

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



MMA Legal

43-59 Princes Street

Stockport

SK1 1RY

Date: 8th May 2026

Your Ref: 100150

Our Ref: LAT/ACCESS/ES

Enquiries to: Emily Svensson

Direct Line: 0141 211 3020

Email: Emily.svensson@nhs.scot

Re: Subject Access Request under the General Data Protection Regulation

PATIENT: GAYLE WILSON

D.O.B: 21/07/1979

Thank you for your request received **22ND APRIL 2026** in which you seek a copy of your client's personal information.

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

QUEEN ELIZABETH UNIVERSITY HOSPITAL/ WESTERN INFIRMARY HOSPITAL/ GARTNAVEL GENERAL HOSPITAL

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

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- Emails

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

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

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

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

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

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

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

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

Yours sincerely

Legal Aspects Team

ELECTRONIC PATIENT RECORDS

ALL HOSPITAL RECORDS HELD NHSGGC

ACS

BEATSON HOSPITAL

CANNIESBURN HOSPITAL

DENTAL HOSPITAL

GARTNAVEL GENERAL HOSPITAL

GLASGOW ROYAL INFIRMARY

INVERCLYDE ROYAL HOSPITAL

NEW VICTORIA ACH

PRINCESS ROYAL MATERNITY

QUEEN ELIZABETH UNIVERSITY HOSPITAL

ROYAL ALEXANDRA HOSPITAL

ROYAL HOSPITAL FOR CHILDREN

STOBHILL HOSPITAL

VALE OF LEVEN

WEST AMBULATORY CARE HOSPITAL

WESTERN INFIRMARY RECORDS

Including:

BADGERNET

CAREVUE

MEDICAL ILLUSTRATION

METAVISION

PHYSIOTHERAPY

RADIOLOGY

WEST MARC

LABS

☐☐☐☐☐☒☐☐☐☐☒☐☐☐☐☐☒

MATERNITY

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MATERNITY

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My Admission Record



Hospital: QEUH Ward: ARU2
 Date of Admission: 14/1/26 Time: 00:10
 Information obtained from: Name: _____
 Patient ☒ Relative ☐ Other ☐ _____
Preferred Name: _____
 Age: 47 Telephone Number: _____
 Consultant: _____

Nan _____
 Add: 2107796165
 WILSON F
 Gayle 21/07/1979
 1-1
 37A DOWANHILL STREET
 Glasgow, Lanarkshire
 Do: CH G11 5RN
 Affix patient ID label

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: <u>Mandy Wilson</u> Relationship: <u>Niece</u> Address: _____ Telephone: <u>07506317763</u> Is this person aware of your admission? Yes ☒ No ☐ Can we share information with this person? Yes ☒ No ☐	Name: _____ Relationship: _____ Address: _____ Telephone: _____ Is this person aware of your admission? Yes ☐ No ☐ Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis (TROP 24)
Chest pain
 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 ☐ Penicillin

Relevant past medical history
T2DM
Mental health issues
 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

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

Name: _____

Addr _____



2107796165

WILSON

Gayle

21/07/1979

DoB: 1-1

CHI: 37A DOWANHILL STREET
Glasgow, Lanarkshire

Affix

G11 5RN

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:

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

Yes

No

☐☒☐☒☐☒☐☒☐☒☐☐☐☐**MRSA Screening**

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?

Yes

No

Unsure

☐☐☒☐☒☐☐☒☐☐☒☐☐☒☐☐☒☐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 swabsNasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐**Creutzfeldt-Jakob Disease (CJD)**

Have you ever been informed that you are at increased risk of CJD or vCJD?

If **YES** inform the IPCT ☐

Yes

No

Unsure

☐☒☐

Name			
Addr	 2107796165 WILSON Gayle 1-1 21/07/1979 F DoB: 37A DOWANHILL STREET CHI: Glasgow, Lanarkshire Affix patient ID G11 5RN		

Lifestyle

Smoking

Are you a: smoker ☒ ex-smoker ☐ when did you stop? 20 pack

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

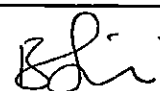
Alcohol

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):	B-JIRI	Signature:	
Designation:	S/N	Date:	14/1/26

My Assessment Record

Name: 
 Address: 2107796165
 WILSON F
 Gayle 21/07/1979
 1-1
 DoB: 37A DOWANHILL STREET
 CHI: Glasgow, Lanarkshire
 G11 5RN
 Affix patient ID label

1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems	✓	✓	
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			
Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems			
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

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

Name: _____
 Address: _____
 2107796165
 WILSON
 Gayle
 21/07/1979
 DoB: 1-1
 CHI: 37A DOWANHILL STREET
 Glasgow, Lanarkshire
 Affix pa G11 5RN

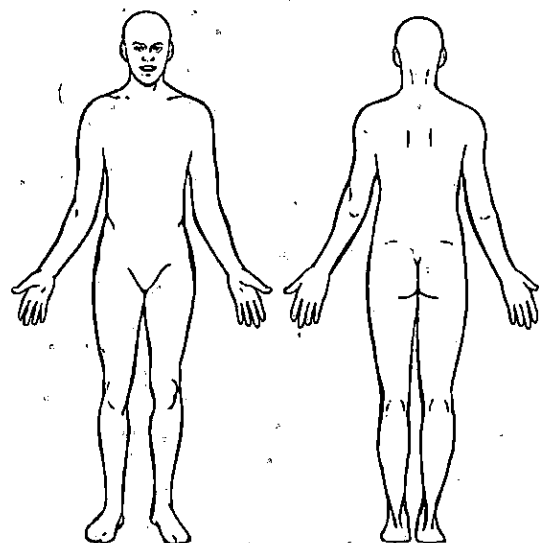
3. Senses

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

Name: 
 Address: 2107796165
 WILSON F
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 1-1
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 Glasgow, Lanarkshire
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 Affix patient ID label

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?

NO

What do you like to eat and drink?

Varied diet

What do you not like to eat and drink?

✓

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

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓	Name: _____ Adc  2107796165 WILSON DoB Gayle 21/07/1979 CHI: 1-1 37A DOWANHILL STREET Affix Glasgow, Lanarkshire G11 5RN
Normal diet and fluids	✓	✓	Assessment of the patient's hydration and nutrition needs
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			
N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS) within 4 hours of admission			
Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓	
Independent (Green)	✓	✓	
Prompting / encouragement / opening packets/cutting up food (Amber)			
Full assistance with eating and drinking (Red)			
Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission? 			
6. Elimination			
Bladder	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Pass urine with no problems	✓	✓	
Frequently pass urine during the day			
Frequently pass urine overnight			
Sense of urgency when need to pass urine			
Urine retention			

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓	Name: _____ Address: _____ 2107796165 WILSON Gayle 1-1 21/07/1979 DoB: _____ CHI: _____ 37A DOWANHILL STREET Glasgow, Lanarkshire Affix patient ID card G11 5RN
Haematuria			
Incontinent			

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 NHSGCC Adult UCC Insertion and Maintenance Care Plan

Bowels

When did your bowels last move?

13/1/26

How often in a day/week do you have a bowel movement? Per day Per week

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?			

Nan _____
 Add  _____
 2107798165
 WILSON F _____
 Gayle 21/07/1979 _____
 1-1
 DoE 37A DOWANHILL STREET _____
 CHI Glasgow, Lanarkshire _____
 Affix patient ID label G11 5RN _____

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?		✓	
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 Podiatry via TrakCare

Wound Care	Yes ✓	No ✓	Name: _____ Address: _____ 2107796165 WILSON Gayle 1-1 DoB: _____ 37A DOWANHILL STREET CHI: _____ Glasgow, Lanarkshire Affix patient ID label
Do you have any wounds? N.B. If yes, complete an assessment chart for wound management		✓	21/07/1979 F G11 5RN

8. Mobility

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

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

9. Maintaining a Safe Environment

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

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

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

10. Sleep and Rest

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

Name: _____
 Addre: _____
 2107795165
 WILSON
 Gayle
 1-1
 DoB: 37A DOWANHILL STREET
 CHI: Glasgow, Lanarkshire
 Affix p: _____
 21/07/1979
 G11 5RN

11. Social Circumstances

Do you:

Live alone ☒	Live with family/ friend/ other ☐
Live in a nursing home ☐	Live in a care home ☐
Live in residential supported care ☐	Live in student accommodation ☐
Live in 'homeless' accommodation ☐	Have no fixed abode ☐
Other please specify _____ ☐	

Dependants

Yes
✓

No
✓

Do you have any dependants?

Do you support anyone (e.g. partner, children, relatives, animals)?

Do they need support from someone else whilst you are in hospital?

Would someone else be able to provide this support when you are in hospital?
 If yes, who?

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☒ Referred ☐

Services

Yes
✓

No
✓

Do you have support from social work, social services or a care package?

If yes, please provide details:

SAMH - meds prompt and community
outing

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?

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

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

Healthcare Chaplain informed Yes ☐ N/A ☒

Name:			
Address:			
	2107796165		
	WILSON		
	Gayle		F
	1-1	21/07/1979	
DoB:	37A DOWANHILL STREET		
CHI:	Glasgow, Lanarkshire		
Affix p			G11 5RN

13. Person Centred Care

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

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

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

Informal Support

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

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

Name:

Contact Details:

.....

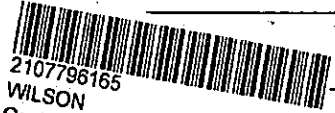
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How do you want the people who matter to you to be involved in your care?

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

Yes ☐ No ☐

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

Nam _____
 Add:  _____
 2107796165
 WILSON
 Gayle
 1-1
 Do 37A DOWANHILL STREET
 Ct Glasgow, Lanarkshire
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 21/07/1979 F
 G11 5RN

Required Support

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

Yes ☐ No ☐

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

Has the carer been advised of the Carers Information Line?

Yes ☐ No ☐ Not appropriate at this time ☐

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?

Yes ☐ No ☐

Are you:

Employed ☐

Unemployed ☐

Self-employed ☐

Retired ☐

Full time education ☐

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

Yes ☐ No ☐ Not applicable ☐

Do you have any money worries?

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

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

Yes ☐ No ☐ If yes when was patient referred ____/____/____

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

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

If yes when was patient referred ____/____/____

Risk Assessments/Other Documentation

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

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
14/1/26 00:30	Admitted with history of chest pain; recent admission with pleural effusion and pericardial effusion. Analgesia given in A&E. On arrival to A&E, pain free. NEWS-2. Awaiting medical review.	Blair B. J. (SW)

Name: _____

Ad _____



2107796165

WILSON

Gayle

21/07/1979

Do

1-1

Ct

37A DOWANHILL STREET

Aff

Glasgow, Lanarkshire

G11 5RN

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
14/1/26	PIU BY MEDICS	
0600	1st EAR CHEST PAIN (TROP 4)	
	PLAN - analgesia, Telemetry ☒ Cardio RIV ☒ <i>Lee</i>	
	TROPONIN ☒ _____	KLOE (SN)
	Patient settled, NEWS as charted, Stable.	LEAR
	Observations. NO concerns voiced at present.	Lee (SN)
0637	STAT DOSE COLCHINE given ☒ _____	Lee (SN)
14/1/26	Seen by consultant.	
1010	Imp: Chest pain, recurrent pericardial effusion	
	Plan: - Add NSAID to colchicine	
	- Cardio RIV	L Ritchie
	Aim (H) later	Whiter (6)
14/1/26 1535	pt in Room. Settled. Independent. Alert.	
	oibited. Bm ↑ 22.0 mmol + ketones 0.7 mmol	
	Given morphine 5mg → Bm ↓ 19.1. ketones 0.2.	
	Eating + drinking well. NEWS stable although on O ₂ therapy AL - 98%. passed urine	
	Independent + ADLs. on Telemetry ☒ _____	So & Smith
15/1/26 0315	NEWS OIB Dependent confirmed NOT commenced on colchicine regular	
	OBG IS-1-0.2 ketones arranged	
	ADLs Paracetamol given 1g after pain	
	OK improves	
15/01/26 0810	pt settled in bed. meds given as per Hgms. NEWS 0. Alert + oriented.	
	await bed in BD - been informed +	

Name: _____
 Address: _____
 2107798165
 WILSON
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 1-1
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 Affix _____
 G11 5RN

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
15/1/26 13 ¹⁵	Patient transferred to Ward 60 + moved into bedspace Plan: - Trial naproxen - Bloods today	
16/1/25 0100 (NIS)	A - HR 90 bpm overnight B - Charts checked & updated C - Potassium 3.3. Settled and asleep - if Bloods OK for discharge. D - Nil.	E.M. Quance J. McNamee J. McNamee
16/01/26 1435	A - NEWS as above. B - Charts checked. C - CRP ↑ - ? For name due to this. - Await medic update. D - Nil	E.M. Quance J. McNamee
17/1/26	A - News remain stable B - Charts checked & up to date C - monitor bloods if OK for discharge. Meds in treatment room D - Nil.	J. McNamee J. McNamee
17/1/26 16:20	A - News ss per chart. B - Bedside charts checked and updated. C - Due medications given ss per Hepms	

Patient name

P 2107796165
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ticker

Emergency Care Nursing Documentation

Initial Investigations					
Initial when complete	Required?	Init		Required?	Init
Patient prepared for exam	☒ Y ☐ N	☒ Y	Pain score	☒ Y ☐ N	☒ Y
NEWS/MEWS/PEWS chart	☒ Y ☐ N	☒ Y	Peak flow	☐ Y ☐ N	
ID Band	☒ Y ☐ N	☒ Y	MSSU Results:		
12-Lead ECG	☐ Y ☐ N				
Blood samples	☐ Y ☐ N				
Blood Gas	☐ Y ☐ N				
Viral Swab	☐ Y ☐ N		B-HCG	+ve	-ve

Communication		Required?
GGC Red Bag with Patient (nursing home resident)	☐ Y ☒ N	
Language or hearing difficulty	☐ Y ☒ N	
Interpreter required	☐ Y ☒ N	
what arrangements have been made?		
Relatives / Carer / Next of Kin present	☐ Y ☒ N	
name, relationship, location, particular concerns		
Signature: ☒ Y		

PVC	Diagnostic Resuscitation Intravenous Fluids Transfusion	Insertion Date: _____ Time: _____	Insertion Side: L R	Size of PVC: _____	Inserted by Signature: _____
Circle reason: D R I F T					
Hand Hygiene	Yes ☐	Skin Decontamination 2% chlorhexidine in 70% isopropyl alcohol	Yes ☐	Sterile transparent semi-permeable dressing affixed	Yes ☐
				PVC Reason Explained	Yes ☐

Risk Assessments and Screening Tools			Required?	Init	Required?			Init
SEPSIS			☐ Y ☒ N		GMAWS			☐ Y ☒ N
FAST +VE	☐ Y ☐ N	STOPPS	☐ Y ☒ N		Public Protection Concern (Adult/Child)			☐ Y ☒ N
ED Falls Risk Assessment			☐ Y ☒ N	☒ Y	Notification of Concern Completed (NOC)			☐ Y ☒ N
Mental Health Triage Assessment			☐ Y ☒ N		Frailty Assessment Completed			☐ Y ☒ N
Ligature low room			☐ Y ☒ N		4AT Assessment			☐ Y ☒ N

Pause for Discharge		
GGC Red Bag with Patient (nursing home resident)	☐ Y ☐ N	
Relatives / Carer with Patient	☐ Y ☐ N	
Name Band Removed	☐ Y ☐ N	
Risk Assessment/Screening Tools Completed	☐ Y ☐ N	
Discharge Information	☐ Y ☐ N	
NEWS Chart completed within 1 hour of discharge	☐ Y ☐ N	
Medications/Fluids prescribed as per medication prescription form	☐ Y ☐ N	
Notes Complete	☐ Y ☐ N	
Belongings	☐ Y ☐ N	
Transport arranged	☐ Y ☐ N	
Own/Taxi/Relative/SAS (Please circle)	☐ Y ☐ N	
PVC Removed Prior to Discharge	☐ Y ☐ N	
Signature: _____		

Pause for Transfer		
GGC Red Bag with Patient (nursing home resident)	☐ Y ☐ N	
Relatives / Carer with Patient	☐ Y ☐ N	
Name Band in situ	☐ Y ☐ N	
Risk Assessment/Screening Tools Complete	☐ Y ☐ N	
Bed Available	☐ Y ☐ N	
SBAR complete	☐ Y ☐ N	
NEWS Chart completed within 1 hour of transfer	☐ Y ☐ N	
Medications/Fluids prescribed as per medication prescription form	☐ Y ☐ N	
PVC/CVC Bundle	☐ Y ☐ N	
Notes Complete	☐ Y ☐ N	
Belongings	☐ Y ☐ N	
Escort Required	☐ Y ☐ N	
Signature: _____		

G11 5RN

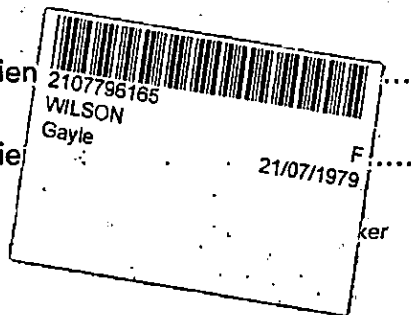
use sticker

Patient

[illegible]

Patient

Patient



Use the following Codes:

Y = Yes

N = No

NA = Not Applicable

NT = No Thanks

S = Sleeping

O = Off the ward

I - Independent

Ongoing Care

	4 Hours	5 Hours	6 Hours	7 Hours	8 Hours	9 Hours	10 Hours	11 Hours	12 Hours
Time									
Nursing notes updated including (NEWS, MEWS, PEWS)									
Food, Fluid, Nutrition (provide details)									
IVI/IVABs									
Routine Medications prescribed and administered									
Falls risk assessment reviewed/checklist									
Skin assessed and supported (PURDRA)									
Pain assessment									
SBAR up to date and completed									
Patient/ relatives updated									
If patient not in cubicle space think about patients dignity requirements eg hearing aids, mobility aids, glasses, interpreter									
STOPPS completed									
PVC/CVC Bundle. Consider is; Dressing intact? PVC patent?									Commence CVC/PVC chart

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



Attach addressograph	Hospital:	Points to consider:
	Ward:	- 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 (below)	2 hourly positioning with skin checks, Complete SSKINS care plan (below)	All devices need a SSKINS care plan (below)

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 below.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Check Skin	Signature
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	

	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 ☐ Nasogastric ☐ 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:

Pat

[illegible]

CLINICAL NOTES - MEDICAL ☐
NURSING ☒Please tick ☒ appropriate directorate

2107796165

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21/07/1979

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Date & Time	Cont'd	Signature, Print Name & Designation
17/1/26	- A/cut echo	
	- Patient appears settled	F. Adam
	B - Nil deviations	FADE SN
17/1/26	Patient's Blood glucose was checked	
17/05	and was 20.5, ket 0.1 and	
	I informed medics and medics	
	advised that we should monitor	
	till tomorrow. Medics also said	
	patient's not so good will be reviewed	
	tomorrow	FADE SN
18/1/26	A - NEWS - 0. BM 12.5 before bed	
02:10	B - checked + updated	
	C - medication given as per Hepma	
	Prn paracetamol given for	
	diabetic med R/U & Echo	
	before discharge	
	D - nil other	NSPrah SN
18/1/26	A - News as per chart	
12:55	B - Bedside charts checked +	
	and updated	
	C - Due medications given	
	as per Hepma	
	- Patient appears settled	
	- Patient is being boarded	
	+ medical day unit	FADE SN
18/1/26	Admitted to ICU, obs (2) BP ↓	
13:14	Sats 95%, will further update,	
	tea + water offered	FADE SN

Date & Time		Signature, Print Name & Designation
18/1/26	Pt settled, family in attendance.	
1545	AMMD echo prior to DIC as per medical notes, pt reports had this but with cheek black.	
	AMMD DIBZENC NURSE RLV ☐	
	Repeat bloods 19/1/26 →	<i>[Signature]</i> Mills Melley
19/1/26	(A) NEWS as charted. NEWS - 0	
	(B) Echo ^{charts} ^ reviewed.	
	(C) Meds given as per Keping	
	- AMW diabetic nurse r/v	
	- For repeat bloods in the morning	
	- For ? repeat Echo - patient said an echo was done while she was in ward yesterday.	<i>[Signature]</i> TW
	- ? For OP cardiology + CT.	
	D - settled overnight	
19/1/26	Patient independently mobile and	
1425	self caring with ADLs. Mobile to toilet. Diet + fluids tolerated.	
	NEWS 0. Medication as charted. Reviewed on ward round: home today. ADL + meds given to patient. Own transport arranged.	
	Discharged from MAU. →	<i>[Signature]</i> Jv. SEWAGH

NHSGGC Bedrail Risk Assessment

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

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT

Use guidance on the reverse of this document when completing this Risk Assessment		DATE	14/1/26	15/1/26	18/1/26	21/1/26	24/1/26	27/1/26	30/1/26	31/1/26
		TIME	00:26	13:10	13:40					
		WARD	Acu 2	6D	ADU					
		HOSPITAL	Queen	Queen	Queen					
			Y	N	Y	N	Y	N	Y	N
1	Is the patient likely to fall, roll, slip or slide from the bed?									
2	Has the patient requested the use of bedrails?									
IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED										
SECTION TWO – COGNITIVE AND PHYSICAL STATUS										
3	Is the patient at risk of climbing out of bed?									
4	Is the patient stressed, delirious or restless?									
5	Is the patient small in stature?									
6	Does the patient have an unusually large or small head that might present an entrapment issue?									
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?									
IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf										
SECTION THREE – COMMUNICATION										
8	Has the patient been consulted regarding the use of bedrails?									
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition									
10	Has the use of bedrails been discussed with relatives/carers?									
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?									
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?									
IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf										
SECTION FOUR – DECISION MAKING										
13	Will bedrails be used for this patient at the present time?									
14	Rationale for use of bedrails: (Please insert code in the box on the right)									
	A – Risk of falling from the bed									
	B – Risk of rolling from the bed									
	C – Risk of slipping from the bed									
	D – Risk of sliding from the bed									
	E – Patient request									
15	Bedrail risk assessment completed by:									
16	Bedrails checked by:									
17	Date	14/1/26	15/1	18/1/26						
Any issues relating to the use of bedrails including discussion with family/relatives/carers should be recorded here.										



A. Alternatives to bed rails:-

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

C. Safe use and application of bedrails:-

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

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

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

D. Record keeping:-**All of the following should be recorded:-**

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

Bedrail risk assessments should be made as follows:-

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

Date: 14/11/26

1. Signed [Signature] Name B. Jiri Designation SLT
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

No thanks.

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[illegible]

Attach Addressograph Label



Ward:

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

[illegible]

Date: 15 / 1 / 26

1. Signed [Signature] Name J. M. Quisenberry Designation Dr
2. Signed [Signature] Name J. M. Quisenberry Designation SW
3. Signed _____ Name _____ Designation _____

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

WILSON
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1-1
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Glasgow, Lanarkshire

Ward: Am...

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

NO thanks

[illegible]

Care Rounds Variance Sheet

Attach Addressograph Label



Ward:

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.

[illegible]

Date: 16/01/26

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 K. MacLure Designation STN/CN
2. Signed [Signature] Name F. MacLure Designation ST
3. Signed [Signature] Name [Signature] Designation ST

Attach



2107796185
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Glasgow, Lanarkshire

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Ward:

6D

G11 5RN

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

USE FOLLOWING CODES

Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward

4/17/18 No thanks

		Times	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse..	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
3	SKIN INSPECTION Pressure areas checked: Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
4	KEEP MOVING Has the patient moved or walked? Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B Chair Assist to walk or stand (W/ST)	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth? Drink taken? Food, snack, or supplement taken? Has oral hygiene been carried out as per care plan?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	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?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
9	ESCALATION Escalate any issues to the registered nurse and document overleaf.	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Care provider / role																							

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:



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.

[illegible]

Date: 12/1/26

1. Signed Kremo Name Kremo Designation an
2. Signed [Signature] Name F. Adam Designation SN
3. Signed [Signature] Name S. [Signature] Designation SN

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

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Gayle

1-1

21/07/1979

Ward: 6A

'Must dos' for n
they want speci..... **G11**

anything

G11 5RN

[illegible]

Care Rounds Variance Sheet

Attach Addressograph Label



Ward:

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.

[illegible]

Date: 18/1/26

1. Signed [Signature] Name Sahmari Designation SN
2. Signed [Signature] Name F. Adam Designation SN
3. Signed [Signature] Name Milne McKinn Designation SN

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

ACKNOWLEDGMENTS

21/07/1979

37A DOWANHILL STREET
Glasgow, Lanarkshire

G11.58N

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



		Times	00	05	10	15	20	25	30	35	40	45	50	55	60
1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N	N	N	N	N	N	N	N	N
2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N	N	N	N	N	N	N	N	N
3	SKIN INSPECTION Pressure areas checked: Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	N	N	N	N	N	N	N	N	N	N	N	N	N	N
4	KEEP MOVING Has the patient moved or walked? Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B Chair Assist to walk or stand (W/ST)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	I	I	I	I	I	I	I	I	I	I	I	I	I
6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth? Drink taken? Food, snack, or supplement taken? Has oral hygiene been carried out as per care plan?	N	N	N	N	N	N	N	N	N	N	N	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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.	S	S	S	S	S	S	S	S	S	S	S	S	S	S
9	ESCALATION Escalate any issues to the registered nurse and document overleaf.	S	S	S	S	S	S	S	S	S	S	S	S	S	S
Care provider / role		S/S													

Care Rounds Variance Sheet

Attach Addressograph Label



Ward:

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.

[illegible]

Date: 19/11/26

Attach Address

2107796165

WILSON

Gayle

21/07/1979

1-1

37A DOWANHILL STREET
Glasgow, Lanarkshire

G11 5RN

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and Clyde

Ward: MDU

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

USE FOLLOWING CODES:

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

[illegible]

Care Rounds Variance Sheet

Attach Addressograph Label



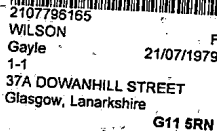
Ward:

Codes

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

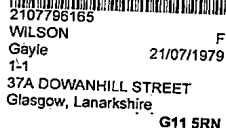
N.B. Record what and to whom escalated.

[illegible]



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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
15/1/26 J	Independent w/ w ADCs		15/1/26 J	Nurse call explained and given 2t hand	
				10. Sleep and Rest	
			15/1/26 J	Promote peaceful environment	
	8. Mobility			12. Privacy, dignity and sexuality	
15/1/26 J	Mobility 4. Independent		15/1/26 J	Maintain 2t 211 times	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	
			15/1/26 J	All care planned discussed & agreed w/ patient / relative	



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[illegible]

Discharge Checklist

Pati  2107796165 CH: WILSON F Gayle 21/07/1979 1-1 37A DOWANHILL STREET Glasgow, Lanarkshire G11 5RN label		Ward: <u>Area 2 / 60 / 1004</u> Discharge destination: <u>Home</u> Estimated Discharge Date (1) <u>17 / 11 / 26</u> Estimated Discharge Date (2) <u>19 / 11 / 26</u> Final date of discharge: <u>1 / 1</u>		
Checklist	Yes	N/A	Initials	Comments
Patient informed				
Relative/carer informed				
Relative/carer involved in discharge planning discussions				
Others informed: Care Home				
Transport arranged				
Own transport (preferred option)				
Ambulance: 1 man/ 2 man am/pm				
Other: Flight, Air ambulance etc.		☒	<u>BS</u>	
Discharge medication				
Immediate Discharge Letter completed				
Compliance aids e.g. Dosette 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. cash				
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:				
Nurse's signature:	Designation:		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



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: <u>ARM 2</u> Date: <u>14/1/26</u> Time: <u>09:20</u>	Ward: <u>60</u> Date: <u>15/1/26</u> Time: <u>13:30</u>	Ward: <u>MEU</u> Date: <u>18/1/26</u> Time: <u>13:40</u>	Ward: Date: Time: -----	Ward: Date: Time: -----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	<u>completed</u>	<u>Complete</u>	<u>indep</u>		
2. Check walking aid (if required) is in reach and in use.	<u>Independent</u>	<u>use</u>	<u>NA</u>		
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	<u>Yes in reach</u>	<u>in reach</u>	<u>immediately nearby</u>		
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	<u>Yes - shoes</u>	<u>✓</u>	<u>Safe</u>		
5. If glasses are worn, check they are available and in use.	<u>Yes</u>	<u>✓</u>	<u>YES</u>		
6. If hearing aid/s are worn, check they are working and in use.	<u>N/A</u>	<u>NA</u>	<u>NA</u>		

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?			<u>✓</u>		<u>✓</u>		<u>✓</u>				
2. Does the patient have cognitive impairment or a possible delirium?			<u>✓</u>		<u>✓</u>		<u>✓</u>				
3. Does the patient attempt to walk alone although unsteady or unsafe?			<u>✓</u>		<u>✓</u>		<u>✓</u>				
4. Does the patient or their relative have a fear or anxiety of the patient falling?			<u>✓</u>		<u>✓</u>		<u>✓</u>				
5. Based on your clinical judgement, is this patient at high risk of falling?			<u>✓</u>		<u>✓</u>		<u>✓</u>				
Signature of nurse completing assessment / update				<u>[Signature]</u>		<u>[Signature]</u>					

Highlight risk of fall at the ward safety brief.

FALLS INTERVENTION ON CHECKLIST

Complete for all patients identified at risk of falling.

Ward:	Ward:	Ward:	Ward:	Ward:
Date:	Date:	Date:	Date:	Date:
Time: -----	Time: -----	Time: -----	Time: -----	Time: -----

BED AND SEATING

Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice.
(Patient care plan 8)

Assess if a low bed is required
(Patient care plan 9)

SAFETY

Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)

Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)

If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.

HEALTH

Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)

Document continence problems and link to care rounding (Patient care plan 6)

Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)

If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.

COMMUNICATION

Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety, precautions with patient / carer / relative. (Patient care plan -negotiated care)

Update the ward team of the patient's mobility status. (Patient care plan 8)

Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)

Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)

Signature of nurse completing interventional plan / or update

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

EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

Person's Name: 2107798165 WILSON Gayle		Named Nurse:		Person is totally independent (tick here and go to date box)	
1. Geni 1-1		21/07/1979			
37A DOWANHILL STREET Glasgow, Lanarkshire		Assessments with comprehension, behaviour, co-operation (specify):			
Weight: Kg BMI		G11 5RN		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		Standard		Walking Aid	
Model		Aid Type		People: 1 2 ≥3	
Sling type				Additional Information / Equipment:	
Sling Size					
3. Toileting					
Hoist		Standard		Walking Aid	
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	
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	
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	
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	
				People: 1 2 ≥3	
				Additional Information / Equipment (eg rope ladder, swivel cushion):	
8. Into Bath or Shower					
Equipment		Handling Aid		Assistance	
Shower Variable / Fixed height bath Bed bath		Shower chair Shower trolley Bathing hoist (eg Alenti)		People: 1 2 ≥3	
				Additional Information / Equipment (eg sling lifting hoist after risk assess):	
9. Walking					
No Walking		Walking Aid		Assistance	
		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					
Recording Symbol:		1st Assessment		2nd Assessment	
Date Assessed:		14/1/26		15/1/26	
Assessor's signature:					
Proposed Review date:		PRN		22/1/26	

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		Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):					
Kg		cm							
BMI									
Risk of Falls: Yes ☐ No ☐									
2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)									
Hoist	Standaid	Walking Aid	Assistance			Supervision		Independent	
Model		Aid Type	People: 1	2	>3	Additional Information / Equipment:			
Sling type									
Sling Size									
3. Toileting									
Hoist	Standaid	Walking Aid	Assistance			Supervision		Independent	
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1	2	>3	Additional Information:			
4. Move on / off bed pan									
Hoist	Manoeuvre	Assistance			Supervision		N/A		
See No 2 Sit to Stand Transfers for details		Roll patient	People: 1	2	>3	Additional Information:			
		Monkey pole							
		Person bridges							
5. Move up / down bed									
Hoist	Handling Aids	Assistance			Supervision		Independent		
See No 2 Sit to Stand Transfers for details		Sliding sheets	People: 1	2	>3	Additional Information:			
		Monkey pole							
		Rope ladder							
6. Lateral Transfer to / from trolley / bed									
Hoist	Handling Aids	Assistance			Supervision		Independent		
See No 2 Sit to Stand Transfers for details		Rigid Transfer Board	People: 1	2	>3	Additional Information / Equipment (eg sliding sheets):			
		Other (Please specify)							
7. Sit up over side of bed									
Bed Rest		Assistance			Supervision		Independent		
		People: 1	2	>3	Additional Information / Equipment (eg rope ladder, swivel cushion):				
8. Into Bath or Shower									
Equipment	Handling Aid	Assistance			Supervision		Independent		
Shower	Shower chair	People: 1	2	>3	Additional Information / Equipment (eg sling lifting hoist after risk assess):				
Variable / Fixed height bath	Shower trolley								
Bed bath	Bathing hoist (eg Alenti)								
9. Walking									
No Walking	Walking Aid	Assistance			Supervision		Independent		
see 'sit to stand transfers'		People: 1	2	>3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)				
10. Other Instructions / Observations / Equipment Used									
		4th Assessment			5th Assessment		6th Assessment		
Recording Symbol:		/ Forward slash			X Where a forward slash exists, add a back slash to make a cross		* Where a slash or cross exists add slashes to make a star		
Date Assessed:									
Assessor's signature:									
Proposed Review date:									



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MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)



Date <u>13/1/25</u> Time <u>2330</u> 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	<u>162</u> <u>544</u> cm	☒	☐	
Admission Weight	<u>84</u> 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	<u>13/1/25</u>	<u>18/1/25</u>						
Time	<u>2330</u>	<u>1308</u>						
Ward	<u>ARC2</u>	<u>1801</u>						
Oedema/ Ascities present Y/N	<u>N</u>	<u>N</u>						
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes	<u>Ch</u>	<u>CU</u>						
Weight (kgs)	<u>84</u>	<u>84</u>						
BMI	<u>32</u>	<u>32</u>						

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	<u>0</u>	<u>0</u>						
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	<u>0</u>	<u>0</u>						
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	<u>0</u>	<u>0</u>						
Step 4 Overall Risk of Malnutrition TOTAL	<u>0</u>	<u>0</u>						
Rescreen on	<u>20/1/25</u>	<u>25/1/25</u>						
Signature	<u>mg</u>	<u>[Signature]</u>						

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
<u>0</u>	LOW RISK - Repeat screening every 7 days
<u>1</u>	MEDIUM RISK - Follow the flowchart for MUST 1 overleaf
<u>2 or greater</u>	HIGH RISK - Follow the flowchart for MUST 2 or greater overleaf

MUST STEP 5 Management Guidelines

MUST 1

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient /carer normal eating patterns and preferences.
- **Use a Food First Approach:**
 - Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
 - Offer full cream milk with and between meals.
 - Order additional MUST snack daily of patients choice (refer to 'catering' section in Nutrition Resource Manual).
- Encourage family and friends to bring in patient preferred snacks.
- Complete a food and drink recording chart, including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a 72 hour period?

YES

Is the patient's intake 'normal' or improved for them?

YES

- Discontinue food and drink recording chart, documenting reason in nursing notes.
- Continue with 'food first' approach as above.
- Rescreen at least every 7 days.

NO

- Encourage higher calorie menu choices indicated with Ⓢ
- Continue with food and drink recording chart for 4 days, and if no improvement in intake, rescreen.

Complete the above steps.

NO

MUST 2 OR GREATER

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient /carer normal eating patterns and preferences.
- **Use a Food First Approach:**
 - Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
 - Offer full cream milk with and between meals.
 - Order additional MUST snack daily of patients choice (refer to 'catering' section in nutritional resource manual).
- Encourage family and friends to bring in patient preferred snacks.
- Complete a food and drink recording chart, including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a 72 hour period?

YES

Is the patient's intake 'normal' or improved for them?

YES

- Discontinue food and fluid chart, documenting reason in nursing notes.
- Continue with 'food first' approach as above.
- Rescreen at least every 7 days.

NO

Complete the above steps

Is the patient dying?

YES

- Discontinue food and drink recording chart.
- Stop screening.
- Offer food and fluid as appropriate.

NO

- Continue with food and drink recording chart.
- Screen at least every 7 days.
- Consider referral to dietetics via Trakcare.

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/

Pressure Ulcer Daily Risk Assessment (PUDRA)



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Hospital:

QEUH

Ward:

ARM 2/60

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	Pressure Damage	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?

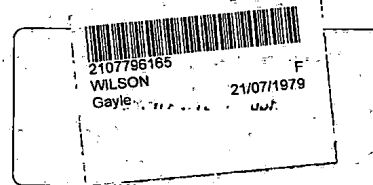
Date	Location of pressure damage	Grade of ulcer	Date	Location of pressure damage	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

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
14/1/26	00:15	N	N	N	N	N	N	4 hrly	SS
15/1/26	13:30	N	N	N	N	N	N	4 hrly	SS
16/01/26	08:30	N	N	N	N	N	N	4 hrly	SS
17/01/26	08:34	N	N	N	N	N	N	4 hrly	SS
18/01/26	08:22	N	N	N	N	N	N	4 hrly	SS
19/1/26	00:30	N	N	N	N	N	N	4 hrly	SS
/ /	:							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



	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 <u>✓</u> hourly. • Skin under medical devices <u>✓</u> hourly. • Specify medical devices used: Catheter ☐ Naso gastric ☐ Oxygen mask ☐ Nasal oxygen ☐ Vascular Access Device ☐ Off loading boot ☐ Other:	Specify: • Mattress: <u>soft foam</u> • Cushion: • Detail additional pressure redistributing equipment: Off loading boot: ☐ Protective product:	• Reposition <u>1</u> hourly in bed. • Reposition <u>✓</u> hourly in chair. • Overnight patient / carer has agreed to repositioning <u>✓</u> 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 <u>✓</u> 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:	<u>En</u> 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:

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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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.

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.

