Hot Clinic 4/8/25

NHS GGC Hospitals, Admission Document

56.7 KG

NHS Greater Glasgow and Clyde

Affix Label

Queen Elizabeth University Hospital

CHI: 2012746039

Total Att: **13**

12 Mth Att: **0**

Title: **MR**

HUGHES **Scott Sean**

DOB **20/12/1974** Age: **50y** Sex: **Male**

FLAT 7-6
39 LINKWOOD CRES
Glasgow
Lanarkshire
G15 7EP
07787255019

Next of kin: **HUGHES, Kyle**
Relationship: **Son**

GP: **A Martin**
0141 211 6100

Attendance Date: **28/02/2025** Arrival Time: **13:15**

Registration Time: **13:15** Date of Incident: **28/02/2025**

Major Incident Desc:

Reason for Attendance: **SDUCC OWN - R/O ACS/PE. 4/7 SHARP LEFT SIDED CP WORSE ON INSPIRATION.**

Nursing Assessment

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

Triage Category: **2** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **28/02/2025 13:22** Nurse name: **Nurse Amy Dickson**

Temp	353	C
HR	83	bpm
BP	150/93	mmHg
MAP	112.00	mmHg
RR	21	bpm
SpO2	99	%
Oxygen	0	%

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: **"pleuritic chest pain worse on inspiration "**

Patient ID label

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

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20/12/1974

Date	Emergency Department Notes
	Seen by (Doctor) / Time seen

Differential Diagnosis/Problem List

NEWS ☐ 0-7

RED FLAG ☐ (Tick)

SEPSIS ☐

CURB 65 ☐

Done/ completed	Immediate Managment Plan

Signature: Designation: Page No:

PLEASE DO NOT WRITE HERE

In-Patient Admission Notes

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Seen By: C HAMILTON Print: Time Seen: Pg. No:

PRF Reviewed Yes / No

Presenting Complaint(s)	
Presenting complaint	C. pain
History of presenting complaint	On Tuesday noticed pain across chest whilst walking to football on Tuesday night - pain been present since BLF moved to left side of chest - pain present on deep inspiration & coughing sneezing and on certain movements. Has chronic cough - no more than normal. Now chronically consisted - no different from normal - [illegible] Known COPD - does get SOB on exertion - no different from normal. - No falls injuries - Not working. No PMH DVT - No periods of immobility.

Past Medical History / Review of portal
Emphysema Folic acid deficiency Alcohol dependance Syndrome Epilepsy Pancreatitis Pneumothorax — Traumatic Status.

Systemic Enquiry
Appetite - poor. Lost weight over past 2 years Bit is fatty Bowels ✓ Urine - no UTIs

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MEDICINES RECONCILIATION – Acceptable to staple fully completed Emed Rec

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

Other (please specify)

Admission Medicines			Plan for Medicines (Dr complete)				Comments Reason for alteration
Name	Dose	Freq	Continue	Amend	Withhold	Stop	
Naproxen	500mg	1 BD					
Dihydrocodeine	30mg	1 QID					
Rivaracetam	75mg	1 NOCT					
Atorvastatin	80mg	1 NOCT					
Trelegy Ellipta		INH					
Thiamine	50mg	1 OD					
Easyhaler Salbutamol							
Potassium Citrate + Citric Acid							

Allergies	List any over-the-counter or alternative medicines
NKOA	
	Do medicines need further clarification ? ☐ Yes ☐ No
List collected by :	Plan approved by :
Designation : Date :	Designation : Date :

Pharmacy review	Comments

Compliance aid : ☐ Yes ☐ No	Community pharmacist Phone
Reviewed by : Designation :	Date :

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Social History \ Family History

Smoking History

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

Alcohol History

10-15 a day Roll up)

____ Units/week FAST score if excess ____

Drinks Every other day - 1 1/2 Bottle vodka + a few pints Sunday.

Recreational Drugs **Driving Status**

NO

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

Unemployed

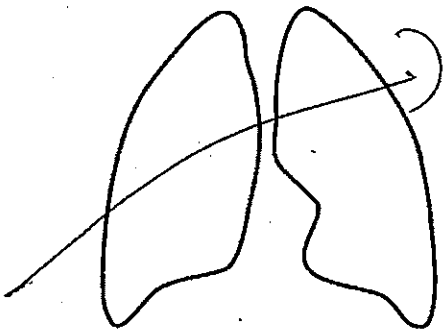
General Examination

Temp: 35.3°	RR: 21
Pulse: 83	CBG:
SpO_2: 99	Weight:
BP: 150/93	Urinalysis:

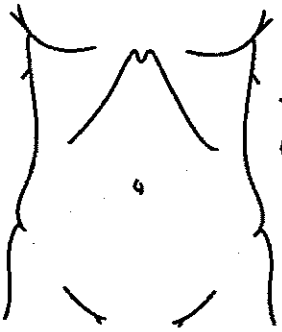
General Appearance:

Alert + orientated

Respiratory



Gastrointestinal System



Cardiovascular

1 + 11 + 0

~~Locomotor~~

Pain on palpation
(L) chest wall

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Neurological system

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

AMT 4 = age, DOB, place, year

AMT score ____ /4

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

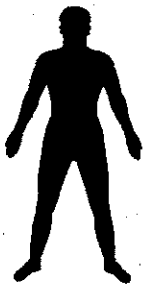
Pupils/fundoscopy:

Cerebellar and extrapyramidal:

Cranial Nerves:

Neck:

Reflexes:



	RUL	LUL	RLL	LLL
Tone				
Power				
Co-ordination				
Sensation				

Plantars: R L

Skin/Other

Cellulitis SCFT new rash

- Localised Rash on torso. — chronic —

WCC 8·2 D-dimer 163 Chol (2)
Hb 140 Co-ag (2)
Plat 173 Trop <4 CRP 5
Gluc 4·8 Bil 11
ALT 142
AST 178
AIP 143
ALB 39

1. 2012746039
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Key Results

CXR

ECG

	APRIL '24	~~FEB~~ 25/12/25	28/12/25
ALT	64	99	142
AST	71	122	178
AIP	99	107	143

(Differential) diagnosis

- C. pain
6P ddx to r/o ACS PTE

Inc MSK pain

NEWS ☐
Red Flag ☐
Sepsis ☐
CURB 65 -1 ☐

Management Plan

Bloods including Trop + D-dim
- ECG
- CXR
- IF Trop ↑ ACS protocol
- IF D-dim ↑ CT PA
IF above NAD discharge home c clarithromycin

Note ↑ derangement IF LFT
HLC or Mr Dargie. For liver screen today to return to SAU in a week for repeat LFTs — asked to attend 10.30 am

☐ Thromboprophylaxis assessed ☐ Medicine Reconciliation ☐ 4AT/TIME
☐ Antimicrobial

Signature: PRINT NAME
PRINT GRADE Page:

Patient ID label

Resuscitation Decision

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

If DNA CPR → Complete appropriate form

Senior Medical review

7/3/25

50 → GPSS

HOT Clinic

BG: emphysema
alcohol XS
epilepsy

seen 28/02 with chest pain –
~~(~)~~ Trl
~~(~)~~ CXR

deranged LFTs

RPT today – much improved

AST 44 ↓ (150)
ALT 51 ↓ (184)
Alk Ph 123 ↓ (189)

