NHS Forth Valley

Carseview House
Castle Business Park
Stirling
FK9 4SW

Telephone: 01324 566292
Fax:

NHS Forth Valley

Private and Confidential

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

Date:	19 May 2026
Your Ref:	100083
Our Ref:	GDP/0021391
Enquiries to:	Legal Admin Team
Extension:	
Direct Line:	01324 566292

Dear Sir/Madam

Re: Alan Wyles

With reference to your recent access request please find enclosed copy health records as requested.

Please note that records held by Forth Valley Royal Hospital will include records for Falkirk Community Hospital and Stirling Health & Care Village.

If we can be of any further assistance then please do not hesitate to contact us.

Yours Sincerely

Legal Admin Team
E-mail: fv.healthrecs-legal@nhs.scot

VIRTUAL FRACTURE CLINIC
TRIAGE FORM

NHS Forth Valley

PATIENT'S NAME Alan Wyles

CHI NUMBER 0405770352

DATE 20/05/21

DIAGNOSIS: # R SCAPHOID

TREATMENT: — REF BE/POP + ?OT

FRAGILITY #: ☐

OUTCOME:

VIRTUAL DISCHARGE ☐

CONSULTANT CLINIC ☑

NURSE LED CLINIC ☐

APPOINTMENT TIMESCALE [4] DAYS [ ] WEEKS

CONSULTANT SIGNATURE [signature]

APPOINTMENT DATE AND TIME Tues 25/5/21 1420 Please send 1st class

PATIENT CONTACTED YES ☐ NO ☑

MESSAGE LEFT YES ☐ NO ☑ unable to contact

APPOINTMENT CONFIRMED BY LETTER ☑

DISCHARGE LETTER/LEAFLET SENT ☐

REFERRAL TO FRACTURE LIASON ☐

NURSE'S SIGNATURE JHughes

THIS IS A RECONSTITUTED DOCUMENT PRINTED FROM EDRM

VIRTUAL FRACTURE CLINIC
TRIAGE FORM

LIST OF VIRTUAL DISCHARGE LETTERS FOR SENDING TO PATIENTS.

PLEASE TICK LETTER TO BE SENT.			
Soft Tissue Injury Hand		Child STI Hand	
Hand Fracture		Child Hand Fracture	
Soft Tissue Elbow		Child Elbow	
Ankle Fracture		Child STI	
Ankle X-Ray		Child Thumb	
Soft Tissue Injury		Child Toe	
Thumb Injury		Child Foot	
Scaphoid Injury		Child STI Forearm/Wrist	
Toe Injury		Child Humeral Fracture	
Heel Injury		Child Wrist Fracture	
Foot Injury			
Wrist Injury			
Wrist Fracture			
Shoulder Fracture			
Clavicle Fracture			
AC Joint Injury			
Volar Plate Injury			

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FVRH Operation Note

Patient Name ALAN WYLES **CHI** 0605770352 **Op Date** 24 Apr 2010

Patient Details

CHI	0605770352
Hospital No	S249901
Name	ALAN WYLES
Date of Birth	06 May 1977
Sex	Male
Patient Type	InPatient
Op Type	Emergency
Op Date	24 Apr 2010
Specialty	GENERAL SURGERY
Theatre No	CEPOD 3

Staff in Attendance

Team 1	Surgeon	MR SEGUN KOMOLAFE
Team 1	Anaesthetist	DR LORNA GALLACHER
Team 1	O.D.A.	MR TIMOTHY YOUNG
Team 1	Floor nurse 1	SN ELLEN PAGUE
Team 1	Floor nurse 2	SN DAVID N MILLER
Team 1	Other	AN TAMMY MCNAMEE
	Attendees	Assistant - Dr Candice Gales, FY1

Op Notes: Side		**Op Notes: Info**	

Procedure 1	G-H59800	INCISION & DRAINAGE OF PILONIDAL SINUS
PROCEDURE: Left lateral position. Ellipse of skin excised to remove midline pits and open up abscess cavity. Haemostasis and copious lavage of cavity. 20ml 0.5% chirocaine instilled into and around wound. Wound loosely packed with aquacel. POST-OP: Eat, drink and mobilise. Can get home tonight if pain-free. Clinic review in 2-3 months.		
OPCS4 Codes:		H598
Procedure Definitions:		

Materials Used Desc	Qty	LOT1	LOT2	LOT3	LOT4	Item Code
ABSCESS & TOE NAIL TRAY	1	1009136				1009136
S3 BTWN PATIENT CLEAN	1	1051551				1051551
S RECOVERY BTWN PATIENT CLEAN	1	1051563				1051563

****End of Report****

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FVRH Operation Note

Patient Name ALAN WYLES CHI 0605770352 Op Date 19 Apr 1999

Patient Details

CHI	0605770352
Hospital No	S0249901
Name	ALAN WYLES
Date of Birth	06 May 1977
Sex	Male
Patient Type	InPatient
Op Type	Trauma
Op Date	19 Apr 1999
Specialty	
Theatre No	TRAUMA

Staff in Attendance

Team 1	Surgeon	DR ANDREW SHAW
Team 1	Anaesthetist	DR TIM SMITH
Team 1	O.D.A.	SR DAVINA QUYN
Team 1	Scrub nurse	SR ALISON EASSON
Team 1	Floor nurse 1	S/N M TARBOTTON
Team 1	Floor nurse 2	AN ROY SMITH

Op Notes: Side		Op Notes: Info	

Procedure 1	TOISU000	TOILET & SUTURING OF WOUND
OPCS4 Codes:		S573
Procedure Definitions:		

Procedure 2	DEB0005R	DEBRIDEMENT OF WOUND - RIGHT FINGER
OPCS4 Codes:		S571
Procedure Definitions:		

Materials Used Desc	Qty	LOT1	LOT2	LOT3	LOT4	Item Code

****End of Report****

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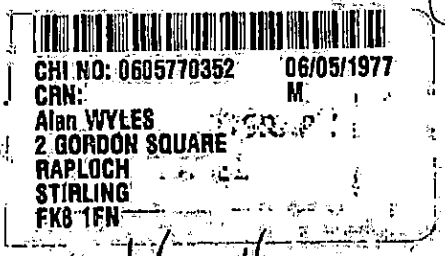
VIRTUAL FRACTURE CLINIC
TRIAGE FORM

NHS Forth Valley

(R)ankle #



NAME.....

CHI NUMBER.....

DATE 26/02/24

DIAGNOSIS: Previous ankle # ongoing pain

TREATMENT: N/V, repeat xrays

FRAGILITY #: ☐

OUTCOME:

VIRTUAL DISCHARGE ☐

CONSULTANT CLINIC ☑

NURSE LED CLINIC ☐

PHYSIOTHERAPY ☐

APPOINTMENT TIMESCALE ☐ DAYS ☐ 1-2 WEEKS

CONSULTANT SIG AND WEEK NO ..... NM 10

APPOINTMENT DATE AND TIME ..... Tues 5/3/24 11:00 XOA

PATIENT CONTACTED YES ☐ NO ☑

MESSAGE LEFT YES ☑ NO ☐ mobile

APPOINTMENT CONFIRMED BY LETTER ☑

DISCHARGE LETTER/LEAFLET SENT ☐

REFERRAL TO FRACTURE LIASON ☐

NURSE'S SIGNATURE ..... JHughes .....

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VIRTUAL FRACTURE CLINIC
TRIAGE FORM

LIST OF VIRTUAL DISCHARGE LETTERS FOR SENDING TO PATIENTS.

PLEASE TICK LETTER TO BE SENT.			
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Hand Fracture		Child Hand Fracture	
Soft Tissue Elbow		Child Elbow	
Ankle Fracture		Child STI	
Ankle X-Ray		Child Thumb	
Soft Tissue Injury		Child Toe	
Thumb Injury		Child Foot	
Scaphoid Injury		Child STI Forearm/Wrist	
Toe Injury		Child Humeral Fracture	
Heel Injury		Child Wrist Fracture	
Foot Injury			
Wrist Injury			
Wrist Fracture			
Shoulder Fracture			
Clavicle Fracture			
AC Joint Injury			
Volar Plate Injury			

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Outpatient Clinic Note

Name: **Alan Wyles**
CHI: **0605770352**

NHS Forth Valley

Registered GP Name: STEELE, CAROLINE
Registered GP Practice: Allan Park Medical Practice

Clinic attended: Oral and Maxillofacial Surgery

Clinic (From PAS): Ms Fiona Wright Oral and Maxillofacial Surgery Wed AM
Date/Time of clinic: Wed 28 Jul 2021 11:30
Lead clinician for clinic: BAU Contingency OMFS OPD

Presenting Complaint, Investigations, Results, Diagnosis:

RFA; TC with patient

CO: still in pain from jaw, unable to eat, taking soft diet
Feels teeth don't come together
Has no teeth and had teeth knocked out so unable to bite
Unable to reg with dentist
MO reduced

Explained jaw will be sore for a while. Encouraged soft diet to minimise movement on jaw.
Advised due to position of fracture, not routinely managed surgically.
Explained that from xray multiple carious teeth and perio involvement- advised to re with GDP, OMFS not suitable for dental management. Likely to need extractions and dentures, encouraged patient to register

Offered face to face review. Pt accepts. Likely discharge after review

F Wright SpDr OMFS 227393

0 Medication Recommendation(s):

No (new, stop or alter) medication recommendation(s) entered/recorded

0 Follow Up action(s):

No 'follow up' info recorded/entered

Further Info:

No 'further info' recorded/entered

Form completed by: Fiona Wright on Wed 28 July 2021 at 12:00
Form sent to: Secondary care document management system(s), eg. EDMS

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Outpatient Clinic Note: Alan Wyles / 0605770352

Outpatient Clinic Note

Name: **Alan Wyles**
CHI: **0605770352**

NHS Forth Valley

Registered GP Name: STEELE, CAROLINE
Registered GP Practice: Allan.Park Medical Practice

Clinic attended: Oral and Maxillofacial Surgery

Clinic (From PAS): BAU Contingency Trauma Clinic Week 1
Date/Time of clinic: Wed 30 Jun 2021 13:50
Lead clinician for clinic: BAU Contingency Trauma Clinic

Presenting Complaint, Investigations, Results, Diagnosis:

RFA: R/v following ED ref- # r condyle - noticed on OPT and CT
C/O:
Fell down concrete steps in around early May time
Difficulty opening mouth - grating and crunching sound r condyle
Difficulty biting
Pt has managed soft diet - soup etc
Not getting any better- staying the same

Meds: 30mg Methadone, 30mg Diazepam
Allergies: Penicillin

E/O: Nodes, Asymmetry sound
Approx 2.5 fingers opening however edentulous ridge upper anterior
Occlusion- not many teeth to occlude- pt feels this is off however appears ok clinically today and no deviation of mandible to note

I/O: Tongue, Bmucosa, Palate h/s, FOM - sound

OPT and PA md today to assess if any further displacement since prev imaging
Shows high condylar # with displacement RHS

Dw JS who advises conservative management and reassess
Dw pt today
1. Soft diet.
2. Analgesics
3. Ibuprofen gel if req

R/V in 4 weeks via telephone

Pt talking about him feeling depressed and has thought about taking his own life multiple times over the years - no suggestion of imminent- advised pt I can discuss with his GMP- pt does not wish or consent to this.

N/V: Telphone r/v 4 weeks

ACARNEY

0 Medication Recommendation(s):

No (new, stop or alter) medication recommendation(s) entered/recorded

0 Follow Up action(s):

No 'follow up' info recorded/entered

Further Info:

No 'further info' recorded/entered

Form completed by: Ailidh Carney on Wed 30 June 2021 at 15:27
Form sent to: Secondary care document management system(s), eg. EDMS

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NHS Forth Valley

Department of Hepatology

Assessment and Treatment Pathway Chronic Hepatitis C

CHI	0605770352	GP	STEELE, CAROLINE
Surname	Wyles	Practice	*Allan Park Medical Practice (25656)*
Forename	Alan		19 Allan Park
Address			Stirling
			FK8 2QD
Post code		Pharmacy	Sainsbury Stirling
Telephone	07907702872		01786 445121

Referral Source	SMS		
Referral date	22/10/2020	**1st Clinic date**	10/11/2020
Seen in clinic by	Telephone call K Prentice	**Liberation Date**	

BBV Status						
HCV Ab +ve	20/05/2019	HCV Genotype	3	Previous Treatment	Prev outcome	Choose an item.
1st HCV PCR +ve	11/06/2019	Viral Load Click here to enter a date.				
HBV status:				HBV vaccination	HIV	Choose an item.
Mode of transmission		Substance misuse	Choose an item.	Substance substitute	Dispensing Interval	

Comments	Patient referred into service after recent appointment with Dr Pye. Patient was diagnosed Hep c positive on 20/05/2019 with a PCR done on 11/06/2019 and genotype 3. Patient then in and out of custody, but never long enough to get treatment. Patient now states that he has been drug free for several months now and is feeling more positive. He regularly meditates and feels he is doing well. Patient now keen to address Hep C. Patient states that he has been given information on HCV disease progression, risk behaviours and avoiding risk behaviours at previous appointments with the Low Moss BBV team and did not wish any more information today. Keen to discuss treatment. Informed patient that we need to have an up to date assessment of his liver including bloods and Fibroscan. Patient is happy to attend to have this done and an appointment has been made for him to attend for these on Monday 16th Nov at 3.30pm.
Past medical history	Nil
Psychiatric history	PTSD, Manic depression, social anxiety,, violet tendencies, although patient believes that he no longer has these issues.

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Psychiatrist			
Key Worker	Calum Morton	**Contact**	
Social history/ Employment	Lives alone		
Smoking			
Alcohol	occasional		
Liberation Date		**Liberated To:**	

Results								
Fibroscan	31/08/2021	Result	4.8kpa	F0-1				
U/S	Click or tap to enter a date.	Result						
ECG	Click or tap to enter a date.	**Reviewed:** Click here to enter a date. **Comments:**						
Weight	Click here to enter a date.							
Bloods	**Date**	**Result**						
LFT's	31/08/2021	Bil-	Alk Phos-	γGT-	ALT-	AST-	Tot Prot-	Albumin-
PT								
FBC	31/08/2021	Hb		Platelets				
Haematinics		Ferritin-		Folate -		Vit B12 -		
Glucose	31/08/2021							
Liver screen	31/08/2021	AFP		IgA		IgM		IgG
		ANF		Liver Auto Antibodies				

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Other		

Current Medication	Diazepam, methadone
Over the counter/Herbal	OTC – Nil Illicit – cannabis- pregablin
Allergies	
Suitability for Treatment	

Clinical Outcomes

Patient Name: Alan Wyles

CHI: 0605770352

Date		Discussion and Outcome
16/11/2020	Clinic Review	DNA SFA
07/12/2020	Clinic Review	DNA letter to patient asking to contact if wishes further app
07/01/2021	Clinic Review	DNA SFA
31/08/2021	Clinic Review Re-referred seen at Mayfield	LMoffat -Attended clinic for HCV assessment. Diagnosed HCV positive in 2019 while in prison, has never been treated. Discussed HCV diagnosis and treatment. No IV drug use for some time and is compliant with his daily pick up at pharmacy. Discussed treatment and the risk of potential interaction with the medication with both prescribed and illicit medication. Aware that compliance with the treatment, will prevent viral resistance in the future and give up to 98% chance of viral clearance. Bloods taken for Genotype and liver screen. Fibroscan carried out , 4.8 kpa indicating F0-1 Fibrosis (normal). Plan to discuss results with Consultants and clinical pharmacist at MDT and inform Alan of treatment plan. Sainsbury pharmacy Stirling Methadone 35mls, diazepam x6 prescribed by cads.
09/09/2021	HEPATOLOGY MDT	Discussed at MDT to have ultrasound requested and commence 12 weeks Epclusa.
13/09/2021	Telephone call	Discussed with keyworker, Alan is attending orthopedics' for further assessment of ? facial # and ? wrist# injuries sustained a few weeks ago. He will attend this appointment tomorrow. Will be seen in Mayfield with key worker to discuss treatment on 28/09/2021.
05/10/2021	Clinic Review	LMoffat, attended clinic today, treatment plan discussed. Aware of importance of compliance and potential for interactions with other medications. Will be taken daily supervised at pharmacist. Eform /care partner completed . prescriptions written
12/10/2021	Telephone call	Unable to contact Alan by telephone
19/10/2021	Telephone call	Unable to contact Alan by telephone. Contacted Pharmacy but unable to tell me if he had stared HCV treatment-phone back

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		tomorrow.
20/10/2021	Telephone call K Prentice	Pharmacy phoned and spoke with manager he is having problems getting the order for Epclusa ordered and delivered, I have emailed the Gilead team for help.
20/10/2021	e-mail	Email received back from gilead team – *The matter has now been sorted. On speaking with the Lloyds Pharmacy Manager it has emerged they had already received the Epclusa. There was just a mix up at Lloyds end when another pharmacist was covering their regular pharmacist at the pharmacy.*
01/11/2021	Telephone call K Prentice	Tried to phone pharmacy to see if they have started patient n treatment – phone just ringing out, will try again
03/11/2021	Telephone call K Prentice	Pharmacy phoned patient has started Epclusa on 21/10/2021.
04/11/2021	Telephone call	LMoffat Key worker reports Alan is managing treatment, feels well with no side effects
16/11/2021	Telephone call	LMoffat , Week 4 treatment. Managing well. Good compliance, feels he has no side effects.
14/12/2021	Telephone review	LMoffat, Week 8 treatment, continues to pick up treatment daily. Not using other drugs, but continues to smoke cannabis.
11/01/2022	Clinic review	LMoffat- treatment completed, felt lethargic throughout otherwise good compliance. Looks well today. Bloods taken to guage end of treatment response, aware that he requires bloods 12 weeks from completion of treatment to confirm outcome of treatment. Will be informed when results available.
27/01/2022	Telephone call	LMoffat, end of treatment bloods show HCV not detected<12. Patient informed for further bloods 12/04/2022
12/4/2022		DNA FAS discussed with KW will attend 17/05/2022
17/05/2022	Clinic review	DNA
28/06/2022	Clinic review	DNA , discussed with keyworker and will be encouraged to attend drop in for bloods

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Treatment Plan

Decision to initiate treatment	09/09/2021	
Requires psychiatry review		
Drug interactions	Discussed: 09/09/2021	Comments: non expected
Action required for drug interactions		
Proposed treatment	Epclusa (Sofosbuvir/Velpatasvir)	

	Date		Date		Date
start	21/10/2021				
1	28/10/2021	9	23/12/2021		
2	04/11/2021	10	30/12/2021		
3	11/11/2021	11	06/01/2022		
4	18/11/2021	12	13/01/2022		
5	25/11/2021				
6	02/12/2021				
7	09/12/2021				
8	16/12/2021			24	07/04/2022

Duration	12 weeks			
Proposed start date	Click or tap to enter a date.			
Prescription completed				
SVR due				

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Outpatient Clinic Note + Med Recommendation(s)

NHS Forth Valley

Name: **Alan Wyles**
CHI: **0605770352**

Registered GP Name: STEELE, CAROLINE
Registered GP Practice: Allan Park Medical Practice

Clinic attended: Gastroenterology

Clinic (From PAS): BAU Contingency Viral Liver Nurse Clinic
Date/Time of clinic: Tue 28 Sep 2021 15:31
Lead clinician for clinic: BAU Contingency Viral Liver Nurse Clinic

Presenting Complaint, Investigations, Results, Diagnosis:

The above patient was recently assessed for Hepatitis C treatment. All the assessment investigations were discussed at our Multidisciplinary meeting with Hepatology Consultants and Pharmacist where a decision was taken that he should have a 12 week course of Epclusa in the treatment of Hepatitis C, Genotype 3.
It has been discussed with the patient that the treatment regime should be taken daily and full compliance with the course will avoid viral resistance in the future and give a 98% chance of viral clearance.

Most patients on treatment have very little side effects. Headache and fatigue can be common. The patient is also aware of potential for drug-drug interactions of this medication.
As there is a risk of life threatening drug interactions can I ask if you would check with the Pharmacist, ourselves or the website www.hep-druginteractions.org if you plan to make any medication changes while the patient is taking Epclusa and update ECS with details of their treatment.
The treatment will be prescribed by the Hepatology team and dispensed daily supervised through the community pharmacy. We hope to start treatment in the next 7-10 days

1 Medication Recommendation(s):

Clinician making recommendation(s): Lorraine Moffat
Designation: Nurse Specialist

1 New medication(s):

(NEW) Recommendation 1 of 1: EPCLUSA 400/100

Form:	Tablets
Strength:	No strength supplied
Dose:	1 tablet
Freq/Duration:	Daily for 12 weeks
Supplied by Hospital?	Yes
Included in FV Formulary?	Yes
SMC approved?	Yes
Licenced for indication?	Yes

0 Follow Up action(s):

No 'follow up' info recorded/entered

Further Info:

If you require further information please contact Hepatology team 01786 434079. Alan will be monitored throughout his treatment by Hepatology team.

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Outpatient Clinic Note with Med Recommendation(s): Alan Wyles / 0605770352

Form completed by:	Lorraine Moffat on Tue 05 October 2021 at 14:52
Form sent to:	Primary and secondary care document management system(s), eg. Docman and EDMS

Outpatient Clinic Note with Med Recommendation(s): Alan Wyles / 0605770352

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Please tick appropriate box

CLINICAL NOTES ☐

NURSING NOTES ☐

PROGRESS NOTES ☐

Consultant Dr A. Ahmed

Write - imprint or Attach Label

Surname WYLES Hospital No.

Forenames ALAN Sex M

CHI 0605770352 D. of B. 06/05/77

Address

Ward / Dept. OPD

Date and Time	
31/08/21.	Pre treatment HCV Fibroscan Imp/Act

FibroScan 402

Lastname : WYLES
Firstname : Alan
Gender : Male
Birth date : 05/05/1977
Code : 0352
Admitting diagnosis : hcv

Fibroscan exam
31/08/2021 11:23:52

Exam type : Medium
Operator : jm
Referring physician : ahmed

Median stiffness : **4.8** Kpa
IQR : 0.8 Kpa
IQR/med. : 17 %
Valid measures : 12
Success rate : 92 %

Legal notice
FibroScan is a medical device designed for use by a qualified and trained operator. Results should be interpreted by a specialist and not medical according to the clinical context taking into account the number of valid liver stiffness measurements (LSM) and the success rate.

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Urgent Outpatient Clinic Note

Name: **Alan Wyles**
CHI: **0605770352**

NHS Forth Valley

Registered GP Name: STEELE, CAROLINE
Registered GP Practice: Allan Park Medical Practice

Clinic attended: Gastroenterology

Clinic (From PAS): BAU Contingency Viral Liver Nurse Clinic
Date/Time of clinic: Tue 31 Aug 2021 13:31
Lead clinician for clinic: BAU Contingency Viral Liver Nurse Clinic

Presenting Complaint, Investigations, Results, Diagnosis:

Attended Outreach Hepatology clinic for HCV assessment. Diagnosed HCV positive in 2019 while in prison, has never been treated. Discussed HCV diagnosis and treatment. No IV drug use for some time and is compliant with his daily pick up at pharmacy. Discussed treatment and the risk of potential interaction with the medication with both prescribed and illicit medication. Aware that compliance with the treatment, will prevent viral resistance in the future and give up to 98% chance of viral clearance. Bloods taken for Genotype and liver screen. Fibroscan carried out , 4.8 kpa indicating F0-1 Fibrosis (normal). Plan to discuss results with Consultants and clinical pharmacist at MDT and inform Alan of treatment plan.

0 Medication Recommendation(s):

No (new, stop or alter) medication recommendation(s) entered/recorded

0 Follow Up action(s):

No 'follow up' info recorded/entered

Further Info:

If you require any further information please contact Hepatology 01786 434079

Form completed by: Lorraine Moffat on Tue 07 September 2021 at 11:58
Form sent to: Primary and secondary care document management system(s), eg. Docman and EDMS

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FVRH Emergency Department Forth Valley Royal Hospital

04

Date of attendance: 02/08/2023 23:49
Presenting complaint: ankle inj

Surname:	Wyles	**Forename:** Alan	**Title:** Mr	
Address:	2 Gordon Square Raploch Stirling Stirlingshire	**Postcode:** FK8 1FN	**CHI:** 0605770352	
Telephone:				
Date of Birth:	06/05/1977	**Sex:** Male	**Age:** 46 Years	
GP Name:	A Dunsmore			
Address:	25686/1 Allan Park Medical Practice 19 Allan Park Stirling Stirling FK8 2QD	**Telephone:** 01786 451375		
Next of Kin				
Name:	Kaila Wyles			
Relationship:	Daughter	**Postcode:**		
Address:		**Telephone:** 07368945417		

Triage Information
seen in ED yesterday, fractured leg. Attends ED tonight for analgesia as ongoing pain.

Observations

P=	**BP=** /	**RR=**	**Sat=**	**BM=**	**Temp=**
Peak Flow=		**GCS=**		**News=**	

Emergency Department / Pre-Hospital Drugs | **Allergies**

Date	Drug	Dose	Route	Signature	Given by	Time
3-8-23	NAPROXEN	500mg	PO	Rec	Rec	0046
"	PARACETAMOL	1G	PO	Rec	Rec	0046
"	OMEPRAZOLE	20mg	PO	Rec	Rec	0046
"	OXYMORPH 10mg/10ML	10mg	IV	Rec	Rec	0046

Naproxen 250mg
28 Tablets
One tablet every 6-8 hours as required.
Maximum 5 tablets in 24 hours.
Presc: Rec Kwm
Disp: Rec

Omeprazole 20mg
7 Capsules
One capsule daily swallow whole with water
Presc: Rec Kwm
Disp: Rec

Rivaroxaban 10mg
Tablets (14) – for lower limb injury thromboprophylaxis)
Presc: Rec Kwm
Disp: Rec

Paracetamol 500mg
32 Caplets
1 or 2 caplets every 4 to 6 hours when required for pain relief
Presc: Rec Kwm
Disp: Rec

NOT REQUIRED.

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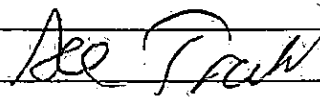
Clinical Notes

Seen by:		Time:	



Attach continuation sheets here

Attach here onto face of pocket

Guidelines Used:	

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National Early Warning Score (NEWS)

NHS Forth Valley

Name: CHI NO: 0603770352 0603/1977 F
CRN:
DOB: ABE VYLER
CHI No: 2 GORDON SQUARE
RAPLOCH
Address: FK8 1RW

* Regardless of NEWS always escalate if concerned about a patient's condition

Total NEWS	Frequency of Monitoring	Clinical Response
0 *	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations
1 - 4	Minimum 4 - 6 hourly	• Inform registered nurse who must assess the patient • Registered Nurse to decide if increased frequency of monitoring and / or escalation of clinical care is required
5 - 6 * or 3 in one Parameter	Increased frequency to a minimum of 1 hourly	• Registered nurse to urgently inform the medical team caring for the patient • Urgent assessment by a clinician with core competencies to assess acutely ill patients • Ensure structured Response Stickers A & B are completed *(Not Applicable in Emergency Dept)*
	Continuous monitoring of vital signs (3 lead ECG and continuous SpO2 monitoring, 15 minute BP cycling - document observations every 30 minutes)	• Registered nurse to immediately inform the medical team caring for the patient • Emergency assessment by clinical team with core competencies to assess acutely unwell patients • Ensure structured Response Stickers A & B are completed *(Not Applicable in Emergency Dept)* • Consider transfer of clinical care to ITU

Exclusion Criteria

Anaesthesia and/or sedation may result in reduced conscious levels for a period of time. Scores that are increasing post-procedure and those including "P" or "U" always require escalation. The post-procedure NEWS score and post procedure plan that will include the frequency of observations should be communicated to the ward staff on transfer/handover of the patient.

Target O2 Saturation

Target SpO2 for most patients should be 94-98%.
Selected patients may require target SpO2 88-92% (Appropriate in specific patients with severe chronic respiratory disease who either have established chronic Type 2 respiratory failure, or are felt to be at significantly increased risk of CO2 retention from oxygen therapy). These patients should use the modified (chronic hypercapnia) EWS. Arterial blood gases should be repeated at 30–60 min to check for rising CO2 or H+ after initiation of oxygen in this context.

Acute Respiratory Failure is a life threatening emergency
Severe Hypoxia (Requiring >60% O2 to maintain target SpO2)
Acute Hypercapnia (pCO2 >6 and H+ >45)
Urgent ST3 (or equivalent) review is required to optimise management.
Duty or on call consultant should be contacted if advice required.
Critical care referral and ventilatory support may be needed.

Pain Score
0 = no pain
1 = mild pain
2 = moderate pain
3 = severe pain

Codes For Recording Oxygen Delivery On NEWS Chart

A = Air (not requiring oxygen or weaning or on PRN oxygen)
N = Nasal Canulae
SM = Simple Mask
V24 =Venturi 24% **V28** = Venturi 28% **V35** = Venturi 35% **V40** = Venturi 40% **V60** = Venturi 60%
H28 = Humidified oxygen at 28% (also H35, H40 & H60 = Humidified Oxygen at 35%, 40% & 60%)
RM = Reservoir Mask
TM = Tracheostomy Mask
CP = Patient on CPAP System
NIV = Patient on NIV System

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Sepsis Screening Tool

NHS Forth Valley

Patient triggering NEWS ≥ 5 OR Clinical Concern
Neutropenia suspected OR MEWS triggering for obstetric patients

Is this likely to be due to infection?

Cough/sputum
Abdominal pain/distension/diarrhoea
Line infection
Endocarditis
Dysuria
Cellulitis
Headache with neck stiffness
Wound infection

Obstetric patients (Refer to FV protocol: Sepsis in Maternity Patients)
Perineal trauma | Vaginal discharge | Prolonged SRM | Sore Throat

YES

Escalate to Doctor/ANP with suspected sepsis
Place Sepsis 6 sticker in notes
Prepare giving set/IV fluids

NO

Escalate to Doctor/ANP
Repeat NEWS/MEWS in max 60 mins

ASSESS FOR OTHER CAUSES OF TRIGGERING

Two people work together to deliver the Sepsis 6 within 60 mins of patient first triggering

- Correct Hypoxia
- Take Blood Cultures
- Give IV antibiotics according to NHS FV Protocol
- Measure whole blood Lactate
- Assess urine output (catheter if obstetric patient)
- Start IV fluids - 20ml/kg minimum 500mls in the first hour

ASSESS FOR SEVERE SEPSIS

SEVERE SEPSIS

Sepsis with organ dysfunction:
- Hypotension
- Renal
- Respiratory
- Hepatic
- Hematologic
- CNS
- Metabolic acidosis

SEPTIC SHOCK

- Hypotension despite fluid resuscitation
- Organ dysfunction

HIGH RISK FACTORS
- Hypotension
- Lactate > 4
- Unexplained INR > 1.5
- APTT > 60 secs
- Bilirubin > 34 (70 if obstetric)
- Platelets < 100

IF SEVERE SEPSIS
Contact middle grade Doctor (Consultant if obstetric patient)
Catheter mandatory if evidence of AKI

NO EVIDENCE OF SEVERE SEPSIS
Assess response to sepsis 6
Continue regular NEWS

Conscious Level Chart (only as required for head injury observation)

ALAN WYLES - CHI [illegible]

DATE: 18/8/23 | TIME: 1605 1705 1805 1905 | DATE: | TIME:

COMA SCALE

Eyes Open	Spontaneously	4		Eyes closed by swelling = C
	To speech	3		
	To pain	2		
	None	1		
Best verbal response	Orientated	5		Endotracheal tube or tracheostomy = T
	Confused	4		
	Inappropriate words	3		
	Incomprehensible sounds	2		
	None	1		
Best motor response	Obey commands	6		Usually record the best arm response
	Localise pain	5		
	Withdraws to pain	4		
	Flexion to pain	3		
	Extension to pain	2		
	None	1		

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

PUPILS	right	Size	3 2 3 3 3 2 3	+ reacts - no reaction C eye closed
		Reaction	+ + + + + + +	
	left	Size	3 2 3 3 3 2 3	
		Reaction	+ + + + + + +	

LIMB MOVEMENT

ARMS	Normal power	5 5 5 5 5 5 5	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	L L L L L L L	
	Mild weakness		
	Severe weakness	R R R R R R R	
	Extension		
	No response		

Pain Assessment & Management Guidelines

Pain Score:
0 = No pain
1 = No pain at rest
Slight pain on movement
2 = Intermittent pain at rest
Moderate pain on movement

For Acute and Chronic Pain:
For mild (1), moderate (2) or severe (3) pain refer to Pain Management Guidelines Forth Valley Formulary Appendix 27 & 28. Implement Pain Assessment Chart

For Cancer Related Pain:
For mild (1), moderate (2) or severe (3) pain score, refer Palliative Guidelines

Supportive and Palliative Care Indicators Tool (SPICT™)

The SPICT™ is a guide to identifying people at risk of deteriorating and dying. Assessment of unmet supportive and palliative care needs may be appropriate.

Look for two or more general indicators of deteriorating health:
- Performance status poor or deteriorating, with limited reversibility, needs help with personal care, in bed or chair for 50% or more of the day)
- Two or more unplanned hospital admissions in the past 6 months
- Weight loss (5–10%) over the past 3 - 6 months and/or body mass index < 20
- Persistent, troublesome symptoms despite optimal treatment of any underlying condition(s)
- Lives in a nursing care home or NHS continuing care unit, or needs care to remain at home
- Patient requests supportive and palliative care, or treatment withdrawal

Look for any clinical indicators of advanced conditions:

Cancer
- Functional ability deteriorating due to progressive metastatic cancer
- Too frail for oncology treatment or treatment IS for symptom control

Dementia / frailty
- Unable to dress, walk or eat without help
- Choosing to eat and drink less; difficulty maintaining nutrition
- Urinary and faecal incontinence
- No longer able to communicate using verbal language, little social interaction
- Fractured femur, multiple falls
- Recurrent febrile episodes or infections, aspiration pneumonia

Neurological disease
- Progressive deterioration in physical and/or cognitive function despite optimal therapy
- Speech problems with increasing difficulty communicating and/or progressive dysphagia
- Recurrent aspiration pneumonia, breathless or respiratory failure

Heart / vascular disease
- NYHA Class III/IV heart failure, or extensive untreatable coronary artery disease with:
  - breathlessness or chest pain at rest or on minimal exertion
- Severe, inoperable peripheral vascular disease

Respiratory disease
- Severe chronic lung disease with:
  - breathlessness at rest or on minimal exertion between exacerbations
- Needs long term oxygen therapy
- Has needed ventilation for respiratory failure or ventilation is contraindicated

Kidney disease
- Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health
- Kidney failure complicating other life limiting conditions or treatments
- Stopping dialysis

Liver disease
- Advanced cirrhosis with one or more complications in past year:
  - diuretic resistant ascites
  - hepatic encephalopathy
  - hepatorenal syndrome
  - bacterial peritonitis
  - recurrent variceal bleeds
- Liver transplant contraindicated

Assess and plan supportive & palliative care
- Review current treatment and medication so the patient receives optimal care
- Consider referral for specialist assessment if symptoms or needs are complex and difficult to manage
- Agree current and future care goals/plans with the patient and family
- Plan ahead if the patient is at risk of loss of capacity
- Handover care plan, agreed levels of intervention, CPR status
- Coordinate care (eg. with a primary care team/s)

Review Date: 202[illegible]

SPICT™ November 2013 www.spict.org.uk Jeyanthi Rajeswaran 01101 9355

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FVRH Emergency Department Forth Valley Royal Hospital

03

Date of attendance: 01/08/2023 21:04
Presenting complaint: ED + Ortho referral from MIU

Surname:	Wyles	**Forename:**	Alan	**Title:**	Mr
Address:	2 Gordon Square Raploch Stirling Stirlingshire	**Postcode:**	FK8 1FN	**CHI:**	0605770352
Telephone:					
Date of Birth:	06/05/1977	**Sex:**	Male	**Age:**	46 Years
GP Name:	A Dunsmore				
Address:	25686/1 Allan Park Medical Practice 19 Allan Park Stirling Stirling FK8 2QD	**Telephone:**	01786 451375		
Next of Kin					
Name:	Kaila Wyles				
Relationship:	Daughter	**Postcode:**			
Address:		**Telephone:**	07368945417		

Triage Information

BIBA from MIU - Ortho referral for (R) ankle fracture - cast applied @ MIU - assualted yesterday sustained (R) ankle injury + head injury / presented ED did not wai - vomiting x 3 today - GCS 15 @ triage

Observations

P=	**BP=** /	**RR=**	**Sat=**	**BM=**	**Temp=**
Peak Flow=		**GCS=**		**News=**	

Emergency Department / Pre-Hospital Drugs | **Allergies**

Date	Drug	Dose	Route	Signature	Given by	Time
1/8/23	ONDANSETRON	4mg	IV		SMAC	0012
1/8/23	ONDANSETRON	8mg	PO		AL	0045

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Clinical Notes

Seen by:		Time:	

EMERGENCY ORTHO

Attacked last night - kicked lateral side of proximal R tibia
⇒ Attended ED last night
Did not wait to be seen
Attended IMU today
(R) Mediannerve ++
Closed NVI

Given pcm in ED
Recasted

Plan
- Check xray
- Await ED reviews RE Head Injury

EMERGENCY
- Check xray satisfactory
- Figures endexapain if being discharged

Guidelines Used:	

Attach continuation sheets here

Attach here onto face of pocket

THIS IS A RECONSTITUTED DOCUMENT PRINTED FROM EDRM

SCH Minor Injuries Stirling Community Hospital

Date of attendance: 01/08/2023 15:08
Presenting complaint: right leg/ankle. Head inj

Surname:	Wyles	**Forename:**	Alan	**Title:**	Mr
Address:	2 GORDON SQUARE RAPLOCH Stirling Stirlingshire	**Postcode:**	FK8 1FN	**CHI:**	0605770352
Telephone:					
Date of Birth:	06/05/1977.	**Sex:**	Male	**Age:**	46 Years

GP Name:	A Dunsmore		
Address:	25686/1 Allan Park Medical Practice 19 Allan Park Stirling Stirling FK8 2QD	**Telephone:**	01786 451375

Next of Kin

Name:	Kaila Wyles		
Relationship:	Daughter	**Postcode:**	
Address:		**Telephone:**	07368945417

Triage Information MIU → ED for m assessment. Orthopaedic aware of #. will require ortho to be called when m. assessed.

Observations see notes for obs

P=	**BP=** /	**RR=**	**Sat=**	**BM=**	**Temp=**
Peak Flow=		**GCS=** 15/15		**News=** 0	

Emergency Department / Pre-Hospital Drugs

Allergies NKDA

Date	Drug	Dose	Route	Signature	Given by	Time
1.8.23	Paracetamol	1g	po	Initials	Initials	1540
1.8.23	Ibuprofen	400mg	PO	Initials	Initials	1940

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Please tick appropriate box

CLINICAL NOTES ☐

NURSING NOTES ☐

PROGRESS NOTES ☐

Consultant

Write - imprint or Attach Label

Surname ..... Hospital No. .....

Forenames ..... Sex .....

CHI ..... D. of B. .....

Address .....

Ward / Dept. .....

Date and Time	
2/8/23	Hassan Hussain → middle grade
01:00	→ was actually last night whilst at funeral
	→ remembers being hit and bang head onto weights in kitchen
	→ had 3× episodes of vomiting
	→ n/v/ chiworks or stomach
	→ no dizziness
	→ feels well generally
	O/E
	Alert
	PEARL no visual field defect
	face typical intact
	sensation intact
	Babinski -ve
	CT → n/ bleed
	? subluxation of C3/4
	tells me has pain in upper back
	imp
	concussion
	Plan
	Head injury advice leaflet
	home

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Date: 1.8.23 Time: 21.30

Named Nurse: Anton Triage Nurse: Anton

Patients preferred name:

CHI NO: 0605770352 06/05/1977
CRN: M
Alan WYLES
2 GORDON SQUARE
RAPLOCH
STIRLING
FK8 1FN

S — Situation

Brief history of complaint B/BA

ED + Ortho referral from MIU. Presented ED Monday after assault. Head injury + (R) ankle injury. ~~Today~~ Did Not Wait today. Vomit x3; Cast applied @ MIU

B — Background

MI ☐ CVA ☐
Asthma ☐ COPD ☐
Angina ☐ HTN ☐
Epilepsy ☐ Diabetes T1/T2
Allergies: Penicillin
Social: Lives Independently

Vulnerable adult/child No ☑ Yes ☐ (see SAS PRF)
Other: Prev. drug use.

Anticoagulated Y / N

Patient's details and NOK checked ☐ Relative/Carer: Informed? YES/NO
Present? YES/NO

A — Assessment

ECG ☐ P/NEWS 0
Bloods ☐ BM 5.0
PVC ☑ GCS/AVPU 15
Urinalysis ☐ Ketones ____
HCG ☐ Pain: 5 /3
Analgesia ☑ Rockwood Score: ____

ED MIU
Ortho ☑
CTB ☑
XRAY ☑
Face CAST ☑

ED Care Rounds (PTO) 1st hour ☐ 1-2hours ☐ 2-3hours ☐ 3-4hours ☐

Mobility: (N) Independent Name Band ☑ Signature: AC

R — Recommendations

Impression:

Outstanding Treatments:

Referred Specialty:
Medics ☐ Paeds ☐
Surgeons ☐ ENT ☐
Gynae ☐ Ortho ☐
Other ____

Recommendation Falls Care Bundle required Yes/No Falls alert added to Trakcare ☐

NEWS: Signature:

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Nursing Notes and

ED Care Round Checklist

PATIENT LABEL

Date	First Hour	1-2 Hours	2-3 Hours	3-4 Hours
Introductions/Updates				
Toileting Assistance (catheter care, commode, bedpan etc)				
Comfort Care (mouth care, pressure area care, position changes etc)				
Environment (clutter free, buzzer in reach)				
Hydration and Nutrition or **NBM**				
Initials and Time				

* If patient has been in department for more than 4 hours – commence NHS FV care and comfort chart.

All care provided and changes to care must be documented below:

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Incident Number: CR0100040197

Patient Information

ALAN WYLES

Age/Gender:	46Y Old Male
Address:	2 GORDON SQ STIRLING FK8 1FN
DOB:	06/05/1977
CHI:	0605770352
Ethnicity:	White Scottish

Date:	01/08/2023
Incident Number:	CR0100040197
Incident Type:	URG
Incident Location:	STIRLING HEALTH AND CARE VILLAGE Dept/Ward Within Hospital IS - MINOR INJURY FK8 2AU

Scottish Ambulance Service

Presenting Complaint

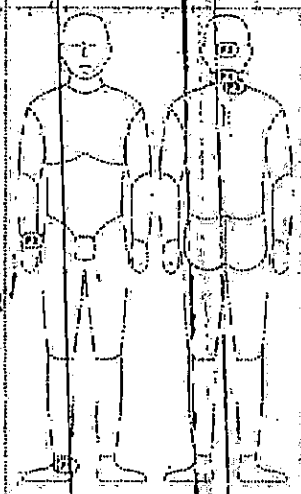
ASSAULT - FRACTURE ANKLE - HEAD INJURY

Additional Comments

As2 call to minor injuries for pt who requires to travel to ae for head injury hpc - pt was assaulted last night hit o back of head fell to ground - and stamped on ankle - was taken to ae by ambulance but left claiming uncomfortable with police questioning- daughter collected and taken home - pt presented at mi this morning - pt has vomited 3 x last around midday - pt also complaining pain in right arm - ankle - put into cast as unstable fracture- pmhx - history of drug abuse but now not using any recreational drugs - on diazapan and buprenorphine oe - airway clear breathing reg no added sounds - pulse reg - d temp reg bm reg gcs 15 pupils = and reactive - e -swelling noted on back of head - pain in upper back neck - pain right arm - and ankle pt has been given paracetamol and ibuprofen for pain relief - pain score 9 - given pre history mi did not provide any other meds pt being taken to fv for head injury assessment - and referral to orthopaedics for ankle nok daughter kaila wyles 07368 945417

PATIENT ASSESSMENT

ACVPU	Alert		<C>	No		
A	Clear					
B	Breathing Adequately: Yes		Respiratory Rate: 16		SPO2: 98	
C	Pulse Rate: 67	BP: 158/78	Cap Refill: <=2 Secs		ECG Rhythm:	
	Rhythm: Reg	Arm:	Central/Peripheral: Peripheral		ECG:	
D	GCS: 15	Eyes: Spontaneously (4)	Voice: Orientated (5)	Motor: Obeys Commands (6)	PEARL: Yes	
E						



Pain

ID	Body Part	Pain Scale
P1	Right Foot	8
P2	Right Hand	9
P3	Back Body	9
P4	Back neck	9
P5	Back Head	9

Fractures and Dislocations

ID	Body Part	Type	Treatments	Distal Checks
F1	Right Foot	Fracture - Closed	Splinting	Normal Findings

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
20:28	67	16	155/77			15									E9883653
20:26	67	16	158/78	98	<=2 Secs	15	Alert		36.7	6.2		4	4		E9883653

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total

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20:26	16 (0)	98 (0)	0	158 (0)	67 (0)	Alert (0)	36.7 (0)	0

HISTORY

AMPLE

Allergies	PENICILLIN
Medication	Diazepam, Buprenorphine
Past Medical History	PT HAS SUFFERED MULTIPLE FRACTURES INPAST PREVIOUSLY ADICT -
Last Eaten	>4 Hours Ago
Events Prior	LAST NIGHT WAS ASSAULTED AT HOME- HIT ON BACK OF HEAD - FELL TO GROUND - STAMPED ON ANKLE - AND KNEE - - BRIEF LOSS OF CONSCIOUSNESS

Social History

Lives alone	Yes	Patient Occupation	SAL ARMY

Patients General Appearance	Normal
Patient Mobility	Fully Mobile
Patient Communication	No Help Required
Patient Clinical Risk Factors	Smoker, Recreational Substances, PREVIOUS DRUG ADICTION - NO REC DRUG USE NOW
Patient Enviromental Risk Factors	None Identified

CLOSE RECORD

Treatment On Scene	Non-Emergency

Conveyance

Transport To Hospital	Normal driving	Pre-Alert	No

INCIDENT LOG

Time Call Received	19:34	Allocated	19:51	Mobile	19:52
First Resource On Scene		Crew On Scene	20:08	Crew Left Scene	20:29
Crew At Hosp		Receiving Hospital	FORTH VALLEY ROYAL HOSPITAL	Clear Time	

Crew ID	Crew Grade	Driver
E9886671	Paramedic	YES
E9883653	Ambulance Technician	NO

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PVC INSERTION BUNDLE AND REMOVAL RECORD

CHI NO: 0605770352 06/05/1977
CRN: M
Alan WYLES
2 GORDON SQUARE
RAPLOCH
STIRLING
FK8 1FN

PLEASE COMPLETE ALL BOXES

The patients skin is decontaminated and allowed to dry	YES / NO
Hand hygiene & gloves donned prior to insertion	YES / NO
Aseptic Non Touch Technique is used to insert PVC	YES / NO
If not possible, use either STERILE GLOVES or MINI CHLORAPREP	
Sterile dressing & sticker (date & time) applied after insertion	YES / NO

Why is PVC clinically indicated for patient?: (please tick)

IV Fluids		Blood Transfusion	
IV Drugs		Diagnostics	
Predicted clinical need			

Colour:
Insertion Site:
Ward/Department:
Inserted by:
Date & Time:
Removed: YES / NO

INVESTIGATIONS

Bloods Required:

FBC U&E GLU LFT CRP AMY CLOTTING G&S ESR PARACETAMOL
TROP D-DIMER CULTURES VBG* ABG* (*attach to notes) URINALYSIS HCG ECG

Others:

SIGN
BLOODS TAKEN? YES / NO TIME TAKEN PRINT

Preliminary Pressure Ulcer Risk Assessment (PPURA):

Mobility:	Person is fully mobile without equipment/assistance
Continence:	Person is fully continent
Nutrition:	Person appears well nourished and able to eat and drink
Skin:	Skin to pressure points satisfactory/intact

Points to Consider
* People who are overweight may not be well nourished
* Use of repose mattress or pressure relieving heel protectors.

Record your answer in the grid below Y = Yes or N = No
If the answer is NO to any assessments undertake a BRADEN and consider any other assessment

DATE	TIME	MOBILITY	CONTINENCE	NUTRITION	SKIN INSPECTED	SKIN INTACT	BRADEN COMPLETED	SIGNATURE
SKIN DESCRIPTION i.e. REDNESS, SKIN BROKEN, BLISTER / ULCER						ACTION TAKEN		

4 A T

ALERTNESS (assess for drowsiness or agitation, if asleep attempt to rouse)		Tick
Normal	0	
Mild sleepiness (easily roused <10 seconds)	0	
Clearly abnormal	4	
AMT4 (age, date of birth, place, current year)		**Tick**
No mistakes	0	
1 mistake	1	
2 or more mistakes	2	
ATTENTION (ask for months of the year backwards)		**Tick**
Achieves 7 or more correctly	0	
Starts but scores less than 7/Refuses to start	1	
Untestable	2	
ACUTE CHANGE OR FLUCTUATION (significant change incl. evidence of psychotic symptoms)		**Tick**
No	0	
Yes	4	
Total score (score of 4 or more indicates likely delirium - initiate TIME bundle)		

FALLS TRIGGER TOOL (Complete only if 65 years or over)

2 or more falls in the last 6 months?	YES / NO	Tries to walk alone and is unsteady?	YES / NO
Fall since admission to department?	YES / NO	Patient/relatives anxious about falls	YES / NO
Admitted to department with fall?	YES / NO	4AT more than 4/evidence of confusion	YES / NO

COMPLETED BY .....

If you have answered yes to 2 or more questions,
- For patients being admitted please document recommendation that a full care bundle is required to be completed:
- Please add FALLS RISK IDENTIFIER to Trakcare (EPR→ Patient Alerts→ New→ Ward Signifiers→ Falls risk).

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PATIENT LABEL

CLINICAL NOTES

Near Patient Testing Results

Troponin.....Initials.....

Time of Trop.....

D-dimer.....

Urine dipstick

Leucs
Nitrite
Protein
Blood
Ketones
Glucose

Blood Gases

Arterial/venous (circle)
Time taken

FiO2
pH
pCO2
PO2
BE
Lactate

Urine Pregnancy Test
HCG positive/negative (circle)

Fast

Free fluid identified:
Yes/No (circle)

AAA

Aorta clearly seen
Yes/No (circle)
Measured diameter.....

Protetanus
Immune/Not immune (circle)

Patient/Legal Guardian Permission to release info for legal purpose including Police Yes / No

Patient Signature..... Print Name..... Date.....

ING1716

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SCH Minor Injuries Stirling Community Hospital

Date of attendance: 01/08/2023 15:08
Presenting complaint: right leg/ankle. Head inj

Surname:	Wyles	**Forename:**	Alan	**Title:**	Mr
Address:	2 GORDON SQUARE RAPLOCH Stirling Stirlingshire	**Postcode:**	FK8 1FN	**CHI:**	0605770352
Telephone:					
Date of Birth:	06/05/1977	**Sex:**	Male	**Age:**	46 Years

GP Name:	A Dunsmore		
Address:	25686/1 Allan Park Medical Practice 19 Allan Park Stirling Stirling FK8 2QD	**Telephone:**	01786 451375

Next of Kin

Name:	Kaila Wyles		
Relationship:	Daughter	**Postcode:**	
Address:		**Telephone:**	07368945417

Triage Information MIU → ED for MI assessment. Orthopaedic aware see notes. If #, will require ortho to be called when MI assessed

Observations see notes for obs.

P=	**BP=** /	**RR=**	**Sat=**	**BM=**	**Temp=**
Peak Flow=		**GCS=** 15/15		**News=** 0	

Emergency Department / Pre-Hospital Drugs	Allergies
	NKDA

Date	Drug	Dose	Route	Signature	Given by	Time
1·8·23	P-racetamol	1g	Po	[signature]	[signature]	1540
1·8·23	Ibuprofen	400mg	Po	[signature]	[signature]	1940

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NEWS KEY 0 | 1 | 2 | 3

NAME:

DOB:

Date	22							
Time	16	16	17	17	19	19		
	2000	2000	30	20	30			
RESP RATE ≥25								
21-24								
12-20	20	20	20	20	20	20		
9-11								
≤8								
SpO2 Default ≥96	97	96	98	97	97	FA		
94-95								
92-93								
≤91								
Chronic ↑ CO2 ≥88								
86-87								
Sign: ☐ ≤85								
Inspired O2 Please tick								
O2 Device or Air Refer to key	A	A	A	A	A	A		
O2 Flow or Rate								
TEMP ≥39°								
38°								
37°								
36°								
Mark ≤35°								
220								
210								
200								
190								
180								
170								
160								
150				A				
140								
130	A	A	A		A	A		
120								
110								
100								
90								
80								
70								
60								
50								
>140								
HEART RATE 130								
120								
110								
100								
90								
80								
70								
Mark 60								
50								
40								
30								
CONSCIOUS LEVEL Alert	✓	✓	✓	✓	✓	✓	✓	
V/P/U								
Blood Sugar								
	0	0	0	0	0	0		
Pain Score (0-3)	3	3	3	3	3	3		
Recognition & Response Checklist								
Urine Output Recorded								
Initials								

CHI NO: 0605770352 06/05/1977 M
CRN:
Alan WYLES
2 GORDON SQUARE
RAPLOCH
STIRLING
FK8 1FN

NEWS Recording Frequency: Score 0 = Routinely | Score 1-4 = Minimum 4-6 hourly

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FVRH Emergency Department Forth Valley Royal Hospital 03

Date of attendance: 20/05/2021 11:45
Presenting complaint: jaw pain bleeding from r ear

Surname: Wyles	**Forename:** Alan	**Title:** Mr	
Address: 2 Gordon Square Stirling	**Postcode:** FK8 1FN	**CHI:** 0605770352	
Telephone:			
Date of Birth: 06/05/1977	**Sex:** Male	**Age:** 44 Years	

GP Name: Cl Steele
Address: 25686/1
Allan Park Medical
Practice
19 Allan Park
Stirling
Stirling
FK8 2QD
Telephone: 01786 451375

Next of Kin
Name: Thomas Begley
Relationship: Friend
Address: 7A hawthorn cres
Stirling
Postcode:
Telephone: 01786471637

Triage Information
Assaulted last week. Pt states stabbed in R arm- 2x lacerations. Pt states pushed down 23 concrete stairs then no recollection of further events. Bleeding for ear for 4/7-no bleeding at present. GCS 15 Pupils 6+ BM 6.6

Observations
P= 80 **BP=** 114 / 80 **RR=** 16 **Sat=** 94 **BM=** **Temp=** 36.6
Peak Flow= **GCS=** **News=** 1

Emergency Department / Pre-Hospital Drugs **Allergies**

Date	Drug	Dose	Route	Signature	Given by	Time
20/5/21	PARACETAMOL	1g	ORAL		SP	13:20
20/5/21	IBUPROFEN	400mg	ORAL		SP	13:20
20/5/21	CEFUROXIME	1.5g	IV		SP	14:00

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Clinical Notes

Seen by:	SARAH PATRICK	Time:	13:10

EDF

(44)? Pt states was assaulted ~2 weeks ago (partial stabs may have been ~3 weeks - 1 month ago)

PMH: HCV +ve
Prev IVDU, engaged with CHDS
DHx: Methadone
+Diazepam
Allergy - PCS? Penicillin

Pt had HI with LOC and vomiting at time (pushed down stairs by) but did not attend ED

Soc Hx - states does not drink or smoke tobacco but smokes cannabis

States was also stabbed in both arms

Now states he has lost teeth and has difficulty Stabbing/electric pain going down R ear - face

States he feels like there is 'blood' over his head

Attach continuation sheets here

Attach here onto face of pocket

Guidelines Used:

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appointment booked 10.20 21/05

FVRH Emergency Department Forth Valley Royal Hospital 03

Date of attendance: 20/05/2021 11:45
Presenting complaint: jaw pain bleeding from r ear

DUPLICATE FROM Stirling

Surname: Wyles	**Forename:** Alan	**Title:** Mr
Address: 2 Gordon Square Stirling	**Postcode:** FK8 1FN	**CHI:** 0605770352
Telephone:		
Date of Birth: 06/05/1977	**Sex:** Male	**Age:** 44 Years

GP Name: Cl Steele
Address: 25686/1
Allan Park Medical Practice
19 Allan Park
Stirling
Stirling
FK8 2QD
Telephone: 01786 451375

Alan- 07519305640

Next of Kin
Name: Thomas Begley
Relationship: Friend
Address: 7A hawthorn cres
Stirling
Postcode:
Telephone: 01786471637

Triage Information
Assaulted last week. Pt states stabbed in R arm- 2x lacerations. Pt states pushed down 23 concrete stairs then no recollection of further events. Bleeding for ear for 4/7-no bleeding at present. GCS 15 Pupils 6+ BM 6.6

Observations
P= 80 BP= 114 / 80 RR=16 Sat=94 BM= Temp= 36.6
Peak Flow= GCS= News= 1

Emergency Department / Pre-Hospital Drugs **Allergies**

Date	Drug	Dose	Route	Signature	Given by	Time

VFC
CLINIC

MAC FAX
CLINIC

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20/6/21. 15:45

Clinical Notes

Seen by:		Time:	

Hdnd see also Dr Lewin
seen by SHO colo
new
fell down stairs a few weeks ago
do ① Pain to (R) side face / jaw
② Pain to (L) wrist
Q CCS IS / self / working
Nil CABG cmon
(R) face / jaw - tube - ? #
poor dentition
poor MO / no malocclusion
(L) wrist - tube ASB
move ok not / nil deps
CT / XRA ① # (L) Scaphoid
② # (R) condyl mobile
- Rx fx flow

Attach continuation sheets here

* VFC / MAXFAX to GP/ fellow up + send Letter to GP.

Attach here onto face of pocket

Guidelines Used:

Currently has left dep + nil allergy cells

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Please tick appropriate box

CLINICAL NOTES ☐

NURSING NOTES ☐

PROGRESS NOTES ☐

Consultant

Write - imprint or Attach Label

Surname WYLES Hospital No.

Forenames ALAN Sex

CHI 0605770352 D. of B.

Address

Ward / Dept.

Date and Time	
20/5/21 16:00	OMFS e/v
	Referral Planned from ED re (R) condylar #
	C/O: pushed down concrete steps approx. a week and a half ago - Sore jaw RHS + had bleeding from (R) ear
	MH: f+w
	O/E: CT scan reviewed - (R) condyle H = medial portion separated
	Nil asymmetry No stable occlusion due to missing / # teeth → No obvious displacement
	Advised pt. no surgical intervention required Advised soft diet
	PLAN: (1) conservative management - soft diet + analgesia (2) RV in 1 week in OPD.
	OMS DCS OMFS

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Emergency Discharge Letter (Authorised)

FVRH Emergency Department
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

A Dunsmore
Allan Park Medical Practice
19 Allan Park
Stirling
Stirling
FK8 2QD

CHI Barcode: 0605770352

Date of Completion: 15-Jul-2025

GP Practice

GP Name:	A Dunsmore	**GP GMC:**	6026670
GP Practice Address:		**GP Practice Code:**	6026670/25686
		GP Clinic Code:	25686
		GP Telephone:	

Patient Demographics

Patient Name:	WYLES, Alan	**Date Of Birth:**	06-May-1977
Patient Address:	2 GORDON SQUARE Stirling Stirlingshire FK8 1FN	**Gender:**	Male
		CHI No:	0605770352
Telephone No:	07835703594		

Admission Details

Patient Location:	FVRH Emergency Department	**Admission Date:**	28-May-2025
Admission Care Provider:	Dr Robert Kalal	**Admission Time:**	13:59
Source Of Admission:	Self referral		

Presenting Complaint

Abdominal pain

Diagnosis

Diagnosis	**Site**	**Laterality**
Other and Unspecified Abdominal Pain		

Discharge Details

Discharge Type:	Admitted	**Discharge Date:**	28-May-2025
Discharge Destination:	Admission to same NHS healthcare provider / hospital - Surgical Ward	**Discharge Time:**	20:09
Referred To:			

Notes for GP

admitted general surgery - see IDL

Person completing record

Authorised by:		**Clinically completed by**	
Name:	Dr Karyn Webster	**Name:**	

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Authorised by		Clinically completed by	
Designation or role:	Consultant	Designation or role:	
Specialty:		Specialty:	
Date completed:	15-Jul-2025		

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
A Dunsmore	GP	Allan Park Medical Practice

THIS IS A RECONSTITUTED DOCUMENT PRINTED FROM EDRM

Immediate Discharge Letter (Authorised)

General Surgery
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

A Dunsmore
Allan Park Medical Practice
19 Allan Park
Stirling
Stirling
FK8 2QD

CHI Barcode: 0605770352

Date of Completion: 01-Jul-2025

Patient Demographics

Patient Name:	WYLES, Alan	**Date Of Birth:**	06-May-1977
Patient Address:	2 GORDON SQUARE Stirling Stirlingshire FK8 1FN	**Gender:**	Male
		CHI No:	0605770352
Telephone No:	07835703594		

GP Practice

GP Name:	A Dunsmore	**GP GMC:**	6026670
GP Practice Address:		**GP Practice Code:**	6026670/25686
		GP Clinic Code:	25686
		GP Telephone:	

Admission Details

Patient Location:	General Surgery	**Admission Care Provider:**	Mr Himanshu Wadhawan
Admission Date:	28-May-2025	**Admission Time:**	20:09
Admission Method:	Emergency Admission, no additional detail added	**Ward:**	FVRH Ward SAU
Source Of Admission:	A&E Ward within Trust		

Discharge Details

Discharge Specialty:	General Surgery	**Discharge Care Provider:**	Mr Himanshu Wadhawan
Discharge Date:	03-Jun-2025	**Ward:**	FVRH Ward B11
Discharge Time:	18:51	**Discharge Destination:**	Private Residence - no additional detail added
Discharge Method:	Regular discharge, no additional detail added		

Clinical Summary including History

Dear Doctor,

Alan Wyles was admitted to FVRH on 28/5/25 with R sided abdominal pain, specifically RIF, and vomiting, and complaining of both diarrhoea and constipation. On examination, tender RUQ and epigastric regions of abdomen noted, no peritonism or guarding. PMHx: prev renal failure, prev IVDU, no previous surgery. Medications: buprenorphine, diazepam. CXR normal. While AUSS concluded sonographic impression of perforated gallbladder wall, gallbladder containing several gallstones (non mobile gallstone within gallbladder neck) with biliary sludge, CT was recommended for clarification, which revealed no evidence of gallbladder perforation, with USS appearances likely accounted for by phyrgian cap. Impacted stone in gallbladder neck noted however. Mr Wyles was struggling with the pain associated and was treated with intravenous antibiotics and analgesia and was later switched to oral antibiotics. Alan later complained of generalised severe headache and photophobia and right-sided paresthesia over deltoid and 4th/5th finger (C8). CT head was requested which revealed no acute intracranial abnormality. On 3/6/25, Alan was planned to be discharged home once medications arrived from pharmacy, however, Alan decided to leave the hosital before they arrived. Planned to be followed-up in 6 weeks in clinic.

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Thank you for your ongoing care of this patient.

Kind regards,
B11 team

Safety Alerts

Nil records exist

Allergy/Intolerance - JAC

Allergy/Intolerance	Reaction
PENICILLINS	Unknown

Allergy records are as recorded at time and date of printing

Medications - JAC

Drug Information:

Drug	Dose	Route	Frequency	GP to Continue	POD	Days Supply
BUPRENORPHINE 2 mg Sublingual Tablets	2mg	Sublingual	ONCE daily at 8am	Y	N	1
BUPRENORPHINE 8 mg Sublingual Tablets	8mg	Sublingual	ONCE daily at 8am	Y	N	1
DIAZEPAM 5 mg Tablets	20mg	Oral	ONCE daily at 8am	Y	N	1
DIAZEPAM 2 mg Tablets	8mg	Oral	ONCE daily at 8am	Y	N	1
PARACETAMOL 500 mg Tablets	1000mg	Oral	FOUR times daily at 8am 12noon 6pm 10pm	N	N	7

Drug Notes:

Drug	Drug Notes
PARACETAMOL 500 mg Tablets	TTO

Additional Medicine Information:

Medicines discontinued during admission (Medicines that patient was recorded as admitted on only)

Drug	Discontinued Reason

Nil records exist

GP Communications:

Usually collects twice weekly from Tesco Pharmacy Stirling - I have contacted them and they will expect him on 5/5/25. Pharmacy please supply x1 day (tomorrow's supply) of buprenorphine and diazepam. Paracetamol TTO from ward stock please. Many thanks.

Outstanding Results -

Responsibility of Hospital

Nil records exist

Person completing record

Authorised by
Name: Dr Kenny Jenkins
Designation or role: Doctor
Specialty:
Date completed: 01-Jul-2025

Clinically completed by
Name: Dr Kenny Jenkins
Designation or role: Doctor
Specialty:

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
A Dunsmore	GP	Allan Park Medical Practice

THIS IS A RECONSTITUTED DOCUMENT PRINTED FROM EDRM

Immediate Discharge Letter (Authorised)

Urology
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

A Dunsmore
Allan Park Medical Practice
19 Allan Park
Stirling
Stirling
FK8 2QD

CHI Barcode: 0605770352

Date of Completion: 27-May-2025

Patient Demographics

Patient Name:	WYLES, Alan	**Date Of Birth:**	06-May-1977
Patient Address:	2 GORDON SQUARE Stirling Stirlingshire FK8 1FN	**Gender:**	Male
		CHI No:	0605770352
Telephone No:	07835703594		

GP Practice

GP Name:	A Dunsmore	**GP GMC:**	6026670
GP Practice Address:		**GP Practice Code:**	6026670/25686
		GP Clinic Code:	25686
		GP Telephone:	

Admission Details

Patient Location:	Urology	**Admission Care Provider:**	Mr James Tweedie
Admission Date:	26-May-2025	**Admission Time:**	20:57
Admission Method:	Emergency Admission, type not known	**Ward:**	FVRH Ward SAU
Source Of Admission:	A&E Ward within Trust		

Discharge Details

Discharge Specialty:	Urology	**Discharge Care Provider:**	Mr James Tweedie
Discharge Date:	27-May-2025	**Ward:**	FVRH Ward B12
Discharge Time:	15:00	**Discharge Destination:**	Private Residence - no additional detail added
Discharge Method:	Regular discharge, no additional detail added		

Clinical Summary Including History

Dear doctor,

Alan Wyles is a 48yo male who was admitted following presentation of right back/flank pain. He was treated with analgesia and IV fluids. CT KUB did not show any pathology. Patient was reviewed by urology and was deemed fit for discharge with encouraged oral fluids.

Nil follow-up.

Thank you for you ongoing support with this patient.

Yours sincerely,
Claire
FY1

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Ward B12 FVRH

IDL written from the clinical notes

Safety Alerts

Nil records exist

Allergy/Intolerance -

Allergy records are as recorded at time and date of printing

Nil records exist

Medications

Drug Information:

Drug	Dose	Route	Frequency	GP to Continue	POD	Days Supply

Nil records exist

Drug Notes:

Drug	Drug Notes

Nil records exist

Additional Medicine Information:

Medicines discontinued during admission (Medicines that patient was recorded as admitted on only)

Drug	Discontinued Reason

Nil records exist

GP Communications:

Outstanding Results -

Responsibility of Hospital

Nil records exist

Person completing record

Authorised by		Clinically completed by	
Name:	Dr Claire MacLeod	Name:	Dr Claire MacLeod
Designation or role:	Doctor	Designation or role:	Doctor
Specialty:		Specialty:	
Date completed:	27-May-2025		

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
A Dunsmore	GP	Allan Park Medical Practice

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Emergency Discharge Letter (Authorised)

FVRH Emergency Department
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

A Dunsmore
Allan Park Medical Practice
19 Allan Park
Stirling
Stirling
FK8 2QD

CHI Barcode: 0605770352

Date of Completion: 26-May-2025

GP Practice

GP Name:	A Dunsmore	**GP GMC:**	6026670
GP Practice Address:		**GP Practice Code:**	6026670/25686
		GP Clinic Code:	25686
		GP Telephone:	

Patient Demographics

Patient Name:	WYLES, Alan	**Date Of Birth:**	06-May-1977
Patient Address:	2 GORDON SQUARE Stirling Stirlingshire FK8 1FN	**Gender:**	Male
		CHI No:	0605770352
Telephone No:	07835703594		

Admission Details

Patient Location:	FVRH Emergency Department	**Admission Date:**	26-May-2025
Admission Care Provider:	Dr Ainsley Heyworth	**Admission Time:**	16:13
Source Of Admission:	999 Emergency Services		

Presenting Complaint

back pain sas corr

Diagnosis

Diagnosis	Site	Laterality
Other and Unspecified Abdominal Pain		

Discharge Details

Discharge Type:	Admitted	**Discharge Date:**	26-May-2025
Discharge Destination:	Admission to same NHS healthcare provider / hospital - Surgical Ward	**Discharge Time:**	20:57
Referred To:			

Notes for GP

Attends with abdominal pain consistent with renal colic, admitted to urology due to pain not well enough controlled for discharge.

Person completing record

Authorised by	Clinically completed by
Name:	**Name:**

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Authorised by	**Clinically completed by**
Designation or role:	**Designation or role:**
Specialty:	**Specialty:**
Date completed: 26-May-2025	

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
A Dunsmore	GP	Allan Park Medical Practice

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Department of Orthopaedic Surgery
Consultant: Mr Ihsan Mahmood
Tel: 01324 566370

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR

NHS Forth Valley

Dr A Dunsmore
Allan Park Medical Practice
19 Allan Park
Stirling
FK8 2QD

Date Dictated: 28/03/2024
Date Typed: 04/04/2024
Our Ref: IM/CG
CHI: 0605770352

Dear Dr A Dunsmore

Alan Wyles DOB: 06-05-1977
2 Gordon Square Raploch Stirling FK8 1FN

This patient failed to attend his appointment today.

Could you please re-refer him if there are ongoing issues.

Thank you.

Yours sincerely

Dictated, not electronically checked by:

Mr Ihsan Mahmood
Consultant Orthopaedic Surgeon

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Hospital use only	Clinic	Day Date	Time	Hospital No.

Date Referral Submitted
(This date is fixed at hospital end):
22-Feb-2024

REFERRAL LETTER

MEDICAL IN CONFIDENCE

0605770352 CHI No: 0605770352

101032249602S
Unique Care Pathway Number: 101032249602S

REFERRAL TO

Trauma and Orthopaedic SurgeryC8 FV Orthopaedic Foot & Ankle	**Consultant / receiving practitioner** and/or **specialty clinic**
Forth Valley Royal Hospital Stirling Road Larbert FK5 4WR	**Hospital and hospital address** Hospital location code: V217H

Urgency of Referral **Routine Orthopaedic Foot & Ankle Referral??**

Administrative Information

Please indicate suitability for Near Me or Telephone consult (preference Near Me):Not suitable for either Phone or Near Me Consultation
Patient has special requirements:No
Religion: Not known
Ethnic Origin: Scottish

PATIENT DETAILS

Surname	Wyles
Forename(s)	Alan
Title	- Sex Male
Previous Surname	-
Date of birth	06-May-1977
CHI no.	0605770352

Patient's address
2 Gordon Square
Raploch
Stirling
Stirlingshire
FK8 1FN

Contact number(s)
Voice: 07597695364

REFERRING HCP DETAILS

Name: MatthewTurner
Organisation name: SMS North (V209B)
Specialty: Substance Use Service (-)

Organisation address
St Ninians Health Centre
FK7 0BS

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CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting Complaint

Description: Previous Right Ankle Fracture

Comment: Previous unstable Right ankle Fracture - attended Fracture Clinic 8/8/2023.
Subsequently declined referral to Physio.
Reviewed at CADS OPC on 2/2/2024.
Reporting ongoing pain and requesting re-referral to Orthopaedics.

Background:
Prescribed Buprenorphine 10mg daily and Diazepam 28mg daily.

Examinations and Investigations

Murmur present:	Not Recorded -
Is a 12 lead ECG:	Not done -
Recent CXR:	Not done -
FBC:	Not Recorded -
Urea and Electrolytes:	Not Recorded -
LFT:	Not Recorded -
TFT:	Not Recorded -
Lipid Profile:	Not Recorded -
Glucose:	Not Recorded -

Reason for referral

Care type requested: Out Patient
Expected outcome: Investigate

Medical history

Active Repeat Therapy

Some Repeats may be Active but not Issued. In these instances, the Date Last Issued field contains the date authorised by the GP.

No current medications recorded

Issued Scripts for Acutes and Inactive Repeats (In last 90 days)

No recent medications recorded

Clinical warnings

Smoking status: Number per day: ? (not known)

Alcohol status: Units per day: ? (not known)

Exercise status: Not Known

Additional relevant information

?

Signature of referring doctor (or other professional) **Date** 22-Feb-2024

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Department of Orthopaedic Surgery
Consultant: Mr Mahmood
Tel: 01324 566945

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR

NHS Forth Valley

Dr A Dunsmore
Allan Park Medical Practice
19 Allan Park
Stirling
FK8 2QD

Date Dictated:	07/09/2023
Date Typed:	01/11/2023
Our Ref:	PZ/KM
CHI:	0605770352

Dear Dr A Dunsmore

Alan Wyles DOB: 06-05-1977
2 Gordon Square Raploch Stirling FK8 1FN

Alan has unfortunately failed to attend his appointment today in our Fracture Clinic. I notice that this was regarding his right ankle fracture.

I am booking him again for a further appointment in one weeks time.

Yours sincerely

Dictated and electronically checked by:

Pamela Zace
Speciality Registrar 3

Chair: Janie McCusker
Chief Executive: Amanda Croft

NHS Forth Valley
Headquarters: Carseview House, Castle Business Park, Stirling, FK9 4SW

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Department of Orthopaedic Surgery
Consultant: Mr Mahmood
Tel: 01324 567634

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR

NHS Forth Valley

Dr A Dunsmore
Allan Park Medical Practice
19 Allan Park
Stirling
FK8 2QD

Date Dictated: 12/09/2023
Date Typed: 29/09/2023
Our Ref: KC/DMcC
CHI: 0605770352

Dear Dr A Dunsmore

Alan Wyles DOB: 06-05-1977
2 Gordon Square Raploch Stirling FK8 1FN

Diagnosis: Unstable right ankle fracture

It has been six weeks since Alan injured his ankle. Originally he was for surgery although he was unreliable and it was difficult to get in touch with him. He did attend the fracture clinic on 8th August where a below elbow cast was applied. Unfortunately Alan missed a few appointments although he returned to the nurse led clinic today where an x-ray was carried out which was satisfactory. The cast was removed and on clinical examination he just showed minor signs of discomfort on palpation to lateral and medial sides of his ankle.

He was given a walker boot to wear for approximately one to two weeks. He maintains he is comfortable in this. I advised him of the importance of physiotherapy. Alan declined a referral and says he will carry out his own physio at home. He has been discharged from the clinic but is well aware to contact us if any issues arise.

Yours sincerely

Dictated and electronically checked by:

Karen Coyle
Staff Nurse

Chair: Janie McCusker
Chief Executive: Amanda Croft

NHS Forth Valley
Headquarters: Carseview House, Castle Business Park, Stirling, FK9 4SW

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THIS IS A RECONSTITUTED DOCUMENT PRINTED FROM EDRM

Department of Orthopaedic Surgery
Consultant: Mr Ihsan Mahmood
Tel: 01324 566945

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR

NHS Forth Valley

Dr A Dunsmore
Allan Park Medical Practice
19 Allan Park
Stirling
FK8 2QD

Date Dictated: 17/08/2023
Date Typed: 06/09/2023
Our Ref: DA/SMcC
CHI: 0605770352

Dear Dr A Dunsmore

Alan Wyles DOB: 06-05-1977
2 Gordon Square Raploch Stirling FK8 1FN

DIAGNOSIS: Right Ankle Fracture
PLAN: Change of Plaster to Below Knee Cast, Non Weight Bearing, VTE Prophylaxis & Follow Up in 3 Week's Time

I reviewed Alan in clinic today. He has sustained a right ankle fracture which was reduced in the Emergency Department. Yesterday's x-rays are promising, however is mortise has not appreciated well because of the plaster, but the talar dome remains well seated. There is no shift on lateral x-ray. The proximal fibula fractures are undisplaced.

Today on examination Alan is still in a below knee plaster. He is weight bearing fully, although he has been advised not to weight bear. He said he is trying his best to bear weight on his right leg.

I had a discussion with Mr Mahmood and we are in agreement that in view of well aligned ankle x-rays, it would be worthwhile continue with conservative treatment.

The plan is to give him a below knee cast and VTE prophylaxis and follow up in 3 week's time with x-ray on arrival. I have reiterated the risks involved with conservative treatment like artiritis and change in position of ankle to Alan he understands that.

Yours sincerely

Electronically dictated, but not checked by;

Dheeraj Attarde
Specialty Doctor

Chair: Janie McCusker
Chief Executive: Cathie Cowan

NHS Forth Valley
Headquarters: Carseview House, Castle Business Park, Stirling, FK9 4SW

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THIS IS A RECONSTITUTED DOCUMENT PRINTED FROM EDRM

Emergency Discharge Letter (Authorised)

FVRH Emergency Department
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept Contact Details:

A Dunsmore
Allan Park Medical Practice
19 Allan Park
Stirling
Stirling
FK8 2QD

CHI Barcode: 0605770352

Date of Completion: 03-Aug-2023

GP Practice

GP Name:	A Dunsmore	**GP GMC:**	6026670
GP Practice Address:		**GP Practice Code:**	6026670/25686
		GP Clinic Code:	25686
		GP Telephone:	

Patient Demographics

Patient Name:	WYLES, Alan	**Date Of Birth:**	06-May-1977
Patient Address:	2 Gordon Square Raploch Stirling Stirlingshire FK8 1FN	**Gender:**	Male
		CHI No:	0605770352
Telephone No:			

Admission Details

Patient Location:	FVRH Emergency Department	**Admission Date:**	02-Aug-2023
Admission Care Provider:	Dr Emma Elliott	**Admission Time:**	23:49
Source Of Admission:	999 Emergency Services		

Presenting Complaint

ankle inj

Diagnosis

Diagnosis	Site	Laterality
ED Injury - bone and joint - Closed fracture		

Procedures

No Procedure Results

Medications

Nil records exist

Discharge Details

Discharge Type:	With follow up	**Discharge Date:**	03-Aug-2023
Discharge Destination:	Private Residence - Usual place of residence	**Discharge Time:**	01:42
Referred To:			

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Notes for GP

In ED last night re ankle fracture which was reduced and placed in cast by Ortho. DC or left without analgeisa and rivaroxaban.

Tonight represents re pain

DC home with naproxen, paracetmaol and rivaroxaban.

Patient declined dihydrocodeine due to subutex.

Dr Ruth Chalmers

Person completing record

Authorised by		Clinically completed by	
Name:	Dr Ruth Chalmers	**Name:**	
Designation or role:	Doctor	**Designation or role:**	
Specialty:		**Specialty:**	
Date completed:	03-Aug-2023		

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
A Dunsmore	GP	Allan Park Medical Practice

THIS IS A RECONSTITUTED DOCUMENT PRINTED FROM EDRM

Department of Orthopaedic Surgery
Staff Nurse: Lynne Faichnie
Tel: 01324 566223

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR

NHS Forth Valley

Mr Alan Wyles
2 Gordon Square
Raploch
Stirling
Stirlingshire
FK8 1FN

Date Dictated: 03/08/2023
Date Typed: 03/08/2023
Our Ref: LF/KM
CHI: 0605770352

Dear Mr Wyles

Alan Wyles DOB: 06-05-1977
2 Gordon Square Raploch Stirling FK8 1FN

We have been trying to contact you with regards to your recent injury but have been unsuccessful.

Could you please contact the Trauma Coordinator or Orthopaedics On Call urgently with regards to your treatment plan on 01324 566000.

Many thanks.

Yours sincerely

Dictated, not electronically checked by:

Lynne Faichnie
Staff Nurse

CC:
Dr A Dunsmore
Allan Park Medical Practice
19 Allan Park
Stirling
FK8 2QD

Chair: Janie McCusker
Chief Executive: Cathie Cowan

NHS Forth Valley
Headquarters: Carseview House, Castle Business Park, Stirling, FK9 4SW

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Emergency Discharge Letter (Authorised)

FVRH Emergency Department
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

A Dunsmore
Allan Park Medical Practice
19 Allan Park
Stirling
Stirling
FK8 2QD

CHI Barcode: 0605770352

Date of Completion: 02-Aug-2023

GP Practice

GP Name:	A Dunsmore	**GP GMC:**	6026670
GP Practice Address:		**GP Practice Code:**	6026670/25686
		GP Clinic Code:	25686
		GP Telephone:	

Patient Demographics

Patient Name:	WYLES, Alan	**Date Of Birth:**	06-May-1977
Patient Address:	2 Gordon Square Raploch Stirling Stirlingshire FK8 1FN	**Gender:**	Male
		CHI No:	0605770352
Telephone No:			

Admission Details

Patient Location:	FVRH Emergency Department	**Admission Date:**	01-Aug-2023
Admission Care Provider:	Dr Emma Elliott	**Admission Time:**	21:04
Source Of Admission:	999 Emergency Services		

Presenting Complaint

ED + Ortho referral from MIU

Diagnosis

Diagnosis	Site	Laterality
ED injury - head injury - Concussion		

Procedures

No Procedure Results

Medications

Nil records exist

Discharge Details

Discharge Type:	With follow up	**Discharge Date:**	02-Aug-2023
Discharge Destination:	Private Residence - Usual place of residence	**Discharge Time:**	01:00
Referred To:			

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Notes for GP

Referred from MIU
Assaulted whilst intoxicated
Sustained R lower limb fractures; seen and treated by orthopedics
CT head clear
Given head injury advice leaflet and discharged

Person completing record

Authorised by		**Clinically completed by**	
Name:		**Name:**	
Designation or role:		**Designation or role:**	
Specialty:		**Specialty:**	
Date completed:	02-Aug-2023		

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
A Dunsmore	GP	Allan Park Medical Practice

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Emergency Discharge Letter (Authorised)

FVRH Emergency Department
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

A Dunsmore
Allan Park Medical Practice
19 Allan Park
Stirling
Stirling
FK8 2QD

CHI Barcode: 0605770352

Date of Completion: 01-Aug-2023

GP Practice

GP Name:	A Dunsmore	**GP GMC:**	6026670
GP Practice Address:		**GP Practice Code:**	6026670/25686
		GP Clinic Code:	25686
		GP Telephone:	

Patient Demographics

Patient Name:	WYLES, Alan	**Date Of Birth:**	06-May-1977
Patient Address:	2 GORDON SQUARE RAPLOCH Stirling Stirlingshire FK8 1FN	**Gender:**	Male
		CHI No:	0605770352
Telephone No:	07597695364		

Admission Details

Patient Location:	FVRH Emergency Department	**Admission Date:**	31-Jul-2023
Admission Care Provider:	Dr Stefano Corrieri	**Admission Time:**	21:50
Source Of Admission:	999 Emergency Services		

Presenting Complaint

assault

Diagnosis

Diagnosis	Site	Laterality
ED diagnosis - Left before clinical assessment		

Procedures

No Procedure Results

Medications

Nil records exist

Discharge Details

Discharge Type:	Patient left before being treated	**Discharge Date:**	31-Jul-2023
Discharge Destination:	Not Known	**Discharge Time:**	22:42
Referred To:			

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Notes for GP

Person completing record

Authorised by		Clinically completed by	
Name:		Name:	
Designation or role:		Designation or role:	
Specialty:		Specialty:	
Date completed:	01-Aug-2023		

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
A Dunsmore	GP	Allan Park Medical Practice

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Emergency Discharge Letter (Authorised)

FVRH Emergency Department
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

A Dunsmore
Allan Park Medical Practice
19 Allan Park
Stirling
Stirling
FK8 2QD

CHI Barcode: 0605770352

Date of Completion: 01-Aug-2023

GP Practice

GP Name:	A Dunsmore	**GP GMC:**	6026670
GP Practice Address:		**GP Practice Code:**	6026670/25686
		GP Clinic Code:	25686
		GP Telephone:	

Patient Demographics

Patient Name:	WYLES, Alan	**Date Of Birth:**	06-May-1977
Patient Address:	2 GORDON SQUARE RAPLOCH Stirling Stirlingshire FK8 1FN	**Gender:**	Male
		CHI No:	0605770352
Telephone No:	07597695364		

Admission Details

Patient Location:	FVRH Emergency Department	**Admission Date:**	31-Jul-2023
Admission Care Provider:	Dr Stefano Corrieri	**Admission Time:**	23:20
Source Of Admission:	Self referral		

Presenting Complaint

head/ankle inj

Diagnosis

Diagnosis	**Site**	**Laterality**
ED diagnosis - Left before clinical assessment		

Procedures

No Procedure Results

Medications

Nil records exist

Discharge Details

Discharge Type:	Patient left before being treated	**Discharge Date:**	31-Jul-2023
Discharge Destination:	Private Residence - Usual place of residence	**Discharge Time:**	23:35
Referred To:			

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Notes for GP

Person completing record

Authorised by		Clinically completed by	
Name:		Name:	
Designation or role:		Designation or role:	
Specialty:		Specialty:	
Date completed:	01-Aug-2023		

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
A Dunsmore	GP	Allan Park Medical Practice

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Emergency Discharge Letter (Authorised)

SCH Minor Injuries
Livilands Gate
Stirling
Stirling
Stirlingshire
FK8 2AU

Dept. Contact Details:

A Dunsmore
Allan Park Medical Practice
19 Allan Park
Stirling
Stirling
FK8 2QD

CHI Barcode: 0605770352

Date of Completion: 01-Aug-2023

GP Practice

GP Name:	A Dunsmore	**GP GMC:**	6026670
GP Practice Address:		**GP Practice Code:**	6026670/25686
		GP Clinic Code:	25686
		GP Telephone:	

Patient Demographics

Patient Name:	WYLES, Alan	**Date Of Birth:**	06-May-1977
Patient Address:	2 Gordon Square Raploch Stirling Stirlingshire FK8 1FN	**Gender:**	Male
		CHI No:	0605770352
Telephone No:			

Admission Details

Patient Location:	SCH Minor Injuries	**Admission Date:**	01-Aug-2023
Admission Care Provider:	Dr Johanna Katai	**Admission Time:**	15:08
Source Of Admission:	Self referral		

Presenting Complaint

right leg/ankle. Head inj

Diagnosis

Diagnosis	Site	Laterality
ED diagnosis - Redirection - ED nurse redirection (as per policy)		

Procedures

No Procedure Results

Medications

Nil records exist

Discharge Details

Discharge Type:	Other	**Discharge Date:**	01-Aug-2023
Discharge Destination:	Other	**Discharge Time:**	20:25
Referred To:			

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Notes for GP

46 yr old man

Head and R ankle injuries
Assaulted last night. Hit to head with bottle. fell to ground. Dazed at time but denies being KO'd. Aware of R lower leg being stamped on.
Attended ED but DNW
Daughter dropped pt off at MIU today - no petrol to take to FVRH

PMH - Drug/alcohol dependancy. Currently on reducing doses of buprenophine and diazepam. Smokes cannabis some evenings. Hep C +ve
DH - A/A
NKDA

Vomited x 3 episodesthis am
Ankle pain ++
Paracetamol taken > 4 hrs ago. Further paracetamol 1g given in MIU

Swelling and abrasion to occiput
C/O tenderness back of neck including c-spine. Moving neck freely
NEWS 0
GCS 15/15

Outwith MIU protocols re HI
Ambulance ordered for < 1 hr - may be longer. ref 10040197

Tender generally R lower leg. Maximally to ankle and proximal to midshaft fibula. No acute tenderness noted to foot or knee
Deoralis pedis present, CRT < 2 secs
Moderate swelling and mild bruising ankle
Mild tingling toes
No wounds

Ix - xray lower leg - maisonneuve #

DW orthopaedics on call - happy with BK backslab
check xray - no apparent change

Patient to be transfered to FV for ED review of Head injury - then orthopaedics to be advised of pt in ED for review/admission
NEWS repeated whilst in MIU

Call from ambulance clinician (approx 1745) to ask re patient's condition. No amb allocatedbut pt 1st in queueafter any999 pts.

? suitablefor PTS - DW Dr Elliot at 1900,as NEWS 0 and 7 hrs after last vomit, then can. No PTS vehicles available.

Amb attended 2000

Person completing record

Authorised by		Clinically completed by	
Name:	Ms Debbie Whyte	Name:	
Designation or role:	Emergency Nurse Practitioner	Designation or role:	
Specialty:		Specialty:	
Date completed:	01-Aug-2023		

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
A Dunsmore	GP	Allan Park Medical Practice

THIS IS A RECONSTITUTED DOCUMENT PRINTED FROM EDRM

Department of Orthopaedic Surgery
Consultant Mr Savaridas
Tel: 01324 567635

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR

NHS Forth Valley

Dr CI Steele
Allan Park Medical Practice
19 Allan Park
Stirling
FK8 2QD

Date Dictated:	14/09/2021
Date Typed:	07/10/2021
Our Ref:	CB/CR
CHI:	0605770352

Dear Dr CI Steele

Alan Wyles DOB: 06-05-1977
2 Gordon Square Raploch Stirling FK8 1FN

Diagnosis: Left scaphoid fracture
Management: Discharged from clinic

We were expecting to see this gentleman in the outpatient clinic and unfortunately he has failed to attend. He will be discharged from follow up at this point however should he have any ongoing problems he can seek re-referral by his GP.

Yours sincerely

Dictated and electronically checked by:

Dr Caitlin Brennan
ST3 in Trauma & Orthopaedics

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Chief Executive: Cathie Cowan

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Department of Orthopaedic Surgery
Consultant: Mr Terence Savaridas
Tel: 01324 567635

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR

NHS Forth Valley

Mr Alan Wyles
2 Gordon Square
Raploch
Stirling
Stirlingshire
FK8 1FN

Date Dictated: 10/08/2021
Date Typed: 12/08/2021
Our Ref: RP/SMcC
CHI: 0605770352

Dear Mr Wyles

I was expecting to see you at the Outpatient clinic today but you failed to attend your appointment. We understand this can be due to a variety of reasons. In accordance with NHS Forth Valley's Access Policy, I am returning you back to the care of your General Practitioner (GP). However, if you contact us within 21 days from the date of your appointment, on **01324 566249,** we will arrange to have you reinstated on the waiting list. If after that period you feel you still require an appointment please arrange this with your GP.

Yours sincerely

Dictated and electronically checked by:

Dr Raju Penematsa
Speciality Doctor

CC

Dr CI Steele
Allan Park Medical Practice
19 Allan Park
Stirling
FK8 2QD

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Department of Orthopaedic Surgery
Consultant: Mr Terence Savaridas
Tel: 01324 567635

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR

NHS
Forth Valley

Dr CI Steele
Allan Park Medical Practice
19 Allan Park
Stirling
FK8 2QD

Date Dictated: 13/07/2021
Date Typed: 30/07/2021
Our Ref: BB/SMcC
CHI: 0605770352

Dear Dr CI Steele

Alan Wyles DOB: 06-05-1977
2 Gordon Square Raploch Stirling FK8 1FN

DIAGNOSIS: Left Scaphoid Fracture
DATE OF INJURY: 20th May 2021
MANGEMENT: Continue in Wrist Splint
REVIEW: 4 Week's Time

I reviewed this patient in the clinic today. He sustained a left scaphoid fracture as well as maxillary fractures following a fall on 20th May 2021. He was initially placed on the list for fixation of the scaphoid. However, this was then postponed because it was felt the maxillofacial injuries should be addressed first. He has seen the Maxillofacial Surgeons who have advised non operative management and the plan is he would be reviewed again in a further 3 week's time.

He still has tenderness in the anatomical snuff box, however, the pain is reduced. He has good range of movement of the wrist. X-rays done today show the fracture line. However, there is some evidence of fracture healing as well.

On review today it appears he is still under the influence of certain substances.

The plan is for him to be reviewed in the clinic in a further 4 week's time with x-ray on arrival. Hopefully by then he will have completed his maxillofacial treatment. We can then discuss the further treatment options for his scaphoid.

Yours sincerely

Dictated and electronically checked by:

Biju Benjamin
Speciality Doctor

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Chief Executive: Cathie Cowan

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Department of Orthopaedic Surgery
Consultant: Mr R A Preiss
Tel: 01324 566820

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR

NHS Forth Valley

Dr CI Steele
Allan Park Medical Practice
19 Allan Park
Stirling
FK8 2QD

Date Dictated:	14/06/2021
Date Typed:	14/06/2021
Our Ref:	CA/Sharon
CHI:	0605770352

Dear Dr Steele

Alan Wyles DOB: 06-05-1977
2 Gordon Square, Stirling FK8 1FN

Diagnosis: **Left scaphoid fracture**
Plan: **Send further appointment**

This gentleman failed to attend his fracture clinic appointment on 14.06.21. Looking back through his notes on Portal I think he was also due in clinic on 25.05.21, however there are no notes & no x-rays to say that he attended this appointment either. The only x-ray we have is from his date of injury on 20.05.21 and he has a left scaphoid fracture.

I will send him a further appointment as this needs to be treated in a cast.

Yours sincerely

Dictated and electronically checked by:

Caroline Atherton
ST5 in Orthopaedics

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Chief Executive: Cathie Cowan

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Department of Orthopaedic Surgery
Consultant: Mr Mujahid A Syed
Tel: 01324 566820

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR

NHS Forth Valley

Dr CI Steele
Allan Park Medical Practice
19 Allan Park
Stirling
FK8 2QD

Date Dictated:	22/06/2021
Date Typed:	23/06/2021
Our Ref:	LR/Sharon
CHI:	0605770352

Dear Dr Steele

Alan Wyles DOB: 06-05-1977
2 Gordon Square Stirling FK8 1FN

Diagnosis: Left scaphoid fracture
Date of injury: 20.05.21
Plan: Add to e-trauma for operative intervention

I reviewed this 44 year old right hand dominant gentleman who is currently unemployed. He sustained the above injury after he was allegedly pushed down a flight of 23 stairs. He sustained an injury to his left wrist and to his mandible and was due to be followed up in our fracture clinic but failed to attend with regards to his scaphoid. I also note that he has failed to attend his Maxillofacial follow-ups also. He advised that he has been having some problems with his mental health but hasn't sought any assistance with this and I also note that he was due to see the Psychiatry Team last week but again failed to attend. He reports that he used to deliberately self-harm as a child but doesn't at present. He denies any elicit substance misuse but does smoke cannabis. He denies alcohol. He has been in a futuro splint since the time of his injury and returns today, almost 5 weeks down the line.

On examination he was neurologically intact in median, radial & ulnar nerve in the left hand. He was tender over the scaphoid at the waist & anatomical snuff box also on compression and also on ulnar abduction of the wrist. He had wrist extension of 30°, flexion of 30° and radial & ulnar abduction were about 15°.

Review of his x-rays today show that his fracture has not united.

I discussed his case with Mr Putti and despite his previous failures to attend, given that this is likely to go on to a non-union he felt that it would be prudent to add him to the etrauma list and to plan for operative intervention. I have explained to the patient what this will entail and that it will be a day case operation and I have taken him through the risks which include infection, non-union, neurovascular injury, pain, stiffness, tendon injury, anaesthetic complications & stiffness. I have advised him that he might be in a plaster cast or splint for a couple of weeks but then we are likely to get him mobilising.

During the consultation he advised that he feels he might be developing an abscess in his left upper jaw as he has lost 3 teeth on the upper & lower jaw. I have advised him that he should have appointment letters from the

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Maxillofacial Team and he needs to contact them in order to get a follow-up appointment arranged.

Once he left the clinic I was mindful that if he does have a mandibular injury then this may affect his ability to have a general anaesthetic. Review of his CT scan shows that he has a comminuted fracture subluxation of the right head & neck of the mandible and he does have some associated dental loss. I spoke to the Maxillofacial Registrar on-call who has advised that they will attempt to contact him and arrange for him to be seen in the clinic tomorrow. We will be in contact with him in due course in relation to his surgery.

Yours sincerely

Dictated and electronically checked by:

Dr Louise Robiati
ST5 in Trauma and Orthopaedics

THIS IS A RECONSTITUTED DOCUMENT PRINTED FROM EDRM

Department of Orthopaedic Surgery
Consultant: Mr A Putti
MBBS,MS(Orth),MCh(Orth),FRCS(Tr&Orth)
Tel: 01324 566945

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR

NHS Forth Valley

Dr CI Steele
Allan Park Medical Practice
19 Allan Park
Stirling
FK8 2QD

Date Dictated: 09/06/2021
Date Typed: 17/06/2021
Our Ref: AP/SMcC
CHI: 0605770352

Dear Dr CI Steele

Alan Wyles DOB: 06-05-1977
2 Gordon Square Stirling FK8 1FN

This gentleman has failed to attend the clinic today. We will send him another appointment in 4-5 day's time.

