complete this section if changed from over page)

Body Build		Problems with comprehension, behaviour, co-operation (specify):
Weight	Height	
Kg	cm	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
BMI		
Risk of Falls: Yes	No	

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 / 2 / ≥3	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 / 2 / ≥3	Additional Information:	

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N/A
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 / 2 / ≥3	Additional Information:	
	Monkey pole			
	Person bridges			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 / 2 / ≥3	Additional Information:	
	Monkey pole			
	Rope ladder			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 / 2 / ≥3	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify)			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 / 2 / ≥3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair	People: 1 / 2 / ≥3	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley			
Bed bath	Bathing hoist (eg Alenti)			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 / 2 / ≥3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	4th Assessment	5th Assessment	6th Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

3103646054 M
WHYTE 31/03/1964
Brian
FLAT 2-3
133 KINNELL AVE
Glasgow, Lanarkshire
G52 3RT

FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs of Admission and on Transfer to Another Ward

NHS Greater Glasgow and Clyde

GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

Action the following safety precautions on admission to your ward. Update weekly or on change of condition.

	Ward: 2A Date: 16/10/17 Time: 08:00	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	✓				
2. Check walking aid (if required) is in reach and in use.	N/A				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	✓				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	✓				
5. If glasses are worn, check they are available and in use.	N/A				
6. If hearing aid/s are worn, check they are working and in use.	N/A				

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).
Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.
ALL patients in older people's wards must have an interventional plan in place (overleaf)

Tick Yes or No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has the patient fallen in the last 6 months – including during this admission?										
2. Does the patient have cognitive impairment or a possible delirium?										
3. Does the patient attempt to walk alone although unsteady or unsafe?										
4. Does the patient or their relative have a fear or anxiety of the patient falling?										
5. Based on your clinical judgement, is this patient at high risk of falling?										
Signature of nurse completing assessment / update										

Highlight risk of fall at the ward safety brief.

Patient Details

FALLS INTERVENT N CHECKLIST

NHS Greater Glasgow and Clyde

Complete for all patients identified at risk of falling.

	Ward: Date: Time: -----:------	Ward: Date: Time: -----:------	Ward: Date: Time: -----:------	Ward: Date: Time: -----:------	Ward: Date: Time: -----:------
BED AND SEATING					
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)					
Assess if a low bed is required (Patient care plan 9)					
SAFETY					
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)					
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)					
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.					
HEALTH					
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)					
Document continence problems and link to care rounding (Patient care plan 6)					
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)					
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.					
COMMUNICATION					
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)					
Update the ward team of the patient's mobility status. (Patient care plan 8)					
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)					
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)					
Signature of nurse completing interventional plan / or update					

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team

EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

NHSGGC Bedrail Risk Assessment

This Risk Assessment Tool is an aide memoire for staff. It should be used in conjunction with the Bedrail Guidance (see reverse) and Guidelines for Falls Prevention and Management (Adults).

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT

Patient Name:

CHI Number:

3103646054
WHYTE
Brian
FLAT 2-3
133 KINNELL AVE
Glasgow, Lanarkshire
G52 3RT
M
31/03/1964
IW

Use guidance on the reverse of this document when completing this Risk Assessment	DATE	16/10/19							
	TIME	0800							
	WARD	23							
	HOSPITAL	EGH							
SECTION ONE – GENERAL		**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**
1	Is the patient likely to fall, roll, slip or slide from the bed?		✓						
2	Has the patient requested the use of bedrails?		✓						
IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED									
SECTION TWO – COGNITIVE AND PHYSICAL STATUS									
3	Is the patient at risk of climbing out of bed?								
4	Is the patient stressed, delirious or restless?								
5	Is the patient small in stature?								
6	Does the patient have an unusually large or small head that might present an entrapment issue?								
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?								
IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
SECTION THREE – COMMUNICATION									
8	Has the patient been consulted regarding the use of bedrails?								
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition								
10	Has the use of bedrails been discussed with relatives/carers?								
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?								
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?								
IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
SECTION FOUR – DECISION MAKING		**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**
13	(Post op only) Will bedrails be used for this patient at the present time?	✓							
14	Rationale for use of bedrails: (Please insert code in the box on the right)								
	A – Risk of falling from the bed								
	B – Risk of rolling from the bed								
	C – Risk of slipping from the bed								
	D – Risk of sliding from the bed								
	E – Patient request								
15	Bedrail risk assessment completed by:	[signature]							
16	Bedrails checked by:								
17	Date	16/10/19							

Any issues relating to the use of bedrails including discussion with family/relatives/carers should be recorded here

A. Alternatives to bed rails:-

- Move the patient to a more observable area
- Increase patient observation
- Ensure the bed is returned to the lowest height appropriate to the patient needs, after care delivery
- Ensure patient needs are anticipated e.g. drinks are accessible, regular toileting, call bell to hand
- Nursing patient on mattress on the floor should be the last resort, and safety checks should be made for hot pipes, trailing wires, electrical sockets etc
- A generic moving and handling assessment must be carried out for staff caring for patients nursed on mattress on the floor.
- Contact Hospital Falls team for advice where appropriate

B. If bedrails are to be used, please consider the following:-

Is patient:-

- Stressed, delirious or restless
- At risk of entrapment
- At risk of climbing over the top of the bed rail
- At risk of being psychologically affected by the use of the bed rail

C. Safe use and application of bedrails:-

- If bedrail is fitted and there is a gap between the lower rail and the mattress then a bedrail should not be used
- If the gap between the bars on the bedrail is greater than 12cm then a bedrail should not be used
- If the bedrail moves away from the side of the mattress then a bedrail should not be used
- If the gap between the bedrail and the headboard is between 6cm and 25cm then a bedrail should not be used
- If the gap between the bedrail and the footboard is between 6cm and 25cm then a bedrail should not be used
- If the bedrail has not been fitted correctly then the bedrail should not be used
- If the bedrail is not secure then the bedrail should not be used
- If the bedrail is not compatible with the frame it will be fitted to then a bedrail should not be used
- If the bedrail is not in good working order then the bedrail should not be used

D. Record keeping:-

All of the following should be recorded:-

- Date and time of assessment
- Bedrail information leaflet given to patient and-or next of kin
- Rationale for decision in care plan or in AWI treatment plan
- Where bedrails are considered appropriate and patient has declined their use
- Any other actions implemented
- Care planning should be reviewed and updated as per record keeping standards

Bedrail risk assessments should be made as follows:-

- On admission
- If patient's condition changes or fall / suspected fall from bed
- Daily/weekly depending on the patient's status

Care Rounds Checklist

Date: _____

Attach Addr...

3103646054
WHYTE
Brian
FLAT 2-3
133 KINNELL AVE
Glasgow, Lanarkshire
G52 3RT

M
31/03/1964

Ward:

NHS Greater Glasgow and Clyde

I have evaluated and deemed that the frequency of care delivery over the next work shift, **based on the patient's most critical need** should be every (please circle) 1hr 2hr (3hr) 4hr

1. Signed G.M... Name G MILHAM Designation SIN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

'Must dos' for t... ...e patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	08	00	14	30	13																	
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N		N		N																	
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N		N		N																	
S	3	**SKIN INSPECTION** Pressure areas checked:	ind	tl	I		I																	
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	int	to	I		I																	
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	C	Y		Y																	
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	/				/																	
		Chair Assist to walk or stand (W/ST)	C	p	C		W																	
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	ind		Ind		A																	
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	Y		N		N																	
		Drink taken?	N		Y		Y																	
		Food, snack, or supplement taken?	N		Y		Y																	
		Has oral hygiene been carried out as per care plan?	N		N		I																	
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y		Y		Y																	
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT				NT																	
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA				NA																	
		Care provider / role	SM SH		M SI		MM NM																	

Care Rounds Variance Sheet

Attach Addressograph Label
Ward:

NHS Greater Glasgow and Clyde

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

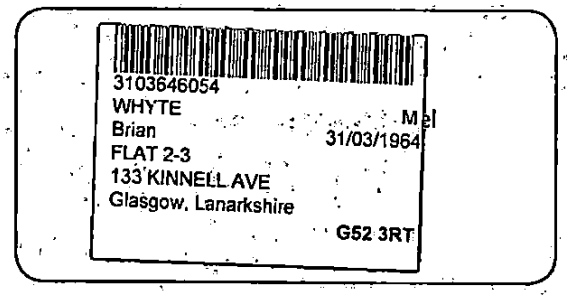
N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

278936 v2.1 • GGC0098

Acute Services Division

NHS Greater Glasgow and Clyde



MRSA Screening

Hospital: GGH

Ward: 2A

Date: 16/10/19

A. Clinical Risk Assessment (CRA) - for patients >23 hours	Yes	No	Not Known
1. Has the patient ever had a previous positive MRSA result?	☐	☑	☐
2. Has the patient been admitted from a care home / institutional setting or another hospital?	☐	☑	☐
3. Does the patient have a wound / ulcer or invasive device which was present prior to admission?	☐	☑	
If **'Yes'** to any question **or** if the patient is within (or admitted to) a High Impact Specialty* complete section B **('Not known' = 'No')**			
***** Orthopaedics / Vascular / Renal / Critical Care** (please circle)			

B. MRSA Swabs taken (✔):

Other(s) Throat -ve

Nose ☑

Perineum ☑

Patient refused ☐

NHS
Greater Glasgow and Clyde

23 HR

3103646054
WHYTE
Brian M
FLAT 2-3 31/03/1964
133 KINNELL AVE
Glasgow, Lanarkshire
G52 3RT

Additional Questionnaire	For use with 23 hour perioperative for ALL patients.		
	Yes	No	Specify
Current Medication			~~Amitriptyline~~ Buprenorphine
Breathing Problems		✓	
Epilepsy		✓	
Heart Condition		✓	
Hypertension		✓	
Any other current or previous medical history			Laperotomy hernia repair PTSD. Ex IVDA awaiting neuro review - ? Seizure.
Any other relevant information			

Has patient ever received healthcare in a hospital outside Scotland in the last 5 years, or been in close contact with someone known to be colonised with CPE.

NO

DO YOU HAVE ANY SWALLOWING DIFFICULTIES .....

NO

DO YOU HAVE ANY DIETARY REQUIREMENTS or food intolerances.....

NO

Do you have a supply of your own medication?

NURSE NAME	**Crystal Cooper**	**Patient's Name:**	Mr Brian Whyte
Date:	**11/12/2018**	**CHI Number:**	3103646054
OPD clinic			

YOU WILL BE OFFERED A DATE FOR YOUR OPERATION WITHIN 12 WEEKS OF GOING ON THE WAITING LIST, THIS MAY NOT BE WITH THE SURGEON WHO'S CLINIC YOU ATTENDED OR ON THE WEST HOSPITALS SITE. ALL PATIENTS WILL BE ADMITTED ON DAY OF SURGERY UNLESS FOR CLINICAL REASONS

QUESTION 1: Do you want to go on the waiting for surgery? *(YES / NO / need to think about it?)*	YES
QUESTION 2: Do you have holidays or commitments booked that would prevent you accepting a date for surgery in the next 9 weeks? If pt does not want surgery until after commitment advise that they will not be put on the W/L until after their return give secretary phone number ask to call on return (details)	NO
QUESTION 3: Do you have any problems with your teeth such as decay or abscesses? Any problems advise to see dentist. (details)	NO
QUESTION 4: Have you ever been diagnosed with high blood pressure? If yes, what high blood pressure medication do you take?	NO
QUESTION 5: Do you take any of the following? Warfarin, Clopidogrel, HRT, OCP ,or any diabetic medication? HbA1c if diabetic repeat blood if not done within 3mths or high at last testing (details)	NO
QUESTION 6: Are you currently being treated for an on going medical condition e.g. asthma, diabetes any cardiac issues, or have been referred by your GP to see a hospital specialist. (details)	NO
QUESTION 6: Do you have a skin condition, such as psoriasis, or any break in your skin on the limb, or area, of your planned surgery? (details)	NO

An excessive BMI is a risk factor for orthopaedic surgery and you will be advised today if your BMI makes you unfit to be listed for surgery until weight loss brings your BMI to within an acceptable level.
When you receive a date for Pre Operative Assessment please contact the Pre Op team if you are unwell or have an infection and they will advise you whether to attend or give you a new date. This will save you a wasted journey and give someone else an opportunity to have surgery.

TO BE COMPLETED BY NURSE

BP 1)	106/54	**BP 2)**		**BP 3)**	
Height	174	**Weight (Kg)**	49.6	**BMI**	16.4
MRSA Screening:		NO	**Letter to GP**		NO
Patient Cancelled		NO	**Secretary Notified**		YES
Booklet issued (Hip, Knee etc..)		NO	**Is patient from Campbeltown? If so, needs medical clerk in from pre-op**		NO

Acute Services Division

Nursing Admission & Assessment

1. Admission

NHS Greater Glasgow and Clyde

late

3103646054
WHYTE
Brian
FLAT 2-3
133 KINNELL AVENUE
Glasgow, Lanarkshire
G52 3RT

M
31/03/1964

Hospital: QEUH	Ward: ARU2
Date of admission: 26/12/15	Time: 1240
Admitting Consultant:	Admitting Nurse: Bell.
Expected date of discharge: / /	

1. Patient Details

Preferred name: BRIAN WHITE	Next of Kin (NoK):
Age: 51	Relationship:
Religion:	NoK Address: 133 KINNELL AVENUE.
Telephone:	
GP:	NoK Telephone:
GP address:	NoK Aware of admission: ☐ Yes ☐ No
	Consent for information to be given to relatives: ☐ Yes ☐ No
	Nominated family contact:
	Telephone - Day:
GP telephone:	Telephone - Evening:

Is the patient a carer? ☐ Yes ☐ No If 'Yes' refer to Duty Social Worker if required: ☐ Referred ☐ Not required

Does the patient have an appointed Welfare Guardian / Power of Attorney? ☐ Yes ☐ No ☐ N/A

a. If 'Yes' please provide – Name: ..... Relationship: .....

Contact telephone number: .....

b. If 'Yes' does the patient have an 'Adult with Incapacity Section 47' certificate in place? ☐ Yes ☐ No ☐

If 'No' to 'b' please inform medical staff. Name of doctor informed: .....

2. Presenting Complaint / Diagnosis

Found unconscious lying over fence.
Hypothermic. GCS 7/15.

Why does the patient think they are in hospital? *Use patients own words:*

3. Allergies (including food allergies)

No known allergies: ☐

4. Observations

Cannard	Waterlow	MUST	Pulse	BP	Resp	SaO_2	Temp
			101	102/57	18	96%	35.9°C
Urinalysis:		AMT4 Score	BM	NEWS Score	Weight Estimated / Actual	Height Estimated / Actual	BMI
				6			

5. Current Medication

METHADONE.

Medicines reconciled on admission? ☐ Yes ☐ No

6. Relevant Past Medical History

7. Risk Assessment

MUST

1. Is the patient's BMI:
   > 20 ..... Score 0
   18.5-20 ..... Score 1
   <18.5 ..... Score 2
   Score ..... ☐
2. Has the patient had unplanned weight loss in the past 3-6 months?
   < 5% ..... Score 0
   5-10% ..... Score 1
   >10% ..... Score 2
   Score ..... ☐
3. If the patient is acutely unwell and there has been or is likely to be no food intake for > 5 days:
   Score = 2
   Not applicable: Score = 0
   Score ..... ☐

MUST Score: ☐

If score 1 or more, complete full Nutrition Profile

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

8. Cognitive Impairment

For all patients ≥ 65 years, ask the following 4 AMT questions:

1. How old are you? ..... years
2. What is your date of birth? / /
3. What is this place? .....
4. What year is it? .....

If the patient does not answer all questions correctly then refer to medical staff.

AMT Score: ..... out of 4

Name of Doctor informed (if required)

..... Grade .....

9. MRSA Screening / CJD / Healthcare outside Scotland

Will the patient be an inpatient >23 hours? ☐ Yes ☐ No If 'Yes' complete the following section.

1. Has the patient ever had a previous positive MRSA result? ☐ Yes ☐ No ☐ Not known
2. Has the patient been admitted from a Care Home/ institutional setting or another hospital? ☐ Yes ☐ No ☐ Not known
3. Does the patient have a wound / ulcer or invasive device which was present prior to this admission? ☐ Yes ☐ No ☐ Not known

If **'Yes'** to any of the above questions **OR** if the patient is admitted to a 'high impact speciality' e.g. **Orthopaedics, Vascular, Renal Unit, Critical Care – then obtain MRSA Swabs:**

☐ **Nasal** ☐ **Perineum** ☐ **Other - Specify:** ☐ **Patient refused**

CJD: Has the patient ever been contacted by Public Health and told that they are possibly at risk of CJD:

☐ Yes ☐ No If 'Yes' contact Infection Control Team. Infection Control Team contacted: ☐

Healthcare outside Scotland

Has the patient been transferred from, or received health care in, a hospital outside of Scotland in the last 12 months:

☐ Yes ☐ No If 'Yes obtain rectal swab and send to microbiology for CPE screen.

Rectal swab taken ☐ Patient refused ☐

10. Lifestyle

Smoking:
Does the patient smoke? ☑ Yes ☐ No
If 'Yes' how many per day:

Does the patient use nicotine replacement therapy? ☐ Yes ☐ No
Does the patient wish referral to Smoking Cessation Service?
☐ Yes ☐ No If 'Yes', date of referral: / /

Drugs: Does the patient use recreational drugs? ☑ Yes ☐ No If 'Yes' specify:

Alcohol (Men): How often do you have **8** or more drinks on one occasion:
☐ Never ☐ Less than monthly
☐ Monthly ☑ Weekly ☐ Daily or almost daily
If 'Monthly' or more then complete FAST Tool.

Alcohol (Women): How often do you have **6** or more drinks on one occasion:
☐ Never ☐ Less than monthly
☐ Monthly ☐ Weekly ☐ Daily or almost daily
If 'Monthly' or more then complete FAST Tool.

11. Admission Documentation Completed By

Name (Please PRINT): CLAIRE BELL	Signature: Claire Bell
Designation: STAFF NURSE	Date: 26.12.15

Acute Services Division

Nursing Admission & Assessment

2. Assessment

Hospital: QEUH	Ward: AKU2
Date of Assessment: 26/12/15	Time: 1300

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

1. Breathing and Circulation

Breathing:

- ☐ No symptoms or history of respiratory problems
- ☐ Dyspnoeic at rest
- ☐ Dyspnoeic on minimal exertion
- ☐ Dyspnoeic on maximum exertion
- ☐ Productive / non-productive cough evident
- ☐ Normally receives oxygen therapy

If 'Yes' provide details:

Circulation:

- ☐ No symptoms
- ☐ Known cardiac or circulatory problems

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial

2. Communication

Assessment of ability to communicate:

What language does the patient speak?:

.....

Interpreter: Required ☐ Not required ☐

If required, provide details and arrangement made:

.....

.....

Does the patient have:

a. Speech difficulties? ☐ Yes ☐ No

b. A learning disability e.g. Down's Syndrome?
☐ Yes ☐ No

If 'Yes' please specify:

.....

If 'Yes' contact Liaison Learning Disability Team.
Liaison Learning Disability Team contacted:
☐ Yes ☐ No

c. A learning difficulty e.g. dyslexia, dyspraxia?
☐ Yes ☐ No

If 'Yes' please specify:

.....

3. Senses

Senses:

Eyesight

- ☐ Normal vision
- ☐ Glasses – ☐ Distance ☐ Reading
- ☐ Prosthesis – ☐ Left ☐ Right
- ☐ Contact lenses
- ☐ Registered blind

Hearing

- ☐ Normal
- ☐ Hearing impaired
- ☐ Hearing aid – ☐ Left ☐ Right

4. Mental Status

Mental Status:

- ☐ Orientated
- ☐ Confused
- ☐ Distressed
- ☐ Aggressive /Abusive
- ☐ Unconcious

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial

5. Hydration and Nutrition

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

MUST Score: ..... If score is 1 or more, complete a Nutrition Profile.

Nutition Profile completed ☐ Yes ☐ No
If 'Yes' do not complete sections 5a to 5d.

- **If score is 0, reassess / screen patient in 7 days.**
- **Complete sections 5a to 5d.**

Date of reassessment: / /

5a 1. Food likes / dislikes:

5a 2. Fluid likes / dislikes:

5c. Help needed with eating and drinking:
☐ Yes ☐ No
If 'Yes' provide details:

5b. Cultural or religious diet needed (e.g. vegetarian, vegan, halal, kosher etc):
☐ Yes ☐ No
If 'Yes' specify diet needed:

5d. Texture Modified Diet needed?
☐ Yes ☐ No
If 'Yes' specify texture: A☐ B☐ C☐ D☐ E☐
Thickened Fluids required? ☐ Yes ☐ No
If 'Yes' specify stage required: 1☐ 2☐ 3☐

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial

6. Elimination

Continent:
☐ Bladder
☐ Bowel

Incontinent:
☐ Bladder
☐ Bowel

NHS GGC Stool Chart commenced:
☐ Required ☐ Not required

Long-term urinary catheter in situ? ☐ Yes ☐ No If 'Yes' – Size: ..... fg Make: .....
Date catheter last changed: / /

Continence assessment commenced:
☐ Yes ☐ No ☐ Not applicable

Containment products in use? Please specify:

☐ Bowels regular
☐ Constipated
☐ Diarrhoea / loose stools

Stoma: ☐ Yes ☐ No
If 'Yes' please specify and list appliances used:

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial

7. Personal Hygiene, Oral Health and Skin Assessment

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Personal hygiene:

☐ Self-caring and independent
☐ Requires assistance

Specify assistance if required:

Oral health:

Self-caring and independent ☐ Yes ☐ No
Does the the patient have a sore mouth ☐ Yes ☐ No
Does the patient have a non healing mouth ulcer ☐ Yes ☐ No

If the patient has a sore mouth or non healing mouth ulcer, refer to dentist (See StaffNet for dentist referral pathway) and implement Oral Care Bundle.

Oral Hygiene Care Bundle:

☐ Required ☐ Not required

Dentures:

☐ Not worn
☐ Upper set
☐ Lower set
☐ Full set
☐ Dentures with patient on admission

Skin assessment:

☐ Skin healthy with no evidence of damage
☐ Skin broken ☐ Skin oedematous ☐ Skin discoloured ☐ Skin clammy
If 'Yes' to any of the above, describe skin condition:

Wound Assessment Chart completed: ☐ Yes ☐ No ☐ Not applicable
Pressure ulcer evident: ☐ Yes ☐ No
If 'Yes' please identify Grade and record on Pressure Ulcer record sheet – Grade: .....

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

	Initial

8. Mobility

Patient fully mobile / independent? ☐ Yes ☐ No If 'No' complete Moving and Handling Assessment.

☐ Limited mobility
☐ Mobile with aid – Specify:
☐ Prosthesis – Specify:

Moving and Handling Plan commenced:

☐ Yes ☐ No

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

	Initial

9. Maintaining a Safe Environment

Pain status:

Does the patient have pain? ☐ Yes ☐ No
If 'Yes' record Pain Score on NEWS chart.

What makes their pain better? Please provide brief details:

Bed rail assessment completed: ☐ Yes ☐ No

Bed rails required:

☐ Required ☐ Not required

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

	Initial

0. Sleep and Rest

Sleep habits:

☐ Less than 8 hours ☐ Afternoon nap
☐ Morning nap

Sleep difficulties:

☐ None ☐ Disturbed
☐ Early wakening e.g. nocturia, insomnia

Medication required: ☐ Yes ☐ No

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

	Initial

1. Social Circumstances

☐ Employed ☐ Unemployed ☐ Retired
☐ Lives alone
☐ Lives with Family
☐ Friend
☐ Dependants
☐ Other: ☐ Nursing Home ☐ Residential

Current Care / Support arrangements:

☐ Social Services ☐ Unpaid carer e.g. family, friends
☐ Private Carers ☐ None

If support services in place, please provide details:

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

	Initial

Privacy, Dignity and Sexuality

Does the patient have issues related to privacy, dignity and/or sexuality that are relevant to admission? ☐ Yes ☐ No	If 'Yes' please provide brief details:

13. Spiritual Care

Is there anything with regard to faith or culture that we can support the patient with during their stay in hospital (e.g. prayer, meditation)? ☐ Yes ☐ No	If 'Yes' please provide brief details:
Is there anything causing the patient a lot of anxiety at the time of admission that staff should be aware of? ☐ Yes ☐ No	If 'Yes' please provide brief details:
Ask the patient: "Would you like the ward staff to arrange for a Hospital Chaplain to visit you while in hospital?" ☐ Yes ☐ No ☐ Not at this time	If 'Yes' please specify faith group:

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

14. Anticipatory Care
(This section is for patients thought to be in the last year of life, where appropriate and relevant)

Appropriate ☐ Not appropriate ☐

Is the **patient** aware of their:
Diagnosis? ☐ Yes ☐ No
Prognosis? ☐ Yes ☐ No

Is the **patient's family** aware of their:
Diagnosis? ☐ Yes ☐ No
Prognosis? ☐ Yes ☐ No

Preferred place of care:
Home: ☐ Hospital ☐ Hospice ☐

Preferred place of death:
Home: ☐ Hospital ☐ Hospice ☐

Current treatment – please identify (e.g. chemotherapy/ radiotherapy):

Other agencies involved in patient's care – please identify (e.g.) Marie Curie, MacMillan Nurses):

DNACPR order in place: ☐ Yes ☐ No
If 'Yes' are the patient's family and next of kin aware? ☐ Yes ☐ No

15. Admission Assessment Completed By

Name (Please PRINT): CLAIRE BELL

Signature: Claire Bell

Designation: STAFF NURSE

Date: 26·12·15

Clinical Notes

Date and Time	Notes	Name, Signature and Designation
26·12·15 1310	Admitted to ARU2 via A+E;	
	-Unknown male found	
	unresponsive hanging over	
	fence	
	-news=6, T=35·9°C, BP102/57,	
	HR=101, alert to pain. GCS 7/15	CLAIRE BELL
	-Awaits SHO clerk in.	Claire Bell S/N

Clinical Notes continue on next page

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Clinical Notes (continued)

Date and Time	Notes	Name, Signature and Designation
26/12/15	W2 s/c Dr KENNON, - E+D	
	- MOBILISE	
	- ? (H) LATER	
1830 26.12.15	Patients family here to take patient home.	Claire BELL/N

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name	
Address	3103546054 WHYTE Brian M 31/03/196 FLAT 2-3 133 KINNELL AVENUE Glasgow, Lanarkshire
CHI No.	G52 3RT
DoB	

	Date	Ward
Admitted		
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.

UNKNOWN
MALE

DATE: 26/1/
TIME: 12 50 16 53

DATE
TIME
NEW
0 1

Resp. Rate Mark: •
35 30 25 20 16 12 8
20 18

SpO_2 (Enter Value)
≥96 94-95 92-93 ≤91
97 96

Any Sup'l O_2 / Room air
% RA A

Temp. Mark: ×
39° 38.5° 38° 37.5° 37° 36.5° 36° 35.5° 35°
35.3°C

Pulse Mark: •
170 160 150 140 130 120 110 100 90 80 70 60 50 40 30
101
98

Blood Pressure Mark: ^ v
230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50

NEWS CORE using Systolic BP
112 102
68 57

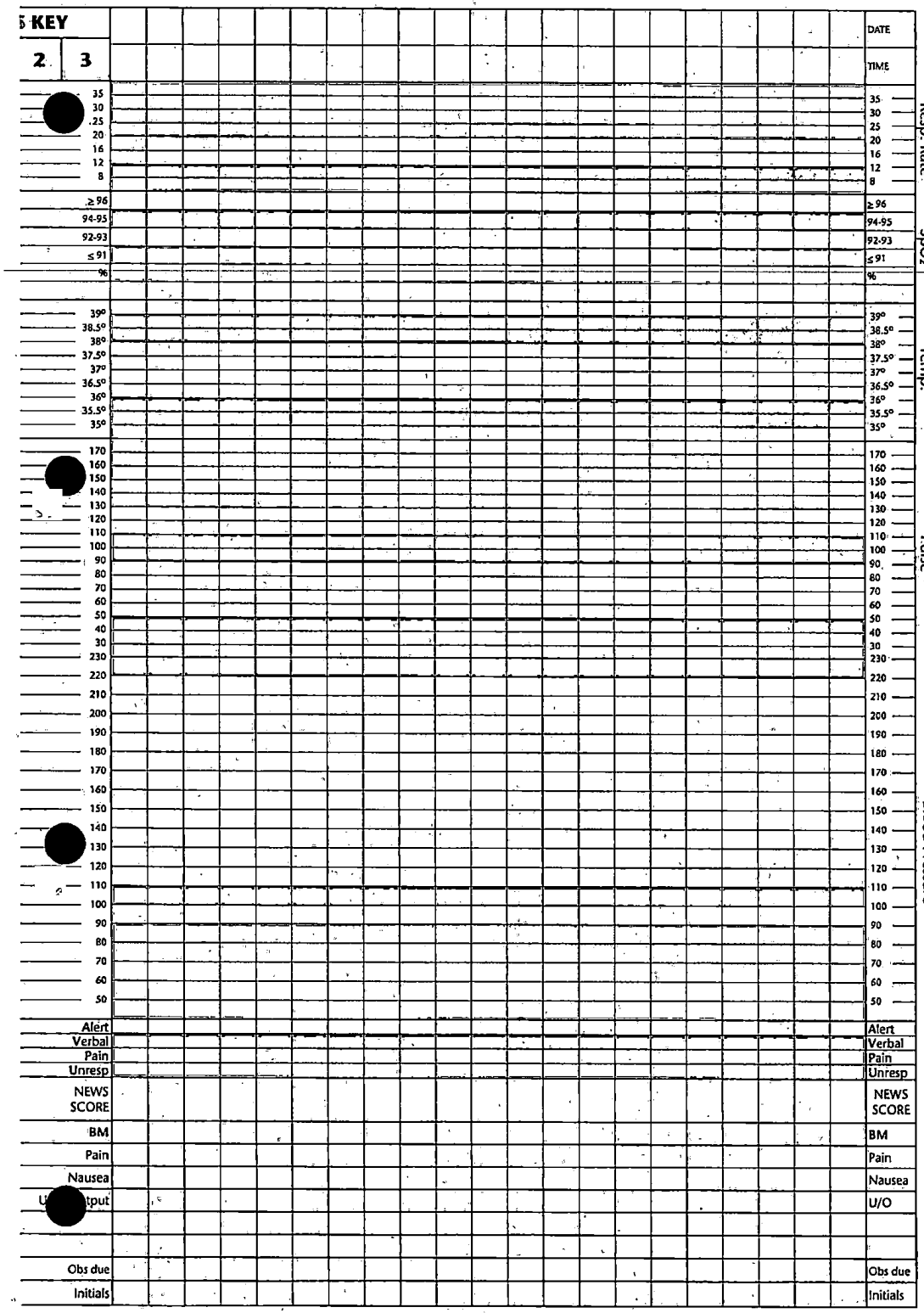
Conscious Level Mark: •
Alert
Verbal
Pain •
Unresp •

Total NEWS (with all obs)
4 6

BM 5.4
Pain ? ?
Nausea ? ?
Urine output ANRU NRU

Obs due
Initials RF CB

NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Neurological Observations

| | | |

Write or affix Name: L
Address:
3103646054
WHYTE
Brian
FLAT 2-3
133 KINNELL AVENUE
Glasgow, Lanarkshire
G52 3RT
M
CHI:
DOB: 31/03/1964
Hospital & ATU

Peripheral Vascular Cannula(PVC) Insertion & Maintenance

NHS Greater Glasgow and Clyde

Modified V.I.P (Visual Infusion Phlebitis) Score		
IV site appears healthy		No signs of phlebitis
One of the following is evident : slight pain or redness near site	1	Possible first signs : Observe cannula
Two or more of the following are evident: pain,redness,swelling	2	Early stage of phlebitis : Remove & resite cannula
All of the following are evident: pain,redness,hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis Remove & resite cannula Seek further advice
As above including: palpable venous cord	4	
As above including :pyrexia	5	

Insertion – Complete all sections

PVC inserted	Date inserted	Insertion site	Colour of PVC	Inserted by: Name & Designation *[only if inserted in ward]*
(ED) Theatre Ward_____	26·12·15	(R) wrist.	Green	Unknown.

Clinical indication	IV Fluids/IV Medication ☑	Urgent access ☑	Interventional procedures ☐	Other Please state:

Insertion Criteria (If no: please explain in comments below)	Clean field used Yes ☐ No ☐ Unknown ☐	Hand hygiene Yes ☐ No ☐ Unknown ☐	Skin asepsis Yes ☐ No ☐ Unknown ☐	Dressing affixed Yes ☐ No ☐ Unknown ☐	Non touch technique (do not re- contaminate cleaned skin) Yes ☐ No ☐ Unknown ☐

Maintenance – To be completed daily

PVC 1	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation Record VIP score	The PVC dressing is intact	The PVC has been inserted less than 72 hours	Hand hygiene before & after all procedures	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 2 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After day 3 consider removal, if there is still a clinical reason justify rationale for PVC to remain in situ.							
Day 4 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

Date removed_____ Reason for PVC removal_____ Reason PVC in greater than 72 hours_____

Date & time	PVC no.	Comments	Signature

CHI:	Modified V.I.P (VI ifusion Phlebitis) Score		
	IV site appears healthy	0	No phlebitis . Observe cannula
	One of the following is evident : slight pain or redness near site	1	Possible first signs : Observe cannula
	Two or more of the following are evident: pain,redness,swelling	2	Early stage of phlebitis - Remove & resite cannula
	All of the following are evident: pain,redness,hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis Remove & resite cannula Seek further advice
	As above including: palpable venous cord	4	
	As above including :pyrexia	5	

Insertion – Complete all sections

PVC inserted ED Theatre Ward_____	Date inserted	Insertion site	Colour of PVC	Inserted by: Name & Designation *[only if inserted in ward]*
Clinical indication IV Fluids/IV Medication ☐	Urgent access ☐	Interventional procedures ☐	Other Please state:	
Insertion Criteria (If no: please explain in comments below) Clean field used Yes ☐ No ☐ Unknown ☐	Hand hygiene Yes ☐ No ☐ Unknown ☐	Skin asepsis Yes ☐ No ☐ Unknown ☐	Dressing affixed Yes ☐ No ☐ Unknown ☐	Non touch technique (do not re- contaminate cleaned skin) Yes ☐ No ☐ Unknown ☐

Maintenance – To be completed daily

PVC 2	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation Record VIP score	The PVC dressing is intact	The PVC has been inserted less than 72 hours	Hand hygiene before & after all procedures	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 2 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After day 3 consider removal, if there is still a clinical reason justify rationale for PVC to remain in situ.							
Day 4 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

Date & time	PVC no.	Comments	Signature

Date removed_____ Reason for PVC removal_____ Reason PVC in greater than 72 hours_____

SOUTH GLASGOW HOSPITALS DIVISION SOUTHERN GENERAL HOSPITAL

N U R S I N G P R O F I L E

Name: BRIAN WHYTE Unit No: SG00731681 Acct No: IP0051427/11

Address: 45 CORNWALL ST
FLAT 0/2
GLASGOW
G41 1BA
Tel:

Consultant: BYRNE,JOHN
DOB: 31/03/64 Age: 47
CHI: 3103646054
Rel:

Ward: SCCU
Date: 30/09/11
Time: 0559
Marital Status: NK

Next of Kin: WILSON,ANNE
Address: 5 FAIRFIELD GARDENS
GLASGOW
Tel: 445 3094
Relationship: SIS

GP: FAWCETT, MARK M
Practice Address: MIDLOCK MEDICAL CENTRE
GLASGOW
G51 1SL
Tel: 0141-427-4271

Other Contact: WILSON,ANNE
Tel: 445 3094 Relationship: SIS

REASON FOR ADMISSION:- ? OVERDOSE

SHORT SUMMARY:- PT ?OD OF TRAMADOL AT HOME? UNSURE WHO CALLED AMBULANCE BROUGHT IN BY THEM DROWSY AND BEHAVING ERRATICLY DENIES DRUG/ALCOHOL ABUSE GCS13 IN A/E GIVEN NARCAN 800MCG IN TOTAL. SMALL LACERATION NOTED ABOVE R EYEBROW. VERY DROWSY ON ADMISSION.

PAST MEDICAL HISTORY	MEDICATIONS ON ADMISSION
- ?EX IVDA/PREV SMOKED HEROIN	1)NIL OF NOTE ?TRAMADOL
- THORACOTOMY SCAR, PREVIOUS STABBING	2)
-	3)
-	4)
-	5)
-	-

********** Allergies **********

NIL

****

ESTIMATED DATE OF DISCHARGE:

SOUTH GLASGOW HOSPITALS DIVISION SOUTHERN GENERAL HOSPITAL

N U R S I N G P R O F I L E

Name: BRIAN WHYTE Unit No: SG00731681 Acct No: IP0051427/11

GENERAL ASSESSMENT

> PT DROWSY ON ADMISSION, IV ACCESS INSITU WITH IV FLIUDS, GCS 8-9
SATS MAINTAINED

SOCIAL/HOME BACKGROUND

> NO HISTORY OBTAINED PT TOO MDROW

RELATIVES AWARE OF ADM Y/N?:- N Comment:

ACTIVITIES OF DAILY LIVING

MAINTAINING SAFE ENVIRONMENT: Cot Sides Required

COMMUNICATING: Unresponsive

BREATHING: Can Maintain Airway

EATING/DRINKING: Nil by Mouth

ELIMINATING:

CLEANSING/DRESSING: Assistance

TEMPERATURE: Apyrexial

MOBILISING: Bedrest

WORKING/PLAYING: Unemployed

SLEEPING:

DYING: Not Appropriate Discuss

SOUTH GLASGOW HOSPITALS DIVISION SOUTHERN GENERAL HOSPITAL

N U R S I N G P R O F I L E

Name: BRIAN WHYTE Unit No: SG00731681 Acct No: IP0051427/11

SKIN CONDITION: LARGR SCAR OVER CHEST LACERATION TO R EYE

Does patient smoke? Y
Does patient want to stop smoking NOW? N
Has patient been referred to `Stop Smoking Service'? N

BP:88/67 mmHG Pulse: 60 /min Resp: 13 /min SpO2: 99 % Temp: 36.2 C
Weight: Kg Height: ft. in / Metric: cm BM: BMI:
Waterlow Score: Urinalysis:

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

Completed By (Sign):_____

Completed by: GILLIAN SMITH on/at 30/09/11 0600 Report Number: 3009-0008

NHS Greater Glasgow and Clyde

Specialty: General Medicine

Nursing Admission Documentation eForm - Version 1.3

Hospital Name: Southern General Hospital

Patient Details		GP Details	
Name:	Brian, Whyte	**Name:**	FAWCETT, MARK
Address:	45 CORNWALL ST FLAT 0/2 Glasgow Lanarkshire	**Address:**	7 MIDLOCK STREET GLASGOW
Postcode:	G41 1BA	**Telephone:**	
Correspondence Address 1:		**Ward:**	20
Correspondence Address 2:		**Specialty:**	General Medicine
Correspondence Postcode:		**Date of Admission:**	25/10/2013
Telephone:		**Time:**	14:58
Patient Contact Number:		**Admitting Consultant:**	kennon
CHI Number:	3103646054	**Expected Date Of Discharge**	
CRN:	70635146W, SG00731681, SG00286043, SG03301660, TJ0	**Admitting Nurse:**	Laura Delaney
D.O.B:	31/03/1964	**Consent:**	Yes
Age:	49	**Sensitivity:**	Sensitive
Sex:	Male		

Next of Kin / Person to Notify

	Next of Kin		Person to Notify
Name:	anne wilson		
Address:			
Landline:	4453094		
Mobile:			
Relationship:	sister		
NOK aware of admission:	Yes	**Consent for information to be given to relatives:**	Yes
minated family contact - Day:		**Night:**	
Does the patient have an appointed Welfare Guardian / Power of Attorney?			No
		Is the patient a carer?	No

1. Presenting Complaint / Diagnosis

Found semiconscious in bushes. Hypothermic but able to give police and ambulance crew his name. GC 12/15 on admission to AE. Temp 34.4. Given warmed fluids and bairhugger applied. Verbal CT head NAD. Catheterised in AE. O/A to ward 20 - responding to voice, localising and making incomprehensible sounds. PEARL but pinprick pupils. Obs stable as charted, sats 100% on 3litres 02. Multiple areas of bruising and abrasions noted on generally over body and face. No dressings required as superficial in nature. IV fluids running from AE.

2.Patient Allergy Summary

3. Observations

Cannard:		**Pulse:**	58	**BP:**	120/61
Waterlow (if required):		**Resp:**	20	**SaO2:**	100
EWS:	0	**Temp:**	37	**BM:**	
Height(m):		**Weight(kg):**		**BMI:**	
Urinalysis:				**AMT4 Score:**	0

4 Current Medication

await kardex

Medicines reconciled on admission?	No

5 Relevant Past Medical History

unknown

6 Risk Assessment

Patient's BMI	> 20
Has the patient had unplanned weight loss?	5 - 10%
Will the patient have a significantly reduced diet intake over the next 5 days?	N/A
MUST Score	1
If MUST score 1 or more complete Nutrition Profile.	no

7 MRSA Screening

Has the patient ever had a previous positive MRSA result?	No
Has the patient been admitted from a care home/institutional setting or another hospital?	No
Does the patient have a wound/ulcer or invasive device which was present prior to admission?	No

s patient is to be admitted to any of the following:

thopaedics	No	Vascular	No	Renal	No	Critical Care	No

MRSA Lab Test Results

Nose	No	Perineum	No	Throat	No	Other	No	Patient refused	No

Other details:	
Has the patient ever been contacted by Public Health and told that they are possibly at risk of CJD?	No
Infection Control Team contacted?	No

8 Lifestyle

Does the patient smoke?			
Refer to smoking cessation clinic?		Referral made to Smoking Cessation Services?	No
Does the patient use recreational drugs?			
How often does patient have 8 or more drinks on one occasion?			
FAST Tool completed?			No

9 Admission Documentation completed by

Name:	Laura Delaney	Designation:	Registered Nurse	Date:	25/10/2013

Nursing Admission Assessment

1 Breathing and Circulation

Breathing

Symptoms or history of respiratory problems?	NA	Productive / non-productive cough evident?	NA
Dyspnoeic at rest?	NA	Dyspnoeic on minimal exertion?	NA
Dyspnoeic on maximum exertion?	NA	Normally receives oxygen therapy?	NA

Circulation

Symptoms?	NA	Known cardiac or circulatory problems?	NA

2 Communication and Mental Status

Assessment of ability to communicate:			
What language does the patient speak	english	Interpreter Required?	
Does the patient have:	Speech difficulties:	No	

	Learning difficulties (e.g. Down's syndrome):	No					
Eyesight							
Normal vision?	Yes	**Glasses?**	NA	**Distance?**	NA	**Reading?**	NA
Prosthesis?	NA	**Left:**	NA	**Right:**	NA		
Contact Lenses?	NA	**Registered Blind?**	NA				
Hearing							
Normal?	Yes	**Hearing impaired?**	NA				
Hearing Aid?	NA	**Left:**	NA	**Right:**	NA		
Mental Status							
Orientated?	NA	**Confused?**	NA	**Distressed?**	NA	**Unconscious?**	NA
Aggressive / Abusive	NA						

3 Hydration and Nutrition

Nutrition screening should be repeated in 7 days on the following date:	01/11/2013		
Nutrition screening required?	Required	**MUST Score:**	1

4 Elimination

Continent (Bladder):	Yes	**Continent (Bowel):**			Yes
Incontinent (Bladder):	NA	**Incontinent (Bowel):**			NA
Long term urinary catheter insitu?	No				
Continence assessment commenced?	No	**Specify any containment products in use:**			
Bowel regular?	Yes	**Constipated?**	NA	**Diarrhoea / loose stools?**	NA
Stoma:	No	**Specify and list appliances used:**			
Immediate Action Taken:	catheterised in AE				

5 Personal Hygiene, Oral Health and Skin Assessment

Personal Hygiene									
Self-caring and independent?	NA			**Requires assistance?**			Yes		
Oral Health									
Oral Care Bundle implemented?	NA								
Self-caring and independent?	No			**Evidence or oral ulceration,**					
Requires assistance?	Yes			**Oral Hygiene Care Bundle?**					
Dentures:	**Not Worn?**	NA	**Upper set?**	NA	**Lower set?**	NA	**Full set?**	NA	**With patient on admission?**	NA
Skin Assessment									
Healthy & Intact?	NA	**Broken?**	Yes	**Clammy?**	NA	**Discoloured?**	Yes	**Oedematous?**	NA
Describe Condition:	bruised and abrasions								
Wound Assessment Chart completed?	N/A			**Pressure ulcer evident?**					No
				Grade:					0

6 Mobility

Patient fully mobile/independent?	No	**Prosthesis?**	No
Limited Mobility?	Yes	**Mobile with aid?**	NA
Moving and handling plan commenced?	Yes		
Immediate Action Taken:	likely independently mobile if found wandering outside but restricted at present		

7 Maintaining a Safe Environment

Patient status			
Does the patient have pain?	No		
Bed rail assessment completed?	No	**Bed rails required?**	No

8 Sleep and Rest

Sleep Habits		Sleep Difficulties	
Less than 8 hours?	NA	None?	Yes
Morning nap?	NA	Early wakening?	NA
Afternoon nap?	NA	Disturbed e.g. nocturiapain?	NA
Medication required?	No		

9. Social Circumstances

Employed?	NA	Unemployed?	NA	Retired?	NA
Lives alone?	NA	Lives with family?	NA	Lives with friend?	NA
Lives with dependants?	NA	Nursing Home?	NA	Residential?	NA
Other?	NA	Other detail:			

Current care/ Support Service arrangements:			
Social Services?	NA	Private Carers (family/friends)?	NA
Unpaid carer?	NA	None?	Yes

10. Privacy, Dignity and Sexuality

Does the patient have issues related to privacy, dignity and / or sexuality that are relevant to admission?	No

11. Spiritual Care

Is there anything with regard to faith or culture that we can support the patient with during their stay in hospital (e.g. prayer, meditation)?	No	Details:	
Is there anything causing the patient a lot of anxiety at the time of admission that staff should be aware of?	No	Details:	
Did patient want ward staff to arrange for a hospital Chaplain to visit while in hospital?	No	Faith group:	

12. Anticipatory Care (where appropriate and relevant)

Is Appropriate?	Not appropriate

13. Action List

Action	Yes/No	Date
Waterlow completed?	NA	
Nutrition Profile Completed?	NA	
Infection Control Team contacted?	NA	
Referral made to Smoking Cessation Service?	NA	
Alcohol Screening and Assessment Tool completed?	NA	
Interpreter arranged?	NA	
Oral Care Bundle implemented?	NA	
Wound Assessment chart completed?	NA	
Pressure Ulcer Record completed?	NA	
Moving and handling plan completed?	Yes	25/10/2013
Bed rail assessment completed?	NA	
Current Care / Support arrangements suspended?	NA	
Referral to Duty Social Worker?	NA	

14. Admission Assessment Completed By

Name:	Laura Delaney	Designation:	Registered Nurse	Date:	25/10/2013

There is no further information for this patient

NHS Greater Glasgow and Clyde

Specialty: General Medicine

Nursing Admission Documentation eForm - Version 1.0 RC 0.1

Hospital Name: Southern General Hospital

Patient Details		GP Details	
Name:	Brian, Whyte	**Name:**	FAWCETT, Mark
Address:	45 CORNWALL ST FLAT 0/2 Glasgow Lanarkshire	**Address:**	7 MIDLOCK STREET GLASGOW
Postcode:	G41 1BA	**Telephone:**	
Correspondence Address 1:		**Ward:**	
Correspondence Address 2:		**Specialty:**	General Medicine
Correspondence Postcode:		**Date of Admission:**	28/07/2013
Telephone:		**Time:**	01:29
atient Contact Number:		**Admitting Consultant:**	
CHI Number:	3103646054	**Expected Date Of Discharge**	
CRN:	70635146W, SG00731681, SG00286043, SG03301660	**Admitting Nurse:**	Catherine Brady
D.O.B:	31/03/1964	**Consent:**	Yes
Age:	49	**Sensitivity:**	Sensitive
Sex:	Male		

Next of Kin / Person to Notify

	Next of Kin	Person to Notify
Name:		
Address:		
Landline:		
Mobile:		
Relationship:		
NOK aware of admission:	No	**Consent for information to be given to relatives:** Yes

Nominated family contact - Day:		**Night:**	
Does the patient have an appointed Welfare Guardian / Power of Attorney?			NA
		Is the patient a carer?	No

1. Presenting Complaint / Diagnosis

ADMITTED 3/7 AGO TO ORTHO WITH A SKULL BASE #. SELF DISCHARGED AS WORRIED ABOUT DOG. NOW COMPLAINING OF HAVING A HEADACHE FOR 24HRS. HAS VOMITTED TWICE AND IS COMPLAINING OF NECK STIFFNESS. HAS BEEN HAVING EPISODES OF HAEMOPTYSIS. ALSO STATES HAS BEEEN HAVING BILATERAL ANTERIOR CHEST PAINS.

2.Patient Allergy Summary

3 Observations

Cannard:		**Pulse:**	82	**BP:**	106/60
Waterlow (if required):		**Resp:**	16	**SaO2:**	98
EWS:	0	**Temp:**		**BM:**	
Height(m):		**Weight(kg):**	54	**BMI:**	
Urinalysis:				**AMT4 Score:**	0

4 Current Medication

CO-CODAMOL

Medicines reconciled on admission?

Relevant Past Medical History

PREVIOUS HEROIN SMOKER- NEVER INJECTED.
STABBED 14 TIMES IN 2010

6 Risk Assessment

Patient's BMI	18.5 - 20
Has the patient had unplanned weight loss?	5 - 10%
Will the patient have a significantly reduced diet intake over the next 5 days?	
MUST Score	2
If MUST score 1 or more complete Nutrition Profile.	yes

7 MRSA Screening

Has the patient ever had a previous positive MRSA result?	No
Has the patient been admitted from a care home/institutional setting or another hospital?	No

Does the patient have a wound/ulcer or invasive device which was present prior to admission?	No

Has patient is to be admitted to any of the following:

Orthopaedics	No	Vascular	No	Renal	No	Critical Care	No

MRSA Lab Test Results

Nose	No	Perineum	No	Throat	No	Other	No	Patient refused	No

Other details:	
Has the patient ever been contacted by Public Health and told that they are possibly at risk of CJD?	
Infection Control Team contacted?	No

8. Lifestyle

Does the patient smoke?	Yes	How many each day?	20
Refer to smoking cessation clinic?	Yes	Referral made to Smoking Cessation Services?	No
Does the patient use recreational drugs?			
How often does patient have 8 or more drinks on one occasion?			Less than Monthly
FAST Tool completed?			No

9 Admission Documentation completed by

Name:	Catherine Brady .	Designation:	Registered Nurse	Date:	28/07/2013

Nursing Admission Assessment

1 Breathing and Circulation

Breathing

Symptoms or history of respiratory problems?	Yes	Productive / non-productive cough evident?	NA
Dyspnoeic at rest?	NA	Dyspnoeic on minimal exertion?	NA
Dyspnoeic on maximum exertion?	Yes	Normally receives oxygen therapy?	NA

Circulation

Symptoms?	NA	Known cardiac or circulatory problems?	NA
Immediate Action Taken:	COMMENCED ON 28% O2 THERAPY IN A+E		

2 Communication and Mental Status

Assessment of ability to communicate:

What language does the patient speak	ENGLISH	Interpreter Required?	

Does the patient have:	Speech difficulties:				No		
	Learning difficulties (e.g. Down's syndrome):				No		
Eyesight							
Normal vision?	Yes	**Glasses?**	NA	**Distance?**	NA	**Reading?**	NA
Prosthesis?	NA	**Left:**	NA	**Right:**	NA		
Contact Lenses?	NA	**Registered Blind?**	NA				
Hearing							
Normal?	Yes	**Hearing impaired?**	NA				
Hearing Aid?	NA	**Left:**	NA	**Right:**	NA		
Mental Status							
Orientated?	Yes	**Confused?**	NA	**Distressed?**	NA	**Unconscious?**	NA
Aggressive / Abusive	NA						

3. Hydration and Nutrition

Nutrition screening should be repeated in 7 days on the following date:			04/08/2013
Nutrition screening required?	Required	MUST Score:	2

4. Elimination

ıntinent (Bladder):	Yes	**Continent (Bowel):**			Yes
Incontinent (Bladder):	NA	**Incontinent (Bowel):**			NA
Long term urinary catheter insitu?	NA				
Continence assessment commenced?	NA	**Specify any containment products in use:**			
Bowel regular?	Yes.	**Constipated?**	NA	**Diarrhoea / loose stools?**	NA
Stoma:	No	**Specify and list appliances used:**			

5. Personal Hygiene, Oral Health and Skin Assessment

Personal Hygiene			
Self-caring and independent?	Yes	**Requires assistance?**	NA
Oral Health			
Oral Care Bundle implemented?	NA		
Self-caring and independent?	Yes	**Evidence or oral ulceration,**	
Requires assistance?	No	**Oral Hygiene Care Bundle?**	

Dentures:	**Not Worn?**	Yes	**Upper set?**	NA	**Lower set?**	NA	**Full set?**	NA	**With patient on admission?**	NA
Skin Assessment									
Healthy & Intact?		Yes	**Broken?**	NA	**Clammy?**	NA	**Discoloured?**	NA	**Oedematous?**	NA
Wound Assessment Chart completed?					No		**Pressure ulcer evident?**			No
							Grade:			0

6 Mobility

Patient fully mobile/independent?	Yes	**Prosthesis?**			
Limited Mobility?	NA	**Mobile with aid?**	Yes	**Specify:**	2 STICKS
Moving and handling plan commenced?					