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	Date	Ward	Time
Admitted			
Transferred	18/1/16	MANA	1306
Transferred			
Transferred			
Transferred			

SpO2 Scale 1 Target >96% Signature: _____ Print Name: _____ Dr/ANP initials ONLY: _____ Date: _____	SpO2 Scale 2 Target 88-92% Signature: _____ Print Name: _____ Dr/ANP initials ONLY: _____ Date: _____	Patient on home oxygen Y ☐ N ☒ 80 If yes, add details of oxygen therapy _____ _____ _____
---	---	--

Document all actions and interventions

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

Pupil Size (mm)

1 2 3 4 5 6 7 8

Glasgow Coma Scale

Date	Time	15/1	15/2	15/3	15/4	15/5	15/6	15/7	15/8	15/9	15/10	15/11	15/12	15/13	15/14	15/15	15/16	15/17	15/18	15/19	15/20	15/21	15/22	15/23	15/24	15/25	15/26	15/27	15/28	15/29	15/30	15/31	15/32	15/33	15/34	15/35	15/36	15/37	15/38	15/39	15/40	15/41	15/42	15/43	15/44	15/45	15/46	15/47	15/48	15/49	15/50	15/51	15/52	15/53	15/54	15/55	15/56	15/57	15/58	15/59	15/60	15/61	15/62	15/63	15/64	15/65	15/66	15/67	15/68	15/69	15/70	15/71	15/72	15/73	15/74	15/75	15/76	15/77	15/78	15/79	15/80	15/81	15/82	15/83	15/84	15/85	15/86	15/87	15/88	15/89	15/90	15/91	15/92	15/93	15/94	15/95	15/96	15/97	15/98	15/99	15/100	15/101	15/102	15/103	15/104	15/105	15/106	15/107	15/108	15/109	15/110	15/111	15/112	15/113	15/114	15/115	15/116	15/117	15/118	15/119	15/120	15/121	15/122	15/123	15/124	15/125	15/126	15/127	15/128	15/129	15/130	15/131	15/132	15/133	15/134	15/135	15/136	15/137	15/138	15/139	15/140	15/141	15/142	15/143	15/144	15/145	15/146	15/147	15/148	15/149	15/150	15/151	15/152	15/153	15/154	15/155	15/156	15/157	15/158	15/159	15/160	15/161	15/162	15/163	15/164	15/165	15/166	15/167	15/168	15/169	15/170	15/171	15/172	15/173	15/174	15/175	15/176	15/177	15/178	15/179	15/180	15/181	15/182	15/183	15/184	15/185	15/186	15/187	15/188	15/189	15/190	15/191	15/192	15/193	15/194	15/195	15/196	15/197	15/198	15/199	15/200	15/201	15/202	15/203	15/204	15/205	15/206	15/207	15/208	15/209	15/210	15/211	15/212	15/213	15/214	15/215	15/216	15/217	15/218	15/219	15/220	15/221	15/222	15/223	15/224	15/225	15/226	15/227	15/228	15/229	15/230	15/231	15/232	15/233	15/234	15/235	15/236	15/237	15/238	15/239	15/240	15/241	15/242	15/243	15/244	15/245	15/246	15/247	15/248	15/249	15/250	15/251	15/252	15/253	15/254	15/255	15/256	15/257	15/258	15/259	15/260	15/261	15/262	15/263	15/264	15/265	15/266	15/267	15/268	15/269	15/270	15/271	15/272	15/273	15/274	15/275	15/276	15/277	15/278	15/279	15/280	15/281	15/282	15/283	15/284	15/285	15/286	15/287	15/288	15/289	15/290	15/291	15/292	15/293	15/294	15/295	15/296	15/297	15/298	15/299	15/300	15/301	15/302	15/303	15/304	15/305	15/306	15/307	15/308	15/309	15/310	15/311	15/312	15/313	15/314	15/315	15/316	15/317	15/318	15/319	15/320	15/321	15/322	15/323	15/324	15/325	15/326	15/327	15/328	15/329	15/330	15/331	15/332	15/333	15/334	15/335	15/336	15/337	15/338	15/339	15/340	15/341	15/342	15/343	15/344	15/345	15/346	15/347	15/348	15/349	15/350	15/351	15/352	15/353	15/354	15/355	15/356	15/357	15/358	15/359	15/360	15/361	15/362	15/363	15/364	15/365	15/366	15/367	15/368	15/369	15/370	15/371	15/372	15/373	15/374	15/375	15/376	15/377	15/378	15/379	15/380	15/381	15/382	15/383	15/384	15/385	15/386	15/387	15/388	15/389	15/390	15/391	15/392	15/393	15/394	15/395	15/396	15/397	15/398	15/399	15/400	15/401	15/402	15/403	15/404	15/405	15/406	15/407	15/408	15/409	15/410	15/411	15/412	15/413	15/414	15/415	15/416	15/417	15/418	15/419	15/420	15/421	15/422	15/423	15/424	15/425	15/426	15/427	15/428	15/429	15/430	15/431	15/432	15/433	15/434	15/435	15/436	15/437	15/438	15/439	15/440	15/441	15/442	15/443	15/444	15/445	15/446	15/447	15/448	15/449	15/450	15/451	15/452	15/453	15/454	15/455	15/456	15/457	15/458	15/459	15/460	15/461	15/462	15/463	15/464	15/465	15/466	15/467	15/468	15/469	15/470	15/471	15/472	15/473	15/474	15/475	15/476	15/477	15/478	15/479	15/480	15/481	15/482	15/483	15/484	15/485	15/486	15/487	15/488	15/489	15/490	15/491	15/492	15/493	15/494	15/495	15/496	15/497	15/498	15/499	15/500	15/501	15/502	15/503	15/504	15/505	15/506	15/507	15/508	15/509	15/510	15/511	15/512	15/513	15/514	15/515	15/516	15/517	15/518	15/519	15/520	15/521	15/522	15/523	15/524	15/525	15/526	15/527	15/528	15/529	15/530	15/531	15/532	15/533	15/534	15/535	15/536	15/537	15/538	15/539	15/540	15/541	15/542	15/543	15/544	15/545	15/546	15/547	15/548	15/549	15/550	15/551	15/552	15/553	15/554	15/555	15/556	15/557	15/558	15/559	15/560	15/561	15/562	15/563	15/564	15/565	15/566	15/567	15/568	15/569	15/570	15/571	15/572	15/573	15/574	15/575	15/576	15/577	15/578	15/579	15/580	15/581	15/582	15/583	15/584	15/585	15/586	15/587	15/588	15/589	15/590	15/591	15/592	15/593	15/594	15/595	15/596	15/597	15/598	15/599	15/600	15/601	15/602	15/603	15/604	15/605	15/606	15/607	15/608	15/609	15/610	15/611	15/612	15/613	15/614	15/615	15/616	15/617	15/618	15/619	15/620	15/621	15/622	15/623	15/624	15/625	15/626	15/627	15/628	15/629	15/630	15/631	15/632	15/633	15/634	15/635	15/636	15/637	15/638	15/639	15/640	15/641	15/642	15/643	15/644	15/645	15/646	15/647	15/648	15/649	15/650	15/651	15/652	15/653	15/654	15/655	15/656	15/657	15/658	15/659	15/660	15/661	15/662	15/663	15/664	15/665	15/666	15/667	15/668	15/669	15/670	15/671	15/672	15/673	15/674	15/675	15/676	15/677	15/678	15/679	15/680	15/681	15/682	15/683	15/684	15/685	15/686	15/687	15/688	15/689	15/690	15/691	15/692	15/693	15/694	15/695	15/696	15/697	15/698	15/699	15/700	15/701	15/702	15/703	15/704	15/705	15/706	15/707	15/708	15/709	15/710	15/711	15/712	15/713	15/714	15/715	15/716	15/717	15/718	15/719	15/720	15/721	15/722	15/723	15/724	15/725	15/726	15/727	15/728	15/729	15/730	15/731	15/732	15/733	15/734	15/735	15/736	15/737	15/738	15/739	15/740	15/741	15/742	15/743	15/744	15/745	15/746	15/747	15/748	15/749	15/750	15/751	15/752	15/753	15/754	15/755	15/756	15/757	15/758	15/759	15/760	15/761	15/762	15/763	15/764	15/765	15/766	15/767	15/768	15/769	15/770	15/771	15/772	15/773	15/774	15/775	15/776	15/777	15/778	15/779	15/780	15/781	15/782	15/783	15/784	15/785	15/786	15/787	15/788	15/789	15/790	15/791	15/792	15/793	15/794	15/795	15/796	15/797	15/798	15/799	15/800	15/801	15/802	15/803	15/804	15/805	15/806	15/807	15/808	15/809	15/810	15/811	15/812	15/813	15/814	15/815	15/816	15/817	15/818	15/819	15/820	15/821	15/822	15/823	15/824	15/825	15/826	15/827	15/828	15/829	15/830	15/831	15/832	15/833	15/834	15/835	15/836	15/837	15/838	15/839	15/840	15/841	15/842	15/843	15/844	15/845	15/846	15/847	15/848	15/849	15/850	15/851	15/852	15/853	15/854	15/855	15/856	15/857	15/858	15/859	15/860	15/861	15/862	15/863	15/864	15/865	15/866	15/867	15/868	15/869	15/870	15/871	15/872	15/873	15/874	15/875	15/876	15/877	15/878	15/879	15/880	15/881	15/882	15/883	15/884	15/885	15/886	15/887	15/888	15/889	15/890	15/891	15/892	15/893	15/894	15/895	15/896	15/897	15/898	15/899	15/900	15/901	15/902	15/903	15/904	15/905	15/906	15/907	15/908	15/909	15/910	15/911	15/912	15/913	15/914	15/915	15/916	15/917	15/918	15/919	15/920	15/921	15/922	15/923	15/924	15/925	15/926	15/927	15/928	15/929	15/930	15/931	15/932	15/933	15/934	15/935	15/936	15/937	15/938	15/939	15/940	15/941	15/942	15/943	15/944	15/945	15/946	15/947	15/948	15/949	15/950	15/951	15/952	15/953	15/954	15/955	15/956	15/957	15/958	15/959	15/960	15/961	15/962	15/963	15/964	15/965	15/966	15/967	15/968	15/969	15/970	15/971	15/972	15/973	15/974	15/975	15/976	15/977	15/978	15/979	15/980	15/981	15/982	15/983	15/984	15/985	15/986	15/987	15/988	15/989	15/990	15/991	15/992	15/993	15/994	15/995	15/996	15/997	15/998	15/999	16/000	16/001	16/002	16/003	16/004	16/005	16/006	16/007	16/008	16/009	16/010	16/011	16/012	16/013	16/014	16/015	16/016	16/017	16/018	16/019	16/020	16/021	16/022
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Patient

2107796165
WILSON
Gayle
21/07/1979
F
37A DOWANHILL STREET
Glasgow, Lanarkshire
G11 5RN

Patient

Emergency Care Nursing Documentation

Initial Investigations					
Initial when complete	Required?	Init		Required?	Init
Patient prepared for exam	☒ Y ☐ N		Pain score	☒ Y ☐ N	01
NEWS/MEWS/PEWS chart	☒ Y ☐ N		Peak flow	☐ Y ☐ N	
ID Band	☒ Y ☐ N		MSSU Results:		
12-Lead ECG	☒ Y ☐ N				
Blood samples	☒ Y ☐ N				
Blood Gas	☒ Y ☐ N				
Viral Swab	☒ Y ☐ N		B-HCG	+ve	-ve

Communication		Required?
GGC Red Bag with Patient (nursing home resident)	☐ Y ☒ N	
Language or hearing difficulty	☐ Y ☒ N	
Interpreter required	☐ Y ☒ N	
what arrangements have been made?		
Relatives / Carer / Next of Kin present	☐ Y ☒ N	
name, relationship, location, particular concerns		
Signature: 01		

PVC	Diagnostic Resuscitation Intravenous Fluids Transfusion	Insertion Date: _____ Time: _____	Insertion Side: L R	Size of PVC: _____	Inserted by _____ Signature _____
Circle reason: D R I F T					
Hand Hygiene	Yes ☐	Skin Decontamination 2% chlorhexidine in 70% isopropyl alcohol	Yes ☐	Sterile transparent semi-permeable dressing affixed	Yes ☐
				PVC Reason Explained	Yes ☐

Risk Assessments and Screening Tools		Required?	Init			Required?	Init
SEPSIS	☐ Y ☒ N		MA	GMAWS	☐ Y ☒ N		MA
FAST +VE	☐ Y ☐ N		MA	Public Protection Concern (Adult/Child)	☐ Y ☒ N		MA
STOPPS	☐ Y ☒ N		MA	Notification of Concern Completed (NOC)	☐ Y ☒ N		MA
ED Falls Risk Assessment	☐ Y ☒ N		MA	Frailty Assessment Completed	☐ Y ☒ N		MA
Mental Health Triage Assessment	☐ Y ☒ N		MA	4AT Assessment	☐ Y ☒ N		MA
Ligature low room	☐ Y ☒ N		MA				

Pause for Discharge

GGC Red Bag with Patient (nursing home resident)	☐ Y ☒ N
Relatives / Carer with Patient	☐ Y ☒ N
Name Band Removed	☐ Y ☒ N
Risk Assessment/Screening Tools Completed	☐ Y ☒ N
Discharge Information	☐ Y ☒ N
NEWS Chart completed within 1 hour of discharge	☐ Y ☒ N
Medications/Fluids prescribed as per medication prescription form	☐ Y ☒ N
Notes Complete	☐ Y ☒ N
Belongings	☐ Y ☒ N
Transport arranged	☐ Y ☒ N
Own/Taxi/Relative/SAS (Please circle)	☐ Y ☒ N
PVC Removed Prior to Discharge	☐ Y ☒ N
Signature: _____	

Pause for Transfer

GGC Red Bag with Patient (nursing home resident)	☐ Y ☒ N
Relatives / Carer with Patient	☐ Y ☒ N
Name Band in situ	☐ Y ☒ N
Risk Assessment/Screening Tools Complete	☐ Y ☒ N
Bed Available	☐ Y ☒ N
SBAR complete	☐ Y ☒ N
NEWS Chart completed within 1 hour of transfer	☐ Y ☒ N
Medications/Fluids prescribed as per medication prescription form	☐ Y ☒ N
PVC/CVC Bundle	☐ Y ☒ N
Notes Complete	☐ Y ☒ N
Belongings	☐ Y ☒ N
Escort Required	☐ Y ☒ N
Signature: _____	

Patient

	
2107796165	F
WILSON	
Gayle	21/07/1979
1-1	
37A DOWANHILL STREET	
Glasgow, Lanarkshire	
G11 5RN	

Patient

Care Rounds Checklist

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

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Use the following Codes:

Y = Yes N = No NA = Not Applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times																
	1	THINK DELIRIUM Is the patient more confused/drowsy than normal? If yes inform registered nurse.																
	2	PAIN: ASSESS AND ADDRESS Is the patient distressed or in pain? If yes inform registered nurse/ Review analgesia																
S	3	SKIN INSPECTION Pressure areas checked? R = RED D = Discoloured PU - Pressure Ulcer INT = Intact M = Moisture																
K	4	KEEP MOVING Has the patient moved or walked? Bed R = Right side (30°) tilt L = Left side (30°) tilt B = Back Chair W/ST = Assist to walk / stand																
		ELIMINATION Does the patient need the toilet?																
I	5	I = Independent A - Assistance given IC = Incontinent (urine/faeces)																
N	6	FOOD FLUIDS AND NUTRITION Is the patient nil by mouth?																
		Drink taken?																
		Food, snack, or supplements taken?																
		Has oral hygiene been carried out as per care plan?																
	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 the lowest position?																
	8	INFORMATION Is there anything else I can help you with? Inform the patient of the time of return																
	9	ESCALATION Is there anything else I can help you with? Inform the patient of the time of return																
		Care provider																
		Role																

Ask the patient if there is anything they specifically want done today:

Patient CHI

NHS
Greater Glasgow
and Clyde

[illegible]

Patient name

Pa 2107796165
WILSON
Gayle
21/07/1979 F sticker

Hospital:

Ward:

Points to consider:

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



Attach addressograph	Hospital:	Points to consider:
	Ward:	• 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 ressure its	Daily skin check	4 hourly positioning Complete SSKINS care plan (below)	2 hourly positioning with skin checks, Complete SSKINS care plan (below)	All devices need a SSKINS care plan (below)

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
/ /			/ /		
/ /			/ /		
/ /			/ /		

Go 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 below.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Check Skin	Signature
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	

	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:

Pa 2107796165
WILSON
Pa Gayle F
1-1 21/07/1979
37A DOWANHILL STREET
Glasgow, Lanarkshire
G11 5RN
sticker

Use the following Codes: Y = Yes N = No NA = Not Applicable NT = No Thanks
S = Sleeping O = Off the ward I - Independent

Ongoing Care

	4 Hours	5 Hours	6 Hours	7 Hours	8 Hours	9 Hours	10 Hours	11 Hours	12 Hours
Time									
Nursing notes updated including (NEWS, MEWS, PEWS)									
Food, Fluid, Nutrition (provide details)									
IVI/IVABs									
Routine Medications prescribed and administered									
Falls risk assessment reviewed/checklist									
Skin assessed and supported (PURDRA)									
Pain assessment									
SBAR up to date and completed									
Patient/ relatives updated									
If patient not in cubicle space think about patients dignity requirements eg hearing aids, mobility aids, glasses, interpreter									
STOPPS completed									
PVC/CVC Bundle. Consider is; Dressing intact? PVC patent?									Commence CVC/PVC chart

Patient C



Date and Time		Name/Signature
1910	(R) sided chest pain since 10am Worse on inspiration Bloods / IV Access ☒ ECG ☒ Had own cocodamol - nil effect Analgesia given. A/W bloods + CXR	O. Stevenson Ollivier
20.15 20.20	given cup of tea Pt obs updated as Charted. A/W further medical plans.	Handy Hos Thoresen

My Admission Record



2107796165
WILSON
Gayle
1-1
37A DOWANHILL STREET
Glasgow, Lanarkshire G11 5J
patient ID label

Hospital: Qent Ward: AMU
Date of Admission: 21/12/15 Time: 23.30
Information obtained from: Name: _____
Patient ☒ Relative ☐ Other ☐
Preferred Name: _____
Age: 46 Telephone Number: _____
Consultant: Dr. Kewin

POC me

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: <u>Mandy</u>	Name: _____
Relationship: <u>Niece</u>	Relationship: _____
Address: _____	Address: _____
Telephone: <u>07506317763</u>	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 ? PE trip LS
CP CPA-NO PE Pericarditis
Pericardial effusion
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 ☐ Penicillin

Relevant past medical history
None

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

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

Name: _____
 A: 2107796185
 F: WILSON
 179 Gayle 21/07/11
 1-1
 D: 37A DOWANHILL STREET
 Glasgow, Lanarkshire G11 5
 C: RN
 Af: _____

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:

1. Been an inpatient in a hospital outside Scotland?

Yes

No

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**

Will the patient be an inpatient for more than 23 hours

Yes

No

Unsure

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 swabsNasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐**Creutzfeldt-Jakob Disease (CJD)**

Have you ever been informed that you are at increased risk of CJD or vCJD?

Yes

No

Unsure

If **YES** inform the IPCT ☐

Nat		
Add	2107796165	21/07/15
	WILSON	
	Gayle	
	1-1	
DoB:	37A DOWANHILL STREET	
CHI:	Glasgow, Lanarkshire	G11 5
Affix		

Lifestyle

Smoking

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

Never smoked ☐

Do you use eCigarettes? Yes ☐ No ☐

If a smoker, the NHS GGC 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 NHS GGC 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):

1 D

Signature:

Designation:

S M R

Date:

2/1/26

My Assessment Record

Name: _____
 Ad  2107796165
 — F WILSON F
 — 379 Gayle 21/07/1975
 — 1-1
 Do 37A DOWANHILL STREET
 CH Glasgow, Lanarkshire
 Affi RN G11 5RN

1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems		✓	
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			
Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems			
Chest pain at rest	✓		
Chest pain on exertion	✓		
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

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

Name: 2107796165
 F WILSON
 379 Gayle 21/07/1979
 1-1
 37A DOWANHILL STREET
 Glasgow, Lanarkshire
 RN G11 5RN

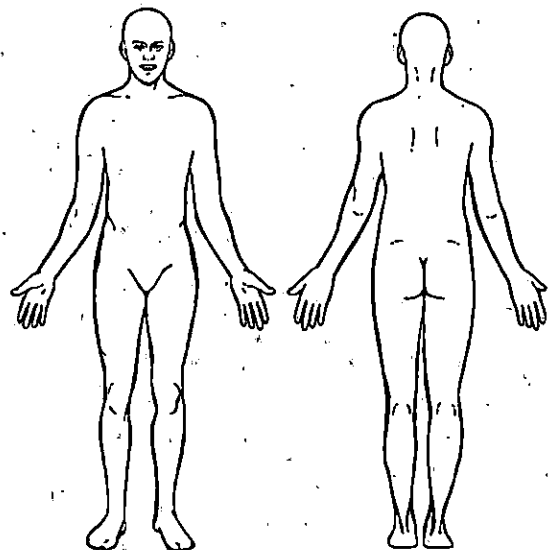
3. Senses

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

N 2107796165
 A F WILSON
 379 Gayle 21/07/11
 1-1
 37A DOWANHILL STREET
 Glasgow, Lanarkshire
 G11 5
 C RN
 AMIA patient ID label

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?

NO

What do you like to eat and drink?

None Specific

What do you not like to eat and drink?

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

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓	Name: _____ 2107796165 F WILSON 979 Gayle 21/07/11 1-1 37A DOWANHILL STREET Glasgow, Lanarkshire RN G11 5
Normal diet and fluids		✓	Assessment of the patient's hydration and nutrition needs
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			
N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS) within 4 hours of admission			
Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓	
Independent (Green).		✓	
Prompting / encouragement / opening packets/cutting up food (Amber)			
Full assistance with eating and drinking (Red)			
Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?			
6. Elimination			
Bladder	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Pass urine with no problems		✓	
Frequently pass urine during the day			
Frequently pass urine overnight			
Sense of urgency when need to pass urine			
Urine retention			

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓	Name:  Address: 2107796165 F WILSON 379 Gayle 21/07/15 DoB: 1-1 37A DOWANHILL STREET Glasgow, Lanarkshire CHI: RN G11 5 Affix 
Haematuria			
Incontinent			

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?

today

How often in a day/week do you have a bowel movement? Per day Per week

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?			

Name: 
 Age: 2107796165
 Sex: F WILSON
 Date: 21/07/11
 Address: 379 Gayle 1-1
 37A DOWANHILL STREET
 Glasgow, Lanarkshire G11 5
 District: Ctrn
 Affiliation:

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?	✓	✓	
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 Podiatry via TrakCare

Wound Care	Yes ✓	No ✓	Name:  Address: 2107796165 F WILSON 379 Gayle 21/07/15 1-1 37A DOWANHILL STREET Glasgow, Lanarkshire DoB: CHI: RN G115 Affix 
Do you have any wounds? N.B. If yes, complete an assessment chart for wound management			

8. Mobility

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

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

9. Maintaining a Safe Environment

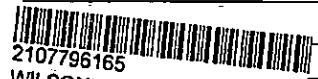
N.B. Complete a falls risk assessment for all patients within 24 hours of admission. If a falls risk is identified complete the falls intervention checklist and document all nursing actions in the care plan.

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

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

10. Sleep and Rest

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

Name: _____
 Ad:  2107796165
 F WILSON
 379 Gayle
 1-1
 D 37A DOWANHILL STREET
 CRN Glasgow, Lanarkshire
 A
 21/07/11
 G11 5

11. Social Circumstances

Do you:

- Live alone ☒ Live with family/ friend/ other ☐
 Live in a nursing home ☐ Live in a care home ☐
 Live in residential supported care ☐ Live in student accommodation ☐
 Live in 'homeless' accommodation ☐ Have no fixed abode ☐
 Other please specify _____ ☐

Dependants

Yes

No

Do you have any dependants?

Do you support anyone (e.g. partner, children, relatives, animals)?

Do they need support from someone else whilst you are in hospital?

Would someone else be able to provide this support when you are in hospital?

If yes, who?

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

Services

Yes

No

Do you have support from social work, social services or a care package?

If yes, please provide details:

SAMH x 3 daily

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?

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

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

Healthcare Chaplain informed

Yes ☐

No ☐

N/A ☒

Name: _____
 Ad:  2107795165
 F WILSON F
 379 Gayle 21/07/1979
 1-1
 DoI 37A DOWANHILL STREET
 CHI Glasgow, Lanarkshire
 Aff: RN G11 5RN

13. Person Centred Care

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

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

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

Informal Support

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

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

Name:

Niece helps

Contact Details:

.....

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

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

Yes ☒ No ☐

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

Name:

Ad:

2107796165

F

WILSON

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Gayle

21/07/1979

Do

37A DOWANHILL STREET

Ch:RN

Glasgow, Lanarkshire

Aff

G11 5RN

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 ☒

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 ____/____/____

N:  2107796165
 Ac F WILSON
 379 Gayle
 21/07/11
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 C
 Affix patient ID

Risk Assessments/Other Documentation

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

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
23:50	Patient admitted to MRI	
2/1/26	Ug ED - CP, TYPON <S	
	CXR - Cardiomegaly	
	CIPA - NO PE - Moderate	
	pericardial effusion	
	Pericarditis	
	Cardiac USS - Mild Pericardial Effusion	

Name:
 2107796165
 F WILSON
 179 Gayle
 21/07/11
 Trans Union

Clinical Notes (cont.)		
Date and Time	Notes	Print Name, Signature and Designation
	PO Morphine, Cyclizine, Omeprazole, Hyposol given in ED	
	Patient asking to go out for Cigarette - Advised against this	
02.10	Sto EIV - Pericarditis	1 Dr
3/1/20	CIPA - NO PE, pericardial effusion	S Nurse (6)
	Colchicine D	
	Simple Analgesia	
	D/W Cardio	
	? formal Echo	
	? if pain free	
06.15	settled night	S Nurse (6)
3/1/20	Now S (6) 135.2°C	
	BW 10.9 mmHg	S Nurse (6)
1000	CONSULTANT SARVESVARAN R/V:	
	IMP: PERICARDITIS	
	PLAN: COLCHICINE	
	D/W CARDIOLOGY	
	? OIP ECHO	
	HOME TODAY	
	1x AS OIP - ? MALIGN	1
	EXCLUDE MALIGNANCY: KL	KRASSLOV (6)

R. Park

Clinical Notes (cont.)

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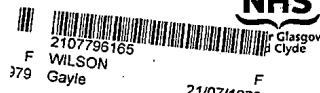
NHSGCC Bedrail Risk Assessment

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

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT

Patient Name:

CHV Number:



Use guidance on the reverse of this document when completing this Risk Assessment	DATE	21/11/20
	TIME	23:50
	WARD	2001
	HOSPITAL	2001

SECTION ONE - GENERAL

1	Is the patient likely to fall, roll, slip or slide from the bed?	Y	N	Y	N	Y	N	Y	N
2	Has the patient requested the use of bedrails?								

IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED

SECTION TWO - COGNITIVE AND PHYSICAL STATUS

3	Is the patient at risk of climbing out of bed?								
4	Is the patient stressed, delirious or restless?								
5	Is the patient small in stature?								
6	Does the patient have an unusually large or small head that might present an entrapment issue?								
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?								

IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE - See Guidance overleaf

SECTION THREE - COMMUNICATION

8	Has the patient been consulted regarding the use of bedrails?								
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition								
10	Has the use of bedrails been discussed with relatives/carers?								
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?								
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?								

IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE - See Guidance overleaf

SECTION FOUR - DECISION MAKING

13	Will bedrails be used for this patient at the present time?	Y	N	Y	N	Y	N	Y	N
14	Rationale for use of bedrails: (Please insert code in the box on the right)								
	A - Risk of falling from the bed								
	B - Risk of rolling from the bed								
	C - Risk of slipping from the bed								
	D - Risk of sliding from the bed								
	E - Patient request								
15	Bedrail risk assessment completed by:	12							
16	Bedrails checked by:								
17	Date	21/11/20							

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

A. Alternatives to bed rails:-

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

C. Safe use and application of bedrails:-

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

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

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

D. Record keeping:-**All of the following should be recorded:-**

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

Bedrail risk assessments should be made as follows:-

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

2107796165
WILSON
Gayle

21/07/19

Care Plan

Created on 02-Jan-2026 22:40:46

Date Commenced and Signature		Date Discontinued and Signature		Date Commenced and Signature		Date Discontinued and Signature
10. 2/1	Independent			10. 2/1	Brown given to use	
				10. Sleep and Rest		
				10. 2/1	Promote	
10. 2/1	8. Mobility Independent					
				12. Privacy, dignity and sexuality		
				10. 2/1	Promote	
					Negotiated care - Please record any planned involvement of patient/family in delivery of care	

Date: _____

Attach Address

NHS
Greater Glasgow
and Clyde

[illegible]

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:



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.

[illegible]

Date: 3.1.26

1. Signed _____ Name Jay Patel Designation Head
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

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

Glasgow, Lanarkshire

'Must do' **here is anything**
they want specifically done today:

NHS
Greater Glasgow
and Clyde

[illegible]

Care Rounds Variance Sheet

Attach Addressograph Label



Ward:

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.

[illegible]

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F WILSON
379 Gayle 21/07/1979 F

FALLS RISK ASSESSMENT

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

GENI
TO BE UNDERTAKEN FOR ALL PATIENTS

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

	Ward: <i>MM1</i> Date: <i>21/7/26</i> Time: <i>13:40</i>	Ward: Date: Time: -----	Ward: Date: Time: -----	Ward: Date: Time: -----	Ward: Date: Time: -----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	<i>Completed MTH</i>				
2. Check walking aid (if required) is in reach and in use.	<i>NA</i>				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	<i>NA Silver to use</i>				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	<i>In use</i>				
5. If glasses are worn, check they are available and in use.	<i>In use</i>				
6. If hearing aid/s are worn, check they are working and in use.	<i>NA</i>				

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		<i>LB</i>									

Highlight risk of fall at the ward safety brief.

FALLS INTERVENTION CHECKLIST

Complete for all patients identified at risk of falling.

Ward:	Ward:	Ward:	Ward:	Ward:
Date:	Date:	Date:	Date:	Date:
Time: -----	Time: -----	Time: -----	Time: -----	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 F

Feb 17 mi • 294647c Version 1_0 • GGC0233



2107796165

WILSON

Gayle

1-1

37A DOWANHILL STREET

Glasgow, Lanarkshire

21/07/19

G11 5

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS
Greater Glasgow
and Clyde

Date <u>21/7/19</u> Time <u>23:50</u> 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	<u>5'11"</u> cm	☐	☒	
Admission Weight	<u>83.20</u> Kg	☒	☐	

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

Patients reported normal weight Yes Unable to Recall ☐Any unplanned weight loss in the last 6 months Yes ☐ how much _____ No ☒ Don't Know ☐

Date	<u>21/7/19</u>						
Time	<u>23:50</u>						
Ward	<u>AMI 1</u>						
Oedema/ Ascities present Y/N	<u>N</u>						
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes	<u>CH</u>						
Weight (kgs)	<u>83.20</u>						
BMI	<u>22.6</u>						

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	<u>0</u>						
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	<u>0</u>						
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	<u>0</u>						
Step 4 Overall Risk of Malnutrition TOTAL	<u>0</u>						
Rescreen on	<u>21/7/19</u>						
Signature	<u>[Signature]</u>						

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

MUST 1

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient /carer normal eating patterns and preferences.
- **Use a Food First Approach:**
 - Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
 - Offer full cream milk with and between meals.
 - Order additional MUST snack daily of patients choice (refer to 'catering' section in Nutrition Resource Manual).
- Encourage family and friends to bring in patient preferred snacks.
- Complete a food and drink recording chart, including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a 72 hour period?

YES

Is the patient's intake 'normal' or improved for them?

YES

- Discontinue food and drink recording chart, documenting reason in nursing notes.
- Continue with 'food first' approach as above.
- Rescreen at least every 7 days.

NO

- Encourage higher calorie menu choices indicated with Ⓢ
- Continue with food and drink recording chart for 4 days, and if no improvement in intake, rescreen.

Complete the above steps

NO

MUST 2 OR GREATER

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient /carer normal eating patterns and preferences.
- **Use a Food First Approach:**
 - Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
 - Offer full cream milk with and between meals.
 - Order additional MUST snack daily of patients choice (refer to 'catering' section in nutritional resource manual).
- Encourage family and friends to bring in patient preferred snacks.
- Complete a food and drink recording chart, including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a 72 hour period?

YES

Is the patient's intake 'normal' or improved for them?

YES

- Discontinue food and fluid chart, documenting reason in nursing notes.
- Continue with 'food first' approach as above.
- Rescreen at least every 7 days.

NO

Complete the above steps

Is the patient dying?

YES

- Discontinue food and drink recording chart.
- Stop screening.
- Offer food and fluid as appropriate.

NO

- Continue with food and drink recording chart.
- Screen at least every 7 days.
- Consider referral to dietetics via Trakcare.

DISCHARGE

If the patient is due for discharge and concerns remain regarding their oral intake, provide NHS GGC "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/

GGC0026

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		Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):							
Kg		cm									
BMI											
Risk of Falls: Yes ☐ No ☐											
2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)											
Hoist	Standaid	Walking Aid	Assistance			Supervision			Independent		
Model		Aid Type	People: 1	2	>3	Additional Information / Equipment:					
Sling type											
Sling Size											
3. Toileting											
Hoist	Standaid	Walking Aid	Assistance			Supervision			Independent		
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1	2	>3	Additional Information:					
4. Move on / off bed pan											
Hoist	Manoeuvre	Assistance			Supervision			N/A			
See No 2 Sit to Stand Transfers for details		Roll patient	People: 1	2	>3	Additional Information:					
		Monkey pole									
		Person bridges									
5. Move up / down bed											
Hoist	Handling Aids	Assistance			Supervision			Independent			
See No 2 Sit to Stand Transfers for details		Sliding sheets	People: 1	2	>3	Additional Information:					
		Monkey pole									
		Rope ladder									
6. Lateral Transfer to / from trolley / bed											
Hoist	Handling Aids	Assistance			Supervision			Independent			
See No 2 Sit to Stand Transfers for details		Rigid Transfer Board	People: 1	2	>3	Additional Information / Equipment (eg sliding sheets):					
		Other (Please specify)									
7. Sit up over side of bed											
Bed Rest		Assistance			Supervision			Independent			
		People: 1	2	>3	Additional Information / Equipment (eg rope ladder, swivel cushion):						
8. Into Bath or Shower											
Equipment	Handling Aid	Assistance			Supervision			Independent			
Shower	Shower chair	People: 1	2	>3	Additional Information / Equipment (eg sling lifting hoist after risk assess):						
Variable / Fixed height bath	Shower trolley										
Bed bath	Bathing hoist (eg Alenti)										
9. Walking											
No Walking	Walking Aid	Assistance			Supervision			Independent			
see 'sit to stand transfers'		People: 1	2	>3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)						
10. Other Instructions / Observations / Equipment Used											
		4 th Assessment			5 th Assessment			6 th 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:											

 2107796185 WILSON Gayle 21/07/15 Created on 02 Jan 2016 22:40 hrs	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	
As above and including: palpable venous cord	4	Seek further advice		
As above and including: pyrexia	5			

Insertion details: Date: <u>21/07/15</u> (Day 1) Time: _____	Where inserted: ☒ ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☐ Unknown	Insertion site: ☐ Hand ☒ Arm Other: _____	Side: ☐ Left ☒ Right	Size of cannula: ☐ 26G Purple ☐ 24G Yellow ☐ 18G Green ☐ 23G Blue ☐ 16G Grey ☒ 20G Pink ☐ 14G Orange	Inserted by: <u>CD</u> Print: _____ Signature: _____ Designation: _____		
Clinical indication:	☐ Diagnostics	☐ Resuscitation	☐ IV medications	☐ Fluids	☐ Transfusion		
Insertion criteria:	Hand hygiene performed ☐ Yes ☐ No	Skin decontamination (2% chlorhexidine in 70% isopropyl alcohol) ☐ Yes ☐ No	Sterile transparent semi-permeable dressing affixed ☐ Yes ☐ No	PVC explained to patient/carer ☐ 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. ✓ Diagnostics - Does the patient need the PVC for a diagnostic procedure e.g. CT scan ✓ Resuscitation - Is the patient at risk of cardiac or respiratory arrest? ✓ Intravenous (IV) - Does the patient require intravenous (IV) medication? Could these be switched to another route? ✓ Fluids - Does the patient require IV fluids? Could this be switched or oral fluids? ✓ Transfusion - Does the patient require a transfusion of blood products?			Signs of local or systemic infection <table border="0"> <tr> <td> Local infection • Erythema / inflammation • Exudate • Hot to touch • Pain/tenderness </td> <td> Systemic Infection • Hypotension • Tachycardia • Pyrexia </td> </tr> </table>			Local infection • Erythema / inflammation • Exudate • Hot to touch • Pain/tenderness	Systemic Infection • Hypotension • Tachycardia • Pyrexia
Local infection • Erythema / inflammation • Exudate • Hot to touch • Pain/tenderness	Systemic Infection • Hypotension • Tachycardia • Pyrexia						

	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 $\leq 37.9^{\circ}\text{C}$, 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. aureus 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		
--	--	--	---

Write or affix label

Name:
Address:
CHI:
DOB:
Hospital & Ward:

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

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 21/12/26	☐ Yes ☒ No	☒ Yes ☐ No	VIP _____	VIP <u>0</u>	☐ Yes ☒ No	☒ Yes ☐ No	☐ Yes ☒ No	☒ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Left in situ ☐ Redressed ☐ Removed	☒ Left in situ ☐ Redressed ☐ Removed	Day _____ Night <u>AD - SN</u>
Day 2 31/12/26	☒ Yes ☐ No	☐ Yes ☐ No	VIP <u>0</u>	VIP _____	☐ Yes ☒ No	☐ Yes ☒ No	☒ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day <u>DM CMEODCN</u> 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	☐ Left in situ ☐ Redressed ☐ Removed	Day _____ Night _____

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

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

Pressure Ulcer Daily Risk Assessment (PUDRA)

 F 2107796165 WILSON 379 Gayle 1-1 37A DOWANHILL STREET Glasgow, Lanarkshire RN G11 5RN 	F 21/07/1979 Hospital: <i>[Signature]</i> Ward: <i>[Signature]</i>	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	Pressure Damage	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
21/07/23	12:30	N	N	N	N	N	N	4 hrly	<i>[Signature]</i>
31/07/23	09:10	N	N	N	N	N	N	4 hrly	<i>[Signature]</i>
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
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/ /	:							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

Attach Addressograph

	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:

Discharge Checklist



2107796165
F WILSON F
379 Gayle 21/07/1979
1-1
37A DOWANHILL STREET
Glasgow, Lanarkshire
RN G11 5RN graph label

Ward:

Discharge destination: *Home*Estimated Discharge Date (1) *4/1/20*Estimated Discharge Date (2) *1/1/*Final date of discharge: *1/1/*

Checklist	Yes	N/A	Initials	Comments
Patient informed				
Relative/carer informed				
Relative/carer involved in discharge planning discussions				
Others informed: Care Home				
Transport arranged				
Own transport (preferred option)				
Ambulance: 1 man/ 2 man am/pm				
Other: Flight, Air ambulance etc.				
Discharge medication				
Immediate Discharge Letter completed				
Compliance aids e.g. Dosette 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. cash				
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:				
Nurse's signature:	Designation:		Date: / /	

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Gayle
1-1
37A DOWANHILL STREET
Glasgow, Lanarkshire
21/07/1979
G11 5RN

	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
Min 12 Hourly Observations	Low Clinical Risk Min 4 Hourly Observation	Medium Clinical Risk Min Hourly Observations	High Clinical Risk 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:

Date:	Time:	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th	13th	14th	15th	16th	17th	18th	19th	20th	21st	22nd	23rd	24th	25th	26th	27th	28th	29th	30th	31st	32nd	33rd	34th	35th	36th	37th	38th	39th	40th	41st	42nd	43rd	44th	45th	46th	47th	48th	49th	50th	51st	52nd	53rd	54th	55th	56th	57th	58th	59th	60th	61st	62nd	63rd	64th	65th	66th	67th	68th	69th	70th	71st	72nd	73rd	74th	75th	76th	77th	78th	79th	80th	81st	82nd	83rd	84th	85th	86th	87th	88th	89th	90th	91st	92nd	93rd	94th	95th	96th	97th	98th	99th	100th
1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th	13th	14th	15th	16th	17th	18th	19th	20th	21st	22nd	23rd	24th	25th	26th	27th	28th	29th	30th	31st	32nd	33rd	34th	35th	36th	37th	38th	39th	40th	41st	42nd	43rd	44th	45th	46th	47th	48th	49th	50th	51st	52nd	53rd	54th	55th	56th	57th	58th	59th	60th	61st	62nd	63rd	64th	65th	66th	67th	68th	69th	70th	71st	72nd	73rd	74th	75th	76th	77th	78th	79th	80th	81st	82nd	83rd	84th	85th	86th	87th	88th	89th	90th	91st	92nd	93rd	94th	95th	96th	97th	98th	99th	100th		
1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th	13th	14th	15th	16th	17th	18th	19th	20th	21st	22nd	23rd	24th	25th	26th	27th	28th	29th	30th	31st	32nd	33rd	34th	35th	36th	37th	38th	39th	40th	41st	42nd	43rd	44th	45th	46th	47th	48th	49th	50th	51st	52nd	53rd	54th	55th	56th	57th	58th	59th	60th	61st	62nd	63rd	64th	65th	66th	67th	68th	69th	70th	71st	72nd	73rd	74th	75th	76th	77th	78th	79th	80th	81st	82nd	83rd	84th	85th	86th	87th	88th	89th	90th	91st	92nd	93rd	94th	95th	96th	97th	98th	99th	100th		
1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th	13th	14th	15th	16th	17th	18th	19th	20th	21st	22nd	23rd	24th	25th	26th	27th	28th	29th	30th	31st	32nd	33rd	34th	35th	36th	37th	38th	39th	40th	41st	42nd	43rd	44th	45th	46th	47th	48th	49th	50th	51st	52nd	53rd	54th	55th	56th	57th	58th	59th	60th	61st	62nd	63rd	64th	65th	66th	67th	68th	69th	70th	71st	72nd	73rd	74th	75th	76th	77th	78th	79th	80th	81st	82nd	83rd	84th	85th	86th	87th	88th	89th	90th	91st	92nd	93rd	94th	95th	96th	97th	98th	99th	100th		
1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th	13th	14th	15th	16th	17th	18th	19th	20th	21st	22nd	23rd	24th	25th	26th	27th	28th	29th	30th	31st	32nd	33rd	34th	35th	36th	37th	38th	39th	40th	41st	42nd	43rd	44th	45th	46th	47th	48th	49th	50th																																																				

Date	1/11	11/11	12/11	13/11	14/11	15/11	16/11	17/11	18/11	19/11	20/11	21/11	22/11	23/11	24/11	25/11	26/11	27/11	28/11	29/11	30/11	1/12	2/12	3/12	4/12	5/12	6/12	7/12	8/12	9/12	10/12	11/12	12/12	13/12	14/12	15/12	16/12	17/12	18/12	19/12	20/12	21/12	22/12	23/12	24/12	25/12	26/12	27/12	28/12	29/12	30/12	31/12									
Time	11.00	12.00	13.00	14.00	15.00	16.00	17.00	18.00	19.00	20.00	21.00	22.00	23.00	00.00	01.00	02.00	03.00	04.00	05.00	06.00	07.00	08.00	09.00	10.00	11.00	12.00	13.00	14.00	15.00	16.00	17.00	18.00	19.00	20.00	21.00	22.00	23.00	00.00	01.00	02.00	03.00	04.00	05.00	06.00	07.00	08.00	09.00	10.00	11.00	12.00	13.00	14.00	15.00	16.00	17.00	18.00	19.00	20.00	21.00	22.00	23.00

A + B Respirations Breaths/min	225	3
	21-24	2
	12-20	0
	9-11	1
	5-8	3

A + B SpO2 Scale 1 Oxygen saturation (%)	97	96	95	94	93	92	91	90	89	88	87	86	85	84	83	82	81	80	79	78	77	76	75	74	73	72	71	70	69	68	67	66	65	64	63	62	61	60	59	58	57	56	55	54	53	52	51	50	49	48	47	46	45	44	43	42	41	40	39	38	37	36	35	34	33	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	16	15	14	13	12	11	10	9	8	7	6	5	4	3	2	1	0
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SpO2 Scale 2 Oxygen saturation (%) Use Scale 2 if target range is 88-92% e.g. in chronic hypercapnic respiratory failure	297 on O2	3
	95-96% on O2	2
	93-94% on O2	1
	93 on air	0
	88-92	0
Only use scale 2 under direction of qualified clinician	86-87	1
	84-85	2
	83	3

Air or oxygen?	A	0
	1	0
	2	0
	3	0
	4	0
	5	0
	6	0
	7	0
	8	0
	9	0
	10	0
	11	0
	12	0
	13	0
	14	0
	15	0
	16	0
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	94	0
	95	0
	96	0
	97	0
	98	0
	99	0
	100	0

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
	41-50	3
	31-40	3
30	3	

C Pulse Beats / min	213	3
	171-210	2
	151-170	2
	131-150	1
	111-130	1
	91-110	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	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50
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Blood glucose	7.0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50
Pain / function score	0A	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50
Time Pt last passed urine	10.20	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50
Fluid balance chart indicated Y/N	N	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50
GCS indicated Y/N	N	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50
Time NEWS due	23.00	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50
Escalation of care Y/N	N	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50
Initials	AB	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50

NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

1. Give oxygen to target saturation >94% (COPD >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.

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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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Previous Patient Notes for Acute Specialties GGC (newest at the top).