Yours sincerely

Electronically dictated, but not checked by;

Mr A Putti MBBS,MS(Orth),MCh(Orth),FRCS(Tr&Orth)
Consultant Orthopaedic Surgeon

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Chair: Janie McCusker
Chief Executive: Cathie Cowan

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Emergency Discharge Letter (Authorised)

FVRH Emergency Department
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

CI Steele
Allan Park Medical Practice
19 Allan Park
Stirling
Stirling
FK8 2QD

CHI Barcode: 0605770352

Date of Completion: 20-May-2021

GP Practice

GP Name:	CI Steele	**GP GMC:**	4730343
GP Practice Address:	Allan Park Medical Practice 19 Allan Park Stirling Stirling FK8 2QD	**GP Practice Code:**	4730343/25686
		GP Clinic Code:	25686/1
		GP Telephone:	01786 451375

Patient Demographics

Patient Name:	WYLES, Alan	**Date Of Birth:**	06-May-1977
Patient Address:	2 Gordon Square Stirling FK8 1FN	**Gender:**	Male
		CHI No:	0605770352
Telephone No:			

Admission Details

Patient Location:	FVRH Emergency Department	**Admission Date:**	20-May-2021
Admission Care Provider:	Dr Stephen Feltbower	**Admission Time:**	11:45
Source Of Admission:	Self referral		

Presenting Complaint

jaw pain
bleeding from r ear

Diagnosis

Diagnosis	Site	Laterality
ED injury - bone and joint - Closed fracture		

Procedures

No Procedure Results

Medications

Nil records exist

Discharge Details

Discharge Type:	Patient left before being treated	**Discharge Date:**	20-May-2021
Discharge Destination:	Private Residence - Usual place of residence	**Discharge Time:**	15:40
Referred To:			

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Notes for GP

Dear GP / Max Fax / VFC

States pushed downa flight of stairs a few weeks ago

c/o pain to the right side of his face when eating

loss of several teeth

pain to his left wrist

OE

GCS 15/ well/ walking/ pink/ alert

top to toe

1 - blood dried R ear canal.
2 - tender over right side jaw
3 - generally poor dentition
4 - tender scaphoid left - distal neurovasc intact

CT/ Xray - 1 # right condyl # mandible
2 - scaphoid # Left
(formal reports awaited)

Patient currently has left department - called mobile number, but no response
have referred patient to Max Fax and Orthopaedic VFC

If returns to department please give splint and follow up advice

HEYWORTH EM CONS
6057645

Person completing record

Name:	Dr Sarah Patrick	**Specialty:**	
Designation or role:	Doctor	**Date completed:**	20-May-2021

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
CI Steele	GP	Allan Park Medical Practice

THIS IS A RECONSTITUTED DOCUMENT PRINTED FROM EDRM

Emergency Discharge Letter (Authorised)

SCH Minor Injuries
Livilands Gate
Stirling
Stirling
Stirlingshire
FK8 2AU

Dept. Contact Details:

CI Steele
Allan Park Medical Practice
19 Allan Park
Stirling
Stirling
FK8 2QD

CHI Barcode: 0605770352

Date of Completion: 29-Apr-2021

GP Practice

GP Name:	CI Steele	**GP GMC:**	4730343
GP Practice Address:	Allan Park Medical Practice 19 Allan Park Stirling Stirling FK8 2QD	**GP Practice Code:**	4730343/25686
		GP Clinic Code:	25686/1
		GP Telephone:	01786 451375

Patient Demographics

Patient Name:	WYLES, Alan	**Date Of Birth:**	06-May-1977
Patient Address:	2 Gordon Square Stirling FK8 1FN	**Gender:**	Male
		CHI No:	0605770352
Telephone No:			

Admission Details

Patient Location:	SCH Minor Injuries	**Admission Date:**	29-Apr-2021
Admission Care Provider:	Dr Ainsley Heyworth	**Admission Time:**	11:24
Source Of Admission:	Self referral		

Presenting Complaint

R arm cuts/L arm inj/cuts

Diagnosis

Diagnosis	Site	Laterality
ED diagnosis - Redirection - ED nurse redirection (as per policy)		

Procedures

No Procedure Results

Medications

Nil records exist

Discharge Details

Discharge Type:	Transferred	**Discharge Date:**	29-Apr-2021
Discharge Destination:	Other	**Discharge Time:**	14:03
Referred To:			

THIS IS A RECONSTITUTED DOCUMENT PRINTED FROM EDRM

Notes for GP

PC: head inj, right forearm lacs, left wrist inj

HPC: attends with friend. was at another friends house, came out into close and staets he fell down 24 concrete steps. states he was KO'd, came too at bottom of stairs and states he had blood coming from his right ear at time. unsure how he sustained lacerations to right forearm. c/o bony pain to left wrist

see portal for PMH and meds

O/E: BP 139/80 P 71 SPO2 98%
undistressed. alert. depp full thickness lacs to forearm - delayed presentation for closure as is. left wrsit swollen and tender.evidence of dry blood on outside of right ear. is able to hear. states had LOC.

Advised due to mechanism of inj he needs to be seen by ED doctor. wishes to attend local pharmacy on route for his medication. splint applied to left wrsit and wet swabs applied to right arm lacs. all injuriesfor full assessment in EDfriend will take pt to ED today for review

plan: ED review

Person completing record.

Name:	Ms Gillian Meek	**Specialty:**	
Designation or role:	Emergency Nurse Practitioner	**Date completed:**	29-Apr-2021

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
CI Steele	GP	Allan Park Medical Practice

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Gastroenterology Unit
Tel: 01786 434079
Email: FV-UHB.hepatology@nhs.net

Stirling Health & Care Village
Livilands
Stirling
FK8 2AU

NHS Forth Valley

Hepatology Team

Consultant:	**Dr. Tim Heron; Dr Asma Ahmed**
Clinical Nurse Specialists:	**Lorraine Moffat (Mob: 07823536968)**
	Karen Prentice (Mob: 07919413067)
	Karen Gibb (Mob: 07554469376)
Pathway Administrator:	**Wendy Mitchell (Tel: 01786 434079)**

Mr Alan Wyles
2 Gordon Square
Stirling
FK8 1FN

Date Dictated:	01/02/2021
Date Typed:	02/02/2021
Our Ref:	KG/HF
CHI:	0605770352

Dear Mr Wyles

Unfortunately you have failed to attend for your appointment with the liver nurse on more than one occasion. We have therefore not reappointed you at this time, however if you would like another appointment please contact us on 01786 434079 and this can be arranged.

Yours sincerely

Dictated and electronically checked by:

K. Gibb

Karen Gibb
Nurse Specialist

*** Any results appended to this letter are the responsibility of the secondary care clinicians**

CC:
Dr CI Steele
Allan Park Medical Practice
19 Allan Park
Stirling
FK8 2QD

INVESTORS IN PEOPLE | Gold Until 2021

Chair: Janie McCusker
Chief Executive: Cathie Cowan

Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SW

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FK8 2AU

NHS Forth Valley

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	Karen Prentice (Mob: 07919413067)
	Karen Gibb (Mob: 07554469376)
Pathway Administrator:	**Wendy Mitchell (Tel: 01786 434079)**

Mr Alan Wyles
2 Gordon Square
Stirling
FK8 1FN

Date Dictated:	7/12/2020
Date Typed:	9/12/2020
Our Ref:	KP/HF
CHI:	0605770352

Dear Mr Wyles

You did not attend your appointment with the liver nurses. It is important for your health that we see you in clinic.

I have not made a further appointment for you at present, however I would appreciate it if you could contact us on 01786 434461 or 01786 434079 to arrange a suitable appointment.

Yours sincerely

Dictated and electronically checked by:

Karen Prentice

Karen Prentice
Specialist Nurse

*** Any results appended to this letter are the responsibility of the secondary care clinicians**

CC:
Dr Ci Steele
Allan Park Medical Practice
19 Allan Park
Stirling
FK8 2QD

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Gastroenterology Unit
Tel: 01786 434079
Email: FV-UHB.hepatology@nhs.net

Stirling Health & Care Village
Livilands
Stirling
FK8 2AU

NHS Forth Valley

Hepatology Team

Consultant:	**Dr. Tim Heron; Dr Asma Ahmed**
Clinical Nurse Specialists:	**Lorraine Moffat (Mob: 07823536968)**
	Karen Prentice (Mob: 07919413067)
	Karen Gibb (Mob: 07554469376)
Pathway Administrator:	**Wendy Mitchell (Tel: 01786 434079)**

Dr Ci Steele
Allan Park Medical Practice
19 Allan Park
Stirling
FK8 2QD

Date Dictated: 11/11/2020
Date Typed: 18/11/2020
Our Ref: KP/HFHF
CHI: 0605770352

Dear Dr Ci Steele

Alan Wyles DOB: 06-05-1977
2 Gordon Square Stirling FK8 1FN

Diagnosis: Hepatitis C PCR positive

Mr Wyles was referred to our service following his recent appointment with Dr Pye. Mr Wyles had previously been diagnosed with Hepatitis C in May 2019 and had a Hep C genotype done in June 2019 which showed genotype 3. Unfortunately due to Mr Wyles situation at the time due to being chaotic with drug use and in and out of custody, he was unable to access treatment at that time. Mr Wyles had been contacted via telephone today and he tells me he is currently doing well, he states he has been drug free for several months now and is in a more positive place. He feels that he is keen to address his Hepatitis C. On chatting with Mr Wyles he tells me he has already been given lots of information about Hepatitis C disease progression, risk behaviours and avoiding risk behaviours and did not wish to discuss any more today. He was keen to discuss treatment. I informed him that we need to have an up to date assessment of his liver done including bloods and fibroscan and we have arranged an appointment for him to attend Stirling Community Hospital on Monday 16th November to have these done. I have explained to Mr Wyles that once we have the results of these we will then review him at our Multidisciplinary Team Meeting and a decision will be made at that point.

Previous Medical History
Manic depression
Social anxiety
Violent tendencies (although patient believes that he no longer has these issues).

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Chief Executive: Cathie Cowan

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Current Medication
Diazepam
Methadone
Over the counter: nil
Illicit: Cannabis

We will inform you of the outcome of Mr Wyles review at MDT.

Yours sincerely

Dictated and electronically checked by:

Karen Prentice

Karen Prentice
Specialist Nurse

*** Any results appended to this letter are the responsibility of the secondary care clinicians**

CC: Dr Richard Pye, Consultant Psychiatrist, SMS

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Emergency Discharge Letter (Authorised)

SCH Minor Injuries
Livilands Gate
Stirling
Stirling
Stirlingshire
FK8 2AU

Dept. Contact Details:

CI Steele
Allan Park Medical Practice
19 Allan Park
Stirling
Stirling
FK8 2QD

CHI Barcode: 0605770352

Date of Completion: 12-May-2020

GP Practice

GP Name:	CI Steele	**GP GMC:**	4730343
GP Practice Address:	Allan Park Medical Practice 19 Allan Park Stirling Stirling FK8 2QD	**GP Practice Code:** **GP Clinic Code:** **GP Telephone:**	4730343/25686 25686/1 01786 451375

Patient Demographics

Patient Name:	WYLES, Alan	**Date Of Birth:**	06-May-1977
Patient Address:	Springkerse House Springkerse Road Stirling FK7 7SN	**Gender:** **CHI No:**	Male 0605770352
Telephone No:	07907702872		

Admission Details

Patient Location:	SCH Minor Injuries	**Admission Date:**	12-May-2020
Admission Care Provider:	Dr Laura Muir	**Admission Time:**	09:08
Source Of Admission:	Other		

Presenting Complaint

l little finger lac

Diagnosis

Diagnosis	Site	Laterality
ED injury - wound - Laceration Open Wound of Finger(S) With Damage to Nail		

Procedures

No Procedure Results

Medications

Nil records exist

Discharge Details

Discharge Type:	With no follow up	**Discharge Date:**	12-May-2020
		Discharge Time:	10:03

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Discharge Destination:	Private Residence - Usual place of residence
Referred To:	

Notes for GP

Person completing record

Name:	Ms Angela Cunningham	**Specialty:**	
Designation or role:	Emergency Nurse Practitioner	**Date completed:**	12-May-2020

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
CI Steele	GP	Allan Park Medical Practice

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Immediate Discharge Letter

NHS Forth Valley

Hospital: Forth Valley Royal Hospital, Larbert
Consultant: Hargreaves, Dr Allister
Specialty: General Medicine
Tel: 01324 566000
Discharging Ward: FVRH - AAU-2

GP Details		Patient Details		Admission Details	
Practice Code:	25864	Patient CHI No:	0605770352	Admission Date:	23/02/2019
		Patient Hospital No:	S278537		
GP Name:	HB Non Principal One	Surname:	Wyles	Admission Type:	Emergency - Non-Injury (e.g. Stroke, MI, Ruptured Appendix)
Address:	Kersiebank Medical Practice, Health Centre, Kersiebank Avenue, Grangemouth, FK3 9EW	Forename:	Alan	Presenting Complaint:	Overdose and Poisoning
		Date of Birth:	06/05/1977		
		Address:	13C Kingseat Avenue, Grangemouth, Stirlingshire, FK3 0AA	Discharge Date:	24/02/2019
				Discharge To:	Private Residence - No Additional Detail

Diagnosis/Problem List

Xa638 - Accidental heroin overdose

Additional comment (Progress, Investigations, Procedures, Complications etc)

Found by SAS with reduced GCS having taken Heroin. Patient refused to engage with medical staff but had no apparent medical reason to be kept in hopsital. Slept overnight and then was dicharged in the am with GCS 15/15 and a normal examination.

Results Outstanding (Y/N) If yes, give details:	No

Information to patient/carer (Y/N):	Patient: Yes Carer (if applicable):

Follow up arrangements

There are no Reviews planned

Authorisor's name:	Dr M Finzel	Authorisor's Signature:
Authorisor's grade:	FY1	
Read/Approved by:		
Date:	07/03/2019	

Discharge Ward Nurse:	

Validation/Contact Name: Hargreaves, Dr Allister

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Name: Alan Wyles

THIS IS THE FINAL DOCUMENT
CHI: 0605770352

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Forth Valley Acute Hospitals Acute Division Medications Discharge Summary			
Name:	Alan Wyles	**Patient's Tel No:**	
Address:	13C Kingseat Avenue, Grangemouth, Stirlingshire, FK3 0AA	**Patient's Tel Eve:**	07731917911
Admission Date:	23/02/2019	**Discharge Date:**	24/02/2019

PATIENT ALERTS

Alert Group	Alert	Alert Comment	When Added	Added By

PATIENT DRUG REACTIONS

penicillin - Adverse Reaction - kidney pain

CURRENT PRESCRIPTION (all medicines currently prescribed) **e.g. clinical indication for prescription monitoring*

MEDICINES DISCONTINUED

Nurse check on discharge:

Signature 1: Signature 2:

Name: Alan Wyles **CHI:** 0605770352

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NHS Forth Valley

NHS Forth Valley Radiology Report

Patient Name:	Wyles, Alan (Mr)	Exam Date:	02/06/2025
Patient ID:	0605770352	Consultant:	KYNASTON MR J CONS GEN SURG
Patient Date of Birth:	06/05/1977	Report Date and Time:	02/06/2025 17:02:17
Patient Address	2 GORDON SQUARE STIRLING STIRLINGSHIRE FK8 1FN	Referring Dept/Location:	FV WARD B 11

Accession: V214031846101, Examination Date: 02/06/2025, Examination: CT Head:

Indication:
Clinical Details :
48M a/w impacted stone in gallbladder neck. Complaining of generalised severe headache and photophobia. Right sided paraesthesia over deltoid and 4th/5th finger (C8). PMH previous IVDU
Provisional Diagnosis :
?intracranial haemorrhage/stroke

Bleep - 1290

Findings:
Noncontrast CT head. Comparison to previous dated 01/08/2023.

No mass, haemorrhage or collection. Normal CSF space configuration. No large vessel territory acute infarct.

Unremarkable skull vault and skull base. Mucoperiosteal disease of the ethmoid sinuses.

Conclusion:
No acute intracranial abnormality.

Final Report By: James Vassallo Consultant Radiologist GMC 7545066 at 02/06/2025 17:02:17
Email Address: **james.vassallo@nhs.scot**

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NHS Forth Valley

NHS Forth Valley Radiology Report

Patient Name:	Wyles, Alan (Mr)	Exam Date:	28/05/2025
Patient ID:	0605770352	Consultant:	NIMMO E ED CONS
Patient Date of Birth:	06/05/1977	Report Date and Time:	29/05/2025 09:01:41
Patient Address	2 GORDON SQUARE STIRLING STIRLINGSHIRE FK8 1FN	Referring Dept/Location:	FV EMERGENCY DEPT

Accession: V214030809501, Examination Date: 28/05/2025, Examination: XR Chest:

Indication:
Clinical Details :
abdominal pain + guarding, erect CXR please ?pneumoperitoneum thank you
Provisional Diagnosis :
?pneumoperitoneum

Findings:
PA chest
-
Comparison is made with chest radiographs dated 02/05/2018 and 19/09/2017.
-
Cardiomediastinal contours are within normal limits.
-
Lungs and pleural spaces are grossly clear.
-
No subdiaphragmatic free air evident to indicate perforation.
-
Unremarkable bony thorax.
-
No significant interval change.
-

Final Report By: Jonathan Sharkey-Mayers Reporting Radiographer HCPC RA78096 at 29/05/2025 09:01:41 Email Address: **jonathan.mayers@nhs.scot.**

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NHS Forth Valley

NHS Forth Valley Radiology Report

Patient Name:	Wyles, Alan (Mr)	Exam Date:	29/05/2025
Patient ID:	0605770352	Consultant:	CANNINGS MISS E CONS SURGN
Patient Date of Birth:	06/05/1977	Report Date and Time:	29/05/2025 10:26:22
Patient Address	2 GORDON SQUARE STIRLING STIRLINGSHIRE FK8 1FN	Referring Dept/Location:	SURGICAL ADMISSIONS UNIT

Accession: V214030855501, Examination Date: 29/05/2025, Examination: US Abdomen:

Indication:
Clinical Details :
48 y o a/w RIF pain, vomiting. Bloods nil acute
Provisional Diagnosis :
?gallstones

Bleep - 1657

Findings:
Sonographic impression of perforation gallbladder wall within the fundal portion. The remaining identified gallbladder wall appears thin with the gallbladder containing several gallstones (non mobile gallstone within gallbladder neck) with biliary sludge. The common duct is of a normal calibre with no intrahepatic duct dilatation.

The liver appears diffusely echobright suggestive of fatty infiltration/parenchymal disease. Small section of focal fatty sparing adjacent to porta hepatis. No solid abnormality identified. Patent portal vein with antegrade flow. No ascitic free fluid. The spleen is not enlarged.

The visualised pancreas, both kidneys and aorta appear grossly normal.

Comment: Sonographic impression of perforated gallbladder wall. As per consultant Radiologist Dr Coad a CT scan should be requested for clarification. Gallbladder contains several gallstones with biliary sludge. Normal biliary tree.

This report requires """further action by the referrer"""

"""The referring team will be informed"""

Preliminary Report By: Lynne Cassidy Sonographer HCPC RA39745 at 29/05/2025 09:51:18.

Final Report By: Lynne Cassidy Sonographer HCPC RA39745 at 29/05/2025 10:26:22 Email Address: **lynne.cassidy3@nhs.scot.**

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NHS Forth Valley

NHS Forth Valley Radiology Report

Patient Name:	Wyles, Alan (Mr)	Exam Date:	29/05/2025
Patient ID:	0605770352	Consultant:	CANNINGS MISS E CONS SURGN
Patient Date of Birth:	06/05/1977	Report Date and Time:	29/05/2025 16:51:08
Patient Address	2 GORDON SQUARE STIRLING STIRLINGSHIRE FK8 1FN	Referring Dept/Location:	SURGICAL ADMISSIONS UNIT

Accession: V214030953801, Examination Date: 29/05/2025, Examination: CT Abdomen/Pelvis With Contrast:

Indication:
Clinical Details :
48 y o a/w RUQ pain, vomiting. Inflammatory markers N. US abdo showed perforated gallbladder. CT required for further clarification
Provisional Diagnosis :
?perforated gallbladder

Bleep - 1657

Findings:
Reference made to previous CT 27/05/2025 and ultrasound and 29/05/2025
-
Mildly thick-walled gallbladder. CT evaluation limited as gallbladder partially collapsed. The abnormality on ultrasound I think is accounted for by a very small phygrian cap which was evident on a prior CT from 4/3/16. No pericholecystic inflammatory fat stranding. No convincing gallbladder perforation at present.
Large stone at the gallbladder neck which may be contributing to symptoms.
No intra or extrahepatic biliary duct dilatation.
-
Otherwise normal liver parenchyma. No abdominal free fluid or gas.
Normal spleen, pancreas, kidneys and adrenals.
-
Mild sigmoid diverticular disease. Otherwise normal appearance of the unprepared small and large bowel. Normal appendix.
-
Several pulmonary cysts at the lung bases, including dependently. These are longstanding.
-
No lymphadenopathy.
No skeletal abnormality.
-
Opinion:
No evidence of gallbladder perforation. Appearances on ultrasound I think are accounted for by phrygian cap. Impacted stone in the gallbladder neck.

Preliminary Report By: Scott Mckinnon Radiologist GMC 7582396 at 29/05/2025 16:24:15.

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NHS Forth Valley

Final Report By: Amy Barrett Consultant Radiologist GMC 616001 at 29/05/2025 16:51:08 Email Address: amy.barrett@nhs.scot.

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NHS Forth Valley

NHS Forth Valley Radiology Report

Patient Name:	Wyles, Alan (Mr)	Exam Date:	27/05/2025
Patient ID:	0605770352	Consultant:	TWEEDLE MR J UROLOGY
Patient Date of Birth:	06/05/1977	Report Date and Time:	27/05/2025 12:12:50
Patient Address	2 GORDON SQUARE STIRLING STIRLINGSHIRE FK8 1FN	Referring Dept/Location:	FV SURGICAL ASSESSMENT UNIT

Accession: V214030193201, Examination Date: 27/05/2025, Examination: CT KUB:

Indication:
Clinical Details :
48 y/o M - a/w 4 day hx. of r flank pain radiating from back, previous AKI requiring dialysis for 4 months 2011, requiring admission due to pain, urine dip showed trace of blood,l u&es N
Provisional Diagnosis :
?renal stone

Bleep - 1093

Noncontrast reduced dose CT KUB stone protocol:

Comparison with CT abdomen pelvis 04/03/2016.

No obstructive uropathy, no renal tract/ureteric or bladder calculi.

Uncomplicated sigmoid diverticulosis.

No other gross pathology demonstrated on this renal calculi specific study.

Final Report By: Christopher Smith Consultant Radiologist GMC 6099441 at 27/05/2025 12:12:50
Email Address: **christopher.smith1@nhs.scot**

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NHS Forth Valley

NHS Forth Valley Radiology Report

Patient Name:	Wyles, Alan (Mr)	Exam Date:	12/09/2023
Patient ID:	0605770352	Consultant:	MAHMODD, DR I; CONS ORTHO SURG
Patient Date of Birth:	06/05/1977	Report Date and Time:	13/09/2023 08:41:54
Patient Address:	2 GORDON SQUARE RAPLOCH STIRLING FK8 1FN	Referring Dept/Location:	ORTHOPAEDIC OPD

Accession: V213875559301, Examination Date: 12/09/2023, Examination: XR Ankle Rt:

Indication:
Clinical Details :
right ankle #
Provisional Diagnosis :
position check in cast

Findings:
Images as requested. If formal report required please contact Radiology Department

Final Report By: Michelle Davidson Radiology Secretary at 13/09/2023 08:41:54 Email Address: **michelle.davidson@nhs.scot.**

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NHS Forth Valley

NHS Forth Valley Radiology Report

Patient Name:	Wyles, Alan (Mr)	Exam Date:	17/08/2023
Patient ID:	0605770352	Consultant:	MAHMODD, DR I, CONS ORTHO SURG
Patient Date of Birth:	06/05/1977	Report Date and Time:	18/08/2023 08:47:58
Patient Address	2 GORDON SQUARE RAPLOCH STIRLING FK8 1FN	Referring Dept/Location:	ORTHOPAEDIC OPD

Accession: V213869738701, Examination Date: 17/08/2023, Examination: XR Tibia/Fibula (Lower Leg) Rt:

Indication:
Clinical Details :
right ankle #proximal fibula #
Provisional Diagnosis :
healing progress

Findings:
Images as requested. If formal report required please contact Radiology Department

Final Report By: Michelle Davidson Radiology Secretary at 18/08/2023 08:47:58 Email Address: **michelle.davidson@nhs.scot**

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NHS Forth Valley

NHS Forth Valley Radiology Report

Patient Name:	Wyles, Alan (Mr)	Exam Date:	01/08/2023
Patient ID:	0605770352	Consultant:	TUCK DR I CONS ED
Patient Date of Birth:	06/05/1977	Report Date and Time:	02/08/2023 09:54:05
Patient Address	2 GORDON SQUARE RAPLOCH STIRLING FK8 1FN	Referring Dept/Location:	STG COMM HOSP MINOR INJURIES UNIT

Accession: V203866026201, Examination Date: 01/08/2023, Examination: XR Ankle Rt:

Indication:
Clinical Details :
Post application of BK backslab for unstable ankle
Provisional Diagnosis :
Position check please

Findings:
Right ankle:

-

Comparison is made with right tibia-fibula radiographs dated 01/08/2023 at 16:18.

-

Right ankle immobilised and cast as shown.

-

The position of the fractures through the right distal tibia appear relatively unchanged when compared with previous images.

-

Persistent, mild lateral talar shift evident.

-

Final Report By: Jonathan Mayers Reporting Radiographer HCPC RA78096 at 02/08/2023 09:54:05
Email Address: **jonathan.mayers@nhs.scot.**

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NHS Forth Valley

NHS Forth Valley Radiology Report

Patient Name:	Wyles, Alan (Mr)	Exam Date:	02/08/2023
Patient ID:	0605770352	Consultant:	SYED, DR M A, CONS ORTHOPDCS
Patient Date of Birth:	06/05/1977	Report Date and Time:	02/08/2023 11:11:44
Patient Address	2 GORDON SQUARE RAPLOCH STIRLING FK8 1FN	Referring Dept/Location:	FV EMERGENCY DEPT

Accession: V213866068101, Examination Date: 02/08/2023, Examination:
XR Ankle Rt
XR Tibia/Fibula (Lower Leg) Rt:

Indication:
Clinical Details :
tib fib # for recasted after push for repeat xray ?position
Provisional Diagnosis :
?position of fracture

Bleep - 67686

Findings:
Right tibia-fibula:

-

Comparison is made with right ankle and right tibia-fibula radiographs dated 01/08/2093.

-

Right tibia-fibula immobilised and cast as shown.

-

The position of the fractures through the distal tibia and proximal fibula appear relatively well reduced when compared with previous images.

-

The previously seen lateral talar shift also appears well reduced.
Tibiotalar joint alignment reestablished.

-

Final Report By: Jonathan Mayers Reporting Radiographer HCPC RA78096 at 02/08/2023 11:11:44
Email Address: **jonathan.mayers@nhs.scot.**

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NHS Forth Valley

NHS Forth Valley Radiology Report

Patient Name:	Wyles, Alan (Mr)	Exam Date:	01/08/2023
Patient ID:	0605770352	Consultant:	TUCK DR I CONS ED
Patient Date of Birth:	06/05/1977	Report Date and Time:	01/08/2023 16:28:24
Patient Address	2 GORDON SQUARE RAPLOCH STIRLING FK8 1FN	Referring Dept/Location:	STG COMM HOSP MINOR INJURIES UNIT

Accession: V203866002901, Examination Date: 01/08/2023, Examination: XR Tibia/Fibula (Lower Leg) Rt:

Indication:
Clinical Details :
Assaulted last night when another man stamped onto R lower leg/ankle. Tender medial/lateral malleoli and proximal to midshaft fibula
Provisional Diagnosis :
?#

Findings:
Left tibia-fibula:

-
Minimally displaced avulsion fracture noted through the distal tip of the right medial malleolus.
-
Additional note of a minimally displaced, oblique, intra-articular fracture through the posterior malleolus of the right distal tibia.
-
Additional note of minimally displaced spiral fracture through the neck of the right proximal fibula.
-
Possible, mild lateral talar shift also evident.
-

Final Report By: Jonathan Mayers Reporting Radiographer HCPC RA78096 at 01/08/2023 16:28:24
Email Address: **jonathan.mayers@nhs.scot**.

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NHS Forth Valley

NHS Forth Valley Radiology Report

Patient Name:	Wyles, Alan (Mr)	Exam Date:	01/08/2023
Patient ID:	0605770352	Consultant:	ELLIOTT, DR E, CONS ED
Patient Date of Birth:	06/05/1977	Report Date and Time:	01/08/2023 21:59:07
Patient Address:	2 GORDON SQUARE RAPLOCH STIRLING FK8 1FN	Referring Dept/Location:	FV EMERGENCY DEPT

Accession: V213866064301, Examination Date: 01/08/2023, Examination: CT Head:

Indication:
Clinical Details :
DTS- Alledged assault, evidence of being beaten around head. Vomiting x3 separate timesAmnesia to event ?LOCOngoing headache
Provisional Diagnosis :
Traumatic ICH

Findings:
Clinical Information: DTS- Alledged assault, evidence of being beaten around head. Vomiting x3 separate timesAmnesia to event ?LOCOngoing headache
Provisional Diagnosis :
Traumatic ICH

Name of Procedure and Technique: CT head

Findings:
No evidence of intra or extra-axial haemorrhage or recent established ischaemic lesion.
Normal ventricular system and cisternal spaces.
No cranial vault, skull base fracture or destructive bone pathology.
The right mandibular condyle appears subluxated with deformity, however the appearances are likely chronic ? Old injury.
Moderate right maxillary sinus and ethmoidal sinuses mucosal thickening. The reminder paranasal sinuses and mastoid cells are well pneumatised without fluid levels.

Conclusion:
No acute intracranial pathology.
The right mandibular condyle appears subluxated with deformity, however the appearances are likely chronic ? Old injury. Correlation with PMH is advised.

Dr Dimitrios Ntountoulakis, Consultant Radiologist, Medica Reporting Ltd
GMC: 6132140

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NHS Forth Valley

If you are a clinician and have a query on this report, please call Medica on 01424 377 901 or email clinical@medicagroup.co.uk

Final Report By: Dimitrios Ntountoulakis Medica Radiologist GMC 6132140 at 01/08/2023 21:59:07

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Medication Administration Profile

Type of Report: Since Admission
Requested By: JRAE2
Current Status: Discharged

Admitted On: 28-May-2025
Discharged On: 3-Jun-2025 Patient Note(s) exist

Patient: **Wyles, Alan**
Hospital No: 0605770352 National No: 060 577 0352
Date of Birth: 6-May-1977
Allergies: PENICILLINS

Weight: kg
Height: cm
Body Surface: m²

Sensitivities:

Episode History:
Consultant: DR HIMANSHU WADHAWAN from 28-May-2025 20:09 to 3-Jun-2025 18:52

Transfer History:
Admitted to Ward: SAU (FVRH) on 28-May-2025 at 20:09
Transferred to Ward B1i on 29-May-2025 at 17:06

Key: ! - denotes unverified order at the time of charting or administration. * - denotes charting was overridden. ? - denotes witnessable administration not witnessed. [@@] - denotes patient was/is on Short Term Leave. [+] - Order Notes exist % - Part Dose (see PAC) <MOD> - Order Modified <DIS> - Order Discontinued <STOPPED> - Order Stopped <RES> - Order Resumed <SUS> - Order Suspended RS - Result <TASK> - Order Suspended (task non-completion) AC - Recommended Action

DRUG DOSE,ROUTE & FREQUENCY/INTERVAL/RATE *VERIFIER*	28-May-2025 Wednesday	29-May-2025 Thursday	30-May-2025 Friday	31-May-2025 Saturday	1-Jun-2025 Sunday	2-Jun-2025 Monday	3-Jun-2025 Tuesday
TEDS Stocking 1 unit Topical 24HO DR ALICE BUCHANAN-SMITH Start Date/Time 28-May-2025 21:26	! 21:45 SWAL1	! 21:10 JHAL	! 21:26 [Other - record in nur AEAP	! 21:26 [Other - record in nur AEAP	! 21:26 [Other - record in nur AEAP	! 21:26 [Patient Refused] KREV	
ENOXAPARIN (INHIXA) 40 mg Injection 40 mg SC Inj 1X18 DR ALICE BUCHANAN-SMITH Start Date/Time 29-May-2025 18:00		! 17:47 SBAI1	! 18:16 SBAI1	! 18:06 TSTA	! 17:37 TSTA	! 17:23 TSTA	! 18:00 [Absent from ward] TSTA
PARACETAMOL 500 mg Tablets OR 1000 mg Oral 4X DR ALICE BUCHANAN-SMITH Start Date/Time 28-May-2025 22:00	! 21:42 SWAL1	! 08:06 DVEI ! 12:36 RMUI ! 17:44 SBAI1 ! 21:50 [Alternative administ JHAL	! 07:56 [Alternative administ AMCA5 ! 12:00 [Patient Refused] SBAI1 ! 16:48 [Alternative administ SBAI1 ! 21:47 AEAP	! 07:55 TSTA ! 12:27 TSTA ! 17:55 TSTA ! 22:06 AEAP TSTA	! 07:34 TSTA ! 12:32 TSTA ! 17:37 [Alternative administ TSTA ! 22:01 AEAP	! 08:18 TSTA ! 12:27 TSTA ! 17:22 TSTA ! 21:45 KREV	! 07:05 KREV ! 12:41 TSTA ! 18:00 [Absent from ward] TSTA
PARACETAMOL 1000 mg in 100mL Intravenous Infusion 1000 mg IV Inf 4X DR ALICE BUCHANAN-SMITH Start Date/Time 28-May-2025 22:00	! 21:42 [Alternative administered] SWAL1	! 08:06 [Alternative administ DVEI ! 12:36 [Alternative administ RMUI ! 17:44 [Alternative administ SBAI1	! 07:56 AMCA5 SBAI1 ! 12:00 [Patient Refused] SBAI1 ! 16:48 SBAI1 GMAH	! 07:55 [Alternative administ TSTA ! 12:27 [Alternative administ TSTA ! 17:55 [Alternative administ TSTA	! 07:34 [Alternative administ TSTA ! 12:32 [Alternative administ TSTA ! 17:37 TSTA LMCC14	! 08:18 [Alternative administ TSTA ! 12:27 [Alternative administ TSTA ! 17:22 [Alternative administ TSTA	! 07:05 [Alternative administ KREV ! 12:41 [Alternative administ TSTA ! 18:00 [Absent from ward] TSTA

Medication Administration Profile

Patient: **Wyles, Alan**
Hospital No: 0605770352 National No: 060 577 0352
Date of Birth: 6-May-1977
Allergies: PENICILLINS

Weight: kg
Height: cm
Body Surface: m²

Type of Report: Since Admission
Requested By: JRAE2
Current Status: Discharged

Admitted On: 28-May-2025
Discharged On: 3-Jun-2025 Patient Note(s) exist

Sensitivities:

Key: ! - denotes unverified order at the time of charting or administration. * - denotes charting was overridden. ? - denotes witnessable administration not witnessed. [@@] - denotes patient was/is on Short Term Leave. [+] - Order Notes exist % - Part Dose (see PAC) <MOD> - Order Modified <DIS> - Order Discontinued <STOPPED> - Order Stopped <RES> - Order Resumed <SUS> - Order Suspended RS - Result <TASK> - Order Suspended (task non-completion) AC - Recommended Action

DRUG DOSE,ROUTE & FREQUENCY/INTERVAL/RATE *VERIFIER*	28-May-2025 Wednesday	29-May-2025 Thursday	30-May-2025 Friday	31-May-2025 Saturday	1-Jun-2025 Sunday	2-Jun-2025 Monday	3-Jun-2025 Tuesday
		! 21:50 JHAL	! 21:47 [Alternative administ	! 22:06 [Alternative administ	! 22:01 [Alternative administ	! 21:45 [Alternative administ	
		SGAI1	AEAP	AEAP	AEAP	KREV	
DIAZEPAM 5 mg Tablets 20 mg Oral 1X08 DR ALICE BUCHANAN-SMITH Start Date/Time 29-May-2025 08:00		<SUS> ABUC3 <RES> DROM	! 08:03 SBAI1	! 07:55 TSTA LMCC14	! 07:35 TSTA	! 08:18 TSTA	! 07:59 TSTA
DIAZEPAM 2 mg Tablets 8 mg Oral 1X08 DR ALICE BUCHANAN-SMITH Start Date/Time 29-May-2025 08:00		<SUS> ABUC3 <RES> DROM	! 08:03 SBAI1	! 07:56 TSTA LMCC14	! 07:35 TSTA	! 08:19 TSTA	! 07:58 TSTA
BUPRENORPHINE 8 mg Sublingual Tablets 8 mg Sublingual 1X08 DR ALICE BUCHANAN-SMITH Start Date/Time 29-May-2025 08:00	<SUS> ABUC3	<RES> DROM	! 07:55 AMCA5 SBAI1	! 07:56 TSTA LMCC14	! 07:32 TSTA LMCC14	! 08:13 TSTA JFOR5	! 07:48 TSTA GMAH
BUPRENORPHINE 2 mg Sublingual Tablets 2 mg Sublingual 1X08 DR ALICE BUCHANAN-SMITH Start Date/Time 29-May-2025 08:00	<SUS> ABUC3	<RES> DROM	! 07:55 AMCA5 SBAI1	! 07:56 TSTA LMCC14	! 07:30 TSTA LMCC14	! 08:13 TSTA JFOR5	! 07:48 TSTA GMAH

Medication Administration Profile

Patient: **Wyles, Alan**
Hospital No: 0605770352 National No: 060 577 0352
Date of Birth: 6-May-1977
Allergies: PENICILLINS

Weight: kg
Height: cm
Body Surface: m²

Type of Report: Since Admission
Requested By: JRAE2
Current Status: Discharged

Admitted On: 28-May-2025
Discharged On: 3-Jun-2025 Patient Note(s) exist

Sensitivities:

Key: ! - denotes unverified order at the time of charting or administration. * - denotes charting was overridden. ? - denotes witnessable administration not witnessed. [@@] - denotes patient was/is on Short Term Leave. [+] - Order Notes exist % - Part Dose (see PAC) <MOD> - Order Modified <DIS> - Order Discontinued <STOPPED> - Order Stopped <RES> - Order Resumed <SUS> - Order Suspended RS - Result <TASK> - Order Suspended (task non-completion) AC - Recommended Action

DRUG DOSE,ROUTE & FREQUENCY/INTERVAL/RATE *VERIFIER*	28-May-2025 Wednesday	29-May-2025 Thursday	30-May-2025 Friday	31-May-2025 Saturday	1-Jun-2025 Sunday	2-Jun-2025 Monday	3-Jun-2025 Tuesday
GENTAMICIN IV Adult (as per online calculator) 1 DOSE as PAPER CH IV Inf 24H DR DARIA ROMANYUC Start Date/Time 29-May-2025 10:52 Stop Date/Time: 1-Jun-2025 12:21		! 11:16 RMUI CMAY	! 12:44 AMCA5 SBAI1	! 13:19 TSTA RTAD	! 10:52 [Drug discontinued] AALA2 <DIS> AALA2		
METRONIDAZOLE 400 mg Tablets 400 mg Oral 3X08/14/20 DR DARIA ROMANYUC Start Date/Time 29-May-2025 14:00 Stop Date/Time: 1-Jun-2025 12:21		! 14:00 [Other - record in nur RMUI ! 21:15 JHAL	! 08:50 SBAI1 ! 13:20 SBAI1 ! 21:47 AEAP	! 07:56 TSTA LMCC14 ! 13:20 TSTA ! 22:06 AEAP	! 07:35 TSTA <DIS> AALA2		
VANCOMYCIN IV INTERMITTENT Infusion 1 DOSE as PAPER CH IV Inf 12H DR DARIA ROMANYUC Start Date/Time 29-May-2025 11:30 Stop Date/Time: 31-May-2025 11:03		! 16:37 DVEI CMAY ! 23:30 JHAL JBON	! 19:42 AEAP SBAI1 ! 23:30 [Drug discontinued] AALA2	<DIS> AALA2			
DIHYDROCODEINE 30 mg Tablets OR 30 mg Oral 4X MS ZOE THOMSON Start Date/Time 30-May-2025 12:00 Modify Reason: Dose ineffective			! 13:21 [Alternative administ SBAI1 ! 18:18 [Alternative administ SBAI1 ! 21:46 [Alternative administ AEAP	! 07:56 [Alternative administ TSTA ! 12:26 [Alternative administ TSTA ! 18:06 [Alternative administ TSTA ! 22:00 [Patient Refused] AEAP	! 08:00 [Patient Refusedl TSTA ! 12:00 [Patient Refused] TSTA ! 18:00 [Patient Refused] TSTA ! 22:00 [Patient Refused] AEAP	! 08:00 [Patient Refused] TSTA ! 12:00 [Patient Refused] TSTA ! 18:00 [Patient Refused] TSTA ! 22:00 [Patient Refused] KREV	! 08:00 [Patient Refused] TSTA ! 12:00 [Patient Refused] TSTA ! 18:00 [Absent from ward] TSTA

Medication Administration Profile

Patient: **Wyles, Alan**
Hospital No: 0605770352 National No: 060 577 0352
Date of Birth: 6-May-1977
Allergies: PENICILLINS

Weight: kg
Height: cm
Body Surface: m²

Type of Report: Since Admission
Requested By: JRAE2
Current Status: Discharged

Admitted On: 28-May-2025
Discharged On: 3-Jun-2025 Patient Note(s) exist

Sensitivities:

Key: ! - denotes unverified order at the time of charting or administration. * - denotes charting was overridden. ? - denotes witnessable administration not witnessed. {@@} - denotes patient was/is on Short Term Leave. [+] - Order Notes exist ½ - Part Dose (see PAC) <MOD> - Order Modified <DIS> - Order Discontinued <STOPPED> - Order Stopped <RES> - Order Resumed <SUS> - Order Suspended RS - Result <TASK> - Order Suspended (task non-completion) AC - Recommended Action

DRUG DOSE,ROUTE & FREQUENCY/INTERVAL/RATE *VERIFIER*	28-May-2025 Wednesday	29-May-2025 Thursday	30-May-2025 Friday	31-May-2025 Saturday	1-Jun-2025 Sunday	2-Jun-2025 Monday	3-Jun-2025 Tuesday
DIHYDROCODEINE 30 mg Tablets 60 mg Oral 4X MS ZOE THOMSON Start Date/Time 30-May-2025 12:00 Modify Reason: Dose ineffective			! 13:21 SBAI1 ! 18:18 SBAI1 ! 21:46 AEAP	! 07:56 TSTA ! 12:26 TSTA ! 18:06 TSTA ! 22:00 [Patient Refused] AEAP	! 08:00 [Patient Refused] TSTA ! 12:00 [Patient Refused] TSTA ! 18:00 [Patient Refused] TSTA ! 22:00 [Patient Refused] AEAP	! 08:00 [Patient Refused] TSTA ! 12:00 [Patient Refused] TSTA ! 18:00 [Patient Refused] TSTA ! 22:00 [Patient Refused] KREV	! 08:00 [Patient Refused] TSTA ! 12:00 [Patient Refused] TSTA ! 18:00 [Absent from ward] TSTA
IBUPROFEN 400 mg Tablets 400 mg Oral 3X08/14/22 MS ZOE THOMSON Start Date/Time 30-May-2025 14:00 Modify Reason: Dose ineffective			! 14:00 [Patient Refused] SBAI1 ! 21:47 AEAP	! 07:58 TSTA ! 13:20 TSTA ! 22:06 AEAP	! 07:35 TSTA ! 12:32 TSTA ! 22:01 AEAP	! 08:19 TSTA ! 12:51 TSTA ! 21:45 KREV	! 07:58 TSTA ! 12:41 TSTA
NICOTINE (Nicotinell 30) 21 mg in 24 hours Patch 21 mg Transderm 24H DR ALHUSSAIN ALI AL AJMI Start Date/Time 30-May-2025 14:55			! 15:47 SBAI1	! 17:59 TSTA	! 17:37 TSTA	! 17:24 TSTA	! 14:55 [Absent from ward] TSTA
VANCOMYCIN IV INTERMITTENT Infusion 1 DOSE as PAPER CH IV Inf 8H DR ALHUSSAIN ALI AL AJMI Start Date/Time 31-May-2025 11:03 Stop Date/Time: 1-Jun-2025 12:21				! 11:08 CCUR2 RTAD ! 18:51 TSTA RTAD	! 03:05 JMAT2 AEAP ! 11:03 [Drug discontinued] AALA2 <DIS> AALA2		

Medication Administration Profile

Patient: **Wyles, Alan**
Hospital No: 0605770352 National No: 060 577 0352
Date of Birth: 6-May-1977
Allergies: PENICILLINS

Sensitivities:

Weight: kg
Height: cm
Body Surface: m²

Type of Report: Since Admission
Requested By: JRAE2
Current Status: Discharged

Admitted On: 28-May-2025
Discharged On: 3-Jun-2025 Patient Note(s) exist

Key: ! - denotes unverified order at the time of charting or administration. * - denotes charting was overridden. ? - denotes witnessable administration not witnessed. [@@] - denotes patient was/is on Short Term Leave. [+] - Order Notes exist % - Part Dose (see PAC) <MOD> - Order Modified <DIS> - Order Discontinued <STOPPED> - Order Stopped <RES> - Order Resumed <SUS> - Order Suspended RS - Result <TASK> - Order Suspended (task non-completion) AC - Recommended Action

DRUG DOSE,ROUTE & FREQUENCY/INTERVAL/RATE *VERIFIER*	28-May-2025 Wednesday	29-May-2025 Thursday	30-May-2025 Friday	31-May-2025 Saturday	1-Jun-2025 Sunday	2-Jun-2025 Monday	3-Jun-2025 Tuesday
CO-TRIMOXAZOLE 960 mg Tablets					! 20:45 AEAP	! 08:19 TSTA	! 07:58 TSTA
960 mg Oral						! 21:45 KREV	<DIS> ABUC3
2X08/20							
DR ALHUSSAIN ALI AL AJMI							
Start Date/Time 1-Jun-2025 20:00							
Stop Date/Time: 3-Jun-2025 10:48							
METRONIDAZOLE 400 mg Tablets					! 12:33 TSTA	! 08:19 TSTA	! 07:58 TSTA
400 mg Oral					! 22:01 AEAP	! 12:51 TSTA	<DIS> ABUC3
3X08/14/22						! 21:45 KREV	
DR ALHUSSAIN ALI AL AJMI							
Start Date/Time 1-Jun-2025 14:00							
Stop Date/Time: 3-Jun-2025 10:48							
Modify Reason: Change in clinical parameters							
BUPRENORPHINE 8 mg Sublingual Tablets		! 08:56 DVEI					
8 mg Sublingual		RMUI					
STAT		<MOD> DVEI					
DR DARIA ROMANYUC							
Start Date/Time 29-May-2025 08:52							
Stop Date/Time: 29-May-2025 08:57							
BUPRENORPHINE 2 mg Sublingual Tablets		! 08:56 DVEI					
2 mg Sublingual		RMUI					
STAT		<MOD> DVEI					
DR DARIA ROMANYUC							
Start Date/Time 29-May-2025 08:52							
Stop Date/Time: 29-May-2025 08:57							

Medication Administration Profile

Type of Report: Since Admission
Requested By: JRAE2
Current Status: Discharged

Admitted On: 28-May-2025
Discharged On: 3-Jun-2025 Patient Note(s) exist

Patient: **Wyles, Alan**
Hospital No: 0605770352 National No: 060 577 0352
Date of Birth: 6-May-1977
Allergies: PENICILLINS

Weight: kg
Height: cm
Body Surface: m²

Sensitivities:

Key: ! - denotes unverified order at the time of charting or administration. * - denotes charting was overridden. ? - denotes witnessable administration not witnessed. !@@! - denotes patient was/is on Short Term Leave. [+] - Order Notes exist % - Part Dose/see PAC <MOD> - Order Modified <DIS> - Order Discontinued <STOPPED> - Order Stopped <RES> - Order Resumed <SUS> - Order Suspended RS - Result <TASK> - Order Suspended (task non-completion) AC - Recommended Action

DRUG DOSE,ROUTE & FREQUENCY/INTERVAL/RATE *VERIFIER*	28-May-2025 Wednesday	29-May-2025 Thursday	30-May-2025 Friday	31-May-2025 Saturday	1-Jun-2025 Sunday	2-Jun-2025 Monday	3-Jun-2025 Tuesday
DIAZEPAM 10 mg Tablets 20 mg Oral STAT DR DARIA ROMANYUC Start Date/Time 29-May-2025 08:53 Stop Date/Time: 29-May-2025 09:03		! 09:02 DVEI <MOD> DVEI					
DIAZEPAM 2 mg Tablets 8 mg Oral STAT DR DARIA ROMANYUC Start Date/Time 29-May-2025 08:53 Stop Date/Time: 29-May-2025 09:03		! 09:02 DVEI <MOD> DVEI					
METRONIDAZOLE 400 mg Tablets 400 mg Oral STAT DR DARIA ROMANYUC Start Date/Time 29-May-2025 10:53 Stop Date/Time: 29-May-2025 11:09		! 11:08 RMUI <MOD> RMUI					
MORPHINE SULPHATE 10 mg in 5mL Oral Solution 10 mg Oral STAT MS LAUREN ADAMSON Start Date/Time 30-May-2025 04:51 Stop Date/Time: 30-May-2025 05:09			! 05:08 JHAL <MOD> JHAL				

Medication Administration Profile

Patient: **Wyles, Alan**
Hospital No: 0605770352 National No: 060 577 0352
Date of Birth: 6-May-1977
Allergies: PENICILLINS

Sensitivities:

Weight: kg
Height: cm
Body Surface: m²

Type of Report: Since Admission
Requested By: JRAE2
Current Status: Discharged

Admitted On: 28-May-2025
Discharged On: 3-Jun-2025 Patient Note(s) exist

Key: ! - denotes unverified order at the time of charting or administration. * - denotes charting was overridden. ? - denotes witnessable administration not witnessed. [@@] - denotes patient was/is on Short Term Leave. [+] - Order Notes exist % - Part Dose (see PAC) <MOD> - Order Modified <DIS> - Order Discontinued <STOPPED> - Order Stopped <RES> - Order Resumed <SUS> - Order Suspended RS - Result <TASK> - Order Suspended (task non-completion) AC - Recommended Action

DRUG DOSE,ROUTE & FREQUENCY/INTERVAL/RATE *VERIFIER*	28-May-2025 Wednesday	29-May-2025 Thursday	30-May-2025 Friday	31-May-2025 Saturday	1-Jun-2025 Sunday	2-Jun-2025 Monday	3-Jun-2025 Tuesday
DIHYDROCODEINE 30 mg Tablets OR 30 mg Oral 4X PRN 4-6hourly for PAINMAX 240mg in 24h DR ALICE BUCHANAN-SMITH Start Date/Time 28-May-2025 21:26 Stop Date/Time: 30-May-2025 10:33		! 03:19 [Alternative administ JROJ ! 07:08 [Alternative administ JROJ ! 15:28 [Alternative administ RMUI ! 22:00 [Alternative administ JHAL	! 08:00 [Alternative administ SBAI1 ! 10:34 [Drug discontinued] ZTHO1 <DIS> ZTHO1				
DIHYDROCODEINE 30 mg Tablets 60 mg Oral 4X PRN 4-6 hourly for PAINMAX 240mg in 24h DR ALICE BUCHANAN-SMITH Start Date/Time 28-May-2025 21:26 Stop Date/Time: 30-May-2025 10:33		! 03:19 JROJ ! 07:08 JROJ ! 15:28 RMUI ! 22:00 JHAL	! 08:00 SBAI1 ! 10:34 [Drug discontinued] ZTHO1 <DIS> ZTHO1				
CYCLIZINE 50 mg Tablets OR 50 mg Oral 8H PRN For nausea and vomitingMAX dose: 150mg/24h DR ALICE BUCHANAN-SMITH Start Date/Time 28-May-2025 21:26 Stop Date/Time: 2-Jun-2025 21:25						<STOPPED>	

Medication Administration Profile

Patient: Wyles, Alan
Hospital No: 0605770352 National No: 060 577 0352
Date of Birth: 6-May-1977
Allergies: PENICILLINS

Weight: kg
Height: cm
Body Surface: m²

Type of Report: Since Admission
Requested By: JRAE2
Current Status: Discharged

Admitted On: 28-May-2025
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DRUG DOSE,ROUTE & FREQUENCY/INTERVAL/RATE *VERIFIER*	28-May-2025 Wednesday	29-May-2025 Thursday	30-May-2025 Friday	31-May-2025 Saturday	1-Jun-2025 Sunday	2-Jun-2025 Monday	3-Jun-2025 Tuesday
CYCLIZINE 50 mg in 1 mL Injection OR 50 mg IV Inj 8H PRN For nausea and vomitingMAX dose: 150mg/24h DR ALICE BUCHANAN-SMITH Start Date/Time 28-May-2025 21:26 Stop Date/Time: 2-Jun-2025 21:25						<STOPPED>	
CYCLIZINE 50 mg in 1 mL Injection 50 mg IM 8H PRN For nausea and vomitingMAX dose: 150mg/24h DR ALICE BUCHANAN-SMITH Start Date/Time 28-May-2025 21:26 Stop Date/Time: 2-Jun-2025 21:25						<STOPPED>	
ONDANSETRON 4 mg in 2mL Injection OR 4 mg IV Slow PRN 6-8 hourlyFor nausea and vomiting DR ALICE BUCHANAN-SMITH Start Date/Time 28-May-2025 21:26 Stop Date/Time: 2-Jun-2025 21:25			! 08:00 [Alternative administ TSTA		! 12:31 [Alternative administ TSTA	<STOPPED>	

Medication Administration Profile

Type of Report: Since Admission
Requested By: JRAE2
Current Status: Discharged

Admitted On: 28-May-2025
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Patient: **Wyles, Alan**
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DRUG DOSE,ROUTE & FREQUENCY/INTERVAL/RATE *VERIFIER*	28-May-2025 Wednesday	29-May-2025 Thursday	30-May-2025 Friday	31-May-2025 Saturday	1-Jun-2025 Sunday	2-Jun-2025 Monday	3-Jun-2025 Tuesday
ONDANSETRON 4 mg Tablets OR 4 mg Oral PRN 6-8 hourlyFor nausea and vomiting DR ALICE BUCHANAN-SMITH Start Date/Time 28-May-2025 21:26 Stop Date/Time: 2-Jun-2025 21:25			! 08:00 TSTA		! 12:31 TSTA	<STOPPED>	
ONDANSETRON 4 mg in 2mL Injection 4 mg IM PRN, 6-8 hourlyFor nausea and vomiting DR ALICE BUCHANAN-SMITH Start Date/Time 28-May-2025 21:26 Stop Date/Time: 2-Jun-2025 21:25			! 08:00 [Alternative administ TSTA		! 12:31 [Alternative administ TSTA	<STOPPED>	
HYOSCINE BUTYLBROMIDE 10 mg Tablets OR 10 mg Oral PRN for abdo pain / spasmsmax: 4 doses in 24 hours DR ALICE BUCHANAN-SMITH Start Date/Time 28-May-2025 21:26					! 12:32 [Alternative administ TSTA ! 17:37 [Alternative administ TSTA		! 17:28 [Absent from ward] TSTA
HYOSCINE BUTYLBROMIDE 10 mg Tablets 20 mg Oral PRN for abdo pain / spasmsmax: 4 doses in 24 hours DR ALICE BUCHANAN-SMITH Start Date/Time 28-May-2025 21:26					! 12:32 TSTA ! 17:37 TSTA		! 17:28 [Absent from ward] TSTA

Medication Administration Profile

Patient: **Wyles, Alan**
Hospital No: 0605770352 National No: 060 577 0352
Date of Birth: 6-May-1977
Allergies: PENICILLINS

Weight: kg
Height: cm
Body Surface: m²

Type of Report: Since Admission
Requested By: JRAE2
Current Status: Discharged

Admitted On: 28-May-2025
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Sensitivities:

Key: ! - denotes unverified order at the time of charting or administration. * - denotes charting was overridden. ? - denotes witnessable administration not witnessed. [@@] - denotes patient was/is on Short Term Leave. [+] - Order Notes exist % - Part Dose (see PAC) <MOD> - Order Modified <DIS> - Order Discontinued <STOPPED> - Order Stopped <RES> - Order Resumed <SUS> - Order Suspended RS - Result <TASK> - Order Suspended (task non-completion) AC - Recommended Action

DRUG DOSE,ROUTE & FREQUENCY/INTERVAL/RATE *VERIFIER*	28-May-2025 Wednesday	29-May-2025 Thursday	30-May-2025 Friday	31-May-2025 Saturday	1-Jun-2025 Sunday	2-Jun-2025 Monday	3-Jun-2025 Tuesday
MORPHINE SULPHATE 10 mg in 5mL Oral Solution 5 mg Oral PRN 4 hrly, max 6 doses 24hescalate if needs more DR ALICE BUCHANAN-SMITH Start Date/Time 28-May-2025 21:27 Stop Date/Time: 30-May-2025 02:32	! 21:42 SWAL1	! 03:56 JROJ ! 10:15 DVEI ! 14:09 RMUI ! 18:38 SBAI1	! 02:30 JHAL <MOD> ZTHO1				
MORPHINE SULPHATE 10 mg in 5mL Oral Solution 10 mg Oral PRN 2 hourlyescalate if needs more MS ZOE THOMSON Start Date/Time 30-May-2025 02:31 Modify Reason: Dose ineffective			! 10:36 SBAI1 ! 15:47 SBAI1 ! 20:34 AEAP	! 05:30 AEAP ! 18:44 TSTA ! 22:08 AEAP	! 03:06 JMAT2 ! 07:39 TSTA ! 12:30 TSTA ! 16:51 RTAD ! 20:03 AEAP	! 00:27 JMAT2 ! 02:27 CGON ! 07:27 AEAP ! 12:26 TSTA ! 16:31 JFOR5	! 00:04 KREV ! 14:59 TSTA
NICORETTE 15 mg Inhalator 15 mg Inhalation PRN AS NEEDED DR ALHUSSAIN ALI AL AJMI Start Date/Time 30-May-2025 17:12							! 17:28 [Absent from ward] TSTA

Medication Administration Profile

Type of Report: Since Admission
Requested By: JRAE2
Current Status: Discharged

Admitted On: 28-May-2025
Discharged On: 3-Jun-2025 Patient Note(s) exist

Patient: **Wyles, Alan**
Hospital No: 0605770352 National No: 060 577 0352
Date of Birth: 6-May-1977
Allergies: PENICILLINS

Weight: kg
Height: cm
Body Surface: m²

Sensitivities:

Patient Notes

Dispensing Note — **Twice weekly dispense**

Added by: Ms May Swallow on 30-May-2025 at 10:27 Prior versions of this note exist.

Twice weekly dispense (Monday and Thursday) Tesco Stirling 0131 289 4129

Last Changed by: Ms May Swallow on 30-May-2025 at 10:31

Pharmacy Only - DHx Complete — **complete**

Added by: Ms May Swallow on 30-May-2025 at 10:32

Complete
see care plan

Pharmacy Only - Priority — **Ph tech care plan**

Added by: Ms May Swallow on 30-May-2025 at 10:30

PC: R sided abdo pain

Diagnosis/Management:
1.
2.
3.

PMH: Prev renal failure, prev IVDU

Renal Function:

Twice weekly disp last collected 26dose is 10mg OD and Diaz dose is 28mg OD
Med Rec: Phone CP on dc
1.
2.
3.

Care Issues:
1. **VTEp:**

Medication Administration Profile

Type of Report: Since Admission
Requested By: JRAE2
Current Status: Discharged

Admitted On: 28-May-2025
Discharged On: 3-Jun-2025 Patient Note(s) exist

Patient: **Wyles, Alan**
Hospital No: 0605770352 National No: 060 577 0352
Date of Birth: 6-May-1977
Allergies: PENICILLINS

Weight: kg
Height: cm
Body Surface: m²

Sensitivities:

2.

3.

4.

5.

Note to appear in Discharge Letter **pods**

Added by: Ms May Swallow on 30-May-2025 at 10:27 Prior versions of this note exist.

Twice weekly dispense (Monday and Thursday) Tesco Stirling 0131 289 4129

Last Changed by: *Ms May Swallow on 30-May-2025 at 10:32*

Note to Nurse **dihydrocodeine**

Added by: MS JESSY ROJAN on 29-May-2025 at 03:22

refused after charted

Medication Administration Profile

Patient: **Wyles, Alan**
Hospital No: 0605770352 National No: 060 577 0352
Date of Birth: 6-May-1977
Allergies: PENICILLINS

Sensitivities:

Weight: kg
Height: cm
Body Surface: m²

Type of Report: Since Admission
Requested By: JRAE2
Current Status: Discharged

Admitted On: 26-May-2025
Discharged On: 27-May-2025

Episode History:
Consultant: DR JAMES TWEEDLE from 26-May-2025 20:57 to 27-May-2025 16:02
Transfer History:
Admitted to Ward: SAU (FVRH) on 26-May-2025 at 20:57
Transferred to Ward B12 on 27-May-2025 at 12:51

Key: ! - denotes unverified order at the time of charting or administration. * - denotes charting was overridden. ? - denotes witnessable administration not witnessed. [@@] - denotes patient was/is on Short Term Leave. [+] - Order Notes exist ½ - Part Dose (see PAC) <MOD> - Order Modified <DIS> - Order Discontinued <STOPPED> - Order Stopped <RES> - Order Resumed <SUS> - Order Suspended RS - Result <TASK> - Order Suspended (task non-completion) AC - Recommended Action

DRUG DOSE,ROUTE & FREQUENCY/INTERVAL/RATE *VERIFIER*	26-May-2025 Monday	27-May-2025 Tuesday					
DIAZEPAM 5 mg Tablets 20 mg Oral 1X08 DR RUARIDH FLEMING Start Date/Time 27-May-2025 08:00 Modify Reason: Prescribed in error		! 08:25 AMCD4 LYOU					
DIAZEPAM 2 mg Tablets 8 mg Oral 1X08 DR RUARIDH FLEMING Start Date/Time 27-May-2025 08:00		! 08:25 AMCD4 LYOU					
BUPRENORPHINE 8 mg Sublingual Tablets 8 mg Sublingual 1X08 DR RUARIDH FLEMING Start Date/Time 27-May-2025 08:00		! 08:25 AMCD4 LYOU					
BUPRENORPHINE 2 mg Sublingual Tablets 2 mg Sublingual 1X08 DR RUARIDH FLEMING Start Date/Time 27-May-2025 08:00		! 08:25 AMCD4 LYOU					

Medication Administration Profile

Type of Report: Since Admission
Requested By: JRAE2
Current Status: Discharged

Admitted On: 26-May-2025
Discharged On: 27-May-2025

Patient: **Wyles, Alan**
Hospital No: 0605770352 National No: 060 577 0352
Date of Birth: 6-May-1977
Allergies: PENICILLINS

Weight: kg
Height: cm
Body Surface: m²

Sensitivities:

Key: !- denotes unverified order at the time of charting or administration. * - denotes charting was overridden. ? - denotes witnessable administration not witnessed. [@@] - denotes patient was/is on Short Term Leave. [+] - Order Notes exist % - Part Dose (see PAC) <MOD> - Order Modified <DIS> - Order Discontinued <STOPPED> - Order Stopped <RES> - Order Resumed <SUS> - Order Suspended RS - Result <TASK> - Order Suspended (task non-completion) AC - Recommended Action

DRUG DOSE,ROUTE & FREQUENCY/INTERVAL/RATE *VERIFIER*	26-May-2025 Monday	27-May-2025 Tuesday					
TEDS Stocking 1 unit Topical 24HO DR RUARIDH FLEMING Start Date/Time 26-May-2025 22:24 Stop Date/Time: 26-May-2025 22:25	!22:24 [Drug discontinued] RFLE2 <DIS> RFLE2						
ENOXAPARIN (INHIXA) 40 mg Injection 40 mg SC Inj 1X18 DR RUARIDH FLEMING Start Date/Time 27-May-2025 18:00							
PARACETAMOL 500 mg Tablets OR 1000 mg Oral 4X DR RUARIDH FLEMING Start Date/Time 27-May-2025 08:00		! 08:32 AMCD4 ! 12:00 [Not Charted prior to SYSTEM					
PARACETAMOL 1000 mg in 100mL Intravenous Infusion 1000 mg IV Inf 4X DR RUARIDH FLEMING Start Date/Time 27-May-2025 08:00		! 08:32 [Alternative administ AMCD4 ! 12:00 [Not Charted prior to SYSTEM					

Medication Administration Profile

Patient: **Wyles, Alan**
Hospital No: 0605770352 National No: 060 577 0352
Date of Birth: 6-May-1977
Allergies: PENICILLINS

Weight: kg
Height: cm
Body Surface: m²

Type of Report: Since Admission
Requested By: JRAE2
Current Status: Discharged

Admitted On: 26-May-2025
Discharged On: 27-May-2025

Sensitivities:

Key: ! - denotes unverified order at the time of charting or administration. ? - denotes witnessable administration not witnessed. [+] - Order Notes exist <MOD> - Order Modified <STOPPED> - Order Stopped <SUS> - Order Suspended <TASK> - Order Suspended (task non-completion)
* - denotes charting was overridden. [@@] - denotes patient was/is on Short Term Leave. % - Part Dose (see PAC) <DIS> - Order Discontinued <RES> - Order Resumed RS - Result AC - Recommended Action

DRUG DOSE,ROUTE & FREQUENCY/INTERVAL/RATE *VERIFIER*	26-May-2025 Monday	27-May-2025 Tuesday					
MORPHINE SULPHATE 10 mg in 1 mL Injection 10 mg SC Inj STAT DR RUARIDH FLEMING Start Date/Time 26-May-2025 22:24 Stop Date/Time: 26-May-2025 22:45	! 22:43 RMUI COBR <MOD> RMUI						
SENNOSIDE B (Senokot) 7.5 mg Tablets 15 mg Oral STAT DR RUARIDH FLEMING Start Date/Time 26-May-2025 22:33 Stop Date/Time: 26-May-2025 22:40	! 22:39 RMUI <MOD> RMUI						
MORPHINE SULPHATE 10 mg in 1 mL Injection 10 mg IV Slow STAT DR RUARIDH FLEMING Start Date/Time 27-May-2025 02:58 Stop Date/Time: 27-May-2025 03:44		! 03:00 RMUI COBR <MOD> RMUI					
DIHYDROCODEINE 30 mg Tablets OR 30 mg Oral 4X PRN 4-6hourly for PAINMAX 240mg in 24h DR RUARIDH FLEMING Start Date/Time 26-May-2025 22:24		! 00:11 [Alternative administ RMUI					

Medication Administration Profile

Patient: **Wyles, Alan**
Hospital No: 0605770352 National No: 060 577 0352
Date of Birth: 6-May-1977
Allergies: PENICILLINS

Weight: kg
Height: cm
Body Surface: m²

Type of Report: Since Admission
Requested By: JRAE2
Current Status: Discharged

Admitted On: 26-May-2025
Discharged On: 27-May-2025

Sensitivities:

Key: ! - denotes unverified order at the time of charting or administration. * - denotes charting was overridden. ? - denotes witnessable administration not witnessed. [@@] - denotes patient was/is on Short Term Leave. [+] - Order Notes exist % - Part Dose (see PAC) <MOD> - Order Modified <DIS> - Order Discontinued <STOPPED> - Order Stopped <RES> - Order Resumed <SUS> - Order Suspended RS - Result <TASK> - Order Suspended (task non-completion) AC - Recommended Action

DRUG DOSE,ROUTE & FREQUENCY/INTERVAL/RATE *VERIFIER*	26-May-2025 Monday	27-May-2025 Tuesday					
DIHYDROCODEINE 30 mg Tablets 60 mg Oral 4X PRN 4-6 hourly for PAINMAX 240mg in 24h DR RUARIDH FLEMING Start Date/Time 26-May-2025 22:24		! 00:11 RMUI					
CYCLIZINE 50 mg Tablets OR 50 mg Oral 8H PRN For nausea and vomitingMAX dose: 150mg/24h DR RUARIDH FLEMING Start Date/Time 26-May-2025 22:24 Stop Date/Time: 31-May-2025 22:23						<STOPPED>	
CYCLIZINE 50 mg in 1 mL Injection OR 50 mg IV Inj 8H PRN For nausea and vomitingMAX dose: 150mg/24h DR RUARIDH FLEMING Start Date/Time 26-May-2025 22:24 Stop Date/Time: 31-May-2025 22:23						<STOPPED>	
CYCLIZINE 50 mg in 1 mL Injection 50 mg IM 8H PRN For nausea and vomitingMAX dose: 150mg/24h DR RUARIDH FLEMING Start Date/Time 26-May-2025 22:24 Stop Date/Time: 31-May-2025 22:23						<STOPPED>	

Medication Administration Profile

Patient: **Wyles, Alan**
Hospital No: 0605770352 National No: 060 577 0352
Date of Birth: 6-May-1977
Allergies: PENICILLINS
Sensitivities:

Weight: kg
Height: cm
Body Surface: m²

Admitted On: 26-May-2025
Discharged On: 27-May-2025

Key: ! - denotes unverified order at the time of charting or administration. * - denotes charting was overridden. ? - denotes witnessable administration not witnessed. [@@] - denotes patient was/is on Short Term Leave. [+] - Order Notes exist % - Part Dose (see PAC) <MOD> - Order Modified <DIS> - Order Discontinued <STOPPED> - Order Stopped <RES> - Order Resumed <SUS> - Order Suspended RS - Result <TASK> - Order Suspended (task non-completion) AC - Recommended Action

DRUG DOSE,ROUTE & FREQUENCY/INTERVAL/RATE *VERIFIER*	26-May-2025 Monday	27-May-2025 Tuesday					
ONDANSETRON 4 mg in 2mL Injection OR 4 mg IV Slow PRN 6-8 hourlyFor nausea and vomiting DR RUARIDH FLEMING Start Date/Time 26-May-2025 22:24 Stop Date/Time: 31-May-2025 22:23		! 01:00 [Alternative administ RMUI				<STOPPED>	
ONDANSETRON 4 mg Tablets OR 4 mg Oral PRN 6-8 hourlyFor nausea and vomiting DR RUARIDH FLEMING Start Date/Time 26-May-2025 22:24 Stop Date/Time: 31-May-2025 22:23		! 01:00 RMUI				<STOPPED>	
ONDANSETRON 4 mg in 2mL Injection 4 mg IM PRN 6-8 hourlyFor nausea and vomiting DR RUARIDH FLEMING Start Date/Time 26-May-2025 22:24 Stop Date/Time: 31-May-2025 22:23		! 01:00 [Alternative administ RMUI				<STOPPED>	

Medication Administration Profile

Type of Report: Since Admission
Requested By: JRAE2
Current Status: Discharged

Admitted On: 26-May-2025
Discharged On: 27-May-2025

Patient: **Wyles, Alan**
Hospital No: 0605770352 National No: 060 577 0352
Date of Birth: 6-May-1977
Allergies: PENICILLINS

Weight: kg
Height: cm
Body Surface: m²

Sensitivities:

Key: ! - denotes unverified order at the time of charting or administration. * - denotes charting was overridden. ? - denotes witnessable administration not witnessed. [@@] - denotes patient was/is on Short Term Leave. [+] - Order Notes exist % - Part Dose (see PAC) <MOD> - Order Modified <DIS> - Order Discontinued <STOPPED> - Order Stopped <RES> - Order Resumed <SUS> - Order Suspended RS - Result <TASK> - Order Suspended (task non-completion) AC - Recommended Action

DRUG DOSE,ROUTE & FREQUENCY/INTERVAL/RATE *VERIFIER*	26-May-2025 Monday	27-May-2025 Tuesday					
HYOSCINE BUTYLBROMIDE 10 mg Tablets OR 10 mg Oral PRN for abdo pain / spasmsmax: 4 doses in 24 hours DR RUARIDH FLEMING Start Date/Time 26-May-2025 22:24 Stop Date/Time: 26-May-2025 22:25	! 22:25 [Drug discontinued] RFLE2 <DIS> RFLE2						
HYOSCINE BUTYLBROMIDE 10 mg Tablets 20 mg Oral PRN for abdo pain / spasmsmax: 4 doses in 24 hours DR RUARIDH FLEMING Start Date/Time 26-May-2025 22:24 Stop Date/Time: 26-May-2025 22:25	! 22:25 [Drug discontinued] RFLE2 <DIS> RFLE2						
MORPHINE SULPHATE 10 mg in 5mL Oral Solution 10 mg Oral PRN 4 hrly, max 6 doses/24h DR ALICE BUCHANAN-SMITH Start Date/Time 27-May-2025 00:22		! 01:04 RMUI ! 08:25 AMCD4 ! 13:11 SRIC2					

Medication Administration Profile

Type of Report: Since Admission
Requested By: JRAE2
Current Status: Discharged

Admitted On: 23-Feb-2019
Discharged On: 24-Feb-2019

Patient: **Wyles, Alan**
Hospital No: 0605770352 National No: 060 577 0352
Date of Birth: 6-May-1977
Allergies: PENICILLINS

Weight: kg
Height: cm
Body Surface: m²

Sensitivities:

Episode History:
Consultant: DR ALLISTER HARGREAVES from 23-Feb-2019 22:24 to 24-Feb-2019 01:56
Transfer History:
Admitted to Ward: AAU-2 on 23-Feb-2019 at 22:24

There are no active medications for this patient.

Medication Administration Profile

Type of Report: Since Admission
Requested By: JRAE2
Current Status: Discharged

Admitted On: 19-Sep-2017
Discharged On: 19-Sep-2017

Patient: **Wyles, Alan**
Hospital No: 0605770352 National No: 060 577 0352
Date of Birth: 6-May-1977
Allergies: PENICILLINS

Weight: kg
Height: cm
Body Surface: m²

Sensitivities:

Episode History:
Consultant: DR ASMA AHMED from 19-Sep-2017 10:08 to 19-Sep-2017 15:53
Transfer History:
Admitted to Ward: CAU (FVRH) on 19-Sep-2017 at 10:08

Key: ! - denotes unverified order at the time of charting or administration. ? - denotes witnessable administration not witnessed. [+] - Order Notes exist <MOD> - Order Modified <STOPPED> - Order Stopped <SUS> - Order Suspended <TASK> - Order Suspended (task non-completion)
* - denotes charting was overridden. [@@] - denotes patient was/is on Short Term Leave. % - Part Dose (see PAC) <DIS> - Order Discontinued <RES> - Order Resumed RS - Result AC - Recommended Action

DRUG DOSE,ROUTE & FREQUENCY/INTERVAL/RATE *VERIFIER*	19-Sep-2017 Tuesday						
VANCOMYCIN IV CONTINUOUS Infusion (Adult) 1500 mg IVCI 2X08/20 DR YASIR ABBAS Start Date/Time 19-Sep-2017 20:00							
PARACETAMOL 500 mg Tablets 1000 mg Oral 4X DR YASIR ABBAS Start Date/Time 19-Sep-2017 12:00	! 11:54 CTOW						
ENOXAPARIN PFS 40 mg in 0.4mL Subcutaneous Injection 40 mg SC Inj 1X18 DR YASIR ABBAS Start Date/Time 19-Sep-2017 18:00							

Immediate Discharge Letter (Authorised)

COPY

Urology
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

A Dunsmore
Allan Park Medical Practice
19 Allan Park
Stirling
Stirling
FK8 2QD

CHI Barcode: 0605770352

Date of Completion: 27-May-2025

Patient Demographics

Patient Name:	WYLES, Alan	**Date Of Birth:**	06-May-1977
Patient Address:	2 GORDON SQUARE Stirling Stirlingshire FK8 1FN	**Gender:**	Male
		CHI No:	0605770352
Telephone No:	07835703594		

GP Practice

GP Name:	A Dunsmore	**GP GMC:**	6026670
GP Practice Address:		**GP Practice Code:**	6026670/25686
		GP Clinic Code:	25686
		GP Telephone:	

Admission Details

Patient Location:	Urology	**Admission Care Provider:**	Mr James Tweedle
Admission Date:	26-May-2025	**Admission Time:**	20:57
Admission Method:	Emergency Admission, type not known	**Ward:**	FVRH Ward SAU
Source Of Admission:	A&E Ward within Trust		

Discharge Details

Discharge Specialty:	Urology	**Discharge Care Provider:**	Mr James Tweedle
Discharge Date:	27-May-2025	**Ward:**	FVRH Ward B12
Discharge Time:	15:00	**Discharge Destination:**	Private Residence - no additional detail added
Discharge Method:	Regular discharge, no additional detail added		

Clinical Summary including History

Dear doctor,

Alan Wyles is a 48yo male who was admitted following presentation of right back/flank pain. He was treated with analgesia and IV fluids. CT KUB did not show any pathology. Patient was reviewed by urology and was deemed fit for discharge with encouraged oral fluids.

Nil follow-up.

Thank you for you ongoing support with this patient.

Yours sincerely,
Claire
FY1

Ward B12 FVRH

IDL written from the clinical notes

COPY

Safety Alerts

Nil records exist

Allergy/Intolerance

Allergy records are as recorded at time and date of printing
Nil records exist

Medications

Drug Information:

Drug	Dose	Route	Frequency	GP to Continue	POD	Days Supply

Nil records exist

Drug Notes:

Drug	Drug Notes

Nil records exist

Additional Medicine Information:

Medicines discontinued during admission (Medicines that patient was recorded as admitted on only)

Drug	Discontinued Reason

Nil records exist

GP Communications:

Outstanding Results

Responsibility of Hospital

Nil records exist

Person completing record

Authorised by		Clinically completed by	
Name:	Dr Claire MacLeod	**Name:**	Dr Claire MacLeod
Designation or role:	Doctor	**Designation or role:**	Doctor
Specialty:		**Specialty:**	
Date completed:	27-May-2025		

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
A Dunsmore	GP	Allan Park Medical Practice

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ALAN WYLES

Scottish Ambulance Service

Age/Gender:	48Y, Male	Incident Date:	26/05/2025 14:49:00
DOB:	06/05/1977	ePCR Number:	20-2-260525-144939
Address:	-	Incident Number:	CR012096489
CHI Number:	0605770352	Incident Type:	EMG
Ethnicity:	White Scottish	Incident Location:	2 GORDON SQUARE STIRLING, FK8 1FN

PATIENT INFO

GP And Surgery

Address:	Allan Park Medical Practice, 19 Allan Park, Stirling	Name:	Allan Park Medical Practice
Postcode:		FK8 2QD	

Next Of Kin

Forename:	thomas	Surname:	muir
Relationship To Patient:		Other	

Capacity Assessed

Deemed to have Capacity

ADDITIONAL COMMENTS

Presenting Complaint:	back pain

Date/Time	Additional Comment	Crew Name
26/05/2025 15:55:00	pt has had lower back pain for 5 days worsening over past three passing urine ok had one episode projectile vomit nil bowel movement 3 days on buprenorphine daily ex iv drug user cannot take ibuprofen or codeine nil pain on urination pt had renal failure 4 years ago and had 4 month dialysis but no probs since pt states feels same as when he had renal failure pain radiating to front worsening then eading slightly unable to lie down with pain no cp no sob	

ACVPU

Options: Alert

CATASTROPHIC HAEMORRHAGE

Catastrophic Haemorrhage: No

AIRWAY

Assessment: Clear

BREATHING

Breathing Adequately:	[redacted]	Initial Respiratory Rate:	18

CIRCULATION

Pulse Rate: 78

EXAMINATION

EXAMINATION

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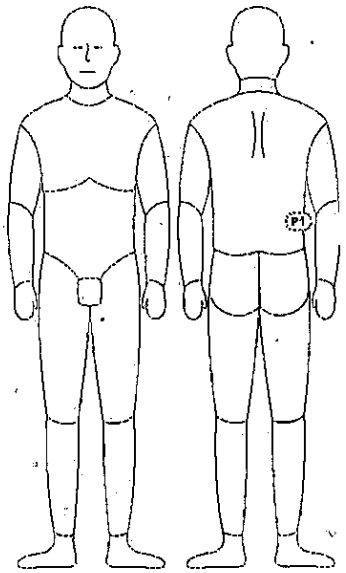
Assessment Graphic



Pain Table

ID	Pain Scale	Body Part
P1	10	Back Body

OBSERVATIONS

Observations Assessment

Timestamp	Pulse	RR	BP	SpO2	GP	GCS	ACVPU	ETCO2	Temp	BM	BGL	Pn (P)	PEF	Crew
26/05/2025 15:31	92	18	151/95	99		15	Alert		36.9	5.4				E9881930
26/05/2025 15:32	78	18	140/113	99										E9881930

GCS

Timestamp	Eyes Value	Eyes Score	Voice Value	Voice Score	Motor Value	Motor Score	Pupil Sizes
26/05/2025 15:31	Spontaneously	4	Orientated	5	Obeys Commands	6	15

NEWS Score

Timestamp	RR	SpO2 scale 1	SpO2 Scale 2	AVPU	BP	P	ACVPU	T	Total
26/05/2025 15:31	18 (0)	99 (0)	-	0	151 (0)	92 (1)	Alert (0)	36.9 (0)	1

DRUGS

Drugs Table

Timestamp	Drug	Batch	Quantity	Route	Pain Before	Pain After	Source	Crew
26/05/2025 15:57	Paracetamol		1 g	OR	10	10	MANUAL	E9881930
26/05/2025 15:58	Entonox		PRN	INH			MANUAL	E9881930

DRUGS

Drugs Table

Timestamp	Drug	Dose	Quantity	Route	Pain Before	Pain After	Status	Clinician
26/05/2025 15:57	Paracetamol		1 g	OR	10	10	MANUAL	E9881930
26/05/2025 15:58	Entonox		PRN	INH			MANUAL	E9881930

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CLOSE REPORT

Clinical Response Feedback

On-Scene Clinical Findings	**Non Emergency**

CONVEYANCE

Transport To Hospital	**Normal Driving**	**Pre-Alert**	**No**
Destination Hospital		**FORTH VALLEY ROYAL HOSPITAL**	

INCIDENT INFORMATION

Dispatch

Dispatch Code	-	**Dispatch Description**	**Back Pain with Difficulty Breathing**

Incident Log

Status Time	Status	Callsign	Person	Hospital
14:28:27	Call Received Time	STI3160		
14:52:25	Mobile	STI3160		
15:19:06	At Scene	STI3160		
15:35:36	Leave Scene	STI3160		FORTH VALLEY ROYAL HOSPITAL

CREW INFORMATION

Additional Crew

Crew ID	Crew Grade
E9881930	Ambulance Paramedic (AP)
E1022644	Ambulance Paramedic Team Leader
E1022490	Ambulance Technician (AT)

Dispatch Code		Dispatch Description	Breathing

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Incident Log

Status Time	Status	Callsign	Reason	Hospital
14:28:27	Call Received Time	STI3160		
14:52:25	Mobile	STI3160		
15:19:06	At Scene	STI3160		
15:35:36	Leave Scene	STI3160		FORTH VALLEY ROYAL HOSPITAL

CREW INFORMATION

Additional Crew

Crew ID	Crew Grade
E9881930	Ambulance Paramedic (AP)
E1022644	Ambulance Paramedic Team Leader
E1022490	Ambulance Technician (AT)

FVRH Emergency Department Forth Valley Royal Hospital

03

COPY

Date of attendance: 26/05/2025 16:13

Presenting complaint: back pain sas corr

Surname: Wyles		**Forename:** Alan	**Title:** Mr
Address 2 GORDON SQUARE Stirling Stirlingshire		**Postcode:** FK8 1FN	**CHI:** 0605770352
Telephone: 07835703594			
Date of Birth: 06/05/1977		**Sex:** Male	**Age:** 48 Years

GP Name: A Dunsmore

Address: 25686/1
Allan Park Medical Practice
19 Allan Park
Stirling
Stirling
FK8 2QD

Telephone: 01786 451375

Next of Kin

Name: Kaila Wyles

Relationship: Daughter

Postcode:

Address:

Telephone: 07368945417

Triage Information

"back pain - moderate pain "
Back pain started 5/7 ago - lower and moving round to abdomen. Passing urine as normal. Bowels last moved 3/7 ago. 1 x vomit.
On buprenorphine
NEWS 0
GCS 15

Obersvations

P= **PB=** / **RR=** **Sat=** **BM=** **Temp=**

eak Flow= **GCS=** **News=**

Emergency Department / Pre-Hospital Drugs

Allergies NKDA

Date	Drug	Dose	Route	Signature	Given by	Time
26/5/25	oromorph	10mg	PO		BD	1935
26/5/25	Oromorph	10mg	PO		SRae	2040

Bladder Scan- 240mls.

Clinical Notes

Seen by:	JMANTIN	Time:	1820

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PC: R sided back pain

HPC: waves of R sided back pain with radiation to front of abdomen and to groin. I vomit due to pain. Able to pass urine. Not opened bowels in the last 3 days. No midline pain. No weakness/numbness. Able to walk. Moving makes pain a little worse but not much.

PMHx: - acute renal failure requiring dialysis 2011 - minimal notes from this but he says dialysis for 4 months.
- Previous IVDU on buprenorphine
- PTSD, manic depression
- hepC.

O/E - alert + oriented.
Clearly in pain
Chest clear, HS1 +1 +0
Abdomen soft, R side / R flank moderate tenderness
No midline spinal tenderness.
Able to stand up and mobilise to bed relatively easily.

Imp: ? renal colic
? constipation.

(P) - Bloods
- Urine
- analgesia.

Guidelines Used:

Attach continuation sheets here

Attach here onto face of pocket

Forth Valley Royal Hospital Assessment Document

NHS Forth Valley

Date of arrival 26/5/25 Time of arrival 2110

Source of referral: GP (ED) Other

GP practice: ALLANPARK MEDICAL

CHI NO: 0605770352 06/05/1977 M
CRN:
Alan WYLES
2 GORDON SQUARE
STIRLING
FK8 1FN

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Age 48

Consent for ECS	Yes	✓	No	

BM | NEWS score 0

Tel

NOK 1 Name KAILA WYLES
Relationship DAUGHTER
Address
07368940417

NOK 2

Presenting complaint BACK PAIN ? RENAL COLIC

B Background

A

NEWS 5 or more or other clinical concern	Yes		No	✓
T° 38°C or more within 14 days of chemotherapy (possible neutropenic sepsis)	Yes		No	✓
Referred with potassium more than 6.4mmo/L or less than 2.8mmol/L	Yes		No	✓
Referred with diabetic ketoacidosis	Yes		No	✓
Reduced GCS	Yes		No	✓
New limb weakness, speech disturbance or numbness for less than 4.5hours	Yes		No	✓
Abdominal pain: Does referral or patient give history of aortic aneurysm?	Yes		No	✓
Abdominal symptom in female under 55 with possibility of pregnancy	Yes		No	✓
NEWS 2-4	Yes		No	✓
New oxygen requirement (not on home oxygen)	Yes		No	✓
Chest pain at time of triage- Obtain ECG, Clinician to review/ sign within 10 minutes	Yes		No	✓
New limb weakness, speech disturbance or numbness for 4.5 hours or longer	Yes		NO	✓
Requires assistance of 1 or more to mobilise	Yes		No	✓
Able to mobilise independently or using own aids/ appliances	Yes	✓	No	

R Very urgent | Urgent | Non-urgent ✓ | Ambulant

Actions					
		Amylase		Cannula	
U&E/ LFT/ CRP/ FBC/Glucose		Calcium		ECG- to be signed within 10mins	
Cultures		Group and save		Troponin 0 hours / 12 hours	

IV

Additional triage comments

Allergies and alerts

NKDA

Name [illegible] Signature [illegible] Date 26/5/25 Time

Assessment

Practitioners Name R. Fleming	Date
Grade F2	Time commenced
GMC/ NMC 7988264	Location SAU

CHI NO: 0605770352 0605/1977
CRN:
Alan WYLES
2 GORDON SQUARE
STIRLING
FK8 1FN
COPY

Presenting Complaint:

28 yr. m

- 2 day hx of progressive confusion + fever
- ? ↓ intake from ? UTI
- denies urinary sx.
- ? viral illness for 2 days
- no recent ABx in 3 mths

Systemic Enquiry:

- ↑ fever
- ↓ intake + ? UTI + abd pain, developing, denies vomit + rash

Height: 5ft 9 **Weight:** 10st 7 **BMI:**

Usual level of activity (please circle)

Bedbound | Dependent for personal care | Requires minimal assistance with ADLs | Slowed. Assistance with heavier household tasks | "Slowed-up" but not requiring assistance | No exercise beyond walking. | Occasional exercise | Regular exercise

Past medical, surgical and anaesthetic history

IVDU	
Angina	
Hypertension	
COPD	
Stroke /TIA	
Diabetes Implement diabetes bundle	

HAEMATOLOGICAL PARALYSIS 2011
R/V IVDU
PTSD
MANIC DEPRESSION
HEP C

Family History parents alive + well
- mum, cervical
- dad suicide

Travel History

Social History

Smoking: Never Ex smoker (since 1 year ago)
Current 5 /day Pack years 5 years

Alcohol: 7 Units / week

Occupation unemployed

Driving license yes/ no

Lives With alone, dog

Support/ Carers

PACKAGE OF CARE YES / NO (please circle)

IF YES CARE PROVIDER_____

NUMBER OF TIMES PER DAY 1/ 2/ 3/ 4 (please circle)

active ~ needs

Medicines Reconciliation At least 2 recent sources, one of which must be patient or carer

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Verbal

☐ Patient *(e.g. verbal recollection or handwritten note)* ☐ Relative/Carer ☑ Electronic patient record
ECS (issued in last 6 months?)
IDL (within last month?)

☐ Patient's own medicines ☐ Nursing home prescription ☐ Community pharmacy ☐ Other

No Known Drug Allergies ☐

Drug / Substance	Reaction/ Side effect	Drug / Substance	Reaction/ Side effect
NSAIDs			

Pharm	ADMISSION MEDICATON	Dose	Frequency	Withhold	Stop	Comment	Kardex
	DIAZEPAM	2mg	OD				
	SUMATRIPTAN	10mg	OD				

RECENT ANTIBIOTICS/RECENTLY DISCONTINUED MEDICATION (within 6 months)

NON-PRESCRIPTION MEDICATIONS AND HERBAL MEDICATIONS

Are you satisfied this medication history is complete and accurate? Yes ☐ No ☐
If 'No' please detail what further action is necessary (e.g. contact GP, carer or access ECS)

Medicine reconciliation completed by? Name: Signature:
Date: Time:

Medicine reconciliation verified by? Name: Signature:
Date: Time:

Examination

Diabetic patients → foot examination and diabetes bundle
GI Bleeding → PR examination
Age >65 or confusion → AMT
If cognition or alertness impaired → consider delirium

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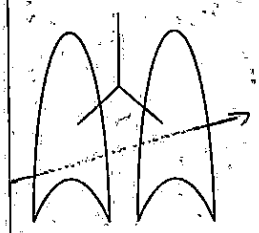
Cardiovascular

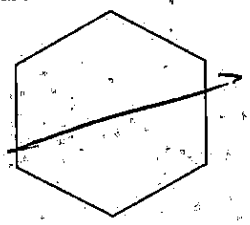
BP - 120/80
HR - 68
Pulses 5 mm

Respiratory



RR 18
100% on RA

Abdominal



No organomegaly
No superficial / deep masses

Bowel sounds: present

PR:

AMT (If <4/4, complete AMT10)

1. Age
2. DOB
3. Year
4. Location

2/4

Ask patient to remember address: "42 West Street"

5. Time to nearest hour
6. Current monarch
7. Date Of WW2
8. Count 20→1
9. Identify 2 people
10. Recall address

/10

Neurological (remember speech, visual assessment, balance, gait)
Cranial nerves:

	R arm			L arm			R leg			L leg		
Tone												
Power												
Sensation												
Coordination												
Reflexes	B	T	S	B	T	S	K	A	Plantar	K	A	Plantar

Temp - 36.5°C

Other

No spinal tenderness

Urine dip - trace of blood / ketones

Cr 115 eGFR 24
Hb 128
WCC 8.2
Urea - 250

Interpretation of results

ECG

Urine HCG

Urinalysis

	Neg	Trace	+		++	+++	++++
Leucocytes							
Nitrites							
Glucose							
Ketones							
Blood							
Protein							

CXR

Other imaging

Additional comments

Differential diagnosis

[redacted]

CHI NO: 0605770352 06/05/1977
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? Renal colic - admit for pain control

Management plan

1) Analgesia -
2) IV Fluids
3) CT KUB in AM -
4) Paracetamol -
5) Caution diclofenac due to CKD in AM

Additional investigations required (e.g. cultures) Please initial and date when sent

	Initial/ Date		Initial/ Date
	Initial/ Date		Initial/ Date

Venous thromboembolism (VTE) risk assessment

Medical patient expected to be mobilising as normal within 2 days		Proceed to VTE risk **actions**
Medical patient with reduced mobility for ≥2 days OR Surgical patient		Assess **thrombosis and bleeding risk factors**

Thrombosis risk factors. ANY thrombosis risk factor(s) should prompt VTE prophylaxis measures unless contraindicated → Assess bleeding risk.

- ☐ Mobility reduced for >2 days
- ☐ Age >60
- ☐ Dehydration
- ☐ Obesity BMI>30 kg/ m^2
- ☐ Significant medical comorbidity (e.g. cardiac, respiratory, endocrine, inflammatory, infectious conditions)
- ☐ Active cancer or cancer treatment
- ☐ Thrombophilia
- ☐ Personal history or first degree relative with history of VTE
- ☐ Use of hormone replacement therapy or oestrogen containing contraceptive
- ☐ Pregnancy or <6/52 post-partum
- ☐ Acute surgical admission with inflammatory or intra-abdominal condition
- ☐ Surgery with significant reduction in mobility
- ☐ Critical care admission
- ☐ Knee or hip replacement
- ☐ Hip facture
- ☐ Total anaesthetic+ surgical time >90mins
- ☐ Pelvic or lower-limb surgery with anaesthetic+ surgical time >60mins
- ☐ Varicose veins with phlebitis

Bleeding risk factors. Consider whether sufficient to preclude pharmacological prophylaxis

- ☐ Active bleeding
- ☐ Acquired bleeding disorder (e.g. acute liver failure)
- ☐ Current use of therapeutic anticoagulation (e.g. warfarin, rivaroxaban, dabigatran)
- ☐ Acute stroke
- ☐ Thrombocytopenia (<75x10^9/L)
- ☐ Uncontrolled hypertension (>230/120mmHg)
- ☐ Untreated inherited bleeding disorder
- ☐ Neurosurgery, spinal surgery or eye surgery
- ☐ Other procedure with high bleeding risk
- ☐ Lumbar puncture, epidural or spinal anaesthesia expected within the next 12 hours
- ☐ Lumbar puncture, epidural or spinal anaesthesia within the previous 4 hours

VTE risk actions

Information provided Provide if admission is anticipated Yes/ No	LMWH Yes/ No/ Contraindicated	Antiembolism stockings Consider if thrombosis risk factors present and bleeding risk factors preclude LMWH Contraindicated in peripheral neuropathy, PVD, ulceration, cellulitis, gross oedema Yes/ No/ Contraindicated

Name Signature Date Time complete

Consultant Ward Round

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WR - Mr TAYLOR.

MAOS 0

STILL REPORTS PAIN. ++

(1) AWAIT CT KUB TODAY. (BOOKED)

(2) REMAIN NBM

C ARMSTRONG
SCP UROLOGY.