CRP + WBC ↑ but no infective symptoms

actively trying to ↓ alcohol intake (gradually)

advice re lifestyle +
meds to monitor LFTs

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

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

Patient ID label

Medical patient thromboprophylaxis decision aid – ENSURE BLACK BOX COMPLETED

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

☐ Yes

☐ No

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

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

☐ Yes

☐ No

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

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

☐ No

☐ Yes

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

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

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

Patient ID label

Results

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

Patient ID label

Post Take Ward Round IAU/ARU

Consultant: _____ Date: _____ Time: _____

Summary

Temp:

Pulse:

BP:

SpO_2:

FiO2:

RR:

Diagnosis:

Plan:

Recommended Destination: _____

Suitable to board if required ☐ Yes ☐ No

Expected Date of Discharge: _____

Signature: _____

Designation: _____

Bleep Number: _____

Patient ID label

Continuation Sheet

Date: Time

Patient ID label

Continuation Sheet	
Date: Time	

Patient ID label

Continuation Sheet

Date: Time	

Patient ID label

Continuation Sheet

Date: Time	

Patient ID label

Nursing Documentation

Done/ Time	

Once only prescriptions (inlcuding tetanus prophylaxis)

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

Discharge prescription packs

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

DISCHARGE CODES: Please Circle

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

Time Ready to Depart								
Discharge Time								
Ward No. (If admitted)		Transfer to Hospital				Consultant (if admitted)		
Outpatient clinic specialty						Admission or specialty clinic consultant		
Clinic Referred to	AE	OP DVT	DME Falls	TIA	Medical	Surgical	First Seizure	Others Specify

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

2012746039
HUGHES M
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Glasgow, Lanarkshire
G15 7EP

	Date	Ward	Time
Admitted			
[illegible]			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 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	[illegible]	[illegible]
Min 12 Hourly Observations	Low Clinical Risk Min 4 Hourly Observation Inform Registered Nurse Agree Frequency of Observation Required		

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

Date:
Time:
Eyes closed by swelling = NT
Endotracheal tube or tracheostomy = NT
Always record the best response
TOTAL
Right size:
Right reaction:
Left size:
Left reaction:
Record right (R) and left (L) separately if there is a difference between the two sides
Record right (R) and left (L) separately if there is a difference between the two sides

Spontaneously 4
To sound 3
To pressure 2
None 1
Not testable NT

Oriented 5
Confused 4
Words 3
Sounds 2
None 1
Not testable NT

Obeys command 6
Localising pressure 5
Normal flexion 4
Abnormal flexion 3
Extension 2
None 1
Not testable NT

Normal power
Mild weakness
Severe weakness
Spastic flexion
Extension
No response

Normal power
Mild weakness
Severe weakness
Spastic flexion
Extension
No response

Pain Score

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

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

Pain Function Score

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

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NEWS 2 Key | T | 2 | 1

HUGHES
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Parameter	Key	Obs 1	Obs 2
Date	[illegible]	18/2/25	19/2/25
Time	[illegible]	03:29	10:15
A + B Respirations Breaths/min			16
A + B SpO2 Scale 1 Oxygen saturation (%)	97	99	98
Air or oxygen?	A	A	A
C Blood Pressure mmHg (Score uses systolic BP only)		140 / [illegible]	108 / 68
C Pulse Beats / min		88	61
D	✓	✓	A
E Temperature		35.[illegible]	36.4
NEWS Total	0	3	

A + B Respirations Breaths/min: ≥25 (3); 21-24 (2); 12-20 (0); 9-11 (1); ≤8 (3)

A + B SpO2 Scale 1 Oxygen saturation (%): ≥96 (0); 94-95 (1); 92-93 (2); ≤91 (3)

SpO2 Scale 2 — Only use scale 2 under direction of qualified clinician: ≥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? Air (A) or O2 device (0); O2 L/min (2)

C Blood Pressure mmHg (Score uses systolic BP only): ≥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: ≥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.: A Alert (0); C New Confusion (3); V Verbal (3); P Pressure (3); U Unresponsive (3)

E Temperature: ≥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)

NEWS Total

[illegible]	70	
[illegible]	OA	
[illegible]	10.20	
[illegible]	N	
[illegible]	N	
[illegible]	23.00	
[illegible]	N	
[illegible]	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)

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NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

[illegible]

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.

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

Hospital (circle)	IRH	RAH	RHSC	GRI	WIG	VI	VIMIU	Stob	VOI	SCH

Queen Elizabeth University Hospital

CHI: 2012746039

Total Att: **12**

12 Mth Att: **1**

Title: **MR**

HUGHES **Scott Sean**

DOB **20/12/1974** Age: **47y** Sex: **Male**

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39 LINKWOOD CRES
Glasgow
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07787255019

Next of kin: **HUGHES, Kyle**
Relationship: **Son**

GP: **A Martin**
0141 211 6100

Attendance Date: **06/08/2022** Arrival Time: **17:16**

Registration Time: **17:16** Date of Incident: **06/08/2022**

Major Incident Desc:

Reason for Attendance: **MIU virtual cons. R shoulder injury. Attend 17.30**

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **06/08/2022 17:55** Nurse name: **Nurse Cara Loomes**

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

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes:

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

2012746039 Scottsean Hughes

Date	CLINICAL NOTES
	Seen by (Dr) Coralcomes.enp. Time seen 1830

06/08/22.

PC/ C/O shoulder injury - RHD.

HPC/ States was intoxicated last night was getting up from chair, mechanical fall to ground, impact C/O shoulder pain +++ on getting up this morning difficulty using arm today. Phoned NHS 24 who advised ED. Has taken dihydrocodine for pain with little effect. Looks sore.

PMHx
Alcohol Dependent.
Epilepsy.

DHx NKDA unemployed
see ECS.

Look swollen over shoulder. No bruising. No wounds, NO obvious deformity

Feel No pain on palpation c-Spine, Scapula, SCJ, clavicle humeral head, humerus! Isolated tenderness ++ ACJ. NV intact, CRT <2seconds. No Altered sensation. Axillary nerve ✓

Move ↓ Reduced ROM due to pain can Abduct 0-100° resisted ✓

Date	CLINICAL NOTES
	extension 0-45° resisted ✓ flexion 0-90° resisted ✓ X-RAY shoulder + ACJ views Imp: Grade 2 ACJ disruption pain ++, swelling and reduced ROM. polysling and VFC flu. warsening advice given

Discharge Codes (Please CIRCLE)					Discharge date	06/08/22
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)		Discharge time	
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.		