Note: Specialty search returns patient notes from 13th November 2018 onwards. Patient notes older than that date, tagged Historical Notes, that don't have a specialty assigned can only be viewed within the Patient Notes section in the Clinical Documents tree.

Patient Note	Created By: Doctor - GP OOH Caledonia House - Thomas Gilhooly	Remote Consultation
Date/Time: 07-Feb-2026 22:23	Organisation:	Role: Doctor - GGC
Specialty: Acute Specialties GGC		Sensitive
Note:		
Thanks for seeing this patient who has presented with right sided chest pain radiating to her back and arm. She was diagnosed with pericarditis in Jan when she had a similar symptoms. I would be grateful for your assessment of this patient.		

Previous Patient Notes for General Medicine (newest at the top).

Note: Specialty search returns patient notes from 13th November 2018 onwards. Patient notes older than that date, tagged Historical Notes, that don't have a specialty assigned can only be viewed within the Patient Notes section in the Clinical Documents tree.

Patient Note		Inpatient Note
Date/Time: 23-Jan-2026 15:08	Created By: Doctor - Fathel Musa	Role: Doctor - GGC
Specialty: General Medicine	Organisation:	Sensitive
Note:		
IDL on 18/01/2026: nil to add and no FDL required		

Previous Patient Notes for Ophthalmology (newest at the top).

Note: Specialty search returns patient notes from 13th November 2018 onwards. Patient notes older than that date, tagged Historical Notes, that don't have a specialty assigned can only be viewed within the Patient Notes section in the Clinical Documents tree.

Patient Note		Outpatient Note
Date/Time: 12-Dec-2025 10:36	Created By: Consultant - Manish Gupta	Role: Doctor - GGC
Specialty: Ophthalmology	Organisation: Queen Elizabeth University Hospital	Sensitive
Note: V/A, FIELDS		

Patient Note		Outpatient Note
Date/Time: 07-Feb-2025 13:06	Created By: Consultant - Manish Gupta	Role: Doctor - GGC
Specialty: Ophthalmology	Organisation: Queen Elizabeth University Hospital	Sensitive
Note: v/a		

Patient Note		Outpatient Note
Date/Time: 04-Oct-2024 15:56	Created By: Consultant - Manish Gupta	Role: Doctor - GGC
Specialty: Ophthalmology	Organisation: Queen Elizabeth University Hospital	Sensitive
Note: V/A, FIELDS		

Affix Label

CHI: 2107796165

Total Att: 25

12 Mth Att: 1

Title: MISS

WILSON

Gayle

DOB 21/07/1979

Age: 45y

Sex: Female

1-1
37A DOWANHILL STREET
Glasgow
Lanarkshire
G11 5RN
07490319509

Next of kin: WILSON, Mandy
Relationship: Niece
07506317763

GP: GM Georgiev
0141 339 0902

Attendance Date: 21/05/2025

Arrival Time: 21:54

Registration Time: 21:54

Date of Incident: 21/05/2025

Major Incident Desc:

Reason for Attendance: taken 16 ibuprofen 1 hr ago - abdo pain

Nursing Assessment

Alerts: Not Recorded

Allergies: Not Recorded

Pain Score:

Triage Category: 2

Tetanus up to date/fully immunised:

Presenting Complaint: Psychiatry Suicidal

Observation Date: 21/05/2025 22:33

Nurse name: Nurse Lisa McClement

Temp	36.4	C
HR	120	bpm
BP	127/81	mmHg
MAP	96.33	mmHg
RR	18	bpm
SpO2	97	%
Oxygen	21	%

BM		mmol/L
PF		1/min
Expected PF		1/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

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

Nursing Notes: "self ref: intentional OD of 16x200 mg ibuprofen at 20:30 tonight been feeling suicidal last few days had recent bereavement BG 15.6 states feels like jumping off a bridge lives supported accommodation "

Patient ID label

78 2107798165 21/07/19
WILSON
Gayle
Julian McClement

Date	Emergency Department Notes	
0010 22/5/25	Seen by (Doctor)	Time seen
	<u>J-CARE SMO</u> D/W presentation for two boxes → IP@ → LETHAL. J. HOSKING	
0154 22/5	<u>J-CARE SMO</u> D/W psych hmb 20 they were can have with teacher J. HOSKING	

Differential Diagnosis/Problem List

0346	<u>J-CARE</u> psych with history can have in daytime angry happy more than J. HOSKING	NEWS ☐ 0-7 RED FLAG ☐ (tick) SEPSIS ☐ CURB 65 ☐
------	--	---

Done/ completed	Immediate Management Plan

Signature:	Designation:	Page No:

PLEASE DO NOT WRITE HERE

Greater Glasgow & Clyde Emergency Departments' Mental Health Triage and Risk Assessment Tool

WILSON
Gayle
21/07/19
2107756165

Part One - Nursing Triage

triage nurse to
complete this page

Patient name
CHI

Triage Observations

document physiological measurements

GCS	BMI	HR	BP	RR	SaO ₂	Temp
15	18.6	120	127/81	18	97	36.1

Outline of Presentation

tick all the categories which apply

Overdose (will also require medical assessment)	☒
Self-injury (will also require wound management)	☐
Other Mental Health Presentation	☐

accompanied by

name, relationship,
particular concerns

Subs want
by self

Describe the appearance/clothing of those attending
alone, as they may leave before review.

Is the patient a young person in foster care or in a residential
care placement? YES/NO

Is the patient a carer for a child or a dependent adult? YES/NO

Is there a child protection concern or concern for a
vulnerable adult at risk? YES/NO

Initial Presentation, Appearance and Behaviour

respond yes or no to each question,
in any order which seems appropriate

Is the patient violent, aggressive or threatening?	Y	N
Is the patient obviously distressed, markedly anxious or highly aroused?	Y	N
Is the patient preoccupied, erratic or impulsive?	Y	N
Is the patient quiet and withdrawn?	Y	N
Do you think the patient is behaving inappropriately to their situation?	Y	N
Do you think the patient presents an immediate risk to you, to others, or to themselves?	Y	N
Do you think the patient is likely to abscond prior to assessment?	Y	N
Do you think the patient's presentation suggests either hallucinations or delusions?	Y	N
Do you think the patient feels their actions are being controlled?	Y	N
Are you aware of a history of mental health problems or psychiatric illness?	Y	N
Are you aware of a history of violence or self-harm?	Y	N
Is the patient currently expressing suicidal thoughts?	Y	N
Is the patient currently intoxicated, with alcohol, or other substances?	Y	N

*Delusions; false but firmly held views and ideas. Hallucinations; false external stimuli (for example, visual or vocal) the patient thinks are real

Triage Risk Assessment

Identify an initial category of risk,
select one or more risks.

High / Moderate / Low - risk

of self-harm / violence / absconding

Triage Category

2

High risk - accompanied **and** in the clinical area.
Moderate risk - accompanied **or** in the clinical area.
Low risk - can be asked to wait **if necessary**.

Immediate management

print toxbase information, and in paracetamol
overdose, note 4-hour time for blood sample.

Patient location,
accompanied by...

Summary Sft white female
heavy build short
brown hair glasses
blue/white track
suit light trousers
Intent on self

Blood sample time?

Toxbase info printed? Y/N

GMAWS considered? Y/N

Any responses in
the first column
High Risk

Other patient can be
categorised as
Moderate Risk

If all responses are
in the third column
Low Risk

name/grade

C. McAliment

signature

21/5/19 22:45

date and time

Part Two - Mental Health Assessment

medical staff to
complete this page

Patient name _____
CHI _____

outline of current presentation and precipitating factors

current and previous mental health problems, self-harm episodes, problematic alcohol and/or drug use, contacts with mental health services

other relevant information, (relationships, finances, employment, housing, physical health, childcare responsibilities, current medications, etc) - protective factors (beliefs, relationships, plans for future) - views of relatives/carers/significant others'

Risk Factors

(this is not an exhaustive list)

alcohol or drug use	
planning or concealment	
evidence of psychosis	
ongoing suicidal intent	
family concern about risk	
access to lethal means	
lack of social support	
age and gender	
chronic illness/pain	
family history of suicide	
disengaged/noncompliant	
unemployed/retired	
previous violent methods	
history of self-harm	
current psychiatric treatment	
previous psychiatric treatment	

Appearance

Behaviour

Speech

Mood

Thought

Insight

Careful consideration should be given to patients who may present particular risks, including patients who may have post-natal depression, or patients with 'first presentations' of mental health problems, especially in adolescence or old age.

Risk Assessment

based on clinical assessment indicate a category of risk for a further episode of self-harm in the short term (48hrs) - consider protective as well as precipitating factors.

High / Moderate / Low

Discharge Advice and Plan for Further Assessment

Indicate the follow-up plan - referral to Liaison Psychiatry, duty doctor, out-of-hours CPN service, CMHT, GP, addiction services, SW, etc - indicate the advice given to the patient, and identities of others informed.

summary

follow up and advice given

service referred to

name/relationship of carer informed

consultant/middle-grade involved in decision or review

If young people in foster care or residential care are assessed, their social work team should be informed (via stand-by SW if out-of-hours) as well as giving information and advice to carers present.

name/grade

signature

date and time

In-Patient Admission Notes


 2107796165
Patie WILSON
 Gayle
 1-1
 37A DOWANHILL STREET
 Glasgow, Lanarkshire
 21/07/1979
 G11 5RN

Seen By:

Print:

Time Seen:

Pg. No:

PRF Reviewed Yes / No

Presenting Complaint(s)	
Presenting complaint	
History of presenting complaint	

Past Medical History / Review of portal

Systemic Enquiry

Patient ID label

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)

[illegible]

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

Pharmacy review	Comments

Compliance aid : ☐ Yes ☐ No

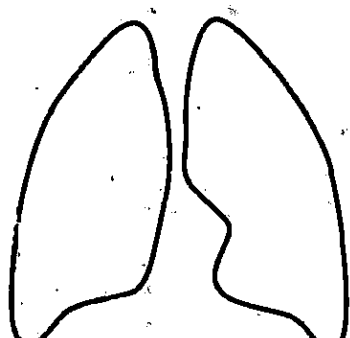
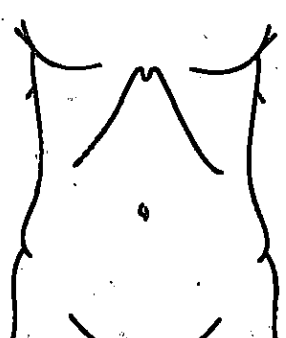
Community pharmacist Phone

Reviewed by : _____ Designation : _____ Date : _____

Patie	
2107798165	
WILSON	
Gayle	F
1-1	21/07/1979
37A DOWANHILL STREET	
Glasgow, Lanarkshire	
G11 5RN	

Social History \ Family History	
Smoking History Ex-smoker/Smoker _____ cpd _____ yrs ☐ Never smoked	
Alcohol History _____ Units/week FAST score if excess _____	
Recreational Drugs Driving Status	
Social Circumstances (home, supports, functional status, occupation, travel)	

General Examination		General Appearance:
Temp: _____	RR: _____	
Pulse: _____	CBG: _____	
SpO ₂ : _____	Weight: _____	
BP: _____	Urinalysis: _____	

Respiratory	Gastrointestinal System
	

Cardiovascular	Locomotor

Patient ID label

Neurological system

GCS: /15

E: /4

M: /6

V: /5

AMT 4 = age, DOB, place, year

AMT score ____ /4

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

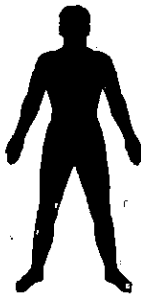
Pupils/fundoscopy:

**Cerebellar and
extrapyramidal:**

Cranial Nerves:

Neck:

Reflexes:



	RUL	LUL	RLL	LLL
Tone				
Power				
Co-ordination				
Sensation				

Plantars: R L

Skin/Other



2107796165

WILSON

Gayle

1-1

37A DOWANHILL STREET
Glasgow, Lanarkshire

21/07/1979

G11 5RN

Key Results

CXR

ECG

(Differential) diagnosisNEWS ☐Red Flag ☐Sepsis ☐CURB 65 ☐**Management Plan**☐ Thromboprophylaxis assessed
☐ Antimicrobial☐ Medicine Reconciliation☐ 4AT/TIME

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

☐ Thromboprophylaxis assessed
☐ Antimicrobial

☐ Medicine Reconciliation
☐ DNACPR

☐ 4AT/TIME
☐ AWI if appropriate

Sepsis Six

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



2107798165

WILSON

Gayle

1-1

37A DOWANHILL STREET
Glasgow, Lanarkshire

F

21/07/1979

G11 5RN

Medical patient thromboprophylaxis decision aid – ENSURE BLACK BOX COMPLETEDIs the patient bed-bound or expected to have reduced mobility relative to normal for ≥ 2 days☐ Yes☐ No

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 thrombophilia	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

- 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 contraindications? Tick if apply

Active bleeding	Untreated inherited bleeding disorder
Acquired bleeding disorder	Thrombocytopenia $< 75 \times 10^9/l$
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	

☐ No☐ Yes

- 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

Enoxaparin 40mg; (reduce to 20mg if weighs < 50 kg 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

[illegible]



2107788165

WILSON

Gayle

1-1

37A DOWANHILL STREET

Glasgow, Lanarkshire

F

21/07/1979

G11 5RN

Post Take Ward Round IAU/ARU

Consultant: _____ Date: _____ Time: _____

Summary

Temp:

Pulse:

BP:

SpO₂: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

[illegible]

Patient ID label	
-------------------------	--

Continuation Sheet	
--------------------	--

[illegible][illegible]

Patient ID label

Date: Time

[illegible]



2107798165

WILSON

Gayle

1-1

37A DOWANHILL STREET
Glasgow, Lanarkshire

21/07/1979

F

G11 5RN

Continuation Sheet

Date: Time



2107796165

WILSON

Gayle

1-1

37A DOWANHILL STREET

Glasgow, Lanarkshire

21/07/1979

F

G11 5RN

Affix Label



CHI: 2107796165

Queen Elizabeth University Hospital

Total Att: 24

12 Mth Att: 0

Title: MISS

WILSON

Gayle

DOB 21/07/1979

Age: 45y

Sex: Female

1-1

37A DOWANHILL STREET

Glasgow

Lanarkshire

G11 5RN

07490319509

Next of kin: WINTERS, Rita

Relationship: Aunt

01412301448

GP: GM Georgiev

0141 339 0902

Attendance Date: 04/01/2025

Arrival Time: 21:44

Registration Time: 21:44

Date of Incident: 04/01/2025

Major Incident Desc:

Reason for Attendance: od, L side pain

Affix

Nursing Assessment

Alerts: Not Recorded

Allergies: Not Recorded

Pain Score:

Triage Category: 3

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 04/01/2025 22:57

Nurse name: Emergency Nurse Practitioner

Temp	35.6	C
HR	114	bpm
BP	140/96	mmHg
MAP	110.67	mmHg
RR	14	bpm
SpO2	96	%
Oxygen		%

BM	Lesley McFarlane
PF	1/min
Expected PF	1/min
Weight	kg
Height	cm
Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

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

Nursing Notes: Self ref- States taken 14 nurofen Thurs and 10 on Friday, due to family worries.
Regretful -tonight c/o R sided abdo pain and nausea

Date

Emergency Department Notes

05/01/25

Ambulance Proforma reviewed Yes / No

Seen by (Doctor)

CONOR RICHARDS

Time seen

0630

45

+

PC: Overdose

BG: EUPD, prev ODs, LD, Meds: zestrone, dapagliflozin, Gliclazide, Quetiapine, Aripiprazole, TZDM, supported living

HPC:

Overdose: - Neurofen (ibuprofen): - Thurs = 14 tablets
- No other meds. - Fri = 10 tablets

Abdo Pain: - LUQ/epigastric pain, No radiation.
- burning type pain.
- onset today
- nausea, no vomiting
- No fever, No LUTS, No stool changes, No dysphagia

?Suicidal: - took OD with harm / help-seeking intent
- regretful now
- trigger is recent bereavement.
- Nil on 4 systemic enquiry.
- seeing CPN next week.

OLG:

① Patient

② 

examined No LUTS
nil added sounds

③ H&H, pulse reg,
nil oedema, w/ BP, calves SRT

④ GCS 15/15, oriented

⑤  epigastric/ LUQ tenderness
BS re-

[Vitals 0]

RR 14

Sats 97% OA

HR 76

BP 131/78

Temp 36.2°C

⑥ VRS

Patient ID label



2107798165
WILSON
Jayle

F
21/07/1979

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen
	<u>Bloody:</u> FBC - Hb 88, WCC 9.6, p^{lt} 131 UREs - Na 133, K 3.6, Cr 48, Ur 3.6 LFTs (N) ALP 6 P^{an} 25	

Differential Diagnosis/Problem List

Ibuprofen OD
self-harm : intent : regretted of OD, not suicidal
NSAID Gastritis

NEWS

☐

0-7

RED FLAG

☐

(Tick)

SEPSIS

☐

CURB 65

☐

Done/ completed	Immediate Management Plan
	- Omeprazole
	- Has Y follow up
	- discharge

Signature:

Designation:

CDF

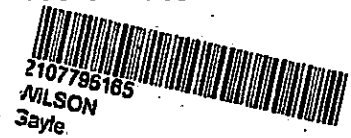
Page No:

2840882

PLEASE DO NOT WRITE HERE

In-Patient Admission Notes

Patient ID label



21/07/1979 F

Seen By:

Print:

Time Seen:

PRF Reviewed Yes / No

Presenting Complaint(s)

Presenting complaint

History of presenting complaint

Past Medical History / Review of portal

Systemic Enquiry

Patient ID label

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)

[illegible]

Allergies

List any over-the-counter or alternative medicines

List collected by :

Do medicines need further clarification? ☐ Yes ☐ No

Designation :

Plan approved by :

Date :

Designation :

Date :

Pharmacy review

Comments

Compliance aid :

- ☐ Yes ☐ No

Community pharmacist

Phone

Reviewed by :

Designation :

Date :

Patient ID label



2107786165

WILSON

Gayle

11-1

F

21/07/1979

37A DOWANHILL STREET
Glasgow, Lanarkshire

G11 5RN

Social History \ Family History

Smoking History

Ex-smoker/Smoker _____ cpd _____ yrs

☐ Never smoked

Alcohol History

_____ Units/week

FAST score if excess _____

Recreational Drugs

Driving Status

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

General Examination

Temp: _____

RR: _____

Pulse: _____

CBG: _____

SpO₂: _____

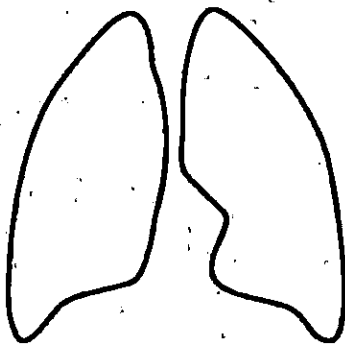
Weight: _____

BP: _____

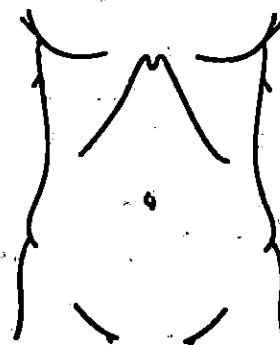
Urinalysis: _____

General Appearance:

Respiratory



Gastrointestinal System



Cardiovascular

Locomotor

Patient ID label

Neurological system

GCS: /15

E: /4

M: /6

V: /5

AMT 4 = age, DOB, place, year

AMT score ____ /4

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

Pupils/fundoscopy:

Cerebellar and
extrapyramidal:

Cranial Nerves:

Neck:

Reflexes:



	RUL	LUL	RLL	LLL
Tone				
Power				
Co-ordination				
Sensation				

Plantars: R L

Skin/Other

Patient ID label



2107796165

WILSON

Gayle

F
21/07/1979

1-1
37A DOWANHILL STREET
Glasgow, Lanarkshire

G11 5RN

Key Results

CXR

ECG

(Differential) diagnosis

NEWS ☐

Red Flag ☐

Sepsis ☐

CURB 65 ☐

Management Plan

☐ Thromboprophylaxis assessed
☐ Antimicrobial

☐ Medicine Reconciliation

☐ 4AT/TIME

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

☐ Thromboprophylaxis assessed
☐ Antimicrobial

☐ Medicine Reconciliation
☐ DNACPR

☐ 4AT/TIME
☐ AWI if appropriate

Sepsis Six

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

Patient ID label

2107798165
WILSON
Gayle
1-1
37A DOWANHILL STREET
Glasgow, Lanarkshire
G11 5RN

21/07/1979

Medical patient thromboprophylaxis decision**BOX COMPLETED**Is the patient bed-bound or expected to have reduced mobility relative to normal for ≥ 2 days☐ Yes☐ No

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 thrombophilia	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

- 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 contraindications? Tick if apply

Active bleeding	Untreated inherited bleeding disorder	
Acquired bleeding disorder	Thrombocytopenia $< 75 \times 10^9/l$	
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		

☐ No☐ Yes

- 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

Enoxaparin 40mg (reduce to 20mg if weighs < 50 kg 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

[illegible]

Patient ID label



2107796165

WILSON

Gayle

1-1

37A DOWANHILL STREET

Glasgow, Lanarkshire

F

21/07/1979

Post Take Ward Round IAU/ARU

Consultant: _____

Time: _____

G11 6RN

Summary

Temp:

Pulse:

BP:

SpO₂:

FiO₂:

RR:

Diagnosis:

Plan:

Recommended Destination: _____

Suitable to board if required ☐ Yes ☐ No

Expected Date of Discharge: _____

Signature: _____

Designation: _____

Bleep Number: _____

Continuation Sheet

Patient ID label	
-------------------------	--

Patient ID label



Gayle

21/07/1979

Glasgow, Lanarkshire.

F	V
179	0
	1
	2
	G

Date: Time[illegible]

Patient ID label

Patient ID label



2
V
F
G



--	--

Date: Time

[illegible]



2107796165

WILSON

Gayle

1-1

21/07/1979

37A DOWANHILL STREET
Glasgow, Lanarkshire

G11 5RN

Greater Glasgow & Clyde Emergency Department Mental Health Triage and Risk Assessment

2107796165
WILSON
Gayle
21/07/1979

NHS
Greater Glasgow
and Clyde

Part One - Nursing Triage

triage nurse to
complete this page

F
CHI

Triage Observations

document physiological measurements

GCS	BM	HR	BP	RR	SaO ₂	Temp
15		114	140/96	14	97.8	35.6

Outline of Presentation

tick all the categories which apply

Overdose (will also require medical assessment)	☒
Self-Injury (will also require wound management)	☐
Other Mental Health Presentation	☐

accompanied by

name, relationship,
particular concerns

Alone

Describe the appearance/clothing of those attending alone, as they may leave before review.

Is the patient a young person in foster care or in a residential care placement? YES/NO

Is the patient a carer for a child or a dependent adult? YES/NO

Is there a child protection concern or concern for a vulnerable adult at risk? YES/NO

Initial Presentation, Appearance and Behaviour

respond yes or no to each question,
in any order which seems appropriate

Is the patient violent, aggressive or threatening?	Y	N
Is the patient obviously distressed, markedly anxious or highly aroused?	Y	N
Is the patient preoccupied, erratic or impulsive?	Y	N
Is the patient quiet and withdrawn?	Y	N
Do you think the patient is behaving inappropriately to their situation?	Y	N
Do you think the patient presents an immediate risk to you, to others, or to themselves?	Y	N
Do you think the patient is likely to abscond prior to assessment?	Y	N
Do you think the patient's presentation suggests either hallucinations or delusions?	Y	N
Do you think the patient feels their actions are being controlled?	Y	N
Are you aware of a history of mental health problems or psychiatric illness?	Y	N
Are you aware of a history of violence or self-harm?	Y	N
Is the patient currently expressing suicidal thoughts?	Y	N
Is the patient currently intoxicated, with alcohol, or other substances?	Y	N

*Delusions: false but firmly held views and ideas. Hallucinations: false external stimuli (for example, visual or vocal) the patient thinks are real

Triage Risk Assessment

identify an initial category of risk,
select one or more risks

High / Moderate / Low - risk
of self-harm / violence / absconding

Triage Category

3

High risk - accompanied and in the clinical area.
Moderate risk - accompanied or in the clinical area.
Low risk - can be asked to wait if necessary.

Immediate management

print toxbase information, and in paracetamol overdose, note 4-hour time for blood sample.

Patient location,
accompanied by...

Summary

White Souper - Grey
Black Joggers
5ft 5in Short hair

Blood sample time?

Toxbase info printed? Y/N

GMAWS considered? Y/N

Any responses in
the first column
High Risk

Other patients can
be categorised as

Moderate Risk

If all responses are
in the third column

Low Risk

name/grade

signature

date and time

4/1/24 2300

Part Two - Mental Health Assessment

medical staff to complete this page

Patient name

.CHI

outline of current presentation and precipitating factors

current and previous mental health problems, self-harm episodes, problematic alcohol and/or drug use, contacts with mental health services

other relevant information, (relationships, finances, employment, housing, physical health, childcare responsibilities, current medications, etc) - protective factors (beliefs, relationships, plans for future) - views of relatives/carers/significant others

Risk Factors

(this is not an exhaustive list)

alcohol or drug use	
planning or concealment	
evidence of psychosis	
ongoing suicidal intent	
family concern about risk	
access to lethal means	
lack of social support	
age and gender	
chronic illness/pain	
family history of suicide	
disorganised/noncompliant	
unemployed/retired	
previous violent methods	
history of self-harm	
current psychiatric treatment	
previous psychiatric treatment	

Appearance

Behaviour

Speech

Mood

Thought

Insight

careful consideration should be given to patients who may present particular risks, including patients who may have post-natal depression, or patients with 'first presentations' of mental health problems, especially in adolescence or old age.

Risk Assessment

based on clinical assessment indicate a category of risk for a further episode of self-harm in the short term (48hrs) - consider protective as well as precipitating factors.

High / Moderate / Low

Discharge Advice and Plan for Further Assessment

Indicate the follow-up plan - referral to Liaison Psychiatry, duty doctor, out-of-hours CPN service, CMHT, GP, addiction services, SW, etc - indicate the advice given to the patient, and identities of others informed.

summary

follow up and advice given

service referred to

name/relationship of carer informed

consultant/middle-grade involved in decision or review

If young people in foster care or residential care are assessed, their social work team should be informed (via stand-by SW if out-of-hours) as well as giving information and advice to carers present.

name/grade

signature

date and time



CHI: 2107796165

Queen Elizabeth University Hospital

SGH

Total Att: 22

12 Mth Att: 2

Title: MISS

WILSON

Gayle

DOB 21/07/1979

Age: 42y

Sex: Female

52 DALHOUSIE ST

Next of kin: WINTERS, Rita

Relationship: Aunt

01412301448

Glasgow
Lanarkshire

G3 6PN

07771241541

GP: NT Bhatti

0141 334 9331

Attendance Date: 30/11/2021

Arrival Time: 04:31

Registration Time: 04:31

Date of Incident: 30/11/2021

Major Incident Desc:

Reason for Attendance: od

Nursing Assessment

Alerts: Not Recorded

Allergies: Not Recorded

Pain Score:

Triage Category: 2

Tetanus up to date/fully immunised:

Presenting Complaint: Psychiatry DSH - Overdose

Observation Date: 30/11/2021 05:05

Nurse name: Nurse Laura Dempster

Temp	36.7	C
HR	101	bpm
BP	139/95	mmHg
MAP	109.67	mmHg
RR	16	bpm
SpO2	96	%
Oxygen		%

BM	8.6	mmol/L
PF		1/min
Expected PF		1/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

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

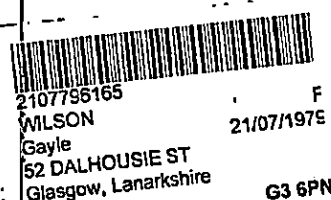
Nursing Notes: OD of x16 paracetamol at 2130 with suicidal ideation. Ongoing suicidal thoughts, mood very low. In homeless accommodation and feels she is not getting sufficient support from staff or from her psychiatrist. Reports x14 neurofen OD last week - did not seek medical help. hx overdose, mental health, anxiety, t2dm, depression, high cholesterol

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) M DENKER

Time seen 6:40

25/11/21

(A2) PC: intentional paracetamol OD

HPC:

* See mental health proforma *

Took 16 x paracetamol with suicidal intent around 21:30 last night.

Regrets that this didn't work, wishes that it had.

This am feels tired but otherwise physically well.

- No vomiting
- No abdo pain
- Nil else on systemic enquiry.

O/E: HR 101
RR 16

BP 139/95
SpO2 96% OA
Temp 36.7°C

 Chest clear.
HS 1+1+0. Regular.

 Abdo SNT.
Bowel sounds normal.

Ump: bloods normal (see reverse)
⇒ no indication for NAC
ongoing suicidal intent.

Plan ① Refer Levenshale

PMH:

EUPD

Depression

Learning difficulties

T2DM

DM:

Sertraline

Quetiapine

Atorvastatin

Dapagliflozin

Cliclozide

Allergic to

Penicillins

⇒ Rash

SH:

in homeless
accommodation

Smokes 20 cig/
day

Denies alcohol

Denies recreational
drugs



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Glasgow, Lanarkshire

21/07/1975

G3 6PA

F12 DENKER

Date	CLINICAL NOTES						
	<u>Bloods:</u> $\text{Hb } 152$ $\text{WCC } 6.9$ $\text{CRP } 11$ $\text{Urea } 3.5$ $\text{Creat } 68$ $\text{eGFR } 760$ $\text{Bili } 8$ $\text{ALT } 22$ $\text{AST } 16$ $\text{ALP } 98$ $\text{Paracetamol } 12 \Rightarrow$ <u>below treatment line</u> $\text{Salicylate } < 50$ $\text{Etheneol } < 10$ $\text{CK } 42$ $\text{Mg}^{2+} 0.76$ $\text{Lactate } 1.5$ $\text{Glu } 10.9$ $\text{Ca}^{2+} \text{ adj } 2.41$ $\text{Phos } 1.62 (\uparrow)$ Coag (N) $\text{INR } 0.9$						
08:15	<u>FY2 DENKER</u> Re-contacted Lennedale - they will kindly phone back.  FY2 DENKER						
30/11/21 0840	<u>Beeston ST1</u> Patient wishing to leave the ED. Says she just wishes to go home. Not wanting to tell me any future plans 'that's for me to know and you to find out'. Not vocalising any active thoughts of suicide, expressing her dislike for her Psyc. team & doesn't wish to speak to them. Pt then left the ED. D/W Cons Dr OOMMEN - Pt has chronic risk of harm to self/suicide but has capacity and does not need to be returned to the ED. D/W Lennedale and they will leave when community team to follow the Pt up. Pt has previously not engaged with services.						
Discharge Codes (Please CIRCLE) be returned to the ED. D/W Lennedale and they will leave when community team to follow the Pt up. Pt has previously not engaged with services.							
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 date 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	

Emergency Department Mental Health Triage and Risk Assessment

Emergency Department Triage

This side to be completed by triage nurse

Patient Name

DoB

2107796165
WILSON
Gayle

21/07/197

Triage Observations

Document physiological measurements

GCS	BM	HR	BP	RR	SaO ₂	Temp
15	8.6	102	129/95	16	96	36.7

Accompany

Name, relationship, particulars, cons

OWN

Outline of Presentation

Tick all those categories which apply and provide a brief summary

Overdose - will require medical assessment	☒
Self-Injury - will require wound management	☐
Other Mental Health Presentation	☐

Or describe the patient's physical appearance/clothing if attending alone as they may leave before assessment

Is the patient a young person in foster care or in a residential care placement? Yes/No

Is the patient a carer for a child or for a dependent-adult? Yes/No

Is there a child protection concern or concern for an adult at risk? Yes/No

Initial Presentation, Appearance and Behaviour

Respond yes or no to each question, in any order which seems appropriate

Is the patient violent, aggressive or threatening?	Yes	No
Is the patient obviously distressed, markedly anxious or highly aroused?	Yes	No
Is the patient quiet and withdrawn?	Yes	No
Do you think the patient is behaving inappropriately to their situation?	Yes	No
Do you think the patient presents an immediate risk to you, to others, or to themselves?	Yes	No
Do you think the patient is likely to abscond prior to assessment?	Yes	No
Do you think the patient's presentation suggests either delusions or hallucinations?*	Yes	No
Do you think the patient's presentation suggests they feel their actions are being controlled?	Yes	No
Are you aware of a history of mental health problems or psychiatric illness?	Yes	No
Are you aware of a history of violence or self harm?	Yes	No
Is the patient currently expressing suicidal thoughts	Yes	No

*Delusions; false but firmly held views and ideas. Hallucinations; false external stimuli (e.g. visual or vocal) the patient thinks are real

Triage Risk Assessment

Indicate an initial category of risk by circling one and selecting one or more risks

**High/Moderate/Low
Risk**

of self-harm/violence/absconding in department

Triage Category

high risk - supervised *and* in the department
moderate risk - supervised *or* in the department
low risk - can be asked to wait if necessary

Any responses in the first column

High Risk

Other patients can be categorized as

Moderate Risk

If all responses are in the third column

Low Risk

Immediate Management

Print toxbase information, and in paracetamol overdose, document 4 hour time for sample

Patient location, supervised by...	OWN
Blood sample time?	Toxbase Information Printed?

Print Name

Signature

Date: 20/11/21

Time: 05:10

Emergency Department Mental Health Assessment

This side to be completed by medical staff

Outline of current presentation and precipitating factors

N21:30 left night took intentional paracetamol OD with suicidal intent. Ongoing suicidality - states if went down would get more paracetamol straight away to try again. Regretful that this attempt did not work.

