Subject Access Request Team
Health Records Department
Glasgow Royal Infirmary
8 – 16 Alexandra Parade
Glasgow
G31 2ER

NHS
Greater Glasgow and Clyde

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

Date: 23/06/2026
Your Ref: 100374
Our Ref: SAR/ACCESS/ CD
Enquiries to: Chrissy
Direct Line: 0141 201 3379
Email: chrissy.davie@nhs.scot

Dear Sir/Madam

Re: Subject Access Request under the General Data Protection Regulation

Patient: GEORGE FINNIE **D.O.B: 23/07/1965**

Thank you for your request received 28TH May 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:

GLASGOW ROYAL INFIRMARY RECORDS

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

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

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

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

Subject Access Request 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	☐

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 17/03/2019

Consultant: Dr Claire Fitzpatrick

WA Best
Drs Gordon best & mcintyre
New Gorbals Health & Care Centre
2 Sandiefield Road
Glasgow
Glasgow
G5 9AB

Dear WA Best

Re: **Finnie George** DOB: **23/07/1965** CHI: **2307656057**
FLAT 9C
Glasgow G5 0JQ

Attended on: **17/03/2019 at 10:10 hrs.** Departed on: **at hrs.**
Discharge Type: **01b - Discharge with follow up by primary care team** Destination: **Private residence**
Previous ED Attendance in last 12 months: **2**

Presenting complaint
unwell

Nursing Assessment:
high bm's. recent increase in insulin. feeling nauseated. ?dka. pmh: diabetes

Investigations in ED:

1. Amylase
2. Bone Profile
3. CRP
4. Glucose
5. LFT
6. Urea and Electrolytes
7. Coagulation screen
8. Full Blood Count

Diagnosis:

Diagnosis	Side	Site
Elevated blood glucose level - Hyperglycaemia, unspecified		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Dear Doctor, This 53 year old male patient presented to ED with raised blood sugars. He is known diabetic on large amounts on insulin (40units Humalog each time he eats, 70 units Triseba at night, 1.5mg Dulaglutide once a week, empaglifozin, metformin) with regular input from the diabetic team. In dept he was not ketotic, not acidotic, bloods were unremarkable other than raised glucose. He had no obvious source of infection. NAD on examination. Imp, hyperglycaemia. Plan, I have advised him to increase his Humalog to 45 units each time he eats, and advised him to contact his diabetic nurse after leaving the dept - he has her mobile number. Many thanks, Dr Rachael Mortimer Locum SHO (GPST3)

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Rachael Mortimer
Doctor

Copies to:

1. WA Best (GP)

School Address:

Final Discharge Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Dr. CW McCrossan
The Gordon Practice
New Gorbals Health & Care Centre
2 Sandiefield Road
Glasgow
G5 9AB

Main Switchboard:	
Department:	Urology
Contact Tel:	01389 817538
Enquiries to:	
Letter Date:	29/10/2025
Reference:	AC/SC
Dictated Date:	12/09/2025
Transcribed Date:	19/10/2025

Dear Dr. CW McCrossan,

George Finnie; D.O.B: 23/07/1965; CHI: 2307656057
Flat 0/4, 1 Bedford Street, Glasgow, G5 9BD

Admission: Specialty - Urology; Ward - GRI Ward 70 Urology
Consultant - Ms Ashley Carrera; Date of Admission - 12/09/2025
Date of Discharge - 13/09/2025; Discharged to - Private Residence - no additional detail added

Clinical Comments:
Procedure: TURBT

Follow Up: Pathology plus MDT

This 60 year old gentleman with type 1 diabetes was referred with haematuria and a CT scan had shown a bladder mass at the left ureteric orifice. He was listed for a GA cystoscopy and TURBT. Unfortunately when the patient attended today he was not aware of the reasons for this. He did have an appointment on the 24th of July which he did not attend, however he was unaware of his scan results. We have explained the nature of the findings and diagnosis to him today and proceeded with a TURBT. This was covered with IV Gentamicin. The tumour was two separate lesions, one at the bladder base and one at the left lateral wall around the area where the ureteric orifice would be. These were resected completely and there was a deeper area of resection at the bladder base. A soft 3 way catheter was inserted and this will be left in situ for a couple of weeks. He, for this reason was not given any Mitomycin C post operatively. The left ureteric orifice was never clearly identified and the lesion was papillary in nature. It does look superficial, but we will wait for his pathology results and discuss him at the MDT and we will keep you updated.

Kind regards.

Yours sincerely

Miss Ashley Carrera

Consultant Urological Surgeon

Electronically Signed: Ms Ashley Carrera, Consultant

cc.

Immediate Discharge Letter - Amendments

This version of the document supersedes earlier versions.

Additional Information: Nathan BABULO, 15-Sep-2025 17:08
No instillagel supply on the ward.
Patient has been advised to contact GP tomorrow to request a supply.
Many thanks, GRI ward 70 (Urology)

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No
Consent for Sharing Withheld: No

COLIN MCCROSSANThe Gordon Practice,New Gorbals Health & Care Centre,2 Sandiefield Road, Glasgow, G5 9AB

Main Switchboard:
Date of Completion: 15-Sep-2025

Dear COLIN MCCROSSAN,

Name	CHI	DoB	Address
George Finnie	2307656057	23-Jul-1965	Flat 0/4, 1 Bedford Street, Glasgow, G5 9BD

Admitted	Type	Discharged	Destination
15-Sep-2025 12:46	IP	15-Sep-2025	

Specialty	Consultant	Ward	Telephone
Urology	Vint	GRI Ward 70 Urology	

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: Nathan Babulo (Nathan Babulo - FY2) on 15 Sep 2025 16:57

Discharge Medication:

Active Drug Name	Route	Dose	Disp	Reason	Further Details	ECS	Since Admission
.Compliance Aid - Dosette	Route unspecified	Burns Pharmacy 10 Braemar Rd · 0141 634 2750	No	Patient's own supply	**Dispensing Details:** N/A		
Atorvastatin 80mg tablets 28 tablet	oral	TAKE ONE DAILY FOR CHOLESTEROL Instalments: dispense weekly,	No	Patient's own supply		Y	
Bisoprolol 2.5mg tablets 28 tablet	oral	1 TABLET DAILY FOR HEART Instalments: Dispense Weekly,	No	Patient's own supply		Y	
Co-codamol 30mg/500mg tablets 224 tablet	oral	when required TAKE ONE OR TWO UP TO FOUR TIMES A DAY.CONTAINS PARACETAMOL, DO NOT TAKE ALONGSIDE OTHER PARACETAMOL CONTAINING PRODUCTS. MAX OF 8 IN 24 HOURS Instalments: dispense weekly,	No	Patient's own supply		Y	
Duloxetine 60mg gastro-resistant capsules	oral	1 capsule once daily	No	Patient's own supply			
Empagliflozin 10mg tablets 28 tablet	oral	1 TABLET ONCE DAILY FOR DIABETES Instalments: Dispense Weekly,	No	Patient's own supply		Y	
Humalog KwikPen 200units/ml solution for injection 3ml pr... 5 pre-filled disposable injection	subcutaneous	AS PER DIABETIC CLINIC	No	Patient's own supply	**Drug Details:** Three times a day as per BMs as directed	Y	
Instillagel gel (CliniMed Ltd)	topical	1 application as required when required	Yes				Added
Isosorbide mononitrate 10mg tablets	oral	1 tablet twice daily., morn, lunch	No	Patient's own supply			
Lansoprazole 15mg gastro-resistant capsules 28 capsule	oral	1 CAP DAILY Instalments: dispense weekly,	No	Patient's own supply		Y	

Active Drug Name	Route	Dose	Disp	Reason	Further Details	ECS	Since Admission
Metformin 1g modified-release tablets 56 tablet	oral	1 TAB TWICE A DAY WITH MEALS Instalments: dispense weekly Notes for patient: Please make an appointment for review. Thank you,	No	Patient's own supply	**Drug Details:** morning and tea	Y	
Pregabalin 150mg capsules 56 capsule	oral	1 capsule once daily in the morning	No	Patient's own supply		Y	
Pregabalin 300mg capsules	oral	1 capsule once daily at night	No	Patient's own supply			
Trazodone 50mg capsules 86 capsule	oral	2 capsules once daily at night	No	Patient's own supply		Y	
Tresiba FlexTouch 200units/ml solution for injection 3ml pre-filled pens (Novo Nordisk Ltd)	subcutaneous	Once daily as directed, patient states taking at night time	No	Patient's own supply			

"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
2025-09-15	Clopidogrel 75mg tablets 28 tablet	oral	1 TABLET(S) DAILY Instalments: dispense weekly,		restart on 15/09

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:	Attended post TURBT (12/09/2025) - d/c with catheter in-situ during initial admission Presented with pain near catheter insertion site, feverish at home O/e - no abdominal / scrotal tenderness, mild infective signs at catheter site (inflamed, mild pustular discharge) Bloods NAD Home with instillagel and co-codamol Many thanks, GRI Ward 70
Discharge Comments:	
Follow Up:	Yes For TWOC next week (22/09) as per initial post op plan
Results Awaited:	Yes CSU awaited
Pharmacist Comments:	
Final Discharge Letter to Follow:	Yes

Yours sincerely,

Nathan BABULO

Prescription Review
Checked by: Nathan BABULO (FY2)
Discharged by: Nathan BABULO (FY2)

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No
Consent for Sharing Withheld: No

COLIN MCCROSSANThe Gordon Practice,New Gorbals Health & Care Centre,2 Sandiefield Road, Glasgow, G5 9AB

Main Switchboard:
Date of Completion: 13-Sep-2025

Dear COLIN MCCROSSAN,

Name	CHI	DoB	Address
George Finnie	2307656057	23-Jul-1965	Flat 0/4, 1 Bedford Street, Glasgow, G5 9BD

Admitted	Type	Discharged	Destination
12-Sep-2025 07:20	IP	13-Sep-2025	

Specialty	Consultant	Ward	Telephone
Urology	Carrera	GRI Ward 70 Urology	

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: Ciara Macpherson (Ciara Macpherson - Foundation Year 1) on 13 Sep 2025 15:25

Discharge Medication:

Active Drug Name	Route	Dose	Disp	Reason	Further Details	ECS	Since Admission
.Compliance Aid - Dosette	Route unspecified	Burns Pharmacy 10 Braemar Rd · 0141 634 2750	No	Patient's own supply			
Atorvastatin 80mg tablets 28 tablet	oral	TAKE ONE DAILY FOR CHOLESTEROL Instalments: dispense weekly,	No	Patient's own supply		Y	
Bisoprolol 2.5mg tablets 28 tablet	oral	1 TABLET DAILY FOR HEART Instalments: Dispense Weekly,	No	Patient's own supply		Y	
Co-codamol 30mg/500mg tablets 224 tablet	oral	when required TAKE ONE OR TWO UP TO FOUR TIMES A DAY.CONTAINS PARACETAMOL, DO NOT TAKE ALONGSIDE OTHER PARACETAMOL CONTAINING PRODUCTS. MAX OF 8 IN 24 HOURS Instalments: dispense weekly,	No	Patient's own supply		Y	
Duloxetine 60mg gastro-resistant capsules	oral	1 capsule once daily	No	Patient's own supply			
Empagliflozin 10mg tablets 28 tablet	oral	1 TABLET ONCE DAILY FOR DIABETES Instalments: Dispense Weekly,	No	Patient's own supply		Y	
Humalog KwikPen 200units/ml solution for injection 3ml pr... 5 pre-filled disposable injection	subcutaneous	AS PER DIABETIC CLINIC	No	Patient's own supply	**Drug Details:** Three times a day as per BMs as directed	Y	
Isosorbide mononitrate 10mg tablets	oral	1 tablet twice daily , morn, lunch	No	Patient's own supply			
Lansoprazole 15mg gastro-resistant capsules 28 capsule	oral	1 CAP DAILY Instalments: dispense weekly,	No	Patient's own supply		Y	
Metformin 1g modified-release tablets 56 tablet	oral	1 TAB TWICE A DAY WITH MEALS Instalments: dispense weekly Notes for patient:	No	Patient's own supply	**Drug Details:** morning and tea	Y	

Active Drug Name	Route	Dose	Disp	Reason	Further Details	ECS	Since Admission
		Please make an appointment for review. Thank you,					
Pregabalin 150mg capsules 56 capsule	oral	1 capsule once daily in the morning	No	Patient's own supply		Y	
Pregabalin 300mg capsules	oral	1 capsule once daily at night	No	Patient's own supply			
Trazodone 50mg capsules 86 capsule	oral	2 capsules once daily at night	No	Patient's own supply		Y	
Tresiba FlexTouch 200units/ml solution for injection 3ml pre-filled pens (Novo Nordisk Ltd)	subcutaneous	Once daily as directed, patient states taking at night time	No	Patient's own supply			

"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
2025-09-13	Clopidogrel 75mg tablets 28 tablet	oral	1 TABLET(S) DAILY Instalments: dispense weekly,		restart on 15/09

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,

	Mr Finnie was admitted to GRI Urology on 12/09 for TURBT of bladder tumour. Mr Finnie is now fit for discharge and has been given worsening advice. Follow up 1. TWOC on ward 70 on Monday 22nd September 2025 2. Await pathology and refer to Bladder cancer MDT 3. Clopidogrel to restart on 14/09. Thank you for your continuing care of this patient. GRI Urology
Discharge Comments:	
Follow Up:	Yes await pathology and mdt discussion TWOC On ward 70 on 22/09
Results Awaited:	Yes await pathology
Pharmacist Comments:	
Final Discharge Letter to Follow:	Yes

Yours sincerely,

Ciara MACPHERSON

Prescription Review
Checked by: Ciara MACPHERSON (Foundation Year 1)
Discharged by: Ciara MACPHERSON (Foundation Year 1)

Letter to Patient:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

George Finnie
Flat 0/4
1 Bedford Street
Glasgow
G5 9BD

Main Switchboard: 0141 211 4000
Department: Urology
Contact Tel: 01389817538
Enquiries to: Elaine.Brown5@nhs.scot
Letter Date: 09/10/2025
Reference: AC/TL
Dictated Date: 01/10/2025
Transcribed Date: 06/10/2025

Dear Mr Finnie,

I contacted you by telephone today to discuss your pathology results from your recent bladder surgery. The pathology results have confirmed that this is bladder cancer which seems to be confined to the superficial wall of the bladder and not deeper in to the muscle layer. We will discuss your case at the multi disciplinary team meeting and we will let you know the outcome of that hopefully next week.

Kind regards.

Yours sincerely

Miss Ashley Carrera

Consultant Urological Surgeon

Electronically Signed: Ms Ashley Carrera, Consultant

cc. electronic copy sent to GP

CHI: 2307656057

Glasgow Royal Infirmary

Total Att: **13**

12 Mth Att: **2**

Title: **MR**

FINNIE **George**

DOB **23/07/1965** Age: **57y** Sex: **Male**

FLAT 9C
305 Caledonia Road
Glasgow
Lanarkshire
G5 0JQ
07555093796

Next of kin: **ENRICI, C**
Relationship: **Partner**
07547 495422

GP: **WA Best**
0141 201 5100

Attendance Date: **23/11/2022** Arrival Time: **15:00**

Registration Time: **15:00** Date of Incident: **23/11/2022**

Major Incident Desc:

Reason for Attendance: **chest pain**

Name: GEORGE FINNIE
CHI: 2307656057

CHEST PAIN

Other:

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

Triage Category: 3

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **23/11/2022 15:46** Nurse name: **Nurse Caitlyn Gallagher**

Temp	**36.7**	C
HR	**121**	bpm
BP	**115/82**	mmHg
MAP	**93.00**	mmHg
RR	**18**	bpm
SpO2	**96**	%
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: **CHEST PAIN. news =2. CCP radiating into left arm, onset at rest, felt dizzy and nauseous at time. ongoing over last 2/52, worse today. crushing feeling. taken own GTN with initial relief. pmh anxiety, depression.cat 0 for ecg please.**

2307656057 23/07/1965 FINNIE George
2307656057 23/07/1965 FINNIE George
2307656057 23/07/1965 FINNIE George
2307656057 23/07/1965 FINNIE George
2307656057 23/07/1965 FINNIE George

To be Completed by Clinician		
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

Date	**Clinical Notes**	
	Seen By	Time Seen

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By

Patient Information

GEORGE FINNIE

Age/Gender: 57y Old Male
Address: 305 CALEDONIAN ROAD FLAT 9C,G5 0JQ
DOB: 23/07/1965
CHI: 2307656057
Ethnicity:

Date: 23/11/2022
Incident Number: CR009306687
Incident Type: EMG
Incident Location: 65 CRUACHAN ROAD RUTHERGLEN GLASGOW, G73 5HH

2307656057
FINNIE M
George 23/07/1965

Presenting Complaint

999 CALL 57YOM CHEST PAIN

Additional Comments

P/C pt complaining of central chest pain radiating into left arm, and back pain has been intermittent past two week worsening today. Pt took GTN at 08.00 which helped for a few hours. Described as central chest pain, crushing feeling, radiating into back and left arm 7/10 pain this morning no pain with crew. o/a pt sitting on sofa, conversing with crew GCS 15, skin warm, dry. o/e all obs as noted, pt states he is on no pain at the moment, although earlier had chest pain, feeling dizzy, nauseous. Oral/fluid intake normal, urine output normal, pt receiving tests on bowels due to loose stools, pt refused to be chaired out of the house. pmhx anxiety depression, diabetic, angina. shx pt lives alone. pt transported to hospital for further investigation.