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

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

CHI: 2012746039

Queen Elizabeth University Hospital

Total Att: **10**

12 Mth Att: **0**

Title: **MR**

HUGHES

Scott Sean

DOB: **20/12/1974**

Age: **44y**

Sex: **Male**

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07787255019

Next of kin: **HUGHES, Kyle**
Relationship: **Son**

GP: **A Martin**
0141 211 6100

Attendance Date: **06/11/2019**

Arrival Time: **21:40**

Registration Time: **21:40**

Date of Incident: **06/11/2019**

Major Incident Desc:

Reason for Attendance: **? stroke**

Nursing Assessment

Alerts: **Not Recorded**

Allergies: **Not Recorded**

Pain Score:

Triage Category: **1**

Tetanus up to date/fully immunised:

Presenting Complaint: **Neurological Motor Weakness Right**

Observation Date: **06/11/2019 21:42**

Nurse name: **Nurse Karen Bowden**

Temp	**35.9**	C
HR	**76**	bpm
BP	**143/109**	mmHg
MAP	**120.33**	mmHg
RR	**15**	bpm
SpO2	**98**	%
Oxygen		%

BM	**4.3**	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm

Visual Acuity	
Left	
Right	
Corrected?	

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

Pupils-Right		Pupils-Left	
Size (mm)	**3**	Size (mm)	**3**
Reaction	**Y**	Reaction	**Y**

Nursing Notes:

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider a		
History variable between accou		
Examination not compatible wi		
Delay in presentation		
Fracture/head injury or significa		

Discuss wi identified

X-Ray and Other Repor is not being admitted)

Printed: 06/11/2019 21:47:36

Patient Sample Report

Status: **ACCEPTED**
Analyzed: 06/11/2019 21:47:27
Sample Type: **Venous**
Operator ID: ANDREW HANLON0

Patient

ID:	2012746039
Last Name:	**HUGHES**
First Name:	**SCOTT**
Gender/Age:	Male, 44 years
Birth Date:	20/12/1974

Cartridge

Lot No.:	190925A
S/N:	000000000500028557
Exp. Date:	22/11/2019

Analyzer

Model:	GEM® *Premier 5000*
Area:	AH_L0ED_A
Name:	ED-POD
S/N:	17030622

Results

			Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)						
cH	**42.9**	nmol/L	--	--	--	--
pCO_2	**6.3**	kPa	--	--	--	--
pO_2	**5.2**	kPa	--	--	--	--
Na^+	**141**	mmol/L	--	133	146	--
K^+	**4.2**	mmol/L	--	3.5	5.3	--
Cl^-	↑ **110**	mmol/L	--	95	108	--
Ca^{++}	**1.16**	mmol/L	--	1.15	1.27	--
Hct	**52**	%	--	--	--	--
Glu	**5.7**	mmol/L	--	3.5	6.0	--
Lac	**1.4**	mmol/L	--	0.6	2.2	--
CO-Oximetry						
tHb	**166**	g/L	--	--	--	--
O_2Hb	↓ **67.1**	%	--	95.0	98.0	--
COHb	↑ **4.9**	%	--	0.5	1.5	--
MetHb	↓ **0.4**	%	--	0.5	1.5	--
HHb	↑ **27.6**	%	--	0.0	5.0	--
sO_2	↓ **70.9**	%	--	95.0	98.0	--
Derived						
BE(B)	**1.3**	mmol/L	--	--	--	--
HCO_3^-(c)	**27.2**	mmol/L	--	--	--	--
Hct(c)	**50**	%	--	--	--	--

↑↓ Outside Reference Range

Other Information

Operator Entered

Temp 37.0 °C

D E

I

ONCE C ...laxis)

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

Date	CLINICAL NOTES
	Seen by (Dr) Time seen

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Date	CLINICAL NOTES

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

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

QEUH – South Glasgow Stroke Service

Stroke admission document **(Version 6. 11/17)**

NHS Greater Glasgow and Clyde

Patient details

Name: SCOTT HUGHES

DOB:

Age: 44 Unit no/CHI: 2012746039

Admission date:
Referral date (if different): 6/11/19

Referral time: 6/11/19

Referred from: GO RESUS

Seen: 22:00

Presenting complaint

Date and time of onset (if known):

Handedness: R / L / Not Known

Details:

PATIENT NOT ABLE TO GIVE CLEAR ONSET TIME STATES THAT (12) AM WAS INITIALLY TINGLING THEN PAINFUL INCREASED ZONE AND THEN NUMB

WIFE AND SON STATE SYMPTOMS ONSET AT 1800HRS WHEN AFTER DETERMINE FROM AUD. — STATES THAT HAND WENT INTO CHAIR SHAPE AND WERE UNABLE TO STRAIGHTEN FINGERS

— CURRENTLY SYMPTOMS MORE EVEN SOMEWHAT BUT ONGOING NUMBNESS

NO HEADACHE, NO VISUAL DISTURBANCE

NO ✓ SPEECH OR LANGUAGE DISORDER

Systematic enquiry

CVS:

GUS:

RS:

LMS:

Abdo:

Other:

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PATIENT STATES THAT DOESN'T TOLERATE MEDICATIONS FOR EPILEPSY AND DOESN'T TAKE THEM ANYMORE AND SON CONFIRM. — UNKNOWN SEIZURES OCCUR IN CURRENT PATIENT LOSES CONSCIOUSNESS AND GENERALISED SHAKING

Medicine Reconciliation

Medical History Sources

GP	☐	Clinic Letter	☐
GP Letter	☐	Community Pharmacy	☐
Patient	☐	ECS	☐
Relative	☐	Other	☐

Admission medicines			Plan for medicines (tick one)				Comments
Name	Dose	Freq	Continue	Amend	Suspend	Stop	
OMEPRAZOLE	20mg	OD					
TRAMADOL	100mg	PRN					
LEVETIRACETAM	1000mg	BD					
CO-TYRAMOL	10/500	2 2 3 2 4-6 U					

Allergies: NKDA None known ☐

Compliance Aid:

Medicines reconciliation:

Is the medication history complete? Yes ☐ No ☐ Is pharmacy review required? Yes ☐ No ☐

Date of pharmacy review: _____ Medicines history source/s: _____

Pharmacy signature: _____ Print name: _____

Stroke risk factors (tick if yes)		Details:
Hypertension	☒	
AF	☐	
Diabetes	☐	
Prev. TIA/stroke	☐	
Hyperlipidaemia	☐	
PVD	☐	
IHD	☐	
Migraine	☐	
HRT/OC pill	☐	

Smoking: current / ex / never Amount per day ____

Alcohol: 30-60 UNITS Units per week ____

Other substances:_____

Occupation: PREVIOUSLY WORKED FOR ATT.

Driver: Yes / No Car/Cat 2

Family History

Other Past Medical History

PREVIOUS ALCOHOLIC HEPATITIS

EPILEPSY

SCIATICA

ACUTE PANCREATITIS

ACCIDENTAL PARACETAMOL OVERDOSE

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Social circumstances

Mobility:

IND

Basic ADL(dressing, toileting etc):

IND

Family / Carer support:

LIVES WITH WIFE ANDSON.