7 Maintaining a Safe Environment:

Patient status			
Does the patient have pain?	No		
Bed rail assessment completed?	No	**Bed rails required?**	No

8 Sleep and Rest

Sleep Habits		**Sleep Difficulties**	
Less than 8 hours?	Yes	**None?**	NA
Morning nap?	NA	**Early wakening?**	NA
Afternoon nap?	NA	**Disturbed e.g. nocturiapain?**	NA
Medication required?			

9 Social Circumstances

Employed?	NA	**Unemployed?**	NA	**Retired?**	NA
Lives alone?	Yes	**Lives with family?**	NA	**Lives with friend?**	NA
Lives with dependants?	NA	**Nursing Home?**	NA	**Residential?**	NA
Other?	NA	**Other detail:**			

Current care/ Support Service arrangements:

Social Services?	NA	**Private Carers (family/friends)?**	NA
Unpaid carer?	NA	**None?**	Yes

10 Privacy, Dignity and Sexuality

Does the patient have issues related to privacy, dignity and / or sexuality that are relevant to admission?	No

11 Spiritual Care

Is there anything with regard to faith or culture that we can support the patient with during their stay in hospital (e.g. prayer, meditation)?	No	Details:	
Is there anything causing the patient a lot of anxiety at the time of admission that staff should be aware of?	No	Details:	
Did patient want ward staff to arrange for a hospital Chaplain to visit while in hospital?	Not at this time	Faith group:	

12. Anticipatory Care (where appropriate and relevant)

Is Appropriate?	Not appropriate

13. Action List

Action	Yes/No	Date
Waterlow completed?	NA	
Nutrition Profile Completed?	Yes	28/07/2013
Infection Control Team contacted?	NA	
Referral made to Smoking Cessation Service?	NA	
Alcohol Screening and Assessment Tool completed?	NA	
Interpreter arranged?	NA	
Oral Care Bundle implemented?	NA	
Wound Assessment chart completed?	NA	
Pressure Ulcer Record completed?	NA	
Moving and handling plan completed?	NA	
Bed rail assessment completed?	NA	
Current Care / Support arrangements suspended?	NA	
Referral to Duty Social Worker?	NA	

14. Admission Assessment Completed By

Name:	Designation:	Date:
Catherine Brady	Registered Nurse	28/07/2013

There is no further information for this patient

NHS GGC Hospitals, Admission Document

NHS Greater Glasgow and Clyde

CHI: 3103646054

Queen Elizabeth University Hospital

15

Total Att: 12

12 Mth Att: 2

Title: MR

WHYTE Brian

DOB 31/03/1964 Age: 56y Sex: Male

FLAT 2-3
133 KINNELL AVE
Glasgow
Lanarkshire
G52 3RT
07931851727

Next of kin: WILSON, ANNE
Relationship: Sister
445 3094

GP: AP Kerr
0141 427 0191

Attendance Date: 05/08/2020 Arrival Time: 10:15

Registration Time: 10:15 Date of Incident: 05/08/2020

Major Incident Desc:

Reason for Attendance: ? od paracetamol accidental

Affix Label

Nursing Assessment

Alerts: Not Recorded

Allergies: Not Recorded Pain Score: 8

Tetanus up to date/fully immunised:

Triage Category: 3

Presenting Complaint:

Observation Date: 05/08/2020 10:30

Temp	37.5	C
HR	91	bpm
BP	106/60	mmHg
MAP	75.33	mmHg
RR	14	bpm
SpO2	94	%
Oxygen		%

Nurse name: Nurse Louise Bell

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils Right		Pupils Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: ?PARACETEMOL OD. HAD NEARVE PAIN IN RIGHT LEG AND LAST 2 DAYS OF NCREASING PAIND. TAKEN 24 PARACETMOL IN LAST 48 HOURS. ?UNDER WEIGHT

Nu

GCC0219 MIS 285791

Patient ID label

Date	Emergency Department Notes	
	Ambulance Proforma reviewed Yes / No Seen by (Doctor)	Time seen

Patient ID label

3103646054
WHYTE
Brian M
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133 KINNELL AVE
Glasgow, Lanarkshire
G52 3RT

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen

Differential Diagnosis/Problem List

NEWS ☐ 0-7

RED FLAG ☐ (Tick)

SEPSIS ☐

CURB 65 ☐

Done/ completed	Immediate Managment Plan

Signature: Designation: Page No:

3103646054

I WHYTE N
4 Brian 31/03/196
FLAT 2-3
133 KINNELL AVE
Glasgow, Lanarkshire
G52 3R1

NHS
Greater Glasgow and Clyde

Hospital ..... QEUH .....

I hereby certify that I am being discharged from this hospital on my own responsibility.

Signed ..... J B Whyte .....

Witness ..... Lauren Young SN .....

I hereby agree to relieve the Health Board of all responsibility in connection with the discharge of ..... from hospital.

Signed .....

Relationship .....

Address .....

Witness .....

Note: A permanent form of writing instrument should be used in completing this form.

STY5017N

In-Patient Admission Notes

3103646054
WHYTE M
Brian 31/03/1964
FLAT 2-3
133 KINNELL AVE
Glasgow, Lanarkshire
G52 3RT

Seen By: Print: N STHEUDS Time Seen: 12:10 Pg. No:

PRF Reviewed Yes / No

Presenting Complaint(s)	
Presenting complaint	Paracetamol overdose – accidental. (R) leg pain - chronic.
History of presenting complaint	Accidental paracetamol OD sunday night into monday morning. ~18-20 500mg paracetamol tablets. Chronic (R) foot + leg pain from previous stabbing + hallux valgus surgery. Made worse recently through painting + doing DIY work for the church. Last had paracetamol 10:30pm yesterday (1-2g unsure). Denies any suicidal plans/thoughts.

Past Medical History / Review of portal
Right hallux IP joint fusion 2019 Previous drug addiction Insomnia (R) leg surgery following stabbing 2010

Systemic Enquiry
nil.

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MEDICINES RECONCILIATION – Acceptable to staple fully completed Emed Rec

Source of medication history (>1 source preferred)
☐ Patient/Relative/carer ☐ GP Phone call ☑ ECS
☐ Patient own drugs ☐ Com. Pharmacist ☐ GP letter/summary
☐ Repeat Prescription

Other (please specify)

Admission Medicines			Plan for Medicines (Dr complete)				Comments
Name	Dose	Freq	Continue	Amend	Withhold	Stop	Reason for alteration
Mirtazapine	45mg	ON					
Zopiclone	7.5mg	ON				✓	GP stopped.
Ensure shake	1	BD					
Buprenorphine	16mg	OD					not on portal.

Allergies: NKDA

List any over-the-counter or alternative medicines

Do medicines need further clarification ? ☐ Yes ☐ No

List collected by :
Designation : Date :

Plan approved by :
Designation : Date :

Pharmacy review

Comments

Compliance aid : ☐ Yes ☐ No

Community pharmacist Phone

Reviewed by : Designation : Date :

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Social History \ Family History

Smoking History uses vape.

Ex-smoker/Smoker _____ cpd _____ yrs ☐ Never smoked

Alcohol History 0 Units/week FAST score if excess _____

Recreational Drugs previously. **Driving Status** not driver.

Social Circumstances (home, supports, functional status, occupation, travel)

lives alone.
2 flights of stairs.

General Examination

Temp:	37.5.	RR:	16.
Pulse:	95.	CBG:	
SpO_2:	94% RA.	Weight:	
BP:	106/60	Urinalysis:	

General Appearance:

Pupils small but reactive + equal.

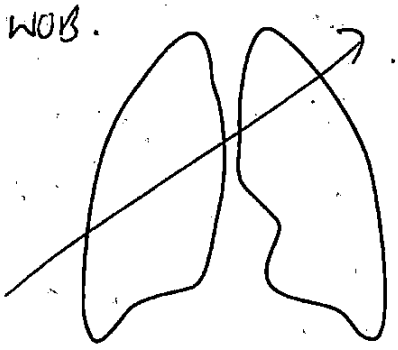
no jaundice.

slim, low weight.

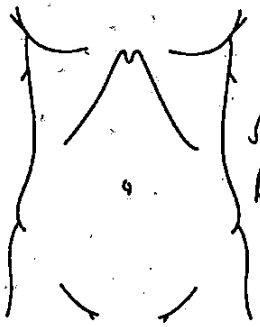
mobilising i stick.

Respiratory

no ↑ WOB.



Gastrointestinal System



SNT
BS+.

Cardiovascular

HS H1+0
WNP.
CNTL3.

Locomotor

(R) foot warm, well perfused, pulses (+), hallux valgus scar present well healed.

(R) leg well healed scar outer aspect.

Patient ID label

Neurological system

GCS: 15 E: /4 M: /6 V: /5

AMT 4 = age, DOB, place, year

AMT score ____ /4

Is the patient more confused/drowsy than normal: Y / N
If yes complete 4AT / TIME

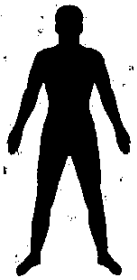
Pupils/fundoscopy: small pupils equal + reactive

Cerebellar and extrapyramidal:

Cranial Nerves:

Neck:

Reflexes:



	RUL	LUL	RLL	LLL
Tone				
Power				
Co-ordination				
Sensation				

Plantars: R L

Skin/Other

Hb 139 PT 11
WCC 6·7 APTT 30
Plts 242 Glu 5·2

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M
31/03/1964

Key Results

CXR —

ECG SR. 98bpm.

(Differential) diagnosis

Accidental paracetamol overdose > 24 hours ago.

Chronic (R) leg + foot pain

NEWS ☐

Red Flag ☐

Sepsis ☐

CURB 65 ☐

Management Plan

(1) Bloods — paracetamol level
— LFTs + INR.

? Home if normal
tbc.

☐ Thromboprophylaxis assessed
☐ Antimicrobial

☑ Medicine Reconciliation

☐ 4AT/TIME

Signature:

PRINT NAME NSHIELDS

PRINT GRADE CT1 ACCS.

Page:

Patient ID label

Resuscitation Decision

Resuscitation status: FOR RESUSCITATION / DNA CPR
(please circle)

If DNA CPR ✓ → Complete appropriate form

Senior Medical review

☐ Thromboprophylaxis assessed
☐ Antimicrobial
☐ Medicine Reconciliation
☐ DNACPR
☐ 4AT/TIME
☐ AWI if appropriate

Sepsis Six
- ☐ Antibiotics within 1 hour
- ☐ Appropriate Cultures
- ☐ Fluids
- ☐ Oxygen
- ☐ Lactate
- ☐ Fluid balance, consider catheter

Pati[illegible] ID label
3103646054
WHYTE
Brian
M
31/03/1964

Medical patient thromboprophylaxis decision aid – ENSURE BLACK BO[illegible] TED

Is the patient bed-bound or expected to have reduced mobility relative to normal for ≥2 days

☐ Yes

☐ No

- No thromboprophylaxis
- Reassess (every 72 hours minimum)and document
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)

Does the patient have any of the following risk factors? Tick if apply			
Active cancer or cancer treatment		Use of oestrogen containing contraceptive	
Age> 60		Hormone replacement therapy	
Dehydration		Pregnancy or <6 weeks post partum (seek specialist advice)	
Known thrombophillia		Critical care admission	
BMI >30		Varicose veins with phlebitis	
Personal/1st degree relative history of VTE		Current significant medical condition e.g. infection, inflammation, cardio resp disease	
Hip fracture			

☐ Yes

☐ No

Does the patient have any of the following contraindications? Tick if apply			
Active bleeding		Untreated inherited bleeding disorder	
Acquired bleeding disorder		Thrombocytopaenia <75 x109/l	
Thyroid, spinal, posterior eye or neurosurgery		Other procedure with high bleeding risk (discuss with senior)	
Concurrent use of anticoagulants e.g. warfarin with INR>2		Uncontrolled hypertension (>230/120)	
Acute stroke		Varicose veins	
Recent (<4 hours) or expected (within 12 hours) lumbar puncture, epidural or spinal anaesthetic			
Other - Document			

- Discuss with senior clinical staff regarding thromboprophylaxis
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)
- Consider mechanical prophylaxis unless contraindicated
- Reassess (every 72 hours minimum)and document

☐ No

☐ Yes

Enoxaparin 40mg (reduce to 20mg if weighs < 50kg or eGFR <30)

- Reassess every 72 hours minimum
- Ensure patient informed (see information leaflet)

Patient informed ☐ Yes ☐ N/A
(only n/a if due to cognitive impairment or similar)
If N/A why? _____
Assessed by _____
Date _____

Patient ID label

Results

Date / Time									
Parameter	Ref Range								
Hb	Male: 130-180 Female: 110-165								
WCC	4.0 - 11.0								
Plts	150 - 450								
MCV	80 - 100								
Neut	2.0 - 7.5								
PT	9.0 - 13.0								
APTT	27.0 - 38.0								
Fibrinogen	1.7 - 4.0								
INR	( )								
Thromb T	11-15 secs								
D-Dimer	0 - 250								
Na+	133 - 146								
K+	3.5 - 5.3								
Cl-	95 - 108								
HCO3-	22 - 29								
Urea	2.5 - 7.8								
Creat	40 - 130								
eGFR									
Glucose	3.5 - 6.0								
Protein	60 - 80								
Albumin	35 - 50								
AlkP	30 - 130								
Bil	<20								
ALT	<50								
AST	<40								
GGT	Male: <70 Female: <40								
ESR	Male: 1 -10 Female: 1 - 12								
CRP	<10								
Troponin hs I	Male: 0 - 34 Female 0 - 16								
CK	Male: 40 - 230 Female: 25 - 200								
Corr Ca++	2.20 - 2.60								
PO4-	0.8 - 1.5								
Mg++	0.70 - 1.00								
Alcohol									
Paracetamol	<100 @4 hr								
Salicylate									
AST	<40								
Amylase	<100								
LDH	170 - 380								
Folate									
B12	200 - 900								
Ferritin	Male: 20 - 300 Female: 15 - 200								
TSH	0.35 - 5.00								
Free T4	9.0 - 21.0								
Digoxin	0.5 – 2.0								

Patient ID label

3103646054
WHYTE
Brian
M
31/03/1964

Post Take Ward Round IAU/ARU

Consultant: _____ Date: _____

Summary

Temp:

Pulse:

BP:

SpO_2:

FiO2:

RR:

Diagnosis:

Plan:

Recommended Destination: _____

Suitable to board if required ☐ Yes ☐ No

Expected Date of Discharge: _____

Signature: _____

Designation: _____

Bleep Number: _____

Patient ID label

Continuation Sheet

Date: Time	
05/08/20 14.00	FYI J. DURAND AHSP 23 is requesting to leave department Note documentation of clerk in w. plan for possible d/c if bloods acceptable. LFTs, CO2g + paracetamol level (N)

Patient ID label

3103646054
WHYTE
Brian
M
FLAT 2-3
31/03/1964
133 KINNELL AVE
Glasgow, Lanarkshire
G52 3RT

Continuation Sheet

Date: Time	

Patient ID label

Continuation Sheet	
Date: Time	

Patient ID label

3103646054
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31/03/1964
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Continuation Sheet

Date: Time	

Patient ID label

Nursing Documentation

Done/ Time	

Once only prescriptions (inlcuding 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

DISCHARGE CODES: Please Circle				Time Ready to Depart	
1. Admission	2. Discharge	3. Refer to G.P.	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 Time	

Ward No. (If admitted)	Transfer to Hospital	Consultant (if admitted)

Outpatient clinic specialty						Admission or specialty clinic consultant		
Clinic Referred to	AE	OP DVT	DME Falls	TIA	Medical	Surgical	First Seizure	Others Specify

My Admission Record

NHS Greater Glasgow and Clyde

3103646054
WHYTE M
Brian 31/03/1964
FLAT 2-3
133 KINNELL AVE
Glasgow, Lanarkshire
G52 3RT

Dr. AF Kerr
The Crescent Medical Practice
12 Walmer Crescent
Glasgow
G51 1AT

Hospital: QEUH. Ward: IMU
Date of Admission: 05.08.2020. Time: 11.20.
Information obtained from: Name:
Patient ☑ Relative ☐ Other ☐ _____
Preferred Name:
Age: 56. Telephone Number:
Consultant:

Communication

What is your first language? English.
Do you require an interpreter? Yes ☐ No ☑
If yes, provide details of arrangements made _____
Do you use British Sign Language (BSL)? Yes ☐ No ☐
Do you need someone to help you to communicate? Yes ☐ No ☑ If yes, who _____

Preferred first contact	Preferred second contact
Name: Anne White	Name: Connie
Relationship: Sister.	Relationship: Niece.
Address: 5 fairfield garden.	Address:
Telephone:	Telephone: 07824 118225.
Is this person aware of your admission? Yes ☑ No ☐	Is this person aware of your admission? Yes ☐ No ☐
Can we share information with this person? Yes ☑ No ☐	Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

Staggered Paracetamol overdose.

Explained to the patient? Yes ☐ No ☐ Not Applicable ☐
Do you understand the reason for your admission? Yes ☐ No ☐

Allergies / Sensitivities (Record food allergies in the Hydration and Nutrition section)

No known allergies ☑.

Relevant past medical history

PTSD.
Prev stab wounds.

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place
Yes ☐ No ☑ If yes, Who asked for a copy? _____
Date they asked for a copy __/__/__ Date Obtained __/__/__

Power of Attorney / Guardianship / Adult with Incapacity

N.
A(3103646054
WHYTE M
Brian 31/03/1964
FLAT 2-3
133 KINNELL AVE
D Glasgow, Lanarkshire
C G52 3RT
A[illegible]

Does someone have Power of Attorney (POA) for you?

Yes ☐ No ☑

OR

Does someone have Guardianship?

Yes ☐ No ☑

If yes, is this for:- Finance ☐ Welfare ☐ Both ☐

Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

Please obtain a copy and place in the patient's notes

Who asked for a copy?_____ Date they asked for a copy __/__/__ Date Obtained __/__/__

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

N.B. If you think the patient may lack capacity inform Medical Staff to assess and, if required, consider the need for an 'Adult with Incapacity' Section 47

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:	Yes	No
1. Been an inpatient in a hospital outside Scotland?	☐	☑
2. Received holiday dialysis outside Scotland?	☐	☑
3. Been told that you have CPE?	☐	☐
4. Been in close contact with a person with CPE?	☐	☑

If the answer is yes to **ANY** of the questions in this section, you must

- Isolate the patient in a side room ☐
- Obtain Rectal swab marked 'for CPE' ☐
- If patient refuses rectal swab, obtain a stool specimen marked 'for CPE' ☐
- **and inform the IPCT** ☐

MRSA Screening

	Yes	No	Unsure
Will the patient be an inpatient for more than 23 hours	☐	☐	☑
If **YES** complete the following section			
1. Have you ever been told that you have MRSA?	☐	☐	☐
2. Have you been admitted from another hospital/ residential setting or care home?	☐	☐	
3. Do you have a wound / skin ulcer or invasive device which you had before admission?	☐	☐	☐

If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabs

Nasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐

Creutzfeldt-Jakob Disease (CJD)

	Yes	No	Unsure
Have you ever been informed that you are at increased risk of CJD or vCJD?	☐	☑	☐

If **YES inform the IPCT** ☐

Na
Ad 3103646054
WHYTE
Brian
FLAT 2-3
133 KINNELL AVE
Do Glasgow, Lanarkshire
CH G52 3RT
Affix patient ID label

M
31/03/196

Lifestyle

Smoking

~~Are you a: smoker ☑ ex-smoker ☐ when did you stop?~~

Never smoked ☐

Do you use eCigarettes? Yes ☑ No ☐ ~20 per day.

If a smoker, the NHSGGC Smokefree policy has been explained and Nicotine Replacement Therapy (NRT) has been offered

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

Do you want to talk to someone about your smoking? Yes ☐ No ☐

If yes, refer to Smokefree Services (Trakcare) Date referred: ___/___/___

Drugs

Do you use recreational or illicit drugs or are you receiving opiate replacement therapy (ORT / Methadone / Suboxone)? Yes ☐ No ☑

If yes, please specify and refer to the NHSGGC Guidelines for the Management of Drug Users in Glasgow and Clyde Acute Hospitals

Previous drug use.

Alcohol

Do you drink alcohol? Yes ☐ No ☑

How often do you have more than 6 units of alcohol on one occasion:

Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐

NB: If daily or almost daily commence the Glasgow Assessment and Management of Alcohol (GAMA), complete FAST Tool and take further action as per guidance.

Name (Please PRINT): J. Fowlds Signature: [signature]

Designation: Staff nurse. Date: 05-08-2020

My Assessment Record

3103646054
WHYTE M
Brian 31/03/1964
FLAT 2-3
133 KINNELL AVE
Glasgow, Lanarkshire
G52 3RT

1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems	✓	✓	
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			

Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems	✓	✓	
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

	Yes ✓	No ✓	Assessment of the patient's communication needs
Do you have any difficulties communicating your needs?		✓	
Do you have any difficulties with your speech?		✓	
Do you have a Learning Disability?		✓	
Do you have support from a Learning Disability Team? Contact details: _____			

N
A 3103646054
WHYTE
Brian
FLAT 2-3
133 KINNELL AVE
D Glasgow, Lanarkshire
G52 3RT
C
Affix patient ID label

3. Senses

Vision	Yes	No	Assessment of the patient's vision
Do you have any problems with your vision?	✓		
Do you wear glasses?	✓		Distance ☐ Reading ☑ Both ☐
Do you have your glasses with you?		✓	
Do you wear contact lenses?		✓	
Do you have your lenses with you?			
Do you wear a prosthesis?			

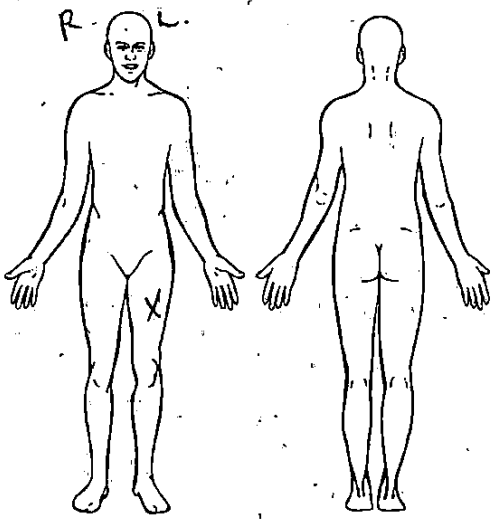
Hearing	Yes	No	Assessment of the patient's hearing
Do you have any problems with your hearing?		✓	
Do you have any hearing loss?		✓	
Do you use a hearing aid?		✓	
Do you have your hearing aid(s) with you?			

Pain	Yes	No	Assessment of the patient's pain
Do you have pain?	✓		

Can you describe where and what the pain is like?

nerve pain.

Mark current pain on body chart



Have you had treatment / intervention for the pain?

N.B. Complete generic pain assessment chart. If unable to self report complete Abbey Pain Scale.

Can you describe any chronic pain that you have?

What makes the pain better?

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4. Cognitive Status THINK DELIRIUM

	Admission Presentation	Normal for the patient	Assessment of the patient's cognitive status
Alert and orientated	✓	✓	
Impaired conscious level			
Confused			
Dementia			
Stressed / Distressed			

N.B. Think Delirium

Complete 4AT for all patients 65 and over, AND for patients of any age with one or more of the following:

- existing cognitive impairment
- previous delirium
- current hip fracture
- severe illness

and follow the guidance

N.B. 'Getting to Know Me' and 'What Matters to Me' should be completed for all patients with dementia, cognitive impairment or complex needs

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

—

What do you like to eat and drink?

loves ensure

smell easier.

What do you not like to eat and drink?

—

N.B. Malnutrition Universal Screening Tool (MUST) to be completed for all patients within 24 hours of admission

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓
Normal diet and fluids	✓	✓
Therapeutic diet		
Cultural, ethnic or religious diet		
Texture Modified Diet Please state _____		
Thickened Fluid Please state _____		
Oral Nutritional supplements Preferred flavour _____		
Enteral Nutrition		
Parenteral Nutrition		
Nil by Mouth		

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Assessment of the patient's hydration and nutrition needs

N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharnygeal Swallow Symptoms (STOPSS) within 4 hours of admission

Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓
Independent (Green)	✓	✓
Prompting / encouragement / opening packets/cutting up food (Amber)		
Full assistance with eating and drinking (Red)		

Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?

6. Elimination

Bladder	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Pass urine with no problems	✓	✓	
Frequently pass urine during the day			
Frequently pass urine overnight			
Sense of urgency when need to pass urine			
Urine retention			

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓
Haematuria		
Incontinent		

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N.B. If new incontinence report to medical staff to rule out infection or physiological cause

What products do you normally use for this continence issue?

✓

No urinary catheter ☑ Urinary catheter in situ: Urethral ☐ Suprapubic ☐

Date urinary catheter last changed ___/___/___

N.B. If Urinary Urethral Catheter (UCC) in situ commence NHSGGC Adult UCC Insertion and Maintenance Care Plan

Bowels

When did your bowels last move? 2 days ago.

How often in a day/week do you have a bowel movement? Per day ☐ Per week 1-2

Do you use any medication e.g. laxative to help your bowels move? Yes ☐ No ☑

Bowel Habit	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Regular	✓	✓	
Constipated			
Diarrhoea / loose stools			
Blood in stools			
Incontinent			

What products do you normally use for this continence issue?

N.B. if concerned about bowel patterns (e.g. infrequent movement or frequent loose stools) consider using the Bristol Stool Chart

Stoma	Yes ✓	No ✓	Assessment of the patient's needs in relation to their stoma
Do you have a stoma?		✓	
Do you require assistance with your stoma care?			
Have you brought any of your stoma products with you?			

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7. Personal Hygiene, Oral Health, Skin Care and Wound Care

Personal Hygiene	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's personal hygiene needs
Independent	✓	✓	
Requires assistance with washing and dressing			
Oral Health	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's oral health needs
No problems	✓	✓	no teeth.
Sore mouth / mucositis / ulcer			
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)			
Dental work	**Yes** ✓	**No** ✓	Description of any dental work
Do you wear dentures?	✓		full set of false teeth.
Do you have your dentures with you?	✓		
Are your dentures a good fit?	✓		
Do you have any other dental work that we need to be aware of?			
Skin Care	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's skin care needs
No problems	✓		Dry skin but states rest of skin is intact.
Skin broken			
Skin oedematous			
Skin discoloured / red			

N.B. Complete PUDRA for all patients within 8 hours of admission

Pressure ulcer identified on admission: Yes ☐ No ☑

Pressure Ulcer Grade: _____

Pressure Ulcer Site: _____ **Adult wound assessment and management chart required**

N.B If Grade 2 pressure damage on ankle or below refer to Podiarty via TrakCare

Wound Care	Yes ✓	No ✓
Do you have any wounds? **N.B. If yes, complete an assessment chart for wound management**		✓

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8. Mobility

Mobility	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's mobility needs
Fully mobile and independent	✓	✓	x1 walking stick.
Unsteady when walking			
Do you use a mobility aid	Yes ☑	No ☐	
Do you have your mobility aid with you?	Yes ☑	No ☐	

N.B. If not fully mobile and independent on admission complete moving and handling assessment within 24 hours of admission

9. Maintaining a Safe Environment

N.B. Complete a falls risk assessment for all patients within 24 hours of admission. If a falls risk is identified complete the falls intervention checklist and document all nursing actions in the care plan.

Safety	Yes ✓	No ✓	Assessment of the patient's ability to maintain a safe environment
Is the patient at risk of falling, rolling, slipping or sliding from the bed?		✓	
Would you like bedrails to be used while in hospital?		✓	

N.B. If yes, to either of the two questions above complete a bedrail risk assessment

10. Sleep and Rest

Sleep	Yes ✓	No ✓	Assessment of the patient's sleep and rest needs
Do you have any difficulties with sleeping?	✓		Takes zopiclone occassionally no longer prescribed.
Do you do or use anything to help you sleep?		✓	

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11. Social Circumstances

Do you:

Live alone	☑	Live with family/ friend/ other	☐
Live in a nursing home	☐	Live in a care home	☐
Live in residential supported care	☐	Live in student accommodation	☐
Live in 'homeless' accommodation	☐	Have no fixed abode	☐

Other please specify_____ ☐

Dependants	**Yes** ✓	**No** ✓
Do you have any dependants?		✓
Do you support anyone (e.g. partner, children, relatives, animals)?		✓
Do they need support from someone else whilst you are in hospital?		✓
Would someone else be able to provide this support when you are in hospital? If yes, who?		

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☑ Referred ☐

Services	**Yes** ✓	**No** ✓
Do you have support from social work, social services or a care package?		✓
If yes, please provide details:		
If yes, has contact been made to cancel arrangements during admission?		

12. Emotional and Spiritual Care

Do you have a religion or beliefs that we can help you observe while you are in hospital?

Protestant.

Is there anything else with regards to your values, religion or culture that we can support you with during your stay in hospital (e.g. prayer meditation)?

Would you like to talk to someone (e.g. Hospital Healthcare Chaplain) about you, your loved ones, your values and beliefs, or any worries you have? Yes ☐ No ☑

Healthcare Chaplain informed Yes ☐ N/A ☑

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13. Person Centred Care

What matters and is important to you whilst you are in hospital?

This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

N.B. Participating in 'What Matters to Me' should be offered to all patients

Informal Support

Who is important to you, to help support you whilst you are in hospital?

NB. If the person who helps is not a preferred contact please ensure their details are listed below.

Name: .....

Contact Details: .....

.....

.....

How do you want the people who matter to you to be involved in your care?

Do you have someone who looks after you or someone that helps you, i.e. an informal carer?

Yes ☐ No ☑

If yes, has the help or support listed above been confirmed with the patient's family/ friends?
(please tick) Yes ☐ No ☑

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Required Support

Has the patient and / or carer been advised of the hospital Support and Information Service?

Yes ☐ No ☑

Referrals can be made via the central phone number: 0141 452 2387

Has the carer been advised of the Carers Information Line?

Yes ☐ No ☑ Not appropriate at this time ☐

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?

Yes ☐ No ☑

Are you:

Employed ☐ Unemployed ☐

Self-employed ☑ - Painter. Retired ☐

Full time education ☐

Has your health had an impact on your ability to carry out your day to day activities at work?

Yes ☑ No ☐ Not applicable ☐

Do you have any money worries?

Yes ☐ No ☑ Not appropriate to ask at this time ☐

If yes would you like referred to a money advice service that can offer confidential advice/ support?

Yes ☐ No ☑ If yes when was patient referred ___/___/___

Would you like a referral to a service that can support you with employment / education/ training/ skills volunteering?

Yes ☐ No ☐ Not applicable ☑ Not appropriate to ask at this time ☐

If yes when was patient referred ___/___/___

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Risk Assessments/Other Documentation

Additional NHSGGC Documentation	Required		Required documents completed		Date, Print and Sign when completed
	Yes ✓	No ✓	Yes ✓	No ✓	
Glasgow Assessment and Management of Alcohol (GAMA)					
Generic Pain Scale Assessment Chart					
Abbey Pain Scale (if unable to self report pain)					
4AT and TIME for Detection, Management and Prevention of Delirium					
Getting to Know Me – Relatives to complete					
What Matters to Me					
Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)					
Malnutrition Universal Screening Tool (MUST)	✓		✓		
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan					
Bristol Stool Chart					
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓		✓		
Adult Wound Assessment and Management Chart					
Moving and Handling Assessment			✓		J Mitchell 05-08-20
Falls Risk Assessment	✓		✓		
Bedrail Risk Assessment			✓		

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
05.08.2020. 11:30	Cared for by myself J.Collins. @11:15. Introductions made to patient. Admission documentation completed. Awaiting medical review. Settled + comfortable at present.	J Mitchell

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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
13·30.	Attended MAU - results awaited to be discussed with pt. Left compression stockings visible. For bed rest at present. IV fluids routine. written in error.	
13·50.	Reviewed by medical staff. Paracetamol levels awaited. Am none if normal	

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation

NEWS – National Early Warning Score

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Greater Glasgow and Clyde

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Address
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CHI No.
DoB

	Date	Ward
Admitted		
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more **or** 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.

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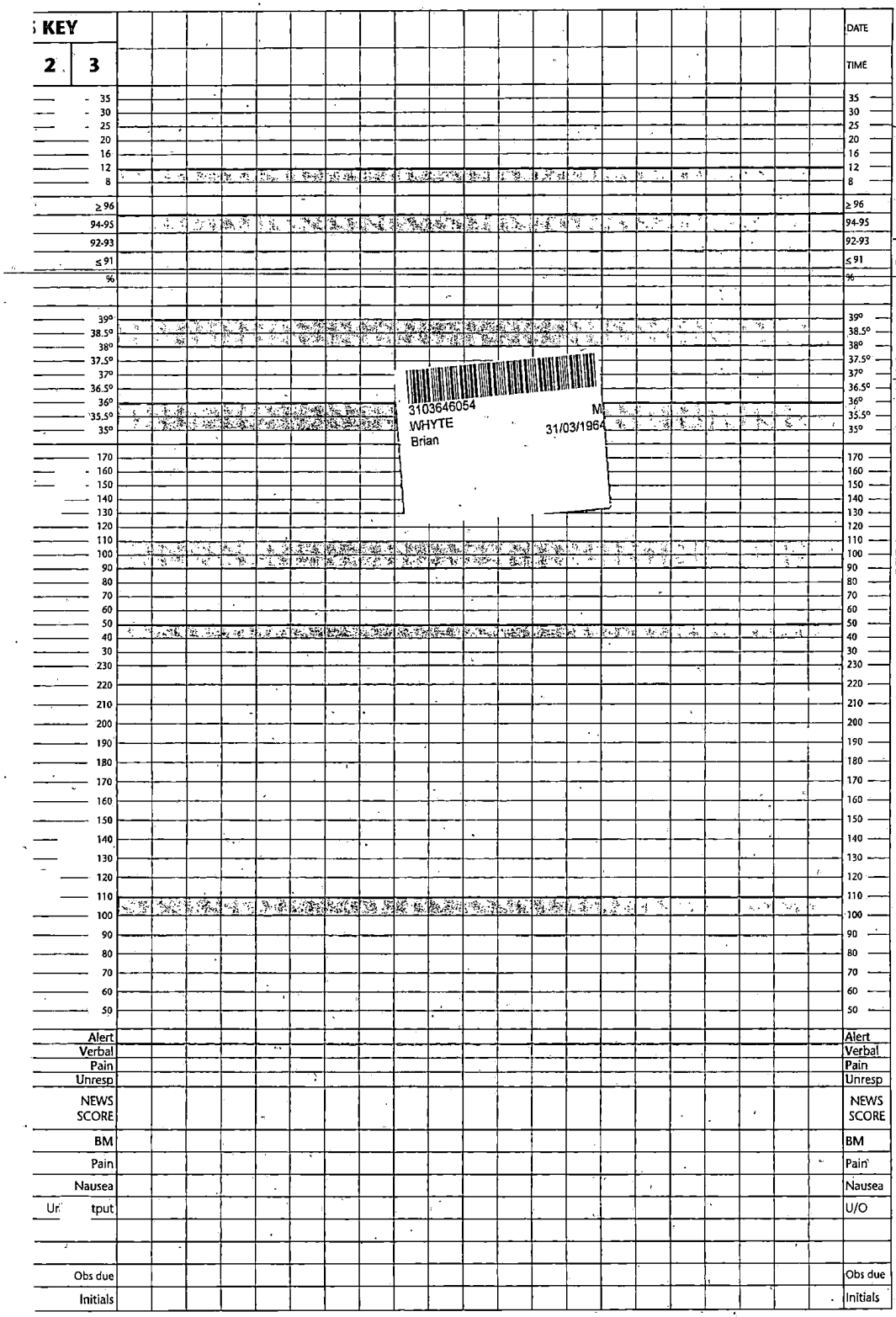
| | | |


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
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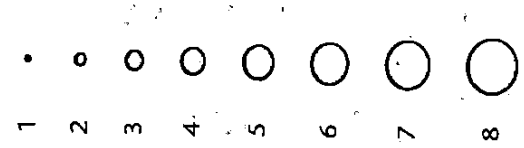
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
Blood Pressure
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Glasgow Coma Scale

Pupil size (mm)



Neurological Observations

| | | |

NHSGGC Bedrail Risk Assessment

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NHS Greater Glasgow and Clyde

This Risk Assessment Tool is an aide memoire for staff. It should be used in conjunction with the Bedrail Guidance (see reverse) and Guidelines for Falls Prevention and Management (Adults).

Patient Name:

CHI Number:

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT

	Use guidance on the reverse of this document when completing this Risk Assessment									
		DATE	05.08.2016							
		TIME	11.21							
		WARD	IAU							
		HOSPITAL	QEUH							
	SECTION ONE – GENERAL		Y	N	Y	N	Y	N	Y	N
1	Is the patient likely to fall, roll, slip or slide from the bed?			✓						
2	Has the patient requested the use of bedrails?			✓						
	IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED									
	SECTION TWO – COGNITIVE AND PHYSICAL STATUS									
3	Is the patient at risk of climbing out of bed?									
4	Is the patient stressed, delirious or restless?									
5	Is the patient small in stature?									
6	Does the patient have an unusually large or small head that might present an entrapment issue?									
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?									
	IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
	SECTION THREE – COMMUNICATION									
8	Has the patient been consulted regarding the use of bedrails?									
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition									
10	Has the use of bedrails been discussed with relatives/carers?									
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?									
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?									
	IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
	SECTION FOUR – DECISION MAKING		Y	N	Y	N	Y	N	Y	N
13	Will bedrails be used for this patient at the present time?			✓						
14	Rationale for use of bedrails: (Please insert code in the box on the right)									
	A – Risk of falling from the bed									
	B – Risk of rolling from the bed									
	C – Risk of slipping from the bed									
	D – Risk of sliding from the bed									
	E – Patient request									
15	Bedrail risk assessment completed by:		[illegible]							
16	Bedrails checked by:		[illegible]							
17	Date		05.08.2016							

Any issues relating to the use of bedrails including discussion with family/relatives/carers should be recorded here

A. Alternatives to bed rails:-

- Move the patient to a more observable area
- Increase patient observation
- Ensure the bed is returned to the lowest height appropriate to the patient needs, after care delivery
- Ensure patient needs are anticipated e.g. drinks are accessible, regular toileting, call bell to hand
- Nursing patient on mattress on the floor should be the last resort, and safety checks should be made for hot pipes, trailing wires, electrical sockets etc
- A generic moving and handling assessment must be carried out for staff caring for patients nursed on mattress on the floor.
- Contact Hospital Falls team for advice where appropriate

B. If bedrails are to be used, please consider the following:-

Is patient:-

- Stressed, delirious or restless
- At risk of entrapment
- At risk of climbing over the top of the bed rail
- At risk of being psychologically affected by the use of the bed rail

C. Safe use and application of bedrails:-

- If bedrail is fitted and there is a gap between the lower rail and the mattress then a bedrail should not be used
- If the gap between the bars on the bedrail is greater than 12cm then a bedrail should not be used
- If the bedrail moves away from the side of the mattress then a bedrail should not be used
- If the gap between the bedrail and the headboard is between 6cm and 25cm then a bedrail should not be used
- If the gap between the bedrail and the footboard is between 6cm and 25cm then a bedrail should not be used
- If the bedrail has not been fitted correctly then the bedrail should not be used
- If the bedrail is not secure then the bedrail should not be used
- If the bedrail is not compatible with the frame it will be fitted to then a bedrail should not be used
- If the bedrail is not in good working order then the bedrail should not be used

D. Record keeping:-

All of the following should be recorded:-

- Date and time of assessment
- Bedrail information leaflet given to patient and-or next of kin
- Rationale for decision in care plan or in AWI treatment plan
- Where bedrails are considered appropriate and patient has declined their use
- Any other actions implemented
- Care planning should be reviewed and updated as per record keeping standards

Bedrail risk assessments should be made as follows:-

- On admission
- If patient's condition changes or fall / suspected fall from bed
- Daily/weekly depending on the patient's status

Care Rounds Checklist

Date: 05-08-2020

I have evaluated and deemed that the frequency of care delivery over the next work shift, **based on the patient's most critical need** should be every (please circle) 1hr 2hr 3hr (4hr)

1. Signed [signature] Name Lauren Young Designation RN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

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'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES: Y = Yes, N = No, NA = Not applicable, NT = No Thanks, S = Sleeping, O = Off the ward, I = Independent

			Times	1115																	
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		N																	
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.		N																	
S	3	**SKIN INSPECTION** Pressure areas checked:		N																	
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		I																	
K	4	**KEEP MOVING** Has the patient moved or walked?		Y																	
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		B																	
		Chair Assist to walk or stand (W/ST)		N																	
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		NT																	
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?		N																	
		Drink taken?		Y																	
		Food, snack, or supplement taken?		N																	
		Has oral hygiene been carried out as per care plan?		H																	
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		Y																	
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.		NT																	
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.		NA																	
			Care provider / role	LY (5)																	

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs of Admission and on Transfer to Another Ward

NHS Greater Glasgow and Clyde

GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

Action the following safety precautions on admission to your ward. Update weekly or on change of condition.

	Ward: IAU Date: 05-08-2010 Time: 11--:--24.	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	Independent c stick.				
2. Check walking aid (if required) is in reach and in use.	Yes				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	Will use				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	Trainers				
5. If glasses are worn, check they are available and in use.	Yes				
6. If hearing aid/s are worn, check they are working and in use.	NA				

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).
Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.
ALL patients in older people's wards must have an interventional plan in place (overleaf)

Tick Yes or No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has the patient fallen in the last 6 months – including during this admission?		✓								
2. Does the patient have cognitive impairment or a possible delirium?		✓								
3. Does the patient attempt to walk alone although unsteady or unsafe?		✓								
4. Does the patient or their relative have a fear or anxiety of the patient falling?		✓								
5. Based on your clinical judgement, is this patient at high risk of falling?		✓								
Signature of nurse completing assessment / update	L Yang									

Highlight risk of fall at the ward safety brief.

Patient Details

FALLS INTERVENTION CHECKLIST

NHS Greater Glasgow and Clyde

Complete for all patients identified at risk of falling.

	Ward: Date: Time: ____:____	Ward: Date: Time: ____:____	Ward: Date: Time: ____:____	Ward: Date: Time: ____:____	Ward: Date: Time: ____:____
BED AND SEATING					
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)					
Assess if a low bed is required (Patient care plan 9)					
SAFETY					
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)					
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)					
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.					
HEALTH					
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)					
Document continence problems and link to care rounding. (Patient care plan 6)					
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)					
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.					
COMMUNICATION					
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)					
Update the ward team of the patient's mobility status. (Patient care plan 8)					
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)					
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)					
Signature of nurse completing interventional plan / or update					

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team

EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

Person Specific (Inpatient) Moving and Handling Assessment Form

Person's Name:	3103646054 1 WHYTE 4 Brian FLAT 2-3 133 KINNELL AVE Glasgow, Lanarkshire G52 3RT	M 31/03/1964	Named Nurse:
Person is totally independent (tick here and go to date box)	✓		

1. Gene

Weight: kg

BMI: cm

ms with comprehension, behaviour, co-operation (specify):

Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):

Risk of Falls: Yes | No

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid ✓	Assistance	Supervision	Independent
Model		Aid Type	People: 1 / 2 / >3	Additional Information / Equipment:	
Sling type		X1 stick.			
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 / 2 / >3	Additional Information:	

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N / A
See No 2 Sit to Stand Transfers for details	Roll patient Monkey pole Independent bridging	People: 1 / 2 / >3	Additional Information:	

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets Monkey pole Rope ladder	People: 1 / 2 / >3	Additional Information:	

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board Other (Please specify)	People: 1 / 2 / >3	Additional Information / Equipment (eg sliding sheets):	

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 / 2 / >3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower Variable / Fixed height bath Bed bath	Shower chair Shower trolley Bathing hoist (eg Ateni)	People: 1 / 2 / >3	Additional Information / Equipment (eg sling lifting hoist after risk assess):	

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 / 2 / >3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:	05.08.2010		
Assessor's signature:	L Young		
Proposed Review date:			

Continuation Sheet

1. General Information (Only complete this section if changed from over page)

Body Build		Problems with comprehension, behaviour, co-operation (specify):
Weight	Height	
Kg	cm	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
BMI		
Risk of Falls: Yes	No	

2. Sit to Stand to Sit Transfers (including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 / 2 / ≥3	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 / 2 / ≥3	Additional Information:	

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N / A
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 / 2 / ≥3	Additional Information:	
	Monkey pole			
	Person bridges			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 / 2 / ≥3	Additional Information:	
	Monkey pole			
	Rope ladder			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 / 2 / ≥3	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify)			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 / 2 / ≥3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair	People: 1 / 2 / ≥3	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley			
Bed bath	Bathing hoist (eg Ateni)			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 / 2 / ≥3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	4th Assessment	5th Assessment	6th Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

3103646054
WHYTE
Brian
FLAT 2-3
133 KINNELL AVE
Glasgow, Lanarkshire
G52 3R1

M
31/03/196

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

CHI: _____

Address: _____

Hospital: _____

NHS Greater Glasgow and Clyde

Insertion criteria: Please complete this section at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☑ Resuscitation/Chest Pain ☐ IV Drugs ☐ Fluids ☐ Transfusion ☐

PVC inserted: Day 0	Date: 05/08/2020 Hospital: Ward Area: ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☑ IAU Unknown ☐
Insertion site:	R Hand ☐ R Arm ☐ R Foot ☐ L Hand ☐ L Arm ☑ L Foot ☐ Other:
Colour of cannula:	Blue ☐ Pink ☐ Green ☑ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☑ If No, state reason: Verbal consent.

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? (Diagnostics, Resuscitation/ Chest Pain, IV Drugs, Fluids, Transfusion)	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 1 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: ___/___/___ Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: ___/___/___

*Reason For Removal: _____

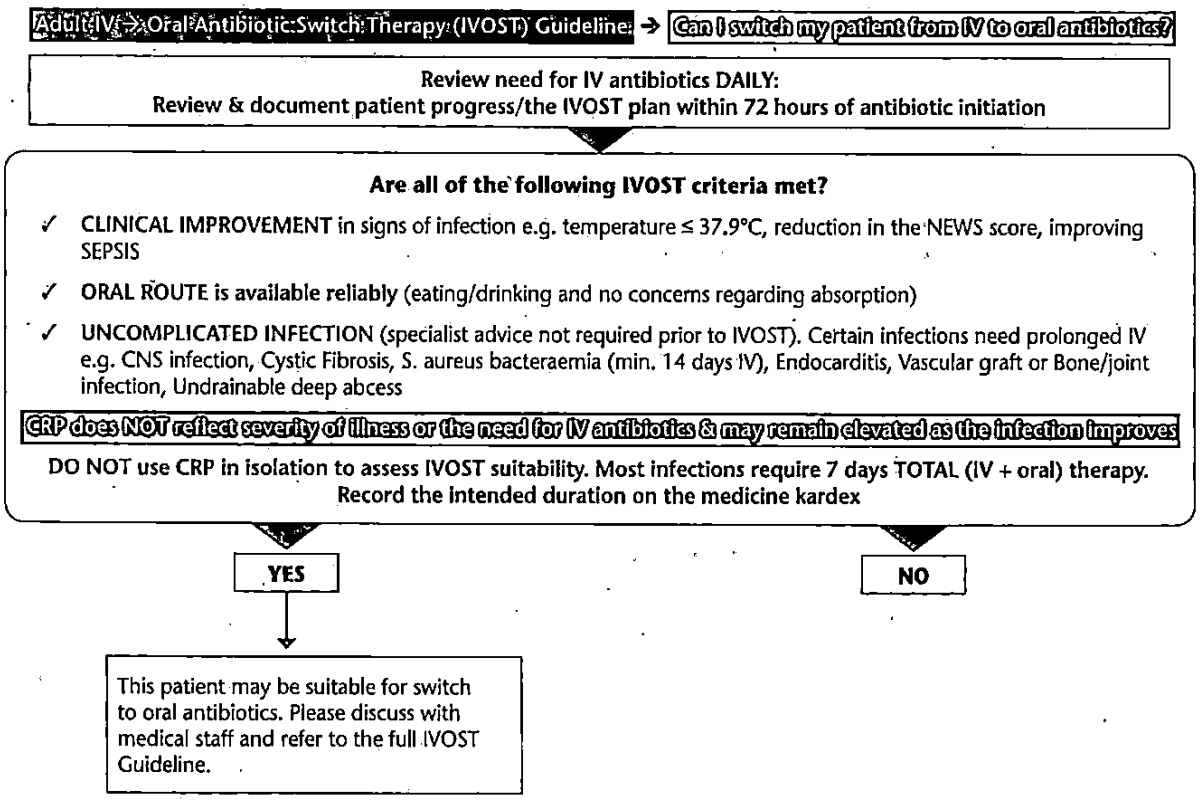
Modified Visual Infusion Phlebitis (VIP) Score

Modified V.I.P (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phlebitis : **Observe cannula**
One of the following is evident : slight pain or redness near site	1	Possible first signs : **Observe cannula**
Two or more of the following are evident: pain, redness, swelling	2	Early stage of phlebitis : **Remove & resite cannula**
All of the following are evident: pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: **Remove & resite cannula**
As above including: palpable venous cord	4	**Seek further advice**
As above including: pyrexia	5	

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and S. aureus bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids ? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?



Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

3103646054 1 WHYTE M 4 Brian 31/03/196 FLAT 2-3 133 KINNELL AVE Glasgow, Lanarkshire G52 3RT	Hospital: QEUH Ward: IAU.	**Points to consider:** • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

1 Pressure Damage	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan overleaf.

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2 Mobility	Does the person require assistance to mobilise?
3 Continence	Does the person have continence issues with urine and/or faeces?
4 Nutrition	Does the person appear malnourished and/or unable to eat or drink?
5 Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?
6 Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY pressure relieving care interventions and complete the pressure ulcer interventional plan overleaf.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
05/08/20	11:25	N	N	N	N	N	N	4 hrly	LY.
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	

Complete prevention of pressure ulcer interventional plan overleaf for all patients with redness/pressure damage and for those at risk.

Prevention of Pressure Ulcer Interventional Plan

NHS Greater Glasgow and Clyde

Attach Addressograph

Aim: To incorporate effective pressure ulcer prevention strategies to reduce/eliminate potential for pressure ulcer development.

Outcome: To prevent pressure ulcer development through establishment of effecting work practices in line with SSKINS bundle.

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer?. YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____

MAIN WIA

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Queen Elizabeth University Hospital

CHI: 3103646054

Total Att: **10**

12 Mth Att: **0**

Title: **MR**

WHYTE **Brian**

DOB: **31/03/1964** Age: **55y** Sex: **Male**

FLAT 2-3
133 KINNELL AVE
Glasgow
Lanarkshire
G52 3RT
07931851727

Next of kin: **WILSON, ANNE**
Relationship: **Sister**
445 3094

GP: **AP Kerr**
0141 427 0191

Attendance Date: **07/11/2019** Arrival Time: **13:06**

Registration Time: **13:06** Date of Incident: **07/11/2019**

Major Incident Desc:

Reason for Attendance: **has dressing on his foot after surgery which has got wet**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **Not Recorded** Pain Score:

Triage Category: **4** Tetanus up to date/fully immunised:

Presenting Complaint: **Foot Post-op Problem**

Observation Date: **07/11/2019 13:34** Nurse name: **Nurse Lesley Bendall**

Temp	36.2.	C
HR	67	bpm
BP	113/67	mmHg
MAP		mmHg
RR		bpm
SpO2	95.	%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils Right		Pupils Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: **Foot surgery 16/10. Requesting dressing change as bandage wet from puddle. Unable to get appt with practice nurse. Concerned re infection**

20m

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

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

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

Date	CLINICAL NOTES
07/11/19 14:05	Seen by (Dr) SIMPSON EMZ Time seen 14:05.

3103646054 31/03/1964
WHYTE
Brian

55 ♂ PC: wishing for wound dressing to be changed

HPC: ® hallux IP joint fusion 16/10/19.
↳ no complication
walked through puddle yesterday - got heel WB shoe wet
couldn't get appointment with practice nurse
→ A&E.
Feels well otherwise
no rigors. no fevers. no infective symptoms.

PMH: nil
Medications: Recent treatment with flucloxacillin from GP (got stitches out and concern r.e. ? infection).
NKDA.