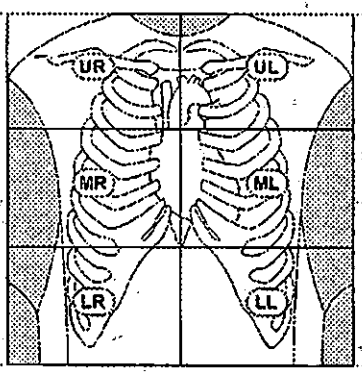
PATIENT ASSESSMENT

ACVPU Alert <C> No

A Clear

B Breathing Adequately: Yes | Respiratory Rate: 18 | SPO2: 95

Oxygen Given: No

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

C

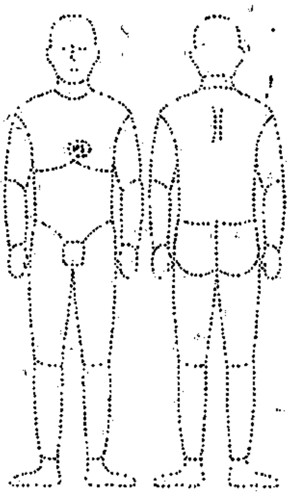
Pulse Rate	BP	Cap Refill	ECG Rhythm
114	129/85	<=2 Secs	Sinus Tachy

Rhythm	Arm	Central/Peripheral	ECG
Reg	Right		12 Lead

D

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

E



Pain

ID	Body Part	Pain Scale
P1	Chest	7

2307656057
FINNIE M
George 23/07/1965
FLAT 9C
305 Caledonia Road
Glasgow, Lanarkshire
G5 0JQ

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
14:00	113	18	137/85	96		15	Alert								E9883357
13:50	114	18	129/85	95	<=2 Secs	15	Alert		36.9	17.1	Sinus Tachy				E9883357

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
13:50	18 (0)	95 (1)		2	129 (0)	114 (2)	Alert (0)	36.9 (0)	5

HISTORY

AMPLE

Allergies	STATIN
Medication	SEE ECS PT HAS MEDS WITH HIM
Past Medical History	Angina, Diabetes (Type 2), ANXIETY DEPRESSION
Last Eaten	>4 Hours Ago
Events Prior	PAST TWO DAYS INTERMITTENT, WORSENING TODAY

Social History

Lives alone	Yes	Patient Occupation	Retired

Patients General Appearance	Normal
Patient Mobility	Mobile With Assistance, Walking Aid With Patient
Patient Communication	No Help Required
Patient Clinical Risk Factors	None Identified
Patient Enviromental Risk Factors	None Identified

SOCRATES

Site	CENTRAL CHEST PAIN	Onset	08.00, INTERMITTENT PAST TWO WEEKS
Character	HEAVY FEELING, Intermittent, Improving	Radiates	Yes, LEFT ARM BACK
Associated Symptoms	Nausea	Exacerbating Or Relieving Symptoms	MOVING WORSENING
Severity	5/10		

Urine Glucose

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

MAJORS

133 4

Affix Label

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

Title: MR.	Sex: M ☑ F ☐
SURNAME: FINNIE	Forename: GEORGE
CHI: 2307656057	Dob:: 23.7.65. Age:
Local address: 9/C 305 CALEDONIA RD GLASGOW.	Next of kin:
	Relationship:
	Tel:
	GP: DR BEST GORBALS HC.
Postcode: G5 0JQ	
Tel:	Tel:

Attendance date: 17/3/19	Arrival time: 1010	Date of incident:

Registration time:	Major incident description:

Reason for attendance: DIABETIC PROBLEM.

Affix Label

Nursing Assessment	Alerts:

Presenting complaint: ↑BMs. gen unwell & nausea. insuline ↑ thursday & reviewed by GP today. feels is worse today. ↑ urinary frequency ↑↑ & thirst ↑ NEWS: 1 low risk ... Ketone meter reading high

Triage category: 2	Pain score:	Tetanus up-to-date / fully immunised?

Allergies:

Observations date: 17/3/19.		Time: 1037.			Nurse's name:	
Temperature	36 °C	BM	27.8	mmol/L	GCS	
HR	97 bpm	PF		1/min	Eyes	
BP	150/88 mmHg	Expected PF		1/min	Motor	
MAP	mmHg	Weight		kg	Verbal	
RR	20 bpm	Height		cm	Total	
SpO₂	100 %	Visual Acuity			Pupils – Right	Pupils – Left
Oxygen	AIR %	Left	6/		Size	Size
		Right	6/		Reaction	Reaction
		With correction?				

Nursing Notes: hx T2DM on insulin. is at red seats

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

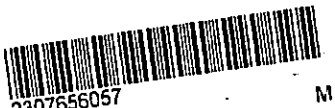
X-Ray and Other Reports to be filed on this side (if the patient is not being admitted)

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

George finnie 2307656057

Date	CLINICAL NOTES
	Seen by (Dr) Time seen



2307656057 M
FINNIE 23/07/1965
George
FLAT 9C
305 CALEDONIA RD
Glasgow, Lanarkshire G5 0JQ

Date	dhx **CLINICAL NOTES** pmhx
	40 units ~~TDS~~. Hum day every tie eat 70 units Gresiba nitke 1.5mg dulaglutide once week. atenolol atorvastatin clopidogrel metformin MR 1g BD lansoprazole gabapentin empagliflozin trazodone. GTN diabetes TIA. angina 2 x (130 + 4.8) + urea + glu. 2x 134.8 + crea + glu 269.6 + urea + 34.0. = 303.6 + urea.

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

Glasgow Royal Infirmary Emergency Department	NHS Greater Glasgow and Clyde	2307656057 FINNIE M George 23/07/1965 FLAT 9C 305 CALEDONIA RD Glasgow, Lanarkshire G5 0JQ

Initial Investigations Ordered

FBC ☐	COAG ☐	DD ☐	INR ☐		G+S ☐		X-match units			
U+Es ☐	LFT ☐	GLU ☐	CRP ☐	TROP ☐	Para ☐	Sal ☐	Ethanol ☐	Mg ☐	VBG ☐	ABG ☐
B culture ☐		C/MSSU ☐		Urinalysis ☐		BHCG ☐		Other		
CXR ☐	AXR ☐	Other imaging:								ECG ☐
Current location:								Sent by:		

Clinical Notes

Date 17/3/19. Time 12[illegible] Name R MORTIMER Grade LOCUM SHO (GPST3) Speciality

Pt with known poorly controlled diabetes on insulin. Had dose increased mid-week by diabetic team but sugars remain high despite this. Denies recent chest /urine infections but has had 2x courses ~~of~~ flucloxacillin for an ingrowing toenail.

pmh.
- diabetes
- depression.
- TIA
- angina

Already on 40 units Humalog each time he eats, 70 units Tresiba at night, dulaglutide 1.5g once a week metformin MR 1g BD and empagliflozin.

Feeling generally unwell, aches all over body, feeling more thirsty and increased urinary frequency

Glasgow Royal Infirmary
Emergency Department

Patient Name
DoB
CHI Number

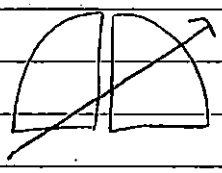
or affix label

Clinical Notes

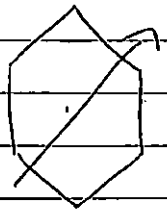
Date	Time	Name	Grade	Speciality

O/E.

HS 1+11+0 regular



chest clear
nil added



abdo SNT
BS ✓

Ⓐ UPU.

Imp Hyperglycaemia.
Not acidotic
Not ketotic

Plan Await bloods
Pt d/w diabetic nurse (Glucema:D).
↑ Humalog to 45 units each time eats
Call diabetic nurse more

R McAvinue
locum SHO (CPST1)

Glasgow Royal Infirmary
Emergency Department

2307656057
FINNIE M
George 23/07/1965
FLAT 9C
305 CALEDONIA RD
Glasgow, Lanarkshire
G5 0JQ

Clinical Notes

Date	Time	Name	Grade	Speciality

Glasgow Royal Infirmary
Emergency Department

Patient Name
DoB
CHI Number

or affix label

HAEM	DATE or TIME		BIOCH	DATE or TIME			DATE or TIME		V/ABG	DATE or TIME	
WCC	8.2		Na	133		Bil	9		FiO_2	6	
Hb	180		K	4.8		ALT	13		H^+	63	
Plat	201		Cl	102		AST	9		$PaCO_2$	6.0	
Neut	6.4		Ur	6.0		GGT			PaO_2	4.4	
DD			Creat	78		A phos	94		Bic	25	
PT	11		eGFR	>60		Alb	41		BE	−1	
APTT	30		Glu	30.6		AdjCa	2.45		Lactate	1.7	
TT	13		CRP			Amyl			Ethanol		
INR			Mg			TropI HS			Para		
			Phos	1.00		BHCG			Sal		

Diagnosis and Plan

Review/Discussed with:	Handover
	☐ Provisional Diagnosis
	☐ Liquids/Fluids
	☐ Analgesic/Medicines
	☐ NEWS
	☐ Investigations & Results
	☐ Talk to receiving team/ward

mi • 287967 Version 1_0 • GGC0226

2307656057
FINNIE
George M
FLAT 9C 23/07/1965
305 CALEDONIA RD
Glasgow, Lanarkshire
G5 0JQ

NHS24 CONTACT REPORT

PCM ID: 75855526
CHI: 2307656057
Surname: FINNIE
Forename: GEORGE
DOB: 23.07.1965
Gender: M
Address: Flat 9/C
305 Caledonia Road
GLASGOW
G5 0JQ

Phone Number: 01413219420
Phone Ext.:

Special Directions:
Temporary Resident: NO

Caller : Self
Date/Time Call Received: 17.03.2019 09:25:00
Date/Time Call Completed: 17.03.2019 09:35:43

Current Location: Flat 9/C
305 Caledonia Road
GLASGOW
G5 0JQ

GP: WILMA BEST
DR J S GORDON & PARTNERS
DR J S GORDON & PARTNERS
NEW GORBALS
2 SANDIEFIELD RD, GLASGOW G 059AB

Call Classification:

CALL SUMMARY:
FINAL ENDPOINT:
Accident & Emergency (ASAP)
REASON FOR CALL / RELEVANT INFORMATION:
BM 32 KEYTONES 2
DIABETIC, INSULIN NCREASD EARLIER THIS WEEK BY DIABETIC NURSE, S/B GP FRIDAY ADIVSED IF DOES NOT COME DOWN TO CALL 111 SUNDAY.
OUTCOME:
Patient advised to go to A&E - For Information Only

Confirmed Symptom(s):
#Blood sugar more than 21.0 ifavailable

PAST MEDICAL HISTORY:

NOTES:

17:03:2019 09:28:10 MCCLAFFERTYJ FEELING SHORT OF BREATH, CHEST PAIN YESTERDAY PINS NEEDLES/NUMBNESS LEFT ARM WHEN GOT UP THIS MORNING
CLINICAL ADVICE SCN H FINDLAY - BM 32 KEYTONES 2, SOB, PINS & NEEDLES LEFT ARM WHEN WOKE THIS MORNING, INSULIN INCREASED THIS WEEK BY DIABETES NURSE. BM INCREASED SINCE. AS PER CLINICIAN ATTEND GLASGOW ROYAL A&E ASAP

Support Line Notes:

Printed: 17/03/2019 11:23:39

Patient Sample Report

Status: **ACCEPTED**
Analyzed: 17/03/2019 11:23:29
Sample Type: **Venous**
Account Number:
Clinician:
Operator ID: CATRIONA MCQUADE0

Patient

ID:	2307656057
Last Name:	**FINNIE**
First Name:	**GEORGE**
Gender/Age:	Male, 53 years
Birth Date:	23/07/1965

Cartridge

Lot No.:	190118C
S/N:	000000000400076057
Exp. Date:	03/04/2019

Analyzer

Model:	GEM® *Premier 5000*
Area:	GRI
Name:	CASU
S/N:	16090423

2307656057
FINNIE M
George 23/07/1965

Results

				Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)							
cH		**43.2**	nmol/L	--	--	--	--
pCO_2		**6.0**	kPa	--	--	--	--
pO_2		**4.4**	kPa	--	--	--	--
Na^+	↓	**130**	mmol/L	--	133	146	--
K^+		**4.8**	mmol/L	--	3.5	5.3	--
Cl^-		**100**	mmol/L	--	95	108	--
Ca^{++}		**1.24**	mmol/L	--	1.15	1.27	--
Glu	↑	**34.0**	mmol/L	--	3.5	6.0	--
Lac		**1.7**	mmol/L	--	0.6	2.2	--
CO-Oximetry							
tHb		**183**	g/L	--	--	--	--
O_2Hb	↓	**66.0**	%	--	95.0	98.0	--
COHb		**1.1**	%	--	0.5	1.5	--
MetHb		**0.7**	%	--	0.5	1.5	--
HHb	↑	**32.2**	%	--	0.0	5.0	--
sO_2	↓	**67.2**	%	--	95.0	98.0	--
Derived							
BE(B)		**-0.6**	mmol/L	--	--	--	--
$HCO_3^-(c)$		**25.4**	mmol/L	--	--	--	--
Hct(c)		**55**	%	--	--	--	--

↑↓ Outside Reference Range

Other Information

Operator Entered

Temp	37.0	°C

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name	nie
Address	2307656057 FINNIE M George 23/07/1965 FLAT 9C 305 CALEDONIA RD Glasgow, Lanarkshire
CHI No.	G5 0JQ 7
DoB	

	Date	Ward
Admitted	19/3/19	A7E
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.

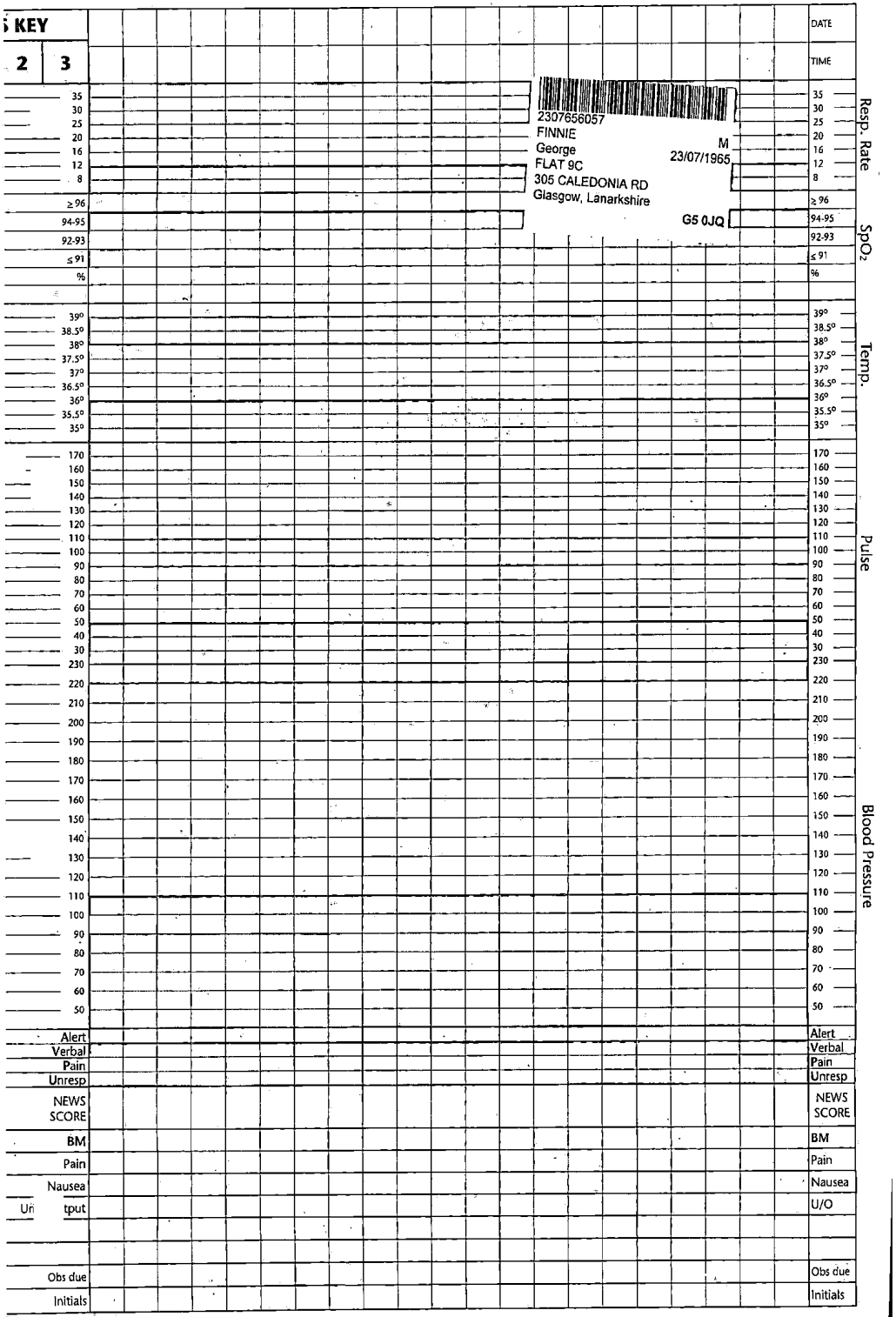
See NEWS Actions Reference Tool for local escalation policy

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.