Accommodation:

- 2 storey
- Bungalow
- Flat (which level)

Other

General examination	Resp
BP 150/90	CLEAR
CVS : HS: 1 & 11 Carotid Bruits Oedema	**Abdo**
Musculoskeletal	**Other**

Neurological assessment

GCS:

Eye ____ Motor ____ Verbal ____ **TOTAL:** 15 /15

AMT: (if conscious and no language disorder)

Not applicable (i.e. unconscious, dysphasia etc) □
Age □
Year □
DOB □
Place (name of hospital or building) □ **TOTAL:** 4/4

NIH Stroke Scale

	DATE	6/11								
1a Level of Consciousness	Time	7:30								
Alert	0	0								
Not alert, fully rousable with minimal stimulation	1									
Not alert, requires repeated stimulation to attend	2									
Coma, reflex movements only	3									
1b Level of Consciousness – ask patient the month and their age (do not provide clues)										
Answers both correctly	0	0								
Answers one correctly (or unable to speak due to physical barrier e.g. ET tube)	1									
Answers both incorrectly (or aphasic or stuporous)	2									
1c Level of Consciousness – ask patient to open and close eyes and nonparetic hand (score 1st attempt)										
Obeys both correctly	0	0								
Obeys one correctly	1									
Obeys both incorrectly	2									
2 Best Gaze – only horizontal eye movements; reflexive movements if coma/aphasia (investigator discretion if visual impairment)										
Normal	0	0								
Partial gaze palsy (or conjugate gaze which can be overcome, or isolated III, IV or VI palsy)	1									
Forced deviation (or conjugate gaze) not overcome by oculocephalic manoeuvre	2									
3 Visual Field Testing (test in good eye if unilateral blindness or enucleation). Use confrontation/startle response if aphasia										
No visual field loss	0	0								
Partial hemianopia (asymmetry, including quadrantanopia, or visual extinction)	1									
Complete hemianopia (or coma: 1a=3)	2									
Bilateral hemianopia (or blind from any cause, including cortical blindness)	3									
4 Facial Paresis – ask to show teeth (or grimace to stimuli), raise eyebrows and close eyes tightly										
Normal symmetrical movement	0	0								
Minor paralysis (flattened nasolabia fold, asymmetry on smiling)	1									
Partial paralysis (total or near total paralysis of the lower face)	2									
Complete paralysis of one or both sides (paralysis of upper and lower face) (or coma: 1a=3)	3									
5 Motor Function Arm – alternate extended right and left arms with palms down at 90 degrees if sitting (or 45 degrees if supine)										
	R	L	R	L	R	L	R	L	R	L
Normal (holds arm at 90 degrees sitting or 45 degrees supine for 10 sec, without drift)	0	0	0	0						
Drift but does not hit bed	1	1								
Drifts to bed but some effort against gravity	2	2								
No effort against gravity	3	3								
No movement (or coma: 1a=3)	4	4								
Tick if untestable (only if joint fusion or limb amputation)	U	U								
6 Motor Function Leg – alternate extended right and left leg at 30 degrees for 5 seconds when supine										
	R	L	R	L	R	L	R	L	R	L
Normal (holds leg at 30 degrees for 5 sec, without drift)	0	0	0	0						
Drift but does not hit bed	1	1								
Drifts to bed but some effort against gravity	2	2								
No effort against gravity	3	3								
No movement (or coma: 1a=3)	4	4								
Tick if untestable (only if joint fusion or limb amputation)	U	U								
7 Limb Ataxia – finger-nose, heel-shin on both sides (only if disproportionate to weakness) U=untestable (joint fusion/amputation)										
No ataxia (or cannot understand or is paralysed or comatose)	0	0								
Present in one limb	1									
Present in two limbs	2									
8 Sensory – pin prick to test arms, legs, trunk and face (compare both sides). Abnormal if due to stroke only. NB .May be bilateral										
Normal	0									
Mild to moderate decrease in sensation – still aware of touch	1	1								
Severe to total sensory loss clearly visible (or no response and quadriplegia, or coma: 1a=3)	2									
9 Best Language – describe picture, name items or objects, read sentences (ask patient to write if intubated)										
No aphasia	0	0								
Mild to moderate aphasia, loss of fluency or comprehension	1									
Severe aphasia, fragmented communication	2									
Mute. No usable speech or comprehension, not follows one-step commands (or coma: 1a=3)	3									
10 Dysarthria – read several words or spontaneous speech if aphasic/unable to read										
Normal articulation	0	0								
Mild to moderate slurring of words	1									
Near unintelligible or unable to speak (or coma: 1a=3)	2									
Tick if untestable (only if intubated or other physical barrier to speech)	U									
11 Extinction and Inattention – visual, tactile, auditory, spatial or personal inattention										
Normal (also if severe visual loss but sensation normal, or aphasic but attends both sides)	0	0								
Inattention or extinction to bilateral simultaneous stimulation in one of the sensory modalities	1									
Severe hemi-inattention to more than one modality (not recognise hand, orients to one side)	2									
TOTAL (each column)		1								
Examiner's initials		KM								

Neurological assessment (continued)

Initial NIH Stroke Scale score (see previous page): **TOTAL:** ____

Additional details (free text)

VARIABLE MOVEMENT OF RIGHT
HAND E.G. CAN MOV GRIP FINGERS
BUT IS ABLE TO USE HAND
(INCLUDING FINGER FLEXION/EXTENSION)
TO POINT TO VISUAL STIMULUS

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Initial Investigations (if not carried out immediately, enter date requested)							Date Requested
Bloods	Glucose		Cholesterol		Other		
	HbA1C indicated?	Y / N	TGs				
ECG							
CT	POSSIBLE SINUSITIS – NO OVERT ACUTE FINDINGS						
MRI							
CTA							
CTP							
Other							

Diagnosis

TIA: Anterior □ Posterior □ Ocular □ Uncertain □

Stroke: TACS □ PACS □ LACS □ POCS □ Ocular □ Uncertain ☑

Type: Ischaemic □ Haemorrhagic □ Awaiting scan □ Not known □

No. of episodes: Single □ Recurrent / multiple □

OR non TIA/stroke diagnosis: (specify)

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MOST LIKELY SEIZURE RELATED PATHOLOGY

- DESPITE MILD INTOXICATION I THINK PATIENT RETAINS CAPACITY AND ∴ IF WISHES TO SELF DISCHARGE I WOULD NOT THINK EDC WOULD BE APPROPRIATE.

Management (see appropriate guidelines)

Thrombolysis □ **(see checklist, if eligible → contact senior on call immediately)**

Other (specify): (e.g. pyrexia, infection, hypoxia, swallow status, hydration, medication review etc.)

(1) FEEL MOST LIKELY PARTIAL SEIZURE EVENT. HOWEVER NOT TYPICAL OF PREVIOUS SEIZURES SO WOULD ADVISE ADMISSION FOR Ix OF POTENTIAL STROKE E.G. MRI (AND NO REFER INFORMATION OBTAINED) IF THIS DOESN'T HAPPEN EVEN I WOULD NOT FOLLOW-UP AS POSSIBLE TIA.

(2) WOULD BE FOR GEN MED ADMISSION WITH FAST TRACK MRI

(3)

Can patient walk to bathroom?
If not prescribe IPCs (if not contra-indicated)

Prescribed: Yes/No

Initial swallowing status (in discussion with nursing staff / SLT):

Normal □

Possibly or definitely unsafe □ → **Keep NBM and arrange SLT review**

Communication

D/W PATIENT.