ECG

CXR/Imaging

Results

Consultant Ward Round

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Diagnoses and significant comorbidities	Plan

Checklist		Estimated LoS <24h 24-48h >48h
Medicine reconciliation		Transfer of Care to:
VTE assessment		Outstanding criteria for ward transfer/discharge (delete as appropriate):
S_pO_2 target prescribed		
Fasting	Yes / No	

Name Signature Date Time

Resuscitation/ Escalation of care/ Anticipatory Care Planning / Advance Directives

Documentation of Discussion with Patient or Family

Treatment options that may help and patient would wish considered (and in what circumstances):-

Treatment options that may not help or patient would not wish:-

Discussed with patient/family: Y /N/Unable

Documentation (circle all that apply): DNACPR ReSPECT AWI

Name Signature Date Time

Date and Time	Daily MDT and Nursing update

Consent (care planning) Yes ☐
Name band Yes ☐
NOK details obtained Yes ☐
Vital Signs Yes ☐
Own medication Yes ☐ No ☐
Dentures Yes ☐ No ☐
Glasses Yes ☐ No ☐
Hearing aids Yes ☐ No ☐

COPY

26/5/25 21:10 Alan 48yr old male admitted to SAU from GP with back pain.
? renal colic.
Started on morphine.
Needs IVFs
Waiting for ED - known. awaits scan via

[signature]

A.B-SMITH F41.

00:30 ATSP for pain R/V.

27/5/25. News 0.

48 M - ? renal colic ? constipation - q/w CT. Results in AM.

Seems in pain, pacing around.

(R) flank → groin pain. constant. worse over 20-30 mins. Came on after taking senna. Difficult to take Hx as pt. distressed and annoyed at questions.

Says can't tolerate NSAIDs since dialysis in 2011 - but takes ibuprofen for headaches when at H.

Declined domperidone from nursing staff.

kidney function normal.

PRN - encourage to take domperidone.
oral morphine PRN.

d/w a/w CT results soon.

continue w/ plan as per surgical specialty SHO.

escalate if ↑↑ pain / any clinical deterioration/concern

[signature] #1292.

Date and Time	Daily MDT and Nursing update COPY
	~~Settled overnight~~
	~~GCS~~
27/5/25	Patient in pain
0120	GCS stable
	Meds as per keprner
	for CTKUB
	Ind with ADL's
	12 Sun
	[redacted]
27/5/25	M. Asami JT3 urology reg
1430	→ CT results explained
	→ once E+D will can go home
	→ no req'd abx
	Meds given
	Obs were stable
27/5/25	Patient left ward-
15:30	phoned Security - seen getting
	on bus - phoned pt
	NO PVC
	Does not wish to return.

Was fit for discharge cyt Tennys S/N

Date: 26/5/25 Time: 1730

Named Nurse: Nicole Patients preferred name: Alan (48)

CHI NO: 0605770352 06/05/1977 M
CRN:
Alan WYLES
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S Situation

Brief history of complaint & pre-hospital treatment:
10/10 back pain 5/7.
Bowels not moved 3/7. Passing urine.
1 x vomit
* on buprenorphine *
Details & NOK checked: (Y) N
Relative/Carer: Informed? (Y) N and present? Y (N) 1g Paracetamol (SAS)

B Back-und

MI ☐ CVA ☐
Asthma ☐ COPD ☐
Angina ☐ HTN ☐
Epilepsy ☐ Diabetes T1/T2

Anticoagulated: Y (N)
Vulnerable adult: Y (N) (see SAS PRF)
Time Critical Medication: Y / N (if Yes give details)

Past Medical History:
Renal failure previously.
Ex IVDU.

Allergies: NKDA.
Social Background: lives alone

A Assess-ment

ECG ☐ NEWS 0.
Bloods ☑ BM ____
PVC ☐ GCS/AVPU ____
Urinalysis ☑ Ketones ____
HCG ☐ Pain: 3 /3
Analgesia ☑.

Care and Comfort Chart Commenced: (Y) N
How often to be done:

Mobility: Ind Name Band ☑ Signature: MF

R Recomm-endations

Impression: ? renal colic
? constipation

Nurse Escort Required: Y / N
Outstanding Treatments:

Referred Specialty:
Medics ☐ Ortho ☐
Surgeons ☑ ENT ☐
Gynae ☐
Other ____

Recommendation Falls Care Bundle required Yes / No Falls alert added to Trakcare ☐

NEWS: 0 Signature:

CHI NO: 0605770352 0705/1977
CRN:
Alan WYLES
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Situation Back pain
? Renal colic

Background NKDA
Doesn't tolerate NSAIDS

Assessment IND.

Recommendation Await scan results -
fasting at present
on IV fluids

CHI NO: 0605770352 06/05/1977
M
CRN:
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RADIOMETER ABL90 SERIES

ABL90 I393-092R0213N0033 19:32 26/05/2025
PATIENT REPORT Syringe - S 65uL Sample # 41483

Identifications

Operator	NIKKI MARTIN
Patient ID	0605770352
Department (Pat.)	ED
Patient last name	WYLES
Patient first name	AKAN
Sample type	Venous
$FO_2(I)$	28.0 %
T	37.0 °C

Blood gas values			
cH^+c	42.4	nmol/L	[-]
pH	7.373		[7.350 - 7.450]
↑ pCO_2	6.72	kPa	[4.50 - 6.00]
↓ pO_2	4.05	kPa	[9.00 - 12.0]
Temperature-corrected values			
$pCO_2(T)$	6.72	kPa	[-]
$pO_2(T)$	4.05	kPa	[-]
Acid-base status			
$cHCO_3^-(P)c$	29.3	mmol/L	[-]
$cBase(B)_c$	2.8	mmol/L	[-]
Electrolyte values			
cNa^+	138	mmol/L	[136 - 146]
↓ cK^+	3.9	mmol/L	[4.0 - 5.0]
cCl^-	97	mmol/L	[95 - 106]
cCa^{2+}	1.20	mmol/L	[1.15 - 1.29]
Metabolite values			
cGlu	6.1	mmol/L	[4.0 - 8.0]
cLac	0.8	mmol/L	[0.5 - 1.6]
Oximetry values			
↑ $ctHb$	163	g/L	[80 - 140]
↓ sO_2	58.5	%	[94.0 - 100.0]
↓ FO_2Hb	56.9	%	[95.0 - 99.0]
↑ $FCOHb$	2.0	%	[0.0 - 0.8]
↑ $FMetHb$	0.7	%	[0.2 - 0.6]

Notes
↑ Value(s) above reference range
↓ Value(s) below reference range
c Calculated value(s)

Solution pack lot: DY-07
Printed 19:32:55 26/05/2025
Sensor cassette run #: 1505-460

CHI NO: 0605770352 06/05/1977
CRN:
Alan WYLES
2 GORDON SQUARE

STIRLING
FK8 1FN

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CHI NO: 0605770352 06/05/1977
M
CRN:
Alan WYLES
2 GORDON SQUARE

STIRLING
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Siemens
Clinitek Status®

Serial Number:
360010

Patient Name:
ALAN WYLES
Patient ID:
0605770352
Multistix® 8 SG
Test date 05-26-2025
Time 7:13PM
Operator NIKKI
Test number 8732
Color Yellow
Clarity Clear

GLU Negative
KET Trace
SG 1.010
BLD Trace-intact
pH 6.0
PRO Negative
NIT Negative
LEU Negative

Results

Fast

Free fluid identified:
Yes/No (circle)

AAA

Aorta clearly seen

Yes/No (circle)
Measured diameter.....

Protetanus

Immune/Not immune (circle)

(circle)

e including Police Yes / No

Print Name..... Date.....

ING1716

PVC INSERTION BUNDLE AND REMOVAL RECORD

CHI NO: 0605770352 06/05/1977
CRN: M
Alan WYLES
2 GORDON SQUARE
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PLEASE COMPLETE ALL BOXES

The patients skin is decontaminated and allowed to dry	YES / NO
Hand hygiene & gloves donned prior to insertion	YES / NO
Aseptic Non Touch Technique is used to insert PVC	YES / NO
If not possible, use either **STERILE GLOVES** or **MINI CHLORAPREP**	
Sterile dressing & sticker (date & time) applied after insertion	YES / NO

Colour: _____
Insertion Site: _____
Ward/Department: _____
Inserted by: _____
Date & Time: _____
Removed: YES / NO

Why is PVC clinically indicated for patient?: (please tick)

IV Fluids		Blood Transfusion	
IV Drugs		Diagnostics	
Predicted clinical need			

INVESTIGATIONS

Bloods Required:

FBC U&E GLU LFT CRP AMY CLOTTING G&S ESR PARACETAMOL
TROP D-DIMER CULTURES VBG* ABG* (*attach to notes) URINALYSIS HCG ECG

Others: _____ SIGN _____

BLOODS TAKEN? YES / NO TIME TAKEN 17:42. PRINT _____

reliminary Pressure Ulcer Risk Assessment (PPURA):

Mobility: Person is fully mobile without equipment/assistance
Continence: Person is fully continent
Nutrition: Person appears well nourished and able to eat and drink
Skin: Skin to pressure points satisfactory/intact

Points to Consider
* People who are overweight may not be well nourished
* Use of repose mattress or pressure relieving heel protectors.

Record your answer in the grid below Y = Yes or N = No
If the answer is NO to any assessments undertake a BRADEN and consider any other assessment

DATE	TIME	MOBILITY	CONTINENCE	NUTRITION	SKIN INSPECTED	SKIN INTACT	BRADEN COMPLETED	SIGNATURE
26/5/25	1745	4	4	4	N	4	AT	NM
SKIN DESCRIPTION i.e. REDNESS, SKIN BROKEN, BLISTER / ULCER						ACTION TAKEN		

4 A T

ALERTNESS (assess for drowsiness or agitation, if asleep attempt to rouse)		Tick
Normal	0	✓
Mild sleepiness (easily roused <10 seconds)	0	
Clearly abnormal	4	

AMT4 (age, date of birth, place, current year)		Tick
No mistakes	0	✓
1 mistake	1	
2 or more mistakes	2	

ATTENTION (ask for months of the year backwards)		Tick
Achieves 7 or more correctly	0	✓
Starts but scores less than 7/Refuses to start	1	
Untestable	2	

ACUTE CHANGE OR FLUCTUATION (significant change incl. evidence of psychotic symptoms)		Tick
No	0	✓
Yes	4	
Total score (score of 4 or more indicates likely delirium - initiate TIME bundle)		

FALLS TRIGGER TOOL (Complete only if 65 years or over)

2 or more falls in the last 6 months?	YES / NO	Tries to walk alone and is unsteady?	YES / NO
Fall since admission to department?	YES / NO	Patient/relatives anxious about falls	YES / NO
Admitted to department with fall?	YES / NO	4AT more than 4/evidence of confusion	YES / NO

COMPLETED BY .....

If you have answered yes to 2 or more questions,
- For patients being admitted please document recommendation that a full care bundle is required to be completed.
- Please add FALLS RISK IDENTIFIER to Trakcare (EPR→ Patient Alerts→ New→ Ward Signifiers→ Falls risk).

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ACUTE ASSESSMENT UNITS/DAY SURGERY UNIT RISK ASSESSMENT and CARE PLAN BOOKLET

CHI NO: 0605770352 06/05/1977
CRN: M
Alan WYLES
2 GORDON SQUARE

STIRLING
FK8 1FN

Date of admission: 26/5/25

Time of admission:

Admission Area: SAU

Assessment	Initial assessment to be completed:	Assesment area nurse Initials	Transfer Area nurse Initials
CPE (1st ward only)	On Admission if required	W	N/A
Falls Trigger Tool	On Admission	W	
Bedrail Assessment	On Admission	W	
Skin, Continence and Personal Hygiene assessment	On Admission	W	
Hydration Assessment	On Admission	W	
4AT	On Admission	W	
MUST Screening and Care Plan	On Admission	W	
Oral Care Assessment and Care Plan	On Admission	W	
Falls history and Falls action plan	On admission if **Yes** to any factors on Falls Trigger tool	W	
Braden/Skin Assessment	On admission **if at risk or not** intact	W	
Patient Handling and Mobiliy Chart	On admission **if not** independent	W	

Daily Assesments to be completed

1.Hydration
2.Skin Assessment
3.Personal Hygiene and continence
4.Bowel Function

Initial Assessments on page 1 must be carried out at time of admission, all other assessments will be reviewed weekly except **Daily Assesments**

The information within this document is confidential and may only be viewed and shared with the permission of the named patient.

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Staff identification This acute assessment and care plan booklet is a legal document. Your signature indicates you have assessed and planned care with your patient/carer and is a true reflection of the care that will be delivered by you or delegated by you.

Name:	Signature:
Name:	Signature:
Name:	Signature:
Name:	Signature:
Name:	Signature:
Name:	Signature:
Name:	Signature:
Name:	Signature:
Name:	Signature:
Name:	Signature:
Name :	Signature:
Name:	Signature:
Name:	Signature:

..luables Policy

Forth Valley Royal Hospital does not take any responsibility for patients own belongings/ valuables.

Any valuables are encouraged to be taken home or can be logged and kept in the safe. A receipt will require to be provided.

Patient/family aware Yes/No
Valuables in safe Yes/No
Valuables kept with patient Yes/No

Details.....

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Nursing Risk Assessments to be completed on Admission

Patients preffered name:
Ward:

Communication Assessment

No concerns ☑ New receptive/expressive difficulties ☐ Pre-existing ☐	Hydration Risk Assessment Complete ☐

Falls Risk/Trigger Tool

	Circle
History of falls prior to admission? **(Falls(s) since admission?**	Y/N
Additional falls risk factors for this patient? E.g. Patient tries to walk alone but unsteady/unsafe, learning disabilities, parkinson's, stroke, cognitive impairment, delirium, continence issues, visual impairment, medication (night sedation), surgery, seizures/epilepsy, fear of falling etc. (if yes to this question, state risk and commence **falls prevention** action plan)	Y/N
Current Mobility: (walks alone but unsafe, cognitive impairment, drip stand, catheter)	Y/N
Bedrails required Y /N if yes complete bedrails assessment	
If answered yes to any of these questions:---complete a **falls history on page 6** and commence **falls prevention** action plan on **page 7**	☐

Skin, Continence and Personal Hygiene assessment

Skin integrity	Continence Care	Personal Hygiene	Mobility
Independent/no concerns ☑	Continent ☑	Independent ☑	Independent ☑
Skin Checked: Intact ☐	Incontinent ☐	Requires set up ☐	Supervision ☐
Skin Checked: at risk/not intact (please circle)	Continence Aids in use.....	Prompting ☐	Assistance of 1 or 2 or 3 (Please Circle)
Braden +/- wound assessments on admission if within 6 hours of admission	Urinary Catheter ☐ Nephrostomy ☐	Assistance of 1 or 2 (Please Circle)	
	Stoma ☐	Full Assistance ☐	

Name: [illegible] Signature: [illegible] Date/Time 26/5/15

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Infection Prevention and Control Risk Assessment

All patients admitted must have a Clinical risk assessment (**CRA**) for Carbapenemase-Producing *Enterobacteriaceae* (**CPE**) and Meticillin Resistant Staphylococcus *aureus* (**MRSA**).**This is a mandatory requirement.**

CPE Clinical Risk Assessment (No patients are excluded from CPE screening).	**Response**
Has the patient had any previous history of CPE (check clinical portal)	YES / NO
Has the patient been transferred directly from another hospital out with NHSFV	YES / NO
Has the patient a history of admission to a hospital out with Forth Valley in the last 12 months (including dialysis patients)	YES / NO
Has the patient been in close contact with a person colonised or infected with CPE	YES / NO

A **YES** response to **ANY** of the above questions suggests the patient has an increased risk of CPE ar ıe following actions must be taken:

- Isolated the patient in a single side room, STOP sign on door, contact precautions (PPE)
- The patient is given an information leaflet and consent is obtained for swabbing;
- CPE screen: Rectal swab taken by a registered nurse or stool specimen and, if present, a wound swab. A urine specimen is required if a urinary catheter is present:
- A rectal swab **must not** be used for children under 16 years. A stool specimen should be sent.

	MRSA Clinical Risk Assessment (Exclusions from MRSA screening include: Day case patients and admissions to paediatric, obstetric and mental health specialities)	**Response**
1	Has the patient a history of MRSA, (check clinical portal)	YES / NO
2	Has the patient been admitted from anywhere other than their own home, e.g. care home, hostel, prison, or transferred from another hospital.	YES / NO
3	Does the patient have any wounds or indwelling medical devices (e.g. PEG, Hickman line, urinary catheter)	YES / NO
4	Will the patient be admitted / transferred to ITU	YES / NO

A **YES** response to questions **1- 3** indicates an increased risk of MRSA colonisation.
Th ollowing actions must be taken:

- The patient is isolated in a single side room, STOP sign on door, contact precautions initiated;
- The patient is given an MRSA screening leaflet and consent obtained for swabbing;
- MRSA screen: swab nose, perineum and if present, wounds and insertion sites of invasive devices. A urine specimen is required if a catheter is present.

Note: this is the minimal screen required and additional swabs can be sent if clinically indicated.
A **YES** response to question **4** confirms admission to a high risk specialty and the following actions must be taken:

- The patient is given an MRSA screening leaflet and consent obtained for swabbing;

Sign	**Date** 26/10/20	**Swabs sent: Yes / No/NA**

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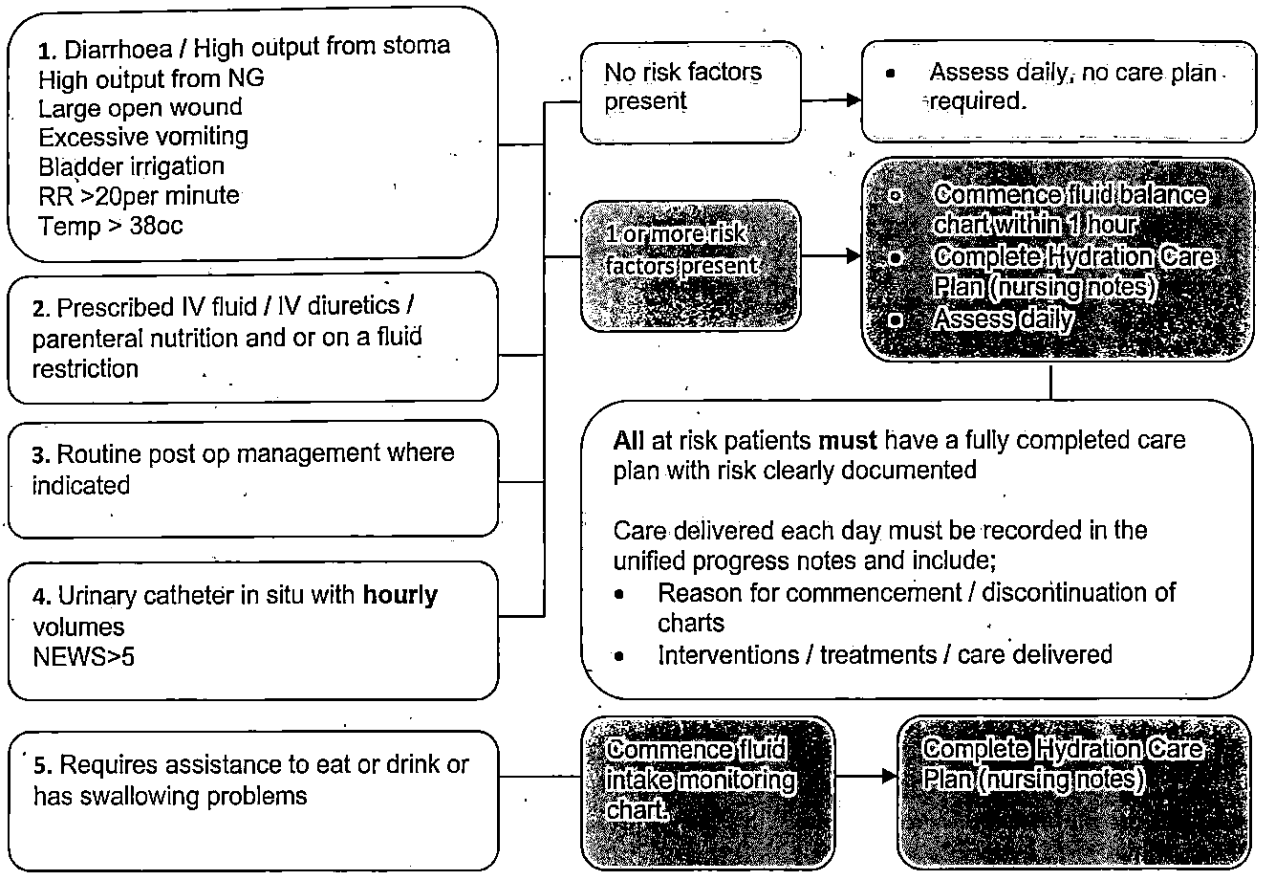
Daily Hydration Risk Assessment

Risk assessment should be carried out within 4 hrs of admission and daily thereafter



Risk Assessment Week 1	Date/time	Date/time	Date/time	Date/time	Date/time	Date/time	Date/time
	26/5/20	27/5/20					
Number of Risks present	0	0					
Fluid Balance or monitoring indicated Y=Yes N=No	N	N					
Care Plan commenced/reviewed Y=Yes N=No	N	N					
Initials of assessor	W.	WC					

N/A

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TO BE COMPLETED FOR **ALL** PATIENTS OVER 65 ON ADMISSION AND WHEN A CHANGE IN PRESENTATION IS EVIDENT

* Signed..... Date.....
(ensure documented in clinical notes)

DATE		/ /	/ /	/ /
1. ALERTNESS: *This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive.* *If asleep, attempt to wake and ask the patient to state their name and address to assist rating.*	Normal (fully alert, but not agitated throughout assessment)	0	0	0
	Mild sleepiness for <10 seconds after waking, then	0	0	0
	Clearly abnormal (agitated or drowsy)	4	4	4
AT4: *date of birth, place (name of hospital or building), current year*	No mistakes	0	0	0
	1 mistake	1	1	1
	2 or more mistakes/un-testable	2	2	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	0	0	0
	Starts but scores <7 months/refuses to start	1	1	1
	Un-testable (cannot start because unwell, drowsy,	2	2	2
4. ACUTE CHANGE OR FLUCTUATING COURSE: *Evidence of significant change or fluctuation in: alertness, cognition (e.g **increased confusion**) or other mental function arising over the last 2 weeks and still evident in last 24hrs*	No	0	0	0
	Yes	4	4	4
	Initials of tester →			
4 or above: Possible delirium +/- cognitive impairment - score daily until score <4 for 2 consecutive days Possible cognitive impairment – only rescore if condition changes Delirium or cognitive impairment unlikely – only rescore if condition changes		**Day 1 4ATscore** ___	**Day 2 4ATscore** ___	**Day 3 4ATscore** ___

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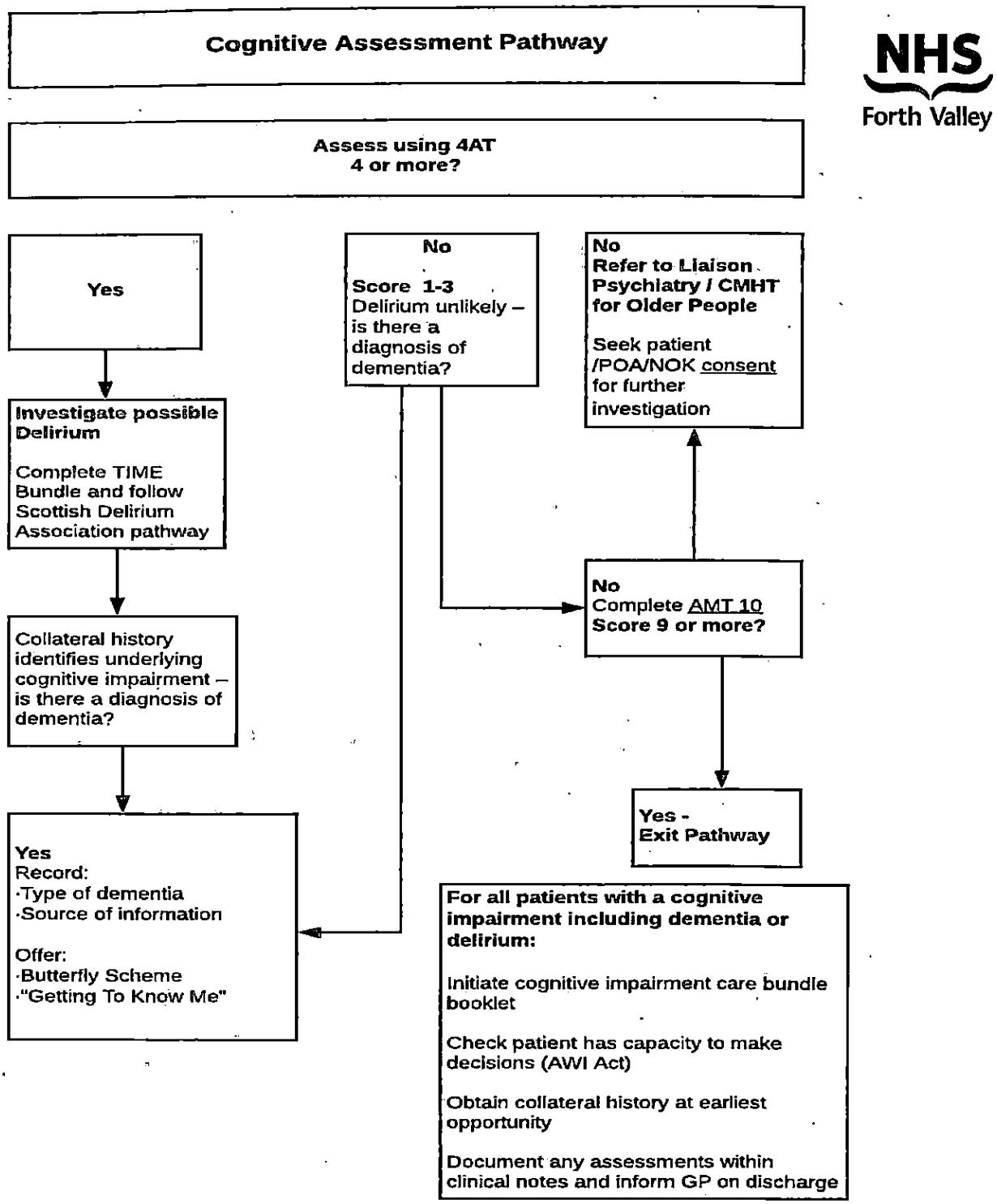
HE 4AT TEST: SCREENING INSTRUMENT FOR COGNITIVE IMPAIRMENT AND DELIRIUM



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Falls History:

To be completed if answered yes to any of the questions on the Falls Risk/Trigger Tool

Falls history assessment: (Date & time of last fall **prior** to admission)

Estimated date and time of the last fall? Date ..... Time of Day.....

First fall? Yes ☐ No ☐ Recurrent falls? Yes ☐ No ☐ Number of falls within the last year? .....

Any warning immediately prior to any falls? Yes ☐ No ☐

Palpitation ☐ Dizziness ☐ Alcohol ☐ Loss of Consciousness ☐
Slip/Trip ☐ Environmental hazards ☐ Associated movement ☐

Explanation about fall/previous falls :(where, when, why) Activity at time of fall? (Please describe)
(consider if fall/injury could be non accidental)

.....

.....

.....

Any injury sustained or previous fracture? Yes ☐ No ☐ (if yes, please describe)

.....

.....

Any pain related to fall? Yes ☐ No ☐ (if yes, please describe)

.....

.....

ny anxiety regarding further falls/confidence affected? Yes ☐ No ☐ (If yes please describe)

.....

.....

Comments/other information/highlight areas of concern:

.....

.....

Data collected from: Patient ☐ Relative ☐ Carer ☐Other: .....

Nurse Signature: _____ **Date/Time:** _____

NO HAND MOTION

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Falls Prevention Action Plan

The following nursing interventions may address some of the falls risk factors. They are however **NOT** exhaustive and staff should use their clinical reasoning/professional judgment when determining falls risk interventions.

Please state all actions taken from the list of interventions below.

Interventions:	Care Plan 1: On Admission
Environmental: • Nurse in most appropriate place on ward for their needs e.g. easily observable area, near toilet etc. • Area hazard free, personal belongings within easy reach • Call system working/within reach at all times • Adequate lighting at all times particularly overnight. • Check infusion stands facilitate mobility. • Use of sound/movement monitors (if available) • Select suitable seating (appropriate height, comfort) • Consider one-way glide sheet for chair • Frequently re-orientate confused patients	
Vision/Hearing • Ensure correct glasses worn/within easy reach and clean. • Determine if patient can recognize objects from the end of the bed - if concerns, refer to medical staff for visual acuity assessment • Consider hearing implications, hearing aid working etc.	
Lying and Standing Blood Pressure: Baseline for all • **Check and record.** If deficit exists, inform medical staff and continue to check twice daily for at least 72 hours. • Advice patient on slow movement from sitting/lying to standing.	**Baseline** Lying: Standing:
Mobility: • Follow mobility risk assessment/care plan. • Consider referral to Physiotherapy and/or OT • If patient requires walking aid is it within easy reach?	
Medication: • Request Medical staff or Pharmaceutical review.	
Delirium (Acute Confusional State) • Complete 4AT risk assessment • Treat causes of delirium, refer to delirium guidelines	
Toileting: • Assess continence. If urine frequency, ward test urine. • Plan routine/frequent toileting. • Consider a commode for night time toileting. • Consider full continence assessment and refer to continence service if indicated.	
Bed and bedrails: • Bed at optimum height and brakes applied. • Assess the need for bedrails • Hi/Low bed assessment and follow pathway	
Footwear/Clothing • Encourage patient to wear shoes not slippers. • Check footwear for secure fit, non-slip sole. Ask relatives to supply safer replacements. • Ensure toenails are in good condition, include plan of care in personal hygiene care plan (Refer to podiatry if infected or neglected) • Suitability and appropriateness of clothing e.g. length	
Inform: • Ensure Medical staff, Physiotherapist, OT, Social Worker etc, are aware of patients falls risk, frequency and nature • Involve/educate patient/relatives in safe practice. • Discuss with patient/relative re specific interventions. • Issue leaflet "How to reduce falls in hospital". • Place patient on care rounds/safety brief	
Additional Falls Risk Management Interventions for Patient:	
Initials of Nurse/Date & Time:	

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Falls Care Plan review weekly or post fall

	Care Plan 2: Review of Interventions Weekly, post fall or changes to the patient's condition Date & Time	Care Plan 3: Review of Interventions Weekly, post fall or changes to the patient's condition Date & Time
Environmental		
Vision and Hearing		
Lying and Standing Blood pressure		
Mobility		
Medication		
Delirium (acute confusion)		
Toileting		
Bedrails		
Footwear and Clothing		
Who did you Inform?		
Additional information		
Post Fall	IR1 No..... Falls No..... Care Plan Reviewed and still in use: Y/N New Care Plan required: Y/N Staff Initials/date/time.....	IR1 No..... Falls No..... Care Plan Reviewed and still in use: Y/N New Care Plan required: Y/N Staff Initials/date/time.....

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Bedrails Assessment

Bedrails NOT to be used Code: A. Risk of climbing over and falling from a greater height. B. Patient is independent. C. Risk of entrapment in bedrails outweighs risk of falling D. Do not use with a high/low bed E. Patient with capacity and oriented but refuses bedrails	Bedrails CAN be used Code: F. Patient with capacity and is alert and oriented and requests bedrails. G. Risk of injury from falling from the bed outweighs the risks of not using bed rails. H. Patient is unconscious.

Assessment to be completed on admission within 6 hours. Review weekly or following a fall and in response to a change in patient condition.

Date and Time	Codes	Bed rail in use	Initials
26/5/25	9	YES/NO	W
		YES/NO	
		YES/NO	
		YES/NO	

Bed rails must be used when the bed is moving
(ie; transferring patient between areas)

BRADEN RISK ASSESSMENT CHART

Individuals with a total score of 16 or less are considered at risk: 15-16 = low risk, 12-14 = moderate risk, 11 or less = high risk.
Undertake and document risk assessment within 6-8 hours of admission to every ward or department.
Reassess if there is a change in individual's condition and repeat regularly according to local protocol or risk score.
1 .Complete skin care plan with BRADEN score included and commence a care and comfort round chart.
2. Consider contributing factors, frailty, diabetes, end of life care.

				DATE	On Admission					
				TIME	26/5/25					
Sensory Perception – Ability to respond meaningfully to pressure related discomfort	**1.Completely Limited** Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation. **OR** limited ability to feel pain over most of body surface.	**2.Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. **OR** has a sensory impairment that limits the ability to feel pain or discomfort over ½ of body.	**3. Slightly Limited** Responds to verbal commands but cannot always communicate discomfort or need to be turned. **OR** has some sensory impairment that limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or voice pain or discomfort.	4					
Moisture – Degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient/client is moved or turned.	**2. Very Moist** Skin is often but not always, moist. Linen must be changed at least once a shift.	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day.	4. **Rarely Moist** Skin is usually dry. Linen only requires changing at routine intervals.	3					
Activity – Degree of physical activity	**1. Bedfast** Confined to bed.	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during day but for very short distance, with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks Frequently** Walks outside the room at least twice a day and inside the room every 2 hours during waking hours.	4					
Mobility – Ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance.	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitations** Makes major and frequent changes in position without assistance.	4					
Nutrition – Usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Takes fluids poorly. Does not take a liquid dietary supplement **OR** is NPO and/or maintained on clear liquids or IV's for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about ½ of any food offered. Occasionally will take a dietary supplement **OR** receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate** Eats over half of most meals. Occasionally will refuse meal but will usually take a supplement if offered **OR** is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	**4. Excellent** Eats most of every meal. Never refuses a meal. Occasionally eats between meals. Does not require supplementation.	3					
Friction and Shear –	**1. Problem** Requires moderate to maximum assistance in moving.	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.		3					
				Indicate appropriate number and add for total score TOTAL SCORE:	21					
				Initials:	W					

12

Consider needs based on score and record in care plan

TOTAL BRADEN SCORE INDICATES THAT THE PATIENT IS:	EQUIPMENT AND ACTION WHICH SHOULD BE **CONSIDERED** FOR EACH "AT RISK" CATEGORY. DOCUMENT EQUIPMENT TO BE USED AND PLAN OF CARE IN THE SKIN CARE PAN. GIVE PATIENTS/CARERS AN INFORMATION LEAFLET.
17+ : NOT AT RISK	◦ Depending on patient's individual requirements an overlay may be required for comfort e.g. Repose/Propad
15 – 16 : LOW RISK	◦ Pressure reducing mattress e.g. SOFTFORM/PENTAFLEX • Mattress Overlay e.g. Repose • Daily skin inspection should be documented in nursing notes
12 – 14 : MODERATE RISK	If skin is intact. • Use pressure reducing mattress e.g. SOFTFORM/PENTAFLEX ◦ Mattress overlay e.g. .Repose **OR** If skin is broken up to a Stage 2 pressure ulcer, • Mattress overlay e.g. Repose or an active pressure relieving mattress overlay e.g. Soft form premiere active ,Tamora(Community) • **Daily** Braden risk assessment • Twice daily skin inspection and document in unified progress notes • Implement turning schedule – reposition changes 2-4 hourly and document in unified progress notes
9 – 11 : HIGH RISK	If skin is broken up to a Stage 3 pressure ulcer • Alternating Dynamic Pressure System, e.g. Softform premiere active ,Tamora (Community) NIMBUS (Acute) • **Daily** Braden risk assessment • Implement turning schedule – reposition changes 2-4 hourly and document in unified progress notes • Skin inspection at each reposition change and document in unified progress notes
6 – 8 : SEVERE RISK	If skin is broken up to a Stage 4 pressure ulcer • Alternating Dynamic Pressure System e.g. NIMBUS, (Community only Softair, Tamora) • **Daily** Braden risk assessment ◦ Implement turning schedule – reposition changes 2 hourly and document in unified progress notes • Skin inspection at each reposition change and document in unified progress notes
When an area of redness or discolouration is noted further action is required. Skin inspection, findings and action taken **must** be documented in unified progress notes.	• If patient is out of bed, a pressure reducing / relieving seating system comparable to the equipment used on the bed should be considered, e.g. Repose, Active Seat Cushion. Patients should be encouraged to reposition at least every **30 minutes** and be assisted if unable to do so. ◦ Patients should not be sitting up in a chair for longer than 2 hours if they have a grade 3 or above pressure injury. • Plan should be documented within the skin care plan along with the care and comfort documentation.

Specialised Equipment (Rentals)/TYPE / AID	DATE COMMENCED	DATE DISCONTINUED/Sent back

Tissue Viability Service
Please advise TV service of all patients with a grade 3 or above pressure injury. Referral/Advice and Support 01324 673747

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'MUST' – Nutritional Risk Screening

STEP 1 (BMI) **(Complete all 5 steps and transfer results to initial screening row below).**	**STEP 2 (Weight Loss)**	**STEP 3 (Acute Disease Effect)**	***If weight** not measured please indicate how this was obtained (see key below)	***If height** not measured please indicate how this was obtained (see key below)
Weight (Kgs) * = 53kg Height (m) * = 1.74 Method used M,R,C* C BMI 27 See BMI charts eater than 20 score 0 18.5 – 20 score 1 Less than 18.5 score 2 (greater than 30=obese)	Pre-illness weight = ... (Can be obtained from previous notes, GP, patient, carer or clothes size) Total unplanned weight loss over 3-6 months Weight loss (kg) = ... Complete with weight loss chart Less than 5% score 0 5-10% score 1 Greater than 10% score 2	Acute illness **AND** there has been or is likely to be no nutritional intake for **5 days** No score 0 Yes score 2	M - Measured R - Reported C - Based solely on clinical impression (See **"Ward information pack"** for alternative measures)	M - Measured R - Reported C - Based solely on clinical impression (See **"Ward information pack"** for alternative measures)

STEP 4 (Overall Risk Score)	**STEP 5 (Care Plan)**
Add scores from steps 1+2+3 to calculate overall risk score SCORE 0 = LOW RISK SCORE 1 = MEDIUM RISK SCORE 2+ = HIGH If risk category arrived at by **clinical impression** alone, indicate risk category LOW/MEDIUM/HIGH in table below and document rationale in progress notes	Implement appropriate Nutritional Care Plan **0 = LOW RISK** **1 = MEDIUM RISK** **2 = HIGH RISK** **Treat as High Risk - immediate Dietetic Referral** -Dysphagia • Decompensated Liver Disease • Enteral Tube Feeding • Multiple Fractures • Pressure Ulcers Grade 3 or more

Initial screening

Date	Time	Ward	Weight (kg)*	Weight ↑↔↓	Method used (M,R,C)	BMI	Step 1 Score	Step 2 Score	Step 3 Score	Total Score	**'MUST' Risk**	Initial
26/5/17		8W	53	↓	C	27	0	0	0	0	LOW	W

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'MUST' Nutritional Care Plan

Low/Medium/High (circle) **Date/Time care plan initiated:** ..26/5/22....

Intervention	Plan of Care	Initials
Has patient been informed of current weight and plan? Discuss the results of the 'MUST' screening/care plan with the patient and family (with agreement and involve them in identifying individualised interventions)	Yes (No) (details if no) On admission & on-going	W
Weigh patient and rescreen	On Admission then weekly	W
Refer high risk patients to Dietitian with **'MUST' score ,BMI and weight loss**	Referred **Y** ☐ **NA** ☑	W
Complete dietary food record charts for med/high risk patients until assessed by dietitian	**Y** ☐ **NA** ☑	W
Med/High risk :Optimise nutritional intake by offering daily • nourishing milky drinks • regular snacks • 3 courses at midday and evening meal. Has signifier been added to patient's and kitchen white boards?	**Y** ☐ **NA** ☑ **Details:** **Y** ☐ **NA** ☑	W

Please √ relevant box and where yes is answered, record details of individual requirement below;

	Initials
Food Allergy- No ☑ **Yes** ☐ **religious, cultural, ethnic requirements - No** ☑ **Yes** ☐ Details:	W

	Initials
Therapeutic diet- No ☑ **Yes** ☐ Details:	W

	Initials
Assistance required with eating/drinking- No ☑ **Yes** ☐ **Adapted cutlery/aids - No** ☑ **Yes** ☐ **Assistance from family - No** ☑ **Yes** ☐ **(If yes please monitor fluid intake)** Details:	W

Oral Health Assessment

Assess within 24 hours of admission to determine if oral care planning is required. Discuss and agree care plan with patient/carer.

Complete this section to determine condition of mouth and the frequency of mouth care required. Document in the care plan and commence '2 Hourly' oral care record for Standard 2-4.

			Date/ Time														
Condition of mouth Check lips, oral soft tissues and teeth with a [illegible]od light	Teeth/dentures clean, mucosa pink and moist	Standard Care 1															
	Mucosa/tongue pink and dry	Standard Care 2															
	Obvious plaque/ swollen or bleeding gums or dry/crusted mouth	Standard Care 3															
	Possible infection	Standard Care 4															

Complete this section to determine frequency of assessment required and document in the care plan.

			Date/ Time														
Eating ability	Able to eat normal diet	1															
	Soft diet/delayed swallow reflex	2															
	Nil by mouth	3															
Physical ability	Requires assistance to access oral hygiene implements	1															
	Requires help with oral hygiene	2															
	Patient not able to carry out any aspect of oral hygiene	3															
Mental ability	Loss of interest/confused	1															
	Memory impaired/confused	2															
	Sedated	3															
Nutritional screening (only score if patient has own teeth)	MUST low	1															
	MUST medium	2															
	MUST high	3															
Additional risk factors	Diabetes mellitus	1															
	Medications	1															
	Smoking	1															
	Loose/damaged dentures	1															
	Open mouth breathing	1															
	Oxygen therapy	1															
	Broken or loose teeth	1															
		Total score															
		Initials															
Re-assessment risk level: Low (2-8)/Medium (9-14)=WEEKLY High (15+) = DAILY																	

Oral Health Care Plan

All patients should attain Standard Care 1 for oral hygiene. If any further care is required, this should be carried out **in addition** to Standard Care 1

Standard Care 1	
Natural teeth	• Brush teeth at least twice per day using fluoride toothpaste and a medium toothbrush. • Spit afterwards – do not rinse.
Dentures	• Remove after each meal and rinse dentures and mouth with water • Brush with toothbrush at least once per day with unperfumed soap and water or denture cream. Repeat this prior to overnight soaking. • Plastic dentures should be brushed then soaked for 20 mins in afresh solution of hypochlorite (1 part to 80mparts cold water/1/2 a teaspoon) in a patient named individual denture bowl. Then rinse and place in fresh water overnight. Dentures with metal parts should be soaked in chlorhexidine 0.2%. All dentures should be rinsed with cold water before replacing in mouth. • Clean palate, gum ridges and tongue with a soft toothbrush or thoroughly moistened foam stick. • Dentures must be stored in a named denture container when not in mouth.
Standard Care 2	
Dry mouth (Xerostomia)	• Follow Care Standard 1 and..... • Review medications that may cause dry mouth • 2 hourly mouth care, i.e. water to rinse and water based lubricating gel to dry lips. * see guidelines regarding use of gels. • Foam sticks thoroughly moistened in water to tongue and mucosa if unable to rinse • Frequent sips or sprays of water or crushed ice cubes are as effective and often preferable to artificial products so should be first choice • Saliva replacement products e.g. Biotene gel or mouthwash (ensure these products are prescribed)
Standard Care 3	
Obvious plaque/ swollen or bleeding gums or dry/crusted mouth	• Follow Care Standard 1 and..... • Remove debris with a medium headed tooth brush with a non foaming fluoridated toothpaste or thoroughly moistened foam stick • Using water rinse 4 times daily • Chlorhexidine mouthwash, spray or gel (ensure these products are prescribed and do not use for more than 1 month).
Standard Care 4	
Infection	• Follow Care Standard 1 and..... • Seek medical/dental advice for appropriate treatment

For further advice please contact the Oral Health Department via email for advice from an oral health promoter fv-uhb.enquiresoralhealth@nhs.net

Oral Health Care Plan

Care Goals	Potential nursing actions (Please include all that apply in the care plan below)
• To enable person to maintain an appropriate level of oral hygiene • To prevent infection • Discuss and agree care plan with patient/carer	• Document condition of the mouth and what care standard will be followed. • What level of assistance does the patient need to look after oral hygiene? • Document frequency of assessment required (daily or weekly) • Commence oral hygiene care deliver chart for patients that require 2 hrly mouth care (following care standard 2-4)

Date/Time	Plan of Care (Read/Review daily and update if required)	Sign
26/8/20	INDEPENDENT C CARE HYGIENE	W

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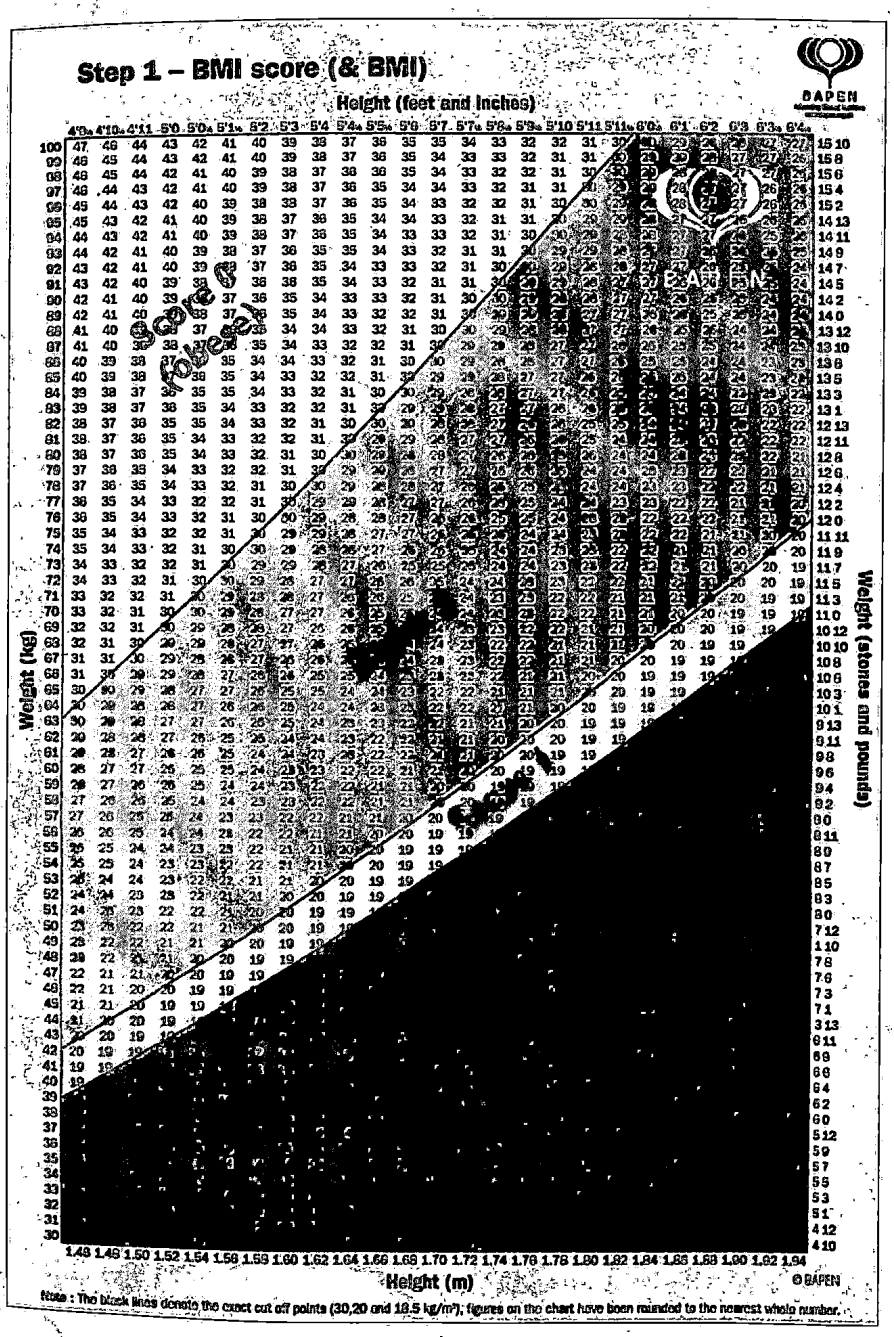

Sample
Not to be used

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Step 2 – Weight loss score

BAPEN
www.bapen.org.uk

KILOGRAMS

Score 0 Wt loss < 5%	Score 1 Wt loss 5 - 10%	Score 2 Wt loss > 10%

Current weight

Weight loss in last 3 to 6 months

kg	Less than (kg)	Between (kg)	More than (kg)
30	1.6	1.6 - 3.3	3.3
31	1.6	1.6 - 3.4	3.4
32	1.7	1.7 - 3.6	3.6
33	1.7	1.7 - 3.7	3.7
34	1.8	1.8 - 3.8	3.8
35	1.8	1.8 - 3.9	3.9
36	1.9	1.9 - 4.0	4.0
37	1.9	1.9 - 4.1	4.1
38	2.0	2.0 - 4.2	4.2
39	2.1	2.1 - 4.3	4.3
40	2.1	2.1 - 4.4	4.4
41	2.2	2.2 - 4.6	4.6
42	2.2	2.2 - 4.7	4.7
43	2.3	2.3 - 4.8	4.8
44	2.3	2.3 - 4.9	4.9
45	2.4	2.4 - 5.0	5.0
46	2.4	2.4 - 5.1	5.1
47	2.5	2.5 - 5.2	5.2
48	2.5	2.5 - 5.3	5.3
49	2.6	2.6 - 5.4	5.4
50	2.6	2.6 - 5.6	5.6
51	2.7	2.7 - 5.7	5.7
52	2.7	2.7 - 5.8	5.8
53	2.8	2.8 - 5.9	5.9
54	2.8	2.8 - 6.0	6.0
55	2.9	2.9 - 6.1	6.1
56	2.9	2.9 - 6.2	6.2
57	3.0	3.0 - 6.3	6.3
58	3.1	3.1 - 6.4	6.4
59	3.1	3.1 - 6.6	6.6
60	3.2	3.2 - 6.7	6.7
61	3.2	3.2 - 6.8	6.8
62	3.3	3.3 - 6.9	6.9
63	3.3	3.3 - 7.0	7.0
64	3.4	3.4 - 7.1	7.1

STONES AND POUNDS

Score 0 Wt loss < 5%	Score 1 Wt loss 5 - 10%	Score 2 Wt loss > 10%

Current weight

Weight loss in last 3 to 6 months

st lb	Less than (st lb)	Between (st lb)	More than (st lb)
4 10	0 3	0 3 - 0 7	0 7
4 12	0 4	0 4 - 0 8	0 8
5 1	0 4	0 4 - 0 8	0 8
5 3	0 4	0 4 - 0 8	0 8
5 5	0 4	0 4 - 0 8	0 8
5 7	0 4	0 4 - 0 9	0 9
5 9	0 4	0 4 - 0 9	0 9
5 12	0 4	0 4 - 0 9	0 9
6 0	0 4	0 4 - 0 9	0 9
6 2	0 5	0 5 - 0 10	0 10
6 4	0 5	0 5 - 0 10	0 10
6 6	0 5	0 5 - 0 10	0 10
6 9	0 5	0 5 - 0 10	0 10
6 11	0 5	0 5 - 0 11	0 11
6 13	0 5	0 5 - 0 11	0 11
7 1	0 5	0 5 - 0 11	0 11
7 3	0 5	0 5 - 0 11	0 11
7 6	0 5	0 5 - 0 12	0 12
7 8	0 6	0 6 - 0 12	0 12
7 10	0 6	0 6 - 0 12	0 12
7 12	0 6	0 6 - 0 12	0 12
8 0	0 6	0 6 - 0 12	0 12
8 3	0 6	0 6 - 0 13	0 13
8 5	0 6	0 6 - 0 13	0 13
8 7	0 6	0 6 - 0 13	0 13
8 9	0 6	0 6 - 0 13	0 13
8 11	0 6	0 6 - 1 0	1 0
9 0	0 7	0 7 - 1 0	1 0
9 2	0 7	0 7 - 1 0	1 0
9 4	0 7	0 7 - 1 0	1 0
9 6	0 7	0 7 - 1 1	1 1
9 8	0 7	0 7 - 1 1	1 1
9 11	0 7	0 7 - 1 1	1 1
9 13	0 7	0 7 - 1 1	1 1
10 1	0 7	0 7 - 1 2	1 2

KILOGRAMS

Score 0 Wt loss < 5%	Score 1 Wt loss 5 - 10%	Score 2 Wt loss > 10%

Current weight

Weight loss in last 3 to 6 months

kg	Less than (kg)	Between (kg)	More than (kg)
65	3.4	3.4 - 7.2	7.2
66	3.5	3.5 - 7.3	7.3
67	3.5	3.5 - 7.4	7.4
68	3.6	3.6 - 7.6	7.6
69	3.6	3.6 - 7.7	7.7
70	3.7	3.7 - 7.8	7.8
71	3.7	3.7 - 7.9	7.9
72	3.8	3.8 - 8.0	8.0
73	3.8	3.8 - 8.1	8.1
74	3.9	3.9 - 8.2	8.2
75	3.9	3.9 - 8.3	8.3
76	4.0	4.0 - 8.4	8.4
77	4.1	4.1 - 8.6	8.6
78	4.1	4.1 - 8.6	8.7
79	4.2	4.2 - 8.7	8.8
80	4.2	4.2 - 8.9	8.9
81	4.3	4.3 - 9.0	9.0
82	4.3	4.3 - 9.1	9.1
83	4.4	4.4 - 9.2	9.2
84	4.4	4.4 - 9.3	9.3
85	4.5	4.5 - 9.4	9.4
86	4.5	4.5 - 9.6	9.6
87	4.6	4.6 - 9.7	9.7
88	4.6	4.6 - 9.8	9.8
89	4.7	4.7 - 9.9	9.9
90	4.7	4.7 - 10.0	10.0
91	4.8	4.8 - 10.1	10.1
92	4.8	4.8 - 10.2	10.2
93	4.9	4.9 - 10.3	10.3
94	4.9	4.9 - 10.4	10.4
95	5.0	5.0 - 10.6	10.6
96	5.1	5.1 - 10.7	10.7
97	5.1	5.1 - 10.8	10.8
98	5.2	5.2 - 10.9	10.9
99	5.2	5.2 - 11.0	11.0

STONES AND POUNDS

Score 0 Wt loss < 5%	Score 1 Wt loss 5 - 10%	Score 2 Wt loss > 10%

Current weight

Weight loss in last 3 to 6 months

st lb	Less than (st lb)	Between (st lb)	More than (st lb)
10 3	0 8	0 8 - 1 2	1 2
10 6	0 8	0 8 - 1 2	1 2
10 8	0 8	0 8 - 1 2	1 2
10 10	0 8	0 8 - 1 3	1 3
10 12	0 8	0 8 - 1 3	1 3
11 0	0 8	0 8 - 1 3	1 3
11 3	0 8	0 8 - 1 3	1 3
11 5	0 8	0 8 - 1 4	1 4
11 7	0 8	0 8 - 1 4	1 4
11 9	0 9	0 9 - 1 4	1 4
11 11	0 9	0 9 - 1 4	1 4
12 0	0 9	0 9 - 1 5	1 5
12 2	0 9	0 9 - 1 5	1 5
12 4	0 9	0 9 - 1 5	1 5
12 6	0 9	0 9 - 1 5	1 5
12 8	0 9	0 9 - 1 6	1 6
12 11	0 9	0 9 - 1 6	1 6
12 13	0 10	0 10 - 1 6	1 6
13 1	0 10	0 10 - 1 6	1 6
13 3	0 10	0 10 - 1 7	1 7
13 5	0 10	0 10 - 1 7	1 7
13 8	0 10	0 10 - 1 7	1 7
13 10	0 10	0 10 - 1 7	1 7
13 12	0 10	0 10 - 1 8	1 8
14 0	0 10	0 10 - 1 8	1 8
14 2	0 10	0 10 - 1 8	1 8
14 5	0 11	0 11 - 1 8	1 8
14 7	0 11	0 11 - 1 9	1 9
14 9	0 11	0 11 - 1 9	1 9
14 11	0 11	0 11 - 1 9	1 9
14 13	0 11	0 11 - 1 9	1 9
15 2	0 11	0 11 - 1 10	1 10
15 4	0 11	0 11 - 1 10	1 10
15 6	0 11	0 11 - 1 10	1 10
15 9	0 11	0 11 - 1 10	1 10

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PATIENT HANDLING ASSESSMENT – 'INITIAL ASSESSMENT'

An assessment of each individual patient must be completed on admission; with the completion of this mobility chart as required.

Ability of patient prior to admission..... INDEPENDENT.....

.....

.....

.....

he patient independent? **YES** ☑ **NO** ☐ (Please tick ✓ as appropriate)

d the patient have a walking stick or frame on admission? **YES** ☐ **NO** ☑

If the patient has been assessed as 'independent' on initial assessment, a mobility chart does **NOT** require to be completed. If this changes, please review; and complete a mobility chart.

If the patient is **not** independent, please complete the mobility chart.

Assessor's Signature:		Date / Time: 26/5/25

PATIENT HANDLING ASSESSMENT – 'MOBILITY CHART'

The form overleaf **must** be completed if the patient is **NOT** independent. Thereafter the mobility chart must be read / reviewed daily; post fall; if patient's condition changes; and on transfer to another area. Document any changes in a new column.

assessment of the patient should be carried out prior to **every** handling intervention. Any changes should be cumented in a new column. Please refer to Manual Handling Guidelines for all manoeuvres. If your patient is lus Size', please refer to the Handling Plus Size Person Guidelines

Areas of concern, risk factors and risk management MUST be documented in the patient record

(Please see below detail of codes)

Codes in Mobility Chart
MC = Mobility Code **HA = Handling Aid / EC = Equipment Code**

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	Date / Time Initial Assessment			Review Date/Time		
Transfers	**Mobility Codes**	**Handling Aids**	**Equipment Codes**	**Mobility Codes**	**Handling Aids**	**Equipment Codes**
Lying to sitting						
Sits up and over the side of the bed						
Sit to stand to sit from bed / chair						
Walking						
Bathing / Showering / Toileting						
Toileting						
Moving up and down the bed						
Turning / Proning						
On / off bed pan						
Lateral transfers						
On / off floor						
Hoist and Sling information		**Criteria for referral to Physiotherapist**				
Make and model of hoist / stand aid		Chest Infection / difficulty clearing secretions / reduced oxygen saturated level				
Type / size of sling / loop selection (as required)		Reduced mobility compared to normal	Recent fall			
Assessor's Signature		Stair assessment: state reason e.g. injury / acute illness				
Assessor's name (Print)		Major surgery e.g. abdominal / neck dissection / mastectomy				
Review Date		Longer term rehabilitation needs				

MC – Mobility Codes	**HA – Handling Aids**	**EC – Equipment Codes**
IND - Independent **AST** - 1 / 2 / 3 or more	**H** - Full body hoist **BH** - Bath hoist	**SC** - Shower chair **ST** - Shower trolley
SUP - Supervision **BR** - Bed Rest	**STA** - Stand aid **Pt T** - Patient turner (specify)	**Co** - Commode **W** - Wheelchair
FWB - Full weight bearing	**GS** - Glide sheet **ES** - Extension straps	**C** - Crutches (specify)
PWB - Partial weight bearing	**HB** - Hand blocks **HS** - Hand sling	**S** - Stick **Z** - Zimmer
NWB - Non weight bearing	**PAT** - Pat slide	**HJ** - Hover jack **HM** - Hover matt

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Skin Assessment and Care Plan

Daily Skin Care Assessment																	
	Date/ Time	26/5/20	22:30														
	Independent, no concerns, assess daily, review if condition changes or a concern is raised.	✓	✓														
	Requires supervision/assistance, visually check skin daily or more often if at risk. Update care plan if there is a change in condition.																
	Dependent, will require skin review at every patient interaction(min 2 hourly) and record findings in nursing notes																
	Date/ Time																
	Independent, no concerns, assess daily, review if condition changes or a concern is raised.																
	Requires supervision/assistance, visually check skin daily or more often if at risk. Update care plan if there is a change in condition.																
	Dependent, will require skin review at every patient interaction(min 2 hourly) and record findings in nursing notes																

Care Needs	Potential nursing actions (Please include all that apply in the care plan below)
• Assess daily above ◦ Review care plan and update only when a change is evident. ◦ Document all care given in unified progress notes.	• Discuss and plan care to include current patient skin condition and skin care regimen. Include any lotions or prescribed emollients. • Assess BRADEN and document current risk as well as any equipment currently in use. • Document level of assistance required to care for skin. ◦ Ensure care and comfort chart is commenced. ◦ Where a wound is present or skin is not intact please include information on the wound/skin tear and ensure a wound chart is commenced. ◦ Provide an information leaflet to patients/carers

Date/Time	Initial plan of care	Sign
26/5/20	I WORK WITH T SKIN CARE	W

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Daily Personal Hygiene & Continence Assessment

1. Daily Personal Hygiene Assessment

	Date/ Time	26/3/20	27/3/20												
	Independent with hygiene (no care plan required)	✓	✓												
	Requires supervision/assistance with hygiene (detailed care plan required)														
■	Dependent with hygiene (detailed care plan required)														

2. Daily Continence Assessment

	Independent with continence, no concerns, review regularly for change	✓	✓												
	Uses continence products, continue to support whilst in hospital with prescribed products. Requires supervision/assistance (detail added to care plan)														
■	Dependent or new continence issue, patient requires full assessment.														
	Initials	[illegible]	[illegible]												

1. Daily Personal Hygiene Assessment

	Date/ Time														
	Independent with hygiene (no care plan required)														
	Requires supervision/assistance with hygiene (detailed care plan required)														
■	Dependent with hygiene (detailed care plan required)														

2. Daily Continence Assessment

	Independent with continence, no concerns, review regularly for change														
	Uses continence products, continue to support whilst in hospital with prescribed products. Requires supervision/assistance (detail added to care plan)														
■	Dependent or new continence issue, requires full assessment.														
	Initials														

Patients assessed as **yellow** or **red** require a detailed care plan overleaf.
All care given each day **must** be documented in the unified progress notes.

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Personal Hygiene & Continence Care Plan

Care Goals	Potential nursing actions (Please include all that apply in the care plan below)
• To enable person to maintain an appropriate level of personal hygiene • To enable person to remain continent or maintain continence level using prescribed products • To promote effective elimination function • To prevent infection • Be fully assessed and have a care plan to support care needs • Discuss and agree care plan with patient/carer	• Document level of assistance required to help with personal hygiene care needs, encourage self care as able and document what the patient requires help with. • Document preference for : Basin/shower/bed bath • Consider how the patient cares for hair and nails and document in plan. • Offer shave as required (document wet/dry) • Offer eye care as required • Provide commode/bed pan/urinal • Walk/wheel to the toilet • Catheter care – complete CAUTI bundle • Provide and document agreed continence product for use in ward. This may include skin cleansers and barrier creams. Carer or family may bring same into ward for use. • Undertake full continence assessment and patient education as appropriate (see intranet for information) • Review and update care plan in line with changing care needs.

Date/Time	Plan of Care (Read/Review daily and update if required)	Sign
26/3/20	INDEPENDENT TOILETING WITH	

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Bowel Function Care Plan and Chart

Daily Bowel Assessment

	Date/ Time	26/10	27/10												
	Patient is independent. Bowels moving normally, verbal or visual confirmation. Commence stool chart to monitor.	✓	✓												
	Requires supervision/assistance with bowel monitoring and care. Commence stool chart to monitor. Detailed care plan required.														
	Dependent with bowel care or bowels not moving. Commence stool chart. Detailed care plan required.														

Daily Bowel Assessment

	Date/ Time														
	Patient is independent. Bowels moving normally, verbal or visual confirmation. Commence stool chart to monitor.														
	Requires supervision/assistance with bowel monitoring and care. Commence stool chart to monitor. Detailed care plan required.														
	Dependent with bowel care or bowels not moving. Commence stool chart. Detailed care plan required.														

Bowel Function Care plan

Potential nursing actions
(Please include all that apply in the care plan below)

- **Please document normal bowel function and/or if the patient has a history of bowel disease**
- **Document if the patient has a stoma and plan of care, level of assistance required.**
- **Assess bowel function daily above and document any changes in the unified progress notes**
- **Review and update care plan below if the patients condition changes.**
- **Record any bowel pattern change, if patient is on aperients or if a specimen has been sent.**
- **Identify type of stool using Bristol Stool Form Scale. Record every episode of stool.**

Date/Time	Plan of Care (Read/Review daily and update if required)	Sign
26/10/15	NO CONSENT TO MAKING JOINT MANUAL	

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Continuation sheet for care plans if require

Date/Time	Plan of Care (Read/Review daily and update if required)	Sign

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PERIPHERAL VASCULAR CATHETER (PVC) DAILY MAINTENANCE

Label	Reason for insertion: **DAY 0**		
Name: Alan WYLES D.O.B: 06/05/1977 CHI: CHI NO: 0605770352 Hospita CRN: (Use ad 2 GORDON SQUARE STIRLING FK8 1FN	Insertion Date: Time:		
	Colour/batch no: Position:		
	Hand hygiene (HH) performed	Yes	No
	Skin cleansed for 30 seconds with antiseptic & left to dry prior to insertion	Yes	No
	Aseptic technique throughout	Yes	No
	Sterile dressing applied including date and time	Yes	No
	Inserted by:		
	Ward inserted:		

Ensure that:
Medical staff review the need for intravenous (IV) therapy **including antibiotics on a daily basis – switch to oral if possible**
An antiseptic containing 70% isopropyl alcohol is used to clean the access hub. **Before accessing, rub the access hub for at least 15 seconds** ("scrub the hub")

MODIFIED VIP (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 sign:	Remove & replace cannula. Observe both sites and document. **Obtain swab**
Two or more of the following are evident: Pain, redness or swelling	2	Early stages of phlebitis:	Remove & replace cannula. Observe both sites and document. Treat if necessary. **Obtain swab**
All of the following are evident: Pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis	Remove and seek further advice. **Obtain swab**
As above including palpable venous cord	4		Remove and seek further advice. **Obtain swab**
As above including pyrexia	5		Seek further advice.

24 hours Date:	Time:	
Is PVC still required	YES	NO
Absence of inflammation/extravasation	YES	NO
VIP score - *please circle*	0 1 2 3 4 5	
PVC dressing intact	YES	NO
PVC inserted <72 hrs	YES	NO
HH before/after procedure	YES	NO
"Scrub the Hub" (before use)	YES	NO
PVC – *please circle*	Left in situ	removed
Reason for removal:		
Signature:		

48 hours Date:	Time:	
Is PVC still required	YES	NO
Absence of inflammation/extravasation	YES	NO
VIP score - *please circle*	0 1 2 3 4 5	
PVC dressing intact	YES	NO
PVC inserted <72 hrs	YES	NO
HH before/after procedure	YES	NO
"Scrub the Hub" (before use)	YES	NO
PVC – *please circle*	Left in situ	removed
Reason for removal:		
Signature:		

72 hours Date:	Time:	
Is PVC still required	YES	NO
Absence of inflammation/extravasation	YES	NO
VIP score - *please circle*	0 1 2 3 4 5	
PVC dressing intact	YES	NO
PVC inserted <72 hrs	YES	NO
HH before/after procedure	YES	NO
"Scrub the Hub" (before use)	YES	NO
PVC – *please circle*	Left in situ	removed
Reason left in situ:		
Discussed with:		
Reason for removal:		
Signature:		

If PVC to remain in situ for longer than 72 hours this must be documented on a daily basis in notes and discussed with medical staff.

Observe closely for clinical signs and symptoms of Phlebitis.

New sheet to be commenced.

NEWS key				FULL NAME:
0	1	2	3	DATE OF BIRTH:

	DATE	26/3				27/3			28/3										
	TIME	17	19	20	22	01:5	06	00	15:10										
		35	40	50	30														
Respirations Breaths/min	≥25																		
	21-24																		
	18-20	20	19			18	18												
	15-17			18	18			17	15										
	12-14																		
	9-11																		
	≤8																		
SpO_2 Scale 1 Oxygen saturation (%)	≥96	97	99	100	99	98	96		98										
	94-95							94											
	92-93																		
	≤91																		
SpO_2 Scale 2† Oxygen saturation (%) Use Scale 2 if target range 88-92 e.g. if hypercapnic respiratory failure	≥97 on O_2																		
	95-96 on O_2																		
	93-94 on O_2																		
	≥93 on air																		
	88-92																		
Tick if using Scale 2 ☐	86-87																		
igned	84-85																		
ONLY use Scale 2 under the rection of a qualified clinician	≤83%																		
Air or oxygen?	A=Air	A	✓	✓	A	A	A	A	A										
	O_2 L/min																		
	Device																		
Blood Pressure	≥220																		
	201-219																		
	181-200																		
	161-180	168	144						157										
	141-160	↑	↑	↑		152		↑	RS										
	121-140	|	|	|	135	↑	122	|	A										
	111-120	|	|	|	|	|	|	|	|									
	101-110	|	|	|	|	↓	|	|	|									
	91-100	↓	↓	|	|	|	|	|	|									
	81-90	83	93	↓	89	87	|	↓	↓										
	71-80						76	77	75										
	61-70																		
	51-60																		
	≤50																		
Pulse Beats/min Use •	≥131																		
	121-130																		
	111-120																		
	101-110																		
	91-100																		
	81-90																		
	71-80																		
	61-70	69	68	•		66	62	68	63										
	51-60				58														
	41-50																		
	31-40																		
	≤30																		
Consciousness Score for NEW onset of confusion (no score if chronic)	Alert	✓	✓	A	A	A	A	A	✓										
	Confusion																		
	V																		
	P																		
	U																		
Temperature °C	≥39.1°																		
	38.1-39.0°																		
	37.1-38.0°																		
	36.1-37.0°	36.5	•	36.5	36.1	36.3	36.3	36.4	36.5										
	35.1-36.0°																		
	≤35.0°																		
NEWS TOTAL		0	0	0	0	0	0	1	0										
Monitoring frequency		12	12	12		4	4	4-6	12										
Escalation of care Y/N		N	N	N		Y		N	Y										
Blood Sugar			✓	✓		✓			N.										
Pain Score 0-3		2	2	2		2			0										
Initials		MP	Sir	MK		FW	MK	AMO	Se										

HI NO: 0605770352 06/05/1977 M
RN:
Alan WYLES
2 GORDON SQUARE
STIRLING
FK8 1FN

DATE OF ADMISSION:

																		DATE
																		TIME
																		≥25
																		21-24
																		18-20
																		15-17
																		12-14
																		9-11
																		≤8
																		≥96
																		94-95
																		92-93
																		≤91
																		≥97 on O_2
																		95-96 on O_2
																		93-94 on O_2
																		≥93 on air
																		88-92
																		86-87
																		84-85
																		≤83%
																		A=Air
																		O_2 L/min
																		Device
																		≥220
																		201-219
																		181-200
																		161-180
																		141-160
																		121-140
																		111-120
																		101-110
																		91-100
																		81-90
																		71-80
																		61-70
																		51-60
																		≤50
																		≥131
																		121-130
																		111-120
																		101-110
																		91-100
																		81-90
																		71-80
																		61-70
																		51-60
																		41-50
																		31-40
																		≤30
																		Alert
																		Confusion
																		V
																		P
																		U
																		≥39.1°
																		38.1-39.0°
																		37.1-38.0°
																		36.1-37.0°
																		35.1-36.0°
																		≤35.0°
																		TOTAL
																		Monitoring
																		Escalation
																		Blood Sugar
																		Pain Score 0-3
																		Initials

National Early Warning Score (NEWS2)

NHS Forth Valley

Name:
DOB: CHI NO: 0605770352 06/05/1977
CHI No: CRN: M
Address: Alan WYLES
2 GORDON SQUARE
STIRLING
FK8 1FN

*** Rega[illegible]late if concerned about a patient's condition**

Total NEWS	Frequency of Monitoring	Clinical Response
0 *	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations
1 - 4 *	Minimum 4 - 6 hourly	• Inform registered nurse who must assess the patient • Registered Nurse to decide if increased frequency of monitoring and / or escalation of clinical care is required
5 - 6 * or 3 in one Parameter	Increased frequency to a minimum of 1 hourly	• Registered nurse to urgently inform the medical team caring for the patient • Urgent assessment by a clinician with core competencies to assess acutely ill patients • Ensure structured Response Stickers A & B are completed *(Not Applicable in Emergency Dept)*
7* or more	Continuous monitoring of vital signs (3 lead ECG and continuous SpO2 monitoring, 15 minute BP cycling - document observations every 30 minutes)	• Registered nurse to immediately inform the medical team caring for the patient • Emergency assessment by clinical team with core competencies to assess acutely unwell patients • Ensure structured Response Stickers A & B are completed *(Not Applicable in Emergency Dept)* • Consider transfer of clinical care to ITU

Exclusion Criteria

Anaesthesia and/or sedation may result in reduced conscious levels for a period of time. Scores that are increasing post-procedure and those including "P" or "U" always require escalation. The post-procedure NEWS score and post procedure plan that will include the frequency of observations should be communicated to the ward staff on transfer/handover of the patient.

Target O2 Saturation

Target SpO2 for most patients should be 94-98%.
Selected patients may require target SpO2 88-92% (Appropriate in specific patients with severe chronic respiratory disease who either have established chronic Type 2 respiratory failure, or are felt to be at significantly increased risk of CO2 retention from oxygen therapy). These patients should use the modified (chronic hypercapnia) EWS. Arterial blood gases should be repeated at 30–60 min to check for rising CO2 or H^+ after initiation of oxygen in this context.

Acute Respiratory Failure is a life threatening emergency
Severe Hypoxia (Requiring >60% O2 to maintain target SpO2)
Acute Hypercapnia (pCO2 >6 and H^+ >45)
Urgent ST3 (or equivalent) review is required to optimise management.
Duty or on call consultant should be contacted if advice required.
Critical care referral and ventilatory support may be needed.

Pain Score

0 = no pain
1 = mild pain
2 = moderate pain
3 = severe pain

Codes For Recording Oxygen Delivery On NEWS Chart

A = Air (not requiring oxygen or weaning or on PRN oxygen)
N = Nasal Canulae
SM = Simple Mask
V24 =Venturi 24% V28 = Venturi 28% V35 = Venturi 35% V40 = Venturi 40% V60 = Venturi 60%
H28 = Humidified oxygen at 28% (also H35, H40 & H60 = Humidified Oxygen at 35%, 40% & 60%)
RM = Reservoir Mask
TM = Tracheostomy Mask
CP = Patient on CPAP System
NIV = Patient on NIV System
OTH = Other Device:_____ (specify which)

COPY

DEPARTMENT OF ORTHOPAEDICS & TRAUMA - CONSULTANT - MR D J ROSS

Dictated – 24.10.02

25.10.02 RJ/BS/278537

Dr F E Lyle
Park Avenue Medical Centre
9 Park Avenue
Stirling
FK8 2QR

Dear Dr Lyle

Allan Wyles, dob 6.5.77
103 Raploch Road, Stirling.

Consultant:	Mr D J Ross
Admitted:	7.9.02
Discharged:	8.9.02
Diagnosis:	Compound fracture left clavicle.
Operation:	Irrigation and bone debridement of compound fracture left clavicle.
Comment:	

This 25 year old right handed gentleman fell off his bicycle on 7.9.02 and sustained a compound fracture of his left clavicle. This was a grade 1 compound injury. He was taken to the operating theatre were the wound was irrigated and the bony ends of the fractured clavicle nibbled back. The wound was closed. He had an uneventful immediate post op. course and was discharged home the following day with arrangements being made for him to be reviewed in the Out-Patient Clinic on 19.9.02.

Yours sincerely

R JOSEPH
Orthopaedic SHO[3]

COPY

DEPARTMENT OF ORAL & MAXILLOFACIAL SURGERY

IH/JC/249901
1st April, 2003

Dr. J. Rankin,
9 Park Avenue,
STIRLING.

Dear Dr. Rankin,

ALAN WYLES (6.5.77)
100d Raploch Road, Stirling.

This patient was referred to the department of oral & maxillofacial surgery via accident & emergency following an alleged assault on the 28.3.03. His presenting complaint with regard to the facial injury was bruising and swelling around the right side of the face but this was improving.

Clinical and radiographic examination did not reveal any evidence of an underlying fracture. Sensation was normal, there was no double vision, eye movements were normal, his occlusion was normal.

I think this young man has just had a soft tissue injury in and around the right periorbital region with some abrasions and bruising. I have discharged him from the department back to your care but would happily see him in the event of any problems arising.

Yours sincerely,

I. HOLLAND
Consultant in Oral & Maxillofacial Surgery.

COPY

DEPARTMENT OF ORTHOPAEDICS & TRAUMA
CONSULTANT - MR G MACKAY
Direct Line to Secretary - 01786 434452 Fax - 01786 434432

Typed - 25 April 2003

GM/RR/S249901

Dr R A Rodger
The Clinic
Burns Terrace
Cowie

Dear Dr Rodger

Alan Wyles, dob 06.05.77
3B Douglas Street, Stirling

This patient failed to attend our clinic today. If you feel that a further appointment is required please do not hesitate to contact the orthopaedic clinic on 01786 434055 to make a new appointment.

Yours sincerely

G Mackay MD FRCS (Ortho.)
Sports Medicine, Knee & Shoulder Surgery

STIRLING ROYAL INFIRMARY, LIVILANDS, STIRLING FK8 2AU

DEPARTMENT OF GENERAL MEDICINE

COPY

SURNAME: Wyles FORENAME: Alan

DATE OF BIRTH: 06.05.77/CHI No.0352 UNIT NO: S278537

ADDRESS: 103 Raploch Road, Stirling FK8 1RS CONSULTANT: Dr. A. D. Howie

GP: Dr. R. I. Hanley, Park Avenue Health Centre, Stirling

DATE OF ADMISSION: 21.08.04 DATE OF DISCHARGE: 25.08.04

DIAGNOSIS: Headache
Intravenous drug abuse
On Methadone programme

HISTORY: This 27 year old man was admitted to ward 29 on the 21st of August 2004. He stated that he was normally stable on a Methadone programme without abuse any other drugs, but on the day of admission admitted to using intravenous Heroine. Shortly after using this he developed a headache and some photophobia as well as vomiting.

ON EXAMINATION: He was sweaty and photophobic. He had no neck stiffness. His optic fundi were normal and there were no focal neurological signs. His pulse was 99 per minute regular and blood pressure 160/88. His heart sounds were normal and lung fields clear.

INVESTIGATIONS: Haemoglobin was 142 grams and white count 6,500. Blood urea and electrolytes and liver function tests were normal. A lumbar puncture was performed, which yielded clear CSF, which did not contain any cells.

PROGRESS AND MANAGEMENT: This quickly settled following admission and was seen the following morning and was feeling well and back to normal. As there was no evidence of meningitis he was discharged on the 22nd of August 2004 to continue with his Methadone as before. No follow arrangements have been made.

FOLLOW UP: Nil

Dr. A. D. Howie,
Consultant Physician

Immediate Discharge Letter

NHS
Forth Valley

COPY

Hospital: Stirling Royal Infirmary

Tel (SRI): 01786 434 000 Fax (SRI): 01786 450 588
Tel (FDRI): 01324 624 000 Fax (FDRI): 01324 617 421

Consultant: Ritchie, Mr Ian Ward: SRI - Ward 27
Specialty: Trauma and Orthopaedic Surgery

GP Details		Patient Details		Admission Details	
Practice Code:	25582	Patient CHI No:	0605770352	Admission Date:	24/04/2010
		Patient Hospital No:	S278537		
GP Name:	Dr Fiona E Lyle	Surname:	Wyles	Admission Type:	Emergency - Injury - Other
Address:	Park Avenue Medical Centre, 9 Park Avenue, Stirling, FK8 2QR	Forename:	Alan	Presenting Complaint:	Local Infections and Abscesses
		Date of Birth:	06/05/1977		
		Address:	27 Waulker Avenue,, Stirling, FK8 1SA	Discharge Date:	24/04/2010
				Discharge To:	Private Residence - Living with Relatives or Friends

Diagnosis/Problem List

XaCwP - Pilonidal cyst

Additional comment (Progress, Investigations, Procedures, Complications etc)

This gentleman was admitted on 23.4.10 complaining of a swelling at the base of his spine which had been present, and increasing in size over the last fortnight. He is a previous IVDU and is currently on methadone. He had a pilonidal abscess incised and drained on 24.4.10. Following this Mr Wyles remained well and had no pain, and was apyrexial. He was allowed to eat and drink as normal, and will be seen in clinic in 2-3 months time.

Results Outstanding (Y/N) If yes, give details:	No

Information to patient/carer (Y/N):	Patient: No Carer (if applicable): No

Follow up arrangements

Henderson

~~Ritchie, Mr Ian~~, Surgical OPD, 3 Months

Doctor's name:	Dr C Williams	Doctor's Signature:	
Doctor's grade:	FY1		
Read/Approved by:			
Date:	27/04/2010		
Named Nurse:	McCover, Lauren	Ward phone no:	

Validation/Contact Name: Ritchie, Mr Ian

THIS IS THE FINAL DOCUMENT

Forth Valley Acute Hospitals Acute Division
Medications Discharge Summary

COPY

Name: Alan Wyles **Address:** 27 Waulker Avenue,, Stirling, FK8 1SA		**Community Pharmacy:** **Contact Name:** **Tel No:**	**GP:** Dr Rose E Lyle **Address:** Park Avenue Medical Centre, 9 Park Avenue, Stirling, FK8 2QR **Tel No:** 01786473529
Date of birth: 06/05/1977	**Patient's Tel No:** **Patient's Tel Eve:**	**Admission Date:**	24/04/2010
		Discharge Date:	24/04/2010
Unit Number: S278537	**Consultant:** Ritchie, Mr Ian		

PATIENT ALERTS

Alert Group	Alert	Alert Comment	When Added	Added By

PATIENT DRUG REACTIONS

CURRENT PRESCRIPTION (all medicines currently prescribed) **e.g. clinical indication for prescription monitoring*

** Prescription Not Prepared For Discharge **

	Drug	Route	Dose	Frequency	Duration (days)	New Drug / Altered Dose	POD
1 *	METHADONE 1mg/mL MIXTURE	Oral	75 mg	ONCE daily			
2 *	MIRTAZAPINE 30mg ORODISPERSIBLE TABLETS	Oral	30 mg	ONCE daily			

MEDICINES DISCONTINUED

Nurse check on discharge:

Signature 1:

Name: Alan Wyles

Signature 2: H Stewart.

CHI: 0605770352

File

Immediate Discharge Letter

NHS
Forth Valley

COPY

Hospital: Stirling Royal Infirmary

Tel (SRI): 01786 434 000 Fax (SRI): 01786 450 588
Tel (FDRI): 01324 624 000 Fax (FDRI): 01324 617 421

Consultant: Ritchie, Mr Ian Ward: SRI - Ward 27
Specialty: Trauma and Orthopaedic Surgery

GP Details		Patient Details		Admission Details	
Practice Code:	25582	Patient CHI No:	0605770352	Admission Date:	24/04/2010
		Patient Hospital No:	S278537		
GP Name:	Dr Fiona E Lyle	Surname:	Wyles	Admission Type:	Emergency - Injury - Other
Address:	Park Avenue Medical Centre, 9 Park Avenue, Stirling, FK8 2QR	Forename:	Alan	Presenting Complaint:	Local Infections and Abscesses
		Date of Birth:	06/05/1977		
		Address:	27 Waulker Avenue,, Stirling, FK8 1SA	Discharge Date:	24/04/2010
				Discharge To:	Private Residence - Living with Relatives or Friends

Diagnosis/Problem List

XaCwP - Pilonidal cyst

Additional comment (Progress, Investigations, Procedures, Complications etc)

This gentleman was admitted on 23.4.10 complaining of a swelling at the base of his spine which had been present, and increasing in size over the last fortnight. He is a previous IVDU and is currently on methadone. He had a pilonidal abscess incised and drained on 24.4.10. Following this Mr Wyles remained well and had no pain, and was apyrexial. He was allowed to eat and drink as normal, and will be seen in clinic in 2-3 months time.

Results Outstanding (Y/N) If yes, give details:	No

Information to patient/carer (Y/N):	Patient: No Carer (if applicable): No

Follow up arrangements

Ritchie, Mr Ian, Surgical OPD, 3 Months

Doctor's name:	Dr C Williams	Doctor's Signature:	
Doctor's grade:	FY1		
Read/Approved by:			
Date:	27/04/2010		
Named Nurse:	McCover, Lauren	Ward phone no:	

Validation/Contact Name: Ritchie, Mr Ian

Name: Alan Wyles

THIS IS THE FINAL DOCUMENT
CHI: 0605770352

Patient

Forth Valley Acute Hospitals Acute Division
Medications Discharge Summary

Name: Alan Wyles **Address:** 27 Waulker Avenue,, Stirling, FK8 1SA		**Community Pharmacy:** **Contact Name:** **Tel No:**	**GP:** Dr Fiona E Lyle **Address:** Park Avenue Medical Centre, 9 Park Avenue, Stirling, FK8 2QR **Tel No:** 01786473529
Date of birth: 06/05/1977	**Patient's Tel No:** **Patient's Tel Eve:**	**Admission Date:**	24/04/2010
		Discharge Date:	24/04/2010
Unit Number: S278537	**Consultant:** Ritchie, Mr Ian		

COPY

PATIENT ALERTS

Alert Group	Alert	Alert Comment	When Added	Added By

PATIENT DRUG REACTIONS

CURRENT PRESCRIPTION (all medicines currently prescribed) **e.g. clinical indication for prescription monitoring*

** Prescription Not Prepared For Discharge **

	Drug	Route	Dose	Frequency	Duration (days)	New Drug / Altered Dose	POD
1 *	METHADONE 1mg/mL MIXTURE	Oral	75 mg	ONCE daily			
2 *	MIRTAZAPINE 30mg ORODISPERSIBLE TABLETS	Oral	30 mg	ONCE daily			

MEDICINES DISCONTINUED

Nurse check on discharge:

Signature 1: Signature 2:

Name: Alan Wyles CHI: 0605770352

Patient

Department of General Surgery
Consultant: Wilson S Hendry
Tel: 01324 566944
Fax:

Stirling Royal Infirmary
Livilands
Stirling
FK8 2AU

COPY

Ref: WSH/HS/F250095
CHI: 0605770352

Clinic Date: 23 August 2010
Date: 24 August 2010

Dr Fiona Lyle
Park Avenue Medical Centre
9 Park Avenue
Stirling
FK8 2QR

Dear Dr Lyle

ALAN WYLES 06/05/1977
27 Waulker Avenue, STIRLING FK8 1SA

This man failed to attend for review today.

Kind regards

Yours sincerely

Wilson Hendry
Consultant General Surgeon

Community Alcohol and Drug Service

Bannockburn Hospital
BANNOCKBURN
FK7 8AH

NHS CORY Forth Valley

MEDICAL IN CONFIDENCE
TIA Clinic
Stirling Royal Infirmary
Livilands
STIRLING
FK8 2AU

Date 19th April 2011
Dictated
Our Ref 150411doc2

Enquiries to Dorothy Christison
Extension 01786 483111
Direct Line 01786 483111
Email Dorothy.christison@nhs.net

TIA clinic

Dear Colleague

Re: Alan Wyles, 27 Waulker Avenue, Stirling, DoB 06.05.77.
CHI No: 060577 0352

Alan is a 32-year-old gentleman with a long history of heroin use. He has been with the Community Alcohol and Drug Service since 2000 and is currently prescribed methadone 75ml daily. Alan has been in custody for the last 10 months and has recently been liberated to rejoin with CADS. Alan described an episode whilst in custody where he woke up at 4.30am in his cell with a headache which he describes as pressure on the left side of his head and face. He described flashing lights behind his eyes, feeling of impending doom and palpitations. He also described loss of vision in his left eye and loss of movement in his left eye and on looking in the mirror he described the left eye as looking down as if he had a squint. There was no loss of consciousness and the episode lasted approximately 10 minutes. Alan denies any episodes prior to or after this one. He denies using alcohol or drugs to intoxication around about this episode.

Family History - Father committed suicide, mother manic depression and died of alcoholism. Brother died at 21 years due to drug use and sister died at 37 years due to drug use.

Alan was examined by the prison doctor and there was no neurological deficit recorded. On examination today Alan was neurologically in tact and there were no worrying signs or symptoms.

My impression is that Alan suffered a cerebral vascular event which must be investigated. I would appreciate your opinion on this client.

Yours sincerely

DR SUSHILA NAYAR
Speciality Doctor

c.c. Jane McQuillian (Key Worker, CADS)

INVESTOR IN PEOPLE

Chairman Ian Mullen OBE BSc MRPharmS DL
Chief Executive Fiona Mackenzie MA(Hons) MBA CIHM DipHSM

Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SW

www.nhsforthvalley.com

Department of Ageing & Health
Consultant: Dr Richard Lenton
Tel: 01786 434465
Fax: 01786 446925

Stirling Royal Infirmary
Livilands
Stirling
FK8 2AU

COPY

T.I.A. SERVICE

Ref: RL/RN/S278537
CHI: 0605770352

Clinic Date: 09 June 2011
Date Typed: 10 June 2011

Dr Sushila Nayar
Speciality Doctor
Community Alcohol and Drug Service
Bannockburn Hospital
Bannockburn
Stirling
FK7 8AH

Dear Dr Nayar

ALAN WYLES 06/05/1977
27 WAULKER AVENUE STIRLING FK8 1SA

Thank you for referring this gentleman who attended the TIA Clinic this afternoon with his carer. I am aware of his contact with the Community Alcohol and Drug Service and his current therapy with Methadone. While he was in prison about three months ago, he was having a nightmare which took the form of flashing images in both eyes, and he woke up during this and experienced numbness of the left side of his face with no vision in his left eye. He also had tingling down the left arm and left leg and when he looked in the mirror he said that his left eye was looking down, his right eye straight ahead. There was no headache. This lasted altogether about five minutes, but he had a strange tingling at the back of his head which lasted for about an hour. For two weeks he has had a sore back with discomfort down the back of his right leg and over the past two or three days his back pain has been very severe. He mentioned that his urine had been dark for the past two days. He has apparently attended the surgery in the last few days because of the back pain, and has been given Diclofenac.

He is not aware of having had migrainous attacks in the past.

Apart from Methadone and Diclofenac he is on no drugs at the moment. He smokes ten cigarettes a day.

On examination he looked well, but was introspective and low in spirits. There were no focal neurological signs apart from reduced knee jerks. There was no abnormality in the cranial nerves. He was in sinus rhythm. His blood pressure was 150/80.

He had carotid dopplers before I saw him at the clinic and these were completely normal. His ECG was normal.

Further to my telephone call this evening to the practice, he has very disturbed renal and liver function tests:

COPY

Sodium 136, potassium 4.8, chloride 101, **urea 15.8**, eGFR 8, **creatinine 703**, AST 8[illegible] ALT 273, bilirubin 7, total protein 69, albumin 40, alk. phos. 256, cholesterol 3.5, haemoglobin 138, **white blood count 11.6**, platelet count 274, MCV 82.4, glucose 4.6.

These results were returned after he left the clinic and clearly they require urgent investigation.

I think the episode three months ago was migrainous in nature and I have reassured him to this effect. He has a brain CT booked for Monday, but it may be that investigation of the biochemical abnormalities will interfere with this, and we will liaise with the X-ray Department about this.

Thank you for referring him.

Yours sincerely

Dr Richard Lenton
Consultant Physician in Ageing & Health

cc. Dr F Lyle, Park Avenue Medical Centre, 9 Park Avenue, Stirling, FK8 2QR

PARK AVENUE MEDICAL CENTRE
9 Park Avenue, Stirling, FK8 2QR.
Tel: (01786) 473529 Fax: (01786) 445234

COPY

Dr. I. Hanley
Dr. I. Weir
Dr. D. Mennie
Dr. J. Rankin

Dr. S. Kennedy
Dr. F. Lyle
Dr. F. Seaman
Dr. O. Watkins.

0605770352
Wyles, Alan
08/05/1977 M
27 Haulker Avenue FK8 1SA
Raploch
Dr D Mennie
Park Avenue MC V57746
V25582

9 June 2011.

Dear Receiving Physician.

Thank you for admitting this 34 year old gentleman. He was seen at hospital clinic today. Bloods checked and result phoned to me. (at ? TIA clinic) - ? TIA/CVA in prison.

Urea 15·8 Alt 273
Creat 703 Alt 811

(Prev bloods 2009 - normal renal function)
ex-Iv d, prev on methadone. Currently on citalopram 20mg and commenced on diclofenac 50mg tds one month ago.
Spoke to patient on phone. c/o worsening back pain + oliguria.

Imp Acute Renal Failure → Admit

many thanks Brienne,

Report Valid On 09/06/11 16:55

PARK AVENUE MEDICAL CENTRE

Registration

Mr Alan Wyles
27 Waulker Avenue
Rapioch
STIRLING
FK8 1SA
Telephone: 450501
Contact: ?
Email: ?
CHI Number: 0605770352
Registered GP: F LYLE

Service Code: Permanent
DoB: 06/05/1977
Age: 34

ContactRelship: ?

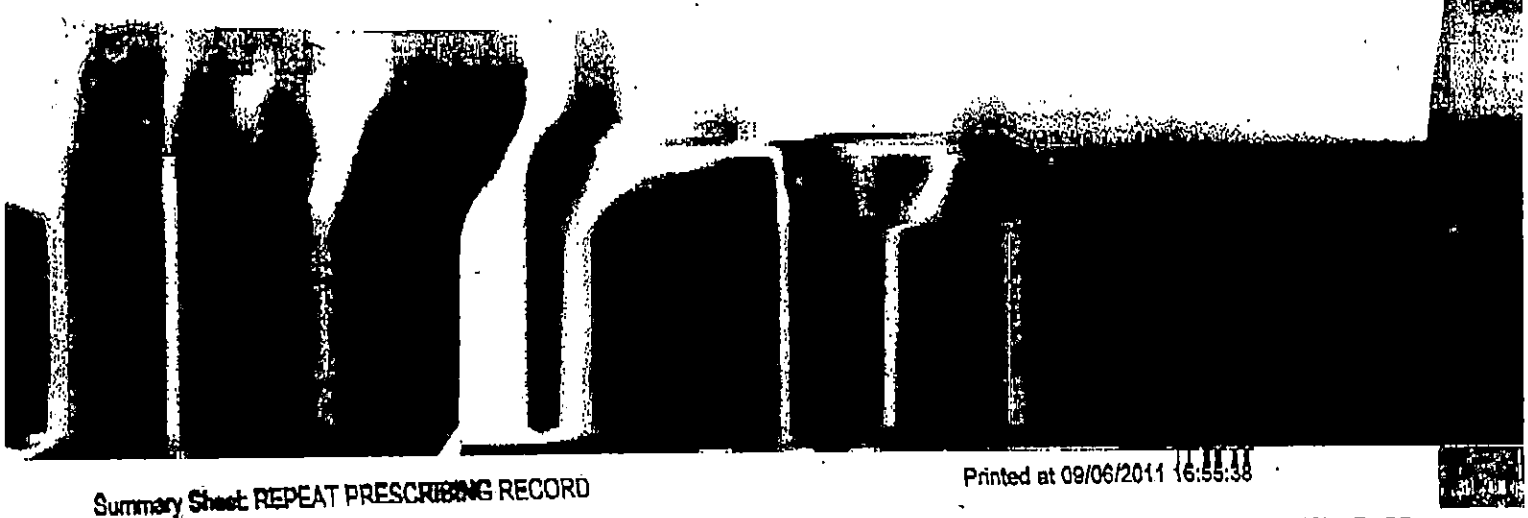
COPY

Acute Prescriptions

Drug/Preparation	Quantity/Dose/Frequency	Date
Diclofenac Sodium Ec TABS 50MG	84 1 Tab 3 times daily	11/05/2011
Citalopram TABS 20MG	28 1 Tab At night	11/05/2011
Propranolol Hydrochloride TABS 40MG	28 1 Tab Twice daily	20/04/2011
Amorolfine Nail Lacquer SOL 5%	5 4 Drops As directed	20/04/2011
Fusidic Acid CREAM 2%	30 Apply Twice daily	24/05/2010
Mirtazapine TABS 30MG	28 1 Tab At night	19/03/2010
Fluoxetine CAPS 20MG	60 1 Cap Daily	15/01/2010
Fluoxetine CAPS 20MG	30 1 Cap Daily	16/07/2009
Vitamins CAPS	30 1 Cap Daily	09/02/2009

Last 4 Clinical Notes

Date	Clinical Notes
11/02/2009	Automatically generated by transaction
16/01/2009	Automatically generated by transaction
15/01/2009	Automatically generated by transaction



Immediate Discharge Letter

NHS Forth Valley

COPY

Hospital: Stirling Royal Infirmary
Consultant: Cross, Dr Melanie
Specialty: General Medicine

Tel: 01786 434000
Discharging Ward: SRI - Clinical Assessment Unit

GP Details		Patient Details		Admission Details	
Practice Code:	25582	Patient CHI No:	0605770352	Admission Date:	09/06/2011
		Patient Hospital No:	S278537		
GP Name:	Dr Fiona E Lyle	Surname:	Wyles	Admission Type:	Emergency - Type Not Known
Address: Park Avenue Medical Centre, 9 Park Avenue, Stirling, FK8 2QR		Forename:	Alan	Presenting Complaint:	Unwell Adult
		Date of Birth:	06/05/1977		
		Address:	27 Waulker Avenue,, Stirling, FK8 1SA	Discharge Date:	10/06/2011
				Discharge To:	Glasgow Western Infirmary

Diagnosis/Problem List

K04.. - Acute renal failure

Additional comment (Progress, Investigations, Procedures, Complications etc)

The above 34 year old man was admitted on the 9/6/11 with acute renal failure. He was seen in the TIA clinic earlier in the day and was found to have acute renal failure and deranged LFTs. He had only passed urine twice in the 3 days prior to admission and had bilateral renal angle pain. On the day of admission he began having a fever and shivering. He is a known IVDU on is currently on methadone.