George Finnie

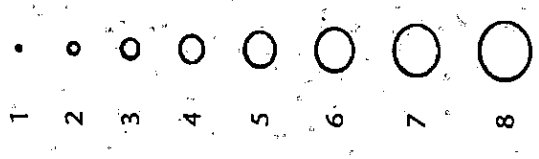
(4)

				NEWS
DATE:	7/3/19		DATE	
TIME:	10^37	11^35	TIME	0 | 1
Resp. Rate Mark: • (35, 30, 25, 20, 16, 12, 8)	• (20)	•	35, 30, 25, 20, 16, 12, 8	
SpO2 (Enter Value) ≥96	100		≥96	
94-95		95	94-95	
92-93			92-93	
≤91			≤91	
Any Sup'l O2 %			%	
Room air	(A)	(A)		
Temp. Mark: X (39°, 38.5°, 38°, 37.5°, 37°, 36.5°, 36°, 35.5°, 35°)	X	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)	•	•	170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40, 30	
Blood Pressure Mark: ◇ NEWS SCORE using Systolic BP (230, 220, 210, 200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50)	^ v	^ v	230, 220, 210, 200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50	
Conscious Level Mark: • Alert	•	•	Alert	
Verbal			Verbal	
Pain			Pain	
Unresp			Unresp	
Total NEWS (with all obs)	(1)	1	NEWS SCORE	
BM	7.8		BM	
Pain			Pain	
Nausea			Nausea	
Urine output			U/O	
Obs due			Obs due	
Initials	TN	CW	Initials	


KEY
2
3
DATE
TIME
2307656057
FINNIE
George
FLAT 9C
305 CALEDONIA RD
Glasgow, Lanarkshire
G5 0JQ
M
23/07/1965
Resp. Rate
SpO2
Temp.
Pulse
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Glasgow Coma Scale

Pupil size (mm)



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*)

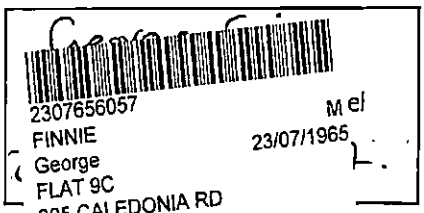
Management Plan and Patient Exclusions

Date and Time	Notes	Signed

Emergency Department Nursing Documentation

Presenting Complaint - ? DKA.

Date: 17/3/19 Time: 1045



NHS Greater Glasgow and Clyde

Assessment Complete by: Name NURSE (Please Pr CARLONA

Patient Prep / Investigations (Please tick/circle when completed)		Communication (Please Circle Tick)	
Prepare patient for examination / Clothing bag labelled + stored	☑	NEWS Chart complete / NEWS SCORE - (Record pain, blood sugar and Neuro Obs on NEWS Chart)	☑
GGC RED BAG - with patient	☐		
12 Lead ECG	☐	ID Band	☐
Weight:	☐	Peak Flow	☐
Blood Samples Obtained: Yes ☐ No ☐		Xrays / CT Scan Performed:	☐
IV Access: Yes ☐ No ☐		Relatives / NOK informed (Carers)	☐
Blood Gas: VBG ☐ ABG ☐		Child Protection Concern (considered in line with policy)	Y/N
		Adult Support and Protection	Y/N

Urinalysis

Leucocytes	☐	Nitrites	☐	Protein	☐	Blood	☐
Ketones	☐	Glucose	☐	PH		S.G.	
MSSU / CSU	☐	Toxiclogy	☐				
HCG	☐	+VE	☐	-VE	☐	Strip No -	

Screening Tools
(Please tick/circle when completed)

SEPSIS RISK? / SIRS Criteria 2 or more	Y/N	**SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms)**	YES
Mental Health Triage Assessment	Y/N	If NOT WHY? - (details)	NO
GMAWS	Y/N	Date - 17/3/19 Time - 1045 Signature -	

4AT

AMT	Correct
Age	
Date of Birth	
Place	
Current year	

No mistakes	= 0
1 mistake	= 1
> 1 mistake	= 2

Attention (months of year backwards)	
> = 7 correct	0
< 7 correct	1
Untestable	2

Alertness	
Normal	0
Mild sleepiness	0
Clearly abnormal	4

Mental status according to family/carer		
Acute change or fluctuating	4	YES
Acute change or fluctuating	0	NO

4AT score /12

STEP 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?

All over 75s and care home residents over 65. For younger patients use clinical judgement and consult local guidelines.

		YES	NO
F	**F**unctional impairment (new or worsening) eg difficulty with self care		
R	**R**esident in a care home?		
A	**A**ltered mental state such as acute confusion or dementia use the 4AT		
I	**I**mmobility/instability. New decline in mobility, difficulty mobilising without help or fall leading up to admission		
L	**L**ikely to require support for discharge? (either new or increase in existing support)		

Are any of the above criteria met? If YES to any of the above move to step 2

STEP 2 Would this person be better managed by another specialty team at present?

Indicator for care by another acute specialty regardless of age.

	YES	NO
Clear need for other specialty input eg exacerbation of known long term condition such as COPD		
Need for HDU/ITU (including non-invasive ventilation)		
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit		
Head injury with loss of consciousness		
Acute abdominal pain/surgical presentation		
Upper GI Bleed		
Chest pain with suspected acute coronary syndrome		
Trauma with suspected fracture		

Are any of the above criteria met?

If **YES** to any criteria in step 2:

- Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.

If **NO** to the list in step 2:

- Prioritise transfer of care to specialist geriatric assessment service in line with local guidance.

Screening Tools / ACTIVE CARE

(Please tick/circle when completed)

		Y/N	Date	Location of Redness/Ulcers	Grade of Ulcer
1) Pressure Damage Does the person have redness and/or existing damage? If YES - continue with a minimum of 2 hourly Active Care + Complete PUDRA					
2) Mobility	Does the person require assistance?	Y/N			
3) Continence		Y/N	**5) Skin**	Is skin compromised by other source, eg neurological deficit, medication, substance, diabetes, co-morbid?	Y/N
4) Nutrition		Y/N	**6) Judgment**	In your clinical judgment is this person at risk for developing pressure damage? IF YES - DETAILS	Y/N

Date	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.

2307656057
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G5 0JQ

M
23/07/1965

aph Label

At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc) *At risk complete risk assessment*	
YES	NO

Pause for Transfer / Discharge. (Please tick when completed)		Tick when completed	N/A	Notes
Relatives Informed of Admission / Discharge		☐	☐	Information on discussion with relatives
Relatives/carer with patient on transfer to ward		☐	Always	
GGC RED BAG - with patient		☐	Always	
Name Band		☐	Always	
Nursing Screening Tools completed		☐	Always	
Bed requested, SBAR COMPLETE		☐	☐	
NEWS chart		☐	Always	
Prescriptions / Charts signed	Infusions	☐	☐	
Cannula		☐	☐	
Notes: medical notes, GP letter, PRF		☐	☐	
Patients requiring analgesia: sufficient		☐	☐	
Belongings (including patients medication)		☐	Always	Please note here if any other tasks required prior to transfer
SAS Transport required and ref. no.		☐	☐	
Print Name Sign -				

Nursing Notes		
Date and Time		Print Name and Signature

Nursing Notes

Date and Time		Print Name and Signature

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

2307856057
FINNIE M
George 23/07/1895

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

SpO2 Scale 1 Target >96%	SpO2 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP initials ONLY:	Dr/ANP initials ONLY:	
Date:	Date:	

Document all actions and interventions

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
	Low Clinical Risk	Medium Clinical Risk	High Clinical Risk
Min 12 Hourly Observations	Min 4 Hourly Observation	Min Hourly Observations	Continuous Monitoring
	Inform Registered Nurse	Urgent Assessment by Medical Team	Urgent Assessment by Senior Medical Team
	Agree Frequency of Observation Required	ACE Response in Medical Notes	ACE Response in Medical Notes
		Think Sepsis if Suspicion of Infection	Consider 2222

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

Discontinuation of NEWS

Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Signed ....

Medical: ....

Date: ....

Pupil Reaction and Size
s = sluggish
+ = reaction
- = no reaction
c = eyes closed

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

Affix Patient ID

Glasgow Coma Scale

Date:
Time:

EYES — Eyes closed by swelling = NT: Spontaneously 4, To sound 3, To pressure 2, None 1, Non testable NT

VERBAL — Endotracheal tube or tracheostomy = NT: Orientated 5, Confused 4, Words 3, Sounds 2, None 1, Non testable NT

MOTOR — Always record the best response: Obeys command 6, Localising pressure 5, Normal flexion 4, Abnormal flexion 3, Extension 2, None 1, Non testable NT

TOTAL

PUPILS — Right size, Right reaction, Left size, Left reaction

ARMS — Record right (R) and left (L) separately if there is a difference between the two sides: Normal power, Mild weakness, Severe weakness, Spastic flexion, Extension, No response

LEGS — Record right (R) and left (L) separately if there is a difference between the two sides: Normal power, Mild weakness, Severe weakness, Spastic flexion, Extension, No response

Pain Function Score

A — No limitations, activity unrestricted by pain or settles quickly
B — Mild limitations, mild activity restrictions
C — Moderate limitations, attempts but reluctant to continue because of pain. Seek Advice
D — Severe limitations, unable to or refuse to perform because of pain. Urgent Review Required

Pain Score

Ask the patient to rate his/her pain by using numerical scale 0 to 10. Use the chart below to assist the patient. If the patient is unable to communicate, use alternative pain scoring tools.

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

NEWS 2 Key	1	2	3

Date	1/11	15/9
Time	11.00	1140

A + B Respirations Breaths/min

Range	Score	Example (1/11)	Entry
≥25	3		
21-24	2		
12-20	0	●	•
9-11	1		
≤8	3		

A + B SpO2 Scale 1 Oxygen saturation (%)

Range	Score	Example (1/11)	Entry
≥96	0	97	99
94-95	1		
92-93	2		
≤91	3		

SpO2 Scale 2 Oxygen saturation (%) Use Scale 2 if target range is 88-92% e.g. in chronic hypercapnic respiratory failure

Only use scale 2 under direction of qualified clinician

Range	Score
≥97 on O2	3
95-96% on O2	2
93-94% on O2	1
≥93 on air	0
88-92	0
86-87	1
84-85	2
≤83	3

Air or oxygen?

Range	Score	Example (1/11)	Entry
Air (A) or O2 device	0	A	A
O2 L/min 2	2		

C Blood Pressure mmHg (Score uses systolic BP only)

Range	Score	Entry
≥220	3	
201-219	0	
181-200	0	
161-180	0	
141-160	0	^
121-140	0	
111-120	0	
101-110	1	
91-100	2	
81-90	3	V
71-80	3	
61-70	3	
51-60	3	
≤50	3	

C Pulse Beats / min

Range	Score	Example (1/11)	Entry
≥131	3		
121-130	2		
111-120	2		
101-110	1		
91-100	1		
81-90	0		•
71-80	0	●	
61-70	0		
51-60	0		
41-50	1		
31-40	3		
≤30	3		

D Any changes in neuro response, do GCS, Immediate medical review. Check Blood Glucose. Think Delirium.

Range	Score	Example (1/11)	Entry
A Alert	0	●	•
C New Confusion	3		
V Verbal	3		
P Pressure	3		
U Unresponsive	3		

E Temperature

Range	Score	Example (1/11)	Entry
≥39	2		
38.1-39.0	1		
37.1-38.0	0		36.4
36.1-37.0	0	●	•
35.1-36.0	1		
≤35.0	3		

NEWS Total	0	0
Blood glucose	7.0	/
Pain / function score	0A	0/A
Time Pt last passed urine	10.20	/
Fluid balance chart indicated Y/N	N.	N
GCS indicated Y/N	N	N
Time NEWS due	23.00	18^4
Escalation of care Y/N	N	N
Initials	AB	/

Abbreviations for recording oxygen device

A	Room Air
N	Nasal Cannulae
SM	Simple Mask
V	Venturi Mask and % eg. V24
NIV	Non Invasive Ventilation
IV	Invasive Ventilation
T	Tracheostomy
CP	CPAP Mask
HFN	High Flow Nasal Oxygen
NEB	Nebuliser
RM	Reservoir Mask (Emergency use only)

Affix Patient ID

Affix Patient ID

NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

1. Give oxygen to target saturation >94% (COPD 88-92%)
2. IV fluids up to 20ml/kg
3. Take blood cultures
4. Measure lactate and FBC
5. Give IV antibiotics
6. Monitor urine output and fluid balance chart

Think ACE

A Action: Working diagnosis (consider SEPSIS). Consider frequency of observations. Management plan. Set review time. Document.

C Communicate: Inform nurse of plan. Inform senior medic if necessary. Document the discussion.

E Escalate: Document the treatment escalation plan. Should include need for next level of care & consideration of resuscitation status.

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

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Ward: 70

Discharge destination: home

Estimated Discharge Date (1) 14/9/25

Estimated Discharge Date (2) / /

Final date of discharge : 13/9/2025

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓		DC	
Relative/carer informed	✓		✓	
Relative/carer involved in discharge planning discussions	✓		✓	
Others informed: Care Home		✓	✓	
Transport arranged				
Own transport (preferred option)	✓		DC	
Ambulance: 1 man/ 2 man am/pm		✓	✓	
Other: Flight, Air ambulance etc.		✓	✓	
Discharge medication				
Immediate Discharge Letter completed	✓		✓	
Compliance aids e.g. Dossette Box (involve pharmacist)		✓	✓	
Medication received	✓		✓	
Medication explained to patient and/or relative/carer	✓			
Own medication returned to patient	✓		✓	
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)		✓	✓	
Informed of discharge				
Social work/ Other agencies		✓		
Homecare		✓		
Homecare request form completed?		✓		
Discharge lounge handover completed?		✓	✓	
Physiotherapist		✓	✓	
Occupational Therapist		✓		
Dietitian		✓		
Speech and Language Therapist		✓	✓	
Clinical Nurse specialist		✓	✓	
Liaison/ District Nurse/Practice Nurse		✓		
Other discharge items				
Access arrangements (e.g. keys, door entry)		✓	✓	
Patients clothing available for day of discharge	✓		✓	
Valuables e.g. cashier		✓	✓	
Intravenous cannula removed	✓			
Equipment ordered (inc. walking aids) in place for discharge		✓	✓	
Part 2 Discharge letter - Required		✓	✓	
- Completed		✓		
Outpatient clinic appointment				
Arranged	✓			
To follow		✓	✓	
If unknown at time of discharge state reason		✓	✓	
Additional information / leaflets / factsheets		✓	✓	

Time of Discharge: 1200

Nurse's signature: [signature]

Designation: SN

Date: 13/9/2025

My Admission Record

NHS Greater Glasgow and Clyde

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Hospital: GRI Ward: SDAU
Date of Admission: 12/9/25 Time: 0850
Information obtained from: Name: George.
Patient ☑ Relative ☐ Other ☐ _____
Preferred Name:
Age: 60 Telephone Number: 07555093796
Consultant: Carrera

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: Claire Enrichi	Name:
Relationship: Partner	Relationship:
Address: Rutherglen.	Address:
Telephone: 07785576922	Telephone:
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

A/A. TURBT

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

Angina TIDM Likely Bladder Tumour
TIA - 2010 IHD peripheral Neuropathy
Toes removed (R) foot

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

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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** ☐

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Lifestyle

Smoking

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

Never smoked ☑

Do you use eCigarettes? Yes ☐ No ☐

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

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): DEARIE Signature: DEARIE

Designation: SN (SDAU) Date: 12/9/25

My Assessment Record

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A 2307656057
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— George
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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	✓	✓	Doesn't use GTN spray
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: _____			

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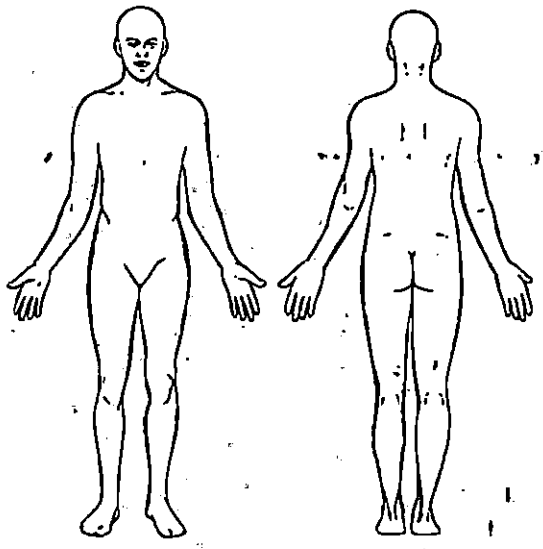
3. Senses

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?

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?

Nil.

What do you like to eat and drink?

Eats varied diet.

Drink – Tea c milk, water, Juice.

What do you not like to eat and drink?

Nil.

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

Sip to send TH 12/9/25

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 ✓
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		

Assessment of the patient's elimination needs

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? 12/9/25

How often in a day/week do you have a bowel movement? Per day ☐ Per week 2-3 days.

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	✓	✓	
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?	✓		upper denture at home.
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	✓	✓	
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 elbow crutch.
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?	✓		Post Op

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?	✓		Can have a disturbed sleep pattern at time.
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)? Mum.	✓	
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? Daughter	✓	

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?

Catholic.

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)?

No.

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?
family.