Who? _____
None available □

PATIENT UNABLE TO SIGN DISCHARGE:

- I HAVE BEEN INFORMED OF MEDICAL ADVICE TO STAY IN HOSPITAL FOR FURTHER TESTS E.G. MRI SCAN TO EXCLUDE ~~THE~~ CEREBROVASCULAR ACCIDENT OR STROKE
- I ACCEPT THE RISKS ASSOCIATED WITH DISCHARGE INCLUDING STROKE LEADING POTENTIALLY TO DISABILITY AND OR FATALITY.

PATIENT SIGNATURE. [signature] WITNESS: [signature]

Research studies

DOCTOR: [signature]

Signature	Print name	Designation

Senior review: Date: Time:

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Thrombolysis referrals only:

Referring hosp _____
Time arrived at above _____
Time referred _____
Time arrived SGH ASU ____

Pre-lysis NIH score _____
Weight: ____ Kg
Bolus dose: ____ mg
Time given: ___:___

Infusion dose: ____ mg
(Given over 1 hour)

Discussed with:	Info sheet:
Patient ☐	☐
Relatives/NOK ☐	☐

Who (name):_____
Relationship:_____

Signature **Print name** **Designation**

Date/ Time	Clinical notes:	Signature

Date/ time	**Clinical notes:**	Signature

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Date/ time	**Clinical notes:**	Signature

Date/ time	**Clinical notes:**	Signature

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Date/ time	**Clinical notes:**	Signature

Blood tests	Date:									
	Range									
Hb	11.5–165 (F)									
WCC	4 – 11									
Plt	150 – 440									
MCV	76 – 99									
ESR	0 - 7									
PT.	10.7 – 13.1									
APTT	20.3 – 32.9									
Fibrinogen	1.5 – 4.0									
D-Dimer	< 500									
INR										
Glucose (random)	3.5-6.0									
Glucose (fasting)	3.5-6.0									
HBA1C	3.9 – 5.9									
Sodium	135 – 145									
Potassium	3.5 – 5.0									
Chloride	97 – 107									
Bicarbonate	23 – 30									
Urea	2.5 – 7.0									
Creatinine	40 – 130									
EGFR	>60									
CRP	< 10									
Total protein	62 – 82									
Alb	36 – 49									
Bilirubin	< 20									
ALP	60 – 260									
AST	< 40									
ALT	< 40									
GGT	F<30, M<50									
Adjusted Calcium	2.15 – 2.60									
Cholesterol	< 5.2									
Triglycerides	0.5 – 3									
Chol/HDL Ratio										
Other:										

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NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name
Addr


CHI No.
DoB

	Date	Ward
Admitted		
Transferred		
Transferred		

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

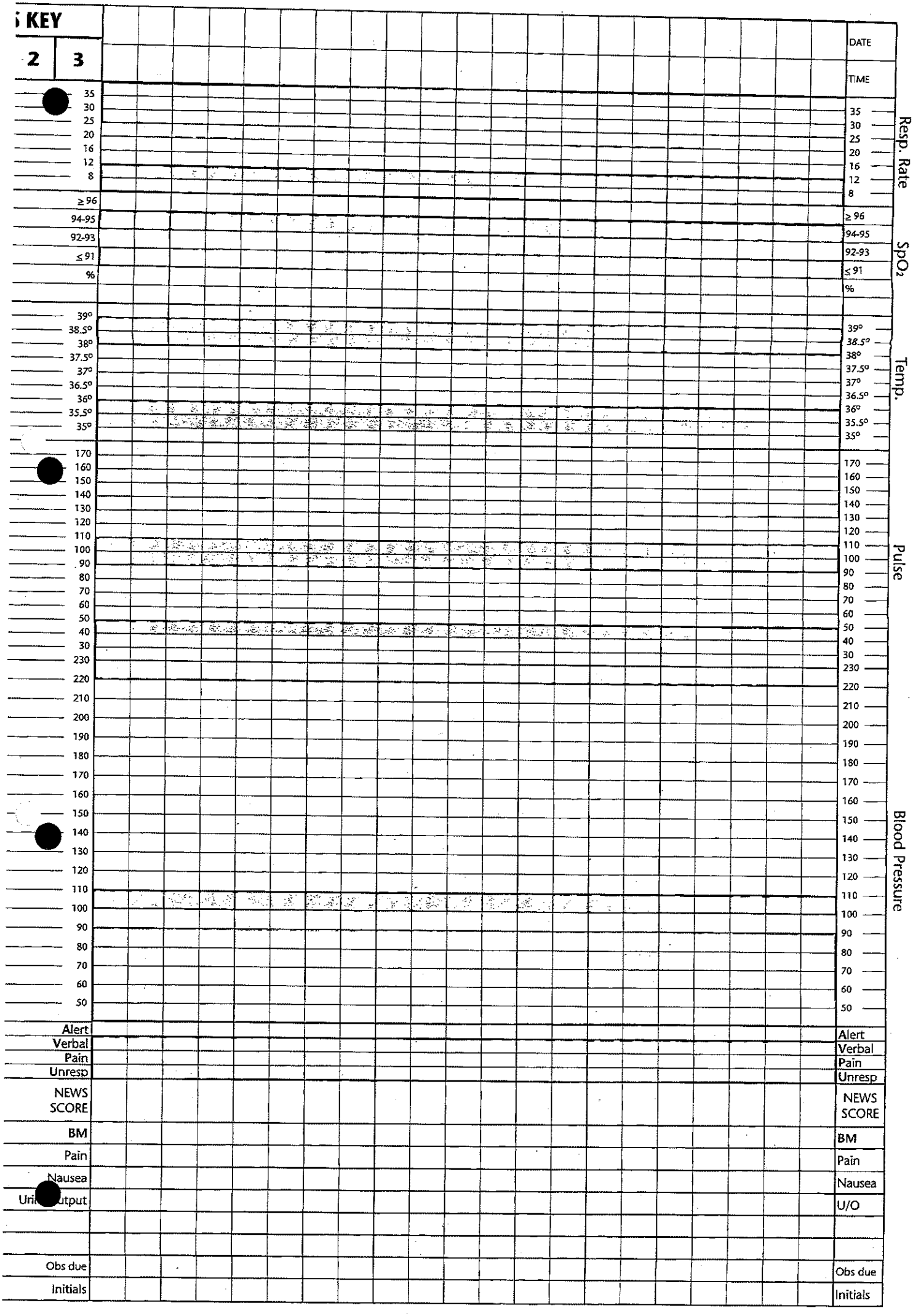
NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

See NEWS Actions Reference Tool for local escalation policy

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

DATE:	6/11
TIME:	2140
Resp. Rate (Mark: •) — 35, 30, 25, 20, 16, 12, 8	
SpO_2 (Enter Value) — ≥96	99
94-95	
92-93	
≤91	
Any Sup'l O_2 %	
Room air	✓
Temp. (Mark: X) — 39°, 38.5°, 38°, 37.5°, 37°, 36.5°, 36°, 35.5°, 35°	
Pulse (Mark: •) — 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40, 30	
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	
Conscious Level (Mark: •) — Alert, Verbal, Pain, Unresp	
Total NEWS (with all obs)	1
BM	4.3
Pain	0
Nausea	0
Urine output	N/U
Obs due	[illegible]
Initials	KB