Previous mental health problems, self harm, addictions, medication etc

Prev. ODs & suicide attempts
Feels her psychiatrist is "useless" and does not care about her at all

Other relevant information; relationships, finances, employment, housing, physical health, childcare etc

Homeless accommodation

Appearance

Poorly kept

Behaviour

Withdrawn
Agitated at times

Speech

Slow, then rapid, agitated

Mood

Low

Thought

Ongoing suicidality
No psychosis

Insight

Has insight

Risk Factors (yes/no/unknown)

male gender	y	n	u
age >18 and <65	y	n	u
depression	y	n	u
alcohol or drug use	y	n	u
separated, widowed, divorced	y	n	u
suicide plan/concealment	y	n	u
evidence of psychosis	y	n	u
ongoing suicidal intent	y	n	u
lack of social support	y	n	u
chronic physical illness/pain	y	n	u
family history of suicide	y	n	u
family concerned about risk	y	n	u
disengaged/poor compliance	y	n	u
unemployed or retired	y	n	u
access to lethal means of harm	y	n	u
previous violent methods	y	n	u
history of self harm/overdose	y	n	u
previous psychiatric treatment	y	n	u
current psychiatric treatment	y	n	u
current use of benzodiazepines	y	n	u

If young people in foster or residential care are assessed, their social work team should be informed, (via standby SW if out-of-hours), and correspondence given to carers present.

Print Name _____

Signature _____

Date & Time _____

Risk Assessment

Based on clinical assessment, indicate a category of risk of a further episode of self-harm in the short term - 48 hrs - considering any protective as well as precipitating factors

High/Moderate/Low

Summary and Plan for Further Assessment

Referral to liaison psychiatry, duty doctor, CPN service, CMHT, GP, addiction services, SW, etc

Summary

Service Referred to

Liverdale MHAU

Time of Referral

11:07:35

Discharge

Indicate the follow-up plan, advice given, and identities of others informed of the decision

Follow up and advice

Caregiver informed

Name and Designation of Consultant or Middle-Grade Involved in Reviewing Patient

Patient name

Patient CHI

2107796165. F
 WILSON 21/07/1979
 Gayle
 52 DALHOUSIE ST
 Glasgow, Lanarkshire G3 6PN

Emergency Care Nursing Documentation

Presenting complaint - and relevant past medical history including allergies

Date and Time		Name/Signature
30/11/21	OP 16 paracetamol at 2130	
0520	Suicidal intent	

Nursing notes - on admission

Date and Time		Name/Signature
30/11/21	ecg 10 bloods	
0520	apex stable	
	ongoing suicidal thoughts	

Triage

Patient prepared for exam - clothing bagged				☒	☐
NEWS Chart	☒	☐	X-rays	☒	☐
ID band	☒	☐			
Peak Flow	☒	☐	Please specify		
12-lead ECG	☒	☐	Urinalysis	☒	☐
IV access	☒	☐			
Blood samples	☒	☐	Positive findings		
Blood Gas	☒	☐	B-HCG	☒	☐

Communication

GGC Red Bag with Patient (nursing home resident)	☒	☐
Language or hearing difficulty	☒	☐
Interpreter required	☒	☐
what arrangements have been made?		
Relatives / Carer / Next of Kin present	☒	☐
name, relationship, location, particular concerns		

Risk Assessments and Screening Tools

SEPSIS	☒	☐	GMAWS	☒	☐
FAST	☒	☐	Adult Support and Protection	☒	☐
Swallow Testing	☒	☐	Mental Health Triage Assessment	☒	☐
Falls Risk (clinical judgement)	☒	☐	Child Protection Concerns	☒	☐

Signature:

Patient name

Patient CHI

or use sticker



Care Rounds Checklist

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**

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Use the following Codes:

Y = Yes **N** = No **NA** = Not Applicable **NT** = No Thanks **S** = Sleeping **O** = Off the ward **I** = Independent

		Times																
	1	THINK DELIRIUM Is the patient more confused/drowsy than normal? If yes inform registered nurse.																
	2	PAIN: ASSESS AND ADDRESS. Is the patient distressed or in pain? If yes inform registered nurse.																
S	3	SKIN INSPECTION Pressure areas checked? R = RED D = Discoloured PU = Pressure Ulcer INT = Intact M = Moisture																
K	4	KEEP MOVING Has the patient moved or walked? Bed R = Right side (30°) tilt L = Left side (30°) tilt B = Back Chair W/ST = Assist to walk / stand																
		ELIMINATION. Does the patient need the toilet?																
I	5	I = Independent A = Assistance given IC = Incontinent (urine/faeces)																
N	6	FOOD FLUIDS AND NUTRITIO. Is the patient nil by mouth? Drink taken? Food, snack, or supplements taken? Has oral hygiene been carried out as per care plan?																
	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 the lowest position?																
	8	INFORMATION Is there anything else I can help you with? Inform the patient of the time of return																
	9	ESCALATION Is there anything else I can help you with? Inform the patient of the time of return																
Care provider																		
Role																		

Ask the patient if there is anything they specifically want done today:

Patient name

Patient CHI

Hospital:

Points to consider:

• Use within 8 hrs of admission to care area

• Re-assess daily and more frequently if a person's condition changes



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PUDRA

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

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

2	Mobility	Does the person require assistance to mobilise or change position (inappropriate for age)?
3	Continence	Does the person have continence issues with urine and/or faeces (inappropriate for age)?
4	Nutrition	Does the person appear malnourished and/or unable to eat or drink/ PYMS score>2?
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? If Yes, please give details:

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

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

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
/ /	:							_____hrly	
/ /	:							_____hrly	
/ /	:							_____hrly	

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

S Skin Inspection	S Surface	K Keep Moving	I Incontinence/ Moisture	N Nutrition	S Self Management/ Shared Care
Check: • Pressure areas _____ hourly • Skin under medical devices _____ hourly • Specify medical devices used	Specify: 1. Mattress 2. Cushion 3. Detail additional pressure redistributing equipment	1. Reposition _____ hourly in bed / chair 2. Overnight patient/carer has agreed to repositioning _____ hourly 3. Specify any manual handling equipment used	1. Skin Care to be carried out _____ hourly 2. Specify products required for increased moisture/ continence management:	1. Optimise nutrition and hydration 2. Refer to MUST	1. Discuss and agree plan with patient/ family/carer YES / NO 2. Prevent Pressure Ulcers" leaflet given to patient/family/ carer YES / NO

Patient CHI

NHS
Greater Glasgow
and Clyde

[illegible]

Date and Time			Name/Signature

GGC Red Bag with Patient (nursing home resident)	Y	N
Relatives / Carer with Patient	Y	N
Name Band	Y	N
Nursing Screening Tools Complete	Y	N
Bed Available	Y	N
SBAR complete	Y	N
NEWS Chart NEWS completed within 1 hour of transfer/discharge	Y	N
Prescriptions and fluid charts signed	Y	N
Cannula	Y	N
Notes Complete	Y	N
Analgesia	Y	N
Belongings	Y	N
Transport	Y	N
Signature:		

[illegible]

Patient name

Patient CHI

or use sticker

4AT assessment - for delirium and cognitive impairment

(1) ALERTNESS This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.		Normal (alert, but not agitated, through assessment) Mild sleepiness (<10 secs) after waking, then normal Clearly abnormal	Circle Score 0 0 4
(2) AMT4 Age, date of birth, place (name of the hospital/building), current year.		No mistakes 1 mistake 2 or more mistakes/untestable	0 1 2
(3) ATTENTION Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.		Achieves 7 months or more correctly Starts but scores <7 months / refuses to start Untestable (cannot start, unwell, drowsy, inattentive)	0 1 2
(4) ACUTE CHANGE OR FLUCTUATING COURSE Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs.		No Yes	0 4
4 or more possible delirium +/- cognitive impairment 1-3 possible cognitive impairment 0 delirium or severe cognitive impairment unlikely (but delirium still possible if (4) information incomplete)		TOTAL	

Frailty Assessment Tool

(Healthcare Improvement Scotland)

Step 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?				circle Y or N	
F	Functional impairment	(new or worsening) eg difficulty with self care	Y	N	
R	Resident	in a care home	Y	N	
A	Altered mental state	such as delirium or dementia (4AT Assessment)	Y	N	
I	Immobility/instability	decline in mobility, difficulty mobilising without help, fall leading to presentation	Y	N	
L	Living at home with support	on a daily basis (homecare, one visit or more per day)	Y	N	
If YES to any of the criteria in Step 1 move to Step 2					
Step 2 Would this person be better managed by another speciality team at present?				circle Y or N	
Clear need for other specialty input eg exacerbation of known long-term condition such as COPD			Y	N	
Need for HDU/ITU (including non-invasive ventilation)			Y	N	
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit			Y	N	
Head injury with loss of consciousness			Y	N	
Acute abdominal pain/ surgical presentation			Y	N	
Upper GI Bleed			Y	N	
Chest pain with suspected acute coronary syndrome			Y	N	
Trauma with suspected fracture			Y	N	
Are any of the 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 YES to any criteria in Step 1 and NO to ALL criteria in STEP 2: Prioritise transfer of care to specialist geriatric assessment service.					

NEWS 2 Key 1 2 3

Date	1/10	1/10	1/10
Time	11:00	11:00	11:00

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A + B Respirations Breaths/min	17	17	17
--------------------------------------	----	----	----

A + B SpO2 Scale 1 Oxygen saturation (%)	97	97	97
--	----	----	----

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			
--	--	--	--

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

C Blood Pressure mmHg Systolic mmHg (SP) Diastolic mmHg (DP)	118	118	118
---	-----	-----	-----

C Pulse Beats / min	60	60	60
---------------------------	----	----	----

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

E Temperature	36.1	36.1	36.1
------------------	------	------	------

	0	0	0
--	---	---	---

Blood glucose	7.0	7.0	7.0
Pain / function score	04	04	04
Time Pt last passed urine	10:20	10:20	10:20
Fluid balance chart Indicated Y/N	N	N	N
GCS indicated Y/N	N	N	N
Time NEWS due	23:00	23:00	23:00
Escalation of care Y/N	N	N	N
Initials	AB	AB	AB

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 P/C		
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.

225 3
21-24 2
12-20 0
9-11 1
≤0 3

296 0
94-95 1
92-93 2
≤91 3

≥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 (A) or
O2 L/min 2

≥120 3
201-219 0
101-200 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

≥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

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

≥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

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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Affix Patient ID

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

SpO2 Scale 1
Target >96%

Signature: _____
Print Name: _____
Dr/ANP Initials ONLY: _____
Date: _____

SpO2 Scale 2
Target 88-92%

Signature: _____
Print Name: _____
Dr/ANP Initials ONLY: _____
Date: _____

Patient on home oxygen Y ☐ N ☐

If yes, add details of oxygen therapy

Document all actions and interventions

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

1 = sluggish
2 = no reaction
3 = eyes closed

Pupil Size (mm)

1 2 3 4 5 6 7 8

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 their pain by using numerical scale 0 to 10. Use this chart below to assist the patient. If the patient is unable to communicate, use alternative pain scoring tool.

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

NI • 31654 v5.1 • GGC0264

2. Bloods at
2am

NHS GGC Hospitals, Emergency Department

NHS
Greater Glasgow
and Clyde



CHI: 2107796165

Queen Elizabeth University Hospital

Total Att:

17

12 Mth Att:

3

Title: MISS

WILSON

Gayle

DOB: 21/07/1979

Age: 40y

Sex: Female

FLAT 0-2
1655 DUMBARTON RD
Glasgow
Lanarkshire
G14 9YD
07770460540

Next of kin: WILSON, VIOLET
Relationship: Parent
0141 563 8676

GP: NT Bhatti
0141 334 9331

Attendance Date: 20/02/2020

Arrival Time: 23:09

Registration Time: 23:09

Date of Incident: 20/02/2020

Major Incident Desc:

Reason for Attendance: taken 26 nuerofen

Nursing Assessment

Alerts: Not Recorded

Allergies: Not Recorded

Pain Score:

Triage Category: 2

Tetanus up to date/fully immunised:

Presenting Complaint: Psychiatry DSH - Overdose

Observation Date: 20/02/2020 23:55

Nurse name: Nurse Tracey Buchan

Temp	36.9	C
HR	114	bpm
BP	138/89	mmHg
MAP	105.33	mmHg
RR	17	bpm
SpO2	96	%
Oxygen	21	%

BM	10.3	mmol/L
PF		1/min
Expected PF		1/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: pt took x26 neurofen tonight between 10 & 11pm. pt states she doesnt want to be alive.

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

Created

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

WILSON, Gayle (Miss)Date of Birth: **21-Jul-1979 (40y)**

Talbot Centre, 52 Dalhousie Street, Glasgow, Lanarkshire, G3 6PN

CHI Number: 210 779 6165

Usual GP: GHOURI, NA (Dr)

Consultations

Date	Consultation Text
21-Feb-2020 06:40	Face to face consultation (Caledonia House) MCCREADIE, Mairi (OOH)
Comment	Situation Request for assessment made by medical staff at the QEUH. Gail had presented to A&E alleging an overdose of 26 Nurofen between 10pm & 11pm on 22/2/20. Background Gail is known to SpringPark CMHT with a diagnosis of EUPD and Learning Difficulties. Her previous history is well documented on Emis notes. Assessment Gail was assessed by Mhairi McCreadie & Joanne Brooks at the QEUH. Gail was asleep on our arrival but easily roused at assessment. Gail engaged well with assessment. She maintained good eye contact, her speech was normal in rate and tone. She was not under the influence of illicit substances or alcohol at the time of assessment. Gail was noted to be reasonably well kempt, appropriately dressed. Gail describes low mood, at assessment her mood was noted to be reactive. She does not complain or present with any symptoms of psychosis. She describes worsening mood since the death of her sister last Summer. She states that her sister was more like a parent, who looked after her and supported her from a young age. She states that she has taken overdoses in the past and also still cutting herself on occasion. She states that her decision to take the overdose last night was impulsive with no particular trigger. She is unhappy with her current supported accommodation, she states that she wants to be moved back into the West End as that is where she feels more comfortable, she states that she has discussed this with her Social worker. At the time of assessment Gail denied any ongoing thoughts to harm herself, or any suicidal plan /intent. She was keen to get home and sleep. She also states that she feels she needs the support of a CPN but has been advised but that this will not be offered at present. Recommendation Gail agreed that we would pass details of this assessment to her team at SpringPark CMHT. Risk Gail denies any ongoing plan or intent to harm herself.
Additional	Discharge from care Appointment Outcome:



2107796165 21/07/1979
WILSON
Gayle



Part Two - Mental Health Assessment

medical staff to complete this page

Patient name 2107796165
CHI WILSON
Gayle

21/07/1979

outline of current presentation and precipitating factors

Upper the sister is deceased; died summer 11
Has felt very low since.
No recent trigger.
Impulsive, no planning 26x ibuprofen tablets.
Thought would be small, wishes it had been.
No regret. States she will OD again if D/C

current and previous mental health problems, self-harm episodes, problematic alcohol and/or drug use, contacts with mental health services

EUPD
LD

other relevant information, (relationships, finances, employment, housing, physical health, childcare responsibilities, current medications, etc) - protective factors (beliefs, relationships, plans for future) - views of relatives/carers/significant others

no close friends or family
no plans for future
medication in ED room

Risk Factors

(this is not an exhaustive list)

alcohol or drug use	
planning or concealment	
evidence of psychosis	
ongoing suicidal intent	
family concern about risk	✓
access to lethal means	✓
lack of social support	✓
age and gender	
chronic illness/pain	
family history of suicide	
disengaged/noncompliant	✓
unemployed/retired	✓
previous violent methods	✓
history of self-harm	✓
current psychiatric treatment	✓
previous psychiatric treatment	✓

Appearance
Obese, blue shirt, grey
joggers, short grey hair
fairly well kept

Behaviour
Lying in bed. Can become
agitated when asked
questions. Good eye contact.

Speech
no real pace +
rhythmic

Mood
"hellish"
obviously autistic

Thought
No delusions.

Insight
yes.

Careful consideration should be given to patients who may present particular risks, including patients who may have post-natal depression, or patients with 'first presentations' of mental health problems, especially in adolescence or old age.

Risk Assessment

based on clinical assessment indicate a category of risk for a further episode of self-harm in the short term (48 hrs) consider protective as well as precipitating factors.

High / Moderate / Low

If young people in foster care or residential care are assessed, their social work team should be informed (via stand-by SW if out-of-hours) as well as giving information and advice to carers present.

Discharge Advice and Plan for Further Assessment

Indicate the follow-up plan - referral to Liaison Psychiatry, duty doctor, out-of-hours GP service, CMEH, GP, addiction services, SW, etc. - indicate the advice given to the patient, and identities of others informed.

summary
N/w Psychiatry liaison
and get D/C

follow up and advice given
Medically sit

name/grade
Discussion CDF
signature
date and time

service referred to
Psychiatry liaison

name/relationship of carer informed

consultant/middle-grade involved in decision or review

Greater Glasgow & Clyde Emergency Departments' Mental Health Triage and Risk Assessment Tool



Part One - Nursing Triage

triage nurse to complete this page

Patient name: **WILSON**
CHI: **Gayle**
2107796165 21/07/1979

Triage Observations						
document physiological measurements						
GCS	BM	HR	BP	RR	SaO ₂	Temp
15	10.3	114	138/89	17	96.1	36.9

accompanied by: name, relationship, particular concerns

Alone

Outline of Presentation (tick all the categories which apply)

Overdose (will also require medical assessment) ☒

Self-injury (will also require wound management) ☐

Other Mental Health Presentation ☐

Describe the appearance/clothing of those attending alone, as they may leave before review.

Is the patient a young person in foster care or in a residential care placement? **YES/NO**

Is the patient a carer for a child or a dependent adult? **YES/NO**

Is there a child protection concern or concern for a vulnerable adult at risk? **YES/NO**

Initial Presentation, Appearance and Behaviour (respond yes or no to each question, in any order which seems appropriate)

Is the patient violent, aggressive or threatening?	Y	☒
Is the patient obviously distressed, markedly anxious or highly aroused?	Y	☒
Is the patient preoccupied, erratic or impulsive?	Y	☒
Is the patient quiet and withdrawn?	Y	☒
Do you think the patient is behaving inappropriately to their situation?	Y	☒
Do you think the patient presents an immediate risk to you, to others, or to themselves?	Y	☒
Do you think the patient is likely to abscond prior to assessment?	Y	☒
Do you think the patient's presentation suggests either hallucinations or delusions?*	Y	☒
Do you think the patient feels their actions are being controlled?	Y	☒
Are you aware of a history of mental health problems or psychiatric illness?	Y	☒
Are you aware of a history of violence or self-harm?	Y	☒
Is the patient currently expressing suicidal thoughts?	Y	☒
Is the patient currently intoxicated, with alcohol, or other substances?	Y	☒

*Delusions; false but firmly held views and ideas. Hallucinations; false external stimuli (for example, visual or vocal) the patient thinks are real

Triage Risk Assessment (identify an initial category of risk, select one or more risks)

High / Moderate / Low - risk of self-harm / violence / absconding

Triage Category: **2**
High risk - accompanied **and** in the clinical area.
Moderate risk - accompanied **or** in the clinical area.
Low risk - can be asked to wait **if necessary**.

Immediate management (print toxbase information, and in paracetamol overdose, note 4-hour time for blood sample)

Patient location, accompanied by... **Alone**

Blood sample time?

Toxbase info printed? **Y/N**

GMAWS considered? **Y/N**

Summary:
po took x 28 paracetamol between 10 + 11pm tonight.
po states she doesn't want to be alive.
po wearing grey joggers, blue grey trainers.

Any responses in the first column: **High Risk**

Other patient can be categorised as: **Moderate Risk**

If all responses are in the third column: **Low Risk**

name/grade: **Buchan**
signature: **Buchan**
date and time: **20/2/20 23.55**

Date	CLINICAL NOTES	
2/2/20	Seen by (Dr) DMILUSIEN, CDF	Time seen 0210
	<u>(40) OD</u> Deliberate OD between 10 pm + 11 pm today: 26 x ibuprofen + 2 x Sertraline 200mg. mild abdominal pain. 5200 mg ibuprofen Mental health problems completed, Dose < 100 mg/kg not toxic according to Foxburg A - parent B - chest clear Hx 1? 90% Hx 1/4 C - HSHU 139/89 Fht pulse regular Hx 1/4 D - ACS 15 (D) low pulse + reflex PEARL CN II - XII intact E -  soft non-tender B/S present 36-90C	<u>PMH</u> <u>EUPD</u> mild LD previous OD; multiple <u>DH</u> Sertraline 200mg OD Simvastatin 40mg nocte quetiapine 50mg nocte Zopiclone 7.5mg nocte <u>SH</u> non smoker non drinker no recreational drugs
	Line ibuprofen OD 1km - ECU → Hx 102 QTC 497 SN - bloods - psych Wilson T/V	



Date	CLINICAL NOTES						
Discharge Codes (Please CIRCLE) 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 date
							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	

Affix Label



CHI: 2107796165

Queen Elizabeth University Hospital

Total Att: 16

12 Mth Att: 2

Title: MISS

WILSON

Gayle

DOB: 21/07/1979

Age: 40y

Sex: Female

TALBOT CENTRE
52 DALHOUSIE STREET
Glasgow
Lanarkshire
G3 6PN
07770460540

Next of kin: WILSON, VIOLET
Relationship: Parent
0141 563 8676

GP: NT Bhatti
0141 334 9331

Attendance Date: 17/12/2019

Arrival Time: 17:50

Registration Time: 17:50

Date of Incident: 17/12/2019

Major Incident Desc:

Reason for Attendance: od

Nursing Assessment

Alerts: Not Recorded

Allergies: Not Recorded

Pain Score:

Triage Category: 3

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 17/12/2019 18:28

Nurse name: Nurse Samantha Lamont1

Temp	36.3	C
HR	124	bpm
BP	127/83	mmHg
MAP	97.67	mmHg
RR	16	bpm
SpO2	95	%
Oxygen		%

BM		mmol/L
PF		1/min
Expected PF		1/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

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

Nursing Notes: "states has taken 26 2mg diazepam - has hx of depression"

Child Assessment Questionnaire

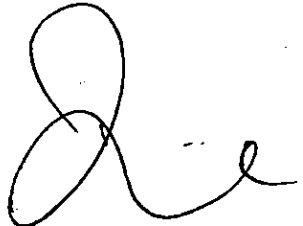
	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

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
12/11/19 2030	<u>Hazen OBTL</u> See mtg performance	  2107796165 21/07/1979 WILSON Gayle

Date	CLINICAL NOTES						
	 2107796165 21/07/1979 WILSON Gayle						
Discharge Codes (Please CIRCLE) 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 date	
						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	

Greater Glasgow & Clyde Emergency Departments' Mental Health Triage and Risk Assessment Tool



Part One - Nursing Triage

Triage Observations						
GCS	BM	HR	BP	RR	SaO ₂	Temp
15		124	127/83	16	95	36.8

Outline of Presentation	
Overdose (will also require medical assessment)	☒
Self-injury (will also require wound management)	☐
Other Mental Health Presentation	☐

Patient name CHI

Accompanied by WILSON Gayle

2107796165 21/07/1979

Describe the appearance/clothing of those attending alone, as they may leave before review.

Is the patient a young person in foster care or in a residential care placement? YES/NO

Is the patient a carer for a child or a dependent adult? YES/NO

Is there a child protection concern or concern for a vulnerable adult at risk? YES/NO

Initial Presentation, Appearance and Behaviour		
Is the patient violent, aggressive or threatening?	Y	N
Is the patient obviously distressed, markedly anxious or highly aroused?	Y	N
Is the patient preoccupied, erratic or impulsive?	Y	N
Is the patient quiet and withdrawn?	Y	N
Do you think the patient is behaving inappropriately to their situation?	Y	N
Do you think the patient presents an immediate risk to you, to others, or to themselves?	Y	N
Do you think the patient is likely to abscond prior to assessment?	Y	N
Do you think the patient's presentation suggests either hallucinations or delusions?*	Y	N
Do you think the patient feels their actions are being controlled?	Y	N
Are you aware of a history of mental health problems or psychiatric illness?	Y	N
Are you aware of a history of violence or self-harm?	Y	N
Is the patient currently expressing suicidal thoughts?	Y	N
Is the patient currently intoxicated, with alcohol, or other substances?	Y	N

Triage Risk Assessment

High / Moderate / Low - risk of self-harm / violence / absconding

Triage Category: **High Risk**

Immediate management: **Summary**

Patient location, accompanied by... **Gray hoodie**

Blood sample time? **green joggers**

Toxbase info printed? Y/N **short brown hair**

GMAWS considered? Y/N

Any responses in the first column **High Risk**

Other patient can be categorised as **Moderate Risk**

If all responses are in the third column **Low Risk**

name/grade **Shamail**

signature

date and time

Part Two - Mental Health Assessment

Patient name _____
CHI _____

outline of current presentation and precipitating factors

Take x26. 2mg diaz ~ 5.30/6pm. Repts this was sth suicidal intent. ↑ stress recently as CPN + psychiatrist are changing → due to see new team tomorrow. Also been thinking re sister (died 2 yrs ago from cardiac arrest) + dad → "Hates Christmas". Has no plans this week. Doesn't care about 4 appt tomorrow. Wants to leave department so she can go and buy lots of paracetamol + take them. Denies event on board. Called crisis post cent who said to go to ED.

current and previous mental health problems, self-harm episodes, problematic alcohol and/or drug use; contacts with mental health services

Depression / DSM / suicidality
Previous admission to Gwent Royal of note HR ~ 120 bpm. Denies paps / CP / SOB. Has been recorded on x2 previous presentations → unclear aetiology.

other relevant information, (relationships, finances, employment, housing, physical health, childcare responsibilities, current medications, etc) - protective factors (beliefs, relationships, plans for future) - views of relatives/carers/significant others

Denies any support or protective factors

Risk Factors

alcohol or drug use	
planning or concealment	
evidence of psychosis	
ongoing suicidal intent	✓
family concern about risk	
access to lethal means	
lack of social support	✓
age and gender	
chronic illness/pain	
family history of suicide	
disengaged/noncompliant	✓
unemployed/retired	
previous violent methods	
history of self-harm	
current psychiatric treatment	
previous psychiatric treatment	

Appearance

Kept

Behaviour

Anxious

Speech

not pressured

Mood

Low

Thought

Own

Insight

Poor

Careful consideration should be given to patients who may present particular risks, including patients who may have post-natal depression, or patients with 'first presentations' of mental health problems, especially in adolescence or old age.

Risk Assessment

High / Moderate / Low

Discharge Advice and Plan for Further Assessment

summary

Repts ongoing suicidality + plans

follow up and advice given

Refer CPNs

service referred to

name/relationship of carer informed

consultant/middle-grade involved in decision or review

If young people in foster care or residential care are assessed, their social work team should be informed (via stand-by SW if out-of-hours) as well as giving information and advice to carers present.

name/grade

signature

date and time

17/12/19

2540

WILSON, Gayle (Miss)Date of Birth: **21-Jul-1979 (40y)**

52 Dalhousie Street, Glasgow,, Lanarkshire, G3 6PN

CHI Number: 210 779 6165

Usual GP: GHOURI, NA (Dr)

Consultations

Date	Consultation Text
17-Dec-2019 23:02	Face to face consultation (Queen Elizabeth University Hospital) MCCREADIE Main (OOH)
Comment	Situation Request for cpn assessment of this 40 year old lady who has been brought to the accident and emergency dept of the QEUH this evening after taking 26 x 2mg of Diazepam tablets which were her own. States this was done with suicidal intent. Cpn assessment agreed. Background Has open referrals to Riverside and Springpark as she is being transferred to Springpark. Gayle states that she is not happy that her care is being transferred and wants to stay at Riverside CMHT. Has an appt with Dr McTaggart at Springpark tomorrow morning but states that she is not going to attend this. Previous referrals to out of hours cpns. Diagnosis includes personality disorder and mild learning disability. Self presented on the advice of support staff and CMHT. Assessment Assessed by cpns Mairi McCreddie and Gaynor Smith in the accident and emergency dept of the QEUH. Gayle presents as a casually dressed lady with her hood up throughout. She maintained good eye contact and her speech was normal in tone, rate and rhythm. Gayle stated that she is upset at present as her care is being transferred and she does not want to go to Possil as she does not think it is safe. She states that she cannot afford a taxi and does not feel safe walking there. She reports that she has a good relationship with her keyworker in Riverside and it is easy for her to get to appts. She is hoping to move to the Riverside catchment area. Mood appeared stable at a good level and Gayle was able to initiate humour with cpns and rapport was easily established. Reports no change in her current level of functioning on a day to day basis. No evidence of any psychotic Sx and none reported. Not preoccupied or distracted at any point. Not upset or distressed. No evidence of any agitation or anxiety. Gayle reports that she was annoyed today which is why she took the tablets. She denied that she had been planning this and did not make any preparations prior to act or conceal the act. On assessment she denied that she has any ongoing thoughts plan or intent to harm herself further. She denies any active suicidal thoughts. She is keen to return home and get some sleep. Gayle at the end of the assessment reported that she was now planning to go and see Dr McTaggart at Springpark in the morning. Recommendation Has appt with Dr McTaggart at Springpark in the morning and is planning to attend this. Utilise out of hours for support as needed. Risk Risk of impulsive behaviours when she feels frustrated or not in control. No evidence of any deterioration in mental health on assessment. Denies any ongoing thoughts plan or intent to harm self.

Affix Label

Hospital (circle)		IRH	RAH	RHC	GRI	WEST MIU	VIMIU	Stob	VOL	GEUH
Title:					Sex: M ☐ F ☐					
Surname:					Forename:					
CHI:					DOB:			Age:		
Local address:					Next of kin:			Relationship:		
 2107796165 WILSON F Gayle 21/07/1979 1-1 37A DOWANHILL STREET Glasgow, Lanarkshire G11 5RN					Tel:					
					GP:					
					Postcode:					
Tel:					Tel:					
Attendance date:				Arrival time:			Date of incident:			
Registration time:					Major incident description:					
Reason for attendance:										

Affix Label

Nursing Assessment					Alerts:			
Presenting complaint:								
Triage category:				Pain score:		Tetanus up-to-date / fully immunised?		
Allergies:								
Observations date:			Time:			Nurse's name:		
Temperature		°C	CBC		mmol/L	GCS		
HR		bpm	PEFR		l/min	Eyes		
BP		mmHg	Expected PF		l/min	Motor		
MAP		mmHg	Weight		kg	Verbal		
RR		bpm	Height		cm	Total		
SpO ₂		%	Visual Acuity			Pupils - Right		Pupils - Left
Oxygen		%	Left	6/		Size		Size
			Right	6/		Reaction		Reaction
			With correction?					
Nursing Notes:								

Patient ID label

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

Patient ID label

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen

Differential Diagnosis/Problem List	
	NEWS ☐ 0-7 RED FLAG ☐ (Tick) SEPSIS ☐ CURS 65 ☐

Done/ completed	Immediate Management Plan

Signature:	Designation:	Page No:

PLEASE DO NOT WRITE HERE

In-Patient Admission Notes

	
2107796165	
WILSON	F
Gayle	21/07/1979
1-1	
37A DOWANHILL STREET	
Glasgow, Lanarkshire	
G11 5RN	

Seen By: Waller
PRF Reviewed Yes / No

Print: Louise
Graham

Time Seen: 04:00 Pg. No:

Presenting Complaint(s)	
Presenting complaint <u>46♀</u>	<u>Chest pain</u>
History of presenting complaint	Recent admission w CP, d/c 03/01. Dx pericarditis + mild pericardial effusion. Was d/c home w colchicine. Pt reports colchicine has been helping. CP worsened at home early hrs yesterday AM. No severity sharp L sided CP. Tender on palpation + on movement. Mild SOB. No nausea / dizziness. Echo was done in ED. ↳ pericardial effusion. No evidence of systolic dysfunction. Unusual effusion has changed in size at all.

Past Medical History / Review of portal
Pericarditis + mild pericardial effusion EUPP Bilateral constricted visual fields

Systemic Enquiry



2107798165

WILSON

F

Gayle

21/07/1979

1-1

37A DOWANHILL STREET

Glasgow, Lanarkshire

G11 5RN

MEDICINES RECONCILIATION - Acceptable to staple fully completed Emed Rec

Source of medication history

☒ Patient/Relative/carer☐ GP Phone call☒ ECS

(>1 source preferred)

☐ Patient own drugs☒ Com. Pharmacist☐ GP letter/summary☐ Repeat Prescription

Other (please specify)

Admission Medicines			Plan for Medicines (Dr. complete)				Comments
Name	Dose	Freq	Continue	Amend	Withhold	Stop	Reason for alteration
SERTRALINE	200mg	OD	☒				
PARALFLOZIN	10mg	OD	☒				
QUETIAPINE	50mg	TAS	☒				
ATORVASTATIN	40mg	OD	☒				
GILLANOL	160mg	BID	☒				
COLCHICINE	500µg	BID	☒				Separate from doxycycline
IDL 8/1/20							
IBUPROFEN	600mg	tds					for 2 weeks from
(continued from - was taking)							8/1/20.
Nicorette 2mg/12hr		1 daily					
ORISPRONE	20mg	daily					for 2 weeks from
							8/1/20 (ARE com)
							while on ibuprofen
Acute Rx							
DUPESPAR	2mg	bd pm					Acute Rx 20/1/20.
Allergies			List any over-the-counter or alternative medicines				

Panicum

Do medicines need further clarification? ☐ Yes ☐ No

List collected by:

Plan approved by:

Designation:

Date:

Designation:

Date:

Pharmacy review

Comments

14/1/20

Collect on Thursdays

Compliance aid:

☒ Yes ☐ No

Community pharmacist

Phone

DICKETS PHARMACY

0141 959 2196

Reviewed by:

NMC

Designation:

Pharmacist

Date:

14/1/20.



2107796165

WILSON

F

Gayle

21/07/1979

1-1

37A DOWANHILL STREET

Glasgow, Lanarkshire

G11 5RN

Social History \ Family History

Smoking History

Ex-smoker/Smoker 20 per day cpd yrs☐ Never smoked

Alcohol History

Units/week

FAST score if excess

Recreational Drugs

Driving Status

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

lives alone, mobilises independently

General Examination

Temp: 35.4RR: 16Pulse: 88

CBG:

SpO₂: 98% OA

Weight:

BP: 102/63

Urinalysis:

General Appearance:

looks well,
comparable

Respiratory

clear
equal
AE

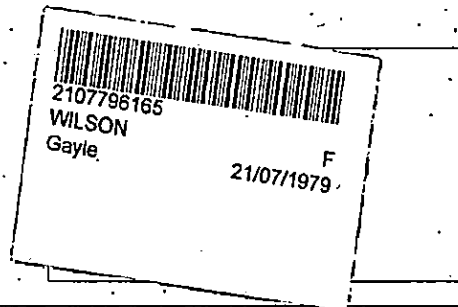
Gastrointestinal System

abdo
ont

Cardiovascular

W ~~ttt~~ 1+1+0cares ontno peripheral oedemaTender on palpation of L chest wall

Locomotor



Neurological system

GCS: 15

E: 4/4

M: 6/6

V: 5/5

AMT 4 = age, DOB, place, year

AMT score ___/4

Is the patient more confused/drowsy than normal: Y / N

If yes complete 4AT / TIME

no focal
neurological
deficit

Pupils/fundoscopy:

Cerebellar and
extrapyramidal:

Cranial Nerves:

Neck:

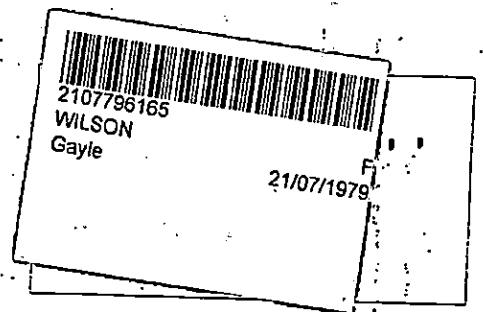
Reflexes:



	RUL	LUL	RLL	LLL
Tone				
Power				
Co-ordination				
Sensation				

Plantars: R L

Skin/Other



Key Results			
CXR	ml ante	ECG	NOR
(Differential) diagnosis			
Chest pain - ? ongoing for pericarditis		NEWS	☐
		Red Flag	☐
		Sepsis	☐
		CURB 65	☐
Management Plan			
① Analgesia			
② Proton			
③ Cardio w			
④ Telecare nurse			
☐ Thromboprophylaxis assessed		☐ Medicine Reconciliation	☐ 4AT/TIME
☐ Antimicrobial			
Signature: 		PRINT NAME	LOUISE GANNAN
		PRINT GRADE	APT 2
		Page:	

Patient ID label

Resuscitation Decision

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

If DNA CPR → Complete appropriate form

Senior Medical review

☐ Thromboprophylaxis assessed
☐ Antimicrobial

☐ Medicine Reconciliation
☐ DNACPR

☐ 4AT/TIME
☐ AWI if appropriate

Sepsis Six

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

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

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 thrombophilia	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

- 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 contraindications? Tick if apply

Active bleeding	Untreated inherited bleeding disorder	
Acquired bleeding disorder	Thrombocytopenia <75 x10 ⁹ /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		

☐ No

☐ Yes

- 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

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



	
2107796165	
WILSON	
Gayle	21/07/1979
1-1	
37A DOWANHILL STREET	
Glasgow, Lanarkshire	
G11 5RN	

Post Take Ward Round IAU/ARU

Consultant: WILSON

Date: 14/1/26 Time: 0841

Summary

460

chest pain

Recent pericarditis & eff.

Re-admitted to ICU C.P.

New resolution

ED echo, new pericardial eff.

Temp:

Pulse:

BP:

SpO₂:

FiO₂:

RR:

Diagnosis:

MI found ECG.

Obs OK

Plan: ECG - low voltages.

Plan Add NSTEMI to diagnosis.

Ask cardiology team for further thoughts given persistent ST.

Hypokalaemia ④ seen

Recommended Destination:

Suitable to board if required ☐ Yes ☐ No

Expected Date of Discharge:

Signature:

Designation:

Bleep Number:

2107796165
WILSON
Gayle
1-1
37A DOWANHILL STREET
Glasgow, Lanarkshire
G11 5RN

Continuation Sheet

Date: Time

14/1/26

14⁰⁰

ARU 2

ST7 Hunter (Cardio)

46F Pericarditis Dx. 2/52 ago. ECG: SR not auto
Pain has never really settled
CRP 7. ACR: NY Good

Bedside V-Scan: - Preserved LV Fr. TNS cl.

- No significant

valve disease.

CRP 171 (1)

- Trivial pericardial effusion E: no

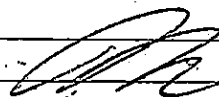
haemodynamic compromise.

Suggest: 1) Switch Ibuprofen to Naproxen 500mg bid
for 2/52 & PPI cover.

2) Continue regular Colchicine

3) R when CRP trending ↓ & pain settled.

If not improving should consider addition of Steroids.


ST7
83613

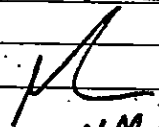
Review

15.1.26

Improving. Now on NSAID + colchicine

Check CRP.

If inflammation trends ↓, can go (+)


WILSON



2107796165
WILSON
Gayle

21/07/1979

Continuation Sheet

Date: Time

15/1/26
1000

FR MacDermid - "Pain Patient" / New Tennessee GP

46.2 ghs (P-13/1)

SG: T20M EVID, neck d/o pericarditis & effusion.

Notes: ① Pericarditis - recent diagnosis 2/52 ago, commenced on colchicine
pain never really settled. ↑CRP. ECG - nil acute.
CRP NAD. Pst c4. Echo (videotape): trivial pericardial
effusion & no haemodynamic compromise.
Now on Naproxen & colchicine post cardio g/h.

Blood today analysed 13/1 - CRP 171 WCC 11.9. Dili 22. D-dimer 2945.