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?
Phone Calls
Visiting

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 ☐
Self-employed ☐
Full time education ☐
Unemployed ☑ ill-health.
Retired ☐

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)	✓		✓		12/9 DClerk
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan					
Bristol Stool Chart					
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓		✓		12/9 DClerk
Adult Wound Assessment and Management Chart					
Moving and Handling Assessment	✓		✓		12/9 DClerk
Falls Risk Assessment	✓		✓		12/9 DClerk
Bedrail Risk Assessment					

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
12/9/25 0905	A/A for theatre today for TURBT -	
	fasting/sips ✓ consent ✓	
	TEDS ✓	
	HR 71–90 – ECG carried out. BM 18.4 mmol,	
	urine negative for Ketones DClerk	DClerk SN

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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
12/9/25	Returned from theatre	
11 40	following TURBT	
	under spinal. Irrigation	
	running - urine clear	
	NBM-0. Catheter to	
	remain for 10 days.	
	Not to change	
	3 way to 2 way	
	until at least Monday.	
	? Remain overweight	
	A/W instructions	
	from A. Correia.	J. [illegible]
13/9/25	Settled night. obs stable	
0530	news (2) hypotensive and slightly	
	tachycardic. Catheter draining	
	old haematuric urine/brown.	
	Irrigation stopped. Catheter to	
	remain for ~~(to dc~~ ~~2 weeks~~). Error	
	2 weeks. Patient had not	
	taken any insulin through	
	day. F+I reviewed. Patient	
	normally takes tresiba at	
	nighttime however did not bring	
	insulin pen with him. unable to	
	source in hospital due to	
	shortage. F+I discussed with	
	med reg and 30 units of	

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Affix patient ID label

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
13/9/25	Toujeo prescribed_ Patient	
0520	Self administered Insulin.	
	BM stable 11.2 at 0230.	
	Careplan and risk assessments	
	updated	P Mitchell M SN
13/9/25 1000.	Patient well. NEWS 0 - apyrexial.	
	mobile and independent.	
	Home today. To return	
	Friday 26th - ward 7 for	
	TON. Letter in book.	
	Rapidcare referral made. &	
	no concerns on discharge.	Ellie Bride E Bride (SN)

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Care Plan

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Care discussed with patient ☐ Yes ☐ No ☐ Unable	If unable, give reason:	
Care discussed with family ☑ Yes ☐ No ☐ Unable	If unable, give reason:	

Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
DC 12/9/25	Record baseline vital signs / follow post op protocols		DC 12/9/25	Daily what matters to me on care rounding	
DC 12/9/25	ANGINA, TIA.				
				5. Hydration and Nutrition	
			DC 12/9/25	Sip To Send Protocol	
			DC 12/9/25	Resume to fluids & diet post op.	
	2, 3. Communication and senses				
DC 12/9/25	Explain procedures/interventions ensure understanding				
DC 12/9/25	Wears glasses.				
				6. Elimination	
	4. Cognitive status		DC 12/9/25	Observe for bowel/urinary function	
	Asesss 4AT on admission		13/9/25 EW	3 day review	
DC 12/9/25	A+O				

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Care Plan

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Date Commenced and Signature	7. Personal Hygiene, oral care, skin care and wound care	Date Discontinued and Signature	Date Commenced and Signature	9. Maintaining a safe environment, Technical Care	Date Discontinued and Signature
AC 12/9/25	Identify Baseline ADL needs - update careplan		AC 12/9/25	Orientate to bed area / toilet facilities /buzzers 3 hrly	
AC 12/9/25	Skin status / daily pudra		AC 12/9/25	Care rounding - see chart for frequency 3 hrly	
				10. Sleep and Rest	
			AC 12/9/25	Limit night time distruptions/ interventions	
	8. Mobility				
AC 12/9/25	Assess needs - see moving/handling careplan			12. Privacy, dignity and sexuality	
AC 12/9/25	Bedrail risk assessment / Assess Falls Risk - on admission		AC 12/9/25	Use curtains during intimate care	
	Mobile in use of x1 elbow crutch.		AC 12/9/25	Conduct discrete conversations	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	
			12/9	Discharge checklist commenced	

Care Rounds Checklist

Date: 12/9/25

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 [illegible] Designation SN
2. Signed [signature] Name Pamela Mitchell Designation SN
3. Signed _____ Name _____ Designation _____

At 2307656057
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'Must dos' for me. Ask the patient if there is anything they want specifically done today:

NIL

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

		Times	14	18	22
	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:	NT	IND	N
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	M	–	I
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	B	Ch	B
		Chair Assist to walk or stand (W/ST)	I	I	–
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	C	C	IC
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N
		Drink taken?	Y	Y	N
		Food, snack, or supplement taken?	Y	Y	N
		Has oral hygiene been carried out as per care plan?	I	I	N
	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	N
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA
		Care provider / role	IB	IB	DB

Care Rounds Variance Sheet

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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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Care Rounds Checklist

Date: 13/9/25

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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 PMitchell Name Pamela Mitchell Designation SN
2. Signed ECBride Name E McBride Designation SN
3. Signed ______ Name ______ Designation ______

Attach A[ddressograph]
230765?057
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Ward: 10

'Must dos' for me. Ask the pa[tient i]f there is anything they want specifically done today:
Nil

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

		Times	02 10	06 03	09 35															
	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:	NT	N	N															
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	IND	I	I															
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y															
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	B	B	I															
		Chair Assist to walk or stand (W/ST)		-	I															
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	I	C															
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N															
		Drink taken?	N	N	Y															
		Food, snack, or supplement taken?	N	N	Y															
		Has oral hygiene been carried out as per care plan?	N	N	N															
	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	NT															
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA															
		Care provider / role	PM	OB	EM SN															

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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MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

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Date 12/9 Time 0800 of initial height and weight on admission to hospital		Actual	*Patient reported	*If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height	1·78 cm	☑	☐	
Admission Weight	108 Kg	☑	☐	

*Obtain accurate height/weight and rescreen as soon as possible

Patients reported normal weight _____ Unable to Recall ☐

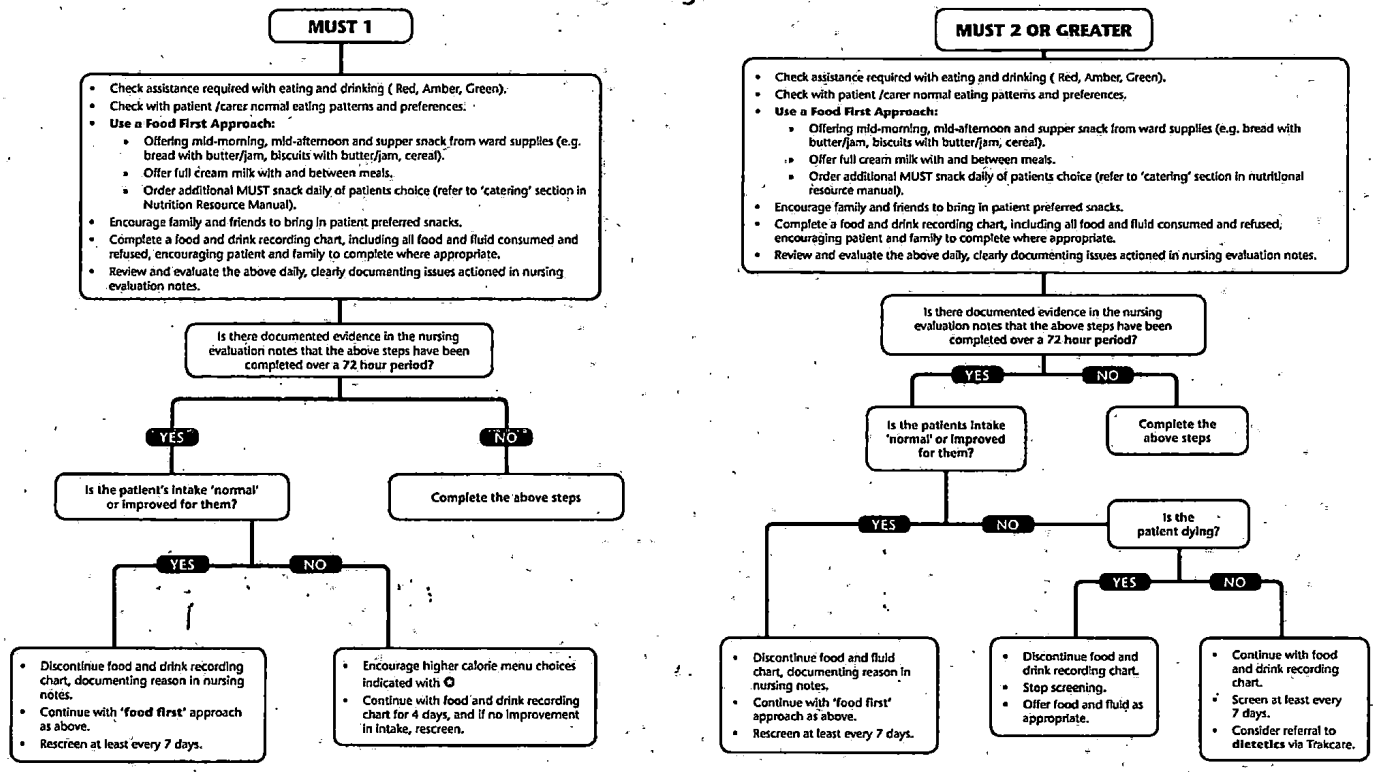
Any unplanned weight loss in the last 6 months Yes ☐ how much_____ No ☑ Don't Know ☐

Date	12/9	12/9						
Time	0800	15:30						
Ward	SDAU	70						
Oedema/ Ascities present Y/N	N	N						
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes	ST	ST						
Weight (kgs)	108	108						
BMI	34	34						
Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days								
Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	0	0						
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	0	0						
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	0	0						
Step 4 Overall Risk of Malnutrition TOTAL	0	0						
Rescreen on	19/9/23							
Signature								

Step 5 Management Guidelines (excludes patients who are Nil by Mouth)

Overall Risk of Malnutrition	Ensure plan of care for specific nutritional requirements, MUST score and plans to improve / increase nutritional intake are documented in the patients care plan
0	LOW RISK - Repeat screening every 7 days
1	MEDIUM RISK - Follow the flowchart for MUST 1 overleaf
2 or greater	HIGH RISK - Follow the flowchart for MUST 2 or greater overleaf

MUST STEP 5 Management Guidelines



DISCHARGE

If the patient is due for discharge and concerns remain regarding their oral intake, provide NHSGGC "*Eating to Feel Better" booklet discussing the reason why the information is being given e.g. reduced appetite and / or weight loss before or during hospital admission.

www.nhsggc.org.uk/patients-and-visitors/information-for-patients/food-in-hospital/discharge-from-hospital/

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Peripheral Venous Cannula (PVC) Insertion & maintenance

Please complete insertion details for each PVC inserted

Care & maintenance to be undertaken & documentation completed twice each day.

Modified Visual Infusion Phlebitis (VIP) Score		
PVC site appears healthy.	0	No phlebitis: Continue care and maintenance
Either slight pain or redness near site	1	Possible first signs: Observe PVC site
Two or more: pain / redness / swelling	2	Early stage of phlebitis: Remove and resite PVC
All: pain / redness / hardening of surrounding area	3	Phlebitis/thrombophlebitis: Remove and resite PVC Seek further advice
As above and including: palpable venous cord	4	
As above and including: pyrexia	5	

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Insertion details:	Where inserted:	Insertion site:	Side:	Size of cannula:	Inserted by:
Date: 12/9/25	☐ ED ☑ Theatre ☐ ITU/HDU	☑ Hand	☐ Left	☐ 26G Purple	Print:
(Day 1)	☐ Ward	☐ Arm	☐ Right	☐ 24G Yellow ☐ 18G Green	Signature:
Time: :	☐ Unknown	Other		☐ 23G Blue ☐ 16G Grey	Designation:
				☑ 20G Pink ☐ 14G Orange	

Clinical indication:	☐ Diagnostics	☐ Resuscitation	☐ IV medications	☐ Fluids	☐ Transfusion

Insertion criteria:	Hand hygiene performed	Skin decontamination (2% chlorhexidine in 70% isopropyl alcohol)	Sterile transparent semi-permeable dressing affixed	PVC explained to patient/carer
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

DRIFT PVCs are associated with an increased risk of phlebitis, thrombosis, infection and S.aureus bacteraemia.

Justify the need for your patient to have a PVC using the DRIFT mnemonic.
- ✓ **D**iagnostics - Does the patient need the PVC for a diagnostic procedure e.g. CT scan
- ✓ **R**esuscitation - Is the patient at risk of cardiac or respiratory arrest?
- ✓ **I**ntravenous (IV) - Does the patient require intravenous (IV) medication? Could these be switched to another route?
- ✓ **F**luids - Does the patient require IV fluids? Could this be switched or oral fluids?
- ✓ **T**ransfusion - Does the patient require a transfusion of blood products?

Signs of local or systemic infection

Local infection
- Erythema / inflammation
- Exudate
- Hot to touch
- Pain/tenderness

Systemic Infection
- Hypotension
- Tachycardia
- Pyrexia

Adult IVOST Guideline:

Always refer to full IV route to Oral route Switch Therapy (IVOST) guidelines

IV → Oral Antibiotic Switch Therapy (IVOST) Guideline

Review need for IV antibiotics daily
Can antibiotic therapy be stopped? (eg: alternative diagnosis)?
If ongoing antibiotics required - document patient progress/IVOST plan within 72 hours

Switch to oral when:
- a **CLINICAL IMPROVEMENT** in signs of infection eg: temperature ≤37.9°C, reduction in the NEWS score, improving SEPSIS
- a **ORAL ROUTE** is available reliably (eating/drinking no concerns regarding absorption)
- a **UNCOMPLICATED INFECTION** i.e. specialist advice not required prior to IVOST: Infection requiring specialist advice includes CNS infection, Cystic fibrosis, S. aureas bacteraemia (minimum 14 days IV), Endocarditis, Vascular graft or bone/joint infection, Undrainable deep abscess.

DO NOT use CRP in isolation to assess IVOST suitability as does not reflect severity of illness
Record the stop date on HEPMA

If IVOST criteria met → Switch to oral
Review MICROBIOLOGY results and NARROW THE SPECTRUM based on cultures
IF not responsive MICROBIOLOGY switch to oral as outlined below

Paediatric IVOST Guideline:

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Address: George
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Glasgow
CHI: M
DOB: 23/07/1965
Hospital & W G5 9BD

PVCs should be removed as soon as no longer clinically indicated.

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Maintenance – to be completed twice daily (Observe for signs and symptoms of local or systemic infection)

Date	Need for PVC reviewed today?		Any sign of PVC site infection?		Is the dressing intact?		Before / after PVC procedures; hand hygiene performed?		PVC patent?		What has been done?		Sign: Print: Designation:
	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	
Day 1 Insertion Date 12/9/25	☑ Yes ☐ No	☑ Yes ☐ No	VIP 0	VIP 0	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☑ Left in situ ☐ Redressed ☐ Removed	Day Night pmitchell RN
Day 2	☐ Yes ☐ No	☐ Yes ☐ No	VIP ___	VIP ___	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 3	☐ Yes ☐ No	☐ Yes ☐ No	VIP ___	VIP ___	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 4	☐ Yes ☐ No	☐ Yes ☐ No	VIP ___	VIP ___	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 5	☐ Yes ☐ No	☐ Yes ☐ No	VIP ___	VIP ___	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 6	☐ Yes ☐ No	☐ Yes ☐ No	VIP ___	VIP ___	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 7	☐ Yes ☐ No	☐ Yes ☐ No	VIP ___	VIP ___	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Removed	Day Night

PVCs should be removed on day 7. Reassess ongoing needs and vessel health for most appropriate vascular access device. Date removed: 3/9/2025

Reason for removal	☐ Site infection	☐ Infiltration	☐ Extravasation	☑ End of treatment	Other:

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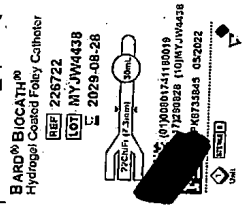
Adult Urethral Urinary Catheter(UUC)

Insertion & Maintenance Care Plan

Catheter I



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Insertion – Complete all sections				
Date and time inserted 12·9·25	Urethral Urinary Catheter inserted Hospital GRI ED ☐ Theatre ☑ ITU/HDU ☐ Ward ____	Gauge 22	20mls in balloon	Inserted by (Print name & designation [if known])
Clinical indication for urethral urinary catheterisation Post-op	Long term urethral urinary catheter ☐ (> 28 days)	Short term urethral urinary catheter ☑ (≤ 28 days)	DR BOYLE	
Patient had urethral urinary catheter inserted in the community/out with NHS GGC Yes ☐ No ☐		Date UUC inserted (if known) ____		

Insertion Criteria		Comments
Alternatives to urethral urinary catheterisation considered	Yes ☑ No ☐	
Hand hygiene is performed immediately before urethral urinary catheter insertion	Yes ☑ No ☐	
Aseptic technique performed at insertion	Yes ☑ No ☐	
Urethral Urinary catheter of smallest gauge used and balloon filled to recommended level	Yes ☐ No ☑	appropriate gauge used
Urethral meatus cleaned with sterile saline and sterile lubricant used	Yes ☑ No ☐	
Aseptic technique maintained when connecting urethral urinary catheter to closed drainage system	Yes ☑ No ☐	

DAILY MAINTENANCE: FOR ALL PATIENTS WITH A URETHRAL URINARY CATHETER:

- Staff must wear gloves and apron and perform hand hygiene before and after urinary catheter procedures
- The drainage bag must be emptied when clinically indicated using a clean disposable container for each patient. Please refer to Insertion and maintenance of adult indwelling urethral urinary catheter SOP.

Maintenance – To be completed daily (observe for signs and symptoms of infection)						
Please regard Day 1 as day of insertion or the day patient is admitted to hospital with Urethral Urinary Catheter.	Ward	Does the patient still require a urethral urinary catheter?	Is the urethral urinary catheter connected to a closed drainage system and changed in line with manufacturer's instructions?	Daily meatal hygiene has been carried out? (soap and water)	Urine drainage bag is situated below the level of the bladder and not in contact with any surface e.g. floor?	Signature and Print Name
Day 1 12/9/25	70	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	[signature] JW
Day 2 13/9/25	70	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	[signature] [illegible] (SN)
Day 3 __/__/__		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	

Date removed: ____ Time removed: ____ Reason for Urethral Urinary Catheter removal: ____ Removed by: ____

CHI Number: _____

Maintenance – To be completed daily (observe for signs and symptoms of infection)						
	Ward	Does the patient still require a urethral urinary catheter?	Is the urethral urinary catheter connected to a closed drainage system and changed in line with manufacturer's instructions?	Daily meatal hygiene has been carried out?	Urine drainage bag is situated below the level of the bladder and not in contact with any surface e.g. floor?	Signature and Print Name
Day 4 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 5 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 6 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 7 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 8 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 9 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 10 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 11 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 12 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 13 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 14 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 15 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 16 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 17 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 18 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 19 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 20 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 21 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 22 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 23 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 24 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 25 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 26 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 27 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 28 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	

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(Inpatient) Moving and Handling Assessment Form

Named Nurse:		Person is totally independent (tick here and go to data box)	✓

Body Build

Weight	Height
108 Kg 34 BMI	178 cm

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 ☐ 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 Alert) ☐	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)	

Independent with elbow crutch.