O/E: looks well.

Apyrexial.
HR 67
BP 113/67

® great toe:
Small scab on medial aspect of incision site.
No discharge. No palpable swelling.
No significant spreading erythema.

Impression: no evidence of infection

(P) Re-dressed foe using finger dressing
New heel boot given - to keep weight until 13th October
follow up as previously arranged (appointment with OPD ortho on 20th Nov).
worsening advice r.e. infection given

Dr Eilidh Simpson
Foundation Trainee
GMC 7597[illegible]

6

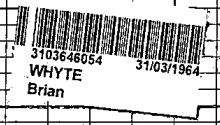
| | | |

KEY

2 3

DATE

TIME



Resp. Rate: 35 30 25 20 16 12 8

SpO2: ≥ 96 | 94-95 | 92-93 | ≤ 91 | %

Temp.: 39° 38.5° 38° 37.5° 37° 36.5° 36° 35.5° 35°

Pulse: 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30

Blood Pressure: 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50

Alert
Verbal
Pain
Unresp

NEWS SCORE

BM

Pain

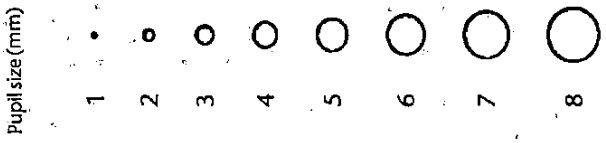
Nausea

Urine output

Obs due

Initials

Glasgow Coma Scale



Neurological Observations

| | | |

(9) JP to finish

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Southern General Hospital

CHI: 3103646054

Total Att: 6

12 Mth Att: 1

Title: MR

WHYTE **Brian**

DOB: **31/03/1964** Age: **51y** Sex: **Male**

133 KINNELL AVE

Glasgow
Lanarkshire
G52 3RT

Next of kin: **WILSON, ANNE**
Relationship: **Sister**
445 3094

GP: **M Fawcett**
0141 427 4271

Attendance Date: **08/04/2015** Arrival Time: **19:08**

Registration Time: **19:08** Date of Incident: **08/04/2015**

Major Incident Desc:

Reason for Attendance: ~~chest pain~~ tender big toe.

Nursing Assessment

Alerts: **Not Recorded** Allergies: **Not Recorded** Pain Score:

Triage Category: **3** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **08/04/2015 19:15**

Temp	**36.3**	C
HR	**92**	bpm
BP	104/65	mmHg
MAP		mmHg
RR	**14**	bpm
SpO2	100	%
Oxygen	21	%

Nurse name: **Nurse Andreia Leite**

BM	6.9	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	**4**
Motor	**6**
Verbal	**5**
Total	**15**

Pupils Right		Pupils Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: **Gp ref (no letter): tender L big toe. taking several cocodamol past couple days. also c/o upper abdo disconfort** and bending down for several months.

97607

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

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

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

SEPSIS

Sepsis: Pneumonia	
Sepsis: UTI	
Sepsis: Other infection	
Sepsis: Abdo pain	
Sepsis: Diarrhoea	
Sepsis: Abdo distension	
Sepsis: Meningitis	
Sepsis: Cellulitis	
Sepsis: Septic arthritis	
Sepsis: Wound infection	
Sepsis: Infected indwelling device	

AMPLE

Allergies	NONE
Other allergies	NONE
Medication	
Past history	CARDIAC ARREST FOLLOWING STABBING (2010).
Last eaten	>5 hrs
Events prior	UPGRADED NON EMERGENCY GP REFERAL. GP OUT EARLIER FOR (R) FOOT PAIN. ORDERED AMBULANCE. PATIENT PHONED BACK AND CLAIMED HAVING CHEST PAIN 999 RESPONSE. O/A PATIENT WALKING DOWNSTAIRS NO DISTRESS CLAIMING UPPER ABDO DISCOMFORT...HAS BEEN TAKING LOTS OF COCODOMOL PAST COUPLE DAYS. PATIENT CLAIMS HE WOULD HAVE USED PUBLIC TRANSPORT TO HOSPITAL BUT IS ON BENEFITS AND HAS NO MONEY.
Report ID	de6962a1-cd22-4894-8164-c9a5ea3fe85b

3103646054 31/03/1964
WHYTE
Brian

WHYTE, BRIAN ID: 3103646054 8-Apr-2015 19:2[illegible] SOUTHERN GENERAL HOSPITAL

31-Mar-1964
Male Caucasian

Loc: 301

Vent. rate [illegible] bpm
PR interval 146 ms
QRS duration 84 ms
QT/QTc 362/422 ms
P-R-T axes 71 72 51

*** Poor data quality, interpretation may be adversely affected
Normal sinus rhythm
Normal ECG

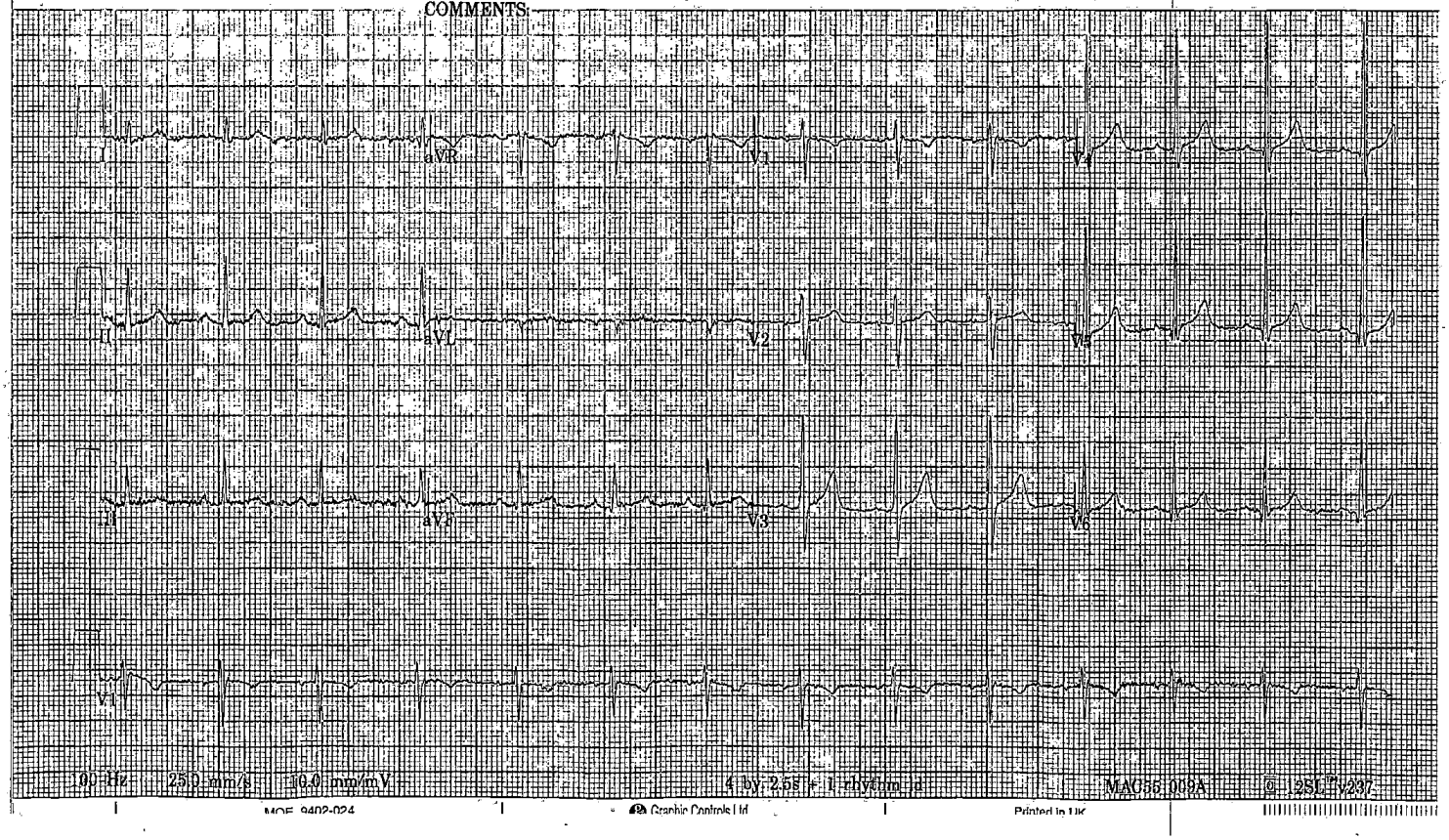
3103646054 31/03/1964
WHYTE
Brian

Technician:
Test ind:

Referred by:

Unconfirmed

COMMENTS:



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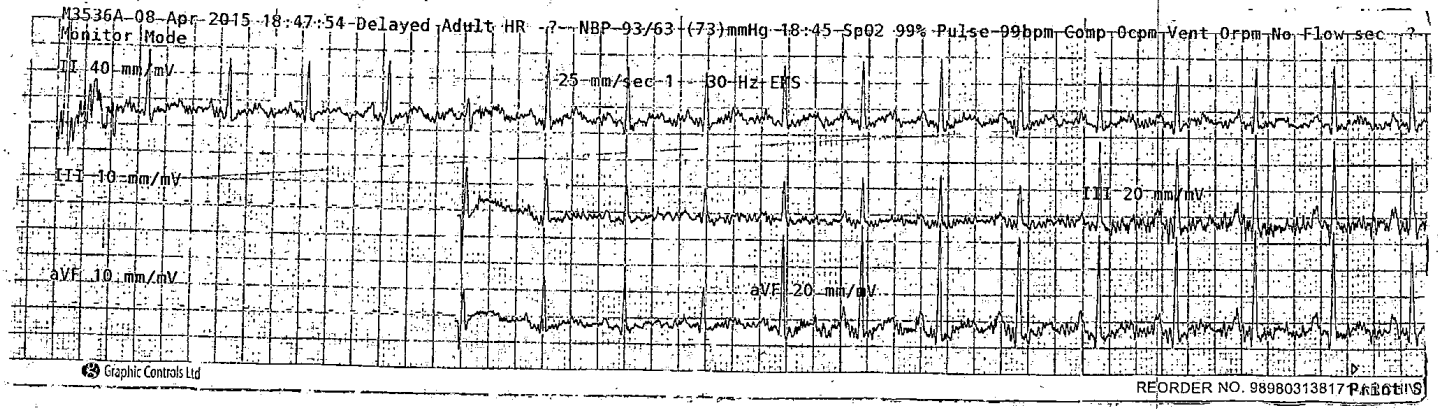
3103646054


M3536A 08-Apr-2015 18:47:54 Delayed Adult HR ?~ NBP 93/63 (73)mmHg 18:45 SpO2 99% Pulse 99bpm Comp 0cpm Vent 0rpm No Flow sec ?
Monitor Mode
II 40 mm/mV
25 mm/sec 1 30 Hz EMS
III 10 mm/mV
III 20 mm/mV
aVF 10 mm/mV
aVF 20 mm/mV
Graphic Controls Ltd
REORDER NO. 989803138171 Rev. B

Honeywell

Date	CLINICAL NOTES
	Seen by (Dr) LOUGHREY (CONS.) Time seen

51 ♂ GP ref – no letter available
Reports chronic pain to (R) leg toe and (R) foot – no injury; no wounds, no systemic upset
Pain in abdomen when bending over "for months"
Apparently called 999 c/o CP – denies any CP/dyspnoea/cough.

PMHx – Cardiac arrest 2010 (Denmark) – bilat lower limb compartment syndrome

Meds – see EDS NKA

3103648054 31/03/1964
WHYTE
Brian

O/E NAD. Apyrexial
(R) foot – neuropathic looking feet. Poor hygiene and podiatry care. Pulses, sensation intact. No wounds/ulcers/erythema.

(1) Chronic pain
– advised regular pain relief and Podiatry

Refused cocodamol 30/500, left without waiting for walking stick
→ 111 call GP name.

JMD.

Date	CLINICAL NOTES

Discharge Codes (~~Please~~ CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)	7. Irregular Discharge	8. D.O.A.		Discharge time	2130

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged	Not arranged	To be arranged

Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By
8/8/15	CO-CODAMOL 30/500	TT	PO	qds		Refused

Designed by Medical Illustration Services ref 243836

Whyte Brian CHI: 3103646054

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No Consent for Sharing Withheld: No

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF
Main Switchboard: 0141 201 1100

Date of Completion: 27/12/2015

Dr. HA McNaughtan
Drs Hilary Mcnaughtan & patrick j
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
G52 3SS

Dear Dr HA McNaughtan,

Name	CHI	DoB	Address
Brian Whyte	3103646054	31/03/1964	FLAT 2-3 Glasgow G52 3RT

Admitted	Type	Discharged	Destination
26/12/2015 13:11	In Patient	26/12/2015	

Specialty	Consultant	Ward	Telephone
General Medicine	Dr Brian Kennon	QEUH ARU2 General Medicine	01414522348 / 01414522349

Reason for Admission and Presenting Complaints	Admission Category
intoxicated, unrousable	Acute Admission no additional detail added

Diagnosis	Site	Side

Date	Procedures/Interventions/Operations

Clinical Comments: Dear Doctor,
Mr Whyte was admitted to the QEUH by ambulance after being found by a passerby unresponsive in a hedge. His GCS was 7 on arrival although his resp rate was normal. He was given naloxone with no effect in A&E. He was hypothermic on arrival; his initial leucocytosis resolved on warming. When he came round he admitted to taking around 20 x 10mg diazepam tablets. He was fully alert and orientated by 6pm and allowed home.
Kind regards

Treatments: None recorded.

Follow-up arranged: nil

Planned Outpatient Investigations: nil

Final Discharge letter to follow: y

Medication Info:

Allergies:

Height: cm **Weight:** kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment

Discontinued Medication:

Drug Name	Dose	UOM	Reason

Yours sincerely,
Dr Kim Lim1
Doctor

Prescription Review
Medications Reviewed by Pharmacist: ,
Dispensed Medications Checked by Pharmacy: ,
Nurse discharging patient: Kim Lim1, Doctor

Whyte Brian CHI: 3103646054

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No Consent for Sharing Withheld: No

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Drug Name	Dose	UOM	Reason

Yours sincerely,
Dr Kim Lim1
Doctor

Prescription Review
Medications Reviewed by Pharmacist:
Dispensed Medications Checked by Pharmacy:
Nurse discharging patient: Kim Lim1, Doctor

Whyte Brian CHI: 3103646054

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No Consent for Sharing Withheld: No

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Height: cm **Weight:** kg

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Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment

Discontinued Medication:

Drug Name	Dose	UOM	Reason

Yours sincerely,
Dr Kim Lim1
Doctor

Prescription Review
Medications Reviewed by Pharmacist: ,
Dispensed Medications Checked by Pharmacy: ,
Nurse discharging patient: Kim Lim1, Doctor

Acute Services Division
Emergency Department
RESUSCITATION CHART

3103646054
WHYTE M
Brian 31/03/196
FLAT 2-3
133 KINNELL AVENUE
Glasgow, Lanarkshire
G52 3RT

NHS Greater Glasgow and Clyde

Date and Time:

Date of Birth: CHI Number:

Incident time: Historians: Ambulance / Police / Relative / Other:

Details and Relevant Factors:

UNKNOWN MALE BIBA AS STANDBY - HYPOTHERMIC UNRESPONSIVE ? UNDER INFLUENCE OF UNKNOWN SUBSTANCES UNABLE TO GIVE ANY DETAILS - NAME, DOB ETC - NO ID IN PT'S CLOTHING. EVIDENCE OF GREEN POWDER AT OUTER CORNERS OF LIPS. BM: 5.2 BP 149/93 HR: 76 RR: 35 GIVEN 400MCG NARCAN BY SAS - LITTLE EFFECT. GCS - 7/10 PUPILS EARL BUT SLUGGISH - SBP (2)

PRF: Yes ☐ No ☐

Accompanied by: Relative / Police / Friend / Other

Procedures	Size/Site/Comment	Time	Care Providers		
			Time arrived	Name/Grade/Speciality	Time referred
Intravenous line (1)	GREEN NCCR HAND				
Intravenous line (2)			0930	SCOTT HEPBURN (CMS)	0930
Intubation					
Chest drain (1)					
Chest drain (2)					
Central venous line					
Urinary catheter					
Nasogastric					
Peritoneal lavage					
Arterial line					

Additional Notes

TEMP: 34.1 - GIVEN 1000MLS WARMED SALINE.
BAIR HUGGER IN SITU.

	Listed	Patient	Police	Other
Clothing				
Valuables				

Ambulance ordered at:

CAT:

Relatives present ☐

Being contacted by:

Discharge to:

Airway and Cervical Spine		Secondary Survey	
Normal ☐	Trauma ☐	Head	☐
Unconcious	☐	Maxillary Facial	☐
Ventilated	☐	CSpine and Neck	☐
Oxygen ☐ Litres/%		Chest	☐
Trauma mask	☐	Abdomen	☐
Hudson	☐	G.U.	☐
Ventmask	☐	Back	☐
ETT ☐ Size:		Limbs	☐
Other		Other (specify:)	
C Spine	Normal ☐		
Immobilised	☐		
Collar ☐	Sandbags ☐		

CVP

Prescribed Drugs

Time	Drug	Dose	Route

Fluids

Time	Fluid	Volume	Total
0950	(N) SALINE	1000MLS	

Losses

Time	Type	Volume

Date: 26/12/15 (0845) (1120)

Use 24 hour clock to record times

Coma Scale					
Eyes open	Spontaneously				
	To speech			✓	
	To pain				
	None	✓	✓		
Best motor response	Obeys commands				
	Localise pain	✓	✓		
	Normal flexion to pain				
	Abnormal flexion to pain				
	Extension to pain				
	None				
Best verbal response	Orientated				
	Confused				
	Inappropriate words				
	Incomprehensible sounds	✓	✓	0	
	None				

Eyes closed by swelling =C

Endotracheal tube or tracheostomy =T

Usually record the best arm response

X Rays

- CS spine ☐
- Pelvis ☐
- Other (specify):

Last ATT

Pupil Scale (mm): 1, 2, 4, 5, 6, 7, 8

		240			
	40	230			
	39	220			
	temp°	210			
	37	200			
	36	190	34.2°C		
	35	180		34.8°C	
		170			
		160			
	Blood	150			
	Pressure	140	14		
	and	130			
	Pulse	120	112		
	Rate	110	113	101	
		100			
	•	90			
		80		80	
		70	77	82	
		60	76	69	
		50			
		40			
	Respiration	30	35	29	28
	X	20			
		10			
% Oxygen sat.			94	97	94
% Oxygen given			RA	RA	2LNC
CVP					
BM STIX			5.2		
CO2					

Pupils					
	Right	Size	2	2	2
		Reaction	+	+	+
	Left	Size	2	2	2
		Reaction	+	+	+

Limb Movement					
	Arms	Normal power	0		0
		Mild weakness			
		Severe weakness			
		Spastic flexion			
		Extension			
		No response			
	Legs	Normal power			0
		Mild weakness			
		Severe weakness			
		Spastic flexion			
		Extension			
		No response			

Ample

Allergies: UNKNOWN

Medications: UNKNOWN

Past medical history: UNKNOWN

Last ate/drank

Events: FOUND BY PASSERS-BY LEANING ON FENCE - UNABLE TO ASCERTAIN ANY DETAILS FROM PT - PHONED 999 AMB TOOK PT INTO HOUSE

Bloods ordered

	Time
Grouped	
X-matched	
Flying squad	

Weight (kg)

Estimated:

Actual:

Length/Height (cm)

Measured:

Cardiac Arrest Use Only

Presenting Rhythm	BM													
Time														
Temp														
Pulse														
Rhythm														
BP														
30;2 2 min cycle														
Adrenaline 1mg														
Amodroine 300mg														
Atropine 3mg														
Shock														
Intubation														
Fluid														
Other (specify)														
Drugs														
Rosc care	BM		Temp		HR		BP		O2		CO2		ITU	
Pacing														
ABG														

Laboratory Results

Blood x-matched YES ☐ NO ☐	Group:	Saved YES ☐ NO ☐	Number of units:
Blood ready for use at:	hrs	Being stored at:	

O -ve YES ☐ NO ☐

Time	Time	Time	Time	Time

MIS'262153

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

CHI: TJ03923171

Queen Elizabeth University Hospital

3103646054
WHYTE
Brian M
31/03/1962
FLAT 2-3
133 KINNELL AVENUE
Glasgow, Lanarkshire
G52 3RT

Total Att: 0
12 Mth Att: 0

Male

Age: 114y

Sex: Male

Next of kin:
Relationship:

Unknown
NK010AA

GP: UNK-Unknown GP

Attendance Date: 26/12/2015 Arrival Time: 09:29
Registration Time: 09:29 Date of Incident: 26/12/2015
Major Incident Desc:

Reason for Attendance: Resus

Affix Label

Nursing Assessment

Alerts: Not Recorded Allergies: Not Recorded Pain Score:
Triage Category: 1 Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 26/12/2015 09:33 Nurse name: Nurse Coral Burgess

Temp	34.2	C
HR	86	bpm
BP	148/96	mmHg
MAP		mmHg
RR	34	bpm
SpO2	88	%
Oxygen	RA	%

BM	5.2	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	0
Motor	5
Verbal	2
Total	7

Pupils-Right		Pupils-Left	
Size (mm)	2	Size (mm)	2
Reaction	4	Reaction	4

Nursing Notes: standby

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

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

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

Date	CLINICAL NOTES
26/12/15	Seen by (Dr) Hagan — Time seen

Unwell ↺.

BIBA.

PMHx – unclear, ?meds, ?allergies.

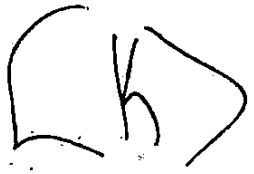
Scattered – found by ore bags. Non-compliant. Literacy.

No history for patient.

Stigmata of wicked day inside – blue/green powder
hand mouth; no IVDU marks.

A – Sig Malacy

B RR 30 SpO_2 98% on.



c/o throat.
Sore neck.
(Note Rel Comms Correction Src)

C P83 BP 148/92. T 34.2. BM 5.0.
IV access; bloods ✓

D A ✓ open speech pain — pupils 2mm equal
P ✓ unsure speech (Head noise by ambulance)
U. bradycardia + RR.

E. Evidence of clinical bacteraemia
Clin RMO

Urine gr. Nit+ 49.4
Hb 142
WCC 1.7
HCO3 25.2

– bloods / warm fluids / Bare Lugs – review.

Date	CLINICAL NOTES
	Amylase 35 WCC 25-6 γGT 22 Gm 5-2 Ca corr 2.50 Neut 22.3 Bili 12 Phos 1.10 CK 1895 Hb 142 ALT 20 CRP 5 Plat 276 ALP 44 alb p 141 Na 138 K 4.5 Ur 8-6 Cr 60

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged	Not arranged	To be arranged

Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Designed by Medical Illustration Services ref 243836

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

Hospital (*circle*)	IRH	RAH	RHSC	GRI	WIG	VI	VIMIU	Stob	VOL	SGH

Title:	Sex: M ☐ F ☐
SURNAME:	Forename:
CHI:	Dob:: Age:
Lo 3103646054 WHYTE M Brian 31/03/1964 FLAT 2/3 133 KINNELL AVENUE Glasgow, Lanarkshire G52 3RT	Next of kin: Relationship: Tel: GP:
Postcode:	
Tel:	Tel:

Attendance date:	Arrival time:	Date of incident:
Registration time:	Major incident description:	
Reason for attendance:		

Affix Label

Nursing Assessment	Alerts:
Presenting complaint:	

Triage category:	Pain score:	Tetanus up-to-date / fully immunised?
Allergies:		

Observations date:			Time:			Nurse's name:			
Temperature		°C	BM		mmol/L	GCS			
HR		bpm	PF		l/min	Eyes			
BP		mmHg	Expected PF		l/min	Motor			
MAP		mmHg	Weight		kg	Verbal			
RR		bpm	Height		cm	Total			
SpO_2		%	Visual Acuity			Pupils – Right		Pupils – Left	
Oxygen		%	Left	6/		Size		Size	
			Right	6/		Reaction		Reaction	
			With correction?						

Nursing Notes:

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen

Differential Diagnosis/Problem List	
	SEWS ☐ 0-7 RED FLAG ☐ (Tick) SIRS ☐ CURB 65 ☐

Done/ completed	Imediate Managment Plan

Signature:	Designation:	Page No:

Acute Medical or Surgical Admission Unit Notes

TJ03923171
UNKNOWN
Male
Unknown
M
01/01/1901
NK010AA

here

Initial Assessment

Seen by (print): KEMACRC CD

Time seen: 26/12/15 13.32

Presenting Complaint

♂ unknown male
admitted c intubated

History of Presenting Complaint

found in hedge
BIBA
blue paste around mouth
no hx for pt
↓ T° in A+E 38.3 (tympanic)

Past Medical History

?

Systemic Enquiry

CVS

RESP

GI

CNS/PNS

GU

Musculoskeletal

MEDICINES RECONCILIATION (ECS can be stapled here and annotated with plan for medicines. Please sign medicines plan.)

Source of medication history Patient ☐ Relative/ carer ☐ GP Surgery ☐ ECS ☐
PODs ☐ Com. Pharmacist ☐ GP letter ☐ Rpt Presc ☐

Admissions medicines				Plan for medicines			
Name	Dose	Frequency	Continue	Stop	Amend	Hold	Comments/ reason

Allergies	Medication needs
None known ☐	Further clarification? Yes ☐ No ☐
Completed by: Designation:	Date:

Drugs prescribed on admission checked and correct

Compliance aid? Yes ☐ No ☐

Comments:	Community Pharmacist
Reviewed by: Designation:	Date:

TJ03923171
UNKNOWN
Male
Unknown
M
01/01/1901
NK010AA

Social History

Smoking History:

Alcohol History:

Other drug use?:

Home circumstances

General Examination

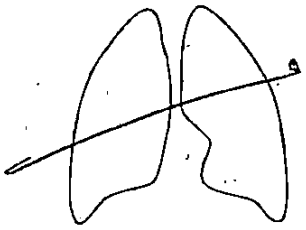
Temp: 35.9	RR: 18
Pulse 101	BG:
SpO2: 96 (A)	Weight:
BP: 102/57	Urinalysis:

Cardiovascular Examination

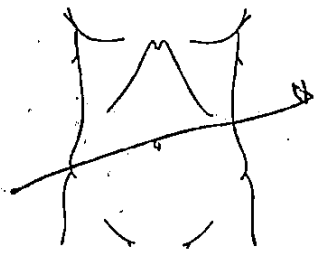
HS NDHO
abdo soft

General Observations

Respiratory Examination



Abdominal Examination



Neurological and Other Examination (e.g. locomotor)

Cranial Nerves

GCS: E: 1 M 5 V: 2 TOTAL 8

AMT ☐

Fundoscopy:

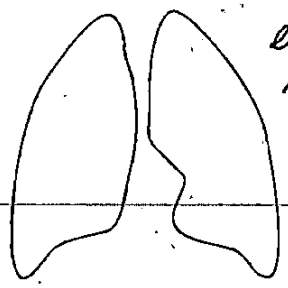
Upper limb neurological examination

Lower limb neurological examination

Other

Key Results:

CXR:



essentially normal

Urinalysis:

ECG:

prolonged QTc 496ms.

Differential Diagnosis/Problem List

(1) 1) intoxication.
2) cellulitis & cardiac Ix 49.4
→? substance misuse

SEWS ☐ 0-7

RED FLAG ☐ (Tick)

If SIRS ☐

CURB 65 ☐

Immediate Managment Plan	Done/ Ordered	Checklist
		Medicines plan documented ☐
1) repeat ECG & QTc		Blood results received ☐
still prolonged → telemetry		Kardex ☐
2) Mgt+ level		Antimicrobials as per Policy
3) Repeat blood		Yes ☐ No ☐
4) VBG		If 'No' state reason:
5) cardiac fluids.		
		DVT prophylaxis indicated
		Yes ☐ No ☐
		DVT prophylaxis prescribed
		Yes ☐ N/A ☐

Doctor Completing Initial Assessment

Name (print): KEMPSTON Signature: Designation: CT1

Page No.

Please affix patient ID label here

Secondary or Senior Focused Review

Seen by (print):

Time seen:

Done/ completed	Continuing Managment Plan

Doctor Completing Initial Assessment

Signature: Designation: Page No.:

Senior Doctor Review

Seen by (print): Konwow

Time seen: 1545 Hrs

TJ03923171
UNKNOWN
Male M
Ple Unknown 01/01/1901
NK010AA

- Now wakened up - BRIAN WHITE 31/3/64
51♂ PHx · Ex-Heroin User - On Methadone
· Sobbing

Pw

1. Collapse 2° Diazepam use

2. Hypothermia - likely accounting for ↑CK level - no infective symptoms

CXR - ↑ markings, CR LZ - not appreciated clinically & no resp symptoms.

GCS 15/15 MSE 10/10

DVT Prophylaxis indicated Yes ☐ No ☑	Antimicrobials choice compliant Yes ☐ No ☐ N/A
DVT Prphylaxis prescribed Yes ☐ N/A ☑	If 'No' state reason
Medicines Reconciliation completed Yes ☑ No ☐	

Done/ completed	Continuing Managment Plan
	To - End.
	- Cont. re-evaluation
	- May get home later if well & obs remain

Signature: Designation: Page No:

Cons

Please affix patient ID label here

Continuation Sheet	
Date: Time	

Continuation Sheet	
Date: Time	

Please affix patient ID label here

Continuation Sheet	
Date: Time	

Continuation Sheet	
Date: Time	

PLEASE DO NOT WRITE HERE

Attach GP Letter, Results or Emergency Care Summary

Serial Blood Results								
	Date:	26/12/15						
	Time:	09:43						
	Signature:							
Sodium	135 - 146	138						
Potassium	3.5 - 5.3	4.5						
Chloride	95 - 108	109						
Urea	2.6 - 7.8	8.6						
Creatinine	40 - 130	60						
Estimated GFR		>60						
Bicarbonate	22 - 29							
Glucose	3.5 - 6.0	5.2						
CRP	0 -10	5						
Magnesium	0.7 - 1.0							
Calcium	2.2 - 2.6	2.59						
Calcium Adj	2.2 - 2.6	2.5						
Phosphate	0.8 - 1.5	1.60						
Cardiac Enzymes & Liver Function Tests	**Normal Values**							
Troponin	<0.04							
CK	<150	1895						
Amylase	0 - 100							
ALT 1085	0 - 50	200/44						
Gamma-GT	0 - 70	82						
Alk Phos	30 - 130	141						
Total Bilirubin	0 - 20	12						
Albumin	35 - 50	42						
Haematology & Clotting Screen	**Normal Values**							
White Blood Count	4.0 - 11.0	25.6						
Haemoglobin	115 - 165	142						
Haematocrit	0.370 - 0.470	0.431						
MCV	80 - 100	87.6						
Platelet Count	150 - 410	276						
Neutrophils	1.8 - 7.7	22.3						
Lymphocytes	1 - 4.8							
Prothrombin Time	9 - 13							
PCT Ratio								
APTT	27 - 38							
APTT ratio	0.8 - 1.2							
Thrombin Time	10 - 16							
TCT Ratio								
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)								
Other								
Arylase		35						
fructosamine		<10						

Emergency Department Nursing Documentation

Done/ Time	

Once only prescriptions (inlcuding 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

DISCHARGE CODES: Please Circle

1. Admission 2. Discharge 3. Refer to G.P. 4. Transfer to other hospital (see below)
5. Died 6. Refer to O.P. Clinic (see below) 7. Irregular Discharge 8. D.O.A.

Time Ready to Depart	
Discharge Time	

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

Outpatient clinic specialty	Admission or specialty clinic consultant

Clinic Referred to	AE	OP DVT	DME Falls	TIA	Medical	Surgical	First Seizure	Others Specify

REPORT

Time 09:36 Date 26/12/2015

PATIENT AND INCIDENT DETAILS

Incident number	CR002615918.001
Name	UNKNOWN UNKNOWN
Address	UNKNOWN
Age	45 years
Gender	Male
Incident location	3 ELDERPARK GARDENS WEST DRUMOYNE GLASGOW
Incident post code	G51 3NX
Incident type	EMG
Call received	26/12/2015, 08:48
Call passed	26/12/2015, 08:49
Crew mobile	26/12/2015, 08:50
Crew at scene	26/12/2015, 09:00
Crew left scene	26/12/2015, 09:17
Patient at hospital	26/12/2015, 09:22
Receiving hospital and department	QEUH Queen Elizabeth University Hospital

PRIMARY SURVEY

RESPONSE

AVPU	Pain

AIRWAY

Airway assessment	Clear

BREATHING

Breathing rate	Fast
Respiratory rate	28

CIRCULATION

Pulse rate	Normal
Cap refill rate	>2 secs
Skin colour	Pale
Skin texture	Cold

C-SPINE INJURY

Suspicion of CSI	No evidence of C-spine injury

PATIENT CONSENT

Patient consent	Risk of refusal explained, Lack of patient consent
Duty of care delegated to	QEUH RESUS

AMPDS

Dispatch code	31D03	Unconscious or Fainting - Not Alert
Final code	26C01	Sick Person, Altered level of consciousness

GCS

Final GCS eye opening	To pain
Final GCS verbal response	Confused
Final GCS motor response	Localised pain

VITAL SIGNS

Time hr : min	09:02	09:15	-	-
Pulse bpm	92	98	-	-
Pulse rhythm	Reg	Reg	-	-
Resp. rpm	28	28	-	-
BP mm Hg	93 / 67	94 / 70	- / -	- / -
Cap refill (secs)	>2 secs	>2 secs	-	-
Peak flow %	-	-	-	-
Blood sugar mmol / l	6.2	-	-	-
Staff / carer concern	-	-	-	-
EtCO2 mm Hg	-	-	-	-
Pain score	-	-	-	-
Temp °C	-	-	-	-
SpO2 %	98	99	-	-
GCS Total	8	11	-	-
NEWS	6	6	-	-
RTS	5.7	6.6	-	-
ECG	NSR	NSR	-	-
Sepsis	2	2	0	-
Lactate	-	-	-	-
AVPU	-	-	-	-

SEPSIS

Sepsis: Pneumonia	
Sepsis: UTI	
Sepsis: Other infection	
Sepsis: Abdo pain	
Sepsis: Diarrhoea	
Sepsis: Abdo distension	
Sepsis: Meningitis	
Sepsis: Cellulitis	
Sepsis: Septic arthritis	
Sepsis: Wound infection	
Sepsis: Infected indwelling device	

EYES AND PUPIL SIZE AND REACTION

	Left	Right
Pupil size	Constricted	Constricted
Pupil reaction	Normal	Normal

AMPLE

Allergies	Unknown
Other allergies	
Medication	UNKNOWN
Past history	UNKNOWN.
Last eaten	>5 hrs
Events prior	999 CALL FOR MALE OF UNKNOWN AGE WHO WAS SEEN OUTSIDE A HOUSE HOLDING ONTO A FENCE, SHAKING, COLD, PALE AND NOT REDUCED GCS.

DRUGS, GASES AND PAIN RELIEF

Pain before	Drug / gas given	Time given	Dose given	Route	Batch No.	Pain after
-	Oxygen	09:06	6L/MIN	Inh	-	-
-	Naloxone	09:08	400MCG	IM	-	-

EMERGENCY SERVICES ON SCENE

Rapid Response Unit (RRU) Technician	Paramedic

PATIENT HANDOVER

On arrival at scene	Seated
Scene removal	Chair
Transportation	Lying
Care delivery at hospital	Trolley

FINAL OBSERVATION AND COMMENTS

O/A PT IS NOW SITTING ON STAIRS INSIDE HOUSE (BROUGHT IN BY MEMBERS OF PUBLIC). PT RESPS FAST AND DEEP. PINPOINT PUPILS. BLUE SUBSTANCE AROUND LIPS. GAVE NARCAN. PT CLOTHES SOAKED, REMOVED THEM AND WARMED PT WITH BLANKETS. PREALERT TO QEUH.

Report ID	c4e4848a-de66-4e66-8656-18434b76f02c

es

on (A) Unknown
Room 55 Male

SOUTHERN GENERAL
SITU

Patient Sample Report

Patient

ID:	TJ03923171
Last Name:	UNKNOWN
First Name:	MALE
Gender/Age:	Male, 114 years
Birth Date:	01.01.1901
Status:	ACCEPTED
Analyzed:	26.12.2015 09:44:47
Sample Type:	~~Arterial~~
Operator ID:	HEPBURN0 SCOTT

Room 1 QV

Analyzer

Model:	GEM® *Premier 4000*
Area:	AH3
Name:	ED-A
S/N:	06100193

Measured (37.0°C)		
cH	↑ 49.4	nmol/L
pCO_2	↑ 6.6	kPa
pO_2	↓↓ 5.7	kPa
Na^+	141	mmol/L
K^+	4.4	mmol/L
Cl^-	102	mmol/L
Glu	5.0	mmol/L
Lac	↑ 2.7	mmol/L
CO-Oximetry		
tHb	142	g/L
O_2Hb	↓ 72.3	%
COHb	↑ 2.4	%
MetHb	0.7	%
HHb	↑ 24.7	%
sO_2	↓ 74.5	%
Derived		
BE(B)	-1.7	mmol/L
HCO_3^-(c)	25.2	mmol/L
Hct(c)	43	%
Operator Entered		
Temp	37.0	°C
O2 and Vent Settings		
FIO_2		%

↑↓ Outside Reference Range
↑↑ ↓↓ Outside Critical Range

Patient Sample Report

Patient

ID:	TJ03923171 0000000000
Last Name:	~~TEST~~
First Name:	~~Dummy~~
Gender/Age:	~~Male, 65 years~~
Birth Date:	01.01.1950
Status:	ACCEPTED
Analyzed:	26.12.2015 14:38:25
Sample Type:	Venous
Operator ID:	S HARTE

Analyzer

Model:	GEM® *Premier 4000*
Area:	AH16
Name:	ACUTE RECEIVING
S/N:	06080137

Measured (37.0°C)		
cH	48.3	nmol/L
pCO_2	5.6	kPa
pO_2	8.4	kPa
Na^+	137	mmol/L
K^+	3.9	mmol/L
Cl^-	103	mmol/L
Glu	2.5	mmol/L
Lac	0.6	mmol/L
CO-Oximetry		
tHb	133	g/L
O_2Hb	90.5	%
COHb	2.4	%
MetHb	1.4	%
HHb	5.8	%
sO_2	94.0	%
Derived		
BE(B)	-4.3	mmol/L
HCO_3^-(c)	21.6	mmol/L
Hct(c)	40	%
Operator Entered		
Temp	37.0	°C
O2 and Vent Settings		
FIO_2		%

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Southern General Hospital

CHI: 3103646054

Total Att: 5

12 Mth Att: 0

Title: MR

WHYTE, Brian

DOB: 31/03/1964 Age: 50y Sex: Male

133 KINNELL AVE
Glasgow
Lanarkshire
G52 3RT

Next of kin: WILSON, ANNE
Relationship: Sister
445 3094

James Douglas
Nephew
07900019243

GP: M Fawcett
0141 427 4271

Attendance Date: 27/11/2014 Arrival Time: 07:38

Registration Time: 07:38 Date of Incident: 27/11/2014

Major Incident Desc:

Reason for Attendance: stand by

Nursing Assessment

Alerts: Not Recorded Allergies: Not Recorded Pain Score:

Tetanus up to date/fully immunised:

Triage Category: 1

Presenting Complaint:

Observation Date: 27/11/2014 07:41

Nurse name: Nurse Margaret Williams

Temp		C
HR		bpm
BP	/	mmHg
MAP		mmHg
RR		bpm
SpO2		%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils Right		Pupils Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: standby

WHYTE, Brian
133 Kinnell Ave, Glasgow, Lanarkshire, G52 3RT
Request (Requested/Received): 27/11/14
Ref: Dr Jason Long - SGH Emergency Department
XR Chest

E-29034718

CRIS 671782 31 03 64 6054 Mob: Portable

Date 27/11/14 | Emergency Department Notes

Seen by (Doctor) MOY | LITTLEWOOD | HUNTER. | Time seen 0715

50♂

Resus.

Standby

found collapsed in street with dog, not responding. Narcan 800μg IM by SAS → no effect.

On arrival

A - obstructed, airway manoeuvres

B - AE (L) = (R) = (W). RR = 22. Sats 100% TM.

C - P - 110 BP = 150/120 good radial

D - GCS E 1 M 3 V 1 Agitate
Pupils Equal reactive - medium
Moving all 4 limbs

BM = 8.9.

Previous clamshell thoracotomy scar. No obvious HJ. No incontinence

→ Seen by Dr Moy initially. → Narcan 400μg IM + 400μg IV with no effect.

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen

In attendance at 0745 (NL)
- likely dx IC bleed or post seizure

→ CT scan requested

→ RSI - alf/propofol/sux - grade 1 (Mac)
BP 105/60 post.
- propofol/roc for maintenance

ICU informed

- ECG ✓
- A-line ✓
- catheter ✓

	08:46	Post RSI 09:00
	H+40	H+57
	pCO_2 5	pCO_2 7.1
	pO_2 14	pO_2 4.34
	HCO_3 25.5	HCO_3 23
	BE -1	BE -4.7
	HCO_3 23	
	K^+ 3.0	↓ vent altered

CT:

CXR - (R) lower lobe consolidation
?aspiration → start IV amox/metronidazole

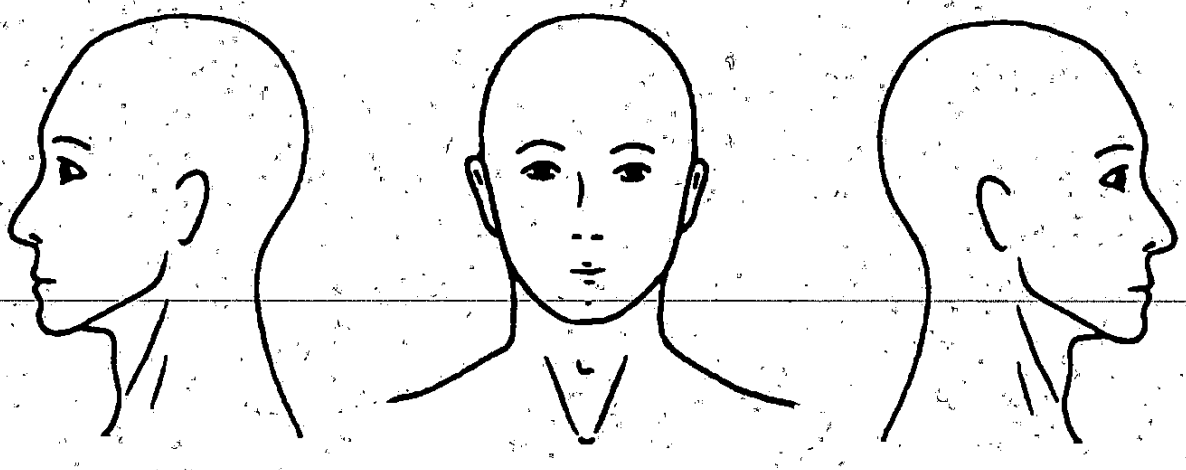
Differential Diagnosis/Problem List

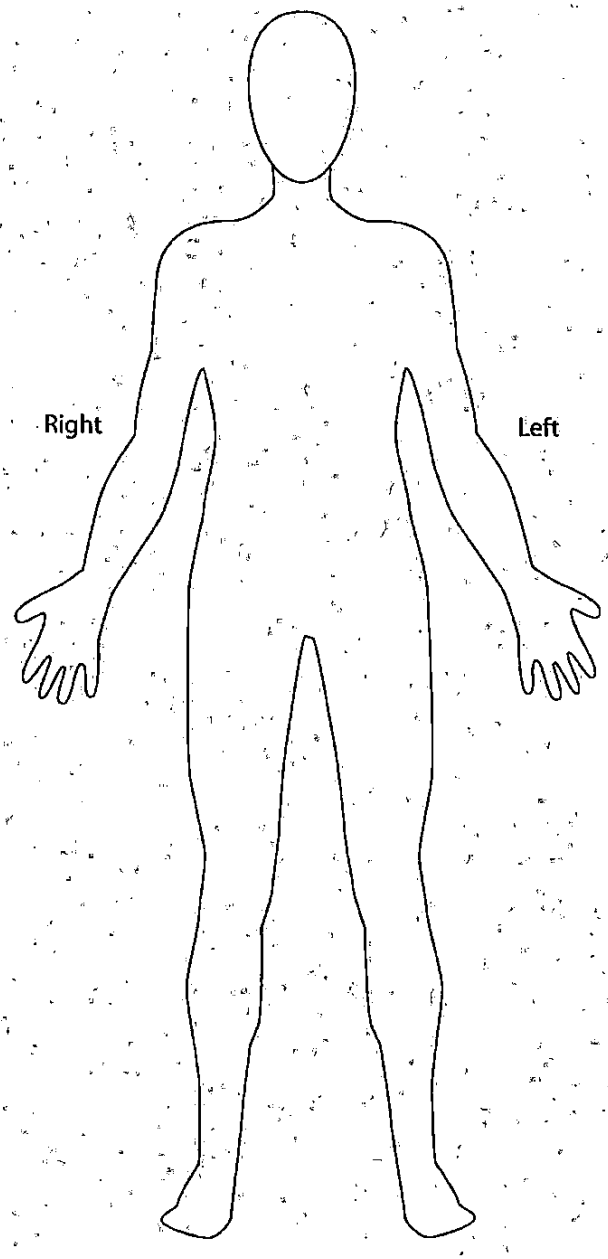
SEWS ☐ 0-7

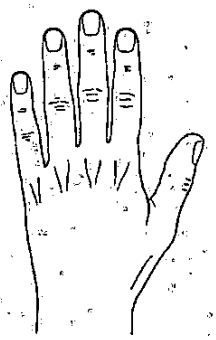
RED FLAG ☐ (Tick)

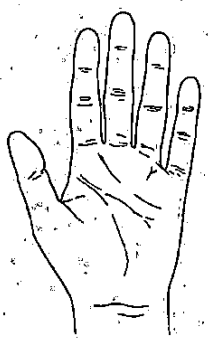
SIRS ☐

CURB 65 ☐

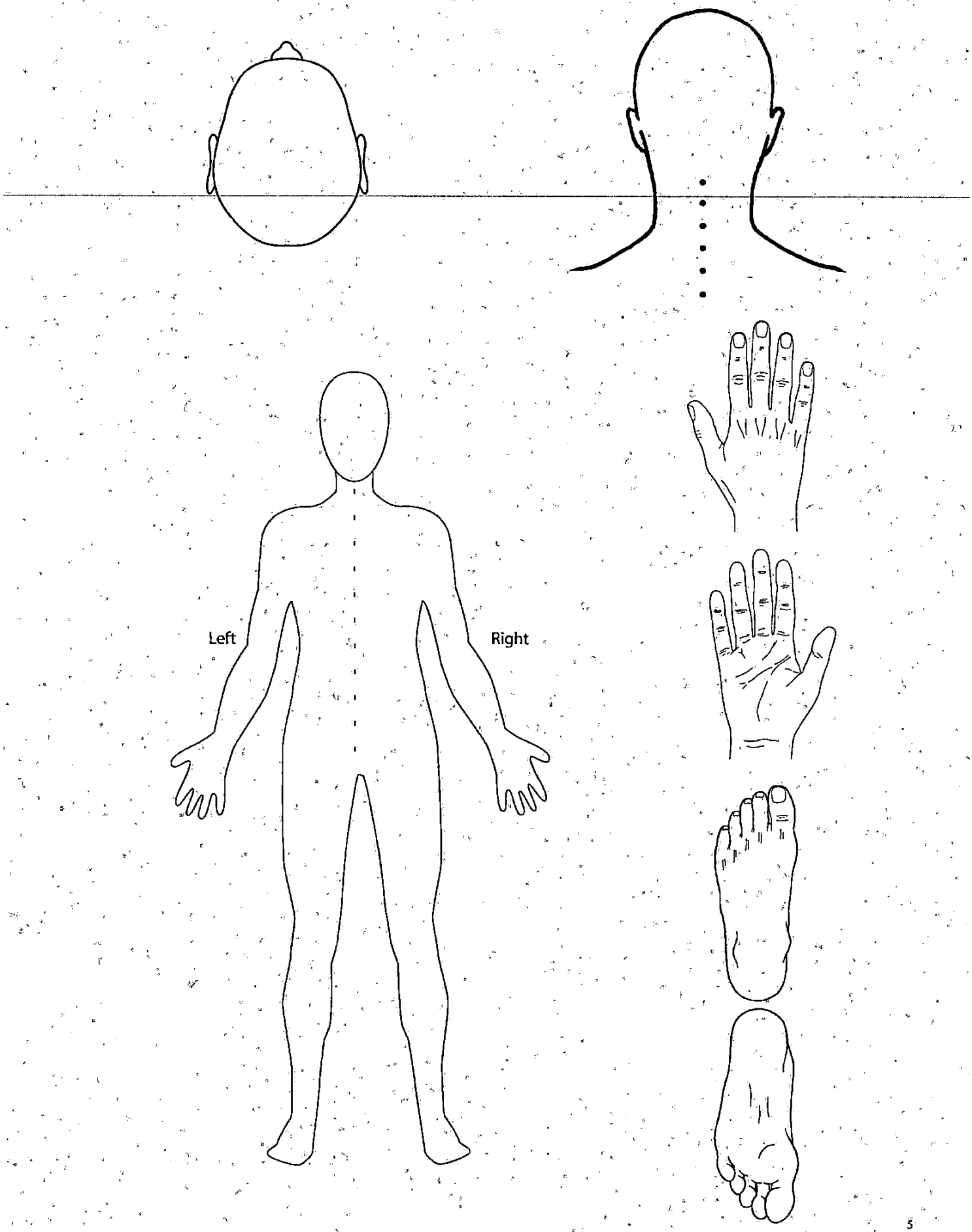



Right
Left





Injuries / Problems



List of injuries / problems

Continuation Sheet	
Date: Time	

SOUTHERN GENERAL HOSPITAL 3103646054 31/03/1964 WHYTE Brian **I.V. THERAPY PRESCRIPTION SHEET**

NAME: BRIAN WHYTE WARD: ED. 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
27/11	0730	A	Nacl 0.9%		1L	Strat			14J21BL	27/11	0730		
27/11	0800	B	Nacl 0.9%		1L	Strat			14J21BL	27/11	0800		
27/11	0850	C	Nacl 0.9%	+20mmol KCl	500ml	4°			14E12E3G	27/11	0900		
		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: 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

INTRAVENOUS INFUSION CHART

SYRINGE PUMPS

NHS
Greater Glasgow and Clyde

3103646054 31/03/1964
WHYTE
Brian

Surname: | D.O.B. | Unit No:

Forename: | Speciality/Ward

1. Check and record rate, amount infused via syringe and totaliser, hourly.
2. All changes to be recorded in red across the chart and signed as witnessed.
3. Reset totaliser and check pump setting with each new syringe.
4. Record Model and Physics reference number of pump.

(FILE IN PATIENT'S NOTES ON DISCHARGE)

Pump Type/Model: | Reference No. 1: | Change of Pump Ref No.:

DRUG	DOSE	INFUSION FLUID/AMOUNT	RATE	DR'S SIGNATURE
Propofol	2%	Plasmix.		

DATE	TIME	DRUG	SETTING ON PUMP	AMOUNT IN SYRINGE	TOTALISER AMOUNT	BLOOD GLUCOSE	NURSES' SIGNATURE	DOCTOR'S SIGNATURE
27/11/09	09[00]	Propofol.	10.0	50.	3		[illegible]	
	09[30]	Propofol.	10.0		10.3.		[illegible]	
	10[00]	off.						