Examination on admission
Obs: Temp 37.7, HR 71, RR 16, BP 144/80, Sats 97% OA.
CVS: NAD
Resp: Few creps left base.
Abdo: soft 1cm liver edge, mildly tender right renal angle. No evidence of chronic liver disease.

vestigations
CXR: NAD
ECG: Sinus rhythm 64 bpm.
Bloods: Na 136, K 4.8, Urea 15.8, Creat 703, AST 811, ALT 273, Bilirubin 7, TP 69, AP 256, Albumin 40. Hb 138, WCC 11.6, Plts 274, CRP 55.
Hep C sAg neg, hep A IgM neg, Hep C neg, HIV neg.

Mr Wyles was given 2 litres of fluid in the 2 hours following discharge however he only passed 18mls of urine. He was continued on 2 hourly IV fluids and transferred to the renal unit at Glasgow Western.

Results Outstanding (Y/N) If yes, give details:	No

Information to patient/carer (Y/N):	Patient: Yes Carer (if applicable): No

Follow up arrangements

There are no Reviews planned

File

Authorisor's name:	Dr R Downey	**Authorisor's Signature:**
Authorisor's grade:	FY1	
Read/Approved by:		
Date:	15/06/2011	

COPY

Discharge Ward Nurse:	Anderson, Amanda

Validation/Contact Name: Cross, Dr Melanie

THIS IS THE FINAL DOCUMENT

Name: Alan Wyles

CHI: 0605770352

File

Forth Valley Acute Hospitals Acute Division Medications Discharge Summary	
Name: Alan Wyles	Patient's Tel No:
Address: 27 Waulker Avenue,, Stirling, FK8 1SA	Patient's Tel Eve:
Admission Date: 09/06/2011	Discharge Date: 10/06/2011

COPY

PATIENT ALERTS

Alert Group	Alert	Alert Comment	When Added	Added By

PATIENT DRUG REACTIONS

penicillin - Adverse Reaction - kidney pain

CURRENT PRESCRIPTION (all medicines currently prescribed) **e.g. clinical indication for prescription monitoring*

MEDICINES DISCONTINUED

Nurse check on discharge:

Signature 1:

Signature 2:

Name: Alan Wyles

CHI: 0605770352

File

NHS Forth Valley
Renal Services

Renal Unit, Forth Valley Royal Hospital
Stirling Road, Larbert, FK5 4WR

Contact 01324 566515 / 566516
e-mail: fv-uhb.renal@nhs.net

COPY

REF: BM/AH
Dict: 23.06.2011.
Typed: 07.07.2011

Dr FE LYLE
PARK AVENUE MEDICAL CENTRE
9 PARK AVENUE
STIRLING
FK8 2QR

Dear Dr LYLE

ALAN WYLES
27 Waulker Avenue
STIRLING
FK8 1SA

Hosp. No.
Date of birth: 06/05/1977
CHI number 0605770352

Diagnosis:
11/06/2011 Acute Renal Failure due to Rhabdomyolysis

Renal replacement therapy history

Date Started	Treatment type	Centre	Comment
12/06/2011	RRT for ARF	Western Infirmary Glasgow	

I saw this patient at the General Renal Clinic at Forth Valley Royal Hospital on Thursday 23/6/2011.

Mr Wyles was discharged from the Renal Unit in Glasgow just 3 days ago after an episode of acute kidney injury. He was found to have rhabdomyolosis and evidence on renal biopsy of acute tubular necrosis. The precipitant for his rhabdomyolosis is not clear although he does describe an injury to his lower back for which he had been taking non-steroidal anti-inflammatory drugs. During his admission Mr Wyles required 2 sessions of dialysis but at discharge his serum creatinine was falling by 200micromol/l.

On review today Mr Wyles tells me that he is feeling much better than he has done at any time over the last few weeks. His blood pressure was rather high today but I wouldn't suggest adding an antihypertensive just at the moment.

Today I have simply repeated Mr Wyles routine bloods I hope to see a further improvement in his serum creatinine and assuming that is the case we will leave his next review for 2 weeks. If for any reason things haven't improved as we would have expected we may arrange to see him sooner than that.

Yours sincerely

BRUCE MACKINNON
CONSULTANT NEPHROLOGIST

COPY

The next appointment at the General Renal Clinic is on 17/08/2011.

Recent Results

Date	Time	Test	Result	Units
07/07/2011	13:52	Systolic BP	125	mm Hg
07/07/2011	13:52	Diastolic BP	68	mm Hg
07/07/2011	13:52	Weight	78.6	kg
23/06/2011	11:04	Height	171.5	cm
23/06/2011	11:30	Potassium	4.9	mmol/L
23/06/2011	11:30	Bicarbonate	24	mmol/L
23/06/2011	11:30	Urea	10.8	mmol/L
23/06/2011	11:30	Creatinine	248	micromol/L
23/06/2011	11:30	eGFR	27	mL/min/1.73m2
23/06/2011	11:30	Glucose	5.7	mmol/L
17/06/2011	08:00	Cholesterol	3.2	mmol/L
23/06/2011	11:30	C reactive protein	19	mg/L
23/06/2011	11:30	Albumin	46	g/L
23/06/2011	11:30	Adjusted Calcium	2.34	mmol/L
23/06/2011	11:30	Phosphate	1.3	mmol/L
23/06/2011	11:30	Alkaline phosphatase	251	units/L
23/06/2011	11:30	Bilirubin	7	micromol/L
23/06/2011	11:30	Gamma GT	118	units/L
23/06/2011	11:30	AsT	18	units/L
23/06/2011	11:30	AlT	25	units/L
23/06/2011	11:30	Haemoglobin	113	g/dL or g/L
23/06/2011	11:30	WBC	8.5	x 10^9 /L
23/06/2011	11:30	Platelets	463	x 10^9 /L
20/06/2011		Ferritin	160	mg/L
20/06/2011		Serum Vit B12	335	nanog/L
20/06/2011		Serum Folate	2.4	microg/L
17/06/2011	08:00	TSH	2.7	m units/L
17/06/2011	08:00	fT4	17	picomol/L
10/06/2011	13:00	uPCR	172	mg/mmol

According to the West of Scottish Electronic Renal Patient Record (SERPR) the current medicine prescription for ALAN WYLES DoB: 06/05/1977 CHI: 0605770352
is:

Allergies
14/06/2011

NHS Forth Valley
Renal Services

Renal Unit, Forth Valley Royal Hospital
Stirling Road, Larbert, FK5 4WR

Contact 01324 566515 / 566516
e-mail: fv-uhb.renal@nhs.net

NHS Forth Valley
COPY

Ref: CS/AH
Dict: 07.07.2011
Typed: 19.07.2011

Dr FE LYLE
PARK AVENUE MEDICAL CENTRE
9 PARK AVENUE
STIRLING
FK8 2QR

Dear Dr LYLE

ALAN WYLES
27 Waulker Avenue
STIRLING
FK8 1SA

Hosp. No.
Date of birth: **06/05/1977**
CHI number **0605770352**

Diagnosis:
11/06/2011 Acute Renal Failure due to Rhabdomyolysis

Renal replacement therapy history

Date Started	Treatment type	Centre	Comment
12/06/2011	RRT for ARF	Western Infirmary Glasgow	

I saw this patient at the General Renal Clinic at Forth Valley Royal Hospital on Thursday 07/07/2011.

I reviewed this young man who is recovering from acute kidney injury secondary to rhabdomyolosis, back at the Renal Clinic today. His renal function continues to slowly improve but he did say he had had some back pain a few days ago. His urine is positive for leucocytes and nitrites although no blood and protein today. I will check he hasn't got a urinary tract infection and let you know if it is positive. He tells me he is currently on a course of antibiotics for a skin infection and I suspect it is either Clarithromycin or Erythromycin as he is penicillin allergic. He is also on his Methadone but no other regular drugs. His blood pressure is fine he himself is feeling much better in general. He has said that this experience has been life changing for him and I think he was quite fearful that he may not survive it. I have repeated all his bloods today and arranged review in 6 weeks.

Yours sincerely

CATHERINE STIRLING
CONSULTANT NEPHROLOGIST

The next appointment at the General Renal Clinic is on 17/08/2011.

COPY

Recent Results

Date	Time	Test	Result	Units
07/07/2011	13:52	Systolic BP	125	mm Hg
07/07/2011	13:52	Diastolic BP	68	mm Hg
07/07/2011	13:52	Weight	78.6	kg
23/06/2011	11:04	Height	171.5	cm
07/07/2011	14:20	Potassium	4.7	mmol/L
07/07/2011	14:20	Bicarbonate	24	mmol/L
07/07/2011	14:20	Urea	4.6	mmol/L
07/07/2011	14:20	Creatinine	114	micromol/L
23/06/2011	11:30	eGFR	27	mL/min/1.73m2
07/07/2011	14:20	Glucose	5.2	mmol/L
17/06/2011	08:00	Cholesterol	3.2	mmol/L
07/07/2011	14:20	C reactive protein	22	mg/L
07/07/2011	14:20	Albumin	45	g/L
07/07/2011	14:20	Adjusted Calcium	2.23	mmol/L
07/07/2011	14:20	Phosphate	1.13	mmol/L
07/07/2011	14:20	Alkaline phosphatase	285	units/L
07/07/2011	14:20	Bilirubin	7	micromol/L
23/06/2011	11:30	Gamma GT	118	units/L
07/07/2011	14:20	AsT	18	units/L
07/07/2011	14:20	AlT	19	units/L
07/07/2011	14:20	Haemoglobin	119	g/dL or g/L
07/07/2011	14:20	WBC	9.5	x 10^9 /L
07/07/2011	14:20	Platelets	369	x 10^9 /L
20/06/2011		Ferritin	160	mg/L
20/06/2011		Serum Vit B12	335	nanog/L
20/06/2011		Serum Folate	2.4	microg/L
17/06/2011	08:00	TSH	2.7	m units/L
17/06/2011	08:00	fT4	17	picomol/L
10/06/2011	13:00	uPCR	172	mg/mmol

According to the West of Scottish Electronic Renal Patient Record (SERPR) the current medicine prescription for ALAN WYLES DoB: 06/05/1977 CHI: 0605770352 is:

Allergies

14/06/2011

NHS Forth Valley
Renal Services

Renal Unit, Forth Valley Royal Hospital
Stirling Road, Larbert, FK5 4WR

Contact 01324 566515 / 566516
e-mail: fv-uhb.renal@nhs.net

NHS Forth Valley COPY

Ref: CS/AH
Dict: 20.07.2011
Typed: 21.07.2011

Dr FE LYLE
PARK AVENUE MEDICAL CENTRE
9 PARK AVENUE
STIRLING
FK8 2QR

Dear Dr LYLE

ALAN WYLES
27 Waulker Avenue
STIRLING
FK8 1SA

Hosp. No.
Date of birth: **06/05/1977**
CHI number **0605770352**

I saw this man recently at the Renal Clinic and you should have received my letter by now. His renal function continues to improve following his acute kidney injury but he had some urinary symptoms at the clinic and his MSU has cultured an e-coli. It is fully sensitive to all the usual antibiotics and he had said to me that he had been on a course of an antibiotic for a skin infection. It may well be that his urine infection has cleared up but if he still has any ongoing symptoms, he may need a further course. I see that he is penicillin allergic but the e-coli is sensitive to Ciproxin, Cefalexin and Trimethoprim. We are due to see him back in August.

Yours sincerely

CATHERINE STIRLING
CONSULTANT NEPHROLOGIST

The next appointment at the General Renal Clinic is on 17/08/2011.

COPY

FORTH VALLEY ROYAL HOSPITAL
RENAL SERVICES
STIRLING ROAD
LARBERT
FK5 4WR

TEL: 01324 566515 or 01324 566516
e-mail: fv-uhb.renal@nhs.net
Fax No 01324 567732

NHS
COPY

Ref: SM/AH
Dict: 17.08.2011
Typed: 02.09.2011

Dr FE LYLE
PARK AVENUE MEDICAL CENTRE
9 PARK AVENUE
STIRLING
FK8 2QR

Dear Dr LYLE

ALAN WYLES
27 Waulker Avenue
STIRLING
FK8 1SA

Hosp. No.
Date of birth: **06/05/1977**
CHI number **0605770352**

Diagnosis:
11/06/2011 Acute Renal Failure due to Rhabdomyolysis

Renal replacement therapy history

Date Started	Treatment type	Centre	Comment
12/06/2011	RRT for ARF	Western Infirmary Glasgow	

This gentleman failed to attend his renal clinic appointment this morning and has been discharged back to your care. He has recovered from an episode of acute kidney injury and his last serum creatinine was 120micromol/l. There is also no evidence of proteinuria at his last review. I would recommend repeating his renal biochemistry, blood pressure and urinalysis again in 4 months time to make sure that things are stable. He did have a urinary tract infection and should this recur, then he will require urology review. Please let me know if your are concerned about his progress and I would be happy to review him again in the Renal Clinic in the future.

Yours sincerely

SCOTT MORRIS
CONSULTANT NEPHROLOGIST

COPY

Department of Ageing & Health
Consultant: Dr Richard Lenton
Tel: 01324 566880

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR

COPY

T.I.A. SERVICE

Ref: RL/jb/S278537
CHI: 0605770352

Dictated Date: 14 September 2011
Date: 23 September 2011

Dr Fiona Lyle
Park Avenue Medical Centre
9 Park Avenue
Stirling
FK8 2QR

Dear Dr Lyle

ALAN WYLES 06/05/1977
27 WAULKER AVENUE, STIRLING FK8 1SA

This gentleman's brain CT request has been returned to me as he was transferred to Glasgow following my seeing him at the TIA clinic..

I am not sure what his current status is, and if you feel that he should have a brain CT please get back to me and I will arrange this.

Yours sincerely

Dr Richard Lenton
Consultant Physician in Ageing & Health

X-ray of lumbar spine 09.06
Normal lumbar vertebral alignment and intervertebral disc spaces. Intact pedicles, spinous processes and posterior structures. Minimal subchrondral sclerosis of the iliac side of the sacroiliac joints, but no erosions. If symptoms persist MRI may be of value.

COPY

Hospital use only	Clinic	5278537	Day Date	Time	Hospital No.

COPY

Date Referral Submitted
(This date is fixed at hospital end):
27-Aug-2012

REFERRAL LETTER

MEDICAL IN CONFIDENCE

CHI No: 0605770352

Unique Care Pathway Number: 1010040970571

REFERRAL TO

AnaestheticsC3
FV Pain Clinic Referral

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

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR

Hospital and **hospital address**

Hospital location code.
V217H

Urgency of Referral **Routine Pain Clinic Referral**

Administrative Information

Patient has special requirements:No

Ethnic Origin: (White) Scottish

PATIENT DETAILS

Surname	Wyles
Forename(s)	Alan
Title	- Sex Male
Previous Surname	-
Date of birth	06-May-1977
CHI no.	0605770352

Patient's address

17 Charles Street
Dunblane
FK15 9BY

Contact number(s)

-

REFERRING PRACTITIONER DETAILS

Name:	Dr. Graeme Clark (GMC: 3679762)
Practice:	Dunblane Medical Practice (25243)
Phone:	Voice: 01786 822595

Practice address:

Health Centre
Well Place
Dunblane

RECEIVED 28 AUG 2012

CLINICAL INFORMATION

COPY

History of presenting complaint / examination findings / investigation results
Presenting Complaint

Description: Persistent right upper leg and lower back pain > 12 months

Comment: I would be grateful if you would see this 35 year old man with over 12 months of persistent right upper leg and lower back pain.

Alan is new to the Practice in Dunblane and he dates his pain to an admission in June 2011 with acute renal failure due to rhabdomyolysis. He had a renal biopsy at this time which confirmed tubular necrosis and required dialysis on a number of occasions. I do note at this time he was on Diclofenac for low back pain. I also note that he has a history of drug addiction and at this time was on Methadone and admitted to benzodiazepine use. He has subsequently been followed up by the Community Addiction Team in Forth Valley.

Alan moved to Dunblane 3-4 months ago although has only recently registered with the Practice. He is on a reducing dose of Methadone and has also been on Co-Codamol 6-8 tablets daily and Temazepam 10mg at night for a number of months. He complains of very persistent right upper leg pain which was initially behind his knee but over the months has affected his whole right upper leg and posterior thigh. This is now felt in his right lower back. I notice his previous GP organized x-ray of his proximal femur and right hip in February 2012 which showed no abnormality.

Alan is a single parent with two daughters aged nine and seven, and has been very keen to view the move to Dunblane as a new start and has been very positive about progress in the last few months. He is engaging with a reducing Methadone programme. I am obviously concerned about his ongoing use of codeine and Temazepam in the context of his problems with drug addiction, although he feels he cannot reduce his medication at present because of his ongoing right leg pain.

I would be grateful for your assessment and advice on further investigation, diagnosis and management. Thank you for your help.

Examinations and Investigations

Murmur present:	Not Recorded	-
Is a 12 lead ECG:	Not done	-
Recent CXR:	Not done	-
FBC:	Not Recorded	-
Urea and Electrolytes:	Not Recorded	-
LFT:	Not Recorded	-
TFT:	Not Recorded	-
Lipid Profile:	Not Recorded	-
Glucose:	Not Recorded	-

Investigations

Smoking Advice Recorded: Not Recorded -

Reason for referral

Care type requested: Out Patient
Expected outcome: Not Specified

Medical history

Active Repeat Therapy

Some Repeats may be Active but not Issued. In these instances, the Date Last Issued field contains the date authorised by the GP.

No current medications recorded

Issued Scripts for Acutes and Inactive Repeats (in last 90 days)

Drug name	Drug code	Formulation	Dosage	Frequency		
Temazepam Tablets 10 mg	0401010T0AAAMAM	14 TABLET	TAKE ONE TAB OCCASIONALLY AT NIGHT TO HELP SLEEP	-	-	42 Days
Co-Codamol 30/500 Tablets	0407010F0AAAHAH	100 TABLET	ONE OR TWO UP TO QDS PRN FOR PAIN	-	-	42 Days
Sertraline Hydrochloride Tablets 50 mg	0403030Q0AAAAAA	28 TABLET	1 DAILY	-	-	28 Days
Sertraline Hydrochloride Tablets 100 mg	0403030Q0AAABAB	28 TABLET	1 DAILY	-	-	28 Days
Co-Codamol 30/500 Tablets	0407010F0AAAHAH	100 TABLET	ONE OR TWO UP TO QDS PRN FOR PAIN	-	-	12 Days
Temazepam Tablets 10 mg	0401010T0AAAMAM	14 TABLET	TAKE ONE TAB OCCASIONALLY AT NIGHT TO HELP SLEEP	-	-	14 Days

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status

Not Known

Alcohol consumption

Units per day (Not Known)

COPY

Additional relevant information

Signature of referring doctor (or other professional)

Date 27-Aug-2012

Dept of Anaesthesia & Pain Management
Consultant: Dr Judith Wilson
Tel: 01324 677553
Fax:

Falkirk Community Hospital
Major's Loan
Falkirk
FK1 5QE

COPY

Ref: JW/MMF/S249901
CHI: 0605770352

Clinic Date: 20 December 2012
Date: 31 December 2012

Dr G Clark
Dunblane Medical Practice
Health Centre
Well Place
Dunblane
FK15 9AL

Dear Dr Clark

ALAN WYLES 06/05/1977
17 CHARLES STREET DUNBLANE PERTHSHIRE FK15 9BY

This gentleman failed to attend the pain management clinic today. He has already DNA'd in November and a further appointment was sent out following this. As he has failed twice I will be sending him no further appointments.

Kind regards,

Yours sincerely

Dr Judith Wilson
Consultant Anaesthetist

Immediate Discharge Letter

NHS Forth Valley

COPY

Hospital: Forth Valley Royal Hospital, Larbert
Consultant: Crumley, Mr Andrew
Specialty: General Surgery

Tel: 01324 56[illegible]000
Discharging Ward: FVRH - Discharge Lounge

GP Details		Patient Details		Admission Details	
Practice Code:	25243	Patient CHI No:	0605770352	Admission Date:	04/03/2016
		Patient Hospital No:	S278537		
GP Name:	Dr Katie Roxburgh	Surname:	Wyles	Admission Type:	Emergency - Non-Injury (e.g. Stroke, MI, Ruptured Appendix)
Address: Dunblane Medical Practice, Health Centre, Well Place, Dunblane, K15 9AL		Forename:	Alan	Presenting Complaint:	Wound
		Date of Birth:	06/05/1977		
		Address:	17 Charles Street,, Dunblane,, Perthshire, FK15 9BY	Discharge Date:	04/03/2016
				Discharge To:	Private Residence - Living Alone

Diagnosis/Problem List

Xa2OY - Stab wound

Additional comment (Progress, Investigations, Procedures, Complications etc)

Dear Doctor,

Alan Wyles was admitted on the 04/03/16 with a stab wound to the left lumbar region.

O/E - 4cm laceration to left lumbar region. No other injuries

Investigations
CT Head: NAD
CT C/A/P: Chest: Bibasal moderate atelectasis. No pneumothorax. Abdo/pel:left gluteal stab wound. Extends to deep ischia. Small subcut haematomas. No intra abdominal pathology.

Management
Wound closed with single stitch. CT head (as above) due to descrease in GCS from 14/15 on admission to 12/15. Now fit for home - arranged to visit district nurse on Monday 07/03/16 for wound review and further review and stitch removal 1/52 following this.

Kind regards,

Kirsty Toms
FY1, AAU2

Results Outstanding (Y/N) If yes, give details:	No

Information to patient/carer (Y/N):	Patient: Yes Carer (if applicable):

Follow up arrangements

File

There are no Reviews planned

Authorisor's name: Dr K Toms **Authorisor's grade:** FHO1 **Read/Approved by:** **Date:** 04/03/2016	**Authorisor's Signature:** COPY
Discharge Ward Nurse:	Smith, Victoria

Validation/Contact Name: Crumley, Mr Andrew

Name: Mr Alan Wyles

THIS IS THE FINAL DOCUMENT
CHI: 0605770352

File

Forth Valley Acute Hospitals Acute Division
Medications Discharge Summary

Name:	Mr Alan Wyles	**Patient's Tel No:**	
Address:	17 Charles Street,, Dunblane,, Perthshire, FK15 9BY	**Patient's Tel Eve:**	07731917911
Admission Date:	04/03/2016	**Discharge Date:**	04/03/2016

COPY

PATIENT ALERTS

Alert Group	Alert	Alert Comment	When Added	Added By

PATIENT DRUG REACTIONS

penicillin - Adverse Reaction - kidney pain

CURRENT PRESCRIPTION (all medicines currently prescribed) **e.g. clinical indication for prescription monitoring*

	Drug	Route	Dose	Frequency	Duration (days)	New Drug / Altered Dose	POD
1	GABAPENTIN 300mg CAPSULES	Oral	900 mg	THREE times daily			
*	weekly disp last collected last thursday contact cp on dc						
2	MIRTAZAPINE 30mg TABLETS	Oral	30 mg	Night			
*	weekly disp						

MEDICINES DISCONTINUED

Nurse check on discharge:

Signature 1: Signature 2:

Name: Mr Alan Wyles CHI: 0605770352

File

Case No 1053654 **Case Active** 18/09/2017 18:23 **Case Type** Fit For Court (FFC)

COPY

Patient Alan Wyles **D.O.B** 06/05/1977 **Age** 40 years

Sex Male **Ethnicity**

Current Address

17 Charles Street Dunblane

Perthshire

FK15 9BY

Home Address (if currently not at home)

Case Origin **Callers Name** **Callers Tel:**

Custody Sergeant 01324 678820

Own Doctor

Surgery

Case Questions

Fitness and Observation Level
- Fitness And Observation Questions Required? - Required
- Fitness And Observation Questions Required? - Required
- Fitness And Observation Questions Required? - Required
- Custody Or Log/Incident Number: - 105428

Case Referral
- Police Custody Service - Forth Valley Police Custody Service

Patient Location
- Patient Type: - Detainee

Additional Referral Information
- Primary Reason For Call: - Drugs

Additional Referral Information
- Location (FTV): - Falkirk Police Station

Patient Location
- Referral Type: -

Case Referral
- Fitness: -
- Fitness: -
- Fitness: -
- Fit For Court: - Medically Fit For Court
- Fit For Court: - Medically Fit For Court
- Fit For Court: - Not Medically Fit For Court
- Healthcare (incl. Mental Health) - Yes

Case Referral
- Reasons and Subsequent Actions (FFC): - Requires to be seen at FVH prior to court
- Appropriate Adult Consideration: - AA Not Required
- Appropriate Adult Consideration: - AA Not Required
- HCP Recommended Minimum Level Of Observations: -
- HCP Recommended Minimum Level Of Observations: -
- Appropriate Adult Consideration: - AA Not Required
- HCP Recommended Minimum Level Of Observations: -
- Minimum Recommended Observation Level: - Standard (Hourly)
- Minimum Recommended Observation Level: - Standard (Hourly)
- *This is the standard level of observations -
- *This is the standard level of observations -
- Minimum Recommended Observation Level: - Standard (Hourly)
- *This is the standard level of observations -

Consultation **Consult By** Martin, James **Consult Start** 05:33

Consult End 05:51

Examination Details

Clinical Codes

NEWS 2
BG 5.5mmols

OBS 2 -PCS
Systolic BP mmHg 128
Pulse bpm 103

COPY

Rate of respiration 14
Blood oxygen saturation % 96.0
Temperature C 38.7
Diastolic BP mmHg 66

Rate of respiration- 14
Blood oxygen saturation- 96.0
Pulse- 103
Diastolic BP- 66
Systolic BP- 128
Temperature- 38.7

Diagnosis

Assessment: Complaining of severe pain on the left side of his neck where he injected yesterday - painful to touch - swelling++ and appears inflamed
Pyrexial and tachycardic, complaining "burning up" then "freezing cold" Temp 38.7
Complaining of feeling generally unwell - appears lethargic.
To be seen at FVH
Given paracetamol 1g at 05:45am

Treatment

Complaining of severe pain on the left side of his neck where he injected yesterday - painful to touch - swelling++ and appears inflamed
Pyrexial and tachycardic, complaining "burning up" then "freezing cold"
Complaining of feeling generally unwell - appears lethargic
To be seen at FVH
Given paracetamol 1g at 05:45am
Continue on hourly rousable obs

Consultation **Consult By** Martin, James **Consult Start** 03:26 **Consult End** 03:28

Examination Details **Clinical Codes**

OBS 2 -PCS
Systolic BP mmHg 128
Pulse bpm 103
Rate of respiration 14
Blood oxygen saturation % 96.0
Temperature C 38.7
Diastolic BP mmHg 66

Diagnosis

Returned from FVH - suicidal comments were made in anger- see discharge letter
medically fit for discharge
Fit for court

Treatment

Consultation **Consult By** Martin, James **Consult Start** 20:13 **Consult End** 20:15

Examination Details **Clinical Codes**

OBS 2 -PCS
Systolic BP mmHg 128
Pulse bpm 103
Rate of respiration 14
Blood oxygen saturation % 96.0
Temperature C 38.7
Diastolic BP mmHg 66

Diagnosis

A&E contacted and request made for psych assessment - informed MO will refer if requires further psych assessment

Case No 1053654 **Case Active** 18/09/2017 18:23 **Case Type** Fit For Court (FFC)

COPY

Treatment

Prescriptions

Follow-up(s)

No Follow Up -
No Follow Up -

B

Immediate Discharge Letter

NHS Forth Valley

COPY

Hospital: Forth Valley Royal Hospital, Larbert
Consultant: Ahmed, Dr Asma
Specialty: General Medicine

Tel: 01324 5[illegible]000
Discharging Ward: FVRH - CAU

GP Details		Patient Details		Admission Details	
Practice Code:	25243	Patient CHI No:	0605770352	Admission Date:	19/09/2017
		Patient Hospital No:	S278537		
GP Name:	Dr Katie Roxburgh	Surname:	Wyles	Admission Type:	Emergency - Non-Injury (e.g. Stroke, MI, Ruptured Appendix)
Address:	Dunblane Medical Practice, Health Centre, Well Place, Dunblane, FK15 9AL	Forename:	Alan	Presenting Complaint:	Neck Pain
		Date of Birth:	06/05/1977		
		Address:	17 Charles Street,, Dunblane,, Perthshire, FK15 9BY	Discharge Date:	19/09/2017
				Discharge To:	Private Residence - No Additional Detail

Diagnosis/Problem List

SP3y7 - Swelling at injection site

Additional comment (Progress, Investigations, Procedures, Complications etc)

Dear Doctor,

Thank you for continuing teh care of Mr Alan Wyles who presented to FVRH on the 19/9 with a painful swollen neck. This was following having injected heroin into the left side of his neck yesterday. he was generally unwell and feverish.

PMH: depression, IVDU
Medications: naproxen, gabapentin, mirtazapine

O/E: left neck tender, swollen

loods: WCC 11, CRP 99

EWS: 0 throughout admission

The patient was treated with one dose of vancomycin IV. Unfortunately Mr Wyles self-discharged before consultant review. he was made aware this was strongly against medical advice and signed a self-discharge form.

Please note I did not personally see the patient and am writing his discharge from clinical notes.

Kind regards,
Lucy Littlejohn FY1

Results Outstanding (Y/N) If yes, give details:	No

Information to patient/carer (Y/N):	Patient: Yes Carer (if applicable):

Follow up arrangements

There are no Reviews planned

File

Authorisor's name: Dr L Littlejohn **Authorisor's grade:** FY1 **Read/Approved by:** **Date:** 20/09/2017	**Authorisor's Signature:** COPY
Discharge Ward Nurse:	

Validation/Contact Name: Ahmed, Dr Asma

THIS IS THE FINAL DOCUMENT

Name: Mr Alan Wyles

CHI: 0605770352

File

LING ROYAL INFIRMARY - THEATRE CARE PLAN

T 03624

Allan Wyles

ADDRESS 100D Raploch Rd Stirling

WARD 28

UNIT NUMBER 023522 DOB 6/5/77

PROCEDURE Wound toilet, washout & suturing laceration left clavicle.

Consultant MR Ross

COPY

For **SURGEON** MR Joseph

Signature Susan Kerr 7/9/02 DATE

Th No 1 (IP) OP Elect- (EM)

Procedure Start 20.10 GA ☐ LA ☑

Closure Time 20.35

Exit Th Time 20.45.

Blood Loss

Position Supine

Urine Output

Positioned By SN Kerr

SPEC - YES / (NO) NUMBER.

TEAM LEADER SN Kerr

Radiographer

LOTIONS			
Chlorhexidine/Spirit	Betadine Antiseptic ✓	Methylene Blue	Bet Alcohol
Tisept	Chlorhexidine/Water	Acetic Acid 5%	Aqueous Iodine

NURSING COMMENTS

IRRIGATION FLUID/ANTIBIOTIC

UND INFILTRATION (LA) Lignocaine. 1% c Adrenaline.

Eye drops/oint.

Time

Given by:

	TYPE	SIZE	POSITION
PACKS			
Drain			
Chest Drain			
Stent - Ureteric Cath			
Catheter			Balloon Amt.
Catheterised by:			

BONE BANK No.

WEDGE/PILLOW

Sling

Splint

Other

SKIN CLOSURE Nylon

DRESSING Mepore.

Th WATERLOW SCORE

SURGEONS INSTRUCTIONS

Sutures Out

Appt.

DATE 7/9/02 Case/Em No 2	TH No 1 PRE-OP	AM (PM) TOTAL	CP No INSTRUMENT/TRAYS Adhere tray batch numbers by item name
ABS 10 x 10	10	10	
5 x 5			07 Sep 2002 5288005, L 40101 Hand & Toe Set
PACKS (abd 30 x 30)			
CAESAREAN ROLLS			12 Oct 2001 5016001, L 36908
PLEDGETS			BONE NIBBLERS 5016001
NEEDLES	1	1	
BLADES	2	2	
SLINGS			
OTHER			

1 - Scrub Person K Campbell

2 - Scrub Person

1st Count Circ Person H Easton

FINAL Count Circ Person H Easton

Signature of person/s completing careplan..... K Campbell

ING372

CLINICAL NOTES

Consultant

Write - imprint or Attach Label

Surname WYCES Hospital No.

Forenames ALLAN Sex

D. of B.

Address

COPY

Ward / Dept.

Date	
7/9/02	25 ♂ Ⓡ Handed
5-40pm	
	Fell off ~~mountain~~ BMX bike today ~ 5.30 pm
	Painful Ⓛ shoulder and Ⓛ chest since
	Nil SOB
	? bone initially protruding through skin over Ⓛ clavicle
	- Nil bone visible now
	Previous cocaine user, Nil drug use since Feb 2002
	Now on Methadone 40 ml
	Diazepam
	Has had Morphine 20 mg IV in A+E
	Has had Tet tox in A+E
	O/E Alert, GCS 15/15
	Nil C-spine tenderness
	1.5 cm wound over and mid-lat Ⓛ clavicle
	Nil bone visible through skin
	# clavicle evident
	Bruising ~~antero~~ postero lateral Ⓛ shoulder
	Tender Ⓛ upper back
	Nil subcutaneous emphysema over chest wall
	Tender @ Ⓛ antero lateral chest wall
	Ⓝ axillary nerve sensation Ⓛ
	Ⓝ sensation Ⓛ hand
	good Ⓛ radial pulse
	Nil bony tenderness of Ⓛ elbow / wrist ; Nil NVD Ⓛ hand
	Pulse 82/min reg, good vol BP 125/60 mmHg RR 16/min not laboured

STM 069

RX78

S278537

CLINICAL NOTES

ALAN WYLES
103 RAPLOCH ROAD
STIRLING

FK8 1RS

M/S
04/05/1977

COPY

Consultant DW Ross

Date	
8/9/02	well post op – home with c&c review 19 Sept DW Ross
26/9/02	FTA SFA RJ

CLINICAL NOTES

S278537
ALAN WYLES
103 RAPLOCH ROAD
STIRLING

FK8 1RS M/S 06/05/1977

COPY

Consultant

Date

S278537
ALAN WYLES
103 RAPLOCH ROAD
STIRLING

FK8 1RS M/S 06/05/1977

Consultant:
Date of admission:
Complaint and duration:

Positive x-ray findings:

Treatment: including operation-date

Post-operative or subsequent course:

Sutures removed:

Date of discharge and to where:

Date of mobilisation or discharge:

Drug Therapy on discharge:

Follow-up:

MR Ross.
07/09/02.
Compound (L) clavicular #.

07/09/02 – toileting of wound (L) clavicular + suturing.

Good progress.

Discharged 08/09/02

DICLOFENAC 500mg tds (3days)

19th Sept 2002 – OPD.

19/9/02 FDA SFA

3/10/2 FU

Master Kn
SEC STORAGE 2004

Accident and Emergency Department
Stirling Royal Infirmary

A&E No. 090123[illegible]

0605770352

COPY 3

urname	WYLES	**Forename**	ALAN	**Title:**	
ddress:	27 WAULKER AVENUE RAPLOCH STIRLING	**Postcode** **Telephone:**	FK8 1SA 450501		
)ate of Birth:	06.05.77	**Sex:**	M	**Age:** 32 yrs	

GP Name:	RANKIN JOHN				
Ad :	PARK AVENUE MEDICAL... 9 PARK AVENUE STIRLING	**Postcode** **Telephone:**	FK8 2QR 01786 473529		

Next of Kin	VICTORIA				
Relationship:	PARTNER				
Address:	27 WAULKER AVENUE RAPLOCH STIRLING	**Postcode** **Telephone:**	FK8 1SA 450501		

Manual CHI Entry:

Date of Attendance: 26.12.09 15:28
Date of Incident:
Pr)ing Complaint: LT SHOULDER/KNEE INJ

• Broad Arm Sling
• Fracture Clinic

Triage	MODERATE PAIN (5 ON 1-10 SCALE; SOMEWHAT DISABLING) ALLEGED ASSAULT KNOCKED TO GROUND LANDING ON LT SIDE C/O PAIN LT HEAD HUMERUS AND SCAPULA DECREASED ROM AND LT KNEE PAIN	**Tetanus Cover:** **Allergies:**	

P= **BP=** / **RR=** **Sat=** **BM=**

PF= **GCS=** E: M: V: Total:

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time

WED 30/12 - 9-35am

© 1998 - 2009 HAS Solutions Pty. Limited

Clinical Notes

Seen by: [illegible] **Time:** [illegible]

COPY

Left right, right handed to ground. RHP

unemployed.

°PH °UR

°PPA/vomit. 75 meth.

c/o (L) Shoulder flexure

no CSpine BT

- Fracture neck.

Old clav collins

Trider ACJ.

Trider GT

Fracture, ↓ Int rot

Flex 90

Abd 70.

Ellbow fracture.

- Xray.

↳ subluxed

↳ Handed over to Dr Tufail.

- x-rays reviewed → subluxation +

?? posterior Dislocation not sure

- D/w ortho on call → Not sure about posterior dislocation will ask Reg to review x-rays I will come back to me.

Guidelines Used:

X-RAY REQUEST

X-RAY REPORT

Attach continuation sheets here

0605770352

Han Wyler

Date:

Clinical Notes

Patient Name: **DoB:**

COPY

26/12/09 Yeung SR.

1925.

32 ♂

Yesterday allegedly involved in fight fell + landed onto (L) shoulder

Pain c/o pain

Well otherwise

O/E (L) Shoulder no deformity tender acromion

- passive movement
  - ext - lat rotation range - 90°
  - abduction - 90°
  - extension - 60°
  - flexion - 40°

- distal medial ulnar, radial nerve (2)

Xray no obvious # / dislocation

d/d ortho registrar 6/52 above

Range of movement - unlikely post dislocation

Imp - Traumatic injury

P/L - Analgesia

Support

F/U clinic Rx

S Yeung SR

CLINICAL NOTES

Write - imprint or Attach Label

Surname ..... Hospital No. .....

Forenames ..... Sex .....

D. of B. .....

Address .....

COPY

Ward / Dept. .....

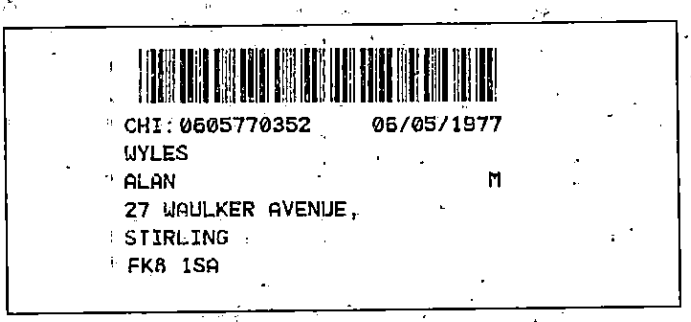
Consultant

Date	
30/12/09	FTA

COPY

WARD 27

PATIENT PROFILE


CHI: 0605770352 06/05/1977
WYLES
ALAN M
27 WAULKER AVENUE,
STIRLING
FK8 1SA

CONSULTANT: Mr Handy

NAMED NURSE: T BANNISTER

DIAGNOSIS: Peri-Anal abcess

THEATRE DATE: _____

OPERATION: _____
GA/LA/SPINAL
CLOSURE: _____ **CAST:** _____
REMOVAL SUTURES/STAPLES: _____

ALLERGIES: Penicillian

MEDICATION

COPY

DRUG	DOSE	FREQUENCY	COMMENTS
Methadone	75ml	x1 morning	
currently taking clarithromycin 500mg x2 daily			

ALCOHOL INTAKE	SMOKING HISTORY	MRSA SCREEN required YES/NO Date carried out
UNITS PER WEEK	YES ✓	
NIL ___	NO ___	
LESS THAN 14 ✓	PREVIOUS ___	
14-21 ___	DETAILS: 15 a day.	
OVER 21 ___		

PAST MEDICAL HISTORY

dislocated shoulder 7 years ago
hx heroin user

PATIENT PROFILE

COPY

NAME	PHONE NUMBER
ADDRESS	MARITAL STATUS
	OCCUPATION
	RETIRED UNEMPLOYED
CHI: AGE: 32	RELIGION

Admitted from A&E 24/04/10 . Transferred From: _____
Admission Time 1139am (24hrs) . Date _____ Time _____
Consultant _____ . NOK informed YES/NO
Named Nurse T BANNISTER .

Next of Kin Victova Phillips. Other contact _____
Address As above Address _____
Phone 4505041 Phone _____
Relationship Partner Relationship _____
Relatives aware of admission? (YES)/NO

GP Dr Hannity . OPERATION
Park Main Medical . Date of operation __/__/__
Centre 9 Park Avenue . Side Left /Right
GP Phone 01786 473529 . Anaesthetic . Wound Closure
. General ---- Clips ----
. Spinal ---- Sutures ----
849701. . Femoral Block ---- Subcuticular ----

HOME CIRCUMSTANCES
Lives with family ✓
Lives Alone ----
Elderly/Disabled partner ----
Care Home ?Type ----------
Family support
Specify _____
House ✓ Flat ----
High Level ---- Low Level ----

Bedrooms Situated Upstairs
Bathroom Situated downstairs
Bath ---- Shower ----
Stairs Internal ---- External ----

MENTAL STATE
Alert/Orientated ✓
Confused ----
Anxious/Distressed ----

. **SENSES**
. Sight(specify eg normal, impaired,blind)
. _____
. Hearing impaired left / right
. Hearing Aid left / right
. Dentures upper/ lower
. _____

. **VALUABLES**
. Items Ring, Gold chain - in pod
. Kept by patient :(YES)/NO - in safe
. Ward Safe : YES/NO Date _____
. Ward POD : YES/NO Date _____
. Jewellery removed for Theatre _____
. Returned to Patient Date _____

. **Admitted by:**
. LMcCafferty
.
.

PATIENT PROFILE (continued)

COPY

ELIMINATION

Bowels regular---------- (YES)/NO

Constipated ---------- YES/(NO)

Diarrhoea/Loose stools--------- YES/(NO)

Frequency of micturition------- YES/(NO)

Incontinent : Urine / Faeces- YES/(NO)
Day/Night - YES/(NO)

OBSERVATIONS ON ADMISSION

BP ____/____
Temperature ____ C
Heart Rate ____ bpm
Pain Score As
Height Chart m
Weight ____ kg
Blood Sugar ____ mmols
SaO2 ____
Resps ____

NUTRITION

Normal Diet(includes vegetarian) --✓--

Vegan----- Halal----- Kosher-----

MUST Score -----

PRE-INJURY MOBILITY

Walked = Indoors Alone ✓
Accompanied ____
Outdoors Alone ____
Accompanied ____
Unable to walk ____

AIDS

None ✓ Frame ____
One Stick ____ Wheelchair ____
Two Sticks ____ Bedbound ____

Pre-injury Function

	Independent	Dependent
Toileting	✓	____
Washing/Dressing	✓	____
Meal Preparation	✓	____
Shopping	✓	____

SLEEP

Hours/night ____

Medication YES/(NO)

MEDICATION

Not with patient ____
Stored in POD ✓
Taken Home ____
Self Medication YES/NO

PRESSURE AREA

BRADEN SCORE 23
Heels Left 0 Right 0
Sacrum 0
Other ____
Specify ____
Pressure relieving mattress - YES/NO
Type ____
Signature/Date

WARD URINALYSIS

TED Stockings Applied - YES/NO

COMMUNITY SERVICES

District Nurse/Home Help, etc

Accident and Emergency Department
Stirling Royal Infirmary

0605770352

A&E No. 10029094

COPY 4

Surname	WYLES	**Forename**	ALAN	**Title:**	
Address:	27 Waulker Avenue, STIRLING	**Postcode**	FK8 1SA		
		Telephone:	450501		
Date of Birth:	06.05.77	**Sex:**	M	**Age:** 32 yrs	

GP Name:	RANKIN JOHN			8497701
Address:	PARK AVENUE MEDICAL... 9 PARK AVENUE STIRLING	**Postcode**	FK8 2QR	
		Telephone:	01786 473529	

Next of Kin	VICTORIA PHILLIPS		
Relationship:	PARTNER		
Address:	27 Waulker Avenue, STIRLING	**Postcode**	FK8 1SA
		Telephone:	450501

Manual CHI Entry:

Date of Attendance: 23.04.10 14:29

Date of Incident:

Presenting Complaint: LUMP ON TAIL BONE

Triage MILD PAIN (<4 ON 1-10 SCALE; MINIMALLY DISABLING) PT HAS HAD ? PERI-ANAL ABCESS FOR SEVERAL MONTHS, WORSE 1/52, C/O ABX BY GP, COURSE NOT COMPLETED. PT SYSTEMICALLY WELL. EVIDENCE SELF HARM RIGHT ARM

Tetanus Cover:

Allergies:

P= 100 BP=133/66 RR= 14 Sat=96% AIR BM= 7.8 T 37.4

PF= GCS=E: M: V: Total:

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time

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Clinical Notes

Seen by: | **Time:**

COPY

C/O Swelling at base of coccyx for 2/52 - [illegible]
a shrinking ↓ in size
Has not attended GP today
Head abscess is same area 1 yr ago treated in
antibiotics
Heroin Addict.
Medicines :- Methadone daily.
Not known to be HIV+ve / Hepc +ve.

Last ate / Drank - 1pm

O/E Looks well Allergies to Penicillin
fully Mobile -

(1) Peri-anal Abscess. NOT fully fluctuant as yet

Commenced Ciprofloxacin 500mg bd
Clindamycin 500mg bd.
to return Mon for I+D

24.10.10
1040

Reviewed — Normal GA

Normal Rectum

Plan — Theatre

Normal
GA #654

Guidelines Used:

Attach continuation sheets here

PROGRESS NOTES

0605770352
WYLES
ALAN
06/05/1977 M
DATE: TIME:
SIGNATURE:

Unit No.
D.of B.

COPY

Date and Time	
24/4/10	Patient admitted to ward via A&E. Has had Peri-anal abcess for several months ↑Pain the past 1/52 commenced on oral clarithromycin by GP admitted for incision & drainage. Patient previously IVDU currently on methadone. Allergy to PENICILLIAN Patient settled on arrival to ward, Independent with ADLs, Oriented to ward Prepared for theatre:-
	→ Gown ☑ → Notes requested ☑
	→ Checklist ☑
	→ Consent ☑
	Kardex at standing. ☑. observations stable as charted. NIL Complaints offered Tds size applied. SNI McAree
24/04 1308	FYI Thurston re kardex
	confirmed with Tesco Pharmacy (0845 677 9658)
	drug history: Methadone 75mg od Mirtazepine 30mg od.
	THURSTON 291 FYI
1545	Methadone prescribed, awaiting stock from pharmacy SNI McAree Case notes locked away in surgical admissions unit.

PROGRESS NOTES

COPY

Date and Time	
24.IV.10 1725	AFEBRILE — remove / CMES I/D PILONIDAL ABSCESS r/v. Et O, mobilise (H) tonight IF PAIN-FREE f/u 2-3/12 remove fn stay
24/04/10 1845	WR KOMOLAFE. WELL Et O Painfree. plan (H) tonight OP appt 2-3/12 time please. FYI #299.
24/4/10 1800	• Pt returned from theatre following I+D of pilonidal sinus under GA. • Wound has blue gauze + mefix applied • Post Op Plan Can eat + drink Pt can go home tonight if pain free Clinic Review 2-3 months • Alert + orientated back to ward • Observations stable. • Pt has tolerated diet + fluids

♦ PROGRESS NOTES

Sur
For
Add

CHI: 0605770352
06/05/1977 M
WYLES Alan
27 WAULKFI
STIRLING
FK8 1SA

COPY

Date and Time	
24/4/10	• Pt has passed urine
18⁰⁰	• Pt seen by Ward Round at 18.45
	PLAN Home.
	• Pt given methadone as charted
	• Pt wished to leave ward at 18.55
	• DN form completed for wound check, this will be telephoned to DN on Monday AM.
	• Pt left with his family at 19⁰⁰ hrs – no complaints offered S/N K. KWILLAGRAN.
28/4/10	Treatment room nurse contacted by staff, pt has an appointment for 30/4/10 for dressing changes.
	Treatment room happy with arrangement
	S/N K. KWILLAGRAN

CONSENT FOR OPERATION

Write - imprint or Attach Label

Surnam
Forenan
CHI: 0605770352 06/05/17
WYLES
ALAN
M
Address 27 WAULKER AVENUE,
STIRLING
FK8 1SA
Ward/Dept

COPY

CONSENT BY PATIENT, PARENT OR LEGAL GUARDIAN

I, ...

of .....

hereby consent to

undergo the operation of*

or

the submission of my child/ward to undergo the operation of*

RAMAL of POLYPOSIS SEPSIS

The nature and purpose of which have been explained to me by

Dr/Mr* Kumanan

I also consent to such additional or alternative operative measures as may be found necessary during the course of the above-mentioned procedure and to the administration of a general, local or other anaesthetic for this purpose.

No assurance has been given to me that the operation will be performed by any particular surgeon.

Date 24.IV.10 Signed .....

(Patient/Parent/Legal Guardian)

RSHS - REGISTRAR

I confirm that I have explained the nature and purpose of this operation to the Patient/Parent/Legal Guardian*

Date 24.IV.10 Signed .....

(Medical/Dental* Practitione

Forth Valley Surgical Safety Checklist
(FV Version 2)
carried out - Confirmed ☑
Date 24/4/10

*Delete as appropriate

Anaesthetic pause
Surgical pause SN DAVID MILLER
Post procedure SN DAVID MILLER

All alterations to this form sho ... the patient or the patients representative.

24 April 2010

17206

Stirling Royal Infirmary NHS Trust

COPY

Patient Details

Hospital Number	**S249901**
Patient Name	**WYLES ALAN**
Date of Birth	06/05/1977
Sex	M
Category Type	
Patient Type	InPatient
Operation Type	Emergency
Date of Operation	24/04/2010
Theatre	CEPOD 3
Confirmed By	

Staff In Attendance - Team 1

Anaesthetist	DR LORNA GALLACHER
Floor nurse 1	SN ELLEN PAGUE
Floor nurse 2	SN DAVID N MILLER
O.D.A.	MR TIMOTHY YOUNG
Other	AN TAMMY MCNAMEE
Surgeon	MR SEGUN KOMOLAFE

Attendees

Assistant - Dr Candice Galea, FY1

Materials Used

Item Code	Item Description	Qty	LOT1	LOT2	LOT3	LOT4
1009136	ABSCESS & TOE NAIL TRAY	1	1009136			
1051551	S3 BTWN PATIENT CLEAN	1	1051551			

Operation Notes

Side: **Op Notes**

Procedures

G-H59800 INCISION & DRAINAGE OF PILONIDAL SINUS

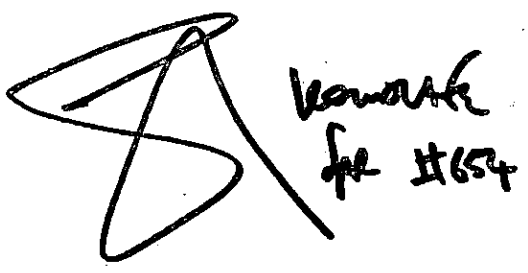
PROCEDURE: Left lateral position. Ellipse of skin excised to remove midline pits and open up abscess cavity. Haemostasis and copious lavage of cavity. 20ml 0.5% chirocaine instilled into and around wound. Wound loosely packed with aquacel.

POST-OP: Eat, drink and mobilise. Can get home tonight if pain-free. Clinic review in 2-3 months.

Alternate Codes H598

Procedure Definitions

***** End of Report *****



INFIRMARY - THEATRE CARE PLAN T 80547

CHI: 0605770352
06/05/1977 M
WYLES Alan
27 WAULKER AVENUE.
STIRLING
FK8 1SA

WARD 27
UNIT NUMBER DOB

PROCEDURE INCISION AND DRAINAGE OF PILONIDAL SINUS

Consultant MR HENRY

COPY

For **SURGEON** MR KOMOLAFE Th No 3 OP
Signature DATE 24.4.10 Elect- EM

Procedure Start 1704
Closure Time 1725
Exit Th Time
Blood Loss 1731
Urine Output

GA ☑ LA ☐

SPEC YES / NO NUMBER. ONEX BACTERIOLOGY

TEAM LEADER SN D MILLER
Radiographer

Position LEFT LATERAL
Positioned By THEATRE THREE STAFF

LOTIONS			
Chlorhexidine/Spirit	~~Betadine~~ Antiseptic ✓	Methylene Blue	Bet Alcohol
Tisept	Chlorhexidine/Water	Acetic Acid 5%	Aqueous Iodine

NURSING COMMENTS

IRRIGATION FLUID/~~ANTIBIOTIC~~ SODIUM CHLORIDE 0.9%

WOUND INFILTRATION (LA) 20 MLS OF CHIROCAINE 5MG/ML USED

Eye drops/oint.
Time
Given by:

PACKS	TYPE	SIZE	POSITION
	QUARTER RIBBON	x1	LEFT BUTTOCKS
Drain			
Chest Drain			
Stent - Ureteric Cath			
Catheter			Balloon Amt.
Catheterised by:			

BONE BANK No.

WEDGE/PILLOW
Sling
Splint
Other

Th WATERLOW SCORE

SKIN CLOSURE DRESSING BLUE GAUZE, MEFIX

SURGEONS INSTRUCTIONS

Sutures Out
Appt.

DATE 24.4.10 Th No 3	TH No 3 PRE-OP	AM (PM) TOTAL
SWABS 10 x 10	5	5
5 x 5		
PACKS (abd 30 x 30)		
CAESAREAN ROLLS		
PLEDGETS		
NEEDLES		
BLADES		
SLINGS		
OTHER HYPO	1	1

ABSCESS & TOE NAIL TRAY

RAYS Adhere tray batch numbers by item name

ID 1009136
LOT 00327
User Code 1251004
(2)

1 - Scrub Person
2 - Scrub Person

1st Count Circ Person SN DAVID MILLER
FINAL Count Circ Person Signature LE. PROVE

Signature of person/s completing careplan SN DAVID MILLER

HEAT RETAINING / PRESSURE RELIEVING / PADDING EQUIPMENT

	ID No.	APPLIED BY	SETTING/PRESSURE	POSITION	TIME ON	TIME OFF	REM/ CHECK BY
DIATHERMY	8 CR ESU38HASNTIPPE		CUT 30 COAG 30	RIGHT LATERAL THIGH	1502	1504	
Bipolar							
TOURNIQUET							
SCD/Flowtron							
Insufflator							
Thermamat							
Lithoclast							
Arthrotome							

COPY

	ID No.	CONNECTED	COMMENTS
Camera			
Microscope			
er			

	ID No.	CONNECTED	COMMENTS	ULTRASOUND TIME	ELAPSED TIME
LASER					
PHACO					

STERIS / AUTOCLAVE BATCH NO. / INSTRUMENT TYPE	QUANTITY	SITE

PROS / IMPLANT / CEMENT ETC	QUANTITY	BATCH No.

ANAESTHETIC CARE PLAN

A 86131

ANAESTHETIST: DR GALLACHER

ANAESTHETIC ASSISTANT: CDP YOUNG

ESCORT:

NAME:

ADDRESS:

COPY

CHI: 0605770352
06/05/1977 M
WYLES Alan
27 WAULKER AVENUE,
STIRLING
FK8 1SA

UNIT NO:

D.O.B.:

WARD:

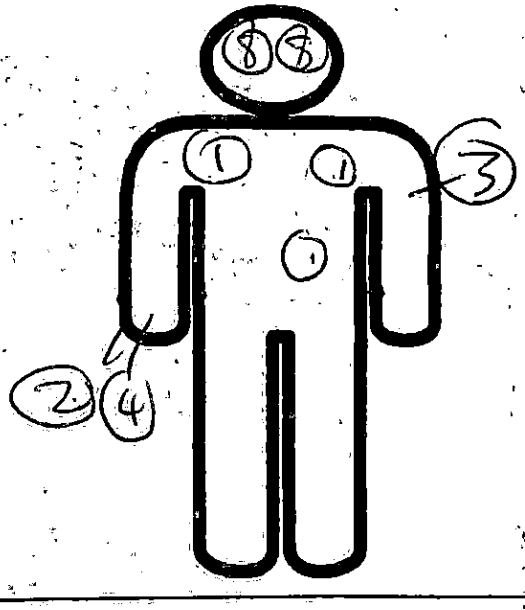
TYPE OF ANAESTHETIC: number start time:

1. GENERAL ✓
2. SPINAL
3. EPIDURAL
4. BLOCK
5. INFILTRATION
6. IV SEDATION

PROBLEMS & COMMENTS

DOCUMENT NUMBER APPROPRIATELY ON DIAGRAM:

1. ECG ✓
2. SpO^2 ✓
3. BP CUFF ✓
4. IV CANNULATION ✓
5. ARTERIAL
6. CVP
7. PCA
8. EYES TAPED ✓



SERIAL No.

ANAESTHETIC MACHINE: 3

MONITOR: 3

BLOOD WARMER:

PRE-OP TEMPERATURE

PERIOP TEMPERATURE

EQUIPMENT (Please state)

POSITION (Please circle)

SUPINE (LATERAL)

PRONE LITHOTOMY OTHER

FLUIDS WARMED (Please circle) YES (NO)

SIGNATURE

DATE 24/10/1

ING371

NHS Forth Valley

Date 24/4/10 Ward 27

Procedure and side

Surgeon

Surname

Sex

COPY

CHI: 0605770352 06/05/1977
WYLES
ALAN
27 WAULKER AVENUE,
STIRLING
FK8 1SA
Date of Birth

CHECKLIST ITEMS	WARD	HANDOVER CHECKS
Verbal Name Check	✓	✓
ID Band Checked	✓	✓
Pre-assess/clerking completed	✓	✓
Pregnant Yes / No	NO	NO
Allergies (see baseline checks Yes / No)	YES	YES
Consent / Incapacity completed	✓	✓
Operation confirmed with patient	✓	✓
Consent form corresponds to list		—
Operation site marked clearly		NO
Nursing notes	✓	✓
Case Notes (SRI, FDRI, Beatson)	LOCKED AWAY	
Drug Kardex	✓	✓
X-Rays (including angios etc)	N/A	N/A
XMatch / G&S form (Y or N/App)	N/A	N/A
Confirm all results available	—	—
Addressograph labels	✓	✓
Bone bank consent	N/A	N/A
Fasted for solids / milk from (time)	23/4 17⁰⁰	1700
Fasted for clear fluids from (time)	23/4 17⁰⁰	1700
Bladder emptied (time or No)	✓	✓
Jewellery removed / taped	✓	—
Body piercings taped etc	N/A	N/A
Nail varnish / makeup removed	N/A	N/A
Contact lenses removed	N/A	N/A
Prosthesis (* or No)	NO	NO
Orthopaedic implants (* or No)	NO	NO
Pacemaker (Yes or No)	NO	NO
Hearing aid (Yes or No)	NO	NO
Able to move by self on trolley	YES	YES

Ward sign and designation SNLM°Cafer

Handover 1 sign and designation

Handover 2 sign and designation

BASELINE WARD CHECKS & DATA

Pre-assessment Document Present and Checked ☐

Any Changes?

Temp 37.6 Weight (kg)

P 81 BP 132/67

RR 16 SaO2 99

BM (Sugar)

Allergies

☐ No ☑ Yes

PENICILLIN

Plate top two teeth L.

☐ Own Teeth ☐ Dentures

Hb Na

WCC K

Platelet U

Clotting Cr

G and S X-Match

No bloods obtained

Thromboprophylaxis

☑ None ☐ GECS

☐ Aspirin ☐ Calf compression

☐ Clexane

Comments

Notes Locked in Surgical admissions Unit.

Items to Theatre

No. of Pillows 1

Cot Sides 2

Bradford Sling

Charnley Wedge

RECOVERY CHART

I+D of PILONIDAL SINUS.

Operation Performed / ~~Additional Notes~~

Recovery Nurse

DAWN MITCHELL.
ELAINE McPHERSON.

COPY

Airway	LMA/SV	SV	SV						
O_2 l/min	5L	5L	AIR						
SpO2	98%	97%	94%						
Resp Rate	16								
Temp	37.3°C								
BM									200
	17								
TIME	35	40	45	50					
									150
									100
									50
A line ☐ Site:-									
CVP ☐ 0									0
Analgesic Drugs									
Sedation Score	2/3	1	1						
Pain Score	0	0	0						
Nausea Score	0	0	0						
Wound Site	0	0	0						
Drains	✓		✓						
NG Tube									
Cannula / IVI / Pump	(R) HAND Satisfactory								
Spinal / Epidural	✓		✓						
C / S / M	✓		✓						
Patient Position	LEFT LATERAL								
Urinary Catheter									
Pressure Areas									

DM DM

Discharge to (ward) ... 27 .....

Criteria Met ☑ ✓ Time 1750

Signed Joan Mitchell

Nursing notes ☑ ✓ Op notes ☑ ✓

Case notes ☒ X X-Rays ☐

M = Morphine mg
F = Fentanyl mcg
T = Tramadol mg

Post-operative instructions

Analgesia **Recovery**

IV Morphine up to ____ mg

IV Fentanyl up to 100 µg

Anti-emetic

☑ Cyclizine 50mg IV

☐ Granisetron 1mg IV

☐ Prochlorperazine 12.5mg IM

COPY

Analgesia **Ward**

☑ Regular oral analgesia as prescribed

Oxygen - in recovery follow protocol thereafter

..... L/Min via nasal cannula

..4.. L/Min via facemask

until fully awake & SpO_2 > 94%.

IV Fluids

☐ as charted ☑ Cap off → ☑ Oral

Other Care

☑ Routine

Investigations required ☐ Recovery ☐ Ward

FBC	☐
U&E	☐
ABG	☐
CXR	☐
ECG	☐

Signed [signature]

ANAESTHETIC ASSESSMENT Date 24/4/10

Age BP ASA II NCEPOD El ☐ Urg ☑ Sch ☐ Em ☐

COPY

PRE-OPERATIVE INSTRUCTIONS

- ☐ Give usual medication
- ☐ EMLA or ametop topical
- ☑ Fast as per Trust guidelines 1700.
- ☑ Free clear fluid until MN.
- ☐ Additional results required before theatre

PRE-MEDICATION

Prescribed by:

Given by:

CO-MORBIDITIES 1+D penanal abscess

32yr ♂

HIV/Hep C negative 1yr ago, but has injected since.

Otherwise well.

Active.

DRUGS

Methadone. 75mg OD.

Mirtazepine 30mg OD.

OK w. NSAID's.

Obs: P81 BP 132/67

RR16 SpO_2 99% o/A.

T° 37.6°C.

Allergies	☐ No	☑ Yes Penicillin
Previous GA	☐ No	☑ Yes
Problems?	☑ No	☐ Yes
FH GA problems	☑ No	☐ Yes
Reflux/full stomach	☑ No	☐ Yes
Airway difficulty	☐ No	☐ Yes

Na
K
U
Cr

Hb
WCC
Platelets

Clotting

G and S
X-match

MPI
NO ✓

Neck ext ✓
TMD ~ 6cm.

Teeth

Partial plate.
* caps/crowns/loose.

Verbal consent and explanation ☑

Explained: ☑ GA ☐ RA ☐ Risks ☐ Day Care

LMA.

-PONV
Pain
Sore throat

Signed / Name

Date 24/4/10 Cons Anaes Broome. ☐ present ☐ discussed ☑ nominal

Anaesthetist Gallacher Procedure

☑ Anaesthetist has verified patient name, id band, procedure and side

☐ Anaesthetist has checked machine and equipment

COPY

20 [redacted] g cannula DRH. Local anaesthetic (LA) ☐ block ☐ spinal ☐ epidural ☑ infiltration By surgeon.

	1630	1700.
FENTANYL (mcg)	75 + 25 + 50	
PROPOFOL (mg)	200 + 50.	
GRANISETRON (mg)	1	
PARACETAMOL (g)		1
DICLOFENAC (mg)		75
METRONIDAZOLE (mg)	500.	
Antibiotic GENTAMICIN (mg)	240	

Airway ☑ Pre O2 ☐ RSI ☐ cricoid P ☐ mask ☐ guedel ☑ LMA size #4. 150

☐ TT ☐ cuff size ☐ oral ☐ nasal grade ☐ pack 100

Maintenance ☐ O2 ☑ N2O ☐ AIR ☐ iso ☐ des 50

Circuit ☑ circle ☑ SV ☐ hand ☑ ECG ☐ IPPV ☑ NIBP 0

position ☐ SpO2 ☐ PE'CO2 ☐ MAC/ET AA ☐ FIO2 ☑ eyecare ☑ pressure points

	99.	97
		5.6
		1.8
		.45

Left Lateral

Warmed ☐ air ☐ fluid ☐ temp

☐ PNS ☐ Vt / RR

☐ Alarm ☐ PAWP/PEEP

urine output (mls)

☐ Reversal

☐ Blood Loss

(1) Hartmann's 500 ml + 75mg diclofenac.

200 180 160 140 120 100 mmHg 80 60 40 20 CVP ☐

IV Cannula Insertion/Removal Record

Name: _____ Ward: _____

Inserted by: DR GALLAGHER Date&Time: 24/4/11 AS

Size/Colour: GREEN 18G Batch No: 9MK0658

Insertion Site: RIGHT HAND

Removed by: Date&Time:

COPY

200
180
160
140
120
100
mmHg
80
60
40
20
CVP

COPY

Scottish Ambulance Service Patient Report Form

Incident Number	CR002772451 on 04/03/2016 at 01:34		
Callsign		Incident Type	EMG
Crew1	E9888133 - Driver	Crew3	
Crew2	E1021540 - Attendant	Crew4	

INCIDENT LOG

Incident Location	CRAIGS SERVICE STATION CRAIGS ROUNDABOUT STIRLING	Incident Postcode	FK7 7NU
Call Received	01:34 - 04/03/2016	Patient at Hospital	02:21 - 04/03/2016
Call Passed	01:36 - 04/03/2016	Patient Handover	-
Crew Mobile	01:36 - 04/03/2016	Crew Clear	-
Crew at Scene	01:50 - 04/03/2016	Clear Reason	
Crew Left Scene	02:07 - 04/03/2016		
Receiving Hospital	FORTH VALLEY ROYAL HOSPITAL		

DIAGNOSIS

Despatch Code	27D03S :
Diagnostic Code	27B04S : 27B04S - Stabbing Unknown Status/Other codes Not applicable

PATIENT DETAILS

Surname	WYLES		
Forename	ALAN		
Middle Initials		Sex	Male
DoB	06/05/1977	Age	38 years 9 months 29 days
Patient Address	DUNBLANE	Patient Postcode	
Patient Telephone		Ethnicity	

PATIENT CONSENT

Mental Capacity Assessed	Deemed To Have Capacity
Level of Consent	Advice Given To Patient, Risk Of Refusal Explained, Risks Of Condition Explained, Treatment Benefits Explained

ADDITIONAL COMMENTS AND OBSERVATIONS

PRU 1 ATTEMPT AT CANNULATION, RIGHT ARM.

PRIMARY SURVEY

AVPU Assessment	Alert
Patient Fitting	No
Catastrophic Haemorrhage	No
Airway Assessment	Clear
Breathing Rate	Normal
Pulse	Fast
Most Peripheral Palpable Pulse Found	Radial
Skin Colour	Normal
Skin Texture	Dry
CSI Assessment	None

Haemorrhage

Estimated Volume Of Blood Loss	<15%
Haemorrhage Treatment Type	Pads, Swabs, Etc, Pressure Dressings

VITAL SIGNS

Time	Pulse	Rthm	AVPU	RR	SYS	DIA	PEF	BG	Temp	SpO2	PS	CRT	ECG	Sepsis	GCS	RTS	NEWS	ETCO2	Lactate
01:50	101	Reg	Alert	18	121	78				98		< 2 Secs	Sinus tachycardia	1	15	7.8	1		
02:15	100	Reg	Alert	18	121	78				100		< 2 Secs	Sinus tachycardia	1	15	7.8	1		

AMPLE

Allergy Type	Unknown,
Previous Medication	
Previous Medical History	PREVIOUS IVDU
Events Prior To Incident	999 CALL FOR 38 Y/O M STAB WOUND TO LOWER BACK AT LEFT SIDE, BY KNIFE APPROX 3 INCH LONG 1 INCH WIDE. PT GCS 15 THROUGHOUT. WOUND DRESSED. PT DENIES TAKING ANY NARCOTICS TODAY.

EYES AND PUPILS

Left Eye		Right Eye	
Left Pupil Size	Normal	Right Pupil Size	Normal
Left Pupil Reaction	Normal	Right Pupil Reaction	Normal
Unequal Reaction To Light			

INJURIES

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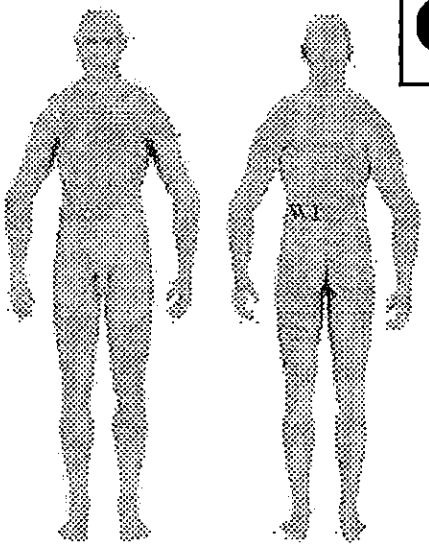
WOUND	W1	Haemorrhage, Open Wound, Pain **Treatment**



EMERGENCY SERVICES

In Attendance	STUDENT, Paramedic, Police, Primary Response Unit (PRU)

SEPSIS

Pulse	*RR*	*SYS*	*Temp*	*GCS*	*BG*	*Pneumonia*	*UTI*	*Other infection*	*Abdo Pain*	*Diarrhoea*	*Abdo distension*	*Meningitis*	*Cellulitis*	*Septic arthritis*	*Wound infection*	*Infected indwelling device*	*No signs of infection*
101	18	121		15		NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO
100	18	121		15		NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO

GCS

Time	*Eye Opening*	*Verbal Response*	*Motor Response*	*Total*
01:50	Spontaneous	Orientated	Obeys Commands	15
02:15	Spontaneous	Orientated	Obeys Commands	15

REPORT MANAGEMENT

Report ID	CR002772451-04032016025141		
Software Version	1.0.389	Report Type	Interim

Accident and Emergency Department
Forth Valley Royal Hospital

0605770352

A&E No. 150000040698

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Surname	Wyles	**Forename**	Alan	**Title:**	
Address:	17 Charles Street, DUNBLANE, Perthshire	**Postcode** **Telephone:**	FK15 9BY 01786841748	**CHI No:** 0605770352	
Date of Birth:	06.05.77	**Sex:**	M	**Age:**	38 yrs

CHI Barcode:

GP Name:	ROXBURGH KATHERINE		
ddress:	DUNBLANE HEALTH CE... WELL PLACE DUNBLANE PERTHSHIRE	**Postcode** **Telephone:**	FK15 9AL 01786 822595

Next of Kin
Relationship:
Address: **Postcode**

Telephone:

Manual CHI Entry:

Date of Attendance: 04.03.16 02:25
Date of Incident: 04.03.16 01:00
Presenting Complaint: STAB WOUND BACK

age **Tetanus Cover:**

Allergies:

P= **BP=** / **RR=** **Sat=** **BM=**

PF= **GCS=** E: M: V: Total:

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time

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CHI: 0605770352 06/05/1977 M

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CLINICAL NOTES

JENKINS

Asked to see pt due to AVPU + RR 8.
Pt easily rousable. GCS 15/15
Denies taking opiates tonight. Denies head injury.
PERLA, not pinpoint.
Power equal upper + lower limbs.

OK for transfer to ward.
No pain relief at this time as drowsy ++

FC0202

DIAGNOSIS

TREATMENTS

Patient/Legal Guardian Permission to release info for legal purpose including Police Yes / No

Patient Signature..... Print Name..... Date.....

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PVC INSERTION BUNDLE AND REMOVAL RECORD — PLEASE COMPLETE ALL BOXES

The patients skin is decontaminated and allowed to dry	YES / NO
Hand hygiene & gloves donned prior to insertion	YES / NO
Aseptic Non Touch Technique is used to insert PVC	YES / NO
If not possible, use either **STERILE GLOVES** or **MINI CHLORAPREP**	
Sterile dressing & sticker (date & time) applied after insertion	YES / NO

Why is PVC clinically indicated for patient?: (please tick)

IV Fluids	✓	Blood Transfusion	
IV Drugs		Diagnostics	
Predicted clinical need			

Colour: Blue Insertion Site: Right index finger

Ward/Department ED

Inserted by: DGALLAGHER Date & Time: 4/3/16 02.50am

INVESTIGATIONS

BLOODS TAKEN? (YES) NO

(FBC)	(GLU)	CLOTTING	TROP	URINALYSIS	XRAY	CXR
(U&E)	CRP	(G&S)	D DIMER	HCG	(ECG)	AXR
LFT	AMY	ESR	ABG	CATHETER	CULTURES	
PARACETAMOL		SALICYLATE		ETHANOL		

Others:

Troponin 0hr result: ..... Troponin 12hr due: .....

Preliminary Pressure Ulcer Risk Assessment (PPURA):

Mobility: Person is fully mobile without equipment/assistance
Continence: Person is fully continent
Nutrition: Person appears well nourished and able to eat and drink

Points to Consider
* People who are overweight may not be well nourished
* please sign after each check

Record your answer in the grid below Y = Yes or N = No
If the answer is **NO** to any assessments undertake a PPURA and consider any other relevant assessment

DATE	TIME	MOBILITY	CONTINENCE	NUTRITION	SKIN INSPECTED	BRADEN	SIGNATURE

Over 65s

AMT 4

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

If score is 3 or less proceed to Delirium screen/cam Initial.....

	Confusion Assessment Method (CAM) Inouye, SK et al.	Box 1	
1	**Acute Onset or fluctuating course** a) Acute change in **mental state from** patient's baselines? **OR** b) Did the (abnormal) behaviour fluctuate in severity or tend to come and go?	☒ Yes	☐ No
2	**Inattention** Difficulty focusing attention or keeping track of conversation, easily distractible	☐ Yes	☐ No
	If there is a **'yes'** answer for questions 1 **AND** 2 then continue to questions 3 and 4.	**Box 2**	
3	**Disorganised Thinking** e.g. disorganised thinking or incoherant speech such as rambling or irrevelant conversation, unclear or illogical flow of ideas	☐ Yes	☐ No
4	**Altered Level of Consciousness** NB Alert = normal *Score 'yes' if vigilant, lethargic, in a stupor or un-arousable*	☐ Yes	☐ No

*Add total **'Yes'** answers for section 1,2,3 and 4*

Initial..... ***Consider diagnosis of delirium if score is 3 or more***

FORTH VALLEY ROYAL HOSPITAL
EMERGENCY DEPARTMENT
STAND-BY REQUEST FORM

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Date 3/3/16 **Time of Call** 0210

E.T.A 8-10mins

Problem: 39 ♂ Stabbed over R2 kidney

Sys 95/
GCS 15/1

Notify Reception ☐

Request for: (Please circle)

Information only | **Stand-by** | Basics GP | Flying Squad

Specialities Informed: (Please Tick)

- A&E Consultant ☐
- Orthopaedic Consultant ☐
- Orthopaedic SHO ☐
- Medical SHO ☐
- Surgical SHO ☐
- Paediatric SHO ☐
- Paediatric Consultant ☐
- Anaesthetics SHO ☐
- Anaesthetic Consultant ☐

Other: (Please Specify) .....

ED TRAUMA DOCUMENT

DATE: 4 3 16

TIME: 02 25

Specialty	Name
ED	WEBSTER

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Method of pre-alert

None	
For Info	
Standby	✓
Other	

Pre-hospital Info/Treatment

Stab injury over (L) kidney Sys 95
GCS 15

History

39 ♂ seen in altercation on CCTV
Walked to Police
Injury ? ? knife 3" blade.

Past Medical History

IVDU
renal failure.
previous Hep screen -ve.

Drug History (remember ECS)

Mirtazepine Gabapentin

Allergies

NKDA

Tetanus status/protetanus result

LMP:

Last ate & drank:

0605

PRIMARY SURVEY

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Airway & C-spine Control

Assessment	Intervention
Airway clear. No C Spine concerns.	C-spine immobilised/not immobilised

Breathing

RR 14 /min (on arrival) Sa02 99.1 % on 10 %02

Examination: No evidence of injury to chest. Equal movement, percussion + air entry N bilateral.

	Yes	No	Side
Tracheal deviation		✓	
Respiratory distress		✓	
Major chest wall trauma		✓	
Tension pneumothorax		✓	
Massive haemorrhage		✓	

	Yes	No	Time
Needle decompression		✓	
State side:			
Other Intervention (state)			

NOTES

Circulation

HR 84 /min (on arrival)
BP 142/90 mmHg (on arrival)

	Yes	No		
IV Line	✓		Site 1 (R) hand	Size Blue
IO access			Site 2	Size
Central Line			Site	
FAST	✓		+ve	-ve ✓ Time 0240.
Resuscitation fluids				
Lactate	✓		Result: 2.3	02.30 Venous.

Peripheries warm/arm, perfused ✓ Cool, shutdown
CRT 2 secs

Haemorrhage to [ ]
Yes or suspected
External ✓ @ renal angle stab wound.
Internal

Chest	
Abdomen	
Pelvis/retroperitoneal	
Limbs	
Other	

Pelvic binder
Limbs splinted

Disability

GCS initial E: 4 M: 6 V: 5 Total = 15

Pupils: 4 + 4 +

BM: 4.9

Log Roll

Notes:

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SECONDARY SURVEY

Not done in ED	Signature Time

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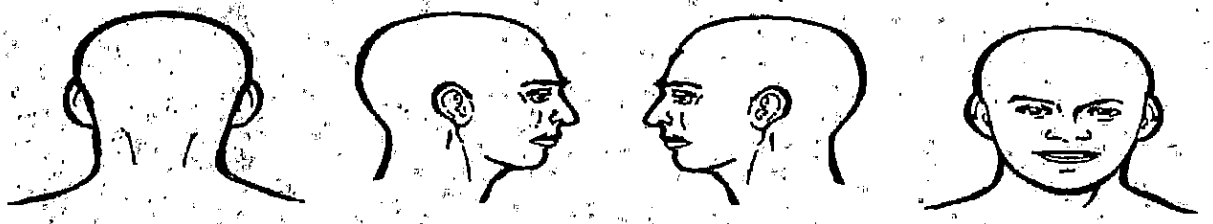

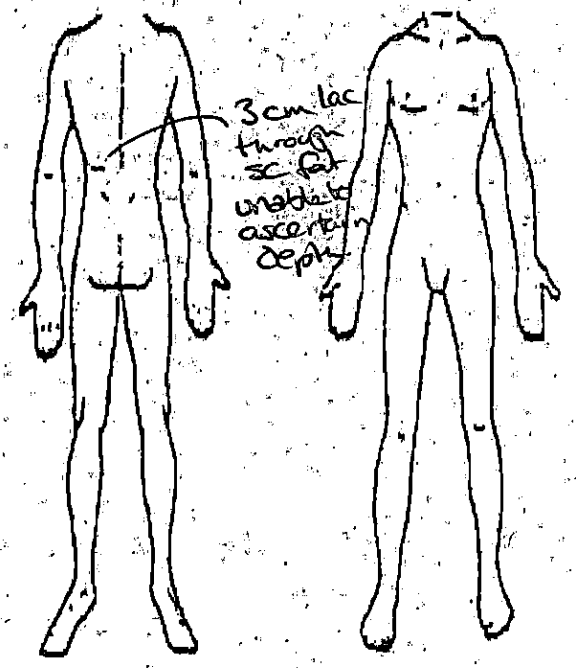

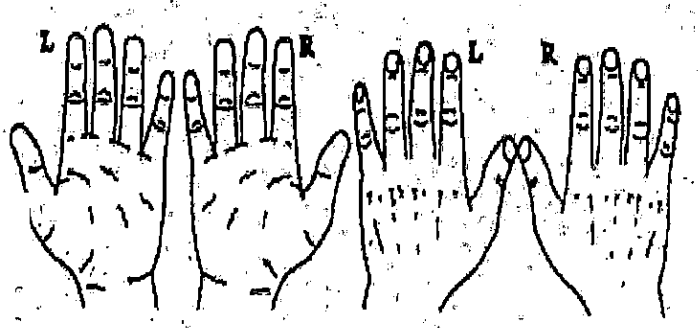

A =	Abrasion
Br =	Bruising
BU =	Burn
L =	Laceration
M =	aMputation
# =	Fracture (closed or suspected)
(#) =	Fracture open
O =	Other
S =	Stab (specify)

NOTES:

Neurological Examination

Cranial nerves: intact

Limbs:

	LUL	RUL	LLL	RLL
Tone				
Power	moving all 4 limbs equally			
Sensation				
Reflexes				
Plantars				

Pupils

TMs

0605770352

INVESTIGATIONS AND PROCEDURES

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LAB/Bedside	Done	Results Seen	X-RAY	
Biochem (NB amylase)	✓		CXR	
FBC	✓			
Coagulation				
G+S/~~x-match~~	✓		Pelvis	
~~ABG~~/VBG	✓	✓		
(er				
Pregnancy Test			C-spine	
Urinalysis				
ECG	✓	✓	NSR	
Protetanus			CT of	

Referred to: Surgical Time: 02 43.

PROCEDURE

Arterial Line			
RSI			
Chest Drain			
Left			
Size		Time	
Right			
Size		Time	
NGT/OGT		Size	
Urinary Cath		Size	

Wound Care: Surgical - examined wound & applied a dressing.

Antibiotics

Splints

SUMMARY OF INJURIES

Region	Description of Injuries	Outstanding Results/ Investigations/Etc
Head		
Spine	**C-spine** not cleared / cleared clinically / cleared radiologically; **T+L spine**	
Chest		
Abdo/Pelvis	laceration to Left Flank	Admit surgical for observation
Extremeties		
Soft Tissue		

NAME: WEBSTER
of person completing form

SIGNATURE:

CHI 060577035*

Clinical Notes

Patient Name:

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M. Kalsey

4

13/6

- 39 yrs

3am — Stabbed in the

L side lumbar region

? 3 inch knife

- NO LOC reported

O/E — Airway → patent Spontaneous

Breathing good air entry

Circulation : oozing from edges of wound

- P = 74 BP = 122/59.

- Abd soft & lax.

- 2° survey. No obvious head injuries

bruise on back above laceration

laceration in L lumbar

≈ 4cm length depth → index finger length

tangential.

DO NOT WRITE HERE

CHI: 0605770352 06/05/1977 M

Date:

Clinical Notes

DoB:

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No overdose injured

GCS 14/15 intoxicated but awake

Neuro - grasp & care

- single tear stitch in hand to approximate & hemostatic

- IV fluids

- Fast

H2 on Mond gav 14.0

Fast Scan - AAA -ve for FF

CT Abd/pelvis arm if any change in Hb CT urgent

urine analysis

Urine Bloods

Admit AAU

Forth Valley Royal Hospital Assessment Document

NHS Forth Valley

Date of arrival [redacted] Time of arrival [redacted]
Source of referral GP (ED) Other
GP practice: [redacted]

RR [redacted] BP
BM
Time [redacted] NEWS score

CHI: 0605770352
Age 38
05/05/1977
M
WYLES Alan
[redacted] CHARLES STREET,
DUNBLANE,
PERTHSHIRE FK15 9BY
Tel

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NOK 1 Name VICTORIA PHILIPS
Relationship EX-PARTNER
Address [redacted]
Tel [redacted]

NOK 2 [redacted]

S Presenting complaint: STAB WOUND (L) LUMBAR REGION

B Background:

A

Probable sepsis- commence Sepsis-6, insert bundle sticker	Yes	[redacted]	No	
Diabetic ketoacidosis- commence DKA pathway	Yes	[redacted]	No	
Referred with hyperkalaemia ≥6.5mmol/L	Yes	[redacted]	No	
Potential stroke, symptoms <3.5 hours→ assessment for thrombolysis Insert bundle sticker for all patients with potential stroke	Yes	[redacted]	No	
Abdominal pain and history of aortic aneurysm	Yes	[redacted]	No	
Abdominal symptom in female <55 with possibility of pregnancy→urgent urine HCG Do not delay further assessment waiting for sample	Yes	[redacted]	No	
Triggering on NEWS (insert bundle sticker) or other clinical concern	Yes	[redacted]	No	
ECG obtained- Clinician to review/ sign/date/ time within 10 minutes if chest/ epigastric pain	Yes		No	
Consent for ECS access	Yes		No	
Potentially suitable for ambulatory care	Yes		No	

R Triage category: 1 | 2 | 3

Samples sent	Yes/ No	
U&E/ LFT/ CRP/ FBC/Glucose	✓	If triage category 1 or 2 insert cannula
Cultures		Site (R) INDEX FINGER
Amylase		Size BLUE
Calcium		Batch
Group and save	✓	Inserted by ED STAFF
Troponin 0 hours / 12 hours (delete as appropriate)		

Name V SMITH Signature [redacted] Date 4/3/16 Time 0530

ING1864

Preliminary Nursing Assessment

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06/05/1977 M
WYLES Alan
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DUNBLANE,
PERTHSHIRE EK15 3BY

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Belongings	With family		With patient	✓	In safe		
Own medication	Yes		No	✓			
Name band	Yes	✓	No				
Patient fasted	Yes	✓	No		Food time		Drink time
Relatives with patient	Yes		No	✓	Informed		

Preliminary Pressure Ulcer Risk Assessment (PPURA)

Mobility: Patient is fully mobile without equipment/ assistance (Y/N)
Continence: Person is fully continent (Y/N)
trition: Person appears well nourished and able to eat and drink (Y/N)
record answer in grid below Y=Yes N=No
If the answer is **NO** to any assessments, complete Braden within 6 hours

Remember
- People who are overweight may not be well nourished
- Please sign after each check

Date	Time	Mobility	Continence	Nutrition	Skin inspected	Braden complete?	Signature/ PRINT
4/3/16	05⁵⁰	Needs assistance until fully awake	4	4	Reports no breaks to skin; clean and dry	4	V Smith

Comments if required:

Preliminary falls assessment- if Yes to any, complete falls bundle within 4 hours if being admitted

≥2 falls in last 6 months?	Yes		No	✓
Patient/ Carer/ Referrer anxious about falls?	Yes		No	✓
Tries to walk alone but unsteady/ unsafe?	Yes		No	✓

Additional nursing comments

Name	Signature	Date	Time complete
V Smith	V Smith	4/3/16	05⁵⁰

Bundle stickers

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DUNBLANE,
PERTHSHIRE FK15 9LY

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A NEWS 5/6 or 3 in one parameter Recognition/escalation

NB MULTIPLE STICKERS NOT REQUIRED FOR ONE EPISODE IF NEWS IMPROVING
ESCALATE IF CLINICAL CONCERN – EVEN IF NEWS<5
Date: 4/3/16 Time: 0525
Clinician contacted using SBAR:
Name MARIM
Nurse in charge informed ☑
EWARD signifier entered ☑
Hourly observations until NEWS < 5 ☑
Start fluid balance chart ☐
Completed by (name): VSmith

B NEWS 5/6 or 3 in one parameter Response/intervention

1. Time attended _____
2. Nurse in charge and Nurse providing care meet with responding clinician to discuss patient ☐
3. Document management plan ☐
4. Due to infection? Y/N Complete sepsis 6 sticker ☐
5. Please document (after discussion with patient and family where possible and appropriate)
a) Would discussion with critical care be appropriate Y ☐ N ☐
b) Resuscitation status for: CPR ☐ DNACPR ☐ Complete form
c) Unmet palliative/supportive care needs
Consider SPICT, accessing KIS, discussion with consultant
Mandatory consultant contact in morning if NEWS5/6 overnight

Signature/Name _____

If no improvement, or NEWS>7, Call for help

Medicines Reconciliation At least 2 recent sources, one of which must be patient or carer

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06/05/1977
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DUNBLANE
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☐ Patient (e.g. verbal recollection or handwritten note) ☐ Relative/Carer ☐ Electronic patient record ECS (issued in last 6 months?) IDL (within last month?)

☐ Patient's own medicines ☐ Nursing home prescription ☐ Community pharmacy ☐ Other

No Known Drug Allergies ☐	OR	Drug / Substance	Reaction/ Side effect
		Penicillin	

Drug / Substance	Reaction/ Side effect

Pharm Cf	Pharm Fb	Pharm Cis	ADMISSION MEDICATON	Dose	Frequency	Withhold	Stop	Comment	Kardex
								Wkly disp last three collected	
✓	✓	½	Mirtazapine 30mg nocte						
✓	✓	½	Gabapentin 300mg 3 TID						

RECENT ANTIBIOTICS/RECENTLY DISCONTINUED MEDICATION (within 6 months)

NON-PRESCRIPTION MEDICATIONS AND HERBAL MEDICATIONS

Are you satisfied this medication history is complete and accurate? Yes ☐ No ☐

If 'No' please detail what further action is necessary (e.g. contact GP, carer or access ECS)

Medicine reconciliation completed by? Name: JTrainor Signature:
Date: 4/3/16 Time:

Medicine reconciliation verified by? Name: Signature:
Date: Time:

Assessment

Practitioners Name	Date
Grade	Time commenced
GMC/ NMC	Location

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Presenting Complaint:

Systemic Enquiry:

Height: **Weight:** **BMI:**

Usual level of activity (please circle)

Bedbound	Dependent for personal care	Requires minimal assistance with ADLs	Slowed. Assistance with heavier household tasks	"Slowed-up" but not requiring assistance	No exercise beyond walking.	Occasional exercise	Regular exercise

Past medical, surgical and anaesthetic history

MI	
Angina	
Hypertension	
COPD	
Stroke /TIA	
Diabetes	
Implement diabetes bundle	

Family History

Travel History

Social History

Smoking: Never Ex smoker (since_____)

Current _____/day Pack years_____

Alcohol: _____ Units / week

Occupation

Driving licence yes/ no

Lives With

Support/ Carers

Examination

Diabetic patients→ foot examination and diabetes bundle
GI Bleeding→ PR examination
Age >65 or confusion→ AMT
If cognition or alertness impaired→ consider delirium

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06/05/1977 M
WYLES Alan
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DUNBLANE,
PERTHSHIRE FK15 9DY

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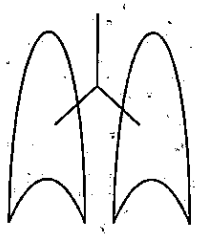
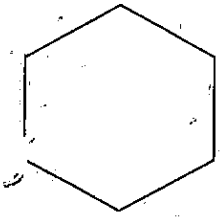
Cardiovascular

Respiratory



Abdominal



Bowel sounds:

PR:

AMT (If <4/4, complete AMT10)

1. Age
2. DOB
3. Year
4. Location

/4

Ask patient to remember address: "42 West Street"

5. Time to nearest hour
6. Current monarch
7. Date Of WW2
8. Count 20→1
9. Identify 2 people
10. Recall address

/10

Neurological (remember speech, visual assessment, balance, gait)
Cranial nerves:

	R arm			L arm			R leg			L leg		
Tone												
Power												
Sensation												
Coordination												
Reflexes	B	T	S	B	T	S	K	A	Plantar	K	A	Plantar

ıer

Interpretation of results

ECG

Urine HCG

Urinalysis

	Neg	Trace	+		++	+++	++++
Leucocytes							
Nitrites							
Glucose							
Ketones							
Blood							
Protein							

CXR

Other imaging

Additional comments

Differential diagnosis

CHI: 0605770352
06/05/1977 M
WYLES Alan
17 CHARLES STREET,
DUNBLANE,
PERTHSHIRE FK15 9BY

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Management plan

Additional investigations required (e.g. cultures) Please initial and date when sent

	Initial/ Date		Initial/ Date
	Initial/ Date		Initial/ Date

Venous thromboembolism (VTE) risk assessment

Medical patient expected to be mobilising as normal within 2 days	☐	Proceed to VTE risk **actions**
Medical patient with reduced mobility for ≥2 days OR Surgical patient	☐	Assess **thrombosis and bleeding risk factors**

Thrombosis risk factors. ANY thrombosis risk factor(s) should prompt VTE prophylaxis measures unless contraindicated → Assess bleeding risk.

- ☐ Mobility reduced for >2 days
- ☐ Age >60
- ☐ Dehydration
- ☐ Obesity BMI>30 kg/ m^2
- ☐ Significant medical comorbidity (e.g. cardiac, respiratory, endocrine, inflammatory, infectious conditions)
- ☐ Active cancer or cancer treatment
- ☐ Thrombophilia
- ☐ Personal history or first degree relative with history of VTE
- ☐ Use of hormone replacement therapy or oestrogen containing contraceptive
- ☐ Pregnancy or <6/52 post-partum
- ☐ Acute surgical admission with inflammatory or intra-abdominal condition
- ☐ Surgery with significant reduction in mobility
- ☐ Critical care admission
- ☐ Knee or hip replacement
- ☐ Hip facture
- ☐ Total anaesthetic+ surgical time >90mins
- ☐ Pelvic or lower-limb surgery with anaesthetic+ surgical time >60mins
- ☐ Varicose veins with phlebitis

Bleeding risk factors. Consider whether sufficient to preclude pharmacological prophylaxis

- ☐ Active bleeding
- ☐ Acquired bleeding disorder (e.g. acute liver failure)
- ☐ Current use of therapeutic anticoagulation (e.g. warfarin, rivaroxaban, dabigatran)
- ☐ Acute stroke
- ☐ Thrombocytopenia (<75x10^9/L)
- ☐ Uncontrolled hypertension (>230/120mmHg)
- ☐ Untreated inherited bleeding disorder
- ☐ Neurosurgery, spinal surgery or eye surgery
- ☐ Other procedure with high bleeding risk
- ☐ Lumbar puncture, epidural or spinal anaesthesia expected within the next 12 hours
- ☐ Lumbar puncture, epidural or spinal anaesthesia within the previous 4 hours

VTE risk actions

Information provided Provide if admission is anticipated Yes/ No	LMWH Yes/ No/ Contraindicated	Antiembolism stockings Consider if thrombosis risk factors present and bleeding risk factors preclude LMWH Contraindicated in peripheral neuropathy, PVD, ulceration, cellulitis, gross oedema Yes/ No/ Contraindicated

Name Signature Date Time complete

Consultant Ward Round

CHI: 0605770352
06/05/1977 M
WYLES Alan
17 CHARLES STREET,
DUNBLANE,
PERTHSHIRE
KY8 9BY

COPY

ECG

CXR/Imaging

Results

Consultant Ward Round

CHI: 0605770352
06/05/1977 M
WYLES Alan
17 CHARLES STREET
DUNBLANE,
PERTHSHIRE FK15 9BY

COPY

Diagnoses and significant comorbidities	Plan

Checklist		Estimated LoS <24h 24-48h >48h
Medicine reconciliation		Transfer of Care to:
VTE assessment		Outstanding criteria for ward transfer/discharge (delete as appropriate):
S_pO_2 target prescribed		
Fasting	Yes / No	

Name	Signature	Date	Time

Resuscitation/ Escalation of care/ Anticipatory Care Planning / Advance Directives

Documentation of Discussion with Patient or Family

Name	Signature	Date	Time

Date and time	Continuation Please sign and PRINT NAME and POSITION

CHI: 0605770352
06/05/1977 M
WYLES Alan
17 CHARLES STREET,
DUNBLANE,
PERTHSHIRE FK15 0EY
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413116.	Patient admitted to AAU 2 at 0500.
0530	Observations recorded, EWS 5 (BP 102/54, SpO_2 93% on 2L O_2 via nasal cannula) Rechecked at 0525, BP & SpO_2 improved however patient very drowsy, rousable but only for a couple of seconds at a time. Surgical registrar contacted & asked to review patient. WTU to be obtained ☐. For CT in am ☐. Awaits review Dr V Smith (VMS11)
413116.	Patient attended for CT scan - await results. Now more alert, orientated to time & place. Observations recorded, EWS 2 as continues on 2L O_2 via nasal cannula. Not yet passed urine - will observe. Dressing & sutures to wound intact. Patient reports he had a pair of trainers, 3 x mobile phones & "some money" on him when in ED, states police took his clothes but not these items. Contacted ED department as no belongings sent through with patient, they stated that police took all his belongings away,
0645	

Date and time

Continuation

Please sign and PRINT NAME and POSITION

Patient Details

CHI: 0605770352
06/05/1977
WYLES Alan M
17 CHARLES STREET
DUNBLANE
PERTHSHIRE FK15 9BY

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4/3/16 as far as they were aware.
Contd: but would decide decd his battery
space to confirm this & let us
know if they find anything.
Patient informed & happy w/t
this. Appears comfortable & undistressed
at present.