NEWS 3 (HR 94, BP 95/63)

On arrival (in dayroom on bed) - looks well. Reports not had any naproxen
yet (last pain with it). Ongoing pain when lying on LHS & improves
when leaning to RHB. Throbbing in nature from chest & shoulder. No other
active complaints.

PE - Mark, chest clear, HS (H/H/O), no tenderness, Abdo soft, Cakes ENT.

Plan: ① Trial naproxen as per cards (if tolerate if worsening)

② Bloods today

③ Home if pain improves to naproxen & bloods satisfactory

16/1/26

135

FR MacDermid

831 P12

Hx Bx EVID noted.

Well today. CRP fully resolved. Naproxen helped ++.

CRP still ↑ gradually. Bloods also today.

NEWS 0. Chest clear. Abdo soft. Cakes ENT B6 ②

Plan: ① Home today if CRP ↓

② OP CT as per arranged

831 P12

1600

CRP remains ↑. Unable to allow cardio Spl. to off discuss re discharge.

Plan → recheck CRP tomorrow if deteriorating & well → (1). 831 P12

Amendment

→ contacted Spl Sullivan (cardio)

would like to see downgrading CRP + dept echo
prior to discharge. Keep until at least Monday for echo.
Gayle happy to stay.

831 P12

Plan: ① Monitor CRP

② Dept echo

③ ? Home early next week if well.

Continuation Sheet

Date: Time

11/1/20

13:34

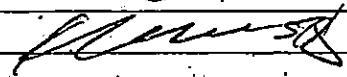
578 Ryschick

46 ① Recent admission w
 Pericarditis
 Chest did not settle
 so re-presented

- CRP 143 (137 ← 171)
- WBC 8.5 (11.9)
- ECG no significant ST Δ
- V. Sin tachycardia ~~ELHO~~ Pericardial effusion
- wants to rule out patient but not in
 clinic

Pons 0

① ② ③ tomorrow
 ② if CRP $\downarrow$ could potentially
 go ④



Continuation Sheet

Date: Time

18/01.

1120

CUM.

62

Day 5.

46.

Admission 03/01

GOLD

- presumed pericarditis

Pulld up

- Th 25, CR 63

TRON

- CRPA - definite pericardial effusion, thus ONI.

- looked 91-75.

Readmitted to Resuscitation Unit for

COP 121 → 85.

Top 64

no acute 91-75.

Bedside echo (PM) - trace pericardial fluid.
cor - cardiomegaly (enlarged).

Fav settled

x2 PO.

CMTS → monitoring abdo/pain C7. (21/01)

Cup - monitoring diagnosis when

so pericarditis, no acute renal problems.

① active NADs / admission

Echo today - not yet available to River.

could get have talk with at Cardiology
River + C7.

2/9c NADs

File advice.

Patient ID label

Nursing Documentation

Date/Time

Once only prescriptions (including tetanus prophylaxis)

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

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.

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	

CLINICAL NOTES - MEDICAL
NURSING☐☐Please tick ☒ appropriate directorate

2107796165

WILSON

Gayle

F

21/07/1979

Date & Time	Signature, Print Name & Designation
19/01	S. McCormick locum SMO
46 ♀ A/w chest pain	
199005/	
① Pericarditis	
-> For 2/52 NSAID	
-> For 3/12 colchicine	
-> Echo N.I. of note.	
-> CPP ↓	
NEWS ①	
Pain free.	
keen for ①.	
① ① ①.	



CHI: 2107796165

Queen Elizabeth University Hospital

Total Att: 27

12 Mth Att: 2

Title: MISS

WILSON

Gayle

DOB: 21/07/1979

Age: 46y

Sex: Female

1-1
37A DOWANHILL STREET
Glasgow
Lanarkshire
G11 5RN
07490319509

Next of kin: WILSON, Mandy
Relationship: Niece
07506317763

GP: GM Georgiev
0141 339 0902

Attendance Date: 13/01/2026

Arrival Time: 10:46

Registration Time: 10:46

Date of Incident: 13/01/2026

Major Incident Desc:

Reason for Attendance: chest pains

Affix Label

Nursing Assessment

Alerts: Not Recorded

Allergies: Not Recorded

Pain Score:

Triage Category: 3

Tetanus up to date/fully immunised:

Presenting Complaint: Cardiac Pain - Chest

Observation Date: 13/01/2026 11:26

Nurse name: Nurse Jason Gillespie

RR	16	bpm
Oxygen	21	%
Air or O2		
SpO2	95	%
HR	108	bpm
BP	122/80	mmHg
CRT		
MAP	94	mmHg
AVPU		
Temp	36.5	C
EWS Total		

BM		mmol/L
PF		1/min
Expected PF		1/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

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

Nursing Notes: "S/P with carer pt states onset this am approx 0300 hrs of left sided chest pain - non radiating"

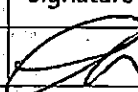
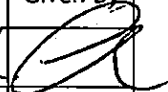
Child Assessment Questionnaire

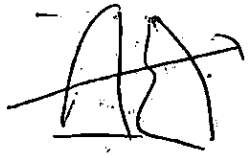
	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

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
13/01/20	IBUPROFEN	400mg	oral	2100		

Date	CLINICAL NOTES
13/01/26	Seen by (Dr) <u>R. MILLER MD EM</u> Time seen <u>1830</u> 46y ♀ PC chest pain PMH: - recent admission with chest pain - and diagnosed pleural effusion. - T2DM. - mental health issues. Spec admitted to hospital last week with ② sided chest pain ↳ pleural effusions and pericardial effusion. ↳ advised pericarditis and d/c with O/P 1x. - returns today with with return of - chest pain, now on ② hand side. - tender on palpation - not feeling slightly breathless. - no radiation. - denies fever, no cough, no abdo pain / no D+V. - not able to pin point any exacerbating or relieving factors. O/E: - looks well  chest clear. good a/cventy RR-16 sat-s-95% RA. HS= 1+11+0 HR-108 BP-122/80 EKG- nil acute.

Date	CLINICAL NOTES
	- bedside echo ↳ pericardial effusion present. no documentation of size/in previous notes so unsure if increased in size. no evidence of systolic dysfunction. CRP - 170 (63 last week). COR - no change. rest of bloods NAD. Troponin <5 no clear explanation of chest pain ↑ CRP. Atc Please admit for further tx. - analgesia.

[Signature]
8/6/2021

Discharge Codes (Please CIRCLE)								Discharge date	
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	

Affix Label



CHI: 2107796165

Queen Elizabeth University Hospital

Total Att: 26

12 Mth Att: 2

Title: MISS

WILSON

Gayle

DOB: 21/07/1979

Age: 46y

Sex: Female

1-1
37A DOWANHILL STREET
Glasgow
Lanarkshire
G11 5RN
07490319509

Next of kin: WILSON, Mandy
Relationship: Niece
07506317763

GP: GM Georgiev
0141 339 0902

Attendance Date: 02/01/2026

Arrival Time: 17:08

Registration Time: 17:08

Date of Incident: 02/01/2026

Major Incident Desc:

Reason for Attendance: chest pain

Affix Label

Nursing Assessment

Alerts

Nursing Assessment

Alerts: Not Recorded

Allergies: Not Recorded

Pain Score:

Triage Category: 2

Tetanus up to date/fully immunised:

Presenting Complaint: Chest Pain

Observation Date: 02/01/2026 17:27

Nurse name: Nurse Kara McKay

RR	20	bpm
Oxygen	21	%
Air or O2		
SpO2	96	%
HR	111	bpm
BP	111/76	mmHg
CRT		
MAP	88	mmHg
AVPU		
Temp	37.8	C
EWS Total		

BM		mmol/L
PF		1/min
Expected PF		1/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

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

Nursing Notes: "woke with tight right sided CP radiating down right arm. SOB + dizzy. nil cardiac hx."

Date	Emergency Department Notes		
02/10/26	Ambulance Proforma reviewed Yes ☒ No ☐	Seen by (Doctor) L1V	Time seen 1800
46F abn CP BG: T2DM, depression HPer patient aware 10⁰⁰ hrs mins later developed sudden onset @ upper chest pain, pleuritic in nature radiating down @ arm. Tender in deep palpation, felt SOB since. DH = penicillin AR^x SH = smoker 20 daily (Loopy). = see Res. = Nil Fentanyl = LMA alone OK A = full normal B = RR 20, SpO₂ 96%, RA C = NR III, BP 111/76 Hs 1 + 1 + 0, tachy. D = CO 17/15 E = T37, 8°C. ① ECG = NEW TMI V4-V6. Blood = CRP 65, WCC 10.6. d-dimer 2975 Trop = C5 CXR = ? cardiomegaly - analgesia + antiemetic R/O COVID + flu = Ove ? PE CTPE = nil per moderate pericardial effusion imp. pain 22° pericardial <i>[Handwritten signature]</i> <i>[Handwritten signature]</i> <i>[Handwritten signature]</i>			

Patient ID label

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen
	For POE cardiac use - mild pulmonary effusion For improper use of. Compromised zone. Cerebral. No medicine in ED, please administer once available	
		

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

Done/ completed	Immediate Management Plan

Signature:	Designation:	Page No:

.....

10/16/16

PLEASE DO NOT WRITE HERE

In-Patient Admission Notes

	
2107796165	21/07/1979
WILSON	
Gayle	

Seen By: Kate Jelstone
PRF Reviewed Yes / No

Print: J. H. M. S. R. W. K.
1MT2

Time Seen: 0030
3/1/26

Pg. No: 8308J.

Presenting Complaint(s)	
Presenting complaint (46)	Chest pain.
History of presenting complaint	Woke up by an onmodation staff at 10am to take morning medications Noticed BCP tight → R arm Went back to sleep. Denies positional Woke up by call from sister and pain ongoing Denies SOB, cough, palpitations No recent viral illness but has been ↑ fatigued, off food.

Past Medical History / Review of portal
EUPD Mild LD 720M

Systemic Enquiry

Patient ID label

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	
<i>Ante</i>							
<i>Diazepam</i>	<i>2mg</i>	<i>BD</i>	<i>PRN</i>				
<i>Seabraline</i>	<i>200mg</i>	<i>OD</i>					
<i>Dapagliflozin</i>	<i>10mg</i>	<i>OD</i>					
<i>Quetiapine</i>	<i>50mg</i>	<i>TDS</i>					
<i>Atorvastatin</i>	<i>40mg</i>	<i>ON</i>					
<i>Glicazide</i>	<i>160mg</i>	<i>BD</i>					

Allergies		List any over-the-counter or alternative medicines	
<i>pen V 1995</i>			
		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 :	

Patient ID label

Social History \ Family History

Smoking History

Ex-smoker/Smoker 20 cpd _____ yrs

☐ Never smoked

Alcohol History

0 Units/week

FAST score if excess _____

Recreational Drugs

0

Driving Status

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

lives alone in supported accommodation, assistance to meds.
sister supports

General Examination

Temp: 36.1

RR: 12

Pulse: 91

CBG:

SpO₂: 94 %

Weight:

BP: 94/71

Urinalysis:

General Appearance:

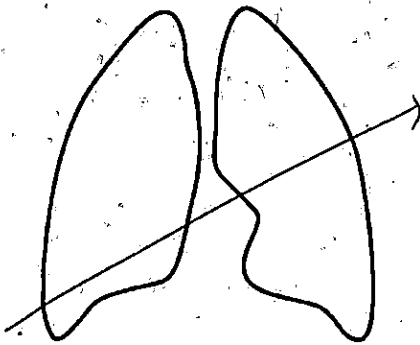
sleeping

comfortable

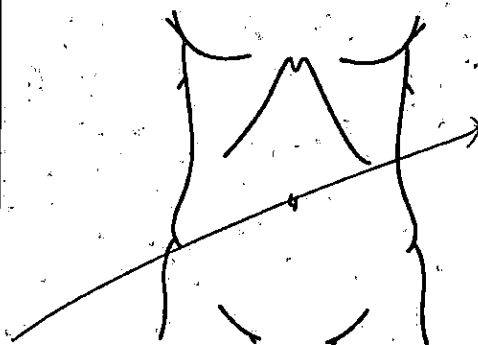
pain free

been out for cigarette

Respiratory



Gastrointestinal System



Cardiovascular

Hb 1 + 1.1 TD

pulse reg.

Locomotor

no oedema

Patient ID label

Neurological system

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

AMT 4 = age, DOB, place, year

AMT score ____ /4

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

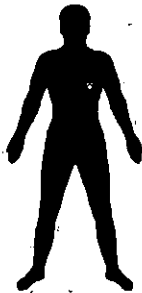
Pupils/funduscopy:

Cerebellar and
extrapyramidal:

Cranial Nerves:

Neck:

Reflexes:



	RUL	LUL	RLL	LLL
Tone				
Power				
Co-ordination				
Sensation				

Plantars: R L

Skin/Other

Key Results

CXR no consol
cannot clearly see @CF

ECG SR 100bpm, QTC 454
TWI V4-V6.

POCT One

POC ECHO (ASE) mild effusion

(Differential) diagnosis

CTPA No PE. Moderate pericardial effusion

NEWS ☐

POC Trop <5

Red Flag ☐

Pericarditis

Sepsis ☐

CURB 65 ☐

Management Plan

① Colicine

Simple analgesia

② Assess to Cardiology morning

? formal ECHO

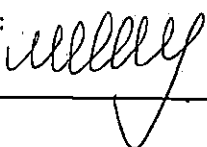
? ⊕ if pain free

☐ Thromboprophylaxis assessed
☐ Antimicrobial

☐ Medicine Reconciliation

☐ 4AT/TIME

Signature:



PRINT NAME John Stone

PRINT GRADE IMT2

Page: 83085.

Patient ID label

Resuscitation Decision

Resuscitation status: **FOR RESUSCITATION** / **DNACPR**
(please circle)

If DNACPR → Complete appropriate form

Senior Medical review

☐ Thromboprophylaxis assessed
☐ Antimicrobial

☐ Medicine Reconciliation
☐ DNACPR

☐ 4AT/TIME
☐ AWI if appropriate

Sepsis Six

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

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

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 thrombophilia	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

- 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 contraindications? Tick if apply

Active bleeding	Untreated inherited bleeding disorder
Acquired bleeding disorder	Thrombocytopenia $< 75 \times 10^9/l$
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	

☐ No

☐ Yes

- 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

Enoxaparin 40mg (reduce to 20mg if weighs < 50 kg 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 _____

Results

Date									
Time									
Parameter	Ref. Range								
Hb	Male: 130-180 Female: 110-165	152							
WCC	4.0 - 11.0	11.7							
Plts	150 - 450	225							
MCV	80 - 100	85.2							
Neut	2.0 - 7.5	9.2							
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	2945							
Na+	133 - 146	137							
K+	3.5 - 5.3	4.3							
Cl-	95 - 108								
HCO3-	22 - 29								
Urea	2.5 - 7.8	4.2							
Creat	40 - 130	59							
eGFR		760							
Glucose	3.5 - 6.0								
Protein	60 - 80								
Albumin	35 - 50								
AlkP	30 - 130	188							
Bil	<20								
ALT	<50								
AST	<40								
GGT	Male: <70 Female: <40								
ESR	Male: 1 - 10 Female: 1 - 12								
CRP	<10	63							
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								

	
2107796165	21/07/1979
WILSON	
Gayle	

Post Take Ward Round IAU/ARU

Consultant: Stasun

Date: 3/1/26 Time: 9am

Summary

46yo ♀
Hum. RUPD
 Mild L.D.
 Type II Diabetes

PC Admitted to Chest Pain

① → Aspirin. ↑ D. chond.

② Tygacil. 216 MRE let
 Tim.

CTPA - 0 PE

Pencil RFFM CR-63.

o/e Abt Hx of Stills -
 Keen for home.

Temp:

Pulse:

BP:

SpO₂:

FiO₂:

RR:

Diagnosis:

PC excluded but ↑ D. chond.
 Pencil RFFM - 12 ~ exclude Hx of OP.
 ~ D. chond. re. Bx as OP.

Plan:

1. Colchicine for 216 500mg bid. 3/12
2. D. chond. re. OP Excl.
 ↳ NSAIDs for 2/52 1biphen
 600mg tid
 C. P. R.
3. Home today
4. Ix as OP to exclude malignancy
 ↳ Bx for Hx of Stills / Tim Mx
 CT Abt / Pelvis, c. const.

Recommended Destination:

Suitable to board if required ☐ Yes ☐ No

Expected Date of Discharge:

Signature:

Designation:

Bleep Number:

Patient ID label

Continuation Sheet

Blank lined paper.

Patient ID label

Continuation Sheet

Date: Time

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.

Continuation Sheet

Date: Time

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.

Patient ID label

Date: Time

[illegible]

[illegible]

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

18

Emergency Attendance Letter



Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel: 0141 452 2930/2931
Fax: 0141 201 2804
Email:

Date Completed: 08/01/2026

Consultant: Dr Andrew Saunders

GM Georgiev
Abingdon Medical Practice
12 Stewartville Street
Glasgow
Glasgow
G11 5PE

Dear GM Georgiev

Re: **Wilson Gayle**
1-1
Glasgow G11 5RN

DOB: 21/07/1979

CHI: 2107796165

Attended on: 02/01/2026 at 17:08 hrs.

Departed on: 02/01/2026 at 22:48 hrs.

Discharge Type: 02 - Admitted

Destination: Admission to this Hospital

Previous ED Attendance in last 12 months: 1

Presenting complaint
chest pain

Nursing Assessment:

woke with tight right sided CP radiating down right arm. SOB + dizzy. nil cardiac hx.

Investigations in ED:

- | | | |
|----------------------------|--|--------------------------|
| 1. Full Blood Count | 2. CRP | 3. Urea and Electrolytes |
| 4. Bicarbonate | 5. LFT | 6. Glucose |
| 7. Coagulation screen | 8. XR Chest | 9. D - Dimer |
| 10. CT-Angiogram pulmonary | 11. CA125 | 12. CEA |
| 13. CA19 - 9. | 14. Immunoglobulins
(without electrophoresis) | |

Diagnosis:

Diagnosis	Side	Site
Acute Nonspecific Idiopathic Pericarditis		

Procedures: **None**Immunisations: **None**Dispensed Medication: **Please see Clinician Notes**Clinician Notes:
admitted

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Cellan Liiv
Doctor

Copies to:

1. GM Georgiev (GP)

School Address:

Emergency Attendance Letter



Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel: 0141 452 2930/2931
Fax: 0141 201 2804
Email:

Date Completed: 22/05/2025

Consultant: Dr Alexandra Johnston

GM Georgiev
Abingdon Medical Practice
12 Stewartville Street
Glasgow
Glasgow
G11 5PE

Dear GM Georgiev

Re: Wilson Gayle

DOB: 21/07/1979

CHI: 2107796165

1-1

Glasgow G11 5RN

Attended on: 21/05/2025 at 21:54 hrs.

Departed on: at hrs.

Discharge Type: 01c - Discharge with referral

Destination: Private residence

Previous ED Attendance in last 12 months: 1

Presenting complaint

taken 16 ibuprofen 1 hr ago - abdo pain

Nursing Assessment:

self ref: intentional OD of 16x200 mg ibuprofen at 20:30 tonight been feeling suicidal last few days had recent bereavement BG 15.6 states feels like jumping off a bridge lives supported accommodation

Investigations in ED:

1. Paracetamol

2. Glucose

3. Urea and Electrolytes

4. Ethanol

5. Salicylate

6. Full Blood Count

Diagnosis:

Diagnosis	Side	Site
Person With Feared Complaint In Whom No Diagnosis Is Made		

Procedures: None

Immunisations: None

Dispensed Medication: Please see Clinician Notes

Clinician Notes:

Dear Doctor, This lady presented after ingesting 16 400mg tablets of ibuprofen. She had normal bloodwork and no residual symptoms after a period of observation. I discussed her case with Mental Health Hub who recommended discharging and follow up with own MH team. They will kindly call her in the day. Kind regards, Dr James Carne

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
James Carne
Doctor

Copies to:

1. GM Georgiev (GP)

School Address:

Emergency Attendance Letter



Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel: 0141 452 2930/2931
Fax: 0141 201 2804
Email:

Date Completed: 05/01/2025

Consultant: Dr Cieran McKiernan

GM Georgiev
Abingdon Medical Practice
12 Stewartville Street
Glasgow
Glasgow
G11 5PE

Dear GM Georgiev

Re: **Wilson Gayle**
1-1
Glasgow G11 5RN

DOB: 21/07/1979

CHI: 2107796165

Attended on: 04/01/2025 at 21:44 hrs.

Departed on: 05/01/2025 at 06:46 hrs.

Discharge Type: 01a - Discharge with no follow up

Destination: Private residence

Previous ED Attendance in last 12 months: 0

Presenting complaint:
od, L side pain

Nursing Assessment:

Self ref- States taken 14 nurofen Thurs and 10 on Friday, due to family worries. Regretful -tonight c/o R sided abdo pain and nausea

Investigations in ED:

1. Full Blood Count
4. Urea and Electrolytes
7. Bone Profile
10. Paracetamol
13. Glucose

2. Coagulation screen
5. LFT
8. CK
11. Salicylate
14. Lactate

3. INR
6. CRP
9. Magnesium
12. Ethanol

Diagnosis:

Diagnosis	Side	Site
Other Gastritis		

Procedures: None

Immunisations: None

Dispensed Medication: Please see Clinician Notes

Clinician Notes:

presented with ibuprofen overdose with help-seeking intent, not suicidal. has psych follow-up arranged. main complaint was abdo pain, likely NSAID gastritis. given omeprazole and discharged to await psych follow-up

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Conor Richards
Doctor

Copies to:

1. GM Georgiev (GP)

School Address:

Emergency Attendance Letter



Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept: Contact Details:
Tel: 0141 452 2930/2931
Fax: 0141 201 2804
Email:

Date Completed: 30/11/2021

Consultant: Dr Michael Gillespie2

NT Bhatti
Peel Street Medical Centre
11 Peel Street
Glasgow
Glasgow
G11 5LL

Dear NT Bhatti,

Re: **Wilson Gayle**
52 DALHOUSIE ST
Glasgow G3 6PN

DOB: 21/07/1979

CHI: 2107796165

Attended on: 30/11/2021 at 04:31 hrs.

Departed on: 30/11/2021 at 08:38 hrs.

Discharge Type: 04a - Incomplete: left before
assessment completed

Destination: Private residence

Previous ED Attendance in last 12 months: 2

Presenting complaint
od

Nursing Assessment:

OD of x16 paracetamol at 2130 with suicidal ideation. Ongoing suicidal thoughts, mood very low. In homeless accommodation and feels she is not getting sufficient support from staff or from her psychiatrist. Reports x14 neurofen OD last week - did not seek medical help. hx overdose, mental health, anxiety, t2dm, depression, high cholesterol

Investigations in ED:

1. Full Blood Count
4. Urea and Electrolytes
7. Bone Profile
10. Paracetamol
13. Glucose

2. Coagulation screen
5. LFT
8. CK
11. Salicylate
14. Lactate (Glasgow only)

3. INR
6. CRP
9. Magnesium
12. Ethanol

Diagnosis:

Diagnosis	Side	Site
Self-poison By Nonopioid Analges/antipyret/antirheum In Unspec Place		

Procedures: None

Immunisations: None

Dispensed Medication: Please see Clinician Notes

Clinician Notes:

Presents following an intentional paracetamol overdose. Bloods and ECG ok, no medical management required. The patient did not wish to speak to the mental health team and wanted to leave Hospital to go home. The case was discussed with the EM Consultant and it was felt that the patient had capacity to leave. I have contacted the mental health hub and they will liaise with her community teams to arrange follow up.

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,

Mark Beeston

Doctor

Copies to:

1. NT Bhatti (GP)

School Address:

Emergency Attendance Letter



Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel: 0141 452 2930/2931
Fax: 0141 201 2804
Email:

Date Completed: 25/02/2020

Consultant: Dr Phil Munro

NT Bhatti
Peel Street Medical Centre
11 Peel Street
Glasgow
Glasgow
G11 5LL

Dear NT Bhatti

Re: **Wilson Gayle**
FLAT 0-2
Glasgow G14 9YD

DOB: 21/07/1979

CHI: 2107796165

Attended on: 20/02/2020 at 23:09 hrs.

Departed on: 21/02/2020 at 06:59 hrs.

Discharge Type: 01b - Discharge with follow up by
primary care team

Destination: Private residence

Previous ED Attendance in last 12 months: 3

Presenting complaint
taken 26 nuerofen

Nursing Assessment:

pt took x26 neurofen tonight between 10 & 11pm. pt states she doesnt want to be alive.

Investigations in ED:

1. Full Blood Count
4. LFT
7. Salicylate

2. CRP
5. Coagulation screen

3. Urea and Electrolytes
6. Paracetamol

Diagnosis:

Diagnosis	Side	Site
Poisoning By Other Nonsteroidal Anti-inflammatory Drugs [nsaid]		

Procedures: None

Immunisations: None

Dispensed Medication: None

Clinician Notes:

Attended with deliberate overdose of ibuprofen. Took 20 tablets. Bloods, observations and ECG all unremarkable. Reviewed by liaison psychiatry nurses who felt she demonstrated future planning and was not expressing any ongoing suicidal ideation. They forwarded details of their assessment to CMHT. Discharged with no follow up.

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
David McCusker
Doctor

Copies to:

1. NT Bhatti (GP)

School Address:

Emergency Attendance Letter



Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel: 0141 452 2930/2931
Fax: 0141 201 2804
Email:

Date Completed: 17/12/2019

Consultant: Dr Peter Davis

NT Bhatti
Peel Street Medical Centre
11 Peel Street
Glasgow
Glasgow
G11 5LL

Dear NT Bhatti

Re: **Wilson Gayle**
TALBOT CENTRE
Glasgow G3 6PN

DOB: **21/07/1979**

CHI: **2107796165**

Attended on: **17/12/2019 at 17:50 hrs.**

Departed on: **17/12/2019 at 23:12 hrs.**

Discharge Type: **01a - Discharge with no follow up**

Destination: **Private residence**

Previous ED Attendance in last 12 months: **2**

Presenting complaint
od

Nursing Assessment:
states has taken 26 2mg diazepam - has hx of depression

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Poisoning By Benzodiazepines		

Procedures: None

Immunisations: None

Dispensed Medication: None

Clinician Notes:

Presented following deliberate ingestion of benzos. Reported suicidal intent so referred to CPNs who reviewed and discharged patient home. Has psych follow up planned

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Iain Hansom
Doctor

Copies to:

1. NT Bhatti (GP)

School Address:

EMERGENCY DEPARTMENT
WESTERN INFIRMARY
DUMBARTON ROAD
GLASGOW
G11 6NT



Dr NADEEM BHATTI
PEEL STREET MEDICAL CENTRE
11 PEEL STREET GLASGOW
G11 5LL

Date: 29 Apr 2013

Dear Dr NADEEM BHATTI,

Re: GAYLE WILSON, 494 GREAT WESTERN ROAD, TALBOT CENTRE, GLASGOW, G12 8EW
Date of Birth: 21/07/1979 CHI number: 2107796165

Your patient attended Western Infirmary on the 29 Apr 2013 at 10:18 PM.

The presenting complaint was:

SELF HARM, ARMS AND LEG

Triage information:

Not recorded

The following investigations were carried out:

None

The A&E diagnosis was:

INTENTIONAL SELF HARM - SELF HARM - SHARP OBJECT

The following treatment was given:

None

At the conclusion of treatment the patient was:

DISCHARGED

Follow-up:

DISCHARGED

Additional information:

Discharged for McNair ward earlier today. Didn't want to be discharged. Superficial incisions to left forearm and both shins. Decided later she wanted to kill herself so aunt brought her here. No new issues compared to earlier today. Discussed with team at GRH and CPNs. Happy for patient to be discharged. Has DART follow up tomorrow.

Yours sincerely,

NAVEED KARIM
EMERGENCY MEDICINE CT1ACCS

EMERGENCY DEPARTMENT
WESTERN INFIRMARY
DUMBARTON ROAD
GLASGOW
G11 6NT



Dr NAYEEM GHOURI
PEEL STREET MEDICAL CENTRE
11 PEEL STREET GLASGOW
G11 5LL

Date: 05 Jan 2013

Dear Dr NAYEEM GHOURI,

Re: GAYLE WILSON, ASPIRE, 18 HILLHEAD STREET, GLASGOW, G12 8PY
Date of Birth: 21/07/1979 CHI number: 2107796165

Your patient attended Western Infirmary on the 05 Jan 2013 at 6:54 PM.

The presenting complaint was:

THIGH ABSCESS FOR SURGEONS

Triage information:

**WOKE UP WITH LUMP ON THIGH. LEG HAS BEEN SORE ALL WEEK.
FEELS WELL TEMP 35.9**

The following investigations were carried out: **None**

The A&E diagnosis was:

PATIENT FOR SPECIALTY TAKE-GP REFERRAL - SURGICAL

The following treatment was given:

None

At the conclusion of treatment the patient was: **DIRECT ADMISSION TO SURGICAL WARD**

Follow-up:

ADMITTED

Additional information:

None

Yours sincerely,

**NONE ASSIGNED IN EDIS
NONE ASSIGNED IN EDIS**

EMERGENCY DEPARTMENT
WESTERN INFIRMARY
DUMBARTON ROAD
GLASGOW
G11 6NT



Dr NAYEEM GHOURI
PEEL STREET MEDICAL CENTRE
11 PEEL STREET GLASGOW
G11 5LL

Date: 11 Aug 2012

Dear Dr NAYEEM GHOURI,

Re: GAYLE WILSON, 0/2 1655 DUMBARTON ROAD, GLASGOW, G14 9YD
Date of Birth: 21/07/1979 CHI number: 2107796165

Your patient attended Western Infirmary on the 11 Aug 2012:

The presenting complaint was:	SELF INFLICTED CUT WRIST
Triage information:	Not recorded
The following investigations were carried out:	None
The A&E diagnosis was:	** INJURY- NOT ASSAULT** - LACERATION - UPPER LIMB LEFT - WRIST
The following treatment was given:	None
At the conclusion of treatment the patient was:	DISCHARGED
Follow-up:	DISCHARGED
Additional information:	None

Yours sincerely,

LUCY ADAM
EMERGENCY DEPARTMENT DOCTOR

EMERGENCY DEPARTMENT
WESTERN INFIRMARY
DUMBARTON ROAD
GLASGOW
G11 6NT



Dr NAYEEM GHOURI
PEEL STREET MEDICAL CENTRE
11 PEEL STREET GLASGOW
G11 5LL

Date: 12 Jun 2012

Dear Dr NAYEEM GHOURI,

Re: GAYLE WILSON, 0/2 1655 DUMBARTON ROAD, GLASGOW, G14 9YD
Date of Birth: 21/07/1979 CHI number: 2107796165

Your patient attended Western Infirmary on the 11 Jun 2012.

The presenting complaint was:	DSH TO WRISTS
Triage information:	Not recorded
The following investigations were carried out:	None
The A&E diagnosis was:	INTENTIONAL SELF HARM - SELF HARM - SHARP OBJECT
The following treatment was given:	STERISTrip/S DRY DRESSING
At the conclusion of treatment the patient was:	DISCHARGED
Follow-up:	DISCHARGED
Additional information:	None

Yours sincerely,

FIONA GUNN
EMERGENCY DEPARTMENT DOCTOR

HOSPITAL INFORMATION MISSING



Dr NAYEEM GHOURI
PEEL STREET MEDICAL CENTRE
11 PEEL STREET GLASGOW

G11 5LL

Date : 11 Jan 2012

Dear Dr NAYEEM GHOURI,

Re: GAYLE WILSON, 2/2 7 SPEIRSHALL CLOSE, GLASGOW, LANARKSHIRE, G14 0LP

Date of Birth: 21/07/1979 CHI number: 2107796165

HOSPITAL INFORMATION MISSING Patient attended on the 10 Jan 2012.

The presenting complaint was: **MENTAL ILLNESS**

Triage information: **PT HAS TAKEN OVERDOSE OF TRAZODONE,
PARACETAMOL AND ASPIRIN OD DENIED.
DISCHARGED FROM HENDERSON HOUSE TODAY.
WANTS TO BE SEEN BY CPN. TEMP 36.5**

The following investigations **None**
were carried out:

The A&E diagnosis was: **PSYCHIATRIC - DEPRESSION**

The following treatment was **None**
given:

At the conclusion of **DISCHARGED**
treatment the patient was:

Follow-up: **DISCHARGED**

Additional information: **None**

Yours sincerely,

CLAIRE MCGROARTY

EMERGENCY MEDICINE S T 5

HOSPITAL INFORMATION MISSING

Dr NAYEEM GHOURI
PEEL STREET MEDICAL CENTRE
11 PEEL STREET GLASGOW

G11 5LL

Date : 15 Jul 2011

Dear Dr NAYEEM GHOURI,

Re: GAYLE WILSON, 2/2 7 SPEIRSHALL CLOSE, GLASGOW, LANARKSHIRE, G14 0LP

Date of Birth: 21/07/1979 CHI number: 2107796165

HOSPITAL INFORMATION MISSING Patient attended on the 15 Jul 2011.

The presenting complaint was: **SUICIDAL THOUGHTS**

Triage information: **BIB POLICE; THREATING SUICIDE. TOOK TAXI TO
ERSKINE BRIDGE AND CHANGED MIND. DENIES
ALCOHOL OR DRUG INTAKE. POLICE FOUND
PATIENT WALKING DOWN GREAT WESTERN RD.
MISSING PERSON TODAY TEMP 35.7**

The following investigations **None**
were carried out:

The A&E diagnosis was: **PSYCHIATRIC - SUICIDAL IDEATION(SEVERE
DEPRESSIVE EPISODE)**

None

The following treatment was
given:

At the conclusion of **DISCHARGED**
treatment the patient was:

Follow-up: **DISCHARGED**

Additional information: **None**

Yours sincerely,

MENA KADHIM

EMERGENCY DEPARTMENT DOCTOR

HOSPITAL INFORMATION MISSING



Dr NAYEEM GHOURI
PEEL STREET MEDICAL CENTRE
11 PEEL STREET GLASGOW

G11 5LL

Date.: 28 Jun 2011

Dear Dr NAYEEM GHOURI,

Re: GAYLE WILSON, 0/2 1655 DUMBARTON ROAD, GLASGOW, G14 9YD
Date of Birth: 21/07/1979 CHI number: 2107796165

HOSPITAL INFORMATION MISSING Patient attended on the 27 Jun 2011.

The presenting complaint was: **SELF HARMS, NEEDS TO SPEAK TO SOMEONE AS
SHE FEELS SHE IS GOING TO DO IT**

Triage information: **HAS CUT HER LEFT ARM OVER THE WEEK END,
WANTS SOMEBODY TO TALK TO,**

The following investigations **None**
were carried out:

The A&E diagnosis was: **PSYCHIATRIC - DEPRESSION**

The following treatment was **None**
given:

At the conclusion of **DISCHARGED**
treatment the patient was:

Follow-up: **DISCHARGED**

Additional information: **None**

Yours sincerely,

CANDICE GALEA

EMERGENCY DEPARTMENT DOCTOR

Clinical letter - GP: FTA



Gartnavel General Hospital
1053 Great Western Road
Glasgow
G12 0YN

0141 211 3000
Community Centre for Health,
MSK Physiotherapy Dept.

0141 211 1438

Steven Spence

10/12/2025

Dr. GM Georgiev
Abingdon Medical Practice
12 Stewartville Street
Glasgow
G11 5PE

Main Switchboard:
Department:

Contact Tel:

Enquiries to:

Letter Date:

Reference:

Dictated Date:

Transcribed Date:

Dear Doctor,

Gayle Wilson; D.O.B: 21/07/1979; CHI: 2107796165
1-1, 37A DOWANHILL STREET, Glasgow, Lanarkshire, G11 5RN

This patient did not keep their first appointment with us on 10/12/25 at 13:30, and did not notify us that they would not be attending.

No further appointment will be offered and they will be removed from our waiting list, unless they contact us within 24 hours.

Yours sincerely

Steven Spence

Band 6 MSK Physiotherapist

Electronically Signed: ,

cc.

Clinical letter - GP: Discharge Letter



Gartnavel General Hospital
1053 Great Western Road
Glasgow
G12 0YN

0141 211 3000

Msk Physiotherapy Partick
Health Centre

01412111438

01412111438

07/05/2025

07/05/2025

07/05/2025

Dr. GM Georgiev
Abingdon Medical Practice
12 Stewartville Street
Glasgow
G11 5PE

Main Switchboard:
Department:

Contact Tel:

Enquiries to:

Letter Date:

Reference:

Dictated Date:

Transcribed Date:

Dear Dr Georgiev,

Gayle Wilson; D.O.B: 21/07/1979; CHI: 2107796165
1-1, 37A DOWANHILL STREET, Glasgow, Lanarkshire, G11 5RN

GP Action Required: Information update.

Presenting Condition: Cervical radiculopathy - left sided pins and needles into arm.

Physiotherapy Comments: I have assessed this patient and provided her with an initial exercise plan to carry out at home. Alongside education and advice to manage symptoms.

Discharge Outcome: As the patient failed to attend the review appointment on 25/04/2025 with no further contact I am unsure her how symptoms currently are.

This patient has now been discharged from our care.

Yours sincerely

Kristina Price

Electronically Signed: ,

cc.

Immediate Discharge Letter

Highly Sensitive: No
Consent for Sharing Withheld: No

GEORGI GEORGIEVAbingdon Medical Practice, 12 Stewartville Street, Glasgow,
G11 5PE

Main Switchboard:
Date of Completion: 18-Jan-2026

Dear GEORGI GEORGIEV,

Name	CHI	DoB	Address
Gayle Wilson	2107796165	21-Jul-1979	1-1, 37A DOWANHILL STREET, Glasgow, Lanarkshire, G11 5RN
Admitted	Type	Discharged	Destination
13-Jan-2026 21:55	IP	18-Jan-2026	
Specialty	Consultant	Ward	Telephone
Cardiology	Corcoran	QEUH Ward 6D Cardiology	
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: Lok Man Tracy Lee (Lok Man Tracy Lee - FY1) on 16 Jan 2026 12:15

Discharge Medication:

Active Drug Name	Route	Dose	Disp	Reason	Further Details	ECS	Since Admission
.Compliance Aid - Dosette	Route unspecified	1 device once a week	No	Patient's own supply	Drug Details: Dunnet's Pharmacy 0141-959-2196		
Atorvastatin 40mg tablets	oral	1 tablet once daily at night	No	Patient's own supply			
Colchicine 500microgram tablets	oral	1 tablet twice daily , (supplied outwith dosette box) , Fixed Period 3 Month(s) from 03 Jan 2026	No	Patient's own supply			
Dapagliflozin 10mg tablets	oral	1 tablet once daily	No	Patient's own supply			
Gliclazide 80mg tablets	oral	2 tablets twice daily , with breakfast and evening meal	No	Patient's own supply			
Naproxen 500mg tablets	oral	1 tablet twice daily , Fixed Period 13 Day(s) from 16 Jan 2026	Yes		Dispensing Details: x26		Added
Omeprazole 20mg gastro-resistant capsules	oral	1 capsule once daily , Fixed Period 2 Week(s) from 03 Jan 2026	No	Patient's own supply	Drug Details: ppi cover for high dose ibuprofen		
Quetiapine 25mg tablets	oral	2 tablets three times daily	No	Patient's own supply			
Sertraline 100mg tablets	oral	2 tablets once daily	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
Dispensed by Olu
Checked by Cheryl Cusiter 16.01.26

Withheld Medication:

Date	Withheld Drug Name	Route	Dose	Note	Withheld Reason
There is no data to display.					

