SAR Team
Health Records Department
Glasgow Royal Infirmary
8 – 16 Alexandra Parade
Glasgow
G31 2ER

NHS
Greater Glasgow and Clyde

Private
MMA Legal
43-59 Princes Street
Stockport
SK1 1RY

Date: 5 May 2026
Your Ref: 100013/Elliot Logan
Ref: SAR / ACCESS /CD
Enquiries to: Catrina
Direct Line: 0141 201 3381
Email: catrina.doogan@nhs.scot

Dear Sir / Madam

Re: Subject Access Request under the General Data Protection Regulation

Patient: DAVID BAILLIE DOB: 23/08/1989

Thank you for your recent request in which you seek a copy of your client's personal information.

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

GLASGOW ROYAL INFIRMARY RECORDS

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

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

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

- Patient health records, photographs or radiology images
- Video/telephone recordings, including CCTV images
- Witness statements
- Incident reports
- Complaints files
- Emails

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

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

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

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

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

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

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

Data Protection Officer
Information Governance Department
NHS GG&C – 2nd Floor
1 Smithhills Street
Paisley
PA1 1EB
Email:

Yours sincerely

SAR Team

MANUAL PATIENT RECORDS

ALL HOSPITAL RECORDS HELD NHSGGC	☐		
ACS	☐		
BEATSON HOSPITAL	☐		
CANNIESBURN HOSPITAL	☐		
DENTAL HOSPITAL	☐		
GARTNAVEL GENERAL HOSPITAL	☐		
GLASGOW ROYAL INFIRMARY (ORTHO)	☑		
INVERCLYDE ROYAL HOSPITAL	☐	MATERNITY	☐
NEW VICTORIA ACH	☐		
PRINCESS ROYAL MATERNITY	☐		
QUEEN ELIZABETH UNIVERSITY HOSPITAL	☐	MATERNITY	☐
ROYAL ALEXANDRA HOSPITAL	☐	MATERNITY	☐
ROYAL HOSPITAL FOR CHILDREN	☐		
STOBHILL HOSPITAL	☐		
VALE OF LEVEN	☐	MATERNITY	☐
WEST CARE AMBULATORY HOSPITAL	☐		
WESTERN INFIRMARY RECORDS	☐		

Including:

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

Attachments

REFERRAL TO

Trauma & Orthopaedic - Spine
GGC General Referral

— **Consultant / receiving practitioner** and/or **specialty clinic**

Western Infirmary/Gartnavel General
Dumbarton Road
Glasgow
G11 6NT

— **Hospital** and **hospital address**

Hospital location code.
G516H

Email address

Urgency of referral ROUTINE
Date of referral 28-Feb-2012 **Date sent** 28-Feb-2012

PATIENT DETAILS

Surname	Baillie
Forename(s)	David
Title	Mr
Sex	Male
Date of birth	23-Aug-1989
CHI no.	2308896337
Area of Residence	-

Patient's address

108 Borland Dr
Glasgow
G13 3DX

Contact number(s)

Voice: 07779369571

101003257568D Unique Care Pathway Number: 101003257568D

REGISTERED GP DETAILS

Name	Dr Philip Ewart		
GMC code	3351905	GP code	07935
Practice name	Fulton Street Medical Centre (18803)		
Practice code	40008		

Practice address

Fulton Street Medical Centre
94 Fulton Street
G13 1JE

Contact number(s)

Voice: 0141 959 3391
Facsimile: 0141 958 1258

REFERRING GP DETAILS

Name	Dr. Suzanne Irving		
GMC code	6092347	GP code	01899
Practice name	Fulton Street Medical Centre (40008)		
Practice code	40008		

Practice address

Fulton Street Surgery
94 Fulton Street
Glasgow
G13 1JE

Contact number(s)

Voice: 0141 959 3391

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: kyphoscoliosis

Comment: This 23 year old male has rcently rejoined society after a period in prison. He presents with chronic back pain which he attributes to his spinal curvature and kyphosis . He is currently on tramadol 200mg bd with pregabalin 300mg bd to manage the pain. I wonder if you would kindly reassess his scoliosis and give your opinion on management? last seen by Mr Reece 2008

Reason for referral

Care type requested: Out Patient

Expected outcome: Advise

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Kyphoscoliosis and scoliosis	he has longstanding spinal . refer to spinal surgeon.	24-Feb-2012	24-Feb-2012
Misuse of drugs NOS	-	29-Dec-2005	29-Dec-2005
Head injury	-	15-Nov-2005	15-Nov-2005

Current medication (Active Repeat medication issued within the last 12 months)

No current medications recorded

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Pregabalin Capsules 300 mg	56	56 capsule	ONE TO BE TAKEN TWICE A DAY	-	24-Feb-2012	24-Feb-2012
Tramadol Hydrochloride M/R tablets 200 mg	56	56 tablet	1 Tab Twice daily	-	24-Feb-2012	24-Feb-2012

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:	Disease: SPICE Basic Health Values, priority=2	18-Feb-2008
Current smoker:	Disease: SPICE Basic Health Values, priority=2	13-Jan-2005

Clinical warnings

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

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

Patient has disability or requires wheelchair access:No

Referred By:Locum

Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

ELECTRONIC PATIENT RECORDS

ALL HOSPITAL RECORDS HELD NHSGGC	☐		
ACS	☐		
BEATSON HOSPITAL	☐		
CANNIESBURN HOSPITAL	☐		
DENTAL HOSPITAL	☐		
GARTNAVEL GENERAL HOSPITAL	☐		
GLASGOW ROYAL INFIRMARY	☑		
INVERCLYDE ROYAL HOSPITAL	☐	MATERNITY	☐
NEW VICTORIA ACH	☐		
PRINCESS ROYAL MATERNITY	☐		
QUEEN ELIZABETH UNIVERSITY HOSPITAL	☐	MATERNITY	☐
ROYAL ALEXANDRA HOSPITAL	☐	MATERNITY	☐
ROYAL HOSPITAL FOR CHILDREN	☐		
STOBHILL HOSPITAL	☐		
VALE OF LEVEN	☐	MATERNITY	☐
WEST CARE AMBULATORY HOSPITAL	☐		
WESTERN INFIRMARY RECORDS	☐		

Including:

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

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Dr. UNK-Unknown GP
Patients Where Practice Code
Is Unknown And Who Are Not
Covered By codes 99942
99957 99976 99981 99995 99961

Main Switchboard: 0141 211 4000
Department: ENT
Contact Tel: 0141 242 9788
Enquiries to: Ann McNaughton
Letter Date: 29/06/2023
Reference: IA/MS
Dictated Date: 13/04/2023
Transcribed Date: 16/06/2023

Dear Dr ,

David John Baillie; D.O.B: 23/08/1989; CHI: 2308896337
The Health Centre, PO Box 2309, Glasgow, G33 9BS

This patient failed to attend his ENT Clinic appointment today. Due to pressure on our waiting times, no further appointment will be sent out.