SGH 9

Forename:	Surname:	Unit No:

DATE	TIME	DRUG	SETTING ON PUMP	AMOUNT IN SYRINGE	TOTALISER AMOUNT	BLOOD GLUCOSE	NURSES' SIGNATURE	DOCTOR'S SIGNATURE

ID: 27-Nov-2014 8:36:28 SOUTHERN GENERAL HOSPITAL

Vent. rate		bpm
PR interval	166	ms
QRS duration	116	ms
QT/QTc	456/538	ms
P-R-T axes	80 78	54

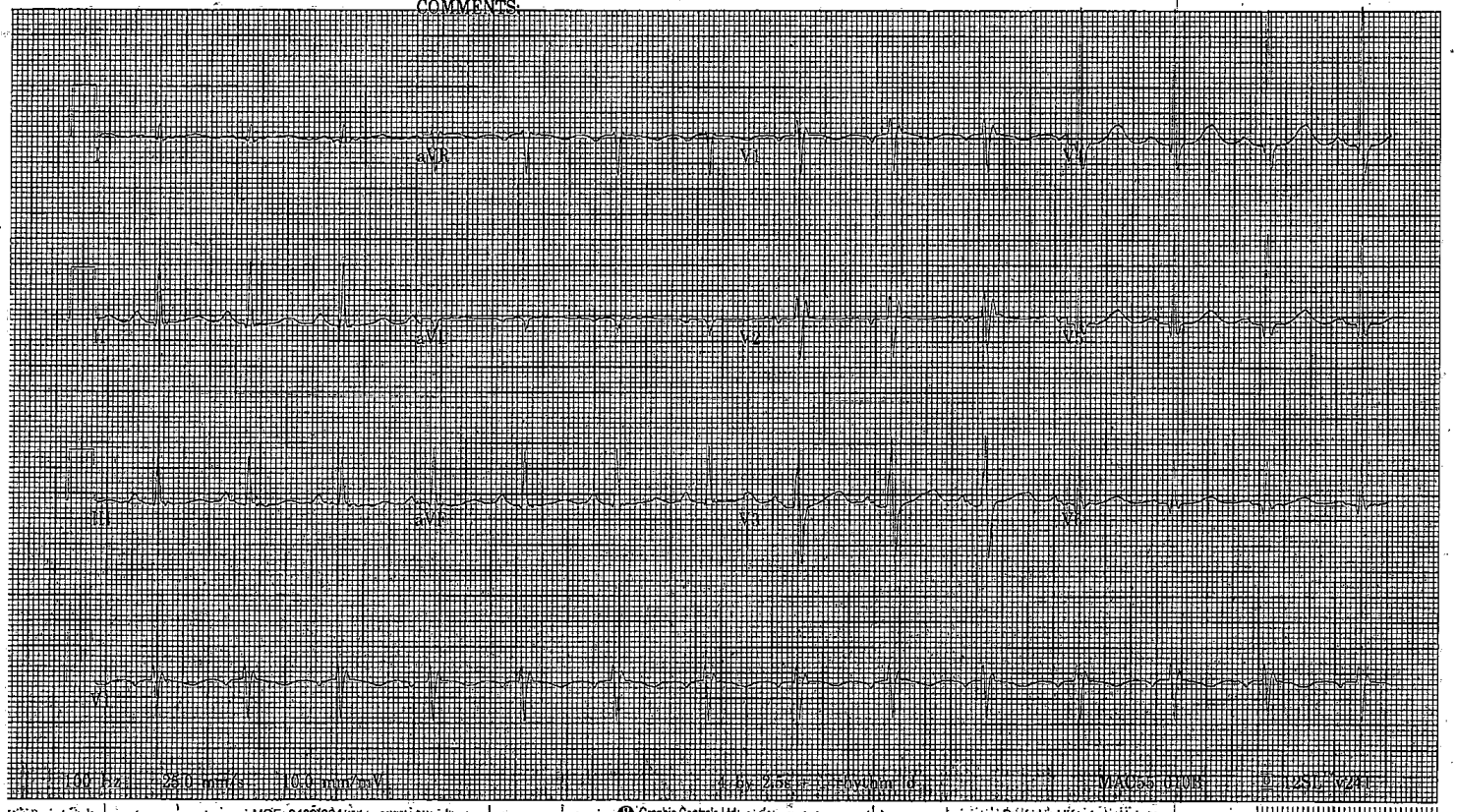
Normal sinus rhythm
Possible Left atrial enlargement
Incomplete right bundle branch block
Possible Lateral infarct, age undetermined
Prolonged QT

[redacted]

Technician:
Test ind:

Referred by: Unconfirmed

COMMENTS:



Southern General Hospital
Emergency Department Urinalysis

Name	Brian Whyte
CHI	
Date	27/11/14

Leucocytes	NEG
Nitrites	NEG
Protein	+
pH	7.0
Blood	trace
Spec Gravity	1.005
Ketones	++
Glucose	NEG
β-HCG	

Continuation Sheet	
Date: Time	

Please affix patient ID label here

Secondary or Senior Focused Review

Seen by (print):

Time seen:

Done/ completed	Continuing Managment Plan

Doctor Completing Initial Assessment

Signature: Designation: Page No.:

Senior Doctor Review

Seen by (print):

Time seen:

Please affix patient ID label here

Done/ completed	Continuing Managment Plan

Signature: Designation: Page No:

on 27 Nov 20

Page 1 of 1

Police

Incident 208/27/11/14

Contact.
Police.
ON 101
if detained.

SOUTHERN GENERAL HO

INTERIM RECEIPT OF PAT

WARD A/E

Date 27/11/14

Patient's Name BRIAN WHYTE

Date of Admission 27/11/14

Home Address 133 KINNELL AVENUE
GLASGOW
G52 3RT

Next of Kin - Name ANNE WILSON

Relationship SISTER.

Address 0141 445 3094

Total Value of Money:- CASH £85.37 (4 x £20, 1 x £5, rest in coins.)

Details of Personal Valuables:-

Description	Quantity	Details

Listed by SUSAN YOUNG Date 27-11-14

Checked by Date 27-11-14

Deposited with :-

Hospital Cashier Signature Date

Night Safe Signature Date

Taken by* Signature Date

*Relationship to patient

N.B. OFFICIAL RECEIPT SHOULD BE RECEIVED WITHIN 48 HOURS

SGH188

PLE ERE

At or

Er y

Serial Blood Results								
	Date:	27/11						
	Time:	0946						
	Signature:							
Sodium	135 - 146	135						
Potassium	3.5 - 5.3	3.5						
Chloride	95 - 108	101						
Urea	2.6 - 7.8	3.9						
Creatinine	40 - 130	61						
Estimated GFR		>60						
Bicarbonate	22 - 29							
Glucose	3.5 - 6.0	10.0.						
CRP	0 - 10	165						
Magnesium	0.7 - 1.0							
Calcium	2.2 - 2.6	2.36						
Calcium Adj	2.2 - 2.6	2.38.						
Phosphate	0.8 - 1.5	1.18						
Cardiac Enzymes & Liver Function Tests	**Normal Values**							
Troponin	<0.04							
CK	<150	184						
Amylase	0 - 100	40.						
ALT	0 - 50	25.						
Gamma-GT	0 - 70							
Alk Phos	30 - 130	110.						
Total Bilirubin	0 - 20	8.						
Albumin	35 - 50	38						
Haematology & Clotting Screen	**Normal Values**							
White Blood Count	4.0 - 11.0	10.5						
Haemoglobin	115 - 165	145.						
Haematocrit	0.370 - 0.470							
MCV	80 - 100	84.9.						
Platelet Count	150 - 410	189.						
Neutrophils	1.8 - 7.7	8.9						
Lymphocytes	1 - 4.8							
Prothrombin Time	9 - 13	12						
PCT Ratio		1.0						
APTT	27 - 38	41						
APTT ratio	0.8 - 1.2	1.4						
Thrombin Time	10 - 16	11						
TCT Ratio		0.7						
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)								
Other								
Magnesium - Ethanol		0.87						
		<10						

Emergency Department Nursing Documentation

Done/ Time	

Once only prescriptions (inlcuding tetanus prophylaxis)

Date Given	Drug (Block Capitals)	Dose	Method of administration	Time of administration	Signature	Given by
27/11/14	AMOXICILLIN	1g.	IV	0950		
27/11/14	METRONIDAZOLE	400mg	IV	0950		

Discharge prescription packs

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

DISCHARGE CODES: Please Circle				Time Ready to Depart	
1. Admission	2. Discharge	3. Refer to G.P.	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 Time	

Ward No. (If admitted)	Transfer to Hospital	Consultant (if admitted)

Outpatient clinic specialty						Admission or specialty clinic consultant		
Clinic Referred to	AE	OP DVT	DME Falls	TIA	Medical	Surgical	First Seizure	Others Specify

Time	07:54	Date	27/11/2014

PATIENT AND INCIDENT DETAILS

Incident number	CR001742582.001
Name	BRIAN WHITE
Age	Unknown ye
Date of birth	31/03/1964
Gender	Male
Incident location	OPP 107 KIRRIEMUIR AVENUE GLASGOW
Incident post code	G52 3DP
Incident type	EMG
Call received	27/11/2014, 06:52
Call passed	27/11/2014, 06:54
Crew mobile	27/11/2014, 06:55
Crew at scene	27/11/2014, 07:06
Crew left scene	27/11/2014, 07:28
Patient at hospital	27/11/2014, 07:47
Receiving hospital and department	SOGH Southern General Hospital

PRIMARY SURVEY

RESPONSE	
AVPU	Pain
AIRWAY	
Airway assessment	Clear
BREATHING	
Breathing rate	Slow
Respiratory rate	
Oxygen given	85%
CIRCULATION	
Pulse rate	Fast
Cap refill rate	
Skin colour	Pale
Skin texture	Dry
PATIENT CONSENT	
Patient consent	Treatment benefits explained

AMPDS

Dispatch code	31D02	Unconscious with Effective Breathing
Final code	23C05	Overdose/Poisoning, Narcotics (heroin)

GCS

Final GCS eye opening	To voice
Final GCS verbal response	Inappropriate
Final GCS motor response	Withdraws pain

VITAL SIGNS

Time hr : min	ECG	Pulse bpm	Pulse rhythm	Resp. rpm	BP mm Hg	Cap refill (secs)	Peak flow %	Blood sugar mmol / l	Pain score	Temp °C	SpO2 %	GCS Total	NEWS	RTS	MCG	Sepsis
07:00		110	-	8	97 / 70	>2 secs	-	-	-	-	80	8	-	5.4	-	1
07:20		110	-	-	- / -	-	-	9.3	-	-	-	10	-	-	-	1
					/ -	-	-	-	-	-	-	-	-	-	-	0

SEPSIS

Sepsis: Pneumonia	
Sepsis: UTI	
Sepsis: Other infection	
Sepsis: Abdo pain	
Sepsis: Diarrhoea	
Sepsis: Abdo distension	
Sepsis: Meningitis	
Sepsis: Cellulitis	
Sepsis: Septic arthritis	
Sepsis: Wound infection	
Sepsis: Infected indwelling de	

EYES AND PUPIL SIZE AND REACTION

	Left	Right
Pupil size	Constricted	Constricted
Pupil reaction	Normal	Normal

AMPLE

Allergies	Unknown
Other allergies	
Medication	UNKNOWN
Past history	DRUGS HISTORY.
Last eaten	
Events prior	FOUND O/S WITH DOG, NOT RESPONDING.

DRUGS, GASES AND PAIN RELIEF

Pain before	Drug / gas given	Time given	Dose given	Route	Batch No.	Pain after
-	Naloxone	07:14	800mcg	IM	7007246 / 10.2015	-

EMERGENCY SERVICES ON SCENE

Paramedic	Technician
Police	

FINAL OBSERVATION AND COMMENTS

49 YOM, DRUGS WARNING (ACCESSED BY POLICE), FOUND LYI O/S BY PUBLIC ON THE GRASS WITH DOG ROUND. O/A POLICE, DOG SAFE IN POLICE VAN. PT ASSISTED SITTING, O/E GCS 8, RESPONDING TO PAIN. PUPILS CONSTRICTED. TRA TAKEN TO AMB, NALXON TITRETED IM OVER 15 MIN IN 3 DOSSES(400, 200, 200 mcg) PT BECOME AGITATED, PUPILS MORE PEARL, GCS 10 TAKEN ON STANDBY.

Patient 100% RA 80/

ID:	(PPV 3103646054
Last Name:	TV 460 WHYTE
First Name:	Freq 15 BRIAN
Gender/Age:	Male, 50 years
Birth Date:	Peep 5 31.03.1964
Status:	ACCEPTED
Analyzed:	27.11.2014 09:49:16
Sample Type:	Arterial
Sample Number:	
Clinician:	
Operator ID:	FIONA HUNTER

Analyzer

Model:	GEM® *Premier 4000*
Area:	SGH ED
Name:	RESUS
S/N:	08061612

Measured (37.0°C)		
cH	↑ 56.2	nmol/L
pCO_2	↑ 7.4	kPa
pO_2	↑ 40.0	kPa
Na^+	137	mmol/L
K^+	↓↓ 2.7	mmol/L
Cl^-	106	mmol/L
Glu	↑ 7.8	mmol/L
Lac	↓ 0.4	mmol/L
Temperature Corrected (33.3°C)		
cH(T)	↑ 50.0	nmol/L
pCO_2(T)	↑ 6.4	kPa
pO_2(T)	↑ 37.7	kPa
CO-Oximetry		
tHb	↓ 115	g/L
O_2Hb	97.7	%
COHb	↑ 2.6	%
MetHb	0.6	%
HHb	↓ -0.9	%
sO_2	↑ 100.9	%
Derived		
BE(B)	↓ -3.2	mmol/L
HCO_3^-(c)	24.6	mmol/L
Operator Entered		
Temp	33.3	°C
O2 and Vent Settings		
FIO_2	100.0	%

↑↓ Outside Reference Range
↑↑ ↓↓ Outside Critical Range

Patient

ID:	3103646054
Last Name:	WHYTE
First Name:	BRIAN
Gender/Age:	Male, 50 years
Birth Date:	31.03.1964
Status:	ACCEPTED
Analyzed:	27.11.2014 07:46:22
Sample Type:	Arterial
Sample Number:	
Clinician:	
Operator ID:	SU YOUNG

Analyzer

Model:	GEM® *Premier 4000*
Area:	SGH ED
Name:	RESUS
S/N:	08061612

Measured (37.0°C)		
cH	40.1	nmol/L
pCO_2	5.1	kPa
pO_2	↑ 14.7	kPa
Na^+	↓ 135	mmol/L
K^+	↓ 3.0	mmol/L
Cl^-	100	mmol/L
Glu	↑ 11.0	mmol/L
Lac	1.9	mmol/L
CO-Oximetry		
tHb	147	g/L
O_2Hb	95.8	%
COHb	↑ 3.2	%
MetHb	0.9	%
HHb	0.1	%
sO_2	↑ 99.9	%
Derived		
BE(B)	-1.0	mmol/L
HCO_3^-(c)	23.5	mmol/L
Operator Entered		
Temp	37.0	°C
O2 and Vent Settings		
FIO_2		%

Patient Summary Report

Patient

ID:	3103646054
Last Name:	WHYTE
First Name:	BRIAN
Gender/Age:	Male, 50 years
Birth Date:	31.03.1964
Status:	ACCEPTED
Analyzed:	27.11.2014 08:54:00
Sample Type:	Arterial
Sample Number:	
Clinician:	
Operator ID:	FIONA HUNTER

Analyzer

Model:	GEM® *Premier 4000*
Area:	SGH ED
Name:	RESUS
S/N:	08061612

Measured (37.0°C)		
cH	↑ 57.4	nmol/L
pCO_2	↑ 7.1	kPa
pO_2	↑ 43.4	kPa
Na^+	137	mmol/L
K^+	↓↓ 2.6	mmol/L
Cl^-	104	mmol/L
Glu	↑ 9.0	mmol/L
Lac	↓ 0.6	mmol/L
CO-Oximetry		
tHb	122	g/L
O_2Hb	97.7	%
COHb	↑ 2.6	%
MetHb	0.5	%
HHb	↓ 0.7	%
sO_2	↑ 100.7	%
Derived		
BE(B)	↓ -4.7	mmol/L
HCO_3^-(c)	23.1	mmol/L
Operator Entered		
Temp	37.0	°C
O2 and Vent Settings		
FIO_2	100.0	%

↑↓ Outside Reference Range

↑↑ LL Outside Critical Range

Acute Services Division
Emergency Department
RESUSCITATION CHART

3103646054 31/03/1964
WHYTE
Brian

NHS Greater Glasgow and Clyde

Date and Time: 27/11/14.	Name:
Date of Birth:	CHI Number:
Incident time: 0725.	Historians: Ambulance / Police / Relative / Other:

Details and Relevant Factors:

STANDBY. CALL. FOUND UNCONSCIOUS. ? OPIATE O.D
GIVEN NARCAN GCS ↑ 14/15. FLUCTUATING TOXICOS LEVEL

PRF: Yes ☑ No ☐

Accompanied by: Relative / Police / Friend / Other

Procedures	Size/Site/Comment	Time
Intravenous line (1)	20G LACF	
Intravenous line (2)	20G RACF	
Intubation	7.5	
Chest drain (1)		
Chest drain (2)		
Central venous line		
Urinary catheter	14 Foley (10mls in balloon)	
Nasogastric	12 Ch.	
Peritoneal lavage		
Arterial line	R. Radial	0930.

Additional Notes

ABG ✓
NP airway size 6
Top set False teeth
Chest x-ray ✓
ECG ✓
Leimnusis + PROTEIN. ++ KETONES.
CT head ✓
sedation Stopped. 10° ↓

James Douglas (nephew)
07990019243

Am whyte !- Sister !- 0799 0815965 - phone 1st nok.

Care Providers		
Time arrived	Name/Grade/Speciality	Time referred
0730	DR MOH	
"	S/N CHESTNUTT	
"	S/N YOUNG	
0900	S/N. BURGESS.	
0800	DR HUNTER	
1056	anaesthetics	

	Listed	Patient	Police	Other
Clothing				
Valuables				

Relatives present ☐

Being contacted by:

Ambulance ordered at:

CAT:

Discharge to:

Airway and Cervical Spine		Secondary Survey	
Normal ☑	Trauma ☐	Head	☐
Unconcious	☑	Maxillary Facial	☐
Ventilated	☑	CSpine and Neck	☐
Oxygen ☑	Litres/% 15	Chest	☐
Trauma mask	☐	Abdomen	☐
Hudson	☐	G.U.	☐
Ventmask	☐	Back	☐
ETT ☑	Size: 7.5 20cm ~~cut~~ to lip	Limbs	☐
Other top dentues retained.		Other (specify:)	
C Spine	Normal ☐		
Immobilised	☐		
Collar ☐	Sandbags ☐		

CVP –

Prescribed Drugs

Time	Drug	Dose	Route
	Naloxone	400mcg	IM
0745	Naloxone	400mcg	IV
0748	Ondansetron	4mg	IV
0751	Naloxone	400mcg	IV
0820	Suxamethonium	100mg	IV
0829	Propofol 1%	150 200mg	IV
0825	Rocuronium.	50mg	IV
0825	Propofol 2% -infusion		IV
0825	Alfentanil.	500 mcg.	
0815	Rocuronium.	30mg	IV
0950	Metoclopramide	10mg	IV
0950	Amoxicillin	1g	IV

Fluids

Time	Fluid	Volume	Total
0730	NaCl (Normed)	1000	1000
0800	NaCl	~~1000~~ 900	1900
1000	NaCl 20 KCl	250 500	3150

Losses

Time	Type	Volume
0830	URINE	250
0900	URINE	480
1000	URINE	40
1100	URINE	50

Date:
Use 24 hour clock to record times

0740 | 0750 | 0810 | 0825 | 0905 | 0935 | @1000 | 1044 | 1150

Coma Scale

Eyes open	Spontaneously
	To speech
	To pain
	None
Best motor response	Obeys commands
	Localise pain
	Normal flexion to pain
	Abnormal flexion to pain
	Extension to pain
	None
Best verbal response	Orientated
	Confused
	Inappropriate words
	Incomprehensible sounds
	None

Intubated Ventilated

INTUBATED

CT

Eyes closed by swelling =C

Endotracheal tube or tracheostomy =T

Usually record the best arm response

X Rays
- CS spine ☐
- Pelvis ☐
- Other (specify):

Last ATT

Pupil Scale (mm)
1 2 3 4 5 6 7 8

temp° 40 39 37 36 35

Blood Pressure and Pulse Rate

240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10

Respiration X

% Oxygen sat.	97 — 98 95 — 100 — 96 96 97
% Oxygen given	15L 4L 100% — 100 — 40 40 60
CVP	
BM STIX	8.8 — 7.8
CO2	

Pupils

Right	Size	2 3 — 2 — 2
	Reaction	+ + — +
Left	Size	2 3 — 2 — 2
	Reaction	+ + — + — +

Limb Movement

Arms	Normal power
	Mild weakness
	Severe weakness
	Spastic flexion
	Extension
	No response
Legs	Normal power
	Mild weakness
	Severe weakness
	Spastic flexion
	Extension
	No response

Ample
- Allergies
- Medications
- Past medical history
- Last ate/drank
- Events

Bloods ordered

	Time
Grouped	
X-matched	
Flying squad	

Weight (kg)
- Estimated:
- Actual:

Length/Height (cm)
- Measured:

Cardiac Arrest Use Only														
Presenting Rhythm	BM													
Time														
Temp														
Pulse														
Rhythm														
BP														
30;2 2 min cycle														
Adrenaline 1mg														
Amodroine 300mg														
Atropine 3mg														
Shock														
Intubation														
Fluid														
Other (specify)														
Drugs														
Rosc care	BM		Temp		HR		BP		O2		CO2		ITU	
Pacing														
ABG														

Laboratory Results			
Blood x-matched YES ☐ NO ☐	Group:	Saved YES ☐ NO ☐	Number of units:
Blood ready for use at:	hrs	Being stored at:	
O -ve YES ☐ NO ☐			

Time	Time	Time	Time	Time

Medical Discharge Form

NHS Greater Glasgow & Clyde

SGH ICU

27/11/2014 07:52 - 28/11/2014 13:38

PATIENT NAME
Brian Whyte

CHI
3103646054

ENCOUNTER ID

ATTENDING

PRIMARY DIAGNOSIS

AGE (ADT)

ALLERGIES & SENSITIVITIES
Unknown

Medical Discharge Form (27/11/2014 16:12) Jill Selfridge

Patient Profile

CHI	3103646054
Patient Name	Brian Whyte
Patient Address	133 Kinnell Avenue Glasgow Lanarkshire G52 3RT
Date of Birth	31/03/1964

Age (Admission)	50 years
Hospital Admit Date & Time	27/11/2014 07:38
Critical Care Admit Date & Time	27/11/2014 11:40
Admitting Specialty	General Medicine

Discharge Summary

Discharge Summary	* Admitted to ITU to facilitate extubation following intubation for decreased GCS (cause unknown). Extuabted quickly following admission, stable and fit for ward level care. Now giving history of mechanical fall preceeding his episode of collapse. Denied headache or syncopal symptoms. Has been treated by GP for CAP for 5 days with amoxicillin. Now for seven day course of co-amoxiclav and clarithromycin to cover potential aspiration. 12:20 Self discharging against medical advice. Multiple conversations with consultant and other staff members with regards his condition and the risks of leaving the hospital. He is adament that he is leaving. We have adivced him to please seek help from medical services should he become unwell and also given him a week long course of antibiotics.

Background

Admission Comments	50 year old found collapsed in the street with dog. Not responding inspite of getting 800 mcg of Naloxone by SAS. On arrival to A&E GCS 5/15, hypothermic , agitated and no focal neurology. further 2 doses of Naloxone. Intubated ventilated in A&E (Grade 1 view); CT scan - NAD. ? vomiting before intubation and possible aspiration. Given single dose of Amox and flagyl. Transferred to itu for further management
Past Medical History	* IVDU - ? Cannabis ? Heroin - ? on methadone Previous stab wound and clam shell thoracotomy Popliteal artery graft.

Problems/Diagnoses

Problem/Diagnosis 1	?Aspiration Pneumonia Status: Active

Outstanding Issues

Cardiovascular	Stable. HR 78 SR. BP 141/69
Respiratory	Possible Aspiration Pneumonia Extubated. Sats 100% OA. ABG (12:00) with FiO2 0.4: PaO2 16.9 PaCO2 4.9, H+ 38, HCO3 29, Lactate 1
Gastrointestinal	Abdomen SNT BS present
Renal	Good urine output- 80ml in last hour charted Na+ 135, K+ 3.5, Cl- 101, Urea 3.9, Creatinine 61, eGFR >60
General	* E4 M6 V4 CRP 165, Hb 145, WCC 10.5, Neutrophils 8.9, Plts 189 Temperature 34.8c

Medications

PLEASE SEE ACCOMPANYING MEDICINES RECONCILIATION FORM

PATIENT NAME
Brian Whyte

CHI
3103646054

ENCOUNTER ID

ATTENDING

PRIMARY DIAGNOSIS

AGE (ADT)

ALLERGIES & SENSITIVITIES
Unknown

MC	Mani Chandran	27/11/2014 11:52 - 27/11/2014 12:25
BV	Beverley Voukelatos	27/11/2014 14:47 - 27/11/2014 14:47
JS	Jill Selfridge	27/11/2014 16:12 - 28/11/2014 12:24
DrPC	Patrick Collins	27/11/2014 16:25 - 28/11/2014 12:00

	27/11/2014 11:51
MC	11:52 CHI
MC	11:52 Patient Name
MC	11:52 Date of Birth
MC	11:52 Age (Admission)
	27/11/2014 11:52
BV	14:47 Patient Address
	27/11/2014 11:56
MC	12:25 Hospital Admit Date & Time
MC	12:25 Critical Care Admit Date & Time
MC	12:25 Admitting Specialty
MC	12:25 Admission Comments
DrPC	16:25 Past Medical History
MC	12:25 Past Medical History: IVDU - ? Cannabis ? Hercin - ? on methadone Previous stab wound and clam shell thoracotomy Popleteal artery graft.
	27/11/2014 16:12
JS	28/11/2014 12:24 Discharge Summary
DrPC	28/11/2014 12:00 Discharge Summary: Admitted to ITU to facilitate extubation. Now extubated, stable and fit for ward level care. Now giving history of mechanical fall preceeding his episode of collapse. Denied headache or syncopal symptoms. Has been treated by GP for CAP for 5 days with amoxicillin. Now for seven day course of co-amoxiclav and clarithromycin to cover potential aspiration.
DrPC	28/11/2014 11:58 Discharge Summary: Admitted to ITU to facilitate extubation. Now extubated, stable and fit for ward level care. Now giving history of mechanical fall preceeding his episode of collapse. Denied headache or syncopal symptoms. Has been treated by GP for CAP for 5 days with amoxicillin.
DrPC	16:26 Discharge Summary: Admitted to ITU to facilitate extubation. Now extubated, stable and fit for ward level care.
DrPC	16:25 Discharge Summary: Admitted to ITU to facilitate extubation. Now extubated.
DrPC	16:25 Problem/Diagnosis 1
DrPC	16:25 Cardiovascular
DrPC	16:25 Respiratory
DrPC	16:25 Gastrointestinal
DrPC	16:25 Renal
DrPC	16:26 General
DrPC	16:25 General E4 M6 V4 CRP 165, Hb 145, WCC 10.5, Neutrophils 8.9, Plts 189 Temperature:

Nursing Care Plan

NHS Greater Glasgow & Clyde

SGH ICU

28/11/2014 08:00 - 28/11/2014 20:00

PATIENT NAME
Brian Whyte

CHI
3103646054

ENCOUNTER ID

ATTENDING

PRIMARY DIAGNOSIS

AGE (ADT)

ALLERGIES & SENSITIVITIES
Unknown

Nursing Care Plan (28/11/2014 11:59) Lindsey Crosbie

Nurse Completing Plan

Day Nurse	L CROSBIE(SN B5)

Other Information

Other Information	Patient determined to go home despite medical advice. Maintaining SPO2 on air therefore 02 discontiued, remains breathless on exertion. Crystalloids discontinued and venflons removed, eating and drinking. Arterial line and urethral catheter also removed. Seen by Dr Cadamy and advised that he has a chest infection and should remain in hospital - however patient continued to want to go home and therefore has taken his own discharge - appropriate documentation completed and patient has now left unit. Given and signed for £85.37 in deed box, receipt signed by Mr Whyte.

LC Lindsey Crosbie 28/11/2014 11:59 - 28/11/2014 13:32

WHYTE, Brian (Mr)
BORN 31-Mar-1964 (62y) GENDER Male
CHI 3103646054

Pre Op Assessment Form

Last updated by Neil STOREY (Neil Storey) 7 years ago (v. 2) Show History
Amendments (1)
v.2 - Anaesthetic opinion
18-Sep-19 16:21 by Neil STOREY

Consent Withheld	No	Sensitivity	Sensitive
The information in this form **can** be shared with all health and care providers		The information in this form **will** be viewable by health and care providers across all specialties	

Emergency Contact Details

Name	Paul Goodwin
Address	07931 851 727 - patient
Landline	—
Mobile	07729 849 225
Relationship	Friend

Assessment

Assessment Nurse	Alan Abraham	Grade	6
Consultant	Moir	Assessment Date	17-Sep-2019

Hospital	West Glasgow ACH - Yorkhill
Specialty	Trauma And Orthopaedic Surgery
Is the patient over 65years?	No

Admission

Procedure	right 1st MTPJ fusion +/- MTPJ

Availability

Are you available at short notice?	—

Period of unavailability

Unavailable from	—
To	—

Reasons for unavailability	—
Further details	—

Admission Date — Admission Time —

Hospital **WHYTE, Brian (Mr)**

Patient Information BORN 31-Mar-1964 (62y) GENDER Male

Local 3103646054

Information Please click here for the POA Guidelines

Anaesthetic

Previous GA	Yes	Previous GA Details	Emergency laparotomy - stabbing. Emergency surgery to legs as popliteal fossa also injured in this attack Hernia repair Circumcision
Dentition Risk	Yes	Dentition Risk Details	Full set
Reduced Neck Movement	No		
Family History	No		
Other Risk	No		
Heartburn	No		
Sickle Cell Disease	—		

Information Please click here for the POA Guidelines

Surgical

Affects Suitability For DSU Or SDA	No	Please Specify	—
Any Serious Surgical Or Anaesthetic Complication	No		

Information Please click here for the POA Guidelines

Cardiovascular

Hypertension	No
Arrhythmias	No
Palpitations / Blackouts	No

Angina

Angina No

Heart Attack?	No
Murmur	No

Heart Failure	No

WHYTE, Brian (Mr)

BORN 31-Mar-1964 (62y) GENDER Male
CHI 3103646054

Information Please click here for the POA Guidelines

Respiratory

Do you have Asthma?	No
Do you have COPD\Emphysema?	No

URTI	Yes	URTI Details	Chest infection August - completed course of Amoxicillin few weeks ago.

Information Please click here for the POA Guidelines

Neurological

Stroke	No		
Epilepsy	No		
Neurological Disease	Yes	Neurological Disease Details	Has outstanding Neuro referral for ? first seizure, patient dismissive of this - feel he was on too much Amitriptyline at the time and became disorientated
Physical Disability	No		

Haematological

Bleeding Disorder	No
Previous DVT	No
Anaemia	No
Blood Products - If you ever need a blood transfusion or other blood products, would you refuse to receive them ?	No

Information Please click here for the POA Guidelines

Others

WHYTE, Brian (Mr)
BORN 31-Mar-1964 (62y) GENDER Male
CHI 3103646054

Kidney Disease	No
Liver Disease	No
Diabetes	No
Rheumatoid Arthritis	No
Has The Patient Ever Been Notified That They Are At Risk Of CJD or vCJD For Public Health Purposes	No
Any Serious Illness Not Already Mentioned?	Yes
Any Serious Illness Not Already Mentioned Details	PTSD following stabbing

Information Please click here for the POA Guidelines

Exercise Tolerance

Level of fitness	Climb stairs without stopping	Additional information	—

Information Please click here for the POA Guidelines

Social

Alcohol

Alcohol > 30U	No
Units / Wk	0
Duration	—

Smoking

Smokes	No		
Cigs/Day	—		
Ex Smoker	Yes	Ex Smoker Details	Quit smoking 3 years ago - been on e-cig18 months

Drugs

IV or Recreational Drug Abuser	—		
Ex User	Yes	Ex User Details	On Bupernorphine from addictions service
Methadone Req	No		
Self-Admin	No		

Pregnancy

Pregnant	—

Information Please click here for the POA Guidelines

Drug History: Full Generic Name & Dose

WHYTE, Brian (Mr) Amitriptyline 10mg 3 tabs nocte
Buprenorphine tablets
BORN 31-Mar-1964 (62y) GENDER Male
CHI 3103646054

Allergies

Allergies	No

Information Please click here for the POA Guidelines

Prosthesis/Implants

Pacemaker	—
Prosthesis/Others	—

Information Please click here for the POA Guidelines

Examination

Weight not taken	No

BMI

Date Taken	17-Sep-2019
Height	1.74 m Actual
Weight	49.7 kg Actual
BMI	16.42 Calculated
Comments	—

Ranitidine 150MG X 2 tabs Dispensed As Per PGD 2018/1621	No

Vital Signs

Pulse	80 bpm
Temperature	—
Systolic BP	103 mmHg
Diastolic BP	70 mmHg
Resp rate	—
SaO2	98 %
Comments	—

Risk Of Sleep Apnoea

Do You Suffer From Daytime Sleepiness, Restless Sleep Or Witnessed Breath Holding During Sleep?	No

Information Please click here for the POA Investigation Guidelines

Investigations & Date Ordered

WHYTE, Brian (Mr)
BORN 31-Mar-1964 (62y) GENDER Male
CHI 3103646054

FBC	No	FBC Date	—
Ferr/Fol/B12	No	Ferr/Fol/B12 Date	—
Glucose	No	Glucose Date	—
HbA1c	No	HbA1c Date	—
Cross Match	No	Cross Match Date	—
Group & Save	No	Group & Save Date	—
Coag Screen	No	Coag Screen Date	—
U&Es	No	U&Es Date	—
LFTs	No	LFTs Date	—
TFT	No	TFT Date	—
Bone	No	Bone Date	—
ECG	No	ECG Date	—
MRSA Screen	No	MRSA Screen Date	—
Echo	No	Echo Date	—
Other	—		

MRSA Screening Clinical Risk Assessment (CRA)

A: Does the Patient require A Clinical Risk Assessment (For Patients > 23 Hours)
Yes

1. Has The Patient Ever Had A Previous Positive MRSA Result?
No

2. Has The Patient Been Admitted From A Care Home/Institutional Setting Or Another Hospital?
No

3. Does The Patient have A Wound/Ulcer Or Invasive Device Which Was Present Prior To Admission
No

If 'Yes' to any question or if the patient is within (or admitted to) a High Impact Speciality* complete section B ['Not known' = 'No']

Orthopaedics
Orthopaedics

B: MRSA Test?
Yes Yes MRSALabOther Other (s) Throat

Date — Ward — Patient Refused —

DVT Risk Factors

VTE Risk

Is The Patient At Risk Of DVT?	Yes
Do They Require Prophylaxsis?	Yes
Comments	—

Day Surgery / Admission Criteria

—

Is this procedure suitable for day surgery?

WHYTE, Brian (Mr)
BORN 31-Mar-1964 (62y) GENDER Male
CHI 3103646054

Admission Criteria

Appropriate admission based on nursing assessment	—
Additional information	—

Advice and Actions

Q 1 Advise to take usual anti-reflux medication	No
Q 2 Dispensed Ranitidine as per PGD directive	No
Q 3 Refer to smoking cessation clinic	No
Q 4 Advise not to take "intravenous or recreational drug (s)" during the 24 hours before surgery (related to Social – Drugs).	No
Q 5 Anticoagulant advice	No
Q 6 Clopidogrel advice	No
Q 7 Aspirin advice	No
Q 8 OCP advice	No
Q 9 Provide Herbal Medicine Advice	No
Q 10 Arrange for dialysis the day before surgery	No
Q 11	

Ensure facilities for dispensing methadone are available, if the patient is taking methadone	No

WHYTE, Brian (Mr)
DOB 31-Mar-1964 (62y) GENDER Male
CHI 3103646054

Q 12	
Fasting Information Discussed	No
Q 13	
Dentition Risk Discussed	No

Pre-operative Assessment Summary

Assessor: Alan Abraham Grade: 6

Routine bloods ECG MRSA screen obtained, pre-op post op routine explained, fasting instructions discussed, information leaflets given.

HS I+II+0
Warm and well perfused
Radial pulse regular
Denies any CV hx or symptoms
Satisfactory obs and ECG

AE - R=L=Good
Exp - R=L=Normal
Breath sounds nil added
Percussion resonant
Recent chest infection - course of Amoxicillin, feels well.
Quit smoking 3 years ago - uses e-cig

Abdo SNT
BMI 16.7 - lost 6 kg since May - weight does appear to fluctuate. Pending dietician referral. Patient states he lost some weight following recent chest infection.

Will check with list anaesthetist that they are satisfied to proceed with patient as planned - with outstanding neuro and dietetics referrals. Neuro I feel could be a red herring, patient had 1 collapse over a year ago, patient describes episode as when he was taking a higher dose of Amitriptyline, and was very cold - he describes this as the shaking from his referral, he was very dismissive that he had a seizure, no episodes of this since. Denies any illegal drug involvement.

Alan Abraham

Anaesthetic Assessment

Anaesthetist: Storey Grade: Consultant

I agree that this patient can be done at GGH with no further investigations at this time.

Recommended Admission Pathway

Review By

Anaesthetist	—		
Other	—		
DSU/23hr Criteria Met	—	SDA Criteria Met	—

Referrals

Smoking Cessation	—

Diagnosis:

Diagnosis	Side	Site
Pain in limb (nontraumatic)	**Right**	**Foot**

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Chronic neuropathic pain in right foot, states no better with cocodamol and unable to walk. Walking freely in ED, left department declining my offer for more cocodamol or a walking stick - I wonder if Mr Whyte's pain medication can be reviewed and if thought needed a referral to the pain clinic considered? He would also benefit from a podiatry review and treatment.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
John Paul Loughrey
Consultant

Copies to:

1. M Fawcett (GP)

School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Southern General Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel: 0141 201 1456
Fax: 0141 232 7588
Email:

Date Completed: 01/12/2014

Consultant: Dr Jason Long

M Fawcett
Midlock Medical Centre
7 Midlock Street
Glasgow
Glasgow
G51 1SL

Dear M Fawcett

Re: **Whyte Brian** DOB: **31/03/1964** CHI: **3103646054**
133 KINNELL AVE
Glasgow G52 3RT

Attended on: **27/11/2014 at 07:38 hrs.** Departed on: **27/11/2014 at 11:35 hrs.**
Discharge Type: **02 - Admitted** Destination: **Admission to this Hospital**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
stand by

Nursing Assessment:
standby

Investigations in ED:

1. Amylase	**2. Bone Profile**	**3. CK**
4. Coagulation screen	**5. CRP**	**6. Ethanol**
7. Full Blood Count	**8. Glucose**	**9. LFT**
10. Urea and Electrolytes	**11. Magnesium**	**12. CT Head**
13. XR Chest	**14. Paracetamol**	**15. Salicylate**

Diagnosis:

Diagnosis	Side	Site
Syncope and collapse		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:
Found collapsed, GCS 4 and vomiting. Intubated, and admitted to ICU.

Followup :
Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Ross Moy
Doctor

Copies to:
1. M Fawcett (GP)
School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Southern General Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel: 0141 201 1456
Fax: 0141 232 7588
Email:

Date Completed: 29/07/2013

Consultant: Dr Fraser Denny

M Fawcett
Midlock Medical Centre
7 Midlock Street
Glasgow
Glasgow
G51 1SL

Dear M Fawcett

Re: **Whyte Brian** DOB: **31/03/1964** CHI: **3103646054**
45 CORNWALL ST
Glasgow G41 1BA

Attended on: **27/07/2013 at 21:10 hrs.** Departed on: **28/07/2013 at 00:50 hrs.**
Discharge Type: **02 - Admitted** Destination: **Admission to same NHS healthcare provider**

Previous ED Attendance in last 12 months: **2**

Presenting complaint
headaches

Nursing Assessment:
999 call, admitted here 2/7 with head and left shoulder injury,had skull # states. had methodone today and c/o head pains, coughed up blood also states

Investigations in ED:

1. Blood Culture	**2. Coagulation screen**	**3. CRP**
4. Full Blood Count	**5. Glucose**	**6. LFT**
7. Urea and Electrolytes		

Diagnosis:

Diagnosis	Side	Site
Septicaemia, unspecified		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Recently self discharged from hospital after sustaining skull base fracture. Presented tonight with headache, vomiting, fever, sob, haemoptysis + pleuritic chest pains. Sweaty and septic on assessment. CXR unremarkable. CT head showed no evidence of abscess. Treated for sepsis of possible chest/CNS source and admitted physicians.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Stephen Beattie
Doctor

Copies to:

1. M Fawcett (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Southern General Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel: 0141 201 1456
Fax: 0141 232 7588
Email:

Date Completed: 25/07/2013

Consultant: Dr Peter Davis

M Fawcett
Midlock Medical Centre
7 Midlock Street
Glasgow
Glasgow
G51 1SL

Dear M Fawcett

Re: **Whyte Brian** DOB: **31/03/1964** CHI: **3103646054**
45 CORNWALL ST
Glasgow G41 1BA

Attended on: **24/07/2013 at 20:02 hrs.** Departed on: **24/07/2013 at 23:53 hrs.**
Discharge Type: **02 - Admitted** Destination: **Admission to same NHS healthcare provider**

Previous ED Attendance in last 12 months: **0**

Presenting complaint
head inj

Nursing Assessment:
stand by

Investigations in ED:

1. Amylase	**2. CK**	**3. CRP**
4. Ethanol	**5. Full Blood Count**	**6. Gamma GT**
7. Glucose	**8. LFT**	**9. Urea and Electrolytes**
10. Coagulation screen		

Diagnosis:

Diagnosis	Side	Site
Fracture of base of skull, closed	**Left**	

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:
Admitted under ortho with a base skull fracture. GCS 14/15

Followup : **Admitted under ortho**
Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Silvia Ruiz-Buitrago
Doctor

Copies to:
1. M Fawcett (GP)

School Address:

SOUTHERN GENERAL HOSPITAL
1345 GOVAN ROAD
GLASGOW G51 4TF
Accident & Emergency Dept
Phone (0141) 201 1456 Fax (0141) 201 2997

DR. MARK M FAWCETT
MIDLOCK MEDICAL CENTRE
7 MIDLOCK STREET
GLASGOW

G51 1SL
0141-427-4271

Dear Dr. MARK M FAWCETT,

Your Patient
Name : BRIAN WHYTE
DOB : 31/03/1964
Address : 45 CORNWALL ST
FLAT 0/2
GLASGOW
LANARKSHIRE
G41 1BA

Consultant : MR MALCOLM W G GORDON

Account # : AE0084131/11 Unit # : SG00731681 CHI # : 310

Attended at : 0313 on 30/09/2011
Left A&E at : 0528 on 30/09/2011

Reason for Visit : ? OVERDOSE

Diagnosis :

Investigations :

Treatments :

Prescribed Drugs : DRUGS DIRECTIONS

Tetanus Given :

Additional Notes:

Follow Up : CCU

Yours sincerely

DR.

If you require any further information please quote this attendance number: AE00

SOUTHERN GENERAL HOSPITAL
1345 GOVAN ROAD
GLASGOW G51 4TF
Accident & Emergency Dept
Phone (0141) 201 1456 Fax (0141) 201 2997

DR. MARK M FAWCETT
MIDLOCK MEDICAL CENTRE
7 MIDLOCK STREET
GLASGOW

G51 1SL
0141-427-4271

Dear Dr. MARK M FAWCETT,

Your Patient	Name	: BRIAN WHYTE
	DOB	: 31/03/1964
	Address	: 45 CORNWALL ST FLAT 0/2 GLASGOW LANARKSHIRE G41 1BA

Consultant : DR NICOLA LITTLEWOOD

Account # : AE0028322/10 Unit # : SG00731681 CHI # : 310

Attended at : 1137 on 09/04/2010
Left A&E at : 1315 on 09/04/2010

Reason for Visit : IMBEDED SUTURE CHEST

Diagnosis : See Additional Notes : BILATERAL : Chest

Investigations :

Treatments : Local Infiltration/Field Block
: Debridement
: Self-Adhesive Dressing

Prescribed Drugs : DRUGS DIRECTIONS

Tetanus Given : N

Additional Notes:
PROTRUDING SUTURE FROM THORACOTOMY WOUND. WOUND OTHERWISE HEALING WELL AND MAKING GOOD RECOVERY. SUTURE DISSECTED OUT UNDER LA AND TRIMMED BACK TO DEEP KNOTS. SAMLL WOUND LEFT OPEN TO HEAL WITH SIMPLE DRESSINGS.
*******NB: PATIENT HAS ASKED FOR NOTE TO BE AMENDED IN THAT HE HAS NEVER INJECTED DRUGS BUT HAD BEEN A HABITUAL HEROIN SMOKER. I HAVE CHANGED OUR RECORDS ACCORDINGLY.

Follow Up :

Yours sincerely

DR PHIL MUNRO

If you require any further information please quote this attendance number: AE00

SOUTHERN GENERAL HOSPITAL
1345 GOVAN ROAD
GLASGOW G51 4TF
Accident & Emergency Dept
Phone (0141) 201 1456 Fax (0141) 201 2997

DR. MARK M FAWCETT
MIDLOCK MEDICAL CENTRE
7 MIDLOCK STREET
GLASGOW

G51 1SL
0141-427-4271

Dear Dr.. MARK M FAWCETT,

Your Patient
Name : BRIAN WHYTE
DOB : 31/03/1964
Address : 45 CORNWALL ST
GLASGOW
LANARKSHIRE
G41 1BA

Consultant : DR PHIL MUNRO

Account # : AE0014293/10 Unit # : SG03301660 CHI # : 310

Attended at : 1305 on 20/02/2010
Left A&E at : 1415 on 20/02/2010

Reason for Visit : STABBING

Diagnosis :	Puncture Wound	: LEFT	: Chest
:	Incised Wound	: BILATERAL	: Leg (lo

Investigations : Chest X-Ray
: Arterial Blood Gases

Treatments : EndotrachealIntubation
: Arterial Line
: Central Venous Line
: Thoracotomy

Prescribed Drugs : DRUGS DIRECTIONS

Tetanus Given : N

Additional Notes:
STABBED IN BOTH LEGS AND LEFT CHEST. ARRESTED EN ROUTE TO HOSPITAL. PULSE RESTORED AFTER RESUSCITATIVE THORACOTOMY AND INTERNAL CARDIAC MASSAGE. NO OBVIOUS TAMPONADE, THORACIC OR ABDOMINAL HAEMORRHAGE. FURTHER BLEEDING FROM RIGHT LEG INDICATED THAT AS SOURCE OF EXSANGUINATION. PRESSURE DRESSING APPLIED AND TRANSFERRED TO OPERATING THEATRE.

Follow Up : THEATRE

Yours sincerely

DR PHIL MUNRO

If you require any further information please quote this attendance number: AE00

Acute Services Division

Diagnostics Directorate

CT Mobile Scanner
Gartnavel General Hospital
1053 Great Western Road
Glasgow
G12 0YN

NHS
Greater Glasgow and Clyde

Dr Linda Stephen (Associate Specialist)
West Glasgow Ambulatory Care Hospital
Dalnair Street
Yorkhill
Glasgow
G3 8SJ

Tel: 0141 201 0447
Date: 26-Mar-2021
CHI No: 3103646054
Hosp Ref: G504H
Page No: **Page 1 of 1**

Dear Doctor,

We would like to inform you that the patient below has failed to arrive for a radiology appointment.

Patient: Mr Brian Whyte
Date of birth: 31-Mar-1964
CHI No: 3103646054
Patient Address:
FLAT 2-3
133 KINNELL AVE
GLASGOW
LANARKSHIRE
G52 3RT
Referrer: Dr Linda Stephen (Associate Specialist) Source: West Glasgow Ambulatory Care Hospital

For: **A CT Scan of your Head**, at: **9:20 am**
For: **A CT Scan of your Head**, at: **9:20 am**

All on: **Thursday 25 March 2021**
All at: **Gartnavel General Hospital, CT Mobile Scanner**

Please note that in some cases DNAs are due to incorrect patient address details on the request form.
We are concerned that your patient still requires their examination.
If this is the case, could you please confirm this and re-request in the normal manner.

We have notified your patient of this DNA.

Yours sincerely

Diagnostics Administrator

31/03/21

Acute Services Division

Diagnostics Directorate

MRI Suite
X-Ray / Imaging (Ground Floor)
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

NHS
Greater Glasgow and Clyde

Dr Linda Stephen (Associate Specialist)
West Glasgow Ambulatory Care Hospital
Dalnair Street
Yorkhill
Glasgow
G3 8SJ

Tel: 0141 347 8379
Date: 05-Dec-2019
CHI No: 3103646054
Hosp Ref: G405H
Page No: **Page 1 of 1**

Dear Doctor,

We would like to inform you that the patient below has failed to arrive for a radiology appointment.

Patient: Mr Brian Whyte
Date of birth: 31-Mar-1964
CHI No: 3103646054
Patient Address:
FLAT 2-3
133 KINNELL AVE
GLASGOW
LANARKSHIRE
G52 3RT
Referrer: Dr Linda Stephen (Associate Specialist) Source: West Glasgow Ambulatory Care Hospital

For: **An MRI Scan of your Head**
On: **Wednesday 04 December 2019 at 12:45 pm**
At: **Queen Elizabeth University Hospital, MRI Suite**

We are concerned that your patient still requires their examination. If this is the case, could you please confirm this and re-request in the normal manner?

A copy of this letter has been sent to your patient.

Yours sincerely
Appointments Officer

10/12/19

Department of Orthopaedic Surgery

NHS
Greater Glasgow and Clyde

Ground Floor
General Outpatient Department
West Glasgow ACH (Old Yorkhill)
Dalnair Street
GLASGOW G3 8SJ

Secretary Tel: 0141 201 0748
Secretary Fax: 0141 201 0765

26/08/2019

Mr B Whyte
Flat 2-3
133 Kinnell Ave
Glasgow
G52 3RT

Dear Mr Whyte

CHI: 3103646054

I am pleased to confirm a date for your **Pre-Operative Assessment** appointment as follows:

Consultant:	**Mr Stuart Moir**
Specialty:	**Orthopaedics Pre-Operative Assessment**
Date and time:	**Tuesday 17/09/2019, at 11:00**
Location:	**Orthopaedics Outpatients Department Ground Floor West Glasgow Ambulatory Care Hospital**

Please enter by the Main Entrance, West Glasgow Ambulatory Care Hospital, Dalnair Street, Glasgow G3 8SJ.

The purpose of this visit is to assess your general medical fitness and to undertake some tests before you are admitted for surgery. This date may be cancelled at short notice to allow for any emergency procedures.

On arrival please report to the Orthopaedic Clinic Reception Desk, Ground Floor, General Outpatient Department.

If you take Hormone Replacement Therapy or the Oral Contraceptive Pill, please contact the Pre-operative Assessment clinic on 0141 201 0102.

If you are **unable** to attend, or if you will **not be available for surgery**, please contact me on the above number and I will make alternative arrangements for you.

Please ensure that you bring a list of all your current medication.

Yours sincerely

Ann Seeth

Miss Ann Seeth
Secretary to Mr J S Moir
Consultant Orthopaedic Surgeon

Department of Orthopaedic Surgery

NHS
Greater Glasgow and Clyde

Ground Floor
General Outpatient Department
West Glasgow ACH (Old Yorkhill)
Dalnair Street
GLASGOW G3 8SJ

Secretary Tel: 0141 201 0748
Secretary Fax: 0141 201 0765

26/08/2019

Mr B Whyte
Flat 2-3
133 Kinnell Ave
Glasgow
G52 3RT

Dear Mr Whyte

CHI: 3103646054

I am please to confirm a date for your **consent** appointment has been arranged as follows:

Consultant:	**Mr Stuart Moir**
Specialty:	**Orthopaedics Consent Clinic**
Date and time:	**Tuesday 08/10/2019, at 14:00**
Location:	**Orthopaedics Outpatients Department Ground Floor West Glasgow Ambulatory Care Hospital**

Please enter by the Main Entrance, West Glasgow Ambulatory Care Hospital, Dalnair Street, Glasgow G3 8SJ.

You must attend this appointment prior to your procedure to further discuss your procedure and sign a consent form. You are required to attend this appointment prior to any procedure. If this appointment is not suitable or if for any reason you no longer need or are unable to keep this appointment, please telephone **0141 201 0748** as soon as possible so that other arrangements can be made, and your appointment can be offered to another patient.

Not Attending costs NHS Scotland approximately £135 per appointment. Failure to do so will result in your name being removed from the waiting list.

Yours sincerely

Ann Seeth

Miss Ann Seeth
Secretary to Mr J S Moir
Consultant Orthopaedic Surgeon

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

Main Switchboard: 0141 201 1100
Department: Nutrition and Dietetics
Contact Tel:
Enquiries to:

Dr. AP Kerr
The Crescent Medical Practice
12 Walmer Crescent
Glasgow
G51 1AT

Letter Date: 05/10/2020
Reference:
Dictated Date: 05/10/2020
Transcribed Date:

Dear Dr Kerr,

Brian Whyte; D.O.B: 31/03/1964; CHI: 3103646054
FLAT 2-3, 133 KINNELL AVE, Glasgow, Lanarkshire, G52 3RT

Telephoned patient today as per pre-arranged consultation.

Unfortunately, Brian reported that he did not wish any further consultations with our service at the present time.

As he has declined intervention, he has therefore been discharged from the service.

Should you have any future concerns please do not hesitate to re-refer him to our service.

Electronically Signed: ,

cc.