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:	12/9/25		
Assessor's signature:	[signature]		
Proposed Review date:	on-going		

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 Aleni) ☐			

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:			

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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: SDAU Date: 12/9 Time: 0800	Ward: 70 Date: 12/9/25 Time: 11:45	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).	Indep + elbow crutch	IND elbow crutch			
2. Check walking aid (if required) is in reach and in use.	✓	✓			
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	N/A pre op	✓			
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	✓	✓			
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.		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	Declare RFV Post op		[signature]							

Highlight risk of fall at the ward safety brief.

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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

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

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raph

Hospital: GRI

Ward: SDAU

Points to consider:
- Use within 8 hrs of admission to care area
- Re-assess daily and more frequently if a person's condition changes

Pressure damage	No RISK ↓	At RISK ↓	Grade 1 – non blanching skin Grade 2,3,4, suspected deep tissue injury (SDTI), ungradable pressure ulcer, Moisture Associate Skin Damage (MASD) ↓	Device Related Pressure Damage i.e. nasogastric, catheters, oxygen tubing ↓
YOU MUST CHECK SKIN at pressure points	Daily skin check	4 hourly positioning Complete SSKINS care plan (Overleaf)	2 hourly positioning with skin checks, Complete SSKINS care plan (overleaf)	All devices need a SSKINS care plan (overleaf)

1	PressureDamage	Does the person have Pressure damage; Grade 1, 2, 3, 4, SDTI, Ungradable?
2	Mobility	Does the person require assistance to mobilise or change position?
3	Continence	Does the person have moisture issues, or, 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. medical devices; neurological deficit; surgery; medication; co-morbidities?
6	Judgement	In your clinical judgement, is this person at risk of developing pressure damage?

Date	Location of pressure damage	Grade of ulcer	Date	Location of pressure damage	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

If NO to all questions, continue Care Rounds Prescribed as assessed for individual need and re-assess daily.
If you have answered YES to any of the questions above, please complete the SSKINS care plan overleaf.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Check Skin	Signature
12/9/25	08:00	N	Y	N	N	N	N	4 hrly	
12/9/25	11:30	N	Y	N	N	N	N	4 hrly	
13/9/25	05:25	N	Y	N	N	N	N	4 hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	

Patient Centred SSKINS care plan

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

NB. Avoid patients lying on back/sitting for prolonged episodes, a total change of position is required, standing only is not sufficient

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NHS Greater Glasgow and Clyde

	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: Catheter ☐ Naso gastric ☐ Oxygen mask ☐ Nasal oxygen ☐ Vascular Access Device ☐ Off loading boot ☐ Other:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment: Off loading boot: ☐ Protective product:	• Reposition ____ hourly in bed. • Reposition ____ hourly in chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used: Tilting device ☐ • Knee bend in place ☐ Record reason for no knee bend:	• Does patient have Moisture Associated Skin Damage Yes ☐ • Skin care to be carried out ____hourly. • Specify products required for increased moisture / continence management: Barrier Cream ☐ Pad / Pants ☐	• Optimise nutrition and hydration. • Refer to MUST	• Provide information in a format appropriate to patient / family/ carer needs : • Specify: Leaflet ☐ Verbal ☐ Not provided record reason:	Date discontinued: ____
Date Reviewed:	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used: Catheter ☐ Naso gastric ☐ Oxygen mask ☐ Nasal oxygen ☐ Vascular Access Device ☐ Off loading boot ☐ Other:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment: Off loading boot: ☐ Protective product:	• Reposition ____ hourly in bed. • Reposition ____ hourly in chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used: Tilting device ☐ • Knee bend in place ☐ Record reason for no knee bend:	• Does patient have Moisture Associated Skin Damage Yes ☐ • Skin care to be carried out ____hourly. • Specify products required for increased moisture / continence management: Barrier Cream ☐ Pad / Pants ☐	• Optimise nutrition and hydration. • Refer to MUST	• Provide information in a format appropriate to patient / family/ carer needs : • Specify: Leaflet ☐ Verbal ☐ Not provided record reason:	Date discontinued: ____

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

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	Date	Ward	Time
Admitted	12/9/25	SOAU	0750
Transferred			
Transferred			
Transferred			
Transferred			

SpO2 Scale 1 Target >96%	SpO2 Scale 2 Target 88-92%	Patient on home oxygen Y ☐ N ☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP initials ONLY:	Dr/ANP initials ONLY:	
Date:	Date:	

Document all actions and interventions

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
	Low Clinical Risk	Medium Clinical Risk	High Clinical Risk
Min 12 Hourly Observations	Min 4 Hourly Observation	Min Hourly Observations	Continuous Monitoring
	Inform Registered Nurse	Urgent Assessment by Medical Team	Urgent Assessment by Senior Medical Team
	Agree Frequency of Observation Required	ACE Response in Medical Notes	ACE Response in Medical Notes
		Think Sepsis if Suspicion of Infection	Consider 2222

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

Discontinuation of NEWS

Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Signed...

Medical:...

Date:......................................

Glasgow Coma Scale

Pupil Reaction and size:
s = sluggish
+ = reaction
- = no reaction
c = eyes closed

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

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Pain Function Score

A	No limitations, activity unrestricted by pain or settles quickly
B	Mild limitations, mild activity restrictions
C	Moderate limitations, attempts but reluctant to continue because of pain. Seek Advice
D	Severe limitations, unable to or refuse to perform because of pain. Urgent Review Required

Pain Score

Ask the patient to rate his/her pain by using numerical scale 0 to 10. Use the chart below to assist the patient. If the patient is unable to communicate, use alternative pain scoring tools.

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

MI • 316654 v5.1 • GGC0264

NEWS 2 Key 1 2 3

	Key								
Date		12/9	12/9	12/9	12/9	12/9	12/9	13/9	14/9
Time		17.50	00/11	11/20	13/10	10/10	20/10	00/00	06/05

A + B Respirations Breaths/min

Range	Score
≥25	3
21-24	2
12-20	0
9-11	1
≤8	3

A + B SpO2 Scale 1 Oxygen saturation (%)

Recorded: 97, 97, 99, 99, 96, 96, 97, 96, 94

Range	Score
≥96	0
94-95	1
92-93	2
≤91	3

SpO2 Scale 2 Oxygen saturation (%) Use Scale 2 if target range is 88-92% e.g. in chronic hypercapnic respiratory failure

Only use scale 2 under direction of qualified clinician

Range	Score
≥97 on O2	3
95-96% on O2	2
93-94% on O2	1
≥93 on air	0
88-92	0
86-87	1
84-85	2
≤83	3

Air or oxygen? A A A A A A A A A

	Score
Air (A) or O2 device	0
O2 L/min 2	2

C Blood Pressure mmHg (Score uses systolic BP only)

Recorded: 125/80, 119/88

Range	Score
≥220	3
201-219	0
181-200	0
161-180	0
141-160	0
121-140	0
111-120	0
101-110	1
91-100	2
81-90	3
71-80	3
61-70	3
51-60	3
≤50	3

C Pulse Beats / min

Recorded: 90, 71, 90

Range	Score
≥131	3
121-130	2
111-120	2
101-110	1
91-100	1
81-90	0
71-80	0
61-70	0
51-60	0
41-50	1
31-40	3
≤30	3

D Any changes in neuro response, do GCS. Immediate medical review. Check Blood Glucose. Think Delirium.

Recorded: A A A A A A

	Score
A Alert	0
C New Confusion	3
V Verbal	3
P Pressure	3
U Unresponsive	3

E Temperature

Range	Score
≥39	2
38.1-39.0	1
37.1-38.0	0
36.1-37.0	0
35.1-36.0	1
≤35.0	3

	Key								
NEWS Total	0	1	1	0	0	0	1	2	2
Blood glucose	7.0	8.4	15.7	—	15.7	/	/	/	/
Pain / function score	0A	2/4	0	—	—	/	0	0	0
Time Pt last passed urine	10.20	8	cath	cath	cath	cath	c	c	c
Fluid balance chart indicated Y/N	N	N	N	N	N	N	Y	Y	Y
GCS indicated Y/N	N	N	N	N	N	N	N	N	N
Time NEWS due	23.00	08				02/00	00/00	06/00	10/00
Escalation of care Y/N	N	N	N	N	N	N	N	N	N
Initials	AB						PM	PM	PM

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Abbreviations for recording oxygen device

A	Room Air
N	Nasal Cannulae
SM	Simple Mask
V	Venturi Mask and % eg. V24
NIV	Non Invasive Ventilation
IV	Invasive Ventilation
T	Tracheostomy
CP	CPAP Mask
HFN	High Flow Nasal Oxygen
NEB	Nebuliser
RM	Reservoir Mask (Emergency use only)

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NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

1. Give oxygen to target saturation >94% (COPD 88-92%)
2. IV fluids up to 20ml/kg
3. Take blood cultures
4. Measure lactate and FBC
5. Give IV antibiotics
6. Monitor urine output and fluid balance chart

Think ACE

A Action: Working diagnosis (consider SEPSIS). Consider frequency of observations. Management plan. Set review time. Document.

C Communicate: Inform nurse of plan: Inform senior medic if necessary. Document the discussion.

E Escalate: Document the treatment escalation plan. Should include need for next level of care & consideration of resuscitation status.

Anaesthetic Record

NHS Greater Glasgow and Clyde

Name / Hosp No / CHI / DoB:
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Date 12/8/25

Pre-op 2nd ~~ward~~ BM ☑ ketones ☑ am meds ☑ ECG ☐

Procedure(s) TURBT

Anaesthetist(s) McAdam / Thomas.

Surgeon(s) Carrera

Elective ☑ Urgent ☐ Immediate ☐

Anaesthetist grade: C ☑ SAS ☐ ST ☐ CT ☑ PA ☐
Surgeon grade: C ☑ SAS ☐ ST ☐ CT ☐

Discussed with supervising consultant ____

Anaesthetic Record

SUMMARY

GA ☐ FM vent OK ☐
Spinal ☑ LMA OK ☐
Epidural ☐ Laryngoscopy gd ____
Sedation ☐
Other LA

ASA 1 2 (3) 4 5
Comment

Anaesthetist Sign / Print R Thomson Aces 3

ASSESSMENT 600

Airway / Dentition
upper plate
MO 73FB. mp II
↓neck ROM. lower A on extension.

fasted
food 6pm
sips water today.

RS
non-smoker

CVS
SOB on stairs
can walk into shops
comfortable wdps (?) household activities
HTN
Angina – on exertion only occurs 1/12.
Possible TIA 2010

GI / Renal / CNS / Other
T2DM – poorly controlled / poor compliance
peripheral neuropathy
foot disease

cervical myelopathy

Previous anaesthesia / Family history
Toe amputation – popliteal block 2024
® hallux amputation – block 2023
laparotomy for gastric ulcer 1980

Assessor Sign / Print / Date R Thomson.

Ht 1.78m
Wt 108 kg
BMI 34

BM 18.4
ketone 0.6.

BP 102/71

ECG NSR @ 92 QTc 443

~~18/8/25~~

Hb	166	Na	(N)
WCC	7.8	K	
Plts	219	U	
XMatch	G+S x1	Cr	
Clotting		Gluc	

HbA1c 99

Allergies / Reactions
NKDA.

Current therapy
Clopidogrel (not said for 7/7?)
Humalog (35 iu TDS)
Pregabalin
metformin
duloxetine
atorvastatin
lansoprazole ☑
trazodone
empagliflozin
ISMN
bisoprolol ☑
co-codamol 30/500
✓ tirzepatide (Weds) pm
? ~~[illegible]~~

OK with NSAIDs ☐ X

Risks discussed
Pt wants spinal.
Risks: pain / bleeding / infection / PDPH / nerve damage / ↓BP. Failure.

Equipment check performed ☑

Vascular access

Cannula (L) DH 20G

A line

CVP

Airway/Ventilation

FM		Pre-ox	☐
LMA		Cricoid P	☐
ETT		SV	☐
Grade		IPPV	☐

Regional Anaesthesia

Spinal @ 09.36
Full asepsis (M/G/G/M)
Hydrex 4% left to dry.
L3/4. Tuffier's line. 3ml 1% lidocaine
25G sprotte. 1st pass
clear CSF. 1 episode of paraesthesia
completely resolved prior to
injection (needle pulled back)
2.8ml of LA mix: 0.5ml heavy 0.5%
bupivacaine + 2% heavy prilocaine 2.3ml
Dense motor block + T10
sensory level

R Thompson

GENTAMICIN mg	400							
Time	09.15	09.45	10.15	10.45				

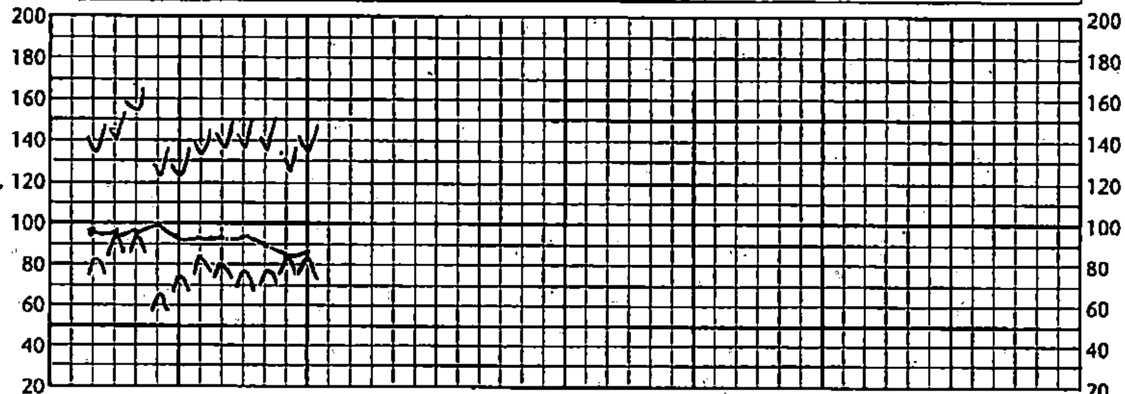
Position

lithotomy

ECG SpO2 ☑
NIBP

Fluid warmer ☐

Patient warmer ☐



IV Fluids	①							
Events	Ⓐ							
FiO_2 N_2O ☐	.21	.21	.21					
SpO_2	97	96	97					
$ETCO_2$								
ETAA								
BM		15.9						

Eye care ☐

Pressure point care ☑ padded

Events	IV fluids	
Ⓐ spinal.	① CSL 1000ml	⑨
Ⓑ	②	⑩
Ⓒ	③	⑪
Ⓓ	④	⑫
Ⓔ	⑤	⑬
Ⓕ	⑥	⑭
Ⓖ	⑦	⑮
Ⓗ	⑧	⑯

NHS
Greater Glasgow and Clyde

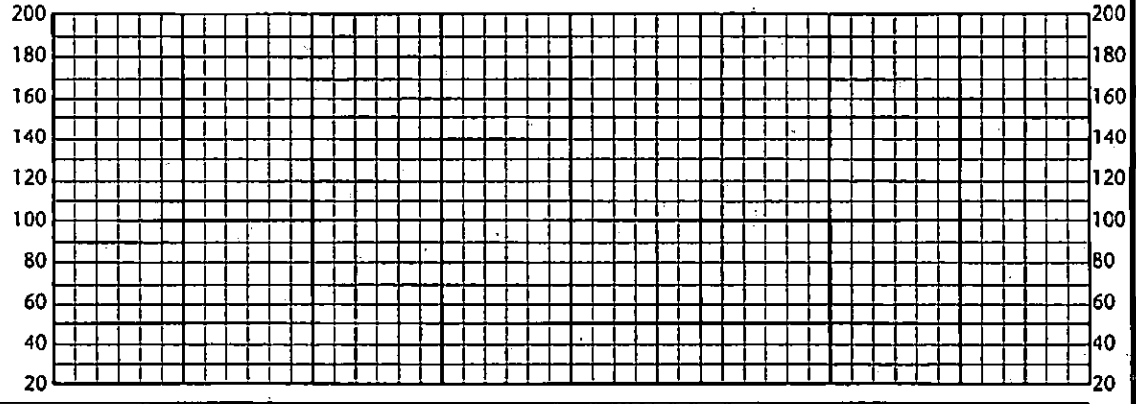
Name

Hospital no.

CHI no.

DoB / Age

Time								



IV Fluids								
Events								
FiO_2 N_2O☐								
SpO_2								
$ETCO_2$								
ETAA								

Anaesthetic Record / Anaesthetic Record / Anaesthetic Record / Anaesthetic Record

Post-op Instructions

Intra-op blood loss _____

Oxygen

Per PCA/other protocol ☐

0-5 L/min in recovery

To keep SaO_2 > 94 %

Fluids ENIL.

Discontinue IV fluids

Monitoring/Investigations

Routine post op monitoring + spinal obs.

BM in recovery + QDS.