Stopped Medication:

Date	Stopped Drug Name	Route	Dose	Note	Stopped Reason
2026-01-16	Diazepam 2mg tablets	oral	1 tablet twice daily when required		Course completed
2026-01-16	Ibuprofen 200mg tablets	oral	3 tablets three times daily, high dose ibuprofen for pericarditis, Fixed Period 2 Week(s) from 03 Jan 2026	high dose ibuprofen for pericarditis	Changed to naproxen as per cardiology
2026-01-14	Nicotine 21mg/24hours transdermal patches	topical	1 patch once daily		Stopped before admission

Reason for Admission and Presenting Complaints	Admission Category
No data available	No data available

Clinical Comments:	Dear Doctor, Thanks for your continued care of Miss Wilson who was admitted to QEUH 13/01/2026 due to chest pain. This lady initially presented a week prior with left sided chest pain and found to have pleural effusions and pericardial effusion. She was diagnosed with pericarditis and referred for OP follow up. On this admission, she reported chest pain on the right side and was slightly breathless. Bedside ECHO in A&E showed pericardial effusion with no evidence of systolic dysfunction. No previous pericardial effusion size documented for comparison. Her CRP was raised compared to last admission. This lady has a background of pericarditis with mild pericardial effusion, T2DM, EUPD, bilaterally constricted visual fields. Plan from Cardiology: 1. Switch ibuprofen to naproxen 500mg for 2 weeks with PPI cover 2. Continued regular colchicine Pain settled with addition of naproxen. Bloods improving and now deemed fit for discharge. FU as per prev IDL. Kind thanks, QEUH 6D
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Discharge Comments:	
Follow Up:	No CT as per prev IDL.
Results Awaited:	No
Pharmacist Comments:	
Final Discharge Letter to Follow:	Yes

Yours sincerely,

Ewan MCLELLAN

Prescription Review

Medications reviewed by pharmacist: Kajal Patel (Pharmacist)

Checked by: Cheryl CUSITER (Pharmacy Technician)

Discharged by: Jordan FLANNAGAN (Charge Nurse)

Immediate Discharge Letter

Highly Sensitive: No
Consent for Sharing Withheld: No

GEORGI GEORGIEV Abingdon Medical Practice, 12 Stewartville Street, Glasgow,
G11 5PE

Main Switchboard:
Date of Completion: 03-Jan-2026

Dear GEORGI GEORGIEV,

Name	CHI	DoB	Address
Gayle Wilson	2107796165	21-Jul-1979	1-1, 37A DOWANHILL STREET, Glasgow, Lanarkshire, G11 5RN

Admitted	Type	Discharged	Destination
02-Jan-2026 22:48	IP	03-Jan-2026	

Specialty	Consultant	Ward	Telephone
Respiratory Medicine	Sarvesvaran	QEUH ARU1 Respiratory	

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: Molly Will (Molly Will - FY1) on 03 Jan 2026 12:33

Discharge Medication:

Active Drug Name	Route	Dose	Disp	Reason	Further Details	ECS	Since Admission
Compliance Aid - Dosette	Route unspecified	1 device once a week	No	Patient's own supply	Drug Details: Dunnet's Pharmacy 0141-959-2196		
Atorvastatin 40mg tablets	oral	1 tablet once daily at night	No	Patient's own supply			Added
Colchicine 500microgram tablets	oral	1 tablet twice daily , Fixed Period 3 Month(s) from 03 Jan 2026	Yes		Dispensing Details: 28x500mcg Drug Details: 2 weeks supplied via hospital pharmacy (outwith dosette box)		Added Amended
Dapagliflozin 10mg tablets	oral	1 tablet once daily	No	Patient's own supply			Added
Diazepam 2mg tablets	oral	1 tablet twice daily when required	No	Patient's own supply			Added Amended
Gliclazide 80mg tablets	oral	2 tablets twice daily , with breakfast and evening meal	No	Patient's own supply			Added
Ibuprofen 200mg tablets	oral	3 tablets three times daily , high dose ibuprofen for pericarditis , Fixed Period 2 Week(s) from 03 Jan 2026	Yes		Dispensing Details: 126x200mg Drug Details: high dose ibuprofen for pericarditis		Added
Nicotine 21mg/24hours transdermal patches	topical	1 patch once daily	No	Non urgent supply GP please prescribe			Added
Omeprazole 20mg gastro-resistant capsules	oral	1 capsule once daily , Fixed Period 2 Week(s) from 03 Jan 2026	Yes		Dispensing Details: 14x20mg Drug Details: ppi cover for high dose ibuprofen		Added
Quetiapine 25mg tablets	oral	2 tablets three times daily	No	Patient's own supply			Added
Sertraline 100mg tablets	oral	2 tablets once daily	No	Patient's own supply			Added

"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
Dispensed by Esther Jamieson 03/01/26
Checked by L. Beverley 3/1/26

Withheld Medication:

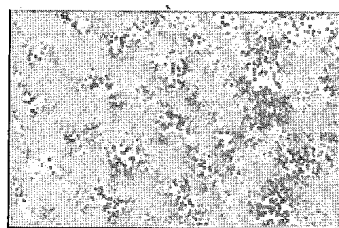
Date	Withheld Drug Name	Route	Dose	Note	Withheld Reason
There is no data to display.					

Stopped Medication:

Date	Stopped Drug Name	Route	Dose	Note	Stopped Reason
2026-01-03	Promethazine hydrochloride 25mg tablets	oral	1 tablet once daily at night		Course completed
2026-01-03	Sertraline 100mg tablets	oral	TWO TO BE TAKEN EACH DAY,		Medication was removed from, made inactive or made unprescribable in the drug database.
2026-01-03	Simvastatin 40mg tablets	oral	ONE TAB AT NIGHT WEEKLY DISPENSE,		Course completed

Reason for Admission and Presenting Complaints	Admission Category
No data available	No data available

Clinical Comments:	Dear Doctor, Miss Gayle Wilson was admitted to QEUI on 02/01/26 with chest pain radiating to the right arm. She had a normal troponin and mild T wave inversion in the lateral leads of her ECG. She had an echo which showed a mild effusion. She had a raised D-dimer however CTPA ruled out a PE. She was diagnosed with pericarditis. She was discussed with cardiology who agreed that she is now fit for discharge with a 3 month course of Colchicine and a 2 week course of high dose Ibuprofen with PPI cover. She has been advised
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	to attend general practice should she experience any troublesome muscle cramping due to an interaction between the Colchicine and her Atorvastatin. Due to her high D-dimer of 2945, and her pericardial effusion, and a raised Ca 125 level of 122, we have requested a malignancy screen and pelvic malignancy should be excluded with a contrast CTAP as an outpatient. Thank you for your ongoing care. Kind regards ARU 1
Discharge Comments:	
Follow Up:	Yes contrast CT AP
Results Awaited:	Yes CT AP - requested tumour markers and myeloma screen
Pharmacist Comments:	
Final Discharge Letter to Follow:	Yes

Yours sincerely,

Molly WILL

Prescription Review

Medications reviewed by pharmacist: Mairi McGinnes (Pharmacist)

Checked by: Lindsay BEVERLEY (Pharmacist)

Discharged by: Caitlin MCCOOL (Nurse)

Case No 7517685

Case Active 03/01/2025 16:13

Case Type Ambulance

Patient Gayle Wilson

Sex F **D.O.B** 21/07/1979 **Age** 45 years

Current Address

Home Address (if currently not at home)

1/1 37A Dowanhill Street
Glasgow

G11 5RN

Current Phone: 07890 521261

Home Phone:

CHI: 2107796165

Case Origin

Callers Name

Callers Tel:

Lorri

Own Doctor Georgiev,Georgi(008)

Surgery Abingdon Medical Practice (008)

NHS24 Received By Anne Pacewicz (Clinical Nurse) ()

NHS24 Triage Start 16:14

NHS24 Triage By Anne Pacewicz (Clinical Nurse) ()

NHS24 Triage End 16:28

NHS24 Reported Condition

NHS24 Outcome EMGI

SAS Ref: 11690927 OVERDOSE 15HRS

NHS24 Recorded Allergies

NHS24 Recorded Medications

NHS24 Recorded Medical History

NHS24 Clinical Summary

Clinical summary created by: Anne Pacewicz (Clinical Nurse) () [03/01/2025 16:29:40]

Reason for call: SAS Ref: 11690927 OVERDOSE 15HRS

03:01:2025 16:14:25 BRYSONC... LORRI SUPPORT WORKER ON PHONEPT TOOK 14 NUROFEN ABOUT 11PM LAST NIGHTREFUSING TO GO TO A&E..

03:01:2025 16:23:46 PACEWICZA.. CALL BACK TO PT AND SUPPORT WORKER AS NO DISPUTED OUTCOME DR IN HRS.CALLED BACK TO DISCUSS NEED FOR REFERRAL TO SAS, DESPITE PT RESISTANCE.INFORMED SUPPORT WORKER CARE BEING REFERRED OVER TO SAS-999..

Outcome: 999 contacted - For information only

NHS24 Disposition

999 - Ambulance (ASAP)

NHS24 Nurse Comments

Reported Condition **Received By**

Received

TAS Assessment **Assessed By**

TAS Assess Start

TAS Assess End

Consultation **Consult By**

Consult Start

Consult End

Examination Details

Clinical Codes

Diagnosis

Treatment

Prescriptions

Follow-up(s)

Case No 7451884

Case Active 21/10/2024 14:08

Case Type Ambulance

Patient Gayle Wilson

Sex F **D.O.B** 21/07/1979 **Age** 45 years

Current Address

Home Address (if currently not at home)

1/1 37A Dowanhill Street
Glasgow

0/1 37A Dowanhill Street

G11 5RN

Current Phone: 07890 521261

Home Phone:

CHI: 2107796165

Case Origin

Callers Name

Callers Tel:

Laurie Anderson

Own Doctor Georgiev,Georgi(008)

Surgery Abingdon Medical Practice (008)

NHS24 Received By John Evans (Pwp Call Taker) ()

NHS24 Triage Start 14:23

NHS24 Triage By John Evans (Pwp Call Taker) ()

NHS24 Triage End 14:25

NHS24 Reported Condition

NHS24 Outcome EMGI

SAS Ref: 11437264 THIRD PARTY. SUPPORT WORKER RE. PT. 16 X 200MG NEUROFEN 10.30-11.00PM. NO SYMPTOMS.

NHS24 Recorded Allergies

NHS24 Recorded Medications
DIABETIC

NHS24 Recorded Medical History

BORDELING PERSONALITY
DISORDER

NHS24 Clinical Summary

Clinical summary created by: John Evans (Pwp Call Taker) () [21/10/2024 14:25:32]

Reason for call: SAS Ref: 11437264 THIRD PARTY. SUPPORT WORKER RE. PT. 16 X 200MG NEUROFEN 10.30-11.00PM. NO SYMPTOMS.Confirmed Symptom(s):

No Confirmed Symptoms

History and Mental state:

Main problem: THIRD PARTY CALL. SUPPORT WORKER REPORTED PT TAKEN 16 X 200MG NEUROFEN TABLETS LAST NIGHT BETWEEN 220:30-23:00 HOURS.

Engagement with services: NOT ASSESSED.

Medication: NOT ASSESSED.

RAG History and mental state: Red

Call Detail(s):

Clinical supervisor: Hutchison Sarah HUTCHISONS Cardonald

Endpoint Management Selected (CT)

21:10:2024 14:28:25 EVANSJ1.. THIRD PARTY CALL. SUPPORT WORKER REPORTED PT TAKEN 16 X 200MG NEUROFEN TABLETS LAST NIGHT BETWEEN 220:30-23:00 HOURS. DW MHNP SARAH HUTCHISON... PT REFUSED OFFER TO BE TAKEN TO A&E BY SUPPORT WORKER. PT STATED WOULD REFUSE TO GO TO A&E BY AMBULANCE. CARE PASSED TO SAS. WORSENING STATEMENT GIVEN. ENDPOINT: 999 - AMBULANCE AS SOON AS POSSIBLE... SAS INCIDENT NUMBER: 11437264...

Outcome: 999 contacted. - For information only

NHS24 Disposition

999 - Ambulance (ASAP)

NHS24 Nurse Comments

Reported Condition , **Received By**

Received

TAS Assessment **Assessed By**

TAS Assess Start

TAS Assess End

Consultation **Consult By**

Consult Start

Consult End

Case No 7451884

Case Active 21/10/2024 14:08

Case TypeAmbulance

Examination Details

Clinical Codes

Diagnosis

Treatment

Prescriptions

Follow-up(s)

Case No 7415028

Case Active 07/09/2024 19:57

Case Type Ambulance

Patient Gayle Wilson

Sex F **D.O.B** 21/07/1979 **Age** 45 years

Current Address

Home Address (if currently not at home)

0/1 37A Dowanhill Street
Glasgow

G11 5RN

Current Phone: 07890 521261

Home Phone:

CHI: 2107796165

Case Origin

Callers Name

Callers Tel:

Gayle

Own Doctor Georgiev,Georgi(008)

Surgery Abingdon Medical Practice (008)

NHS24 Received By Bradley Farrant (Pwp Call Taker) ()

NHS24 Triage Start 20:20

NHS24 Triage By Bradley Farrant (Pwp Call Taker) ()

NHS24 Triage End 20:23

NHS24 Reported Condition

NHS24 Outcome EMGI

SAS Ref: 1129994 OVERDOSE. 1 HOUR AGO

NHS24 Recorded Allergies

NHS24 Recorded Medications
DIABETIC

NHS24 Recorded Medical History

BORDELING PERSONALITY
DISORDER

NHS24 Clinical Summary

Clinical summary created by: Bradley Farrant (Pwp Call Taker) () [07/09/2024 20:23:46]

Reason for call: SAS Ref: 1129994 OVERDOSE. 1 HOUR AGOConfirmed Symptom(s):

No Confirmed Symptoms

Call Detail(s):

Clinical supervisor: Jarvie Iain JARVIE I1 Cardonald

Endpoint Management Selected (CT)

07:09:2024 20:18:25 FARRANTB.. SUPPORT WORKER CALLING TOOK 16 NEUROFEN. NO PAIN OR DISCOMFORT RIGHT NOW. PT DID NOT KNOW IF THEY DID THIS TO END THIER LIFE. NO OTHER HARM DONE TO SELF... NO DRUGS OR ALCOHOL TAKEN. SUPPORT WORKER DOES NOT DRIVE. WEIGHT 14 STONE. NO FOOD ALL DAY. PT REFUSED TO COMMUNICATE. PT STATES THEY DO NOT KNOW IF THEY PLAN TO HARM THEMSELVES MOVING FORWARD... PT HAS PRN DIAZAPAM. PT STATES THEY WOULD RATHER ACCESS THIS THAN GOING AND TAKIGN 16 MORE NEUROFEN. SUPPORT WORKER - LAURIE - WITH PT RIGHT NOW... DW I JARVIE PT STATED THEY DID NOT WANT TO ENGAGE AND THERE WAS NO OTHER WAY TO GET PT TO HOSPITAL TONIGHT OTHER THAN AN AMBULANCE. SAS NO - 1129994. 999 AMBULANCE..

Outcome: 999 contacted - For information only.

NHS24 Disposition

999 - Ambulance (ASAP)

NHS24 Nurse Comments

Reported Condition **Received By**

Received

TAS Assessment **Assessed By**

TAS Assess Start

TAS Assess End

Consultation **Consult By**

Consult Start

Consult End

Examination Details

Clinical Codes

Diagnosis

Treatment

Case No 7415028

Case Active 07/09/2024 19:57

Case TypeAmbulance

Prescriptions

Follow-up(s)

Case No 7039175

Case Active 16/07/2023 16:08

Case Type Ambulance

Patient Gayle Wilson
Current Address
1/1 37A Dowanhill Street
Glasgow

Sex F D.O.B 21/07/1979 Age 43 years
Home Address (if currently not at home)

G11 SRN

Current Phone: 07377 871490

Home Phone:

CHI: 2107796165

Case Origin

Callers Name
Laurie

Callers Tel:

Own Doctor Bhatti, Nadeem (030)
Surgery Peel Street Medical Centre

NHS24 Received By Cheryl Campbell (Call Taker SI) ()
NHS24 Triage By Cheryl Campbell (Call Taker SI) ()
NHS24 Reported Condition
SAS Ref: 9998699 MEDICATION ERROR 1/7

NHS24 Triage Start 16:12
NHS24 Triage End 16:52
NHS24 Outcome EMGI

NHS24 Recorded Allergies

NHS24 Recorded
Medications
DIABETIC

NHS24 Recorded Medical History
BORDELING PERSONALITY
DISORDER

NHS24 Clinical Summary

Clinical summary created by: Cheryl Campbell (Call Taker SI) () [16/07/2023 16:52:45]
Reason for call: SAS Ref: 9998699 MEDICATION ERROR 1/7 Confirmed Symptom(s):
Medication enquiry - not overdose
Missed and / or lost medication
Caller wants advice regarding medication
No extra dose, overdose or warfarin taken

Symptom(s) not found:
No fever

Risk Factor(s):
No travel outside Europe in last 21 days or to an affected country

Call Detail(s):

16:07:2023 16:11:46 CAMPBELL C6.. SUPPORT WORKER CALLING, PT HAS BROKEN INTO LOCKED MEDICATION IN OWN FLAT, PT HAS TAKING DIAZEPAM 2MG, 30 TABLETS WAS ON RECORD, PT STATES TO CARERS HAS TAKING 3 YESTERDAY, THIS IS HER MAX DOSAGE, 27 UNACCOUNTED FOR.... PT REFUSING TO GIVE CARER BOX TO PROVE MEDICATION IS STILL THERE. CARER DOES NOT THINK SHE HAS TAKING THEM, PT SAYS HASNT TAKING THEM ALL BUT CANT SAY FOR SURE. PT HAS HX OF DOING THIS... CALLED PT BUT DIDNT WANT TO SPEAK TO ME ABOUT THE SITUATION SAYS SHE FELT FINE, CARER ALSO SAY NO SYMPTOMS.. DW PA OBAYDA AL-SHARBATI. UNACCOUNTED FOR. 27 DIAZEPAM 2MG TABLETS. REFUSES TO HAND OVER. ASSUMING SHE HAS TAKEN FULL LOT (AND HAS A HISTORY OF THIS - HAS DONE BEFORE WITH QUETIAPINE) IT IS LIKELY TOXIC. WEIGHT UNKNOWN... TRIED TO SPEAK TO PATIENT WHILST ON PHONE - MADE IT CLEAR DOES NOT WISH TO ENGAGE. CAPACITY IN QUESTION. OUTCOME : 999.. POLICE INCIDENT NUMBER: 2546..

Outcome: 999 contacted - For information only

NHS24 Disposition

999 - Ambulance (ASAP)

NHS24 Nurse Comments

Reported Condition Received By

Received

TAS Assessment Assessed By

TAS Assess Start

Case No 7039175

Case Active 16/07/2023 16:08

Case Type Ambulance

TAS Assess End

Consultation

Consult By

Consult Start

Consult End

Examination Details

Clinical Codes

Diagnosis

Treatment

Prescriptions

Follow-up(s)

Case No 6862082

Case Active 13/01/2023 23:12

Case Type Ambulance

Patient Gayle Wilson

Sex F D.O.B 21/07/1979 Age 43 years

Current Address

Home Address (if currently not at home)

Talbot Association Ltd Rm 8, 52 Dalhousie Street
Glasgow

Talbot Association Ltd 52 Dalhousie Street

G3 6PN

Current Phone: 07800 713370

Home Phone:

CHI: 2107796165

Case Origin:

Callers Name

Callers Tel:

David (Support Worker)

Own Doctor Bhatti,Nadeem(030)

Surgery Peel Street Medical Centre

NHS24 Received By Tracy Hill (Clinical Nurse) ()

NHS24 Triage Start 23:13

NHS24 Triage By Tracy Hill (Clinical Nurse) ()

NHS24 Triage End 23:48

NHS24 Reported Condition

NHS24 Outcome EMGI

SAS Ref: 9479342 PT HAS TAKEN X4 DAYS DOSES OF MEDS

NHS24 Recorded Allergies

NHS24 Recorded
Medications

NHS24 Recorded Medical History

NHS24 Clinical Summary

Clinical summary created by: Tracy Hill (Clinical Nurse) () [13/01/2023 23:48:47]

Reason for call: SAS Ref: 9479342 PT HAS TAKEN X4 DAYS DOSES OF MEDS

13:01:2023 23:18:29 HAMILTON... PT IS DROWSY, WHITES OF EYES ARE RED, NOT IN PAIN/ DISCOMFORT, DIZZY ON
STANDING, PAIN IN L/SIDE, JUST ABOVE HIP, BREATHING SHALLOW, LIPS LOOK PURPLE... ATORVASTATIN, 40MG, X4,
DAPAGLIFLOZIN 10MG X4, GLICLAZIDE, 80MG, X4, QLETIAPINE 25MG X16 SERTRALINE 100MG X8. TAKEN AROUND
5PM. ALSO DRANK 1/2 BOTTLE OF BUCKFAST (APPROX 175MLS). SUPPORTED LIVING...

13:01:2023 23:47:05 HILLT.. TOOK 160MG ATORVASTATIN = 2.133 MG/KG. TOX LEVEL 3MG/KG DAPAGLIFLOZIN 40MG =
0.533MG/KG. TOX LEVEL 0.7MG/KG SERTRALINE 800MG = 10.666 MG/KG. TOX LEVEL 7MG/KG QLETIAPINE 400MG =
5.33MG/KG. TOX LEVEL 15MG/KG... ABOVE TOX LEVEL FOR SERTRALINE. PT DROWSY AND DIZZY ON STANDING. PAIN IN
LEFT ABDO ABOVE HIP. ALSO DRANK 1/2 BOTTLE OF BUCKFAST. ADVISED 999 EMERGENCY AMBULANCE SAS 9479342..

Outcome: 999 contacted - For information only

NHS24 Disposition

999 - Ambulance (ASAP)

NHS24 Nurse Comments

Reported Condition Received By

Received

TAS Assessment Assessed By

TAS Assess Start

TAS Assess End

Consultation Consult By

Consult Start

Consult End

Examination Details

Clinical Codes

Diagnosis

Treatment

Prescriptions

Follow-up(s)

Case No 6573227

Case Active 13/01/2022 23:12

Case Type Ambulance

Patient Gayle Wilson

Sex F D.O.B 21/07/1979 Age 42 years

Current Address

Home Address (if currently not at home)

Talbot Association Ltd 52 Dalhousie Street
Glasgow

G3 6PN

Current Phone: 07490 319509

Home Phone:

CHI: 2107796165

Case Origin

Callers Name

Callers Tel:

Gayle

Own Doctor Bhatti,Nadeem(030)

Surgery Peel Street Medical Centre

NHS24 Received By Elaine Clark (Pwp Call Taker) ()

NHS24 Triage Start 23:19

NHS24 Triage By Elaine Clark (Pwp Call Taker) ()

NHS24 Triage End 23:20

NHS24 Reported Condition

NHS24 Outcome EMGI

SAS Ref: 8250656 TAKEN OVERDOSE - 10 MINS AGO

NHS24 Recorded Allergies

NHS24 Recorded
Medications

NHS24 Recorded Medical History

NHS24 Clinical Summary

Clinical summary created by: Elaine Clark (Pwp Call Taker) () [13/01/2022 23:20:14]

Reason for call: SAS Ref: 8250656 TAKEN OVERDOSE - 10 MINS AGO Confirmed Symptom(s):

Internal use only

Endpoint Management Selected (CT)

Call Detail(s):

Clinical supervisor: S DOUGLAS

13:01:2022 23:19:16 CLARKE... LIVES IN SUPPORTED ACCOMMODATION - TAKEN 14 X QUETIAPINE 25MG EACH WITH INTENTION OF END LIFE - FEELS DROWSY... NO ILLICIT DRUGS/ALCOHOL - NEGATIVE FOR COVID-19 SYMPTOMS - PT REFUSING TO SPEAK TO STAFF - DW MHP S DOUGLAS - CALLED EMERGENCY AMBULANCE REF 8250656..

Outcome: 999 contacted - For information only

NHS24 Disposition

999 - Ambulance (ASAP)

NHS24 Nurse Comments

Reported Condition Received By

Received

TAS Assessment Assessed By

TAS Assess Start

TAS Assess End

Consultation Consult By

Consult Start

Consult End

Examination Details

Clinical Codes

Diagnosis

Treatment

Prescriptions

Follow-up(s)

Case No: 6530130

Case Active 29/11/2021 23:35

Case Type Ambulance

Patient: Gayle Wilson

Sex F D.O.B 21/07/1979 Age 42 years

Current Address

Home Address (if currently not at home)

Talbot Association Ltd 52 Dalhousie Street
Glasgow

G3 6PN

Current Phone: 0141 332 8512

Home Phone:

CHI: 2107796165

Case Origin

Callers Name

Callers Tel:

Sean

Own Doctor Bhatti,Nadeem(030)

Surgery Peel Street Medical Centre

NHS24 Received By Rachael Jess (Call Taker Si) ()

NHS24 Triage Start 23:54

NHS24 Triage By Rachael Jess (Call Taker Si) ()

NHS24 Triage End 23:49

NHS24 Reported Condition

NHS24 Outcome EMGI

SAS Ref: 8105011 HISTORY OF MENTAL HEALTH, OVERDOSE ON PARACETAMOL - STATES TAKEN X 16 - UNSURE OF TIMEFRAME, PT DOESN'T WANT TO ENGAGE WITH STAFF, NO COVID.

NHS24 Recorded Allergies

NHS24 Recorded Medications

NHS24 Recorded Medical History

NHS24 Clinical Summary

Clinical summary created by: Rachael Jess (Call Taker Si) () [29/11/2021 23:49:41]

Reason for call: SAS Ref: 8105011 HISTORY OF MENTAL HEALTH, OVERDOSE ON PARACETAMOL - STATES TAKEN X 16 - UNSURE OF TIMEFRAME, PT DOESN'T WANT TO ENGAGE WITH STAFF, NO COVID. Confirmed Symptom(s):
Clinical supervision

Call Detail(s):

Clinical supervisor: A.DEMPSEY

29:11:2021 23:48:31 JESSR... DELIBERATE OVERDOSE - X 16 PARACETAMOL. INFO VIA 3RD PARTY WHO IS SOCIAL CARE WORKER, UNSURE OF RECREATIONAL DRUGS OR ALCOHOL. 999 AMBULANCE...

Outcome: 999 contacted - For information only

NHS24 Disposition

999 - Ambulance (ASAP)

NHS24 Nurse Comments

Reported Condition Received By

Received

TAS Assessment Assessed By

TAS Assess Start
TAS Assess End

Consultation Consult By

Consult Start
Consult End

Examination Details

Clinical Codes

Diagnosis

Treatment

Prescriptions

Follow-up(s)

Hospital use only	Clinic	Day Date	Time	Hospital No.
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REFERRAL LETTER MEDICAL IN CONFIDENCE	Attachments
	Ophthalmology - 210779 18072023 144301 Fundus (Upper) L 001GAYLE
	Ophthalmology - cdv photo 001GAYLE260724
	Ophthalmology - 210779 26072024 140604 OCTReport L 001GAYLE
	Ophthalmology - 210779 26072024 140533 OCTReport R 001GAYLE
	Ophthalmology - 210779 18072023 144227 Fundus (Upper) R 001GAYLE
	Ophthalmology - cdv photo 00120 07 24

Additional Support Needs:
No known ASN requirements

REFERRAL TO			
Ophthalmology - General Ophthalmology GGC General (optom use only)		Consultant / receiving practitioner and/or specialty clinic	
West Glasgow 1053 Great Western Road Glasgow G12 0YN		Hospital and hospital address Hospital location code. G516H Email address -	
Urgency of referral Urgent		Date sent 26-Jul-2024	
Date of referral 26-Jul-2024			

PATIENT DETAILS		Patient's address	
Surname	WILSON	1-1 37A DOWANHILL STREET GLASGOW G11 5RN Contact number(s) Voice: 07490319509 ** Patient does consent to send past medical history and drug history via SCI Gateway to the Hospital indicated **	
Forename(s)	GAYLE		
Title	Miss		
Sex	Female		
Date of birth	21-Jul-1979		
CHI no.	2107796165		
Area of Residence	-		
Reference:	-		

1010337397493	Unique Care Pathway Number: 1010337397493
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REFERRING HCP DETAILS		Organisation address	
HCP Name	MalihaFrancis	GLASGOW GLASGOW G11 6DD Contact number(s) Voice: 0141 339 1444	
HCP code	53231		
HCP Position	-		
Organisation name	Forde Opticians Limited (49331)		
Location code	-		

OPTOMETRY INFORMATION

Diagnosis	Optic Nerve, Non-specific		Treatment Instigated	-	Treatment	-			
Right	Ocular Examination - External/Internal					Left			
Please find comments below under Administrative information.			Please find comments below under Administrative information.						
Applanation Tonometry	R	15 mmhg	L	16 mmhg	RAPD	No			
Time	14:12		Applanation	No					
Fields	Yes								
Attached									
Vision	Sph	Cyl	Axis	Prism	VA	PH VA	Add	NVA	Test Date
R	-4.25	++0.50	90	----	6/7.5-1	-	+1.75	N5	26-Jul-2024
L	-3.75	+0.75	85	----	6/7.5	-	+1.75	N5	
								Images Attached	Yes

CLINICAL INFORMATION**History of presenting complaint****Presenting complaint**

Description: Optometrist Direct Referral

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history**Current medication** (Active Repeat medication issued within the last 12 months)

No current medications recorded

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

No recent medications recorded

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Clinical warnings**Additional Support Needs**

No known ASN requirements

Additional relevant information**Administrative information**

Patient History and Details: Gayle attended for a routine Diabetic eye test and was asymptomatic. She had a change in rx, Dilated fundus photos show no DR and Disc appearance in unchanged from last years photos/notes. However her disc OCT shows NRR loss today and there is definite repeatable VF loss L>R. Full threshold VF was not attempted as it was too complex/difficult for this px. There are no previous VFs to compare to and we did not have any further patient details from beyond 2023. As a result it is unclear if her LE VF loss is longstanding or worsening, I have therefore referred her as urgent to be vetted by HES.

Medications: sertraline

Gliclazide

quitiapin

statin

and one more diab med name unknown

Comment Right: external eye - blepharitis mild

a/c clear and quiet

lens clear. mild changes

vitreous no significant floaters

disc - Clear/Distinct Margins

mild ppa,

c/d 0.15

nrr appears intact, possibly some paler areas nasally?

photos appear unchanged

macula flat/clear

periphery - flat/healthy no DR

Comment Left: external eye - blepharitis mild

a/c clear and quiet

lens clear. mild changes

vitreous no significant floaters

disc - Clear/Distinct Margins

mild ppa,

c/d 0.15

nrr appears intact, possibly some paler areas or just ppa? photos appear unchanged

macula flat/clear

periphery - flat/healthy no DR

Previous Attendance at Hospital Eye Service?:No

If Yes, Location:(Not Known)

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Patient consent:Yes

Ophthalmology -

210779 18072023 144301 Fundus(Upper)

L 001GAYLE

Ophthalmology -

cdv photo 001GAYLE260724

Ophthalmology - 210779 26072024 140604 OCTReport L 001GAYLE

Ophthalmology - 210779 26072024 140533 OCTReport R 001GAYLE

Ophthalmology - 210779 18072023 144227 Fundus(Upper) R 001GAYLE

Ophthalmology - cdv photo 00120 07 24

Signature of referring doctor (or other professional) Date

Insulin Prescription and Administration Form

N Ac Do Chi 2107796165 WILSON Gayle 21/07/1979	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
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****Ensure that the insulin type and administration times are also prescribed on the Kardex.
Administration 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: 4 /day.

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)					
11/07/26						units					Y / N
						units					Y / N
	Before Breakfast					units					Y / N
	1055		22.0		Novorapid	5		GA	LR	1108	Y / N
	Before Lunch					units					Y / N
	1348		10.1			units					Y / N
	Before Dinner					units					Y / N
18/07/26	1838		18.3			units					Y / N
	Before Bed					units					Y / N
	0020		5.2			units					Y / N
						units					Y / N
						units					Y / N
	Before Breakfast		13.1			units					Y / N
						units					Y / N
01/08/26	Before Lunch					units					Y / N
						units					Y / N
	Before Dinner					units					Y / N
						units					Y / N
	Before Bed					units					Y / N
						units					Y / N
						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)					
17/1						units					Y / N
						units					Y / N
	Before Breakfast		12.0			units					Y / N
						units					Y / N
	Before Lunch			17.9		units					Y / N
						units					Y / N
	Before Dinner			20.5		units					Y / N
						units					Y / N
18/1	Before Bed		12.5			units					Y / N
						units					Y / N
						units					Y / N
	Before Breakfast		14.8			units					Y / N
						units					Y / N
	Before Lunch			16.4		units					Y / N
						units					Y / N
	Before Dinner			15.7		units					Y / N
26/1						units					Y / N
						units					Y / N
	Before Bed					units					Y / N
						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

Insulin Prescription and Administration Form

Name: 2107796165
 Address: WILSON
 Gayle
 1-1 21/07/1979
 37A DOWANHILL STREET
 Glasgow, Lanarkshire
 DoB:
 Chi number: G11 5RN
 Affix patient data label

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 administration times are also prescribed on the Kardex.
Administration 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)			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)					
19/1/20						units					Y / N
						units					Y / N
	Before Breakfast					units					Y / N
						units					Y / N
	Before Lunch					units					Y / N
						units					Y / N
	Before Dinner					units					Y / N
						units					Y / N
	Before Bed					units					Y / N
						units					Y / N
						units					Y / N
	Before Breakfast					units					Y / N
						units					Y / N
	Before Lunch					units					Y / N
						units					Y / N
	Before Dinner					units					Y / N
						units					Y / N
	Before Bed					units					Y / N
						units					Y / N
						units					Y / N
	Before Breakfast					units					Y / N
						units					Y / N
	Before Lunch					units					Y / N
						units					Y / N
	Before Dinner					units					Y / N
						units					Y / N
						units					Y / N
	Before Bed					units					Y / N
						units					Y / N
						units					Y / N
	Before Breakfast					units					Y / N
						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					Y / N
						units					Y / N
						units					Y / N
	Before Breakfast					units					Y / N
						units					Y / N
	Before Lunch					units					Y / N
						units					Y / N
	Before Dinner					units					Y / N
						units					Y / N
	Before Bed					units					Y / N
						units					Y / N
						units					Y / N
						units					Y / N
	Before Breakfast					units					Y / N
						units					Y / N
	Before Lunch					units					Y / N
						units					Y / N
	Before Dinner					units					Y / N
						units					Y / N
	Before Bed					units					Y / N

Guidelines for capillary blood glucose readings falling into the shaded area

Hypoglycaemia: Glucose < 4mmol/L	Hyperglycaemia: Glucose ≥ 15mmol/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.	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



Inpatient prescription & administration record for
Gayle Wilson (2107796165)
Admission: 13/01/2026 => 19/01/2026

02:43
22/01/26

Patient Demographics

WILSON Gayle (2107796165)

DOB: 21/07/1979

1-1, 37A Dowanhill Street,
Glasgow,
Lanarksh,
G11 5RN

Admitted: 13/01/2026 22:00

Discharged: 19/01/2026 15:41

Transfer history

Admission	2026-01-13 10:46:00	QED QEUH ED
Transfer	2026-01-13 22:00:00	QARU2 QEUH ARU2
Transfer	2026-01-15 10:07:00	Q6D QEUH 6D
Transfer	2026-01-18 15:17:00	QMDU QEUH MDU

Responsible Consultant history

Assigned No Consultant	13/01/26	10:46
Rahat Maitland	13/01/26	22:00
Matthew Walters	15/01/26	10:07
David Corcoran	15/01/26	15:27

Allergy

Admission Allergy Check performed by:

Current recorded allergy (reaction): PENICILLINS (Unknown)

torvastatin 40 mg Tablets

☒ 14/01/26 22:00 40 mg ONCE daily at 10pm (Oral)

Louise Gallacher

14/01/26	22:00	14/01/2026	22:34	Joanna Adams
15/01/26	22:00	15/01/2026	22:04	Kirsty MacInnes/ Zanele Nkomo
16/01/26	22:00	16/01/2026	21:28	Zanele Nkomo
17/01/26	22:00	17/01/2026	21:25	SAFINAH NALUMU
18/01/26	22:00	18/01/2026	21:31	Tshering Wangmo

Colchicine 500 micrograms Tablets

☒ 14/01/26 07:00 500 microgram TWICE DAILY 7am:10pm (Oral)

Louise Gallacher

14/01/26	07:00	Suspended		
14/01/26	22:00	14/01/2026	22:34	Joanna Adams
15/01/26	07:00	15/01/2026	08:09	Marie Effa
15/01/26	22:00	15/01/2026	22:04	Kirsty MacInnes/ Zanele Nkomo
16/01/26	07:00	16/01/2026	08:33	Elise McQuade
16/01/26	22:00	16/01/2026	21:28	Zanele Nkomo
17/01/26	07:00	17/01/2026	08:32	Eunice Adom
17/01/26	22:00	17/01/2026	21:25	SAFINAH NALUMU
18/01/26	07:00	18/01/2026	08:20	Eunice Adom
18/01/26	22:00	18/01/2026	21:31	Tshering Wangmo
19/01/26	07:00	19/01/2026	08:42	Sarah Lynagh

☒ 14/01/26 04:57 500 microgram (Oral)

Louise Gallacher

14/01/26	04:57	14/01/2026	06:34	Louise Crear
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Dapagliflozin 10 mg Tablets

☒ 14/01/26 07:00 10 mg ONCE DAILY MORNING 7am (Oral)

Louise Gallacher

14/01/26	07:00	14/01/2026	08:56	Marie Effa
15/01/26	07:00	15/01/2026	08:08	Marie Effa
16/01/26	07:00	16/01/2026	08:32	Elise McQuade
17/01/26	07:00	17/01/2026	08:31	Eunice Adom
18/01/26	07:00	18/01/2026	08:19	Eunice Adom
19/01/26	07:00	19/01/2026	08:41	Sarah Lynagh

Gliclazide 80 mg Tablets

☒ 14/01/26 07:00 160 mg TWICE daily at 7am and 5pm (Oral)

Louise Gallacher

14/01/26	07:00	14/01/2026	08:58	Marie Effa
14/01/26	17:00	14/01/2026	16:40	Marie Effa
15/01/26	07:00	15/01/2026	08:09	Marie Effa
15/01/26	17:00	15/01/2026	17:55	Elise McQuade
16/01/26	07:00	16/01/2026	08:33	Elise McQuade
16/01/26	17:00	16/01/2026	17:37	Elise McQuade
17/01/26	07:00	17/01/2026	08:31	Eunice Adom

Key:	Prescription details	Reported 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)
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Gliclazide 80 mg Tablets

(Continued)

17/01/26	17:00	17/01/2026	17:21	Eunice Adom
18/01/26	07:00	18/01/2026	08:20	Eunice Adom
18/01/26	17:00	18/01/2026	17:40	Sharon McAulay
19/01/26	07:00	19/01/2026	08:43	Sarah Lynagh

Naproxen 500 mg Tablets

☒ 14/01/26 17:00 500 mg TWICE daily at 7am and 5pm (Oral)

Melissa Harrison NMP

14/01/26	17:00			Marie Effa	Drug unavailable
15/01/26	07:00			Marie Effa	Drug unavailable
15/01/26	17:00	15/01/2026	17:56	Elise McQuade	
16/01/26	07:00	16/01/2026	08:34	Elise McQuade	
16/01/26	17:00	16/01/2026	17:37	Elise McQuade	
17/01/26	07:00	17/01/2026	08:32	Eunice Adom	
17/01/26	17:00	17/01/2026	17:21	Eunice Adom	
18/01/26	07:00	18/01/2026	08:21	Eunice Adom	
18/01/26	17:00	18/01/2026	17:40	Sharon McAulay	
19/01/26	07:00	19/01/2026	08:43	Sarah Lynagh	

☒ 15/01/26 10:35 500 mg (Oral)

Alexander Macdonald

15/01/26	10:35	15/01/2026	11:26	Elise McQuade	
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Omeprazole 20 mg Capsules

☒ 15/01/26 07:00 20 mg ONCE DAILY MORNING 7am (Oral)

Louise Gallacher

15/01/26	07:00	15/01/2026	08:09	Marie Effa	
16/01/26	07:00	16/01/2026	08:33	Elise McQuade	
17/01/26	07:00	17/01/2026	08:32	Eunice Adom	
18/01/26	07:00	18/01/2026	08:21	Eunice Adom	
19/01/26	07:00	19/01/2026	08:44	Sarah Lynagh	

Paracetamol 500 mg Tablets

☒ 14/01/26 23:45 1,000 mg (Oral)

Louise Gallacher

14/01/26	23:45	15/01/2026	00:11	Joanna Adams	
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Quetiapine 25 mg Tablets

☒ 14/01/26 07:00 50 mg THREE times daily - 7am;5pm;10pm (Oral)

Louise Gallacher

14/01/26	07:00	14/01/2026	08:56	Marie Effa	
14/01/26	17:00	14/01/2026	16:40	Marie Effa	
14/01/26	22:00	14/01/2026	22:34	Joanna Adams	
15/01/26	07:00	15/01/2026	08:08	Marie Effa	
15/01/26	17:00	15/01/2026	18:15	Elise McQuade	
15/01/26	22:00	15/01/2026	22:03	Kirsty MacInnes/ Zanele Nkomo	
16/01/26	07:00	16/01/2026	08:32	Elise McQuade	
16/01/26	17:00	16/01/2026	17:37	Elise McQuade	
16/01/26	22:00	16/01/2026	21:27	Zanele Nkomo	
17/01/26	07:00	17/01/2026	08:31	Eunice Adom	
17/01/26	17:00	17/01/2026	17:21	Eunice Adom	
17/01/26	22:00	17/01/2026	21:25	SAFINAH NALUMU	
18/01/26	07:00	18/01/2026	08:20	Eunice Adom	
18/01/26	17:00	18/01/2026	17:41	Sharon McAulay	
18/01/26	22:00	18/01/2026	21:30	Tshering Wangmo	
19/01/26	07:00	19/01/2026	08:41	Sarah Lynagh	

Sando-K 12 mmol Effervescent Tablets

☒ 15/01/26 22:00 2 Tablet THREE TIMES DAILY 7am:12pm:10pm (Oral) for 2 day(s)

Maryam Sahibqran

15/01/26	22:00	15/01/2026	22:04	Kirsty MacInnes/ Zanele Nkomo	
16/01/26	07:00	16/01/2026	08:34	Elise McQuade	
16/01/26	12:00	16/01/2026	13:09	Elise McQuade	

☒ Discontinued on: 16/01/2026 15:58:00 by: Alexander Macdonald . Reason: Course Complete

Sertraline 100 mg Tablets

☒ 14/01/26 07:00 200 mg ONCE daily at 7am (Oral)

Louise Gallacher

14/01/26	07:00	14/01/2026	08:56	Marie Effa	
15/01/26	07:00	15/01/2026	08:08	Marie Effa	
16/01/26	07:00	16/01/2026	08:32	Elise McQuade	
17/01/26	07:00	17/01/2026	08:31	Eunice Adom	
18/01/26	07:00	18/01/2026	08:19	Eunice Adom	
19/01/26	07:00	19/01/2026	08:39	Sarah Lynagh	

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)
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Ibuprofen 400 mg Tablets as required

☒ 14/01/26 08:45 400 mg THREE TIMES DAILY 7am:12pm:10pm (Oral) Pain/Fever

Louise Gallacher

☐ Discontinued on: 14/01/2026 14:09:00 by: Melissa Harrison NMP . Reason: Rationalising Medication

Paracetamol 500 mg Tablets as required

☒ 14/01/26 23:44 1,000 mg FOUR times daily - 7am:12pm:5pm:10pm (Oral) FOR PAIN

Louise Gallacher

1,000.00	15/01/2026	08:10	Marie Effa
1,000.00	17/01/2026	21:25	SAFINAH NALUMU



Inpatient prescription & administration record for
Gayle Wilson (2107796165)
Admission: 02/01/2026 => 03/01/2026

02:43
06/01/26

Patient Demographics		Admitted:	02/01/2026 23:05
WILSON Gayle (2107796165)		Discharged:	03/01/2026 15:00
DOB: 21/07/1979			
1-1, 37A Dowanhill Street, Glasgow, Lanarksh, G11 5RN			

Transfer history		Responsible Consultant history	
Admission	2026-01-02 17:09:00 QED QEUH ED	Assigned No Consultant	02/01/26 17:09
Transfer	2026-01-02 23:05:00 QARU1 QEUH ARU1	Brian Kennon	02/01/26 23:05
		Joseph Sarvesvaran	03/01/26 10:32

Allergy	
Admission Allergy Check performed by: Katharine Johnstone	
Current recorded allergy (reaction): PENICILLINS (Unknown)	

***torvastatin 40 mg Tablets**

03/01/26 22:00 40 mg ONCE daily at 10pm (Oral)

Katharine Johnstone

Colchicine 500 micrograms Tablets

03/01/26 07:00 500 microgram TWICE DAILY 7am:10pm (Oral)

Katharine Johnstone

03/01/26 07:00	03/01/2026 08:39	Caitlin McCool
03/01/26 01:05	500 microgram (Oral)	Katharine Johnstone
03/01/26 01:05	03/01/2026 01:33	Tracey Dolan

Dapagliflozin 10 mg Tablets

03/01/26 07:00 10 mg ONCE DAILY MORNING 7am (Oral)

Katharine Johnstone

03/01/26 07:00	03/01/2026 08:36	Caitlin McCool
Diazepam 2 mg Tablets		
03/01/26 07:00	2 mg TWICE DAILY 7am:10pm (Oral)	Katharine Johnstone
03/01/26 07:00	03/01/2026 08:38	Caitlin McCool

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

03/01/26 17:00 40 mg ONCE daily at 5pm (Subcutaneous Bolus Injection)

Katharine Johnstone

Gliclazide 80 mg Tablets

03/01/26 07:00 180 mg TWICE daily at 7am and 5pm (Oral)

Katharine Johnstone

03/01/26 07:00	03/01/2026 08:43	Caitlin McCool
Discontinued on: 03/01/2026 08:46:21 by: Katharine Johnstone. Reason: Discontinued due to conflict		
03/01/26 17:00	160 mg TWICE daily at 7am and 5pm (Oral)	Katharine Johnstone

Ibuprofen 400 mg Tablets

03/01/26 07:00 400 mg THREE TIMES DAILY 7am:12pm:10pm (Oral)

Katharine Johnstone

03/01/26 07:00	03/01/2026 08:37	Caitlin McCool
03/01/26 12:00	03/01/2026 12:18	Caitlin McCool

Quetiapine 25 mg Tablets

03/01/26 07:00 50 mg THREE TIMES DAILY 7am:12pm:10pm (Oral)

Katharine Johnstone

03/01/26 07:00	03/01/2026 08:43	Caitlin McCool
03/01/26 12:00	03/01/2026 12:18	Caitlin McCool

Sertraline 100 mg Tablets

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)
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Sertraline 100 mg Tablets

(Continued)

☒ 03/01/26 07:00 200 mg ONCE daily at 7am (Oral)

Katharine Johnstone

03/01/26 07:00

03/01/2026 08:37

Caitlin McCool

Paracetamol 500 mg Tablets as required

☒ 03/01/26 01:06 1,000 mg FOUR times daily - 7am;12pm;5pm;10pm (Oral) FOR PAIN

Katharine Johnstone

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)
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Please ensure this document is destroyed after use.

Wilson, Gayle

ID:2107796165

14-JAN-2026 09:22:55

GREATER GLASGOW SITE-QEARU2 ROUTINE RECORD

21-JUL-1979 (46 yr)

Female

Room:
Loc:1304

Vent. rate 79 BPM
PR interval 166 ms
QRS duration 72 ms
QT/QTc 372/426 ms
P-R-T axes 42 57 55

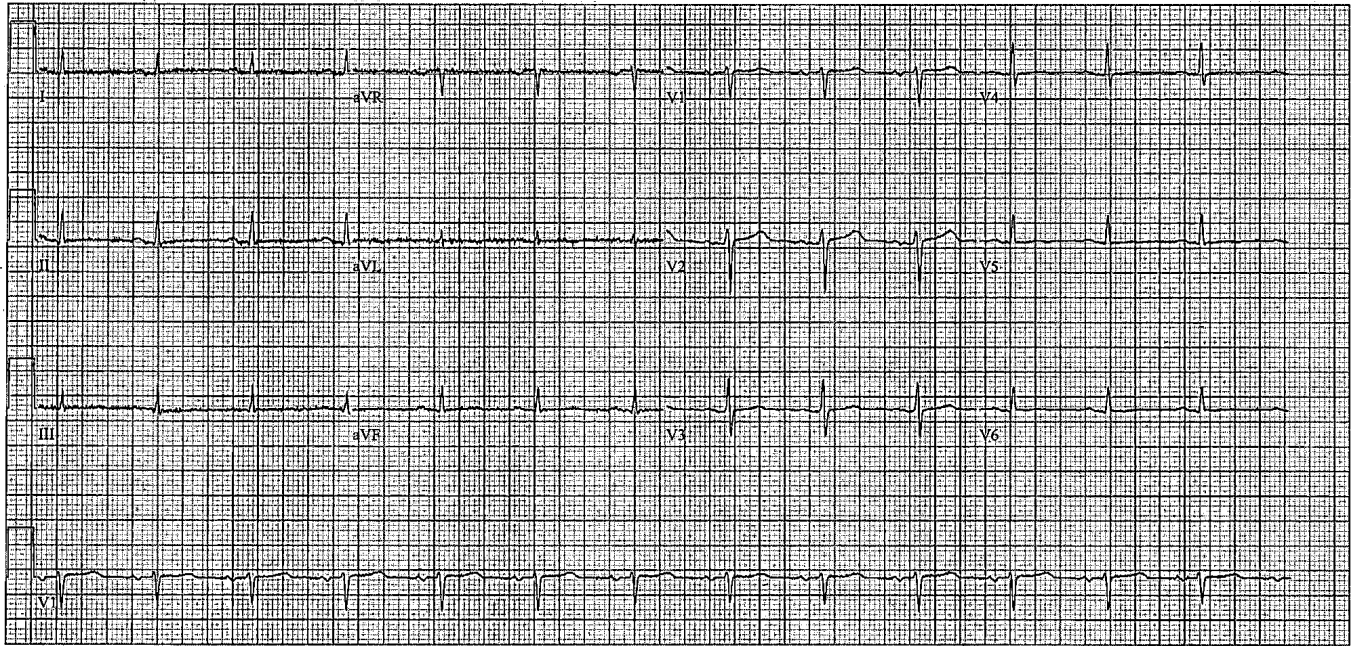
Normal sinus rhythm
Nonspecific T wave abnormality
Abnormal ECG

Technician: 362
Test ind:CP

Unconfirmed

COMMENTS:

Location:



25mm/s 10mm/mV 100Hz 9.0:10 12SL245 CID: 1053

SID: 2163434 EID:13 EDT: ORDER:

Page 1 of 1

Wilson, Gayle

ID:2107796165

13-JAN-2026 12:13:15

GREATER GLASGOW SITE-QEED ROUTINE RECORD

21-JUL-1979 (46 yr)

Female

Room:

Loc:1301

Vent. rate

PR interval

QRS duration

QT/QTc

P-R-T axes

104

152

66

318/418

42 48

BPM

ms

ms

ms

-6

Sinus tachycardia

Low voltage QRS

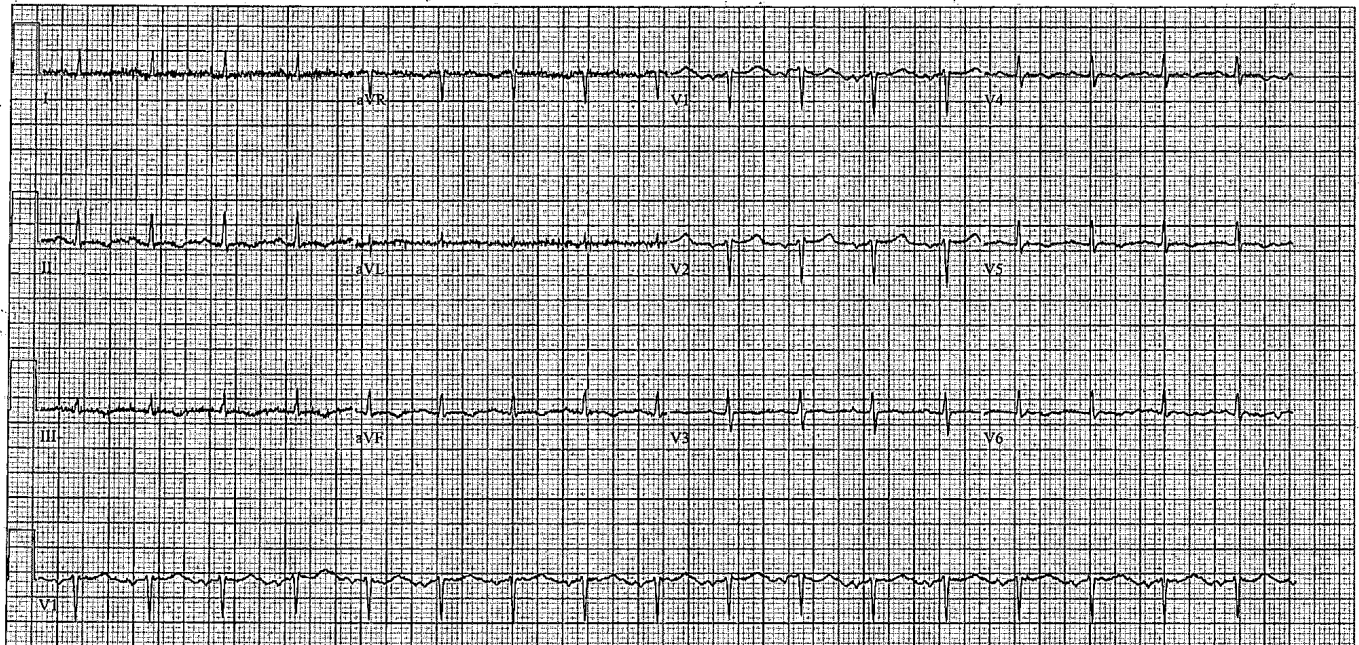
Nonspecific T wave abnormality

Abnormal ECG

Technician: mw
Test ind:

Unconfirmed

Comments:



25mm/s 10mm/mV 100Hz 9.0.10 12SL 243 CID:1036

SID: 2163434 EID:13 EDT: ORDER:

Page 1 of 1

Wilson, Gayle

ID:2107796165

02-JAN-2026 17:37:55

GREATER GLASGOW SITE-QEED ROUTINE RECORD

21-JUL-1979 (46 yr)

Female

Room:

Loc:1301

Vent. rate

PR interval

QRS duration

QT/QTc

P-R-T axes

100

140

68

352/454

46 70

BPM

ms

ms

ms

96

Normal sinus rhythm

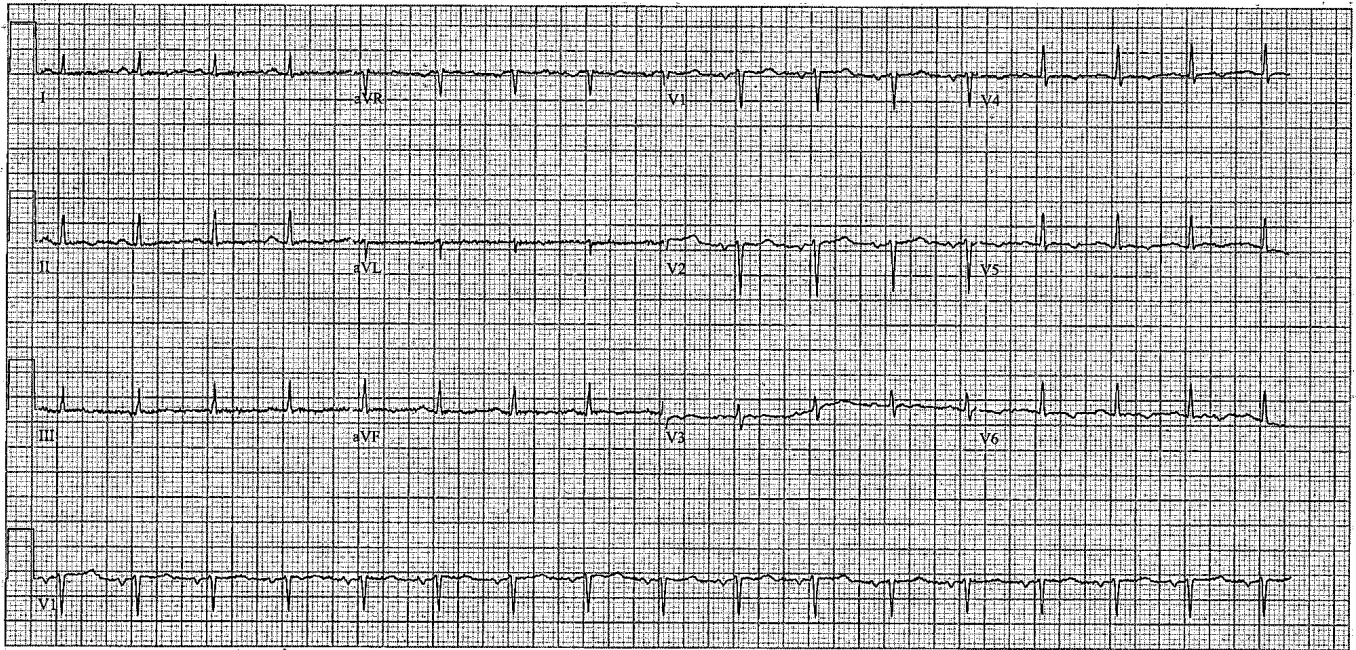
Nonspecific T wave abnormality

Abnormal ECG

Technician: os
Test ind:

Unconfirmed

Comments:



25mm/s 10mm/mV 100Hz 9.0.10 12SL 243 CID: 1037

SID: 2163434 EID: 13 EDT: ORDER:

Page 1 of 1

Wilson, Gayle

ID:2107796165

21-FEB-2020 02:58:58

GREATER GLASGOW SITE-QEED ROUTINE RECORD

21-JUL-1979 (40 yr)
Female

Vent. rate 102 BPM
PR interval 156 ms
QRS duration 68 ms
QT/QTc 382/497 ms
P-R-T axes 35 74 60

Sinus tachycardia
Otherwise normal ECG

Technician: NICOLA
Test ind:UWA

Referred by: A/E

Unconfirmed

COMMENTS:



25mm/s 10mm/mV 100Hz 9.0.4 12SL 237 CID: 51

SID: 2163434 EID: EDT: ORDER:

Page 1 of 1

Wilson, Gayle
Female
21/07/1979 (46 Years)

Vent. rate
PR interval
QRS duration
QT/QTc-Baz
P-R-T axes

70 PM
110 ms
110 ms
372/426 ms
42 57 55

Patient ID: 2107791
Normal sinus rhythm
Nonspecific T wave abnormality
Abnormal ECG

14/01/2026 09:22:55
Acute Receiving Unit 2

PRINTED IN UK 2

Location: 1304

Technician ID: 362

COMMENTS:
Location:

Test Indication: CP

Unconfirmed



25mm/s 10.0mm/mV 0.56-100 Hz ZPD 50 Hz

MAC 5 1.00 SP05

12SL v24 4 by 2.5s + 1 rhythm Id

Page 1 of 1

Wilson, Gayle

Female
21.07.1979 (46 Years)

Location: 1301

Vent. rate 10 PM
PR interval 15 ms
QRS duration 66 ms
QT/QTc-Baz 318/418 ms
P-R-T axes 42 48 -6

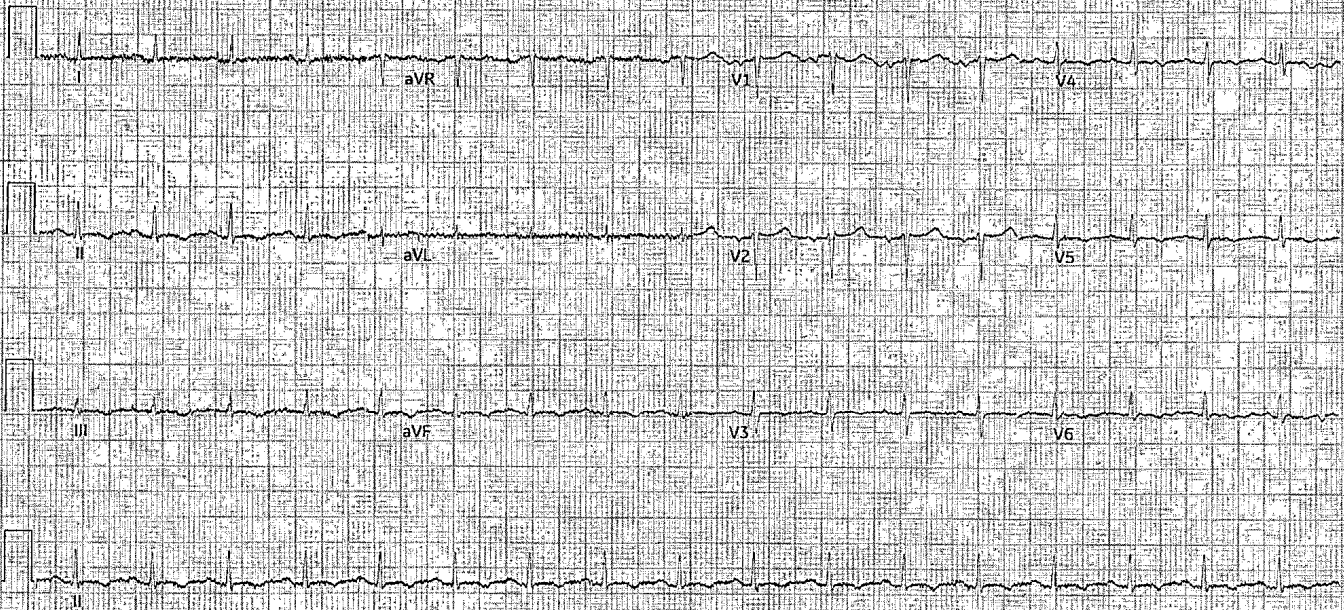
Patient ID: 2107796
Sinus tachycardia
Low voltage QRS
Nonspecific T wave abnormality
Abnormal ECG

13.01.2026 12:13:15
QEUH ED

Technician ID: mw

Comments:

Unconfirmed



25 m/s 10.0mm/mV

0.56-100 Hz ZPD 50 Hz

MAC™ 7 1.00 SP06

12SL-v23.1 4 by 2.5s + 1 rhythm Id

Page 1 of 1

Wilson, Gayle

Female:
21.07.1979 (46 Years)

Location: 1301

Heart rate: 100 BPM
PR interval: 140 ms
QRS duration: 68 ms
QT/QTc-Baz: 352/454 ms
P-R-T axes: 46 70 96

Patient ID: 2107796

Normal sinus rhythm
Nonspecific T wave abnormality
Abnormal ECG

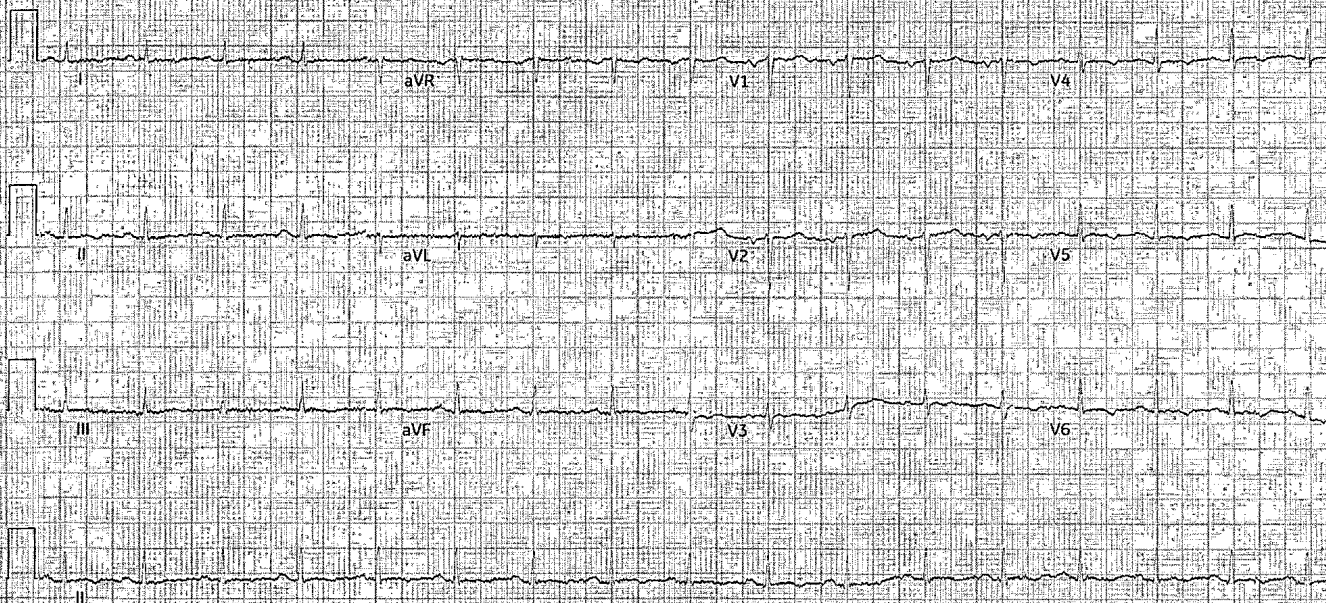
02.01.2026 17:37:55

QUEUED

Technician ID: os

Comments:

Unconfirmed



25mm/s 10.0mm/mV

0.56-100 Hz ZPD 50 Hz

IAC™ 7 1:00 SP06

12SL v23.1.4

2.5s + 1 rhythm Id

Page 1 of 1

WILSON, GAYLE

ID: 2107796165

30-Nov-2021

5:16:53

QUEEN ELIZABETH UNIVERSITY HOSPITAL

Vent. rate 91 n
PR interval 154 ms
QRS duration 72 ms
QT/QTc 372/472 ms
P-R-T axes 54 93 53

Normal sinus rhythm
Normal ECG

Loc: 1301

Technician:
Test ind:

[Handwritten signature]

2107796165
WILSON
Gayle
52 DALHOUSIE ST
Glasgow, Lanarkshire
21/07/1978
G3 6PA

COMMENTS:

Referred by:

Unconfirm



WILSON, GAYLE

ID: 2107796165

21-Feb-2020 2:5

QUEEN ELIZABETH UNIVERSITY HOSPITAL

21-Jul-1979
Female

Vent. rate 102 bpm
PR interval 156 ms
QRS duration 68 ms
QT/QTc 382/497 ms
P-R-T axes 35 74 60

Sinus tachycardia
Otherwise normal ECG

Loc: 136

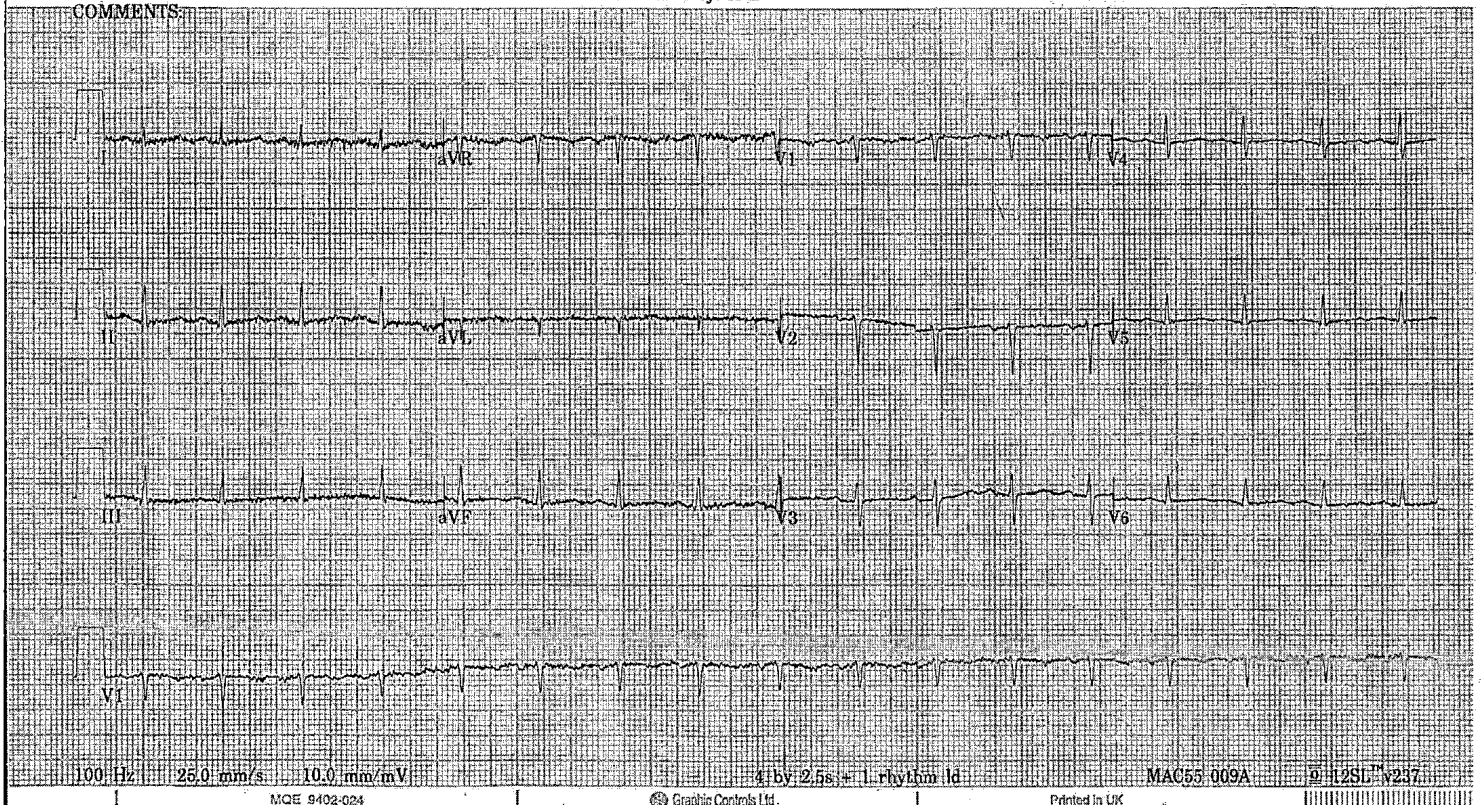
Technician: NICOLA
Test ind: UWA



Referred by: A/E

Unconfirmed

COMMENTS:



Name:	Gayle Wilson	Exam:	Transthoracic Echocardiogram
CHI Number:	2107796165	Responsible Clinician:	Dr Corcoran
Date of birth:	21/07/1979 (46 years)	Referral Source:	IP
Gender	female	Scan Location:	6d
Exam Date:	18/01/2026	Scanned by:	Stuart Rennie
Reported by:	Stuart Rennie		

Physical Exam Data

Height 158 cm. Weight 78.0 kg. BMI 31.2 kg/m². BSA 1.80 m². Sinus rhythm.

Indication/Referral Source

? constrictive pericarditis

Study Quality

View: Fair acoustic access.

Measurements

Left Ventricle 2D mode

IVSd	1.1 cm	LVIDs Index	1.66 cm/m ²	LVEDV (Auto EF BIP)	83.4 ml
LVIDd	4.5 cm	LVPWd	1.1 cm	LVEDVI (Auto EF BIP)	46 ml/m ²
LVIDd Index	2.5 cm/m ²	LVD Mass (ASE)	172 g	LVEF (Auto EF BIP)	56 %
LVIDs	3.0 cm				

Right Ventricle 2D mode

RV Major	6.5 cm	RV Minor	2.3 cm
----------	--------	----------	--------

Right Ventricle Doppler

RVOT Vmax	0.96 m/s	RVOT max PG	3.7 mmHg
-----------	----------	-------------	----------

Left Atrium M mode

LA Diam	3.7 cm	LA / Ao	1.44
---------	--------	---------	------

Left Atrium 2D mode

LA Diam	3.5 cm	LA Volume Index	26.0 ml/m ²	LAESV (A-L A4C)	49.5 ml
LAAs (A4C)	19.0 cm ²	LALs (A4C)	6.2 cm	LAESV (A-L A2C)	40.3 ml
LAAs (A2C)	15.0 cm ²	LALs (A2C)	4.8 cm	LAESV (A-L BIP)	51.0 ml

Mitral Valve Doppler

MV E Velocity	0.82 m/s	MV PHT	33 ms	MV max PG	2.8 mmHg
MV A Velocity	0.73 m/s	MVA PHT	6.6 cm ²	MV mean PG	1.6 mmHg
MV E / A	1.13	MV Vmax	0.83 m/s	MV VTI	21.6 cm
MV Dec. Time	115 ms				

Mitral Valve TDI

MV E' Sept	8.9 cm/s	MV E' Lat	8.9 cm/s	MV E' Avg	8.9 cm/s
MV E / E' Sept	9.2	MV E / E' Lat	9.2	MV E / E' Avg	9.20

Aortic Valve Doppler

LVOT Vmax	0.98 m/s	AV Vmax	1.22 m/s	AV mean PG	2.7 mmHg
LVOT max PG	3.9 mmHg	Dimensionless Index	0.81	AV VTI	23.0 cm
LVOT VTI	17.8 cm	AV max PG	6.0 mmHg		

Aorta M mode

Ao Root Diam	2.6 cm
--------------	--------

Aorta 2D mode

SOV Diam	2.8 cm	Ao st junct Diam	2.7 cm	Ao Asc Diam	2.9 cm
SOV Diam Index (h)	1.79 cm/m	Ao st junct Diam Index (h)	1.71 cm/m	Ao Asc Diam Index (h)	1.83 cm/m

Tricuspid Valve M mode

TAPSE	2.1 cm
-------	--------

Pulmonary Valve Doppler

PV Vmax	1.16 m/s	PV max PG	5.4 mmHg
---------	----------	-----------	----------

Other

LVIDd Index	2.48 cm/m ²	RAESV MOD	41 ml	LALs A2C	4.8 cm
Sinuses Of Valsalva	28.35 mm	RAVI	23.11 ml/m ²	LAESV Index (A-L)	28.33 ml/m ²
Ao st junct	26.99 mm	MV Velocity	0.01 m/s	LAESV Ind MOD BP	26.04 ml/m ²
RV base diam	2.8 cm	MV Time	114 ms	LVVED BiP Q	83 ml
RALS	5.8 cm	LVOT Env.TI	266 ms	LVEF BiP Q	56 %
RAESV A-L	42 ml	AV/LVOT	1.24	LVS V BiP Q	46 ml

Left Ventricle

Normal cavity size.

No hypertrophy present.

Normal systolic function.

Right Ventricle

Normal cavity size. Normal systolic function.

Left Atrium

Normal cavity size.

Right Atrium

Normal right atrial size.

Aortic Valve

Normal (trileaflet) aortic valve. No stenosis. No aortic regurgitation.

Mitral Valve

Normal mitral valve anatomy thin and mobile leaflets.

No evidence of mitral stenosis. Trivial mitral regurgitation.

Tricuspid Valve

Normal tricuspid valve.

No evidence of tricuspid valve stenosis.

No tricuspid regurgitation.

Pulmonary Valve

Normal pulmonary valve structure and function.

No evidence of pulmonary stenosis. Trivial pulmonary regurgitation.

Aorta

Normal aortic root, ascending aorta and aortic arch. No evidence of coarctation.

Systemic Veins

Normal inferior vena cava.

Interatrial Septum

Intact

Conclusion

Non dilated LV with good overall systolic function

RV is normal in size and function
No obvious significant valvular abnormalities seen

CT Abdomen and pelvis with contrast

Performed	21-Jan-2026 14:02	Received	27-Jan-2026 20:51
Reported	27-Jan-2026 20:49	Order Number	G405H43055040
Status	Final	Source System	MiSys

CT Abdomen and pelvis with contrast

Final

Gayle Wilson

Clinical History: 46F admitted with chest pain. Pericardial effusion, D-dimer 2945, CA-125 122. ?pelvic malignancy

CASE HISTORY:

Clinical History: 46F admitted with chest pain. Pericardial effusion, D-dimer 2945, CA-125 122. ?pelvic malignancy

}
Exam Description: CT Abdomen and pelvis with contrast

The liver demonstrates a smooth contour. The liver is enlarged. No suspicious focal liver lesion. Prior cholecystectomy. The spleen is enlarged measuring 17.1 cm.

Unremarkable appearances of the adrenal glands and kidneys. No hydronephrosis.

No focal pancreatic mass or duct dilatation.

No bowel obstruction. No suspicious next mass. No focal bladder lesion. No ascites.

No enlarged inguinal, pelvic sidewall or retroperitoneal lymph nodes by CT size criteria.

Slightly thickened distal oesophagus is non-specific.

There is a shallow left-sided pleural effusion. Mild to moderate pericardial effusion with a depth of 15 mm.

No aggressive osseous lesion.

Impression:

Hepatosplenomegaly with a shallow unilateral left-sided pleural effusion. Mild to moderate pericardial effusion. Recommend haematology opinion to exclude a low-grade lymphoproliferative disorder.

Reported by:

Dr Ayyaz Quddus
Consultant Radiologist
GMC: 7454368
Axon Diagnostics
clinicalqueries@axondiagnostics.com

Reported by: AXON Reporting

Verified by: AXON Reporting

XR Chest

Performed	13-Jan-2026 19:19	Received	28-Jan-2026 19:11
Reported	28-Jan-2026 19:09	Order Number	G405H43093575
Status	Final	Source System	MiSys

XR Chest

Gayle Wilson

Final

Clinical History :

chest pain and shortness of breath ?infection ?effusion

XR Chest :

The heart is not enlarged. The lungs are clear of active disease. No significant focal lung lesion seen.

Reported by: Dr Sean Kelly and None

Verified by: Dr Sean Kelly

CT Angiogram pulmonary

Performed	02-Jan-2026 20:30	Received	03-Jan-2026 10:31
Reported	03-Jan-2026 10:29	Order Number	G405H43054280
Status	Final	Source System	MiSys

CT Angiogram pulmonary

Final

Gayle Wilson

Clinical History :

46F a/w pleuritic cp, sob, tachycardia at rest

CXR: nil focal consolidation

D dimer: 2750

imp: ?PE

CT Angiogram pulmonary : No previous for comparison.

Satisfactory opacification of pulmonary trunk.

No acute pulmonary embolism. No evidence of a right heart strain.

Moderate volume low density pericardial effusion.

Background centrilobular emphysema. Minor ground-glass changes and atelectasis within the lung bases.

Unremarkable appearance of the partly included abdomen on this non-dedicated phase.

No sinister bony findings.

Conclusion:

No acute pulmonary embolism.

Moderate volume low density pericardial effusion.

Sticky note added to PACS at 21:43.

Information passed onto Dr Emma Louis Little at 21:45.

Consultant review: No PE. There is some breathing artefact but no definite evidence of emphysema. Atelectasis in the lingula and right middle lobe. Small bilateral pleural effusions. Lower respiratory tract infection is not excluded. Non-specific pericardial effusion.

Reported by: Dr Laju Etchie (SpR) and Dr Clare Fenlon**Verified by:** Dr Clare Fenlon

XR Chest

Performed	02-Jan-2026 19:27	Received	13-Jan-2026 06:56
Reported	13-Jan-2026 06:54	Order Number	G405H43054235
Status	Final	Source System	MiSys

XR Chest

Final

Gayle Wilson

Clinical History :

46F a/w cp

?CAP

XR Chest :

The heart is not enlarged. The lungs are clear of active disease. No significant focal lung lesion seen.

Reported by: Dr Sean Kelly and None

Verified by: Dr Sean Kelly

XR Foot Lt

Performed	22-Apr-2010 22:02	Received	23-Apr-2010 11:22
Reported	23-Apr-2010 11:02	Order Number	G516H13750732
Status	Final	Source System	MiSys

XR Foot Lt

Final

Gayle Wilson

Clinical History : Pain dorsum of foot.

XR Foot Lt :

No significant bone or joint abnormality demonstrated.

Reported by: DR ND RABY and BLANK CLINICIAN

Verified by: DR ND RABY

MANUAL PATIENT RECORDS

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

Including:

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

Western Infirmary
Glasgow G11 6NT
Telephone: 0141 211 2000



NURSE TO COMPLETE

Out Patient appointment date.....

Diagnosis informed (circle) Patient Relative

Circle support services set up:

District Nurse Home Help Health Visitor ✓
 Oncology referral Hospice: day care OR home care
 Discharge address if not home:

WARD USE ONLY	
Medication Rec. on Ward by: _____	
Checked against kardex: _____	
Issued by: _____	Date: _____
Signature of Recipient: _____	
All known drug sensitivities / adverse reactions: _____	

[illegible]

Dispensed by: _____ Date: ____/____/____
 Checked by: _____
 Non-childproof containers required: Yes ☐ No ☐
 Medicine compliance aids required: Yes ☐ No ☐
 Specify: _____

Medication Collected by:

You must use a ballpoint pen and fully complete this form or the prescription will not be dispensed

Note File By 3/12/13
**Accident and Emergency Department
Western Infirmary**

A&E No. 13000000847



50938417A

3

Surname	WILSON	Forename	GAYLE	Title: MISS
Address:	ASPIRE 18 HILLHEAD STREET GLASGOW	Postcode	G12 8PY	CHI No: 2107796165
		Telephone:	0141 563 8676	
Date of Birth:	21.07.79	Sex:	F	Age: 33 yrs



CHI Number: 2107796165

GP Name:	GHOURI NAYEEM			
Address:	PEEL STREET MEDICAL ... 11 PEEL STREET GLASGOW	Postcode	G11 5LL	
		Telephone:	0141 334 9331	

Next of Kin	VIOLET WILSON			
Relationship:	PARENT			
Address:	0/2 1655 DUMBARTON ROAD	Postcode	G14 9YD	
	GLASGOW	Telephone:	0141 563 8676	
Primary Carer:	UP0003894R			

Date of Attendance: 05.01.13 18:54

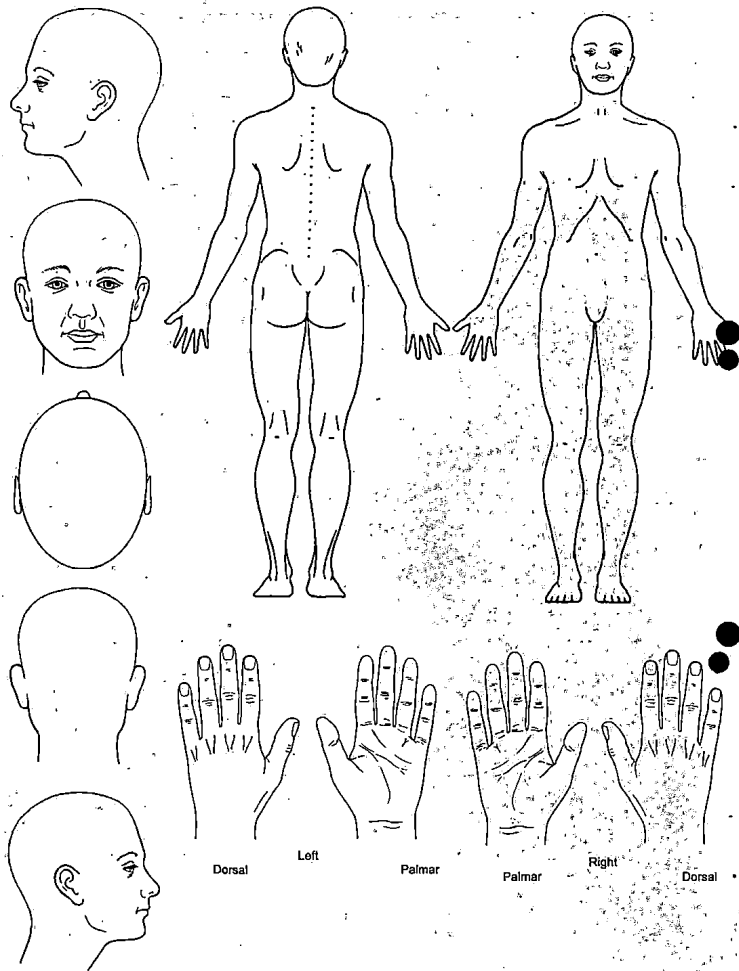
Date of Incident:

Presenting Complaint: THIGH ABSCESS
FOR SURGEONS

Triage	WOKE UP WITH LUMP ON THIGH. LEG HAS BEEN SORE ALL WEEK. FEELS WELL TEMP 35.9	Tetanus Cover:
		Allergies:
P= 105	BP= 126/90	RR= 16
		Sat= 98
PF=	GCS= E: M: V: Total:	BM=

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time



Signed

CLINICAL NOTES - EMERGENCY DEPARTMENT

Consultant _____ Seen by _____
 Grade: FY1, FY2, S... 2, ST3, ST4-6, FTSTA, Locum, ENP, Consultant, Other (Please circle) A
 Date 05/01/13 21:00 Hrs
 Referral: acute surgery, SHL / MacDonald
 30358417A
 WILSON
 21/07/1979
 ASPIRE
 18 HILLHEAD STREET
 GLASGOW
 CHI-2107796165 012 871

PC/1

33

HOPE...

- normally fit and well
- this morning woke with swelling medial aspect of right
- not sustained any trauma / bites
- feeling right hand
- no lumps
- no discharge

PMH, depression

no DM

OH, mitral regurg

antacid - 4mg qd

Allergies - penicillin

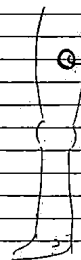
SH, smoker x 20 days

Alcohol occasional

OK

meds and analgesia

Afebrile = 35.9 BP = 126/90 HR = 16 RR = 18 SpO2 = 98% on RA



examination
 5x5cm lump, indurated skin, non fluctuant
 not painful

Imps right thigh absent

Plus, Abx, clindamycin 300mg BD

fever 38.5°C 20 Jan

if become systemic, refer to radiology to hospital

OK
 OK
 20 Jan

This image shows a single sheet of white, lined notebook paper. It features horizontal blue or grey ruling lines spaced evenly down the page. On the left side, there is a vertical margin line. Along the right edge, there are three circular binder holes. The paper appears slightly aged or off-white. There is no handwriting or printed text on the page.[illegible]

Date

UNITARY MED

RECORD

Consultant:

Seen By:

Grade:

FY1

FY2

CMT1/2

ST3+

NP

Other

Time

Presenting Complaint

History Presenting Complaint

Past Medical History

Social History

- Home circumstances
- Exercise tolerance
- Driving
- Smoking history
- Alcohol History
- Activities of Daily Living

Systemic Enquiry:

- CVS
- Resp
- GI
- Neuro
- GUS
- Other

PATIENT LABEL

Source of Medical History
(2 Sources)

Patient	☐	Relative/Carer	☐
GP Phone call	☐	ECS	☐
Patient own Drugs	☐	Com. Pharmacist	☐
GP Letter/Summary	☐	Repeat Script	☐

Other (please specify) _____

[illegible]

Allergies: None known ☐		List any over the counter/alternative medicines:	
Do medicines need further clarification Yes ☐ No ☐		Plan Initiated by:	
List collected by: Date:		Designation: Date:	
Compliance aid: Yes ☐ No ☐		Community pharmacist: Phone:	

Reviewed by: _____ Designation: _____ Date: _____

NHS GG&C 't Risk Assessment for Venous Thromboembolism (VTE)
[excluding ortho, ophthalmology, urology, gynaecology, oncology, cardiology, pediatrics, obstetrics & ENT who have specialty-specific policies]

- Risk Assessment must be completed for all patients within 24 hours of admission to hospital
- Patients must be reassessed every 48 hours or sooner if condition changes
- Assessment must be documented in Kardex
- Provide patient information on VTE prevention

Pt Addressograph

Surgical patients start here

Non-operative [mainly medical] patients start here

Is the patient bed-bound or expected to have

Yes

Does the patient have any risk factors for thrombosis? (tick ✓ all that apply)

Age >60	Use of oestrogen-containing contraceptive therapy
Active cancer or cancer treatment	Use of hormone replacement therapy
Dehydration	Pregnancy or < 6 weeks post partum [seek specialist advice]
Known thrombophilias	Critical care admission eg HDU/ITU
Obesity (BMI>30)	Varicose veins with phlebitis
Current significant medical condition e.g. Serious infection	Total anaesthetic + surgical time >90 minutes
Heart failure	Surgery involving pelvis or lower limb with a total anaesthetic + surgical time >60 minutes
Respiratory disease	
Inflammatory disease	Acute surgical admission with inflammatory or intra-abdominal condition
Personal history or first degree relative with a history of VTE	Hip fracture*

- Risk assessment now complete
- No thromboprophylaxis required.
- Continue to review every 48 to 72 hours or sooner if condition changes.
- Document all assessments on kardex.

Yes, 1 or more ticks

No ticks

Does the patient have any bleeding risk factors? (tick x all that apply)

Active bleeding	Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrand)
Acquired bleeding disorders (e.g. acute liver failure)	Neurosurgery, spinal or posterior eye surgery
Concurrent use of anticoagulants (such as warfarin with INR >2)	Lumbar puncture, epidural/spinal anaesthesia expected within the next 12 hours
Acute stroke	Other procedure with high bleeding risk – discuss with senior if unsure
Uncontrolled hypertension (230/120 mmHg or higher)	Lumbar puncture, epidural/spinal anaesthesia within the previous 4 hours
Thrombocytopenia ($<75 \times 10^9/l$)	Thyroid surgery

- Consider mechanical prophylaxis e.g. AES unless contra-indicated.
- Reassess patient every 48 to 72 hours or sooner if condition changes

No bleeding risk factor ticks

Surgical patients – Enoxaparin 40mg + AES
Medical patients – Enoxaparin 40mg
 Prescribe Enoxaparin at 6pm [on day of surgery, at the later of 4h post-op or 6pm]
 Reduce Enoxaparin to 20mg if $< 50\text{Kg}$ or $\text{eGFR} < 30$
 Discontinue at discharge or when returned to pre-morbid mobility

Contraindications to anti-embolism stockings (AES)

- ☐ Peripheral neuropathy
- ☐ Peripheral vascular disease
- ☐ Cellulitis or Gross oedema
- ☐ Leg deformity or Fragile skin
- ☐ Leg / foot ulcers

Risk assessment result – please circle all that apply

VTE risk factors: YES / NO Bleeding risk factors: YES / NO Prescribed: LMWH / AES / NONE

Assessors Name: _____ Date: _____

Patient Informed Yes / No Information leaflet provided Yes / No

RAT Medicine & Surgery May 19/06/2012 – TEST OF CHANGE 0

EXAMINATION

Vital Signs: HR BP RR T O2 sat FIO2

MEWS:

AMT: Age What year Date of birth Location AMT /4

General Appearance: Jaundice, anaemia, cyanosis, clubbing, oedema, Lymphadenopathy

Cardiovascular:

Respiratory



Abdominal



Neurological

PR

Other (if appropriate): e.g. musculoskeletal, skin

INVESTIGATIONS

ECG

CXR

Other

ABG

Time					
FIO2					
H+					
PO2					
PCO2					
HCO3					
BE					
LAC					

DIFFERENTIAL

GNOSIS

APPROPRIATE PROTOCOLS AND/OR CLINICAL SCORES (E.G. GRACE / MOD GEN A)

Affix protocol sticker as required
i.e. Sepsis Six or ACS

MANAGEMENT AND FURTHER INVESTIGATIONS

Date/ time									
Na				HB			Paracetamol		
K				MCV			Salicylate		
Cl				WCC					
Ur				Neut					
Cr				Plts					
Gluc									
Ca									
Mg				INR					
Bil				APTT					
Ast				PT					
Alt									
GGT									
ALP				TROP					
Alb				D-Dimers					
CRP				Amylase					

Destination/ Speciality

EDD

Name:

Sign:

Date:

Time:

CONTINUATION

CONTINUATION

Call No: 3650895	CHI: 2107796165	Date: 5-01-2013	NHS 24 No: 12599126
Patients Name: Gayle Wilson	D.O.B. 21/07/1979 Age: 33 years	Callers Name: Relationship:	
Address Today: Aspire - Room 11 18 Hillhead Street Glasgow Post Code: G12 8PY Phone Number: 07747 781577	Home Address if different: 0/2 1655 Dumbarton Road Scotstoun Glasgow Post Code: G14 9YD Call Type: PCEC Within 4 Hrs		
Name of GP: Ghouri,NA(030) Surgery: 030 11 Peel Street Practice Number: Speed Dial: CONTACT DETAILS () . FAX NUMBER() () . PRACTICE(0141 334 9331) () . SPEED DIAL(187) () . MORNING FAX(0141 339 9798)	Time Call Received at NHS 24: 05/01/2013 17:11:15 Time Details Received at GEMS: 05/01/2013 17:24:41 Time Patient Arrived: 05/01/2013 17:58:10 Consultation Start time: 05/01/2013 18:20:42 Consultation End time: 05/01/2013 18:42:36		
Dispatched To: Western			

Clinical Information

Examination Results:

STATES THAT RIGHT LEG HAS BEEN SORE ALL WEEK BUT WHEN WOKE THIS MORNING FOUND A RED LUMP AT THE TOP OF THE LEG ON THE INSIDE. IS PAINFUL TO TOUCH AND PAINFUL WHEN WALKING. ((Non-Clinical User) (Glasgow))

Clinical summary created by: (Nurse Advisor) (Cardonald) [05/01/2013 17:25:25]

RED PAINFUL SWOLLEN LUMP RIGHT INNER THIGH FOR TODAY AND APPROX 2 - 3 INCHES WIDE. FEVERISH. STATES LEG HAS BEEN PAINFUL ALL WEEK. WESTERN INFIRMARY PCEC 4 HOURS.

LUMP ON RIGHT LEG 1 DAY SEE AV

Clinicians Notes

70y old female lives in homeless unit. 1 week hx of upper rt leg pain, now notices lump right inner thigh, tender. Denies ivda. feels bit feverish. E & D ok. Not used analgesia.

PMhx- depression, prev DSH. hypercholesterolaemia/ DHx- simvastatin. mirtazepine. allergy- PENICILLIN. smoker 10/day no etoh no iv drug abuse

Overweight
P- 115 R
T- 36.5
sats - 95% RA

Lower limb- no evidence of groin iv sites.
5cm fluctuant mass on inner aspect upper 1/3 Rt thigh. some overlying erythema. tender ++ not pulsatile

note old DSH marks rt lower leg. CRT <2s. pedal pulses intact. can w/b, walkign with slight limp.

imp- Rt thigh abscess

Vulnerable adult.- needs further evaluated ? u/s abscess ? I & D referred- ortho asked to be referred to surgeon given site of abscess

surgeons 18.40hrs kindly accepted.

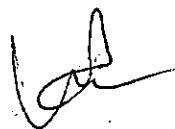
Prescription Items:

Clinical Code/s: M0... Skin/subcutaneous infections

Informational Outcome: Hospital Referral

Referral:

Consulting Clinician: Adie, Leigh(CC)

A handwritten signature in black ink, appearing to read 'Leigh Adie', is located in the upper right quadrant of the page. The signature is fluid and cursive.

[illegible]

[illegible]

Name: [REDACTED]
 Address: 50938417A
 WILSON
 GAYLE 21/07/1979
 DoB:.... ASPIRE
 18 HILLHEAD STREET
 GLASGOW G12 8PY
 CHI nur CHY-2107796165
 CHY-2107796165

Hospital: WIR	Ward: WAO
Date of admission: 5/1/83	Time: 12:35
Admitting Consultant: Mr. S. S. S. S. S.	Admitting Nurse: B. K. S.

Preferred name:	Next of Kin (NoK):
Age: 33	Relationship:
Religion:	NoK Address:
Telephone:	NoK Telephone:
GP:	NoK Aware of admission: ☐ Yes ☐ No
GP address: Dr. N Ghousei Peel Street Medical Centre 11 Peel Street Glasgow G11 5LJ	Consent for information to be given to relatives: ☐ Yes ☐ No
GP telephone:	Nominated family contact: Telephone - Day: Telephone - Evening:

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

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

Contact telephone number:

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

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

WOUND ON THIGH
- LEG SORE ALL WEEK.

No known allergies: ☐

Cannard (if required)	Waterlow	MUST	Pulse	BP	Resp	SaO ₂	Temp
Urinalysis:		AMT4 Score	BM	EWS Score	Weight	Height	BMI

Medicines reconciled on admission? ☐ Yes ☐ No	
--	--

7. Risk Assessment

MUST

1. Is the patient's BMI: > 20 Score 0
18.5-20 Score 1
<18.5 Score 2

2. Has the patient had unplanned weight loss in the past 3-6 months?
< 5% Score 0
5-10% Score 1
>10% Score 2

3. If the patient is acutely unwell and there has been or is likely to be no food intake for > 5 days:
Score = 2
Not applicable: Score = 0

MUST Score: If score 1 or more, complete full Nutrition Profile

Cannard
Has the patient fallen in the last 6 months?
☐ Yes ☐ No
If 'Yes' complete a full Cannard Screening Tool.

8. Cognitive Impairment

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

- How old are you? years
- What is your date of birth? / /
- What is this place?
- What year is it?

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

AMT Score: out of 4

Name of Doctor informed (if required) Grade:

9. MRSA Screening / CJD

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

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

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

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

CJD: Has the patient ever been contacted by Public Health and told that they are possibly at risk of CJD?
☐ Yes ☐ No If 'Yes' contact Infection Control Team. Infection Control Team contacted: ☐

10. Lifestyle

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

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

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

11. Admission Documentation Completed By

Name (Please PRINT): Signature:

Designation: Date:

2. Assessment

Hospital: Ward:
Date of Assessment: 5/1/13 Time: 20:35

Name:
Address: 5093 8417A
WILSON
GAYLE 21/07/1979
DoB:
18 HILLHEAD STREET
GLASGOW G12 8PT
CHI - 2107796165
Affix patient data label

1. Breathing and Circulation

Breathing:
☐ No symptoms or history of respiratory problems ☐ Productive / non-productive cough evident
☐ Dyspnoeic at rest ☐ Normally receives oxygen therapy
☐ Dyspnoeic on minimal exertion If 'Yes' provide details:
☐ Dyspnoeic on maximum exertion

Circulation:
☐ No symptoms ☐ Known cardiac or circulatory problems

Immediate Action Taken

Initial

2. Communication

Assessment of ability to communicate:
What language does the patient speak?

Interpreter: Required ☐ Not required ☐
If required, provide details and arrangement made:

Does the patient have:

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

If 'Yes' please specify:

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

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

If 'Yes' please specify:

Immediate Action Taken

Initial

3. Senses

Senses:
Eyesight
☐ Normal vision
☐ Glasses – ☐ Distance ☐ Reading
☐ Prosthesis – ☐ Left ☐ Right
☐ Contact lenses
☐ Registered blind
Hearing
☐ Normal
☐ Hearing impaired
☐ Hearing aid – ☐ Left ☐ Right

4. Mental Status

Mental Status:
☐ Orientated
☐ Confused
☐ Distressed
☐ Aggressive / Abusive
☐ Unconscious

5. Hydration and Nutrition

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

Nutrition Profile completed ☐ Yes ☐ No

Do not complete sections 5a to 5d.

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

Date of reassessment:

5a1. Food likes / dislikes:

5c. Help needed with eating and drinking:

☐ Yes ☐ No

If 'Yes' provide details:

5a2. Fluid likes / dislikes

5b. Cultural or religious diet needed
(e.g. vegetarian, vegan, halal, kosher etc):

☐ Yes ☐ No

If 'Yes' specify diet needed:

5d. Texture Modified Diet needed?

☐ Yes ☐ No

If 'Yes' specify texture: A ☐ B ☐ C ☐ D ☐ E ☐

Thickened Fluids required? ☐ Yes ☐ No

If 'Yes' specify stage required: 1 ☐ 2 ☐ 3 ☐

Immediate Action Taken

Initial

6. Elimination

Continent:

☐ Bladder

☐ Bowel

Incontinent:

☐ Bladder

☐ Bowel

NHS GGC Stool Chart commenced:

☐ Required ☐ Not required

Long-term urinary catheter in situ? ☐ Yes ☐ No

If 'Yes' - Size: fg Make:

Continence assessment commenced:

☐ Yes ☐ No ☐ Not applicable

Containment products in use? Please specify:

☐ Bowels regular

☐ Constipated

☐ Diarrhoea / loose stools

Stoma: ☐ Yes ☐ No

If 'Yes' please specify and list appliances used:

Immediate Action Taken

Initial

7. Personal Hygiene, Oral Health and Skin Assessment

Personal Hygiene:

☐ Self-caring and independent

☐ Requires assistance

Specify assistance if required:

Oral health:

Self-caring and independent ☐ Yes ☐ No

Evidence of oral ulceration, infection, dry mouth ☐ Yes ☐ No

Requires assistance ☐ Yes ☐ No

If assistance required or evidence of ulceration etc, implement Oral Care Bundle.

Oral Hygiene Care Bundle:

☐ Required ☐ Not required

Dentures:

☐ Not worn

☐ Upper set

☐ Lower set

☐ Full

☐ Dentures with patient on admission

Skin assessment:

☐ Skin healthy with no evidence of damage

☐ Skin broken

☐ Skin oedematous

☐ Skin discoloured

☐ Skin clammy

If 'Yes' to any of the above, describe skin condition:

Wound Assessment Chart completed: ☐ Yes ☐ No ☐ Not applicable

Pressure ulcer evident: ☐ Yes ☐ No

If 'Yes' please identify Grade and record on Pressure Ulcer record sheet - Grade:

Immediate Action Taken

Initial

8. Mobility

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

☐ Limited mobility

☐ Mobile with aid - Specify:

☐ Prosthesis - Specify:

Moving and Handling Plan commenced:

☐ Yes ☐ No

Immediate Action Taken

Initial

9. Maintaining a Safe Environment

Pain status:

Does the patient have pain? ☐ Yes ☐ No

If 'Yes' record Pain Score on EWS chart.

What makes their pain better? Please provide brief details:

Bed rail assessment completed: ☐ Yes ☐ No

Bed rails required:

☐ Required ☐ Not required

Immediate Action Taken

Initial

Sleep habits:		Sleep difficulties:	
☐ Less than 8 hours	☐ Afternoon nap	☐ None	☐ Disturbed e.g. nocturia, insomnia
☐ Morning nap		☐ Early waking	
Medication required: ☐ Yes ☐ No			
Immediate Action Taken			
			Initial
1 Social Circumstances			
☐ Employed ☐ Unemployed ☐ Retired ☐ Lives alone ☐ Lives with Family ☐ Friend ☐ Dependants ☐ Other: ☐ Nursing Home ☐ Residential		If support services in place, please provide details:	
Current Care / Support Service arrangement:		Current Care / Support arrangements suspended:	
☐ Social Services ☐ Private Carers ☐ None		☐ Yes ☐ No ☐ Not applicable	
Immediate Action Taken			
			Initial
12 Privacy, Dignity and Sexuality			
Does the patient have issues related to privacy, dignity and/or sexuality that are relevant to admission?		If 'Yes' please provide brief details:	
☐ Yes ☐ No			
13. Spiritual Care			
Is there anything with regard to faith or culture that we can support the patient with during their stay in hospital (e.g. prayer, meditation)?		If 'Yes' please provide brief details:	
☐ Yes ☐ No			
Is there anything causing the patient a lot of anxiety at the time of admission that staff should be aware of?		If 'Yes' please provide brief details:	
☐ Yes ☐ No			
Ask the patient: "Would you like the ward staff to arrange, for a Hospital Chaplain to visit you while in hospital?"		If 'Yes' please specify faith group:	
☐ Yes ☐ No ☐ Not at this time			

[illegible]



50938417A
WILSON
GAYLE 21/07/1979 F
ASPIRE
18 HILLHEAD STREET
GLASGOW G12 8PY
CHI-2107796165

24 Hour Fluid Balance Chart

Name:		Case Record No:										Ward: <u>WOW</u>		Date: <u>5/11/13</u>			
		INPUT (mls)								IN		OUTPUT (mls)				OUT	
TIME HRS (Please delete 1 column)	ORAL	NASO GASTRIC TPN	BLOOD COLLOID PLASMA	IV (1) /	TYPE	IV (2)	IV (3) Drugs	Hourly Total	Cumulative Total	URINE	URINE Cumulative Total	Gastric Aspirate / Vomit	Drain 1		Hourly Total	Cumulative Total	
08 14																	
09 01																	
10 02																	
11 03																	
12 04																	
13 05																	
14 06																	
15 06																	
16 07																	
17 08																	
18 09																	
19 10																	
20 11																	
21 12																	
22 13																	
23 14																	
24 15																	
01 16																	
02 17																	
03 18																	
04 19																	
05 20																	
06 21																	
07 22																	
07 23																	
TOTALS																	
TOTAL IN MLS										BALANCE			TOTAL OUT MLS				

commenced.

GUIDELINES FOR RECORDING INTRAVENOUS INFUSIONS ON 24 HOUR FLUID BALANCE CHART

ALL INTRAVENOUS INFUSIONS TO BE RECORDED ON COMPLETION OF INFUSION.

TYPE OF PARENTAL FLUID TO BE RECORDED IN APPROPRIATE COLUMNS:-

BLOOD/COLLOID/PLASMA

IV (1)

IV (2)

IV (3)

- RECORD ANY BLOOD OR BLOOD PRODUCTS, e.g.
 - ◆ UNITS OF PACKED BLOOD CELLS
 - ◆ FROZEN PLASMA
 - ◆ GELOFUSINE
- PLEASE RECORD TYPE OF INTRAVENOUS FLUID AND AMOUNT, e.g.
 - ◆ SODIUM CHLORIDE 0.9%
 - ◆ GLUCOSE 5%
 - ◆ RINGER LACTATE
- FOR USE IF MORE THAN ONE INTRAVENOUS INFUSION IN PROGRESS, e.g. CVP LINE

FOR RECORDING INTRAVENOUS DRUGS SUCH AS ANTIBIOTICS. CROSS REFERENCE BY USING THE CODED LETTER OF THE PATIENT'S MEDICATION PRESCRIPTION SHEET, e.g.

A. 100mls

- RECORDING INTRAVENOUS PRESCRIPTIONS GIVEN BY SYRINGE DRIVER /INFUSION PUMP, e.g. HEPARIN, INSULIN, DOPAMINE.
- ADDITIONAL COLUMN FOR USE IF MORE THAN TWO INFUSIONS IN PROGRESS AT ANY ONE TIME

CARE PLAN

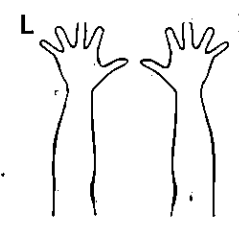
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Signature of nurse: SM

Date: 05/04/15

Adult Peripheral Venous Cannulation (PVC) Chart

Please use 1 chart per PVC

PVC Insertion Information Ensure the PVC dressing has date and time of insertion written on it: This implies that appropriate technique has been used for insertion.		Date: _____ (See IV Dressing) Time: _____ Reason for Insertion: _____ Flushed on insertion ☐ (if known)	
Affix patient's label  Name: 50938417A WILSON Address: GAYLE 21/07/1979 D.O.B: ASPIRE 18 HILLHEAD STREET GLASGOW G12 8PY CHI number: CHI-2107796165 Hospital:			
Other Site: _____			

PVC Maintenance Information			
Modified V.I.P (Visual Infusion Phlebitis) Score			
IV site appears healthy	0	No Phlebitis	Observe Cannula
ONE of the following is evident: - slight pain or redness near site	1	Possible first signs	Observe Cannula
TWO of the following are evident: - pain - redness - swelling	2	Early stage of phlebitis	Re-site Cannula
ALL of the following are evident: - pain - redness - hardening of the surrounding tissue	3	Phlebitis / Thrombophlebitis Re-site Cannula & Seek Further Advice	
As above including: - palpable venous cord	4		
As above including: - pyrexia	5		

Day 1 (24 hours after insertion) All 5 questions below MUST be answered The PVC must be monitored at least once per day	Day 2 All 5 questions below MUST be answered The PVC must be monitored at least once per day
1. Continuing clinical indication for PVC? Yes / No 2. VIP Score? ☐ 3. PVC Dressing dry & intact? Yes / No 4. Was PVC dressing renewed? Yes / No / NA 5. Was PVC Removed? Yes / No Removal Reason: _____ Comments/Actions Taken: _____ Date: _____ Initials: _____	1. Continuing clinical indication for PVC? Yes / No 2. VIP Score? ☐ 3. PVC Dressing dry & intact? Yes / No 4. Was PVC dressing renewed? Yes / No / NA 5. Was PVC Removed? Yes / No Removal Reason: _____ Comments/Actions Taken: _____ Date: _____ Initials: _____

After Day 3 consider removal, if there is still a clinical reason justify rationale for PVC to remain in situ

Date: _____ Initials: _____

Day 3 All 5 questions below MUST be answered The PVC must be monitored at least once per day	Day 4 All 5 questions below MUST be answered The PVC must be monitored at least once per day
1. Continuing clinical indication for PVC? Yes / No 2. VIP Score? ☐ 3. PVC Dressing dry & intact? Yes / No 4. Was PVC dressing renewed? Yes / No / NA 5. Was PVC Removed? Yes / No Removal Reason: _____ Comments/Actions Taken: _____ Date: _____ Initials: _____	1. Continuing clinical indication for PVC? Yes / No 2. VIP Score? ☐ 3. PVC Dressing dry & intact? Yes / No 4. Was PVC dressing renewed? Yes / No / NA 5. Was PVC Removed? Yes / No Removal Reason: _____ Comments/Actions Taken: _____ Date: _____ Initials: _____

ADAPTED WATERLOW PRESSURE AREA RISK ASSESSMENT CHART

WRITE.



Surname	50938417A	
	WILSON	F
Forename	GAYLE	21/07/1979
	ASPIRE	
DoB	18 HILLHEAD STREET	
	GLASGOW	G12 8PY
Location	CHI-2107796165	

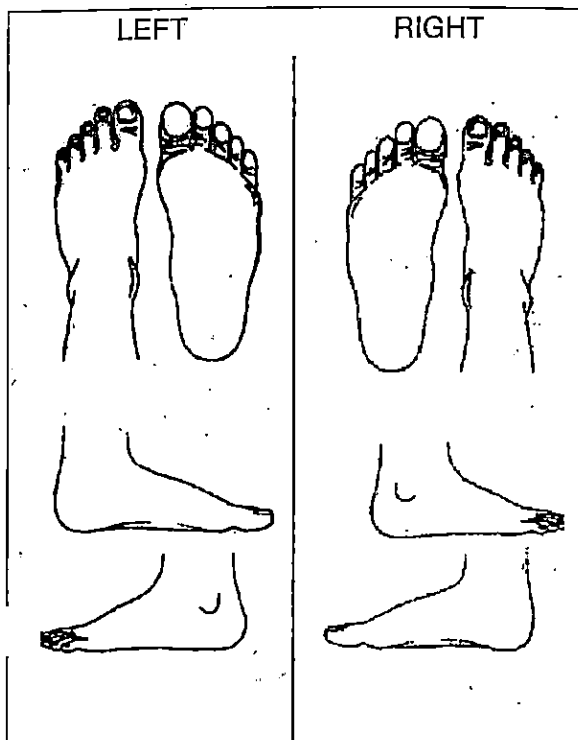
More than one score/category can be used: 10+= 'At Risk': 15+= 'High Risk': 20+= 'Very High Risk'
Complete assessment on admission/1st visit, if there is a change in individuals condition and repeat regularly according to local protocol

Patient regularly according to local protocol					
Sex					
Male	1				
Female	2				
Age					
14 -49	1				
50 -64	2				
65 - 74	3				
75 - 80	4				
81+	5				
Build/Weight for Height (BMI=weight in Kg/height in m²)					
Average - BMI 20-24.9	0				
Above average - BMI 25-29.9	1				
Obese - BMI > 30	2				
Below average - BMI < 20	3				
Continence					
Complete/catheterised	0				
Incontinent urine	1				
Incontinent faeces	2				
Doubly incontinent (urine & faeces)	3				
Skin Type - Visual Risks Area					
Healthy	0				
Tissue paper (thin/fragile)	1				
Dry (appears flaky)	1				
Oedematous (puffy)	1				
Clammy (moist to touch)/pyrexia	1				
Discoloured (bruising/mottled)	2				
Broken (established ulcer)	3				
Mobility					
Fully mobile	0				
Restless/fidgety	1				
Apathetic (sedated/depressed/reluctant to move)	2				
Restricted (restricted by sever pain or disease)	3				
Bedbound (unconscious/unable to change position/traction)	4				
Chairbound (unable to leave chair without assistance)	5				
Nutritional Element					
Unplanned weight loss in past 3-6 months					
<5% Score 0, 5-10% Score 1, >10% Score 2	0-2				
BMI > 20 Score 0, BMI 18.5-20 Score 1, BMI < 18.5 Score 2	0-2				
Patient acutely ill or no nutritional intake > 5 days	2				
Special Risks - Tissue Malnutrition					
Multiple organ failure/terminal cachexia	8				
Single organ failure e.g. cardiac, renal, respiratory	5				
Peripheral vascular disease	5				
Anaemia = Hb < 8	2				
Smoking	1				
Special Risks - Neurological Deficit					
Diabetes/MS/CVA/motor/sensory/paraplegia Max 6	4-6				
Special Risks - Surgery/Trauma					
On table > 6 hours	8				
Orthopaedic/below waist/spinal (up to 48 hours post op)	5				
On table > 2 hours (up to 48 hours post op)	5				
Special Risks - Medication					
Cytotoxic, anti-inflammatory, long term/high dose steroid Max 4	4				
Total Score					
Date					
Initials					
Time					

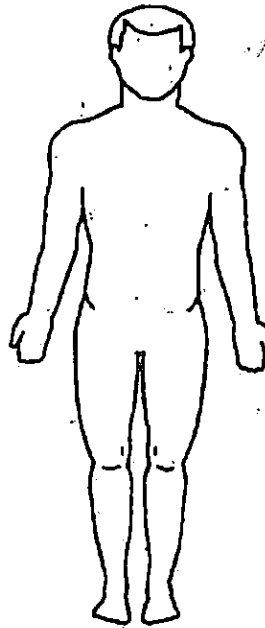
Ensure plan of care is implemented / reviewed for all identified areas of concern.

PRESSURE ULCER RECORD

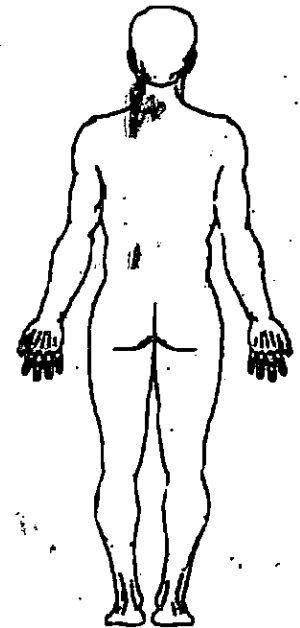
Indicate by circling and numbering all pressure damage on diagrams, then complete box below.
Indicate care plan/wound assessment chart.



Anterior view



Posterior view



SCOTTISH ADAPTED EPUAP PRESSURE ULCER GRADING TOOL

- GRADE 1** Non-blanchable erythema of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness may also be used as indicators, particularly on individuals with darker skin.
- GRADE 2** Partial thickness skin loss involving epidermis, dermis or both. The ulcer is superficial and presents clinically as an abrasion or blister.
- GRADE 3** Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia.
- GRADE 4** Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss.

DATE	NUMBER OF ULCER(S)	LOCATION OF ULCER(S)	GRADE OF ULCER(S)	LOCATION OF ULCER(S)

Pressure Ulcers may deteriorate from Grade 1 to Grade 4, but can not be reversed and should be documented as a healing grade of pressure ulcer, eg healing grade 4.

Discharge Checklist

Patient's name:		Ward:			
Unit number:	50938417A WILSON	Discharge destination:			
CHI number:	GAYLE 21/07/1979 ASPIRE 18 HILLHEAD STREET GLASGOW G12 8PY CHI-2107796165	Estimated Discharge Date (1) / /			
		Estimated Discharge Date (2) / /			
		Final date of discharge: / /			
Checklist	Yes	N/A	Initials	Comments	
Patient informed					
Relative/carer informed					
Others informed: Care Home					
Transport arranged					
Own transport (preferred option)					
Ambulance-1 man/ 2 man am/pm					
Other: Flight, Air ambulance etc.					
Discharge medication					
Discharge prescription completed					
Compliance aids e.g. Dosette Box (involve pharmacist)					
Medication received					
Medication explained to patient and/or relative/carer					
Own medication returned to patient					
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)					
Informed of discharge					
Social work/ Other agencies/Home help					
Physiotherapist					
Occupational Therapist					
Dietician					
Speech and Language Therapist					
Clinical Nurse specialist e.g. Care Home Liaison					
Liaison/ District Nurse/Practice Nurse					
Other discharge items					
Access arrangements (e.g. keys, door entry)					
Patients clothing available for day of discharge					
Valuables e.g. cash					
Intravenous cannula removed					
Equipment ordered (inc. walking aids) in place for discharge					
Part 2 Discharge letter - Required					
- Completed					
Out patient clinic appointment e.g. Anticoagulation clinic					
Arranged / To follow					
If unknown at time of discharge state reason					
Additional information / leaflets / factsheets					
Time of Discharge:					
Nurse's signature:	Designation:			Date: / /	