Clinical letter - GP: Discharge

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

Dr. AP Kerr
The Crescent Medical Practice
12 Walmer Crescent
Glasgow
G51 1AT

Main Switchboard:	0141 201 1100
Department:	Physiotherapy
Contact Tel:	0141 452 2935
Enquiries to:	
Letter Date:	13/03/2020
Reference:	
Dictated Date:	13/03/2020
Transcribed Date:	13/03/2020

Dear Dr Kerr,

Brian Whyte; D.O.B: 31/03/1964; CHI: 3103646054
FLAT 2-3, 133 KINNELL AVE, Glasgow, Lanarkshire, G52 3RT

Presenting Condition: Right shoulder pain

Diagnosis: Possible atypical frozen shoulder

Treatment: Assessment and advice

Treated from 12/2/20 to 12/2/20

Comments: Patient failed to attend 2nd appointment.

GP Action Required:

Discharge Outcome:

The patient failed to attend review appointment(s) 26/2/20 with no further contact.

This patient has now been discharged from our care.

Yours sincerely

Graeme Lusk

Physiotherapist

Electronically Signed: ,

cc.

Clinical letter - GP: Discharge

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

Dr. AP Kerr
The Crescent Medical Practice
12 Walmer Crescent
Glasgow
G51 1AT

Main Switchboard: 0141 201 1100
Department: Physiotherapy
Contact Tel: 0141 452 2935
Enquiries to:
Letter Date: 12/02/2020
Reference:
Dictated Date: 12/02/2020
Transcribed Date: 12/02/2020

Dear Dr Kerr,

Brian Whyte; D.O.B: 31/03/1964; CHI: 3103646054
FLAT 2-3, 133 KINNELL AVE, Glasgow, Lanarkshire, G52 3RT

I assessed Brian today after he self referred for shoulder pain. He has a 4/12 history of insidious onset right shoulder pain. He presents with some capsular restriction but more in the posterior capsule of the shoulder which is less usual for a diagnosis of frozen shoulder and I would like him to have an X-Ray to rule out any GHJ OA changes.

Would it be possible to write Brian an X-Ray request card that he can pick up from the practice? I have asked him to phone the practice to check that this is ready before coming down.

I think he will also need some advice on regular analgesia to allow him to perform his physiotherapy stretches.

Thanks

Graeme Lusk

Physiotherapist

Electronically Signed: ,

cc.

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF
0141 201 1100

Dr. AP Kerr
The Crescent Medical Practice
12 Walmer Crescent
Glasgow
G51 1AT

Main Switchboard:
Department:
Contact Tel:
Enquiries to:
Letter Date: 22/10/2019
Reference:
Dictated Date:
Transcribed Date:

Dear ,

Brian Whyte; D.O.B: 31/03/1964; CHI: 3103646054
FLAT 2-3, 133 KINNELL AVE, Glasgow, Lanarkshire, G52 3RT

Thank you for referring the above patient for advice regarding nutritional support.

NUTRITION AND DIETETIC DIAGNOSIS :

PROBLEM Inadequate dietary intake

AETIOLOGY : previous assault, drug addiction therapy

SIGNS AND SYMPTOMS : very low weight/BMI

NUTRITIONAL AIM OF TREATMENT :

To advise regarding improving nutritional status and prevent further weight loss.

Height 1.74m Weight 50.7kg BMI 16.75kg/m2

Estimated Nutritional Requirements :

2324 kcals and 40 - 76 grams protein daily.

Estimated Nutritional intake :

Unable to assess.

Dietary assessment indicates that the above patient has an erratic eating pattern and reports he sometimes does not eat for 2-3 days. He was also very upset at the consultation as he reported that his dog died 3 weeks ago and this was his main life companion.

However, he seems keen to try to help himself and has agreed the following measures :

Establish a regular meal pattern

Breakfast 2 x weetabix + FF milk + banana + honey

Lunch soup and bread + butter

Evening meal - ready meal such as macc cheese.

Try to include kcal dense between meal snacks.

As he seems keen to try to help himself I would be grateful if you would prescribe the following :

ENSURE SHAKE X 2 DAILY, 60 per month, mixed flavours.

Has written information for reference. I would also suggest that he gets repeat prescriptions for the above until his next clinic appointment on 3.2.20 (first available review appointment).
Should you have any queries please do not hesitate to contact me.

Yours sincerely,

Electronically Signed: ,

cc.

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF
Main Switchboard: 0141 201 1100
Department:
Contact Tel:
Enquiries to:

Dr. AP Kerr
The Crescent Medical Practice
12 Walmer Crescent
Glasgow
G51 1AT

Letter Date: 22/10/2019
Reference:
Dictated Date:
Transcribed Date:

Dear ,

Brian Whyte; D.O.B: 31/03/1964; CHI: 3103646054
FLAT 2-3, 133 KINNELL AVE, Glasgow, Lanarkshire, G52 3RT

Thank you for referring the above patient for advice regarding nutritional support.

NUTRITION AND DIETETIC DIAGNOSIS :

PROBLEM Inadequate dietary intake

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Should you have any queries please do not hesitate to contact me.

Yours sincerely,

Electronically Signed: ,

cc.

Clinical letter - GP: Discharge

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

Dr. AP Kerr
The Crescent Medical Practice
12 Walmer Crescent
Glasgow
G51 1AT

Main Switchboard: 0141 201 1100
Department: Orthopaedics
Contact Tel: 0141 201 0748
Enquiries to: ann.seeth@ggc.scot.nhs.uk
Letter Date: 25/10/2019
Reference: JSM/AS
Dictated Date: 16/10/2019
Transcribed Date: 21/10/2019

Dear Doctor,

Brian Whyte; D.O.B: 31/03/1964; CHI: 3103646054
FLAT 2-3, 133 KINNELL AVE, Glasgow, Lanarkshire, G52 3RT

Mr Whyte had surgery to his right foot at Gartnavel on 16th October when a interphalangeal joint arthrodesis was performed to correct his clawed hallux which was secured with some memory staples.

He will be heel weight bearing in a woollen crepe bandage and post-op shoe for the next few weeks, he will be reviewed in due course.

Yours Sincerely

Mr J S Moir

Consultant Orthopaedic Surgeon

Queen Elizabeth University Hospital/West Glasgow ACH

Electronically Signed: Mr Stuart Moir, Consultant

cc.

LM/LMT

Department of Urology
New Victoria Hospital
Room 2.10.D
55 Grange Road
GLASGOW G42 9LF

Date Dictated: 28/05/12
Date Typed: 18/06/12
CHI: 3103646054

Enquiries to: Lynne Thomas
Tel/Fax: 0141 347 8213/8927

DR ADAMS STRUMP
MIDLOCK MEDICAL CENTRE
GLASGOW
G51 1SL

Dear Dr Adams Strump

BRIAN WHYTE DOB: 31/03/64 (SG00731681)
45 CORNWALL ST, FLAT 0/2, GLASGOW, G41 1BA

Your patient failed to attend my Urology Clinic on 28 May 2012. No further appointment has been sent out.

Kind regards,
Yours sincerely

Lindsay Morrison
Associate Specialist in Urology

Department of Vascular Surgery
Mr W P Stuart
Direct Line: 0141 232 9504
Fax No: 0141 211 1741
E-mail: Wesley.Stuart@ggc.scot.nhs.uk
E-mail: Moyra.Harris@ggc.scot.nhs.uk

Western Infirmary Hospital
Dumbarton Road
Glasgow
G11 6NT
0141 211 2000

WPS/mh

Dictated: 23/06/11
Typed: 27/06/11

Clinic Southern General Hospital

DR MARK M FAWCETT
MIDLOCK MEDICAL CENTRE
GLASGOW
G1 1SL

Dear Dr Fawcett

BRIAN WHYTE DOB: 31/03/64 (SG00731681) CHI: 3103646054
45 CORNWALL ST, FLAT 0/2, GLASGOW, G41 1BA

This gentleman was due to be seen in my clinic today. He has failed to attend yet again. No further appointment has been sent out. Please let me know if he still wishes or needs to be seen.

He had undergone emergency surgery following stab wounds to the popliteal fossa.

Yours sincerely

W P STUART MD FRCS
Consultant Vascular Surgeon

Glasgow South Vascular Surgery
Mr W P Stuart

Direct Line: 0141 201 2736
Fax No: 0141 201 1157
E-mail: Wesley.Stuart@ggc.scot.nhs.uk
E-mail: Moyra.Harris@ggc.scot.nhs.uk

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
0141 201 1100

WPS/mh

Dictated: 17/09/10
Clinic: 12/08/10
Typed: 21/09/10

CHI: 3103646054
SG00731681

: Brian Whyte
45 Cornwall Street
Flat 0/2
Glasgow
G41 1BA

Dear Mr Whyte

The scan of the graft in your leg shows that the blood flow to your leg is satisfactory. I will see you back in the clinic as planned.

Yours sincerely

W P STUART MD FRCS
Consultant Vascular Surgeon

cc Dr M Fawcett, Midlock Medical Centre, Glasgow, G51 1SL

Clinic Letter

NHS
Greater Glasgow and Clyde

West Glasgow ACH - Yorkhill
Dalnair Street
Glasgow
G3 8SJ
0141 211 2000

Dr. AP Kerr
The Crescent Medical Practice
12 Walmer Crescent
Glasgow
G51 1AT

Main Switchboard:	0141 211 2000
Department:	Neurology
Contact Tel:	0141-201-0511
Enquiries to:	deirdre.nolan@ggc.scot.nhs.uk
Letter Date:	02/06/2021
Reference:	LS/DN
Dictated Date:	02/06/2021
Transcribed Date:	02/06/2021

Dear Dr. AP Kerr,

Brian Whyte; D.O.B: 31 Mar 1964; CHI: 3103646054
FLAT 2-3, 133 KINNELL AVE, Glasgow, Lanarkshire, G52 3RT

Attendance: Specialty - Neurology; Clinic - WILSNE6-LINDA STEPHEN SEIZURE WED PM **NO OVERBOOKINGS UNLESS INSTRUCTED BY DR STEPHEN**
Date and Time of Appointment - 02/06/2021 15:30

Clinical Comments:
Mr Whyte had an appointment for a telephone consultation at my Seizure Clinic today. I telephoned his mobile phone number, but was diverted to voicemail.

He did not attend for his CT of brain on 25 March.

I have not reappointed him.

Yours sincerely

Dr Linda Stephen

Associate Specialist

Honorary Clinical Senior Lecturer

Electronically Signed: Dr Linda Stephen, Associate Specialist

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

West Glasgow ACH - Yorkhill
Dalnair Street
Glasgow
G3 8SJ
0141 211 2000

Dr. AP Kerr
The Crescent Medical Practice
12 Walmer Crescent
Glasgow
G51 1AT

Main Switchboard:	0141 211 2000
Department:	Neurology
Contact Tel:	0141-201-0511
Enquiries to:	deirdre.nolan@ggc.scot.nhs.uk
Letter Date:	19/01/2021
Reference:	LS/DN
Dictated Date:	19/01/2021
Transcribed Date:	19/01/2021

Dear Dr. AP Kerr,

rian Whyte; D.O.B: 31 Mar 1964; CHI: 3103646054
FLAT 2-3, 133 KINNELL AVE, Glasgow, Lanarkshire, G52 3RT

Attendance: Specialty - Neurology; Clinic - WILSNE3-DR STEPHEN FIRST SEIZURE TUES AM
NO OVERBOOKINGS UNLESS INSTRUCTED BY DR STEPHEN
Date and Time of Appointment - 19/01/2021 12:00

Clinical Comments:
Mr Whyte had a telephone consultation with me at my Seizure Clinic today. He says he continues to have episodes of blacking out though as before there are still no useful witnesses to these. He says the last of these occurred on 2 January and one previous to that occurred at the end of last year.

He did not attend for his MRI of brain on 10 December 2019 and I have re-requested this.

have sent Mr Whyte an appointment for my clinic when hopefully his MRI result will be available.

Yours sincerely

Dr Linda Stephen

Associate Specialist

Honorary Clinical Senior Lecturer

Electronically Signed: Dr Linda Stephen, Associate Specialist

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

West Glasgow ACH - Yorkhill
Dalnair Street
Glasgow
G3 8SJ

Dr. AP Kerr
The Crescent Medical Practice
12 Walmer Crescent
Glasgow
G51 1AT

Main Switchboard: 0141 211 2000
Department: Neurology
Contact Tel: 0141-201-0511
Enquiries to: deirdre.nolan@ggc.scot.nhs.uk
Letter Date: 08/07/2020
Reference: LS/DN
Dictated Date: 08/07/2020
Transcribed Date: 08/07/2020

Dear Dr. AP Kerr,

Brian Whyte; D.O.B: 31 Mar 1964; CHI: 3103646054
FLAT 2-3, 133 KINNELL AVE, Glasgow, Lanarkshire, G52 3RT

Attendance: Specialty - Neurology; Clinic - WILSNE6-LINDA STEPHEN SEIZURE WED PM **NO OVERBOOKINGS UNLESS INSTRUCTED BY DR STEPHEN**
Date and Time of Appointment - 08/07/2020 15:45

Clinical Comments:
This man had an appointment for a telephone consultation at my Seizure Clinic today. I telephoned the mobile number he had provided for the appointment at his allocated appointment time. I was diverted to voicemail and left a message asking him to phone me within the appointment time slot. He did not do so.

I have not reappointed him.

Yours sincerely

Dr Linda Stephen

Associate Specialist

Honorary Clinical Senior Lecturer

Electronically Signed: Dr Linda Stephen, Associate Specialist

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

West Glasgow ACH - Yorkhill
Dalnair Street
Glasgow
G3 8SJ
0141 211 2000

Dr. AP Kerr
The Crescent Medical Practice
12 Walmer Crescent
Glasgow
G51 1AT

Main Switchboard:	
Department:	Orthopaedics
Contact Tel:	
Enquiries to:	
Letter Date:	28/11/2019
Reference:	JSM/MM
Dictated Date:	28/11/2019
Transcribed Date:	19/12/2019

Dear Dr. AP Kerr,

Brian Whyte; D.O.B: 31 Mar 1964; CHI: 3103646054
FLAT 2-3, 133 KINNELL AVE, Glasgow, Lanarkshire, G52 3RT

Attendance: Specialty - Orthopaedics ; Clinic - WISMOR7-MR MOIR ORTHO THUR AM
Date and Time of Appointment - 28/11/2019 10:40

Clinical Comments:
Mr Whyte was reviewed at the clinic today only six weeks from surgery.

Clinically and radiologically this is looking fine, he is very pleased with the posture of his toe. There was slight eschar on the dorsum of the IP joint, but I think it reasonable to discharge him at this time.

Yours sincerely

Mr J S Moir

Consultant Orthopaedic Surgeon

Queen Elizabeth University Hospital / West Glasgow ACH

Electronically Signed: Mr Stuart Moir, Consultant

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

West Glasgow ACH - Yorkhill
Dalnair Street
Glasgow
G3 8SJ
0141 211 2000

Dr. AP Kerr
The Crescent Medical Practice
12 Walmer Crescent
Glasgow
G51 1AT

Main Switchboard:
Department: Neurology
Contact Tel: 0141-201-0511
Enquiries to: deirdre.nolan@ggc.scot.nhs.uk
Letter Date: 23/10/2019
Reference: LS/DN
Dictated Date: 23/10/2019
Transcribed Date: 24/10/2019

Dear Dr. AP Kerr,

Brian Whyte; D.O.B: 31 Mar 1964; CHI: 3103646054
FLAT 2-3, 133 KINNELL AVE, Glasgow, Lanarkshire, G52 3RT

Attendance: Specialty - Neurology; Clinic - WILSNE6-LINDA STEPHEN SEIZURE WED PM **NO OVERBOOKINGS UNLESS INSTRUCTED BY DR STEPHEN**
Date and Time of Appointment - 23/10/2019 14:00

Clinical Comments:
Many thanks for referring this 55 year old man whom I saw at my Seizure Clinic today. He tells me he has been having episodes of loss of consciousness for at least the last 5 years. The majority of these have been unwitnessed or witnessed by passers by who are not available to give a history. He gets no particular warning prior to passing out, but finds himself on the ground. He is incontinent of urine with the events but does not bite his tongue. His events have resulted in hospital admissions in the last few years. One involved a head injury. Another was thought to be the result of opiate abuse.

Mr Whyte was initially referred in November last year having been found, lying in the street, shaking. According to the referral letter he was taken by ambulance to the Queen Elizabeth University Hospital but did not wait to be seen. He thinks he has had some blackouts since then but cannot really give me any useful history.

He lives on his own. He has recently had surgery to fuse his right hallux IP joint and is currently walking with crutches.

He has had multiple stabbings and showed me his scars today.

He has a history of opiate abuse and takes 8 mg twice daily of Buprenorphine.

His other medication comprises Omeprazole, Amoxycillin, ibuprofen and Di-hydrocodeine.

He has no history of birth trauma, febrile convulsions or family history of epilepsy or seizures.

A CT of brain in 2014 was normal, although I note he had a fracture of his left temporal bone on a CT in 2013 when he was found by the police, wandering, hypothermic, in the street.

A 12 lead resting ECG from September shows normal sinus rhythm with a ventricular rate of 76 bpm.

It is difficult to be certain as to why Mr Whyte is having episodes of loss of consciousness. Should he have any more I have asked him to try and record as much detail of these as possible. Ideally a witness description would be most useful.

I have requested an MRI of brain for him and have arranged to see him back at my clinic with the result on 25 February.

Yours sincerely

Dr Linda Stephen

Associate Specialist

Honorary Clinical Senior Lecturer

Electronically Signed: Dr Linda Stephen, Associate Specialist

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

West Glasgow ACH - Yorkhill
Dalnair Street
Glasgow
G3 8SJ
0141 211 2000

Orthopaedics

ann.seeth@ggc.scot.nhs.uk

Dr. AP Kerr
The Crescent Medical Practice
12 Walmer Crescent
Glasgow
G51 1AT

Main Switchboard:
Department:
Contact Tel:
Enquiries to:
Letter Date: 08/10/2019
Reference: JSM/AS
Dictated Date: 08/10/2019
Transcribed Date: 09/10/2019

Dear Dr. AP Kerr,

Brian Whyte; D.O.B: 31 Mar 1964; CHI: 3103646054
FLAT 2-3, 133 KINNELL AVE, Glasgow, Lanarkshire, G52 3RT

Attendance: Specialty - Orthopaedics ; Clinic - WISMOR4-MR S MOIR ORTHO TUES PM
Date and Time of Appointment - 08/10/2019 14:00

Clinical Comments:
Mr Whyte has been left with a neurological deficit in his right lower limb following stabbing injuries some years ago. His principle complaint is of a clawed hallux and he is weight bearing on the plantar tip of the toe where he has a callosity. The toe is painful to move. There is only a jog of movement in the IP joint anyway.

He requires an IPJ arthrodesis and also extensor tendon lengthening at the MTP joint with capsular release if necessary. This will be secured with a couple of memory staples and possibly a percutaneous k-wire for a few weeks. The principle risks are infection and non-union, although he tells me he is no longer smoking cigarettes but instead uses a vape.

It should be done as a day case, he will probably be in a wool & crepe bandage and post op shoe for a week or two post-operatively but he will actually need probably minimal protection of the big toe over the next few weeks.

Yours Sincerely

Mr J S Moir

Consultant Orthopaedic Surgeon

Queen Elizabeth University Hospital/West Glasgow ACH

Electronically Signed: Mr Stuart Moir, Consultant

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

West Glasgow ACH - Yorkhill
Dalnair Street
Glasgow
G3 8SJ
0141 211 2000

Dr. AP Kerr
The Crescent Medical Practice
12 Walmer Crescent
Glasgow
G51 1AT

Main Switchboard:	
Department:	Orthopaedics
Contact Tel:	
Enquiries to:	
Letter Date:	11/12/2018
Reference:	MB/GT
Dictated Date:	11/12/2018
Transcribed Date:	28/12/2018

Dear Dr. AP Kerr,

Brian Whyte; D.O.B: 31 Mar 1964; CHI: 3103646054
FLAT 2-3, 133 KINNELL AVE, Glasgow, Lanarkshire, G52 3RT

Attendance: Specialty - Orthopaedics ; Clinic - WIPODOR4-ORTHO PODIATRY MORAG BERKELY TUES PM
Date and Time of Appointment - 11/12/2018 14:30

Clinical Comments:
Thank you for referring Mr Whyte to the Orthopaedic Foot and Ankle clinic, he was seen today at the West Glasgow ACH.
Mr Whyte attended complaining of pain in his right 1st toe. Mr White unfortunately sustained significant sensory and motor nerve damage following stabbing injuries in 2010. This has resulted in significant muscle loss to his right leg and these have produced a fixed flexion deformity of the right 1st interphalangeal joint.

Today check x-rays confirm this. In addition the lesser toes also have retracted however these are not symptomatic at this time.

Today we have discussed both surgical and conservative management; Mr Whyte is keen to proceed to surgery. I have discussed his case with Mr Moir the Orthopaedic Foot and Ankle Consultant and he advises a simple fusion of the 1st interphalangeal joint. Mr Whyte is happy to proceed with this. We have discussed risks including scarring, and sensitivity from scarring, risk of infection, risk of slow or non union of the bony surgical site, risks associated with general anaesthetic and also risks associated with the use of a tourniquet. Mr Whyte is also aware that he will be unable to weight bear on his forefoot for around six weeks and it takes around three months to return to his normal walking activities and around six months for anything more high impact.

Mr Whyte is happy to proceed to surgery and has been prelisted today. He will be contacted in due course for further appointments.

Yours sincerely,

Morag Berkley

ESP Podiatrist in Orthopaedics

Electronically Signed: Podiatrist Morag Berkley, Podiatrist

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF
0141 201 1100

Dr. AP Kerr
The Crescent Medical Practice
12 Walmer Crescent
Glasgow
G51 1AT

Main Switchboard:
Department:
Contact Tel:
Enquiries to:
Letter Date: 06/09/2018
Reference:
Dictated Date:
Transcribed Date:

Dear Dr. AP Kerr,

Brian Whyte; D.O.B: 31 Mar 1964; CHI: 3103646054
FLAT 2-3, 133 KINNELL AVE, Glasgow, Lanarkshire, G52 3RT

Attendance: Specialty - Orthotics; Clinic - SUKGRF7-ORTHOTIST K GREEN THURSDAY AM
Date and Time of Appointment - 06/09/2018 11:00

Clinical Comments:
This patient has now finished their episode of care with the Orthotic Service.

If you need to contact the Orthotist regarding this episode of care you can do so via our helpline on 0141 211 1459.

ACTION REQUIRED BY GP

none

Clinical Presentation:

Patient attended for assessment due to podiatry referral - consent gained for assessment. Patient reports he got stabbed a few years ago which caused a lot of nerve damage to his right leg. Patient reports he is lucky to be alive and also to have this right leg at all. Patient reports he gets recurrent ulceration on the end of his right toe which at the moment is in remission. Patient reports he is quite active. Patient reports he is not diabetic.
Summary of Relevant Test Results:

o/e patient full right limb is significantly atrophied in comparison to the left limb. Patient right side shows fixed flexion of all toes with apex of hallux touching the ground and there is no correction at all. 1:1 in/eversion range which is uncomfortable to patient. Tight calf range for gait. Muscle strength on

this side is a 4 universally. Patient left side has normal hallux range, 2:1 in/eversion range and good calf range for gait - no pain on movement and muscle strengths 5. Patient gait shows lateral trunk bend and positive trendelenberg due to hip weakness with lesser steps on this affected side. Patient objective: to make feet more comfortable and stop further ulceration. Orthotic objective: insoles to redistribute plantar pressures from the apex of hallux, shoes to accommodate insoles and rocker soles to reduce forefoot trauma and promote 3rd rocker therefore improving sagittal plane motion.

Management to Date and Outcome:

Measures and scans taken today - patient chose Potenza I back mesh and lace . Shoes fitted well and reported comfortable

Reason For Discharge:

treatment complete

Guidance on Re Referral:

please reffer again if new assessment required

Discharge Information given to patient:

orthosis leaflet supplied

Electronically Signed: ,

cc.

Department of Vascular Surgery
Mr W P Stuart
Direct Line: 0141 232 9504
Fax No: 0141 211 1741
E-mail: Wesley.Stuart@ggc.scot.nhs.uk
E-mail: Moyra.Harris@ggc.scot.nhs.uk

Western Infirmary Hospital
Dumbarton Road
Glasgow
G11 6NT
0141 211 2000

WPS/mh

Dictated: 16/12/10
Typed: 22/12/10

Clinic Southern General Hospital

DR MARK M FAWCETT
MIDLOCK MEDICAL CENTRE
LASGOW
51 1SL

Dear Dr Fawcett

BRIAN WHYTE DOB: 31/03/64 (SG00731681) CHI: 3103646054
45 CORNWALL ST, FLAT 0/2, GLASGOW, G41 1BA

I reviewed this patient at the clinic today. As you will be aware he had an interposition graft for popliteal artery trauma done as an emergency over a year ago now. He now has slowly improving function in his right leg and some of the neurological function has returned. He is clearly ambulant with a stick. His vein graft scan has suggested that the vein is really quite small but functioning reasonably well. I will see him again in six months time.

Yours sincerely

I P STUART MD FRCS
Consultant Vascular Surgeon

Glasgow South Vascular Surgery
Mr W P Stuart

Direct Line: 0141 201 2736
Fax No: 0141 201 1157
E-mail: Wesley.Stuart@ggc.scot.nhs.uk
E-mail: Moyra.Harris@ggc.scot.nhs.uk

Southern General Hospital
1345 Govan Road
Glasgow
G51 1TF
0141 201 1100

WPS/mh

Dictated: 12/08/10
Typed: 16/08/10

DR MARK M FAWCETT
MIDLOCK MEDICAL CENTRE
GLASGOW
G51 1SL

ear Dr Fawcett

BRIAN WHYTE DOB: 31/03/64 (SG00731681) CHI: 3103646054
45 CORNWALL ST, FLAT 0/2, GLASGOW, G41 1BA

I saw Mr Whyte today in the clinic. As you will be aware he was admitted with a stab injury to both the chest and his right leg back in March. He was shocked and unconscious on admission and with the presumption that the injury to the chest was the most life threatening a clam shell thoracotomy was performed, although there proved to be no significant intrathoracic injury. His popliteal fossa was then explored and a divided vein artery and nerve were repaired. The artery was repaired with an interposition vein graft.

In the clinic today this gentleman has made a very good recovery. He is still walking on two crutches and says that he has not received any offer of physiotherapy so I have arranged that today. He is slowly getting power and sensation back in his foot, but this is far from complete. The leg is still very wasted, but the pulse is good in the popliteal fossa and the foot is well perfused.

I will arrange for him to have physiotherapy and I will arrange for him to have a vein graft surveillance of his short interposition segment. I will see him back at the clinic in four months time.

It is worth noting that the chest has healed up without complication save for a little tenderness at the level of the sternum. This gives him minimum symptoms.

Yours sincerely

W P STUART MD FRCS
Consultant Vascular Surgeon

cc Dr Phil Munro, A E Consultant, S.G.H.

SOUTHERN GENERAL HOSPITAL

RHEUMATOLOGY DEPARTMENT
Dr S Fraser 0141 201 1762
Dr E Morrison 0141 201 1761
Dr D Crosbie 0141 201 2180
Sr D McGhee 0141 201 1118
Fax No: 0141 201 1783

LMG/AK/ 731681 CHI: 3103646054

Date Dictated: 06/10/2011
Date Typed: 12/10/2011

Dr M Fawcett
Midlock Health Centre
7 Midlock Street
Glasgow
G51 1SL

Dear Dr Fawcett

BRIAN WHYTE, D.O.B. 31/03/1964
FLAT 0/2, 24 CORNWALL STREET, GLASGOW, G41 1BA

DATE OF ADMISSION:	30/09/2011
DATE OF DISCHARGE:	01/10/2011
DIAGNOSIS:	Possible Tramadol dose
MEDS ON DISCHARGE:	Paracetamol 1gm prn

Mr Whyte presented via medical receiving with the following issues.

1. **POSSIBLE TRAMADOL OVERDOSE.** He presented to accident and emergency with a low GCS and a vague history from the ambulance crew about a possible Tramadol overdose. He was intially very drowsy but his GCS improved with support of therapy only.He had a CT of his head which showed no significant abnormalities. He was discharged once independently mobile on the ward with no formal follow up arranged.

Yours sincerely

Dr Lucy McGeoch
SpR in Rheumatology

Dr D Crosbie
Consultant Physician/Rheumatologis

Final Discharge Letter

NHS Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF
0141 201 1100

Dr. HA McNaughtan
Drs Hilary Mcnaughtan & patrick j
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
G52 3SS

Main Switchboard:	
Department:	acute receiving unit
Contact Tel:	0141 452 2322/3
Enquiries to:	
Letter Date:	19/02/2016
Reference:	bk/sm
Dictated Date:	15/02/2016
Transcribed Date:	18/02/2016

Dear Dr. HA McNaughtan,

Brian Whyte; D.O.B: 31/03/1964; CHI: 3103646054
FLAT 2-3, 133 KINNELL AVENUE, Glasgow, Lanarkshire, G52 3RT

Admission: Specialty - General Medicine; Ward - QEUH ARU2 General Medicine
Consultant - Dr Brian Kennon; Date of Admission - 26/12/2015
Date of Discharge - 26/12/2015; Discharged to - Private Residence - no additional detail added

Follow Up: nil

Clinical Comments:
I have nothing to add to the immediate discharge letter sent for this patient.

Yours sincerely

Dr Brian Kennon

Consultant Physician

Electronically Signed: Dr Brian Kennon, Consultant

cc.

Final Discharge Letter

NHS Greater Glasgow and Clyde

Dr. M Fawcett
Midlock Medical Centre
7 Midlock Street
Glasgow
G51 1SL

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

Main Switchboard: 0141 201 1100

Date of Completion: 26/08/2013

Email Enquiries to:
Contact Tel Details: 0141 201 1401

Dictated: 01/08/2013
Transcribed: 19/08/2013

Dear Dr. M Fawcett,

Patient

Name:	Whyte Brian
CHI:	3103646054
DOB:	31/03/1964
Address:	45 CORNWALL ST
	Glasgow
	G41 1BA

Admission

Admitted:	28/07/2013 00:50
Discharged:	30/07/2013 19:00
Admission Type:	In Patient
Discharge to:	Private Residence - no additional detail added
Consultant:	Dr Evelyn Millar
Specialty:	General Medicine

Reason for Admission: Admission for treatment - Where the patient is expected to be treated for a diagnosed condition not otherwise specified

Diagnosis

Diagnosis	Code
Closed fracture of skull and facial bones, part unspecified	S02.90
Other bacterial pneumonia	J15.8

Clinical Comments:

ADMITTED – 27 07 13

ABSCONDED FROM WARD – 30 07 13

DIAGNOSIS – non displaced fracture of left parietal bone – extension to petrous portion of the left temple bone, left mastoid air cells and posterior aspect of left temporomandibular fossa; small right parietal lobe traumatic subarachnoid haemorrhage; pneumonia]

FOLLOW UP – nil

This gentleman re-presented having absconded following a significant head injury. He had evidence of pneumonia and was treated accordingly. Repeat CT scan showed a tiny volume of sub arachnoid blood present in the right parietal lobe. In addition the previously noted fracture through the left parietal bone extension to the petrous portion of the left temple lobe, left mastoid air cells and posterior aspect of the left temperomandibular fossa were seen. There was some evidence of haemorrhage within the sphenoid sinus, left mastoid air cells and left inner ear.

The patient was discussed with the neurosurgeons who reviewed the scan and felt no surgical intervention was necessary and advised observation. Unfortunately Mr Whyte absconded shortly thereafter.

Yours sincerely

Dr Andrew Kernohan

Consultant Physician

Electronically Signed: Dr Andrew Kernohan, Consultant

cc.

Department of Surgery
Victoria Infirmary
Langside Road
Glasgow G42 9TY

Mr Alan Hair
Consultant Surgeon
Department of Surgery
Telephone/Fax 0141 201 5463/5581
E-mail: margaret.robinson@sgh.scot.nhs.uk

Our ref: AH/MR

Date Dictated: 01/07/10
Date Typed: 07/07/10

DR MARK FAWCETT
MIDLOCK MEDICAL CENTRE
GLASGOW
G51 1SL

ear Dr Fawcett

BRIAN WHYTE DOB: 31/03/64 (SG00731681) CHI: 3103646054
45 CORNWALL ST, FLAT 0/2, GLASGOW, G41 1BA

Brian's casenotes have been returned to me as he has yet again failed to attend for assessment of his colon on numerous occasions.

I had written to you in January 2010 after he had been referred to me but I was certainly not the originator of the referral on this occasion but as it is not readily identifiable from the notes I thought I would write. Obviously he does not wish his colon investigated and I see that he has also failed to attend Mr Stuart's vascular clinic recently.

I will not make any further arrangements for him to be seen.

Yours sincerely

Mr Alan Hair
nsultant Colorectal Surgeon

DEPARTMENT OF VASCULAR SURGERY
W STUART
Direct Line: 0141 201 2736
Fax: 0141 201 1157

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
0141 201 1100

WPS/mh

Typed: 14/05/10

Clinic: 13/05/10

DR MARK M FAWCETT
MIDLOCK MEDICAL CENTRE
GLASGOW
G51 1SL

Dear Dr Fawcett

BRIAN WHYTE DOB: 31/03/64 (SG00731681) CHI: 3103646054
45 CORNWALL ST, FLAT 0/2, GLASGOW, G41 1BA

This gentleman had been admitted with multiple stab wounds including an injury to his popliteal fossa. He was due for review in the clinic today but failed to attend. A further appointment will be sent out. He should probably be enrolled upon scanning of his vein graft and I would certainly be interested in seeing how the nerve repair is doing for him.

Kind Regards,

Yours sincerely,

W P STUART MD FRCS
Consultant Vascular Surgeon

DEPARTMENT OF VASCULAR SURGERY
W STUART
Direct Line: 0141 201 2736
Fax: 0141 201 1157

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
0141 201 1100

WPS/JW

Typed: 16/03/10

Dr M Fawcett
Midlock Medical Centre
7 Midlock Street
GLASGOW
G51 1SL

Dear Dr Fawcett

BRIAN WHYTE DOB: 31/03/64 (SG00731681) CHI: 3103646054
45 CORNWALL ST, , GLASGOW, G41 1BA

Admitted: 20/02/10
Discharged: 12/03/10
Diagnosis: Multiple Stab Wounds
1. Anterolateral chest (2 wounds)
2. Posterior Knee/Lateral Thigh on the Right Side
3. Left Popliteal Fossa

Procedure:
1. Clam shell thoracotomy performed in A E
2. Exploration of right lower thigh and popliteal fossa, with reconstruction of neurovascular structures
3. Exploration of left popliteal fossa
4. Fasciotomy of right lower leg with opening of anterior and lateral compartments

Complications: Respiratory failure requiring a prolonged period of ventilation in intensive care
Follow-up: Routine vascular out-patient clinic

Mr White is 45 years old and is a reformed intravenous drug user, who now uses Methadone. He was admitted as an emergency to the resuscitation room of the Accident Emergency Department, with multiple stab wounds. On arrival to hospital he was undergoing CPR, having had a cardiac arrest on route. In Accident Emergency he had an immediate clam shell thoracotomy, as he had two anterior chest wounds but there was no evidence of a cardiac injury. During this time he went on to receive aggressive volume resuscitation, and with this his output was restored.

Thereafter he was taken to the operating theatre and he became apparent that the principle problem related to wounds in his right leg. He had arterial and venous injuries from which he had been exsanguinating. In conjunction with this his sciatic nerve had been divided. His vasculature was repaired as were his

BRIAN WHYTE
DOB:31/03/64

neurological structures. Following this his clam shell thoracotomy was closed.

As one would expect he spent a prolonged period of time in intensive care with respiratory failure, although he went on to make what has ultimately been a good recovery. There are clearly issues with regard to his neurological function, and presently he has a foot drop for which he has been provided with a splint. From a vascular point of view the limb is warm and well perfused, although remains swollen. The lateral fasciotomy wound is granulating and we will review this in the fullness of time.

We plan to see him in the out-patient clinic in the next few weeks, to re-assess his progress. Clearly should there be any problems prior to this we would be happy to see him sooner.

Yours sincerely

Keith Hussey
ST4 in General Surgery

Department of Surgery
Victoria Infirmary
Langside Road
Glasgow G42 9TY

Mr Alan Hair
Consultant Surgeon
Department of Surgery
Telephone/Fax 0141 201 5463/5581
E-mail: margaret.robinson@sgh.scot.nhs.uk

Our ref: AH/MR

Date Dictated: 13/01/10
Date Typed: 15/01/10

DR MARK FAWCETT
MIDLOCK MEDICAL CENTRE
GLASGOW
G51 1SL

ar Dr Fawcett

BRIAN WHYTE DOB: 31/03/64 (SG00731681) CHI: 3103646054
45 CORNWALL ST, FLAT 0/2, GLASGOW, G41 1BA

Further to my previous letter of November 2009, Mr Whyte was given a further appointment to attend for colonoscopy on 30/12/09. Unfortunately he failed to attend for this also.

He has now failed to attend on 3 occasions, but given the worrying nature of his symptoms I would be obliged if you could try and persuade him to attend for this investigation and re-refer him.

Yours sincerely

Mr Alan Hair
Consultant Colorectal Surgeon

Department of Surgery
Victoria Infirmary
Langside Road
Glasgow G42 9TY

Mr Alan Hair
Consultant Surgeon
Department of Surgery
Telephone/Fax 0141 201 5463/5581
E-mail: margaret.robinson@sgh.scot.nhs.uk

Our ref: AH/MR

Date Dictated: 27/11/09
Date Typed: 07/12/09

DR MARK FAWCETT
MIDLOCK MEDICAL CENTRE
GLASGOW
G51 1SL

Dear Dr Fawcett

BRIAN WHYTE DOB: 31/03/64 (SG00731681) CHI: 3103646054
45 CORNWALL ST, FLAT 0/2, GLASGOW, G41 1BA

Just a quick letter to let you know that Mr Whyte was given 2 appointments for colonoscopy on 28/10/09 and 23/11/09 but he refused to have the procedure done.

His initial referral was quite worrying with dark red bleeding and apparently a palpable rectal mass but as the patient has refused the procedure we cannot take things further.

If you manage to persuade Mr Whyte to be investigated we would be grateful if you could re-refer him.

Yours sincerely

Mr Simon Denley
ST5 to Mr Alan Hair

Department of Surgery
Victoria Infirmary
Langside Road
Glasgow G42 9TY

Mr Alan Hair
Consultant Surgeon
Department of Surgery
Telephone/Fax 0141 201 5463/5581
E-mail: margaret.robinson@sgh.scot.nhs.uk

Our ref: AH/MR

Date Dictated: 06/11/09
Date Typed: 09/11/09

DR MARK FAWCETT
MIDLOCK MEDICAL CENTRE
GLASGOW
G51 1SL

Dear Dr Fawcett

BRIAN WHYTE DOB: 31/03/64 (SG00731681) CHI: 3103646054
45 CORNWALL ST, FLAT 0/2, GLASGOW, G41 1BA
ADMISSION TYPE: ELECTIVE
ADMISSION DATE: 28/10/09
DISCHARGE DATE: 28/10/09
CONSULTANT: MR ALAN HAIR
PROCEDURE: COLONOSCOPY WHICH WAS CANCELLED

Mr Whyte was referred and vetted to get an urgent colonoscopy but for some reason this was not carried out.

It is not entirely clear of the reasons why this was not carried out but he has been given another date and we will forward the result once this is available.

Yours sincerely

Mr Simon Denley
ST5 to Mr Alan Hair

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No
Consent for Sharing Withheld: No

AMY KERRThe Crescent Medical Practice,12 Walmer Crescent,Glasgow, G51 1AT

Gartnavel General Hospital,1053 Great Western Rd,Glasgow G12 OYN
Main Switchboard: 0141 2113000
Date of Completion: 16-Oct-2019

Dear AMY KERR,

Name	CHI	DoB	Address
Brian Whyte	**3103646054**	**31-Mar-1964**	**FLAT 2-3, 133 KINNELL AVE, Glasgow, Lanarkshire, G52 3RT**

Admitted	Type	Discharged	Destination
16-Oct-2019 07:34	DC	16-Oct-2019	Private Residence - no additional detail added

Specialty	Consultant	Ward	Telephone
Orthopaedics	Moir	GGH Ward 2A - Orthopaedics	0141 2113000

Primary Diagnosis
There is no data to display.

Secondary Diagnosis
There is no data to display.

Significant Operations / Procedures:
There is no data to display.

Last Discharge Review: Mohammad Naim Abdel Majid Hassan (Mohammad Naim Abdel Majid Hassan - FY1 Aug 18) on 16 Oct 2019 13:05

Discharge Medication:

Active Drug Name	Route	Dose	Disp	Reason	Further Details	ECS	Since Admission
Amitriptyline 10mg tablets	oral	THREE TO BE TAKEN IN THE EVENING,	No	Other see comments	**Dispensing Details:** patient states he no longer takes this	Y	
Buprenorphine 8mg sublingual tablets sugar free	sublingual	TWO TO BE TAKEN A DAY,	No	Community Pharmacist to Supply		Y	
Dihydrocodeine 30mg tablets	oral	Take 1-2 tablets every 6 hours as required for pain relief. Do not exceed 8 tablets in 24 hours , Fixed Period 10 Day(s) from 16 Oct 2019	Yes				Added
Paracetamol 500mg tablets	oral	2 tablets four times daily , Fixed Period 10 Day(s) from 16 Oct 2019	Yes				Added
Zopiclone 7.5mg tablets	oral	ONE TO BE TAKEN AT NIGHT,	No	Patient's own drugs at home		Y	

"Added" means this medicine was added to the Clinical Portal record after admission. It does not necessarily mean this medicine was started by the hospital.

Dispensing Comments
There is no data to display.

Withheld Medication:

Date	Withheld Drug Name	Route	Dose	Note	Withheld Reason
There is no data to display.					

Stopped Medication:

Date	Stopped Drug Name	Route	Dose	Note	Stopped Reason
There is no data to display.					

Reason for Admission and Presenting Complaints	Admission Category
No data available	No data available

Clinical Comments:	Dear Doctor, Thank you for continuing the care of Mr Whyte who attended GGH on 16/10/2019 for fusion of his right hallux IP joint. Procedure was uneventful and MR Whyte seems to be recovering well post-op. He is now medical fit for discharge: Post op Instruction - Heel WB Shoe for 4 weeks No DVT prophylaxis required Follow - up: - Stitches to be removed 10-14 days post op by DN - OPD appointment in 6 weeks time Kind Regards Dr Mohammad Hassan GGH - Ward 2A Orthopaedics
Follow Up:	Yes 10-14 days RoS by DN OPD in 6 weeks time
Results Awaited:	No
Pharmacist Comments:	
Final Discharge Letter to Follow:	Yes

Yours sincerely,

Mohammad Naim Abdel Majid Hassan

Prescription Review
Checked by: Esther McHarg (**ORTHONU - GGH, 2A/B, SN, Ortho)
Discharged by: Esther McHarg (**ORTHONU - GGH, 2A/B, SN, Ortho)

Whyte Brian CHI: 3103646054

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No Consent for Sharing Withheld: No

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF
Main Switchboard: 0141 201 1100

Date of Completion: 27/12/2015

Dr. HA McNaughtan
Drs Hilary Mcnaughtan & patrick j
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
G52 3SS

Dear Dr HA McNaughtan,

Name	CHI	DoB	Address
Brian Whyte	3103646054	31/03/1964	FLAT 2-3 Glasgow G52 3RT

Admitted	Type	Discharged	Destination
26/12/2015 13:11	In Patient	26/12/2015	

Specialty	Consultant	Ward	Telephone
General Medicine	Dr Brian Kennon	QEUH ARU2 General Medicine	01414522348 / 01414522349

Reason for Admission and Presenting Complaints	Admission Category
intoxicated, unrousable	Acute Admission no additional detail added

Diagnosis	Site	Side

Date	Procedures/Interventions/Operations

Clinical Comments: Dear Doctor,
Mr Whyte was admitted to the QEUH by ambulance after being found by a passerby unresponsive in a hedge. His GCS was 7 on arrival although his resp rate was normal. He was given naloxone with no effect in A&E. He was hypothermic on arrival; his initial leucocytosis resolved on warming. When he came round he admitted to taking around 20 x 10mg diazepam tablets. He was fully alert and orientated by 6pm and allowed home.
Kind regards

Treatments: None recorded.

Follow-up arranged: nil

Planned Outpatient Investigations: nil

Final Discharge letter to follow: y

Medication Info:

Allergies:

Height: cm **Weight:** kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment

Discontinued Medication:

Drug Name	Dose	UOM	Reason

Yours sincerely,
Dr Kim Lim1
Doctor

Prescription Review
Medications Reviewed by Pharmacist: ,
Dispensed Medications Checked by Pharmacy: ,
Nurse discharging patient: Kim Lim1, Doctor

Whyte Brian CHI: 3103646054

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No Consent for Sharing Withheld: No

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF
Main Switchboard: 0141 201 1100

Date of Completion: 27/12/2015

Dr. HA McNaughtan
Drs Hilary Mcnaughtan & patrick j
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
G52 3SS

Dear Dr HA McNaughtan,

Name	CHI	DoB	Address
Brian Whyte	3103646054	31/03/1964	FLAT 2-3 Glasgow G52 3RT

Admitted	Type	Discharged	Destination
26/12/2015 13:11	In Patient	26/12/2015	

Specialty	Consultant	Ward	Telephone
General Medicine	Dr Brian Kennon	QEUH ARU2 General Medicine	01414522348 / 01414522349

Reason for Admission and Presenting Complaints	Admission Category
intoxicated, unrousable	Acute Admission no additional detail added

Diagnosis	Site	Side

Date	Procedures/Interventions/Operations

Clinical Comments: Dear Doctor,
Mr Whyte was admitted to the QEUH by ambulance after being found by a passerby unresponsive in a hedge. His GCS was 7 on arrival although his resp rate was normal. He was given naloxone with no effect in A&E. He was hypothermic on arrival; his initial leucocytosis resolved on warming.
When he came round he admitted to taking around 20 x 10mg diazepam tablets. He was fully alert and orientated by 6pm and allowed home.
Kind regards

Treatments: None recorded.

Follow-up arranged: nil

Planned Outpatient Investigations: nil

Final Discharge letter to follow: y

Medication Info:

Allergies:

Height: cm **Weight:** kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment

Discontinued Medication:

Drug Name	Dose	UOM	Reason

Yours sincerely,
Dr Kim Lim1
Doctor

Prescription Review
Medications Reviewed by Pharmacist: ,
Dispensed Medications Checked by Pharmacy: ,
Nurse discharging patient: Kim Lim1, Doctor

Whyte Brian CHI: 3103646054

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No Consent for Sharing Withheld: No

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Main Switchboard: 0141 201 1100

Date of Completion: 26/10/2013

Dr. M Fawcett
Midlock Medical Centre
7 Midlock Street
Glasgow
G51 1SL

Dear Dr M Fawcett,

Name	CHI	DoB	Address
Brian Whyte	3103646054	31/03/1964	45 CORNWALL ST Glasgow G41 1BA

Admitted	Type	Discharged	Destination
25/10/2013 12:50	In Patient	26/10/2013	

Specialty	Consultant	Ward	Telephone
General Medicine	Dr David Murdoch	SGH Ward 22 - General Medicine	0141 201 1777

Reason for Admission and Presenting Complaints	Admission Category
Found by police with reduced GCS	Acute Admission no additional detail added

Diagnosis	Site	Side

Date	Procedures/Interventions/Operations

Clinical Comments: This gentleman was found by police on 25/10/13 wandering in the undergrowth in Kinning Park. He was hypothermic and confused, likely secondary to drug misuse.

A CT did not demonstrate any acute abnormalities.His observations returned to normal and his GCS recovered.

We have been unable to confirm his regular medications and no further follow up is arranged - this gentleman is known to Govan CAT.

Treatments: None recorded.

Follow-up arranged: Nil

Planned Outpatient Investigations: Nil

Final Discharge letter to follow: yes

Medication Info:

Allergies:

Height: cm **Weight:** kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment

Discontinued Medication:

Drug Name	Dose	UOM	Reason

Yours sincerely,
Dr Elizabeth Day
Doctor

Prescription Review

Medications Reviewed by Pharmacist: ,
Dispensed Medications Checked by Pharmacy: ,
Nurse discharging patient: Steven Flood, Nurse

Whyte Brian CHI: 3103646054

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No Consent for Sharing Withheld: No

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Main Switchboard: 0141 201 1100

Dr. M Fawcett
Midlock Medical Centre
7 Midlock Street
Glasgow
G51 1SL

Date of Completion: 31/07/2013

Dear Dr M Fawcett,

Name	CHI	DoB	Address
Brian Whyte	3103646054	31/03/1964	45 CORNWALL ST Glasgow G41 1BA

Admitted	Type	Discharged	Destination
28/07/2013 00:50	In Patient	30/07/2013	Private Residence - no additional detail added

Specialty	Consultant	Ward	Telephone
General Medicine	Dr Evelyn Millar	SGH Ward 4 - General Surgery	0141 201 1637

Reason for Admission and Presenting Complaints	Admission Category
Initial head injury followed by pneumonia in right middle lobe	Admission for treatment - Where the patient is expected to be treated for a diagnosed condition not otherwise specified

Diagnosis	Site	Side

Date	Procedures/Interventions/Operations

Clinical Comments: 49 year old gentleman admitted on 24/07/13 after being found lying on street by police. ? Assault. Patient unaware of what happened. GCS of 10/15 on admission. He was found to have a head injury, with abrasions to the right zigoma and blood from the left ear canal. This was discussed with neurosurgery and max fax who both felt no further action or review was required. Mr Whyte had a CT scan which showed no evidence of an intracranial bleed or c-spine fracture. Mr Whyte signed an irregular self discharge form on 25/07/13, however, his family brought him back to the ward the following day due to concern.
On 27/07/13 Mr Whyte was started on treatment for ?sepsis following episodes of vomiting with associated headache and neck stiffness. This was felt to be a right middle lobe pneumonia secondary to hypoventilation due to musculoskeletal pain. He was treated with amoxicillin and metronidazole and is now apyrexial. Mr Whyte still has some sputum production on coughing but feels this is improving. Discharged on oral amoxicillin and metronidazole.

Treatments: see notes

Follow-up arranged: nil

Planned Outpatient Investigations: nil

Final Discharge letter to follow: yes

Medication Info:

Allergies:

Height: cm **Weight:** kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment
Amoxicillin Capsules	Oral	500	MG	THREE Times a Day	5 Days	ward supply
Methadone Hydrochloride Mixture 1mg/1ml	Oral	50	MG	ONCE a Day	No duration defined	
Metronidazole Tablets	Oral	400	MG	THREE Times a Day	5 Days	ward supply
Paracetamol Tablets	Oral	500	MG	No Frequency Defined	No duration defined	

New Medication Started: yes

Medication Comment: to complete 5 further days of amox and met

Discontinued Medication:

Drug Name	Dose	UOM	Reason

Yours sincerely,
Dr Kirsten Cameron1
Doctor

Prescription Review
Medications Reviewed by Pharmacist: ,
Dispensed Medications Checked by Pharmacy: ,
Nurse discharging patient: Ian Mathew, Nurse

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

DEPARTMENT OF GENERAL SURGERY

WARD: S04 CONSULTANT: MR WESLEY PAUL STUART
CONTACT TEL: 0141 201 2736

IMMEDIATE DISCHARGE LETTER

PATIENT: BRIAN WHYTE
45 CORNWALL ST
GLASGOW
G41 1BA

DOB: 31/03/64

UNIT NO: SG00731681
ACCT NO: IP0010521/10
CHI NO: 3103646054

GP: DR MARK M FAWCETT

GLASGOW
G51 1SL

DATE OF ADMISSION: 20/02/10
DATE OF DISCHARGE: 12/03/10

ADMISSION TYPE: EMERGENCY
DISCHARGE TO: HOME

REASON FOR ADMISSION: STABBING
MAIN DIAGNOSIS: MULTIPLE STAB WOUNDS.

OTHER ACTIVE PROBLEMS:

OPERATIONS/PROCEDURES/ TREATMENT: REQUIRED RECONSTRUCTION OF VASCULATURE OF RIGHT SFA AND 4 X CHEST DRAINS. REQUIRED ICU CARE. PAIN CONTROLLED. NOW MOBILISING. FOR HOME WITH ANALGESIA.

RESULTS AWAITED: N
CURRENT MEDICATION: SEE PRESCRIPTION
DISCONTINUED DRUGS? N
COMMENT:

ALLERGIES:
NKDA

REVIEW? Y DETAILS: OUT PATIENT 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: FY1.RAFMA RAFFERTY,MARK
DESIGNATION: FOUNDATION DR YEAR 1
PAGE NUMBER: 7502

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

DEPARTMENT OF GENERAL SURGERY

WARD: S04 CONSULTANT: MR WESLEY PAUL STUART
CONTACT TEL: 0141 201 2736

IMMEDIATE DISCHARGE LETTER

PATIENT: BRIAN WHYTE
45 CORNWALL ST
GLASGOW
G41 1BA

DOB: 31/03/64 UNIT NO: SG00731681
ACCT NO: IP0010521/10
CHI NO: 3103646054
GP: DR MARK M FAWCETT

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
PARACETAMOL	OTAB	1G	4 TIMES A DAY	INDEFINITE

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

Medication	Form	Dose	Frequency	Duration
DIAZEPAM	OTAB	5MG	3 TIMES A DAY	INDEFINITE

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

Medication	Form	Dose	Frequency	Duration
SENNA	OTAB	2 TABS	NOCTE	INDEFINITE

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

Medication	Form	Dose	Frequency	Duration
TRAMADOL	OTAB	100MG	4 TIMES A DAY	INDEFINITE

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

Medication	Form	Dose	Frequency	Duration
	OTAB	20MG	AS REQUIRED	REVIEW

New Drug? Y New Dose? Y Comments: 10MG/5ML THEREFORE PLEASE SUPPLY 300ML
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:

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: 1203-0032 Date(Time): 12/03/10 (1011 Hours) Status: Draft

Letter to Patient: VAL2

NHS Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF
Main Switchboard: 0141 201 1100
Department: Dietetics
Contact Tel: 0800 592 087
Enquiries to:

Brian Whyte
FLAT 2-3
133 KINNELL AVE
Glasgow
Lanarkshire
G52 3RT

Letter Date: 02/10/2024
Reference:
Dictated Date: 02/10/2024
Transcribed Date: 02/10/2024

Dear Brian,

We recently wrote to you inviting you to contact us regarding your dietetic referral and it would appear from our records that to date, you have not responded.

Please telephone us on **0800 592 087 to advise us if you wish to remain on this waiting list and inform us of any periods of unavailability you may have.**

If you do not contact us within one week of the date of this letter, we will assume that you no longer want to remain on this waiting list, and will remove your name from the list. We will inform your GP or Referrer.

If you have already called and updated us with the required information since the date of this letter, please ignore this reminder and accept our apologies.

You can contact us between the hours of 8am – 8pm Monday to Friday and 9am – 1pm on a Saturday, excluding public holidays.

Yours sincerely

Prescribing Support Dietitians

Electronically Signed: ,

cc.

Letter to Patient: VAL1

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

Brian Whyte
FLAT 2-3
133 KINNELL AVE
Glasgow
Lanarkshire
G52 3RT

Main Switchboard: 0141 201 1100
Department: Dietetics
Contact Tel: 0800 592 087
Enquiries to:
Letter Date: 25/09/2024
Reference:
Dictated Date: 25/09/2024
Transcribed Date: 25/09/2024

Dear Briane,

We are reviewing our waiting lists (which are currently 24 weeks) and according to our records your name is on the waiting list for a dietetic outpatient appointment.

The role of the dietitian is to undertake a dietary assessment to provide advice on what foods and drinks should be included or excluded from the diet to promote weight gain.

The QR codes below are a link to very informative web pages created by NHS Greater Glasgow & Clyde and NHS inform. We would encourage you to look at this information as it provides self-care information and guidance meantime.

Please note if you have already been started on oral nutritional supplements (ONS) you should continue to take these as prescribed and if these were started by your GP these will continue to be prescribed on a paper prescription until the dietitian review. If you have been seen by a dietitian in a hospital and started on ONS you should have already been set up on the Community Pharmacy Nutritional Support service where the prescription is done by your community pharmacist electronically).

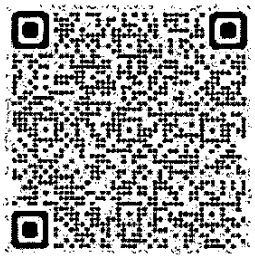
We understand that once recovered from an acute illness someone's appetite can improve greatly. If after reading the dietary information enclosed with this letter you feel you would still like a dietetic consultation, please telephone us on **0800 592 087 to advise us if you wish to remain on this waiting list and inform us of any periods of unavailability you may have.**

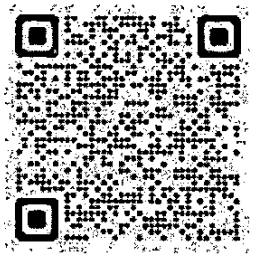
You can contact us between the hours of 8am – 8pm Monday to Friday and 9am – 1pm on a Saturday, excluding public holidays.

If we do not hear from you within two weeks of the date on this letter, we will assume that you no longer require an appointment. We will remove your name from the waiting list and will inform your GP or Referrer accordingly. At which time any ONS prescriptions will be stopped. In the future if you have any concerns regarding your oral intake/ or weight loss, please contact your GP for another referral.

Yours sincerely

Prescribing Support Dietitians





Electronically Signed: ,

cc.

Letter to Patient:

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

Brian Whyte
FLAT 2-3
133 KINNELL AVE
Glasgow
Lanarkshire
G52 3RT

Main Switchboard:	0141 201 1100
Department:	Neurology
Contact Tel:	0141-201-0511
Enquiries to:	Deirdre Nolan
Letter Date:	16/02/2021
Reference:	LS/DN
Dictated Date:	12/02/2021
Transcribed Date:	15/02/2021

Dear Mr Whyte,

I was sorry to hear that you were too claustrophobic to have your MRI of brain earlier this month. I have therefore requested a CT brain scan for you which you should find easier. You have an appointment for my Seizure Clinic in June when the result of the scan should be available.

Best wishes.

Yours sincerely

Dr Linda Stephen

Associate Specialist

Honorary Clinical Senior Lecturer

Electronically Signed: Dr Linda Stephen, Associate Specialist

cc. Dr A P Kerr The Crescent Medical Practice 12 Walmer Crescent Glasgow G51 1AT

Department of Trauma & Orthopaedics

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

Telephone: - 0141 451 5958

14/01/2019

Mr Brian Whyte
Flat 2-3
133 Kinnell Ave
Glasgow
G52 3RT

Dear Mr Whyte,

Hospital Number: 3103646054

We are writing to you on behalf of the Queen Elizabeth University Hospital Orthopaedic Department. You are currently on our Orthopaedic waiting list.

We have unsuccessfully tried to contact you by telephone.

Could you please contact us **within the next 7 days** to advise whether you still wish to proceed with your surgery.

Failure to contact us may result in you being removed from our waiting list.

Yours sincerely

Department of Trauma & Orthopaedics

Trauma & Orthopaedic - Ankle & Foot

Queen Elizabeth University Hospital

1345 Govan Road

Glasgow G51 4TF

04/06/2019

DR AP Kerr

The Crescent Medical Practice

12 Walmer Crescent

Glasgow

351 1AT

Dear Dr AP Kerr

Patient Name: Brian Whyte

CHI Number: 3103646054

Referral Date: 03/06/2019

Thank you for your referral. On this occasion I am unable to offer a consultation to your patient.

Please see the following reasons.

( ) Please refer to the referral guidance directory for referral criteria for this service.

http://www.staffnet.ggc.scot.nhs.uk/Info%20Centre/PoliciesProcedures/GGC%20Referral%20Guidance/Pages/GGCReferralGuidance.aspx

( ) Insufficient clinical information to allow specialty to triage referral.

Enter free text here

( ) Other

Mr Whyte remains on the orthopedic surgical waiting list and has not missed any appointments

Yours sincerely

Podiatrist Euan McGivern

User ID Euan McGivern

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Trauma & Orthopaedic - Wrist & Hand GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Queen Elizabeth University Hospital 1345 Govan Road Glasgow G51 4TF	——	**Hospital** and **hospital address** Hospital location code. G405H Email address -

Urgency of referral Routine
Date of referral 03-Jun-2019 **Date sent** 03-Jun-2019

PATIENT DETAILS

Surname	Whyte
Forename(s)	Brian
Title	Mr
Sex	Male
Date of birth	31-Mar-1964
CHI no.	3103646054
Area of Residence	-

Patient's address

2-3
133 Kinnell Avenue
GLASGOW
G52 3RT

Contact number(s)

Voice: 07501230012
Voice: 07501230012

101018838821B Unique Care Pathway Number: 101018838821B

REGISTERED GP DETAILS

Name	Dr Amy Kerr		
GMC code	6026525	GP code	00868
Practice name	The Crescent Medical Practice (18955)		
Practice code	52058		

Practice address

The Crescent Medical Practice
12 Walmer Crescent
Cessnock
GLASGOW
G51 1AT

Contact number(s)

Voice: 0141 427 0191
Facsimile: 0141 427 1351
E-mail: GG-UHB.gp52058clinical@nhs.net

REFERRING GP DETAILS

Name	Dr. Amy Kerr		
GMC code	6026525	GP code	00868
Practice name	14 Hillington Road South (52058)		
Practice code	52058		

Practice address

Glasgow
G52 2AA

Contact number(s)

Voice: 0141 882 9098

** Please address any correspondence to Lee Janson **

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: Right foot and toe pathology/possible missed appointment

Comment: Brian Whyte is a 55 year old male who was seen on or about 11 December 2018 at the Orthopaedic Foot and Ankle clinic. At that clinic appointment he was found to have a fixed flexion deformity of the right 1st interphalangeal joint. As per that letter, a procedure to correct the problem was planned. Unfortunately the patient experienced marked violence at his residency and was forced to move to a friend's house. He is concerned that he may have missed any letters for a follow up appointment and/or procedure. Brian has now been able to move back to his house and I have reinforced that he needs to have continued access to that location to receive any future letters.

As such, I'd appreciate your reviewing of Mr Whyte's clinic records and, if a follow up appointment letter was sent, I'd appreciate a re-appointment of a clinic visit.

Thank you for your care of Brian Whyte.

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
[D]Insomnia NOS	-	05-Dec-2011	05-Dec-2011
[D]Respiratory failure NOS	-	20-Feb-2010	20-Feb-2010
[X]Assault by sharp object	multiple stab wounds	20-Feb-2010	20-Feb-2010

Past procedures (High and medium priority - all)

Description	Date performed	Date recorded
Drug addiction therapy	09-Apr-2015	09-Apr-2015
Plain X-ray ankle joint	24-Aug-2004	24-Aug-2004

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

No current medications recorded

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Amitriptyline Hydrochloride Tablets 10 mg	56	56 TABLET	TWO TO BE TAKEN IN THE EVENING	-	31-May-2019	31-May-2019
Amitriptyline Hydrochloride Tablets 10 mg	56	56 TABLET	TWO TO BE TAKEN IN THE EVENING	-	31-Jan-2019	31-Jan-2019
Amitriptyline Hydrochloride Tablets 10 mg	56	56 tablet	TWO AT NIGHT	-	17-Dec-2018	17-Dec-2018
Amitriptyline Hydrochloride Tablets 10 mg	56	56 tablet	ONE TO BE TAKEN IN THE EVENING	-	13-Nov-2018	31-Jan-2019

Blood Pressure

Date Recorded	Systolic	Diastolic
29-Aug-2017	110	70

Body Measurements

Date Recorded	Height	Weight	BMI
31-May-2019	-	55	-
17-Dec-2018	-	49.6	-

07-Feb-2017 - 50 -

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Stopped smoking:		31-Dec-1988
Teetotaller:		13-Dec-2016

Clinical warnings

Additional Support Needs

No known ASN requirements

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

Referred By:Locum

Electronic Attachment Present:No

Correspondence recipient:Lee Janson

Social circumstances

Ethnic Origin: (White) Scottish

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Neurology - First Seizure GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Queen Elizabeth University Hospital 1345 Govan Road Glasgow G51 4TF	——	**Hospital** and **hospital address** Hospital location code. G405H Email address

Urgency of referral Routine
Date of referral 03-Jun-2019 **Date sent** 03-Jun-2019

PATIENT DETAILS

Surname	Whyte
Forename(s)	Brian
Title	Mr
Sex	Male
Date of birth	31-Mar-1964
CHI no.	3103646054
Area of Residence	-

Patient's address

2-3
133 Kinnell Avenue
GLASGOW
G52 3RT

Contact number(s)

Voice: 07501230012
Voice: 07501230012

101018838425B | Unique Care Pathway Number: 101018838425B

REGISTERED GP DETAILS

Name	Dr Amy Kerr		
GMC code	6026525	GP code	00868
Practice name	The Crescent Medical Practice (18955)		
Practice code	52058		

Practice address

The Crescent Medical Practice
12 Walmer Crescent
Cessnock
GLASGOW
G51 1AT

Contact number(s)

Voice: 0141 427 0191
Facsimile: 0141 427 1351
E-mail: GG-UHB.gp52058clinical@nhs.net

REFERRING GP DETAILS

Name	Dr. Amy Kerr		
GMC code	6026525	GP code	00868
Practice name	14 Hillington Road South (52058)		
Practice code	52058		

Practice address

Glasgow
G52 2AA

Contact number(s)

Voice: 0141 882 9098

** Please address any correspondence to Lee Janson **	

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: ?First onset seizure/missed appointment

Comment: Brian Whyte is a 55 year old male who was referred on or about 22 May 2018 for possible first onset seizures. He was provided an appointment on 4 March 2019, but did not receive the clinic appointment letter. The patient has just presented to the GP and reported that he unfortunately was experiencing marked violence at his house and had to move to a friend's house. The situation has now improved and he has been able to move back to his house. I have reinforced that he needs to have access to that house to receive any future clinic letters. As such, I'd appreciate you re-appointing a clinic appointment for Mr Whyte for assessment of possible and new onset seizures.

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
[D]Insomnia NOS	-	05-Dec-2011	05-Dec-2011
[D]Respiratory failure NOS	-	20-Feb-2010	20-Feb-2010
[X]Assault by sharp object	multiple stab wounds	20-Feb-2010	20-Feb-2010

Past procedures (High and medium priority - all)

Description	Date performed	Date recorded
Drug addiction therapy	09-Apr-2015	09-Apr-2015
Plain X-ray ankle joint	24-Aug-2004	24-Aug-2004

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

No current medications recorded

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Amitriptyline Hydrochloride Tablets 10 mg	56	56 TABLET	TWO TO BE TAKEN IN THE EVENING	-	31-May-2019	31-May-2019
Amitriptyline Hydrochloride Tablets 10 mg	56	56 TABLET	TWO TO BE TAKEN IN THE EVENING	-	31-Jan-2019	31-Jan-2019
Amitriptyline Hydrochloride Tablets 10 mg	56	56 tablet	TWO AT NIGHT	-	17-Dec-2018	17-Dec-2018
Amitriptyline Hydrochloride Tablets 10 mg	56	56 tablet	ONE TO BE TAKEN IN THE EVENING	-	13-Nov-2018	31-Jan-2019

Blood Pressure

Date Recorded	Systolic	Diastolic
29-Aug-2017	110	70

Body Measurements

Date Recorded	Height	Weight	BMI
31-May-2019	-	55	-
17-Dec-2018	-	49.6	-
07-Feb-2017	-	50	-

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Stopped smoking:		31-Dec-1988

Teetotaller: 13-Dec-2016

Clinical warnings

Additional Support Needs
No known ASN requirements

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
Referred By:Locum
Electronic Attachment Present:No
Correspondence recipient:Lee Janson

Social circumstances
Ethnic Origin: (White) Scottish

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Neurology - First Seizure GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Queen Elizabeth University Hospital 1345 Govan Road Glasgow G51 4TF	——	**Hospital** and **hospital address** Hospital location code. G405H Email address -

Urgency of referral Routine
Date of referral 19-Nov-2018 **Date sent** 22-Nov-2018

PATIENT DETAILS

Surname	Whyte
Forename(s)	Brian
Title	Mr
Sex	Male
Date of birth	31-Mar-1964
CHI no.	3103646054
Area of Residence	-

Patient's address

133 Kinnell Avenue
Flat 2-3
GLASGOW
G52 3RT

Contact number(s)

Voice: 07501230012
Voice: 07501230012

101017444107N Unique Care Pathway Number: 101017444107N

REGISTERED GP DETAILS

Name	Dr Amy Kerr		
GMC code	6026525	GP code	00868
Practice name	The Crescent Medical Practice (18955)		
Practice code	52058		

Practice address

The Crescent Medical Practice
12 Walmer Crescent
Cessnock
GLASGOW
G51 1AT

Contact number(s)

Voice: 0141 427 0191
Facsimile: 0141 427 1351
E-mail: GG-UHB.gp52058clinical@nhs.net

REFERRING GP DETAILS

Name	Dr. Patrick Manson		
GMC code	6071843	GP code	00493
Practice name	14 Hillington Road South (52058)		
Practice code	52058		

Practice address

Glasgow
G52 2AA

Contact number(s)

Voice: 0141 882 9098

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: ? seizure

Comment: I wonder if you could see this man in clinic. He came to see me this week having had which sounds like a possible seizure last week when he collapsed in the street and is amnesic of events around the time but he was told that he was lying on the floor shaking. He was apparently taken by ambulance to the Queen Elizabeth A&E from where he left before being seen. Unfortunately we have not received any information from the ambulance or the hospital about this nor could I find anything on the clinical portal. He tells me he had a similar previous episode a year ago. He is on methadone replacement therapy and seems to be a reformed character. He is adamant that he did not take any illicit substances or street bought medication or alcohol and he does seem to be genuine about this. I would be grateful for your assessment in clinic as to whether he would benefit from further investigation of this and last year's episodes.

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Date of onset	Date recorded
[D]Respiratory failure NOS	20-Feb-2010	20-Feb-2010

Past procedures (High and medium priority - all)

Description	Date performed	Date recorded
Drug addiction therapy	09-Apr-2015	09-Apr-2015
Plain X-ray ankle joint	24-Aug-2004	24-Aug-2004

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

No current medications recorded

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Amitriptyline Hydrochloride Tablets 10 mg	56	56 tablet	ONE TO BE TAKEN IN THE EVENING	-	13-Nov-2018	13-Nov-2018
Amitriptyline Hydrochloride Tablets 10 mg	28	28 tablet	ONE TO BE TAKEN IN THE EVENING	-	13-Nov-2018	13-Nov-2018
Naproxen Tablets 500 mg	28	28 TABLET	ONE TO BE TAKEN TWICE A DAY	-	05-Oct-2018	05-Oct-2018
Paracetamol Tablets 500 mg	100	100 tablet	2 QID	-	05-Oct-2018	05-Oct-2018

Blood Pressure

Date Recorded	Systolic	Diastolic
29-Aug-2017	110	70

Body Measurements

Date Recorded	Height	Weight	BMI
07-Feb-2017	-	50	-

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Stopped smoking:		31-Dec-1988
Teetotaller:		13-Dec-2016

Clinical warnings

Additional Support Needs
No known ASN requirements

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
Referred By:Referring GP
Electronic Attachment Present:No

Social circumstances
Ethnic Origin: (White) Scottish

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Trauma & Orthopaedic - Wrist & Hand GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Queen Elizabeth University Hospital 1345 Govan Road Glasgow G51 4TF	——	**Hospital** and **hospital address** Hospital location code. G405H Email address -

Urgency of referral Routine
Date of referral 10-Oct-2018 **Date sent** 10-Oct-2018

PATIENT DETAILS

Surname	Whyte
Forename(s)	Brian
Title	Mr
Sex	Male
Date of birth	31-Mar-1964
CHI no.	3103646054
Area of Residence	-

Patient's address

133 Kinnell Avenue
Flat 2-3
GLASGOW
G52 3RT

Contact number(s)

Voice: 07501230012
Voice: 07501230012

101017166270P Unique Care Pathway Number: 101017166270P

REGISTERED GP DETAILS

Name	Dr Amy Kerr		
GMC code	6026525	GP code	00868
Practice name	The Crescent Medical Practice (18955)		
Practice code	52058		

Practice address

The Crescent Medical Practice
12 Walmer Crescent
Cessnock
GLASGOW
G51 1AT

Contact number(s)

Voice: 0141 427 0191
Facsimile: 0141 427 1351
E-mail: GG-UHB.gp52058clinical@nhs.net

REFERRING GP DETAILS

Name	Dr. Amy Kerr		
GMC code	6026525	GP code	00868
Practice name	The Crescent Medical Practice (52058)		
Practice code	52058		

Practice address

12 Walmer Crescent
Glasgow
G51 1AT

Contact number(s)

Voice: 0141 427 0191

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: Hammer toe

Comment: Dear doctor, this gentleman is bothered by hammering of the great toe on the right side, I would be grateful for your opinion as to wether surgery may help

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
[D]Insomnia NOS	-	05-Dec-2011	05-Dec-2011
[D]Respiratory failure NOS	-	20-Feb-2010	20-Feb-2010
[X]Assault by sharp object	multiple stab wounds	20-Feb-2010	20-Feb-2010

Past procedures (High and medium priority - all)

Description	Date performed	Date recorded
Drug addiction therapy	09-Apr-2015	09-Apr-2015
Plain X-ray ankle joint	24-Aug-2004	24-Aug-2004

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

No current medications recorded

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Naproxen Tablets 500 mg	28	28 TABLET	ONE TO BE TAKEN TWICE A DAY	-	05-Oct-2018	05-Oct-2018
Paracetamol Tablets 500 mg	100	100 tablet	2 QID	-	05-Oct-2018	05-Oct-2018

Blood Pressure

Date Recorded	Systolic	Diastolic
29-Aug-2017	110	70

Body Measurements

Date Recorded	Height	Weight	BMI
07-Feb-2017	-	50	-

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Stopped smoking:		31-Dec-1988
Teetotaller:		13-Dec-2016

Clinical warnings

Additional Support Needs

No known ASN requirements

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

Referred By:Referring GP
Electronic Attachment Present:No

Social circumstances
Ethnic Origin: (White) Scottish

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

Referral letter:

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF
0141 201 1100

ORTHOTICS
GGH

Main Switchboard:	
Department:	Podiatry
Contact Tel:	0141 531 6878
Enquiries to:	Eva Milligan
Letter Date:	31/05/2018
Reference:	
Dictated Date:	31/05/2018
Transcribed Date:	31/05/2018

Dear Orthotics,

Brian Whyte; D.O.B: 31/03/1964; CHI: 3103646054
FLAT 2-3, 133 KINNELL AVE, Glasgow, Lanarkshire, G52 3RT

Clinical presentation - Re-occurring ulceration at right 1st apex due to extremely clawed toe.
Management to date and outcome - off-the-shelf footwear advice and regular podiatry which has been unsuccessful in preventing ulceration.
Trigger for escalation: Regular podiatry and off-the-shelf footwear not preventing ulceration.
Aim of referral: Prevention of ulceration.
Many Thanks
Eva Milligan (Podiatrist)

Electronically Signed: ,

cc.

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Trauma & Orthopaedic - Ankle & Foot 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 16-Oct-2014 **Date sent** 16-Oct-2014

PATIENT DETAILS

Surname	Whyte
Forename(s)	Brian
Title	Mr
Sex	Male
Date of birth	31-Mar-1964
CHI no.	3103646054
Area of Residence	-

Patient's address

133 Kinnell Avenue
Glasgow
G52 3RT

Contact number(s)

Voice: 07932069127

101008064663E Unique Care Pathway Number: 101008064663E

REGISTERED GP DETAILS

Name	Dr Mark Fawcett		
GMC code	4438737	GP code	04103
Practice name	Midlock Medical Centre (18951)		
Practice code	52005		

Practice address

Midlock Medical Centre
7 Midlock Street
Glasgow
G51 1SL

Contact number(s)

Voice: 0141-427-4271
Facsimile: 0141-427-1401

REFERRING GP DETAILS

Name	Dr. Mark Fawcett		
GMC code	4438737	GP code	04103
Practice name	Midlock Medical Centre (52005)		
Practice code	52005		

Practice address

7 Midlock Street
Glasgow
G51 1SL

Contact number(s)

Voice: 0141 427 4271

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: Hallux Valgus

Comment: This gentleman is having trouble with a painful 1st MTPJ on the right foot which has a marked valgus deformation. I would be grateful for your review

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
[D]Insomnia NOS	-	05-Dec-2011	05-Dec-2011
Overdose of drug	tramadol	01-Oct-2011	01-Oct-2011
[X]Stabbing	multiple stab wounds	20-Feb-2010	20-Feb-2010
Respiratory failure	-	20-Feb-2010	20-Feb-2010

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Ankle X-ray	Start Date: 10/08/2004	24-Aug-2004	24-Aug-2004

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

No current medications recorded

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Promethazine Hydrochloride Tablets 10 mg	7	7 tablet	ONE AT NIGHT	-	14-Aug-2014	14-Aug-2014

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Smoker :		31-May-2013
Current smoker:	Smoker$$ Status.clm - Repeat after an Interval 1Y	04-Nov-2011
Current smoker:	Smoker$$ Status.clm - Repeat after an Interval 1Y	18-Mar-2011
Current smoker:	Smoker$$ Status.clm - Repeat after an Interval 1Y	03-Dec-2009
Light smoker - 1-9 cigs/day:	Smoker$$ Status.clm - Repeat after an Interval 12M	15-Aug-2008
Teetotaller:	Alcohol Intake$$.clm - No Action Required	03-Aug-2004

Clinical warnings

Additional Support Needs

No known ASN requirements

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

Social circumstances
Ethnic Origin: (White) British

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Urology 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 02-Mar-2012 **Date sent** 19-Mar-2012

PATIENT DETAILS

Surname	Whyte
Forename(s)	Brian
Title	Mr
Sex	Male
Date of birth	31-Mar-1964
CHI no.	3103646054
Area of Residence	-

Patient's address

0-2
45 Cornwall St
Glasgow
G41 1BA

Contact number(s)

Voice: 07932069127

101003280218P | Unique Care Pathway Number: 101003280218P

REGISTERED GP DETAILS

Name	Dr Mark Fawcett		
GMC code	4438737	GP code	04103
Practice name	Midlock Medical Centre (18951)		
Practice code	52005		

Practice address

Midlock Medical Centre
7 Midlock Street
Glasgow
G51 1SL

Contact number(s)

Voice: 0141-427-4271
Facsimile: 0141-427-1401

REFERRING GP DETAILS

Name	Dr. Barry Adams Strump		
GMC code	1334311	GP code	05185
Practice name	Midlock Medical Centre (52005)		
Practice code	52005		

Practice address

7 Midlock Street
Glasgow
G51 1SL

Contact number(s)

Voice: 0141 427 4271

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: bladder and anal incontinence

Comment: This man was under care of Mr Stuart following severe stabbing in 2010. Recently he has been losing both bladder and anal control. He has also recently started using heroin again.
I am not sure what cause of incontinence is, could be neurological but I would appreciate your opinion.

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
[D]Insomnia NOS	-	05-Dec-2011	05-Dec-2011
Overdose of drug	tramadol	01-Oct-2011	01-Oct-2011
Respiratory failure	-	20-Feb-2010	20-Feb-2010
[X]Stabbing	multiple stab wounds	20-Feb-2010	20-Feb-2010

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Ankle X-ray	Start Date: 10/08/2004	24-Aug-2004	24-Aug-2004

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

No current medications recorded

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Diazepam Tablets 10 mg	10	10 tablet	ONE TABLET TWICE DAILY	-	25-Jan-2012	27-Feb-2012
Diazepam Tablets 10 mg	21	21 TABLET	ONE TO BE TAKEN THREE TIMES A DAY	-	13-Jan-2012	13-Jan-2012
Diazepam Tablets 2 mg	21	21 TABLET	ONE TO BE TAKEN THREE TIMES A DAY	-	06-Jan-2012	06-Jan-2012
Temazepam Tablets 10 mg	7	7 TABS	1 Tab At night	-	05-Dec-2011	14-Dec-2011
Temazepam Tablets 10 mg	7	7 TABS	1 Tab At night	-	04-Oct-2011	04-Oct-2011
Diazepam Tablets 10 mg	21	21 TABS	1 Tab 3 times daily	-	04-Nov-2011	04-Nov-2011

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:	Smoker$$ Status.clm - Repeat after an Interval 1Y	04-Nov-2011
Current smoker:	Smoker$$ Status.clm - Repeat after an Interval 1Y	18-Mar-2011
Current smoker:	Smoker$$ Status.clm - Repeat after an Interval 1Y	03-Dec-2009
Light smoker - 1-9 cigs/day:	Smoker$$ Status.clm - Repeat after an Interval 12M	15-Aug-2008
Current smoker:	Smoker$$ Status.clm - Repeat after an Interval 1Y	15-Aug-2008
Teetotaller:	Alcohol Intake$$.clm - No Action Required	03-Aug-2004

Clinical warnings

Additional Support Needs
No known ASN requirements

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**

Anaesthetic Record

NHS Greater Glasgow and Clyde

3103646054
WHYTE M
Brian 31/03/1964
FLAT 2-3
133 KINNELL AVE
Glasgow, Lanarkshire
G52 3RT

Pre-op

Procedure(s) Fusion (R) 1st MTP

Anaesthetist(s) NS

Surgeon(s) JSM

Elective ☑
Urgent ☐
Immediate ☐

C	SAS	ST	CT	PA
☑	☐	☐	☐	☐
☑	☐	☐	☐	

Date 16/10/19

Discussed with supervising consultant _____

SUMMARY

ASA 1 (2) 3 4 5
Comment

GA	☑	FM vent OK	☐
Spinal	☐	LMA OK	☑
Epidural	☐	Laryngoscopy gd	____
Sedation	☐		
Other LA			

Anaesthetist
Sign / Print _____

ASSESSMENT

Airway / Dentition

MPT

RS

✓

CVS

✓

GI / Renal / CNS / Other

Previous anaesthesia / Family history

✓ Stabbing

Assessor
Sign / Print / Date _____

Ht
Wt kg
BMI

BP ____ / ____
ECG SR

Hb	Na
WCC	K
Plts WNAD	U WNAD
XMatch	Cr
Clotting	Gluc

Allergies / Reactions

✓

Current therapy
Amitriptyline
Buprenorphine

OK with NSAIDs ☑

Risks discussed

Anaesthetic Record
Anaesthetic Record
Anaesthetic Record
Anaesthetic Record

Equipment check performed ☐

Vascular access

Cannula 20G

A line

CVP

Airway/Ventilation

FM — Pre-ox ☑

LMA 4 — Cricoid P ☐

ETT — SV ☑

Grade — IPPV ☐

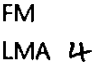
Regional Anaesthesia

② Lt TAP Block

15ml 0.25% levob

Propofol	200								
Fent	100								
Midaz	2								
Ceftriaxone	1.5								
Time	15								

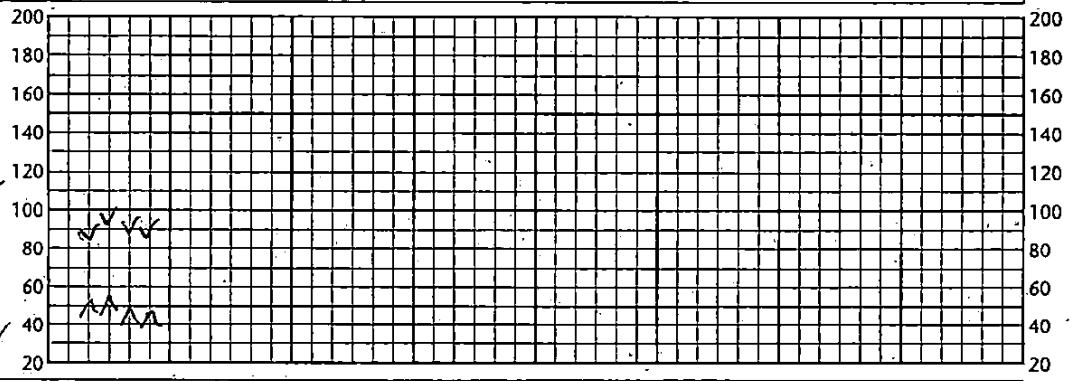
Position



ECG SpO_2 ☑
NIBP

Fluid warmer ☐

Patient warmer ☑



IV Fluids ①

Events

FiO_2 N_2O ☐	57								
SpO_2	98								
$ETCO_2$	3.6								
ETAA	2.1								

Eye care ☑

Pressure point care ☑

Events

Ⓐ
Ⓑ
Ⓒ
Ⓓ
Ⓔ
Ⓕ
Ⓖ
Ⓗ

IV fluids

① RL 500
②
③
④
⑤
⑥
⑦
⑧

⑨
⑩
⑪
⑫
⑬
⑭
⑮
⑯

NHS
Greater Glasgow and Clyde

Name

Hospital no.

CHI no.

DoB / Age

Anaesthetic Record

Anaesthetic Record

Anaesthetic Record

Anaesthetic Record

Time								

200 180 160 140 120 100 80 60 40 20

IV Fluids								
Events								
FiO_2 N_2O☐								
SpO_2								
$ETCO_2$								
ETAA								

Post-op Instructions

Intra-op blood loss _____

Oxygen

Per PCA/other protocol ☐

_____ L/min in recovery

To keep SaO_2 > ____ %

Fluids

Monitoring/Investigations

Continue Fluids

Anaesthetic Notes

NHS Greater Glasgow and Clyde — Intraoperative Accountable Items Count Record

Date 16/10/19

3103646054
WHYTE M
Brian 31/03/1964
FLAT 2-3
133 KINNELL AVE
Glasgow. Lanarkshire
G52 3RT

WARD 2a
HOSPITAL GGH
THEATRE E

COUNTS	Scrub/Registered Practitioner Print Name	Circulating Practitioner(s) - Signature & Print name
PRE - OP SWAB COUNT	SN RAVINDRAN	CMUNRO CMUNRO
PRE - OP INSTRUMENT COUNT	SN RAVINDRAN	M Smith M.SMITH
FINAL COUNT	SN RAVINDRAN	WPLYON WPLyon
FINAL INSTRUMENT COUNT	SN RAVINDRAN	WPLYON WPLyon
FINAL DISPATCH COUNT	SN RAVINDRAN	WPLYON WPLyon

SCRUB PRACTITIONER VERIFICATION

I have reviewed this count and can verify my count is correct
SCRUB PRACTITIONER 1- SIGNATURE: B
SCRUB PRACTITIONER 2 - SIGNATURE :
To be signed by replacement scrub practitioner if applicable N/A ☑

OPERATION : RIGHT :- HALLUX INTERPHALANGEAL JOINT ARTHRODESIS FOOT

HANDOVER COUNT IN EVENT OF REPLACEMENT SCRUB PERSONEL DURING PROCEDURE (This Section N/A) ☑

Temporary Change of Scrub Practitioner (Comments if required)	Outgoing Scrub (1) Print Name	Incoming Scrub (2) Print Name	Circulating Practitioner Signature/Print Name and Time
	Outgoing Scrub (2) Print Name	Incoming Scrub (1) Print Name	Circulating Practitioner Signature/Print Name and Time
Permanent Change of Scrub Practitioner and/or Circulating Practitioner	Outgoing Scrub (1) Print Name	Incoming Scrub (2) Print Name	Circulating Practitioner (1) Signature/Print Name and Time
			Circulating Practitioner (2) Signature/Print Name and Time

TALLY OF EACH ITEM USED - ADD ANY ITEMS SPECIFIC TO YOUR SPECIALITY

Swabs (2x2)	—	Pledgelets	—	Caesarean Roll		ACCOUNTABLE ITEMS THAT ARE TO REMAIN IN SITU e.g. Abdo packs/Swabs, Quantity and Location
Swabs (10x10)	10	Tapes	—			
Abdominal packs	—	Sloops/Slings	—			
Sutures	2	Bulldogs	—			
Blades	3	Shods	—			
IV needles	—	Ports	—			
Syringes	7	Tibbs Cannula	—			
Discard-a-pad	1	Staple Gun Inserts	—			
Diathermy pencil	—	Spears	—			
Diathermy tips	—	Retrieval Bag (Bert)	—			
Scratch pad	—	Digital Tourniquets	—	Throat Pack IN		
Reels	—	Pen & Ruler	—	Throat pack OUT		
Patties	—	Bi-Polar	—	Total Number		

TOURNIQUET RIGHT THIGH 250mm Hg
↑ 0924
↓ 1002

DISCREPANCY IN COUNT - THIS SECTION N/A ☑

DETAIL WHICH COUNT DISCREPANCY OCCURRED

Detail of the discrepancy:-

ACTION TAKEN AND OUTCOME (e.g. search undertaken, wound explored, plain x-ray taken)

Scrub Practitioner Signature if count still incorrect .....

Ensure Datix is Completed ☐
Datix Incident Number.....

SURGEONS SIGNATURE IF COUNT INCORRECT FOLLOWING ALL POSSIBLE ACTIONS .....

PLEASE INSERT TRACEABILITY LABELS ON BACK OF BLUE COPY- TO REMAIN IN THEATRE. mi • 240937 V2.0 GGC0063

Acute Services Division
Surgery & Anaesthetics

GG&C Day Surgery/23 hour Care Plan

NHS Greater Glasgow and Clyde

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WHYTE M
Brian 31/03/1964
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Glasgow, Lanarkshire
G52 3RT

Admission Checklist

Hospital : GGH	Consultant : Mr Mair	Date : 16/10/19
Proposed Operation:- Fusion Right TS+ IPJ		
Patient Questionnaire Completed?	Yes ☐	No ☑
Pre-Op assessment Completed?	Yes ☑	No ☐
Escort Details (responsible Adult)Name: James (Friend)	Telephone Number:	
Confirm "Next of Kin" on pre-assessment Yes Name: Paul Goodwin	Telephone No: 07729 869225	
Interpreter Required? If "YES" confirmation of booking Duration of booking (if known).....	Yes ☐	No ☑
Carer required to stay with patient?	Yes ☐	No ☑
ate of LMP? N/A	Date.....	
Are you, or could you be pregnant? If "Yes" pregnancy test must be performed	Yes ☐	No ☐
Pregnancy test results	+VE	-VE
Group and save results checked Date done.....	Yes ☐	No N/A
Anti D required	Yes ☐	No ☑
Is the patient on Anti-Coag therapy? If "Yes" state type..... Are INR results available within last 24hrs? If "No" INR taken date .....time.....	Yes ☐ Yes ☐ Result.....	No ☑ No ☐
Is the patient diabetic If "Yes" BM on admission results.....	Yes ☐ NIDD ☐ DD ☐	No ☑
Urinalysis done Results.....	Yes ☐	No N/A
CJD single question asked Answer to CJD single question	Yes ☑ DD ☐ At Increased Risk ☐ Not at increased Risk ☑	Comment if required If at risk theatre notified By..... To.....
If CJD question has not been asked then ask the question " Have you ever been notified that you are at an increased risk of CJD or vCJD for public health purposes?"	Yes, I have been notified No, I have not been notified	Comment if required
Alert Sticker (if required)	Yes ☐	N/A ☑
Does the patient have any pressure area issues? If 'Yes': Area..... Issue+/- Score..... Tissue Viability contacted Yes N/A	Yes ☐	No ☑
Other Information- Document any other relevant information e.g. needle phobia , request for female practitioner 'Getting to know you' information.		
Fit Form required	Yes ☐ No ☑	

Baseline Observations

	Time...08.00	Time.....
SP02	99%	
BP	90/53	
HR	71	
Temp	36.5	
Staff Initials	EM.	

Please print & sign name when checklist completed E MITHANI	Name : E M - Time : 08 00

Acute Services Division
Surgery & Anaesthetics

GG&C Day Surgery/23 hour Care Plan
Admission Checklist

Patient mode of transport to theatre Trolley ☑ Walking ☐ Chair ☐

Pre-op Checklist - to be completed immediately prior to the patient being given a Pre Med

Preoperative Checks	Admission Check	Reception Check N/A	Anaesthetic Check
Identity band correct (Name, DOB, CHI number, Gender) and checked with Patient	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
Case Notes/Scanner Folder	Yes ☐ No ☑	Yes ☐ No ☑	Yes ☐ No ☑
Addressograph Labels	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
X-Rays and Scans – Hardcopy	Yes ☐ No ☑ N/A ☐	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☑
Prescription Chart	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
Alert sticker	[redacted]	Please see page 1 Checked ☐	Please see page 1 Checked ☐
Consent / Incapacity (circle) Signed & Dated	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
Checked against theatre list	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
Check with:			
Patient/Incapacity/Consent(Circle)	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
Procedure and site for Surgery	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
Correct site marked		Yes ☑ No ☐	
Comments & details eg Welfare Guardian/ Power of Attorney	Yes ☐ No ☑		Yes ☐ No ☑
Allergies/Sensitivities and Reactions	Yes ☐ No ☑	Yes ☐ No ☑	Yes ☐ No ☑
If Yes, please specify			
Fasted from - specify time (24hr clock	Food: Before midnight Fluid: 2300	Checked: ✓	Checked: before midnight 2300
Blood Glucose Score N/A	Time: Score:	Time: N/A Score	Time: N/A Score
Internal Prosthesis in situ e.g metalwork, pacemaker, implant	Yes ☐ No ☑	Yes ☐ No ☑ N/A ☐	Yes ☐ No ☑ N/A ☐
If 'Yes' state location and type			
External prosthesis e.g. hair extensions, hair pieces.	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☑
If left in situ, state location on patient			
If removed state where stored			
Jewellery/Body piercing removed	Yes ☐ No ☐ N/A ☑	Yes ☑ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☑
If 'Yes' state where stored			
Jewellery/Body piercing taped	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☑
If 'Yes' state Location on body			
Make-up/Nail polish removed	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☑
Comments			
False Nails	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☑
Comments			
Loose Teeth /caps/crowns/bridges /dental work	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☑ N/A ☐
State Location:			
Dentures Removed If "Yes' state where stored:	Yes ☑ No ☐ N/A ☐ IN WARD	Yes ☑ No ☐ N/A ☐ Top a bottom	Yes ☑ No ☐ N/A ☐ IN WARD
Spectacles/ contact lenses removed (circle) If 'Yes' state where stored:	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☑

Acute Services Division
Surgery & Anaesthetics

GG&C Day Surgery/23 hour Care Plan
Admission Checklist

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Preoperative Checklist *continued*			
Pre-operative checks	**Admission Check**	**Reception Check N/A**	**Anaesthetic Check**
Hearing aid(s)	R ☐ L ☐ N/A ☑	R ☐ L ☐ N/A ☑	R ☐ L ☐ N/A ☑
Hearing aid(s) removed If removed state where stored:	Insitu ☐ Removed ☐	Insitu ☐ Removed ☐	Insitu ☐ Removed ☐
CJD question asked Answer to CJD question		Please see page 1 Checked ☑	Please see page 1 Checked ☑
If CJD question has not been asked then ask the question " Have you ever been notified that you are at an increased risk of CJD or vCJD ' public health purposes?"		Please see page 1 Checked ☑	Please see page 1 Checked ☑
RSA screen results (if applicable)	Positive ☐ Results Pending ☐	Negative ☑ N/A ☐	Comments if required:
Inhalers / Sprays with patient State Type	Yes ☐ No ☐ N/A ☑	Type:	
Anti-embolic/DVT Prophylaxis State Type	Yes ☐ No ☐ N/A ☑	Type:	
Paper Pants in situ	Yes ☐ No ☑ N/A ☐	Own underwear.	
Voided urine/ Catheter in situ/ Urostomy (circle)	Yes ☑ No ☐ N/A ☐	Comment if required	Comment if required
Date of Last Menstrual period		See P1 Checked ☑	See P1 Checked ☐
Is there any chance you are pregnant?		See P1 Checked ☐	See P1 Checked ☐
Pregnancy test carried out Pregnancy test result		See P1 Checked ☐	See P1 Checked ☐
Tampon Removed Comments:	Yes ☐ No ☐ N/A ☑	See Admission Check Checked ☐	See Admission Check Checked ☐
Local anaesthetic cream applied	Yes ☐ N/A ☑	If "Yes" time applied..... Site(s) applied.....	If "Yes" time applied..... Site(s) applied..... .....
Pre-Medication Given	Yes ☐ N/A ☑	Yes ☐ N?A ☐	Yes ☐ N/A ☐
Trolley/Bed checked for head down tilt and O2/Accessories	Bed ☐ Trolley ☑ Operating Chair ☐ Yes ☐ No ☐	Bed ☐ Trolley ☑ Operating Chair ☐ Yes ☐ No ☐	Bed ☐ Trolley ☐ Operating Chair ☐ Yes ☐ No ☐
Any relevant medical history or other information	Laparotomy, hernia repair, following PTSD, awaiting neuro review - ?seizure Stabbing Insury Ex IVDA.		
Please print and sign name once the checklist is complete	Admission: ZA Emirhanoğlu Time: 0800	Reception: N/A ☐ S Campbell Time: 850.	Anaesthetic Assistant: [illegible] Time 9.00

Acute Services Division
Surgery & Anaesthetics

GG&C Day Surgery/23 hour Care Plan

Anaesthetics

A: 3103646054
N: WHYTE
Brian M
C: FLAT 2-3 31/03/1964
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Glasgow, Lanarkshire
G52 3RT

Surgical Brief

Surgical Brief carried out: Yes ☑ No ☐	If 'No' please specify				
Baseline Observations Date & Time	Pulse: 66	BP: 101/56	Temp: 36.0°	SpO2: 98%	Resps: 17
Anaesthetic Assistant has confirmed with Anaesthetist that cross matched blood is:	Required: Yes ☐ N/A ☑	Available: Yes ☐ No ☐	Or patient has been grouped and saved: Yes ☐ No ☐		
STOP BEFORE YOU BLOCK carried out Yes ☑ No ☐ N/A ☐					
Anaesthetic Type – Please Tick all that apply					
General Anaesthetic LMA 4	Epidural ☐	Spinal ☐	Regional Block ☐	Throat Spray ☐	
Local Anaesthetic	Site: RIGHT FOOT	Drug: LEVOBUPIVACAINE 0.25%	mls: 20		
Sedation	Drug:	mls:			

Skin Prep used for Anaesthetic Monitoring/Block(s)

This section NOT applicable ☑

SPINAL/EPIDURAL	Yes ☐ N/A ☐	Specify Prep:
REGIONAL BLOCK	Yes N/A	Specify Prep:
OTHER SPECIFY	Yes N/A	Specify Prep:

Blood Glucose Monitoring

This section NOT applicable ☑

Time								
BM score								

Safe use of SpO2 probe to prevent injury

This section NOT applicable ☐

SpO2 Probe rotated hourly	Yes ☐ No ☐ N/A ☑				Initial Position LEFT EARLOBE		
Time Rotated							
Probe Position							

Prevention of Eye Injury

This section NOT applicable ☐

Eyes protected from injury during procedure	Yes ☑ No ☐	Specify: EYES TAPED

Maintenance of Norm-thermia

This section NOT applicable

Actions taken to maintain the patient's Temperature	Yes ☑	Warm air blanket device – specify: UPPER TORSO BAIRHUGGER	Yes ☑ No ☐ N/A ☐
	No ☐	Warm Fluids	Yes ☐ No ☐ N/A ☐
		Warming Mat	Yes ☐ No ☐ N/A ☐
		Thermal Hat	Yes ☐ No ☐ N/A ☐
		IV fluid warmer	Yes ☐ No ☐ N/A ☐
		Other - specify	Yes ☐ No ☐ N/A ☐
Patients Temperature documented by Anaesthetist		Yes	No

Acute Services Division
Surgery & Anaesthetics

GG&C Day Surgery/23 hour Care Plan

Anaesthetics

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Record of Anaesthetic Pump Infusion Device Numbers	This section NOT applicable ☑

Comments/Events

Acute Services Division
Surgery & Anaesthetics

Affix Ad

Name : 3103646054
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GG&C Day Surgery/23 hour Care Plan

Theatre

Safe Positioning

This section NOT applicable ☐

Moving aids used to move patient	Yes ☑ No ☐	Pat Slide ☑	Hover Mattress ☐	Sliding sheet ☐	Other specify: ☐	Roll Board ☐

Pre - op Pressure Area Care

Pre-operative skin issues (please circle)	Excoriation Level: 0 1 2 3	PU Grade: N/A 1 2 3 4

Area of concern identified (include area of body)	Actions Taken

Position 1

Time:				Positioning Devices				Pressure Relieving	Arm Position	
Supine	☑	Prone	☐	Head ring	☐	Lateral supports	☐	Gel Pads ☐	R Arm Position	L Arm Position
Left Lateral	☐	Right Lateral	☐	Pillows	☑	Hydraulic leg supports	☐	Heel gel Pads ☐	At side ☑	At side ☐
Lloyd Davis	☐	Jack-knife	☐	Straps	☐	Limb Traction	☐	Full gel mattress ☐	On boards ☐	On boards ☐
Tren-delenburg	☐	Deckchair	☐	Wedge	☐	Side Supports	☐	Gel Wedge ☐	Across chest ☐	Across chest ☑
Reverse Tren-delenberg	☐	Lower Limb Traction	☐	Sandbag	☐	Bolster	☐	Pillows ☐	Hand Table ☐	Hand Table ☐
Lithotomy	☐	Other	☐						Hand Traction ☐	Hand Traction ☐
									Secured with:	Secured with:
									Straps ☐	Straps ☐
									J Board ☑	J Board ☑
									Pressure Care:	Pressure Care:
									Gel / Foam Pads ☐	Gel / Foam Pads ☐

Position 2

This section NOT applicable ☑

Time:				Positioning Devices				Pressure Relieving	Arm Position	
Supine	☐	Prone	☐	Head ring	☐	Lateral supports	☐	Gel Pads ☐	R Arm Position	L Arm Position
Left Lateral	☐	Right Lateral	☐	Pillows	☐	Hydraulic leg supports	☐	Heel gel Pads ☐	At side ☐	At side ☐
Lloyd Davis	☐	Jack-knife	☐	Straps	☐	Limb Traction	☐	Full gel mattress ☐	On boards ☐	On boards ☐
Tren-delenburg	☐	Deckchair	☐	Wedge	☐	Side Supports	☐	Gel Wedge ☐	Across chest ☐	Across chest ☐
Reverse Tren-delenberg	☐	Lower Limb Traction	☐	Sandbag	☐	Bolster	☐	Pillows ☐	Hand Table ☐	Hand Table ☐
Lithotomy	☐	Other	☐						Hand Traction ☐	Hand Traction ☐
									Secured with:	Secured with:
									Straps ☐	Straps ☐
									J Board ☐	J Board ☐
									Pressure Care:	Pressure Care:
									Gel / Foam Pads	Gel / Foam Pads

Electrosurgery

This section NOT applicable ☐

Monopolar Yes ☐ N/A ☑	Bipolar Yes ☐ N/A ☐

Site(s) of Monopolar electrode

Skin site(s) assessed and meets safety criteria as per policy	Yes ☐ No ☐	If 'No' state reason:
Skin site(s) hair removal	Yes ☐ N/A ☐	State site:
Electrode site(s) checked after patient repositioned and is satisfactory	Yes ☐ No ☐ N/A ☐	If 'No' state reason and action:

Acute Services Division
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Tourniquets — This section NOT applicable ☐

Tourniquet equipment applied	Yes ☑ No ☐ N/A ☐		
Padding under tourniquet	Yes ☑ No ☐ N/A ☐		
Cover over tourniquet	Yes ☑ No ☐ N/A ☐		
Post op skin check(s) satisfactory	Yes ☑ No ☐	If 'No' state reason and action:	

Site	Time Inflated	Pressure	Time deflated	Time re-inflated	Pressure	Time deflated
RIGHT THIGH	09.24	250mmHg	10.02			

Digit Tourniquets — This section NOT applicable ☐

Digit applied:	Time applied :	Time Removed:
Digit applied:	Time applied :	Time Removed:

Skin Preparation — This section NOT applicable ☐

Site	Clipped	Preparation solution used	
RIGHT FOOT	Yes ☐ No ☐ N/A ☑	Aqueous Iodine based solution Alcohol Iodine based solution ✓ Aqueous Iodine and sodium chloride 50/50	Chlorhexidine solution ☐ Chlorhexidene acetate Solution ☐ .....% Other ☐ Specify:.....%
Site	Clipped	Preparation solution used	
	Yes ☐ No ☐ N/A ☐	Aqueous Iodine based solution Alcohol Iodine based solution Aqueous Iodine and sodium chloride 50/50	Chlorhexidine solution ☐ Chlorhexidene acetate Solution ☐ .....% Other ☐ Specify:.....%

Local Anaesthetic Infiltration to Wound — This section NOT applicable ☐ ✓

Site	Drug	Quantity
Site	Drug	Quantity

Drains — This section NOT applicable ☐

Drain	Site	Type	Size	Secured with	Dressing
1					
2					
3					

Wound Closure and Dressings (including Packing) — This section NOT applicable ☐

Wound Closure used: Yes ☑ No ☐ N/A ☐ | Wound Dressings: Yes ☑ No ☐ N/A ☐

	Site	Wound closure	Dressings	Packing
1	RIGHT FOOT	3/0 DEXON	INADINE, BLUE SWABS VASELINE + CREPE	N/A
2				

Acute Services Division
Surgery & Anaesthetics

GG&C Day Surgery/23 hour Care Plan

Theatre

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Urinary Catheter Inserted prior to admission This section NOT applicable ☑

Type	Size	Anaesthetic lubricant applied / inserted	Balloon inflated with	Prepping Solution
		mls	mls	

Operation / Procedure Performed

RIGHT FOOT :- HALLUX INTERPHALANGEAL JOINT ARTHRODESIS.