Anaesthetic Notes

Greater Glasgow & Clyde Urology

Bladder Cancer Operation Note & MDT Referral

Name:
DOB:
CHI:

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Flat 0/4
1 Bedford Street
Glasgow
G5 9BD

Date: 12/9/25
Consultant: Carreras
Anaesthesia: Spinal
Anaesthetist: McAdam
ASA: 1 2 (3) 4 5

Operation: TURBT

Surgeon: Hassdon CT2 / Boyle STS

Supervisor: Green (scrubbed/(unscrubbed)) Supervisor completed op: yes/(no)

Indication: First cystoscopy/ new tumour / repeat TURBT/ recurrence / check

Findings (delete or circle accordingly):

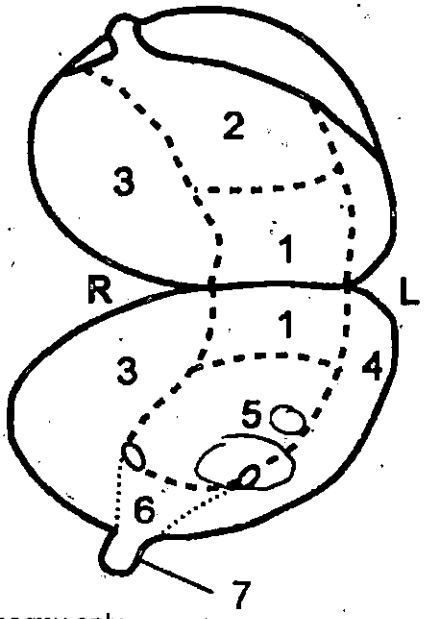
Tumour number: 1 (2) 3 >3

Appearance: (papillary) solid
mixed red patch

Size of largest tumour (mm):
<5 (6-10) 11-30 >30

Site(s):

1. Dome 2.Anterior wall 3.R lateral wall
4. (L lateral wall) 5. (Posterior wall) 6.Trigone
7.Bl. neck
R UO L UO Diverticulum



Complete resection: (yes) / no / not sure / biopsy and diathermy only

Extra-peritoneal perforation: yes / (no) / thin wall/ cystoscopy only

EUA: (1) (cTa) cT1 cT2 cT3 cT4 (2) Bladder mobile: yes / no / not sure

Postoperative Instructions: (1) Irrigation: (yes) / no
(2) Intravesical 40mg Mitomycin C within 6 hours: yes / (no)
(3) TWOC after 24H: yes / (no) If no keep catheter for 10 days WA 70
(4) Needs imaging: yes (no) If yes, please specify:
(5) If Hb<130 the request iron/transferrin before discharge

Follow up (Please tick): (1) Refer to MDT decision ✓
(2) CNS results clinic (yes) / no clinic or Consultant clinic yes / no
(3) If high grade; is re-resection appropriate (yes) / no
(4) Are they fit for cystectomy yes (no)
(5) Significant Co-morbidity?: give details T2DM on insulin

Forward to MDT coordinator immediately post op. ggc.mdturologyggc@nhs.scot

Signature: [signature]

Print name: Boyle

Operation note: TURBT

NHS
Greater Glasgow and Clyde
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000
Department: Urology
Contact Tel:
Enquiries to:

Letter Date: 12/09/2025
Reference: CB
Dictated Date: 12/09/2025
Transcribed Date: 12/09/2025

Glasgow Royal Infirmary
Department: Urology

12/9/25
S: Boyle ST5 Hassoun CT2
ss Carrera (unscrubbed)
A: McAdam
GA
ASA 3

Indication: New diagnosis bladder tumour on CT. 1 episode of haematuria. Poorly controlled T2DM on insulin. Patient was unaware of diagnosis until today.

Procedure/findings: Consent, spinal, pause, IV gent, modified LD position, prep and drape.

EUA - no palpable masses.

Rigid cystoscopy - urethra NAD, occlusive prostate, right UO seen, tumour on bladder base extending to left lateral wall. Largest tumour 1cm. Some early papillary change around tumour also. est of bladder NAD.

Bipolar resection of tumour. Deep resection at base.

Ellick to remove chips.

Haemostasis with loop.

Left UO not seen.

3way catheter 20ml in balloon.

Post op:

1. Irrigate till clear.

2. Not for mitomycin.

3. Keep catheter for 10 days. Spiggot 3 way catheter. Do not change until Monday.

4. TWOC Ward 70 if possible.

5. Refer to MDT.

6. Restart Clopidogrel Monday.

Boyle ST5

NHS Intraoperative Accountable Items Count Record

Date 12.9.25

AD 2307656057
NA FINNIE George Flat 0/4 M 23/07/1965
DO 1 Bedford Street Glasgow G5 9BD
HO

WARD SOAU
HOSPITAL GRI
THEATRE F

COUNTS	Scrub/Registered Practitioner Print Name	Circulating Practitioner - Signature & Print name
PRE - OP SWAB COUNT	H. TAYLOR	E PEARSON EPurd
PRE - OP INSTRUMENT COUNT	H. TAYLOR	E PEARSON EPurd
FINAL SWAB COUNT	H. TAYLOR	E PEARSON EPurd
FINAL INSTRUMENT COUNT	H. TAYLOR	E PEARSON EPurd
FINAL DISPATCH COUNT	H. TAYLOR	EP

SCRUB PRACTITIONER VERIFICATION

I have reviewed this count and can verify my count is correct
SCRUB PRACTITIONER 1 (Sign) - .....
SCRUB PRACTITIONER 2 (Sign) - ..... N/A ☑

OPERATION : Cystoscopy + Trans urethral resection of bladder tumour Patient. T.U.R.B.T.

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)	0	Pledgelets	0	Caesarean Roll	0	ACCOUNTABLE ITEMS THAT ARE TO REMAIN IN SITU e.g. Abdo packs/Swabs, Quantity and Location
Swabs (10x10)	10	Tapes	0			
Abdominal packs	0	Sloops/Slings	0			
Sutures	0	Bulldogs	0			
Blades	1	Shods	0			
IV needles	0	Ports	0			
Syringes	1	Tibbs Cannula	0			
Discard-a-pad	0	Staple Gun Inserts	0			
Diathermy pencil	0	Spears	0			
Diathermy tips	0	Retrieval Bag (Bert)	0			
Scratch pad	0	Digital Tourniquets	0	Throat Pack IN	☑	
Reels	0	Pen & Ruler	0	Throat pack OUT	☑	
Patties	0	Bi-Polar	0	Total Number	0	

DISCREPANCY IN COUNT - THIS SECTION N/A ☑

DETAIL IN 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
.....

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.

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Theatre: F

Date: 12/9/25

Patient Safety Checklists
North Sector Theatre Suite

NHS Greater Glasgow and Clyde

Anaesthetic Pause (Sign in)
Before any form of sedation or anaesthesia

Patient, Anaesthetist, Assistant/ODP to participate in the anaesthetic pause and cease their tasks:

Silence for pause.

Ask the patient their name and DoB. Check this matches name band and CHI is correct? (Y) N

Does the patient have any Allergies? Y/(N)
Or metalwork? Y/(N)

Ask the patient what operation they are having?
Is there a signed consent form for the expected procedure? (Y) N

Laterality – has the patient been marked? Y/ N/ (NA)
If lateral block planned attach **STOP BEFORE YOU BLOCK** sticker. Y/ N
If neuraxial block, check last dose LMWH >12h Y/ N

Pregnancy: confirm that the pregnancy status question has been asked. Y/ N/ (NA)
(n/a in males, females >55, previous hysterectomy/BSO, post menopausal, surgery for ERPOC)

Anaesthetic equipment available and checked ready to use? (Y)/ N/ NA

Name/Signed [signature]

Surgical Pause - Pre Skin Incision
Before start of surgical intervention

All the theatre team to participate in the surgical pause and cease their tasks:

Silent theatre for pause.

Scrub Team to Confirm:
Patient Name, DoB, CHI on Name Band and Consent Form? (Y) N
Operation and Laterality on Consent Form (and check mark if laterality)? (Y) N

Anaesthetic Team to Confirm:
Patient Allergies? Y/(N)
Antibiotics given in correct dose? (Y)/ N/ NA
A.S.A. 3
Warming required ? Y/(N)
Any concerns ? Y/(N)

Anaesthetic Assistant to Confirm:
Position of any metalwork/ pacemaker? Y/(N)

Surgeon to Confirm:
Does imaging need to be displayed? Y/(N)
Any concerns? Y/(N)
Intra-op DVT prophylaxis? Y/(N)
If yes circle TEDS/Flowtrons/LMWH Y/(N)

Circulating Team to Transfer Information above to the Theatre Whiteboard? YES

Emergency cases: CEPOD category agreed? Y/ N
ELLSA data completed ? Y/ N/ NA

Name/Signed [signature]

Sign Out
Towards the end of procedure

All the theatre team to participate in the surgical sign out and cease their tasks:

Silent theatre for sign out.

Lead surgeon at table (start of skin closure) (Y) N

Has the correct procedure been recorded? (Y) N
Is the swab, needle and instrument count correct? (Y) N

Is there a specimen? (Y) N
Confirm - labelled and recorded correctly? (Y) N
urethral catheter
Are there any packs or drains in the patient? (Y) N
What are the post-op instructions for these?

What is the estimated blood loss (EBL)? minimal ml

Are more antibiotics required? Y/(N)
Has post-op VTE prophylaxis been prescribed? (Y)/NA

Can the patient eat and drink immediately post-op? (Y) N
Any concerns for the recovery and management of this patient? Y/(N)

Is the post-op destination still appropriate? (Y) N

Name/Signed Eyurdan SN

Acute Services Division

NHS Greater Glasgow and Clyde

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Glasgow
G5 9BD

Perioperative Care Plan

Hospital: GRI	Consultant: Carrera
Ward: SDAU	Date: 12/9/25

Theatre Staff - The following information can be found within the My Admission Record (MAR)

Checked by:	Reception Practitioner	Anaesthetic Practitioner
• Relevant Medical History - see MAR	Yes ☑ No ☐	Yes ☑ No ☐

THEATRE STAFF – For Baseline Observations refer to NEWS 2 chart.

Height: 1.78 Weight: 108 kg BMI - 34

WARD Other information

Document any other relevant information e.g. needle phobia, preferred name, interpreter arranged.
Please provide e.g. theatre buddy, 'Getting to know me' document if available.

* Clopidogrel - stopped 2 weeks ago.
Urine negative for Ketones.

WARD Safety Checklist

Up-to-date Blood Results available on Clinical Portal	Yes ☑ No ☐	Comments if required:
Blood Cross Matched confirmed by labs	Yes ☐ No ☐ N/A ☑	
Blood Grouped and Saved confirmed by labs 1st sample ☑ 2nd Sample ☐	Yes ☐ No ☐ N/A ☐	
Antibodies +ve ☐ -ve ☑		

Date of Last Menstrual Period (LMP) N/A ☐ N/A	Date __/__/__	Comments
Is there any chance you are pregnant? N/A ☐	Yes ☐ No ☐	Comments
Pregnancy test carried out with the patient's consent	Yes ☐ Refused ☐	Comments
Pregnancy test result N/A ☐	Postive ☐ Negative ☐	
Tampon removed N/A ☐	Yes ☐	Comments
MRSA Positive ☐ Negative ☐ Results pending ☐ N/A ☑		Comments
CPE Positive ☐ Negative ☐ Results pending ☐ N/A ☑		
Other Positive ☐ Negative ☐ Results pending ☐ N/A ☑		
PUDRA Yes ☑ N/A ☐	Patient Refused ☐	Comments
PVC care plan in place Yes ☐ No ☐	N/A ☑	Comments

Topical Local Anaesthetic applied	Yes ☐ No ☐ N/A ☑	
Specify site and time applied	Site 1:	
	Time:	
	Site 2:	
	Time:	

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M
23/07/1965

SAFETY Checklist – Ward Check completed immediately prior to the patient being given a Pre-Med

Preoperative checks	Ward Check	Reception Check N/A ☐	Anaesthetic Practitioner
IDENTITY BAND CORRECT (Name, DoB, CHI number, gender, Ward)	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
Case Notes / Scanner Folder (circle)	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
ECG	Yes ☑ No ☐ N/A ☐	Yes ☑ No ☐ N/A ☐	Yes ☑ No ☐ N/A ☐
MAR document	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
NEWS chart	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
Falls risk assessment	Yes ☐ No ☐ N/A ☑	Yes ☑ No ☐ N/A ☐	Yes ☑ No ☐ N/A ☐
Prescription Chart HEPMA	Yes ☑ No ☐	Yes ☑ No ☐ H epma	Yes ☑ No ☐
Alert Sticker – specify:	Yes ☐ No ☑	Yes ☐ No ☒	Yes ☐ No ☒
Biometry	Yes ☐ No ☑	Yes ☐ No ☑	Yes ☐ No ☒
CONSENT FORM checks AWI ☐			
Correct patient information	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
Procedure and laterality matches Theatre list	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
Patient confirms proposed procedure	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
Correct site marked	Yes ☐ No ☑ N/A ☐	Yes ☐ No ☐ N/A ☒	Yes ☐ No ☐ N/A ☒
Signed by Surgeon and Patient	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
Dated 12/9/25			
ADULTS WITH INCAPACITY (AWI) N/A ☑			
Check;			
2 page Certificate of Incapacity for Single Procedure;	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Procedure and laterality matches Theatre list	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Dated and Signed by operating surgeon	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Correct site marked	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
4 page Capacity Documentation for Medical treatment present	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Certificate of Incapacity under section 47 completed and;	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Dated and signed by medical practitioner	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
ALLERGIES/Sensitivities and Reactions (Please also include food allergies)	Yes ☐ No ☑	Yes ☐ No ☒	Yes ☐ No ☒
If 'Yes' specify:	NKDA		
Fasted from – specify time (24 hr clock) N/A ☐	Food: 18	Food: FFMN	Food: FFMN
	Fluid: Sip to send	Fluid:	Fluid:
Blood Glucose Score – if relevant *	Time 0810 Score: 18.4 N/A ☐	Time: Score: N/A ☐ Checked	Time: Score: N/A ☐ Checked
INTERNAL PROSTHESIS in situ e.g. metalwork, pacemaker, implant etc If 'Yes' state location and type	Yes ☐ No ☑	Yes ☐ No ☒	Yes ☐ No ☒
EXTERNAL PROSTHESIS N/A ☐ e.g. hairpiece, false eye etc. If 'Yes' state type where stored	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☒	Yes ☐ No ☐ N/A ☒

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Pre-operative checks	Ward Check	Reception Check N/A ☐	Anaesthetic Assistant
Dentures removed N/A ☑	Yes ☐ No ☐ N/A ☐	Yes ☑ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐
If 'Yes' state where stored	n/a	In basin in Upper	
Loose teeth, caps and crowns and veneers State site and type	Yes ☐ No ☑	Yes ☐ No ☑	Yes ☐ No ☑
Hearing aid(s) N/A ☑	R ☐ L ☐ Insitu ☐ Removed ☐	R ☐ L ☐ Insitu ☐ Removed ☐	R ☐ L ☐ Insitu ☐ Removed ☐
If removed state where stored			
Spectacles/Contact lenses removed N/A ☐	Yes ☐ No ☑	Yes ☐ No ☐	Yes ☐ No ☐
If 'Yes' state where stored	WITH PT	Insitu.	
Make-up/ Nail polish removed N/A ☑	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
False nails in situ – Anaesthetist informed N/A ☑	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Jewellery/Body piercing removed N/A ☑	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
If 'yes' state where stored If unable to remove, please tape and state location			
Have you ever been notified that you are at increased risk of CJD or vCJD for public health purposes? Please complete additional CJD question form for High Risk Ophthalmology Procedures	Yes ☐ No ☑ Not Known ☐ Yes ☐ N/A ☑	If yes, contact Infection Control Team and Theatres. Infection Control Team Informed on ___/___/___ Comments if required:	
Inhalers/ sprays with patient N/A ☑	Yes ☐ No ☐	Type: Does not use GTN spray.	
Anti-embolic Prophylaxis prescribed N/A ☐	Yes ☑ No ☐	Type: A = 24cms.	
Paper pants in situ – If 'No' specify reason:	Yes ☑ No ☐	State reason:	
Voided urine/ Catheter in situ/ Urostomy (circle)	Yes ☑ No ☐	Comment if required:	
Pre-Medication given N/A ☑	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Trolley/ Bed checked for head down tilt and O_2/ Accessories	Bed ☐ Trolley ☐ Operating chair ☐ Yes ☐ No ☑		Bed ☐ Trolley ☐ Operating chair ☐ Yes ☐ No ☐
PLEASE PRINT NAME AND SIGN ONCE CHECKLIST IS COMPLETE	Print: D Clarke SN Sign: D Clarke Time: 0750 (SOAU)	Print: R Partridge Sign: Time:	Print: Sign: Time::

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Surgical Brief

Surgical Brief carried out:	Yes ☑ No ☐	If 'No' specify reason: \

Anaesthetics

Baseline Observations	Pulse: pls see anaesthetic chart	BP:	Temp:	SpO_2:	Resps:

Stop Before You Block — This section NOT applicable ☐

Stop Before You Block carried out:	Yes ☐ No ☐

Anaesthetic Type – Please tick all that apply

General Anaesthetic ☐	Epidural ☐ Spinal ☑ Combined ☐	Regional Blocks ☐	Throat spray ☐ Time: _____
Local Anaesthetic ☑	Site: lumbar Drug: Lido caine 1% plain		mls
Sedation ☐	Drug:		mls

Skin Prepping used for Patient Monitoring / Blocks — This section NOT applicable ☐

ARTERIAL CATHETER	Yes ☐ N/A ☐	Chlorhexidine 2%/70% alcohol ☐ Chlor-a-prep solution ☐	Yes ☐ Yes ☐	Other ☐ Specify prep:
CVP CATHETER	Yes ☐ N/A ☐	Chlorhexidine 2%/70% alcohol ☐ Chlor-a-prep solution ☐	Yes ☐ Yes ☐	Other ☐ Specify prep:
SPINAL / EPIDURAL / COMBINED	Yes ☑ N/A ☐	Specify prep: Chlorhexidine Spray		
REGIONAL BLOCK	Yes ☐ N/A ☐	Specify prep: —		

Blood Glucose Monitoring — This section NOT applicable ☐

Time								
BM Score								

Prevention of Eye Injury — This section NOT applicable ☑

Eyes protected from injury during procedure	Yes ☐	Specify:

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

Anaesthetics continued

Maintenance of Normothermia

This section NOT applicable ☐

Actions taken to maintain the patient's temperature	Yes ☐ No ☑	Warm air blanket device – specify:	Yes ☐ No ☐ N/A ☐
		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 ☐
Temperature documented by Anaesthetist		Other – specify:	Yes ☐ No ☐ N/A ☐