DATE	NEWS	
TIME	0	1
35, 30, 25, 20, 16, 12, 8		
≥96, 94-95, 92-93, ≤91, %		
39°, 38.5°, 38°, 37.5°, 37°, 36.5°, 36°, 35.5°, 35°		
170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40, 30		
230, 220, 210, 200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50		
Alert, Verbal, Pain, Unresp		
NEWS SCORE		
BM		
Pain		
Nausea		
U/O		
Obs due		
Initials		


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

Glasgow Coma Scale

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

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Neurological Observations

Date:				6/11
Time:				2140
COMA SCALE	E – Eyes open	Spontaneously	4	o
		To speech	3	
		To pain	2	
		None	1	
	V – Best Verbal response	Orientated	5	o
		Confused	4	
		Inappropriate words	3	
		Incomprehensible sounds	2	
		None	1	
	M – Best motor response	Obeys	6	o
		Localises	5	
		Flexion - withdrawal	4	
		Flexion - abnormal	3	
		Extension to pain	2	
		None	1	
TOTAL SCORE				15
PUPILS	R	Size		3
		Reaction		+
	L	Size		3
		Reaction		+
LIMB MOVEMENT	ARMS	Normal power		L
		Mild weakness		R
		Severe weakness		
		Spastic flexion		
		Extension		
		No response		
	LEGS	Normal power		L
		Mild weakness		R
		Severe weakness		
		Spastic flexion		
		Extension		
		No response		

Eyes closed by swelling = C

Endotracheal tube or tracheostomy = T

Usually record the best arm response

+ reacts
– no reaction
c. eyes closed

Record right (R) and left (L) separately if there is a difference between the two sides

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

Patient Information		Date:	06/11/2019
SCOTT HUGHES		Incident Number:	CR006005999
Age/Gender:	44y Old Male	Incident Type:	EMG
Address:	7/6 7/6 39 LINKWOOD CRESCENT DRUMCHAPEL GLASGOW,G15 7EP	Incident Location:	7/6 7/6 39 LINKWOOD CRESCENT DRUMCHAPEL GLASGOW, G15 7EP
DOB:	20/12/1974		
CHI:	2012746039		
Ethnicity:			

Scottish Ambulance Service

Presenting Complaint

POSS CVA/TIA

Additional Comments

SUDDEN ONSET OF PAIN/NUMBNESS NECK/SHOLDER R SIDE AT 18:00 HRS ALSO HEADACHE .PATIENT HAS BEEN DRINKING 4XGUINNESS/4 DOUBLE VODKAS TONIGHT.

PATIENT ASSESSMENT

AVPU	Alert		<C>	No			
A	Clear						
B							
C	Pulse Rate	BP		Cap Refill	ECG Rhythm		
	80	174/99					
	Rhythm	Arm		Central/Peripheral	ECG		
	Reg						
D	GCS	Eyes		Voice	Motor	PEARL	
	15	Spontaneously (4)		Orientated (5)	Obeys Commands (6)		
E							

Observations

Time	P	RR	BP	SpO2	CR	GCS	AVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
21:20	78	18	170/98			15	Alert								E0005320
21:05	80	20	174/99	98		15	Alert		36.8	3.6					E0005320

NEWS

Time	Clinical Risk	NEWS
21:20		0
21:05		0

HISTORY

AMPLE

Allergies	Unknown

Medication	WITH TREATMENT
Past Medical History	Hypertension, TIA, EPILEPTIC
TIA	When:5 6 YEARS AGO

MEDICAL

Stroke

Face	Negative
Arms	Positive
Speech	Negative
Time	Less than 4.5hrs or Unknown

G15 7EP
Glasgow, Lanarkshire
39 LINKWOOD CRES
FLAT 7-6
Scott, S
M
20/12/1974
HUGHES
2012746039

BM Checked	Yes	Pre Alert	Yes

CLOSE RECORD

Treatment On Scene	Emergency

Conveyance

Transport To Hospital	Emergency driving	Pre Alert	Yes

INCIDENT LOG

Time Call Received	19:36	Allocated	20:30	Mobile	20:30
First Resource On Scene		Crew On Scene	20:53	Crew Left Scene	21:13
Crew At Hosp		Receiving Hospital	QUEEN ELIZABETH UNIVERSITY HOSPITAL	Clear Time	

Crew ID	Crew Grade	Driver
E0028258	Paramedic	YES
E0005320	Ambulance Technician	NO

Patient Information		Incident Date:	24/06/2018
SCOTT SEAN HUGHES		Incident Number:	CR004737457
Age/Gender:	43 years 0 months 0 days Old Male	Incident Type:	EMG
Address:	2012746039	Incident Location:	OS 12 SHAFTON ROAD KNIGHTSWOOD GLASGOW, G13 2NE
DOB:	20/12/1974		
CHI:			
Ethnicity:	White Scottish		

Scottish Ambulance Service

Presenting Complaint

SIEZURE

Additional Comments

KNOWN EPILEPTIC WHO HAS HAD A WITNESSED SIEZURE 18.25HRS. PARTNER STATES LASTED FOR 1MIN. STATES HE TAKES SIEZURES DAILY HAS STOPPED TAKING HIS KEPRA GP KNOWS AND IS TAKING HASH TO SEE IF IT HELPS [IS INSIDE HIS OMEPRAZOLE BOX]. HAS BEEN DRINKING TODAY. O/A PT IN GARDEN AND PARTNER REFUSING TO LET HIM IN HOUSE.

PATIENT ASSESSMENT

AVPU	Alert		<C>		
A	Clear				
B					
C	Pulse Rate	BP	Cap Refill	ECG Rhythm	
	93	126/89	<=2 Secs	Sinus Rhythm	
	Rhythm	Arm	Central/Peripheral	ECG	
	Reg	Right		3 Lead	
D	GCS	Eyes	Voice	Motor	PEARL
	15	Spontaneously (4)	Orientated (5)	Obeys Commands (6)	Yes
E					

Observations

Time	P	RR	BP	SpO2	CR	GCS	AVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
19:45	88	18	120/89	100	<=2s	15	Alert		36.1	6.3	Sinus Rhythm				E001673X
19:30	93	18	126/89	97	<=2 Secs	15	Alert		36.1	6.3	Sinus Rhythm				E001673X

NEWS

Time	Clinical Risk	NEWS
19:45		0
19:30	LOW Immediate Clinical Risk. Treat as per Clinical Practice Guidelines including considering the use of alternative pathways (if appropriate and available).	1

Drugs

HISTORY

AMPLE

Allergies	None
Medication	KEPRA [STOPPED TAKING IT] / OMEPRAZOLE
Past Medical History	Epilepsy
Last Eaten	>4 Hours Ago
Events Prior	WITNESSED SIEZURE

[redacted] CARE RECORD

CLOSE RECORD

Treatment On Scene	Non Emergency	Conveyance	

04/12/386046

1/2

Incident Number: CR004737457

6/24/2016

Transport To Hospital	Normal driving	Pre Alert	No

INCIDENT LOG

Time Call Received	18:25	Allocated	19:15	Mobile	19:17
First Resource On Scene		Crew On Scene	19:27	Crew Left Scene	19:38
Crew At Hosp		Receiving Hospital	QUEEN ELIZABETH UNIVERSITY HOSPITAL	Clear Time	