Blood Tags This section NOT applicable ☐

Blood Tags checked and dispatched appropriately: : Yes ☐ No ☐ N/A ☐

Post - op Pressure Area Care

Skin Inspection Scores Post operative (circle)	Excoriation level: 0 1 2 3	Pressure Ulcer Grade: N/A 1 2 3 4

Action taken if required

Notes / Comments / Events This section NOT applicable ☐

Traceability Stickers

T-00388-001 5514534
12mm & 20mm Memory Staples
KellMed
1.6mm x 150mm K WIRE, SINGLE TROCAR, STERILE
REF 323.150s
LOT 1902531-31 2024-03
PARKWAY FARM BUSINESS PARK, DORCHESTER, DT1 3AR

S12015-007 5827550
REM B Power Tool
KellMed
1.6mm x 150mm K WIRE, SINGLE TROCAR, STERILE
REF 323.150s
LOT 1905531-34 2024-06
PARKWAY FARM BUSINESS PARK, DORCHESTER, DT1 3AR

T-00198-018 5829502
GGC Ortho Medium Tray
KellMed
2.5mm x 110mm DRILL BIT, QUICK FIT, STERILE
REF 915.110s
LOT 1901419-41 2024-02
PARKWAY FARM BUSINESS PARK, DORCHESTER, DT1 3AP

S1872-001 5828275
Tamper Set (ortho)

REF P3613 LOT 5279780 STERILE R 2021-10
MEMORY® 12 QTY. 1
Memory staple width : 12 mm 13/15

BIOMET TRAUMA
56 EAST BELL DRIVE
P.O. BOX 587
WARSAW, IN 46581 USA

Acute Services Division
Surgery & Anaesthetics

GG&C Day Surgery/23 hour Care Plan

Immediate Post-op Recovery

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M
31/03/1964

Post -Op Instructions e.g. sutures, physio, follow up appointments

Verbal Handover from Theatre to Recovery

Verbal handover given by: To:

Handover should include the following:

Patient	Anaesthetic	Theatre	Other
Patient's name	Anaesthetic Type	Drains	
Theatre	Airway type	Wounds/Dressings	
Procedure	Peripheral IV	Urinary Catheter	
Allergies	Local Anaesthetic infiltration	Skin Inspection results	
	Pain management	Intra-operative events	
		Post-Op Instructions	

Pressure Area Issues (Skin inspection score post-operative see page 9)

N/A ☐

Area of Concern identified (include area of body)	Actions Taken

Notes / Comments / Events This section NOT applicable ☐

Acute Services Division
Surgery & Anaesthetics

GG&C Day Surgery/23 hour Care Plan

Immediate Post-operative Recovery

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G52 3RT

Post-operative Observations

Time	10.10	10.15	10.30	10.45	11.00	11.15
Airway type	4	4	1	1	1	1
O_2 Therapy	7L	7L	4L	RA	RA	RA
SpO_2	99%	100%	100%	98%	98%	98%
Resp. Rate	12	12	12	12	12	12
CVP	–	–	–			
Temp.	35.6°		35.5°		35.6°	
Pain Score	–	–	0	0	0	0
P.O.N.V.	–	–	0	0	0	0
Sedation Score	3	3	1	0	0	0
BM Score	–	–	–	–		
HemoCue Score	–	–	–	–		
Hourly Urine Vol. / Total Urine Vol.	/	/	/	/	/	/
Wound Score	0	0	0	0	0	0
Wound Score						
Wound Score						
PV Staining						
Circulation +ve/-ve	+VE	+VE	+VE	+VE	+VE	+VE
Sensation +ve/-ve	+VE	+VE	-VE	-VE	-VE	-VE
Movement +ve/-ve	+VE	+VE	-VE	-VE	-VE	-VE
Pedal Pulse – Left						
Pedal Pulse – Right						
Drain 1						
Drain 2						
Drain 3						
Drain 4						
Staff initials	LW	LW	LW	LW	LW	LW

Affix Addressograph Label

Name :

CHI :

DOB :

Time							
210							
200							
190							
180							
170							
160							
150							
140							
130							
120							
110							
100							
90							
80							
70							
60							
50							
40							
30							
Airway type							
O_2 Therapy							
SpO_2							
Resp. Rate							
CVP							
Temp.							
Pain Score							
P.O.N.V.							
Sedation Score							
BM Score							
HemoCue Score							
Hourly Urine Vol. / Total Urine Vol.							
Wound Score							
Wound Score							
Wound Score							
PV Staining							
Circulation +ve/-ve							
Sensation +ve/-ve							
Movement +ve/-ve							
Pedal Pulse – Left							
Pedal Pulse – Right							
Drain 1							
Drain 2							
Drain 3							
Drain 4							
Staff initials							

Key to Scoring / Abbreviations

Airway Type	
1	Maintaining own airway
2	Guedel
3	Naso-pharyngeal
4	L.M.A.
5	E.T.T.
6	Tracheostomy
Post Operative Nausea and Vomiting Assessment	
0	None
1	Mild – *Not distressed; No retching/vomiting*
2	Moderate – *Troublesome; Occasional retching/vomiting*
3	Severe – *Distressing; Frequent retching/vomiting*
Sedation Score	
0	Awake
S	Normal Sleep
1	Drowsy, easy to rouse – *Eyes open to speech or light shaking*
2	Sedated, difficult to rouse – *Eyes open only to vigorous shaking*
3	Unconscious, unrousable
Wound Score	
0	Dry and Intact
1	Slight Staining
2	Moderate Staining
3	Saturation / Pad required

Pain Score

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Severe Pain			

Acute Services Division
Surgery & Anaesthetics

Affix 3103646054 M
Nam WHYTE 31/03/1964
Brian
CHI : FLAT 2-3
133 KINNELL AVE
DOB : Glasgow. Lanarkshire G52 3RT

GG&C Day Surgery/23 hour Care Plan

Discharge Recovery

2nd Stage Recovery

Verbal Handover from Immediate Recovery to 2nd Stage Recovery

Verbal handover given by: To:

Handover should include the following:

Patient	Anaesthetic	Theatre	Recovery	Other
Patient's name	Anaesthetic Type	Drains	Skin Inspection results	
Theatre	Local anaesthetic infiltration	Wounds/Dressings	Post Op Instructions	
Procedure	Peripheral IV	Urinary Catheter	Pain management	
Allergies	Pain Management	Intra-operative events		

Pre Mobilisation Patient Checks

Time		Comments
BP		
HR		
SpO2		
Wound Site 1		
Wound Site 2		
Diet & Fluids tolerated		
Operated limb N/A ☐ Colour Sensation Movement		

Signature:

Events / Comments — This section NOT applicable ☐

Events / Comments	Time	Signature

Acute Services Division
Surgery & Anaesthetics

GG&C Day Surgery/23 hour Care Plan

Discharge Criteria

3103646054
WHYTE M
Brian 31/03/1964
FLAT 2-3
133 KINNELL AVE
Glasgow, Lanarkshire
G52 3RT

Discharge Criteria

	Yes	N/A	Comments
Able to dress, sit & walk unaided	✓		
Stable Vital Signs	✓		BP / HR SpO2 % See NEWS.
Sedation Score (alert & orientated)	✓		
Pain Controlled (mild <3 to 0)	✓		
Post - op Nausea & vomiting satisfactory	✓		
Tolerating Food & Fluids	✓		
Voided Urine post-op	✓		
Advice given if not voided urine post-op		✓	
Wound site(s) checked & satisfactory 1. 2.	✓		
CSM of operated limb checked & satisfactory	✓		
IV Cannula removed	✓		
ID bracelet/ECG electrodes removed	✓		
Anti-D given		✓	
Appliances given		✓	
Post –Op discharge letter	✓		
Follow up appointment arranged	✓		By post ☑ Given ☐
Practice/ District Nurse referral		✓	
Post- Op Instructions given	✓		
Discharge medication	✓		
Responsible adult escort	✓		
Responsible adult supervision overnight	✓		
Any skin issues prior to discharge reported		✓	
Patient advised that while awaiting collection after discharge that they must alert staff if there is any change in their condition.	✓		
Admission, dosage, frequency and contraindications of discharge drugs discussed with patient	✓		

Patient met discharge criteria at 11.10 hrs By S/N S Mulhearn

Patient left DSU at 16.30 Destination

Discharged into the care of Paul Goodwin. Relationship FRIEND

Acute Services Division
Surgery & Anaesthetics

GG&C Day Surgery/23 hour Care Plan

Notes

Affix A: 3103646054
Name: WHYTE Brian M
CHI: FLAT 2-3 31/03/1964
DOB: 133 KINNELL AVE
Glasgow, Lanarkshire
G52 3RT

0900 Admitted to ward for theatre today under the care of Mr Mair. Pt ID'd on ward & Name Marked & consented SN ... / EM-LTMs
10.10HRS PATIENT RECEIVED INTO RECOVERY BREATHING SPONTANEOUSLY OBSERVATIONS AS CHARTED SN Lashtefani
10-45HRS BIG TOE WARM - DUSKY IN COLOUR - SURGEON INFORMED. SURGEON REVIEWED NO FURTHER DESIGN BUTLER BANDAGE REPLACED SN Lashtefani
16/10/19 RTW following I+T IM therapeutic antibiotics s.i.s
• News 2 - due to temp & BP hypothermic O/A
• Wound dry
• tolerating lunch & diet
SN ...
1145 Patient fit for discharge home.
Has passed urine, Venflon removed.
NEWS remains 2 - Same as pre op observations
IDL letter & prepack analgesia given
OP appointments to follow in post
GA / foot info sheets given.
Awaiting escort for discharge home
SN ... / EM-LTMs
1630 Pt discharged home with ... / EM-LTMs

Acute Services Division
Surgery & Anaesthetics

Affix Addressograph Label

Name :

CHI :

DOB :

GG&C Day Surgery/23 hour Care Plan

Notes

Acute Services Division
Surgery & Anaesthetics

Affix Addressograph Label

Name :

CHI :

DOB :

GG&C Day Surgery/23 hour Care Plan

Notes

Operation Sheet Mr Moir **Date: 16/10/2019**

Mr Brian Whyte		**Surgeon:**	Moir
Hospital No: 3103646054	**D.O.B.:** 31/03/1964	**Assistant:**	Marshall
Operation: Right Fusion of Hallux IPJ		**Anaesthetist:**	Neil Storey
Indication: Acquired Claw Toe (Right)			

Preparation and Position:

Supine, tourniquet 30mins

Incision and Approach :

Dorsal over IPJ

Findings :

As radiology

Procedure :

Flat cuts, fix K wire then two 12mm memory staples

Closure :

Vicryl, nylon
Inadine, wool & crepe

Post Op Instructions :

Heel weight bear postop shoe 4 weeks
Dressings 10-14 days for RoS
DVT prophylaxis required
OPD six weeks

Consultant Orthopaedic Surgeon

Procedure	Code Type	Code
Other deformities of toe(s) (acquired)	ICD 10	M20.5
Fusion of interphalangeal joint of toe NEC	OPCS	W59.5
Interphalangeal joint of toe	OPCS	Z86.6
Right sided operation	OPCS	Z94.2

cc:

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: __/__/__ Time: _____ | Sheet No ..... | 2nd Prescription in use 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

Hospit
DOB: 3103646054
WHYTE M
Brian 31/03/1964
FLAT 2-3
Date o 133 KINNELL AVE
Consu Glasgow, Lanarkshire
G52 3RT

Height:
Weight:
Surface area:
Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
16/10	BUPRENORPHINE	1mg	Oral	1250	[signature]	SM	1255

TARGET OXYGEN SATURATIONS

Please CIRCLE a target saturation and prescribe oxygen on the Regular Prescription section.

94 – 98%	88 – 92% (e.g. in hypercapnic respiratory failure)	Other (please specify)

On Home Oxygen? Yes / No _____ L/min

DATE: ____/____/____ PRESCRIBER (PRINT & SIGN): _____

DATE →

MONTH →

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

Patient's Own Medicine

| | | |

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

D DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

E DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

F DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

G DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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.

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

Patient's Own Medicine

H — DRUG: BUPRENORPHINE

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DOSE: 16mg | ROUTE: S/Lingual | DATE: 1 16/10

PRESCRIBER (PRINT & SIGN): B. BUTCHER FI

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

STOPPED — DATE: — INITIALS:

0700-0900 circled

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

J — DRUG

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

STOPPED — DATE: — INITIALS:

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

K — DRUG

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

STOPPED — DATE: — INITIALS:

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

L — DRUG

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

STOPPED — DATE: — INITIALS:

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 →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

M DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

N DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

P DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

R DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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.

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

S DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

T DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

V DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

W DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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 →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

X DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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.

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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 →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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.

All Routes: As Required Prescriptions

| | | |

| | | |

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	(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. 40995 Ver 4, 09/2010 GGC0029

Hospital 3103646054
WHYTE M
DOB: Brian 31/03/1964
FLAT 2-3.
Date of 133 KINNELL AVE
Glasgow, Lanarkshire
Consult G52 3RT

Gartnavel General Hospital ACH

Short Stay Prescription Chart
(less than 24 hours)

NHS
Greater Glasgow and Clyde

Pre-operative Medication (if required)

Drug	Dose	Route	Doctor's Signature	Time Given	Nurse's Signature	Witness

Drugs to be given in hospital

Date	Drug Name	Dose	Route	Frequency	Times of Adminsitration				Doctor's Signature
16/10	CO-CODAMOL 30/500	2 tab	O	6°					
Nurse Record of Administration				Sign Box					

Date	Drug Name	Dose	Route	Frequency	Times of Adminsitration				Doctor's Signature
16/10	IBUPROFEN	400mg	O	8°					
Nurse Record of Administration				Sign Box					

Date	Drug Name	Dose	Route	Frequency	Times of Adminsitration				Doctor's Signature
16/10	FENTANYL AS PROTOCOL		IV						
Nurse Record of Administration				Sign Box					

Date	Drug Name	Dose	Route	Frequency	Times of Adminsitration				Doctor's Signature
16/10	ONDANSETRON	4mg	IV	6°					
Nurse Record of Administration				Sign Box					

Date	Drug Name	Dose	Route	Frequency	Times of Adminsitration				Doctor's Signature
Nurse Record of Administration				Sign Box					

Continued

Date	Drug Name	Dose	Route	Frequency	Times of Adminsitration				Doctor's Signature
Nurse Record of Administration				Sign Box					

Date	Drug Name	Dose	Route	Frequency	Times of Adminsitration				Doctor's Signature
Nurse Record of Administration				Sign Box					

Date	Drug Name	Dose	Route	Frequency	Times of Adminsitration				Doctor's Signature
Nurse Record of Administration				Sign Box					

Date	Drug Name	Dose	Route	Frequency	Times of Adminsitration				Doctor's Signature
Nurse Record of Administration				Sign Box					

Date	Drug Name	Dose	Route	Frequency	Times of Adminsitration				Doctor's Signature
Nurse Record of Administration				Sign Box					

Date	Drug Name	Dose	Route	Frequency	Times of Adminsitration				Doctor's Signature
Nurse Record of Administration				Sign Box					

Discharge Drugs

Date	Name of Drug	Strength	Quantity	Doctor's Sig.	Nurse's Sig.
16/10	COCODAMOL	30/500	1pk		
16/10	IBUPROFEN	400mg	1pk		

UNKNOWN, MALE ID: 0000000000 26-Dec-2015 14:15:56 QUEEN ELIZABETH UNIVERSITY HOSPITAL

Vent. rate pr
PR interval 162 ms
QRS duration 94 ms
QT/QTc 384/490 ms
P-R-T axes 73 73 57

Normal sinus rhythm
Prolonged QT
Abnormal ECG

Loc: 55

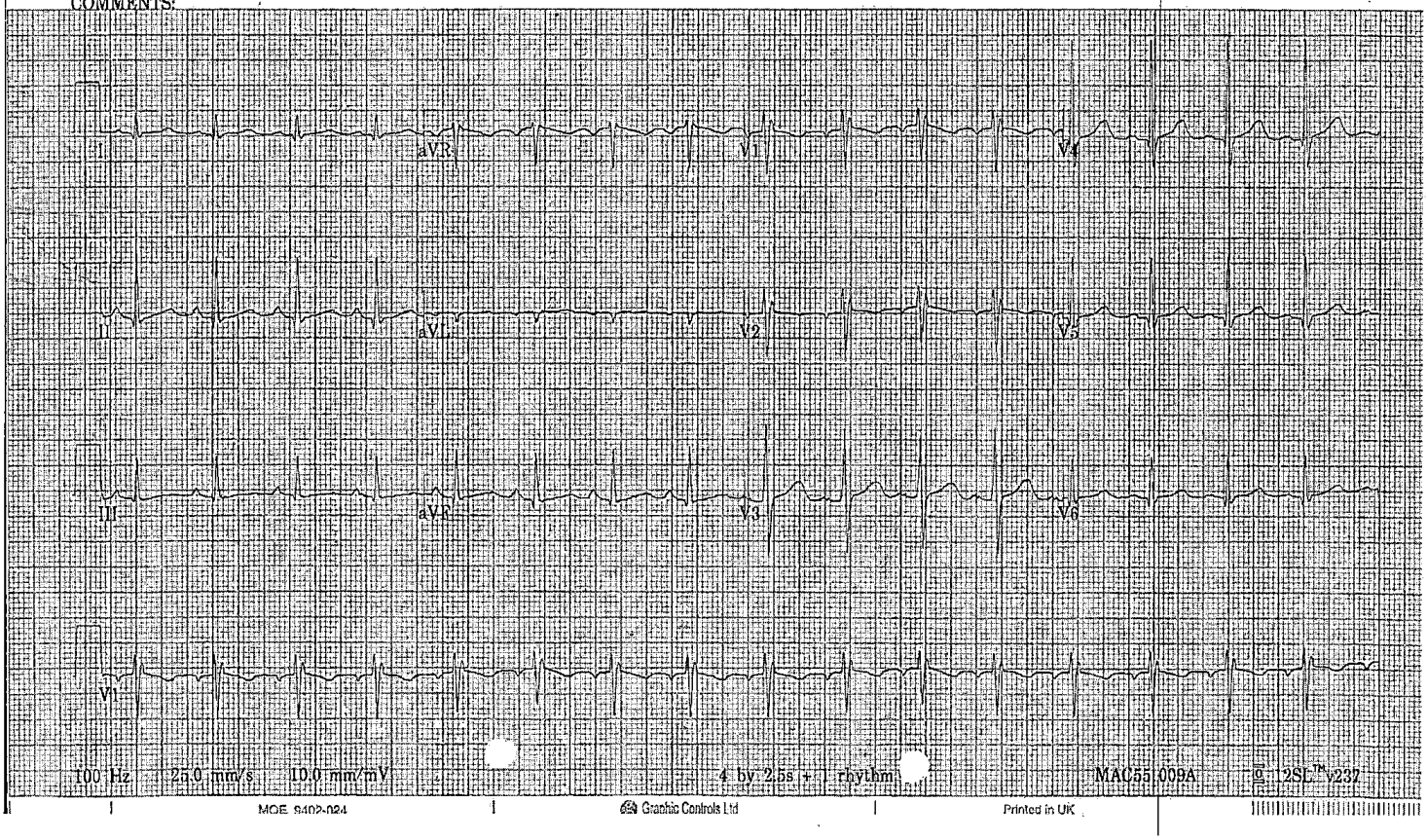
[redacted]

Technician:
Test ind:

3103646054
WHYTE M
Brian 31/03/1964
FLAT 2-3
133 KINNELL AVENUE
Glasgow, Lanarkshire
G52 3RT

Referred by: Unconfirmed

COMMENTS:



ID: 0000000999 26-Dec-2015 11:17:19 SOUTH GLASGOW UNIVERSITY HOSPITAL

Male Caucasian

Vent. rate		bpm
PR interval	*	ms
QRS duration	96	ms
QT/QTc	408/493	ms
P-R-T axes	* 83	101

Accelerated Junctional rhythm
Abnormal ECG

3103646054
WHYTE M
Brian 31/03/1964
FLAT 2-3
133 KINNELL AVENUE
Glasgow, Lanarkshire
G52 3RT

Technician:
Test ind:

Referred by:

Unconfirmed

COMMENTS:

MQE 9402-024 Graphic Controls Ltd Printed in UK

Patient n TJ03923171
UNKNOWN
Date of b Male M 01/01/1901
Unknown
CHI No: NK010AA
t label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg)..... Height (cm).....

Prescription details									Administration details				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments
		0.9% NaCl	500										
		0.9% NaCl	1000	IV	4°								
		0.9% NaCl	1000	IV	6°								
		5% glucose	500	IV	4°								

*Prescriber should sign this box if the fluid/additive is no longer required.

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow (drops/min) = Volume of fluid (ml) x 20 / Duration of admin (min)

NB: 1ml = 20 drops (for a standard giving set)

Example:

500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

Patient name: .....

Date of birth: .....

CHI No: .....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details - continued									Administration details - continued				
Date	Time	Name of fluid Name of additive	Volume (ml) Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments

*Prescribers should sign this box if the fluid/additive is no longer required.

eMedicines Reconciliation Form - v1.2

NHS Greater Glasgow and Clyde

CHI Number: 3103646054 Patient Name: Brian Whyte

Hospital Name:	Southern General
Consultant's Name:	Kernohan

Patient Details

Name:	Whyte, Brian
Address:	45 CORNWALL ST,FLAT 0/2,Glasgow,Lanarkshire,
Postcode:	G41 1BA
CHI Number:	3103646054
CRN:	70635146W, SG00731681, SG00286043, SG03301660
D.O.B:	31/03/1964
Gender:	Male

Sources Checked

ECS	X	**Patient**	X	**Carer**	
Relative		**GP Surgery**		**GP Printout**	
Patients own drugs		**Other**			
Other Details					

Active

Current

Source	Date Started	Drug	Formulation	Dose	Frequency
ECS	26/07/2013	Co-Codamol 8/500	Tablets	N/A	TWO TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN REQUIRED (MAXIMUM OF 8 IN 24 HOURS)
ECS	23/07/2013	Tramadol Hydrochloride	50 mg Capsules	N/A	ONE QDS

Stopped or withheld medicines

Not Current

Source	Prescribed Date	Drug	Formulation	Dose	Frequency
ECS	23/07/2013	Diazepam	2 mg Tablets	N/A	ONE TABLET TWICE DAILY

Allergies - ECS Summary

No ECS Allergies Found

Additional Allergy Notes

No Allergies Added

Prescriber Sign Off

Signed off by	Grade	Sign off date
Sanjiv Nandwani	ST	28/07/2013 03:07

Patient Agreement to Investigation or Treatment
Consent Form

NHS
Greater Glasgow and Clyde

Patient details (or pre-printed label)	
Hospital / clinit / GP practice	3103646054 M WHYTE 31/03/1964 Brian FLAT 2-3 133 KINNELL AVE Glasgow, Lanarkshire G52 3RT
Patient's surname / family name	
Patient's first name	
Date of birth	Gender Male ☐ Female ☐
CHI number	
Special requirements (e.g. other language / communication method)	

Statement for practitioner
(to be filled in by practitioner with appropriate knowledge of proposed procedure)

Describe proposed operation, investigation or other treatment.
Where appropriate specify site or side (write in full).

Right hallux metatarsal joint arthrodesis + extensor tendon tightening

Specific risks / complications
Please detail any specific risk/complications related to the procedure that were discussed.

RISKS OF FOOT SURGERY

INFECTION
NUMBNESS
HYPERSENSITIVE SCAR
MAL-UNION
NON-UNION (HIGHER IF SMOKER)
PROLONGED RECOVERY (6MONTHS – 1 YEAR)
CRPS (CHRONIC PAIN SYNDROME)
SWELLING
PERSISTENT DISCOMFORT/PAIN
RECURRENCE OF SYMPTOMS
DVT (CLOTS IN LEGS)
PE (CLOTS IN LUNGS)

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). I have explained who will be doing the procedure if not myself.

Signature of practitioner	
Name / Designation (print)	MCIR
Date	

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.
- Who will be performing my procedure on the day
- 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.

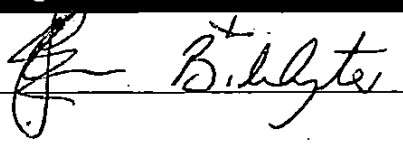
I have been told about additional procedures which may become necessary during treatment. I have listed below **any procedures which I do NOT wish to be carried out without further discussion.**

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 to the following	**Agree**	**Disagree**
to photographic images and video recordings being held in records, and made available for teaching, audit and ethically-approved research purposes, 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 / parent agreement to treatment

Signature 	Date 8/10/19.
Name (print)	

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
Signature of practitioner	Date

NHS GG&C Risk Assessment for Venous Thromboembolism (VTE)

Trauma and Orthopaedic surgery

- **Risk Assessment should be completed for all patients on admission to hospital**
- **Patients should be reassessed every 48 - 72 hours or sooner if condition changes**
- **Assessment should be documented in Kardex**
- **Provide patient information on VTE prevention**

3103646054
WHYTE M
Brian 31/03/1964
FLAT 2-3
133 KINNELL AVE
Glasgow, Lanarkshire
G52 3RT

Operative patients start here

Non-operative patients start here

Is the patient bed-bound or expected to have reduced mobility relative to normal state for≥ 2 days?

Yes

No

Indicators of patients at standard and increased risk of VTE (tick all that apply)

STANDARD RISK	INCREASED RISK	
☐ Acute trauma/surgical admission	☐ Critical care admission	☐ Varicose veins with phlebitis
☐ Dehydration	☐ Obesity (BMI>30Kg/m^2)	☐ Current significant medical condition e.g.
☐ Age >60 years	☐ Active cancer or cancer treatment	• Serious Infection
☐ Surgical procedure with total naesthetic/surgical time >90 minutes, or >60 minutes if surgery of lower limb	☐ Thrombophilia	• Heart Failure
☐ Expected significant reduction in mobility relative to their normal state for more than 2 days	☐ Personal history or first degree relative with a history of VTE	• Respiratory Failure
☐ Hip or knee replacement surgery or other major orthopaedic elective surgery	☐ Pregnancy or ≤6 weeks post partum (seek specialist advice)	• Inflammatory Disease
	☐ Hormone replacement therapy, tamoxifen	
	☐ Oestrogen containing contraceptive pill	

Yes — Standard/Increased Risks — No

- Risk assessment now complete
- No thromboprophylaxis required
- **Complete Risk Assessment Result box at foot of page**
- Continue to review every 48 – 72 hours or sooner if condition changes.
- **Document all assessments on kardex**
- **Tick to confirm** ☐

Does the patient have any bleeding risk factors? (tick all that apply)

- ☐ Surgery expected within the next 12 hours
- ☐ Surgery expected within the next 48 hours and/or risk of clinically important bleeding
- ☐ Active bleeding or risk of bleeding including
  - New-onset stroke
  - Platelet count <75 x 10^9/L
  - Acute liver failure
  - Active duodenal ulcer or gastric ulcer
- ☐ Concurrent use of therapeutic anticoagulant
- ☐ Acute bacterial endocarditis
- ☐ Any spinal intervention (prophylactic enoxaparin is contraindicated for 12 hours before spinal and epidural anaesthetics and lumbar puncture. Enoxaparin contraindicated for 4 hours after spinal and epidural anaesthetics and removal of epidural catheter.)
- ☐ Persistent uncontrolled hypertension (BP ≥ 230/120 mmHg)
- ☐ Untreated inherited bleeding disorder (e.g. haemophilia or Von Willebrands)
- ☐ Spinal surgery (seek specialist advice)
- ☐ Proliferative diabetic retinopathy

Yes — Bleeding Risks — No

- Discuss with senior clinical staff before prescribing pharmacological prophylaxis
- Consider mechanical prophylaxis e.g. AES unless contra-indicated
- Reassess patient every 48 hours or sooner if condition changes
- **Complete risk assessment result box at foot of page**

NO BLEEDING RISKS

- Prescribe thromboprophylaxis for standard/increased risk as denoted overleaf
- **Complete Risk Assessment Result box at foot of page**
- Continue to review every 48 - 72 hours or sooner if condition changes
- **Document all assessments on kardex**
- **Tick to confirm** ☐

Risk Assessment Result (tick all that apply)

VTE Risk factors assessed ☐Yes ☐No Bleeding Risk factors assessed ☐Yes ☐No Patient Informed ☐Yes ☐No

Prescribed: ☐Thromboprophylaxis in accordance with Table overleaf ☐AES ☐NONE Information leaflet supplied ☐Yes ☐No

Assessors Name: (PRINT NAME) Assessors signature: Date:

It is the responsibility of the consultant in charge to decide on the appropriate VTE prophylaxis. Follow recommendations recorded in the patient specific VTE prophylaxis instruction sheet. Contra-indications or drug interactions with any of these agents must be observed – if in doubt discuss directly with consultant's team.

Thromboprophylaxis on Admission

Procedure	During admission	
• **Hip fracture** • **Lower limb fractures** • **Total hip replacement** • **Other major elective surgery to lower limbs**	Standard VTE risk	Enoxaparin SC 40mg once daily started on the day of surgery at 6pm or at least 4 hours after surgery, whichever is latest Reduce dose to 20mg if eGFR <30ml/min or if patient weights <50Kg
	Increased VTE risk	Enoxaparin SC 40mg once daily started on the day of surgery at 6pm or at least 4 hours after surgery, whichever is latest Reduce dose to 20mg if eGFR <30ml/min or if patient weights <50Kg
Total knee replacement	Standard VTE risk	Aspirin orally 150mg daily **Or** Enoxaparin SC 40mg once daily started on the day of surgery at 6pm or at least 4 hours after surgery, whichever is latest Reduce dose to 20mg if eGFR <30ml/min or if patient weights <50Kg
	Increased VTE risk	Enoxaparin SC 40mg once daily started on the day of surgery at 6pm or at least 4 hours after surgery, whichever is latest Reduce dose to 20mg if eGFR <30ml/min or if patient weights <50Kg
Rivaroxaban (under consultant advice only) A small proportion of patients may require thromboprophylaxis with rivaroxaban following total hip or total knee replacement – in these cases follow orthopaedic and/or haematology consultant recommendations. Check BNF for advice on dose and duration of treatment. Discuss arrangements with clinical pharmacist if patient is to be discharged on rivaroxaban. *Note that rivaroxaban is licensed for orthopaedics thromboprophylaxis only after elective hip or knee replacement and its use following an initial course of enoxaparin is off-label.*		
Other elective surgery (including upper limb, arthroscopy and forefoot surgery)	Standard VTE risk	No need for pharmacological; thromboprophylaxis
	Increased VTE risk	Follow recommendations from orthopaedic and/or haematology consultant
Elective spinal surgery	Thromboprophylaxis assessment done on a case-by-case basis depending on the type of surgery and risk factors – follow recommendations from spinal surgeon	
Multiple Trauma	Thromboprophylaxis assessment done on a case-by-case basis depending on the extent of injuries – follow recommendations from orthopaedic and/or haematology consultant	
Spinal cord injury	Thromboprophylaxis assessment done on a case-by-case basis depending on the type of injury – follow recommendations from the spinal injuries team	
Orthopaedic patients who do not require surgery	Follow thromboprophylaxis guideline in the Therapeutics Handbook	

Thromboprophylaxis on Discharge

Procedure	On discharge	
• **Hip fracture**	Standard VTE risk	Continue enoxaparin SC for an overall treatment course of 2 weeks or until discharge (whichever is sooner)
	Increased VTE risk	Continue enoxaparin SC for an overall treatment course of 5 weeks*
• **Lower limb fractures** • **Total hip replacement** • **Other major elective surgery To lower limbs** • **Total knee replacement**	Standard VTE risk	Aspirin orally 150mg daily for 5 weeks
	Increased VTE risk	Continue enoxaparin SC for an overall treatment course of 5 weeks*
Rivaroxaban (under consultant advice only) A small proportion of patients may require thromboprophylaxis with rivaroxaban following total hip or total knee replacement – in these cases follow orthopaedic and/or haematology consultant recommendations. Check BNF for advice on dose and duration of treatment. Discuss arrangements with clinical pharmacist if patient is to be discharged on rivaroxaban. *Note that rivaroxaban is licensed for orthopaedics thromboprophylaxis only after elective hip or knee replacement and its use following an initial course of enoxaparin is off-label.*		
Other elective surgery (including upper limb, arthroscopy and forefoot surgery)	Standard VTE risk	No need for pharmacological; thromboprophylaxis
	Increased VTE risk	Follow recommendations from orthopaedic and/or haematology consultant
Elective spinal surgery	Thromboprophylaxis assessment done on a case-by-case basis depending on the type of surgery and risk factors – follow recommendations from spinal surgeon	
Multiple Trauma	Thromboprophylaxis assessment done on a case-by-case basis depending on the extent of injuries – follow recommendations from orthopaedic and/or haematology consultant	
Spinal cord injury	Thromboprophylaxis assessment done on a case-by-case basis depending on the type of injury – follow recommendations from the spinal injuries team	
Orthopaedic patients who do not require surgery	Follow thromboprophylaxis guideline in the Therapeutics Handbook	

*Arrangements for the supply and administration of enoxaparin after discharge are currently under discussion with Primary Care. Contact clinical pharmacist for information on local arrangements in your hospital.

SOUTHERN GENERAL HOSPITAL — **Against Advice**

SURNAME (Block Letters)	FIRST NAMES (Block Letters)	UNIT NUMBER
WHYTE	BRIAN	31/03/94 (6054)

This is to cerify that I go out/~~take out~~ OF ITU

on my own responsibility, having been warned by the medical staff of the risk involved.

Witnessed SELFMADE Signature B. Whyte

Designation ST 5 ICM Address 13 KINNELL AVE

Date 28-11-94

AGAINST ADVICE

SGH 283

SOUTHERN GENERAL HOSPITAL / VICTORIA INFIRMARY

34686

INTERIM RECEIPT OF PATIENT'S MONEY AND VALUABLES

WARD A/E

Date 27/11/14

Patient's Name BRIAN WHYTE

Date of Admission 27/11/14

Home Address 122 KINTAIL AVENUE
GLASGOW
G52 2LT

Next of Kin - Name ANNE WILSON

Relationship SISTER

Address 0141 445 2097

Total Value of Money:- CASH £85.37 (4 x £20, 1 x £5, rest in coins)

Details of Personal Valuables:-

Description	Quantity	Details

Listed by SUSAN YOUNG

Date 27.11.14

Checked by

Date 27.11.14

Deposited with :-

Hospital Cashier	Signature	Date
Night Safe	Signature	Date
Taken by*	Signature	Date

*Relationship to patient

N.B. OFFICIAL RECEIPT SHOULD BE RECEIVED WITHIN 48 HOURS

SGH188

NHS Greater Glasgow & Clyde

75475

Patient's Property and Valuables Accepted for Safekeeping

Hospital: SGH Ward: SITU Date of Admission: 27/1/14

Patient's full name: BRIAN WHYTE

Permanent address: 133 K MOSS AVE GLASGOW G52 3Q

1. Cash etc.

a) Bank Notes EIGHTY FIVE POUNDS

b) Coins SEVEN SEVEN PENCE

c) Cheque, Giro etc (specify)

	Amount	
	85	
		37
Total	85	37

2. Bank/Building Society Books, Credit/Debit Cards etc NIL

Name of Bank/Building Society	Cheque book, Card, Pay-in-book	Comments

3. Pension Books etc NIL

Type of Pension	Book No	Comments

4. Other Property/Valuables/Jewellery/Watches/Phones/Keys etc (specify) NIL

5. Clothing NIL

Pyjamas			Shirt			Other items
Nightdress			Jumper			
Dressing Gown			Trousers			
Slippers	L	R	Shoes	L	R	
Vest			Boots	L	R	
Pants			Coat			
Socks			Jacket			
Bra			Towel			
Slip			Electric Razor			
Tights			Toilet Bag & Contents			
Skirt						
Blouse						

I agree that the property and valuables noted above represent a true list of property and valuables handed over by me for safe keeping and that any other property and valuables retained by me are held on my own responsibility.

Signature of patient or staff member B. Whyte Status

Signature of officer receiving items listed above: RECEIVED FROM A+E

B. Vosekalns Status SN Date 27/1/14

92627

SURGICAL INTENSIVE CARE UNIT

VENTILATOR CHECKLIST

PLEASE COMPLETE THIS FORM BEFORE PATIENT CONNECTION AND FILE IN PATIENTS CASESHEET ON DISCHARGE.

VENTILATOR MAKE : ...SERVO I .....

PHYSICS ASSET NO.....

SET UP BY : Anne McGill .....

POST SET UP CHECK DONE BY Minnie .....

PRE USE CHECKS CARRIED OUT IN ACCORDANCE WITH THE MANUFACTURERS INSTRUCTIONS (THIS ALLOWS A CHECK OF INTERNAL FUNCTIONS, GAS SUPPLY, INTERNAL LEAKAGE, PRESSURE TRANSDUCERS, OXYGEN CELL; FLOW TRANSDUCERS, SAFETY VALVE, BATTERIES, CIRCUIT AND BREATHING SYSTEM

ALL PRE USE CHECKS MUST BE PASSED BEFORE VENTILATOR IS USED

PATIENTS NAME :.....

RE CHECKED PRIOR TO USE BY .....

DATE CONNECTED.....

DATE DISCONNECTED.....

REASON : EXTUBATION / FAULT

Acute Services Division

Critical Care, High Dependency, Coronary Care

NHS
Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

Patient name: 3103646054 WHYTE Brian 31/03/196
Ward: SITU
CHI number: 133 KINNELL AVE Glasgow, Lanarkshire G52 3R t/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.)

.he 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 ward)

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						Date: 9/11 Ward: ITU	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				1						
Age	13-59 0	60-70 1	71-80 2	81+ 1		0						
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	0						
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed bound/ wheelchair 1		Bed Rest						
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3								
				TOTAL SCORE		2						
				ACTION(S) TAKEN Enter action code(s) from Care Plan 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

	NURSING INTERVENTIONS	Date: 2-11 Ward: MU	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	Other interventions.							

Review Cannard score weekly / monthly as per policy. Enter action code(s) selected in action taken section on Falls Risk Assessment.

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.

Patient's Name:

3103646054

D.o.B.: WHYTE

Unit number: 4 Brian 31/03/196

133 KINNELL AVE

Ward: Glasgow, Lanarkshire

G52 3R

Use addressograph label

South Glasgow Hospitals

24 Hour Fluid Balance Chart

NHS Greater Glasgow and Clyde

Instructions

Date: 28/11/14 | 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								
07								
08	100					180		180
09	100					180		
10								
11								
12								
13								
14								
15								
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								
05								
07								
08								
09								
10								
11								
12								
13								
14								
15								
17								
18								
19								
20								
21								
22								
23								
24								
	Individual Totals:							
				Total Intake:			**Total Output:**	
Final Fluid Balance +/-								

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name
Address

3103646054
M WHYTE
4 Brian 31/03/196
133 KINNELL AVE
Glasgow, Lanarkshire
CHI No. T G52 3R
DoB

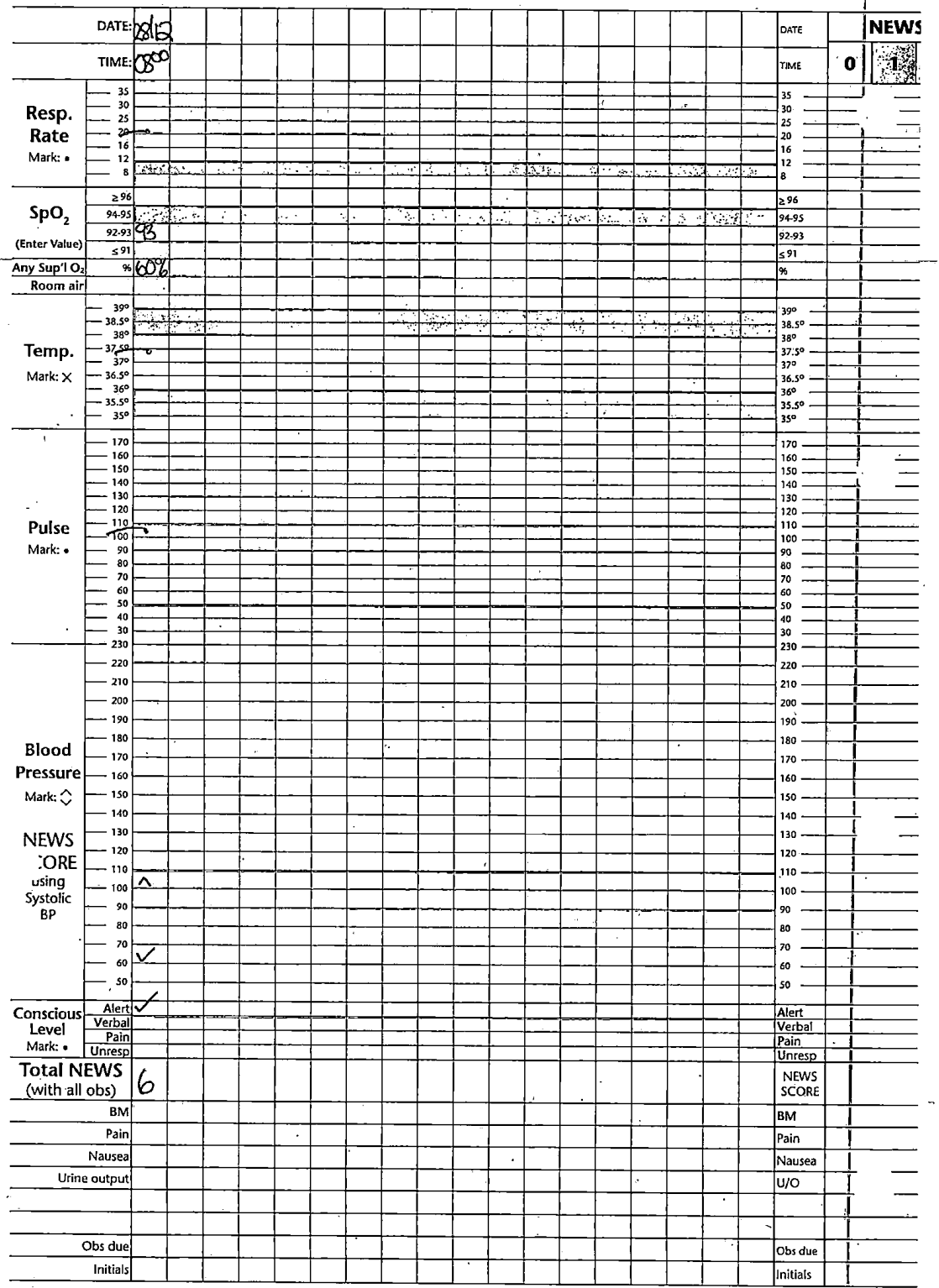
	Date	Ward
Admitted		
Transferred		
Transferred		

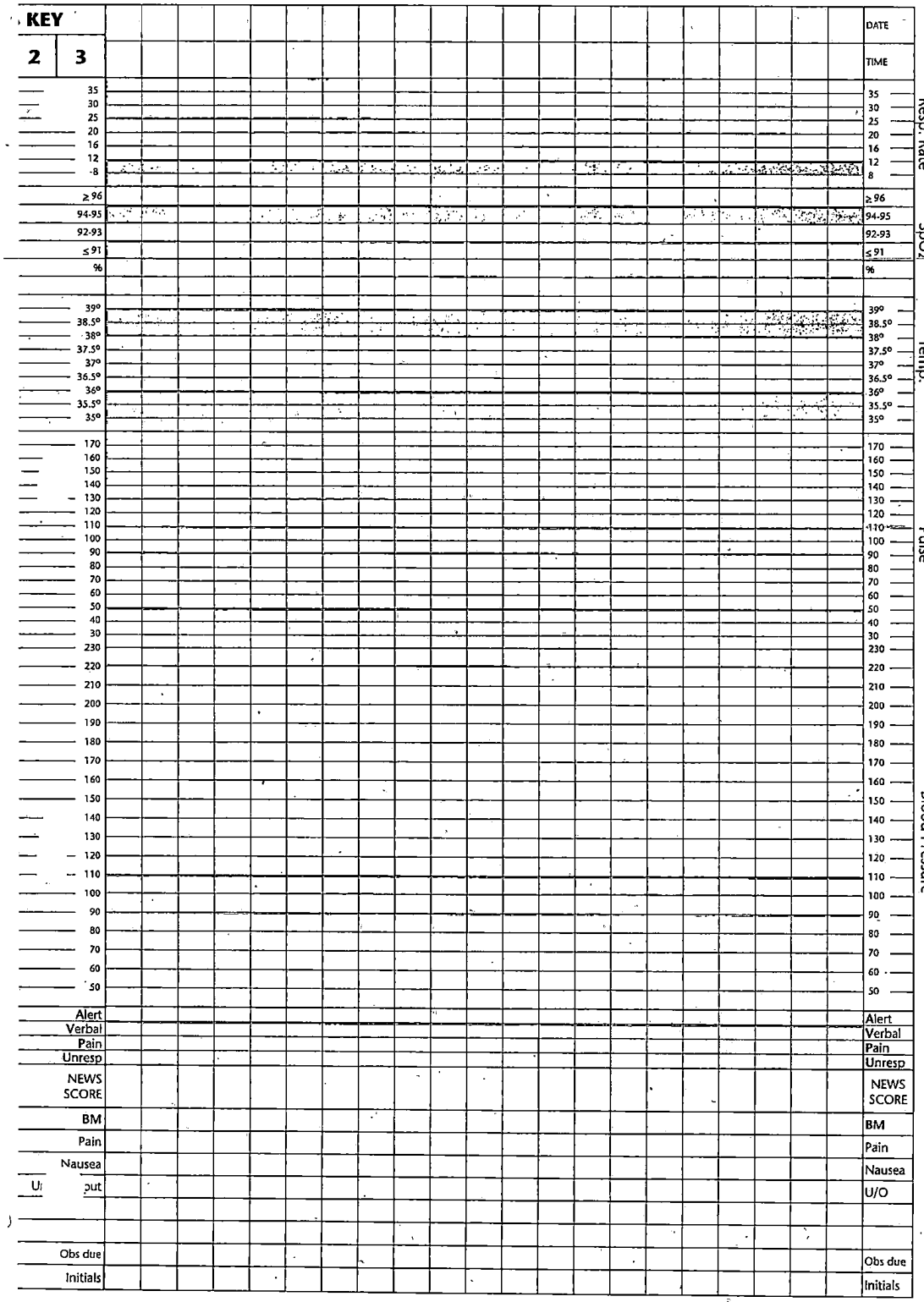
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.


DATE: 28/5
TIME: 0800
Resp. Rate
Mark: •
35
30
25
20
16
12
8
SpO2
(Enter Value)
≥ 96
94-95
92-93
≤ 91
98
Any Sup'l O2
%
60%
Room air
Temp.
Mark: X
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
Mark: •
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Blood Pressure
Mark: ◇
NEWS SCORE using Systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
6
BM
Pain
Nausea
Urine output
Obs due
Initials
DATE
TIME
NEWS
0
1
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

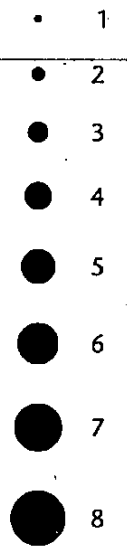

KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
Blood Pressure
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Neurological Observations

Date:																										
Time:																										
COMA SCALE	E Eyes open	Spontaneously	4																							Eyes closed by dwelling = C
		To speech	3																							
		To pain	2																							
		None	1																							
	V Best Verbal response	Orientated	5																							Endotracheal tube or tracheostomy = T
		Confused	4																							
		Inappropriate words	3																							
		Incomprehensible sounds	2																							
		None	1																							
	M Best motor response	Obeys	6																							Usually record the best arm response
		Localises	5																							
		Flexion - withdrawal	4																							
		Flexion - abnormal	3																							
		Extension to pain	2																							
		None	1																							
		TOTAL SCORE																								
PUPILS	R	Size																								+ reacts – no reaction c. eyes closed
		Reaction																								
	L	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																								
		Spastic flexion																								
		Extension																								
		No response																								
	LEGS	Normal power																								
		Mild weakness																								
		Severe weakness																								
		Spastic flexion																								
		Extension																								
		No response																								

Glasgow Coma Scale

Pupil size (mm)



Pain Score

Ask the patient to rate his/her pain by choosing a number between 0 and 10. Use the diagram below to assist the patient. If patient's pain is chronic, use generic tool. If patient is unable to communicate, use observational tool.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Severe Pain			

Nausea and Vomiting
0 = None
1 = Mild (*Not distressing – no retching/vomiting*)
2 = Moderate (*Troublesome – occasional retching/vomiting*)
3 = Severe (*Distressing – frequent retching/vomiting*)

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

3103646054
WHYTE
Brian 31/03/196
133 KINNELL AVE
Glasgow, Lanarkshire
G52 3R

SCH / ITU

Peripheral Vascular Cannula(PVC) Insertion & Maintenance

NHS Greater Glasgow and Clyde

Modified V.I.P (Visual Infusion Phlebitis) Score	
IV site appears healthy	0 Possible risk signs Observe cannula
One of the following is evident : slight pain or redness near site	1 Possible risk signs Observe cannula
Two or more of the following are evident: pain,redness,swelling	2 Early stage of phlebitis : Remove & resite cannula
All of the following are evident: pain,redness,hardening of surrounding tissue	3 Phlebitis/Thrombophlebitis: Remove & resite cannula Seek further advice
As above including: palpable venous cord	4
As above including :pyrexia	5

Insertion – Complete all sections

PVC inserted	Date inserted	Insertion site	Colour of PVC	Inserted by: Name & Designation *[only if inserted in ward]*
(ED) Theatre Ward_____	07/11/14	(L) HAND	PINK	

Clinical indication	IV Fluids/IV Medication ☑	Urgent access ☑	Interventional procedures ☐	Other Please state:

Insertion Criteria (if no: please explain in comments below)	Clean field used	Hand hygiene	Skin asepsis	Dressing affixed	Non touch technique (do not re- contaminate cleaned skin)
	Yes ☐ No ☐ Unknown ☑	Yes ☐ No ☐ Unknown ☑	Yes ☐ No ☐ Unknown ☑	Yes ☐ No ☐ Unknown ☑	Yes ☐ No ☐ Unknown ☑

Maintenance – To be completed daily

PVC 1	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation Record VIP score	The PVC dressing is intact	The PVC has been inserted less than 72 hours	Hand hygiene before & after all procedures	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 2 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After day 3 consider removal, if there is still a clinical reason justify rationale for PVC to remain in situ.							
Day 4 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

Date removed_____ Reason for PVC removal_____ Reason PVC in greater than 72 hours_____

Date & time	PVC no.	Comments	Signature

MIS 269426

CHI:	Modified V.I.P (' Infusion Phlebitis) Score	
	IV site appears healthy	0
	One of the following is evident : slight pain or redness near site	1
	Two or more of the following are evident: pain,redness,swelling	2
	All of the following are evident: pain,redness,hardening of surrounding tissue	3
	As above including: palpable venous cord	4
	As above including :pyrexia	5

Possible first signs : Observe cannula Early stage of phlebitis : Remove & resite cannula Phlebitis/Thrombophlebitis: Remove & resite cannula Seek further advice

Insertion – Complete all sections

PVC inserted ED Theatre Ward_____	Date inserted 27/11/14	Insertion site (R) AC	Colour of PVC PINK	Inserted by: Name & Designation *[only if inserted in ward]*
Clinical Indication IV Fluids/IV Medication ☑	Urgent access ☑	Interventional procedures ☐	Other Please state:	
Insertion Criteria (If no: please explain in comments below) Clean field used Yes ☐ No ☐ Unknown ☑	Hand hygiene Yes ☐ No ☐ Unknown ☑	Skin asepsis Yes ☐ No ☐ Unknown ☑	Dressing affixed Yes ☐ No ☐ Unknown ☑	Non touch technique (do not re- contaminate cleaned skin) Yes ☐ No ☐ Unknown ☑

Maintenance – To be completed daily

PVC 2	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation **Record VIP score**	The PVC dressing is intact	The PVC has been inserted less than 72 hours	Hand hygiene before & after all procedures	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 2 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After day 3 consider removal, if there is still a clinical reason justify rationale for PVC to remain in situ.							
Day 4 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

Date & time	PVC no.	Comments	Signature

Date removed_____ Reason for PVC removal_____ Reason PVC in greater than 72 hours_____

South Glasgow Hospitals
Southern General Hospital, Glasgow G51 4TF. Tel. 0141 201 1100

[illegible] Discharge Letter and Medicine Prescri[illegible] Form - Confidential Ref No: 216751

NHS Greater Glasgow and Clyde

VIMI - DISCHARGE - 2725 SGH

Dear Doctor .....
Surgery .....

Fix ID label to all 4 copies

Patient: .....
Address: .....
.....
.....
DOB: ...../ ...../ .....
Weight .....

3103646054
WHYTE
Brian 31/03/196
133 KINNELL AVE
Glasgow, Lanarkshire
G52 3R

Ward: SITH/SGH CPU/ITU Tel: .....
Consultant: .....
Specialty INTENSIVE CARE
Named Nurse: .....
Admission date: 27 / 11 / 14
Mode of admission ED
Source of admission .....
Discharge date: ...../...../.....