Record of Anaesthetic Pump Infusion Device Numbers

This section NOT applicable ☑

Anaesthetic Practitioner Comments

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

Theatre

Safe Positioning

This section NOT applicable ☐

Moving aids used to move patient	Yes ☑ No ☐	Pat Slide ☑	Sliding sheet ☑	Roll board ☐
		Hover Mattress ☐	Other:	

Pressure Area Care (THIS MUST BE COMPLETED)

Pre-operative skin inspection scores (please circle)	Excoriation Level: 0 mild / moderate / severe	Pressure Ulcer Grade: No concerns identified ☑ 1 2 3 4 Ungradable Suspected Deep tissue

No areas of concern identified ☑ Patient refused ☐

Area of concern identified (include area of body)	Actions taken
red spot on left shin and few	
rashes both lower legs	

Position	Positioning Devices		Pressure redistribution	Arm Position
Position 1 **Time:**	Head ring ☐	Lateral supports ☐	Gel pads ☑	**R Arm Position** / **L Arm Position**
Supine ☐ Prone ☐	Pillows ☑	Hydraulic leg supports ☑	Heel gel pads ☐	At side ☑ / At side ☑
Left Lateral ☐ Right lateral ☐	Straps ☐	Limb traction ☐	Full gel mattress ☐	On boards ☐ / On boards ☐
Lloyd Davis ☐ Jack-knife ☐	Wedge ☐	Side supports ☐	Gel wedge ☐	Across chest ☐ / Across chest ☐
Tren-delenburg ☐ Reverse Tren-delenburg ☐	Sandbag ☐	Bolster ☐	Pillows ☐	Hand table ☐ / Hand table ☐
Lower limb traction ☐ Deckchair ☐	Oxford pillow ☐	Other ☐		Hand traction ☐ / Hand traction ☐
Other ☐ Lithotomy ☐	Bean bag ☐			**Secured with:** / **Secured with:**
	Head Pad ☐			J-board ☑ / J-board ☑
				Straps ☐ / Straps ☐
				Pressure care: / **Pressure care:**
				Gel/ Foam pads ☑ / Gel/ Foam pads ☑
Position 2 **Time:**	Head ring ☐	Lateral supports ☐	Gel pads ☐	**R Arm Position** / **L Arm Position**
Supine ☐ Prone ☐	Pillows ☐	Hydraulic leg supports ☐	Heel gel pads ☐	At side ☐ / At side ☐
Left Lateral ☐ Right lateral ☐	Straps ☐	Limb traction ☐	Full gel mattress ☐	On boards ☐ / On boards ☐
Lloyd Davis ☐ Jack-knife ☐	Wedge ☐	Side supports ☐	Gel wedge ☐	Across chest ☐ / Across chest ☐
Tren-delenburg ☐ Reverse Tren-delenburg ☐	Sandbag ☐	Bolster ☐	Pillows ☐	Hand table ☐ / Hand table ☐
Lower limb traction ☐ Deckchair ☐	Oxford pillow ☐	Other ☐		Hand traction ☐ / Hand traction ☐
Other ☐ Lithotomy ☐	Bean bag ☐			**Secured with:** / **Secured with:**
	Head Pad ☐			J-board ☐ / J-board ☐
				Straps ☐ / Straps ☐
				Pressure care: / **Pressure care:**
				Gel/ Foam pads ☐ / Gel/ Foam pads ☐
Position 3 **Time:**	Head ring ☐	Lateral supports ☐	Gel pads ☐	**R Arm Position** / **L Arm Position**
Supine ☐ Prone ☐	Pillows ☐	Hydraulic leg supports ☐	Heel gel pads ☐	At side ☐ / At side ☐
Left Lateral ☐ Right lateral ☐	Straps ☐	Limb traction ☐	Full gel mattress ☐	On boards ☐ / On boards ☐
Lloyd Davis ☐ Jack-knife ☐	Wedge ☐	Side supports ☐	Gel wedge ☐	Across chest ☐ / Across chest ☐
Tren-delenburg ☐ Reverse Tren-delenburg ☐	Sandbag ☐	Bolster ☐	Pillows ☐	Hand table ☐ / Hand table ☐
Lower limb traction ☐ Deckchair ☐	Oxford pillow ☐	Other ☐		Hand traction ☐ / Hand traction ☐
Other ☐ Lithotomy ☐	Bean bag ☐			**Secured with:** / **Secured with:**
	Head Pad ☐			J-board ☐ / J-board ☐
				Straps ☐ / Straps ☐
				Pressure care: / **Pressure care:**
				Gel/ Foam pads ☐ / Gel/ Foam pads ☐

Pressure Area care Chart

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

Insert KEY to identify pressure re-distribution:-
E – Elevation **U**- unable to access
R - Reposition

Prevention of Compartment Syndrome
Legs in Lloyd Davis or Lithotomy Position:

This Section NOT Applicable ☐
Patient legs must be rested for 5 minutes every 3 hours. If this does not happen please document reason in comments section.

Time Legs Positioned	Position	Time legs lowered and duration	Time legs lowered and duration	Time legs lowered and duration	Time legs lowered and duration
09 42	Lithotomy				

TIME (Hourly)	HEAD/FACE N/A ☐	ARMS N/A ☐		HEELS N/A ☐		LEGS N/A ☐		O2 SENSOR	OPERATING TABLE RE-POSITION N/A ☐	30° TILT With PILLOW N/A ☐	SIGNATURE
		Left	Right	Left	Right	Left	Right				

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

Theatre continued

Electrosurgery

This section NOT applicable ☐

Monopolar: Yes ☐ N/A ☐		Bipolar: Yes ☑ N/A ☐
Site(s) of Monopolar Return Electrode:		
Skin site(s) assessed and meets safety criteria as per policy	Yes ☐ No ☐	If 'No' state reason:
Skin site(s) clipped	Yes ☐ N/A ☐	State site:
Return Electrode site(s) checked after patient repositioned and is satisfactory	Yes ☐ No ☐ N/A ☐	If 'No' state reason and action:

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) is satisfactory	Yes ☐ No ☐	If 'No' state reason and action:

Site and side	Time inflated	Pressure	Time deflated	Time re-inflated	Pressure	Time de-flated

Digit Tourniquet

This section NOT applicable ☑

Site and side applied	Time applied	Time removed

Prescribed DVT Prophylaxis

Contraindicated ☐ This section NOT applicable ☐

Intermittent Pneumatic Compression Devices: _____ mmHg	Yes ☐ No ☐ N/A ☐	Left ☐ Right ☐ Bilateral ☐
Foot Pump Devices: _____ mmHg	Yes ☐ No ☐ N/A ☐	Left ☐ Right ☐ Bilateral ☐
TED Stockings	Yes ☐ No ☑ N/A ☐	Left ☐ Right ☐ Bilateral ☐
Other – Specify:	Yes ☐ No ☐ N/A ☐	Left ☐ Right ☐ Bilateral ☐

Fluids for Irrigation

This section NOT applicable ☐

Saline

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

Theatre continued

Skin Preparation This section NOT applicable ☐

Site – specify: N/A ☐	Clipped	Preparation solution used	
Penile	Yes ☐ No ☐ N/A ☑	Aqueous iodine based solution ☐ Alcohol iodine based solution ☐ Aqueous iodine and sodium chloride 50/50 ☐ Batch no: ______ Expiry Date______	Chlorhexidine gluconate solution:____% ☐ Chlorhexidine acetate solution: 0.05 % ☑ Other – Specify: ______% ☐ Batch no: ______ Expiry Date: ______

Site – specify: N/A ☐	Clipped	Preparation solution used	
	Yes ☐ No ☐ N/A ☐	Aqueous iodine based solution ☐ Alcohol iodine based solution ☐ Aqueous iodine and sodium chloride 50/50 ☐ Batch no: ______ Expiry Date: ______	Chlorhexidine gluconate solution:____% ☐ Chlorhexidine acetate solution: ______% ☐ Other – Specify: ______% ☐ Batch no: ______ Expiry Date: ______

Site – specify: N/A ☐	Clipped	Preparation solution used	
	Yes ☐ No ☐ N/A ☐	Aqueous iodine based solution ☐ Alcohol iodine based solution ☐ Aqueous iodine and sodium chloride 50/50 ☐ Batch no: ______ Expiry Date: ______	Chlorhexidine gluconate solution:____% ☐ Chlorhexidine acetate solution: ______% ☐ Other – Specify: ______% ☐ Batch no: ______ Expiry Date: ______

Site – specify: N/A ☐	Clipped	Preparation solution used	
	Yes ☐ No ☐ N/A ☐	Aqueous iodine based solution ☐ Alcohol iodine based solution ☐ Aqueous iodine and sodium chloride 50/50 ☐ Batch no: ______ Expiry Date: ______	Chlorhexidine gluconate solution:____% ☐ Chlorhexidine acetate solution: ______% ☐ Other – Specify: ______% ☐ Batch no: ______ Expiry Date: ______

Local Anaesthetic Infiltration to Wound This section NOT applicable ☑

Site	Drug	Quantity

Drains This section NOT applicable ☐

Drain	Site	Type	Size	Secured with	Dressing
1	urethral -				
2					
3					
4					

Name: .....

Address: .....

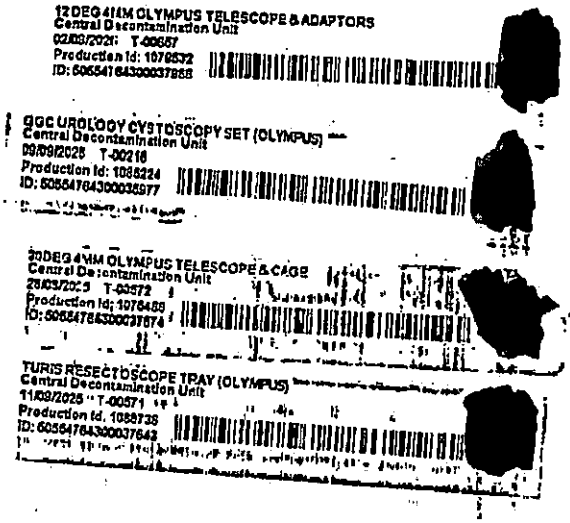
.....

DoB: .....

CHI number: .....

Affix patient data label

Traceability Stickers



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

Traceability Stickers

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

Blood Tag Dispatch

This section NOT applicable ☑

Blood Tags checked and dispatched appropriately: Yes ☐ No ☐

Wound Closure and Dressings (including Packing)

This section NOT applicable ☑

Wound Closure used: Yes ☐ No ☐ N/A ☐ | Wound Dressings: Yes ☐ No ☐ N/A ☐

	Site	Skin Closure	Dressings	Packing and number of pieces
1		Type: Absorbable ☐ Non Absorbable ☐ Other.....		
2		Type: Absorbable ☐ Non Absorbable ☐ Other.....		
3		Type: Absorbable ☐ Non Absorbable ☐ Other.....		
4		Type: Absorbable ☐ Non Absorbable ☐ Other.....		

Electrosurgery

Electrosurgery return electrode site post-op skin check(s) is satisfactory	Yes ☐ No ☐	If 'No' state reason and action:

Operation / Procedure Performed

Cystoscopy, T.U.R.B.T
Trans urethral resection of bladder tumour

Pressure Area Care (MUST BE COMPLETED)

Post-operative skin inspection scores (please circle)	Excoriation Level: mild / moderate / severe	Pressure Ulcer Grade: No concerns identified ☐ 1 2 3 4 Ungradeable Suspected deep tissue

No areas of concern identified ☐ Patient refused ☐

Actions taken if required:

Notes / Comments

Note / Comment	Time	PRINT and Sign

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

Immediate Post-Operative Recovery

Surgical handover Instructions e.g. ' hand high elevation'

Verbal Handover from Theatre to Recovery

Verbal Handover given by: To:

Handover should include the following

Patient		**Other**
Patient's name		RSI
Theatre		Awake Fibre Optic Intubation
Procedure		
Allergies		

Recovery

This section NOT applicable ☐

Safe Positioning

This section NOT applicable ☐

Moving aids used to move patient: Yes ☐ No ☐ If 'Yes' please specify (right)	Pat Slide ☐ Sliding Sheet ☐ Roll Board ☐ Hover Mattress ☐ Other ☐ Specify:

Pressure Area Care (MUST BE COMPLETED)

Patient refused ☐

See post operative skin inspection score from theatre on previous page

Skin inspection required a minimum 2 hourly

Time	Patient Position	No Concerns Identified	Excoriation Level N/A ☐	Pressure Ulcer Grade N/A ☐

Area of concern identified (include area of body)	Actions taken (continue in events section on page 16)

2307656057
FINNIE M
George 23/07/1955
Flat 0/4
1 Bedford Street
Glasgow
G5 9BD

Post-operative Observations

Time	10:30	10:45	11:00																
210																			
200																			
190																			
180																			
170																			
160																			
150																			
140			138																
130			^																
120			|																
110		110	|																
100	97	^	|																
90	^	|	|																
80	|	1	↓																
70	|	v	81																
60	v	72																	
50	65																		
40																			
30																			
Airway type	1	1	1																
O_2 Therapy	Air	Air	Air																
SpO_2	99	99	99																
Resp. Rate	16	16	16																
CVP		1																	
Temp.	36°																		
Pain Score	0	0																	
P.O.N.V.	0	0																	
Sedation Score	0	0																	
BM Score	15.7	→																	
PV staining																			
Hourly Urine Vol.	1000	500	1000																
Total Urine Vol.	1000	1500	2500																
Wound Score																			
KETONES	0.1	→																	
Circulation +ve/-ve	+ve	+ve																	
Sensation +ve/-ve	-ve	-ve																	
Movement +ve/-ve	-ve	-ve																	
Pedal Pulse – R / L																			
Drain 1																			
Staff initials	JM	JM																	

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

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							
PV Staining							
Hourly Urine Vol. / Total Urine Vol.	/	/	/	/	/	/	/
Wound Score							
Circulation +ve/-ve							
Sensation +ve/-ve							
Movement +ve/-ve							
Pedal Pulse – R / L							
Drain 1							
Staff initials							

Key to Scoring / Abbreviations

Airway Type	
1	Own
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			

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

Events

Event	Action	Outcome

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

Events

Event	Action	Outcome

2307656057
FINNIE M
George 23/07/1965

Discharge

NEWS 2 Score: (1) AP	Time: 11:00	Local Discharge Criteria met: Yes ☑ No ☐

Discharge Comments

Patient settled in recovery. No complaints of pain or nausea.
Observations satisfactory. BM 15.7 Ketones 0.1
Irrigation insitu. Passing good volumes via catheter.
IV fluids insitu, tolerating oral fluids.
For transfer to ward 70.

Verbal Handover from Recovery to Ward

Verbal Handover given by: JMcGuire To: Ward 70.

Handover should include the following

Patient	Anaesthetic	Theatre	Recovery	Other
Patient's name	Anaesthetic type	Drains	Skin Inspection results	
Theatre	CVP/Arterial Line	Wounds/Dressings	Surgical Instructions	
Procedure	Local anaesthetic Infiltration	Urinary catheter	NEWS 2 Score	
Allergies		Intra-operative events		
	IV Fluids			
	PVC			
	PVC Documentation			

Blood Tag Dispatch

This section NOT applicable ☐

Blood Tags checked and dispatched appropriately: Yes ☐ No ☐

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

Use this page to document further patient information if required.

Operation note: TURBT

This version supersedes letter dated 12 Sep 2025

NHS
Greater Glasgow and Clyde
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000
Department: Urology
Contact Tel:
Enquiries to:
Letter Date: 12/09/2025
Reference: CB
Dictated Date: 12/09/2025
Transcribed Date: 12/09/2025

12/9/25
S: Boyle ST5 Hassoun CT2
Miss Carrera (unscrubbed)
A: McAdam
GA
ASA 3

Glasgow Royal Infirmary
Department: Urology

Indication: New diagnosis bladder tumour on CT. 1 episode of haematuria. Poorly controlled T2DM on insulin. Patient was unaware of diagnosis until today.

Procedure/findings: Consent, spinal, pause, IV gent, modified LD position, prep and drape.

EUA - no palpable masses.

Rigid cystoscopy - urethra NAD, occlusive prostate, right UO seen, tumour on bladder base extending to left lateral wall. Largest tumour 1cm. Some early papillary change around tumour also. Rest of bladder NAD.

Bipolar resection of tumour. Deep resection at base.

Ellick to remove chips.

Haemostasis with loop.

Left UO not seen.

3way catheter 20ml in balloon.

Post op:

1. Irrigate till clear.

2. Not for mitomycin.

3. Keep catheter for 10 days. Spiggot 3 way catheter.

4. TWOC Ward 70 if possible.

5. Refer to MDT.

6. Restart clopidogrel Monday. Enoxaparin tonight.

Boyle ST5

Insulin Prescription and Administration Form

NHS Greater Glasgow and Clyde

Name ....
Address ....
2307656057.
FINNIE M
George 23/07/1965 ....
Flat 0/4
DoB: 1 Bedford Street ....
Glasgow
Chi r G5 9BD ....

Diabetes: Type 1 ☐ Type 2 ☐ Secondary ☐

Self administering insulin: Yes ☐ No ☐

Usual diabetes medication and device:

If unwell, vomiting or septic, check for ketones and request urgent medical review.

- When prescribing insulin always write the word units in full (do not abbreviate to U or IU)
- Always measure the dose and administer insulin using an insulin syringe
- Rapid acting and premix insulin should be given with meals
- Long acting insulin should be given at the same time every day

****Ensure that the insulin type and adminstration times are also prescribed on the Kardex. Adminstration of all doses must be recorded on both chart and Kardex.****

Refer to **guidelines on reverse of form** when blood glucose falls into the shaded areas.

Frequency of capillary blood glucose (CBG) monitoring: ______________ /day.