Crew ID	Crew Grade	Driver
E001673X	Ambulance Technician	YES
E0023116	Paramedic	NO

X ray MAJ 8

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

CHI: 2012746039

Queen Elizabeth University Hospital

Total Att: **9**

12 Mth Att: **0**

Title: **MR**

HUGHES **Scott Sean**

DOB: **20/12/1974** Age: **43y** Sex: **Male**

12 Shafton Road

Glasgow
G13 2NE
07787255019

Next of kin: **HUGHES, Kyle**
Relationship: **Son**

GP: **D Taylor**
0141 954 8860

Attendance Date: **27/03/2018** Arrival Time: **23:08**

Registration Time: **23:08** Date of Incident: **27/03/2018**

Major Incident Desc:

Reason for Attendance: **fall down stairs - multiple injuries**

Nursing Assessment

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

Triage Category: **2** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **27/03/2018 23:30** Nurse name: **Nurse Karen Droy1**

Temp		C
HR	120	bpm
BP	158/95	mmHg
MAP	116.00	mmHg
RR	14	bpm
SpO2	97	%
Oxygen		%

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

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

Pupils Right		Pupils Left	
Size (mm)	3	Size (mm)	3
Reaction	Y	Reaction	Y

Nursing Notes: **"multiple injuries. fallen down 13 stairs lastnight- unable to recall events ? ETOH at time. insure if LOC. bump to head. lac to bridge of nose. c/o back pain, neck pain. swelling to left ankle. no c-spine tenderness. "**

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES
	Seen by (Dr) Time seen

280318 0230 K. FAIR - FY2

43 →

- Fall down 15 stairs
- 4am 27/03/18
- Cannot recall fall - wife heard him fall and when he did not come back to bed she found him lying at bottom of stairs moaning.
- Once up he was acting strangely (eg trying to urinate in cupboard)
- Ongoing headache
- No vomiting, no seizures, ~~etc~~
- ongoing pain left foot
- Pain bridge of nose.

PMHx
Generally well
epilepsy

DHx
NKDA
Keppra

SHx
lives with wife
~~H~~ smokes 10/day
2-3 beers most days.

& O/E
smell of alcohol

Facial nerve intact
sensation face (N)
PEARL
Coordination (N)
No pronator drift
Power 5/5 all limbs.

orientated to time place + person.

tender C8/T1-2

Lt leg
- Pain on palpation of Proximal fibula.
- Dorsiflexion on calf squeeze
- Medial malleolus ok
- lateral malleolus-tender
- CRT 2 secs
- swelling mid foot ++ - mid foot
  c/o ↓ sensation on swollen areas

Date	CLINICAL NOTES

Xrays

Lt foot - broken 3rd metatarsal

Lt ankle - No #

L proximal fibula - No #

CT head + Neck - No evidence of intracranial or spinal injury.

(P) Discharge
Walking boot
analgesia
Advice leaflet.

Dr Katherine Fair
Foundation Tra...
GMC 7517625 Page No.....

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
280318	CO-CODAMOL 30/500	2	PO	QDS	KRew	KRew

(22)

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

CHI: 2012746039

Queen Elizabeth University Hospital

Total Att: 7

12 Mth Att: 1

Title: **MR**

HUGHES **Scott**

DOB: **20/12/1974** Age: **41y** Sex: **Male**

4 TALLANT TERRACE
FLAT 0/2
Glasgow
Lanarkshire
G15 7NZ
0141 944 3853

Next of kin: **HUGHES, Kyle**
Relationship: **Son**

GP: **A Martin**
0141 211 6100

Attendance Date: **31/12/2015** Arrival Time: **06:35**

Registration Time: **06:35** Date of Incident: **31/12/2015**

Major Incident Desc:

Reason for Attendance: **assault**

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **31/12/2015 06:39**

Temp	35.3	C
HR	96	bpm
BP	156/99	mmHg
MAP		mmHg
RR	22	bpm
SpO2	96%	%
Oxygen	2l	%

Nurse name: **Nurse Karen Ann Robertson**

BM	4.7	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: **"999, alleged assault, HI, punched and kicked about the head, ?assault happened 2-3hrs prior to ambulance being called. hx epilepsy. "**

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

HUGHES, SCOTT ID: 2012746039 31-Dec-2015 6:44:34 SOUTH GLASGOW UNIVERSITY HOSPITAL

20-Dec-1974
Male Caucasian

Loc: 301

[redacted]

Technician: 333
Test ind:

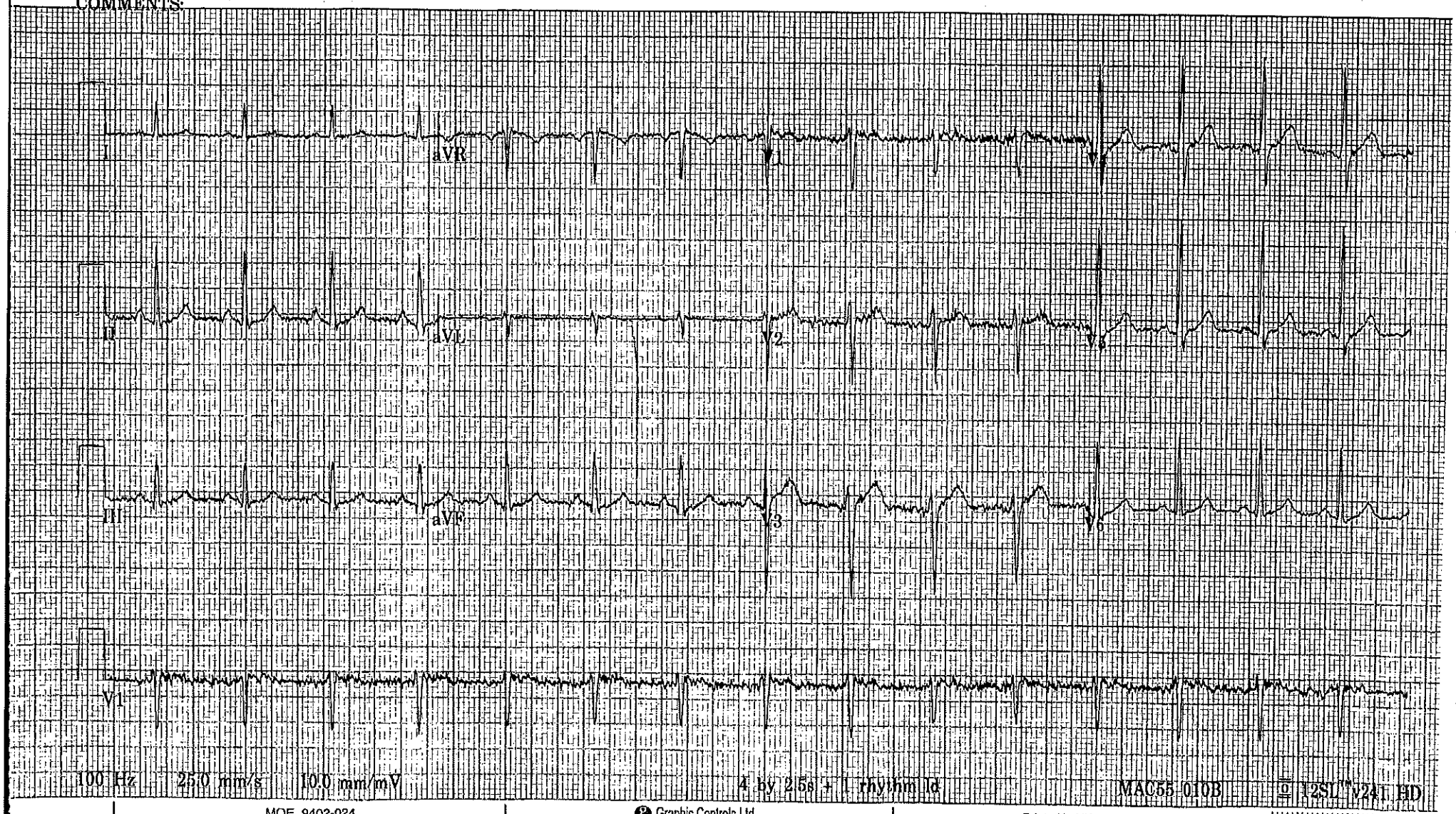
Vent. rate	92 bpm
PR interval	128 ms
QRS duration	82 ms
QT/QTc	342/422 ms
P-R-T axes	69 57 56