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:
readmitted unconscious. Treated for community acquired pneumonia. Self-discharging against medical advice.

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)
CLARITHROMYCIN	TABLETS	500mg		X							X		7 days	✓			Dispensed.
CO-AMOXICLAV	TABLETS	500/125		X			X				X		7 days	✓			Dispensed.

Medicines discontinued	Reason (if known) e.g. side effects

Clinical Pharmacy check: M
All known drug sensitivity / adverse reactions:

Dispensed by: ..... Date: ...../...../.....
Checked by: M

WARD USE ONLY
Med. rec. on ward by: .....
Issued by: ..... Date: ...../...../.....
Signature of recipient:

Doctor's name: PATRICK COLLINS Signature: [signature] Date 28 / 11 / 2014
Doctor's grade: FY1 Pager number: 6228
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.

WHYTE, BRIAN ID: 3103646054 28-Nov-2014 11:45:07 SOUTHERN GENERAL HOSPITAL

31-Mar-1964
Male Caucasian

Loc: 303

Vent. rate 1 pm
PR interval 130 ms
QRS duration 84 ms
QT/QTc 340/443 ms
P-R-T axes 58 62 49

Sinus tachycardia

[redacted]

Technician: 324
Test ind:

Referred by: DR CADAMY, SGSITU

Unconfirmed

COMMENTS:

MQE 9402-024 Graphic Controls Ltd Printed in UK

Whyte, Brian ID:3103646054 17-SEP-2019 11:10:49 GREATER GLASGOW SITE-WIOROP ROUTINE RECORD

31-MAR-1964 (55 yr)
Male Caucasian

Room:
Loc:737

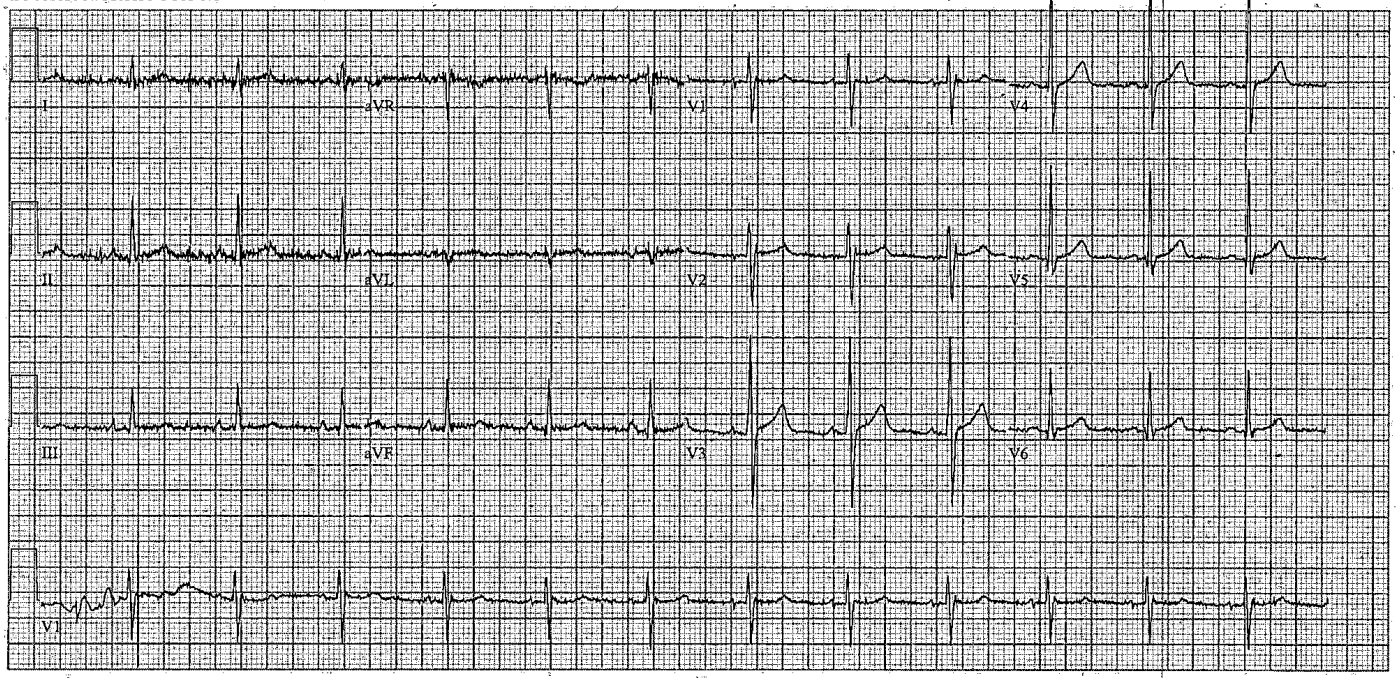
Vent. rate	76	BPM	Normal sinus rhythm
PR interval	128	ms	Normal ECG
QRS duration	86	ms	
QT/QTc	374/420	ms	
P-R-T axes	64 72	51	

Technician: 729
Test ind:

Referred by: MR MOIR

Unconfirmed

LOCATION:ORTHO POA O/P



25mm/s 10mm/mV 150Hz 9.0.4 12SL 241 CID: 39

SID: 2231558 EID: EDT: ORDER:

WHYTE, Brian ID:3103646054 28-JUL-2017 11:47:50 GREATER GLASGOW SITE-QEED ROUTINE RECORD

31-MAR-1964 (53 yr)		Vent. rate	71	BPM	Normal sinus rhythm
Male	Caucasian	PR interval	134	ms	Normal ECG
		QRS duration	90	ms	
Room:		QT/QTc	390/423	ms	
Loc:1301		P-R-T axes	38 73	58	

Technician: 324
Test ind:COLLAPSE

Referred by: QEED DR ALLEN UNCONFIRMED ECG REPORT Sys Admin 8

COMMENTS:

25mm/s 10mm/mV 150Hz 7.1.1 12SL 241 CID: 27

SID: 2231558 EID:21008 EDT: 16:01 28-JUL-2017 ORDER:

WHYTE, Brian ID:3103646054 08-APR-2015 19:29:41 GREATER GLASGOW SITE-SGAE ROUTINE RECORD

31-MAR-1964 (51 yr)
Male Caucasian

Room:
Loc:301

Vent. rate	82	BPM
PR interval	146	ms
QRS duration	84	ms
QT/QTc	362/422	ms
P-R-T axes	71 72	51

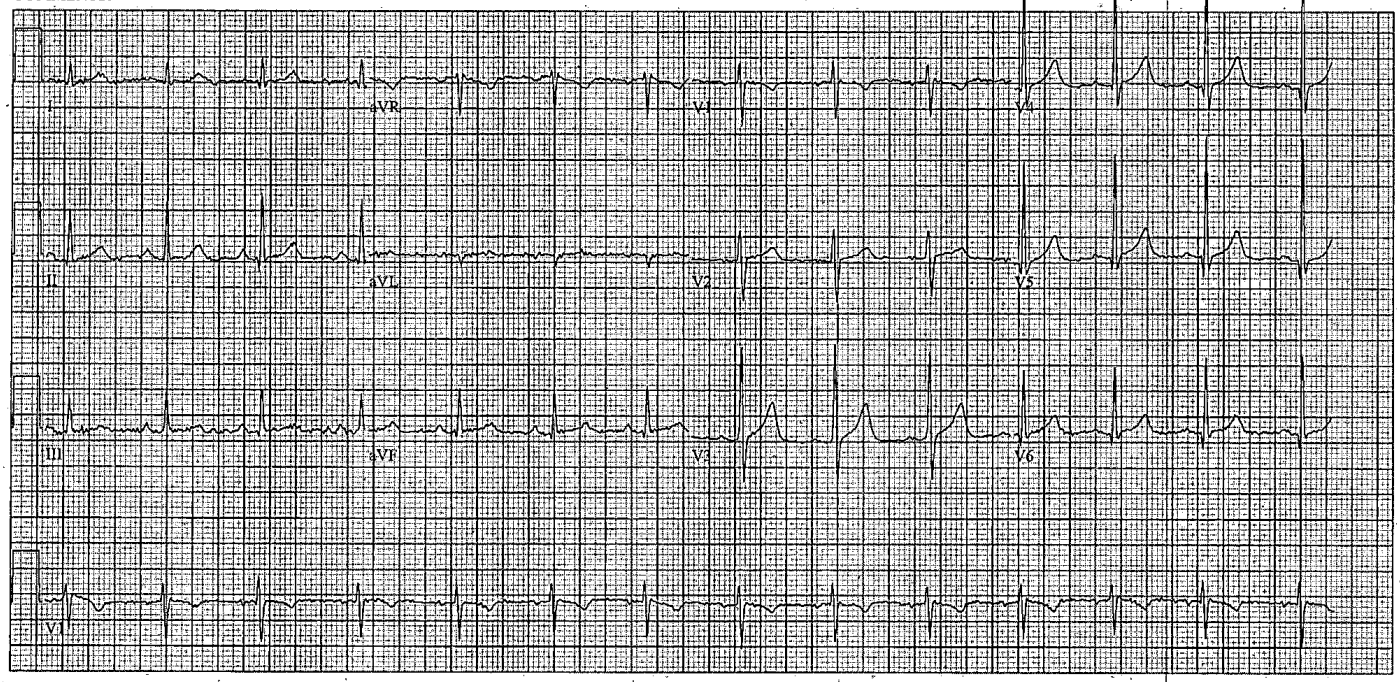
*** Poor data quality, interpretation may be adversely affected
Normal sinus rhythm
Normal ECG

Technician:
Test ind:

Referred by:

UNCONFIRMED ECG REPORT Sys Admin 7

COMMENTS:



25mm/s 10mm/mV 100Hz 7.1.1 12SL 237 CID: 6

SID: 2231558 EID:21017 EDT: 14:28 09-APR-2015 ORDER:

WHYTE, Brian ID:3103646054 28-NOV-2014 11:45:32 GREATER GLASGOW SITE-SGSITU ROUTINE RECORD

31-MAR-1964 (50 yr)	Vent. rate	103	BPM	Sinus tachycardia
Male Caucasian	PR interval	128	ms	
	QRS duration	84	ms	
Room:	QT/QTc	340/445	ms	
Loc:303	P-R-T axes	67 63	57	

Technician: 324
Test ind:

Referred by: SGSITU DR CADAMY UNCONFIRMED ECG REPORT Sys Admin 16

COMMENTS:

25mm/s 10mm/mV 100Hz 7.1.1 12SL 241 CID: 2 SID: 2231558 EID:21016 EDT: 13:55 01-DEC-2014 ORDER:

WHYTE, Brian ID:3103646054 25-OCT-2013 09:16:02 GREATER GLASGOW SITE-SHWD2 ROUTINE RECORD

31-MAR-1964 (49 yr)
Male Caucasian

Room:
Loc:1

Vent. rate	80	BPM
PR interval	154	ms
QRS duration	92	ms
QT/QTc	420/484	ms
P-R-T axes	65 82	57

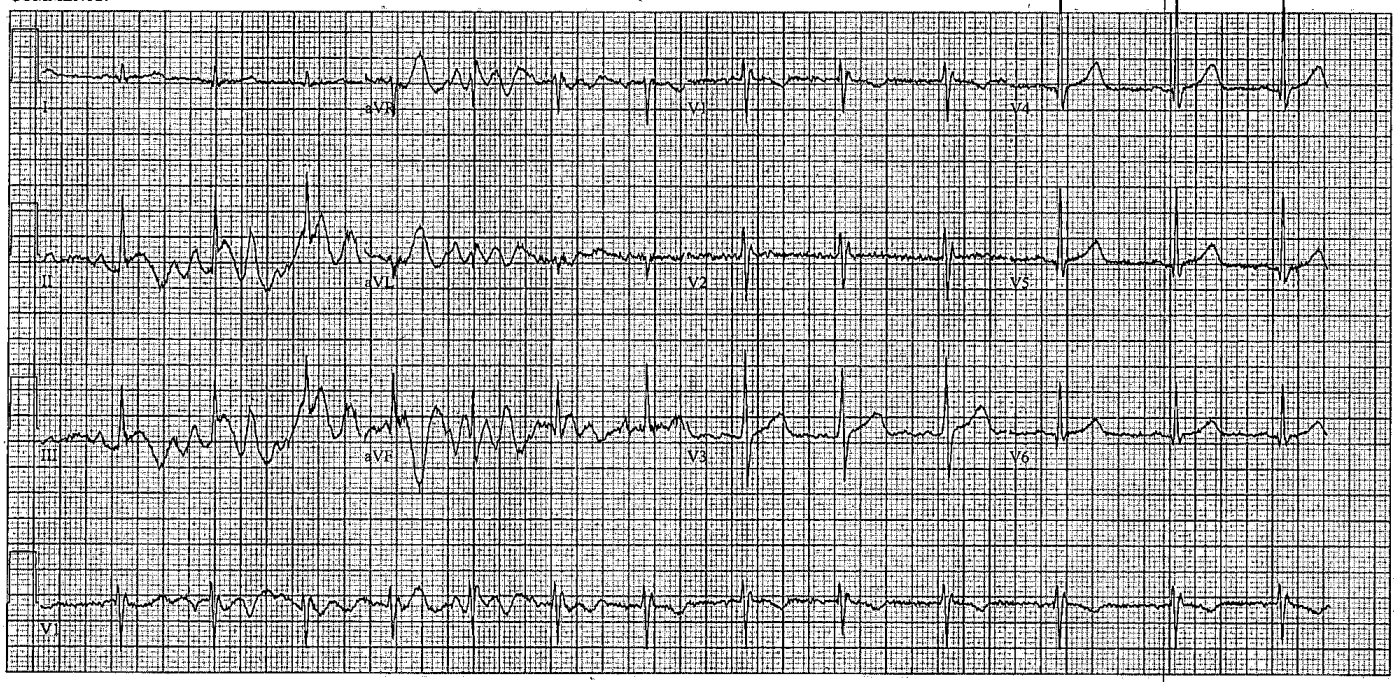
Normal sinus rhythm with sinus arrhythmia
Incomplete right bundle branch block
Prolonged QT

History:Unknown
Technician:
Test ind:

Referred by:

UNCONFIRMED ECG REPORT Sys Admin 2

COMMENTS:



25mm/s 10mm/mV 150Hz 7.1.1 12SL 237 CID: 255

SID: 2231558 EID:21002 EDT: 10:20 25-OCT-2013 ORDER:

WHYTE, Brian ID:3103646054 24-JUL-2013 21:14:52 GREATER GLASGOW SITE-SHWD1 ROUTINE RECORD

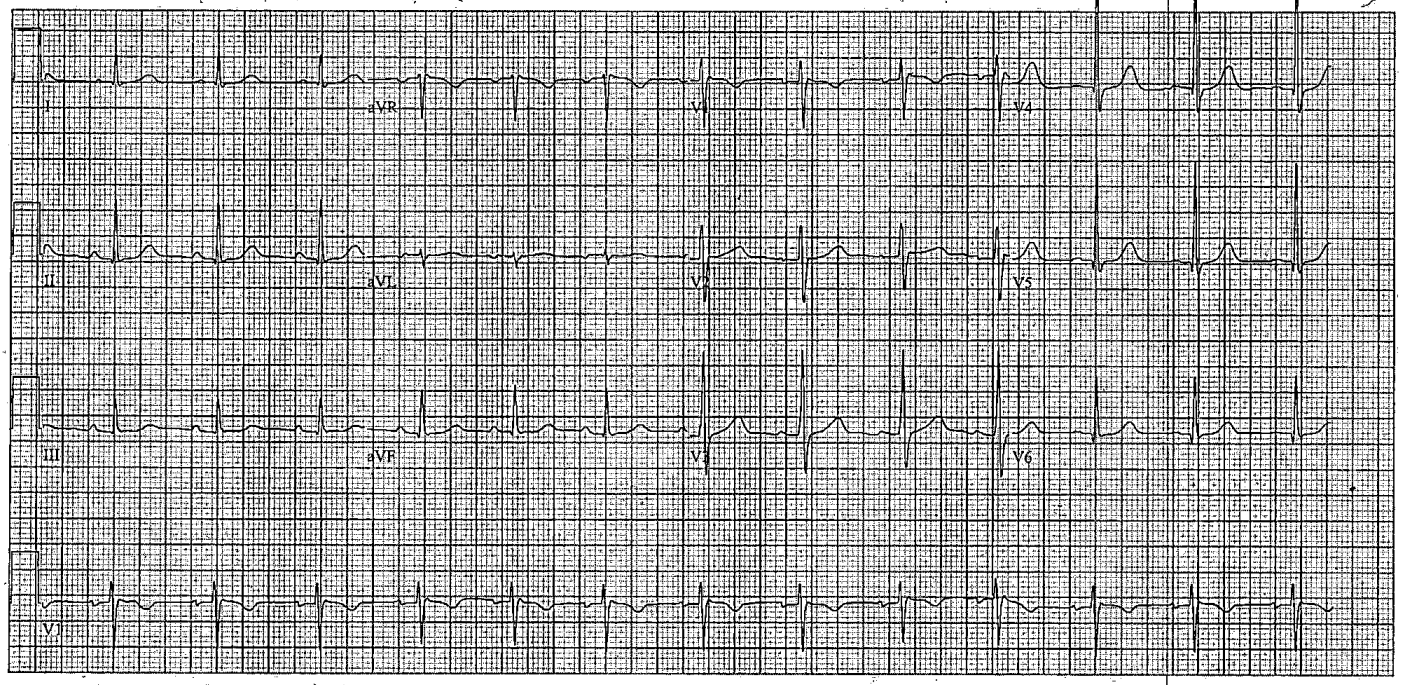
31-MAR-1964 (49 yr)
Male Caucasian

Room:
Loc:0

Vent. rate	79	BPM	SINUS RHYTHM
PR interval	167	ms	
QRS duration	99	ms	
QT/QTc	394/452	ms	
P-R-T axes	65 68	52	

Technician:
Test ind:

Referred by: UNCONFIRMED ECG REPORT Sys Admin 1



25mm/s 10mm/mV 150Hz 7.1.1 12SL NO SERIAL CID: 70 SID: 2231558 EID:21001 EDT: 10:46 25-JUL-2013 ORDER:

WHYTE, BRIAN ID:3103646054 30-JUN-2008 13:45:45 GREATER GLASGOW SITE-SHGPOP ROUTINE RECORD

31-MAR-1964 (44 yr)
Male Caucasian

Room:
Loc:53

Vent. rate	67	BPM
PR interval	144	ms
QRS duration	94	ms
QT/QTc	382/403	ms
P-R-T axes	53 76	61

Normal sinus rhythm
Incomplete right bundle branch block

Technician: ALI.G
Test ind:CP

Referred by: DR DAVIE RACPC

UNCONFIRMED ECG REPORT Sys Admin 4

25mm/s 10mm/mV 100Hz 7.1.1 12SL 237 CID: 1

EID:2004 EDT: 15:54 05-MAY-2011 ORDER:

WHYTE, BRIAN ID: 3103646054 5-Aug-2020 10:34 QUEEN ELIZABETH UNIVERSITY HOSPITAL

31-Mar-1964
Male

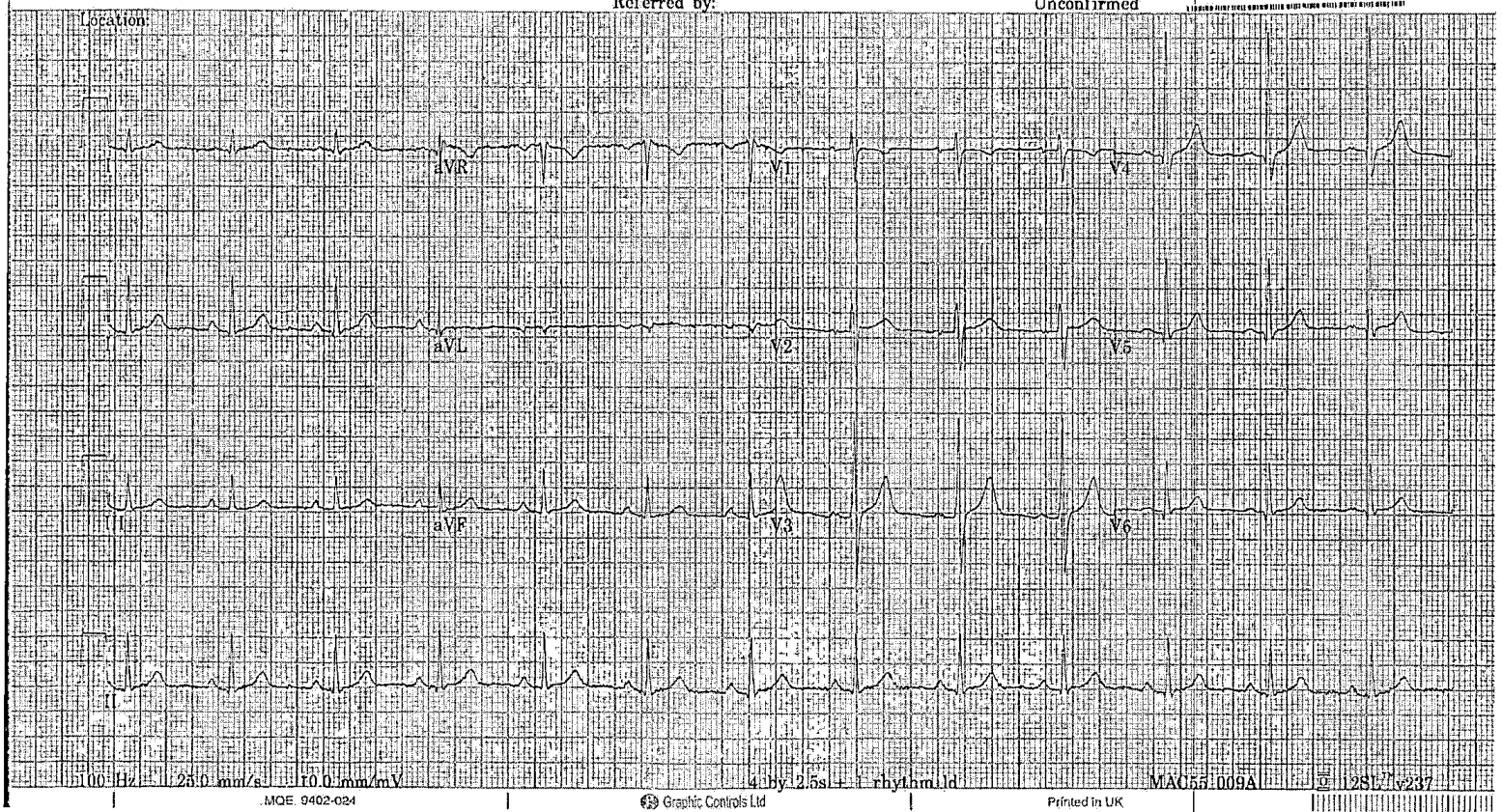
Loc: 13[redacted]

Technician:

Vent. rate	78 bpm	Normal sinus rhythm
PR interval	154 ms	Normal ECG
QRS duration	88 ms	
QT/QTc	360/410 ms	
P-R-T axes	76 69 61	

3103646054
WHYTE M
Brian 31/03/1964
FLAT 2-3
133 KINNELL AVE
Glasgow, Lanarkshire
G52 3RT

Referred by: Unconfirmed



WHYTE, BRIAN ID: 3103646054 28-Jul-2017 11:47:50 QUEEN ELIZABETH UNIVERSITY HOSPITAL

31-Mar-1964
Male

Loc: 1301

Vent. rate	71	bpm
PR interval	134	ms
QRS duration	90	ms
QT/QTc	390/423	ms
P-R-T axes	38	73	58

Normal sinus rhythm
Normal ECG

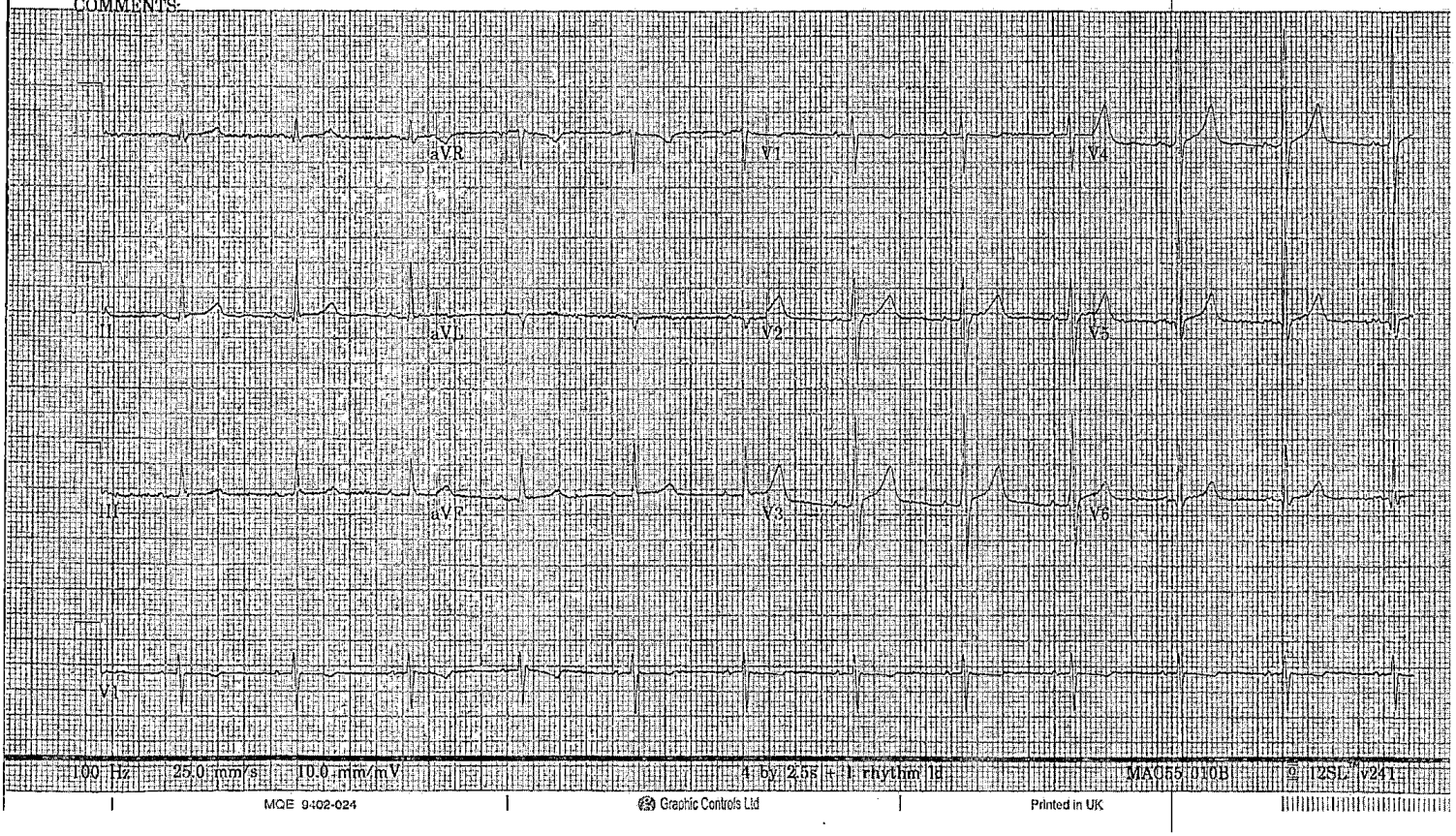
NSR

Technician: 324
Test ind: COLLAPSE

Referred by: DR ALLEN, QEED

Unconfirmed

COMMENTS:



MQE 9402-024 Graphic Controls Ltd Printed in UK

XR Chest

Performed	18-Mar-2024 14:34	Received	27-Mar-2024 08:18
Reported	27-Mar-2024 08:16	Order Number	G405H40741193
Status	Final	Source System	MiSys

XR Chest Final
Brian Whyte
Clinical History :

^ SOB. Ex smoker. Previous chest trauma . Pigeon exposure

XR Chest :
The heart is not enlarged. The lungs are clear of active disease. No significant focal lung lesion identified. Old healed left posterior rib fractures noted. Relatively coarse lung markings and emphysematous changes identified in keeping with the smoking history.

Reported by: Dr Sean Kelly
Verified by: Dr Sean Kelly

MRI Head

Performed	06-Feb-2021 18:57	Received	08-Feb-2021 09:56
Reported	08-Feb-2021 09:54	Order Number	G516H36890370
Status	Final	Source System	MiSys

MRI Head Final
Brian Whyte
Claustrophobic, patient not scanned

Reported by: Auto Reporting
Verified by: Fiona Greene

XR Foot Rt

Performed	28-Nov-2019 10:25	Received	28-Nov-2019 11:27
Reported	28-Nov-2019 11:25	Order Number	G516H35761686
Status	Final	Source System	MiSys

XR Foot Rt Final
Brian Whyte
Auto reported

A radiological report will not be issued for this examination. The referrer (or a more experienced clinical colleague) will interpret and evaluate the outcome of this examination and document this outcome in the patient's case notes within an appropriate time-scale. Should the referrer wish advice or a formal report please contact the Radiology Department. Reference: Procedure 10, Evaluation of Medical Exposure, Ionising Radiation (Medical Exposure) Regulations IR(ME) R 2017

Reported by: Auto Reporting
Verified by: Auto Reporting

XR Forefoot Rt

Performed	11-Dec-2018 14:59	Received	11-Dec-2018 15:22
Reported	11-Dec-2018 15:20	Order Number	G516H34565080
Status	Final	Source System	MiSys

XR Forefoot Rt Final
Brian Whyte
Auto reported

In line with agreed protocols, a radiological report will not be issued for this examination, unless requested. The interpretation and recording of the findings remain the responsibility of the referrer or a more experienced clinical colleague.

Reported by: Auto Reporting
Verified by: Auto Reporting

XR Toe great Rt

Performed	28-Jul-2017 13:19	Received	29-Jul-2017 14:13
Reported	29-Jul-2017 14:11	Order Number	G405H32891613
Status	Final	Source System	MiSys

XR Chest Final
Brian Whyte
Clinical History :
chest pain, previous thoracotomy. Painful right great toe with erythema, no trauma, ? osteomyelitis

XR Chest :
Comparison made with 26/12/2015.

The cardiomediastinal contours are within normal limits, without cardiomegaly. The lungs are expanded consistent with emphysema but no focal or diffuse pulmonary abnormality observed. Healed left 8th posterior rib fracture.

XR Toe great Rt :
No fracture demonstrated.

Reported by: Dr Gordon Cowell
Verified by: Dr Gordon Cowell

XR Chest

Performed	28-Jul-2017 13:19	Received	29-Jul-2017 14:13
Reported	29-Jul-2017 14:11	Order Number	G405H32891612
Status	Final	Source System	MiSys

XR Chest Final
Brian Whyte
Clinical History :
chest pain, previous thoracotomy. Painful right great toe with erythema, no trauma, ? osteomyelitis

XR Chest :
Comparison made with 26/12/2015.

The cardiomediastinal contours are within normal limits, without cardiomegaly. The lungs are expanded consistent with emphysema but no focal or diffuse pulmonary abnormality observed. Healed left 8th posterior rib fracture.

XR Toe great Rt :
No fracture demonstrated.

Reported by: Dr Gordon Cowell
Verified by: Dr Gordon Cowell

XR Chest

Performed	26-Dec-2015 11:25	Received	27-Dec-2015 15:17
Reported	27-Dec-2015 15:15	Order Number	G405H30976490
Status	Final	Source System	MiSys

XR Chest Final
Brian Whyte
Clinical History :

found hypothermic ?drug use, reduced a/e globally

XR Chest :
Mobile supine film.

Mediastinum and cardiac contours are unremarkable. No acute pulmonary pathology. No free air under the diaphragm.

Reported by: Dr Kirsty Slaven
Verified by: Dr Kirsty Slaven

XR Chest

Performed	28-Nov-2014 09:52	Received	28-Nov-2014 14:31
Reported	28-Nov-2014 14:29	Order Number	G405H29716935
Status	Final	Source System	MiSys

XR Chest Final
Brian Whyte
Clinical History :

Collaps ?cause. Admitted to ITU for extubation. R sided creps. ?CAP ?aspiration pneumonia

XR Chest :
Portable AP erect film.

Heart is clearly not enlarged.
Normal cardiac and mediastinal contours.
Slight blunting of both costophrenic angles keeping with small pleural effusions.
No other focal lung lesion detected.

Reported by: Dr Alan Ramsay
Verified by: Dr Alan Ramsay

CT Head

Performed	27-Nov-2014 09:04	Received	27-Nov-2014 09:53
Reported	27-Nov-2014 09:51	Order Number	G405H29712341
Status	Final	Source System	MiSys

CT Head Final
Brian Whyte
Clinical History :

stand by reduced GCS. GCS 6. About to be intubated. Posturing ? intracranial bleed.

CT Head :
Unremarkable appearances of the cerebrum and cerebellum. No mass, collection or haemorrhage or hydrocephalus.
No CT evidence of major vascular territory infarction. No new cranial vault injury.

Reported by: Dr Menelaos Philippou
Verified by: Dr Menelaos Philippou

XR Chest

Performed	27-Nov-2014 08:51	Received	28-Nov-2014 11:12
Reported	28-Nov-2014 11:10	Order Number	G405H29712352
Status	Final	Source System	MiSys

XR Chest Final
Brian Whyte
Clinical History :

intubated collapse right creps ?lrti ?et position

XR Chest :
Portable supine chest film. Comparison is made with the previous examination dated 25/10/2013.

Even allowing the projection, cardio-mediastinal contours are within normal limits. Right costophrenic angle is not included in the examination. Visible lungs are clear.

Reported by: Dr Emel Allan (SpR)
Verified by: Dr Emel Allan (SpR)

CT Head

Performed	25-Oct-2013 11:44	Received	25-Oct-2013 14:55
Reported	25-Oct-2013 12:26	Order Number	G405H28448349
Status	Final	Source System	MiSys

CT Head Final
Brian Whyte
Clinical History :
Found semiconscious with the frontal head injury.

CT Head :
Comparison is made to the CT head performed on 27/07/2013.

Cerebral parenchyma is unremarkable with no evidence of haemorrhage, infarct or space-occupying lesion. Previously noted left parietal bone fracture is unchanged from previous with no evidence of acute bony injury. Benign bony lesion is again demonstrated in the left parietal bone superiorly. A small extra-cranial contusion is noted over the right frontal bone.

Reported by: Dr Daniel Heffernan Ho (SpR) and Dr John Morrison
Verified by: Dr Daniel Heffernan Ho (SpR)

XR Chest

Performed	25-Oct-2013 09:34	Received	27-Oct-2013 09:28
Reported	27-Oct-2013 09:26	Order Number	G405H28447659
Status	Final	Source System	MiSys

XR Chest Final
Brian Whyte
Clinical History :

XR Chest :
The heart is not enlarged despite the AP projection. The lungs are clear of active disease. There is a fracture involving the left eighth rib posteriorly, left 6th rib anterolaterally and possibly the 9th rib posteriorly with no associated pneumothorax

Reported by: Dr Sean Kelly
Verified by: Dr Sean Kelly

CT Head

Performed	27-Jul-2013 23:58	Received	28-Jul-2013 11:30
Reported	28-Jul-2013 11:08	Order Number	G405H28177318
Status	Final	Source System	MiSys

CT Head Final
Brian Whyte
Clinical History :
Recent left temporoparietal skull base fracture extending to petrous bones and TMJ. Re-presented with possible CNS sepsis. Query abscess.

CT Head : Unenhanced helical acquisition of the skull. Comparison is made with studies dated 24/07/2013 and 3/9/2011.

There is a single new small focus of high density at the periphery of right parietal lobe that lies within a sulcus and is suggestive of a tiny volume of subarachnoid blood. There has been resolution of intracranial gas. No additional significant intracranial abnormality is evident. There is preservation of grey-white matter differentiation. No evidence of intracerebral abscess.

Non-displaced fractures again noted through the left parietal bone with extension to the petrous portion of the left temporal bone, left mastoid air cells and the posterior aspect of the left temporomandibular fossa. Persistent high density fluid within the left mastoid air cells, left inner ear and sphenoid sinuses in keeping with haemorrhage.

Summary: Single small focus of high density at the periphery of right parietal lobe - suggestive of haemorrhage. No intracranial abscess.

Provisional report phoned to the referring clinician at time of reporting.

Reported by: Dr Robert Foster (SpR) and Dr William Russell Pickard
Verified by: Dr William Russell Pickard

XR Chest

Performed	27-Jul-2013 23:06	Received	01-Aug-2013 15:16
Reported	01-Aug-2013 14:54	Order Number	G405H28177290
Status	Final	Source System	MiSys

XR Chest Final
Brian Whyte
Clinical History :
Pleuritic pain, haemoptysis, pneumonia? Effusion?

XR Chest :
Comparison made with 25 zero 70 13.

The cardiomediastinal contours are within normal limits, without cardiomegaly. Patchy alveolar consolidation is evident bordering the right cardiac border, in keeping with lower zone infection . Patchy changes also evident within the left lower zone. The lungs are otherwise clear.

Reported by: Dr Gordon Cowell
Verified by: Dr Gordon Cowell

XR Shoulder Rt

Performed	25-Jul-2013 14:39	Received	30-Jul-2013 17:47
Reported	30-Jul-2013 17:25	Order Number	G405H28170641
Status	Final	Source System	MiSys

XR Chest Final
Brian Whyte
Clinical History :
Assaulted last night, GCS 10/15, now 15/15. Tender left and right shoulders, left chest wall, left pelvis and lumbar spine.

XR Chest :
There is subtle patchy opacification at the right base which may represent infection or contusion. No obvious rib fracture is demonstrated and there is no evidence of pneumothorax. Clinical correlation is advised.
The left lung is clear. The heart is not enlarged.

XR Lumbar spine :
The vertebral alignment, disc spaces and facet joints are normal. There is no evidence of bony injury seen. The overlying bowels are rather gassy, distended.

XR Pelvis :
No evidence of bony injury.

XR Shoulder Lt :
No fracture seen. No evidence of degenerative change.

XR Shoulder Rt :
No fracture seen. There is flattening and sclerosis of the greater tubercle of the right humerus indicating rotator cuff tendinopathy. No soft tissue calcification is seen.

Reported by: Dr Edit Gyomber
Verified by: Dr Edit Gyomber

XR Shoulder Lt

Performed	25-Jul-2013 14:39	Received	30-Jul-2013 17:47
Reported	30-Jul-2013 17:25	Order Number	G405H28170640
Status	Final	Source System	MiSys

XR Chest Final
Brian Whyte
Clinical History :
Assaulted last night, GCS 10/15, now 15/15. Tender left and right shoulders, left chest wall, left pelvis and lumbar spine.

XR Chest :
There is subtle patchy opacification at the right base which may represent infection or contusion. No obvious rib fracture is demonstrated and there is no evidence of pneumothorax. Clinical correlation is advised.
The left lung is clear. The heart is not enlarged.

XR Lumbar spine :
The vertebral alignment, disc spaces and facet joints are normal. There is no evidence of bony injury seen. The overlying bowels are rather gassy, distended.

XR Pelvis :
No evidence of bony injury.

XR Shoulder Lt :
No fracture seen. No evidence of degenerative change.

XR Shoulder Rt :
No fracture seen. There is flattening and sclerosis of the greater tubercle of the right humerus indicating rotator cuff tendinopathy. No soft tissue calcification is seen.

Reported by: Dr Edit Gyomber
Verified by: Dr Edit Gyomber

XR Pelvis

Performed	25-Jul-2013 14:39	Received	30-Jul-2013 17:47
Reported	30-Jul-2013 17:25	Order Number	G405H28170639
Status	Final	Source System	MiSys

XR Chest Final
Brian Whyte
Clinical History :
Assaulted last night, GCS 10/15, now 15/15. Tender left and right shoulders, left chest wall, left pelvis and lumbar spine.

XR Chest :
There is subtle patchy opacification at the right base which may represent infection or contusion. No obvious rib fracture is demonstrated and there is no evidence of pneumothorax. Clinical correlation is advised.
The left lung is clear. The heart is not enlarged.

XR Lumbar spine :
The vertebral alignment, disc spaces and facet joints are normal. There is no evidence of bony injury seen. The overlying bowels are rather gassy, distended.

XR Pelvis :
No evidence of bony injury.

XR Shoulder Lt :
No fracture seen. No evidence of degenerative change.

XR Shoulder Rt :
No fracture seen. There is flattening and sclerosis of the greater tubercle of the right humerus indicating rotator cuff tendinopathy. No soft tissue calcification is seen.

Reported by: Dr Edit Gyomber
Verified by: Dr Edit Gyomber

XR Lumbar spine

Performed	25-Jul-2013 14:39	Received	30-Jul-2013 17:47
Reported	30-Jul-2013 17:25	Order Number	G405H28170638
Status	Final	Source System	MiSys

XR Chest Final
Brian Whyte
Clinical History :
Assaulted last night, GCS 10/15, now 15/15. Tender left and right shoulders, left chest wall, left pelvis and lumbar spine.

XR Chest :
There is subtle patchy opacification at the right base which may represent infection or contusion. No obvious rib fracture is demonstrated and there is no evidence of pneumothorax. Clinical correlation is advised.
The left lung is clear. The heart is not enlarged.

XR Lumbar spine :
The vertebral alignment, disc spaces and facet joints are normal. There is no evidence of bony injury seen. The overlying bowels are rather gassy, distended.

XR Pelvis :
No evidence of bony injury.

XR Shoulder Lt :
No fracture seen. No evidence of degenerative change.

XR Shoulder Rt :
No fracture seen. There is flattening and sclerosis of the greater tubercle of the right humerus indicating rotator cuff tendinopathy. No soft tissue calcification is seen.

Reported by: Dr Edit Gyomber
Verified by: Dr Edit Gyomber

XR Chest

Performed	25-Jul-2013 14:39	Received	30-Jul-2013 17:47
Reported	30-Jul-2013 17:25	Order Number	G405H28170637
Status	Final	Source System	MiSys

XR Chest Final
Brian Whyte
Clinical History :
Assaulted last night, GCS 10/15, now 15/15. Tender left and right shoulders, left chest wall, left pelvis and lumbar spine.

XR Chest :
There is subtle patchy opacification at the right base which may represent infection or contusion. No obvious rib fracture is demonstrated and there is no evidence of pneumothorax. Clinical correlation is advised.
The left lung is clear. The heart is not enlarged.

XR Lumbar spine :
The vertebral alignment, disc spaces and facet joints are normal. There is no evidence of bony injury seen. The overlying bowels are rather gassy, distended.

XR Pelvis :
No evidence of bony injury.

XR Shoulder Lt :
No fracture seen. No evidence of degenerative change.

XR Shoulder Rt :
No fracture seen. There is flattening and sclerosis of the greater tubercle of the right humerus indicating rotator cuff tendinopathy. No soft tissue calcification is seen.

Reported by: Dr Edit Gyomber
Verified by: Dr Edit Gyomber

CT Spine cervical

Performed	24-Jul-2013 20:37	Received	25-Jul-2013 16:25
Reported	25-Jul-2013 16:03	Order Number	G405H28168934
Status	Final	Source System	MiSys

CT Head Final
Brian Whyte
Clinical History :
GCS 13. Left otorrhoea. Mechanism of injury? Found in street by police.

CT Head :
Noncontrast study under sedation.
Comparison made with previous CT brain dated 30/09/2011.

No intracranial pathology is demonstrated. In particular, no intra or extra-axial haemorrhage. The ventricular system and basal cisterns are within normal limits, with no evidence of hydrocephalus or mass effect.

There is left parietal scalp swelling and a vertical fracture extending through the petrous part of the left temporal bone, extending into the parietal bone. Associated fluid is seen in the left mastoid air cells. There is gas around the left TMJ. No mandibular fracture can be seen. However, there is the suggestion of a fracture involving the left external ear canal (temporal bone) at its articulation with the mandibular condyle. There is opacification of the ethmoid air cells and fluid/high density material (presumably blood) within the sphenoid sinuses. There are multiple gas bubbles in the cavernous sinus region and a subtle linear lucency through the right sphenoid, close to the clivus on the sagittal reconstruction, highly suspicious for a fracture.

CT Spine cervical :
Noncontrast study from skull base to T4.

Normal vertebral alignment and height, with no acute fracture demonstrated. No localised prevertebral soft tissue swelling.
There is marked emphysematous changes at both lung apices with some apical scarring. No pneumothorax.

Conclusion:
1. No intracranial haemorrhage or cervical spine fracture.
2. Vertical left parieto-temporal skull fracture involving the petrous bone with likely fracture involving the TMJ. Further fracture of the sphenoid bone is suspected with associated gas in the cavernous sinus.

Discussed with referring A&E doctor at time of reporting.

Reported by: Dr Gillian Cassels (SpR) and Dr Paul Duffy
Verified by: Dr Paul Duffy

CT Head

Performed	24-Jul-2013 20:37	Received	25-Jul-2013 16:25
Reported	25-Jul-2013 16:03	Order Number	G405H28168933
Status	Final	Source System	MiSys

CT Head Final
Brian Whyte
Clinical History :
GCS 13. Left otorrhoea. Mechanism of injury? Found in street by police.

CT Head :
Noncontrast study under sedation.
Comparison made with previous CT brain dated 30/09/2011.

No intracranial pathology is demonstrated. In particular, no intra or extra-axial haemorrhage. The ventricular system and basal cisterns are within normal limits, with no evidence of hydrocephalus or mass effect.

There is left parietal scalp swelling and a vertical fracture extending through the petrous part of the left temporal bone, extending into the parietal bone. Associated fluid is seen in the left mastoid air cells. There is gas around the left TMJ. No mandibular fracture can be seen. However, there is the suggestion of a fracture involving the left external ear canal (temporal bone) at its articulation with the mandibular condyle. There is opacification of the ethmoid air cells and fluid/high density material (presumably blood) within the sphenoid sinuses. There are multiple gas bubbles in the cavernous sinus region and a subtle linear lucency through the right sphenoid, close to the clivus on the sagittal reconstruction, highly suspicious for a fracture.

CT Spine cervical :
Noncontrast study from skull base to T4.

Normal vertebral alignment and height, with no acute fracture demonstrated. No localised prevertebral soft tissue swelling.
There is marked emphysematous changes at both lung apices with some apical scarring. No pneumothorax.

Conclusion:
1. No intracranial haemorrhage or cervical spine fracture.
2. Vertical left parieto-temporal skull fracture involving the petrous bone with likely fracture involving the TMJ. Further fracture of the sphenoid bone is suspected with associated gas in the cavernous sinus.

Discussed with referring A&E doctor at time of reporting.

Reported by: Dr Gillian Cassels (SpR) and Dr Paul Duffy
Verified by: Dr Paul Duffy

CT Head

Performed	30-Sep-2011 16:06	Received	30-Sep-2011 17:30
Reported	30-Sep-2011 17:08	Order Number	G405H26250899
Status	Final	Source System	MiSys

CT Head Final
Brian Whyte
Clinical History : Suspected Tramadol overdose. Patient very drowsy. Upgoing left plantar.

CT Head :

Non contrast examination.

There is no evidence of intra or extra-axial haemorrhage or acute focal area of infarction.
Unremarkable brain parenchyma and ventricles.

Reported by: Dr Bindu Kumar (SpR) and Dr Alan Ramsay
Verified by: Dr Bindu Kumar (SpR)

US Graft surveillance

Performed	24-Aug-2010 13:31	Received	25-Aug-2010 10:53
Reported	25-Aug-2010 10:33	Order Number	G405H25147397
Status	Final	Source System	MiSys

US Graft surveillance Final
Brian Whyte
Clinical History : Stab injury, interposition graft distal SFA.

US Graft surveillance : Examination performed by Claire Bowman, Sonographer.

There is good triphasic flow within the right common femoral artery, profunda femoral artery and the proximal and mid superficial femoral artery. There appears to be a branch in the distal superficial femoral artery. ?Graft or collateral. The flow within this vessel is triphasic. This vessel communicates with the mid popliteal artery and the remainder of the popliteal artery is widely patent with biphasic flow. The proximal popliteal artery appears to have no flow within it. The posterior tibial artery, perineal artery and anterior tibial artery appear patent with low monophasic flow.

Reported by: Claire Bowman (Sonog)
Verified by: Claire Bowman (Sonog)

XR Chest

Performed	27-Feb-2010 07:31	Received	02-Mar-2010 13:29
Reported	02-Mar-2010 13:08	Order Number	G405H13593184
Status	Final	Source System	MiSys

XR Chest Final
Brian Whyte
Clinical History : ? Tube position.

XR Chest :

Rotated AP erect film. Heart size and mediastinal contours cannot be accurately assessed. The ET tube is in a satisfactory position.

Reported by: DR S KELLY and BLANK CLINICIAN
Verified by: DR S KELLY

XR Chest

Performed	26-Feb-2010 15:32	Received	26-Feb-2010 16:14
Reported	26-Feb-2010 16:14	Order Number	G405H13592621
Status	Final	Source System	MiSys

XR Chest Final
Brian Whyte
Examination not performed. Contact department for details

Reported by: AUTO REPORTING and BLANK CLINICIAN
Verified by: AUTO REPORTING

XR Chest

Performed	25-Feb-2010 14:57	Received	09-Mar-2010 10:05
Reported	09-Mar-2010 09:45	Order Number	G405H13590184
Status	Final	Source System	MiSys

XR Chest Final
Brian Whyte
Clinical History : Chest drain removed.

XR Chest : ET-tube and NG-tube lie in satisfactory position. The right basal chest drain has been removed.
The right lung appears fully inflated although there is a small pneumothorax on the left side. Opacification at the right base has improved.

Reported by: DR J MORRISON and BLANK CLINICIAN
Verified by: DR J MORRISON

XR Chest

Performed	23-Feb-2010 10:01	Received	25-Feb-2010 12:07
Reported	25-Feb-2010 11:46	Order Number	G405H13583429
Status	Final	Source System	MiSys

XR Chest Final.
Brian Whyte
Clinical History : Post 2 chest drains removal. Still 2 insitu. High oxygen demand.

XR Chest :
Comparison has been made with the previous film performed on 21/02/10.
The heart and mediastinal contours cannot be accurately assessed because of the AP projection. The distal end of the NG tube is noted below the left hemidiaphragm, presumably within the stomach. Satisfactory position of the right sided central line and the ET tube. A right sided chest drain is noted with its tip near the vertebral column. A left sided chest drain is noted with its tip in the basal region. There has been a small increase in the size of the right sided pleural effusion with some further air space shadowing in the right mid-zone. No other significant interval change of note.

Reported by: DR I KHAN and BLANK CLINICIAN
Verified by: DR I KHAN

XR Chest

Performed	21-Feb-2010 12:08	Received	22-Feb-2010 16:22
Reported	22-Feb-2010 15:52	Order Number	G405H13579535
Status	Final	Source System	MiSys

XR Chest Final
Brian Whyte
Clinical History : Multiple stabs.

XR Chest : Rotated AP erect film.

NG tube and ET tube tip noted. Satisfactory position. Right internal jugular line also noted.
There are two right sided intercostal chest drains and one left basal intercostal chest drain with a hydropneumothorax persisting on the right.
There is no significant pneumothorax on the left and no signs of additional active disease or significant interval change compared to the film 24hrs earlier.

Reported by: DR S KELLY and BLANK CLINICIAN
Verified by: DR S KELLY

XR Chest

Performed	20-Feb-2010 21:48	Received	22-Feb-2010 14:51
Reported	22-Feb-2010 14:26	Order Number	G405H13579212
Status	Final	Source System	MiSys

XR Chest Final
Brian Whyte
Clinical History : Stabbing chest and leg. Post op.

XR Chest : Portable AP erect film.

Bilateral basal and right apical chest drains in situ. Both lungs appear fully inflated. Tip of ET tube close to the carina. Tip of RIJ line in SVC. Tip of NG tube in stomach.

Reported by: DR GDK URQUHART and BLANK CLINICIAN
Verified by: DR GDK URQUHART

Mobile image intensifier lower limb Rt

Performed	20-Feb-2010 17:12	Received	22-Feb-2010 14:41
Reported	22-Feb-2010 14:41	Order Number	G405H13579077
Status	Final	Source System	MiSys

Mobile image intensifier lower limb Rt Final

Brian Whyte

These films have been 'fast-tracked' through the department to be reviewed by the referring clinician. A formal radiologist's report will only be provided on request.

Reported by: AUTO REPORTING and BLANK CLINICIAN
Verified by: AUTO REPORTING

XR Chest

Performed	20-Feb-2010 13:55	Received	24-Feb-2010 09:07
Reported	24-Feb-2010 08:38	Order Number	G405H13578955
Status	Final	Source System	MiSys

XR Chest Final
Brian Whyte
Clinical History : Stabbing.

XR Chest : PATIENT IN WARD SITU.

Supine film.

The tip of the NG tube and ET tube are in satisfactory position. There is a left sided pneumothorax and a left internal jugular line tip is projected over the upper portion of the SVC.

Reported by: DR S KELLY and BLANK CLINICIAN
Verified by: DR S KELLY