Thank you.Yours sincerely,

Ms Ida Amir

Consultant ENT Surgeon

Electronically Signed: Dr Ida Amir, Consultant

cc.

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Dr. UNK-Unknown GP
Patients Where Practice Code
Is Unknown And Who Are Not
Covered By codes 99942
99957 99976 99981 99995 99961

Main Switchboard: 0141 211 4000
Department: ENT
Contact Tel: 0141 242 9788
Enquiries to: ann.mcnaughton@ggc.scot.nhs.uk
Letter Date: 27/04/2023
Reference: IA/AMN
Dictated Date: 28/02/2023
Transcribed Date: 24/04/2023

Dear Doctor ,

David John Baillie; D.O.B: 23/08/1989; CHI: 2308896337
The Health Centre, PO Box 2309, Glasgow, G33 9BS

This patient failed to attend his ENT clinic appointment today. One further appointment will be sent out.

Yours sincerely

Ms Ida Amir

Consultant ENT Surgeon

Electronically Signed: Dr Ida Amir, Consultant

cc.

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Ear, Nose & Throat (ENT) GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Glasgow Royal Infirmary 84 Castle Street Glasgow G4 0SF	——	**Hospital** and **hospital address** Hospital location code. G107H Email address -

Urgency of referral Routine
Date of referral 03-May-2022 **Date sent** 03-May-2022

PATIENT DETAILS

Surname	BAILLIE
Forename(s)	DAVID
Title	Mr
Sex	Male
Date of birth	23-Aug-1989
CHI no.	2308896337
Area of Residence	-

Patient's address

THE HEALTH CENTRE
P.O. BOX 2309
GLASGOW
G33 9BS

Contact number(s)
-

101026218229K | Unique Care Pathway Number: 101026218229K

REGISTERED GP DETAILS

Name	Dr Hmp Barlinnie		
GMC code	1234572	GP code	09172
Practice name	Headquarters		
Practice code	31391		

Practice address

5 REDHEUGHS RIGG
EDINBURGH
EH12 9HW

Contact number(s)
-

REFERRING HCP DETAILS

HCP Name	SuchitraSenthil
HCP code	5205040
HCP Position	Dr
	HMP Barlinnie

Organisation address

81 Lee Ave
Glasgow
G33 2QX

Contact number(s)

Organisation name	
Location code	G101P

-

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: right csom

Comment: Thank you for assessing David who c/o ongoing right ear discharge since the age of 9 yrs
now worse green yellow discharge
has had a few course of abx with no effect
Your assessment will be appreciated

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history
Pre-existing conditions (High & medium priority - all)

Description	Date of onset	Date recorded
Misuse of drugs NOS	09-Nov-2007	09-Nov-2007

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

Date Recorded	Systolic	Diastolic
02-Sep-2021	138	80
19-Aug-2019	117	73
21-May-2019	136	80
20-Apr-2018	130	70
23-Oct-2017	100	70

Body Measurements

Date Recorded	Height	Weight	BMI
02-Sep-2021	1.85	65.2	19
14-Apr-2021	1.85	70.8	20.6
19-Aug-2019	1.85	58.8	17.1
21-May-2019	1.85	64.4	18.8
20-Apr-2018	1.85	90	26.2

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 30.	02-Sep-2021
Current smoker:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 40.	19-Aug-2019
Heavy smoker - 20-39 cigs/day:	Smoking status on date of event: Smoker.	21-May-2019
Heavy smoker - 20-39 cigs/day:	Smoking status on date of event: Smoker, Date patient started smoking: 1998.	20-Apr-2018
Heavy smoker - 20-39 cigs/day:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 30.	23-Oct-2017
Teetotaller:	Drinking status on eventdate: Life teetotaler.	02-Sep-2021

Teetotaller:	Drinking status on eventdate: Life teetotaler.	19-Aug-2019
Teetotaller:	Drinking status on eventdate: Life teetotaler.	21-May-2019
Alcohol intake within recommended sensible limits:	Drinking status on eventdate: Current drinker.	20-Apr-2018
Alcohol intake within recommended sensible limits:	Drinking status on eventdate: Current drinker.	23-Oct-2017

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

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

Referred By:Referring GP

Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

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

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 04/06/2021

Consultant: Dr Scott Taylor

UNK-Unknown GP
Patients Where Practice Code
Is Unknown And Who Are Not
Covered By codes 99942
99957 99976 99981 99995 99961

Dear UNK-Unknown GP

Re: **Baillie David John** DOB: **23/08/1989** CHI: **2308896337**

Unknown OS1 8AA

Attended on: **04/06/2021 at 14:25 hrs.** Departed on: **04/06/2021 at 15:22 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
hand inj

Nursing Assessment:

Investigations in ED:
1. XR Hand Rt

Diagnosis:

Diagnosis	Side	Site
Contusion of Other Parts of Wrist and Hand	**Right**	**Hand**

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

***No GP action required* Punched a sign 4 days ago and attends on GP advice for an XR due to swelling and tenderness of the hand. On examination there was swelling and tenderness of the 2nd and 3rd metacarpals heads with superficial abrasions which were dry and healing well. There was no redness/heat on assessment but I note the patient advised he has already been prescribed ABx by GP. ROM was good throughout. XR showed no acute fracture but shortening of the 4th and 5th metacarpals suggestive of previous bony injury. Discharged with worsening advice.**

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Elaine Urquhart
Physiotherapist

Copies to:

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

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

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 27/03/2019

Consultant: Dr Donogh Maguire

PA Ewart
Fulton Street Medical Centre
Fulton Street Surgery
94 Fulton Street
Glasgow
Glasgow
G13 1JE

Dear PA Ewart

Re: **Baillie David** DOB: **23/08/1989** CHI: **2308896337**
Chez Nous Guest House Glasgow
Glasgow G13 2DT

Attended on: **25/03/2019 at 05:28 hrs.** Departed on: **25/03/2019 at 05:42 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **-4**

Presenting complaint
hand injury

Nursing Assessment:
Wasnt triaged due to aggression and voilence previous day. Police present Dr Kerr assessed in triage and sent back to custody.

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Contusion of wrist and hand		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:
Representation to ED following sedation for agitated delirium. Complaining of bruising and pain to hand - from when he was pulling against handcuffs, and venflon insertion during sedation. Discharged.

Followup :
Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Joanna-Lee Kerr
Doctor

Copies to:
1. PA Ewart (GP)

School Address:

CHI: 2308896337

Glasgow Royal Infirmary

Total Att: **9**

12 Mth Att: **0**

Title:

BAILLIE **David John**

DOB **23/08/1989** Age: **31y** Sex: **Male**

Next of kin: **BAILLIE, David**
Relationship: **Father**

Unknown
OS1 8AA

GP: **UNK-Unknown GP**
11111 111111

07424598407

Attendance Date: **04/06/2021** Arrival Time: **14:25**

Registration Time: **14:25** Date of Incident: **04/06/2021**

Major Incident Desc:

Reason for Attendance: **hand inj**

Nursing Assessment

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

Triage Category: **0** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **04/06/2021 14:36** Nurse name: **Physiotherapist Elaine Urquhart**

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

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

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes:

Date	Clinical Notes
4/6/21	Seen By E-Urquhart PT — Time Seen 14:55

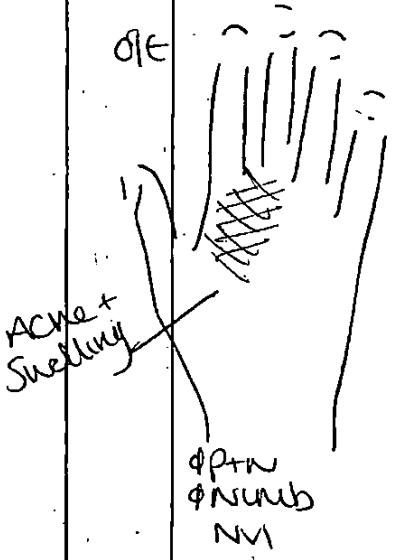
P-C 31 yr old RHD (M) C (R) hand injury.

H.P.C Reports punched a sign in frustration 4/7 ago → saw GP 2° ongoing pain/swelling who prescribed ABx + advised ED for ?#

P.M.H Nil

S.H NCA

D.H Mirtazapine



Obs: x2 superficial abrasions over 2nd + 3rd MC head - healing well.
Swelling 2nd + 3rd MC
Nil Red/Heat
Old deformity of 4th + 5th MC head ?Prev #

Palp: BT 2nd + 3rd MC head
NBT elsewhere hand, wrist, ASB
Wrist ✓✓ Fist ✓ ↓ROM = ↑Guarding

XR NBI - likely Prev inj 4th + 5th MC

Impr: Contusion - ↓Evidence of inf but already prescribed ABx by GP.
Pt adament abrasions from punching the sign + not from contact c another person/teeth

Rx/ RICE/Analgesia advice
Issued Ex's
AI Worsening advice given
PI D/c'd

E-Urquhart PT

Once Only Prescriptions (Including Tetanus Prophylaxis)

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

[redacted]

CHI: 2308896337

Glasgow Royal Infirmary

Total Att: 8

12 Mth Att: 4

Title: MR

BAILLIE **David**

DOB: **23/08/1989** Age: **29y** Sex: **Male**

Chez Nous Guest House Glasgow

Glasgow
G13 2DT
07548377851

Next of kin: **BAILLIE, David**
Relationship: **Father**

GP: **PA Ewart**
0141 959 3391

Attendance Date: **25/03/2019** Arrival Time: **05:28**

Registration Time: **05:28** Date of Incident: **25/03/2019**

Major Incident Desc:

Reason for Attendance: **hand injury**

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **25/03/2019 05:41** Nurse name: **Nurse Nicole Pratt**

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

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **"Wasnt triaged due to aggression and voilence previous day. Police present Dr Kerr assessed in triage and sent back to custody. "**

2308896337 23/08/1989 BAILLIE David
2308896337 23/08/1989 BAILLIE David
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2308896337 23/08/1989 BAILLIE David
2308896337 23/08/1989 BAILLIE David

To be Completed by Clinician

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

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

Date	Clinical Notes
	Seen By [illegible] Time Seen
25/10/14 0611	Agitated delirium 1/7 ago ? in hand cuffs. IV line R dorsal hand. (? sedated him). Now presents c hand pain. in custody

No evidence of #. Swelling + bruising 2° to pulling against cuffs - punctiformally ?

NV intact

R

Reg AD: No evidence acute # from venflon + cuffs.

Once Only Prescriptions (Including Tetanus Prophylaxis)

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

XR Hand Rt

Performed	04-Jun-2021 15:02	Received	04-Jun-2021 15:55
Reported	04-Jun-2021 15:53	Order Number	G107H37321772
Status	Final	Source System	MiSys

XR Hand Rt Final
David John Baillie
Clinical History :

Punch injury 4/7 ago. Swollen and tender 2nd & 3rd MC ?#

XR Hand Rt :
No acute bony injury demonstrated.

Code A: Agreement: DO NOT,USE for linked CRIS reports. This result will be autosigned in TrakCare as there is no major discrepancy between the radiology report and the referrer's 'sticky note' interpretation.

Report by Lianne Boyce - Reporting Radiographer.

Reported by: Lianne Boyce
Verified by: Lianne Boyce

Glasgow Royal Infirmary

CHI: 2308896337

(6)

Total Att: 7

12 Mth Att: 3

Title: MR ✓

BAILLIE **David** ✓

DOB: **23/08/1989** Age: **29y** Sex: **Male**

Chez Nous Guest House Glasgow

Next of kin: **BAILLIE, David** Mercedes Mum
Relationship: ~~Father~~ Partner.

Glasgow 34 Monkbridge Ave
G13 2DT
✓ **07548377851** Glasgow

GP: **PA Ewart** ✓
0141 959 3391

Attendance Date: **24/03/2019** Arrival Time: **06:09**

Registration Time: **06:09** Date of Incident: **24/03/2019**

Major Incident Desc:

Reason for Attendance: **assaulted g1997**

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **24/03/2019 06:17** Nurse name: **Nurse Michael Harkins**

Temp	**35.7**	C
HR	**81**	bpm
BP	**125/76**	mmHg
MAP	**92.33**	mmHg
RR	**17**	bpm
SpO2	**98**	%
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: **NEWS: 1 "Low Risk CPE. " "Alleged assault, states struck to back of head with hammer and bottles. "**

2308896337
BAILLIE M
David 23/08/1989
Chez Nous Guest House Glasgow
Glasgow
G13 2DT

To be Completed by Clinician

Child Assessment Questionnaire

Previous attendance (consider any relevant trauma from previous presentations

History variable between accounts

Examination not compatible with hist

Delay in presentatic

Fracture / head inju

e toddler

Discus

any factors identified

Date	Clinical N		Time Seen	
	Seen By			

Status: **ACCEPTED**
Analyzed: 24/03/2019 07:55:39
Sample Type: **Venous**
Account Number:
Clinician:
Operator ID: KIRSTY MACDONALD0

Patient

ID:	2308896337
Last Name:	BAILLIE
First Name:	DAVID
Gender/Age:	Male, 29 years
Birth Date:	23/08/1989

Cartridge

Lot No.:	181215A
S/N:	00000000400059968
Exp. Date:	24/03/2019

Analyzer

Model:	GEM® *Premier 5000*
Area:	GRI
Name:	RESUS
S/N:	17030616

Results			Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)						
cH	45.4	nmol/L	--	--	--	--
pCO_2	5.5	kPa	--	--	--	--
pO_2	10.6	kPa	--	--	--	--
Na^+	136	mmol/L	--	133	146	--
K^+	3.8	mmol/L	--	3.5	5.3	--
Cl^-	105	mmol/L	--	95	108	--
Ca^{++}	1.15	mmol/L	--	1.15	1.27	--
Glu	4.6	mmol/L	--	3.5	6.0	--
Lac	↑ 2.6	mmol/L	--	0.6	2.2	--
CO-Oximetry						
tHb	139	g/L	--	--	--	--
O_2Hb	↓ 93.4	%	--	95.0	98.0	--
COHb	↑ 3.2	%	--	0.5	1.5	--
MetHb	0.5	%	--	0.5	1.5	--
HHb	2.9	%	--	0.0	5.0	--
sO_2	97.0	%	--	95.0	98.0	--
Derived						
BE(B)	-3.5	mmol/L	--	--	--	--
$HCO_3^-(c)$	22.1	mmol/L	--	--	--	--
Hct(c)	42	%	--	--	--	--

↑↓ Outside Reference Range

Other Information

Operator Entered
Temp 37.0 °C

O rophylaxis)

Date Given	Drug (Block			ne of istration	Signature	Given By

Emergency Department Nursing Documentation

2308895337
BAILLIE M
David 23/08/1989
Chez Nous Guest House Glasgow
Glasgow
G13 2DT

NHS Greater Glasgow and Clyde

Presenting Complaint -

Date: 24/03/19 Time: 07[00]

Assessment Complete by: Name NURSE (Please Print) Amy M Park

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

Urinalysis

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

Screening Tools (Please tick/circle when completed)			
SEPSIS RISK? / SIRS Criteria 2 or more	Y/N	**SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms)**	**YES**
Mental Health Triage Assessment	Y/N	If NOT WHY? - (details) N/A	**NO**
GMAWS	Y/N	Date - 24/3/19 Time - 0619 Signature - Amy M Park.	

4AT

AMT	Correct
Age	✓
Date of Birth	✓
Place	✓
Current year	✓

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

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

Alertness	
Normal	0
Mild sleepiness	0
Clearly abnormal	4

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

4AT score /12

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

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

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

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

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

Indicator for care by another acute specialty regardless of age.

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

Are any of the above criteria met?

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

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

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

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

Screening Tools / ACTIVE CARE

(Please tick/circle when completed)

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

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

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

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

Nursing Notes

Date and Time		Print Name and Signature
24/3/19 0735	Presented with head injury after being struck with a hammer and bottle. Pulse T 35.7°C GCS 15/15 alert and orientated. Pt c/o that trolley was wet when he lay on it & his tracksuit was ruined. Trolley dry when patient lay on it. Pt verbally and abusive to police. Aggressive and agitated. Requiring restraint	Agnes McPake Agnes McPake cont'd

Nursing Notes		
Date and Time		Print Name and Signature
0735	by police. Taken to resus for assessment by Dr Kerr	M Bowie SN
0745	Trolley checked when pt where manageable. and is completely dry.	M Bowie SN
0830	Patient given ketamine and midazolam. Police present. observations stable	SN

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Emergency Department

NHS
Greater Glasgow and Clyde

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Initial Investigations Ordered

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

Clinical Notes

Date	Time	Name	Grade	Speciality

24/08/15 Written retrospectively

0020 29 ♂:

in hand cuffs under arrest ? assault wielding hammer

appearing intoxicated ++, ? emphysematous;

head dilated pupils, verbal speech, aggression, agitation, persistence in such unmanageable

→ transfer to resus

A – no evidence head/C-spine

B clear

C radial ++

D GCS 14 M6 V4

E no other injuries evident apparent

sedated 300mg im ketamine + midazolam + ketamine

DD: amphetamines psychosis delirium agitated

→ IVA VBG noted

→ ECG → +/- CTT head & further

Glasgow Royal Infirmary
Emergency Department

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Glasgow
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Clinical Notes [redacted]

Date	Time	Name	Grade	Speciality

Cerard ST3 Em

Reassessed over past 4 hours – seen at height of agitation – didn't require sedation for [illegible]

dissociated for several hours, manageable

now making appropriate noises & responding to voice, but still too flat for cells.

In police custody – police with [illegible].
Bloods unremarkable

Admit Ward 46 under Em
until fit for custody.

[illegible] ST3

Glasgow Royal Infirmary
Emergency Department

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Glasgow
G13 2DT

Clinical Notes

Date	Time	Name	Grade	Speciality

Glasgow Royal Infirmary
Emergency Department

Patient Name
DoB
CHI Number
or affix label

HAEM	DATE or TIME		BIOCH	DATE or TIME			DATE or TIME		V/ABG	DATE or TIME	
WCC			Na			Bil			FiO_2		
Hb			K			ALT			H^+		
Plat			Cl			AST			$PaCO_2$		
Neut			Ur			GGT			PaO_2		
DD			Creat			A phos			Bic		
PT			eGFR			Alb			BE		
PTT			Glu			AdjCa			Lactate		
TT			CRP			Amyl			Ethanol		
INR			Mg			TropI HS			Para		
			Phos			BHCG			Sal		

Diagnosis and Plan

Review/Discussed with:

Handover

- ☐ Provisional Diagnosis
- ☐ Liquids/Fluids
- ☐ Analgesic/Medicines
- ☐ NEWS
- ☐ Investigations & Results
- ☐ Talk to receiving team/ward

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Ward 46
Short Stay Medicine
HEAD INJURY
Nursing Documentation

2308896337
BAILLIE M
David 23/08/1989
Chez Nous Guest House Glasgow
Glasgow
G13 2DT

NHS Greater Glasgow and Clyde

Hospital: GRI	Date: 24/3/19
Time: 1315 pm	Admitting Nurse: JMcQuinn

PATIENT DETAILS CHECKED AND CORRECT	YES	NO	N/A
Patient Name:	✓		
Patient Address:	✓		
Date of Birth:	✓		
Next of Kin Name and Contact Details: No contact number	✓		
Next of Kin Informed: No contact number			
GP Details:	✓		
Religion: Nil	✓		

Presenting Complaint:
Irratic behaviour - given Ketamine.

Past Medical History:	Current Medications:
Mental Health issues Audio-visual hallucinations self harm	Suboxone Mirtazapine. Amoxil

Allergies: Nil Known

Resp Rate	SpO2	Temp	Pulse	Blood Pressure
16	100% on air	36.1 °C	62	121/71
GCS	**NEWS**	**Blood Glucose**	**ID Band**	**Interpreter**
15/15	0			

Height:	6ft	Weight:	12st	MUST:	0	BMI:		

If BMI <18 commence food chart and refer to dietician ☐

Cognitive impairment - For all patients > 65 years, complete TIME	YES	NO	N/A

Urinalysis:

If positive obtain MSSU ☐ Date obtained:

Ward 46
Short Stay Medicine
HEAD INJURY
Nursing Documentation

2308896337 M
BAILLIE 23/08/1989
David
Chez Nous Guest House Glasgow
Glasgow G13 2DT

NHS Greater Glasgow and Clyde

Peripheral Vascular Catheter (PVC) Bundle

Reason for PVC Insertion:
- ☐ IV Fluids
- ☐ IV Drugs
- ☐ Suspected haemorrhage
- ☐ Diagnostic tests

Insertion Date: 24/3/19
Insertion Time: ____:____

Hand hygiene performed immediately before PVC insertion.	☐
Skin anticseptic containing 70% isopropyl alcohol used to cleanse the skin and left to dry.	☐
Aseptic technique maintained throughout insertion procedure.	☐
Sterile, transparent, semi pereable dressing used to cover catheter site. + Blue Darm	☐

Size/colour: Pink green Insertion site: (R) Hand.

Red Flags (Requires escalation/specialist referral/separate Risk Assessments)

Child Protection concern	X	Learning Disabilities	X
Adult Support and Protection	X	Patient has appointed Welfare Guardian/Power of Attorney	X
Confused Patient *(if more confused than baseline, consider DELIRIUM)*	X	Patient has Adult with Incapacity Section 47 certificate in place	X
Substance Misuse	✓	Infection Risk	X
Has swallow test been carried out?	X	STOPPS completed?	X
		Falls Risk? *(If at risk, complete full falls Bundle)*	X

Dietry Requirements (Specify):

Pressure Area Assessment

1 Pressure Damage	Does the person have redness and/or existing damage? Yes / No If YES, prescribe a minimum of 2 HOURLY Active Care to avoid further damage occuring and complete the pressure ulcer intervention plan (PUDRA Chart).

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?	Yes / No
3 Continence	Does the person have continence issues with urine and/or faeces	Yes / No
4 Nutrition	Does the person appear malnourished and/or unable to eat or drink	Yes / No
5 Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?	Yes / No
6 Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:	Yes / No

Active Care Plan Commenced ☐

Ward 46
Short Stay Medicine
HEAD INJURY
Infection Risk

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23/08/1989

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MRSA Screening / CJD / Healthcare outside Scotland

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

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

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

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

Appropriate Care Plan Used	☐ Yes	☐ No	☐ N/A
Is patient Isolated	☐ Yes	☐ No	☐ N/A

If 'NO' - Reason: – No healthcare outside of Scotland in last 5 years.
No CJD
Pt has no knowledge of being a carrier of bacteria in contact ∴ a carrier of CPE

Lifestyle

Smoking:

Are you a smoker ☑ ex-smoker ☐ never smoked ☐

If ex-smoker when did they stop? .....

If smoker how many cigarettes per day....14.....

If smoker, or recent ex-smoker, would they like to use nicotine replacement therapy to prevent withdrawal discomfort while in hospital? ☐ Yes ☐ No

If smoker, would they like to stop now with the support from stop smoking service? ☐ Yes ☐ No

If Yes refer to Smoking Cessation Service

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

Alcohol (Men): How often do you have 8 or more drinks on one occasion:

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

If 'Monthly' or more then complete FAST Tool.

Alcohol (Women): How often do you have 6 or more drinks on one occasion:

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

If 'Monthly' or more then complete FAST Tool.

Admission Documentation Completed By

Name (Please PRINT): AMcQuinn	Signature: AMcQuinn
Designation: CNS	Date: 24/3/19

Ward 46
Short Stay Medicine
HEAD INJURY
Nursing Documentation

Mr D Baillie
Chez Nous Guest House Glasgow
Glasgow
G13 2DT
CHI
2308896387

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	AIM	ASSESSMENT / INTERVENTIONS
1 MONITORING OF VITAL SIGNS Standard observations (BP, P, T, R, SaO_2) - requirement & frequency CSM/Neurovascular observations Special observations eg. blood glucose, peak flow, Neurological obs Special requirements (O_2, chest physio)	To detect abnormalities and maintain optimum function.	4° Viral signs + NEWS
2 IV THERAPY Peripheral / Central Line - Sites Use of Venflon Careplan Infusion Chart in use NB: 4° temp required if patient has an IV	Early detection / prevention of the problems of IV therapy.	Pink venflon (R) hand Green venflon (E) arm
3 MAINTAINING SAFETY Level of conciousness Chronic / Acute confusion Alcohol withdrawal Seizures Wandering / at risk of injury	To maintain safety at all times.	no problems identified
4 MOBILITY / MOVING & HANDLING Assess DVT risk using SIGN guidelines Specify limitations/current ability & aids used Traction Active/Passive exercise TED Stockings on admission	To prevent / reduce the complications of reduced mobility. To move the patient safely. To promote independence.	independantly mobile
5 PRESSURE AREA CARE Waterlow score Interventions	The patients skin will remain healthy and intact.	no problems identified
6 PAIN Monitor effectiveness of analgesia - involve patient & medical staff - use of Pain Chart	The patient will state that he is comfortable.	no % pain
7 PERSONAL HYGIENE Self caring or Specify assistance required Mouth care Eye care	To maintain a high standard of personal hygiene. To promote independence.	self caring
8 NUTRITIONAL STATUS Score: (Use nutrition risk assessment) Special Dietary requirements Fasting / fluid restrictions Fluid balance monitoring required	To maintain adequate nutritional intake. To promote healing.	standard diet free fluids
9 URINARY & BOWEL FUNCTION Independent or specify aids used (urinals, bedpan etc) Catheterised - size free drainage / hourly volumes Bowel - Stoma, Aperients – Chart daily	To detect any problems with output. To promote independence.	- Continent

Ward 46
Short Stay Medicine
HEAD INJURY
Nursing Documentation

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CHI [illegible]
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Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☐	Information on discussion with relatives
Belongings (including patients medication)	☐	Always	
New medications explained	☐	☐	
PVC removed	☐	☐	
Relatives aware of Discharge	☐	☐	Please note here if any other tasks required prior to discharge
Social/Support Services required and contacted	☐	☐	
SAS Transport required and ref. no.	☐	☐	Print name
Other means of transport arranged by nurse	☐	☐	
Follow-up organised and explained	☐	☐	F/U

Date:_____ Signature:_____

Clinical Notes - Medical ☐ Nursing ☐

Please tick appropriate directorate

24/3/19 Nursing staff 1325pm
Admitted via A+E dept - under police arrest. Running around wielding a hammer appears intoxicated ?alcohol ?drugs. Given Ketamine in A+E to sedate due to violence also given Midazolam for examination, ECG done + bloods lactate ↑ 2.6. Re-reviewed after 6hrs - appropriate answers given to questions but apparently "still too flat" to allow

Ward 46
Clinical Notes
Medical ☐ Nursing ☐
Please tick appropriate Directorate

Mr D Baillie
Chez Nous Guest House Glasgow
Glasgow
G13 2DT

CHI: [illegible]
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Greater Glasgow and Clyde

Date and Time		Signature/ Designation
	home. ½c police for r/v later.	
	O/A ward 46 obs satisfactory.	
	AM Quinn	
	AM Quinn (CNS)	
24/3/19 17[15]	alert and orientated spoke to ED consultant Alan Davidson who states if pt alert and mobile & passing urine can go back into police custody. urine awaited ——	
18[05] 24/3/19	pt states to have £20 on person in ED pt verbally agressive to staff. ED called and state no money on person in ED, —— pt passed urine	

Ward 46

Clinical Notes

Medical ☐ Nursing ☐

Please tick appropriate Directorate

Patient Label

NHS Greater Glasgow and Clyde

Date and Time		Signature/ Designation
24/3/19 1810	pt d/c	

Ward 46
Clinical Notes
Medical ☐ Nursing ☐
Please tick appropriate Directorate

Patient Label

NHS
Greater Glasgow and Clyde

Date and Time		Signature/ Designation

MEDICINE

PRESCRIPTION FORM

Hospital Name: .....

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐

Date _____ Name (Print) _____

Discharge Prescription Prepared & Reconciled YES ☐

Date _____ Name (Print) _____

Date and time this form prepared:	Sheet No	2nd Prescription in use
__/__/__ Time: _____	.....	YES ☐ NO ☐

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the symptomatic relief policy & local protocol:

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name _____ Tel No. _____

Address _____

Compliance Aid Details _____

Patient consent to share discharge information Y/N

Print & Sign _____

PATIENT DETAILS

2308895337

BAILLIE M

David 23/08/1985

Chez Nous Guest House Glasgow

Glasgow

G13 2DT

Height:
Weight:
Surface area:
Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
24/10/19	lorazepam	300mg	nm	0945	[signature] Keel	JK	0945
	midazolam	5.0mg	iv	0955	[signature]	JIC	0955
	haloperidol	2.5mg	iv	0955	[signature]	JIC	0955

TARGET OXYGEN SATURATIONS

Please CIRCLE a target saturation and prescribe oxygen on the Regular Prescription section.

94 – 98%	88 – 92% (e.g. in hypercapnic respiratory failure)	Other (please specify)

On Home Oxygen? Yes / No _____ L/min

DATE: ____/____/____ PRESCRIBER (PRINT & SIGN): _____

DATE →

MONTH →

RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)

IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N

ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N

SIGNATURE OF ASSESSOR

ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N

Parenteral Drugs : Regular Prescription

Patient's Own Medicine

A DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

B DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

C DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

REVIEW THE NEED FOR IV ANTIBIOTIC DAILY. SWITCH TO ORAL THERAPY AS SOON AS POSSIBLE (SEE IVOST POLICY)

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

D DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

E DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

F DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

G DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

H DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

J DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

K DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

L DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

Note: To discontinue a prescription; initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

M DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

N DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

P DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

R DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

S DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

T DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

V DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

W DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

X DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by
Ordered from Pharm

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by
Ordered from Pharm

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by
Ordered from Pharm

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by
Ordered from Pharm

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

All Routes: As Required Prescriptions

BEFORE ADMISSION ☐ / NEW DOSE ☐ / NEW MEDICATION ☐					STOPPED	Patient's Own Medicine
	LL	DRUG			DATE:	For Use Y/N
	DOSE	ROUTE	INDICATION		INITIALS:	Qty:
	PRESCRIBER (PRINT & SIGN)		MAX.FREQ.		DATE:	Date:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					Assessed by:
						Ordered from Pharm.

DATE						
TIME						
DOSE						
GIVEN BY						

BEFORE ADMISSION ☐ / NEW DOSE ☐ / NEW MEDICATION ☐					STOPPED	Patient's Own Medicine
	MM	DRUG			DATE:	For Use Y/N
	DOSE	ROUTE	INDICATION		INITIALS:	Qty:
	PRESCRIBER (PRINT & SIGN)		MAX.FREQ.		DATE:	Date:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					Assessed by:
						Ordered from Pharm.

DATE						
TIME						
DOSE						
GIVEN BY						

BEFORE ADMISSION ☐ / NEW DOSE ☐ / NEW MEDICATION ☐					STOPPED	Patient's Own Medicine
	NN	DRUG			DATE:	For Use Y/N
	DOSE	ROUTE	INDICATION		INITIALS:	Qty:
	PRESCRIBER (PRINT & SIGN)		MAX.FREQ.		DATE:	Date:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					Assessed by:
						Ordered from Pharm.

DATE						
TIME						
DOSE						
GIVEN BY						

BEFORE ADMISSION ☐ / NEW DOSE ☐ / NEW MEDICATION ☐					STOPPED	Patient's Own Medicine
	PP	DRUG			DATE:	For Use Y/N
	DOSE	ROUTE	INDICATION		INITIALS:	Qty:
	PRESCRIBER (PRINT & SIGN)		MAX.FREQ.		DATE:	Date:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					Assessed by:
						Ordered from Pharm.

DATE						
TIME						
DOSE						
GIVEN BY						

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

BEFORE ADMISSION ☐	RR	DRUG			STOPPED DATE: INITIALS:	DATE																						Patient's Own Medicine For Use Y/N
NEW DOSE ☐		DOSE	ROUTE	INDICATION		TIME																						Qty:
		PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DATE:	DOSE																						Date:
NEW MEDICATION ☐		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				GIVEN BY																						Assessed by:
																												Ordered from Pharm.
BEFORE ADMISSION ☐	SS	DRUG			STOPPED DATE: INITIALS:	DATE																						For Use Y/N
NEW DOSE ☐		DOSE	ROUTE	INDICATION		TIME																						Qty:
		PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DATE:	DOSE																						Date:
NEW MEDICATION ☐		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				GIVEN BY																						Assessed by:
																												Ordered from Pharm.
BEFORE ADMISSION ☐	TT	DRUG			STOPPED DATE: INITIALS:	DATE																						For Use Y/N
NEW DOSE ☐		DOSE	ROUTE	INDICATION		TIME																						Qty:
		PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DATE:	DOSE																						Date:
NEW MEDICATION ☐		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				GIVEN BY																						Assessed by:
																												Ordered from Pharm.
BEFORE ADMISSION ☐	VV	DRUG			STOPPED DATE: INITIALS:	DATE																						For Use Y/N
NEW DOSE ☐		DOSE	ROUTE	INDICATION		TIME																						Qty:
		PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DATE:	DOSE																						Date:
NEW MEDICATION ☐		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				GIVEN BY																						Assessed by:
																												Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

2306896337
BAILLIE M
David 23/08/1985
Chez Nous Guest House Glasgow
Glasgow
G13 2DT

Drug Allergies / Sensitivities None Known ☐ Yes ☐ (provide details below)

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

Warning: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed by a doctor.

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).

2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).

3. Print & Sign your full name clearly against each prescription entry.

4. Time should be recorded in 24hr format e.g. 0600, 1800.

5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.

6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.

7. The following metric unit abbreviations must be used –

Milligram = mg — Gram = g
Millilitre = ml — Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

8. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - Inirathecal **must be written in full.**

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.

2. Insert initials in the relevant date column and time row each time a drug is administered.

3. Check that all drugs prescribed at a certain time have been administered.

4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

(3) Patient refused
(4) Drug not available
(5) Nil by mouth/fasting
(6) Patient unavailable
(7) Patient asleep
(8) Time varied on doctor's instructions
(9) Dose withheld on doctor's instructions
(10) Nausea/vomiting
(11) Unable to swallow
(12) No intravenous access
(13) Patient Self-Administration of Medicine
(14) Other - Record in nursing notes
(15) Prescription clarification required

Cat. No. 40995 Ver 4, 09/2010 GGC0029

Care Rounds Checklist

Date: 24/3/19

Attach Add: Mr D Baillie, Chez Nous Guest House Glasgow, Glasgow, G13 2DT

CHI: 2308896337

Ward: 46

NHS Greater Glasgow and Clyde

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

1. Signed A McQuinn Name A McQUINN Designation CNS
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

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

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

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

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GGC0098

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name	
Address	2308896337 BAILLIE M David 23/08/1989
CHI No.	
DoB	

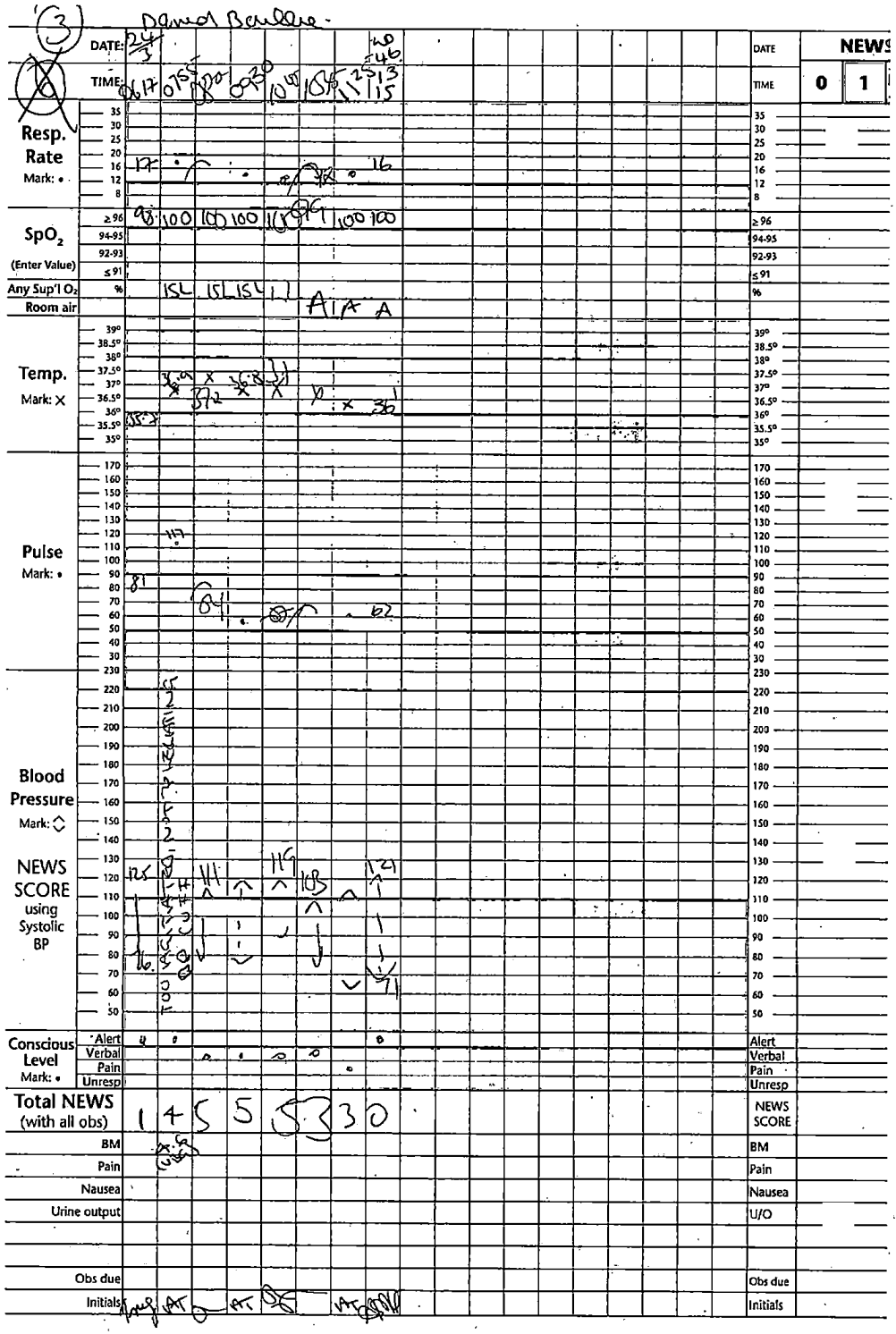
	Date	Ward
Admitted		
Transferred		
Transferred		

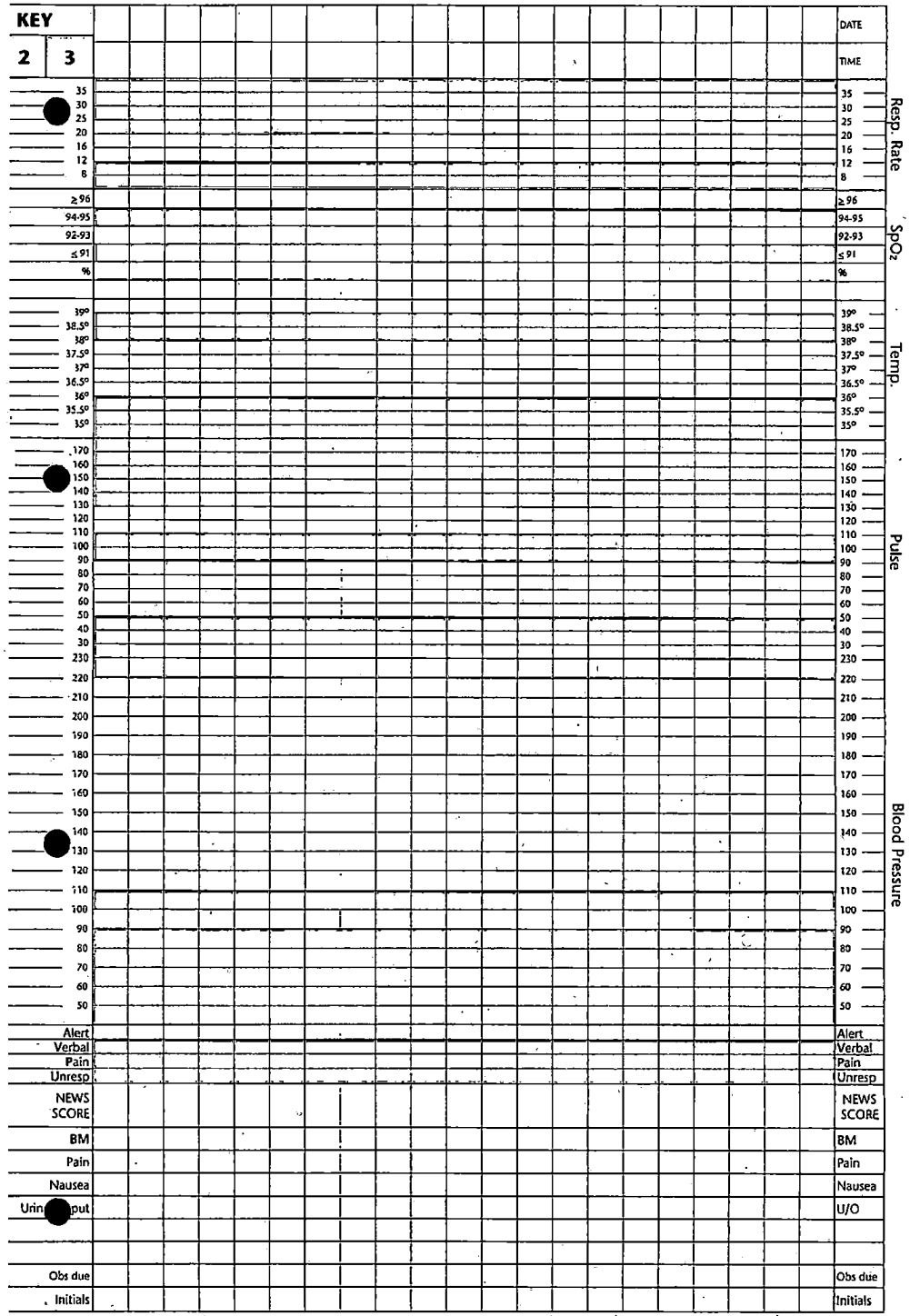
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic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

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

See NEWS Actions Reference Tool for local escalation policy

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


(3)
Dawod Bandeh
DATE
TIME
NEWS
0
1
Resp. Rate
Mark: •
SpO2
(Enter Value)
Any Sup'l O2
Room air
Temp.
Mark: X
Pulse
Mark: •
Blood Pressure
Mark: ◇
NEWS SCORE using Systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
NEWS SCORE
BM
Pain
Nausea
Urine output
U/O
Obs due
Initials


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

Glasgow Coma Scale

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

Neurological Observations

Date:				24/3	23/3/19																		
Time:				0617	0930	10	105																
COMA SCALE	E Eyes open	Spontaneously	4	4																			Eyes closed by swelling = C
		To speech	3		•	•																	
		To pain	2				•																
		None	1																				
	V Best Verbal response	Orientated	5	4																			Endotracheal tube or tracheostomy = T
		Confused	4		•	✓																	
		Inappropriate words	3				•																
		Incomprehensible sounds	2																				
		None	1																				
	M Best motor response	Obeys	6	6																			Usually record the best arm response
		Localises	5		•	✓	✓																
		Flexion - withdrawal	4																				
		Flexion - abnormal	3																				
		Extension to pain	2																				
		None	1																				
TOTAL SCORE				15	12	10	16																
PUPILS	R	Size																					+ reacts - no reaction c. eyes closed
		Reaction																					
	L	Size																					
		Reaction																					
LIMB MOVEMENT	ARMS	Normal power																					Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness																					
		Severe weakness																					
		Spastic flexion																					
		Extension																					
		No response																					
	LEGS	Normal power																					
		Mild weakness																					
		Severe weakness																					
		Spastic flexion																					
		Extension																					
		No response																					

Pain Score

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

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

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

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

(2)

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

Write or affix patient label

Name: David Baillie CHI: 2308896337

DOB: 23/8/89 Address: _____

Ward: 46 Hospital: GRI

NHS Greater Glasgow and Clyde

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

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

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

PVC inserted: Day 0	Date: 24/3/19 Hospital: GRI Area: ED ☑ Theatre ☐ ITU/HDU ☐ Ward ☐ _____ Unknown ☐ _____
Insertion site:	R Hand ☑ R Arm ☐ R Foot ☐ L Hand ☐ L Arm ☐ L Foot ☐ Other: _____
Colour of cannula:	Blue ☐ Pink ☑ Green ☐ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☑ If No, state reason: Too drowsy

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

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

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

***Date PVC Removed:** ___/___/___

***Reason For Removal:** _____

Modified Visual Infusion Phlebitis (VIP) Score

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

DRIFT

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

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

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → **Can I switch my patient from IV to oral antibiotics?**

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature ≤ 37.9°C, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE** is available reliably (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, S. aureus bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abcess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy. Record the intended duration on the medicine kardex

YES → This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

NO

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

Write or affix patient label

Name: David Baillie CHI: 2308896337

DOB: 23/8/89 Address: _____

Ward: 46 Hospital: GRI

NHS Greater Glasgow and Clyde

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

PVC inserted: Day 0	Date: 24/3/19 Hospital: GRI Area: ED ☑ Theatre ☐ ITU/HDU ☐ Ward ☐ _____ Unknown ☐
Insertion site:	R Hand ☐ R Arm ☐ R Foot ☐ L Hand ☐ L Arm ☑ L Foot ☐ Other: _____
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Day 1 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

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

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

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YES

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

NO