Normal sinus rhythm
Normal ECG

Referred by: SGAE

Unconfirmed

COMMENTS:



MQE 9402-024 Graphic Controls Ltd Printed in UK

E-Pass PATIENT REPORT

Time	06:28	Date	31/12/2015

PATIENT AND INCIDENT DETAILS

Incident number	CR002627448.001
Name	SCOTT HUGHES
Age	41 years
Date of birth	20/12/1974
Gender	Male
Incident location	0/2 4 TALLANT TERRACE DRUMCHAPEL GLASGOW
Incident post code	G15 7NZ
Incident type	EMG
Call received	31/12/2015, 05:42
Call passed	31/12/2015, 05:42
Crew mobile	31/12/2015, 05:43
Crew at scene	31/12/2015, 05:52
Crew left scene	31/12/2015, 06:12
Receiving hospital and department	QEUH Queen Elizabeth University Hospital

PRIMARY SURVEY

RESPONSE	
AVPU	Alert
AIRWAY	
Airway assessment	Clear
BREATHING	
Breathing rate	Normal
Respiratory rate	16

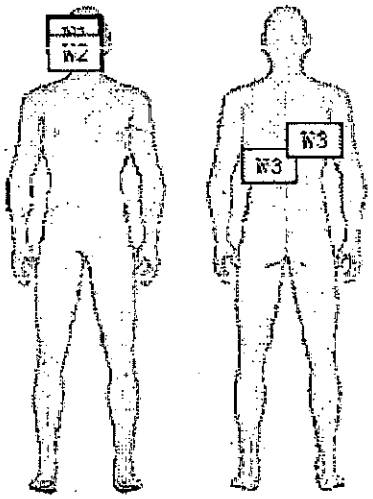
2012746039 20/12/1974
HUGHES
Scott

CIRCULATION	
Pulse rate	Fast
Most peripheral pulse found	Radial
Cap refill rate	<2 secs
Skin colour	Normal
Skin texture	Dry
Blood loss	External

C-SPINE INJURY	
Suspicion of CSI	No evidence of C-spine injury

INJURIES

WOUND	W1. Pain, Laceration, Open wound, Swelling, Haemorrhage, None W2. Pain, Tenderness, Swelling, None W3. Abrasion W4.



AMPDS

Dispatch code	04D02A	Not Alert after an Assault
Final code	04B01	Assault, Possibly dangerous body area

GCS

Final GCS eye opening	Spontaneous
Final GCS verbal response	Orientated
Final GCS motor response	Obeys commands

VITAL SIGNS

ime	06:00	06:15	-
uls	102	96	-
uls	Reg	Reg	-
esi	16	16	-
P r	171 / 104	166 / 104	- / -
ap	<2 secs	<2 secs	-
eal	-	-	-
loc	5.0	-	-
taf	-	-	-
tC(	-	-	-
ain	4/10	4/10	-
em	36.2	-	-
pO	97	96	-
CS	15	15	-
EV	1	1	-
TS	7.6	7.6	-
ECG	Sinus tachy	NSR	-
ep:	1	1	0
act	-	-	-
AVP	Alert	Alert	-

SEPSIS

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

2012746039 20/12/1974
HUGHES
Scott

EYES AND PUPIL SIZE AND REACTION

	Left	Right
Pupil size	Normal	
Pupil reaction	Normal	

AMPLE

Allergies	None
Other allergies	
Medication	NIL
Past history	EPILEPSY
Last eaten	>5 hrs
Events prior	

SUBSTANCES AFFECTING CONDITION

Alcohol	

PATIENT HANDOVER

On arrival at scene	Standing
Scene removal	Walking
Transportation	Lying
Care delivery at hospital	Trolley

ETHNICITY

Ethnicity White	British
White Other	
Not stated	

FINAL OBSERVATION AND COMMENTS

41 YEAR OLD MALE ASSAULTED. PUNCHED AND KICKED ABOUT THE HEAD, FACE AND BODY. PATIENT THINKS THIS ASSAULT HAPPENED 2 OR 3 HOURS PRIOR TO AMBULANCE BEING CALLED AND MAY HAVE BEEN LYING ON FLOOR FOR THAT PERIOD ? UNCON. LACERATION AND SWELLING TO RIGHT EYE, SWELLING TO RIGHT SIDE OF FACE, BLEEDING FROM NOSE AND MOUTH WITH BRUISING ? FOOTPRINTS TO FACE, FOREHEAD AND NECK. ALSO ABRASIONS TO BACK

Report ID	0c140891-78dd-4738-a5df-a7806e79e7dd

Date	CLINICAL NOTES
	Seen by (Dr) P. SHEPHERD Time seen 06:50

41 ♂ ASSAULT & HI.

BG: Nil.

Assaulted after forced entry into pt's house by 3/4 unidentified men. Pt. Feels men were coming for him rather than to burgle. Pt had been out drinking, also had 1 line cocaine.

Punched & kicked about the face & body. Pt unsure of whether he lost consciousness. Called son who called an ambulance. Pain mostly around (R) side of face, (L) lateral abdomen & (R) hand. c/o headache on ipsilateral side to facial swelling. Denies nausea/vomiting. Oriented to T P P.

SE CVS/Resp - nil
GI - (L) lateral abdo pain.
GU - nil
CNS - nil
MSK - as above.


2012746039 20/12/1974
HUGHES
Scott

PHx. Nil reg Ax. NKDA

SHx Smoking ~10 cpd
Alcohol ~ 70 guinesses/wk.
Illicit drugs cocaine use.
Occupation ~~unemployed~~. BT salesman
ADLs independent
(H) alone.