Dr V Lt (VSMITH).

4/3/16 Further IV fluids prescribed &
07¹⁰ Commenced as directed.

Dr V Lt (VSMITH).

4/3/16 Seen.

Pt EWS 5. ↓ GCS
E 3
V 4
M 5

12/15

? Drugs was 14/15

to r/o head injury

↳ CT Head

Read

↳ CT was clear ! discharge

11

Date and time	**Continuation** Please sign and PRINT NAME and POSITION

CHI: 0605770352
06/05/1977 M
MYLES Alan
17 CHARLES STREET,
DUNBLANE,
PERTHSHIRE

COPY

04/03/16

WR CRUMLEY

0835 OBS - STABLE, APYREXIAL. ON O2

COMPLAINING OF SORE (2) ERG - NO INJURYS

DRESSY

PLAN / (1) E+D

(5) STOP IV FLUID

(3) (H) LATER

(9) STOP O2 VT #1249 PU

4/3/16 0720W Patient discharged home and advised to see practice nurse or monday for wound change or dressing. Rec Rx following monday to have sticles removed

Transport organised to take him home in pyjamas. He will contact the police to get belongings back.

Observations stable, Eyes O.

Analgesic given as charted

SA Anderson

Date: 4.3.16

Time: 0235

Named nurse: Denise + Amie

Patients preferred name: Alan.

COPY

S

Situation

Presenting complaint:

Stabbing.

History of presenting complaint:

Alleged assault. Stab wound to Rt (L) ~~t~~no kidney area.

B

Background - Relevant medical history No known allergies.

previous IVDU

renal failure

Relative / Carer informed? YES / NO Present YES / NO

A

Assessment - Clinical condition and likely diagnosis include EWS on arrival and prior to admission.

NEWS-2

GCS 15/15

BM 4.9

N access ☑

Bloods ☑

ECG ☑

chest xray ☑

Surgical review ☑

stiched + cleaned ☑

Mobility: Independant

Pain Score: /10

R

Recommendations - Direction for ward staff, include outstanding treatments and obs required.

Urinalysis ☐

Signature: AGilchrist

EWS SCORE : 2

FVRH Emergency Department Forth Valley Royal Hospital

02

COPY

Date of attendance: 28/05/2025 13:59

Presenting complaint: Abdominal pain

Surname: Wyles	**Forename:** Alan	**Title:** Mr
Address 2 GORDON SQUARE Stirling Stirlingshire	**Postcode:** FK8 1FN	**CHI:** 0605770352
Telephone: 07835703594		
Date of Birth: 06/05/1977	**Sex:** Male	**Age:** 48 Years

GP Name: A Dunsmore

Address: 25686/1
Allan Park Medical Practice
19 Allan Park
Stirling
Stirling
FK8 2QD

Telephone: 01786 451375

Next of Kin

Name: Kaila Wyles

Relationship: Daughter

Postcode:

Address:

Telephone: 07368945417

Triage Information

"abdo pain - severe pain "
Discharged from B12 1/7
"attend due to ongoing right sided back pain radiating to back "
Pmh renal failure

Obersvations

P= 83 **PB=** 150 / 96 **RR=** 22 **Sat=** **BM=** **Temp=** 36.6

Peak Flow= **GCS=** **News=** 2

Emergency Department / Pre-Hospital Drugs

Allergies Penicillin

Date	Drug	Dose	Route	Signature	Given by	Time
28/5/25	ORAMORPH	10mg	ORAL	[signature] 1420	LW	1420
28/5	ORAMORPH	10mg	PO	[signature]	LS	1550
28/5	DICLOFENAC	75mg	IM	[signature]	LS	1550
28/5	ONDANSETRON	4mg	PO	[signature]	LS	1930

Clinical Notes

Seen by: IAN CAMPBELL – FELDPATRICK CDF **Time:**

COPY

48 ♂

- INTENSE (R) SIDED ABDOMINAL PAIN FOR 4/7.
- ATTENDED 1/7 AGO + R/V BY UROLOGY + DC.
- SHARP, CONSTANT. BRINGING PT TO TEARS.
- SWEATY, ANXIOUS. VOMITING ++. RADIATES TO FLANK.
- LAST VOMIT ~5AM TODAY. DIARRHOEA.
- CT KUB 27/5/25: UNCOMPLICATED SIGMOID DIVERTICULOSIS, NO STENTS.
- D/C. W. NO Dx OR TREATMENT. OR FU.
- ~~NAD~~ NO COLLAPSE / LOTS.

BG: PREV RENAL FAILURE.
PREV IVDU → on BUPRENORPHINE. 8mg S/L OD.
~~NKA~~ PENICILLIN ALLERGY: 'RENAL FAILURE'.
SMOKES. LIVES ALONE.

A: IN ACUTE PAIN — BLOODS: ↑ AMYLASE.
PATENT AIRWAY — = NAD 29
B — CHEST CLEAR. — OTHERWISE (N)
— VERY DIFFICULT IN ARCOLA. MULTIPLE FAILED ATTEMPTS.
C: NS 1+11+0 NAD 9C. — IMPERFECTIC / DDx.
SWEATY ++. BP 150/96 — - APPENDICITIS
CRT <2s. — - DIVERTICULOSIS / DIVERTICULITIS
D: ALERT, INVOLUNTARY GUARDING — - PERFORATED VISCUS
E: RUS ABDOMEN. BS +VE.

PLAN
- eCXR
- D/W SURGEONS + REQUEST R/V.
ABLE D/W CONS NIMMO CDF 19

LACTATE: 1.0

Guidelines Used:

Attach continuation sheets here

Attach here onto face of pocket

PVC INSERTION BUNDLE AND REMOVAL RECORD

PLEASE COMPLETE ALL BOXES

CHI NO: 0605770352 06/05/1977
CRN: M
Alan WYLES
2 GORDON SQUARE
STIRLING
FK8 1FN

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The patients skin is decontaminated and allowed to dry	YES / NO
Hand hygiene & gloves donned prior to insertion	YES / NO
Aseptic Non Touch Technique is used to insert PVC	YES / NO
If not possible, use either **STERILE GLOVES** or **MINI CHLORAPREP**	
Sterile dressing & sticker (date & time) applied after insertion	YES / NO

Why is PVC clinically indicated for patient?: (please tick)

IV Fluids		Blood Transfusion	
IV Drugs		Diagnostics	
Predicted clinical need			

Colour:
Insertion Site:
Ward/Department:
Inserted by:
Date & Time:
Removed: YES / NO

INVESTIGATIONS

Bloods Required:

FBC U&E GLU LFT CRP AMY CLOTTING G&S ESR PARACETAMOL
TROP D-DIMER CULTURES VBG* ABG* (*attach to notes) URINALYSIS HCG ECG
Others:

BLOODS TAKEN? YES / NO TIME TAKEN

SIGN
PRINT

Preliminary Pressure Ulcer Risk Assessment (PPURA):

Mobility: Person is fully mobile without equipment/assistance
Continence: Person is fully continent
Nutrition: Person appears well nourished and able to eat and drink
Skin: Skin to pressure points satisfactory/intact

Points to Consider
* People who are overweight may not be well nourished
* Use of repose mattress or pressure relieving heel protectors.

Record your answer in the grid below Y = Yes or N = No
If the answer is **NO** to any assessments undertake a BRADEN and consider any other assessment

DATE	TIME	MOBILITY	CONTINENCE	NUTRITION	SKIN INSPECTED	SKIN INTACT	BRADEN COMPLETED	SIGNATURE
28/5/25	1540	Ind	Ind	Ind	No	Yes	No	
SKIN DESCRIPTION i.e. REDNESS, SKIN BROKEN, BLISTER / ULCER						ACTION TAKEN		
Ind with ADLs								

4 A T

ALERTNESS (assess for drowsiness or agitation, if asleep attempt to rouse)

Normal		Tick
Mild sleepiness (easily roused <10 seconds)	0	✓
Clearly abnormal	0	
AMT4 (age, date of birth, place, current year)	4	
No mistakes		Tick
1 mistake	0	✓
2 or more mistakes	1	
ATTENTION (ask for months of the year backwards)	2	
Achieves 7 or more correctly		Tick
Starts but scores less than 7/Refuses to start	0	✓
Untestable	1	
ACUTE CHANGE OR FLUCTUATION (significant change incl. evidence of psychotic symptoms)	2	
No		Tick
Yes	0	✓
Total score (score of 4 or more indicates likely delirium - initiate TIME bundle)	4	
FALLS TRIGGER TOOL (Complete only if 65 years or over)		0

2 or more falls in the last 6 months?	YES / NO	Tries to walk alone and is unsteady?	YES / NO
Fall since admission to department?	YES / NO	Patient/relatives anxious about falls	YES / NO
Admitted to department with fall?	YES / NO	4AT more than 4/evidence of confusion	YES / NO

COMPLETED BY ..... (signature)

If you have answered yes to 2 or more questions,

- For patients being admitted please document recommendation that a full care bundle is required to be completed.
- Please add FALLS RISK IDENTIFIER to Trakcare (EPR→ Patient Alerts→ New→ Ward Signifiers→ Falls risk).

Alan WYLES
2 GORDON SQUARE

STIRLING
STIRLINGSHIRE
FK8 1EN

COPY

RADIOMETER ABL90 SERIES

CLINICAL N

ABL90 I393-092R0213N0033 14:31 28/05/2025
PATIENT REPORT Syringe - S 65uL Sample # 41546

Identifications

Operator	KIRSTIN KINNAIRD
Patient ID	0605740352
Department (Pat.)	ED
Patient last name	WYLES
Patient first name	ALAN
Sample type	Venous
$FO_2(I)$	28.0 %
T	37.0 °C

Blood gas values

cH^+c	38.0	nmol/L	[-]
pH	7.420		[7.350 - 7.450]
↑ pCO_2	6.13	kPa	[4.50 - 6.00]
↓ pO_2	3.43	kPa	[9.00 - 12.0]

Temperature-corrected values

$pCO_2(T)$	6.13	kPa	[-]
$pO_2(T)$	3.43	kPa	[-]

Acid-base status

$cHCO_3^-(P)c$	29.8	mmol/L	[-]
$cBase(B)c$	4.3	mmol/L	[-]

Electrolyte values

↓ cNa^+	129	mmol/L	[136 - 146]
cK^+	4.4	mmol/L	[4.0 - 5.0]
↓ cCl^-	92	mmol/L	[95 - 106]
↓ cCa^{2+}	1.13	mmol/L	[1.15 - 1.29]

Metabolite values

$cGlu$	5.6	mmol/L	[4.0 - 8.0]
$cLac$	1.0	mmol/L	[0.5 - 1.6]

Oximetry values

↑ $ctHb$	170	g/L	[80 - 140]
↓ sO_2	54.1	%	[94.0 - 100.0]
↓ FO_2Hb	52.0	%	[95.0 - 99.0]
↑ $FCOHb$	3.7	%	[0.0 - 0.8]
$FMetHb$	0.2	%	[0.2 - 0.6]

Notes

↑	Value(s) above reference range
↓	Value(s) below reference range
c	Calculated value(s)

Solution pack lot: DY-07
Printed 14:32:03 28/05/2025
Sensor cassette run #: 1505-460

Troponin
Time of
D-dimer
Urine di
Leucs
Nitrite
Protein
Blood
Ketones
Glucose

d identified:
(circle)
early seen
(circle)
ed diameter.....
inus
e/Not immune (circle)

Patient/Legal Gu ermission to release info for legal purpose including ce Yes / No

Patient Signature..... Print Name..... Date.....

ING1716

Date: 28/5/25 Time: 1545

CHI NO: 0605770352 06/05/1977
M
CRN:
Alan WYLES
2 GORDON SQUARE
STIRLING
FK8 1FN

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Named Nurse: Kilcan/Lauren Patients preferred name: Alan (48)

S Situation

Brief history of complaint & pre-hospital treatment:
dlc 117 from BR.
Ongoing (R) sided abdo pain → back

Details & NOK checked: Y / N
Relative/Carer: Informed? Y / N and present? Y / N

B Back-ground

MI ☐ CVA ☐
Asthma ☐ COPD ☐
Angina ☐ HTN ☐
Epilepsy ☐ Diabetes T1/T2

Anticoagulated: Y / N
Vulnerable adult: Y / (N) (see SAS PRF)
Time Critical Medication: Y / N (if Yes give details)

Past Medical History:

Allergies: penicillin

Social Background: alone

A Assess-ment

ECG ☑ NEWS 2
Bloods ☑ BM 5.6
PVC ☐ GCS (A) VPU 15
Urinalysis ☐ Ketones /
HCG ☐ Pain: 2 /3
Analgesia ☑

Care and Comfort Chart Commenced: (Y) / N
How often to be done:

Mobility: Ind Name Band ☐ Signature: LStewart

R Recomm-endations

Impression: abdo pain

Nurse Escort Required: Y / N

Outstanding Treatments:

Referred Specialty:
Medics ☐ Ortho ☐
Surgeons ☑ ENT ☐
Gynae ☐
Other _____

Recommendation Falls Care Bundle required Yes / No Falls alert added to Trakca ☐

NEWS: 0 Signature:

COPY

CHI NO: 0605770352 06/05/1977
CRN: M
Alan WYLES
2 GORDON SQUARE
STIRLING
FK8 1FN

Situation R side Abdo Pain

* Penicillin allergy

Background Prev renal failure
WDU

Assessment ? Perf GB
A/w ct report

Incl fast

Recommendation IV Med
Gent 1205
Vanc 1630

◆ PROGRESS NOTES

Date and Time	

REFERRALS MADE TO PAMS, SPECIALIST NURSES

Surname Wiles Unit No. .....
Forename Alison D.of B. .....
Address .....
.....
.....

COPY

DISCIPLINE	REFERRAL MADE BY	DATE	1ST VISIT MADE BY	DATE
Physiotherapy				
Occupational Therapy				
Dietician				
SALT				
FALGO / CARE				
Community Liaison Nurse				
Stroke Liaison Nurse				
Respiratory Specialist Nurse				
Diabetic Specialist Nurse				
Oncology Specialist Nurse				
Palliative Care Nurse/Team				
Parkinsons Disease Specialist Nurse				
Cardiac Rehabilitation Nurse				
Stoma/Breast Care Nurse				
Leg Ulcer Nurse				
Urology Specialist Nurse				
MS Specialist Nurse				
Epilepsy Specialist Nurse				
Psychiatric Liaison Nurse				
Community Psychiatric Nurse				
Day Hospital				
Social Worker				
Chiropodist				
Pharmacist				
Community Physiotherapy				
Community Occupational Therapy				
Community Dietician				
Chaplain				
Others (*Please specify*)				

◆ PROGRESS NOTES

Date and Time	
	Seen by Dr Howie - feeling well Venflon removed, discharged ha C. Tubb

COPY

◆ PROGRESS NOTES

Surname Wilks Unit No. 615177
Forename Aidan D.of B.
Address

COPY

Date and Time	
03[00]	Admitted to Wd 29. Paracetamol 1g given for pyrexia – 39°. Lumbar ~~puncture~~ puncture to be carried out. LMF Bande
03:45am	LP – performed by Dr Griffiths / Dr McMillan. Size 22 G spinal needle. 4ml 2% lignocaine L4/5.
[illegible]am	CSF – colourless, transparent. obtained for: protein – 0.44 glc – 3.7 gram stain RCC < 1/mm³ WCC < 1/mm³ No bacteria seen.
	Still nauseous – vomited x1 again. Patient now feels like he is going to have diarrhoea. If passes stool please obtain sample for stool culture + bacteriology form.
07[00]	LP results NAD. T 37°. Eyes. CMcMillan (SHO 183)
8am	Admission bloods Na 136 Hb 142 AST 60 K 3.8 WBC 6.5 ALT 39 CL 100 plt 196 bili 17 ur 5.0 Tp 72 cr 101 albumin 45 alk phos 265 Lymphs.

◆ Dietary Status
- ☑ Normal diet
- ☐ Special diet (specify below)
- ☐ Diabetic
- ☐ Low fat
- ☐ Reducing
- ☐ Soft
- ☐ Liquidised
- ☐ High protein
- ☐ Low protein
- ☐ Low sodium
- ☐ Low residue
- ☐ Gluten free
- ☐ Recent weight loss
- ☐ Recent weight gain
- ☐ Vegetarian
- ☐ Vegan
- ❖ Assessment score: _____
- ☐ Referred to dietician

Comments

◆ Skin
- ☐ Normal
- ☑ Dry
- ☐ Moist
- ☐ Diaphoretic
- ☐ Rash
- ☐ Bruising
- ☐ Burns
- ☐ Lacerations
- ☐ Pressure Ulcer
- ☐ Leg Ulcer
- ☐ Wound Assessment Chart
- ❖ Waterlow Score: _____

Comments

◆ Ears
- ☑ Normal
- ☐ Hearing Loss
- ☐ Hearing aid L / R
- ☐ Tinnitus
- ☐ Vertigo
- ☐ Discharge
- ☐ Pain

Comments

◆ Eyes
- ☑ Normal vision
- ☐ Glasses
- ☐ Contact lenses
- ☐ Blind
- ☐ Prosthesis
- ☐ Blurred vision
- ☐ Diplopia
- ☐ Discharge
- ☐ Itching
- ☐ Photophobia
- ☐ Pain
- ☐ Cataract
- ☐ Glaucoma
- ☐ Sclera colour:

Comments

◆ Genito-urinary system
- ☑ Normal
- ☐ Frequency
- ☐ Urgency
- ☐ Dysuria
- ☐ Nocturia
- ☐ Urinary incontinence

Comments

◆ Reproductive system F
- ❖ LMP date:
- ☐ Irregular
- ☐ Discharge
- ☐ Vaginal infections
- ☐ Menopause
- ☐ HRT
- ☐ Other

Comments

◆ Reproductive System M
- ☐ Prostate problems
- ☐ Lesion
- ☐ Other

Comments

◆ Activity Tolerance
- ☑ Normal
- ☐ Weakness
- ☐ Dizziness
- ☐ Exertional dyspnoea
- ☐ Dyspnoea at rest
- ☐ Angina
- ☐ Pain at rest
- ☐ Oxygen needed
- ☐ Intermittent claudication
- ☐ Unsteady gait

Comments

COPY

◆ Rest Pattern
Sleep habits
- ☐ less than 8 hours
- ☐ 8 hours
- ☐ more than 8 hours
- ☐ Morning nap
- ☐ Afternoon nap

Sleep difficulties
- ☐ None
- ☐ Early awakening
- ☐ Unrefreshing sleep
- ☐ Nightmares
- ☐ Insomnia
- ☐ Disturbed – nocturia
- ☐ Disturbed - dyspnoea
- ☐ Disturbed - pain

Comments

❖ Self Care Ability

	A			B		
	1	2	3	1	2	3
Dressing and grooming	✓			✓		
Eating and drinking	✓			✓		
Toileting	✓			✓		
Transferring	✓				✓	
Walking	✓				✓	

Key
- A Prior to current episode of ill-health
- B At present time
- 1 Independent
- 2 Assistance of Carer
- 3 Assistance of aid

❖ Change in Health Status

	1	2	3
Mental status	✓		
Sleep pattern	✓		
Appetite	✓		
Bowel habit	✓		
Urinary continence	✓		
Pain			✓
Activity tolerance			✓

Key
- 1 No change
- 2 Experienced change in last week
- 3 Change related to current illness

NURSING ASSESSMENT RECORD

ADMITTING NURSE: LMcBride

Surname: Wyles Unit No:
Forename: Alan D of B:
Address:

COPY

◆ REASON FOR ADMISSION

Headaches, Photophia + Pyrexia

◆ OBSERVATIONS ON ADMISSION (ensure observations are completed on page 5 – Doctor's clerking notes)

Weight/kgs: Urinalysis:

SPECIFIC OBSERVATIONS

Peak Flow: BM: Preg Test *(please circle)*: Not applicable Negative Positive

Previous MRSA: ☐ Yes ☐ No ☐ Unknown

◆ MENTAL STATUS

- ☐ Alert
- ☐ Co-operative
- ☐ Calm
- ☐ Lethargic
- ☐ Withdrawn
- ☐ Depressed
- ☐ Agitated
- ☐ Anxious
- ☐ Aggressive

Orientated to:

- ☐ Time
- ☐ Place
- ☐ Person

COMMENTS:

◆ NEUROLOGICAL SYSTEM

- ☐ Pupils:PERLA
- ☐ Dizziness
- ☐ Headaches
- ☐ Numbness
- ☐ Paraplegia
- ☐ Hemiplegia, R / L
- ☐ Hemiparesis, R / L
- ☐ Swallowing deficit
- ☐ Aphasic
- ☐ Expressive dysphasia
- ☐ Receptive dysphasia
- ❖ GCS Score: 15

COMMENTS:

◆ CARDIOVASCULAR SYSTEM

- ☐ No problem identified
- ☐ Oedema
- ☐ Cyanosis
- ☐ Cold extremities
- ☐ Palpitations
- ☐ Previous CABG
- ☐ Pacemaker in situ

COMMENTS:

◆ RESPIRATORY SYSTEM

- ☐ No problem identified
- ☐ Dyspnoea
- ☐ Cough
- ☐ Haemoptysis
- ☐ Orthopnoea
- ☐ Known COPD
- ☐ Known asthmatic

COMMENTS:

◆ SPEECH

Normal, clear
Dysarthric
Hesitant
Hoarse

COMMENTS:

◆ MUSCULOSKELETAL SYSTEM

- ☐ No problem identified
- ☐ Stiffness
- ☐ Pain
- ☐ Weakness
- ☐ Paralysis upper limb R / L
- ☐ Paralysis lower limb R / L
- ☐ Paresis upper limb R / L
- ☐ Paresis, lower limb R / L
- ☐ Limited ROM
- ☐ Tenderness
- ☐ Swelling
- ☐ Arthritis
- ☐ Prosthesis

Physical Activity

- ☐ No limitations
- ☐ Walks with supervision
- ☐ Walks with assistance
- ☐ Uses walking aid
- ☐ Walking stick
- ☐ Zimmer
- ☐ Rolator
- ☐ Crutches
- ☐ Wheelchair independent
- ☐ Wheelchair outside only
- ☐ Other

COMMENTS:

◆ GI SYSTEM

- ☐ No problem identified
- ☐ Change in appetite
- ☐ Indigestion
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Bleeding
- ☐ Abdominal pain
- ☐ Abdominal distension
- ☐ Ascites
- ☐ Haemorrhoids
- ☐ Constipation
- ☐ Diarrhoea
- ❖ Last BO ___/___/___
- ❖ Stools per day:
- ❖ Stools per week:
- ☐ Stoma

COMMENTS:

◆ MOUTH AND THROAT

- ☐ No problem identified
- ☐ Dentures
- ☐ Sores/plaque on tongue
- ☐ Gum swelling/bleeding
- ☐ Sore throat
- ☐ Diminished taste
- ❖ Eiler's score: _____

COMMENTS:

MIDDLE GRADE REVIEW

◆ **SENIOR HOUSE OFFICER / REGISTRAR REVIEW**

COPY

Allan Wyles:
(27) ♂.

PC: headache, fever, photophobia, vomiting

Background: IVDA
on methadone programme but still injecting heroin.
(45ml ↑/day)

HPC: Injected heroin tonight - used a dirty needle
soon after ~~fracture~~ rapid onset of headache - posterior → frontal.
assoc. rigors, vomiting, photophobia. (but not sudden like thunderclap).
vomited food stuffs. No blood. ×1.
Pyrexia - Temp 38.4°C.

DHx: methadone 45ml/day.

Allergies: once had back pain after penicillin.

SHx: lives with partner + child.

O/E: sweaty, photophobic.
BP 160/88, pulse 99, RR 16/min, Sats 97% on air, Temp 38.4°C
HS I+II+0.
CVS nad
Abd soft, non-tender.

NS: GCS 15/15. fundoscopy
cranial nerves intact.

	RA	LA	RL	LL
tone	N	N	N	N
power	5/5	5/5	5/5	5/5
sens	N	N	N	N
coord	N	N	N	N

no focal neurological abnormality.

Impression: ? meningitis
?? bacteraemia.
? other sepsis.

Plan: 2g iv ceftriaxone.
needs LP.

◆ **CPR STATUS: FOLLOWING DISCUSSION WITH PATIENT / FAMILY (*Please indicate*)**

Bloods ↓↓.

CXR = N.

urinalysis: protein: trace
leuc -ve
blood -ve
nitrite -ve
glc -ve

DOES THE PATIENT NEED TO BE ADMITTED TO HOSPITAL OR IS OUTPATIENT / AMBULATORY CARE AN OPTION?

Signature: E McCulloch Date: 22/8/04.

Name & Pager No. C McCULLOCH (SHO 183)

THIS SECTION TO BE COMPLETED ONLY BY A DOCTOR

IMPRESSION AND DIFFERENTIAL DIAGNOSIS

Surname ..... Unit No .....
Forename ..... D.O.B. .....
Address .....
.....

COPY

MANAGEMENT PLAN *(refer to protocol if appropriate)*

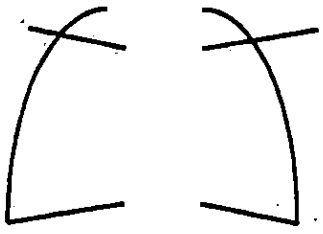
IS DVT PROPHYLAXIS INDICATED? YES / NO ANY CONTRA-INDICATIONS TO THIS? YES / NO
PRESCRIBED? YES / NO

DOES PATIENT NEED TO BE ADMITTED? IS OUTPATIENT / AMBULATORY CARE AN OPTION? YES / NO
IF YES, DISCUSS WITH SHO OR OTHER SENIOR COLLEAGUES

INITIAL INVESTIGATIONS REQUESTED *(refer to protocol if appropriate)*

☐ FBC	☐ U & E	*Others:*	
☐ ESR	☐ Glucose	☐ Cardiac markers	☐ Clotting Factors
☐ ABG	☐	☐ LFT	☐
☐ ECG	☐ CXR	☐ Calcium	☐

CXR



Comments

ECG Interpretation

House Officer's Signature: _____ Date: _____
Name & Pager No:

THIS SECTION TO BE COMPLETED ONLY BY A DOCTOR

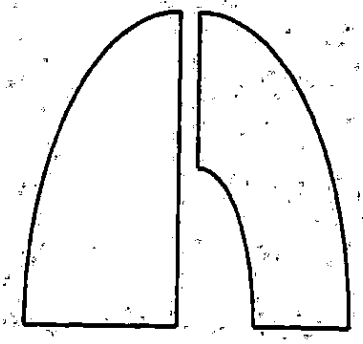
RESP

Trachea

Expansion

Percussion

Breath Sounds



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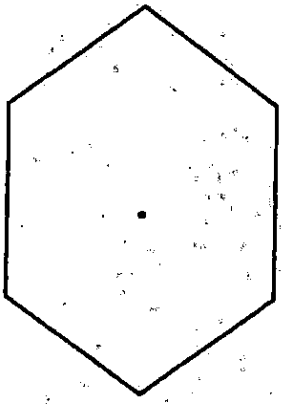
ABDOMEN



Liver

Kidneys

Spleen

Bowel Sounds

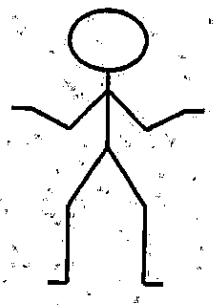
PR Exam

CNS - ***complete stroke proforma and insert here if CVA suspected***

ABBREVIATED MENTAL TEST SCORE (AMTS)

Age	Monarch
DOB	Recall 42 West Street
Year	20 – 1
Time of Day	Home Address
Prime Minister	WWI
Score /10	<8 probable cognitive impairment

	POWER	TONE	COORDINATION	SENSATION
RUL				
LUL				
RLL				
LLL				



REFLEXES

THIS SECTION TO BE COMPLETED ONLY BY A DOCTOR

Surname Wyles Unit No
Forename Alan D.o.B.
Address

COPY

◆ SYSTEMS REVIEW

CVS

RESP

GI

GU

CNS

◆ ON PHYSICAL EXAMINATION

General Examination

Temp 39.1 Pulse 100 Resp Rate BP erect supine 148/71

Oxygen Saturation Anaemia Y / N Clubbing Y / N

Cyanosis Y / N Jaundice Y / N Lymphadenopathy Y / N

Breast Examination

Normal Y / N If no, please comment:

CVS

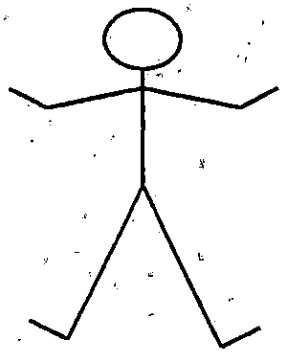
JVP

Apex

Heart Sounds

Neck Bruit Y / N If yes, please comment:

Oedema



Peripheral Pulses

THIS SECTION TO BE COMPLETED BY ANY MEMBER OF INTEGRATED CARE TEAM

◆ PAST MEDICAL HISTORY

COPY

	YES	NO		YES	NO		YES	NO
IHD / MI	☐	☐	Hypertension	☐	☐	COPD	☐	☐
Rheumatic Fever	☐	☐	Diabetes Mellitus	☐	☐	TB	☐	☐
CVA / TIA	☐	☐	Asthma	☐	☐	Jaundice	☐	☐
						Epilepsy	☐	☐

Remarks:

I.V.D.A

◆ FAMILY MEDICAL HISTORY

	YES	NO		YES	NO
IHD / MI	☐		DM	☐	☐
Asthma	☐		Cancer	☐	☐
CVA / TIA	☐		Hypertension	☐	☐

Remarks:

◆ SOCIAL HISTORY

Occupation: _____

Smoking: Yes ☐ Amount per day : _____

No ☐ Ex-smoker : since _____

Never smoked ☐

Alcohol : Units per week: _____

Home Circumstances:

Lives with: Partner

Support:

◆ DRUG HISTORY / MEDICATIONS

(including 'over the counter' preparations)

Methadone

◆ DRUG ALLERGIES

◆ INFORMATION

DISPENSING AID: Y / N

Filled by (please circle):

Self Carer Pharmacist

Location of Dispensing Aid:

Home Hospital

INHALER:

Type: _____

Technique: Satisfactory Poor

Referral to Ward Link Nurse:

Yes (date_____) No

DOMICILLIARY OXYGEN:

Yes No

THIS SECTION TO BE COMPLETED ONLY BY A DOCTOR

DATE: _____ TIME: _____

MALE / FEMALE *(please circle)*

AGE OF PATIENT: _____

Surname Wyles
Forename Alan
Address .....
Unit No .....

COPY

◆ **PRESENTING COMPLAINT**

◆ **HISTORY OF PRESENTING COMPLAINT**

ALERT ~ HIGH RISK FACTORS:

NAME OF GP	ADDRESS	TEL NO:
Dr Hanley	Park Avenue	COPY

NEXT OF KIN DETAILS	
Next Of Kin: Victoria Phillips	Alternative Next of kin:
Relationship: Partner	Relationship:
Other family member details:	
Address: S/A	Address:
Tel No: 07731 917911	Tel No:
Relative/Carer present Y / N (If answer NO then) →	Name of Relative/Carer contacted:
Name of person present on admission:	Tel No:

DISCHARGE ADDRESS (IF DIFFERENT TO HOME ADDRESS)	GP NAME AND ADDRESS (IF NOT OWN)
Name of Carer: Address: Tel No:	Name of GP: Address: Tel No:

Discharge Date: _____

DISCHARGE CHECKLIST	DATE	Please circle appropriately	SIGNATURE
Patient involved in discharge planning?		Yes / Not applicable	
Relatives / carers involved in discharge planning?		Yes / Not applicable	
Special preparation for discharge planning arranged?		Yes / Not applicable	
Review home circumstances		Yes / Not applicable	
Pre-discharge home visit undertaken?		Yes / Not applicable	
Provide written information to patient / relative / carers		Yes / Not applicable	
Discharge Summary completed		Yes / Not applicable	
Discharge Summary at Pharmacy		Yes / Not applicable	
Discharge Summary returned from Pharmacy		Yes / Not applicable	
Discharge medication(s) checked		Yes / Not applicable	
Patient educated re: Discharge medications		Yes / Not applicable	
7 day supply of drugs / dressings / appliances		Yes / Not applicable	
Venflon removed?		Yes / Not applicable	
Transport arranged for discharge		Yes / Not applicable	
Referral to Community based services (If discharge is cancelled please inform Home Care Organiser or Liaison Nurse as appropriate)		Yes / Not applicable	
Nursing Transfer Document completed		Yes / Not applicable	
Home Help contacted (if applicable)		Yes / Not applicable	
MECS contacted (if applicable)		Yes / Not applicable	
Meals on Wheels contacted (if applicable)		Yes / Not applicable	
Access to house/Outdoor clothes, shoes etc		Yes / Not applicable	
Heating and food available		Yes / Not applicable	
Follow up hospital appointment arranged		Yes / Not applicable	
Transport arranged for follow up hospital appointment		Yes / Not applicable	
Follow up appointment details:			
Other information			

FORTH VALLEY ACUTE HOSPITALS NHS TRUST

PATIENT DETAILS	
Name: Alan Wyles.	Title: (Mr.) Mrs. Miss Ms Dr. COPY
Address: 27 Walker Avenue Roploch.	DOB: 6/5/77. Age: 27
Postcode:	Unit No:
	Tel No:

PRESENTING COMPLAINT	FINAL DIAGNOSIS
1 Headaches	1
2 Photophobia	2
3 Pyrexia	3
4	4
5	5

EPISODE INFORMATION			
Admission date: 22/8/04	Admission time: 0300	Admitting Consultant: Howie	
Admitting ward: 29	Admitted from: A+E	Admitting Nurse: L McBride	
Expected Length of Stay:		Admitting SHO: McCulloch	
Ready for Discharge Date:		Date of Referral to Social Work Department:	
Actual Discharge Date:		Date of Discharge Planning Meeting:	

CONSULTANT / NAMED NURSE MOVEMENT			
Date:	Consultant:	Ward:	Named Nurse:
Date:	Consultant:	Ward:	Named Nurse:
Date:	Consultant:	Ward:	Named Nurse:
Date:	Consultant:	Ward:	Named Nurse:

PAMS MOVEMENT			
Named P/T:	Contact No:	Named O/T:	Contact No:
Named P/T:	Contact No:	Named O/T:	Contact No:
Named SALT:	Contact No:	Named Dietician:	Contact No:
Named Pharmacist:	Contact No:	Named Pharmacist:	Contact No:

ALLERGIES	SPECIAL NOTES	ALERTS
? Penicillin		I.V.D.A.

VISIT REQUIRED BY CHAPLAIN? Y / N	RELIGION:

RECORDING PROCESS			
Admitted through Delta	Y / N	Bloods	(Y) / N
Demography printed	Y / N	Cannulation	(Y) / N
Admission Book	(Y) / N	ECG	(Y) / N
Casenotes ordered	(Y) / N	X-Ray	(Y) / N
Hospital Appointments pending:			

CLINICAL NOTES

Patient's Name ALLAN WYCES A&E No. 23033

COPY

Abdo :- Soft + non-tender
- NAD

ECG -

Imp :- ? meningitis
- ? chest/UTI/GI sepsis

Plan: IV access — bloods inc. cultures

Results	
Na	
K	
Cl	
Urea	
Creat	
Gluc	
Amyl	
Hb	142
WBC	6.5
Plat	196
MCV	
H+	
PCO_2	
BICARB	
PO_2	
PT	
INR	
PTT	
TT	
FIB	

Patient's Name Allan Wyles A&E No. 23033

TEMP 38·4 BP 160/88 PULSE 99 BM - 5·8. RESPS 16 O₂ SATURATION 97% on air

COPY

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS)

DRUG	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION	SIGNATURE	GIVEN BY	
CEFTRIAXONE	2g.	iv	02:15	[illegible]	[illegible]	

SEEN BY (PRINT) N. MACINNES TIME 0150.

2/8/04 ATF

PC - Headache, photophobia, ~~[illegible]~~ fever.

HPC - Feeling generally unwell for several days.
- ± ~2 hrs ago sudden onset severe headache ↳ back of head, now → frontal.
- Also vomited X2.
- °chest symptoms °urinary symptoms.
- NDA on methadone programme.

OE - Pyrexial (38·4). Shivering, clammy - ~~Sats~~ 97% on air
- tachycardic 99. - BP 160/88
- °rash.

Nursing Notes
Flow Chart
Discriminator
Triage Category

Neuro :- GCS 15/15 - PERL
- photophobic +
- (N) power/tone/reflexes/sensation.

CNS: - I+II+O
- no nystagmus
- °splinter haemorrhages.

Chest - good AE throughout
(x-ray) - few scattered basal crepts.
- res. no percuss^

Nurse's Signature ..... - res. no percuss^

COPY

SCOTTISH AMBULANCE SERVICE - PATIENT REPORT FORM

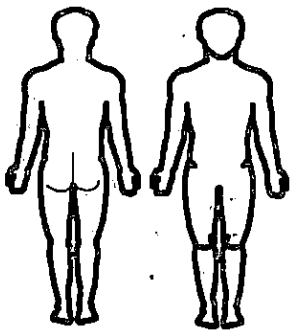
CCS INCIDENT No. 1169 1 0

Last Name: WILKS
F. Name: ALAN
Location: 27 WAIKER AV / KAPOCH / STIRLING
Age: 27
Sex: X
D of B: 06 05 77

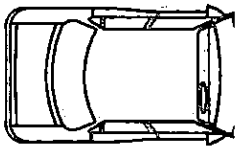
Date: 27 0
Time of Call: 0
Time at Patient: 0
Time Left: 0
AMPDS Code: 18 C
AMPDS Revised:

Airway Clear [V] Suction [ ] N/OPA [ ] ET [ ] LMA [ ] Successful ? [ ] C-spin
Breathing [V] Rate [V] BVM [ ] Ventilation [ ] Successful ? [ ] Paralysis [ ]
Ise [V] Rate [V] CPR [ ] IV/IO [ ] Fluids [ ] Successful ? [ ] E [ ]
Despite the above unable to
Clear airway [ ] Detect breathing [ ] Detect pulse [ ] [V] [ ] [ ] [ ]

Injury Site	Wound	#	Pain	Splint	Dressed
Head			X		
Neck					
Chest					
Abdomen					
Back					
R/Arm					
R/Leg					
L/Arm					
L					



RTA [ ]
Trapped [ ]
Ejected [ ]
M / cyclist [ ]
Cyclist [ ]
Pedestrian [ ]
>20 min: Extricate [ ]



Allergies: PENICILLIN
Medication:
Assisted by and Name
Doctor [ ] Nurse [ ]

Temp. [ ] °C
PEFR [ ] %
B. Sugar [ ] mmol

Time	Pulse	Resp	BP	C / Refill	SpO2 %	GCS	Lpup
0017	65	24	REG	RAD	X	456	
0023	63	24	168	104	V	97 on Air	456
0029	60		REG	RAD		456	

Time	Fluid/Drug/Gas	Dose	Unit	Route	Effect	Rhythm	No. Joules	Repeat	Re
11									

Condition at STIRLING hospital Pulse [V] Breathing [X] Conscious [X] Time at Hospital [0]

History and Additional Information 999 :- SUDDEN ONSET OF SEVERE HEADACHE IN BED PAIN BACK OF HEAD UNABLE TO TOLERATE LIGHT VOMITED IN AMBULANCE

PMH -
MAIN MEDICATION (LAST TAKEN THIS AM)

COPY

(3)

Forth Valley Acute Hospitals NHS Trust
Stirling Royal Infirmary
Livilands, Stirling FK8 2AU

NHS
Forth Valley

Falkirk Royal In
Majors Loan, Falkirk F

Consultant: Mrs U. Mackintosh ☑

CRN

Consultant: Dr G. N. O

Consultant

PATIENT

SURNAME: Wyles	DATE: 22/08/04	TIME OF ARRIVAL: 00.45	A&E NO.: 230	
FORENAME: Allan.	SEX: M / MARITAL STATUS:	DATE OF INCIDENT: 21/08/04	TIME OF IN: PM	
MAIDEN NAME:	DOB: 6/5/77	LOCATION OF INCIDENT: Home.		
ADDRESS: 27 Walker Ave Raploch.	AGE: 27	COMPLAINT: Unwell.		
POST CODE: FK8 1SA	OCCUPATION/SCHOOL: Unemployed	GP NAME: Dr Han'		
TEL: 07731917911.		ADDRESS: Park Av.		
TEMPORARY ADDRESS	PREVIOUS ATTENDANCE: (Y) N			
TEL	RTA: Y (N)			
NOK NAME: Victoria Philips	REFERRED BY: Self.			
ADDRESS: S1A	ARRIVAL: AMBULANCE			
TEL.	(Y) N	XRAY NO.		
NOTIFIED N/Y RELATIONSHIP: Partner.				

TO BE COMPLETED BY DOCTOR AFTER SEEING PATIENT

Dear Doctor, _____

the above named patient attended the Accident & Emergency Department today _____

DIAGNOSIS _____

X RAY / ECG / INVESTIGATIONS SHOW _____

TREATMENT GIVEN _____

DRUGS _____

TETANUS PROPHYLAXIS COVERED / HAS BEEN GIVEN ADT COURSE _____ ADT BOOSTER _____ IMMUNOGLOBU

OUTCOME

DRUGS GIVEN IN ACCIDENT & EMERGENCY DEPARTMENT

DRUG	DOSE	ROUTE	TIME	SIGNATURE
Co-[illegible]	[illegible]	[illegible]	11:02-15	[illegible]

COPY

RELATIVES		CLOTHING		DENTURES	
WITH PATIENT (Partner)	✓	WITH PATIENT	✓	N/A	✓
AWARE		WITH RELATIVE		TOP	
UNABLE TO CONTACT		OTHER: SPECIFY		BOTTOM	
				WITH PATIENT: Y/N	

DISCHARGE INFORMATION

REVIEW

GP _____
CLINIC _____
A/E _____
OTHER _____
(SPECIFY) _____

LETTER (INSTRUCTION)

GP _____
PATIENT _____
OTHER _____
(SPECIFY) _____

TRANSPORT ARRANGEMENTS

CAR _____ BY PATIENT _____
SAS _____ BY RELATIVE _____
OTHER _____ BY STAFF _____
N/A/ _____

COMMENTS

DISCHARGE (specify)

WARD _____

HOME _____

OTHER _____

AMBULANCE ORDERED

BY _____

TIME _____

VALUABLES ring x1

WITH PATIENT ✓
IN A & E SAFE _____

RECEIPT NO. _____
SIGNATURE _____

NAMED NURSE: JGrove

ASSOCIATE NURSE: _____

STIRLING ROYAL INFIRMARY

ACCIDENT & EMERGENCY NURSING ASSESSMENT FORM

TRIAGE 3

COPY

NAME Allan Wyles D.O.B. 06/05/77 ADDRESS 27 Walker Ave Raploch TEL. NO.	PRESENTING COMPLAINT Unwell	DATE 22/08/04
NEXT OF KIN: NAME Victoria Phillips ADDRESS SIA Partner TEL. NO. RELATIONSHIP	ALLERGIES ? Penicillin	TIME 00.45

OBSERVATIONS

TEMP	PULSE	RESP	BP	BM	O_2 SAT
38.4	99	16	160/88	5.8.	97% on ra
X-RAY	**ECG**	**BLOODS**	**IV ACCESS**	**RISK ASSESSMENT**	**INTERVENTION**
				0	

ABSOLUTE RISK (Score 2)	RELATIVE RISK (Score 1)
Unconsciousness	Age over 70
Dehydration	Restricted Mobility
Paralysis	Incontinence
	Pronounced Emaciation
	Redness over bony prominences

ASSESSMENT & TREATMENT

Patients history - 999 call
Sudden onset of severe headache
whilst in bed, pain back of head
lower back pain
Methadone last taken this am
Vomited x 1

O/A - complaining of headache
lower back pain
Alert and orientated

COPY

Forth Valley Acute Hospitals NHS Trust

Falkirk & District Royal Infirmary
Major's Loan
Falkirk
FK1 5QE
Telephone 01324 624000
Fax 01324 616006
www.show.scot.nhs.uk/nhsfv

Patient Identification Number for this trial: FOSTIR008

CONSENT FORM

Title of Project:
Predictors of outcome following brief intervention in patients with alcohol related facial injuries

A study to see if a short, nurse led assessment and advice on patient's alcohol drinking patterns can reduce facial injuries

Name of Researcher:
Mr I.S. Holland

Please initial box

1. I confirm that I have read and understand the information sheet dated 01/04/03 (version .....) for the above study and have had the opportunity to ask questions. AW

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without the quality of my medical care or legal rights being affected. AW

3. I agree to take part in the above study. AW

ALAN WYLES Name of Patient	01/04/03 Date	 Signature
FIONA OAKEY Name of Person taking consent (if different from researcher)	01/04/03 Date	 Signature
MR I. HOLLAND Researcher	01/04/03 Date	 Signature

1 for patient; 1 for researcher; 1 to be kept with hospital notes

CONTINUATION NOTES

COPY

NOTES

COPY

DEFINITIVE REVIEW

DURATION OF FIXATION (to nearest week) [ ][ ]

If not possible to determine enter 1 in box 41 and state why below [ ]

.....

.....

CESSATION OF C.S.F. LEAK (if relevant)

Number of days following injury [ ][ ]
0 0 = not known

SCARS specify [ ]

0 none
1 present
2 present and may require revision

.....

.....

.....

COMPLICATIONS [ ]

0 none 1 present

Delayed union [ ]
0 no 1 yes
(i.e. > 4/52 for maxilla > 6/52 for mandible)

Non-union [ ]
0 no 1 yes
or
Malunion (Malar Flattening) [ ]
0 no 1 yes

specify.....

.....

.....

Persistant diplopia [ ]
0 no 1 yes

Malocclusion [ ]
0 no 1 yes

Prolonged trismus [ ]
0 no 1 yes

Prolonged paræsthesia [ ]
0 no 1 yes

Anosmia [ ]
0 no 1 yes

Epiphora [ ]
0 no 1 yes

Other [ ]
0 no 1 yes

specify.....

.....

OTHER COMPLICATIONS.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

TREATMENT

Note: where the same fixation contributes to the stability of fractures in more than one region complete for each region independently.

PRELIMINARY TREATMENT

(debridement, removal of fragments, antibiotics, etc.)

Soft tissue wound
& IV to the chest area
& RT compound region

IMPRESSIONS

0 none 1 taken [ ] 15

DEFINITIVE TREATMENT

0 nil
1 undertaken
2 conservative treatment only [ ]

Time elapsed since injury until definitive treatment [ ]
0 not known
1 < 24 hours
2 1-2 days
3 3-4 days
4 5-7 days
5 [illegible] days

COPY

Treated as: [ ]
1 out-patient
2 in-patient on visit
3 in-patient other hospital
4 other

Other specify.....

Anaesthesia [ ]
0 none
1 general
2 local analgesia
3 sedation + L.A.

Reduction [ ]
0 none
1 closed
2 open
3 traction (including elastics)
4 late refracture
5 other

SUMMARY OF DEFINITIVE TREATMENT

Conservative Rx (D)
X ray - no displaced #'s

FIXATION-MANDIBLE

IMF [ ]
0 none
1 IMF – eyelet wiring
2 IMF – arch bars on either jaw
3 IMF – cast cap splints
4 IMF – Gunning-type splints
5 IMF – other

Connecting bar used [ ]
0 no 1 yes

OTHER FIXATION [ ] [ ] [ ]
0 none
1 LBW via incision
2 LBW via wound
3 UBW
4 cortical wire
5 bone plate
6 pins
7 tranosseous circum. wire
8 other internal wiring
9 other

If 8 or 9 specify.....

FIXATION-MAXILLA

IMF [ ]
0 none
1 IMF – eyelet wiring
2 IMF – arch bars on either jaw
3 IMF – cast cap splints
4 IMF – Gunning-type splints
5 IMF – other

Connecting bar used [ ]
0 no 1 yes

OTHER FIXATION [ ]
0 none
1 craniomaxillary
2 craniomandibular
3 other

Specify [ ] [ ] [ ]
1 headcap
2 halo
3 supraorbital pins
4 4-pin box frame
5 other extraskeletal
6 internal suspension (circumzygomatic)
7 internal suspension (frontal suspension)
8 other internal suspension (including combined 7 & 8)
9 other

specify.....

ZYGOMATICO-MAXILLARY

[ ] [ ] R L
0 no fixation
1 F.Z. wiring
2 infraorbital wiring
3 other orbital rim wiring
4 antral pack
5 pin fixation
6 multiple of above
7 other
specify.....

NASAL

[ ]
0 no fixation
1 direct wiring
2 lead plates (or similar)
3 POP splint (or similar) only
4 other

ORBITAL FLOOR

Explored [ ] [ ] R L
0 no 1 yes

if explored [ ] [ ] R L
0 no graft inserted
1 silastic sheet
2 bone graft
3 cartilage graft
4 other implant

OTHER OPERATIVE TREATMENT

.....

.....

.....

FRACTURES: NASAL BONES (definitive assessment; if necessary, postoperative)

0 intact 1 fractured

CLASSIFICATION

1 undisplaced
2 depressed bridge
3 deviation
4 extensive naso-ethmoid

SEPTUM

haematoma 0 no 1 yes

fracture detected 0 no 1 yes

SUBPERIOSTEAL HAEMATOMA

0 no 1 yes

COPY

FRACTURES: CRANIO-FACIAL

Frontal/Temporal Sphenoidal
0 Intact
1 Fractured

Frontal sinus Fractured
0 no
1 yes

MANDIBULAR FRACTURES

FRACTURES: MANDIBLE (definitive assessment; if necessary, postoperative)

0 intact 1 fractured

Only complete these sections if MANDIBLE FRACTURED

FRACTURED SITE

1 condyle
2 coronoid
3 angle
4 body
5 canine
6 symphysis
7 ramus
8 alveolus
9 other
0 more than 2 sites

CLASSIFICATION (if single or double)

1 Class I – teeth on both fragments
2 Class II – teeth on only 1 fragment
3 Class III – edentulous

ANGLE/BODY FRACTURES

1 HFVF
2 HFVU
3 HUVF
4 HUVU
5 not classifiable

INFECTION 0 no 1 yes

if present specify .....

.....

DESCRIPTION (main site/s)

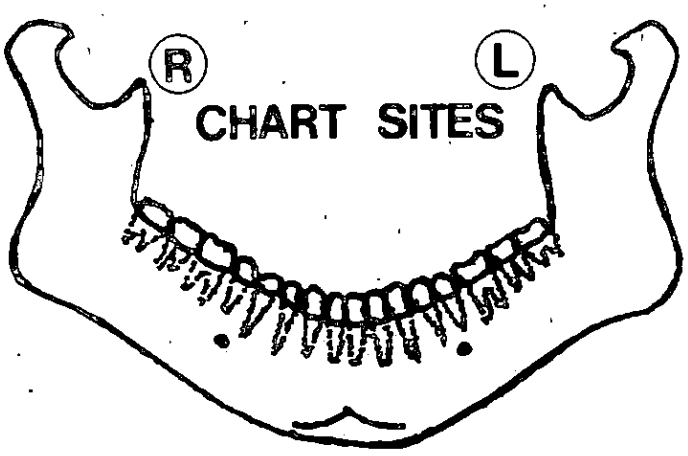
A 1 simple 3 compound extra-orally
2 compound intra-orally 4 compound both

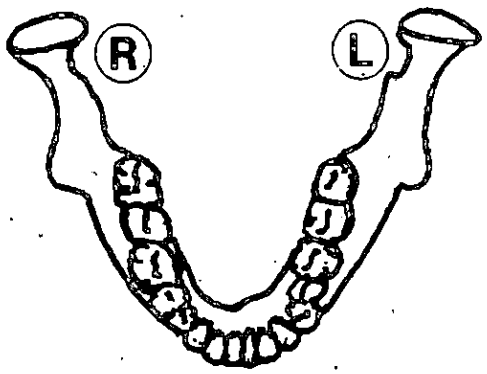
B 0 undisplaced 1 displaced

C 0 non-comminuted 2 comminuted
1 Greenstick

D 1 bone loss 0 no bone loss

E 1 mental Dysaesthesia 0 no change





MIDDLE THIRD FRACTURES

FRACTURES: ZYGOMATICO-MAXILLARY or ORBITAL
(definitive assessment; if necessary, postoperative)

0 intact
1 unilateral
2 bilateral

FRACTURES: MAXILLA
(definitive assessment; if necessary, postoperative)

0 intact
1 fractured

COPY

Only complete this section if these regions fractured

MALAR FRACTURE SITES

0 intact
1 undisplaced (any site)
2 zygomatic arch only
3 Tripod F.Z. suture undistracted
4 Tripod F.Z. suture distracted
5 pure blow-out
6 orbital rim only
7 comminuted-other than above

R L

CLINICAL FEATURES

Facial flattening
0 no
1 yes

Infraorbital anaesthesia
0 no
1 yes

Trismus
0 no
1 yes

Recent epistaxis
0 no
1 yes

Subconjunctival ecchymosis
0 no
1 yes

Diplopia 0 no
1 yes

chart distribution
thus 1 or 11: — or =

R L

Eye movements
0 normal
1 abnormal

describe abnormality if present: –

ORBITAL INVOLVEMENT

0 not involved 3 roof
1 floor only 4 lat. wall plus/minus floor
2 medial wall 5 multiple

R L

PUPIL LEVEL

0 normal 1 abnormal
specify if abnormal

R L

ENOPHTHALMOS

0 normal 1 yes

R L

INJURY TO GLOBE

0 no 1 yes
specify if injured

R L

INJURY TO LACRIMAL APPARATUS

0 no 1 yes

R L

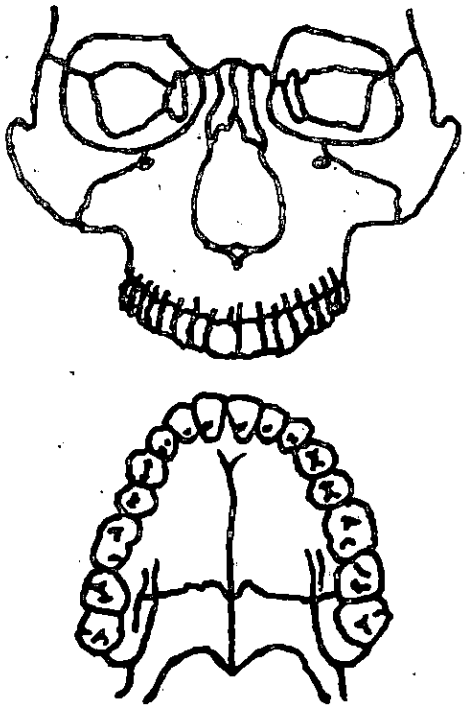
specify if injured

VISUAL ACUITY

6/6 6 6
R L

PREOPERATIVE OPHTHALMIC ASSESSMENT

0 no 1 yes



MAXILLARY FRACTURE SITES
(classify MAJOR fracture on each side)

0 nil 4 combined I, II or III
1 Le Fort I 5 tuberosity
2 Le Fort II 6 alveolar (except 5)
3 Le Fort III 7 other

R L

PALATAL SPLIT

0 nil 1 present

INFECTION

0 no 1 yes
if present specify

DESCRIPTION

A 1 simple 3 compound extra-orally
2 compound intra-orally 4 compound both

B 0 undisplaced 2 displaced

PALPATION

Orbital margins: No steps

Nasal bones: No any

Malar:

Condyles: Bone margin good TMJ noted

Mandibular borders: nad

Maxillary stability: present

COPY

OTHER OBSERVATIONS

no LSCM.

MAXILLO-FACIAL EXAMINATION: Intra-Oral

nad

Lacerations 0 none 1 present

Ecchymosis 0 none 1 present

Occlusion 0 normal 1 deranged

If deranged, specify .....

Mandibular midline
0 normal 1 displaced

If displaced specify .....

Maxillary midline
0 normal 1 displaced

If displaced, specify .....

Dentures 0 none 1 intact 2 broken 3 lost 4 at home
upper
lower

Teeth (count only teeth usable for splint fixation)

0 edentulous
1 lower anteriors only
2 less than 7 teeth
3 7-16 teeth
4 17-full dentition for age

Dental Injury

broken 0 no 1 yes

chipped 0 no 1 yes

Subluxed 0 no 1 yes

Avulsed 0 no 1 yes

Specify details .....

Oral Hygiene
1 good 2 fair 3 poor

Chart as follows:—

missing teeth

teeth for extraction (write reason adjacent)

roots

unerupted teeth

			e	d	c	b	a	a	b	c	d	e			
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
			e	d	c	b	a	a	b	c	d	e			

RIGHT LEFT

PRELIMINARY ASSESSMENT

CEREBRAL STATE

0 conscious 1 unconscious

If unconscious, specify depth
1 responds to command
2 responds to pain
3 no response

Pulse rate per minute

AIRWAY

0 clear 1 obstructed

SHOCK

0 absent 1 present
(i.e. I.V. fluids needed)

EPISTAXIS

0 absent 2 left
1 right 3 both

BLEEDING FROM EAR

0 absent 2 left
1 right 3 both

COPY

PUPIL REACTION

0 Normal both
1 Abnormal either

If abnormal specify by appropriate ringing.

	Right	Left
	dilated constricted	dilated constricted
Light reflex	brisk slow nil	brisk slow nil
Accommodation	brisk slow nil	brisk slow nil
Consensual Reflex	present absent	present absent

C.S.F. LEAKAGE

0 nil 2 R. otorrhoea 4 combined
1 rhinorrhoea 3 L. otorrhoea

AMNESIA

0 absent 1 present

If present RA/ PTA/ BOTH
delete as appropriate.

DURATION

1 hours
2 days
3 weeks

Number

ASSOCIATED INJURIES

(non maxillo-facial)
0 none 1 present

If present specify
1 skull 4 other fractures
2 thoracic cage 5 other
3 abdominal 6 multiple

.....

.....

MAXILLO-FACIAL EXAMINATION: Extra-Oral

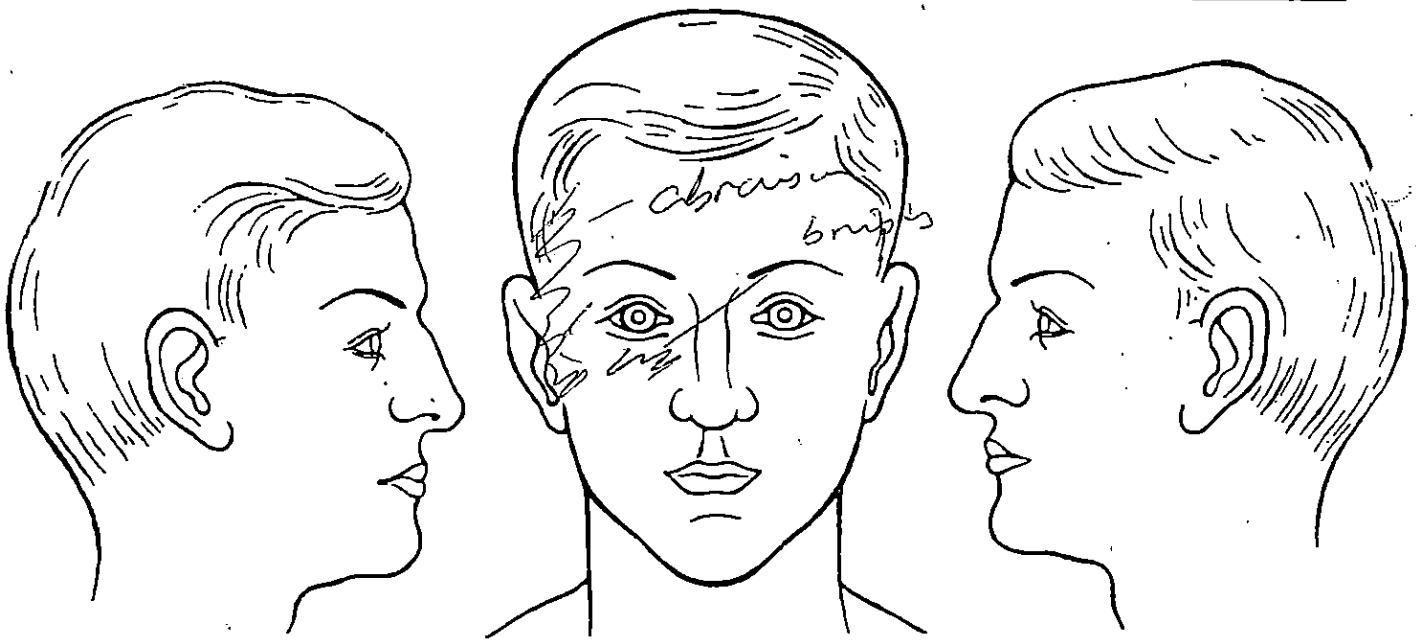
INSPECTION

Chart injuries below: extent in cms.
special features — penetrating nerve injury, etc.

SOFT TISSUE INJURIES

0 none 4 lacerations
1 abrasions 5 bruising
2 puncture wounds 6 swelling
3 tissue loss 7 multiple

S
1



Name	Record No.
Address	D. of B. Sex
Postcode	Consultant

S249901

ALAN WYLES
100D RAPLOCH ROAD
STIRLING

FK8 1RS 06/05/1977 M/S

COPY

GENERAL DATA not recorded elsewhere

TREATMENT PRIOR TO ARRIVAL

Dressings.....

Sutures.....

Operations.....

.....

Tetanus Toxoid.....

Antibiotics.....

Started (time).....

Other Drugs .....

.....

I.V. Fluids.....

.....

Age .....

CAUSE OF INJURY

0. car (no seat belt) 4. sport 7. dental surgery
1. car (seat belt) 5. industrial 8. fall
2. motor-cycle 6. alleged assault 9. other
3. other RTA

[ ]

DATE OF ACCIDENT

day		month		year	
2	8	0	3	0	3

TIME OF ACCIDENT (24 hour clock)

2	0	0	0

REFERRING HOSPITAL AREA BOARD

[4]

1 Greater Glasgow 2 Argyll and Clyde
3 Lanarkshire 4 Forth Valley
5. Ayrshire & Arran 6. Dumfries & Galloway
7 Other .....

PLACE OF ACCIDENT

1. home 3. public
2. work 4. other

[3]

SOURCE OF REFERRAL A&E

.....

DATE FIRST EXAMINED

day		month		year	
0	1	0	4	0	3

TRANSPORT

1. stretcher 2. chair 3. walking

[3]

P.C. alleged assault 28/3/03
L.O.C. ? How long
- No N/Vomit
- no ↓ sensation
diplopia
occ nomal
- ongoing now
- injury to left dorsal
- bruising to left hand

RX 747

ORAL & MAXILLO FACIAL SURGERY

CONFIDENTIAL

COPY

S249901 NS CAN AFFECT SURGICAL TREATMENT

ALAN WYLES
100D RAPLOCH ROAD
STIRLING
FK8 1RS

M/S
06/05/1977

TEL NO :-

OCCUPATION:-

EXPECTANT MOTHER YES (NO)

	YES	NO	DETAILS
1. Do you feel generally healthy?	☐	☑	
2. Have you had rheumatic fever?	☐	☐ ?	
3. Have you had Hepatitis or Jaundice?	☐	☑	
4. Do you have any heart complaints, such as heart attack, high blood pressure, angina, heart-murmur, or a replacement heart valve?	☐	☑	
5. Do you suffer from bronchitis, asthma or other chest condition?	☐	☑	
6. Do you have Arthritis?	☐	☑	
7. (a) Are you receiving any tablets, creams, ointments from your doctor?	☑	☐	
(b) Are you taking or have you taken steroids in the last two years?	☐	☑	
8. Are you allergic to any medicines, foods or materials?	☑	☐	Penacillen
9. Are you epileptic or prone to fainting attacks?	☐	☑	
10. Have you ever bled excessively following a cut or tooth extraction?	☐	☑	
11. Have you been hospitalised? If 'Yes', what for and when?	☐	☐	Last admitted with shattered collar bone & cracked shoulder blade.
12. Has the Blood Transfusion Unit ever refused your blood?	☐	☑	
13. Are you attending any other hospital clinics or specialists?	☐	☐	(C.A.D.S)

Doctor's Name and Address

Dr Ranken
Park Avenue
Stirling

Tel:-

Dentist's Name and Address

No Dentist

Tel:-

If you are not sure of any of the questions or if your medical circumstances change, please inform the Surgeon.

I certify that the above information is correct.

DATE: ..... SIGNATURE .....

RELATIONSHIP TO PATIENT .....

RX 1166

CLINICAL NOTES

Patient's Name ..... A&E No. .....

COPY

Tenderness over right 3/3 sterno.
scalic movement are normal & not painful

Right shoulder
- bruising seen on right shoulder
- shoulder movements are normal.

left shoulder
- swelling seen over left clavicle
- previous left # to clavicle
- shoulder movements are extremely painful
- tender over left elbow & ~~Rad~~ middle 3 finger.

- not complaining of pain anywhere else

mx- Rule out # skull, face, lt clavicle & lt elbow

X- ⇒ # left clavicle.
? # right 3/3 sterna

plan- - Analgesia
- Broad Arm sling
- # clinic
- Maxillofacial clinic on tuesday
- Review if needed

[signature]
A/Trainee
11:25 pm

Results	
Na	
K	
Cl	
Urea	
Creat	
Gluc	
Amyl	
Hb	
WBC	
Plat	
MCV	
H+	
PCO_2	
BICARB	
PO_2	
PT	
INR	
PTT	
TT	
FIB	

Patient's Name ..... A&E No.....

TEMP_____ BP_____ PULSE _____ RESPS _____ O_2 SATURATION _____

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS)

COPY

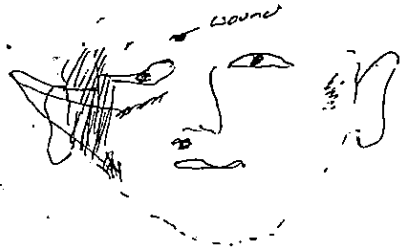
DRUG	DOSE	METHOD OF ADMINISTRATION	TIME OR ADMINISTRATION	SIGNATURE	GIVEN BY	
ibuprofen	400mg	PO	2145		CP	
Paracetamol	1000mg	PO	2145		CP	

SEEN BY (PRINT) MATHEW TIME 9:30pm

He has been out drinking - had taken about ½ a bottle wine ahead he says that he had been assaulted by more than one person. He says that he has been kicked, punched and hit on his face shoulders, head and back. Now complains of pain in back of the head, front of face - on his left shoulder/clavicle & Rt elbow/forearm

O/E - BP 150/90 P-90, RR-24. GCS 15/15
- PERL on both sides.
- [illegible]

Face
bruising and grazes seen over the R+SL side face
a small wound above Rt eyebrow (2cm)
- small wound (2cm) behind Rt ear
Right side lower eyelids are swollen
dull ache felt over back of the head.



Nursing Notes

Flow Chart

Discriminator

Triage Category

Nurse's Signature .....

Forth Valley Acute Hospitals NHS Trust
Stirling Royal Infirmary
Livilands, Stirling FK8 2AU

NHS
Forth Valley

Falkirk Royal Infirmary
Majors Loan, Falkirk FK1 5QE

(3)

MAX FAX TUE 1.4.
Consultant: Mrs U. Mackintosh ☑
Mr McKAY STATUS QUO

CRN 32640

Consultant: Dr G. N. Oliverman ☐

COPY

PATIENT

SURNAME: WYLES	DATE: 28.3.03	TIME OF ARRIVAL: 21:06	A&E NO: 7488
FORENAME: ALLAN	SEX: M	MARITAL STATUS:	DATE OF INCIDENT: 28.3.03
MAIDEN NAME:	DOB: 6/5/77	AGE: 26	TIME OF INCIDENT: 20:45
ADDRESS: 100A RANNOCH RD STIRLING	LOCATION OF INCIDENT: OTHER	COMPLAINT: ASSAULT	
POST CODE:	OCCUPATION/SCHOOL: UE		
TEL.			
TEMPORARY ADDRESS:	PREVIOUS ATTENDANCE: Y N		
TEL	RTA: Y N		

NOK

NAME	REFERRED BY: 999	GP NAME:
ADDRESS	ARRIVAL: AMBULANCE (Y) N	ADDRESS: ?
TEL.		XRAY NO.
NOTIFIED N/Y RELATIONSHIP: PARTNER		

TO BE COMPLETED BY DOCTOR AFTER SEEING PATIENT

Dear Doctor,

the above named patient attended the Accident & Emergency Department today

DIAGNOSIS Assault # L1 clavicle ? # R 3rd metac.

X RAY / ECG / INVESTIGATIONS SHOW

TREATMENT GIVEN Analgesia
Broad arm sling
clinic
max facial clinic appointment

DRUGS

TETANUS PROPHYLAXIS COVERED / HAS BEEN GIVEN ADT COURSE ADT BOOSTER IMMUNOGLOBULIN

OUTCOME

ADMITTED TO OP CLINIC ~~Max Fax Clinic Tues 1.4.03~~ Mr McKay Thurs. 3.4.03.

DISCHARGED TO TIME OF DISCHARGE

DOCTORS / ENP NAME (print): MATHEW

SIGNATURE:

Date and time	Continuation Please sign and PRINT NAME and POSITION	Patient Details COPY

Date and time	Continuation Please sign and PRINT NAME and POSITION	Patient Details COPY

Date and time	Continuation Please sign and PRINT NAME and POSITION	Patient Details
23/12	Pt admitted to AAU2 via ED with Heroin O.D	COPY
22[45]	Drowsy but rousable	
	EWS 4 - RR 10 A(V)PU	
	Pt refused Narcan by SAS + ED.	
	Await r/v	+HHAYBURN S/N +HHayburn
24/2 0100	Venflon removed	
	Pt discharged	
	Hospital taxi booked	+HHAYBURN S/N +HHayburn

Consultant Ward Round

Patient details

COPY

Diagnoses and significant comorbidities	Plan

Checklist		Estimated LoS <24h 24-48h >48h
Medicine reconciliation		Transfer of Care to:
VTE assessment		Outstanding criteria for ward transfer/discharge (delete as appropriate):
S_pO_2 target prescribed		
Fasting	Yes / No	

Name Signature Date Time

Resuscitation/ Escalation of care/ Anticipatory Care Planning / Advance Directives

Documentation of Discussion with Patient or Family

Name Signature Date Time

Consultant Ward Round

Patient details

COPY

CG

KR/Imaging

esults

Differential diagnosis

Patient details

COPY

1) ? hernia wall, post dural hx

Management plan

No medical reason to be admitted or kept in hospital.

Additional investigations required (e.g. cultures) Please initial and date when sent

	Initial/ Date		Initial/ Date
	Initial/ Date		Initial/ Date

Venous thromboembolism (VTE) risk assessment

Medical patient expected to be mobilising as normal within 2 days	☐	Proceed to VTE risk **actions**
Medical patient with reduced mobility for ≥2 days OR Surgical patient	☐	Assess **thrombosis and bleeding risk factors**

Thrombosis risk factors. ANY thrombosis risk factor(s) should prompt VTE prophylaxis measures unless contraindicated → Assess bleeding risk.

- ☐ **Mobility reduced for >2 days**
- ☐ **Age >60**
- ☐ **Dehydration**
- ☐ **Obesity BMI>30 kg/ m^2**
- ☐ **Significant medical comorbidity (e.g. cardiac, respiratory, endocrine, inflammatory, infectious conditions)**
- ☐ **Active cancer or cancer treatment**
- ☐ **Thrombophilia**
- ☐ **Personal history or first degree relative with history of VTE**
- ☐ **Use of hormone replacement therapy or oestrogen containing contraceptive**
- ☐ **Pregnancy or <6/52 post-partum**
- ☐ **Acute surgical admission with inflammatory or intra-abdominal condition**
- ☐ **Surgery with significant reduction in mobility**
- ☐ **Critical care admission**
- ☐ **Knee or hip replacement**
- ☐ **Hip facture**
- ☐ **Total anaesthetic+ surgical time >90mins**
- ☐ **Pelvic or lower-limb surgery with anaesthetic+ surgical time >60mins**
- ☐ **Varicose veins with phlebitis**

Bleeding risk factors. Consider whether sufficient to preclude pharmacological prophylaxis

- ☐ **Active bleeding**
- ☐ **Acquired bleeding disorder (e.g. acute liver failure)**
- ☐ **Current use of therapeutic anticoagulation (e.g. warfarin, rivaroxaban, dabigatran)**
- ☐ **Acute stroke**
- ☐ **Thrombocytopenia (<75x10^9/L)**
- ☐ **Uncontrolled hypertension (>230/120mmHg)**
- ☐ **Untreated inherited bleeding disorder**
- ☐ **Neurosurgery, spinal surgery or eye surgery**
- ☐ **Other procedure with high bleeding risk**
- ☐ **Lumbar puncture, epidural or spinal anaesthesia expected within the next 12 hours**
- ☐ **Lumbar puncture, epidural or spinal anaesthesia within the previous 4 hours**

VTE risk actions

Information provided Provide if admission is anticipated **Yes/ No**	**LMWH Yes/ No/ Contraindicated**	**Antiembolism stockings** Consider if thrombosis risk factors present and bleeding risk factors preclude LMWH Contraindicated in peripheral neuropathy, PVD, ulceration, cellulitis, gross oedema **Yes/ No/ Contraindicated**

Name | Signature | Date | Time complete

Examination

Diabetic patients → foot examination and diabetes bundle
GI Bleeding → PR examination
Age >65 or confusion → AMT
If cognition or alertness impaired → consider delirium

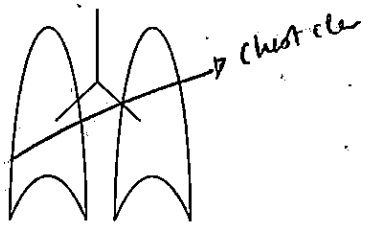
Patient Details

COPY

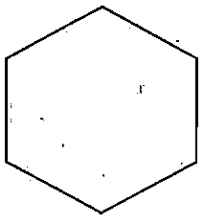
Cardiovascular

HS I + II ✓

Respiratory



Abdominal



AVT

B l sounds:

PR:

AMT (If <4/4, complete AMT10)

1. Age
2. DOB
3. Year
4. Location

/4

Ask patient to remember address: "42 West Street"

5. Time to nearest hour
6. Current monarch
7. Date Of WW2
8. Count 20→1
9. Identify 2 people
10. Recall address

/10

Neurological (remember speech, visual assessment, balance, gait)
Cranial nerves:

	R arm			L arm			R leg			L leg		
Tone												
Power												
Sensation												
Coordination												
Reflexes	B	T	S	B	T	S	K	A	Plantar	K	A	Plantar

SEWS 0, GCS 15

Other

awoken from sleep. but able to stand on 2 feet
No obvious head injury.

Pupils NR prompt
equal and reactive

Interpretation of results

ECG

N/A

Urine HCG

Urinalysis

	Neg	Trace	+	++	+++	++++
Leucocytes						
Nitrites						
Glucose						
Ketones						
Blood						
Protein						

CXR

N/A.

Other imaging

Additional comments

Medicines Reconciliation At least 2 recent sources, one of which must be patient or carer

Patient details

COPY

☐ Patient *(e.g. verbal recollection or handwritten note)*
☐ Relative/Carer
☐ Electronic patient record
ECS (issued in last 6 months?)
IDL (within last month?)
☐ Referral letter
Verbal
☐ Patient's own medicines
☐ Nursing home prescription
☐ Community pharmacy
☐ Other

No Known Drug Allergies ☐	OR	Drug / Substance	Reaction/ Side effect	Drug / Substance	Reaction/ Side effect

Pharm	ADMISSION MEDICATON	Dose	Frequency	Withhold	Stop	Comment	Kardex
	??						

RECENT ANTIBIOTICS/RECENTLY DISCONTINUED MEDICATION (within 6 months)

NON-PRESCRIPTION MEDICATIONS AND HERBAL MEDICATIONS

Are you satisfied this medication history is complete and accurate? Yes ☐ No ☑

If 'No' please detail what further action is necessary (e.g. contact GP, carer or access ECS)

Medicine reconciliation completed by? Name: Signature:
Date: Time:

Medicine reconciliation verified by? Name: Signature:
Date: Time:

Assessment

Practitioners Name Ayegbusi	Date 23/2/19.	Patient details
Grade ST5	Time commenced 01:00	COPY
GMC/ NMC	Location	

Presenting Complaint:

Pt not willing to engage
Unclear why he is in hospital.
Ambulance notes: apparently reported ~~to~~ take overdose. GCS 13 Reports psych but refusing any treatment.
Was then given option either Hosp/Police
It is not also clear why he was admitted by ED

Systemic Enquiry:

Pt denies any use of illicit substance.
Also wishes to go home but he lives in Slough
Reports no medical concerns.

Height: **Weight:** **BMI:**

Usual level of activity (please circle)

Bedbound | Dependent for personal care | Requires minimal assistance with ADLs | Slowed. Assistance with heavier household tasks | "Slowed-up" but not requiring assistance | No exercise beyond walking | Occasional exercise | Regular exercise

Past medical, surgical and anaesthetic history

MI	
Angina	
Hypertension	
COPD	
Stroke /TIA	
Diabetes	
Implement diabetes bundle	

??

Family History

Travel History

Social History ??

Smoking: Never Ex smoker (since_____)

Current _____/day Pack years_____

Alcohol: _____ Units / week

Occupation

Driving licence yes/ no

Lives With

Support/ Carers

Bundle stickers

Patient details

COPY

Preliminary Nursing Assessment

Patient Details

COPY

Belongings	With family		With patient		In safe		Bagged & labelled	
Own medication	Yes		No	✓				
Name band	Yes	✓	No					
Patient fasted	Yes		No	✓	Food time		Drink time	
Relatives with patient	Yes		No	✓	Informed			

Preliminary Pressure Ulcer Risk Assessment (PPURA)

Mobility: Patient is fully mobile without equipment/ assistance (Y/N)

Continence: Person is fully continent (Y/N)

Nutrition: Person appears well nourished and able to eat and drink (Y/N)

Record answer in grid below Y=Yes N=No

answer is **NO** to any assessments, complete Braden within 6 hours

Remember

- People who are overweight may not be well nourished
- Please sign after each check

Date	Time	Mobility	Continence	Nutrition	Skin inspected	Braden complete?	Signature/ PRINT
23/2	2300	N	Y	Y	Not seen		

Comments if required:

Preliminary falls assessment- if Yes to any, complete falls bundle within 4 hours if being admitted

≥2 falls in last 6 months?	Yes		No	✓
Patient/ Carer/ Referrer anxious about falls?	Yes		No	✓
Tries to walk alone but unsteady/ unsafe?	Yes		No	✓

Additional nursing comments

Name	Signature	Date	Time complete
	[illegible]	23/2	2300

Forth Valley Royal Hospital Assessment Document

NHS Forth Valley

Date of arrival 23/2/19 Time of arrival 2220

Source of referral: GP (ED) Other

GP practice:

CHI: 0605770352
06/05/1977 M Age 41 yr
WYLES Alan
13C KINGSEAT AVENUE
GRANGEMOUTH
STIRLINGSHIRE FK3 0AA

COPY

Address

Consent for ECS Yes No

BM NEWS score

Tel

NOK 1 Name

Relationship

Address

Tel

NOK 2

C Presenting complaint O.D - Heroin

B Background

A	NEWS 5 or more or other clinical concern	Yes		No
	T° 38°C or more within 14 days of chemotherapy (possible neutropenic sepsis)	Yes		No
	Referred with potassium more than 6.4mmo/L or less than 2.9mmol/L	Yes		No
	Referred with diabetic ketoacidosis	Yes		No
	Reduced GCS	Yes		No
	New limb weakness, speech disturbance or numbness for less than 4.5hours	Yes		No
	Abdominal pain: Does referral or patient give history of aortic aneurysm?	Yes		No
	Abdominal symptom in female under 55 with possibility of pregnancy	Yes		No
	NEWS 2-4	Yes		No
	New oxygen requirement (not on home oxygen)	Yes		No
	Chest pain at time of triage- Obtain ECG, clinician to review/sign within 10 minutes	Yes		No
	New limb weakness, speech disturbance or numbness for 4.5 hours or longer	Yes		NO
	Requires assistance of 1 or more to mobilise	Yes		No
	Able to mobilise independently or using own aids/ appliances	Yes		No

R Very urgent Urgent Standard Ambulant

Actions					
U&E/ LFT/ CRP/ FBC/Glucose		Amylase		Cannula	
Cultures		Calcium		ECG- to be signed within 10mins	
		Group and save		Troponin 0 hours/12 hours	

Additional triage comments

Allergies and alerts

Name Signature Date 23/2/19 Time 2230

PATIENT LABEL

COPY

CLINICAL NOTES

Near Patient Testing Results

Troponin.....Initials.....

Time of Trop.....

D-dimer.....

Urine dipstick

Leucs
Nitrite
Protein
Blood
Ketones
Glucose

Blood Gases

Arterial/venous (circle)
Time taken

FiO2
pH
pCO2
PO2
BE
Lactate

Urine Pregnancy Test
HCG positive/negative (circle)

Fast

Free fluid identified:
Yes/No (circle)

AAA

Aorta clearly seen
Yes/No (circle)
Measured diameter.....

Protetanus

Immune/Not immune (circle)

Patient/Legal Guardian Permission to release info for legal purpose including Police Yes / No

Patient Signature..... Print Name..... Date.....

CHI: 0605770352 06/05/1977 M
WYLES
ALAN
SPRINGKERSE HOUSE
STIRLING
FK7 7SN.

COPY

PVC INSERTION BUNDLE AND REMOVAL RECORD

PLEASE COMPLETE ALL BOXES

The patients skin is decontaminated and allowed to dry	YES / NO
Hand hygiene & gloves donned prior to insertion	YES / NO
Aseptic Non Touch Technique is used to insert PVC	YES / NO
If not possible, use either **STERILE GLOVES** or **MINI CHLORAPREP**	
Sterile dressing & sticker (date & time) applied after insertion	YES / NO

Why is PVC clinically indicated for patient?: (please tick)

IV Fluids		Blood Transfusion	
IV Drugs		Diagnostics	✓
Predicted clinical need	✓		

Colour: Pink
Insertion Site: L ACF
Ward/Department: ED.
Inserted by: Dr Thomson
Date & Time: 23/2/19 2200

INVESTIGATIONS

BLOODS TAKEN? YES / NO

Circle where appropriate:

FBC LFT U&E PARACETAMOL GLU CRP AMY G&S CLOTTING
ESR TROP HCG D-DIMER URINALYSIS BLOOD CULTURES ABG* VBG* (*attach to notes)

Others: CK

reliminary Pressure Ulcer Risk Assessment (PPURA):

Jobility: Person is fully mobile without equipment/assistance
Continence: Person is fully continent
Nutrition: Person appears well nourished and able to eat and drink
Skin: Skin to pressure points satisfactory/intact

Points to Consider
* People who are overweight may not be well nourished
* Use of repose mattress or pressure relieving heal protectors.

Record your answer in the grid below Y-= Yes or N = No
If the answer is **NO** to any assessments undertake a BRADEN and consider any other assessment

DATE	TIME	MOBILITY	CONTINENCE	NUTRITION	SKIN INTACT	SKIN INSPECTED	BRADEN COMPLETED	SIGNATURE
23/2/19	2025	Y	Y	Y	Y	N	N	
SKIN DESCRIPTION i.e. REDNESS, SKIN BROKEN, BLISTER / ULCER						ACTION TAKEN		
Pr Independent								

4AT under 65

ALERTNESS (assess for drowsiness or agitation, if asleep attempt to rouse)	
Normal	0
Mild sleepiness (easily roused <10 seconds)	0
early abnormal	4
AMT4 (age, date of birth, place, current year)	
No mistakes	0
1 mistake	1
2 or more mistakes	2
ATTENTION (ask for months of the year backwards)	
Achieves 7 or more correctly	0
Starts but scores less than 7/Refuses to start	1
Untestable	2
ACUTE CHANGE OR FLUCTUATION (significant change incl. evidence of psychotic symptoms)	
No	0
Yes	4
Total score (score of 4 or more indicates likely delirium – initiate TIME Bundle)	

FALLS TRIGGER TOOL

65 years or over?	YES / NO	Tries to walk alone and is unsteady?	YES / NO
2 or more falls in the last 6 months?	YES / NO	Patient/relatives anxious about falls	YES / NO
Fall since admission to department?	YES / NO	4AT more than 4/evidence of confusion	YES / NO
Admitted to department with fall?	YES / NO	COMPLETED BY	

If you have answered yes to 2 or more questions,
- For patients being admitted please document recommendation that a full care bundle is required to be completed.
- For patients being discharged please refer to Fastrack: YES / DECLINED

Clinical Notes

Seen by: A Thomson STT | **Time:** 2125

41 ↗ ?odose. ?heroin.
No naxa with BAS (pt refusal)
GCS 13/15 on arrival

EWS 6
RR 10
SpO2 95% air
BM 6.1

mently Es V4 M6; 13/15
easily rousable.
gives No LA. denies drug use @ present
denies pain/headache/other injry

%. ~~OD~~ → clear.

STAT.

No obvious injection site.
calves STT. nil pedal oedema/calves STT
PEARL - 2mm.
FAST-ve. No obvious peripheral weakness, moving all limbs

~~Imp~~ - Heroin use.

~~Plan~~ Observe - refer medicine if remains GCS<15
or aft legs
recs ONS
no overt indication for naxone

Guidelines Used:

COPY

Attach continuation sheets here

Attach here onto face of pocket

CHI: 0605770362 06/05/1977 M
WYLES ALAN
STIRLING ROYAL INFIRMARY FK8 2AU

Emergency Department
Forth Valley Royal Hospital

0605770352

0605770352

A&E No. 1[illegible]000039338

COPY 2

Surname	WYLES	**Forename**	ALAN	**Title:**	
Address:	SPRINGKERSE HOUSE SPRINGKERSE ROAD STIRLING	**Postcode** **Telephone:**	FK7 7SN 01786841748	**CHI No:** 0605770352	
Date of Birth:	06.05.77	**Sex:**	M	**Age:** 41 yrs	

CHI Barcode:

0605770352

GP Name:

Address: **Postcode**

Telephone:

Next of Kin
Relationship:
Address: **Postcode**

Telephone:

Manual CHI Entry:

Date of Attendance: 23.02.19 20:26
Date of Incident:

Presenting Complaint: OD

Triage TOOK HEROIN O/D APPROX 19.15 GCS 13 WITH SAS REFUSED ALL TREATMENT POLICE THREATENED CELLS OR HOSPITAL PT CHOOSE HOSPITAL REFUSED NARCAN EWS 6 DUE TO RESPS 10 SATS 95% B.P 110/51 ALERT TO VOICE

Tetanus Cover:

Allergies:

P= **BP=** / **RR=** **Sat=** **BM=**

PF= **GCS=**E: M: V: Total:

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time

Treatment On Scene	Non Emergency		

Conveyance

Transport To Hospital	Normal driving	Pre Alert	No

COPY

INCIDENT LOG

Time Call Received	19:12	Allocated	19:13	Mobile	19:13
First Resource On Scene		Crew On Scene	19:16	Crew Left Scene	19:55
Crew At Hosp	20:14	Receiving Hospital	FORTH VALLEY ROYAL HOSPITAL	Clear Time	

Crew ID	Crew Grade	Driver
E9888031	Ambulance Technician	YES
E9887820	Ambulance Technician	NO

Patient Information		Date:	23/02/2019
ALAN WYLES		Incident Number:	PA005340901
Age/Gender:	41 years 9 months 17 days Old Male	Incident Type:	EMG
Address:	C/O 5 SPRINGKERSE HOUSE SPRINGKERSE ROAD STIRLING,FK7 7SN	Incident Location:	5 SPRINGKERSE HOUSE SPRINGKERSE ROAD STIRLING, FK7 7SN
DOB:	06/05/1977		
CHI:	0605770352		
Ethnicity:			

COPY

Presenting Complaint

HEROIN OVERDOSE

Additional Comments

999 CALL TO 42 Y/O MALE REPORTED TO HAVE TAKEN HEROIN OVERDOSE. ON ARRIVAL PT IS ALERT TO VOICE, GCS IS 13 DUE TO EYES OPENING TO PAIN, EYES ARE PINPOINT. CREW HAVE DRAWN UP NARCAN BUT PT HAS SUDDENLY WOKEN UP AND ALMOST LASHED OUT AT CREW. PT REFUSING ALL HELP FROM CREW INCLUDING ADMINISTRATION OF NARCAN. PT TOLD IN NNO UNCERTAIN TERMS HE WILL BECOME ILL. PT STILL REFUSES. POLICE HAVE ARRIVED ON SCENE AND GIVEN PT ULTIMATUM TO GO TO CELLS OR A&E. PT HAPPY TO TRAVEL TO HOSPITAL BUT STILL REFUSING TREATMENT FOR HEROIN OVERDOSE. PT TRANSFERRE TO FVRH A&E.

PATIENT ASSESSMENT

AVPU	Voice		<C>	No			
A	Clear						
B							
C	Pulse Rate	BP	Cap Refill	ECG Rhythm			
	66	123/66	<=2 Secs	Sinus Rhythm			
	Rhythm	Arm	Central/Peripheral	ECG			
	Reg	Right	Peripheral	3 Lead			
D	GCS	Eyes	Voice	Motor	PEARL		
	13	To Pain (2)	Orientated (5)	Obeys Commands (6)	Yes		
E							

Observations

Time	P	RR	BP	SpO2	CR	GCS	AVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
20:12	65	14	124/71	97	<=2s	15	Voice				Sinus Rhythm				E9887820
19:55	66	14	123/66	96	<=2 Secs	13	Voice		37.2	5.4	Sinus Rhythm				E9887820

NEWS

Time	Clinical Risk	NEWS
20:12	MEDIUM Immediate Clinical Risk. Treat as per Clinical Practice Guidelines. This patient should be conveyed to hospital.	3
19:55	MEDIUM Immediate Clinical Risk. Treat as per Clinical Practice Guidelines. This patient should be conveyed to hospital.	3

HISTORY

Substances Affecting Condition

Substances	Opioids

MEDICAL

Overdose

Mode Of Poisoning	Inhaled		
OD Poisoning Substance Type	Opioids		
Poisoning Date	23/02/2019	Poisoning Time	19:00

OTHER

Additional Resources (On Scene)

Police

CLOSE RECORD

TRANSFER HANDOVER SBAR

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WYLES
ALAN
17 CHARLES STREET
DUNBLANE
FK15 9BY
COPY
40

PATIENTS DETAILS AFFIX LABEL	
WARD NUMBER	CAU
S **SITUATION** PRESENTING COMPLAINT Penicillin A	Injected into neck → now swollen & tender
B **B KGROUND** [redacted]SAL HISTORY DIAGNOSIS CURRENT MEDICATION	IVDU (15 years) Drug dependency ? methadone Depression
A **ASSESSMENT** YOUR CLINICAL OPINION	Δcellulitis
R **RECOMENDATION** RECOMENDED ACTION AND WHEN REQUIRED	HAT ☐ Bloods ☑ CXR ☑ Ψrlu ☐ IV ABX ☑ ECG ☑ IV Fluids?
MOBILITY	Independent
N[redacted]S SCORE	
INDWELLING LINES /CATHETERS	PVC
PATIENTS OWN MEDICATIONS CONTROLLED DRUGS	Ward stock
INFECTION RISK	PVC
N.B REMEMBER TO COLLECT CHARTS FROM BOTTOM OF BED **SEND CASE NOTES** **PRINT OFF MAC AND MAP**	
NURSES NAME NURSES SIGNATURE DATE &TIME	

Date and time	**Continuation** Please sign and PRINT NAME and POSITION	Patient Details

COPY

19.9.17 11⁴⁰	Transferred from trolley 2.
	Patient fully independent. Bloods ☑ ECG ☑ CXR ☑
	IV vancomycin in situ. Await CTR. (S/N)
15¹⁰	Mobilising Indep to toilet.
	Remains in police custody. News = 0
	Now more awake + alert. Awaiting
	consultant review. (S/N)
15³⁰	Police left hospital. Patient
	wished to self-DIC.
	Spoken to Registrar about this
	who deemed the patient to have
	consent. Venflon removed & self DIC
	form signed. (S/N)

CHI NO: 0605770352 06/05/1977
CRN: S278537 M

Alan Wyles
17 Charles Street,
DUNBLANE,
Perthshire
FK15 9BY

SURNAME (Block Letters) | FIRST NAME (Block Letters) | Against Advice UNIT NUMBER

This is to certify that I am leaving this Hospital at my own request, at my own risk, and on my own responsibility, and against the advice of the Medical Staff.

Signature .....

Address .....

Date 19/9/17

AGAINST ADVICE (Patient)

STB044

Consultant Ward Round

Patient details

COPY

Diagnoses and significant comorbidities	Plan

Checklist		Estimated LoS <24h 24-48h >48h
Medicine reconciliation		Transfer of Care to:
VTE assessment		Outstanding criteria for ward transfer/discharge (delete as appropriate):
S_pO_2 target prescribed		
Fasting	Yes / No	

Name	Signature	Date	Time

Resuscitation/ Escalation of care/ Anticipatory Care Planning / Advance Directives

Documentation of Discussion with Patient or Family

Name	Signature	Date	Time

Consultant Ward Round

Patient details

COPY

ECG

CXR/Imaging

Results

Differential diagnosis

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- Cellulitis

Management plan

- Bloods ✓
- ECG ✓
- Continue Abx IV
- IV fluids
- ↓ RIV

CXR ✓

Additional investigations required (e.g. cultures) Please initial and date when sent

	Initial/ Date		Initial/ Date
	Initial/ Date		Initial/ Date

Venous thromboembolism (VTE) risk assessment

Medical patient expected to be mobilising as normal within 2 days	☐	Proceed to VTE risk **actions**
Medical patient with reduced mobility for ≥2 days OR Surgical patient	☐	Assess **thrombosis and bleeding risk factors**

Thrombosis risk factors. ANY thrombosis risk factor(s) should prompt VTE prophylaxis measures unless contraindicated → Assess bleeding risk.

- ☐ **Mobility reduced for >2 days**
- ☐ **Age >60**
- ☐ **Dehydration**
- ☐ **Obesity BMI>30 kg/ m²**
- ☐ **Significant medical comorbidity (e.g. cardiac, respiratory, endocrine, inflammatory, infectious conditions)**
- ☐ **Active cancer or cancer treatment**
- ☐ **Thrombophilia**
- ☐ **Personal history or first degree relative with history of VTE**
- ☐ **Use of hormone replacement therapy or oestrogen containing contraceptive**
- ☐ **Pregnancy or <6/52 post-partum**
- ☐ **Acute surgical admission with inflammatory or intra-abdominal condition**
- ☐ **Surgery with significant reduction in mobility**
- ☐ **Critical care admission**
- ☐ **Knee or hip replacement**
- ☐ **Hip facture**
- ☐ **Total anaesthetic+ surgical time >90mins**
- ☐ **Pelvic or lower-limb surgery with anaesthetic+ surgical time >60mins**
- ☐ **Varicose veins with phlebitis**

Bleeding risk factors. Consider whether sufficient to preclude pharmacological prophylaxis

- ☐ **Active bleeding**
- ☐ **Acquired bleeding disorder (e.g. acute liver failure)**
- ☐ **Current use of therapeutic anticoagulation (e.g. warfarin, rivaroxaban, dabigatran)**
- ☐ **Acute stroke**
- ☐ **Thrombocytopenia (<75x10⁹/L)**
- ☐ **Uncontrolled hypertension (>230/120mmHg)**
- ☐ **Untreated inherited bleeding disorder**
- ☐ **Neurosurgery, spinal surgery or eye surgery**
- ☐ **Other procedure with high bleeding risk**
- ☐ **Lumbar puncture, epidural or spinal anaesthesia expected within the next 12 hours**
- ☐ **Lumbar puncture, epidural or spinal anaesthesia within the previous 4 hours**

VTE risk actions

Information provided Provide if admission is anticipated **Yes/ No**	**LMWH Yes/ No/ Contraindicated**	**Antiembolism stockings** Consider if thrombosis risk factors present and bleeding risk factors preclude LMWH Contraindicated in peripheral neuropathy, PVD, ulceration, cellulitis, gross oedema **Yes/ No/ Contraindicated**

Name	Signature	Date	Time complete
Y Adnan		19/9/17	10:35

Examination

Diabetic patients → foot examination and diabetes bundle
GI Bleeding → PR examination
Age >65 or confusion → AMT
If cognition or alertness impaired → consider delirium

Patient Details

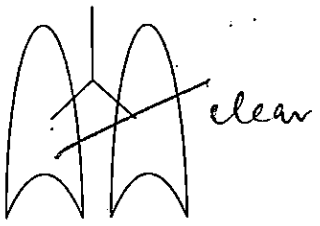
COPY

Cardiovascular

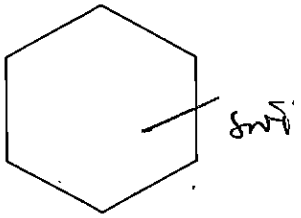
1-11-0
BP 128/52
HR 68

no ankle swelling.

Respiratory



Abdominal



Bowel sounds:

PR:

AMT (If <4/4, complete AMT10)

1. Age
2. DOB
3. Year
4. Location

/4

Ask patient to remember address: "42 West Street"

5. Time to nearest hour
6. Current monarch
7. Date Of WW2
8. Count 20→1
9. Identify 2 people
10. Recall address

/10

Neurological (remember speech, visual assessment, balance, gait)
Cranial nerves:

	R arm			L arm			R leg			L leg		
Tone												
Power												
Sensation												
Coordination												
Reflexes	B	T	S	B	T	S	K	A	Plantar	K	A	Plantar

Other

(L) side of neck. Swollen & Tender on touch

(L) ankle - bruised tender

Interpretation of results

ECG

Urine HCG

Urinalysis

	Neg	Trace	+		++	+++	++++
Leucocytes							
Nitrites							
Glucose							
Ketones							
Blood							
Protein							

CXR

Other imaging

Additional comments

Medicines Reconciliation At least 2 recent sources, one of which must be patient or carer

Patient details

COPY

☐ Patient *(e.g. verbal recollection or handwritten note)*
☐ Relative/Carer
☐ Electronic patient record
ECS (issued in last 6 months?)
IDL (within last month?)
☐ GP
Referral letter
Verbal
☐ Patient's own medicines
☐ Nursing home prescription
☐ Community pharmacy
☐ Other

No Known Drug Allergies ☑	OR	Drug / Substance	Reaction/ Side effect	Drug / Substance	Reaction/ Side effect
		Penicillin			

Pharm	ADMISSION MEDICATON	Dose	Frequency	Withhold	Stop	Comment	Kardex
	Naproxen	500mg	BD				
	GabaPentine	900mg	TDS				
	Mirtagapine	30mg	ON				

RECENT ANTIBIOTICS/RECENTLY DISCONTINUED MEDICATION (within 6 months)

NON-PRESCRIPTION MEDICATIONS AND HERBAL MEDICATIONS

Are you satisfied this medication history is complete and accurate? Yes ☑ No ☐
If 'No' please detail what further action is necessary (e.g. contact GP, carer or access ECS)

Medicine reconciliation completed by? Name: Y Abbas Signature:
Date: 19/9/17 Time: 10:05

Medicine reconciliation verified by? Name: Signature:
Date: Time:

Assessment

Practitioners Name	M Abbas	Date	19/9/17
Grade	SHO	Time commenced	1020 S
GMC/ NMC	7059958	Location	CAU

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Presenting Complaint:

40 f

IVDU for last 15 yrs.

Injected heroin into (L) neck yesterday. Now presented with painful swollen injected site of neck. Generally unwell, feeling feverish. Denied cough, no urinary symptoms, denied injected any where else.

Systemic Enquiry: On Methadone as well?

Height: **Weight:** **BMI:**

Usual level of activity (please circle)

Bedbound | Dependent for personal care | Requires minimal assistance with ADLs | Slowed. Assistance with heavier household tasks | "Slowed-up" but not requiring assistance | No exercise beyond walking. | Occasional exercise | Regular exercise

Past medical, surgical and anaesthetic history

MI	
Angina	
Hypertension	
COPD	
Stroke /TIA	
Diabetes	
Implement diabetes bundle	

Depression

Drug Dependence

IVDU

Family History

Travel History

Social History

Smoking: Never Ex smoker (since_____)

Current _____/day Pack years_____

Alcohol: _____ Units / week No ?

Occupation

Driving licence yes/ no

Lives With

Support/ Carers

Bundle stickers

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WYLES
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Preliminary Nursing Assessment

Patient Details

COPY

Belongings	With family		With patient	✓	In safe		Bagged		Labelled
Own medication	Yes		No	✓					
Name band	Yes	✓	No						
Patient fasted	Yes		No	✓	Food time		Drink time		
Relatives with patient	Yes		No	✓	Informed				

Preliminary Pressure Ulcer Risk Assessment (PPURA)

Mobility: Patient is fully mobile without equipment/ assistance (Y/N)

Continence: Person is fully continent (Y/N)

Nutrition: Person appears well nourished and able to eat and drink (Y/N)

Record answer in grid below Y=Yes N=No

If answer is **NO** to any assessments, complete Braden within 6 hours

Remember

- People who are overweight may not be well nourished
- Please sign after each check

Date	Time	Mobility	Continence	Nutrition	Skin inspected	Braden complete?	Signature/ PRINT
18/9/17	1130	IND	IND	IND	PE states intact	✓	

Comments if required:

Preliminary falls assessment- if Yes to any, complete falls bundle within 4 hours if being admitted

≥2 falls in last 6 months?	Yes		No
Patient/ Carer/ Referrer anxious about falls?	Yes		No
Tries to walk alone but unsteady/ unsafe?	Yes		No

Additional nursing comments

Name	Signature	Date	Time complete

Forth Valley Royal Hospital Assessment Document

Time of arrival: 09:40 Location: CAU

Source of referral: GP (ED) Other

GP practice:

NOK NAME Victoria Phillips

Relationship Partner

TEL: 07751580239

27 Walker Avenue, Raploch

CHI ... e.....

Name: CHI: 0605770352 06/05/1977 M
WYLES
ALAN
17 CHARLES STREET
DUNBLANE
FK15 9BY

COPY

Tel.....

S Situation-Presenting complaint: cellulitis neck

B Background-Duration/severity/past medical history: See ED clerk in.

Time: **NEWS** 0 **AVPU** (Circle) **PAIN SCORE** 0

A Assessment

Probable sepsis- commence Sepsis-6, insert bundle sticker	Yes		No
Diabetic ketoacidosis- commence DKA pathway	Yes		No
Referred with hyperkalaemia ≥6.5mmol/L or Hypokalaemia ≤2.8mmol/L	Yes		No
Potential stroke, symptoms <3.5 hours → assessment for thrombolysis. Insert bundle sticker for all patients with potential stroke	Yes		No
Abdominal pain and history of aortic aneurysm	Yes		No
Abdominal symptom in female ≤55 with possibility of pregnancy → urgent urine HCG. Do not delay further assessment waiting for sample	Yes		No
Triggering on NEWS or clinical concern	Yes		No
ECG obtained- clinician to review/ sign/date/ time within 10 minutes if chest/ epigastric pain	Yes		No
Consent for ECS access	Yes		No

R Recommendation-Triage category: 1 2 3

EG: Bloods/access/ECG/4 AT/ABG/Weight/MSU etc.

ED Vaplon Bloods

Date Name Signature

PLEASE ENSURE THAT EVERY ENTRY HAS A TIME AND SIGNATURE

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DUNBLANE
FK15 9BY

COPY

NURSING NOTES

19/09/17. Parent reports an allergic to penicillin.
08:35. Doctor informed. ——— Juliette (SIN) PATIENT

Date: 19/9/17 Time: 0750

Named Nurse: Amie Gilchrist Triage Nurse:
Sophie Freeman

Patients preferred name:

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DUNBLANE
FK15 98Y

COPY

S

Situation: Presenting Complaint: Male 40yo

Skin condition

History of presenting complaint

In police custody. complaining of (L) sided neck pain, injected in this area yesterday painfull + hot to touch.

B

Background: Relevant medical history, social circumstances etc.

IVDU

Allergies: ~~NKDA~~ Penicillin

Relative/ Carer informed? police YES/NO PRESENT? YES/NO

Patient's details and NOK checked ☑

A

Assessment: investigations and treatments undertaken in ED.

ED review ☑

PAIN: /3

(A) V P U

IV access ☑

Bloods ☑

IV Abx ☑

Mobility: Independant Name Band ☑ Signature: AGilchrist

R

Directions for admission ward staff, including outstanding treatments.

Impression: ? cellulitis

Plan: Admit medics

Recommendation Falls Care Bundle required Yes/(No)

NEWS: 0 Signature: AGilchrist

PATIENT COPY

CLINICAL NOTES

Near Patient Testing Results

Troponin.....Initials.....

Time of Trop.....

D-dimer.....

Urine dipstick

Leucs
Nitrite
Protein
Blood
Ketones
Glucose

Blood Gases

Arterial/venous (circle)
Time taken

FiO2
pH
pCO2
PO2
BE
Lactate

Urine Pregnancy Test
HCG positive/negative (circle)

Fast

Free fluid identified:
Yes/No (circle)

AAA

Aorta clearly seen
Yes/No (circle)
Measured diameter.....

Protetanus
Immune/Not immune (circle)

Patient/Legal Guardian Permission to release info for legal purpose including Police - Yes / No

Patient Signature..... Print Name..... Date.....

PVC INSERTION BUNDLE AND REMOVAL RECORD

CHI: 0605770352 06/05/1977 M
WYLES
ALAN
17 CHARLES STREET
DUNBLANE
FK15 9BY

COPY

PLEASE COMPLETE ALL BOXES

The patients skin is decontaminated and allowed to dry	YES / NO
Hand hygiene & gloves donned prior to insertion	YES / NO
Aseptic Non Touch Technique is used to insert PVC	YES / NO
If not possible, use either **STERILE GLOVES** or **MINI CHLORAPREP**	
Sterile dressing & sticker (date & time) applied after insertion	YES / NO

Why is PVC clinically indicated for patient?: (please tick)

IV Fluids		Blood Transfusion	
IV Drugs		Diagnostics	
Predicted clinical need	✓		

Colour: Pink
Insertion Site: left arm
Ward/Department: ED
Inserted by: B Cowper
Date & Time: 19/9/17 07.40

INVESTIGATIONS

BLOODS TAKEN? (YES) / NO

Circle where appropriate:

(FBC) LFT (U&E) PARACETAMOL GLU (CRP) AMY G&S CLOTTING
ESR TROP HCG D-DIMER URINALYSIS (BLOOD CULTURES) ABG* VBG* (*attach to notes)

Others:

Preliminary Pressure Ulcer Risk Assessment (PPURA):

Mobility: Person is fully mobile without equipment/assistance
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Nutrition: Person appears well nourished and able to eat and drink
Skin: Skin to pressure points satisfactory/intact

Points to Consider
* People who are overweight may not be well nourished
* Use of repose mattress or pressure relieving heal protectors.

Record your answer in the grid below Y = Yes or N = No
If the answer is **NO** to any assessments undertake a BRADEN and consider any other assessment

DATE	TIME	MOBILITY	CONTINENCE	NUTRITION	SKIN INTACT	SKIN INSPECTED	BRADEN COMPLETED	SIGNATURE
19/9/17	0850	4	4	4	4	N	N	

SKIN DESCRIPTION i.e. REDNESS, SKIN BROKEN, BLISTER / ULCER	ACTION TAKEN
Pt states skin is intact.	

4 A T

ALERTNESS (assess for drowsiness or agitation, if asleep attempt to rouse)	
Normal	0
Mild sleepiness (easily roused <10 seconds)	0
Clearly abnormal	4
AMT4 (age, date of birth, place, current year)	
No mistakes	0
1 mistake	1
2 or more mistakes	2
ATTENTION (ask for months of the year backwards)	
Achieves 7 or more correctly	0
Starts but scores less than 7/Refuses to start	1
Untestable	2
ACUTE CHANGE OR FLUCTUATION (significant change incl. evidence of psychotic symptoms)	
No	0
Yes	4
Total score (score of 4 or more indicates likely delirium – initiate TIME Bundle)	

Under 65

FALLS TRIGGER TOOL

65 years or over?	YES / (NO)	Tries to walk alone and is unsteady?	YES / (NO)
2 or more falls in the last 6 months?	YES / (NO)	Patient/relatives anxious about falls	YES / (NO)
Fall since admission to department?	YES / (NO)	4AT more than 4/evidence of confusion	YES / (NO)
Admitted to department with fall?	YES / (NO)	COMPLETED BY	

If you have answered yes to 2 or more questions,
- For patients being admitted please document recommendation that a full care bundle is required to be completed.
- For patients being discharged please refer to Fastrack: YES / DECLINED

Clinical Notes

19/9/17

Seen by:	B COLLIER FY2	Time:	07.00

COPY

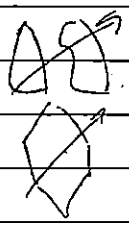
CHI: 0605770352
WYLES
ALAN
17 CHARLES STREET
DUNBLANE
FK15 9AY

PC: 40 ♂ Painful neck

HPC: Brought in by police. Injected heroin into neck yesterday with blue needle. Now has painful, swollen area on left side of neck. Feeling generally unwell, lethargic, and switching between hot + cold. Temp in police custody 38.7°C - given paracetamol, tachycardic @ 103. Paracetamol at 05.45.
No SOB or chest pain.

PMHx: Anxiety / depression, IVDU NKDA

O/E: RR 17 Sats 98% HR 52 BP 115/60 Temp 37.5
HS I + II + 0



2cm swollen, tender area on left side of neck. Erythematous. No obvious tracking.

Imp: Cellulitis to left side of neck. Pyrexia improved with paracetamol.

(P) Flucloxacillin
Admit medicine

10/9/17 08:31 T. Hwang (GPST1)
Pt reports allergy to penicillins, as for IV Abx as per Dr. Collier, as per guidelines → for vancomycin.

COLLIER FY2.

Attach continuation sheets here

Attach here onto face of p[illegible]ket

Guidelines Used:	

Emergency Department
Forth Valley Royal Hospital

0605770352

0605770352

A&E No. 17000013547

COPY 3

Surname	WYLES	**Forename**	ALAN	**Title:**	
Address:	17 CHARLES STREET	**Postcode**	FK15 9BY	**CHI No:**	0605770352
	DUNBLANE PERTHSHIRE	**Telephone:**	01786841748		
Date of Birth:	06.05.77	**Sex:**	M	**Age:**	40 yrs

CHI Barcode:

0605770352

GP Name:	ROXBURGH KATHERINE		
dress:	DUNBLANE HEALTH CE... WELL PLACE DUNBLANE PERTHSHIRE	**Postcode** **Telephone:**	FK15 9AL 01786 822595

Next of Kin
Relationship:
Address: **Postcode**

Telephone:

Manual CHI Entry:

Date of Attendance: 19.09.17 06:39
Date of Incident:
Presenting Complaint: HIGH TEMP/UNWELL

...age INJECTION SITE L NECK INFLAMED AND PAINFUL. PYREXIAL AND FEELING GEN UNWELL. IN POLICE CUSTODY, GIVEN PARACETAMOL BY CUSTODY NURSES 0550

Tetanus Cover:

Allergies: Penicillin

weight 74.98 kg.

P= **BP=** / **RR=** **Sat=** **BM=**

PF= **GCS=** E: M: V: Total:

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time	
19/9/17	~~FLUCLOXACILLIN~~	1g	IV		AG	~~0830~~	not given patient reports allergy
19/09/17	Vancomycin	1500mg	Infusion		AM/MK	0855	

Thank you for your ongoing care of this patient.

Kind regards,
B11 team.

COPY

Safety Alerts

Nil records exist

Allergy/Intolerance - JAC

Allergy/Intolerance	Reaction
PENICILLINS	Unknown

Allergy records are as recorded at time and date of printing

Medications - JAC

Drug Information:

Drug	Dose	Route	Frequency	GP to Continue	POD	Days Supply
BUPRENORPHINE 2 mg Sublingual Tablets	2mg	Sublingual	ONCE daily at 8am	Y	N	1
BUPRENORPHINE 8 mg Sublingual Tablets	8mg	Sublingual	ONCE daily at 8am	Y	N	1
DIAZEPAM 5 mg Tablets	20mg	Oral	ONCE daily at 8am	Y	N	1
DIAZEPAM 2 mg Tablets	8mg	Oral	ONCE daily at 8am	Y	N	1
PARACETAMOL 500 mg Tablets	1000mg	Oral	FOUR times daily at 8am 12noon 6pm 10pm	N	N	7

Drug Notes:

Drug	Drug Notes
PARACETAMOL 500 mg Tablets	TTO

Additional Medicine Information:

Medicines discontinued during admission (Medicines that patient was recorded as admitted on only)

Drug	Discontinued Reason

Nil records exist

GP Communications:

Usually collects twice weekly from Tesco Pharmacy Stirling - I have contacted them and they will expect him on 5/5/25. Pharmacy please supply x1 day (tomorrow's supply) of buprenorphine and diazepam. Paracetamol TTO from ward stock please. Many thanks.

Outstanding Results -

Responsibility of Hospital

Nil records exist

Person completing record

Authorised by		Clinically completed by	
Name:	Dr Kenny Jenkins	Name:	Dr Kenny Jenkins
Designation or role:	Doctor	Designation or role:	Doctor
Specialty:		Specialty:	
Date completed:	01-Jul-2025		

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
A Dunsmore	GP	Allan Park Medical Practice

Forth Valley Acute Hospitals Acute Division
Medications Discharge Summary

Name:	Alan Wyles	Patient's Tel No:	
Address:	13C Kingseat Avenue, Grangemouth, Stirlingshire, FK3 0AA	Patient's Tel Eve:	07731917911
Admission Date:	23/02/2019	Discharge Date:	24/02/2019

COPY

PATIENT ALERTS

Alert Group	Alert	Alert Comment	When Added	Added By

PATIENT DRUG REACTIONS

penicillin - Adverse Reaction - kidney pain

CURRENT PRESCRIPTION (all medicines currently prescribed) *e.g. clinical indication for prescription monitoring*

MEDICINES DISCONTINUED

Nurse check on discharge:

Signature 1:

Signature 2:

Name: Alan Wyles

CHI: 060577035

File

Forth Valley Acute Hospitals Acute Division
Medications Discharge Summary

Name:	Mr Alan Wyles	**Patient's Tel No:**	
Address:	17 Charles Street,, Dunblane,, Perthshire, FK15 9BY	**Patient's Tel Eve:**	07731917[illegible]
Admission Date:	19/09/2017	**Discharge Date:**	19/09/2017

COPY

PATIENT ALERTS

Alert Group	Alert	Alert Comment	When Added	Added By

PATIENT DRUG REACTIONS

penicillin - Adverse Reaction - kidney pain

CURRENT PRESCRIPTION (all medicines currently prescribed) **e.g. clinical indication for prescription monitoring*

MEDICINES DISCONTINUED

Nurse check on discharge:

Signature 1:

Signature 2:

Name: Mr Alan Wyles

CHI: 0605770352

File

EMERGENCY & URGENT CARE ASSESSMENT RECORD - VERSION 4

PART A + B COMBINED DOCUMENT

NHS Forth Valley

COPY

PATIENT DETAILS

Surname:	CHI:0605770352	Title:	(Mr)	Mrs	Miss
Forename:			Ms	Dr	
Address:	CRN:S278537 06/05/1977 M	DOB:			
	WYLES ALAN	Age:	34.		
	27 Waulker Avenue, STIRLING	CHI No/			
		Patient ID:			
Postcode:	FK8 1SA	Tel No:			

NEXT OF KIN DETAILS

Next of Kin:	Evelyn mckenzie	Alt. Next of Kin	Victoria wyles
Relationship:	mother in law.	Relationship:	Partner
Address:		Address:	
Tel No:	01786 450501.	Tel No:	01786 450501

Other Family Member Details:

Name of Relative/ Carer		Present on Admission?	Y/N
		Contacted?	Y/N
		Tel No:	

GP

Name:	Dr Menzie
Practice:	Park Avenue.
Address:	
Postcode:	

Date of Attendance: **Date of Incident/Onset**

PRESENTING COMPLAINT

1 Back pain ? ARF.

2

Allergies:

- ☐ Drugs
- ☐ Latex
- ☐ Metal
- ☐ Food
- ☐ Nil known

penicillin - kidney pain

Alert High Risk Factors:

Named Consultant: Dr [illegible] / Cross

Named Nurse: Amanda.

SPECIAL REQUIREMENTS	YES	NO	ACTION
Translation Service		✓	
Visual Impairment		✓	
Hearing Impairment		✓	
Learning Disability		✓	
Neck Breather		✓	
Requires assistance with ADLs		✓	
Other relevant information:			

Date	9/6/11	Time	1925	Signature	AA

ING1727

Pt Nan

CHI:0605770352
CRN:S278537 06/05/1977
WYLES ALAN M
27 Waulker Avenue,
STIRLING
FK8 1SA

COPY

Practitioners name: R MORAN C-SCALLY
Specialty: ACUTE CARE. Grade: FY1 ST2.
Patient age: 34 Date: 09 / 06 / 2011 Time: 21 : 01 Location: CAU

PRESENTING COMPLAINT	CATASTROPHIC
BACKGROUND Including ISTORY OF PRESENTING COMPLAINT	(34) → BACKGROUND: EX. IVDU. → ON METHADONE → NOT INJECTED FOR 4 YEARS SENT TO TIA CLINIC TODAY → ? TIA IN PRISON → BLOODS TAKEN + RESULTS PHONED TO GP. → ARF + DERANGED LFT'S C/O ↓ URINE OUTPUT - PASSED URINE ONCE IN 3 DAYS. → LAST PASSED URINE THIS MORNING ALSO C/O BILAT. RENAL ANGLE PAIN + HAD RIGORS + SHIVERING TODAY STARTED ON REG. DICLOFENAC 1/12 AGO ° D+V, C/O ↓ APPETITE BUT DRINKING PLENTY ° ABDO PAIN ° DYSURIA/HAEMATURIA
Previous Medical History	☐ IHD ☑ TIA prev IX, ☐ Stroke ☐ Diabetes Mellitus ☐ MI ☐ COPD ☐ Hypertension ☐ Asthma Other: EX-IVDU - methadone. Depression

Pt Nai

CHI:0605770352
CRN:S278537 06/05/1977
WYLES,ALAN M
27 Waulker Avenue,
STIRLING

FK8 1SA

COPY

Drug History	Compliance Device: Y / N	Filled by: patient / relative/ carer / community pharmacy .....
	Self medicates at home ☐	Supervised by carers ☐
	History obtained by:	Grade: ..... Date: .....
	ECS Permission obtained by:	Date:..... On Eward ☐ E Careplan ☐
Allergies:		

Pt	POD	GP	ECS	Comm.Pharm	Other	**Drug Name and route /dose / frequency** (please include all of these)	Continue	Date Withheld	Date Stopped	Comments / Reason for change	Kardex
						methadone 72ml.					
						Citalopram 20mg – Stopped					
						Diclofenac 50mg TDS			9/6		

Any Herbal / OTC Meds:

Medicines Reconciliation carried out

By: ..... Date: .....

CHI:0605770352
CRN:S278537 06/05/1977 M
Pt Nam WYLES ALAN
27 Waulker Avenue,
STIRLING
FK8 1SA

COPY

Can All Practitioners adding to document please sign /date / time each entry

Family History

☐ IHD / MI ☐ Asthma ☐ Diabetes Mellitus
☐ Cancer ☐ Hypertension ☐ Stroke / TIA
Other:

Social History

Occupation: unemployed
Lives with: partner Support/carers
☑ Smoker (Amount per day..10..) ☐ Ex Smoker (Since.....) ☐ Never Smoked
☐ Alcohol (Units per week)..Nil.....
Normal Exercise Capacity: Indep ADLs:

Systems Review

CVS NIL

RESP COUGH, CHRONIC, NON PRODUCTIVE
° SOB / WHEEZE / HAEMOPTYSIS

GI NIL

GU

CNS NIL

Examination

Weight : ..... kg Height: ..... m BMI: .....

General

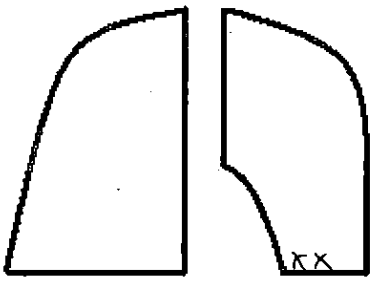
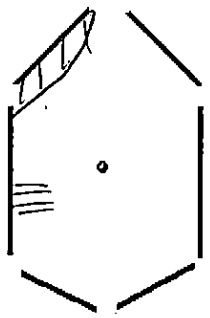
SMOKEY + CHARMING

Obs

Temp: 37.7 Heart Rate: 71. Resp Rate: 16 BP_{supine}: BP_{erect}: 144/80
SpO_2 97% (FiO_2: AIR) Anaemia Y/(N) Clubbing Y/(N)
Cyanosis Y/(N) Jaundice Y/(N) Cervical Lymphadenopathy Y/N
Blood Sugar: **MEWS SCORE :**

CHI:0605770352
Pt N CRN:S278537 06/05/1977 M
WYLES ALAN
27 Waulker Avenue,
STIRLING
FK8 1SA

COPY

CVS	JVP → ⅔ Apex Heart Sounds I+II +O Oedema NIL Neck Bruit Y / N	Peripheral Pulses
Respiratory	Trachea: Expansion: Percussion: Breath Sounds: FEW CREPS @ BASE CLEAR ⊂ COUGHING	 R L
Abdomen	 SOFT 1CM LIVER EDGE ° ASCITES NODULAR TOUCH @ RIGHT ANGLE Bowel sounds: ° EVIDENCE OF Rectal examination: CHRONIC LIVER DISEASE.	Liver: Kidneys: Spleen:
OTHER (eg. face, limbs, trunk, skin)	° RASHES	

CHI:0605770352
CRN:S278537 06/05/1977
WYLES ALAN M
27 Waulker Avenue,
STIRLING
FK8 1SA

Pt Na

COPY

NEURO

PEARL.
ALERT + ORIENTATED
MOVING 4 LIMBS EQUALLY

Cranial nerves:

Cerebellar:

Reflexes	B	T	S	K	A	Plantars	Clonus
L							
R							

CNS Exam

Limb	R arm	L arm	R leg	L leg
Tone				
Power				
Sensation				
Co-ordination				

Abbreviated Mental Test Score (AMTS)

How old are you (exact age only)?
What is your date of birth?
What place is this?
What year is it?

4

A score of 3 or less warrants further investigation

Glasgow Coma Scale

Best Eye Opening

Best Motor Response

Best Verbal Response

Score 15

X-ray / ECG Interpretation

CXR
lung fields clear RO.

AXR

ECG Interpretation
S.R. Rate 64 bpm
Regular.
(N) PR, QRS, QTc + Axis.
? Tavr III, ? Qwaves II, III.

Urinalysis

Pt Nam

CHI:0605770352
CRN:S278537 06/05/1977 M
WYLES ALAN
27 Waulker Avenue,
STIRLING
FK8 1SA

ABG 21Y.
H+ 46·2
pCO2 5·24
pO2 10·5

K+ 4·1
Na 133
lactate 0·8
HCO3 20·7

BE −4·4
pH 7·335

COPY

IMPRESSION/ DIFFERENTIAL DIAGNOSIS	1. ARF. – ? ACUTE INTERSTITIAL NEPHRITIS 2° TO NSAIDS 2. DERANGED LFT'S. → HEPATITIC PICTURE → NORMAL FEB 2009. → LIKELY 2° TO RENAL FAILURE
INITIAL MANAGEMENT PLAN	1- ADMIT MEDICINE 2 STOP DICLOFENAC 3 IV FLUIDS 4. CATHETERISE & 1° VOLUMES → PT REFUSED – MEASURE UO & BOTTLES 5. RENAL USS 6. LIVER SCREEN – HEP SEROLOGY – LIVER USS. 7. SEPTIC SCREEN – BLOOD + URINE CULTURES 8. VENOUS BLOODS 9. RECHECK. U+E'S MANANE

Investigations

PLEASE TICK BOX IF REQUESTED

☑ FBC	☑ CRP
☐ ESR	☐ ABG
☑ Clotting Factors	☑ Blood Cultures
☑ U&Es	☐ CXR
☑ LFTs	☑ ECG
☑ Glucose	☐ HCG ☐ Positive ☐ Negative
☑ Calcium mg	☐ Urinalysis
☐ Ohr Troponin Date/Time.....	☐ .....
☐ 12 hr Troponin Date/Time.....	☐ .....

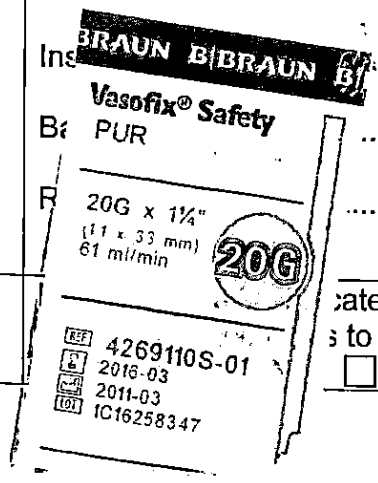
IV Cannula Insertion/ Removal Record

Ward .....

Ins.....

Ba.....Ir

R.....



DVT Prophylaxis

cated ☐ Y

s to this? [

☐ No

PVC Insertion Bundle and Removal Record

Is PVC clinically indicated for this patient (YES,) why:

IV Fluids		Blood Transfusion	
IV Drugs	✓	Diagnostics	
Predicted clinical need		Please tick	

The patients skin is decontaminated and allowed to dry (YES) / NO

Hand hygiene & gloves donned prior to insertion (YES) / NO

Aseptic Non Touch Technique is used to insert PVC (YES) / NO

If not possible, use either STERILE GLOVES or MINI CHLORAPREP

Sterile dressing & sticker (date & time) applied after insertion (YES) / NO

Ward/Department CAU.

Inserted by: Uhela. Date&Time: 9/6/11

Size/Colour: Pink Batch No:

Insertion Site: (L) hand.

Removed by: Date&Time:

Pt CHI:0605770352
CRN:S278537 06/05/1977 M
WYLES ALAN
27 Waulker Avenue,
STIRLING
FK8 1SA

COPY

Resu

Following discussion with patient/family please indicate

PLEASE COMPLETE & ATTACH NHS FV DNAR FORM

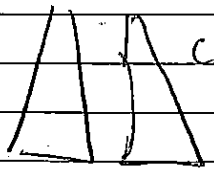
Practitioner Signature Date/Time	PRINT NAME : Scrum	SIGNATURE:
	BLEEP NO: 295	
	DATE / TIME:	

Family Dialogue	

Date/Time	Clinical Notes – MEDICAL/SURGICAL MIDDLE GRADE REVIEW
9/6/11	Patient admitted with a 3/7 history of lower back pain, lethargy, nausea/vomiting and poor appetite.
	Gp checked his bloods and found his ut E's to be deranged.
	urea 15.8 creat 403, ALT 273 AST 811
	pain in back 7/10 to severity at present.
	Routine Bloods + cultures ☐
	ECG ☐
	Acute medical review
21/6/11	- SS Medics to assess
	to IV fluids
	Strict fluid balance
	to Renal ucs
	Liver ucs
	to ABG ✓
	Awaiting bed allocation
	refusing catheter at this time
	- Passed 3rd urine
	with Blood ++++ Leuc +
	Protein ++ MSU sent

CHI:0605770352
CRN:S278537 06/05/1977 M
Pt Nam WYLES,ALAN,
27 Waulker Avenue,
STIRLING
FK8 1SA

COPY

Date/Time	Clinical Notes – CONSULTANT REVIEW *(Please finish each note with Practitioner Name/Job Title)*
10/6/11	- Only passed 1Cm/s last 1° volume
03°°	Medics aware fr 2x 500cm/s
	& Saline Start bags
	Second bag in progress at this
	time
	Feeling ↑ nausea
	Vitals stable -
	1° volume at 03°° 8/10
	D/W informed
	fr transfer HDU
Size 14	Catheter inserted Aseptically 10cm in bella
10/6/11	ST2 R/V.
0300	RENAL OUTPUT - 18ml/s IN 2 HOURS
	DESPITE 2 LITRES FLUID
	REMAINS HAEMODYNAMICALLY STABLE.
	BP 150/70.
	 CHEST CLEAR JVP NOT ELEVATED
	D/W ON-CALL RENAL SPR.
	→ LIKELY ACUTED INTERSTITIAL NEPHRITIS
	ADVISED: CONTINUE IV FLUIDS 2°
	CONTINUE TO MONITOR UO
	ATTENUATE SEPSIS
	RENAL USS AWAIT
	THEY WILL LIKELY TRANSFER
	BUT NO BEDS AT MOMENT
	→ FOR CLINICAL FLUID STATUS MONITORING
	→ TRANSFER TO HDU FOR CVP
	MONITORING IF BECOMES
	HAEMODYNAMICALLY UNSTABLE
	OR SIGNS OF OVERLOAD

9

EDAW

Pt Name / CHI / Addressograph

NHS Forth Valley

COPY

Senior Clinician Patient Management Plan

EDD:
<48 hrs ☐ >48 hrs ☐

Consultant

Please sign and date at end of each entry

Date Time	Problem No	Clinical Problem List / Background	Recommendations/ Desired Outcomes and Actions	Complete Sign & date

Pt Name / CHI / Addressograph

NHS
Forth Valley

COPY

Senior Clinician Patient Management Plan

EDD:
<48 hrs ☐ >48 hrs ☐

Consultant

Please sign and date at end of each entry

Date Time	Problem No	Clinical Problem List / Background	Recommendations/ Desired Outcomes and Actions	Complete Sign & date

CHI:0605770352
CRN:S278537 06/05/1977
WYLES ALAN M
27 Waulker Avenue,
STIRLING
FK8 1SA

- Old Blood Results 2009 - Photocopy
- Photocopy All Notes | Kardex | Obs Charts
- For TIF to ARD.

COPY

Date / Time	Clinical Notes (Please finish each note with Practitioner Name / Job Title)
10/6/11	- IC values as charted
06[00]	IV fluids agency 2°
	? for transfer to CKI Renal
	if bed becomes available
	Vitals stable
	States feels need to pass water
	not able to do so due to
	catheter
	Dr's will review 2 hourly
	unless ↑ unstable
	Fr vpt bloods in am ✓
0745	FOC Team called re IV fluids. Further
	2 hrly N. Saline prescribed.
	Awaiting medical review. UMcBride
10/6/11	c/o loin pain.
9am	7/10.
	Analgesia complicated by renal function.
	fentanyl patch is available
	∴ use this.
	Monitor resps.
	Clarke
	574 245
10/6/11	N/W Dr Catherine McClean. Renal on-call
9:40am	Western Infirmary Glasgow 0141 211 2000
	Needs urgent → amylase ✓ page @ 4603
	CBV ✓ 07747 777 865
	HIV ✓
	US scan - ✓
	CK ✓ added on ✓
	Urine for PCR ✓
	Called then as soon as US results known.
	245

CHI:0605770352
CRN:S278537 06/05/1977
WYLES ALAN M
27 Waulker Avenue,
STIRLING
FK8 1SA

Pt

COPY

Date / Time	Clinical Notes (Please finish each note with Practitioner Name / Job Title)
1000	Fentanyl 12 mcg patch in situ. CSU obtained for Protein & Creatinine Observations stable Awaiting ultrasound. LMCBride
10/06/11	Call from MICRO Hep C Ag -ive Hep A IgM -ive Hep C virus -ive HIV -ive
10/6/11	→ Urine protein, creatine ratio was sent in- boric acid container → needs plain container. THOMPS RN
1300	CSU re-sent in plain container. LMCB Attended for USS
100611	M/H machoss : Locum Consultant: BJp 087
1400	Above Hx Noted: • 38 y.o. IVDU (on methadone) • TIA in Prison (at clinic yesterday → bloods deranged) • Urea (16·7) • AST (811) Creat (854) • ALT (273) • Recent Diclofenac Use - No Hx of Long Lre / Immobility — 2CK.

CHI:0605770352
CRN:S278537 06/05/1977 M
P WYLES ALAN
27 Waulker Avenue,
STIRLING
FK8 1SA

COPY

Date / Time	Clinical Notes (Please finish each note with Practitioner Name / Job Title)
	Examination: ↑ Oedema ↑ Periph Oedema ? Facial Swelling
	↓ Urine OP 10-20 mls/hr
	(Renal Function Worse Today)
	· Sats 97% on Not obviously fluid overloaded
	· BP: 140/70
	· P-62
	RS: ↓ Chest Clear
	CVS: ↑JJ↑O JVP° °AS °DVT
	Abdo: Obese Soft Non Tender
	? Interstitial nephritis
	Dmp ① Acute Renal Failure - ? Cause ?
	② Convalescence Currently. ③ Hepatitis ? Cause
	(P) ① T/F AKI WBA D
Diurnal VS.	② Probably needs Renal Bx D
	③ Chase outstanding → amylase
	→ HBV
	→ CXR
	→ Urine PCR ↓
16/6/10	D/W AKI → Bed available today for T/F.
	# Must have old Utes from 2009 #
	* Must Photocopy All Current Episode Paperwork for T/F *

Renal Consultant
B/p 031

Pt Name / CHI / Addressograph

COPY

Date / Time	Clinical Notes *(Please finish each note with Practitioner Name / Job Title)*
	For transfer to GRI this pm. Will phone when location of bed known.
	Pr independent round bed area.
	Hourly urine volumes continue as charted
	IV fluids now 6hrly.
	Pt asking about methadone dose — Advised that is being withheld at moment due to renal function. LMcBride
2000	Glasgow Western contacted re transfer. Bed available in Level 7 West but they are now expecting pr. mane. Renal Unit will phone us back once decision made LMcBride
10/6/11	D/w [redacted] → To transfer to level 7 west @ Renal Unit renal unit
	H Baluch 857
2015	For transfer to Glasgow. Transport arranged. LMcBride
2130	Pr feeling nauseous cyclizine 50mgs IV given — AABoardridge
2330	Pr transfer to Western Glasgow — MBoardridge

Pt Nam

CHI:0605770352
CRN:S278537 06/05/1977 M
WYLES ALAN
27 Waulker Avenue,
STIRLING
FK8 1SA

COPY

Nursing Intervention

Pressure Area Assessment

Pressure Areas Intact Yes ☑ No ☐

Absolute Risk (Score 2	**Relative Risk (Score 1)**
Unconsciousness	Age >70yrs
Dehydration	Restricted mobility
Paralysis	Incontinence
	Pronounced Emaciation
	Redness over bony prominences

Score (Circle) Low 0 Medium 1 High 2

Intervention .....

Pain Score	0	1	2	3	4	5	6	7	8	9	10

Analgesia Given Yes ☑ No ☐

Effect of analgesia	0	1	2	3	4	5	6	7	8	9	10

Belongings ☑ With patient ☐ Family ☐ Safe ☐ Bagged ☐ Labeled

Own Medication ☑ Yes ☐ No

Name band ☑ Yes ☐ No

Patient Fasted Food ☐ Yes ☑ No

Food Time 5/6/11 1pm. **Drink** Time .....

Relatives with Patient ☑ Yes ☐ No ☐ Informed

Named Nurse:

..... Time/Date: .....

Signature: .....

NHS
Forth Valley

Forth Valley Acute Hospitals NHS Trust
Stirling Royal Infirmary
Livilands, Stirling FK8 2AU

23522
A&E No.

COPY

Consultant: Mrs U. Mackintosh

PATIENT	SURNAME Wyles	CRN	DATE 7.9.02	TIME OF ARRIVAL 17.00
	FORENAME Allan	SEX m / MARITAL STATUS S	DATE OF INCIDENT	TIME OF INCIDENT
	MAIDEN NAME	DOB 6.5.77	LOCATION OF INCIDENT Fall - Bicycle	
	ADDRESS 103 Raploch Rd Stirling	AGE 25	COMPLAINT (L) Shoulder Inj	
	POST CODE TEL.	OCCUPATION/SCHOOL —	GP NAME Dr Lyle	
T	TEMPORARY ADDRESS TEL.	PREVIOUS ATTENDANCE (Y) / N	ADDRESS Park Ave	
		RTA Y / (N)		
NOK	NAME ADDRESS Victoria Phillips TEL. NOTIFIED N/Y RELATIONSHIP Partner	REFERRED BY		
		ARRIVAL: AMBULANCE Y / (N)		

TO BE COMPLETED BY DOCTOR AFTER SEEING PATIENT

Dear Doctor, Lyle

the above named patient attended the Accident & Emergency Department today 7/9/2

DIAGNOSIS Compound # (L) clavicle, # (L) scapula

(X RAY) / ECG / INVESTIGATIONS SHOW (L) shoulder
=) as above

TREATMENT GIVEN IV analgesia & antiemetic
Refer Orthopaedics

DRUGS

TETANUS PROPHYLAXIS COVERED / HAS BEEN GIVEN — TT COURSE ____ TT BOOSTER ____ IMMUNOGLOBULIN ____

OUTCOME

ADMITTED TO 28 — OP CLINIC

DISCHARGED TO — TIME OF DISCHARGE

SIGNATURE

STIRLING ROYAL INFIRMARY

ACCIDENT & EMERGENCY NURSING ASSESSMENT FORM PAGE 1

COPY

NAME Allan Wyles D.O.B. 6.5.77 ADDRESS 100d Raploch Rd. Raploch. TEL. NO. 450150	PRESENTING COMPLAINT Fall.	DATE 7/9/02
NEXT OF KIN: NAME Victoria Philips (Girlfriend) ADDRESS S/A. TEL. NO. Same RELATIONSHIP	ALLERGIES Penicillan	TIME 5-10pm

Church Rd Lane 466 716 078 16 341547

OBSERVATIONS

TEMP 36/7	PULSE 72	RESP 18	BP 122/64	BM	O2 SAT 93% on Air
X-RAY ✓ Portable	ECG	BLOODS	IV ACCESS ✓	RISK ASSESSMENT	INTERVENTION

ABSOLUTE RISK (Score 2)	RELATIVE RISK (Score 1)
Unconsciousness Dehydration Paralysis	Age over 70 Restricted Mobility Incontinence Pronounced Emaciation Redness over bony prominences

ASSESSMENT & TREATMENT

Patient fell off his BMX bike. Complained of severe pain in (L) shoulder.

Noted (+= obvious deformity of (L) clavicle

c/A Pain ++ Pain relieving

Tetanus Refreshed and diazepam - used to Smoke Menthol. Stopped Wheezing

DRUGS GIVEN IN ACCIDENT & EMERGENCY DEPARTMENT

COPY

DRUG	DOSE	ROUTE	TIME	SIGNATURE
Morphine	10mg	IV	17:05	Dr [illegible]
Morphine		IV	17:30	Dr [illegible]
Cefuroxime	1.5gm	IV	17:35	Dr Mallikarjun
ADT	0.5ml	IM/SC	17:35	[illegible]
Cyclizine	50mg	IV	17:15	Dr Mallikarjun

RELATIVES		CLOTHING		DENTURES	
		Top Coat RT pocket			
WITH PATIENT	☐	WITH PATIENT	☑	N/A	☑
AWARE	☐	WITH RELATIVE	☐	TOP	☐
UNABLE TO CONTACT	☐	OTHER: SPECIFY	☐	BOTTOM	☐
				WITH PATIENT: Y/N	

DISCHARGE INFORMATION

REVIEW	LETTER (INSTRUCTION)	TRANSPORT ARRANGEMENTS
GP _____	GP _____	CAR _____ BY PATIENT _____
CLINIC _____	PATIENT _____	SAS _____ BY RELATIVE _____
A/E _____	OTHER _____	OTHER ___ BY STAFF _____
OTHER _____	(SPECIFY) _____	N/A/ _____
(SPECIFY) _____		
		COMMENTS _____
DISCHARGE (specify)	**AMBULANCE ORDERED**	**VALUABLES** 2 Rings Mobile Phone
WARD _____	BY _____	WITH PATIENT _____
		IN A & E SAFE _____
HOME _____	TIME _____	
		RECEIPT NO. _____
OTHER _____		SIGNATURE _____

NAMED NURSE: [illegible]

ASSOCIATE NURSE: _____

Patient's Name Allan Wyles A&E No. 23522

TEMP ____ BP ____ PULSE ____ RESPS ____ O_2 SATURATION ____

COPY

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS)

DRUG	DOSE	METHOD OF ADMINISTRATION	TIME OR ADMINISTRATION	SIGNATURE	GIVEN BY
ADT	0.5 mL	sc im	1740		
Morphine	10 mg 2mg 3 mg 2 mg	IV IV IV IV	1718 1737 1730 1742 1732		
Cyclizine	50 mg	IV	1718		
Cefuroxime	1.5 g	IV	1736		

SEEN BY (PRINT) KEEN TIME 1715

DATE

Fall off BMX.
Banged head & hurt (L) shoulder
& KB.

O/E GCS 15
PERRLA FROEM
Fully orientated
In considerable pain

Obvious # (L) clavicle - skin tented
Skin wound not over # but v. suspicious.

IV access
- analgesia given

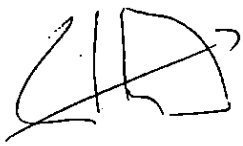
PMH - Used to smoke Heroin - not for 1yr - denies IVDA.
DH - Methadone 40 mL
Diazepam 30 mg
Allergic to Penicillin
(claims makes his back / Kidneys painful).

Nursing Notes Otherwise well
Ø recent illness

Flow Chart Last ate 1300.

Discriminator

Triage Category



Clear
Good AE - breath sounds to apices.
Sats 100

No other apparent injuries

XR (L) shoulder
⇒
Refer Orthopaedics

Nurse's Signature ____

STIRLING ROYAL INFIRMARY
NHS TRUST

TO BE COMPLETED BY DOCTOR BOOOKING IN CASE

COPY

DATE & TIME OF BOOKING:- 7/9/02 SIGNATURE [signature] 18?
(of Doctor booking Emergency)

ANAESTHETIST INFORMED - _____ (Fill in name of Anaesthetist)
YES _____ NO ~~—~~ for LA

PATIENTS NAME ALLAN WYLES
ADDRESS
(Label can be used)

Unit Number AHE 23522 WARD 28
DOB. 6/5/77

Please tick appropriate criteria.
1 _____ EMERGENCY - Life saving operation - Required within 1 Hr
2 _____ URGENT - Operation ASAP after resuscitation - Required within 6 Hrs
3 _____ PROMPT - Early operation required- Within 24 Hrs
(See note below)

Consultant Surgeon: Mr D Ross

Operating Surgeon: Mr R Forsey

Diagnosis: Compound # (L) Clavicle

Proposed Operation: Irrigation / Debridement of wound

Specialised equipment required: _____

Estimated length of time: 20 mins

Preferred Date & Time: 7/9/02

DATE & TIME GIVEN BY THEATRE STAFF FOR CASE _____

TO BE COMPLETED BY THEATRE PERSONNEL

ANAESTHETIC START TIME _____ DATE _____

OPERATION:- POSTPONED ☐ CANCELLED ☐
REASON: _____

Comments.

NOTE - CRITERIA E.G. :-
1 Ruptured Aneurysm or life threatening of Major Trauma.
2 Operation required to save limb or organ or to prevent / treat major sepsis or haemorrhage.
3 Intestinal obstruction without perforation, Adult appendicitis, many fractures include // NOF.

CONSENT FOR OPERATION

Write - imprint or Attach Label

Surname WYLES Hosp No

Forenames ALAN Sex

D.O.B.

COPY

Address

Ward/Dept

CONSENT BY PATIENT, PARENT OR LEGAL GUARDIAN

I, ...

of .....

hereby consent to

undergo the operation of*

or

the submission of my child/ward to undergo the operation of*

Irrigation | Debridement of Compound Fracture LEFT Clavicle

The nature and purpose of which have been explained to me by

Dr/Mr* Joseph

I also consent to such additional or alternative operative measures as may be found necessary during the course of the above-mentioned procedure and to the administration of a general, local or other anaesthetic for this purpose.

No assurance has been given to me that the operation will be performed by any particular surgeon.

Date 7/9/02 Signed Alan Wyles

(Patient/Parent/Legal Guardian)*

I confirm that I have explained the nature and purpose of this operation to the Patient/Parent/Legal Guardian*

Date 7/9/02 Signed Robert Joseph

(Medical/Dental* Practitioner)

*Delete as appropriate

All alterations to this form should be countersigned by the patient or the patients representative.

OPERATION RECORD

UNIT	DATE 7/9/02	UNIT NO.	D.O.B. 6/5/77
CONSULTANT MR Ross		NAME ALAN WYLES	

COPY

SURGEON MR R JOSEPH C/SR/R/SHO/HO

ASSISTANT ..... C/SR/R/SHO/HO

ANAESTHETIST ~~LA~~ C/SR/R/SHO

ANAESTHETIC LA

ADMISSION ELECTIVE/EMERGENCY

OPERATION ELECTIVE/EMERGENCY

OPERATION IRRIGATION / DEBRIDEMENT BONE
COMPOUND FRACTURE LEFT CLAVICLE

CODING		

OPERATIVE DIAGNOSIS .....

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

OPERATIVE FINDINGS AND TECHNIQUES

- ~4 ml LA used at wound site - 1% lignocaine c 1:250 000 Adrenaline
- Wound extended minimally in either direction along line of clavicle
- Irrigation c Normal Saline + Betadine
- Sharp end of medial fragment of # blunted c bone nibblers
- Closure c 3/0 Ethilon interrupted - entire wound closed ; Mepore dressing
- (L) Broad arm sling post op

Post Op

- Cefuroxime 750 mg IV q 8h x 24 hrs
- Observe closely
- Maintain (L) Broad Arm Sling

Robert Joseph

Harlow Healthcare 0191-455 4266 9048

Forth Valley Royal Hospital Assessment Document

NHS Forth Valley

Date of arrival 28/5/25 Time of arrival 2030

Source of referral: GP (ED) Other

GP practice:

CHI ..... Age 48

Nar CHI NO: 0605770352 0[redacted]/05/97
CRN: M
Alan WYLES
2 GORDON SQUARE

COPY

Adc STIRLING
FK8 1FN

Consent for ECS | Yes | | No |

BM | | NEWS score | |

Tel 07835703594

NOK 1 Name.....

Relationship..... ~~Daughter~~

Address..... No NOK copy Alan

.....

Tel.....

NOK 2.....

S Presenting complaint (R) sided abdo pain

B Background

A	NEWS 5 or more or other clinical concern	Yes		No
	T° 38°C or more within 14 days of chemotherapy (possible neutropenic sepsis)	Yes		No
	Referred with potassium more than 6.4mmo/L or less than 2.8mmol/L	Yes		No
	Referred with diabetic ketoacidosis	Yes		No
	Reduced GCS	Yes		No
	New limb weakness, speech disturbance or numbness for less than 4.5 hours	Yes		No
	Abdominal pain: Does referral or patient give history of aortic aneurysm?	Yes		No
	Abdominal symptom in female under 55 with possibility of pregnancy	Yes		No
	NEWS 2-4	Yes		No
	New oxygen requirement (not on home oxygen)	Yes		No
	Chest pain at time of triage- Obtain ECG, Clinician to review/ sign within 10 minutes	Yes		No
	[redacted]mb weakness, speech disturbance or numbness for 4.5 hours or longer	Yes		No
	Requires assistance of 1 or more to mobilise	Yes		No
	Able to mobilise independently or using own aids/ appliances	Yes		No

R | Very urgent | | Urgent | | Non-urgent | | Ambulant

Actions					
U&E/ LFT/ CRP/ FBC/Glucose		Amylase		Cannula	
Cultures		Calcium		ECG- to be signed within 10mins	
		Group and save		Troponin 0 hours / 12 hours	

Allergies and alerts

Penicillin

Name J ROSAN Signature Date 28/5/25 Time

Assessment

Practitioners Name ALICE B-S.	Date 28/5/25.	CHI NO: 0605770352 06/05/1977 CRN: Alan WYLES 2 GORDON SQUARE STIRLING FK8 1FN
Grade F41.	Time commenced 21:20	
GMC/ NMC 8062543	Location SAU.	

COPY

Presenting Complaint: See Separate Note in notes- seen by Mark McInnes (CST4) in ED- documented by Dasha F41.

Copied: RIF pain, vomiting.
Combo diarrhoea + constipation.
Pain feels like pressure.

Systemic Enquiry: no previous operations.

5.8 F — **Height:**
13 stone — **Weight:**
BMI:

Usual level of activity (please circle)

Bedbound | Dependent for personal care | Requires minimal assistance with ADLs | Slowed. Assistance with heavier household tasks | "Slowed-up" but not requiring assistance | No exercise beyond walking. | Occasional exercise | Regular exercise

Past medical, surgical and anaesthetic history

N	X
Angina	X
Hypertension	X
COPD	X
Stroke /TIA	X
Diabetes	X
Implement diabetes bundle	

prev Renal failure
prev IVDU

Family History

Travel History

Social History

Smoking: Never Ex smoker (since_____)
Current Vap /day Pack years_____

Alcohol: 2 beers some days / Units / week

Occupation Unemployed.

Driving license yes/ no

Lives With Alone + Dog

Support/ Carers

PACKAGE OF CARE YES / (NO) (please circle)

IF YES CARE PROVIDER_____

NUMBER OF TIMES PER DAY 1/ 2/ 3/ 4 (please circle)

Ind @ ADL

Medicines Reconciliation At least 2 recent sources, one of which must be patient or carer

CHI NO: 0605770352 06/05/1977
CRN: M
Alan WYLES
2 GORDON SQUARE
STIRLING
FK8 1FN

COPY
Verbal

☑ Patient *(e.g. verbal recollection or handwritten note)* ☐ Relative/Carer ☑ Electronic patient record ECS (issued in last 6 months?) IDL (within last month?)
☐ Patient's own medicines ☐ Nursing home prescription ☐ Community pharmacy ☐ Other PORTAL

No Known Drug Allergies ☐

Drug / Substance	Reaction/ Side effect	Drug / Substance	Reaction/ Side effect
penicillin ✓			

ADMISSION MEDICATON 3P 01786 451375 Tesco St. - 01312891429

Pharm	Dose	Frequency	Withhold	Stop	Comment	Kardex
Tesco Stirling - Pharmacy. ✓					~~Beta Elsa~~	
buprenorphine (SL) (10mg)	8mg	OD	✓		until checked by day team. ✓	✓
diazepam. (28mg)	28mg	OD ✓				✓
Naloxone 1mg/ml						
					Twice weekly Pick up. Mon & Thurs.	
					Pt = 10mg OD.	
Ph CP on D/C.					last collected 26 5 25.	

RECENT ANTIBIOTICS/RECENTLY DISCONTINUED MEDICATION (within 6 months)

NON-PRESCRIPTION MEDICATIONS AND HERBAL MEDICATIONS

NO

Are you satisfied this medication history is complete and accurate? Yes ☑ No ☐

If 'No' please detail what further action is necessary (e.g. contact GP, carer or access ECS)

M Swallow Pharmtech F1072 30 5 25.

Medicine reconciliation completed by? Name: Signature:
Date: Time:

Medicine reconciliation verified by? Name: Signature:
Date: Time:

Examination

Diabetic patients → foot examination and diabetes bundle
GI Bleeding → PR examination
Age >65 or confusion → AMT
If cognition or alertness impaired → consider delirium

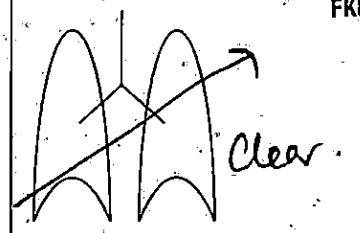
CHI NO: 0605770352 06/05/1977 M
CRN:
Alan WYLES
2 GORDON SQUARE
STIRLING
FK8 1FN

COPY

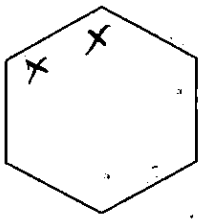
Cardiovascular

HS 1+11+0.
Peripherally warm.
CRT < 2sec.
No peripheral oedema.

Respiratory



Abdominal



Tender RUQ + epigastrium.
✗ peritonism
✗ guarding

Bowel sounds:

PR:

AMT (If <4/4, complete AMT10)

1. Age
2. DOB
3. Year
4. Location

/4

Ask patient to remember address: "42 West Street"

5. Time to nearest hour
6. Current monarch
7. Date Of WW2
8. Count 20→1
9. Identify 2 people
10. Recall address

/10

Neurological (remember speech, visual assessment, balance, gait)
Cranial nerves:

	R arm			L arm			R leg			L leg		
Tone												
Power												
Sensation												
Coordination												
Reflexes	B	T	S	B	T	S	K	A	Plantar	K	A	Plantar

Other

Interpretation of

CHI NO: 0605770352 06/05/1977 M
CRN:
Alan WYLES
2 GORDON SQUARE
STIRLING
FK8 1FN

CG

CXR

Urine HCG

Urinalysis

Leucocytes	
Nitrites	
Glucose	
Ketones	
Blood	
Protein	

Siemens
Clinitek Status®
Serial Number:
Patient:
Multistix® 10 SG
Test date 05-2E
Time
Operator
Test number Not En
Color Not En
Clarity
GLU Negative
BIL Negative
KET Negative
SG 1.015
BLO Trace-Intact
pH 6.0
PRO Negative
URO 0.2 E.U./dL
NIT Negative
LEU Negative

g

mments

Differential diagnosis

CHI NO: 0605770352 06/05/1977
CRN: M
Alan WYLES
2 GORDON SQUARE
STIRLING
FK8 1FN

COPY

? gallstones.

Management plan

US abdo in AM
analgesia.
day team to confirm buprenorphine/meds w/ pt own pharmacy please.
SAU protocol.

Additional investigations required (e.g. cultures) Please initial and date when sent

Venous thromboembolism (VTE) risk assessment

Medical patient expected to be mobilising as normal within 2 days		Proceed to VTE risk **actions**
Medical patient with reduced mobility for ≥2 days OR Surgical patient		Assess **thrombosis and bleeding risk factors**

rombosis risk factors. ANY thrombosis risk factor(s) should prompt VTE prophylaxis measures unless contraindicated → Assess bleeding risk.

- ☐ Mobility reduced for >2 days
- ☐ Age >60
- ☐ Dehydration
- ☐ Obesity BMI>30 kg/ m^2
- ☐ Significant medical comorbidity (e.g. cardiac, respiratory, endocrine, inflammatory, infectious conditions)
- ☐ Active cancer or cancer treatment
- ☐ Thrombophilia
- ☐ Personal history or first degree relative with history of VTE
- ☐ Use of hormone replacement therapy or oestrogen containing contraceptive
- ☐ Pregnancy or <6/52 post-partum
- ☐ Acute surgical admission with inflammatory or intra-abdominal condition
- ☐ Surgery with significant reduction in mobility
- ☐ Critical care admission
- ☐ Knee or hip replacement
- ☐ Hip facture
- ☐ Total anaesthetic+ surgical time >90mins
- ☐ Pelvic or lower-limb surgery with anaesthetic+ surgical time >60mins
- ☐ Varicose veins with phlebitis

Bleeding risk factors. Consider whether sufficient to preclude pharmacological prophylaxis

- ☐ Active bleeding
- ☐ Acquired bleeding disorder (e.g. acute liver failure)
- ☐ Current use of therapeutic anticoagulation (e.g. warfarin, rivaroxaban, dabigatran)
- ☐ Acute stroke
- ☐ Thrombocytopenia (<75x10^9/L)
- ☐ Uncontrolled hypertension (>230/120mmHg)
- ☐ Untreated inherited bleeding disorder
- ☐ Neurosurgery, spinal surgery or eye surgery
- ☐ Other procedure with high bleeding risk
- ☐ Lumbar puncture, epidural or spinal anaesthesia expected within the next 12 hours
- ☐ Lumbar puncture, epidural or spinal anaesthesia within the previous 4 hours

VTE risk actions

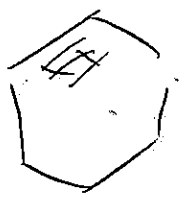
Information provided	LMWH	Antiembolism stockings
Provide if admission is anticipated Yes/ No	(Yes) No/ Contraindicated	Consider if thrombosis risk factors present and bleeding risk factors preclude LMWH Contraindicated in peripheral neuropathy, PVD, ulceration, cellulitis, gross oedema Yes/ No/ Contraindicated

Name ALICE BUCHANAN-SMITH Signature Date 28/5/21 Time complete 22:00

Consultant Ward Round

Patient details

COPY



ECG

CXR/Imaging

Results

Consultant Ward Round

Patient details

COPY

Diagnoses and significant comorbidities	Plan

Checklist		Estimated LoS <24h 24-48h >48h
Medicine reconciliation		Transfer of Care to:
VTE assessment		Outstanding criteria for ward transfer/discharge (delete as appropriate):
S_pO_2 target prescribed		
Fasting	Yes / No	

Name Signature Date Time

Resuscitation/ Escalation of care/ Anticipatory Care Planning / Advance Directives

Documentation of Discussion with Patient or Family

Treatment options that may help and patient would wish considered (and in what circumstances):-

Treatment options that may not help or patient would not wish:-

Discussed with patient/family: Y /N/Unable Documentation (circle all that apply): DNACPR ReSPECT AWI

Name Signature Date Time

Date and Time	Daily MDT and Nursing update

Consent (care planning) Yes ☐
Name band Yes ☐
NOK details obtained Yes ☐
Vital Signs Yes ☐
Own medication Yes ☐ No ☐
Dentures Yes ☐ No ☐
Glasses Yes ☐ No ☐
Hearing aids Yes ☐ No ☐

Alan WYLES
2 GORDON SQUARE

STIRLING
STIRLINGSHIRE
FK8 1FN

COPY

28/5/25 2030 Allan arrived from ED with abdo pain - Routine bloods done in ED Independent around bed space Analgesia + Anti-emetic given in ED (14) for review
S/N J ROSAN /

29/5/25 0300 settled since admission pain settled after analgesia Independent mobilising slept reasonable well Fe u/s in the morn
S/N J ROSAN

29.05.25. :53. Mama Romanyie PH1 #1657. MW Surrey Tesco pharmacy.
- confirmed Allan taken diazepam 2mg OD and buprenorphine sublingual tablets 10mg OD.
- unit collected on Monday 26.05.25.

29/5/25 1452 Pt alert & orientated. Cannula inserted pre US Scan, US showed ? GB perf. CT scan ordered to confirm. Pt ED. post US Scan as per nurses in charge. Meds as per Homa. EWS 0. Ind with AMU's. IVABx given. AW (CTAP OVERNIGHT)

Date and Time	Daily MDT and Nursing update COPY
29/5/25	CTAP booked for 15:40. PVeite SIN
1500	
Nursing 29/5/25 1730	Arrived to BIU @ 17.15 from SAU. Obs Charted, news ① 95% spo2 RA buzzer to hand fasting until CT report results IV cannc running from SAU. c/o pain. analgesia given independent. no acute concerns identified

Date and Time	Daily MDT and Nursing update	COPY

COPY

Date and Time	Daily MDT and Nursing update

Please tick appropriate box

CLINICAL NOTES ☐

NURSING NOTES ☐

PROGRESS NOTES ☐

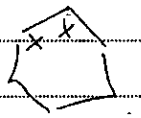
Consultant

Write - imprint or Attach Label

S
F CHI NO: 0605770352 06/05/1977
C CRN: M
A Alan WYLES
2 GORDON SQUARE
STIRLING
FK8 1FN

Hospital No.

COPY

Date and Time	
28.05.25.	Ward r/v Mr McCann (STR) / surgical reg. on call.
18:36.	• Pt complains of MF pain, vomiting
	• combination of diarrhoea + constipation
	• Pain feels like pressure
	• No prev. operations.
	• Allergic to penicillin
	• Vapes.
	• No recent xs alcohol intake, no illicit drug use.
	O/E:  Tender RUQ + epigastrium
	ø peritonism ø. guarding
	ø palpable mass / liver edge.
	Imp: ? gallstones vs LRTI
	Plan: ① CXR TO r/v. If (N) admit.
	② US abdo.
	③ Analgesia
	④ ETD
18:44.	CXR (N). Admit to surgery.
	US in AM.

B11 Daily Nursing Patient Update

Date: 30/5/25

COPY

Patient Label

CHI NO: 0605770352 06/05/1977 M
CRN:
Alan WYLES
2 GORDON SQUARE
STIRLING
FK8 1FN

Age: 48.	Post op days: /
Diagnosis: Gallstones	
PDD: /	
Named Nurse	Night Shift: Julia
	Day Shift: Sophie
Consultant	Mr Wadawan

Fluid Balance	
In:	
Out:	
Balance:	
Cummulative Balance:	

Night Report:

30/5/25
03:45am
Alan has been settled O/N
sleeping well,
meds given as per nepma
OBS stable as charted,
Independent on feet,
Passing urine ok,
Gent level obtained and sent,
VANC due at 04:40am.
No new issues.
oramorph increased Julia Halpin
pain +++. Staff Nurse

Safety Checklist	Tick
Ward Round Plan	
Blood Results checked	
X-ray check	
Prophylaxis	
Antibiotic Review	
Repeat Bloods tomorrow Y/N	
Fluid Balance	
Diabetic Control	
Resus Status	
Urinary Catheter	
Wound Check	
Discharge planning	

Additional Ward Round Notes:

WR Kynaston. Bloods NAD.
Impacted stone gallbladder neck.
Struggling w/ pain, intermittent
flares, first started 1/52 ago.
No prev similar episodes.

Plan ① IV access
② abx
③ Analgesia

Signature: **Position:**

B11 Daily Nursing Patient Update

Date: 30/5/25

1720

COPY

Daily Nursing Updates	Initials		Additional Charts	Initials
MUST - Dietary intake			Wound Chart	
Braden - Pressure Areas			Stoma Chart	
Falls Risk - mobility			News Chart	
PVC/Cauti/Piccline				

Combined Day Report Please sign, date and time all entries

30/5/25 1720

Alan has been very emotional and irate due to pain and problems at home.
meds as per nepma. Reviewed by 20e pain nurse.
obs charted, news 0
iv gent ~~dose~~ given @ 1230
iv vanc due @ 1800 - after level taken
~~IV route~~ oral metro given
Passing urine, no bo today
?4 input, seems like has a lot going on at home
eating & drinking, independent
no acute concerns

SN SBOLVED

Discharge Planning:		
Physio		
OT		
Dietetics		
District Nurses		

B11 Daily Nursing Patient Update

Date: 31/05/25

COPY

Patient Label

CHI NO: 0605770352 06/05/1977 M
CRN:
Alan WYLES
2 GORDON SQUARE

STIRLING
FK8 1FN

Age: 48yrs	Post op days:
Diagnosis: ? Gall stones	
PDD:	
Named Nurse	Night Shift: Asha
	Day Shift: Tara
Consultant	Mr. Wadhawan

In:	
Out:	
Balance:	
Cummulative Balance:	

31/05/25

@ 05:05 Hrs Alan had a settled night
→ Obs checked & recorded
→ Due meds accepted as per Hepma
→ Endep c ADLs; able to E&D
→ utilized PRN Oramorph; pain (+) on and off
→ Noted c PVC 22g (blue) on rt. foot; intact & patent
→ on 2nd triple therapy (Pip. Vanc, Gent & Oral Metro)
→ On Buprenorphine Sublingual tablets in mane
→ pa: Nil new Concerns @ present

S/N ASHA Sherry

Ward Round Plan	
Blood Results checked	
X-ray check	
Prophylaxis	
Antibiotic Review	
Repeat Bloods tomorrow Y/N	
Fluid Balance	
Diabetic Control	
Resus Status	
Urinary Catheter	
Wound Check	
Discharge planning	
Signature:	Position:

MR Wadhawan

Still struggles with pain
Feels slightly improved

Feels lethargic

Plan
Cont IV Abx

B11 Daily Nursing Patient Update

Date: 31/5/25

COPY

MUST - Dietary intake			Wound Chart	
Braden - Pressure Areas			Stoma Chart	
Falls Risk - mobility			News Chart	
PVC/Cauti/Piccline				

31/5/25 @ 15:00hrs: Patient has had a settled day
Medication given as per hepma
10mg of buprenorphine wafer given as prescribed
Vancomycin 1000mg given at 11:05 next due at 19:05
Gent given at 13:18 when vancomycin was completed
Requiring paracetemol, dihydrocodeine and iburprophen for pain
Prescribed 28mg diazepam in AM
Reports passing urine with no issues
Reports bowels unknown when last moved I will ask doctors to prescribe lactulose as patient has used this before and it works well
News 0 as charted
Eating and drinking good amounts with no issues
PVC in right foot flushing, no redness
Independent with ADLs and mobility
Nil else to note

Yusufu Stafford SN
TARA STAFFORD

Physio		
OT		
Dietetics		
District Nurses		

B11 Daily Nursing Patient Update

Date: 01/06/25

COPY

Patient Label	Age: 48yr.	Post op days:
CHI NO: 0605770352 06/05/1977 CRN: M Alan WYLES 2 GORDON SQUARE STIRLING FK8 1FN	Diagnosis ? Gall Stones.	
	PDD:	
	Named Nurse	Night Shift: Asha Day Shift: Jane.
	Consultant	Mr. Wadhawan.

Fluid Balance	
In:	
Out:	
Balance:	
Cummulative Balance:	

Night Report:

01/06/25

@ 06:30hrs.

→ Alan had a settled night.
→ Obs checked & recorded.
→ Due meds accepted as per Hepma.
→ Indep c AOL's; able to E&D.
→ Noted c pvc 22g (blue) on rt. foot; intact & patent
→ on Rx Vanc, Gent. & oral Metro.
→ utilized prn Oramorph.
→ for Vanc levels in mane.
→ Slept for long spells & nil issues overnight.

S/N ASHA SHERRY

Safety Checklist	Tick
Ward Round Plan	
Blood Results checked	
X-ray check	
Prophylaxis	
Antibiotic Review	
Repeat Bloods tomorrow Y/N	
Fluid Balance	
Diabetic Control	
Resus Status	
Urinary Catheter	
Wound Check	
Discharge planning	

Additional Ward Round Notes:

WR Wadhawan MEWS 0.

Hx noted

C/O migraines - nil Bloods (N)

Pain slightly improved controlled

Plan / MOST (H) ora feeding better
Plan for Clinic f/w ora discharged

Signature: **Position:**

B11 Daily Nursing Patient Update Date: 1/6/2025

COPY

Daily Nursing Updates	Initials		Additional Charts	Initials
MUST - Dietary intake			Wound Chart	
Braden - Pressure Areas			Stoma Chart	
Falls Risk - mobility			News Chart	
PVC/Cauti/Piccline				

Combined Day Report Please Sign, date and time all entries

15:37 Patient has been complaining of severe pain and migraine, he states he feels very unwell
Looks pale, no vomiting but feels nauseous anti sickness given
Not taken dihydrocodeine as it causes (buprenorphine) espranor to come out of System
Buprenorphine given as per hepma
Medication given as per hepma
News 0
Reports passing urine with no issue
Reports bowels closed since Friday, doctors asked to prescribe laxative
Independent with ADLs and mobility
Eating and drinking indepently
Nil else to note

SN
TARA STAFFORD

Discharge Planning:		
Physio		
OT		
Dietetics		
District Nurses		

B11 Daily Nursing Patient Update

Date: 02/06/25

COPY

Patient Label	Age: 48 yr.	Post op days:
CHI NO: 0605770352 06/05/1977 M CRN: Alan WYLES 2 GORDON SQUARE STIRLING FK8 1FN	Diagnosis: ? Gall Stones.	
	PDD:	
	Named Nurse: Night Shift: Asha	
	Day Shift: Vara	
	Consultant: Mr. Wadhawan.	

Night Report:

02/06/25 @ 05:00 Hrs →
→ Alan had a settled night.
→ Obs checked & recorded.
→ Due meds accepted as per Hepma.
→ Indep c AOL's; able to E&D.
→ Noted c pvc 22g (Blue) on rt. foot; ✓ intact & patent.
→ On Oral Metro & Oral Co-trimoxazole.
→ utilized prn Oramorph.
→ (H) when well & plan for clinic follow up upon discharge.
→ Nil Concerns @ present.

S/n Asha Sherry.

Fluid Balance	
In:	
Out:	
Balance:	
Cummulative Balance:	

Safety Checklist	Tick
Ward Round Plan	
Blood Results checked	
X-ray check	
Prophylaxis	
Antibiotic Review	
Repeat Bloods tomorrow Y/N	
Fluid Balance	
Diabetic Control	
Resus Status	
Urinary Catheter	
Wound Check	
Discharge planning	
Signature:	

Additional Ward Round Notes:

mr Wadhawan

Mx notes:

Still c/o pain

Bloods (N)

Plan / Medical Opinion

Position: FY2

B11 Daily Nursing Patient Update Date:

COPY

Daily Nursing Updates	Initials		Additional Charts	Initials
MUST - Dietary intake			Wound Chart	
Braden - Pressure Areas			Stoma Chart	
Falls Risk - mobility			News Chart	
PVC/Cauti/Piccline				

Combined Day Report	Please Sign, date and time all entries

Discharge Planning:		
Physio		
OT		
Dietetics		
District Nurses		

Please tick appropriate box

CLINICAL NOTES ☐

NURSING NOTES ☐

PROGRESS NOTES ☐

Consultant

Surname....
Forename(s)....
CHI....
Address....

CHI NO: 0605770352 06/0[illegible]
CRN:
Alan WYLES
2 GORDON SQUARE
STIRLING
FK8 1FN

COPY

Date and Time	
02/05/25 11:10	• Alan was sitting/lying in bed. • Looked comfortable & felt fine. • Complaining of numbness in the 4th & 5th digit of his right hand. • Ongoing for three days • No ↓ loss of power or any weakness or other change to Sensation. • Not really changed in last 3 days but mentioned that it felt slightly better after showers this morning. • Notes that he had ongoing fasciculations of the anterior lateral right thigh for the majority of the day yesterday but this has now resolved. • Alan also mentioned that when he first had his Pain associated with his giardiasis, his Anterior right abdomen and chest felt numb but has now also resolved. • Alan describes this as the Sensation he gets after getting a 'dig of the dentist'.
O/E:	Cranial nerve exam unremarkable Upper Neuro: Tone normal Power 5/5 Sensation – Light touch reduced on right of deltoid, 4th & 5th digit Compared to Left – Pin prick Sensation normal Reflexes – Difficulty eliciting bicep reflex – Other reflexes normal Continued.

Please tick appropriate box

CLINICAL NOTES ☐

NURSING NOTES ☐

PROGRESS NOTES ☐

Consultant

Write - imprint or Attach Label

Surnar
Forena CHI NO: 0605770352 06/05/1977
CHI CRN: M
Addres2 Alan WYLES
GORDON SQUARE
STIRLING
FK8 1FN

COPY

Date and Time	
	→ Lower neuro: · Tone normal exam · Power 5/5 · Sensation normal to both light touch & pinprick. · Reflexes normal. · No visible fasciculations or muscle wasting or visible on exams.
	Plan · Email to neuro for advice on next steps · ? outpatient referral.
	Medical student Lewis Bickett
2/6/25 15:25	~~ATSP on~~ noted chest pain about 14:30. ECG 93bpm T wave inversion V2, V3, V4 (not on previous ECG on portal from 5/2) More a tightness in central chest lasting a few minutes - self resolved. NEWS 0. chest ~~ERROR - wrong patient notes - apologies.~~

Please tick appropriate box

CLINICAL NOTES ☐

NURSING NOTES ☐

PROGRESS NOTES ☐

Consultant

Write - imprint or Attach Label

Surname Wyles Hospital No.

Forenames Alan Sex

CHI D. of B.

Address

COPY

Ward / Dept. B11

Date and Time	
2/6/25 14:32	Patient has been complaining of having severe pain and migraines Medication given as per hepma. Oramorph, Iburprofen, paracetemol given for pain Ondansetron given for sickness Cannot take dihydrocodeine due to this causing with drawals with buprenorphine. NEWS 0 as charted Reports bowels last moved Friday. Laxatives needed Reports passing urine with no issues Independent with ADLs and mobility. PVC in right foot dated 30/5/2025 Doctor completed neuro obs due to severe migraines Nil else to note SN TARA STAFFORD

Please tick appropriate box

CLINICAL NOTES ☐

NURSING NOTES ☐

PROGRESS NOTES ☐

Consultant

Write - imprint or Attach Label

Surname..... Hospital No.....

Forenames..... Sex.....

CHI..... D. of B.....

Address.....

.....

COPY

Ward / Dept.....

Date and Time	

Please tick appropriate box

CLINICAL NOTES ☐

NURSING NOTES ☐

PROGRESS NOTES ☐

Consultant

Label

CHI NO: 0605770352 06/0[illegible]
CRN: M
Alan WYLES
2 GORDON SQUARE

STIRLING
FK8 1FN

COPY

Date and Time	
2/6/25 15:30	Neurological exam noted by Medical Student Same findings on my examination Alan tells me he has had generalised severe headache for 2/7 with photophobia. Paraesthesia over 4m/5m fingers (palmar) has been ongoing. PEARL. Neuro exam as previously documented. Discussed with A. Mearns (FY2) CT head requested J. ANDERSON (FY1)
3/6/25 14:25	Patient has been settled Medication given as per hepma Pain relief required for pain NEWS 0 as charted Independent with ADLs Reports passing urine with no issues Bowels closed at present Eating and drinking good amounts with no issues PVC removed Patient for home today Awaiting discharge medication for last number of hours ~~pain~~ patient very unhappy with this. Contacted pharmacy a number of times Will discharge once medication arrives Worsening advise given Nil else Yours truly SN TARA STAFFORD

Please tick appropriate box

CLINICAL NOTES ☐

NURSING NOTES ☐

PROGRESS NOTES ☐

Write - imprint or Attach Label

Surname ..... Hospital No. .....

Forenames ..... Sex .....

CHI ..... D. of B. .....

Address .....

Ward / Dept .....

COPY

Consultant

Date and Time	

RX

FORTH VALLEY ACUTE HOSPITALS

B11 Daily Nursing Patient Update

Date: 03/06/25

0100 hrs

COPY

Patient Label	Age:	Post op days:
Alan WYLES 2 GORDON SQUARE STIRLING STIRLINGSHIRE FK8 1FN	Diagnosis	
	PDD:	
	Named Nurse	Night Shift: MM
		Day Shift:
Night Report:	Consultant	

Meds as per nepma
ews 0 as charted
E+D
NWB mobility
Refused oxycodone.
PRN aromagh gum as per nepma
No B/O since friday.
PVC in R foot 30/05/25
No new concerns at present.

(Staff nurse MM Dell)

Fluid Balance	
In:	
Out:	
Balance:	
Cummulative Balance:	

Safety Checklist	Tick
Ward Round Plan	
Blood Results checked	
X-ray check	
Prophylaxis	
Antibiotic Review	
Repeat Bloods tomorrow Y/N	
Fluid Balance	
Diabetic Control	
Resus Status	
Urinary Catheter	
Wound Check	
Discharge planning	

Additional Ward Round Notes:

WR Kynaston. NEWS: 0.

Δ impacted GS @ GIB neck.

~~plans~~ pt not @ bed side.

CT head. aiw report.

(P) f/u mr. Wadhawan 6/52

(H) H ↑ (W)

Orrey. CDF

Signature: **Position:**

B11 Daily Nursing Patient Update

Date: 3/6/25

COPY

Daily Nursing Updates	Initials		Additional Charts	Initials
MUST - Dietary intake			Wound Chart	
Braden - Pressure Areas			Stoma Chart	
Falls Risk - mobility			News Chart	
PVC/Cauti/Piccline				

Combined Day Report — Please sign, date and time all entries

14.25 Patient has been settled
Medication given as per hepma
Pain relief required for pain
News 0 as charted
Independent with ADLs
Reports passing urine with no issues
Bowels closed at present
Eating and drinking good amounts with no issues
PIC removed
Patient for home today
Awaiting discharge medication for last number of hours
patient very unhappy with this
contacted pharmacy a number of times
Will discharge once medication arrives
Worsening advice given
Nil other concerns

Yasmin SN

15:08 Patient would not wait any longer on medication. He left before medication. Worsening advice given
I contacted pharmacy to cancel prescription
I contacted addictions case worker on ~~104~~ 01786468282 to inform who will reinstate this from tomorrow

Yasmin SN TARA STAFFORD

TARA STAFFORD

Discharge Planning:		
Physio		
OT		
Dietetics		
District Nurses		

TIA CLINIC

PROGRESS NOTES

Surname WYLES Unit No
Forename ALAN D of B
Address 06/05/74

COPY

Date and Time	
5/5/11	Referred via letter from CADS team
	Attending for
	ECG
	BLOODS
	CAROTID
	→ BP. 150/80
	Hx: Migraine – ↓ in Spite of Vascular risk of Stroke
	5.30pm. Severe abnormalities of renal & liver functions GP informed.
	LENOX

TIA CLINIC

PROGRESS NOTES

DR WESTON

Surname
Forename
Address

CHI: 0605770352
06/05/1977
WYLES Alan
27 WAULKER AVENUE,
STIRLING
FK8 1SA

COPY

Date and Time	
9/6/11	Referred via Letter fm CADS ~~Retired~~ ~~Historian~~ ERROR Attending for CAROTIDS 12.00 — No stenosis ECG BLOODS John McCall 684
	About 3/12 ago. Having nightmare - flashing images at back of eyes nothing specific. Woke up after this & (L) face then numb, no vision from (L) eye. No headache Tingling down (L) arm & (L) leg. Looked in mirror & (L) eye looking down. Rested 5 minutes. Shaken up & worried. Tingling at back of head lasted about 1hr after.
2/52 ago	Since then nothing as severe Got pains down back (R) leg - sore to straighten Pain in lower back radiating to front Urine last 2 days dark brown

PROGRESS NOTES

Date and Time

COPY

GP at Park Avenue Medical Centre
U.P. 01786 447357
Dr. Hanley.

Sometimes when he looks at black + white print - looks green.
NO cause of having migraine in past.

Episode described overleaf - associated with a sensation of sense pressure behind (L) ear.
Feeling of impending doom
N/D.

Couple of days before.
Last bout of breath.
No episodes of faint lot.
Says he has panic attacks.

No drugs
looking for employment.

GP gave him diclofenac re back
Episodes 10/dear.

O/E looks well.
N/White.
Tone, power, coord (N).
Reflexes (N) (apart from L biceps was). Pl. L.
Carotids (N).

Wyles, Alan
ID: 0605770352
DOB 06-May-1977
40yr, Male

19-Sep-2017 10:48:14

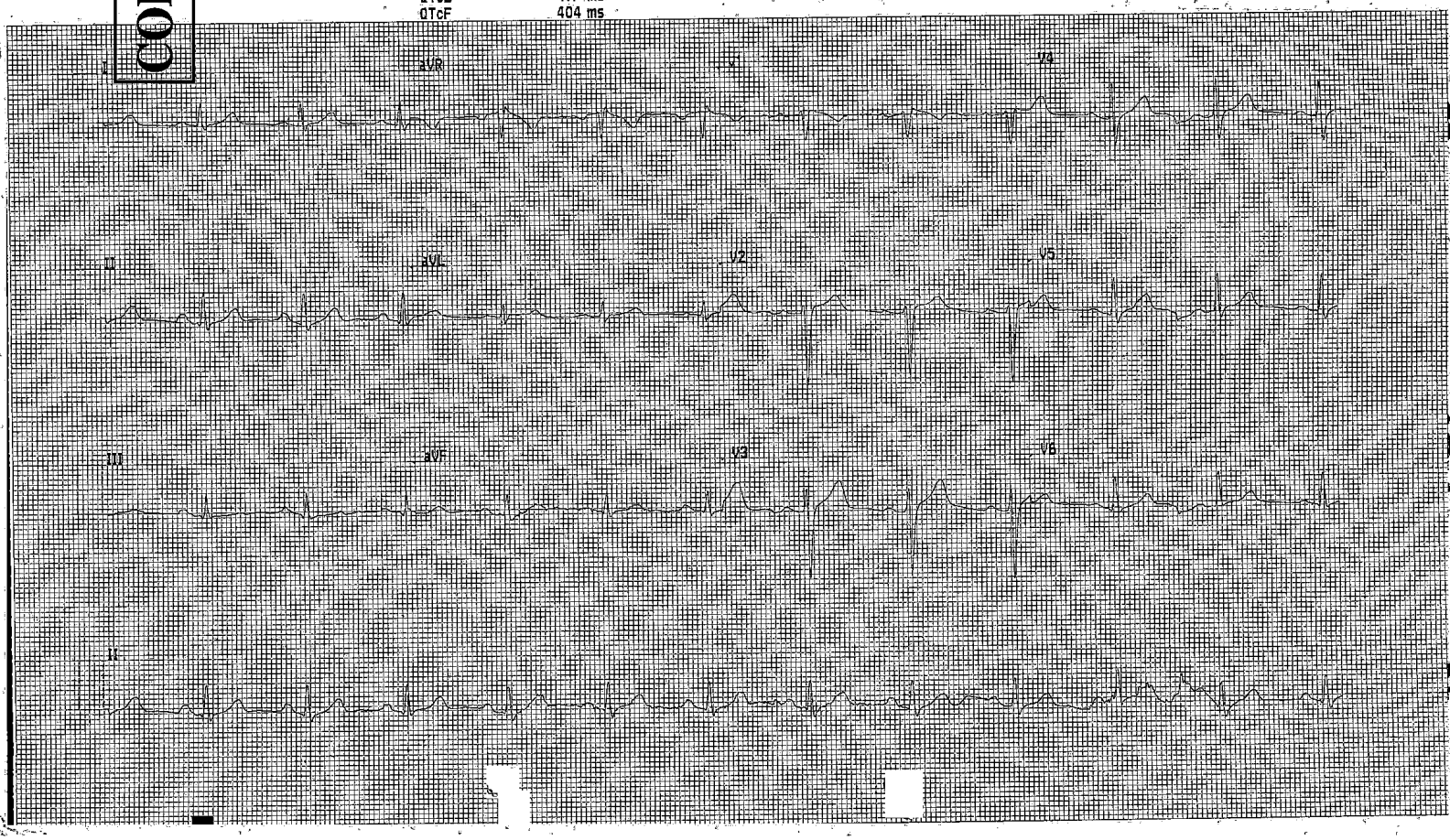
Vent rate	72 BPM
PR int	197 ms
QRS dur	113 ms
QT/QTc	379/404 ms
P-R-T axes	51 49 29
Avg RR	823 ms
QTcB	417 ms
QTcF	404 ms

SINUS RHYTHM
MODERATE INTRAVENTRICULAR CONDUCTION DELAY [110+ ms QRS DURATION]
BORDERLINE ECG

UNCONFIRMED REPORT

CHI NO: 0605770352 06/05/1977
CRN: S278537 M
Alan Wyles
17 Charles Street,
DUNBLANE,
Perthshire
FK15 9BY

COPY



RADIOMETER ABL800 FLEX

ABL625 A&E 02:31 04/03/2016
PATIENT REPORT Syringe - S 195uL Sample # 73398

Identifications

Patient ID	0605770352
Patient Last Name	WYLES
Patient First Name	ALAN
Sample type	Venous
T	37.0 °C

Blood Gas Values			
$c_{tot}{}^{c}$	42.3	nmol/L	
pH	7.374		[7.350 - 7.450]
↑ p_{CO_2}	6.19	kPa	[4.50 - 6.00]
↓ p_{O_2}	6.87	kPa	[9.00 - 12.0]
Oximetry Values			
↑ c_{tHb}	14.0	g/dL	[8.0 - 14.0]
↓ s_{O_2}	86.0	%	[94.0 - 100.0]
↑ f_{O_2Hb}	83.8	%	[0.2 - 0.6]
↑ f_{COHb}	2.1	%	[0.0 - 0.8]
f_{HHb}	13.6	%	[-]
f_{MetHb}	0.5	%	[0.2 - 0.6]
Electrolyte Values			
c_{K^+}	4.2	mmol/L	[4.0 - 5.0]
c_{Na^+}	140	mmol/L	[136 - 146]
$c_{Ca^{2+}}$	1.17	mmol/L	[1.15 - 1.29]
Metabolite Values			
↑ c_{Lac}	2.3	mmol/L	[0.5 - 1.6]
Temperature Corrected Values			
pH(T)	7.374		
$p_{CO_2}(T)$	6.19	kPa	
$p_{O_2}(T)$	6.87	kPa	
Oxygen Status			
c_{O_2c}	16.5	Vol%	
p_{O_c}	3.56	kPa	
Acid-Base Status			
$c_{Base(Ecf)_c}$	1.8	mmol/L	
$c_{HCO_3^-(P,st)_c}$	25.2	mmol/L	

Notes

↑	Value(s) above reference range
↓	Value(s) below reference range
c	Calculated value(s)

Printed 02:32:27 16-03-04

04.03.2016 3:30:59

Location:
Order Number:
Indication:
Medication 1:
Medication 2:
Medication 3:

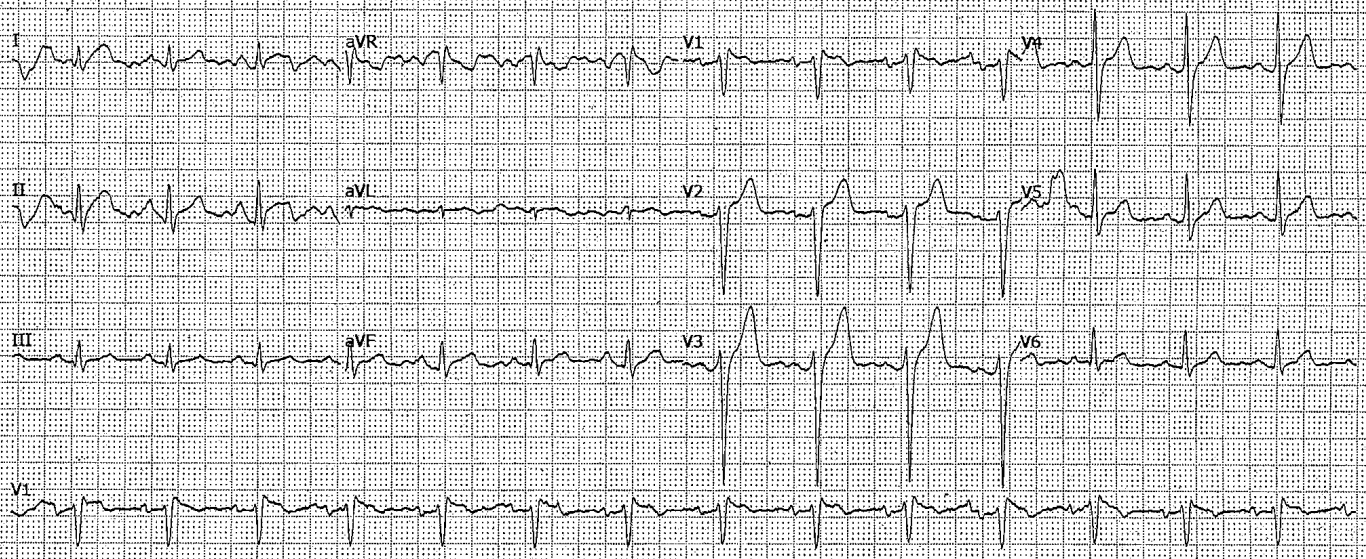
Room:

87 bpm
--/-- mmHg

Technician:
Ordering Ph:
Referring Ph:
Attending Ph:

QRS	116 ms
QT / QTcBaz	352 / 423 ms
PR	156 ms
P	96 ms
RR / PP	686 / 689 ms
P / QRS / T	67 / 53 / 52 degrees

Normal sinus rhythm
Incomplete right bundle branch block
Borderline ECG



GE MAC1600 1.0.4 12SL™ v2 25 mm/s 10 mm/mV 0.16-40 Hz 50 Hz Unconfirmed 4x2.5x3_25_R1 1/1

ID:
DOB:
yr.

CHI:0605770352
CRN:S278537 06/05/1977
WYLES ALAN M
27 Waulker Avenue,
STIRLING

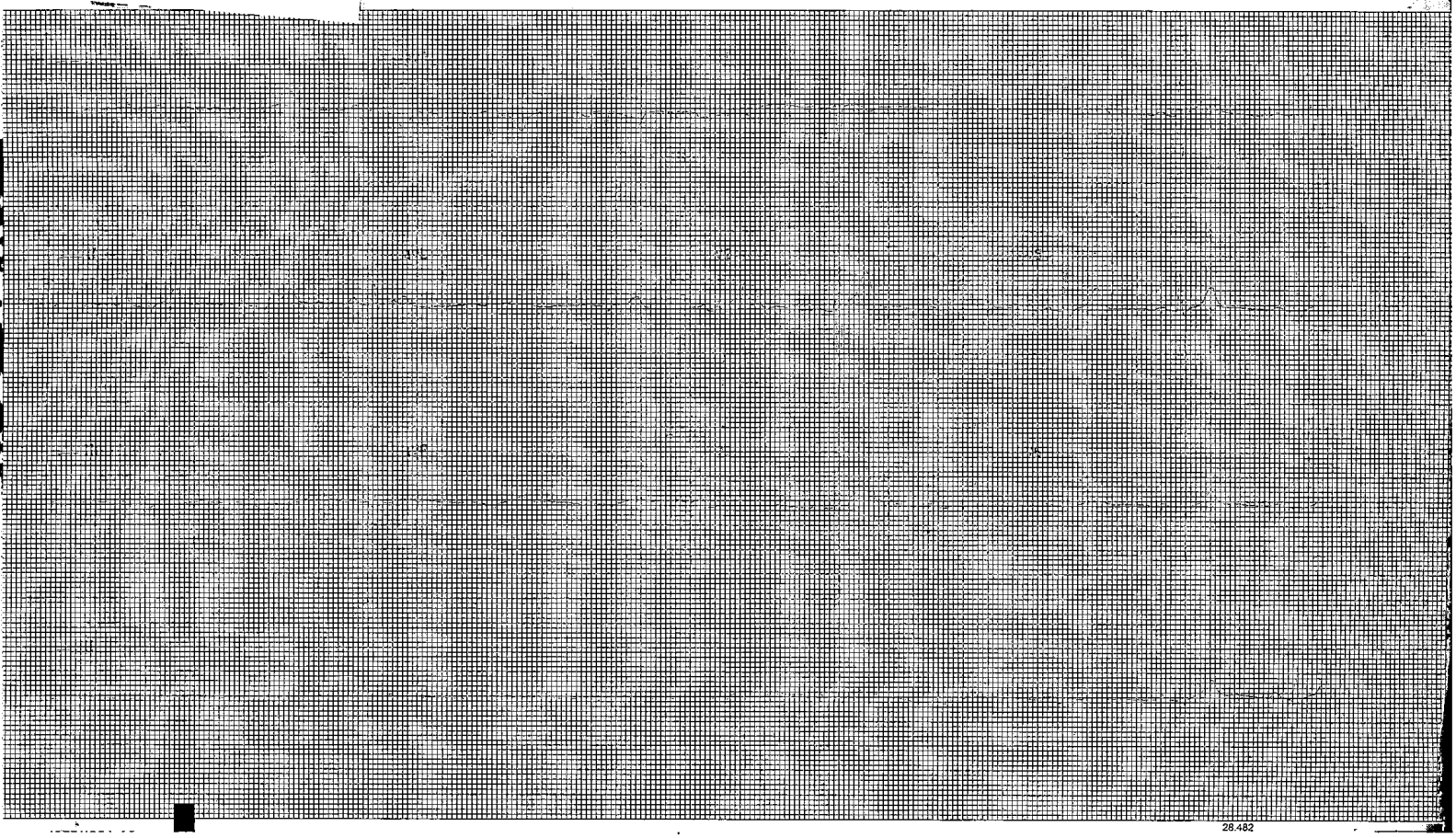
FK8 1SA

9-Jun-201[illegible]

Vent rate	[illegible] BPM
PR int	[illegible]2 ms
QRS dur	[illegible]5 ms
QT/QTc:	375/385 ms
P-R-T axes.	44 31 29

SINUS RHYTHM
NONSPECIFIC INTRAVENTRICULAR CON[illegible]ELAY 110+ MS QRS DURATION]
ST ELEVATION. PROBABLY EARLY RE[illegible]ON ST ELEVATION WITH NORMALLY INFLECTED T WAVE]
BORDERLINE ECG

UNCONFIRMED REPORT



28.482

RADIOMETER ABL800 FLEX

ABL825 Stirling A&E 22 01 09/06/2011
PATIENT REPORT Syringe - S 195uL Sample # 30312

Identifications

Patient ID	0605
Patient First Name	ALAN
Patient Last Name	WYLI
Operator	iain a
Date of birth	06/0
FO_2(I)	21.0
Department	CAU
Sample type	Arte

CHI:0605770352
CRN:S278537 06/05/1977
WYLES ALAN M
27 Waulker Avenue,
STIRLING
FK8 1SA

Blood Gas Values

cH^+_c	46.2	nmol/L	
↓ pH	7.335		[7.350 - 7.450]
pCO_2	5.24	kPa	[4.50 - 6.00]
pO_2	10.5	kPa	[9.00 - 12.0]

Oximetry Values

ctHb	121	g/L	[80 - 140]
sO_2	96.8	%	[94.0 - 100.0]
↑ FO_2Hb	91.8	%	[0.2 - 0.6]
↑ $FCOHb$	4.4	%	[0.0 - 0.8]
$FHHb$	3.0	%	[-]
↑ $FMetHb$	0.8	%	[0.2 - 0.6]

Electrolyte Values

cK^+	4.1	mmol/L	[4.0 - 5.0]
↓ cNa^+	133	mmol/L	[136 - 146]
↓ cCa^{2+}	1.13	mmol/L	[1.15 - 1.29]

Metabolite Values

cLac	0.8	mmol/L	[0.5 - 1.6]

Acid Base Status

$cBase(Ecf)_c$	-4.4	mmol/L
$cHCO_3^-(P,st)_c$	20.7	mmol/L

Notes
↑ value(s) above reference range
↓ value(s) below reference range
c calculated value(s)

Printed 22:02:45 11-06-09

E-Pacer PATIENT REPORT

Time	18:42	Date	09/06/2011

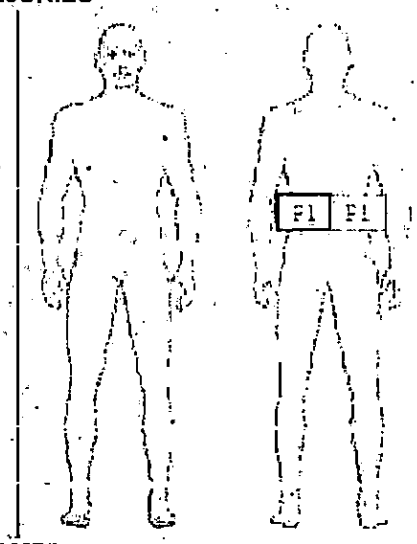
PATIENT AND INCIDENT DETAILS

Incident number	ED003061807.001
Name	ALAN WYLES
Age	34
Date of birth	06/05/1977
Gender	Male
CHI number	0606770352
Incident location	27 WAULKER AVENUE STIRLING
Incident post code	FK8 1SA
[illegible] type	URG
[illegible] ived	09/06/2011, 18:07
[illegible] ssed	09/06/2011, 18:15
Crew mobile	09/06/2011, 18:19

PRIMARY SURVEY

RESPONSE	
AVPU	Alert
AIRWAY	
Airway assessment	Clear
BREATHING	
Breathing rate	Normal
Respiratory rate	20
CIRCULATION	
Cap refill rate	<2 secs
PATIENT CONSENT	
Patient consent	Treatment benefits explained, Risks of condition explained, Risk of refusal explained, Capacity to understand risks and treatment
Duty of care delegated to	CAU

INJURIES



AMPDS

Final code	05A01	Back Pain, Non-traumatic Injuries

GCS

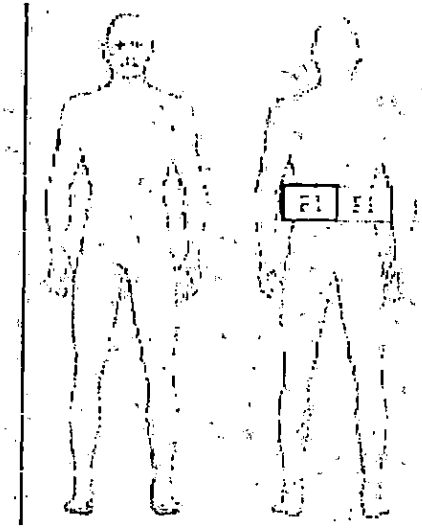
Final GCS eye opening	Spontaneous
Final GCS verbal response	Orientated
Final GCS motor response	Obeys commands

VITAL SIGNS

Time hr.: min	Pulse bpm	Resp. rpm	BP mm Hg	Cap refill (secs)	Peak flow %	Blood sugar mmol / l	Temp °C	SpO2 %	GCS Total	RTS	SEWS	ECG	Pain score
18:30	94	20	147 / 90	<2 secs	-	-	-	-	15	7.550	-	-	-

AMPLE

Allergies	
Other allergies	PENICILIN
Medication	DICLOFENIC
Past history	TIA?
[illegible] eaten	>5 hrs
	PT HAS BEEN UNWELL FOR 3 DAYS TODAY BEING WORST, PT HAS HAD INCREASING BACK PAIN AND URINATED



AMPDS

Final code	05A01 Back Pain, Non-traumatic Injuries

GCS

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

VITAL SIGNS

Time hr : min	Pulse bpm	Resp. rpm	BP mm Hg	Cap refill (secs)	Peak flow %	Blood sugar mmol / l	Temp °C	SpO2 %	GCS Total	RTS	SEWS	ECG	Pain score
8:30	94	20	147 / 90	<2 secs	-				15	7.550	-	-	-

AMPLE

Allergies	
Other Allergies	PENICILIN
Medication	DICLOFENIC
Past history	TIA?
Last eaten	>5 hrs
Events prior	PT HAS BEEN UNWELL FOR 3 DAYS TODAY BEING WORST, PT HAS HAD INCREASING BACK PAIN AND URINATED TODAY FOR THE FIRST TIME IN 3 DAYS VERY DARK ? BLOOD, PRIOR TO THAT SAID URINE WAS DARK, PT ALSO HASNT HAD A PROPER BOWEL MOVEMENT, PT FEELS NASIOUS AND HAS VOMITED IN THE MORNING
Report ID	cf26eb0f-049a-41a3-95d0-

E-Pacer PATIENT REPORT

Time	18:42	Date	09/06/2011

PATIENT AND INCIDENT DETAILS

Incident number	ED003061807 001
Name	ALAN WYLES
Age	34
Date of birth	06/05/1977
Gender	Male
CHI number	0606770352
Incident location	27 WAULKER AVENUE STIRLING
Post code	FK8 1SA
Type	URG
Call received	09/06/2011, 18:07
Call passed	09/06/2011, 18:15
Crew mobile	09/06/2011, 18:19

PRIMARY SURVEY

RESPONSE	
AVPU	Alert
AIRWAY	
Airway assessment	Clear
BREATHING	
Breathing rate	Normal
Respiratory rate	20
CIRCULATION	

STIRLING ROYAL INFIRMARY

Department of Vascular Surgery

Vascular Office: phone 01786 434437, fax 01786 434473

Scan/test results: phone 01786 434165

NHS Forth Valley

Carotid Duplex Scan Report

To: Dr R Lenton
Consultant Physician
Stirling Royal Infirmary
Livilands
Stirling
FK8 2AU

0605770352	**WYLES**	**Alan**	0

09/06/2011 **Referral text:** Left eye visual disturbance.

Clinical Report

Scan number 9775

Scan by Heather

Referral Date

	RIGHT	LEFT
Indication:		
Common carotid:	Normal	Normal
Bulb:		
Internal carotid:	Normal	Normal
External carotid:	Normal	Normal
Vertebral:	Normal	Normal

Clinical Comment: No evidence of stenosis

NHS
Forth Valley

S0278537/ S0249901

RADIOLOGY REPORT- Stirling Royal Infirmary

CHI NUMBER: 0605770352 **Examination Number:** 30874606
Name: Wyles, Alan DOB: 06/05/1977
Address: 27 Waulker Avenue,, STIRLING, , FK8 1SA -- **CC:** -
Examination: XR Lumbar Spine
Examination Date: 09/06/2011 **Examination Time:** 15:30
Dictating Radiologist: DR DON COLLIE, LOCUM CONS R/IST
Typed by: None
Referring Consultant: LENTON DR R AGE/HEALTH
Referring Department / Location: SRI: TIA OPD

Clinical history:
Severe low back pain worse for 3 days. Unable to sleep. No history of trauma.

Findings:
Normal lumbar vertebral alignment and intervertebral disc spaces. Intact pedicles, spinous processes and posterior structures. Minimal subchondral sclerosis of the iliac side of the sacroiliac joints, but no erosions. If symptoms persist MRI may be of value.

Examination Date: 09/06/2011
Examination: XR Lumbar Spine
Date Reported: 17/07/2011
Dictating Radiologist / Clinical Specialist By DR DON COLLIE, LOCUM CONS R/IST

Verified by: DR DON COLLIE, LOCUM CONS R/IST on 17/07/2011

FORTH VALLEY HOSPITALS

X-Ray Appointments
Forth Valley Royal Hospital
Larbert
01324 567000

Date 14·6·11

Referrer DR LENTON
TIA CLINIC

Please find enclosed request card

Name and chi number ALAN WYLES - CHI-0605770352

Exam booked CT BRAIN

IF YOU STILL REQUIRE THIS EXAMINATION TO BE DONE THE REQUEST FORM MUST BE REDATED

This patient did not attend for examination on.	**A DNA letter was sent to the patient on**	**Incomplete Referral**

Since you requested this patient to have a	**The patient has had this exam done on (report enclosed)**	**The Consultant Radiologist has suggested an alternative exam would be of greater diagnostic value.**

Other reason for return
PT TRANSFERRED TO GLASGOW
SD78537

13/6/11 1pm.

RETURN TO REFERRER

PT TRANSFERRED TO GLASGOW

NHS Forth Valley

s on this request form

For contrast examinations:

Creatinine

Egfr & Date:

Asthma Yes No

Diabetes Yes No

Address: WYLES Alan
27 WAULKER AVENUE.
STIRLING
FK8 1SA

Post Code

Phone Number

Priority: Routine / Urgent

Copy to:

EXAMINATION REQUESTED: CT brain please

Allergies or Previous Contrast reaction (Give Details)

CLINICAL DETAILS: What questions should this examination answer?

Severe episodic (L) headache with one episode of (L) visual loss + conjugate gaze.

Name: GENTON | Signature: [signature] | Designation & Pager No: | Date: 9/6/11

AREA BELOW THIS LINE IS FOR USE BY THE RADIOLOGY DEPARTMENT ONLY

Prep required: BLD

Appointment date:

1st rebook

2nd rebook

Date rec'd SRI

Date rec'd FDRI

tient informed of prep	Yes / No	Signature	Date
Ward informed of prep	Yes / No		
Justified by Entitled Practitioner	OR	Authorised by Entitled Operator	
Practitioner's signature		Operator's signature	

Patient's ID checked prior to exposure

Signature of operator & method of ID used**

**To be completed by the person(s) who initiate the exposure

Pregnant Yes / No Breast feeding Yes / No

Pregnancy / breast feeding status noted

Patient's signature | Date | Operator's signature**

Date of LMP | Observe pregnancy 10-Day rule (For high dose procedure only) | Yes / No | Date

DAP/Exposure factors or activity	Room Number SRI	Room Number FDRI	Prescription record		Other Information
			Drug	Route	
			Person Injecting	Contrast type	
	Screening Time			Batch no.	
	CTDI		Designation	Use by	
	DLP		Isotope type	Time given	
				Date given	

GP Open Access Times - FVRH (Mon to Fri) 8.30am until 4.30pm
SRI (Mon to Fri) - 9.00am until 12.30pm & 2.00pm until 4.30pm

ING1461

0605770352
WYLES
ALAN
06/05/1977 M
DATE: TIME:
SIGNATURE:

Name: _____ Ward: 27

DOB: _____ CHI: _____

NHS Forth Valley

COPY

CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE RED OR TWO YELLOW SCORES AT ANY ONE TIME

	Date:	24/4/10 Post OP													Amended limits
	Time:	1145 am	18[00]	18[30]											
RESP (write rate in corresp. box)	>30														
	21-30														
	11-20	16	16	16											
	0-10														
Saturations	90-100%	99	96	96											
	<90%														
02 Conc.	%	2LR	2LR	2LR											%
x Temp	39														
	38														
	37	37·6	37·6	36·3											
	36														
	35														
HEART RATE	170														
	160														
	150														
	140														
	130														
	120														
	110														
	100														
	90														
	80	81													
	70		65	68											
	60														
	50														
	40														
BLOOD PRESSURE (score on systolic)	200														
	190														
	180														
	170														
	160														
	150														
	140	132													
	130		118	124											
	120														
	110														
	100														
	90														
	80														
	70														
	60	67	50	73											
	50														
NEURO RESPONSE (X)	Alert	✓	✓	✓											
	Voice														
	Pain														
	Unresponsive														
UO <30mls/hr for 3 hrs (√)															
BM (Glucose)															
Pain Score (X)	2-3														
	0-1	0	0	0											
Nausea	YES (√)														
	NO (√)	✓	✓	✓											
Looks unwell	YES (√)														
Looks unwell	NO (√)	✓	✓	✓											
Total Yellow Scores															
Total Red Scores															
Dr Called (√)	YES														
	NO	✓	✓	✓											

MUST - Nutritional Risk Screening

NHS Forth Valley

COPY

Patient Details (or attach ID label)

0605770352
WYLES
ALAN
06/05/1977 M
DATE TIME
SIGNATURE
Unit/CHI No:

Ward: 27

Date of Admission: 24/11/10

Normal weight: 12 stone 5'8 Source: Patient

Step 1 BMI	Weight (kg)	Measured / (Reported) / Estimated (circle)	Height (m)	Measured / (Reported) / Estimated (circle)	BMI (see chart)	Step 1 Score (circle)
	77kg		1.74		25	(> 20 = 0) / 18.5-20 = 1 / < 18.5 = 2
Step 2 Weight Loss over last 3-6 months	Wt Loss *(kg)	Measured / Reported / Estimated (circle)	% Change (see chart)			Step 2 Score (circle)
			Nil			(< 5% = 0) / 5-10% = 1 / > 10% = 2

* this refers to the total unplanned weight loss over the last 3 – 6 months

Step 3 Acute Disease Effect	Acute illness AND there has been, or is likely to be, no nutritional oral intake for 5 days Not NBM = score 0 NBM = score 2	Step 3 Score (circle) (0) 2
Step 4 Overall Risk Score	Add scores from Steps 1 + 2 + 3 = Total	Total Score: 0
Step 5 Manage-ment	Develop and Implement appropriate Nutritional Care Plan	Nutritional Care Plan (circle) (0 = Low Risk) 1 = Medium Risk 2+ = High Risk

Screening results reported to: .....

Screening completed by: L.M. Cover Date: 24/11/10

Low Risk Nutritional Care Plan

NHS Forth Valley

COPY

Patient Details (or attach ID label)

CHI: 0605770352

Nam 06/05/1977 M .....

WYLES Alan

D.O 27 WAULKER AVENUE, ...

STIRLING

FK8 1SA

Uni .....

Date: 24/4/10

Completed by: LM Corr R

Low Risk Actions	√

Low Risk
Set treatment aims:

- Weight maintenance
- Maintain current nutritional intake

Actions

- Provide help and advice on food choices, eating and drinking if required.
- Repeat Screening on Sunday or if condition deteriorates.

Refer to the dietitian if:

- Enteral Feeding is required
- Specialist dietary advice is required following a diagnosis of Type 1 diabetes, renal disease, Coeliac disease.
- Consistency modified diet is required e.g. smooth, soft/moist.
- Patient has pressure sores grade 3 or over.
- Patient has multiple fractures.

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NHS FORTH VALLEY
NURSING DISCHARGE LETTER

COPY

Hospital: Stirling Royal Infirmary **Telephone Number:** 01786 434000

Patient Profile

Surname	Wyles	Forename	Alan	Lives Alone?	Yes / No
Address	27 Waulker Avenue,, Stirling, FK8 1SA	Day Time Phone No		GP Practice	Park Avenue Medical Centre
		Evening Phone No		Consultant	Ritchie, Mr Ian
Unit No.	S278537	D.o.B	06/05/1977	Hospital / Ward	SRI - Ward 27
CHI No.	0605770352	Sex	Male	Admission Date	24/04/2010

Discharge to: Private Residence - Living with Relatives or Friends		Transfer Date	24/04/2010
Details to where transfered (if different from address above): Additional Information (Address etc)		Next of Kin	miss victoria wyles
		Address	s/a
		Phone No.	01786450501
Diagnosis/ Treatment	«DIAGNOSES_ACTIVE_LIST»	GP	Dr Fiona E Lyle Park Avenue Medical Centre 01786473529
Any procedures carried out (if any) are listed in the table below.			

Nursing Treatment Required (Dressings, Injections, Catheter Type/Size)

Patient admitted with Per-anal abcess went to theatre 24/4/10 for incision and drainage of pilonidal sinus. Discharged home 24/4/10 for wound check 27/4/10

Dressing None supplied

Functional Ability on Discharge

«EPISODE_ACTIVITIES_OF_DAILY_LIVING»

Services Requested / Equipment Ordered and Supplied

«EPISODE_SERVICES_AND_EQUIPMENT»

Reviews

Patient to phone GP surgery for appointment	**Yes**	**No**	
Supply of drugs/Prescription given home with patient	**Yes**	**No**	
Information given to patient/carer	**Written**	**Verbal**	

Name	P Mulgrew	**Designation**	Staff Nurse	**Date**	24/04/2010
Signature					

Alan Wyles 06/05/1977 0605770352

Draft - 24/04/2010 20:20

NHS Forth Valley

NHS FORTH VALLEY
NURSING DISCHARGE LETTER

COPY

Hospital: Stirling Royal Infirmary **Telephone Number:** 01786 434000

Patient Profile

Surname	Wyles	Forename	Alan	Lives Alone?	Yes / No
Address	27 Waulker Avenue,, Stirling, FK8 1SA	Day Time Phone No		GP Practice	Park Avenue Medical Centre
		Evening Phone No		Consultant	Ritchie, Mr Ian
Unit No.	S278537	D.o.B	06/05/1977	Hospital / Ward	SRI - Ward 27
CHI No.	0605770352	Sex	Male	Admission Date	24/04/2010

Discharge to: Private Residence - Living with Relatives or Friends	Transfer Date 24/04/2010
Details to where transfered (if different from address above):	Next of Kin miss victoria wyles
Additional Information (Address etc)	Address s/a
	Phone No. 01786450501
Diagnosis/ Treatment «DIAGNOSES_ACTIVE_LIST»	GP Dr Fiona E Lyle
Any procedures carried out (if any) are listed in the table below.	Park Avenue Medical Centre 01786473529

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Functional Ability on Discharge

«EPISODE_ACTIVITIES_OF_DAILY_LIVING»

Services Requested / Equipment Ordered and Supplied

«EPISODE_SERVICES_AND_EQUIPMENT»

Reviews

Patient to phone GP surgery for appointment	Yes		No	
Supply of drugs/Prescription given home with patient	Yes		No	
Information given to patient/carer	Written		Verbal	

Name	P Mulgrew	Designation	Staff Nurse	Date	24/04/2010
Signature					

NEWS KEY 0 | 1 | 2 | 3

NAME: **DOB:**

COPY

| | | |

CHI:

WARD:

COPY

Date			
Time			
≥25			3
21-24			2
20			
9-11			1
≤8			3
Default	Chronic Hypoxia		
≥96	≥88		
94-95			1
92-93	86-87		2
≤91	≤85		3
Please tick			2
Refer to key			
≥39°			2
38°			1
37°			
36°			
≤35°			1
230			3
220			3
210			3
200			
190			
180			
170			
160			
150			
140			
130			
120			
110			1
100			2
90			3
80			3
70			3
60			3
50			
>140			3
130			2
120			2
110			1
100			1
90			
80			
70			
60			
50			1
40			3
30			3
Alert			
V / P / U			3
Blood Sugar			
TOTAL SCORE			
Pain Score (0-3)			
Recognition Sticker			
Response Sticker			
Urine Output Recorded			
Initials			

Score 5-6 (or 3 in one parameter) = 1 hourly

Score 7 or More = Continuous

National Early Warning Score (NEWS)

Name:
DOB:
CHI No:
Address:

COPY

Regardless of NEWS always escalate if concerned about a patient's condition

Total NEWS	Frequency of Monitoring	Clinical Response
0*	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations
1-4*	Minimum 4 - 6 hourly	• Inform registered nurse who must assess the patient • Registered Nurse to decide if increased frequency of monitoring and / or escalation of clinical care is required
5-6* or 3 in one Parameter	Increased frequency to a minimum of 1 hourly	• Registered nurse to urgently inform the medical team caring for the patient • Urgent assessment by a clinician with core competencies to assess acutely ill patients • Ensure structured Response Stickers A & B are completed *(Not Applicable in Emergency Dept)*
7 or more*	Continuous monitoring of vital signs	• Registered nurse to immediately inform the medical team caring for the patient • Emergency assessment by clinical team with core competencies to assess acutely unwell patients • Ensure structured Response Stickers A & B are completed *(Not Applicable in Emergency Dept)* • Consider transfer of clinical care to HDU or ITU

Exclusion Criteria

Anaesthesia and/or sedation may result in reduced conscious levels for a period of time. Scores that are increasing post-procedure and those including "P" or "U" always require escalation. The post-procedure NEWS score and post procedure plan that will include the frequency of observations should be communicated to the ward staff on transfer/handover of the patient.

For patients with known hypercapnoeic respiratory failure due to COPD, recommended British Thoracic Society target saturations of 88-92% should be used. These patient's will still "score" if their SpO2 are below 92% unless the score is "reset" by a competent clinical decision-maker. These patients will then use the Chronic Hypoxia alternate SpO2 scoring. This should be amended on the NEWS chart as appropriate.

Codes For Recording Oxygen Delivery On NEWS Chart

A = Air (not requiring oxygen or weaning or on PRN oxygen)
N = Nasal Canulae
SM = Simple Mask
V24 =Venturi 24% V28 = Venturi 28% V35 = Venturi 35% V40 = Venturi 40% V60 = Venturi 60%
H28 = Humidified oxygen at 28% (also H35, H40 & H60 = Humidified Oxygen at 35%, 40% & 60%)
RM = Reservoir Mask
TM = Tracheostomy Mask
CP = Patient on CPAP System
NIV = Patient on NIV System
OTH = Other Device:_____ (specify which)

Level Chart (only as required for head injury observation)

COPY

			DATE:	DATE:
			TIME:	TIME:
GCS		Spontaneously	4	Eyes closed by swelling = C
		To speech	3	
		To pain	2	
		None	1	
MASCALE	Best verbal response	Orientated	5	Endotracheal tube or tracheostomy = T
		Confused	4	
		Inappropriate words	3	
		Incomprehensible sounds	2	
		None	1	
	Best motor response	Obey commands	6	Usually record the best arm response
		Localise pain	5	
		Withdraws to pain	4	
		Flexion to pain	3	
		Extension to pain	2	
		None	1	

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

PUPILS	right	Size		+ reacts - no reaction c. eye closed
		Reaction		
	left	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		
		Extension		
		No response		

Pain Assessment & Management Guidelines

Pain Score:

0 = No pain
1 = No pain at rest
2 = Slight pain on movement
2 = Intermittent pain at rest
3 = Moderate pain on movement
3 = Continuous pain at rest

For Acute and Chronic Pain:
For mild (1), moderate (2) or severe (3) pain refer to Pain Management Guidelines Forth Valley Formulary Appendix 27 & 28. Implement Pain Assessment Chart

For Cancer Related Pain:
For mild (1), moderate (2) or severe (3) pain score, refer Palliative Guidelines.

NHS
Forth Valley

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CARE BUNDLE AND ASSESSMENT BOOKLET

CHI: 0605770352
06/05/1977 M
WYLES Alan
17 CHARLES STREET,
DUNBLANE,
PERTHSHIRE FK15 9BY

Date of admission 4/3/16

Ward admitted to AAU 2

Consultant Crumley

Ward transferred to .....

Date of transfer .....

Consultant .....

Ward transferred to .....

Date of transfer .....

Consultant .....

Booklet number .....

Initial assessments completed and signed

MRSA - on admission	☐
Braden - within 6 hours of admission	☐
MUST - within 24 hours of admission	☐
Patient handling and mobility - within 24 hours of admission	☐
Bed rails - within 24 hours of admission	☐
Falls - within 6 hours of admission	☐
Oral care - within 24 hours of admission	☐
Stool chart - within 24 hours of admission	☐

The information within this document is confidential and may only be viewed and shared with the permission of the named patient

This care bundle and assessment booklet is a legal document. Your signature indicates you have reviewed and updated it and it is a true reflection of the care given by you or delegated by you.

COPY

Staff identification – must be completed by all staff prior to recording in this document

Date	Designation	Print name	Signature	Initials
4/3/16	SN	V. SMITH	V Lic	VS

CHI: 0605770352
06/05/1977 M
WYLES Alan
17 CHARLES STREET,
DUNBLANE,
PERTHSHIRE FK15 9BY

Photograph here

INFECTION PREVENTION AND CONTROL RISK ASSESSMENT

NHS Forth Valley

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On admission all patients must be assessed for risk of infection. If the patient has any suspicion of / or confirmed infection (diarrhoea, vomiting, productive cough, unknown skin rash, fever of unknown origin or risk factors such as recent travel) –

- Ensure appropriate placement. If the patient cannot be isolated a risk assessment must be completed.
- Ensure additional infection control precautions (contact, droplet, airborne) as per NHS Forth Valley policies.

Clinical Risk Assessment (CRA) for Meticillin Resistant *Staphylococcus aureus* (MRSA)

This risk assessment must be completed for all patients being admitted.
(Exclusions: Patients admitted to obstetric/maternity, mental health, paediatric wards and all day cases)

All questions must be completed (please circle yes or no for each question)

Has the patient any previous history of MRSA		Has the patient been admitted from anywhere other than their own home (e.g. Care home, prison, hostel) or transferred from another hospital		Does the patient have any wound / ulcer or indwelling medical device (e.g. peg tube, urinary catheter, Hickman line etc)		Is the patient being admitted / transferred to ITU, orthopaedics or a surgical ward with vascular speciality	
Yes	(No)	Yes	(No)	Yes	(No)	Yes	(No)
Screen for MRSA	No further action	Screen for MRSA	No further action	Screen for MRSA	No further action	Screen for MRSA	No further action

New stub wound to ©. lumbar region only

A **YES** response to question 1, 2 or 3 indicates there is a risk of MRSA skin carriage; the patient should be isolated in a single room and swabs taken. Ensure staff in receiving ward are aware of infection risk and a single side room is available

All admissions to high risk specialities, including surgical wards with vascular patients, must have screening swabs taken.

MRSA admission screen – nose, perineum, wounds, invasive device insertion site and a CSU if a urinary catheter is present. Note: this is the minimal screen required and additional swabs can be sent if clinically indicated.

Date	Sign / Print Name
4/3/16	V Lit (VSmith)

ABC
ASSURING BETTER CARE
Tissue Viability

Audit
Date: Time:
PPURA Completed in ED: Y N
Braden Completed within 6 hours of admission Y N

CHI: 0605770352
06/05/1977 M
WYLES Alan
17 CHARLES STREET,
DUNBLANE,
PERTHSHIRE FK15 9BY
ch label)

NHS Forth Valley

BRADEN RISK ASSESSMENT CHART

Individuals with a total score of 16 or less are considered at risk: **15-16 = low risk, 12-14 = moderate risk, 11 or less = high risk**

Undertake and document risk assessment within 6 hours of admission or on first home visit. Reassess if there is a change in individual's condition and repeat regularly according to local protocol
Complete care and comfort round chart.

If pressure ulcer present record grade and commence a care plan and wound assessment chart				**DATE**	4/3						
				TIME	0555						
Sensory Perception Ability to respond meaningfully to pressure related discomfort	**Completely Limited = 1** Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation. **OR** limited ability to feel pain over most of body surface.	**Very Limited = 2** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. **OR** has a sensory impairment that limits the ability to feel pain or discomfort over ½ of body.	**Slightly Limited = 3** Responds to verbal commands but cannot always communicate discomfort or need to be turned. **OR** has some sensory impairment that limits ability to feel pain or discomfort in 1 or 2 extremities.	**No Impairment = 4** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or voice pain or discomfort.	4						
Moisture Degree to which skin is exposed to moisture	**Constantly Moist = 1** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient/client is moved or turned.	**Very Moist = 2** Skin is often but not always, moist. Linen must be changed at least once a shift.	**Occasionally Moist = 3** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**Rarely Moist = 4** Skin is usually dry. Linen only requires changing at routine intervals.	4						
Activity Degree of physical activity	**Bedfast = 1** Confined to bed.	**Chairfast = 2** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**Walks Occasionally = 3** Walks occasionally during day but for very short distance, with or without assistance. Spends majority of each shift in bed or chair.	**Walks Frequently = 4** Walks outside the room at least twice a day and inside the room every 2 hours during waking hours.	4						
Mobility Ability to change and control body position	**Completely Immobile = 1** Does not make even slight changes in body or extremity position without assistance.	**Very Limited = 2** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**Slightly limited = 3** Makes frequent though slight changes in body or extremity position independently.	**No Limitations = 4** Makes major and frequent changes in position without assistance.	4						
Nutrition Usual food intake pattern	**Very Poor = 1** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** is NPO and/or maintained on clear liquids or IV's for more than 5 days.	**Probably Inadequate = 2** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement **OR** receives less than optimum amount of liquid diet or tube feeding.	**Adequate = 3** Eats over half of most meals. Eats a total of 4 servings of protein (meat or dairy products) each day. Occasionally will refuse meal but will usually take a supplement if offered **OR** is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	**Excellent = 4** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	3						
Friction and Shear	**Problem = 1** Requires moderate to maximum assistance in moving.	**Potential Problem = 2** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**No Apparent Problem = 3** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.		3						
			Indicate appropriate number and add for total score	TOTAL SCORE:	22						
				SIGNATURE:	VS						

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'MUST' – Nutritional Risk Screening

NHS Forth Valley

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CHI: 0605770352
06/05/1977 M .....
WYLES Alan
17 CHARLES STREET, ...
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PERTHSHIRE FK15 9BY

Ward: AAU 2

Date of Admission: 4/3/16

Usual/pre-illness weight:..... .....

STEP 1 (BMI)	STEP 2 (Weight Loss)	STEP 3 (Acute Disease Effect)	*If weight/ height not measured please indicate how this was obtained
Weight (kg) = ... Height (m) = ... **BMI(kg/m²)= .....** See BMI charts Greater than 20 score 0 18.5 – 20 score 1 Less than 18.5 score 2 (greater than 30=obese)	Total unplanned weight loss over 3-6 months Weight loss (kg) = ... **% weight loss =** See Weight Loss Chart Less than 5% score 0 5-10% score 1 Greater than 10% score 2	Acute illness **AND** there has been or is likely to be no nutritional intake for **5 days** No score 0 Yes score 2	Reported Estimated Based solely on clinical impression (See **"Ward information pack"** for alternative measures)

STEP 4 (Overall Risk Score)	STEP 5 (Care Plan)
Add scores from steps 1+2+3 to calculate overall risk score SCORE 0 = LOW RISK SCORE 1 = MEDIUM RISK SCORE 2+ = HIGH *(Please record all details in the table below)* If risk category arrived at by clinical impression alone, circle risk category LOW/MEDIUM/HIGH and document rationale in care plan	Implement appropriate Nutritional Care Plan **0 = LOW RISK** **1 = MEDIUM RISK** **2 = HIGH RISK** **Treat as High Risk - immediate Dietetic Referral** ▪ Dysphagia ▪ Decompensated Liver Disease ▪ Enteral Tube Feeding ▪ Multiple Fractures ▪ Pressure Ulcers Grade 3 or more

'MUST' SCREENING

Date	Weight (kg)	Weight ↑↔↓	BMI (kg/m²)	Step 1 Score	Step 2 Score	Step 3 Score	Total Score	'MUST' Risk	Sign/Print Name

Report 'MUST' screening results to nursing staff and housekeeper if appropriate

BAPEN

The 'Malnutrition Universal Screening Tool '('MUST') is adapted here with the kind permission of BAPEN (British Association for Parenteral and Enteral Nutrition). ***See 'MUST' ward folder for further information.***

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g Risk Assessment Form

each individual patient, along with a mobility chart, if required.

ddress	Date of Birth
	CHI Number

Patient weight .....Height.....BMI .....

Please state the patient's ability prior to admission: .....

.....

RELEVANT MEDICAL HISTORY *e.g. CVA, arthritis etc.*	PHYSICAL HANDLING CONSTRAINTS *e.g. eye sight, hearing, speech etc.*
PSYCHOLOGICAL HANDLING CONSTRAINTS *e.g. confused, aggressive etc.*	TISSUE VIABILITY *e.g. Intact / Red / Skin Lesions*
FALLS HISTORY *(Does the patient have any previous history of falling to the ground, past or present? If patient is aged 65 or over, has a history of falls; please complete Clinical Quality indicator (CQI) assessment)*	
ATTACHMENTS *e.g. IV infusions, indwelling catheters, oxygen therapy etc.*	DAY / NIGHT VARIATIONS *(Please specify)*
CULTURE / RELIGIOUS CONSIDERATIONS *(Please specify)*	ENVIRONMENTAL CONSIDERATIONS *(particularly useful in the community)*
OTHER CONSIDERATIONS *e.g. social factors, age, weight of patient etc.*	

Please complete the following as to how the patient currently transfers / mobilises (Please tick ✓ as appropriate)

Transfers (including to / from bed; wheelchair; commode; toilet)				
Independent ☐	Supervision ☑	Assistance of 1 ☐ 2 ☐ 3 ☐	Standaid ☐	Hoist ☐
Move up and down the bed				
Independent ☑	Supervision ☐	Assistance of 1 ☐ 2 ☐ 3 ☐	Glide Sheet ☐	Hoist ☐
Sit up over the side of the bed				
Independent ☐	Supervision ☑	Assistance of 1 ☐ 2 ☐ 3 ☐	Bed Rest ☐	
Bathing (including in and out of the bath / shower)				(please specify)
Independent ☐	Supervision ☑	Assistance of 1 ☐ 2 ☐ 3 ☐	Hoist ☐	Other ☐:.....
Walking				
Independent ☐	Supervision ☑	Assistance of 1 ☐ 2 ☐ 3 ☐	Walking Aid ☐	No Walking ☐
Did the patient have a walking stick or frame on admission? YES ☐ N0 ☑ Until fully awake.				

Is the patient independent? **YES** ☐ **N0** ☑ (Please tick ✓ as appropriate)

If **YES**, please sign and date below;
If **NO**, please sign and date below and complete a **mobility chart** for the patient. Supervise at present.

Assessor's Name (Print): VJMITH	Date: 4/3/16
Signature: V	Review Date:
Mobility Chart Completed: **YES** ☑ **N0** ☐	Date:

If patient has been assessed as 'independent' on initial assessment; and this status changes, please review and complete another 'individual patient assessment form'.

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PATIENT HANDLING ASSESSMENT – 'MOBILITY CHART'

NHS Forth Valley

This form ... the 'Individual Patient Handling Risk Assessment Form

Name of p ..... Date of birth: ..... CHI Number: .....

A risk asse... should be carried out prior to every handling intervention. Any changes should be documented in a new column. Please refer to Manual Handling Guidelines for all manoeuvres.

DATE:	4/3/16	AST		AST		AST		AST		AST		AST
Lying to sitting	IND											
Sit to stand to sit	SUP	x1										
Walking	SUP	x1										
Bathing / Showering / Toileting	SUP	x1										
Moving up the bed	IND											
Turning / Proning	IND											
On / off bed pan	Bottles Commode	x1										
Lateral transfers	PS	x4										
Falls assessment (Y / N)	YES											
On / off floor	HOVERJACK											
State make and model of hoist / stand aid												
State sling type and size												
Signed												

MOBILITY CODES
AST 1 / 2 / 3: Requires assistance of 1 / 2 / 3 or more staff
SUP: Supervision only **IND:** Independent
FWB: Full Weight Bearing
PWB: Partial Weight Bearing
NWB: Non Weight Bearing
BR: Bed Rest

HANDLING AIDS / EQUIPMENT CODES
H: Full body lifting hoist (specify hoist type + size of sling)
STA: Stand aid (specify hoist type + size of sling)
BH: Bathing hoist (specify hoist type)
SC: Shower chair **ST:** Shower Trolley
Pt T: Pt turner (specify e.g. Etac, Samhall, Cricket,)
W: Wheelchair or pushchair

GS: Glide sheet(s) **ES:** (Extension Straps)
PAT: Pat slide
HB: Hand blocks **HS:** Handling sling
C: Crutches (specify)
S: Stick(s)
Z: Zimmer

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Name:		CHI No.	

CHI: 0605770352
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FALLS CARE PLAN BUNDLE TRIGGER

Age 65 years or older?	Yes	☐	No	☑	Sign:
2 Falls or more in the last 6 months?	Yes	☐	No	☑	
Fall since admission?	Yes	☐	No	☑	Date: 4/3/16
Tries to walk alone but unsteady/unsafe?	Yes	☐	No	☑	Time: 06[illegible]
Patient or relatives anxious about falls?	Yes	☐	No	☑	
AMT4<4 or AMT 10 score 8 or less or acute confusion?	Yes	☐	No	☑	

ermine

lood flow pressure monitor, measurements are recommended after 10 minutes of lying supine, followed by measurements every 30 seconds standing for 3 minutes. Measurements may be continued for longer if blood pressure is still falling after 3 minutes. If the patient does

If NO to all questions in trigger complete only first 4 elements of care bundle (shaded bundle 2)
If YES to any questions above, complete full falls care plan bundle (bundle 3), (unless clinically inappropriate) ***mobility or at any time it is considered clinically appropriate***

Care Plan Bundle (2 & 3)	State Care to be Undertaken (bundle 4)
Call Ensure call bell explained and in reach. sider alternatives for patients unable to recall use of call bell *e.g. move bed in sight of nurses' station, telehealth care e.g movement alarms.*	Call bell to hand.
Footwear Check footwear is safe. Refer to In-patient Falls resource pack guidance and if required supply ward stock slippers.	Check prior to mobilising
Mobility Ensure patient has correct, appropriate walking aid and appropriate supervision/physical assistance when mobilising; ensure mobility issues are documented; request physio assessment.	Needs supervision until fully awake.
Vision/Hearing Ensure eyesight is checked wearing glasses if worn; able to identify pen/key from bed length away? If eyesight too poor to identify objects, ask doctor to review. Ensure glasses are worn or within reach. Advise patient/relatives on accessible opticians. Ensure hearing aid is in good working order, if required ask audiology to check, access amplifier etc.,	No issues
Medication Request a review of medication if [illegible]nt is on 4 medications or more or if the patient is on specific medications associated with heightened falls risk or **Anticoagulation medication**. Avoid unnecessary anti-depressants, sleeping tablets, sedation, anti-psychotics.	
Environment Patient in most appropriate place on ward for their needs *e.g. close to nurses' station, close to toilet, quietest area.* Consider wider aspects e.g. lighting, seating at referral. **Appropriate use of bed rails (see guidance)**	
Continence Perform urinalysis if there are signs of UTI.*(UTI's should only be treated if symptomatic)* Consider if there are signs of urgency.Does the risk of falls appear to be associated with patient's need to use toilet? If so, a routine of frequent toilet visits may be helpful in preventing falls.	
L&S BP Check Lying & Standing BP and record. If deficit exists inform doctor, advise patient on slow movement from sitting/lying to standing, consider anti-embolism/compression stockings.	
Cognition Complete a cognitive assessment and if clinically indicated, a delirium screen. Document and report results and refer as appropriate.	
Inform Provide falls leaflet to patient/family, engage them in care planning, discuss movement sensors, if issued, check contact wishes in event of fall.	

...ral hypotension

...erate standing for this period ...west systolic blood pressure ...ng upright posture should be ...orded. A decrease in systolic blood ...sure >20mmHg or a decrease in ...stolic blood pressure to <90mmgH ...defined as postural hypotension ...gardless whether or not symptoms occur.

Time	Heart rate	Blood Pressure	Symptoms
Supine t=0min			
Supine 10 min			
Continuous BP recording			
Stand 60 sec			
Stand 90 sec			
Stand 2 min			
Stand 2 min 30 sec			
Stand 3 min			

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...nd state care to be undertaken below. *Review care to be undertaken if situation changes i.e. a fall, changing*

	Evaluation			
...ign, Date, Time	Care Evaluated	Sign, Date, Time	Care Evaluated	Sign, Date, Time

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Addressograph label

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Initial Risk Assessment for Bed Rails

✓	Bed rails can be used
	Complete full risk assessment
	bed rails not recommended complete full risk assessment

Mobility

Circle appropriate box in algorithm

		Patient being transported on bed/trolley	Patient is immobile or hoist dependent	Patient is neither independent nor immobile	Patient can mobilise without help from staff
Mental State	Patient is confused and disorientated				
	Patient is drowsy				
	Patient is alert and orientated			✓	
	Patient is unconscious				

If algorithm box is green, bed rails can be used, if algorithm is amber or red and staff feel bed rails should still be used please complete full risk assessment below

Is more detailed risk assessment needed Yes/No

Full risk Assessment

Relevant medical condition – please tick all that apply
Cognitive Impairment: **Cerebral Palsy:** **CVA:**
Other-specify
Disability / Weakness – please tick
Leans to one side: **Hemiplegic:** **Amputee:**
Other-specify
Comprehension & Behaviour – (Orientation, Alertness, Confusion, Agitation, Learning Disability)
Consent obtained from patient – Yes/No if no why?
OR agreement with: **welfare guardian:** **Other Agency:**

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PATIENT ASSESSMENT, CARE PLAN AND REVIEW

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Start date of document....4.3.16.....

End date of document.....

Number of document.....

Frequency of Completion

This should be completed daily in every acute area or in-patients with longer term needs this can be less often. If patient care requirements change, document time, date and change in care in the actual nursing action box.

In community hospitals, this should be reviewed according to patient's condition but no less frequent than weekly.

The information within this document is confidential and may only be viewed and shared with the permission of the named patient

This care plan is a legal document. Your signature indicates you have reviewed and updated it and it is a true reflection of the care given by you or delegated by you.

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Staff identification – must be completed by all staff prior to recording in this document

Date	Designation	Print name	Signature	Initials
4/3/16	SN	V SMITH	V Smith	VS

			Date		Date 4/7/16
	Potential Care Requirement	***Goal***	***Assessment***	***Potential Nursing Actions***	***Actual Nursing Actions***
1	Patient Involvement in Planning Care	Enable patient to be included in planning their care	Patient/carer is involved in planning care ✓	***Please discuss and document patients goals***	
			Patient/carer requires prompting/assistance to participate in planning care		
			Patient/carer requires in-depth assistance in planning care		
2	Cognitive Function		No significant impairment ✓	**A.** Complete using Cognitive Assessment checklist and butterfly documentation **B.** Use REACH response **C.** Encourage involvement of relatives or carers **D.** Refer to Learning Disability or Liaison Psychiatry team according to protocols	
			Cognitive impairment has no significant impact on treatment		
			Delirium suspected/identified		
			Newly identified		
			Significant impact		
3	Behaviour that Challenges	To minimise the risk of distress or harm to patient, other patients and staff	No risk identified ✓	**A.** Reduce stress/distress - specify **B.** Use of ABC chart **C.** Complete patient risk assessment **D.** Implement safe working procedures **E.** Contact Risk Management for advice	
			Behaviour or psychological symptoms that are easily managed		
			Behaviours or psychological symptoms that need additional assistance or supervision		
			Verbal aggression towards self/other		
			Physical aggression towards self/others		
			Risk of absconding		
					Sign

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			Date		Date 4/3/16
	Potential Care Requirement	***Goal***	***Assessment***	***Potential Nursing Actions***	***Actual Nursing Actions***
4	Vital signs monitoring – including TPR, respiration, Sp02, blood glucose, Glasgow coma scale	Early recognition of change and early escalation to most appropriate health professional	Within normal parameters Out with normal parameters for patient ✓	**A.** T, P, BP, Resp, Sp02, - state frequency **B.** Blood transfusion observation **C.** Blood glucose – state frequency **D.** Neurological observation – state frequency **E.** Other – e.g. daily weight – please specify	COPY A -1°
5	Nutrition	Ensure the patient is monitored and given nutrition	Every patient will have a nutritional screening and a MUST care plan	**A.** Complete MUST care plan **B.** Review MUST care plan **C.** Complete patient board **D.** Enteral feeding **E.** TPN	To be completed ☺
6	Fluid Hydration	Prevention of dehydration	Independent Requires assistance/supervision/ Encouragement/fluid balance monitoring ✓ Dependent	**A.** Prompt to drink **B.** Assist to drink **C.** Requires specialist equipment – specify **D.** Monitor fluid balance **E.** Administer fluid replacement therapy – specify (IV, S/C, enteral **F.** Document equipment required (e.g. volumetric pump) **G.** Complete patient board	
7	Pressure Area Care	Prevent the acquisition of pressure ulcers	Braden = 15-16 – Low risk Braden = 13-14 – Moderate risk ✓ Braden = 12 or less High risk	**A.** Re-assess Braden Score **B.** Use of SSKINS bundle **C.** Document type of pressure relieving equipment in use **D.** Inspect skin – specify how often	
8	Mobility	Promote and maintain maximum mobility	Independent Requires assistance/ supervision/ walking aid ✓ Dependent	**A.** Complete mobility chart **B.** Complete patient bed board	A
9	Falls	Prevent falls	No history of falls and < 65 years No history of falls and > 65 years or history of falls – any age Bed rails in use ✓	**A.** Falls Care Plan **B.** Ensure patient bed board is up to date **C.** Complete/update bed rails risk assessment	A
					Sign

	Potential Care Requirement	Goal	Date / Assessment		Potential Nursing Actions	Date 4/3/16 / Actual Nursing Actions
10	Personal Hygiene	Enable patient to maintain appropriate level of personal hygiene	Independent		**A.** Self care **B.** Basin/shower/bed bath **C.** Hair washed **D.** Shave **E.** Nail Care **F.** Other **G.** Document changes **Specify level of assistance required**	COPY B x1 (Specimen)
			Requires assistance/supervision/ encouragement	✓		
			Dependent			
11	Oral Hygiene	Enable patient to maintain appropriate level of oral hygiene	Independent	✓	**A.** Self care **B.** Assistance to brush **C.** Mouthwash **D.** Denture care **E.** Full oral hygiene – state frequency	A
			Requires assistance/supervision/ encouragement			
			Dependent			
12	Elimination	Promote effective elimination function. Prevent Infection	Independent		**A.** Provide commode **B.** Walk/wheel to toilet – specify **C.** Catheter care – specify how often **D.** Hourly urine volumes **E.** Continence assessment **F.** Provide and change continence aids – specify **G.** Stool chart **H.** Review need for catheter **I.** Stoma care	A – Bottles or Commode
			Requires assistance/supervision/ catheter/stoma	✓		
			Dependent			
13	Pain	Provide appropriate pain management	No pain/mild pain	✓	**A.** Document pain an nausea score on EWS – state frequency **B.** Administer analgesia as prescribed **C.** Document additional pain assessment charts in use e.g. Abbey pain scale **D.** Complete infusion device chart	A B C
			Moderate pain/breakthrough medication required			
			Severe pain PCA/PCEA continuous sub cut infusion			
14	Infection Control	To prevent/reduce risk of infection	Not at risk of infection		**A.** Ensure MRSA risk assessment has been completed **B.** Ensure all invasive devices are documented **C.** Ensure patient is appropriately placed in ward **D.** Control measures in place	A B – Commode.
			Infection risks present: Previous infection identified			
			Invasive device in situ	✓		
			On antibiotics			
			Has diarrhoea or vomiting			
			Produce cough			
			Exfoliating skin conditions			
			Large leaking wounds			
			Suspected/confirmed infection			
15	Wound Care	Promote optimum wound healing	No wound/healed surgical wound		**A.** Complete wound assessment chart **B.** Refer to Wound Formulary for appropriate dressing choice **C.** Refer to Tissue Viability team for further advice	
			Clean, closed surgical wound			
			Open wound/skin integrity broken	✓		
						sign

Date 4/13/16

	Potential Care Requirement	Goal	Assessment		Potential Nursing Actions	Actual Nursing Actions
16	Communication	Enable effective communication	No communication difficulties identified	✓	**A.** Ensure environment private to enable conversation **B.** Give eye contact, speak clearly and ensure understanding **C.** Patient has glasses **D.** Patient has a working hearing aid **E.** Refer to Speech & Language **F.** Interpreter service **G.** Use written communication **H.** Contact sensory impairment centre	COPY A B
			Existing communication difficulty identified			
			New communication difficulty identified			
17	Emotional wellbeing (including spiritual and expressing sexuality)		No concerns identified	✓	**A.** Communicate about condition **B.** Ensure record is kept in family dialogue sheet **C.** Encourage use of personal clothes and belongings **D.** Consider referral to chaplaincy service	A
			Difficulty expressing concerns			
			Inability to manage			
18	Sleep	Promote and enable effective sleep	No difficulty with sleep identified	✓	**Specify actions required** **A.** Consider sleep assessment chart	
			Existing difficulty with sleep identified			
			New difficulty with sleep identified			
19	Discharge Plan	Facilitate a timely, safe and effective discharge	Simple discharge	✓	**A.** Ensure patient has PDD on e-ward **B.** Communicate PDD to patient **C.** Communicate PDD to relatives **D.** Commence discharge plan and dialogue	
			Complex discharge			
						Sign:

All Routes: As Required Prescriptions

Patient's Own Medicine

| | | |

FORTH VALLEY ACUTE HOSPITALS
Infusion Fluids / Blood Products Page

NHS Forth Valley

WARD	CONSULTANT	PATIENT DETAILS (Name and Address)
ALLERGIES - Please use RED INK		COPY

HEIGHT (m)	WEIGHT (kg)	DATE	SURFACE AREA (m^2)

HOSP | TE:

DATE

- enter dosage times as 24hour clock
- please write in block capitals in black pen
- IV site MUST be checked prior to and after IV administration

A

APPROVED DRUG NAME	DOSE	ROUTE
		IV

INFUSION FLUID	TOTAL VOLUME
(D) Saline	500ml

DOCTORS SIGNATURE	DATE	RATE
[signature]	14 3 16	4hr.

START TIME	INFUSION STARTED BY:
0255	AG 11/2017
PUMP NO.	BATCH NO.
	15L18T4H

B

APPROVED DRUG NAME	DOSE	ROUTE
		IV

INFUSION FLUID	TOTAL VOLUME
(N) SALINE	500ml

DOCTORS SIGNATURE	DATE	RATE
[signature]	04/03/16	6°

START TIME	INFUSION STARTED BY:
4/3/16	
TIME STARTED	VL
0710	
PUMP NO.	BATCH NO. Exp
	15K26T4E 10/17

C

APPROVED DRUG NAME	DOSE	ROUTE

INFUSION FLUID	TOTAL VOLUME

DOCTORS SIGNATURE	DATE	RATE

START TIME	INFUSION STARTED BY:
TIME STARTED	
PUMP NO.	BATCH NO.

D

APPROVED DRUG NAME	DOSE	ROUTE

INFUSION FLUID	TOTAL VOLUME

DOCTORS SIGNATURE	DATE	RATE

START TIME	INFUSION STARTED BY:
TIME STARTED	
PUMP NO.	BATCH NO.

E

APPROVED DRUG NAME	DOSE	ROUTE

INFUSION FLUID	TOTAL VOLUME

DOCTORS SIGNATURE	DATE	RATE

START TIME	INFUSION STARTED BY:
TIME STARTED	
PUMP NO.	BATCH NO.

F

APPROVED DRUG NAME	DOSE	ROUTE

INFUSION FLUID	TOTAL VOLUME

DOCTORS SIGNATURE	DATE	RATE

START TIME	INFUSION STARTED BY:
TIME STARTED	
PUMP NO.	BATCH NO.

G

APPROVED DRUG NAME	DOSE	ROUTE

INFUSION FLUID	TOTAL VOLUME

DOCTORS SIGNATURE	DATE	RATE

START TIME	INFUSION STARTED BY:
TIME STARTED	
PUMP NO.	BATCH NO.

H

APPROVED DRUG NAME	DOSE	ROUTE

INFUSION FLUID	TOTAL VOLUME

DOCTORS SIGNATURE	DATE	RATE

START TIME	INFUSION STARTED BY:
TIME STARTED	
PUMP NO.	BATCH NO.

National Early Warning Score (NEWS)

NHS Forth Valley

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Name:
DOB:
CHI No:
Address:

CHI: 0605770352 06/05/1977 M
WYLES
ALAN
17 CHARLES STREET
DUNBLANE
FK15 9BY.

*** Regardless of NEWS always escalate if concerned about a patient's condition**

Total NEWS	Frequency of Monitoring	Clinical Response
0 *	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations
1 - 4 *	Minimum 4 - 6 hourly	• Inform registered nurse who must assess the patient • Registered Nurse to decide if increased frequency of monitoring and / or escalation of clinical care is required
5 - 6 * or 3 in one Parameter	Increased frequency to a minimum of 1 hourly	• Registered nurse to urgently inform the medical team caring for the patient • Urgent assessment by a clinician with core competencies to assess acutely ill patients • Ensure structured Response Stickers A & B are completed *(Not Applicable in Emergency Dept)*
7* or more	Continuous monitoring of vital signs (3 lead ECG and continuous SpO2 monitoring, 15 minute BP cycling - document observations every 30 minutes)	• Registered nurse to immediately inform the medical team caring for the patient • Emergency assessment by clinical team with core competencies to assess acutely unwell patients • Ensure structured Response Stickers A & B are completed *(Not Applicable in Emergency Dept)* • Consider transfer of clinical care to ITU

Exclusion Criteria

Anaesthesia and/or sedation may result in reduced conscious levels for a period of time. Scores that are increasing post-procedure and those including "P" or "U" always require escalation. The post-procedure NEWS score and post procedure plan that will include the frequency of observations should be communicated to the ward staff on transfer/handover of the patient.

Target O2 Saturation

Target SpO2 for most patients should be 94-98%.
Selected patients may require target SpO2 88-92% (Appropriate in specific patients with severe chronic respiratory disease who either have established chronic Type 2 respiratory failure, or are felt to be at significantly increased risk of CO2 retention from oxygen therapy). These patients should use the modified (chronic hypercapnia) EWS. Arterial blood gases should be repeated at 30–60 min to check for rising CO2 or H^+ after initiation of oxygen in this context.

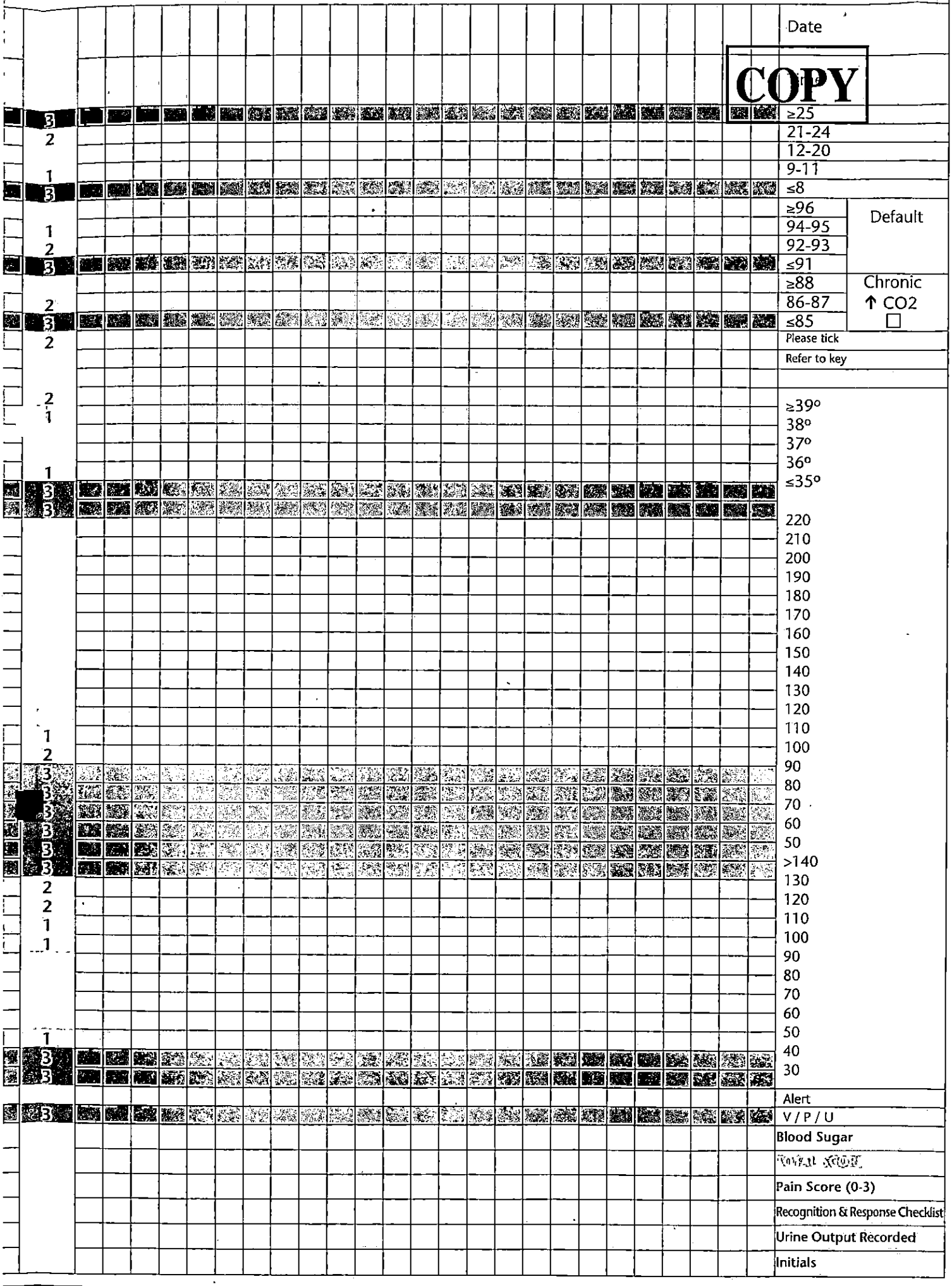
Acute Respiratory Failure is a life threatening emergency
Severe Hypoxia (Requiring >60% O2 to maintain target SpO2)
Acute Hypercapnia (pCO2 >6 and H^+ >45)
Urgent ST3 (or equivalent) review is required to optimise management.
Duty or on call consultant should be contacted if advice required.
Critical care referral and ventilatory support may be needed.

Pain Score
0 = no pain
1 = mild pain
2 = moderate pain
3 = severe pain

Codes For Recording Oxygen Delivery On NEWS Chart

A = Air (not requiring oxygen or weaning or on PRN oxygen)
N = Nasal Canulae
SM = Simple Mask
V24 =Venturi 24% V28 = Venturi 28% V35 = Venturi 35% V40 = Venturi 40% V60 = Venturi 60%
H28 = Humidified oxygen at 28% (also H35, H40 & H60 = Humidified Oxygen at 35%, 40% & 60%)
RM = Reservoir Mask
TM = Tracheostomy Mask
CP = Patient on CPAP System
NIV = Patient on NIV System
OTH = Other Device:_____ (specify which)

CHI: **WARD:**



Score 5-6 (or 3 in one parameter) = 1 hourly

Score 7 or More = Continuous

I: 0605770352 06/05/1977 M
'LES
AN
CHARLES STREET
INBLANE
15 9BY

NAME: **DOB:**

COPY

Date			8/9/17				
Time			0250	0340	0950	1210	
RESP RATE	≥25						3
	21-24						2
	12-20		17	16	17	18	
	9-11						1
	≤8						3
SpO2 Tick if using Patients with Chronic Hypercapnia	Default	≥96	98	96	96	97	
		94-95					1
		92-93					2
		≤91					3
	Chronic ↑ CO2	≥88					
		86-87					2
Sign:	☐	≤85					3
Inspired O2	Please tick						2
O2 Device or Air	Refer to key		A	A	A	A	
O2 Flow or Rate							
TEMP		≥39°					2
		38°					1
		37°					
		36°					
Mark •		≤35°					3
SYSTOLIC BLOOD PRESSURE		220					
		210					
		200					
		190					
		180					
		170					
		160					
		150					
		140					
		130					
		120			^	^	
Mark ↕		110	↑	↑	:		1
		100	:	:	:	:	
		90	:	:	:	:	2
		80	:	:	:	:	3
		70	↓	↓	:	↓	3
		60			✓		3
		50					3
HEART RATE		>140					3
		130					2
		120					2
		110					1
		100					1
		90					
		80					
		70					
		60					
Mark •		50					1
		40					3
		30					3
CONSCIOUS LEVEL	Alert		✓	✓	✓	✓	
	V / P / U						3
Blood Sugar							
TOTAL SCORE			0	0	0	0	
Pain Score (0-3)						0	
Recognition & Response Checklist				/	N	x	
Urine Output Recorded				/	N	x	
Initials			AG	MR	BS	CT	

NEWS Recording Frequency: Score 0 = Routinely Score 1-4 = Minimum 4-6 hourly

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PATIENT ASSESSMENT, CARE PLAN AND REVIEW

Affix

CHI NO: 0605770352 06/05/1977
CRN: S278537 M
Alan Wyles
17 Charles Street,
DUNBLANE,
Perthshire
FK15 9BY

Start date of document 19/9/17

End date of document

Number of document (1)

Frequency of Completion

This should be completed daily in every acute area or in-patients with longer term needs this can be less often. If patient care requirements change, document time, date and change in care in the actual nursing action box.

In community hospitals, this should be reviewed according to patient's condition but no less frequent than weekly.

The information within this document is confidential and may only be viewed and shared with the permission of the named patient

			-Date			Date
	Potential Care Requirement	***Goal***	***Assessment***		***Potential Nursing Actions***	***Actual Nursing Actions***
1	Patient Involvement in Planning Care	Enable patient to be included in planning their care	Patient/carer is involved in planning care	✓	***Please discuss and document patients' goals***	
			Patient/carer requires prompting/assistance to participate in planning care			
			Patient/carer requires in-depth assistance in planning care			
2	Cognitive Function		No significant impairment	✓	**A.** Complete using Cognitive Assessment checklist and butterfly documentation **B.** Use REACH response **C.** Encourage involvement of relatives or carers **D.** Refer to Learning Disability or Liaison Psychiatry team according to protocols	
			Cognitive impairment has no significant impact on treatment			
			Delirium suspected/identified			
			Newly identified			
			Significant impact			
3	Behaviour that Challenges	To minimise the risk of distress or harm to patient, other patients and staff	No risk identified	✓	**A.** Reduce stress/distress - specify **B.** Use of ABC chart **C.** Complete patient risk assessment **D.** Implement safe working procedures **E.** Contact Risk Management for advice	
			Behaviour or psychological symptoms that are easily managed			
			Behaviours or psychological symptoms that need additional assistance or supervision			
			Verbal aggression towards self/other			
			Physical aggression towards self/others			
			Risk of absconding			
						Sign

COPY

			Date			Date
	Potential Care Requirement	***Goal***	***Assessment***		***Potential Nursing Actions***	***Actual Nursing Actions***
4	Vital signs monitoring – including TPR, respiration, Sp02, blood glucose, Glasgow coma scale	Early recognition of change and early escalation to most appropriate health professional	Within normal parameters Out with normal parameters for patient	✓	**A.** T, P, BP, Resp, Sp02, - state frequency **B.** Blood transfusion observation **C.** Blood glucose – state frequency **D.** Neurological observation – state frequency **E.** Other – e.g. daily weight – please specify	
5	Nutrition	Ensure the patient is monitored and given nutrition	Every patient will have a nutritional screening and a MUST care plan		**A.** Complete MUST care plan **B.** Review MUST care plan **C.** Complete patient board **D.** Enteral feeding **E.** TPN	
6	Fluid Hydration	Prevention of dehydration	Independent Requires assistance/supervision/ Encouragement/fluid balance monitoring Dependent	✓	**A.** Prompt to drink **B.** Assist to drink **C.** Requires specialist equipment – specify **D.** Monitor fluid balance **E.** Administer fluid replacement therapy – specify (IV, S/C, enteral **F.** Document equipment required (e.g. volumetric pump) **G.** Complete patient board	
7	Pressure Area Care	Prevent the acquisition of pressure ulcers	Braden = 15-16 – Low risk Braden = 13-14 – Moderate risk Braden = 12 or less High risk		**A.** Re-assess Braden Score **B.** Use of SSKINS bundle **C.** Document type of pressure relieving equipment in use **D.** Inspect skin – specify how often	
8	Mobility	Promote and maintain maximum mobility	Independent Requires assistance/ supervision/ walking aid Dependent	✓	**A.** Complete mobility chart **B.** Complete patient bed board	
9	Falls	Prevent falls	No history of falls and < 65 years No history of falls and > 65 years or history of falls – any age Bed rails in use	✓	**A.** Falls Care Plan **B.** Ensure patient bed board is up to date **C.** Complete/update bed rails risk assessment	
						Sign CT

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	Potential Care Requirement	Goal	Date Assessment		Potential Nursing Actions	Date Actual Nursing Actions
10	Personal Hygiene	Enable patient to maintain appropriate level of personal hygiene	Independent	✓	**A.** Self care **B.** Basin/shower/bed bath **C.** Hair washed **D.** Shave **E.** Nail Care **F.** Other **G.** Document changes **Specify level of assistance required**	
			Requires assistance/supervision/ encouragement			
			Dependent			
11	Oral Hygiene	Enable patient to maintain appropriate level of oral hygiene	Independent	✓	**A.** Self care **B.** Assistance to brush **C.** Mouthwash **D.** Denture care **E.** Full oral hygiene – state frequency	
			Requires assistance/supervision/ encouragement			
			Dependent			
2	Elimination	Promote effective elimination function. Prevent Infection	Independent	✓	**A.** Provide commode **B.** Walk/wheel to toilet – specify **C.** Catheter care – specify how often **D.** Hourly urine volumes **E.** Continence assessment **F.** Provide and change continence aids – specify **G.** Stool chart **H.** Review need for catheter **I.** Stoma care	
			Requires assistance/supervision/ catheter/stoma			
			Dependent			
13	Pain	Provide appropriate pain management	No pain/mild pain	✓	**A.** Document pain an nausea score on EWS – state frequency **B.** Administer analgesia as prescribed **C.** Document additional pain assessment charts in use e.g. Abbey pain scale **D.** Complete infusion device chart	
			Moderate pain/breakthrough medication required			
			Severe pain PCA/PCEA continuous sub cut infusion			
14	Infection Control	To prevent/reduce risk of infection	Not at risk of infection		**A.** Ensure MRSA risk assessment has been completed **B.** Ensure all invasive devices are documented **C.** Ensure patient is appropriately placed in ward **D.** Control measures in place	
			Infection risks present: Previous infection identified			
			Invasive device in situ	✓		
			On antibiotics	✓		
			Has diarrhoea or vomiting			
			Produce cough			
			Exfoliating skin conditions			
			Large leaking wounds			
			Suspected/confirmed infection			
15	Wound Care	Promote optimum wound healing	No wound/healed surgical wound	✓	**A.** Complete wound assessment chart **B.** Refer to Wound Formulary for appropriate dressing choice **C.** Refer to Tissue Viability team for further advice	Neck Cellulitis
			Clean, closed surgical wound			
			Open wound/skin integrity broken			
						sign CT

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	Potential Care Requirement	Goal	Assessment		Potential Nursing Actions	Date Actual Nursing Actions
16	Communication	Enable effective communication	No communication difficulties identified	✓	**A.** Ensure environment private to enable conversation **B.** Give eye contact, speak clearly and ensure understanding **C.** Patient has glasses **D.** Patient has a working hearing aid **E.** Refer to Speech & Language **F.** Interpreter service **G.** Use written communication **H.** Contact sensory impairment centre	COPY
			Existing communication difficulty identified			
			New communication difficulty identified			
17	Emotional wellbeing (including spiritual and expressing sexuality)		No concerns identified	✓	**A.** Communicate about condition **B.** Ensure record is kept in family dialogue sheet **C.** Encourage use of personal clothes and belongings **D.** Consider referral to chaplaincy service	
			Difficulty expressing concerns			
			Inability to manage			
18	Sleep	Promote and enable effective sleep	No difficulty with sleep identified	✓	**Specify actions required** **A.** Consider sleep assessment chart	
			Existing difficulty with sleep identified			
			New difficulty with sleep identified			
19	Discharge Plan	Facilitate a timely, safe and effective discharge	Simple discharge	✓	**A.** Ensure patient has PDD on e-ward **B.** Communicate PDD to patient **C.** Communicate PDD to relatives **D.** Commence discharge plan and dialogue	
			Complex discharge			
						Sign: CT

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CARE BUNDLE AND ASSESSMENT BOOKLET

CHI NO: 0605770352 06/05/1977
CRN: S278537 M
Alan Wyles
17 Charles Street,
DUNBLANE,
Perthshire
FK15 9BY

Date of admission ..19.9.17

Ward admitted to ..CAU..

Consultant .....

Ward transferred to .....

Date of transfer .....

Consultant .....

ard transferred to .....

Date of transfer .....

Consultant .....

Booklet number ...(1)...

Initial assessments completed and signed

MRSA – on admission	☐
Braden – within 6 hours of admission	☐
4 AT – within 6 hours of admission	☐
MUST – within 24 hours of admission	☐
Patient handling and mobility – within 24 hours of admission	☐
Bed rails - within 24 hours of admission	☐
Falls – within 24 hours of admission	☐
Oral care – within 24 hours of admission	☐
Stool chart – within 24 hours of admission	☐

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Infection Prevention and Control
Risk Assessment

NHS Forth Valley

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On admission, **ALL** patients must be assessed for risk of infection and action taken to minimise the risk

MRSA Clinical Risk Assessment (CRA) All questions must be answered

1	Has the patient any history of MRSA (check eward and clinical portal)	YES	(NO)
2	Has the patient been admitted from anywhere other than their own home (e.g.) care home, prison, hostel or transferred from other hospital	YES	(NO)
3	Does the patient have any wounds / ulcers or indwelling medical advices (e.g. urinary catheter, PEG, Hickman line, etc)	YES	(NO)
4	Is the patient being admitted / transferred to ITU, B23 or B31	YES	(NO)

A **YES** response to questions 1, 2 or 3 indicates there is a risk of MRSA skin carriage. The patient must be **isolated in a single room and swabs taken.**

A **YES** response to question 4 confirms admission to high risk speciality and the patient must have an **MRSA screen** sent.

MRSA ADMISSION SCREEN – swabs from nose, perineum, wounds and invasive device insertion site. Also send a CSU if urinary catheter is present. NOTE: this is the minimal screen required and additional swabs can be sent if clinically indicated.

Additional Presentations Requiring Placement in a Single Room	**Yes**	**No**	**NA**
Multi drug resistant organisms e.g. CPE, VRE		✓	
Suspected infective diarrhoea e.g., C.*diff*, food poisoning, Norovirus		✓	
Suspected or confirmed Influenza		✓	
Suspected or confirmed Pulmonary Tuberculosis (TB)		✓	
Fever in a returning traveller		✓	
New or unexplained rashes (consider Scabies)		✓	
Suspected infective rash e.g. measles, rubella, chickenpox		✓	
Suspected meningitis or encephalitis		✓	
Transfers from other hospitals, including community hospitals & care homes		✓	
Immunosuppressed patients		✓	
If yes to any of the above and patient not placed in single room a risk assessment must be completed			

Nurse completing the risk assessment (Sign and print):	[signature]
Date	19-9-17

BRADEN RISK ASSESSMENT CHART

Individuals with a total score of 16 or less are considered at risk: 15-16 = low risk, 12-14 = moderate risk, 11 or less = high risk.
Undertake and document risk assessment within 6 hours of admission or on first home visit. Reassess if there is a change in individual's condition and repeat regularly according to local protocol
Complete care and comfort round chart.

					DATE	19/9/17					
					TIME	1130					
Sensory Perception – Ability to respond meaningfully to pressure related discomfort	**1.Completely Limited** Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation. **OR** limited ability to feel pain over most of body surface.	**2.Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. **OR** has a sensory impairment that limits the ability to feel pain or discomfort over ½ of body.	**3. Slightly Limited** Responds to verbal commands but cannot always communicate discomfort or need to be turned. **OR** has some sensory impairment that limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or voice pain or discomfort.		4					
Moisture – Degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient/client is moved or turned.	**2. Very Moist** Skin is often but not always, moist. Linen must be changed at least once a shift.	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry. Linen only requires changing at routine intervals.		4					
Activity – Degree of physical activity	**1. Bedfast** Confined to bed.	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during day but for very short distance, with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks Frequently** Walks outside the room at least twice a day and inside the room every 2 hours during waking hours.		4					
Mobility – Ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance.	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitations** Makes major and frequent changes in position without assistance.		4					
Nutrition – Usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** is NPO and/or maintained on clear liquids or IV's for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement **OR** receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat or dairy products) each day. Occasionally will refuse meal but will usually take a supplement if offered **OR** is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4					
Friction and Shear –	**1. Problem** Requires moderate to maximum assistance in moving.	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.			3					
				Indicate appropriate number and add for total score	TOTAL SCORE:	23					
					SIGNATURE:	CT					

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THE 4AT TEST: SCREENING INSTRUMENT FOR COGNITIVE IMPAIRMENT AND DELIRIUM

4AT

NHS Forth Valley

Is there an existing dementia diagnosis? If yes – details_____

		DATE	19/9/17	/ /	/ /	/ /	/ /	/ /	/ /
1. ALERTNESS: *This includes patients who may be markedly drowsy (e.g. 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 (fully alert, but not agitated throughout assessment)		0	0	0	0	0	0	0
	Mild sleepiness for <10 seconds after waking, then normal		0	0	0	0	0	0	0
	Clearly abnormal		4	4	4	4	4	4	4
2. AMT4: *Age, date of birth, place (name of hospital or building), current year*	No mistakes		0	0	0	0	0	0	0
	1 mistake		1	1	1	1	1	1	1
	2 or more mistakes/un-testable		2	2	2	2	2	2	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		0	0	0	0	0	0	0
	Starts but scores <7 months/refuses to start		1	1	1	1	1	1	1
	Un-testable (cannot start because unwell, drowsy, inattentive		2	2	2	2	2	2	2
4. ACUTE CHANGE OR FLUCTUATING COURSE: *Evidence of significant change or fluctuation in: alertness, cognition, other mental function (e.g. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs*	No		0	0	0	0	0	0	0
	Yes		4	4	4	4	4	4	4
		Initials of tester →	CT						
4 or above: Possible delirium +/- cognitive impairment *(score daily until score <4 for 2 consecutive days)*		**Day 1 4ATscore**	**Day 2 4ATscore**	**Day 3 4ATscore**	**Day 4 4ATscore**	**Day 5 4ATscore**	**Day 6 4ATscore**	**Day 7 4ATscore**
1 – 3: Possible cognitive impairment		0	—	—	—	—	—	—
0: Delirium or cognitive impairment unlikely								

If score is 4 or above, please initiate TIME bundle. If there is no diagnosis and the 4AT score is 1-3, please obtain AMT10 and collateral history and refer to Liaison Psychiatry for Older People if any concerns regarding normal level of cognition.

COPY

1 2 3

NAME:

DOB:

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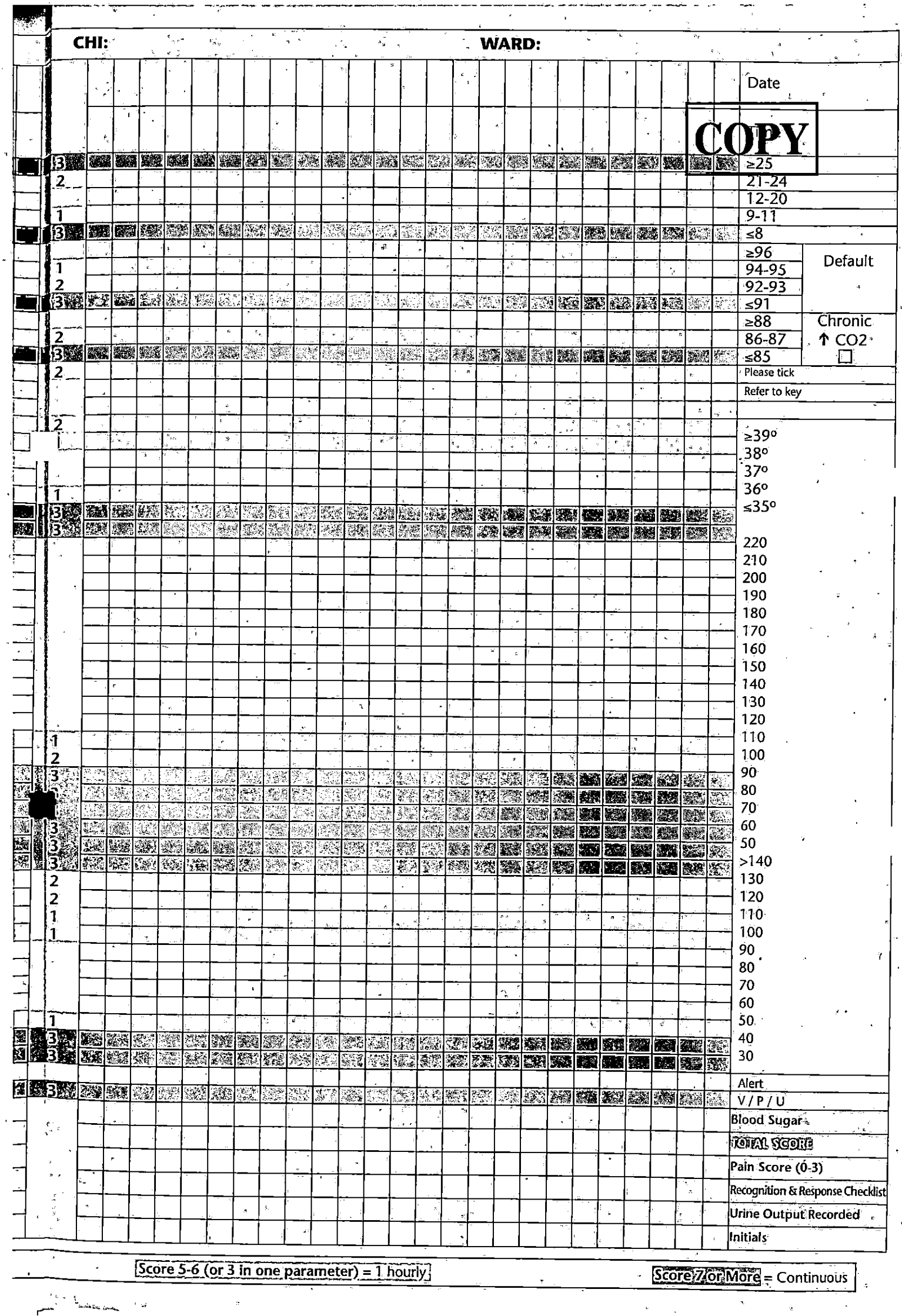
CHI: 0605770352
WYLES
ALAN
SPRINGKERSE HOUSE
STIRLING
FK7 7SN
06/05/1977

| | | |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≥88
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Alert
V / P / U
Blood Sugar
TOTAL SCORE
Pain Score (0-3)
Recognition & Response Checklist
Urine Output Recorded
Initials
Score 5-6 (or 3 in one parameter) = 1 hourly
Score 7 or More = Continuous

Early Warning Score (NEWS)

NHS Forth Valley

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06/05/1977 M

HOUSE

NEWS always escalate if concerned about a patient's condition

	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations
1 - 4	Minimum 4 - 6 hourly	• Inform registered nurse who must assess the patient • Registered Nurse to decide if increased frequency of monitoring and / or escalation of clinical care is required
5 - 6	Increased frequency to a minimum of 1 hourly	• Registered nurse to urgently inform the medical team caring for the patient • Urgent assessment by a clinician with core competencies to assess acutely ill patients • Ensure structured Response Stickers A & B are completed *(Not Applicable in Emergency Dept)*
7 + or more	Continuous monitoring of vital signs (3 lead ECG and continuous SpO2 monitoring, 15 minute BP cycling - document observations every 30 minutes)	• Registered nurse to immediately inform the medical team caring for the patient • Emergency assessment by clinical team with core competencies to assess acutely unwell patients • Ensure structured Response Stickers A & B are completed *(Not Applicable in Emergency Dept)* • Consider transfer of clinical care to ITU

Criteria

anaesthesia and/or sedation may result in reduced conscious levels for a period of time. Scores that are increasing post-procedure and those including "P" or "U" always require escalation. The post-procedure NEWS care and post procedure plan that will include the frequency of observations should be communicated to the ward staff on transfer/handover of the patient.

Target O2 Saturation

Target SpO2 for most patients should be 94-98%.

Selected patients may require target SpO2 88-92% (Appropriate in specific patients with severe chronic respiratory disease who either have established chronic Type 2 respiratory failure, or are felt to be at significantly increased risk of CO2 retention from oxygen therapy). These patients should use the modified (chronic hypercapnia) EWS. Arterial blood gases should be repeated at 30–60 min to check for rising CO2 or H^+ after initiation of oxygen in this context.

Acute Respiratory Failure is a life threatening emergency

Acute Hypoxia (Requiring >60% O2 to maintain target SpO2)

Severe Hypercapnia (pCO_2 >6 and H^+ >45)

Urgent ST3 (or equivalent) review is required to optimise management.

Duty or on call consultant should be contacted if advice required.

Critical care referral and ventilatory support may be needed.

Pain Score

0 = no pain
1 = mild pain
2 = moderate pain
3 = severe pain

Codes For Recording Oxygen Delivery On NEWS Chart

(not requiring oxygen or weaning or on PRN oxygen)

A = Air
N = Nasal Canulae
SM = Simple Mask
V24 = Venturi 24% V28 = Venturi 28% V35 = Venturi 35% V40 = Venturi 40% V60 = Venturi 60%
H28 = Humidified oxygen at 28% (also H35, H40 & H60 = Humidified Oxygen at 35%, 40% & 60%)
RM = Reservoir Mask
TM = Tracheostomy Mask
Patient on CPAP System
Patient on NIV System
Device: _____ (specify which)

Conscious Level Chart (only as required for head injury observation)

			DATE: 23/2/19	DATE:
			TIME: 1930	TIME:

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COMA SCALE	Eyes Open	Spontaneously	4	Eyes closed by swelling = C
		To speech	3 e e	
		To pain	2	
		None	1	
	Best verbal response	Orientated	5 6	Endotracheal tube or tracheostomy = T
		Confused	4 e	
		Inappropriate words	3	
		Incomprehensible sounds	2	
		None	1	
	Best motor response	Obey commands	6 v v	Usually record the best arm response
		Localise pain	5	
		Withdraws to pain	4	
		Flexion to pain	3	
		Extension to pain	2	
		None	1	

1 2 3 4 5 6 7 8

Pupil Scale (mm)

PUPILS	right	Size	3 3 3	+ reacts - no reaction c. eye closed
		Reaction	+ + +	
	left	Size	3 3 3	
		Reaction	+ + c	
LIMB MOVEMENT ARMS		Normal power	R L	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	R L	
		Mild weakness		
		Severe weakness		
		Extension		
		No response		

Pain Assessment & Management Guidelines

Pain Score:

0 = No pain
1 = No pain at rest
Slight pain on movement
2 = Intermittent pain at rest
Moderate pain on movement
3 = Continuous pain at rest

For Acute and Chronic Pain:
For mild (1), moderate (2) or severe (3) pain refer to Pain Management Guidelines Forth Valley Formulary Appendix 27 & 28. Implement Pain Assessment Chart

For Cancer Related Pain:
For mild (1), moderate (2) or severe (3) pain score, refer Palliative Guidelines.

NHS Forth Valley

PERIPHERAL VASCULAR CATHETER (PVC) DAILY MAINTENANCE

Label	Reason for insertion:	DAY 0	
Name [redacted]	Insertion Date: 23/2/19 Time:	COPY	
D.O.B. CHI: 0605770352	Colour/batch no: PINK. Position (L) ACF		
CHI: 06/05/1977 M	Hand hygiene (HH) performed	Yes	No
Hospi WYLES Alan	Skin cleansed for 30 seconds with antiseptic & left to dry prior to insertion	Yes	No
(Use i 13C KINGSEAT AVENUE	Aseptic technique throughout	Yes	No
GRANGEMOUTH	Sterile dressing applied including date and time	Yes	No
STIRLINGSHIRE FK3 0AA	Inserted by:		
	Ward inserted: ED		

Ensure that:
Medical staff review the need for intravenous (IV) therapy **including antibiotics on a daily basis – switch to oral if possible**
An antiseptic containing 70% isopropyl alcohol is used to clean the access hub. **Before accessing, rub the access hub for at least 15 seconds** ("scrub the hub")

MODIFIED VIP (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 sign:	Remove & replace cannula. Observe both sites and document. **Obtain swab**
Two or more of the following are evident: Pain, redness or swelling	2	Early stages of phlebitis:	Remove & replace cannula. Observe both sites and document. Treat if necessary. **Obtain swab**
All of the following are evident: Pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis	Remove and seek further advice. **Obtain swab**
As above including palpable venous cord	4		Remove and seek further advice. **Obtain swab**
As above including pyrexia	5		Seek further advice.

24 hours Date:	Time:	
Is PVC still required	YES	NO
Absence of inflammation/extravasation	YES	NO
VIP score - *please circle*	0 1 2 3 4 5	
PVC dressing intact	YES	NO
PVC inserted <72 hrs	YES	NO
HH before/after procedure	YES	NO
"Scrub the Hub" (before use)	YES	NO
PVC – *please circle*	Left in situ	removed
Reason for removal:		
Signature:		

48 hours Date:	Time:	
Is PVC still required	YES	NO
Absence of inflammation/extravasation	YES	NO
VIP score - *please circle*	0 1 2 3 4 5	
PVC dressing intact	YES	NO
PVC inserted <72 hrs	YES	NO
HH before/after procedure	YES	NO
"Scrub the Hub" (before use)	YES	NO
PVC – *please circle*	Left in situ	removed
Reason for removal:		
Signature:		

72 hours Date:	Time:	
Is PVC still required	YES	NO
Absence of inflammation/extravasation	YES	NO
VIP score - *please circle*	0 1 2 3 4 5	
PVC dressing intact	YES	NO
PVC inserted <72 hrs	YES	NO
HH before/after procedure	YES	NO
"Scrub the Hub" (before use)	YES	NO
PVC – *please circle*	Left in situ	removed
Reason left in situ:		
Discussed with:		
Reason for removal:		
Signature:		

If PVC to remain in situ for longer than 72 hours this must be documented on a daily basis in notes and discussed with medical staff.

Observe closely for clinical signs and symptoms of Phlebitis.

New sheet to be commenced.

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Forth Valley

ACUTE HOSPITAL ASSESSMENT & CARE PLAN BOOKLET

COPY

Affix addressograph here

CHI NO: 0605770352 06/05/1977
CRN: M
Alan WYLES
2 GORDON SQUARE

STIRLING
FK8 1FN

Date of admission:
Time of admission:
Ward admitted to:
Date/Time of transfer:
Ward transferred to:
Date/Time of transfer:
Ward transferred to:
Booklet number:

Assessment	Initial assessment to be completed within:	Admitting Area Initials	Transfer Area Initials
CPE (1st ward only)	On admission		N/A
Hydration Assessment	4 hours		
BRADEN/Skin Assessment	6 – 8 hours		
Falls Trigger Tool/Care Plan	6 hours		
Bed Rails Assessment	6 hours		
4AT	24 hours		
Personal Hygiene and Continence	24 hours		
Oral Care Assessment and Care Plan	24 hours		
MUST Screening and Care Plan	24 hours		
Patient Handling and Mobility Chart	24 hours		
Bowel Function assessment and Care Plan	24 hours		

Daily assessments

1. Hydration
2. Skin assessment
3. Personal hygiene & continence
4. Bowel function

Assessments must be carried out by the required time **on admission or transfer.**

Apart from daily assessment, all other assessments will be reviewed weekly

If patients conditions changes, assessments must be stepped up to appropriate level of monitoring immediately

Patient/Carer consented to or participated in care plan process:

Staff Initials:.....

Communication Assessment
No concerns ○
New expressive difficulties (inability to name 3 objects clearly or slurred speech evident) ○
New receptive difficulties (not understanding or following commands i.e. close eyes, make fist) ○
Pre-existing. (Not new to this admission) ○ (Document details in progress notes).
Check for any communication support materials being used at home, please document in the unified progress notes.

The information within this document is confidential and may only be viewed and shared with the permission of the named patient.

This acute assessment and care plan booklet is a legal document. Your signature indicates you have assessed and planned care with your patient/carer and is a true reflection of the care that will be delivered by you or delegated by you.

COPY

Staff identification – must be completed by all staff prior to recording in this document (once only)

Date	Designation	Print name	Signature	Initials
03/06/20	B11	Katie Hill		

Infection Prevention and Control Risk Assessment

COPY

All patients admitted must have a Clinical risk assessment (**CRA**) for Carbapenemase-Producing *Enterobacteriaceae* (**CPE**) and Meticillin Resistant Staphylococcus *aureus* (**MRSA**).**This is a mandatory requirement.**

CPE Clinical Risk Assessment (No patients are excluded from CPE screening).	**Response**	
Has the patient had any previous history of CPE (check clinical portal)	YES	NO
Has the patient been transferred directly from another hospital out with NHSFV	YES	NO
Has the patient a history of admission to a hospital out with Forth Valley in the last 12 months (including dialysis patients)	YES	NO
Has the patient been in close contact with a person colonised or infected with CPE	YES	NO

A **YES** response to **ANY** of the above questions suggests the patient has an increased risk of CPE and the following actions must be taken:

- Isolated the patient in a single side room, STOP sign on door, contact precautions (PPE)
- The patient is given an information leaflet and consent is obtained for swabbing;
- CPE screen: Rectal swab taken by a registered nurse or stool specimen and, if present, a wound swab. A urine specimen is required if a urinary catheter is present:
- A rectal swab **must not** be used for children under 16 years. A stool specimen should be sent.

	MRSA Clinical Risk Assessment (Exclusions from MRSA screening include: Day case patients and admissions to paediatric, obstetric and mental health specialities)	**Response**	
1	Has the patient a history of MRSA, (check clinical portal)	YES	NO
2	Has the patient been admitted from anywhere other than their own home, e.g. care home, hostel, prison, or transferred from another hospital.	YES	NO
3	Does the patient have any wounds or indwelling medical devices (e.g. PEG, Hickman line, urinary catheter)	YES	NO
	Will the patient be admitted / transferred to ITU, B23 or B31	YES	NO

A **YES** response to questions **1- 3** indicates an increased risk of MRSA colonisation. The following actions must be taken:

- The patient is isolated in a single side room, STOP sign on door, contact precautions initiated;
- The patient is given an MRSA screening leaflet and consent obtained for swabbing;
- MRSA screen: swab nose, perineum and if present, wounds and insertion sites of invasive devices. A urine specimen is required if a catheter is present.

Note: this is the minimal screen required and additional swabs can be sent if clinically indicated.

A **YES** response to question **4** confirms admission to a high risk specialty and the following actions must be taken:

- The patient is given an MRSA screening leaflet and consent obtained for swabbing;
- MRSA screen: swab nose, perineum and if present, wounds and insertion sites of invasive devices. A urine specimen is required if a catheter is present.

Sign	**Date** 08/06/25	**Swabs sent: Yes / No/NA**

NHS Forth Valley

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ACUTE HOSPITAL ASSESSMENT & CARE PLAN BOOKLET

Affix addressograph here

CHI NO: 0605770352 06/05/1977
CRN: M
Alan WYLES
2 GORDON SQUARE

STIRLING
FK8 1FN

Date of admission:
Time of admission:
Ward admitted to:
Date/Time of transfer:
Ward transferred to:
Date/Time of transfer:
Ward transferred to:
Booklet number:

Assessment	Initial assessment to be completed within:	Admitting Area Initials	Transfer Area Initials
CPE (1st ward only)	On admission		N/A
Hydration Assessment	4 hours		
BRADEN/Skin Assessment	6 – 8 hours		
Falls Trigger Tool/Care Plan	6 hours		
Bed Rails Assessment	6 hours		
4AT	24 hours		
Personal Hygiene and Continence	24 hours		
Oral Care Assessment and Care Plan	24 hours		
MUST Screening and Care Plan	24 hours		
Patient Handling and Mobility Chart	24 hours		
Bowel Function assessment and Care Plan	24 hours		

Daily assessments

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2. Skin assessment
3. Personal hygiene & continence
4. Bowel function

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Staff Initials.....

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New expressive difficulties (inability to name 3 objects clearly or slurred speech evident) ○
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Staff identification – must be completed by all staff prior to recording in this document (once only)

Date	Designation	Print name	Signature	Initials
03/05/23	BII	Katie Hill		

Infection Prevention and Control Risk Assessment

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2	Has the patient been admitted from anywhere other than their own home, e.g. care home, hostel, prison, or transferred from another hospital.	YES	NO
3	Does the patient have any wounds or indwelling medical devices (e.g. PEG, Hickman line, urinary catheter)	YES	NO
	Will the patient be admitted / transferred to ITU, B23 or B31	YES	NO

A **YES** response to questions **1- 3** indicates an increased risk of MRSA colonisation. The following actions must be taken:

- The patient is isolated in a single side room, STOP sign on door, contact precautions initiated;
- The patient is given an MRSA screening leaflet and consent obtained for swabbing;
- MRSA screen: swab nose, perineum and if present, wounds and insertion sites of invasive devices. A urine specimen is required if a catheter is present.

Note: this is the minimal screen required and additional swabs can be sent if clinically indicated.

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- MRSA screen: swab nose, perineum and if present, wounds and insertion sites of invasive devices. A urine specimen is required if a catheter is present.

Sign	**Date** 08/06/23	**Swabs sent: Yes / No/NA**

Daily Hydration Risk Assessment

Risk assessment should be carried out within 4 hrs of admission and daily thereafter

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1. Diarrhoea / High output from stoma
High output from NG
Large open wound
Excessive vomiting
Bladder irrigation
RR >20per minute
Temp > 38oc

2. Prescribed IV fluid / IV diuretics / parenteral nutrition and or on a fluid restriction

3. Routine post op management where indicated

4. Urinary catheter in situ with **hourly** volumes
NEWS>5

5. Requires assistance to eat or drink or has swallowing problems

No risk factors present → Assess daily, no care plan required.

1 or more risk factors present →
- Commence fluid balance chart within 1 hour
- Complete Hydration Care Plan.
- Assess daily

All at risk patients **must** have a fully completed care plan with risk clearly documented

Care delivered each day must be recorded in the unified progress notes and include;
- Reason for commencement / discontinuation of charts
- Interventions / treatments / care delivered

Commence fluid intake monitoring chart. → Complete Hydration Care Plan.

Daily Assessment

Care plan to be completed for all patients assessed as 'at risk'

Risk Assessment Week 1	Date/ Time	Date	Date	Date	Date	Date	Date
	3/6						
Number of Risks present	0						
Fluid Balance or monitoring indicated **Y= Yes N= No**	N						
Care Plan commenced/reviewed Y=Yes N=No	N						
Initials of assessor	[illegible]						

Hydration Care plan

Potential nursing actions
(Please include all that apply in the care plan below)

COPY

- Commence fluid balance chart (Risk1-4). Clearly document the risk/reason.
- Commence fluid intake monitoring chart (Risk 5) for at least 3days to establish that the patient is adequately hydrated.
- Set daily fluid balance/intake target with medical team.
- Review 24hr fluid balance at midnight and document in unified progress notes for medical team.
- Offer drinks at each care and comfort round (If appropriate) and document preferences for drinks.
- Encourage patient /carers to be involved with fluid intake and documentation on pictorial fluid chart.
- Describe individual patients care needs.

Date/Time	Plan of Care (Read/Review daily and update if required)	Sign
03/06/22 - 0230am	IND w oral intake	

Skin Assessment and Care Plan

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Daily Skin Care Assessment

	Date/ Time	8/6 0220													
	Independent, no concerns, assess daily, review if condition changes or a concern is raised.	✓													
	Requires supervision/assistance, visually check skin daily or more often if at risk. Update care plan if there is a change in condition.														
	Dependent, will require skin review at every patient interaction(min 2 hourly) and record findings in nursing notes														
	Date/ Time														
	Independent, no concerns, assess daily, review if condition changes or a concern is raised.														
	Requires supervision/assistance, visually check skin daily or more often if at risk. Update care plan if there is a change in condition.														
	Dependent, will require skin review at every patient interaction(min 2 hourly) and record findings in nursing notes														

Care Needs	**Potential nursing actions (Please include all that apply in the care plan below)**
• Assess daily above • Review care plan and update only when a change is evident. • Document all care given in unified progress notes.	• Discuss and plan care to include current patient skin condition and skin care regimen. Include any lotions or prescribed emollients. • Assess BRADEN and document current risk as well as any equipment currently in use. • Document level of assistance required to care for skin. • Ensure care and comfort chart is commenced. • Where a wound is present or skin is not intact please include information on the wound/skin tear and ensure a wound chart is commenced. • Provide an information leaflet to patients/carers

Date/Time	**Initial plan of care**	**Sign**
08/06/25 0300hrs	Skin intact - control to monitor	

Bedrails Assessment

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Bedrails NOT to be used
Code:

A. Risk of climbing over and falling from a greater height.
B. Patient is independent.
C. Risk of entrapment in bedrails outweighs risk of falling
D. Do not use with a high/low bed
E. Patient with capacity and oriented but refuses bedrails

Bedrails CAN be used
Code:

F. Patient with capacity and is alert and oriented and requests bedrails.
G. Risk of injury from falling from the bed outweighs the risks of not using bed rails.
H. Patient is unconscious.

Assessment to be completed on admission within 6 hours. Review weekly or following a fall and in response to a change in patient condition.

Date and Time	Codes	Bed rail in use	Initials
08/06/25 0300hrs	f	YES/NO	ar
		YES/NO	
		YES/NO	
		YES/NO	
		YES/NO	
		YES/NO	
		YES/NO	
		YES/NO	

Bed rails must be used when the bed is moving (ie; transferring patient between areas)

Daily Personal Hygiene & Continence Assessment

COPY

1. Daily Personal Hygiene Assessment

	Date/ Time	03/5 0800												
	Independent with hygiene (no care plan required)	✓												
	Requires supervision/assistance with hygiene (detailed care plan required)													
■	Dependent with hygiene (detailed care plan required)													

2. Daily Continence Assessment

	Independent with continence, no concerns, review regularly for change	✓												
	Uses continence products, continue to support whilst in hospital with prescribed products. Requires supervision/assistance (detail added to care plan)													
■	Dependent or new continence issue, patient requires full assessment.													
	Initials	M												

1. Daily Personal Hygiene Assessment

	Date/ Time													
	Independent with hygiene (no care plan required)													
	Requires supervision/assistance with hygiene (detailed care plan required)													
■	Dependent with hygiene (detailed care plan required)													

2. Daily Continence Assessment

	Independent with continence, no concerns, review regularly for change													
	Uses continence products, continue to support whilst in hospital with prescribed products. Requires supervision/assistance (detail added to care plan)													
■	Dependent or new continence issue, requires full assessment.													
	Initials													

Patients assessed as **yellow** or **red** require a detailed care plan overleaf.
All care given each day **must** be documented in the unified progress notes.

Personal Hygiene & Continence Care Plan

COPY

Care Goals	Potential nursing actions (Please include all that apply in the care plan below)
• To enable person to maintain an appropriate level of personal hygiene • To enable person to remain continent or maintain continence level using prescribed products • To promote effective elimination function • To prevent infection • Be fully assessed and have a care plan to support care needs • Discuss and agree care plan with patient/carer	• Document level of assistance required to help with personal hygiene care needs, encourage self care as able and document what the patient requires help with. • Document preference for : Basin/shower/bed bath • Consider how the patient cares for hair and nails and document in plan. • Offer shave as required (document wet/dry) • Offer eye care as required • Provide commode/bed pan/urinal • Walk/wheel to the toilet • Catheter care – complete CAUTI bundle • Provide and document agreed continence product for use in ward. This may include skin cleansers and barrier creams. Carer or family may bring same into ward for use. • Undertake full continence assessment and patient education as appropriate (see intranet for information) • Review and update care plan in line with changing care needs.

Date/Time	Plan of Care (Read/Review daily and update if required)	Sign
03/06/25 0800hrs	IND with personal care	[illegible]

Oral Health Assessment

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Assess within 24 hours of admission to determine if oral care planning is required. Discuss and agree care plan with patient/carer.

Complete this section to determine condition of mouth and the frequency of mouth care required. Document in the care plan and commence '2 Hourly' oral care record for Standard 2-4.

			Date/ Time	03/6													
Condition of mouth Check lips, oral soft tissues and teeth with a good light	Teeth/dentures clean, mucosa pink and moist	Standard Care 1		✓													
	Mucosa/tongue pink and dry	Standard Care 2															
	Obvious plaque/ swollen or bleeding gums or dry/crusted mouth	Standard Care 3															
	Possible infection	Standard Care 4															

Complete this section to determine frequency of assessment required and document in the care plan.

			Date/ Time														
Eating ability	Able to eat normal diet	1															
	Soft diet/delayed swallow reflex	2															
	Nil by mouth	3															
Physical ability	Requires assistance to access oral hygiene implements	1															
	Requires help with oral hygiene	2															
	Patient not able to carry out any aspect of oral hygiene	3															
ental ability	Loss of interest/confused	1															
	Memory impaired/confused	2															
	Sedated	3															
Nutritional screening (only score if patient has own teeth)	MUST low	1															
	MUST medium	2															
	MUST high	3															
Additional risk factors	Diabetes mellitus	1															
	Medications *	1															
	Smoking	1															
	Loose/damaged dentures	1															
	Open mouth breathing	1															
	Oxygen therapy	1															
	Broken or loose teeth	1															
		Total score															
		Initials															
Re-assessment risk level: Low (2-8)/Medium (9-14)=WEEKLY High (15+) = DAILY																	

Oral Health Care Plan

COPY

Care Goals	Potential nursing actions (Please include all that apply in the care plan below)
• To enable person to maintain an appropriate level of oral hygiene • To prevent infection • Discuss and agree care plan with patient/carer	• Document condition of the mouth and what care standard will be followed. • What level of assistance does the patient need to look after oral hygiene? • Document frequency of assessment required (daily or weekly) • Commence oral hygiene care deliver chart for patients that require 2 hrly mouth care (following care standard 2-4)

Date/Time	Plan of Care (Read/Review daily and update if required)	Sign
03/05/23 – 0300hr	IND w oral care	

'MUST' – Nutritional Risk Screening

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STEP 1 (BMI) (Complete all 5 steps and transfer results to Initial screening row below).	**STEP 2 (Weight Loss)**	**STEP 3 (Acute Disease Effect)**	*If weight not measured please indicate how this was obtained (see key below)	*If height not measured please indicate how this was obtained (see key below)
Weight (Kgs) * = 83kg..... Height (m) * = 1.74..... Method used M,R,C* R.... BMI ....27..... See BMI charts Greater than 20 score 0 18.5 – 20 score 1 '--s than 18.5 score 2 reater than 30=obese)	Pre-illness weight = ... (Can be obtained from previous notes, GP, patient, carer or clothes size) Total unplanned weight loss over 3-6 months Weight loss (kg) = ... Complete with weight loss chart Less than 5% score 0 5-10% score 1 Greater than 10% score 2	Acute illness **AND** there has been or is likely to be no nutritional intake for **5 days** No score 0 Yes score 2	M - Measured R - Reported C - Based solely on clinical impression (See **"Ward information pack"** for alternative measures)	M - Measured R - Reported C - Based solely on clinical impression (See **"Ward information pack"** for alternative measures)

STEP 4 (Overall Risk Score)	**STEP 5 (Care Plan)**
Add scores from steps 1+2+3 to calculate overall risk score SCORE 0 = LOW RISK SCORE 1 = MEDIUM RISK SCORE 2+ = HIGH If risk category arrived at by **clinical impression** alone, indicate risk category LOW/MEDIUM/HIGH in table below and document rationale in progress notes	Implement appropriate Nutritional Care Plan **0 = LOW RISK** **1 = MEDIUM RISK** **2 = HIGH RISK** **Treat as High Risk - immediate Dietetic Referral** ▪Dysphagia ▪ Decompensated Liver Disease ▪ Enteral Tube Feeding ▪ Multiple Fractures ▪ Pressure Ulcers Grade 3 or more

Initial screening

	Time	Ward	Weight (kg)*	Weight ↑↔↓	Method used (M,R,C)	BMI	Step 1 Score	Step 2 Score	Step 3 Score	Total Score	'MUST' Risk	Initial

Rescreening

Pre-illness weight =.....

Date	Time	Ward	Weight (kg)*	Weight ↑↔↓	Method used (M,R,C)	BMI	Step 1 Score	Step 2 Score	Step 3 Score	Total Score	'MUST' Risk	Initial

Bowel Function Care Plan and Chart

COPY

Daily Bowel Assessment

	Date/ Time	2/8													
	Patient is independent. Bowels moving normally; verbal or visual confirmation. Commence stool chart to monitor.	✓													
	Requires supervision/assistance with bowel monitoring and care. Commence stool chart to monitor. Detailed care plan required.														
	Dependent with bowel care or bowels not moving. Commence stool chart. Detailed care plan required.														

Daily Bowel Assessment

	Date/ Time														
	Patient is independent. Bowels moving normally, verbal or visual confirmation. Commence stool chart to monitor.														
	Requires supervision/assistance with bowel monitoring and care. Commence stool chart to monitor. Detailed care plan required.														
	Dependent with bowel care or bowels not moving. Commence stool chart. Detailed care plan required.														

Bowel Function Care plan

Potential nursing actions
(Please include all that apply in the care plan below)

- **Please document normal bowel function and/or if the patient has a history of bowel disease**
- **Document if the patient has a stoma and plan of care, level of assistance required.**
- **Assess bowel function daily above and document any changes in the unified progress notes**
- **Review and update care plan below if the patients condition changes.**
- **Record any bowel pattern change, if patient is on aperients or if a specimen has been sent.**
- **Identify type of stool using Bristol Stool Form Scale. Record every episode of stool.**

Date/Time	Plan of Care (Read/Review daily and update if required)	Sign
2/06/25 -	NKD normal bowel function assistance not required	A

NHS Forth Valley

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ACUTE ASSESSMENT UNITS/DAY SURGERY UNIT
RISK ASSESSMENT and CARE PLAN BOOKLET

CHI NO: 0605770352 06/05/1977
CRN: M
Alan WYLES
2 GORDON SQUARE

STIRLING
FK8 1FN

Date of admission: 28/

Time of admission: 2030

Admission Area: SAU

Assessment	Initial assessment to be completed:	Assesment area nurse Initials	Transfer Area nurse Initials
CPE (1st ward only)	On Admission if required	JH	N/A
Falls Trigger Tool	On Admission	JH	
Bedrail Assessment	On Admission	JH	
Skin, Continence and Personal Hygiene assessment	On Admission	JH	
Hydration Assessment	On Admission	JH	
4AT	On Admission	N/A	
MUST Screening and Care Plan	On Admission	JH	
Oral Care Assessment and Care Plan	On Admission	JH	
Falls history and Falls action plan	On admission if **Yes** to any factors on Falls Trigger tool	JH	
Braden/Skin Assessment	On admission **if at risk or not** intact	JH	
Patient Handling and Mobiliy Chart	On admission **if not** independent	JH	

Daily Assesments to be completed

1.Hydration
2.Skin Assessment
3.Personal Hygiene and continence
4.Bowel Function

Initial Assessments on page 1 must be carried out at time of admission, all other assessments will be reviewed weekly except **Daily Assesments**

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Forth Valley

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Staff identification This acute assessment and care plan booklet is a legal document. Your signature indicates you have assessed and planned care with your patient/carer and is a true reflection of the care that will be delivered by you or delegated by you.

Name: JESS ROSAN	Signature:
Name: ASHA SHERY	Signature:
Name:	Signature:
Name:	Signature:
Name:	Signature:
Name:	Signature:
Name:	Signature:
Name:	Signature:
Name:	Signature:
Name:	Signature:
Name :	Signature:
Name:	Signature:
Name:	Signature:

Valuables Policy

Forth Valley Royal Hospital does not take any responsibility for patients own belongings/ valuables.

Any valuables are encouraged to be taken home or can be logged and kept in the safe. A receipt will require to be provided.

Patient/family aware Yes/No
Valuables in safe Yes/No
Valuables kept with patient Yes/No

Details.....

NHS
Forth Valley

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Nursing Risk Assessments to be completed on Admission

Patients preffered name:
Ward:

Communication Assessment

No concerns	☑	Hydration Risk Assessment Complete
New receptive/expressive difficulties	☐	☐
Pre-existing	☐	

Falls Risk/Trigger Tool

	Circle
History of falls prior to admission? **(Falls(s) since admission?**	Y/N
Additional falls risk factors for this patient? E.g. Patient tries to walk alone but unsteady/unsafe, learning disabilities, parkinson's, stroke, cognitive impairment, delirium, continence issues, visual impairment, medication (night sedation), surgery, seizures/epilepsy, fear of falling etc. (if yes to this question, state risk and commence **falls prevention** action plan)	Y/N
Current Mobility: (walks alone but unsafe, cognitive impairment, drip stand, catheter)	Y/N
Bedrails required Y /N if yes complete bedrails assessment	
If answered yes to any of these questions:---complete a **falls history on page 6** and commence **falls prevention** action plan on **page 7**	☐

Skin, Continence and Personal Hygiene assessment

Skin integrity	Continence Care	Personal Hygiene	Mobility
Independent/no concerns ☑	Continent ☑	Independent ☑	Independent ☑
Skin Checked: Intact ☐	Incontinent ☐	Requires set up ☐	Supervision ☐
Skin Checked: at risk/not intact (please circle)	Continence Aids in use.....	Prompting ☐	Assistance of 1 or 2 or 3 (Please Circle)
Braden +/- wound assessments on admission if within 6 hours of admission	Urinary Catheter ☐ Nephrostomy ☐	Assistance of 1 or 2 (Please Circle)	
	Stoma ☐	Full Assistance ☐	

Name: [illegible] Signature: [signature] Date/Time 2.8.15 [illegible]

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Infection Prevention and Control Risk Assessment

All patients admitted must have a Clinical risk assessment (**CRA**) for Carbapenemase-Producing *Enterobacteriaceae* (**CPE**) and Meticillin Resistant Staphylococcus *aureus* (**MRSA**).**This is a mandatory requirement.**

CPE Clinical Risk Assessment (No patients are excluded from CPE screening).	**Response**	
Has the patient had any previous history of CPE (check clinical portal)	YES	NO
Has the patient been transferred directly from another hospital out with NHSFV	YES	NO
Has the patient a history of admission to a hospital out with Forth Valley in the last 12 months (including dialysis patients)	YES	NO
Has the patient been in close contact with a person colonised or infected with CPE	YES	NO

A **YES** response to **ANY** of the above questions suggests the patient has an increased risk of CPE
l the following actions must be taken:

- Isolated the patient in a single side room, STOP sign on door, contact precautions (PPE)
- The patient is given an information leaflet and consent is obtained for swabbing;
- CPE screen: Rectal swab taken by a registered nurse or stool specimen and, if present, a wound swab. A urine specimen is required if a urinary catheter is present:
- A rectal swab **must not** be used for children under 16 years. A stool specimen should be sent.

	MRSA Clinical Risk Assessment (Exclusions from MRSA screening include: Day case patients and admissions to paediatric, obstetric and mental health specialities)	**Response**	
1	Has the patient a history of MRSA, (check clinical portal)	YES	NO
2	Has the patient been admitted from anywhere other than their own home, e.g. care home, hostel, prison, or transferred from another hospital.	YES	NO
3	Does the patient have any wounds or indwelling medical devices (e.g. PEG, Hickman line, urinary catheter)	YES	NO
4	Will the patient be admitted / transferred to ITU	YES	NO

A **YES** response to questions **1- 3** indicates an increased risk of MRSA colonisation.
l following actions must be taken:

- The patient is isolated in a single side room, STOP sign on door, contact precautions initiated;
- The patient is given an MRSA screening leaflet and consent obtained for swabbing;
- MRSA screen: swab nose, perineum and if present, wounds and insertion sites of invasive devices. A urine specimen is required if a catheter is present.

Note: this is the minimal-screen required and additional swabs can be sent if clinically indicated.
A **YES** response to question **4** confirms admission to a high risk specialty and the following actions must be taken:

- The patient is given an MRSA screening leaflet and consent obtained for swabbing;

Sign	**Date** 28/5	**Swabs sent: Yes / No/NA**

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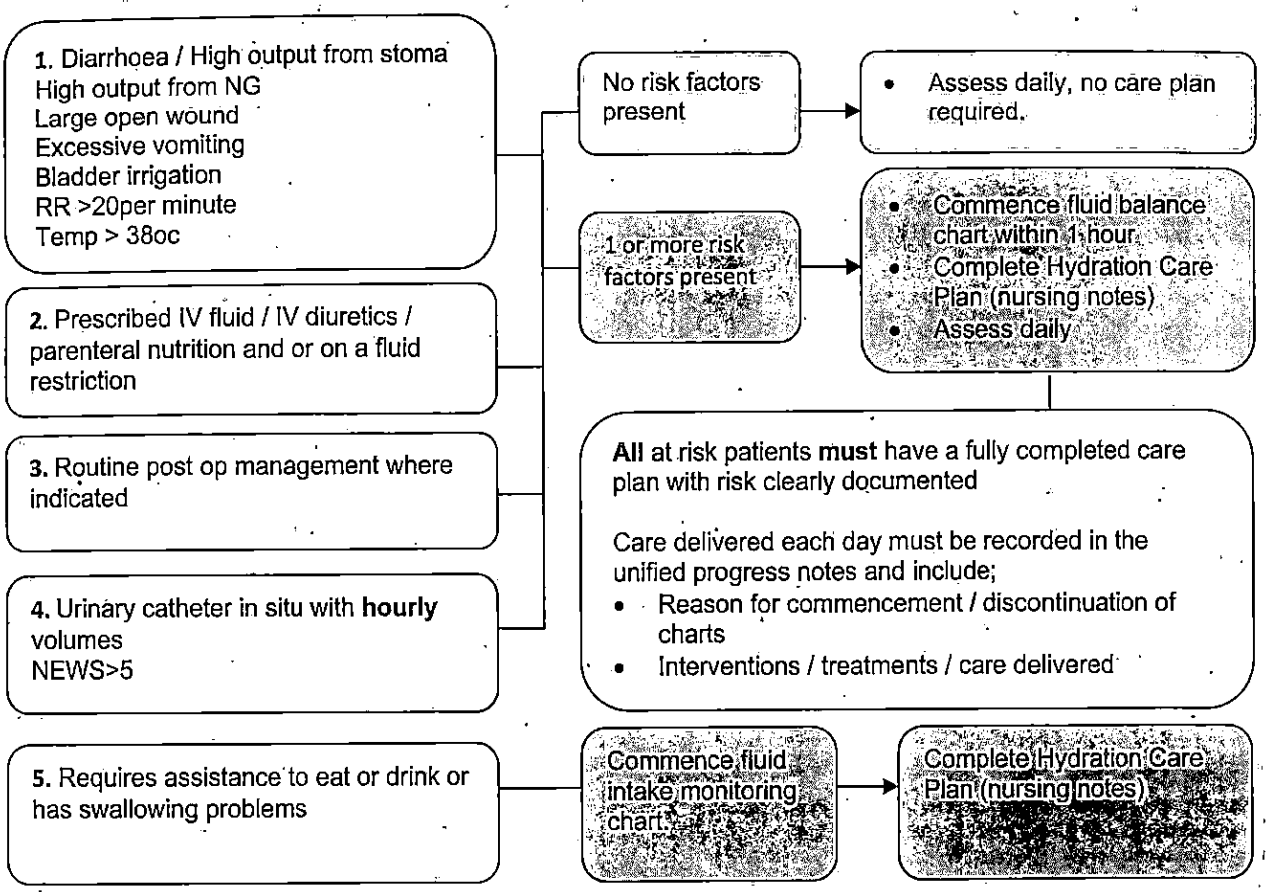
Daily Hydration Risk Assessment

Risk assessment should be carried out within 4 hrs of admission and daily thereafter



Risk Assessment Week 1	**Date/time** 28/5/25	**Date/time** 31/5/25 01:00 Hrs	**Date/time** 1/6/25	**Date/time** 2/6/25 02:30 Hrs	**Date/time**	**Date/time**	**Date/time**
Number of Risks present	0	0	0	0			
Fluid Balance or monitoring indicated Y=Yes N=No	N	N	N	N			
Care Plan commenced/reviewed Y=Yes N=No	N	N	N	N			
Initials of assessor	SM						

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N/A

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TO BE COMPLETED FOR **ALL** PATIENTS OVER 65 ON ADMISSION AND WHEN A CHANGE IN PRESENTATION IS EVIDENT

* Signed..... Date.....
(ensure documented in clinical notes)

DATE		/ /	/ /	/ /
1. ALERTNESS: *This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive.* *If asleep, attempt to wake and ask the patient to state their name and address to assist rating.*	Normal (fully alert, but not agitated throughout assessment)	0	0	0
	Mild sleepiness for <10 seconds after waking, then	0	0	0
	Clearly abnormal (agitated or drowsy)	4	4	4
2. AMT4: *date of birth, place (name of hospital or building), current year*	No mistakes	0	0	0
	1 mistake	1	1	1
	2 or more mistakes/un-testable	2	2	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	0	0	0
	Starts but scores <7 months/refuses to start	1	1	1
	Un-testable (cannot start because unwell, drowsy,	2	2	2
4. ACUTE CHANGE OR FLUCTUATING COURSE: *Evidence of significant change or fluctuation in: alertness, cognition (e.g **increased confusion**) or other mental function arising over the last 2 weeks and still evident in last 24hrs*	No	0	0	0
	Yes	4	4	4
	Initials of tester →			

4 or above:	Possible delirium +/- cognitive impairment - score daily until score <4 for 2 consecutive days	**Day 1 4ATscore**	**Day 2 4ATscore**	**Day 3 4ATscore**
1 – 3:	Possible cognitive impairment – only rescore if condition changes			
0:	Delirium or cognitive impairment unlikely – only rescore if condition changes			

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HE 4AT TEST: SCREENING INSTRUMENT FOR COGNITIVE IMPAIRMENT AND DELIRIUM

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Cognitive Assessment Pathway

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Assess using 4AT
4 or more?

Yes

Investigate possible Delirium

Complete TIME Bundle and follow Scottish Delirium Association pathway

Collateral history identifies underlying cognitive impairment – is there a diagnosis of dementia?

Yes
Record:
·Type of dementia
·Source of information

Offer:
·Butterfly Scheme
·"Getting To Know Me"

No

Score 1-3
Delirium unlikely – is there a diagnosis of dementia?

No
Refer to Liaison Psychiatry / CMHT for Older People

Seek patient /POA/NOK consent for further investigation

No
Complete AMT 10
Score 9 or more?

Yes -
Exit Pathway

For all patients with a cognitive impairment including dementia or delirium:

Initiate cognitive impairment care bundle booklet

Check patient has capacity to make decisions (AWI Act)

Obtain collateral history at earliest opportunity

Document any assessments within clinical notes and inform GP on discharge

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No Falls

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Falls History:

To be completed if answered yes to any of the questions on the Falls Risk/Trigger Tool

Falls history assessment: (Date & time of last fall **prior** to admission)

Estimated date and time of the last fall? Date ..... Time of Day.....

First fall? Yes ☐ No ☐ Recurrent falls? Yes ☐ No ☐ Number of falls within the last year? .....

Any warning immediately prior to any falls? Yes ☐ No ☐

Palpitation ☐ Dizziness ☐ Alcohol ☐ Loss of Consciousness ☐
Slip/Trip ☐ Environmental hazards ☐ Associated movement ☐

Information about fall/previous falls :(where, when, why) Activity at time of fall? (Please describe) (consider if fall/injury could be non accidental)

.....

.....

.....

Any injury sustained or previous fracture? Yes ☐ No ☐ (if yes, please describe)

.....

.....

Any pain related to fall? Yes ☐ No ☐ (if yes, please describe)

.....

.....

Anxiety regarding further falls/confidence affected? Yes ☐ No ☐ (If yes please describe)

.....

.....

Comments/other information/highlight areas of concern:

.....

.....

Data collected from: Patient ☐ Relative ☐ Carer ☐Other: .....

Nurse Signature: _____ **Date/Time:**_____

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Falls Prevention Action Plan

The following nursing interventions may address some of the falls risk factors. They are however NOT exhaustive and staff should use their clinical reasoning/professional judgment when determining falls risk interventions.

Please state all actions taken from the list of interventions below.

Interventions:	Care Plan 1: On Admission
Environmental: • Nurse in most appropriate place on ward for their needs e.g. easily observable area, near toilet etc. • Area hazard free, personal belongings within easy reach • Call system working/within reach at all times • Adequate lighting at all times particularly overnight. • Check infusion stands facilitate mobility. • Use of sound/movement monitors (if available) • Select suitable seating (appropriate height, comfort) • Consider one-way glide sheet for chair • Frequently re-orientate confused patients	
Vision/Hearing • Ensure correct glasses worn/within easy reach and clean. • Determine if patient can recognize objects from the end of the bed - if concerns, refer to medical staff for visual acuity assessment • Consider hearing implications, hearing aid working etc.	
Lying and Standing Blood Pressure: Baseline for all • **Check and record.** If deficit exists, inform medical staff and continue to check twice daily for at least 72 hours. • Advice patient on slow movement from sitting/lying to standing.	**Baseline** Lying: Standing:
Mobility: • Follow mobility risk assessment/care plan. • Consider referral to Physiotherapy and/or OT • If patient requires walking aid is it within easy reach?	
Medication: • Request Medical staff or Pharmaceutical review.	
Delirium (Acute Confusional State) • Complete 4AT risk assessment • Treat causes of delirium, refer to delirium guidelines	
Toileting: • Assess continence. If urine frequency, ward test urine. • Plan routine/frequent toileting. • Consider a commode for night time toileting. • Consider full continence assessment and refer to continence service if indicated.	
Bed and bedrails: • Bed at optimum height and brakes applied. • Assess the need for bedrails • Hi/Low bed assessment and follow pathway	
Footwear/Clothing • Encourage patient to wear shoes not slippers. • Check footwear for secure fit, non-slip sole. Ask relatives to supply safer replacements. • Ensure toenails are in good condition, include plan of care in personal hygiene care plan (Refer to podiatry if infected or neglected) • Suitability and appropriateness of clothing e.g. length	
Inform: • Ensure Medical staff, Physiotherapist, OT, Social Worker etc, are aware of patients falls risk, frequency and nature • Involve/educate patient/relatives in safe practice. • Discuss with patient/relative re specific interventions. • Issue leaflet "How to reduce falls in hospital". • Place patient on care rounds/safety brief	
Additional Falls Risk Management Interventions for Patient:	
Initials of Nurse/Date & Time:	

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Falls Care Plan review weekly or post fall

	Care Plan 2: Review of Interventions Weekly, post fall or changes to the patient's condition Date & Time	Care Plan 3: Review of Interventions Weekly, post fall or changes to the patient's condition Date & Time
Environmental		
Vision and Hearing		
Lying and Standing Blood pressure		
Mobility.		
Medication		
Delirium (acute confusion)		
Toileting		
Bedrails		
Footwear and Clothing		
Who did you Inform?		
Additional information		
Post Fall	IR1 No..... Falls No..... Care Plan Reviewed and still in use: Y/N New Care Plan required: Y/N Staff Initials/date/time.....	IR1 No..... Falls No..... Care Plan Reviewed and still in use: Y/N New Care Plan required: Y/N Staff Initials/date/time.....

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Bedrails Assessment

Bedrails NOT to be used Code: A. Risk of climbing over and falling from a greater height. B. Patient is independent. C. Risk of entrapment in bedrails outweighs risk of falling D. Do not use with a high/low bed E. Patient with capacity and oriented but refuses bedrails	Bedrails CAN be used Code: F. Patient with capacity and is alert and oriented and requests bedrails. G. Risk of injury from falling from the bed outweighs the risks of not using bed rails. H. Patient is unconscious.

Assessment to be completed on admission within 6 hours. Review weekly or following a fall and in response to a change in patient condition.

Date and Time	Codes	Bed rail in use	Initials
28/5/25	B	YES/NO	SN
		YES/NO	
		YES/NO	
		YES/NO	

Bed rails must be used when the bed is moving (ie; transferring patient between areas)

BRADEN RISK ASSESSMENT CHART

Individuals with a total score of 16 or less are considered at risk: 15-16 = low risk, 12-14 = moderate risk, 11 or less = high risk.
Undertake and document risk assessment within 6-8 hours of admission to every ward or department.
Reassess if there is a change in individual's condition and repeat regularly according to local protocol or risk score.
1 .Complete skin care plan with BRADEN score included and commence a care and comfort round chart.
2. Consider contributing factors, frailty, diabetes, end of life care.

				DATE	On Admission					
				TIME						
Sensory Perception – Ability to respond meaningfully to pressure related discomfort	**1.Completely Limited** Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation. **OR** limited ability to feel pain over most of body surface.	**2.Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. **OR** has a sensory impairment that limits the ability to feel pain or discomfort over ½ of body.	**3. Slightly Limited** Responds to verbal commands but cannot always communicate discomfort or need to be turned. **OR** has some sensory impairment that limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or voice pain or discomfort.						
Moisture – Degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient/client is moved or turned.	**2. Very Moist** Skin is often but not always, moist. Linen must be changed at least once a shift.	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry. Linen only requires changing at routine intervals.						
Activity – Degree of physical activity	**1. Bedfast** Confined to bed.	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during day but for very short distance, with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks Frequently** Walks outside the room at least twice a day and inside the room every 2 hours during waking hours.						
Mobility – Ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance.	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitations** Makes major and frequent changes in position without assistance.						
Nutrition – Usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Takes fluids poorly. Does not take a liquid dietary supplement **OR** is NPO and/or maintained on clear liquids or IV's for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about ½ of any food offered. Occasionally will take a dietary supplement **OR** receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate** Eats over half of most meals. Occasionally will refuse meal but will usually take a supplement if offered **OR** is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	**4. Excellent** Eats most of every meal. Never refuses a meal. Occasionally eats between meals. Does not require supplementation.						
Friction and Shear –	**1. Problem** Requires moderate to maximum assistance in moving.	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.							
			Indicate appropriate number and add for total score	TOTAL SCORE:						
				Initials:						

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Consider needs based on score and record in care plan

TOTAL BRADEN SCORE INDICATES THAT THE PATIENT IS:	EQUIPMENT AND ACTION WHICH SHOULD BE **CONSIDERED** FOR EACH "AT RISK" CATEGORY. DOCUMENT EQUIPMENT TO BE USED AND PLAN OF CARE IN THE SKIN CARE PAN. GIVE PATIENTS/CARERS AN INFORMATION LEAFLET.
17+ : NOT AT RISK	◦ Depending on patient's individual requirements an overlay may be required for comfort e.g. Repose/Propad
15 – 16 : LOW RISK	◦ Pressure reducing mattress e.g. SOFTFORM/PENTAFLEX ◦ Mattress Overlay e.g. Repose ◦ Daily skin inspection should be documented in nursing notes
12 – 14 : MODERATE RISK	If skin is intact. • Use pressure reducing mattress e.g. SOFTFORM/PENTAFLEX • Mattress overlay e.g. .Repose **OR** If skin is broken up to a Stage 2 pressure ulcer, • Mattress overlay e.g. Repose or an active pressure relieving mattress overlay e.g. Soft form premiere active ,Tamora(Community) • **Daily** Braden risk assessment • Twice daily skin inspection and document in unified progress notes • Implement turning schedule – reposition changes 2-4 hourly and document in unified progress notes
9 – 11 : HIGH RISK	If skin is broken up to a Stage 3 pressure ulcer • Alternating Dynamic Pressure System, e.g. Softform premiere active ,Tamora (Community) NIMBUS (Acute) • **Daily** Braden risk assessment • Implement turning schedule – reposition changes 2-4 hourly and document in unified progress notes • Skin inspection at each reposition change and document in unified progress notes
6 – 8 : SEVERE RISK	If skin is broken up to a Stage 4 pressure ulcer • Alternating Dynamic Pressure System e.g. NIMBUS, (Community only Softair, Tamora) • **Daily** Braden risk assessment • Implement turning schedule – reposition changes 2 hourly and document in unified progress notes ◦ Skin inspection at each reposition change and document in unified progress notes
When an area of redness or discolouration is noted further action is required. Skin inspection, findings and action taken **must** be documented in unified progress notes.	• If patient is out of bed, a pressure reducing / relieving seating system comparable to the equipment used on the bed should be considered, e.g. Repose, Active Seat Cushion. Patients should be encouraged to reposition at least every **30 minutes** and be assisted if unable to do so. • Patients should not be sitting up in a chair for longer than 2 hours if they have a grade 3 or above pressure injury. • Plan should be documented within the skin care plan along with the care and comfort documentation.

Specialised Equipment (Rentals)/TYPE / AID	DATE COMMENCED	DATE DISCONTINUED/Sent back

Tissue Viability Service
Please advise TV service of all patients with a grade 3 or above pressure injury. Referral/Advice and Support 01324 673747

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'MUST' – Nutritional Risk Screening

STEP 1 (BMI) (Complete all 5 steps and transfer results to Initial screening row below).	**STEP 2 (Weight Loss)**	**STEP 3 (Acute Disease Effect)**	***If weight** not measured please indicate how this was obtained (see key below)	***If height** not measured please indicate how this was obtained (see key below)
Weight (Kgs) * = 46.3 Height (m) * = 1.74 Method used M,R,C* R BMI 27 See BMI charts Greater than 20 score 0 18 20 score 1 Less than 18.5 score 2 (greater than 30=obese)	Pre-illness weight = ... (Can be obtained from previous notes, GP, patient, carer or clothes size) Total unplanned weight loss over 3-6 months Weight loss (kg) = ... Complete with weight loss chart Less than 5% score 0 5-10% score 1 Greater than 10% score 2	Acute illness **AND** there has been or is likely to be no nutritional intake for **5 days** No score 0 Yes score 2	M - Measured R - Reported C - Based solely on clinical impression (See **"Ward information pack"** for alternative measures)	M - Measured R - Reported C - Based solely on clinical impression (See **"Ward information pack"** for alternative measures)

STEP 4 (Overall Risk Score)	**STEP 5 (Care Plan)**
Add scores from steps 1+2+3 to calculate overall risk score SCORE 0 = LOW RISK SCORE 1 = MEDIUM RISK SCORE 2+ = HIGH If risk category arrived at by **clinical impression** alone, indicate risk category LOW/MEDIUM/HIGH in table below and document rationale in progress notes	Implement appropriate Nutritional Care Plan **0 = LOW RISK** **1 = MEDIUM RISK** **2 = HIGH RISK** **Treat as High Risk - immediate Dietetic Referral** ▪ Dysphagia ▪ Decompensated Liver Disease ▪ Enteral Tube Feeding ▪ Multiple Fractures ▪ Pressure Ulcers Grade 3 or more

Initial screening

Date	Time	Ward	Weight (kg)*	Weight ↑↔↓	Method used (M,R,C)	BMI	Step 1 Score	Step 2 Score	Step 3 Score	Total Score	'MUST' Risk	Initial
1/5/15		SPH	63		R	27	0	0	0	0	Low	SL

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'MUST' Nutritional Care Plan

Low/Medium/High (circle) **Date/Time care plan initiated:** 29/5/15

Intervention	Plan of Care	Initials
Has patient been informed of current weight and plan? Discuss the results of the 'MUST' screening/care plan with the patient and family (with agreement and involve them in identifying individualised interventions)	Yes / No (details if no) On admission & on-going	JH
Weigh patient and rescreen	On Admission then weekly	JH
Refer high risk patients to Dietitian with **'MUST' score ,BMI and weight loss**	Referred **Y** ☐ **NA** ☑	JH
Complete dietary food record charts for med/high risk patients until assessed by dietitian	**Y** ☐ **NA** ☑	JH
Med/High risk :Optimise nutritional intake by offering daily • nourishing milky drinks • regular snacks • 3 courses at midday and evening meal. Has signifier been added to patient's and kitchen white boards?	**Y** ☐ **NA** ☑ **Details:** **Y** ☐ **NA** ☐	JH

Please √ relevant box and where yes is answered, record details of individual requirement below;

	Initials
Food Allergy- No ☐ **Yes** ☐ **religious, cultural, ethnic requirements - No** ☐ **Yes** ☐ Details:	JH

	Initials
Therapeutic diet- No ☑ **Yes** ☐ Details:	JH

	Initials
Assistance required with eating/drinking- No ☑ **Yes** ☐ **Adapted cutlery/aids - No** ☑ **Yes** ☐ **Assistance from family - No** ☐ **Yes** ☐ **(If yes please monitor fluid intake)** Details:	JH

Oral Health Assessment

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Assess within 24 hours of admission to determine if oral care planning is required. Discuss and agree care plan with patient/carer.

Complete this section to determine condition of mouth and the frequency of mouth care required. Document in the care plan and commence '2 Hourly' oral care record for Standard 2-4.

			Date/ Time	29/5/25														
Condition of mouth Check lips, oral soft tissues and teeth with a good light	Teeth/dentures clean, mucosa pink and moist	Standard Care 1		✓														
	Mucosa/tongue pink and dry	Standard Care 2																
	Obvious plaque/ swollen or bleeding gums or dry/crusted mouth	Standard Care 3																
	Possible infection	Standard Care 4																

Complete this section to determine frequency of assessment required and document in the care plan.

			Date/ Time	29/5/25														
Eating ability	Able to eat normal diet	1																
	Soft diet/delayed swallow reflex	2																
	Nil by mouth	3		✓														
Physical ability	Requires assistance to access oral hygiene implements	1																
	Requires help with oral hygiene	2																
	Patient not able to carry out any aspect of oral hygiene	3																
tal ability	Loss of interest/confused	1																
	Memory impaired/confused	2																
	Sedated	3																
Nutritional screening (only score if patient has own teeth)	MUST low	1		✓														
	MUST medium	2																
	MUST high	3																
Additional risk factors	Diabetes mellitus	1																
	Medications	1		✓														
	Smoking	1																
	Loose/damaged dentures	1																
	Open mouth breathing	1																
	Oxygen therapy	1																
	Broken or loose teeth	1																
			Total score															
			Initials	SH														
Re-assessment risk level: Low (2-8)/Medium (9-14)=WEEKLY High (15+) = DAILY																		

Oral Health Care Plan

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All patients should attain Standard Care 1 for oral hygiene. If any further care is required, this should be carried out **in addition** to Standard Care 1

Standard Care 1	
Natural teeth	• Brush teeth at least twice per day using fluoride toothpaste and a medium toothbrush. • Spit afterwards – do not rinse.
Dentures	• Remove after each meal and rinse dentures and mouth with water • Brush with toothbrush at least once per day with unperfumed soap and water or denture cream. Repeat this prior to overnight soaking. • Plastic dentures should be brushed then soaked for 20 mins in afresh solution of hypochlorite (1 part to 80mparts cold water/1/2 a teaspoon) in a patient named individual denture bowl. Then rinse and place in fresh water overnight. Dentures with metal parts should be soaked in chlorhexidine 0.2%. All dentures should be rinsed with cold water before replacing in mouth. • Clean palate, gum ridges and tongue with a soft toothbrush or thoroughly moistened foam stick. • Dentures must be stored in a named denture container when not in mouth.
Standard Care 2	
Dry mouth (Xerostomia)	• Follow Care Standard 1 and..... • Review medications that may cause dry mouth • 2 hourly mouth care, i.e. water to rinse and water based lubricating gel to dry lips. * see guidelines regarding use of gels. • Foam sticks thoroughly moistened in water to tongue and mucosa if unable to rinse • Frequent sips or sprays of water or crushed ice cubes are as effective and often preferable to artificial products so should be first choice • Saliva replacement products e.g. Biotene gel or mouthwash (ensure these products are prescribed)
Standard Care 3	
Obvious plaque/ swollen or bleeding gums or dry/crusted mouth	• Follow Care Standard 1 and..... • Remove debris with a medium headed tooth brush with a non foaming fluoridated toothpaste or thoroughly moistened foam stick • Using water rinse 4 times daily • Chlorhexidine mouthwash, spray or gel (ensure these products are prescribed and do not use for more than 1 month).
Standard Care 4	
Infection	• Follow Care Standard 1 and..... • Seek medical/dental advice for appropriate treatment

For further advice please contact the Oral Health Department via email for advice from an oral health promoter fv-uhb.enquiresoralhealth@nhs.net

Oral Health Care Plan

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Care Goals	Potential nursing actions (Please include all that apply in the care plan below)
• To enable person to maintain an appropriate level of oral hygiene • To prevent infection • Discuss and agree care plan with patient/carer	• Document condition of the mouth and what care standard will be followed. • What level of assistance does the patient need to look after oral hygiene? • Document frequency of assessment required (daily or weekly) • Commence oral hygiene care deliver chart for patients that require 2 hrly mouth care (following care standard 2-4)

Date/Time	Plan of Care (Read/Review daily and update if required)	Sign

463 (22)
174

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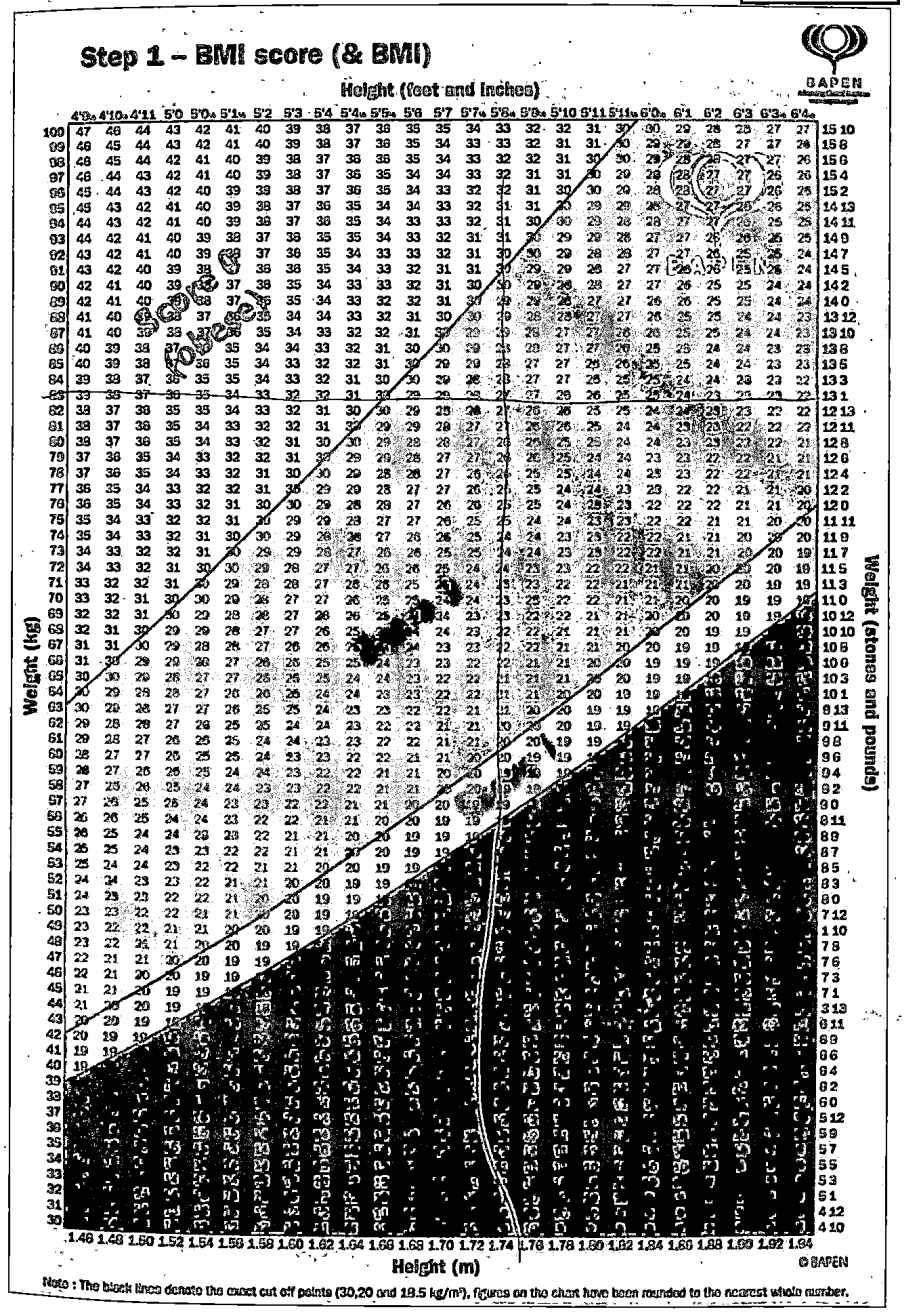
Step 1 – BMI score (& BMI)

BAPEN



Note : The black lines denote the exact cut off points (30,20 and 19.5 kg/m²), figures on the chart have been rounded to the nearest whole number.

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BAPEN

Step 2 – Weight loss score

KILOGRAMS

Current weight (kg)	Score 0 Wt loss < 5% – Weight loss in last 3 to 6 months: Less than (kg)	Score 1 Wt loss 5-10% – Weight loss in last 3 to 6 months: Between (kg)	Score 2 Wt loss > 10% – Weight loss in last 3 to 6 months: More than (kg)
30	1.6	1.6-3.3	3.3
31	1.6	1.6-3.4	3.4
32	1.7	1.7-3.6	3.6
33	1.7	1.7-3.7	3.7
34	1.8	1.8-3.8	3.8
35	1.8	1.8-3.9	3.9
36	1.9	1.9-4.0	4.0
37	1.9	1.9-4.1	4.1
38	2.0	2.0-4.2	4.2
39	2.1	2.1-4.3	4.3
40	2.1	2.1-4.4	4.4
41	2.2	2.2-4.6	4.6
42	2.2	2.2-4.7	4.7
43	2.3	2.3-4.8	4.8
44	2.3	2.3-4.9	4.9
45	2.4	2.4-5.0	5.0
46	2.4	2.4-5.1	5.1
47	2.5	2.5-5.2	5.2
48	2.5	2.5-5.3	5.3
49	2.6	2.6-5.4	5.4
50	2.6	2.6-5.6	5.6
51	2.7	2.7-5.7	5.7
52	2.7	2.7-5.8	5.8
53	2.8	2.8-5.9	5.9
54	2.8	2.8-6.0	6.0
55	2.9	2.9-6.1	6.1
56	2.9	2.9-6.2	6.2
57	3.0	3.0-6.3	6.3
58	3.1	3.1-6.4	6.4
59	3.1	3.1-6.6	6.6
60	3.2	3.2-6.7	6.7
61	3.2	3.2-6.8	6.8
62	3.3	3.3-6.9	6.9
63	3.3	3.3-7.0	7.0
64	3.4	3.4-7.1	7.1

STONES AND POUNDS

Current weight (st lb)	Score 0 Wt loss < 5% – Weight loss in last 3 to 6 months: Less than (st lb)	Score 1 Wt loss 5-10% – Weight loss in last 3 to 6 months: Between (st lb)	Score 2 Wt loss > 10% – Weight loss in last 3 to 6 months: More than (st lb)
4 10	0 3	0 3 - 0 7	0 7
4 12	0 4	0 4 - 0 8	0 8
5 1	0 4	0 4 - 0 8	0 8
5 3	0 4	0 4 - 0 8	0 8
5 5	0 4	0 4 - 0 8	0 8
5 7	0 4	0 4 - 0 9	0 9
5 9	0 4	0 4 - 0 9	0 9
5 12	0 4	0 4 - 0 9	0 9
6 0	0 4	0 4 - 0 9	0 9
6 2	0 5	0 5 - 0 10	0 10
6 4	0 5	0 5 - 0 10	0 10
6 6	0 5	0 5 - 0 10	0 10
6 9	0 5	0 5 - 0 10	0 10
6 11	0 5	0 5 - 0 11	0 11
6 13	0 5	0 5 - 0 11	0 11
7 1	0 5	0 5 - 0 11	0 11
7 3	0 5	0 5 - 0 11	0 11
7 6	0 5	0 5 - 0 12	0 12
7 8	0 6	0 6 - 0 12	0 12
7 10	0 6	0 6 - 0 12	0 12
7 12	0 6	0 6 - 0 12	0 12
8 0	0 6	0 6 - 0 12	0 12
8 3	0 6	0 6 - 0 13	0 13
8 5	0 6	0 6 - 0 13	0 13
8 7	0 6	0 6 - 0 13	0 13
8 9	0 6	0 6 - 0 13	0 13
8 11	0 6	0 6 - 1 0	1 0
9 0	0 7	0 7 - 1 0	1 0
9 2	0 7	0 7 - 1 0	1 0
9 4	0 7	0 7 - 1 0	1 0
9 6	0 7	0 7 - 1 1	1 1
9 8	0 7	0 7 - 1 1	1 1
9 11	0 7	0 7 - 1 1	1 1
9 13	0 7	0 7 - 1 1	1 1
10 1	0 7	0 7 - 1 2	1 2

KILOGRAMS

Current weight (kg)	Score 0 Wt loss < 5% – Weight loss in last 3 to 6 months: Less than (kg)	Score 1 Wt loss 5-10% – Weight loss in last 3 to 6 months: Between (kg)	Score 2 Wt loss > 10% – Weight loss in last 3 to 6 months: More than (kg)
65	3.4	3.4 - 7.2	7.2
66	3.5	3.5 - 7.3	7.3
67	3.5	3.5 - 7.4	7.4
68	3.6	3.6 - 7.6	7.6
69	3.6	3.6 - 7.7	7.7
70	3.7	3.7 - 7.8	7.8
71	3.7	3.7 - 7.9	7.9
72	3.8	3.8 - 8.0	8.0
73	3.8	3.8 - 8.1	8.1
74	3.9	3.9 - 8.2	8.2
75	3.9	3.9 - 8.3	8.3
76	4.0	4.0 - 8.4	8.4
77	4.1	4.1 - 8.6	8.6
78	4.1	4.1 - 8.6	8.7
79	4.2	4.2 - 8.7	8.8
80	4.2	4.2 - 8.9	8.9
81	4.3	4.3 - 9.0	9.0
82	4.3	4.3 - 9.1	9.1
83	4.4	4.4 - 9.2	9.2
84	4.4	4.4 - 9.3	9.3
85	4.5	4.5 - 9.4	9.4
86	4.5	4.5 - 9.6	9.6
87	4.6	4.6 - 9.7	9.7
88	4.6	4.6 - 9.8	9.8
89	4.7	4.7 - 9.9	9.9
90	4.7	4.7 - 10.0	10.0
91	4.8	4.8 - 10.1	10.1
92	4.8	4.8 - 10.2	10.2
93	4.9	4.9 - 10.3	10.3
94	4.9	4.9 - 10.4	10.4
95	5.0	5.0 - 10.6	10.6
96	5.1	5.1 - 10.7	10.7
97	5.1	5.1 - 10.8	10.8
98	5.2	5.2 - 10.9	10.9
99	5.2	5.2 - 11.0	11.0

STONES AND POUNDS

Current weight (st lb)	Score 0 Wt loss < 5% – Weight loss in last 3 to 6 months: Less than (st lb)	Score 1 Wt loss 5-10% – Weight loss in last 3 to 6 months: Between (st lb)	Score 2 Wt loss > 10% – Weight loss in last 3 to 6 months: More than (st lb)
10 3	0 8	0 8 - 1 2	1 2
10 6	0 8	0 8 - 1 2	1 2
10 8	0 8	0 8 - 1 2	1 2
10 10	0 8	0 8 - 1 3	1 3
10 12	0 8	0 8 - 1 3	1 3
11 0	0 8	0 8 - 1 3	1 3
11 3	0 8	0 8 - 1 3	1 3
11 5	0 8	0 8 - 1 4	1 4
11 7	0 8	0 8 - 1 4	1 4
11 9	0 9	0 9 - 1 4	1 4
11 11	0 9	0 9 - 1 4	1 4
12 0	0 9	0 9 - 1 5	1 5
12 2	0 9	0 9 - 1 5	1 5
12 4	0 9	0 9 - 1 5	1 5
12 6	0 9	0 9 - 1 5	1 5
12 8	0 9	0 9 - 1 6	1 6
12 11	0 9	0 9 - 1 6	1 6
12 13	0 10	0 10 - 1 6	1 6
13 1	0 10	0 10 - 1 6	1 6
13 3	0 10	0 10 - 1 7	1 7
13 5	0 10	0 10 - 1 7	1 7
13 8	0 10	0 10 - 1 7	1 7
13 10	0 10	0 10 - 1 7	1 7
13 12	0 10	0 10 - 1 8	1 8
14 0	0 10	0 10 - 1 8	1 8
14 2	0 10	0 10 - 1 8	1 8
14 5	0 11	0 11 - 1 8	1 8
14 7	0 11	0 11 - 1 9	1 9
14 9	0 11	0 11 - 1 9	1 9
14 11	0 11	0 11 - 1 9	1 9
14 13	0 11	0 11 - 1 9	1 9
15 2	0 11	0 11 - 1 10	1 10
15 4	0 11	0 11 - 1 10	1 10
15 6	0 11	0 11 - 1 10	1 10
15 8	0 11	0 11 - 1 10	1 10

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PATIENT HANDLING ASSESSMENT – 'INITIAL ASSESSMENT'

An assessment of each individual patient must be completed on admission; with the completion of this mobility chart as required.

Ability of patient prior to admission..... Independent .....

.....

.....

.....

Is the patient independent? **YES** ☑ **NO** ☐ (Please tick ✓ as appropriate)

Did the patient have a walking stick or frame on admission? **YES** ☐ **NO** ☑

If the patient has been assessed as 'independent' on initial assessment, a mobility chart does **NOT** require to be completed. If this changes, please review; and complete a mobility chart.

If the patient is **not** independent, please complete the mobility chart.

Assessor's Signature:	Date / Time: 29/5/25

PATIENT HANDLING ASSESSMENT – 'MOBILITY CHART'

The form overleaf **must** be completed if the patient is **NOT** independent. Thereafter the mobility chart must be read / reviewed daily; post fall; if patient's condition changes; and on transfer to another area. Document any changes in a new column.

An assessment of the patient should be carried out prior to **every** handling intervention. Any changes should be documented in a new column. Please refer to Manual Handling Guidelines for all manoeuvres. If your patient is 'Plus Size', please refer to the Handling Plus Size Person Guidelines

Areas of concern, risk factors and risk management MUST be documented in the patient record

(Please see below detail of codes)

Codes in Mobility Chart
MC = Mobility Code **HA = Handling Aid / EC = Equipment Code**

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	Date / Time Initial Assessment 29/5/25			Review Date/Time		
Transfers	**Mobility Codes**	**Handling Aids**	**Equipment Codes**	**Mobility Codes**	**Handling Aids**	**Equipment Codes**
Lying to sitting	Independent.					
Sits up and over the side of the bed						
Sit to stand to sit from bed / chair						
Walking						
Bathing / Showering / Toileting						
Toileting						
Moving up and down the bed						
Turning / Proning						
On / off bed pan						
Lateral transfers						
On / off floor						
Hoist and Sling information		**Criteria for referral to Physiotherapist**				
Make and model of hoist / stand aid		Chest Infection / difficulty clearing secretions / reduced oxygen saturated level				
Type / size of sling / loop selection (as required)		Reduced mobility compared to normal	Recent fall			
Assessor's Signature	[signature]	Stair assessment: state reason e.g. injury / acute illness				
Assessor's name (Print)	J Ross	Major surgery e.g. abdominal / neck dissection / mastectomy				
Review Date		Longer term rehabilitation needs				

MC – Mobility Codes	**HA – Handling Aids**	**EC – Equipment Codes**
IND - Independent **AST** - 1 / 2 / 3 or more	**H** - Full body hoist **BH** - Bath hoist	**SC** - Shower chair **ST** - Shower trolley
SUP - Supervision **BR** - Bed Rest	**STA** - Stand aid **Pt T** - Patient turner (specify)	**Co** - Commode **W** - Wheelchair
FWB - Full weight bearing	**GS** - Glide sheet **ES** - Extension straps	**C** - Crutches (specify)
PWB - Partial weight bearing	**HB** - Hand blocks **HS** - Hand sling	**S** - Stick **Z** - Zimmer
NWB - Non weight bearing	**PAT** - Pat slide	**HJ** - Hover jack **HM** - Hover matt

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Skin Assessment and Care Plan

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Daily Skin Care Assessment

	Date/ Time	29/5	31/5	1/6	2/6										
■	Independent, no concerns, assess daily, review if condition changes or a concern is raised.	✓	✓	✓	✓										
	Requires supervision/assistance, visually check skin daily or more often if at risk. Update care plan if there is a change in condition.														
■	Dependent, will require skin review at every patient interaction(min 2 hourly) and record findings in nursing notes														
	Date/ Time														
	Independent, no concerns, assess daily, review if condition changes or a concern is raised.														
	Requires supervision/assistance, visually check skin daily or more often if at risk. Update care plan if there is a change in condition.														
■	Dependent, will require skin review at every patient interaction(min 2 hourly) and record findings in nursing notes														

Care Needs	Potential nursing actions (Please include all that apply in the care plan below)
• Assess daily above • Review care plan and update only when a change is evident. ◦ Document all care given in unified progress notes.	• Discuss and plan care to include current patient skin condition and skin care regimen. Include any lotions or prescribed emollients. • Assess BRADEN and document current risk as well as any equipment currently in use. • Document level of assistance required to care for skin. • Ensure care and comfort chart is commenced. • Where a wound is present or skin is not intact please include information on the wound/skin tear and ensure a wound chart is commenced. ◦ Provide an information leaflet to patients/carers

Date/Time	Initial plan of care	Sign

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Daily Personal Hygiene & Continence Assessment

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1. Daily Personal Hygiene Assessment

	Date/ Time	29/5	31/5	1/6	2/6										
	Independent with hygiene (no care plan required)	✓	✓	✓	✓										
	Requires supervision/assistance with hygiene (detailed care plan required)														
■	Dependent with hygiene (detailed care plan required)														

2. Daily Continence Assessment

	Independent with continence, no concerns, review regularly for change	✓	✓	✓	✓										
	Uses continence products, continue to support whilst in hospital with prescribed products. Requires supervision/assistance (detail added to care plan)														
■	Dependent or new continence issue, patient requires full assessment.														
	Initials	SH	[illegible]	[illegible]	[illegible]										

1. Daily Personal Hygiene Assessment

	Date/ Time														
	Independent with hygiene (no care plan required)														
	Requires supervision/assistance with hygiene (detailed care plan required)														
■	Dependent with hygiene (detailed care plan required)														

2. Daily Continence Assessment

	Independent with continence, no concerns, review regularly for change														
	Uses continence products, continue to support whilst in hospital with prescribed products. Requires supervision/assistance (detail added to care plan)														
■	Dependent or new continence issue, requires full assessment.														
	Initials														

Patients assessed as **yellow** or **red** require a detailed care plan overleaf.
All care given each day **must** be documented in the unified progress notes.

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Personal Hygiene & Continence Care Plan

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Care Goals	Potential nursing actions (Please include all that apply in the care plan below)
• To enable person to maintain an appropriate level of personal hygiene • To enable person to remain continent or maintain continence level using prescribed products • To promote effective elimination function ◦ To prevent infection • Be fully assessed and have a care plan to support care needs • Discuss and agree care plan with patient/carer	• Document level of assistance required to help with personal hygiene care , needs, encourage self care as able and document what the patient requires help with. ◦ Document preference for : Basin/shower/bed bath • Consider how the patient cares for hair and nails and document in plan. ◦ Offer shave as required (document wet/dry) • Offer eye care as required • Provide commode/bed pan/urinal • Walk/wheel to the toilet ◦ Catheter care – complete CAUTI bundle • Provide and document agreed continence product for use in ward. This may include skin cleansers and barrier creams. Carer or family may bring same into ward for use. • Undertake full continence assessment and patient education as appropriate (see intranet for information) • Review and update care plan in line with changing care needs.

Date/Time	Plan of Care (Read/Review daily and update if required)	Sign
29/6/15	Independent with ADL No continence issues	SR

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Bowel Function Care Plan and Chart

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Daily Bowel Assessment

	Date/ Time	29/5	31/5	1/6	2/6									
	Patient is independent. Bowels moving normally, verbal or visual confirmation. Commence stool chart to monitor.			✓	✓									
	Requires supervision/assistance with bowel monitoring and care. Commence stool chart to monitor. Detailed care plan required.													
	Dependent with bowel care or bowels not moving. Commence stool chart. Detailed care plan required.													

Daily Bowel Assessment

	Date/ Time													
	Patient is independent. Bowels moving normally; verbal or visual confirmation. Commence stool chart to monitor.													
	Requires supervision/assistance with bowel monitoring and care. Commence stool chart to monitor. Detailed care plan required.													
	Dependent with bowel care or bowels not moving. Commence stool chart. Detailed care plan required.													

Bowel Function Care plan

Potential nursing actions
(Please include all that apply in the care plan below)

- **Please document normal bowel function and/or if the patient has a history of bowel disease**
- **Document if the patient has a stoma and plan of care, level of assistance required.**
- **Assess bowel function daily above and document any changes in the unified progress notes**
- **Review and update care plan below if the patients condition changes.**
- **Record any bowel pattern change, if patient is on aperients or if a specimen has been sent.**
- **Identify type of stool using Bristol Stool Form Scale. Record every episode of stool.**

Date/Time	Plan of Care (Read/Review daily and update if required)	Sign

Immediate Discharge Letter

NHS Forth Valley

Forth Valley Royal Hospital, Larbert
Tel: 01324 566 000

Serial No: 0f735b30-2538-42bf-8532-82e2a86e27f5

*** Non-verified Orders Exist ***

Consultant: DR HIMANSHU WADHAWAN

Ward: B11

GP Details		Patient Details		Admission Details	
GP Name & Address :	A Dunsmore Allan Park Medical Practi 19 Allan Park Stirling	CHI No:	0605770352	Admission Date :	28/05/2025
		Surname :	Wyles	Admission Type :	Planned Admission
		Forename :	Alan	Presenting Complaint :	
		DOB :	06/05/1977		
		Address :	2 GORDON SQUARE Stirling STIR FK8 1FN	Planned Discharge Date :	03/06/2025
				Outpatient Follow Up :	
		Patient Tel :	07835703594		

Discharge Comments and Follow up arrangements

GP Communication

Usually collects twice weekly from Tesco Pharmacy Stirling - I have contacted them and they will expect him on 5/5/25.
Pharmacy please supply x1 day.(tomorrow's supply) of buprenorphine and diazepam.
Paracetamol TTO from ward stock please.
Many thanks.

DR ALICE BUCHANAN-SMITH 03/06/2025 11:09

** End of Discharge Notes **

Discharging Doctor : DR ALICE BUCHANAN-SMITH

Grade : Foundation Year 1

Originally Printed : 03/06/2025 @ 11:09

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Continuation sheet for care plans if require

Date/Time	Plan of Care (Read/Review daily and update if required)	Sign

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Continuation sheet for care plans if require

Date/Time	Plan of Care (Read/Review daily and update if required)	Sign

NEWS key			
0	1	2	3

FULL NAME:

DATE OF BIRTH:

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		DATE	28/5/25		29/5	29/5	29/5	29/5	30/5	30/5	31/5	31/5	1/6			01/06	2/6	3/6/25
		TIME	1500	1800	2000	0600	0955	1715	2000	1115	2000	0800	1200	0724				0750
Respirations Breaths/min	≥25																	
	21-24	22																
	18-20		20	19	20	20	20	20	18	18	20	18	18			18		
	15-17													16	16		17	17	16
	12-14																	
	9-11																	
	≤8																	
SpO₂	≥96		97	97	96	97	95	99	97	98	97	98	97	98	96	100	97	97	96
	94-95																		
	92-93																		
	≤91																		
	≥97 on O₂																		
	95-96 on O₂																		
	93-94 on O₂																		
	≥93 on air																		
	88-92																		
	86-87																		
	84-85																		
	≤83%																		
A ox	A=Air	RA	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A
	L/min																		
	evice																		
Blood Pressure mmHg Score uses systolic BP only Use ↕	≥220																		
	201-219																		
	181-200																		
	161-180	150								162									
	141-160		141	154		165					160	148	177	153	165		127	140	126
	121-140				136											110			
	111-120																		
	101-110													101					
	91-100				94						93								
	81-90	96	83	76		75				83		91							79
	71-80															67	79	84	
	61-70																		
	51-60																		
	≤50																		
Pulse Beats/min Use •	≥131																		
	121-130																		
	111-120																		
	101-110																		
	91-100																		
	81-90	85								83			83	77	81	85		84	88
	71-80			80	80	80					78	80							
	61-70		67																
	51-60																		
	41-50																		
	31-40																		
	≤30																		
Consciousness Score for NEW onset of confusion (no score if chronic)	Alert	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A
	Confusion																		
	V																		
	P																		
	U																		
Temperature °C	≥39.1°																		
	38.1-39.0°																		
	37.1-38.0°																		
	36.1-37.0°		36.9	36.8	36.4	36.1				36.5C	36.6	37C	36.1	36.3	36.3	36.2C	36.4		36.1
	35.1-36.0°																		
	≤35.0°																		
NEWS TOTAL		2	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0
Monitoring frequency		12	12	4-6	4-6	4-6	4-6	6	6	12	12	12	12	12	12	4-6	12	12	12
Escalation of care Y/N		N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Blood Sugar				—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Pain Score 0-3				—	—	—	—	—	—	0	0		0	0	0	—	0	0	—
Initials				MM	MM	FB	SB	JH	OM		LMB		WMB	LMB			W	WM	

CHI NO: 0605710352
CRN:
Alan WYLES
2 GORDON SQUARE
STIRLING
FK8 1FN
06/05/1977
M

DATE OF ADMISSION:

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	DATE
	TIME
3	≥25
2	21-24
	18-20
	15-17
	12-14
1	9-11
3	≤8
	≥96
1	94-95
2	92-93
3	≤91
3	≥97 on O_2
2	95-96 on O_2
1	93-94 on O_2
	≥93 on air
1	88-92
2	86-87
	84-85
3	≤83%
	A=Air
2	O_2 L/min
	Device
3	≥220
	201-219
	181-200
	161-180
	141-160
	121-140
	111-120
1	101-110
2	91-100
	81-90
3	71-80
	61-70
	51-60
	≤50
3	≥131
2	121-130
	111-120
1	101-110
	91-100
	81-90
	71-80
	61-70
1	51-60
	41-50
3	31-40
	≤30
	Alert
	Confusion
3	V
	P
	U
2	≥39.1°
1	38.1-39.0°
	37.1-38.0°
	36.1-37.0°
1	35.1-36.0°
3	≤35.0°
	TOTAL
	Monitoring
	Escalation
	Blood Sugar
	Pain Score 0-3
	Initials

National Early Warning Score (NEWS2)

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Name: Alan WYLES
DOB: 06/05/1977
CHI No: CHI NO: 0605770352
CRN:
M
Address: 2 GORDON SQUARE
STIRLING
FK8 1FN

*** Regardless of NEWS always escalate if concerned about a patient's condition**

Total NEWS	Frequency of Monitoring	Clinical Response
0 *	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations
1 - 4 *	Minimum 4 - 6 hourly	◦ Inform registered nurse who must assess the patient • Registered Nurse to decide if increased frequency of monitoring and / or escalation of clinical care is required
5 - 6 * or 3 in one Parameter	Increased frequency to a minimum of 1 hourly	• Registered nurse to urgently inform the medical team caring for the patient ◦ Urgent assessment by a clinician with core competencies to assess acutely ill patients • Ensure structured Response Stickers A & B are completed *(Not Applicable in Emergency Dept)*
7* or more	Continuous monitoring of vital signs (3 lead ECG and continuous SpO2 monitoring, 15 minute BP cycling - document observations every 30 minutes)	• Registered nurse to immediately inform the medical team caring for the patient • Emergency assessment by clinical team with core competencies to assess acutely unwell patients ◦ Ensure structured Response Stickers A & B are completed *(Not Applicable in Emergency Dept)* ◦ Consider transfer of clinical care to ITU

Exclusion Criteria

Anaesthesia and/or sedation may result in reduced conscious levels for a period of time. Scores that are increasing post-procedure and those including "P" or "U" always require escalation. The post-procedure NEWS score and post procedure plan that will include the frequency of observations should be communicated to the ward staff on transfer/handover of the patient.

Target O2 Saturation

Target SpO2 for most patients should be 94-98%.
Selected patients may require target SpO2 88-92% (Appropriate in specific patients with severe chronic respiratory disease who either have established chronic Type 2 respiratory failure, or are felt to be at significantly increased risk of CO_2 retention from oxygen therapy). These patients should use the modified (chronic hypercapnia) EWS. Arterial blood gases should be repeated at 30–60 min to check for rising CO_2 or H^+ after initiation of oxygen in this context.

Acute Respiratory Failure is a life threatening emergency
Severe Hypoxia (Requiring >60% O2 to maintain target SpO2)
Acute Hypercapnia (pCO_2 >6 and H^+ >45)
Urgent ST3 (or equivalent) review is required to optimise management.
Duty or on call consultant should be contacted if advice required.
Critical care referral and ventilatory support may be needed.

Pain Score
0 = no pain
1 = mild pain
2 = moderate pain
3 = severe pain

Codes For Recording Oxygen Delivery On NEWS Chart

A = Air (not requiring oxygen or weaning or on PRN oxygen)
N = Nasal Canulae
SM = Simple Mask
V24 =Venturi 24% V28 = Venturi 28% V35 = Venturi 35% V40 = Venturi 40% V60 = Venturi 60%
H28 = Humidified oxygen at 28% (also H35, H40 & H60 = Humidified Oxygen at 35%, 40% & 60%)
RM = Reservoir Mask
TM = Tracheostomy Mask
CP = Patient on CPAP System
NIV = Patient on NIV System
OTH = Other Device:_____ (specify which)

NHS Forth Valley

PERIPHERAL VASCULAR CATHETER (PVC) DAILY MAINTENANCE

Label			
N: CHI NO: 0605770352 06/05/1977 C CRN: F Alan WYLES M (2 GORDON SQUARE STIRLING FK8 1FN	Reason for insertion: IV ROSC	DAY 0 COPY	
	Insertion Date: 28/5/25 Time:		
	Colour/batch no: PINK Position: R HAND		
	Hand hygiene (HH) performed	Yes	No
	Skin cleansed for 30 seconds with antiseptic & left to dry prior to insertion	Yes	No
	Aseptic technique throughout	Yes	No
	Sterile dressing applied including date and time	Yes	No
	Inserted by:		
	Ward inserted: SAU		

Ensure that:
Medical staff review the need for intravenous (IV) therapy **including antibiotics on a daily basis – switch to oral if possible**
An antiseptic containing 70% isopropyl alcohol is used to clean the access hub. **Before accessing, rub the access hub for at least 15 seconds** ("scrub the hub")

MODIFIED VIP (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 sign:	Remove & replace cannula. Observe both sites and document. **Obtain swab**
Two or more of the following are evident: Pain, redness or swelling	2	Early stages of phlebitis:	Remove & replace cannula. Observe both sites and document. Treat if necessary. **Obtain swab**
All of the following are evident: Pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis	Remove and seek further advice. **Obtain swab**
As above including palpable venous cord	4		Remove and seek further advice. **Obtain swab**
As above including pyrexia	5		Seek further advice.

24 hours Date: 28/5/25 Time: 1750		
Is PVC still required	YES	NO
Absence of inflammation/extravasation	YES	NO
VIP score - *please circle*	0 1 2 3 4 5	
PVC dressing intact	YES	NO
PVC inserted <72 hrs	YES	NO
HH before/after procedure	YES	NO
"Scrub the Hub" (before use)	YES	NO
PVC – *please circle*	Left in situ	removed
Reason for removal:		
Signature:		

48 hours Date:	Time:	
Is PVC still required	YES	NO
Absence of inflammation/extravasation	YES	NO
VIP score - *please circle*	0 1 2 3 4 5	
PVC dressing intact	YES	NO
PVC inserted <72 hrs	YES	NO
HH before/after procedure	YES	NO
"Scrub the Hub" (before use)	YES	NO
PVC – *please circle*	Left in situ	removed
Reason for removal:		
Signature:		

72 hours Date:	Time:	
Is PVC still required	YES	NO
Absence of inflammation/extravasation	YES	NO
VIP score - *please circle*	0 1 2 3 4 5	
PVC dressing intact	YES	NO
PVC inserted <72 hrs	YES	NO
HH before/after procedure	YES	NO
"Scrub the Hub" (before use)	YES	NO
PVC – *please circle*	Left in situ	removed
Reason left in situ:		
Discussed with:		
Reason for removal:		
Signature:		

If PVC to remain in situ for longer than 72 hours this must be documented on a daily basis in notes and discussed with medical staff.

Observe closely for clinical signs and symptoms of Phlebitis.

New sheet to be commenced.

NHS Forth Valley

PERIPHERAL VASCULAR CATHETER (PVC) DAILY MAINTENANCE

Label	Reason for insertion: IV Antibiotics	DAY 0 COPY
Name: [redacted]	Insertion Date: 30/05/25 Time:	
D.O.B: CHI NO: 0605770352 06/05/1977	Colour/batch no: Position: Right Hand	
CHI: CRN: M	Hand hygiene (HH) performed	Yes No
Hospital: Alan WYLES	Skin cleansed for 30 seconds with antiseptic & left to dry prior to insertion	Yes No
(Use addr: 2 GORDON SQUARE	Aseptic technique throughout	Yes No
STIRLING FK8 1FN	Sterile dressing applied including date and time	Yes No
	Inserted by: AL	
	Ward inserted: B11	

Ensure that:
Medical staff review the need for intravenous (IV) therapy **including antibiotics on a daily basis – switch to oral if possible**
An antiseptic containing 70% isopropyl alcohol is used to clean the access hub. **Before accessing, rub the access hub for at least 15 seconds** ("scrub the hub")

MODIFIED VIP (VISUAL INFUSION PHLEBITIS) SCORE

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One of the following is evident: Slight pain or redness near site	1	Possible first sign:	Remove & replace cannula. Observe both sites and document. **Obtain swab**
Two or more of the following are evident: Pain, redness or swelling	2	Early stages of phlebitis:	Remove & replace cannula. Observe both sites and document. Treat if necessary. **Obtain swab**
All of the following are evident: Pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis	Remove and seek further advice. **Obtain swab**
As above including palpable venous cord	4		Remove and seek further advice. **Obtain swab**
As above including pyrexia	5		Seek further advice.

24 hours Date: 31/05/25 Time: 21:00 hrs		
Is PVC still required	YES	NO
Absence of inflammation/extravasation	YES	NO
VIP score - *please circle*	0 1 2 3 4 5	
PVC dressing intact	YES	NO
PVC inserted <72 hrs	YES	NO
HH before/after procedure	YES	NO
"Scrub the Hub" (before use)	YES	NO
PVC – *please circle*	~~Left in situ~~	removed
Reason for removal:		
Signature:		

48 hours Date: 01/06/25 Time: 21:00 hrs		
Is PVC still required	YES	NO
Absence of inflammation/extravasation	YES	NO
VIP score - *please circle*	0 1 2 3 4 5	
PVC dressing intact	YES	NO
PVC inserted <72 hrs	YES	NO
HH before/after procedure	YES	NO
"Scrub the Hub" (before use)	YES	NO
PVC – *please circle*	~~Left in situ~~	removed
Reason for removal:		
Signature:		

72 hours Date: 02/06/25 Time: 21:00 hrs		
Is PVC still required	YES	NO
Absence of inflammation/extravasation	YES	NO
VIP score - *please circle*	0 1 2 3 4 5	
PVC dressing intact	YES	NO
PVC inserted <72 hrs	YES	NO
HH before/after procedure	YES	NO
"Scrub the Hub" (before use)	YES	NO
PVC – *please circle*	Left in situ	removed
Reason left in situ:		
Discussed with:		
Reason for removal:		
Signature:		

If PVC to remain in situ for longer than 72 hours this must be documented on a daily basis in notes and discussed with medical staff.

Observe closely for clinical signs and symptoms of Phlebitis.

New sheet to be commenced.

ADULT PARENTERAL GENTAMICIN (GGC): PRESCRIBING, ADMINISTRATION & MONITORING CHART

NHS SCOTLAND

Use for patients prescribed intravenous gentamicin as per the GGC dosing guidance. Not for prophylactic indication or where synergistic doses (usually in endocarditis) are being used.
Refer to full guidance for information on EXCLUSIONS and Cautions / Contra-indications to gentamicin.

Alan WYLES
2 GORDON SQUARE

STIRLING
STIRLINGSHIRE
FK8 1FN

apply patient label

Age: 48. Sex: (M) / F
Weight: 13 stone Height: 5'8.
Creatinine: 69. on: 29 / 05 / 25

Initial Gentamicin Dose*: 400mg
Predicted Frequency*: 24 °
*this is not a prescription and may change. Doses must be prescribed individually below.

Source of first dose: Online calculator (preferred method) ☐ Manual calculation ☐ Weight based, creatinine not known ☐

PROMPT ADMINISTRATION
within 1 hour of recognition of sepsis reduces mortality

SIGNS OF GENTAMICIN TOXICITY
RENAL: ↓ urine output/oliguria or ↑ creatinine
OTO/VESTIBULAR: NEW tinnitus, dizziness, poor balance, hearing loss, oscillating vision
Toxicities may occur irrespective of gentamicin concentration

Step 1: Calculate and prescribe the first dose of gentamicin (see overleaf for more details)
- If creatinine is known - use the online gentamicin dose calculator.
- If creatinine is not known - give 5 mg/kg gentamicin (maximum 400 mg) or, if CKD 5, give 2.5 mg/kg (maximum 180 mg) on advice of senior medical staff.
- Prescribe gentamicin 'as per chart' on the medication chart (kardex). AVOID specifying dose or administration time on the kardex.
- Prescribe individual doses in the prescription record section below, specifying the date and time the dose should be given.

Step 2: Monitor creatinine and gentamicin concentration and reassess the dosage regimen
- Check gentamicin concentration after the first dose and then at least every 2 days (see overleaf for more details).
- Monitor creatinine daily. Seek advice if renal function is unstable (e.g. a change in creatinine of >15-20%).

Step 3: Assess daily: the ongoing need for gentamicin; signs of toxicity
- Consider an alternative agent if creatinine is increasing or the patient becomes oliguric.
- If gentamicin continues for >7 days, suggest referral to audiology for assessment.
- Refer to guidelines or clinical pharmacist for further advice on prescribing, monitoring and administration.

TOXICITY Before prescribing each dose check: Renal & Oto-vestibular function	Gentamicin Prescription Record: Complete each time a dose is to be given (ensuring gentamicin is prescribed 'as per chart' on the kardex)				Administration Record: Complete each time gentamicin is administered (in addition to the kardex)			Monitoring Record: Record ALL sample dates/times accurately below. See overleaf for monitoring advice.			
	Date to be given	Time to be given 24 h clock	Gentamicin Dose (mg)	Prescriber's signature, PRINTED name and STATUS	*Infuse over 30 mins* Date given	*Infuse over 30 mins* Time started 24 h clock	Given by	Date of sample	Time of sample 24 h clock	Gent level (mg/L)	Action/ Comments (please initial action to be taken)
Cr = 69 micromol/L	29.05.25	11:00	400 mg.	D. Romanyuk FY01	29/5/25	1705	CM.	29/05/25	23:00	0,80	24 hourly ☑ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other:
Cr = micromol/L	30.05.25	11:30	400mg	A. ALASMI FY1	30/5/25	1235	SB AM	30/5/25	19:10	270	24 hourly ☑ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other:
*Discuss with an infection specialist or microbiology and document in the notes if treatment continues beyond 3 to 4 days * Risks of prolonged treatment must be considered and treatment options discussed with microbiology or infection specialist											
Cr = micromol/L	31.5.25	12.30	400	A. ALASMI FY1	31/5/25	13.18	[illegible]				24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other:
Cr = micromol/L											24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other:

Discuss with an infection specialist before continuing onto a second sheet

Copy

Vancomycin intermittent infusion

Prescription, administration and monitoring chart

NHS Forth Valley

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Use online vancomycin calculator

All patients on vancomycin MUST have a vancomycin prescription, administration and monitoring chart which MUST be completed after each dose as well as a valid prescription on HEPMA. HEPMA prescription should state as per paper chart and changes to frequency etc should be altered on HEPMA as well as on this chart.

This dosing guideline applies to all adult patients on vancomycin except haemodialysis patients and is for pulsed vancomycin therapy only.

Addressograph sticker

Name MARY WYLES

Date of birth 06.05.77.

CHI No 0605770352.

Baseline requirements Date 29.05.25.

Age 48. years Actual body weight (ABW) 13 STONE. kg

Serum creatinine 69. micromol/L

Height 5'8. feet & inches or ..... cm

Use online vancomycin calculator.

Ideal body weight (IBW) 68.7 kg

Initial creatinine clearance 135.3. ml/min

Step 1 Document Baseline requirements

- Document patient's weight (kg), height, age and serum creatinine.

Step 2 Loading infusion

- The loading dose is based on **actual** body weight (ABW). It does not depend on creatinine clearance.

Actual body weight (ABW)	Dose	Volume of sodium chloride 0.9% or glucose 5%	Duration of infusion
<40 kg	750 mg	250 ml	90 minutes
40 - 59 kg	1000 mg	250 ml	120 minutes
→ 60 - 90 kg	1500 mg	500 ml	180 minutes
>90 kg	2000 mg	500 ml	240 minutes

Preparation and administration – VANCOMYCIN MUST ALWAYS BE DILUTED PRIOR TO ADMINISTRATION

- Reconstitute with the required volume of water for injection (10 ml water for a 500 mg vial & 20 ml water for a 1 gram vial).
- Add required volume of reconstituted solution to an intravenous infusion bag – see above.
- **Maximum concentration for peripheral infusion** 5 mg /ml
- **Vancomycin must be administered by intravenous infusion at a rate no greater than 10 mg/minute. Failure to do so can result in anaphylaxis, shock and red man syndrome.**

Step 3 Maintenance intermittent infusion Dose

- **Calculate maintenance dose using ON-LINE CALCULATOR.** If on-line calculator is not available, refer to dosing tables in FV Acute Care Antimicrobial Guidelines (either on intranet or via App)
- Give first maintenance infusion 12, 24 or 48 hours after loading infusion according to recommended dose interval.

Step 4 Maintenance intermittent infusion preparation and administration

- Reconstitute with the required volume of water for injection (10 ml water for a 500 mg vial & 20 ml water for a 1 gram vial).
- **Vancomycin must be diluted before administration -** Further dilute the vancomycin by adding it to an intravenous bag of sodium chloride 0.9% or glucose 5%.
- **Maximum concentration for infusion** 5 mg /ml e.g. 1 gram given in 250 ml NaCl 0.9%).see table below.
- **Vancomycin must be administered by intravenous infusion at a rate no greater than 10 mg/minute. Failure to do so can result in anaphylaxis, shock and red man syndrome.**

Vancomycin dose	Volume of diluent - sodium chloride 0.9% or glucose 5%	Duration of infusion
500 mg	100 ml	60 minutes
750 mg	250 ml	90 minutes
1000 mg	250 ml	120 minutes
1250 mg	250 ml	150 minutes
→ 1500 mg	500 ml	180 minutes

Vancomycin intermittent infusion – prescription, administration and monitoring chart

Patient name **CHI No**

COPY

Step 5 Vancomycin prescriptions

- All prescriptions for vancomycin MUST be clear and unambiguous and MUST be prescribed on HEPMA "as per paper chart". Changes to dosing frequency MUST be altered on HEPMA as well as on chart
- These are initial dosage guidelines. The handling of vancomycin is highly variable and early analysis of the trough concentration is required to optimise therapy
- **Record the exact times of all doses administered below.**
- **Initial prescription must include a single loading dose and all maintenance doses until the first vancomycin level is available.**
- **Document date and time of level required when prescribing dose.**

Date	Creatinine (µmol/l)	Time	Vancomycin Dose (mg)	Level required		Prescriber Signature	Time infusion started	Nurses' Signatures		Sample taken		Measured trough Level mg/L	Action Required
				Date	Time					Date	Time		
29.05.25	Loading dose	11:30	1500mg.				1630	DV					
29.05.25	69.	23:30	1500mg.				04:30	JH	JB				
30.05.25		16:30	1500mg.	30.05.25	1630		19:40	SB				8.4	↑ bad
31.5.25		11:00	1000mg				11:05	CC	RY				
31.5.25		19.00	1000mg				19.00		RY				
1.6.25		03:00	1000mg				0300						
Review need for continuing therapy													
1.6.25		11:00	1000mg	1.6.25	1055								

Step 6 Monitoring of Vancomycin concentrations

Select target trough concentration ☑ **10 - 20 mg/L (standard)**

☐ **15 -20mg/L (deep seated infections e.g. bacteraemia, endocarditis, osteomyelitis)**

- Check and document creatinine daily. Recalculate creatinine clearance and dose if there is a significant change in creatinine.

heck trough (pre dose) concentration immediately prior to third dose (or within 48 hours, whichever is sooner). If renal function impaired or deteriorating / nproving then check levels daily.

- Document level and next dose on the prescription chart and the case note.
- Give next dose pending trough result unless renal function is deteriorating.

Step 7 Adjustment of Vancomycin Doses

- Always check the dosing history and sampling times are correct before making adjustments.
- After dose adjustments take a trough level at 24 hours and again 24 hours later to ensure that new dose is appropriate.

Vancomycin trough	Suggested dose change
≤5 mg/L	Reload patient and seek advice from pharmacist
>5 but <10 mg/l	Increase total dose by one dose band
10 - 15 mg/L	If patient responding and the target range is 10-15mg/L, maintain current dose. If patient seriously ill or target concentration 15-20mg/L, consider increasing dose by one dose band
15-20 mg/L	Maintain present dose. Resample every 48 hours if renal function stable
>22 mg/L	Stop until <20 mg/l then seek advice from pharmacist

Vancomycin Dose Banding – for dose adjustment in response to levels	
Dose, volume of sodium chloride 0.9%, duration and interval	
500mg in 250ml over 1 hour	48 hourly
500mg in 250ml over 1 hour	24 hourly
750mg in 250ml over 1.5 hours	24 hourly
500mg in 250ml over 1 hour	12 hourly
750mg in 250ml over 1.5 hours	12 hourly
1000mg in 250ml over 2 hours	12 hourly
1250mg in 500ml over 2.5 hours	12 hourly
1500mg in 500ml over 3 hours	12 hourly
1000mg in 250ml over 2 hours	8 hourly
1250mg in 250ml over 2.5 hours	8 hourly
1500mg in 500ml over 3 hours	8 hourly

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Immediate Discharge Letter

NHS Forth Valley

COPY

Forth Valley Royal Hospital, Larbert
Tel: 01324 566 000

Serial No: 0f735b30-2538-42bf-8532-82e2a86e27f5

Consultant: DR HIMANSHU WADHAWAN

Ward: B11

GP Details		Patient Details		Admission Details	
GP Name & Address :	A Dunsmore Allan Park Medical Practi 19 Allan Park Stirling	CHI No:	0605770352	Admission Date :	28/05/2025
		Surname :	Wyles	Admission Type :	Planned Admission
		Forename :	Alan	Presenting Complaint :	
		DOB :	06/05/1977		
		Address :	2 GORDON SQUARE Stirling STIR FK8 1FN	Planned Discharge Date :	03/06/2025
				Outpatient Follow Up :	
		Patient Tel :	07835703594		

** PLEASE NOTE: DETAILED CLINICAL INFORMATION REGARDING PATIENT EPISODE TO-FOLLOW **

Patient Drug Reactions

Allergen	Reaction	Allergen	Reaction
PENICILLINS	Unknown		

Forth Valley Acute Hospitals - Acute Division
Medications Discharge Summary

Medication	Route	Dose & Frequency	Days Supply or POD	GP?	V
BUPRENORPHINE 2 mg Sublingual Tablets **ADMIT ON**	Sublingual	2 mg ONCE daily at 8am	1	Yes	✓RM
BUPRENORPHINE 8 mg Sublingual Tablets **ADMIT ON**	Sublingual	8 mg ONCE daily at 8am	1	Yes	✓RM
DIAZEPAM 2 mg Tablets **ADMIT ON**	Oral	8 mg ONCE daily at 8am	1	Yes	✓RM
DIAZEPAM 5 mg Tablets **ADMIT ON**	Oral	20 mg ONCE daily at 8am	1	Yes	✓RM
PARACETAMOL 500 mg Tablets	Oral	1000 mg FOUR times daily at 8am 12noon 6pm 10pm	7	No	✓RM

TTO
Mr Rex Ma 03/06/2025 11:39

** Last Item **

Discharging Doctor : DR ALICE BUCHANAN-SMITH **Grade :** Foundation Year 1

Printed: 03/06/2025 @ 12:42:33
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Immediate Discharge Letter

NHS Forth Valley

Forth Valley Royal Hospital, Larbert
Tel: 01324 566 000

Serial No: 0f735b30-2536-42bf-8532-82e2a86e27f5

Consultant: DR HIMANSHU WADHAWAN

Ward: B11

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		Surname :	Wyles	Admission Type :	Planned Admission
		Forename :	Alan	Presenting Complaint :	
		DOB :	06/05/1977		
		Address :	2 GORDON SQUARE Stirling STIR FK8 1FN	Planned Discharge Date :	03/06/2025
				Outpatient Follow Up :	
		Patient Tel :	07835703594		

Discharge Comments and Follow up arrangements

GP Communication

Usually collects twice weekly from Tesco Pharmacy Stirling - I have contacted them and they will expect him on 5/5/25.
Pharmacy please supply x1 day (tomorrow's supply) of buprenorphine and diazepam.
Paracetamol TTO from ward stock please.
Many thanks.

DR ALICE BUCHANAN-SMITH 03/06/2025 11:09

** End of Discharge Notes **

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Dispensed by : Checked by : Date :

Discharging Doctor : DR ALICE BUCHANAN-SMITH Grade : Foundation Year 1

Originally Printed : 03/06/2025 @ 11:09

Immediate Discharge Letter

Forth Valley Royal Hospital, Larbert
Tel: 01324 566 000

Consultant: DR HIMANSHU WADHAWAN

NHS Forth Valley

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Ward: B11

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GP Name & Address :	A Dunsmore Allan Park Medical Practi 19 Allan Park Stirling	CHI No:	0605770352	Admission Date :	28/05/2025
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		Forename :	Alan	Presenting Complaint :	
		DOB :	06/05/1977		
		Address :	2 GORDON SQUARE Stirling STIR FK8 1FN	Planned Discharge Date :	03/06/2025
				Outpatient Follow-Up :	
		Patient Tel :	07835703594		

Notes Transferred from the Inpatient Chart

Patient Note

Twice weekly dispense (Monday and Thursday) Tesco Stirling 0131 289 4129

Ms May Swallow 30/05/2025 10:32

** End of Transferred Notes **

Dispensed by : **Checked by :** **Date :**

Discharging Doctor : DR ALICE BUCHANAN-SMITH **Grade :** Foundation Year 1

Printed: 03/06/2025 @ 12:42:33
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Immediate Discharge Letter

NHS Forth Valley

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Tel: 01324 566 000

Serial No: 0f735b30-2538-42bf-8532-82e2a86e27f5

Consultant: DR HIMANSHU WADHAWAN

Ward: B11

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				Outpatient Follow Up :	
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** PLEASE NOTE: DETAILED CLINICAL INFORMATION REGARDING PATIENT EPISODE TO-FOLLOW **

Patient Drug Reactions

Allergen	Reaction	Allergen	Reaction
PENICILLINS	Unknown		

Forth Valley Acute Hospitals - Acute Division
Medications Discharge Summary

Medication	Route	Dose & Frequency	Days Supply or POD	GP?	V	Notes
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ADMIT ON	Sublingual	2 mg ONCE daily at 8am	1	Yes	✔RM	
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ADMIT ON	Sublingual	8 mg ONCE daily at 8am	1	Yes	✔RM	
DIAZEPAM 2 mg Tablets						
ADMIT ON	Oral	8 mg ONCE daily at 8am	1	Yes	✔RM	
DIAZEPAM 5 mg Tablets						
ADMIT ON	Oral	20 mg ONCE daily at 8am	1	Yes	✔RM	
PARACETAMOL 500 mg Tablets						
	Oral	1000 mg FOUR times daily at 8am 12noon 6pm 10pm	7	No	✔RM	

TTO
Mr Rex Ma 03/06/2025 11:39

** Last Item **

COPY

Dispensed by : Checked by : Date :

Discharging Doctor : DR ALICE BUCHANAN-SMITH Grade : Foundation Year 1

Originally Printed : 03/06/2025 @ 11:09

Immediate Discharge Letter

Forth Valley Royal Hospital, Larbert
Tel: 01324 566 000

NHS Forth Valley

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Consultant: DR HIMANSHU WADHAWAN

Ward: B11

GP Details		Patient Details		Admission Details	
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		Forename :	Alan	Presenting Complaint :	
		DOB :	06/05/1977		
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DR ALICE BUCHANAN-SMITH 03/06/2025 11:09

** End of Discharge Notes **

Discharging Doctor : DR ALICE BUCHANAN-SMITH

Grade : Foundation Year 1

Immediate Discharge Letter

Forth Valley Royal Hospital, Larbert
Tel: 01324 566 000

Consultant: DR HIMANSHU WADHAWAN

Ward: B11

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				Outpatient Follow Up :	
		Patient Tel :	07835703594		

Notes Transferred from the Inpatient Chart

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Ms May Swallow 30/05/2025 10:32

** End of Transferred Notes **

COPY

Discharging Doctor : DR ALICE BUCHANAN-SMITH

Grade : Foundation Year 1

Printed: 03/06/2025 @ 11:09:37

Immediate Discharge Letter

NHS Forth Valley

Forth Valley Royal Hospital, Larbert
Tel: 01324 566 000

Serial No: 0f735b30-2538-42bf-8532-82e2a86e27f5

*** Non-verified Orders Exist ***

Consultant: DR HIMANSHU WADHAWAN

Ward: B11

GP Details		Patient Details		Admission Details	
GP Name & Address :	A Dunsmore Allan Park Medical Practi 19 Allan Park Stirling	CHI No:	0605770352	Admission Date :	28/05/2025
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		DOB :	06/05/1977		
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				Outpatient Follow Up :	
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** PLEASE NOTE: DETAILED CLINICAL INFORMATION REGARDING PATIENT EPISODE TO-FOLLOW **

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ADMIT ON	Sublingual	2 mg ONCE daily at 8am	1	Yes	
BUPRENORPHINE 8 mg Sublingual Tablets					
ADMIT ON	Sublingual	8 mg ONCE daily at 8am	1	Yes	
DIAZEPAM 2 mg Tablets					
ADMIT ON	Oral	8 mg ONCE daily at 8am	1	Yes	
DIAZEPAM 5 mg Tablets					
ADMIT ON	Oral	20 mg ONCE daily at 8am	1	Yes	
PARACETAMOL 500 mg Tablets					
	Oral	1000 mg FOUR times daily at 8am 12noon 6pm 10pm	7	No	

** Last Item **

Discharging Doctor : DR ALICE BUCHANAN-SMITH

Grade : Foundation Year 1

Immediate Discharge Letter

NHS Forth Valley

Forth Valley Royal Hospital, Larbert
Tel: 01324 566 000

Serial No: 0f735b30-2538-42bf-8532-82e2a86e27f5

*** Non-verified Orders Exist ***

Consultant: DR HIMANSHU WADHAWAN

Ward: B11

GP Details		Patient Details		Admission Details	
GP Name & Address :	A Dunsmore Allan Park Medical Practi 19 Allan Park Stirling	CHI No:	0605770352	Admission Date :	28/05/2025
		Surname :	Wyles	Admission Type :	Planned Admission
		Forename :	Alan	Presenting Complaint :	
		DOB :	06/05/1977		
		Address :	2 GORDON SQUARE Stirling STIR FK8 1FN	Planned Discharge Date :	03/06/2025
				Outpatient Follow Up :	
		Patient Tel :	07835703594		

Notes Transferred from the Inpatient Chart

Patient Note

Twice weekly dispense (Monday and Thursday) Tesco Stirling 0131 289 4129

Ms May Swallow 30/05/2025 10:32

** End of Transferred Notes **

Discharging Doctor : DR ALICE BUCHANAN-SMITH **Grade :** Foundation Year 1