Date	Time	CBG Readings (mmol/L) <4	4.0-14.9	≥15	Insulin Preparation	Dose (units)	Print prescriber's name and sign below	Given by	Checked by	Time given	Ketones present Y / N
12/9						units units					Y / N
						units units					Y / N
	Before Breakfast				HUMALOG	35 units units	[signature] FY1 MANSFIELD	Not administered PT Theatre.			Y / N
						units units					Y / N
	Before Lunch	Postop 15.7mmol			HUMALOG	35 units units	[signature] FY1 MANSFIELD	Not administered PT theatre.			Y / N
						units units					Y / N
	Before Dinner		12.1		HUMALOG	35 units units	[signature] FY1 MANSFIELD				Y / N
						units units					Y / N
	Before Bed			15.7	~~TRESIBA~~ TOUJEO	30 units units	[signature] (FY1) S. THIRIMANNE	[signature]	[signature]	2330	Y / N
13/9/25	0235		11.2			units units		Patient self admin			Y / N
						units units					Y / N
	Before Breakfast		9.5		HUMALOG	34 units units	[signature] (FY1) S. THIRIMANNE	[signature]	Patient self admin	0645	Y / N
						units units					Y / N
	Before Lunch					units units					Y / N
						units units					Y / N
	Before Dinner					units units					Y / N
						units units					Y / N
	Before Bed					units units					Y / N
						units units					Y / N
						units units					Y / N
	Before Breakfast					units units					Y / N
						units units					Y / N
	Before Lunch					units units					Y / N
						units units					Y / N
	Before Dinner					units units					Y / N
						units units					Y / N
	Before Bed					units units					Y / N

Date	Time	CBG Readings (mmol/L)			Insulin		Print prescriber's name and sign below	Given by	Checked by	Time given	Ketones present Y / N
		<4	4.0-14.9	≥15	Preparation	Dose (units)					
						units units					Y / N
						units units					Y / N
	Before Breakfast					units units					Y / N
						units units					Y / N
	Before Lunch					units units					Y / N
						units units					Y / N
	Before Dinner					units units					Y / N
						units units					Y / N
	Before Bed					units units					Y / N
						units units					Y / N
						units units					Y / N
	Before Breakfast					units units					Y / N
						units units					Y / N
	Before Lunch					units units					Y / N
						units units					Y / N
	Before Dinner					units units					Y / N
						units units					Y / N
	Before Bed					units units					Y / N

Guidelines for capillary blood glucose readings falling into the shaded area

Hypoglycaemia: Glucose < 4mmol/L

Requires urgent treatment as per protocol: **www.diabetes.org.uk** or **StaffNet**

Urgent medical review if unwell/deteriorating at any stage.

- **Mild and able to swallow:** 15-20g carbohydrate such as 4-5 Glucotabs®, 60ml Glucojuice®, 100ml original Lucozade® or 150-200ml pure fruit juice
- **Severe:** 100mls IV 20% Glucose or 150-200mls IV 10% Glucose (or 1mg Glucagon IM if venous access problematic)

Check glucose after 10-15 minutes to ensure resolved – if glucose >4mmol/L give two biscuits / sandwich, if not then treat again as per protocol Following treatment of hypoglycaemia, review insulin doses, but **do not omit insulin in type 1 diabetes.**

Hyperglycaemia: Glucose ≥ 15mmol/L

Check urine or blood for ketones – need urgent medical review if ketones present or if unwell.

Assess risk of DKA in patients with type 1 diabetes and monitor closely – consider increase in insulin doses; may need IV insulin infusion.

Assess risk of hyperglycaemic hyperosmolar syndrome in type 2 diabetes.

If hyperglycaemic at same time on two consecutive days (even if mild), ask medical team to review diabetes treatment.

Consider and address causes of hypoglycaemia or hyperglycaemia

- Assess oral intake: too little or too much carbohydrate
- Consider renal failure, liver failure, pancreatic disease, sepsis or steroid therapy
- Review medication: check correct insulin (or other medication), dose and time of administration
- Check Injection sites in patients taking insulin

Contact Numbers

On-call medical page: _____ Hospital at night _____

Diabetes specialist nurse page: _____ Ext: _____

Name: .....

Address: .....

.....

DoB: .....

Chi number: .....

Affix patient data label

Approved by: NHSGGC Safer Use of Medicines Committee, Dec 2014. Date of review: Dec 2016

mi • 243189 Version 1_0 • GGC0123

Inpatient prescription & administration record for George Finnie (2307656057) Admission: 12/09/2025 => 13/09/2025

04:05
16/09/25

Patient Demographics

FINNIE George (2307656057)
DOB: 23/07/1965
Flat 0/4, 1 Bedford Street,
Glasgow,
G5 9BD

Admitted: 12/09/2025 07:20
Discharged: 13/09/2025 17:23

Transfer history

Admission	2025-09-12 07:20:00	RSDA GRI SDAU
Transfer	2025-09-12 09:18:00	R70 GRI WARD 70
Transfer	2025-09-12 15:47:00	R7 GRI WD 7/16
Transfer	2025-09-12 16:55:00	R70 GRI WARD 70

Responsible Consultant history

Assigned No Consultant 12/09/25 07:20

Allergy

Admission Allergy Check performed by: Harriet Charlton
Current recorded allergy (reaction): doxycycline (Unknown); simvastatin (Unknown)

torvastatin 80 mg Tablets

added by **Harriet Charlton** on 12/09/2025 at 08:53

Title: Allergic to simvastatin

When pt is up on the ward, if we could check the medications he's brought with him before admoinistering this medication as Mr Finnie was not sure about his allergy

☒ 12/09/25 22:00 80 mg ONCE daily at 10pm (Oral) — Harriet Charlton

12/09/25 22:00 Suspended

Bisoprolol 2.5 mg Tablets

☒ 13/09/25 07:00 2.5 mg ONCE daily at 7am (Oral) — Harriet Charlton

13/09/25 07:00 13/09/2025 08:51 Eleanor McBride

☒ 12/09/25 08:48 2.5 mg (Oral) — Rebecca Thomas

12/09/25 08:48 Rebecca Thomas Drug discontinued

Discontinued on: 12/09/2025 11:14:00 by: Rebecca Thomas . Reason: Course Complete

Clopidogrel 75 mg Tablets

☒ 13/09/25 07:00 75 mg ONCE DAILY MORNING 7am (Oral) — Harriet Charlton

13/09/25 07:00 Suspended

uloxetine 60 mg Capsules

☒ 13/09/25 07:00 60 mg ONCE DAILY MORNING 7am (Oral) — Harriet Charlton

13/09/25 07:00 13/09/2025 08:53 Eleanor McBride

Empagliflozin 10 mg Tablets

☒ 13/09/25 07:00 10 mg ONCE daily at 7am (Oral) — Harriet Charlton

13/09/25 07:00 Eleanor McBride Drug unavailable

Enoxaparin (Inhixa) 40 mg in 0.4mL Pre-Filled Syringe

☒ 12/09/25 17:00 40 mg ONCE daily at 5pm (Subcutaneous Bolus Injection) — Myra McAdam

12/09/25 17:00 Pamela Mitchell Other - see patient nursing notes
13/09/25 17:00 Stephen Mitchell Other - see patient nursing notes

GENTAMICIN PROPHYLAXIS / CATHETER STAT DOSE

☒ 12/09/25 09:30 400 mg (Intravenous Intermittent Infusion) — Myra McAdam

12/09/25 09:30 12/09/2025 09:30 Myra McAdam

Humalog (Insulin lispro) KwikPen 200units/mL AS PER CHART

Key: Prescription details | Recorded as "Admitted On" | Prescribed as "Self Administer" | Discontinuation details | HEPMA Prescription additional notes | HEPMA Patient admission notes (admission specific) | HEPMA Patient retained notes (not specific to admission)

Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, NHS Ayrshire & Arran and NHS Greater Glasgow & Clyde

HEPMA MAP v1.0

Humalog (Insulin lispro) KwikPen 200units/mL AS PER CHART *(Continued)*

☒ 12/09/25 12:00 1 Dose(s) THREE times daily at 7am, 12 noon, and 5pm (Subcutaneous Bolus Injection) — Myra McAdam

12/09/25	12:00	Stephen Mitchell	Self Administers	
12/09/25	17:00	Pamela Mitchell	Other - see patient nursing notes	
13/09/25	07:00	Pamela Mitchell	Self Administers	
13/09/25	12:00	Stephen Mitchell	Other - see patient nursing notes	
13/09/25	17:00	Stephen Mitchell	Other - see patient nursing notes	

Lansoprazole 15 mg Capsules

☒ 13/09/25 07:00 15 mg ONCE DAILY MORNING 7am (Oral) — Harriet Charlton

13/09/25	07:00	13/09/2025	08:49	Eleanor McBride	

☒ 12/09/25 08:48 15 mg (Oral) — Rebecca Thomas

12/09/25	08:48	Stephen Mitchell	Other - see patient nursing notes	

Metformin 1000 mg Modified Release Tablets

☒ 12/09/25 22:00 1,000 mg TWICE DAILY 7am:10pm (Oral) — Harriet Charlton

12/09/25	22:00	12/09/2025	22:04	Pamela Mitchell	
13/09/25	07:00			Eleanor McBride	Drug unavailable

Paracetamol 500 mg Tablets

☒ 12/09/25 12:00 1,000 mg FOUR TIMES DAILY 7am:12pm:5pm:10pm (Oral) — Myra McAdam

12/09/25	12:00			Stephen Mitchell	Other - see patient nursing notes
12/09/25	17:00			Pamela Mitchell	Other - see patient nursing notes
12/09/25	22:00			Pamela Mitchell	Refused by Patient
13/09/25	07:00	13/09/2025	06:51	Pamela Mitchell	
13/09/25	12:00			Stephen Mitchell	Other - see patient nursing notes
13/09/25	17:00			Stephen Mitchell	Other - see patient nursing notes

Pregabalin 150 mg Capsules

☒ 13/09/25 08:00 150 mg ONCE daily at 8am (Oral) — Harriet Charlton

13/09/25	08:00	13/09/2025	08:51	Eleanor McBride

Pregabalin 300 mg Capsules

☒ 12/09/25 22:00 300 mg ONCE DAILY NIGHT 10pm (Oral) — Harriet Charlton

12/09/25	22:00	12/09/2025	22:03	Pamela Mitchell

TRAZODONE 50 mg Capsules

☒ 12/09/25 22:00 100 mg ONCE DAILY NIGHT 10pm (Oral) — Harriet Charlton

12/09/25	22:00	12/09/2025	22:04	Pamela Mitchell

Tresiba (Insulin degludec) 200 units/mL FT Pen AS PER CHART

☒ 12/09/25 22:00 1 Dose(s) ONCE DAILY NIGHT 10pm (Subcutaneous Bolus Injection) — Myra McAdam

12/09/25	22:00	Pamela Mitchell	Drug unavailable	

yclizine 50 mg in 1 mL Injection as required

☒ 12/09/25 09:52 50 mg every 8 HOURS (Intravenous Slow Bolus Injection) FOR NAUSEA — Myra McAdam

Dihydrocodeine 30 mg Tablets as required

☒ 12/09/25 09:52 30 mg every 4 HOURS (Oral) FOR PAIN for 5 day(s) — Myra McAdam

FENTANYL 100 micrograms in 2mL Injection (Recovery Only) as required

☒ 12/09/25 09:52 25 microgram every 5 MINUTES (Intravenous (Recovery) Bolus Inj) RECOVERY ONLY, FOR PAIN UP TO 25MCG IN 5MINUTES for 1 day(s) — Myra McAdam

Morphine sulfate 10 mg in 5mL Oral Solution as required

☒ 12/09/25 09:53 10 mg every HOUR (Oral) FOR PAIN *prescribed as part of either/or protocol:Morphine Oral Solution 5Mg-10Mg 1H Prn Dose Range* — Myra McAdam

10.00	12/09/2025	15:41	Travis Tempest	

☒ 12/09/25 09:53 20 mg every HOUR (Oral) FOR PAIN *prescribed as part of either/or protocol:Morphine Oral Solution 5Mg-10Mg 1H Prn Dose Range* — Myra McAdam

			Travis Tempest	Alternative administered

Key: Prescription details | Recorded as "Admitted On" | Prescribed as "Self Administer" | Discontinuation details | HEPMA Prescription additional notes | HEPMA Patient admission notes (admission specific) | HEPMA Patient retained notes (not specific to admission)

Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, NHS Ayrshire & Arran and NHS Greater Glasgow & Clyde

HEPMA MAP v1.0

MORPHINE SULFATE 10 mg in 1 mL Injection (Recovery only) as required

☒ 12/09/25 09:52 5 mg (Intravenous (Recovery) Bolus Inj) RECOVERY PAIN PROTOCOL SCN/BAND6 AND ABOVE ONLY for 2 dose(s) — Myra McAdam

Ondansetron 4 mg in 2mL Injection as required

☒ 12/09/25 09:52 4 mg every 8 HOURS (Intravenous Slow Bolus Injection) FOR NAUSEA — Myra McAdam

Paracetamol 500 mg Tablets as required

☒ 12/09/25 09:52 1,000 mg (Oral) RECOVERY DOSE ONLY FOR PAIN for 1 dose(s) *prescribed as part of either/or protocol:Grianaesthesia Minor Surgery Generic.* — Myra McAdam

Paracetamol IN RECOVERY ONLY 1000 mg in 100mL IV Infusion as required

☒ 12/09/25 09:52 1,000 mg (Intravenous Intermittent Infusion) RECOVERY DOSE ONLY FOR PAIN for 1 dose(s) *prescribed as part of either/or protocol:Grianaesthesia Minor Surgery Generic.* — Myra McAdam

Prochlorperazine 3 mg Buccal Tablets as required

☒ 12/09/25 09:52 3 mg every 12 hours (Buccal) FOR NAUSEA — Myra McAdam

Patient level notes

added by **Francis Quinn** on 12/09/2025 at 09:53

Title: GRI Anaesthesia Major Surgery Generic

GRI Anaesthesia Major Surgery Generic

PO/IV Paracetamol STAT dose - If you have given a STAT dose of paracetamol please select **'Retrospective STAT order'** in the **'Order Entry'** tab and enter the time administered.

PO Paracetamol - Please adjust start time in the **'Order Entry'** tab to at least 4hours from PO/IV STAT dose if necessary.

Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, NHS Ayrshire & Arran and NHS Greater Glasgow & Clyde

HEPMA MAP v1.0

Finnie, George ID:2307656057 12-SEP-2025 08:42:00 GREATER GLASGOW SITE-GRTHRY ROUTINE RECORD

23-JUL-1965 (60 yr)
Male

Room:
Loc:229

Vent. rate	90	BPM
PR interval	142	ms
QRS duration	104	ms
QT/QTc	362/442	ms
P-R-T axes	45 26	48

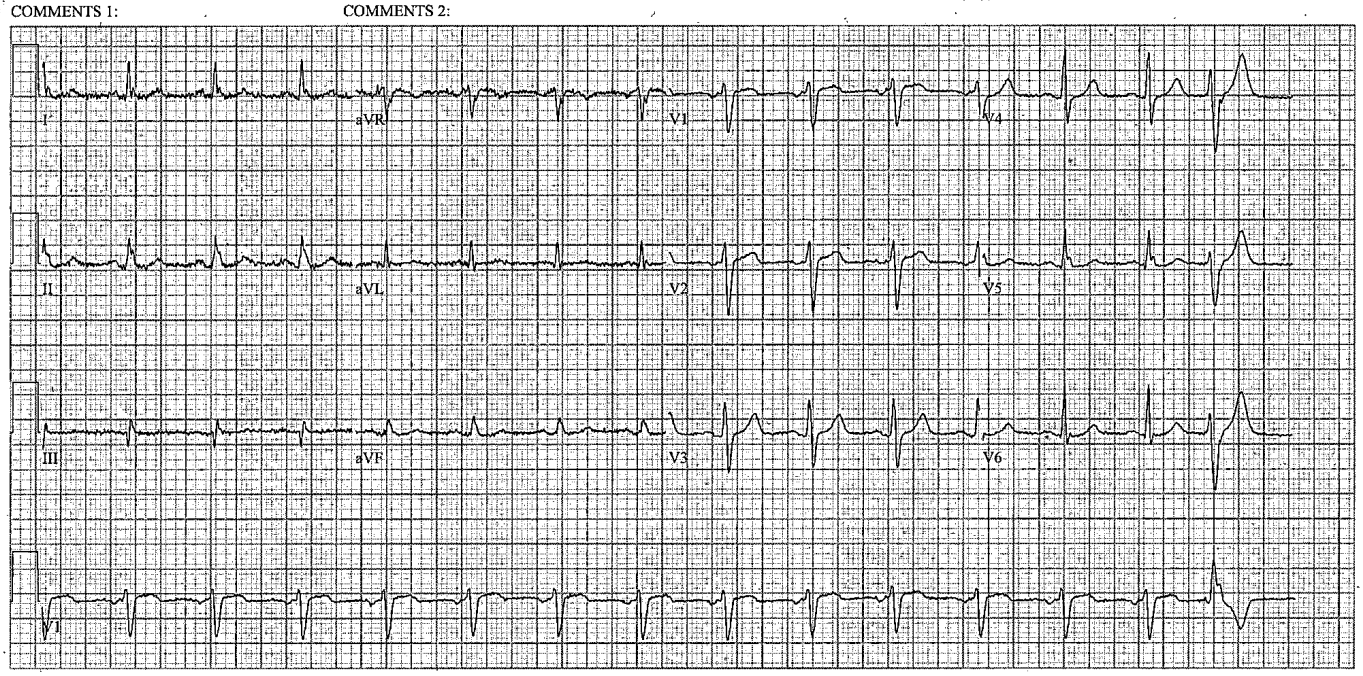
Sinus rhythm with occasional premature ventricular complexes
Otherwise normal ECG

Technician:
Test ind:

Unconfirmed

COMMENTS 1:

COMMENTS 2:



25mm/s 10mm/mV 40Hz 9.0.10 12SL 245 CID: 1505

SID: 3296445 EID:13 EDT: ORDER: