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

NHS
Greater Glasgow and Clyde

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

Date: 25/06/2026
Your Ref: 100828
Our Ref: SAR/ACCESS/ CD
Enquiries to: Chrissy
Direct Line: 0141 201 3379
Email: chrissy.davie@nhs.scot

Dear Sir/Madam

Re: Subject Access Request under the General Data Protection Regulation

Patient: WENDY MCLEISH **D.O.B: 25/05/1987**

Thank you for your request received 01ST June 2026 in which you seek a copy of your client's personal information.

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

GLASGOW ROYAL INFIRMARY, PRINCESS ROYAL MATERNITY & STOBHILL HOSPITAL RECORDS

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

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

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

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

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

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

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

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

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

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

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

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

Yours sincerely

Subject Access Request Team

ELECTRONIC PATIENT RECORDS

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

Including:

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

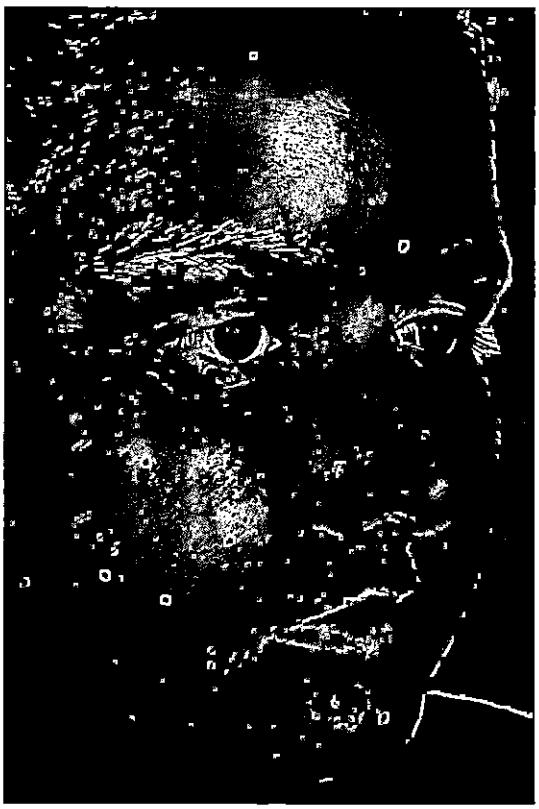
Medical Illustration Services

NHS
Greater Glasgow and Clyde

MIS No: C23-036341

CHI: 2505876061

Date: 27/06/2023





Consent Status	A	B	C

A = Records ONLY, B = Teaching & Records, C = Publication

These photographs form part of the confidential clinical record and are the copyright of NHS Greater Glasgow and Clyde. They may not be reproduced in any way without written permission from the copyright holder as shown.

ELECTRONIC PATIENT RECORDS

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

Including:

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

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

Stobhill Hospital
133 Balornock Road
Glasgow
G21 3UW
Main Switchboard: 0141 201 3000
Department: Gynaecology
Contact Tel: 0141 355 1828
Enquiries to: Jacqueline Cooper

Dr. AL McGinley
Dr Wilson dr mcginley & dr sheppar
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

Letter Date: 22/10/2015
Reference: SW/EJ
Dictated Date: 19/10/2015
Transcribed Date: 20/10/2015

Dear Dr McGinley,

Wendy McLeish; D.O.B: 25/05/1987; CHI: 2505876061
0/1 51 COXTON PLACE, Glasgow, Lanarkshire, G33 5EJ

I have now received the histology report for this patient dated 14th September and it confirmed the presence of products of conception.

Yours sincerely

Dr Wong

Consultant Gynaecologist

Electronically Signed: Dr Sandra Wong, Consultant

cc.

Clinical letter - GP: GP LETTER

NHS
Greater Glasgow and Clyde

Stobhill Hospital
133 Balornock Road
Glasgow
G21 3UW

Dr. AL McGinley
Dr Wilson dr mcginley & dr sheppar
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

Main Switchboard: 0141 201 3000
Department: GYNAECOLOGY
Contact Tel: 0141 355 1828
Enquiries to: Jacqui Cooper
Letter Date: 15/09/2015
Reference: SW/AMMCS
Dictated Date: 14/09/2015
Transcribed Date: 14/09/2015

Dear Dr. McGinlay,,

Wendy McLeish; D.O.B: 25/05/1987; CHI: 2505876061
0/1 51 COXTON PLACE, Glasgow, Lanarkshire, G33 5EJ

This patient was admitted to Stobhill Surgical Day Unit for surgical evacuation of retained products of conception. The procedure was completed under general anaesthetic without any complication.

She will be discharged home later on today when well and no further follow up has been arranged.

Yours sincerely

Electronically Signed: Dr Sandra Wong, Consultant

cc.

Operation note: OPERATION NOTE

NHS
Greater Glasgow and Clyde

Stobhill Hospital
133 Balornock Road
Glasgow
G21 3UW

Main Switchboard: 0141 201 3000
Department: GYNAECOLOGY
Contact Tel:
Enquiries to:

Letter Date: 15/09/2015
Reference: SW/AMMCS
Dictated Date: 14/09/2015
Transcribed Date: 14/09/2015

14th September, 2015.
Dr. S. Wong

Stobhill Hospital
Department: GYNAECOLOGY

Surgical evacuation of retained products of conception under general anaesthetic

Findings:

7 - 8 week size anteverted uterus, adnexae NAD.

Procedure:

Cervix dilated to Hegar 8. 8 mm suction curette used, products of conception obtained for histology assessment. Sharp curette used to check cavity and confirmed to be empty, good haemostasis.

Plan:

Home later on today well and no follow up.

Department of Respiratory Medicine
Stobhill ACH
Pulmonary Function Report

NHS Greater Glasgow and Clyde

CHI:	**2505876061**				
Last Name:	**McLeish**	**Height:**	**157 cm**	**Physician:**	**Dr Bayes**
First Name:	**Wendy**	**Weight:**	**94.0 kg**	**Ward:**	**Stobhill B19**
Date of Birth:	**25/05/1987**	**BMI:**	**38 kg/m²**	**Smoking status:**	**Non-Smoker**
Age:	**35 Years**	**Race:**	**Caucasian**	**Smoking pk-yrs:**	
Gender:	**female**	**Pred. Module:**	**GLI_ECCS**	**Physiologist:**	**Wood C**
Visit date:	**17/04/2023**	**Indication:**	**Cough ?Asthma**		

Note GLI ethnic correction only adjusts for spirometry.

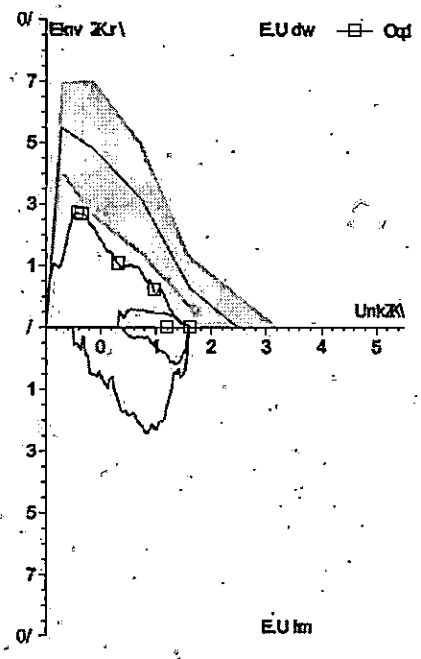
SR Range Normal +/- 1.64 to 1.64 Mild +/- 1.65 to 2.50 Moderate +/- 2.51 to 4.00 Severe +/- >4.00

Spirometry

		Pred	Best Pre	% Pred	SR	Best Post	% Pred	SR	% Chg	%Pred Chg
FVC	L	3.46	2.60	75.2	-2.05					
FEV 1	L	2.89	2.19	75.8	-1.98					
FEV 1 % FVC	%	84	84		0.07					
FEV 1 % VC MAX	%	84	84		0.07					
PEF	L/s	6.48	3.70	57.2	-3.08					
MMEF 75/25	L/s	3.19	2.17	68.0	-1.38					

		Meas
SpO2	%	95

		Meas
FeNO	ppb	7



Comments

Reported to ERS/ATS 2021 and ARTP 2020 guidelines unless otherwise stated.

O' sdnst m' ald sn odqnd rolqnl dsqk sn `m` bbdos ald nqqlod` s` ald r s` nc` qc
Adr sqdr t lsqdonqsdc , lmsdqqdsv lsg b` t shnm
R` lat s` l nkv lsgdlc

Cxm l lb lt mf unlt l dr `qd qdct bdc v lsg nn `lqknv nar sq bshnm

Qdonqsdc9B V nnc
Qdonqsudqtsdc9Q U` t f gm

ELECTRONIC PATIENT RECORDS

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

Including:

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

Clinical letter - Others:

NHS
Greater Glasgow and Clyde

Princess Royal Maternity
16 Alexandra Parade
Glasgow
G31 2ER

Dictation for Notes Only

Main Switchboard:	0141 211 5400
Department:	Anaesthetics
Contact Tel:	0141 211 5337
Enquiries to:	Fiona McManus
Letter Date:	12/01/2017
Reference:	CG/FMcM/23123532
Dictated Date:	23/12/2016
Transcribed Date:	10/01/2017

Dear ,

Wendy McLeish; D.O.B: 25/05/1987; CHI: 2505876061
0/1 51 COXTON PLACE, Glasgow, Lanarkshire, G33 5EJ

This 29 year old is in her second pregnancy having already had one miscarriage. In 2011 she was admitted to Intensive Care Unit at the Royal Infirmary as a consequence of severe pneumonia requiring intubation ventilation and eventually ECMO. She made a good recovery from this episode, however, she does say that she is experiencing reduced exercise capabilities relating to her breathing. She underwent a recent chest x-ray and VQ scans to exclude pulmonary emboli as a consequence of representing with chest pain, however, the results were totally normal. She has had previous general anaesthesia for wrist surgery with no problems.

She states that she has reduced level of her exercise activity but currently she is clinically well and manages normal daily activities without any difficulty. She is suitable for a spinal anaesthesia.

Of interest she takes mirtazapine for depression and propranolol for tremor.

Yours sincerely

Dr Chris Greenhalgh
Consultant Anaesthetist

Electronically Signed: Dr Kerry Litchfield, Doctor

cc.

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

Princess Royal Maternity
16 Alexandra Parade
Glasgow
G31 2ER
0141 211 5400

Dr. AL McGinley
Dr Wilson dr mcginley & dr sheppar
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

Main Switchboard:	
Department:	
Contact Tel:	0141 211 5236
Enquiries to:	Jackie McGeoch - Obstetrics
Letter Date:	28/10/2016
Reference:	ERO'C/JM/23123532
Dictated Date:	04/10/2016
Transcribed Date:	17/10/2016

Dear Dr McGinley,

Wendy McLeish; D.O.B: 25/05/1987; CHI: 2505876061
0/1 51 COXTON PLACE, Glasgow, Lanarkshire, G33 5EJ

I saw Wendy for booking today at Dr Mathers antenatal clinic. She is a para 0+1 having had a previous early miscarriage. She has got an agreed EDD of 1st March 2017 and a BMI of 31.4.

Wendy has a significant past medical history of having had previous Pneumonia which was complicated by ARDS and she had ecmo and a prolonged ICU admission for this. She has since been discharged from the Respiratory clinic however I will request and anaesthetic review regarding this.

Wendy also has a history of anxiety and depression for which she is medicated with Mirtazapine and Propranolol. She had tried to reduce the dose of Mirtazapine however on discussion with her CPN via the perinatal Mental Health Team, she has gone back to her original dose of 45mg. She also takes Propranolol prn. In view of this I will arrange growth scans at 30 and 36 weeks.

Wendy also has a history of benign essential tremor for which she is seeing the Neurologist.

Wendy will be seen by our SNiP's Team on Thursday and follow-up can be arranged via them.

Kind regards

Yours sincerely

Dr Eimear O'Connor

ST2 O&G

Electronically Signed: Dr Eimear OConnor, Doctor

cc.

McLeish Wendy CHI: 2505876061

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No Consent for Sharing Withheld: No

Princess Royal Maternity
16 Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 5400
Date of Completion: 26/02/2017

Dr. AL McGinley
Dr Mcginley & Dr Sheppard
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

Dear Dr AL McGinley,

Name	CHI	DoB	Address
Wendy McLeish	2505876061	25/05/1987	0/1 51 COXTON PLACE Glasgow G33 5EJ

Admitted	Type	Discharged	Destination
24/02/2017 07:24	In Patient	26/02/2017	

Specialty	Consultant	Ward	Telephone
Obstetrics	Dr Elizabeth Ellis	PRM (MAT) Ward 72 - Obstetrics	

Reason for Admission and Presenting Complaints	Admission Category
	Pregnant but not in Labour (includes threatened abortion)

Diagnosis	Site	Side

Date	Procedures/Interventions/Operations

Clinical Comments:

Dear Doctor,
Ms McLeish delivered by EILUSCS on 24/02/17.
EBL 400ml
Hb 126
Weight 78.5kg
VTE risk moderate - 7 days of clexane
NKDA
Note: Mrs McLeish was previously on propranolol 80mg daily. This was reduced to 10mg daily during pregnancy. Since she is now post-partum I have titrated her dose up to 20mg at time of discharge. I would appreciate if you would be able to review this in due course and perhaps titrate up again towards 80mg daily.
Kind regards

Emma Donoghue
FY2 OBGYN #12037

Treatments: None recorded.

Follow-up arranged: postnatal

Planned Outpatient Investigations: nil

Final Discharge letter to follow: y

Medication Info:

Allergies:

Height: cm **Weight:** kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment
Diclofenac Sodium E/C Tablets	Oral	50	mg	THREE Times a Day	No duration defined	
Enoxaparin Syringe Injection	Injected	40	mg	ONCE a Day	7 Days	s/c inj. add 1 sharps box
Ferrous Sulphate Tablets	Oral	200	mg	THREE Times a Day	No duration defined	
Paracetamol Tablets	Oral	1000	mg	FOUR Times a Day	No duration defined	

Medication Comment: scrn JG

Discontinued Medication:

Drug Name	Dose	UOM	Reason

Yours sincerely,
Dr Emma Donoghue
Doctor

Prescription Review
Medications Reviewed by Pharmacist: Erin Flynn, Pharmacist
Dispensed Medications Checked by Pharmacy: Lorna Rankine, Pharmacist
Nurse discharging patient: Laura McKean, Midwife

McLeish Wendy CHI: 2505876061

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No Consent for Sharing Withheld: No

Princess Royal Maternity
16 Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 5400
Date of Completion: 07/12/2016

Dr. AL McGinley
Dr Wilson dr mcginley & dr sheppar
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

Dear Dr AL McGinley,

Name	CHI	DoB	Address
Wendy McLeish	2505876061	25/05/1987	0/1 51 COXTON PLACE Glasgow G33 5EJ

Admitted	Type	Discharged	Destination
05/12/2016 23:24	In Patient	07/12/2016	

Specialty	Consultant	Ward	Telephone
Obstetrics	Dr Elizabeth Ellis	PRM (MAT) Ward 73 - Obstetrics	0141 211 5213

Reason for Admission and Presenting Complaints	Admission Category
	Pregnant but not in Labour (includes threatened abortion)

Diagnosis	Site	Side

Date	Procedures/Interventions/Operations

Clinical Comments: Ms Mcleish was admitted to ward 73 on 5/12/16 due to right sided pleuritic chest pain and SOB. She also had one episode of haemoptysis. It was noted she has a history of a previous pneumonia and can experience pain related to this however the pain felt worse. She had some right sided crackles on examination. She had been commenced on a course of 5 days of amoxicillin prior to her admission which she will complete.
CXR was normal, as were her bloods. A VQ scan did not show any evidence of PE.
She was therefore discharged home.
Yours sincerely
Amanda Rodger
GPST2

Treatments: None recorded.

Follow-up arranged: nil

Planned Outpatient Investigations: nil

Final Discharge letter to follow: yes

Medication Info:

Allergies:

Height: cm **Weight:** kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment
Amoxicillin Capsules	Oral	500	mg	THREE Times a Day	2 Days	POS
Mirtazapine Tablets	Oral	45	mg	ONCE a Day	No duration defined	POS
Propranolol Hydrochloride Tablets	Oral	10	mg	As Required	No duration defined	POS

Discontinued Medication:

Drug Name	Dose	UOM	Reason

Yours sincerely,
Dr Amanda Rodger
Doctor

Prescription Review
Medications Reviewed by Pharmacist: ,
Dispensed Medications Checked by Pharmacy: ,
Nurse discharging patient: Susan Melly, Midwife

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Obstetrics GGC Obstetrics	——	**Consultant / receiving practitioner** and/or **specialty clinic**
The Princess Royal Maternity Unit 16 Alexandra Parade Glasgow G31 2ER	——	**Hospital** and **hospital address** Hospital location code. G108H Email address -

Urgency of referral Routine
Date of referral 14-Jul-2016 **Date sent** 14-Jul-2016

PATIENT DETAILS

Surname	Mcleish
Forename(s)	Wendy
Title	Miss
Sex	Female
Date of birth	25-May-1987
CHI no.	2505876061
Area of Residence	-

Patient's address

0/1 51 Coxton Place
GARTHAMLOCK
Glasgow
G33 5EJ

Contact number(s)

Voice: 07454750438

101011771902N Unique Care Pathway Number: 101011771902N

REGISTERED GP DETAILS

Name	Dr Anne McGinley		
GMC code	3341180	GP code	07307
Practice name	Easterhouse Health Centre (13448)		
Practice code	46471		

Practice address

9 Auchinlea Road
Easterhouse
Glasgow

Contact number(s)

Voice: 0141 531 8150
Facsimile: 0141 531 8158

REFERRING GP DETAILS

Name	Dr Marie Wilson		
GMC code	2551656	GP code	01376
Practice name	Easterhouse Health Centre (13448)		

Practice address

9 Auchinlea Road
Easterhouse
Glasgow

Practice code	46471

Contact number(s)

Voice: 0141 531 8150
Facsimile: 0141 531 8158

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: Pregnant

Comment: Pregnant. LMP - Thinks end of May but not sure. Para 0+1 Miscarriage last September. On Mirtazapine. Limited information on safety in pregnancy. Discussed trying to reduce - not sure - will think about this. Has stopped alcohol. No other drugs. Feeling well.

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

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

Description	Comment	Date of onset	Date recorded
Miscarriage	surgical ERPC	03-Sep-2015	03-Sep-2015
Alcohol problem drinking	-	06-Jun-2012	06-Jun-2012
Pneumonia due to unspecified organism (Bilateral)	-	30-Dec-2011	30-Dec-2011
Adult respiratory distress syndrome	-	30-Nov-2011	30-Nov-2011
Overdose of drug	fluoxetine	22-Sep-2011	22-Sep-2011
Anxiety with depression	-	19-Jul-2011	19-Jul-2011
Death of father	-	31-Jan-2011	31-Jan-2011
Has a tremor	seen by nuerologist 2012, felt to be benign	01-Apr-2007	01-Apr-2007
Death of mother	age 29 MI	01-Jan-1991	01-Jan-1991

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Folic Acid Tablets 400 micrograms	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	05-Sep-2014	14-Jul-2016

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Propranolol Hydrochloride Tablets 10 mg	28	28 tablet	ONE TO BE TAKEN THREE TIMES A DAY IF NEEDED	-	18-May-2016	08-Jun-2016
Beclometasone Aqueous nasal spray 50 micrograms/actuation	200	200 DOSE	TWO SPRAYS TO BE USED IN EACH NOSTRIL TWICE A DAY	-	18-May-2016	18-May-2016
Cetirizine Hydrochloride Tablets 10 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	18-May-2016	18-May-2016
Salbutamol Cfc-free inhaler 100 micrograms/puff	1	1 INHALER	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY	-	29-Apr-2016	29-Apr-2016
Volumatic Spacer device	1	1 device	TO BE USED AS DIRECTED	-	29-Apr-2016	29-Apr-2016
Propranolol Hydrochloride Tablets 10 mg	21	21 tablet	ONE TO BE TAKEN THREE TIMES A DAY	-	29-Apr-2016	03-May-2016

Mirtazapine Tablets 45 mg	28	28 tablet	ONE TO BE TAKEN AT NIGHT	-	29-Apr-2016	08-Jun-2016
Amoxicillin Capsules 500 mg	15	15 CAPSULE	ONE TO BE TAKEN THREE TIMES A DAY	-	29-Apr-2016	03-May-2016
Propranolol Hydrochloride Tablets 40 mg	56	56 tablet	ONE TO BE TAKEN THREE TIMES A DAY	-	01-Apr-2016	01-Apr-2016
Hydrocortisone And Miconazole Cream 1 % + 2 %	30	30 GRAM	APPLY THINLY TO THE AFFECTED AREA ONCE OR TWICE DAILY	-	15-Mar-2016	15-Mar-2016
Paracetamol Tablets 500 mg	56	56 TABLET	TWO TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN REQUIRED (MAXIMUM OF 8 IN 24 HOURS)	-	15-Mar-2016	15-Mar-2016
Ibuprofen Tablets 400 mg	42	42 TABLET	ONE TO BE TAKEN THREE TIMES A DAY WHEN REQUIRED WITH OR AFTER FOOD	-	15-Mar-2016	15-Mar-2016
Mirtazapine Tablets 45 mg	28	28 tablet	ONE TO BE TAKEN AT NIGHT	-	15-Mar-2016	01-Apr-2016
Mirtazapine Tablets 30 mg	28	28 tablet	1 Tab At night	-	06-Jan-2016	01-Feb-2016
Propranolol Hydrochloride Tablets 40 mg	56	56 tablet	ONE TO BE TAKEN THREE TIMES A DAY	-	06-Jan-2016	18-Feb-2016

Blood Pressure

Date Recorded	Systolic	Diastolic
09-Jul-2015	123	90
08-Aug-2013	116	77
14-Jan-2013	118	86
11-Jan-2013	118	77
21-Aug-2012	103	67

Body Measurements

Date Recorded	Height	Weight	BMI
29-Apr-2014	-	74	-
28-Jun-2013	158	74	29.5
31-Jan-2011	158	57	22.83

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Never smoked tobacco:		14-Jul-2016
Ex smoker (Stopped 2005):		09-Jul-2015
Never smoked tobacco:		29-Apr-2014
Never smoked tobacco :	Sore across back. Not breathless. Chest clear. Temperature nomral. PO2 99 Pulse 90 pASIN COMING AND GOING. Has also had diarrhoea today. Has been to toliet 4-5 times. No blood in diarrhoe- TRUNCATED	08-Aug-2013
Non-smoker :		28-Jun-2013
Alcohol consumption, 3 units/week:		17-Apr-2012
Light drinker - 1-2u/day:	Alcohol Intake$$.clm - Repeat after an Interval	21-Jan-2010

Investigations

Description/Question	Result/Comment	Date
Chosen place for Delivery:	Maternity Unit	-
Risk Assessment on booking identified in this pregnancy:	High Risk	-
LMP (last menstrual period) :	2016-05-31	-
EDD (expected date of delivery) estimated:	2016-02-07	-
High risk factors:	Previous miscarriage - anxious for early scan because of this and unsure about dates. On Mirtazapine for depression. PH Alcohol problms - has stopped drinking now.	-
Are you aware of any Vulnerability or Child Protection issues in relation to this pregnancy?:	Yes	-
Vulnerability Details:	PH Alcohol problems. Depression.	-

Clinical warnings

Allergies

Description	Comment	Date recorded
Adverse reaction to propranolol	possible wheeze with this	29-Apr-2016

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

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

Referred By:Referring GP

Electronic Attachment Present:No

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Obstetrics GGC Obstetrics	——	**Consultant / receiving practitioner** and/or **specialty clinic**
The Princess Royal Maternity Unit 16 Alexandra Parade Glasgow G31 2ER	——	**Hospital** and **hospital address** Hospital location code. G108H Email address -

Urgency of referral ROUTINE
Date of referral 09-Jul-2015 **Date sent** 09-Jul-2015

PATIENT DETAILS

Surname	Mcleish
Forename(s)	Wendy
Title	Miss
Sex	Female
Date of birth	25-May-1987
CHI no.	2505876061
Area of Residence	-

Patient's address

0/1 51 Coxton Place
GARTHAMLOCK
Glasgow
G33 5EJ

Contact number(s)

Voice: 07454750438

101009577469U | Unique Care Pathway Number: 101009577469U

REGISTERED GP DETAILS

Name	Dr Anne McGinley		
GMC code	3341180	GP code	07307
Practice name	Easterhouse Health Centre (13448)		
Practice code	46471		

Practice address

9 Auchinlea Road
Easterhouse
Glasgow

Contact number(s)

Voice: 0141 531 8150
Facsimile: 0141 531 8158

REFERRING GP DETAILS

Name	Dr. Martin Connolly		
GMC code	7036867	GP code	99999
Practice name			

Practice address

Easterhouse Health Centre
9 Auchinlea Road
Glasgow

	Dr Wilson, Dr Mcginley & Dr Sheppar (46471)		Contact number(s)
Practice code	46471		Voice: 0141 531 8150

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: Pregnant

Comment: Many thanks for arranging antenatal care of this primagravida. LMP 22/05/15. No known obstetric issues. BP 123/79 today. Ex smoker. Started on folic acid and given dietary advice. On mirtazapine, advised will aim to reduce/stop during pregnancy.

Kind regards,

Dr Martin Connolly

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

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

Description	Comment	Date of onset	Date recorded
Alcohol problem drinking	-	06-Jun-2012	06-Jun-2012
Pneumonia due to unspecified organism (Bilateral)	-	30-Dec-2011	30-Dec-2011
Adult respiratory distress syndrome	-	30-Nov-2011	30-Nov-2011
Overdose of drug	fluoxetine	22-Sep-2011	22-Sep-2011
Anxiety with depression	-	19-Jul-2011	19-Jul-2011
Death of father	-	31-Jan-2011	31-Jan-2011
Has a tremor	seen by nuerologist 2012, felt to be benign	01-Apr-2007	01-Apr-2007
Death of mother	age 29 MI	01-Jan-1991	01-Jan-1991

Past procedures (High and medium priority - all)

Description	Date performed	Date recorded
Patient pregnant	09-Jul-2015	09-Jul-2015

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Folic Acid Tablets 400 micrograms	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	05-Sep-2014	09-Jul-2015
Propranolol Hydrochloride Tablets 40 mg	56	56 tablet	ONE TO BE TAKEN THREE TIMES A DAY CAN BE ISSUED AS HALF 80MG TABLET TRHEE TIMES A DAY	-	13-Feb-2014	14-May-2015

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Mirtazapine Tablets 15 mg	56	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	14-May-2015	14-May-2015
Cetirizine Hydrochloride Tablets 10 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	08-Apr-2015	08-Apr-2015
Beclometasone Aqueous nasal spray 50 micrograms/actuation	200	200 DOSE	TWO SPRAYS TO BE USED IN EACH	-	08-Apr-2015	08-Apr-2015

			NOSTRIL TWICE A DAY			
Mirtazapine Tablets 15 mg	56	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	26-Mar-2015	26-Mar-2015
Piroxicam Gel 0.5 %	60	60 GRAM	Rub into the affected site three to four times daily	-	06-Feb-2015	06-Feb-2015

Blood Pressure

Date Recorded	Systolic	Diastolic
09-Jul-2015	123	90
08-Aug-2013	116	77
14-Jan-2013	118	86
11-Jan-2013	118	77
21-Aug-2012	103	67

Body Measurements

Date Recorded	Height	Weight	BMI
29-Apr-2014	-	74	-
28-Jun-2013	158	74	29.5
31-Jan-2011	158	57	22.83

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Ex smoker (Stopped 2005):		09-Jul-2015
Never smoked tobacco:		29-Apr-2014
Never smoked tobacco :	Sore across back. Not breathless. Chest clear. Temperature nomral. PO2 99 Pulse 90 pASIN COMING AND GOING. Has also had diarrhoea today. Has been to toliet 4-5 times. No blood in diarrhoe- TRUNCATED	08-Aug-2013
Non-smoker :	,	28-Jun-2013
Non-smoker :	systemically better but still clear productive cough after RTI 26 12 12, cocnern re risk ards recurrnace. , denies inh subs misuse	11-Jan-2013
Alcohol consumption, 3 units/week:		17-Apr-2012
Light drinker - 1-2u/day:	Alcohol Intake$$.clm - Repeat after an Interval	21-Jan-2010

Investigations

Description/Question	Result/Comment	Date
Chosen place for Delivery:	Maternity Unit	-
LMP (last menstrual period) :	2015-05-22	-
EDD (expected date of delivery) estimated:	2016-02-22	-
Are you aware of any Vulnerability or Child Protection issues in relation to this pregnancy?:	Not Known	-

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Patient has disability or requires wheelchair access:No
Referred By:Referring GP
Electronic Attachment Present:No

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

MANUAL PATIENT RECORDS

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

Including:

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

Clinical letter - Others:

NHS
Greater Glasgow and Clyde

Princess Royal Maternity
16 Alexandra Parade
Glasgow
G31 2ER

Dictation for Notes Only

Main Switchboard:	0141 211 5400
Department:	Anaesthetics
Contact Tel:	0141 211 5337
Enquiries to:	Fiona McManus
Letter Date:	12/01/2017
Reference:	CG/FMcM/23123532
Dictated Date:	23/12/2016
Transcribed Date:	10/01/2017

Dear ,

Wendy McLeish; D.O.B: 25/05/1987; CHI: 2505876061
0/1 51 COXTON PLACE, Glasgow, Lanarkshire, G33 5EJ

This 29 year old is in her second pregnancy having already had one miscarriage. In 2011 she was admitted to Intensive Care Unit at the Royal Infirmary as a consequence of severe pneumonia requiring intubation ventilation and eventually ECMO. She made a good recovery from this episode, however, she does say that she is experiencing reduced exercise capabilities relating to her breathing. She underwent a recent chest x-ray and VQ scans to exclude pulmonary emboli as a consequence of representing with chest pain, however, the results were totally normal. She has had previous general anaesthesia for wrist surgery with no problems.

She states that she has reduced level of her exercise activity but currently she is clinically well and manages normal daily activities without any difficulty. She is suitable for a spinal anaesthesia.

Of interest she takes mirtazapine for depression and propranolol for tremor.

Yours sincerely

Dr Chris Greenhalgh
Consultant Anaesthetist

Electronically Signed: Dr Kerry Litchfield, Doctor

cc.

23123352

Glasgow Royal Infirmary: Diagnostic Imaging Report

MCLEISH, WENDY
DoB : 25/05/1987
0/1 51 COXTON PLACE, GLASGOW, LANARKSHIRE, G33 5EJ
CHI. No. : 2505876061
Ref. Locn. : Princess Royal Maternity W73
CRIS No. : 5226123
Referrer : Dr Elizabeth Ellis
Curr Ward:

VERIFIED Verified By: Dr James Neilly 07/12/16 1607.

Clinical History : 27 weeks gestation. shortness of breath and chest and back pain. bloods normal. chest x ray normal. on clexane. ??PE

NM Lung Ventilation SPECT : Technegas ventilation study

NM Lung Perfusion SPECT : Matched non-segmental perfusion defect in the left upper lobe posteriorly. Allowing for gravity-dependent distribution of MAA, perfusion was otherwise normal to both lungs. There are no mismatched segmental or subsegmental perfusion defects.

Conclusions: The findings do not support a diagnosis of pulmonary embolism.

Dee 4.1.17

Event Number : E-31127960 Examination Date : **07/12/16**

Ref. Source : Dr Elizabeth Ellis, Glasgow Royal Infirmary, 84 Castle Street, Glasgow, G4 0SF

Examinations : **NM Lung Ventilation SPECT,NM Lung Perfusion SPECT**

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

Princess Royal Maternity
16 Alexandra Parade
Glasgow
G31 2ER

Dr. AL McGinley
Dr Wilson dr mcginley & dr sheppar
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

Main Switchboard:	0141 211 5400
Department:	
Contact Tel:	0141 211 5236
Enquiries to:	Jackie McGeoch - Obstetrics
Letter Date:	28/10/2016
Reference:	ERO'C/JM/23123532
Dictated Date:	04/10/2016
Transcribed Date:	17/10/2016

ar Dr McGinley,

Wendy McLeish; D.O.B: 25/05/1987; CHI: 2505876061
0/1 51 COXTON PLACE, Glasgow, Lanarkshire, G33 5EJ

I saw Wendy for booking today at Dr Mathers antenatal clinic. She is a para 0+1 having had a previous early miscarriage. She has got an agreed EDD of 1st March 2017 and a BMI of 31.4.

Wendy has a significant past medical history of having had previous Pneumonia which was complicated by ARDS and she had ecmo and a prolonged ICU admission for this. She has since been discharged from the Respiratory clinic however I will request and anaesthetic review regarding this.

ndy also has a history of anxiety and depression for which she is medicated with irtazapine and Propranolol. She had tried to reduce the dose of Mirtazapine however on discussion with her CPN via the perinatal Mental Health Team, she has gone back to her original dose of 45mg. She also takes Propranolol prn. In view of this I will arrange growth scans at 30 and 36 weeks.

Wendy also has a history of benign essential tremor for which she is seeing the Neurologist.

Wendy will be seen by our SNiP's Team on Thursday and follow-up can be arranged via them.

Kind regards

Yours sincerely

Dr Eimear O'Connor

ST2 O&G

Electronically Signed: Dr Eimear OConnor, Doctor

cc.

NHS
Greater Glasgow and Clyde

Princess Royal Maternity
16 Alexandra Parade
Glasgow G31 2ER
20/09/2016

Miss Wendy McLeish
0/1 51 COXTON PLACE
Glasgow
G33 5EJ

Dear Miss Wendy McLeish

CHI Number: **2505876061**

It would appear from our records that you did not keep your appointment on:

Consultant: **Dr Alan Mathers**
Date and time: **Tuesday 20th September 2016, at 14:00**

We have arranged another appointment on:

Date and time: **04/10/2016, at 15:30**
Consultant: **Dr Alan Mathers**
Location: **Level 2 Princess Royal Maternity**

If for any reason you no longer need or are unable to keep this appointment, please telephone **0141 211 5393** or email* **Maternity.Appointments@ggc.scot.nhs.uk** as soon as possible so that other arrangements can be made, and your appointment can be offered to another patient.

You can contact us between the hours of 9am-4pm Monday-Friday, excluding Public Holidays.

Please note if you cancel your appointment we may place you back on the waiting list and contact you in due course.

*If you are contacting us by email you should include the following information:
Your name
Your CHI number
Consultant name
Date and time of your appointment
Reason: e.g. Unable to attend and require a further appointment.
For security purposes, please do not include any clinical information in your correspondence.

Yours sincerely

Joyce McFadyen

Health Records Manager

Jackie McHugh

SCGC Op Rebook after DNA V1

NHS
Greater Glasg
and Clyde

Princess Royal Maternity
16 Alexandra Parade
Glasgow G31 2ER
14/09/2016

Miss Wendy McLeish
0/1 51 COXTON PLACE
Glasgow
G33 5EJ

Dear Miss Wendy McLeish

CHI Number: 2505876061

An Outpatient appointment has been arranged for you as follows:

Consultant: PRM Obs Scan
Specialty: Ultrasonics
Date and time: 19/10/2016, at 11:00
Location: Level 2 Princess Royal Maternity

If this appointment is not suitable or if for any reason you no longer need or are unable to keep this appointment, please telephone **0141 211 5393** or email*

Maternity.Appointments@ggc.scot.nhs.uk as soon as possible so that other arrangements can be made, and your appointment can be offered to another patient.

You can contact us between the hours of 9am-4pm Monday-Friday, excluding Public Holidays.

*If you are contacting us by email you should include the following information:

Your name
Your CHI number
Consultant name
Date and time of your appointment
Reason: e.g. Unable to attend and require a further appointment.
For security purposes, please do not include any clinical information in your email.

Yours sincerely

Joyce McFadyen

Health Records Manager
User ID Annmarie Mckean

Received 17/8/16

2312353 2

REFERRAL TO SNIPS FORM

NHS
Greater Glasgow and Clyde

Please complete form and send: **FAO - SNIPS**

Southern General Maternity	Antenatal Clinic, 1345 Govan Rd, Glasgow G51 4TF
Princess Royal Maternity	Antenatal Clinic, 16 Alexandra Parade, Glasgow G31 2ER
Royal Alexandra Maternity Unit	Corsebar Rd, Paisley PA2 9PN – FAO MW Dick/Dougan
Inverclyde Royal Hospital	Larkfield Rd, PA16 0XN, FAO – MW Sloan
Vale-of-Leven Hospital	Main St, G83 0UA, FAO -MW McAlpine

REFERRING UNIT

PRM	SGH	RAH	IRH	Vol	OBAN
✓					

2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

GP: Dr. AL McGinley, Dr Wilson dr mcginley & dr sheppar, Easterhouse Health Centre, 9 Auchinlea Road, Glasgow, G34 9HQ

HV:

SW: ✓

Patient Contact Tel No: 07454780482

Reason for Referral – *please tick appropriate box/boxes*

Mental Illness: *use Referral to Perinatal Mental health service form*	✓
Substance Abuse e.g. drugs/alcohol: PAST PAST	✓
Gender Based Violence:	
Young, Vulnerable <16 years:	
Complex Teenage Pregnancy	
Blood Borne Virus	
Learning Difficulties:	
Complex Asylum Seeker/Refugee	
Homeless	
Shared Referral Form (Social Work/CP)	✓

Additional Comments:
WAS IN CARE AGE 3yr-18 yrs
MOVED BACK WORCS 2011
ALCOHOL IN PAST AT WEEKENDS 10
UNITS AT WEEKEND NIL SINCE PREGNANT
ON METHADONE/MEPTADONE.
SW REFERRAL RAISED CONCERNS OF ABUSE.
MOVED AWAY FROM FAMILY

Team/Midwife:
Consultant: Dr Mathews
Parity: 0+1
E.D.D: March 2017
Next A/N Appointment: Dr Mathews oct 16
Interpreter Required? Yes (No)
Language spoken: English

Patient's Community Pharmacy Name & Number as reqd

Referrer: Erasmus
Name: Erasmus (sign and print)

Designation

Contact No.

PTO

Women & Children's Directorate

GP/Health Visitor – Notification Letter

NHS Greater Glasgow and Clyde

2505876061
MCLEISH
Wendy F
0/1 51 COXTON PLACE 25/05/1987
Glasgow, Lanarkshire
G33 5EJ

Dr. AL McGinley
Dr Wilson dr mcginley & dr sheppar
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ
ph

Date 15/8/10

Dear Doctor / Health Visitor, WILSON

The above named woman has booked for care at RAH maternity unit.

Following history taking, she has presented as:

- [ ] Low risk and suitable for midwife led care
- [x] High risk requiring maternity team care
- [ ] High risk requiring special needs in pregnancy service (SNIPS)

The woman's named midwife/obstetrician is Dr MAMAS

She is approximately 11 weeks advanced in her pregnancy, her EDD is 1/3/11 / (will be) confirmed following ultrasound examination on 30/9/10

I have arranged a follow-up appointment as per national guidelines for antenatal care. If you have any further medical or social information which helps inform her care please contact me on the number below.

For SNIPS please tick appropriate box/boxes:

Substance abuse e.g. drugs/alcohol	
Mental Illness	
Gender Based Violence	
Young, Vulnerable <16 years	
Complex Teenage Pregnancy	
BBV	
Learning Difficulties	
Complex Asylum Seeker/Refugee	
Homeless	
Complex Social Issues	
Shared Referral Form (social work/CP/VPL)	

Yours sincerely,

Midwife

Contact Tel. No... 2115240

1 copy to GP + 1 to HV +1 to case-notes

MIS 250565

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER

MEDICAL IN CONFIDENCE

Attachments

REFERRAL TO

Obstetrics
GGC Obstetrics

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

The Princess Royal Maternity Unit
16 Alexandra Parade
Glasgow
G31 2ER

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

Hospital location code.
G108H

Email address
-

Urgency of referral Routine
Date of referral 14-Jul-2016 **Date sent** 14-Jul-2016

PATIENT DETAILS

Surname	Mcleish
Forename(s)	Wendy
Title	Miss
Sex	Female
Date of birth	25-May-1987
CHI no.	2505876061
Area of Residence	-

Patient's address

0/1 51 Coxton Place
GARTHAMLOCK
Glasgow
G33 5EJ

Contact number(s)
Voice: 07454750438

101011771902N Unique Care Pathway Number: 101011771902N

REGISTERED GP DETAILS

Name	Dr Anne McGinley		
GMC code	3341180	GP code	07307
Practice name	Easterhouse Health Centre (13448)		
Practice code	46471		

Practice address

9 Auchinlea Road
Easterhouse
Glasgow

Contact number(s)
Voice: 0141 531 8150
Facsimile: 0141 531 8158

REFERRING GP DETAILS

Name	Dr Marie Wilson		
GMC code	2551656	GP code	01376
Practice name	Easterhouse Health Centre (13448)		
Practice code	46471		

Practice address

9 Auchinlea Road
Easterhouse
Glasgow

Contact number(s)
Voice: 0141 531 8150
Facsimile: 0141 531 8158

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: Pregnant

Comment: Pregnant. LMP - Thinks end of May but not sure. Para 0+1 Miscarriage last September. On Mirtazapine. Limited information on safety in pregnancy. Discussed trying to reduce - not sure - will think about this. Has stopped alcohol. No other drugs. Feeling well.

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

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

Description	Comment	Date of onset	Date recorded
Miscarriage	surgical ERPC	03-Sep-2015	03-Sep-2015
Alcohol problem drinking	-	06-Jun-2012	06-Jun-2012
Pneumonia due to unspecified organism (Bilateral)	-	30-Dec-2011	30-Dec-2011
Adult respiratory distress syndrome	-	30-Nov-2011	30-Nov-2011
Overdose of drug	fluoxetine	22-Sep-2011	22-Sep-2011
Anxiety with depression	-	19-Jul-2011	19-Jul-2011
Death of father	-	31-Jan-2011	31-Jan-2011
Has a tremor	seen by nuerologist 2012, felt to be benign	01-Apr-2007	01-Apr-2007
Death of mother	age 29 MI	01-Jan-1991	01-Jan-1991

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Folic Acid Tablets 400 micrograms	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	05-Sep-2014	14-Jul-2016

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Propranolol Hydrochloride Tablets 10 mg	28	28 tablet	ONE TO BE TAKEN THREE TIMES A DAY IF NEEDED	-	18-May-2016	08-Jun-2016
Beclometasone Aqueous nasal spray 50 micrograms/actuation	200	200 DOSE	TWO SPRAYS TO BE USED IN EACH NOSTRIL TWICE A DAY	-	18-May-2016	18-May-2016
Cetirizine Hydrochloride Tablets 10 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	18-May-2016	18-May-2016
Salbutamol Cfc-free inhaler 100 micrograms/puff	1	1 INHALER	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY	-	29-Apr-2016	29-Apr-2016
Volumatic Spacer device	1	1 device	TO BE USED AS DIRECTED	-	29-Apr-2016	29-Apr-2016
Propranolol Hydrochloride Tablets 10 mg	21	21 tablet	ONE TO BE TAKEN THREE TIMES A DAY	-	29-Apr-2016	03-May-2016
Mirtazapine Tablets 45 mg	28	28 tablet	ONE TO BE TAKEN AT NIGHT	-	29-Apr-2016	08-Jun-2016
Amoxicillin Capsules 500 mg	15	15	ONE TO BE TAKEN THREE	-	29-Apr-	03-May-

		CAPSULE	TIMES A DAY		2016	2016
Propranolol Hydrochloride Tablets 40 mg	56	56 tablet	ONE TO BE TAKEN THREE TIMES A DAY	-	01-Apr-2016	01-Apr-2016
Hydrocortisone And Miconazole Cream 1 % + 2 %	30	30 GRAM	APPLY THINLY TO THE AFFECTED AREA ONCE OR TWICE DAILY	-	15-Mar-2016	15-Mar-2016
Paracetamol Tablets 500 mg	56	56 TABLET	TWO TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN REQUIRED (MAXIMUM OF 8 IN 24 HOURS)	-	15-Mar-2016	15-Mar-2016
Ibuprofen Tablets 400 mg	42	42 TABLET	ONE TO BE TAKEN THREE TIMES A DAY WHEN REQUIRED WITH OR AFTER FOOD	-	15-Mar-2016	15-Mar-2016
Mirtazapine Tablets 45 mg	28	28 tablet	ONE TO BE TAKEN AT NIGHT	-	15-Mar-2016	01-Apr-2016
Mirtazapine Tablets 30 mg	28	28 tablet	1 Tab At night	-	06-Jan-2016	01-Feb-2016
Propranolol Hydrochloride Tablets 40 mg	56	56 tablet	ONE TO BE TAKEN THREE TIMES A DAY	-	06-Jan-2016	18-Feb-2016

Blood Pressure

Date Recorded	Systolic	Diastolic
09-Jul-2015	123	90
08-Aug-2013	116	77
14-Jan-2013	118	86
11-Jan-2013	118	77
21-Aug-2012	103	67

Body Measurements

Date Recorded	Height	Weight	BMI
29-Apr-2014	-	74	-
28-Jun-2013	158	74	29.5
31-Jan-2011	158	57	22.83

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Never smoked tobacco:		14-Jul-2016
Ex smoker (Stopped 2005):		09-Jul-2015
Never smoked tobacco:		29-Apr-2014
Never smoked tobacco :	Sore across back. Not breathless. Chest clear. Temperature nomral. PO2 99 Pulse 90 pASIN COMING AND GOING. Has also had diarrhoea today. Has been to toliet 4-5 times. No blood in diarrhoe- TRUNCATED	08-Aug-2013
Non-smoker :		28-Jun-2013
Alcohol consumption, 3 units/week:		17-Apr-2012
Light drinker - 1-2u/day:	Alcohol Intake$$.clm - Repeat after an Interval	21-Jan-2010

Investigations

Description/Question	Result/Comment	Date
Chosen place for Delivery:	Maternity Unit	-
Risk Assessment on booking identified in this pregnancy:	High Risk	-
LMP (last menstrual period) :	2016-05-31	-
EDD (expected date of delivery) estimated:	2016-02-07	-

High risk factors:	Previous miscarriage - anxious for early scan because of this and unsure about dates. On Mirtazapine for depression. PH Alcohol problms - - has stopped drinking now.
Are you aware of any Vulnerability or Child Protection issues in relation to this pregnancy?:	Yes
Vulnerability Details:	PH Alcohol problems. Depression.

Clinical warnings

Allergies

Description	Comment	Date recorded
Adverse reaction to propranolol	possible wheeze with this	29-Apr-2016

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

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

Referred By:Referring GP

Electronic Attachment Present:No

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

Clinical letter - GP: GP LETTER

NHS
Greater Glasgow and Clyde
Stobhill Hospital
133 Balornock Road
Glasgow
G21 3UW
Main Switchboard: 0141 201 3000
Department: GYNAECOLOGY
Contact Tel: 0141 355 1828
Enquiries to: Jacqui Cooper
Letter Date: 15/09/2015
Reference: SW/AMMCS
Dictated Date: 14/09/2015
Transcribed Date: 14/09/2015

Dr. AL McGinley
Dr Wilson dr mcginley & dr sheppar
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

Dear Dr. McGinlay,,

Wendy McLeish; D.O.B: 25/05/1987; CHI: 2505876061
0/1 51 COXTON PLACE, Glasgow, Lanarkshire, G33 5EJ

This patient was admitted to Stobhill Surgical Day Unit for surgical evacuation of retained products of conception. The procedure was completed under general anaesthetic without any complication.

She will be discharged home later on today when well and no further follow up has been arranged.

Yours sincerely

Electronically Signed: Dr Sandra Wong, Consultant

cc.

Perinatal Mental Health Service
Leverndale Hospital
510 Crookston Road
Glasgow
G53 7TU

NHS
Greater Glasgow and Clyde

STRICTLY CONFIDENTIAL

Linda Fellows
Community Midwife
Princess Royal Maternity Hospital
16 Alexandra Parade
Glasgow
G31 2ER

Date 08 August 2015
Your Ref
Our Ref CH/JA

Direct Line 0141 211 6500
Extension
Fax 0141 211 6523

Dear Midwife Fellows

Re: Wendy McLeish Chi: 2505876061

Address: 0/1 51 Coxton Place, Glasgow, G33 5EJ

Many thanks for letting us know about this woman who is currently pregnant/postnatal with an

EDD: 25/02/2016 / D.O.B of Baby: .....

You have identified:

- Current depression / anxiety of mild to moderate severity with no prior psychiatric contact

We wished to bring this to your attention, but have not arranged to see her at the present time. If you have any concerns about current significant mental illness or high risk of early postpartum major mental illness, or if there is a significant change in her presentation, please get back in touch and we can make arrangements to see her.

The Perinatal Mental Health Service prioritises women who currently experience mental illness of a moderate to severe nature or women who are at high risk of early postpartum significant mental illness. **Further referral guidance is provided overleaf**. Any referral can be discussed by telephone on 0141 211 6500.

Yours sincerely

Clare Haughey
***for* Perinatal Mental Health Service**

Cc: Dr McGinley, Easterhouse Health Centre
Health Visitor, Easterhouse Health Centre
Dr Mathers, Consultant Obstetrician PRMH

SNIPS 20/8/15

NHS
Greater Glasgow and Clyde

REFERRAL TO SNIPS FORM

Please complete form and send: **FAO - SNIPS**

Southern General Maternity	Antenatal Clinic, 1345 Govan Rd, Glasgow G51 4TF
Princess Royal Maternity	Antenatal Clinic, 16 Alexandra Parade, Glasgow G31 2ER
Royal Alexandria Maternity Unit	Corsebar Rd, Paisley PA2 9PN – FAO MW Dick/Dougan
Inverclyde Royal Hospital	Larkfield Rd, PA16 0XN, FAO – MW Sloan
Vale-of-Leven Hospital	Main St, G83 0UA, FAO -MW McAlpine

REFERRING UNIT

PRM	✓	SGH		RAH		IRH		VoL		OBAN	

WENDY MCLEISH
0/1 51 COXTON PL
GLASGOW
G33 5EJ. DOB 25/5/87
CHI-2505876061

Patient Addressograph

GP: DR AL. MCGINLEY
HV: none
SW: none
Patient Contact Tel No: 07 454750438

Reason for Referral – *please tick appropriate box/boxes*

Mental Illness: *use Referral to Perinatal Mental health service form*	✓
Substance Abuse e.g. drugs/alcohol:	
Gender Based Violence:	
Young, Vulnerable <16 years:	
Complex Teenage Pregnancy	
Blood Born Virus	
Learning Difficulties:	
Complex Asylum Seeker/Refugee	
Homeless	
Shared Referral Form (Social Work/CP)	✓

Team/Midwife: LINDA FELLOWS
Consultant: DR MATHER
Parity: 0+0
E.D.D: 25/2/16
Next A/N Appointment:
Interpreter Required? Yes / (No)
Language spoken: ENGLISH.

Patient's Community Pharmacy Name & Number as reqd

Additional Comments:
Was in care & a child Father history of Drug Abuse.
Wendy drug overdose Sep 2011.
No history of drug abuse.
Alcohol in past not a present.
On Propranolol for tremor.
Also has sleeping Tablet (in main case notes).
Partner history of assault custodial sentance

Referrer:
Name (sign and print)
Designation
Contact No.

PTO

PD Midwife GG&C Dec 2011

Wendy fully aware of Social work, mental health + SNIPS repeal
Linda Fellows

Women & Children's Directorate

GP/Health Visitor – Notification Letter

NHS
Greater Glasgow and Clyde

2505876061
MCLEISH
Wendy F
0/1 51 COXTON PLACE 25/05/1987
Glasgow, Lanarkshire
G33 5EJ

Date 3/8/15

Dear Doctor / Health Visitor, MCGINLEY

The above named woman has booked for care at RAM.
maternity unit.
Following history taking, she has presented as:

Low risk and suitable for midwife led care	
High risk requiring maternity team care	✓
High risk requiring special needs in pregnancy service (SNIPS)	?

The woman's named midwife/obstetrician is DR MATHERS / LINDA FELLOWS
She is approximately 10 weeks advanced in her pregnancy, her EDD is ..... / will be confirmed following ultrasound examination on.....

I have arranged a follow-up appointment as per national guidelines for antenatal care. If you have any further medical or social information which helps inform her care please contact me on the number below.

For SNIPS please tick appropriate box/boxes:

Substance abuse e.g. drugs/alcohol	
Mental Illness	
Gender Based Violence	
Young, Vulnerable <16 years	
Complex Teenage Pregnancy	
BBV	
Learning Difficulties	
Complex Asylum Seeker/Refugee	
Homeless	
Complex Social Issues	
Shared Referral Form (social work/CP/VPL)	

Yours sincerely,

Linda Fellows

Midwife

Contact Tel. No... 211245

1 copy to GP + 1 to HV +1 to case-notes

MIS 250565

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER

MEDICAL IN CONFIDENCE

GGC Obstetrics (Glasgow, vR13.0)

REFERRAL TO

Obstetrics
GGC Obstetrics

Consultant / receiving practitioner and/or specialty clinic

The Princess Royal Maternity Unit
16 Alexandra Parade
Glasgow
G31 2ER

Hospital and hospital address

Hospital location code: G108H

Email address:

Urgency of referral ROUTINE
Date of referral 09-Jul-2015 **Date sent** 09-Jul-2015

PATIENT DETAILS

Surname	Mcleish
Forename(s)	Wendy
Title	Miss
Sex	Female
Date of birth	25-May-1987
CHI no.	2505876061
Area of Residence	-

Patient's address

0/1 51 Coxton Place
GARTHAMLOCK
Glasgow
G33 5EJ

Contact number(s)

Voice: 07454750438

101009577469U Unique Care Pathway Number: 101009577469U

REGISTERED GP DETAILS

Name	Dr Anne McGinley		
GMC code	3341180	GP code	07307
Practice name	Easterhouse Health Centre (13448)		
Practice code	46471		

Practice address

9 Auchinlea Road
Easterhouse
Glasgow

Contact number(s)

Voice: 0141 531 8150
Facsimile: 0141 531 8158

REFERRING GP DETAILS

Name	Dr. Martin Connolly		
GMC code	7036867	GP code	99999
Practice name	Dr Wilson, Dr Mcginley & Dr Sheppar (46471)		
Practice code	46471		

Practice address

Easterhouse Health Centre
9 Auchinlea Road
Glasgow

Contact number(s)

Voice: 0141 531 8150

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: Pregnant

Comment: Many thanks for arranging antenatal care of this primagravida. LMP 22/05/15. No known obstetric issues. BP 123/79 today. Ex smoker. Started on folic acid and given dietary advice. On mirtazapine, advised will aim to reduce/stop during pregnancy.Kind regards,Dr Martin Connolly

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

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

Description	Comment	Date of onset	Date recorded
Alcohol problem drinking	-	06-Jun-2012	06-Jun-2012
Pneumonia due to unspecified organism (Bilateral)	-	30-Dec-2011	30-Dec-2011
Adult respiratory distress syndrome	-	30-Nov-2011	30-Nov-2011
Overdose of drug	fluoxetine	22-Sep-2011	22-Sep-2011
Anxiety with depression	-	19-Jul-2011	19-Jul-2011
Death of father	-	31-Jan-2011	31-Jan-2011
Has a tremor	seen by nuerologist 2012, felt to be benign	01-Apr-2007	01-Apr-2007
Death of mother	age 29 MI	01-Jan-1991	01-Jan-1991

Past procedures (High and medium priority - all)

Description	Date performed	Date recorded
Patient pregnant	09-Jul-2015	09-Jul-2015

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Folic Acid Tablets 400 micrograms	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	05-Sep-2014	09-Jul-2015
Propranolol Hydrochloride Tablets 40 mg	56	56 tablet	ONE TO BE TAKEN THREE TIMES A DAY CAN BE ISSUED AS HALF 80MG TABLET TRHEE TIMES A DAY	-	13-Feb-2014	14-May-2015

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Mirtazapine Tablets 15 mg	56	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	14-May-2015	14-May-2015
Cetirizine Hydrochloride Tablets 10 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	08-Apr-2015	08-Apr-2015
Beclometasone Aqueous nasal spray 50 micrograms/actuation	200	200 DOSE	TWO SPRAYS TO BE USED IN EACH NOSTRIL TWICE A DAY	-	08-Apr-2015	08-Apr-2015
Mirtazapine Tablets 15 mg	56	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	26-Mar-2015	26-Mar-2015
Piroxicam Gel 0.5 %	60	60 GRAM	Rub into the affected site three to four times daily	-	06-Feb-2015	06-Feb-2015

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Ex smoker (Stopped 2005):		09-Jul-2015
Never smoked tobacco:		29-Apr-2014
Never smoked tobacco :	Sore across back. Not breathless. Chest clear. Temperature nomral. PO2 99 Pulse 90 pASIN COMING AND GOING. Has also had diarrhoea today. Has been to toliet 4-5 times. No blood in diarrhoe- TRUNCATED	08-Aug-2013
Non-smoker :		28-Jun-2013
Non-smoker :	systemically better but still clear productive cough after RTI 26 12 12, cocnern re risk ards recurrnace. , denies inh subs misuse	11-Jan-2013
Alcohol consumption, 3 units/week:		17-Apr-2012
Light drinker - 1-2u/day:	Alcohol Intake$$.clm - Repeat after an Interval	21-Jan-2010

Investigations

Description/Question	Result/Comment	Date
Chosen place for Delivery:	Maternity Unit	-
LMP (last menstrual period) :	2015-05-22	-
EDD (expected date of delivery) estimated:	2016-02-22	-
Are you aware of any Vulnerability or Child Protection issues in relation to this pregnancy?:	Not Known	-

Clinical warnings

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

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

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:No

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

Clexane 20:30 MST 22:00 + 08:00

Postnatal Transfer Checklist (SBAR format)

Form to be completed prior to transfer to postnatal ward

Please file in maternal casenotes

2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

Mother

S Mode of Delivery? ELCS Date 24/2/17 Time 15:50
Blood Loss? 400 mls
Complications? _____
Perineum: 1° Tear? ☐ 2° Tear? ☐ 3/4° Tear? ☐ N/A ☐

B Pre delivery Hb? 110 Latest Weight? 88.8 Kg
Hep B/GBS/HIV all negative? Yes ☑ No ☐
Rubella Status? Immune? ☐ Requires MMR? ☐
Any underlying medical conditions? NO
Any regular medication? Mirtazapine 45mgs, Propanolol 10mgs
Allergies? NKDA
Able to take NSAIDs? Yes ☑ No ☐
Social work issues? Yes ☑ No ☐ Informed of delivery? ☐

A Regional block? Yes ☑ No ☐
Epidural removed intact? Yes ☐ N/A ☑
Foley catheter in situ? Yes ☑ No ☐
Passed urine spontaneously? Yes ☐ No ☑
Maternal pyrexia in labour? Yes ☐ No ☑
Rhesus negative bloods? Yes ☑ No ☐ N/A ☐
Syntocinon infusion ___IU Ongoing @ ___mls/hr Discontinued @ ___:___

R Thromboprophylaxis risk assessment? Low ☐ Med ☑ High ☐
Timely discharge? Yes ☐ No ☑
Sutures/staple to be removed? Yes ☐ No ☑
Yellow sheet checked? Yes ☑ No ☐
Datix required Yes/No Completed Yes / No

Baby

S M/(F) Weight 2805 g
B Gestation 39/40 wks
A GBS/ PROM: Adequate prophylaxis? Yes ☐ No ☐ * N/A ☑
Feeding method? Breast ☐ Formula ☑ First feed @ 17.00
R Baby Bands x2 **with baby's CHI** Yes ☑
NEWS protocol indicated Yes ☐ No ☑
Hypoglycaemic Protocol indicated Yes ☐ No ☑
Any concerns _____
(* Contact paediatrician)

Signed Donnaghan Date 24/2/17 Time 19:25

A Neg
A Pos
Direct coomb neg
Anti-D ready

Princess Royal Maternity

NHS
Greater Glasgow and Clyde

You are Having an Elective Caesarean Delivery

Please attend for your Preoperative assessment on:

_____

Your caesarean delivery is:

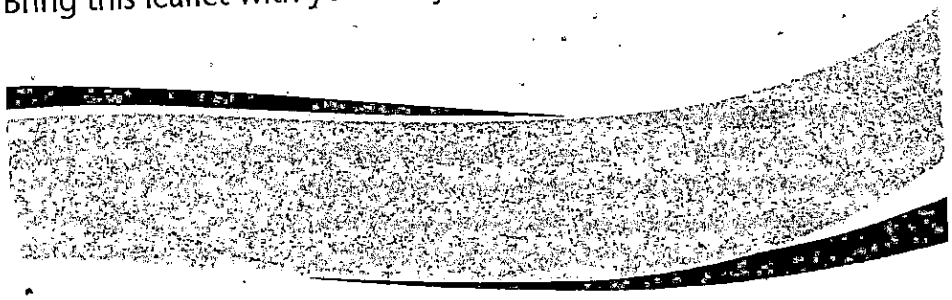
Date: 24/2/17

Time: 7.30am

Ward: 73 Queen 6

This is the provisional date for your caesarean delivery.

Bring this leaflet with you and your hand held records.



Together, we have agreed that we will deliver your baby by caesarean. We have written this leaflet, explaining what will happen next, to help you prepare for and recover from your caesarean delivery.

Before you come into hospital

Caesarean Delivery Preparation Class and Preoperative Assessment Clinic

The week before your baby's planned delivery date, we will invite you to attend the Caesarean Delivery Preparation Class or Preoperative Assessment Clinic. Here we will explain what will happen and answer any questions.

- You will see a midwife, the physiotherapist and the anaesthetist (the doctor who provides anaesthesia for your delivery).
- They will explain what will happen before the delivery of your baby and then your preparation for your return home.
- They will ask you more detailed questions about your health.

We will clarify the date of your caesarean however, please note that this may change at short notice due to unforeseen emergencies.

Sometimes you will attend the hospital for other reasons in the lead up to your planned delivery. In this case, we may explain the above to you at this time instead of attending the class.

Eating and drinking before your caesarean delivery

As you are having anaesthetic, **we ask that you do not eat any food (including milky drinks and sweets) after midnight on the night before your caesarean.**

You can drink clear fluids, which include: still water, black tea, and black coffee up till 6am on the morning of your caesarean.

We will give you two antacid tablets called Ranitidine. Take one at bed-time the night before, and one on the morning of your caesarean.

The day of your delivery

Please arrive at the hospital at 7.30am with your birthing partner and go to the ward noted on the front of this leaflet. Occasionally, we ask some women to attend the night before their caesarean.

The midwife will make this clear to you before your date of delivery.

Once you have settled into hospital:

- The midwife will examine you and take a blood test,
- The obstetric doctor and anaesthetic doctor will come and meet you, and
- If you have not done so previously, we will ask you to sign a form saying that you are consenting to the caesarean.

On the morning of your caesarean we decide the theatre list order and base this on clinical priority. Occasionally, the order is disrupted by emergencies from the labour ward. Unfortunately, this sometimes leads to a delay for some women. If this happens to you, we apologise and ask for your patience.

Very occasionally if there are a lot of emergencies in labour ward or unforeseen complications we have to change the date of your delivery after you arrive in the hospital. We do our best to avoid this but if it this happens we will arrange a suitable date usually within the next 7 days. This is a rare event.

Your anaesthetic

Most women deliver under spinal anaesthesia. This is an injection of local anaesthetic into your lower back which numbs you from the chest down. This is often the safest option, provides you with better pain relief, and allows you to be awake for the delivery.

General anaesthesia (going to sleep) is a safe alternative and in certain circumstances may be the safest option. Your anaesthetist will discuss this with you.

For a spinal anaesthetic:

- We insert a 'drip' in your arm.
- To give you the anaesthetic, you will be either sitting up on the bed or lying on your side.
- We inject the anaesthetic into an area in your lower back. Once completed, your legs will feel 'heavy' and numb.
- When you are numb we will insert a catheter into your bladder.
- When everything is ready to begin, your birth partner can come into theatre and sit next to you. They will be wearing a theatre gown for hygiene reasons.

Side effects and risks of a spinal anaesthetic

- Sickness, light-headedness, itching or shivering. If you experience any of these, tell your anaesthetist and they will try and make you feel better.
- Occasionally a woman will experience a severe headache after spinal anaesthesia. If this occurs tell your midwife and an anaesthetist will visit you.
- Nerve damage:
    - Rarely (1 in 1000), a spinal anaesthetic can damage the nerves in the back. Usually this results in temporary weakness or numbness in your legs which resolves.
    - Very rarely (1 in 24,000) this damage can be permanent and may result in paralysis (1 in 168,000).

For more information about your anaesthetic you can visit: www.labourpains.com

During the delivery

Doctors, midwives, and sometimes paediatric staff are all present so theatre can be quite a busy place.

- We place a screen in front of you but, if you wish, we can lower this when your baby is being born.
- We make a cut across your tummy between your hip bones. The cut is usually about 20cm long.
    - Delivering the baby takes about 5 minutes, although this may take longer if you have had a caesarean or other operations before. You may feel some pushing and pulling sensations during this.
    - Repairing the cut takes a bit longer, usually about 30 minutes although again this can be longer if you have had previous operations.
    - All the stitches used inside your tummy will dissolve and do not need removed. The stitches in your skin may or may not need to be removed. Your doctor can tell you which type of stitch they used.
- The anaesthetist will stay beside you throughout the operation. If you experience any discomfort, let the anaesthetist know.
    - Rarely, there may be mild pain which we can treat with a painkiller through the drip or to breathe in. If this does not work or if the pain is severe, the anaesthetist will give you a general anaesthetic and put you to sleep.
- If you feel sick or faint during the operation tell the anaesthetist and they will give you medicine to make you feel better.

After the delivery

- When the caesarean is complete we will transfer you to the recovery area.
    - We keep a close eye on you and your baby for approximately an hour before we transfer you to the postnatal ward.
    - You can have a drink of water and, if not feeling sick and your recovery is straightforward, some food i.e. toast.
- We encourage skin to skin contact with your baby as soon as possible after the caesarean.
    - Your baby will be with you unless they need to go to the 'Special Care Baby Unit'.
- We will usually stop your 'drip' before you leave the recovery area.
- We expect that you will be able to get up and walk approximately 6 to 8 hours after your caesarean. However, you must ask for assistance the first time you get out of bed.
- If all is well we can remove your catheter 12 hours after your operation (at the latest 7am the following morning).
- We will check your wound, blood pressure, temperature, pulse and sanitary towel regularly. This is routine for everyone.
- A nurse call (buzzer) system in the ward lets you call for assistance when you require it.
- If your baby is beside you the midwives and the health care assistants will help to change nappies and assist you.

What are the effects of a caesarean delivery compared to a vaginal delivery?

Compared to a vaginal delivery you have a **lower risk** of:

- Pain in your perineum (this is the name for the area between your vagina and back passage).
- In the short term you are at a lower risk of leakage of urine (called incontinence) but in the long term there is no benefit.
- A prolapse of your womb; this means your womb (also called the uterus) drops into the vagina. You are only at a reduced risk of this if all your children have been delivered by caesarean.

Compared to a vaginal delivery you have the **same risk** of:

- Losing more than 1 litre of blood. Losing less than a litre is unlikely to cause any problems.
- An infection in your wound or inside the uterus after having your baby.
- Damage to the neck of the womb, also called the cervix.
- Problems controlling your bowels after having your baby.
- Postnatal depression.
- Back pain.
- Pain during sexual intercourse.

Compared to a vaginal delivery you have a **higher risk** of:

- Pain in your tummy
- Staying in hospital longer. Most women are in hospital for about 2 days after a section but it will depend on your own situation and how you and your baby are after the caesarean.

- Needing to come back into the hospital after you go home. This can be for a variety of reasons.
- An injury to your bladder or the tube connecting the bladder to your kidney, called the ureter.
- Going back for another operation after your baby is born.
- Never having any more children. This can be for a variety of reasons.
- Needing your womb (uterus) removed at the time of delivery or shortly after. The most common cause for this is heavy bleeding after having your baby. This is a serious complication.
- Being admitted to the Intensive Care Unit. This is a serious complication.
- Developing a clot in your leg (called a DVT or deep venous thrombosis) or a clot in your lung (called a PE or pulmonary embolism). This is a serious complication.
- In a future pregnancy your placenta may stick to the scar from your caesarean inside your womb and cover the entrance to the womb. This condition is called placenta praevia. This is a serious complication.
- In a future pregnancy there is a chance that the scar from your caesarean may open inside your womb. This has implications for your health and the health of any future pregnancy. This is a serious complication.
- Death after your baby is born.
- A baby dying before birth in a future pregnancy.

Risks for your baby

The most common problems affecting babies born by caesarean is breathing difficulties. About 35 of every 1,000 babies born by caesarean have breathing difficulties compared with 5 of every

1,000 babies born after vaginal birth. The risk is reduced if your baby is delivered after 39 weeks. Most of these babies do not require treatment and we would observe them in the Neonatal Unit for a few hours.

There is also a small risk of your baby getting a small cut on their skin during the operation. This happens in about 1% of caesarean deliveries.

Pain Relief

- Following your delivery, it is important you are comfortable enough to care for your baby.
- Following your delivery, you will experience pain over your wound and we will prescribe pain killing medication. Everyone feels pain differently, and will require different amounts of pain killer.
- In theatre we usually add a long acting painkiller to your spinal anaesthetic and at the end of the procedure give you a painkilling suppository tablet into your back passage.
- For pain relief following your caesarean we will prescribe:
    - Paracetamol you can take 1 gram 4 times a day.
    - Diclofenac you can take 50 mgs 3 times a day. This is a non-steroidal anti-inflammatory (NSAID). However, some women may not be able to take this.
    - We will also prescribe morphine or 'morphine like' tablets, you can take some regularly and others as required.
    - Morphine injections are also available if the above does not make you comfortable.
    - All of these medications are safe during breastfeeding.

- Please say when you need pain relief so you can be as comfortable as possible and avoid letting the pain interfere with the care of your baby.
- You will go home with a supply of the pain killers listed above. We expect that you will need to take them for a week or so. You should gradually reduce the amount you take as the pain lessens, stopping the morphine like painkillers first, and then the diclofenac.

Your visitors

Wait and see how you feel after the caesarean. You may wish to have plenty of rest and visitors can be exhausting. Initially, we will be busy making sure that you are comfortable. Your birth partner can phone and can let them know your wishes. Visiting is 'open' for partners. For other visitors please check with the ward staff. For privacy and safety reasons, we encourage no more than 3 visitors at a bedside.

Later on

- As soon as the sensation begins to return in your legs, move your feet and ankles regularly as this helps to improve your circulation.
- Before you are ready to get up, your midwife will make sure the sensation in your legs has returned to normal.
- We will encourage you to mobilise (get up and about) usually around 6 to 8 hours after your operation.
- We give all women having an elective caesarean a daily injection (Enoxaprin) to decrease the risk of blood clots in their legs and lungs. Your midwife will teach you, or a close relative, how to inject this as you will continue this for a short time at home.
- We advise all women to wear leg stockings for up to 6 weeks after their operation.

Physiotherapy

The physiotherapist will visit you on the day following your caesarean to teach you simple movements which will help you to feel more comfortable. They will give you a booklet containing information on exercises which you should practice frequently.

Going home

Each woman's recovery from caesarean delivery will be different. It will depend on your recovery from the caesarean, your baby's health, and the time it takes for your baby to establish feeding. If your recovery is going well, you may be able to go home the day after the caesarean. However, we advise you to stay for at least 24 hours. You can discuss going home with your midwife.

Driving

Most women do not feel fit to drive for a few weeks after a caesarean delivery, and many wait till after their 6-week check. You should stop driving after a caesarean delivery and only start driving again when your doctor says it's safe to do so.

You should also check your car insurance to see if there are any restrictions about driving after a caesarean delivery.

Your Care

Everyone is cared for individually depending on their needs. This is a very general summary of what you can expect during your stay at the hospital, and variations may occur to suit your circumstances.

We hope this is of some help and we wish you a speedy recovery.

PERINATAL MENTAL HEALTH SERVICE
Pregnancy & Early Postnatal Care Plan (PEPP)

Name:	Wendy McLeish	DOB: 25.05.87

EDD: 3/3/17	Date plan agreed: 16/12/16

	Name & contact details	Next contact / Frequency of contact
CPN	Lorraine Docherty, Perinatal Mental Health Service, Tel: 0141 211 6500	
Psychiatrist	Dr R Cantwell, Perinatal Mental Health Service, Tel: 0141 211 6504	
Midwife	Princess Royal Maternity Hospital	
Obstetrician	Dr Ellis, Prncess Royal Maternity Hospital	
Health Visitor	Dr Wilson's Practice, Easterhouse Health Centre	
GP	Dr Wilson, Easterhouse Health Centre	
Social Worker		
Other professional		
Family member/named person		

Urgent/out of hours mental health contacts: NHS24: 111
Crisis team:

Risk of illness: Raised risk of anxiety

Early warning signs:
1. Worsening tremor
2.
3.

Current management:
1. Mirtazepine 45mgs at night
2. Propranolol 10mgs up to once daily
3.
4.

Planned antenatal changes:
1. No change in medication
2.
3.

Immediate postnatal plan: *Intention to breastfeed?* No

1. Inform PMHS (2116500) of delivery to arrange community follow-up
2. Continue medication unchanged
3.
4.

Advance statement completed? ☐ Yes ☒ No

Sign / print name (PMHS worker): Dr R Cantwell Date: 16.12.16

Sign / print name (Patient): Wendy McLeish Date: 16.12.16

GLASGOW AND CLYDE BLOOD TRANSFUSION

Surname	Forename	Sex	DOB
MCLEISH	WENDY	Female	25-May-1987

Hospital	Consultant	Location	Patient Id. Numb
GLASGOW ROYAL INF	Not known	Out Patients	PRM2505876061

Specimen No.G,16.5167837.R Date/time of collection 02-Dec-16 09:46
Date/time of receipt 02-Dec-16 09:46

Patient Blood Group
A NEG

Antibody Screen

STORE AT 4C

STOP, SEE BACK OF THIS TAG BEFORE TRANSFUSION
NHS SCOTLAND G
Bag 1 of 1
© Scottish National Blood Transfusion Service 2011 V11

DONOR UNITS BLOOD WILL BE DERESERVED ON 10/12/16

EXPIRY DATE	PRODUCT CODE	DONOR GROUP	PACK/BATCH NUMBER
30/11/18	ADR15	NG	43681000 8

Peel off label above and place in patient's Medical Records

Surname: MCLEISH	Forename: WENDY
DOB: 25/05/1987	Gender: Female

Patient Location
Ward : Out Patients PRM
Hosp : GLASGOW ROYAL INF

Patient's Identity No: 2505876061	Date/Time Required: 08/12/16 09:00
Patient's Blood Group: A NEG	Component: Anti-D 1500iu (Rhophy De-reservation date 10/12/16

Donation Number: 4368100018 NG

Once transfusion has been started, you must send the completed section below back to the Hospital Transfusion Laboratory as per local policy. This is a legal requirement

8/12/16
called m/w

Date and Time Reported
2-Dec-16 11:08

Authorised By
Sandra McKay

PERINATAL MENTAL HEALTH SERVICE
Pregnancy & Early Postnatal Care Plan (PEPP)

Name:	Wendy McLeish	DOB: 25.05.87

EDD:	3/3/17	Date plan agreed:	16/12/16

	Name & contact details	Next contact / Frequency of contact
CPN	Lorraine Docherty, Perinatal Mental Health Service, Tel: 0141 211 6500	
Psychiatrist	Dr R Cantwell, Perinatal Mental Health Service, Tel: 0141 211 6504	
Midwife	Princess Royal Maternity Hospital	
Obstetrician	Dr Ellis, Prncess Royal Maternity Hospital	
Health Visitor	Dr Wilson's Practice, Easterhouse Health Centre	
GP	Dr Wilson, Easterhouse Health Centre	
Social Worker		
Other professional		
Family member/named person		

Urgent/out of hours mental health contacts:	NHS24: 111 Crisis team:

Risk of illness: Raised risk of anxiety

Early warning signs:
1. Worsening tremor
2.
3.

Current management:
1. Mirtazepine 45mgs at night
2. Propranolol 10mgs up to once daily
3.
4.

Planned antenatal changes:
1. No change in medication
2.
3.

Immediate postnatal plan: *Intention to breastfeed?* No

1. Inform PMHS (2116500) of delivery to arrange community follow-up
2. Continue medication unchanged
3.
4.

Advance statement completed? ☐ Yes ☒ No

Sign / print name (PMHS worker): Dr R Cantwell Date: 16.12.16

Sign / print name (Patient): Wendy McLeish Date: 16.12.16

Acute Services Division
Women & Children's Directorate

NHS
Greater Glasgow and Clyde

Fetal Anomaly Scan Request Form

2505876061
MCLEISH
Wendy F
0/1 51 COXTON PLACE 25/05/1987
Glasgow, Lanarkshire
G33 5EJ

Consultant Dr Mathews

20wks gestation wk beg: _____

EDD Bord March '17'

Pregnancy Type
(Please Circle)

(Single) Multiple

Examination Required
(Please Tick all relevant information)

☐ **Medical FAS** ☐ **Sonographer FAS**

- ☐ BMI ≥ 40
- ☐ Maternal Diabetes Type1 or 2
- ☐ Epileptics on anticonvulsants
- ☐ FH congenital cardiac anomaly (1st degree rel.)
- ☐ Previous fetal abnormality amenable to U/S diagnosis
- ☐ Teratogen exposure which could result in problems amenable to U/S detection
- ☐ MCDA twins
- ☐ Raised MSAFP
- ☐ Unexplained increased NT
- ☐ Fetal viral infection

Additional Clinical Information:

Referrer Name: Gam Designation: Gyn

Signature: MW Date: 15/8/16

Letter 21/9/16 SL

23/23532

D 3117

GLASGOW AND CLYDE BLOOD TRANSFUSION

Jen 30/9/16. 14/9/16

Surname	Forename	Sex	DOB
MCLEISH	WENDY	Female	25-May-1987

Hospital	Consultant	Location	Patient Id. Numb
General Practioners	Nur E Neil	Easterhouse HC	Ob2505876061

Specimen No.G,16.5141011.K

Date/time of collection 15-Aug-16 09:19
Date/time of receipt 15-Aug-16 13:41

Patient Blood Group	Antibody Screen
A NEG	Negative

Rh(D) NEGATIVE CARD AND STICKER ISSUED
BOOKING VISIT

DONOR UNITS BLOOD WILL BE DERESERVED ON

EXPIRY DATE	PRODUCT CODE	DONOR GROUP	PACK/BATCH NUMBER

Date and Time Reported
15-Aug-16 14:56

Authorised By
Fayrouz Kraish

Acute Service Division

Women and Children

Department of EPAS

Specialty:Obstetrics

NHS Greater Glasgow and Clyde

Early Pregnancy Assessment Tool - Version 1.0

Hospital: Glasgow Royal Infirmary

Patient Details		GP Details	
Name:	MCLEISH, WENDY	**Name:**	MCGINLEY, ANNE
Address:	0/1 51 COXTON PLACE Glasgow Lanarkshire	**Address:**	Easterhouse Health Centre 9 Auchinlea Road Glasgow
Postcode:	G33 5EJ	**Telephone:**	
Correspondence Address 1:			
Correspondence Address 2:			
Correspondence Postcode:			
Telephone:			
Patient Contact Number:	07454750438	**Consent:**	Yes
CHI Number:	2505876061	**Sensitivity:**	Highly Sensitive
CRN:	23123532V, 10606785V, ZRV11368851	**Consultant Name:**	
D.O.B:	25/05/1987	**Form Date:**	27/08/2015
Sex	Female		

Next of Kin / Person to Notify	Next of Kin	Person to Notify
Name		James
Address		s/a
Landline		
Mobile		07475660161
Relationship		partner

Presenting Complaint

Presenting Complaint:	Follow up scan

Obstetric History

High risk factors:			
LMP:	22/05/2015	Cycle:	Regular
Date of pregnancy test:		Estimated gestation by LMP :	13+
Parity:	0+0	Last smear:	up to date-nad
Past obstetric history of note:		Date:	Place: Details:
Blood group:		Hb:	
Relevant thrombophilia:			

Additional Obstetric History

High risk factors:			
LMP:		Cycle:	
Date of pregnancy test:		Estimated gestation by LMP :	
Parity:		Last smear:	
Past obstetric history of note:		Date:	Place: Details:
Blood group:		Hb:	
Relevant thrombophilia:			

Relevant Medical History

Past Medical history:	wrist and throat operation - no problems with GA; NKDA.
Smoker: No	Medication:Yes
All Medication:	Propanolol 40mg TID Mitrazipine 15mg OD

Patient Allergy Summary

Ultrasounds

Ultrasound Details

Visit Date:11/09/2015	Ultrasonographer:Jennifer McGill/EMCGUIRE	LMP:22/05/2015

Ultrasound Date:	11/09/2015
Second sac?	No
Membrane seperation?	No
Adnexal mass?	No
Ovarian cyst?	No
Free fluid?	No
RPOC (measure)	Yes
Tenderness elicted	No

Foetus Information

Foetus Number	Heart Activity	Gestation Sac Size	Yolk Sac	CRL
		5.2x3x11.8mm	seen	

Ultrasound Details

Visit Date:03/09/2015	Ultrasonographer:Jennifer McGill (Checked by Donna Bean)	LMP:22/05/2015

Ultrasound Date:	03/09/2015
Second sac?	No
Membrane seperation?	No

Adnexal mass?	No
Ovarian cyst?	No
Free fluid?	No
RPOC (measure)	No
Tenderness elicted	No

Foetus Information

Foetus Number	Heart Activity	Gestation Sac Size	Yolk Sac	CRL
		8.9x10.7x11.5mm	?seen	

Ultrasound Details

Visit Date:27/08/2015	Ultrasonographer:Jennifer McGill	LMP:22/05/2015

Ultrasound Date:	27/08/2015
Menstrual age:	13+
Ultrasound age:	5+
Second sac?	No
Membrane seperation?	No
Adnexal mass?	No
Ovarian cyst?	No
Free fluid?	No
RPOC (measure)	No
Tenderness elicted	No

Foetus Information

Foetus Number	Heart Activity	Gestation Sac Size	Yolk Sac	CRL
		12.7x11.5x8.1mm	seen	

Ultrasound Comments

Date: 11/09/2015	TAS/TVS= Av uterus measures 85.7x42x32.3mm -appearance of collapsing gestation sac and RPOC (AP diameter 17.5mm) at fundus For SERPOC as planned
Date: 03/09/2015	TAS/TVS= AV uterus measures 80.3x53.2x42.2mm -IU gestation sac, yolk sac not clearly seen today (MSD 10.4mm) -areas of SCH surrounding sac -both ovaries and adnexa NAD Non-continuing pregnancy
Date: 27/08/2015	TAS/TVS= AV uterus measures 76.2x51.9x39.2mm -IU gestation sac and yolk sac seen (MSD 10.8mm) -both ovaries seen NAD -difficult scan due to bowel gas -no free fluid seen -no tenderness elicited rescan 1/52 - guarded prognosis

Outcomes

Non continuing pregnancy

Date :03/09/2015

Explanation and management options discussed:	Yes	Anti D required:	No
Records /CWW informed:	Yes	GP Letter:	Yes
Pre-pregnancy appointment arranged:	No	Management option chosen:	Surgical
Further information:	undecided:- considering management options		
Pre Assessment arranged:	Friday 11/09/15 @ EPAS PRM		
Consent:	Yes		
Date and location of procedure:	Stobhill 14/09/15		
Bloods:	FBC, G&S 11/09/15		
Surgical Management leaflet given:	Yes	Sensitive Disposal Form completed:	Yes
Information leaflet given:	No	Pre-Pregnancy appointment arranged:	No

Intra-uterine pregnancy - uncertain viability

Date: 27/08/2015

Explanation and emergency contacts given:	Yes		
Further information:			
Information leaflet given:	No	Pre-Pregnancy appointment arranged:	No

Further Details

27/08/15 10.30
Wendy attended EPAS for follow up scan, booking/dating scan last week should IU gestation sac and ?yolk sac. Wendy reports some minimal PVB over the past week, pain free, feels well otherwise:-
-u/s= inconclusive, see report. Findings fully discussed with Wendy and partner.
-for rescan in 1/52 for viability, advised Wendy to self refer or seek medical attention meantime if any concerns.
SM J.McGill

03/09/15 09.00
Planned attendance for rescan, reports PVB over the past week, some clots passed and cramps yesterday, settling today:-
-u/s= non-continuing pregnancy, see report. Findings fully discussed with Wendy and partner, condolences offered.
-discussed management options, Wendy wishing to consider options at home. She will contact EPAS when a decision is made.
-advised to self refer or seek medical attention if any concerns or feels unwell, aware of emergency contact numbers.
SM J.MCGill

03/09/15 14.45
Wendy contacted EPAS, wishing surgical evacuation:-
-SERPOC arranged Stobhill, Mon 14/09/15 @ 08.00hrs, Dr Wong, STO030906.
-Pre-op at EPAS, Fri 11/09/15 @ 12.15hrs.
-self refer or seek medical attention meantime if any concerns.
SM J.McGill

11/09/15 12.15
Wendy attended for SERPOC prep, reports PVB and clots passed at the weekend, Pv loss settled since then:-
-u/s= see report. Findings fully discussed with Wendy.
-keen to go ahead with SERPOC as planned.
-FBC, G&S taken, consent and SD7x2 obtained. Wendy referred to pre-op assessment for review.
-aware of time and place of procedure on Monday, advised to seek medical attention if any concerns over the weekend.
SM J.MCGill

Outcomes & Management

Date	USS Result	HGC Results	Action Plan & Follow Up

MEDICINE **PRESCRIPTION FORM** Hospital Name: .....

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐
Date _____ Name (Print) _____
Discharge Prescription Prepared & Reconciled YES ☐
Date _____ Name (Print) _____

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

DOCTOR'S DECLARATION (if required by Local Protocol)

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

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name _____ Tel No. _____
Address _____
Compliance Aid Details _____
Patient consent to share discharge information Y/N
Print & Sign _____

PATIENT DETAILS

Hospital N 2505876061
DOB: MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ
Date of Ad
Consultan

Height:
Weight: BK 78-5kg G
Surface area:
Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
5/12/16	CLEXANE	40mg	SC	2250			2255
8/12/16	ANTI D	1500 iu	IM	17:00			
24/12	CLEXANE	40mg	S/C	20[30]			21.00
24/12	CO-AMOXICLAV	1.2g	IV	15[30]			15.30
24/12	DICLOFENAC	100mg	PR	16[20]		THEATRE	16.20
24/12	MST	20mg	PO	22[00]			23.27
25/12	MST	10mg	PO	08[00]			08.20.
24/12	ANTI-D	500 iu	IM	23:00			21.30

D-Gam 500 IU BATCH: JDC16300 JDC16300

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

_____
_____

Midwife Administration by Symptoma... Relief Policy or other Protocol

Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

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

Notes for Users

FOR PRESCRIBERS:

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

DATE →	1	2	24	25																										
MONTH →	12	12	2	2																										

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

IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N

ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N

SIGNATURE OF ASSESSOR

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

Parenteral Drugs : Regular Prescription

Patient's Own Medicine

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

A DRUG Clexane

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE 80mg | ROUTE SC | DATE 5/12/16 | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

B DRUG Enoxaparin

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE 40mg | ROUTE S/C | DATE 24/2 | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

C DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

D DRUG

DOSE | ROUTE | DATE

STOPPED DATE:
INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

E DRUG

DOSE | ROUTE | DATE

STOPPED DATE:
INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

F DRUG

DOSE | ROUTE | DATE

STOPPED DATE:
INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

G DRUG

DOSE | ROUTE | DATE

STOPPED DATE:
INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

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

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

X DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

Y DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

AA DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

BB DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Name

CHI No.

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

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

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

Notes

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approv... circumstances where bioavailability differences between ... drug are so important as to warrant prescribing by brand name ...

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

Patient's Own Medicine
For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

GG DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

HH DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

JJ DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

KK DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

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

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

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

FOR PRESCRIBERS:
1. Prescribe drugs generically unless circumstances where bioavailability differences of drug are so important as to warrant prescribing by brand.

All Routes: As Required Prescriptions

| | | |

BEFORE ADMISSION ☐	NEW DOSE ☐	NEW MEDICATION ☐	DRUG	DOSE	ROUTE	INDICATION	PRESCRIBER (PRINT & SIGN)	MAX.FREQ.	STOPPED DATE: / INITIALS:	DATE:
			RR							
			SS							
			TT							
			VV							

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

	RR	SS	TT	VV
DATE				
TIME				
DOSE				
GIVEN BY				

Patient's Own Medicine

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

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

Name _____

CHI No _____

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

_____

_____

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

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

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
24-2-17	panadol	4mg	oral	2100	[redacted]	[redacted]	2100

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).
2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).
3. Print & Sign your full name clearly against each prescription entry.
4. Time should be recorded in 24hr format e.g. 0600, 1800.
5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.
6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.
7. The following metric unit abbreviations must be used –

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

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

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

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

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

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.
2. Insert initials in the relevant date column and time row each time a drug is administered.
3. Check that all drugs prescribed at a certain time have been administered.
4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

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

Cat. No. 40995 Ver 4, 09/2010

Immediate Discharge Letter The Princess Royal Maternity Unit

NHS Greater Glasgow and Clyde

Dr Anne Mcginley
Dr Mcginley & Dr Sheppard
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

The Maternity Unit,
The Princess Royal Maternity Unit
16 Alexandra Parade
Glasgow
G31 2ER

26/02/2017

Dear Dr Mcginley

Re :

Mcleish , Wendy CHI: 2505876061
0/1 51 Coxton Pl, Glasgow, G33 5EJ
25/05/1987

This para 0+0 delivered on 24/02/2017 at 15:50. This baby was born at The Princess Royal Maternity Unit.

Labour & Delivery			
Labour onset		Type Of Delivery	**4) Elective CS**
Induction		Augmentation	
Length 1st Stage (hrs,mins)		Delivery Complications	
Length 2nd Stage (hrs,mins)		Placenta	**Complete**
Length 3rd Stage (hrs,mins)		Membranes	**Complete**
3rd stage comments	**Cord traction**	Tears	**No**
Pain Relief	**Spinal**	Episiotomy	**No**
Blood Loss (mls)		Skin Closure	
Reasons for Instrumental Delivery			

Infant			
Baby H.P.I.		CHI Number	**2402170484**
Outcome	**Livebirth**	OFC (cm)	**33.1**
Sex	**Girl**	Crown Heel (cm)	
Gestation	**39+0**	Cord	**On**
Apgars	**10(at 5 Mins)**	Hips	***Normal(Left) Normal(Right)***
Birth Weight (grams)	**2805**	Max Bilirubin	
Subsequent Weight (grams)		Phototherapy	**No**
Vitamin K	**Intra Muscular on 24/02/2017**	Hearing (L, R)	**Pass | Pass on 25/02/2017**
Baby Discharge Comments		Blood Spot PKU	**Not done**
		Blood Spot CH	**Not done**
		Blood Spot CF	**Not done**
		Blood Spot Repeat	
		Feeding on Discharge	**Formula only**

Post Natal			
Blood Group	**A Negative**	Discharge date	**26/02/2017**
Anti D	**Given**	Discharge Address	**0/1 51 coxton place g335ej 07454750438**
Date Given	**25/02/2017**		
Rubella Vaccine	**Not Required**	Drugs on Discharge	**analgesia and clexane and iron**
Date Given		Follow Up Appt.	**for routine 6/52 p/n check with gp**
Postnatal Hb Result	**Obtained**	Discharge Comments	
Treatment	**Oral Iron**		
Last Smear		Contraception	**Other** ***Obtained From :*** **GP referral**

Signature _____ Date 26/2/17 Consultant Letter Required? **Y / N**

McLeish Wendy CHI: 2505876061

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No Consent for Sharing Withheld: No

Princess Royal Maternity
16 Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 5400
Date of Completion: 26/02/2017

Dr. AL McGinley
Dr Mcginley & Dr Sheppard
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

Dear Dr AL McGinley,

Name	CHI	DoB	Address
Wendy McLeish	2505876061	25/05/1987	0/1 51 COXTON PLACE Glasgow G33 5EJ

Admitted	Type	Discharged	Destination
24/02/2017 07:24	In Patient	26/02/2017	

Specialty	Consultant	Ward	Telephone
Obstetrics	Dr Elizabeth Ellis	PRM (MAT) Ward 72 - Obstetrics	

Reason for Admission and Presenting Complaints	Admission Category
	Pregnant but not in Labour (includes threatened abortion)

Diagnosis	Site	Side

Date	Procedures/Interventions/Operations

Clinical Comments:

Dear Doctor,
Ms McLeish delivered by EILUSCS on 24/02/17.
EBL 400ml
Hb 126
Weight 78.5kg
VTE risk moderate - 7 days of clexane
NKDA
Note: Mrs McLeish was previously on propranolol 80mg daily. This was reduced to 10mg daily during pregnancy. Since she is now post-partum I have titrated her dose up to 20mg at time of discharge. I would appreciate if you would be able to review this in due course and perhaps titrate up again towards 80mg daily.
Kind regards

Emma Donoghue
FY2 OBGYN #12037

Treatments: None recorded.

Follow-up arranged: postnatal

Planned Outpatient Investigations: nil

Final Discharge letter to follow: y

Medication Info:

Allergies:

Height: cm **Weight:** kg

scharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment
Diclofenac Sodium E/C Tablets	Oral	50	mg	THREE Times a Day	No duration defined	
Enoxaparin Syringe Injection	Injected	40	mg	ONCE a Day	7 Days	s/c inj. add 1 sharps box
Ferrous Sulphate Tablets	Oral	200	mg	THREE Times a Day	No duration defined	
Paracetamol Tablets	Oral	1000	mg	FOUR Times a Day	No duration defined	

Medication Comment: scm JG

Discontinued Medication:

Drug Name	Dose	UOM	Reason

urs sincerely,
Dr Emma Donoghue
Doctor

Prescription Review
Medications Reviewed by Pharmacist: Erin Flynn, Pharmacist
Dispensed Medications Checked by Pharmacy: Lorna Rankine, Pharmacist
Nurse discharging patient: Laura McKean, Midwife

Pa
Sti

2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

Postnatal Follow-Up

Consultant Review

Tick all boxes that apply for any complications. Notes should go to the named consultant to arrange further follow up or communication:

- ☐ Any woman admitted to labour ward HDU, surgical HDU or ITU
- ☐ Any woman whose baby required SCBU/NICU admission
- ☐ Any woman whose baby was born with an anomaly
- ☐ Any pregnancy that resulted in a stillbirth or neonatal death
- ☐ Any woman who required postnatal follow up in DCU
- ☐ All women who have had a caesarean section under general anaesthetic
- ☐ Any woman who had a PPH >2L
- ☐ Any woman who had an unexpected severe post-operative or postnatal complication
- ☐ Any case potentially thought to result in a complaint
  - Please state nature of concern below:

M/W Signature	
Print	
Date	
Con. Signature	
Date	

OR

Regular Follow Up Options

Please tick the appropriate boxes!

ANC Follow up in 6 weeks:

- ☐ Any woman who sustained a third degree tear
- ☐ Any women who experienced a shoulder dystocia
- ☐ Type 1 or 2 diabetes (Tuesday morning diabetes clinic)

Anaesthetic Complication:
Casenotes to Fiona McManus, Secretary, Level 4 for Consultant Anaesthetic review:

- ☐ Anaesthetic Complication

OR

If there are no antenatal or intrapartum complications the notes should be sent for filing:

- ☑ Notes to filing

Midwife Signature	dmcmcan
Print Name	C. McNEAD
Date	26/12/17

GLASGOW AND CLYDE BLOOD TRANSFUSION

Surname	Forename	Sex	DOB
MCLEISH	WENDY	Female	25-May-1987

Hospital	Consultant	Location	Patient Id. Numb
GLASGOW ROYAL INF	Dr Elizabeth Ellis	Labour Suite	PRM2505876061

Specimen No.G,17.5172781.L Date/time of collection 24-Feb-17 19:00
Date/time of receipt 24-Feb-17 19:00

Patient Blood Group
A NEG

Antibody Screen

STORE AT 4C

DONOR UNITS BLOOD WILL BE DERESERVED ON 26/02/17

EXPIRY DATE	PRODUCT CODE	DONOR GROUP	PACK/BATCH NUMBER
31/08/18	AD500	NG	JDC16300

Peel off label above and place in patient's Medical Records

Surname: MCLEISH	Forename: WENDY
DOB: 25/05/1987	Gender: Female

Patient Location
Ward : Labour Suite PRM
Hosp : GLASGOW ROYAL INF

Patient's Identity No: 2505876061	Date/Time Required: 24/02/17 19:00
Patient's Blood Group: A NEG	Component: Anti – D 500iu (BP De – reservation dat 26/02/17

Donation Number: JDC16300 NG

Once transfusion has been started, you must send the completed section below back to the Hospital Transfusion Laboratory as per local policy. This is a legal requirement

Date and Time Reported
24-Feb-17 19:01

Authorised By
Vinnured Gohil

WOMEN AND CHILDRENS DIRECTORATE
HIGH RISK ANAESTHETIC CONSULTATION RECORD

NHS Greater Glasgow and Clyde

PLEASE CIRCLE WHERE INDICATED AND COMPLETE AS APPROPRIATE IN BLACK BALLPOINT INK.

PATIENT LA
2505876061
MCLEISH
Wendy F
25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

DATE 23.12.16

ANAESTHETIST

GRADE

NUMBER

Personal details

AGE 29 GESTATION 30 EDD 3/3/17

LOCATION ANC MEDICAL CLINIC DAY SU M T W TH F SA

[redacted] Poto

ON EXAMINATION

HISTORY

Prev 2011 admission for Pneumonia → TV + Eclamp
good recovery
Reasonable exercise level

DRUGS Nitrofurantoin
Prednisolone — tremor

EXAMINATION

Recent CXR + lung ventil scan: (to exclude PE)
— normal results.

ALLERGIES NKDA

ASA 1 2 3 4 5 E

INVESTIGATIONS

FBC - GA - U&Es / LFT: WNL
CVS - NAD RS - Pt states reduced level of activity but currently clinically well.

PROBLEM LIST

MANAGEMENT PLAN

[redacted] - Suitable for Spinal anaesthesia

OUTCOME

DATE DELIVERED MODE OF DELIVERY SVD INST ELCS EMCS

ANAES/ANALGESIA NONE TENS N20 OPIATE EPIDURAL SPINAL CSE GA

CRITICAL INCIDENT NO YES DETAILS

MATERNAL OUTCOME SAME WORSE DEATH

NEONATAL OUTCOME GOOD POOR DEATH

ICU ADMISSION NO YES

ELECTIVE STAND BY UNPLANNED

LENGTH OF STAY = DAYS

MANAGEMENT PLAN FOLLOWED YES

NO DETAILS

McLeish Wendy CHI: 2505876061

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No Consent for Sharing Withheld: No

Princess Royal Maternity
16 Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 5400
Date of Completion: 07/12/2016

Dr. AL McGinley
Dr Wilson dr mcginley & dr sheppar
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

Dear Dr AL McGinley,

Name	CHI	DoB	Address
Wendy McLeish	2505876061	25/05/1987	0/1 51 COXTON PLACE Glasgow G33 5EJ

Admitted	Type	Discharged	Destination
05/12/2016 23:24	In Patient	07/12/2016	

Specialty	Consultant	Ward	Telephone
Obstetrics	Dr Elizabeth Ellis	PRM (MAT) Ward 73 - Obstetrics	0141 211 5213

Reason for Admission and Presenting Complaints	Admission Category
	Pregnant but not in Labour (includes threatened abortion)

Diagnosis	Site	Side

Date	Procedures/Interventions/Operations

Clinical Comments: Ms Mcleish was admitted to ward 73 on 5/12/16 due to right sided pleuritic chest pain and SOB. She also had one episode of haemoptysis. It was noted she has a history of a previous pneumonia and can experience pain related to this however the pain felt worse. She had some right sided crackles on examination. She had been commenced on a course of 5 days of amoxicillin prior to her admission which she will complete.
CXR was normal, as were her bloods. A VQ scan did not show any evidence of PE.
She was therefore discharged home.
Yours sincerely
Amanda Rodger
GPST2

Treatments: None recorded.

Follow-up arranged: nil

Planned Outpatient Investigations: nil

Final Discharge letter to follow: yes

Medication Info:

Allergies:

Height: cm **Weight:** kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment
Amoxicillin Capsules	Oral	500	mg	THREE Times a Day	2 Days	POS
Mirtazapine Tablets	Oral	45	mg	ONCE a Day	No duration defined	POS
Propranolol Hydrochloride Tablets	Oral	10	mg	As Required	No duration defined	POS

Discontinued Medication:

Drug Name	Dose	UOM	Reason

Yours sincerely,
Dr Amanda Rodger
Doctor

Prescription Review

Medications Reviewed by Pharmacist: ,
Dispensed Medications Checked by Pharmacy: ,
Nurse discharging patient: Susan Melly, Midwife

NM-NEAST-FORM-005 Nursing Instructions	North East Sector



Nursing Instructions following a Diagnostic Administration of a Radioactive Substance

MCLEISH, Wendy
0/1 51 Coxton Place, Glasgow, Lanarkshire, G33 5EJ
Appointed (Diary): **07/12/16**
Ref: Dr Elizabeth Ellis - Princess Royal Maternity W73
NM Lung Ventilation SPECT 0930 GRSYMB
NM Lung Perfusion SPECT 0955 GRSYMB

E-31127960
CRIS: 5226123 ChiNo: 2505876061 DOB: 25/05/1987

Procedure
Name of Test: LUNG SCAN
Radionuclide and activity 85mBq Tc99m
Administered on:
WED (day) 7/12/16 (date) 10:30 (time)

Nursing Instructions to be followed until date below:

- Continue to carry out nursing duties, keep direct contact with the patient to a minimum.
- Pregnant nurses - no close contact with patient, unless essential for patient care.
- Observe standard hygiene precautions when dealing with potentially contaminated urine, faeces, saliva, vomit, fouled linen or a spill of any such material (ie wear disposable gloves and apron).
- Mop up any spill with paper towels and wash the area involved. Place contaminated disposables in a plastic bag and contact the Radiation Protection Supervisor.
- Transfer fouled linen to laundry in alginate bags.
- Try to avoid taking blood, urine or CSF samples during this time.
- No 24 hour urine collections to be taken for 48 hours following administration

Date to resume normal nursing

THUR (day) 8/12/16 (date) 10:30 (time)

Any problems? –

Radiation Protection Supervisor (GRI):	Dr A A Bolster	0141 211 4762
Radiation Protection Supervisor (Stobhill):	Dr G Ainslie-McLaren	0141 355 1553
Radiation Protection Advisor:	Dr D Gentle	0141 211 3432

NHS
Greater Glasgow and Clyde

Special Needs in Pregnancy

Please file Special Needs in Pregnancy notes after this page.

25177

Record of Case Conference pre / post

2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

PRM SGH RAH IRH VOL OBAN (please tick)

Date: _____ **Chair:** _____

Midwife Present: _____ **Health Visitor:** _____

Parents Present: Yes / No (please tick)

Father's Name: _____ **Child's Name (if appropriate):** _____

Concerns discussed:

Decisions of Case Conference:

Action to be taken:

Key contact (Name and Telephone Number): _____

Area Team (Address and Telephone Number): _____

Signature: _____ **Date:** _____

NHS
Greater Glasgow and Clyde

NHS GG&C Women and Children's Services
Princess Royal Maternity Hospital

Check list for routine antenatal Anti D prophylaxis

2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

A) 28 WEEK VISIT

Confirm 15-20 week rhesus status

Information given to Patient (YES) NO

Counselled by: Name and signature of Doctor/Midwife CMcGee Date 8/12/16

Print _____

Anti D Accepted (YES) NO

If Anti D declined
reason for declining _____

Blood taken for antibody check at 28 weeks (YES) NO Date 8/12/16
(prior to Anti-D administration)

Anti D given (YES) NO

Batch Number: 4368100018 NG Date given: 8/12/16

Given by: Name and signature of Midwife/Doctor CMcGee

Where given PRM ☑ Springburn ☐ Rutherglen ☐ Easterhouse ☐

189853-9

Consent Routine Antenatal Anti-D Prophylaxis For Rh-D Negative women

NHS
Greater Glasgow and Clyde

Consultant: Dr Ellis Hospital: PRM

Affix addressograph or complete:

Name:

Address:

D.O.B.:

Unit No.:

Hospital No.:

2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

I confirm that I have read and understood the Information Leaflet on 'Routine Antenatal Anti-D Prophylaxis'.

***I consent / ~~do not consent~~ to receiving routine prophylactic Anti-D injection during this pregnancy.**

***Delete as appropriate**

Signature: W McLeish Date: 8/12/16

Witness: [signature] (Midwife) Date: 8/12/16

MIS 193810

Maternity Summary Record

Please use black ink

Confidential

Personal details

CHI ..... Age 29

Previous surname .....

Likes to be called .....

Home ✆ 07454750438

Other ✆ .....

Affix label here or complete by hand

Unit No

Surname/family nam 2505876061

First name(s) MCLEISH F

Date of birth /Wendy 25/05/1987

Address 0/1 51 COXTON PLACE

Glasgow, Lanarkshire

G33 5EJ

Change of details

Your address .....

..... Postcode .....

Home ✆ .....

Other ✆ .....

Parity 0 + 1

Agreed EDD / /

LMP 25/5/16

EDD 1/3/17

Blood group .....

Irregular antibodies Yes ☐ No ☐

Partner/supporter details

Please tick if emergency contact ☑

Name JAMES WARD

Date of Birth 18/11/87

Relationship PARTNER

Address 155 ROCKSAVAGE GDNS

BELLSHILL

Postcode ML3

Home ✆ 07475660161.

Other ✆ .....

Thrombosis risk factors

☐ Previous DVT ☐ BMI ≥30 ☐ Age >35

☐ Parity >4 ☐ Other .....

Allergies Penicillin

Height 158 Weight 78.5 BMI 31.4

Gestation BMI calculated .....

Special features

PREVIOUS MALE RECURRENT MISCARRIAGE SYNDROME FOLLOWED BY NORMAL 2011

Alternative/emergency contact

Name AA

Relationship .....

Address .....

..... Postcode .....

Home ✆ .....

Other ✆ .....

Named midwife .....

GP .....

Directions to home .....

	Date	Type of Delivery	Sex	Weight	Gestation	Place of Birth	Comments
1	2015	MISCARRIAGE		GRI	12/40		
2							
3							
4							
5							
6							
7							
8							

Personal details

Family origin White/Scanty

Current religion or faith

Language used at home Glasgow

Help needed with interpreting, communicating or advocacy No ☑ Yes ☐

Cultural requirements/details on the above

Occupation O.O.W.

ide details of social circumstances/family support.
ail any change of partner during pregnancy or the postnatal period

lives alone

Referrals

/ / To

/ / To

/ / To

Key professionals

Named midwife Gaynor Rowan

Midwifery team B

Base

✆

Obstetrician

Clinic

✆

Health Visitor

Base

✆

Social Worker

Base

✆

Health status

Specific dietary needs No ☑ Yes ☐

Smoking status

At risk of passive smoking No ☑ Yes ☐

Problem alcohol use No ☐ Yes ☐ Previously Methadone

Problem drug use No ☑ Yes ☐ Subs/Wt.

Details of any of the above

Domestic Abuse/Routine Enquiry

Seen alone at booking No ☐ Yes ☑

Routine enquiry question asked No ☐ Yes ☑

If not asked, document reason why

Abuse disclosed No ☑ Yes ☐

Current ☐ Past ☐

Please document in 'Further information/details of maternity care' and ensure all appropriate referrals made

If domestic abuse disclosed remember to tick the box in the women held record referring midwives back to summary record (box in special features area).

Comments

Child protection

Issue raised on 15/8/16

Comments

Kenny was in care from Aut 47kg until 18yrs

Please document in 'Further information/details of maternity care' and ensure all appropriate referrals made

General Practitioner Dr. AL McGinley

Base Dr Wilson dr mcginley & dr sheppar

✆ Easterhouse Health Centre

Practice code 9 Auchinlea Road

Glasgow

G34 9HQ

Other

Designation

Base

✆

Other

Designation

Base

✆

Chronology of Significant Events

Please detail below the strengths, assets and challenges faced by women and their families throughout pregnancy, birth and the post-natal period.

The chronology should contain:

- The date and time
- A brief description of the event
- Cross-reference to other records e.g. computerised records
- Each entry must be signed

Date / Time	Event	Action / Outcome	Signature

Planned place of birth and Pathway for antenatal care red or green

Lead professional DC midwives

Designation CONSULTANT

Change(s) to Planned place of birth and Pathway for antenatal care red or green

Reason .....

Signed .....

Booking completed by Erinan Print Erinan Designation MW

Date 25/8/16 Gestation 11+ weeks Location ERC

Date	Gestation	BP	Urinalysis	Further information / details of plan of care
Remember to sign each entry and print your signature alongside your first entry. Please use 24 hour clock.				
16/8/16	11+4	114/74	CC	Booking Book Cons x
				Growth USS 9/52 seen x
				Accepted. Aware Woman Care x
				for Vaccine. USS 30/8/16
			–	Previous PPH + Recurrent Pregnancy Syndrome Following Pregnancy – Induced Coma
			–	Was in Critical Care for 3 wks – 10yrs Anxiety – On Mirtazapine 30mg X1 Previous 90
			–	Has appointment 9/9/16 Mental Health Service
			–	Previous Midwife Post-Natal Visit Weekends till 5pm Pregnant Partner Cervical Cancer Recall

Date	Further information/details of maternity care Remember to sign each entry
10/8/16	Referral a RMHT High risk Booker for Medical Known ? SHIPS team. (G) Glasgow Woman aware of referrals Tom Tom.
20/9/16	Reappt 2/52. DNA (8) Halsall
4/10/16	18+ ANC well O/E Fndl=Dates Abdo soft FHH SNIPS appt 6/10/16 on Mirtazipine 45mg S/B CPN Propranolol 10mg PRN HIV result not on portal - phoned virology - not requested Email to Virology to add test SWMcPhee
	St 20 Clear. Mirtazepine - was on reduced dose, now ↑ to 45mg. Dreamt routinely see CPN. Been referred to PNMH. Occasional propranolol → few times a week.
	Pneumonia + ARDS - 2012 + ECMO Occasional breathlessness Discharged from Resp. ( ) for Anaesthetic r/v.
Growth scan 30+3d.	Wishing caesarean section - Discussed risks + benefits Reports anxiety ++ regarding birth. Referred to clinical psychologist. To see SNIPS on Thursday Clair Fitz.

Maternity Summary Record (continued) Name .....

2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

Remember to sign each entry	Gestation	Further information/details of maternity care
6/10/16	18+5	Attended SMRS ante (attended PNM ante 27 ago).
		Had ante with midwife (Marshall clinic) 2 wks ago.
		- mirtazapine 45mg from 30mg.
		- feeling is not helping anxiety.
		- also on propranolol long prn - taking 2x per week.
		Was ante for FMAS 19/10/16
		Feels mood stable but anxiety constant all the time.
		- when mood low was previously had thoughts of self harm
		- 1/52 (year ago.
		Previous alcohol - drinking with friends @ weekend
		- Nil since pregnancy confirmed
		phone call to PNMW Appts will be sent for CBT & PNMW follow up

GCC0038 41657

Date	Gestation	Further information/details of maternity care Remember to sign each entry
		contd
		contact no given for PNMH & SNPS.
		Happy to ref to SNPS one.
		(4) KHOKHAR (GALAXY)
10/11/16	24.	MIRAZONE 45mg NOCTE
		PROPANOLOL 10mg WHEN REQD
		3/4 TIMES WEEKLY
		LIAISING W/ PNMH -
		CPN DOING CBT -
		GOOD SUPPORT FROM
		PARTNER.
		ADULT RDS -
	*	Rep ANAESTHETIC REVIEW *
	+	DIABETES HEALTH ED *
		URINE NAD
		P-64, BP 120/70.
		OE ABDOMEN SOFT,
		=22cm, FMF, NIC PV
		FOH W/C DOPPLER 120-140
		MOOD "OKAY"
		Ref 4/52 FOR ABDOMEN
		PLAN, ANTI D: SEE DR ELLIS
10-11-16.		- As above. ABDOMEN
		See 4/52 & growth scan please.
		Ellis

Maternity Summary Record (continued) Name .....

2505876061
MCLEISH F
Wendy 25/05/198
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

Date	Gestation	Further information/details of maternity care
Remember to sign each entry		
8.12.16	27+6	Discharged yesterday – chest pain, ? PE – V/Q scan ve.
BP 106/66 PYS.		
Urine:		
		Symptoms improved. Finishing course of antibiotics. Some niggling twinges – ? mechanical
		Anaesthetic review Jan 17.
		U/S scan. Keen on proposal – rpt 4/52
		Elli
Rhv		Anti D 1500 iu IM as per protocol. O/E fundus = 28cms, long lie, cephpres, FHR tve.
		Donation No: 4368100018 Component: Anti–D 1500iu (Rhophylac) Signature 1: Date Given: Signature 2: Time Given: Hospital : Ward :
		Plan 4/52 ~~~ contd
5/1/17	31+6	Well, active fetus.
BP 113/81		O/E fundus = 32cms, long lie, cephpres FHR tve via scan.
urine NAD.		
		Continues on progandol, engaging ½ PNMHT ✓.
		no further chest pain.
		HB 124 (5/12/16).
		Anaes – R/V 23/12/16 ✓.
5.1.17.		U/S scan POT 4/52 Elli

Date	Gestation	Further information/details of maternity care Remember to sign each entry
2/2/16		MOOD GOOD
1445	35+6	MIRTAZAPINE 45MG NOCTE
		PROPANOLOL 10MG WHEN
48.6kg		REQD. - 2/3 TIMES
		WEEKLY
		LIAISING WITH PNMH
		CHEST "ALRIGHT"
		ANAEST REVIEW -
		P-68, BP 120/80
		WISHES OBSERVED
-2.16.	35+6.	Obstetrically well 24.2.17
		V. anxious.
		US - scans growth.
		Pat 2/52.
		V. worried about labour —
		feeling something going wrong
		Has always felt she would
		regret CS i.e. event of having
		a baby
		- Discussed at booking but
		not referred to psychology
		Adamant she does not wish to
		change her mind.
		Discussed risks / haemorrhage, shock,
		trauma, future adherent placentas
		- CS booked for 39/5
		- See d Consent 1152 - has
		leaflet.

23123532
MAT General Medical Record
MCLEISH
Wendy
CHI: 2505876061

Date	Gestation	Further information/details of maternity care Remember to sign each entry
9/2/17	36+6	VE Urine nad No oedema Hb 131g 2/2/17 S/f funds = 36cm cephalic/long axis Fmvt ✓ FHR 148–159 bpm ① BP 125/90 1445 ② BP 129/74 1480 ③ BP 129/89 1455 – Asymptomatic
9.2.17	36+6	BP as above. Bedcad 117/79 Asymptomatic. No proteinuria → See Day Case 13.2.17 – BP check. ANC 1152 – Still wishes CS ∴ consent ✓ – will come in at any time if any symptoms / change in FM. Elvis
16/2/17	37+6	Ward round P – 74, B/P 120/80 Feels well Plenty FMF NIC PV O/E ABDOMEN SOFT, = 37cm, CEPHALIC PRES,

Time	Gestation	Further information/observations (if any)
Remember to sign each entry		
16/2/17	37 +6	FMF, VX FREE
		FM H/C DOPTAE 120-140.
		UNCONFIRMING
		CHECK LIST ✓
		PRE-OP MANE ABANDEN

GG & C MATERNITY ULTRASOUND REPORT

2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

PATIENT NAME:

ADDRESS:

DATE OF BIRTH:

HOSPITAL / CHI NUMBER:

SINGLE / TWINS / TRIPLETS 03rd

EDD (BY SCAN): ~~23rd~~ 22nd March '17

BOOKING DATA AND EARLY PREGNANCY SCANNING

Date	30/8/16	14/9/16	
Menstrual Age	14+5		
Ultrasound Age	13+0	15+5	
Fetal Number	Single	one	
Fetal Heart	+ve	+ve	
CRL	67.0		
NT Measurement	2.6	outside	
HC	85.5mm	118.4m	
HL	9.4mm	16.9m	
Yolk Sac			
Second Sac			
Placental Site	Anterior		
Screening Status (Please circle as appropriate)	Success Declined Failed <11+2 Or >14+1 For 2nd Tri screening: Today OR M/W Appt from	Success Declined Failed < 11+2 Or (>14+1) (For 2nd Tri screening:) Today OR M/W Appt from	Success Declined Failed < 11+2 Or >14+1 For 2nd Tri screening: Today OR M/W Appt from .....
Comments	On trolley 2 (1st arrived by V. Hancock) Fetal Stomach + bladder seen		
Review	2/52 for HC EDD		
Sonographer	K. Gillespie		
Print Name	K. GILLESPIE		

POSTNATAL SCANS

Date			
Indication	Comment	Comment	Comment
Review			
Sonographer			
Print Name			

G & C MATERNITY ULTRASOUND REPORT
FETAL ANOMALY SCREENING

2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

All bold fields are mandatory

Date	19-10-16	
Gestational Age	20+6	
HC (mm)	183mm	
Ventricle (mm)	5.6mm	
Cerebellum	✓	
TCD (mm)	21.6mm	
Lips and Nasal Tip	~~N/A~~ ✓	
Profile	Face not seen	
4 Chamber Heart	✓	
RVOT	✓	
LVOT	✓	
Diaphragm	✓	
AC (mm)	162mm	
Stomach	✓	
Abdominal Wall	✓	
Kidneys	✓	
Bladder	✓	
Spine	✓	
Upper Limbs	✓	
Hands	✓	
Lower Limbs	✓	
Feet	✓	
FL (mm)	33mm	
Fetal Sex (if requested)	? Girl today	
Liquor Volume	NORMAL	
Placental Site	RIGHT LAT	
Comments	12cm fibroid in OS Growth scan due to maternal body habitus (BMI 42)	
Review		
Sonographer	SR Fall	
Print Name	STAFF	

GG & C MATERNITY ULTRASOUND REPORT

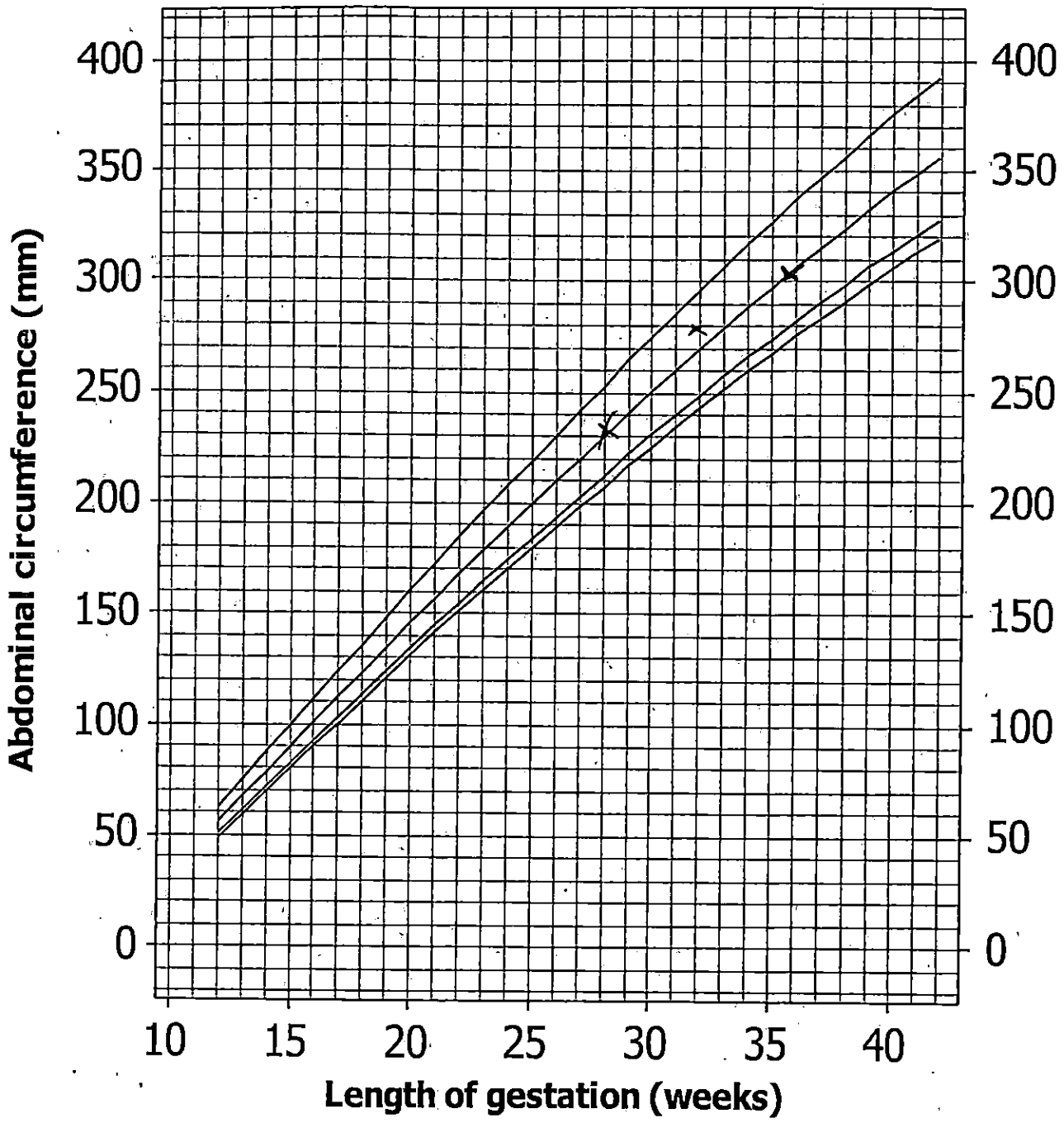
2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

FETAL GROWTH AND DOPPLER

Date	8/12/16	13/1/17	2/2/17
Gestational Age	27+6	31+6	35+6
Presentation	Cephalic	Cephalic	Cephalic
Fetal Heart	+VE	+ve	+ve
HC	26cm POSSIBLE		
AC	23.2cm	27.9cm	30.2cm
FL			
EFW			
Amniotic Fluid	NORMAL	Normal	Normal
Umbilical Artery	EDF present	EDF present	EDF present
Mid Cerebral PSV			
Mid Cerebral PI			
Ductus Venosus			
Uterine Artery			
Placental Site	RIGHT	Rt lat wall	Rt lat wall
Comment	RIGHT SIDED PLACENTA NO PRAEVIA	Appears to be fundal fibroids	Appears to be fundal fibroids
Review			
Sonographer		S. Clark	S. Clark
Print Name		CLARK (SONO)	CLARK (SONO)

Abdominal circumference growth

5th, 10th, 50th and 95th centiles



Adapted from Loughna et al. Ultrasound, August 2009, Vol 17, Number 3

Nursing Pre-Operative Check List

NHS Greater Glasgow and Clyde

Patient's Name:
Address:
Hospital Number:
Ward:
Date:

2505876061 F
MCLEISH 25/05/1987
Wendy
0/1 51 COXTON PLACE
Glasgow, Lanarkshire G33 5EJ

CHECK LIST		COMMENTS
CONSENT FOR OPERATION	✓	
IDENTIFICATION BAND	✓	
CASE SHEET, X-RAYS, BRADMA PLATE		
FASTING REGULATIONS	✓	yes -
TUBES IN SITU (eg: CATHETER, NASO-GASTRIC TUBE)	✓	NO TUBES
PHYSICAL DISABILITIES	✓	NO DISABILITIES
SKIN PREPARATION		
PROSTHESIS REMOVED		
DENTURES	✓	2x veneers front two teeth
OTHER (eg: wig, contact lens etc)	✓	NO
NAIL POLISH	✓	NO
MAKE UP	✓	NO
HAIRPINS	✓	NO
JEWELLERY	✓	NO.
WEDDING RING TAPED	✓	earrings - removed
UNDERCLOTHING REMOVED	✓	yes
IMMEDIATELY PRIOR TO THEATRE		
URINE VOIDED		
ANY KNOWN ALLERGY (eg: Elastoplast)		
OTHER NECESSARY INFORMATION		
eg: ACUPUNCTURE NEEDLES		

Signature _____ Grade _____ Ward _____

ANTENATAL AND BIRTH HISTORY

Obstetrician
Paediatrician
Mother's H.P.I.
Mother's surname: Mcleish
Mother's forenames: Wendy
Home address: 0/1 51 Coxton Pl
Glasgow
Postcode: G33 5EJ
Telephone: 07454750438
Mother's occupation
Partner / Supporter details
Surname
Forenames
Age
Occupation

GP's name: Anne, Mcginley
GP address: Dr Mcginley & Dr Sheppard
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ
Telephone: 0141 531 8150

LABOUR AND DELIVERY RECORD

Onset
Induction
Augmentation
Length 1st Stage
2nd Stage
Drugs
Delivery: 4) Elective CS
Membrane rupture-delivery interval: < 6 hours
Placenta: Complete

INFANT RESUSCITATION RECORD

Baby's name: Baby
Baby H.P.I.
Date of birth: 24/02/2017
Time: 15:50
Sex: Female
Est. Gestation: 39+0
CHI: 2402170484

Apgar Score

	0	1	2
Colour	Blue or Pale	Blue Extremities	Pink
Heart Rate	Absent	Less than 100	More than 100
Response to Stimulation	Absent	Weak Movement	Cry
Respiratory Effort	Absent	Weak, Irregular	Regular
Tone	Absent	Some Flexion	Active Movement

Score at 1 Minute 9

	0	1	2
Colour	Blue or Pale	Blue Extremities	Pink
Heart Rate	Absent	Less than 100	More than 100
Response to Stimulation	Absent	Weak Movement	Cry
Respiratory Effort	Absent	Weak, Irregular	Regular
Tone	Absent	Some Flexion	Active Movement

Score at 5 Minutes 10

Minutes to Regular Respiration: 1

RESUSCITATION: Nil / Facial Oxygen

COMMENTS ON RESUSCITATION

MATERNAL RECORD

Age 29
Parity — LB 0 SB 0 Abor 0
Marital status: Never Married
Relevant past Medical / Family History
Past obstetric history

Date	Place	Gest	Delivery	Sex	BW	Outcome

THIS PREGNANCY

EDD: 01/03/2017
BMI: 32.5
Health in pregnancy
Problems specify: miscarriage 2015
Drugs in pregnancy: propranolol/mirtazapine for anxiety

Maternal serology

Blood Group		Antibody		Syphilis
ABO	Rh	Type	Titre	Negative
A	Negative			

ALCOHOL RELATED DATA
Alcohol pre-pregnancy
Alcohol Risks Discussed
Comments
Current Alcohol Intake
Alcohol Referral
Comments
Alcohol Problem

DRUGS RELATED DATA
Injected Illicit Drugs
Drug Misuse This Pregnancy
Drugs Used(1)
Drugs Used(2)
Drugs Used(3)
Drugs Used(4)
Drugs Referral
Comments

Postnatal Assessment and Managemen

(to be assessed on Labour Ward)

2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5E.

- Any previous VTE+ ☐
- Anyone requiring antenatal LMWH ☐

→ **High risk**
At least 6 weeks postnatal prophylactic LMWH

- Caesarean section ☒
- Asymptomatic thrombophilia (inherited or acquired) ☐
- BMI > 40 kg/m² * ☐
- Prolonged hospital admission ☐
- MEDICAL COMORBIDITIES, e.g. heart or lung disease, SLE, cancer, inflammatory conditions, nephrotic syndrome, sickle cell disease, intravenous drug user ☐
- appendicectomy ☐

→ **Intermediate risk**
At least 7 days postnatal prophylatic LMWH

Note: if persisting or > 3 risk factors, consider extending thromboprophylaxis with LMWH

- Age > 35 years ☐
- Obesity (BMI > 30kg/m²) * ☐
- Parity ≥ 3 ☐
- Smoker ☐
- Any surgical procedure in the puerperium ☐
- Gross varicose veins ☐
- Current systemic infection ☐
- Immobility, e.g. paraplegia, SPD, long-distance travel ☐
- Pre-eclampsia ☐
- Mid-cavity rotational operative delivery ☐
- Prolonged labour (>24 hours) ☐
- PPH > 1 litre or blood transfusion ☐

→ 2 or more risk factors

→ < 2 risk factors

Lower risk
Mobilisation and avoidance of dehydration

Antenatal and postnatal prophylactic dose of LMWH - Drug of Choice in GGC is enoxaparin

* Drug calculations based on most recent weight

Weight < 50 kg = 20 mg enoxaparin **or** 2500 units dalteparin **or** 3500 units tinzaparin daily ☐
Weight 50–90 kg = 40 mg enoxaparin **or** 5000 units dalteparin **or** 4500 units tinzaparin daily ☐
Weight 91–130 kg = 60 mg enoxaparin **or** 7500 units dalteparin **or** 7000 units tinzaparin daily ☐
Weight 131–170 kg = 80 mg enoxaparin **or** 10000 units dalteparin **or** 9000 units tinzaparin daily ☐
Weight > 170 kg = 0.6 mg/kg/day enoxaparin **or** 75 units/kg/day dalteparin **or** 75 units/kg/day tinzaparin ☐

Key

ART = assisted reproductive therapy, *BMI = body mass index (based on most recent weight), gross varicose veins = symptomatic, above the knee or associated with phlebitis/oedema/skin changes, immobility = ≥ 3 days, LMWH = low-molecular-weight heparin, OHSS = ovarian hyperstimulation syndrome, PPH = postpartum haemorrhage, SLE = systemic lupus erythematosus, SPD = symphysis pubis dysfunction with reduced mobility, thrombophilia = inherited or acquired, long-distance travel = > 4 hours, VTE = venous thromboembolism

Postnatal Assessment of Risk Factors

	Red High	Amber Intermediate	Green Low
Postnatal Assessment	☐	☒	☐

Assessed by: Name DONOGHUE

Signature

Designation FY2 Date 24/2/17

NHS GG&C Obstetric Guideline - Thromboprophylaxis during Pregnancy and the Puerperium - Risk Assessment & Management

NHS Greater Glasgow and Clyde

Antenatal Assessment and Management

(to be assessed at booking and repeated if admitted)

- Single previous VTE+
  - Thrombophilia or family history ☐
  - Unprovoked/estrogen-related ☐
- Previous recurrent VTE (> 1)

→ **High risk**
Requires antenatal prophylaxis with LMWH

- Single previous VTE with no family history or thrombophilia ☐
- Thrombophilia + no VTE ☐
- MEDICAL COMORBIDITIES, e.g. heart or lung disease, SLE, cancer, inflammatory conditions, nephrotic syndrome, sickle cell disease, intravenous drug user ☐
- Surgical procedure, e.g. appendicectomy ☐

→ **Intermediate risk**
Consider antenatal prophylaxis with LMWH

- Age > 35 years ☐
- Obesity (BMI > 30kg/m²) * ☐
- Parity ≥ 3 ☐
- Smoker ☐
- Gross varicose veins ☐
- Current systemic infection ☐
- Immobility, e.g. paraplegia, SPD, long-distance travel ☐
- Pre-eclampsia ☐
- Dehydration/hyperemesis/OHSS ☐
- Multiple pregnancy or ART ☐

→ **3 or more risk factors**
2 or more if admitted

→ **< 3 risk factors**

→ **Lower risk**
Mobilisation and avoidance of dehydration

Antenatal and postnatal prophylactic dose of LMWH - Drug of Choice in GGC is enoxaparin

* Drug calculations based on most recent weight

Weight < 50 kg = 20 mg enoxaparin **or** 2500 units dalteparin **or** 3500 units tinzaparin daily
Weight 50–90 kg = 40 mg enoxaparin **or** 5000 units dalteparin **or** 4500 units tinzaparin daily
Weight 91–130 kg = 60 mg enoxaparin **or** 7500 units dalteparin **or** 7000 units tinzaparin daily
Weight 131–170 kg = 80 mg enoxaparin **or** 10000 units dalteparin **or** 9000 units tinzaparin daily
Weight > 170 kg = 0.6 mg/kg/day enoxaparin **or** 75 units/kg/day dalteparin **or** 75 units/kg/day tinzaparin

Antenatal Assessment of Risk Factors

Patient Addressograph label

	Red High	Amber Intermediate	Green Low
Booking Visit	☐	☐	☐
Antenatal Admission	☐	☐	☐

Thromboprophylaxis Required Yes ☐ No ☐

Assessed by: Name_____

Signature_____

Designation_____ Date_____

Key: Red – Obstetric Consultant Clinic Referral required
Amber – Obstetric Consultant Clinic Referral required
Green – No thromboprophylaxis required

Note *Risk assessment and management of Thromboprophylaxis is an ongoing process throughout pregnancy and the post-natal period

2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

MATERNITY DAY ASSESSMENT

Date 13·2·17 Time 1420
Referral [illegible] Gestation 37+3

URINALYSIS
13/02/2017 14:53
No: 31.
Pat. ID:

*BIL	15	umol/l	+
UBG	norm		
KET	neg		
ASC	0.2	g/l	+
GLU	norm		
PRO	neg		
ERY	neg		
pH	6		
NIT	neg		
*LEU	75	Leu/ul	++
SG	1.025		

Fetal Assessment

CTG: Yes ☐ No ☑
Comments: Full AN assessment 9·2·17.
Active baby.

Ultrasound

Yes ☐ No ☑
Comments:

MATERNAL ASSESSMENT

Time 1425				HB	
BP	124/74 (93)	123/71 (92)	119/75 (93)	WCC	
			122/73	Platelets	
Pulse 88 bpm		SpO2 95%	Temp 36·5	RR 16.	Blood glucose	Chloride
Fundal height 36cm		3 from 9/2/17 @ clinic.			AST	Urea
Presentation ceph					ALT	Creatinine
FH		FMF +v			Alk Phos	Protein
Oedema Nil					GGT	Albumin
Headaches Nil					Urinary Creatinine	Bilirubin
Visual Disturbances NIL					Ratio	Urate
Urinalysis: Protein -ve					MSSU	Basal RBS
Glucose norm		Blood -ve			Microalbumin	2nd RBS
Leucocytes ++		Ketones -ve.			HVS/LVS	HbA1C

Midwife Comments

S - 29 yr old, P0+1, 37+3, A NEG. Feels well, any ptaudit of PET. Baby active
- BP profile.

B - POH 2015 miscarriage D+C
PMH - Adult respiratory distress syndrome 2011
- tremour s/b neurologist thought benign 2012
- Anxiety on ~~mirtazapine~~ mirtazapine ~~and~~ / propanalol
- NKDA
current pregnancy - MAU 27+2 H/o abdo + chest pain, SOB, ?PE, VQ -ve.
- SW
- PNMH
- SNIPS.
- EL CS 24/2

A - reports well
- obs as charted. BP average 122/73 (booking 117/79)
- FMF ✓
- AN check 9/2/17
- urinalysis NAD

R - Medical rv. ✓

Signature ST1 M Paterson L PATERSON

Time of discharge 5.40 Follow up 17·2·17 PreOp 13.15
16·2·17 Dr Ellis

Doctors Comments and Management Plan

13/2/17.

Borderline ↑ DBP 9/2/17 → 90

(N) profile today
feels well.
no protenuria

(P) No further BP monitoring
Review ANC this week.

MARTIN
ST3

Signature_____ Designation_____

MIS 170180/3 MDAS

Planned Caesarean Delivery Enhanced Recovery Pathway

2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

Age	26	**Parity**	0+1	**ASA**	1
No. of prev Sections	0	**Pre-op Hb (g/dl)**	131	**Attended Pre-op Education**	X
BMI at booking	31.4				

Cons Anaesthetist GMC No: 4266651 **Cons Obstetrician GMC No:** .....

Operation: (LUSCS) +/- sterilisation.

Other : .....

Anaesthetic: (Regional) / General

Time into theatre: 24/12/17 __:__

Time of anaesthesia: 24/12/17 __:__

Last ate: __/__/____ __:__

Last drank: __/__/____ __:__

Time out of theatre: __/__/____ __:__

Estimated blood loss: 400 mls.

Indication:

- ☐ 1x previous caesarean
- ☐ >1 previous caesarean
- ☐ Breech
- ☐ Previous traumatic vaginal delivery
- ☑ Maternal request
- ☐ Multiple pregnancy
- ☐ Abnormal placentation
- ☐ Maternal co-morbidity
- ☐ Fetal morbidity

Other:

- ☐ .....

Time first ate after delivery: __/__/____ __:__

Time IV fluids discontinued: __/__/____ __:__

Time mobilised (stood out of bed): __/__/____ __:__

Time of catheter removal: __/__/____ __:__

Re-catheterised? Yes / No

Reason for re-catheterisation: Urinary Retention / Assess Urine Output / Other: .....

Rescue antiemetic given? Yes / No

Time of discharge: __/__/____ __:__

Infant feeding at discharge: breast / mixed / formula

Readmitted within 30 days? Yes / No __/__/____

Reason for readmission: Maternal / Neonatal Comment: .....

Prescribed antibiotics for a post-op wound infection within 30 days of delivery? Yes / No

NHS Greater Glasgow and Clyde

Anaesthesia for labour and delivery

*This is a scannable form - **PLEASE DO NOT USE LABELS.***
Please keep all text within the boxes and mark boxes with an X when required.

Hospital code 1

1 CHI 2505876061 Name WENDY MCLEISH

2 Date of 1st procedure (please use dd/mm/yyyy) 24/02/2017 Time of 1st procedure (24hr clock) 15:20

3 Mode of Delivery: SVD ☐
Instrumental ☐
1) Emergency CS ☐ (immediate threat to life of woman or fetus)
2) Urgent CS ☐ (maternal or fetal compromise which is not immediatly life threatening)
3) Scheduled CS ☐ (needing early delivery but no maternal or fetal compromise)
4) Elective CS ☒ (at a time to suit the patient and maternity team)

4 Was mother high risk? Yes ☒ No ☐ If Yes, reason High BMI (≥40) ☐ Other ☒

5 Did woman labour? Yes ☐ No ☒

LABOUR ANALGESIA

6 Anaesthetist(s) present (Please complete your assigned code) code ___ code ___ code ___

7 1st procedure Epidural ☐
Remifentanil PCA ☐
CSE ☐
Other ☐
Other, please specify

8 Indicate if time lapse request to procedure was over 30 minutes: 30-60 minutes ☐ > 60 minutes ☐

9 **COMPLICATIONS** Resite labour epidural ☐ Reason
Inadequate block ☐
Failed epidural - convert to Remi PCA ☐
Failed epidural - convert to CSE ☐
ADP ☐
Remifentanil PCA discontinued ☐
Intrathecal catheter used for labour analgesia ☐

10 Location of delivery Delivery in labour ward ☐ Delivery in theatre ☐

11 Epidural Placement Bundle 18g Tuohy ☐ LoR Saline ☐ Best position ☐ Consider Syntocinon Off ☐

Est. Depth Space (cm) <4 ☐ 4-8 ☐ >8 ☐ Actual Depth Space: ___ cm N/A ☐

Redrape/Reassess after 4? Yes ☐ N/A ☐

ASK MOTHER

12 *Missed to follow up* ☐

*How satisfied were you with **labour** analgesia?*

Labour analgesia Excellent ☐ Good ☐ Adequate ☐ Poor/failed ☐

PTO

Any queries contact: Clinical Efectiveness Department, CGSU 0141 452 (8)2289 / 0141 201 (8)9340

Record 384

DO NOT FILE IN CASENOTES

FILE IN ANAESTHETISTS OFFICE

OPERATIVE ANAESTHESIA

13 Anaesthetist(s) present (Please complete your assigned code)

code	code	code	code
015	187		

14 1st procedure
- Spinal [X]
- Epidural top up [ ]
- CSE [ ]
- GA [ ]
- Other [ ]

Other, please specify:

15 Indication(s):
- Instrumental [ ]
- 1) Emergency CS [ ]
- 2) Urgent CS [ ]
- 3) Scheduled CS [ ]
- 4) Elective CS [ ]
- MROP [ ]
- Other [ ]

Other, please specify:

16 **COMPLICATIONS** (tick all that apply)

- Failure - Convert to Spinal [ ]
- Failure - Convert to GA [ ]
- Failure - Resite Spinal [ ]
- Paraesthesia [ ]
- High Block (≥T2 + SpO2<94) [ ]
- Epidural top up failed [ ]
- No epidural top up attempted [ ]
- ADP [ ]
- Operative Pain Needing Treatment [ ]
- Aspiration [ ]
- Other [ ]

Other, please specify:

17 Postnatal review date and time — Date of postnatal review: [ ][ ] / [ ][ ] / [ ][ ][ ][ ] Time of postnatal review: [ ][ ] : [ ][ ]

Discharge before review [ ]

ASK MOTHER

18 *How satisfied were you with anaesthetic for **delivery**?*

Delivery anaesthesia Excellent [ ] Good [ ] Adequate [ ] Poor/failed [ ]

19 *Did you experience nausea?* Yes [ ] No [ ]

*If **Yes**, specify location(s)* In theatre [ ] In recovery [ ] On ward [ ]

20 *Since your delivery has the medication you have been provided with enabled you to do what you wanted to for yourself and your baby?*

Yes [ ] Mostly [ ] Very little [ ] Not at all [ ]

21 *Did you request extra analgesia?* Yes [ ] No [ ]

22 Need further review Yes [ ] No [ ]

If Yes, comment

Any queries contact: Clinical Efectiveness Department, CGSU 0141 452 (8)2289 / 0141 201 (8)9340

NHS Greater Glasgow and Clyde

Admission Front Sheet

Personal Details

Name:	MISS Wendy McLeish	**CHI Number:**	2505876061
Sex:	Female	**Episode No:**	I0002058539
Board Of Residence:		**Date of Birth:**	25/05/1987
Ethnicity:		**Overseas Vistor:**	
Occupation:		**Age:**	29y
A.K.A.:		**Marital Status:**	Never Married (Single)
Phone: (H):	07769733984	**Country of Birth:**	
(W):		**Religion:**	Any other religion
(M):	07454750438		
Home Address:		**Temporary Address:**	0/1 51 COXTON PLACE Glasgow Lanarkshire G33 5EJ

Admission Details

Adm Date:	24/02/2017	**Ward:**	PRM (MAT) Ward 73 - Obstetric Assessment Unit
Adm Time:	07:24	**Room:**	
SignificantFacility:	11-Other	**Bed:**	
Payor:	NHS	**Adm Type:**	In Patient
Consultant:	Dr Elizabeth Ellis		
Specialty:	Obstetrics		

Referral/GP Details

Attend Source:
Referring Doctor: AL McGinley

Contact Details

Preferred:		**Phone: (H):**	
		(W):	
		(M):	
		Relationship:	

Allergy Details

Allergen	Severity

97315

Elective LUSCS Record

Please use black ink

Confidential

Personal details

CHI .....

Likes to be called

Date and time of Caesarean section 24/2/17 :

Indication MAT REQ

Consultant Obstetrician DC ECCLES

Admission Ward 73

Affix label here or Unit No

2505876061

Surname/family n. MCLEISH F

First name(s) Wendy 25/05/1987

Date of birth

Address 0/1 51 COXTON PLACE

Glasgow, Lanarkshire

G33 5EJ

Postcode

Current Pregnancy Date of Assessment 16/2/17 Time 15:00

Singleton/multiple:	Age 29	Parity 0+1
EDD:	BP 120/80	Pulse 76
Gestation at Caesarean section: 39		
Blood Group: A -VE	BMI 31.4	FH 120-140
Irregular antibodies:		
Height 1.58 cms	Booking Weight 78.5 kg	Current Weight 78.8 kg

Number of previous Caesarean sections? NIL Any complications at Caesarean section? .....

Is interpreter required? No ☑ Yes ☐ Language required ENGLISH

Has interpreter been arranged? No ☑ Yes ☐ N/A ☐ Contact name/ .....

telephone no .....

Investigations required

FBC ☐ Blood Group & Save ☐ Cross matched No ☐ Yes ☐ Number of units ☐ Date / / Time

Others

Comments .....

Pre-operative Medication

Drug	Dose	Route	Prescription Signed	Tablets given to patient
Ranitidine	150mg x 2	Oral	✓	✓

Neonatal Notes Required Yes ☐ No ☐ Baby Unit Number .....

Any specific advice pre CS [eg NNU to be informed, scan to be performed, etc]:

.....

Pre Anaesthetic Questionnaire

Have you had an anaesthetic in the past? Please circle Spinal Epidural General No

Planned anaesthetic .....

I agree to have nothing to eat six hours before surgery. Water may be drunk up to two hours before surgery.

Signed: W McLeish Date 16/2/17

Witnessed: ..... Date 16/2/17

Admission date: 24/2/17

Admitted by: .....

Maternity Notes Yes No

Birth Partner: JAMES WALD Relationship: PARTNER

Current Medication: .....

Date / / Time BP: ..... Pulse: ..... FH: .....

Please complete the "Whose Signature" page at the back of this record

Elective LUSCS Record pre-operative information

	Yes	No
Have you had any problems with anaesthetics?		✓
Do you have any family members with a history of anaesthetic problems? DONT KNOW		
Are you taking any medication, drugs, inhalers or tablets? Please specify: PROPANOLOL, 10mg OCCASIONALLY AMITRIPTYLINE 45mg NOCTE		✓
Do you have any allergies? Please specify:		✓
Have you had any complications in this or any previous pregnancies? Please specify		✓
Have you had any problems with your heart, high blood pressure or protein in your urine? Please specify: ONE OFF OCCASION OF ↑BP.		
Do you get chest pain after exercising or climbing stairs?		✓
Have you had trouble with your breathing or do you take medicine for a breathing problem? Please specify: ASTHMA R.O.S	✓	
Do you smoke? If yes, how many per day?		✓
Do you have a cough or produce phlegm?		✓
Do you drink alcohol? If yes, how many units per day?		✓
Have you been drinking alcohol in the last 3 months?		✓
Were you on antenatal Thromboprophylaxis?		✓
Instructions given when to stop	N/A	
Do you use recreational drugs? If yes, describe:		✓
Do you have loose teeth, caps or dentures? TWO FRONTAL ✓ WEEKS.	✓	
Do you have any neck or jaw stiffness?		✓
Have you ever had any convulsions, fits, blackouts or funny turns? Date of last episode:		✓
Have you had any jaundice, hepatitis or liver disease?		✓
Do you have diabetes? During pregnancy only? Controlled by: Diet Insulin		✓
Have you had any antenatal admissions in this pregnancy? Please Specify:		✓
Have you had any other illnesses? Please specify:		✓
Do you have a history of Group B Strep?		✓
Do you have a prosthesis or a pacemaker?		✓
Do you have any physical disabilities?		✓
Have you had any illnesses from which you have not fully recovered? Please specify:		✓
Advised to avoid shaving/waxing prior to the operation to reduce infection		✓

Consent Form

Name of proposed procedure or course of treatment Caesarean Section
(Include brief explanation if medical term not clear)

Statement of health professional
(to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient, in particular, I have explained:
The intended benefits: *Delivery of baby/babies through a cut in the abdomen (tummy) and uterus (womb) in a situation where the risks of vaginal delivery are more than those of a caesarean section operation*

Serious risks*:

- Emergency hysterectomy, 7–8 women in every 1000 (uncommon)
- Need for further surgery at a later date, 5 women in every 1000 (uncommon)
- Admission to intensive care unit, 9 women in every 1000 (uncommon)
- Increased risk of a tear in the womb in future pregnancies, 2–7 women in every 1000 (uncommon)
- Developing a blood clot, 4–16 women in every 10 000 (rare)
- Stillbirth in future pregnancies, 1–4 women in every 1000 (uncommon)
- In a future pregnancy, the placenta covers the entrance to the womb (placenta praevia), 4–8 women in every
- 1000 (uncommon)
- Injury to the urinary system, 1 woman in every 1000 (rare)
- Death, approximately 1 woman in every 12 000 (very rare)

Frequent risks*:

- Common: persistent wound and abdominal discomfort, repeat caesarean section in subsequent pregnancies, readmission to hospital, minor cuts to the baby's skin
- Uncommon: haemorrhage, infection

Any extra procedures which may become necessary during the procedure
blood transfusion other procedure (please specify) hysterectomy, repair to damaged organs

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

The following leaflet/tape has been provided Having a Caesarean Section

This procedure will involve (please circle):
general and/or regional anaesthesia local anaesthesia sedation

Signed Elizabeth C Ellis Date 9.2.17.

Name (PRINT) ELIZABETH ELLIS Job title Associate Specialist

Contact details (if patient wishes to discuss options later) _____

Woman's Consent

Signed [illegible] Date 24/2/17

Name (PRINT) [illegible]

Statement of interpreter (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe she can understand

Signed _____ Date _____

Name (PRINT) _____

* Royal College of Obstetricians and Gynaecologists. Consent advice no. 7: caesarean section. 2009 [cited 2011 Sept 22]; Available from: http://www.rcog.org.uk/files/rcog-corp/CA7-15072010.pdf

Adapted from RCOG Consent Advice No 7 2009

Findings on admission

Date	Time	Details
Please use 24 hour clock and sign each entry and insert your details in the 'Whose signature?' section on the back cover.		
24/2/17	1515	OTO 39wks ELCS maternal request
	152	Verflon sited by Dr Lichfield
	1533	Spinal in situ
	1537	FHH with pinard — G Pamp MW
	1540	catheterised with carsuit
	1546	Knife to skin
	1550	ELCS of live female
		placenta & membranes delivered
		uterus confirmed empty
		abdomen repaired in layers pdysorb
		throughout. — G Pamp MW
		capysan to skin
		EBL — — G Pamp MW

WHO Surgical safety checklist for maternity cases only

(adapted from the WHO Surgical safety checklist)

SIGN IN (to be said out loud after the arrival of the woman and the midwife)

- ☐ Has the woman confirmed her identity, procedure and consent?
- ☐ Caesarean section category? 1 2 3 4
- ☐ Is the anaesthetic machine and medication check complete?
- ☐ Does the woman have a known allergy?
- ☐ Is there a difficult airway risk?
- ☐ Are blood products available?
- ☐ Has the appropriate/recent antacid prophylaxis been given?
- ☐ Is the resuscitaire checked and ready?
- ☐ Has the neonatal team been called, if needed?

TIME OUT (to be said out loud before skin incision)

- ☐ **Have all team members introduced themselves by name and role?**
- ☐ **What is the woman's name?**

Obstetrician:

- ☐ What additional procedure(s) are planned?
- ☐ Are there any critical or unusual steps you want the team to know about?
- ☐ Are there any conerns about the placental site?

Anaesthetist:

- ☐ Are there any specific concerns?

Scrub practitioner:

- ☐ Has the sterility of the instruments been confirmed?
- ☐ Are there any equipment issues or concerns?

Midwife:

- ☐ Are cord blood samples needed?
- ☐ Is the urinary catheter draining?
- ☐ Has the FSE been removed?
- ☐ Has VTE prophylaxis been undertaken?

SIGN OUT (to be said out loud before the woman leaves theatre)

Practitioner verbally confirms with the team:

- ☐ Has the name of the procedure and any additional procedures been recorded?
- ☐ Has it been confirmed that instruments, swabs and sharps counts are correct?
- ☐ Have specimens been labelled?
- ☐ Has blood loss been recorded?

Obstetrician, Anaesthetist, Midwife:

- ☐ Have the key concerns for recovery and management been discussed?
- ☐ Has post-operative VTE prophylaxis been prescribed?
- ☐ Have antibiotics been given?

Anaesthetist and theatre team:

- ☐ Have any equipment problems been identified that need to be addressed?

Midwife:

- ☐ Has the baby/babies been labelled?
- ☐ Have relevant cord bloods been taken, if relevant?
- ☐ Have cord gases been recorded, if required?

Routine Surveillance of Infection Care Bundle

If at all possible avoid hair removal; if hair removal is necessary, avoid the use of razors

	Yes	No
Were clippers used		
Were Prophylactic antibiotics prescribed as per local antibiotic policy/SIGN guideline, for the specific operation category.		
Were the antibiotics administered within 60 minutes prior to the operation.		
Was the patient's body temperature normal throughout the operation (excludes cardiac patients).		
Was the patient's blood glucose level normal throughout the operation (diabetic patients only).		

List all members of the operation team and their role

Name	Role
Gillian Powys	mw Floor
Dawn Short	SHO Reg ans
Emma Donnachie	FY1
Gillian Stewart	anx
Resmol Joseph	ODP
Gillian Stewart	
Ashan Fali	anesth
Daisie Collins	mw scrub

Details of operative delivery

Type of delivery: Elective LUSCS.

Indication(s): Maternal Request
Primigravida
Robson 2C.

Operator: Sholt (STR)

Assistant: Donoghue (tyr.

Decision made / / :
Procedure started / / :
Time of delivery / / :
Procedure concluded / / :
Location

RCA/RCOG classification of urgency of caesarean * 4

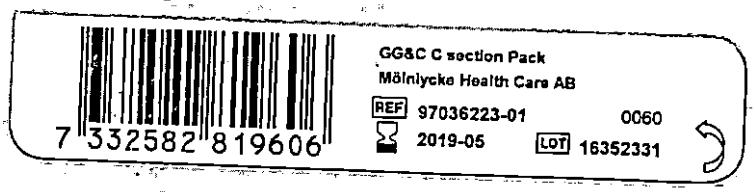
Sterilisation
Anaesthetist

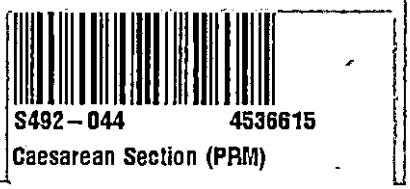
Operation notes

Date	Time	Details
Please use 24 hour clock and sign each entry and insert your details in the 'Whose signature?' section on the back cover.		
E 4/4/17	1620	findings: live infant female born in good condition EBL = 400ml (N) tubes & ovaries Procedure: spinal anaesthesia, ~~GA~~, sterile prep & drape, IDC. Incision 2cm above pubic symphysis Pfannenstiel entry into abdomen Bladder retracted down arcuate hysterotomy Cephalic presentation delivered c fundal pressure. Placenta CCT uterus confirmed empty & closed in 2 layers Polysorb to sheath subcuticular to skin. Opsite dressing PV toilet minimal PR Voltarol ✓ PTO

* 1 Emergency: immediate threat to life of woman or fetus; 2 urgent: maternal or fetal compromise which is not immediately life threatening; 3 Scheduled: needing early delivery but no maternal or fetal compromise; 4 Elective: at a time to suit the patient and maternity team

Instruments Tracking Label





	Yes	No
Swabs correct		
Needles correct		
Instruments correct		
Sutured by	Supervised by	

Signed (scrub staff)

Signed (floor staff)

Comments

st-operative instructions

Revised thrombosis risk

☐ Low ☐ Moderate ☐ High

Measurement and size of TED stockings

Details

Actions required

Catheter ☐ In/Out ☐ Indwelling

Details

ıtoperative care

☐ Ward ☐ High dependency

☐ Intensive care ☐ Transfer to other hospital

Other

Ensure all relevant prescribing undertaken

Oxytocics

Details

Antibiotics

☐ Prophylactic ☐ Other ☐ None

Details

Analgesia

Details

Details completed & relevant prescribing by

Print name

Comments

Please complete the "Whose Signature" page at the back of this record

Birth summary - details

Mode of delivery ELCS on Fri day 24/2/17 at 15:50 Sex F

Indication maternal request Presentation vx Location TH1

Livebirth/Stillbirth Gestation 39 Birthweight 2805 g OFC ..... cm

Anaesthesia ☑ Spinal ☐ Epidural

☐ Combined spinal/epidural ☐ General

☐ Pudendal block ☐ Other

Placenta, cord & membranes delivery:

Controlled cord traction ☐ Maternal effort ☐

Manual removal

Placenta appears ☑ Complete ☐ Incomplete

Membranes appear ☑ Complete ☐ Incomplete

Cord blood taken on 24/2/17 at 16:00

Indication Rh neg

Number of umbilical cord vessels 3

Sent to pathology ☑ No ☐ Yes

Indication

Comments

Routine Oxytocic drug administered	Dose	Route
Syntocin	20	IV

Blood loss ml

Blood transfusion/products received ☑ No ☐ Yes

Details

Post delivery Maternal observations

First set on / / at :

Temperature °C Pulse BP /

Pain/analgesia

Fundus Lochia

Second set on / / at :

Temperature °C Pulse BP /

Pain/analgesia

Fundus Lochia

Urinary function

Mother transferred on / / at :

To

Reason

Labour and birth summary - baby

APGAR	1min	5mins	10mins
Activity (muscle tone)	2	2	
Pulse	2	2	
Grimace (reflex, irritability)	2	2	
Appearance (skin colour)	1	1	
Respiration	2	2	
Total scores			
Time to first breath	At birth		

Resuscitation (tick all that apply)	
Nil	✓
Inflation breaths	
Ventilation breaths	
Suction under direct vision	
Mask & IPPV	
Drugs-specify below	
Cardiac massage	
Endo-tracheal tube	
Description of baby at birth/resuscitation details	
Other-specify below	
Resuscitation performed by	
Sign	

Cord pH results No pH taken ☐

Venous pH Arterial pH

Base Excess Base Excess

Skin-to-skin contact offered / / at : ☐ Declined

Ended / / at :

Reason discontinued

Comments

First feed offered / / at :

Type of feed

Comments

Baby identification checked & correct by
Signed G Lamp

Please complete the "Whose Signature" page at the back of this record

NHS Greater Glasgow and Clyde — Intraoperative Accountable Items Count Record

Date 24.2.17

ADD 2505876061
MCLEISH F
Wendy 25/05/1987
NAI 0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ
DO

HOSP /CHI no.

WARD LW

HOSP- PRMH

THEATRE- 1

COUNTS	Scrub Nurse(s) Print Name	Circulating Nurse(s) - Signature & Print name
PRE - OP SWAB COUNT CORRECT	J Collins	Gillian Stewart G Stewart
PRE - OP INSTRUMENT COUNT CORRECT	J Collins	Gillian Stewart G Stewart
FINAL SWAB COUNT CORRECT	J Collins	Gillian Stewart G Stewart
FINAL INSTRUMENT COUNT CORRECT	J Collins	G Stewart
FINAL SWAB DISPATCH COUNT CORRECT	J Collins	G Stewart

SCRUB NURSE VERIFICATION - PLEASE SIGN ON PAGE UNDERNEATH.

I have reviewed this count sheet and can verify my count(s) correct
SCRUB NURSE 1- SIGNATURE - J Collins
SCRUB NURSE 2 SIGNATURE -
To be signed by replacement scrub nurse if applicable

HANDOVER COUNT IN EVENT OF REPLACEMENT OF SCRUB NURSE DURING PROCEDURE

	Outgoing Scrub Nurse - Print Name	Incoming Scrub Nurse - Print Name	Circulating Nurse(s) - Signature & Print name
OUTGOING COUNT *To be completed for permanent and temporary replacement*			
INCOMING COUNT *To be completed for temporary replacement*			

OPERATION: Elective LWCS

TALLY OF EACH ITEM USED - ADD ANY ITEMS SPECIFIC TO YOUR SPECIALITY

Swabs (2x2)		Tapes				ITEMS REMAINING IN SITU (Type & Number)
Swabs (10x10)	10	Sloops/Slings				
Abdominal packs	10	Bulldogs				
Sutures	4	Shods				
Blades	2	Tibbs Cannula				
IV needles		Ports				
Syringes		Staple Gun Inserts				
Dis[illegible]-a-pad	1	Spears				
Diathermy pencil	1	Throat packs - Anae				
Diathermy tips	1	Throat packs - Scrub				
Scratch pad	1	Retrieval Bag (Bert)				
Reels		Digital Tourniquets				
Patties						
Pledgelets						

BRILLANT AquaFlate REF A310114
All-Silicone
Long-Term
(up to 12 weeks use)
Standard, 2-way Foley
SIZE Ch. 14 (4.7mm) / 10ml
LOT 16IT28
2021-08
Teleflex Medical, IDA Business & Technology Park, Dublin Road, Athlone, Co. Westmeath, Ireland

DISCREPANCY IN COUNT - ACTIONS AND OUTCOME

COUNT IN WHICH DISCREPANCY OCCURRED

DETAILS

ACTIONS TAKEN AND OUTCOME (I.E. SWABS ISOLATED, SEARCH UNDERTAKEN, WOUND EXPLORED, X - RAY TAKEN) -

SCRUB NURSES SIGNATURE IF COUNT STILL INCORRECT FOLLOWING ALL POSSIBLE ACTIONS

SURGEONS SIGNATURE IF COUNT INCORRECT FOLLOWING ALL POSSIBLE ACTIONS

PLEASE INSERT TRACEABILITY STICKERS ON BACK OF COPY- TO STAY IN THEATRE.

mu • 240937 V1.0 • GGC0062

Princess Royal Maternity

NHS Greater Glasgow and Clyde

Department of Anaesthesia

Obstetric Anaesthesia/Analgesia

SURNAME
FORENAME
CHI NO.
AGE
WARD

2505876061 F
MCLEISH 25/05/1987
Wendy
0/1 51 COXTON PLACE
Glasgow, Lanarkshire G33 5EJ

DATE 24/02/2017

PRE-OP INSTRUCTIONS

Pre-operative notes

- Pneumonia needing Trache + ECMO in 2011
- Well now. Manages 2x flights of stairs.

CONSENT / RISKS DISCUSSED

Technique	☑	Prolongs labour	☑
Failure / Indequate	☑	↑ instrumental	☑
↓ BP	☑	PDPH	☑
Motor weakness	☑	Infection	☑
U-catheter	☑	Neuro damage (temp)	☑
Pulling / tugging	☑	Neuro damage (perm)	☑
Rescue analgesia	☑	Paralysis	☐
Info card read	☐		

AIRWAY Mo > 3FB Neck ext > 90°
MP II TMD > 6.5 cm
Calder A

CURRENT MEDICATION
Mirtazepine
Propranolol
NSAIDS: OK

ASA GRADE 1 (2) 3 4 5 E

C. SECTION CATEGORY 1 2 3 (4)

ALLERGIES NKDA OK c Penicillin

PARA

WEEKS 39+

Hb 131
WBC 11·8
PLATELETS 241
DATE 2/2/17

OTHER RESULTS

HEIGHT (M) 1·58
WEIGHT (KG) 88·8
BMI 35·5
PRE-OP BP 121/91

POST-OPERATIVE INSTRUCTIONS AND NOTES

Post-op analgesia bundle Yes ☑ No ☐

EARLY EATING/DRINKING

PROCEDURE PERFORMED

ELEC

PROBLEMS FOR FUTURE REFERENCE

ANAESTHETIST A. UAL / UNCRATED

If Trainee: Consultant Present ☑ Informed ☐ Not informed ☐

SURGEON

Continuous epidural analgesia record

Technique details

Asepsis ☐ Sitting Lateral 16G/18G Level ☐

LOR to Air/Saline at ☐ cm. Catheter ☐ cm at skin

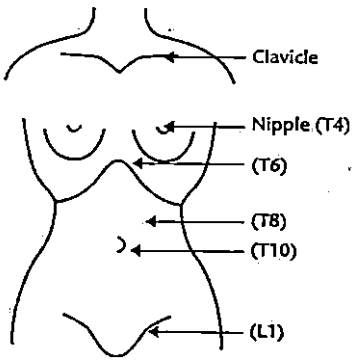
Aspiration:

Comments:

	Cumulative Dose (ml) from syringe / bag
	Volume Remaining (ml)
	Infusion (mls/hr)
	Top up No.
	Time

200
180
160
140
120
100
80
60
40

	Motor block
1	No motor block
2	Bends knee, unable to raise straight leg off the bed
3	Foot movements only
4	No movements



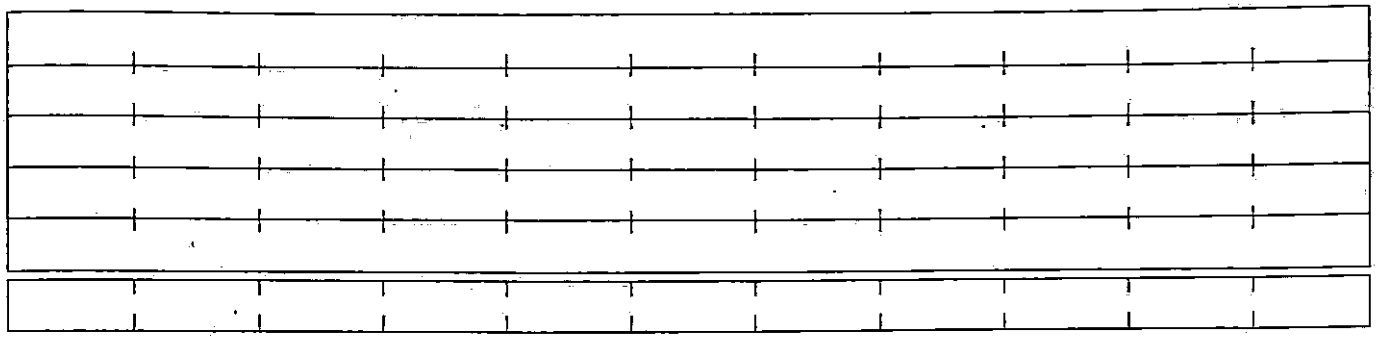
R L R L R L R L R L R L R L

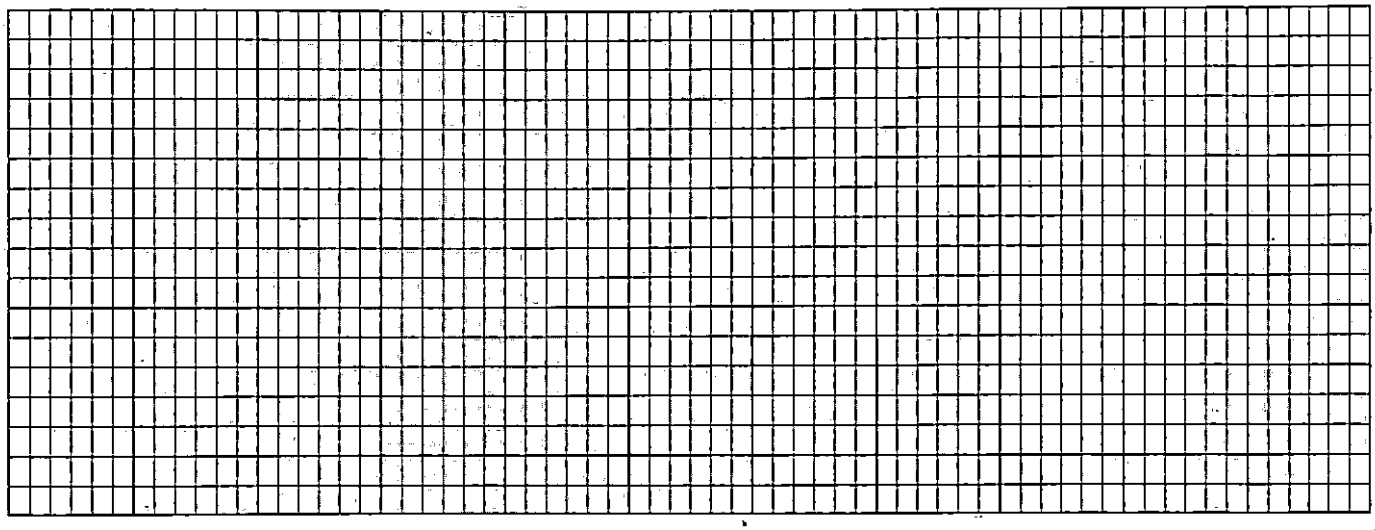
	Motor block R/L

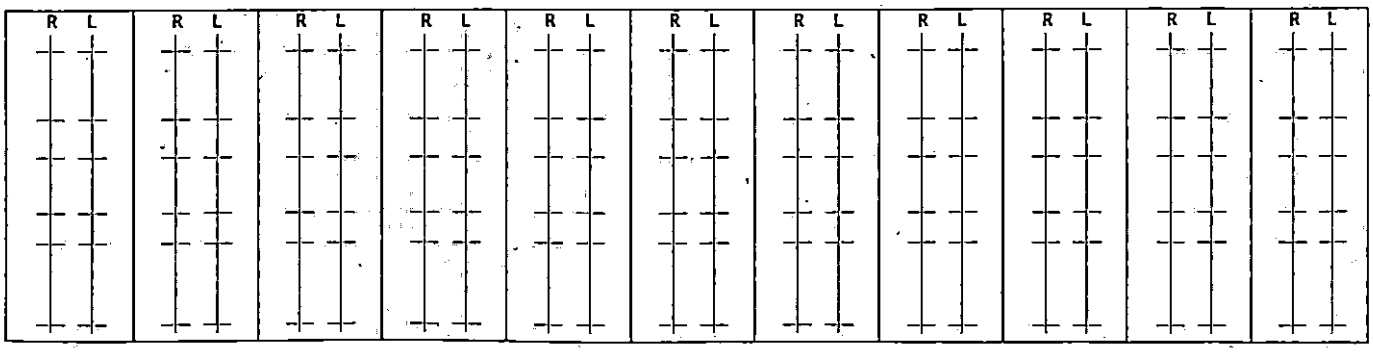
	Time	Anaesthetist Top-up	Sign.
1			
2			
3			
4			
5			
6			
7			
8			
9			

IV SITES

EPIDURAL INFUSION









Time	IV Fluids

Time	Events

Machine Check ☐ ✓

GA ☐
RSI ☐
Pre Ox ☐

Airway	Ventilation		IV Sites	
☐ Oral/Nasal ☐ Mask	☑ Spontaneous	Vt	Hand 166	(L) R
☐ Cuff	☐ IPPV	f	Forearm	L R
Tube/LMA size:	Circuit	PAW	Internal jugular	L R
Laryngoscopy Grade: 1 2 3 4	Ventilator		A-line	L R
	☐ Filter		Blood warmer/FAW	☐

Asepsis ☑ ✓ (Sitting)/Lateral Level: L3/L4

Spinal ☑ ✓ Epidural ☐ CSE ☐ LOR to air/saline at cm

LA to skin: 2mls 1% Lidocaine Catheter cm at skin

Needle: 25g Sprotte c introducer Clear CSF ☐ No paraesthesia ☐

Intrathecal Drugs: 2.5mls Heavy Marcain + 300mcg Diamorphine

Comments: Clear CSF
No paraesthesia

ECG ☑ ✓
SpO_2 ☐ ✓
NIBP ☐ ✓
$ETCO_2$ ☐
ETAA ☐
IABP ☐
PNS ☐
CVP ☐

Block height to cold (c) to sharp (s) Motor block ☑

Upper	R/L	T2
Lower	R/L	S1

Drugs	Time	15	30	45	00	15	30	45	00
SYNTO				20 IU →					
PHENYLEPHRINE					60mcg				
AUGMENTIN			1.2g						
DICLOFENAC					100 (PR)				
Dexamethasone				8mg					

Fluids:
1) Ru 1000
2) Ru 500 + SYNTO.
3) CSL 2L

EBL 400mls

SpO_2 99 RA
FiO_2
$EtCO_2$
EtAA
Temp
Fluid/events

210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0

CVP
Blood Loss
Urine Output

MIS 271302

NHS
Greater Glasgow and Clyde

Antenatal + PNA Admissions

Please file all
Antenatal and PNA Admissions
after this page

24803

ASSESSMENT - Include Advice Given

Via Dr Sucetha (Reg)

limited information

Via GP ? PE.

No other information

[redacted]sion Support

Guidelines/Pathway	☑	Discuss with other midwife	☐	Discuss with Medical staff	☐
Call back advice given	☐	Woman agrees with plan	☑		

Discussed with (insert name) .....

RECOMMENDATION

Outcome from Call

Requested to attend unit for assessment	☑	Woman requests attendance in unit for assessment	☐
Own transport No / Yes			
Ambulance required No / Yes			
Routine ☐ Urgent ☐ 999 ☐		Time arranged	hrs
Stay at home with advice to telephone if further support required (Self Care)	☐	Stays at home with follow up appointment	☐
GP Care	☐	Early Pregnancy Unit	☐
Routine Appointment	☐	Community Midwife	☐
	☐	Other	☐

Signature/Designation	MW
Print Name	JENKINS

It is recommended if a woman calls 3 times she is offered a face to face consultation

Final Outcome if Woman Attends

Referred to:

Admitted to Ward (CLU)	☐	Home – no additional follow up (Routine ANC only)	☐
Admitted to LW (CLU)	☐	Home – with follow up appointment detail	☐
Admitted to CMU/MLU	☐	Referred to GP	☐
Admitted to EPU/DCU	☐	Referred to other	☐
		If referred on, where?	

Time in		hrs	Time out		hrs

23123532

NHS SCOTLAND

MATERNITY CALL RECORD

Please complete clearly in black ink and BLOCK capitals for telephone contact made within a 24 hour period (Refer to guidance and file in main record when complete).

SITUATION	
Woman's Details:	
Surname:	McLeish
First Name:	Wendy
Patient ID/CHI:	2505826061
Home Address / Current Location	?
Post Code:	?
Calling from home address	No ☐ Yes ☐
Telephone No:	
Midwife	
Planned Place of birth	
Additional Information: i.e. Requires Interpreter	

SITUATION		
Call Details:		
Date 5/12/16	Time 1800	hrs
Call Number (circle) 1 2 3 Time call completed:		hrs
Relationship of caller to woman (include name):	Dr Sucetha	
Location of call taker	Rcy	
Parity	?	
EDD / /		
Gestation 21+		
Previous pregnancy Mode of Delivery / Comments		
SVD	☐	
Forceps/Ventouse	☐	
Caesarean Section	☐	
Relevant Obstetric/Medical History (i.e. quick labour, pre-term breech)		

BACKGROUND - Call Reason (record relevant details only)

	No	Yes		
Contractions	☐	☐	Frequency	Duration secs
SRM	☐	☐	Time of SRM Hrs	Colour:
Other PV Loss	☐	☐	Describe	
Bleeding	☐	☐	Describe	
eg	☐	☐	**Anti D required?**	**No** ☐ **Yes** ☐
Fetal Movements	☐	☐	Usual Movements felt?	**No** ☐ **Yes** ☐
Headache	☐	☐	Describe:-	
Visual disturbance	☐	☐		
Oedema	☐	☐	Describe:-	
Urinary problems	☐	☐	Describe:-	
Abdominal pain (not contractions)	☐	☐	Describe (circle)	**None / Mild / Mod / Severe**
			Pain Score (circle)	**0 1 2 3 4 5 6 7 8 9 10**

CONSIDER USING PAIN SCORE FOR UTERINE ACTIVITY

Group B Strep	☐	☐
Other, please detail		
Woman's description Anxiety/Distress		

Postnatal	**N** ☐	**Y** ☐	Temp **N** ☐ **Y** ☐	Blood loss **N** ☐ **Y** ☐	Feeling unwell **N** ☐ **Y** ☐
Delivery date / / 20			SVD ☐	Forceps/Ventouse ☐	Caesarean Section ☐

Call Reason / Clinical Summary Include relevant Information such as how long contractions present

Name _____ CHI [ ][ ][ ][ ][ ][ ][ ][ ][ ]

2505876061
MCLEISH
Wendy F
0/1 51 COXTON PLACE 25/05/1987
Glasgow, Lanarkshire
G33 5E

Date	Gestation	Antenatal/Ward 68 admission

Remember to sign each entry

5/12/16 1940 — 0+1 27+2. chest pain

referred by GP with history of left sided chest pain, abd pain

nil PR

FHF.

PMH

2011 Pneumonia
ARDS
Anxiety - on Mirtazapine
Propanalol PRN.
- PMHT, CPN, SMIP input.

POH

0+1

2015 UK 12wks good

OH

obs satisfactory

OE Abd soft
f 28 wks.
FHR by Doppler
FHR 146 bpm clear & regular
with audible
CTG commenced.

GP medical RIP

Thomas
MW Thomas

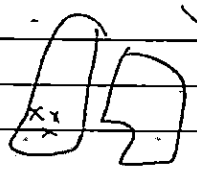
5/12/16 2240 Fy2 Brown.

Apologised for the delay.

PO+1 27+2 Chest pain.

Presented with 2/52 Hx chest pain on (R) side worsening gradually over 2 weeks.

CHI

	Gestation	Antenatal/Ward 68 admission
ber to sign each entry		
2/16		Bagel cont
		Pain (R) sided pleuritic.
		Associated with SOB on exertion of 10-20m.
		Associated cough.
		1x episode haemoptysis 2 days ago
		No palpitation.
		No leg swelling.
		No (L) sided CP.
		No syncope.
		PMHx: ITU adm c pneumonia 2011.
		Has had longstanding pleuritic pain since.
		Now + worsening cough.
		Anxiety.
		Drug Hx: Mirtazapine
		Propranolol.
		NKDA.
		POHx: PO+1.
		No issues this pregnancy.
		Non smoker.
		Non drinker.
		O/E: Looks well
		Obs Normal.
		HS 1+1+0.
		No leg swelling.
		 Crepts (R) side.
		Abdo ( ) Soft. F=D. BS✓.

Name _____ CHI

Date	Gestation	Antenatal/Ward 68 admission
Remember to sign each entry		
6.12.16	04[30]	Wendy is sleeping and settled best undisturbed just for 1st feed mw
	0750	Care by myself mw E. Richardson Nct @ bedside (Richardson) mw
	0936	MEWS = 0. Feels same as yesterday some S.O.B + described it more as back pain rather than chest pain. FMF. NVPV. Legs nAAD. Fp fundus = D, soft non tender FHR C 140bpm - CTG commenced Wendy stated she had just returned from chest x ray. mw
	1017	CTG - baseline 140bpm, accels, no decels, good variability. reassuring + ay continued.
	12.00	MR Scott Po 27+3 Chest pain / ROR ? PE (Note hx MDS / pneumonia 2011) On tx dose clexane CXR - Normal. Hb 12.4 WCC 10.5 CRP 6 Not at bedside (P) V/Q + review when back Scott 20.6 cars
	1450	MEWS = 0. Feels same as earlier + no change. Looks well. V/Q Remains @ 0930 - Wendy informed

Name WENDY MCLEISH. CHI 250587 6961

Date	Gestation	Antenatal/Ward 68 admission
Remember to sign each entry		
SR 116		Bragel adm Imp: ? Likely pneumonia / LRTI Co-existing PE ↳ However in view of episode of haemoptysis, PE should be excluded. Plan: 1) Admit. 2) Therapeutic clexane. 3) CXR ± V/Q scan #12214.
	2255	Clexane given as prescribed. NHoMo ↳ NHoWe
	2215	~~Ward round.~~ IN RETROSPECT CTG baseline 140 bpm good STV Accels no decels FMF reassuring ADC NHoMo NHoWe
	2300	Weekly Admitted to Ward 73 from MCA. Case taken over by Sister Jane Corry (bank midwife). PO+1 @ 27+2. ~ Admitted for observations following chest pain and shortness of breath. ° Abdo pain, Nil PV. FMF. Routine Observations:- BP: 110/65 MAP: 78 Pulse: 78 T: 36.7°C SATS: 96% RR: 15 Not currently experiencing chest pain. Plan for V/Q scan tomorrow. Knows to alert staff with any concerns. MW.

Name _____ CHI [| | | | | |] [| | | |]

Date	Gestation	Antenatal/Ward 68 admission
Remember to sign each entry		
6·12·16	19:00	MEWS=0 SpO_2 97%, RR16. Pain remains the same. Awaiting VQ tomorrow. Looks well. FMFV No new concerns reported. Advised to alert staff to any concerns M Bre (LEVE)
	1945	care by myself MW HBlackburn. Introductions made. No concerns at present. Plan - VQ scan tomorrow 0930. Aware to let me know if any concerns. Has been for shower. Looks well. ~~HBC~~ MW (HBLACKBURN)
	0530	Wendy has slept throughout night. No further changes or concerns ~~HBC~~ MW
	0755	care by myself MW E Richardson Nct @ bedside. (ERICHARDSON) m/w
	1105	partner returned wendy to ward but when i went to see her she was not @ bedside again. plan - chase VQ scan. - dos - (N) i/v VQ (N). m/w
	1125.	MEWS=0 Feels well. FMF a.s. (N). nil PV. very minimal S.O.B. no chest pain. ~~FW~~ o/p fundus = D, long ue, cephpres, head free soft non tender. fhr c145bpm - CTG commenced to assess fetal wellbeing
	1210	CTG reassuring - baseline 140bpm, accels, no decels, good v mobility. m/w.

2505876061
MCLEISH
Wendy F
25/05/1987

M

Name _____ CHI | | | | | | | | | | |

Date	Gestation	Antenatal/Ward 68 admission
Remember to sign each entry		
7/12/16	1630	Discharged home as no scan — no evidence of PE. Reviewed by SHO. MEWS=0. Feels well. USS + ANC assessment as planned. Knows to call MEAU if any concerns. * no hand held notes

MIS 170180-1 cont' sheet

NHS
Greater Glasgow and Clyde

Postnatal Notes

Please file intra Postnatal notes after this page.

24803

Name _____ CHI _____

Date	Postnatal
Remember to sign each entry	

2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

24/2/17 23:10 ST1 Hopper

ATSP as feeling "shaky" when sitting up. Feels better lying down
PO+O, ELCS today for maternal request. 4pm
Denies pain, denies SOB/Cough/Chest pain.
No fever. No dizziness.
Minimal lochia.
Has eaten + drank since. Toast and pain killers recently.
Vomited following toast earlier
O/E -
HR 70, BP 122/66, RR 14, Sats 95% on air
Pulse Reg. HS 1 + 11 + 0
Chest Clear.
Abdo SNT
Uterus firm + contracted
NO T/ Mild staining (R) hand & dressing looks old
Plan - Check Temp. - 36.6°C
Check BM
Encourage oral intake, Eat + Drink.
FBC made.
Review if further concerns

HOPPER

26/2/17 DISCUSSED WITH REGISTRAR
DECIDED INFANT, WIENLO
THE JAR" BOUNCES

26/2/17 Wendy discharged home with baby. PNMHT contacted - closed at present, message left as pt flu in community in PIN period.

dmmeanslm
(CMENZAN),

170180/5 cont sheets green 80g

Name _____ CHI

2505876061
MCLEISH Wendy F 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

Date	Gestation	Antenatal/Ward 68 admission
Remember to sign each entry		
24.02.17	0700	Admitted to ward 73 for
	S-	ELLUSCS
		POTØ1 Maternal request at 39.1/40
	B-	POH - 2015 misc at 12/40.
		PMH - Previous adult respiratory distress syndromes following pneumonia induced coma.
		H10 Anxiety and depression
		BMI - 31.4.
		Allergies - nil
		Meds ~~absent~~ Ppt. Propanolol
		Blood group - Rh Neg.
		USS - 26/10/16 NAD.
	A-	On admission - Appears well
		BP131/70 P79 T36.5 RR15Sa°2.99%.
		on palpation - fundus = dates
		long lie, cephallic presentation. 4/5ths palpable. Abdo soft non-tender. Nil PV. FMF by mum ✓ FHH 138BPM
		Loud and regular with dioptone for 1 minute.
	R-	FBC, Cts obtained and sent to lab.
		Ted stockings measured and applied
		Obs stable. MEWS=0.
		GIP as above.
		Consent form signed
		Pre theatre checklist complete.
		Awaiting transfer. HF (mw) (HB WACKBURN)
4/2/17	1115	SR Shokt. introduction / consent agreed
	1430	FHH 140BPM prior to transfer HF (mw)

2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

ALERTS

NHS
Greater Glasgow and Clyde

This page must always be first, do **not** file anything on top.

DR MATHERS

Named Consultant:
Named Midwife:

Consultant Transferred to:

Date Changed	Signed

Allergies: No Yes
List

24803

Pregnancy Special Features:

Labour and Birth Special Features:

Notes for Anaesthetists:

Notes for Paediatricians:

Operation note: OPERATION NOTE

NHS
Greater Glasgow and Clyde
Stobhill Hospital
133 Balornock Road
Glasgow
G21 3UW
Main Switchboard: 0141 201 3000
Department: GYNAECOLOGY
Contact Tel:
Enquiries to:

Letter Date: 15/09/2015
Reference: SW/AMMCS
Dictated Date: 14/09/2015
Transcribed Date: 14/09/2015

14th September 2015

Dr. S. Wong

Stobhill Hospital
Department: GYNAECOLOGY

Surgical evacuation of retained products of conception under general anaesthetic

Findings:

7 - 8 week size anteverted uterus, adnexae NAD.

Procedure:

Cervix dilated to Hegar 8. 8 mm suction curette used, products of conception obtained for histology assessment. Sharp curette used to check cavity and confirmed to be empty, good haemostasis.

an:

Home later on today well and no follow up.

NHS Greater Glasgow and Clyde — Intraoperative Accountable Items Count Record

Date 14/9/15

ADDRESSOGRAPH

NAME
2505876061
DO MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
HO Glasgow, Lanarkshire
G33 5EJ

WA

HOSP- Stobhill/AEH

THEATRE- 5

COUNTS	Scrub Nurse(s) Print Name	Circulating Nurse(s) - Signature & Print name
PRE - OP SWAB COUNT CORRECT	SW David	I Stark
PRE - OP INSTRUMENT COUNT CORRECT	SW David	I Stark
FINAL SWAB COUNT CORRECT	SW David	I Stark
FINAL INSTRUMENT COUNT CORRECT	SW David	I Stark
FINAL SWAB DISPATCH COUNT CORRECT	SW David	I Stark

SCRUB NURSE VERIFICATION - PLEASE SIGN ON PAGE UNDERNEATH.

I have reviewed this count sheet and can verify my count(s) correct

SCRUB NURSE 1- SIGNATURE -

SCRUB NURSE 2 SIGNATURE -
To be signed by replacement scrub nurse if applicable

HANDOVER COUNT IN EVENT OF REPLACEMENT OF SCRUB NURSE DURING PROCEDURE

	Outgoing Scrub Nurse - Print Name	Incoming Scrub Nurse - Print Name	Circulating Nurse(s) - Signature & Print name
OUTGOING COUNT *To be completed for permanent and temporary replacement*	A		
INCOMING COUNT *To be completed for temporary replacement*		A	

OPERATION: EVAE

TALLY OF EACH ITEM USED - ADD ANY ITEMS SPECIFIC TO YOUR SPECIALITY

Swabs (2x2)		Tapes				ITEMS REMAINING IN SITU (Type & Number)
Swabs (10x10)	5	Sloops/Slings				
Abdominal packs		Bulldogs				A
Sutures		Shods				
E		Tibbs Cannula				
IV needles		Ports				
Syringes		Staple Gun Inserts				
Discard-a-pad		Spears				
Diathermy pencil		Throat packs - Anae				
Diathermy tips		Throat packs - Scrub		N		
Scratch pad		Retrieval Bag (Bert)				
Reels		Digital Tourniquets				
Patties						
Pledgelets						

DISCREPANCY IN COUNT - ACTIONS AND OUTCOME

COUNT IN WHICH DISCREPANCY OCCURRED

DETAILS

ACTIONS TAKEN AND OUTCOME (I.E. SWABS ISOLATED, SEARCH UNDERTAKEN, WOUND EXPLORED, X - RAY TAKEN) -

N

A

SCRUB NURSES SIGNATURE IF COUNT STILL INCORRECT FOLLOWING ALL POSSIBLE ACTIONS

SURGEONS SIGNATURE IF COUNT INCORRECT FOLLOWING ALL POSSIBLE ACTIONS

NHS
Greater Glasgow and Clyde

Day Surgery Assessment/Admission Pack

Date of Assessment 11/9/15

Date of Admission 14/9/15

Consultant DR WONG



ASSESSMENT

TELEPHONE NO. HOME _____

WORK _____

PROCEDURE _____

Height; _____ Weight: _____ =BMI _____

Refer to nomogram if patient appears obese. If result is more than 30 patient not suitable.

B.P. _____ P. _____

[illegible] you :	YES	NO	
[illegible]ble to be driven home by private car			1
have easy access to your home (stairs, ..)			2
have someone to take you home			3
have a telephone at home			4
have easy access to a lavatory			5
have someone at home able to look after you for 24 hours			6
do you have any dependents			7

Have you ever suffered from any of the following :	YES	NO	
chest pain on exercise or at night			8
breathlessness			9
asthma or bronchitis			10
[illegible] blood pressure			11
heart murmur			12
fainting easily			13
convulsions or fits			14
jaundice (yellowness)			15
indigestion or heartburn			16
kidney or urinary trouble			17
anaemia or other blood problems			18
excessive bleeding or bruising			19
arthritis			20
muscle disease or progressive weakness			21
diabetes			22

Have you ever had:	YES	NO	
a serious illness			23
allergy or reaction to medicines, Elastoplast, etc			24

Do you:

	YES	NO	
take any medicines (tablets, patches, injections, inhalers).....			25
.....			
smoke.....			26
drink more than 1½ pints of beer or 3 shorts a day			27
or have you ever used intravenous drugs.....			28
If a woman, are you pregnant or taking the "pill"			29
Is there anything else the surgeon / anaesthetist should know.....			30

What operations have you had before if any (please list)? 31

.....

.....

.....

Did you have any anaesthetic or surgical complications (please list)? 32

.....

.....

When was your last general anaesthetic ? .....

Has any member of your family had problems with anaesthetics ? (please tick box) ..... YES☐ NO☐ 33

How long will it take you to travel home : .....hrs. .....mins 34

Do you have any Prosthesis 35

HAVE YOU ANY QUESTIONS ABOUT THE PROCEDURE ..... YES☐ NO ☐ 36

COMMENTS: .....

.....

FURTHER INVESTIGATIONS CARRIED OUT (PLEASE TICK BOX)

U & E's - ☐ **HAEMOGLOBIN -** ☐ **E.C.G -** ☐ **CXR -** ☐

REQUIRES ANAESTHETIC OPINION : .....YES☐ NO. ☐

REASON : .....

NURSES SIGNATURE : .....

ANAESTHETIC DETAILS

DR..... DATE.....

ANAESTHETISTS COMMENTS : .....

.....

ADMISSION

CARE PLAN - Any changes in health since assessment: Details _____

PRE-OPERATIVE PREPARATION						Tick
1.	LAST TIME PATIENT ATE OR DRANK					
2.	CONSENT SIGNED					
3.	IDENTITY BAND					
4.	CASE NOTES, X-RAYS, DRUG KARDEX					
5.	OPERATION SITE PREPARED AND MARKED					
6.	TEETH - DENTURES REMOVED, CROWNS/CAPS/BRIDGE					
7.	PROSTHESIS REMOVED - CONTACT LENS, GLASSES					
8.	REMOVED - MAKE-UP, NAIL VARNISH, UNDERWEAR, JEWELLERY (TAPED/REMOVED)					
9.	ALLERGIES					
10.	VOIDED URINE					
11.	BASELINE OBSERVATIONS	P:		BP:		

PROBLEMS/NEEDS	INTERVENTION	OUTCOME

Signature -

THEATRE

OPERATION PERFORMED _____

DIATHERMY BIPOLAR/MONOPOLOR ☐
HEEL RESTS ☐
FLOWTRON BOOTS ☐
SHEEPSKIN HEEL PADS/MAT ☐
HEATED WATER BED ☐
ARM BOARDS ☐

PATIENT POSITION

LATERAL RIGHT ☐ TRENDELENBURG ☐
LATERAL LEFT ☐ REVERSE ☐
SUPINE ☐ LITHOTOMY ☐
PRONE ☐ LLOYD DAVIS ☐

TOURNIQUET TIME ON OFF

SPECIAL COMMENTS

SPECIMENS: PATH BACT OTHER
DRAINS
CATHETER

COUNTS CORRECT

SWABS - FIRST ☐
- FINAL ☐
INSTRUMENTS ☐
SHARPS - NEEDLES ☐
- BLADES ☐

THROAT PACK OUT ☐
PACK IN SITU ☐
INSTRUCTION FOR REMOVAL

Name of Scrub Nurse: _____

Signature of Circulating Nurse: _____

2505876061
MCLEISH F
Wendy 25/05/1987
1/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5E

POST OPERATIVE RECOVERY ROOM INSTRUCTIONS

ROUTINE - Pulse & B.P.

- Oxygen/recovery

SPECIAL Information/Instructions

PLEASE ISSUE T

Cocodamol 8/500		C	
Paracetamol 1g		D	
Ibuprofen 400mgs		Dihydrocodeine 30mgs	
Buccastem 3mgs			
Azithromycin 1g		Microgynon 30	

ONCE ONLY PRESCRIPTIONS

Date Given	Time	Medicine (Block Capitals)	Dose	Route	Signature	Given By	Time
14/9/15		METRONIDAZOLE	1g	PR			
14/9/15		AZYTHROMYCIN	1g	PO		MT	TTH
14/9/15		MISOPROSTOL	400 MICROGRAM	SL			8.40
14/9/15		Anti D	250IU	IM			11.30 am

POST OPERATIVE OBSERVATIONS

Signature:

TIME																
PULSE																
BLOOD PRESSURE																
SATURATION (SaO^2)																
RESPIRATORY RATE																
AIRWAY																
OXYGEN																
PAIN SCORE																
SEDATION SCORE																
PONV SCORE																
TEMPERATURE																
WOUND																
VENFLON																

PAIN SCORE -
Assess using visual analogue scale ruler (VAS)

0 — 5 — 10

No pain — Worst pain ever

SEDATION SCORE

S = Normal sleep
0 = Alert
1 = Responds to verbal command
2 = Responds to painful stimuli
3 = Unresponsive and unrousable

PONV SCORE

0 = No symptoms
1 = Nausea
2 = Vomiting
3 = Persistent symptoms despite treatment

FLUID BALANCE

Time	Input	Volume	Initial	Time	Output	Volume	Initial

MULTI-DISCIPLINARY NOTES

DISCHARGE MEDICATION

DISCHARGE CRITERIA	Yes	No
1. Venflon Remove	☐	☐
2. Stable Vital Signs - Respiration, Pulse, B.P.	☐	☐
3. Alert and orientated	☐	☐
4. Able to dress, sit and walk unaided	☐	☐
5. Tolerating food and fluids	☐	☐
6. Information given regarding :-		
* Post anaesthetic instructions	☐	☐
* Procedure	☐	☐

* Discharged at _____ to _____ care

POST SURGICAL INSTRUCTIONS

* Follow-up appointment _____

* Special instructions

NURSES SIGNATURE _____

CONSENT FORM

2505876061 F
MCLEISH 25/05/1987
Wendy
0/1 51 COXTON PLACE
Glasgow, Lanarkshire G33 5EJ

Special requirements (e.g. other language / Communication method) .....

Proposed operation, investigation or other treatment.
Where appropriate specify site or side: (WRITTEN IN FULL)

Surgical evacuation of missed miscarriage.

I have explained the procedure named on this form to the patient in the terms which, in my judgement, are suited to their understanding. In particular, I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any sign if cant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure (please specify major procedure above).

An information leaflet/tape has been provided .....

..... (Title)

Signature of Practitioner J McGill

Name / Designation (Print) J. McGILL M|W.

Date 11 / 09 / 15

Risks discussed:- Haemorrhage - transfusion. Infection, trauma to cervix, uterine perforation

STATEMENT TO BE COMPLETED BY PATIENT/PARENT*

(* parental responsibility for a minor without capacity)

You should read this form and the notes below carefully. If there is anything you do not understand ask the Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

I understand

- the procedure, important risks and appropriate alternatives which have been explained to me by the practitioner named on this form.
- that a practitioner other than the practitioner who has been providing treatment so far might carry out the procedure.
- that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to the medical treatment proposed, to safeguard or promote physical or mental health.

I've been told about additional procedures which may become necessary during treatment. I have listed below **any procedures which I do NOT wish to be carried out without further discussion.**

I agree -

- to the administration of an anaesthetic or to sedation if required.
- to the procedure named on this form
- that the examination for the purposes of teaching will not be undertaken without my consent
- to the emergency administration of blood or blood products

Please sign here if you refuse to consent to the emergency administration of blood or blood products.

Signature ..... Date ...../...../.....

Additionally you have to agree or disagree the following:-	Agree	Disagree
that information and/or images kept in records may be used anonymously for education, audit, and research with appropriate ethical approval, to improve the quality of patient care.	☐	☑
that surplus tissue not essential for my diagnosis or future treatment may be used for medical education and ethically approved medical research.	☐	☑

PATIENT AGREEMENT FOR TREATMENT

Signature: W. McIsh ..... Date 11/9/15

Name (Print): WENDY MCLEISH

CONFIRMATION OF CONSENT

(to be completed when patient is admitted for procedure if form signed in advance)

I confirm that I have no further questions and wish the procedure to go ahead.

Signature: ..... Print name.....

Date ...../...../.....

Acute Services Division
Surgery & Anaesthetics

GG&C Day Surgery/23 hour Care Plan

NHS Greater Glasgow and Clyde

2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

Admission Checklist

Hospital: STOBHILL ACH	Consultant: SANDRA WOOD	Date: 14-9-15
Proposed Operation:- EVAC		

Patient Questionnaire Completed?	Yes ☐	No ☐ N/A
Pre-Op assessment Completed?	Yes ☑	No ☐
Escort Details (responsible Adult)Name: PARTNER JAMES WARD	Telephone Number: 07475660161	
Confirm "Next of Kin" on pre-assessment Yes Name:	Telephone No:	
Interpreter Required? If "YES" confirmation of booking Duration of booking (if known).....	Yes ☐	No ☑
Carer required to stay with patient?	Yes ☐	No ☑
Date of LMP?	Date.....	N/A
Are you, or could you be pregnant? If "Yes" pregnancy test must be performed	Yes ☐	No ☐ N/A
Pregnancy test results	+VE	-VE N/A
Group and save results checked Date done..11-9-15..... ANES.	Yes ☑	No N/A
Anti D required	Yes ☑	No ☐
Is the patient on Anti-Coag therapy? If "Yes" state type..... Are INR results available within last 24hrs? If "No" INR taken date .....time.....	Yes ☐ Yes ☐ Result.....	No ☑ No ☑
Is the patient diabetic If "Yes" BM on admission results.....	Yes ☐ NIDD ☐ DD ☐	No ☑
Urinalysis done Results.....	Yes ☐	No N/A
CJD single question asked Answer to CJD single question	Yes ☐ DD ☑ At Increased Risk ☐ Not at increased Risk ☑	Comment if required If at risk theatre notified By..... To.....
If CJD question has not been asked then ask the question " Have you ever been notified that you are at an increased risk of CJD or vCJD for public health purposes?"	Yes, I have been notified No, I have not been notified	Comment if required
Alert Sticker (if required)	Yes ☐	N/A ☑
Does the patient have any pressure area issues? If 'Yes': Area..... Issue+/- Score..... Tissue Viability contacted Yes N/A	Yes ☐	No ☑
Other Information- Document any other relevant information e.g. needle phobia , request for female practitioner 'Getting to know you' information.		
Fit Form required	Yes ☐	No ☑

Baseline Observations

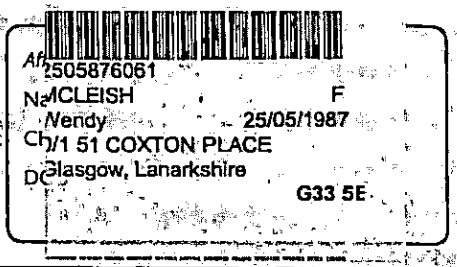
	Time.....	Time.....
SP02 96		
BP 124/85		
HR 82		
Temp 37.0		
Staff Initials LM		

Please print & sign name when checklist completed	Name: LYNN Time: 8.35

221983

Acute Services Division
Surgery & Anaesthetics

GG&C Day Surgery/23 hour Care Plan
Admission Checklist



Patient mode of transport to theatre Trolley ☑ Walking ☐ Chair ☐

Pre-op Checklist - to be completed immediately prior to the patient being given a Pre Med

Preoperative Checks	Admission Check	Reception Check N/A	Anaesthetic Check
Identity band correct (Name, DOB, CHI number, Gender) and checked with Patient	Yes ☑ No ☐	Yes ☐ No ☐	Yes ☑ No ☐
Case Notes/Scanner Folder	Yes ☑ No ☐	Yes ☐ No ☐	Yes ☑ No ☐
Addressograph Labels	Yes ☑ No ☐	Yes ☐ No ☐	Yes ☑ No ☐
X-Rays and Scans – Hardcopy	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☑ N/A ☐
scription Chart	Yes ☑ No ☐	Yes ☐ No ☐	Yes ☑ No ☐
Alert sticker		Please see page 1 Checked ☐	Please see page 1 Checked ☐
Consent / Incapacity (circle) Signed & Dated	Yes ☑ No ☐	Yes ☐ No ☐	Yes ☑ No ☐
Checked against theatre list	Yes ☑ No ☐	Yes ☐ No ☐	Yes ☑ No ☐
Check with: Patient/Incapacity/Consent(Circle)	Yes ☑ No ☐	Yes ☐ No ☐	Yes ☑ No ☐
Procedure and site for Surgery	Yes ☐ No ☑	Yes ☐ No ☐	Yes ☐ No ☑
Correct site marked	Yes ☐ No ☑		
Comments & details eg Welfare Guardian/ Power of Attorney			Yes ☐ No ☑
Allergies/Sensitivities and Reactions	Yes ☑ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
If Yes, please specify	NKDA		NIL KNOWN
Fasted from - specify time (24hr clock	Food: 2300 Fluid: 2300	Checked:	Checked: 11pm
Blood Glucose Score N/A	Time: Score:	Time: Score	Time: Score N/A
ernal Prosthesis in situ – metalwork, pacemaker, implant	Yes ☐ No ☑	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☑ N/A ☐
If 'Yes' state location and type			
External prosthesis e.g. hair extensions, hair pieces.	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☑ N/A ☐
If left in situ, state location on patient			
If removed state where stored			
Jewellery/Body piercing removed	Yes ☐ No ☑ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☑ N/A ☐
If 'Yes' state where stored.			
Jewellery/Body piercing taped	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☑ N/A ☐
If 'Yes' state Location on body			
Make-up/Nail polish removed	Yes ☐ No ☒ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☑ N/A ☐
Comments ON TOE NAILS			
False Nails	Yes ☐ No ☑ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☑ N/A ☐
Comments			
Loose Teeth /caps/crowns/bridges /dental work	Yes ☑ No ☒ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐
State Location:	Veneers Front 2 teeth		Veneers x 2 upper
Dentures Removed If 'Yes' state where stored:	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☑ N/A ☐
Spectacles/ contact lenses removed (circle) If 'Yes' state where stored:	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☑ N/A ☐

Acute Services Division
Surgery & Anaesthetics

GG&C Day Surgery/23 hour Care Plan

Admission Checklist

2505876061
Affix MCLEISH F
Wendy 25/05/1987
Na D/1 51 COXTON PLACE
CH Glasgow, Lanarkshire
DOB G33 5E

Preoperative Checklist *continued*

Pre-operative checks	Admission Check	Reception Check N/A	Anaesthetic Check
Hearing aid(s) Hearing aid(s) removed If removed state where stored;	R ☐ L ☐ N/A ☑ Insitu ☐ Removed ☐	R ☐ L ☐ N/A ☐ Insitu ☐ Removed ☐	R ☐ L ☐ N/A ☑ Insitu ☐ Removed ☐
CJD question asked Answer to CJD question	[redacted]	Please see page 1 Checked ☐	Please see page 1 Checked ☑
If CJD question has not been asked then ask the question "Have you ever been notified that you are at an increased risk of CJD or vCJD for public health purposes?"	[redacted]	Please see page 1 Checked ☐	Please see page 1 Checked ☑
MRSA screen results (if applicable)	Positive ☐ Results Pending ☐	Negative ☐ N/A ☑	Comments if required:
Inhalers / Sprays with patient State Type	Yes ☐ No ☐ N/A ☑	Type: Nil	
Anti-embolic/DVT Prophylaxis State Type	Yes ☐ No ☐ N/A ☑	Type:	
Paper Pants in situ	Yes ☐ No ☑ N/A ☐		removed
(Voided urine) Catheter in situ/ Urostomy (circle)	Yes ☑ No ☐ N/A ☐	Comment if required	Comment if required
Date of Last Menstrual period	[redacted]	See P1 Checked ☐	See P1 Checked ☑
Is there any chance you are pregnant?	[redacted]	See P1 Checked ☐	See P1 Checked ☑
Pregnancy test carried out Pregnancy test result	[redacted]	See P1 Checked ☐	See P1 Checked ☑
Tampon Removed Comments:	Yes ☐ No ☐ N/A ☑	See Admission Check Checked ☐	See Admission Check Checked ☐ removed
Local anaesthetic cream applied	Yes ☐ N/A ☑	If "Yes" time applied..... Site(s) applied.....	If "Yes" time applied..... Site(s) applied..... .....
Pre-Medication Given	Yes ☐ N/A ☑	Yes ☐ N?A ☐	Yes ☐ N/A ☑
Trolley/Bed checked for head down tilt and O2/Accessories	Bed ☐ Trolley ☑ Operating Chair ☐ Yes ☐ No ☐	Bed ☐ Trolley ☐ Operating Chair ☐ Yes ☐ No ☐	Bed ☐ Trolley ☑ Operating Chair ☐ Yes ☐ No ☐
Any relevant medical history or other information	Wrist + throat op.		
Please print and sign name once the checklist is complete	Admission: Time: 0835	Reception: N/A ☐ Time:	Anaesthetic Assistant: Time 9 55

Acute Services Division
Surgery & Anaesthetics

GG&C Day Surgery/23 hour Care Plan

Anaesthetics

Affix Add... 2505876061
Name : MCLEISH Wendy F
CHI : 0/1 51 COXTON PLACE 25/05/1987
DOB : Glasgow, Lanarkshire
G33 5EJ

Surgical Brief

Surgical Brief carried out: - Yes ☐ No ☐	If 'No' please specify				
Baseline Observations Date & Time	Pulse: 72	BP: 114/62	Temp:	SpO2: 97%	Resps:
Anaesthetic Assistant has confirmed with Anaesthetist that cross matched blood is:	Required: Yes ☐ N/A ☑	Available: Yes ☐ No ☐	Or patient has been grouped and saved: Yes ☐ No ☐		
STOP BEFORE YOU BLOCK carried out Yes ☐ No ☐ N/A ☑					

naesthetic Type – Please Tick all that apply

General Anaesthetic ✓ LMA3	Epidural ☐	Spinal ☐	Regional Block ☐	Throat Spray ☐
Local Anaesthetic	Site:	Drug:	mls:	
Sedation	Drug:	mls:		

Skin Prep used for Anaesthetic Monitoring/Block(s) — This section NOT applicable ☐

SPINAL/EPIDURAL	Yes ☐ N/A ☐	Specify Prep:
REGIONAL BLOCK	Yes N/A	Specify Prep:
OTHER SPECIFY	Yes N/A	Specify Prep:

Blood Glucose Monitoring — This section NOT applicable ☐

Time								
BM score								

Safe use of SpO2 probe to prevent injury — This section NOT applicable ☐

SpO2 Probe rotated hourly	Yes ☐ No ☐ N/A ☐				Initial Position		
Time Rotated							
Probe Position							

Prevention of Eye Injury — This section NOT applicable ☐

Eyes protected from injury during procedure	Yes ☑ No ☐	Specify: taped with micropore

Maintenance of Norm-thermia — This section NOT applicable

Actions taken to maintain the patient's Temperature	Yes ☐ No ☐	Warm air blanket device – specify:	Yes ☐	No ☐	N/A ☐
		Warm Fluids	Yes ☐	No ☐	N/A ☐
		Warming Mat	Yes ☐	No ☐	N/A ☐
		Thermal Hat	Yes ☐	No ☐	N/A ☐
		IV fluid warmer	Yes ☐	No ☐	N/A ☐
		Other - specify	Yes ☐	No ☐	N/A ☐
Patients Temperature documented by Anaesthetist	Yes	No			

Acute Services Division
Surgery & Anaesthetics

GG&C Day Surgery/23 hour Care Plan

Anaesthetics

Affix A

Name MCLEISH F
CHI : 2505876061
Wendy 25/05/1987
DOB 0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

Record of Anaesthetic Pump Infusion Device Numbers

This section NOT applicable ☐

Comments/Events

Acute Services Division
Surgery & Anaesthetics

GG&C Day Surgery/23 hour Care Plan

Theatre

2505876061 F
MCLEISH 25/05/1987
Wendy
0/1 51 COXTON PLACE
Glasgow, Lanarkshire G33 5EJ

Safe Positioning — This section NOT applicable ☐

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

Pre-op Pressure Area Care

Pre-operative skin issues (please circle)	Excoriation Level: (0) 1 2 3	PU Grade: (N/A) 1 2 3 4

Area of concern identified (include area of body)	Actions Taken

Position 1

Time:				Positioning Devices				Pressure Relieving		Arm Position		
Supine	☐	Prone	☐	Head ring	☐	Lateral supports	☐	Gel Pads	☐	R Arm Position	L Arm Position	
Left Lateral	☐	Right Lateral	☐	Pillows	☑	Hydraulic leg supports	☑	Heel gel Pads	☐	At side ☑	At side ☑	
Lloyd Davis	☑	Jack-knife	☐	Straps	☐	Limb Traction	☐	Full gel mattress	☐	On boards ☐	On boards ☐	
Tren-delenburg	☐	Deckchair	☐	Wedge	☐	Side Supports	☐	Gel Wedge	☐	Across chest ☐	Across chest ☐	
Reverse Tren-delenberg	☐	Lower Limb Traction	☐	Sandbag	☐	Bolster	☐	Pillows	☐	Hand Table ☐	Hand Table ☐	
Lithotomy	☐	Other	☐							Hand Traction ☐	Hand Traction ☐	
										Secured with:	Secured with:	
										Straps ☐	Straps ☐	
										J Board ☑	J Board ☑	
										Pressure Care:	Pressure Care:	
										Gel / Foam Pads ☑	Gel / Foam Pads ☐	

Position 2 — This section NOT applicable ☐

Time:				Positioning Devices				Pressure Relieving		Arm Position		
Supine	☐	Prone	☐	Head ring	☐	Lateral supports	☐	Gel Pads	☐	R Arm Position	L Arm Position	
Left Lateral	☐	Right Lateral	☐	Pillows	☐	Hydraulic leg supports	☐	Heel gel Pads	☐	At side ☐	At side ☐	
Lloyd Davis	☐	Jack-knife	☐	Straps	☐	Limb Traction	☐	Full gel mattress	☐	On boards ☐	On boards ☐	
Tren-delenburg	☐	Deckchair	☐	Wedge	☐	Side Supports	☐	Gel Wedge	☐	Across chest ☐	Across chest ☐	
Reverse Tren-delenberg	☐	Lower Limb Traction	☐	Sandbag	☐	Bolster	☐	Pillows	☐	Hand Table ☐	Hand Table ☐	
Lithotomy	☐	Other	☐							Hand Traction ☐	Hand Traction ☐	
										Secured with:	Secured with:	
										Straps ☐	Straps ☐	
										J Board ☐	J Board ☐	
										Pressure Care:	Pressure Care:	
										Gel / Foam Pads	Gel / Foam Pads	

Electrosurgery — This section NOT applicable ☐

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

Acute Services Division
Surgery & Anaesthetics

GG&C Day Surgery/23 hour Care Plan

Theatre

Affix A
Name 2505876061
CHI : MCLEISH Wendy F
DOB 0/1 51 COXTON PLACE 25/05/1987
Glasgow, Lanarkshire
G33 5EJ

Tourniquets — This section NOT applicable ☐

Tourniquet equipment applied	Yes ☐ No ☐ N/A ☐		
Padding under tourniquet	Yes ☐ No ☐ N/A ☐		
Cover over tourniquet	Yes ☐ No ☐ N/A ☐		
Post op skin check(s) satisfactory	Yes ☐ No ☐	If 'No' state reason and action:	

Site	Time inflated	Pressure	Time deflated	Time re-inflated	Pressure	Time deflated

Digit Tourniquets — This section NOT applicable ☐

Digit applied:	Time applied :	Time Removed:
Digit applied:	Time applied :	Time Removed:

Skin Preparation — This section NOT applicable ☐

Site	Clipped	Preparation solution used	
vagina	Yes ☐ No ☐ N/A ☑	Aqueous Iodine based solution Alcohol Iodine based solution Aqueous Iodine and sodium chloride 50/50	Chlorhexidine solution ☐ Chlorhexidene acetate Solution ☑ 0.015 % Other Specify:.....% ☐

Site	Clipped	Preparation solution used	
	Yes ☐ No ☐ N/A ☐	Aqueous Iodine based solution Alcohol Iodine based solution Aqueous Iodine and sodium chloride 50/50	Chlorhexidine solution ☐ Chlorhexidene acetate Solution ☐ .....% ☐ Other Specify:.....%

Local Anaesthetic Infiltration to Wound — This section NOT applicable ☐

Site	Drug	Quantity
Site	Drug	Quantity

Drains — This section NOT applicable ☐

Drain	Site	Type	Size	Secured with	Dressing
1					
2					
3					

Wound Closure and Dressings (including Packing) — This section NOT applicable ☐

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

	Site	Wound closure	Dressings	Packing
1				
2				

Acute Services Division
Surgery & Anaesthetics

GG&C Day Surgery/23 hour Care Plan

Theatre

Affix
Nam 2505876061
CHI MCLEISH F
Wendy 25/05/1987
DOB 0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

Urinary Catheter	Inserted prior to admission		This section NOT applicable ■	
Type	Size	Anaesthetic lubricant applied / inserted	Balloon inflated with	Prepping Solution
		mls	mls	

Operation / Procedure Performed

surgical evacuation of missed miscarriage

Blood Tags — This section NOT applicable ■

Blood Tags checked and dispatched appropriately: : Yes ☐ No ☐ N/A ☐

Post - op Pressure Area Care

Skin Inspection Scores Post operative (circle)	Excoriation level: (0) 1 2 3	Pressure Ulcer Grade: (N/A) 1 2 3 4

Action taken if required

Notes / Comments / Events — This section NOT applicable ☐

Traceability Stickers

Donation No: SDDN0855
Component: Anti-D 250iu (BPL)
Signature 1: T Elliott Date Given: 14/9/15
Signature 2: L Hart Time Given: 11-30 am
Hospital Stobhill ACH Ward ONE Surgery

D-Gam 250 IU BATCH: SDDN 0855 LHun

Acute Services Division
Surgery & Anaesthetics

GG&C Day Surgery/23 hour Care Plan
Immediate Post-op Recovery

Ad
Na 2505876061 F
CH MCLEISH 25/05/1987
Wendy
DO 0/1 51 COXTON PLACE
Glasgow, Lanarkshire G33 5EJ

Op Instructions e.g. sutures, physio, follow up appointments

Verbal Handover from Theatre to Recovery

Verbal handover given by: Summers. To:

Handover should include the following:

Patient	Anaesthetic	Theatre	Other
Patient's name	Anaesthetic Type	Drains	
Theatre	Airway type	Wounds/Dressings	
edure	Peripheral IV	Urinary Catheter	
Allergies	Local Anaesthetic infiltration	Skin Inspection results	
	Pain management	Intra-operative events	
		Post-Op Instructions	

Pressure Area Issues (Skin inspection score post-operative see page 9)

N/A ☐

Area of Concern identified (include area of body)	Actions Taken

es / Comments / Events This section NOT applicable ■

Acute Services Division
Surgery & Anaesthetics

GG&C Day Surgery/23 hour Care Plan

Immediate Post-operative Recovery

Affix
Name
CHI 2505876061
DOB MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

Post-operative Observations

Time	10 25	10 35	10 40	11 30		12 10
210						
200						
190						
180						
170						
160						
150						
140						
130						
120		↑	116	112	Paracetamol	114
110			↑	↑		
100						
90	↑		↓	↓		
80						
70	↓	↓	↓	↓		
60					Anti D 0.5	✓ 73
50						
40						
30						
Airway type	4	1	1	1		1
O_2 Therapy	5L	5L	5V	5V		MR
SpO_2	98	98	100	95		98
Resp. Rate	20	23	Reg	Rn		R
CVP	-	-				
Temp.	37	-	—	-		
Pain Score	0	0	0	0		
O.N.V.	0	0	0	0		
Sedation Score	3	0	0			
BM Score	—	-	—	0		
HemoCue Score	-	-	—	—		
Hourly Urine Vol. / Total Urine Vol.	/	/	/	/	/	/
Wound Score	)	)	)			
Wound Score	)	)	)	)		
Wound Score	)	)	)			
PV Staining	0	0	1			
Circulation +ve/-ve	)	)	)	)		
Sensation +ve/-ve	)	)	)	)		
Movement +ve/-ve	)	)	)	)		
Pedal Pulse – Left	)	)	)	)		
Pedal Pulse – Right	)	)	)	)		
Drain 1	)	)	)	)		
Drain 2	)	)	)	)		
Drain 3	)	)	)	)		
Drain 4	)	)	)	)		
Staff initials	RD	RD	KEITH			

Affix

Name: 2505876061

CHI: MCLEISH F

Wendy 25/05/1987

DOB: 0/1 51 COXTON PLACE

Glasgow, Lanarkshire

G33 5EJ

Time							
210							
200							
190							
180							
170							
160							
150							
140							
130							
120							
110							
100							
90							
80							
70							
60							
50							
40							
30							
Airway type							
O_2 Therapy							
SpO_2							
Resp. Rate							
CVP							
Temp.							
Pain Score							
P.O.N.V.							
Sedation Score							
BM Score							
HemoCue Score							
Hourly Urine Vol. / Total Urine Vol.							
Wound Score							
Wound Score							
Wound Score							
PV Staining							
Circulation +ve/-ve							
Sensation +ve/-ve							
Movement +ve/-ve							
Pedal Pulse – Left							
Pedal Pulse – Right							
Drain 1							
Drain 2							
Drain 3							
Drain 4							
Staff initials							

Key to Scoring / Abbreviations

Airway Type	
1	Maintaining own airway
2	Guedel
3	Naso-pharyngeal
4	L.M.A.
5	E.T.T.
6	Tracheostomy
Post Operative Nausea and Vomiting Assessment	
0	None
1	Mild – *Not distressed; No retching/vomiting*
2	Moderate – *Troublesome; Occasional retching/vomiting*
3	Severe – *Distressing; Frequent retching/vomiting*
Sedation Score	
0	Awake
S	Normal Sleep
1	Drowsy, easy to rouse – *Eyes open to speech or light shaking*
2	Sedated, difficult to rouse – *Eyes open only to vigorous shaking*
3	Unconscious, unrousable
Wound Score	
0	Dry and Intact
1	Slight Staining
2	Moderate Staining
3	Saturation / Pad required

Pain Score

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

Acute Services Division
Surgery & Anaesthetics

GG&C Day Surgery/23 hour Care Plan

Discharge Recovery

Affi 2505876061
Nai MCLEISH Wendy F 25/05/1987
CHI 0/1 51 COXTON PLACE
Glasgow, Lanarkshire
DO G33 5E

2nd Stage Recovery

Verbal Handover from Immediate Recovery to 2nd Stage Recovery

Verbal handover given by: To:

Handover should include the following:

Patient	Anaesthetic	Theatre	Recovery	Other
Patient's name	Anaesthetic Type	Drains	Skin Inspection results	
Theatre	Local anaesthetic infiltration	Wounds/Dressings	Post Op Instructions	
Procedure	Peripheral IV	Urinary Catheter	Pain management	
Allergies	Pain Management	Intra-operative events		

Pre Mobilisation Patient Checks

Time		Comments
BP		
HR		
SpO2		
Wound Site 1		
Wound Site 2		
Diet & Fluids tolerated		
Operated limb N/A ☐		
Colour		
Sensation		
Movement		

Signature:

Events / Comments

This section NOT applicable ☐

Events / Comments	Time	Signature

Acute Services Division
Surgery & Anaesthetics

GG&C Day Surgery/23 hour Care Plan

Discharge Criteria



Discharge Criteria

	Yes	N/A	Comments
Able to dress, sit & walk unaided	✓		
Stable Vital Signs	✓		BP 126/80 HR 79 SpO2 96% on air
Sedation Score (alert & orientated)	✓		
Pain Controlled (mild <3 to 0)	✓		
Post –op Nausea & vomiting satisfactory	✓		
Tolerating Food & Fluids	✓		
Voided Urine post-op	✓		
Advice given if not voided urine post-op		✓	
Wound site(s) checked & satisfactory 1. 2.			NIL PV
CSM of operated limb checked & satisfactory		✓	
IV Cannula removed	✓		
ID bracelet/ECG electrodes removed		✓	
Anti-D given	✓		
Appliances given		✓	
Post –Op discharge letter		✓	
Follow up appointment arranged		✓	By post ☐ Given ☐
Practice/ District Nurse referral		✓	
Post- Op Instructions given	✓		
Discharge medication	✓		
Responsible adult escort	✓		
Responsible adult supervision ovemight	✓		
Any skin issues prior to discharge reported		✓	
Patient advised that while awaiting collection after discharge that they must alert staff if there is any change in their condition.	✓		
Admission, dosage, frequency and contraindications of discharge drugs discussed with patient	✓		

Patient met discharge criteria at 12.30 hrs By M. TRAIL

Patient left DSU at 13.25 Destination HOME

Discharged into the care of PARTNER Relationship

Acute Services Division
Surgery & Anaesthetics

GG&C Day Surgery/23 hour Care Plan

Notes

A 2505876061
N MCLEISH F
Wendy 25/05/1987
C 0/1 51 COXTON PLACE
D Glasgow, Lanarkshire
G33 5EJ

14/9/15: Anti D given as prescribed at 11·30 am.

2ND ALL PERTINENT POST OP INFO GIVEN
NIL PV
UNCOMPLAINING
PATIENT STATES SHE FEELS READY FOR DISCH

Acute Services Division
Surgery & Anaesthetics

GG&C Day Surgery/23 hour Care Plan

Notes

2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

Acute Services Division
Surgery & Anaesthetics

Affix Addressograph Label

Name :

CHI :

DOB :

GG&C Day Surgery/23 hour Care Plan

Notes

Anaesthetic Record

NHS Greater Glasgow and Clyde

Nam
2505876061
Hos MCLEISH Wendy F
CHI 0/1 51 COXTON PLACE 25/05/1987
Glasgow, Lanarkshire
G33 5EJ
DoB

Pre-op

Procedure(s) knee

Anaesthetist(s) Green

Surgeon(s) Wray

Elective ☑
Urgent ☐
Immediate ☐

C	SAS	ST	CT	PA
☑	☐	☐	☐	☐
☐	☐	☐	☐	

Date 18 / 9 / 15

Discussed with supervising consultant _____

SUMMARY

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

ASA 1 2 3 4 5
Comment

Anaesthetist Sign / Print _____

ASSESSMENT

28yr ♀

Airway / Dentition

veneers - warned.
MPI

RS

CVS

GI / Renal / CNS / Other

Previous anaesthesia / Family history

ok

Assessor Sign / Print / Date _____

Ht
Wt kg
BMI

BP ___ / ___
ECG

Hb	Na
WCC	K
Plts	U
XMatch	Cr
Clotting	Gluc

Allergies / Reactions

x

Current therapy

propranolol

OK with NSAIDs ☐

Risks discussed

GA
DSU.
dental damage

Anaesthetic Record
Anaesthetic Record
Anaesthetic Record
Anaesthetic Record

Equipment check performed ☑

Vascular access 22G RAH

Cannula

A line

CVP

Airway/Ventilation

FM

LMA 3

ETT

Grade

Pre-ox ☑ O2 4lv 2v

Cricoid P ☐

SV ☑

IPPV ☐

Regional Anaesthesia

Alfentanil	1mg							
Propofol	200mg							
Diclofenac	100mg PR							
Time 1000								

Position

Inthatory

ECG SpO_2 ☑

NIBP

Fluid warmer ☐

Patient warmer ☐

200 180 160 140 120 100 80 60 40 20

IV Fluids								
Events								
FiO_2 N_2O ☐	.6							
SpO_2	95							
$ETCO_2$	6.1							
ETAA	2.7							

Eye care ☑

Pressure point care ☐

Events

Ⓐ Ⓑ Ⓒ Ⓓ Ⓔ Ⓕ Ⓖ Ⓗ

IV fluids

① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫ ⑬ ⑭ ⑮ ⑯

NHS
Greater Glasgow and Clyde

Name

Hospital no.

CHI no.

DoB / Age

Anaesthetic Record

Time								

200 180 160 140 120 100 80 60 40 20

IV Fluids								
Events								
FiO_2 N_2O☐								
SpO_2								
$ETCO_2$								
ETAA								

Post-op Instructions

Intra-op blood loss _____

Oxygen

Per PCA/other protocol ☐

_____ L/min in recovery

To keep SaO_2 > ____ %

Fluids

Monitoring/Investigations

Anaesthetic Notes

GLASGOW AND CLYDE BLOOD TRANSFUSION

Surname	Forename	Sex	DOB
MCLEISH	WENDY	Female	25-May-1987

Hospital	Consultant	Location	Patient Id. Numb
GLASGOW ROYAL INF	Jennifer McGill	EPAS Early Preg	A2505876061

Specimen No.G,15.5088757.T

Date/time of collection 11-Sep-15 15:00
Date/time of receipt 11-Sep-15 15:00

Patient Blood Group
A NEG

Antibody Screen

STORE AT 4C

DONOR UNITS BLOOD WILL BE DERESERVED ON 16/09/15

EXPIRY DATE	PRODUCT CODE	DONOR GROUP	PACK/BATCH NUMBER
31/05/16	AD250	NG	SDDN0855

Date and Time Reported
11-Sep-15 15:33

Authorised By
Ghazala Humayun

New Stobhill Hospital
Post-Operative Instructions

NHS Greater Glasgow and Clyde

Monitoring in recovery - NIBP, SpO2, ECG, Resp Rate.

Oxygen as protocol unless otherwise instructed.

Anaesthetist Print Name, Sign & Date.

14/4/15



2505876061
MCLEISH
Wendy F
25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

IV Analgesia				
Morphine as per recovery guidelines (2012) ☐		Dose Given	Given by	Time
Fentanyl as per recovery guidelines (2012) ☐				
Antiemetics				
Ondansetron 4mg iv 6hrly	☑			
Cyclizine 50mg iv 8hrly	☑			
Prochloperazine 12.5mg im 8hrly	☐			

TTAs to be dispensed (all oral)		PRN ✓	REG ✓		PRN ✓	REG ✓
Paracetamol	1g	✓				
Cocodamol	8/500					
Cocodamol	30/500					
Dihydrocodeine	30mg					
Diclofenac	50mg					
Ibuprofen	400mg	✓				
Ondansetron	4mg					
Buccastem	3mg					

Dispensed by:

NURSE NAME & SIGNATURE

TTAs administered in ward

Medication	Dose	Given by	Time

Once only prescriptions

Date	Time	Medicine	Dose	Route	Signature/Name	Given by	Time

Other post-op instructions

NHS Greater Glasgow and Clyde

Authorisation for sensitive disposal following pregnancy loss (SD7).

2505876061
MCLEISH Wendy F
25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire G33 5EJ

~~Doctor/Midwife/ Nurse in charge~~ : J McGill
Ward/Dept : EPAS
Hospital : PRM
Date of Delivery : 14/9/15
Gestational Age : 1st trimester

Complete either Section A or B. Delete whichever is NOT applicable

Section A:

The options for sensitive disposal have been explained to me (Yes) / No

I give authorisation for my pregnancy loss to be sensitively disposed of by the hospital in accordance with procedures outlined (Yes) / No

If NO, please indicate if:
1) I have not yet decided, or
2) I will make my own arrangements through a funeral director, or
3) I wish to take my pregnancy loss out of the hospital (release of tissue form to be signed)

I understand that if I change my mind I must phone the hospital within one week. (Yes) / No

Section B:

I have declined to discuss this matter and recognise that the hospital will proceed according to their standard procedure. Yes/ No

Signature of the woman: W. McLeish
Date Signed: 11/9/15
Witness Signature: J McGill
Witness name (Block Capitals): J McGill
Designation: M/W

Original with Specimen

PRM. E.P.A.S.

NHS
Greater Glasgow and Clyde

Name: 2505876061
MCLEISH
Wendy F
Address: 0/1 51 COXTON PLACE 25/05/1987
Glasgow, Lanarkshire
G33 5EJ

Date: 3/9/15

Unit No.: JMcCu

NON - CONTINUING PREGNANCY → CANCEL BOOKING APPT: IF ALREADY MADE — *tick box* ☑

CONTINUING PREGNANCY → GEST: AGE

EDD ESTABLISHED?

EDD.

YES

12 WEEK BPD SCAN REQUIRED

YES

BOOKING & SCAN AT 12 WEEKS WEEK BEG. ..... — *tick box* ☐

NO

CANCEL BOOKING SCAN CLINIC ONLY — *tick box* ☐

NO

BOOKING & SCAN AT 12 WEEKS WEEK BEG. ..... — *tick box* ☐

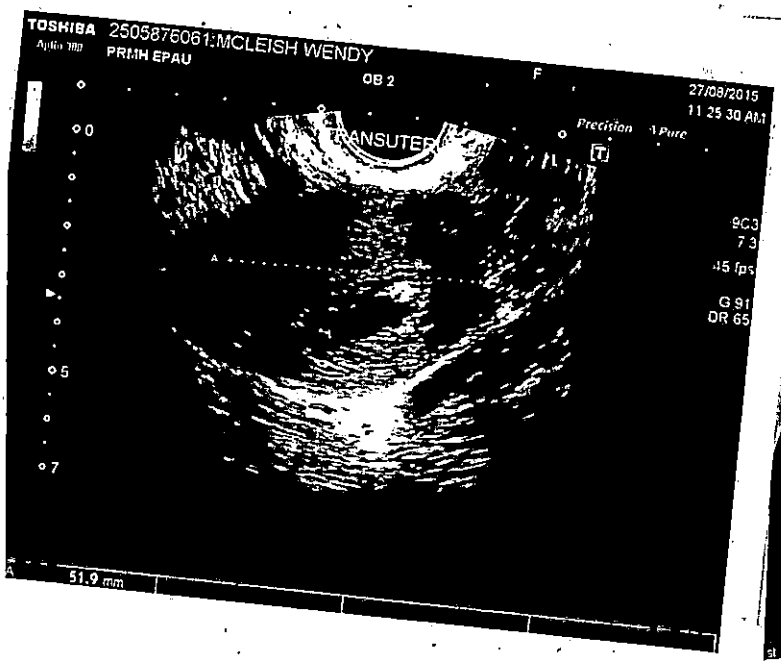
OR MEDICAL RECORDS STAFF.

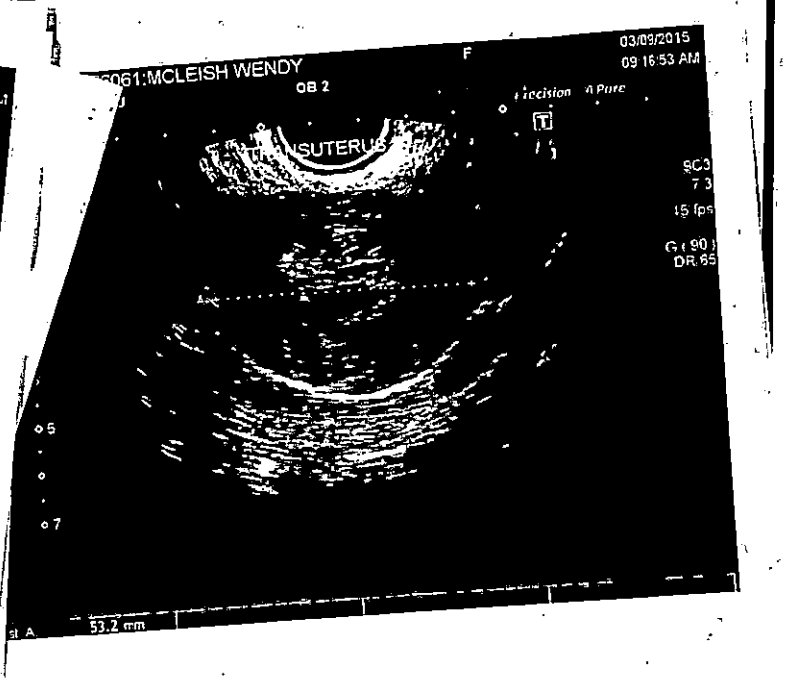
Does patient already have a booking appointment ? YES / NO

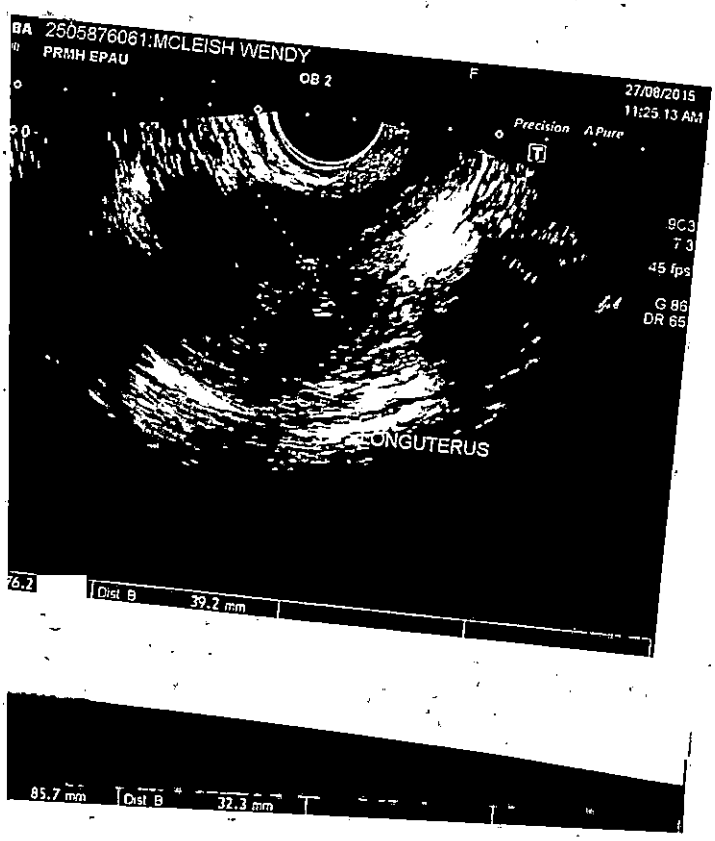
S - Check timing and change if necessary.

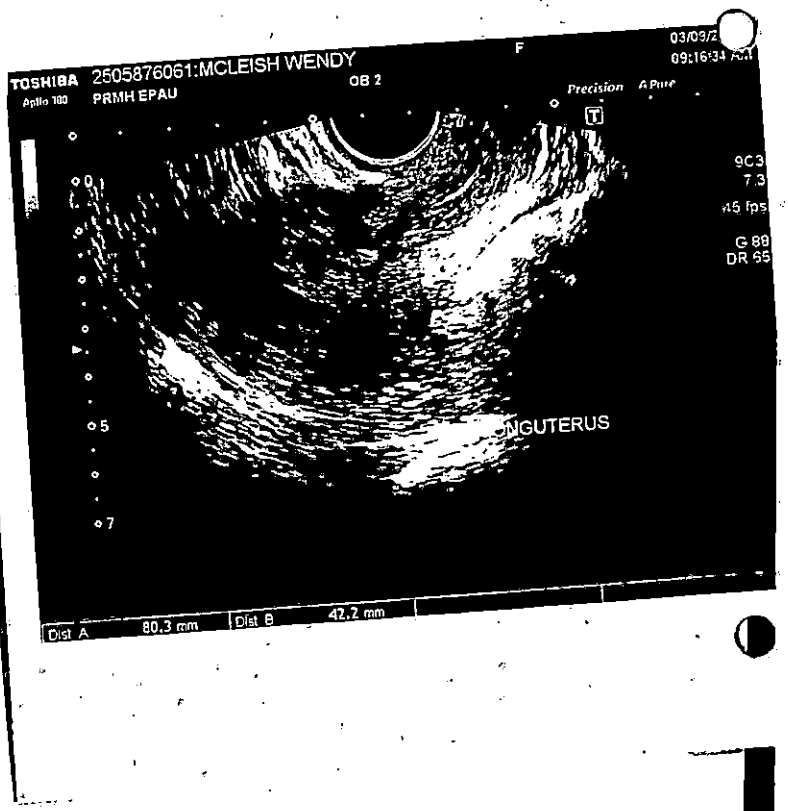
D - Leave form on front of notes until booking letter arrives - then make apppointment.

246133


TOSHIBA
2505876061:MCLEISH WENDY
PRMH EPAU
OB 2
F
27/08/2015
11:25:30 AM
Precision
A Pure
TRANSUTER
9C3
7.3
45 fps
G 91
DR 65
51.9 mm


2505876061:MCLEISH WENDY
OB 2
F
03/09/2015
09:16:53 AM
Precision
A Pure
TRANSUTERUS
9C3
7.3
45 fps
DR 65
53.2 mm


2505876061:MCLEISH WENDY
PRMH EPAU
OB 2
F
27/08/2015
11:25:13 AM
Precision
A Pure
9C3
7.3
45 fps
G 86
DR 65
LONGUTERUS
Dist B
39.2 mm
85.7 mm
Dist B
32.3 mm


TOSHIBA
2505876061:MCLEISH WENDY
Aplio 100
PRMH EPAU
OB 2
F
Precision
A Pure
9C3
7.3
45 fps
G 88
DR 65
NGUTERUS
Dist A
80.3 mm
Dist B
42.2 mm

Early Pregnancy Assessment Service
Level 2 Princess Royal Maternity
16 Alexandra Parade
Glasgow
G31 2ER

0141 211 5317

Date 3/9/15

Dear Doctor McGinley

RE:

2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

Your patient was seen today at the Early Pregnancy Unit. Sadly ultrasound findings confirmed a non continuing pregnancy

non-continuing pregnancy 5+

Management options were discussed as below. A decision was reached and arrangements have been made to facilitate this choice.

Expectant

Medical

Surgical

Undecided - Considering management options

Yours Sincerely

Early Pregnancy Midwife Sonographer/Associate Specialist Doctor

0Early Pregnancy Assessment **Telephone Advice Call**

Source Of Referral : Self / GP / CMW / A&E / Other:

Date Of Call : 1.9.15	**Time Of Call :** 1250 **OR** Answer Machine
Patient Name : Wendy. M'leish.	**Address :**
Date Of Birth : 25 5 87. **Age :**	**Telephone Number :** 07454750438.
GP Details :	**Previously Attended :** Gyn / EPAS / A&E **Booking Hospital :** / 27/8/15.
PARA :	**Previous Chlamydia :** Yes / No **Blood group :**
L.M.P. : **Gestation :** **Date Of P.P.T. :**	**Smoker :** Yes / No **How Many Per Day :** **Contraception :**

Reason For Call : Saturday attended A+E. has appt 3/9

PV Bleed : Spotting / Period Like / Heavy **Other :** Patient told by A+E to. Phone epas on Tuesday as. will be closed on Monday.

Pain : Central / Left Side / Right Side

Cramp / Mild / Moderate / Severe

Previous : Miscarriage / Molar / Ectopic

Advice Given :

Continues to have PVB since the weekend
to scan again on Thurs 3/9/15 as planned
- Self refer or attend A+E if worsening symptoms

CALL BACKS

Time	Outcome	Initials

Appointment Given : Yes / No **Date :** _____ **Time :** _____ **Childcare Discussed :** Yes / No

Signature: _____

PRM		SGH		RAH		IRH		VOL		OBAN	

NHS Greater Glasgow and Clyde

SNIPS - SUMMARY OF CONTACTS

Patient Details (addressograph) Name: 2505876061 MCLEISH F Wendy 25/05/1987 Addres 0/1 51 COXTON PLACE Glasgow, Lanarkshire G33 5EJ Tel:	KCND Pathway: Named Midwife: Consultant: Team:
GP: Dr. AL McGinley Dr Wilson dr mcginley & dr sheppar Address: Easterhouse Health Centre 9 Auchinlea Road Glasgow G34 9HQ Tel:	HV: Address: Tel:
	SW TEAM LEAD. Andrea Nairn 0141-276-3400

253166-7

SNIPS Chronology of Events

NHS
Greater Glasgow and Clyde

2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

Date	Event	Outcome	Sign/Print/ Designation
5/8/15	For discussion ONE Glasgow GP 10815		

File in case notes behind ALERT Sheet

253166-3

Maternity Summary Record

Please use black ink

Confidential

Personal details

CHI ..... Age 28

Previous surname .....

Likes to be called .....

Home ✆ .....

Other ✆ 07456750438.

Change of details

Your address .....

.....

..... Postcode .....

Home ✆ .....

Other ✆ .....

Partner/supporter details

Please tick if emergency contact ☑

Name James Ward

Date of Birth 18/1/87

Relationship Partner.

Address N/A.

.....

..... Postcode .....

Home ✆ .....

Other ✆ 07475660161.

Alternative/emergency contact

Name .....

Relationship .....

Address .....

.....

..... Postcode .....

Home ✆ .....

Other ✆ .....

Named midwife .....

.....

GP .....

.....

Affix label here or complete by hand

Unit No

Surname/family name

First name(s)

Date of birth / /

Address

2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

Parity 0 + 0

Agreed EDD / / LMP 22/5/15
EDD 25/2/16.

Blood group .....

Irregular antibodies Yes ☐ No ☐

Thrombosis risk factors

☐ Previous DVT ☐ BMI ≥30 ☐ Age >35

☐ Parity >4 ☐ Other .....

Allergies NOT AWARE.

Height 1.55 Weight 78 BMI 1.55

Gestation BMI calculated 10

Special features

Previous adult Respiratory Distress Syndrome following Pneumonia.

Directions to home

.....

.....

.....

.....

	Date	Time	Urine	Weight	Blood pressure	Name of midwife
1						
2						
3						
4						
5						
6						
7						
8						

Ethnic origin Caucasion

Current religion or faith non

Language used at home English

Help needed with interpreting, communicating or advocacy No ☒ Yes ☐

Cultural requirements/details on the above

Occupation Hair Assistant/unemployed

Provide details of social circumstances/family support. Detail any change of partner during pregnancy or the postnatal period

Referrals

/ / To

/ / To

/ / To

Key professionals

Named midwife Linda Fallons

Midwifery team B

Base RRM

✆

Obstetrician Dr Manners

Clinic

✆

Health Visitor

Base

✆

Social Worker

Base

✆

Health status

Specific dietary needs No ☒ Yes ☐

Smoking status non

At risk of passive smoking No ☐ Yes ☒

Problem alcohol use No ☐ Yes ☐

Problem drug use No ☒ Yes ☐

Details of any of the above

had been dancing 2or3 now only at weekend 10 units Saturday no alcohol since discovering pregnat

Domestic Abuse/Routine Enquiry

Seen alone at booking No ☐ Yes ☒

Routine enquiry question asked No ☐ Yes ☒

If not asked, document reason why

Abuse disclosed No ☒ Yes ☐

Current ☐ Past ☐

Please document in 'Further information/details of maternity care' and ensure all appropriate referrals made

If domestic abuse disclosed remember to tick the box in the women held record referring midwives back to summary record (box in special features area).

Comments

Child protection

Issue raised on / /

Comments

Please document in 'Further information/details of maternity care' and ensure all appropriate referrals made

General Practitioner Dr. AL McGinley
Dr Wilson dr mcginley & dr sheppar
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

Base

✆

Practice code

Other

Designation

Base

✆

Other

Designation

Base

✆

Chronology of Significant Events

Please detail below the strengths, assets and challenges faced by women and their families throughout pregnancy, birth and the post-natal period.

The chronology should contain:

- The date and time
- A brief description of the event
- Cross-reference to other records e.g. computerised records
- Each entry must be signed

Date / Time	Event	Action Taken	Signature

Planned place of birth and Pathway for antenatal care red or green

.....

.....

Lead professional ..... Consultant

Designation ..... Dr Mathas

Change(s) to Planned place of birth and Pathway for antenatal care red or green

Reason .....

Signed .....

Booking completed by ..... Print ..... Designation .....

Date / / Gestation ..... weeks Location .....

Date	Gestation	BP	Urinalysis	Further information/details of maternity care
Remember to sign each entry and print your signature alongside your first entry. Please use 24 hour clock.				
3/8/15	10	110/83	clear	High Risk booker @ Eastonhouse
				Previous history Pneumonia resulting
				in Adult Respiratory Distress Syndrome ?
				Induced Coma.
				Has in care as a child due to her parents
				(fathers drug history)
				Anxious gr/l. History of overdose
				will have perinatal MH referal
				& Social work " (partner has had custodial sentence)
				Her medication @ present is Propranolol &
				mirtazapine 1 5mg daily.
				Only GP involved with this medication
				Wendy aware that she will have routine
				referral to PMH & SW. ? SNIPS involvement
				I will discuss with them PTO

3.1.8	Medical referral arranged following booking u/s
	Social work & Perinatal Mental Health referral completed ↓Fellow. ↓Fellow.

41725

Maternity Summary Record (continued) Name .....

2505876061
MCLEISH
Wendy
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ
F
25/05/1987

Remember to sign each entry

Date	Gestation	Further information/details of maternity care
25/8/15	? 13 ; ? 8-9.	Reports red post coital bleed last night + spot of pink today. U/S 20/8 Sac seen (patient states) was empty attended today for ? ~~booking~~ ? medication. Review. No c/s In view of history D/w. EPA. — for Scan Wednesday Thursday as planned + will be re appointed if continuing pregnancy Weekday will return Thursday appears to be happy re plan Unterkasson Bank m/w

41657

GG & C MATERNITY ULTRASOUND REPORT

PATIENT NAME: 2505876061 MCLEISH Wendy F 25/05/1987

ADDRESS: 0/1 51 COXTON PLACE Glasgow, Lanarkshire G33 5EJ

DATE OF BIRTH:

HOSPITAL / CHI NUMBER:

SINGLE / TWINS / TRIPLETS

EDD (BY SCAN):

BOOKING DATA AND EARLY PREGNANCY SCANNING

Date	20.08.15.		
Menstrual Age			
Ultrasound Age			
Fetal Number			
Fetal Heart			
CRL			
NT Measurement			
HC			
FL			
Yolk Sac	? Seen.		
Second Sac			
Placental Site			
Screening Status (Please circle as appropriate)	Success Declined Failed < 11+2 Or >14+1 For 2nd Tri screening: Today OR M/W Appt from	Success Declined Failed < 11+2 Or >14+1 For 2nd Tri screening: Today OR M/W Appt from	Success Declined Failed < 11+2 Or >14+1 For 2nd Tri screening: Today OR M/W Appt from .....
Comments TAS + TVS performed with consent telephone. Gestational sac seen < 25mm. 8.4 x 8.2 x 12.4mm ? yolk sac ? fetal pole			
Review review @ EDAS in 1/52.			
Sonographer			
Print Name McCullough			

POSTNATAL SCANS

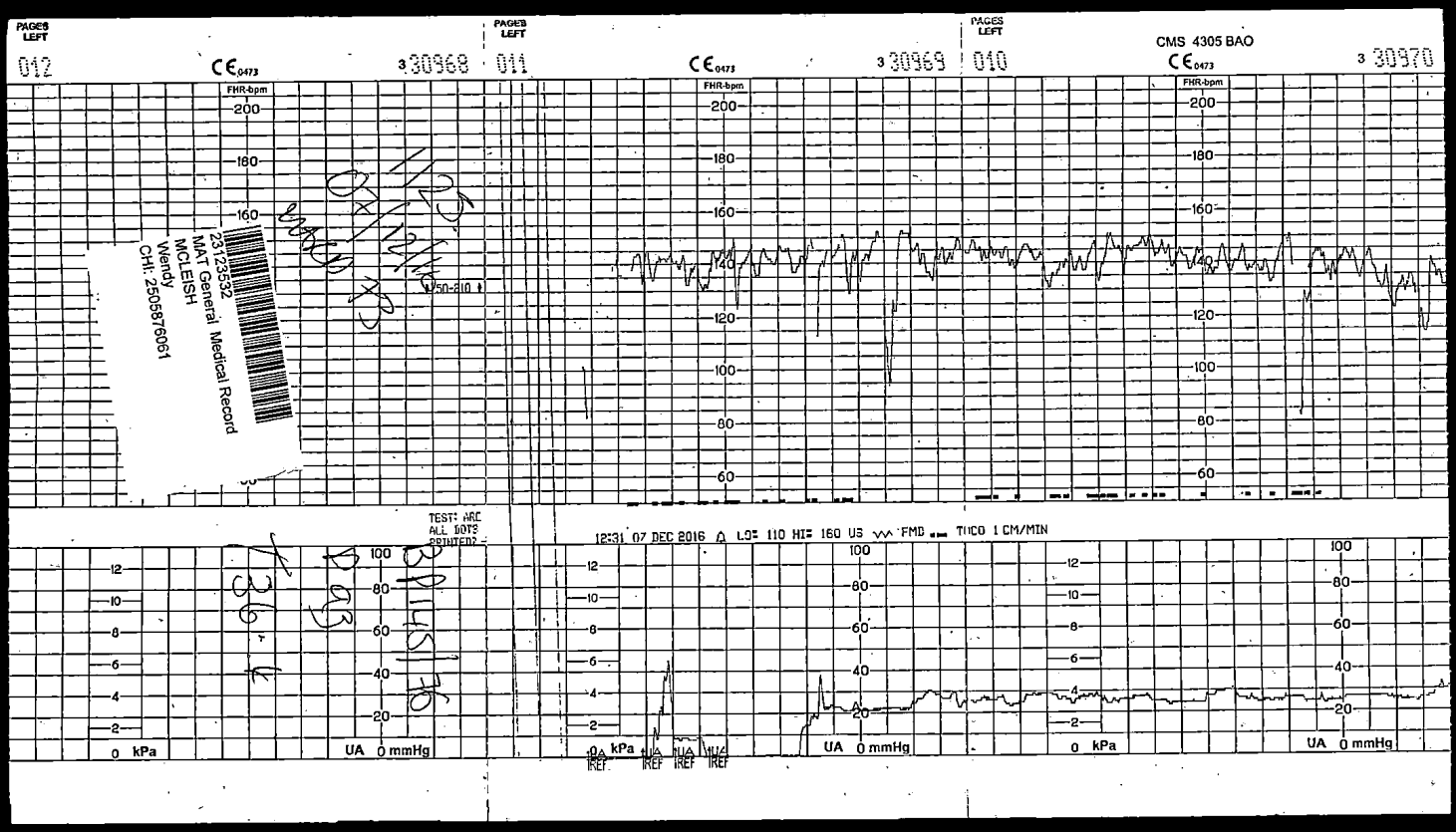
Date			
Indication	Comment	Comment	Comment
Review			
Sonographer			
Print Name			

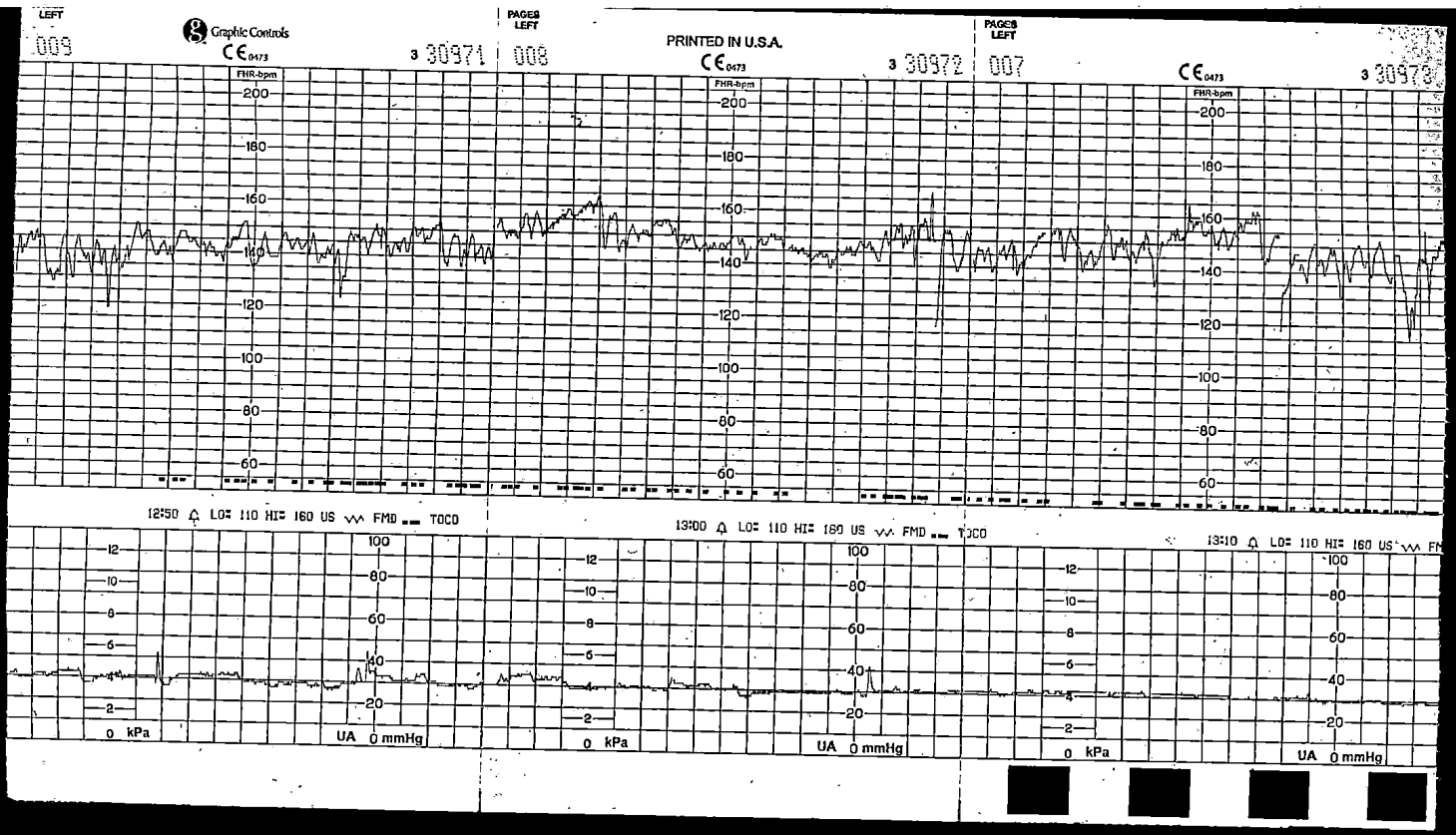
Fetal Anomaly Screening – Ultrasound Report NHS GG&C

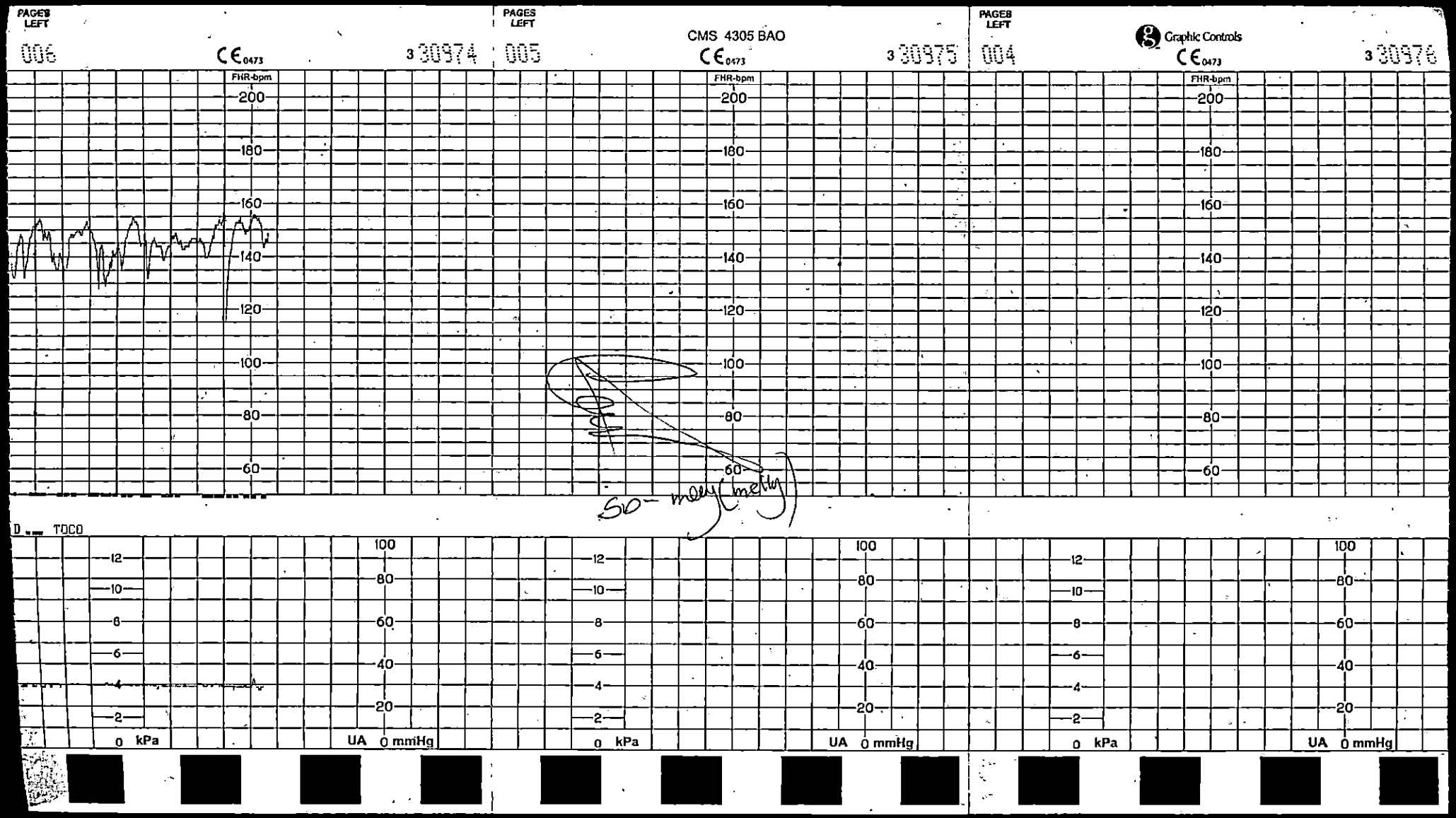
2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

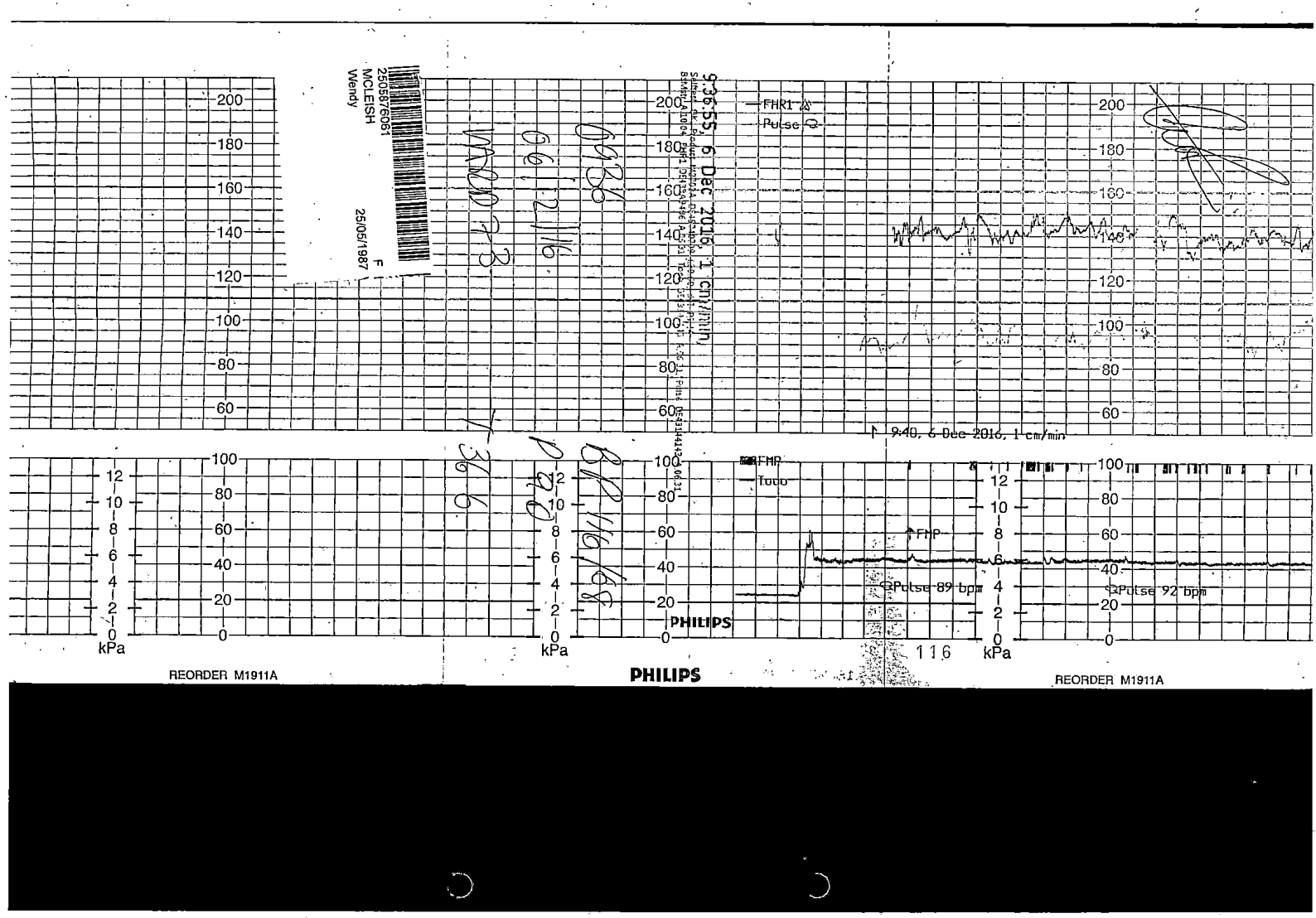
Text in Bold – Mandatory information/ measurements/anatomy checks

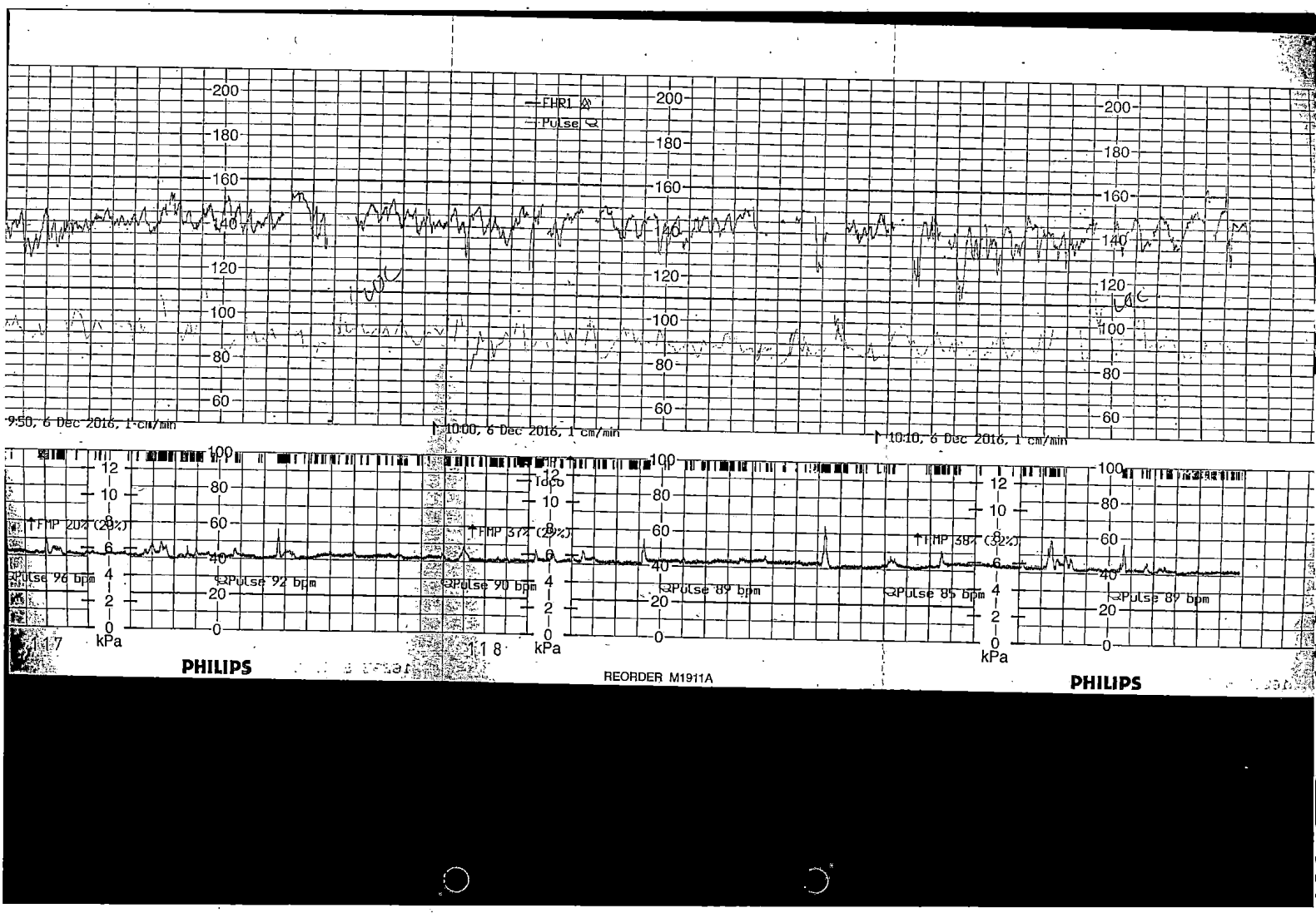
Date		
Gestational Age		
HC (mm)		
Ventricles (mm)		
Cerebellum		
TCD (mm)		
Lips and nasal tip		
Profile		
4 chamber heart		
RVOT		
LVOT		
Diaphragm		
AC (mm)		
Stomach		
Abdominal wall		
Kidneys		
Bladder		
Spine		
Upper limbs		
Hands		
Lower limbs		
Feet		
FL (mm)		
Fetal sex (if requested)		
Liquor Volume		
Placental Site		
Comments		
Review		
Operator		

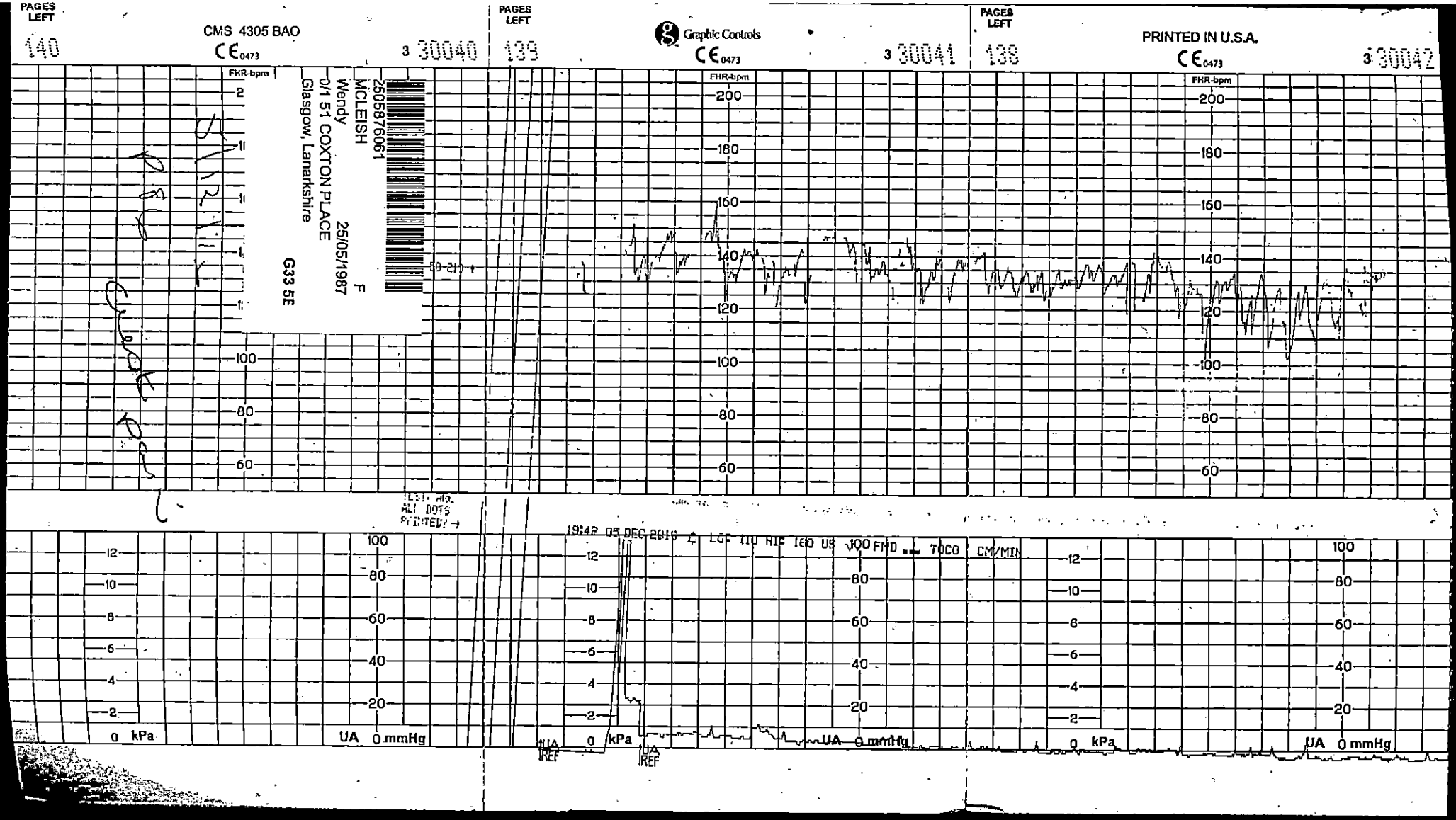

PAGES LEFT
012
CE 0473
3 30968
PAGES LEFT
011
CE 0473
3 30969
PAGES LEFT
010
CMS 4305 BAO
CE 0473
3 30970
FHR-bpm
200
180
160
140
120
100
80
60
MAT General Medical Record
MCLEISH
Wendy
CHI: 2505876061
TEST: ARE ALL DOTS PRINTED?
12:31 07 DEC 2016 Δ LOW 110 HIGH 160 US FMB TOCO 1 CM/MIN
12
10
8
6
4
2
0 kPa
100
80
60
40
20
UA 0 mmHg

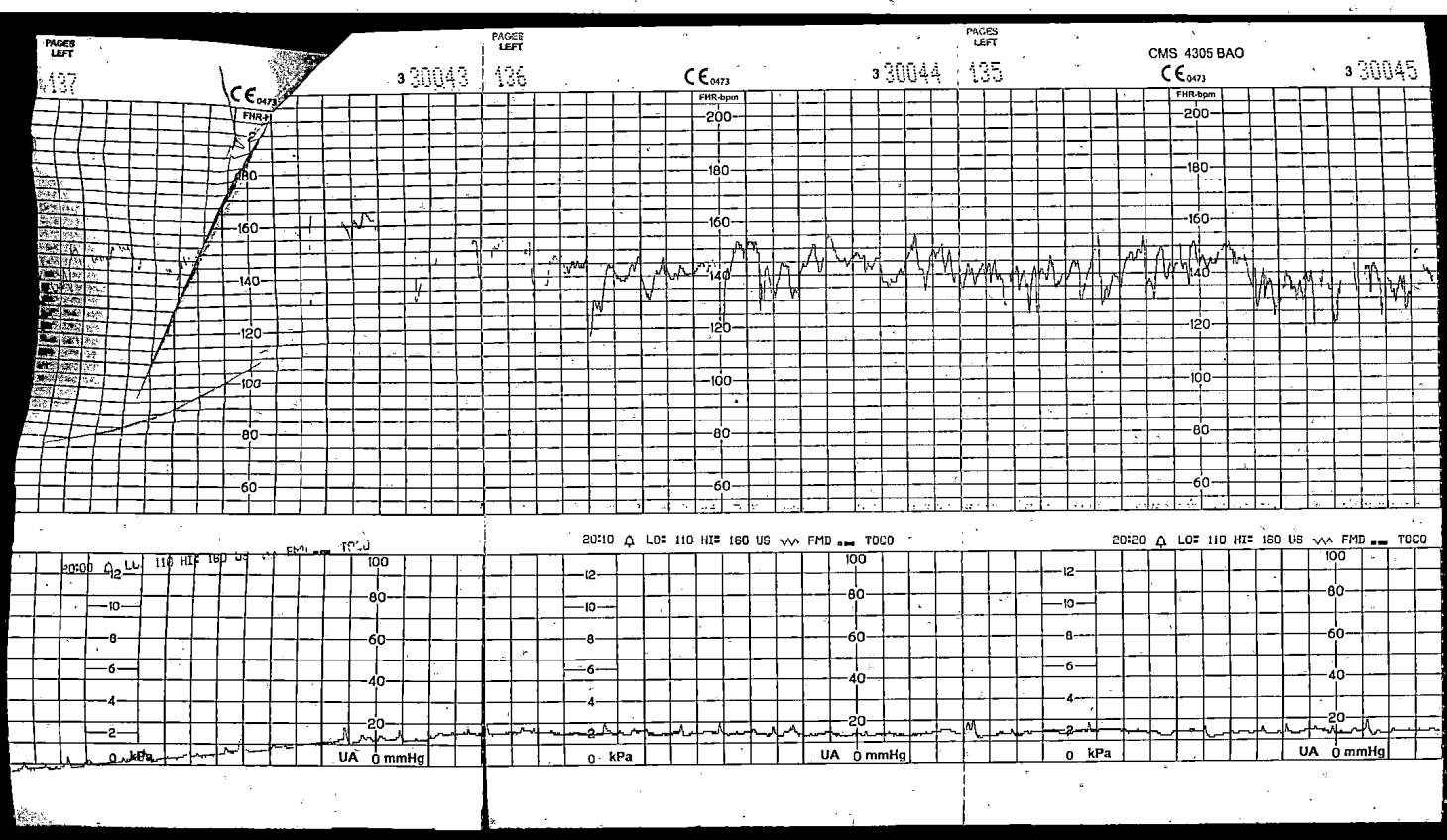

PAGES LEFT
009
Graphic Controls
CE 0473
3 30971
PAGES LEFT
008
PRINTED IN U.S.A.
CE 0473
3 30972
PAGES LEFT
007
CE 0473
3 30973
FHR-bpm
200
180
160
140
120
100
80
60
12:50 LO= 110 HI= 160 US FMD TOCO
13:00 LO= 110 HI= 160 US FMD TOCO
13:10 LO= 110 HI= 160 US
12
10
8
6
4
2
0 kPa
100
80
60
40
20
UA 0 mmHg

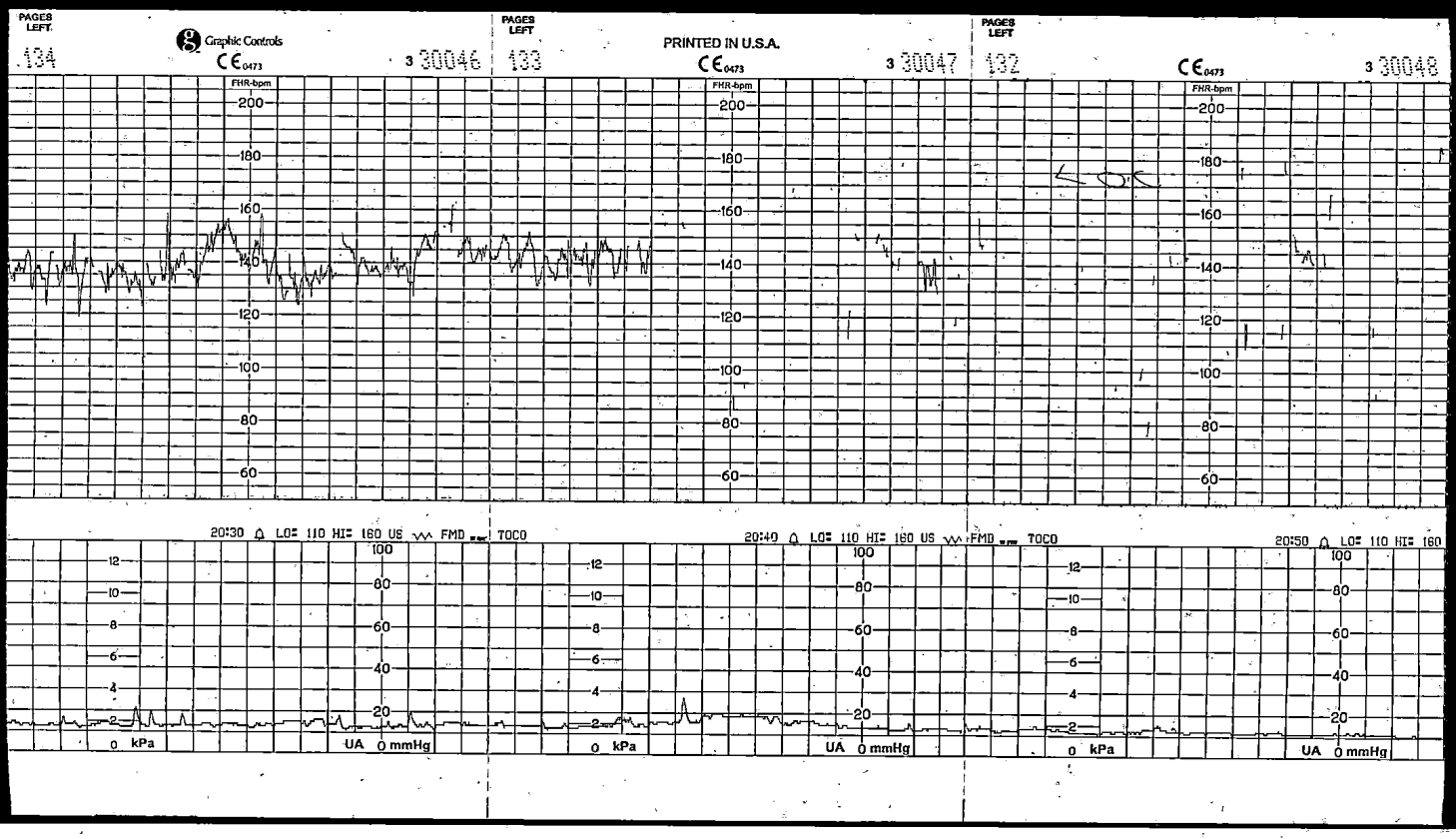

PAGES LEFT
006
CE 0473
3 30974
FHR-bpm
200
180
160
140
120
100
80
60
D TOCO
12
10
8
6
4
2
0 kPa
100
80
60
40
20
UA 0 mmHg
PAGES LEFT
005
CMS 4305 BAO
CE 0473
3 30975
FHR-bpm
200
180
160
140
120
100
80
60
So- many (melly)
12
10
8
6
4
2
0 kPa
100
80
60
40
20
UA 0 mmHg
PAGES LEFT
004
Graphic Controls
CE 0473
3 30976
FHR-bpm
200
180
160
140
120
100
80
60
12
10
8
6
4
2
0 kPa
100
80
60
40
20
UA 0 mmHg

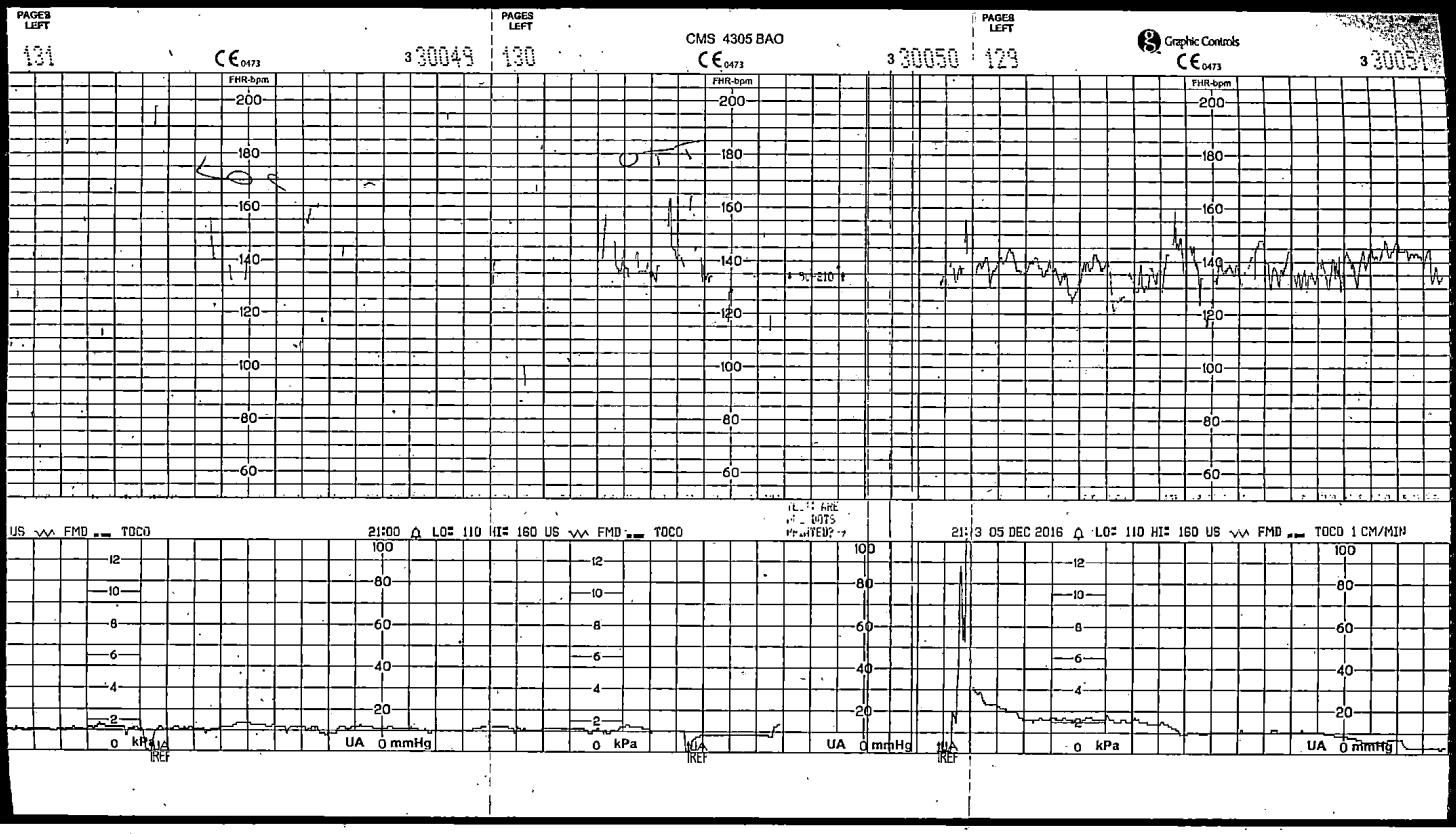

MCLEISH
Wendy
25/05/1987
FHR1
Pulse
9:55, 6 Dec 2016, 1 cm/min
9:40, 6 Dec 2016, 1 cm/min
FHP
Toco
Pulse 89 bpm
Pulse 92 bpm
kPa
PHILIPS
REORDER M1911A

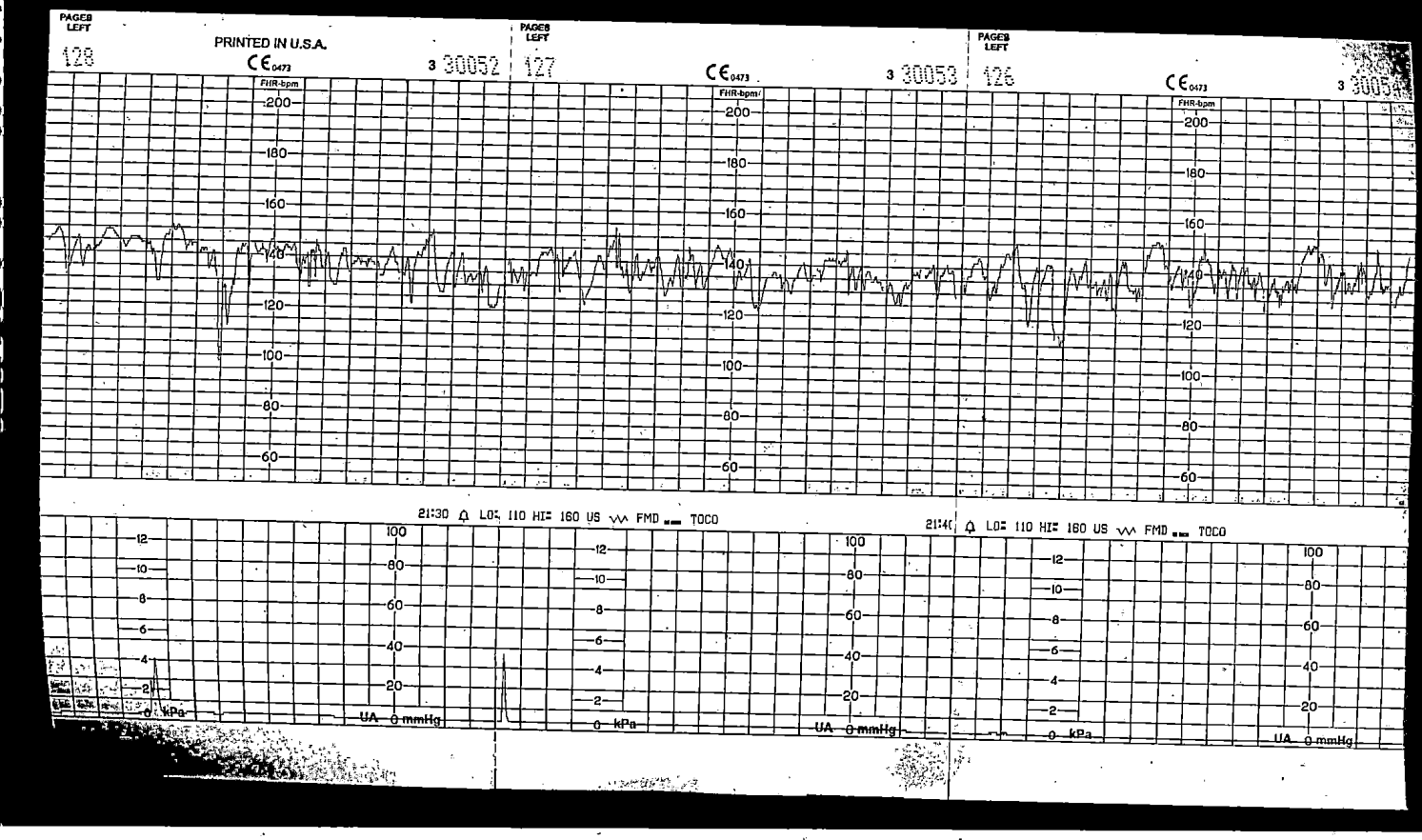

FHR1
Pulse
9:50, 6 Dec 2016, 1 cm/min
10:00, 6 Dec 2016, 1 cm/min
10:10, 6 Dec 2016, 1 cm/min
TOCO
FMP 20% (20%)
FMP 37% (37%)
FMP 38% (32%)
Pulse 98 bpm
Pulse 92 bpm
Pulse 90 bpm
Pulse 89 bpm
Pulse 85 bpm
Pulse 89 bpm
kPa
PHILIPS
REORDER M1911A

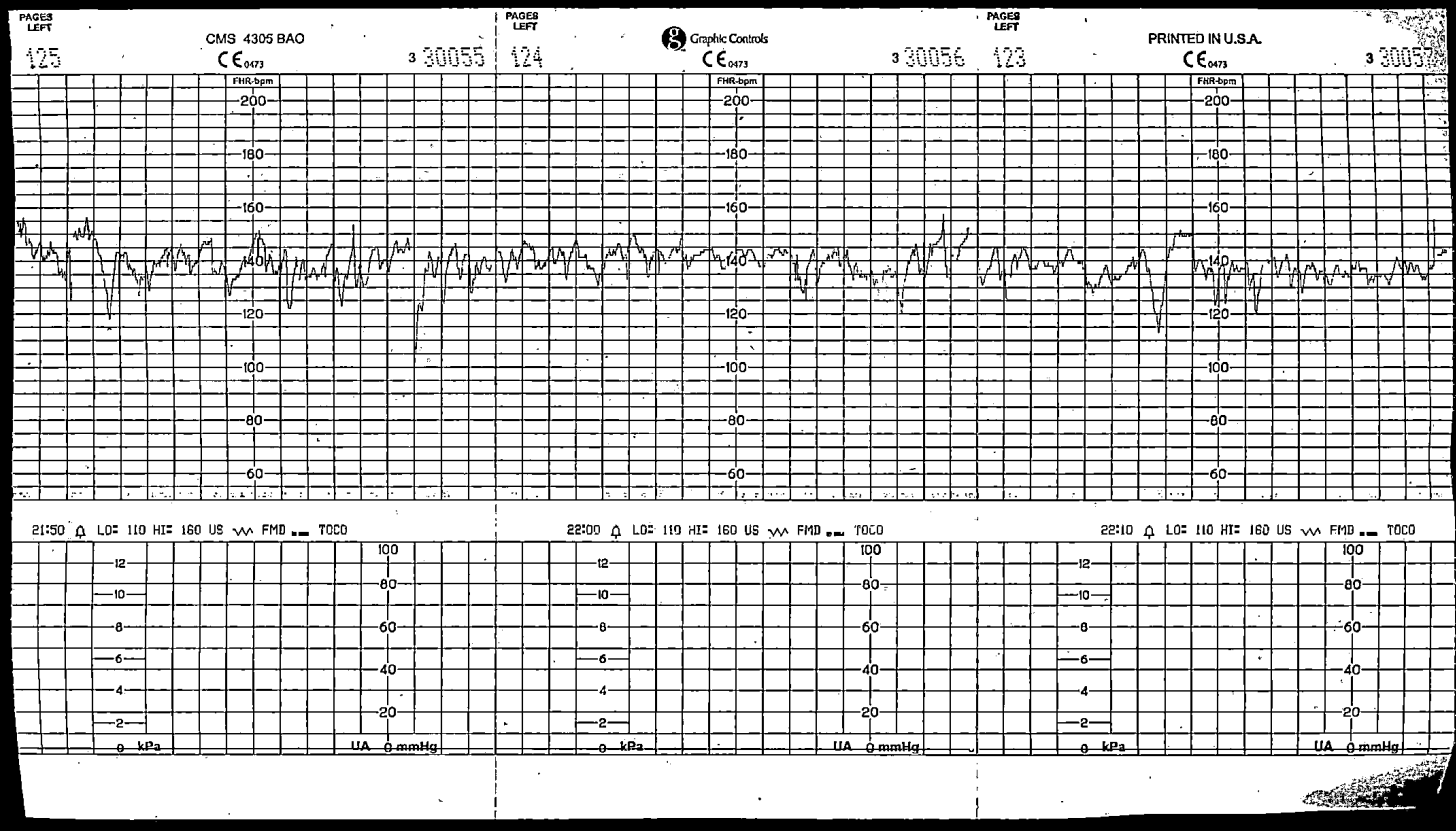

PAGES LEFT
140
CMS 4305 BAO
CE 0473
3 30040
FHR-bpm
250587606 1
MCLEISH
Wendy
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
25/05/1987
F
G33 5E
PAGES LEFT
139
Graphic Controls
CE 0473
3 30041
PAGES LEFT
138
PRINTED IN U.S.A.
CE 0473
3 30042
200
180
160
140
120
100
80
60
12
10
8
6
4
2
0 kPa
UA 0 mmHg
TOCO
CM/MIN

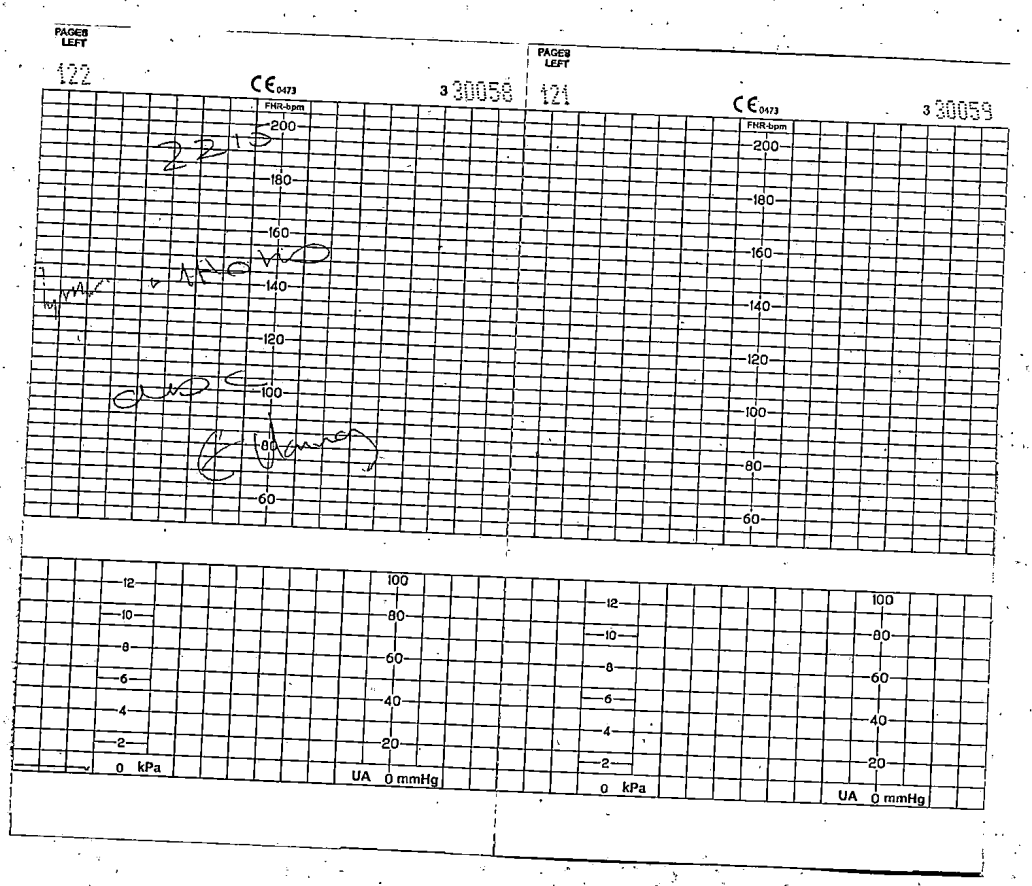

PAGES LEFT
137
3 30043
PAGES LEFT
136
3 30044
PAGES LEFT
135
CMS 4305 BAO
3 30045
FHR-bpm
200
180
160
140
120
100
80
60
20:10 LO: 110 HI: 160 US FMD TOCO
20:20 LO: 110 HI: 160 US FMD TOCO
12
10
8
6
4
2
0 kPa
100
80
60
40
20
UA 0 mmHg


PAGES LEFT
134
Graphic Controls
CE 0473
3 30046
PAGES LEFT
133
PRINTED IN U.S.A.
CE 0473
3 30047
PAGES LEFT
132
CE 0473
3 30048
FHR-bpm
200
180
160
140
120
100
80
60
20:30 LO= 110 HI= 160 US FMD TOCO
20:40 LO= 110 HI= 160 US FMD TOCO
20:50 LO= 110 HI= 160
12
10
8
6
4
2
0 kPa
100
80
60
40
20
UA 0 mmHg


PAGES LEFT
131
CE 0473
30049
PAGES LEFT
130
CMS 4305 BAO
CE 0473
30050
PAGES LEFT
129
Graphic Controls
CE 0473
30051
FHR-bpm
200
180
160
140
120
100
80
60
US FMD TOCO
21:00 LO= 110 HI= 160 US FMD TOCO
21:3 05 DEC 2016 LO= 110 HI= 160 US FMD TOCO 1 CM/MIN
12
10
8
6
4
2
0 kPa
100
80
60
40
20
UA 0 mmHg
UA REF


PAGES LEFT
128
PRINTED IN U.S.A.
CE 0473
3 30052
FHR-bpm
200
180
160
140
120
100
80
60
21:30 LO: 110 HI: 160 US FMD TOCO
12
10
8
6
4
2
0 kPa
100
80
60
40
20
UA 0 mmHg
PAGES LEFT
127
CE 0473
3 30053
PAGES LEFT
126
CE 0473
3 30054


PAGES LEFT
125
CMS 4305 BAO
CE 0473
3 30055
PAGES LEFT
124
Graphic Controls
CE 0473
3 30056
PAGES LEFT
123
PRINTED IN U.S.A.
CE 0473
3 30057
FHR-bpm
200
180
160
140
120
100
80
60
21:50 LO: 110 HI: 160 US FMD TOCO
22:00 LO: 110 HI: 160 US FMD TOCO
22:10 LO: 110 HI: 160 US FMD TOCO
12
10
8
6
4
2
0 kPa
100
80
60
40
20
UA 0 mmHg


PAGES LEFT
122
CE 0473
3 30058
FHR-bpm
200
180
160
140
120
100
80
60
12
10
8
6
4
2
0 kPa
100
80
60
40
20
UA 0 mmHg
PAGES LEFT
121
CE 0473
3 30059
FHR-bpm
200
180
160
140
120
100
80
60
12
10
8
6
4
2
0 kPa
100
80
60
40
20
UA 0 mmHg

SNIPS MIDWIVES 0141 211 5366

(73)

PRM

NHS SCOTLAND

Ward 72 : 0141 211 5214

Bed 1 / Bay 1

Your Combined Pregnancy and Postnatal Record

Confidential

MCA - 0141 211 5352 or 5276 (24hrs).

PLEASE USE BLACK INK

23123532
MAT General Medical Record
MCLEISH
Wendy
CHI: 2505876061

ANGIE 07881811430



Please bring your record to all healthcare appointments and hospital admissions.

If found please return this record to the nearest Maternity Unit or General Practitioner surgery as soon as possible.

Getting it right for every child (GIRFEC)

Giving you, your baby and your family the best possible start in life is a priority for all the services who are working closely together using the Getting It Right for Every Child (GIRFEC) programme. GIRFEC is used to assess and understand how best to meet your needs and your baby's needs. The practice model below shows some of the things that are important to help you and your baby grow and develop. Your Midwife, Health Visitor/ Public Health Nurse will explain how this works and how they will work with you to make sure that both you and your baby receive the help and support you require.

The principles of GIRFEC include

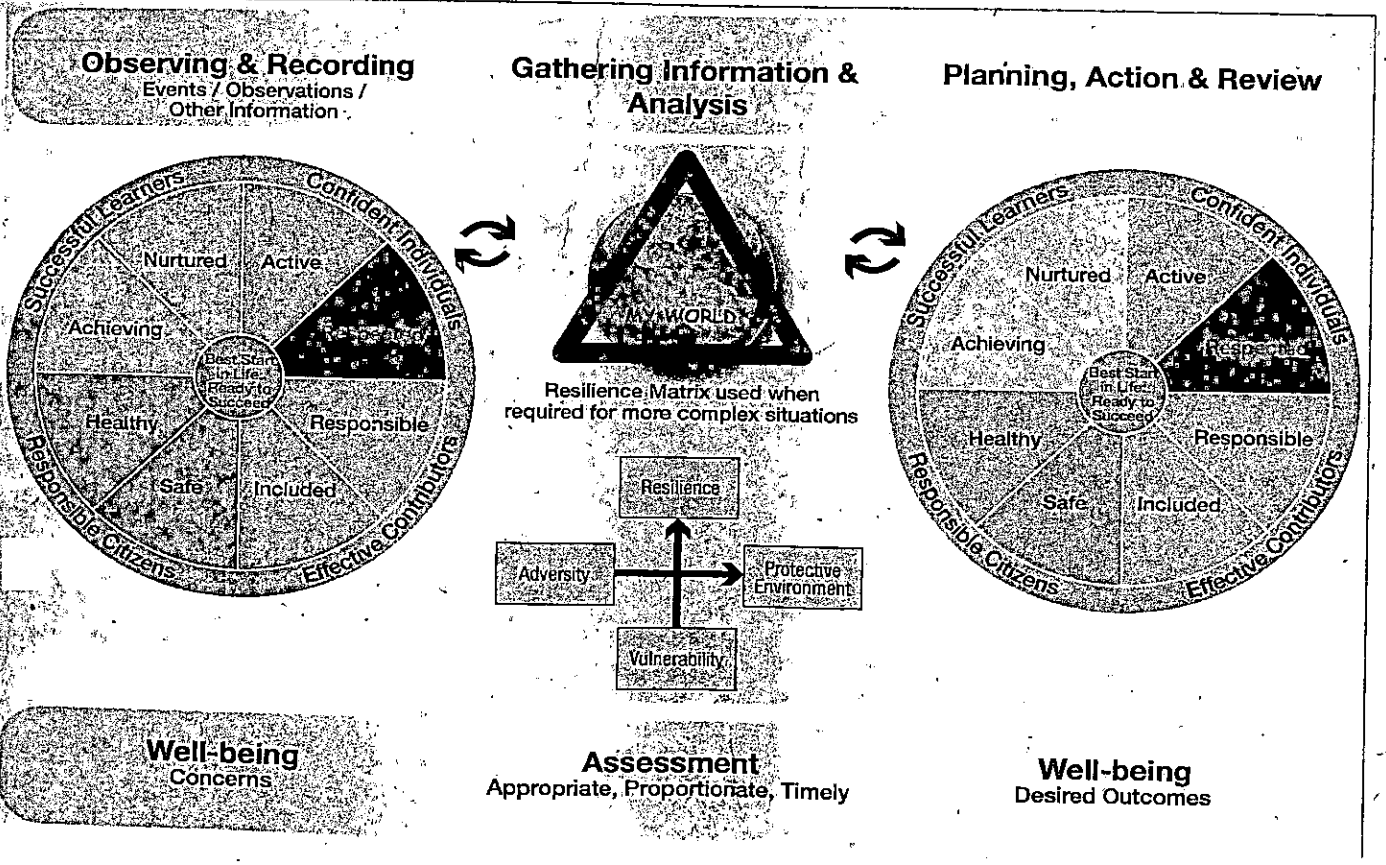
- The use of the wellbeing indicators – Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible and Included – to determine appropriate assessment using the My World Triangle.
- The My World Triangle assessment considers the strengths and pressures for the woman and family around the three domains – How I grow and develop, What I need from people who look after me and My wider world
- The use of the 5 GIRFEC questions
- Early assessment, early support, early intervention, multi-agency approach are key to implementing GIRFEC.
- Consider the woman's and family's strengths and pressures.

Maternity team staff should ask themselves

- What is getting in the way of this woman or baby's well-being?
- Do I have all the information I need to help this woman or baby?
- What can I do now to help this woman or baby?
- What can my service do to help this woman or baby?
- What help if any may be needed from others?

After considering all of the principles described above, it is important that any assessment includes the impact that factors may have on the child and family, and what the desired outcomes are. Therefore the plan for the child and family must include action to be taken and when a review is required. The GIRFEC approach is summarised in the National Practice Model below

The National Practice Model



Consider referral to Health Visitor/Public health nurse for allocation of Health Plan Indicator

Outcome of referral: Health Plan Indicator allocated (circle as appropriate): core additional

Gestation at allocation

Health Visitor/Public Health Nurse details –

Name

Date

Your combined pregnancy and postnatal record

This is your pregnancy/postnatal record. It contains important information that will be used to help you and your maternity care team plan care for you and your baby. You will usually be asked to carry your record during your pregnancy, as this will help communication between you and your maternity care team.

Some women may prefer not to carry their combined pregnancy/postnatal record. If you do not want to carry your record, please tell your midwife. Your midwife will arrange to hold your record for you, or for it to be kept at the maternity unit or your GP practice.

Please keep your record safe, confidential and protect it from damage. If you lose your record, please contact your midwife or maternity unit as soon as possible.

Please remember to take this record with you to all health appointments during your pregnancy. For example, whenever you see your midwife, GP, obstetrician, physiotherapist or when you go for an ultrasound scan. Nearer the time when your baby is due, you may want to carry your record with you when you go out and about.

Please feel free to write in your record where you see this symbol:

Your Record remains the property of your NHS Board. At the end of your maternity care it will be returned to the NHS Board where it will be stored safely. If you would like a copy of your completed record, please speak to your midwife or contact the data controller of the NHS Board responsible for your care. (There may be a small charge for this.)

Details about how your personal information is used by staff within NHSScotland can be found in the leaflet 'Confidentiality – it's your right'. This is available from your midwife, GP practice or on-line at http://www.hris.org.uk Follow the links on confidentiality, consent and having your say.

Help and advice

Please use the following services

✆ .....

✆ .....

Contact details

Maternity unit ..... Prem.

✆ .....

✆ .....

Antenatal clinic ..... GNC 531 8100

✆ .....

Delivery suite ..... Mon am

✆ ..... Tues-am

Wed-pm.

Ultrasound department .....

✆ .....

Health Visitor .....

Base .....

✆ .....

Named midwife GAIL TOWSON

Midwifery team B

Base Prem

✆ .....

General Practitioner .....

Address ..... Dr. AL McGinley
Dr Wilson dr mcginley & dr sheppar
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

✆ .....

GP informed of pregn

Obstetrician .....

Base .....

✆ .....

Domestic Abuse Helpline: 0800 027 1234 (24 hours)

Scottish Women's Aid: www.scottishwomensaid.co.uk

NHS 24: 08454 24 24 24

Rape Crisis Scotland Helpline: 08088 01 03 02 (free number), 6pm to midnight

Email: info@rapecrisisscotland.org.uk

Local information

Your midwife or doctor will write details of local services below, e.g. antenatal clinic times, breastfeeding support groups and antenatal education sessions.

Supervisors of midwives are experienced practising midwives who have undertaken additional education and training to support, guide and supervise midwives. Supervisors of midwives develop and maintain safe practice to ensure protection of you, your baby and family. For more information on the role of the supervisor see www.nmc-org.uk. To contact a supervisor of midwives at your hospital speak to any midwife.

.....

.....

.....

Please note that supervised students may be learning alongside the maternity staff who care for you. If you have any concerns or preferences about this, please speak to your midwife.

Plan of care for your pregnancy

This chart is used to record a plan of care for your pregnancy. Your midwife or doctor will tick the boxes to show when an appointment is due, where it will take place, and whether a blood test or ultrasound scan is planned. Details of each appointment can be written below.

If this is your first baby you will usually have 10 appointments, if you have had a baby before you will usually have 7 appointments. The first appointment may be sometime between 8 and 12 weeks.

Week number	8		10		12		14		16		18		20		22		24		26		28		30		32		34		36		38		40	41	42
Health centre/surgery																																			
Maternity unit																																			
Home																																			
Blood tests																																			
Ultrasound																																			

Your appointments

Day	Date	Time	Where & who with	Things you want to discuss
Monday	19/9/16	9-15	Clinic	

Record of Maternity Care Pathway and Caseload Midwife or Obstetrician as per National Pathways for Maternity Care

Pathways available: Green – Midwife Led Care or Red – Maternity Team Care. Women allocated Amber status only whilst awaiting a further opinion from a member of the maternity team.

Booking Status: GREEN/RED (Please Circle)					
Date/ Location of booking	Gestation	Agreed Pathway	Reason e.g. Previous LUSCS	Booked With Midwife/Obstetrician Name	Signature
Subsequent Changes					
Date/ Location	Gestation	Pathway Change e.g. green to red, red to green	Reason for transfer to different pathway e.g. raised BP	Care transferred to e.g. Midwife to Obstetrician, obstetrician to Midwife. Insert Name	Signature

Important information

Surname/ family name .....

First name(s) .....

Previous surname .....

Likes to be called .....

Date of birth .....

Your address .....

.....

..... Postcode .....

Home ✆ .....

...er ✆ .....

Occupation .....

Change of address/phone details .....

.....

..... Postcode .....

Home ✆ .....

Other ✆ .....

Planned place of birth		Lead professional
Home		
Hospital		
CMU		
ıer		

Affix label here or complete by hand

Unit no .....

CHI .....

2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

Your partner/supporter for this pregnancy

Name .....

Occupation .....

Relationship to you .....

Partner's date of birth .....

Address .....

..... Postcode .....

Home ✆ .....

Other ✆ .....

Emergency contact person/next of kin
Who would you like contacted in an emergency?

☐ **Your partner/supporter** ☐ **Alternative person:**

Name .....

Relationship to you .....

Address .....

..... Postcode .....

Home ✆ .....

Other ✆ .....

When is your baby due? - Your "Estimated Date of Delivery" or EDD

This information is used to work out when your baby is due. This is called your estimated date of delivery (EDD). It is helpful to think of your EDD as a 'rough guide'. Most babies are born during the fortnight before, or the fortnight after your EDD.

Date of the first day of bleeding of your last menstrual period (LMP)? 25/5/16

How sure are you of this date? ☐ sure ☐ fairly sure ☒ not sure

Average number of days between the first day of each period (monthly cycle) 28 days

Have you had any vaginal bleeding since your last menstrual period? ☒ No ☐ Yes

Had you been using any contraception? ☒ No ☐ Yes

Type ..... Date stopped / /

History taken by EDunsm

Date of Booking Appointment 15/8/16

Agreed EDD 03 March 17

Use this EDD in all communication

Your body mass index (BMI) 31.4
(weight [kg]/height [m]²)

Weight at booking 78.5 kg Height 1.58 m

Comments/details .....

.....

.....

Provisional EDD based on LMP and monthly cycle 1/3/16

EDD using dating scan / /

Agreed by Signed .....

Your previous pregnancies

Is current pregnancy with a new partner No ☐ Yes ☐ Para ..... + ...

Full name..... Boy ☐ Girl ☐ Date of birth ..... Type of birth.....

Place of birth..... Birthweight (g) ..... Gestation.....

Labour onset Spontaneous ☐ Induced ☐ Planned Caesarean ☐

Anaesthetic None ☐ Epidural/Spinal ☐ General ☐

3rd stage Normal ☐ Haemorrhage ☐ Retained placenta ☐

Perineum Intact ☐ Episiotomy ☐ Tear 1° ☐ 2° ☐ 3/4° ☐

Breast ☐ Formula ☐

Further relevant information.....

Problems A/N.....

P/N.....

Psychological.....

Full name..... Boy ☐ Girl ☐ Date of birth ..... Type of birth.....

Place of birth..... Birthweight (g) ..... Gestation.....

Labour onset Spontaneous ☐ Induced ☐ Planned Caesarean ☐

Anaesthetic None ☐ Epidural/Spinal ☐ General ☐

3rd stage Normal ☐ Haemorrhage ☐ Retained placenta ☐

Perineum Intact ☐ Episiotomy ☐ Tear 1° ☐ 2° ☐ 3/4° ☐

Breast ☐ Formula ☐

Further relevant information.....

Problems A/N.....

P/N.....

Psychological.....

Full name..... Boy ☐ Girl ☐ Date of birth ..... Type of birth.....

Place of birth..... Birthweight (g) ..... Gestation.....

Labour onset Spontaneous ☐ Induced ☐ Planned Caesarean ☐

Anaesthetic None ☐ Epidural/Spinal ☐ General ☐

3rd stage Normal ☐ Haemorrhage ☐ Retained placenta ☐

Perineum Intact ☐ Episiotomy ☐ Tear 1° ☐ 2° ☐ 3/4° ☐

Breast ☐ Formula ☐

Further relevant information.....

Problems A/N.....

P/N.....

Psychological.....

Early Pregnancy Losses (less than 24 weeks)

Year	Gestation	Nature of loss	Comments
2015	12	Miscarriage	D&C GA

Your previous pregnancies

Full name..... Boy ☐ Girl ☐ Date of birth..... Type of birth.....

Place of birth..... Birthweight (g) ..... Gestation.....

Labour onset Spontaneous ☐ Induced ☐ Planned Caesarean ☐

Anaesthetic None ☐ Epidural/Spinal ☐ General ☐

3rd stage Normal ☐ Haemorrhage ☐ Retained placenta ☐

Perineum Intact ☐ Episiotomy ☐ Tear 1° ☐ 2° ☐ 3/4° ☐

Breast ☐ Formula ☐

Further relevant information.....

Problems A/N.....

P/N.....

Psychological.....

Full name..... Boy ☐ Girl ☐ Date of birth..... Type of birth.....

Place of birth..... Birthweight (g) ..... Gestation.....

bour onset Spontaneous ☐ Induced ☐ Planned Caesarean ☐

Anaesthetic None ☐ Epidural/Spinal ☐ General ☐

3rd stage Normal ☐ Haemorrhage ☐ Retained placenta ☐

Perineum Intact ☐ Episiotomy ☐ Tear 1° ☐ 2° ☐ 3/4° ☐

Breast ☐ Formula ☐

Further relevant information.....

Problems A/N.....

P/N.....

Psychological.....

Full name..... Boy ☐ Girl ☐ Date of birth..... Type of birth.....

Place of birth..... Birthweight (g) ..... Gestation.....

Labour onset Spontaneous ☐ Induced ☐ Planned Caesarean ☐

Anaesthetic None ☐ Epidural/Spinal ☐ General ☐

3rd stage Normal ☐ Haemorrhage ☐ Retained placenta ☐

Perineum Intact ☐ Episiotomy ☐ Tear 1° ☐ 2° ☐ 3/4° ☐

Breast ☐ rmula ☐

Further relevant information.....

Problems A/N.....

P/N.....

Psychological.....

Full name..... Boy ☐ Girl ☐ Date of birth..... Type of birth.....

Place of birth..... Birthweight (g) ..... Gestation.....

Labour onset Spontaneous ☐ Induced ☐ Planned Caesarean ☐

Anaesthetic None ☐ Epidural/Spinal ☐ General ☐

3rd stage Normal ☐ Haemorrhage ☐ Retained placenta ☐

Perineum Intact ☐ Episiotomy ☐ Tear 1° ☐ 2° ☐ 3/4° ☐

Breast ☐ Formula ☐

Further relevant information.....

Problems A/N.....

P/N.....

Psychological.....

Your health – Have you ever had, or do you currently have, any of the following:

Allergies - Please document in special features

	No	Yes	Details
Operations	☐	☑	RUC 2015
Problems with anaesthetics	☐	☐	(R) WRIST OF 2009 - CAR ACCIDENT Consider anaesthetic review
Admission(s) to intensive care	☐	☑	MILD RESPIRATORY DISTRESS SYNDROME FOLLOWING PNEUMONIA - PUT INTO INDUCED COMA 2011.
Difficulties accessing your veins	☑	☐	
Asthma or lung problems	☐	☐	
High blood pressure	☑	☐	
Heart problems	☑	☐	
Diabetes/thyroid disorders	☑	☐	
Epilepsy/neurological problems	☑	☐	HAD TRAUMA INVESTIGATED NEGATIVELY
Blood transfusions	☐	☐	2012 THOUGHT TO BE BENIGN
Blood clots/clotting problems	☑	☐	
Kidney or urinary problems	☑	☐	
Liver problems or hepatitis	☑	☐	
Gastro-intestinal disorders	☑	☐	
Problems with fertility or your reproductive system*	☑	☐	
Vaginal infections	☑	☐	
Chicken pox?	☐	☑	
Genetic disorder	☐	☐	
Date of your last cervical smear (month/year)	2015		Result NORMAL Next smear due 2019
Referred for colposcopy?	☐	☐	Treatment
Cancer of any kind	☑	☐	
Problems with bones or joints	☐	☐	
Is there anything else about your health which you feel is important for your care providers to know?	☐	☑	

*** Please see "Your Guide to Screening tests during pregnancy" if you have had assisted conception**

Family health – Does anyone in your immediate family, or your baby's father or his immediate family, have a history of the following:

	No	Yes	Don't know	Details
Family history of anaesthetic complications	☐	☐	☐	NO INFO ~~RE~~ FAMILY HISTORY - ~~LOSS~~ WAS IN CARE FROM 4 YRS.
Asthma or allergies	☐	☐	☐	
Diabetes	☐	☐	☐	
Genetic disorders/attending a genetics clinic	☐	☐	☐	
Pre-eclampsia	☐	☐	☐	
Blood clots (thrombosis)	☐	☐	☐	
Recent/active Tuberculosis (TB)	☐	☐	☐	
Hip problems detected at birth or shortly afterwards	☐	☐	☐	
Abnormalities present at birth	☐	☐	☐	
Family history of twins or multiple births	☐	☐	☐	
Learning disabilities	☐	☐	☐	
Permanent hearing loss	☐	☐	☐	
Are you and your baby's father blood relatives?	☐	☐	☐	

Family Origin Questionnaire (If mixed, tick more than one box)

How do you describe your ethnic group origin

The term ethnic origin is to describe where your family originates from, as distinct from where you were born. This information will help us to decide which blood screening tests you should be offered and whether your baby may need a BCG (TB) vaccination.

	You	Baby's father
A African or African Caribean (Black)		
1 Caribbean Islands	☐	☐
2 Africa (excluding North Africa)	☐	☐
3 Any other African or African-Caribbean family origins. Please write in		
B South Asia (Asian)		
1 India or African-Indian	☐	☐
2 Pakistan	☐	☐
3 Bangladesh	☐	☐
C South East Asia (Asian)		
1 China including Hong Kong, Taiwan, Singapore	☐	☐
2 Thailand, Indonesia, Burma	☐	☐
3 Malaysia, Vietnam, Philippines, Cambodia, Laos	☐	☐
4 Any other Asian family origins (eg Caribbean-Asian) Please write in		
D Other non-European (Other)		
1 North Africa, South America etc	☐	☐
2 Middle East (Saudi Arabia, Iran etc)	☐	☐
3 Any other Non-European family origins Please write in		
E Southern and Other European (White)		
1 Sardinia	☐	☐
2 Greece, Turkey, Cyprus	☐	☐
3 Italy, Portugal, Spain	☐	☐
any other Mediterranean country	☐	☐
5 Albania, Czech Republic, Poland, Romania, Russia etc	☐	☐
F *United Kingdom (White) refer to guidance on FOQ		
1 England, Scotland, N Ireland, Wales	☐	☐
G *Northern European (White) refer to guidance on FOQ		
1 Austria, Belgium, Ireland, France, Germany, Netherlands	☐	☐
2 Scandinavia, Switzerland etc	☐	☐
3 Any other European family origins, (eg Australia, N America, S Africa) Please write in		

*Hb Variant Screening may be requested by parents in low risk groups

Higher risk for alpha zero thalassaemia

Don't know (incl. pregnancies with donor egg/sperm) ☐

Declined to answer ☐

Declined screening ☐

For more information on the use of the FOQ see www.nsd.scot.nhs.uk

What language do you usually use at home? Gaelic

Do you need help with interpreting, communicating? No ☐ Yes ☐ Details

What is your current religion or faith, if any?

Is blood transfusion acceptable to you? No ☐ Yes ☐
Details

Female genital cutting or piercing No ☐ Yes ☐
Details

Is there any other information that you feel is important for your maternity care? For example your beliefs, social conventions and customs, family structure, ceremonies, dress or diet?
No ☐ Yes ☐
Details

Are you a refugee or an asylum seeker? No ☐ Yes ☐
Details

Have you had a full medical examination since arriving in the UK? No ☐ Yes ☐
If no refer to GP

For health information for refugees or asylum seekers visit www.scottishrefugeecouncil.org.uk

TB risk questions:

	No	Yes
Has either parent or any grandparents been born in a high prevalence area (40 per 100,000)?	☐	☐
Details		
Is family likely to live for more than 3 months in a high prevalence area?	☐	☐
Details		
Baby requires BCG	☐	☐
Details		

- If yes to any of these questions please document need for neonatal BCG on the baby's special features box and on the baby record
- For list of countries and areas with TB rates of >40 per 100,000 see www.hpa.org.uk and www.hps.scot.nhs.uk/tb-countries

CJD or vCJD

Have you ever been notified that you are at increased risk of CJD or vCJD for public health purposes?
No ☐ Yes ☐

Other health-related questions to be discussed with maternity team staff

	No	Yes	Details of information given		
Have you been taking folic acid?		✓	☐ Pre-conception ☐ Before 12 weeks ☐ After 12 weeks	Dose of folic acid	400mcg 5mg
Vitamin D (10 mcg/day),			Healthy Start vitamins No ☐ Yes ☐	Other vitamins/supplements No ☑ Yes ☐	
What do you know about healthly eating during pregnancy?	Awake		Do you have any special dietary needs?		
Dietetic referral made					

See Ready Steady Baby for foods you can eat and foods to avoid: www.readysteadybaby.org.uk.
Vitamin D is needed to keep bones and teeth healthy. You should take supplements containing 10mcg of vitamin D every day throughout pregnancy and whilst breastfeeding. This is particularly important if you have dark skin or cover your skin.

What do you know about the benefits of physical activity in pregnancy	awake	Advice given Further information is available from www.takelifeon.co.uk	
Do you go to the dentist regularly?		✓	

NHS Dental care is free throughout pregnancy and for 1 year following birth. It is recommended you attend the dentist regularly as gum disease is more common in pregnancy and may require treatment.
If you have troublesome vomiting in early pregnancy please wait 30 minutes after vomiting before brushing your teeth, this will cut down on tooth erosion.

Are there any health and safety issues related to your work?	N/A	Advice given www.hse.gov.uk	
What do you know about drinking alcohol in pregnancy?	Awake - alcohol nil since pregnant.		
How many units of alcohol did you drink each day before you were pregnant? Number 7 to 8 weekend only	How many units of alcohol a day are you drinking now? Number 0 How many units of alcohol do you drink in an average week? Number 0 If drinking where are you drinking, at home, in clubs/pubs		

The Chief Medical Officer for Scotland's current guidance is to avoid alcohol completely if pregnant or trying to conceive.
One unit of alcohol = half a pint of 3.5% beer or lager or one 25ml measure of spirits. One small (125ml) glass of average strength (12% wine) contains 1.5 units.
If unsure of units - ask type and amount of alcohol drunk e.g. wine, spirits, beers, alcopops

Consider delivering brief intervention. Refer to Alcohol brief interventions antenatal professional pack

What do you know about smoking in pregnancy?

Have you smoked in the 12 months prior to pregnancy?	✓		CO level Date	Former smokers: date stopped
Do you or anyone in the household currently smoke?	✓		We encourage you to keep your baby smoke free before and after birth	
Are you interested in getting help to stop?	✓		Current smokers: cigarettes smoked per day Number	
Referral made to smoking cessation service	✓		Consider delivering brief intervention	
Have you used any street drugs, gas or glue in the last year?	✓		Substances used	
If yes, are you currently using any street drugs, gas or glue?	✓			
Have you ever injected drugs?	✓			
Does your current partner use any street drugs, gas or glue or inject drugs?	✓			
Referral for advice on substance abuse	✓			
Do you currently or have you ever attended an addiction service? (including smoking and alcohol)		✓	Attended for alcohol MW since 2012.	
Does your partner currently or has s/he attended an addiction service	✓			
Self harm				
Overdose		✓	2011	

Medication

	No	Yes
Are you taking any medication prescribed to you by a doctor, or have you stopped any medication recently?	☐	☐
Are you taking any 'over the counter' preparations or medications not prescribed to you? (If yes, include indications)	☐	☐

Details .....

Prescribed medication	Dose	Frequency	Route	Duration
PARACETAMOL	1gm	QID	O	5/52
MIRTAZAPINE	45mg	N/30	X1	5/52

Your mental health

	No	Yes
1. Do you have a close family member (parent or sibling) with a history of bipolar disorder (manic depression) or any other serious mental illness? Details		
2. Do you have a history of bipolar disorder (manic depression), puerperal psychosis, schizophrenia or other serious mental illness?		
3. During the past month, have you often been bothered by feeling down, depressed or hopeless?	/	
4. During the past month, have you often been bothered by having little interest or pleasure in doing things?	/	
5. If "yes" to questions 3 or 4 then ask: Is this something you feel you need or want help with? * If yes refer to GP for ongoing support		*
Are any of the problems on-going at the moment?	NO FU CURRENTLY	
Are you getting any help with the problems at the moment?		
Details of any agency providing mental health support	ATTENDS GP MENS CAPT	
Are they aware of current pregnancy?	CAROLINE FOR MENTAL HEALTH ON 9/9/10	
Referral needed Details	AT OLD QUAY	

Home circumstances and support needs

Are you still in school?	/	
Are you living in or leaving looked after care services?	/	
Do you feel that you have someone to support you through your pregnancy?		/
Are you in temporary housing?	/	
Do you need further advice on finances, benefits or housing issues?	/	
Qualifies for Healthy Start Vouchers		/
Referral to income maximisation services		
Money and debt advice services	/	
Financial capability support	/	
If you have other children do they live with you?	/	
If no, who looks after them?	/	
Does your current partner have any other children?	/	
If yes, who looks after them?		
Have you ever needed social work assistance?		/
Have you or your partner ever been involved in the Criminal Justice System?		/
Do you need support with reading or filling in forms		
Do you consider yourself to have a disability, either physical, mental or do you have any learning difficulties		/
Do you get support or have you ever had support with independent living?		/
Referral needed Details		

WB INCOME NOT 4/52 - 18/52

MENTAL HEALTH

Other support and professionals, (social worker, smoking cessation, substance misuse team, etc)

Name (job title) .....

Contact no. ✆ .....

Address

.....

.....

Name (job title)

.....

Contact no. ✆ .....

Address

.....

.....

Other involved workers
(family support, learning support worker, guidance teacher etc)

.....

See Maternity summary record ☐

Special Features

Name Wendy McLean

Age 29 Parity 0 F1

Agreed EDD 08/Aug/17

Blood group A NEG

Thrombosis risk factors

☐ Previous history ☒ BMI ≥30 ☐ Age >35

☐ Parity >4 ☐ Other .....

Allergies Codeine

BMI 31.4 Smoker No ☒ Yes ☐

Pregnancy	
Special features	Plans for care
Previous Acute Respiratory Stress Syndrome	
Pulmonary Pneumonia - Intubated	
H/O Anxiety & Depression	

Routine Enquiry asked Yes ☒ Date 15/8/16

IMPORTANT PLEASE NOTE – All pregnant women should receive the seasonal flu vaccine which helps protect against the H1N1 virus. Seasonal flu vaccines are available from your GP between October and March.

Flu vaccine accepted/declined

Date administered / /

Consent for blood and other tests offered in pregnancy (Blood Group, Full Blood Count & Infectious Diseases)

I have received the information leaflet *'Your Guide to Screening Tests During Pregnancy'* and have had an opportunity to discuss the tests I am being offered with a health professional. I understand the reasons for the tests and the consequences of the results. I also understand the significance of not having these tests performed. I am aware that my decision whether or not to have these tests will not affect the quality of care delivered by health care professionals during my pregnancy.

☒ I wish ☐ I do not wish to be tested for Blood Group antibody screen

☒ I wish ☐ I do not wish to be tested for Full Blood Count

☒ I wish ☐ I do not wish to be tested for Rubella status

☒ I wish ☐ I do not wish to be tested for Syphilis

☒ I wish ☐ I do not wish to be tested for Hepatitis B

☒ I wish ☐ I do not wish to be tested for HIV

☒ I wish ☐ I do not wish to be tested for Haemoglobinopathies Partner requires testing Yes ☐ No ☐

☐ I wish ☐ I do not wish to be tested for blood glucose levels

☐ I wish ☐ I do not wish to be tested for .....

☐ I wish ☐ I do not wish to be tested for .....

Signature: A W McLean Date 15/8/16

Witness: Granny (Health professional)

Designation: MW Date 15/8/16

Please complete the "Whose Signature" page at the back of the record

Please ensure that any results are attached so that they do not obscure the special features boxes.

Special features labour, birth & after your baby is born		
Special features	Plans for care	Notes for paediatrician

Antenatal Steroids given No ☐ Yes ☐ Date ../../.. Time ..:.. Details .....

Repeat dose Date ../../.. Time ..:.. Date ../../.. Time ..:..

Screening tests in pregnancy

During your pregnancy you will be offered several tests to check on your baby's health. These include ultrasound scans and may include blood tests to screen for risk of fetal abnormalities including Down's Syndrome and Spina Bifida.

Your local maternity team will explain what ultrasound scans will be offered to you and you will be asked to complete the appropriate consent for these tests.

The ultrasound scans you are likely to be offered by your local maternity services are (tick as appropriate):

- ☑ Dating scan
- ☑ Nuchal translucency scan 11-13 weeks
- ☑ Fetal anomaly scan
- ☐ Detailed scan at ..... weeks
- ☐ Growth scan as required
- ☐ Placental site scan as required
- ☐ Other

Consent for screening tests offered in pregnancy Down's Syndrome)

☑ I wish ☐ I do not wish to be screened for the risk of Down's Syndrome

Signature: K W. McLeish Date 15/8/16

Witness: [illegible] (Health professional)

(Please sign and print name)

Designation: MW Date 15/8/16

For more information on the national screening programmes see www.nsd.scot.nhs.uk

See Maternity summary record ☐

Special Features

Name Wendy McLean

Age 29 Parity 0+1

Agreed EDD OB/Midwife

Blood group A NEG

Thrombosis risk factors

☐ Previous history ☒ BMI ≥30 ☐ Age >35

☐ Parity >4 ☐ Other .....

Allergies Codeine

BMI 31.4 Smoker No ☒ Yes ☐

Pregnancy	
Special features	Plans for care
Previous Anal Respiratory Sync Syndrome	
Fallopian Pregnancy - Injured Lung	
NAD Anxiety & Depression	

Tests during pregnancy

During your pregnancy you will be offered several tests to check on your health and your baby's health. Your midwife will give you information leaflets on many of these tests. Maternity care staff will discuss all the tests with you. When you are sure that you understand about the tests, you will be asked if you want to have them done or not, and your wishes will be followed. For some of the blood tests you will be asked to sign a consent form.

Maternity care staff will tell you how to find out the results of any tests that you have. They will also organise any follow up care that may be needed.

Results should be filed in accordance with your NHS board's policy.

Test	Gestation when test(s) taken	Date taken indicate if declined	Results/Action
Blood Group at booking	15/8/16		A NEG
Antibody screen - 28 weeks			
Full Blood Count - booking 28 weeks 36 weeks	15/8/16		
Rubella status			
Syphillis	15/8/16		
Hepatitis B			
HIV			
Haemoglobinopathy - sickle cell and thalassaemia -document outcome in baby's special features box and baby record	15/8/16		
Screening ☐ Fetal anomalies ultrasound ☐ Down's Syndrome			
Random blood glucose			
Couple's Haemoglobinopathy result if performed			
Mid stream urine specimen for bacteriology			
CVS please include indication for procedure			
Amniocentesis please include indication for procedure			
CO results			
Other			

If you have RhD Negative blood this section applies to you ☑

Your blood is RhD Negative. You will be offered 'Anti-D' to prevent any problems developing. If you are RhD Negative and have any vaginal bleeding you must go to the hospital as soon as possible as you may need to have Anti D

Discussions/plans Signed .....

Prophylactic 'Anti-D' given 28 weeks Dose 1500 IU Signed ..... Date given 3/8/12/16

Please complete the "Whose Signature" page at the back of the record

Please ensure that any results are attached so that they do not obscure the special features boxes.

Special features: Labour, birth & after your baby is born		
Special features	Plans for care	Notes for paediatrician

Antenatal Steroids given No ☐ Yes ☐ Date ..../..../.... Time ....:.... Details .....

Repeat dose Date ..../..../.... Time ....:.... Date ..../..../.... Time ....:....

Conversations in pregnancy: Key points

Remember: explore what parents already know → accept → offer relevant information*

Encouraging parents to connect with their baby	Taking time out to connect: talking to baby, noticing and responding to movements
Skin contact	The value of skin contact What this means for mother and baby
Responding to baby's needs	How closeness, comfort and love can help baby's brain develop Responsive feeding
Feeding	Value of breastfeeding as protection, comfort and food How to get off to a good start

Confirmation that a conversation has taken place to cover relationship building, responsiveness and feeding, as per mother's needs

	Signature:	Date:	Comments:
1	[signature]	5/8/16	agrees to IVF info board to IVF
2			
3			

*refer to the health professionals' guide for more information

See Maternity summary record ☐

Special Features

Name Wendy McLean

Age 29 Parity 0+1

Agreed EDD 08/Nov/07

Blood group A Neg

Thrombosis risk factors

☐ Previous history ☒ BMI ≥30 ☐ Age >35

☐ Parity >4 ☐ Other .....

Allergies Latex

BMI 31.4 Smoker No ☒ Yes ☐

Pregnancy

Special features	Plans for care
Previous Acute Respiratory Distress Syndrome	
Pulmonary Thromboembolism - Inferior Vena	
HO Anxiety & Depression	

Infant feeding - Antenatal Checklist

All of the following should be discussed with each pregnant woman by 34 weeks of pregnancy.

	Discussed (or note if mother declined discussion)	Signed	Date
Getting your baby off to a good start			
Importance of early skin-to-skin contact (keeps baby warm and calm, promotes bonding, helps with breastfeeding)	☐		/ /
Baby-led feeding and feeding cues (to ensure adequate milk intake and supply)	☐		/ /
Rooming in / keeping baby near (for baby-led feeding and reduction of risk of SIDS)	☐		/ /
Why breastfeeding is important			
Benefits for the baby Reduced risk of gastro-enteritis, diarrhoea, urinary tract, chest and ear infections, obesity and diabetes. Latest evidence suggests reduced risk of Sudden Infant Death Syndrome and childhood leukaemia.	☐		/ /
Benefits for the mother Reduced risk of breast cancer, ovarian cancer and osteoporosis	☐		/ /
Making breastfeeding work			
Effective positioning and attachment (to ensure adequate milk intake and pain-free feeding)	☐		/ /
Effect of teats, dummies, nipple shields (may interfere with breastfeeding)	☐		/ /
No other food or drink needed for 6 months (for maximum health benefits)	☐		/ /
'From bump to breastfeeding' DVD given (for later discussion, see below)	☐		/ /
Further discussion			
Leaflets given and discussed:			
'From bump to breastfeeding' DVD discussed (suggest between 28 and 34 weeks)	☐		/ /

Antenatal checklist reproduced with permission of UNICEF baby friendly initiative.

Consider need to refer to HV/PHN for HPI

Please ensure that any results are attached so that they do not obscure the special features boxes.

Special features: Labour, birth & after your baby is born		
Special features	Plans for care	Notes for paediatrician

Antenatal Steroids given No ☐ Yes ☐ Date ..../..../.... Time ....:.... Details .....

Repeat dose Date ..../..../.... Time ....:.... Date ..../..../.... Time ....:....

Notes

Special Features

Name Wendy McLEAN

Age 29 Parity 0+1

Agreed EDD 08/Mar/17

Blood group A NEG

Thrombosis risk factors

☐ Previous history ☒ BMI ≥30 ☐ Age >35

☐ Parity >4 ☐ Other

Allergies Codeine

BMI 31.4 Smoker No ☒ Yes ☐

Pregnancy	
Special features	Plans for care
PREVIOUS MALE RESPIRATORY SYNDROME	
FOLLOWED THROUGHOUT - INDUCED LABOUR	
MILD ANXIETY & DEPRESSION	

Antenatal appointments

Date/venue	Blood pressure	Urinalysis	Oedema (swelling)	Weeks pregnant	Height of uterus (cm)	Presenting part	Fetal lie/position	Fifths palpable	Baby's heartbeat	Baby's movements felt	Blood test taken and results
16/8/16	117/79	CC	=	11+4							
19/9/16		Aphl.									
4/10/16	112/72	NAD	—	18+	=	O	Abdo soft	FHH			HbS38
10/11/16	120/70	✓	✓	24	=	22cm	soft	½			
8/12/16	100/66	NAD	NAD	29+	28cm	cephalic	long	½ tue scan			RhL

Consider need to refer to HV/PHN for HPI

Please ensure that any results are attached so that they do not obscure the special features boxes.

Special features: labour, birth & after your baby is born		
Special features	Plans for care	Notes for paediatrician

Antenatal Steroids given No ☐ Yes ☐ Date ../../.. Time ..:.. Details .....
Repeat dose Date ../../.. Time ..:.. Date ../../.. Time ..:..

Weight in late pregnancy ..... kg
Date ../../..

Most women will begin to feel fetal movements between 18 and 24 weeks. You should be aware of fetal movements up to and including the onset of labour and should report if movements decrease or stop to the maternity unit as soon as possible. Do not wait until the next day to seek help.

Other information/plans/referrals etc	Return in (weeks)	Signature
Baby Bloods Baby screening USS discussed screening Anti-Whooping cough vaccine & flu vaccine (OCT) USS 30/8/16. ~~Mum's fetal respiratory distress syndrome 2/11~~ (following) Pneumonia - induced comm Ongoing mental health issues - Anxiety on mirtazapine 30mg ~~from 45mg x1~~ ~~Promoted 15mg OD~~ - Medicard 2012 Risk Planned AT Midwifery Treatment to be Birth MAT on 9/9/16 In view of history for Medical Review on Neonatal - Planned Caesarean Section		Centre Thom.
		OMcCall
Well SNIPS 6/10/16.		SMARTLE
Need to see a GUS	4/52	ABoulden
Well, on antibiotics for URTI. Active Retro. Anti D 1500 iu. IM.	(4)	

Please complete the "Whose Signature" page at the back of the record

Special Features

Name Wendy McLean

Age 29 Parity 0 1

Agreed EDD 08/06/17

Blood group A Neg

Thrombosis risk factors

☐ Previous history ☒ BMI ≥30 ☐ Age >35

☐ Parity >4 ☐ Other .....

Allergies Codeine

BMI 31.4 Smoker No ☒ Yes ☐

Pregnancy	
Special features	Plans for care
Previous Asth Respiratory stress syndrome	
Following pneumonia - induced labour	
MH Anxiety & Depression	

Antenatal appointments

Date/venue	Blood pressure	Urinalysis	Oedema (swelling)	Weeks pregnant	Height of uterus (cm)	Presenting part	Fetal lie/position	Fifths palpable	Baby's heartbeat	Baby's movements felt	Blood test taken and results
5/1/17	118/81	NAD	NO	31+6	32cms	cephalic	long		+ve	✓	HB 124 5/12/16.
2/2/17	120/80	✓	✓	36+1		SCANNED				✓	✓
9/2 @ 123/90 @ 129/79 17 @ 124/84		NIL	NIL	36+5	36 cm	cephalic	Fixed	4/5	Present	✓	HB 130g
16/2/17	120/80	✓	✓	37+6	37 cm	cephalic	Fixed	4/5	+ve 140	FMF	

Consider need to refer to HV/PHN for HPI

Please ensure that any results are attached so that they do not obscure the special features boxes.

Special features Labour, birth & after your baby is born		
Special features	Plans for care	Notes for paediatrician

Antenatal Steroids given No ☐ Yes ☐ Date ../../.. Time ..:.. Details .....

Repeat dose Date ../../.. Time ..:.. Date ../../.. Time ..:..

Weight in late pregnancy 88·5 kg

Date 2/2/17

Most women will begin to feel fetal movements between 18 and 24 weeks. You should be aware of fetal movements up to and including the onset of labour and should report if movements decrease or stop to the maternity unit as soon as possible. Do not wait until the next day to seek help.

Other information/plans/referrals etc	Return in (weeks)	Signature
Well, active fetus. U/S Sats - Mod anaes. R/V 23/12 - Engaging I/C PNMHT -	(4)	
For elect CSCS 24/2 FRIDAY WD 73	1	
Well today, consent ☑ + DW for RF ASAP Mon 13/2/17 @ 1400	(1) RECALL	
C/S LEAFLET week - ✓ C/S 24/2/17		

Please complete the "Whose Signature" page at the back of the record

Name Wendy McLean

Age 29 Parity 0+1

Agreed EDD 08/08/17

Blood group A Neg

Thrombosis risk factors

☐ Previous history ☒ BMI ≥30 ☐ Age >35

☐ Parity >4 ☐ Other

Allergies Codeine

BMI 31.4 Smoker No ☒ Yes ☐

Pregnancy	
Special features	Plans for care
Previous Acute Respiratory Stress Syndrome	
Failure Thrombocytopenia - induced labour	
HO Anxiety & Depression	

Antenatal assessments/admissions/multi-professional assessment

Date	Time	Details
Please use 24 hour clock and sign each entry. Remember to complete the 'Whose signature?' section on the back cover of the record		
6/2/16		SNP arranged @ 18+5. Full antenatal 2/7 @ anc. Full history in case notes (4). [illegible]
13/2/17		Attended day unit bp are 120/73. Feels well, baby active. Home if worsening symptoms. Follow up @ clinic on 16/3/17. [illegible]

Special Features

Name Wendy McLean

Age 29 Parity 0+1

Agreed EDD 08/Mar/07

Blood group A NEG

Thrombosis risk factors

☐ Previous history ☒ BMI ≥30 ☐ Age >35

☐ Parity >4 ☐ Other .....

Allergies Codeine

BMI 31.4 Smoker No ☒ Yes ☐

Pregnancy	
Special features	Plans for care
PREVIOUS ANAL RESPIRATORY DISTRESS SYNDROME	
FAMILIAL PNEUMONIA - INBRED LINE	
MILD ANXIETY & DEPRESSION	

Antenatal assessments/admissions/multi-professional assessment

Date	Time	Details
Please use 24 hour clock and sign each entry. Remember to complete the 'Whose signature?' section on the back cover of the record.		

Please ensure that any results are attached so that they do not obscure the special features boxes.

Special features Labour, birth & after your baby is born		
Special features	Plans for care	Notes for paediatrician

Antenatal Steroids given No ☐ Yes ☐ Date ..../..../.... Time ..... : ..... Details .....

Repeat dose Date ..../..../.... Time ..... : ..... Date ..../..../.... Time ..... : .....

Antenatal assessments/admissions/multi-professional assessment

Date	Time	Details
Please use 24 hour clock and sign each entry. Remember to complete the 'Whose signature?' section on the back cover of the record		

Please ensure that any results are attached so that they do not obscure the special features boxes.

Special features: Labour, birth & after your baby is born		
Special features	Plans for care	Notes for paediatrician

Antenatal Steroids given No ☐ Yes ☐ Date ..../..../.... Time ..... : ..... Details .....

Repeat dose Date ..../..../.... Time ..... : ..... Date ..../..../.... Time ..... : .....

Antenatal assessments/admissions/multi-professional assessment

Date	Time	Details
Please use 24-hour clock and sign each entry Remember to complete the 'Whose signature?' section on the back cover of the record		

Please ensure that any results are attached so that they do not obscure the special features boxes.

Special features Labour, birth & after your baby is born		
Special features	Plans for care	Notes for paediatrician

Antenatal Steroids given No ☐ Yes ☐ Date ..../..../.... Time ....:.... Details .....

Repeat dose Date ..../..../.... Time ....:.... Date ..../..../.... Time ....:....

Antenatal assessments/admissions/multi-professional assessment

Date	Time	Details
Please use 24 hour clock and sign each entry Remember to complete the 'Whose signature?' section on the back cover of the record		

Please ensure that any results are attached so that they do not obscure the special features boxes.

Special features labour, birth & after your baby is born		
Special features	Plans for care	Notes for paediatrician

Antenatal Steroids given No ☐ Yes ☐ Date ../../.. Time ..:.. Details .....

Repeat dose Date ../../.. Time ..:.. Date ../../.. Time ..:..

Information for you

Your midwife or doctor will give you the following leaflets, booklets and information.

Forms

Date received

FW8 Maternity Exemption form (your entitlement to free prescriptions during pregnancy and for one year after your baby is born) ../../..

- Mat B1 form (for an employer or the Benefits Agency confirming your estimated date of delivery. You can ask for this form from your 20th week of pregnancy) ../../..

Benefits and Entitlements

- Parent's Guide to Money
- 'A Guide to Maternity Benefits' NI 17A www.dwp.gov.uk ../../..
- 'Pregnancy and work: what you need to know as an employee' www.bis.gov.uk ../../..

Screening tests in pregnancy

- 'Your guide to screening tests during pregnancy' ../../..

Pregnancy, babycare and breastfeeding

- 'Ready, Steady, Baby' www.readysteadybaby.org.uk There are Easy Read versions of 'Ready, Steady, Baby', available free from Health Scotland Telephone 0131 536 5500 and ask for 'My Pregnancy, My Choice' and 'You and your Baby' ../../..
- Information on wearing a car seat belt safely during pregnancy see 'Ready, Steady, Baby' ../../..
- 'Reduce the Risk of Cot Death' www.scottishcotdeathtrust.org ../../..
- 'Off to a Good Start: All you Need to Know about Breastfeeding your Baby' www.healthscotland.com ../../..
- 'Breastfeeding and Returning to Work' www.healthscotland.com ../../..
- 'Your Guide to Newborn Screening Tests' ../../..
- 'Your Baby's Hearing screen' www.healthscotland.com ../../..
- 'BCG and your baby' www.healthscotland.com ../../..
- 'Talking about postnatal depression' www.healthscotland.com ../../..
- How to Stop Smoking and Stay Stopped www.healthscotland.com +/- Fresh Start ../../..
- Smokeline NHS Stop smoking 0800 84 84 84 and www.canstopsmoking.com
- Support for alcohol issues is available from Drinkline Scotland on 0800 7 314 314 or at www.alcohol-focus-scotland.org.uk

Others

- Antenatal education sessions discussed Yes ☐ No ☐ ../../..
  Booked to attend Yes ☐ No ☐

Your ultrasound scans

Details of any ultrasound scans that you may choose to have will be entered below or the computer print out results of your scans will be attached.

Dating Scan +/- NT measurement

Date	Gestation	EDD by scan	Fetal heart	NT measurement if performed	Signature
14/9/16	16+5	03 March 17	No ☐ Yes ☑		
Details	HC - 118.4mm				

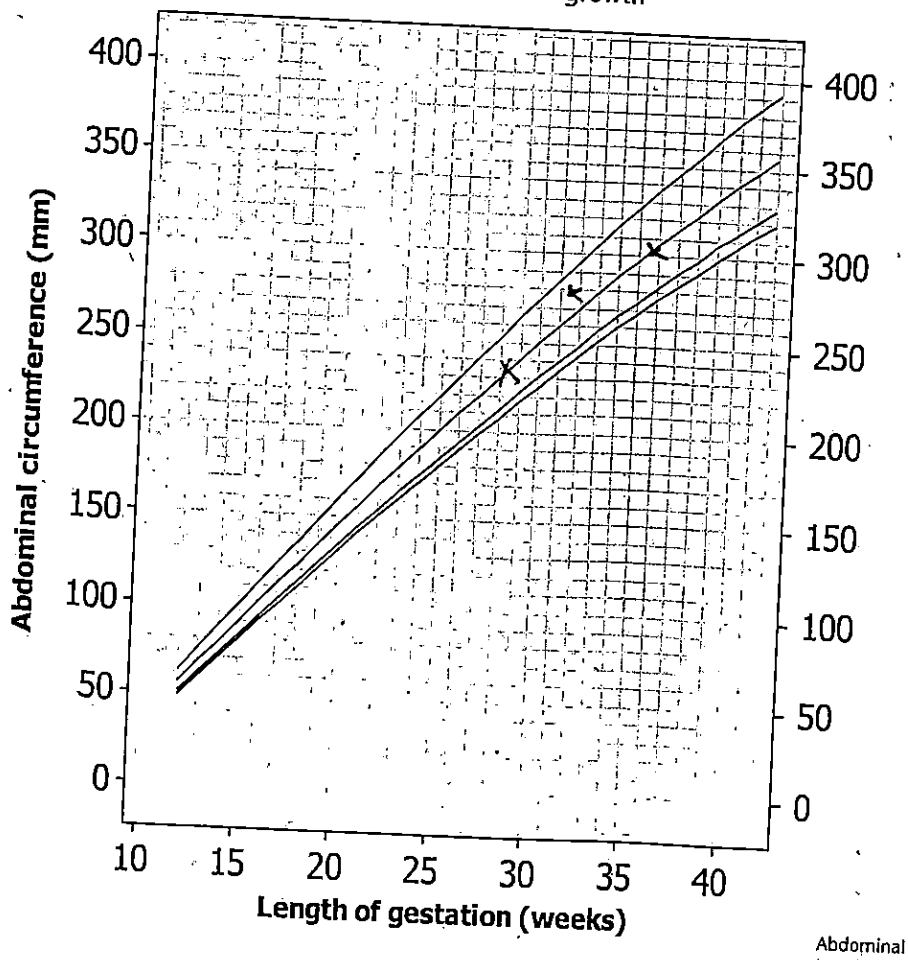
Detailed Scan/ Fetal Anomaly Scan delete as appropriate

Date	Summary of findings	Signature
19/10/16	No LA seen. LV (N) Brain ty = dilated, Ant placenta normal.	SS
	Base Menu completed No ☐ Yes ☑	

Other Scans

Date	Gestation	Amniotic Fluid Index (AFI) Oligo/normal/ polyhydramnios	Growth Within Normal Limits/<5th Centile/>95th Centile	Fetal presentation (Cephalic, breech, transverse)	Fetal movement/ heart activity	Placental position	Doppler	Signature
8/12/16	20+6	N	N	Cephalic	+ve	Ant	EDP	
5/1/17	31+6	N	N	Cephalic	+ve	Ant	EDP	
2/2/17	35+6	N	N	Cephalic	+ve	Ant	EDP	

Abdominal circumference growth

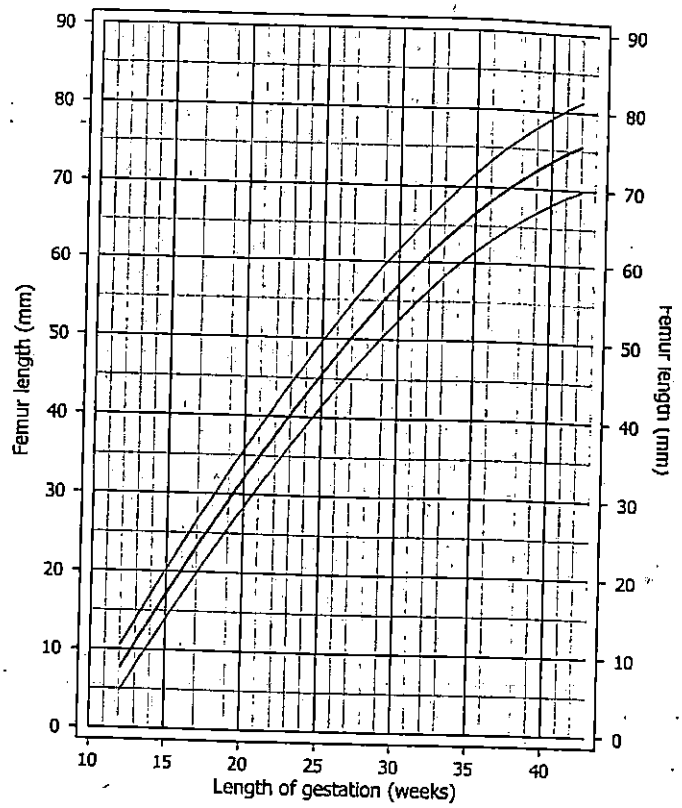


Abdominal circumference growth chart adapted from Loughna et al. Ultrasound, August 2009, Vol 17, Number 3 (lines show 5th, 10th, 50th, 95th centiles)

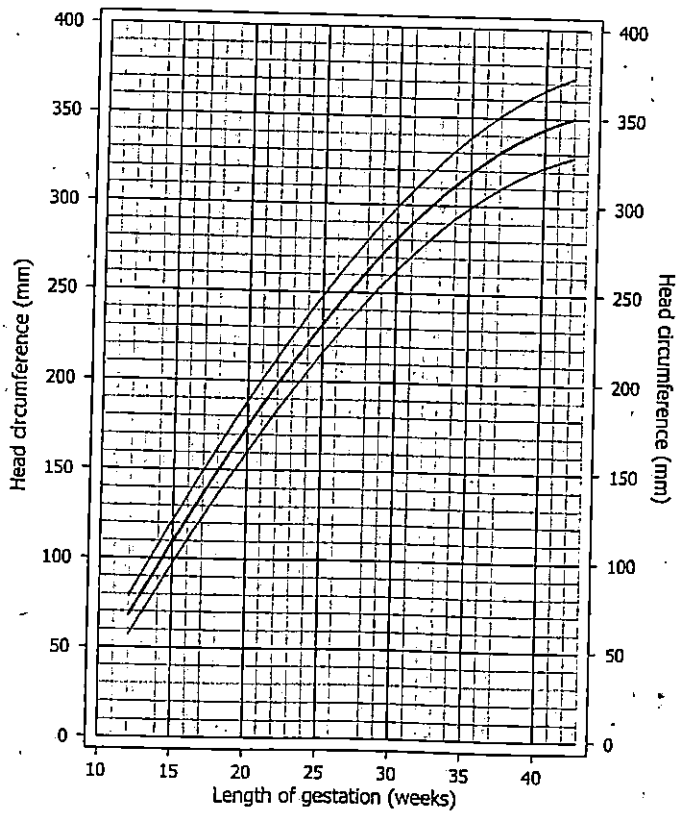
Your ultrasound scans (continued)

Details of any ultrasound scans that you may choose to have will be entered below.

Femur length



Head circumference growth



Growth charts supplied by the British Medical Ultrasound Society (lines show 5th, 50th and 95th centiles)

Any further notes on ultrasound scans

(Please date and sign entry and complete 'Whose Signature' page at back of record)

SCA

0/8/16 Singl 1-U.P FHHtve, meas ↳ 13+0 Resca 2/52 for HC + T21 screening

Your preferences for labour and the birth of your baby

Please use the section below to write down your preferences for labour and birth.
Alternatively you may wish to attach your own birth plan here. Plans for labour and birth will be individual. They depend on your wishes, your health, your circumstances and what is available at your maternity unit or in your home. You will probably find it helpful to discuss these issues with your birth partner, your midwife, and/or members of your maternity care team during your pregnancy.

During labour, members of your maternity care team will read this section and discuss it with you so they understand your preferences. However you may need to keep an open mind if complications arise for you or your baby. If this happens, your midwife or doctor will discuss events with you and your birth partner. They will be able to inform you of your options in your particular circumstances.

How do I feel about labour and birth?
What are my expectations?

Who do I want with me during labour and birth?

My environment for labour and birth
Things I might want to consider: privacy, quiet, my own music, food and drink, lighting, comfort aids such as pillows, bean bags, chairs or a mattress.

If everything is straightforward, how do I want my baby's heartbeat to be monitored during labour?
e.g. at intervals with a hand-held 'doppler' or ear-trumpet (Pinard stethoscope).
Do I understand when continuous electronic monitoring of my baby's heartbeat may be advised?

How will I cope with labour/contractions?
Things I might want to try: relaxation and breathing, changing my position, massage, water (shower, bath or water pool), complementary therapies, a T.E.N.S. machine, 'gas and air', injection of a morphine-related drug or an epidural? (Note: an epidural service is not available in all maternity units and at all times).

Vaginal examinations to assess my progress during labour
My feelings about these are:

How would I like to give birth?
My position for birth - kneeling, standing, squatting or sitting upright ?
Discovering the sex of my baby - do I want to find this out for myself?
Would I like my placenta to be delivered with or without an injection? (An injection often helps to reduce bleeding).

After my baby's birth
(Note: skin-to-skin contact with your baby is usually encouraged straight after birth)
Would I like my baby to have Vitamin K?

Other questions or special requirements that I have

If you have given birth before, you may want to think about your experiences. Please write down anything you would like your midwife or other maternity staff to know.

Discussion of preferences for labour and birth/issues arising
(Maternity care staff - please sign and date all entries)

Signature: ..... **Date** / /

Preparing for birth - what to pack in your bag

Here are some suggestions for what to take to the maternity unit. Please remember to take your Pregnancy Record, as it is very important. If you are having a home birth, your midwife will discuss other things that you will need to prepare.

For the birth	After the birth	
• comfortable clothes • music • snacks and drinks • toiletries • phone numbers • phone cards or change • camera •	• clothes/nightwear for you • underwear • maternity bra • sanitary towels • breast pads •	• clothes for going home • baby clothes – sleep suits, vests, scratch mitts, hats and shawl • nappies •
		Please note If you are travelling by car your baby will need a properly fitted car seat for all journeys.

Your notes and questions

Please use this page to write down any notes or questions

Your notes and questions (continued)

Please use this page to write down any notes or questions

Your postnatal care

The chart below is used to plan your postnatal care. Your midwife (and sometimes other members of your maternity team) will discuss and arrange your care with you, according to your needs and your baby's needs. Maternity staff will explain the reasons for each appointment or visit, as well as where it will take place, who with and when.

Hand hygiene is particularly important after childbirth. Please wash your hands in warm soapy water before and after changing your sanitary towel and after every trip to the toilet.

You should be alert to signs of infection after childbirth. You should seek advice from your midwife, general practitioner or maternity hospital if you have any of the following:-

- High temperature/feeling feverish/flu like symptoms
- Sore throat – especially if other members of the family also have sore throats
- Breathlessness
- Abdominal or chest pain
- Diarrhoea and/or vomiting
- Severe headache

Studies have shown that the safest place for your baby to sleep is on their back, in a cot, in your room for the first 6 months. Side-sleeping or prone (tummy) sleeping is not advised (unless there is a medical reason for doing so). This is the most important thing you can do to reduce the risk of cot death. For further information speak to a member of the maternity team, ensure you have a copy of the leaflet "Reduce the Risks of Cot Death" or look online at www.scottishcotdeathtrust.org

Your postnatal appointments

Day	Date	Time*	Reason for visit/appointment	Where & who with

*For some home visits an approximate time or 'morning' or 'afternoon' visit may be given.

Your notes

Please use this space to jot down any notes or questions about your care or your baby's care.

Princess Royal Maternity

NHS Greater Glasgow and Clyde

SNIPS.

WENDY McLEISH CHI 2505876061 Addressograph label	Discharge Address FLAT 0/1 House & Flat No. 51 COXTON PLACE Discharge Phone No. G33 5EJ Mobile No. 074547 50438
Gestation 39+0 Parity 0+0 Blood Group A NEGATIVE 1 Day Hb Date Hb N/R g/dl	GP Name DR A. McGINLEY Address EASTERHOUSE H/C Phone No.

Delivery Details

Mode ELCS Date 24.02.17 Time 15.50

Placenta: ~~Complete~~/Incomplete/Retained (MRP)

Membranes: ~~Complete~~/Incomplete/Ragged

Perineum: Episiotomy/Tear Repaired Y/N EBL N/R mls

Sutures: To be removed Y/N

Baby Details

Sex F CHI No 0484 Name Khara Apgars 10/5

Birth wt 2805 Discharge wt 2909g Feeding Method ATF

Guthrie Discussed (Y)/N Date 1/3/17 Guthrie Done (Y)/N Date 1/3/17

Ward discharge comments:

Signed

Community Discharge Day: 11 Date 6/3/17 No. of Visits: 4 No. of Miss Visits: 4

Community discharge comments fit for discharge

Signed

239850

Name | 1st Line of Address | Midwife Name

Date	P/N Day	Miss/Visit	Midwife	Comments
21/2/17	(4)	1st visit	Jo	Both well
28/2/17	5	miss		
1/3/17	(6)	visit	Jo	PKU + weight & Sats
2/3	(7)	miss		
3/3	(8)	visit	Laura	Review wound please (AM please)
4/3	(9)	miss		
5/3	(10)	miss		
6/3	(11)	visit	? Angie Ross	

Record Significant Comments/Treatments/Investigations

Signed

Immediate Discharge Letter The Princess Royal Maternity Unit

Dr Anne Mcginley
Dr Mcginley & Dr Sheppard
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

NHS Greater Glasgow and Clyde

The Maternity Unit,
The Princess Royal Maternity Unit
16 Alexandra Parade
Glasgow
G31 2ER

26/02/2017

Dear Dr Mcginley

Re :

Mcleish , Wendy
0/1 51 Coxton Pl, Glasgow, G33 5EJ
25/05/1987

CHI: 2505876061

This para 0+0 delivered on 24/02/2017 at 15:50. This baby was born at The Princess Royal Maternity Unit.

Labour & Delivery			
Labour onset		Type Of Delivery	**4) Elective CS**
Induction		Augmentation	
Length 1st Stage (hrs,mins)		Delivery Complications	
Length 2nd Stage (hrs,mins)		Placenta	**Complete**
Length 3rd Stage (hrs,mins)		Membranes	**Complete**
3rd stage comments	**Cord traction**	Tears	**No**
Pain Relief	**Spinal**	Episiotomy	**No**
Blood Loss (mls)		Skin Closure	
Reasons for Instrumental Delivery			

Infant			
Baby H.P.I.		CHI Number	**2402170484**
Outcome	**Livebirth**	OFC (cm)	**33.1**
Sex	**Girl**	Crown Heel (cm)	
Gestation	**39+0**	Cord	**On**
Apgars	**10(at 5 Mins)**	Hips	***Normal(Left) Normal(Right)***
Birth Weight (grams)	**2805**	Max Bilirubin	
Subsequent Weight (grams)		Phototherapy	**No**
Vitamin K	**Intra Muscular on 24/02/2017**	Hearing (L,R)	**Pass | Pass on 25/02/2017**
Baby Discharge Comments		Blood Spot PKU	**Not done**
		Blood Spot CH	**Not done**
		Blood Spot CF	**Not done**
		Blood Spot Repeat	
		Feeding on Discharge	**Formula only**

Post Natal			
Blood Group	**A Negative**	Discharge date	**26/02/2017**
Anti D	**Given**	Discharge Address	**0/1 51 coxton place g335ej 07454750438**
Date Given	**25/02/2017**		
Rubella Vaccine	**Not Required**	Drugs on Discharge	**analgesia and clexane and iron**
Date Given		Follow Up Appt.	**for routine 6/52 p/n check with gp**
Postnatal Hb Result	**Obtained**	Discharge Comments	
Treatment	**Oral Iron**		
Last Smear		Contraception	**Other** ***Obtained From :*** **GP referral**

Signature Lmcmcan Date 26/2/17 Consultant Letter Required? **Y / N**

NHS
Greater Glasgow and Clyde

NHS GREATER GLASGOW & CLYDE
Maternity Early Warning Chart

Please affix patient label

2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

Parity 0+1

EDD

Date ~~15~~/05/12/16

Chart No. 1

CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE RED OR TWO YELLOW SCORES AT ANY ONE TIME OR ANY OTHER CLINICAL CONCERNS

OBSERVATIONS	
White Zone	Routine observations
Yellow Zone	Increase observations as per local guidelines
Red Zone	Increase observations as per local guidelines

SCORING REFERENCES

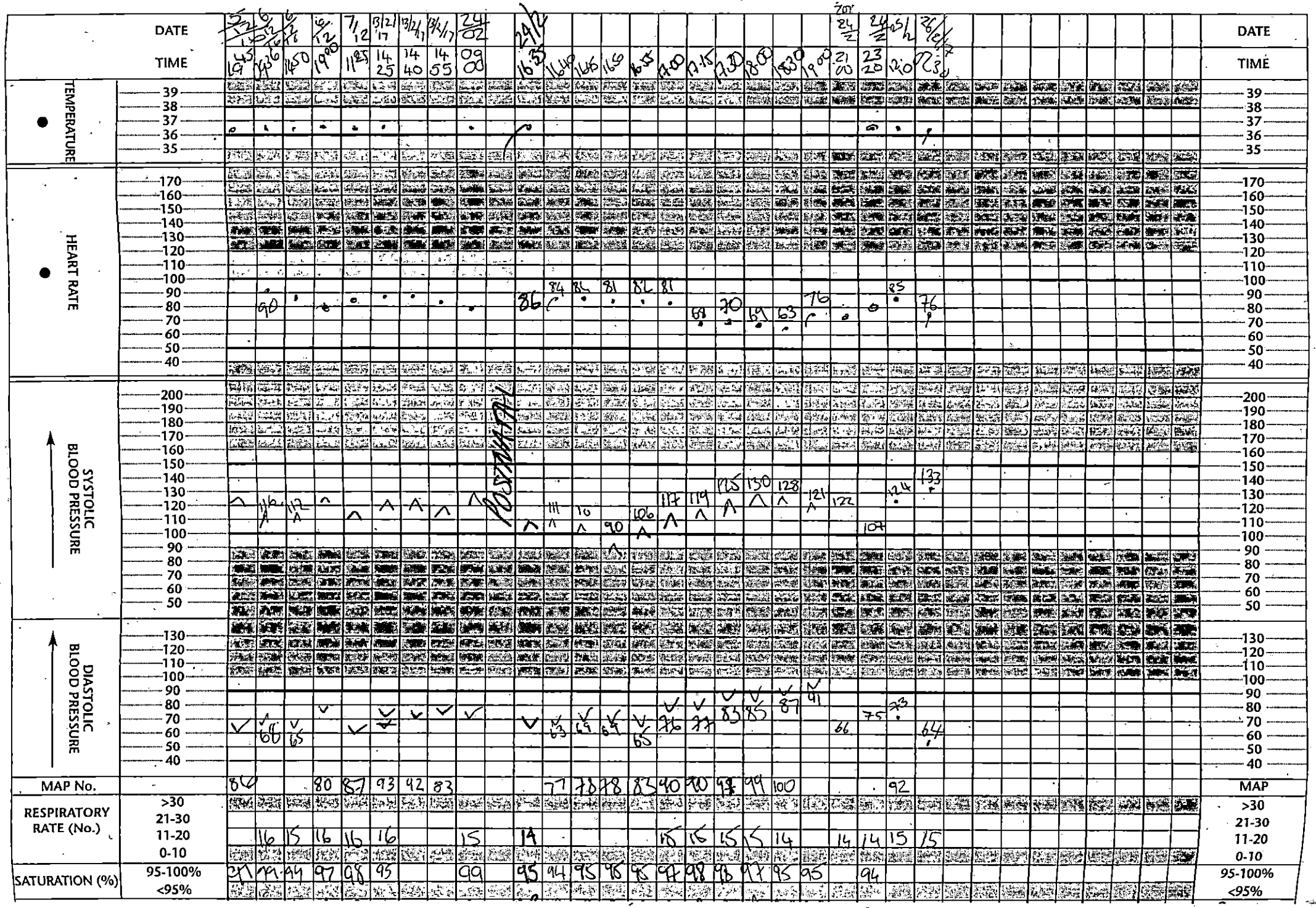
Pain Score
- Score 0 = No pain at rest, No pain on movement
- Score 1 = No pain at rest, Slight pain on movement
- Score 2 = Intermittent pain on rest, Moderate pain on movement
- Score 3 = Continuous pain at rest, Severe pain on movement

Nausea Score
- Score 0 = None
- Score 1 = Mild (not distressing, no retching/vomiting)
- Score 2 = Moderate (troublesome, occasional retching/vomiting
- Score 3 = Severe (distressing, frequent retching/vomiting)

Sedation Score
- Score 0 = None (patient alert)
- Score 1 = Mild (occasionally drowsy, easy to arouse)
- Score 2 = Moderate (frequently drowsy, easy to arouse)
- Score 3 = Severe (somnolent, difficult to arouse)
- Score S = Sleep (normal sleep, easy to arouse)

DATE/TIME	ACTION TAKEN/COMMENTS	SIGNATURE
5/12/16	seen in HCA	NHolm
13.2.17	Daycare	STMWatson
22/2/17	into recovery following an EL C/S	
1635	for maternal request - EBL 600mls	
	Obs as charted - NAD	
17.00	obs as per MEWS = 0	L Connaghan
	Sucked 20mls aptamil	F-CONNAGHAN
18.00	Vomitted + itch ++ : ondansetron	
	and naloxone given as per drug Kardex	
	Obs = 0	L Connaghan
		F-CONNAGHAN

DATE/TIME	ACTION TAKEN/COMMENTS	SIGNATURE
16/2/17 18.30	Call from blood bank to inform that Anti-D is required and ready for Wendy. L Connaghan F-connaghan	
19.25	Transferred to F/N ward L Connaghan	


DATE
TIME
TEMPERATURE
HEART RATE
SYSTOLIC BLOOD PRESSURE
DIASTOLIC BLOOD PRESSURE
MAP No.
RESPIRATORY RATE (No.)
SATURATION (%)
POSTMORTEM

NEURO RESPONSE (✓)	voice																														pain
	pain																														unresponsive
	unresponsive																														
CLINICAL CONCERNS/ LOOKS UNWELL																															CLINICAL CONCERN
TOTAL YELLOW SCORES																															TOTAL
TOTAL RED SCORES																															TOTAL
PAIN SCORE																															PAIN
NAUSEA SCORE																															NAUSEA
SEDATION SCORE																															SEDATION
REFLEXES (✓/✗)																															REFLEXES
FLUID INTAKE	oral																														oral
	crystalloid																														crystalloid
	colloid																														colloid
	blood																														blood
DRUGS BY INFUSION																															
	TOTAL																														TOTAL
FLUID OUTPUT	urine																														urine
	drain																														drain
	gastric																														gastric
	TOTAL																														TOTAL
FUNDUS CHECK (✓/✗)																															FUNDUS
WOUND/PERINEUM CHECK (✓/✗)																															WOUND/ PERINEUM
PV LOSS CHECK (✓/✗)																															PV LOSS
DOCTOR NOTIFIED (✓/✗)																															DR NOTIFIED
SIGNATURE (INITIALS)																															SIGNATURE

CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE RED OR TWO YELLOW SCORES AT ANY ONE TIME OR ANY OTHER CLINICAL CONCERNS

Immediate Discharge Letter The Princess Royal Maternity Unit

NHS Greater Glasgow and Clyde

Dr Anne Mcginley
Dr Mcginley & Dr Sheppard
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

The Maternity Unit,
The Princess Royal Maternity Unit
16 Alexandra Parade
Glasgow
G31 2ER
26/02/2017

Dear Dr Mcginley

Re :

Mcleish , Wendy
0/1 51 Coxton Pl, Glasgow, G33 5EJ
25/05/1987

CHI: 2505876061

This para 0+0 delivered on 24/02/2017 at 15:50. This baby was born at The Princess Royal Maternity Unit.

Labour & Delivery			
Labour onset		Type Of Delivery	**4) Elective CS**
Induction		Augmentation	
Length 1st Stage (hrs,mins)		Delivery Complications	
Length 2nd Stage (hrs,mins)		Placenta	**Complete**
Length 3rd Stage (hrs,mins)		Membranes	**Complete**
3rd stage comments	**Cord traction**	Tears	**No**
Pain Relief	**Spinal**	Episiotomy	**No**
Blood Loss (mls)		Skin Closure	
Reasons for Instrumental Delivery			

Infant			
Baby H.P.I.		CHI Number	**2402170484**
Outcome	**Livebirth**	OFC (cm)	**33.1**
Sex	**Girl**	Crown Heel (cm)	
Gestation	**39+0**	Cord	**On**
Apgars	**10(at 5 Mins)**	Hips	***Normal(Left) Normal(Right)***
Birth Weight (grams)	**2805**	Max Bilirubin	
Subsequent Weight (grams)		Phototherapy	**No**
Vitamin K	**Intra Muscular on 24/02/2017**	Hearing (L, R)	**Pass | Pass on 25/02/2017**
Baby Discharge Comments		Blood Spot PKU	**Not done**
		Blood Spot CH	**Not done**
		Blood Spot CF	**Not done**
		Blood Spot Repeat	
		Feeding on Discharge	**Formula only**

Post Natal			
Blood Group	**A Negative**	Discharge date	**26/02/2017**
Anti D	**Given**	Discharge Address	**0/1 51 coxton place g335ej 07454750438**
Date Given	**25/02/2017**		
Rubella Vaccine	**Not Required**	Drugs on Discharge	**analgesia and clexane and iron**
Date Given		Follow Up Appt.	**for routine 6/52 p/n check with gp**
Postnatal Hb Result	**Obtained**	Discharge Comments	
Treatment	**Oral Iron**		
Last Smear		Contraception	**Other** ***Obtained From :*** **GP referral**

Signature Dr mcginley Date 26/2/17 Consultant Letter Required? **Y / N**

Immediate Discharge Letter The Princess Royal Maternity Unit

Dr Anne Mcginley
Dr Mcginley & Dr Sheppard
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

NHS
Greater Glasgow and Clyde

The Maternity Unit,
The Princess Royal Maternity Unit
16 Alexandra Parade
Glasgow
G31 2ER

24/02/2017

Dear Dr Mcginley

Re :

Mcleish , Wendy
0/1 51 Coxton Pl, Glasgow, G33 5EJ
25/05/1987

CHI: 2505876061

This para 0+0 delivered on 24/02/2017 at 15:50. This baby was born at The Princess Royal Maternity Unit.

Labour & Delivery			
Labour onset		Type Of Delivery	**4) Elective CS**
Induction		Augmentation	
Length 1st Stage (hrs,mins)		Delivery Complications	
Length 2nd Stage (hrs,mins)		Placenta	**Complete**
Length 3rd Stage (hrs,mins)		Membranes	**Complete**
3rd stage comments	**Cord traction**	Tears	**No**
Pain Relief	**Spinal**	Episiotomy	**No**
Blood Loss (mls)		Skin Closure	
Reasons for Instrumental Delivery			

Infant			
Baby H.P.I.		CHI Number	**2402170484**
Outcome	**Livebirth**	OFC (cm)	
Sex	**Girl**	Crown Heel (cm)	
Gestation	**39+0**	Cord	
Apgars	**10(at 5 Mins)**	Hips	
Birth Weight (grams)	**2805**	Max Bilirubin	
Subsequent Weight (grams)		Phototherapy	
Vitamin K	**Intra Muscular on 24/02/2017**	Hearing (L, R)	**Not Recorded | Not Recorded**
Baby Discharge Comments		Blood Spot PKU	
		Blood Spot CH	
		Blood Spot CF	
		Blood Spot Repeat	
		Feeding on Discharge	

Post Natal			
Blood Group	**A Negative**	Discharge date	
Anti D		Discharge Address	
Date Given			
Rubella Vaccine		Drugs on Discharge	
Date Given		Follow-Up Appt.	
Postnatal Hb Result		Discharge Comments	
Treatment			
Last Smear		Contraception	**Contraception not discussed** **Reason :**

Signature _____ Date_____ Consultant Letter Required? **Y / N**

ARh neg. Hb 110 24/2 ~~AGA~~ Vivd neg-

Complete this page by hand or affix hospital computer discharge summary here.

Postnatal discharge summary

Discharged from .....

To (address) ..... ✆ .....

GP ..... at ..... ✆ .....

Named caseload holder as per KCND Pathways for Maternity Care

Obstetrician ..... Midwife ..... Paediatrician .....

GIRFEC lead professional .....

Labour, birth and postnatal period

☐ Gravida ☐ Para

Onset of labour ☐ Spontaneous ☐ Induced: indication .....

Mode of delivery ..... on ..... day ..../..../.... at ....:.... Sex .....

Indication ..... Presentation ..... Position ..... Location .....

Livebirth/Stillbirth Gestation ..... Birthweight ..... g Blood loss ..... mls

APGARs ☐ 1minute ☐ 5 minutes ☐ 10 minutes Placenta/membranes .....

Perineum/abdominal wound ..... Sutures .....

Haemoglobin ..... g/dl on ..../..../.... Repeat ☐ Not needed ☐ done due on ..../..../....

Blood group ..... Irregular antibodies ☐ Yes ☐ No anti-D needed ☐ No ☐ Yes anti-D given on ..../..../....

Blood transfusion ☐ Yes ☐ No

Rubella status ..... Vaccination needed ☐ No ☐ Yes Vaccinated on ..../..../....

Contraception/sexual health needs discussed ☐ No ☐ Yes

Details .....

Cervical smear due ☐ No ☐ Yes: due in ..... (month) 20 .....

Discharge medication ☐ No ☐ Yes: details .....

Postnatal check with ..... Arranged for ..../..../.... Mother to arrange ☐

Problems identified during pregnancy, labour/birth

Problems in the postnatal period/referrals, investigations or results pending including recommendation to seek pre-pregnancy counselling prior to planning any subsequent pregnancies

Signed ..... Designation .....

Your progress

Normal pulse range 50-100bpm: Normal Temp range 36-38°c: Normal systolic BP 90-150mmHg: normal diastolic BP below 90mmHg: Normal resp rate 11-20rpm

Postnatal day	Date/time use 24 hour clock	General wellbeing and pain assessment	Mobility, exercise and preventing blood clots: Revised postnatal thrombosis risk	Breasts	Fundus
(1)	24/2/17 1915	T 37.0°C P 75 BP 124/67 (92) RR 15 bpm well	INT immobile TEDS ✓	NAD	N/P
(2)	25/2/17 0500	T 36.1 P 75 BP 108/65 RR 15 Sats 97% freely (tube	mobile. teds.	comfr	N/P
	25/2/17 12.10	T 36.4 P ~~78~~ 85 BP 124/73 RR 15			
(3)	26/2/17 0730	T 36.4°C P 76 BP 133/64 RR 15 Feels well. Analgesia as per taudex	Fully mobile legs. painfree Ankles oedematous -advised re Care of same	Comfortable	N/P
(4)	27/2/17 1510	136 P 70 BP 110/60. well	mobile clearance	comfy.	N/P
(5)	1/3/17	Postnatally well mood ok appetite good	mobile clearance.	filling. -advised	N/P
(8)	3/3/17 0900	T36.5 BP 118/80 P 76 well appetite good mood good	mobile. legs NAD clearance ✓	full advised	N/P
(11)	6/3/17 1445	T 36.0C P 88 BP 131/84	Mobile c/o pain Clearance	Softer - massaged	N/P

 Please complete the "Whose Signature"

Observations outwith this range seek advice from a multi-professional colleague

Blood loss	Perineum / abdominal wound	Passing urine, bowels and pelvic floor	Plan of care	Signed
Ave o clots	Duoderm intact clean + dry	Catheter in situ clear urine	Routine post op care 4° OBS.	~~[illegible]~~ (M)
ave	duoderm moderately stained on (R) side	catheter in situ clear	Adjust prepared close. Postop care support & babycare. obs	[illegible]
				(Unsigned) Lindsay (Unsigned) M/W error
Serosa minimal o clots	Duoderm dressing intact dd staining to dressing	PUV BNO yet. Eating & drinking well	Routine postop care	Lindsay (Unsigned) M/W
red [illegible]	Dressing insitu - old staining	PUV BO	on going	Blanche
red [illegible]	Dressing [illegible] removed	PUV BO	on going	Blanche
serosa min no clots	blistered area where dressing was - repeat improving wound site clean dry	PUV BO	routine	[illegible] L. SMITH
stopped healing well	PUV BOO	Mood good sleeping OK	[illegible]	

Your progress

Normal pulse range 50-100bpm: Normal Temp range 36-38°c: Normal systolic BP 90-150mmHg, normal diastolic BP below 90mmHg: Normal resp rate 11-20rpm

Postnatal day	Date/ time use 24 hour clock	General wellbeing and pain assessment	Mobility, exercise and preventing blood clots Revised postnatal thrombosis risk	Breasts	Fundus

Observations outwith this range seek advice from a multi-professional colleague

Blood loss	Perineum/ abdominal wound	Passing urine, bowels and pelvic floor	Plan of care	Signed

Your postnatal care

Please use 24 hour clock and sign each entry.
Remember to complete the 'Whose signature?' section on the back cover of the record

Date/time	Further multi-professional information/planning, delivering and evaluating postnatal care
24/2/17 1920	Admitted to Ward 72, Orientated to Ward call buzzer shown. Check satisfactory on charted. Aware to ask for assistance when req'd. Offered (illegible)
2100	BP 122/66 P71. Wound slight staining on (R) side of dressing. Loins dry catheter clear urine. (illegible)
2320	BP 107/75 P80 Sats 94% T36.6 BM 5.3 SHO paged to R/V as wendy feels "shaky". SHO R/V as per blue notes.
25-2-17 00.30	Mobilised, mobilising well. Tried to back to bed.
0530	PIN check as charted
0740	urinary catheter removed.
25/2/17	Physiotherapy (1) Re consent to Rx (2) Redi Charge Rx AM PM exs gave re (illegible)
0900	Care taken over by myself at shift change well. analgesia given.
1115	Passed 80ml urine spontaneously
1600	No new concerns noted. Spoke with SNIPS MW A. Bonken. Wendy can go home when ready.
25/2/17 2130	Care taken over by myself M/W Lindsay @ 1945 hrs Blood bank Contacted to confirm Rhesus status: Mum A Negative Baby A positive DCT Negative

Please complete the "Whose Signature" page at the back of the record

Date/time	Further multi-professional information/planning, delivering and evaluating postnatal care

25/2/17 2130

Donation No: JDC16300
Component: Anti – D 500iu (BPL)
Signature 1: A Lindsay
Signature 2: SPECIMEN
Date Given: 25/2/17
Time Given: 2130
Hospital : PRM
Ward : 72

Anti D given ☑
No complaints offered. Medicines as per Kardex. To call if needs assistance.
A Lindsay M/W
(Lindsay)

A Lindsay M/W Lindsay Applicant

28/2/17 0230 P/N check as charted. Confident with Parentcraft. Keen for home birth. Discharge talk given:
1) S.I.D.S discussed + leaflet given
2) Birth Registration card explained
3) Aware of visits from Community Midwives + health visitor
4) Hospital contact numbers given
5) Newborn screening discussed + leaflet given
6) Knows to return to GP for 6/52 wks P/N check. Not due P/N smear test. To Register baby with GP
7) Undecided re family planning. Will see GP re this. Condoms + leaflets given Meantime
8) Knows to return to GP for 6/52 wks P/N check.
9) Confident with all aspects of parentcraft. States confident with preparing formula feeds - declines bottle making demonstration. Has had bathing demo.

Discharge address: Flat 0/1 51 Coxton Place
G33 5EJ
Contact Tel: 07454750438

IV Cannula removed - Site satisfactory post removal of same
A Lindsay M/W
(Lindsay)

26/2/17 1000 Care taken over by myself slm L. mcmoran
Wendy well, wishing to go home today.
Wendy happy + all aspects of baby care.
Has already had discharge talk + FBC sent ✓ lmmcmoran slm

Date/time	Further multi-professional information/planning, delivering and evaluating postnatal care

25/2/17 2130

Donation No: JDC16300
Component: Anti – D 500iu (BPL)
Signature 1: A Lind
Signature 2: SPECIMEN
Date Given: 25/2/17
Time Given: 2130
Hospital : PRUH
Ward : 72

Anti D given ☑
No Complaints offered. Medicines as per Kardex. To call if needs assistance.
A Lindsay M/W
(Specimen)

A Lindsay M/W SPECIMEN

28/2/17 0230

P/N check as charted. Confident with parentcraft. Keen for home visit. Discharge talk given:
1) S.I.D.S discussed + leaflet given
2) Birth Registration card explained
3) Aware of visits from Community Midwives + health visitor
4) Hospital contact numbers given
5) Newborn Screening discussed + leaflet given
6) Knows to return to GP for 6/52 wks P/N check. Not due P/N Smear test. To register baby with GP.
7) Undecided re family planning. Will see GP re this Condoms + leaflets given Meantime
8) Knows to return to GP for 6/52 wks P/N check.
9) Confident with all aspects of parentcraft. States confident with preparing formula feeds - declines bottlemaking demonstration. Has had bathing demo.

Discharge address: Flat 0/1 · 51 Coxton Place
G33 5EJ
Contact Tel: 07454750438

IV Cannula removed - Site satisfactory post removal of Sure
A Lindsay M/W
(Specimen)

26/2/17 10⁰⁰

Care taken over by myself slm L. Mcmeans
Wendy well, wishing to go home today.
Wendy happy + all aspects of baby care.
Has already had discharge talk + FBC sent ✓ Lmcmeans slm

Your postnatal care

Please use 24 hour clock and sign each entry.

Date/time	Further multi-professional information/planning, delivering and evaluating postnatal care
27/2/17 15:30	First Home Visit. Discussed signs ✓ Birth Registration ✓ PKU ✓ Steristrip, making feeds
1/3/17 11:10	Wendy feels dressing uncomfortable, itchy. Wound inspected for dressing removal. Healing well, no signs of infection. Advised re baths & keeping wound dry. Mandie

Please complete the "Whose Signature" page at the back of the record

Conversations in the postnatal period: Key points

Remember: explore what parents already know → accept → offer relevant information*

After birth

All mothers are offered support with
- Unhurried skin contact
- Recognising early feeding cues
- Offering the first feed in skin contact

Signature:	Date:	Comments:

Postnatal

All mothers are offered support to
- Appreciate the importance of closeness and responsiveness for mother/baby wellbeing
- Hold their baby for feeding
- Understand responsive feeding

Breastfeeding mothers are offered support to
- Hand express
- Value exclusive breastfeeding
- Understand how to know their baby is getting enough milk
- Access help with feeding when at home

Mothers who formula feed are offered support to
- Sterilise equipment and make up feeds
- Feed their baby first milks
- Limit the number of people who feed their baby

Signature:	Date:	Comments:
1		
2		
3		

Breastfeeding Assessments

Breastfeeding assessments carried out using the breastfeeding assessment form (minimum of two in the first ten days) and an appriopriate plan of care made. This may include referral for additional/specialist support.

Signature:	Date:	Comments:
1		
2		
3		

*refer to the health professionals' guide for more information

Breastfeeding your baby

Breastfeeding your baby may be a new experience for you, or you may already have skills and confidence. This section contains items for discussion, observation and support as you breastfeed your baby. Your midwife and maternity care team will support you. When you and your midwife feel you are confident with the items, you can then sign them off to mark your progress.

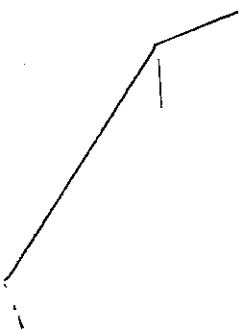
Your copy of 'Off to a Good Start: All you Need to Know about Breastfeeding your Baby' provides sound advice that you and your partner can refer to. Please let your midwife know if you need another copy. Or visit www.healthpromotionagency.org.uk

	Discussed/demonstration Date/signed (staff)	I feel confident Date/signed (mum/partner)
Positioning myself for breastfeeding	...../...../.....	...../...../.....
Positioning my baby for breastfeeding	...../...../.....	...../...../.....
Principles of good attachment	...../...../.....	...../...../.....
How to recognise that my baby is feeding well including effective milk transfer	...../...../.....	...../...../.....
My baby's feeding and sleeping patterns for the first few days	...../...../.....	...../...../.....
'Baby led' feeding	...../...../.....	...../...../.....
When my milk 'comes in'	...../...../.....	...../...../.....
Rooming in at the maternity unit	...../...../.....	...../...../.....
Sharing a bed with my baby - the risks discussed further information is available from www.scottishcotdeathtrust.org and in the leaflet "Reduce the Risk of Cot Death"	...../...../.....	...../...../.....
Winding my baby	...../...../.....	...../...../.....
My baby's needs (exclusive breastmilk for around the first six months of life)	...../...../.....	...../...../.....
Why dummies or teats should not be used	...../...../.....	...../...../.....
How to hand express my breastmilk	...../...../.....	...../...../.....
Expressing breastmilk a) washing & dry storing equipment	...../...../.....	...../...../.....
b) safe storage	...../...../.....	...../...../.....
Signs that my baby is feeding well and thriving	...../...../.....	...../...../.....
Monitoring for wet and dirty nappies	...../...../.....	...../...../.....
Breastfeeding support in my community	...../...../.....	...../...../.....
Information on alcohol consumption and breastfeeding	...../...../.....	...../...../.....

Breastfeeding support is available from the following organisations:-
The Breastfeeding Network 0300 100 0210 www.breastfeeding network.org.uk
National Breastfeeding Helpline 0300 100 0212 www.feedgoodfactor.org.uk
NCT – 0300 330 0771 7 days 0800 -2200 www.nct.org.uk
La Leche League - 0845 120 2918 www.laleche.org.uk

Other things that I want to ask about: .....

.....



Formula feeding your baby

As with general baby care, you may already be skilled in making up formula feeds and formula feeding your newborn baby, or it may be a new challenge. Your midwife and maternity care team will support you. The list below can be used to check that you feel confident formula feeding your baby. Please sign off the items when you feel ready.

	Discussed/demonstration Date/signed (staff)	I feel confident Date/signed (mum/partner)
Using bottled milk/disposable teats in the maternity unit	...../...../.....	...../...../.....
The importance of good hand hygiene	...../...../.....	...../...../.....
Sterilising equipment	...../...../.....	...../...../.....
Making up a formula feed correctly and safely (always following the manufacturer's instructions)	...../...../.....	...../...../.....
Making up each feed as required, use of whey based milks for first 12 months and one to one demonstration if required	...../...../.....	...../...../.....
Giving a formula feed correctly and safely	...../...../.....	...../...../.....
Winding my baby	...../...../.....	...../...../.....
My baby's feeding and sleeping patterns for the first few days	...../...../.....	...../...../.....
'Baby led' feeding	...../...../.....	...../...../.....
'Rooming in' at the maternity unit	...../...../.....	...../...../.....
Sharing a bed with my baby - the risks discussed	...../...../.....	...../...../.....

Further information is available from www.scottishcotdeathtrust.org and in the leaflet "Reduce the Risk of Cot Death"

Choosing the right type of milk for my new baby (whey based)	...../...../.....	...../...../.....
Signs that my baby is feeding well and thriving	...../...../.....	...../...../.....

Further information on preparing formula feeds can be found at www.babyfriendly.org.uk Including information in different languages.

Other things about feeding that I want to ask about: .....

Feeling confident with your baby

Whether you are a first time parent, or if you have experience of looking after new babies, there may be things that you want to discuss and practice with maternity care staff. The list below can be used as a starting point to ensure that you feel confident meeting your baby's needs. Please sign off the items when you feel ready. Remember there can be lots to learn, and it can be quite normal for this to take a while.

Don't forget that your 'Ready, Steady, Baby!' book contains useful advice and information that you and your partner/supporter can refer to. Or visit www.readysteadybaby.org.uk

	Discussed/demonstration Date/signed (staff)	I feel confident Date/signed (mum/partner)
Baby communication and attachment (skin to skin, touch or massage, talking to baby, eye contact, responding to non-verbal cues, instinctive skills and how babies learn etc)	Discussed during visit 26/12/17	
Handling my baby safely		
Choosing nappies for my baby		
Changing my baby's nappies		
Caring for my baby's cord		
A 'top and tail' wash/caring for my baby's skin		
Bathing my baby		
How to reduce the risk of cot death		
Signs that my baby is well		
Signs that my baby may be ill		
Car safety and home safety		
Registering the birth/registering with a GP		
Social support		
Other things I want to ask about:		

Information for you (indicate when received) ☐

Do you still have your copy of 'Ready, Steady, Baby!' ☐ No ☐ Yes

Easy Read Versions of Ready Steady Baby are available from NHS Health Scotland free of charge please contact 0131 536 5500

Please remember that some health advice changes over time. Friends and relatives may be unaware of new guidance about preventing cot death. Please share your information with them to help keep your baby safe.

Your questions or concerns

Being a parent with a new baby can be challenging and exciting, but also tiring and stressful. The following section is for you to write in. Please jot down anything that you or your partner wish to discuss with your midwife/the maternity team caring for you. Here are some suggestions:

How I feel I am coping

My mood and emotions

How I feel I am doing as a parent

Not liking my baby at the moment

Difficulties with my baby's feeding

Managing my tiredness

Questions about my baby

Coping with my baby's crying

My anxieties

Relationships with my family

Thinking about your pregnancy, labour and birth

Pregnancy, labour, birth and the time afterwards are unique experiences. They can have a powerful effect on how you feel and your relationships with your baby, partner, family and your maternity care team.

Your midwife will ask you about your experiences in the early days following the birth. You may have questions that you want to ask or issues to discuss – or you may not. You may find it helpful to think about your experiences of maternity care so far, and discuss events with your partner or the person supporting you. Please use the space below to jot down any questions or issues to discuss.

Please remember that you can talk to any member of your maternity care team (such as your midwife, General Practitioner or obstetrician) about your experiences *at any time after the birth.* Some women wish to do this a few weeks, or even many months after the birth, or if they are thinking about becoming pregnant again.

Your health after the birth

Blood tests/other tests and results				
Date	Time	Investigation	Indication	Result/actions

Discharge from midwifery care

Date 6/3/17 Days postnatal 4

Special features identified (please sign and date each entry)

BP 134/84

General wellbeing and mental health

Generally well
mood
good

Current smoker? ☑ No ☐ Yes ...../day

Has risk of passive smoking to baby been explained? ☐ No ☑ Yes

Don't smoke or allow anyone else to smoke in the same room as your baby.

It's best if nobody smokes in the house, including visitors.
Anyone wishing to smoke should go outside.

Do not smoke or allow anyone to smoke in a car your baby is travelling in.

For further information about alcohol consumption following the birth.
See www.readysteadybaby.org.uk

Contraception

Longer acting contraception (LAC) discussed Yes ☑ No ☐

Reversible contraception discussed Yes ☑ No ☐

Has LAC contraception been provided Yes ☐ No ☑

It is recommended that you commence a reliable method of contraception by Day 21

I DNAD from GP

	Any problems		Details
Passing urine	☑ No	☐ Yes	
Pelvic floor	☑ No	☐ Yes	
Bowel function	☑ No	☐ Yes	
Breasts	☑ No	☐ Yes	
Perineum/abdomen	☑ No	☐ Yes	
Lochia/menstruation	☑ No	☐ Yes	
Cervical smear due	☑ No	☐ Yes	

Sexual health
(www.sexualhealthscotland.co.uk)

Physical Exercise and Healthy Lifestyle Advice
Importance of healthy eating and maintaining a healthy weight discussed Yes ☑ No ☐

Concerns

NV nothing

Handover to health visitor completed ☐ No ☑ Yes Details

Health Plan Indicator allocated (circle as appropriate): core additional **Include in handover to health visitor**

Six week follow-up appointment discussed/arranged ☐ No ☑ Yes Details GP

Signed [signature] Print name R GALLAGHER Designation MCN

Please complete the "Whose Signature" page at the back of the record

Whose signature?

Whenever anyone writes in this record for the first time, they should fill in their details below.

Name (please print)	Signature	Job title
S. GUTHRIE	S Guthrie	SCNO
W DAND		MW
SMACPHEE		MW
[illegible]	[illegible]	[illegible]
P BOWDEN		
P WYNN		M
C MORRIS		MW
R JOLLEN		RSN.
A LINDSAY	A Lindsay	Midwife
L. McLEAN		MW.
[illegible]	[illegible]	[illegible]
L SMITH		MW

MANUAL PATIENT RECORDS

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

Including:

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

GLASGOW ROYAL INFIRMARY
Queen Elizabeth Building
16 Alexandra Parade
Glasgow
G31 2ER

Switchboard: 0141 211 4000
Direct Dial: 0141 211 4381
Fax Number: 0141 211 1120

Contact Email: Lynn.Murray@ggc.scot.nhs.uk

DEPARTMENT OF RESPIRATORY MEDICINE
DR CHALMERS' RESPIRATORY CLINIC – 26th March 2012

Dr Marie Wilson
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

ES/LM

Dict: 26/03/2012
Typed: 30/03/2012

Dear Dr Wilson

Wendy McLeish ~ 25/05/1987 ~ CHI: 2505876061 ~ CRN: 23123532V
0/1 51 Coxton Place,Glasgow, G33 5EJ

Problems:
1. Right upper lobe pneumonia requiring ITU admission and transfer to Leicester for ECMO
2. Anxiety
3. Tremor
4. Previous drug overdose

I reviewed this 24 year old lady in Dr Chalmers clinic on 26.3.2012.

She had a prolonged admission from November 2011 to January 2012 with a severe right upper lobe pneumonia requiring admission to Intensive Care. She continued to deteriorate during her ITU admission and required to be transferred to Leicester for VV ECMO before finally being transferred back to Glasgow Royal Infirmary on 20th December 2011. There was also the time during Miss McLeish's prolonged admission for her to be seen our colleagues in Neurology regarding her long standing tremor. Overall Miss McLeish feels greatly improved since discharge and is eating and drinking normally. Her weight has returned to normal.

On examination she appeared anxious but well and oxygen saturations were 99% on air. The chest was clear to auscultation. Chest x-ray performed in clinic showed no focal consolidation and I have not made her any further appointments at the Respiratory Clinic.

Kind regards.

Yours Sincerely

Dr Eliana Saffouri
ST4

Acute Services Division

Emergency Care and
Medical Services Directorate

NHS
Greater Glasgow
and Clyde

Royal Infirmary
16 Alexandra Parade
Glasgow
G31 2ER

NEUROLOGY DEPARTMENT
DR P SHAH
CONSULTANT NEUROLOGIST
TELEPHONE: 0141 211 4481

Dictated 19/03/2012
Typed 28/03/2012
Our Ref PS/AC

Dr R Madhok
Consultant Rheumatologist
Centre for Rheumatic Diseases
Ward 15
Glasgow Royal Infirmary

Dear Dr Madhok

Wendy McLeish - 25/05/1987 - CHI: 2505876061 - CRN: 23123532V
0/1 51 Coxton Place, Glasgow, G33 5EJ

Many thanks for your referral. I reviewed this lady in the Neurology Outpatient Clinic she was accompanied by her support worker, Jackie Robertson.

She is 24 years old, right handed single lady who is currently is unemployed and lives with her boyfriend.

She was admitted with pneumonia recently and had to be managed in ITU and was transferred to the Lister for further specialist treatment. She was ventilated for four weeks and since her discharge from hospital has been finding her whole body quite shaky and some times her legs or hands shake. Where the cannulation scar is on her left thigh she feels some tightness when walking and her legs can feel weak. Her support worker has noticed that she becomes shaky when she is nervous or trying to concentrate. She has previously been shaky prior to her recent illness but again this was in certain situations or when she would be nervous rather than all the time.

Her current treatment is Propranolol, Fluoxetine and Cilest oral contraceptive pill.

She has hay fever but otherwise did not report other allergies.

She has been depressed for about a year or so and tried to take her life a couple of times. This started when her dad died. Her support worker suggested that her depression is perhaps better though not fully controlled.

She does not smoke but stated that she drinks alcohol more than recommend. She herself does not feel that this is a problem but stated that she can often drink when she is alone or bored.

On examination today, her eye movements were normal. Fundi were normal. There was no facial or bulbar weakness. Tone and power across the extremities were normal. Deep tendon reflexes were symmetrical and normal. She had normal pinprick and vibration sense. Her gait was normal and tandem walking was intact. She was able to walk on her heels, toes and was able to hop.

She also reported that she gets frequency with micturition and can often go to the toilet up to ten times at night but does not pass much urine and only has a few drops dribbling. She thought if she can sleep then she may not go to the toilet but has difficulty getting to sleep and can get maximum four hours sleep on a good day.

She had postural tremors of her out stretched hands which were easily distractible.

Comment

This lady's tremulousness is related to anxiety and depression. She may continue to take the beta blocker for symptomatic relief. She feels quite weak and I have explained that this would not be unusual for someone who has been managed in ITU for a few weeks whereby the muscles can get de-conditioned and it may take her a while to regain her strength. Further input from the physiotherapist may be helpful. She is undergoing treatment for her depression and this will be helpful. Today I have checked her thyroid function tests, full blood count and will forward the results eventually.

I have not arranged further routine follow-up.

Yours sincerely

Pushkar Shah
Consultant Neurologist

GLASGOW ROYAL INFIRMARY
Queen Elizabeth Building
16 Alexandra Parade
Glasgow
G31 2ER

Switchboard: 0141 211 4000
Direct Dial: 0141 211 4381
Fax Number: 0141 211 1120

Contact Email: Lynn.Murray@ggc.scot.nhs.uk

DEPARTMENT OF RESPIRATORY MEDICINE

Consultants: Dr M M Cotton
Dr G W Chalmers
Dr J van der Horst
Dr B Choo-Kang

Dr Marie Wilson
Dr Wilson, Dr McGinley
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

EL/LM

Dict: 13/03/2012
Typed: 13/03/2012

Dear Dr Wilson

Wendy McLeish ~ 25/05/1987 ~ CHI: 2505876061 ~ CRN: 23123532V
0/1 51 Coxton Place, Glasgow, G33 5EJ

Date of admission: 20th November 2011
Date of discharge: 2nd January 2012
Consultant: Dr G W Chalmers

Diagnosis:

1. Right upper lobe pneumonia requiring ITU and transfer to Leicester for ECMO
2. Sepsis
3. Anxiety
4. Tremor

Wendy McLeish was admitted on 20th November 2011 right sided chest pain, shortness of breath, diarrhoea and a cough. On attendance she was hypotensive at 97/59 mmHg and tachycardiac at 107. She was also hypoxic at 93% on air. On examination she had decreased air entry in the right upper zone, scattered right basal crepitations and increased vocal residence at the right mid zone. She remained hypotensive throughout her admission in the Medical Receiving Unit despite aggressive fluid replacement therapy and boluses of Metaraminol. She continued to deteriorate in the Medical Receiving Unit and eventually developed a respiratory rate of 50, saturations in the 80s on 98% oxygen, and as a consequence the Intensive Care Unit Anaesthetists were contacted for review. At this time she was commenced on IV Amoxycillin, Clarithromycin and Augmentin. She was transferred to the Intensive Care Unit on 21st November 2011. She was intubated on 22nd November 2011 for respiratory failure.

According to her ITU notes she progressed in ITU at first with gradual weaning of her Noradrenaline until she deteriorated in respiratory function on 26th November 2011, and continued to have deteriorating respiratory function until the 28th November 2011. As she continued to deteriorate she was transferred to Leicester for VV ECMO through an RIJ line from 30th November 2011 until 7th December 2011. She then went onto CVVH until 9th December 2011 and had a tracheostomy inserted on 2nd December 2011. While at Glenfields in Leicester she had Methyl, Prednisolone and Azithromycin for lung re-modelling, and she was eventually transferred back to Glasgow Royal Infirmary on 20th December 2011. She was catheterised and NG fed. Her tracheostomy was removed on 28th December 2011. She made a satisfactory recovery on the respiratory ward and was seen by a Neurological Consultant, Dr Miller on 30th December 2011 to assess her for her long standing tremor.

Cont/.....

A comprehensive set of tests were requested to investigate her tremor including thyroid function tests which were normal, immunoglobulins which were normal, protein electrophoresis which was normal, copper which was normal, ANCA, complement, rheumatoid factor and auto antibodies were all normal. B12, Folate and Ferritin were normal and her calcium was normal. Mrs McLeish refused a Huntingdon genetics test.

Unfortunately on the 2nd January 2012 Wendy decided to leave the Ward as she was "bored of the depressing Ward". Despite conversations with myself and Dr Wilson she signed the irregular discharge form and discharged herself against medical advice.

Ideally we would like to see her again in the Respiratory Clinic which ideally would have been 4-6 weeks after her discharge, but due to a delay in dictating this letter that has not been offered to her. We will send her an appointment for 1 week's time. She also has outpatient follow up with the Neurologists on 19th March 2012.

Kind regards.

Yours sincerely,

Dr Emily Leadbeater
FY2 in Respiratory Medicine

GLASGOW ROYAL INFIRMARY
Queen Elizabeth Building
16 Alexandra Parade
Glasgow
G31 2ER

Switchboard: 0141 211 4000
Direct Dial: 0141 211 4381
Fax Number: 0141 211 1120

Contact Email: Lynn.Murray@ggc.scot.nhs.uk

DEPARTMENT OF RESPIRATORY MEDICINE

Mrs Wendy McLeish
Flat 0/1
51 Coxton Place
GLASGOW
G33 5EJ

EL/LM

Dict: 13/03/2012
Typed: 13/03/2012

Dear Mrs McLeish,

CHI: 2505876061 ~ CRN: 23123532V

Further to your recent admission to the Respiratory Ward at Glasgow Royal Infirmary an appointment has been made for you to attend Dr Chalmers' Respiratory Clinic on Monday 26th March 2012 at 3:00pm. If this is not suitable can you please contact Dr Chalmers' Secretary on 0141 211 4381 and we can arrange another appointment. An appointment card is enclosed.

Kind regards.

Yours sincerely,

Dr Emily Leadbeater
FY2 in Respiratory Medicine

Encl – appointment card.

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

Attachments
Neurology - 13082010_Referral_91339
Neurology - 12122011_Clinical Letter_125516

REFERRAL TO

Neurology
GGC General Referral

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

Glasgow Royal Infirmary
84 Castle Street
Glasgow
G4 0SF

Hospital and **hospital address**

Hospital location code: G107H

Email address:

Urgency of referral ROUTINE
Date of referral 18-Jan-2012 **Date sent** 18-Jan-2012

PATIENT DETAILS

Surname	Mcleish
Forename(s)	Wendy
Title	Miss
Sex	Female
Date of birth	25-May-1987
CHI no.	2505876061
Area of Residence	

Patient's address

0/1 51 Coxton Place
GARTHAMLOCK
Glasgow
G33 5EJ

Contact number(s)

Voice: 07769733984

101003059742N Unique Care Pathway Number: 101003059742N

REGISTERED GP DETAILS

Name	Dr Anne McGinley		
GMC code	3341180	GP code	07307
Practice name	Easterhouse Health Centre (13448)		
Practice code	46471		

Practice address

9 Auchinlea Road
Easterhouse
Glasgow
G34 9HQ

Contact number(s)

Voice: 0141 531 8150
Facsimile: 0141 531 8158

REFERRING GP DETAILS

Name	Dr. Dalila Malek		
GMC code	6128612	GP code	54241
Practice name	Dr Wilson, Dr Mcginley & Dr Sheppar (46471)		
Practice code	46471		

Practice address

Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

Contact number(s)

Voice: 0141 531 8150

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: Tremor

Comment: Dear Dr Miller,

Many thanks for seeing this young lady at your clinic. I believe she has been referred to you as an inpatient regarding an odd tremor, while in ward 7 at GRI when she had a prolonged admission for pneumonia in November 2011. She has unfortunately self-discharged prior to review.

Wendy has a known history of benign essential tremor since 2010, has been on Propranolol and she was first referred to neurology that year for further management. She did not keep her appointment.

Her tremor has been gradually worsening with little benefit from Propranolol and she is very keen for your specialist opinion. She confirmed she would attend on this instance and I have confirmed her current address as above. We would greatly value your input.

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

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

Description	Comment	Date of onset	Date recorded
Adult respiratory distress syndrome	-	30-Nov-2011	30-Nov-2011
Overdose of drug	fluoxetine	22-Sep-2011	22-Sep-2011
Benign essential tremor	-	08-Jul-2010	08-Jul-2010

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

No current medications recorded

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Fluoxetine Hydrochloride Capsules 20 mg	30	30 capsule	TWO TO BE TAKEN EACH DAY WEEKLY DISPENSE	-	05-Jan-2012	05-Jan-2012
Propranolol Hydrochloride Tablets 40 mg	42	42 tablet	ONE TO BE TAKEN THREE TIMES A DAY SEE DOC FOR NEXT	-	05-Jan-2012	05-Jan-2012
Propranolol Hydrochloride Tablets 40 mg	100	100 TABS	1 Tab 3 times daily	-	16-Nov-2011	16-Nov-2011
Fluoxetine Hydrochloride Capsules 20 mg	56	56 CAPSULE	TWO TO BE TAKEN DAILY	-	01-Nov-2011	01-Nov-2011
Propranolol Hydrochloride Tablets 40 mg	100	100 TABS	1 Tab 3 times daily	-	28-Sep-2011	28-Sep-2011
Fluoxetine Hydrochloride Capsules 20 mg	56	56 CAPSULE	TWO TO BE TAKEN DAILY	-	27-Sep-2011	27-Sep-2011
Zopiclone Tablets 7.5 mg	14	14 tablet	1 Tab At night	-	27-Sep-2011	27-Sep-2011
Fluoxetine Hydrochloride Capsules 20 mg	40	40 capsule	TAKE 20 MG THEN 40 MG ALTERNATE DAYS	-	14-Sep-2011	14-Sep-2011
Fluoxetine Hydrochloride Capsules 20 mg	28	28 capsule	ONE TO BE TAKEN EACH DAY WEEKLY DISPENSE	-	26-Aug-2011	26-Aug-2011

Propranolol Hydrochloride Tablets 40 mg	100	100 TABS	1 Tab 3 times daily	11-Aug-2011	11-Aug-2011
Cetirizine Hydrochloride Tablets 10 mg	30	30 TABS	1 Tab Daily	12-Jul-2011	11-Aug-2011

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Never smoked tobacco:	Smoker$$ Status.clm - No Action Required	21-Jan-2010
Light drinker - 1-2u/day:	Alcohol Intake$$.clm - Repeat after an Interval	21-Jan-2010

Clinical warnings

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

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

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:Yes

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

Neurology - 13082010_Referral_91339

Neurology - 12122011_Clinical Letter_125516

GLASGOW ROYAL INFIRMARY
Queen Elizabeth Building
16 Alexandra Parade
Glasgow
G31 2ER

Switchboard: 0141 211 4000
Direct Dial: 0141 211 4381
Fax Number: 0141 211 1120

Contact Email: Lynn.Murray@ggc.scot.nhs.uk

DEPARTMENT OF RESPIRATORY MEDICINE

Consultants: **Dr M M Cotton**
Dr G W Chalmers
Dr J van der Horst
Dr B Choo-Kang

Dr Marie Wilson
Dr Wilson, Dr McGinley
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

EL/LM

Dict: 13/03/2012
Typed: 13/03/2012

Dear Dr Wilson

Wendy McLeish ~ 25/05/1987 ~ CHI: 2505876061 ~ CRN: 23123532V
0/1 51 Coxton Place, Glasgow, G33 5EJ

Date of admission: 20th November 2011
Date of discharge: 2nd January 2012
Consultant: Dr G W Chalmers

Diagnosis:

1. Right upper lobe pneumonia requiring ITU and transfer to Leicester for ECMO
2. Sepsis
3. Anxiety
4. Tremor

Wendy McLeish was admitted on 20th November 2011 right sided chest pain, shortness of breath, diarrhoea and a cough. On attendance she was hypotensive at 97/59 mmHg and tachycardiac at 107. She was also hypoxic at 93% on air. On examination she had decreased air entry in the right upper zone, scattered right basal crepitations and increased vocal residence at the right mid zone. She remained hypotensive throughout her admission in the Medical Receiving Unit despite aggressive fluid replacement therapy and boluses of Metaraminol. She continued to deteriorate in the Medical Receiving Unit and eventually developed a respiratory rate of 50, saturations in the 80s on 98% oxygen, and as a consequence the Intensive Care Unit Anaesthetists were contacted for review. At this time she was commenced on IV Amoxycillin, Clarithromycin and Augmentin. She was transferred to the Intensive Care Unit on 21st November 2011. She was intubated on 22nd November 2011 for respiratory failure.

According to her ITU notes she progressed in ITU at first with gradual weaning of her Noradrenaline until she deteriorated in respiratory function on 26th November 2011, and continued to have deteriorating respiratory function until the 28th November 2011. As she continued to deteriorate she was transferred to Leicester for VV ECMO through an RIJ line from 30th November 2011 until 7th December 2011. She then went onto CVVH until 9th December 2011 and had a tracheostomy inserted on 2nd December 2011. While at Glenfields in Leicester she had Methyl, Prednisolone and Azithromycin for lung re-modelling, and she was eventually transferred back to Glasgow Royal Infirmary on 20th December 2011. She was catheterised and NG fed. Her tracheostomy was removed on 28th December 2011. She made a satisfactory recovery on the respiratory ward and was seen by a Neurological Consultant, Dr Miller on 30th December 2011 to assess her for her long standing tremor.

Cont/.....

A comprehensive set of tests were requested to investigate her tremor including thyroid function tests which were normal, immunoglobulins which were normal, protein electrophoresis which was normal, copper which was normal, ANCA, complement, rheumatoid factor and auto antibodies were all normal. B12, Folate and Ferritin were normal and her calcium was normal. Mrs McLeish refused a Huntingdon genetics test.

Unfortunately on the 2nd January 2012 Wendy decided to leave the Ward as she was "bored of the depressing Ward". Despite conversations with myself and Dr Wilson she signed the irregular discharge form and discharged herself against medical advice.

Ideally we would like to see her again in the Respiratory Clinic which ideally would have been 4-6 weeks after her discharge, but due to a delay in dictating this letter that has not been offered to her. We will send her an appointment for 1 week's time. She also has outpatient follow up with the Neurologists on 19th March 2012.

Kind regards.

Yours sincerely,

Dr Emily Leadbeater
FY2 in Respiratory Medicine

GLASGOW ROYAL INFIRMARY
Queen Elizabeth Building
16 Alexandra Parade
Glasgow
G31 2ER

Switchboard: 0141 211 4000
Direct Dial: 0141 211 4381
Fax Number: 0141 211 1120

Contact Email: Lynn.Murray@ggc.scot.nhs.uk

DEPARTMENT OF RESPIRATORY MEDICINE

Mrs Wendy McLeish
Flat 0/1
51 Coxton Place
GLASGOW
G33 5EJ

EL/LM

Dict: 13/03/2012
Typed: - 13/03/2012

Dear Mrs McLeish,

CHI: 2505876061 ~ CRN: 23123532V

Further to your recent admission to the Respiratory Ward at Glasgow Royal Infirmary an appointment has been made for you to attend Dr Chalmers' Respiratory Clinic on Monday 26th March 2012 at 3:00pm. If this is not suitable can you please contact Dr Chalmers' Secretary on 0141 211 4381 and we can arrange another appointment. An appointment card is enclosed.

Kind regards.

Yours sincerely,

Dr Emily Leadbeater
FY2 in Respiratory Medicine

Encl – appointment card.

Dr Jason Lang
FY1
Ward 7/16
Glasgow Royal Infirmary.

Faxed
24741
28/12/11
1620

20th December 2011.

Neurology Consultant
GRI
Glasgow

Dear Dr

Re: *** In Patient Review ***

23123532V
MCLEISH F
WENDY 25/05/1987
0/1 51 COXTON PLACE

GLASGOW G33 5EJ
CHI-2505876061

We would be grateful for your opinion on this 24 year old female who has a tremor involving her arms and legs but sparing the rest of her body. The tremor is more pronounced in the arms. It is not present during sleep. She is not able to control or stop the tremor. She was initially referred to Neurology by her GP in 2009 however she failed to attend. At that time there was some improvement with propranolol and alcohol.

She was initially admitted with severe community acquired pneumonia requiring ITU treatment, and subsequently sent for ECMO in Leicester. She also required dialysis. She had deranged LFT's with a degree of jaundice since her return to our care. She has had a normal liver ultrasound, within the bounds of the limited study due to the tremor. She is now able to eat and drink normally and can communicate better now that her tracheostomy has been removed.

Additional past medical history includes cocaine abuse and anxiety. We would be grateful for your impression of her tremor and any recommendations you could make regarding treatment.

Yours faithfully,

Jason Lang
FY1
Ward 7/16 – GRI
#3932

Dr Jason Lang
FY1
Ward 7/16
Glasgow Royal Infirmary.

20th December 2011.

Neurology Consultant
GRI
Glasgow

Dear Dr

Re: *** In Patient Review ***.



23123532V
MCLEISH F
WENDY 25/05/1987
0/1 51 COXTON PLACE

GLASGOW G33 5EJ
CHI-2505876061

We would be grateful for your opinion on this 24 year old female who has a tremor involving her arms and legs but sparing the rest of her body. The tremor is more pronounced in the arms. It is not present during sleep. She is not able to control or stop the tremor. She was initially referred to Neurology by her GP in 2009 however she failed to attend. At that time there was some improvement with propranolol and alcohol.

She was initially admitted with severe community acquired pneumonia requiring ITU treatment, and subsequently sent for ECMO in Leicester. She also required dialysis. She had deranged LFT's with a degree of jaundice since her return to our care. She has had a normal liver ultrasound, within the bounds of the limited study due to the tremor. She is now able to eat and drink normally and can communicate better now that her tracheostomy has been removed.

Additional past medical history includes cocaine abuse and anxiety. We would be grateful for your impression of her tremor and any recommendations you could make regarding treatment.

Yours faithfully,

Jason Lang
FY1
Ward 7/16 – GRI
#3932

EMERGENCY MEDICAL RETRIEVAL SERVICE

Tel:0141 248 2894 Fax: 0141 221 1501 | www.emrs.scot.nhs.uk | Advice Only? Y / N

EMRS consultant	HAY	2nd team member	McGregor	Paramedic			
Patient location	GRI ICU		Mission No.	1	Date	30/4/11	
Team (circle one)	Duty 1 / Duty 2	Additional					
Referral Source	Direct	ED staff	Flight paramedic	Land paramedic	EMDC	Other	

Activation time	12:30	EMDC call time	12:40	EMDC decision		Team Ready	12:50	Airborne time	16:15
On Scene	14:00	Depart Scene	16:00	Arrive Hospital		Back at SECC		Additional Request?	
Delay Reason									
Transport outward		Hellmed 5	GLA King Air	ABZ King Air	Royal Navy	Land	Other -		
Transport return		Hellmed 6	GLA King Air	ABZ King Air	Royal Navy	Land	Other -		
Patient Name	Wendy McLeish			DOB	25/5/87	Weight (kg)	96.0kg		

Referring Clinician	Name	Martin Hughes	Phone No.	01412114225/4897

Clinical details incl PMH & meds

10/7 Pneumonia. Lynn ECMO 07989876262
ICU for 9 days

Advice given

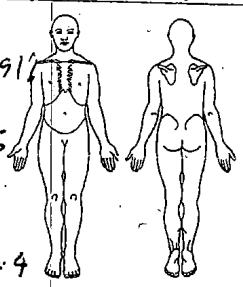
We will review in ICU & if we think stable with transfer.

Fluid Balance -1244ml since 7am

Clinical findings

Sedated & ventilated.

F:O2 1.0 28/15 BIPAP Sp02 91%
No vasopressors
HR 130 BP 105/80 CVP 15
On Dialysis - tolerating fluid off 1400
Temp 40.6 overnight now 37.4
CXR consolidation all (R) lung & (L) lower zone & upper



Working Diagnosis

Severe Pneumonia

AIRWAY

Reason for Intubation: Intubated already

Grade: I / II / III / IV — No. of attempts — Adjunct: Bougie / Stylet

ETT size: 7.5 — Outcome: Successful / LMA / Surgical airway / Abandoned — all the way

Length at lips: 27 cm — Complication during Intubation: Sats<90% / SBP<90 / none

Oxygenation & Ventilation — Mode – Self Vent / IPPV / Pressure Control / Other

FIO2 % 100 — TV 340 ml — Resp Rate 26 /min — PEEP 12 cm H_2O

IV Access — YES / NO — Number of peripheral cannulae 0 1 2 3

Monitoring — Arterial Line YES / NO Location L. radial — Central Line YES / NO Location R int jug.

Temperature probe YES / NO — Urinary catheter YES / NO — NG or OG tube YES / NO

Drug / Fluid	Dose	Route	Time
Rocuronium	100mg	IV	19:30
Alfentanil 500mg/ml	8ml	IV	10:25:20
Propofol 2%	4ml/h	IV	100mg 16:30
Normal 10mg%	2 ml/h	IV	

Interventions (tick all that apply)

SAM Pelvic Splint		Vacuum mattress		Thoracostomies	LEFT	RIGHT
Joint reduction		Fracture reduction		Chest Drain	LEFT	RIGHT
Therapeutic hypothermia				Kendrick Splint	LEFT	RIGHT
DC Cardioversion		External Pacing - Used		External pacing attached – not used		
Other (specify)				Temperature control (blanket x2 & head cover)		

Observations	Time	Pulse	BP	RR	E/4	V/5	M/6	$ETCO_2$	O_2 Sats	Left Pupil	Right Pupil	Temp (°C)
At Referral	12:30	110	114/60	20	—	—	—	7.5	88	3	3	37.2
EMRS arrival	14:00	115	105/60	20	—	—	—	7.0	91	3	3	37
Before EMRS departure	16:00	135	119/60	26	Paralysed			8.4	~~78~~	3	3	38.6
At Handover	18:50	140	125/60	26	—	—	—	8.8	90	3	3	37.4

Patient Destination

Initially Triaged to:	Final Disposition:	Triage Rationale:
Leicester	Leicester	ECMO.

Please complete and sign over the page

V12 March 2011

EMERGENCY MEDICAL RETRIEVAL SERVICE Tel:0141 248 2894 Fax: 0141 221 1501 **www.emrs.scot.nhs.uk** **Advice Only? Y / N**

Time	HR	SBP	DBP	MAP	RR	FiO2	SaO2	ETCO2	E/4	V/5	M/6	CVP
18:40	-	Resuscitation				to	46%	Bagged				
		back to 90%.										
		Further 2 defibrillations to										
		60s. All responded to										
		bagging										

Na 139 K 5.4 (pre dialysis) Cl 103 Urea 11.8
Creat 207 Bil 14 Alt 41 Alb 25 γGT 171
Alkp 80 Alb 10 Mg 0.89 Ca 1.78
phosphate 2.07 CRP 316
WCC 7.6 Hb 78 plat 199
APTT 41.1 PT 15 F: 1.1

Additional Drug / Fluid	Dose	Route	Time

Urgency – circle one (see activation SOP for definitions)

Time Critical | (Intensive) | III - Unstable | III - Stable | Unwell | Well

Complications during transfer (tick all that apply)

Propaq power failure		Propaq Monitoring Failure (specify)	
Oxygen supply failure		Ventilator failure (specify)	
Desaturation	✓	Hypotension req fluids	Hypotension req pressors
None		Other (specify)	

Advice Only Calls – Non Activation (tick all that apply)

EMRS not available (specify)		Aircraft not available (specify)	
Critical Care not required		Medical Escort not required	
Intervention not appropriate (eg comorbidities)		Adverse weather	
Passed to Paediatric Team		Passed to Shock Team	
Destination			
Transport Used			

Additional Notes

Drugs Chloline 500 tds IV
Clexane 40 - 6 pm (with holding
lactulose.
Silvex bd.
Meropenem 1g tds
Metronidazole tds
Losec 40 IV bd.
Paracetamol 750 qds IV
senna
Vancomycin 1500mg g'day (level 13.6)
due 1 g today

EMRS Consultant (BLOCK CAPITALS)	Signed
Alasdair MAY	
EMRS Registrar / CCP (BLOCK CAPITALS)	**Signed**
McKeown	

Appendix 2

Kalyx

HM Prison Addiewell
Station Road
Addiewell
West Lothian
EH55 8QA
Tel: 01506 874 500
Fax: 01506 874 ~~544~~
501

Dear Dr. MILLAR

Exceptional Escorted Days Absence – Patient/Doctor confirmation

An application has been made by a prisoner at HM Prison Addiewell for an Exceptional Escorted Days Absence in order to visit your patient:

NAME: WENDY MCLEISH DOB 25/5/87

ADDRESS: INTENSIVE CARE UNIT
GLASGOW ROYAL INFIRMARY

PRISONER: GERALD MCLEISH

The prisoner claims to be the (relationship): BROTHER of your patient.

In order to consider this request fully we require to establish the following:

Is your patient dangerously ill	**Yes** ☑ **No** ☐
Is your patient too ill to travel to visit HM Prison Addiewell?	**Yes** ☑ **No** ☐
Could your patient travel to a prison nearer to home?	**Yes** ☐ **No** ☑

Any additional information you could provide would be of great value:

Critically unwell patient in the Intensive Care Unit, Glasgow Royal Infirmary

Please sign and date the bottom of this letter and fax to the above number.

I appreciate your assistance in this matter and assure you that any response you provide will remain confidential.

Yours sincerely,

J. RICHARDS LOMOND SRO.

Unit Senior PCO
HM Prison Addiewell

Doctor's Signature: _____ **Date:** 23.11.11

DR KATE SLADE

Royal Infirmary
16 Alexandra Parade
Glasgow
G31 2ER

NEUROLOGY DEPARTMENT
DR P SHAH
CONSULTANT NEUROLOGIST
TELEPHONE: 0141 211 4481

Dictated 25/10/2010
Typed 28/10/2010
Our Ref PS/CB

Dr Marie Wilson
Easterhouse Health Centre
9 Auchinlea Road
GLASGOW
G34 9HQ

Dear Dr Wilson

Wendy McLeish - 25/05/1987 - CHI: 2505876061 - CRN: 23123532V
0/1 51 Coxton Place, Glasgow, G33 5EJ

Miss McLeish failed to attend her Neurology Out-patient Clinic appointment today.

I have not arranged a further appointment.

Kind regards.

Yours sincerely

Pushkar Shah
Consultant Neurologist

c.c. Miss Wendy McLeish, 0/1, 51 Coxton Place, Glasgow, G33 5EJ.

25.10

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

WILLIAM DURWARD (Consultant)
Neurology
GGC General Referral

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

Glasgow Royal Infirmary
84 Castle Street
Glasgow
G4 0SF

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

Hospital location code: G107H

Email address:

Urgency of referral ROUTINE
Date of referral 13-Aug-2010 **Date sent** 13-Aug-2010

13/8/10

PATIENT DETAILS

Surname	Mcleish
Forename(s)	Wendy
Title	Miss
Sex	Female
Date of birth	25-May-1987
CHI no.	2505876061

Patient's address

0/1 51 Coxton Place
GARTHAMLOCK
Glasgow
UK
G33 5EJ

Contact number(s)

Voice: 07769733984

101000864465M Unique Care Pathway Number: 101000864465M

REGISTERED GP DETAILS

Name	Dr Anne McGinley		
GMC code	3341180	GP code	G07307
Practice name	Easterhouse Health Centre		
Practice code	46471		

Practice address

9 Auchinlea Road
Glasgow
G34 9HQ

Contact number(s)

Voice: 0141 531 8150
Facsimile: 0141 531 8158

REFERRING GP DETAILS

Name	Dr. Marie Wilson		
GMC code	2551656	GP code	01376
Practice name	EASTERHOUSE HEALTH CENTRE (46471)		
Practice code	46471		

Practice address

9 AUCHINLEA ROAD
GLASGOW

Contact number(s)

Voice: 0141 531 8150

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: Essential tremour ?

Comment: Thank you for seeing this young woman who has tremour affecting her hands in particular. This now happens most days. Alcohol helps reduce tremour. There has been slight benefit from propranalol but not much. This does not stop her day to day functioning or activities. She is keen to find out if anything further could be done to improve her symptoms as she finds the tremour embarrasing. She is otherwise well and takes OCP for contraception. BP is normal I was considering trying primidone but am a little reluctant as this is not available in the suggested starting dose fro Benign essentia tremour and because of the side effects. I would be grateful for your assessment and advice on other alternatives.

Reason for referral

Care type requested: Out Patient

Expected outcome: Investigate

Past medical history

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

Description	Comment	Date of onset
Benign essential tremor	-	08-Jul-2010
Death of mother	age 29 MI	01-Jan-1991

Past procedures (High and medium priority - all)

Description	Comment	Date performed
Child: clinical psychologist	in care a lot as a child Sexualised behaviour as a child	26-Oct-1994

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

No current medications recorded

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Duration
Propranolol Hydrochloride	100	TABS 40MG	1 Tab	3 times daily	13-Aug-2010	0 Days
Cilest	126	TABS	-	-	13-Aug-2010	0 Days
Aciclovir	1	Cold Sore CREAM 5%	-	-	13-Aug-2010	0 Days
Cilest	126	TABS	-	-	13-Aug-2010	0 Days
Aciclovir	1	Cold Sore CREAM 5%	-	-	13-Aug-2010	0 Days
Propranolol Hydrochloride	100	TABS 40MG	1 Tab	3 times daily	13-Aug-2010	0 Days
Cetirizine Hydrochloride	30	TABS 10MG	1 Tab	Daily	08-Jul-2010	0 Days
Propranolol Hydrochloride	100	TABS 40MG	1 Tab	3 times daily	08-Jul-2010	0 Days
Flucloxacillin	20	CAPS 250MG	1 Cap	4 times daily	21-Apr-2010	0 Days
Fusidic Acid	5	Eye DROPS 1%	1 Drop	Twice daily	26-Mar-2010	0 Days

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Never smoked tobacco:		21-Jan-2010
Light drinker - 1-2u/day:		21-Jan-2010

Clinical warnings

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

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

Patient has disability or requires wheelchair access:No
Referred By:Referring GP
Electronic Attachment Present:No

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

FINAL DISCHARGE LETTER

Glasgow Royal Infirmary 84 Castle Street, Glasgow G4 0SF 0141-211-4803 or 211 4381

3rd Floor Medical Unit **Ward:** 7-16 **Consultant:** Chalmers

Dr. M WILSON
DR WILSON, DR MCGINLEY & DR S
EASTERHOUSE HEALTH CENTRE
9 AUCHINLEA ROAD
GLASGOW
0141 531 8150

23123532V
MCLEISH F
WENDY 25/05/1987
0/1 51 COXTON PLACE

GLASGOW G33 5EJ
CHI-2505876061

Admitted: 12/12/11
Estimated Discharge:
Discharged: 2/1/12 irregula D/C
Follow Up: Resp 4-6/52
Died:
GP informed: by:

Main Diagnoses:

Previous/inactive Diagnoses:

Presenting complaint:

Examination:

Diagnostic tests/ procedures and relevant results:

Results awaited/ unresolved issues and further action/follow up plan (say if done or who to do):

Medication on discharge, changes and why:

Date: **Signed:** **Name:** **Position:** **Typed:** **Ref:**

GLASGOW ROYAL INFIRMARY

Radiology Report

Patient Name:	MCLEISH WENDY	**Report Date:**	22-Dec-2011 12:03
Patient ID:	2505876061	**Accession No.:**	G107H26482206
Patient Birth Date:	25-May-1987	**Report Status:**	F
Referring Physician:	Dr Brian Choo-Kang	**Reason For Study:**	

[Report Summary]
Clinical History : CAP ITU admission. ECMO. Patient now jaundiced, liver enzymes deranged, ? cause.
[US Abdomen and pelvis]
US Abdomen and pelvis :
Technically limited examination due to marked tremor causing movement artefacts and degraded image. As best seen, normal appearance of the liver, gallbladder, biliary tree, both kidneys and spleen. Pancreas was obscured. No free fluid.

Reported by : *Frith Noble*

2nd Report by :

Verified by : *Frith Noble*

Produced by Carestream Health PACS

NHS

MCLEISH, Wendy
0/1 51 Coxton Place, , Glasgow, Lanarkshire, G33 5EJ
Referrer: Dr Brian Choo-Kang - GRI WARD 7

DoB: **25/05/1987**
Chi No: **2505876061**
CRIS No: **5226123**
Hosp No: **23123532V**

VERIFIED Verified By: Frith Noble 22/12/11 1203.
Clinical History : CAP ITU admission. ECMO. Patient now jaundiced, liver enzymes deranged, ? cause.

US Abdomen and pelvis :

Technically limited examination due to marked tremor causing movement artefacts and degraded image. As best seen, normal appearance of the liver, gallbladder, biliary tree, both kidneys and spleen. Pancreas was obscured. No free fluid.

Hospitals

Rpt Src: Glasgow Royal Infirmary, 84 Castle Street, Glasgow, G4 0SF
Exam: US Abdomen and pelvis
Exam Date: 22/12/11 Event: E-26262463

[redacted]

NHS Greater Glasgow and Clyde

MCLEISH, Wendy
0/1 51 Coxton Place, , Glasgow, Lanarkshire, G33 5EJ
Referrer: Dr Brian Choo-Kang - GRI WARD 7

DoB: **25/05/1987**
Chi No: **2505876061**
CRIS No: **5226123**
Hosp No: **23123532V**

VERIFIED Verified By: Dr Giles Roditi 28/12/11 1421.
Clinical History : NG tube in situ - check position.

XR Chest :

AP erect ward film. NGT appears in satisfactory position in this patient with tracheostomy in situ. There is continuing bilateral basal consolidation.

North Glasgow Hospitals

Ref. Src: Glasgow Royal Infirmary, 84 Castle Street, Glasgow, G4 0SF
Exams; XR Chest
Exam Date: 23/12/11 Event: E-26269701

NHS
Greater Glasgow and Clyde

MCLEISH, Wendy
0/1 51 Coxton Place, , Glasgow, Lanarkshire, G33 5EJ
Referrer: Dr Barbara Miles - GRI INTENSIVE CARE UNIT

W 7/16.

DoB: **25/05/1987**
Chi No: **2505876061**
CRIS No: **5226123**
Hosp No: **23123532V**

VERIFIED Verified By: Dr Giles Roditi 21/12/11 1736.
Clinical History : Tracheostomy in place, deteriorating respiratory function with raised inflammatory markers.

XR Chest :

AP erect ward film. Tracheostomy tube in situ, NGT is looped in stomach fundus region as before. There is persistent consolidative shadowing medially in the right lung partly obscuring the hilum with some further patchy consolidation in the left mid zone though this is fairly similar to the film of 12/12/11.

Glasgow Hospitals

Ref. Src: Glasgow Royal Infirmary, 84 Castle Street, Glasgow, G4 0SF
Exams: XR Chest
Exam Date: 17/12/11 Ev E-26252856

IMAGING

REMOVE ONE STRIP AT A TIME TO AFFIX REPORT, STARTING FROM BOTTOM LINE

NHS Greater Glasgow and Clyde

Glasgow Royal Infirmary
MCLEISH, Wendy
0/1 51 Coxton Place, , Glasgow, Lanarkshire, G33 5EJ
Referrer: Dr Malcolm Booth - GRI INTENSIVE CARE UNIT

Diagnostic Imaging Report
DoB: **25/05/1987**
Chi No: **2505876061**
CRIS No: **5226123**
Hosp No: **23123532V**

VERIFIED Verified By: Dr Cindy Chew 14/12/11 0938.

Clinical History :
Pneumonia. NG tube placement.

XR Chest :
The tracheostomy is noted, tip is projected level of clavicles. NG tube is noted tip projected under left hemidiaphragm.
Focal consolidation is still demonstrated at the left lung and right upper lobe. Things have improved from previous examination dated 29/11/2011.

North Glasgow Hospitals

Ref. Src: Glasgow Royal Infirmary, 84 Castle Street, Glasgow, G4 0SF
Exams: XR Chest
Exam Date: 12/12/11 Event: E-26239828 **Page 1 of 1**

Nor Exam Date: 30/11/11 Event: E-26210744 08964 **Page 1 of 1**

North Exam Date: 29/11/11 Event: E-26206873 08964 **Page 1 of 1**

Nort Exam Date: 24/11/11 Event: E-26195680 08964 **Page 1 of 1**

Nort Exam Date: 27/11/11 Event: E-26202901 08964 **Page 1 of 2**

Nort Exam Date: 27/11/11 Event: E-26202901 0896 **Page 2 of 2**

No Exam Date: 27/11/11 Event: E-26202708 0896 **Page 1 of 1**

Nort Exam Date: 21/11/11 Event: E-26186097 08964 **Page 1 of 1**

Kalamazoo S-1057985-12x8.25 © Copyright 01/2002 Tel: 0121 256 2000

NHS Greater Glasgow and Clyde

Glasgow Royal Infirmary

MCLEISH, Wendy
0/1 51 Coxton Place, , Glasgow, Lanarkshire, G33 5EJ
Referrer: DR M HUGHES : GRI INTENSIVE CARE UNIT

Diagnostic Imaging Repor
DoB: 25/05/1987
Chi No: 2505876061
CRIS No: 5226123
Hosp No: 23123532V

VERIFIED Verified By: Dr Patricia Deonarine (SpR) 30/11/11 1448 and: Dr Colin Noble
Last Verified By: Dr Colin Noble 30/11/11 1448.

Clinical History :
Worsening respiratory failure. Significant pulmonic changes on the right ? Loculation? Empyema.

US Thorax and pleural cavity :

Portable ultrasound chest in ITU.

Ultrasound confirms a small right-sided simple pleural effusion, of maximal depth posteromedially. No echogenic material, loculations or debris is seen on ultrasound to suggest an empyema.

Findings discussed with the referring team at the time of scanning.

North Glasgow Hospitals

Ref. Src: Glasgow Royal Infirmary, 84 Castle Street, Glasgow, G4 0SF
Exams: US Thorax and pleural cavity
Exam Date: 30/11/11 Event: E-26210744 **Page 1 of 1**

North | Exam Date: 29/11/11 Event: E-26206873 **Page 1 of 1** 08964

Norl | Exam Date: 24/11/11 Event: E-26195680 **Page 1 of 1** 08964

Norl | Exam Date: 27/11/11 Event: E-26202901 **Page 1 of 2** 089(

Nort | Exam Date: 27/11/11 Event: E-26202901 **Page 2 of 2** 0896

Noi | Exam Date: 27/11/11 Event: E-26202708 **Page 1 of 1** 08964

Nort | Exam Date: 21/11/11 Event: E-26186097 **Page 1 of 1** 08!

Kalamazoo S-10579851-12x6.25 © Copyright 01/2002 Tel: 0121 256 2000

NHS

Glasgow Royal Infirmary

MCLEISH, Wondy
0/1 51 Coxton Place, , Glasgow, Lanarkshire, G33 5EJ
Referrer: Dr Malcolm Booth - GRI INTENSIVE CARE UNIT

Diagnostic Imaging Report

DoB: 25/05/1987
Chi No: 2505876061
CRIS No: 5226123
Hosp No: 23123532V

VERIFIED Verified By: Dr Giles Roditi 01/12/11 1254.

Clinical History : Increasing oxygen requirements with diminished expansion right lung - exclude pneumothorax.

XR Chest :

AP erect. ETT, NGT and right subclavian CVC appear in satisfactory unaltered positions. There is extremely dense consolidation of the right lung with fluid capping the apex as before. Quite dense consolidation in the left mid and lower zones persists with only the left apex spared. Allowing for differences in technical factors there appears to be have been little change when compared with 27/11/11.

North Glasgow Hospitals

Ref. Src: Glasgow Royal Infirmary, 84 Castle Street, Glasgow, G4 0SF
Exams: XR Chest
Exam Date: 29/11/11 Event: E-26206873 Page 1 of 1 08964

Nort Exam Date: 24/11/11 Event: E-26195680 Page 1 of 1 08964

Nort Exam Date: 27/11/11 Event: E-26202901 Page 1 of 2 0896

Nort Exam Date: 27/11/11 Event: E-26202901 Page 2 of 2 0896

Nor Exam Date: 27/11/11 Event: E-26202708 Page 1 of 1 08964

Nort Exam Date: 21/11/11 Event: E-26186097 Page 1 of 1 089

Kalamazoo S-1057951-12e8.25 © Copyright 01/2002 Tel: 0121 250 2000

[redacted]

CHI No: [redacted]
Hosp No: 23123652V

VERIFIED Verified By: Dr John Shand 30/11/11 1052.

Clinical History :
Increasing oxygen requirements.

XR Chest :
There is complete consolidation of the right lung with partial consolidation of the left lung. The radiological appearance of the lungs is deteriorating compared to the previous examination 21 November 2011. ET tube is in the trachea, right subclavian line to the SVC and the nasogastric tube is coiled in the stomach.

North Glasgow Hospitals

Ref. Src: Glasgow Royal Infirmary, 84 Castle Street, Glasgow, G4 0SF
Exams: XR Chest
Exam Date: 24/11/11 Event: E-26195680 **Page 1 of 1**

08964

Nort Exam Date: 27/11/11 Event: E-26202901 **Page 1 of 2**

0896

Nort Exam Date: 27/11/11 Event: E-26202901 **Page 2 of 2**

0896

Nor Exam Date: 27/11/11 Event: E-26202708 **Page 1 of 1**

08964

Nort Exam Date: 21/11/11 Event: E-26186097 **Page 1 of 1**

089

Kalamazoo S-10579851-12c8.25 © Copyright 01/2002 Tel: 0121 256 2000

NHS

Glasgow Royal Infirmary

MCLEISH, Wendy

0/1 61 Coxton Place, , Glasgow, Lanarkshire, G33 5EJ

Referrer: Dr Tara Qureshi - GRI INTENSIVE CARE UNIT

Diagnostic Imaging Repo

DoB: **25/05/1987**

Chi No: **2505876061**

CRIS No: **5226123**

Hosp No: **23123532V**

SYNTAX CHECKED by: Dr John Shand 27/11/11 1312 Report By: Dr Sophia Sakellariou (SpR) 27/11/11 and: Dr John Shand.

Clinical History :

Community-acquired pneumonia that does not improve despite antibiotics. Patient in ITU and ventilated. Pyrexial and raised markers. ? Empyema ? Any other underlying cause for lack of response to treatment

CT Thorax : Volume acquisition through the thorax post intravenous contrast. No previous imaging available for comparison.

NG tube, ET tube and right subclavian line noted in situ in satisfactory position.

There is extensive consolidation with air bronchograms in both lungs affecting the entirety of the right lung and the lingula and basal segments of the left lower lobe. Focal areas of pulmonary consolidation also seen in the left upper apical segment. Bilateral pleural effusions are also present, maximum depth of fluid on the right posterior basal pleura 4cm, left posterior basal pleura 1cm. No evidence of empyema. No evidence of pulmonary embolus in this non dedicated scan. There is evidence of right heart strain with aorta:pulmonary trunk ratio of 2.3:3.4, enlarged right atrium and contrast seen in

North Glasgow Hospitals

Ref. Src: Glasgow Royal Infirmary, 84 Castle Street, Glasgow, G4 0SF

Exams: CT Thorax

Exam Date: 27/11/11 Event: E-26202901 **Page 1 of 2**

0896

Exam Date: 27/11/11 Event: E-26202901 **Page 2 of 2**

0896

Exam Date: 27/11/11 Event: E-26202708 **Page 1 of 1**

08964

Exam Date: 21/11/11 Event: E-26186097 **Page 1 of 1**

089

Glasgow Royal Infirmary
MOLLISON, Wendy
0/16 Coxton Place, Glasgow, Lanarkshire, G33 5EJ
Referrer: Dr Tara Quasim - GRI INTENSIVE CARE UNIT

Diagnostic Imaging Report
DoB: **25/05/1987**
Chi No: **2505876061**
CRIS No: **5226123**
Hosp No: **23123532V**

the hepatic veins. No evidence of pneumothorax.
Small volume reactive mediastinal and axillary lymphadenopathy. Unremarkable upper abdominal organs allowing for scan phase. Unremarkable bony skeleton.

Conclusion: Extensive bilateral consolidation and small pleural effusions, right larger than left. Evidence of developing pulmonary hypertension and right heart strain.

North Glasgow Hospitals
No
Nort
13700 S-10579851-1268.25 © Copyright 01/2002 Tel: 0121 256 2000

Glasgow Royal Infirmary

McLELLAN, Wendy

[redacted] Coxton Place, , Glasgow, Lanarkshire, G33 5EJ

Referral: DR M HUGHES - GRI INTENSIVE CARE UNIT

Diagnostic Imaging Report

DoB: **25/05/1987**
Chi No: **2505876061**
CRIS No: **5226123**
Hosp No: **23123532V**

VERIFIED Verified By: Dr John Shand 27/11/11 1319.

Clinical History :
Worsening respiratory failure with right bronchial breathing.

XR Chest :
There is complete consolidation of the right lung and the lower two thirds of the left lung. The ET tube in the mid trachea, nasogastric tube is in the stomach and a right subclavian line is probably within the SVC. The left sided changes are progressing slightly when compared to 24 November 2011.

North Glasgow Hospitals

Ref. Src: Glasgow Royal Infirmary, 84 Castle Street, Glasgow, G4 0SF
Exams: XR Chest
Exam Date: 27/11/11 Event: E-26202708

08964

Nort
Exam Date: 21/11/11 Event: E-26186097
Page 1 of 1
08

[redacted] Infirmary
[redacted], Glasgow, Lanarkshire, G33 6EJ
[redacted] GRI INTENSIVE CARE UNIT

Diagnostic Imaging Repo
DoB: **25/05/1987**
Chi No: **2505876061**
CRIS No: **5226123**
Hosp No: **23123532V**

Verified By: Dr Christopher Smith (SpR) 21/11/11 1215.

Clinical History:
Intubation,pneumonia, central line, NG tube.

XR Chest :
Portable supine examination, the patient is rotated.

The tip of the central line lies low, probably in the right atrium. Ideally it should be withdrawn. ET and NG tubes are appropriately sited. As on previous examinations there is bilateral consolidative changes with air bronchograms, worse on the right with increasing consolidation at the right base and left mid zone, compared with the study performed 24 hours previously.

North Glasgow Hospitals

Ref. Src: Glasgow Royal Infirmary, 84 Castle Street, Glasgow, G4 0SF
Exams: XR Chest
Exam Date: 21/11/11 Event: E-26186097

085

7/16

Physiotherapy Treatment

North Glasgow Division ICU

GRI ICU

20/12/2011 08:00 - 20/12/2011 16:00

Patient Full Name	**WENDY MCLEISH**	Hospital No	**23123532V**	Encounter ID	
GP	**Dr M Wilson**	Diagnosis			
Hosp Admit Da	**21/11/2011 00:00**	Sex	**Female**	Age	**24 years**

Physiotherapy Treatment (20/12/2011 11:49) Judith Kelly

Physiotherapy Assessment

Admission Comments	**Repatriation from ECMO centre, Leicester. Events: - Admitted to GRI ICU on 21/11 with CAP - intubated following day for resp failure - Transferred to them on 30/11/11 - VV ECMO (RIJ line) from 30/11 to 07/12 - CVVH until 9/12 - Furosemide infusion since then - Trachesotomy 2/12 - Methyprednisolone and azithromycin commenced on 5/12 - for 'lung remodelling' as per ECMO Glenfield protocol - to wean after 7/7 - At time of transfer, ventilated on CPAP, FiO2 0.35 - Tending to be hypertensive - on Doxazocin - Sedation issues - on propofol and midazolam and morphine and clonidine**
Physio: Change Since Last Treatment?	**(Physio - new patient?) No (Change in status?) No (Change in physio management?) No (Comments) pt keen to get up to sit. agreeable with n/s to get UTS at 11 am n/s hoisted pt to regular chair**
Physio Assessment: Subjective	**(Consenting to treatment?) Yes (Able to comply?) Yes (Comments:) very keen and agreeable to input**
Physiotherapy Auscultation	**(Left) Good UZ; Good MZ; Fair LZ (Right) Good UZ; Good MZ; Fair LZ (Added sounds?) nil added**
Physiotherapy Palpation	**nil palpable. short, shallow breaths**
Physiotherapy Precautions	**Trachy**
Sedation Score Actual	**Awake but Calm**
Sedation Score Target	**Awake but Calm**
Pain Score	**0=No Pain**

Physiotherapy: Respiratory Problems/Analysis

Physio - Trache	**Yes; 01/12/2011**
Physiotherapy - General Problems	**Fatigue**
Physio - Respiratory Problems	**Sputum retention; Prolonged intubation**
Physio - Respiratory Analysis	**(Appropriate to Rx) Yes (Problem List Changed?) No (Reason for resp list change) pt agreeable to input. SpO2: 99-100% on 28% via t-piece for physio input swedish nose insitu SpO2: 93-94% on RA // m/s happy with this**

Physiotherapy: Rehabilitation Problems/Analysis

Physio - Rehabilitation Problems	**Bedrest/decreased mobility**
Physio - Rehabilitation Analysis	**(Appropriate to Rx?) Yes (Problem List changed?) No (Reason for rehab list change) pt agreeable to input. STS with Stand aid x 2 from chair**
	- second stand better than first - initiated second stand herself. good posture with verbal prompts -...

Physiotherapy: Plan/Treatment

Physiotherapy Treatment Plan	**(Physiotherapy Plan - Respiratory) Airway suctioning; DBXs; FET (Physiotherapy Plan - Rehab) Sit to stand (Physio Treatment Positioning) Chair**

Physiotherapy: Findings/Conclusion

Physio - Airway	**Tracheostomy**
Physio - Secretions	**Blood Stained; Mucoid**
Physio - Suction	**Coughs & Clears**
Physio - Post Rx auscultation	**(Physio auscultation post rx (L)) isq, (Physio auscultation post rx (R)) isq (Physio: Added sounds),**

Physiotherapy: Findings/Conclusion

Physiotherapy Findings	(Physio: Problems with Rx?) No, (Physio: Cough Response) Strong, (Physio: Effectiveness of Cough) Clearing Intermittently, (Physio: Overall Clearance) Fair, (Physio: Rehab Findings) Normal Tone (L); Normal Tone (R), (Physio: Foot Support) TEDS,
Physio: Conclusion/Plan of Management	(Physio: Conclusion) managed well with stand aid stands x2 nil issues, () , (Physio: Next Resp Treatment) Assess, (Physio: Next Rehab Treatment) Assess
Physio: Treated by (name/grade)	Judith Kelly SGPT

DrLY Lorna Young	12/12/2011 18:33 - 12/12/2011 18:42
JK Judith Kelly	20/12/2011 11:49 - 20/12/2011 12:01

PT/OT CONTINUATION & PROGRESS NOTES

Page Number _____

NHS Greater Glasgow and Clyde

CHI No.: _____

NAME: Wendy McLeish Date of Birth 25/5/87.

Date/Time	PT/OT/Support Worker	Continuation Notes & Progress Record	Signature & Designation
21/12/11	PT	S/L T/F to Wd 7/16. Handover from ICU incl. O/E - pt sleeping. Unable to rouse. O/I - SaO_2 99% on HTM Fi 0.28 - Ausc → nil added. Fair/Good BS T/O. - Cough → strong ineffective unable to Ax. NS/ICU PTs report pt C&C c relative ease. R/I ① Chest Ax. A/I No ch PT indicated at present (unable to do active tech/rehab as pt unrousable). P/I R/U 1/7.	Ward RHeo (BnP)
22/12/11	PT	S/L Consent v. Awake & responsive. O/I - SaO_2 97% on Fi 0.28 (HTM). - Pt C&E sputum - large amount of loose green/yellow ~~post~~ tenacious secretions in T.M. - Ausc → Initially scattered crepes but pt C&E sputum during Ax/Rx & NAD added thereafter. Good BS. - Cough → strong moist effective. Generally clearing from trachea ⊕ x1 suction of tube to aid clearance. (No "deep suction" reqd). R/I ⊕ Attempted PBE but pt struggled c technique & then C&E ⊕ (Clearing Mood	

MIS 243722

PT/OT CONTINUATION & PROGRESS NOTES

Page Number _____

NHS Greater Glasgow and Clyde

CHI No.: _____

NAME: Wendy McLeish Date of Birth 25/5/87

Date/Time	PT/OT/Support Worker	Continuation Notes & Progress Record	Signature & Designation
		(2) Yankauer to clear area around trache	
		(3) Suction x 1 to trache tube.	
		A// Copious loose secretions are being cleared (I) c minimal assistance using suction. At present is largely a nursing issue. However - due to large amounts of secretions - she would benefit from ongoing PT to monitor chest. D/W NS today (the above)	
		P// Rehab → Lie to Sit. → Sit ⊼. → STS c st aid	MWood RHOOD (Band 5)
22/12/11 PM	PT.	S// Consent ✓.	
		O// - Lie to sit. AO1 +S/V g/f. - STS → Encore st aid + AO2. Good LL ext. Tremulous I/M. - T/F UTS → as above.	
		R// (1) STS Px c st aid (2) UTS.	
		A// NS to use st aid to T/F. Fatigued quickly	MWood
		P// R/V ✓ 7	RHOOD
23/12/11 ~9 AM	PT.	S// Consent ✓. NS to get pt UTS	Band 5
		O// - SaO2 99% on 28% O2 (HFTM). - Ausc → Nil added. Good BS T/O - Note pt c&c thro' trache directly before Ax	
		R - Cough → strong, effective.	Physical signature
		R// (1) Ax Chest.	
		A// No Ax reqd (I) c&c ⊼ ease. ✓	MWood
		P// R/V Wed.	RHOOD

MIS 243722

PT/OT CONTINUATION & PROGRESS NOTES

Page Number _____

NHS Greater Glasgow and Clyde

CHI No.: _____

NAME: Wendy McLeish Date of Birth 25/5/87.

Date/Time	PT/OT/Support Worker	Continuation Notes & Progress Record	Signature & Designation
28/12/11 ~10Am	PT.	S// - Consent ✓. - Keen to mob. - May be for decannulation this Am/pm. - Feels chest is clear O// - SaO_2 maint O/A. - B. Bib in situ. - Ausc ⇒ Nil added. Good BS T/O - Cough ⇒ Strong, Moist - Lid to sit ⇒ 5m min AO1. - STS ⇒ S/V. - Mob ⇒ WZF + AO1. ~4m. Tremor ongoing but maint ± well. R// ① Mob Px (② Chest Ax) A// - NS to mob / T/F ± WZF + AO1. - Chest clear. P// - Mob Px - R/V chest as req'd.	Mood RHOT (BCAT)
29/12/11 ~9.30Am	PT.	S// Pt declined ~~in~~ mob ✓ due to feeling tired ++. Feels chest is clear. Maint SaO_2 O/A. P// R/V PM if able (caseload allows). Otherwise 'tf	Mood RHOT (BCAT)
30/12/11	PT	S// Consent ✓. Keen to mob. O// - SaO_2 maint. O/A. - Lie to sit AO1. - STS ①. - Mob ⇒ WZF + S/V. ~25m. Generally steady. R// ① Mob Px. A// Keen to prog to G. C's prior to D/C ④. P// R/V next wk.	Mood RHOT (BCAT)

Critical Care MEDICAL Discharge (GRI)

North Glasgow Division ICU

GRI ICU

12/12/2011 13:55 - 20/12/2011 16:51

Patient Full Name: **WENDY MCLEISH** Hospital No: **23123532V** Encounter ID:

GP: **Dr M Wilson** Diagnosis:

Hosp Admit Da: **21/11/2011 00:00** Sex: **Female** Age: **24 years**

Critical Care MEDICAL Discharge (GRI) (20/12/2011 10:50) Simon Patten

Medical Discharge

Discharge ICU Consultant	Quasim
Unit Stay	8 days
Ventilated?	Yes
Filtered/Dialysed?	Yes
Swan?	No
Unit Outcome	Improved
In Case of Deterioration	Would Re-Admit

Expected Hospital Outcome	Survivor
Reason Discharged	Fully Ready non-ICU Care
Drug Kardex Completed	Yes
Discharging Doctor	Patten

Latest Lab Results

Sodium (135-145)	^ 133 mmol/l
Potassium (3.5-5.0)	4.6 mmol/l
Urea (2.5-7.5)	6.8 mmol/l
Glucose (3.5-5.5)	4.50 mmol/l

Haemoglobin (90-160)	102 gm/l
White Cell Count (4-11)	10.20 10*9L
PT (10-13)	11 seconds
APTT (26-36)	29

Latest Blood Gas Results

bg PO2 (9 - 20)	17.7 kPa
bg PCO2 (3.5 - 6.5)	5

bg H+ ions (35 - 50)	^ 33.3 mmol/l

Medical Summary

Medical Comments	* Events: - Admitted to GRI ICU on 21/11 with CAP - intubated following day for resp failure - Transferred to them on 30/11/11 - VV ECMO (RIJ line) from 30/11 to 07/12 - CVVH until 9/12 - Furosemide infusion since then - Trachesotomy 2/12 - Methyprednisolone and azithromycin commenced on 5/12 - for 'lung remodelling' as per ECMO Glenfield protocol - to wean after 7/7 - At time of transfer, ventilated on CPAP, FiO2 0.35 - Tending to be hypertensive - on Doxazocin Since repatriation has been making good progress now managed 24hrs off ventilator. Achieving excellent gas exchange on Fi02 0.28, although resp rate is high she is able to tolerate this very well with no change recently. Occassionally has short lived panic attacks that respond to diazepam. now off methylprednisolone and azithromycin Strength improving and she is due for further mobilisation today. Tracheostomy in place, cuff defalted yesterday and today, good cough occasionally requiring suction so not quite ready for decannualtion today but possibly in next two days. Outreach informed. If there are any further information you require please contact me on bleep 3222.

DrSP Simon Patten 20/12/2011 10:50 - 20/12/2011 11:27

20/12/2011 10:50
DrSP 11:27 Medical Comments

* Please R/V and reduce accordingly the oramorph + dorridine depending on agitation - JB

	20/12/2011 10:50
DrSP	1100 Medical Comments: Events: - Admitted to GRI ICU on 21/11 with CAP - intubated following day for resp failure - Transferred to them on 30/11/11 - VV ECMO (RIJ line) from 30/11 to 07/12 - CVVH until 9/12 - Furosemide infusion since then - Tracheostomy 2/12 - Methyprednisolone and azithromycin commenced on 5/12 - for 'lung remodelling' as per ECMO Glenfield protocol - to wean after 7/7 - At time of transfer, ventilated on CPAP, FiO2 0.35 - Tending to be hypertensive - on Doxazocin Since repatriation has been making good progress now managed 24hrs off ventilator. Achieving excellent gas exchange on FiO2 0.28, although resp rate is high she is able to tolerate this very well with no change recently. Occassionally has short lived panic attacks that respond to diazepam. now off methylprednisolone and azithromycin. Strength improving and she is due for further mobilisation today. If there are any further information you require please contact me on bleep 3222.

2. Problem List (GRI)

North Glasgow Division ICU

GRI ICU

12/12/2011 13:55 - 20/12/2011 16:51

Patient Full Name: **WENDY MCLEISH** Hospital No: **23123532V** Encounter ID:

GP: **Dr M Wilson** Diagnosis:

Hosp Admit Da: **21/11/2011 00:00** Sex: **Female** Age: **24 years**

2. Problem List (GRI) (12/12/2011 18:31) Barbara Miles

Problems

Problem 1	**12/12/2011; CAP - post ECMO therapy; ;**
Problem 2	**13/12/2011; Renal dysfunction ; Resolved;**
Problem 3	**16/12/2011; Agitation; Active;**
Problem 4	**16/12/2011; Deranged LFTs; ;**

DrBM Barbara Miles	12/12/2011 18:31 - 16/12/2011 14:45
DrLY Loma Young	12/12/2011 18:48 - 12/12/2011 18:48
DrLD Locum Doctor 7 7	13/12/2011 01:00 - 13/12/2011 01:00
BM Brenda Mason	16/12/2011 11:39 - 16/12/2011 11:39
DrRK Rachel Kearns	19/12/2011 12:26 - 19/12/2011 12:26

Patient Full Name	**WENDY MCLEISH**	Hospital No	**23123532V**	Encounter ID	
GP	**Dr M Wilson**	Diagnosis			
Hosp Admit Da	**21/11/2011 00:00**	Sex	**Female**	Age	**24 years**

4. Procedures (12/12/2011 18:31) Lorna Young

This form should be used to document all invasive procedures

DrLY Lorna Young	12/12/2011 18:31 - 12/12/2011 18:31

3. Investigations/Scans (12/12/2011 18:31) Lorna Young

This form should be used to document all on and off-unit investigations/scans/x-rays

DrLY Lorna Young	12/12/2011 18:31 - 12/12/2011 18:31

5. Medical Summary (GRI)

North Glasgow Division ICU

GRI ICU

12/12/2011 13:55 - 20/12/2011 16:51

Patient Full Name	**WENDY MCLEISH**	Hospital No	**23123532V**	Encounter ID	
GP	**Dr M Wilson**	Diagnosis			
Hosp Admit Da	**21/11/2011 00:00**	Sex	**Female**	Age	**24 years**

5. Medical Summary (GRI) (12/12/2011 18:31) Lorna Young

Demographics

Important medical information that needs to be communicated on discharge:

This form should be reviewed and updated daily on the ward round. Any additions made should be discussed with the Consultant/Senior Trainee.

Date of Birth	**25/05/1987**
ICU Admit Date & Time	**12/12/2011 18:31**
Under Care of (ICU Cons):	**Booth**

Operations/Procedures

Operations/Procedures	**Repatriation from ECMO centre, Leicester.** **Events:** **- Transferred to them on 30/11/11** **- VV ECMO (RIJ line) from 30/11 to 07/12** **- CVVH until 9/12 - Furosemide infusion since then** **- Trachesotomy 2/12** **- Methyprednisolone and azithromycin commenced on 5/12 - for 'lung remodelling' as per ECMO Glenfield protocol - to wean after 7/7**

Other Significant Medical Issues

Other Significant Medical Issues	**Required dialysis on night of re-admission for hyperkalaemia**

DrLY	Lorna Young	12/12/2011 18:31 - 13/12/2011 09:36
BM	Brenda Mason	13/12/2011 10:17 - 13/12/2011 10:17

Patient Full Name	**WENDY MCLEISH**	Hospital No	**23123532V**	Encounter ID	
GP	**Dr M Wilson**	Diagnosis			
Hosp Admit Da	**21/11/2011 00:00**	Sex	**Female**	Age	**24 years**

6. Visiting Specialist Reviews (12/12/2011 18:31) Agency Nurse 5

Visiting Specialists

Visiting Specialist Note 1	**20/12/2011; addictions liaison; seen patient .denies any alcohol hx.admits to prev cocaine use ,no other drugs reported.on diazepam 10mg qid for agitation.patient not currently known to addiction services in community.we will follow up in respiratory.hx..**

AN5 Agency Nurse 5 12/12/2011 18:31 - 20/12/2011 12:02

Microbiology Flow Chart (GRI)

North Glasgow Division ICU

GRI ICU

12/12/2011 13:55 - 20/12/2011 16:51

Patient Full Name	**WENDY MCLEISH**	Hospital No	**23123532V**	Encounter ID	
GP	**Dr M Wilson**	Diagnosis			
Hosp Admit Da	**21/11/2011 00:00**	Sex	**Female**	Age	**24 years**

Microbiology Flow Chart (GRI) (13/12/2011 12:26) Tara Quasim

Flow Chart

PLEASE ENTER THE DATE, SAMPLE SOURCE, MICROBIOLOGY REPORT AND SENSITIVITIES	
Microbiology	**13/12/11: On linezolid, mero and fluconazole. Stop Abx. if deteriorates then restart. MGB** **14.12.11 ETA N/G.** **15/12/11 nil to add** **16/12/11 nil to add. SP** **17/12/11 ETT no growth BM** **18/12/11 NIL NEW. sp** **19.12.11 - nil new. if dteriorates, for linezolid, mero and fluconazole rk** **20.12.11: no growth so far. TQ**

DrQT Tara Quasim	13/12/2011 12:26 - 20/12/2011 12:12
DrMB Malcolm Booth	13/12/2011 12:32 - 13/12/2011 12:32
DrMH Martin Hughes	14/12/2011 12:14 - 14/12/2011 12:14
DrSP Simon Patten	15/12/2011 12:15 - 18/12/2011 13:02
DrBM Barbara Miles	17/12/2011 13:02 - 17/12/2011 13:02
DrRK Rachel Kearns	19/12/2011 14:13 - 19/12/2011 14:13

Critical Care MEDICAL Discharge (GRI)

North Glasgow Division ICU

GRI ICU

12/12/2011 13:55 - 20/12/2011 16:51

Patient Full Name	WENDY MCLEISH	Hospital No	23123532V	Encounter ID	
GP	Dr M Wilson	Diagnosis			
Hosp Admit Da	21/11/2011 00:00	Sex	Female	Age	24 years

Critical Care MEDICAL Discharge (GRI) (20/12/2011 10:50) Simon Patten

Medical Discharge

Discharge ICU Consultant	Quasim
Unit Stay	8 days
Ventilated?	Yes
Filtered/Dialysed?	Yes
Swan?	No
Unit Outcome	Improved
In Case of Deterioration	Would Re-Admit

Expected Hospital Outcome	Survivor
Reason Discharged	Fully Ready non-ICU Care
Drug Kardex Completed	Yes
Discharging Doctor	Patten

Latest Lab Results

Sodium (135-145)	^ 133 mmol/l
Potassium (3.5-5.0)	4.6 mmol/l
Urea (2.5-7.5)	6.8 mmol/l
Glucose (3.5-5.5)	4.50 mmol/l

Haemoglobin (90-160)	102 gm/l
White Cell Count (4-11)	10.20 10*9L
PT (10-13)	11 seconds
APTT (26-36)	29

Latest Blood Gas Results

bg PO2 (9 - 20)	17.7 kPa
bg PCO2 (3.5 - 6.5)	5

bg H+ ions (35 - 50)	^ 33.3 mmol/l

Medical Summary

Medical Comments	Events: - Admitted to GRI ICU on 21/11 with CAP - intubated following day for resp failure - Transferred to them on 30/11/11 - VV ECMO (RIJ line) from 30/11 to 07/12 - CVVH until 9/12 - Furosemide infusion since then - Trachesotomy 2/12 - Methyprednisolone and azithromycin commenced on 5/12 - for 'lung remodelling' as per ECMO Glenfield protocol - to wean after 7/7 - At time of transfer, ventilated on CPAP, FiO2 0.35 - Tending to be hypertensive - on Doxazocin Since repatriation has been making good progress now managed 24hrs off ventilator. Achieving excellent gas exchange on Fi02 0.28, although resp rate is high she is able to tolerate this very well with no change recently. Occassionally has short lived panic attacks that respond to diazepam. now off methylprednisolone and azithromycin. Strength improving and she is due for further mobilisation today. Tracheostomy in place, cuff defalted yesterday and today, good cough occasionally requiring suction so not quite ready for decannualtion today but possibly in next two days. Outreach informed. If there are any further information you require please contact me on bleep 3222.

DrSP Simon Patten. 20/12/2011 10:50 - 20/12/2011 11:27

Admission & Demographics

North Glasgow Division ICU

GRI ICU

21/11/2011 05:53 - 22/11/2011 00:33

Patient Full Name: **WENDY MCLEISH** Hospital No: **23123532V** Encounter ID:

GP: **Dr M Wilson** Diagnosis:

Hosp Admit Da: **20/11/2011 20:00** Sex: **Female** Age: **24 years**

Admission & Demographics (21/11/2011 09:53) Marilyn Marmion

Admission Form

Patient Full Name	* WENDY MCLEISH
Hospital No	23123532V
Date of Birth	* 25/05/1987
Age	24 years
Sex	Female
Admitting ICU Consultant	Malcolm Daniel
Allergies	No known allergies

Other Demographics

CHI No	2505876061
ICU Admit Date & Time	21/11/2011 09:30
Admitted from	medical HDU, 52

Admission Type	Emergency
Level of Care	ICU
Pt Occupation	unemployed
Marital Status	Single

Contacts

Patient Address	0/1 51 COXTON PLACE, GLASGOW, , G33 5EJ
Next of Kin	* Gerald 2nd contact (Brother)
Next of Kin Address	HM prison, Shotts, Lanarkshire, ML7 4LE
Second Contact	James 1st contact (Partner) (Mobile): 07769733984 (Home): (Work):
General Practitioner	Dr M Wilson
GP Address	Easterhouse Health Centre, 9 Auchinlea Road, Glasgow, , G34 9HQ
GP Phone Number	0141 531 8150
Other relevant contacts	Elizabeth Surgeon Aunt home 7731720 Mob 07835080122

Please print and file this form in the patients notes once completed.

DrSKT	Shashi K Timalapur	21/11/2011 09:53 - 21/11/2011 10:16
MM	Marilyn Marmion	21/11/2011 09:53 - 21/11/2011 21:19
HIS	HIS	21/11/2011 09:53 - 21/11/2011 09:53
BM	Brenda Mason	21/11/2011 10:10 - 21/11/2011 10:10

21/11/2011 09:52

HIS	09:53 Pt Name: Last Name: MCLEISH; First Name: WENDY; Suffix: Ms;
DrSKT	09:53 Pt Name: Last Name: McLeish; First Name: Wendy; Suffix: Ms;
DrSKT	09:53 Hospital No
BM	10:10 Date of Birth
DrSKT	09:53 Date of Birth: 25/05/2011
BM	10:10 Age
DrSKT	09:53 Sex

21/11/2011 09:53

DrSKT	10:16 Admitting ICU Consultant
DrSKT	10:16 Allergies
HIS	09:53 CHI No
DrSKT	10:16 ICU Admit Date & Time
DrSKT	10:16 Admitted from
DrSKT	10:16 Admission Type
DrSKT	10:16 Level of Care
DrSKT	10:16 Pt Occupation
DrSKT	10:16 Marital Status
HIS	09:53 Patient Address

MM	21:19 Next of Kin
DrSKT	10:16 Next of Kin: Gerald (Brother)
DrSKT	10:16 Next of Kin Address
BM	10:10 General Practitioner
BM	10:10 GP Address
BM	10:10 GP Phone Number

ADULTS WITH INCAPACITY
(SCOTLAND) ACT 2000

Certificate of Incapacity under Section 47 of the Adults with Incapacity (Scotland) Act 2000

I SHASHI TIMALAPUR, ST5 ANAESTHETICS (name)

of ICU, Glasgow Royal INFIRMARY (address)

*am the medical practitioner primarily responsible for the medical treatment of; or

*am a person who is *a ~~dental practitioner~~/an ~~ophthalmic optician~~/a ~~registered~~ nurse and who satisfies such requirements as are prescribed by the Adults with Incapacity (Requirements for Signing Medical Treatment Certificates) (Scotland) Regulations 2007 and who is primarily responsible for treatment of the kind in question of:

WENDY MCLEISH (name)

of 01 ST Cotton Place, Glasgow (address) 25/05/87 (date of birth)

for whom the *guardian/welfare attorney/person appointed by intervention order/nearest relative/carer

GERALD BROTHER

I have examined the patient named above on 24/11/17 (date). I am of the opinion that *he/she is incapable within the meaning of the Adults with Incapacity (Scotland) Act 2000 ("the 2000 Act") in relation to a decision about the following medical treatment:

ICU Management of her Community acquired Pneumonia and Sepsis

because of (nature of incapacity) Community Acquired Pneumonia

His incapacity is likely to continue for 1 months.

I therefore consider it appropriate for the authority conferred by section 47(2) of the 2000 Act to subsist from:

24/11/17 (date of examination) until 24/12/17, being a period which does not exceed one year from the *date of the examination on which this certificate is based/date of revocation of the certificate issued previously by me; or

*I am of the opinion that (a) *he/she is suffering from *a severe or profound learning disability/dementia/a severe neurological disorder; and (b) *what he/she is suffering from is unlikely to improve within the meaning of the Adults with Incapacity (Conditions and Circumstances Applicable to Three Year Medical Certificates) (Scotland) Regulations 2007/ YY and therefore consider it appropriate for the authority conferred by section 47(2) of the 2000 Act to subsist until:

DD/MM/YY being a period which does not exceed three years from the *date of the examination on which this certificate is based/date of revocation of the certificate issued previously by me.

The authority conferred by section 47(2) of the 2000 Act shall subsist for the period specified above or until such earlier date as this certificate is revoked.

In assessing the capacity of the patient, I have observed the principles set out in section 1 of the 2000 Act.

Signed [signature] Date 24/11/17

*delete as appropriate

GRI ICU 21/11/2011 05:53 - 30/11/2011 14:54

Patient Full Name	**WENDY MCLEISH**	Hospital No	**23123532V**	Encounter ID	
GP	**Dr M Wilson**	Diagnosis			
Hosp Admit Da	**20/11/2011 20:00**	Sex	**Female**	Age	**24 years**

1. Admission History and Examination (GRI) (21/11/2011 09:53) Morna Ball

THE ADMITTING DOCTOR SHOULD COMPLETE THIS FORM, PRINT IT AND FILE IT IN THE PATIENT'S CASE NOTES

Admission History

Admission Comments	24 year old girl admitted to medical HDU on 20/11/11 with 4 day h/o shortness of breath, chest pain, feeling unwell and diarrhoea. In AE she was confused, hypoxic and hypotensive. In the medical HDU she was managed with antibiotics, fluid resuscitation(approx 8 lts of fluids given in 12 hours) high flow oxygen. In last 2 hours she became increasingly hypoxic, hypotensive not responding to IV fluids, confused and agitated (she was abusive to ward staff and doctors, hit and kicked the doctors and ward staff). Her spo2 was 82-83 with 100% oxygen, BP 70/50 responding to metaraminal, good urine output. Her chest Xray shows Rt upper and middle lobe consolidation, CRP 382. She was transferred to ICU after 4 mg of haloperidol to control agitation, intubated with alfentanil/propofol, RSI- Grade 1 intubation. PMH: anxiety/depression. Essential tremors- under investigation- Did not attend the neurology clinic. Cocaine smoker. Previous drug overdose: Aug 2011- alcohol with ibuprofen sept 2011- Fluoxetine overdose.
Is this patient a re-admission?	No
Hospital Admit Date &Time	20/11/2011 20:00
ICU Admit Date & Time	21/11/2011 09:30
Admitted from (Name)	High Dependency Unit (GRI)
Admitted from (Type)	06. HDU in this hospital
Specialty	General Medicine
Planned admission	No
Days to Unit	1
Under Care of (ICU Cons):	Daniel
Also Under (Hosp Cons)	Mckay
Incapacity Form completed?	Yes
Presenting ICU Admission Complaint	Shortness of breath, tachypnoic, confused and agitated. type 1 respiratory failure due to Right upper/middle lobe pneumonia.
Pre Sedation GCS	14
Past Medical History	Anxiely/depression. Cocaine- smoked. denies IV usage.
	Previous Drug overdose. Alcohol with ibuprofen in aug 2011. Fluoxetine in sept 2011. Essential tremors. Did not attend neurology clinic.
Drug History	(Home Medication) denies any- previously on. Propanolol 2. fluoxetine. GP surgery phoned-
	Patient on fluoxetine 20mg daily (last dispensed 1/11/11) propranolol 40mg tid (last dispensed 16/11/11). M.Ball (page 1514). (Hospital Meds Pre-ICU)...
Allergies	No known allergies

Chronic Health

Alcohol Excess >30units/wk	No
Smoking	No
Employment	Unemployed
Residential	Own/family house
Recreational Drug Use	Other routes
Exercise Tolerance	METS: 6 NYHA: I
Comorbidities	1.Anxiety/depression.; Cocaine smoker; Previous drug overdose.
Oncology	No;

Chronic Health

Statin pre-ICU	No
Chronic Health Evaluation	Total Positive: ; Severe CVS: No; Severe Resp: No

Physical Exam

CVS Findings	HR 94 bpm, SR BP 132/74 mm of hg. s1 s2 heard.
Respiratory Findings	On PSIMV Chest- NVBS =, occ creps in Rt upper zone. on Fio2 0.7, spo2 100.
Neuro Findings	confused and agitated before intubation. Abusive to ward satff.
GI Findings	PA soft.
Renal Findings	Good urine output.

Assessment/Plan

Summary	Community acquired pneumonia. Sepsis
Plan	Sedation/ventilation Arterial line/central line Send Blood cultures/atypical screen/urine for leigionella antigen/urine and ETA cultures.
	NG tube Check FBC/UE/LFT/CRP Svo2. ABG Antibiotics. Start feeding once NG tube is confirmed. CXR Micro advice. inotropes if needed.
PLEASE ADD THE ADMISSION PACKAGE AND COMPLETE THE PROBLEM LIST	

MB	Morna Ball	21/11/2011 09:53 - 21/11/2011 15:16
HIS	HIS	21/11/2011 09:54 - 21/11/2011 09:54
DrSK	Shashi K Tumalapur T	21/11/2011 10:16 - 21/11/2011 10:51

2. Problem List (GRI)

North Glasgow Division ICU

GRI ICU

21/11/2011 05:53 - 30/11/2011 14:54

Patient Full Name	WENDY MCLEISH	Hospital No	23123532V	Encounter ID	
GP	Dr M Wilson	Diagnosis			
Hosp Admit Da	20/11/2011 20:00	Sex	Female	Age	24 years

2. Problem List (GRI) (21/11/2011 09:54) Brenda Mason

Problems

Problem 1	**21/11/2011; Community acquired pneumonia. Rt upper lobe pneumonia.; Active;**
Problem 2	**21/11/2011; Confusion/agitation. ; Active;**
Problem 3	**21/11/2011; Sepsis secondary to chest infection; Active;**
Problem 4	**22/11/2011; Poor Nutrition; Active;**
Problem 5	**25/11/2011; Constipation - no BO for 5/7 since admission; ;**

BM Brenda Mason	21/11/2011 09:54 - 22/11/2011 12:10
DrSK Shashi K Timalapur	21/11/2011 10:23 - 21/11/2011 10:33
DrLD Locum Doctor 10 10	25/11/2011 10:48 - 25/11/2011 10:48

Patient Full Name	**WENDY MCLEISH**	Hospital No	**23123532V**	Encounter ID	
GP	**Dr M Wilson**	Diagnosis			
Hosp Admit Da	**20/11/2011 20:00**	Sex	**Female**	Age	**24 years**

3. Investigations/Scans (21/11/2011 09:54) Martin Hughes

This form should be used to document all on and off-unit investigations/scans/x-rays

Investigation 1	**21/11/2011; Chest X-Ray**
Investigation 1 Report	**ETT/NG in right place. Central line to be pulled back by 2-3 cms.** **No evidence of pneumothorax.** **Opacity of almost all rt lung.**
Investigation 2	**27/11/2011; CT**
Investigation 2 Report	**CT Thorax : Volume acquisition through the thorax post intravenous contrast. No previous imaging available for comparison.** **NG tube, ET tube and right subclavian line noted in situ in satisfactory position. There is extensive consolidation with air bronchograms in both lungs affecting the entirety of the right lung and the lingula and basal segments of the left lower lobe. Focal areas of pulmonary consolidation also seen in the left upper apical segment. Bilateral pleural effusions are also present, maximum depth of fluid on the right posterior basal pleura 4cm, left posterior basal pleura 1cm. No evidence of empyema. No evidence of pulmonary embolus in this non dedicated scan. There is evidence of right heart strain with aorta:pulmonary trunk ratio of 2.3:3.4, enlarged right atrium and contrast seen in the hepatic veins. No evidence of pneumothorax. Small volume reactive mediastinal and axillary lymphadenopathy. Unremarkable upper abdominal organs allowing for scan phase. Unremarkable bony skeleton.** **Conclusion: Extensive bilateral consolidation and small pleural effusions, right larger than left. Evidence of developing pulmonary hypertension and right heart strain. rk**
Investigation 3	**23/11/2011; HIV, HEP screen**
Investigation 3 Report	**all negative rk**
Investigation 4	**23/11/2011; resp viruses**
Investigation 4 Report	**all negative rk**
Investigation 5	**29/11/2011; Chest X-Ray**
Investigation 5 Report	**worsening consolidation left lung. Right lung remains consolidated throughout rk**
Investigation 6	**30/11/2011; Ultrasound**
Investigation 6 Report	**Chest US - Dr Noble - relatively small effusion, maximum depth posteriorly. No obvious debris and no features on recent Ct to suggest empyema.**
Investigation 7	**30/11/2011; Echocardiogram**
Investigation 7 Report	**Not ideally postioned , but most views ok.** **LV systolic function good. LV dimensions normal, if anything hypovolaemic.** **RV however is dilated (> LV, 4.4 cm) with good systolic function** **Despite this only moderate PA hypertension - 32 plus CVP - 50.** **Moderate TR.** **Other valves appear normal. PV not well visualised, but minimal PR seen.** **M Hughes**

DrMH Martin Hughes	21/11/2011 09:54 - 30/11/2011 12:52
DrSK Shashi K Timalapur	21/11/2011 10:23 - 21/11/2011 12:01
DrLY Lorna Young	27/11/2011 15:47 - 27/11/2011 15:47
DrMD Malcolm Daniel	28/11/2011 15:50 - 28/11/2011 15:50
DrRK Rachel Kearns	28/11/2011 23:36 - 29/11/2011 02:17

Patient Full Name	**WENDY MCLEISH**	Hospital No	**23123532V**	Encounter ID	
GP	**Dr M Wilson**	Diagnosis			
Hosp Admit Da	**20/11/2011 20:00**	Sex	**Female**	Age	**24 years**

4. Procedures (21/11/2011 09:54) Kenny Fraser

This form should be used to document all invasive procedures

Procedure 1	**21/11/2011; Arterial Line Insertion**
Procedure 2	**21/11/2011; NG Tube Insertion**
Procedure 3	**21/11/2011; Central Line Insertion**
Procedure 4	**23/11/2011; Blood Cultures**
Procedure 5	**26/11/2011; Blood Cultures**
Procedure 6	**29/11/2011; Blood Cultures**
Procedure 6 Note	**peripheral, arterial and central**
Procedure 7	**29/11/2011; Arterial Line Insertion**
Procedure 8	**29/11/2011; Renal Line Insertion**
Procedure 8 Note	**Asceptic techniques** **US used** **No immediate complications**

DrKF Kenny Fraser	21/11/2011 09:54 - 29/11/2011 18:05
DrSK Shashi K Timalapur	21/11/2011 10:23 - 21/11/2011 10:23
DrCM Cara Marshall	23/11/2011 09:04 - 23/11/2011 09:04
DrMC Mohammed Chekroud	26/11/2011 22:43 - 26/11/2011 22:43
DrRK Rachel Kearns	29/11/2011 00:36 - 29/11/2011 03:56

5. Medical Summary (GRI)

North Glasgow Division ICU

GRI ICU

21/11/2011 05:53 - 30/11/2011 14:54

Patient Full Name	**WENDY MCLEISH**	Hospital No	**23123532V**	Encounter ID	
GP	**Dr M Wilson**	Diagnosis			
Hosp Admit Da	**20/11/2011 20:00**	Sex	**Female**	Age	**24 years**

5. Medical Summary (GRI) (21/11/2011 09:54) Alex Puxty

Demographics

Important medical information that needs to be communicated on discharge:

This form should be reviewed and updated daily on the ward round. Any additions made should be discussed with the Consultant/Senior Trainee.

Date of Birth	**25/05/1987**
ICU Admit Date & Time	**21/11/2011 09:30**
Under Care of (ICU Cons):	**Daniel**
Also Under (Hosp Cons)	**mckay**

Operations/Procedures

Operations/Procedures	**Intubation- grade 1.** **CT scan 27.11.11**

Significant Investigation Results

Significant Investigation Results	**Resp viruses, atypical screen (inc legionella) and hep/HIV serology negative**

Other Significant Medical Issues

Other Significant Medical Issues	**Community acquired pneumonia. Rt upper lobe pneumonia.**

DrSK Shashi K Timalapur T	21/11/2011 09:53 - 21/11/2011 10:23
DrAP Alex Puxty	21/11/2011 09:54 - 30/11/2011 14:47
BM Brenda Mason	21/11/2011 10:10 - 21/11/2011 10:10
DrLY Loma Young	27/11/2011 15:47 - 27/11/2011 15:47

6. Visiting Specialist Reviews

GRI ICU

North Glasgow Division ICU

21/11/2011 05:53 - 30/11/2011 14:54

Patient Full Name	WENDY MCLEISH	Hospital No	23123532V	Encounter ID	
GP	Dr M Wilson	Diagnosis			
Hosp Admit Da	20/11/2011 20:00	Sex	Female	Age	24 years

6. Visiting Specialist Reviews (21/11/2011 09:54) Lynne Beveridge

Visiting Specialists

Visiting Specialist Note 1	**21/11/2011; Dentistry; Routine examination.** **This girl has a very healthy dentition with no problems apart from partially erupted lower hird molar teeth.** **No treatment required.**

LB Lynne Beveridge 21/11/2011 09:54 - 21/11/2011 17:05

Patient Full Name	WENDY MCLEISH	Hospital No	23123532V	Encounter ID	
GP	Dr M Wilson	Diagnosis			
Hosp Admit Da	20/11/2011 20:00	Sex	Female	Age	24 years

Admission & Demographics (21/11/2011 09:53) Elizabeth Brewer

Admission Form

Patient Full Name	* WENDY MCLEISH
Hospital No	23123532V
Date of Birth	* 25/05/1987
Age	24 years
Sex	Female
Admitting ICU Consultant	Malcolm Daniel
Allergies	No known allergies

Other Demographics

CHI No	2505876061
ICU Admit Date & Time	21/11/2011 09:30
Admitted from	medical HDU, 52

Admission Type	Emergency
Level of Care	ICU
Pt Occupation	unemployed
Marital Status	Single

Contacts

Patient Address	0/1 51 COXTON PLACE, GLASGOW, , G33 5EJ
Next of Kin	* Gerald 2nd contact (Brother)
Next of Kin Address	* HM prison, Addiewell, west lothian, EH55 8QA
Next of Kin Phone Number	(Home): 01506 874500 (Mobile): (Work):
Second Contact	James 1st contact (Partner) (Mobile): 07769733984 (Home): (Work):
General Practitioner	Dr M Wilson
GP Address	Easterhouse Health Centre, 9 Auchinlea Road, Glasgow, , G34 9HQ
GP Phone Number	0141 531 8150
Other relevant contacts	* Elizabeth Surgeon Aunt home 7731720 Mob 07835080122 Louise Maley - 07766030065

Please print and file this form in the patients notes once completed.

DrSK T	Shashi K Timalapur	21/11/2011 09:53 - 21/11/2011 10:16
EB	Elizabeth Brewer	21/11/2011 09:53 - 23/11/2011 17:57
HIS	HIS	21/11/2011 09:53 - 21/11/2011 09:53
BM	Brenda Mason	21/11/2011 10:10 - 21/11/2011 10:10
MM	Marilyn Marmion	21/11/2011 21:19 - 21/11/2011 21:19

21/11/2011 09:52

HIS	09:53 Pt Name: Last Name: MCLEISH; First Name: WENDY; Suffix: Ms;
DrSK T	09:53 Pt Name: Last Name: McLeish; First Name: Wendy; Suffix: Ms;
DrSK T	09:53 Hospital No
BM	10:10 Date of Birth
DrSK T	09:53 Date of Birth: 25/05/2011
BM	10:10 Age
DrSK T	09:53 Sex

21/11/2011 09:53

DrSK T	10:16 Admitting ICU Consultant
DrSK T	10:16 Allergies
HIS	09:53 CHI No
DrSK T	10:16 ICU Admit Date & Time
DrSK T	10:16 Admitted from
DrSK T	10:16 Admission Type
DrSK T	10:16 Level of Care

DrSK T	10:16 Pt Occupation
DrSK T	10:16 Marital Status
HIS	09:53 Patient Address
MM	21:19 Next of Kin
DrSK T	10:16 Next of Kin: Gerald (Brother)
EB	23/11/2011 17:57 Next of Kin Address
DrSK T	10:16 Next of Kin Address: HM prison, Shotts, Lanarkshire, ML7 4LE
MM	21:19 Second Contact
BM	10:10 General Practitioner
BM	10:10 GP Address
BM	10:10 GP Phone Number
EB	23/11/2011 17:57 Other relevant contacts
MM	21:19 Other relevant contacts: Elizabeth Surgeon Aunt home 7731720 Mob 07835080122

Patient Full Name	WENDY MCLEISH	Hospital No	23123532V	Encounter ID	
GP	Dr M Wilson	Diagnosis			
Hosp Admit Da	20/11/2011 20:00	Sex	Female	Age	24 years

Senior Review/Daily Ward Round Note (GRI) (21/11/2011 17:42) Colin Miller

Patient Information

Hospital Admit Date &Time	* 20/11/2011 20:00	ICU Admit Date & Time	21/11/2011 09:30

Clinical Summary

Admission Comments	* 24 year old girl admitted to medical HDU on 20/11/11 with 4 day h/o shortness of breath, chest pain, feeling unwell and diarrhoea. In AE she was confused, hypoxic and hypotensive. In the medical HDU she was managed with antibiotics, fluid resuscitation(approx 8 lts of fluids given in 12 hours) high flow oxygen. In last 2 hours she became increasingly hypoxic, hypotensive not responding to IV fluids, confused and agitated (she was abusive to ward staff and doctors, hit and kicked the doctors and ward staff). Her spo2 was 82-83 with 100% oxygen, BP 70/50 responding to metaraminal, good urine output. Her chest Xray shows Rt upper and middle lobe consolidation, CRP 382. She was transferred to ICU after 4 mg of haloperidol to control agitation, Intubated with alfentanil/propofol, RSI- Grade 1 intubation. PMH: anxiety/depression. Essential tremors- under investigation- Did not attend the neurology clinic. Cocaine smoker. Previous drug overdose: Aug 2011- alcohol with ibuprofen sept 2011- Fluoxetine overdose.
Past 24hr Progress	18.00 becoming pyrexial, peripheries a little cool, no oedema Note Hb 7.8, Alb 13 and Mg++ 0.43 CNS eye opens to voice and moving all limbs spontaneously RS PSV 15/10 50% 28*375. Sa02 93%,Auscultation BB R Ant and post chest and L base gases ABD soft BS present, NG high aspirates at 30ml/hr, BM +ve CVS. MAP~55 HR 110 ST Fluids OK diuresis Drugs as charted CDM

Problem List

Problem 1	21/11/2011; Community acquired pneumonia. Rt upper lobe pneumonia.; Active;
Problem 2	* 21/11/2011; Confusion/agitation. ; Active;
Problem 3	*
Problem 4	21/11/2011; Sepsis due to chest infection; Active;

Patient Full Name **WENDY MCLEISH** Hospital No **23123532V** Encounter ID

Problem List

Plan for the day

Plan for the day	**optomise ventillation** **NG feed may need Metoclopramide** **Viral screen and atypicals sent** **MG++ K+** **Fluid bolus if diuresis or MAP drop further** **Given drug history ? for echo**

HIS	HIS	21/11/2011 09:54 - 21/11/2011 09:54
DrSK T	Dhanni K Tirunagar	21/11/2011 10:16 - 21/11/2011 10:51
DrCM	Colin Miller	21/11/2011 17:42 - 21/11/2011 18:12

	21/11/2011 09:53
DrSK T	10:16 ICU Admit Date & Time
DrSK T	10:51 Admission Comments
DrSK T	10:16 Admission Comments: 24 year old girl admitted to medical HDU on 20/11/11 with 4 day h/o shortness of breath, chest pain, feeling unwell and diarrhoea. In AE she was confused, hypoxic and hypotensive. In the medical HDU she was managed with antibiotics, fluid resuscitation(approx 8 lts of fluids given in 12 hours) high flow oxygen. In last 2 hours she became increasingly hypoxic, hypotensive not responding to IV fluids, confused and agitated (she was abusive to ward staff and doctors, hit and kicked the doctors and ward staff). Her spo2 was 82-83 with 100% oxygen, BP 70/50 responding to metaraminal, good urine output. Her chest Xray shows Rt upper and middle lobe consolidation, CRP 382. She was transferred to ICU after 4 mg of haloperidol to control agitation, intubated with alfentanil/propofol, RSI- Grade 1 intubation.
	21/11/2011 09:54
DrSK T	10:16 Hospital Admit Date & Time
HIS	09:54 Hospital Admit Date & Time: 21/11/2011 00:00
DrSK T	10:23 Problem 1
DrSK T	10:33 Problem 2
DrSK T	10:23 Problem 2: 21/11/2011; Confusion/agitation; Active;
DrSK T	10:33 Problem 3
DrSK T	10:23 Problem 3: 21/11/2011; Hypoxia; Active;
DrSK T	10:23 Problem 4

Medical Progress Notes (GRI)

North Glasgow Division ICU

GRI ICU

21/11/2011 08:00 - 22/11/2011 07:00

Patient Full Name	**WENDY MCLEISH**	Hospital No	**23123532V**	Encounter ID	
GP	**Dr M Wilson**	Diagnosis			
Hosp Admit Da	**20/11/2011 20:00**	Sex	**Female**	Age	**24 years**

Medical Progress Notes (GRI) (21/11/2011 12:43) Malcolm Daniel

Notes

ICU Consultant:
Community acquired pneumonia - on augmentin and clarithromycin.
Fluid resuscitated: MAP > 65 mmHg - no vasopressors or inotropes currently.
Cultures taken, antibiotics next dose written up. Had 6 am dose already.
Central line has been pulled back and sutured.

DrMD Malcolm Daniel 21/11/2011 12:43 - 21/11/2011 12:46

Patient Full Name	WENDY MCLEISH	Hospital No	23123532V	Encounter ID	
GP	Dr M Wilson	Diagnosis			
Hosp Admit Da	20/11/2011 20:00	Sex	Female	Age	24 years

Senior Review/Daily Ward Round Note (GRI) (22/11/2011 11:59) Brenda Mason

Patient Information

Under Care of (ICU Cons):	Daniel
Also Under (Hosp Cons)	mckay

Hospital Admit Date &Time	* 20/11/2011 20:00
ICU Admit Date & Time	21/11/2011 09:30

Clinical Summary

Present on Ward Round:	Booth; Miller; Slade
Admission Comments	* 24 year old girl admitted to medical HDU on 20/11/11 with 4 day h/o shortness of breath, chest pain, feeling unwell and diarrhoea. In AE she was confused, hypoxic and hypotensive. In the medical HDU she was managed with antibiotics, fluid resuscitation(approx 8 lts of fluids given in 12 hours) high flow oxygen. In last 2 hours she became increasingly hypoxic, hypotensive not responding to IV fluids, confused and agitated (she was abusive to ward staff and doctors, hit and kicked the doctors and ward staff). Her spo2 was 82-83 with 100% oxygen, BP 70/50 responding to metaraminal, good urine output. Her chest Xray shows Rt upper and middle lobe consolidation, CRP 382. She was transferred to ICU after 4 mg of haloperidol to control agitation, intubated with alfentanil/propofol, RSI- Grade 1 intubation. PMH: anxiety/depression. Essential tremors- under investigation- Did not attend the neurology clinic. Cocaine smoker. Previous drug overdose: Aug 2011- alcohol with ibuprofen sept 2011- Fluoxetine overdose.
Past 24hr Progress	Her inflammatory markers have improved insofar as her WCC has come up from 3 to 6.5, CRP remains raised. Overall, her respiratory function is slightly better. Noradrenaline has been started for labile blood pressure.
Dictated by	Booth

Problem List

Problem 1	21/11/2011; Community acquired pneumonia. Rt upper lobe pneumonia.; Active;
Objective 1	FIO2 0.4, PSV 12/15 with good gas exchange. Air entry is generally harsh but the fine crepitations that she had on medical HDU have resolved. Currently on Co-amoxiclav and Clarithromycin but no +ve Microbiology as yet.
Assessment 1	Community Acquired Pneumonia.
Plan 1	Continue current antibiotics.
Problem 2	* 21/11/2011; Confusion/agitation. ; Active;
Objective 2	She has a history of agitation, became confused on the Medical Ward due to sepsis. This was probably compounded by her history of drug use. Currently she is sedated with Propofol and Morphine and, at present, a sedation hold would not be safe.
Assessment 2	Settled on current sedation.
Plan 2	Continue sedation.
Problem 3	* 21/11/2011; Sepsis secondary to chest infection; Active;
Objective 3	Remains apyrexial. WCC has improved from 3.5 to 6.5 and CRP remains elevated. She is currently requiring some Noradrenaline for her labile BP but MAP is currently 65. Her peripheries are warm and well perfused and there is minimal oedema.
Assessment 3	Sepsis secondary to pneumonia.
Plan 3	Continue current antibiotics and Noradrenaline. Accept a MAP >55 or systolic >100 providing she is passing adequate volumes of urine.

Patient Full Name **WENDY MCLEISH** Hospital No **23123532V** Encounter ID

Problem List

Problem 4	* 22/11/2011; Poor Nutrition; Active;
Objective 4	On admission to the ICU she was hypomagnesaemic and hypophosphataemic. These have been replaced. Magnesium is now satisfactory and she is undergoing Phosphate replacement at present.

Other Data

Glasgow Coma Scale	To speech-3; No response-1; Obeys commands-6; 10
Neuro status comment	Sedated for safety but able to obey commands. CAM-ICU +ve.
Sedation Score Actual	Roused by Voice
Sedation Score Target	Awake but Calm
Feeding	NG, ,
Skin Care Issues	Nil of note.
Prophylaxis/DVT	Enoxaparin; TED stockings
GI prophylaxis	Feeding; Omeprazole

Plan for the day

Plan for the day	Continue antibiotics. Wean Noradrenaline, accept MAP >55 or systolic >100, providing passing urine. Wean respiratory support to aim for 10/10, FIO2 0.4, accept SPO2 >92, PO2 >10 or PCO2 <7.

HIS	HIS	21/11/2011 09:54 - 21/11/2011 09:54
DrSK	Shashi K Timalapur	21/11/2011 10:16 - 21/11/2011 10:51
BM	Brenda Mason	22/11/2011 11:59 - 22/11/2011 12:10

21/11/2011 09:53

DrSK T	10:16 ICU Admit Date & Time
DrSK T	10:51 Admission Comments
DrSK T	10:16 Admission Comments: 24 year old girl admitted to medical HDU on 20/11/11 with 4 day h/o shortness of breath, chest pain, feeling unwell and diarrhoea. In AE she was confused, hypoxic and hypotensive. In the medical HDU she was managed with antibiotics, fluid resuscitation(approx 8 lts of fluids given in 12 hours) high flow oxygen. In last 2 hours she became increasingly hypoxic, hypotensive not responding to IV fluids, confused and agitated (she was abusive to ward staff and doctors, hit and kicked the doctors and ward staff). Her spo2 was 82-83 with 100% oxygen, BP 70/50 responding to metaraminal, good urine output. Her chest Xray shows Rt upper and middle lobe consolidation, CRP 382. She was transferred to ICU after 4 mg of haloperidol to control agitation, intubated with alfentanil/propofol, RSI- Grade 1 intubation.

21/11/2011 09:54

DrSK T	10:16 Hospital Admit Date &Time
HIS	09:54 Hospital Admit Date &Time: 21/11/2011 00:00
DrSK T	10:23 Problem 1
DrSK T	10:33 Problem 2
DrSK T	10:23 Problem 2: 21/11/2011; Confusion/agitation; Active;
BM	22/11/2011 12:10 Problem 3
DrSK T	10:33 Problem 3
DrSK T	10:23 Problem 3: 21/11/2011; Hypoxia; Active;
BM	22/11/2011 12:10 Problem 4
DrSK T	10:23 Problem 4: 21/11/2011; Sepsis due to chest infection; Active;

Patient Full Name	WENDY MCLEISH	Hospital No	23123532V	Encounter ID	
GP	Dr M Wilson	Diagnosis			
Hosp Admit Da	20/11/2011 20:00	Sex	Female	Age	24 years

Senior Review/Daily Ward Round Note (GRI) (23/11/2011 10:31) Colin Miller

Patient Information

Under Care of (ICU Cons):	Daniel	Hospital Admit Date &Time	* 20/11/2011 20:00
Also Under (Hosp Cons)	mckay	ICU Admit Date & Time	21/11/2011 09:30

Clinical Summary

Admission Comments	* 24 year old girl admitted to medical HDU on 20/11/11 with 4 day h/o shortness of breath, chest pain, feeling unwell and diarrhoea. In AE she was confused, hypoxic and hypotensive. In the medical HDU she was managed with antibiotics, fluid resuscitation(approx 8 lts of fluids given in 12 hours) high flow oxygen. In last 2 hours she became increasingly hypoxic, hypotensive not responding to IV fluids, confused and agitated (she was abusive to ward staff and doctors, hit and kicked the doctors and ward staff). Her spo2 was 82-83 with 100% oxygen, BP 70/50 responding to metaraminal, good urine output. Her chest Xray shows Rt upper and middle lobe consolidation, CRP 382. She was transferred to ICU after 4 mg of haloperidol to control agitation, Intubated with alfentanil/propofol, RSI- Grade 1 intubation. PMH: anxiety/depression. Essential tremors- under investigation- Did not attend the neurology clinic. Cocaine smoker. Previous drug overdose: Aug 2011- alcohol with ibuprofen sept 2011- Fluoxetine overdose.
Past 24hr Progress	* Seems settled. E2 VT M5. A few episodes overnight requiring sedation. Swinging pyrexia. Cultures taken. Noradrenaline continues at 7ml/hr(~12mcg/min) Increased oxygen requirements and support overnight. Remains on co-amoxiclav and clarythromycin. CVS: Warm, well perfused. BP 130/50 (70) HR 120. HS I + II + 0. NA 7ml/hr. Resp: PSV 12/14 Fi02 0.5 RR 25 SpO2 98% Good air entry bilaterally. Auscultation Bronchial breathing RHS worse on back. Good cough minimal spit. gases mild metabolic acidosis. GI: Abdomen soft. No obvious masses. Bowel sounds present. No BM since admission. PR soft faeces Neuro: Sedated. On propofol 6ml/hr. Morphine 2ml/hr. E2VtM5. Best response is weak flexion to nailbed of toes but not fingers, grimaces to facial stimulation only. Renal: Balance ex ins loss +2.5, Diuresis 1.7L U4.5 Cr 70 Drugs as charted

Problem List

Problem 1	21/11/2011; Community acquired pneumonia. Rt upper lobe pneumonia.; Active;
Objective 1	Oxygen requirements and support increased overnight. Swinging pyrexia. PSV 12/14 Fi02 0.5 RR 25 SpO2 98% Good air entry bilaterally. Nil added. Minimal secretions.
Assessment 1	Worsened overnight. Antibiotics continue.
Plan 1	Keep sedated/intubated. Chase atypical screen.
Problem 2	* 21/11/2011; Confusion/agitation. ; Active;
Objective 2	A few episodes of agitation overnight requiring sedation.
Assessment 2	Ongoing agitation. Settled at present.
Plan 2	Not for sedation break today.
Problem 3	* 21/11/2011; Sepsis secondary to chest infection; Active;
Objective 3	BP 130/50 (70) HR 120. HS I + II + 0. NA 7ml/hr. Ongoing pyrexia.
Assessment 3	Ongoing sepsis.

Problem List

Plan 3	**Try to wean noradrenaline. Aim for MABP>60. Stop background hartmanns.**
Problem 4	*** 22/11/2011; Poor Nutrition; Active;**
Objective 4	**Phoshate 0.71 Magnesium 0.8**
Plan 4	**Replace phosphate**

Plan for the day

Plan for the day	*** 23.11.11** **Stop background Hartmann's** **Reduce NA - aim for MAP > 60** **Addiphos** **Chase atypical screen** **HIV/HepBC test** **Stop omeprazole** **Thank you. agree with above plan** **COTT advanced to 24cm at lips as cuff was at larynx causing a leak** **reduce Propofol and PSV** **ETA and blood in EDTA tube for pneumonococcal PCR (Bact)** **CDM**

Fluid Balance

Fluid Balance	*

HIS	HIS	21/11/2011 09:54 - 21/11/2011 09:54
DrSK	Shashi K Timalapur	21/11/2011 10:16 - 21/11/2011 10:51
BM	Brenda Mason	22/11/2011 12:10 - 22/11/2011 12:10
DrCM	Colin Miller	23/11/2011 10:31 - 23/11/2011 17:36
DrKS	Kate Slade	23/11/2011 10:35 - 23/11/2011 12:30

21/11/2011 09:53

DrSK T 10:16 ICU Admit Date & Time

DrSK T 10:51 Admission Comments

DrSK T 10:16 Admission Comments: 24 year old girl admitted to medical HDU on 20/11/11 with 4 day h/o shortness of breath, chest pain, feeling unwell and diarrhoea.
In AE she was confused, hypoxic and hypotensive. In the medical HDU she was managed with antibiotics, fluid resuscitation(approx 8 lts of fluids given in 12 hours) high flow oxygen.
In last 2 hours she became increasingly hypoxic, hypotensive not responding to IV fluids, confused and agitated (she was abusive to ward staff and doctors, hit and kicked the doctors and ward staff).
Her spo2 was 82-83 with 100% oxygen, BP 70/50 responding to metaraminal, good urine output.
Her chest Xray shows Rt upper and middle lobe consolidation, CRP 382.
She was transferred to ICU after 4 mg of haloperidol to control agitation, intubated with alfentanil/propofol, RSI- Grade 1 intubation.

21/11/2011 09:54

DrSK T 10:16 Hospital Admit Date &Time

HIS 09:54 Hospital Admit Date &Time: 21/11/2011 00:00

DrSK T 10:23 Problem 1

DrSK T 10:33 Problem 2

DrSK T 10:23 Problem 2: 21/11/2011; Confusion/agitation; Active;

BM 22/11/2011 12:10 Problem 3

DrSK T 10:33 Problem 3

DrSK T 10:23 Problem 3: 21/11/2011; Hypoxia; Active;

BM 22/11/2011 12:10 Problem 4

DrSK T 10:23 Problem 4: 21/11/2011; Sepsis due to chest infection; Active;

23/11/2011 10:31

DrKS 10:35 Under Care of (ICU Cons):

DrKS 10:35 Also Under (Hosp Cons)

DrCM 17:36 Past 24hr Progress

DrCM 14:21 Past 24hr Progress: Seems settled. E2 VT M5. A few episodes overnight requiring sedation. Swinging pyrexia. Cultures taken. Noradrenaline continues at 7ml/hr(~12mcg/min)
Increased oxygen requirements and support overnight. Remains on co-amoxiclav and clarythromycin.

CVS: Warm, well perfused. BP 130/50 (70) HR 120. HS I + II + 0. NA 7ml/hr.
Resp: PSV 12/14 FiO2 0.5 RR 25 SpO2 98% Good air entry bilaterally. Auscultation Bronchial breathing RHS worse on back. Good cough minimal spit. gases mild metabolic acidosis.
GI: Abdomen soft. No obvious masses. Bowel sounds present. No BM since admission
Neuro: Sedated. On propofol 6ml/hr. Morphine 2ml/hr. E2VtM5. Best response is weak flexion to nailbed of toes but not fingers, grimaces to facial stimulation only.
Renal Balance ex ins loss +2.5, Diuresis 1.7L U4.5 Cr 70
Drugs as charted

23/11/2011 10:31

DrKS	10:50 Past 24hr Progress: Seems settled. E2 VT M5. A few episodes overnight requiring sedation. Swinging pyrexia. Cultures taken. Noradrenaline continues at 7ml/hr. Increased oxygen requirements and support overnight. Remains on co-amoxiclav and clarythromycin. CVS: Warm, well perfused. BP 130/50 (70) HR 120. HS I + II + 0. NA 7ml/hr. Resp: PSV 12/14 Fi02 0.5 RR 25 SpO2 98% Good air entry bilaterally. Nil added. GI: Abdomen soft. No obvious masses. Bowel sounds present. Neuro: Sedated. On propofol 6ml/hr. Morphine 2ml/hr. E2VtM5 Renal: UO 125ml/hr U4.5 Cr 70
DrKS	10:35 Past 24hr Progress: Seems settled. E2 VT M5. A few episodes overnight requiring sedation. Swinging pyrexia. Cultures taken. Noradrenaline continues at 7ml/hr. Increased oxygen requirements and support overnight. Remains on co-amoxiclav and clarythromycin.
DrKS	10:50 - Objective 1
DrKS	10:50 - Assessment 1
DrKS	10:50 - Plan 1
DrKS	10:50 - Objective 2
DrKS	10:50 - Assessment 2
DrKS	10:50 - Plan 2
DrKS	10:50 - Objective 3
DrKS	10:50 - Assessment 3
DrKS	10:50 - Plan 3
DrKS	10:50 - Objective 4
DrKS	10:50 - Plan 4
DrCM	17:36 Plan for the day
DrCM	14:34 Plan for the day: 23.11.11 Stop background Hartmann's Reduce NA - aim for MAP > 60 Addiphos Chase atypical screen HIV/HepBC test Stop omeprazole Thank you, agree with above plan COTT advanced to 24cm at lips as cuff was at larynx causing a leak reduce Propofol and PSV CDM ETA and blood in EDTA tube for pneumonococcal PCR (Bact)
DrCM	14:23 Plan for the day: 23.11.11 Stop background Hartmann's Reduce NA - aim for MAP > 60 Addiphos Chase atypical screen HIV/HepBC test Stop omeprazole Thank you, agree with above plan COTT advanced to 24cm at lips as cuff was at larynx causing a leak reduce Propofol and PSV CDM
DrCM	14:21 Plan for the day: 23.11.11 Stop background Hartmann's Reduce NA - aim for MAP > 60 Addiphos Chase atypical screen HIV/HepBC test Stop omeprazole Thankyou, agree with above plan reduce Propofol and PSV CDM
DrKS	12:30 Plan for the day: Stop backgroung Hartmann's Reduce NA - aim for MAP > 60 Addiphos Chase atypical screen HIV/HepBC test Stop omeprazole
DrKS	11:09 Plan for the day: Stop backgroung Hartmann's Reduce NA - aim for MAP > 60 Addiphos Chase atypical screen Stop omeprazole
DrKS	11:09 Fluid Balance
DrKS	10:50 Fluid Balance: Stop backgroung Hartmann's Reduce NA - aim for MAP > 60 Addiphos Chase atypical screen Stop omeprazole

Patient Full Name	WENDY MCLEISH	Hospital No	23123532V	Encounter ID	
GP	Dr M Wilson	Diagnosis			
Hosp Admit Da	20/11/2011 20:00	Sex	Female	Age	24 years

Senior Review/Daily Ward Round Note (GRI) (24/11/2011 13:32) Brenda Mason

Patient Information

Under Care of (ICU Cons):	Daniel	Hospital Admit Date &Time	* 20/11/2011 20:00
Also Under (Hosp Cons)	mckay	ICU Admit Date & Time	21/11/2011 09:30

Clinical Summary

Admission Comments	* 24 year old girl admitted to medical HDU on 20/11/11 with 4 day h/o shortness of breath, chest pain, feeling unwell and diarrhoea. In AE she was confused, hypoxic and hypotensive. In the medical HDU she was managed with antibiotics, fluid resuscitation(approx 8 lts of fluids given in 12 hours) high flow oxygen. In last 2 hours she became increasingly hypoxic, hypotensive not responding to IV fluids, confused and agitated (she was abusive to ward staff and doctors, hit and kicked the doctors and ward staff). Her spo2 was 82-83 with 100% oxygen, BP 70/50 responding to metaraminal, good urine output. Her chest Xray shows Rt upper and middle lobe consolidation, CRP 382. She was transferred to ICU after 4 mg of haloperidol to control agitation, Intubated with alfentanil/propofol, RSI- Grade 1 intubation. PMH: anxiety/depression. Essential tremors- under investigation- Did not attend the neurology clinic. Cocaine smoker. Previous drug overdose: Aug 2011- alcohol with ibuprofen sept 2011- Fluoxetine overdose.
Past 24hr Progress	She remains pyrexial, 38-39C. Hb 7.4, WCC 7.7, platelets 159, CRP 257, all basically unchanged. U's & E's OK. Slow rise in LFT's and bilirubin. Peripheries are warm, trace oedema. When sedation is lightened, she desaturates a lot so, therefore, she is being sedated. However, when turned, she does eye-open and nods to explanation to what's happening. When lightened she moves all limbs vigorously and coughs strongly. She is on pressure support 13/14, 50% giving her a rate of ~ 28 x 400mls minute volume, 11 litres. She is hyperoxic, ET aspirate purulent this morning. Auscultation harsh throughout all lung fields, especially posterior with bronchial breathing at the Left apex. Cardiovascularly stable. Noradrenaline down to 6.5mcg/minute. BP 105/40, HR 120 sinus tachycardia. Heart sounds 1 & 2 OK. Abdomen soft, slightly distended. NG feeding running OK, bowel sounds absent. PR by nursing staff, soft faeces, no bowel motions to date. Fluid balance +1.6 litres excluding insensible loss. Diuresis 2 litres. Drugs as charted.
Dictated by	Miller

Problem List

Problem 1	21/11/2011; Community acquired pneumonia. Rt upper lobe pneumonia.; Active;
Plan 1	Stop Clarithromycin as Legionella urinary antigen –ve.
Problem 2	* 21/11/2011; Confusion/agitation. ; Active;
Plan 2	Start Haloperidol regularly. When lightened she went wild. Try to get the Propofol down a bit once the Haloperidol is on board.
Problem 3	* 21/11/2011; Sepsis secondary to chest infection; Active;
Plan 3	Continue to wean Noradrenaline.
Problem 4	* 22/11/2011; Poor Nutrition; Active;

Patient Full Name **WENDY MCLEISH** Hospital No **23123532V** Encounter ID

Problem List

Plan for the day

Plan for the day	**Haloperidol.** **Lactulose, Senna.** **Stop Clarithromycin.** **Change Paracetamol to NG.**

HIS	HIS	21/11/2011 09:54 - 21/11/2011 09:54
DrSK T	Shashi K Timalapur	21/11/2011 10:16 - 21/11/2011 10:51
BM	Brenda Mason	22/11/2011 12:10 - 24/11/2011 13:40

	21/11/2011 09:53
DrSK T	10:16 ICU Admit Date & Time
DrSK T	10:51 Admission Comments
DrSK T	10:16 Admission Comments: 24 year old girl admitted to medical HDU on 20/11/11 with 4 day h/o shortness of breath, chest pain, feeling unwell and diarrhoea. In AE she was confused, hypoxic and hypotensive. In the medical HDU she was managed with antibiotics, fluid resuscitation(approx 8 lts of fluids given in 12 hours) high flow oxygen. In last 2 hours she became increasingly hypoxic, hypotensive not responding to IV fluids, confused and agitated (she was abusive to ward staff and doctors, hit and kicked the doctors and ward staff). Her spo2 was 82-83 with 100% oxygen, BP 70/50 responding to metaraminal, good urine output. Her chest Xray shows Rt upper and middle lobe consolidation, CRP 382. She was transferred to ICU after 4 mg of haloperidol to control agitation, intubated with alfentanil/propofol, RSI- Grade 1 intubation.
	21/11/2011 09:54
DrSK T	10:16 Hospital Admit Date &Time
HIS	09:54 Hospital Admit Date &Time: 21/11/2011 00:00
DrSK T	10:23 Problem 1
DrSK T	10:33 Problem 2
DrSK T	10:23 Problem 2: 21/11/2011; Confusion/agitation; Active;
BM	22/11/2011 12:10 Problem 3
DrSK T	10:33 Problem 3
DrSK T	10:23 Problem 3: 21/11/2011; Hypoxia; Active;
BM	22/11/2011 12:10 Problem 4
DrSK T	10:23 Problem 4: 21/11/2011; Sepsis due to chest infection; Active;

Medical Progress Notes (GRI)

North Glasgow Division ICU

GRI ICU

23/11/2011 08:00 - 24/11/2011 07:00

Patient Full Name	WENDY MCLEISH	Hospital No	23123532V	Encounter ID	
GP	Dr M Wilson	Diagnosis			
Hosp Admit Da	20/11/2011 20:00	Sex	Female	Age	24 years

Medical Progress Notes (GRI) (24/11/2011 03:12) Rachel Kearns

Notes

0300 - reviewed. Note increase in PS required overnight due to worsening tachypnoea. FiO2 requireemetns slightly increaseed also. CXR - significant;y worsened appearances with complete white out of right lung. ETT position satisfactory . Warm peripherally. Reasonable UOP. Note multiple ectopics.

Plan
check U+Es incl Mg + replace elecs
ABG and venous gas please
fluid challenge as first line for DO2
rpt all cultures
continue current antibiotics unless significantly worsens
RKearns

DrRK Rachel Keams 24/11/2011 03:12 - 24/11/2011 03:19

Medical Progress Notes (GRI)

North Glasgow Division ICU

GRI ICU

24/11/2011 08:00 - 25/11/2011 07:00

Patient Full Name	**WENDY MCLEISH**	Hospital No	**23123532V**	Encounter ID	
GP	**Dr M Wilson**	Diagnosis			
Hosp Admit Da	**20/11/2011 20:00**	Sex	**Female**	Age	**24 years**

Medical Progress Notes (GRI) (24/11/2011 16:19) Kate Slade

Notes

PV examination performed to exclude retained tampon (consent not obtained - sedated and ventilated)
No discharge. No obvious masses on bimanual.
KSlade

DrKS Kate Slade 24/11/2011 16:19 - 24/11/2011 16:22

23/11/2011

Patient Full Name	WENDY MCLEISH	Hospital No	23123532V	Encounter ID	
GP	Dr M Wilson	Diagnosis			
Hosp Admit Da	20/11/2011 20:00	Sex	Female	Age	24 years

Senior Review/Daily Ward Round Note (GRI) (25/11/2011 10:36) Locum Doctor 10

Patient Information

Under Care of (ICU Cons):	Daniel	Hospital Admit Date &Time	* 20/11/2011 20:00
Also Under (Hosp Cons)	mckay	ICU Admit Date & Time	21/11/2011 09:30

Clinical Summary

Present on Ward Round:	L Young
Admission Comments	* 24 year old girl admitted to medical HDU on 20/11/11 with 4 day h/o shortness of breath, chest pain, feeling unwell and diarrhoea. In AE she was confused, hypoxic and hypotensive. In the medical HDU she was managed with antibiotics, fluid resuscitation(approx 8 lts of fluids given in 12 hours) high flow oxygen. In last 2 hours she became increasingly hypoxic, hypotensive not responding to IV fluids, confused and agitated (she was abusive to ward staff and doctors, hit and kicked the doctors and ward staff). Her spo2 was 82-83 with 100% oxygen, BP 70/50 responding to metaraminal, good urine output. Her chest Xray shows Rt upper and middle lobe consolidation, CRP 382. She was transferred to ICU after 4 mg of haloperidol to control agitation, Intubated with alfentanil/propofol, RSI- Grade 1 intubation. PMH: anxiety/depression. Essential tremors- under investigation- Did not attend the neurology clinic. Cocaine smoker. Previous drug overdose: Aug 2011- alcohol with ibuprofen sept 2011- Fluoxetine overdose.
Past 24hr Progress	Issues - vent and O2 requirements weaning down Norad nearly off Persistently pyrexial > 39'C On IV fluids with educed rate of enteral feed as large aspirates Good U/O - normal U&Es

Problem List

Problem 1	21/11/2011; Community acquired pneumonia. Rt upper lobe pneumonia.; Active;
Objective 1	Bronchial breathing Rt upper zone on asucultation FiO2 0.4 - improvement SPONT mode - 15/11
	Good cough - fairly minimal ETT aspirates - 'rusty coloured'
Problem 2	* 21/11/2011; Confusion/agitation. ; Active;
Problem 3	* 21/11/2011; Sepsis secondary to chest infection; Active;
Objective 3	Persistently pyrexial 39'C and above
Problem 4	* 22/11/2011; Poor Nutrition; Active;
Objective 4	Alb 15
Problem 5	25/11/2011; Constipation - no BO for 5/7 since admission; ;
Objective 5	Abdo Soft - BS quiet
Plan 5	Commenced on senna and lactulose

Problem List

Other Data

Neuro status comment	**Sedated for safety but able to obey commands. CAM-ICU +ve.**
Sedation Score Actual	**Roused by Voice**
Sedation Score Target	**Awake but Calm**
Feeding	**NG, ,**
Skin Care Issues	**Nil of note.**
Prophylaxis/DVT	**Enoxaparin; TED stockings**
GI prophylaxis	**Feeding; Omeprazole**

Plan for the day

Plan for the day	**Norad will likely be weaned off entirely today** **Still poorly absorbing feed - brought back down to 30mls/hr supplemented by Hartmann's** **? prokinetics to try to re-establish full enteral feeding** **Start senna and lactulose** **Reduce IV fluids**

HIS	HIS	21/11/2011 09:54 - 21/11/2011 09:54
DrSKT	Shashi K Timalapur	21/11/2011 10:16 - 21/11/2011 10:51
BM	Brenda Mason	22/11/2011 12:10 - 22/11/2011 12:10
DrLD10	Locum Doctor 10	25/11/2011 10:36 - 25/11/2011 10:52

21/11/2011 09:53

DrSKT	10:16 ICU Admit Date & Time
DrSKT	10:51 Admission Comments
DrSKT	10:16 Admission Comments: 24 year old girl admitted to medical HDU on 20/11/11 with 4 day h/o shortness of breath, chest pain, feeling unwell and diarrhoea. In AE she was confused, hypoxic and hypotensive. In the medical HDU she was managed with antibiotics, fluid resuscitation(approx 8 lts of fluids given in 12 hours) high flow oxygen. In last 2 hours she became increasingly hypoxic, hypotensive not responding to IV fluids, confused and agitated (.she was abusive to ward staff and doctors, hit and kicked the doctors and ward staff). Her spo2 was 82-83 with 100% oxygen, BP 70/50 responding to metaraminal, good urine output. Her chest Xray shows Rt upper and middle lobe consolidation, CRP 382. She was transferred to ICU after 4 mg of haloperidol to control agitation, intubated with alfentanil/propofol, RSI- Grade 1 intubation.

21/11/2011 09:54

DrSKT	10:16 Hospital Admit Date &Time
HIS	09:54 Hospital Admit Date &Time: 21/11/2011 00:00
DrSKT	10:23 Problem 1
DrSKT	10:33 Problem 2
DrSKT	10:23 Problem 2: 21/11/2011; Confusion/agitation; Active;
BM	22/11/2011 12:10 Problem 3
DrSKT	10:33 Problem 3
DrSKT	10:23 Problem 3: 21/11/2011; Hypoxia; Active;
BM	22/11/2011 12:10 Problem 4
DrSKT	10:23 Problem 4: 21/11/2011; Sepsis due to chest infection; Active;

Patient Full Name	WENDY MCLEISH	Hospital No	23123532V	Encounter ID	
GP	Dr M Wilson	Diagnosis			
Hosp Admit Da	20/11/2011 20:00	Sex	Female	Age	24 years

Senior Review/Daily Ward Round Note (GRI) (26/11/2011 10:45) Lorna Young

Patient Information

Hospital Admit Date &Time	* 20/11/2011 20:00
ICU Admit Date & Time	21/11/2011 09:30

Length of ICU Stay	6 days

Resuscitation Status

Status	For resuscitation
DNR Form Completed	No

Clinical Summary

Present on Ward Round:	L Young
Admission Comments	* 24 year old girl admitted to medical HDU on 20/11/11 with 4 day h/o shortness of breath, chest pain, feeling unwell and diarrhoea. In AE she was confused, hypoxic and hypotensive. In the medical HDU she was managed with antibiotics, fluid resuscitation(approx 8 lts of fluids given in 12 hours) high flow oxygen. In last 2 hours she became increasingly hypoxic, hypotensive not responding to IV fluids, confused and agitated (she was abusive to ward staff and doctors, hit and kicked the doctors and ward staff). Her spo2 was 82-83 with 100% oxygen, BP 70/50 responding to metaraminal, good urine output. Her chest Xray shows Rt upper and middle lobe consolidation, CRP 382. She was transferred to ICU after 4 mg of haloperidol to control agitation, Intubated with alfentanil/propofol, RSI- Grade 1 intubation. PMH: anxiety/depression. Essential tremors- under investigation- Did not attend the neurology clinic. Cocaine smoker. Previous drug overdose: Aug 2011- alcohol with ibuprofen sept 2011- Fluoxetine overdose.
Past 24hr Progress	Little progress made RESP: Remains on FiO2 0.5, PS up to 16/12 PEEP (SPONT). Persistently tachypnoeic RR 28-30bpm pCO2 7, pO2 12 On auscultation - bronchial BS RUZ (unchanged) CVS: Norad currently off BP 102/50 (Mean 61) warm peripheries but becoming oedematous ++ MICRO: Continues to be peristently pyrexial > 39'C - WCC up to 10.6, CRP 254 (relatively static) Acceptable U/O 50-60ml/hr - U+Es normal - Ca, Phos, Mg all within normal limits Sputum sent y'day - result awaited. On Augmentin and Gent GI: Enterally fed up to 50ml/hr now (from 30ml/hr yesterday) with crystalloids at 25ml/hr abdo slightly distended bu soft, no BS heard. On prokinetics and laxatives Hb 66 - for G&S Note - SN caring for Wendy today mentioned a small amount of PV bleeding overnight (PV exam done earlier this week by Dr Slade - NAD), and FOB +ve result on PR exam but no obsvious malaena

Problem List

Problem 1	21/11/2011; Community acquired pneumonia. Rt upper lobe pneumonia.; Active;
Problem 2	* 21/11/2011; Confusion/agitation. ; Active;

Patient Full Name **WENDY MCLEISH** Hospital No **23123532V** Encounter ID

Problem List

Problem 3	* 21/11/2011; Sepsis secondary to chest infection; Active;
Problem 4	* 22/11/2011; Poor Nutrition; Active;
Problem 5	25/11/2011; Constipation - no BO for 5/7 since admission; ;

Plan for the day

Plan for the day	C/w prokinetics and laxatives until proper effect PEEP lowered slightly - PC increased slightly Chase sputum result from y'day Transfuse today in view of low Hb Restart PPI

HIS	HIS	21/11/2011 09:54 - 21/11/2011 09:54
DrSKT	Shashi K Timalapur	21/11/2011 10:16 - 21/11/2011 10:51
BM	Brenda Mason	22/11/2011 12:10 - 22/11/2011 12:10
DrLD10	Locum Doctor 10	25/11/2011 10:48 - 25/11/2011 10:48
DrLY	Lorna Young	26/11/2011 10:45 - 26/11/2011 11:04

21/11/2011 09:53

DrSKT	10:16 ICU Admit Date & Time
DrSKT	10:51 Admission Comments
DrSKT	10:16 Admission Comments: 24 year old girl admitted to medical HDU on 20/11/11 with 4 day h/o shortness of breath, chest pain, feeling unwell and diarrhoea. In AE she was confused, hypoxic and hypotensive. In the medical HDU she was managed with antibiotics, fluid resuscitation(approx 8 lts of fluids given in 12 hours) high flow oxygen. In last 2 hours she became increasingly hypoxic, hypotensive not responding to IV fluids, confused and agitated (she was abusive to ward staff and doctors, hit and kicked the doctors and ward staff). Her spo2 was 82-83 with 100% oxygen, BP 70/50 responding to metaraminal, good urine output. Her chest Xray shows Rt upper and middle lobe consolidation, CRP 382. She was transferred to ICU after 4 mg of haloperidol to control agitation, intubated with alfentanil/propofol, RSI- Grade 1 intubation.

21/11/2011 09:54

DrSKT	10:16 Hospital Admit Date &Time
HIS	09:54 Hospital Admit Date &Time: 21/11/2011 00:00
DrSKT	10:23 Problem 1
DrSKT	10:33 Problem 2
DrSKT	10:23 Problem 2: 21/11/2011; Confusion/agitation; Active;
BM	22/11/2011 12:10 Problem 3
DrSKT	10:33 Problem 3
DrSKT	10:23 Problem 3: 21/11/2011; Hypoxia; Active;
BM	22/11/2011 12:10 Problem 4
DrSKT	10:23 Problem 4: 21/11/2011; Sepsis due to chest infection; Active;

25/11/2011 10:36

DrLD10	10:48 Problem 5

Patient Full Name	WENDY MCLEISH	Hospital No	23123532V	Encounter ID	
GP	Dr M Wilson	Diagnosis			
Hosp Admit Da	20/11/2011 20:00	Sex	Female	Age	24 years

Senior Review/Daily Ward Round Note (GRI) (27/11/2011 09:30) Lorna Young

Patient Information

Under Care of (ICU Cons):	Daniel	Hospital Admit Date &Time	* 20/11/2011 20:00
Also Under (Hosp Cons)	mckay	ICU Admit Date & Time	21/11/2011 09:30

Resuscitation Status

Status	For resuscitation
DNR Form Completed	No

Clinical Summary

Present on Ward Round:	Quasim; L Young
Admission Comments	* 24 year old girl admitted to medical HDU on 20/11/11 with 4 day h/o shortness of breath, chest pain, feeling unwell and diarrhoea. In AE she was confused, hypoxic and hypotensive. In the medical HDU she was managed with antibiotics, fluid resuscitation(approx 8 lts of fluids given in 12 hours) high flow oxygen. In last 2 hours she became increasingly hypoxic, hypotensive not responding to IV fluids, confused and agitated (she was abusive to ward staff and doctors, hit and kicked the doctors and ward staff). Her spo2 was 82-83 with 100% oxygen, BP 70/50 responding to metaraminal, good urine output. Her chest Xray shows Rt upper and middle lobe consolidation, CRP 382. She was transferred to ICU after 4 mg of haloperidol to control agitation, intubated with alfentanil/propofol, RSI- Grade 1 intubation. PMH: anxiety/depression. Essential tremors- under investigation- Did not attend the neurology clinic. Cocaine smoker. Previous drug overdose: Aug 2011- alcohol with ibuprofen sept 2011- Fluoxetine overdose.
Past 24hr Progress	* MICRO: Continues to be significantly pyrexial > 39°C CRP down to 200 WCC 9.4 (stable) Not given Gent last night, apparently because level was high BUT a 24hr trough was 0.5 - a dose could have been given according to the nomogram. Dose changed to 10am daily to give dose just now, with level now due after 4pm. For CT chest today to look for concealed source of ongoing pyrexia ? empyema / abscess
	RESP: FiO2 increased now to 0.7 Currently on trial of APRV - 20/0
	CVS: no support HS I + II + 0 calves SNT, TEDS on GI: enterally fed RENAL: good u/o. U+E normal HAEM: Hb now 80 followng 2u RCC transfusion yesterday

Problem List

Problem 1	21/11/2011; Community acquired pneumonia. Rt upper lobe pneumonia.; Active;

Patient Full Name: **WENDY MCLEISH** Hospital No: **23123532V** Encounter ID:

Problem List

Problem 2	* 21/11/2011; Confusion/agitation. ; Active;
Problem 3	* 21/11/2011; Sepsis secondary to chest infection; Active;
Problem 4	* 22/11/2011; Poor Nutrition; Active;
Problem 5	25/11/2011; Constipation - no BO for 5/7 since admission; ;

Other Data

Feeding	NG, ,
Prophylaxis/DVT	Enoxaparin; TED stockings
GI prophylaxis	Feeding; Omeprazole

Plan for the day

Plan for the day	* CT chest

HIS	HIS	21/11/2011 09:54 - 21/11/2011 09:54
DrSKT	Shashi K Timalapur	21/11/2011 10:16 - 21/11/2011 10:51
BM	Brenda Mason	22/11/2011 12:10 - 22/11/2011 12:10
DrLD10	Locum Doctor 10	25/11/2011 10:48 - 25/11/2011 10:48
DrLY	Loma Young	27/11/2011 09:30 - 27/11/2011 09:45

	21/11/2011 09:53
DrSKT	10:16 ICU Admit Date & Time
DrSKT	10:51 Admission Comments
DrSKT	10:16 Admission Comments: 24 year old girl admitted to medical HDU on 20/11/11 with 4 day h/o shortness of breath, chest pain, feeling unwell and diarrhoea. In AE she was confused, hypoxic and hypotensive. In the medical HDU she was managed with antibiotics, fluid resuscitation(approx 8 lts of fluids given in 12 hours) high flow oxygen. In last 2 hours she became increasingly hypoxic, hypotensive not responding to IV fluids, confused and agitated (she was abusive to ward staff and doctors, hit and kicked the doctors and ward staff). Her spo2 was 82-83 with 100% oxygen, BP 70/50 responding to metaraminal, good urine output. Her chest Xray shows Rt upper and middle lobe consolidation, CRP 382. She was transferred to ICU after 4 mg of haloperidol to control agitation, intubated with alfentanil/propofol, RSI- Grade 1 intubation.
	21/11/2011 09:54
DrSKT	10:16 Hospital Admit Date &Time
HIS	09:54 Hospital Admit Date &Time: 21/11/2011 00:00
DrSKT	10:23 Problem 1
DrSKT	10:33 Problem 2
DrSKT	10:23 Problem 2: 21/11/2011; Confusion/agitation; Active;
BM	22/11/2011 12:10 Problem 3
DrSKT	10:33 Problem 3
DrSKT	10:23 Problem 3: 21/11/2011; Hypoxia; Active;
BM	22/11/2011 12:10 Problem 4
DrSKT	10:23 Problem 4: 21/11/2011; Sepsis due to chest infection; Active;
	25/11/2011 10:36
DrLD10	10:48 Problem 5
	27/11/2011 09:30
DrLY	09:45 Past 24hr Progress
DrLY	09:37 Past 24hr Progress: Continues to be significantly pyrexial > 39'C WCC FIO2 increased now to 0.7 Currently on trial of APRV - 20/0.
DrLY	09:45 Plan for the day
DrLY	09:37 Plan for the day

Patient Full Name	**WENDY MCLEISH**	Hospital No	**23123532V**	Encounter ID	
GP	**Dr M Wilson**	Diagnosis			
Hosp Admit Da	**20/11/2011 20:00**	Sex	**Female**	Age	**24 years**

Senior Review/Daily Ward Round Note (GRI) (28/11/2011 11:27) Malcolm Daniel

Patient Information

Under Care of (ICU Cons):	**Daniel**	Hospital Admit Date &Time	* **20/11/2011 20:00**
Also Under (Hosp Cons)	**mckay**	ICU Admit Date & Time	**21/11/2011 09:30**

Clinical Summary

Admission Comments	* 24 year old girl admitted to medical HDU on 20/11/11 with 4 day h/o shortness of breath, chest pain, feeling unwell and diarrhoea. In AE she was confused, hypoxic and hypotensive. In the medical HDU she was managed with antibiotics, fluid resuscitation(approx 8 lts of fluids given in 12 hours) high flow oxygen. In last 2 hours she became increasingly hypoxic, hypotensive not responding to IV fluids, confused and agitated (she was abusive to ward staff and doctors, hit and kicked the doctors and ward staff). Her spo2 was 82-83 with 100% oxygen, BP 70/50 responding to metaraminal, good urine output. Her chest Xray shows Rt upper and middle lobe consolidation, CRP 382. She was transferred to ICU after 4 mg of haloperidol to control agitation, intubated with alfentanil/propofol, RSI- Grade 1 intubation. PMH: anxiety/depression. Essential tremors- under investigation- Did not attend the neurology clinic. Cocaine smoker. Previous drug overdose: Aug 2011- alcohol with ibuprofen sept 2011- Fluoxetine overdose.
Past 24hr Progress	Put on APRV yesterday. Lowish MAP today, variable tidal volumes.
Dictated by	Daniel

Problem List

Problem 1	21/11/2011; Community acquired pneumonia. Rt upper lobe pneumonia.; Active;
Objective 1	CT scan of chest yesterday. This showed extensive bilateral consolidation with small pleural effusions, Right larger than Left. Bilateral air entry on auscultation this morning, bilateral crepitations. On APRV, FIO2 0.7, PaO2 13.5, PaCO2 8.
Assessment 1	Variable tidal volumes on APRV, and probable effect on low MAP.
Plan 1	Change to PSV. Accept we have to increase her FIO2. Head-up. Over the course of the day, see if we can reduce her PEEP to 10 and her FIO2 to 0.6.
Problem 2	* 21/11/2011; Confusion/agitation. ; Active;
Objective 2	Sedated on Morphine and Propofol.
Assessment 2	In terms of ventilatory requirements, we will keep these going today.
Plan 2	We have no plans for stopping sedation. We will review this tomorrow.
Problem 3	* 21/11/2011; Sepsis secondary to chest infection; Active;
Objective 3	Pyrexial. Temperature 39.4 this morning. Looking at the graphical trends, it looks like her temperature has been coming down, her antibiotics were changed on Saturday. No +ve cultures today.
Assessment 3	Pneumonia, haemodynamically stable.
Problem 4	* 22/11/2011; Poor Nutrition; Active;
Objective 4	She has been on Metoclopramide over the weekend to improve absorption of enteral feed. No large aspirates in the last 24hrs.
Plan 4	Stop Metoclopramide.

Patient Full Name **WENDY MCLEISH** Hospital No **23123532V** Encounter ID

Problem List

Problem 5	**25/11/2011; Constipation - no BO for 5/7 since admission; ;**
Objective 5	**Has been FOB +ve. Bowels moving.**
Plan 5	*** Plan for endoscopy - if remains FOB+ve.**

Other Data

Prophylaxis/DVT	**Enoxaparin; TED stockings**

Plan for the day

Plan for the day	**Change to PSV.** **Accept we have to increase her FIO2.** **Head-up.** **Over the course of the day, see if we can reduce her PEEP to 10 and her FIO2 to 0.6.** **We have no plans for stopping sedation. We will review this tomorrow.** **Stop Metoclopramide.** **Plan for endoscopy.**

HIS	HIS	21/11/2011 09:54 - 21/11/2011 09:54
DrSK	Shashi K Timalapur	21/11/2011 10:16 - 21/11/2011 10:51
BM	Brenda Mason	22/11/2011 12:10 - 28/11/2011 11:42
DrLD 10	Locum Doctor 10	25/11/2011 10:48 - 25/11/2011 10:48
DrMD	Malcolm Daniel	28/11/2011 11:27 - 28/11/2011 16:56

21/11/2011 09:53

DrSK T	10:16 ICU Admit Date & Time
DrSK T	10:51 Admission Comments
DrSK T	10:16 Admission Comments: 24 year old girl admitted to medical HDU on 20/11/11 with 4 day h/o shortness of breath, chest pain, feeling unwell and diarrhoea. In AE she was confused, hypoxic and hypotensive. In the medical HDU she was managed with antibiotics, fluid resuscitation(approx 8 lts of fluids given in 12 hours) high flow oxygen. In last 2 hours she became increasingly hypoxic, hypotensive not responding to IV fluids, confused and agitated (she was abusive to ward staff and doctors, hit and kicked the doctors and ward staff). Her spo2 was 82-83 with 100% oxygen, BP 70/50 responding to metaraminal, good urine output. Her chest Xray shows Rt upper and middle lobe consolidation, CRP 382. She was transferred to ICU after 4 mg of haloperidol to control agitation, intubated with alfentanil/propofol, RSI- Grade 1 intubation.

21/11/2011 09:54

DrSK T	10:16 Hospital Admit Date & Time
HIS	09:54 Hospital Admit Date & Time: 21/11/2011 00:00
DrSK T	10:23 Problem 1
DrSK T	10:33 Problem 2
DrSK T	10:23 Problem 2: 21/11/2011; Confusion/agitation; Active;
BM	22/11/2011 12:10 Problem 3
DrSK T	10:33 Problem 3
DrSK T	10:23 Problem 3: 21/11/2011; Hypoxia; Active;
BM	22/11/2011 12:10 Problem 4
DrSK T	10:23 Problem 4: 21/11/2011; Sepsis due to chest infection; Active;

25/11/2011 10:36

DrLD 10	10:48 Problem 5

28/11/2011 11:27

BM	11:42 Under Care of (ICU Cons):
BM	11:42 Also Under (Hosp Cons)
BM	11:42 Past 24hr Progress
BM	11:42 Dictated by
BM	11:42 - Objective 1
BM	11:42 - Assessment 1
BM	11:42 - Plan 1
BM	11:42 - Objective 2
BM	11:42 - Assessment 2
BM	11:42 - Plan 2
BM	11:42 - Objective 3
BM	11:42 - Assessment 3
BM	11:42 - Plan 3
BM	11:42 - Objective 4
BM	11:42 - Plan 4
BM	11:42 - Objective 5
DrMD	16:56 - Plan 5
BM	11:42 - Plan 5: Plan for endoscopy.
BM	11:42 Prophylaxis/DVT
BM	11:42 Plan for the day

Patient Full Name	**WENDY MCLEISH**	Hospital No	**23123532V**	Encounter ID	
GP	**Dr M Wilson**	Diagnosis			
Hosp Admit Da	**20/11/2011 20:00**	Sex	**Female**	Age	**24 years**

Senior Review/Daily Ward Round Note (GRI) (29/11/2011 11:37) Colin Miller

Patient Information

Under Care of (ICU Cons):	Daniel	Hospital Admit Date &Time	* 20/11/2011 20:00
Also Under (Hosp Cons)	mckay	ICU Admit Date & Time	21/11/2011 09:30

Clinical Summary

Admission Comments	* 24 year old girl admitted to medical HDU on 20/11/11 with 4 day h/o shortness of breath, chest pain, feeling unwell and diarrhoea. In AE she was confused, hypoxic and hypotensive. In the medical HDU she was managed with antibiotics, fluid resuscitation(approx 8 lts of fluids given in 12 hours) high flow oxygen. In last 2 hours she became increasingly hypoxic, hypotensive not responding to IV fluids, confused and agitated (she was abusive to ward staff and doctors, hit and kicked the doctors and ward staff). Her spo2 was 82-83 with 100% oxygen, BP 70/50 responding to metaraminal, good urine output. Her chest Xray shows Rt upper and middle lobe consolidation, CRP 382. She was transferred to ICU after 4 mg of haloperidol to control agitation, intubated with alfentanil/propofol, RSI- Grade 1 intubation. PMH: anxiety/depression. Essential tremors- under investigation- Did not attend the neurology clinic. Cocaine smoker. Previous drug overdose: Aug 2011- alcohol with ibuprofen sept 2011- Fluoxetine overdose.
Past 24hr Progress	Remains difficult to oxygenate. We tried her on a period of PSV, but had to put her back on APRV. On high FIO2.
Dictated by	Daniel

Problem List

Problem 1	21/11/2011; Community acquired pneumonia. Rt upper lobe pneumonia.; Active;
Objective 1	This morning on APRV, FIO2 0.95, PaO2 11.9, PaCO2 8.8. Oxygen saturation in blood gas, 95.
Assessment 1	Critical oxygenation.
Plan 1	We are managing her with APRV currently. We changed her antibiotics overnight to Meropenem and Vancomycin. We need to check a Vancomycin level later this afternoon.
Problem 2	* 21/11/2011; Confusion/agitation. ; Active;
Objective 2	Currently sedated on Morphine and Propofol.
Plan 2	Because of her high level ventilator requirement, we are not going to stop the sedation.
Problem 3	* 21/11/2011; Sepsis secondary to chest infection; Active;
Objective 3	She remains pyrexial. Her temperature has not come down. The trend of reduction in temperature on Sunday has been reversed. No +ve cultures today. I have reviewed her chart. Her pyrexia does not seem to be related to the time of administration of the Metoclopramide.I don't think this is the cause.
Assessment 3	Pneumonia, haemodynamically stable.
Problem 4	* 22/11/2011; Poor Nutrition; Active;
Problem 5	25/11/2011; Constipation - no BO for 5/7 since admission; ;
Objective 5	She has been FOB +ve. Haemodynamically stable. Has needed transfusion.

Patient Full Name **WENDY MCLEISH** Hospital No **23123532V** Encounter ID

Problem List

Plan 5	**We should plan for an endoscopy when her respiratory function is more stable. I don't think she could tolerate lying flat for an endoscopy.**

Other Data

Feeding	**NG, Nutrison multifibre @ 30mls/hr, Target is 65mls/hr.**
Prophylaxis/DVT	**Enoxaparin; TED stockings**

Plan for the day

Plan for the day	**Dr Hughes has kindly agreed to echo her tomorrow. CDM**

HIS	HIS	21/11/2011 09:54 - 21/11/2011 09:54
DrSKT	Shashi K Timalapur	21/11/2011 10:16 - 21/11/2011 10:51
BM	Brenda Mason	22/11/2011 12:10 - 29/11/2011 11:47
DrLD10	Locum Doctor 10	25/11/2011 10:48 - 25/11/2011 10:48
DrCM	Colin Miller	29/11/2011 11:37 - 29/11/2011 16:50

	21/11/2011 09:53
DrSKT	10:16 ICU Admit Date & Time
DrSKT	10:51 Admission Comments
DrSKT	10:16 Admission Comments: 24 year old girl admitted to medical HDU on 20/11/11 with 4 day h/o shortness of breath, chest pain, feeling unwell and diarrhoea. In AE she was confused, hypoxic and hypotensive. In the medical HDU she was managed with antibiotics, fluid resuscitation(approx 8 lts of fluids given in 12 hours) high flow oxygen. In last 2 hours she became increasingly hypoxic, hypotensive not responding to IV fluids, confused and agitated (she was abusive to ward staff and doctors, hit and kicked the doctors and ward staff). Her spo2 was 82-83 with 100% oxygen, BP 70/50 responding to metaraminal, good urine output. Her chest Xray shows Rt upper and middle lobe consolidation, CRP 382. She was transferred to ICU after 4 mg of haloperidol to control agitation, intubated with alfentanil/propofol, RSI- Grade 1 intubation.
	21/11/2011 09:54
DrSKT	10:16 Hospital Admit Date &Time
HIS	09:54 Hospital Admit Date &Time: 21/11/2011 00:00
DrSKT	10:23 Problem 1
DrSKT	10:33 Problem 2
DrSKT	10:23 Problem 2: 21/11/2011; Confusion/agitation; Active;
BM	22/11/2011 12:10 Problem 3
DrSKT	10:33 Problem 3
DrSKT	10:23 Problem 3: 21/11/2011; Hypoxia; Active;
BM	22/11/2011 12:10 Problem 4
DrSKT	10:23 Problem 4: 21/11/2011; Sepsis due to chest infection; Active;
	25/11/2011 10:36
DrLD10	10:48 Problem 5
	29/11/2011 11:37
BM	11:47 Under Care of (ICU Cons):
BM	11:47 Also Under (Hosp Cons)
BM	11:47 Past 24hr Progress
BM	11:47 Dictated by
BM	11:47 - Objective 1
BM	11:47 - Assessment 1
BM	11:47 - Plan 1
BM	11:47 - Objective 2
BM	11:47 - Plan 2
BM	11:47 - Objective 3
BM	11:47 - Assessment 3
BM	11:47 - Objective 5
BM	11:47 - Plan 5
BM	11:47 Feeding
BM	11:47 Prophylaxis/DVT

Patient Full Name	WENDY MCLEISH	Hospital No	23123532V	Encounter ID	
GP	Dr M Wilson	Diagnosis			
Hosp Admit Da	20/11/2011 20:00	Sex	Female	Age	24 years

Senior Review/Daily Ward Round Note (GRI) (30/11/2011 11:56) Martin Hughes

Patient Information

Hospital Admit Date &Time	20/11/2011 20:00	ICU Admit Date & Time	21/11/2011 09:30

Clinical Summary

Admission Comments	24 year old girl admitted to medical HDU on 20/11/11 with 4 day h/o shortness of breath, chest pain, feeling unwell and diarrhoea. In AE she was confused, hypoxic and hypotensive. In the medical HDU she was managed with antibiotics, fluid resuscitation(approx 8 lts of fluids given in 12 hours) high flow oxygen. In last 2 hours she became increasingly hypoxic, hypotensive not responding to IV fluids, confused and agitated (she was abusive to ward staff and doctors, hit and kicked the doctors and ward staff). Her spo2 was 82-83 with 100% oxygen, BP 70/50 responding to metaraminal, good urine output. Her chest Xray shows Rt upper and middle lobe consolidation, CRP 382. She was transferred to ICU after 4 mg of haloperidol to control agitation, intubated with alfentanil/propofol, RSI- Grade 1 intubation. PMH: anxiety/depression. Essential tremors- under investigation- Did not attend the neurology clinic. Cocaine smoker. Previous drug overdose: Aug 2011- alcohol with ibuprofen sept 2011- Fluoxetine overdose.
Past 24hr Progress	Deteriorating from a poor position
Dictated by	Hughes

Problem List

Problem 1	21/11/2011; Community acquired pneumonia. Rt upper lobe pneumonia.; Active;
Objective 1	Hypoxaemic and hypercapnic on APRV, Fio2 1.0. Did not respond to recruitment. Widespread consolidation on CT chest. Does have a pleural effusion, but on US, I would not be happy to tap it. Ongoing inflammatory responce. Developing renal failure. Hypotensive.
Assessment 1	Severe unresponsive pneumonia
Plan 1	Referred to, and accepted by, Glenfield - thank you. Meantime needs - dialysis and UF as the easiest way to remove fluid. Vasoconstricors started to allow fluid removal. Changed to BiPAP to assess response (no APRV on transport ventilators). Echo
Problem 2	21/11/2011; Confusion/agitation. ; Active;
Problem 3	21/11/2011; Sepsis secondary to chest infection; Active;
Objective 3	Ongoing inflammatory response and temp - source unclear. US chest ? tap
Problem 4	22/11/2011; Poor Nutrition; Active;
Problem 5	25/11/2011; Constipation - no BO for 5/7 since admission; ;

Patient Full Name **WENDY MCLEISH** Hospital No **23123532V** Encounter ID

Problem List

Other Data

Sedation Score Actual	**Unrousable**
Sedation Score Target	**Unrousable**
Feeding	**NG, Nutrison multifibre @ 30mls/hr, Stopped absorbing overnight**
Prophylaxis/DVT	**Enoxaparin; TED stockings**
GI prophylaxis	**Feeding; Omeprazole**

HIS HIS	21/11/2011 09:54 - 21/11/2011 09:54
DrSK Shashi K Timalapur	21/11/2011 10:16 - 21/11/2011 10:51
BM Brenda Mason	22/11/2011 12:10 - 22/11/2011 12:10
DrLD Locum Doctor 10 10	25/11/2011 10:48 - 25/11/2011 10:48
DrMH Martin Hughes	30/11/2011 11:56 - 30/11/2011 12:29

Patient Full Name	WENDY MCLEISH	Hospital No	23123532V	Encounter ID	
GP	Dr M Wilson	Diagnosis			
Hosp Admit Da	21/11/2011 00:00	Sex	Female	Age	24 years

Senior Review/Daily Ward Round Note (GRI) (13/12/2011 09:17) Lorna Young

Patient Information

Hospital Admit Date &Time	21/11/2011 00:00	ICU Admit Date & Time	12/12/2011 18:31

Clinical Summary

Present on Ward Round:	L Young
Admission Comments	* Repatriation from ECMO centre, Leicester. Events: - Admitted to GRI ICU on 21/11 with CAP - intubated following day for resp failure - Transferred to them on 30/11/11 - VV ECMO (RIJ line) from 30/11 to 07/12 - CVVH until 9/12 - Furosemide infusion since then - Trachesotomy 2/12 - Methyprednisolone and azithromycin commenced on 5/12 - for 'lung remodelling' as per ECMO Glenfield protocol - to wean after 7/7 - At time of transfer, ventilated on CPAP, FiO2 0.35 - Tending to be hypertensive - on Doxazocin - Sedation issues - on propofol and midazolam and morphine and clonidine
Past 24hr Progress	Arrived yesterday required dialysis overnight for hyperkalaemia (K+ 6.8) - last dilaysed 4 days ago Passing variable urine volumes No U+E results yet today but K+ down to 4.8 on ABG sample Sedation: levels increased overnight - agitate ++ clonidine withheld due to bradycardia, on propofol at 11ml/hr and alfentanil at 1ml/hr CVS: no support, BP 149/92, HR 60bpm (SR) RESP: SPONT 12/8 FiO2 0.35, Sats 95% GI: being fed, abdo distended but soft and tympanic, bowels moving (watery stool)

Problem List

Problem 1	12/12/2011; CAP - post ECMO therapy; ;
Problem 2	; Renal dysfunction ; Active;

Other Data

Patient Full Name **WENDY MCLEISH** Hospital No **23123532V** Encounter ID

Other Data

Prophylaxis/DVT	**Enoxaparin; TED stockings**
GI prophylaxis	**Feeding; Omeprazole**
Family	**informed of repatriation**

Plan for the day

Plan for the day	**Review methyprednisolone to reduce dose today** **Reduce propofol and aim to reduce vent support** **Await U+Es and monitor UO to consider further need for dialysis today**

HIS	HIS	12/12/2011 17:56 - 12/12/2011 17:56
DrLY	Lorna Young	12/12/2011 18:33 - 13/12/2011 09:36
DrLD7	Locum Doctor 7	13/12/2011 01:00 - 13/12/2011 01:00

	12/12/2011 17:55
DrLY	18:42 Admission Comments
DrLY	18:38 Admission Comments: Repatriation from ECMO centre, Leicester. Events: - Admitted to GRI ICU on 20/11 with CAP - Transferred to them on 30/11/11 - VV ECMO (RIJ line) from 30/11 to 07/12 - CVVH until 9/12 - Furosemide infusion since then - Tracheostomy 2/12 - Methyprednisolone and azithromycin commenced on 5/12 - for 'lung remodelling' as per ECMO Glenfield protocol - to wean after 7/7 - At time of transfer, ventilated on CPAP, FiO2 0.35 - Tending to be hypertensive - on Doxazocin - Sedation issues - on propofol and midazolam and morphine and clonidine
DrLY	18:33 Admission Comments: Repatriation from ECMO centre, Leicester. Events: - Transferred to them on 30/11/11 - VV ECMO (RIJ line) from 30/11 to 07/12 - CVVH until 9/12 - Furosemide infusion since then - Tracheostomy 2/12 - Methyprednisolone and azithromycin commenced on 5/12 - for 'lung remodelling' as per ECMO Glenfield protocol - to wean after 7/7 - At time of transfer, ventilated on CPAP, FiO2 0.35 - Tending to be hypertensive - on Doxazocin - Sedation issues - on propofol and midazolam and morphine and clonidine
	12/12/2011 17:56
HIS	17:56 Hospital Admit Date &Time
	12/12/2011 18:31
DrLD7	13/12/2011 01:00 Problem 2

GRI ICU 14/12/2011 08:00 - 15/12/2011 07:00

Patient Full Name	WENDY MCLEISH	Hospital No	23123532V	Encounter ID	
GP	Dr M Wilson	Diagnosis			
Hosp Admit Da	21/11/2011 00:00	Sex	Female	Age	24 years

Senior Review/Daily Ward Round Note (GRI) (14/12/2011 12:10) Martin Hughes

Patient Information

Hospital Admit Date &Time	21/11/2011 00:00	ICU Admit Date & Time	12/12/2011 18:31

Clinical Summary

Admission Comments	* Repatriation from ECMO centre, Leicester. Events: - Admitted to GRI ICU on 21/11 with CAP - intubated following day for resp failure - Transferred to them on 30/11/11 - VV ECMO (RIJ line) from 30/11 to 07/12 - CVVH until 9/12 - Furosemide infusion since then - Trachesotomy 2/12 - Methyprednisolone and azithromycin commenced on 5/12 - for 'lung remodelling' as per ECMO Glenfield protocol - to wean after 7/7 - At time of transfer, ventilated on CPAP, FiO2 0.35 - Tending to be hypertensive - on Doxazocin - Sedation issues - on propofol and midazolam and morphine and clonidine
Past 24hr Progress	Slow progress
Dictated by	Hughes

Problem List

Problem 1	12/12/2011; CAP - post ECMO therapy; ;
Objective 1	Slow wean. Continue this process
Problem 2	; Renal dysfunction ; Active;
Objective 2	Resolving. Potassium out of proportion to the rest of U and E. No obvious cause (platelets, acidosis, addisons, drugs, administration, and has been normal during this admission) Worht checking renin aldosterone levels (hyporeninaemic hypoaldosteronism secondary to heparin)

Other Data

Glasgow Coma Scale	Spontaneously-4; No response-1; Obeys commands-6;
Neuro status comment	Still agitated at times. Obeying commands for me today. Add haloperidol and diazepam. hopefully can reduce propofol
Feeding	NG, ,

Patient Full Name **WENDY MCLEISH** Hospital No **23123532V** Encounter ID

Other Data

Prophylaxis/DVT	**Enoxaparin; TED stockings**
GI prophylaxis	**Feeding; Omeprazole**

HIS	HIS	12/12/2011 17:56 - 12/12/2011 17:56
DrLY	Lorna Young	12/12/2011 18:33 - 12/12/2011 18:48
DrLD	Locum Doctor 7 7	13/12/2011 01:00 - 13/12/2011 01:00
DrMH	Martin Hughes	14/12/2011 12:10 - 14/12/2011 12:40
DR	Donna Rougvie	14/12/2011 12:16 - 14/12/2011 12:16

	12/12/2011 17:55
DrLY	18:42 Admission Comments
DrLY	18:38 Admission Comments: Repatriation from ECMO centre, Leicester. Events: - Admitted to GRI ICU on 20/11 with CAP - Transferred to them on 30/11/11 - VV ECMO (RIJ line) from 30/11 to 07/12 - CVVH until 9/12 - Furosemide infusion since then - Tracheostomy 2/12 - Methyprednisolone and azithromycin commenced on 5/12 - for 'lung remodelling' as per ECMO Glenfield protocol - to wean after 7/7 - At time of transfer, ventilated on CPAP, FiO2 0.35 - Tending to be hypertensive - on Doxazocin - Sedation issues - on propofol and midazolam and morphine and clonidine
DrLY	18:33 Admission Comments: Repatriation from ECMO centre, Leicester. Events: - Transferred to them on 30/11/11 - VV ECMO (RIJ line) from 30/11 to 07/12 - CVVH until 9/12 - Furosemide infusion since then - Tracheostomy 2/12 - Methyprednisolone and azithromycin commenced on 5/12 - for 'lung remodelling' as per ECMO Glenfield protocol - to wean after 7/7 - At time of transfer, ventilated on CPAP, FiO2 0.35 - Tending to be hypertensive - on Doxazocin - Sedation issues - on propofol and midazolam and morphine and clonidine
	12/12/2011 17:56
HIS	17:56 Hospital Admit Date &Time
	12/12/2011 18:31
DrLY	18:33 ICU Admit Date & Time
DrLY	18:48 Problem 1
DrLD	13/12/2011 01:00 Problem 2
7	
	14/12/2011 12:10
DR	12:16 Past 24hr Progress
DR	12:16 Dictated by

Patient Full Name	WENDY MCLEISH	Hospital No	23123532V	Encounter ID	
GP	Dr M Wilson	Diagnosis			
Hosp Admit Da	21/11/2011 00:00	Sex	Female	Age	24 years

Senior Review/Daily Ward Round Note (GRI) (15/12/2011 10:32) Colin Miller

Patient Information

Hospital Admit Date &Time	21/11/2011 00:00	ICU Admit Date & Time	12/12/2011 18:31

Clinical Summary

Admission Comments	* Repatriation from ECMO centre, Leicester. Events: - Admitted to GRI ICU on 21/11 with CAP - intubated following day for resp failure - Transferred to them on 30/11/11 - VV ECMO (RIJ line) from 30/11 to 07/12 - CVVH until 9/12 - Furosemide infusion since then - Trachesotomy 2/12 - Methyprednisolone and azithromycin commenced on 5/12 - for 'lung remodelling' as per ECMO Glenfield protocol - to wean after 7/7 - At time of transfer, ventilated on CPAP, FiO2 0.35 - Tending to be hypertensive - on Doxazocin
	- Sedation issues - on propofol and midazolam and morphine and clonidine
Past 24hr Progress	remains apyrexial. K+ 5, Ur 13, CR 70, LFTs remain a little elevated but stable, Hb 11.9~, WCC 20(9.3), CRP 6~. CNS: slept OK, comfortable, not as confused today and unaware that she had previously bee confused. Moving all limbs to command. Propofol now off. CVS: Overnight hypertension resolved. 150/80, 75 SR, ?soft syst bruit at LSE. well perfused, no oedema. Clonidine withheld because of bradycardias, self terminating ABD: NG running OK, Flexiseal in situ (250ml) abd soft, BS present RS: PSV 5/5 35%O2, ~25*350ml, good cough, mucoid spit,Auscultation vesicular harsher posteriorally. gases OK, lactate 1.8 Fluids: Balance - 1.5L ex ins loss, diuresis 2.4L Drugs as charted
Dictated by	Miller

Problem List

Problem 1	12/12/2011; CAP - post ECMO therapy; ;
Problem 2	; Renal dysfunction ; Active;
- Assessment 2	High K despite polyuria. awaiting renin and aldosterone results. CK

Plan for the day

Patient Full Name **WENDY MCLEISH** Hospital No **23123532V** Encounter ID

Plan for the day

Plan for the day	**Review methyprednisolone to reduce dose today** **Reduce propofol and aim to reduce vent support** **Await U+Es and monitor UO to consider further need for dialysis today** **15.12.11 SALT and ? feed** **U+Es 18.00 may need more IHD to Rx high K.** **Tpeice for 2 hours in the first instance** **Stop Clonidine. Add CK** **CDM**

HIS	HIS	12/12/2011 17:56 - 12/12/2011 17:56
DrLY	Lorna Young	12/12/2011 18:33 - 12/12/2011 18:48
DrLD 7	Locum Doctor 7	13/12/2011 01:00 - 13/12/2011 01:00
DrCM	Colin Miller	15/12/2011 10:32 - 15/12/2011 11:25

	12/12/2011 17:55
DrLY	18:42 Admission Comments
DrLY	18:38 Admission Comments: Repatriation from ECMO centre, Leicester. Events: - Admitted to GRI ICU on 20/11 with CAP - Transferred to them on 30/11/11 - VV ECMO (RIJ line) from 30/11 to 07/12 - CVVH until 9/12 - Furosemide infusion since then - Tracheostomy 2/12 - Methyprednisolone and azithromycin commenced on 5/12 - for 'lung remodelling' as per ECMO Glenfield protocol - to wean after 7/7 - At time of transfer, ventilated on CPAP, FiO2 0.35 - Tending to be hypertensive - on Doxazocin - Sedation issues - on propofol and midazolam and morphine and clonidine
DrLY	18:33 Admission Comments: Repatriation from ECMO centre, Leicester. Events: - Transferred to them on 30/11/11 - VV ECMO (RIJ line) from 30/11 to 07/12 - CVVH until 9/12 - Furosemide infusion since then - Tracheostomy 2/12 - Methyprednisolone and azithromycin commenced on 5/12 - for 'lung remodelling' as per ECMO Glenfield protocol - to wean after 7/7 - At time of transfer, ventilated on CPAP, FiO2 0.35 - Tending to be hypertensive - on Doxazocin - Sedation issues - on propofol and midazolam and morphine and clonidine
	12/12/2011 17:56
HIS	17:56 Hospital Admit Date &Time
	12/12/2011 18:31
DrLY	18:33 ICU Admit Date & Time
DrLY	18:48 Problem 1
DrLD 7	13/12/2011 01:00 Problem 2

Patient Full Name	WENDY MCLEISH	Hospital No	23123532V	Encounter ID	
GP	Dr M Wilson	Diagnosis			
Hosp Admit Da	21/11/2011 00:00	Sex	Female	Age	24 years

Senior Review/Daily Ward Round Note (GRI) (16/12/2011 11:24) Barbara Miles

Patient Information

Under Care of (ICU Cons):	Booth
Hospital Admit Date &Time	21/11/2011 00:00

ICU Admit Date & Time	12/12/2011 18:31

Resuscitation Status

Status	For resuscitation

Clinical Summary

Present on Ward Round:	Miles
Admission Comments	* Repatriation from ECMO centre, Leicester. Events: - Admitted to GRI ICU on 21/11 with CAP - intubated following day for resp failure - Transferred to them on 30/11/11 - VV ECMO (RIJ line) from 30/11 to 07/12 - CVVH until 9/12 - Furosemide infusion since then - Trachesotomy 2/12 - Methyprednisolone and azithromycin commenced on 5/12 - for 'lung remodelling' as per ECMO Glenfield protocol - to wean after 7/7 - At time of transfer, ventilated on CPAP, FiO2 0.35 - Tending to be hypertensive - on Doxazocin - Sedation issues - on propofol and midazolam and morphine and clonidine
Past 24hr Progress	* Wendy has had some problems with agitation. We had to abort her time on the t-piece yesterday because of this. She is currently on Propofol, Alfentanil, Diazepam and Haloperidol regularly and prn. She is apyrexial with a WCC of 13 and a low CRP. She is currently undergoing her sedation hold. She is on Doxazosin for hypotension and currently on sedation hold her BP is 161/105. She is on minimal respiratory support of 5/5 and 28% oxygen with tidal volumes of 370 and a RR of 26 and saturations of 98%. She is passing good volumes of urine and is diuresing naturally. Her Urea has fallen but her Potassium remains relatively high @ 5.2.
Dictated by	Miles

Problem List

Problem 1	12/12/2011; CAP - post ECMO therapy; ;
- Objective 1	Chest is harsh generally to auscultation with bronchial breathing especially around the right edge of the sternum. She has minimal aspirates to suction. She is on 5/5, as stated previously, and 28% oxygen. She spend some period of time on a t-piece yesterday. She is on a reducing dose of Methylprednisolone. She was also on Azithromycin on transfer back from Leicester. This has subsequently been discontinued and the plan would be for Methylprednisolone to discontinue later today. She does probably still have some degree of peripheral oedema. Her Albumin is 29, which is relatively static.
- Assessment 1	Wendy is being held back from further weaning because of sedation issues.
- Plan 1	Try for 4 periods of 2hrs each on the t-piece today.
Problem 2	* 13/12/2011; Renal dysfunction ; Active;
- Objective 2	Wendy has not been dialysed since Wednesday. At this point she was dialysed for hyperkalaemia rather than for fluid balance. She has been passing good volumes of urine and is, in fact, polyuric. Her Potassium this morning is 5.2, Urea 11.9 and Creatinine 64. Her Potassium has been around 5 since she came off dialysis on Wednesday. She passed 4 litres of urine in the last 24hrs and was, on paper, -ve 2.5 litres. She continues with generally high urine volumes @ ~100-200mls/hr. Cardiovascularly she is tolerating this quite well with a HR of 70 and BP of 160/102. She does appear to have Polyuria post acute renal failure. It is possible we may need to replace some of this fluid but currently her Sodium is normal. She has not had a blood gas done since the 14th. At this point, her HCO3 was normal.

Problem List

- Plan 2	**Recheck U's & E's this afternoon.** **Remove dialysis line.**
Problem 3	**16/12/2011; Agitation; Active;**
- Subjective 3	**It is difficult to converse with Wendy currently as she is oversedated.**
- Objective 3	*** She has been running on 2mls/hr of Alfentanil and 8mls/hr of Propofol. This had to be increased because she was pulling at her tracheostomy and lines. She has been on Haloperidol and Diazepam , as well as Propofol and Alfentanil, for some time. Clonidine had previously been prescribed but had been withheld and then discontinued because of episodes of bradycardia. The discontinuation of the Clonidine cannot explain her problems with agitation yesterday as it has actually been withheld for some time. Wendy does have a background of drug abuse. She does not appear to be an intravenous user and does not appear to have been entered into any kind of rehabilitation programme and was not on Methadone. It is not entirely clear that she is, in fact, delirious rather than just obstreperous in complying with her treatment. However, we will not make much progress weaning her from the ventilator if we cannot keep her connected to her tracheostomy and to her i.v. lines.**
- Plan 3	**Increase Diazepam to 30mg daily (previously she was on 20mg daily).** **Increase Haloperidol to 5mg qid (she has been receiving large numbers of prn doses over the last 24hrs).** **Start some regular oral Morphine and attempt to wean off her i.v. Alfentanil.** **The risk is that she will become oversedated but currently we are struggling to detach her from her Propofol infusion which is delaying our attempts to wean.**
Problem 4	**16/12/2011; Deranged LFTs; ;**

HIS HIS	12/12/2011 17:56 - 12/12/2011 17:56
DrLY Loma Young	12/12/2011 18:33 - 12/12/2011 18:48
DrLD Locum Doctor 7 7	13/12/2011 01:00 - 13/12/2011 01:00
DrBM Barbara Miles	16/12/2011 11:24 - 16/12/2011 14:45
BM Brenda Mason	16/12/2011 11:39 - 16/12/2011 11:39

12/12/2011 17:55

DrLY	18:42 Admission Comments
DrLY	18:38 Admission Comments: Repatriation from ECMO centre, Leicester. Events: - Admitted to GRI ICU on 20/11 with CAP - Transferred to them on 30/11/11 - VV ECMO (RIJ line) from 30/11 to 07/12 - CVVH until 9/12 - Furosemide infusion since then - Tracheostomy 2/12 - Methyprednisolone and azithromycin commenced on 5/12 - for 'lung remodelling' as per ECMO Glenfield protocol - to wean after 7/7 - At time of transfer, ventilated on CPAP, FiO2 0.35 - Tending to be hypertensive - on Doxazocin - Sedation issues - on propofol and midazolam and morphine and clonidine

DrLY	18:33 Admission Comments: Repatriation from ECMO centre, Leicester. Events: - Transferred to them on 30/11/11 - VV ECMO (RIJ line) from 30/11 to 07/12 - CVVH until 9/12 - Furosemide infusion since then - Tracheostomy 2/12 - Methyprednisolone and azithromycin commenced on 5/12 - for 'lung remodelling' as per ECMO Glenfield protocol - to wean after 7/7 - At time of transfer, ventilated on CPAP, FiO2 0.35 - Tending to be hypertensive - on Doxazocin - Sedation issues - on propofol and midazolam and morphine and clonidine

12/12/2011 17:56

HIS	17:56 Hospital Admit Date &Time

12/12/2011 18:31

DrLY	18:33 ICU Admit Date & Time
DrLY	18:48 Problem 1
BM	16/12/2011 11:39 Problem 2
DrLD 7	13/12/2011 01:00 Problem 2: ; Renal dysfunction ; Active;

16/12/2011 11:24

BM	11:39 Under Care of (ICU Cons):
BM	11:39 Status
BM	11:39 Present on Ward Round:
DrBM	14:45 Past 24hr Progress
BM	11:39 Past 24hr Progress: Wendy has had some problems with agitation. We had to abort her time on the t-piece yesterday because of this. She is currently on Propofol, Diazepam and Haloperidol regularly and prn. She is apyrexial with a WCC of 13 and a low CRP. She is currently undergoing her sedation hold. She is on Doxazosin for hypotension and currently on sedation hold her BP is 161/105. She is on minimal respiratory support of 5/5 and 28% oxygen with tidal volumes of 370 and a RR of 26 and saturations of 98%. She is passing good volumes of urine and is diuresing naturally. Her Urea has fallen but her Potassium remains relatively high @ 5.2.
BM	11:39 Dictated by
BM	11:39 - Objective 1
BM	11:39 - Assessment 1
BM	11:39 - Plan 1
BM	11:39 - Objective 2
BM	11:39 - Plan 2

16/12/2011 11:24

BM	11:39 Problem 3
BM	11:39 - Subjective 3
DrBM	14:45 - Objective 3
BM	11:39 - Objective 3: She has been running on 2mls/hr of Alfentanil and 8mls/hr of Propofol. This had to be increased because she was pulling at her tracheostomy and lines. She has been on Haloperidol and Diazepam as well as Propofol and Alfentanil, for some time. Clonidine had previously been prescribed but had been withheld and then discontinued because of episodes of bradycardia. The discontinuation of the Clonidine cannot explain her problems with agitation yesterday as it has actually been withheld for some time. Wendy does have a background of drug abuse. She does not appear to be an intravenous user and does not appear to have been entered into any kind of rehabilitation programme and was not on Methadone. It is not entirely clear that she is, in fact, delirious rather than just obstreperous in complying with her treatment. However, we will not make much progress weaning her from the ventilator if we cannot keep her connected to her tracheostomy and to her i.v. lines.
BM	11:39 - Plan 3

Patient Full Name	WENDY MCLEISH	Hospital No	23123532V	Encounter ID	
GP	Dr M Wilson	Diagnosis			
Hosp Admit Da	21/11/2011 00:00	Sex	Female	Age	24 years

Senior Review/Daily Ward Round Note (GRI) (17/12/2011 09:57) Barbara Miles

Patient Information

Hospital Admit Date &Time	21/11/2011 00:00	ICU Admit Date & Time	12/12/2011 18:31

Resuscitation Status

Status	For resuscitation

Clinical Summary

Present on Ward Round:	Miles
Admission Comments	* Repatriation from ECMO centre, Leicester. Events: - Admitted to GRI ICU on 21/11 with CAP - intubated following day for resp failure - Transferred to them on 30/11/11 - VV ECMO (RIJ line) from 30/11 to 07/12 - CVVH until 9/12 - Furosemide infusion since then - Trachesotomy 2/12 - Methyprednisolone and azithromycin commenced on 5/12 - for 'lung remodelling' as per ECMO Glenfield protocol - to wean after 7/7 - At time of transfer, ventilated on CPAP, FiO2 0.35 - Tending to be hypertensive - on Doxazocin - Sedation issues - on propofol and midazolam and morphine and clonidine
Past 24hr Progress	Spent much of last 24h on T piece as seemed to be more settled RR generally around 30, 28% O2 HR has climbed over the early evening overnight into a ST Alfentanil Iml/hr stopped this mornign as loaded with increased doses of morphien and diazepam yesterday Coughing fit during physio - little to aspirate from chest - vomited - HR increased to 150 at times and RR increased to 50+. Not settling when coughing ceasing Restarted on alfentanil (with bolus) and put back on Ventilator (TVs 250ml)
Dictated by	Miles

Problem List

Problem 1	12/12/2011; CAP - post ECMO therapy; ;
Objective 1	Chest harsh but not much added sounds Little to aspirate from chest
Problem 2	* 13/12/2011; Renal dysfunction ; Active;
Objective 2	K has now normalised Negative balance overall BP tolerating Urea 10
Problem 3	16/12/2011; Agitation; Active;
Objective 3	See above
Problem 4	16/12/2011; Deranged LFTs; ;
Objective 4	Static

Patient Full Name **WENDY MCLEISH** Hospital No **23123532V** Encounter ID

Problem List

Other Data

Neuro status comment	**Obeying commands - cough an issue**
Sedation Score Actual	**Agitated and Restless**
Prophylaxis/DVT	**Enoxaparin; TED stockings**
GI prophylaxis	**Feeding; Omeprazole**

Plan for the day

Plan for the day	* **Stop haloperidol, restart clonidine** **Increase morphine dose and diazepam and see if we can wean off alfentanil in future** **Stop doxazocin - may need another agent but BP mostly agitation related currently** **Check CRP** **CXR** **Restart feed again later- antiemetic** **Reculture**

HIS	HIS	12/12/2011 17:56 - 12/12/2011 17:56
DrLY	Lorna Young	12/12/2011 18:33 - 12/12/2011 18:48
DrLD 7	Locum Doctor 7	13/12/2011 01:00 - 13/12/2011 01:00
BM	Brenda Mason	16/12/2011 11:39 - 16/12/2011 11:39
DrBM	Barbara Miles	16/12/2011 14:45 - 17/12/2011 13:56

12/12/2011 17:55

DrLY 18:42 Admission Comments

DrLY 18:38 Admission Comments: Repatriation from ECMO centre, Leicester.
Events:
- Admitted to GRI ICU on 20/11 with CAP
- Transferred to them on 30/11/11
- VV ECMO (RIJ line) from 30/11 to 07/12
- CVVH until 9/12 - Furosemide infusion since then
- Tracheostomy 2/12
- Methyprednisolone and azithromycin commenced on 5/12 - for 'lung remodelling' as per ECMO Glenfield protocol - to wean after 7/7
- At time of transfer, ventilated on CPAP, FiO2 0.35
- Tending to be hypertensive - on Doxazocin
- Sedation issues - on propofol and midazolam and morphine and clonidine

DrLY 18:33 Admission Comments: Repatriation from ECMO centre, Leicester.
Events:
- Transferred to them on 30/11/11
- VV ECMO (RIJ line) from 30/11 to 07/12
- CVVH until 9/12 - Furosemide infusion since then
- Tracheostomy 2/12
- Methyprednisolone and azithromycin commenced on 5/12 - for 'lung remodelling' as per ECMO Glenfield protocol - to wean after 7/7
- At time of transfer, ventilated on CPAP, FiO2 0.35
- Tending to be hypertensive - on Doxazocin
- Sedation issues - on propofol and midazolam and morphine and clonidine

12/12/2011 17:56

HIS 17:56 Hospital Admit Date &Time

12/12/2011 18:31

DrLY 18:33 ICU Admit Date & Time

DrLY 18:48 Problem 1

BM 16/12/2011 11:39 Problem 2

DrLD 7 13/12/2011 01:00 Problem 2: ; Renal dysfunction ; Active;

16/12/2011 11:24

BM 11:39 Problem 3

17/12/2011 09:57

DrBM 13:56 Plan for the day

DrBM 10:09 Plan for the day: Stop haloperidol
Increase morphine dose and see if we can wean off alfentanil in future
Stop doxazocin - may need another agent but BP mostly agitation related currently
Check CRP
CXR
Restart feed again later- antiemetic
Reculture

DrBM 10:05 Plan for the day: Stop haloperidol
Increase morphine dose and see if we can wean off alfentanil in future
Stop doxazocin - may need another agent but BP mostly agitation related currently
Check CRP
CXR

Senior Review/Daily Ward Round Note (GRI ICU

North Glasgow Division ICU

18/12/2011 08:00 - 19/12/2011 07:00

Patient Full Name	WENDY MCLEISH	Hospital No	23123532V	Encounter ID	
GP	Dr M Wilson	Diagnosis			
Hosp Admit Da	21/11/2011 00:00	Sex	Female	Age	24 years

Senior Review/Daily Ward Round Note (GRI) (18/12/2011 10:22) Barbara Miles

Patient Information

Hospital Admit Date &Time	21/11/2011 00:00	ICU Admit Date & Time	12/12/2011 18:31

Resuscitation Status

Status	For resuscitation

Clinical Summary

Present on Ward Round:	Miles
Admission Comments	* Repatriation from ECMO centre, Leicester. Events: - Admitted to GRI ICU on 21/11 with CAP - intubated following day for resp failure - Transferred to them on 30/11/11 - VV ECMO (RIJ line) from 30/11 to 07/12 - CVVH until 9/12 - Furosemide infusion since then
	- Trachesotomy 2/12 - Methyprednisolone and azithromycin commenced on 5/12 - for 'lung remodelling' as per ECMO Glenfield protocol - to wean after 7/7 - At time of transfer, ventilated on CPAP, FiO2 0.35 - Tending to be hypertensive - on Doxazocin - Sedation issues - on propofol and midazolam and morphine and clonidine
Past 24hr Progress	Over the last 48 hours we have stopped the continuous propofol infusion and generally Wendy is more co-operative. Attempts to stop the alfentanil yesterday after loading morphine on Friday not successful due tocoughing - she vomited, got very tachypnoeic and had to go back on the ventilator. Currently she is on 30mg /day morphine and 40mg per day diazepam and 50mcg clonidine tds. Haloperidol has been stopped. She is slightly sedated but awake and interactive and noddign to questions appropriately. I have stopped the alfenanil infusion again to see if we can manage without it - coughing has been less of an issue overnight. CXR yesterday was a little better - CRP has gone up and WCC down today. Temperature was up to 37.7 yesterday but has now settled; blood cultures taken and CVP was removed yesterday. On no ABs. HR has also settled today - she no longer has a ST and is back closer to HR on 16/12 at around 88 BP is acceptable at 135/91. Soft SM as on Friday RR is 30 and TVs are 340 on 5/5 28%, SaO2 are 100%, ABG are good with PaO2 16 and no acidosis. Bronchial breathing at R sternal edge
	Feed is at 65ml/hr, bowels are moving Diuresis has slowed but she remains in a negative balance - Na is slightly low and K has normalised and urea is till falling towards normal, Cr is normal LFTs remain elevated and rising slowly over last 24h - still mildly jaundiced with a transaminitis Amylase is elevated at 150. Abdomen is completely soft and non tender. Bs present

Problem List

Problem 1	12/12/2011; CAP - post ECMO therapy; ;
Problem 2	* 13/12/2011; Renal dysfunction ; Active;
Problem 3	16/12/2011; Agitation; Active;
Problem 4	16/12/2011; Deranged LFTs; ;

Patient Full Name **WENDY MCLEISH** Hospital No **23123532V** Encounter ID

Problem List

Other Data

Neuro status comment	**Obeying commands**
Sedation Score Actual	**Awake but Calm**
Sedation Score Target	**Awake but Calm**
Feeding	**NG, ,**
Prophylaxis/DVT	**Enoxaparin; TED stockings**
GI prophylaxis	**Feeding; Omeprazole**

Plan for the day

Plan for the day	**Stop omeprazole as full fed and off steroids now, RF normalising** **Stop alfentanil - otherwise continue with current regime for now** **Investigate LFTs as no immediate cause and not settling** **T piece trial again and sit out this afternoon if possible** **Liaise with addicition services Monday**

HIS	HIS	12/12/2011 17:56 - 12/12/2011 17:56
DrLY	Lorna Young	12/12/2011 18:33 - 12/12/2011 18:48
DrLD	Locum Doctor 7 7	13/12/2011 01:00 - 13/12/2011 01:00
BM	Brenda Mason	16/12/2011 11:39 - 16/12/2011 11:39
DrBM	Barbara Miles	16/12/2011 14:45 - 18/12/2011 10:48

12/12/2011 17:55

DrLY	18:42 Admission Comments
DrLY	18:38 Admission Comments: Repatriation from ECMO centre, Leicester. Events: - Admitted to GRI ICU on 20/11 with CAP - Transferred to them on 30/11/11 - VV ECMO (RIJ line) from 30/11 to 07/12 - CVVH until 9/12 - Furosemide infusion since then - Tracheostomy 2/12 - Methyprednisolone and azithromycin commenced on 5/12 - for 'lung remodelling' as per ECMO Glenfield protocol - to wean after 7/7 - At time of transfer, ventilated on CPAP, FiO2 0.35 - Tending to be hypertensive - on Doxazocin - Sedation issues - on propofol and midazolam and morphine and clonidine
DrLY	18:33 Admission Comments: Repatriation from ECMO centre, Leicester. Events: - Transferred to them on 30/11/11 - VV ECMO (RIJ line) from 30/11 to 07/12 - CVVH until 9/12 - Furosemide infusion since then - Tracheostomy 2/12 - Methyprednisolone and azithromycin commenced on 5/12 - for 'lung remodelling' as per ECMO Glenfield protocol - to wean after 7/7 - At time of transfer, ventilated on CPAP, FiO2 0.35 - Tending to be hypertensive - on Doxazocin - Sedation issues - on propofol and midazolam and morphine and clonidine

12/12/2011 17:56

HIS	17:56 Hospital Admit Date &Time

12/12/2011 18:31

DrLY	18:33 ICU Admit Date & Time
DrLY	18:48 Problem 1
BM	16/12/2011 11:39 Problem 2
DrLD 7	13/12/2011 01:00 Problem 2: ; Renal dysfunction ; Active;

16/12/2011 11:24

BM	11:39 Problem 3

Senior Review/Daily Ward Round Note (GRI)

GRI ICU

19/12/2011 08:00 - 20/12/2011 07:00

Patient Full Name	WENDY MCLEISH	Hospital No	23123532V	Encounter ID	
GP	Dr M Wilson	Diagnosis			
Hosp Admit Da	21/11/2011 00:00	Sex	Female	Age	24 years

Senior Review/Daily Ward Round Note (GRI) (19/12/2011 12:03) Rachel Kearns

Patient Information

Under Care of (ICU Cons):	Booth
Hospital Admit Date &Time	21/11/2011 00:00

ICU Admit Date & Time	12/12/2011 18:31

Clinical Summary

Present on Ward Round:	Booth; Quasim; Kearns
Admission Comments	* Repatriation from ECMO centre, Leicester. Events: - Admitted to GRI ICU on 21/11 with CAP - intubated following day for resp failure - Transferred to them on 30/11/11 - VV ECMO (RIJ line) from 30/11 to 07/12 - CVVH until 9/12 - Furosemide infusion since then - Trachesotomy 2/12 - Methyprednisolone and azithromycin commenced on 5/12 - for 'lung remodelling' as per ECMO Glenfield protocol - to wean after 7/7 - At time of transfer, ventilated on CPAP, FiO2 0.35 - Tending to be hypertensive - on Doxazocin - Sedation issues - on propofol and midazolam and morphine and clonidine
Past 24hr Progress	* Less agitated on current regime of morphine 30mg, diazepam 40mg per day and clonidine 50 mics tds. Today she is reading magazines and listening to music. On T piece for 5 hrs so far today and managed 14 hrs each of the last 2 days. She is less tachycardic and apyrexial past 36 hrs. She is less polyuric and U+Es have normalised.
Dictated by	Kearns

Problem List

Problem 1	12/12/2011; CAP - post ECMO therapy; ;
- Objective 1	* on minmal oxygen. resp rate remains high whether on the ventilator or not. Ant chest exam only - reduced AE at bases. Cough strong and secretions minimal
- Plan 1	* Try 24 hrs on t piece today getting close to decannulation - liaise with resp re transfer
Problem 2	* 13/12/2011; Renal dysfunction ; Resolved;
Problem 3	16/12/2011; Agitation; Active;
- Objective 3	This is better on current regime. Today she is sitting up in a chair reading magazines!
- Plan 3	* continue to mobilise refer to addiction services wean morphine
Problem 4	16/12/2011; Deranged LFTs; ;
- Objective 4	these are increased again today,particulaarly GGT and AST.
- Plan 4	liver US

Patient Full Name: WENDY MCLEISH Hospital No: 23123532V Encounter ID:

Problem List

Other Data

Glasgow Coma Scale	Spontaneously-4; Orientated-5; Obeys commands-6; 15
Neuro status comment	alert and appropriate
Sedation Score Actual	Awake but Calm
Sedation Score Target	Awake but Calm
Feeding	NG, ,
Prophylaxis/DVT	Enoxaparin; TED stockings
GI prophylaxis	Feeding

Plan for the day

Plan for the day	up to sit TV / magazines liaise with addiction team and respiratory as may be able to be discharged soon liver US replace Mg

Fluid Balance

Fluid Balance	even to 1L -ve

HIS	HIS	12/12/2011 17:56 - 12/12/2011 17:56
DrLY	Lorna Young	12/12/2011 18:33 - 12/12/2011 18:48
DrLD 7	Locum Doctor 7	13/12/2011 01:00 - 13/12/2011 01:00
BM	Brenda Mason	16/12/2011 11:39 - 16/12/2011 11:39
DrBM	Barbara Miles	16/12/2011 14:45 - 16/12/2011 14:45
DrRK	Rachel Kearns	19/12/2011 12:03 - 19/12/2011 14:00

12/12/2011 17:55

DrLY 18:42 Admission Comments

DrLY 18:38 Admission Comments: Repatriation from ECMO centre, Leicester.
Events:
- Admitted to GRI ICU on 20/11 with CAP
- Transferred to them on 30/11/11
- VV ECMO (RIJ line) from 30/11 to 07/12
- CVVH until 9/12 - Furosemide infusion since then
- Tracheostomy 2/12
- Methyprednisolone and azithromycin commenced on 5/12 - for 'lung remodelling' as per ECMO Glenfield protocol - to wean after 7/7
- At time of transfer, ventilated on CPAP, FiO2 0.35
- Tending to be hypertensive - on Doxazocin
- Sedation issues - on propofol and midazolam and morphine and clonidine

DrLY 18:33 Admission Comments: Repatriation from ECMO centre, Leicester.
Events:
- Transferred to them on 30/11/11
- VV ECMO (RIJ line) from 30/11 to 07/12
- CVVH until 9/12 - Furosemide infusion since then
- Tracheostomy 2/12
- Methyprednisolone and azithromycin commenced on 5/12 - for 'lung remodelling' as per ECMO Glenfield protocol - to wean after 7/7
- At time of transfer, ventilated on CPAP, FiO2 0.35
- Tending to be hypertensive - on Doxazocin
- Sedation issues - on propofol and midazolam and morphine and clonidine

12/12/2011 17:56

HIS 17:56 Hospital Admit Date &Time

12/12/2011 18:31

DrLY 18:33 ICU Admit Date & Time

DrLY 18:48 Problem 1

DrRK 19/12/2011 12:26 Problem 2

BM 16/12/2011 11:39 Problem 2: 13/12/2011; Renal dysfunction ; Active;

DrLD 7 13/12/2011 01:00 Problem 2: ; Renal dysfunction ; Active;

DrBM 16/12/2011 14:45 Problem 4

16/12/2011 11:24

BM 11:39 Problem 3

19/12/2011 12:03

DrRK 12:26 Past 24hr Progress

DrRK 12:08 Past 24hr Progress: Less agitated on current regime of morphine 30mg, diazepam 40mg per day and clonidine 50 mics tds. On T piece for 5 hrs so far today and managed 14 hrs each of the last 2 days. She is less tachycardic and apyrexial past 36 hrs. She is less polyuric and U+Es have normalised.

DrRK 12:30 - Objective 1

DrRK 12:26 - Objective 1: on minmal oxygen. resp rate remains high whether on the ventilator or not. Ant chest exam only - reduced AE at bases.

DrRK 12:30 - Plan 1

DrRK 12:25 - Plan 1: Try 24 hrs on t piece today

DrRK 14:00 - Plan 3

DrRK 12:26 - Plan 3: continue to mobilise refer to addiction services

Medical Progress Notes (GRI)

North Glasgow Division ICU

GRI ICU

19/12/2011 08:00 - 20/12/2011 07:00

Patient Full Name	WENDY MCLEISH	Hospital No	23123532V	Encounter ID	
GP	Dr M Wilson	Diagnosis			
Hosp Admit Da	21/11/2011 00:00	Sex	Female	Age	24 years

Medical Progress Notes (GRI) (19/12/2011 14:34) Rachel Kearns

Notes

*** 1600 - resp reg has reviewed. happy to accept care once discharged form ICU. Also contacted Addiction team - will review tomorrow. rk**

DrRK Rachel Kearns 19/12/2011 14:34 - 19/12/2011 16:16

19/12/2011 14:34

DrRK	16:16 Note
DrRK	14:36 Note: 14:30 - resp reg contacted. Will review later. Also contacted Addiction team - will review tomorrow. rk

Blood Component Prescription and Record of Transfusion

Please use one form per transfusion episode

NHS Greater Glasgow and Clyde

F
C 23123532V
H MCLEISH WENDY F 25/05/1987
D 0/1 51 COXTON PLACE
M GLASGOW G33 5EJ
CHI-2505876061

Affix Patient Label

Consultant: DANIEL

Date (DD/MM/YYYY): 29/11/11

Hospital: GRI

Ward: ITU

Part 1. To be completed by medical staff or authorised non medical prescriber (please tick)

Reason for transfusion: Hb: 6.2

Special requirements: CMV neg ☐ Irradiated ☐ Blood warmer required ☐ None ☐

Special instructions:

Previous reaction: Yes ☐ No ☑ Unknown ☐

Consent discussion recorded: Yes ☐ No ☐ Not possible prior to transfusion ☐ Incapacitated ☐

Blood Transfusion leaflet given: Yes ☐ No ☑ Previously given ☐ Not available ☐

Unit	Date	Component	Duration	Vol/mLs	Practitioner's signature	Print name and GMC / NMC number	Prescription cancelled (Initial)
1	29/11/11	PRC	1°	300	Kenneth N	FRASER 6024772	
2							
3							
4							
5							
6							
7							
8							

Part 2. Pre-transfusion checklist - To be completed by person administering each product

Unit	Date	Patient IV access	Baseline obs	Inspect bag	Verbal ID *	Wristband ID	Check expiry date	Sign and print name(s)	Time Unit Taken/Down
1	29/11/11	☑	☑	☑	☐	☑	☑	P Gilbride P GILBRIDE	1100
2		☐	☐	☐	☐	☐	☐		
3		☐	☐	☐	☐	☐	☐		
4		☐	☐	☐	☐	☐	☐		
5		☐	☐	☐	☐	☐	☐		
6		☐	☐	☐	☐	☐	☐		
7		☐	☐	☐	☐	☐	☐		
8		☐	☐	☐	☐	☐	☐		

* Where appropriate

IF THERE ARE ANY DISCREPANCIES, DO NOT PROCEED – CONTACT YOUR HOSPITAL TRANSFUSION LABORATORY (HTL).

82486

Part 3. Apply pink section of Compatibility Label below

ination No: G101 611 275 513 R ire mponent: Red Cells In Additive Date Given: 29/11/11 gnature 1: [signature] Time Given: 1015 gnature 2: [signature] spital: GRI Ward ICU	2. Complete and apply pink section of Compatibility Label when transfusion commenced. If unit not transfused, record reason here and sign:
3. Complete and apply pink section of Compatibility Label when transfusion commenced. If unit not transfused, record reason here and sign:	4. Complete and apply pink section of Compatibility Label when transfusion commenced. If unit not transfused, record reason here and sign:
5. Complete and apply pink section of Compatibility Label when transfusion commenced. If unit not transfused, record reason here and sign:	6. Complete and apply pink section of Compatibility Label when transfusion commenced. If unit not transfused, record reason here and sign:
7. Complete and apply pink section of Compatibility Label when transfusion commenced. If unit not transfused, record reason here and sign:	8. Complete and apply pink section of Compatibility Label when transfusion commenced. If unit not transfused, record reason here and sign:

Part 4. Care during Transfusion

Frequency of vital signs (All observations to be recorded on patient's current MEWS / SEWS chart):

Temperature, pulse, blood pressure and respiration rate should be measured and recorded:

- before the start of each unit of blood or blood product.

The patient should be in an observed area during the transfusion as life-threatening reactions may occur. Where appropriate, patients / guardians should be informed of possible symptoms of a transfusion reaction, they should alert staff immediately if they feel unwell. Stop the transfusion and seek medical advice if you suspect a transfusion reaction. Symptoms can include pyrexia, urticaria, hypotension, and respiratory distress.

- at 15 minutes after commencement and hourly thereafter until the completion of each unit.
- further observations during the transfusion are at the discretion of each clinical area and dependent on the patient's condition.
- on the completion of each unit. This is a minimum requirement. Some clinical areas may require more frequent observations particularly in unstable or unconscious patients.

1. Record signature, date and time on the pink section of the compatibility label above.
2. Once transfusion has commenced, fully complete blue section of the compatibility label and return this to the HTL. Under the Blood Safety and Quality Regulations (2005) **THIS IS A LEGAL REQUIREMENT.**

Only staff who have completed transfusion training, available at *www.learnbloodtransfusion.org.uk* can participate in the clinical transfusion process.

TRAIN or REVALIDATE online at *www.learnbloodtransfusion.org.uk*

Additional Comments

Further advice on blood transfusion, including reactions is available on Staffnet at:

www.staffnet.ggc.scot.nhs.uk/Acute/Diagnostics/BloodTransfusion/Pages/BloodTransfusion.aspx

Designed by Medical Illustration Services • MIS 209909

Blood Component Prescription and Record of Transfusion

Please use one form per transfusion episode

NHS Greater Glasgow and Clyde

Patient n
CHI num 23123532V
MCLEISH F
Hospital WENDY 25/05/1987
D.O.B. 0/1 51 COXTON PLACE
GLASGOW G33 5EJ
M / F: CHI-2505876061

Affix Patient Label

Consultant: QUASM

Date (DD/MM/YYYY): 26/11/11

Hospital: GRI

Ward: ICU W

Part 1. To be completed by medical staff or authorised non medical prescriber (please tick)

Reason for transfusion: ↓↓Hb Hb: 66

Special requirements: CMV neg ☐ Irradiated ☐ Blood warmer required ☐ None ☑

Special instructions:

Previous reaction: Yes ☐ No ☐ Unknown ☑

Consent discussion recorded: Yes ☐ No ☐ Not possible prior to transfusion ☑ Incapacitated ☐

Blood Transfusion leaflet given: Yes ☐ No ☐ Previously given ☐ Not available ☐

Unit	Date	Component	Duration	Vol/mLs	Practitioner's signature	Print name and GMC / NMC number	Prescription cancelled (Initial)
1	26/11	RCC	30mins	1 UNIT		6148220 LYOUNG	
2	26/11	RCC	30mins	1 UNIT		6148220 LYOUNG	
3							
4							
5							
6							
7							
8							

Part 2. Pre-transfusion checklist - To be completed by person administering each product

Unit	Date	Patient IV access	Baseline obs	Inspect bag	Verbal ID.*	Wristband ID	Check expiry date	Sign and print name(s)	Time Unit Taken Down
1	26/11	☑	☑	☑	☐	☑	☑	JBUCHANAN JBU	
2	26/11	☑	☑	☑	☐	☑	☑	JBUCHANAN	2025
3		☐	☐	☐	☐	☐	☐		
4		☐	☐	☐	☐	☐	☐		
5		☐	☐	☐	☐	☐	☐		
6		☐	☐	☐	☐	☐	☐		
7		☐	☐	☐	☐	☐	☐		
8		☐	☐	☐	☐	☐	☐		

* Where appropriate

IF THERE ARE ANY DISCREPANCIES, DO NOT PROCEED – CONTACT YOUR HOSPITAL TRANSFUSION LABORATORY (HTL).

82486

Part 3. Apply pink section of Compatibility Label below

ation No: G101 611 080 723 Z ponent: Red Cells In Additive nature 1: [signature] Date Given: nature 2: LCantrell Time Given: 16:2 pital : CRH Ward ICU GICU	Donation No: G101 611 079 684 G Component: Red Cells In Additive Signature 1: [signature] Date Given: 26/11 Signature 2: Time Given: 18:45 Hospital : GLI Ward ICU
3. Complete and apply pink section of Compatibility Label when transfusion commenced. If unit not transfused, record reason here and sign:	4. Complete and apply pink section of Compatibility Label when transfusion commenced. If unit not transfused, record reason here and sign:
5. Complete and apply pink section of Compatibility Label when transfusion commenced. If unit not transfused, record reason here and sign:	6. Complete and apply pink section of Compatibility Label when transfusion commenced. If unit not transfused, record reason here and sign:
7. Complete and apply pink section of Compatibility Label when transfusion commenced. If unit not transfused, record reason here and sign:	8. Complete and apply pink section of Compatibility Label when transfusion commenced. If unit not transfused, record reason here and sign:

Part 4. Care during Transfusion

Frequency of vital signs (All observations to be recorded on patient's current MEWS / SEWS chart):

Temperature, pulse, blood pressure and respiration rate should be measured and recorded:

- before the start of each unit of blood or blood product.

The patient should be in an observed area during the transfusion as life-threatening reactions may occur. Where appropriate, patients / guardians should be informed of possible symptoms of a transfusion reaction, they should alert staff immediately if they feel unwell. Stop the transfusion and seek medical advice if you suspect a transfusion reaction. Symptoms can include pyrexia, urticaria, hypotension, and respiratory distress.

- at 15 minutes after commencement and hourly thereafter until the completion of each unit.
- further observations during the transfusion are at the discretion of each clinical area and dependent on the patient's condition.
- on the completion of each unit. This is a minimum requirement. Some clinical areas may require more frequent observations particularly in unstable or unconscious patients.

1. Record signature, date and time on the pink section of the compatibility label above.
2. Once transfusion has commenced, fully complete blue section of the compatibility label and return this to the HTL. Under the Blood Safety and Quality Regulations (2005) THIS IS A LEGAL REQUIREMENT.

Only staff who have completed transfusion training, available at *www.learnbloodtransfusion.org.uk* can participate in the clinical transfusion process.

TRAIN or REVALIDATE online at *www.learnbloodtransfusion.org.uk*

Additional Comments

Further advice on blood transfusion, including reactions is available on Staffnet at:
www.staffnet.ggc.scot.nhs.uk/Acute/Diagnostics/BloodTransfusion/Pages/BloodTransfusion.aspx

Designed by Medical Illustration Services • MIS 209909

Glasgow Royal Haematology ** LIVE **
Patient enquiry ---- Express results

Reg	Name	D.o.B.	Sex	Loc.
23123532V	MCLEISH WENDY	25.05.87	F	ICU GRI

Specimen R,11.5531102.J Type Citrate/EDTA
Collected 13.12.11 06:22 A.Diag

.....FBC.....		BASO	0.01
WBC	11.5	.....C/Screen.....	
Hb	124	PT	13
Hct	0.378	PT C Ratio	1.2
MCV	92.4	APTT	127
MCH	30.3	APTT Ratio	3.8
Plts	356	.....F1.....	
NEUT	8.8	F.I Clauss	2.3
LYMPH	1.3		
MONO	1.4		
EOS	0.00		

C/Screen THROMBIN TIME - PROTAMINE = 13 SECS.
? HEPARIN TX / CONTAMINATION OF SAMPLE.

Quit \ Earlier req \ Later req \ ED \ LD
Back \ PHoned comment <B> ..

North Glasgow Biochemistry & Immunology ** LIVE **
Patient enquiry ---- Express results

Reg	Name	D.o.B.	Sex	Loc.
23123532V	MCLEISH WENDY	25.05.87	F	ROYAL ITU

Specimen N,11.0762340.A Type Specimen
Collected 12.12.11 20:30 A.Diag

.....U&E.....

Sodium	136
Potassium	+ 6.8
Chloride	101
Urea	+ 24.9
Creat	+ 151
eGFR	- 37

U&E PHONED TO STAFF NURSE ITU WEST HIGH K+
Stage 3 CKD

Quit \ Earlier req \ Later req \ ED \ LD
Back \ PHoned comment <B> ..

Accident and Emergency Department
Glasgow Royal Infirmary

23123532V

A&E No. 11000075549

3

Surname	MCLEISH	**Forename**	WENDY	**Title:** MISS	
Address:	0/1 51 COXTON PLACE	**Postcode**	G33 5EJ	**CHI No:**	2505876061
	GLASGOW	**Telephone:**	07769733984 → Baytread		
Date of Birth:	25.05.87	**Sex:**	F	**Age:**	24 yrs

CHI Number: 2505876061

GP Name:	WILSON MARIE		
Address:	EASTERHOUSE HEALTH...	**Postcode**	G34 9HQ
	9 AUCHINLEA ROAD GLASGOW	**Telephone:**	0141 531 8150

Next of Kin	GERALD		
Relationship:	BROTHER		
Address:	H M PRISON, SHOTTS PR...	**Postcode**	ML7 4LE
	NEWMILL & CANTHILL ... SHOTTS LANARKSHIRE	**Telephone:**	
Primary Carer:			

Date of Attendance: 20.11.11 19:58

Date of Incident:

Presenting Complaint: BACK/LEG PAINS DIAHORREA

Med HDU

Triage	PT C/O 4/7 HX OF DIARRHOEA UNABLE TO TAKE FLUIDS IN HYPOTENSIVE WITH SAS GIVEN FLUIDS ALSO C/O PAIN IN HER BACK TEMP 37.4	**Tetanus Cover:**	
		Allergies:	

P= 107 **BP=** 95 /59 **RR=** 18 **Sat=** 96 **BM=**6.5

PF= **GCS=** E: M: V: Total:

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time
20/11/11	Amoxycillin	1g	~~PO~~ IV			22:00
	Clarithromycin	500mg	PO/IV			22:00
	Co-Codamol	30/500	PO			23:00
	Diclofenac	50mg	PR			23:00

© iSOFT Group Limited

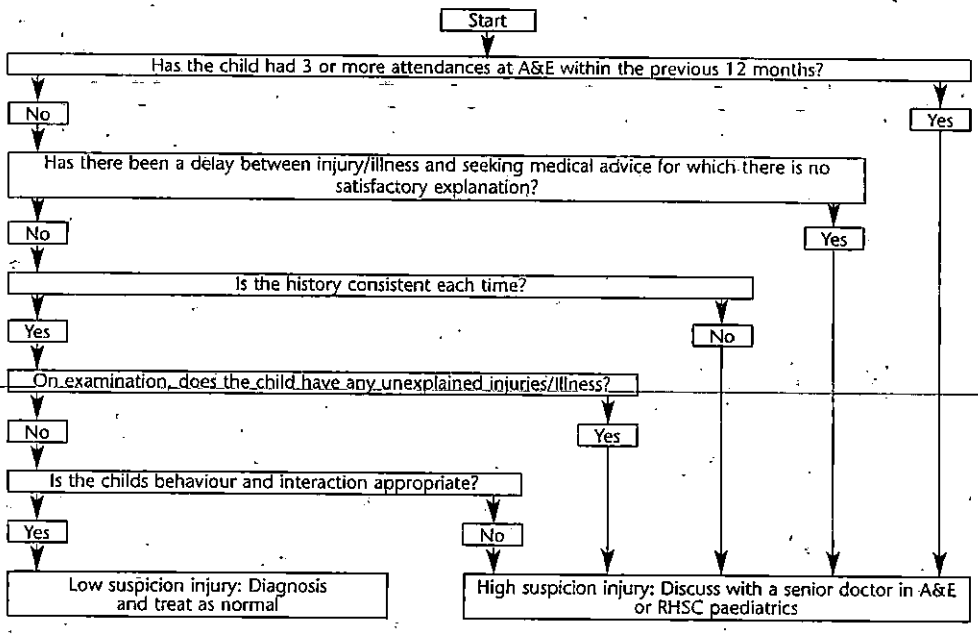
Glasgow Royal Infirmary
Unitary Patient Record
(Part A – Acute Assessment)

NHS
Greater Glasgow and Clyde

23123532V
MCLEISH
WENDY F
25/05/1987
0/1 51 COXTON PLACE
GLASGOW G33 5EJ
CHI-2505876061

Injury/Illness Flow Chart for all Patients 16 and under

Please tick the appropriate box as you go through the Flow Chart



All Clinical Staff Consider

H.I.Form ☐

Audit Form ☐

Police Consent ☐

Clinical Notes

20/11/11 2040 ABDULAH CA AF

24y Female

c/o Right chest pain
SOB
Abdominal pain
Diarrhoea

Background: Previous DVT SD / DSH
Anxiety / Depression.

TO PC: (R) sided sharp chest pain + Dry cough
x 2/52 Getting worse x 4 hrs.

Please complete where appropriate:

AMT (if >65 years)	CURB Score (if <65 years)
	SIRS

80907

Acute Medicine Unit
Glasgow Royal Infirmary
Unitary Patient Record
(Part A – Acute Assessment)

231235532V
MCLEISH F
WENDY 25/05/1987
0/1 51 COXTON PLACE
GLASGOW G33 5BJ
CHI-2505876061

Clinical Notes

Watery D&V x 3-4 /dy ? Generalized abdominal pain for 4/7

Denies any dry OD.

D&V Denies any

Sociality Smoker
Occasional EtOH
Unemployed

O/E

SOB
RR 18 Sat 97% 5
Pulse 107
Temp 37.6°
Sat 93–96% on Air

Chest Clear.

Abdomen – soft
Generally Tender.
(-) Murphy's sign.
BS – ill heard.

Urea 2.2
on Air.
Bloodgas
pH 37.1
Hbg 15.6
PCO2 3.3
PO2 8.9

Heart & Lungs
NAD.

Acute Medicine Unit
Glasgow Royal Infirmary
Unitary Patient Record
(Part A - Acute Assessment)

NHS
Greater Glasgow and Clyde

23123532V F
MCLEISH 25/05/1987
WENDY
0/1 51 COXTON PLACE G33 5EJ
GLASGOW
CHI-2505876061

Clinical Notes

IP Mixed Metabolic + Respiratory alkalosis

? Chest infection

? Gastroenteritis.

? Panic attack.

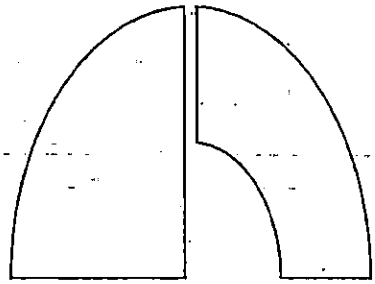
Rx Blood tests
CxR. (ERECT).

Analgesia ☐. wait till pancreatic
IV fluids. + Salicylate level.
O2 28%.

CTR – large upper/middle lobe.
BP – 01/59.

THR to resus.
Refer to medicine.

X-Ray results



MISS W MCLEISH

0/1 51 COXTON PLACE

GLASGOW

G33 5EJ

ECG findings

Other investigations

Biochem/Haematology results

Indicate which lab tests have been requested

Haem		
WCC	9.2	
Hb	96	
Plat	181	
MCV	94	
Neut		
DDim		
PT	16	
PTT	29	
TT	12	
INR	1.4	

Bioch		
Na+	128	
K+	3.0	
Cl-	102	
Ur	10.9	
Creat	90	
Glu	5.9	
CRP	372	
Bil	20	
AST	39	
ALT	26	
GGT	65	
ALP	44	
Prot	57	
Alb	20	
Glob		
Ca++	2.12	
Amyl		
TSH		
FT4		
Tropl		
Chol		
Trig		
Para		
Sal		
S osm		
ABG		
H^+		
P_aCO_2		
P_aO_2		
Bic		
BE		
FiO_2		
Lactate		

Fluids Prescribed in A&E

Drugs Prescribed in A&E

Refusal of Treatment

Hereby I declare that I am leaving

*(or taking _____ away from)

the _____ Hospital at my own desire and contrary to the advice of medical staff.

I have had the risks of so doing explained to me, and accept full responsibility for my action.

Signature _____

Witness Date _____

* Delete whichever is inapplicable.

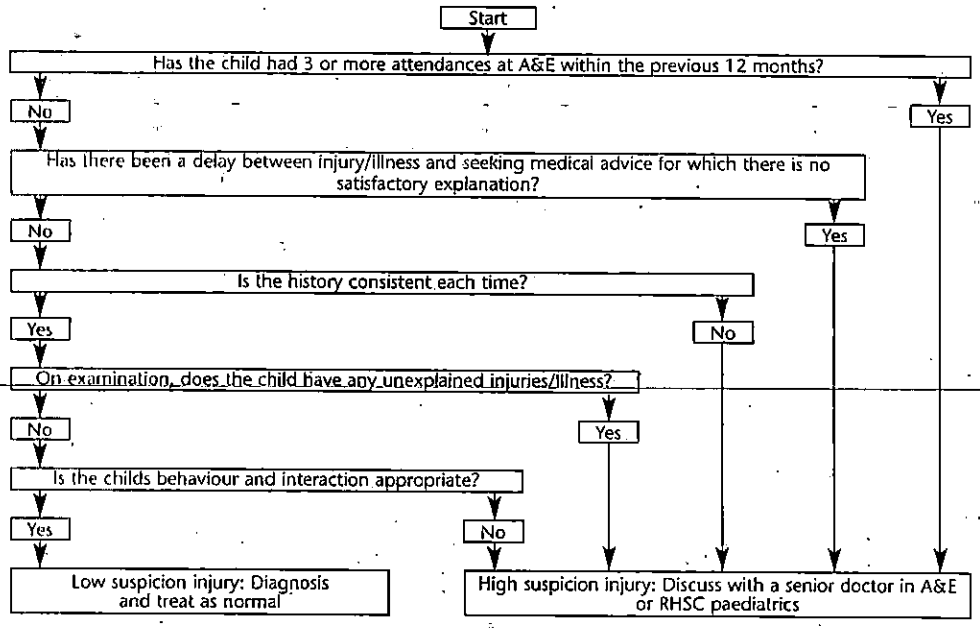
Glasgow Royal Infirmary
Unitary Patient Record
(Part A - Acute Assessment)

NHS
Greater Glasgow and Clyde

23123532V
MCLEISH
WENDY 25/05/1987
0/1 51 COXTON PLACE
GLASGOW G33 5EJ
CHI-2505876061

Injury/Illness Flow Chart for all Patients 16 and under

Please tick the appropriate box as you go through the Flow Chart



All Clinical Staff Consider

H.I.Form ☐

Audit Form ☐

Police Consent ☐

Clinical Notes

20/11/11 22⁰⁰ b. Reed SHO medicine

24 F. depression & DSH

4/7 PSOB, dry cough. ↓ ® Chest discomfort
Semi white sputum
- Non Smoker

Nil Medicine Wrong ID
- NKDA

Sh lives: partner - denies alcohol XS
- on docitabine & depression - denies ongoing drug use
ex-cocaine user 2 mth/yrs - denies smoking
ex-cannabis use

Please complete where appropriate:

AMT (if >65 years)	CURB Score (if <65 years)
	SIRS

Acute Medicine Unit
Glasgow Royal Infirmary
Unitary Patient Record
(Part A - Acute Assessment)

23123532V
MCLEISH
WENDY F
25/05/1987
0/1 51 COXTON PLACE
GLASGOW G33 5EJ
CHI-2505876061

Clinical Notes

-Fx. mother - died? natural
father - died last yr -
- brother in jail

S/E - lives Shotts 4/2
w/ elec

C/E - GCS 15/15
- RR 10 9
BP 105/51
SaO2 98% on 28%
Appears Borderline pyrexial
dry mucus membranes
HS 1 + 1 1 - 0
JVP - unseen

↓RE Upper zone
Scattered Crackles
- Focal resonance on percussion

Fluid Balance

In - 2 litres 2500ml
Out Urine 1045ml

CXR R upper zone consolidation

ABG

ABG - (A) H+ 37.6, PaCO2 3.3, PaO2 8.9 Lac 2.2
HCO3 - 15.6

Bloods - Hyponatraemic
- Inflammatory markers
-

Inj Augmentin pneumonia
+ sepsis

- Responding to fluids

- Releasing central access

(A) Alert ITU to make aware currently not requiring ITU support

- IV Abx
- Fluid Resuscitate

- Releasing Central access

Acute Medicine Unit
Glasgow Royal Infirmary
Unitary Patient Record
(Part A - Acute Assessment)

NHS
Greater Glasgow and Clyde

23123532V
MCLEISH F
WENDY 25/05/1987
0/1 51 COXTON PLACE
GLASGOW G33 5EJ
CHI-2505876061

Clinical Notes

- 1° Urine Volumes
- Hrly x Hyp C Mane
- Atypical cover sent D+
HDU cover

- Sputum pt MCKS of expectoration.

R/L 23⁴⁰ - GCS 15/15

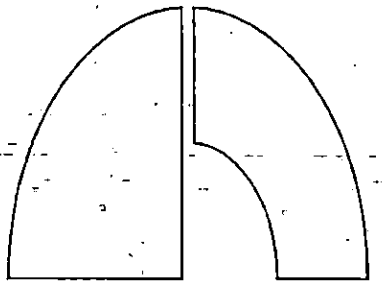
HR 106
BP 101/45 - IL bag running

good urine volumes

SpO2 96% on 3L. RR

BRES

X-Ray results



MISS W MCLEISH

0/1 51 COXTON PLACE

GLASGOW

G33 5EJ

ECG findings

Other investigations

Biochem/Haematology results

Indicate which lab tests have been requested

Haem		
WCC		
Hb		
Plat		
MCV		
Neut		
DDim		
PT		
PTT		
TT		

Bioch		
Na^+		
K^+		
Cl^-		
Ur		
Creat		
Glu		
CRP		
Bil		
AST		
ALT		
GGT		
ALP		
Prot		
Alb		
Glob		
Ca^{++}		
Amyl		
TSH		
FT4		
Tropl		
Chol		
Trig		
Para		
Sal		
S osm		
ABG		
H^+		
$PaCO_2$		
PaO_2		
Bic		
BE		
FiO_2		
Lactate		

Fluids Prescribed in A&E

Drugs Prescribed in A&E

Refusal of Treatment

Hereby I declare that I am leaving

*(or taking _____ away from)

the _____ Hospital at my own desire and contrary to the advice of medical staff.

I have had the risks of so doing explained to me, and accept full responsibility for my action.

Signature _____

Witness Date _____

* Delete whichever is inapplicable.

Acute Medicine Unit
Glasgow Royal Infirmary
Unitary Patient Record (Part B)

NHS
Greater Glasgow and Clyde

23123532V
MCLEISH F
WENDY 25/05/1987
0/1 51 COXTON PLACE
GLASGOW G33 5EJ
CHI=2505876061

Date 21/11/11 Consultant Ward 52

Ward Review KEITH SIC

0930 Written in Retrospect.
Hx of (12) Upper GI Bleed Previous.
Hx of DSH + Previous Cocaine Smoking.

Sepsis + Hypotension
given 3L of fluid + Metronidazole 13 Cipro.
very Agitated pt.
Shouting + kicking out Spitting
Hypoxic.

on Arrival A→ patent
B→ RR 30 Sats 80% on 15L 98%
C→ HR 110
BP 80/40
Cap Refill 5 seconds,
D→ Confused + Agitated.

Returning ABG's + Diagnosis
-BP L 50 Systolic - given 0.5g, 0.5g, 0.5g, 0.5g Metronidazole
given 1g of Co-Amoxiclav
+ ITU Contacted.
→ Arrived.
needed Co-Amoxiclav 1g IV.
IF ITU for Intubation + Care.

[signature]
SR

Please complete where appropriate:

AMT (if >65 years)	CURB Score (if <65 years)	DVT Prophylaxis
	SIRS	- indicated ☐ - not indicated ☐

01927

Medicine Reconciliation Form

Source of Information: Patient ☐ Relative/ carer ☐ GP surg ☐ GP computer printout/letter ☐ Patient's own drugs ☐ Other (specify).....

Admission Medicines (including OTC, herbal, homeopathic)				Plan for medicines (unless indicated to stop or hold medication should be continued on drug kardex)				
Name	Dose	Freq	Route	Amend	withhold	Stop	continue	Reason for alteration
Allergies/adverse events								

List obtained by ..... Designation .....

Recently altered/discontinued medicines prioir to admission and reasons why .....

.....

Compliance aid? Y ☐ N ☐ Type..... If, Y Community Pharmacy ..... Phone .....

Senior Medical staff review: Sign ..... Title..... Date and Time .....

Reviewed by pharmacist ..... Date and Time .....

Comments

Acute Medicine Unit
Glasgow Royal Infirmary
Unitary Patient Record (Part B)

NHS
Greater Glasgow and Clyde

23123532V
MCLEISH F
WENDY 25/05/1987
0/1 51 COXTON PLACE
GLASGOW G33 5EJ
CHI-2505876061

Date Consultant Ward

Consultant Review

Date Name Designation

Estimated Date of Discharge Date and Time

Social Circumstances

Name (print): CLAIRE · Signature: [signature] Time: 01 10 Named Nurse:

Religion/Spiritual Belief:	NIL	**Occupation:** Unemployed ·	**Rm/B:** 1 | 2 .
Domestic Arrangements: (please circle)	**Lives;** (Alone) Family Partner House Bound		
Housing: (please circle)	Sheltered Residential Nursing House Bungalow (Flat (position)) **Stairs;** Internal / External ground floor		
Carers: (please circle)	Cared for by partner / Other Carer for partner / Other Family issues.		
Services: (please circle)	Meals on wheels District Nurse Home Carers CPN Day Hospital		
Personal Belongings: (please circle)	Clothing Listed Dentures - Top/Bottom Prosthetics Policy Explained **Any Valuables** If yes - With Patient ☐ Deed Box ☐ Finance Dept ☐		

Smoking History non smoker · Alcohol Screen ☑ social at weekends · FAST +ve ☐ -ve ☐

Observations	Temp. 36.5°	BP. 81| 57 .	P. 105	RR. 30	SPO2. 97%	MEWS.

Functional Assessment

PRE-ADMISSION	ON ADMISSION
Breathing	CAP - SATS 97% 35% O^2. RR 30.
☐ Breathing Problems Resp Problem Specify: ☐ Domiciliary Oxygen ☐ Domiciliary NEB ☐ Breathless On Exertion	
Circulation	Sinus tachy Hypertensive
☐ No circulatory problems ☑ Problem with circulation (e.g. PVD) specify: palpatations	
Safety and Comfort	State orientation / conscious level: GCS 15|15 ·
☑ No Problems with pain ☐ Chronic pain specify: ☐ Risks to safety (e.g. self harm) specify:	Pain on admission: NIL ·
Mobility	Moving and Handling Requirements specify: Inaepenaent / unsteady.
☑ Mobile Independently ☐ Problems with mobility specify:	
Personal Hygiene	Independent.
☑ Independent ☐ Requires Assistance/Aids specify:	
Elimination	Catheter insitu - draining good vols.
☑ No problems ☐ Problems with elimination specify:	No bowel movements yet.

Acute Medicine Unit
Glasgow Royal Infirmary
Unitary Patient Record (Part B)

NHS Greater Glasgow and Clyde

23123532V F
MCLEISH
WENDY 25/05/1987
0/1 51 COXTON PLACE
GLASGOW G33 5EJ
CHI-2505876061

Date 21/11/11 Consultant Ward 52

PRE-ADMISSION	ON ADMISSION
Sleeping	To assess o/n
☑ No problems sleeping ☐ Problems with sleeping specify: ☐ Use of night sedation specify:	
Communication/Sensory Impairment	Communicates well.
☑ No Problems Communicating ☐ Specify Any Problems ☐ (e.g. Dysphasia, use of hearing aids / glasses):	

Nutrition

- ☑ Normal Diet
- ☐ Special Diet specify:
- ☐ Appetite specify:
- ☐ Recent Weight Changes specify:
- ☐ No Problems Swallowing
- ☐ Swallowing Difficulties specify:

☐ **Nutrition Risk Score=**
(If greater than 10 refer to Dietician.)

Waterlow Chart

Circle scores in table. Add total. Several scores per catagory can be used.

Build/Weight for Height		Skin Type: Visual Risk Area		Sex: Age	
Average	(0)	Healthy	(0)	Male	1
Above Average	1	Tissue Paper / Dry	1	Female	(2)
Obese	2	Oedematous	1	14 - 49	(1)
Below Average	3	Clammy (—Temp)	1	50 - 64	2
		Discoloured	2	65 - 74	3
		Broken/ Spot	3	75 - 80	4
				81+	5

Continence		Mobility		Appetite	
Complete/ Catheter	(0)	Fully	(0)	Average	(0)
Occ. Incontinence/ Cath/ Incontinent	1	Restless/ Fidgety	1	Poor	1
Faecally Incontinent	2	Apathetic	2	NG Tub/ Fluids Only	2
Doubly Incontinent	3	Restricted	3	NBM/ Anorexic	3
		Inert/ Traction	4		
		Chairbound	5		

SPECIAL RISKS

Tissue Malnutrition		Neurological Deficit		Medication	
Terminal Cachexia	8	Diabetes MS, CVA,		Cytotoxics	
Cardiac Failure	5	Motor Sensory Paraplegia	4 - 6	High Dose Steroids	4
PVD	5				
Anaemia	2				
Smoker	(1)				

SCORE ~~10+ = AT RISK~~ ~~15+ = HIGH RISK~~ ~~20+ = VERY HIGH RISK~~

Pressure Areas — specify:

Skin condition:
Waterlow score (3)
Torrance score:

Clinical Notes

NURSING 21/11/11 0140 -

Transfer from ATE RESUS with (R) sided CAP with Sepsis. Is on 35% O^2 SATS 97-100%.
Catheter insitu draining well. 1° urine vols.
IV amoxicillin + Clarithromycin + Augmentin given. Is in sinus tachycardia, hypotensive, apyrexial.
For HIV and Hep C screen tomorrow.
ITU to review, if deteriorates.

eternal
(SIN)

1130. R/V on HDU

- Not as well

agitated

21/11/11 ICU Review.
Note Hx of recent chest pneumonia. Hypotensive Overhead.
Combative Not tolerating O2 mask (trauma).
Once more calm - frightened of mask - willing to try again
⇒ SpO2 94-96% : RR 30 Speaking in sentences
A/E good bard crep. (has received ~6L)
CVS HR 102SR BP 94/72 Peripheries warm + well perfused.
PUmp 60-100 ml/hr.
CNS: E4 M6 V5 = 15/15
Impression
1) CAP -
2) Fluid overload - PUmp well.
Support
1) Continue humidified O2
2) Continue current Clarythro + Amoxyl - plan to change to co-amoxyclav
3) Accept BP 80-90/- providing PUmp ≥ 30ml/hr.
We will review if she should deteriorate

Mycroft
(Cor ICU)

Clinical Notes

NURSING 21/11/11 05^{00} –

Patient became hypotensive and dropped her SATS. Registrar involved commenced on fast fluids and Nebulizers. SATS came up after nebulizers. BP remained hypotensive at 60 systolic. Central line refused by patient, but willing to allow medics to try arterial line. ITU attended as below documented. Attempted several Arterial lines unsucessful at each turn. Became aggitated and had 2x 1.5 mg of metaraminol and ~~extra~~ ephidrine 12 mgs. All documented on front of Kardex. BP remained hypotensive. ITU consultant attended to ~~r/v patient decided to continue tx in HDU~~ 98% Hum O^2, BP 80-90, K^+ replacement, and IV augmentin. If further deterioration for ITU review again.

Urine o/p - 50-100 mls/hr. 1°: Urine vols.
BP remains between 80-90 systolic
Sinus tachycardic heart rhythm -
IV Abx
Maintenence IV fluids.

Etienne (SIN).

NURSING 21/11/11 07^{00}

Patient refusing to wear O^2 mask, and keep any of her monitors on. Trying to pull out catheter and climb out of bed. Has very poor balance unable to get up unaided.

Etienne (SIN).

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES

Dr. M WILSON
SHEDR WILSON, DR MCGINLAY & DI
EASTERHOUSE HEALTH CENTRE
9 AUCHINLEA ROAD
GLASGOW
G34 9HQ

MRS W MCGINLAY
0/1 51 COXTON PLACE
GLASGOW
G33 5BW

Date & Time		Signature, Print Name & Designation
21/11/11	Admission In Retrospect	
	attended ward & R/w pt	
	- more unwell, hypotensive despite more fluids	
	- hypoxic & agitated	
	- still refusing central access - agreeable to arterial line	
	- called ITU Dr	
	- On ITU arrival further deterioration with agitation and worsening hypotension	
	given ephedrine & metaraminol by anaesthetist	
	- unable to get art line despite numerous attempts	
	- ↓ response to inotropes but not ITU	
	hypoxic & ventilated ↑ O2.	
	- R/v Dr Foster as documented	
06⁰⁰	R/v - BP ~ 80-90 systolic good urine output overnight	
	SpO2 97% when tolerating 9 @ 98% RR spontaneously	
	however has removed all IV access already	

193443

Date & Time		Signature, Print Name & Designation
	and poorly tolerant of O2 mask.	
0845	Patient deteriorated sats ↓ BP ↓ aggitated ++. ITU will take patient Raymond contacted aware patient will be going to ITU She is estranged from other members of family. Her father has died recently but I have asked him to try and contact her relatives in view of current deterioration in condition. Given 5mg Haloperidol 2mg metaraminol to improve BP & sedate patient prior to transfer. Transferred with high flow O2 ITU/Reg/nurse escort.	

Patient Observation Chart

NHS Greater Glasgow and Clyde

Name
Address
Hospital No.
DOB

23123532V
MCLEISH F
WENDY 25/05/1987
0/1 51 COXTON PLACE
GLASGOW G33 5EJ
CHI-2505876061

Admitted Date _____ Ward _____
Transferred Date _____ Ward _____
Transferred Date _____ Ward _____

Patient Observation Chart Guidelines

Not all patients will require every part of this observation chart to be completed. Clinical judgement should be used to dictate the type and frequency of vital sign monitoring required.

The following patients are considered to be at high risk of developing a critical illness therefore it would be considered good practice to commence MEWS at the earliest opportunity.

- All emergency admissions
- Unstable patients
- Patients whose condition is causing concern
- Patients requiring frequent or increasing frequency of observations
- Patients who have stepped down from a higher level of care
- Patients with a chronic health problem
- Patients who are failing to progress
- Post-operative patients

There are also patients in whom the use of MEWS may be inappropriate:

- Day case patients
- Patients requiring no observations
- Patients who are terminally ill
- Planned discharges.

This is not an exhaustive list. Although the majority of patients may benefit from utilisation of the scoring system, a nurse's own clinical judgement dictates whether he/she feels the patient reqiures scoring. For guidance on the use of MEWS, refer to the Nurse in Charge.

Pain Score

Remember to check scores after pain relief.
Patient asked to report pain at rest and on movement.
0 = No pain at rest or on movement
1 = No pain at rest, slight pain on movement
2 = Intermittent pain at rest, moderate on movement
3 = Continuous pain at rest severe on movement
Review 5 mins after I/V, 1 hour after I/M, S/C or oral analgesia.
Sustained pain score of 2 or pain score of 3 requires intervention.

Sedation Score

0 = Awake, alert, orientated
1 = Mild, aroused by verbal stimulus
2 = Moderate, aroused by physical stimulus
3 = Severe, no response
S = Normal sleep, easy to rouse
Score 2 or 3 requires immediate intervention

Nausea Score

0 = No nausea
1 = Mild (No treatment wanted)
2 = Moderate (Treatment required)
3 = Severe (Clinical problem persists despite treatment)
Review 1 hour after treatment. Inform doctor if additional treatment required.

(9) Wendy McKeach

DATE	20/11/11																	
Time	2000	20	21 15	22	23	00 10	23 35	00 10	00 20									TEMP X
BP ^	147	137																
BP v	85	87																
Pulse •	95	98			101		97	95	94									
Resp. Rate	18	19	22	24	26		22	20	20									
Inspiration O_2%	A	A	A	28%	35%	35%	35%	35%	35%									
SpO_2%	96	93	97%	100	98		97	97%	97%									
Pain Score																		
Sedation Score																		
Nausea Score																		
Blood Glucose	6.5																	
IVacc	✓																	
Bloods	✓																	
IS Scan	✓																	
Xray	✓																	
Gen.	✓																	

MEWS																		
	Resp. Rate																	
	Pulse																	
	Systolic BP																	
	GCS / AVPU																	
	Urine Output																	
	Temp.																	
	SpO_2%																	
	TOTAL																	

Modified Early Warning Score (MEWS)

Score	3	2	1	0	1	2	3
Resp. Rate		≤8	9-10	11-20	21-25	26-30	≥31
Pulse		≤40	41-50	51-100	101-110	111-130	≥131
Systolic BP	≤84	85-89	90-100	101-199		>200	
GCS / AVPU	≤8	9-13	14 New agitation or confusion	15 / Alert	Voice	Pain	Unresponsive
Urine	<10mls/hr for 2 hrs	<30mls/hr for 2 hrs					
Temp. (°C)		≤35.0	35.1-35.9	36.0-37.4	37.5-38.5	≥38.6	
SpO_2%	≤87	88-91	92-94	95-100			

DATE																	
Time																	TEMP X
BP ^ v and Pulse •	240																
	230																40°C
	220																
	210																39°C
	200																
	190																38°C
	180																
	170																37°C
	160																
	150																36°C
	140																
	130																35°C
	120																
	110																
	100																
	90																
	80																
	70																
	60																
	50																
	40																
Resp. Rate																	
Inspiration O_2%																	
SpO_2%																	
Pain Score																	
Sedation Score																	
Nausea Score																	
Blood Glucose																	

MEWS																	
	Resp. Rate																
	Pulse																
	Systolic BP																
	GCS / AVPU																
	Urine Output																
	Temp.																
	SpO_2%																
	TOTAL																

Calling Criteria

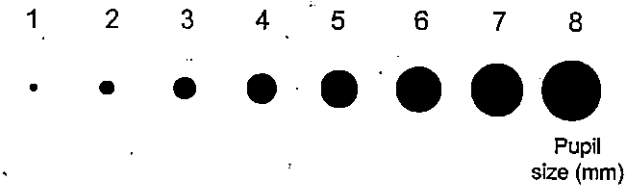
Score is 1-3	Increase frequency of patient observations, monitor trends and inform Nurse in Charge.
Score is 3 in one category	Contact Senior Nurse and increase frequency of patient observations.
Score is 4 and above or increasing by 2 or more Patient's GCS falls by 2 or more Any patient whose condition is causing concern	Contact Senior Nurse and increase frequency of patient observations Contact Critical Care Outreach Team.

The Senior Nurse will direct patient care and contact the appropriate medical staff when necessary.

Neurological Observation Chart

DATE			20/11																	
Time			21 15																	
COMA SCALE	E Eyes open	Spontaneously	4																	Eyes closed by dwelling = C
		To speech	3																	
		To pain	2																	
		None	1																	
	V Best verbal response	Orientated	5																	Endotracheal tube or tracheostomy = T
		Confused	4																	
		Inappropriate words	3																	
		Incomprehensible sounds	2																	
		None	1																	
	M Best motor response	Obeys	6																	Usually record the best arm response
		Localises	5																	
		Flexion - withdrawal	4																	
		Flexion - abnormal	3																	
		Extension to pain	2																	
		None	1																	
		TOTAL SCORE		15																
PUPILS	R	Size																		= reacts — no reaction c. eyes closed
		Reaction																		
	L	Size																		
		Reaction																		
LIMB MOVEMENT	ARMS	Normal power																		Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness																		
		Severe weakness																		
		Spastic flexion																		
		Extension																		
		No response																		
	LEGS	Normal power																		
		Mild weakness																		
		Severe weakness																		
		Extension																		
		No response																		

Glasgow Coma Scale



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

Medical Illustration Services, MIS 111948 - Reorder CEDAR 35497

MEDICINE **PRESCRIPTION FORM** Hospital Name: .....

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐
Date _____ Name (Print) _____
Discharge Prescription Prepared & Reconciled YES ☐
Date _____ Name (Print) _____

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

DOCTOR'S DECLARATION (if required by Local Protocol)

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

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name _____ Tel No. _____
Address _____
Compliance Aid Details _____
Patient consent to share discharge information Y/N
Print & Sign _____

PATIENT DETAILS

Hospital Number:	Height:
DOB:	Weight:
Date of Admission: __/__/__	Surface area:
Consultant Name:	Ward:

23123532V
MCLEISH F
WENDY 25/05/1987
0/1 51 COXTON PLACE
GLASGOW G33 5EJ
CHI-2505876061

Name _____
CHI No _____

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
1	AUGMENTIN	1.2g	IV	0400			0625
2/1	Gaviscon	10ml	IV	QDS			0530
	Metoclopramide	10mg	IV	0400			0530
21-11	METRONIDAZOLE	500mg	IV				0615
21-11	HALOPERIDOL	2.5mg	IV				0615

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

_____
_____

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only

(Maximum number of doses as per protocol)

Warning: Check the As Required and Regular Prescription sections to ensure that the

Notes for Users

FOR PRESCRIBERS:

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

DATE → 21

MONTH → 11

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

IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N

ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N

SIGNATURE OF ASSESSOR

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

Parenteral Drugs : Regular Prescription

A

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG: Augmentin

DOSE: 1.2g | ROUTE: iv | DATE: 20/11

PRESCRIBER (PRINT & SIGN):

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

		Patient's Own Medicine	For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
Other time							
0700-0900	(H)						
1200-1400	~~1400~~						
1600-1800	✓						
2200-2400	✓						
Other time							

B

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG: Clexane

DOSE: 40mg | ROUTE: SC | DATE: 21/11

PRESCRIBER (PRINT & SIGN):

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

		Patient's Own Medicine	For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
Other time							
0700-0900	✓						
1200-1400							
1600-1800							
2200-2400							
Other time							

C

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG:

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN):

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

		Patient's Own Medicine	For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
Other time							
0700-0900							
1200-1400							
1600-1800							
2200-2400							
Other time							

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

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

| | | |

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

Warning: Check the As Required and Regular Prescription sections to ensure that the

Notes for Users

FOR PRESCRIBERS:

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

Oral and Other Drugs: Regular Prescription

DATE → 7
MONTH → 11

																																Patient's Own Medicine
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	H DRUG Clonidine																															For Use Y/N
DOSE	ROUTE	DATE	STOPPED DATE:	Other time																												Qty:
PRESCRIBER (PRINT & SIGN)			STOPPED INITIALS:	0700-0900																												Date:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1200-1400																												Assessed by:
				1600-1800																												Ordered from Pharm.
				2200-2400																												
				Other time																												
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	J DRUG Clarithromycin																															For Use Y/N
DOSE 500mg	ROUTE O	DATE 21/11/11	STOPPED DATE:	Other time																												Qty:
PRESCRIBER (PRINT & SIGN)			STOPPED INITIALS:	0700-0900 ✓	(3)																											Date:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1200-1400																												Assessed by:
				1600-1800 ✓																												Ordered from Pharm.
				2200-2400 ✓																												
				Other time																												
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	K DRUG																															For Use Y/N
DOSE	ROUTE	DATE	STOPPED DATE:	Other time																												Qty:
PRESCRIBER (PRINT & SIGN)			STOPPED INITIALS:	0700-0900																												Date:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1200-1400																												Assessed by:
				1600-1800																												Ordered from Pharm.
				2200-2400																												
				Other time																												
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	L DRUG																															For Use Y/N
DOSE	ROUTE	DATE	STOPPED DATE:	Other time																												Qty:
PRESCRIBER (PRINT & SIGN)			STOPPED INITIALS:	0700-0900																												Date:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1200-1400																												Assessed by:
				1600-1800																												Ordered from Pharm.
				2200-2400																												
				Other time																												

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

M

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

N

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

P

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

R

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Name

CHI No

23123512V
MCLEISH F
WENDY 25/05/1987
0/1 51 COXTON PLACE
GLASGOW G33 5EJ
CHI-2505876061

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

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

Warning: Check the As Required and Regular Prescription sections to ensure that the

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

S DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

T DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

V DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

W DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

Patient's Own Medicine
For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

X DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

Y DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

AA DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

BB DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Name
CHI No

23123532V
MCLEISH F
WENDY 25/05/1987
0/1 51 COXTON PLACE
GLASGOW G33 5EJ
CHI-2505876061

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

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

Warning: Check the As Required and Regular Prescription sections to ensure that the

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

Patient's Own Medicine
For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

CC DRUG
DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN)
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

DD DRUG
DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN)
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

EE DRUG
DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN)
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FF DRUG
DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN)
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

GG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

HH

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

JJ

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

KK

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

Name

CHI No

23123532V
MCLEISH F
WENDY 25/05/1987
0/1 51 COXTON PLACE
GLASGOW G33 5EJ
CHI-2505876061

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

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

Warning: Check the As Required and Regular Prescription sections to ensure that the

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generally using the approved name, [illegible] circumstances where bioavailability of [illegible]

All Routes: As Required Prescriptions

Patient's Own Medicine

BEFORE ADMISSION ☐ **NEW DOSE** ☐ **NEW MEDICATION** ☐

LL | DRUG: Saline neb | STOPPED DATE: | INITIALS:
DOSE: 10ml | ROUTE: neb | INDICATION: BSB
PRESCRIBER (PRINT & SIGN): [signature] | MAX.FREQ. [illegible] | DATE: 21/11
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

| | | |

Patient's Own Medicine

| | | |

Patient ID label

Wendy McLeish

Daily Observations
Medical HDU

Glasgow Royal Infirmary

NHS
Greater Glasgow and Clyde

Date of Admission to HDU 21/11/11 **Todays date** 21/11

Daily Checks

Central Line

Date line inserted

Central line dressing intact Yes ☐ No ☐ Dressing changed Yes ☐ No ☐

Date and time giving set due for change (72hrs) Line changed Yes ☐ No ☐

Arterial Line

Date line inserted

Central line dressing intact Yes ☐ No ☐ Dressing changed Yes ☐ No ☐

Date and time giving set due for change (72hrs) Line changed Yes ☐ No ☐

Femoral Line

Date line inserted

Central line dressing intact Yes ☐ No ☐ Dressing changed Yes ☐ No ☐

Date and time giving set due for change (72hrs) Line changed Yes ☐ No ☐

Urinary Catheter

Date inserted 21/11/11

Intact and draining well Yes ☑ No ☐ Removed Yes ☐ No ☐

Venflon 1

Date inserted (Keep for 72 hrs) 21/11/11 Date to be removed 24/11/11

Position Green (R) hand Removed Yes ☐ No ☐

Venflon 2

Date inserted (Keep for 72 hrs) Date to be removed

Position Removed Yes ☐ No ☐

Venflon 3

Date inserted (Keep for 72 hrs) Date to be removed

Position Removed Yes ☐ No ☐

Daily Observation Chart

GCS	1	2	3	4	5	6
Eyes	Not open	Opens to pain	Opens to voice	Spontaneously	N/A	N/A
Verbal	No sounds	Incomprehensible	Inappropriate words	Confused	Oriented	N/A
Motor	No movement	Extension to pain	Flexion to pain	Withdrawal to pain	Localizes pain	Obeys commands

Pain Score

0 = No pain
1 = Mild
2 = Moderate
3 = Severe
4 = Worst pain

	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800
Pain score 0 to 4											
GCS - Eyes	4										
GCS - Verbal	4										
GCS - Motor	6										
GCS - total	14										
Pupils equel/reactive											
NIV Mask intact Y/N											
IPAP											
EPAP											
BM											
CVP											
MAP	56	47									
Cardiac Rhythm	/	/									
Oxygen %	98 / Hum	98 /									
Resp Rate	48										
Oxygen Sats	84 / 8	90 /									
TEMP											

Blood Pressure: 220, 210, 200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40, 30

Pulse: 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 60, 50, 40, 30

O2 sats target	
Pulse Target	
MAP target	

Po2 target	
PCo2 Target	
CVP target	

2000	2100	2200	2300	2400	0100	0200	0300	0400	0500	0600	0700	
												Pain score 0 to 4
												GCS - Eyes
												GCS - Verbal
												GCS - Motor
												GCS - total
												Pupils equel/reactive
												Mask intact - Y/N
												IPAP
												EPAP
												BM
												CVP
												MAP
												Cardiac Rhythm
												Oxygen %
												Resp Rate
												Oxygen Sats
												TEMP

220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30

Blood Pressure

190 180 170 160 150 140 130 120 110 100 90 80 60 50 40 30

Pulse

Daily Fluid Balance – Medical HDU GRI

Input (mls)								Prev In		
Time	Oral	NG	Blood products	IV (1)	IV (2)	IV Abs	IV drugs	Hourly Total	Cumulative	Balance
8am					4x10 500			500	500	
9am										
10am										
11am										
12am										
1pm										
2pm										
3pm										
4pm										
5pm										
6pm										
7pm										
8pm										
9pm										
10pm										
11pm										
12am										
1am										
2am										
3am										
4am										
5am										
6am										
7am										
Totals										

Output (mls)					Prev out		
Cumulative	Urine Total	Urine	Gastric NG	Stoma bowels	LVP	Drain	Time
15	15	15					8am
							9am
							10am
							11am
							12pm
							1pm
							2pm
							3pm
							4pm
							5pm
							6pm
							7pm
							8pm
							9pm
							10pm
							11pm
							12am
							1am
							2am
							3am
							4am
							5am
							6am
							7am
							Totals

Patie

23123532V F
MCLEISH 25/05/1987
WENDY
0/1 51 COXTON PLACE
G33 5EJ
GLASGOW
CHI-2505876061

Daily Observations
Medical HDU

Glasgow Royal Infirmary

NHS
Greater Glasgow and Clyde

Date of Admission to HDU 21/11/11 Todays date

Daily Checks

Central Line

Date line inserted

Central line dressing intact Yes ☐ No ☐ Dressing changed Yes ☐ No ☐

Date and time giving set due for change (72hrs) Line changed Yes ☐ No ☐

Arterial Line

Date line inserted

Central line dressing intact Yes ☐ No ☐ Dressing changed Yes ☐ No ☐

Date and time giving set due for change (72hrs) Line changed Yes ☐ No ☐

Femoral Line

Date line inserted

Central line dressing intact Yes ☐ No ☐ Dressing changed Yes ☐ No ☐

Date and time giving set due for change (72hrs) Line changed Yes ☐ No ☐

Urinary Catheter

Date inserted 20/11/11

Intact and draining well Yes ☑ No ☐ Removed Yes ☐ No ☐

Venflon 1

Date inserted (Keep for 72 hrs) 20/11/11 Date to be removed

Position (L) forearm Removed Yes ☐ No ☐

Venflon 2

Date inserted (Keep for 72 hrs) 20/11/11 Date to be removed

Position (R) cubital fossa Removed Yes ☐ No ☐

Venflon 3

Date inserted (Keep for 72 hrs) Date to be removed

Position Removed Yes ☐ No ☐

Daily Observation Chart

GCS	1	2	3	4	5	6
Eyes	Not open	Opens to pain	Opens to voice	Spontaneously	N/A	N/A
Verbal	No sounds	Incomprehensible	Inappropriate words	Confused	Oriented	N/A
Motor	No movement	Extension to pain	Flexion to pain	Withdrawal to pain	Localizes pain	Obeys commands

Pain Score

0 = No pain
1 = Mild
2 = Moderate
3 = Severe
4 = Worst pain

	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900
Pain score 0 to 4												
GCS - Eyes												
GCS - Verbal												
GCS - Motor												
GCS - total												
Pupils equel/reactive												
NIV Mask Intact Y/N												
IPAP												
EPAP												
BM												
CVP												
MAP												
Cardiac Rhythm												
Oxygen %												
Resp Rate												
Oxygen Sats												
TEMP												

Blood Pressure: 220, 210, 200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40, 30

Pulse: 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 60, 50, 40, 30

O2 sats target	
Pulse Target	
MAP target	

Po2 target	
PCo2 Target	
CVP target	

2000	2100	2200	2300	2400	0100	0200	0300	0400	0500	0600	0700	
					0	0	0	0	0	0	0	Pain score 0 to 4
					4	4	4	4	4	4	4	GCS - Eyes
					5	4	4	4	4	4	4	GCS - Verbal
					6	6	6	6	6	6	6	GCS - Motor
					15	14	14	14	14	14	14	GCS - total
					✓	✓	✓	✓	✓	✓	✓	Pupils equel/reactive
												Mask intact Y/N
												IPAP
												EPAP
										4.9		BM
												CVP
					62	46	70	80				MAP
					ST	ST	ST	SR	ST	ST	ST	Cardiac Rhythm
					35%	NEBS	98% Hum	98% Hum	98% Hum	98% Hum	98% Hum	Oxygen %
					30	31	48	36		35	36	Resp Rate
					99%	96%	95%	96%	91%	86%	84%	Oxygen Sats
					36.5°	36.6°	36.4°	36.6°				TEMP
					85 / ∧ ∨ 35	87 / ∧ 32	86 / ∧ ∨ 66	91 / ∧ ∨ 87 / ∧ ∨ 40	85 / ∧ ∨ 41	83 / ∧ ∨ 82		Blood Pressure
					104	104	102	100	107	109		Pulse

Daily Fluid Balance – Medical HDU GRI

Input (mls)							Prev in				Output (mls)					Prev out		
Time	Oral	NG	Blood products	IV (1)	IV (2)	IV Abs	IV drugs	Hourly Total	Cumulative	Balance	Cumulative	Urine Total	Urine	Gastric NG	Stoma bowels	LVP	Drain	Time
8am																		8am
9am																		9am
10am																		10am
11am																		11am
12am																		12pm
1pm																		1pm
2pm																		2pm
3pm																		3pm
4pm																		4pm
5pm																		5pm
6pm																		6pm
7pm																		7pm
8pm																		8pm
9pm																		9pm
10pm																		10pm
11pm																		11pm
12am																		12am
1am	Transfer from A+E								5500		[illegible] FRS Transfer from A+E							1am
2am				500				500	6000		1860	1860	125					2am
3am				500				500	6500		1960	1960	100					3am
4am				500				500	7000		2110	2110	150					4am
5am						100		100	7100		2235	2235	125					5am
6am								0	7100		2355	2355	120					6am
7am											2555	2555	200					7am
Totals																		Totals

GLASGOW ROYAL INFIRMARY

23123532V
MCLEISH
WENDY F
0/1 51 COXTON PLACE 25/05/1987
GLASGOW G33 5EJ
CHI-2505876061

I.V THERAPY PRESCRIPTION SHEET

iPAS — 500ml

No. 05199

	DATE	FLUID (USE BLOCK LETTERS) ADDITIVE DRUG	Vol (ml). Dose (mg)	Route of Admin.*	Dur. of Admin.*	SIGNATURE	Serial No. Batch No.	Time Begun	Given By Added by
A	20/11/11	N/Saline 0.9%	500	IV	START		6/2013		CROW
B	20/11/11	N/Saline 0.9%	1LT	IV			11927730 6/2014	20 40	
C	20/11	N/Saline 0.9%	1000 ml	IV					
D	20/11	@Saline	500ml	IV			11I 20T 4C 08/13	0130	
E	20/1	@Saline	IC	IV	—				
F	20/1	@Saline	5C	IV	2°				
G	20/1	@Saline	500ml	IV	Stat		11I 20T4C 08/13	0130	
H		[illegible]							
I		Haemaccel	500ml	IV	1°			0230	
J	21/11/11	(N) Saline	500ml	IV	STAT		11I 20T4C 08/13	03	
K	21/11/11	(N) Saline	500ml	IV	STAT		11I 20T4C 08/13	0820	
L									
M									
N									
O									

RATE OF FLOW (Drops/Min.) = VOL. OF FLUID (ml) x 15 / (Duration (Mins.))

(1ml = 15 drops)

Approximate Rate for 500ml.

1 hr. = 120 Drops/min.

4 hr. = 30 Drops/min.

6 hr. = 22 Drops/min.

8 hr. = 15 Drops/min.

6.62

SHEET NO .....

GLASGOW ROYAL INFIRMARY

I.V THERAPY
PRESCRIPTION SHEET

Wendy
M Reid

PATIENT ID LABEL

No. 05199

	DATE	FLUID (USE BLOCK LETTERS) ADDITIVE DRUG	Vol (ml). Dose (mg)	Route of Admin.*	Dur. of Admin.*	SIGNATURE	Serial No. Batch No.	Time Begun	Given By Added by
A	10/11/11	Saline KCl 20mmol	500ml	IV	4hr		11F2465 05/14	6PM	Ward
B									
C									
D									
E									
F									
G									
H									
I									
J									
K									
L									
M									
N									
O									

RATE OF FLOW (Drops/Min.) = VOL. OF FLUID (ml) x 15 / (Duration (Mins.) (1ml = 15 drops)) = 6.62

Approximate Rate for 500ml.

1 hr. = 120 Drops/min.

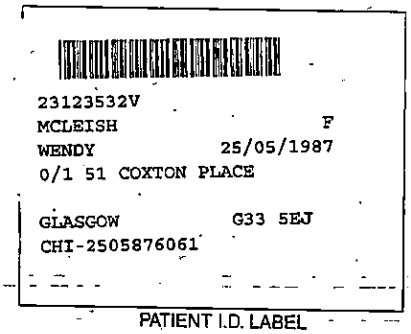
4 hr. = 30 Drops/min.

6 hr. = 22 Drops/min.

8 hr. = 15 Drops/min.

SHEET NO .....

GLASGOW ROYAL INFIRMARY



PATIENT I.D. LABEL

24hr. FLUID BALANCE CHART (including Blood)

12mn - 12mn

Date 20/11

INTAKE				TIME	OUTPUT			
CODE LETTER OR DESCRIPTION OF INTAKE	ORAL ml.	I.V. ml.	OTHER		URINE	GASTRIC	OTHER	COMMENTS
Na Saline 0.9%		1000						
Na Saline 0.9%		1000						
Na Saline 0.9%		500ml		22p-	450ml			
Na Saline 0.9%		500ml		2p				
SMP		250ml						
Saline 0.9%		1000ml		23[10]	935ml			
				00	180ml			175ml
				12mn.				

TOTAL INTAKE = mls.

TOTAL OUTPUT = mls.

APPROXIMATE MEASURES:- TUMBLER = 200mls. ORDINARY CUP = 150 mls. FEEDING CUP = 175mls. SOUP BOWL = 250mls.

23123532V
MCLEISH F
WENDY 25/05/1987
0/1 51 COXTON PLACE

GLASGOW G33 5EJ
CHI-2505876061

NHS
Greater Glasgow and Clyde

Medical Receiving Unit

Daily Summary of Fluid Balance

Date	Oral	I.V.	Other	Total	Urine	Gastric	Other	Total

Routine Urine Chart

Date								
Protein								
24hr volume								
Colour								
S.G.								
Reaction								
Sugar								
Ketones								
Bilirubin								
Urobilinogen								
Blood								
Nitrite								
Leucocyte								
Sample Sent								

Stool Chart

Date	Time	Colour	Consistency	Abnormalities	F.O.B.	
					-ve	+ve

MIS 169087

North Glasgow Biochemistry & Immunology ** LIVE **
Patient enquiry ---- Express results

Reg	Name	D.o.B.	Sex	Loc.
23123532V	MCLEISH WENDY	25.05.87	F	ROYAL CASUALTY

Specimen N,11.0714875.X Type Specimen
Collected 20.11.11 21:16 A.Diag ? OD

.....CRP.....
CRP + 372
.....Amylase.....
Amylase 39
.....Parac'mol.....
Pmol mg/L 18
.....Salicylate.....
Salic mg/L <50

Parac'mol Refer to BNF diagram for paracetamol overdose. Treatment levels - 200mg/L @ 4h, 100mg/L @ 8h, 50mg/L @ 12h.Less if high risk patient
Salicylate Salicylate intoxication >350mg/L, severe toxicity >700mg/L, >280mg/L if under 5 years.

Quit \ Earlier req \ Later req \ ED \ LD \ Prev res
Back \ PHoned comment <B> ..

North Glasgow Biochemistry & Immunology ** LIVE **
Patient enquiry ---- Express results

Reg	Name	D.o.B.	Sex	Loc.
23123532V	MCLEISH WENDY	25.05.87	F	ROYAL CASUALTY

Specimen N,11.0714875.X Type Specimen
Collected 20.11.11 21:16 A.Diag ? OD

......U&E.....			AST	39		T Prot	- 51
Sodium	- 128		ALT	26		Alb	- 20
Potassium	- 3.0		G-GT	+ 65		Globulin	31
Chloride	102		A Phos	44		Calcium	1.73
Urea	+ 10.9		T Prot	- 51		Ad Cal	2.12
Creat	90		Alb	- 20		Phos	- 0.63
eGFR	>60		Globulin	31		.....Glucose.....	
.....LFTs.....			.....Bone.....			Glucose	+ 5.9
Bili	- 20		A Phos	- 44			

Parac'mol Refer to BNF diagram for paracetamol overdose. Treatment levels - 200mg/L @ 4h, 100mg/L @ 8h, 50mg/L @ 12h.Less if high risk patient
Salicylate Salicylate intoxication >350mg/L, severe toxicity >700mg/L, >280mg/L if under 5 years.

Quit \ Earlier req \ Later req \ ED \ LD \ Next res
Back \ PHoned comment <N> ..

Glasgow Royal Haematology ** LIVE **
Patient enquiry ---- Express results

Reg	Name	D.o.B.	Sex	Loc.
23123532V	MCLEISH WENDY	25.05.87	F	Accident & Emer

Specimen R,11.5495725.S Type Citrate/EDTA
Collected 20.11.11 21:00 A.Diag

.....FBC.....		.....C/Screen.....	
WBC	9.2	PT	16
Hb	96	PT C Ratio	1.4
Hct	0.275	APTT	29
MCV	94.8	APTT Ratio	0.9
MCH	33.1	TCT	12
Plts	181	TCT Ratio	0.9
NEUT	8.2		
LYMPH	0.9		
MONO	0.1		
EOS	0.00		
BASO	0.00		

C/Screen This report does not include any comment on the platelet count.

Quit \ Earlier req \ Later req \ ED \ LD
Back \ PHoned comment <B> ..

Nutrition Profile

NHS Greater Glasgow and Clyde

Name:	Date of admission: 21 / 11 / 11
Address: 23123532V MCLEISH F WENDY 25/05/1987 0/1 51 COXTON PLACE GLASGOW G33 5EJ CHI-2505876061	Time:
DoB:	HOSPITAL: GRI
CHI number:	Ward: 52
Affix patient data label	

To be recorded within 24 hours of admission*

Height: 5 1 4 m/ft Actual ☐ Patient/ carer reported ☑ Alternative measurement ☐

Weight: 9 1 2 kg/stones Actual ☐ Patient/ carer reported ☑ Alternative measurement ☐

Recent unplanned weight loss: Yes ☐ No ☑

If 'Yes' how much?: kg/stones. Over what period of time?: weeks/months

Is there evidence of recent weight loss?

No ☑ Loose clothing ☐ History of reduced food intake/appetite ☐ Swallowing problem ☐

Eating and drinking likes and dislikes (including appetite and/or NBM status):

Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☑

Please state:

Are there any contributing factors that may affect food intake such as **physical** (e.g. swallowing difficulties), **physiological** (e.g. nausea), **psychological** (e.g. dementia), **social or environmental**? Yes ☐ No ☑

Please specify all factors:

Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☑

Please state:

Profile completed by: Name (PRINT): CLAIRE Signature: [signature] Date: 21/11/11

NOTE: This is ADMISSION DATA - please refer to changes in Care Plan.

* Quality Improvement Scotland (2003). Food, Fluids and Nutritional Care in Hospitals Edinburgh QIS

Malnutrition Universal Screening Tool ('MUST')

Date										
Initials										
Height (see page 1)	Weight									
Oedema or ascites present Y/N										
BMI										

'MUST'

Step 1: BMI Score (refer to chart on page 4)									
>20 (>30 = Obese) 0									
8.5 - 20 1									
<18.5 2									
Step 2: Weight Loss Score									
Unplanned weight loss in past 3-6 months:									
<5% 0									
5-10% 1									
>10% 2									
Step 3: Acute Disease Effect Score									
If patient is acutely ill **and** there has been or is likely to be no or virtually no food intake for > 5 days..... Score 2									
Not applicable ..... Score 0									
Step 4: Overall Risk of Malnutrition Total:									

Step 5: Management Guidelines

Score of Overall Risk of Malnutrition	Action Required
0	**LOW RISK** - *Routine Clinical Care* • Repeat screening. Hospital Acute .....Weekly Hospital Rehabilitation .....Monthly
1	**MEDIUM RISK** - *Observe* • Document dietary intake for 3 days on a Food Record Chart. • If no improvement in intake: - Encourage oral intake. - Assist patient to choose high-energy meals/snacks **and** offer full cream milk to drink with and between meals. • Repeat screening weekly.
2 or more	**HIGH RISK** - *Treat** • Refer to Dietitian **and** document food intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks **and** offer full cream milk to drink with and between meals. • Monitor **and** review Care Plan weekly. * Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

Management Plan

FOR ALL PATIENTS

- Provide help and advice on food choices and eating and drinking when necessary.
- Treat underlying conditions and initiate appropriate treatment to relieve symptoms that affect nutritional intake e.g. nausea, vomiting, constipation, diarrhoea and/or pain.
- Refer to dietitian if any specialist advice is required.
- Complete nursing checklist for swallowing difficulties if appropriate.
- Use a recognised system to identify when equipment or asssistance is required at mealtimes (e.g. red mats, coloured napkins).

Referral Services

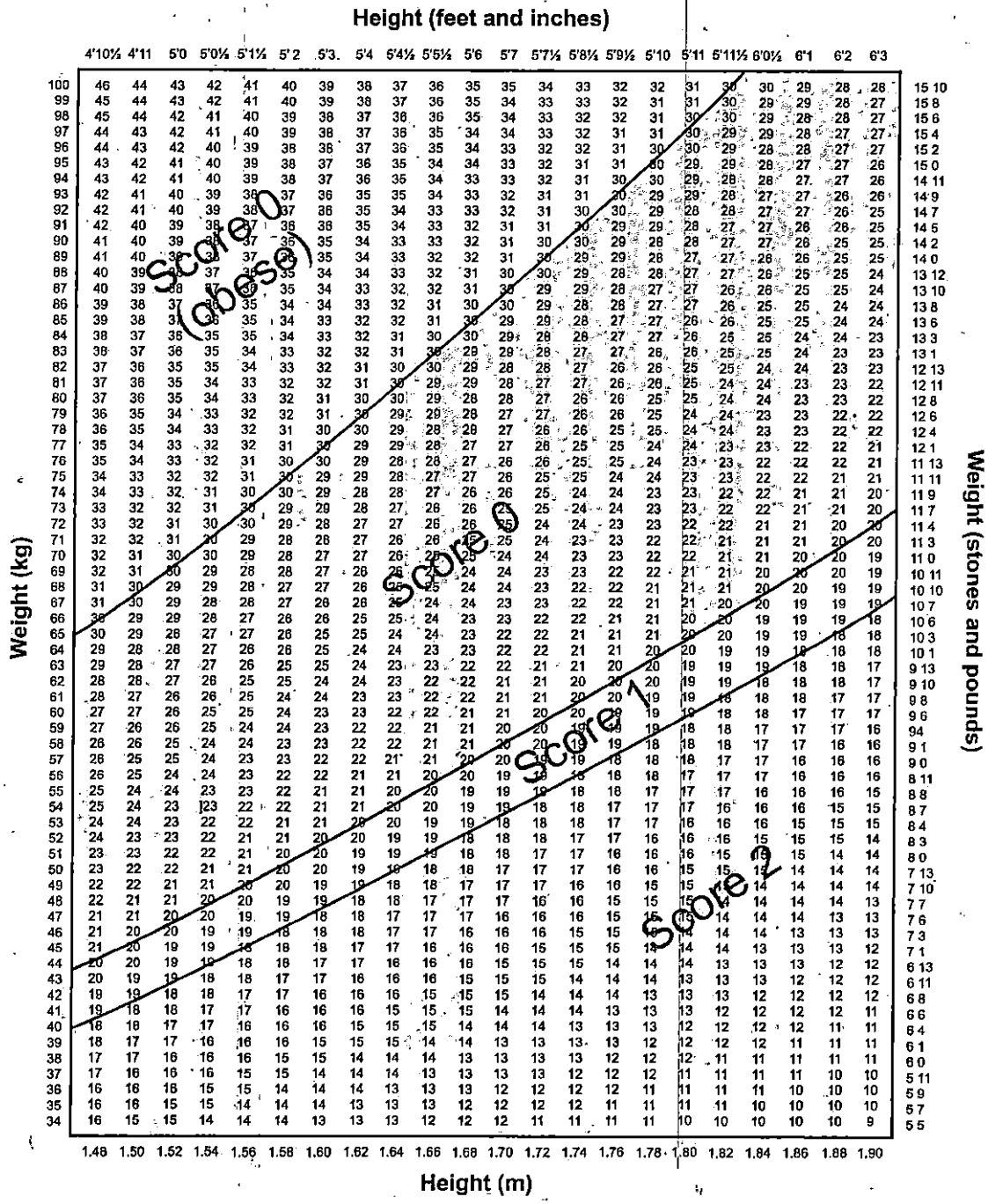
Dietitian	Date: / /	Outcome:
Speech and Language Therapy	Date: / /	Outcome:
Occupational Therapy	Date: / /	Outcome:
Dental Service	Date: / /	Outcome:

Multidisciplinary Nutrition Care Plan

Date	Overall Risk	Action	Review date	Name (PRINT) Signature/Designation

N.B. Ensure discharge plan includes most recent 'MUST' score and any necessary follow-up requirements.

Step 1 - BMI Score



Step 2 - Weight Loss Score

Weight before weight loss (kg)	Score 0 Wt loss <5%	Score 1 Wt loss 5-10%	Score 2 Wt loss >10%
34 kg	<1.7 kg	1.7-3.4 kg	>3.4 kg
36 kg	<1.8 kg	1.8-3.6 kg	>3.6 kg
38 kg	<1.9 kg	1.9-3.8 kg	>3.8 kg
40 kg	<2 kg	2-4 kg	>4 kg
42 kg	<2.1 kg	2.1-4.2 kg	>4.2 kg
44 kg	<2.2 kg	2.2-4.4 kg	>4.4 kg
46 kg	<2.3 kg	2.3-4.6 kg	>4.6 kg
48 kg	<2.4 kg	2.4-4.8 kg	>4.8 kg
50 kg	<2.5 kg	2.5-5 kg	>5 kg
52 kg	<2.6 kg	2.6-5.2 kg	>5.2 kg
54 kg	<2.7 kg	2.7-5.4 kg	>5.4 kg
56 kg	<2.8 kg	2.8-5.6 kg	>5.6 kg
58 kg	<2.9 kg	2.9-5.8 kg	>5.8 kg
60 kg	<3 kg	3-6 kg	>6 kg
62 kg	<3.1 kg	3.1-6.2 kg	>6.2 kg
64 kg	<3.2 kg	3.2-6.4 kg	>6.4 kg
66 kg	<3.3 kg	3.3-6.6 kg	>6.6 kg
68 kg	<3.4 kg	3.4-6.8 kg	>6.8 kg
70 kg	<3.5 kg	3.5-7 kg	>7 kg
72 kg	<3.6 kg	3.6-7.2 kg	>7.2 kg
74 kg	<3.7 kg	3.7-7.4 kg	>7.4 kg
76 kg	<3.8 kg	3.8-7.6 kg	>7.6 kg
78 kg	<3.9 kg	3.9-7.8 kg	>7.8 kg
80 kg	<4 kg	4-8 kg	>8 kg
82 kg	<4.1 kg	4.1-8.2 kg	>8.2 kg
84 kg	<4.2 kg	4.2-8.4 kg	>8.4 kg
86 kg	<4.3 kg	4.3-8.6 kg	>8.6 kg
88 kg	<4.4 kg	4.4-8.8 kg	>8.8 kg
90 kg	<4.5 kg	4.5-9 kg	>9 kg
92 kg	<4.6 kg	4.6-9.2 kg	>9.2 kg
94 kg	<4.7 kg	4.7-9.4 kg	>9.4 kg
96 kg	<4.8 kg	4.8-9.6 kg	>9.6 kg
98 kg	<4.9 kg	4.9-9.8 kg	>9.8 kg
100 kg	<5 kg	5-10 kg	>10 kg
102 kg	<5.1 kg	5.1-10.2 kg	>10.2 kg
104 kg	<5.2 kg	5.2-10.4 kg	>10.4 kg
106 kg	<5.3 kg	5.3-10.6 kg	>10.6 kg
108 kg	<5.4 kg	5.4-10.8 kg	>10.8 kg
110 kg	<5.5 kg	5.5-11 kg	>11 kg
112 kg	<5.6 kg	5.6-11.2 kg	>11.2 kg
114 kg	<5.7 kg	5.7-11.4 kg	>11.4 kg
116 kg	<5.8 kg	5.8-11.6 kg	>11.6 kg
118 kg	<5.9 kg	5.9-11.8 kg	>11.8 kg
120 kg	<6 kg	6-12 kg	>12 kg
122 kg	<6.1 kg	6.1-12.2 kg	>12.2 kg
124 kg	<6.2 kg	6.2-12.4 kg	>12.4 kg
126 kg	<6.3 kg	6.3-12.6 kg	>12.6 kg

Weight before weight loss (st/lb)	Score 0 Wt loss <5%	Score 1 Wt loss 5-10%	Score 2 Wt loss >10%
5st 4lb	<4lb	4lb-7lb	>7lb
5st 7lb	<4lb	4lb-8lb	>8lb
5st 11lb	<4lb	4lb-8lb	>8lb
6st	<4lb	4lb-8lb	>8lb
6st 4lb	<4lb	4lb-9lb	>9lb
6st 7lb	<5lb	5lb-9lb	>9lb
6st 11lb	<5lb	5lb-10lb	>10lb
7st	<5lb	5lb-10lb	>10lb
7st 4lb	<5lb	5lb-10lb	>10lb
7st 7lb	<5lb	5lb-11lb	>11lb
7st 11lb	<5lb	5lb-11lb	>11lb
8st	<6lb	6lb-11lb	>11lb
8st 4lb	<6lb	6lb-12lb	>12lb
8st 7lb	<6lb	6lb-12lb	>12lb
8st 11lb	<6lb	6lb-12lb	>12lb
9st	<6lb	6lb-13lb	>13lb
9st 4lb	<7lb	7lb-13lb	>13lb
9st 7lb	<7lb	7lb-13lb	>13lb
9st 11lb	<7lb	7lb-1st	>1st
10st	<7lb	7lb-1st	>1st
10st 4lb	<7lb	7lb-1st	>1st
10st 7lb	<7lb	7lb-1st 1lb	>1st 1lb
10st 11lb	<8lb	8lb-1st 1lb	>1st 1lb
11st	<8lb	8lb-1st 1lb	>1st 1lb
11st 4lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 7lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 11lb	<8lb	8lb-1st 3lb	>1st 3lb
12st	<8lb	8lb-1st 3lb	>1st 3lb
12st 4lb	<9lb	9lb-1st 3lb	>1st 3lb
12st 7lb	<9lb	9lb-1st 4lb	>1st 4lb
12st 11lb	<9lb	9lb-1st 4lb	>1st 4lb
13st	<9lb	9lb-1st 4lb	>1st 4lb
13st 4lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 7lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 11lb	<10lb	10lb-1st 5lb	>1st 5lb
14st	<10lb	10lb-1st 6lb	>1st 6lb
14st 4lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 7lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 11lb	<10lb	10lb-1st 7lb	>1st 7lb
15st	<11lb	11lb-1st 7lb	>1st 7lb
15st 4lb	<11lb	11lb-1st 7lb	>1st 7lb
15st 7lb	<11lb	11lb-1st 8lb	>1st 8lb
15st 11lb	<11lb	11lb-1st 8lb	>1st 8lb
16st	<11lb	11lb-1st 8lb	>1st 8lb
16st 4lb	<11lb	11lb-1st 9lb	>1st 9lb
16st 7lb	<12lb	12lb-1st 9lb	>1st 9lb
16st 11lb	<12lb	12lb-1st 9lb	>1st 9lb

VI MEDICAL ILLUSTRATION • NUTRITION & DIET • 12366/01.09.08

STORES ORDER CODE 41850

Falls Assessment Care Plan

Please tick all applicable nursing interventions

Action code	NURSING INTERVENTIONS	Date: / Ward:	Date: / Ward:	Date: / Ward:	Date: / Ward:	Date: / Ward:	Date: / Ward:	Date: / Ward:
1	Falls prevention and general safety precautions discussed with patient and family.							
2	Move to more observable area of ward to optimise supervision.							
3	Advise patient they may experience dizziness when they mobilise initially.							
4	Requires assistance with mobilisation.							
5	Observe trip hazard due to invasive lines, drains and catheters.							
6	Do not leave the patient unattended when using commode, toilet, in shower or the bathroom area.							
7	If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.							
8	Monitor lying and standing / sitting BP and pulse.							
9	A. Patient requires footwear or podiatry referral. (Date referred: / requested :) B. Request family / carer to provide suitable footwear.							
10	Commence continence assessment, follow Local Guidelines.							
11	Refer to Occupational Therapist.							
12	Select suitable seating (refer to policy).							
13	Non slip mat on chair /floor following advice from therapists.							
14	Refer to Physiotherapist.							
15	Review Transfer techniques.							
16	Request medication review.							
17	Bed/chair monitor in use.							
18	Falls map in use for seven days for patient who has second or subsequent falls.							
19	Bed rails/bumpers to be used (refer to policy).							
20	Patient requires low bed / mattress on the floor (refer to policy.)							
21	Patient requires one to one nursing care.							
22	Refer to Hospital Falls Prevention Co-ordinator (see criteria on front cover).							
23	Other interventions.							

Review Cannard score weekly / monthly as per policy. Enter action code(s) selected in action taken section on Falls Risk Assessment page above.

Cannard Falls Risk Assessment

Glossary of terms used in risk assessment

SIGHT DEFICIT means patient cannot see well even when wearing glasses or is registered blind.

HEARING DEFICIT means person has hearing problems even with a hearing aid or has hearing problems and does not wear a hearing aid.

BALANCE DEFICIT means person is unable to stand without the support of another person or a walking frame.

MEDICINES FOR SOME MENTAL ILLNESSES include Chlorpromazine (Largactil), Risperidone (Risperdal), Lithium (Camcolit or Priadel), Haloperidol, Chloral hydrate (Welldorm), Clomethiazole (Heminevrin), antidepressants, Diazepam, Lorazepam and Amitriptyline.

CARDIOVASCULAR SYSTEM MEDICATION all antihypertensive medication and inotropes including Captopril, atenolol and many others.

WATER TABLETS (DIURETICS) are such as Bendroflumethiazide, Furosemide and Co-amilofruse.

SEDATIVES / ANALGESIA AT NIGHT include medicines such as Diazepam, Temazepam, Nitrazepam, Chlordiazepoxide and Zopiclone (Zimovane) Morphine PCA, Fentanyl, Tramadol and Oxycontin.

INABILITY TO CO-OPERATE includes failure to use walking aids or putting themselves in situations with a high risk of falling (usually due to mental impairment).

RESTRICTED MOBILITY means the person requires supervision and/or help to walk (i.e. is not safe to walk alone even with an aid).

HESITANT IN INITIATING MOVEMENT means difficulty in starting to walk.

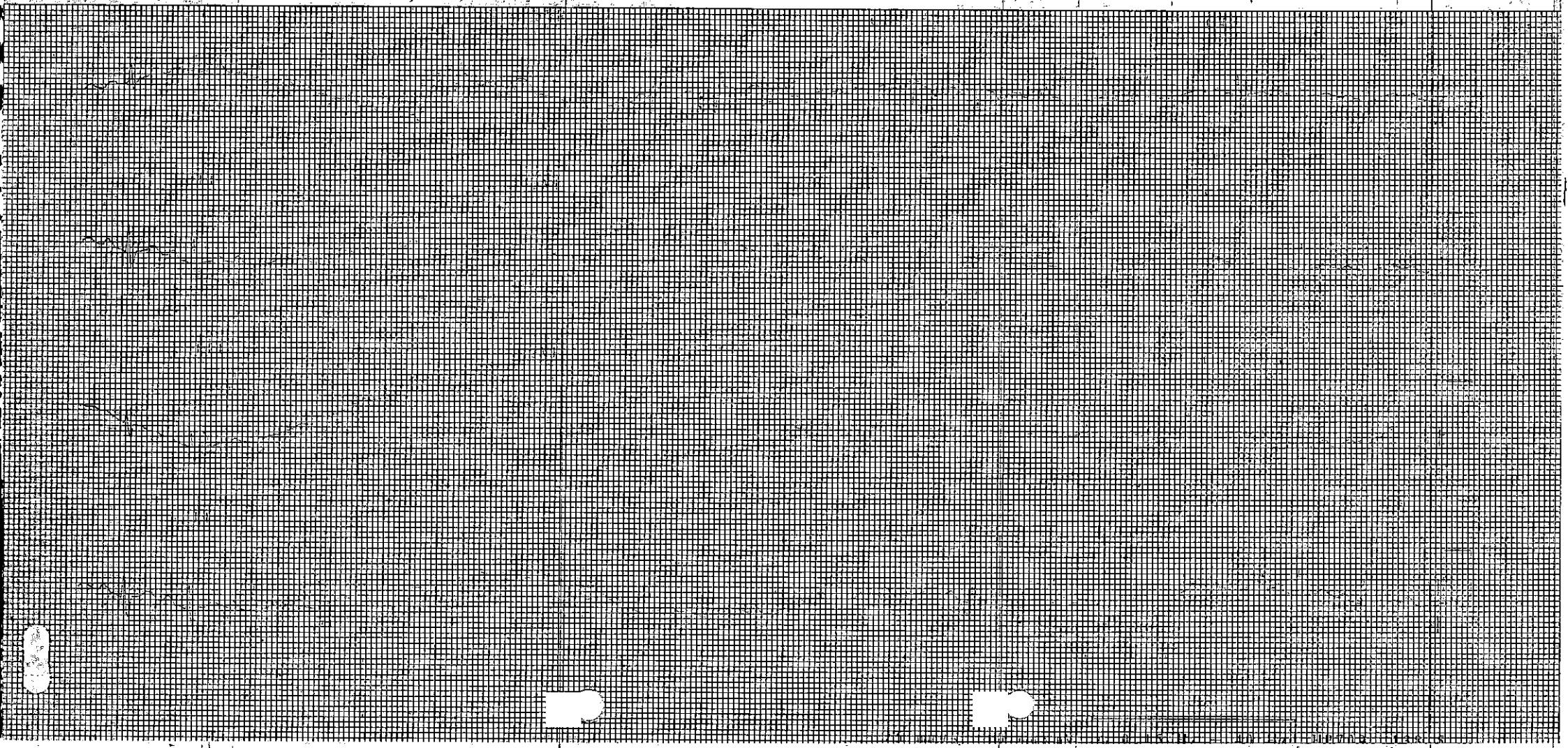
POOR TRANSFER means the person requires help and is not safe to do the following alone - get in or out of bed, on or off a chair, move from chair to standing.

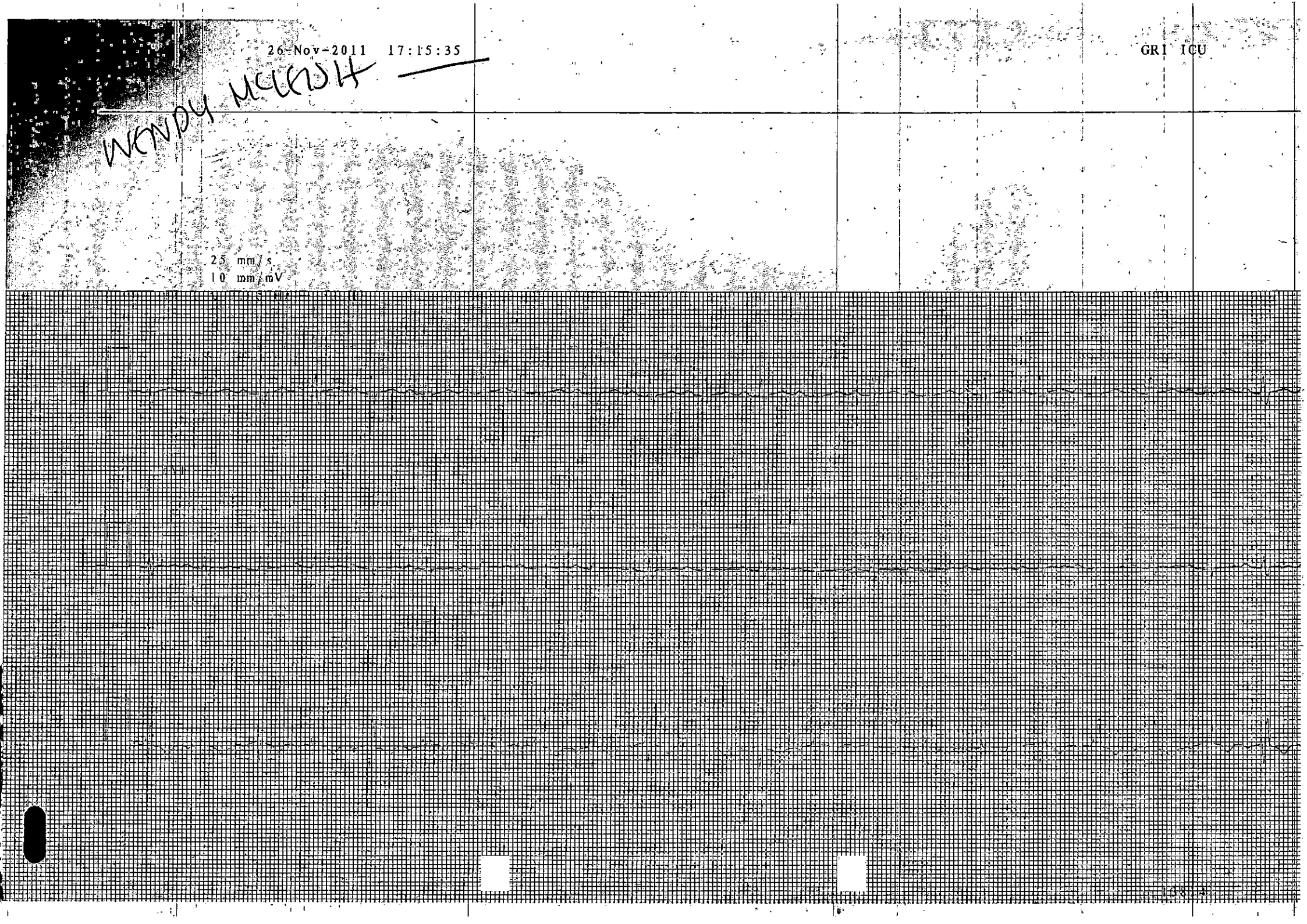
26-Nov-2011 23:11:18

GRI ICU

Rate	123
PR	165
QRSD	83
QT	263
QTc	376
--Axis--	
P	55
QRS	8
T	33

23123532V
MCLEISH
WENDY
CHI-2505876061

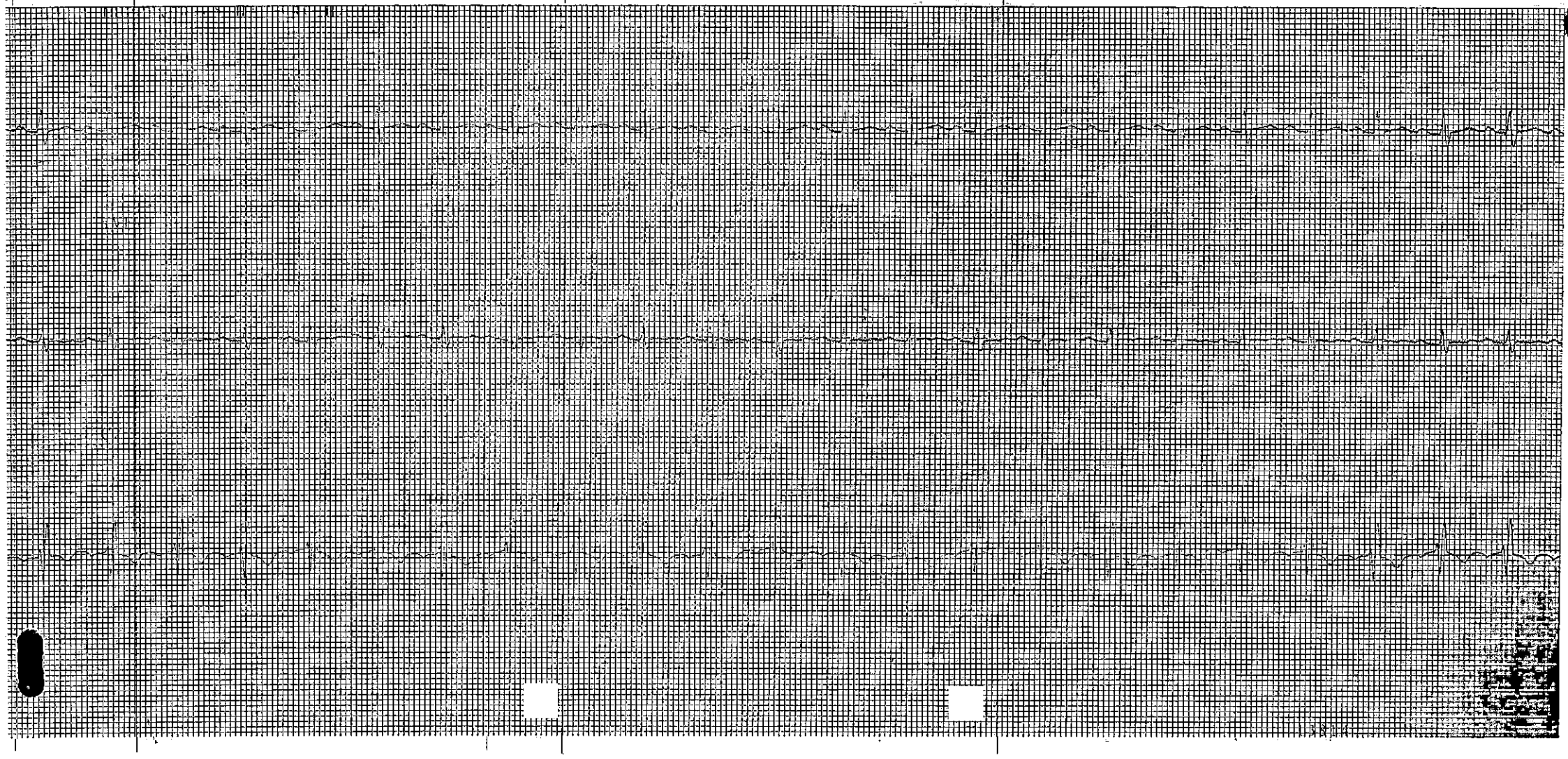


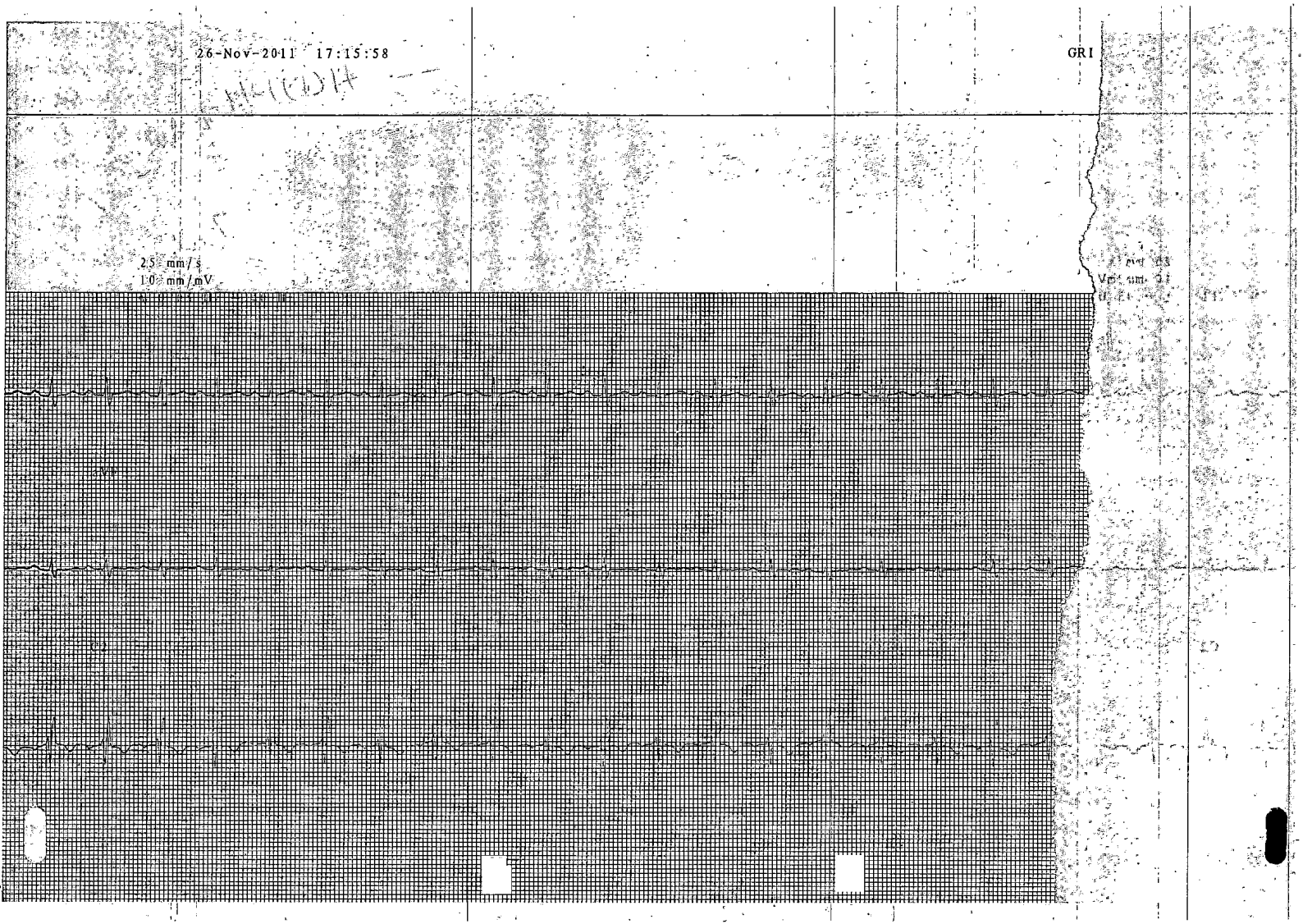

26-Nov-2011 17:15:35
WENDY MCCASH
GRI ICU
25 mm/s
10 mm/mV

26-Nov-2011 17:15:46

GRI ICU

2.5 mm/s
10 mm/mV



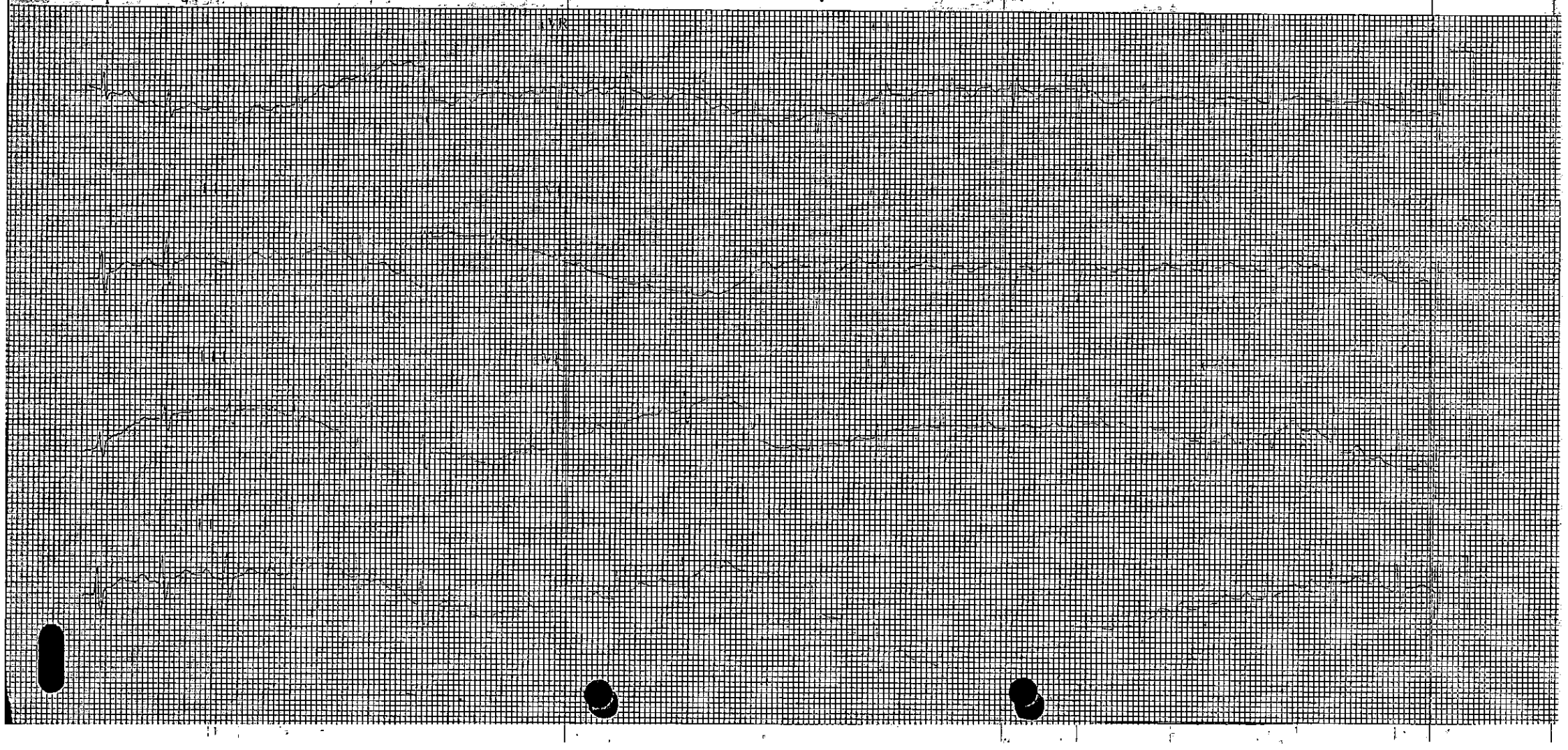

26-Nov-2011 17:15:58
GRI
25 mm/s
10 mm/mV

26-Nov-2011 23:12:23

GRI ICU

Rate	123
PR	167
QRSD	86
QT	264
QTc	377
--Axis--	
P	59
QRS	31
T	41

23123532V
MCLEISH
WENDY
CHI-2505876061



24-Nov-2011 00:51:27

GRI ICU

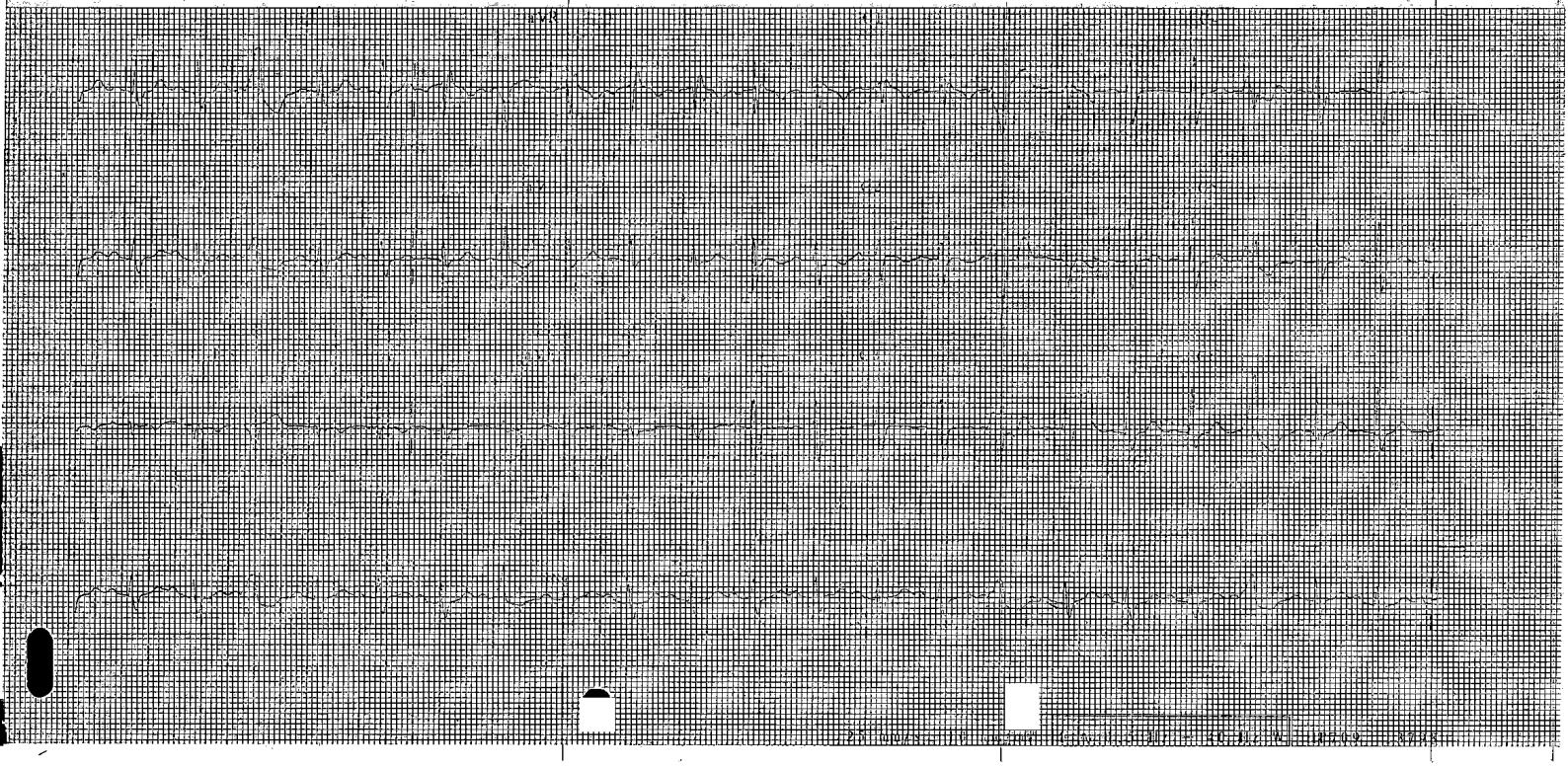
23123532V
MCLEISH F
WENDY 25/05/1987
0/1 51 COXTON PLACE

GLASGOW G33 5EJ
CHI-2505876061

Rate	127
PR	155
QRSD	100
QT	262
QTc	381

--Axis--

P	30
QRS	-47
T	3



NHS GREATER GLASGOW & CLYDE

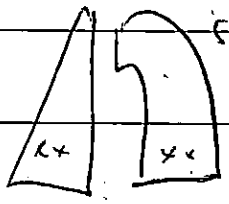
CLINICAL NOTES

23123532V
MCLEISH F
WENDY 25/05/1987
0/1 51 COXTON PLACE
GLASGOW G33 5EJ
CHI-2505876061

Date	H@N GPST SHO on call	Signature	Print
20/12/11	ATSP Re: step down from ICU to ward 7/16		
2335	Complex admission.		
	24 ♀ Depression hx of cocaine snorting † DSH anxiety.		
	E/A on 20/11/11 with 4/7 hx of SOB/diarrhoea + chest discomfort.		
	Rx for CAP → T/F to ITU on 21/11/11 for ongoing respiratory		
	failure requiring ventilation ± meropenem/vancomycin		
	Negative microbiology/virology		
	Neg HIV/hepatitis screen. CT chest 27/11/11 → widespread consolidation of both lungs. ± (R) pleural effusion ↳ too small to tap		
	+ve TnT 1·63 on 30/11/11.		
	Worsening gas exchange in ITU ± ↓ urinary volumes		
	↳ required haemodialysis.		
	* T/F to Glenfield, Leicester for ~~ECMO~~ ECMO		
	↳ methylpred. + azithromycin for lung remodelling as per ECMO protocol - now finished		
	- Repatriation from Glenfield, off ventilator ± ~~needing NIV~~ and despite ↑RR able to tolerate well off ventilation		
	- Noted to have been ↑ tachypnoeic + tachycardic throughout admission →		

193443

120/80

Date		Signature	Print
	O/E BP ~~10H/8E~~ Sats 97% on 28% O_2		
	P103bpm reg RR28. (prev. >35)	Trached in place	
	No verbal response but able to fully comprehend		
	+ follow ~~intact~~ commands.	At times coughing ++.	
		± some expectoration	
	 ~~somewhat~~ crepts	HS I+II+0	
		JVP ↩.	
		leg shakings on bilat	
	ABDO SNT		
	BS active		
	Urine vols (catheter in situ)		
	↳ pass good volumes at present		
	↳ concentrated +.		
	NG tube in place. - feed running at 65mls/hr		
	On veg oramorph → helps agitation		
	+ diazepam. → to be reviewed to ↓		
	Plan ~~background~~ NEx Titre O_2 ↓.		
	Suction if any ↑ expectorant causing		
	respiratory compromise		
	Watch U/O → if ↓, for background IVF - at		
	present NG feed running ± fluid bolues.		
	prn diazepam/oramorph - pain		
	↳ agitation		
			OTEN #1025//

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES

23123532V
MCLEISH
WENDY F
25/05/1987
0/1 51 COXTON PLACE
GLASGOW G33 5EJ
CHI-2505876061

Date		Signature	Print
21/12/M	wk		
	24 yo ♀ +/- hx ITU		
	- Admitted 19/12/M c/ sepsis CAP		
	→ ITU (severe resp failure		
	→ Glenfield for ECMO		
	ARF → HFO,		
	Sedated, ventilated, tracheostomy, NG feed.		
	Currently:		
	Agitated		
	Tracheostomy in situ → responds to		
	follows commands.		
	→ FiO2 28%		
	Chest clear.		
	Abdo soft.		
	U&Es also since tracheostomy: ? dysnatraemia		
	- TFTs (not initially).		
	(P) Liver screen + USS.		
	Check RNF re discharge + U&Es.		
	If agitation at the end, to consider d/c		
	diazepam / clonidine / quetiapine over		several days

193443

Date		Signature	Print
	Trache care - via Outreach CC team		
	Cont NG feeding.		
	Am to MS review.		
		CMO- ward copy	
21.12.11	Critical Care Outreach - Trache visit.		
11:26	A - Size 7.0 double lumen fenestrated cuffed (deflated) tracoe tracheostomy		
	B - SpO_2 98% on 28% Humidified O_2 via trache mask. RR 29. Thick purulent moderate secretions on suction.		
	C - BP 115/79 P 94. UOP good. NG feed continues.		
	D - E4 V_T M_6. Apyrexial.		
	Suggest:- Regular trache care as per GGT Trache guidelines.		
	- 1-2 hrly inner cannula trache check and document		
	- Repeat tracheal aspirate for CTS please		
	- Consider saline nebs for	contd	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES

23123532V
MCLEISH F
WENDY 25/05/1987
0/1 51 COXTON PLACE
GLASGOW G33 5EJ
CHI-2505876061

Date		Signature	Print
21/12 cont'd	thick secretions – No spare tracheostomy tubes sent with Wendy on d/c from ITU, datix to be completed by OR team. Size 4, 6 + 8 Shiley spare tracheostomy left with tracheostomy tracheostomy can be located Will visit tomorrow, Wendy is not quite ready for speaking valve due to ++ secretions. Any concerns please radiopage (91) 07623603702.		O'Neill CN
15.10 22/12/11	CRITICAL CARE OUTREACH Sao_2 95% on 28% humidified oxygen via tracheostomy mask. Respiratory rate 20 bpm. Moderate haemonuscoid secretions on suctioning Inner cannula clean. Size 6+7 Tracoe Tubes left as spares in box. HR – 120bpm BP – 114/85 T – 36.8 MEWS 2. Good urine output Awake & orientated		

193443

Date		Signature	Print
cont'd	- Check inner cannula 2-4hrly + chart		
	- Suction as required		
	- Finger occlusion applied for 30-60secs and managed well, coughing using vocal cords		
	- ? try speaking valve tomorrow.	LBarrie 07623 603702	RGN LBARRIE
23/12/11	DIETETIC R/V.		
	Cont's on NG feeding,		
	suggest gradually tiny rate		
	of feed to allow rest		
	period. Note Mg ↓ - please		
	replace. Cont ↑ rate 65mls/hr		
	x 24° (1500mls Nutrison		
	multifibre) today. ↑ rate 80mls/hr		
	x ~19° on 24.12.11. + ↑ 100mls/hr		
	x 15° on 25.12.11.		
	If up to sit please check WT.		
	to r/v nxt wk ~ 28/12/11. Dr.	K LOCHRANE.	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - ~~NURSING~~

23123532V
MCLEISH F
WENDY 25/05/1987
0/1 51 COXTON PLACE
GLASGOW G33 5EJ
CHI-2505876061

Date & Time		Signature, Print Name & Designation
23/12/11	ward moving / F42 Leadbeater	
	ISAS	
	1. CAP Required ~~and~~ ECMO	
	2 ITU - prolonged stay	
	3. Liver dysfunction - steady, live u/s yesterday	
	4 Tracheostomy - on speaking valve	
	5. NG feeding - dietician	
	6. Tremulous - persistant and longstanding	
	7. Previous renal dysfunction - required haemodialysis now improved	
	8. Previous panic attacks - improved by diazepam	
	Good cough, using speaking valve	
	Cancious + responsive but not much communication	
	Denies pain, nausea, SOB.	
	Uncomplaining but is feeling 'weird'.	
	Refused bloods today - will try late	
	Urine output good	
	HR 100 BP 101/70 T 36.0°C RR 22 Sats 98% SL+NC	
	CRP 25 WCC 12.0.	
	(P) continue as above.	
	Urinalysis given slight ↑WCC/CRP	
	check LFTs over weekend	
	weekend r/v.	
		Leadbeater F42

193443

Date & Time		Signature, Print Name & Designation
23/12/11 1305	CRITICAL CARE OUTREACH SaO_2 98% on 28% humidified oxygen via trachy mask. Respiratory rate 22bpm. Good strong cough, expectorating haemo-mucoid secretions. Inner cannula cleaned and replaced, coated with secretions. Tried of speaking valve tolerated for 8 mins - attempting to vocalise although voice weak. Cardiovascularly stable. Awake & orientated Suggest - check & clean inner cannula 2-hrly & chart - Try speaking valve later under supervision - Blue Dye WST by Outreach Team tomorrow.	LBARRIE- RGN Norland Bank 07623603702
24.12.11 1215	Critical Care Outreach → (A) Missing inner fenestrated tube. Have inserted one from spare tracheé size 7.0. If tracheé comes out for any reason remember fenestrated tube to be Repr. Inner tube thick with secretions, cleaned as per guidelines now in pot clearly labelled (not to discard) with patient details. Fenestrated in situ. (B) RR 20bpm, SpO_2 97%. Moderate mucoid secretions, slightly blood stained on tracheal suctioning. Strong cough. Good voice on finger occlusion. Swallowing test performed - passed 24.12.11 @ 1130hrs. Can have sips of fluid under close supervision - when if no issues soft diet. Try speaking valve when visitors in.	P.TO → RGN

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - NURSING

23123532V
MCLEISH F
WENDY 25/05/1987
0/1 51 COXTON PLACE
GLASGOW, G33 5EJ
CHI-2505876061

Date & Time		Signature, Print Name & Designation
24.12.11 Contd	(C) Cardiovascularly stable, passing urine. (D) GCS 15/15. Plan review in 24hrs unless issues radiopage (91) 07623603702. Suggest → very close supervision with fluids & soft diet if appropriate. (Passed NST) May need to be closer to nursing station for safety (tracheostomy + observations) Issues re: n/g tube. Unsure if had migrated our. pH 5.0 - advanced now @ 62cm. pH remains 5.0. According to correct n/g tube placement policy pH ≤ 5.5 suggests correct tube placement. If any doubt recheck before commencing feed. Requires feed until normal diet established. Try speaking valve later with visitors. Document on back of careplan duration in place if appropriate. If tires, ↑ secretions remove to rest. Do not leave on overnight. Check inner cannula at least 2° initially for secretions to avoid tube occlusion. If any coughing/choking with oral intake repeatedly then place back on NBM. EGN R.Weir	
24/12	CAR4a Slow but steady progress. Gen/cardiovascularly stable. Trach o/g. Afebrile → Down titrate BZD/clonidine → Stop IV metronidazole (? only started yesterday ?) → CXR to review LFTs - probably slowly deranging	

193443

Date & Time		Signature, Print Name & Designation
23.12.11 1030	Critical Care Outreach → Trache as before, patient: Tolerating speaking valve. Continues on fluids & soft diet. NJ tube remains in situ. Continue trache care as per NHS GG+C guidelines Good cough, expectorate sligurly blood stained. Hb 103 on 22-12-11. Will review in 24hrs. Plan to trial without O2 if appropriate with buchanan bib for humidification	RGN K. Weir
	25/12/11 Seen beforehand CNN no agitation (leg / wrist / physical all agitation) CCU. EEMO - Handwriting Discharge CCU to ward 7/6 on 26/12/11	
	WBC 22 (H: N) CRP 15. CRP P. Hb 103 EOS 0.6 (Peak 1.3 on 19/12/11)	
	O/E appears comfortable. not anxious or agitated - Looks calm. Writing and Cog - not unable perhaps decreased scheme. rigidity & persistent and I think involuntary - he does not need other agency. → Neuro opinion need and + document if writing stops when asleep.	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - ~~NURSING~~

23123532V
MCLEISH F
WENDY 25/05/1987
0/1 51 COXTON PLACE
GLASGOW G33 5EJ
CHI-2505876061

Date & Time		Signature, Print Name & Designation
26/12/11	STR - Team review on ward → N/S report that she's stop altogether when in a deep deep. - No temps - No bloods are weekend (? refusing) - Now getting up and using commode Plan: - Re-check bloods - Neuro review later this week	
27-12-11 11.45 am	Outreach Review - tracheostomy as before. SpO_2 100% on 28% humidified O_2 therapy thereafter O_2 therapy stopped SpO_2 97% on Room Air. Buchanan Bib insitu to aid humidification. Moderate mucoid secretions on suctioning. GCS 15 with Speaking Valve insitu. Patient eating / drinking as charted. Suggest - Continue regular tracheostomy care, continue regular Saline nebulisers, keep buchanan bib insitu if patient remains on room air, if $SpO_2 \leq 95\%$ consult medical staff and recommence humidified O_2 therapy. Encourage patient to use speaking valve. If any concerns arise contact outreach (91) 07623~~63762~~. If any Immediate concerns contact ICU.	M. PARKER

193443

Date & Time		Signature, Print Name & Designation
27/11/11	CARLA Continued satisfying progress Team ward life mediations — reasonable to continue to wean (slowly, patiently, sensitive) + liaise re of any plans, advise on	
12/11 1530	Critical Care Outreach (tracheostomy visit) tracheostomy as before patient meets decannulation criteria therefore we will visit tomorrow morning and decannulate if the multi disciplinary team agree: 07623 [illegible]	A. McCafferty C/S
28/12/11	Complete fix on above - ITU admission Resp failure. CAP - Rx'd CXR and CRVIT. - Late (M). Also UTI - Critical illness. CRP 9. - Plan for decannulation today. - Swift down - Throat swab + ve. Monitor progress - anaesthetic	[illegible]

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - NURSING

23123532V 25/05/1987
WENDY MCLEISH
0/1 51 COXTON PLACE
GLASGOW
G33 5EJ CHI-2505876061

Date & Time		Signature, Print Name & Designation
28.12.11	Critical Care Outreach (tracheostomy)	
	Patient remains stable on room air decannulated without incident. Sats 95% on room air vocalising well, tracheostomy site dressed with tegaderm & sterile swab. Please monitor wound healing and re-dress with occlusive dressings as required. Will review again tomorrow if any concerns please page (91) 07623605802	A. McGeffery RGN.
29/12/11	DIETETIC RIV:	
	NAD out, now taking normal diet & no problems.	
	Pt reports appetite good & keen to eat & drink.	
	PLAN	
	1. Cont diet, regular meals & snacks.	
	2. Additional full cr. milk.	
	3. Cont food intake chart	
	4. WT check (pt self reports ^ long).	
	will F/U ~ 1 IWK.	Dr. K COCHRANE
29/12/11	Addenbrooke's	
	Thanks for referral. Patient seen & discussed with Consultant. Illicit drug misuse prior to admission. Drinks at weekends only. Approx 10-12 units over Fri/Sat. Previously known to CAT 2005.	

193443

Date & Time	Addictions contd 418 4943	Signature, Print Name & Designation
28/12/11	Plan ① Suggest ↓ diazepam as per plan slowly	
	② Would desire feel she needs any input from addictions team at present	
	③ Any problems please call us to come back & see	CPN4/Ward 4
29/12/11 1330	FY(1) LANG	
	D/N Neurology ([redacted]), [redacted] 7536	
	Unable to speak to medical staff except city cover. Recommended speak to Dr Shah's Secretary who suggested faxing # 24741 with referral letter. Dr Shah's Secy at GRI (# 24481) had no answer.	
	Faxed letter (in notes) and will await R/V as instructed	LANG FY(1) 3932
29/12	LTR RV Jonasson	
0	(24) Severe CAP → Resp. Failure	
	ITU → intubated	
	Transfer to Leicester for ECMO 30/11 – 7/12	
	CVVH	
	Tracheostomy 2/12	
	ITU Stepdown 20/12/11	
	Now decannulated – see note yesterday – voice returned	
	Working c PT → using ZF on ward	Denies falls. Feels unsteady
	Ongoing involuntary twitching	
	Note declined addictions team input	
	Has refused bloods (again) Has capacity.	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - NURSING


23123532V
MCLEISH
WENDY
CHI-2505876061

Date & Time		Signature, Print Name & Designation
cont.	Awaite neurology r/v / advice (letter faxed yesterday) ↓ diazepam / oramorph doses ↳ keep under review.	J O'Hara CT2 (1253)
29-12-11 1040	~~FYI Deadbeat Ward~~ CRITICAL CARE OUTREACH	
29/12/11 11.10.	No problems since decannulation yesterday. Observations stable. Dressing intact to stoma site - change daily or as required Contact CCO on 07623603702 if any queries/issues.	LBARRIE-RGN Lorraine Barrie
30/12/11	NEURO CONS (MILLER)	
	Hx of recent critical illness noted. Patient with nurses having wash - not assessed from outside room → tremor looks odd, fluency severity + frequency appears distractible. Activity in legs + nowhere else. I will come back next week to assess + please do tremor/movement disorder screen ↳ TFTs, U+E, LFTs, CRP, glucose, Bone Profile, Copper Studies, Urine Copper, Iron studies, B12, Folate ABG, ESR, Blood film, Vasculitis Screen. ↳ Cont for Huntingdons Genetics (Women + movement disorder) Would be good to get a idea of what tremor does during course of day - ? at distraction i.e. ↓ when active	

193443

Date & Time		Signature, Print Name & Designation
	or does it vary during bolus or after incapsing/thaw.	
	Does it interfere with neuro-obs.	
	Will return next Friday to review again	
		Consultant
10-12-11 1420	F42 leadbeater WIR	
	(1) CAP requiring ECHO + ITU	
	(2) tracheostomy revised	
	(3) MOVEMENT disorder/tremor - reviewed by neurology earlier today who will see again next week	
	Note above questions + requests from neurology - Wendy currently refusing bloods ~~neurology~~. Discussed with her today - unreliable now.	
	looks and feels well. Says that has only had tremor since been on ward 7/16 - however referral from GP in 2009 to neurology for ?ECT	
	(P) bloods await neuro review continue	
		Leadbeater #1243 F42

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES ~~NURSING~~

MISS W MCLEISH

0/1 51 COXTON PLACE

GLASGOW

G33 5EJ

Date & Time	F42 Leadbeater	Signature, Print Name & Designation
2-1-12	Wendy wishes to Irregularly discharge today - "bored of depressing ward"	
	I have explained that she was very unwell previously and should remain in hospital to complete Rx (i.e. neuro for tremor)	30-12 Bili 19 (26) AST 23 (32) ALT 61 (111) GGT 235 (348) ALP 217 (315) CRP 3.2 (9.6)
	She is adamant she wishes to go (H).	U+E (N)
	I explained risks - i.e. of getting worse, becoming as unwell as she was.	Cal 2.63 (↑) phos 1.64 (↑)
	She states her tremor is 2° to drugs we gave her.	TFTs (N) Mg^{2+} 0.66 (↓)
	States she will not use zimmer.	Hb 11.0 (10.0) WCC 7.7 (9.3)
		Plts 500 (334) lymphocytosis
	Ideally she should have flu in 4-6 weeks but I feel she may not attend.	
	I informed D/ Cara Tweed ST3 of this - he will talk to her.	
		C Leadbeater M2 #1243

193443

Date & Time		Signature, Print Name & Designation
2/1/14 1350	WILSON GPST1	
	Reviewed on behalf of Dr Tweed. History noted. Still wishes to self-discharge. Ms McLeish has capacity + competence to make this decision. She is orientated, understands why she is in hospital and the risks involved with an unplanned discharge. Specifically I discussed that she is awaiting review of a tremor by the neurologists and although she plans to do this via her GP there may be an unfortunate delay with this referral pathway. I explained that prescribed medications cannot be supplied as the pharmacy is now closed. I mentioned my concerns regarding her mobility, risk of falls and injury and potential readmission to hospital.	
	Discharge against medical advice/ refusal of treatment form signed.	WILSON GPST1 3336

HEART LINK ECMO CENTRE
GLENFIELD HOSPITAL

DISCHARGE SUMMARY

Hold on to our hearts

OurRef S2664312 Leicester11/12/11
DOB 25/05/1987

To whom it may concern,

Re: Wendy McLeish
1/1 51 Coxton PL
Glasgow G33 53EJ

Date of admission: 30/11/2011 **Date of discharge**: 12/12/2011

Diagnoses: **ARDS Pneumonia**

Procedures:

VV- ECMO run 30/11/11 to 07/12/11
Percutaneous tracheotomy 02/12/11 (# 7.0)

Background: Ms. Wendy McLeish was referred from Glasgow Royal Infirmary. She is a Cocaine smoker and suffers from anxiety and depression .

She was presented to Glasgow A+E on the 20th November with 4 days of SOB, chest pain, hypotensive and confused.

On the admission:
Her 02-saturation was 83% with 100% FiO2. She was intubated on 23rd and ventilated and transferred to the intensive care unit. From the beginning it has been difficult to achieve adequate oxygenation.

She was started on Co-Amoxicillin and Clarithromycin, the 28th on Tazocin , meropenem and vancomycin. She is HIV, HCV ,H1N1 negative.

On 30/10/11 she was referred for ECMO support. When She arrived in Glenfield Hospital ,transferred by Glasgow transport team without a discharge letter.

She was cannulated for VV-ECMO on the 30th November at 19:17 by the Glenfield ECMO team with a double lumen 31 Fr s cannula via the RIJV . a new quadrilumen CVC was inserted in the RFV. Ecmo support was started, reducing the pressure ventilation setting.

CVVH via vascath in LFV was started for decreased urine output.

Her initial CRP was 232 and he was continued with Meropenem, Tazocin and Fluconazole.

Tracheostomy performed on the 2nd November with size 7.0 TRACOE (percutaneous).

CXR showed bilateral consolidation R>L on 3th November,

Steroid and Azithromycin were commenced on the 5th November .

Weaning from ECMO support reducing flow and sweep flow, she was decannulated on 7th November.
CVVH DF treatment was stopped on the 9 November, but her Creatinine and Urea were increasing, she has a good urine output with 0.2 ml/h Furosemide (250mg/25ml)

Neurologically she is good, awake, respond to stimuli .
Weaning from the ventilation Ms McLeish is still on CPAP (PEEP 8 and ASB 1FiO2 35%
Haemodynamically she is stable with BP 148/88 mm Hg, HR= 96 bpm in SR. SpO2 96%.
Good A/E in both lungs with some crepitations more on the R lung
NGT feeds with Nutrison 57ml/h .
Fluid balance over the last 24 hrs was negative – 1123mls Abdomen soft.

Medication:

Meropenem	500mg	iv	qds
Fluconazole	400mg	iv	bd
Linezolid	600mg	iv	bd
Omeprazole	40mg	iv	bd
Deltaparin	2500 U	sc	od
Fluoxetine	40mg	ng	od
Clortrimazole 1% cream			
Clonidine	50 mcg	ng	tds
Azithromycin	40mg	ng	od
Doxazocin	2mg	ng	od
Pabrinex	1 pair	iv	od

Morphine 4ml/h (60mg/60ml)

Midazolam	4ml/h	(50mg/50ml)
Furosemide	0.2ml/h	(250mg/25ml neat)
Methylprednisolon	2 ml/h	(125mg/48 ml)
Actrapid	3 ml/h	(50 unit/50 ml)

Please do not hesitate to contact the ECMO Fellow on-call if you have any queries.

Her previous CXRs have been copied on a CD. Please find last few days blood result's printout attached.

Yours sincerely,
Dr. Giuseppe Pelella
CT / ECMO Fellow

Patient Name	Gender	D.O.B	Hospital No
MCLEISH, WENDY	F	25-May-1987	PIMS S2664312

10-Dec-2011 17:00 Liver Function Test (LFT)

	Result		
Laboratory Sample Number			
CP653384C			
Alanine Transaminase (ALT)	199	H	[2-53 iu/L]
Total Bilirubin	17		[0-21 umol/L]
Overall Date Resulted			
10/12/2011 18:48:00			

10-Dec-2011 17:00 Bone Profile (Serum)

	Result		
Laboratory Sample Number			
CP653384C			
Albumin	37		[35-50 g/L]
Adjusted Calcium	2.40		[2.2-2.6 mmol/L]
Inorganic Phosphate	2.11	H	[0.8-1.5 mmol/L]
Alkaline Phosphatase	135	H	[30-130 iu/L]
Overall Date Resulted			
10/12/2011 18:48:00			

10-Dec-2011 17:00 Magnesium

	Result		
Laboratory Sample Number			
CP653384C			
Magnesium	1.02	H	[0.7-1.0 mmol/L]
Overall Date Resulted			
10/12/2011 18:48:00			

10-Dec-2011 17:00 Total Protein

	Result		
Laboratory Sample Number			
CP653384C			
Total Protein	63		[60-80 g/L]
Overall Date Resulted			
10/12/2011 18:50:00			

10-Dec-2011 17:00 Gamma-GT (GGT)

	Result		
Laboratory Sample Number			
CP653384C			
Gamma-GT (GGT)	267	H	[0-35 iu/L]
Overall Date Resulted			
10/12/2011 18:50:00			

Patient Name	Gender	D.O.B.	Hospital No.
MCLEISH, WENDY	F	25-May-1987	PIMS S2664312

10-Dec-2011 17:00 Chloride

			Result
Laboratory Sample Number			
CP653384C			
Chloride	94 L	[95-108 mmol/L]	
Overall Date Resulted			
10/12/2011 18:50:00			

10-Dec-2011 17:00 Coagulation Screen plus Fibrinogen

			Result
Laboratory Sample ımber			
CP653384C			
R	1.1		
PTT	27.2	[25.0-35.0 Secs]	
APTT Ratio	0.9		
Fibrinogen	3.0	[2.0-4.0 g/L]	
Overall Date Resulted			
10/12/2011 20:17:00			

10-Dec-2011 17:00 Prothrombin Time (PT)

			Result
Laboratory Sample Number			
CP653384C			
Prothrombin Time (PT)	14.2	[12.0-15.0 Secs]	
Overall Date Resulted			
10/12/2011 20:17:00			

Patient Name	Gender	D.O.B	Hospital No.
MCLEISH, WENDY	F	25-May-1987	PIMS S2664312

11-Dec-2011 06:28 Full Blood Count — **Result**

Laboratory Sample Number CP653443K			
White Blood Cell Count	7.1		[4.0-11.0 x10*9/L]
Red Cell Count	4.27		[3.90-5.60 x10*12/L]
Haemoglobin	12.9		[11.5-16.5 g/dL]
Haematocrit	0.380		[0.370-0.470 L/L]
Mean Cell Volume	89		[80.0-99.0 fl]
Mean Cell Haemoglobin	30.4		[27.0-32.0 pg]
Platelet Count	331		[140-400 x10*9/L]
Neutrophil Count	4.99		[1.50-7.50 x10*9/L]
Lymphocyte Count	1.41		[1.00-4.00 x10*9/L]
Monocyte Count	0.60		[0.2-0.8 x10*9/L]
Eosinophil Count	0.02	L	[0.04-0.40 x10*9/L]
Basophil Count	0.03		[0.02-0.10 x10*9/L]
Nucleated Red Blood Cells.	<0.20		[0.00-0.20 x10*9/L]
Overall Date Resulted 11/12/2011 07:33:00			

11-Dec-2011 06:28 Urea & Electrolytes — **Result**

Laboratory Sample Number CP653443K			
Sodium	133		[133-146 mmol/L]
Potassium	5.8	H	[3.5-5.3 mmol/L]
Urea	36.5	H	[2.5-7.8 mmol/L]
Creatinine	280	H	[60-120 umol/L]
GFR (MDRD)	19		[mL/min]

Important information relevant to this test, please click to expand:
Multiply eGFR by 1.21 if Afro-Caribbean.
See www.emrn.org.uk website.

Overall Date Resulted
11/12/2011 08:11:00

11-Dec-2011 06:28 Amylase — **Result**

Laboratory Sample Number CP653443K			
Amylase	153	H	[30-110 iu/L]
Overall Date Resulted 11/12/2011 08:11:00			

Patient Name	Gender	D.O.B	Hospital No.
MCLEISH, WENDY	F	25-May-1987	PIMS S2664312

11-Dec-2011 06:28 Liver Function Test (LFT)

	Result	
Laboratory Sample Number		
CP653443K		
Alanine Transaminase (ALT)	166 H	[2-53 iu/L]
Total Bilirubin	15	[0-21 umol/L]
Overall Date Resulted		
11/12/2011 08:11:00		

11-Dec-2011 06:28 Bone Profile (Serum)

	Result	
Laboratory Sample Number		
CP653443K		
Albumin	35	[35-50 g/L]
Adjusted Calcium	2.38	[2.2-2.6 mmol/L]
Inorganic Phosphate	2.34 H	[0.8-1.5 mmol/L]
Alkaline Phosphatase	119	[30-130 iu/L]
Overall Date Resulted		
11/12/2011 08:11:00		

11-Dec-2011 06:28 Magnesium

	Result	
Laboratory Sample Number		
CP653443K		
Magnesium	0.97	[0.7-1.0 mmol/L]
Overall Date Resulted		
11/12/2011 08:11:00		

-Dec-2011 06:28 Total Protein

	Result	
Laboratory Sample Number		
CP653443K		
Total Protein	64	[60-80 g/L]
Overall Date Resulted		
11/12/2011 09:40:00		

11-Dec-2011 06:28 Gamma-GT (GGT)

	Result	
Laboratory Sample Number		
CP653443K		
Gamma-GT (GGT)	238 H	[0-35 iu/L]
Overall Date Resulted		
11/12/2011 09:40:00		

Patient Name	Gender	D.O.B	Hospital No.
MCLEISH, WENDY	F	25-May-1987	PIMS S2664312

11-Dec-2011 06:28 Coagulation Screen plus Fibrinogen — Result

Laboratory Sample Number: CP653443K

INR	1.1	
APTT	27.0	[25.0-35.0 Secs]
APTT Ratio	0.9	
Fibrinogen	2.6	[2.0-4.0 g/L]

Overall Date Resulted: 11/12/2011 08:03:00

11-Dec-2011 06:28 Chloride — Result

Laboratory Sample Number: CP653443K

Chloride	93 L	[95-108 mmol/L]

Overall Date Resulted: 11/12/2011 09:40:00

11-Dec-2011 06:28 C-Reactive Protein — Result

Laboratory Sample Number: CP653443K

C-Reactive Protein	14 H	[0-10 mg/L]

Overall Date Resulted: 11/12/2011 08:11:00

11-Dec-2011 06:28 Prothrombin Time (PT) — Result

Laboratory Sample Number: CP653443K

Prothrombin Time (PT)	14.1	[12.0-15.0 Secs]

Overall Date Resulted: 11/12/2011 08:03:00

11-Dec-2011 15:45 Coagulation Screen plus Fibrinogen — Result

Laboratory Sample Number: CP653539V

INR	1.1	
APTT	27.0	[25.0-35.0 Secs]
APTT Ratio	0.9	
Fibrinogen	2.5	[2.0-4.0 g/L]

Overall Date Resulted: 11/12/2011 17:03:00

Patient Name	Gender	D.O.B	Hospital No.
MCLEISH, WENDY	F	25-May-1987	PIMS S2664312

11-Dec-2011 15:45 Full Blood Count

	Result		
Laboratory Sample Number			
CP653539V			
White Blood Cell Count	9.5		[4.0-11.0 x10*9/L]
Red Cell Count	4.54		[3.90-5.60 x10*12/L]
Haemoglobin	13.3		[11.5-16.5 g/dL]
Haematocrit	0.401		[0.370-0.470 L/L]
Mean Cell Volume	88		[80.0-99.0 fl]
Mean Cell Haemoglobin	29.3		[27.0-32.0 pg]
Platelet Count	405	H	[140-400 x10*9/L]
Neutrophil Count	7.17		[1.50-7.50 x10*9/L]
Lymphocyte Count	1.64		[1.00-4.00 x10*9/L]
Monocyte Count	0.65		[0.20-0.80 x10*9/L]
Eosinophil Count	0.00	L	[0.04-0.40 x10*9/L]
Basophil Count	0.03		[0.02-0.10 x10*9/L]
Nucleated Red Blood Cells.	<0.20		[0.00-0.20 x10*9/L]
Overall Date Resulted			
11/12/2011 16:55:00			

11-Dec-2011 15:45 Urea & Electrolytes

	Result		
Laboratory Sample Number			
CP653539V			
Sodium	133		[133-146 mmol/L]
Potassium	6.0	H	[3.5-5.3 mmol/L]
Urea	40.9	H	[2.5-7.8 mmol/L]
Creatinine	294	H	[60-120 umol/L]
eGFR (MDRD)	18		[mL/min]

Important information relevant to this test, please click to expand:
Multiply eGFR by 1.21 if Afro-Caribbean.
See www.emrn.org.uk website.

Overall Date Resulted
11/12/2011 18:04:00

11-Dec-2011 15:45 Amylase

	Result		
Laboratory Sample Number			
CP653539V			
Amylase	130	H	[30-110 iu/L]
Overall Date Resulted			
11/12/2011 18:04:00			

Patient Name	Gender	D.O.B	Hospital No.
MCLEISH, WENDY	F	25-May-1987	PIMS S2664312

11-Dec-2011 15:45 Liver Function Test (LFT)

	Result		
Laboratory Sample Number			
CP653539V			
Alanine Transaminase (ALT)	155	H	[2-53 iu/L]
Total Bilirubin	16		[0-21 umol/L]
Overall Date Resulted			
11/12/2011 18:04:00			

11-Dec-2011 15:45 Bone Profile (Serum)

	Result		
Laboratory Sample Number			
CP653539V			
Albumin	35		[35-50 g/L]
Adjusted Calcium	2.39		[2.2-2.6 mmol/L]
Inorganic Phosphate	2.19	H	[0.8-1.5 mmol/L]
Alkaline Phosphatase	103		[30-130 iu/L]
Overall Date Resulted			
11/12/2011 18:04:00			

11-Dec-2011 15:45 Magnesium

	Result		
Laboratory Sample Number			
CP653539V			
Magnesium	0.91		[0.7-1.0 mmol/L]
Overall Date Resulted			
11/12/2011 18:04:00			

11-Dec-2011 15:45 Total Protein

	Result		
Laboratory Sample Number			
CP653539V			
Total Protein	65		[60-80 g/L]
Overall Date Resulted			
11/12/2011 18:04:00			

11-Dec-2011 15:45 Gamma-GT (GGT)

	Result		
Laboratory Sample Number			
CP653539V			
Gamma-GT (GGT)	233	H	[0-35 iu/L]
Overall Date Resulted			
11/12/2011 18:04:00			

Patient Name	Gender	D.O.B	Hospital No.
MCLEISH, WENDY	F	25-May-1987	PIMS S2664312

11-Dec-2011 15:45 C-Reactive Protein — **Result**

Laboratory Sample Number
CP653539V

C-Reactive Protein	13	H	[0-10 mg/L]

Overall Date Resulted
11/12/2011 18:04:00

11-Dec-2011 15:45 Chloride — **Result**

Laboratory Sample Number
CP653539V

Chloride	94	L	[95-108 mmol/L]

Overall Date Resulted
11/12/2011 18:04:00

11-Dec-2011 15:45 Prothrombin Time (PT) — **Result**

Laboratory Sample Number
CP653539V

Prothrombin Time (PT)	14.2		[12.0-15.0 Secs]

Overall Date Resulted
11/12/2011 17:03:00

12-Dec-2011 05:56 Coagulation Screen plus Fibrinogen — **Result**

Laboratory Sample Number
CP653619F

INR	1.2		
APTT	168.7	H	[25.0-35.0 Secs]
APTT Ratio	5.6	H	

Important information relevant to this test, please click to expand:
Range 2.2 - 4.5 for unfractionated heparin ONLY
Please note new higher therapeutic range.
(The new reagent is more sensitive. This range equates to previous range of 2.0 to 3.0.)

Fibrinogen	2.4		[2.0-4.0 g/L]

Overall Date Resulted
12/12/2011 08:14:00

Patient Name	Gender	D.O.B	Hospital No.
MCLEISH, WENDY	F	25-May-1987	PIMS S2664312

12-Dec-2011 05:56 Full Blood Count — **Result**

Laboratory Sample Number			
CP653619F			
White Blood Cell Count	7.9		[4.0-11.0 x10*9/L]
Red Cell Count	4.24		[3.90-5.60 x10*12/L]
Haemoglobin	12.6		[11.5-16.5 g/dL]
Haematocrit	0.382		[0.370-0.470 L/L]
Mean Cell Volume	90		[80.0-99.0 fl]
Mean Cell Haemoglobin	29.7		[27.0-32.0 pg]
Platelet Count	368		[140-400 x10*9/L]
Neutrophil Count	5.89		[1.50-7.50 x10*9/L]
Lymphocyte Count	1.34		[1.00-4.00 x10*9/L]
Monocyte Count	0.70		[0.2-0.8 x10*9/L]
Eosinophil Count	0.01	L	[0.04-0.40 x10*9/L]
Basophil Count	0.03		[0.02-0.10 x10*9/L]
Nucleated Red Blood Cells.	<0.20		[0.00-0.20 x10*9/L]
Overall Date Resulted			
12/12/2011 07:39:00			

12-Dec-2011 05:56 Urea & Electrolytes — **Result**

Laboratory Sample Number			
CP653619F			
Sodium	136		[133-146 mmol/L]
Potassium	5.5	H	[3.5-5.3 mmol/L]
Urea	23.4	H	[2.5-7.8 mmol/L]
Creatinine	150	H	[60-120 umol/L]
GFR (MDRD)	39		[mL/min]

Important information relevant to this test, please click to expand:
Multiply eGFR by 1.21 if Afro-Caribbean.
See www.emrn.org.uk website.

Overall Date Resulted
12/12/2011 09:48:00

12-Dec-2011 05:56 Amylase — **Result**

Laboratory Sample Number			
CP653619F			
Amylase	95		[30-110 iu/L]
Overall Date Resulted			
12/12/2011 09:48:00			

Patient Name	Gender	D.O.B.	Hospital No.
MCLEISH, WENDY	F	25-May-1987	PIMS S2664312

12-Dec-2011 05:56 Liver Function Test (LFT) — **Result**

Laboratory Sample Number			
CP653619F			
Alanine Transaminase (ALT)	156	H	[2-53 iu/L]
Total Bilirubin	16		[0-21 umol/L]
Overall Date Resulted			
12/12/2011 09:48:00			

12-Dec-2011 05:56 Bone Profile (Serum) — **Result**

Laboratory Sample Number			
CP653619F			
Albumin	34	L	[35-50 g/L]
Adjusted Calcium	2.47		[2.2-2.6 mmol/L]
Inorganic Phosphate	1.42		[0.8-1.5 mmol/L]
Alkaline Phosphatase	90		[30-130 iu/L]
Overall Date Resulted			
12/12/2011 09:48:00			

12-Dec-2011 05:56 Magnesium — **Result**

Laboratory Sample Number			
CP653619F			
Magnesium	1.02	H	[0.7-1.0 mmol/L]
Overall Date Resulted			
12/12/2011 09:48:00			

12-Dec-2011 05:56 Total Protein — **Result**

Laboratory Sample Number			
CP653619F			
Total Protein	62		[60-80 g/L]
Overall Date Resulted			
12/12/2011 10:05:00			

12-Dec-2011 05:56 Gamma-GT (GGT) — **Result**

Laboratory Sample Number			
CP653619F			
Gamma-GT (GGT)	209	H	[0-35 iu/L]
Overall Date Resulted			
12/12/2011 10:05:00			

Patient Name	Gender	D.O.B	Hospital No.
MCLEISH, WENDY	F	25-May-1987	PIMS S2664312

12-Dec-2011 05:56 C-Reactive Protein — **Result**

Laboratory Sample Number
CP653619F

C-Reactive Protein	11 H	[0-10 mg/L]

Overall Date Resulted
12/12/2011 09:48:00

12-Dec-2011 05:56 Chloride — **Result**

Laboratory Sample
mber
CP653619F

Chloride	101	[95-108 mmol/L]

Overall Date Resulted
12/12/2011 10:05:00

12-Dec-2011 05:56 Prothrombin Time (PT) — **Result**

Laboratory Sample Number
CP653619F

Prothrombin Time (PT)	15.2 H	[12.0-15.0 Secs]

Overall Date Resulted
12/12/2011 08:14:00

Number A 03274

SSCCN/CNet/NWMCCN Transfer Form

NHS

Patient Details

Name: WENDY MCLEISH

DOB: 25.5.87

NHS Number: _____ Postcode: _____

Staff Arranging Transfer

Referring Doctor: SANJEEV ARYA.

Name: ECMO FELLOW

Speciality: ECMO Grade: _____

Receiving Hospital: GLASGOW ROYAL INF

ITU Clinician: _____ Grade: _____

Specialist Clinician: _____ Speciality: _____

Transfer Details

Transfering Hospital: GLENFIELD (please circle)

Transfering from: ICU / HDU / A&E / Theatre / Ward / Other

Speciality: Cardiac / Renal / Neuro / Resp / Liver / Other

Recipient Hospital: GLASGOW ROYAL INFIRMARY

Recipient Unit: ICU / HDU / TH / WD / Other

Reason: Tertiary referral / No ICU bed / Repat / Other

Date of Transfer: 12.12.11 Time: 1215

Clinical Diagnosis/Patient History

POST VV ECMO GAP

Ambulance Details

Time ambulance booked: _____

Time patient Ready for transfer: _____

Time ambulance arrived: 1100

Time of departure: 1215

Time of arrival at receiving unit: _____

Monitors

ECG: ☑ $EtCO_2$: ☐

IBP: ☑ CVP: ☐

NIBP: ☐ Other: _____

SpO_2: ☑

Spinal Imobilisation?

Yes: ☐

No: ☑

Escorting Personnel

Escort 1: Doctor / Nurse / ODP / Other (please circle)

Name: J ENNIS GMC/~~NMC~~: _____

Signed: _____ Grade: BAND 6.

Escort 2: Doctor / Nurse / ODP / Other (please circle)

Name: SANJEEV GMC/~~NMC~~: _____

Signed: _____ Grade: FELLOW

Lines and Catheters

	Site	Insertion date
Arterial Line:	(L) RADIAL	SEE LOTUS NOTES
CVP:	R IJV.	
Cannula 1:		
2:		
NGT:	R NOSTRIL	
Urinary Cath:	URETHRAL	
Chest Drain:	—	
Other:	PASSATH L FV.	

Airway & Ventilation

Mechanical ☑ Spont ☐

ETT size: _____ @ _____ cm

Trachy: Size TRACOE 7

Vent Mode: CMV ASB

Tidal Vol: 350 / 16.4 mv

Peak Press: 23

PEEP: 9

FIO_2: 40%

Resp Rate: SPONTANEOUS

Start Time:	1230	1300	1330	1400	1500	1600	1700
Drugs & fluids (mls/hr)							
MORPHINE	2	2	4	2	4	4	4
MIDAZ	6	6	6	4	4	6↑	6
PROPOFOL	7	5↓	5	5↓	7↑	9↑	9
METHYLPREDNISOLONE	2	2	2	2	2	2	2
Pupil L size/reaction	3↓						
Pupil R size/reation	3↓						
220							
200							
180							
Pulse = X 160	141	149	150	150	145	149	145
BP = ∧V V∧ 140	114	114	114	114	114	114	114
SAO2 = ● 120	112	112	112	112	110	110	105
100	103	100	100	100	100	100	100
80	87	87	87	87	87	85	87
60	57	56	56		59	58	58
SaO2 ~~ETCO2~~	96	98	97	97	98	95	98
~~CVP~~	18	14	17	16	15	16	15

White copy: File in patient notes, Blue copy: Post to Network Office, Yellow copy: File on receiving unit

ECMO

ECMO *Adult Discharge or Transfer summary*

Na NHS S2664312
Ac MCLEISH Un-Known
WENDY
1/1 51 COXTON PL
GLASGOW
D(G33 5EJ
G 25-MAY-1987 F
U5118413
(A

Consultant: ECMO TEAM	Admission diagnosis: pneumonia ? cause ? sepsis
Date of admission to ECMO centre: 30/10/11	Secondary diagnosis:
	Brief Summary of treatment: On admission taken to theatre for cannulation put on VV ecmo

Western Infirmary
Glasgow
0141 2115247 0
52468 GILBERT

Next of Kin: James Ward
Contact details: 07769733984
Tel.....Home.....Mobile
Aware of transfer Y/N

Cannulation details: Avalon 31 Fr Double lumen cannula at RSV		Length of ECMO treatment: From 30/10/11 to 7/12/11	
Respiratory			
Self ventilating		Ventilated	
O_2	40%	~~ETT~~ / Trachae size	7.0
RR	SPONT	ETT length	
Latest CXR		Mode	CMV ASB
		Peak Pressure	ASB 12
		Pressure support	
		PEEP	8
SaO_2 95%		Rate SPONT.	
ABG's	pCO_2	pH	pO_2
HCO_3	BE	Sats	
Cardiovascular			
Heart Rate	91 (SR)	BP 148/95 (M) 119	
Inotropes	Drug:	Rate:	
	Drug:	Rate:	
Renal			
Urine output	50-60 mls/hr	Fluid balance (24 hours)	-800mls
CVVH DISCONTINUED PRIOR TO TRANSPORT			

Neurology					
Sedation	PROPOFOL 1% STARTED @ 12⁰⁰ FOR TRANSFER				
Drug:	midazolam 50mg/50ml	Rate:	4 mls/hr		
Drug:	morphine 60mg/60mls	Rate:	4 mls/hr		
GIT	NUTRISON protein Plus 64 mls/hr				
Bowels open	(Y)/N				

Nutrition					
Nasogastric tube		Type: Size:	Ryles	Enteral feeds	Yes
Stopped at	1130	Aspirated at	1130	TPN	
Diet		SALT test			

Skin condition		
Lines in situ	Position	Date Inserted
Arterial	(L) Radial	21/11/11
Peripheral vas cath	(R) Femoral	30/11/11
Central	(R) Femoral	30/11/11

Infusions	Drug	Dose	Date commenced

Medications	Drug	Dose	Date commenced
Refer	ITU Drug chart		

Latest Blood Results					
Hb		PCV		WCC	
INR		APTT		Urea	
Creatinine		Bilirubin		Alk Phos	
ALT		Amylase			

Microbiology			
MRSA status	negative		
Positive Cultures			

Further Information:

Any Queries	Contact CICU 0116 256315 or ECMO fellows 0116 2871471 and page

DRUG SENSITIVITIES (MUST BE COMPLETED)

Medicine	Reaction

No known allergies ☑

Signature | Designation | Date

S No. S2664312
NHS Un-Known
Patier MCLEISH
WENDY
1/1 51 COXTON PL
GLASGOW
G33 5EJ
25-MAY-1987 F
U5118413
Date

ADULT INPATIENT MEDICATION ADMINISTRATION RECORD

University Hospitals of Leicester NHS
NHS Trust

DEPARTMENT OF ADULT CRITICAL CARE MEDICINE

Chart ☐ of ☐ Year ☐ Site: LRI ☐ LGH ☐ GH ☐

DRUG HISTORY

MEDICINES MANAGEMENT CHECKLIST

Check		Initial	Date
Pre-admission	☑		
Drug history check	☐	☑	7/12
Source:			
Rewritten drug chart check	☐	☑	7/12
Allergy check	☐	☑	7/12
Patient's own medicines	☐		
Pharmacy check	☐		

Body weight (Kg): IBW: Height (m):

PRESCRIPTION FOR ONCE-ONLY MEDICATION

	Date	Time	Medicine	Dose	Route	Prescriber's signature and Print name	Given by / Checked by		Time given	Pharmacy
1	7/12/11	15.35	Gentamycin	IV	156mg	SA S.Ayre	AH	VM		
2	7/12/11	15.35	Flucloxacillin	IV	1gm	SA S.Ayre	AH	VM		
3	7/12/11	16.10	KETAMINE	IV	150mg	SA S.Ayre				
4	7/12/11	16.10	Atracurium	IV	50mg	SA S.Ayre				
5	7/12/11	16.10	Fluisendie	iv	200mg	SA S.Ayre	AH	RMS	2.00	
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										

UNIT No:

PATIENT NAME:

DRUG SENSITIVITIES (MUST BE COMPLETED)

Medicine	Reaction

No known allergies ☑

Signature | Designation | Date

S No. S2664312

Patient NHS Un-Known
MCLEISH
WENDY
1/1 51 COXTON PL
GLASGOW
G33 5EJ
25-MAY-1987 F
U511841 3

Date

INTRAVENOUS INSULIN INFUSION

Human Soluble Insulin (Actrapid) — **50 units (0.5 ml) insulin made up to 50 ml with 49.5 ml 0.9% sodium chloride**

Pharmacy

Glucose BM level	Guide (units/hour)	Infusion Rate (mls/hour)
<4[a] mmol/L	0.5	
4.1 - 7 mmol/L	1	RATE
7.1 - 9 mmol/L	1.5	ACCORDING
9.1 - 11 mmol/L	2	TO ITU
11.1 - 17 mmol/L	3	INSULIN
17.1 - 28[b] mmol/L	4	PROTOCOL
>28[b] mmol/L	6	
a Inform Dr immediately	Prescriber's sign	A. BANCH
	Prescriber's print	A. Bell
b Inform Dr if on two separate occasions	Date	
	BM frequency	minimum 4 hourly

Date	6/12	7/12/11	8/12/11	9/12/11	10/12/11	11/12/11	12/12/11								
Time	22[50]	2[00]	04.15	0900	09.00	1025	2150								
DRAWN UP BY	SB	RE	MB	J	MJ	SC	VJ								
CHECKED BY	R	LEJ	SB	RD	JR	JR	JM								
STARTED BY	SB	LEJ 2300	SB	D	JR		VJ								
Date															
Time															
DRAWN UP BY															
CHECKED BY															
STARTED BY															
Date															
Time															
DRAWN UP BY															
CHECKED BY															
STARTED BY															
Date															
Time															
DRAWN UP BY															
CHECKED BY															
STARTED BY															

UNIT No:

PATIENT NAME:

1 Refused 2 Vomiting/Nausea 3 Nil by mouth 4 Not required 5 Drug not on ward 6 Omission, other treatment in progress
7 No IV access 8 Unable to take 9 Patient not present

REGULAR ANTIMICROBIAL THERAPY

| | | |

REGULAR MEDICINES

DATE OF ADMINISTRATION → 6/12 | 7/12 | 8/12/11 | 9.12.11 | 10/12/11 | 11/12/11

TIME DRUG DUE ↓

MRSA DECOLONISATION PROPHYLAXIS REGIMEN

55 **NASAL ANTIBIOTIC CREAM (MUPIROCIN 2%)**

Apply | Both Nostrils | TDS | START DATE

SIGNATURE | PRINT H.K | REVIEW ON DISCHARGE FROM ITU

56 **ANTIBACTERIAL WASH; BRAND:**

APPLY DIRECTLY ONTO SKIN USING A CLOTH ONCE DAILY INSTEAD OF SOAP

USE TO WASH HAIR TWICE A WEEK

SIGNATURE | PRINT H.K | REVIEW ON DISCHARGE FROM ITU

57 **CHLORHEXIDINE 1% ORAL GEL**

Apply | Topical | QDS | START When on Mechanical Ventilation

SIGNATURE | PRINT HK | STOP When off Mechanical Ventilation

SPECIAL INSTRUCTIONS & PHARMACY
PART OF MOUTHCARE REGIMEN

58 **DALTEPARIN** ~~Start when ECHO TCCH (Heparin) stopped~~

DOSE 2-500 | Subcutaneously | Once Daily 18.00 | START DATE 9.12.11

SIGNATURE | PRINT HK | STOP DATE

SPECIAL INSTRUCTIONS & PHARMACY
THROMBOPROPHYLAXIS

59 **RANITIDINE**

DOSE | ROUTE | FREQ. | START DATE

SIGNATURE | PRINT | STOP DATE

SPECIAL INSTRUCTIONS & PHARMACY
STRESS ULCERATION

60 MEDICINE CLONIDINE

DOSE ~~mcg~~ 50 | ROUTE NG | FREQ. TDS | START DATE 6.12.11

SIGNATURE A. Bard | PRINT A. BARD | STOP DATE

SPECIAL INSTRUCTIONS & PHARMACY

08.00 | 14.00 | 22.00

CODE FOR DRUG OMISSIONS When drug is not administered, record the appropriate number in the box, circle and sign. Doctors to be informed at discretion of nurse.

PATIENT NAME:

UNIT No:

DRUG SENSITIVITIES (MUST BE COMPLETED)

Medicine	Reaction

No known allergies ✓

Signature: Designation: Date:

S No. S2664312

Patier NHS Un-Known
MCLEISH
WENDY
1/1 51 COXTON PL
GLASGOW
G33 5EJ
25-MAY-1987 F
CHI No. 0511841B

REGULAR MEDICINES

DATE OF ADMINISTRATION → 6/12/11 | 7/12/11 | 8/12/11 | 9/12/11 | 10/12 | 11/12/11 | 12/12

TIME DRUG DUE →

---

61 MEDICINE: Fluxotine

DOSE: 40mg | ROUTE: NG | FREQ: OD | START DATE: 1.12.11

SIGNATURE | PRINT: HK | STOP DATE

SPECIAL INSTRUCTIONS & PHARMACY

TIME	6/12/11 DOSE GIVEN/CHECKED	7/12/11 DOSE GIVEN/CHECKED	8/12/11 DOSE GIVEN/CHECKED	9/12/11 DOSE GIVEN/CHECKED	10/12 DOSE GIVEN/CHECKED	11/12/11 DOSE GIVEN/CHECKED	12/12 DOSE GIVEN/CHECKED
08.00	✓	✓	✓	✓ (5)	✓	✓	✓
				1400 ✓			

---

62 MEDICINE: OMEPRAZOL IV 5/7 Celtrasi (new stock)

DOSE: 40mg | ROUTE: IV | FREQ: BD | START DATE: 5.12.11

SIGNATURE | PRINT: HK | STOP DATE

SPECIAL INSTRUCTIONS & PHARMACY

TIME	6/12/11 DOSE GIVEN/CHECKED	7/12/11 DOSE GIVEN/CHECKED	8/12/11 DOSE GIVEN/CHECKED	9/12/11 DOSE GIVEN/CHECKED	10/12 DOSE GIVEN/CHECKED	11/12/11 DOSE GIVEN/CHECKED	12/12 DOSE GIVEN/CHECKED
10	✓	✓	✓	✓	✓	✓	
22	✓	✓	✓	✓	✓	✓	

---

63 MEDICINE: FLUOXETINE

DOSE: 40mg | ROUTE: NG | FREQ: OD | START DATE: 1.12.11

SIGNATURE | PRINT | STOP DATE

SPECIAL INSTRUCTIONS & PHARMACY

---

64 MEDICINE: Clotimazol Creme

DOSE: Topical | ROUTE | FREQ: BD | START DATE: 2.12.11

SIGNATURE | PRINT: HK | STOP DATE

SPECIAL INSTRUCTIONS & PHARMACY

TIME	6/12/11 DOSE GIVEN/CHECKED	7/12/11 DOSE GIVEN/CHECKED	8/12/11 DOSE GIVEN/CHECKED	9/12/11 DOSE GIVEN/CHECKED	10/12 DOSE GIVEN/CHECKED	11/12/11 DOSE GIVEN/CHECKED	12/12 DOSE GIVEN/CHECKED
10.00	✓	✓	✓	✓	✓	✓	
22.00	✓	✓	✓	✓	✓	✓	

---

65 MEDICINE: Lacri-Lube (Eye Ointment)

DOSE: Topical | ROUTE | FREQ: QDS | START DATE: 12.11.11

SIGNATURE: A.Burt | PRINT: A.Burt | STOP DATE

SPECIAL INSTRUCTIONS & PHARMACY

TIME	6/12/11 DOSE GIVEN/CHECKED	7/12/11 DOSE GIVEN/CHECKED	8/12/11 DOSE GIVEN/CHECKED	9/12/11 DOSE GIVEN/CHECKED	10/12 DOSE GIVEN/CHECKED	11/12/11 DOSE GIVEN/CHECKED	12/12 DOSE GIVEN/CHECKED
06		✓	✓		✓	4	
12	✓	✓	✓	✓	✓	4	
18		✓	✓	✓	✓	4	
24	✓	✓	✓	✓	10		

---

66 MEDICINE: Vitamin B Comp

DOSE: 1Tab | ROUTE: NG | FREQ: TDS | START DATE: 4.12.11

SIGNATURE | PRINT: HK | STOP DATE

SPECIAL INSTRUCTIONS & PHARMACY

TIME	6/12/11 DOSE GIVEN/CHECKED	7/12/11 DOSE GIVEN/CHECKED	8/12/11 DOSE GIVEN/CHECKED	9/12/11 DOSE GIVEN/CHECKED	10/12 DOSE GIVEN/CHECKED	11/12/11 DOSE GIVEN/CHECKED	12/12 DOSE GIVEN/CHECKED
8							
16							
24							

UNIT No:

PATIENT NAME:

1 Refused 2 Vomiting/Nausea 3 Nil by mouth 4 Not required 5 Drug not on ward 6 Omission - other treatment in progress
7 No IV access 8 Unable to take

REGULAR MEDICINES

DATE OF ADMINISTRATION → 6.12.11 | 7.12.11 | 8/12/11 | 9/12 | 10/12 | 11/12/11 | 12/12/11

TIME DRUG DUE → (TIME / DOSE GIVEN/CHECKED)

67 MEDICINE: Azitromycin
DOSE: 400mg | ROUTE: NG | FREQ: every 48hr. | START DATE: 5.12.11
SIGNATURE | PRINT: HK | STOP DATE
SPECIAL INSTRUCTIONS & PHARMACY
1800 | X | MK | ✓ | JB | X | 1800 | ✓ | X

68 MEDICINE: PABRINEX
DOSE: 2 PAIRS | ROUTE: IV | FREQ.: TDS | START DATE: 6-12-11
SIGNATURE: SA | PRINT: S.Arya | STOP DATE
SPECIAL INSTRUCTIONS & PHARMACY: For 48 hrs then R/V
6:00 | SR | SR | DECREASE TO OD
16:00 | BB | VB
22:00 | SR | SR

69 MEDICINE: DOXAZOCIN
DOSE: 2mg | ROUTE: NG | FREQ.: OD | START DATE: 7-12-11
SIGNATURE: SA | PRINT: S.ARYA | STOP DATE
SPECIAL INSTRUCTIONS & PHARMACY
10:00 | TG | SR | JB | 1400 | 1000

70 MEDICINE: Ted s Stockings
DOSE: Prophylaxis | ROUTE | FREQ. | START DATE: 9.12.11
SIGNATURE | PRINT: HK | STOP DATE: 9.12.11
SPECIAL INSTRUCTIONS & PHARMACY

71 MEDICINE: PABRINEX
DOSE: 1 PAIR | ROUTE: IV | FREQ.: OD | START DATE: 9/12/11
SIGNATURE | PRINT: C-HARVEY | STOP DATE
SPECIAL INSTRUCTIONS & PHARMACY
0600 | IM | SR | SR

72 MEDICINE
DOSE | ROUTE | FREQ. | START DATE
SIGNATURE | PRINT | STOP DATE
SPECIAL INSTRUCTIONS & PHARMACY

CODE FOR DRUG OMISSIONS When drug is not administered, record the appropriate number in the box, circle and sign. Doctors to be informed at discretion of nurse.

PATIENT NAME:

CONTINUOUS INTRAVENOUS MEDICINE INFUSIONS

79

DATE	MEDICINE	DOSE/RATE	TOTAL AMOUNT	TOTAL VOLUME	DILUENT	SIGN/PRINT	PHARM.
(6.12.11) 30.11.11	Heparin	APP ECMO	25.000 units	50ml	0.9% Nacl	HK	

DATE	7/12																			
TIME	830																			
DRAWN UP BY	S																			
CHECKED BY																				
STARTED BY																				

80

DATE	MEDICINE	DOSE/RATE	TOTAL AMOUNT	TOTAL VOLUME	DILUENT	SIGN/PRINT	PHARM.
(6.12.11) 30.11.11	MIDAZOLAM	0.5-20ml/h	50mg	50ml	0.9% Nacl	HK	

DATE	6/12	6/12	6/12	7/12	7/12	7/12	8/12	8/12	8/12	8/12	8.12	8.12	9/12	9/12	9/12	9	10/12	9/12	11	10/12	11/12
TIME	2200	2200	2200	0830	0830	2130	0500	0930	0930	0930	2130	2130	0900	1630	1900	2015	2045	0900			
DRAWN UP BY	SS	SS	SS	S	S	RE	WS	SS	WS	WS	WS	WS									
CHECKED BY	RE	RE	RE	WS	WS	WS	ET	WS	SS	SS											
STARTED BY	SS	SS			WS	WS		SS	SS	WS	WS	WS									

81

DATE	MEDICINE	DOSE/RATE	TOTAL AMOUNT	TOTAL VOLUME	DILUENT	SIGN/PRINT	PHARM.
(6.12.11) 30.11.11	MORPHINE	0.5-20ml/h	60mg	60ml	Na 0.9%	HK	

DATE	06/12	06/12	7/12	7/12	8/12	8/12	8.12	8.12	9.12	9/12	9/12	9/12	10/12	11/12	11/12	12/12					
TIME	2200	2200	2100	2100	0930	0930	2100	2100	0630	1030	1630	2045	1230	2045	0045	0200					
DRAWN UP BY	SS	SS	RE	RE	WS	WS	WS	WS	WS	S	S	RE	S	S	S	WS					
CHECKED BY	RE	RE	LEK	LEK	SS	SS	SS	SS	SS												
STARTED BY	SS		LEK 2130	CMB	SS	SS	WS	WS	WS	S	S		S	S	S	WS					

82

DATE	MEDICINE	DOSE/RATE	TOTAL AMOUNT	TOTAL VOLUME	DILUENT	SIGN/PRINT	PHARM.
30.11.11	Propofol 1%	0-4mg/Kg/h APP.	500mg	50ml	NEAT	HK	

DATE	06/12	06/12	06/12	06/12	7/12	11/12	11/12	7/12	7/12	8/12	8/12	8/12	8/12	8/12	8/12	9/12	9/12	10/12	10/12	10/12
TIME	2200	2200	2200	2200	0845	0845	0845	1915	2100	0500	0900	0900	0900	2100	2100	0900	2300	0115	0220	0900
DRAWN UP BY	SS	SS	SS	SS	WS	WS	WS	WS	RE	ET	WS	WS	WS	WS	WS	S	S			
CHECKED BY	RE	RE	RE	RE	RE	RE	RE	RE	LEK	LEK	SS	SS	SS	CB	CB	WS	AS	AS		
STARTED BY	SS	SS	SS						LEK 0720		SS	SS	WS	WS	WS	S				

CODE FOR DRUG OMISSIONS — When drug is not administered, record the appropriate number in the box, circle and sign. Doctors to be informed at discretion of nurse.

PATIENT NAME:

DRUG SENSITIVITIES (MUST BE COMPLETED)

Medicine	Reaction

No known allergies ☑

Signature [illegible] Design from

S No. S2664312
NHS Un-Known
Patier MCLEISH
WENDY
1/1 51 COXTON PL
GLASGOW
G33 5EJ
25-MAY-1987 F
U511841 3
Date 6-12-11

CONTINUOUS INTRAVENOUS MEDICINE INFUSIONS

83

DATE	MEDICINE	DOSE/RATE	TOTAL AMOUNT	TOTAL VOLUME	DILUENT	SIGN/PRINT	PHARM.
5.12.11	Methylprednisolon (APP)	2ml/h.	125mg	48ml	0.9% NaCl	HK.	

DATE	7/12	8/12	9.12	10/12	11.12	12/12													
TIME	08[illegible]	[illegible]	6.30	04[illegible]	[illegible]	[illegible]													
DRAWN UP BY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]													
CHECKED BY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]													
STARTED BY		[illegible]	[illegible]	[illegible]															

84

DATE	MEDICINE	DOSE/RATE	TOTAL AMOUNT	TOTAL VOLUME	DILUENT	SIGN/PRINT	PHARM.
30.11.11	~~Paracetamol~~	1g.					

DATE																			
TIME																			
DRAWN UP BY																			
CHECKED BY																			
STARTED BY																			

85

DATE	MEDICINE	DOSE/RATE	TOTAL AMOUNT	TOTAL VOLUME	DILUENT	SIGN/PRINT	PHARM.
7.12.	Heparin C.V.V.H.	20.000 iu APP.	ACT 160-180 APP.	20ml	NEAT	HK	

DATE	7/12	8/12	9/12	10/12	11/12														
TIME	19.[illegible]	23[illegible]	07.10	[illegible]															
DRAWN UP BY	[illegible]	[illegible]	[illegible]	[illegible]															
CHECKED BY	[illegible]	[illegible]	[illegible]	[illegible]															
STARTED BY		[illegible]	[illegible]																

86

DATE	MEDICINE	DOSE/RATE	TOTAL AMOUNT	TOTAL VOLUME	DILUENT	SIGN/PRINT	PHARM.
8.12.11	FRUSEMIDE ~~250mg~~	0-20mg/hr.	250 mg	250ml	neat	S. Ayre	

DATE	9.12	9.12	9/12	10/12	11/12														
TIME	2.00	6.30	20[illegible]	[illegible]	[illegible]														
DRAWN UP BY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]														
CHECKED BY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]														
STARTED BY	[illegible]	[illegible]																	

UNIT No:

PATIENT NAME:

1 Refused 2 Vomiting/Nausea 3 Nil by mouth 4 Not required 5 Drug not on ward 6 Omission - other treatment in progress
7 No IV access 8 Unable to take 9 Patient not in ward 10 [illegible] 11 Awaiting medical advice

CONTINUOUS INTRAVENOUS MEDICINE INFUSIONS

PATIENT NAME:

UNIT No:

87	DATE	MEDICINE	DOSE/RATE	TOTAL AMOUNT	TOTAL VOLUME	DILUENT	SIGN/PRINT	PHARM.
	(6/12/11)	Midazolam	0.5-20mg/hr	50mg	50ml	40ml 5 Nacl		
	DATE	11/12/11						
	TIME	1530						
	DRAWN UP BY	[illegible]						
	CHECKED BY	[illegible]						
	STARTED BY	[illegible]						

88	DATE	MEDICINE	DOSE/RATE	TOTAL AMOUNT	TOTAL VOLUME	DILUENT	SIGN/PRINT	PHARM.
	11 Dec	Propofol	2.3 - 30ml/h	500 mg	50 ml	Neat	[signature]	
	DATE	12/12/11						
	TIME	0020						
	DRAWN UP BY	[signature]						
	CHECKED BY	[signature]						
	STARTED BY							

89	DATE	MEDICINE	DOSE/RATE	TOTAL AMOUNT	TOTAL VOLUME	DILUENT	SIGN/PRINT	PHARM.
	DATE							
	TIME							
	DRAWN UP BY							
	CHECKED BY							
	STARTED BY							

90	DATE	MEDICINE	DOSE/RATE	TOTAL AMOUNT	TOTAL VOLUME	DILUENT	SIGN/PRINT	PHARM.
	DATE							
	TIME							
	DRAWN UP BY							
	CHECKED BY							
	STARTED BY							

CODE FOR DRUG OMISSIONS When drug is not administered, record the appropriate number in the box, circle and sign. Doctors to be informed at discretion of nurse.

AS REQUIRED MEDICINES

95 DRUG: PARACETAMOL | INDICATION: Pain / Temp. | PRINT NAME / SIGNATURE: H.K

DOSE: 1g. | ROUTE: IV/NG | MAX. FREQ.: 6h. | SPECIAL INSTRUCTIONS: | START DATE: 30.11.11 | REVIEW DATE: | PHARM.

DATE	Time Dose	given by Check	DATE	Time Dose	given by Check	DATE	Time Dose	given by Check	DATE	Time Dose	given by Check	DATE	Time Dose	given by Check	DATE	Time Dose	given by Check
10/12	0200 1g	SD															

96 DRUG: Potassium Ac. phosphate | INDICATION: ↓ Phosph. (APP) | PRINT NAME / SIGNATURE: H.K.

DOSE: 40mmol | ROUTE: IV. | MAX. FREQ.: Keep Phos. 7.1 | SPECIAL INSTRUCTIONS | START DATE: 30/11/11 | REVIEW DATE: | PHARM.

DATE	Time Dose	given by Check	DATE	Time Dose	given by Check	DATE	Time Dose	given by Check	DATE	Time Dose	given by Check	DATE	Time Dose	given by Check	DATE	Time Dose	given by Check
8.12.11	2130 4pm	AM															

97 DRUG: Magnesium Sulph. | INDICATION: ↓ Mag. (APP) | PRINT NAME / SIGNATURE: H.K.

DOSE: 8 mmol | ROUTE: IV. | MAX. FREQ.: Keep Mag. 7.1 | SPECIAL INSTRUCTIONS | START DATE: 30/11/11 | REVIEW DATE: | PHARM.

DATE	Time Dose	given by Check	DATE	Time Dose	given by Check	DATE	Time Dose	given by Check	DATE	Time Dose	given by Check	DATE	Time Dose	given by Check	DATE	Time Dose	given by Check
7/12	1130																
8.12.11	2130 8mmol 4pm	IM AM															
12/12/11	0100 8mmol 4pm	IM AM															

98 DRUG: Sandoz Phosph. | INDICATION: ↓ PO4 | PRINT NAME / SIGNATURE: A. Dawn A. Baker

DOSE: 1-2 Tabs | ROUTE: NG | MAX. FREQ.: PRN | SPECIAL INSTRUCTIONS | START DATE: 3/12/11 | REVIEW DATE: | PHARM.

DATE	Time Dose	given by Check	DATE	Time Dose	given by Check	DATE	Time Dose	given by Check	DATE	Time Dose	given by Check	DATE	Time Dose	given by Check	DATE	Time Dose	given by Check
7/12	1130 2 tabs	AM															

CODE FOR DRUG OMISSIONS When drug is not administered, record the appropriate number in the box, circle and sign. Doctors to be informed at discretion of nurse.

UNIT No:

PATIENT NAME:

DRUG SENSITIVITIES (MUST BE COMPLETED)

Medicine	Reaction

No known allergies ☑

Signature | Designation | Date

S No. S2664312
NHS Un-Known
Patier MCLEISH
WENDY
1/1 51 COXTON PL
GLASGOW
G33 5EJ
25-MAY-1987 F
U5118413
Date

FLUSHES

115 **ARTERIAL LINE + CVP LINE** | SIGNATURE A.Bauch | PRINT NAME A.BAUCH

500ML SODIUM CHLORIDE 0.9% TO RUN @ 3ML/HR

DATE	TIME	SIGN.	DATE	TIME	SIGN.	DATE	TIME	SIGN.	DATE	TIME	SIGN.	DATE	TIME	SIGN.	DATE	TIME	SIGN.
7/2/11	21:25	LEF/Re															

116 **SWAN GANZ CATHETERS AND IABP (INTRA AORTIC BALLOON PUMPS)** | SIGNATURE | PRINT NAME

500 UNITS HEPARIN SODIUM IN 500ML SODIUM CHLORIDE 0.9% TO RUN @ 3ML/HR

DATE	TIME	SIGN.	DATE	TIME	SIGN.	DATE	TIME	SIGN.	DATE	TIME	SIGN.	DATE	TIME	SIGN.	DATE	TIME	SIGN.

UNIT No:

PATIENT NAME:

TITRATION OF ENTERAL/PARENTERAL FEEDING

INCREASING ENTERAL FEED RATE				DECREASING PARENTERAL FEED RATE	
Date	Feed	Rate	Length of time (hrs)	Rate (ml/hr)	Length of time (hrs)

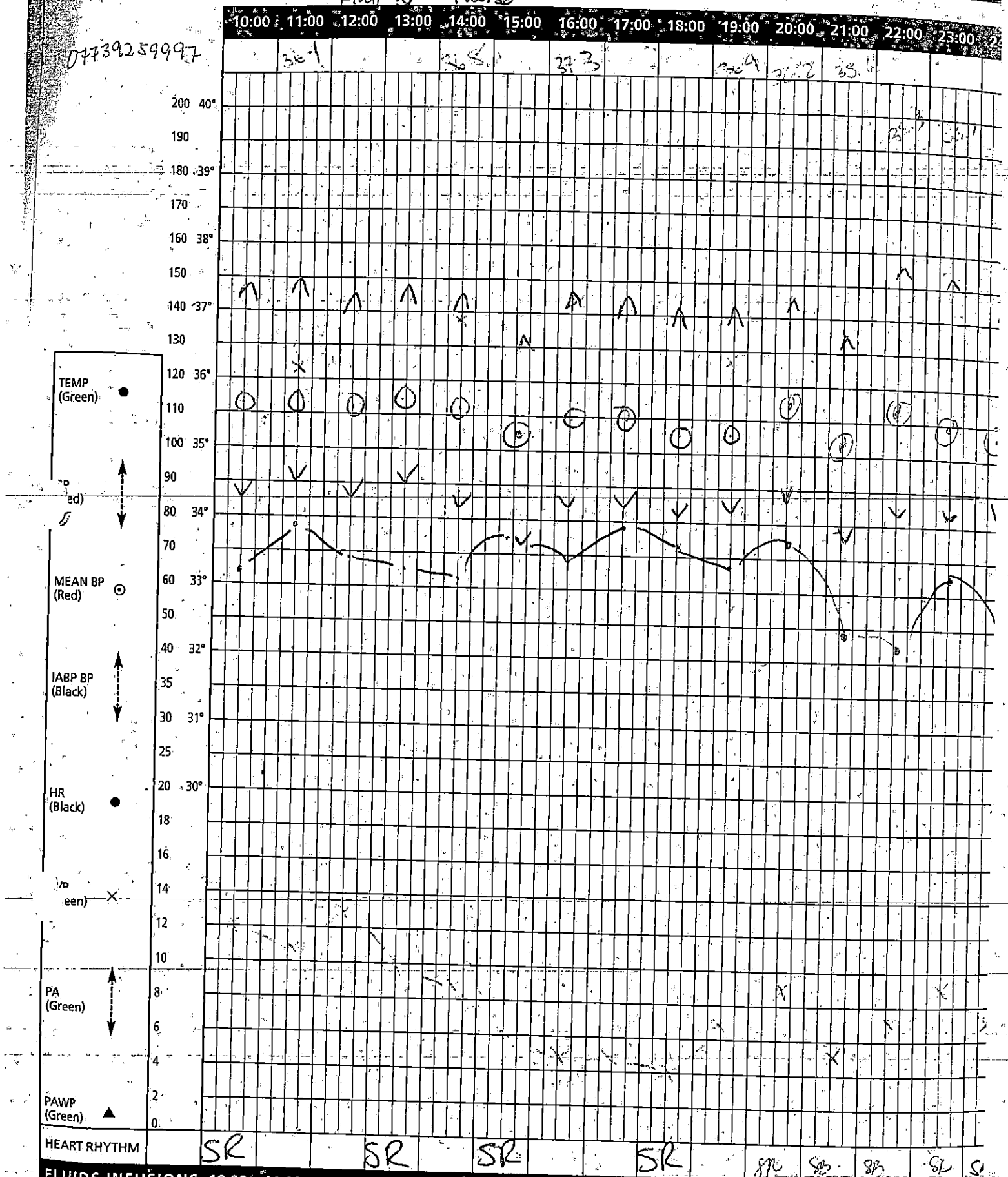
DATE: 11/12/11

BEDSIDE SAFETY CHECKS

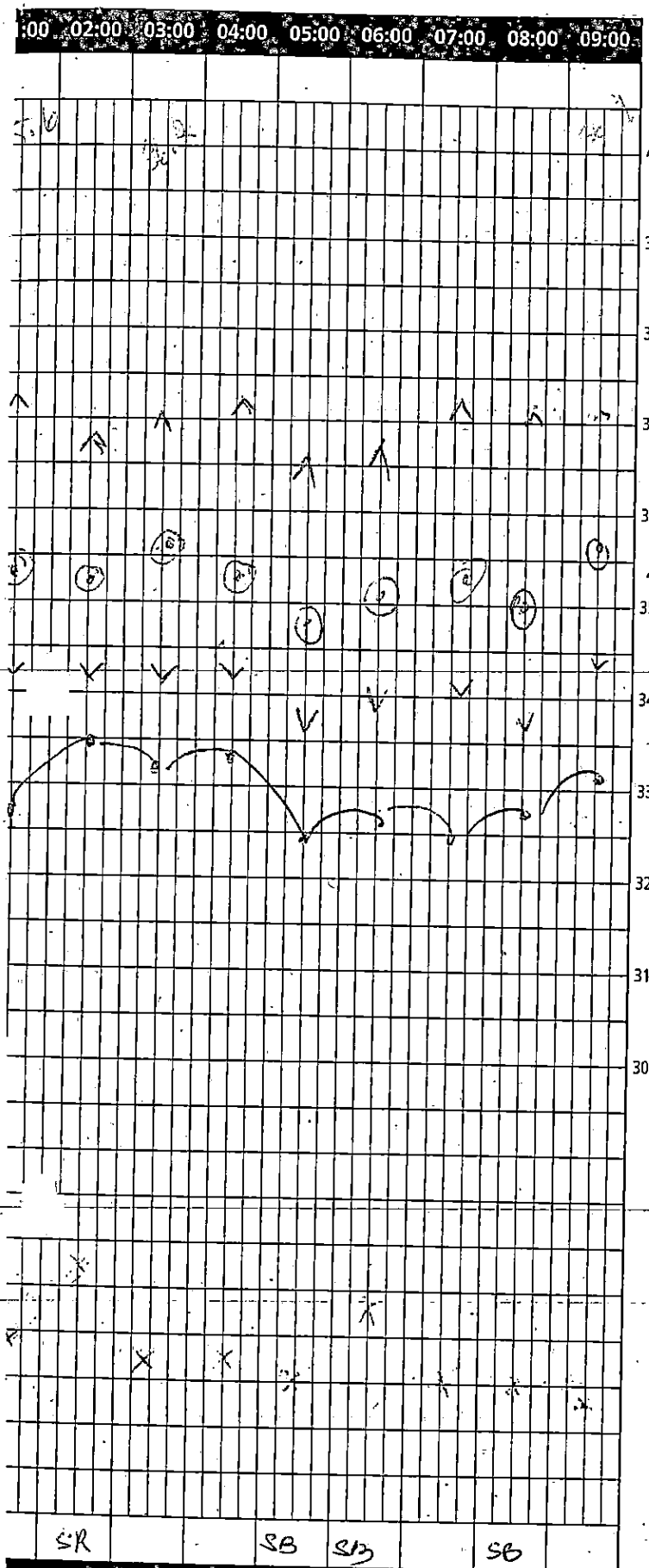
	Day	Night	Day
Bed space number		19	
Date, name and signature on ITU chart		✓	
ID label attached to all documentation		✓	
Legible ID band and allergy band (if applicable) attached to patient		✓	
Drug infusions - Correct prescription - Correct rate - Labelled correctly		✓	
Record all drug dosages (mcg/kg etc) on ITU chart at the beginning of each shift and when rate altered		✓	
Transducers zero'd and appropriately positioned		✓	
Pressure bag pumped to 300mmhg		✓	
Monitor and ventilator alarms set appropriately		✓	
Monitor and ventilator plugged into UPS electrical supply		✓	
Pumps and all other electrical equipment plugged into mains supply		✓	
Bed plugged into mains supply electricity		✓	
Ventilator type and name written on ITU chart		✓	
Bacterial filter on expiratory port of the ventilator is dry		✓	
Dry circuit – HME filter in situ		n/a	
Wet circuit – No HME filter in situ		✓	
Fisher Paykel humidifier AND wires available at the bed space		✓	
Oxygen analyser (for high flow) available at the bed space		✓	
Clean functional waters bag and O_2 tubing attached to flow meter		✓	
O_2 flow meter connected to piped O_2 outlet		✓	
Working portable O_2 cylinder, no less than half full, available at the bed space		✓	
Tracheostomy box available if applicable (correct tube size)		✓	
High suction set on 18-20 KPa - working		✓	
Low suction set on 5-10 KPa - working - attached to drain		✓ n/a	
Suction filters clean and dry, changed in the last 3 months		✓	
Fire evacuation box available and intact		✓	

Flat ↓ Rooms

07739259997



FLUIDS INFUSIONS	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	24
CHECK INITIAL IVI RATES (INITIAL CHANGES)	SL	SL	SL	SL	SL	SL	SL	SL	SL	SL					
Furosemide	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2						
Methylpred	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Morphine	5	4	4	4	4	4	4	4	4	4	4	4	4	4	4
Midazolam	5	4	4	4	4	4	4	4	4	4	4	4	4	4	4
Actrapid	2.5	3	3	3	3	3	3	3	2	2	2	2	1	1	1



		DATE DUE	TIME	DONE SI
CHANGES	DAILY / PRN			
	HME	N/A.		
	VENT FILTER			
	ET TAPE AND FOAM	N/A		
	TRACHY DRESSING	12/12/11	1600	
	NG GIVING SETS ??	9/12/11 - changed 14/12/11 1130am SE		
	TPN GIVING SETS	N/A		
	NEBULISER ACORNS	N/A		
	YANKER SUCKERS	PRN		
	CATHETER MOUNTS	With Inline		
	72 HOURS			
	INLINE SUCTION	12/12/11		
	TRANSDUCER SETS	12/12/11		
	IV LINES	12/12/11		
	WEEKLY			
	VENT / CPAP CIRCUITS	13/12/11		
	WATERS BAG			
	CATHETER BAG			

		TIME	DONE SI
TESTS	U & E AM		
	U & E PM	1545	SE
	FBC AM		
	FBC PM	1545	SE
	CLOTTING AM		
	CLOTTING PM	1545	SE
	LFTs	1545	SE
	AMYLASE		
	CRP		
	OTHER		
	OTHER		
	CXR		
	ECG		
LEVELS	GENTAMYCIN		
	VANCOMYCIN		
	OTHER		
	OTHER		
SAMPLES	SPUTUM		
	URINE		
	BLOOD		
	MRSA		
	OTHER		

PREVIOUS 24 HOUR FLUID BALANCE		WEIGHT: (kg)
In	3261	78kg
Balance	-1229	
Out	4490	HEIGHT: (cm)
Fluid balance since admission		

	SR			SB	SB		SB	
00	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00
	2	2	2	2	2	2	2	2
	4	4	4	4	4	4	4	4
	4	4	4	4	4	4	4	4
	2	2	2	2	1.5	1.5	1.5	1.5

VENTILATION	10:00	11:00	12:00	13:00	14:00	15
FIO_2	35%	35%	35%	35%	35%	35
MODE	CPAP ASB	CPAP ASB	CPAP ASB	CPAP ASB	CPAP ASB	CP AS
RATE						
IE RATIO						
INSP PRESSURE						
PEEP/CPAP	8	8	8	8	8	

University Hospitals of Leicester NHS
NHS Trust

ADULT INTENSIVE CARE UNIT

Decannulated 7/12/11

S2664312

DIAGNOSIS / PROCEDURE: VV ECMO for community acquired pneumonia

REFERRING CONSULTANT:

ITU CONSULTANT: ECMO team

NHS Un-Known
MCLEISH
WENDY
1/1 51 COXTON PL
GLASGOW
G33 5EJ
25-MAY-1987 F
U5118413

CARDIAC SURGERY ☐ GENERAL ☐ ECMO ☑

CARE BUNDLES	Y/N	COMMENTS
STELLISEPT	Y	
BACTROBAN	Y	
CORSODYL GEL	Y	
SAT UP >30°	Y	
GUT PROPHYLAXIS	Y	
SEDATION HOLD	N	TIME
INSULIN PROTOCOL	Y	
ANTICOAGULATION	Y	
ANTIEMBOLIC STOCKINGS	Y	IF NO, REASON
DAILY SKIN CHECK IF EMBOLIC STOCKINGS N SITU	Y	
PA[illegible]ACT	Y	IF NO, DOCUMENT IN CARE PLAN
MATTRESS TYPE	Totalcare Sport	

DAY	NIGHT	DAY
NAME Susan Elliott	NAME Josie Duggan	NAME A. Jarvis
SIGNATURE	SIGNATURE	SIGNATURE
BEDSIDE SAFETY CHECKS ☑	BEDSIDE SAFETY CHECKS ☐	BEDSIDE SAFETY CHECKS ☑
DAMP DUSTING ☐	DAMP DUSTING ☐	DAMP DUSTING ☐

LINES	INSERTION SITE	DATE INSERTED	SITE OBSERVED	PHLEBITIC SCORE	DRESSING INTACT/ TRANSPARENT	DATE REMOVED
CENTRAL LINE	R femoral	30/11/11	Y	0	Y	
ARTERIAL LINE	L Radical	21/11/11	Y	0	Y	
SWAN SHEATH						
PERIPHERAL LINE						
PASCATH	L femoral	30/11/11	Y	0	Y	
OTHER						

			COMMENTS	
PACING WIRES				
CATHETER	Urethral	21/11/11	catheter care given	
NG TUBE	R Nostril	21/11/11		
CHEST DRAINS				
STAPS / SUTURES				
SURGICAL WOUND				
OTHER				

00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00
35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%
9P CPAP ASB	CPAP ASB	CPAP ASB	CPAP ASB	CPAP ASB	CPAP ASB	CPAP ASB	CPAP ASB	CPAP ASB	CPAP ASB	CPAP ASB	CPAP ASB	CPAP ASB	CPAP ASB	CPAP ASB	CPAP ASB	CPAP ASB	CPAP ASB
8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8

Heparin proposal											8	5	3	5	16
NG feed	57	57	57	64	64	64	64	64	64	64	64	64	64	64	64
Drugs	110	200	320		5					40			200→110		30
HOURLY INPUT	181	270	390	77	82	77	77	77	77	117	78	83	79	206	382
FLUIDS IN	181	451	841	918	1000	1077	1154	1231	1308	1425	1503	1586	1665	2061	2443
BALANCE	-4	+116	+431	+433	+415	+307	+174	+141	+115	+260	-237	-416	-581	-776	-1
FLUIDS OUT	185	255	410	485	585	770	980	1090	1190	1685	1740	2002	2246	2837	2925
HOURLY OUTPUT	185	70	155	75	100	185	210	110	40	85	465	308	156	133	125
..... E	185	70	155	75	100	185	210	110	40	75	305	160	20	45	30
CVVH		60				90				70	160	148	136	88	70
NG LOSSES + pH										110			180		
BOWELS / STOMA													BM x1 type 6		
CHEST DRAINAGE HOURLY															
CHEST DRAINAGE RUNNING TOTAL															

SERVICES	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00
PERIPHERAL TEMPERATURE C / W	W			W			W			W	W		W		W
FOOT PULSES L / R	✓ ✓			✓ ✓			✓ ✓			✓ ✓	✓ ✓		✓ ✓		✓ ✓
PUPIL SIZE L / R	2 2			2 2			2 2			2 2	2 2		3 3		3 3
PUPIL REACTION L / R	+ +			+ +			+ +			+ +	+ +		+ +		+ +
COMA SCORE/ SEDATION SCORE	4			4			4			4	+2		-4		-4
PACING MODE	N/A														
SET RATE															
A PACING / SENSING															
V PACING / SENSING	N/A														
PAIN SCORE REST	Unable to assess	→	→	→	→	→									
MOVEMENT															
ST CHANGES															
AUGMENTATION															

5+	5+	5+	6	6	6	off		
64	64	64	64	64	64	64	64	64
	20				145			
81	182	82	83	83	128	75	75	75
520	2682	2708	2791	2874	3102	3277	3352	3521
44	-59	-117	-383	-502	-192	-200	-240	-341
576	2685	2824	3174	3517	3294	3852	4008	4168
16	112	140	319	233	217	263	196	115
5	30	45	150	40	25	70	60	40
01	82	95	169	193	192	193	136	75
	80R							
		BD 7+ syr 1c			BD smear			

	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00
		W			W			
		✓			✓			
		3			3			
		+			+			
		+2	+2					

TIDAL VOLUME						
MINUTE VOLUME						
PEAK PRESSURE						
SPONT RATE	24	22	27	32	22	
SPONT T.V.	229	307	235	280	279	4
SPONT M.V.	6.07	6.14	6.37	8.91	5.80	7
HUMIDIFIER TEMP°C	36.9	37.2	37.1	35.6	36.9	3
SATS	98	95	96	97	97	9
NITRIC PPM $EtCO_2$	4.7	4.6	4.6	4.5	5.2	4.
ECMO FLOW						
ECMO SWEEP						

BLOOD GASES	10:00	11:00	12:00	13:00	14:00	15
pH	7.40			7.41		7.
$PaCO_2$	5.44			4.91		5.
PaO_2	11.19			11.86		10
SaO_2	96.7			97.1		9
HCO_3	24.4			23.5		24
BE	0.2			1.0		1.
Na^+ mmol/L	130.5			131.6		13
K^+ mmol/L	5.59			5.36		5.
Hb g/dl	13.4			12.9		13.
HCT	43.9			43.2		44
BLOOD GLUCOSE	9.3			11.9		8.
LACTATE	1.5			1.6		1.

INTERVENTIONS	10:00	11:00	12:00	13:00	14:00	15
POSITION / PA CARE	Rolled		Toe cleaners ✓	Rotation		
MOUTH CARE			✓			✓
EYE CARE			✓			✓
SUCTION & NATURE OF TRACHEAL SECRETIONS			✓ ✓ Thick white		✓	
TRACHEOSTOMY INNER TUBE CLEAN / CHANGE	✓					
SATS PROBE MOVED	✓					

NURSING COMMENTS / SIGNIFICANT EVENTS

VENTILATOR TYPE: Drager

NAME: Vulcan

NUMBER:

ET SIZE:

LENGTH:

DATE INSERTED

14	19	18	15	21	11	11	19	14	14	16	15	15	13	12	10	12	13
498	561	484	549	335	381	368	338	356	431	467	550	447	376	481	372	477	451
639	739	724	691	5.05	5.49	3.30	7.87	5.54	7.26	7.07	12.9	4.22	6.20	6.53	4.40	5.05	5.39
37.2	37.1	37.2	37.2	37.9	37.2	33.4	37.0	36.9	37	37.4	36.1	38.1	36.5	36.3	37.3	36.7	37.6
93	95	96	96	95	100	95	99	100	100	97	99	96	98	98	100	100	97
5.1	4.8	4.9	5.6	5.9	5.0	5.0	5.2	4.9	4.7	4.8	4.1	5.2	4.7	4.4	5.0	4.1	4.8

16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00
			7.41		7.37			7.35			7.39		7.35			7.39	
			4.82		5.92			6.14			5.63		6.19			5.62	
			11.0		14.26			14.06			11.05		12.27			10.46	
			96.5		97.8			97.7			92.4		90.8			95.8	
			23.4		23.9			23.6			24.3		24.0			24.7	
			1.2		0.4			-0.7			0.1		0.2			0.5	
			132.9		135.6			134.7			131.2		136.1			136.7	
			5.10		5.31			5.46			5.38		5.40			5.58	
			13.1		13.3			13.0			12.9		12.4			12.5	
			42.6		43.5			42.4			43.3		37.3			40.6	
			8.6		6.8			9.1			10.3		5.4			8.5	
			1.6		1.4			1.6			1.7		0.7			1.5	

16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00
		Set up				Rolled				(B)	Rolled			Rolled			(B)
		✓				✓					✓			✓			✓
		✓				✓								✓			✓
		✓				✓	✓			✓	✓			✓		✓	(P)

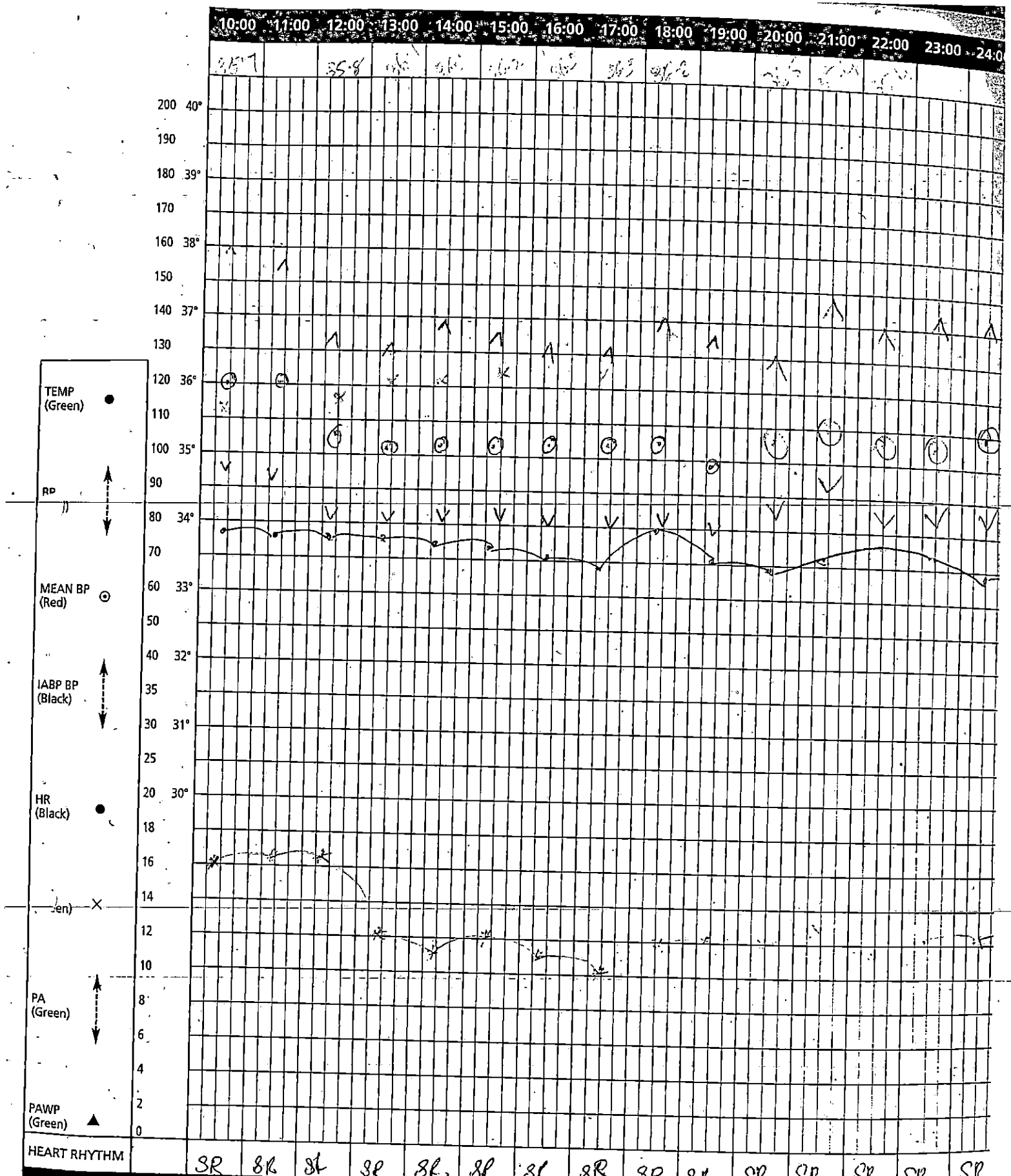
Full washed down. 08:45 pt flushed Removed & 80mls
09:00 lines swapped over.

GRADE OF INTUBATION:	TRACHY TYPE: Tracoe	CHART NUMBER: 12	DAYS IN ITU: 11
	SIZE: 7.0	DATE: 11/12/11	
	DATE INSERTED: 2/12/11		

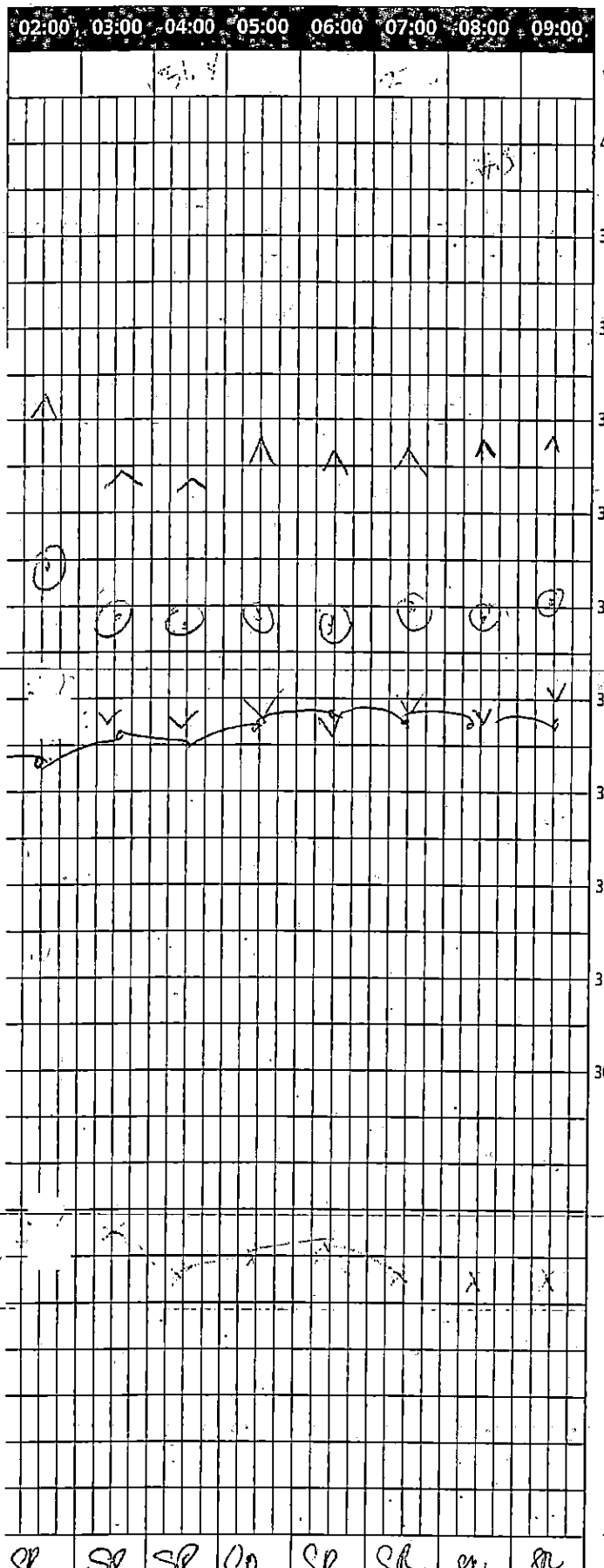
DATE: 8/12/11

BEDSIDE SAFETY CHECKS

	Day	Night	Day
Bed space number	19	19	
Date, name and signature on ITU chart	SJ	LAB	
ID label attached to all documentation	SJ	LAB	
Legible ID band and allergy band (if applicable) attached to patient	SJ	LAB	
Drug infusions - Correct prescription - Correct rate - Labelled correctly	SJ	LAB	
Record all drug dosages (mcg/kg etc) on ITU chart at the beginning of each shift and when rate altered	SJ	✓	
Transducers zero'd and appropriately positioned	SJ	✓	
Pressure bag pumped to 300mmhg	SJ	✓	
Monitor and ventilator alarms set appropriately	SJ	✓	
Monitor and ventilator plugged into UPS electrical supply	SJ	✓	
Pumps and all other electrical equipment plugged into mains supply		✓	
Bed plugged into mains supply electricity		✓	
Ventilator type and name written on ITU chart		✓	
Bacterial filter on expiratory port of the ventilator is dry		✓	
Dry circuit – HME filter in situ		✓	
Wet circuit – No HME filter in situ		✓	
Fisher Paykel humidifier AND wires available at the bed space		✓	
Oxygen analyser (for high flow) available at the bed space		NO	
Clean functional waters bag and O_2 tubing attached to flow meter		✓	
O_2 flow meter connected to piped O_2 outlet		✓	
Working portable O_2 cylinder, no less than half full, available at the bed space		✓	
Tracheostomy box available if applicable (correct tube size)		✓	
High suction set on 18-20 KPa - working		✓	
Low suction set on 5-10 KPa - working - attached to drain		✓ ✓	
Suction filters clean and dry, changed in the last 3 months		✓	
Fire evacuation box available and intact		✓	



FLUIDS INFUSIONS	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00
CHECK INITIAL IVI RATES (INITIAL CHANGES)	86	86	82	85	82	86	82	85	82	85	RABS	RABS	RABS	RABS	RAB
HEPARIN 20 mg/ml 25ml 125 : 48.	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	1.1	1.1	1.1	1
METHYL PREDNISOLONE	2	2	2	2	2	2	2	2.0	2.0	2.0	2.0	2	2	2	2
PROPOFOL 50 : 50	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
MORPHINE 60 : 60	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
MIDAZOLAM 50 : 50	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10



		DATE DUE	TIME	DONE / SIGN
CHANGES	DAILY / PRN			
	HME			
	VENT FILTER	22:00 / 7:00	LRB	
	ET TAPE AND FOAM			
	TRACHY DRESSING	8/12	09 08 8 8 17:00	88
	NG GIVING SETS	8/12	0800	88
	TPN GIVING SETS			
	NEBULISER ACORNS			
	YANKER SUCKERS			
	CATHETER MOUNTS			
	72 HOURS			
	INLINE SUCTION	10/12		
	TRANSDUCER SETS	9/12		
	IV LINES			
	WEEKLY			
	VENT / CPAP CIRCUITS	13/12		
	WATERS BAG			
	CATHETER BAG			

		TIME	DONE / SIGN
TESTS	U & E AM	6.00	RAB
	U & E PM		
	FBC AM	6.00	RAB
	FBC PM		
	CLOTTING AM	6.00	RAB
	CLOTTING PM		
	LFTs	6.00	
	AMYLASE		
	CRP		
	OTHER		
	OTHER		
	CXR		
	ECG		
LEVELS	GENTAMYCIN		
	VANCOMYCIN		
	OTHER		
	OTHER		
SAMPLES	SPUTUM		
	URINE		
	BLOOD		
	MRSA		
	OTHER		

PREVIOUS 24 HOUR FLUID BALANCE		WEIGHT: (kg)
In	4181	78kg
Balance	-356	
Out	4537	HEIGHT: (cm)
Fluid balance since admission		

	SR	SR	SR	SR	SR	SR	SR	SR
	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00
	RAB	CB	CB	RAB	RAB	RAB	JW	JW
	Off							
	2	2	2	2	2	2	2	2
	10	10	10	10	10	10	10	10
	10	10	10	10	10	10	10	10
	10	10	10	10	10	10	10	10

VENTILATION	10:00	11:00	12:00	13:00	14:00	15:00
FIO_2	61%	60%	60%	55	55	53
MODE	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB
RATE	18	18	18	18	18	18
IE RATIO	1:2:3	1:2:3	1:2:3	1:2:3	1:2:3	1:2:3
INSP PRESSURE	25	25	25	25	25	25
PEEP/CPAP	8	8	8	8	8	8

University Hospitals of Leicester NHS
NHS Trust

ADULT INTENSIVE CARE UNIT

S2664312
NHS Un-Known
MCLEISH
WENDY
1/1 51 COXTON PL
GLASGOW
G33 5EJ
25-MAY-1987 F
U5118413

Decannulated - 7/12/11
DIAGNOSIS / PROCEDURE: POST-VV-ecmo FOR comm ACQUIRED pneumonia
REFERRING CONSULTANT:
ITU CONSULTANT: Ecmo Team

CARDIAC SURGERY ☐ GENERAL ☐ ECMO ☑

CARE BUNDLES	Y/N	COMMENTS
STELLISEPT	Y	
BACTROBAN	Y	
CORSODYL GEL	Y	
SAT UP >30°	Y	
GUT PROPHYLAXIS	Y	
SEDATION HOLD	N	TIME
INSULIN PROTOCOL	Y	
ANTICOAGULATION	Y	
ANTIEMBOLIC STOCKINGS		IF NO, REASON heparin
DAILY SKIN CHECK IF EMBOLIC STOCKINGS N SITU	N	
PA ACT		IF NO, DOCUMENT IN CARE PLAN
MATTRESS TYPE		TOTAL CARE Sport

DAY	NIGHT	DAY
NAME SHITA MATHEW	NAME Liby Baju	NAME
SIGNATURE	SIGNATURE	SIGNATURE
BEDSIDE SAFETY CHECKS ☑	BEDSIDE SAFETY CHECKS ☑	BEDSIDE SAFETY CHECKS ☐
DAMP DUSTING ☐	DAMP DUSTING ☐	DAMP DUSTING ☐

LINES	INSERTION SITE	DATE INSERTED	SITE OBSERVED	PHLEBITIC SCORE	DRESSING INTACT/ TRANSPARENT	DATE REMOVED
CENTRAL LINE	ⓇFEMORAL	30:11:11	Y	0	—	
	ⓇSUBCLAVIAN	21:11:11	Y	0	—	
ARTERIAL LINE	Ⓛ RADIAL	29:11:11	Y	0	—	
SWAN SHEATH						
PERIPHERAL LINE						
VASCATH	Ⓛ FEMORAL	30:11:11	Y	0	—	
OTHER						

				COMMENTS	
PACING WIRES					
CATHETER	URETHRAL	21-11-11	Y	Catheter care given	
NG TUBE	ⓇNOSTRIL	21-11-11	Y		
CHEST DRAINS					
CLIPS / SUTURES					
SURGICAL WOUND					
OTHER					

16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00
53%	53%	50	50%	50%	50%	50%	45%	45%	45%	45%	45%	45	45%	45%	45%	45%	45
BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB
18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18
1:2:3	1:2:3	1:2:3	1:2:3	1:2:3	1:2:3	1:2:3	1:2:3	1:2:3	1:2:3	1:2:3	1:2:3	1:2:3	1:2:3	1:2:3	1:2:3	1:2:3	1:2:3
25	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25
8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8

ACTRAPID	1	3	3	3	2	4	1	1	1	1	1	1	1	1	1
Fruxmeli															
NG FEED	57	57	57	57	57	57	57	57	57	57	57	57	57	57	57
													5ml MgSO4 20		
DRUGS	30 200	100	10 300			30			10			200	100	20	30
KT Acid phosphate													5	5	5
HOURLY INPUT	321	192	402	92	92	122	92	91	101	91	90	311	196	111	39
FLUIDS IN	321	513	915	1007	1099	1221	1313	1404	1505	1595	1685	1996	2192	2303	2342
BALANCE	-76	-71	+167	+58	-90	-222	-334	-547	-697	-2??	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
FLUIDS OUT	242	502	748	949	1198	1450	1697	1952	2202	2465	2719	2886	2989	3110	3231
URLY OUTPUT	242	260	246	201	249	252	247	255	250	263	249	172	103	121	121
	5	10	10	0	10	5	0	10	0	20	0	10	5	20	0
CVVH	237	250	236	201	239	247	247	245	250	243	249	162	98	107	121
NG LOSSES + pH	(30 R)					(25 R)			(20 R)					(10 R)	
BOWELS / STOMA															
CHEST DRAINAGE HOURLY															
CHEST DRAINAGE RUNNING TOTAL															

OBSERVATIONS	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00
PERIPHERAL TEMPERATURE C/W	W			W			W			W	W		W		
FOOT PULSES L/R	✓ ✓			✓ ✓			✓ ✓			✓ ✓			✓ ✓		
PUPIL SIZE L/R	4 4			3 3			3 3			3 3	3 3		3 3		
PUPIL REACTION L/R	+ +			+ +			+ +			+ +	+ +		+ +		
COMA SCORE/ SEDATION SCORE	2-3			-2-1			2-1			-1	-3		-3		
PACING MODE															
SET RATE											N/A		N/A		
A PACING / SENSING															
V PACING / SENSING															
PAIN SCORE REST	reduced unable to assess						sedated unable to assess						sedated		
MOVEMENT															
ST CHANGES															
IABP AUGMENTATION											N/A		N/A		
IABP RATIO															

	2	2	2	2	2	2	2	2
7	57	57	57	57	57	57	57	57
					10			
					120		5 →	
5	5	5	5	5	off			
11	90	97	97	97	222	92	92	97
85	2875	2972	3069	3166	3388	3480	3572	3669
7	141						532	560
57	3599	3594	3669	3769	3859	3984	4104	4229
12	142	75	75	90	90	125	120	
)	40	75	75	90	90	125	120	125
13	102							
			20R				30R	
						80+		
					Tym -5			

	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00
)			W			W	W	
			✓			✓	✓	
2			3			3	3	
+			+			+	+	
2			-3			-3	-3	
WNK			NIA			NIA	NIA	
natural			sedated			sedated ventilated		
NIA			NIA			NIA		

TIDAL VOLUME	484	429	438	447	411	41
MINUTE VOLUME	12.5	11.5	9.3	10.1	10.7	8.
PEAK PRESSURE	27	27	28	26	27	2
SPONT RATE	14	15	4	9	11	1
SPONT T.V.	323	456	397	406	389	4
SPONT M.V.	5.6	7.27	2.78	3.5	5.1	3.
HUMIDIFIER TEMP°C	304	310	310	308	308	31
SATS	84 92	93	98	95	93	9
~~NITRIC PPM~~						
~~ECMO FLOW~~ ETCO2	1		4.2	4.5	4.2	4
~~ECMO SWEEP~~						

BLOOD GASES	10:00	11:00	12:00	13:00	14:00	15
pH	7.38		7.37		7.37	
$PaCO_2$	5.5		5.94		6.92	
PaO_2 >8	8.94		11.84		9.25	
SaO_2	94.2		96.7		94.6	
HCO_3	23.4		24.2		24.3	
BE	-1.1		-0.0		0.2	
Na^+ mmol/L	134.4		137.0		136.6	
K^+ mmol/L	4.69		4.56		4.79	
Hb g/dl	12.7		12.2		12.6	
HCT	42.6		41.3		42.6	
BLOOD GLUCOSE	10.0		9.6		6.6	
LACTATE	1.3		1.2		1.1	

INTERVENTIONS	10:00	11:00	12:00	13:00	14:00	15
POSITION / PA CARE	Semi Prone		(B)	(L)		
MOUTH CARE	✓		✓			
EYE CARE	✓			✓		
SUCTION & NATURE OF TRACHEAL SECRETIONS	(B)✓				✓	
TRACHEOSTOMY INNER TUBE CLEAN / CHANGE						
SATS PROBE MOVED						

NURSING COMMENTS / SIGNIFICANT EVENTS

VENTILATOR TYPE: DRAGER	ET SIZE:
NAME: VLICAN	LENGTH:
NUMBER:	DATE INSERTED

	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14
	454	493	343	463	452	496	489	481	460	417	396	498	473	468	432	463	
	9.9	8.3	8.1	7.83	7.81	9.95	8.48	7.54	8.56	7.43	7.61	9.39	8.04	7.80	8.02	8.14	
	27	26	26	26	26	26	26	26	26	26	26	26	26	26	26	26	
	6	4	1	4	1	2	1	1	2	0	0	2	1	3	1	0	
	404	443	467	478	443	441	308	368	391	-	-	477	401	426	413		
	4.28	3.21	0.22	0.37	1.58	3.26	2.69	1.08	2.92	-	-	1.20	2.23	1.87	3.23		
	31.1	31.1	30.8	31.0	31.0	31.2	30.8	31.0	31.0	30.9	31.0	30.6	30.8	30.9	31.0	30.9	
	94	96	96	97	96	93	94	93	95	93	95	941	951	94	95	96	
	4.2	4.5	5.0	4.6	4.5	4.7	4.2	4.5	4.6	4.6	4.2	4.4	4.6	4.4	4.6	4.6	

17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00
	7.38	7.37			7.36			7.35		7.35			7.38			
	6.80	5.9			6.0			6.05		5.6			5.6			
	9.79	9.94			10.05			10.84		9.8			9.95			
	93.9	95.3			95.3			95.9		98.0			95.6			
	22.1	24.1			23.8			23.2		22.6			23.8			
	-0.2	-0.1			-0.5			-1.2		-2.0			-0.6			
	138.3	134.1			136.6			134.9		134			132.1			
	4.95	4.90			4.70			4.79		5.1			5.20			
	12.5	12.4			12.3			12.1		12.1			12.3			
	42.4	41.7			41.8			41.3		40.7			41.6			
	7.4	7.1			8.4			9.0		7.7			8.4			
	1.3	1.2			1.1			1.3		1.2			1.2			

17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00
				✓	Utrad				(B)				(B)			
					✓				✓				✓			
				✓	✓				✓				✓			
				✓ T++	✓				✓	✓			✓			✓
					=											P
						✓							✓			

Reemo co-ordinator / Reemo fellow

Start trialling off · 200 Filter → To change set when it gets dusty Commenced IV frusemide

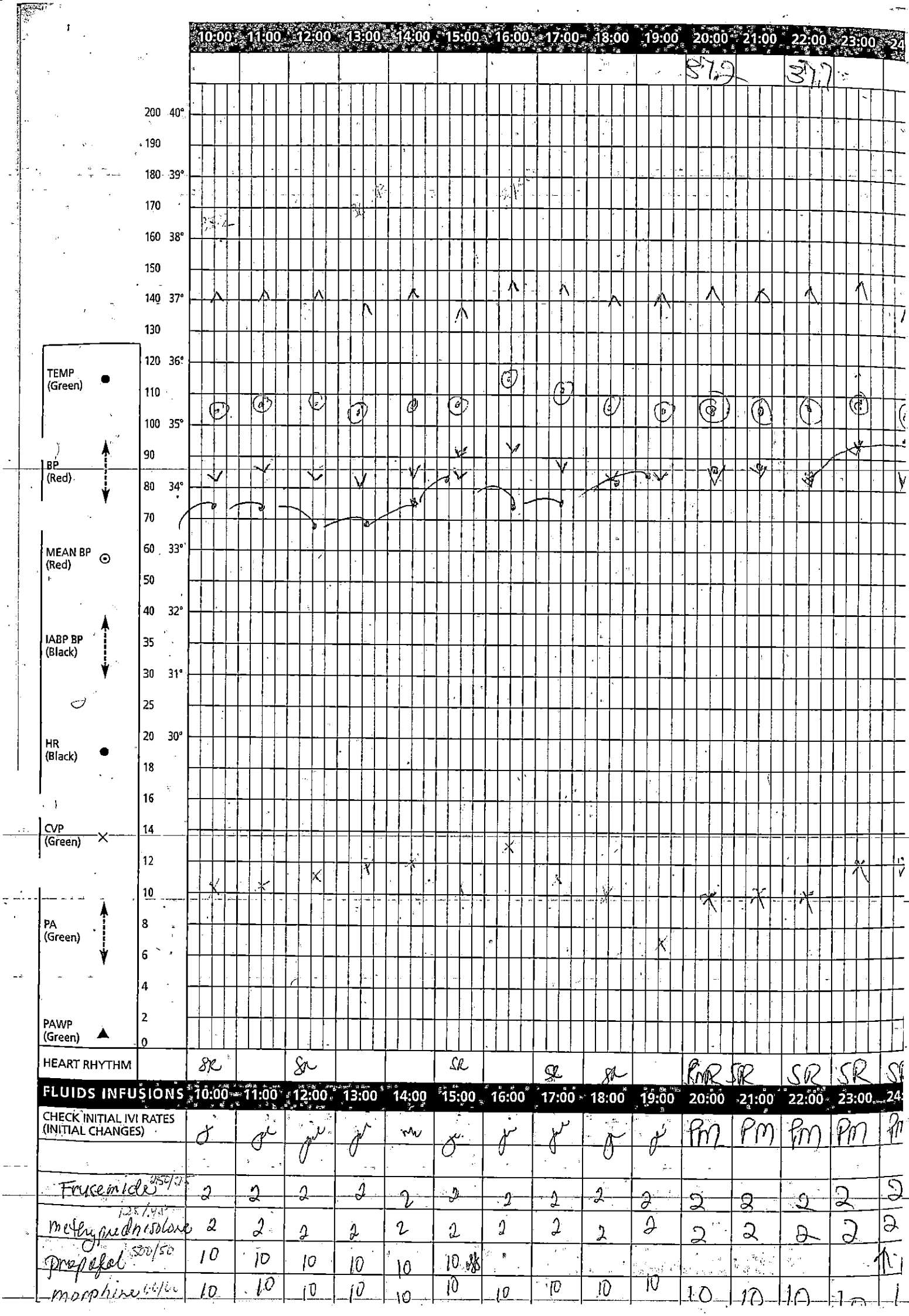
Tracheostomy dressing ☐

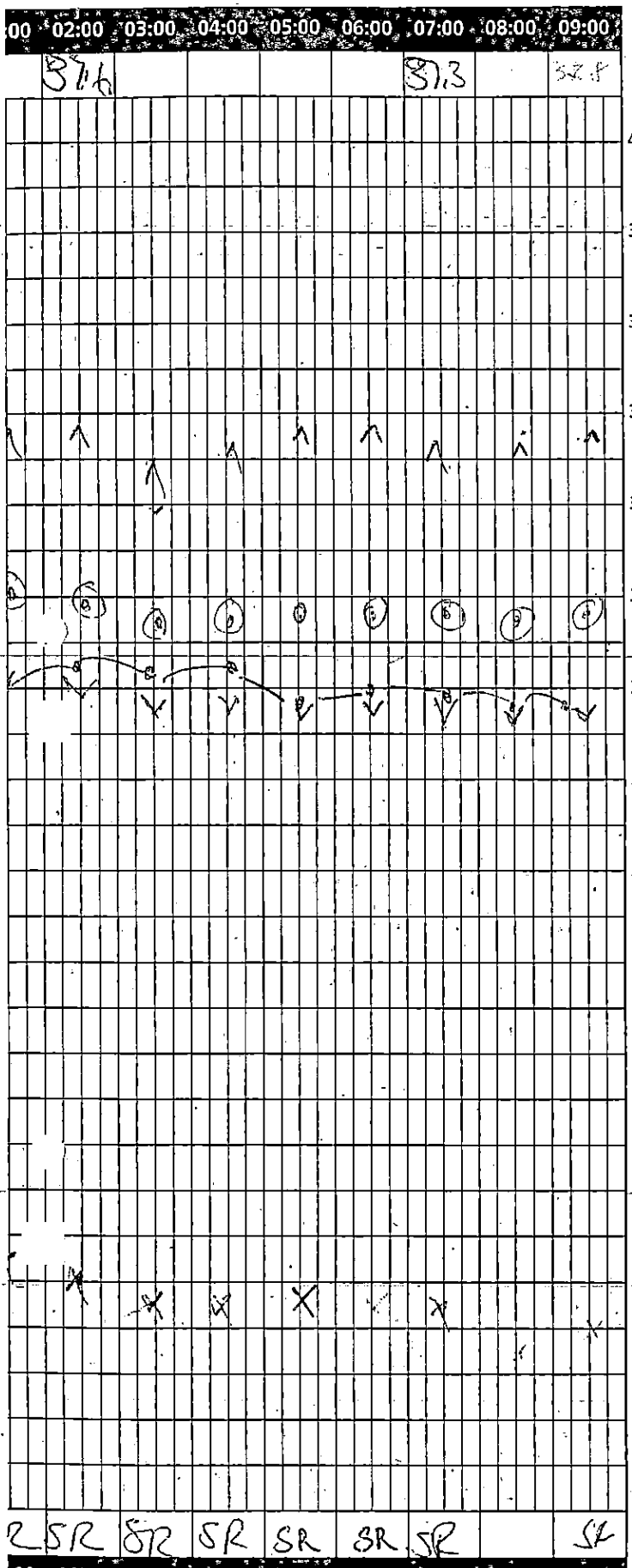
GRADE OF INTUBATION:	TRACHY TYPE: Tracoe	CHART NUMBER: 9	DAYS IN ITU: 8
	SIZE: 7.0	DATE: 8/12/11	
	DATE INSERTED: 2/12/11		

Printed By Ward Direct Ltd Tel 0116 2863016 ATCH (V2) 05/2010

DATE: 9/12/11

BEDSIDE SAFETY CHECKS	Day	Night	Day
Bed space number	19	19	
Date, name and signature on ITU chart	✓	✓	
ID label attached to all documentation	✓	✓	
Legible ID band and allergy band (if applicable) attached to patient	✓	✓	
Drug infusions - Correct prescription - Correct rate - Labelled correctly	✓	✓	
Record all drug dosages (mcg/kg etc) on ITU chart at the beginning of each shift and when rate altered	✓	✓	
Transducers zero'd and appropriately positioned	✓	✓	
Pressure bag pumped to 300mmhg	✓	✓	
Monitor and ventilator alarms set appropriately	✓	✓	
Monitor and ventilator plugged into UPS electrical supply	✓	✓	
Pumps and all other electrical equipment plugged into mains supply	✓	✓	
Bed plugged into mains supply electricity	✓	✓	
Ventilator type and name written on ITU chart	✓	✓	
Bacterial filter on expiratory port of the ventilator is dry	✓	✓	
Dry circuit – HME filter in situ	✓	NO	
Wet circuit – No HME filter in situ	✓	✓	
Fisher Paykel humidifier AND wires available at the bed space	✓	✓	
Oxygen analyser (for high flow) available at the bed space	missing	Nil	
Clean functional waters bag and O_2 tubing attached to flow meter	✓	✓	
O_2 flow meter connected to piped O_2 outlet	✓	✓	
Working portable O_2 cylinder, no less than half full, available at the bed space	✓	✓	
Tracheostomy box available if applicable (correct tube size)	✓	✓	
High suction set on 18-20 KPa - working	✓	✓	
Low suction set on 5-10 KPa - working - attached to drain	✓ N/A	✓ NO	
Suction filters clean and dry, changed in the last 3 months	✓	✓	
Fire evacuation box available and intact	✓	✓	


10:00 11:00 12:00 13:00 14:00 15:00 16:00 17:00 18:00 19:00 20:00 21:00 22:00 23:00
200 40°
190
180 39°
170
160 38°
150
140 37°
130
120 36°
110
100 35°
90
80 34°
70
60 33°
50
40 32°
35
30 31°
25
20 30°
18
16
14
12
10
8
6
4
2
0
TEMP (Green)
BP (Red)
MEAN BP (Red)
IABP BP (Black)
HR (Black)
CVP (Green)
PA (Green)
PAWP (Green)
HEART RHYTHM
SR SR SR SR SR SR SR SR SR SR SR SR SR SR
FLUIDS INFUSIONS 10:00 11:00 12:00 13:00 14:00 15:00 16:00 17:00 18:00 19:00 20:00 21:00 22:00 23:00
CHECK INITIAL IVI RATES (INITIAL CHANGES)
Frusemide 250/50
methylprednisolone 125/50
propofol 500/50
morphine 60/50
2 2 2 2 2 2 2 2 2 2 2 2 2 2
2 2 2 2 2 2 2 2 2 2 2 2 2 2
10 10 10 10 10 10 10
10 10 10 10 10 10 10 10 10 10 10 10 10 10



		DATE DUE	TIME	DONE / SI
CHANGES	DAILY / PRN			
	HME	PRN / n/a		
	VENT FILTER	PRN ✓		
	ET TAPE AND FOAM	n/a		
	TRACHY DRESSING	PRN ✓		
	NG GIVING SETS	9/12/11		
	TPN GIVING SETS	n/a		
	NEBULISER ACORNS	n/a		
	YANKER SUCKERS	PRN		
	CATHETER MOUNTS	n/a		
	72 HOURS			
	INLINE SUCTION	12/12 ✓		
	TRANSDUCER SETS	12/12 ✓		
	IV LINES			
	WEEKLY			
	VENT / CPAP CIRCUITS	13/12		
	WATERS BAG			
	CATHETER BAG			

		TIME	DONE / SI
	U & E AM		
	U & E PM		
TESTS	FBC AM		
	FBC PM		
	CLOTTING AM		
	CLOTTING PM		
	LFTs		
	AMYLASE		
	CRP		
	OTHER		
	OTHER		
	CXR		
	ECG		
LEVELS	GENTAMYCIN		
	VANCOMYCIN		
	OTHER		
	OTHER		
SAMPLES	SPUTUM		
	URINE		
	BLOOD		
	MRSA		
	OTHER		

PREVIOUS 24 HOUR FLUID BALANCE		WEIGHT: (kg)
In	3L 0.9	78 kgs
Balance	− 5L 0.	HEIGHT: (cm)
Out	4 2.9	
Fluid balance since admission		

VENTILATION	10:00	11:00	12:00	13:00	14:00	15
FIO_2	45%	45%	45%	45%	45%	4
MODE	BiPAP ASB	BiPAP ASB	BiPAP ASB	BiPAP ASB	BiPAP ASB	BiP
RATE	18	18	18	18	18	
IE RATIO	1:2.3	1:2.3	1:2.3	1:2.3	1:2.3	1:
INSP PRESSURE	25	25	25	25	25	2
PEEP/CPAP	8	8	8	8	8	8

	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00
	SR	SR	SR	SR	SR	SR		SR
	M	AM	PM	PM	N	N	PM		
	2	2	2	2	2	2	2	2
	2	2	2	2	2	2	2	2
	10	12	12	12	12	12	12	12
	5	5	5	5	5	5	5	5

University Hospitals of Leicester NHS
NHS Trust

ADULT INTENSIVE CARE UNIT

S2664312

Decannulated 7/12/11

DIAGNOSIS / PROCEDURE: Post VV ecmo - community acquired pneumonia

REFERRING CONSULTANT:

ITU CONSULTANT: ECMO TEAM

NHS Un-Known
MCLEISH
WENDY
1/1 51 COXTON PL L
GLASGOW
G33 5EJ
25-MAY-1987 F
U5118413

CARDIAC SURGERY ☐ GENERAL ☐ ECMO ☑

RE BUNDLES	Y/N	COMMENTS
ELLISEPT	Y	
CTROBAN	Y	
RSODYL GEL	Y	
T UP >30°	Y	
JT PROPHYLAXIS	Y	
DATION HOLD	N	TIME
ISULIN PROTOCOL	Y	
NTICOAGULATION	Y	
NTIEMBOLIC TOCKINGS		IF NO, REASON
DAILY SKIN CHECK IF EMBOLIC STOCKINGS NS		
PA ACT		IF NO, DOCUMENT IN CARE PLAN
MATTRESS TYPE		Total Care sport

DAY	NIGHT	DAY
NAME Josie Bagasan	NAME Prisca Malank	NAME Josie Bagasan
SIGNATURE	SIGNATURE	SIGNATURE
BEDSIDE SAFETY CHECKS ☑	BEDSIDE SAFETY CHECKS ☑	BEDSIDE SAFETY CHECKS ☐
DAMP DUSTING ☑	DAMP DUSTING ☑	DAMP DUSTING ☐

LINES	INSERTION SITE	DATE INSERTED	SITE OBSERVED	PHLEBITIC SCORE	DRESSING INTACT/ TRANSPARENT	DATE REMOVED
CENTRAL LINE	① Femoral ② Subclavian	30/11/11 21/11/11	Y Y	0 0	✓	
ARTERIAL LINE	① Radial	29/11/11				
SWAN SHEATH						
PERIPHERAL LINE						
VASCATH	① Femoral	30/11/11	Y	0	✓	
OTHER						

				COMMENTS
PACING WIRES				
CATHETER	Urethral	21/11/11	Y	catheter care given
NG TUBE	② nastric	21/11/11	Y	
CHEST DRAINS				
CLIPS / SUTURES				
SURGICAL WOUND				
OTHER				

16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:0
45%	45%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%
BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB
18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18
1:2:3	1:2:3	1:2:3	1:2:3	1:2:3	1:2:3	1:2:3	1:2:3	1:2:3	1:2:3	1:2:3	1:2:3	1:2:3	1:2:3	1:2:3	1:2:3	1:2:3	1:2
25	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25
8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8

Midazolam	10				10		10	10	10		10	10	10	10	10
Actrapid 50/50	1	1	1	2	2	2	1	1	1	1	1	1	1	1	1
DRUGS NG/N	200 10	40	20	300					20→				315		31
NG Feed	57	57	84	57	57	57	57	57	57	57	57	57	57	57	57
HOURLY INPUT	302	202	112	393	93	93	82	82	82	102	82	82	397	82	39
FLUIDS IN	302	504	616	1009	1102	1195	1277	1359	1441	1543	1625	1707	2104	2186	2257
BALANCE	+187	+209	+161	+434	+487	+500	+492	+269	+241	+183	+170	−98	−26	−56	+16
FLUIDS OUT	115	255	455	575	615	695	785	1090	1180	1365	1455	1805	2130	2230	2239
HOURLY OUTPUT	115		200	120	40	80	290				100	350	325	200	14
	115	140	200	120	40	80	290	105	90	175	100	350	325	200	14
CVVH															
NG LOSSES + pH			35				40 R) Ph 6.0			30 R			90 R		
BOWELS / STOMA			80 type 6 x1						80 type 6			80 FL			SN
CHEST DRAINAGE HOURLY															
CHEST DRAINAGE RUNNING TOTAL															
Splint	on → off				on →		off								

OBSERVATIONS	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00
PERIPHERAL TEMPERATURE C / W	W		W			W			W			W			
FOOT PULSES — L / R	✓ / ✓		✓ / ✓			✓ / ✓			✓ / ✓			✓ / ✓			
PUPIL SIZE L / R	3 / 3		3 / 3			2 / 2			2 / 2			2 / 2			
PUPIL REACTION L / R	✓ / ✓		✓ / ✓			✓ / ✓			✓ / ✓			✓ / ✓			
COMA SCORE/ SEDATION SCORE	−3		−3			−3/+1			−3/+1			+1			
PACING MODE															
SET RATE	n/a														
A PACING / SENSING															
V PACING / SENSING															
PAIN SCORE REST	sedated		sedated			sedated			sedated						
MOVEMENT															
ST CHANGES															
IABP AUGMENTATION															
IABP RATIO															

	10	11	12	13	14	15	16	17	18
TIDAL VOLUME	465	442	425	447	462	4			
MINUTE VOLUME	7.83	7.66	7.72	7.18	8.17	5			
PEAK PRESSURE	26	26	26	26	27				
SPONT RATE	0	0	3	0	0				
SPONT T.V.			428						
SPONT M.V.			0.59						
HUMIDIFIER TEMP°C	30.9	30.9	30.9	31.0	31.0				
SATS	95	97	97	96	96	9			
NITRIC PPM ~~ET~~ CO_2	4.4	4.5	4.5	4.7	4.9	4			
ECMO FLOW									
ECMO SWEEP									

BLOOD GASES	10:00	11:00	12:00	13:00	14:00	15
pH	7.38		7.35			7
$PaCO_2$	5.02		5.89			5.
PaO_2	8.88		10.66			9.
SaO_2	94.2		95.8			95
HCO_3	23.8		22.8			23
BE	-0.6		-1.7			-1
Na^+ mmol/L	136.7		135.6			13
K^+ mmol/L	5.40		5.33			5.
Hb g/dl	12.4		12.2			12
HCT	42.0		41.8			42
BLOOD GLUCOSE	8.6		9.7			6.
LACTATE	1.3		1.3			1.

INTERVENTIONS	10:00	11:00	12:00	13:00	14:00	15
POSITION / PA CARE	(B)		PRONE			
MOUTH CARE			✓			
EYE CARE			✓			
SUCTION & NATURE OF TRACHEAL SECRETIONS			✓✓ +	✓		V H
TRACHEOSTOMY INNER TUBE CLEAN / CHANGE			White Lubricant			ab W
SATS PROBE MOVED						

NURSING COMMENTS / SIGNIFICANT EVENTS: Full washed done.

VENTILATOR TYPE: DRAGER — ET SIZE:

NAME: Vulcan — LENGTH:

NUMBER: — DATE INSERTED

397	572	405	420	399	409	442	376	575	429	388	440	382	384	409	396	385	389
6.70	6.77	6.59	13.4	8.85	8.81	9.89	7.51	6.34	7.21	7.24	7.01	6.69	6.7	6.7	6.75	6.62	6.71
26	26	26	26	26	26	28	26	27	27	27	26	26	26	26	26	26	26
1	0	3	17	1	17	7	0	0	0	0	0	0	0	0	0	0	0
383		388	444														
0.20		1.72	5.06	0.47	0.11	5.80											
30.9	31.0	37.3	36.0	36.8	37.2	37.6	37.2	37.2	37.1	37	38	37.2	36.8	37.1	37	37	37
95	96	96	95	95	94	95	95	97	97	97	97	98	97	97	97	98	98
4.7	4.3	4.3	4.5	4.2	4.6	4.5	4.7	4.9	4.8	5.0	4.8	5.1	5.0	4.9	4.9	5.0	4.9
								2321									

16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00
		1726 7.38		1.40				1.56			1.56			1.37	1.36		
		5.36		5.02				5.65			5.90			5.45	5.52		
		9.69		9.33				11.2						10.5	11.4		
		95.5		95				96.4			10.5			95.9	96.6		
		23.3		23.1				22.7			23.6			22.8	22.8		
		-1.2		-1.5				-1.9			-0.7			-1.8	-2.0		
		134.9		132.7				135.4			134.1			130.9	132.3		
		5.38		5.57				5.26			5.41			5.76	5.41		
		12.5		12.5				12.4			12.5			12.5	12.3		
		42.3		41.4				41.8			43			42.1	41.4		
		7.1		7.1				8.6			8.7			7.9	8.0		
		1.3		1.5				1.5			1.3			1.4	1.4		

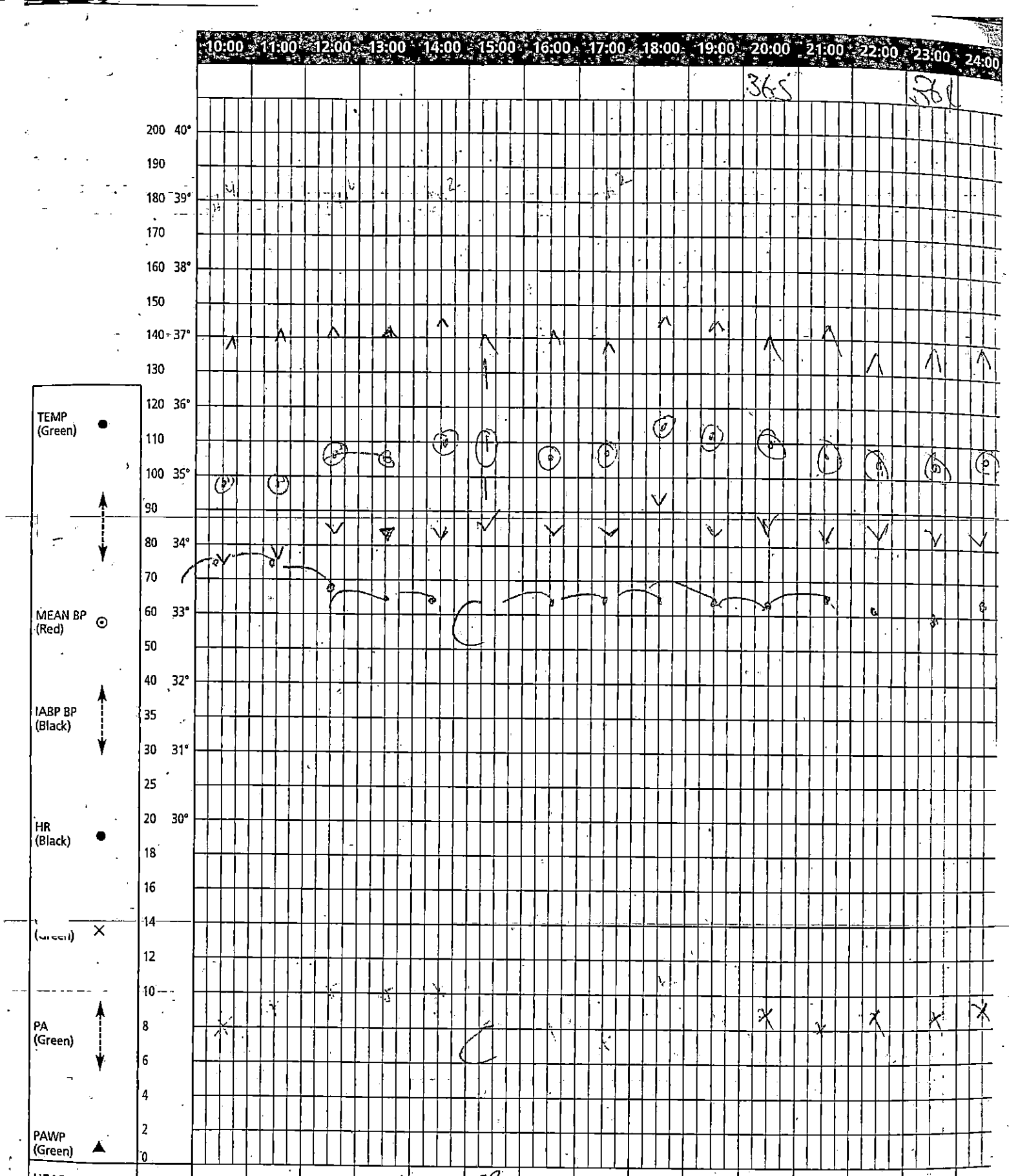
16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00
					Rt lobe			Rt lobe									

	GRADE OF INTUBATION:	TRACHY TYPE: Tracoe	CHART NUMBER: 10	DAYS IN ITU: 9
		SIZE: 7.0	DATE: 9/12/11	
		DATE INSERTED: 2/12/11		

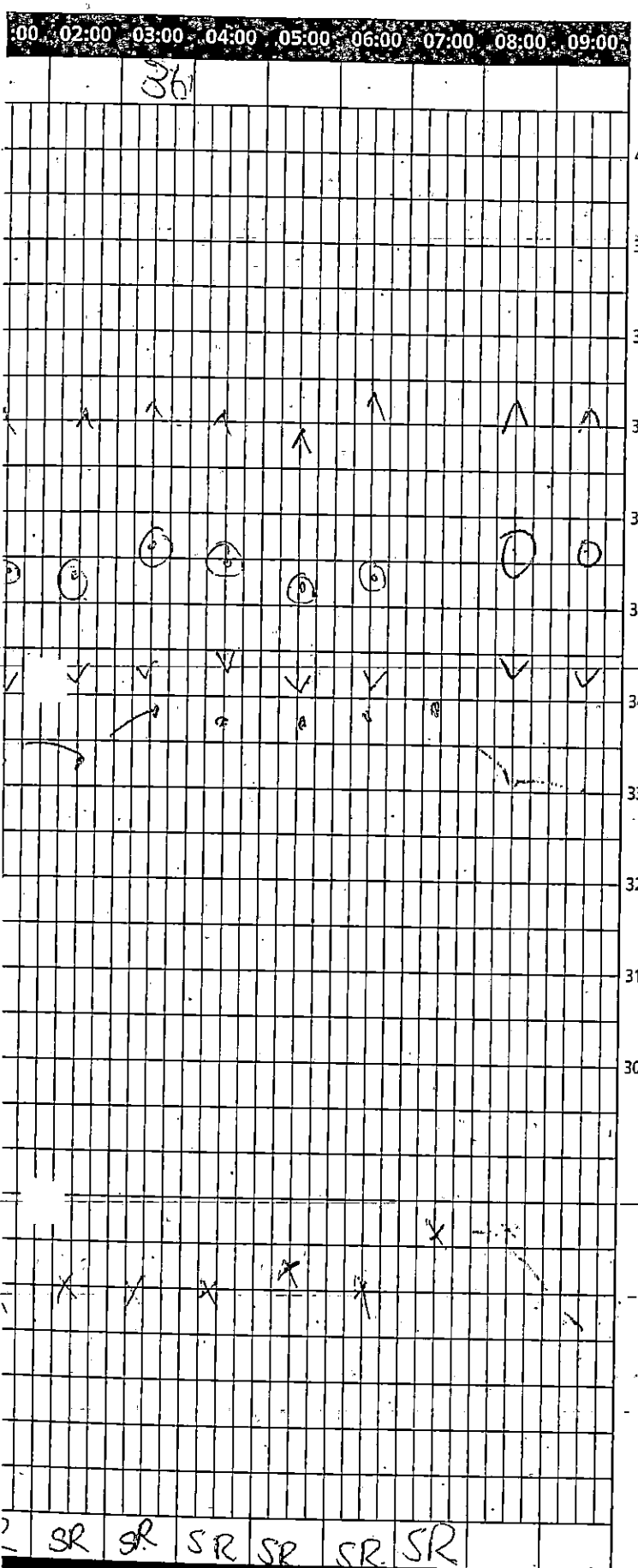
DATE: 18/12/19

BEDSIDE SAFETY CHECKS

	Day	Night	Day
Bed space number	19		19
Date, name and signature on ITU chart	✓		✓
ID label attached to all documentation	✓		✓
Legible ID band and allergy band (if applicable) attached to patient	✓		✓
Drug infusions - Correct prescription - Correct rate - Labelled correctly	✓		✓ ✓ ✓
Record all drug dosages (mcg/kg etc) on ITU chart at the beginning of each shift and when rate altered	✓		✓
Transducers zero'd and appropriately positioned	✓		✓
Pressure bag pumped to 300mmhg	✓		✓
Monitor and ventilator alarms set appropriately	✓		✓
M[illegible]or and ventilator plugged into UPS electrical supply	✓		✓
Pumps and all other electrical equipment plugged into mains supply	✓		✓
Bed plugged into mains supply electricity	✓		✓
Ventilator type and name written on ITU chart	✓		✓
Bacterial filter on expiratory port of the ventilator is dry	✓		✓
Dry circuit – HME filter in situ	n/a		N/A
Wet circuit – No HME filter in situ	✓		✓
Fisher Paykel humidifier AND wires available at the bed space	✓		✓
Oxygen analyser (for high flow) available at the bed space	n/a		NO
Clean functional waters bag and O_2 tubing attached to flow meter	✓		✓
O_2 flow meter connected to piped O_2 outlet	✓		✓
Working portable O_2 cylinder, no less than half full, available at the bed space	✓		✓
Tracheostomy box available if applicable (correct tube size)	✓		✓
High suction set on 18-20 KPa - working	✓		✓
Low suction set on 5-10 KPa - working - attached to drain	✓ n/a		✓ N/A
Suction filters clean and dry, changed in the last 3 months	✓		✓
Fire evacuation box available and intact	✓		✓



FLUIDS INFUSIONS	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00
CHECK INITIAL IVI RATES (INITIAL CHANGES)											PM	PM	PM	PM	PM
Frusemide	2	2	2	2	2	1	0.5	0.5	0.5	0.1					
methylprednisolone 125/ml	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Propofol	12	12	12	12	6	OH							10	10	10
Morphine 60/60	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
Midazolam 50/50	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5



		DATE DUE	TIME	DONE / SI
CHANGES	DAILY / PRN			
	HME	PRN / n/a		
	VENT FILTER	PRN		
	ET TAPE AND FOAM	n/a		
	TRACHY DRESSING	PRN		
	NG GIVING SETS	9/12/11		
	TPN GIVING SETS	n/a		
	NEBULISER ACORNS	n/a		
	YANKER SUCKERS	PRN		
	CATHETER MOUNTS	PRN		
	72 HOURS			
	INLINE SUCTION	12/12		
	TRANSDUCER SETS	12/12		
	IV LINES	r/c N Lines		
	WEEKLY			
	VENT / CPAP CIRCUITS	13/12		
	WATERS BAG			
	CATHETER BAG			

		TIME	DONE / SI
TESTS	U & E AM		
	U & E PM		
	FBC AM		
	FBC PM		
	CLOTTING AM		
	CLOTTING PM		
	LFTs		
	AMYLASE		
	CRP		
	OTHER		
	OTHER		
	CXR	✓	
	ECG		
LEVELS	GENTAMYCIN		
	VANCOMYCIN		
	OTHER		
	OTHER		
SAMPLES	SPUTUM		
	URINE		
	BLOOD		
	MRSA		
	OTHER	Central line tip ✓	

PREVIOUS 24 HOUR FLUID BALANCE		WEIGHT: (kg)
In	3568	78 kgs
Balance		HEIGHT: (cm)
Out	3900	
Fluid balance since admission		

	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00
	SR	SR	SR	SR	SR	SR		
	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00
	g	g	PM	PM	PM	AM	BE	BE
				0.5	0.5	0.2	0.2	0.2
	2	2	2	2	2	2	2	2
	10	10	10	10	10			
	5	5	5	5	5	5	5	5
	5	5	5	5	5	5	5	5

VENTILATION	10:00	11:00	12:00	13:00	14:00	15
FIO_2	40%	40%	40%	40%	40%	CC
MODE	BiPAP ASB	BiPAP ASB	BiPAP ASB	BiPAP ASB	BiPAP ASB	BiP ASB
RATE	18	18	18	18	18	18
IE RATIO	1:2.3	1:2.3	1:2.3	1:2.3	1:2.3	1:
INSP PRESSURE	25	25	25	25	25	2
PEEP/CPAP	8	8	8	8	8	8

University Hospitals of Leicester NHS
NHS Trust

ADULT INTENSIVE CARE

S2664312

Decannulated 7/12/11

DIAGNOSIS / PROCEDURE: Post VV ecmo - community acquired pneumonia

REFERRING CONSULTANT:

ITU CONSULTANT: ECMO TEAM.

NHS Un-Known
MCLEISH
WENDY
1/1 51 COXTON PL
GLASGOW

G33 5EJ
25-MAY-1987 F
U5118413

CARDIAC SURGERY ☐ GENERAL ☐ ECMO ☐

CARE BUNDLES	Y/N	COMMENTS
TELLISEPT	Y	
ACTROBAN	Y	
CORSODYL GEL	Y	
AT UP >30°	Y	
UT PROPHYLAXIS	Y	
EDATION HOLD	N	TIME
NSULIN PROTOCOL	Y	
NTICOAGULATION	Y	
NTIEMBOLIC TOCKINGS	U	IF NO, REASON For review
AILY SKIN CHECK IF MBOLIC STOCKINGS N SITU	(L) and (R) groin wound line	
As INTACT		IF NO, DOCUMENT IN CARE PLAN
IATTRESS TYPE	Total care sport	

DAY	NIGHT	DAY
NAME: JUSIE BAGASANI	NAME: Prisca Malonza	NAME: Susan Elliott
SIGNATURE: jbagasani	SIGNATURE:	SIGNATURE: S Elliott
BEDSIDE SAFETY CHECKS ☑	BEDSIDE SAFETY CHECKS ☑	BEDSIDE SAFETY CHECKS ☑
DAMP DUSTING ☑	DAMP DUSTING ☑	DAMP DUSTING ☐

INES	INSERTION SITE	DATE INSERTED	SITE OBSERVED	PHLEBITIC SCORE	DRESSING INTACT/ TRANSPARENT	DATE REMOVED
ENTRAL LINE	(R) Femoral. (L) Subclavian	30/11/11 21/11/11	Y Y	0 0	✓ ✓	10/12/11
RTERIAL LINE	(L) Radial	29/11/11	Y	0	✓	
VAN SHEATH						
ERIPHERAL LINE						
ASCATH	(L) Femoral	30/11/11	Y	0	✓	
THER						

			COMMENTS
ACING WIRES			
ATHETER	Urethral	21/11/11	Catheter care done.
G TUBE	(R) nostril	21/11/11	
HEST DRAINS			
IPS / SUTURES			
URGICAL WOUND			
THER			

:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00
0%	40%	35%	35%	35%	35%	35%	35%	35%	35	35	35	35%	35%	35%	35%	35%	35%
PAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	BIPAP ASB	CPAP ASB
18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	
1:24	1:23	1:23	1:23	1:23	1:23	1:23	1:23	1:23	1:23	1:23	1:23	1:23	1:23	1:23	1:25	1:25	
25	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25	
8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	

Drugs NG/IV	110	200		310					10→				380		34
NG Feed	57	57	57	57	57	57	57	57	57	57	57	57	57	57	57
HOURLY INPUT	201	284	84	394	79	72	71	74	71	81	71	71	381	81	42
FLUIDS IN	201	485	569	963	1042	1114	1185	1259	1330	1411	1482	1553	1934	2015	2057
BALANCE	+131	+275	-11	+75	-173	-336	-365	-351	-661	-911	-1088	-1217	-996	-1096	-761
FLUIDS OUT	70	210	610	885	1215	1450	1550	1610	1991	2322	2570	2770	2930	3111	3198
HOURLY OUTPUT	70	140	400	275	340	222	100	90	350	400	180	200	160	175	100
URINE	70	140	400	275	340	222	100	90	350	400	180	200	160	175	100
CVVH															
NG LOSSES + pH			5 / 7	70 R pH 5.5				80 R pH 5.5				65 R			
BOWELS / STOMA			bo small					bo small						small	
CHEST DRAINAGE HOURLY															
CHEST DRAINAGE RUNNING TOTAL															

OBSERVATIONS	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00
PERIPHERAL TEMPERATURE C / W	W			W				W			WW			WW	
FOOT PULSES L / R	✓ ✓			✓ ✓				✓ ✓			✓ ✓			✓ ✓	
PUPIL SIZE L / R	2 2			2 2				2 2			2 2			2 2	
PUPIL REACTION L / R	✓ ✓			✓ ✓				✓ ✓			+ +			+ +	
COMA SCORE/ SEDATION SCORE	-4			-4				-4			-1				
PACING MODE	sedated														
SET RATE															
A PACING / SENSING	n/a														
V PACING / SENSING															
PAIN SCORE REST	sedated														
MOVEMENT															
ST CHANGES															
IABP AUGMENTATION															
IABP RATIO															

TIDAL VOLUME	390	403	372	380	388	35		
MINUTE VOLUME	6.65	6.67	6.72	6.5	6.71	6.6		
PEAK PRESSURE	26	26	26	26	26	26		
SPONT RATE	0	0	0	0	0	0		
SPONT T.V.								
SPONT M.V.								
HUMIDIFIER TEMP°C	36.9	35.3	35.4	35.6	34.7	34		
SATS	98	97	97	99	97	9		
NITRIC PPM								
ECMO FLOW $etCO_2$								
ECMO SWEEP								

BLOOD GASES	10:00	11:00	12:00	13:00	14:00	15:
pH	7.34				7.35	
$PaCO_2$	5.98				6.12	
PaO_2	11.22				11.30	
SaO_2	96.4				96.2	
HCO_3	22.9				23.3	
BE	-1.6				-1.0	
Na^+ mmol/L	128.9				130.9	
K^+ mmol/L	5.68				5.34	
Hb g/dl	12.8				12.5	
HCT	43.3				43.4	
BLOOD GLUCOSE	8.7				13.4	
LACTATE	1.3				1.5	

INTERVENTIONS	10:00	11:00	12:00	13:00	14:00	15:
POSITION / PA CARE			Rolled			
MOUTH-CARE	✓		✓			
EYE CARE			✓			
SUCTION & NATURE OF TRACHEAL SECRETIONS	✓✓ ++ thick		✓✓ ++	✓✓ +	✓✓	
TRACHEOSTOMY INNER TUBE CLEAN / CHANGE						
SATS PROBE MOVED						

NURSING COMMENTS / SIGNIFICANT EVENTS	
	Full wash & done.

VENTILATOR TYPE:	DRAGER	ET SIZE:	
NAME:	Vulcan	LENGTH:	
NUMBER:		DATE INSERTED:	

420	342	396	365	461	408	375	348	375	500	390	381	490	401	479	392		
7.59	7.15	6.85	7.06	6.44	7.01	695	6.37	6.35	6.64	7.09	6.75	6.89	7.01	6.92	7.20	755	
27	26	26	26	26	27	27	26	26	26	26	26	26	26	26	26	26	
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	+9	26
																482	321
																3.13	643
31.8	31.0	31.4	30.9	31.1	31.3	312	308	31	309	31.1	30.7	30.7	31.1	31	31.1	31	37.2
96	96	96	96	95	95	95	95	95	95	95	95	95	95	94	96	95	94.1
				5.5	4.5	4.2	45	4.6	5.1	4.4	4.8	5.7	4.8	7.1	4.7	3.6	4.4

16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00
7.38				7.39			7.38			7.37		7.38	7.37	7.37			
5.62				5.42			5.54			5.72		5.72	5.72	5.82			
10.01				10.2			10.2			10.43		10.2	10.4	10.4			
95.5				95.7			95.5			95.7		95.5	95.7	95.7			
24.1				23.8			23.4			23.4		24.2	23.4	23.6			
-0.2				-0.5			-1.0			-1.0		-0.0	-1.0	-0.8			
134.0				132			131.4			129.8		132	129.8	132.7			
5.72				5.38			5.32			5.36		5.58	5.36	5.43			
13.2				13.1			13.1			13.3		13.1		12.9			
44.7				44.3			43.7			44.2		44.1		43.5			
8.4				8.7			9.2			11.7		9.5		9.7			
1.3				1.4			1.4			1.5		1.5		1.5			

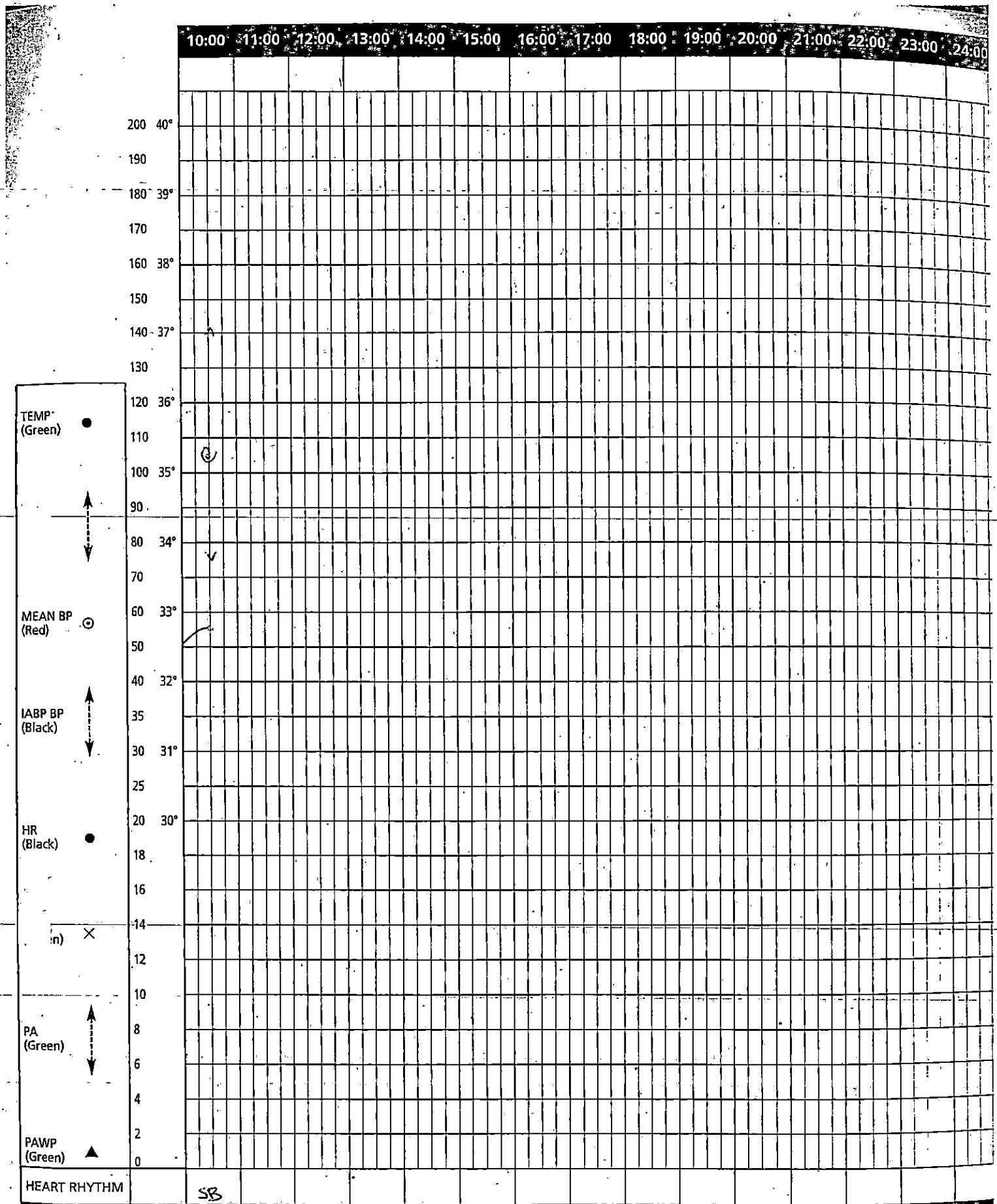
16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00
Rolled @	Rolled					Rolled											
✓	✓					✓								✓			
✓	✓					✓								✓			
✓	✓			✓ white coughing+	✓ white						✓			✓			

GRADE OF INTUBATION:	TRACHY TYPE: Tracoe	CHART NUMBER: 11	DAYS IN ITU: 10
	SIZE: 7.0	DATE: 10/12/11	
	DATE INSERTED: 2/12/11		

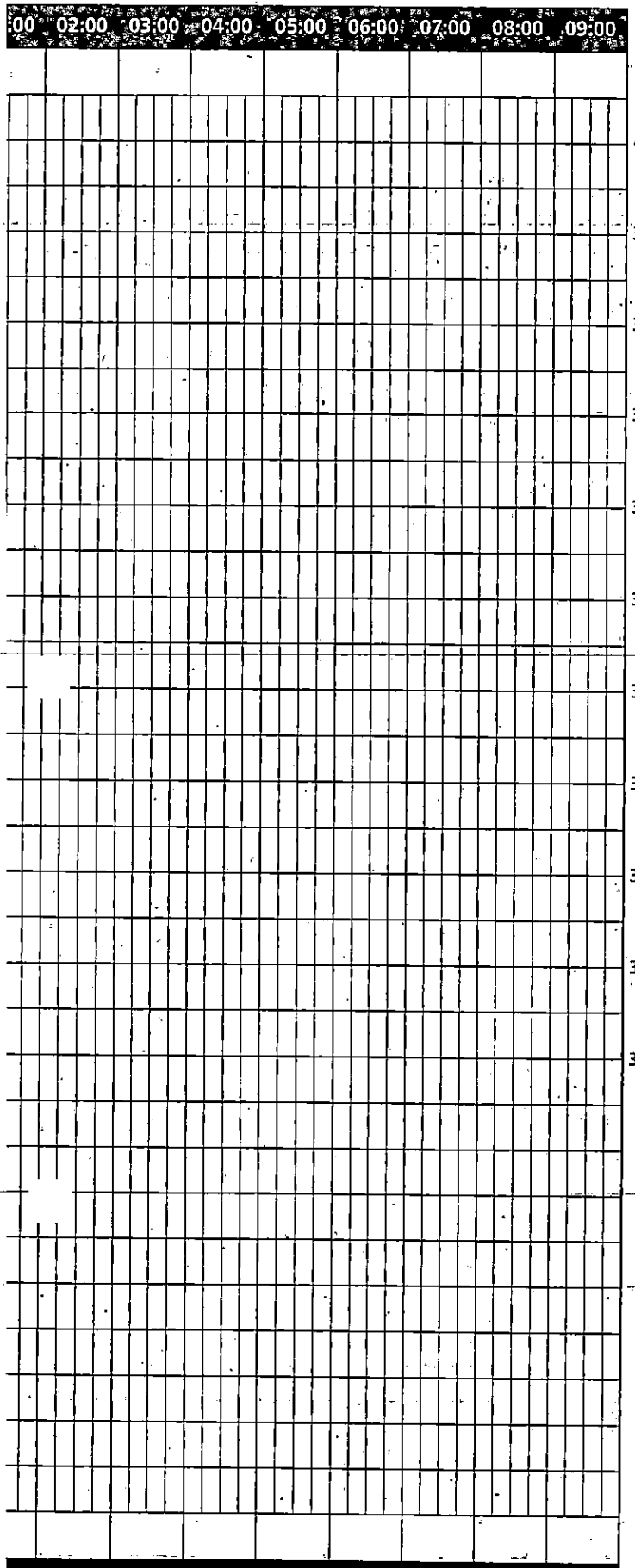
(Redform)3101820KR Printed By Rural Press Ltd. Tel 0116 2869396 AICC V2- 05/2011

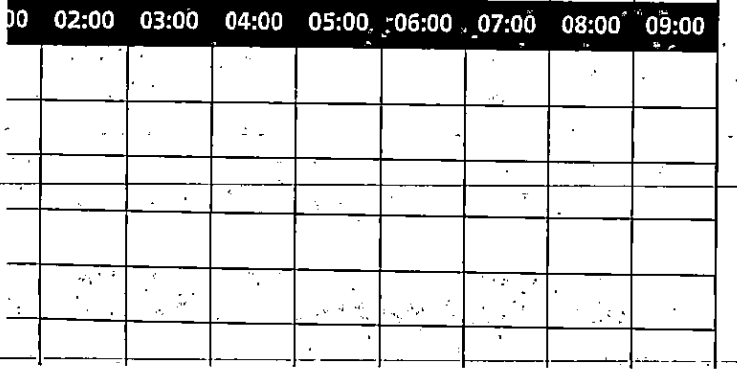
DATE: 12.12.2011

BEDSIDE SAFETY CHECKS			
	Day	Night	Day
Bed space number			
Date, name and signature on ITU chart			
ID label attached to all documentation			
Legible ID band and allergy band (if applicable) attached to patient			
Drug infusions - Correct prescription - Correct rate - Labelled correctly			
Record all drug dosages (mcg/kg etc) on ITU chart at the beginning of each shift and when rate altered			
Transducers zero'd and appropriately positioned			
Pressure bag pumped to 300mmhg			
itor and ventilator alarms set appropriately			
Monitor and ventilator plugged into UPS electrical supply			
Pumps and all other electrical equipment plugged into mains supply			
Bed plugged into mains supply electricity			
Ventilator type and name written on ITU chart			
Bacterial filter on expiratory port of the ventilator is dry			
Dry circuit – HME filter in situ			
Wet circuit – No HME filter in situ			
Fisher Paykel humidifier AND wires available at the bed space			
Oxygen analyser (for high flow) available at the bed space			
Clean functional waters bag and O_2 tubing attached to flow meter			
O_2 flow meter connected to piped O_2 outlet			
Working portable O_2 cylinder, no less than half full, available at the bed space			
Tracheostomy box available if applicable (correct tube size)			
~~High suction set on 18-20 KPa – working~~			
Low suction set on 5-10 KPa - working - attached to drain			
Suction filters clean and dry, changed in the last 3 months			
Fire evacuation box available and intact			



FLUIDS INFUSIONS	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00
CHECK INITIAL IVI RATES (INITIAL CHANGES)															
METHYLPREDNISOLONE	2														
Actrapid	1.5														
Morphine	2														
Midazolam	2														
H-															





		DATE DUE	TIME	DONE / SI
CHANGES	DAILY / PRN			
	HME	/		
	VENT FILTER			
	ET TAPE AND FOAM	/		
	TRACHY DRESSING	13.12.11		
	NG GIVING SETS	13.12.11		
	TPN GIVING SETS	/		
	NEBULISER ACORNS	/		
	YANKER SUCKERS	PRN		
	CATHETER MOUNTS			
	72 HOURS			
	INLINE SUCTION			
	TRANSDUCER SETS			
	IV LINES	14.12.11		
	WEEKLY			
	VENT / CPAP CIRCUITS			
	WATERS BAG			
	CATHETER BAG			

		TIME	DONE / SI
TESTS	U & E AM		
	U & E PM		
	FBC AM		
	FBC PM		
	CLOTTING AM		
	CLOTTING PM		
	LFTs		
	AMYLASE		
	CRP		
	OTHER		
	OTHER		
	CXR		
	ECG		
LEVELS	GENTAMYCIN		
	VANCOMYCIN		
	OTHER		
	OTHER		
SAMPLES	SPUTUM		
	URINE		
	BLOOD		
	MRSA		
	OTHER		

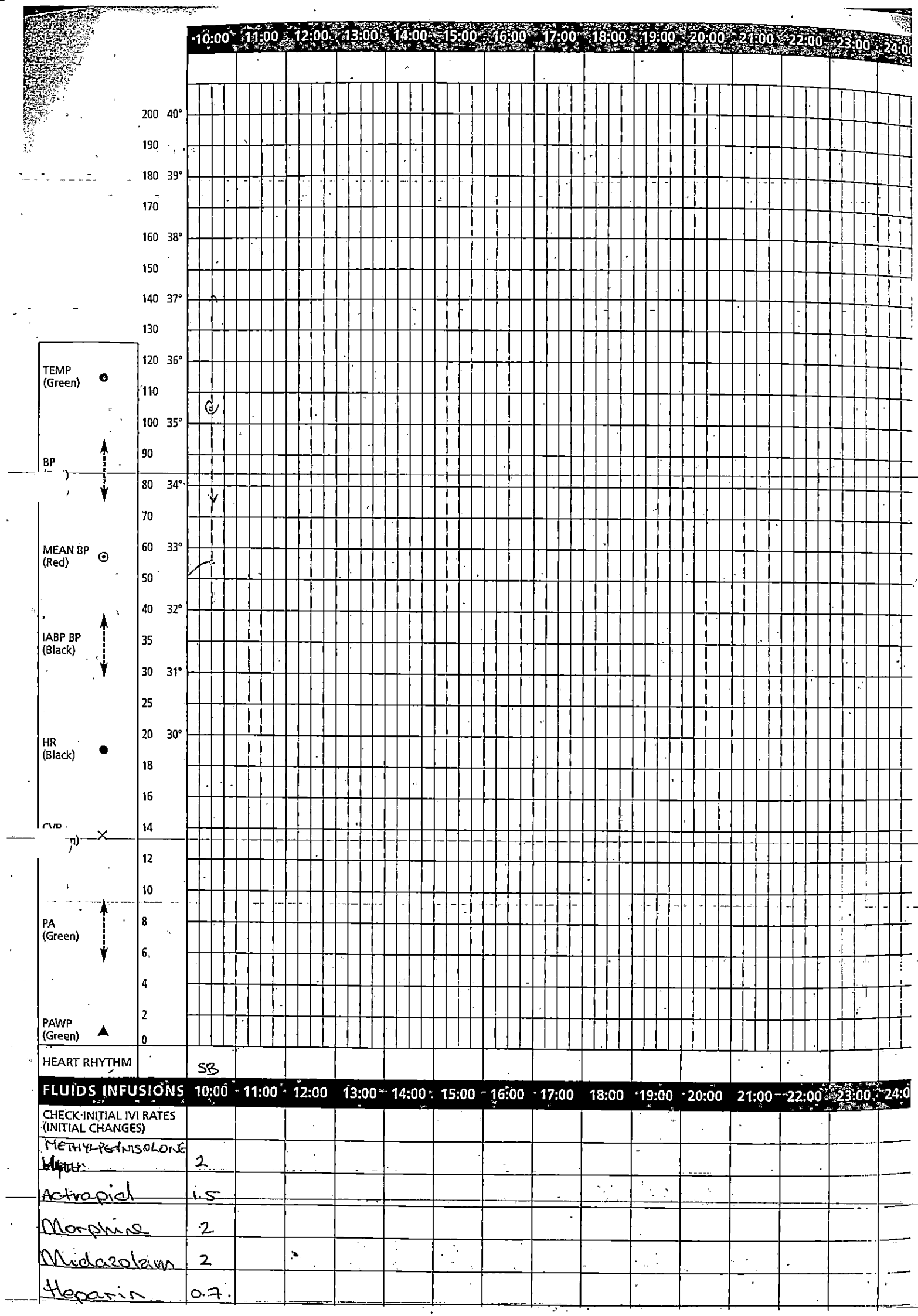
PREVIOUS 24 HOUR FLUID BALANCE	
In	3327
Balance	341
Out	4168
Fluid balance since admission	

WEIGHT: (kg)

78 kg

HEIGHT: (cm)

VENTILATION	10:00	11:00	12:00	13:00	14:00	15
FIO_2	35%					
MODE	CPAP ASB					
RATE						
IE RATIO						
INSP PRESSURE						
PEEP/CPAP	8					


10:00 11:00 12:00 13:00 14:00 15:00 16:00 17:00 18:00 19:00 20:00 21:00 22:00 23:00 24:00
200 40°
190
180 39°
170
160 38°
150
140 37°
130
120 36°
110
100 35°
90
80 34°
70
60 33°
50
40 32°
35
30 31°
25
20 30°
18
16
14
12
10
8
6
4
2
0
TEMP (Green)
BP
MEAN BP (Red)
IABP BP (Black)
HR (Black)
PA (Green)
PAWP (Green)
HEART RHYTHM
SB
FLUIDS INFUSIONS 10:00 11:00 12:00 13:00 14:00 15:00 16:00 17:00 18:00 19:00 20:00 21:00 22:00 23:00 24:00
CHECK-INITIAL IVI RATES (INITIAL CHANGES)
METHYLPREDNISOLONE
2
Actrapid
1.5
Morphine
2
Midazolam
2
Heparin
0.7

IV Drugs															
NG Feed	64														
HOURLY INPUT															
FLUIDS IN															
BALANCE															
FLUIDS OUT	152														
HOURLY OUTPUT	152														
URINE	75														
CVVH	77														
NG LOSSES + pH															
BOWELS / STOMA															
CHEST DRAINAGE HOURLY															
CHEST DRAINAGE RUNNING TOTAL															

OBSERVATIONS		10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00
PERIPHERAL TEMPERATURE	C / W	W														
FOOT PULSES	L / R	✓ ✓														
PUPIL SIZE	L / R															
PUPIL REACTION	L / R															
COMA SCORE/ SEDATION SCORE																
PACING	MODE															
	SET RATE															
A PACING / SENSING																
V PACING / SENSING																
PAIN SCORE	REST															
	MOVEMENT															
ST CHANGES																
IABP AUGMENTATION																
ABP RATIO																

TIDAL VOLUME						
MINUTE VOLUME						
PEAK PRESSURE						
SPONT RATE	20					
SPONT T.V.	489					
SPONT M.V.	5.80					
HUMIDIFIER TEMP°C	37.2					
SATS	96					
~~NITRIC PPM~~ ET CO2	4.8					
ECMO FLOW						
ECMO SWEEP						
BLOOD GASES	10:00	11:00	12:00	13:00	14:00	1
pH						
$PaCO_2$						
PaO_2						
SaO_2						
HCO_3						
BE						
Na^+ mmol/L						
K^+ mmol/L						
Hb g/dl						
HCT						
BLOOD GLUCOSE						
LACTATE						
INTERVENTIONS	10:00	11:00	12:00	13:00	14:00	1
POSITION / PA CARE						
MOUTH CARE						
EYE CARE						
SUCTION & NATURE OF TRACHEAL SECRETIONS,						
TRACHEOSTOMY INNER TUBE CLEAN / CHANGE						
SATS PROBE MOVED						
NURSING COMMENTS / SIGNIFICANT EVENTS						

02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00

VENTILATOR TYPE: DRAGER.	ET SIZE:
NAME: VOLCAN.	LENGTH:
NUMBER:	DATE INSERTE

16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00

16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00

INLINE SUCTION ☐

TRANSDUCER ☐

	GRADE OF INTUBATION:	TRACHY TYPE: TRACOE	CHART NUMBER: 13	DAYS IN ITU: 12
		SIZE: 7.0	DATE: 12.12.2011	
		DATE INSERTED: 2.12.2011		

Printed for Rural Press Ltd Tel 0116 2866706 AICC V2 05/2010

Surnan S2664312
NHS Un-Known
Forena MCLEISH
WENDY
Date of 1/1 51 COXTON PL
GLASGOW
Hospit G33 5EJ
25-MAY-1987 F
U5118413

University Hospitals of Leicester NHS Trust

Consultant: Remo

MICROBIOLOGY FLOW CHART

DATE	SAMPLE	RESULT	ACTION TAKEN (Antibiotics / line change etc.)
30/11/11	MRSA Urine	negative	
1/12/11	Sputum M/Cs	no growth	
1/12/11	Urine C/S	Candida species	
1/12/11	MRSA nose/perineum -	negative	
1/12/11	MRSA Sputum	negative	
1/12/11	Blood C/S (Art line) -		
2/12/11	BAL for H1N1	not detected.	
2/12/11	Sputum C/S	no growth.	
2/12/11	BAL C/S (Right)	no growth.	
2/12/11	BAL C/S	no growth	
2/12/11	Urine for L. pneumophilia Antigen -	not detected	

Surname:

Forename:

Date of Birth:

Hospital S No:

University Hospitals of Leicester NHS
NHS Trust

Consultant:

MICROBIOLOGY FLOW CHART

DATE	SAMPLE	RESULT	ACTION TAKEN (Antibiotics / line change etc.)

University Hospitals of Leicester NHS
NHS Trust

Adult Intensive Care Unit
Blood Results

(Please record abnormal results in red pen)

P S2664312
NHS Un-Known
MCLEISH
WENDY
1/1 51 COXTON PL
GLASGOW
G33 5EJ
25-MAY-1987 F
U5118413

Date			3/12/11	4.12.11	4.12.11	4/12/11	5.12.11	05/12/11	06/12/11	06/12/11
Time sample taken			1800	0252	06.00	1642	06.00	1636	06.00	17.19
Time result charted			2035	0580	09.40	2100	08.30	2130	08.45	20.45
Result taker sign			P	PM	RA	AS	SAS	L	P	P
Sodium	mmol/L	133 -146	138		137	137	137	136	135	134
Potassium	mmol/L	3.5 - 5.3	4.7		4.8	5.1	4.7	5.2	6.0	5.3
Chloride	mmol/L	95 -108	105		107	104	104	104	102	102
Urea	mmol/L	2.5 - 7.8	5.2		5.2	7.5	7.7	8.1	11.3	10.6
Creatinine	µmol/L	60 -120	114		111	*141	134	152	159	134
eGFR	ml/min	57	54		55	42	45	39	37	45
T protein	g/L	60 - 80	58		59	59	61	62	64	67
Albumin	g/L	35 - 50	33		35	*32	35	35	35	36
Ad Calcium	mmol/L	2.2 - 2.6	2.46		2.54	2.48	2.51	2.53	2.58	
Magnesium	mmol/L	0.7 -1.0	0.95		0.96	*0.91	0.87	1.6	0.93	1.07
Phosphate	mmol/L	0.8 -1.5	0.92		0.81	1.19	1.0	0.99	1.27	
Alk phos	U/L	30 -130	91		98	113	115	135	184	174
ALT	U/L	2 - 53	47		38	36	31	31	32	32
GGT	U/L	0 - 50	131		134	143	139	154	210	183
Bilirubin	µmol/L	< 21	30		38	23	24	20	18	16
Amylase	U/L	30 -110	93		95	106	108	106	95	77
WCC	x10^9/L	4 -11	6.6	7.8	7.6	8.4	7.6	10.1	11.0	11.4
Hb	g/dL	13 - 18	12.5	12.6	12.9	12.3	12.2	13.1	13.7	13.2
Hct	%	40 - 54	0.380	0.379	0.390	0.367		0.397	0.410	0.392
Platelets	x10^9/L	140 -400	116	111	110	120	110	136	150	155
Neutrophil	x10^9/L	1.5 - 7.5	4.38	5.16				7.60	7.8	8.02
INR		0.9 -1.2	1.0	1.0	1.0	1.0	0.9	0.9	0.9	0.9
APTT	sec	25 - 35	67	79.9	73.2	64.5	2.2	60.6	52.9	39.8
APTTR		0.8 -1.2	2.2	2.7	2.4	2.2		2.0	1.8	1.3
Fibrinogen	g/L	2 - 4	3.8	3.1	3.3	3.5	3.2	3.3	3.3	2.8
CRP	mg/L	0 -10	135		98	68	48		42	34
Troponin I	ng/L	< 0.04								
CK	U/L	25 - 200								

Results taken over the telephone must be documented in the pink booklet

915

University Hospitals of Leicester NHS
NHS Trust

Adult Intensive Care Unit
Blood Results

(Please record abnormal results in red pen)

S2664312
NHS Un-Known
MCLEISH
WENDY
1/1 51 COXTON PL
GLASGOW

G33 5EJ
25-MAY-1987 F
U5118413

Date			30.11.11	30.11.11	01.12.11	1/12/11	2/12/11	2.12.11	2.12.11	3/12/11
Time sample taken			19:03	21:15	0614	18:01		1739	1739	1703
Time result charted			22:50	22:50	0930	20:39	0930	21:59	2139	9:28
Result taker sign			[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Sodium	mmol/L	133-146	137	137	138	137	137	137	139	137
Potassium	mmol/L	3.5 - 5.3	5.4	4.6	4.7	3.8	5.4	5.4	4.4	4.7
Chloride	mmol/L	95 -108	99	101	107	103	102			107
Urea	mmol/L	2.5 - 7.8	8.4	9.2	12.3	9.4	7.5	7.5	5.8	5.3
Creatinine	µmol/L	60 -120	160	161	201	149	138	138	120	114
eGFR	ml/min	57	36	36	28		43	43	51	54
T protein	g/L	60 - 80	58	52	54	52	60		54	55
Albumin	g/L	35 - 50	25	22	27	27	33	33	30	30
Ad Calcium	mmol/L	2.2 - 2.6	2.26	2.43	2.27	2.32	2.43	2.	2.49	2.49
Magnesium	mmol/L	0.7 -1.0	0.81	0.81	1.03	0.84	0.93		0.87	0.92
Phosphate	mmol/L	0.8 -1.5	1.69	0.92	1.76	0.72	1.45		0.60	0.99
Alk phos	U/L	30 -130	85	76	70	57	80		99	98
ALT	U/L	2 - 53	27	24	22	17	18	18	26	49
GGT	U/L	0 - 50	154	135	116	100	137		170	155
Bilirubin	µmol/L	<21	10	14	18	27	46	46	63	43
Amylase	U/L	30 -110	137	141	115	84	104	104	86	84
WCC	x10⁹/L	4 -11	7.1	6.1	5.6	4.4	6.3		8.0	6.7
Hb	g/dL	13 - 18	8.3	7.6	10.2	11.1	12.5		12.4	12.5
Hct	%	40 - 54	0.261	0.236	0.308	0.339	0.37		0.37	0.37
Intelets	x10⁹/L	140 - 400	307	248	206	172	176		158	133
Neutrophil	x10⁹/L	1.5 - 7.5	5.72	4.45	4.14	3.20	5.02		6.37	4.77
INR		0.9 -1.2	1.2	1.2	1.2	1.1	1.1		1.2	1.1
APTT	sec	25 - 35	36.5	52.9	44.8	44.9	56.9		72.4	84.4
APTTR		0.8 -1.2	1.2	1.8	1.6	1.5	1.9		2.4	2.8
Fibrinogen	g/L	2 - 4	7.0	5.8	4.9	3.7	3.8		3.3	3.7
PT						14.8	14.6		15.2	14.6
CRP	mg/L	0 -10	277	232	167					147
Troponin I	ng/L	< 0.04								
CK	U/L	25 - 200								

Results taken over the telephone must be documented in the pink booklet

University Hospitals of Leicester NHS
NHS Trust

AICU CONTINUATION SHEET

Each entry must be signed

MOTHERWELL
WENDY
1/1 51
GLASGOW
G33 5EJ
25-MAY-1907

Date

30/11/11

20 hrs

Admission notes

No transfer letter

24 y ♀ transferred from glasgow Royal Infirmary on conventional ventilation with a 4 days hx of SOB, chest pain, feeling unwell and diarrhoea. Hepatitis and HIV neg HxN1 neg

Hx of cocaine smoking, anxiety and depression, no IVDU, presented to A+E on 20/11/11 with a

Shivers confused and hypotensive and received 8 lt of fluids in the first 12 hrs

As D_2-Sat 83% with 100% facial oxygen I+V and started on Noradrenalin

CXR & R upper and middle lobe consolidation

C+P 582, legionella Ag in urine neg

27/11/11 CT chest bilat extensive consolidation with small pleural effusion R>L

On admission started on Co-Amoxiclav and Clarithromycin. As deterioration on 28/11/11 ↑ FiO_2 1.0, $paCO_2$ ↑ 9-10, pO_2 7.7 antibiotics changed to Tazocin, Meropenem and Vancomycin

All cultures are neg so far

On 29/11/11 reduced urine output. 30/11/11 Vascath inserted and started on CVVH

On transfer (transferred by glasgow team) desaturated to 30-40% for 30-60 sec improved a/fr suctioning

On admission at GLH taken directly to theatre for VV-ECMO cannulation under floucroscopy

At 1917 hrs uncomplicated cannulation

Date

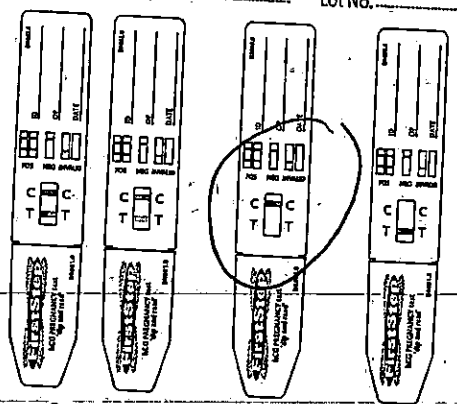
with Avoken 3.1Fr Double lumen cannula
and insertion of quad lumen antibiotic coated
Central line RFV under US guidance
CXR : tip of ECMO cannula Th 11-12
tip of ETT Th 2
tip of R subclavian central line IVC/RA
tip of UAT in stomach
O/E CNS : pupils 2mm sluggish reactive
CVS : well perfused, mild to moderate oedema, normal $S_1 + S_2$
RS : well ventilated
Abdomen : soft, BS +, no HSM
- continue Meropenem and Vancomycin
- start enteral feeds
- start Furosemide infusion
- watch urine output if decreased start CVVH via Vas.cath in LFV
- aim for neg balance (-1 litre)

A. Davey
A. BAKER
ECMO fellow

Interpretation of Results

Patient Name Wendy Mcleish

Patient Number S2664312 Lot No.



Pregnant Not pregnant Invalid

CIRCLE THE PICTURE WHICH MATCHES TEST RESULT

Result recorded by M. Dale RN

Result verified by

Contact Concateno support on +44 (0)1235 861 483

University Hospitals of Leicester NHS
NHS Trust

AICU CONTINUATION SHEET

Each entry must be signed

Unit No 52664312

Name Wendy McLeish
DOB 25/5/82

Date

3/12/11 CXR-am ? pleural effusion R>L.
Chest U/S done by ITU Reg Will
R side pl effusion ≈ 2.7 cms
adv:- Repeat CXR tomorrow
keep on eye.

S. Arya cons fellow

4.12.11 1025 Physio rev
S Circuit derived.
O Sat up.
Sedated & mechanically ventilated + prepted
ventilated BIPAP ASV3 90_2 0.3 29/10
ABG ok - PaO_2 6 kpa
Cons flow 3-4 Sweep 6-5
Cal (P) Need effort consideration tbc
CVS stable
Uro - CVVH.
M Sedated + Salbu
Cough + clear yellow sputum.
Pren, all movements stiff but full ROM
delivered all cuts
bilateral decr.
H normal secretions.
I: PN tom.

4/12/11 10:30(AM) — Vascath Removed
12F 3 Lumen

Blood samples x2

plan:- Start CVVH

S. Arya
Icons fellow

Date

2/11 0900

PHYSIO

(S) Pt in best interests.

(O) HR 107 RR 9916l Afebrile

BiPAP ASB 30% PEEP 10 ASB 14 TV 060 mls SaO2 90%

RR 29.

ECMO flow 4.9 sweep 6.5

ABG @ 0900 pH 7.37 pCO2 5.73 pO2 6.91 HCO3 29.8 BE -0.3

Meds: omeprazole, Heparin, Propofol, morphine, midazolam

Renal: U/O 25/10/10, (on CWH) balance +35ml.

Musc: poor AE throughout.

Pt: Suction E 2mls NaCl x 3 - 1x thick plug of creamy secs PCOM to LUL/LL.

OP suction.

(A) Effective cough, 1x plug cleared then nil else

Minimal TV 103 mls post Pt

movements stiff throughout, pt resisting ++.

fresh blood on OP suction (platelets 110)

(P) R/W ? for bronch

[signature] Fellow PT

12/11 1215

PHYSIO

(S) Consent assumed + Pt in best interests

(O) HR 100 RR 9916l7 Afebrile

BiPAP ASB 30% PEEP 10 ASB 14 TV 105 SaO2 96%

ABG @ 13:15 pH 7.39 pCO2 5.57 pO2 7.84 HCO3 24.2 BE 0.0

ECMO flow 5.4 sweep 6L

Meds: As AM

Renal: U/O: 10/10/20

Balance +47

Daily assessment, Heartlink ECMO Centre, Glenfield Hospital, Leicester

Date: 1-12-11	ECMO Consultant: GJP	S2664312 NHS Un-Known MCLEISH WENDY 1/1 51 COXTON PL GLASGOW G33 5EJ 25-MAY-1987 F U5118413
Date admitted / days ICU: (Referring ICU) 30-11-11 (Glenfield)	ECMO Fellow on call: S. Arya	
ECMO started / stopped: 30-11-11	ECMO Coordinator: (Day) (Night) Megan	

Summary of diagnoses and progress:	Summary of last 24h:
- Pneumonia & ARDS ? cause - ? Sepsis.	- Transferred from Glasgow - cannulated & ECMO started. double lumen #31 F.

Airway: Oral / nasal / tracheostomy / own	Size / type: #7.5
Respiratory assessment: poor B/E. B/L	Ventilator settings: Bipap ↓ rest vent settings
Cardiovascular assessment: BP = 95/64, HR = 90/min. peripheries cold	Inotropes/pressors: noradr @ 1 ml/hr.
Neurological assessment / pupils: - 3 + / 3 + coughs on suction not moving limbs	Sedative drugs: Morphine @ 5 Midazolam @ 5 Propofol @ 5
Haematology / coagulation / bleeding: /	Hb: 10.2 Plts: 206 Heparin management: 12.5 U/hr.

ECMO circuit issues: /	ECMO settings: Flow: 4 Sweep: 4.5 Revs: 3300

Doctor name:	Signature:	Date:	Time:
S. Arya		1.12.11	9.00

Daily assessment, Heartlink ECMO Centre, Glenfield Hospital, Leicester

Gastrointestinal / abdominal assessment:
Abd soft on Ranitidine Bd.

Feeding: NG @ 40 ml/hr

Bowels: BS (+) BC (-)

S2664312
NHS Un-Known
MCLEISH
WENDY
1/1 51 COXTON PL
GLASGOW
G33 5EJ
25-MAY-1987 F
U5118413

Musculoskeletal / cutaneous:
/

Renal assessment: U = 12 (9.2)
Urine output: Cr = 280 (161).

Renal Replacement therapy parameters:
On CVVH @ 30 ml/kg/hr
Removed = 300 ml/hr

Input (iv fluid / feed):

Fluid balance: + 1.2 L

Na: Weight:

Lines and tubes:
clean

Line	Site	Date	Days
CVC	R Internal Jugular (tunnelled)	27/11	
CVC/vascath	RVC Rt Femoral	30/11	
Arterial	L Radial	27/11	
Peripheral			
Other	VAS cath		

Infection issues:
WBC = 5.6 (6.1)
CRP = 167 (232)

Anti-bacterial / fungal / viral	Date	Days
Meropenem	30-11	1
Tazocin	30-11	1
Fluconazole	30-11	1

Drug chart review: ✓

Radiology review: CXR (-)

Other issues: gets apetalol on
on reducing sedation

Daily plan:
- Tracheostomy
- Chase micro
- FB = -500 ml TO -1 L.
- ↑ NG Feed.

Checklist:	Compliant?	Reason (if not)
>30° head up	✓	
Sedation hold	X	
DVT prophylaxis	✓	
Gastroprophylaxis	✓	
Oral hygiene	✓	
Glucose control	✓	
Lines reviewed	✓	
Antibiotics reviewed	✓	

Doctor name: S. Arya | Signature: SA | Date: 1.12.11 | Time: 9.00

University Hospitals of Leicester NHS
NHS Trust

AICU CONTINUATION SHEET

Each entry must be signed

02004319
NHS Unknown
MCLEISH
WENDY
1/1 51 COXTON PL
GLASGOW
G33 5EJ
25-MAY-1987 F
U5110413

Date

Physiotherapy RIV.

1/12/11 1200.

S: Above noted. Ventilated & sedated. Consent in pt best interest. Stable, awaiting tracheostomy.

O: HR 90 SR BP 94/69 (77) CVP 11 Sats 94% Temp 36.1.

Morphine 5 midaz 5 Heparin 2 Noad 1 D/Saline 40 propofol 5.

NG off (for trach).

FB -133 ovo on CVVH.

BIPAP for 30' peep 10 ASB 10 PSup 20 rate 12. TV 916mls.

pH 7.38 pCO2 5.69 pO2 8.35 Sats 93.9 HCO3- 23.9 BE -0.4 Hb 11 lactate 1.1 BM 7.1. AaG 40 [illegible]

WCC 5.6 CRP 167 (↓). Urea 12.3↑ creat 201↑

CXR bilateral consolidation @ >①

AUSA marked ↓ bs bibasally. Transmitted bronchial exhibitory sounds & added upper crackles + transmitted ext sounds upper lobes.

VBGs on vent nad + suction x 2 ⇒ obtained initially pale yellow → white secretions strong cough. Upp lobes on ext to mucus into bags.

Rec ① sat lying vbg on vent → upp lobes → nad + suction x 1 after white secretions. Remain v. slight ↑ bs upper lobes ↓ bibasally TV's 15a. Due to min volume o/n at present. Stable Hb for transf.

A: No secretions obtained at point despite very strong cough.

P: Ext. RIV Unit medical. Trach discussed. Awaiting results from [illegible]

[illegible] Registrar
Bleep 2552 Critical Care

1/12/11 — Dr Dalkin
1pm

Thankyou for referring patient for nutritional support we received.

Anthropometry: Est Dry wt 75kg
BMI < 30 kg/m²

Estimated Reqs: 1900 kcals/day
81-94g P/day

Plan: Am req feed 64mls/hr - 2p ⇒ Infatrini ⇒ 1900 kcals 95g P

With IV Started (Dalkin) 2552

Date

Physiotherapy R/V.

/12/11
15.45.

S: ISQ. Pass & sleep ISQ. vent settings ISQ. Inhalers ISQ.
a tracheostomy as yet.

O: HR 87 SR BP 112/79 (98) CVP 14 Sao2 89% Apyrexic.
Ausc bronchial vesicular bs (R) UL ↓ bs bibasally
transmitted ext sounds upper lobes.
Ubs in synchrony 2 vent read & suction x 2 obtained mod
loose white secs thro endotr cleared. Repeat abga &
CXR tomorrow → I to purulent riches min white watery secs.
re-assess ISQ. TV very low 160-88mls.
PM's as able. Ankles & knee ext + flex 100° (L) + (R).
Slight knee bend in ext rot due to guard bil (R) CVVH (L) groin
peripheries v. cool/clammy.
PM's upper limbs WNL although peripheral coloration.
Tolerated interventions all.

A: very complicated (R) relatively min obtained on fiberoptic very
effective cough reflex.
On Gentamycin, Ruomycin Rifaxo.

P: Cont. monitor & Rx as per as appropriate + cont review meds
extubation re: splints for prophylaxis ankles.

HJ Robinson
Band 2 Physiotherapy

2/12/11
10.20

Physiotherapy R/V.

S: NIS report ↑ pass & sleeps overnight.
Pass 4.76 sleep 8.5.

O: HR 108 ST BP 100/68 (81). CVP 15 Sao2 89%. temp 36.4.
morphine 10 midaz 10 Hep 3.2. propof 2.
Dex saline off. propofol 10. NE read 20
On CVVH. FB=1366.

BIPAP ASS RO2 41% peep 10 rate 10 ASB 14 pinsp 20
TV 69-104.
pH 7.38 pCO2 5.23 pO2 6.75 SaO2 86% HCO3 22.5 BE 2.2.

Ass bronchial vent bs (R) UL ↓ bs bibasally.
pre-oxygenated (L) sat tilt on bed ~~Asst~~ HR. written in error moved ubs
synchronised & vent read & suction obtained loose yellow secretions
sample obtained for MCBS.
Re-ass ISQ.
PM's ↑ hip flex + ext (L) UL. peripheries very cold & still colonated.
↓ from shoulder 60° due to ↑ hip.

P: Review pm. Aiming for heels & brace.

HJ Robinson
CTL Physiotherapy
Band 2 2552

PHYSIOTHERAPY INITIAL ASSESSMENT SHEET – GITU

S2664312
NHS Un-Known

U: MCLEISH
Na: WENDY
Ad: 1/1 51 COXTON PL
GLASGOW
G33 5EJ
25-MAY-1987 F
U5118413
Postcode: DOB:

Date: 1/12/11 Time: 12.00
Consent: Yes / No / NA Consultant: Peake
Contraindications/Additional Information:
Physiotherapist: Initials: HJE
Signature: H Robinson

Conditions/Diagnosis:
Pneumonia ? Sepsis. ARDS.
VV ECMO cannulated 30/11/11.

ETT: Size: 7.5
Trache: Fenestrated / Non Fenestrated
Date: Size:

PC: Date admitted: 30/11/11.
Summary of Rx/admission:
Admitted Glasgow Royal Infirmary 30/11/11 A+E. ↓ SaO2 + CP
Hypoxic, collapsed + hypotensive.
H1N1 neg. HIV neg.

PMH:

: Accommodation:

DH:

Lives with:
Stairs: Yes / No Bed: Up / Down Toilet: Up / down
Smoker / Ex Smoker / Non-Smoker PY Hx:
Walking aids:
ADL's: Carers:
Occupation:

All other physio interventions are documented in the medical notes.

Signature: Print: Grade: Contact No:

Name:		Hosp No:	

PROBLEM LIST/TREATMENT PLAN

Date	No	Problem	Goal	Treatment Plan	Date Achieved
1/12/11	1)	Retained secretions	Resolve crackles, improved SOB. Good Peak flow.	(Nebs +/-) Suction coughing, manual techniques	

OUTCOME MEASURE

DISCHARGE SUMMARY

Chest: ☐ Maintaining chest independently ☐ Chest problematic ref to community PT

Discharged to: ☐ Home ☐ Outlying hospital ☐ NA ☐ Completed safe and independent

Mobility:

Postural Advice:

Follow up required: ☐ Pulmonary Rehab ☐ OP Respiratory ☐ OP Musculoskeletal ☐ OP Neuromobility

Signature:	Print Name:	Date:

University Hospitals of Leicester NHS
NHS Trust

AICU CONTINUATION SHEET

Each entry must be signed

Unit No 5266412

25/1/1937

Name Henry McCann

Date

REF 301-07-P

TRACOE



4 035324 015153

Size 7
OD 10.4 mm
ID 7.0 mm
Length 74 mm

LOT 0000-1000060693

2/12/11
1100.

Acute InR

Assisted & Pressure Support

Tracheostomy & Bx :

Sedn - Propofol / Morph / Midaz.

Paralysis - Atracurium

Ventilator - BiPAP Ass fio2 10%?

Bx :

(R) UL
ML
LL

- Bx sample for

(R) UL & LL.

& Wound.

(L) UL - Tumours - Bx taken.
LL - Clear.

Screw used for tracheostomy & pt tracheostomy - uneventful.

Screw Cleaned.

Tracheostomy Acute InR.

Disinfection cycle log

Machine serial number	: 05017, Left
Location	: Glenfield
Endoscope	: 11
Endoscope type	: LF-TP
Endoscope ID	: 11
Serial number	: 1423728
Patient	: 99
Physician	: 0
Assistant	: 0
Parameter set	: 1-17-202 A
Cycle number	: 589
Cycle completion date	: 12/2/2011
Operator loading	: Val Mepham
Operator unloading	: Val Mepham

CYCLE : PASS

9:40:17 AM Endoscope disinfection
9:40:17 AM 1 Leak test
9:40:58 AM 2 Flush rinse
9:43:34 AM 3 Wash
9:48:15 AM 3
Detergent contact time = 00:02:10
9:48:15 AM 3
Basin temperature [°C] = 26.40
9:48:15 AM 4 Flush rinse
9:48:16 AM 5 Post rinse
9:54:52 AM 5
Rinse contact time = 00:02:26
9:54:52 AM 5
Basin temperature [°C] = 27.10
9:54:52 AM 6 Wash
9:54:54 AM 7 Flush rinse
9:54:56 AM 8 Post rinse
9:54:58 AM 9 Disinfection
10:09:18 AM 9
Disinfectant contact time = 00:10:52
10:09:18 AM 9
Basin temperature [°C] = 24.80
10:09:18 AM 10 Flush rinse
10:11:07 AM 11 Post rinse
10:11:09 AM 12 Post rinse
10:11:11 AM 13 Final rinse
10:19:31 AM 13
Rinse contact time = 00:05:16
10:19:31 AM 13
Basin temperature [°C] = 27.20
10:19:31 AM 14 Vent
10:21:13 AM 14.5
(-105) Leak test vented but pressure remains h
10:21:13 AM Cycle end

2/12/11 (10:45 am) – Date

Trachy #7.0 Bodied uneventful CXR – OK. Aseptic technique

SA S. Anger ECMO fellow

2/12/11 14:50

OCCUPATIONAL THERAPY: Consent presumed in patients best interest. OT intervention necessary due to shortening at TA's as reported by physio. On assessment I was able to achieve full passive range at both TA's following stretches. In order to prevent shortening OT has provided prophylactic Leeder splints set to 105°. Patients skin is intact but dry on both feet: Specific OT Rx is to be found on purple documentation in notes. OT to return in 1 hour to review.

BETTANY #2776.

/12/11 15:56

OCCUPATIONAL THERAPY: On my return Wendy was having clonus in (R) leg. S/N reports that it has been occuring for ~30minutes. This resolved immediately upon removal of splint therefore please do not splint her again until OT can review on 5/12/11=

BETTANY #2776

12/11 5:45

Physiotherapy Rev.

S: Pt has had bronchoscopy & tracheostomy ++ yellow secs observed

O: HR 109 BP 96/59 (72) Sats 96%.

Nor adj L/min. change ISQ from Am. vent settings (Seam TV 50mL)

Oor bilateral crackles. ↑ crackles ⓒ a previous Rev.

Suction x3 obtained moderate large volume of yellow secretions ~~ogh~~ observed

be is 6TV 9mL or ~~usp~~ kilo a vent as ~~oddered~~ ordered. Sat 98% 7 post Rx

Oor ⊇ regular sounds. Splinted noted done. Oor ⊇ regular BNTs

TJ Physiotherapy Bleep 2882 ~~occupational~~

University Hospitals of Leicester NHS
NHS Trust

AICU CONTINUATION SHEET

Each entry must be signed

0266451J
NHS Un-Known
MCLEISH
WENDY
1/1 51 COXTON PL
GLASGOW

G33 5EJ
25-MAY-1987 F
U5118413

Date

3/12/11 09.00

PHYSIOTHERAPY

S) Consent assumed in pt's best interests. N/S report. Stable overnight.

O) Vent n2 trache on BIPAP ASB 20/10 + 14. Rate 10 FiO_2 .3 Sats 85% V_T 50-90mls.

ABG pH 7.38 PO_2 7.12 PCO_2 5.7 HCO_3 24.1 BE -0.2

CVS HR 100 BP 100/61 MAP 75. ECMO Flow 3.4 Sweep 6.5

RENAL 4/0 0/10/0 CVVH 254/217/148 FB +620

INFE Propofol, M+M, heparin, Noradd, NG.

BLOODS Todays awaited.

AUSC" Harsh U2s. ↓↓ A/E globally.

Rx; Suction x 3// min pluggy yellow secs ± old blood clots.

TA stretches bilat.

PROM ULs within limits of lines.

A) ↓BP during suction to 82 systolic. Recovered. Spont. Coughing appropriately on suction. Cold peripheries. FPROM @ feet.

Same ? clonus noted (L) hand on stretches.

P) N/S to suction as req'd.

R/v for chest clearance + PROM cont.

CSRIVER SMITH

Daily assessment, Heartlink ECMO Centre, Glenfield Hospital, Leicester

Date:	ECMO Consultant:
2-12-11	GJP
Date admitted / days ICU: (Referring ICU) 30-11-11 (Glenfield)	**ECMO Fellow on call:** S. Arya
ECMO started / stopped: 30-11-11	**ECMO Coordinator:** (Day) (Night) Megan

NHS Un-Known
MCLEISH
WENDY
1/1 51 COXTON PL
GLASGOW
G33 5EJ
25-MAY-1987 F
U5118413

Summary of diagnoses and progress:	Summary of last 24h:
Pneumonia ARDS ? cause ? Sepsis	Remained stable ↓PO_2 = 4

Airway: Oral / nasal / tracheostomy / own

Respiratory assessment:
poor B/L B/L

ABG
pH = 7.38
PO_2 = 6.75
PCO_2 = 5.23

Size / type: #7.5

Ventilator settings:
Bipap 20/10
a&b = 14
FiO2 = 40%

Cardiovascular assessment:
BP = 103/63, HR = 112/min
peripheries -

Inotropes/pressors:
noradrenaline 2 ml/hr

Neurological assessment / pupils: ✓
Cough on suction
not moving limbs

Sedative drugs:
morphine 10mg
midazolam 10 mg
Propofol 10 ml

Haematology / coagulation / bleeding:
✓

Hb:
Plts:
Heparin management:

ECMO circuit issues:	ECMO settings: VV
✓	Flow: 4.7 Sweep: 3.6 L Revs: 3850

Doctor name:	Signature:	Date:	Time:
S. Arya	SA	2.12.11	10.10

Daily assessment, Heartlink ECMO Centre, Glenfield Hospital, Leicester

Gastrointestinal / abdominal assessment:
Soft

Feeding: NG 40ml

Bowels: ~~no~~ peristalsis

Musculoskeletal / cutaneous:
—

S2664312
NHS Un-Known
MCLEISH
WENDY
1/1 51 COXTON PL
GLASGOW
G33 5EJ
25-MAY-1987 F
U5118413

Renal assessment: U. 175 (9.4)
Urine output: Creat 138 (149)

Renal Replacement therapy parameters:
CCVH

Input (iv fluid / feed):

Fluid balance: + 1.1L

Na: 137 Weight: 86.5

and tubes:
Clear

Line	Site	Date	Days
CVC		27.11	
CVC/vascath		30.11	
Arterial		24.11	
Peripheral			
Other			

Infection issues:
WBC 6.3
CRP ! (164

Anti-bacterial / fungal / viral	Date	Days
Meropenem	30.11	
Tazocin	30.11	
Fluconazol	30.11	

Drug chart review:
✓

Radiology review:

Other issues:
—

Daily plan:
☐ Tracheostomy / Today or Monday
- Bronch
- CXR
- — Soon / Babcock

Checklist:	Compliant?	Reason (if not)
>30° head up ✓		
Sedation hold		
DVT prophylaxis Elan		
Gastroprophylaxis ✓		
Oral hygiene ✓		
Glucose control ✓		
Lines reviewed ✓		
Antibiotics reviewed ✓		

Doctor name:	Signature:	Date:	Time:

Daily assessment, Heartlink ECMO Centre, Glenfield Hospital, Leicester

Date: 3·12·11	ECMO Consultant: RKF	S2664312 NHS Un-Known MCLEISH WENDY 1/1 51 COXTON PL GLASGOW G33 5EJ 25-MAY-1987 F U5118413
Date admitted / days ICU: (Referring ICU) day3 (Glenfield)	ECMO Fellow on call: S. Anya	
ECMO started / stopped: 30/11/11	ECMO Coordinator: (Day) (Night) Kim	

Summary of diagnoses and progress:	Summary of last 24h:
Pneumonia + ARDS & Sepsis ? Cause	Remained stable

Airway: Oral / nasal / tracheostomy / own	Size / type: 7·0
Respiratory assessment: PCO_2=7·4 H/E P0/F.	Ventilator settings: Bipap 20/10
Cardiovascular assessment: BP = 95/56, HR = 106/m peripheries well perfused	Inotropes/pressors: Noradr @ 0·06 µg/kg/m
Neurological assessment / pupils: −3+ | 3+ coughs on suction not moving limbs	Sedative drugs: morphine/10 midazolam @ 10 propofol @ 10
Haematology / coagulation / bleeding: none	Hb: 12·5 Plts: 133 Heparin management:

ECMO circuit issues: small clots at base of oxygenator	ECMO settings: VV Flow: 3·5 Sweep: 6L Revs: 3100

Doctor name:	Signature:	Date:	Time:
S Anya		3·12·11	

Daily assessment, Heartlink ECMO Centre, Glenfield Hospital, Leicester

Gastrointestinal / abdominal assessment: Soft. BS (+)	S2664312 NHS Un-Known MCLEISH WENDY 1/1 51 COXTON PL GLASGOW G33 5EJ 25-MAY-1987 F U5118413
Feeding: NG @ 64 ml/h. Bowels: BO (-)	
Musculoskeletal / cutaneous: —	

Renal assessment: Urine output: 0 Renal Replacement therapy parameters: CVVH Sensorp @ 150 ml/hr.	Input (iv fluid / feed): Fluid balance: +380 Na: 137 Weight:

L and tubes: Clean

Line	Site	Date	Days
CVC	Rt Fem		~~3~~
CVC/vascath	(C) Fem.	30/11	3
Arterial	(C) Rad.		3p
Peripheral			
Other			

Infection issues:
WBC - 6.7 (8.0)
CRP = 147 (167)

Anti-bacterial / fungal / viral	Date	Days
~~Tazocin~~	~~30-11~~	~~3~~
Meropenem	30-11	3
Fluconazole	30-11	3
Levofloxacin	1/12	2

Drug chart review:	Radiology review:	Other issues:
✓	CXR (+) Post Tendy OK. ? Rt & Lt effusion	—

Daily plan:
CXR.
Reduce sedation
FB = even.

Checklist:	Compliant?	Reason (if not)
>30° head up	✓	
Sedation hold	X - gets agitated	
DVT prophylaxis	on Heparin	
Gastroprophylaxis	✓	
Oral hygiene	✓	
Glucose control	✓	
Lines reviewed	✓	
Antibiotics reviewed	✓	

Doctor name:	Signature:	Date:	Time:
S. Arya	SA	3.12.11	

Daily assessment, Heartlink ECMO Centre, Glenfie[illegible] Hospital, Glasgow

Date: 4·12·11	ECMO Consultant: RKF
Date admitted / days ICU: (Referring ICU) (Glenfield) 30/4	ECMO Fellow on call: S. Arya
ECMO started / stopped: 30·11	ECMO Coordinator: (Day) (Night) bi

9266431.2
NHS Un-Known
MCLEISH
WENDY
1/1 51 COXTON PL
GLASGOW
G33 5EJ
25-MAY-1987 F
U5118413

Summary of diagnoses and progress:	Summary of last 24h:
Pneumonia + ARDS & Sepsis.	Remained stable c/s chest yesterday small effusion (Rt side)

Airway: Oral / nasal / tracheostomy / own

Respiratory assessment:
A/C pool.

ABG	
pH	7·36
pCO2	5·93
PO2	6·93

Cardiovascular assessment:
BP = 109/58, HR = 101/min
peripheries well perfused.

Neurological assessment / pupils: 3+ | 3+
Coughs on suction
Not moving limbs, shivers intermittently

Haematology / coagulation / bleeding:
none

Size / type: #7.0

Ventilator settings:
Bipap 20/10
FiO_2 = 30%.

Inotropes/pressors:
Nor Adr off.

Sedative drugs:
Morphine 10
Midazolam 10
Propofol 10

Hb: 12·8
Plts: 110
Heparin management: 2·4 u/kg

ECMO circuit issues:	ECMO settings:
Small clots box oxygenator	Flow: 3-5 Sweep: 6L Revs: 3100

Doctor name:	Signature:	Date:	Time:
S. Arya	SA	4·12·11	9:15

Daily assessment, Heartlink ECMO Centre, Glenfield Hospital, Leicester

Gastrointestinal / abdominal assessment:

Soft BS+ BO this morning (formed)

Feeding: Bowels:

NGT 60 ml/hr · Small streaks of blood in NG started on Omeprazole infusion

Musculoskeletal / cutaneous:

✓

Patient name: Wendy McLeish

Date of birth: 25.5.89

Hospital number: 8266831/2

Renal assessment: (U=5.2 Cr=111)

Urine output: ~~<~~ 15 ml/last hr

Renal Replacement therapy parameters:

CVVH removing 200 ml/hr

Input (iv fluid / feed):

Fluid balance: +569

Na: 138 Weight: ~~78.5~~

Lines and tubes:

Clean

Line	Site	Date	Days
CVC	Rt Fem	28/11	4
~~CVC~~/vascath	② Fem	30/11	4
Arterial	① Radial	28/11	5
Peripheral			
Other			

Infection issues:

WBC = 7.6

CRP = 98

Anti-bacterial / fungal / viral	Date	Days
Tazocin	30/11	4
Meropenem	30/11	4
Fluconazole	30/11	4
Linezolid	1/12	3

Drug chart review: ✓

Radiology review: CXR ① - R>L PL effusion

Other issues: —

Daily plan:

- FBC - even
- Reduce sedation (N & M)

Checklist:	Compliant?	Reason (if not)
>30° head up	✓	
Sedation hold	X	
DVT prophylaxis	✓ on Repan	
Gastroprophylaxis		
Oral hygiene	—	
Glucose control	—	
Lines reviewed	—	
Antibiotics reviewed	—	

Doctor name:	Signature:	Date:	Time:
S. Arya	SA	6.12.11	9:15

Daily assessment, Heartlink ECMO Centre, Glenfield Hospital, Leicester

Date: 5/12/11	ECMO Consultant: GJP	S2664312 NHS Un-Known MCLEISH WENDY 1/1 51 COXTON PL GLASGOW G33 5EJ 25-MAY-1987 F U5118413
Date admitted / days ICU: (Referring ICU) (Glenfield)	ECMO Fellow on call: Chris	
ECMO started / stopped: 30/11/11	ECMO Coordinator: (Day) Maggie (Night)	

Summary of diagnoses and progress:	Summary of last 24h:
Pneumonia ? cause	Bleeding from NG feed

Airway: Oral / nasal / tracheostomy / own	Size / type:
Respiratory assessment:	Ventilator settings: BiPAP 20/10 FiO_2 .3
Cardiovascular assessment: BP 102/65	Inotropes/pressors: Nil
Neurological assessment / pupils: Eyes open spontaneously	Sedative drugs: Propofol 10 Morphine 9 Midazolam 9
Haematology / coagulation / bleeding: No bleeding problems Minor PV loss	Hb: 12.2 Plts: 110 Heparin management: 15 units ACT 199

ECMO circuit issues:	ECMO settings:
No problems	Flow: 3.48 Sweep: Revs: 3100

Doctor name:	Signature:	Date:	Time:
C. HARVEY	cjharvey	5/12/11	

Daily assessment, Heartlink ECMO Centre, Glenfield Hospital, Leicester

Gastrointestinal / abdominal assessment:

NG feed BS ✓ Abdo soft

Feeding: Bowels:

BMs in situ loose stools

Musculoskeletal / cutaneous:

N.I

S2664312
NHS Un-Known
MCLEISH
WENDY
1/1 51 COXTON PL
GLASGOW
,
G33 5EJ
25-MAY-1987 F
U5118413

Renal assessment: Urea 7.7 Creat 104

Urine output:

Renal Replacement therapy parameters:

Input (iv fluid / feed):

Fluid balance: +358

Na: 138 **Weight:** 78.5kg

L and tubes:

Line	Site	Date	Days
CVC	(R) Femoral	30/11	
CVC/vascath	(R) subclavian	21/11	
Arterial	(L) radial	29/11	
Peripheral			
Other	(R) femoral	30/11	

Infection issues:

WCC 7.6

CRP 48

Anti-bacterial / fungal / viral	Date	Days
Meropenem	30/11	
Linezolid	30/11	
Fluconazole	30/11	

Drug chart review:

✓

Stop Omeprazole infusion

Radiology review:

Bilateral consolidation (R) (L) on 3/12/11

Repeat today

Other issues:

N.I

Daily plan:

Aim for negative 1000 mls

Commence steroids + Azithromycin

Checklist:	Compliant?	Reason (if not)
>30° head up	✓	
Sedation hold	✓	
DVT prophylaxis	✓	
Gastroprophylaxis	✓	
Oral hygiene	✓	
Glucose control	✓	
Lines reviewed	✓	
Antibiotics reviewed	✓	

Doctor name:	Signature:	Date:	Time:
C.HARVEY		5/12/11	0950

University Hospitals of Leicester NHS
NHS Trust

AICU CONTINUATION SHEET

Each entry must be signed

Unit No

Name WENDY MULLIN

Date

PHYSIO SR 5/12/11 - 1350

S consent assumed + RA in best interest

O HR 101 BP 102/69 Apyrexial

BiPAP ASB 30% PEEP 10 AVA 14 TV 0.71 SAO2 96% RR 14

ABG pH 7.39 PaCO2 5.17 PaO2 7.87 HCO3 24.2 BE 0.0

ECMO Flow 3.49 sweep 6.7

↓ U/O

Resp: poor AE T/O

RA: percussion x 30 secs to R + L

suction x 4

R Thick creamy secs cleared x 2

TV remain ↓.

P cw tomorrow if TTOE pm

5/12/11 14:00

OCCUPATIONAL THERAPY -

I have reviewed Wendy re: splints as per plan. No clonus present in R foot on examination today. Patient is trialling off ECMO at present. I have put heeler splints on both feet to maintain 105° at both TA's. OT to provide paperwork and commence regime as appropriate. To review in 1 hour

BETTINA #2776.

5/12/11 05:00

OCCUPATIONAL THERAPY - Splints have been reviewed following 1 hour off & later wear. No clonus noted. Please proceed with 1/2 hours on, 2 hours as indicated on purple sheets. OT to

review 7/12/11 ——— BOLLA BETTANY #2776

Date

PHYSIO

5/12/11. 08.50
(S) consent to Rx assumed + Rx in best interest
(O) HR 90 BP 119/100 Apyrexial
BiPAP ASB 30% - PEEP 10 - ASB 14 - TV - 081 SPO2 95% CE 12
ABG @ 0700 PH 7.39 PCO2 5.4 PO2 6.7 HCO3 23.4 BE -1.1.
ECMO flow 3.18 sweep 6.5 on rotation.
meds. Heparin, propofol, morphine, midazolam, methyl prednisolone,
Renal on CWH, balance +35J
Bloods: WCC 11.0, platelets 150, CRP 47
Ausc: minimal AE. ? bronchial BS TO (R) side.
Rx: Suction x 3 - loose creamy secs cleared & effective cough
PROM to UL/LL - (C) UL restricted as has femoral vascath.
(A) clearing loose secs on suction
Poor TV continue - dense consolidation (R) side on CXR.
Tone noted throughout ROM - cogwheel type resistance T/O.
but ROM achieved
(P) R/W. cont to maxim ROM / chest clearance

[signature] PT

5/12/11 14.00
PHYSIO
(S) Consent to Rx assumed, Rx in best interest.
(O) HR 107 SR BP 142/84 Apyrexial
BiPAP ASB 30% PEEP 10 ASB 14 RR 30 TV 179
ABG @ 11.00 PH 7.4 PCO2 5.21 PO2 8.12 HCO3 23.6
BE - 0.9
meds: Heparin, methylprednisolone, propofol, morphine, midazolam
visible shaking movements throughout
Renal - on CWH. Balance - 4FJ
Ausc: BSTO (R) side, bronchial BS (R)
Rx: Suction x 3 - loose clear secs cleared x?
(A) Unable to wear splint as affecting CWH flow
Stable T/O Rx.
(P) R/W [signature] PT

Daily assessment, Heartlink ECMO Centre, Glenfield Hospital, Leicester

Date: 6/12/11	ECMO Consultant: Mr Firmin	S2664312 NHS Un-Known MCLEISH WENDY 1/1 51 COXTON PL GLASGOW G33 5EJ 25-MAY-1987 F U5118413
Date admitted / days ICU: (Referring ICU) (Glenfield) 30/11/11	ECMO Fellow on call: A. Bauch	
ECMO started / stopped: 30/11/11	ECMO Coordinator: (Day) Gail Faulkner (Night)	

Summary of diagnoses and progress:	Summary of last 24h:
Pneumonia ARDS	• CVVHDF restarted as K↑ • started on insulin • started on steroids

Airway: Oral / nasal / tracheostomy / own	Size / type: #7
Respiratory assessment: VT ~100 Desat 94 bilat air entry / crepitations R base	Ventilator settings: BIPAP 20/10 f 10 FiO_2 0.3 ASB 14 pH 7.1 CO_2 4 D 7 lactate
Cardiovascular assessment: HR 98 Normal S1 and S2 well perfused	Inotropes/pressors: nil
Neurological assessment / pupils: pupils 2-3mm bilat PERLA	Sedative drugs: Propofol 10 Morphine 9 Midazolam 9
Haematology / coagulation / bleeding: no concerns	Hb: 13.2 Plts: 150 Heparin management: 1000/kg/h ACT 178

ECMO circuit issues: ccct at bottom of oxygenator	ECMO settings: Flow: 3.2 Sweep: 1.5 Revs: 3050

Doctor name:	Signature:	Date:	Time:
A. BAUCH	A Bauch	6/12/11	10

Daily assessment, Heartlink ECMO Centre, Glenfield Hospital, Leicester

Gastrointestinal / abdominal assessment: soft, BS ↓↓

Feeding: DGT 64 ml/H

Bowels: opened

Musculoskeletal / cutaneous: skin intact

S2664312
NHS Un-Known
MCLEISH
WENDY
1/1 51 COXTON PL
GLASGOW

G33 5EJ
25-MAY-1987 F
U5118413

Renal assessment: Urea 11.3
Creatinine 159

Urine output: 15-75ml/H

Renal Replacement therapy parameters: -

Input (iv fluid / feed):
in 4331
out 4214

Fluid balance: + 117

Na: 135

Weight: 78.5

Li and tubes: Ucal

Line	Site	Date	Days
CVC	RFV	30/11	
CVC/vascath	LFV	30/11	
Arterial	L radial	29/11	
~~Peripheral~~	R subclavian	21/11	
Other			

Infection issues:
WBC 11
CRP 42

Anti-bacterial / fungal / viral	Date	Days
Meropenem	30/11	
Linezolid	30/11	
Fluconazole	30/11	

Drug chart review: ✓
~~WBC 11~~
~~CRP 42~~

Radiology review: ✓

Other issues: ✓

Daily plan:
- ~~Wean~~ start Clonidine
- Wean Morphine
- ~~CVVR~~
- L radial artery removed
- prone overnight

Checklist:	Compliant?	Reason (if not)
>30° head up ✓		
Sedation hold ✓		
DVT prophylaxis ✓		
Gastroprophylaxis ✓		
Oral hygiene ✓		
Glucose control ✓		
Lines reviewed ✓		
Antibiotics reviewed ✓		

Doctor name:	Signature:	Date:	Time:
A BAUCH	A. Bauch	6/12/11	10

University Hospitals of Leicester NHS
NHS Trust

Unit No

AICU CONTINUATION SHEET

Each entry must be signed

Name WENDY MCLEISH

Date

7/12/11 12:05 (A) Rx in best interests · trialling off ECMO · proned overnight

(C) HR 72 BP 154/93 apyrexial
55% BIPAP ASB PEEP 8 ASB 14 TV 314
ABG @ 12:00 pH 7.39 PCO2 5.4 PO2 10.4 HCO3 24.1 BE 0.0
meds: Heparin, methylprednisolone, diprofol, morphine, Micardis
on CVVH, ve balance 9.1
Ausc: bronchial BS ©
°new CXR
Rx: in © side HR
~~insp Hold x 4 x 3~~
Suction x 3 - nil watery secs cleared
PEEP to 6L/L

(A) much more settled c ↑ sedation, PEEP achieved 10
responded very well to proning c TV 400 post Rx

(P) CXR: con c chest clearance + marking ECG
~~ITU~~ TRUCARE PT

7.12.11 decannulated after 164 hrs on ECMO
6 hrs trial off
- ~~68~~ ~~Aseptic precautions taken~~
- uneventful

S. Arija
(ECMO fellow)

8/12/11 PHYSIO 10.05.
(S) Rx in best interests
(O) HR 77 BP 151/101 apyrexial
BIPAP ASB 60% PEEP 8 ASB 14 TV 440 SPO2 89% RR 30
ABG @ 0000 pH 7.37 PCO2 5.9 PO2 9.6 HCO3 27.9
BE -0.3

Date

meds: Heparin, methyl prednisolone, propofol, morphine
midazolam

Resp: on c/w/H: balance - 376

Ausc: BSTO, bronchial BS bibasally
CXR: effusion (R), consolidation (L) base
Rx: Insp Holds x 4 x 3
Suction x 7, 1 c NaCl.

(A) Thick blood stained secs.
SpO2 97% post Rx. BSTO, bronchial BS basally
(P) R/W pcm tomorrow

Treated PT

PHYSIO

21/12/11. (S) PT Rx in best interests
915. (O) HR 73 SR BP 126/79 Apyrexial.
45% BiPAP NSB PEEP 8 NSB 14 TV 460 FiO2 1.8
ABG @ 0600 pH 7.38 pCO2 5.6 pO2 9.95, HCO3 27.8
BE - 0.6

meds: Methyl prednisolone, propofol, morphine,
midazolam, Actrapid, furosemide.
Resp: U/O 125/100/125, balance -560
Bloods: WCC 13.8, Hb 12.9, neutrophil 10.9
Ausc: BSTO bronchial @ UL
Rx: Saline suction x 3 // loose clear secs on suction
pcm to UL/LL
Ankle splint applied.

(A) Strong effective cough on suction.
good TV. (524 post Rx).
When aware tend to resist pcm but full range achieved
c prompts +++ to relax.

(P) NB to cont regular suction.
R/W range of movement, chest clearance

Treated PT

University Hospitals of Leicester NHS
NHS Trust

AICU CONTINUATION SHEET

Each entry must be signed

S2664312
NHS Un-Known
MCLEISH
WENDY
1/1 51 COXTON PL
GLASGOW
G33 5EJ
25-MAY-1987 F
U5118413

Date	
10/12/11 11:30	Physio Review S) Pt seen in best interests O) CVS HR 75, BP 135/38 RESP BiPAP / ASB, FiO2 40%, PEEP 8, ASB 14, TV 460, RR 18, SpO2 97%. ABGs pH 7.34, PCO2 9.8, PO2 11.22, HCO3 22.4, BE -1.6. Meds Furosemide, Propofol, morphine, midazolam, actrapid Renal u/o 160, 70, 60 +227. Bloods CRP 19, Platelets 320, WCC 7.5. Resp Upper R/L creps. Rx - NAC + Sunkist x2 II Poor clear secretions cleared. - UL + LL poor sticking - Applied S/Hub bilateralller. A) Shows costs on inter. Manual secretions cleared P/C/D none Amit Ramesh
10/12/11 09.40	Physio (S) Rx in pt best interests - consent assumed (O) CVS - HR-63 BP 144/87(111) CVP:11 Temp 36.5°C Resp - CPAP ASB PEEP:8 ASB:14 FiO_2 35% SpO_2 95% Renal - 1123-f/D u/o: 400/210/175 mls/hr. ABGs pH: 7.37 $PaCO_2$: 5.82 PaO_2: 10.4 HCO_3: 23.6 BE: -0.8 Infusions: fruesemide (0.2) methyl prednisolone (2) propofol - off. morphine (5) midazolam (5). actrapid (2.5). ABGs error pH nw cont.

Date 13/12/11 04.40

Physio cont.

Ans C BSTO. bronchial BS (R) base crepS (R) LL.

Rx
1. Repositioned into sitting, head up 45°
2. NaCl suction x 4 (checked by W/S) - mod. vol of loose white secs cleared.
3. PROM ex's + stretches all limbs adv lung allow - encouraged active movement
4. splints applied post TA stretches x3 - bi-lat.

(A) Strong cough on suction - clearing well c NaCl
↑ AE (B) LL post Rx + ↓ crepS.

Plan

r/v name

NWANNEN BSP7

12/12/11 9.15
PH 7.516
(S) consor assumed + Rx in best interests
(O) HR 55 BP 144/84 apyrexial
35% BiPAP ASS PEEP 8 ASB 14 TV 419 SpO2 95% RR 15
ABG @ 0800 PH 7.39 PCO2 5.62 PO2 10.6 HCO3 24.7 BE 0.5
Recall on CWH, -ve balance -500
Meds: morphine, midazolam, methylprednisolone
Anc: BSTO, bronchial (R) LL
Rx: Inh. Holds c DTE x3
Suction x2
Active assisted UL/LL exercises throughout evening
(C) LL due to CWH.
(A) minimal clear secs on suction
Strong effective cough
Full range of movement.

(A) Rw remain ~~on~~ thoracic PT

Daily assessment, Heartlink ECMO Centre, Glenfield Hospital, Leicester

Date: 7.12.11	ECMO Consultant: RAF	Patient name: Wendy McLeish
Date admitted / days ICU: (Referring ICU) 30-11-11 (Glenfield)	ECMO Fellow on call: Mr Kharaf	Date of birth: 25.5.87
ECMO started / stopped: 30-11-11	ECMO Coordinator: (Day) Maggie (Night)	Hospital number: S2664312

Summary of diagnoses and progress:	Summary of last 24h:
Pneumonia ARDS	- proned Improved gasses - stable overnight

Airway: Oral / nasal / tracheostomy / own 8.12	Size / type: #7.0
Respiratory assessment: Sat. 93, pH 7.39, pCO_2 5.6, pO_2 8.22, HCO_3 24.5, BE. 0.3, Lact. 1.2 A/C ++ B/L. Methylprednisolone	Ventilator settings: Bipap 20/10 FiO_2 = 30%
Cardiovascular assessment: BP = 170/100, HR = . Feet cold B/L	Inotropes/pressors: -
Neurological assessment / pupils: 2+ / 2+ Cough reflex ⊕ Shivers intermittently	Sedative drugs: Morphine Midazolam Propofol NG — Clonidine
Haematology / coagulation / bleeding: no Issues	Hb: 13 Plts: 167 Heparin management: 11 U/kg/hr.

ECMO circuit issues:	ECMO settings:
clots on base of oxygenator	Flow: 2.6 Sweep: 6 Revs: 2550

Doctor name: S. Daya	Signature:	Date: 7/12/11	Time: 9:45

Daily assessment, Heartlink ECMO Centre, Glenfield Hospital, Leicester

Gastrointestinal / abdominal assessment:
Soft - NBF, BS +

Feeding: NGC 65 ml/h

Bowels: BO +

Musculoskeletal / cutaneous:

Patient name:

Date of birth:

Hospital number:

Renal assessment: U = 10.1 (10.6)
CrCl = 112 (134)

Urine output:

Renal Replacement therapy parameters:
CVVH

Input (iv fluid / feed):

Fluid balance:

Na: 137 Weight: 78.6

Lines and tubes:
Clean

Line	Site	Date	Days
CVC	RFV	30/11	
~~CVC~~/vascath	RFV	30/11	
Arterial	L radial	29/11	
~~Peripheral~~	R subclavian	(21/11 Blocked)	
Other			

Infection issues:
WBC = 10.6 (11.4)
CRP = - (84)

Anti-bacterial / fungal / viral	Date	Days
Meropenem	30/11	
Levofloxacin	30/11	
Fluconazole	30/11	

Drug chart review:	Radiology review:	Other issues:
✓	✓	—

Daily plan:
- Unprone
- Trial off

Checklist:	Compliant?	Reason (if not)
>30° head up	✓	
Sedation hold	✓	
DVT prophylaxis	✓	
Gastroprophylaxis	✓	
Oral hygiene	✓	
Glucose control	✓	
Lines reviewed	✓	
Antibiotics reviewed	✓	

Doctor name:	Signature:	Date:	Time:
S Arya	SA	7.12.11	10:15

Daily assessment, Heartlink ECMO Centre, Glenfield Hospital, Leicester

Gastrointestinal / abdominal assessment:

Feeding: NG. Bowels: + ve BS.

Musculoskeletal / cutaneous:

—

S2664312
NHS Un-Known
MCLEISH
WENDY
1/1 51 COXTON PL
GLASGOW

G33 5EJ
25-MAY-1987 F
U5118413

Renal assessment: Urea 7.33 (162) Creat 130 (99)

Urine output: 4ml/h Furosemide inf. 20mg/h.

Renal Replacement therapy parameters: CCVH stopped.

Input-(iv fluid / feed): 4.1L.

Fluid balance: -376ml.

Na: 133. Weight: 78

Wound tubes: Clean. recan.

Line	Site	Date	Days
CVC	RIJV.	30.11	
~~CVC~~/vascath	RIJV.	30.11	
Arterial	L.R.d. 4.12. (29.11)		
Peripheral	R. Subclavian	21.11.	
Other			

Infection issues: WBC 10.1 (13.8) CRP 273 (24)

Anti-bacterial / fungal / viral	Date	Days
Meropenem	30.11	
~~Teicoplanin~~	30.11	
Fluconazol	30.11	

Drug chart review: ✓

Radiology review:

Other issues: — BP.!

Daily plan:
- RR? Stop Propofol.
- Start Dalteparin.
- ~~Warm output if patient ok. Trial~~
- CXR (tomorrow)
- Review Infection / Renal parameters

Checklist:

	Compliant?	Reason (if not)
>30° head up ✓		
Sedation hold		
DVT prophylaxis ✓		
Gastroprophylaxis ✓		
Oral hygiene ✓		
Glucose control ✓		
Lines reviewed ✓		
Antibiotics reviewed ✓		

Doctor name:	Signature:	Date:	Time:
H. Khairat		9.12.11	930

Daily assessment, Heartlink ECMO Centre, Glenfield Hospital, Leicester

Date: 9.12.11	ECMO Consultant: Mr. Firmin	S2664312 NHS Un-Known MCLEISH WENDY 1/1 51 COXTON PL GLASGOW , G33 5EJ 25-MAY-1987 F U5118413
Date admitted / days ICU: (Referring ICU) 30.11.11 (Glenfield)	ECMO Fellow on call: Mr. C. Harvey	
ECMO started / stopped: 7.12.11.	ECMO Coordinator: (Day) Samantha Harris - Fox (Night) Grace Alexander	

Summary of diagnoses and progress:	Summary of last 24h:
ARDS Pneumonia	Stable

Airway: Oral / nasal / tracheostomy / own

Size / type: #7

Respiratory assessment: PH. 7.38, PCO2 5.6, PO2 9.95 Sat. 95! BE- 0.6. HCO3 23.8, Lact. 1.2. Open bd. Airway. Coops band.

Ventilator settings: FiO2 45% BIPAP 28/8

Cardiovascular assessment: - 141/65, MAP 90. P. 75 ↓ Warm periph,

Inotropes/pressors: —

Neurological assessment / pupils: PEARL 3ø moves all limbs

Sedative drugs: - Propofol. - MK. - Midazolam.

Haematology / coagulation / bleeding: —

Hb: 12.1
Plts: 249
Heparin management: —

ECMO circuit issues:	ECMO settings:
—	Flow: Sweep: — Revs:

Doctor name:	Signature:	Date:	Time:
Haitem Khairat		9.12.	930

Daily assessment, Heartlink ECMO Centre, Glenfield Hospital, Leicester

Date: 10/12/11	ECMO Consultant: GJF
Date admitted / days ICU: (Referring ICU) 30/11 (Glenfield)	ECMO Fellow on call: Giuseppe Pellela
ECMO started / stopped: 30/11 - 7/12/11 16:00	ECMO Coordinator: (Day) Gail (Night) Gail

S2664312
NHS Un-Known
MCLEISH
WENDY
1/1 51 COXTON PL
GLASGOW

G33 5EJ
25-MAY-1987 F
U5118413

Summary of diagnoses and progress:	Summary of last 24h:
ARDS . Pneumonia	↓ Propofol Stable all the night

Airway: Oral / nasal / tracheostomy / own — Size / type: 7 (2/12/11

Respiratory assessment: Good AE

Ventilator settings: BIPAP FiO2 60%
Rate: 18
25/8 ΔSB: 14

Cardiovascular assessment: Warm and pink skin
BP: 141/79
SpO2 97% good pulse

Inotropes/pressors:

Neurological assessment / pupils: Sleeping
Size 3 pupils Reactive to Light

Sedative drugs:

Haematology / coagulation / bleeding:
INR 1

Hb: 12.8
Plts: 32
Heparin management:

ECMO circuit issues: /

ECMO settings:
Flow:
Sweep:
Revs: /

Doctor name:	Signature:	Date:	Time:
PELELLA		10/12/11	10:50

Daily assessment, Heartlink ECMO Centre, Glenfield Hospital, Leicester

Gastrointestinal / abdominal assessment:
Soft . mobile

Feeding: NG . 57ml/h

Bowels: open

Musculoskeletal / cutaneous:

S2664312
NHS Un-Known
MCLEISH
WENDY
1/1 51 COXTON PL
GLASGOW

G33 5EJ
25-MAY-1987 F
U5118413

Renal assessment: CREA 237↑ UREA 26.1↑
FUROSEMIDE: 2ml/h eGFR = 23

Urine output: 70-325ml/h

Renal Replacement therapy parameters: NO CVVH

Input (iv fluid / feed):

Fluid balance:

Na: 128.9 K+ 5.6 Weight:

Lines and tubes:

Line	Site	Date	Days
CVC	L Femoral R Subclavian	30/11 21/11	10/1 19
~~CVC~~/vascath	R Femoral	30/11	10
Arterial	L Radial	29/11	11
Peripheral			
Other			

Infection issues: ALT 263↑
WCC: 7.5
CRP 19

Anti-bacterial / fungal / viral	Date	Days
Meropenem	30/11 / 11	10
Fluconazole	20/11 / 11	20
Linezolid	1/12/14	9

Drug chart review: Yes

Radiology review:

Other issues: pressure sore on the chin

Daily plan:
- Remove the R Subclavian line
- CVVH ?
- CXR

Checklist:	Compliant?	Reason (if not)
>30° head up ✓	✓	
Sedation hold	no	
DVT prophylaxis	✓	
Gastroprophylaxis	✓	
Oral hygiene	✓	
Glucose control	✓	
Lines reviewed	✓	
Antibiotics reviewed	✓	

Doctor name:	Signature:	Date:	Time:
PELELLA		10/12/14	11:00

Daily assessment, Heartlink ECMO Centre, Glenfield Hospital, Leicester

Gastrointestinal / abdominal assessment:

Feeding: 57 NS feed

Bowels:

Musculoskeletal / cutaneous:

S2664312
NHS Un-Known
MCLEISH
WENDY
1/1 51 COXTON PL
GLASGOW
G33 5EJ
25-MAY-1987 F
U5118413

Renal assessment:

Urine output: 400 - 175 ml / 0.2 ml/kg Fn

Renal Replacement therapy parameters:

Input (iv-fluid /-feed): +3192

Fluid balance: 1123 ml.

Na: 132 Weight:

Lines and tubes: clear

Line	Site	Date	Days
CVC			
CVC/vascath			
Arterial			
Peripheral			
Other			

Infection issues:

WCC
CRP

Anti-bacterial / fungal / viral	Date	Days
Meropenem		to 11
Fluconazole		26
Vancomycin		to

Drug chart review: ✓

Radiology review:

Other issues: P. dose until the chest

Daily plan: Wean on CPAP

Checklist:	Compliant?	Reason (if not)
>30° head up	✓	
Sedation hold	✓	
DVT prophylaxis	✓	
Gastroprophylaxis	✓	
Oral hygiene	✓	
Glucose control	✓	
Lines reviewed	✓	
Antibiotics reviewed	✓	

Doctor name:	Signature:	Date:	Time:
Pellelle		11 Dec	10:20

Daily assessment, Heartlink ECMO Centre, Glenfield Hospital, Leicester

Date: 11/12/14	ECMO Consultant: GVJP + Clare	S2664312 NHS Un-Known MCLEISH WENDY 1/1 51 COXTON PL GLASGOW G33 5EJ 25-MAY-1987 F U5118413
Date admitted / days ICU: (Referring ICU) (Glenfield)	ECMO Fellow on call: Qi'weffe	
ECMO started / stopped:	ECMO Coordinator: (Day) Geej (Night) Gej	

Summary of diagnoses and progress:	Summary of last 24h:
ARDS Pneumonia	- Stable - Urea Creatinine ↑ - Furosemide 250 mg/50 ml/6 + - removed the R subclavian line

Airway: Oral / nasal / tracheostomy / own — Size / type: 7

Respiratory assessment: Crepitations at the Top of the R lung

Ventilator settings: CPAP
FIO_2: 35%
PEEP 5 ASB 14

Cardiovascular assessment: 147/84 mmHg CVP: 14
HR: 65 bpm
SpO_2 96%

Inotropes/pressors:

Neurological assessment / pupils:

Sedative drugs: MM + M

Haematology / coagulation / bleeding:

Hb: 12.9
Plts:
Heparin management:

ECMO circuit issues:

ECMO settings:
Flow:
Sweep:
Revs:

Doctor name:	Signature:	Date:	Time:
Fellele		11 Dec	10:20

Universally Hospitals of Leicester NHS
NHS Trust

Adult Intensive Care Unit
Blood Results

(Please record abnormal results in red pen)

S2664312
NHS Un-Known
MCLEISH
WENDY
1/1 51 COXTON PL
GLASGOW

G33 5EJ
25-MAY-1987 F
U5118413

Date			11/12/11	11/12/11	12/12/11					
Time sample taken			0628	1545	05.56					
Time result charted			0910	1720	0910					
Result taker sign			AP	SK	AP					
Sodium	mmol/L	133 -146	133	133	136					
Potassium	mmol/L	3.5 - 5.3	5.8	6.0	5.5					
Chloride	mmol/L	95 -108	93	94						
Urea	mmol/L	2.5 - 7.8	36.5	40.9	23.4					
Creatinine	µmol/L	60 -120	280	294	150					
eGFR	ml/min	57	19	18	39					
Uprotein	g/L	60 - 80	64	65						
Albumin	g/L	35 - 50	35	35						
Adjusted Calcium	mmol/L	2.2 - 2.6	2.38	2.39	2.47					
Magnesium	mmol/L	0.7 -1.0	2.34	0.91	1.02					
Phosphate	mmol/L	0.8 -1.5	2.34	2.19	1.42					
Alk phos	U/L	30 -130	119	103						
ALT	U/L	2 - 53	166	155	156					
GGT	U/L	0 - 50	238	130						
Bilirubin	µmol/L	< 21	15	16						
Amylase	U/L	30 -110	153	130	95					
WCC	x10⁹/L	4 -11	7.1	9.5	7.9					
Hb	g/dL	13 - 18	12.9	13.3	12.6					
HCT	%	40 - 54	0.380	0.401	0.382					
Plat/Hb	x10⁹/L	140 - 400	331	405	368					
Neutrophil	x10⁹/L	1.5 - 7.5	4.99	7.17	5.89					
INR		0.9 -1.2	1.1	1.1	1.2					
APTT	sec	25 - 35	27.0	27.0	168.7					
APTTR		0.8 -1.2	0.9	0.9	5.6					
Fibrinogen	g/L	2 -4	2.6	2.5	2.4					
D-dimer					15.2					
CRP	mg/L	0 -10	14	13	11					
Troponin I	ng/L	< 0.04								
CPK	U/L	25 - 200								

Results taken over the telephone must be documented in the pink booklet.

University Hospitals of Leicester NHS Trust

Adult Intensive Care Unit Blood Results

(Please record abnormal results in red pen)

S2664312
NHS Un-Known
MCLEISH
WENDY
1/1 51 COXTON PL
GLASGOW

G33 5EJ
25-MAY-1987 F
U5118413

Date			7/12/11	7/12/11	8/12/11	8/12/11	9/12/11	9.12.11	10/12/11	10.12.11
Time sample taken			0600	1800	05.48	17.49	a.m	17.02	0600	1700
Time result charted			0855	1930	08.30	20.30	0944	2200	09.05	20.36
Result taker sign			W.	W.	[illegible]	DAB	[illegible]	PM	MT	PM
Sodium	mmol/L	133 - 146	137	136	137	134	133	133	131	132
Potassium	mmol/L	3.5 - 5.3	5.2	5.2	5.1	5.1	5.5	5.5	5.9	5.8*
Chloride	mmol/L	95 - 108	103	104	104	102	99			
Urea	mmol/L	2.5 - 7.8	10.1	9.2	9.7	10.0	↑13.3	19.6	26.5 ↑	31.1*
Creatinine	µmol/L	60 - 120	112	99	97	99	↑130	198	235 ↑	265*
eGFR	ml/min	57	55	63	65	63	46	32	23	20
T protein	g/L	60 - 80	63	68	67	66	62	64	65	63
Albumin	g/L	35 - 50	34	38	37	37	36	35	36	37
Ad Calcium	mmol/L	2.2 - 2.6	2.61	2.58	2.62	2.61	0.55	2.46	2.43	2.40
Magnesium	mmol/L	0.7 - 1.0	0.96	1.02	0.91	0.85	1.03	0.99	1.03	1.02
Phosphate	mmol/L	0.8 - 1.5	0.86	1.23	1.03	0.81	1.75	1.76	2.00	2.11
Alk phos	U/L	30 - 130	150	145	140	147	148	133	127	135
ALT	U/L	2 - 53	33	60	87	139	191	204	218	199
GGT	U/L	0 - 50	176	226	232	244	256		263	267
Bilirubin	µmol/L	< 21	15	16	15	16	15	19	16	19
Amylase	U/L	30 - 110	74	88	92	97	115	130	157	185
					09.00					
WCC	$x10^9$/L	4 - 11	10.6	12.9	15.1	13.8	10.0	9.7	7.5	9.1
Hb	g/dL	13 - 18	13.0	12.5	12.7	12.9	12.1	12.6	12.4	13.1
Hct	%	40 - 54	0.393	0.379	0.387	0.388	0.378	0.383	0.378	0.393
Iatelets	$x10^9$/L	140 - 400	167	182	217	201	249	280	328	318
Neutrophil	$x10^9$/L	1.5 - 7.5	7.83	9.76	12	10.98	7.82	7.27	5.30	6.38
INR		0.9 - 1.2	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.1
APTT	sec	25 - 35	40.9	55.4*	↑102.6	45.3	29.5	29.3	28.0	14.2
APTTR		0.8 - 1.2	1.4	1.9*	3.4	1.5	1.0	1.0	0.9	0.9
Fibrinogen	g/L	2 - 4	2.3	2.0	2.1	2.7	2.8	2.9	2.9	3.0
PT					13.9	13.6	13.4		13.8	
CRP	mg/L	0 - 10			19	24	27		19	
Troponin I	ng/L	< 0.04								
CK	U/L	25 - 200								

Results taken over the telephone must be documented in the pink booklet.

23123532V F
MCLEISH
WENDY 25/05/1987
0/1 51 COXTON PLACE
GLASGOW G33 5EJ
CHI-2505876061

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - NURSING

Date & Time	24 ♀ (R), Lives c boyfriend	Signature, Print Name & Designation
19/3/12	Jackie Robertson, (Support worker).	
	Wendy seen in hospital c Pneumonia. Transferred to specialist Unit in Leicester for 1 month.	
	Back is horrible whole body Shaky sometimes leg or hands.	
	When thinks is concentration scan feels when walking	
	feels left leg is weaker.	
	Becomes shaky when nervous or trying to concentrate	
	Rx: Propranolol, Celeste pill Fluoxetin before hospital admn	
	Allergies - Hay fever.	
	- Depressed - 1 yr.	
	- Tried to take life couple of times	
	- Dad died.	
	- Supp. worker feels that Depression is better.	
	Rx:	
	- Non smoker	
	- Alcohol - drinks more than recommended does not feel it is a problem, but drinks when bored	
	Rx, ECG (N)	
	Cardiac (N)	
	No Carotid / Subclavian bruits	
	Tone / Power (N) DTR ++ Plt.	

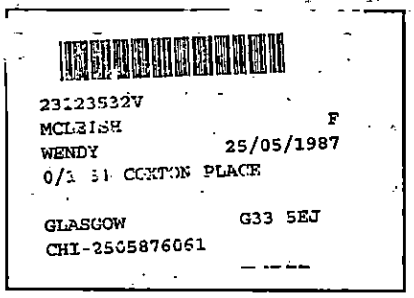
193443

Date & Time		Signature, Print Name & Designation
	(W) Asymptomatic, unbr. gait ⊖ tenderness right wrist on walk on heels down not to hop	
	Nocturnal frequency can go down. If steps can get it has stop cont distractions	
	Immuno. postural, dismetabolic.	
	→ PT, Dermis, anxiety ⊖	
	→ TFT, HBC.	
	<-> Cont. -β blockers.	
6/8/12	Improved. ESI weight ⊖ chest clear	
	Pain: CXR	

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary

Date 2/1/2012



Refusal of Treatment

I ..... Wendy McLeish .....

of ..... 0/1 51 Coxton Place .....

Hereby declare that I am leaving

~~*(or taking ..... away from)~~

the ..... Glasgow Royal Infirmary .. Hospital at my own desire and contrary to the advice of medical staff.

I have had the risks of so doing explained to me, and accept full responsibility for my action.

Signature .....

Witness .....

Peggy 3336

* Delete whichever is inapplicable.

MEDICINE — PRESCRIPTION FORM

Hospital Name: .....

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐

Date _____ Name (Print) _____

Discharge Prescription Prepared & Reconciled YES ☐

Date _____ Name (Print) _____

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

DOCTOR'S DECLARATION (if required by Local Protocol)

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

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name _____ Tel No. _____

Address _____

Compliance Aid Details _____

Patient consent to share discharge information Y/N

Print & Sign _____

PATIENT DETAILS

Hospital Number: 2312553ZV	Height:
DOB: 25/05/87	Weight:
Date of Admission: 21/11/11	Surface area:
Consultant Name: Quasim.	Ward: MAU

Name Wendy Mcleish

CHI No 2505877661

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
21/12	GASTROGRAFFIN	60mls	PO	2200	Co G	K Shaw	1045 PM
22/12	GASTROGRAFFIN	10mls	PO	0800	Co G	VB	0830

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

NIL

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

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

Notes for Users

FOR PRESCRIBERS:

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

DATE →	21	22	23	24	25	26	27	28	29	30	31	1													
MONTH →	12	12	12	12	12	12	12	12	12	12	12	1													

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

IS DRUG THROMBOPROPHYLAXIS INDICATED? (Y) N																									
ARE ANTIEMBOLISM STOCKINGS INDICATED? (Y) N																									
SIGNATURE OF ASSESSOR																									
ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N																									

Parenteral Drugs : Regular Prescription

A

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG: ENOXAPARIN

DOSE: 40mg | ROUTE: SC | DATE: 20/12/11

PRESCRIBER (PRINT & SIGN): PATTON

STOPPED DATE: | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

Other time																									
0700-0900																									
1200-1400																									
1600-1800	VB	VB	AS	AS	JM	JM	CM	CM	(W3)	VB	(B3)	(B3)													
2200-2400																									
Other time																									

Patient's Own Medicine: For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

B

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☑

DRUG: Metronidazole

DOSE: 500mg | ROUTE: IV | DATE: 23/12

PRESCRIBER (PRINT & SIGN):

STOPPED DATE: 24/12 | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: TID

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

Patient's Own Medicine: For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

C

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG:

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN):

STOPPED DATE: | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

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

Patient's Own Medicine: For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

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

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

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

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

D DRUG

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

E DRUG

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

F DRUG

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

G DRUG

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

Name: Wendy Mcleish
CHI No: 2505876061

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

NIL

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

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

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generally using the approved (base) names as circumstances where bioavailability differences between names of the same drug are so important as to warrant prescribing by proprietary name, e.g. in the case of controlled release lithium or theophylline.

Oral and Other Drugs: Regular Prescription

DATE: 20 21 22 23 24 25 26 27 28 29 30 31 1 2

MONTH: 12 12 12 12 12 12 12 12 12 12 12 12 1 1

Patient's Own Medicine

H DRUG: Clonidine

DOSE: 50mcg | ROUTE: PO NG | DATE: 20/12/11 | STOPPED DATE: 24/1 | INITIALS:

PRESCRIBER (PRINT & SIGN): PATTEN

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

	20	21	22	23	24	25	26	27	28	29	30	31	1	2
Other time														
0700-0900	X	ordered (4)	(5)	KM	14 AS									
1200-1400	X	VB	VB	KM	AS									
1600-1800														
2200-2400		VB	VB	EW										
Other time														

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

J DRUG: DIAZEPAM

DOSE: 10mg | ROUTE: PO NG | DATE: 20/12/11 | STOPPED DATE: 24/1 | INITIALS:

PRESCRIBER (PRINT & SIGN): PATTEN

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

	20	21	22	23	24	25	26	27	28	29	30	31	1	2
Other time														
0700-0900	X	ordered (4)	(5)	KM	14 AS									
1200-1400	X	VB	VB	KM	AS									
1600-1800	X	VB	VB											
2200-2400		TLS	VB	EW										
Other time														

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

K DRUG: Fluoxetine

DOSE: 40mg | ROUTE: PO NG | DATE: 20/12/11 | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN): PATTEN

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

	20	21	22	23	24	25	26	27	28	29	30	31	1	2
Other time														
0700-0900	X	ordered (4)	(5)	KM	14 AS									
1200-1400		VB												
1600-1800														
2200-2400														
Other time														

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

L DRUG: Oromorph

DOSE: 7-5mg | ROUTE: PO NG | DATE: 20/12/11 | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN): PATTEN

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

	20	21	22	23	24	25	26	27	28	29	30	31	1	2
Other time														
0700-0900	X		(5)											
1200-1400	X	VB	VB											
1600-1800														
2200-2400														
Other time														

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

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

Oral and Other Drugs: Regular Prescription

DATE →	20	21	22	23	24	25	26	27	28	29	30	31	1	2	Patient's Own Medicine
MONTH →	12	12	12	12	12	12	12	12	12	12	12	12	1	1	

M — DRUG: Chlorhexidine — DOSE: 10ml — ROUTE: PO — DATE: 20/12/11 — PRESCRIBER (PRINT & SIGN): PATTON — ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: Mouthwash — STOPPED DATE: — INITIALS:

Time	20	21	22	23	24	25	26	27	28	29	30	31	1	2
Other time														
0700-0900	X	VB	VB	KM	AD	cm	cm	cm	P	cm	VB	W	W	3
1200-1400	X	VB	VB	KM	AS	cm	cm	cm	M	cm	VB	W	M	3
1600-1800	X	VB	VB	KM	AS	cm	cm	cm	M	cm	VB	W	M	3
2200-2400		KS	KS	EW					JR	JR	KS	KS	JR	
Other time														

Patient's Own Medicine: For Use Y/N — Qty: — Date: — Assessed by: — Ordered from Pharm.

N — DRUG: Saline Nebs — DOSE: 5mg — ROUTE: Neb — DATE: 21/12 — PRESCRIBER (PRINT & SIGN): — ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: — STOPPED DATE: — INITIALS:

Time	20	21	22	23	24	25	26	27	28	29	30	31	1	2
Other time														
0700-0900	X	X	VB	KM	AD	cm	cm	KM	P	3	3	3	3	8
1200-1400	X		VB	VB	KM	AS	cm	3	3	3	3	3	3	3
1600-1800	X		VB	VB	KM	AS	cm	3	3	3	3	3	3	3
2200-2400	X		KS	KS	EW			3	3	JR	JR	3	3	JR
Other time														

Patient's Own Medicine: For Use Y/N — Qty: — Date: — Assessed by: — Ordered from Pharm.

P — DRUG: Metronidazole — DOSE: 400mg — ROUTE: PO — DATE: 23/12 — PRESCRIBER (PRINT & SIGN): — ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: 7 days — STOPPED DATE: — INITIALS:

Time	20	21	22	23	24	25	26	27	28	29	30	31	1	2
Other time														
0700-0900														
1200-1400														
1600-1800														
2200-2400														
Other time														

Patient's Own Medicine: For Use Y/N — Qty: — Date: — Assessed by: — Ordered from Pharm.

R — DRUG: Clonidine — DOSE: 50mcg — ROUTE: PO — DATE: 24/12 — PRESCRIBER (PRINT & SIGN): — ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: — STOPPED DATE: — INITIALS:

Time	20	21	22	23	24	25	26	27	28	29	30	31	1	2
Other time														
0700-0900						cm	cm	cm	P	cm	VB	W	M	3
1200-1400														
1600-1800														
2200-2400								C	JR	JR	KS	KS	JR	
Other time														

Patient's Own Medicine: For Use Y/N — Qty: — Date: — Assessed by: — Ordered from Pharm.

BEFORE ADMISSION ☐ — NEW DOSE ☐ — NEW MEDICATION ☐

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

Name: Wendy McLeish

CHI No: 2505877061

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

NIL

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

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

Notes for users

1. Prescribe drug generic name, dose, frequency, circumstances when needed, duration, and route of administration. Do not prescribe more than a 5 day supply.

Oral and Other Drugs: Regular Prescription

DATE: 24 25 26 27 28 29 30 31 1 2
MONTH: 12 12 12 12 12 12 12 12 1 1

S — DRUG: DIAZEPAM
DOSE: 10mg | ROUTE: O | DATE: 24/12 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐
Patient's Own Medicine: For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

Time	24	25	26	27	28	29	30	31	1	2
0700-0900		CM	CM	CM	CM	CM				
1200-1400										
1600-1800										
2200-2400										

T — DRUG: DIAZEPAM
DOSE: 5mg | ROUTE: O | DATE: 24/12 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐
Patient's Own Medicine: For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

Time	24	25	26	27	28	29	30	31	1	2
1200-1400	X	CM	CM	CM	CM					
1600-1800	PB	CM	CM	CM	CM					

V — DRUG: DIAZEPAM
DOSE: 5mg | ROUTE: O | DATE: 29/12 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: ↓ DOSE
BEFORE ADMISSION ☐ NEW DOSE ☑ NEW MEDICATION ☐
Patient's Own Medicine: For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

Time	29	30	31	1	2
0700-0900	X VB	MM	MM	(3)	
1200-1400	CM VB	MM	MM	(3)	3
1600-1800	CM VB	MM	MM	3	
2200-2400	OK	ILS	ILS	JIL	

W — DRUG: ORAMORPH
DOSE: 5mg | ROUTE: O | DATE: 29/12 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: ↓ DOSE
BEFORE ADMISSION ☐ NEW DOSE ☑ NEW MEDICATION ☐
Patient's Own Medicine: For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

Time	29	30	31	1	2
0700-0900	X	MM	MM	(3)	
1200-1400		MM	MM	(3)	3
1600-1800					
2200-2400					

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

Patient's Own Medicine: For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

X DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

Y DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

AA DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

BB DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Name: Wendy Mcleish

CHI No: 2505877061

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

NIL

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

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

Notes for Users

FOR PRESCRIBERS

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

CC DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DD DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

EE DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

FF DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

GG DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

HH DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

JJ DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

KK DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Name Wendy Mclerish

CHI No 2505877061

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

NIL

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only

(Maximum number of doses as per protocol)

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

Notes for Users

FOR PRESCRIBERS:

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

All Routes: As Required Prescriptions

Patient's Own Medicine

| | | |

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

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

Name Wendy McLeish

CHI No 2505877061

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

NIL

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

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

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

Notes for Users

FOR PRESCRIBERS:

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

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

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

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

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

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

7. The following metric unit abbreviations must be used –

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

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

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

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

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

FOR NURSES

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

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

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

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

Codes for Non-Administration of Drugs

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

Cat. No. 40995 Ver 4, 09/2010

Patient I.D. Label

Wendy McLeish 24

Patient handover information

NHS Greater Glasgow and Clyde

Ward/To Ward: ITU (West)

Transfer Date:

EDD:

Presenting Complaint / Condition

Chest pain, SOB, Intubated - struggled to ventilate

Allergies:

Relevant Past Medical History: (including previous inpatient management issues)

Depression, Self harm, ? cocaine smoker,

Current Management: (Immediate handover details)

IV Access: (Y) N	IV Medication: (Y) N	IV Fluids: Y / N	Oxygen: / %	Sews Mews	NG (Y) N

Trachy insitu - 08g ventilator for 36 hrs Pt expectorating
Swedish nose - sats 97% on air
NG 65ml/hr, IV Pabrinex, Meds through NG,

Investigation Results:

Investigations Pending:

Patient appears orientated	Yes ☑ No ☐ GCS
Mobility	Independent ☐ Assistance of 1 ☐ Assistance of 2 ☑ Fully Dependant ☐
Skin	Intact ☑ Other ☐ Waterlow Score ☐ Special Bed ☐
MUST	Yes ☑ No ☐
Alcohol Management Plan	Yes ☐ No ☐

Diet	Normal ☐ Special ☐ Fasting: Nil by mouth ☑
Property/ Valuables	Clothing: Dentures: Glasses:
Infection Risk	Yes ☐ No ☐
Patient Medication	Sent: N/A:
Relatives informed of transfer	Yes ☑ No ☐
CANNARD	Yes ☐ No ☐

Any other Issues:

Tachypoeic - doctors aware, catheterised

P.T.O. if more space required

MIS 200112

Any Questions please contact:

Signature:

Print:

Acute Services Division

NHS Greater Glasgow and Clyde

Discharge Checklist

Patient's name: 23123532V MCLEISH F	Ward:
Unit number: WENDY 25/05/1987 0/1 51 COXTON PLACE	Discharge destination:
CHI number: GLASGOW G33 5EJ CHI-2505876061	Estimated Discharge Date (1) irreg / /
	Estimated Discharge Date (2) / /
	Final date of discharge : / /

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

FORM NUMBER 0005752

Name: Ward: 7/16 Date: 20/12/11 Case R

23123532V
MCLEISH F
WENDY 25/05/1987
0/1 51 COXTON PLACE
GLASGOW G33 5EJ
CHI-2505876061

ACTIVITIES OF DAILY LIVING

HOME CIRCUMSTANCES/ SOCIAL SUPPORT

- Lives with family ☐
- Lives alone ☐
- Nursing home ☐
- Residential care ☐
- Elderly/disabled partner ☐
- Family support (specify below) ☐

_____

- District Nurse (_____days/week) ☐
- (cancelled ☐)
- Home help(_____days/week) ☐
- (cancelled ☐)
- Other services (specify below) ☐

_____

_____

Stairs: Internal ☐ External ☐

Comments: _____

_____

NUTRITION

- Normal menu (includes vegetarian) ☐
- Vegan ☐ Child's menu ☐
- Halal ☐ Kosher ☐
- Refer to Dietician if any below ticked:
- Inability to eat/swallow ☐
- (refer to speech and language therapist)
- Any recent weight changes ☐
- Medically related nutrition problems (e.g. diabetes) ☐
- Other (specify): NG feed ongoing

_____

_____

BREATHING

- 1. No symptoms ☐
- 2. Breathless with moderate exercise ☐
- 3. Breathless with minimal exertion ☐
- 4. Breathless at rest ☐
- 5. Uses Inhalers ☐

Comments: Trachy unsite

_____

SMOKING

- Non-smoker ☐
- Smoker: _____ per day ☐
- Ex-smoker ☐
- Aware of hospital policy ☐

HYGIENE

- Bath ☐ Shower ☐
- Requires assistance ☐ Stand up wash ☐
- Skin assessment: _____

_____

Other: _____

ELIMINATION

- Bowels regular ☐
- Constipated ☐
- Diarrhoea/Loose stools ☐
- Uses aperient ☐
- Has stoma:
  - Colostomy ☐
  - Urostomy ☐
  - Ileostomy ☐

appliances used: _____

_____

- Frequency of micturition ☐
- Incontinent: urine/faeces ☐
- day/night ☐
- stress ☐
- No urinary symptoms ☐

Comments: _____

_____

SLEEP

- Hours/night ☐
- Medication ☐

details: _____

MENTAL STATE

- Alert/Orientated ☐
- Confused: day/night ☐
- Anxious/~~Distressed~~ ☑
- Unconscious ☐
- Other (specify):

SENSES

Glasses: distance ☐
reading ☐
Hearing impaired: left/right ☐
Hearing aid: left/right ☐
Dentures: upper ☐
lower ☐
Communication Difficulties ☐
Other: _____

ALCOHOL INTAKE

Units/week: nil ☐
less than 14 ☐
14 - 21 ☐
over 21 ☐
(1 unit = 1 measure spirits/half pint beer/ lager/1 glass wine)

MOBILITY (Pre admission)

Mobile without aid ☐
Mobile with aid ☐
(Specify type/side held: _____)
Furniture walking ☐
Chair Bound ☐
Housebound ☐

RELATIVE PARTICIPATION

PROFILE COMPLETED BY:

(Please print name in block capitals)
SARINDER
Signature: DSL
Designation: SN
Countersigned (if applicable):

OTHER RELEVANT INFORMATION

Patient understands but is unable to verbalise at present.

Name: Ward: 7/16 Date: 20/12/11 Cas

231203332V
MCLEISH No.: F
WENDY 25/05/1997
0/1 51 COXTON PLACE
GLASGOW G33 5BJ
CHI-2505876061

CARE PLAN EVALUATION

1. Basic Care and Hygiene	5. Observations	9. Sleep
2. Nutrition	6. Technical Care	10. Special
3. Elimination	7. Wound Care	11. Other Relevant Information
4. Mobility	8. Specimens/Investigations	

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
20/12/11	23⁰⁰		Parent transfered to ward 7/16.	
			from ITU. Orgionally admited	
			21/11/11 with chestpain & SOB.	
			Treated for CAPE required haemodialysis	
			& also transferred to ~~leister~~ Leicester	
			for ECMO.	
			Extubated 36 hrs ago.	
			Trachy insitu – no inner tube.	
			Currently able to cough independantly	
			to clear airway but requiring	
			assistance with clearing up sputum.	
			28% @ humidified @ in progress	
			(transferred are on 24)	
			NG feed in progress. 65ml/L.	
			catheter insitu.	
			Parent unable to speak but is	
			aware of things happening to her	
			& around her. MEWS 4-6.	
			Awaiting medical review.	
			Seems very shaky & a bit agitated.	
			Prescribed regular oramorph	
			diazepam & clonadine.	SNTiller
21/12/11	04⁰⁰	3	Urine vds. sanspachy. Bowels inactive	
		5	Remains tachypnoeic RR>30	
			(was like this in ITU)	
			medics aware. Less tachycardic.	
			BP stable. Currently apyrexial	
		6	~~Trachy cleaned and managed~~	
			to expectorated.	
			28% @ continues	
			oramorph, clonidine & diazepam	
			given as ~~prescribed~~ via N.G.	
		11	Appeared to settle & sleep	
			for a few hours.	
		7	Assisted with personal changes	
		2	NU By Math. Meds given via	
			NG. feed continues.	
			Oral hygiene attended to.	SNTiller
21/12/11	D/S	(1)	Pt fully bedbathed this morning.	
	1850	(2)	NG feed continues at 65ml/hr.	PTO
			Oral care given. NBM	V.Brackenridge

EVALUATION OF CARE

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
21/12/11 (cont)	D/S 1850	(3)	Catheter patent and draining well. No bowel movements.	
		(4)	Regular positional turns carried out.	
		(5)	Obs as charted.	
		(6)	28% humidified oxygen continues. Regular trachy care carried out.	
		(8)	For CT of chest/abdo/pelvis tomorrow. To be fasted from midnight.	
		(11)	Settled day. Meds given via NG. To continue current treatment. Pt commenced on regular saline nebs. Pt seen by critical care outreach — see medical notes.	V. Boatheridge
22/12/11	N/S. @0110.		Medication given as prescribed via NG tube.	
			→ Oramorph 7.5mg given.	
		(5)	⇒ Observations = BP 118/73 P86 T36.5 RR 20 SpO_2 99% on 28% humidified O_2. News @ last night.	
		(6)	⇒ Tracheostomy care carried out frequently. (See chart). Patient managing to expectorate well.	
		(6)	⇒ NG tube remains in situ. Currently fasting in preparation for planned CT.	
			→ Medical staff asked to R/V re. GASTROGRAFIN prescription. Same prescribed. (See Kardex)	
			⇒ Regular positional changes (See chart).	
			⇒ Catheter remains in situ. Patent and draining well.	
		(5)	Observations ⇒ BP 119/85 P81 T 36.6 RR 20 SpO_2 98% on 28% O_2. News 0.	
		A	Patient settled and appeared to sleep well. No complaints offered. Limbs twitching 0/10.	
			- would benefit from physio referral.	K. Shovlin

Name: Wendy McLeish Ward: 7/16 Date: Case Record No.:

CARE PLAN EVALUATION		
1. Basic Care and Hygiene	5. Observations	9. Sleep
2. Nutrition	6. Technical Care	10: Special Needs
3. Elimination	7. Wound Care	11. Other Relevant Information
4. Mobility	8. Specimens/Investigations	

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
22/12/11	D/S	(1)	Pt fully bedbathed this morning	
	1900	(2)	NG feed running at 65ml/hr	
		(3)	Catheter patent and draining well. No bowel movements.	
		(4)	Regular positional turns done. Pt up to sit for 10 minutes today with physios and standaid.	
		(5)	Obs stable as charted.	
		(6)	28% humidified oxygen continues. Trachy site kept clean – minimal suctioning required.	
		(8)	Attended for CT of chest/abdo/pelvis – await results	
		(11)	Settled day. Not seen on ward round. Seen by critical care outreach – see medical notes	V.Brocheridge
		(11)	CAT team to be contacted on 418-4943 when pts trachy removed	V.Brocheridge
23/12/11	N/S.	(1)	All nursing care given.	
		(2)	NG feed continues running @ 65ml/hr.	
		(3)	Catheter remains insitu. Patent & draining well. Urine concentrated.	
		(4)	Remains nursed in bed. Positional changes as tolerated. Continues to be nursed on pressure relieving mattress.	
		(5)	Observations = BP 115/82 P100 T 37.4 RR 22 SpO_2 99% on 28% O_2. NEWS (1) Prior to settling last night.	
		(6)	28% humidified O_2 continues. Tracheostomy care carried out frequently. No suctioning required. Patient continues to expectorate well.	
			- Medication given via NG tube → Oramorph given as prescribed	

EVALUATION OF CARE

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
		(9)	Patient settled and appeared to sleep well.	
		(5)	observations - BP 116/78 P100 T 36.2 RR 24 SpO_2 99% on 28% O_2. MEWS (1).	
		(11)	Patient not as tremorous last night. Much more settled. Not requiring suctioning. (see Tracheostomy tube Care Sheet).	K Shaw
23/12/11	D/S		Patient has had settled day. No complaints. Full assistance & bed bath given Up to sit @ bedside for 30 mins. Meds given as per kardex. Obs stable as charted. Feed finished. PH checked 4. New feed commenced 12.30 13.15 Patient coughing +++. small vomit. On examination NG tube came out. Awaiting NG tube placement Seen by critical outreach team. for Swallow Test 24/12/11	K Miller SN E Miller SN
23/12/11			NG tube replaced, position satisfactory, PH 4., feed commenced.	
24/12/11	N/S 6am	(9)	Slept well	
			At beginning of night tried for short period with speaking valve, saturation 95%.	
		(6)	28% humidified O_2 via tracheostomy mask	
		(5)	Recordings stable.	
		(3)	B/O ++ overnight.	
		(2)	Nil orally.	
		(3)	2 hourly urine volumes via catheter satisfactory.	
		(2)	NG feed running 65ml/hr.	
			All care given.	E Miller SN
24/12/11	D/S.		Care as planned. Settled morning	
		(1)	All care given with personal hygiene	
		(2)	Feed running as per ducker protocol	
		(3)	Using Catheter patent output + pain no blood noted or hx of reflux	

Name: Wendy McIlrish Ward: 7/16 Date: Case Record No.:

CARE PLAN EVALUATION		
1. Basic Care and Hygiene	5. Observations	9. Sleep
2. Nutrition	6. Technical Care	10. Special Needs
3. Elimination	7. Wound Care	11. Other Relevant Information
4. Mobility	8. Specimens/Investigations	

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
24/12/11	Cont	(4)	Room on bedrest managed to mobilise around bed to change position	
		(5)	Observations charted MEWS 0-1 RR 21	
		(6)	Tracheostomy remains in site with 22fr Shiley Tracheostomy Mask, inner tube taken out and cleaned 3 hourly. Tolerated Speaking valve at various hours today Sats 97-98% on same. Reviewed by outreach passed Blue dye Swallow test, managed small sips of water after which no coughing or choking, managed small yogurt at supper time. Reviewed by Dr Carlin medications reviewed and changed medications not given this am as NG tube looked very long unable to get aspirate. S/W outreach tube pushed in slightly and aspirate was 5 NG tube at 62cm.	A Smith
	N/S	4	> Slept for long periods	
		3+4	> Moved bowels has fed PEN	
			> Catheter patent c/ satisfactory output however seems very concentrated colour	
			> NG tube patent — feeds @ 80 ml/hr — Continues — Next feed to run @ 100 ml/hr for 18 hours. (1.5 litres)	
			> Prescribed analgesia given orally.	
			> Other MEDS given via NG tube	
			> Nebs therapy tolerated well	
			> Tracheostomy done	
			> Secretions suctioned PRN	
			> patient has good cough	
			> Used Speaking valve @ visiting time *	
			> on 28% humidified O2	
			> Sats on Speaky valve 94-98%	
			> Can manage water via ~~Cup~~ straw	

Upgraded

EVALUATION OF CARE

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
25/12/14	0600		> feeding finished	
25/12/14	1645	(1) (2)	Cuffs Bed bathed Tolerating soft diet + fluids no signs of aspiration Keep propped up in bed	
		(3) (4)	Catheter patent output for position change in bed skin intact	
		(5) (6)	Observations stable as charted Tracheotomy with 7/2 x expectorate thick blood stained sputum inner tube cleaned + checked as per current protocol seen by outreach agree current management ? trial off O2 tomorrow Left review Spoke to wife on the afternoon telephoned well.	S/N MC (MESSAGE)
		(7)	seen by Dr Van der Poorten continue current management ? does twitching stop with deep drowsy Same	
	N/S	9	> Slept on + off O/N > Twitching episodes documented. NO shaking nor twitchy - when asleep. > OBS Stable > NG Tube patent - MEDS given thru this. > Can sips fluid > Nebs therapy refused > 28% Humid O2 continues with Hudent O2 Sats > TRIAL OFF O2 > Catheter out per patients request > Urine Output - to be observed.	

Name: Ward: 7/16 Date:

.231235532V
MCLEISH
WENDY F
0/1 51 COXTON PLACE 25/05/1987
GLASGOW G33 5EJ
CHI-2505876061

CARE PLAN EVALUATION

1. Basic Care and Hygiene	5. Observations	9. S
2. Nutrition	6. Technical Care	10.
3. Elimination	7. Wound Care	11. Other Relevant Information
4. Mobility	8. Specimens/Investigations	

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
20/12/14	15:30	(1)	Assisted wash. hair washed at bedside	
		(2)	Tolerating soft diet + fluids	
		(3)	up to commode x2 assist wise OK	
		(4)	transferring with x2 up to sit for short periods	
		(5)	observations stable as charted	
		(6)	O2 discontinued by outreach see Note. Buchan bib in situ. Continue using speaking valve throughout day. regular tracky care as charted. keep sats 92-96%	S/N Mcleish (Mapwe)
		(7)	reviewed by CC Neuro ? review later this week regarding twitching.	
	N/N	9	> Slept on + off all night > NG tube accidentally pulled out @ day shift as reported > MEDS tolerated orally > OBs stable > Sats on Air 93-95% > Refusing Saline Meds > Speaking Valve in use @ Visiting time. > Tracheostomy Care DONE > Buchanan BiB in situ > NO Urine Output Overnight	Jayadeva
21/12/14	15:40	(1)	Fully assisted with hygiene needs	
		(2)	Tolerating soft diet + fluids	
		(3)	Up to Commode	S/N Mcleish (MCLEWE)
		(4)	Transferring with x2 up to sit	
		(5)	observations as charted	
		(6)	Tracheostomy care as charted. Buchan BiB + speaking valve in situ - seen by outreach for decannulation tomorrow reposed Nebuliser.	

EVALUATION OF CARE

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
28/12/11	N/S	(3)(4)	mobile up to commode at bedside with assistance of 1 nurse.	
		(5)	Observations stable as per chart.	
		(9)	Slept for long periods overnight. Prescribed medication given as per Kardex. ~~Tracheostomy~~ care given only needed Suction once overnight. Patient cooperated Settled for most of night. Needs referred to physio.	
28-12-11	15.25	(1)	PT SELF CARING WITH HYGIENE NEEDS.	
		(2)	SMALL AMOUNTS OF DIET + FLUID TAKEN.	
		(3)(4)	PT UP TO COMMODE WHEN REQUIRED.	
		(5)	OBSERVATIONS AS CHARTED.	
		(6)	PTS TRACHEOSTOMY OUT TODAY. SPEAKING FINE + COPING WELL.	
		(11)	PHYSIO REVIEW AND MOBILISING FOR SHORT DISTANCES ONLY. GOOD START. NO COMPLAINTS.	
29/12/11	4am	(9)	Slept well overnight	
		(3)(4)	Using commode as required with assistance x1 to pass urine	
		(5)	Observations stable as charted.	
		(11)	Refusing nebulisers. States that she does not feel that she has any sputum to bring up.	
29/12/11	15.15	(1)	Assisted with Bath today	
		(2)	Tolerating diet + fluids	
		(3)	Up to commode	
		(4)	Mobile short distance physio input	
		(5)	Observations as charted	
		(11)	Seen & assessed by MDT. Any problems seen on ward round. Oramorph and diazepam reduced. Awt Neurology review	

Name: WENDY McLeish Ward: 7/16 Date: 28/12/11 Case Record No.:

CARE PLAN EVALUATION		
1. Basic Care and Hygiene	5. Observations	9. Sleep
2. Nutrition	6. Technical Care	10. Special Needs
3. Elimination	7. Wound Care	11. Other Relevant Information
4. Mobility	8. Specimens/Investigations	

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
30/12/11	5.15 am	(9)	Slept well overnight.	
		(3)	Commode as required with assistance x1.	
		(5)	Observations stable as charted.	JRoss
30/12/11	D/S C1830	(1)	Pt washed at bedside with minimal assistance.	
		(2)	Independent. Appetite fair.	
		(3+4)	Mobile to toilet with zimmer and supervision	
		(5)	Obs stable as charted.	
		(11)	Settled day. Pt improving. Neurology consultant saw pt briefly this morning – see medical notes. To continue current treatment.	V. Brockenridge
31/12/11	N/S. @0600.	(1)	Assistance required with ADLs.	
		(4)	Mobile to toilet with aid of Zimmer & Supervision	
		(5)	Observations = BP 110/74 P 94 T 36.2 RR 19 SpO_2 95% on Air	
			Neros (D). prior to settling.	
		(7)	Dressing to tracheostomy site intact	
		(11)	Medication:-	
			- Refused Saline Nebs.	
			- Oramorph 5mg given as prescribed.	
		(9)	Patient settled and appeared to sleep well. No complaints offered.	
		(5)	Observations still to be checked.	K. Shaw
31-12-11	7.20	(1)	PT SHOWERED THIS MORNING WITH MINIMAL ASSISTANCE	
		(2)	ORAL INTAKE FAIR – REFUSING HOSPITAL FOOD BUT EATING FOOD BROUGHT IN.	
		(3+4)	PT UP TO COMMODE WHEN REQUIRED. HAS VENTURED TO TOILET WITH ZIMMER.	
		(5)	OBSERVATIONS AS CHARTED.	
		(11)	PT HAD VISITORS IN AND WAS VERY VOCAL, SWEARING SAYING SHE WAS GOING TO SIGN HERSELF OUT AS SHE WANTED HOME. DR SPOKE TO PT AND HAS	

EVALUATION OF CARE

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
			ADVISED HER THAT IT IS FOR HER OWN	
			SAFETY + WELLBEING THAT SHE REMAIN	
			IN HOSPITAL. SHE HAS AGREED TO STAY	
			TILL WEDNESDAY. SHE IS ALSO SAYING	
			THAT ALL SHE GETS IS DRUGS = EG ORAMORPH	
			3x DAILY. FEELS AS THOUGH IT IS MORE	
			THAN THIS. VERY UNSETTLED DAY -	
			MOOD ↑↓ - THINK VISITORS HAVE	
			AGGRAVATED THE SITUATION.	
	17.30		TRACHY SITE REDRESSED WITH STERILE	
			SWABS + TEGADERM.	
01/01/12	N/S.	④	Mobile around ward c aid of Zimmer.	
	@ 06⁰⁰	⑤	Observations = BP 104/65 P95	
			T 36.2 RR 19 SpO_2 95% on Air	
			Mews ⓪ prior to settling	
		⑦	Dressing to tracheostomy site intact.	
		⑪	Medication:-	
			- Refused Saline nebs.	
			- Oramorph 5mg given as prescribed.	
		→	Patient requesting alcohol for bells.	
			DNO FH1 - patient not suitable at	
			present. Informed patient who was	
			not happy. Slightly aggitated.	
		→	Continues to twitch while awake.	
		⑨	Patient settled and appeared to	
			sleep well.	
		⑤	Observations not checked as yet as	
			patient still fast asleep and was	
			late to settle due to New Year	
			Celebration	K. Shook.
1/1/12	15.50	①	PT SELF CARING WITH SHOWER	
			THIS MORNING.	
		②	ORAL INTAKE GOOD - EATING FOOD	
			BROUGHT UP BUT REFUSING	
			HOSPITAL FOOD -- DRINKING MILK.	
		③+④	PT MOBILISING WITH ZIMMER FRAME	
			TO TOILET WHEN REQUIRED.	
		⑤	OBSERVATIONS NOT TAKEN YET - DUE	
			TO FAMILY VISITING. WILL UPDATE.	
		⑪	PT HAPPY TODAY AS FAMILY AND	
			FRIENDS VISITING. WENT OUTSIDE	
			WITH SISTER FOR FRESH AIR. PT	
			NOT AS VERBAL TODAY ABOUT	
			SIGNING HERSELF OUT... ALTHOUGH	
			STILL HAS ATTITUDE.	

Name: Ward: 7116 Date:

23123532V F
MCLEISH 25/05/1987
WENDY
0/1 51 COXTON PLACE
GLASGOW G33 5EJ
CHI-2505876061

CARE PLAN EVALUATION

1. Basic Care and Hygiene	5. Observations	9. Sleep
2. Nutrition	6. Technical Care	10. Special Needs
3. Elimination	7. Wound Care	11. Other Relevant Information
4. Mobility	8. Specimens/Investigations	

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
2/1/12	N15	(9)	Slept for long spells.	
		3/4	Independently mobile to toilet with zimmer.	
		(5)	Observations stable as charted. Sp02 94% lying flat in bed. Asymptomatic.	
		(11)	Patient states that she is signing herself out in the morning. Have explained that medical staff were keen to keep her as an inpatient until Wednesday. She states that she will speak to medical staff in the morning but is adament that she is signing herself out.	JR 55
2/1/12.	1700.	1.	Refused wash ~~cc~~	
		2.	Refusing diet. Refusing meds except fluoxetine.	
		3/5	Mobile to toilet & to phone	
		11	Vital sgns satisfactory	
			Patient taking irregular discharge against medical & nursing advice. Form ~~cc~~ signed.	
			States she has fluoxetine at home and that her boyfriend will look after her	
			Tracheostomy site redressed. Parent advised to attend GP/treatment room nurses to keep an eye on. ~~her~~ site.	

POSITIONAL, ORAL AND EYE CARE CHART

WARD 7-16

231235332V
MCLEISH F
WENDY 25/05/1987
0/1 51 COXTON PLACE

GLASGOW G33 5EJ
CHI-2505876061

TIME	Date: 22/12/11	Date: 22/12/11	Date: 24/12/11	Date: 25/12/11
0100	A (KS).			
0200			A EW	
0300	A (KS)	A (TL).		
0400				
0500	A (EC)		A EW	
0600		A (AQ)		
0700	A (KS)			
0800				
0900			A SA	A,B,C.
1000				
1100			A BC BG	A,B.
12MD				
1300				
1400				
1500				
1600				A,B.
1700				
1800				
1900				
2000	A (KS)	A EW	A B C	
2100	A (KS)			
2200		A EW		
2300	A (AQ).	A B C EW	A	
12 MN				

Please insert initials when carrying out task.

A = Positional
B = Oral hygiene
C = Eye care

25/12/11

		Twitching
10:30 PM -	asleep -	absent (none)

26/12/11

0125 =	awake -	Yes (Hands + Feet)
	Semi-awake-	Yes (Hands + Feet)
0140 -	ASLEEP	= No Twitching.
0200 -	asleep	No twitching
0430 -	half awake -	Yes — (Hands + Feet)
0450 -	asleep	- No Twitching

2/1/12

2am - Asleep No twitching.
7am Just waking twitching legs + arms

Patient Observation Chart

Name	WENDY
Address	MC Leish
Hospital No.	
DOB	7/14

Admitted Date _____ Ward _____
Transferred Date _____ Ward _____
Transferred Date _____ Ward _____

Patient Observation Chart Guidelines

Not all patients will require every part of this observation chart to be completed. Clinical judgement should be used to dictate the type and frequency of vital sign monitoring required.

The following patients are considered to be at high risk of developing a critical illness therefore it would be considered good practice to commence MEWS at the earliest opportunity.

- All emergency admissions
- Unstable patients
- Patients whose condition is causing concern
- Patients requiring frequent or increasing frequency of observations
- Patients who have stepped down from a higher level of care
- Patients with a chronic health problem
- Patients who are failing to progress
- Post-operative patients

There are also patients in whom the use of MEWS may be inappropriate:

- Day case patients
- Patients requiring no observations
- Patients who are terminally ill
- Planned discharges.

This is not an exhaustive list. Although the majority of patients may benefit from utilisation of the scoring system, a nurse's own clinical judgement dictates whether he/she feels the patient reqiures scoring. For guidance on the use of MEWS, refer to the Nurse in Charge.

Pain Score

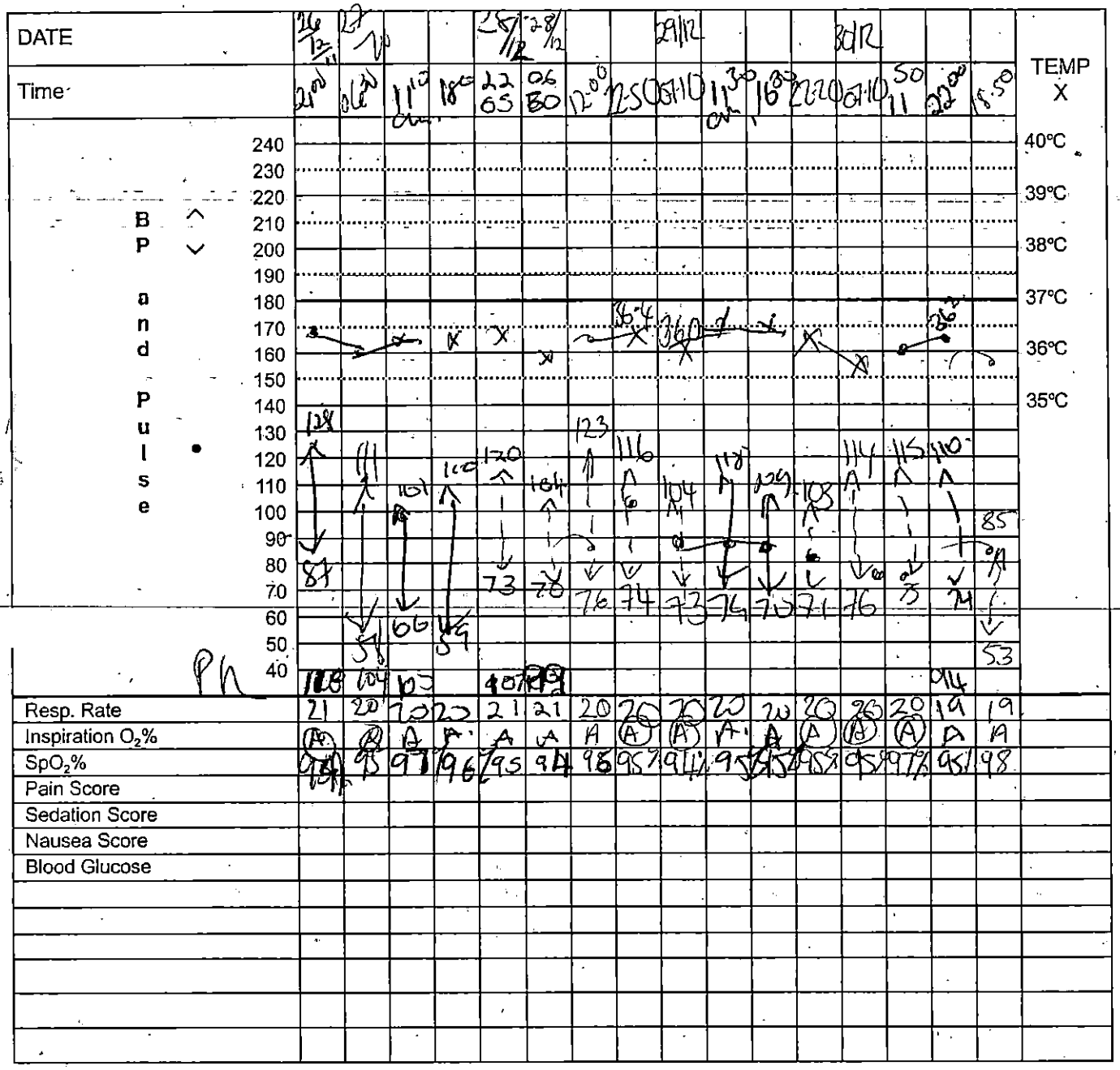
Remember to check scores after pain relief.
Patient asked to report pain at rest and on movement.
0 = No pain at rest or on movement
1 = No pain at rest, slight pain on movement
2 = Intermittent pain at rest, moderate on movement
3 = Continuous pain at rest severe on movement
Review 5 mins after I/V, 1 hour after I/M, S/C or oral analgesia.
Sustained pain score of 2 or pain score of 3 requires intervention.

Sedation Score

0 = Awake, alert, orientated
1 = Mild, aroused by verbal stimulus
2 = Moderate, aroused by physical stimulus
3 = Severe, no response
S = Normal sleep, easy to rouse
Score 2 or 3 requires immediate intervention

Nausea Score

0 = No nausea
1 = Mild (No treatment wanted)
2 = Moderate (Treatment required)
3 = Severe (Clinical problem persists despite treatment)
Review 1 hour after treatment. Inform doctor if additional treatment required.



MEWS																
	Resp. Rate	1	0	0	0	1	1	0	0	0	0	0	0	0	0	0
	Pulse	1	1	0	0	1	0	0	0	0	0	0	0	0	0	0
	Systolic BP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
	GCS / AVPU	0	0	0	0	0	0	0	0	0	0	0	0	0	2	6
	Urine Output	0	0	0	0	0	0	0	0	0	0	0	0	0	2	6
	Temp.	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
	SpO2%	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0
	TOTAL	4	1	0	0	2	3	0	0	0	0	0	0	0	6	3

Modified Early Warning Score (MEWS)

Score	3	2	1	0	1	2	3
Resp. Rate		≤8	9-10	11-20	21-25	26-30	≥31
Pulse		≤40	41-50	51-100	101-110	111-130	≥131
Systolic BP	≤84	85-89	90-100	101-199		>200	
GCS / AVPU	≤8	9-13	14 New agitation or confusion	15 / Alert	Voice	Pain	Unresponsive
Urine	<10mls/hr for 2 hrs	<30mls/hr for 2 hrs					
Temp. (°C)		≤35.0	35.1-35.9	36.0-37.4	37.5-38.5	≥38.6	
SpO2%	≤87	88-91	92-94	95-100			

DATE	31/12	1/1	1/1		2/1/12												
Time	1030	0645	1640	2258	7am	7am	1145										TEMP X
BP <> and Pulse • 240																	40°C
230																	
220																	39°C
210																	
200																	38°C
190																	
180																	37°C
170																	
160																	36°C
150																	
140																	35°C
130																	
120																	
110																	
100																	
90																	
80																	
70																	
60																	
50																	
40																	
Resp. Rate	14		19	18	18		17										
Inspiration O_2%	A		A	A	A		A										
SpO_2%	95		90	94	96		98%										
Pain Score																	
Sedation Score																	
Nausea Score																	
Blood Glucose																	

MEWS																
	Resp. Rate	0		0	0	0		1								
	Pulse	0		0	0	0										
	Systolic BP	0		0	0	0										
	GCS / AVPU	1		0	0	0										
	Urine Output	1		0	0	0										
	Temp.	0		0	0	1										
	SpO_2%	0		2	1	4										
	TOTAL	0		2	1	4		0								

Calling Criteria

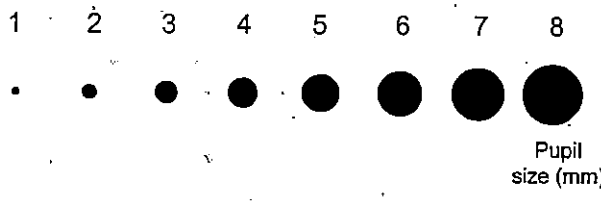
Score is 1-3	Increase frequency of patient observations, monitor trends and inform Nurse in Charge.
Score is 3 in one category	Contact Senior Nurse and increase frequency of patient observations.
Score is 4 and above or increasing by 2 or more Patient's GCS falls by 2 or more Any patient whose condition is causing concern	Contact Senior Nurse and increase frequency of patient observations Contact Critical Care Outreach Team.

The Senior Nurse will direct patient care and contact the appropriate medical staff when necessary.

Neurological Observation Chart

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

Glasgow Coma Scale



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

Medical Illustration Services, MIS 111948 - Reorder CEDAR 35497

Patient Observation Chart

NHS Greater Glasgow and Clyde

Name
Address
Hospital N
DOB

23123532V
MCLEISH F
WENDY 25/05/1987
0/1 51 COXTON PLACE
GLASGOW G33 5EJ
CHI-2505876061

Admitted Date Ward
Transferred Date 20/12/11 Ward 7/16
Transferred Date Ward

Patient Observation Chart Guidelines

Not all patients will require every part of this observation chart to be completed. Clinical judgement should be used to dictate the type and frequency of vital sign monitoring required.

The following patients are considered to be at high risk of developing a critical illness therefore it would be considered good practice to commence MEWS at the earliest opportunity.

- All emergency admissions
- Unstable patients
- Patients whose condition is causing concern
- Patients requiring frequent or increasing frequency of observations
- Patients who have stepped down from a higher level of care
- Patients with a chronic health problem
- Patients who are failing to progress
- Post-operative patients

There are also patients in whom the use of MEWS may be inappropriate:

- Day case patients
- Patients requiring no observations
- Patients who are terminally ill
- Planned discharges.

This is not an exhaustive list. Although the majority of patients may benefit from utilisation of the scoring system, a nurse's own clinical judgement dictates whether he/she feels the patient reqiures scoring. For guidance on the use of MEWS, refer to the Nurse in Charge.

Pain Score

Remember to check scores after pain relief.
Patient asked to report pain at rest and on movement.
0 = No pain at rest or on movement
1 = No pain at rest, slight pain on movement
2 = Intermittent pain at rest, moderate on movement
3 = Continuous pain at rest severe on movement
Review 5 mins after I/V, 1 hour after I/M, S/C or oral analgesia.
Sustained pain score of 2 or pain score of 3 requires intervention.

Sedation Score

0 = Awake, alert, orientated
1 = Mild, aroused by verbal stimulus
2 = Moderate, aroused by physical stimulus
3 = Severe, no response
S = Normal sleep, easy to rouse
Score 2 or 3 requires immediate intervention

Nausea Score

0 = No nausea
1 = Mild (No treatment wanted)
2 = Moderate (Treatment required)
3 = Severe (Clinical problem persists despite treatment)
Review 1 hour after treatment. Inform doctor if additional treatment required.

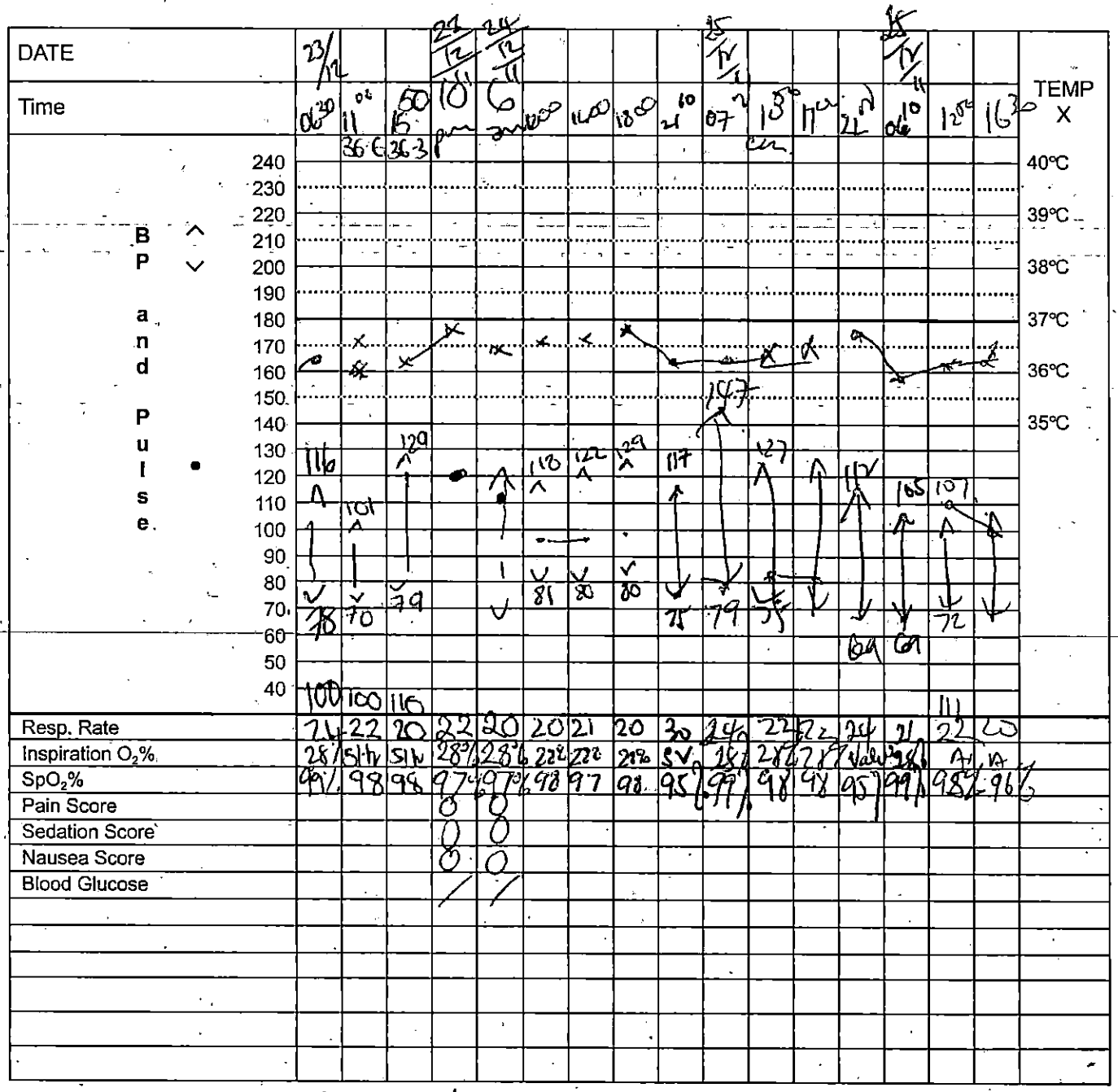
7/16

DATE	20/12	20/12			21/12/11								22/12			23/12
Time	19:10	8:30 pm	20:00	24:45	00:00	01:00	02:00	03:00	05:00	12:55	18:49	22:15	07:00	12:30	16:00	22:15
Resp. Rate	35	40	34	32	28	29	30	31	32	24	20	20	20	20	38	22
Inspiration O_2%	24	25	28%	28%	28%	28%	28%	28%	28%	28%	28%	28%	28%	28%	28%	28%
SpO_2%	97	96	98%	96%	96%	97%	96%	97	98%	99	96	99	96%	95%	100%	99%
Pain Score		0	0													
Sedation Score		0	0													
Nausea Score		0	0													
Blood Glucose		/	/													

MEWS																
	Resp. Rate	3	3	3	3	2	2	2	3	3	1	0	0	0	0	3	1
	Pulse	0	2	2	2	1	0	0	1	1	0	0	0	0	2	2	0
	Systolic BP	0	0	0							0	0	0	0	0	0	0
	GCS / AVPU	0	0	0							0	0	0	1	0	0	2
	Urine Output	0	0	0							0	0	0	1	0	0	2
	Temp.	0	1	1							0	0	0	0	0	0	0
	SpO_2%	0	0	0							0	0	0	0	0	0	0
	TOTAL	4	6	6	5	3	2	2	4	3	1	0	0	2	2	0	1

Modified Early Warning Score (MEWS)

Score	3	2	1	0	1	2	3
Resp. Rate		≤8	9-10	11-20	21-25	26-30	≥31
Pulse		≤40	41-50	51-100	101-110	111-130	≥131
Systolic BP	≤84	85-89	90-100	101-199		>200	
GCS / AVPU	≤8	9-13	14 New agitation or confusion	15 / Alert	Voice	Pain	Unresponsive
Urine	<10mls/hr for 2 hrs	<30mls/hr for 2 hrs					
Temp. (°C)		≤35.0	35.1-35.9	36.0-37.4	37.5-38.5	≥38.6	
SpO_2%	≤87	88-91	92-94	95-100			



MEWS																
	Resp. Rate															
	Pulse															
	Systolic BP															
	GCS / AVPU															
	Urine Output															
	Temp.															
	SpO_2%															
	TOTAL															

Calling Criteria

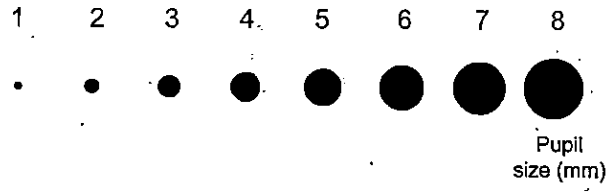
Score is 1-3	Increase frequency of patient observations, monitor trends and inform Nurse in Charge.
Score is 3 in one category	Contact Senior Nurse and increase frequency of patient observations.
Score is 4 and above or increasing by 2 or more Patient's GCS falls by 2 or more Any patient whose condition is causing concern	Contact Senior Nurse and increase frequency of patient observations Contact Critical Care Outreach Team.

The Senior Nurse will direct patient care and contact the appropriate medical staff when necessary.

Neurological Observation Chart

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

Glasgow Coma Scale



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

Medical Illustration Services, MIS 111948 - Reorder CEDAR 35497

MRSA Screening:

A: Clinical Risk Assessment (CRA)- for patients >23 hours

	YES	NO
1. Has the patient ever had a previous positive MRSA result?	☐	☑
2. Has the patient been admitted from a care home/institutional setting or another hospital?	☑	☐
3. Does the patient have a wound/ulcer or invasive device which was present prior to admission?	☐	☑

prolonged stay on ITU.

If **'Yes'** to any question **or** if the patient is within (or admitted to) a High Impact Speciality* complete section B **['Not known' = 'No']**

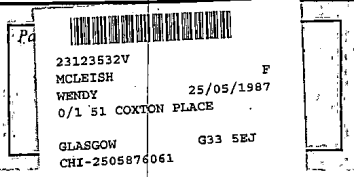
***Orthopaedics / Vascular / Renal / Critical Care** [please circle]

B: MRSA Lab Test: **Nose** ☐ **Perineum** ☐

Other (s) .....

Date: 23/1/11 **Ward:** 7/6 **Patient refused** ☐

To order more copies please contact :
MRSA Project Team
Level 11, Western Infirmary
Glasgow, G11 6NT
Tel: 0141 211 2127
E Mail: MRSA.ProjectTeam@ggc.scot.nhs.uk



Glasgow Royal Infirmary

NHS
Greater Glasgow and Clyde

Patie
23123532V
Hosp MCLEISH F
WENDY 25/05/1987
0/1 51 COXTON PLACE
D.O. GLASGOW G33 5EJ
CHI-2505876061
Ward:

Ward 7/16 Respiratory Unit
Care Plan
Specimens Chart
Skin Inspection Chart

Specimen Requested	Date Requested	Date Obtained	Comments

Careplan 1 to 6

		Date	Date	Date	Date	Date
1. Personal Hygiene						
a	• Independent					
b	• Immersion bath / shower with assistance / assisted wash					
c	• Bed bath	21/12/11	22/12/11	23/12/11	24/12	25/12
d	• Oral hygiene	21/12/11	22/12/11	23/12/11	24/12	25/12
e	• Pressure area care	21/12/11	22/12/11	23/12/11	24/12	25/12
f	• Waterlow: if > 15 assess daily					
2. Mobility						
a	• Fully Mobile					
b	• Bedrest					
c	• Minimal assistance / walking aid required:					
b	• Dependent (see moving and handling careplan)	21/12/11	22/12/11	23/12/11	24/12	25/12
3. Elimination						
a	• Independent					
b	• Commode / ~~Bed pan~~ commode	21/12/11	22/12/11	23/12/11	24/12	25/12
c	• Urinalysis on admission then weekly	✓				
d	• Urinary catheter in situ; Size : mls in balloon	21/12.	22/12/11	23/12/11	24/12	25/12
e	• Bowels tick if moved				✓	✓
4. Nutrition						
a	• Normal diet					
b	• Special / modified diet : SOFT diet					
c	• Nasogastric / Gastrostomy feeding		22/12/11	23/12/11	24/12	25/12
d	• ~~Fasting~~ / Nil by mouth	21/12/11	22/12/11		24/12	25/12
5. Observations						
	• Mews	21/12/11	22/12/11	23/12/11	24/12	25/12
b	• FOB's					
c	• Weight: Weekly ✓ : Daily : Other					
d	• Fluid balance	21/12/11	22/12/11	23/12/11	24/12	25/12
e	• BM Stix pre meals + 10pm					
6. Technical Care						
a	• Intravenous infusion				24/12	
b	• Intravenous access	@wrist			@wrist	
c	• Venflon site:	green.			green ?	
d	• Venflon colour:					
e	• Date inserted:	20/12/11				
f	• Nebulisers		22/12/11	23/12/11	24/12	25/12
g	• Hourly urine volumes:	25/12/11				
h	• Oxygen therapy	28%	28%	28%	28% via T mask	28% via mask
i	• Inhaler Technique					
j	Tracheostomy	20/12/11			24/12	25/12
Signature:			K. Shah K Shah			

Careplan 1 to 6 Continuation Sheet

1.	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
a											
b				29/12	30/12	31/12	01/01/12	2/1/12			
c	26/12	27/12	28/12								
d	26/12	27/12	28/12	29/12	30/12	31/12	01/01/12	2/1/12			
e			28/12								
f											
2.											
a											
b											
c				29/12	30/12	31/12	01/01/12	2/1/12			
b	26/12	27/12	28/12								
3.											
						31/12	01/01/12	2/1/12			
b	26/12	27/12	28/12	29/12	30/12	31/12	01/01/12				
c											
d	Out 25/12										
e			28/12								
4.											
a					30/12	31/12	01/01/12	2/1/12			
b	26/12	27/12	28/12	29/12							
c											
d											
5.											
	26/12	27/12	28/12	29/12	30/12	31/12	01/01/12	2/1/12			
b											
			28/12	29/12	30/12	31/12	01/01/12	2/1/12			
d	26/12	27/12	28/12	29/12							
e											
6.											
a											
b											
c											
d											
e											
f	26/12	refusing	refusing	refusing	Refusing	Refusing	Refusing	refusing			
g											
h	28/12 Thurs	OFF									
i											
j	26/12	27/12	28/12	documented							
Signature:				JRoss	JRoss	K Shaw	K Shaw	JRoss			

NATVNS SCOTLAND

NHS Greater Glasgow and Clyde

WRITE, IMPRINT OR ATTACH LABEL

Surname _____ CHI _____

Forenames _____ Sex _____

DoB _____

Location _____

DAILY REPOSITIONING & SKIN INSPECTION CHART

DATE _____

- Inspect skin for evidence of change
- Reassess at every positional change and document below
- Reposition the person to reduce the risk of further damage, eg using the 30 degree tilt
- Use manual handling aids to minimise risk of friction and shear
- Individuals on any form of pressure redistribution equipment still require skin inspection and regular repositioning
- Provide suitable seating including pressure redistribution cushions, if required, encourage repositioning/mobilisation where possible
- Acutely ill people are seated out for no longer than 2 hours and returned to bed for no less than 1 hour

(Reference: Best Practice Statement–Prevention & Management of Pressure Ulcers–March 2009)

IME	REPOSITIONING (USING CODES) FROM	TO	SKIN INSPECTION COMMENTS	ACTION TAKEN	SIGNATURE
Eg 08:00	L	U	Left Hip Non-Blanching	Reassess at next positional change	

Code: L = LEFT, R = RIGHT, B = BACK, P = PRONE (FRONT), M = MOBILISED, U = UP TO SIT

NHS
Greater Glasgow and Clyde

NATVNS
SCOTLAND

V 23123532V
S MCLEISH
WENDY F
F 0/1 51 COXTON PLACE 25/05/1987
GLASGOW G33 5EJ
CHI-2505876061

ADAPTED WATERLOW PRESSURE AREA RISK ASSESSMENT CHART

More than one score/category can be used: **10+= 'At Risk': 15+= 'High Risk': 20+= 'Very High Risk'**

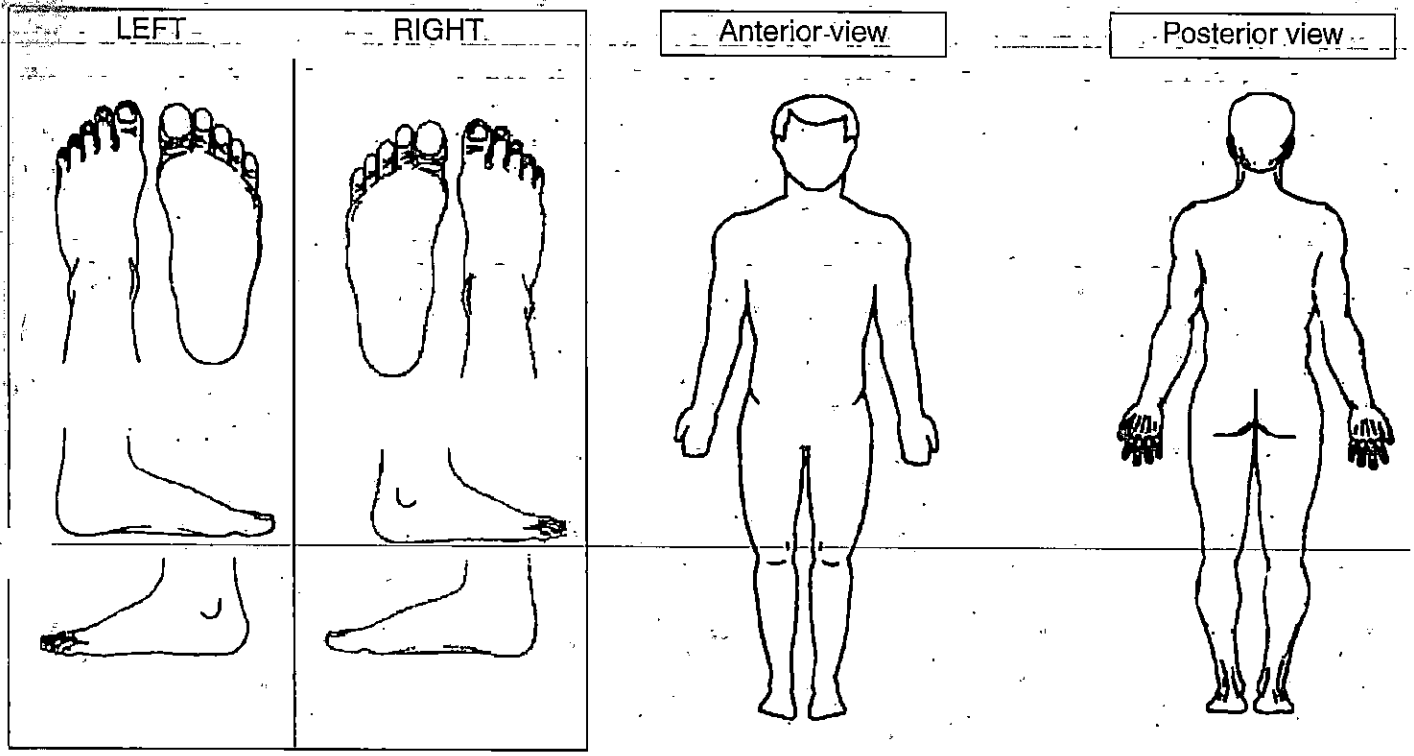
Complete assessment on admission/1st visit, if there is a change in individuals condition and repeat regularly according to local protocol

Sex										
Male	1									
Female	2	2	2	2	2					
Age										
14 -49	1	1	1	1	1					
50 -64	2									
65 - 74	3									
75 - 80	4									
81+	5									
Build/Weight for Height (BMI=weight in Kg/height in m²)										
Average - BMI 20-24.9	0	0	0	0	0					
Above average - BMI 25-29.9	1									
Obese - BMI > 30	2									
Below average - BMI < 20	3									
Continence										
Complete/catheterised	0	0	0	0	0					
Incontinent urine	1									
Incontinent faeces	2									
Doubly incontinent (urine & faeces)	3									
Skin Type - Visual Risks Area										
Healthy	0	0	0		0					
Tissue paper (thin/fragile)	1									
Dry (appears flaky)	1			1						
Oedematous (puffy)	1									
Clammy (moist to touch)/pyrexia	1									
Discoloured (bruising/mottled)	2									
Broken (established ulcer)	3									
Mobility										
Fully mobile	0				0					
Restless/fidgety	1									
Apathetic (sedated/depressed/reluctant to move)	2									
Restricted (restricted by sever pain or disease)	3			3						
Bedbound (unconscious/unable to change position/traction)	4									
Chairbound (unable to leave chair without assistance)	5	5	5							
Nutritional Element										
Unplanned weight loss in past 3-6 months										
<5% Score 0; 5-10% Score 1; >10% Score 2	0-2				0					
BMI > 20 Score 0, BMI 18.5-20 Score 1, BMI < 18.5 Score 2	0-2									
Patient acutely ill or no nutritional intake > 5 days	2									
Special Risks - Tissue Malnutrition										
Multiple organ failure/terminal cachexia	8									
Single organ failure e.g. cardiac, renal, respiratory	5									
Peripheral vascular disease	5									
Anaemia = Hb < 8	2									
Smoking	1	1	1	1	1					
Special Risks - Neurological Deficit										
Diabetes/MS/CVA/motor/sensory/paraplegia *Max 6*	4-6									
Special Risks - Surgery/Trauma										
On table > 6 hours	8									
Orthopaedic/below waist/spinal (up to 48 hours post op)	5									
On table > 2 hours (up to 48 hours post op)	5									
Special Risks - Medication										
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*	4									
Total Score		9	9	8	4					
Date		21/11/11	24/11/11	29/11/11	2/12/11					
Initials		[illegible]	[illegible]	OK	[illegible]					
Time		0530	0400	0415	0330					

Ensure plan of care is implemented / reviewed for all identified areas of concern.

PRESSURE ULCER RECORD

Indicate by circling and numbering all pressure damage on diagrams, then complete box below. Indicate care plan/wound assessment chart.



SCOTTISH ADAPTED EPUAP PRESSURE ULCER GRADING TOOL

GRADE 1 Non-blanchable erythema of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness may also be used as indicators, particularly on individuals with darker skin.

GRADE 2 Partial thickness skin loss involving epidermis, dermis or both. The ulcer is superficial and presents clinically as an abrasion or blister.

GRADE 3 Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia.

GRADE 4 Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss.

DATE	NUMBER OF ULCER(S)	LOCATION OF ULCER(S)	GRADE OF ULCER(S)	LOCATION OF ULCER(S)

Prossure Ulcers may deteriorate from Grade 1 to Grade 4, but can not be reversed and should be documented as a healing grade of pressure ulcer, eg healing grade 4.

G AND HANDLING CARE PLAN

Patient's Detai	23123532V MCLEISH WENDY F 0/1 51 COXTON PLACE 25/05/1987 GLASGOW G33 5EJ CHI-2505876061	Named Nurse:	Tinder.	If Patient is totally independent, tick here and go to date box.

BODY BUILD				Problems with comprehension, behaviour, co-operation (specify):
Obese		Tall		Agitated at times.
Above average		Medium		
Average		Short		
Below Average		Weight	Kg	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
RISK OF FALLS				Trachy + O2, catheter.
High		Low		

Into Bath or shower.

HANDLING AID		WHICH BATH		ASSISTANCE		SUPERVISION		INDEPENDENT		BED BATH	✓
Ambulift		Parker		People 1		2		Additional Information:			
Shower Chair		Variable Height									
Other (specify)		Fixed Height									
		Shower									

Transfers (including to/from: bed; wheelchair; commode; toilet).

HOIST (specify)				MANUAL SUPPORT			ASSISTANCE	✓	INSTRUCTION		SUPERVISION		INDEPENDENT	
People 1	2	3		People 1	2		Additional Information:							
				Walking Aid (specify)										

Toiletting

HOIST (specify)				MANUAL SUPPORT			ASSISTANCE		INSTRUCTION	✓	SUPERVISION		INDEPENDENT	
People 1	2	3		People 1	2		Additional Information:							
				Walking Aid (specify)			Bed pan, catheter insitu.							

Walking.

NO WALKING	✓	MANUAL SUPPORT		ASSISTANCE		INSTRUCTION		SUPERVISION		INDEPENDENT	
		People 1	2	Distance Walked/Additional Information:							
		Walking Aid (specify)									

Move up/down bed.

HOIST (specify)				HANDLING AIDS		ASSISTANCE	✓	INSTRUCTION		SUPERVISION		INDEPENDENT	
People 1	2	3		Sliding aid (fabric)	✓	Additional Information:							
				Rope ladder									
				Hand blocks									

Sit up over side of bed.

ROPELADDER		SWIVEL CUSHION		ASSISTANCE		INSTRUCTION		SUPERVISION		INDEPENDENT	✓

Move on/off bed pan.

HOIST		ROLL PATIENT	✓	PATIENT BRIDGES		MONKEY POLE		N/A	

Transfer to/from trolley (or bed etc).

SLIDING AID - RIGID	✓	SLIDING AID - FABRIC	✓	ASSISTANCE	✓	INSTRUCTION		SUPERVISION		INDEPENDENT	

Other Instructions.

24/12/11 Bed rest
29/12/11 – Assistance x1 to sit/commode + Zimmer
2/1/12 – Independently mobile with Zimmer

Date Assessed:	24/12/11	24/12/11	29/12/11	2/1/12		
Assessor's Signature:	[illegible]	[illegible]	JRoss	JRoss		
Proposed Review Dates:	24/12/11	30/12/11	3/01/12	6/1/12		

nto Bath or shower.

HANDLING AID	WHICH BATH	ASSISTANCE	SUPERVISION	INDEPENDENT	BED BATH
Ambulift	Parker	People 1	2	Additional Information:	
Shower Chair	Variable Height				
Other (specify)	Fixed Height				
	Shower				

ransfers (including to/from: bed; wheelchair; commode; toilet).

HOIST (specify)	MANUAL SUPPORT	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT
People 1 2 3	People 1 2	Additional Information:			
	Walking Aid (specify)				

Toiletting

HOIST (specify)	MANUAL SUPPORT	ASSISTANCE	INSTRUCTION	SUPERVISION	NDEPENDENT
People 1 2 3	People 1 2	Additional Information:			
	Walking Aid (specify)				

Walking

NO WALKING	MANUAL SUPPORT	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT
	People 1 2	Distance Walked/Additional Information:			
	Walking Aid (specify)				

Move up/down bed.

HOIST (specify)	HANDLING AIDS	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT
People 1 2 3	Sliding aid (fabric)	Additional Information:			
	Rope ladder				
	Hand blocks				

Sit up over side of bed.

ROPELADDER	SWIVEL CUSHION	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT

Move on/off bed pan.

HOIST	ROLL PATIENT	PATIENT BRIDGES	MONKEY POLE	N/A

Transfer to/from trolley (or bed etc).

SLIDING AID - RIGID	SLIDING AID - FABRIC	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT

Other Instructions.

Date Assessed:						
Assessor's Signature:						
Proposed Review Dates:						

Nutrition Profile

NHS Greater Glasgow and Clyde

Name: [redacted]	Date of admission: 20/12/11
Address: 23123532V MCLEISH F WENDY 25/05/1987 0/1 51 COXTON PLACE GLASGOW G33 5EJ	Time: 1915
DoB: CHI-2505876061	HOSPITAL: GRI
CHI number:	Ward: 7/16
Affix patient data label	

To be recorded within 24 hours of admission*

Height: m/ft Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Weight: kg/stones Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Recent unplanned weight loss: Yes ☐ No ☐

If 'Yes' how much?: kg/stones. Over what period of time?: weeks/months

Is there evidence of recent weight loss?

No ☐ Loose clothing ☐ History of reduced food intake/appetite ☐ Swallowing problem ☐

Eating and drinking likes and dislikes (including appetite and/or NBM status):

~~Nil By Mouth~~. ~~Being NG fed~~ — NG OUT
Fluid & Soft Textured diet

Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☐

Please state:

Are there any contributing factors that may affect food intake such as **physical** (e.g. swallowing difficulties), **physiological** (e.g. nausea), **psychological** (e.g. dementia), **social or environmental?** Yes ☐ No ☐

Please specify all factors:

prolonged stay in ITU — agitated at times.

Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☐

Please state:

Profile completed by: Name (PRINT): TLINDEN Signature: [signature] Date: 1/12/11

NOTE: This is ADMISSION DATA - please refer to changes in Care Plan.

* Quality Improvement Scotland (2003). Food, Fluids and Nutritional Care in Hospitals Edinburgh QIS

Malnutrition Universal Screening Tool ('MUST')

Date	22/12									
Initials	KS									
Height (see page 1) ? Weight	?									
Oedema or ascites present Y/N	N									
BMI										

'MUST'

Step 1: BMI Score (refer to chart on page 4) >20 (>30 = Obese) ..... 0 ~~18.5 - 20~~ ..... 1 <18.5 2	?									
Step 2: Weight Loss Score Unplanned weight loss in past 3-6 months: <5% ..... 0 5-10% ..... 1 >10% 2	0									
Step 3: Acute Disease Effect Score If patient is acutely ill **and** there has been or is likely to be no or virtually no food intake for > 5 days..... Score 2 Not applicable ..... Score 0	0									
Step 4: Overall Risk of Malnutrition Total:	0									

Step 5: Management Guidelines

Score of Overall Risk of Malnutrition	Action Required
0	**LOW RISK** - *Routine Clinical Care* • Repeat screening. Hospital Acute .....Weekly Hospital Rehabilitation .....Monthly
1	**MEDIUM RISK** - *Observe* • Document dietary intake for 3 days on a Food Record Chart. • If no improvement in intake: - Encourage oral intake. - Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Repeat screening weekly.
2 or more	**HIGH RISK** - *Treat** • Refer to Dietitian and document food intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks **and** offer full cream milk to drink with and between meals. • Monitor **and** review Care Plan weekly. * Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

Management Plan

FOR ALL PATIENTS

- Provide help and advice on food choices and eating and drinking when necessary.
- Treat underlying conditions and initiate appropriate treatment to relieve symptoms that affect nutritional intake e.g. nausea, vomiting, constipation, diarrhoea and/or pain.
- Refer to dietitian if any specialist advice is required.
- Complete nursing checklist for swallowing difficulties if appropriate.
- Use a recognised system to identify when equipment or asssistance is required at mealtimes (e.g. red mats, coloured napkins).

Referral Services

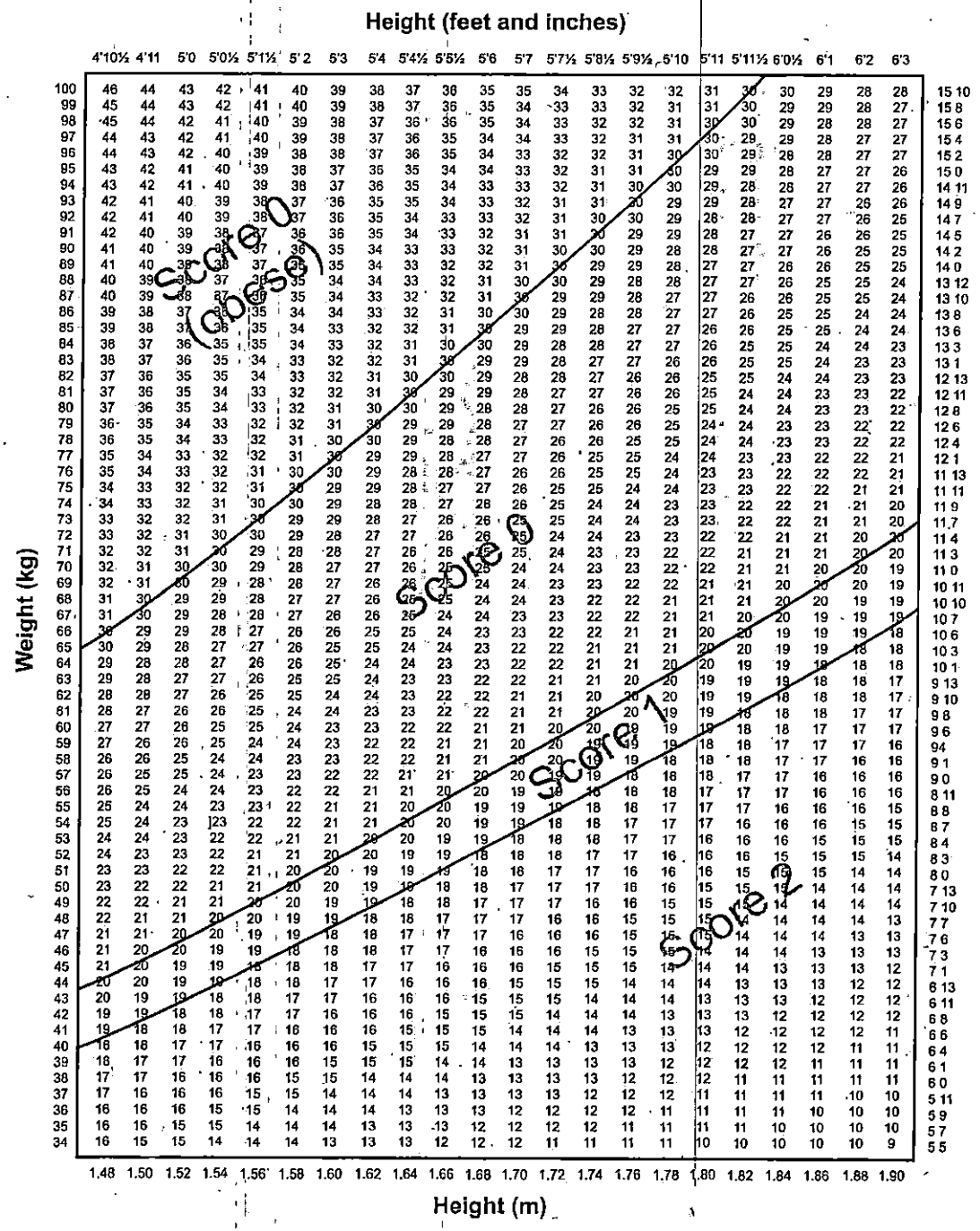
Dietitian	Date: / /	Outcome:
Speech and Language Therapy	Date: / /	Outcome:
Occupational Therapy	Date: / /	Outcome:
Dental Service	Date: / /	Outcome:

Multidisciplinary Nutrition Care Plan

Date	Overall Risk	Action	Review date	Name (PRINT) Signature/Designation
22/12/11	0.	Low risk.		
		- NG Feed. Currently NBM. (Fasting for CT Abdo / Pelvis).	24/12.	K. Shaw.
24/12/11	0.	Passed swallow TEST - Can managed Yogurt, ICE CREAM + SOFT diet	30/12/11	
		- Refusing NG Feeds at present - For dietitian review mealtime - Food Chart Commenced		
28/12/11		DIETITIAN - See medical notes.		
		Please check WT if up to sit.		K. COCHRANE

N.B. Ensure discharge plan includes most recent 'MUST' score and any necessary follow-up requirements.

Step 1 - BMI Score



Step 2 - Weight Loss Score

Weight before weight loss (kg)	Score 0 W't loss <5%	Score 1 W't loss 5-10%	Score 2 W't loss >10%
34 kg	<1.7 kg	1.7-3.4 kg	>3.4 kg
36 kg	<1.8 kg	1.8-3.6 kg	>3.6 kg
38 kg	<1.9 kg	1.9-3.8 kg	>3.8 kg
40 kg	<2 kg	2-4 kg	>4 kg
42 kg	<2.1 kg	2.1-4.2 kg	>4.2 kg
44 kg	<2.2 kg	2.2-4.4 kg	>4.4 kg
46 kg	<2.3 kg	2.3-4.6 kg	>4.6 kg
48 kg	<2.4 kg	2.4-4.8 kg	>4.8 kg
50 kg	<2.5 kg	2.5-5 kg	>5 kg
52 kg	<2.6 kg	2.6-5.2 kg	>5.2 kg
54 kg	<2.7 kg	2.7-5.4 kg	>5.4 kg
56 kg	<2.8 kg	2.8-5.6 kg	>5.6 kg
58 kg	<2.9 kg	2.9-5.8 kg	>5.8 kg
60 kg	<3 kg	3-6 kg	>6 kg
62 kg	<3.1 kg	3.1-6.2 kg	>6.2 kg
64 kg	<3.2 kg	3.2-6.4 kg	>6.4 kg
66 kg	<3.3 kg	3.3-6.6 kg	>6.6 kg
68 kg	<3.4 kg	3.4-6.8 kg	>6.8 kg
70 kg	<3.5 kg	3.5-7 kg	>7 kg
72 kg	<3.6 kg	3.6-7.2 kg	>7.2 kg
74 kg	<3.7 kg	3.7-7.4 kg	>7.4 kg
76 kg	<3.8 kg	3.8-7.6 kg	>7.6 kg
78 kg	<3.9 kg	3.9-7.8 kg	>7.8 kg
80 kg	<4 kg	4-8 kg	>8 kg
82 kg	<4.1 kg	4.1-8.2 kg	>8.2 kg
84 kg	<4.2 kg	4.2-8.4 kg	>8.4 kg
86 kg	<4.3 kg	4.3-8.6 kg	>8.6 kg
88 kg	<4.4 kg	4.4-8.8 kg	>8.8 kg
90 kg	<4.5 kg	4.5-9 kg	>9 kg
92 kg	<4.6 kg	4.6-9.2 kg	>9.2 kg
94 kg	<4.7 kg	4.7-9.4 kg	>9.4 kg
96 kg	<4.8 kg	4.8-9.6 kg	>9.6 kg
98 kg	<4.9 kg	4.9-9.8 kg	>9.8 kg
100 kg	<5 kg	5-10 kg	>10 kg
102 kg	<5.1 kg	5.1-10.2 kg	>10.2 kg
104 kg	<5.2 kg	5.2-10.4 kg	>10.4 kg
106 kg	<5.3 kg	5.3-10.6 kg	>10.6 kg
108 kg	<5.4 kg	5.4-10.8 kg	>10.8 kg
110 kg	<5.5 kg	5.5-11 kg	>11 kg
112 kg	<5.6 kg	5.6-11.2 kg	>11.2 kg
114 kg	<5.7 kg	5.7-11.4 kg	>11.4 kg
116 kg	<5.8 kg	5.8-11.6 kg	>11.6 kg
118 kg	<5.9 kg	5.9-11.8 kg	>11.8 kg
120 kg	<6 kg	6-12 kg	>12 kg
122 kg	<6.1 kg	6.1-12.2 kg	>12.2 kg
124 kg	<6.2 kg	12.4 kg	>12.4 kg
126 kg	<6.3 kg	12.6 kg	>12.6 kg

Weight before weight loss (st/lb)	Score 0 W't loss <5%	Score 1 W't loss 5-10%	Score 2 W't loss >10%
5st 4lb	<4lb	4lb-7lb	>7lb
5st 7lb	<4lb	4lb-8lb	>8lb
5st 11lb	<4lb	4lb-8lb	>8lb
6st	<4lb	4lb-8lb	>8lb
6st 4lb	<4lb	4lb-9lb	>9lb
6st 7lb	<5lb	5lb-9lb	>9lb
6st 11lb	<5lb	5lb-10lb	>10lb
7st	<5lb	5lb-10lb	>10lb
7st 4lb	<5lb	5lb-10lb	>10lb
7st 7lb	<5lb	5lb-11lb	>11lb
7st 11lb	<5lb	5lb-11lb	>11lb
8st	<6lb	6lb-11lb	>11lb
8st 4lb	<6lb	6lb-12lb	>12lb
8st 7lb	<6lb	6lb-12lb	>12lb
8st 11lb	<6lb	6lb-12lb	>12lb
9st	<6lb	6lb-13lb	>13lb
9st 4lb	<7lb	7lb-13lb	>13lb
9st 7lb	<7lb	7lb-13lb	>13lb
9st 11lb	<7lb	7lb-1st	>1st
10st	<7lb	7lb-1st	>1st
10st 4lb	<7lb	7lb-1st	>1st
10st 7lb	<7lb	7lb-1st 1lb	>1st 1lb
10st 11lb	<8lb	8lb-1st 1lb	>1st 1lb
11st	<8lb	8lb-1st 1lb	>1st 1lb
11st 4lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 7lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 11lb	<8lb	8lb-1st 3lb	>1st 3lb
12st	<8lb	8lb-1st 3lb	>1st 3lb
12st 4lb	<9lb	9lb-1st 3lb	>1st 3lb
12st 7lb	<9lb	9lb-1st 4lb	>1st 4lb
12st 11lb	<9lb	9lb-1st 4lb	>1st 4lb
13st	<9lb	9lb-1st 4lb	>1st 4lb
13st 4lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 7lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 11lb	<10lb	10lb-1st 5lb	>1st 5lb
14st	<10lb	10lb-1st 6lb	>1st 6lb
14st 4lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 7lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 11lb	<10lb	10lb-1st 7lb	>1st 7lb
15st	<11lb	11lb-1st 7lb	>1st 7lb
15st 4lb	<11lb	11lb-1st 7lb	>1st 7lb
15st 7lb	<11lb	11lb-1st 8lb	>1st 8lb
15st 11lb	<11lb	11lb-1st 8lb	>1st 8lb
16st	<11lb	11lb-1st 8lb	>1st 8lb
16st 4lb	<11lb	11lb-1st 9lb	>1st 9lb
16st 7lb	<12lb	12lb-1st 9lb	>1st 9lb
16st 11lb	<12lb	12lb-1st 9lb	>1st 9lb

VI MEDICAL ILLUSTRATION • NUTRITION & DIET • 12366/01.09.08
STORES ORDER CODE 41850

Acute Services Division

Hospital / Department 7/16 GRI

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

23123532V
MCLEISH
Patient nan WENDY P 7/16
25/05/1987
0/1 51 COXTON PLACE
Ward: ..... GLASGOW G33 5EJ
CHI-2505876061
CHI numb .....Unit/Hospital number .....

Contents

1. Canard Falls Risk Assessment Scoring Form
2. Falls Assessment Care Plan
3. Glossary of terms used in risk assessment

Notes: Risk assessment should be completed within 24 hours of admission.

Assessment Wards: Risk assessment and care plan should be reviewed weekly.

Continuing Care Wards: Mobile and 'at risk' patients should have risk assessment and care plan reviewed monthly.

Cannard Falls Risk Assessment

(Must be completed within 24 hours)

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						DATE 21/12/11	DATE 28/12	DATE	DATE	DATE	DATE	DATE
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			0	0					
Sex	Male 1	Female 2				2	2					
Age	60-70 1	71-80 2	81+ 1			0	0					
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0		2	2					
Medication type **	Drugs for mental illness 1	Blood pressure / water tablets 1	Sleeping tablets 1	None of these 0		1,1	1,1					
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	—	/					
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed bound 1		3	3					
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		3	3					
				TOTAL SCORE		12	12					
				ACTION(S) TAKEN Enter action code(s)		1,2,3 14,17	1,2,3,4 10,17					
SCORE 2 - 8 = LOW, 9 - 12 = MEDIUM, 13+ = HIGH RISK				NURSE SIGNATURE		[signature]	[signature]					

** If you are in any doubt about whether a person's medicine belongs to one of the types listed ask the person or carer or please phone the number on the medicine container and ask the community or hospital pharmacist.

* Please see back page for clarification

Falls Assessment Care Plan

Please tick all applicable nursing interventions

		NURSING INTERVENTIONS	DATE 21/12	DATE 28/12	DATE	DATE	DATE	DATE	DATE
Action code		**LOW, MODERATE AND HIGH RISK**							
1		Prevention and general safety precautions discussed with patient and family.	✓	✓					
		MODERATE AND HIGH RISK							
2		Move to more observable area of ward to optimise supervision.	✓	✓					
3		Refer to Physiotherapist.	✓	✓					
4		Refer to Occupational Therapist.		✓					
5		Patient requires footwear or podiatry referral. (Date referred:)							
6		Commence continence assessment							
7		Monitor lying and standing BP and pulse.							
8		Request medication review.							
9		Select suitable seating (refer to policy).							
10		Non-slip mat on chair/floor following advice of OT.							
11		Bed rails/bumpers to be used (refer to policy).	✓	✓					
12		Falls map in use for seven days.							
13		Bed/chair monitor in use.							
14		If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.							
15		Patient to be nursed on mattress on the floor (refer to policy.)							
16		Patient requires one to one nursing care.							
17		Other interventions. buzzer to hand.	✓	✓					
		HIGH RISK ONLY (Score of 13 or over)							
18		Provide hip protectors to patients being discharged to care homes/longterm NHS facilities							
		SIGNATURE	[illegible]	[illegible]					

Review Cannard score weekly / monthly as per policy.

Enter action code(s) selected in action taken section on Falls Risk Assessment.

Cannard Falls Risk Assessment

Glossary of terms used in risk assessment

SIGHT DEFICIT means patient cannot see well even when wearing glasses or is registered blind.

HEARING DEFICIT means person has hearing problems even with a hearing aid or has hearing problems and does not wear a hearing aid.

BALANCE DEFICIT means person is unable to stand without the support of another person or a walking frame.

MEDICINES FOR SOME MENTAL ILLNESSES include Chlorpromazine (Largactil), Risperidone (Risperdal), Lithium (Camcolit or Priadel), Haloperidol, Chloral hydrate (Welldorm), Clomethiazole (Heminevin), antidepressants.

BLOOD PRESSURE TABLETS include Captopril, atenolol and many others.

WATER TABLETS (DIURETICS) are such as Bendroflumethiazide, Furosemide and Co-amilofruse.

SLEEPING TABLETS include medicines such as Diazepam, Temazepam, Nitrazepam, Chlordiazepoxide and Zopiclone (Zimovane).

INABILITY TO CO-OPERATE includes failure to use walking aids or putting themselves in situations with a high risk of falling (usually due to mental impairment).

RESTRICTED MOBILITY means the person requires supervision and/or help to walk (i.e. is not safe to walk alone even with an aid.

HESITANT IN INITIATING MOVEMENT means difficulty in starting to walk.

POOR TRANSFER means the person requires help and is not safe to do the following alone - get in or out of bed, on or off a chair, move from chair to standing.

NHSGGC&C Bedrail Risk Assessment

This Risk Assessment Tool is an aide memoir for staff. It should be used in conjunction with the Bedrails Algorithm (see reverse) and Guidelines for the and Falls Prevention (Adults). This document does NOT replace the need for clinical judgement.

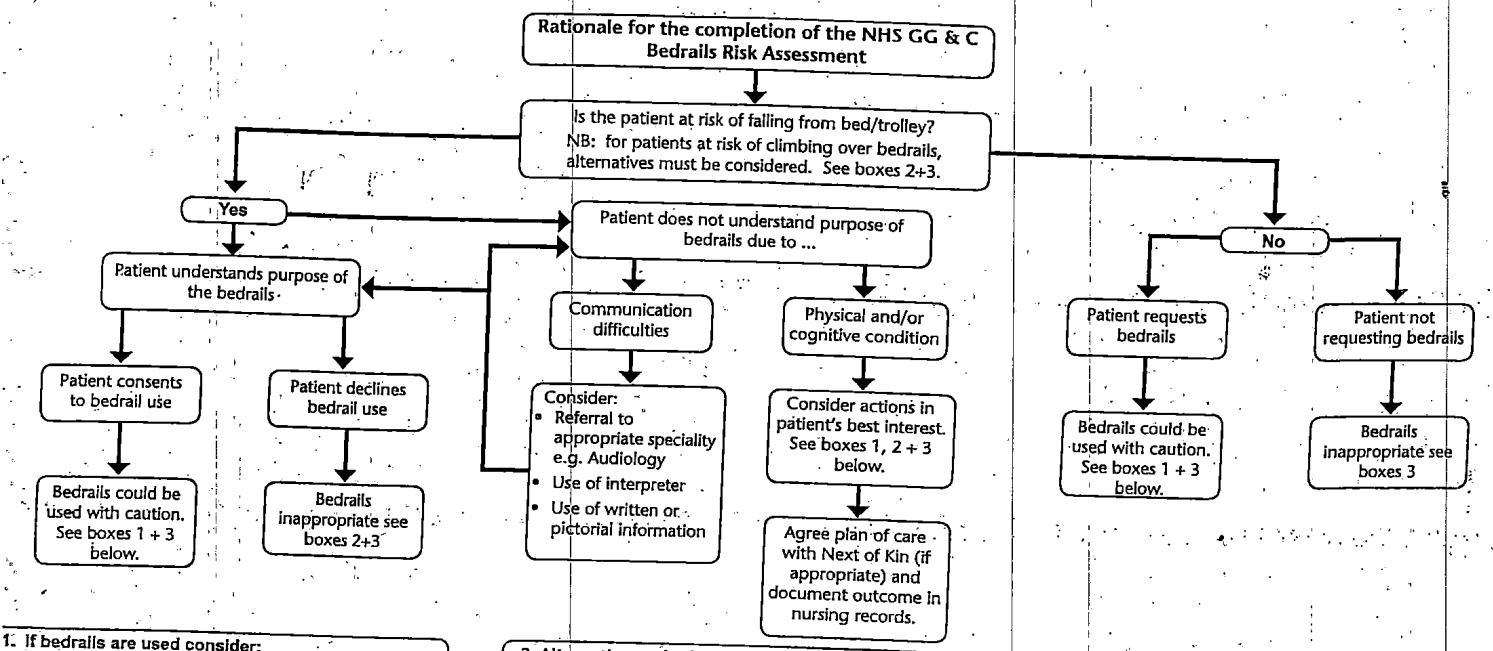
23123532V
MCLEISH F
WENDY 25/05/1987
0/1 51 COXTON PLACE
GLASGOW G33 5EJ
CHI-2505876061

Use algorithm on the reverse of this document when completing this Risk Assessment	DATE			DATE			D/	
SECTION ONE	Y	N	N/A	Y	N	N/A	Y	N
Is the patient at risk of climbing out of bed or trolley?		✓						
Is the patient agitated ~~or confused?~~ occ only	✓							
Does using bedrails present a higher risk to the patient than falling out of bed?								
IF YES, TO ANY OF SECTION 1, DO NOT USE BEDRAILS								
SECTION TWO								
Has an alternative to bedrails been considered? i.e. see bedrails algorithm box 2		✓						
Is the patient likely to roll, slip or slide from the bed?		✓						
Has the patient been consulted regarding the use of bedrails?	✓							
Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/ cognitive condition.	✓							
Has the decision to use or not use bedrails been discussed with relatives / carers		✓						
Has the patient / relatives been given a copy of the bedrail information leaflet		✓						
IF YES, TO ANY OF SECTION 2, THEN BEDRAILS MAY BE APPROPRIATE HOWEVER, CONSIDER THE FOLLOWING POINTS								
SECTION THREE								
Is the patient small in stature?		✓						
Does the patient have an unusually large or small head?		✓						
When bedrail fitted is there a gap between the lower rail and mattress?	✓							
Is there a gap between the bedrail and the headboard less than 60mm or greater than 250mm		✓						
Are there large spaces between the bars of bedrails		✓						
Does the bedrail move away from the side of the mattress when in use?		✓						
Will the bedrail fall off the bed?		✓						
Will any of above create an entrapment hazard?		✓						
IF YES TO SECTION 1 & 3 BEDRAILS ARE NOT APPROPRIATE								
SECTION FOUR								
Has the bedrail been fitted correctly?	✓							
Is the bedrail secure?	✓							
Is the bedrail compatible with the bed frame it will be fitted to?	✓							
Are the bedrails used in good working order?	✓							
Does the patient have access to the call buzzer at all times?	✓							
If pressure relieving overlay mattress, or air filled mattress in use, are extra height bedrails fitted?		✓						
If bariatric bed in use is compatible extra wide mattress fitted?	✓							

IF YES TO SECTIONS 2 & 4 BEDRAILS MAY BE USED THIS RISK ASSESSMENT SHOULD BE USED IN CONJUCTION WITH BED RAILS ALGORITHM (see reverse)

Assessors Signature	[signature]
Date	22/2/11
Bedrails [illegible] checked by	
Date	

Bedrails Algorithm



1. If bedrails are used consider:

- Risk of entrapment and harm to limbs
- Risk of patient climbing over the top
- The psychological effect of bedrails to the patient
- Use of air filled mattresses or mattress overlays require extra height bedrails
- Bariatric beds must be used with a compatible extra wide mattress.

2. Alternatives to bedrails

- Move patient to observable area to maximise supervision
- Bed Monitor (see criteria) accessed via Hospital Falls Prevention coordinator
- Ensure bed returned to lowest height after care delivery
- Ensuring patient needs anticipated e.g. drinks are accessible, regular toileting, call bell to hand etc
- Nursing patient on mattress on the floor should be a last resort and safety checks should be made for hot pipes, trailing wires, electric sockets etc. Moving & handling risk assessment for staff must be completed

3. Remember to document in nursing records:

- Date and time assessment made
- Patient & NOK given bedrails information leaflet
- Rationale for decision made in care plan
- Where bedrails are considered appropriate and the patient has declined their use.
- Actions taken, including discussion with Next of Kin
- Care planning and reviews

Assessment should be made:

- On admission
- If patient's condition changes
- Daily / weekly depending on the situation

23123532V F
MCLEISH 25/05/1987
WENDY
0/1 51 COXTON PLACE
GLASGOW G33 5EJ
CHI-2505876061

NHS
Greater Glasgow and Clyde

Ward 7 GRI

NG Feed

Date								
23/12/11		805		805	1815			1815
23/12/11								
24/12/11	160	100	1645	1905	1145			1145
25/12/11	350	—	460	1250	1230			1230
26/12/11	500		500	1150				650
28/12/11	610		610	850	850			850

Date								
Protein								
Colour								
S.G.								
Reaction								
Sugar								
Ketones								
Bilirubin								
Urobilinogen								
Blood								
Nitrite								
Leucocyte								
Sample Sent								

Date						

Checklist for Swallowing Difficulties in Patients with a Tracheostomy Tube

NHS Greater Glasgow and Clyde

Hospital: GRI Ward: 7/16

23123532V F
MCLEISH
WENDY 25/05/1987
0/1 51 COXTON PLACE
GLASGOW G33 5EJ
CHI-2505876061

Preliminary Observations:
Before carrying out the Water Swallow Test (WST) below, patient **MUST** be able to

- maintain an upright sitting position in a bed or chair.
- stay awake and alert for 15 minutes while seated upright.
- attempt swallowing without undue associated pain.
- maintain oxygenation on air or oxygen therapy ≤ 40%.
- haemodynamically stable vital signs for 24 hours.
- cope with oral secretions, e.g. no drooling / excess salivation.

Cuff Deflation (if cuff is present and inflated)

- Satisfy criteria for cuff deflation (see Tracheostomy guidelines for further information)

Occlusion of Tracheostomy Tube

- If speaking valve is used, attach to tracheostomy tube OR
- If decannulation cap is tolerated, attach to tracheostomy tube

Water Swallow Test Procedure

PART I. *Add 4 drops of dye to 75mls / half cup sterile water. Give patient 3 x 5ml teaspoons of dyed water. Stop if answer is YES at any time; put patient Nil By Mouth and repeat full WST once per day over 2 day period. If answer is NO to all of Part I, proceed directly to Part II.*

Does the patient show signs of any of the following during or immediately after WST?	DAY 1		DAY 2	
	YES	NO	YES	NO
• coughing		X		X
• choking		X		X
• (increased) breathlessness / decreased O_2 sats ≥ 2%		X		X
• wet/gurgly voice when stoma occluded		X		X
• **return of dye**		X		X

Suction Protocol – If there is return of dye at any time discontinue WST

PART II. Ask patient to take sips of remaining dyed water. Proceed as per Part I.

Does the patient show signs of any of the following during or immediately after WST?	DAY 1		DAY 2	
	YES	NO	YES	NO
• coughing		X		X
• choking		X		X
• (increased) breathlessness / decreased O_2 sats ≥ 2%		X		X
• wet/gurgly voice when stoma occluded		X		X
• **return of dye**		✓		X

Suction Protocol – If there is return of dye at any time discontinue WST

Document daily WST outcomes below (indicate with a tick to appropriate box):

Outcome of Water Swallow Test	Signature: K Weir	Signature: Cmcf
	DAY 1: date/time: 24/12/11 @ 1130 hrs	DAY 2: date/time: 25/12/11
PASS (NO to all of Parts I and II)	✓	11am.
FAIL (YES at any time)		

MIS 166788

When carrying out regular routine tracheal suction following this procedure, observe carefully for presence of dye.

- Patients PASSING the WST should proceed to soft diet and fluids under observation as per tracheostomy guidelines
- Patients FAILING at any stage of procedure should remain NIL BY MOUTH and have the test carried out daily for 2 days
- Suctioned secretions should be monitored on a regular ongoing basis for presence of dye/aspirate
- If patient fails WST over 2 days as documented above CONTACT SPEECH AND LANGUAGE THERAPY DEPT

Glasgow Royal Infirmary	Ext: 24819	Gartnavel General Hospital	Ext: 53027
Western Infirmary	Ext: 52215	Stobhill Hospital	Ext: 13751
Beatson WOS Cancer Centre	Ext: 57007	Canniesburn Unit	Ext: 25774
Southern General Hospital	Ext: 61441	Victoria Hospital	Ext: 65949

RECORD OF TRACHEOSTOMY TUBE CARE

NHS Greater Glasgow and Clyde

PATIENT DETAILS	NAME	Wendy McLeish				DOB	25/5/87						HOSPITAL NUMBER				
Type of Tracheostomy Tube	DOUBLE LUMEN / SINGLE LUMEN			CUFFED / UNCUFFED			FENESTRATED (outer) / NON-FENESTRATED (outer)					Size 7			Date inserted / Due Changed		
Tube Care DOUBLE LUMEN TUBES ONLY Remove, clean & replace 2-4 hourly increasing frequency if lumen appears narrowed or occluded by secretions.	DATE	26/12		27/12	27/12	27/12	27/12	27/12	27/12	28/12							
	TIME	22.00		7.30	10.30	18.20	1.20	20.00	00.00								
	COMPLETED	✓		✓	✓	✓	✓	✓	✓								
	SIGN	Jm		CM	CM	CM	CM	CM	CM								
Humidification Check adequate humidification Replace/Renew as required or every 24 hours. W – Water H – HMEF B – Buchanan Bib N – Nebulised Saline	DATE			27/12													
	TIME			7.30													
	W/H/B/N			B													
	SIGN			CM													
Suction **Open/Closed Circuit** Frequency as required to maintain patent lumen/airway Secretions 1- Minimal M - Mucoid 2- Moderate P - Purulent 3- Profuse B – Blood BD – Blue Dye (Swallow Test)	DATE	27/12															
	TIME	16.00															
	1/2/3 M/P/B	1M															
	SIGN	CM															
Equipment Checks Each shift, check Essential Equipment	DATE	27/12															
	SIGN	CM															
Cuff Care Each shift, check Cuff Pressure (If no cuff is present or cuff deflated record X) **Cuff Pressure 15-30 cms H_2O**	DATE	27/12															
	PRESSURE	X															
	SIGN	CM															

WEANING PLAN RECORD OF CARE

PATIENT DETAILS	NAME			DOB			HOSPITAL NUMBER	
Cuff Deflation Criteria Indications → If Yes to all: • Leave cuff deflated • Swallow assessment • Observe for signs of resp failure/ aspiration	INDICATIONS	Oxygenation maintained on ≤40% O_2 therapy	CVS Stable	Cough using vocal cords	Able to sit upright for 10 minutes and remain alert	Coping with oral secretion, no signs of drooling	Occasional suctioning required	Normal respiratory rate and breathing pattern

Weaning If present, **deflate** cuff (if not already deflated) • Attach weaning device • Recommence O_2 therapy • Ensure patient can be observed & monitored closely for signs of respiratory distress Weaning devices: **Single** lumen tracheostomy tube • Use speaking valve **Double** lumen tracheostomy tube • Use fenestrated inner lumen with speaking valve attachment or decannulation cap *OR* • Remove inner lumen, use decannulation cap The appropriate weaning device must be clearly identified (circle above)	Date	Yes to all cuff deflation criteria	Weaning Device Time on	Weaning Device Time off	SIGN	Whilst weaning device in situ observe for **Adverse Signs** • Respiratory distress • Increased RR • Tachycardia • Deterioration in oxygenation • Hypotention • Reduced consciousness • Haemodynamic instability • Increasing MEWS • Difficulty in removing secretions • Patient complaining of breathlessness • Ongoing concern If signs of clinical deterioration are present • Review patient • Remove weaning device, re-attach oxygen administration device, and document • Review weaning process, cuff deflation criteria and re-inflate cuff if indicated If there are no signs of clinical deterioration, increase time weaning device is in use, as tolerated by the patient
	WEANING DEVICES MUST BE REMOVED OVERNIGHT					

Decannulation Indications → If Yes to all: • Decannulate • Continue to monitor patient for signs of clinical deterioration	INDICATIONS	Oxygenation maintained on ≤40% O_2 therapy	CVS Stable	Cough using vocal cords	Able to sit upright for 15 minutes and remain alert	Upper airway unobstructed	Date of decannulation 08·12·11
		Healthcare team agree patient fit to decan	Surgical issues resolved	Normal respiratory rate and breathing pattern	Occasional suctioning required	Swallow assessed	Sign K.Weir

MIS 166758-1

GLASGOW ROYAL INFIRMARY

* FLUID CHART *

24hr. FLUID BALANCE CHART (including blood)

12mn – 12mn

Date...29/12/11.....

Wendy McLeish WRD 7/16

Patient id label

INTAKE 610				TIME	OUTPUT 850			
CODE LETTER OR DESCRIPTION OF INTAKE	ORAL ml.	I.V ml.	OTHER		URINE	GASTRIC	OTHER	COMMENTS
				8 00	200			
				7.	200			
Milk	100			9am				
				10	200			
Water	100			11				
Lunch	50			Noon				
				13				
Water	100			14				
				15				
				16	200			
Juice	100			17				
				18				
				19				
				20				
				21				
				22				
				23				
				12mn.				
	Total intake	=			Total output	=		

APPROXIMATE MEASURWES: TUMBLER = 200mls ORDINARY CUP = 150mls FEEDING CUP = 175mls SOUP BOWL = 250mls

FOOD ASSESSMENT CHART

WARD:	NAME:	PATIENT LABEL
7/16	Wendy McLeish.	

PLEASE RECORD ALL FOOD AND DRINK TAKEN ON THIS CHART DAILY- e.g. 1 bowl porridge. 1 slice brown bread, 1 cup of tea with milk and sugar, 6 spoonfuls of soup, half portion of fish etc

SPECIAL INSTRUCTIONS:

DAY 1 DATE: 27/12/11	DAY 2 DATE: 28/12/11	DAY 3 DATE: 29/12/11
BREAKFAST Milk.	**BREAKFAST** Milk x a.	**BREAKFAST** Milk.
MID-MORNING	**MID-MORNING** Milk.	**MID-MORNING** x2 chocolates
LUNCH Pasta Bolognaise - All Yoghurt taken	**LUNCH** Pudding.	**LUNCH** Small Pastry
MID-AFTERNOON	**MID-AFTERNOON** Water.	**MID-AFTERNOON**
EVENING MEAL Omelette 1/4 taken Yoghurt - All.	**EVENING MEAL** Milk Taken	**EVENING MEAL** Pasta. - V4 taken
BEDTIME	**BEDTIME**	**BEDTIME**

Wendy McHeish

Patient id label

GLASGOW ROYAL INFIRMARY

* FOOD CHART *

24hr. FLUID BALANCE CHART (including blood)

12mn – 12mn

Date 28-29/12/11

INTAKE				TIME	OUTPUT			
CODE LETTER OR DESCRIPTION OF INTAKE	ORAL ml.	I.V ml.	OTHER		URINE	GASTRIC	OTHER	COMMENTS
				01 ∞				
				02 ∞				
				03 ∞				
				04 ∞				
				05 ∞				
				06 ∞				
Milk x2	200			07 ∞	200			
				08 ∞				
				09 ∞	100			
Milkshake	100			10 ∞	100			
Weaks	90			11 ∞				
Crush	100			Noon				
Water	100			13 ∞	100			
				14 ∞				
				15 ∞	100			
				16 ∞				
No Crush	✓			17 ∞				
				18 ∞				
				19 ∞				
				20 ∞	100			
				21 ∞				
				22 ∞				
Water	150			23 ∞	100			
				12mn.				
	Total intake	=	610		Total output	=	850	

APPROXIMATE MEASURWES: - TUMBLER = 200mls ORDINARY CUP = 150mls FEEDING CUP = 175mls SOUP BOWL = 250mls

Food chart

Wendy
McLeish
7/16

GLASGOW ROYAL INFIRMARY

24hr. FLUID BALANCE CHART (including blood)
12mn – 12mn

Date 27/12/11

Patient id label

INTAKE 500				TIME	OUTPUT 650			
CODE LETTER OR DESCRIPTION OF INTAKE	ORAL ml.	I.V ml.	OTHER		URINE	GASTRIC	OTHER	COMMENTS
				1				
				2				
				3				
				4				
				5				
				6				
				7				
NO BREAKFAST				8				
SIPS OF WATER	20			9	150			
water	150			10				
				11				
lunch	200			12				
				13	150			
				14				
~~Drink~~	~~200~~			15				
				16	200			
Dinner	200			17				
				18				
				19				
				20				
				21				
				22				
				23				
				24				
				12mn.				
	Total intake	=			Total output	=		

RECORD OF TRACHEOSTOMY TUBE CARE

NHS Greater Glasgow and Clyde

PATIENT DETAILS	NAME Wendy McLeish					DOB 25/5/87						HOSPITAL NUMBER			
Type of Tracheostomy Tube	DOUBLE LUMEN ✓ / SINGLE LUMEN		CUFFED ✓ / UNCUFFED			FENESTRATED (~~outer~~) 2nd / NON-FENESTRATED (outer) ✓					Size Tracheo 7.0	Date inserted		
Tube Care DOUBLE LUMEN TUBES ONLY Remove, clean & replace 2-4 hourly increasing frequency if lumen appears narrowed or occluded by secretions.	DATE	24.12.11	24/12	24/12	24/12	25/5/12	25/12/4	25/12/4	25/12	25/12	25/12	26/12	26/12	26/12	
	TIME	1130	1400	1700	2200	0300	8am	1100	1400	1700	2200	9am	12	1500	1900
	COMPLETED	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	SIGN	KW	AS	AS	[illegible]	[illegible]	cm	cm	cm	cm	[illegible]	cm	cm	cm	cm
Humidification Check adequate humidification Replace/Renew as required or every 24 hours. W – Water H – HMEF B – Buchanan Bib N – Nebulised Saline	DATE	24.12.11	24/12	24/12	24/12	25/12/11	25/12				25/12	26/12			
	TIME	1100	1400	1700	2200	1000						9am			
	W/H/B/N	W	W	W	W	W						W			
	SIGN	KWeir	AS	AS	[illegible]	KWeir					[illegible]	cm			
Suction **Open/Closed Circuit** Frequency as required to maintain patent lumen/airway Secretions 1- Minimal M - Mucoid 2- Moderate P - Purulent 3- Profuse B – Blood BD – Blue Dye (Swallow Test)	DATE	24.12.11	24/12	24/12	24/12	25/12					25/12	26/12			
	TIME	1100	1400	1700	2100	1600					2130				
	1/2/3 M/P/B	2MB	2M	2MB	1M 1M	1M					1M				
	SIGN	KWeir	AS	AS	[illegible]	Cm									
Equipment Checks Each shift, check Essential Equipment	DATE	24.12.11	24/12			25.12.11						26/12			
	SIGN *	KWeir	AS			KWeir						cm			
Cuff Care Each shift, check Cuff Pressure (If no cuff is present or cuff deflated record X) **Cuff Pressure 15-30 cms H_2O**	DATE														
	PRESSURE														
	SIGN														

* missing inner tube

WEANING PLAN RECORD OF CARE

PATIENT DETAILS	NAME			DOB			HOSPITAL NUMBER	
Cuff Deflation Criteria Indications → If Yes to all: • Leave cuff deflated • Swallow assessment • Observe for signs of resp failure/ aspiration	INDICATIONS	Oxygenation maintained on ≤40% O_2 therapy	CVS Stable	Cough using vocal cords	Able to sit upright for 10 minutes and remain alert	Coping with oral secretion, no signs of drooling	Occasional suctioning required	Normal respiratory rate and breathing pattern

Weaning If present, **deflate** cuff (if not already deflated) • Attach weaning device • Recommence O_2 therapy • Ensure patient can be observed & monitored closely for signs of respiratory distress Weaning devices: **Single** lumen tracheostomy tube • Use speaking valve **Double** lumen tracheostomy tube • Use fenestrated inner lumen with speaking valve attachment or decannulation cap *OR* • Remove inner lumen, use decannulation cap **The appropriate weaning device must be clearly identified (circle above)**	Date	Yes to all cuff deflation criteria	Weaning Device Time on	Weaning Device Time off	SIGN	Whilst weaning device in situ observe for **Adverse Signs** • Respiratory distress • Increased RR • Tachycardia • Deterioration in oxygenation • Hypotention • Reduced consciousness • Haemodynamic instability • Increasing MEWS • Difficulty in removing secretions • Patient complaining of breathlessness • Ongoing concern If signs of clinical deterioration are present • Review patient • Remove weaning device, re-attach oxygen administration device, and document • Review weaning process, cuff deflation criteria and re-inflate cuff if indicated If there are no signs of clinical deterioration, increase time weaning device is in use, as tolerated by the patient
	WEANING DEVICES MUST BE REMOVED OVERNIGHT					

Decannulation **Indications** → **If Yes to all:** • **Decannulate** • **Continue to monitor patient for signs of clinical deterioration**	INDICATIONS	Oxygenation maintained on ≤40% O_2 therapy	CVS Stable	Cough using vocal cords	Able to sit upright for 15 minutes and remain alert	Upper airway unobstructed	Date of decannulation
		Healthcare team agree patient fit to decannulate	Surgical issues resolved	Normal respiratory rate and breathing pattern	Occasional suctioning required	Swallow assessed	Sign

MIS 242353-1

RECORD OF TRACHEOSTOMY TUBE CARE

NHS Greater Glasgow and Clyde

PATIENT DETAILS	NAME Wendy McLEISH					DOB 25/5/87							HOSPITAL NUMBER		
Type of Tracheostomy Tube	DOUBLE LUMEN ✓ / SINGLE LUMEN		CUFFED ✓ / UNCUFFED			FENESTRATED (outer) / NON-FENESTRATED (outer) ✓					Size PEAC Hole 7		Date inserted / Due Changed		
Tube Care DOUBLE LUMEN TUBES ONLY Remove, clean & replace 2-4 hourly increasing frequency if lumen appears narrowed or occluded by secretions.	DATE	20/12	21·12	21/12	21/12	21/12	22/12	22/12	22/12	22/12		23/12	23/12	24/12	24/12
	TIME	1200	11⁰⁰	1400	1800	2100	0131	0345	0530	1500	2100	0300	1230	[redacted]	62m
	COMPLETED	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	[redacted]	✓
	SIGN			VB	VB	KS.	KS.	KS.	KS	LHB	KS.	TL	LHB	EW	EW
Humidification Check adequate humidification Replace/Renew as required or every 24 hours. W – Water H – HMEF B – Buchanan Bib N – Nebulised Saline	DATE	20/12	21·12	21/12		21/12				22/12	23/12		23/12	23/12	
	TIME	1200	11⁰⁰	1800		2230				1500	2200		1230	10pm	
	W/H/B/N	H	W	W		W				W	W		W	W	
	SIGN			VB		KS.				LHB	KS.		LHB	EW	
Suction **Open/Closed Circuit** Frequency as required to maintain patent lumen/airway Secretions 1- Minimal M - Mucoid 2- Moderate P - Purulent 3- Profuse B – Blood BD – Blue Dye (Swallow Test)	DATE	20/12	21·12	21/12	21/12					22/12			23/12	23/12	
	TIME	1200	11⁰⁰	1500	1800					1500			1230	comfy	
	1/2/3 M/P/B	M2	2P	1P	1P					2MB			Coughing & Up. secretions		
	SIGN			VB	VB					LHB			LHB		
Equipment Checks Each shift, check Essential Equipment	DATE			21/12		21/12				22/12			23/12	24/12	
	SIGN			VB		KS.				LHB			LHB	EW	
Cuff Care Each shift, check Cuff Pressure (If no cuff is present or cuff deflated record X) **Cuff Pressure 15-30 cms H_2O**	DATE	1200												24/12	
	PRESSURE	cuff down								CUFF DEFLATED				cuff deflated	
	SIGN														

WEANING PLAN RECORD OF CARE

PATIENT DETAILS	NAME			DOB			HOSPITAL NUMBER	
Cuff Deflation Criteria → Indications If Yes to all: • Leave cuff deflated • Swallow assessment • Observe for signs of resp failure/ aspiration	INDICATIONS	Oxygenation maintained on ≤40% O_2 therapy	CVS Stable	Cough using vocal cords	Able to sit upright for 10 minutes and remain alert	Coping with oral secretion, no signs of drooling	Occasional suctioning required	Normal respiratory rate and breathing pattern

Weaning If present, **deflate** cuff (if not already deflated) • Attach weaning device • Recommence O_2 therapy • Ensure patient can be observed & monitored closely for signs of respiratory distress Weaning devices: **Single** lumen tracheostomy tube • Use speaking valve **Double** lumen tracheostomy tube • Use fenestrated inner lumen with speaking valve attachment or decannulation cap *OR* • Remove inner lumen, use decannulation cap The appropriate weaning device must be clearly identified (circle above)	Date	Yes to all cuff deflation criteria	Weaning Device Time on	Weaning Device Time off	SIGN	Whilst weaning device in situ observe for **Adverse Signs** • Respiratory distress • Increased RR • Tachycardia • Deterioration in oxygenation • Hypotention • Reduced consciousness • Haemodynamic instability • Increasing MEWS • Difficulty in removing secretions • Patient complaining of breathlessness • Ongoing concern If signs of clinical deterioration are present • Review patient • Remove weaning device, re-attach oxygen administration device, and document • Review weaning process, cuff deflation criteria and re-inflate cuff if indicated If there are no signs of clinical deterioration, increase time weaning device is in use, as tolerated by the patient
	20/12/11	YES	do	do	[signature]	
	23/12/11	Y	1235	1243	L Barnie	
	23-12-11	YES	~~YES~~ 1930	2030	L Walsh	
	24/12/11	Yes	1430	1530	A Smith	
	WEANING DEVICES MUST BE REMOVED OVERNIGHT					

Decannulation → Indications If Yes to all: • Decannulate • Continue to monitor patient for signs of clinical deterioration	INDICATIONS	Oxygenation maintained on ≤40% O_2 therapy	CVS Stable	Cough using vocal cords	Able to sit upright for 15 minutes and remain alert	Upper airway unobstructed	Date of decannulation
		Healthcare team agree patient fit to decannu	Surgical issues resolved	Normal respiratory rate and breathing pattern	Occasional suctioning required	Swallow assessed	Sign

Adult Peripheral Venous Cannulation (PVC) Chart

Please use 1 chart per PVC

NHS Greater Glasgow and Clyde

Affix patient l

Name: 23123532V MCLEISH WENDY F

Address: 25/05/1987 0/1 51 COXTON PLACE

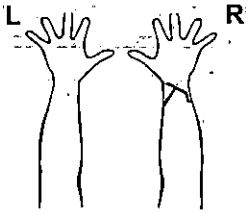
D.O.B: GLASGOW G33 5EJ

CHI number: CHI-2505876061

Hospital: Ward:

PVC Insertion Information

*Ensure the PVC dressing has **date** and **time** of insertion written on it. This implies that appropriate technique has been used for insertion.*



Date: 20/12/11

Time: ?

(See IV Dressing)

Reason for Insertion: _____

Flushed on insertion ☐ (if known)

Other Site: _____

PVC Maintenance Information

Modified V.I.P (Visual Infusion Phlebitis) Score

IV site appears healthy	0	No Phlebitis	**Observe Cannula**
ONE of the following is evident: - slight pain or redness near site	1	Possible first signs	**Observe Cannula**
TWO of the following are evident: - pain -redness - swelling	2	Early stage of phlebitis	**Re-site Cannula**
ALL of the following are evident: - pain - redness - hardening of the surrounding tissue	3	Phlebitis / Thrombophlebitis	
As above including: - palpable venous cord	4	**Re-site Cannula & Seek Further Advice**	
As above including: - pyrexia	5		

Day 1 (24 hours after insertion)

All 5 questions below MUST be answered
The PVC must be monitored at least once per day

1. Continuing clinical indication for PVC? (Yes) / No
2. VIP Score? 0
3. PVC Dressing dry & intact? (Yes) / No
4. Was PVC dressing renewed? Yes / No / (NA)
5. Was PVC Removed? Yes / (No)

Removal Reason: _____

Comments/Actions Taken:

not required. Observe. Remove

Date: 21/3/11 Initials: TC

Day 2

All 5 questions below MUST be answered
The PVC must be monitored at least once per day

1. Continuing clinical indication for PVC? (Yes) / No
2. VIP Score? 0
3. PVC Dressing dry & intact? (Yes) / No
4. Was PVC dressing renewed? Yes / (No) / NA
5. Was PVC Removed? Yes / (No)

Removal Reason: _____

Comments/Actions Taken:

To be removed. D/w medics.

Date: 22/12/11 Initials: KS.

After Day 3 consider removal, if there is still a clinical reason justify rationale for PVC to remain insitu:

Date: Initials:

Day 3

All 5 questions below MUST be answered
The PVC must be monitored at least once per day

1. Continuing clinical indication for PVC? (Yes) / No
2. VIP Score? 0
3. PVC Dressing dry & intact? (Yes) / No
4. Was PVC dressing renewed? Yes / (No) / NA
5. Was PVC Removed? Yes / (No)

Removal Reason: _____

Comments/Actions Taken:

needs renewed

Date: 24/12 Initials: GW

Day 4

All 5 questions below MUST be answered
The PVC must be monitored at least once per day

1. Continuing clinical indication for PVC? Yes (No)
2. VIP Score? 0
3. PVC Dressing dry & intact? (Yes) / No
4. Was PVC dressing renewed? Yes (No) / NA
5. Was PVC Removed? (Yes) / No

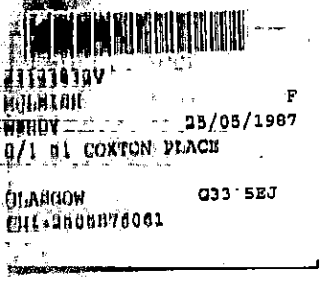
Removal Reason: Not Rigid

Comments/Actions Taken:

Date: 24/12/11 Initials: AO

ENTERAL FEEDING REGIMEN

NHS
Greater Glasgow and Clyde



FEED: NUTRISON MULTI FIBRE	WARD: 7/16
Route of feeding: NG	
Date Feeding Regimen to Commence: 23 / 12 / 11	
Dietitian Signature ....K. Cochrane.....	

K. COCHRANE

NUTRITIONAL REQUIREMENTS

KCals ..1472.....per day Protein ..62.5.....g per Day

Provided by feed:

KCals ..1500.....per day Protein ..60.....g per Day

☑ feed as sole source of nutritional intake ☐ feed in addition to oral intake

Date Regimen to Commence	Type of Feed	Volume over 24hours	Rate and Number of hours feed to run
Day 1. 23/12/11	NUTRISON MULTIFIBRE	1500mls	65mls/hr x 24°
Day 2. 24/12/11	"	"	80mls/hr x ~19°
Day 3. 25/12/11	"	"	100mls/hr x 15°

Continue Day 3 regimen until advised of any changes by Dietitian.
If regimen changes a new chart will be commenced.
Please ensure volume of feed given is recorded on fluid balance charts.

Date	Feed	Volume	Time feed commenced	pH check Ng tubes only at start of NEW FEED	Signature
23/12/11	NUTRISON MULTIFIBRE	1000mls	1230	pH = ~~4~~ 4pH	K Cochrane Stopped 1330
24/12/11	MULTIFIBRE	1000ml	1200	pH = 5	Adm
25/12/11	Repeated	cml			

REMEMBER TO FLUSH TUBE WITH STERILE WATER BEFORE COMMENCING A NEW FEED, BEFORE AND AFTER ANY MEDICATIONS GIVEN, AND BETWEEN INDIVIDUAL MEDICATIONS

- DO NOT MIX MEDICATIONS. FOLLOW PROTOCOL -PROCEED WITH FEED IF pH 4 OR BELOW. IF ABOVE 4 , FOLLOW PROTOCOL TO CHECK POSITION OF FEEDING TUBE

ENTERAL FEEDING REGIMEN

Date	Feed	Volume	Time feed commenced	pH check Ng tubes only at start of NEW FEED	Signature
				pH =	

ELECTRONIC PATIENT RECORDS

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

Including:

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

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

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

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 21/12/2025

Consultant: Dr Donogh Maguire

M Lyons
Meadowpark Surgery
Parkhead Hub
1251 Duke Street
Glasgow
Glasgow
G31 5NZ

Dear M Lyons

Re: **McLeish Wendy** DOB: **25/05/1987** CHI: **2505876061**
0/1
Glasgow G31 3SF

Attended on: **20/12/2025 at 23:08 hrs.** Departed on: **21/12/2025 at 02:58 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **8**

Presenting complaint
vomiting/SOB

Nursing Assessment:
UNWELL since this morning; NEWS=1; chest tightness, also ?epigastric / central chest pain in triage, intermittent, worse on movement and inspiration - Hx small ASD and refereed for closure; pain in the back as well; pt reporting 3 falls today - slipped from couch and the toilet - no obvious injuries; FAST negative in triage; other Hx FND, epilepsy. Suitable for cat. 3 if nil acute on ecg

Investigations in ED:

1. Full Blood Count	**2. CRP**	**3. Urea and Electrolytes**
4. Bicarbonate	**5. LFT**	**6. Glucose**
7. Amylase	**8. Troponin I hs**	

Diagnosis:

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

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:

Dear Doctor, Wendy McLeish presented to GRI ED 21/12 with back pain, nausea and vomiting. She states unable to keep down oral intake for 3/7. She also reports 1/7 of worsening back pain since falling off her couch. She states she felt her left leg was giving way leading to falls. On examination, no focal neurological deficit could be elicited. She did not vomit in the department She was treated with analgesia and anti-emetics and improved and was discharged home.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Declan Todd
Doctor

Copies to:

1. M Lyons (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

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

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 20/09/2025

Consultant: Dr Hannah Bell

M Lyons
Meadowpark Surgery
Parkhead Hub
1251 Duke Street
Glasgow
Glasgow
G31 5NZ

Dear M Lyons

Re: **McLeish Wendy** DOB: **25/05/1987** CHI: **2505876061**
FLAT 3/2
Glasgow G31 3LY

Attended on: **19/09/2025 at 11:06 hrs.** Departed on: **19/09/2025 at 17:44 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **7**

Presenting complaint
facial/head injuries

Nursing Assessment:
Multiple injuries. NEWS 0, Vague historian, states bitten by dog to nose. No broken skin but severe panda eye bruising, swelling to nose and forehead. Also multiple bruises to left and right forearms, similar to defensive type marks. Under Ix for seizures. On GAbapentin, DF118 and Lamotragine. 2 for consideration of CT

Investigations in ED:
1. CT Head **2. CT Facial bones** **3. XR Chest**

Diagnosis:

Diagnosis	Side	Site
Superficial Injury of Other Parts of Head		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:

Attended ED with significant facial bruising. Pt tells me her friends dogs bit her nose but injuries not really in keeping with dog bite, pattern of injuries more in keeping with assault Pt adamant that injuries were sustained through dog however CT head and facial bones normal Pt tells me feels safe to go home, discharged with friend/social worker

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Michael Burke
Doctor

Copies to:

1. M Lyons (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

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

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 13/09/2025

Consultant: Dr Emma Sur

M Lyons
Meadowpark Surgery
Parkhead Hub
1251 Duke Street
Glasgow
Glasgow
G31 5NZ

Dear M Lyons

Re: **McLeish Wendy** DOB: **25/05/1987** CHI: **2505876061**
FLAT 3/2
Glasgow G31 3LY

Attended on: **12/09/2025 at 12:57 hrs.** Departed on: **12/09/2025 at 16:34 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **6**

Presenting complaint
acute distress

Nursing Assessment:
?MH. NEWS 0. SAS called this morning due to acute behavioural episode. Agitated, running into road & smashing up house. Police on scene. Partner states pt keeps trying to jump out of window. Appears distracted. Partner unsure if any extra prescribed meds taken. Hx PTSD.

Investigations in ED:

1. CRP	**2. Urea and Electrolytes**	**3. LFT**
4. Thyroid function tests	**5. Full Blood Count**	**6. Glucose**

Diagnosis:

Diagnosis	Side	Site
Acute and Transient Psychotic Disorder, Unspecified		
Acute and Transient Psychotic Disorder, Unspecified		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:

38F presented with an episode of acute distress in the context of stress at home. She attended after being BIBA for running around in street exposing herself. She was also noted to be agitated in the house and throwing objects around in distress. She was noted also to have 2x small lumps on her neck around the thyroid which the she plans to attend the GP for. One of these appears red and inflammed and she had raised WCC. She was reviewed by psychiatry and discharged as a likely acute distress with 6x 5mg diazepam. She was also discharged with PO doxycycline for cellulitis (already completed flucloxacillin).

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Andrew Tait
Doctor

Copies to:

1. M Lyons (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

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

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 16/04/2025

Consultant: Dr Alan Davidson

M Lyons
Meadowpark Surgery
Parkhead Hub
1251 Duke Street
Glasgow
Glasgow
G31 5NZ

Dear M Lyons

Re: **McLeish Wendy** DOB: **25/05/1987** CHI: **2505876061**
FLAT 3/2
Glasgow G31 3LY

Attended on: **15/04/2025 at 19:36 hrs.** Departed on: **16/04/2025 at 00:26 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **5**

Presenting complaint
back pain

Nursing Assessment:
BACK PAIN NEWS 0 - pt has had 3/7 hx of upper back pain, attended gp today who told pt to go home and call 999. on sas arrival pt had 3 lidocaine patches on her back, also admits to dihydrocodeine and gabapentin. denies chest pain. pt states she feels 'not herself' and 'a bit dazed'. denies other drugs/ alcohol. hx perv pneumonia, sciatica, pulmonary fibrosis

Investigations in ED:
1. XR Chest

Diagnosis:

Diagnosis	Side	Site
Pleurisy		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:

Presented with thoracic rt back pain and ?sob Patient's NEWS 0. Exam normal. No acute symptoms CXR - nil focal Discharged with worsening advice - likely pleurisy secondary to recent CAP

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Rebecca Osborne
Doctor

Copies to:

1. M Lyons (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

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

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 25/03/2025

Consultant: Dr Patrick O'Mailley

M Lyons
Meadowpark Surgery
Parkhead Hub
1251 Duke Street
Glasgow
Glasgow
G31 5NZ

Dear M Lyons

Re: **McLeish Wendy** DOB: **25/05/1987** CHI: **2505876061**
FLAT 3/2
Glasgow G31 3LY

Attended on: **24/03/2025 at 19:22 hrs.** Departed on: **at hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **5**

Presenting complaint
Expected at GRI A+E on 24/ Unwell ?icteric non traumatic arm swelling

Nursing Assessment:-
ARM PAIN. NEWS 2. 4/7 hx of R arm pain and swelling. no injury?CLOT. advised to attend. appears under influence. recent abx for pneumonia. looks unwell.

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Contusion of Other and Unspecified Parts of Forearm		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:

NHS 24 referral with ?right arm injury. Waited >8.5hrs in ED. Called 999 tonight, but it is unclear why she did this; all she will say is that she couldn't get any transport to hospital. 'Bumped' right arm in a fall 3/7 ago. Two tiny, old bruises to dorsum of right mid-forearm. No swelling. No tenderness. Moving right arm fully. She said she was advised on NHS 24 consultation that she may have a 'blood clot' and may be 'jaundiced', but there is no mention of this in the letter. There was no evidence at all of an upper limb DVT. She did not look overtly jaundiced and she had normal sclerae. Her skin had a generally darker tone which she said is chronic. All obs normal, SaO2 94% on air. Chest was clear on examination and she had no resp distress. I offered a CXR but she said she'd rather wait until she finished her course of clarithromycin from GP. I explained there was no evidence of any acute issue and she was satisfied with this.

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Ryan Connelly
Consultant

Copies to:

1. M Lyons (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

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

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 26/02/2025

Consultant: Dr Fiona Ritchie

M Lyons
Meadowpark Surgery
Parkhead Hub
1251 Duke Street
Glasgow
Glasgow
G31 5NZ

Dear M Lyons

Re: **McLeish Wendy** DOB: **25/05/1987** CHI: **2505876061**
FLAT 3/2
Glasgow G31 3LY

Attended on: **25/02/2025 at 19:07 hrs.** Departed on: **26/02/2025 at 00:42 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **2**

Presenting complaint
head injury

Nursing Assessment:
FALL NEWS 4 GCs 14/15 fall down unknow amount of stairs yesterday unable to straighten neck complaints of c-spine tenderness drowsy in triage denies drug/alcohol pmh sciatica epilepsy scarring of lungs pnumonia required ECMO 2012

Investigations in ED:
1. CT Spine cervical

Diagnosis:

Diagnosis	Side	Site
Unspecified Injury of Neck		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:

Wendy McLeish presented with C-spine pain and tenderness after a mechanical fall down 6 stairs. CT C-spine showed nil acute. She was found to have multiple bruises on her arms and legs which she attributed to her fall. She recently had bloods taken by her GP, which showed nil acute. She denied any physical abuse from her partner. She was discharged with crisis team numbers, as she was tearful in the department, but denied any suicidal ideation or concerns for her safety.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Nandini Mishra
Doctor

Copies to:

1. M Lyons (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

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

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 09/04/2024

Consultant: Dr Samantha Perry

MM Morris
Meadowpark Surgery
568 Alexandra Parade
Glasgow
Glasgow
G31 3BP

Dear MM Morris

Re: **McLeish Wendy** DOB: **25/05/1987** CHI: **2505876061**
FLAT 3/2
Glasgow G31 3LY

Attended on: **09/04/2024 at 13:07 hrs.** Departed on: **09/04/2024 at 16:41 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **2**

Presenting complaint
RTC

Nursing Assessment:
SHOULDER/BACK PAIN RTC NEWS 1 Patient attends after being involved in RTC on Saturday at 2200. Passenger in a car going 50mph on motorway, coming off junction, lost control, car spun until coming to a complete stop. Airbags deployed, no C-spine pain, mobilised at scene. PMH Arthritis, Asthma,.

Investigations in ED:
1. CT Head **2. CT Spine cervical**

Diagnosis:

Diagnosis	Side	Site
Concussion		
Sprain and Strain of Cervical Spine		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Any medication dispensed or changed is recorded in this letter in the free text below**

Clinician Notes:
Normal CT head and neck home with HI/concussion and neck injury advice sheets.

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

Yours sincerely,
Catherine Aspden
Doctor

Copies to:
1. MM Morris (GP)
School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

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

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 26/02/2024

Consultant: Dr Patrick O'Mailley

MM Morris
Meadowpark Surgery
568 Alexandra Parade
Glasgow
Glasgow
G31 3BP

Dear MM Morris

Re: **McLeish Wendy** DOB: **25/05/1987** CHI: **2505876061**
FLAT 3/2
Glasgow G31 3LY

Attended on: **26/02/2024 at 17:24 hrs.** Departed on: **26/02/2024 at 23:14 hrs.**
Discharge Type: **01b - Discharge with follow up by primary care team** Destination: **Private residence**
Previous ED Attendance in last 12 months: **4**

Presenting complaint
numbness to fingers

Nursing Assessment:
Altered sensation to fingertips since this morning. FAST -ve in triage. **Low Blood glucose. Given 2x glucojuice in triage. News 1.**

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Paraesthesia of Skin		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Any medication dispensed or changed is recorded in this letter in the free text below**

Clinician Notes:

36F presented with 1/7 ascending paraesthesia of her fingertips, now involving both hands up to the wrist. Neurological examination normal, no sign radial nerve palsy, power normal across all movements allowing for essential tremor. Reassured and discharged. Advised if persists to seek neuropathy bloods from her GP (B12, thyroid etc.)

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Alexander Kriss
Doctor

Copies to:

1. MM Morris (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

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

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 28/01/2024

Consultant: Dr Fiona Ritchie

MM Morris
Meadowpark Surgery
568 Alexandra Parade
Glasgow
Glasgow
G31 3BP

Dear MM Morris

Re: **McLeish Wendy** DOB: **25/05/1987** CHI: **2505876061**
FLAT 3/2
Glasgow G31 3LY

Attended on: **28/01/2024 at 06:34 hrs.** Departed on: **at hrs.**
Discharge Type: **01c - Discharge with referral** Destination: **Private residence**
Previous ED Attendance in last 12 months: **3**

Presenting complaint
right ankle injury.

Nursing Assessment:
ANKLE INJURY. Legs gave way during night, twisting R ankle. Slight swelling evident. Mobilised with SAS. Taken own analgesia. Sensation intact. Hx sciatica.

Investigations in ED:
1. XR Ankle Rt

Diagnosis:

Diagnosis	Side	Site
Closed Fracture of Shaft of Tibia		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Any medication dispensed or changed is recorded in this letter in the free text below**

Clinician Notes:

Patient presented today with a fracture to her right distal tibia. I have referred her to Ortho for follow up.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Elaine Houston
Nurse

Copies to:

1. MM Morris (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

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

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 14/01/2023

Consultant: Dr Christine Aiken

MM Morris
Meadowpark Surgery
568 Alexandra Parade
Glasgow
Glasgow
G31 3BP

Dear MM Morris

Re: **McLeish Wendy** DOB: **25/05/1987** CHI: **2505876061**
FLAT 3-2
Glasgow G31 3LY

Attended on: **11/01/2023 at 11:15 hrs.** Departed on: **11/01/2023 at 16:34 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
medical - letter on Portal. cough and pleuritic chest pain ? pe hx pneumonia

Nursing Assessment:
2/12 of ongoing cvhest infections has had 4 courses of abx with no improvement. had CAP 10 years ago with ITU admission. under respiratory. Worsing SOB and CP this AM. Reduced SPO2 at GP normal in triage. appears vague PMH Asthma, Bronchitis

Investigations in ED:

1. Full Blood Count	**2. Coagulation screen**	**3. Urea and Electrolytes**
4. Glucose	**5. LFT**	**6. Bone Profile**
7. CRP	**8. D - Dimer**	**9. Troponin I hs**
10. Coagulation screen	**11. XR Chest**	

Diagnosis:

Diagnosis	Side	Site
Other Chest Pain		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:

Dear Doctor, Mrs McLeish presented to the AAU on the 11/01/23 with SOB and right anterior and central stabbing chest pain. ECG: NSR, old incomplete RBBB and old TWI in V1,V2. D-Dimer negative; Troponin negative; remaining bloods unremarkable. CXR clear. Pain likely MSK Patient medically fit for discharge, with worsening advice. Thank you very much for your ongoing care of this patient in the community. Kindest regards AAU GRI

Followup :

Highly sensitive: N, Consent for sharing withheld: N

Yours sincerely,
Thea Rodig
Doctor

Copies to:

1. MM Morris (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

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

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 01/11/2019

Consultant: Dr Phil Anderson

AL McGinley
Lochend Surgery
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
Glasgow
G34 9HQ

Dear AL McGinley

Re: **McLeish Wendy** DOB: **25/05/1987** CHI: **2505876061**
126 LIBERTON ST
Glasgow G33 2HJ

Attended on: **01/11/2019 at 09:31 hrs.** Departed on: **01/11/2019 at 13:30 hrs.**
Discharge Type: **02 - Admitted** Destination: **Admission to this Hospital**
Previous ED Attendance in last 12 months: **1**

Presenting complaint
assault

Nursing Assessment:
assaulted this am. haematoma evident to (R) sided of ear. also (R) ear bitten. has been taking valium. BM 3.8 with sas - given glucogon. NEWS 3

Investigations in ED:
1. Needlestick/ blood exposure recipient - Storage ONLY

Diagnosis:

Diagnosis	Side	Site
Superficial injury of scalp		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

GP TO BE AWARE Assaulted by partner - hit on head with bottle and bitten on right ear. GCS 15 with no focal neurology. Ear wound closed by plastics in the dept. Follow up arranged 7/7 & oral co-amox & top chloramphenicol. Admitted to ward 46 for neuro obs post head injury. 2 year old daughter in house at time. Police ran checks on aunt and child currently with Aunt - Sharon Ward. Social work contacted and notification of concern completed. Police also informed SW. Police plan to arrest Wendy when medically fit for discharge and social work will follow up plans with daughter Khara Wood 24/2/17.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Caitlin Irvine
Doctor

Copies to:

1. AL McGinley (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

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

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 02/09/2019

Consultant: Dr Richard Stevenson

AL McGinley
Lochend Surgery
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
Glasgow
G34 9HQ

Dear AL McGinley -

Re: **McLeish Wendy** DOB: **25/05/1987** CHI: **2505876061**
6 CARNTYNE GROVE
Glasgow G32 6LZ

Attended on: **16/08/2019 at 11:09 hrs.** Departed on: **16/08/2019 at 15:03 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
appears to be intoxicated

Nursing Assessment:
BIBA, NEWS 3. Domestic incident this morning with partner. Partner locked pt and 2 year old daughter and friend in the house and left with the keys. Pt states she fell out of ground floor window when climbing out. Friend advised the child was passed out of the window and was then passed back inside the house. Pt climbed back into the house using a cot side as a ladder. Pt is intoxicated with alcohol and is drowsy with slurred speech. SAS state there were knifes and joints lying around the house and the home was unsuitable for a child. Friend left and the pt contacted her sister in law Sharon Ward to collect the child, who collected keys before collecting pts daughter. Pt sustained left arm injury and has bruising to right hand and forearm. Denies any other injury. Low risk CPE

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Acute Alcohol intoxication		
Alcohol Dependance		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:
Presented intoxicated no other concerns; due to concerns for child under care of Wendy police were contacted and social work referral made.

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

Yours sincerely,
Richard Stevenson
Consultant

Copies to:
1. AL McGinley (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

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

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 07/09/2015

Consultant: Dr Scott Taylor

AL McGinley
Dr Wilson dr mcginley & dr sheppar
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
Glasgow
G34 9HQ

Dear AL McGinley

Re: **McLeish Wendy** DOB: **25/05/1987** CHI: **2505876061**
0/1 51 COXTON PLACE
Glasgow G33 5EJ

Attended on: **29/08/2015 at 20:34 hrs.** Departed on: **29/08/2015 at 22:58 hrs.**
Discharge Type: **01c - Discharge with referral** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
9WKS PREF PVB

Nursing Assessment:
8/40 gest c/o PVB and abdo cramps. Seen at EPAS during the week and scaned to go back next week but advused to attend A&E if bleeding gets worse

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Haemorrhage in early pregnancy - Threatened abortion		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

9 weeks gestation - further episode of PV bleeding with lower abdo cramping - settled by arrival to dept - clots passed but no ongoing bleed. Haemodynamically stable. Abdo SNT. Known to EPAS - confirmed intrauterine sac on recent scan. Pt clinically well - avised to contact EPAS Monday am for follow up. Worsening adice re further bleeding /pain given. HCG pos in dept.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Douglas Maxwell
Doctor

Copies to:

1. AL McGinley (GP)

School Address:

HOSPITAL INFORMATION MISSING



Dr MARIE WILSON
EASTERHOUSE HEALTH CENTRE
9 AUCHINLEA ROAD GLASGOW

G34 9HQ

Date : 21 Nov 2011

Dear Dr MARIE WILSON,

Re: WENDY MCLEISH, 0/1 51 COXTON PLACE, GLASGOW, G33 5EJ
Date of Birth: 25/05/1987 CHI number: 2505876061

HOSPITAL INFORMATION MISSING Patient attended on the 20 Nov 2011.

The presenting complaint was: **BACK/LEG PAINS DIAHORREA**

Triage information: **PT C/O 4/7 HX OF DIARRHOEA UNABLE TO TAKE FLUIDS IN HYPOTENSIVE WITH SAS GIVEN FLUIDS ALSO C/O PAIN IN HER BACK TEMP 37.4**

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

The A&E diagnosis was: **RESPIRATORY - PNEUMONIA**

The following treatment was given: **None**

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

Follow-up: **ADMITTED**

Additional information: **None**

Yours sincerely,

TAREQ ABDULLAH

EMERGENCY DEPARTMENT DOCTOR

HOSPITAL INFORMATION MISSING



Dr ALBERT BURTON
WOODSIDE HEALTH CENTRE
BARR STREET GLASGOW

G20 7LR

Date : 22 Sep 2011

Dear Dr ALBERT BURTON,

Re: WENDY MCLEISH, 0/1 51 COXTON PLACE, GLASGOW, G33 5EJ
Date of Birth: 25/05/1987 CHI number: 2505876061

HOSPITAL INFORMATION MISSING Patient attended on the 22 Sep 2011.

The presenting complaint was:	**OVERDOSE**
Triage information:	**PT HAS TAKEN UNKNOWN AMOUNT OF FLUOXETINE TONIGHT. WASHED DOWN WITH APPROX 12 BUDS. STATES THAT SHE WANTS TO DIE.**
The following investigations were carried out:	**FULL BLOOD COUNT** **BLOOD - LFTS** **BLOOD - U+E** **BLOOD GLUCOSE** **SERUM SALICYLATE AND PARACETAMOL** **ECG**
The A&E diagnosis was:	**INTENTIONAL SELF HARM - ANTI-DEPRESSANT**

The following treatment was given:	**None**
At the conclusion of treatment the patient was:	**TRANSFERRED DIRECTLY TO ZONE 2**
Follow-up:	**DISCHARGED**
Additional information:	**None**

Yours sincerely,

RICHARD STEVENSON

CLINICAL FELLOW

HOSPITAL INFORMATION MISSING



Dr ANNE MCGINLEY
EASTERHOUSE HEALTH CENTRE
9 AUCHINLEA ROAD GLASGOW

G34 9HQ

Date : 22 Sep 2011

Dear Dr ANNE MCGINLEY,

Re: WENDY MCLEISH, 0/1 51 COXTON PLACE, GLASGOW, G33 5EJ
Date of Birth: 25/05/1987 CHI number: 2505876061

HOSPITAL INFORMATION MISSING Patient attended on the 22 Sep 2011.

The presenting complaint was:	**MEDICAL**
Triage information:	**Not recorded**
The following investigations were carried out:	**None**
The A&E diagnosis was:	**INTENTIONAL SELF HARM - ANTI-DEPRESSANT**
The following treatment was given:	**None**
At the conclusion of treatment the patient was:	**DISCHARGED**

Follow-up: **DISCHARGED**

Additional information: **None**

Yours sincerely,

ANDREW AINSWORTH

DIABETES AND ENDOCRINE

HOSPITAL INFORMATION MISSING



Dr ALBERT BURTON
WOODSIDE HEALTH CENTRE
BARR STREET GLASGOW

G20 7LR

Date : 31 Aug 2011

Dear Dr ALBERT BURTON,

Re: WENDY MCLEISH, 0/1 51 COXTON PLACE, GLASGOW, G33 5EJ
Date of Birth: 25/05/1987 CHI number: 2505876061

HOSPITAL INFORMATION MISSING Patient attended on the 31 Aug 2011.

The presenting complaint was: **OVERDOSE / INTOXICATED**

Triage information: **CLAIMS TO HAVE TAKEN APPROX 24 X 400MG IBUPROFEN TABLETS WITH ALCOHOL & A MIXTURE OF OTHER DRUGS AT 0100, UNSURE WHAT BUT SHE STATES IT'S DIFFERENT ONES TO THE WHAT SHE OVERDOSED ON LAST WEEK. TEARFUL IN TRIAGE, WANTS TO DIE. BROTHER IN LAW IN CWA WITH CHEST PAIN - BROUGHT IN TOGETHER**

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

The A&E diagnosis was: **INTENTIONAL SELF HARM - OTHER DRUG/S**

The following treatment was given:	**None**
At the conclusion of treatment the patient was:	**DISCHARGED**
Follow-up:	**DISCHARGED**
Additional information:	**Intentional overdose with x 14 400mg ibuprofen while intoxivcated/drunk. No other drugs taken. OE clearly drunk, no other concerns/symptoms. Explains feels empty and wants to be with dead father. No ongoing specific intentions of self-harm. Left dept before being given advice re mood/depression.**

Yours sincerely,

CHRISTOPHER KENNEDY

EMERGENCY DEPARTMENT DOCTOR

HOSPITAL INFORMATION MISSING



Dr ALBERT BURTON
WOODSIDE HEALTH CENTRE
BARR STREET GLASGOW

G20 7LR

Date : 24 Aug 2011

Dear Dr ALBERT BURTON,

Re: WENDY MCLEISH, 0/1 51 COXTON PLACE, GLASGOW, G33 5EJ
Date of Birth: 25/05/1987 CHI number: 2505876061

HOSPITAL INFORMATION MISSING Patient attended on the 24 Aug 2011.

The presenting complaint was: **OVERDOSE**

Triage information: **ALLEGED OD OF ? 7X FLUOXETINE. ? WHAT TIME. PATIENT HAS BEEN DRINKING, STATES 2X BTL LAMBRINI. HX DEPRESSION, RECENT DEATH OF FATHER. TEARFULL AT TRIAGE. GCS 14.**

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

The A&E diagnosis was: **ALCOHOL RELATED PROBLEMS - OTHER ALCOHOL RELATED PROBLEM-SPECIFY IN G P LETTER**

None

The following treatment was given:	
At the conclusion of treatment the patient was:	**DISCHARGED**
Follow-up:	**DISCHARGED**
Additional information:	**Fluoxetine overdose This lady took overdose of Fluoxetine 160mg at 2am this morning along with 2 Lambirinis. She had complex family and childhood issues which has forced her to do so. She was regratful at the end and affirmed that she will not do it again. No clinical complaints. Not suicidal, regratful. OE GCS 15/15, orientred alert. Clear chest. S1+S2+0. Soft abdomen. Normal LFTs, FBC, UEs, CRP Paracetamol levels <15, Salicylates <50. She had no harmful intent. After discussion with middle grade, she was discharged home in company of her friend. She was instructed to see GP in next 2-3 days. She promised to do so today. She may need referral to CPN.**

Yours sincerely,

FAISAL MAHMOOD

EMERGENCY DEPARTMENT DOCTOR

HOSPITAL INFORMATION MISSING



Dr ALBERT BURTON
WOODSIDE HEALTH CENTRE
BARR STREET GLASGOW

G20 7LR

Date : 06 Aug 2011

Dear Dr ALBERT BURTON,

Re: WENDY MCLEISH, 0/1 51 COXTON PLACE, GLASGOW, G33 5EJ
Date of Birth: 25/05/1987 CHI number: 2505876061

HOSPITAL INFORMATION MISSING Patient attended on the 06 Aug 2011.

The presenting complaint was: **FALL HEAD INJURY**

Triage information: **PT LEFT FROM TRIAGE**

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

The A&E diagnosis was: **NONE ASSIGNED IN EDIS**

The following treatment was given: **None**

At the conclusion of treatment the patient was: **PATIENT LEFT BEFORE ASSESSMENT COMPLETE**

Follow-up: **NOT KNOWN**

Additional information: **None**

Yours sincerely,

NONE ASSIGNED IN EDIS

NONE ASSIGNED IN EDIS

HOSPITAL INFORMATION MISSING



Dr ALBERT BURTON
WOODSIDE HEALTH CENTRE
BARR STREET GLASGOW

G20 7LR

Date : 29 Jun 2011

Dear Dr ALBERT BURTON,

Re: WENDY MCLEISH, 0/1 51 COXTON PLACE, GLASGOW, G33 5EJ
Date of Birth: 25/05/1987 CHI number: 2505876061

HOSPITAL INFORMATION MISSING Patient attended on the 29 Jun 2011.

The presenting complaint was:	**RIB INJ**
Triage information:	**PT C/O LSIDED RIB PAIN WHICH PT HAS HAD FOR 8/7. TONIGHT PT STATES THAT SHE SNEEZED AND HAS BEEN SORE SINCE. PT HAS BEEN DRINKING ALCOHOL TONIGHT AND HAS TAKEN BLUES. NO SOB. NO CHEST PAIN. NO BACK PAIN**
The following investigations were carried out:	**None**
The A&E diagnosis was:	**** INJURY- NOT ASSAULT** - MUSCLE INJURY - OTHER-SPECIFY IN G P LETTER**

The following treatment was given:	**None**
At the conclusion of treatment the patient was:	**DISCHARGED**
Follow-up:	**DISCHARGED**
Additional information:	**Left muscular chest wall injury 8 days ago, aggrivated when sneezed today.**

Yours sincerely,

CIARA DOHERTY

EMERGENCY MED. MIDDLE GRADE

Department of Trauma & Orthopaedics
Glasgow Royal Infirmary
84 Castle Street
Glasgow
G4 0SF

NHS
Greater Glasgow and Clyde

Virtual Clinic Tel: 0141 201 6416
Virtual Clinic Fax: 0141 211 4060

Clinic Date: 29/01/2024
Typed: 29/01/2024

VIRTUAL TRIAGE ASSESSMENT

Dear Dr Morris,

Re: Miss Wendy McLeish 25/05/1987; CHI: 2505876061; CRN:2505876061; Flat 3/2 312 Cumbernauld Rd Glasgow Lanarkshire G31 3LY

Your patient was recently followed up at the Virtual Fracture Clinic at Glasgow Royal Infirmary and the following details were recorded:

Patient Assessment I

Bodily site:	Ankle, As follows: tillaux #
Laterality:	Right
Injury Type:	Fracture
Management plan:	Fracture clinic

Patient Assessment II

Patient contacted:	Phone
Site:	GRI
Outcome:	# Clinic - Monday (Foot and ankle)
Consultant:	Jane Madeley

Patient Assessment III

Patient Called Helpline:	No
Outcome of Helpline:	
Nurses notes:	: 29/01/2024 09:38 Kathryn Hyndman advised of cons r/v as above boot wearing advice given together with elevation appt given for foot and ankle cl 1/52 5/2/24 TTBC

NB Discharged patients will receive a separate letter with advice on how to manage their injury.

Yours sincerely

The Orthopaedic Department
Glasgow Royal Infirmary
www.nhsggc.org.uk/orthopaedics

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Dr. MM Morris
Meadowpark Surgery
568 Alexandra Parade
Glasgow
G31 3BP

Main Switchboard: 0141 211 4000
Department: Respiratory Medicine
Contact Tel: 0141 451 5366
Enquiries to: lindsay.fraser2@nhs.scot
Letter Date: 04/02/2025
Reference: AW/LMF
Dictated Date: 31/01/2025
Transcribed Date: 31/01/2025

Dear Dr Morris,

Wendy McLeish; D.O.B: 25/05/1987; CHI: 2505876061
FLAT 3/2, 312 CUMBERNAULD RD, Glasgow, Lanarkshire, G31 3LY

The above patient has now had her CTPA. There is no pulmonary emboli. There is however changes in keeping with right sided heart failure. I have already referred her to the Golden Jubilee.

Yours sincerely

Dr Angela Wright
Consultant in Respiratory Medicine

Electronically Signed: Dr Angela Wright, Consultant

cc.

MB/VF

Date dictated: 30 January 2025
Date typed: 3 February 2025

Dr Angela Wright
Consultant Respiratory Physician
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

SCOTTISH PULMONARY VASCULAR UNIT

Dear Angela

Patient Name: Wendy McLeish **CHI:** 2505876061 **DOB:** 25/05/1987
Patient Address: 0/2 312 Cumbernauld Road, Glasgow, G31 3LY

Wendy has now had her CTPA and we reviewed this at the SPVU MDT today. We noted that there was a probable ASD on the CTPA and this would fit with her echocardiogram suggesting a volume rather than pressure overloaded RV.

We will arrange to see her in our clinic and do a more detailed echo study and can then refer her on to our colleagues in the Adult Congenital Service.

Yours sincerely

Dr Melanie Brewis
Consultant Pulmonary Vascular Physician
SCOTTISH PULMONARY VASCULAR UNIT

CC
(D) Dr MM Morris, Meadowpark Surgery, 568 Alexandra Parade, Glasgow, G31 3BP
Authorised on 05/02/2025 11:30:55 by Dr Melanie Brewis.

Dr Martin Johnson
Director

Dr Colin Church
Dr Mel Brewis
SPVU Consultants

Dr Mike Sproule
Dr Simon Sheridan
Consultant Radiologists

Dr Christopher Rush
Consultant Cardiologist

Dr Stephanie Lua
Dr Jamie Ingram
Dr Will Kerrigan
Pulmonary Vascular Fellows

Dr David Welsh
Research Scientist

Miss Emma Russell
Clinical Pharmacist

Dr Klaudia Suchorab
Principal Clinical Psychologist

Mrs Agnes Crozier
Mr Jim Mearns
Mr Andy Kerr
Mrs Sarah Cooper
Clinical Nurse Specialists

Mrs Val Irvine
Research Nurse Manager

Mrs Fiona Thompson
Joyce Thompson
Mrs Christina Kay
Senior Research Nurses

Ms Veronica Ferry
Mrs Kirsty Menzies
Medical Secretaries

Mr Jay Thaker
Data Manager

Mrs Kimberley Gonzalez
Waitlist Coordinator

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000
Department: Orthopaedics
Contact Tel: 0141 201 3105/201 3114
Enquiries to:

Dr. MM Morris
Meadowpark Surgery
568 Alexandra Parade
Glasgow
G31 3BP

Letter Date: 28/03/2024
Reference: NJM/LMC
Dictated Date: 25/03/2024
Transcribed Date: 25/03/2024

Dear Dr Morris,

Wendy McLeish; D.O.B: 25/05/1987; CHI: 2505876061
FLAT 3/2, 312 CUMBERNAULD RD, Glasgow, Lanarkshire, G31 3LY

This lady had a tillaux fracture of her right ankle in January. Check x-rays today show no further displacement but the fracture is still visible..

On clinical review she has global tenderness round the ankle but no significant swelling today. She is not tender over the syndesmosis or the fragment itself. She does get a lot of current pain issues secondary to sciatica for which she takes gabapentin. At this point we will continue to help her with rehabilitation and I have made a referral for physiotherapy. We will review her back in a further couple of months with fresh x-rays on arrival.

Yours Sincerely

Miss N Jane Madeley F.R.C.S (Tr&Orth)

Consultant Orthopaedic Surgeon

foot.ankle@ggc.scot.nhs.uk

www.nhsggc.org.uk/orthopaedics

Electronically Signed: Miss Nicola Jane Madeley, Consultant

cc.

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000
Department: Orthopaedics
Contact Tel: 0141 201 3105/201 3114
Enquiries to:

Dr. MM Morris
Meadowpark Surgery
568 Alexandra Parade
Glasgow
G31 3BP

Letter Date: 28/02/2024
Reference: NS/LMC
Dictated Date: 26/02/2024
Transcribed Date: 26/02/2024

Dear Dr Morris,

Wendy McLeish; D.O.B: 25/05/1987; CHI: 2505876061
FLAT 3/2, 312 CUMBERNAULD RD, Glasgow, Lanarkshire, G31 3LY

Diagnosis: Tillaux fracture right ankle

Management: conservative

Outcome: review in 6 weeks with x-ray on arrival

I have reviewed this 36-year-old lady in clinic today. She had a fall on the 20th of January and sustained a Tillaux fracture which has been treated conservatively.

She is still complaining of pain although her ankle is getting better.

X-rays show that the fragment has not displaced and that the syndesmosis has not widened.

I have asked her to continue with the boot for another two weeks and then to wean herself out of the boot. I have also given her foot and ankle exercise sheet with an exercises programme to follow.

We will see her in 6 weeks' time for a further review.

Yours Sincerely,

Nadia Scibarras,

Orthopaedic Registrar

www.nhsggc.scot/orthopaedicsgri

Electronically Signed: Dr Nadia Sciberras, Doctor

cc.

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000
Department: Orthopaedics
Contact Tel: 0141 201 3719
Enquiries to:

Letter Date: 08/02/2024
Reference: TA/AMMCK
Dictated Date: 05/02/2024
Transcribed Date: 05/02/2024

Dr. MM Morris
Meadowpark Surgery
568 Alexandra Parade
Glasgow
G31 3BP

Dear Dr Morris,

Wendy McLeish; D.O.B: 25/05/1987; CHI: 2505876061
FLAT 3/2, 312 CUMBERNAULD RD, Glasgow, Lanarkshire, G31 3LY

Diagnosis: Tillaux fracture on the right ankle

Management: Conservative

Outcome: Review in the clinic in three weeks with x-ray on arrival

I reviewed this 36 year old lady in the clinic today. She had a fall on 28 January and she sustained a minimally displaced **Tillaux** fracture in the right ankle. It was isolated, closed and neurovascularly intact injury.

Today she is still complaining of pain in her ankle but it is getting better. She does not have any other complaints. She was in a boot and we sent her for an x-ray.

The x-ray did not show any displacement on the fracture and therefore we are going to continue with conservative management.

I advised the patient that she can mobilise now as her pain allows and we will see her in three weeks in the clinic with x-ray on arrival. She is happy with this plan and she has our number if she has any problems before then.

Yours sincerely

Tariq Altell

Clinical Fellow

www.nhsggc.scot./orthopaedicsgri

Electronically Signed: Dr Tareq Altell, Doctor

cc.

Respiratory Medicine
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

04/11/2022

Dr S Broadley
Meadowpark Surgery
568 Alexandra Parade
Glasgow
G31 3BP

Dear Dr S Broadley
CHI Number: 2505876061
Patient Name: Wendy McLeish
Referral Date: 04/11/2022

Advice Response to recent Referral:

Thank you for your letter about this patient.

I can see that she is already on the waiting list for a respiratory appointment. As a 35 year old non smoker (smoking status not entirely clear from SCI Gateway referral) her overall risk of lung cancer is low and the CXR does suggest improvement a 5 weeks after the first one, so I would suggest in the interim period before her clinic appointment that you organise a further CXR in about 4-6 weeks.

Kind regards

Yours Sincerely

Dr Brian Choo-Kang

User ID: Brian Choo-Kang

OP Advice Letter

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000
Department: Respiratory Medicine
Contact Tel: 0141 201 3831
Enquiries to: Dr Bayes' Secretary

Dr. MM Morris
Meadowpark Surgery
568 Alexandra Parade
Glasgow
G31 3BP

Letter Date: 28/10/2022
Reference: HB/MAC
Dictated Date: 14/10/2022
Transcribed Date: 14/10/2022

Dear Dr Morris ,

Wendy McLeish; D.O.B: 25/05/1987; CHI: 2505876061
FLAT 3-2, 312 CUMBERNAULD RD, Glasgow, Lanarkshire, G31 3LY

Thank you for your referral regarding the above 35 year old lady with cough and recent lower respiratory tract infections/pneumonia on chest x-ray. I have organised for her to be reviewed at the Respiratory Clinic but it is likely that this represents post infective cough. It would be worthwhile doing an updated chest x-ray at 4-6 weeks to ensure resolution of the changes at her left base. This was the suggestion in the report and you may already have this in hand. I will leave this with you and obviously if there is any concern on the repeat chest x-ray, please do not hesitate to contact us.

Yours sincerely

DR HANNAH BAYES

Consultant Respiratory Physician

Electronically Signed: Dr Hannah Bayes, Consultant

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

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

Dr. M Lyons
Meadowpark Surgery
Parkhead Hub
1251 Duke Street
Glasgow
G31 5NZ

Main Switchboard:	0141 211 4000
Department:	Respiratory Medicine
Contact Tel:	0141 451 5366
Enquiries to:	lindsay.fraser2@nhs.scot
Letter Date:	11/03/2026
Reference:	EP/LMF
Dictated Date:	11/03/2026
Transcribed Date:	20/03/2026

Dear Dr. M Lyons,

Wendy McLeish; D.O.B: 25 May 1987; CHI: 2505876061
0/1, 257 TODD STREET, Glasgow, Lanarkshire, G31 3SF

Attendance: Specialty - Respiratory Medicine; Clinic - GRAWRE5-DR A WRIGHT RESP WED AM
Date and Time of Appointment - 11/03/2026 11:30

Follow Up: None- discharged

Clinical Comments:
Diagnoses:
1. Previous ECMO for respiratory failure secondary to severe pneumonia
2. New finding of small ASD, currently awaiting dental work prior to closure by Golden Jubilee
3. Possible epilepsy
4. Cognitive changes following ECMO – under neurology follow up

Wendy was originally referred to our service with exertional breathlessness. Further investigation with TTE showed RV overload: CTPA revealed no PE but a small ASD, for which she is now under the Golden Jubilee.

Today she was accompanied by her cousin. She tells me that her exertional breathlessness has been stable since we last saw her.

However, the last few weeks have been difficult for her. She describes a persistent feeling in her right chest, described as 'bubbling' or a 'wheeze that I can feel'. These sensations have been constant, and she has been more breathless than normal. Feeling feverish, with green productive cough, and reduced appetite. No pain, presyncope or syncope. She is feeling unwell enough that her cousin has moved in with her over the last few weeks, although this is partly due to relationship difficulties that they are both experiencing. She has not left the house during this period, and thinks there is an

element of anxiety with this. She called an ambulance last week, who she felt dismissed her, and said 'there was nothing wrong'.

On examination she looked well, comfortable at rest, lungs were clear, warm and well perfused with no oedema. Saturations 96% on air, heart rate 54 bpm and BP 109/63.

I have updated bloods today including chest x-ray which I will comment on when signing off this letter. I have issued her with a prescription for 500 mg of Amoxicillin TDS for five days to cover a possible chest infection.

Her case was discussed with Dr Wright today and we are happy to discharge her from the Respiratory Clinic given her ongoing follow up with the Golden Jubilee. Should she have further difficulty of a respiratory nature we would of course be happy to see her back.

Yours sincerely

Dr Eleanor Parkhill

IMT3 in Respiratory Medicine

26/03 - bloods from clinic were normal (FBC, UEs, LFTs, CRP). CXR NAD.

Electronically Signed: Dr Eleanor Parkhill, Doctor

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

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

Dr. M Lyons
Meadowpark Surgery
Parkhead Hub
1251 Duke Street
Glasgow
G31 5NZ

Main Switchboard: 0141 211 4000
Department: Respiratory Medicine
Contact Tel: 0141 451 5366
Enquiries to: lindsay.fraser2@nhs.scot
Letter Date: 28/01/2026
Reference: AW/LMF
Dictated Date: 28/01/2026
Transcribed Date: 30/01/2026

Dear Dr. M Lyons,

Wendy McLeish; D.O.B: 25 May 1987; CHI: 2505876061
0/1, 257 TODD STREET, Glasgow, Lanarkshire, G31 3SF

Attendance: Specialty - Respiratory Medicine; Clinic - GRAWRE5-DR A WRIGHT RESP WED AM
Date and Time of Appointment - 28/01/2026 11:30

Follow Up: Respiratory Clinic Dr Wright 11/3/26 at 11.30 am

Clinical Comments:
The above patient failed to attend a return appointment on 28 January 2026. A further appointment will be sent in due course.

Yours sincerely

Dr Angela Wright

Consultant in Respiratory Medicine

Electronically Signed: Dr Angela Wright, Consultant

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

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

Dr. M Lyons
Meadowpark Surgery
Parkhead Hub
1251 Duke Street
Glasgow
G31 5NZ

Main Switchboard: 0141 211 4000
Department: Respiratory Medicine
Contact Tel: 0141 451 5366
Enquiries to: lindsay.fraser2@nhs.scot
Letter Date: 20/08/2025
Reference: AW/LMF
Dictated Date: 20/08/2025
Transcribed Date: 21/08/2025

Dear Dr. M Lyons,

Wendy McLeish; D.O.B: 25 May 1987; CHI: 2505876061
FLAT 3/2, 312 CUMBERNAULD RD, Glasgow, Lanarkshire, G31 3LY

Attendance: Specialty - Respiratory Medicine; Clinic - GRAWRE5-DR A WRIGHT RESP WED AM
Date and Time of Appointment - 20/08/2025 11:10

Follow Up: Respiratory Clinic Dr Wright 25/2/26 at 9.30 am

Clinical Comments:
Diagnoses:

1. Previous ECMO for respiratory failure secondary to pneumonia
2. Small ASD – has been referred to cardiology services at the golden Jubilee

The above patient had a return appointment on 20 August 2025. She is actually doing well from a chest point of view and as you will be aware from previous correspondence has been diagnosed with a small ASD. She has been referred for closure. I will therefore send out an appointment to come and see me in the New Year.

Yours sincerely

Dr Angela Wright

Consultant in Respiratory Medicine

Electronically Signed: Dr Angela Wright, Consultant

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

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

Dr. MM Morris
Meadowpark Surgery
568 Alexandra Parade
Glasgow
G31 3BP

Main Switchboard:	
Department:	Respiratory Department
Contact Tel:	0141 451 5366
Enquiries to:	lindsay.fraser@ggc.scot.nhs.uk
Letter Date:	04/12/2024
Reference:	AW/RS
Dictated Date:	04/12/2024
Transcribed Date:	04/12/2024

Dear Dr. MM Morris,

Wendy McLeish; D.O.B: 25 May 1987; CHI: 2505876061
FLAT 3/2, 312 CUMBERNAULD RD, Glasgow, Lanarkshire, G31 3LY

Attendance: Specialty - Respiratory Medicine; Clinic - GRAWRE5-DR A WRIGHT RESP WED AM
Date and Time of Appointment - 04/12/2024 11:00

Follow Up: Dr Wright's Clinic 7th May 2025

Clinical Comments:
Diagnosis:

1. Previous ECMO for respiratory failure

2. Patient reports breathlessness on exertion – no desaturation on 6 minute walk test

3. Both Echo and HRCT scan are suggestive of PH

Plan from clinic:

1. CTPA - requested

2. Referral to SVPU Unit - dictated

I reviewed Wendy in my respiratory clinic on 4th December 2024. Since I last saw her she has had an Echo and 6 minute walk test.

These show she does not desaturate but again there is a suggestion of PH.

I explained this to Wendy today and subsequently booked a CTPA. I will also ask for some advice from our colleagues at the Golden Jubilee National Hospital SVPU.

I have updated her blood tests today.

In clinic she appeared a little bit shaky but respiratory examination was normal.

Yours sincerely

Dr A Wright

Consultant in Respiratory Medicine

Electronically Signed: Dr Angela Wright, Consultant

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

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

Dr. MM Morris
Meadowpark Surgery
568 Alexandra Parade
Glasgow
G31 3BP

Main Switchboard: 0141 211 4000
Department: Respiratory Medicine
Contact Tel: 0141 451 5366
Enquiries to: lindsay.fraser@ggc.scot.nhs.uk
Letter Date: 29/05/2024
Reference: AW/LMF
Dictated Date: 29/05/2024
Transcribed Date: 29/05/2024

Dear Dr. MM Morris,

Wendy McLeish; D.O.B: 25 May 1987; CHI: 2505876061
FLAT 3/2, 312 CUMBERNAULD RD, Glasgow, Lanarkshire, G31 3LY

Attendance: Specialty - Respiratory Medicine; Clinic - GRAWRE5-DR A WRIGHT RESP WED AM
Date and Time of Appointment - 29/05/2024 10:00

Follow Up: Respiratory Clinic Dr Wright 4/12/24 at 11 am

Clinical Comments:
Diagnoses:

1. Previous ECMO for respiratory failure due to pneumonia
2. Recent CT scan showed no established parenchymal lung disease

Plan from clinic:

1. Six minute walk test
2. Spirometry
3. Echo to assess for pulmonary hypertension

The above patient attended for a face to face return appointment today. Wendy reports really quite severe breathlessness in that if she walks from the toilet to the living room she is very short of breath. This level of symptom burden is obviously not in keeping with her previous results.

We will get the above investigations carried out and take things from there.

Yours sincerely

Dr Angela Wright

Consultant in Respiratory Medicine

Electronically Signed: Dr Angela Wright, Consultant

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

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

Dr. MM Morris
Meadowpark Surgery
568 Alexandra Parade
Glasgow
G31 3BP

Main Switchboard: 0141 211 4000
Department: Respiratory Medicine
Contact Tel: 0141 201 3831
Enquiries to: Fiona.maclellan@ggc.scot.nhs.uk
Letter Date: 19/07/2023
Reference: MA/CH
Dictated Date: 19/07/2023
Transcribed Date: 19/07/2023

Dear Dr. MM Morris,

Wendy McLeish; D.O.B: 25 May 1987; CHI: 2505876061
FLAT 3/2, 312 CUMBERNAULD RD, Glasgow, Lanarkshire, G31 3LY

Attendance: Specialty - Respiratory Medicine; Clinic - GRAWRE5-DR A WRIGHT RESP WED AM
Date and Time of Appointment - 19/07/2023 09:20

Requested Out-patient Investigations:
HRCT

Follow Up: Interval HRCT

Clinical Comments:
Diagnosis:

1. Previous intubation and ventilation and ECMO for severe pneumonia 2011

2. Non smoker

Plan:

1. Repeat HRCT - requested.

I reviewed Ms McLeish over the telephone on behalf of Dr Wright today. She reports a difficult few months with an inpatient stay in March of this year for ataxia. From a breathlessness point of view things are fairly static. She remains significantly breathless on moderate exertion but does not feel this has changed significantly over the past few months, if not years. She also reports an ongoing productive cough of white sputum which she says is new from her admission in March, but on

previous review she has been reporting this since October of last year. She has had multiple previous courses of antibiotics for this which have done minimal to help.

A HRCT done earlier this year demonstrated some traction bronchiectasis secondary to her previous severe pneumonia. There was some associated ground glass opacities which were suggestive of intercurrent infection and we have therefore arranged an interval HRCT to assess whether these changes have resolved. She also undertook PFTs in April, however, the results are non diagnostic due to inadequate effort so I have left her inhaled therapy unchanged. As things are static we will review Ms McLeish in 6 months time following the results of her interval HRCT.

Yours sincerely

Dr Mark Andonovic

ST5

Electronically Signed: Dr Mark Andonovic, Doctor

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Plastic Surgery Unit
84 Castle Street
Glasgow
G4 0SF
0141 211 4000

Dr. MM Morris
Meadowpark Surgery
568 Alexandra Parade
Glasgow
G31 3BP

Main Switchboard:	0141 211 4000
Department:	Plastic Surgery
Contact Tel:	0141 201 6394
Enquiries to:	Dionne.McLeod@ggc.scot.nhs.uk
Letter Date:	27/06/2023
Reference:	DM/BB
Dictated Date:	27/06/2023
Transcribed Date:	04/07/2023

Dear Dr. MM Morris,

Wendy McLeish; D.O.B: 25 May 1987; CHI: 2505876061
FLAT 3/2, 312 CUMBERNAULD RD, Glasgow, Lanarkshire, G31 3LY

Attendance: Specialty - Plastic Surgery; Clinic - GRGPCPS3-GENERIC PLASTICS CONS TUES AM
Date and Time of Appointment - 27/06/2023 08:50

Clinical Comments:
Diagnosis: resolved lesion right nasal side wall.

Plan: discharge.

I met with this lady in clinic today. She was referred in 2022 with a lesion on her right nasal side wall suspicious of a basal cell carcinoma. Photographs then show a clear lesion present. On review today, this has now resolved, leaving only a mild area of erythema. There was no raised or rolled edge presence and no clinical evidence of BCC or skin malignancy. Therefore reassured that she doesn't require any treatment. I've taken a further photograph to record the improvement and discharged her from the clinic. I've asked her to return to see yourself if the lesion recurs.

Kind regards,

Yours sincerely,

Mr David McGill

Consultant Plastic Surgeon

Electronically Signed: Mr David McGill, Consultant

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Plastic Surgery Unit
84 Castle Street
Glasgow
G4 0SF
0141 211 4000

Dr. MM Morris
Meadowpark Surgery
568 Alexandra Parade
Glasgow
G31 3BP

Main Switchboard:	0141 211 4000
Department:	Plastic Surgery Unit
Contact Tel:	0141 201 6394
Enquiries to:	dionne.macleod@ggc.scot.nhs.uk
Letter Date:	14/03/2023
Reference:	NF/PL
Dictated Date:	24/03/2023
Transcribed Date:	14/03/2023

Dear Dr. MM Morris,

Wendy McLeish; D.O.B: 25 May 1987; CHI: 2505876061
FLAT 3/2, 312 CUMBERNAULD RD, Glasgow, Lanarkshire, G31 3LY

Attendance: Specialty - Plastic Surgery; Clinic - GRGPCPS3-GENERIC PLASTICS CONS TUES AM
Date and Time of Appointment - 14/03/2023 09:50

Clinical Comments:
This lady has failed to turn up in the Plastic Surgery Clinic on two occasions regarding the referral for the lesion on her nose.

No further appointments have been sent but the patient has been written to directly to inform of the potential concerns of a skin cancer.

She has been advised to seek medical advice accordingly.

Yours sincerely

John Scott

Consultant Plastic Surgeon

Electronically Signed: Mr John Scott, Consultant

cc.

Clinic Letter

NHS Greater Glasgow and Clyde

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

Dr. MM Morris
Meadowpark Surgery
568 Alexandra Parade
Glasgow
G31 3BP

Main Switchboard:	
Department:	Respiratory Medicine
Contact Tel:	0141 201 3831
Enquiries to:	Fiona.maclellan@ggc.scot.nhs.uk
Letter Date:	18/01/2023
Reference:	AW/LMF
Dictated Date:	24/01/2023
Transcribed Date:	24/01/2023

Dear Dr. MM Morris,

Wendy McLeish; D.O.B: 25 May 1987; CHI: 2505876061
FLAT 3/2, 312 CUMBERNAULD RD, Glasgow, Lanarkshire, G31 3LY

Attendance: Specialty - Respiratory Medicine; Clinic - GRAWRE5-DR A WRIGHT RESP WED AM
Date and Time of Appointment - 18/01/2023 09:00

Requested Out-patient Investigations:
HRCT

Follow Up: Respiratory Clinic Dr Wright 19 July 2023 at 9.20 am

Clinical Comments:
Diagnoses:

1. Previous intubation and ventilation and ECMO for severe pneumonia
2. Non-smoker

Plan from Clinic:

1. HRCT scan – requested
2. PFT's

Thank you for referring the above patient who I reviewed face to face on 18 January 2023. Apologies that the letter was not dictated at the time of clinic.

As you will be aware Wendy has a severe respiratory history in that about ten years ago she was intubated and ventilated due to severe type 1 respiratory failure secondary to a pneumonia. She was actually transferred to Leicester where she had ECMO.

Over the years Wendy has not been largely troubled by her chest however she now is. In October she had treatment for pneumonia and she feels that since then she has just been troubled by ongoing cough and sputum. She has had four sources of antibiotics for this. I cannot see any recent sputum samples.

She also feels very breathless doing any sort of walking, however on better days can get out to the shops. She is able to sleep through the night and does not have any nocturnal symptoms.

As a teenager she had the odd cigarette, however was not a smoker. She does not vape or use any e-cigarettes. She does not have any pets and is allergic to cats. She has hay fever.

In clinic she was comfortable at rest, there was no finger clubbing. Auscultation did reveal some creps and I wonder whether or not her previously severe pneumonia has resulted in some bronchiectasis. I have therefore booked an HRCT scan and we are still awaiting PFT's.

Wendy would like me to clarify that she has never been a regular smoker. The referral does point towards a smoking history however she says that she said she only ever had the odd cigarette as a teenager.

Yours sincerely

Angela Wright

Consultant Respiratory Physician

Electronically Signed: Dr Angela Wright, Consultant

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Plastic Surgery Unit
84 Castle Street
Glasgow
G4 0SF
0141 211 4000

Dr. MM Morris
Meadowpark Surgery
568 Alexandra Parade
Glasgow
G31 3BP

Main Switchboard:	0141 211 4000
Department:	Plastic Surgery Unit
Contact Tel:	0141 201 6405
Enquiries to:	Sheryl.Noble@ggc.scot.nhs.uk
Letter Date:	13/12/2022
Reference:	NF/MG
Dictated Date:	13/12/2022
Transcribed Date:	20/01/2023

Dear Dr. MM Morris,

Wendy McLeish; D.O.B: 25 May 1987; CHI: 2505876061
FLAT 3/2, 312 CUMBERNAULD RD, Glasgow, Lanarkshire, G31 3LY

Attendance: Specialty - Plastic Surgery; Clinic - GRGPCPS3-GENERIC PLASTICS CONS TUES AM
Date and Time of Appointment - 13/12/2022 08:30

Clinical Comments:
Diagnosis: Suspicious lesion side of nose.

Wendy McLeish was scheduled to be seen in the See & Treat Clinic at Glasgow Royal Infirmary today regarding her crusted lesion on the side of her nose. She did not attend this appointment. We will send her one further appointment.

Yours sincerely

Mr Neil Fairbairn

Consultant Plastic Surgeon

Electronically Signed: Mr Neil Fairbairn, Consultant

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000
Department: Podiatry
Contact Tel: 0141 347 8909
Enquiries to:

Letter Date: 08/07/2021
Reference:
Dictated Date: 08/07/2021
Transcribed Date: 08/07/2021

Dr. MM Morris
Meadowpark Surgery
568 Alexandra Parade
Glasgow
G31 3BP

Dear Dr. MM Morris,

Wendy McLeish; D.O.B: 25 May 1987; CHI: 2505876061
FLAT 3-2, 312 CUMBERNAULD RD, Glasgow, Lanarkshire, G31 3LY

Attendance: Specialty - Podiatry; Clinic - SHP4R17-GENERAL PODIATRY 4 THURSDAY AM
Date and Time of Appointment - 08/07/2021 10:15

Clinical Comments:
Telephone appointment S: Patient contacted due to painful corns O: Patient states she has corns between her toes and on the sole of her feet which are painful. She has used plasters which have not helped. She states one of her toe nails fell off a year ago and is growing back and there is some redness around the nail, no signs of infection. A: Expalined to patient the nail may grow back in a different shape or thickness so advsied to clear the sulcus with a soft brush as there may be a tightness in the sulcus, advised to file nail to maintain. Explained current service delivery and that we could not see her for corns at this time. Advised patient I would add her to the waiting list but it may be a number of months before she is appointed. Advsied she could go privately for treatment, file callus and apply emollient. Expalined the corns between her toes are likely caused by footwear advised wider toe box and suggetsed gel pads between toes. Advised to call back if she has further concerns. P: Added to routine waiting list for painful lesions E: Routine need R: When routine clinics resume Rebecca Smtih (Poditrist)

Electronically Signed:

cc.

GLASGOW ROYAL INFIRMARY
Queen Elizabeth Building
16 Alexandra Parade
Glasgow
G31 2ER

Switchboard: 0141 211 4000
Direct Dial: 0141 211 4381
Fax Number: 0141 211 1120

Contact Email: Lynn.Murray@ggc.scot.nhs.uk

DEPARTMENT OF RESPIRATORY MEDICINE
DR CHALMERS' RESPIRATORY CLINIC – 26th March 2012

Dr Marie Wilson
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

ES/LM

Dict: 26/03/2012
Typed: 30/03/2012

Dear Dr Wilson

Wendy McLeish ~ 25/05/1987 ~ CHI: 2505876061 ~ CRN: 23123532V
0/1 51 Coxton Place, Glasgow, G33 5EJ

Problems:

1. Right upper lobe pneumonia requiring ITU admission and transfer to Leicester for ECMO
2. Anxiety
3. Tremor
4. Previous drug overdose

I reviewed this 24 year old lady in Dr Chalmers clinic on 26.3.2012.

She had a prolonged admission from November 2011 to January 2012 with a severe right upper lobe pneumonia requiring admission to Intensive Care. She continued to deteriorate during her ITU admission and required to be transferred to Leicester for VV ECMO before finally being transferred back to Glasgow Royal Infirmary on 20th December 2011. There was also the time during Miss McLeish's prolonged admission for her to be seen our colleagues in Neurology regarding her long standing tremor. Overall Miss McLeish feels greatly improved since discharge and is eating and drinking normally. Her weight has returned to normal.

On examination she appeared anxious but well and oxygen saturations were 99% on air. The chest was clear to auscultation. Chest x-ray performed in clinic showed no focal consolidation and I have not made her any further appointments at the Respiratory Clinic.

Kind regards.

Yours Sincerely

Dr Eliana Saffouri
ST4

Acute Services Division

Emergency Care and
Medical Services Directorate

NHS
Greater Glasgow and Clyde

Royal Infirmary
16 Alexandra Parade
Glasgow
G31 2ER

NEUROLOGY DEPARTMENT
DR P SHAH
CONSULTANT NEUROLOGIST
TELEPHONE: 0141 211 4481

Dictated 19/03/2012
Typed 28/03/2012
Our Ref PS/AC

Dr R Madhok
Consultant Rheumatologist
Centre for Rheumatic Diseases
Ward 15
Glasgow Royal Infirmary

Dear Dr Madhok

Wendy McLeish - 25/05/1987 - CHI: 2505876061 - CRN: 23123532V
0/1 51 Coxton Place, Glasgow, G33 5EJ

Many thanks for your referral. I reviewed this lady in the Neurology Outpatient Clinic she was accompanied by her support worker, Jackie Robertson.

She is 24 years old, right handed single lady who is currently is unemployed and lives with her boyfriend.

She was admitted with pneumonia recently and had to be managed in ITU and was transferred to the Lister for further specialist treatment. She was ventilated for four weeks and since her discharge from hospital has been finding her whole body quite shaky and some times her legs or hands shake. Where the cannulation scar is on her left thigh she feels some tightness when walking and her legs can feel weak. Her support worker has noticed that she becomes shaky when she is nervous or trying to concentrate. She has previously been shaky prior to her recent illness but again this was in certain situations or when she would be nervous rather than all the time.

Her current treatment is Propranolol, Fluoxetine and Cilest oral contraceptive pill.

She has hay fever but otherwise did not report other allergies.

She has been depressed for about a year or so and tried to take her life a couple of times. This started when her dad died. Her support worker suggested that her depression is perhaps better though not fully controlled.

Wendy McLeish - 25/05/1987 - CHI: 2505876061 - CRN: 23123532V
0/1 51 Coxton Place, Glasgow, G33 5EJ

She does not smoke but stated that she drinks alcohol more than recommend. She herself does not feel that this is a problem but stated that she can often drink when she is alone or bored.

On examination today, her eye movements were normal. Fundi were normal. There was no facial or bulbar weakness. Tone and power across the extremities were normal. Deep tendon reflexes were symmetrical and normal. She had normal pinprick and vibration sense. Her gait was normal and tandem walking was intact. She was able to walk on her heels, toes and was able to hop.

She also reported that she gets frequency with micturition and can often go to the toilet up to ten times at night but does not pass much urine and only has a few drops dribbling. She thought if she can sleep then she may not go to the toilet but has difficulty getting to sleep and can get maximum four hours sleep on a good day.

She had postural tremors of her out stretched hands which were easily distractible.

Comment

This lady's tremulousness is related to anxiety and depression. She may continue to take the beta blocker for symptomatic relief. She feels quite weak and I have explained that this would not be unusual for someone who has been managed in ITU for a few weeks whereby the muscles can get de-conditioned and it may take her a while to regain her strength. Further input from the physiotherapist may be helpful. She is undergoing treatment for her depression and this will be helpful. Today I have checked her thyroid function tests, full blood count and will forward the results eventually.

I have not arranged further routine follow-up.

Yours sincerely

Pushkar Shah
Consultant Neurologist

GLASGOW ROYAL INFIRMARY
Queen Elizabeth Building
16 Alexandra Parade
Glasgow
G31 2ER

Switchboard: 0141 211 4000
Direct Dial: 0141 211 4381
Fax Number: 0141 211 1120

Contact Email: Lynn.Murray@ggc.scot.nhs.uk

DEPARTMENT OF RESPIRATORY MEDICINE

Consultants: Dr M M Cotton
Dr G W Chalmers
Dr J van der Horst
Dr B Choo-Kang

Dr Marie Wilson
Dr Wilson, Dr McGinley
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

EL/LM

Dict: 13/03/2012
Typed: 13/03/2012

Dear Dr Wilson

Wendy McLeish ~ 25/05/1987 ~ CHI: 2505876061 ~ CRN: 23123532V
0/1 51 Coxton Place, Glasgow, G33 5EJ

Date of admission: 20th November 2011
Date of discharge: 2nd January 2012
Consultant: Dr G W Chalmers

Diagnosis:

1. Right upper lobe pneumonia requiring ITU and transfer to Leicester for ECMO
2. Sepsis
3. Anxiety
4. Tremor

Wendy McLeish was admitted on 20th November 2011 right sided chest pain, shortness of breath, diarrhoea and a cough. On attendance she was hypotensive at 97/59 mmHg and tachycardiac at 107. She was also hypoxic at 93% on air. On examination she had decreased air entry in the right upper zone, scattered right basal crepitations and increased vocal residence at the right mid zone. She remained hypotensive throughout her admission in the Medical Receiving Unit despite aggressive fluid replacement therapy and boluses of Metaraminol. She continued to deteriorate in the Medical Receiving Unit and eventually developed a respiratory rate of 50, saturations in the 80s on 98% oxygen, and as a consequence the Intensive Care Unit Anaesthetists were contacted for review. At this time she was commenced on IV Amoxycillin, Clarithromycin and Augmentin. She was transferred to the Intensive Care Unit on 21st November 2011. She was intubated on 22nd November 2011 for respiratory failure.

According to her ITU notes she progressed in ITU at first with gradual weaning of her Noradrenaline until she deteriorated in respiratory function on 26th November 2011, and continued to have deteriorating respiratory function until the 28th November 2011. As she continued to deteriorate she was transferred to Leicester for VV ECMO through an RIJ line from 30th November 2011 until 7th December 2011. She then went onto CVVH until 9th December 2011 and had a tracheostomy inserted on 2nd December 2011. While at Glenfields in Leicester she had Methyl, Prednisolone and Azithromycin for lung re-modelling, and she was eventually transferred back to Glasgow Royal Infirmary on 20th December 2011. She was catheterised and NG fed. Her tracheostomy was removed on 28th December 2011. She made a satisfactory recovery on the respiratory ward and was seen by a Neurological Consultant, Dr Miller on 30th December 2011 to assess her for her long standing tremor.

Cont/.....

A comprehensive set of tests were requested to investigate her tremor including thyroid function tests which were normal, immunoglobulins which were normal, protein electrophoresis which was normal, copper which was normal, ANCA, complement, rheumatoid factor and auto antibodies were all normal. B12, Folate and Ferritin were normal and her calcium was normal. Mrs McLeish refused a Huntingdon genetics test.

Unfortunately on the 2nd January 2012 Wendy decided to leave the Ward as she was "bored of the depressing Ward". Despite conversations with myself and Dr Wilson she signed the irregular discharge form and discharged herself against medical advice.

Ideally we would like to see her again in the Respiratory Clinic which ideally would have been 4-6 weeks after her discharge, but due to a delay in dictating this letter that has not been offered to her. We will send her an appointment for 1 week's time. She also has outpatient follow up with the Neurologists on 19th March 2012.

Kind regards.

Yours sincerely,

Dr Emily Leadbeater
FY2 in Respiratory Medicine

GLASGOW ROYAL INFIRMARY
Queen Elizabeth Building
16 Alexandra Parade
Glasgow
G31 2ER

Switchboard: 0141 211 4000
Direct Dial: 0141 211 4381
Fax Number: 0141 211 1120

Contact Email: Lynn.Murray@ggc.scot.nhs.uk

DEPARTMENT OF RESPIRATORY MEDICINE

Mrs Wendy McLeish
Flat 0/1
51 Coxton Place
GLASGOW
G33 5EJ

EL/LM

Dict: 13/03/2012
Typed: 13/03/2012

Dear Mrs McLeish,

CHI: 2505876061 ~ CRN: 23123532V

Further to your recent admission to the Respiratory Ward at Glasgow Royal Infirmary an appointment has been made for you to attend Dr Chalmers' Respiratory Clinic on Monday 26th March 2012 at 3:00pm. If this is not suitable can you please contact Dr Chalmers' Secretary on 0141 211 4381 and we can arrange another appointment. An appointment card is enclosed.

Kind regards.

Yours sincerely,

Dr Emily Leadbeater
FY2 in Respiratory Medicine

Encl – appointment card.

GLASGOW ROYAL INFIRMARY UNIVERSITY NHS TRUST TELEPHONE 0141 211 4000
84 CASTLE STREET, GLASGOW G4 0SF
TQ/BM INTENSIVE CARE UNIT Tel: 0141 232 0917 (Direct Line)

ADMITTED 21/11/11 12/12/11	DISCHARGED 30/11/2011 20/12/2011	WARD ICU	AGE 24	HOSPITAL NUMBER 23123532V

DISPOSAL	NAME AND ADDRESS
WARD 7	Wendy McLeish 0/1 51 Coxton Place Glasgow G33 5EJ
FOLLOW UP	CHI NO: 2505876061

FINAL DIAGNOSIS AND ANY OTHER COMPLICATING ILLNESS	ISC CODE	DISTRIBUTION OF LETTERS
		Dr M Wilson, Easterhouse Health Centre, 9 Auchinlea Road, Glasgow, G34 9HQ Dr G Chalmers, Consultant Respiratory Physician, Glasgow Royal Infirmary
1. Community Acquired Pneumonia		
2.		
3.		OPERATION / CODE
4.		1.
5.		2.
6.		3.

Dear Dr Wilson

Wendy was initially admitted to Glasgow Royal Infirmary on the 21st November with a Community Acquired Pneumonia. Despite being intubated, she progressively deteriorated until eventually she was referred to Glenfield in Leicester for ECMO because of difficulties in ventilating her. She remained in Glenfield until the 12th December when she was transferred back to ourselves.

On her return the main issue for Wendy was really delirium, for which she required a combination of Propofol, Midazolam, Morphine and Clonidine. Over the next 7 days, this was gradually withdrawn and I am pleased to say she was doing very well by the time she was discharged from ourselves.

Despite being on a variety of antibiotics, no organism was ever identified to be the cause of her pneumonia, though we all felt it was likely to have been a strep pneumonia. She had an atypical screen which included Legionella pneumophila as well as Hepatitis and HIV serology, which were all negative.

By the time she was discharged from us, she was really doing very well. She was able to interact with staff and was watching television and reading magazines and was close to decannulation. She was discharged to the Respiratory Ward and they will continue to review her until her discharge from hospital.

Wendy has done extremely well, given the severity of her illness and I hope she continues to improve from here on in with little in the way of residual respiratory compromise.

Please do not hesitate to contact us if you or Wendy requires any further information regarding her stay in the Intensive Care Unit.

Yours sincerely

TARA QUASIM
CONSULTANT IN ANAESTHESIA & INTENSIVE CARE

Acute Services Division

ACUTE ASSESSMENT UNIT

Dr Allan Cameron
Dr Pauline Grose
Dr Ravi Jamdar
Dr Gerard McKay

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

NHS Greater Glasgow and Clyde

Dictated 27/09/2011
Typed 28/09/2011
Ref AC/ET

Secretary:
Emma Thomson Tel: 0141 211 5719
Email:
Emma.Thomson3@ggc.scot.nhs.uk

Dr Marie Wilson
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

Dear Dr Wilson,

Wendy McLeish - 25/05/1987 - CHI: 2505876061 - CRN: 23123532V
0/1 51 Coxton Place, Glasgow, G33 5EJ

DATE OF ADMISSION:	22nd September 2011
DATE OF DISCHARGE:	22nd September 2011
CONSULTANT:	Dr Cameron
DIAGNOSIS:	Fluoxetine overdose
MEDICATION:	Propranolol 40mg tds, Fluoxetine 20mg once daily
FOLLOW UP:	Community Mental Health Team

This 24 year old woman presented after an impulsive overdose of somewhere between 240-480mg of Fluoxetine whilst intoxicated. Fortunately there were no physical sequelae.

She was reviewed by the Psychiatry Liaison Team who felt that there was no real suicidal intent. She has follow up arranged with the Community Mental Health Team at Auchinlea.

Yours sincerely,

Dr Allan Cameron
Consultant Physician in Acute Medicine

Royal Infirmary
16 Alexandra Parade
Glasgow
G31 2ER

NEUROLOGY DEPARTMENT
DR P SHAH
CONSULTANT NEUROLOGIST
TELEPHONE: 0141 211 4481

Dictated 25/10/2010
Typed 28/10/2010
Our Ref PS/CB

Dr Marie Wilson
Easterhouse Health Centre
9 Auchinlea Road
GLASGOW
G34 9HQ

Dear Dr Wilson

Wendy McLeish - 25/05/1987 - CHI: 2505876061 - CRN: 23123532V
0/1 51 Coxton Place, Glasgow, G33 5EJ

Miss McLeish failed to attend her Neurology Out-patient Clinic appointment today.

I have not arranged a further appointment.

Kind regards.

Yours sincerely

Pushkar Shah
Consultant Neurologist

c.c. Miss Wendy McLeish, 0/1, 51 Coxton Place, Glasgow, G33 5EJ.

Department of Trauma & Orthopaedics
Glasgow Royal Infirmary
84 Castle Street
Glasgow
G4 0SF

Telephone: **0141 211 4000**
Fax: **0141 211 0481**
Appointments: **0141 211 5067 / 5146**

MR R INGRAM - FRACTURE CLINIC

Clinic and dictated: 05/08/2009
Typed: 07/08/2009
Our Reference: RI/EMCG/23123532V

Dr Albert Burton
Woodside Health Centre
Barr Street
Glasgow
G20 7LR

Dear Dr Burton

Re: Ms Wendy McLeish 25/05/1987; CHI: 2505876061; 0/1 51 Coxton Place Glasgow G33 5EJ

This young lady was reviewed in clinic today and the k-wires removed from her wrist. She has been out back into cast and will be seen again in 2 weeks time with a plaster off on arrival and an x-ray on arrival.

Kind regards.

Yours sincerely

R INGRAM
Consultant Orthopaedic Surgeon

Department of Trauma & Orthopaedics
Glasgow Royal Infirmary
84 Castle Street
Glasgow
G4 0SF

Telephone: **0141 211 4000**
Fax: **0141 211 0481**
Appointments: **0141 211 5067 / 5146**

MR R INGRAM - FRACTURE CLINIC

Clinic and dictated: 15/07/2009
Typed: 16/07/2009
Our Reference: CC/EMCG/23123532V

Dr Albert Burton
Woodside Health Centre
Barr Street
Glasgow
G20 7LR

Dear Dr Burton

Re: Ms Wendy McLeish 25/05/1987; CHI: 2505876061; 0/1 51 Coxton Place Glasgow G33 5EJ

I say Wendy today back at the clinic a week since her k-wiring of her right wrist. The overall position has been well maintained and we will change the cast to a lightweight cast today.

She will return in 3 weeks time for removal of a cast and removal of wires and application in front of the cast for 2 more weeks.

We will let you know how we get on in due course.

Yours sincerely

Calum Cree
Specialist Registrar Orthopaedics

Final Discharge Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000
Department: General Medicine
Contact Tel: 0141 201 6655
Enquiries to: Megan.Kelly3@ggc.scot.nhs.uk
Letter Date: 20/04/2023
Reference: CA/MK
Dictated Date: 19/04/2023
Transcribed Date: 20/04/2023

Dr. MM Morris
Meadowpark Surgery
568 Alexandra Parade
Glasgow
G31 3BP

Dear Dr. MM Morris,

Wendy McLeish; D.O.B: 25/05/1987; CHI: 2505876061
FLAT 3/2, 312 CUMBERNAULD RD, Glasgow, Lanarkshire, G31 3LY

Admission: Specialty - General Medicine; Ward - GRI C19 Ward 46 Medical
Consultant - Dr Christine Aiken; Date of Admission - 25/03/2023
Date of Discharge - 26/03/2023; Discharged to - Private Residence - no additional detail added

Follow Up: Nil

Clinical Comments:
Wendy McLeish was admitted via the Assessment Unit with 2-3 week history of feeling confused and falls. She denied any symptoms preceding the falls but admitted to 3 episodes of faecal incontinence when she passed liquid stool. Her concern was that this was similar to the symptoms she had with her previous pneumonia when she required ECMO.

Examination revealed her to be mildly hypotensive at 97mm Hg systolic with mildly reduced coordination of her left side. Blood tests showed a slight elevated white cell count at 13.5 but nil else of note. CT head showed no abnormalities and she was mobile with no issues on the ward. She had no further episodes of faecal incontinence and she was felt for discharge. The suspicion was that she had gastroenteritis leading to her symptoms. No routine follow up has been arranged.

Yours sincerely,

Dr Christine Aiken

Consultant Physician Acute Medicine

Electronically Signed: Dr Christine Aiken, Consultant

cc.

Final Discharge Letter

NHS Greater Glasgow and Clyde

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

Dr. AL McGinley
Lochend Surgery
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

Main Switchboard: 0141 211 4000
Department: General Medicine
Contact Tel: 0141 211 4000
Enquiries to: Sandra.campbell3@ggc.scot.nhs.uk
Letter Date: 21/12/2020
Reference: EL/JC
Dictated Date: 17/12/2020
Transcribed Date: 17/12/2020

Dear Dr. AL McGinley,

Wendy McLeish; D.O.B: 25/05/1987; CHI: 2505876061
126 Liberton Street , Easterhouse, Glasgow, Lanarkshire, G33 2HJ

Admission: Specialty - General Medicine; Ward - GRI Ward 50 MR Respiratory
Consultant - Dr Eric Livingston; Date of Admission - 08/12/2020
Date of Discharge - 09/12/2020; Discharged to - Private Residence - no additional detail added

Follow Up: First seizure clinic

Clinical Comments:
Ms Wendy McLeish a 33 year old lady was admitted after she collapsed with ?seizure while shopping. No further seizures were witnessed. Her past medical history is significant of anxiety/ depression. She denied recent alcohol or drug use. There were no acute changes on CT head. Since there were no further seizure episodes and she was clinically well she was discharged with no change to medication. Mariana Kostova CF

Final comments

She has been referred to first seizure clinic

Dr Eric Livingston

Respiratory Consultant

Electronically Signed: Dr Eric Livingston, Consultant

cc.

Final Discharge Letter

NHS
Greater Glasgow and Clyde

Dr. AL McGinley
Dr Wilson dr mcginley & dr sheppar
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Main Switchboard: 0141 211 4000

Date of Completion: 08/10/2013

Email Enquiries to: jean.cairney@ggc.scot.nhs.uk
Contact Tel Details: 0141 211 5719

Dictated: 27/09/2013
Transcribed: 27/09/2013

Dear Dr. AL McGinley,

Patient

Name:	McLeish Wendy
CHI:	2505876061
DOB:	25/05/1987
Address:	0/1 51 COXTON PLACE
	Glasgow
	G33 5EJ

Admission

Admitted:	09/08/2013 17:49
Discharged:	09/08/2013 21:44
Admission Type:	In Patient
Discharge to:	Private Residence - no additional detail added
Consultant:	Dr Allan Cameron
Specialty:	General Medicine

Reason for Admission: Admission for treatment - Where the patient is expected to be treated for a diagnosed condition not otherwise specified

Clinical Comments:

Diagnosis: Respiratory tract infection

This 26 year old lady attended the Assessment Unit with shortness of breath on exertion with central chest tightness.

On examination she appeared well. Observations were satisfactory and she had a tender chest wall around her lower ribs. She had a mildly tender epigastrium but the remainder of the examination was unremarkable. Urinalysis revealed +++leucocytes and +protein. Chest x-ray was normal and bloods

showed a raised CRP at 129 and white cell count of 11.1. She was treated for a probable chest and urinary tract infection with oral Amoxycillin. She was discharged home.

Yours sincerely,

Dr Christine Aiken Consultant Physician Acute Medicine

Follow-up arranged: none

Electronically Signed: Dr Christine Aiken, Consultant

cc.

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No
Consent for Sharing Withheld: No

MARGARET MORRISMeadowpark Surgery,568 Alexandra Parade,Glasgow, G31 3BP

Main Switchboard:
Date of Completion: 19-Apr-2023

Dear MARGARET MORRIS,

Name	CHI	DoB	Address
Wendy McLeish	**2505876061**	**25-May-1987**	**FLAT 3/2, 312 CUMBERNAULD RD, Glasgow, Lanarkshire, G31 3LY**

Admitted	Type	Discharged	Destination
25-Mar-2023 00:42	IP	26-Mar-2023	

Specialty	Consultant	Ward	Telephone
General Medicine	Aiken	GRI C19 Ward 46 Medical	

Primary Diagnosis
There is no data to display.

Secondary Diagnosis
There is no data to display.

Significant Operations / Procedures:
There is no data to display.

Last Discharge Review: Lorena Mihaita (Lorena Mihaita - Foundation Year 2) on 26 Mar 2023 16:30

Discharge Medication:

Active Drug Name	Route	Dose	Disp	Reason	Further Details	ECS	Since Admission
Airomir 100micrograms/dose Autohaler (Teva UK Ltd)	inhalation	200 micrograms four times daily when required	No	Patient's own supply			Added
Dihydrocodeine 30mg tablets	oral	60 mg four times daily when required	No	Patient's own supply			Added
Gabapentin 100mg capsules	oral	1 capsule three times daily	No	Patient's own supply			Added
Lamotrigine 25mg tablets	oral	75 mg once daily	No	Patient's own supply			Added
Lidocaine 5% medicated plasters	topical	1 patch once daily when required	No	Patient's own supply			Added
Sertraline 50mg tablets	oral	1 tablet once daily	No	Patient's own supply			Added

"Added" means this medicine was added to the Clinical Portal record after admission. It does not necessarily mean this medicine was started by the hospital.

Dispensing Comments
There is no data to display.

Withheld Medication:

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

Stopped Medication:

Date	Stopped Drug Name	Route	Dose	Note	Stopped Reason
2023-03-26	Desogestrel 75microgram tablets (Cerelle)	oral	1 Tab Daily,		Stopped before admission
2023-03-26	Mirtazapine 45mg tablets	oral	ONE TO BE TAKEN AT NIGHT,		Stopped before admission
2023-03-26	Propranolol 10mg tablets	oral	when required ONE TO BE TAKEN THREE TIMES A DAY IF NEEDED,		Stopped before admission

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

Clinical Comments:	Dear doctor, Thank you for taking over the care of Wendy Mcleish (35 year old female) who was admitted in ward 46 GRI with three weeks history of confusion and ataxia. She also had 3 episodes of faecal incontinence (liquid stools). O/E, there was slight decrease in co-ordination, rest of the examination including neuro exam was normal. Chest XR showed nil focal , CT brain showed nothing significant. Regards Ward 46
Discharge Comments:	
Follow Up:	No none
Results Awaited:	No
Pharmacist Comments:	
Final Discharge Letter to Follow:	Yes

Yours sincerely,

Lorena MIHAITA

Prescription Review
Checked by: Lorena MIHAITA (Foundation Year 2)
Discharged by: Christine AIKEN (GRI- medical)

Immediate Discharge Letter

Highly Sensitive: No
Consent for Sharing Withheld: No

NHS Greater Glasgow and Clyde

ANNE MCGINLEYLochend Surgery,Easterhouse Health Centre,9 Auchinlea Road, Glasgow, G34 9HQ

Glasgow Royal Infirmary,84 Castle St G4 0SF
Main Switchboard: 0141 2114000
Date of Completion: 09-Dec-2020

Dear ANNE MCGINLEY,

Name	CHI	DoB	Address
Wendy McLeish	**2505876061**	**25-May-1987**	**126 LIBERTON ST, Glasgow, Lanarkshire, G33 2HJ**

Admitted	Type	Discharged	Destination
08-Dec-2020 17:32	IP	09-Dec-2020	Private Residence - living with relatives or friends

Specialty	Consultant	Ward	Telephone
General Medicine	Livingston	GRI Ward 50 MR Respiratory	0141 2114000

Primary Diagnosis
There is no data to display.

Secondary Diagnosis
There is no data to display.

Significant Operations / Procedures:
There is no data to display.

Last Discharge Review: Mariana Kostova (Mariana Kostova - CF) on 09 Dec 2020 12:26

Discharge Medication:

Active Drug Name	Route	Dose	Disp	Reason	Further Details	ECS	Since Admission
Desogestrel 75microgram tablets (Cerelle)	oral	1 Tab Daily,	No	Patient's own supply		Y	
Mirtazapine 45mg tablets	oral	ONE TO BE TAKEN AT NIGHT,	No	Patient's own supply		Y	
Propranolol 10mg tablets	oral	when required ONE TO BE TAKEN THREE TIMES A DAY IF NEEDED,	No	Patient's own supply		Y	

"Added" means this medicine was added to the Clinical Portal record after admission. It does not necessarily mean this medicine was started by the hospital.

Dispensing Comments
There is no data to display.

Withheld Medication:

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

Stopped Medication:

Date	Stopped Drug Name	Route	Dose	Note	Stopped Reason
2020-12-09	Co-amoxiclav 500mg/125mg tablets	oral	1 tablet three times daily , Fixed Period 7 Day(s) from 01 Nov 2019		Course Completed

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

Clinical Comments:	Dear Dr., Ms Wendy McLeish, 33yo lady admitted to GRI after episode of seizures. Ms McLeish collapsed while waiting in the line. During her admission she was closely monitored and no further seizures were witnessed. Her past medical history is significant of anxiety/depression. She denied any recent alcohol or drug use.

	There were no acute changes on CT head. Since there were no further seizure episode and she felt to be clinically well, we felt suitable to discharge her home. There were no changes to medications. Follow-up: - First seizure clinic referral sent (will be contacted) Thank you for your ongoing care. Kind Regards, Ward 50 Team, FY1
Discharge Comments:	-
Follow Up:	Yes First seizure clinic referral sent (will be contacted)
Results Awaited:	No
Pharmacist Comments:	
Final Discharge Letter to Follow:	Yes

Yours sincerely,

Mariana Kostova

Prescription Review
Checked by: Mariana Kostova (CF)
Discharged by: Roddy Delapena (Staff Nurse)

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No
Consent for Sharing Withheld: No

ANNE MCGINLEYLochend Surgery,Easterhouse Health Centre,9 Auchinlea Road, Glasgow, G34 9HQ

Glasgow Royal Infirmary,84 Castle St G4 0SF
Main Switchboard: 0141 2114000
Date of Completion: 01-Nov-2019

Dear ANNE MCGINLEY,

Name	CHI	DoB	Address
Wendy McLeish	**2505876061**	**25-May-1987**	**126 LIBERTON ST, Glasgow, Lanarkshire, G33 2HJ**

Admitted	Type	Discharged	Destination
01-Nov-2019 13:30	IP	01-Nov-2019	Private Residence - no additional detail added

Specialty	Consultant	Ward	Telephone
Emergency Medicine	Anderson	GRI Ward 46 Head Injury/General Medicine	0141 2114000

Primary Diagnosis
Injury of head

Secondary Diagnosis
Human bite - wound

Significant Operations / Procedures:
There is no data to display.

Last Discharge Review: Oonagh Murray (Oonagh Murray - FY2) on 01 Nov 2019 17:28

Discharge Medication:

Active Drug Name	Route	Dose	Disp	Reason	Further Details	ECS	Since Admission
Co-amoxiclav 500mg/125mg tablets	oral	1 tablet three times daily , Fixed Period 7 Day(s) from 01 Nov 2019	Yes				Added

"Added" means this medicine was added to the Clinical Portal record after admission. It does not necessarily mean this medicine was started by the hospital.

Dispensing Comments
There is no data to display.

Withheld Medication:

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

Stopped Medication:

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

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

Clinical Comments:	Dear Doctor, This patient was brought in by the police and ambulance after an alleged assault. She had sustained a haematoma to right temple and a human bite to left ear. This was reviewed, cleaned and debrided by plastics. The patient was admitted to Ward 46 for a period of observation. She was given two dose of IV co-amoxiclav and discharged with 7 days of oral co-amoxiclav and topical chloramphenicol BD. The patient was advised to return if redness and pain in ear does not settle. Yours Sincerely, Oonagh Murray FY2
Follow Up:	Yes Dressings Clinic Plastics OPD 08/11/19 11:00
Results Awaited:	No

Pharmacist Comments:	
Final Discharge Letter to Follow:	No

Yours sincerely,

Oonagh Murray

Prescription Review
Checked by: Oonagh Murray (FY2)
Discharged by: Oonagh Murray (FY2)

Letter to Patient: na

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Wendy McLeish
FLAT 3/2
312 CUMBERNAULD RD
Glasgow
Lanarkshire
G31 3LY

Main Switchboard: 0141 211 4000
Department: Gastroenterology
Contact Tel: 0141-201-6368
Enquiries to: madiha.rasul2@nhs.scot
Letter Date: 10/06/2025
Reference: NL/CT
Dictated Date: 09/06/2025
Transcribed Date: 09/06/2025

Dear Ms McLeish ,

We were due to have a face to face consultation at my clinic this morning, 9th June. You did not attend, and I hope you are well.

I believe this appointment was confirmed with you, and given the pressures on the waiting list I am unable to routinely reappoint you. You will require to be re-referred from primary care should you still wish to be seen.

Kind regards.

Dr Eliana Saffouri

Consultant Gastroenterologist

Electronically Signed: Dr Eliana Saffouri, Consultant

cc. Dr M Lyons
Meadowpark Surgery,
Parkhead Hub,
1251 Duke Street,
Glasgow,
G31 5NZ

Letter to Patient:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000
Department: Respiratory Medicine
Contact Tel: 0141 451 5366
Enquiries to: lindsay.fraser@ggc.scot.nhs.uk
Letter Date: 15/01/2024
Reference: AW/LMF
Dictated Date: 10/01/2024
Transcribed Date: 12/01/2024

Wendy McLeish
FLAT 3/2
312 CUMBERNAULD RD
Glasgow
Lanarkshire
G31 3LY

Dear Mrs McLeish,

I tried to give you a call a few times today, however could not get through. Your mobile would just ring and then go to the Giff-Gaff mobile answer service.

I will therefore send out a further appointment. This will be face to face if this is okay as I am seeing the vast majority of my patients in person now.

I hope that you are well.

Yours sincerely

Dr Angela Wright
Consultant in Respiratory Medicine

Electronically Signed: Dr Angela Wright, Consultant

cc. Dr Morris:
Meadowpark Surgery:
568 Alexandra Parade:
Glasgow:
G31 3BP:

Letter to Patient:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Wendy McLeish
FLAT 3/2
312 CUMBERNAULD RD
Glasgow
Lanarkshire
G31 3LY

Main Switchboard:	0141 211 4000
Department:	Respiratory Medicine
Contact Tel:	0141 201 3831
Enquiries to:	Secretary
Letter Date:	16/08/2023
Reference:	AW/CH
Dictated Date:	14/08/2023
Transcribed Date:	15/08/2023

Dear Wendy,

Thank you for attending for your CT scan. This has now been reported. It has been compared to your previous scan from March.

There has been an improvement in the non specific changes that were previously there. There are no new changes and nothing that shows that progressive fibrosis.

I have copied in your GP so they are also aware of this.

Yours sincerely,

Dr Angela Wright

Consultant Physician

Electronically Signed: Dr Angela Wright, Consultant

cc. Dr MM Morris
Meadowpark Surgery
568 Alexandra Parade
Glasgow
G31 3BP

Letter to Patient:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000
Department: Respiratory Department
Contact Tel: 0141 201 3831
Enquiries to: Fiona MacLellan

Letter Date: 30/03/2023
Reference: AW/RS
Dictated Date: 28/03/2023
Transcribed Date: 29/03/2023

Wendy McLeish
FLAT 3/2
312 CUMBERNAULD RD
Glasgow
Lanarkshire
G31 3LY

Dear Wendy,

Thank you for attending for your CT scan which has now been reported.

There is some longstanding changes which we feel is likely the sequelae of your sever lung infection in 2011.

There is some new scattered changes which look a bit more recent and we wondered whether or not at the time of the scan you had a recent or ongoing infection. A follow up has been advised and I will get this organised.

Yours sincerely

Dr A Wright

Consultant in Respiratory Medicine

Electronically Signed: Dr Angela Wright, Consultant

cc.
Dr Morris
Meadowpark Surgery

568 Alexandra Parade
Glasgow
G31 3BP

Letter to Patient:

NHS
Greater Glasgow and Clyde

Plastic Surgery Unit
84 Castle Street
Glasgow
G4 0SF
Main Switchboard: 0141 211 4000
Department: Plastics
Contact Tel: 0141 201 6394
Enquiries to: dionne.macleod@ggc.scot.nhs.uk
Letter Date: 03/04/2023
Reference: JS/PL
Dictated Date: 14/03/2023
Transcribed Date: 24/03/2023

Wendy McLeish
FLAT 3/2
312 CUMBERNAULD RD
Glasgow
Lanarkshire
G31 3LY

Dear Miss McLeish,

I understand that you have been unable to attend the Plastic Surgery Clinic on two occasions with regard to the lesion on your nose.

Your referring Doctor suspected the may be skin cancer. I would encourage you to reattend your GP and seek further referral for specialist advice.

Kind regards

Yours sincerely

John Scott

Consultant Plastic Surgeon

Electronically Signed: Mr John Scott, Consultant

cc. Dr M.M. Morris
Meadowpark Surgery
568 Alexandra Parade
GLASGOW
G31 3BP

Case No 7560398 **Case Active** 22/02/2025 13:50 **Case Type** Direct Referral ED

Patient Wendy Mcleish **Sex** F **D.O.B** 25/05/1987 **Age** 37 years

Current Address
3/2 312 Cumbernauld Road
Glasgow

G31 3LY

Home Address (if currently not at home)

Current Phone: 07912 347436 **Home Phone:** **CHI:** 2505876061

Case Origin **Callers Name** Wendy **Callers Tel:**

Own Doctor Morris,Margaret
Surgery Meadowpark Surgery

NHS24 Received By Bridget Tod (Call Taker Si) () **NHS24 Triage Start** 13:55
NHS24 Triage By Bridget Tod (Call Taker Si) () **NHS24 Triage End** 14:37
NHS24 Reported Condition **NHS24 Outcome** AEP
HEAD INJURY 2 DAYS

NHS24 Recorded Allergies **NHS24 Recorded Medications** **NHS24 Recorded Medical History**

NHS24 Clinical Summary
Clinical summary created by: Bridget Tod (Call Taker Si) () [22/02/2025 14:38:56]
Reason for call: HEAD INJURY 2 DAYS
22:02:2025 13:53:27 TODB.. RETURN CALLER. ATTENDED GP DUE TO LOW B12 LEVELS. SUSTAINED HEAD INJURY ON RADIATOR. STATES ALSO FELL ON ROAD AND DOWN THE STAIRS... BOTTOM IS BRUISED AND HIPS PAINFUL. ANKLE SWOLLEN AFTER FALL. UNABLE TO STAND - FALLS ON STANDING. LEGS SHAKY. STATES CANNOT SEE PROPERLY. KNOWN CARDIAC ISSUES. ESSENTIAL TREMOR. HAS SEIZURES. STATES OXYGEN LEVELS ARE 90%... DISORIENTED... CHEST PAIN... STATES HAS SCIATICA... FEELS CONSTRICTING BAND IN CHEST... HEART RATE 53.. PT IS ALONE... BACK PAIN WORSENED IN LAST 5 MINUTES. HAS JUST FALLEN... PT ATTENDING A&E GLASGOW ROYAL INFIRMARY...
22:02:2025 14:34:53 BRADERS.. DIFFICULT TRIAGE/SPEECH APPEARS SLURRED/DIFFICUKLT TO UNDERSTAND,RECURRENT FALLS MONTHS/AWAITING INVESTIDATIONS/LAST FALL 2 DAYS AGO/UNSURE IF LOC. NO WOUNDS... CONFUSION/BILATERAL VISUSAL CHANGE TODAY /UNABLE TO CONFIRM EXACT TIME. CHRONIC CHEST PAIN/WORSE TODAY. SOB O2 SATS 85 % /NORMALL 95 %. TALKING IN SENTENCES.. CHRONIC VOMITING WEEKS/NAUSEA/VOMITING TODAY. PT DECLINED 999. A/E ASAP GRI..
Outcome: Patient advised to go to A&E

NHS24 Disposition
Accident & Emergency (ASAP)

NHS24 NUrse Comments

Reported Condition **Received By** **Received**

TAS Assessment **Assessed By** **TAS Assess Start**
TAS Assess End

Consultation **Consult By** **Consult Start**
Consult End

Examination Details **Clinical Codes**

Diagnosis

Treatment

Prescriptions

Case No 7560398 **Case Active** 22/02/2025 13:50 **Case Type**Direct Referral ED

Follow-up(s)

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Gastroenterology GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Glasgow Royal Infirmary 84 Castle Street Glasgow G4 0SF	——	**Hospital** and **hospital address** Hospital location code. G107H Email address

Urgency of referral Urgent - Suspected Cancer
Date of referral 23-Apr-2025 **Date sent** 23-Apr-2025

PATIENT DETAILS

Surname	McLeish
Forename(s)	Wendy
Title	Miss
Sex	Female
Date of birth	25-May-1987
CHI no.	2505876061
Area of Residence	-

Patient's address

Flat 3.2
312 Cumbernauld Road
Glasgow
G31 3LY

Contact number(s)

Voice: 07912347436

101036262898Y

Unique Care Pathway Number: 101036262898Y

REGISTERED GP DETAILS

Name	Dr Margaret Morris		
GMC code	4305792	GP code	05029
Practice name	Meadowpark Surgery (18882)		
Practice code	46625		

Practice address

Meadowpark Practice
1251 Duke Street
Glasgow
G31 5NZ

Contact number(s)

Voice: 0141 800 0272

REFERRING GP DETAILS

Name	Dr. Samuel Broadley		
GMC code	7477241	GP code	06807
Practice name	Meadowpark Surgery (46625)		

Practice address

Parkhead Hub
1251 Duke Street
Glasgow
G31 5NZ

Practice code	46625

Contact number(s)

Voice: 0141 800 0272

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: Weight loss

Comment: 37yo patient. PMH bronchiectasis + recurrent LRTI, epilepsy, historical polysubstance misuse - states now abstinent.

Presents with 4 month history of abnormal weight loss of "around a stone". States was 85kg when last seen by respiratory in December 2024. Weight with us on 3rd April was 74kg. States appetite poor and gets full earlier during meals. Bowel habit irregular for years, with no changes / bleeding / daily diarrhoea. No urinary symptoms. Periods regular with no abnormal bleeding.

On examination - abdomen soft, mild tenderness to RIF + LIF, no guarding, no flank tenderness. Urinalysis - leuc +, prot ++.

Blood testing overall satisfactory with no evidence of anaemia.

I would be grateful for your specialist assessment. I have requested qFIT testing in the interim. Many thanks

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

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

Description	Comment	Date of onset	Date recorded
Closed fracture distal tibia	-	29-Jan-2024	29-Jan-2024
Epilepsy	-	15-Sep-2023	15-Sep-2023
Bronchiectasis	-	29-Mar-2023	29-Mar-2023
Lumbago with sciatica	-	01-Feb-2023	01-Feb-2023
Asthma	-	12-Sep-2022	12-Sep-2022
Vulnerable child in family	-	16-Mar-2021	16-Mar-2021
Assault by bite of human being	by partner. bite to R ear, blunt head trauma by bottle.	01-Nov-2019	01-Nov-2019
Social worker involved	-	02-Sep-2019	02-Sep-2019
Alcohol problem drinking	-	02-Sep-2019	02-Sep-2019
Miscarriage	surgical ERPC	03-Sep-2015	03-Sep-2015
Pneumonia due to unspecified organism	(Bilateral)	30-Dec-2011	30-Dec-2011
Adult respiratory distress syndrome	-	30-Nov-2011	30-Nov-2011
Overdose of drug	fluoxetine.	22-Sep-2011	22-Sep-2011
Anxiety with depression	-	19-Jul-2011	19-Jul-2011
Death of father	-	31-Jan-2011	31-Jan-2011
Has a tremor	seen by nuerologist 2012, felt to be benign	01-Apr-2007	01-Apr-2007
Death of mother	age 29 MI	01-Jan-1991	01-Jan-1991

Past procedures (High and medium priority - all)

Description	Date performed	Date recorded
Elective caesarean delivery NOS	26-Feb-2017	26-Feb-2017

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
	60	60 tablet		-	03-Apr-2025	

Fexofenadine Hydrochloride Tablets 180 mg			TAKE ONE TABLET UP TO TWICE DAILY			03-Apr-2025
Folic Acid Tablets 5 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY FOR 4 MONTHS THEN STOP	-	31-Mar-2025	31-Mar-2025
Propranolol Hydrochloride Tablets 40 mg	84	84 TABLET	ONE TO BE TAKEN THREE TIMES A DAY	-	03-Jun-2024	15-Apr-2025
Gabapentin Capsules 300 mg	84	84 CAPSULE	TAKE ONE CAPSULE THREE TIMES DAILY	-	24-May-2024	15-Apr-2025
Lansoprazole Capsules (Gastro-Resistant) 30 mg	28	28 CAPSULE	ONE TO BE TAKEN EACH DAY	-	22-May-2024	15-Apr-2025
Sertraline Hydrochloride Tablets 100 mg	28	28 TABLET	ONE TO BE TAKEN EACH DAY	-	22-May-2024	15-Apr-2025
Lamotrigine Tablets 25 mg	56	56 tablet	TAKE ONE TABLET TWICE DAILY (TOTAL DOSE 75MG TWICE DAILY)	-	02-Oct-2023	15-Apr-2025
Dihydrocodeine Tablets 30 mg	224	224 tablet	TAKE 2 TABLETS FOUR TIMES DAILY	-	28-Feb-2023	15-Apr-2025
Lamotrigine Tablets 50 mg	56	56 TABLET	TAKE ONE TABLET TWICE DAILY (TOTAL DOSE 75MG TWICE DAILY)	-	11-Oct-2022	15-Apr-2025
Clenil Modulite Cfc-free inhaler 100 micrograms/actuation	2	2 INHALER	TWO PUFFS TO BE INHALED TWICE A DAY	-	12-Sep-2022	15-Apr-2025
Salbutamol Cfc-free inhaler 100 micrograms/puff	1	1 INHALER	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY	-	12-Aug-2021	15-Apr-2025

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Ciprofloxacin Tablets 500 mg	14	14 tablet	ONE TO BE TAKEN TWICE A DAY FOR 1 WEEK	-	24-Mar-2025	27-Mar-2025
Clarithromycin Tablets 500 mg	20	20 tablet	ONE TO BE TAKEN TWICE A DAY FOR 10 DAYS	-	17-Mar-2025	17-Mar-2025
Metoclopramide Hydrochloride Tablets 10 mg	15	15 TABLET	ONE TO BE TAKEN EVERY 8 HOURS WHEN REQUIRED	-	17-Mar-2025	17-Mar-2025
Amoxicillin Capsules 500 mg	42	42 capsule	ONE TO BE TAKEN THREE TIMES A DAY FOR 14 DAYS	-	10-Mar-2025	10-Mar-2025
Cyanocobalamin Tablets 100 micrograms	60	60 tablet	1 Tab Daily THEN REPEAT BLOODS	-	14-Feb-2025	14-Feb-2025
Ralvo Medicated Plaster 700 mg	30	30 patch	APPLY ONE PLASTER ONCE DAILY (12 HOURS ON 12 HOURS OFF)	-	06-Feb-2025	06-Feb-2025
Lidocaine Medicated Plaster 5 %	7	7 PLASTER	APPLY ONE PLASTER ONCE DAILY (12 HOURS ON 12 HOURS OFF). LAST ISSUE - DISCONTINUED	-	07-Nov-2024	07-Nov-2024

Blood Pressure

Date Recorded	Systolic	Diastolic
08-Sep-2022	122	92
21-Sep-2021	120	60
17-Jul-2018	128	77

09-Jul-2015	123	90
08-Aug-2013	116	77

Body Measurements

Date Recorded	Height	Weight	BMI
03-Apr-2025	-	74	-
10-Oct-2022	-	90	-
10-Jun-2021	160.02	82.55	32.24
23-Mar-2021	158	83	33.25
23-Mar-2021	-	83	-

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Non-smoker :		08-Sep-2022
Non-smoker :	hx noted, ongoing longstanding anxiety, tremors, seen by neurology and advised related to anxiety, using propranolol, feels doesn't help her, also uses saba for sob up stairs at times, bu- TRUNCATED	07-Oct-2021
Ex-smoker - amount unknown :		12-Aug-2021
Never smoked tobacco:		10-Jun-2021
Never smoked tobacco:		16-Sep-2019
Non-drinker alcohol :		07-Oct-2021
Alcohol consumption, 1 units/week:		10-Jun-2021
Alcohol consumption, 3 units/week:		17-Apr-2012
Light drinker - 1-2u/day:	Alcohol Intake$$.clm - Repeat after an Interval	21-Jan-2010

Clinical warnings

Allergies

Description	Comment	Date recorded
Adverse reaction to propranolol	possible wheeze with this	29-Apr-2016

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

Is patient aware they are being referred under a suspicion of cancer pathway?:Yes

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

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

Referred By:Referring GP

Electronic Attachment Present:No

Social circumstances

Ethnic Origin: (White) Scottish

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

Referral letter:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000
Department: Respiratory Medicine
Contact Tel: 0141 451 5366
Enquiries to: lindsay.fraser2@nhs.scot

Letter Date: 18/12/2024
Reference: AW/LMF
Dictated Date: 10/12/2024
Transcribed Date: 12/12/2024

Dr Melanie Brewis
Consultant in Respiratory Medicine
Scottish Pulmonary Vascular Unit
Golden Jubilee National Hospital
CLYDEBANK
G81 4DY

Dear Dr Brewis,

Wendy McLeish; D.O.B: 25/05/1987; CHI: 2505876061
FLAT 3/2, 312 CUMBERNAULD RD, Glasgow, Lanarkshire, G31 3LY

I would value your advice on this 37 year old patient. Wendy had respiratory failure secondary to a pneumonia around ten years ago and for this was treated with ECMO.

She was referred to respiratory with, what she feels to be, severe breathlessness.

Both her transthoracic echo as well as HRCT scan have features suggestive of pulmonary hypertension.

I have ordered a CTPA in case there is any evidence of chronic blood clot.

A six minute walk test has been done and she did not desaturate.

On examination she does not have any clinical signs of right sided heart failure and also she is never wheezy.

I wondered whether or not that given her young age and previous medical history she would benefit from review in your tertiary service.

Yours sincerely

Dr Angela Wright

Consultant in Respiratory Medicine

Electronically Signed: Dr Angela Wright, Consultant

cc.

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Plastic Surgery GGC Plastics	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Glasgow Royal Infirmary 84 Castle Street Glasgow G4 0SF	——	**Hospital** and **hospital address** Hospital location code. G107H Email address -

Urgency of referral Urgent - Suspected Cancer
Date of referral 02-May-2023 **Date sent** 02-May-2023

PATIENT DETAILS

Surname	McLeish
Forename(s)	Wendy
Title	Miss
Sex	Female
Date of birth	25-May-1987
CHI no.	2505876061
Area of Residence	-

Patient's address

Flat 3.2
312 Cumbernauld Road
Glasgow
G31 3LY

Contact number(s)

Voice: 07912347436

101029472044I

Unique Care Pathway Number: 101029472044I

REGISTERED GP DETAILS

Name	Dr Margaret Morris		
GMC code	4305792	GP code	05029
Practice name	Meadowpark Surgery (18882)		
Practice code	46625		

Practice address

568 Alexandra Parade
Glasgow
G31 3BP

Contact number(s)

Voice: 0141 554 0464
Facsimile: 0141 550 2002

REFERRING GP DETAILS

Name	Dr. Sabha Ali		
GMC code	6156945	GP code	08541
Practice name	Meadowpark Surgery (46625)		

Practice address

568 Alexandra Parade
Glasgow
G31 3BP

Practice code	46625	Contact number(s)
		Voice: 0141 554 0464

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: Suspicious lesion on nose. missed appointment.

Comment: Dear Plastics,
This patient missed her appointment regarding a crusted lesion on her nose. She would like to be seek your advice and has asked for a re-referral.
Many thanks for considering this,
Dr S Ali

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

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

Description	Comment	Date of onset	Date recorded
Bronchiectasis	-	29-Mar-2023	29-Mar-2023
Lumbago with sciatica	-	01-Feb-2023	01-Feb-2023
Asthma	-	12-Sep-2022	12-Sep-2022
Vulnerable child in family	-	16-Mar-2021	16-Mar-2021
Assault by bite of human being	by partner. bite to R ear, blunt head trauma by bottle.	01-Nov-2019	01-Nov-2019
Social worker involved	-	02-Sep-2019	02-Sep-2019
Alcohol problem drinking	-	02-Sep-2019	02-Sep-2019
Miscarriage	surgical ERPC	03-Sep-2015	03-Sep-2015
Pneumonia due to unspecified organism	(Bilateral)	30-Dec-2011	30-Dec-2011
Adult respiratory distress syndrome	-	30-Nov-2011	30-Nov-2011
Overdose of drug	fluoxetine	22-Sep-2011	22-Sep-2011
Anxiety with depression	-	19-Jul-2011	19-Jul-2011
Death of father	-	31-Jan-2011	31-Jan-2011
Has a tremor	seen by nuerologist 2012, felt to be benign	01-Apr-2007	01-Apr-2007
Death of mother	age 29 MI	01-Jan-1991	01-Jan-1991

Past procedures (High and medium priority - all)

Description	Date performed	Date recorded
Elective caesarean delivery NOS	26-Feb-2017	26-Feb-2017

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Ralvo Medicated Plaster 700 mg	30	30 patch	APPLY ONE PLASTER ONCE DAILY (12 HOURS ON 12 HOURS OFF)	-	28-Feb-2023	18-Apr-2023
Dihydrocodeine Tablets 30 mg	224	224 tablet	TAKE 2 TABLETS FOUR TIMES DAILY	-	28-Feb-2023	18-Apr-2023
Gabapentin Capsules 100 mg	84	84 capsule	TAKE ONE CAPSULE THREE TIMES DAILY	-	28-Feb-2023	18-Apr-2023
Lamotrigine Tablets 50 mg	28	28 tablet	TAKE ONE TABLET ONCE DAILY (TOTAL DAILY DOSE 75MG)	-	11-Oct-2022	18-Apr-2023

Lamotrigine Tablets 25 mg	28	28 tablet	TAKE ONE TABLET ONCE DAILY (TOTAL DAILY DOSE 75MG)	-	11-Oct-2022	18-Apr-2023
Clenil Modulite Cfc-free inhaler 100 micrograms/actuation	2	2 INHALER	TWO PUFFS TO BE INHALED TWICE A DAY	-	12-Sep-2022	18-Apr-2023
Salbutamol Cfc-free inhaler 100 micrograms/puff	1	1 INHALER	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY	-	12-Aug-2021	18-Apr-2023

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Cyclizine Tablets 50 mg	15	15 tablet	ONE TO BE TAKEN THREE TIMES A DAY	-	16-Mar-2023	16-Mar-2023
Mirtazapine Tablets 15 mg	21	21 tablet	WEEK 1 - TAKE 2 TABLETS ONCE DAILY. WEEK 2 - TAKE ONE TABLET ONCE DAILY FOR 1 WEEK THEN STOP	-	28-Feb-2023	28-Feb-2023
Sertraline Hydrochloride Tablets 50 mg	28	28 tablet	WEEK 3 ONWARDS - TAKE ONE TABLET ONCE DAILY	-	28-Feb-2023	28-Feb-2023
Gabapentin Capsules 100 mg	84	84 capsule	TAKE ONE CAPSULE THREE TIMES DAILY	-	01-Feb-2023	01-Feb-2023
Paracetamol Tablets 500 mg	224	224 tablet	TAKE 2 TABLETS FOUR TIMES DAILY	-	01-Feb-2023	01-Feb-2023
Dihydrocodeine Tablets 30 mg	224	224 tablet	TAKE 2 TABLETS FOUR TIMES DAILY	-	01-Feb-2023	01-Feb-2023
Ralvo Medicated Plaster 700 mg	30	30 patch	APPLY ONE PLASTER ONCE DAILY (12 HOURS ON 12 HOURS OFF)	-	01-Feb-2023	01-Feb-2023
Co-Codamol 30/500 Tablets	50	50 TABLET	TWO TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN REQUIRED (MAXIMUM OF 8 IN 24 HOURS)	-	23-Jan-2023	23-Jan-2023
Mirtazapine Tablets 45 mg	28	28 tablet	ONE TO BE TAKEN AT NIGHT	-	10-May-2022	16-Feb-2023

Blood Pressure

Date Recorded	Systolic	Diastolic
08-Sep-2022	122	92
21-Sep-2021	120	60
17-Jul-2018	128	77
09-Jul-2015	123	90
08-Aug-2013	116	77

Body Measurements

Date Recorded	Height	Weight	BMI
10-Oct-2022	-	90	-
10-Jun-2021	160.02	82.55	32.24
23-Mar-2021	158	83	33.25
23-Mar-2021	-	83	-
17-Jul-2018	-	-	29.64

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Height (m):	160.02	-

Weight (kg):	90	-
BMI (Weight / Height):	32.24	-
Non-smoker :		08-Sep-2022
Non-smoker :	hx noted, ongoing longstanding anxiety, tremors, seen by neurology and advised related to anxiety, using propranolol, feels doesn't help her, also uses saba for sob up stairs at times, bu- TRUNCATED	07-Oct-2021
Ex-smoker - amount unknown :		12-Aug-2021
Never smoked tobacco:		10-Jun-2021
Never smoked tobacco:		16-Sep-2019
Non-drinker alcohol :		07-Oct-2021
Alcohol consumption, 1 units/week:		10-Jun-2021
Alcohol consumption, 3 units/week:		17-Apr-2012
Light drinker - 1-2u/day:	Alcohol Intake$$.clm - Repeat after an Interval	21-Jan-2010

Clinical warnings

Allergies

Description	Comment	Date recorded
Adverse reaction to propranolol	possible wheeze with this	29-Apr-2016

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

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

Referred By:Referring GP

Electronic Attachment Present:No

Social circumstances

Ethnic Origin: (White) Scottish

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Respiratory Medicine GGC General Referral or Advice	—	**Consultant / receiving practitioner** and/or **specialty clinic**
Glasgow Royal Infirmary 84 Castle Street Glasgow G4 0SF	—	**Hospital** and **hospital address** Hospital location code. G107H Email address -

Urgency of referral Urgent - Suspected Cancer
Date of referral 03-Nov-2022 **Date sent** 03-Nov-2022

PATIENT DETAILS

Surname	McLeish
Forename(s)	Wendy
Title	Miss
Sex	Female
Date of birth	25-May-1987
CHI no.	2505876061
Area of Residence	

Patient's address

Flat 3.2
312 Cumbernauld Road
Glasgow
G31 3LY

Contact number(s)

Voice: 07912347436

101027872658X

Unique Care Pathway Number: 101027872658X

REGISTERED GP DETAILS

Name	Dr Margaret Morris		
GMC code	4305792	GP code	05029
Practice name	Meadowpark Surgery (18882)		
Practice code	46625		

Practice address

568 Alexandra Parade
Glasgow
G31 3BP

Contact number(s)

Voice: 0141 554 0464
Facsimile: 0141 550 2002

REFERRING GP DETAILS

Name	Dr. Samuel Broadley		
GMC code	7477241	GP code	06807
Practice name	Meadowpark Surgery (46625)		

Practice address

568 Alexandra Parade
Glasgow
G31 3BP

Practice code	46625

Contact number(s)

Voice: 0141 554 0464

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: Ongoing persistent cough post-LRTI - persistent post-consolidative changes left base

Comment: Thank you for your advice regarding this patient's ongoing persistent cough post-treatment for LRTI + routine specialist review of this. I am writing to update that her repeat CXR has been reported with "asymmetry left base has improved but not resolved". I would be grateful for your specialist assessment as appropriate in light of this finding - please let me know if you require any further information from original referral. Many thanks

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

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

Description	Comment	Date of onset	Date recorded
Asthma	-	12-Sep-2022	12-Sep-2022
Vulnerable child in family	-	16-Mar-2021	16-Mar-2021
Assault by bite of human being	by partner. bite to R ear, blunt head trauma by bottle.	01-Nov-2019	01-Nov-2019
Social worker involved	-	02-Sep-2019	02-Sep-2019
Alcohol problem drinking	-	02-Sep-2019	02-Sep-2019
Pityriasis versicolor	-	18-Feb-2019	18-Feb-2019
Miscarriage	surgical ERPC	03-Sep-2015	03-Sep-2015
Pneumonia due to unspecified organism	(Bilateral)	30-Dec-2011	30-Dec-2011
Adult respiratory distress syndrome	-	30-Nov-2011	30-Nov-2011
Overdose of drug	fluoxetine	22-Sep-2011	22-Sep-2011
Anxiety with depression	-	19-Jul-2011	19-Jul-2011
Death of father	-	31-Jan-2011	31-Jan-2011
Has a tremor	seen by nuerologist 2012, felt to be benign	01-Apr-2007	01-Apr-2007
Death of mother	age 29 MI	01-Jan-1991	01-Jan-1991

Past procedures (High and medium priority - all)

Description	Date performed	Date recorded
Elective caesarean delivery NOS	26-Feb-2017	26-Feb-2017

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Clenil Modulite Cfc-free inhaler 100 micrograms/actuation	2	2 INHALER	TWO PUFFS TO BE INHALED TWICE A DAY	-	12-Sep-2022	12-Sep-2022
Mirtazapine Tablets 45 mg	28	28 tablet	ONE TO BE TAKEN AT NIGHT	-	10-May-2022	11-Oct-2022
Salbutamol Cfc-free inhaler 100 micrograms/puff	1	1 INHALER	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY	-	12-Aug-2021	11-Oct-2022

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued

Lamotrigine Tablets 50 mg.	28	28 tablet	TAKE ONE TABLET ONCE DAILY (TOTAL DAILY DOSE 75MG)	-	11-Oct-2022	11-Oct-2022
Lamotrigine Tablets 25 mg	28	28 tablet	TAKE ONE TABLET ONCE DAILY (TOTAL DAILY DOSE 75MG)	-	11-Oct-2022	11-Oct-2022
Lamotrigine Tablets 50 mg	112	112 TABLET	WEEK 1+2 - TAKE ONE TABLET ONCE DAILY. WEEK 3 ONWARDS - TAKE ONE TABLET ONCE DAILY (TOTAL DAILY DOSE 75MG)	-	10-Oct-2022	10-Oct-2022
Lamotrigine Tablets 25 mg	28	28 tablet	WEEK 3 ONWARDS - TAKE ONE TABLET TWICE DAILY (TOTAL DAILY DOSE 75MG)	-	10-Oct-2022	10-Oct-2022
Fexofenadine Hydrochloride Tablets 180 mg	60	60 tablet	TAKE ONE TABLET UP TO TWICE DAILY	-	10-Oct-2022	10-Oct-2022
Clarithromycin Tablets 500 mg	10	10 TABLET	ONE TO BE TAKEN TWICE A DAY FOR 5 DAYS	-	23-Sep-2022	23-Sep-2022
Prednisolone Tablets 5 mg	40	40 TABLET	EIGHT TO BE TAKEN IN THE MORNING	-	12-Sep-2022	12-Sep-2022
Clarithromycin Tablets 500 mg	10	10 TABLET	ONE TO BE TAKEN TWICE A DAY FOR 5 DAYS	-	12-Sep-2022	12-Sep-2022
Amoxicillin Capsules 500 mg	15	15 CAPSULE	ONE TO BE TAKEN THREE TIMES A DAY FOR 5 DAYS	-	08-Sep-2022	08-Sep-2022
Benzydamine Hydrochloride Spray Sugar Free 0.15 %	1	1 SPRAY	USE 4-8 SPRAYS ONTO AFFECTED AREA EVERY 90 MINUTES TO 3 HOURS	-	08-Sep-2022	08-Sep-2022
Lamotrigine Tablets 25 mg	56	56 tablet	START AT ONE DAILY FOR 2 WEEKS. INCREASE DOSE BY 25MG EVERY 2 WEEKS UNTIL YOU REACH A DOSE OF 75MG TWICE DAILY (3 IN THE MORNING AND 3 AT NIGHT)	-	06-Sep-2022	06-Sep-2022
Amoxicillin Capsules 500 mg	15	15 CAPSULE	ONE TO BE TAKEN THREE TIMES A DAY FOR 5 DAYS	-	15-Jul-2022	15-Jul-2022
Hyoscine Butylbromide Tablets 10 mg	56	56 tablet	ONE TO BE TAKEN THREE TIMES A DAY	-	15-Jul-2022	15-Jul-2022
Propranolol Hydrochloride Tablets 40 mg	84	84 TABLET	ONE TO BE TAKEN THREE TIMES A DAY	-	10-May-2022	27-Jul-2022

Blood Pressure

Date Recorded	Systolic	Diastolic
08-Sep-2022	122	92
21-Sep-2021	120	60
17-Jul-2018	128	77
09-Jul-2015	123	90
08-Aug-2013	116	77

Body Measurements

Date Recorded	Height	Weight	BMI
10-Oct-2022	-	90	-
10-Jun-2021	160.02	82.55	32.24
23-Mar-2021	158	83	33.25
23-Mar-2021	-	83	-

17-Jul-2018 - - 29.64

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Non-smoker :		08-Sep-2022
Non-smoker :	hx noted, ongoing longstanding anxiety, tremors, seen by neurology and advised related to anxiety, using propranolol, feels doesn't help her, also uses saba for sob up stairs at times, bu- TRUNCATED	07-Oct-2021
Ex-smoker - amount unknown :		12-Aug-2021
Never smoked tobacco:		10-Jun-2021
Never smoked tobacco:		16-Sep-2019
Non-drinker alcohol :		07-Oct-2021
Alcohol consumption, 1 units/week:		10-Jun-2021
Alcohol consumption, 3 units/week:		17-Apr-2012
Light drinker - 1-2u/day:	Alcohol Intake$$.clm - Repeat after an Interval	21-Jan-2010

Clinical warnings

Allergies

Description	Comment	Date recorded
Adverse reaction to propranolol	possible wheeze with this	29-Apr-2016

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

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

Referred By:Referring GP

Electronic Attachment Present:No

Social circumstances

Ethnic Origin: (White) Scottish

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments
Dermatology - 26082022_Administration Letter_748935
Dermatology - 26082022_Administration Letter_748895

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Dermatology GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Glasgow Royal Infirmary 84 Castle Street Glasgow G4 0SF	——	**Hospital** and **hospital address** Hospital location code. G107H Email address -

Urgency of referral Urgent
Date of referral 28-Oct-2022 **Date sent** 28-Oct-2022

PATIENT DETAILS

Surname	McLeish
Forename(s)	Wendy
Title	Miss
Sex	Female
Date of birth	25-May-1987
CHI no.	2505876061
Area of Residence	-

Patient's address
Flat 3.2
312 Cumbernauld Road
Glasgow
G31 3LY

Contact number(s)
Voice: 07912347436

101027815472K

Unique Care Pathway Number: 101027815472K

REGISTERED GP DETAILS

Name	Dr Margaret Morris		
GMC code	4305792	GP code	05029
Practice name	Meadowpark Surgery (18882)		
Practice code	46625		

Practice address
568 Alexandra Parade
Glasgow
G31 3BP

Contact number(s)
Voice: 0141 554 0464
Facsimile: 0141 550 2002

REFERRING GP DETAILS

Practice address

Name	Dr. Matthew Lyons		
GMC code	7134018	GP code	02836
Practice name	Meadowpark Surgery (46625)		
Practice code	46625		

568 Alexandra Parade
Glasgow
G31 3BP

Contact number(s)

Voice: 0141 554 0464
Facsimile: 0141 550 2002

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: ?BCC

Comment: I would be grateful for your opinion regarding a crusting lesion on the side of this patient's nose. It has a slightly rolled edge. She spends a lot of time on sunbeds and the lesion itself has been painful and is enlarging. I have attached some photos.

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

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

Description	Comment	Date of onset	Date recorded
Asthma	-	12-Sep-2022	12-Sep-2022
Vulnerable child in family	-	16-Mar-2021	16-Mar-2021
Assault by bite of human being	by partner. bite to R ear, blunt head trauma by bottle.	01-Nov-2019	01-Nov-2019
Social worker involved	-	02-Sep-2019	02-Sep-2019
Alcohol problem drinking	-	02-Sep-2019	02-Sep-2019
Pityriasis versicolor	-	18-Feb-2019	18-Feb-2019
Miscarriage	surgical ERPC	03-Sep-2015	03-Sep-2015
Pneumonia due to unspecified organism	(Bilateral)	30-Dec-2011	30-Dec-2011
Adult respiratory distress syndrome	-	30-Nov-2011	30-Nov-2011
Overdose of drug	fluoxetine	22-Sep-2011	22-Sep-2011
Anxiety with depression	-	19-Jul-2011	19-Jul-2011
Death of father	-	31-Jan-2011	31-Jan-2011
Has a tremor	seen by nuerologist 2012, felt to be benign	01-Apr-2007	01-Apr-2007
Death of mother	age 29 MI	01-Jan-1991	01-Jan-1991

Past procedures (High and medium priority - all)

Description	Date performed	Date recorded
Elective caesarean delivery NOS	26-Feb-2017	26-Feb-2017

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Clenil Modulite Cfc-free inhaler 100 micrograms/actuation	2	2 INHALER	TWO PUFFS TO BE INHALED TWICE A DAY	-	12-Sep-2022	12-Sep-2022
Mirtazapine Tablets 45 mg	28	28 tablet	ONE TO BE TAKEN AT NIGHT	-	10-May-2022	11-Oct-2022
Salbutamol Cfc-free inhaler 100 micrograms/puff	1	1 INHALER	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY	-	12-Aug-2021	11-Oct-2022

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
	28	28 tablet		-	11-Oct-2022	

Lamotrigine Tablets 50 mg			TAKE ONE TABLET ONCE DAILY (TOTAL DAILY DOSE 75MG)			11-Oct-2022
Lamotrigine Tablets 25 mg	28	28 tablet	TAKE ONE TABLET ONCE DAILY (TOTAL DAILY DOSE 75MG)	-	11-Oct-2022	11-Oct-2022
Lamotrigine Tablets 50 mg	112	112 TABLET	WEEK 1+2 - TAKE ONE TABLET ONCE DAILY. WEEK 3 ONWARDS - TAKE ONE TABLET ONCE DAILY (TOTAL DAILY DOSE 75MG)	-	10-Oct-2022	10-Oct-2022
Lamotrigine Tablets 25 mg	28	28 tablet	WEEK 3 ONWARDS - TAKE ONE TABLET TWICE DAILY (TOTAL DAILY DOSE 75MG)	-	10-Oct-2022	10-Oct-2022
Fexofenadine Hydrochloride Tablets 180 mg	60	60 tablet	TAKE ONE TABLET UP TO TWICE DAILY	-	10-Oct-2022	10-Oct-2022
Clarithromycin Tablets 500 mg	10	10 TABLET	ONE TO BE TAKEN TWICE A DAY FOR 5 DAYS	-	23-Sep-2022	23-Sep-2022
Prednisolone Tablets 5 mg	40	40 TABLET	EIGHT TO BE TAKEN IN THE MORNING	-	12-Sep-2022	12-Sep-2022
Clarithromycin Tablets 500 mg	10	10 TABLET	ONE TO BE TAKEN TWICE A DAY FOR 5 DAYS	-	12-Sep-2022	12-Sep-2022
Amoxicillin Capsules 500 mg	15	15 CAPSULE	ONE TO BE TAKEN THREE TIMES A DAY FOR 5 DAYS	-	08-Sep-2022	08-Sep-2022
Benzydamine Hydrochloride Spray Sugar Free 0.15 %	1	1 SPRAY	USE 4-8 SPRAYS ONTO AFFECTED AREA EVERY 90 MINUTES TO 3 HOURS	-	08-Sep-2022	08-Sep-2022
Lamotrigine Tablets 25 mg	56	56 tablet	START AT ONE DAILY FOR 2 WEEKS. INCREASE DOSE BY 25MG EVERY 2 WEEKS UNTIL YOU REACH A DOSE OF 75MG TWICE DAILY (3 IN THE MORNING AND 3 AT NIGHT)	-	06-Sep-2022	06-Sep-2022
Amoxicillin Capsules 500 mg	15	15 CAPSULE	ONE TO BE TAKEN THREE TIMES A DAY FOR 5 DAYS	-	15-Jul-2022	15-Jul-2022
Hyoscine Butylbromide Tablets 10 mg	56	56 tablet	ONE TO BE TAKEN THREE TIMES A DAY	-	15-Jul-2022	15-Jul-2022
Propranolol Hydrochloride Tablets 40 mg	84	84 TABLET	ONE TO BE TAKEN THREE TIMES A DAY	-	10-May-2022	27-Jul-2022

Blood Pressure

Date Recorded	Systolic	Diastolic
08-Sep-2022	122	92
21-Sep-2021	120	60
17-Jul-2018	128	77
09-Jul-2015	123	90
08-Aug-2013	116	77

Body Measurements

Date Recorded	Height	Weight	BMI
10-Oct-2022	-	90	-
10-Jun-2021	160.02	82.55	32.24
23-Mar-2021	158	83	33.25
23-Mar-2021	-	83	-

17-Jul-2018 - - 29.64

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Non-smoker :		08-Sep-2022
Non-smoker :	hx noted, ongoing longstanding anxiety, tremors, seen by neurology and advised related to anxiety, using propranolol, feels doesn't help her, also uses saba for sob up stairs at times, bu- TRUNCATED	07-Oct-2021
Ex-smoker - amount unknown :		12-Aug-2021
Never smoked tobacco:		10-Jun-2021
Never smoked tobacco:		16-Sep-2019
Non-drinker alcohol :		07-Oct-2021
Alcohol consumption, 1 units/week:		10-Jun-2021
Alcohol consumption, 3 units/week:		17-Apr-2012
Light drinker - 1-2u/day:	Alcohol Intake$$.clm - Repeat after an Interval	21-Jan-2010

Clinical warnings

Allergies

Description	Comment	Date recorded
Adverse reaction to propranolol	possible wheeze with this	29-Apr-2016

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

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

Referred By:Referring GP

Electronic Attachment Present:Yes

Social circumstances

Ethnic Origin: (White) Scottish

Dermatology - 26082022 Administration Letter 748935

Dermatology - 26082022 Administration Letter 748895

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Respiratory Medicine GGC General Referral or Advice	—	**Consultant / receiving practitioner** and/or **specialty clinic**
Glasgow Royal Infirmary 84 Castle Street Glasgow G4 0SF	—	**Hospital** and **hospital address** Hospital location code. G107H Email address -

Urgency of referral Routine
Date of referral 13-Oct-2022 **Date sent** 14-Oct-2022

PATIENT DETAILS

Surname	McLeish
Forename(s)	Wendy
Title	Miss
Sex	Female
Date of birth	25-May-1987
CHI no.	2505876061
Area of Residence	-

Patient's address

Flat 3.2
312 Cumbernauld Road
Glasgow
G31 3LY

Contact number(s)

Voice: 07912347436

1010276753467

Unique Care Pathway Number: 1010276753467

REGISTERED GP DETAILS

Name	Dr Margaret Morris		
GMC code	4305792	GP code	05029
Practice name	Meadowpark Surgery (18882)		
Practice code	46625		

Practice address

568 Alexandra Parade
Glasgow
G31 3BP

Contact number(s)

Voice: 0141 554 0464
Facsimile: 0141 550 2002

REFERRING GP DETAILS

Name	Dr. Samuel Broadley		
GMC code	7477241	GP code	06807
Practice name	Meadowpark Surgery (46625)		

Practice address

568 Alexandra Parade
Glasgow
G31 3BP

Practice code	46625	Contact number(s)
		Voice: 0141 554 0464

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: Advice - Persistent Cough weeks post LRTI treatment (Left basal consolidation on initial x-ray)

Comment: Dear Colleague,

This 35-year old patient presents with five weeks' history of productive cough and increased shortness of breath following a coryzal illness. She has a more longstanding history of intermittent episodes of shortness of breath on exertion with wheeze with a background of eczema and hayfever. She is an ex-smoker.

She was initially assessed for this in September 2022 following her acute symptoms and found to have a diffuse wheeze heard to all zones with no focal crepitations, with saturations at 98% on room air. As she was already prescribed Propranolol for anxiety symptoms, the patient was hesitant to stop this. She was then prescribed Prednisolone and Clenil alongside Arithromycin antibiotics.

An acute chest x-ray shows evidence of bibasal air space opacification, particularly to the left side. It is reportedly in keeping with possible infection.

She then contacted us two weeks later where she reported that her cough remained unchanged and was then prescribed a course of Amoxicillin.

She attended us on Monday 10th October 2022 for a review and reported that her wheeze had dramatically improved but continuing to cough up thick clear sputum with no blood. She does not describe any unexplained weight loss or examination.

On examination (10th October 2022): She has a normal habitus and weighs 90kg; her chest is clear at all zones; heart rate is 80bpm (regular); no clubbing or lymphadenopathy.

In light of her background and the recent x-ray findings, I would be grateful for your specialist advice on appropriate next steps or investigations.

Many thanks,
Dr Samuel Broadley

Reason for referral

Care type requested: Out Patient
Expected outcome: Advise

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

Description	Comment	Date of onset	Date recorded
Asthma	-	12-Sep-2022	12-Sep-2022
Vulnerable child in family	-	16-Mar-2021	16-Mar-2021
Assault by bite of human being	by partner. bite to R ear, blunt head trauma by bottle.	01-Nov-2019	01-Nov-2019
Social worker involved	-	02-Sep-2019	02-Sep-2019
Alcohol problem drinking	-	02-Sep-2019	02-Sep-2019
Pityriasis versicolor	-	18-Feb-2019	18-Feb-2019
Miscarriage	surgical ERPC	03-Sep-2015	03-Sep-2015
Pneumonia due to unspecified organism	(Bilateral)	30-Dec-2011	30-Dec-2011
Adult respiratory distress syndrome	-	30-Nov-2011	30-Nov-2011
Overdose of drug	fluoxetine	22-Sep-2011	22-Sep-2011
Anxiety with depression	-	19-Jul-2011	19-Jul-2011
Death of father	-	31-Jan-2011	31-Jan-2011
Has a tremor	seen by nuerologist 2012, felt to be benign	01-Apr-2007	01-Apr-2007
Death of mother	age 29 MI	01-Jan-1991	01-Jan-1991

Past procedures (High and medium priority - all)

Description	Date performed	Date recorded
Elective caesarean delivery NOS	26-Feb-2017	26-Feb-2017

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Clenil Modulite Cfc-free inhaler 100 micrograms/actuation	2	2 INHALER	TWO PUFFS TO BE INHALED TWICE A DAY	-	12-Sep-2022	12-Sep-2022
Mirtazapine Tablets 45 mg	28	28 tablet	ONE TO BE TAKEN AT NIGHT	-	10-May-2022	11-Oct-2022
Salbutamol Cfc-free inhaler 100 micrograms/puff	1	1 INHALER	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY	-	12-Aug-2021	11-Oct-2022

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Lamotrigine Tablets 50 mg	28	28 tablet	TAKE ONE TABLET ONCE DAILY (TOTAL DAILY DOSE 75MG)	-	11-Oct-2022	11-Oct-2022
Lamotrigine Tablets 25 mg	28	28 tablet	TAKE ONE TABLET ONCE DAILY (TOTAL DAILY DOSE 75MG)	-	11-Oct-2022	11-Oct-2022
Lamotrigine Tablets 50 mg	112	112 TABLET	WEEK 1+2 - TAKE ONE TABLET ONCE DAILY. WEEK 3 ONWARDS - TAKE ONE TABLET ONCE DAILY (TOTAL DAILY DOSE 75MG)	-	10-Oct-2022	10-Oct-2022
Lamotrigine Tablets 25 mg	28	28 tablet	WEEK 3 ONWARDS - TAKE ONE TABLET TWICE DAILY (TOTAL DAILY DOSE 75MG)	-	10-Oct-2022	10-Oct-2022
Fexofenadine Hydrochloride Tablets 180 mg	60	60 tablet	TAKE ONE TABLET UP TO TWICE DAILY	-	10-Oct-2022	10-Oct-2022
Clarithromycin Tablets 500 mg	10	10 TABLET	ONE TO BE TAKEN TWICE A DAY FOR 5 DAYS	-	23-Sep-2022	23-Sep-2022
Prednisolone Tablets 5 mg	40	40 TABLET	EIGHT TO BE TAKEN IN THE MORNING	-	12-Sep-2022	12-Sep-2022
Clarithromycin Tablets 500 mg	10	10 TABLET	ONE TO BE TAKEN TWICE A DAY FOR 5 DAYS	-	12-Sep-2022	12-Sep-2022
Amoxicillin Capsules 500 mg	15	15 CAPSULE	ONE TO BE TAKEN THREE TIMES A DAY FOR 5 DAYS	-	08-Sep-2022	08-Sep-2022
Benzydamine Hydrochloride Spray Sugar Free 0.15 %	1	1 SPRAY	USE 4-8 SPRAYS ONTO AFFECTED AREA EVERY 90 MINUTES TO 3 HOURS	-	08-Sep-2022	08-Sep-2022
Lamotrigine Tablets 25 mg	56	56 tablet	START AT ONE DAILY FOR 2 WEEKS. INCREASE DOSE BY 25MG EVERY 2 WEEKS UNTIL YOU REACH A DOSE OF 75MG TWICE DAILY (3 IN THE MORNING AND 3 AT NIGHT)	-	06-Sep-2022	06-Sep-2022
	15			-	15-Jul-2022	

Amoxicillin Capsules 500 mg		15 CAPSULE	ONE TO BE TAKEN THREE TIMES A DAY FOR 5 DAYS			15-Jul-2022
Hyoscine Butylbromide Tablets 10 mg	56	56 tablet	ONE TO BE TAKEN THREE TIMES A DAY	-	15-Jul-2022	15-Jul-2022
Propranolol Hydrochloride Tablets 40 mg	84	84 TABLET	ONE TO BE TAKEN THREE TIMES A DAY	-	10-May-2022	27-Jul-2022
Zopiclone Tablets 7.5 mg	7	7 TABLET	ONE TO BE TAKEN AT NIGHT WHEN REQUIRED FOR ACUTE ANXIETY. ONE-OFF COURSE - NOT FOR RECURRENT OR LONG-TERM USE	-	10-May-2022	10-May-2022

Blood Pressure

Date Recorded	Systolic	Diastolic
08-Sep-2022	122	92
21-Sep-2021	120	60
17-Jul-2018	128	77
09-Jul-2015	123	90
08-Aug-2013	116	77

Body Measurements

Date Recorded	Height	Weight	BMI
10-Oct-2022	-	90	-
10-Jun-2021	160.02	82.55	32.24
23-Mar-2021	158	83	33.25
23-Mar-2021	-	83	-
17-Jul-2018	-	-	29.64

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Non-smoker :		08-Sep-2022
Non-smoker :	hx noted, ongoing longstanding anxiety, tremors, seen by neurology and advised related to anxiety, using propranolol, feels doesn't help her, also uses saba for sob up stairs at times, bu- TRUNCATED	07-Oct-2021
Ex-smoker - amount unknown :		12-Aug-2021
Never smoked tobacco:		10-Jun-2021
Never smoked tobacco:		16-Sep-2019
Non-drinker alcohol :		07-Oct-2021
Alcohol consumption, 1 units/week:		10-Jun-2021
Alcohol consumption, 3 units/week:		17-Apr-2012
Light drinker - 1-2u/day:	Alcohol Intake$$.clm - Repeat after an Interval	21-Jan-2010

Clinical warnings

Allergies

Description	Comment	Date recorded
		29-Apr-2016

Adverse reaction to propranolol	possible wheeze with this

Additional Support Needs
No known ASN requirements

Additional relevant information
Administrative information
OK to send correspondence to home address?:Yes
Patient will accept any site:Yes
Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Referred By:Referring GP
Electronic Attachment Present:No

Social circumstances
Ethnic Origin: (White) Scottish

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Neurology GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Glasgow Royal Infirmary 84 Castle Street Glasgow G4 0SF	——	**Hospital** and **hospital address** Hospital location code. G107H Email address -

Urgency of referral Routine
Date of referral 04-Apr-2022 **Date sent** 04-Apr-2022

PATIENT DETAILS

Surname	McLeish
Forename(s)	Wendy
Title	Miss
Sex	Female
Date of birth	25-May-1987
CHI no.	2505876061
Area of Residence	-

Patient's address

Flat 3.2
312 Cumbernauld Road
Glasgow
G31 3LY

Contact number(s)

Voice: 07912347436

101025993459X

Unique Care Pathway Number: 101025993459X

REGISTERED GP DETAILS

Name	Dr Margaret Morris		
GMC code	4305792	GP code	05029
Practice name	Meadowpark Surgery (18882)		
Practice code	46625		

Practice address

568 Alexandra Parade
Glasgow
G31 3BP

Contact number(s)

Voice: 0141 554 0464
Facsimile: 0141 550 2002

REFERRING GP DETAILS

Name	Dr. Samuel Broadley		
GMC code	7477241	GP code	06807
Practice name	Meadowpark Surgery (46625)		

Practice address

568 Alexandra Parade
Glasgow
G31 3BP

Practice code	46625

Contact number(s)

Voice: 0141 554 0464

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: Longstanding tremor

Comment: 34yo patient with longstanding multiple-decade history of widespread tremor. In context of anxiety and previous alcohol + polysubstance misuse - reports has been abstinent for a prolonged period. Remains under GP follow-up for anxiety symptoms - feels propranolol only thing that can improve things on occasion - tolerates this without wheeze in context of asthma diagnosis.

She has presented reporting worsening tremor symptoms over the last few months. This is most notable to both hands equally. No associated weakness / sensory changes / pain / co-ordination issues. No focal weakness / slowness in movements. No memory changes.

On examination she appears well with a course variable tremor. Power + function normal and equal with subjective sensation normal also. No co-ordination issues or past pointing with a normal gait.

She received a neurology review of this tremor in 2012 where it was felt these were attributed to anxiety. However in light of its chronicity and worsening features irrespective of her anxiety, I'd be grateful for your routine specialist assessment.

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

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

Description	Comment	Date of onset	Date recorded
Vulnerable child in family	-	16-Mar-2021	16-Mar-2021
Assault by bite of human being	by partner. bite to R ear, blunt head trauma by bottle.	01-Nov-2019	01-Nov-2019
Social worker involved	-	02-Sep-2019	02-Sep-2019
Alcohol problem drinking	-	02-Sep-2019	02-Sep-2019
Pityriasis versicolor	-	18-Feb-2019	18-Feb-2019
Miscarriage	surgical ERPC	03-Sep-2015	03-Sep-2015
Pneumonia due to unspecified organism	(Bilateral)	30-Dec-2011	30-Dec-2011
Adult respiratory distress syndrome	-	30-Nov-2011	30-Nov-2011
Overdose of drug	fluoxetine	22-Sep-2011	22-Sep-2011
Anxiety with depression	-	19-Jul-2011	19-Jul-2011
Death of father	-	31-Jan-2011	31-Jan-2011
Has a tremor	seen by nuerologist 2012, felt to be benign	01-Apr-2007	01-Apr-2007
Death of mother	age 29 MI	01-Jan-1991	01-Jan-1991

Past procedures (High and medium priority - all)

Description	Date performed	Date recorded
Elective caesarean delivery NOS	26-Feb-2017	26-Feb-2017

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Salbutamol Cfc-free inhaler 100 micrograms/puff	1	1 INHALER	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY	-	12-Aug-2021	03-Feb-2022
	84	84 tablet	ONE TO BE TAKEN THREE TIMES A DAY IF NEEDED	-	15-Jun-2021	10-Mar-2022

Propranolol Hydrochloride Tablets 10 mg

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Mirtazapine Tablets 45 mg	28	28 TABLET	ONE TO BE TAKEN AT NIGHT	-	04-Apr-2022	04-Apr-2022
Cerelle Tablets 75 micrograms	168	168 tablet	1 Tab Daily	-	21-Feb-2022	21-Feb-2022
Mirtazapine Tablets 30 mg	56	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	11-Jan-2022	10-Mar-2022
Amoxicillin Capsules 500 mg	15	15 CAPSULE	ONE TO BE TAKEN THREE TIMES A DAY FOR 5 DAYS	-	09-Dec-2021	09-Dec-2021
Prednisolone Tablets 5 mg	40	40 TABLET	EIGHT TO BE TAKEN IN THE MORNING	-	09-Dec-2021	09-Dec-2021
Mirtazapine Tablets 30 mg	56	56 tablet	ONE TO BE TAKEN AT NIGHT	-	10-Nov-2021	10-Nov-2021

Blood Pressure

Date Recorded	Systolic	Diastolic
21-Sep-2021	120	60
17-Jul-2018	128	77
09-Jul-2015	123	90
08-Aug-2013	116	77
14-Jan-2013	118	86

Body Measurements

Date Recorded	Height	Weight	BMI
10-Jun-2021	160.02	82.55	32.24
23-Mar-2021	158	83	33.25
23-Mar-2021	-	83	-
17-Jul-2018	-	-	29.64
29-Apr-2014	-	74	-

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Non-smoker :	hx noted, ongoing longstanding anxiety, tremors, seen by neurology and advised related to anxiety, using propranolol, feels doesn't help her, also uses saba for sob up stairs at times, bu- TRUNCATED	07-Oct-2021
Ex-smoker - amount unknown :		12-Aug-2021
Never smoked tobacco:		10-Jun-2021
Never smoked tobacco:		16-Sep-2019
Never smoked tobacco:		17-Jul-2018
Non-drinker alcohol :		07-Oct-2021
Alcohol consumption, 1 units/week:		10-Jun-2021
Alcohol consumption, 3 units/week:		17-Apr-2012
Light drinker - 1-2u/day:	Alcohol Intake$$.clm - Repeat after an Interval	21-Jan-2010

Clinical warnings

Allergies

Description	Comment	Date recorded
Adverse reaction to propranolol.	possible wheeze with this	29-Apr-2016

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

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

Referred By:Referring GP

Electronic Attachment Present:No

Social circumstances

Ethnic Origin: (White) Scottish

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments
Neurology - 12122011_Clinical Letter_125516
Neurology - 13082010_Referral_91339

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Neurology GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Glasgow Royal Infirmary 84 Castle Street Glasgow G4 0SF	——	**Hospital** and **hospital address** Hospital location code. G107H Email address -

Urgency of referral ROUTINE
Date of referral 18-Jan-2012 **Date sent** 18-Jan-2012

PATIENT DETAILS

Surname	Mcleish
Forename(s)	Wendy
Title	Miss
Sex	Female
Date of birth	25-May-1987
CHI no.	2505876061
Area of Residence	-

Patient's address
0/1 51 Coxton Place
GARTHAMLOCK
Glasgow
G33 5EJ

Contact number(s)
Voice: 07769733984

101003059742N Unique Care Pathway Number: 101003059742N

REGISTERED GP DETAILS

Name	Dr Anne McGinley		
GMC code	3341180	GP code	07307
Practice name	Easterhouse Health Centre (13448)		
Practice code	46471		

Practice address
9 Auchinlea Road
Easterhouse
Glasgow
G34 9HQ

Contact number(s)
Voice: 0141 531 8150
Facsimile: 0141 531 8158

REFERRING GP DETAILS

Name	Dr. Dalila Malek

Practice address
Easterhouse Health Centre

GMC code	6128612	GP code	54241
Practice name	Dr Wilson, Dr Mcginley & Dr Sheppar (46471)		
Practice code	46471		

9 Auchinlea Road
Glasgow
G34 9HQ

Contact number(s)

Voice: 0141 531 8150

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: Tremor

Comment: Dear Dr Miller,

Many thanks for seeing this young lady at your clinic. I believe she has been referred to you as an inpatient regarding an odd tremor, while in ward 7 at GRI when she had a prolonged admission for pneumonia in November 2011. She has unfortunately self-discharged prior to review.

Wendy has a known history of benign essential tremor since 2010, has been on Propranolol and she was first referred to neurology that year for further management. She did not keep her appointment.

Her tremor has been gradually worsening with little benefit from Propranolol and she is very keen for your specialist opinion. She confirmed she would attend on this instance and I have confirmed her current address as above. We would greatly value your input.

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

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

Description	Comment	Date of onset	Date recorded
Adult respiratory distress syndrome	-	30-Nov-2011	30-Nov-2011
Overdose of drug	fluoxetine	22-Sep-2011	22-Sep-2011
Benign essential tremor	-	08-Jul-2010	08-Jul-2010

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

No current medications recorded

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Fluoxetine Hydrochloride Capsules 20 mg	30	30 capsule	TWO TO BE TAKEN EACH DAY WEEKLY DISPENSE	-	05-Jan-2012	05-Jan-2012
Propranolol Hydrochloride Tablets 40 mg	42	42 tablet	ONE TO BE TAKEN THREE TIMES A DAY SEE DOC FOR NEXT	-	05-Jan-2012	05-Jan-2012
Propranolol Hydrochloride Tablets 40 mg	100	100 TABS	1 Tab 3 times daily	-	16-Nov-2011	16-Nov-2011
Fluoxetine Hydrochloride Capsules 20 mg	56	56 CAPSULE	TWO TO BE TAKEN DAILY	-	01-Nov-2011	01-Nov-2011
Propranolol Hydrochloride Tablets 40 mg	100	100 TABS	1 Tab 3 times daily	-	28-Sep-2011	28-Sep-2011
Fluoxetine Hydrochloride Capsules 20 mg	56	56 CAPSULE	TWO TO BE TAKEN DAILY	-	27-Sep-2011	27-Sep-2011
Zopiclone Tablets 7.5 mg	14	14 tablet	1 Tab At night	-	27-Sep-2011	27-Sep-2011
Fluoxetine Hydrochloride Capsules 20 mg	40	40 capsule	TAKE 20 MG THEN 40 MG ALTERNATE DAYS	-	14-Sep-2011	14-Sep-2011

Fluoxetine Hydrochloride Capsules 20 mg	28	28 capsule	ONE TO BE TAKEN EACH DAY WEEKLY DISPENSE	-	26-Aug-2011	26-Aug-2011
Propranolol Hydrochloride Tablets 40 mg	100	100 TABS	1 Tab 3 times daily	-	11-Aug-2011	11-Aug-2011
Cetirizine Hydrochloride Tablets 10 mg	30	30 TABS	1 Tab Daily	-	12-Jul-2011	11-Aug-2011

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Never smoked tobacco:	Smoker$$ Status.clm - No Action Required	21-Jan-2010
Light drinker - 1-2u/day:	Alcohol Intake$$.clm - Repeat after an Interval	21-Jan-2010

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

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

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:Yes

Neurology - 12122011_Clinical Letter_125516

Neurology - 13082010_Referral_91339

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

WILLIAMDURWARD (Consultant) Neurology GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Glasgow Royal Infirmary 84 Castle Street Glasgow G4 0SF	——	**Hospital** and **hospital address** Hospital location code. G107H Email address

Urgency of referral ROUTINE
Date of referral 13-Aug-2010 **Date sent** 13-Aug-2010

PATIENT DETAILS

Surname	Mcleish
Forename(s)	Wendy
Title	Miss
Sex	Female
Date of birth	25-May-1987
CHI no.	2505876061
Area of Residence	-

Patient's address

0/1 51 Coxton Place
GARTHAMLOCK
Glasgow
UK
G33 5EJ

Contact number(s)

Voice: 07769733984

101000864465M | Unique Care Pathway Number: 101000864465M

REGISTERED GP DETAILS

Name	Dr Anne McGinley		
GMC code	3341180	GP code	G07307
Practice name	Easterhouse Health Centre		
Practice code	46471		

Practice address

9 Auchinlea Road
Glasgow
G34 9HQ

Contact number(s)

Voice: 0141 531 8150
Facsimile: 0141 531 8158

REFERRING GP DETAILS

Name	Dr. Marie Wilson		
GMC code	2551656	GP code	01376

Practice address

9 AUCHINLEA ROAD
GLASGOW

Practice name	EASTERHOUSE HEALTH CENTRE (46471)
Practice code	46471

Contact number(s)
Voice: 0141 531 8150

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: Essential tremour ?

Comment: Thank you for seeing this young woman who has tremour affecting her hands in particular. This now happens most days. Alcohol helps reduce tremour. There has been slight benefit from propranalol but not much. This does not stop her day to day functioning or activities. She is keen to find out if anything further could be done to improve her symptoms as she finds the tremour embarrasing. She is otherwise well and takes OCP for contraception. BP is normal I was considering trying primidone but am a little reluctant as this is not available in the suggested starting dose fro Benign essentia tremour and because of the side effects. I would be grateful for your assessment and advice on other alternatives.

Reason for referral

Care type requested: Out Patient

Expected outcome: Investigate

Past medical history

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

Description	Comment	Date of onset
Benign essential tremor	-	08-Jul-2010
Death of mother	age 29 MI	01-Jan-1991

Past procedures (High and medium priority - all)

Description	Comment	Date performed
Child: clinical psychologist	in care a lot as a child Sexualised behaviour as a child	26-Oct-1994

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

No current medications recorded

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Propranolol Hydrochloride	100	TABS 40MG	1 Tab	3 times daily	13-Aug-2010	-
Cilest	126	TABS	-	-	13-Aug-2010	-
Aciclovir	1	Cold Sore CREAM 5%	-	-	13-Aug-2010	-
Cilest	126	TABS	-	-	13-Aug-2010	-
Aciclovir	1	Cold Sore CREAM 5%	-	-	13-Aug-2010	-
Propranolol Hydrochloride	100	TABS 40MG	1 Tab	3 times daily	13-Aug-2010	-
Cetirizine Hydrochloride	30	TABS 10MG	1 Tab	Daily	08-Jul-2010	-
Propranolol Hydrochloride	100	TABS 40MG	1 Tab	3 times daily	08-Jul-2010	-
Flucloxacillin	20	CAPS 250MG	1 Cap	4 times daily	21-Apr-2010	-
Fusidic Acid	5	Eye DROPS 1%	1 Drop	Twice daily	26-Mar-2010	-

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Never smoked tobacco:		21-Jan-2010
Light drinker - 1-2u/day:		21-Jan-2010

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

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

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:No

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

Previous Patient Notes for Plastic Surgery (newest at the top).

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

Patient Note		**Outpatient Note**
Date/Time: 27-Jun-2023 09:32	**Created By:** Consultant in Plastic Surgery - David McGill	**Role:** Doctor - GGC
Specialty: Plastic Surgery	**Organisation:**	Sensitive
Note: Seen in see and treat. Originally referred 2022 but DNA'd. Photos then show lesion right nasal side wall ? BCC. Since then this has improved. No raised lesion present, mild erythema only. No obvious need for biopsy today. Observe and refer if recurs. Photo taken today to document improvement. Discharge		

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

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

Patient Note		**Inpatient Note**
Date/Time: 11-Jan-2023 14:07	**Created By:** nurse - Julia Duczmal	**Role:**
Specialty: Acute Specialties GGC	**Organisation:**	Sensitive
Note: CEPHEID POCT NEGATIVE - LOW COVID RISK		

Previous Patient Notes for (newest at the top).

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

Patient Note		**Historical Note**
Date/Time: 10-Feb-2017 09:28	**Created By:** Midwife - Community PRM - Angela Bowden	**Role:**
Specialty:	**Organisation:**	Sensitive
Note: sw full name is delia ruiz glen, updated and ?no further action. will update me asap. advised of el cs date		

Patient Note		**Historical Note**
Date/Time: 09-Feb-2017 07:46	**Created By:** Midwife - Community PRM - Angela Bowden	**Role:**
Specialty:	**Organisation:**	Sensitive
Note: sw delai, tel parkhead 01415650140 or 0141 276 3469		

Patient Note		**Historical Note**
Date/Time: 07-Feb-2017 12:12	**Created By:** Midwife - Community PRM - Angela Bowden	**Role:**
Specialty:	**Organisation:**	Sensitive
Note: sw delia updated re wendy. tel 0141 565 0140, parkhead sw.		

Patient Note		**Historical Note**
Date/Time: 03-Feb-2017 07:55	**Created By:** Midwife - Community PRM - Angela Bowden	**Role:**
Specialty:	**Organisation:**	Sensitive
Note:		

still no update from sw. as before please inform andrea Nairn if delivers, tel 0141 276 3400, easterhouse sw

Patient Note		Historical Note
Date/Time: 10-Jan-2017 12:23	Created By: Midwife - Community PRM - Angela Bowden	Role:
Specialty:	Organisation:	Sensitive
Note:		
still no allocated sw, in thwe interim contact andrea nairn, easterhouse sw, tel 0141 276 3400		

Patient Note		Historical Note
Date/Time: 06-Sep-2016 15:10	Created By: Midwife - Community - Elaine Thomson	Role:
Specialty:	Organisation:	Sensitive
Note:		
social work referral completed and sent		

Patient Note		Historical Note
Date/Time: 15-Aug-2016 12:25	Created By: Midwife - Community - Elaine Thomson	Role:
Specialty:	Organisation:	Sensitive
Note:		
letter to gp/hv .high risk pregnany .for referral to PNMHT,on propranolol,mitazapine .Social work referral as partner convivted of assault charge.SNIPS referral complete .Wendy aware of referrals		

Patient Note		Historical Note
Date/Time: 05-Aug-2015 07:27	Created By: Midwife - Community PRM 20210507 MJ - RITM0106954 - Kate Jessamine	Role:
Specialty:	Organisation:	Highly Sensitive
Note:		

for discussion at next NE liason SW group in view of Wendy prev in care /FH drug misuse and partners recent incarceration

Patient Note		Historical Note
Date/Time: 03-Aug-2015 13:14	**Created By:** Midwife - Community PRM - Linda Fellows	**Role:**
Specialty:	**Organisation:**	Sensitive

Note:

Completed Social Work referal and Perinatal Mental Health referal

Patient Note		Historical Note
Date/Time: 03-Aug-2015 10:29	**Created By:** Midwife - Community PRM - Linda Fellows	**Role:**
Specialty:	**Organisation:**	Sensitive

Note:

Booker at Easterhouse high risk due to medication on Propanalol and Mirtazapine.
Wendy was in care as a child due to history of parental drug abuse. She has no history of this. however has history of drug overdose and will have Perinatal Mental Health referal.
Also Social Work referal necessary as partner has had a criminal conviction for assault. wendy aware of both of these referals. Will discuss with Snips.
Had Pneumonia with Adult Respiratory Distress Syndrome 2011 induced coma for that.
Letter to GP and HV stating High Risk

WENDY MCLEISH

2505876061

Scottish Ambulance Service

Age/Gender:	38Y, Female	**Incident Date:**	20/12/2025 22:20:00
DOB:	25/05/1987	**ePCR Number:**	28-2-201225-222044
Address:	0/1 257 TODD STREET HAGHILL GLASGOW, G31 3SF	**Incident Number:**	CR012778314
		Incident Type:	EMG
CHI Number:		**Incident Location:**	0/1 257 TODD STREET HAGHILL GLASGOW, G31 3SF
Ethnicity:			

PATIENT INFO

Capacity Assessed

	Deemed to have Capacity

Clinical Assessment

Consent Decision:	**Consent Gained**	**Clinical Assessment Explained/Discussed:**	**Benefits of Assessment Explained, Risks of No Assessment Explained**

Treatments

Consent Decision:	**Consent Gained**	**Treatment Explained/Discussed:**	**Benefits of treatment explained, Risks of No treatment explained**

ADDITIONAL COMMENTS

Presenting Complaint:	**Vomiting, sob, chest tightness, back pain**	

Timestamp	Additional Comment	Crew Name
20/12/2025 22:53:00	999 call 38yof sob, chest tightness, vomiting, vomiting, back pain. O/a pt on couch, states gas hole in heart awaiting appointment for surgery, today vomiting cant keep fluids or food down, sob, pain in back, chest tightness,left leg weakness resulted in several falls, reduced appetite, reduced urine output and urine is dark in colour. o/e pulse 100 other obs normal. Med his; epilepsy, fnd, hole in heart, sciatica, depression, anxiety 'took meds for pain relief nil effect and vomiting back up. Taken to gri.	

ACVPU

Options:	**Alert**

CATASTROPHIC HAEMORRHAGE

Catastrophic Haemorrhage:	**No**

AIRWAY

Assessment:	**Clear**

BREATHING

Breathing Adequately:	**Yes**	**Initial Respiratory Rate:**	**16**
Initial SpO2:	**96**	**Initial SpO2 On Air:**	**Yes**
Oxygen Given:		**No**	

CIRCULATION

Pulse Rate:	**100**	**Rhythm:**	**Reg**
Most Distal Pulse Found:	**Radial**	**Cap Refill:**	**<=2 Secs**
Central Peripheral:	**Peripheral**	**Arm:**	**Right**
Systolic Pressure:	**128**	**Diastolic Pressure:**	**84**
ECG:		**3 Lead**	

Rhythm

Rhythm:	**Sinus Tachy**

2505876061

Skin

Appearance:	**Normal**	**Skin Texture:**	**Dry**
Skin Temperature:		**Warm**	

DISABILITY

Initial GCS:

Timestamp	Eyes Value	Eyes Score	Voice Value	Voice Score	Motor Value	Motor Score	Final Score
20/12/2025 22:43:00	Spontaneously	4	Orientated	5	Obeys Commands	6	15

Eyes

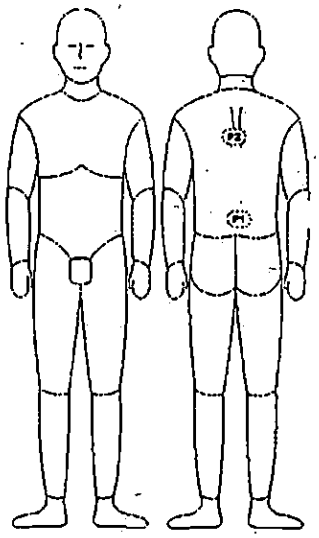
Left Pupil Size (Mm):	**4**	**Right Pupil Size (Mm):**	**4**
Pupils Equal And Reactive To Light (Pearl):		**Yes**	

Blood Glucose

Blood Sugar Value (MMOL/L):	**6.4**

EXAMINATION

Assessment Graphic



Pain Table

ID	Pain Scale	Body Part
P1	6	Back Body
P2	6	Back Body

OBSERVATIONS

Observations Assessment

Timestamp	Pulse	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	Temp	BM	ECG	P(L | R)	PEF	Crew
20/12/2025 22:25:00	100	16	128/84	96	<=2 Secs	15	Alert		37.2	6.4	Sinus Tachy	4|4		E9885979
20/12/2025 22:44:00	98	16	126/89	95	<=2 Secs	15	Alert							E9885979

GCS

Timestamp	Eyes Value	Eyes Score	Voice Value	Voice Score	Motor Value	Motor Score	Final Score
20/12/2025 22:25:00	Spontaneously	4	Orientated	5	Obeys Commands	6	15
20/12/2025 22:44:00	Spontaneously	4	Orientated	5	Obeys Commands	6	15

NEWS Score

Timestamp	RR	SpO2 Scale 1	SpO2 Scale 2	AirO2	BP	P	ACVPU	T	Total
20/12/2025 22:25:00	16 (0)	96 (0)		0	128 (0)	100 (1)	Alert (0)	37.2 (0)	1

AMPLE

2505876061

Medication	
Medication:	**On ecs**
Neurological Disease	
Epilepsy:	**Yes**
Other	
Other:	**Hole in heart, anxiety, depression, FND**
Last Eaten	
Last Eaten:	**>4 Hours Ago**
CLOSE REPORT	
Clinical Response Feedback	
On-Scene Clinical Findings	**Emergency**
CONVEYANCE	

Transport To Hospital	**Normal Driving**	**Pre-Alert**	**No**
Destination Hospital		**GLASGOW ROYAL INFIRMARY**	
INCIDENT INFORMATION			
Dispatch			
Dispatch Code	**10D04**	**Dispatch Description**	**Clammy or Cold Sweats with Chest Pains**

Incident Log

Status Time	Status	Callsign	Reason	Hospital
22:07:03	Call Received Time	GGE5825		
22:22:49	Mobile	GGE5825		
22:27:41	At Scene	GGE5825		
22:54:26	Leave Scene	GGE5825		GLASGOW ROYAL INFIRMARY

CREW INFORMATION

Additional Crew

Crew ID	Crew Grade
E9885979	Ambulance Technician (AT)
E102308X	Ambulance Paramedic (AP)

[redacted]

CHI: 2505876061

Glasgow Royal Infirmary

8

Total Att: 29

12 Mth Att: 8

Title: MISS

MCLEISH **Wendy**

DOB: **25/05/1987** Age: **38y** Sex: **Female**

0/1
257 TODD STREET
Glasgow
Lanarkshire
G31 3SF
07912347436

Next of kin: **WARD, James**
Relationship: **Partner**

GP: **M Lyons**
0141 800 0272

Attendance Date: **20/12/2025** Arrival Time: **23:08**

Registration Time: **23:08** Date of Incident: **20/12/2025**

Major Incident Desc:

Reason for Attendance: **vomiting/SOB**

Nursing Assessment

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

Triage Category: 0 3 Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **20/12/2025 23:40** Nurse name: **Nurse Julia Duczmal**

RR	18	bpm
Oxygen		%
Air or O2		
SpO2	100	%
HR	79	bpm
BP	117/94	mmHg
CRT		
MAP	102	mmHg
AVPU		
Temp	35.6	C
EWS Total		

BM	6.4 sas	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

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

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

Nursing Notes: **UNWELL since this morning; NEWS=1; chest tightness, also ?epigastric / central chest pain in triage, intermittent, worse on movement and inspiration - Hx small ASD and refereed for closure; pain in the back as well; pt reporting 3 falls today - slipped from couch and the toilet - no obvious injuries; FAST negative in triage; other Hx FND, epilepsy. Suitable for cat. 3 if nil acute on ecg**

2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy

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

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

Date	**Clinical Notes**	
	Seen By	Time Seen

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By
21/12	Prochlorperazine	TTO			DG	

MEDICINE **PRESCRIPTION FORM**

Hospital Name: .....

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐
Date _____ Name (Print) _____
Discharge Prescription Prepared & Reconciled YES ☐
Date _____ Name (Print) _____

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

DOCTOR'S DECLARATION (if required by Local Protocol)

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

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name _____ Tel No. _____
Address _____
Compliance Aid Details _____
Patient consent to share discharge information Y/N
Print & Sign _____

PATIENT DETAILS

Ho
DO
Dal
Co

2505876061
MCLEISH F
Wendy 25/05/1987
0/1
257.TODD STREET
Glasgow, Lanarkshire
G31 3SF

Height:
Weight:
Surface area:
Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
21/12	Prochlorperazine	20mg	PO	0245	DTE	ef	0300
21/12	Dihydrocodeine	60mg	PO	0245	DTE	ef/BD	0300

TARGET OXYGEN SATURATIONS

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

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

On Home Oxygen? Yes / No _____ L/min

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

DATE →

MONTH →

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

IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N

ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N

SIGNATURE OF ASSESSOR

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

Parenteral Drugs : Regular Prescription

Patient's Own Medicine

A

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

B

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

C

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

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

2505978001
MCLEISH
Wendy
0/1
25/05/1997 F
257 TODD STREET
Glasgow, Lanarkshire
G31 3SF

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

| | | |

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

| | | |

Oral and Other Drugs: Regular Prescription

2505676061
MCLEISH
Wendy
0/1
257 TODD STREET
Glasgow, Lanarkshire
G31 3SF

DATE
MONTH

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

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

M DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

N DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

P DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

R DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

S DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

T DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

V DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

W DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

2505876061
MCLEISH
Wendy
0/1
257 TODD STREET
Glasgow, Lanarkshire
G31 3SF
25/05/1982

Oral and Other Drugs: Regular Prescription

DATE
MONTH

Patient's Own Medicine

| | | |

Oral and Other Drugs: Regular Prescription

DATE
MONTH

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

Patient's Own Medicine
For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

2508876061
MCLEISH
Wendy
0/1
25/05/198
257 TODD STREET
Glasgow, Lanarkshire
G31 3SF

Oral and Other Drugs: Regular Prescription

DATE
MONTH

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

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

GG DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

HH DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

JJ DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

KK DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

All Routes: As Required Prescriptions

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

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

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

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

2505876061
MCLEISH F
Wendy 25/05/1987

Name

CHI No

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

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

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

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

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).
2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).
3. Print & Sign your full name clearly against each prescription entry.
4. Time should be recorded in 24hr format e.g. 0600, 1800.
5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.
6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.
7. The following metric unit abbreviations must be used –

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

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

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

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

Please note - intrathecal must be written in full.

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.
2. Insert initials in the relevant date column and time row each time a drug is administered.
3. Check that all drugs prescribed at a certain time have been administered.
4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

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

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

Glasgow Royal Infirmary
Emergency Department

NHS
Greater Glasgow and Clyde

2505876061
MCLEISH F
Wendy 25/05/1987

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

Clinical Notes

Date 21/12/25 Time 0200 Name Declan Todd Grade FY2 Speciality ED

PC: Back Pain

PMHx: ETOH XS
Asthma Sciatica
Bronchiectasis
Epilepsy
Small ASD
Seen by neuro ? FND

HPC: Long standing hx back pain, worse since 1/7/day. Fell off couch. Feels L leg giving way.

Also epigastric pain for 1/7. Unable to keep food + drink down. ~~Feel nauseous~~

DHx: As per ECS

~~For~~Last ate yesterday morning

Not passed urine since yesterday. Not moved bowels for 3-4 days which is usual for her.

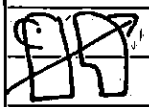
No abnormal sensation/spasms. No SOB/cough/palpitations.

Denies alcohol + drug use

O/E

HS 1+1+0 Abdomen soft, does states pain on palpation upper abdomen, no guarding





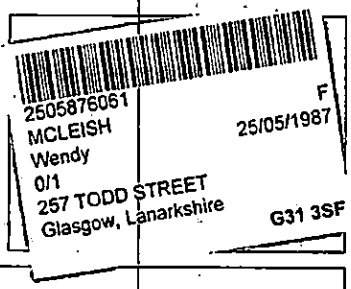
CNS intact

Normal tone, power, reflexes + sensation B/L upper limbs

Normal tone, reflexes + sensation B/L lower limbs. Power variable on examination.

NEWS 1 - BP 101/51 Bloods NAD →

Glasgow Royal Infirmary
Emergency Department



Clinical Notes

Date 21/12/13 Time 0200 Name Declan Todd Grade FY2 Speciality ED

(F) D/W Reg Natasha Brannan
Trial anti-emetics + analgesia, ↓ settles (H) DT

0340
Improved – D/C w Prochlorperazine DT

Glasgow Royal Infirmary
Emergency Department

2505876061
MCLEISH F
Wendy 25/05/1987

Clinical Notes

Date	Time	Name	Grade	Speciality

Glasgow Royal Infirmary
Emergency Department

2505876061
MCLEISH
Wendy
F
25/05/1987

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

Diagnosis and Plan	

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

mi • 287967 Version 1_0 • GGC0226

Patient name

Patient CHI

2505876061
MCLEISH F
Wendy 25/05/1987
0/1
257 TODD STREET
Glasgow, Lanarkshire
G31 3SF

NHS
Greater Glasgow and Clyde

Emergency Care Nursing Documentation

Initial Investigations

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

Communication

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

Signature:

PVC

Circle reason: D R I F T

Diagnostic
Resuscitation
Intravenous Fluids
Transfusion

Insertion
Date: _____
Time: _____

Insertion Side: L R

Insertion Site:

Size of PVC:

Inserted by
_____
Signature
_____

Hand Hygiene Yes ☐

Skin Decontamination 2% chlorhexidine in 70% isopropyl alcohol Yes ☐

Sterile transparent semi-permeable dressing affixed Yes ☐

PVC Reason Explained Yes ☐

Risk Assessments and Screening Tools

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

Pause for Discharge

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

Signature:

Pause for Transfer

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

Signature:

Patient name

Patient CHI

2505876061
MCLEISH F
Wendy 25/05/1987
0/1
257 TODD STREET
Glasgow, Lanarkshire
G31 3SF

NHS
Greater Glasgow and Clyde

Care Rounds Checklist

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

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

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

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

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

Patient name

Patient CHI

2505876061
MCLEISH
Wendy
0/1
257 TODD STREET
Glasgow, Lanarkshire
G31 3SF
F
25/05/1987

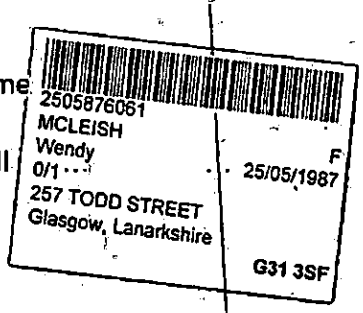
NHS
Greater Glasgow and Clyde

Nursing notes

Date and Time		Name/Signature
21/12/25 0000	Pt moved into admin & multiple complaints Observations on chart - NEWS 1. Bloods and ECG done Awaits medical c/v	

Patient name

Patient CHI



NHS Greater Glasgow and Clyde

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

Ongoing Care

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

Patient nam

Patient CHI

2505876061
MCLEISH
Wendy F
0/1 25/05/1987
257 TODD STREET
Glasgow, Lanarkshire
G31 3SF

Hospital:

Ward:

Points to consider:

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

NHS
Greater Glasgow and Clyde

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

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

1	**PressureDamage**	**Does the person have Pressure damage; Grade 1, 2, 3, 4, SDTI, Ungradable?**
2	**Mobility**	**Does the person require assistance to mobilise or change position?**
3	**Continence**	**Does the person have moisture issues, or, continence issues with urine and/or faeces?**
4	**Nutrition**	**Does the person appear malnourished and/or unable to eat or drink?**
5	**Skin**	**Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?**
6	**Judgement**	**In your clinical judgement, is this person at risk of developing pressure damage?**

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

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

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

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

Patient name

Patient CHI

2505876061
MCLEISH
Wendy
0/1
257 TODD STREET
Glasgow, Lanarkshire
F
25/05/1987
G31 3SF

NHS
Greater Glasgow and Clyde

Nursing notes cont.

Date and Time			Name/Signature	

NHSGGC Adult In-Patient National Early Warning Score (NEWS)

NHS Greater Glasgow and Clyde

2505876061
MCLEISH
Wendy F
0/1 25/05/1987
257 TODD STREET
Glasgow, Lanarkshire
G31 3SF

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP Initials ONLY:	Dr/ANP Initials ONLY:	
Date:	Date:	

Document all actions and Interventions

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

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

Discontinuation of NEWS

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

Signed .....

Medical: .....

Date: .....

Pupil Reaction and size
s = sluggish
n = normal
no = no reaction
c = eyes closed
Pupil Size (mm) 1 2 3 4 5 6 7 8

Glasgow Coma Scale

Date:
Time:
Eyes (E): Spontaneously 4; To sound 3; To pressure 2; None 1; Not possible NT
Eyes closed by swelling = NT
Verbal (V): Orientated 5; Confused 4; Words 3; Sounds 2; None 1; Not possible NT
Endotracheal tube or tracheostomy = NT
Motor (M): Obeys command 6; Localising pressure 5; Flexion Withdrawal 4; Abnormal flexion 3; Extension 2; None 1; Not possible NT
Assess record the best response
TOTAL 15
Right size: 4
Right reaction: 4
Left size: 4
Left reaction: 4
Record dp/dt (R) and time if abnormal or if there is a difference between the two sides
Record dp/dt (R) and time if abnormal or if there is a difference between the two sides

Pain Function Score

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

Pain Score

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

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

2505876061
MCLEISH
Wendy F
25/05/1987
257 TODD STREET
Glasgow, Lanarkshire
G31 3SF

011 - 316654 v5.2 GGC0024

8 WENDY MCLEISH

NEWS 2 Key	1	2	3

| | | |

CHI: 2505876061

Glasgow Royal Infirmary

85

Total Att: 28

12 Mth Att: 7

Title: **MISS**

MCLEISH **Wendy**

DOB: **25/05/1987** Age: **38y** Sex: **Female**

FLAT 3/2
312 CUMBERNAULD RD
Glasgow
Lanarkshire
G31 3LY
07912347436

Next of kin: **WARD, James**
Relationship: **Partner**

GP: **M Lyons**
0141 800 0272

Attendance Date: **19/09/2025** Arrival Time: **11:06**

Registration Time: **11:06** Date of Incident: **19/09/2025**

Major Incident Desc:

Reason for Attendance: **facial/head injuries**

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **19/09/2025 11:16** Nurse name:

Temp	**36.0**	C
HR	**72**	bpm
BP	**118/107**	mmHg
MAP	**110.67**	mmHg
RR	**16**	bpm
SpO2	**96**	%
Oxygen		%

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **Multiple injuries. NEWS 0, Vague historian, states bitten by dog to nose. No broken skin but severe panda eye bruising, swelling to nose and forehead. Also multiple bruises to left and right forearms, similar to defensive type marks. Under Ix for seizures. On GAbapentin, DF118 and Lamotragine. 2 for consideration of CT**

2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy

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

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

Date	Clinical Notes		
	Seen By		Time Seen
19/9	Pmhx: Epilepsy Bronchiectasis		

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By
19/9	Co-codamol 30/500	x2	PO	14:58		

Glasgow Royal Infirmary
Emergency Department

NHS
Greater Glasgow and Clyde

2505876061 F
MCLEISH 25/05/1987
Wendy
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

Initial Investigations Ordered

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

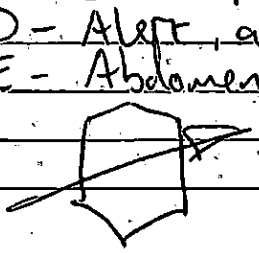
Clinical Notes

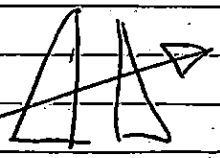
Date 19/9 Time Name M.Burke Grade CF Specialty ED

38 F — PmHx: Epilepsy SocHx: lives alone N.T ETOH x5

HoPC: Presents with social worker, was supposed to be signing for new flat this morning social worker went round to her flat and found her to be covered in bruises and blood.
- @ Triage noted to have bilateral panda eyes.
- Pt tells myself + triage that she has been bitten by her friends dog on her face overnight.
- Story not really in keeping with injuries.
- Denies LOC or seizure activity.

O/E — Significant facial swelling, bilateral panda eyes.
C-spine n/t pain, bruises to wrists
A- Patent
B- Chest clear, sats 96% OA RR 16, Nil chest wall bruising
C- BP 118/107, HR 72, CRT <2s
D- Alert, apyrexial.
E- Abdomen soft, non-tender, nil bruising





Glasgow Royal Infirmary
Emergency Department

2505876061 F
MCLEISH
Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

Clinical Notes

Date	Time	Name	Grade	Speciality

M. Burke cont

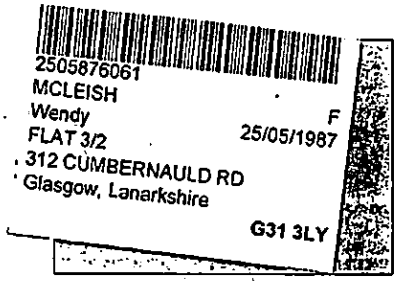
Imp – Injuries in keeping with assault
Pt continues to deny however.
Plan – · CT head + facial bones + CXR
· Re-visit history post imaging.
· Pt adamant feels safe at home

M. Burke

Update 1640
→ CTB reported as (N)
Patient remains well, still adamant wounds are from friends dog and not willing to talk any further about this.
Patient says she feels safe at home
Discharged with head injury worsening advice leaflet + verbal advice

M. Burke

Glasgow Royal Infirmary
Emergency Department



Clinical Notes

Date	Time	Name	Grade	Speciality

Glasgow Royal Infirmary
Emergency Department

2505876061
MCLEISH F
Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

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

Diagnosis and Plan

Review/Discussed with:

Handover

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

mi • 287967 Version 1_0 • GGC0226

Pat 2505876061 .....
MCLEISH F
Pat Wendy 25/05/1987 .....
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

NHS
Greater Glasgow and Clyde

Emergency Care Nursing Documentation

Initial Investigations

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

Signature: ABST

Communication

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

Signature:

Risk Assessments and Screening Tools

	SEPSIS	Y	N	GMAWS	Y	N
	FAST	Y	N	Adult Support and Protection	Y	N
Time:	Swallow Testing	Y	N	Mental Health Triage Assessment	Y	N
	Falls Risk (clinical judgement)	Y	N	Child Protection Concerns	Y	N
	4AT Assessment	Y	N	Frailty Assessment	Y	N
				Public Protection (NOC)	Y	N

Signature:

Pause for Discharge or Transfer

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

Signature:

Patient name .....

Patient CHI .....

or use sticker

NHS

Greater Glasgow and Clyde

Care Rounds Checklist

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

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

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

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

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

Patie

2505876061
MCLEISH F
Patie Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

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

NHS
Greater Glasgow and Clyde

PUDRA

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

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

2	Mobility	Does the person require assistance to mobilise or change position (inappropriate for age)?
3	Continence	Does the person have continence issues with urine and/or faeces (inappropriate for age)?
4	Nutrition	Does the person appear malnourished and/or unable to eat or drink/ PYMS score>2?
5	Skin	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?
6	Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

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

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

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

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

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

Patient name .....

Patien

2505876061
MCLEISH F
Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

NHS
Greater Glasgow and Clyde

Ongoing Care

	4 Hours	5 Hours	6 Hours	7 Hours	8 Hours	9 Hours	10 Hours	11 Hours	12 Hours
Time									
Nursing notes updated including (NEWS, MEWS,PEWS)									
FFN (provide details)									
IV/PVABs									
Routine Medications prescribed and administered									
Falls risk assessment									
Skin assessed and supported (PURDRA)									
Analgesia assessment									
Nurse call system in place									
SEAR commenced									
Patient/ relatives updated									
Elimination needs met (does the patient know where toilet is)									
If patient not in cubicle space think about patients dignity requirements eg hearing aids, mobility aids, glasses, interpreter									
STOPPS completed									

Patient 2505876061

Patient MCLEISH F
Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

NHS
Greater Glasgow and Clyde

Nursing notes

Date and Time	Name/Signature
19/9/25 15:44 Multiple injuries. states was bitten by dog on face. severe bilateral swollen + panda eyes xrays and CT obtained. medic in attendance.	[illegible] (SN)
1745. D/C as per medics	[illegible] (SN)

Patient name .....

Patient CHI .....

or use sticker

NHS
Greater Glasgow and Clyde

Nursing notes cont.

Date and Time	Name/Signature

5

LLENOS
MCLEISH

NEWS 2 Key	1	2	3

| | | |

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

2505976061
MCLEISH F
Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP Initials ONLY:	Dr/ANP Initials ONLY:	
Date:	Date:	

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed.....

Medical:.....

Date:.....

Pupil Reaction and size

s = sluggish
+ = reaction
– = no reaction
c = eyes closed

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

Glasgow Coma Scale

Pain Score

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

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

C Moderate limitations, attempts but reluctant to continue because of pain. **Seek Advice**

D Severe limitations, unable to or refuse to perform because of pain. **Urgent Review Required**

...ons, activity unrestricted by pain or settles quickly

...ild limitations, mild activity restrictions

2505976061
MCLEISH F
Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

mi • 316654 v2.1 • GGC0264

CHI: 2505876061

Glasgow Royal Infirmary

2

Total Att: 27

12 Mth Att: 6

Title: **MISS**

MCLEISH **Wendy**

DOB: **25/05/1987** Age: **38y** Sex: **Female**

FLAT 3/2
312 CUMBERNAULD RD
Glasgow
Lanarkshire
G31 3LY
07912347436

Next of kin: **WARD, James**
Relationship: **Partner**

GP: **M Lyons**
0141 800 0272

Attendance Date: **12/09/2025** Arrival Time: **12:57**

Registration Time: **12:57** Date of Incident: **12/09/2025**

Major Incident Desc:

Reason for Attendance: **acute distress**

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **12/09/2025 13:12** Nurse name: **Nurse Morag Paterson2**

Temp	36.3	C
HR	83	bpm
BP	128/88	mmHg
MAP	101.33	mmHg
RR	19	bpm
SpO2	98	%
Oxygen		%

BM	5.2	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

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

Nursing Notes: **"?MH. NEWS 0. SAS called this morning due to acute behavioural episode. Agitated, running into road & smashing up house. Police on scene. Partner states pt keeps trying to jump out of window. Appears distracted. Partner unsure if any extra prescribed meds taken. "**

2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy

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

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

Date	Clinical Notes		
	Seen By	Time Seen	

12/9/14

Dr Mowbray & cons

Y fit for d/c home.

? acute stress response
? illicit substance (denies).
? panic disorder

No indication for I/P Y.

we will refer to crisis team. Y fit for d/c.

① Diazepam 5mg x 6 ~~~ MIH2

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By
12/9/14	Doxycycline	100mg BD	PO	TTO		AC

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

NHS Greater Glasgow and Clyde

2505876061
MCLEISH
Wendy F
25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

Part One - Nursing Triage

Triage document physiological measurements

GCS	BM	HR	BP	RR	SaO2	Temp
15	5.2	83	128/89	19	98%	36.3

Accompanied by

name, relationship, concerns

Outline of Presentation tick all the categories which apply

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

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

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

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

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

Initial Presentation, Appearance and Behaviour respond yes or no to each question

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

Triage Risk Assessment identify an initial category of risk, and one or more risks

High / Moderate / Low

Self-harm / Violence / Absconding

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

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

Other patients can be categorised **Moderate Risk**

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

Immediate management

Summary
white female. dark hair. Diamond earrings. Grey/purple puffer. Black leggings. slides

Patient location...

accompanied by...

Blood sample time?	
TOXBASE info printed?	YES / NO
GMAWS considered?	YES / NO

Signature

Name M Paterson

Date 19/9/25 Time 18:10

©NHSGG&C Mental Health and Acute Services Interface Group.

Part Two - Mental Health Assessment

patient name (or use sticker)

CHI

outline of current presentation and precipitating factors

(30)+ body. had epoch of tremors last day becoming very agitated running around house throwing things at walls ran out each & exposing self in street not used for potty. Previously refused to come for therapy in between. Denies voices apart from day mins.

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

Previously refused CPTSD but to follow up
Denies suicidal ideation.
Denies hallucinations
Previous psychotic episode

ECG sin tach
Bloods sent.

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

Past - Cerebral dysfunction, PTSD, fall down stairs, Bronchiectasis, Resp failure with exacerbation

Presentation

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

Appearance dishevelled / unwashed

Behaviour tearful, agitated, not openly disruptive

Mood stable ok

Speech Coherent

Thought nil clear abnormality

Insight impaired

Risk Factors

(not an exhaustive list)

38 Age

Gender F

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

Risk Assessment

High / Moderate / Low

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

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

Discharge Advice, Plan for Further Assessment

Summary of problems,advice given, and service referred to (Liaison Psychiatry, CPNs, CMHT, SW, Addictions, GP etc)

Referred to liaison psych
seen & discharged to GP with diazepam
WOR schedule

Name/relationship of carers informed.

Consultant or Middle-grade involved in discussion or review

Signature

Name Andrew [illegible]

Designation CPST1 Date 12/9/19 Time

© NHSGG&C Mental Health and Acute Services Interface Group.

Patient name

Patient CHI

2505876061
MCLEISH F
Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

NHS
Greater Glasgow and Clyde

Emergency Care Nursing Documentation

Initial Investigations

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

Communication

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

Signature:

PVC

Circle reason:
D R I F T

Diagnostic
Resuscitation
Intravenous Fluids
Transfusion

Insertion
Date: _____
Time: _____

Insertion Side: L R

Insertion Site:

Size of PVC:

Inserted by
_____
Signature
_____

Hand Hygiene Yes ☐

Skin Decontamination 2% chlorhexidine in 70% isopropyl alcohol Yes ☐

Sterile transparent semi-permeable dressing affixed Yes ☐

PVC Reason Explained Yes ☐

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

Pause for Discharge

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

Signature:

Pause for Transfer

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

Signature:

Patient name

Patient CHI

2505876061
MCLEISH F
Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

NHS
Greater Glasgow and Clyde

Care Rounds Checklist

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

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

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

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

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

Patient name

Patient CHI

2505876061 F
MCLEISH
Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

ospital:

ard:

Points to consider:

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

NHS Greater Glasgow and Clyde

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

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

1	PressureDamage	**Does the person have Pressure damage; Grade 1, 2, 3, 4, SDTI, Ungradable?**
2	Mobility	**Does the person require assistance to mobilise or change position?**
3	Continence	**Does the person have moisture issues, or, continence issues with urine and/or faeces?**
4	Nutrition	**Does the person appear malnourished and/or unable to eat or drink?**
5	Skin	**Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?**
6	Judgement	**In your clinical judgement, is this person at risk of developing pressure damage?**

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

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

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

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

Patient name .....

Patient CHI .....

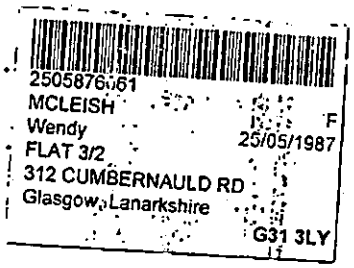
or use sticker

NHS
Greater Glasgow and Clyde

Nursing notes cont.		
Date and Time		**Name/Signature**

Patient name

Patient CHI



NHS
Greater Glasgow and Clyde

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

Ongoing Care

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

Patient name

Patient CHI

2505876061
MCLEISH
Wendy F
25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

NHS
Greater Glasgow and Clyde

Nursing notes

Date and Time		Name/Signature
12/09/25 14:17	Pt presents with ?MH. Acute behaviour change. aggitated. RIV by ED Dr. Bloods ✓ NEWS (0) at triage GCS (15). Dr contacting Psych.	(CB Island) C/B d S/N
1423	Patient NEWS 0 and ECG done.	A Wilson (RN)
14:45	mobile up to toilet	paula Quigley
1520	Patient awaiting psych input	
1610	Reviewed by psych, home with mental health crisis team referal.	A Wilson (RN)

WENDY MCLEISH

Scottish Ambulance Service

Age/Gender:	**38 Years, 3 Months, 18 Days, Female**	**Incident Date:**	**12/09/2025 11:33:08**
DOB:	**25/05/1987**	**ePCR Number:**	**68-2-120925-113322**
Address:	**3/2 312 CUMBERNAULD ROAD DENNISTON GLASGOW G31 3LY**	**Incident Number:**	**CR012427610**
CHI Number:	**2505876061**	**Incident Type:**	**EMG**
Ethnicity:	**-**	**Incident Location:**	**3/2 312 CUMBERNAULD ROAD DENNISTON GLASGOW, G31 3LY**

PATIENT INFO

ADDITIONAL COMMENTS

Presenting Complaint:	**acute distress**

Timestamp	Additional Comment	Crew Name
12/09/2025 12:28:00	999 to 38yo F in acute distress. call initially for seizure but updated with pt displaying abnormal behaviour, shouting and being violent towards partner.	-
12/09/2025 12:29:00	HPC - no episodes like this before, but was previously interacting with stobhill in april	-
12/09/2025 12:38:00	PMH - complex PTSD w/ hx of domestic violence and drug/alcohol abuse. epilepsey, asthma	-
12/09/2025 12:38:00	OA - pt on floor, screaming, agitated. initially verbally aggressive but not violent towards crew.	-
12/09/2025 12:40:00	OE - obs as stated, unable to obtain others, obs only obtainable after calming. initially very tachycardic, reduced over time. pt has described several stressors that may contribute to event. pt is not oriented to time or place. possible hallucinations/delusions regarding stressful events regarding care of children that have not occurred. it is possible pt has taken overdose of prescribed medication	-
12/09/2025 12:47:00	tx - police arrived after pt walked into traffic. initially cuffed after attempting to hit police, but calmed over time. discussed with stobhill and transported to GRI ED.	-

ACVPU

Options:	**Acute Confusion**

CATASTROPHIC HAEMORRHAGE

Catastrophic Haemorrhage:	**No**

AIRWAY

Assessment:	**Clear**

BREATHING

Breathing Adequately:	**Yes**	**Initial Respiratory Rate:**	**40**
Initial SpO2:		**97**	

CIRCULATION

Pulse Rate:	**156**

OBSERVATIONS

Observations Assessment

Timestamp	Pulse	RR	BP	SpO2	GP	GCS	ACVPU	ETCO2	Temp	BM	ECG	Pt.	FSF	Crew
12/09/2025 12:40	111		137/87	96					37.6					E9680814
12/09/2025 12:25	156	40		97										E9680814

CLOSE REPORT

Clinical Response Feedback

On-Scene Clinical Findings	Non Emergency

CONVEYANCE

INCIDENT INFORMATION

Dispatch

Dispatch Code	12D02E	Dispatch Description	Continuous or Multiple Fits - Fitting History

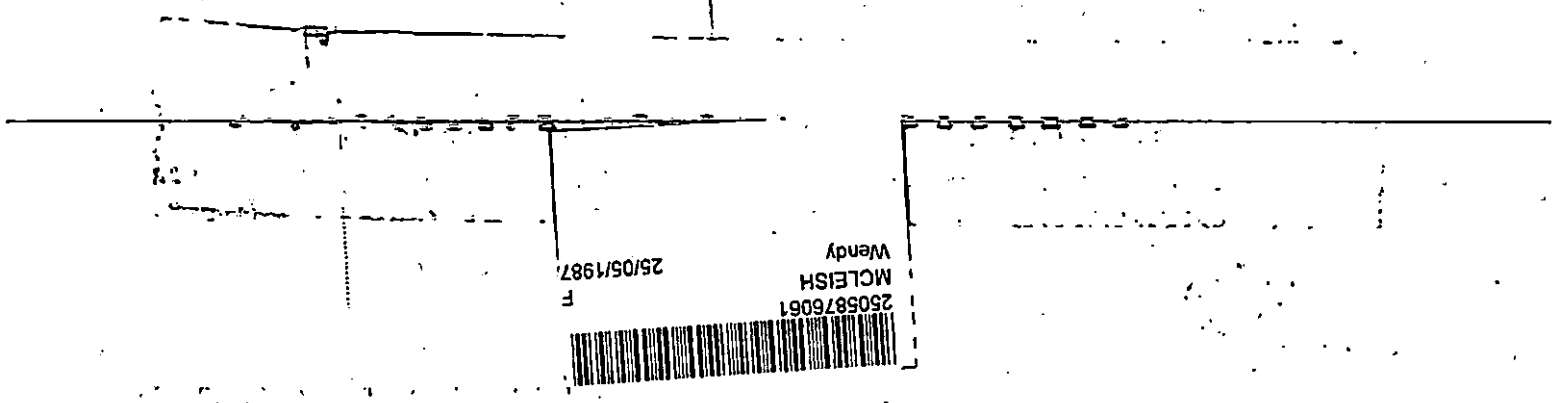
Incident Log

Status Time	Status	Callsign	Reason	Hospital
11:31:15	Call Received Time	GGS4510		
11:33:45	Mobile	GGS4510		
11:42:23	At Scene	GGS4510		

CREW INFORMATION

Additional Crew

Crew ID	Crew Grade
E9880814	Newly Qualified Paramedic (NQP)
E9886946	Ambulance Technician (AT)



2 Wendy Meleish.

NEWS 2 Key | 1 | 2 | 3

| | | |

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

2505876281
MCLEISH, Wendy F
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY. 25/05/1987

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP initials ONLY:	Dr/ANP initials ONLY:	
Date:	Date:	

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed.....

Medical: .....

Date: .....

Pupil Reaction and size
s = sluggish
+ = reaction
- = no reaction
c = eyes closed
Pupil Size (mm) 1 2 3 4 5 6 7 8

Glasgow Coma Scale

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

| | | |

CHI: 2505876061

Glasgow Royal Infirmary

(5)

Total Att: 26

12 Mth Att: 5

Title: MISS

MCLEISH Wendy

DOB 25/05/1987 Age: 37y Sex: Female

FLAT 3/2
312 CUMBERNAULD RD
Glasgow
Lanarkshire
G31 3LY
07912347436

Next of kin: WARD, James
Relationship: Partner

GP: M Lyons
0141 800 0272

Attendance Date: 15/04/2025 Arrival Time: 19:36

Registration Time: 19:36 Date of Incident: 15/04/2025

Major Incident Desc:

Reason for Attendance: back pain

Nursing Assessment

Alerts: Yes Allergies: Not Recorded Pain Score:

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

Presenting Complaint:

Observation Date: 15/04/2025 19:56 Nurse name: Nurse Courtney Taylor

Temp	35.5	C
HR	72	bpm
BP	121/90	mmHg
MAP	100.33	mmHg
RR	15	bpm
SpO2	97	%
Oxygen		%

BM	5.6 (sas)	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

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

Nursing Notes: **"BACK PAIN NEWS 0 - pt has had 3/7 hx of upper back pain, attended gp today who told pt to go home and call 999. on sas arrival pt had 3 lidocaine patches on her back, also admits to dihydrocodeine and gabapentin. denies chest pain. pt states she feels 'not herself' and 'a bit dazed'. denies other drugs/alcohol. hx perv pneumonia, sciatica, pulmonary fibrosis "**

2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy

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

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

Date	Clinical Notes
16/4	Seen By OSBORNE Time Seen 0010

37, Back pain.

HPC: Vague initial hx - States GP sent to call aga. Had thoracic & back pain today. OIB - Chronic No acute symptoms - No productive cough - No CP / collapse / fever

PMHx: PUL HTN, RVSO, ESS. tremor, sciatica, Fibrosis, PREV ECHO for Resp fem

Ohx: See ECS.

Shx: (S) with partner - smokes cannabis Daughter stays with aunt - Social Denies ETOH, drugs, smoking work

O/E Looks well No resp distress

AF Clear NS 1+11+0 No wheeze. SL mild pt. oedema

CxR: N. I fecal

D/S Discharge Worsening Advice

Once Only Prescriptions (Including Tetanus Prophylaxis)

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

Patient name

Patient CHI

2505876061
MCLEISH F
Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3L

NHS
Greater Glasgow and Clyde

Emergency Care Nursing Documentation

Initial Investigations

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

Signature:

Communication

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

Signature:

Risk Assessments and Screening Tools

	SEPSIS	Y	N	GMAWS	Y	N
	FAST	Y	N	Adult Support and Protection	Y	N
Time:	Swallow Testing	Y	N	Mental Health Triage Assessment	Y	N
	Falls Risk (clinical judgement)	Y	N	Child Protection Concerns	Y	N
	4AT Assessment	Y	N	Frailty Assessment	Y	N
				Publie Protection (NOC)	Y	N

Signature:

Pause for Discharge or Transfer

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

Signature:

Patient name .....

Patient CHI .....

or use sticker

NHS
Greater Glasgow and Clyde

Care Rounds Checklist

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

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

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

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

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

Patient name .....

Patient CHI .....

or use sticker

NHS
Greater Glasgow and Clyde

Nursing notes cont.

Date and Time	Name/Signature

Patient

Patient

2505876061
MCLEISH F
Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

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

NHS
Greater Glasgow and Clyde

PUDRA

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

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

2	Mobility	Does the person require assistance to mobilise or change position (inappropriate for age)?
3	Continence	Does the person have continence issues with urine and/or faeces (inappropriate for age)?
4	Nutrition	Does the person appear malnourished and/or unable to eat or drink/ PYMS score>2?
5	Skin	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?
6	Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

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

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

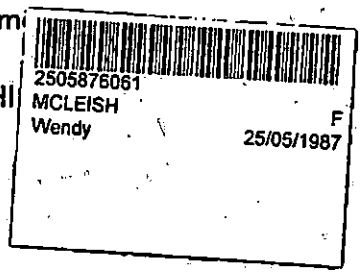
Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
/ /	:							____hrly	
/ /	:							____hrly	
/ /	:							____hrly	

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

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

Patient nam

Patient CHI



NHS
Greater Glasgow and Clyde

Ongoing Care

	4 Hours	5 Hours	6 Hours	7 Hours	8 Hours	9 Hours	10 Hours	11 Hours	12 Hours
Time									
Nursing notes updated including (NEWS, MEWS,PEWS)									
FFN (provide details)									
IVI/IVABs									
Routine Medications prescribed and administered									
Falls risk assessment									
Skin assessed and supported (PURDRA)									
Analgesia assessment									
Nurse call system in place									
SBAR commenced									
Patient/ relatives updated									
Elimination needs met (does the patient know where toilet is)									
If patient not in cubicle space think about patients dignity requirements eg hearing aids, mobility aids, glasses, interpreter									
STOPPS completed									

Patient name .....

Patient CHI .....

or use sticker

NHS
Greater Glasgow and Clyde

Nursing notes

Date and Time		Name/Signature
15/4/25 2028	Back pain. Upper back pain. States seen GP who advised by SAS. Has 3 lidocaine patches + tiktok dihydrocodeine + gabapentin. Denies CP. Feels dazed. Up walking in department NAD	
2220	went outside for vape Back in department NAD	
22:21	- Moved onto couch T - mobilising independently out of bed department News score 0, awaiting doctors review	

PECOS GGC0107

mi • 262617-A v2.0

Patient Information

WENDY MCLEISH

Age/Gender:	39Y Old Female
Address:	3/2 312 CUMBERNAULD ROAD DENNISTON GLASGOW,G31 3LY
DOB:	25/05/1987
CHI:	2505876061
Ethnicity:	

Date:	15/04/2025
Incident Number:	CR011976993
Incident Type:	EMG
Incident Location:	3/2 312 CUMBERNAULD ROAD DENNISTON GLASGOW, G31 3LY

Scottish Ambulance Service

Presenting Complaint

BACK PAIN

Additional Comments

{[oa]] pru and partner o/s, pt alert. [[hxpc]] pt hashad few days upper back pain, attended gp who suggested 999. [[pmh]] essential tremor syndrome , sciatica, pulmo fibrosis, bronchiectasis, prev pneumoia 6 weeks ago. right side heart valve ?narrow, awaiting jubilee appt. [[shx]] lives with partner, denies drug/alcohol use. supported by charity marthas mummies for parents who have had children taken away by social care. partner smoking weed in flat. Flat in disarray. [[dhx]] taken dihydrocodeine and gabapentin. Has 3 7000mg lidocaine patches on. [[oe]][[neuro]] pt slight disoriented, fast neg, no ha, no seizure. [[cvs]] good colour, no cp, no loc. [[resp]] no dib/sob, ausc clear. productive white cough. [[plan]] convey to grl. Removed 2 lidocaine patches

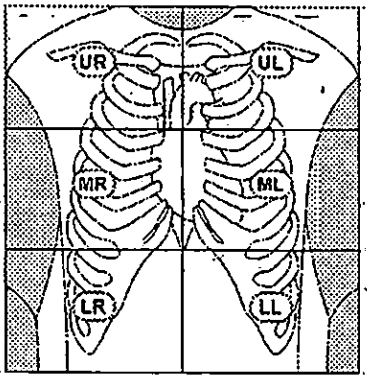
PATIENT ASSESSMENT

ACVPU Alert <C> No

A Clear

B Breathing Adequately Yes Respiratory Rate 18 SPO2 97

Oxygen Given No

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

C

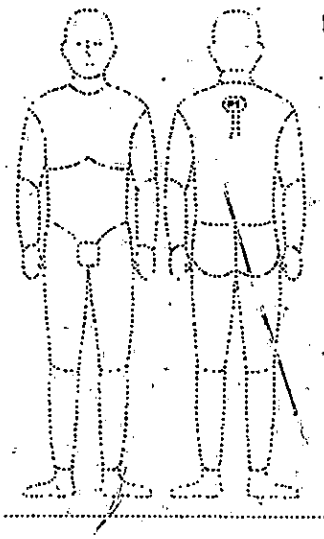
Pulse Rate	BP	Cap Refill	ECG Rhythm
79	115/71		

Rhythm	Arm	Central/Peripheral	ECG
Reg	Right		

D

GCS	Eyes	Voice	Motor	PEARL
14	Spontaneously (4)	Confused (4)	Obeys Commands (6)	

E



Pain

ID	Body Part	Pain Scale
P1	Back Body	7

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
19:20	79	16	115/71	97		14	Alert		36.8	5.6					E9883175

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
19:20	16 (0)	97 (0)		0	115 (0)	79 (0)	Alert (0)	36.8 (0)	0

CLOSE RECORD

Treatment On Scene Non-Emergency

Conveyance

Transport To Hospital Normal driving **Pre-Alert** No

INCIDENT LOG

Time Call Received	18:10	**Allocated**	18:55	**Mobile**	18:55
First Resource On Scene		**Crew On Scene**	18:58	**Crew Left Scene**	19:26
Crew At Hosp	19:31	**Receiving Hospital**	GLASGOW ROYAL INFIRMARY	**Clear Time**	

Crew ID	Crew Grade	Driver
E9886516	Ambulance Technician	YES
E9883175	Paramedic	NO

(5) Wendy McLeish C7

NEWS 2 Key | 1 | 2 | 3

| | | |

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

2505876061
MCLEISH Wendy F 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3L

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP initials ONLY:	Dr/ANP initials ONLY:	
Date:	Date:	

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed.....

Medical:.....

Date:.....

Pupil Reaction and size
s = sluggish
+ = reaction
- = no reaction
c = eyes closed
Pupil Size (mm) 1 2 3 4 5 6 7 8

Glasgow Coma Scale

Date:
Time:
EYES
Eyes closed by swelling = NT
Spontaneously 4
To sound 3
To pressure 2
None 1
NT
VERBAL
Endotracheal tube or tracheostomy = NT
Orientated 5
Confused 4
Words 3
Sounds 2
None 1
NT
MOTOR
Always record the best response
Obeys commands 6
Localising pressure 5
Normal flexion 4
Abnormal flexion 3
Extension 2
None 1
NT
TOTAL 15
PUPIL
Right size:
Right reaction:
Left size:
Left reaction:
ARMS
Record right (R) and left (L) separately to identify significant difference between the two sides
Normal power
Mild incidence
Severe incidence
Severe Incidence
Spastic Flexion
Extension
No response
LEGS
Record right (R) and left (L) separately to identify significant difference between the two sides
Normal power
Mild incidence
Severe incidence
Severe Incidence
Spastic Flexion
Extension
No response

Affix Patient ID

Pain Function Score

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

Pain Score

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

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

ml • 316654 v3.1 • CGC0264

2505876061
MCLEISH
Wendy
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

F
25/05/1987

e sticker

NHS
Greater Glasgow and Clyde

Emergency Care Nursing Documentation

Initial Investigations

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

Signature:

Communication

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

Signature:

Risk Assessments and Screening Tools

	SEPSIS	Y	N	GMAWS	Y N
	FAST	Y	N	Adult Support and Protection	Y N
Time:	Swallow Testing	Y	N	Mental Health Triage Assessment	Y N
	Falls Risk (clinical judgement)	Y	N	Child Protection Concerns	Y N
	4AT Assessment	Y	N	Frailty Assessment	Y N
				Publie Protection (NOC)	Y N

Signature:

Pause for Discharge or Transfer

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

Signature:

Patient name .....

Patient .....



ticker

NHS
Greater Glasgow and Clyde

Care Rounds Checklist

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

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

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

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

Patient name .....

Patient CHI .....

or use sticker

NHS
Greater Glasgow and Clyde

Nursing notes cont.

Date and Time	Name/Signature

Patient na

Patient CH

2505876061
MCLEISH
Wendy 25/05/198

Hospital:

Ward:

Points to consider:

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

NHS
Greater Glasgow and Clyde

PUDRA

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

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

2	**Mobility**	Does the person require assistance to mobilise or change position (inappropriate for age)?
3	**Continence**	Does the person have continence issues with urine and/or faeces (inappropriate for age)?
4	**Nutrition**	Does the person appear malnourished and/or unable to eat or drink/ PYMS score>2?
5	**Skin**	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?
6	**Judgement**	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

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

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

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

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

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

Patient name .....

Patient CHI .....

or use sticker

NHS
Greater Glasgow and Clyde

Ongoing Care									
	4 Hours	5 Hours	6 Hours	7 Hours	8 Hours	9 Hours	10 Hours	11 Hours	12 Hours
Time									
Nursing notes updated including (NEWS, MEWS,PEWS)									
FFN (provide details)									
IVI/IVABs									
Routine Medications prescribed and administered									
Falls risk assessment									
Skin assessed and supported (PURDRA)									
Analgesia assessment									
Nurse call system in place									
SBAR commenced									
Patient/ relatives updated									
Elimination needs met (does the patient know where toilet is)									
If patient not in cubicle space think about patients dignity requirements eg hearing aids, mobility aids, glasses, interpreter									
STOPPS completed									

Pati.....

Pati.....

2505876061 F
MCLEISH 25/05/1987
Wendy
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire G31 3L[illegible]er

NHS
Greater Glasgow and Clyde

Nursing notes

Date and Time	Name/Signature
0303 Pt brought to ED c/o 4/3/24 cuts to presented with arm pain 9/7 awaits review by medics. Wounds x 2 Bandaged 0909 Pt seen by doctor 10/3/24 Pt c/o done — [illegible]	

NEWS 2 Key | 1 | 2 | 3

| | | |

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

2505876061
MCLEISH
Wendy
F
25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1
Target >96%
Signature:
Print Name:
Dr/ANP initials ONLY:
Date:

Sp02 Scale 2
Target 88-92%
Signature:
Print Name:
Dr/ANP initials ONLY:
Date:

Patient on home oxygen Y☐ N☐
If yes, add details of oxygen therapy

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed.....

Medical: .....

Date: .....

Pupil Reaction and size
s = sluggish
+ = reaction
- = no reaction
c = eyes closed
Pupil Size (mm) 1 2 3 4 5 6 7 8

2505876061
MCLEISH
Wendy
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
25/05/1987
G31 3LY

Glasgow Coma Scale

| | | |

CHI: 2505876061

Glasgow Royal Infirmary

9

Total Att: 25

12 Mth Att: 5

Title: MISS

MCLEISH

Wendy

DOB: 25/05/1987 Age: 37y Sex: Female

FLAT 3/2
312 CUMBERNAULD RD
Glasgow
Lanarkshire
G31 3LY
07912347436

Next of kin: WARD, James
Relationship: Partner

GP: M Lyons
0141 800 0272

Attendance Date: 24/03/2025 Arrival Time: 19:22

Registration Time: 19:22 Date of Incident: 24/03/2025

Major Incident Desc:

Reason for Attendance: **Expected at GRI A+E on 24/ Unwell ?icteric non traumatic arm swelling**

Nursing Assessment

Alerts: Yes

Allergies: Not Recorded Pain Score:

Triage Category: 3

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 24/03/2025 20:08

Nurse name: Nurse Laura Carruthers

Temp	35.9	C
HR	62	bpm
BP	114/74	mmHg
MAP	87.33	mmHg
RR	19	bpm
SpO2	94	%
Oxygen		%

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

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

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

Nursing Notes: **"ARM PAIN. NEWS 2. 4/7 hx of R arm pain and swelling. no injury?CLOT. advised to attend. appears under influence. recent abx for pneumonia. looks unwell. "**

2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy

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

Discuss with Senior Medical Staff / Nurse on duty any factors identified			
Date	**Clinical Notes**		
	Seen By	Time Seen	

Once Only Prescriptions (Including Tetanus Prophylaxis)						
Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate

Wendy McLeish

2505876061

Date & Time		Signature, Print Name & Designation
25/5/25	CONNELLY CONS	EM.
	37yr ♀ ?(R) Arm Injury	
	Background	
	Complex PMH ECMO 2012 for pneumonia Bronchiectasis Drug + alcohol misuse Epilepsy Peripheral neuropathy	
	- Referral from FNC - Called 999 as couldn't get transport - Says arm was told by FNC ? "clot" in arm, also ? "laundried", but no mention of this in letter - Says she "bumped" (R) arm when she fell 3/7 ago, c/o 'bruising' to arm - Has no other complaints other than chronic issues. Has a rash on her arms + legs, and feels like she "had a breakdown" a few weeks ago - No acute issues at all - When I asked if she felt she was laundried, she said 'no' and said her GP has "always looked after me"	

83949 GCC0072

Date & Time		Signature, Print Name & Designation
	- No chest pain or SOB - Otherwise well.	
	O/E	Obs (N)
	Very well does not Unstressed	
	No jaundice; sclerae ~~Sclerae~~ Sclerae not yellow	
	(R) Arm: No swelling No discolouration No bruising Non-tender Full ROM.	
	Imp: No acute issue. No evidence of upper limb DVT, no jaundice	
	Plan: Reassure D/C & GP F/U	
	Counselled Cons CM.	

2505876061

Patient Information

WENDY MCLEISH

Age/Gender:	37 years 9 months 30 days Old Female	**Date:**	24/03/2025
Address:	DOWNSTAIRS 3/2 312 CUMBERNAULD ROAD DENNISTON GLASGOW,G31 3LY	**Incident Number:**	CR011809645
DOB:	25/05/1987	**Incident Type:**	EMG
CHI:		**Incident Location:**	DOWNSTAIRS 3/2 312 CUMBERNAULD ROAD DENNISTON GLASGOW, G31 3LY
Ethnicity:			

Scottish Ambulance Service

Presenting Complaint

RHS ARM PAIN / JAUNDICED

Additional Comments

999 call for 37 y/o F c/o pain in right arm... O/a p/t sitting in close outside of flat. Alert and oriented. Apx 3 days ago p/t hit right arm off wall and has pain from wrist which radiates into forearm, crew noted slight bruising on arm. P/t contacted GP Today regarding arm and p/t states that GP told her to go to hospital. Query clot? P/t states they have been on abx for pnumonia and has not felt well during this course of abx. Crew noted that p/t appears jaundiced... O/e crackles in lower left lobe, 3-lead ECG performed due to p/t being o/s on street, rest of obs within normal ranges and as stated below... P/t happy to organise own transport to hospital. Eprf with p/t for use at hospital.

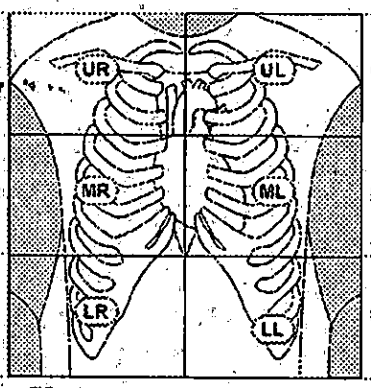
PATIENT ASSESSMENT

ACVPU Alert <C> No

A Clear

B Breathing Adequately: Yes — Respiratory Rate: 18 — SPO2: 99

Initial SPO2 On: Air — Oxygen Given: No

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

C

Pulse Rate	BP	Cap Refill	ECG Rhythm
78	121/84	<=2 Secs	Sinus Rhythm

Rhythm	Arm	Central/Peripheral	ECG
Reg	Left	Peripheral	3 Lead

D

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

E

WENDY MCCLEISH

22/03/25 Incident Number: CRG1900849

Site: RIGHT ARM Onset: HIT ON WALL: 21/03/2025, 12:00

Character: THROBING PAIN, Constant, Worsening Radiates: Yes, FROM WRIST TO FOREARM

Exacerbating Or Relieving Symptoms: EXACERBATION ON MOVEMENT Severity: 8/10

2595876061

MEDICAL

Consent

Capacity Assessed	Deemed To Have Capacity
Clinical Assessment	Consent Gained, Benefits Of Assessment Explained
Clinical Treatment	Consent Gained, Benefit Of Treatment Explained

Refusal

The Presenting Complaint And/Or Condition Has Been Discussed With The Ambulance Crew And At Present, The Following Is Being Refused: Transport

Patient Signature

W McCleish

CLOSE RECORD

Treatment On Scene: Non-Emergency

Non-Conveyance

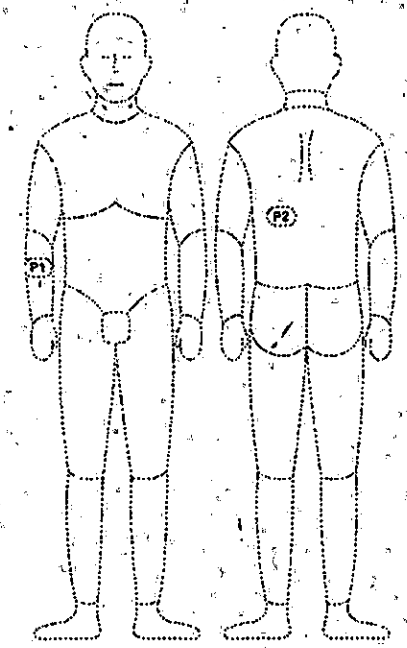
I have Seen, Examined the patient and (the patient/parent/carer/guardian and) I have reached the following decision: Self-Travel

INCIDENT LOG

Time Call Received	18:00	Allocated	18:01	Mobile	18:03
First Resource On Scene		Crew On Scene	18:14	Crew Left Scene	
Crew At Hosp		Receiving Hospital		Clear Time	

Crew ID	Crew Grade	Driver
E9988216	Paramedic	YES
P122053S	Student Paramedic (BSc Placement)	NO

WENDY MYERSM



Pain

ID	Body Part	Pain Scale
P1	Right Lower Arm	8
P2	Back Body	4

250587606|

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
18:30	67	16	116/65	100	<=2s	15	Alert		36.9	4.1	Sinus Rhythm	3	3		P122053S
18:20	78	18	121/84	99	<=2 Secs	15	Alert		36.9	4.1	Sinus Rhythm	3	3		P122053S

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
18:30	16 (0)	100 (0)		0	116 (0)	67 (0)	Alert (0)	36.9 (0)	0
18:20	18 (0)	99 (0)		0	121 (0)	78 (0)	Alert (0)	36.9 (0)	0

HISTORY

AMPLE

Allergies	HAY FEVER
Medication	SEE ECS
Past Medical History	Asthma, Epilepsy, DEPRESSION, ANXIETY, CYATICA, BRONCHITIS , NARROW HEART VALVE
Last Eaten	>4 Hours Ago
Events Prior	PAIN IN ARM AFTER HITTING OFF WALL

Social History

Lives alone: No Living With: PARTNER

Patients General Appearance	Normal
Patient Mobility	Fully Mobile
Patient Communication	No Help Required
Patient Clinical Risk Factors	Smoker
Patient Enviromental Risk Factors	None Identified

SOCRATES

Glasgow Royal Infirmary

CHI: 2505876061

(17)

Total Att: 22

12 Mth Att: 3

Title: MISS

MCLEISH Wendy

DOB 25/05/1987 Age: 37y Sex: Female

FLAT 3/2
312 CUMBERNAULD RD
Glasgow
Lanarkshire
G31 3LY
07912347436

Next of kin: WORD, James
Relationship: Partner

GP: M Lyons
0141 800 0272

Attendance Date: 25/02/2025 Arrival Time: 19:07

Registration Time: 19:07 Date of Incident: 25/02/2025

Major Incident Desc:

Reason for Attendance: head injury

Nursing Assessment

Alerts: Yes Allergies: Not Recorded Pain Score:

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

Presenting Complaint:

Observation Date: 25/02/2025 19:18 Nurse name: Nurse Lorraine McLellan1

Temp	35.0	C
HR	106	bpm
BP	130/91	mmHg
MAP	104.00	mmHg
RR	18	bpm
SpO2	100	%
Oxygen		%

BM	5.2	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

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

Nursing Notes: "FALL NEWS 4 GCs 14/15 fall down unknow amount of stairs yesterday unable to straighten neck complaints of c-spine tenderness drowsy in triage denies drug/ alcohol pmh sciatica epilepsy scarring of lungs pnumonia required ECMO 2012 "

2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy

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

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

Date	**Clinical Notes**	
	Seen By	Time Seen

Once Only Prescriptions (Including Tetanus Prophylaxis)

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

Glasgow Royal Infirmary
Emergency Department

NHS
Greater Glasgow and Clyde

2505876061
MCLEISH F
Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

Initial Investigations Ordered

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

Clinical Notes

Date 25/2/25 Time 20:48 Name NANDINI MISHRA Grade F1/2 Specialty A+E

37F Fall down 6 stairs 2/7 ago Neck pain

BG: Prev bilateral pneumonia requiring ECMO, bronchiectasis, Asthma, Epilepsy

HPC: Slipped and fell down 6 stairs 2/7 ago. No LOC, no N+V. Neck pain began afterwards. Able to get up off floor + mobilise immediately afterward. No head wound.

Ongoing C-Spine pain + stiffness. Longstanding paraesthesia in upper limbs → referred to Neuro by GP.

DH: Cyanocobalamin Adverse rxn to Ferrous fumarate
Ralvo
Clenil
Lamotrigine
Salbutamol
Lansoprazole
Sertraline

Glasgow Royal Infirmary
Emergency Department

2505876061
MCLEISH F
Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

Clinical Notes

Date	Time	Name	Grade	Specialty

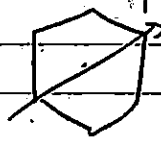
SH: Lives with partner. Daughter is staying w/ aunt - has social worker
Doesn't drink, smoke or use drugs.

O/E: A - Patent

B - 

C - HS: H: I: C: O. Pulse regular, good volume. CRT <2s

D - PEARL. No nystagmus/diplopia
(N) none + pain in all limbs

E - 

JL Bruising on thighs bilaterally. Says she thinks it's from fall.

Abrasion to (R) cheek + forehead → says she tried to 'jump out window' to get away from partner because he was 'annoying her'. Did not jump out of window, ~~t~~ came as partner pulled her back.

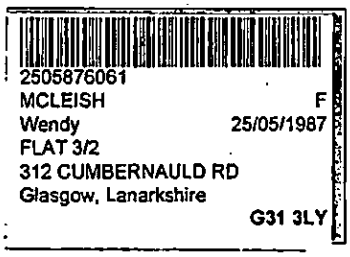
Denies suicidal ideation. Denies physical or verbal abuse from partner.

Tender over C4-5 on palpation.

Imp: MSK injury after mechanical fall

Plan (1) Discuss w/ reg re CT C-spine is indicated

Glasgow Royal Infirmary
Emergency Department



Clinical Notes

Date	Time	Name	Grade	Speciality

Glasgow Royal Infirmary
Emergency Department

2505876061
MCLEISH F
Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

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

Diagnosis and Plan

Review/Discussed with:

Handover

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

mi • 287967 Version 1_0 • GGC0226

Patient name

Patient CHI

2505876061 F
MCLEISH
Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

NHS Greater Glasgow and Clyde

Emergency Care Nursing Documentation

Initial Investigations

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

Signature: HF

Communication

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

Signature: HF

Risk Assessments and Screening Tools

	SEPSIS	Y	N	GMAWS	Y	N
	FAST	Y	N	Adult Support and Protection	Y	N
Time:	Swallow Testing	Y	N	Mental Health Triage Assessment	Y	N
	Falls Risk (clinical judgement)	Y	N	Child Protection Concerns	Y	N
	4AT Assessment	Y	N	Frailty Assessment	Y	N
				Public Protection (NOC)	Y	N

Signature:

Pause for Discharge or Transfer

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

Signature:

Patient name

Patient CHI

2505876061 F
MCLEISH 25/05/1987
Wendy
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire G31 3L

NHS
Greater Glasgow and Clyde

Care Rounds Checklist

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

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

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

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

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

Patient name

Patient CHI

2505876061
MCLEISH
Wendy F
FLAT 3/2 25/05/1987
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

Hospital:

Ward:

Points to consider:

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

NHS
Greater Glasgow and Clyde

PUDRA

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

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

2	**Mobility**	Does the person require assistance to mobilise or change position (inappropriate for age)?
3	**Continence**	Does the person have continence issues with urine and/or faeces (inappropriate for age)?
4	**Nutrition**	Does the person appear malnourished and/or unable to eat or drink/ PYMS score>2?
5	**Skin**	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?
6	**Judgement**	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

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

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

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

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

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

Patient name

Patient CHI

2505876061
MCLEISH
Wendy
F
FLAT 3/2
25/05/1987
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

NHS
Greater Glasgow and Clyde

Nursing notes cont.

Date and Time	Name/Signature

Patient name

Patient CHI

2505876061
MCLEISH F
Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3L

NHS
Greater Glasgow and Clyde

Nursing notes

Date and Time	Name/Signature

25/12/25 Fall down stairs. c spine 1955 tenderness at cervical space C1. ——— Staff Nurse

20:10 Patient on ubicle 17.
Patient has been sitting at edge of bed.
Asked patient to lie flat on back due to c spine tenderness. GCS 15/15.
Awaits medical r/v.

H. Robertson SN

22:45 Multiple complaints from patient
Sandwich given as requested.
Patient going outside for smoke against advice - doctor aware.

H. Robertson SN

Patient name

Patient CHI

2505876061
MCLEISH F
Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

NHS
Greater Glasgow and Clyde

Ongoing Care

	4 Hours	5 Hours	6 Hours	7 Hours	8 Hours	9 Hours	10 Hours	11 Hours	12 Hours
Time									
Nursing notes updated including (NEWS, MEWS,PEWS)									
FFN (provide details)									
IVI/IVABs									
Routine Medications prescribed and administered									
Falls risk assessment									
Skin assessed and supported (PURDRA)									
Analgesia assessment									
Nurse call system in place									
SBAR commenced									
Patient/ relatives updated									
Elimination needs met (does the patient know where toilet is)									
If patient not in cubicle space think about patients dignity requirements eg hearing aids, mobility aids, glasses, interpreter									
STOPPS completed									

WENDY MCLEISH

NEWS 2 Key | 1 | 2 | 3

2505876061
MCLEISH
Wendy
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY
25/05/1987
F

| | | |

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

2505876051
MCLEISH
Wendy
F
25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%
Signature:
Print Name:
Dr/ANP initials ONLY:
Date:

Sp02 Scale 2 Target 88-92%
Signature:
Print Name:
Dr/ANP initials ONLY:
Date:

Patient on home oxygen Y☐ N☐

If yes, add details of oxygen therapy

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed.....

Medical: .....

Date: .....

Pupil Reaction and Size

s = sluggish
+ = reaction
- = no reaction
c = eyes closed

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

Glasgow Coma Scale

Eyes: Spontaneously 4; To sound 3; To pressure 2; None 1; Not testable NT
Verbal: Oriented 5; Confused 4; Words 3; Sounds 2; None 1; Not testable NT
Motor: Obeys command 6; Localises pressure 5; Normal flexion 4; Abnormal flexion 3; Extension 2; None 1; Not testable NT
Eyes closed by swelling = NT
Extubated/hole in/tube or tracheostomy = NT
Always record the best response
TOTAL
Right size:
Right reaction:
Left size:
Left reaction:
Record right (R) and left (L) pupil size and chart is a reference between the two sides
Record right (R) and left (L) pupil reaction and chart is a reference between the two sides

Pain Function Score

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

Pain Score

Ask the patient to rate his/her pain by using numerical scale 0 (no pain) to 10. Observe how the patient is unable to communicate, use alternative pain scoring tool.

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

2505876051
MCLEISH
Wendy
F
25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

NHS • 316654 v5.1 • GGC1264

CHI: 2505876061

Glasgow Royal Infirmary

Total Att: 20
12 Mth Att: 2

Title: **MISS**

MCLEISH **Wendy**

DOB **25/05/1987** Age: **36y** Sex: **Female**

FLAT 3/2
312 CUMBERNAULD RD
Glasgow
Lanarkshire
G31 3LY
07912347436

Next of kin: **SAME?, GERALD**
Relationship: **Brother**

GP: **MM Morris**
0141 554 0464

Attendance Date: **09/04/2024** Arrival Time: **13:07**
Registration Time: **13:07** Date of Incident: **09/04/2024**
Major Incident Desc:

Reason for Attendance: **RTC**

Nursing Assessment

Alerts: **Yes**
Triage Category: ~~3~~ 2
Allergies: **Not Recorded** Pain Score:
Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **09/04/2024 13:40**

Temp	**35.8**	C
HR	**86**	bpm
BP	**134/88**	mmHg
MAP	**103.33**	mmHg
RR	**17**	bpm
SpO2	**97**	%
Oxygen		%

Nurse name: **Nurse Holly Mew**

BM	**7.1**	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

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

Pupils-Right		Pupils-Left	
Size (mm)	**2**	Size (mm)	**2**
Reaction	**Y**	Reaction	**Y**

Nursing Notes: **SHOULDER/BACK PAIN RTC NEWS 1 Patient attends after being involved in RTC on Saturday at 2200. Passenger in a car going 50mph on motorway, coming off junction, lost control, car spun until coming to a complete stop. Airbags deployed, no C-spine pain, mobilised at scene. PMH Arthritis, Asthma;.**

2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy

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

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

Date	Clinical Notes
14/6	Seen By CASPOW FY1. Time Seen 14.35

Sunday eve RTC
ambulance but didn't want to come.

Neck + back pain. Gradual onset
3-4 hours sat right + Sunday morning.
Headache coming + going ..
Passenger seatbelt ✓
Somph. Coming stationary + dual carriageway.
Sweaty + pain. exited on hill.
Didn't ~~[illegible]~~ roll.
Airbags.
Self extricated.

Scanning lungs — Diclofenac
Anxiety. — Gabapentin
Sobbing. — Sertraline
Opposite — Lansoprazole
dependents.

O/E Alert GCS 15. Anxious.
No external signs HI.
C spine tender at C4.
Pain + spasm Limbs (N)
Coordination (N)

PERL 4 eyemovements (N).
Facial movements + sensation (N)
No signs BOS TT.
No signs chest wall injury
AE L-R air added

Once Only Prescriptions (Including Tetanus Prophylaxis)

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

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate

Wendy McLeish
2505876061

Date & Time	CASUALTY OFFICER NOTES (cont)	Signature, Print Name & Designation
36 F		
	Abdo SNT. T°35.8	
	HR86	
	In view of vanity tongue BP 134/88	
	headaches → CT head RR 17	
	C spine tenderness + high SpO2 97%	
	velocity collision → CT neck	
	CT NAD	
	Home w head injury + neck/RTC advice sheets	

83949 GGC0072

DNA - 21 35 /16

Glasgow Royal Infirmary

CHI: 2505876061

Total Att: 19

12 Mth Att: 4

Title: MISS [redacted]

MCLEISH Wendy

DOB 25/05/1987 Age: 36y Sex: Female

FLAT 3/2
312 CUMBERNAULD RD
Glasgow
Lanarkshire
G31 3LY

Next of kin: SAME?, GERALD
Relationship: Brother

GP: MM Morris
0141 554 0464

Attendance Date: 26/02/2024 Arrival Time: 17:24

Registration Time: 17:24 Date of Incident: 26/02/2024

Major Incident Desc:

Repeat BM: 20:35 4.9mmol/L

BM 5.7 22/10 Rpt.

Reason for Attendance: numbness to fingers

DNA 2141 Contacted ~~mobile~~ Pr. No answer. Jlampbell

Nursing Assessment

Alerts: Yes

Allergies: Not Recorded

Pain Score:

Triage Category: 3

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 26/02/2024 18:51

Nurse name: Nurse Daryl McKillop

Temp	35.5	C
HR	90	bpm
BP	135/90	mmHg
MAP	105.00	mmHg
RR	17	bpm
SpO2	97	%
Oxygen		%

BM	2.4	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

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

Nursing Notes: "Altered sensation to fingertips since this morning. FAST -ve in triage. **Low Blood glucose**. Given 2x glucojuice in triage. News 1. "

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

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

Date	Clinical Notes

Seen By A KRISS FY2 — Time Seen 2300

36♀ Bilateral hand tingling. GP ref ? Radial nerve palsy

States awoke today with bilateral fingertip paraesthesia. No trauma

Paraesthesia spread proximally during the day now both full hands affected to wrist

Denies visual sx / LOC / recent illness / speech changes / new pain anywhere

PMH/ severe pneumonia (ITU)
ETOH
Sciatica + epilepsy
Ψ issues

SH/ Lives ± boyfriend
Denies drugs / smoking
Denies alcohol

OE/ Tone, power, reflexes & coordination Ⓝ in both upper limbs and hands
Describes paraesthesia & 'funny' sensation both hands
No wrist drop, power 5/5 all movement of fingers, thumbs & wrist
Eye movements Ⓝ, PEARL, gait Ⓝ (allowing for ankle injury). GCS 15
Good radial pulse bilaterally

Imp/ Peripheral neuropathy ?2° ETOH. No acute pathology

Plan/ Ⓝ
If persists, see GP for neuropathy blood screen (B12, folate etc.)
Agreed ± Pat (c/c)

Once Only Prescriptions (Including Tetanus Prophylaxis)

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

CHI: 2505876061

Glasgow Royal Infirmary

Total Att: **18**

12 Mth Att: **3**

Title: **MISS**

MCLEISH **Wendy**

DOB **25/05/1987** Age: **36y** Sex: **Female**

FLAT 3/2
312 CUMBERNAULD RD
Glasgow
Lanarkshire
G31 3LY

Next of kin: **SAME?, GERALD**
Relationship: **Brother**

GP: **MM Morris**
0141 554 0464

Attendance Date: **28/01/2024** Arrival Time: **06:34**

Registration Time: **06:34** Date of Incident: **28/01/2024**

Major Incident Desc:

Reason for Attendance: **right ankle injury.**

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **28/01/2024 06:52** Nurse name: **Nurse Morag Paterson2**

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

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

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **"ANKLE INJURY. Legs gave way during night, twisting R ankle. Slight swelling evident. Mobilised with SAS. Taken own analgesia. Sensation intact. Hx sciatica. "**

Dihydrocodeine PO 30mg

2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy

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

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

Date	Clinical Notes
	Seen By [illegible] ENP — Time Seen
PC	(R) ankle injury
PMH	Sciatica Mental Health — Drugs See portal
H/PC	got up during the night for toilet + slipped legs gave way + went over on her (R) ankle. Got ambulance in.
On E.	Non weight Br. (R) ankle swollen +++ 0 wounds. R.O.M. Hip to knee good range of movement GASTROC N emus 0 ACHILLES 0 Calcaneus 0. Based 5 to 0 CSM ✓ CAP Refill < 2 sec. N/V intact.
Plan	XRAY (R) ankle. # to distal TB. Discussed with ORTHO. for Boot + VC. [illegible] ENP

Once Only Prescriptions (including Tetanus Prophylaxis)

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

app. made. 28/01/24.

CLINIC REQUESTS MIU

PATIENT DETAILS

NAME: WENDY McLEISH

CHI: 2505876061

MOBILE: 07912 347 436

FRACTURE/ VIRTUAL TRAUMA CLINIC **SHOULDER/KNEE**		
ENT	MON - THURS	
ENT PAEDS	AS PER GENERIC EMAIL	
BURNS	AS PER PHONECALL TO WARD 45	
MAXILLOFACIAL	EMAIL TO TARAN SINGH	

Patient Information

WENDY MCLEISH

Age/Gender:	36Y Old Female
Address:	3/2 312 CUMBERNAULD ROAD DENNISTON, GLASGOW,G31 3LY
DOB:	25/05/1987
CHI:	2505876081
Ethnicity:	

Date:	28/01/2024
Incident Number:	CR010585354
Incident Type:	EMG
Incident Location:	3/2 312 CUMBERNAULD ROAD DENNISTON GLASGOW, G31 3LY

Scottish Ambulance Service

Presenting Complaint

ANKLE INJURY

Additional Comments

999 call 36 y/o f, ?ankle injury. // O/A // pt met crew at door with crutches, alert. // Hx // approx 0300 pt went to bathroom, legs gave way, pt ankle injury ?break. // Mhx // palpations, central tremors. chest infection, scarred lungs (due to pneumonia), sciatica, epileptic (last seizure few months prior), depression, anxiety, previous ankle break (due to RTC). // No known allergies // O/E // baseline obvs non remarkable, right ankle swollen, pain 8/10 > 6/10, PMSC after site, no loc, nausea or vomit. // Treatment // entonox approx 0500, pt taken own dihydrocodine at 0315, self mobilised to ambulance transfer to gri for further assessment.

PATIENT ASSESSMENT

ACVPU Alert <C> No

A Clear

B Breathing Adequately: Yes | Chest Signs/Sounds: Cough

Respiratory Rate 18 | SPO2 97 | Oxygen Given No

C

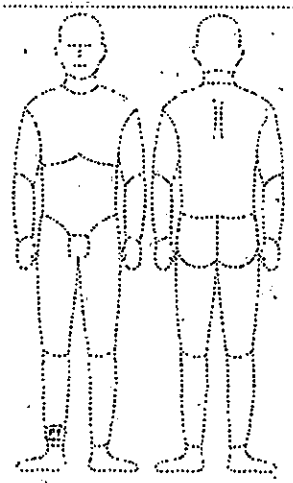
Pulse Rate	BP	Cap Refill	ECG Rhythm
100	134/75	<=2 Secs	Sinus Rhythm

Rhythm	Arm	Central/Peripheral	ECG
Reg	Left	Peripheral	3 Lead

D

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

E



Pain

ID	Body Part	Pain Scale
P1	Right Lower Leg	8

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
05:00	93	18	134/97	100	<=2s	15			37	7.9					E9882147
04:00	100	18	134/75	97	<=2 Secs	15	Alert		37	7.9	Sinus Rhythm				E9882147

NEWS2

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

Wendy McLeish

1/28/2024 Incident Number: C250876061

04:00	18 (0)	97 (0)	0	134 (0)	100 (1)	Alert (0)	37 (0)	1

Drugs

Time	Drug	Dosage	Units	Route	Drug Expiry Date	Pain Before	Pain After	CrewID
04:00	Entonox		PRN	INH				E9882147

HISTORY

AMPLE

2505876061

Allergies	None
Last Eaten	3 Hours Ago

Social History

Lives alone	Yes	Patient Occupation	Unemployed

Patients General Appearance	Normal
Patient Communication	No Help Required
Patient Clinical Risk Factors	Smoker
Patient Enviromental Risk Factors	Unkempt Living

SOCRATES

Site	RIGHT ANKLE, INNER AND HEEL	Onset	0300
Character	THROBBING, Improving	Radiates	No
Severity	8/10		

MEDICAL

CLOSE RECORD

Treatment On Scene: Non-Emergency

Conveyance

Transport To Hospital	Normal driving	Pre-Alert	No

INCIDENT LOG

Time Call Received	03:58	Allocated	04:34	Mobile	04:34
First Resource On Scene		Crew On Scene	04:49	Crew Left Scene	
Crew At Hosp		Receiving Hospital		Clear Time	

Crew ID	Crew Grade	Driver
E0031291	Ambulance Technician	YES
E9882147	Student Technician Level 4	NO

CHI: 2505876061

Glasgow Royal Infirmary

(6)

Total Att: 16

12 Mth Att: 2

Title: **MISS**

MCLEISH **Wendy**

DOB **25/05/1987** Age: **35y** Sex: **Female**

FLAT 3/2
312 CUMBERNAULD RD
Glasgow
Lanarkshire
G31 3LY
07912347436

Next of kin: **SAME?, GERALD**
Relationship: **Brother**

GP: **MM Morris**
0141 554 0464

Attendance Date: **10/03/2023** Arrival Time: **13:14**

Registration Time: **13:14** Date of Incident: **10/03/2023**

Major Incident Desc:

Reason for Attendance: **general unwell**

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **10/03/2023 13:38** Nurse name: **Nurse Philip Perham**

Temp	36.2	C
HR	78	bpm
BP	136/88	mmHg
MAP	104.00	mmHg
RR	14	bpm
SpO2	92	%
Oxygen		%

BM	5.4	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

Pupils-Right		Pupils-Left	
Size (mm)	2	Size (mm)	2
Reaction	Y	Reaction	Y

Nursing Notes: **UNWELL NEWS 0 Attende ED yesterday staes abdo pain and SOB - Did not wait to Be seen - appears Intoxicated _ SAS Gave Narcan at Initial call this am as Reduced Responses and Pinpoint Pupils LOW COVID RISK Being Ix for COPD/Lung CA Denies Drugs Alcohol**

2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy

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

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

Date	Clinical Notes

Seen By Prelwell STG | Time Seen

PC: Drowsiness

HPC: 3/7 Drowsiness, Partner concerned Has Been Slurring Speech + Difficult to Rouse.
Attended yesterday But self Discharged.
Wendy + Partner both Deny Drugs or alcohol.
Wendy states Last Drank 2 weeks ago.
On Citalopram, OHS + mirtazapine But Denies OD + recent change in Dose.
+ ES cross referring Sertraline + mirtazapine Correctly Hx

OE: Drowsy Rousable to GCS 15

[redacted]

2+2to eye ref-112

[redacted] Soft mild Generalised upper zone tenderness
Calves SNT

SIS Power Both upper Limbs & altered sensation
PERRL pin size & normal eye movements & diplopia
& Pos pointing
unsteady slightly ataxic Gait.

Impr: appears intoxicated But Denies Hx
? Drowsy Due to cross titration mirtazapine + Sertraline
? undisclosed Drug use

Pl) 2nd prescriber: reasonable to observe overnight
Hold Cipralex, OHC + mirtazapine
Home when medically safe.

Once Only Prescriptions (Including Tetanus Prophylaxis)

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

16:40: Prelwell: now alert + GCS 15
states "greater not helping me
Offered extension for observation not declined
Pl) DC
appr

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☑ NURSING ☐

Please tick ✔ appropriate directorate

2505876061
MCLEISH F
Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

Date & Time	Prefswell ST4 ED.	Signature, Print Name & Designation
10/7		
16:40	Wendy now fully GCS 15,	
	Resolution of slurred speech	
	Fully ambulant.	
	Walking into other cubicles + attempting	
	to interact with Patients.	
	AT this Point she appears to be at Baseline	
	From a neurological Point of view.	
	Explained to Wendy that she is now	
	Discharged at ~~of~~ which Point she	
	Become verbally abusive to myself	
	+ ED Nurse	
	Swearing + Raising voice telling	
	other patients "They're telling me	
	there is nothing F*xxing Wrong with me"	
	Joined By ED Con O'neil + Patient	
	escorted from major area.	
	States she will Be "Back tomorrow"	
	~~Sho~~	
	* at DC she was GCS 15 + fully mobile *	

83949 GGC0072

Patient Information

WENDY MCLEISH

Age/Gender:	35Y Old Female
Address:	3/2 312 CUMBERNAULD ROAD DENNISTON GLASGOW,G31 3LY
DOB:	25/05/1987
CHI:	2505876061
Ethnicity:	

Date:	10/03/2023
Incident Number:	CR009614327
Incident Type:	EMG
Incident Location:	3/2 312 CUMBERNAULD ROAD DENNISTON GLASGOW, G31 3LY

Scottish Ambulance Service

Presenting Complaint

GENERALLY UNWELL

Additional Comments

999 for 35 y.o.f 1st party caller for s.o.b and not responding appropriately. o/a pt gcs 15, slurred responses and appears under the influence. Narcotic use denied. o/e constricted pupils and pt drowsy. Naloxone given as precaution. pt was admitted yesterday via ambulance, however self discharged as was "starving". Pt returned home via taxi. phoned 999 today as still not feeling well. Staggering on walking. Able to communicate in full sentences. Describes some mild pain in upper right abdo. Soft but tender. fast -ive. currently under investigation for a "shadow" on the lung. ?copd awaiting diagnosis. H/o pnuemonia. urinating frequently, normal. bowels moving, feels constipated.

PATIENT ASSESSMENT

ACVPU Alert <C> No

A Clear

B Breathing Adequately: Yes | Respiratory Rate: 18 | SPO2: 95 | Initial SPO2 On: Air | Oxygen Given: No

C

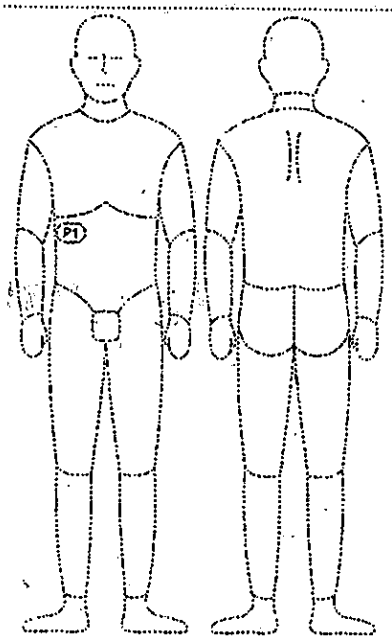
Pulse Rate	BP	Cap Refill	ECG Rhythm
96	120/90	<=2 Secs	Sinus Rhythm

Rhythm	Arm	Central/Peripheral	ECG
Reg	Left		3 Lead

D

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

E



Pain

ID	Body Part	Pain Scale
P1	Abdomen	3

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
12:20	94	18	119/90	95	<=2s	15	Alert								E9888803

12:10	96	18	120/90	95	<=2 Secs	15	Alert	36.8	5.4	Sinus Rhythm	3	3	E9888803

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
12:10	18 (0)		95 (0)	0	120 (0)	96 (1)	Alert (0)	36.8 (0)	1

Drugs

Time	Drug	Dosage	Units	Route	Drug Expiry Date	Pain Before	Pain After	CrewID
12:35	Naloxone (Narcan)	400	mcg	IM	01/2025			E9888803

HISTORY

AMPLE

Allergies	None
Medication	Mirtazapine, Dihydrocodeine, Gabapentin
Past Medical History	SCIATICA. PTSD. SHADOW ON LUNGS. ?COPD
Last Eaten	Unknown
Events Prior	STAGGERING. LETHARGIC. DROWSY. UPPER ABDO PAIN.

2505876061
MCLEISH
Wendy
F
25/05/1987

Social History

Lives alone	No	Living With	PARTNER	Patient Occupation	Does Not Work

Patients General Appearance	Normal
Patient Mobility	Fully Mobile
Patient Communication	No Help Required
Patient Clinical Risk Factors	None Identified
Patient Enviromental Risk Factors	None Identified

CLOSE RECORD

Treatment On Scene: Non-Emergency

Non-Conveyance

I have Seen, Examined, Treated the patient and (the patient/parent/carer/guardian and) I have reached the following decision:

INCIDENT LOG

Time Call Received	10:35	Allocated	11:34	Mobile	11:36
First Resource On Scene		Crew On Scene	12:01	Crew Left Scene	
Crew At Hosp		Receiving Hospital		Clear Time	

Crew ID	Crew Grade	Driver
E9888803	Paramedic	YES

Emergency Department Nursing Documentation

Presenting Complaint - Abdo pain.

Date: 10/3/23 Time: 1405

2505876061
MCLEISH F
Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

NHS Greater Glasgow and Clyde

Assessment Complete by: Name NURSE (Please Print) UR

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

Urinalysis

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

Screening Tools
(Please tick/circle when completed)

SEPSIS RISK? / SIRS Criteria 2 or more	Y/N	**SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms)**	YES
Mental Health Triage Assessment	Y/N	If NOT WHY? - (details) NIA	NO
GMAWS	Y/N	Date - 10/3/23 Time - 405 Signature -	

4AT	
AMT	Correct
Age	
Date of Birth	
Place	
Current year	

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

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

Alertness	
Normal	0
Mild sleepiness	0
Clearly abnormal	4

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

4AT score

/12

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

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

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

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

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

Indicator for care by another acute specialty regardless of age.

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

Are any of the above criteria met?

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

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

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

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

Screening Tools / ACTIVE CARE

(Please tick/circle when completed)

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

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

2505876061
MCLEISH
Wendy
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY
F
25/05/1987
Label

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

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

Nursing Notes

Date and Time		Print Name and Signature
10/3/23	Patient in cubicle Awaits rlv. left ED 1/7 before assessment. Appears under the influence of something - denies this OE	
16.45	Patient up and walking, swearing around the department, ~~behaving~~ in front of other patients, inappropriate behaviour towards staff, shouting even when in the cubicle, NFC given	LE

Wendy McLeish

NEWS 2 Key | 1 | 2 | 3

| | | |

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

2505876061
MCLEISH F
Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP initials ONLY:	Dr/ANP initials ONLY:	
Date:	Date:	

Document all actions and interventions

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

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

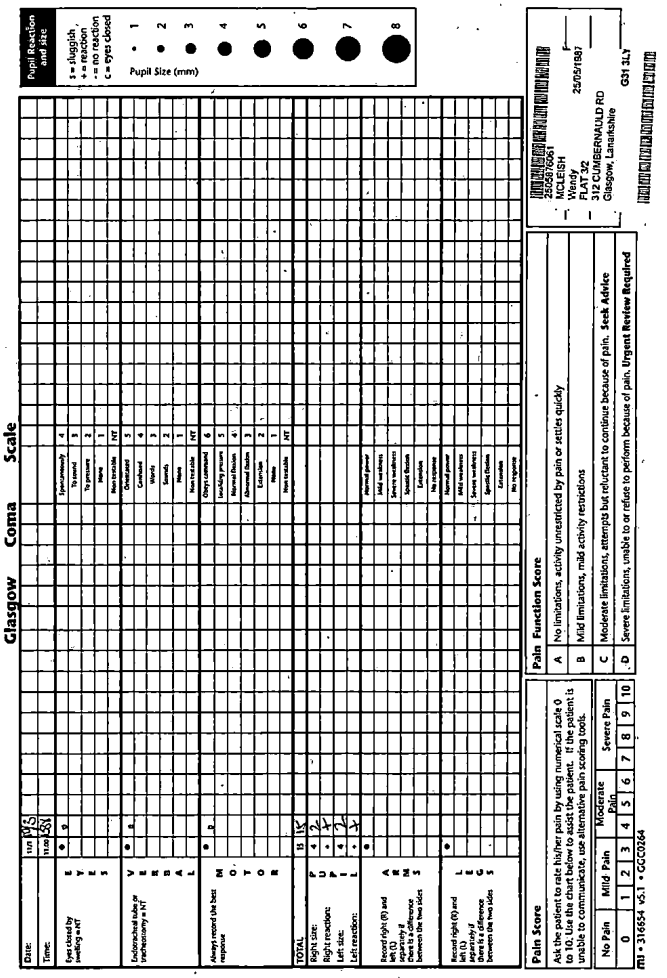
Discontinuation of NEWS

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

Signed.....

Medical:.....

Date:.....



2505876061
MCLEISH
Wendy
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
F
25/05/1987
G31 3LY

mi • 316554 v5.1 • GGC0264

Glasgow Royal Infirmary

CHI: 2505876061

Total Att: 15

12 Mth Att: 1

Title: MISS

MCLEISH

Wendy

DOB 25/05/1987 Age: 35y Sex: Female

FLAT 3/2
312 CUMBERNAULD RD
Glasgow
Lanarkshire
G31 3LY
07912347436

Next of kin: SAME?, GERALD
Relationship: Brother

GP: MM Morris
0141 554 0464

Attendance Date: 09/03/2023 Arrival Time: 15:16

Registration Time: 15:16 Date of Incident: 09/03/2023

Major Incident Desc:

Reason for Attendance: chest pain

Nursing Assessment

Alerts: Yes Allergies: Not Recorded Pain Score:

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

Presenting Complaint:

Observation Date: 09/03/2023 15:25

Nurse name: Nurse Danielle Barlow.

Temp	36.3	C
HR	94	bpm
BP	123/80	mmHg
MAP	94.33	mmHg
RR	15	bpm
SpO2	96	%
Oxygen		%

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

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **"CHEST PAIN-onset at 9am,central CP non radiating.Under ix with respiratory for ? shadow on lungs attended ED for same in Jan.Appears unwell,under influence-denies any drug/alcohol intake.NEWS 0."**

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

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

Date	Clinical Notes		
	Seen By	Time Seen	

DNA

Trop <4

Na 136 Kr 4·5 Cl 109 urea 7·5 Creat 51

Bil 9 ALT 36 AST 17 AP 72 Alb 34

Glucose 5·5

WCC 9·8 Hb 150 Plt 249

CRP 5

Coag (N)

Once Only Prescriptions (Including Tetanus Prophylaxis)

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

3/2023 Incident Number CR009612430

2505876061
MCLEISH
Wendy 25/05/198
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3L

Patient Information

WENDY MCLEISH

Age/Gender:	35 years 9 months 15 days Old Female
Address:	3/2 312 CUMBERNAULD ROAD DENNISTON GLASGOW,G31 3LY
DOB:	25/05/1987
CHI:	2505876061
Ethnicity:	

Date:	09/03/2023
Incident Number:	CR009612430
Incident Type:	EMG
Incident Location:	3/2 312 CUMBERNAULD ROAD DENNISTON GLASGOW, G31 3LY

Presenting Complaint

CHEST PAIN

Additional Comments

Called to 35 yof with chest pain - o/a p/t walked to ambulance with partner, p/t seems agitated and paniced rr raised. 26 RR. partner said p/t not herself for 2 days, seems out of it. P/t says she has been feeling "staggery" woke with a pain in chest about 9am. H/x p/t is under respiritary team for invstigation lung condition "shadow" on left lung. o/e all feild sounded and crackle on left base. Spo2 99%, ECG normal sinus rhythm, conveyed to GRI for further investigation.

PATIENT ASSESSMENT

ACVPU	<C>
A	
B	
C	
D	

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
14:45	100	20	132/79	96		15	Alert				Sinus Rhythm				E9883611
14:35	93	25	142/78	96		15	Alert		36.7	4.8	Sinus Rhythm				E9883611

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
14:35	25 (3)	96 (0)		0	142 (0)	93 (1)	Alert (0)	36.7 (0)	4

HISTORY

AMPLE

Allergies	HAYFEAVER
Medication	LAMOTRIGINE, MIRTAZAPINE, RALVO, SETRALINE, GABAPENTIN, DIHYDTCCODENE, SALBUTAMOL
Past Medical History	COPD, Epilepsy
Last Eaten	Within Past Hour
Events Prior	FEELING UNWELL CHEST PAIN

CLOSE RECORD

Treatment On Scene: Non-Emergency

Conveyance

Transport To Hospital	Normal driving	Pre-Alert	No

INCIDENT LOG

Time Call Received	14:17	Allocated	14:19	Mobile	14:19
First Resource On Scene		Crew On Scene	14:25	Crew Left Scene	15:02

3/5/23 Incident Number: C[illegible]

Crew At Hosp	15:09	Receiving Hospital	GLASGOW ROYAL INFIRMARY	Clear Time	

Crew ID	Crew Grade	Driver
E0031224	Paramedic	YES
E9883611	Ambulance Technician	NO

2505876061
MCLEISH
Wendy 25/05/198
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3L

W1R

Glasgow Royal Infirmary

CHI: 2505876061

Total Att: 14
12 Mth Att: 0

Title: MISS

MCLEISH Wendy

bloods ✓
ECG ✓
Swab ✓

DOB 25/05/1987 Age: 35y Sex: Female

FLAT 3-2
312 CUMBERNAULD RD
Glasgow
Lanarkshire
G31 3LY
07912347436

Next of kin: SAME?, GERALD
Relationship: Brother

GP: MM Morris
0141 554 0464

Attendance Date: 11/01/2023 Arrival Time: 11:15
Registration Time: 11:15 Date of Incident: 11/01/2023
Major Incident Desc:

Reason for Attendance: medical - letter on Portal. cough and pleuritic chest pain ? pe hx pneumonia

Nursing Assessment

Alerts: Yes
Allergies: Not Recorded
Pain Score:
Triage Category: 3
Tetanus up to date/fully immunised

Presenting Complaint:

Observation Date: 11/01/2023 11:59
Nurse name: Nurse Rachel Tucker

Temp	35.5	C
HR	96	bpm
BP	132/87	mmHg
MAP	102.00	mmHg
RR	16	bpm
SpO2	95	%
Oxygen		%

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: "2/12 of ongoing cvhest infections has had 4 courses of abx with no improvement. had CAP 10 years ago with ITU admission. " "under respiratory. Worsing SOB and CP this AM. Reduced SPO2 at GP normal in triage. appears vague " "PMH Asthma, Bronchitis "

Patient ID label

SATA/AAU MEDICATION DOCUMENTATION

NHS Greater Glasgow and Clyde

Once Only Prescriptions

Date	Drug	Dose	Route	Time	Prescriber (Print & Sign)	Given By	Time Given

Discharge Medications

Date	Drug	Dose	Route	Time	Prescriber (Print & Sign)	Given By	Time Given

Glasgow Royal Infirmary
Acute Medicine Unit
(Part B - Medical Admission)

NHS
Greater Glasgow and Clyde

2505876061 F
MCLEISH
Wendy 25/05/1987
FLAT 3-2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

Date & Time 11/01/23 - 1450 Consultant [redacted] Ward AAU

Ward Review (Should be completed within 2hrs of transfer from ED)

Check List	
VTE	☐
Med - Rec	☐
Kardex	☐
CxR	☐
ECG	☐
Oxygen	☐
Patient on Bleeders list	☐

A Mullan (INT2)

35yr → Chest Pain + SOB

Ongoing SOB + cough for months due to see resp next week.
GP referred up as new @ sided / central CP.
Sharp stabbing pain @ ant + central / epigastric.
Worse when coughing. No fever / haemoptysis.
No headache / visual disturbance.
Cough - white sputum. Pain as above.
States SOB but still managing 6 flights of stairs daily no issue. No palpatations.
No abdopain. No nausea / vomiting.
Bowels moving. No LUTS

BG: Benign tremor
Anxiety / Depression
Pityriasis Vesicolor
Asthma
Admission Nov 2011
↳ CAP required ITU had ECMO

SHx: lives alone
not working
not smoking
no alcohol - 2/52 wks

O/E: NEWS = 1 → T° 35·6 BP 132/87
HR 96 RR 16
Sats 95 (OA)
Looks very well
HS 1+1+0
HR - reg
Clear
Warm + well perfused
Calves SNT
Oedema





Tender epigastric + @ ant chest wall
? MSK
Soft
BS +

Ward Review

ECG : (N) SR
incomplete RBBB (not new)
TWI V_1 + V_2 (not new)

Bloods: WCC 8·0 | U+E (N) | Bil 10 | Ca (N)
Hb 149 | Trop < 4 | AST 51 (35) | Coag (N)
plt 298 | Glu 5·2 | ALT 106 (70)
CRP 24 | D-dimer < 150 | ALP 107
Alb 34

Imp: MSK pain
Slight deconsaturations ? 2° abx +/- recent viral illness

Plan (1) CXR → nil acute.
(2) (H) with worsening advice

Amull
IMT2

NHS GG&C Adult Risk Assessment for Venous Thromboembolism (VTE)

[excluding orthopaedics, obstetrics & ENT who have specialty-specific policies]

NHS Greater Glasgow and Clyde

- **Risk Assessment must be completed for all patients within 24 hours of admission to hospital**
- **Patients must be reassessed every 48-72 hours or sooner if condition changes**
- **Reassessment must be documented in Kardex**
- **Please complete risk assessment and then sign and date Risk Assessment Result box at bottom of page.**

Pt Addressograph

Operative patients

Non-operative patients

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

Yes ☐ | No ☐

Does the patient have any risk factors for thrombosis? (tick √ all that apply)

Age ≥60 ☐	Use of oestrogen-containing contraceptive therapy ☐
Active cancer or cancer treatment ☐	Use of hormone replacement therapy or tamoxifen ☐
Dehydration ☐	Pregnancy or < 6 weeks post partum ☐
Known thrombophilias ☐	Critical care admission eg HDU/ITU ☐
Obesity (BMI>30) ☐	Surgical procedure with total anaesthetic/surgical time >90 min, or >60 min if surgery on lower limb or pelvis ☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or Inflammatory disease ☐	Acute surgical admission with inflammatory or intra-abdominal condition including Pelvic Inflammatory Disease ☐
Personal history or first degree relative with a history of VTE ☐	Hip fracture ☐
Varicose veins with phlebitis ☐	All gynaecological surgery except uncomplicated gynaecological diagnostic day case procedures ☐

- No thromboprophylaxis required.
- Continue to reassess every 48-72 hours or, sooner if condition changes.
- Document all reassessments in drug kardex.
- Complete Risk Assessment Result Box.

Yes, 1 or more risk factors identified ☐ | **No risk factors identified ☐**

Indicators of high risk bleeding (tick √ all that apply)

Active bleeding ☐	Lumbar puncture, epidural/spinal anaesthesia • Expected within the next 12 hours • Within the previous 4 hours ☐
Acquired bleeding disorders (e.g. liver failure) ☐	Other procedure with high bleeding risk – discuss with senior if unsure ☐
Concurrent use of other anticoagulants (e.g. warfarin, rivaroxaban, apixaban, edoxaban) is a contra-indication to additional pharmacological thromboprophylaxis ☐	Acute bacterial endocarditis ☐
Acute stroke (within 14 days) ☐	Surgery expected within the next 12 hours ☐
Persistent uncontrolled hypertension (BP > 230/120 mmHg) ☐	Trauma with high bleeding risk e.g. Head injury ☐
Thrombocytopenia (<75 x 10⁹/l) ☐	eGFR <30ml/minute/1.73m² - Dose reduction required ☐
Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands) ☐	Heparin induced Thrombocytopenia ☐
High risk of peri- or post-procedural bleeding, e.g. neurosurgery, spinal, posterior eye surgery and thyroid surgery ☐	

- Discuss with senior clinical staff before deciding to prescribe pharmacological prophylaxis
- Consider mechanical prophylaxis e.g. AES unless contra-indicated.
- Reassess patient every 48-72 hours or sooner if condition changes.

No contraindications to pharmacological prophylaxis identified ☐ | **Contraindications to pharmacological prophylaxis identified ☐**

Operative patients – Enoxaparin 40mg + AES ☐*
*prior to application of AES, please check contraindications to AES

Non-operative patients – Enoxaparin 40mg ☐
Prescribe Enoxaparin at 6pm
(on day of surgery, at the later of either 4h post-op or 6pm)
Reduce Enoxaparin to 20mg if <50Kg or eGFR <30ml/minute/1.73m² ☐
If weight> 120kg, consider Enoxaparin 40mg bd (see StatNet Guideline).
Discontinue at discharge or when returned to pre morbid mobility

Contraindications to anti-embolism stockings (AES) Y ☐ N ☐
Peripheral neuropathy ☐
Peripheral arterial disease ☐
Cellulitis or Gross oedema ☐
Leg deformity or Fragile skin ☐
Leg / foot ulcers ☐
Allergy ☐
Unusual leg size/shape ☐

Risk assessment result – please tick √ all that apply

VTE risk factors: YES ☐ NO ☐ Indicators of high risk bleeding: YES ☐ NO ☐ Prescribed: LMWH ☐ AES ☐ NONE ☐

Patient informed of VTE risks and benefits of thromboprophylaxis YES ☐ NO ☐ N/A ☐ Information leaflet provided YES ☐ NO ☐

Print Assessor's Name: _____ Signature: _____ Date: _____

Medicine Reconciliation Form

Source of information: ECS ☐

Patient ☐ Relative/carer ☐ GP surg ☐ GP computer printout/letter ☐ Patient's own drugs ☐ Other (specify) _____

Admission Medicines (including OTC, herbal, homeopathic)				Plan for medicines (unless indicated to stop or hold medication should be continued on drug kardex)				
Name	Dose	Freq	Route	Amend	withhold	Stop	continue	Reason for alteration
Allergies/adverse events								

List obtained by _____ Designation _____

Recently altered/discontinued medicines prior to admission and reasons why _____

Compliance aid? Y ☐ N ☐ Type _____ If, Y Community Pharmacy _____ Phone _____

Senior Medical staff review: Sign _____ Title _____ Date and Time _____

Reviewed by pharmacist _____ Date and Time _____

Comments

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name: [redacted] F
2505876061
Address: MCLEISH, Wendy 25/05/1987
FLAT 3-2
DOB: 312 CUMBERNAULD RD
Glasgow, Lanarkshire
CHI Num: G31 3LY

1. Triage (Consider Mental Health Triage Assessment - if applicable)

Hospital

Date: Time:

Triage Nurse

Patient Preferred Name:

Transport SAS/Self:

2. Presenting Complaint

2/12 of chest infection/wound recent treatment of PO Abx had respiratory appointment next week. GP this morning

PMH Asthma

Category: Gap Score:

3. Observations

Allergies (including food allergies):

No Known allergies ☐

Resp. Rate	Sp02	Temperature	Pulse	Blood Pressure
18	95%	35.5	96	132/87
GCS	NEWS Score	PEFR	Blood Glucose	Pain Score
/15				/10

4. Communication

I.D. band on? Y / N

Relatives present? Y / N

Relatives / NOK informed? Y / N

Interpreter required? Y / N

5. 4AT and TIME for Detection, Management, and Prevention of Delirium

Complete for patients: age 65 and over; patients of any age with an existing cognitive impairment; previous delirium; current hip fracture; or severe illness. These patients are at high risk of delirium. This should be done on admission; at each transition of care; if SQiD positive; or if any clinical concerns.

mi • 287900 v5.0 • GGC02SS

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name: _____

Address: _____

_____

DOB: _____

CHI Number: _____

Named Nurse/Team Leader: _____

Assessment Completed by: Name (PLEASE PRINT) _____

6. Patient Preparation

Prepare patient for examination	☐	IV Cannula (if required)		Y/N
Clothing bag labelled and stored	☐	Blood samples taken		Y/N
GGC RED BAG - with patient	☐	If Yes, list requests		
12 Lead ECG	☐	Cardiac Monitoring		Y/N
X rays performed	☐	Height:	Weight:	

Urinalysis

Leucocytes	Nitrites	Protein	pH
Blood	S.G.	Ketones	Glucose
MSSU/CSU Sent ☐			
HCG specimen if indicated	+ve ☐	-ve ☐	Strip Lot no:

7. Peripheral Vascular Catheter (PVC) Bundle

Reason for PVC Insertion: ☐ IV Fluids ☐ IV Drugs ☐ Suspected haemorrhage ☐ Diagnostic tests Insertion Date: ___/___/___ Insertion Time: ____:____	Hand hygiene performed immediately before PVC insertion. Skin antiseptic containing 70% isopropyl alcohol used to cleanse the skin and left to dry. Aseptic technique maintained throughout insertion procedure. Sterile, transparent, semi permeable dressing used to cover catheter site. Size/Colour: _____ Insertion site: _____ Signature: _____	☐ ☐ ☐ ☐

8. Adult Urethral Urinary Catheter Insertion (Use maintenance care plan as appropriate)

Clinical Indication for Insertion: Insertion Date: ___/___/___ Insertion Time: ____:____ Signature: _____	Hand hygiene performed immediately before insertion. Aseptic technique maintained throughout insertion procedure and connection to closed drainage. Urethral meatus cleansed with saline and lubricant used. Guage: _____ _____ mls in balloon	☐ ☐ ☐

9. General Safety Precautions to be Undertaken by All Patients

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

Date: Time: :

1. Document mobility status in clinical record and complete a moving and handling assessment if appropriate	
2. Check walking aid (if required) is in reach and in use.	
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	
5. If glasses are worn, check they are available and in use	
6. If hearing aid/s are worn, check they are working and in use.	

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name:
Address:
DOB:
CHI Number:

10. Risk Assessment

If Yes to any of the 5 questions below complete the falls interventional plan. Whether Yes or No, update this assessment in acute wards, or, at the time of a fall or, upon a change in patient's clinical condition.

	YES	NO	YES	NO
1. Has the patient fallen in the last 6 months - including during this admission?				
2. Does the patient have cognitive impairment or a possible delirium?				
3. Does the patient attempt to walk alone although unsteady or unsafe?				
4. Does the patient or their relative have a fear or anxiety of the patient falling?				
5. Based on your clinical judgement, is this patient at high risk of falling?				
Signature of nurse completing assessment / update				

11. Screening Tool (Requires escalation/specialist referral/separate Risk Assessments)

Child Protection concern	Y / N / NA	Learning Disabilities	Y / N / NA
Adult Support and Protection	Y / N / NA	Patient has appointed Welfare Guardian/Power of Attorney	Y / N / NA
>65 years: 4AT/TIME BUNDLE COMPLETE?	Y / N / NA	Patient has Adult with Incapacity Section 47 certificate in place	Y / N / NA
Mental Health Triage	Y / N / NA	Infection Risk	Y / N / NA
Has swallow test been carried out?	Y / N / NA	STOPPS completed? Y / N / NA Date Time Sign	
Sepsis Risk: Systemic inflammatory response syndrome (SIRS) Criteria 2 or more → commence Sepsis Bundle	Y / N / NA	Anticipatory Care Planning? (If applicable, complete GAEL chart)	Y / N / NA
FRAILTY SCREENING Completed on Trakcare	Y / N / NA	SUBSTANCE MISUSE FAST SCORE / GMAWS	Y / N / NA

12. Pressure Area Assessment

1 Pressure Damage — Does the person have redness and/or existing damage? Yes / No

If YES, prescribe a minimum of 2 HOURLY Active Care to avoid further damage occuring and complete the pressure ulcer intervention plan (PUDRA Chart).

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

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

13. Record of Intentional Rounding – ask whenever patient is visited but no longer than every 2 hours

1. Think delirium: Is the patient more confused?
2. Comfort: Are you comfortable?
3. Pain: Do you have any pain?
4. Drink/Mouth Care: Would you like a drink?
5. Food: Are you hungry?
6. Continence: Do you need to go to the toilet?
7. Possessions: buzzer, tissues, glasses within reach, water available and relatives at bedside?
8. Is there anything else I can do for you?

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

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

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name: 2505876061 MCLEISH F
Addre Wendy 25/05/1987
FLAT 3-2,
312 CUMBERNAULD RD
DOB: Glasgow, Lanarkshire
G31 3LY
CHI Number:

Communication with Relatives		Signatures	Time
Next of Kin:	Tel:		

Nursing Notes		
Date and Time		Print Name and Signature

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name:_____

Address:_____

DOB:_____

CHI Number:_____

Pause for Transfer (Please tick when completed)		Tick when completed	N/A	Notes
	Relatives Informed	☐	☐	Information on discussion with relatives
	Cannula	☐	☐	
	Name Band	☐	☐	
	4AT	☐	☐	
	NEWS >7	☐	Always	
Snr Dr:_____ Page no.:_____				
Prescriptions signed	Infusions	☐	☐	
	Drugs	☐	☐	
	Fluids	☐	☐	
	GMAWS	☐	☐	
GGC RED BAG - with patient		☐	☐	Please note here if any other tasks required prior to transfer
	Belongings (including patients medication)	☐	Always	
	Bed requested, accepted and ward informed/SBAR completed	☐	Always	
	Notes: medical notes; GP letter, PRF	☐	Always	
Investigations	CXR reviewed	☐		
	ECG reviewed	☐	☐	Print name
	Bloods sent	☐	☐	
	Bloods reviewed	☐	☐	
	Patient on 02: cylinder checked	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	

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

Document Owner: Pamela Cheung, AAU Team, GRI

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

2505876061 F
MCLEISH 25/05/1987
Wendy -
FLAT 3-2
312 CUMBERNAULD RD
Glasgow, Lanarkshire G31 3LY

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target ≥96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y ☐ N ☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP Initials ONLY:	Dr/ANP Initials ONLY:	
Date:	Date:	

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed:

Medical:

Date:

Glasgow Coma Scale

Date:
Time:

		1st	2nd
EYES	Spontaneously	4	
	To sound	3	
	To pain	2	
	None	1	
	Not testable	NT	
VERBAL	Oriented	5	
	Confused	4	
	Words	3	
	Sounds	2	
	None	1	
	Not testable	NT	
MOTOR	Obeys command	6	
	Localising pain	5	
	Withdrawal from pain	4	
	Abnormal flexion	3	
	Extension	2	
	None	1	
	Not testable	NT	
TOTAL		/15	

Always record the best response.

	1st	2nd
Right size:		
Right reaction:		
Left size:		
Left reaction:		

Record right (R) and left (L) separately at appropriate frequency between hourly and 4 hourly

	1st	2nd
ARMS	Normal power	
	Mild weakness	
	Severe weakness	
	Specific Focal Deficits	
	Extension	
	No response	

Record right (R) and left (L) separately at appropriate frequency between the hourly and 4hrly

	1st	2nd
LEGS	Normal power	
	Mild weakness	
	Severe weakness	
	Specific Focal Deficits	
	Extension	
	No response	

Pupil Reaction and Size

4 = unequal
5 = no reaction
6 = eyes closed

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

Pain Score

Ask the patient to rate his/her pain by using numerical scale 0 to 10 (0 = No Pain, 10 = Severe Pain). If the patient is unable to communicate, use alternative pain scoring tool.

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

Pain Function Score

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

Affix Patient ID

MI • 316664 • 5.1 • GGC0264

NEWS 2 Key | 1 | 2 | 3 |

| | | |

Glasgow Royal Infirmary

CHI: 2505876061

Total Att: **11**

12 Mth Att: **0**

Title: **MISS**

MCLEISH **Wendy**

DOB: **25/05/1987** Age: **32y** Sex: **Female**

6 CARNTYNE GROVE

Glasgow
Lanarkshire
G32 6LZ
07769733984

Next of kin: **SAME?, GERALD**
Relationship: **Brother**

GP: **AL McGinley**
0141 531 8150

Attendance Date: **16/08/2019** Arrival Time: **11:09**

Registration Time: **11:09** Date of Incident: **16/08/2019**

Major Incident Desc:

Reason for Attendance: **appears to be intoxicated**

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **16/08/2019 11:22** Nurse name: **Nurse Fiona Jack**

Temp	**36.1**	C
HR	**118**	bpm
BP	**102/67**	mmHg
MAP	**78.67**	mmHg
RR	**17**	bpm
SpO2	**97**	%
Oxygen		%

BM	**4.6 (sas)**	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm

Visual Acuity	
Left	
Right	
Corrected?	

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

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

Nursing Notes: **BIBA, NEWS 3. Domestic incident this morning with partner. Partner locked pt and 2 year old daughter and friend in the house and left with the keys. Pt states she fell out of ground floor window when climbing out. Friend advised the child was passed out of the window and was then passed back inside the house. Pt climbed back into the house using a cot side as a ladder. Pt is intoxicated with alcohol and is drowsy with slurred speech. SAS state there were knifes and joints lying around the house and the home was unsuitable for a chil**

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

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

Date	Clinical Notes		
	Seen By	Time Seen	

Sister in law - Sharon Ward.
153 Rockburn Cres
Bellshill
ML4 3EX

Brother in law - Darren Ward.

Childs name - Cara Ward.
24.02.17

GN Kirsteen Scanlon
276 8240

Once Only Prescriptions (Including Tetanus Prophylaxis)

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

Glasgow Royal Infirmary
Emergency Department

NHS
Greater Glasgow and Clyde

WENDY MCLEISH
DOB 25/05/1982 6067
C.I. Number
Patient label

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

Clinical Notes

16/03/19 1130 Suspension Cons ATE

FC Intoxicated

NFC Intoxicated with alcohol
No active complaints
Possible domestic marker — now denies this

Child known ward - ? to family

Police contacted to check of welfare
SW contacted message left

AWH
alcohol XS

O/E well. No cyanosis/jaundice/pallor

RR 80 Reg
HS 1+11+0 no murmurs

Check
AE R-CCN
BS R-CCN

Glasgow Royal Infirmary
Emergency Department

Patient Name
DoB
CR Number
or affix label

Clinical Notes

Inj alcohol intoxication

→ fit to discharge.

- SW child protection referral

Y/T 5/6/2015 SW

Glasgow Royal Infirmary
Emergency Department

Wendy McLeish
25/05/876061

Patient Name
DoB
CR Number
or affix label

Clinical Notes

Glasgow Royal Infirmary
Emergency Department

Patient Name
DoB
CHI Number
or affix label

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

Diagnosis and Plan

Review/Discussed with:

Handover

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

mt • 287967 Version 1_0 • GGC0226

Patient Information		Date:	16/06/2019
WENDY MCLEISH		Incident Number:	CR005782646
Age/Gender:	32 years 2 months 22 days Old Female	Incident Type:	EMG
Address:	6 CARNTYNE GROVE CARNTYNE GLASGOW,G32 6LZ	Incident Location:	6 CARNTYNE GROVE CARNTYNE GLASGOW, G32 6LZ
DOB:	25/05/1987		
CHI: / Ethnicity:	2505876061		

Scottish Ambulance Service

Presenting Complaint

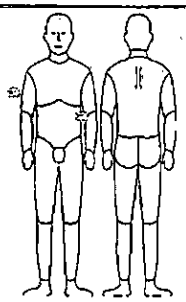
LEFT ARM PAIN/ INTOXICATED.

Additional Comments

EMERGENCY 999 CALL TO 31YOF C/O PAIN IN HER LEFT ARM.O/A BEDROOM WINDOW WAS WIDE OPEN.PATIENT STATED SHE HAD NO KEYS WHEN SHE CALLED 999.CREW LOOKED THREW WINDOW AND PATIENT WAS SITTING ON THE HALL FLOOR.2YR OLD GIRL CAME OVER TO THE WINDOW.PATIENT STATED SHE COULD NOT GET UP AND HAD NO HOUSE KEYS.CREW GAINED ACCESS THROUGH BEDROOM WINDOW.O/E PATIENTS WORDS WERE SLURRED AND SHE SAID HER ARMS AND LEGS WERE SORE AS SHE HAD FELL WHEN TRYING TO CLIMB OUT OF THE WINDOW.PATIENT STATED HER PARTNER HAD LOCKED HER IN AFTER AN ARGUEMENT AND HAD TOOK THE KEYS THEN SHE WAS TRYING TO GET OUT TO GO AND GET THE KEYS BACK.PATIENT STATED A FRIEND WAS WITH HER AND SHE ALREADY HAD THE 2YEAR OLD OUTSIDE WHO ALSO EXITED THROUGH THE WINDOW.PATIENT CLIMBED BACK IN THE WINDOW AS SHE.HAD HURT HERSELF ASSISTED BY THE SIDE OF A COT AS A LADDER.CHILD WAS HANDED BACK TO PATIENT THROUGH WINDOW THEN PATIENT SAT ON HALL FLOOR AS HER LEGS WERE SORE.PATIENT IS INTOXICATED, STATES SHE WAS DRINKING ALCOHOL LAST NIGHT AND THE CHILD STAYED AT HER FRIEND BIANCAS.BASELINE OBS TAKEN.CHILD TAKEN AWAY BY SISTER AND BROTHER IN LAW.PATIENT STAGGERED OUT TO THE AMBULANCE WITH ASSISTANCE.HOUSE UNKEMPT,ALCOHOL BOTTLE IN KITCHEN AND EVIDENCE OF RECREATIONAL DRUGS USE ON WINDOW SILL.WILL INFORM HOSPITAL OF VULNERABLE CHILD AND COMPLETE APPROPRIATE PAPER WORK.

PATIENT ASSESSMENT

AVPU	Alert		<C>	No
A	Clear			
B				
C	Pulse Rate	BP	Cap Refill	ECG Rhythm
	122	106/77	<=2 Secs	
	Rhythm	Arm	Central/Peripheral	ECG
	Reg			
D	GCS	Eyes	Voice	Motor / PEARL
	15	Spontaneously (4)	Orientated (5)	Obeys Commands (6) / Yes
E				



Wounds

ID	Body Part	Wounds	Treatments
W1	Right Upper Arm	Abrasion	None

Pain

ID	Body Part	Pain Scale
P1	Left Lower Arm	4

Observations

Time	P	RR	BP	SpO2	CR	GCS	AVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
10:35	118	18	106/76	98	<=2s	15	Alert		36.1						E9887834
10:15	122	18	106/77	97	<=2 Secs	15	Alert		36.1	4.6					E9887834

NEWS

Time	Clinical Risk	NEWS
10:35	POTENTIAL Clinical Risk. Patient is likely to require conveyance to hospital.	3
10:15	POTENTIAL Clinical Risk. Patient is likely to require conveyance to hospital.	3

HISTORY

AMPLE

Allergies	None

Medication	MIRTAZAPINE, PROPANOL
Past Medical History	DEPRESSION,ANXIETY
Last Eaten	>4 Hours Ago
Events Prior	DRINKING ALCOHOL.

Social History

Lives alone	No	Living With	CHILD	Patient Occupation	Does Not Work

Patients General Appearance	Normal
Patient Mobility	Fully Mobile
Patient Communication	No Help Required
Patient Clinical Risk Factors	Alcohol
Patient Enviromental Risk Factors	Unkempt Living

Safeguarding

Safeguarding History	Poor State Of Cleanliness, Drug Abuse In Household, Alcohol Abuse In Household
Safeguarding Signs/Concerns	Neglect

Safeguarding Assessment	Child < 16	Safeguarding Category Of Risk	Medium

Substances Affecting Condition

Substances	Alcohol

CLOSE RECORD

Treatment On Scene	Emergency

Conveyance

Transport To Hospital	Normal driving	Pre Alert	No

INCIDENT LOG

Time Call Received	09:25	Allocated	09:48	Mobile	09:49
First Resource On Scene		Crew On Scene	09:56	Crew Left Scene	10:43
Crew At Hosp	10:55	Receiving Hospital	GLASGOW ROYAL INFIRMARY	Clear Time	

Crew ID	Crew Grade	Driver
E0036943	Paramedic	YES
E9887834	Ambulance Technician	NO

CHI: 2505876061

Glasgow Royal Infirmary

(14)

Total Att: 10
12 Mth Att: 0

Title: **MISS**

MCLEISH **Wendy**

DOB: **25/05/1987** Age: **28y** Sex: **Female**

0/1 51 COXTON PLACE

Glasgow
Lanarkshire
G33 5EJ
07769733984

Next of kin: **SAME?, GERALD**
Relationship: **Brother**

GP: **AL McGinley**
0141 531 8150

Attendance Date: **29/08/2015** Arrival Time: **20:34**

Registration Time: **20:34** Date of Incident: **29/08/2015**

Major Incident Desc:

Asymbl / Mirtazapine

Reason for Attendance: **9WKS PREF PVB**

1/52.
DLMP 8D
22 May
1st Preg.
EPAS 1wm x2
1st time

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **29/08/2015 20:42** Nurse name: **Nurse Leza McCall**

Temp	**36.1**	C
HR	**79**	bpm
BP	**121/60**	mmHg
MAP	**80.33**	mmHg
RR	**16**	bpm
SpO2	**99**	%
Oxygen		%

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

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **8/40 gest c/o PVB and abdo cramps. Seen at EPAS during the week and scaned to go back next week but advused to attend A&E if bleeding gets worse**

2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy

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

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

Date	**Clinical Notes**
	Seen By / Time Seen

Once Only Prescriptions (Including Tetanus Prophylaxis)

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

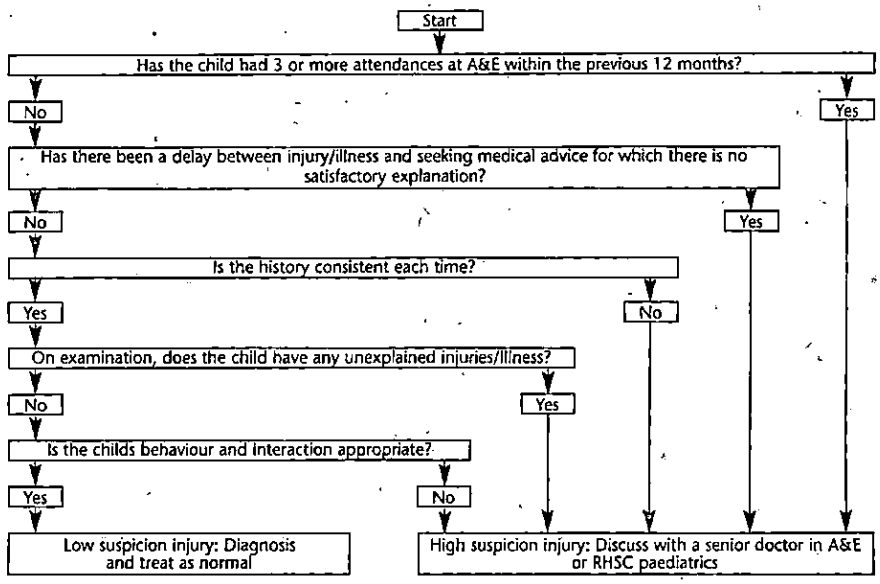
Glasgow Royal Infirmary
Unitary Patient Record
(Part A - Acute Assessment)

NHS
Greater Glasgow and Clyde

2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

Injury/Illness Flow Chart for all Patients 16 and under

Please tick the appropriate box as you go through the Flow Chart



All Clinical Staff Consider

H.I.Form ☐

Audit Form ☐

Police Consent ☐

Clinical Notes

29/8/15 2245 D.Maxwell SIT EM

28 y B/G: 1st Pregnancy
LMP 22/5/15
10/40 Gest.

R/V Bleeding.

Seen by GPAS x2 over 1/12 for threatened miscarriage following bleeding in early pregnancy. Last U/S 27/8 demonstrated intrauterine sac ? viability
Due Hx U/S next Monday
This evening passed fresh clots - lge sized

Please complete where appropriate:

AMT (if >65 years)	CURB Score (if <65 years)
	SIRS

80907

Acute Medicine Unit
Glasgow Royal Infirmary
Unitary Patient Record
(Part A - Acute Assessment)

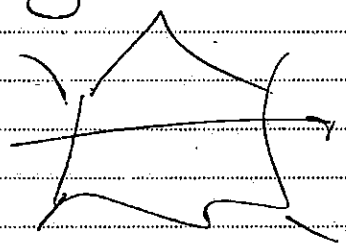
Clinical Notes

Flushed down toilet at home.
Abdo with mild cramp like / comp.
No loc / presyncope
No active PV bleeding.
Otherwise well.

O/E: T 36' BP 124/60 SpO2 99% on RA
HR 79 RR 16

Well clinically
Pulse 60 reg.

Abdo



NAD.
Bowels.
No Rebound / Guarding

Urine - βHCG +ve

Impression: Threatened Miscarriage - Already Confirmed U.P.

Advised - must be aware that this may represent threat to pregnancy with standard prognosis
- As well / confirmed IUP / No pain advised home.
- To contact GP/S Monday for follow up
- If severe pain / prolonged bleeding / unwell to return to ED.

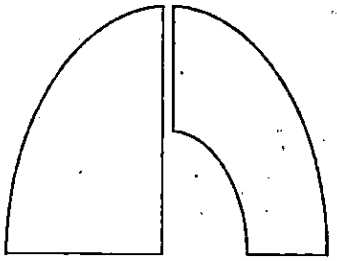
Acute Medicine Unit
Glasgow Royal Infirmary
Unitary Patient Record
(Part A - Acute Assessment)

NHS
Greater Glasgow and Clyde

2505876061
MCLEISH
Wendy
F
0/1 51 COXTON PLACE
25/05/1987
Glasgow, Lanarkshire
G33 5EJ

Clinical Notes

X-Ray results



ECG findings

Other investigations

Biochem/Haematology results

Indicate which lab tests have been requested

Haem	Date and time	
WCC		
Hb		
Plat		
MCV		
Neut		
DDim	Date and time	
PT		
PTT		
TT		

Bioch	Date and time	
Na^+		
K^+		
Cl^-		
Ur		
Creat		
Glu		
CRP		
Bil	Date and time	
AST		
ALT		
GGT		
ALP		
Prot		
Alb		
Glob		
Ca^{++}		
Amyl	Date and time	
TSH		
FT4		
Tropl	Date and time	
Chol		
Trig		
Para	Date and time	
Sal		
S osm		
ABG	Date and time	
H^+		
P_aCO_2		
P_aO_2		
Bic		
BE		
FiO_2		
Lactate		

Fluids Prescribed in A&E

Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time

Drugs Prescribed in A&E

Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time

Refusal of Treatment

Hereby I declare that I am leaving

*(or taking _____ away from)

the _____ Hospital at my own desire and contrary to the advice of medical staff.

I have had the risks of so doing explained to me, and accept full responsibility for my action.

Signature _____

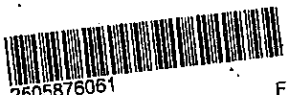
Witness Date _____

* Delete whichever is inapplicable.

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name
Address



2505876061 F
MCLEISH 25/05/1987
Wendy
0/1 51 COXTON PLACE
Glasgow, Lanarkshire G33 5EJ

CHI No.
DoB

	Date	Ward
Admitted		
Transferred		
Transferred		

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

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

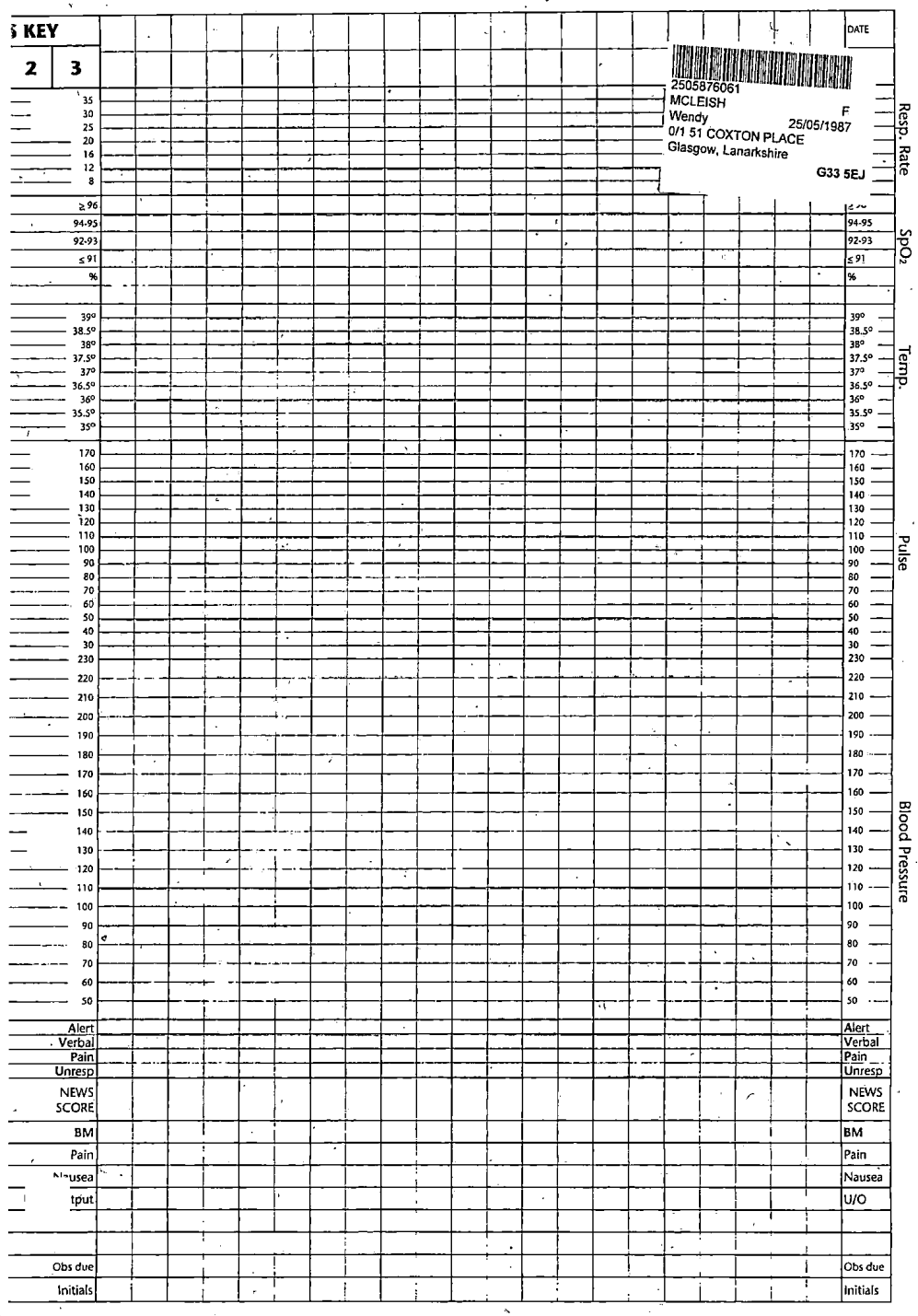
See NEWS Actions Reference Tool for local escalation policy

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

14 WENDY MCLEISH

		DATE	TIME
DATE:		29/8	
TIME:		1662	
Resp. Rate Mark: •	35 30 25 20 16 12 8		
SpO_2 (Enter Value)	≥96 94-95 92-93 ≤91	99	
Any Sup'l O_2 Room air	%		
Temp. Mark: ×	39° 38.5° 38° 37.5° 37° 36.5° 36° 35.5° 35°	36.1 ×	
Pulse Mark: •	170 160 150 140 130 120 110 100 90 80 70 60 50 40 30		
Blood Pressure Mark: ◇	230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50	121	
NEWS SCORE using Systolic BP		1	
		V60	
Conscious Level Mark: •	Alert Verbal Pain Unresp		
Total NEWS (with all obs)		0	
BM			
Pain			
Nausea			
Urine output			
Obs due			
Initials			

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


KEY
2
3
DATE
2505876061
MCLEISH
Wendy
F
25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ
Resp. Rate
SpO2
Temp.
Pulse
Blood Pressure
35
30
25
20
16
12
8
≥ 96
94-95
92-93
≤ 91
%
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
tput
U/O
Obs due
Initials

Neurological Observations

| | | |

NHS GGC Hospitals, Emergency Department

5

NHS Greater Glasgow and Clyde

Affix Label

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

Title:	Sex: M ☐ F ☒
SURNAME: 2505876061 F MCLEISH Wendy 25/05/1987 0/1 51 COXTON PLACE Glasgow, Lanarkshire G33 5EJ	Forename:
	Dob:: 25/05/87. Age: 26
	Next of kin:
	Relationship:
	Tel:
	GP:
Postcode:	
Tel:	Tel:

Attendance date: 9/8/13	Arrival time: 1749	Date of incident:
Registration time:	Major incident description:	

Reason for attendance:

GP Referral for medics

Affix Label

Nursing Assessment | Alerts:

Presenting complaint:

Chest tightness & SOB worse on exertion

Triage category: 3+	Pain score:	Tetanus up-to-date / fully immunised?

Allergies: NKDA

Observations date: 9/8/13			Time: 1810			Nurse's name: C. MCFALL			
Temperature	36.3	°C	BM		mmol/L	GCS			
Regular HR	83	bpm	PF		l/min	Eyes			
BP	116/73	mmHg	Expected PF		l/min	Motor			
MAP	94	mmHg	Weight		kg	Verbal			
RR	16	bpm	Height		cm	Total			
SpO_2	98	%	Visual Acuity			Pupils – Right		Pupils – Left	
Oxygen	(A)	%	Left	6/		Size		Size	
			Right	6/		Reaction		Reaction	
			With correction?						

Nursing Notes:

hx - panic attacks takes propanolol, pneumonia, ARDS. since yesterday had SOB & chest tightness. Felt shaky & heart racing through the night.

97607

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES

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

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged	Not arranged	To be arranged

Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

21 tabs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By
9/8/17	AMOXICILLIN	500mg	Oral	TDS		
9/8/17	Cocodamol 30/500	2 tabs	Oral	PRN QDS		

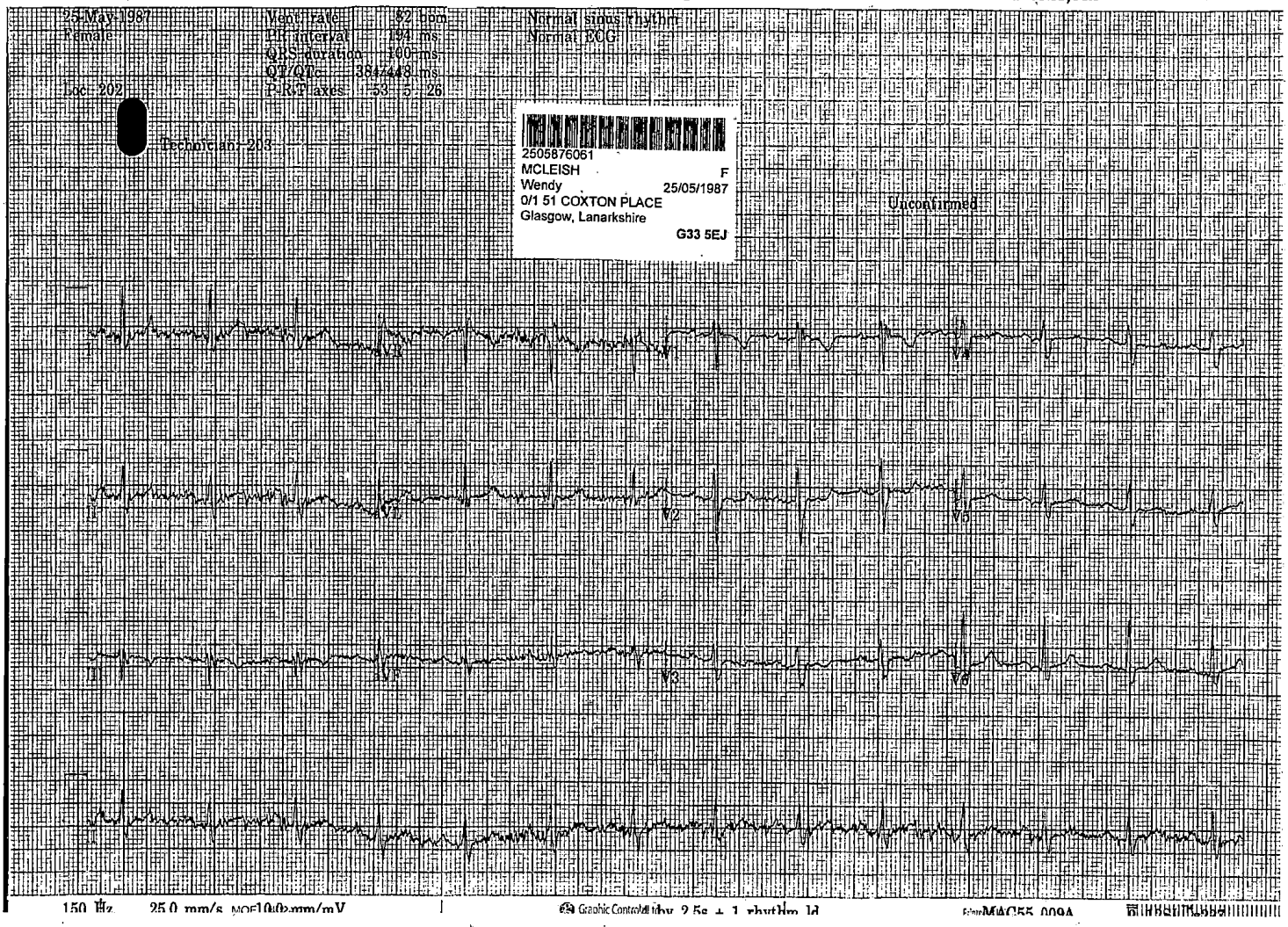
32 tabs

Designed by Medical Illustration Services ref 243836

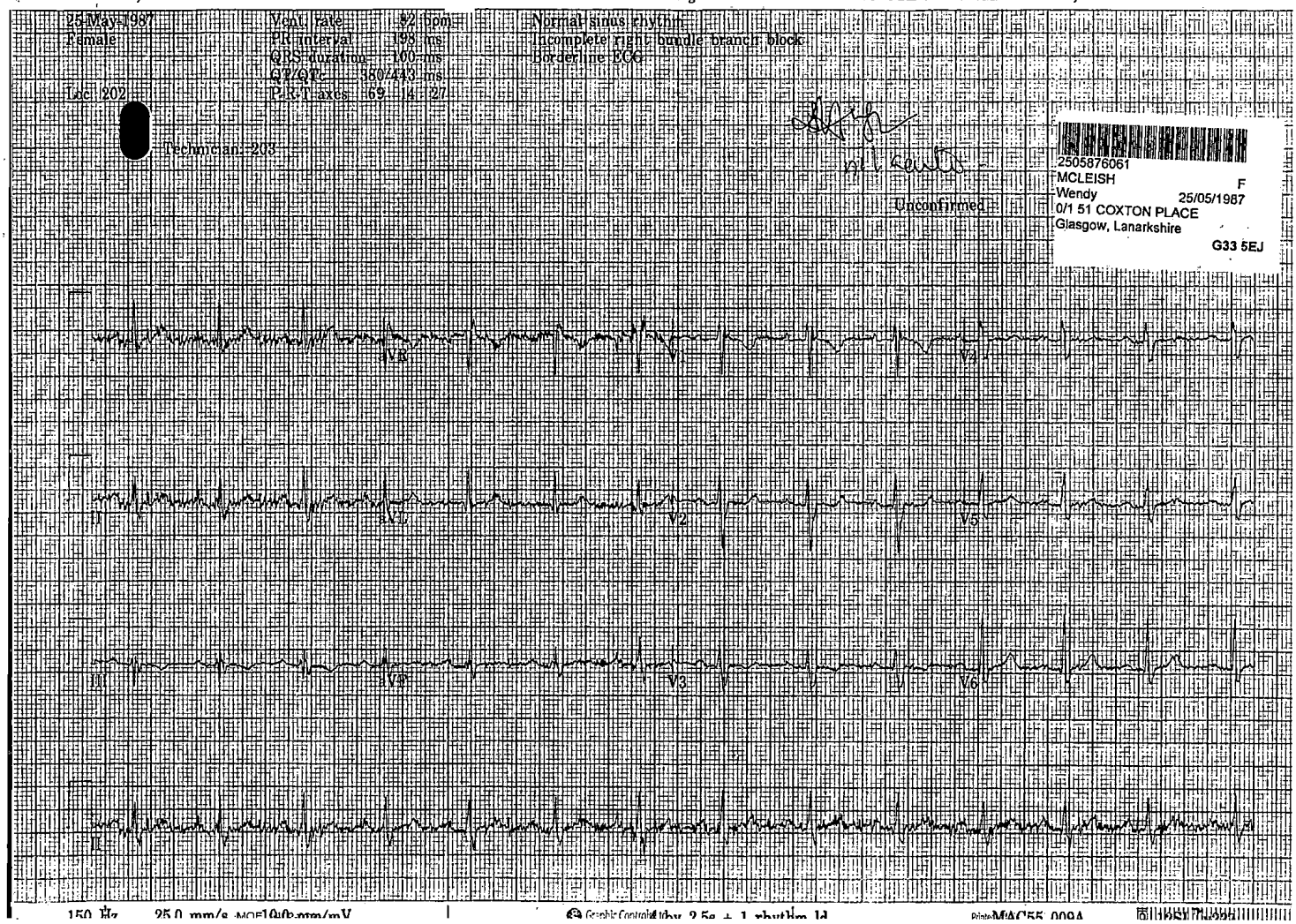
Date	CLINICAL NOTES
	Seen by (Dr) Time seen



2505876061
MCLEISH F
Wendy 25/05/1987


25-May-1987
Female
Loc: 202
Technician: 203
Ventricular rate 82 bpm
PR interval 194 ms
QRS duration 100 ms
QT/QTc 384/448 ms
P-R-T axes -53 5 26
Normal sinus rhythm
Normal ECG
2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ
Unconfirmed
I
II
III
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6
150 Hz 25.0 mm/s
Graphic Control 10 x 2.5s + 1 rhythm 1d

MCLEISH, WENDY 2505876061 9-Aug-2013 17:20:11 ACUTE ASSESSMENT UNIT,GRI



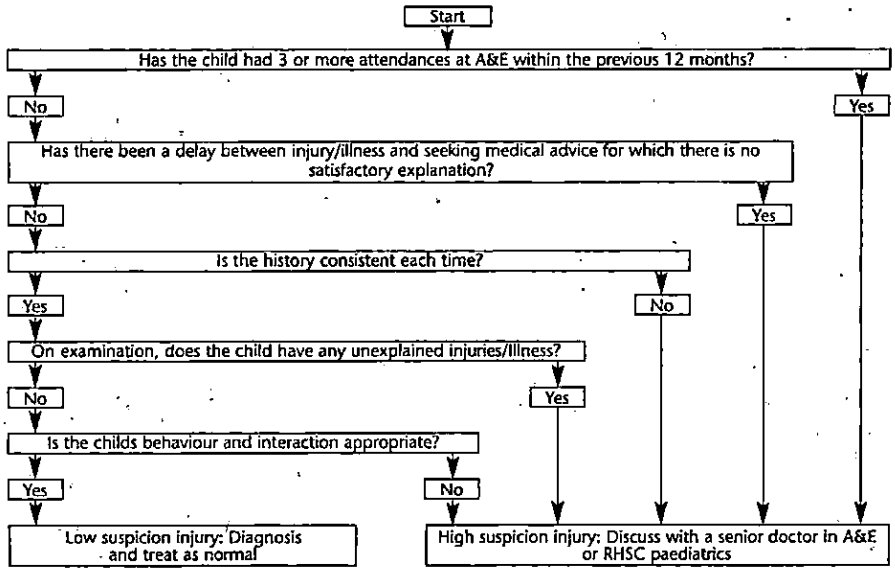
Glasgow Royal Infirmary
Unitary Patient Record
(Part A - Acute Assessment)

NHS
Greater Glasgow and Clyde

2505876061 F
MCLEISH 25/05/1987
Wendy
0/1 51 COXTON PLACE
Glasgow, Lanarkshire G33 5EJ

Injury/Illness Flow Chart for all Patients 16 and under

Please tick the appropriate box as you go through the Flow Chart



All Clinical Staff Consider

H.I.Form ☐

Audit Form ☐

Police Consent ☐

Clinical Notes

9/8/13 18:45 Dr DUFFY EBTC MEDICINE.

(26) Chest pain + SOB.

+

Yesterday patient had lumbar back pain - this settled. Attended GP today c/o SOB o/e
GP requested xray at Shettleston H/C + pt had it today but not able to access this.
When walking along road to see GP
- sudden SOB + chest tightness centrally.
- also throbbing chest pain on (L) + (R) side of chest
- SOB on minimal exertion since yesterday. Ishot pleuritic.

PMH Pneumonia - (R) upper lobe pneumonia requiring ITU admission + transfer to Leicester for ECMO
Benign Essential tremor } prolonged admission Nov 2011 → Jan 2012.

Please complete where appropriate:

AMT (if >65 years)	CURB Score (if <65 years)
	SIRS

80907

leuc ⊕⊕⊕ ⊕urea pH 5. Bile-neg.

Acute Medicine Unit
Glasgow Royal Infirmary
Unitary Patient Record
(Part A - Acute Assessment)

2505876061
MCLEISH
Wendy F
0/1 51 COXTON PLACE 25/05/1987
Glasgow, Lanarkshire
G33 5EJ

Clinical Notes

PMH - Anxiety

FH mum died of MI at 29.

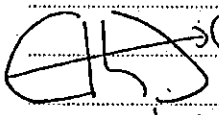
SE ø cough ø sputum ø abdo pain ø dysuria. Urinary frequency.

DH fluoxetine
omeprazole

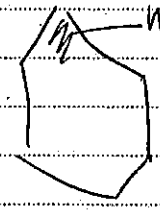
SH Non-smoker
Alcohol one/week.
Lives w/ boyfriend.

o/e well, alert, oriented + undistressed. Moist mucous membranes.

Obs P83 BP 116/73 RR 16 Sats 98% on RA Temp 38.7



HS I+II+0
Calves-SNT
-equal circumference.



Tender chest wall around lower ribs -bilaterally.

Urinalysis - leuc +++
- protein +
- pH 5.

CXR - NAD.

Imp ?UTI
?viral infection.

Plan
1. Oral amoxicillin to cover chest + urine
2. Analgesia.
3. Strong advice to return if any worsening or not resolving.

Dr RPSI.

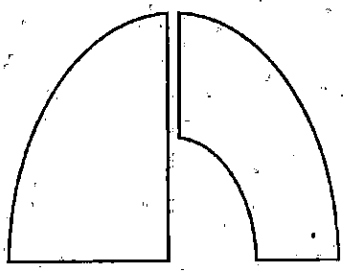
Acute Medicine Unit
Glasgow Royal Infirmary
Unitary Patient Record
(Part A - Acute Assessment)

NHS
Greater Glasgow and Clyde

2505876061
MCLEISH
Wendy
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ
F
25/05/1987

Clinical Notes

X-Ray results



ECG findings

Other investigations

2505876061
MCLEISH F
Wendy 25/05/1987

Biochem/Haematology results

Indicate which lab tests have been requested

Haem	9/8/17 Date and time
WCC	11.1
Hb	131
Plat	278
MCV	92.8
Neut	82
DDim	Date and time
PT	
PTT	
TT	

Bioch	9/8/17 Date and time
Na^+	135
K^+	3.7
Cl^-	106
Ur	3.8
Creat	54
Glu	4.9
CRP	129
Bil	Date and time
AST	15
ALT	21
GGT	
ALP	86
Prot	
Alb	32
Glob	
Ca^{++}	2.55
Amyl	Date and time
TSH	
FT4	
Tropl	<0.04 Date and time
Chol	
Trig	
Para	Date and time
Sal	
S osm	
ABG	Date and time
H^+	
$PaCO_2$	
PaO_2	
Bic	
BE	
FiO_2	
Lactate	

Fluids Prescribed in A&E

Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time

Drugs Prescribed in A&E

Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time

Refusal of Treatment

Hereby I declare that I am leaving

*(or taking _____ away from)

the _____ Hospital at my own desire and contrary to the advice of medical staff.

I have had the risks of so doing explained to me, and accept full responsibility for my action.

Signature _____

Witness Date _____

* Delete whichever is inapplicable.

2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

Registration Details - Patient No: 4917

Personal details...		Address details...	
Date of birth	25/05/1987	Post Code	G33 5EJ
Sex	F	House Name Flat No	
Surname	Mcleish	No and Street	0/1 51 Coxton Place
Previous Surname		Village	GARTHAMLOCK
Forenames	Wendy	Town	Glasgow
Calling Name	Wendy	County	UK
Title	Miss		
Birth Surname			
Marital Status	Marital status unknown		
Ethnic Origin	(White) Scottish		
Gpass Patient ID			

HA/HB Details...		Contact details...	
Trading partner	Greater Glasgow	Home Tel No	07733979634
Registered GP	Dr Anne McGinley	Work Tel No	
Usual GP	Dr Anne McGinley	Mobile Tel No	
Residential Inst		E Mail Address	
Branch Surgery			
CHI Number	2505876061		
NHS Number	617/87/408		

Practice Information...		Distances	
Dispensing	N	Rural Mileage	
Hospital Number		Blocked Special	
Records At	Easterhouse Health Centre	Walking Quarters	

Further Information		Upload Consent	
Long/Short stay or Dead		SCI-DC Consent	Implied Consent (default)
Date of registration	30/08/2012		

AMS\CMS Details		ECS (GP Summary) Consent	
AMS Consent	Yes	Patient Consent	Implied Consent (default)
CMS Status	Not Registered		
Pharmacy Details			
Compliance Check	Yes		

To Receiving Physician - Please see entry from today - c/o fever & pain in chest/SOB ? viral but smoker so prevnar serve pneumovax 2011. NVB - also had CXR today

Medical Record

Problems

Active Problems		Authorised By	Code
30/07/2013	Dyspepsia	Dr Sheppard	J16y4
06/06/2012	Alcohol problem drinking	Dr Sheppard	E23-2
06/06/2012	Substance misuse of Benzodiazepines	Dr Sheppard	EMISNQND16
30/12/2011	Pneumonia due to unspecified organism (Bilateral)	Dr Malek	H26
30/11/2011	Adult respiratory distress syndrome	Dr Wilson	H585-1
01/11/2011	Misuse of Cocaine unspecified (Primary)	Dr Sheppard	EMISNQMI91
22/09/2011	Overdose of drug fluoxetine	Dr Wilson	SL-5
19/07/2011	Anxiety with depression	Dr Sheppard	E2003
31/01/2011	Death of father	Dr Rafferty	13M7
01/04/2007	Has a tremor seen by nuerologist 2012, felt to be benign	Dr Sheppard	1B22
01/01/1991	Death of mother age 29 MI	Ms Fergusson	13M8

Past Problems	Authorised By	Code

Due Diary Entries		Authorised By	Code
17/04/2015	Cervical smear due SCCRS Recall	Ms Boyle	685F.

Overdue Diary Entries	Authorised By	Code
None		

Alerts	Authorised By	Code
None		

Drug Allergies	Authorised By	Code
None		

Non Drug Allergies	Authorised By	Code
None		

Health Status

17/04/2012	Cervical smear result Cervical smear: negative
28/06/2013	Height 158 cm
28/06/2013	Weight 74 Kg
28/06/2013	Body Mass Index 29.5 kg/m2
08/08/2013	Blood pressure reading O/E - BP reading
08/08/2013	Blood pressure reading 116/77 mm Hg
08/08/2013	Smoking Status Never smoked tobacco

Consultations

09/08/2013 Dr James Curran at Easterhouse Health Centre

History: still having diarrhoea more SOB today and pain both sides of ribs and anterior chest also felt SOB when walking some symptoms similaer to episode of pneumonia she had in 2001 -was on ECMO intubated

Examination: p 90 rr 20 sat 98% t 37.2 chest clear

Comment: prob viral but patient very concerned in view of similarity to previous episode - refer medical receiving

---

08/08/2013 Dr Marie Wilson at Easterhouse Health Centre

History: Never smoked tobacco Sore across back. Not breathless. Chest clear. Temperature nomral. PO2 99 Pulse 90 pASIN COMING AND GOING. Has also had diarrhoea today. Has been to toilet 4-5 times. No blood in diarrhoea. No vomiting. cxr

Examination: O/E - BP reading
Blood pressure reading 116/77 mm Hg Abdomen soft. No guarding or rebound. No tenderness on examination. Likely viral infection?. nO OTHER HOUSEHOLD CONTACTS AFFECTED.

Medication: Paracetamol Tablets 500 mg *32 tablet TWO TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN REQUIRED (MAXIMUM OF 8 IN 24 HOURS)*

08/08/2013 Dr Ashok Bhuvanagiri at Easterhouse Health Centre

Comment: Telephone encounter has pain in her back finding it hard to breath 316 2392/ / back pain sicne am, no red flags , full control on the urination and bowels, mild diarrhoea, concerend this may be pneumonia ended up inn the hosptial inn the past, sometimes hard to breath, but no cough or fever, lives with boy friend , offered a HV if she wishes, but tired to convince may not serious problem and by talking to her she has no problems with breathibng. But patient not keen for a HV either by me or Dr. Wilson today and only wants to talk to Dr. ES , thinks she can only knows her conditon, informed Dr. MW.

2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

08/08/2013	Dr Marie Wilson at Easterhouse Health Centre
History	Has pain in her back finding it hard to breath 316 2392 - Sore back , diarrhoea, feeling more breathless. Offered to see today. Will come down to surgery.

01/08/2013	Dr Emma Sheppard at Data Entry
Problem (REVIEW)	**Dyspepsia**
History	no further black stool. Close questioning exludes classic malaena. Hgb OK. had been taking friends diclofenac. stop this, se after 3w PPI as peptac no help
Medication	Omeprazole Capsules (Gastro-Resistant) 20 mg *21 capsule ONE TO BE TAKEN EACH DAY*

Problem (REVIEW)	**Anxiety with depression**
History	anx symps persist despite fluox 8w. propran not working > stop this. see 3w + PRN. must be seen w sample if further malaena

Medication

Current Date Commenced	Drug Details	Date Last Issue	Authorised By	Type
08/08/2013	**Paracetamol Tablets 500 mg** TWO TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN REQUIRED (MAXIMUM OF 8 IN 24 HOURS) 32 tablet	08/08/2013P	Dr Marie Wilson	ACUTE
01/08/2013	**Omeprazole Capsules (Gastro-Resistant) 20 mg** ONE TO BE TAKEN EACH DAY 21 capsule	01/08/2013P	Dr Emma Sheppard	ACUTE
30/07/2013	**Hydrocortisone Cream 1 %** APPLY THINLY TO THE AFFECTED AREA ONCE OR TWICE DAILY 30 GRAM	30/07/2013P	Dr Emma Sheppard	ACUTE
30/07/2013	**Fluoxetine Hydrochloride Capsules 20 mg** ONE TO BE TAKEN EACH DAY 30 capsule	30/07/2013P	Dr Emma Sheppard	ACUTE
30/07/2013	**Peptac Liquid (aniseed)** 10-20ML TO BE TAKEN AFTER MEALS AND AT BEDTIME 100 ml	30/07/2013P	Dr Emma Sheppard	ACUTE
19/07/2013	**Cetirizine Hydrochloride Tablets 10 mg** ONE TO BE TAKEN EACH DAY 56 TABLET	19/07/2013P	Dr Anne McGinley	ACUTE
12/07/2013	**Phenoxymethylpenicillin Tablets 250 mg** TWO TABLETS FOUR TIMES DAILY 56 tablet	12/07/2013P	Dr Marie Wilson	ACUTE

2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

MEDICINE **PRESCRIPTION FORM** Hospital Name: .....

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐
Date _____ Name (Print) _____
Discharge Prescription Prepared & Reconciled YES ☐
Date _____ Name (Print) _____

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

DOCTOR'S DECLARATION (if required by Local Protocol)

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

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name _____ Tel No. _____
Address _____
Compliance Aid Details _____
Patient consent to share discharge information Y/N
Print & Sign _____

PATIENT DETAILS

Hospital Number: 2505876061
DOB: MCLEISH Wendy F 25/05/1987
Date of Admissi t:
Consultant Nan ce area:
:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
9/8	DIHYDROCODEINE	30mg	O	18:35	[signature]	[signature]	1840
9/8	Dihydrocodeine	30mg	O	20:20	[signature]		2030
9/8	Paracetamol	1g	O	20:20	[signature]	[signature]	2030.

DATE →

MONTH →

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

IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N

ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N

SIGNATURE OF ASSESSOR

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

Parenteral Drugs : Regular Prescription

Patient's Own Medicine

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

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

A DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

B DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

C DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

D DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

E DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

F DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

G DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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



2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 6EJ

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

H DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

J DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

K DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

L DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

M DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

N DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

P DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

R DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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



2505876061
VICLEISH
Wendy

F
25/05/1987

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

S DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

T DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

V DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

W DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

X DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

Oral and Other Drugs: Regular Prescription

DATE
MONTH

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

Patient's Own Medicine: For Use Y/N; Qty:; Date:; Assessed by:; Ordered from Pharm.

CC DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

DD DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

EE DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FF DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

GG DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

---

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

HH DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

---

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

JJ DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

---

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

KK DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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



2505876061
MCLEISH F
Wendy 25/05/1987

All Routes: As Required Prescriptions

| | | |

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

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

2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

Name

CHI No

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

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

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

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

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).
2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).
3. Print & Sign your full name clearly against each prescription entry.
4. Time should be recorded in 24hr format e.g. 0600, 1800.
5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.
6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.
7. The following metric unit abbreviations must be used –

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

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

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

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

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

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.
2. Insert initials in the relevant date column and time row each time a drug is administered.
3. Check that all drugs prescribed at a certain time have been administered.
4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

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

Cat. No. 40995 Ver 4, 09/2010

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name

2505876061
MCLEISH F
Wendy 25/05/1987
0/1 51 COXTON PLACE
Glasgow, Lanarkshire
G33 5EJ

	Date	Ward
Admitted	9/8/13	AAU
Transferred		
Transferred		

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

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

See NEWS Actions Reference Tool for local escalation policy

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

S Wendy McLeish

2013 DATE: 9/8 | TIME: 18 10 | 50 19

NEW: 0 1

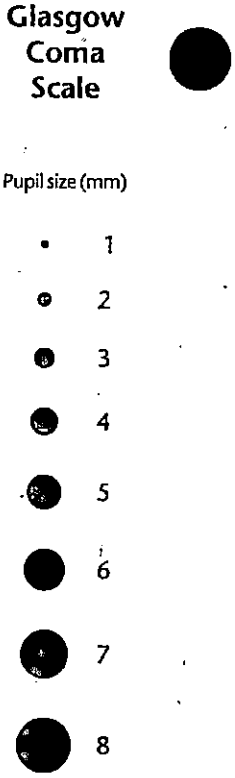
| | | |

Neurological Observations

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

Glasgow Coma Scale

Pupil size (mm)



Pain Score

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

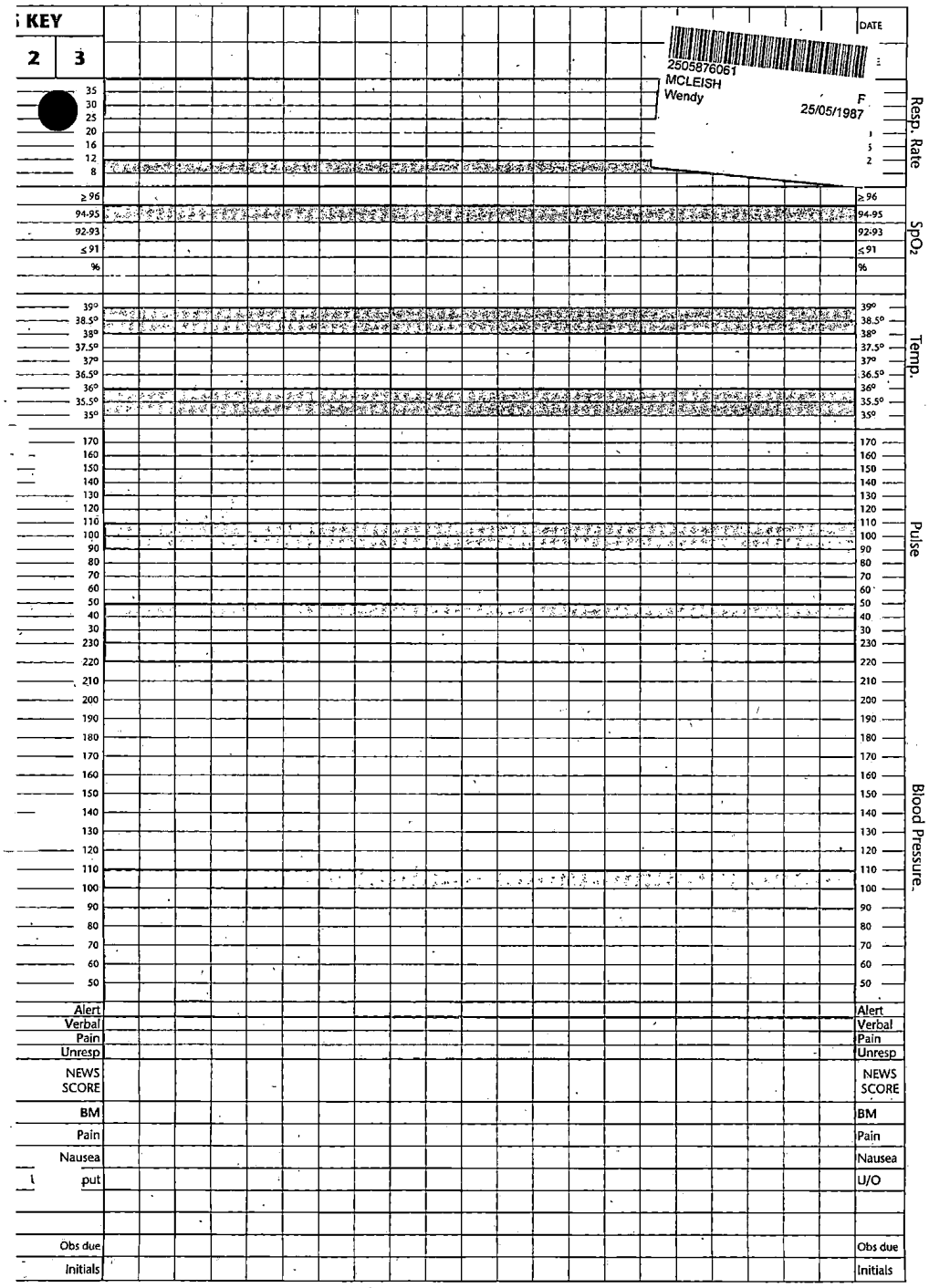
0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Severe Pain			

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

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

Redesigned by Medical Illustration Services • 231261


KEY
2
3
DATE
2505876061
MCLEISH
Wendy
F
25/05/1987
Resp. Rate
SpO2
Temp.
Pulse
Blood Pressure.
35
30
25
20
16
12
8
≥ 96
94-95
92-93
≤ 91
%
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
put
U/O
Obs due
Initials

17

CHI: 2505876061

Glasgow Royal Infirmary

Total Att: 13
12 Mth Att: 0

Title: **MISS**

MCLEISH **Wendy**

DOB **25/05/1987** Age: **33y** Sex: **Female**

126 LIBERTON ST

Glasgow
Lanarkshire
G33 2HJ
07769733984

Next of kin: **SAME?, GERALD**
Relationship: **Brother**

GP: **AL McGinley**
0141 531 8150

Attendance Date: **08/12/2020** Arrival Time: **12:48**
Registration Time: **12:48** Date of Incident: **08/12/2020**
Major Incident Desc:

Reason for Attendance: **fall/? seizure**

Nursing Assessment

Alerts: **Yes** Allergies: **Not Recorded** Pain Score:
Triage Category: **3** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **08/12/2020 12:56** Nurse name: **Nurse Islay Riddell**

Temp	36.5	C
HR	109	bpm
BP	128/94	mmHg
MAP	105.33	mmHg
RR	17	bpm
SpO2	98	%
Oxygen		%

BM	5.9	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

Pupils-Right		Pupils-Left	
Size (mm)	5	Size (mm)	5
Reaction	Y	Reaction	Y

Nursing Notes: **?COLLAPSE/ SEIZURE. NEWS 1. witnessed collapse at shop ?involuntary movements ?seizure. loc ?5 mins. no hx of same. feels well now. no pmh. small lac to back to head no other injuries. covid low**

2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy

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

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

Date	Clinical Notes	
	Seen By	Time Seen

Once Only Prescriptions (Including Tetanus Prophylaxis)

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

2505876061
MCLEISH
Wendy F
126 LIBERTON ST 25/05/1987
Glasgow, Lanarkshire
G33 2HJ

Printed: 08/12/2020 14:59:13

Patient Sample Report

Status: ACCEPTED
Analyzed: 08/12/2020 14:58:59
Sample Type: Venous
Account Number:
Clinician:
Operator ID: KATHRYN SCOTT0

Patient

ID:	2505876061
Last Name:	MCLEISH
First Name:	WENDY
Gender/Age:	Female, 33 years
Birth Date:	25/05/1987

Cartridge

Lot No.:	201102F
S/N:	00000000500113537
Exp. Date:	21/12/2020

Analyzer

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

Results			Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)						
cH	45.7	nmol/L	--	--	--	--
pCO_2	5.7	kPa	--	--	--	--
pO_2	3.9	kPa	--	--	--	--
Na^+	135	mmol/L	--	133	146	--
K^+	4.1	mmol/L	--	3.5	5.3	--
Cl^-	106	mmol/L	--	95	108	--
Ca^{++}	1.22	mmol/L	--	1.15	1.27	--
Glu	5.0	mmol/L	--	3.5	6.0	--
Lac	1.0	mmol/L	--	0.6	2.2	--
CO-Oximetry						
tHb	147	g/L	--	--	--	--
O_2Hb	↓ 45.1	%	--	95.0	98.0	--
COHb	1.3	%	--	0.5	1.5	--
MetHb	0.8	%	--	0.5	1.5	--
HHb	↑ 52.8	%	--	0.0	5.0	--
sO_2	↓ 46.1	%	--	95.0	98.0	--
Derived						
BE(B)	-2.6	mmol/L	--	--	--	--
$HCO_3^-(c)$	23.2	mmol/L	--	--	--	--
Hct(c)	44	%	--	--	--	--

↑↓ Outside Reference Range

Other Information

Operator Entered		
Temp	37.0	°C

Patient Information			Date:	08/12/2020
WENDY MCLEISH			Incident Number:	CR007013806
A 2505876061	I Female		Incident Type:	EMG
P MCLEISH	F	ITYNE.,G33 2HJ	Incident Location:	FARMFOODS SHANDWICK SQUARE EASTERHOUSE GLASGOW, G34 9DT
Wendy	25/05/1987			
D 126 LIBERTON ST				
c Glasgow, Lanarkshire				
E	G33 2HJ			

Scottish Ambulance Service

Presenting Complaint

A FAINT.

Additional Comments

This 33 year old female was leaving a shop after buying messages and collapsed onto the shop floor,she tells me that she has no recollection of this incident.The Manager of the shop told our PRU personnel that the patient after collapsing onto the floor had involentary movements which resembled a seizure but there is no history of epilepsy.Her only meds are Mitazapine and Propanolol.She now has a small haematoma to her head with a small amount of blood loss.This call was a 999 from shop staff.

PATIENT ASSESSMENT

ACVPU	Alert	<C>	No
A	Clear		
B	Breathing Adequately: Yes	Respiratory Rate: 16	SPO2: 98
	Oxygen Given: No		

C	Pulse Rate	BP	Cap Refill	ECG Rhythm
	104	107/62	<=2 Secs	
	Rhythm	Arm	Central/Peripheral	ECG

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

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
12:00	97	16	110/63	95											E0005851
11:45	104	16	107/62	98	<=2 Secs	15	[redacted]ert		37.6	5.9				[redacted]	E0005851

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
12:00	16 (0)	95 (1)	[redacted]	0	110 (1)	97 (1)		[redacted]	3
11:45	16 (0)	98 (0)		0	107 (1)	104 (1)	Alert (0)	37.6 (0)	2

CLOSE RECORD

Treatment On Scene	Emergency

Conveyance

Transport To Hospital	Normal driving	Pre Alert	No

INCIDENT LOG

Time Call Received	11:01	Allocated	11:37	Mobile	12:13
First Resource On Scene		Crew On Scene	12:22	Crew Left Scene	12:22
Crew At Hosp	12:41	Receiving Hospital	GLASGOW ROYAL INFIRMARY	Clear Time	

Crew ID	Crew Grade	Driver
E0040827	Paramedic	YES
E0005851	Ambulance Technician	NO

(17)

Emergency Department Nursing Documentation

2505878061
MCLEISH
Wendy F
126 LIBERTON ST 25/05/1987
Glasgow, Lanarkshire
G33 2HJ

NHS Greater Glasgow and Clyde

Presenting Complaint - Seizure.

Date: 8 / 12 20 Time: 1440

Assessment Complete by: Name NURSE (Please Print)

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

Urinalysis

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

Screening Tools (Please tick/circle when completed)			
SEPSIS RISK? / SIRS Criteria 2 or more	Y/N	SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms)	YES
Mental Health Triage Assessment	Y/N	If NOT WHY? - (details) NI	NO
GMAWS	Y/N	Date - 08/12/20 Time - 1440 Signature - LAUREN McQUEEN S/N	

4AT	
AMT	Correct
Age	✓
Date of Birth	✓
Place	✓
Current year	✓

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

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

Alertness	
Normal	0
Mild sleepiness	0
Clearly abnormal	4

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

4AT score

1 /12

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

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

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

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

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

Indicator for care by another acute specialty regardless of age.

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

Are any of the above criteria met?

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

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

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

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

Screening Tools / ACTIVE CARE

(Please tick/circle when completed)

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

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

2505876051
MCLEISH
Wendy F
126 LIBERTON ST 25/05/1987
Glasgow, Lanarkshire
G33 2HJ

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

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

Nursing Notes

Date and Time		Print Name and Signature
08/12/20 1506	BIBA - ? collapse/seizure @ shop today - LOC ? 5 mins. Small lac to back of head. Bloods obtained ECG recorded + saved.	
	News (1) GCS (15)	LAUREN MCQUEEN S/N
1545.	News stable GCS (15) PEARL, awaiting plan. At 1550 pt. commenced on	
	full tonic clonic seizure - help called Pt patient moved onto side. High flow O2 commenced	

Nursing Notes		
Date and Time		Print Name and Signature
	seizure self resolved without IV's. BM 6.6. Known post-ictal - for CT brain + admission	
	NEWS 0 ———	

Glasgow Royal Infirmary
Emergency Department

NHS
Greater Glasgow and Clyde

2505876061
MCLEISH
Wendy
126 LIBERTON ST
Glasgow, Lanarkshire
F
25/05/1987
G33 2HJ

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

Clinical Notes

03/12/2016 Thu 437 [redacted] Stobhill-ED Speciality

Smith

ICU Admiss - Chest Sepsis Anty Depres

33 F// ?seizure

D+A

Paprulol

Mirtazapine

+ HCP// Tells us felt well today
+ no infectious symptoms
was feeling lightheaded earlier as
had not eaten anything so had a
can of fizzy juice + felt better.

While waiting in line collapsed
Denies any preceeding lightheadedness / Chest pain / Abd
N. V. / palpitations / headache

Sys dy head on + ↓ headache last few days
NS prodrome symptoms / neck stiffness or photophobia

Alert orientated ambulate time
No paraesthesia / numbness / deliquescence
No incontinence / tongue biting

Hit head on ly down - No confusion / vomiting

SAS note sys - manager had involuntary movements that
"resembled a seizure"

Glasgow Royal Infirmary
Emergency Department

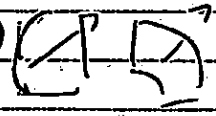
Patient Name
DoB
CHI Number
or affix label

Clinical Notes

Date	Time	Name	Grade	Speciality

RE Patient looks well
Obs normal

(A) Patent - full sevenes

(B)  Good AE Bilat

(C) Hs 1 + III O wnl ECG - SR nil acute
Colles SM Good rad Reg Rad

(D) GCS 15 Cranial nerves ⟩ SNT.
PERRL Intact -
Normal Movement
No Nystagmus

	P	S	T	R	
RUL	5	✓	✓	✓	Head wound
RLL	5	✓	✓	✓	- small 0-5cm wound
LUL	5	✓	✓	✓	at (L) occiput
LLL	5	✓	✓	✓	cleaned - no sutures
					needed
					- not bleeding

VBG H^+ 45.7 Glu 5 HCO3 23 No Neck Pain.
Lac 1 Hb 147

Imp // ? seizure vs syncope

Plan // Bloods
Post fit claim

Glasgow Royal Infirmary
Emergency Department

2505876061
MCLEISH
Wendy
126 LIBERTON ST
Glasgow, Lanarkshire
G33 2HJ
F
25/05/1981

Clinical Notes

Date	Time	Name	Grade	Speciality

1542

WCC 9-8 CRP 14 CK 159
Hb 143 U+E - NAD Ca^{2+} 2.28
LFT - Bil 19 PO_4^{3-} 0.69
AST 35
ALT 70
ALK 107.
ALB 38

at this time patient had a seizure in the department 1 min self terminating tonic clonic seizure postictal afterwards.

Requested CT head + for ANU admission Patient did deny drugs or alcohol

Glasgow Royal Infirmary
Emergency Department

Patient Name
DoB
CHI Number
or affix label

HAEM	DATE or TIME		BIOCH	DATE or TIME			DATE or TIME		V/ABG	DATE or TIME	
WCC	9-8		Na	137		Bil	19		FiO_2		
Hb	143		K	4-1		ALT	35		H^+		
Plat	312		Cl	107		AST	70		$PaCO_2$		
Neut			Ur	5.4		GGT			PaO_2		
DD			Creat	58		A phos	107		Bic		
PT			eGFR	>60		Alb	38		BE		
PTT			Glu			AdjCa			Lactate		
TT			CRP	14		Amyl			Ethanol		
INR			Mg	0.83		TropI HS			Para		
			Phos			BHCG			Sal		

Diagnosis and Plan

- New seizure onset epilepsy
- Admit Medics for further investigation + monitoring
- Chase CT Head

Review/Discussed with:

Handover

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

mi • 287967 Version 1_0 • GGC0226

My Admission Record

NHS Greater Glasgow and Clyde

2505876061
MCLEISH
Wendy
F
25/05/1987
patient ID label

Hospital: ARI Ward: 50
Date of Admission: 8/12/20 Time: 1840
Information obtained from: Name:

Patient ☐ Relative ☐ Other ☐ _____

Preferred Name:
Age: Telephone Number:
Consultant:

(R) pink
5F3 12 32

Communication

What is your first language? _____
Do you require an interpreter? Yes ☐ No ☐
If yes, provide details of arrangements made _____
Do you use British Sign Language (BSL)? Yes ☐ No ☐
Do you need someone to help you to communicate? Yes ☐ No ☐ If yes, who _____

Preferred first contact	**Preferred second contact**
Name: James Ward Relationship: partner Address: Telephone: 07858353379 Is this person aware of your admission? Yes ☑ No ☐ Can we share information with this person? Yes ☑ No ☐	Name: Relationship: Address: Telephone: Is this person aware of your admission? Yes ☐ No ☐ Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

Explained to the patient? Yes ☐ No ☐ Not Applicable ☐
Do you understand the reason for your admission? Yes ☐ No ☐

Allergies / Sensitivities (Record food allergies in the Hydration and Nutrition section)

No known allergies ☑

Relevant past medical history

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place
Yes ☐ No ☐ If yes, Who asked for a copy? _____
Date they asked for a copy __/__/__ Date Obtained __/__/__

Power of Attorney / Guardianship / Adult with Incapacity

Name:
2505876061
MCLEISH
Wendy F
126 LIBERTON ST 25/05/1987
Glasgow, Lanarkshire
G33 2HJ

Does someone have Power of Attorney (POA) for you?

Yes ☐ No ☑

OR

Does someone have Guardianship?

Yes ☐ No ☑

If yes, is this for:- Finance ☐ Welfare ☐ Both ☐

Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

Please obtain a copy and place in the patient's notes

Who asked for a copy?_____ Date they asked for a copy __/__/__ Date Obtained __/__/__

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

N.B. If you think the patient may lack capacity inform Medical Staff to assess and, if required, consider the need for an 'Adult with Incapacity' Section 47

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:	Yes	No
1. Been an inpatient in a hospital outside Scotland?	☐	☑
2. Received holiday dialysis outside Scotland?	☐	☑
3. Been told that you have CPE?	☐	☑
4. Been in close contact with a person with CPE?	☐	☑

If the answer is yes to **ANY** of the questions in this section, you must

- Isolate the patient in a side room ☐
- Obtain Rectal swab marked 'for CPE' ☐
- If patient refuses rectal swab, obtain a stool specimen marked 'for CPE' ☐
- **and inform the IPCT** ☐

MRSA Screening

	Yes	No	Unsure
Will the patient be an inpatient for more than 23 hours	☑	☐	☐
If **YES** complete the following section			
1. Have you ever been told that you have MRSA?	☐	☑	☐
2. Have you been admitted from another hospital/ residential setting or care home?	☐	☑	
3. Do you have a wound / skin ulcer or invasive device which you had before admission?	☐	☐	☐

If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabs

Nasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐

Creutzfeldt-Jakob Disease (CJD)

	Yes	No	Unsure
Have you ever been informed that you are at increased risk of CJD or vCJD?	☐	☐	☐

If **YES inform the IPCT** ☐

Na 2505876081
Ad MCLEISH F
Wendy 25/05/1987
Dc
CH
Affix patient ID label

Lifestyle

Smoking

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

Never smoked ☒

Do you use eCigarettes? Yes ☐ No ☐

If a smoker, the NHSGGC Smokefree policy has been explained and Nicotine Replacement Therapy (NRT) has been offered

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why:_____

Do you want to talk to someone about your smoking? Yes ☐ No ☐

If yes, refer to Smokefree Services (Trakcare) Date referred: ___/___/___

Drugs

Do you use recreational or illicit drugs or are you receiving opiate replacement therapy (ORT / Methadone / Suboxone)? Yes ☐ No ☒

If yes, please specify and refer to the NHSGGC Guidelines for the Management of Drug Users in Glasgow and Clyde Acute Hospitals

Alcohol

Do you drink alcohol? Yes ☐ No ☒

How often do you have more than 6 units of alcohol on one occasion:

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

NB: If daily or almost daily commence the Glasgow Assessment and Management of Alcohol (GAMA), complete FAST Tool and take further action as per guidance.

Name (Please PRINT): EMcNeil Signature:

Designation: SN Date: 8/12/20

My Assessment Record

Name: _____

Address: _____



2505876061 F
MCLEISH 25/05/1987
Wendy
126 LIBERTON ST
Glasgow, Lanarkshire G33 2HJ

1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems	✓	✓	
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			

Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems	✓	✓	
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

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

Name 2505876061
Addre MCLEISH
Wendy
126 LIBERTON ST
Glasgow, Lanarkshire
F
25/05/1987
G33 2HJ
DoB:
CHI:
Affix patient ID label

3. Senses

Vision	Yes ✓	No ✓	Assessment of the patient's vision
Do you have any problems with your vision?		✓	
Do you wear glasses?		✓	Distance ☐ Reading ☐ Both ☐
Do you have your glasses with you?		✓	
Do you wear contact lenses?		✓	
Do you have your lenses with you?		✓	
Do you wear a prosthesis?		✓	
Hearing	**Yes** ✓	**No** ✓	Assessment of the patient's hearing
Do you have any problems with your hearing?		✓	
Do you have any hearing loss?		✓	
Do you use a hearing aid?		✓	
Do you have your hearing aid(s) with you?		✓	
Pain	**Yes** ✓	**No** ✓	Assessment of the patient's pain
Do you have pain?		✓	

Can you describe where and what the pain is like?

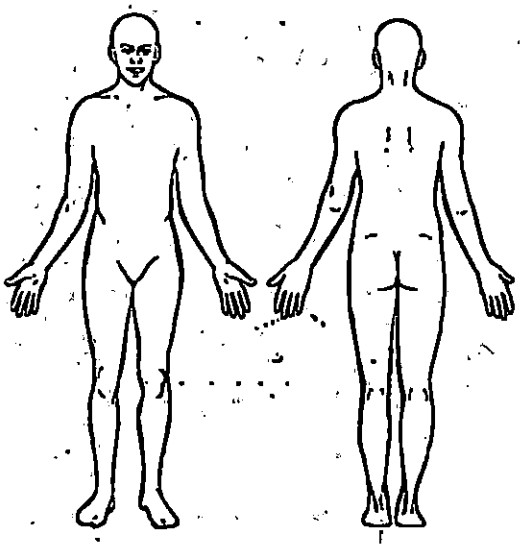
Have you had treatment / intervention for the pain?

N.B. Complete generic pain assessment chart. If unable to self report complete Abbey Pain Scale.

Can you describe any chronic pain that you have?

What makes the pain better?

Mark current pain on body chart



Name:
2505876061
MCLEISH F
Wendy 25/05/1982
126 LIBERTON ST
Glasgow, Lanarkshire
G33 2HJ

4. Cognitive Status THINK DELIRIUM

	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's cognitive status
Alert and orientated	✓	✓	
Impaired conscious level			
Confused			
Dementia			
Stressed / Distressed			

N.B. Think Delirium

Complete 4AT for all patients 65 and over, AND for patients of any age with one or more of the following:

- existing cognitive impairment
- previous delirium
- current hip fracture
- severe illness

and follow the guidance

N.B. 'Getting to Know Me' and 'What Matters to Me' should be completed for all patients with dementia, cognitive impairment or complex needs

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

N/A

What do you like to eat and drink?

What do you not like to eat and drink?

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

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓
Normal diet and fluids	✓	✓
Therapeutic diet		
Cultural, ethnic or religious diet		
Texture Modified Diet Please state _____		
Thickened Fluid Please state _____		
Oral Nutritional supplements Preferred flavour _____		
Enteral Nutrition		
Parenteral Nutrition		
Nil by Mouth		

2505876061
MCLEISH
Wendy
126 LIBERTON ST
Glasgow, Lanarkshire
G33 2HJ
F
25/05/1987

Affix patient ID label

Assessment of the patient's hydration and nutrition needs

N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharnygeal Swallow Symptoms (STOPSS) within 4 hours of admission

Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓
Independent (Green)	✓	✓
Prompting / encouragement / opening packets/cutting up food (Amber)		
Full assistance with eating and drinking (Red)		

Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?

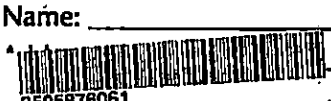
6. Elimination

Bladder	Admission Presentation ✓	Normal for the patient ✓
Pass urine with no problems	✓	✓
Frequently pass urine during the day		
Frequently pass urine overnight		
Sense of urgency when need to pass urine		
Urine retention		

Assessment of the patient's elimination needs

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓
Haematuria		
Incontinent		

Name: _____



2505876061
MCLEISH
Wendy
126 LIBERTON ST
Glasgow, Lanarkshire
G33 2HJ
F
25/05/198

N.B. If new incontinence report to medical staff to rule out infection or physiological cause

What products do you normally use for this continence issue?

No urinary catheter ☐ Urinary catheter in situ: Urethral ☐ Suprapubic ☐

Date urinary catheter last changed ___/___/___

N.B. If Urinary Urethral Catheter (UCC) in situ commence NHSGGC Adult UCC Insertion and Maintenance Care Plan

Bowels

When did your bowels last move?

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

Do you use any medication e.g. laxative to help your bowels move? Yes ☐ No ☐

Bowel Habit	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Regular	✓	✓	
Constipated			
Diarrhoea / loose stools			
Blood in stools			
Incontinent			

What products do you normally use for this continence issue?

N.B. If concerned about bowel patterns (e.g. infrequent movement or frequent loose stools) consider using the Bristol Stool Chart

Stoma	Yes ✓	No ✓	Assessment of the patient's needs in relation to their stoma
Do you have a stoma?		✓	
Do you require assistance with your stoma care?		✓	
Have you brought any of your stoma products with you?		✓	

2505876061
MCLEISH
Wendy
126 LIBERTON ST
Glasgow, Lanarkshire
F
25/05/1987
G33 2HJ

7. Personal Hygiene, Oral Health, Skin Care and Wound Care

Personal Hygiene	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's personal hygiene needs
Independent	✓	✓	
Requires assistance with washing and dressing			
Oral Health	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's oral health needs
No problems	✓	✓	
Sore mouth / mucositis / ulcer			
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)			
Dental work	**Yes** ✓	**No** ✓	Description of any dental work
Do you wear dentures?	✓		Veneers front Two
Do you have your dentures with you?	✓		
Are your dentures a good fit?	✓		
Do you have any other dental work that we need to be aware of?		✓	
Skin Care	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's skin care needs
No problems	✓	✓	
Skin broken			
Skin oedematous			
Skin discoloured / red			

N.B. Complete PUDRA for all patients within 8 hours of admission

Pressure ulcer identified on admission: Yes ☐ No ☐

Pressure Ulcer Grade: _____

Pressure Ulcer Site: _____ **Adult wound assessment and management chart required**

N.B If Grade 2 pressure damage on ankle or below refer to Podiarty via TrakCare

Wound Care	Yes ✓	No ✓
Do you have any wounds? **N.B. If yes, complete an assessment chart for wound management**		

2505876061 F
MCLEISH 25/05/198
Wendy
126 LIBERTON ST
Glasgow, Lanarkshire G33 2HJ

Affix patient ID label

8. Mobility

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

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

9. Maintaining a Safe Environment

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

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

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

10. Sleep and Rest

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

Na
Ac
2505876061
MCLEISH F
Wendy 25/05/1987
126 LIBERTON ST
Glasgow, Lanarkshire
G33 2HJ

11. Social Circumstances

Do you:

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

Dependants	**Yes** ✓	**No** ✓
Do you have any dependants?	✓	
Do you support anyone (e.g. partner, children, relatives, animals)?	✓	
Do they need support from someone else whilst you are in hospital?		✓
Would someone else be able to provide this support when you are in hospital? If yes, who?		✓

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

Services	**Yes** ✓	**No** ✓
Do you have support from social work, social services or a care package?		✓
If yes, please provide details:		
If yes, has contact been made to cancel arrangements during admission?		

12. Emotional and Spiritual Care

Do you have a religion or beliefs that we can help you observe while you are in hospital?

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

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

Healthcare Chaplain informed Yes ☐ N/A ☑

N
Ac
2505876061
MCLEISH F
Wendy 25/05/1987
Dc
Cl
Afl

13. Person Centred Care

What matters and is important to you whilst you are in hospital?
This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

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

Informal Support

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

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

Name: .....

Contact Details: .....

.....

.....

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

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

Yes ☐ No ☐

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

2505876061
MCLEISH
Wendy
F
25/05/1987

Required Support

Has the patient and / or carer been advised of the hospital Support and Information Service?
Yes ☐ No ☐
Referrals can be made via the central phone number: 0141 452 2387

Has the carer been advised of the Carers Information Line?
Yes ☐ No ☐ Not appropriate at this time ☐
Carers Information Line: 0141 353 6504
Carers Information Leaflet provided?
Yes ☐ No ☐

Are you:
Employed
Self-employed
Full time education

Has your health
Yes ☐

Do you have
Yes ☐
If yes woul
Yes ☐

Would
volur
Yes ☐
If y

1145 HRS
P 104
SpO2 96%
B.P. 107/62
R. 16.
T. 37.6.
B.M. 5.9.

1200 HRS
P. 97.
SpO2 95%
B.P. 110/63.
R. 16.

WENDY McLEISH
D.O.B. 29.08.1987.

MEDS: PROPANOLOL
MIRTAZAPINE.

ivities at work?

ıfidential advice/ support?
/___/___

yment / education/ training/ skills

opriate to ask at this time ☐

2505876061
MCLEISH
Wendy
25/05/1987
F
Affix patient ID label

Risk Assessments/Other Documentation

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

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
8/12/20	33yo female	
1840	admitted with seizures	
	1:1 care observations	
	ap charted. Medications	
	administered as per	
	Kardex. Independent	
	with ADLs	

Na 2505876061
Ad MCLEISH
Wendy
126 LIBERTON ST
Glasgow, Lanarkshire
G33 2HJ
F
25/05/1987
Affix patient ID label

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
	HAS stated only valuable that she has is a mobile phone. Seems settled. No complaints	-CMHC

Glasgow Royal Infirmary
Acute Medicine Unit

(Part B - Medical Admission)

NHS
Greater Glasgow and Clyde

2505876061
MCLEISH
Wendy F
126 LIBERTON ST 25/05/1987
Glasgow, Lanarkshire
G33 2HJ

Date & Time 8/12/20 19:00 Consultant wright . Ward 50 .

Ward Review (Should be completed within 2hrs of transfer from ED)

Check List

- VTE ☐
- Med - Rec ☐
- Kardex ☐
- CxR ☐
- ECG ☐
- Oxygen ☐
- Patient on Bleeders list ☐

PC

1st seizure during last seizure did not tongue bite or urinary incontinence

NPC

At farmfoods, no recollection, woke up on floor. Someone called ambulance for her. Has had headache for past few days on + off relieved by paracetamol + ibuprofen. Denies any of the following: - Bilateral vomiting - nuchal rigidity - cough - Photophobia - Blurred vision - fever - Injuries

Reports - normal appetite, bowel movements, menstruation

Denies any recreational drugs. Drinks approx once a month. Non smoker.

Social Hx

- Lives 'sometimes' c boyfriend
- Denies any issues at home.
- Reports mood has been 'ok' recently.

Past Medical Hx

- Pneumonia + ICU admission + ECMO in 2011
- Anxiety / depression

O/E

Chest clear.

Ward Review

MS 1 + 11 + 0

ECG - Sinus rhythm.
QTc 412.

GCS 15/15. Alert, sitting up in bed, fully coherent

Bloods

CRP 14. U+E's ⇒ (N)
Mg^{2+} 0.83 " LFT's
PO_4^{2-} 0.69 ↳ ALT-70
Ca^{2+} 2.28. ↳ albumin (N).
WCC 9.8.

CT Head - Nil acute findings.

Hx Exam

Notes from ED, patient had stereotypical clonic seizure self terminating lasting 1 minute ~ post ictal -

Exam - 1st seizure, no obvious precipitant

Plan

- bloods for discharge overnight
- 1st seizure clinic referral.

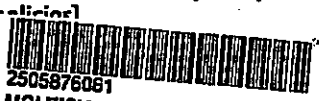
KSM

NHS GG&C Adult Risk Assessment for Venous Thromboembolism (VTE)

[excluding orthopaedics, obstetrics & ENT who have specialty-specific policies]

NHS Greater Glasgow and Clyde

- **Risk Assessment must be completed for all patients within 24 hours of admission to hospital**
- **Patients must be reassessed every 48-72 hours or sooner if condition changes**
- **Reassessment must be documented in Kardex**
- **Please complete risk assessment and then sign and date Risk Assessment Result box at bottom of page.**



2505876081
MCLEISH
Wendy F
126 LIBERTON ST 25/05/1987
Glasgow, Lanarkshire
G33 2HJ

Operative patients

Non-operative patients

Is the patient bed-bound or expected to have reduced mobility relative to normal state for ≥ 2 days?

Yes ☐ No ☐

Does the patient have any risk factors for thrombosis? (tick √ all that apply)

Age >60	☐	Use of oestrogen-containing contraceptive therapy	☐
Active cancer or cancer treatment	☐	Use of hormone replacement therapy or tamoxifen	☐
Dehydration	☐	Pregnancy or < 6 weeks post partum	☐
Known thrombophilias	☐	Critical care admission eg HDU/ITU	☐
Obesity (BMI>30)	☐	Surgical procedure with total anaesthetic/surgical time >90 min, or >60 min if surgery on lower limb or pelvis	☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or Inflammatory disease	☐	Acute surgical admission with inflammatory or intra-abdominal condition including Pelvic Inflammatory Disease	☐
Personal history or first degree relative with a history of VTE	☐	Hip fracture	☐
Varicose veins with phlebitis	☐	All gynaecological surgery except uncomplicated gynaecological diagnostic day case procedures	☐

- No thromboprophylaxis required.
- Continue to reassess every 48-72 hours or sooner if condition changes.
- Document all reassessments in drug kardex.
- Complete Risk Assessment Result Box.

Yes, 1 or more risk factors identified ☐

No risk factors identified ☐

Indicators of high risk bleeding (tick √ all that apply)

Active bleeding	☐	Lumbar puncture, epidural/spinal anaesthesia • Expected within the next 12 hours • Within the previous 4 hours	☐
Acquired bleeding disorders (e.g. liver failure)	☐	Other procedure with high bleeding risk – discuss with senior if unsure	☐
Concurrent use of other ant'coagulants (e.g. warfarin, rivaroxaban, apixaban, edoxaban) is a contra-indication to additional pharmacological thromboprophylaxis	☐		
Acute stroke (within 14 days)	☐	Acute bacterial endocarditis	☐
Persistent uncontrolled hypertension (BP > 230/120 mmHg)	☐	Surgery expected within the next 12 hours	☐
Thrombocytopenia (<75 x 10⁹/l)	☐	Trauma with high bleeding risk e.g. Head injury	☐
Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands)	☐	eGFR <30ml/minute/1.73m²: Dose reduction required	☐
High risk of peri- or post-procedural bleeding, e.g. neurosurgery, spinal, posterior eye surgery and thyroid surgery	☐	Heparin induced Thrombocytopenia	☐

- Discuss with senior clinical staff before deciding to prescribe pharmacological prophylaxis
- Consider mechanical prophylaxis e.g. AES unless contra-indicated.
- Reassess patient every 48-72 hours or sooner if condition changes.

No contraindications to pharmacological prophylaxis identified ☐

Contraindications to pharmacological prophylaxis identified ☐

Operative patients – Enoxaparin 40mg + AES ☐*
*prior to application of AES, please check contraindications to AES
Non-operative patients – Enoxaparin 40mg ☐
Prescribe Enoxaparin at 6pm
[on day of surgery, at the later of either 4h post-op or 6pm]
Reduce Enoxaparin to 20mg if <50Kg or eGFR <30ml/minute/1.73m² ☐
If weight> 120kg, consider Enoxaparin 40mg bd (see StaffNet Guideline).
Discontinue at discharge or when returned to pre-morbid mobility

Contraindications to anti-embolism stockings (AES) Y☐ N☐

Peripheral neuropathy	☐
Peripheral arterial disease	☐
Cellulitis or Gross oedema	☐
Leg deformity or Fragile skin	☐
Leg / foot ulcers	☐
Allergy	☐
Unusual leg size/shape	☐

Risk assessment result – please tick √ all that apply

VTE risk factors: YES ☐ NO ☐ Indicators of high risk bleeding: YES ☐ NO ☐ Prescribed: LMWH ☐ AES ☐ NONE ☐

Patient informed of VTE risks and benefits of thromboprophylaxis YES ☐ NO ☐ N/A ☐ Information leaflet provided YES ☐ NO ☐

Print Assessor's Name: _____ Signature: _____ Date: _____

RAT Medicine & Surgery – TEST OF CHANGE 09

mi • 250744 Version 9_0 • GGC0015

Medicine Reconciliation Form

Source of information: ECS ☑

Patient ☑ Relative/carer ☐ GP surg ☐ GP computer printout/letter ☐ Patient's own drugs ☐ Other (specify) _____

Admission Medicines (including OTC, herbal, homeopathic)				Plan for medicines (unless indicated to stop or hold medication should be continued on drug kardex)				
Name	Dose	Freq	Route	Amend	withold	Stop	continue	Reason for alteration
Mirtazapine	45mg	OD	PO				✓	
Propranolol-PRN	10mg	TDS	PO				✓	?
Aknil - Cerelle (Desogestrel)	75mcg	OD	PO				✓	1/10/20

2505876081
MCLEISH F
Wendy 25/05/198
126 LIBERTON ST
Glasgow, Lanarkshire
G33 2HJ

Allergies/adverse events	
NKDA	adverse reaction to propranolol in ECS not pt decides it → ? wheeze but pt ordering Cerazette

List obtained by _____ Designation _____

Recently altered/discontinued medicines prior to admission and reasons why _____

Compliance aid? Y ☐ N ☒ Type _____ If, Y Community Pharmacy _____ Phone _____

Senior Medical staff review: Sign _____ Title _____ Date and Time _____

Reviewed by pharmacist _____ Date and Time 10AM 9/12/20

Comments

Consultant Review

33 y/o f non-smoker
- Depression
- Anxiety

Seen in front of husband
from home c ATE

- Been very ill with vomiting
- No cough / fever / dysp

- D - CT head - nil acute
CRP 14
Hb 9.8 CCAM >60
Hct 43 Mg2+ 0.83
MCV 82

Exam - SR
- mid-sternal tenderness

DC
- Agreed
Q / w 9CT c -
Chest clear
HR RRR
Hyperventilating

Imp - 1st ATE

2505876061
MCLEISH
Wendy
126 LIBERTON ST
Glasgow, Lanarkshire
25/05/198
G33 2H.

Check List	
VTE	☐
Med - Rec	☐
Kardex	☐
CxR	☐
ECG	☐
Oxygen	☐
EDD	

Pt shown images + discussed
Imp. If unwell, come back
Keep.

- Refer 1st ATE clinic

PRINT NAME	DESIGNATION
SIGNATURE	DATE & TIME 9/12

Clinical Notes

9/12/2020 Nursing Night -
0145

Patient settled.
Reports very tired.
Minimal conversation engagement.
Independent w/ mobility T FIXs
Toileting d+f.
NEWS stable.
Meds as charted.
Mirtazapine @ bd on PR very firm already and says does not need.
Seizure chart in situ.
Nil witnessed overnight.

Liam Ward
Walk Jr

9/12/20 Pharmacy RV
1am

If pt not for (R) consider thromboprophylaxis in light of AF and CHA2DS2

#13914

9/12/20 - neurology CT

1st seizure clinic referral done.
Patient non-driver.

Liam

Clinical Notes

9/12/20 1500 Nursing
Independent with personal care. Observations as charted. News 0.
Medications as per kardex. No further seizure activity today.
Home later with 1st seizure clinic referral. Settled at present.
No concerns voiced. N Finnigan S/N

9/12/20
- No meds given
- Home
- Refer 1st seizure clinic

Dr

19:10 9/12/20 Nursing:
Discharged home with IV. No venflon in situ.
Own transport home. Flu at 1st seizure clinic.
N Finnigan S/N

2505876061
MCLEISH
Wendy
126 LIBERTON ST
Glasgow, Lanarkshire
F
25/05/1987
G33 2HJ

Glasgow Royal Infirmary

CHI: 2505876061

Total Att: 17
12 Mth Att: 3

Title: MISS

MCLEISH

Wendy

DOB 25/05/1987

Age: 35y

Sex: Female

FLAT 3/2
312 CUMBERNAULD RD
Glasgow
Lanarkshire
G31 3LY
07912347436

Next of kin: SAME?, GERALD
Relationship: Brother

James partner 07713098799

GP: MM Morris
0141 554 0464

Attendance Date: 24/03/2023 Arrival Time: 13:12

Registration Time: 13:12 Date of Incident: 24/03/2023

Major Incident Desc:

Reason for Attendance: SELF- low covid/flu risk- new confusion, ataxia (witnessed by gp), falls and incontinence. Prev substance misuse.

Nursing Assessment

Alerts: Yes

Allergies: Not Recorded Pain Score:

Triage Category: 2

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 24/03/2023 14:41

Nurse name: Nurse Aileen Buchanan

Temp	34.6	C
HR	90	bpm
BP	121/83	mmHg
MAP	95.67	mmHg
RR	22	bpm
SpO2	94	%
Oxygen		%

BM	7.1	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

Pupils Right		Pupils Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: SOB with new ataxia - unstaeady at triage, new confusion - admits to falls with HI off floor tiles. GCS 15/15 but concern re neuro symptoms h/o pneumonia Commenced 2litres o2 at triage

2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy

Glasgow Royal Infirmary
Acute Medicine Unit
(Part B - Medical Admission)

NHS
Greater Glasgow and Clyde

2505876061
MCLEISH F
Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

Date & Time 24/5/23 1505 Consultant Ward ~~15 ATU~~

Ward Review (Should be completed within 2hrs of transfer from ED)

Check List

- VTE ☐
- Med - Rec ☐
- Kardex ☐
- CxR ☐
- ECG ☐
- Oxygen ☐
- Patient on Bleeders list ☐

P. Hows ITU Z -

⑤ Pc : 3540 presents w/ ataxia + confusion

Hx : Substance abuse ,
On PPI presumptive epilepsy ECHO
Hx of seizures - ? cause .

Bloods ACW
No Radiology
No micro

Meds : See ECG/Kepra

Obs : 5 Temp early 34.6°C ?

⑥ For last 2-3 weeks : - Been falling confused. Muddled.
Housemate ~~Aunt~~ 10/10.
- Partner reports she sometimes seems muddled
- Falling

Before falls : ⊘ dizziness ⊘ Palpitations ⊘ SOB ⊘ Headache

During falls : ⊘ LOC ⊘ Seizures Faecal incontinence
⊘ Seizure Hit Zx

After falls : ⊘ LOC ⊘ N+V - ATO ✓

Ward Review

Previous events

Otherwise: Has been incontinent of urine the last 6/52. She feels then she needs to do. No alcohol for 3/52. No drug abuse - repeatedly. No headache. No resp symptoms

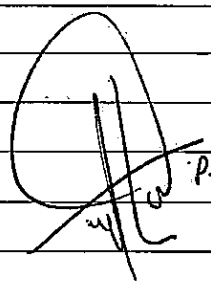
O/E: BP 111+70 Temp 36.6
On O2. Looks fallen-skinned

Neuro: All intact. No saddle anaesthesia. Plantars ↓ No new bulk from Sensation (N) reported

Could not heel-toe walk.
No nystagmus.
Coordination (N) except pull-pointing on (L) side.

Assessment: Not overly certain.

DDx: ? NPH ⇒ But no "dementia"
? Cerebellar Sx ⇒ But coordination (N) clinically
? ↓ T4 ⇒ Would explain ↓ Temp
? Vernicke's ⇒ But no nystagmus.
? ↓ Cortisol No broad based gait. No recent alcohol.
? CES ⇒ No saddle anaesthesia. Can feel need to PU.



Plan: ① Recent Bloods incl B12/Folate/HbA1c/TFTs/Cortisol
② CXR
③ Give Rabeprazole
④ ECG
⑤ Recent OZ
⑥ Glucose
⑦ Brain Huggies
⑧ Recent DG
⑨ Permit post CTB
⑩ Full examination
⑪ US B.Ps
⑫ Urine TOX

NHS GG&C Adult Risk Assessment for Venous Thromboembolism (VTE)

[excluding orthopaedics, obstetrics & ENT who have specialty-specific policies]

NHS Greater Glasgow and Clyde

- **Risk Assessment must be completed for all patients within 24 hours of admission to hospital**
- **Patients must be reassessed every 48-72 hours or sooner if condition changes**
- **Reassessment must be documented in Kardex**
- **Please complete risk assessment and then sign and date Risk Assessment Result box at bottom of page.**

Pt Addressograph

Operative patients

Non-operative patients

Is the patient bed-bound or expected to have reduced mobility relative to normal state for ≥ 2 days?

Yes ☐ | No ☐

Does the patient have any risk factors for thrombosis? (tick √ all that apply)

Age >60	☐	Use of oestrogen-containing contraceptive therapy	☐
Active cancer or cancer treatment	☐	Use of hormone replacement therapy or tamoxifen	☐
Dehydration	☐	Pregnancy or < 6 weeks post partum	☐
Known thrombophilias	☐	Critical care admission eg HDU/ITU	☐
Obesity (BMI>30)	☐	Surgical procedure with total anaesthetic/surgical time >90 min, or >60 min if surgery on lower limb or pelvis	☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or Inflammatory disease	☐	Acute surgical admission with inflammatory or intra-abdominal condition including Pelvic Inflammatory Disease	☐
Personal history or first degree relative with a history of VTE	☐	Hip fracture	☐
Varicose veins with phlebitis	☐	All gynaecological surgery except uncomplicated gynaecological diagnostic day case procedures	☐

- No thromboprophylaxis required.
- Continue to reassess every 48-72 hours or sooner if condition changes.
- Document all reassessments in drug kardex.
- **Complete Risk Assessment Result Box.**

Yes, 1 or more risk factors identified ☐

No risk factors identified ☐

Indicators of high risk bleeding (tick √ all that apply)

Active bleeding	☐	Lumbar puncture, epidural/spinal anaesthesia • Expected within the next 12 hours • Within the previous 4 hours	☐
Acquired bleeding disorders (e.g. liver failure)	☐	Other procedure with high bleeding risk – discuss with senior if unsure	☐
Concurrent use of other anticoagulants (e.g. warfarin, rivaroxaban, apixaban, edoxaban) is a contra-indication to additional phamacological thromboprophylaxis	☐		
Acute stroke (within 14 days)	☐	Acute bacterial endocarditis	☐
Persistent uncontrolled hypertension (BP > 230/120 mmHg)	☐	Surgery expected within the next 12 hours	☐
Thrombocytopenia (<75 x 10⁹/l)	☐	Trauma with high bleeding risk e.g. Head Injury	☐
Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands)	☐	eGFR <30ml/minute/1.73m²: Dose reduction required	☐
High risk of peri- or post-procedural bleeding, e.g. neurosurgery , spinal, posterior eye surgery and thyroid surgery	☐	Heparin induced Thrombocytopenia	☐

- **Discuss with senior clinical staff before deciding to prescribe pharmacological prophylaxis**
- Consider mechanical prophylaxis e.g. AES unless contra-indicated.
- Reassess patient every 48-72 hours or sooner if condition changes.

No contraindications to pharmacological prophylaxis identified ☐

Contraindications to pharmacological prophylaxis identified ☐

Operative patients – Enoxaparin 40mg + AES ☐*

*prior to application of AES, please check contraindications to AES

Non-operative patients – Enoxaparin 40mg ☐

Prescribe Enoxaparin at 6pm

[on day of surgery, at the later of either 4h post-op or 6pm]

Reduce Enoxaparin to 20mg if <50Kg or eGFR <30ml/minute/1.73m² ☐

If weight> 120kg, consider Enoxaparin 40mg bd (see StaffNet Guideline).

Discontinue at discharge or when returned to pre-morbid mobility

Contraindications to anti-embolism stockings (AES) Y☐ N☐

Peripheral neuropathy	☐
Peripheral arterial disease	☐
Cellulitis or Gross oedema	☐
Leg deformity or Fragile skin	☐
Leg / foot ulcers	☐
Allergy	☐
Unusual leg size/shape	☐

Risk assessment result – please tick √ all that apply

VTE risk factors: YES ☐ NO ☐ Indicators of high risk bleeding: YES ☐ NO ☐ Prescribed: LMWH ☐ AES ☐ NONE ☐

Patient informed of VTE risks and benefits of thromboprophylaxis YES ☐ NO ☐ N/A ☐ Information leaflet provided YES ☐ NO ☐

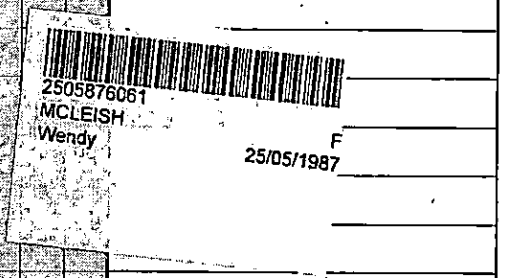
Print Assessor's Name: _____ Signature: _____ Date: _____

Medicine Reconciliation Form

Source of information: ECS ☐

Patient ☐ Relative/carer ☐ GP surg ☐ GP computer printout/letter ☐ Patient's own drugs ☐ Other (specify) _____

Admission Medicines (including OTC, herbal, homeopathic)				Plan for medicines (unless indicated to stop or hold medication should be continued on drug kardex)				
Name	Dose	Freq	Route	Amend	withhold	Stop	continue	Reason for alteration
Allergies/adverse events								



List obtained by _____ Designation _____

Recently altered/discontinued medicines prior to admission and reasons why _____

Compliance aid? Y ☐ N ☐ Type _____ If, Y Community Pharmacy _____ Phone _____

Senior Medical staff review: Sign _____ Title _____ Date and Time _____

Reviewed by pharmacist _____ Date and Time _____

Comments

Consultant Review

35 y.o. F

Bloods WCC 13·5, neut 9·3
ECG (N) SR
CxR Nil focal.

3/52 h/o feeling confused & shaking + falls.
3 episodes of faecal incontinence – liquid stool.
No other episodes. No urinary incontinence.
Anxious no similar symptoms & prev pneumonia when needed ECMO.
Denies illicit drugs/alcohol.

OE: NEWS 4 Sats 95% RA 35·6 BP 97 systolic.
HS Nl
Chest clear
Slight ↓ co-ordination on Lt cf Rt.
No ataxic gait.
Romberg –ve.

Impression – Unclear – ? mild gastroenteritis ⇒ symptoms

Plan – LFTs BP
– CT head
– may need PT input
– EDD 24-48°

2505876061
MCLEISH
Wendy
F
25/05/1987

Check List	
VTE	☐
Med - Rec	☐
Kardex	☐
CxR	☐
ECG	☐
Oxygen	☐
EDD	

PRINT NAME	DESIGNATION
SIGNATURE	DATE & TIME 25/05/25 10:16

Clinical Notes

26/03/23 L. Mihaita - Locum SHO Weekend review
09:15 (35) a/w ataxia and confusion; faecal incontinence

PMHx: substance abuse
new pneumonia requiring ECMO
asthma

- ? gastro-enteritis
- 4/5 BP 24-25/03 : no deficit
- awaiting CTB

Obs Stable - RR 15 | SpO_2 96% on RA
HR 77 | BP 131/84
apyrexial

Bloods 24/03
U&Es (N)
PO4 | K | AST haemolysed
CRP 8 | WCC 13.8
TSH (N) | Ca (N)
LFTs (N)

Not working on GHAWS.
No headache | N+V
No CP | SOB. Mild cough with clear sputum
No abdominal pain. Having bowels regularly, formed stools.
Nb LUTS.
(N) power | tone | sensation in all limbs.
Cranial nn grossly intact
Able to mobilise independently
Reports difficulty walking in a straight line.

Unclear presentation.
Plan: CTB - clear
Encourage oral fluids
Change Pabrinex to Thiamine

Shona Srihanto

2505876061
MCLEISH
Wendy
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY
F
25/05/1987

Ward 46
Short Stay Medicine
HEAD INJURY
Nursing Documentation

2505876061
MCLEISH F
Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

NHS Greater Glasgow and Clyde

Hospital: GRI	Date: 24/03/23
Time: 0050	Admitting Nurse: Neave McIntyre

PATIENT DETAILS CHECKED AND CORRECT	YES	NO	N/A
Patient Name:	✓		
Patient Address:	✓		
Date of Birth:	✓		
Next of Kin Name and Contact Details: Palmer (James) 07713095749	✓		
Next of Kin Informed:	✓		
GP Details:			
Religion:			

Presenting Complaint:
↑ confusion falls GP referal

Past Medical History:
Substance abuse
Previous Seizure

Current Medications:
Dihydrocodeine

Allergies: NKDA

Resp Rate	SpO2	Temp	Pulse	Blood Pressure
GCS	**NEWS**	**Blood Glucose**	**ID Band**	**Interpreter**

Height: 5'2 Weight: 11st 0lbs MUST: BMI:

If BMI <18 commence food chart and refer to dietician ☐

Cognitive impairment - For all patients > 65 years, complete TIME	YES	NO	N/A

Urinalysis:

If positive obtain MSSU ☐ Date obtained:

Ward 46
Short Stay Medicine
HEAD INJURY
Nursing Documentation

2505876061
MCLEISH F
Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

NHS Greater Glasgow and Clyde

Peripheral Vascular Catheter (PVC) Bundle

Reason for PVC Insertion:
- ☐ IV Fluids
- ☐ IV Drugs
- ☐ Suspected haemorrhage
- ☐ Diagnostic tests

Insertion Date: / /

Insertion Time: :

Hand hygiene performed immediately before PVC insertion.	☐
Skin anticseptic containing 70% isopropyl alcohol used to cleanse the skin and left to dry.	☐
Aseptic technique maintained throughout insertion procedure.	☐
Sterile, transparent, semi pereable dressing used to cover catheter site. Size/colour: Pink Insertion site: Left Arm	☑

Red Flags (Requires escalation/specialist referral/separate Risk Assessments)

Child Protection concern		Learning Disabilities	
Adult Support and Protection		Patient has appointed Welfare Guardian/Power of Attorney	
Confused Patient *(if more confused than baseline, consider DELIRIUM)*		Patient has Adult with Incapacity Section 47 certificate in place	
Substance Misuse		Infection Risk	
Has swallow test been carried out?		STOPPS completed?	
		Falls Risk? *(If at risk, complete full falls Bundle)*	

Dietry Requirements (Specify): Nil

Pressure Area Assessment

1 Pressure Damage	Does the person have redness and/or existing damage? Yes / (No) If YES, prescribe a minimum of 2 HOURLY Active Care to avoid further damage occuring and complete the pressure ulcer intervention plan (PUDRA Chart).

Date	Location of redness/ulcers	Grade of ulcer	Date	Location of redness/ulcers	Grade of ulcer

2 Mobility	Does the person require assistance to mobilise?	Yes / (No)
3 Continence	Does the person have continence issues with urine and/or faeces	Yes / (No)
4 Nutrition	Does the person appear malnourished and/or unable to eat or drink	Yes / (No)
5 Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?	Yes / (No)
6 Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:	Yes / (No)

Active Care Plan Commenced ☑

Ward 46
Short Stay Medicine
HEAD INJURY
Infection Risk

2505876061
MCLEISH F
Wendy 25/05/1987

NHS Greater Glasgow and Clyde

MRSA Screening / CJD / Healthcare outside Scotland

Will the patient be an inpatient >23 hours? ☐ Yes ☐ No If 'Yes' complete the following section.

1. Has the patient ever had a previous positive MRSA result?	☐ Yes	☑ No	☐ Not known
2. Has the patient been admitted from a Care Home/ institutional setting or another hospital?	☐ Yes	☑ No	☐ Not known
3. Does the patient have a wound / ulcer or invasive device which was present prior to this admission?	☐ Yes	☑ No	☐ Not known

If 'Yes' to any of the above questions OR if the patient is admitted to a 'high impact speciality' e.g. Orthopaedics, Vascular, Renal Unit, Critical Care – then obtain MRSA Swabs:

☐ **Nasal** ☐ **Perineum** ☐ **Other - Specify:** ☐ **Patient refused**

CPE

1. Has the patient been CPE positive?	☐ Yes	☑ No	☐ Not known
2. Has the patient been an inpatient in hospital outwith Scotland in the last 12 months?	☐ Yes	☑ No	☐ Not known
3. Has the patient had dialysis outwith Scotland in the last 12 months?	☐ Yes	☑ No	☐ Not known
4. Has the patient been in close conatct with a person infected with CPE?	☐ Yes	☑ No	☐ Not known

CJD

1. Have you been notified that you are at increased risk of CJD?	☐ Yes	☑ No	☐ Not known

Appropriate Care Plan Used	☑ Yes	☐ No	☐ N/A
Is patient Isolated	☐ Yes	☐ No	☑ N/A
If 'NO' - Reason:			

Ward 46
Short Stay Medicine
HEAD INJURY
Nursing Documentation

2505876061 F
MCLEISH
Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire G31 3LY

NHS Greater Glasgow and Clyde

Lifestyle

Smoking:

Are you a smoker ☐ ex-smoker ☐ never smoked ☐

If ex-smoker when did they stop? .....

If smoker how many cigarettes per day.....

vape

If smoker, or recent ex-smoker, would they like to use nicotine replacement therapy to prevent withdrawal discomfort while in hospital? ☐ Yes ☐ No

If smoker, would they like to stop now with the support from stop smoking service? ☐ Yes ☐ No

If Yes refer to Smoking Cessation Service

Drugs: Does the patient use recreational drugs? ☐ Yes ☑ No If 'Yes' specify:

Alcohol (Men): How often do you have **8** or more drinks on one occasion:

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

If 'Monthly' or more then complete FAST Tool.

Alcohol (Women): How often do you have **6** or more drinks on one occasion: Pt states never

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

If 'Monthly' or more then complete FAST Tool.

Admission Documentation Completed By

Name (Please PRINT): Neave McIntyre	Signature: NMcIntyre
Designation: Staff Nurse	Date: 25/03/23

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☑	Information on discussion with relatives
Belongings (including patients medication)	☑	Always	
New medications explained	☐	☑	
PVC removed	☑	☐	
Relatives aware of Discharge	☑	☐	Please note here if any other tasks required prior to discharge
Social/Support Services required and contacted	☐	☑	
SAS Transport required and ref. no.	☐	☑	Print name
Other means of transport arranged by nurse	☐	☑	
Follow-up organised and explained	☐	☑	F/U

Date: 26/03/23 Signature: [signature]

Ward 46
Short Stay Medicine
HEAD INJURY
Nursing Documentation

2505876061
MCLEISH F
Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

NHS Greater Glasgow and Clyde

	AIM	ASSESSMENT / INTERVENTIONS
1 MONITORING OF VITAL SIGNS Standard observations (BP, P, T, R, SaO_2) - requirement & frequency CSM/Neurovascular observations Special observations eg: blood glucose, peak flow, Neurological obs Special requirements (O_2, chest physio)	To detect abnormalities and maintain optimum function.	NEWS Stable.
2. IV THERAPY Peripheral / Central Line - Sites Use of Venflon Careplan Infusion Chart in use NB: 4° temp required if patient has an IV	Early detection / prevention of the problems of IV therapy.	(L) Arm Pink PVC
3 MAINTAINING SAFETY Level of conciousness Chronic / Acute confusion Alcohol withdrawal Seizures Wandering / at risk of injury	To maintain safety at all times.	↑ confusion on admission.
4. MOBILITY / MOVING & HANDLING Assess DVT risk using SIGN guidelines Specify limitations/current ability & aids used Traction Active/Passive exercise TED Stockings on admission	To prevent / reduce the complications of reduced mobility. To move the patient safely. To promote independence.	Independent/ Supervision due to falls risk
5 PRESSURE AREA CARE Waterlow score Interventions	The patients skin will remain healthy and intact.	pt states intact.
6 PAIN Monitor effectiveness of analgesia - involve patient & medical staff - use of Pain Chart	The patient will state that he is comfortable.	Analgesia
7 PERSONAL HYGIENE Self caring or Specify assistance required Mouth care Eye care	To maintain a high standard of personal hygiene. To promote independence.	Independent
8 NUTRITIONAL STATUS Score: (Use nutrition risk assessment) Special Dietary requirements Fasting / fluid restrictions Fluid balance monitoring required	To maintain adequate nutritional intake. To promote healing.	NDF
9 URINARY & BOWEL FUNCTION Independent or specify aids used (urinals, bedpan etc) Catheterised - size free drainage / hourly volumes Bowel - Stoma, Aperients – Chart daily	To detect any problems with output. To promote independence.	Independent

Ward 46
Clinical Notes

Medical ☐ Nursing ☐

Please tick appropriate Directorate

2505876061
MCLEISH
Wendy F
25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

NHS Greater Glasgow and Clyde

Date and Time		Signature/ Designation
25/03/23 0100	Nursing note night News as charted, Pt transferred to 4b following ↑ confusion previous Ataxic Pt independent/supervision at present due to confusion and falls risk. Plan for L/S BP ☐☐ Urine ☐ GMAWS ☐ CTB ☐ Rpt bloods ☐.	NMAH (SN)
25/3/23 1545	Nursing Day Patient care as charted. Observations as per NEWS. Medications as per Hepma. L+S BP's as charted. Awaiting CTB. For rpt bloods 26/3/23. GMAWS as charted. IV pabrinex as per Hepma.	H Bullen (S/N) H Bullen

Ward 46

Clinical Notes

Medical ☐ Nursing ☐

Please tick appropriate Directorate

2505876061
MCLEISH
Wendy F
FLAT 3/2 25/05/1987
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

NHS Greater Glasgow and Clyde

Date and Time		Signature/ Designation
26/3/23 - 00.40	nursing nightshift- Pt settled and sleeping at present, observations taken and documented as per chart	
	medications administered and documented as per kerma.	
	E+O as normal, independent with all ADLs.	
	imp - unclear ?mild gastroenteritis	
	LtS BP ☐☐☐	
	CTH ☐	
	?PT/OT input	
	EOD 24°-48°	
	no further comments at present, will continue to monitor ———	EB-e (SN)
26.03.23 13³⁵	Nursing dayshift - Meds per kerma. Obs charted. NEWS (2) due to HR 92, temp 35.9. BM 5.9. Pt angry this am as not allowed off ward. Explained to pt the unsafe + h-staff cant take care of pt if not on ward. for CTB ☐	
	Because of new confusion GMWMD - not signing. Bloods obtained 26/03 ☒	Consent B4 T Campbell
16⁴⁵	Pt discharged from ward 46. No new meds. Belongings given PVC removed CTB - nil acute Relatives aware of discharge Om transport arranged. Checklist complete.	Responsible T Campbell

Ward 46

Clinical Notes

Medical ☐ Nursing ☐

Please tick appropriate Directorate

2505876061
MCLEISH, Wendy F
FLAT 3/2 25/05/1987
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

NHS Greater Glasgow and Clyde

Date and Time		Signature/ Designation

CHI: 2505876061

Glasgow Royal Infirmary

3711

Total Att: 12

12 Mth Att: 1

Title: MISS

MCLEISH

Wendy

DOB: 25/05/1987 Age: 32y Sex: Female

126 LIBERTON ST

Glasgow
Lanarkshire
G33 2HJ
~~0ZZ68733984~~
07938803174

Next of kin: SAME?, GERALD Gibson
Relationship: Brother Friends Bianca
5F 2m.
10 Grans

GP: AL McGinley
0141 531 8150

Pts child I/C Shona Ward
Shona Ward
07542592801

Attendance Date: 01/11/2019 Arrival Time: 09:31

Registration Time: 09:31 Date of Incident: 01/11/2019

Major Incident Desc:

Reason for Attendance: assault

Nursing Assessment

Alerts: Yes

No
Allergies: Not Recorded Pain Score:

Triage Category: 3

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 01/11/2019 09:37

Nurse name: Nurse Anne-Marie Tonner

Temp	35.2	C
HR	73	bpm
BP	98/63	mmHg
MAP	74.67	mmHg
RR	15	bpm
SpO2	98	%
Oxygen		%

BM	8.3	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

Pupils-Right		Pupils-Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: assaulted this am. haematoma evident to (R) sided of ear. also (R) ear bitten. has been taking valium. BM 3.8 with sas - given glucogon. NEWS 3

2505876061 25/05/1987 MCLEISH Wendy

2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy
2505876061 25/05/1987 MCLEISH Wendy

SW - Della Ruiz Glen 0141 565 0140 / 276 3469 / 276 8640

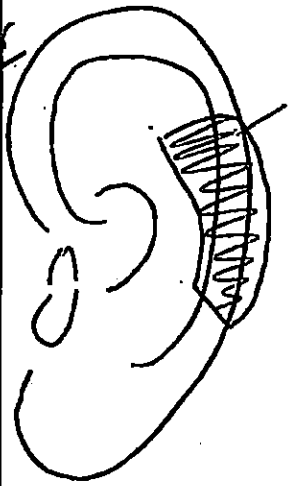
Kirsty Scanlon

To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

Date	Clinical Notes
01/11/19	Seen By C. IRVINE 10:50 Time Seen 10:30

(R) Ear



~2-3cm wound
Cartilage exposed
Flap present.

SH:
Lives w daughter
non smoker
denies drug acc alcohol

P
=wound cleaned. -Permethrin applied 13:25.
Plastics ? head lice.
Co-amox
Bloods for storage
Notification & concern + d/s S/W.
S/W Wendy aware + consented.

12:30 Police w Wendy. They have reported house contained drugs + paraphernalia. As mum in house they plan to stay w Wendy + arrest on d/s.
They saw Khara this am + ran checks on Sharon Ward prior to child being taken away.
Obs - BP 106/61 HR 79 Sats 99%
Discussed w Laura McCourt Social work 565 0140 who will arrange follow up police already warned SW.
Ward 18 accepted - Thanks - Permethrin to be washed off at 13:35.
LiO

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By
01/11/19	CO-AMOXICLAV	625mg	O	11°°	LiO	LiO
1/11/19	CO-AMOXICLAV	1.2g	IV	1135	[illegible]	

ADULT HEAD INJURY ASSESSMENT FORM - GLASGOW ROYAL INFIRMARY

Patient ID 2505876061
Name: MCLEISH, Wendy, F, 25/05/1987
126 LIBERTON ST, Glasgow, Lanarkshire, G33 2HJ
DOB: **Age**

Doctor C. IRVINE
Grade FY2
Date 01 / 11 / 19
Time seen 10 : 30

HISTORY / MECHANISM OF INJURY **SOURCE:** (Patient) Witnesses Ambulance / Police

32 Assaulted by partner
+ hit by ~~on~~ bottle on (R) temple & bitten (R) ear
↳ reports ~ 1hr ago
↳ reports a few hrs ago.
Unsure why partner did this. Does not think partner has any BBVs. Non IVDU.
Neighbours called police.
2yr old daughter (Khara Ward) in house at time
21/02/17
Partner occasionally stays w/ Wendy + Khara & sometimes stays w his mum. Denies prev assault & sexual assault.
Police advised Wendy to get family member to pick up Khara

LOC	(No)	Yes	Duration:	
Amnesia: PT	(No)	<5m	5-60	Hrs:
Amnesia: RG	(No)	Duration:		
Headache	(No)	Yes:		
Vomiting	(No)	freq	time	
Alcohol	No	5 units/day		
Drugs	(No)	DESCRIBE		
Seizure	(No)	Yes: TIME		

PMH
Anxiety
Depression

Prev presentation 16/8/19 - Medication overdose (citalopram) 2 days

↓ Currently w/ friend Sharon Ward. 14 Roman Drive.

Immunisations up to date

DH Aspirin | Clopidogrel | NOAC | Warfarin: INR=
Mirtazapine
Propranolol
NCOA.

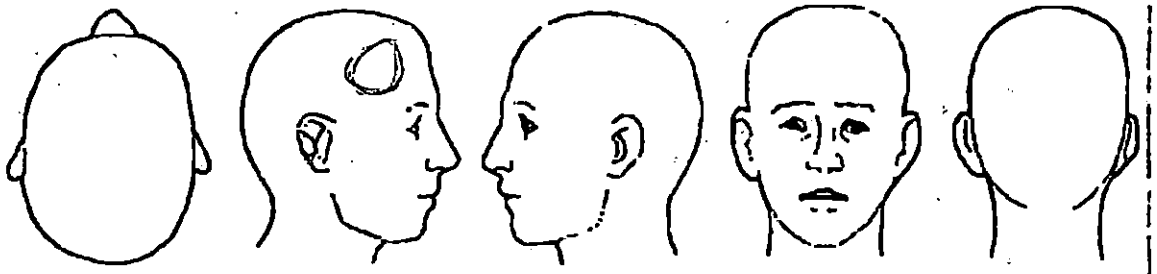
TETANUS
(Complete)
Booster
Uncertain

EXAMINATION

HR	73	BP	98/63	RR	15	BM	8·3	Temp	35·2	SaO_2	96	on O_2

GCS	Description	Score
E		4 /4
M		6 /6
V		5 /5
Total		15/15
CN I-XII	(Normal) / Abnormal ▼	Look unkempt.

	LEFT			RIGHT		
EYES	✓			✓		
	REACTS: Y (N)	(N)/A	VA	REACTS: Y (N)	(N)/A	VA
EARS	Clear	(Wax)	Abnormal	Clear	(Wax)	Abnormal
Limbs upper	(Normal)		Weakness	(Normal)		Weakness
Limbs lower	(Normal)		Weakness	(Normal)		Weakness
Speech:	(Normal) / Abnormal - slurred			Balance/Gait:	(OK) / unsteady	
Face Movement/Sens:	(Normal) / Abnormal - DESCRIBE					



Egg sized haematoma to ® temple. Blue/green bruising wound ® ear - see ED card for further details
No cervical tenderness. Multiple ? head lice eggs.

Wound Closure	NONE	GLUE SUTURES [No:] STAPLES [No:]
Skull #	NO	COMMENT
Base of Skull #	NO	COMMENT
Neck Injury	NO	COMMENT

OTHER INJURIES / PROBLEMS	NONE	LISTED ON ED CARD

IMAGING				
Immediate CT		NO	YES	COMMENT
CT within 8hrs		NO	YES	
C-Spine	CT	NO		RESULT
	X-ray	NO		RESULT
Other		NO		RESULT

IMPRESSION

Minor head injury - intoxicated
wound to ® ear - req. plastics

TREATMENT				
IV Access	NO	YES		REFUSED
Bloods	NO	YES	Do BV and SO ready significant results here	
Pabrinex	NO	I+II TDS		2x (I+II) TDS
GMAWS	NO	Symptom triggered		Fixed + symptom triggered
Analgesia	NO	Cocodamol	PRN	REGULAR
		Declined.		

OUTCOME			
Home	YES	*NB:* ALCOHOL HIWC SUPERVISION - WHO	
Admit	46 AAU	65 OTHER	
D/W Neurosurgery	NO	YES	COMMENTS
Specialty Involvement	NO	YES	

Signature

MIS 272617

Patient Information		Date:	01/1/2019
WENDY MCLEISH		Incident Number:	CR0059899926
Age/Gender:	32 years 5 months 7 days Old Female	Incident Type:	EMS
Address:	126 LIBERTON STREET CARNTYNE GLASGOW,G33 2HJ	Incident Location:	126 LIBERTON STREET CARNTYNE GLASGOW, G33 2HJ
DOB:	25/05/1987		
CHI:			
Ethnicity:			

Scottish Ambulance Service

Presenting Complaint

ASSAULT

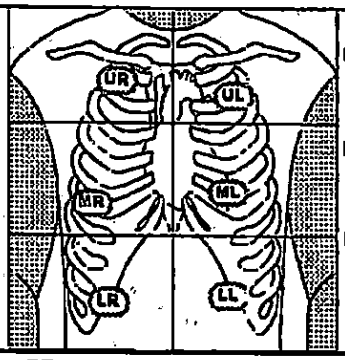
Additional Comments

999 CALL TO 32 Y/O F. O/A PT SITTING ON CHAIR WITH 2 ADULT MALES, ONE ADULT FEMALE, 2 AND A HALF YEAR OLD DAUGHTER WHO WAS SLEEPING AND POLICE PRESENT.PT HAD BEEN ASSAULTED. PT SLURRING HER WORDS.O/E PT HAS HAEMATOMA TO RIGHT OF FOREHEAD AND LACERATION TO RIGHT EAR.PT STATED IT HAD BEEN BITTEN. OBS AS BELOW. 4 LEAD ECG SHOWED NSR.PT HX OF ANXIETY AND DEPRESSION.PT LOW BM AND C/O HEADACHE. GLUCOSE GEL AND PARACETEMOL GIVEN TO GOOD EFFECT. PT HOUSE WAS IN DISARRAY AND OCCUPANTS APPEARED TO BE INTOXICATED AND WHITE COATING ON TONGUE AND MOUTH. PT STATED THAT SHE HAD 4 OR 5 VODKAS. PTS DAUGHTER WAS WOKEN UP BY POLICE. CREW HELPED FEED HER. PT FRIEND IN HOUSE C/O FEELING SICK. OBS TAKEN AND ANOTHER CREW ARRIVED TO DEAL WITH HER. PT NAME JADE HOBBS. SEE PRF FROM OTHER CREW. WHITE STREET VALIUM TABLETS FOUND ON FLOOR WITH ROCHE 10 IMPRINTED ON THEM. PT WALKED TO AMBULANCE. BP WAS HYPOTENSIVE IN AMBULANCE. LEGS RAISED TO GOOD EFFECT. PT CONVEYED TO GRI WITH POLICE IN ATTENDANCE UNDER NORMAL DRIVING CONDITIONS

PATIENT ASSESSMENT

AVPU	Alert		<C>	No
A	Clear			

B

Normal Breath Sounds	UR		UL	Normal Breath Sounds
Normal Breath Sounds	MR		ML	Normal Breath Sounds
Normal Breath Sounds	LR		LL	Normal Breath Sounds

C

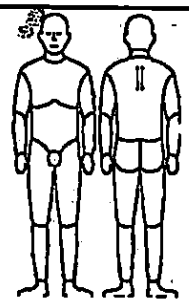
Pulse Rate	BP	Cap Refill	ECG Rhythm
92	123/86	<=2 Secs	Sinus Rhythm

Rhythm	Arm	Central/Peripheral	ECG
Reg	Right	Peripheral	3 Lead

D

GCS	Eyes	Voice	Motor	PEARL
15	Spontaneously (4)	Orientated (5)	Obeys Commands (6)	Yes

E



Wounds

ID	Body Part	Wounds	Treatments
W1	Head	Laceration	None
W2	Head	Haematoma	None

Pain

ID	Body Part	Pain Scale
P1	Head	7

Observations

Time	P	RR	BP	SpO2	CR	GCS	AVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
09:20	69	12	88/61	98	<=2s	15	Alert		36.9			4	4		E9887580
09:00	75	14	97/62	98	<=2s	15	Alert		35.8			4	4		E9887590
08:15	92	14	97/64	100	<=2s	15	Alert			8.2		5	5		E9887580

07:55	92	18	123/86	98	<=2 Secs	15	Alert		36.4	3.4	Sinus Rhythm	7	7		E9887590

NEWS

Time	Clinical Risk	NEWS
09:20	LOW Immediate Clinical Risk. Treat as per Clinical Practice Guidelines including considering the use of alternative pathways (if appropriate and available).	2
09:00	POTENTIAL Clinical Risk. Patient is likely to require conveyance to hospital.	3
08:15	POTENTIAL Clinical Risk. Patient is likely to require conveyance to hospital.	3
07:55	LOW Immediate Clinical Risk. Treat as per Clinical Practice Guidelines including considering the use of alternative pathways (if appropriate and available).	1

Drugs

Time	Drug	Dosage	Units	Route	Drug Expiry Date	Pain Before	Pain After	CrewID
07:55	Paracetamol	1	g	OR	03/2023	7	7	E9887590
07:58	Glucose 40% Oral Gel	25	g	OR	02/2021			E9887590

HISTORY

AMPLE

Allergies	None
Medication	Propranolol, CITALOPRAM

Social History

Lives alone	No	Living With	2 AND A HALF Y/O DAUGHTER	Patient Occupation	Does Not Work

Patients General Appearance	Normal
Living Arrangement	TEMPORARY ACCOMODATION
Patient Mobility	Fully Mobile
Patient Communication	No Help Required
Patient Clinical Risk Factors	Alcohol, Recreational Substances
Patient Environmental Risk Factors	Unkempt Living

SOCRATES

Site	FOREHEAD	Onset	0700 APPROX
Character	DULL THROB, Constant	Radiates	No
Exacerbating Or Relieving Symptoms	WORSE ON BLINKING	Severity	7/10

Safeguarding

Safeguarding History	Drug Abuse In Household, Alcohol Abuse In Household, Domestic Violence

Safeguarding Assessment	Child < 18	Safeguarding Category Of Risk	Medium	Hazards In Household	DRUGS,TOYS,CLOTHES,H ITEMS ON FLOOR

MEDICAL

CLOSE RECORD

Treatment On Scene	Non Emergency

Conveyance

Transport To Hospital	Normal driving	Pre Alert	No	Patient Accompanied By	POLICE OFFICER G2589

INCIDENT LOG

Time Call Received	07:19	Allocated	07:21	Mobile	07:21
First Resource On Scene		Crew On Scene	07:26	Crew Left Scene	09:10
Crew At Hosp	09:20	Receiving Hospital	GLASGOW ROYAL INFIRMARY	Clear Time	

Crew ID	Crew Grade	Driver
E0000075	Ambulance Technician	YES
E9887590	Ambulance Technician	NO

Ward 46
Short Stay Medicine
HEAD INJURY
Nursing Documentation

2505876061
MCLEISH F
Wendy 25/05/1987
126 LIBERTON ST,
Glasgow, Lanarkshire
G33 2HJ

NHS Greater Glasgow and Clyde

Hospital: GRI	Date: 1/11/19
Time: 14:00	Admitting Nurse: MMCLuan

PATIENT DETAILS CHECKED AND CORRECT	YES	NO	N/A
Patient Name:	✓		
Patient Address:	✓		
Date of Birth:	✓		
Next of Kin Name and Contact Details: Name only			
Next of Kin Informed:		✓	
GP Details:	✓		
Religion:			

Presenting Complaint: Alledged assault by partner Hit by bottle on R temple + bitten R ear. Police in attendance.

Past Medical History:	Current Medications:
Anxiety Depression	Propranolol + mirtazapine

Allergies: NKDA

Resp Rate	SpO2	Temp	Pulse	Blood Pressure
16	96	35.2	81	107/60
GCS	**NEWS**	**Blood Glucose**	**ID Band**	**Interpreter**
15	2		✓	No

Height:	Weight:	MUST:	BMI:

If BMI <18 commence food chart and refer to dietician ☐

Cognitive impairment - For all patients > 65 years, complete TIME	YES	NO	N/A

Urinalysis:

If positive obtain MSSU ☐ Date obtained:

Ward 46
Short Stay Medicine
HEAD INJURY
Nursing Documentation

2505876061
MCLEISH F
Wendy 25/05/1987
126 LIBERTON ST
Glasgow, Lanarkshire
G33 2HJ

NHS Greater Glasgow and Clyde

Peripheral Vascular Catheter (PVC) Bundle

Reason for PVC Insertion:
- ☐ IV Fluids
- ☐ IV Drugs
- ☐ Suspected haemorrhage
- ☐ Diagnostic tests

Insertion Date: 1/11/19
Insertion Time: ___:ED

Hand hygiene performed immediately before PVC insertion.	☐
Skin anticseptic containing 70% isopropyl alcohol used to cleanse the skin and left to dry.	☐
Aseptic technique maintained throughout insertion procedure.	☐
Sterile, transparent, semi pereable dressing used to cover catheter site.	☐

Size/colour: Venflon PINK Insertion site: RACF

Red Flags (Requires escalation/specialist referral/separate Risk Assessments)

Child Protection concern referred to SWS	✓	Learning Disabilities	X
Adult Support and Protection	X	Patient has appointed Welfare Guardian/Power of Attorney	X
Confused Patient *(if more confused than baseline, consider DELIRIUM)*	X	Patient has Adult with Incapacity Section 47 certificate in place	X
Substance Misuse	?	Infection Risk	
Has swallow test been carried out?	X	STOPPS completed?	X
		Falls Risk? *(If at risk, complete full falls Bundle)*	X

Dietry Requirements (Specify):

Pressure Area Assessment

1 Pressure Damage	Does the person have redness and/or existing damage? Yes / (No) If YES, prescribe a minimum of 2 HOURLY Active Care to avoid further damage occuring and complete the pressure ulcer intervention plan (PUDRA Chart).

Date	Location of redness/ulcers	Grade of ulcer	Date	Location of redness/ulcers	Grade of ulcer

2 Mobility	Does the person require assistance to mobilise?	Yes / (No)
3 Continence	Does the person have continence issues with urine and/or faeces	Yes / (No)
4 Nutrition	Does the person appear malnourished and/or unable to eat or drink	Yes / (No)
5 Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?	Yes / (No)
6 Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:	Yes / (No)

Active Care Plan Commenced ☐

Ward 46
Short Stay Medicine
HEAD INJURY
Infection Risk

2505876061
MCLEISH
Wendy
F
25/05/1987

NHS Greater Glasgow and Clyde

MRSA Screening / CJD / Healthcare outside Scotland

Will the patient be an inpatient >23 hours? ☐ Yes ☐ No If 'Yes' complete the following section.

1. Has the patient ever had a previous positive MRSA result? ☐ Yes ☑ No ☐ Not known
2. Has the patient been admitted from a Care Home/ institutional setting or another hospital? ☐ Yes ☑ No ☐ Not known
3. Does the patient have a wound / ulcer or invasive device which was present prior to this admission? ☐ Yes ☑ No ☐ Not known

If 'Yes' to any of the above questions OR if the patient is admitted to a 'high impact speciality' e.g. Orthopaedics, Vascular, Renal Unit, Critical Care – then obtain MRSA Swabs:

☐ **Nasal** ☐ **Perineum** ☐ **Other - Specify:** ☐ **Patient refused**

CPE

1. Has the patient been CPE positive? ☐ Yes ☑ No ☐ Not known
2. Has the patient been an inpatient in hospital outwith Scotland in the last ~~12 months~~ 5 years. ☐ Yes ☑ No ☐ Not known
3. Has the patient had dialysis outwith Scotland in the last 12 months? ☐ Yes ☑ No ☐ Not known
4. Has the patient been in close conatct with a person infected with CPE? ☐ Yes ☐ No ☐ Not known

CJD

1. Have you been notified that you are at increased risk of CJD? ☐ Yes ☑ No ☐ Not known

Appropriate Care Plan Used	☐ Yes	☐ No	☐ N/A
Is patient Isolated	☐ Yes	☐ No	☐ N/A

If 'NO' - Reason:

Ward 46
Short Stay Medicine
HEAD INJURY
Nursing Documentation

2505876061
MCLEISH F
Wendy 25/05/1987
126 LIBERTON ST
Glasgow, Lanarkshire
G33 2HJ

NHS Greater Glasgow and Clyde

Lifestyle

Smoking:
Are you a smoker ☐ ex-smoker ☐ never smoked ☑
If ex-smoker when did they stop? .....
If smoker how many cigarettes per day.....

If smoker, or recent ex-smoker, would they like to use nicotine replacement therapy to prevent withdrawal discomfort while in hospital? ☐ Yes ☐ No

If smoker, would they like to stop now with the support from stop smoking service? ☐ Yes ☐ No
If Yes refer to Smoking Cessation Service

Drugs: Does the patient use recreational drugs? Denies ☐ Yes ☐ No If 'Yes' specify:

Alcohol (Men): How often do you have 8 or more drinks on one occasion:
☐ Never ☐ Less than monthly
☐ Monthly ☐ Weekly ☐ Daily or almost daily
If 'Monthly' or more then complete FAST Tool.

Alcohol (Women): How often do you have 6 or more drinks on one occasion:
☐ Never ☐ Less than monthly
☑ Monthly ☐ Weekly ☐ Daily or almost daily
If 'Monthly' or more then complete FAST Tool.

Admission Documentation Completed By

Name (Please PRINT): MCEwan	Signature: MMCEwan
Designation: S/N	Date: 1/11/19

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☐	Information on discussion with relatives
Belongings (including patients medication)	☐	Always	
New medications explained	☐	☐	
PVC removed	☐	☐	
Relatives aware of Discharge	☐	☐	Please note here if any other tasks required prior to discharge
Social/Support Services required and contacted	☐	☐	
SAS Transport required and ref. no.	☐	☐	Print name
Other means of transport arranged by nurse	☐	☐	
Follow-up organised and explained	☐	☐	F/U

Date: _____ Signature: _____

Ward 46
Short Stay Medicine
HEAD INJURY
Nursing Documentation

2505876051
MCLEISH F
Wendy [illegible] 25/05/1987

NHS Greater Glasgow and Clyde

1 MONITORING OF VITAL SIGNS Standard observations (BP, P, T, R, SaO_2) - requirement & frequency CSM/Neurovascular observations Special observations eg. blood glucose, peak flow, Neurological obs Special requirements (O_2, chest physio)	**AIM** To detect abnormalities and maintain optimum function.	**ASSESSMENT / INTERVENTIONS** Observations as per News neuro-obs BMS
2 IV THERAPY Peripheral / Central Line - Sites Use of Venflon Careplan Infusion Chart in use NB: 4* pump required if patient has an IV	Early detection / prevention of the problems of IV therapy.	Venflon (R ACF
3 MAINTAINING SAFETY Level of conciousness Chronic / Acute confusion Alcohol withdrawal Seizures Wandering / at risk of injury	To maintain safety at all times.	GCS 15 nurse call buzzer explained
4 MOBILITY / MOVING & HANDLING Assess DVT risk using SIGN guidelines Specify limitations/current ability & aids used Traction Active/Passive exercise TED Stockings on admission	To prevent / reduce the complications of reduced mobility. To move the patient safely. To promote independance.	Independent
5 PRESSURE AREA CARE Waterlow score Interventions	The patients skin will remain healthy and intact.	PV Snakes skin intact. Bite to (R) ear
6 PAIN Monitor effectiveness of analgesia - involve patient & medical staff - use of Pain Chart	The patient will state that he is comfortable.	PRN Analgesia
7 PERSONAL HYGIENE Self caring or Specify assistance required Mouth care Eye care	To maintain a high standard of personal hygiene. To promote independence.	Independent. Head lice seen in ED.
8 NUTRITIONAL STATUS Score: (Use nutrition risk assessment) Special Dietary requirements Fasting / fluid restrictions Fluid balance monitoring required	To maintain adequate nutritional intake. To promote healing.	normal diet + fluids.
9 URINARY & BOWEL FUNCTION Independant or specify aids used (urinals, bedpan etc) Catheterised - size free drainage / hourly volumes Bowel - Stoma, Aperients – Chart daily	To detect any problems with output. To promote independence.	Independent.

Ward 46
Clinical Notes
Medical ☐ Nursing ☐
Please tick appropriate Directorate

2505876061 F
MCLEISH 25/05/1987
Wendy
126 LIBERTON ST
Glasgow, Lanarkshire G33 2HJ

NHS
Greater Glasgow and Clyde

Date and Time		Signature/ Designation
1/11/19 14[00]	Nursing Patient admitted from ED. Alledged assault by partner. Police in attendance. GCS 15. News 2. Haematoma/bruising to (R) Temple. Blue laceration to (R) ear - sutured by plastics Team. Head hic noted in ED + treated. When Police attended 2 yr. old child (Khava) DOB 24/2/17. in the house which contained drug paraphernalia - Police documented in ED notes as having ran checks on the Aunt Shauni Ward Bardhill Glasgow 14 Roman Drive who has the child at present + consider the child to be safe in her care. Case d/w. Lorna McCourt Social Work. (565140) who will arrange follow up. for	

Ward 46
Clinical Notes
Medical ☐ Nursing ☐
Please tick appropriate Directorate

2505876061
MCLEISH F
Wendy 25/05/1987
126 LIBERTON ST
Glasgow, Lanarkshire
G33 2HJ

NHS
Greater Glasgow and Clyde

Date and Time	Nursing	Signature/ Designation
1/11/19 14[00]	child.	
	Plan oral antibiotics	
	To treat ear laceration	
	neonates	
	BM	
	house with SWD	
	regarding Pts	
	daughter.	
	Patient has (L) facial	
	droop + abnormal	
	blinking (L) eye,	
	slurred speech,	
	denies drugs or	
	recent alcohol.	
	Awaits medical r/v	MMCMan
	S/N	MCMan
16[00]	Social worker allocated	
	to Khara Ward is	
	Sian Millard. 0141	
	276 3423. Social worker	
	Sian millard came to	
	the ward at 15[40]. 1/11/19	
	to speak with patient	
	+ inform her that her	
	Daughter Khara Ward	
	will remain in the	
	care of the paternal	
	Aunt Sharon Ward of	

Ward 46
Clinical Notes

Medical ☐ Nursing ☐

Please tick appropriate Directorate

2505876051
MCLEISH F
Wendy 25/05/1987
126 LIBERTON ST
Glasgow, Lanarkshire
G33 2HJ

NHS Greater Glasgow and Clyde

Date and Time		Signature/ Designation
	Nursing.	
1/11/19 16[00] cont'd	14 Roman Drive Bellshill: ML4 2SQ Tel No: 07542592801 until the situation is reviewed after the weekend.	M McLellan S/N M McLellan
1/11/19 17[00]	Alert + oriented Obs stable Only complaints are pain in (R) ear + localised pain in head where struck states struck with a bottle last night, denies LOC. (R) pinna still bak quite red - for further dose of coamoxiclav IV + could switch to oral. Follows up already arranged. Can be discharged to Police advise return if ear does not settle	J Burns
1745.	Pt charged and released from police. med fit for D/C from hosp. FU appt given. OABX given with instruction. Pt calling police RE house key Await call back	J A Martin S/N

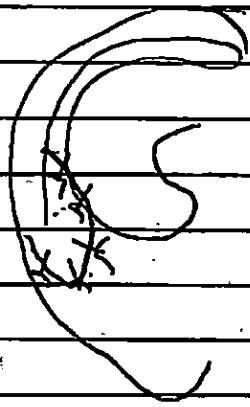
NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate

2505876061
MCLEISH
Wendy F
126 LIBERTON ST 25/05/1987
Glasgow, Lanarkshire
G33 2HJ

Date & Time		Signature, Print Name & Designation
1/11/19 12.40	IC Scott FY2 Plastics On-call.	
	ATSP in ED minor	
	human bite to left ear - assault.	
	Seen w/ M. Reams ST4	
	10ml 1% lidocaine instilled preauricular	
	500ml saline washout	
	Cartilage in skin flap -debrided	
	Full thickness cartilage loss	
	Non viable tip of flap excised	
	Rest of wound edges excised	
	Remainder of flap viable.	
	9x sutures w/ 6-0 ethilon.	
	Superficial abrasions in post auricular area.	
	Cleaned + topical chloramphenicol applied.	
	Ⓟ 1x 1.2g IV co-amoxiclav in dept	
	1/52 PO co-amoxiclav	
	Dressing clinic 1/52 for removal of sutures	
	Topical chloramphenicol BD 5 days	



83949 GGC0072

MLeft FY2 #13261

Date & Time		Signature, Print Name & Designation
	APPOINTMENT	
	DRESSING CLINIC	
	PLASTICS OPD	
	FRIDAY 8th NOVEMBER 2019	
	@ 11:00 AM	
19:30pm	Spoke with police at London Road who advised will contact officers to Return Keys to patients at ward Incident No° 3711.	E. Mellis
20:30pm	Police from London Road contacted ward advised Keys at Hutchison police Station and will bring Keys to ward However patient had already left ward as wanted to Make her own way to police station was to offered to stay but patient declined Ventilon Removed. Social work contacted and advised patient discharged	E. Mellis E. Mellis

NHS GREATER GLASGOW & CLYDE

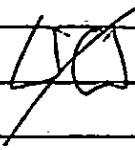
CLINICAL NOTES - MEDICAL ☑ NURSING ☐

Please tick ✔ appropriate directorate

2505876061
MCLEISH
Wendy
F
25/05/1987

Date & Time		Signature, Print Name & Designation
11/03/20		
1214.		
	ECHO - Rt 2° pneumo.	
	ASD.	Gr-Ley
	Epilepsy ? Cfg-D. Neuro. Hb.	
	Functional breathlessness.	
	CTPA - no PE.	
	TTE - RV overload.	
		Cleric.
		Substituted.
	Dentist work. → GJNRH.	
	Last few weeks.	
	- ? ↑ SOB. All + tightness worse.	
	R clinic wrote "bibasal" "urgently ↑".	Contact.
	↓ pain	
	Not sure if fine. Cough - dry.	Same year.
	↓ appetite (year).	
	↓ dietary / LOL.	
	Covid Staging.	↓ smoking.
	Ambulance a week ago,	Covid swelling in
		bilateral
	↓ D smoking. Months.	
	Inhalers not keys.	

83949 GGC0072

Date & Time		Signature, Print Name & Designation
	 1 volume water. Hb 54. 96%. dil.	109/63
	— Bloods	
	— CXR	
	— ABGs.	
		7753224

Acute Services Division

All Directorates

Department of

Specialty:Plastic Surgery

OutPatient Continuation Sheet eForm - Version 0.23

Hospital:	Glasgow Royal Infirmary

Patient Details		**GP Details**	
Name:	McLeish, Wendy	**Name:**	MCGINLEY, ANNE
Address:	126 LIBERTON ST Glasgow Lanarkshire	**Address:**	Easterhouse Health Centre 9 Auchinlea Road Glasgow
Postcode:	G33 2HJ	**Telephone:**	
Correspondence Address 1:			
Correspondence Address 2:			
Correspondence Postcode:			
Telephone:			
Patient Contact Number:	07454750438	**Consent:**	Yes
CHI Number:	2505876061	**Sensitivity:**	Sensitive
CRN:	23123532V, 10606785V, ZRV11368851		
D.O.B:	25/05/1987		
Sex	Female		

Typed Notes

9.50am

Patient seen in NLC following visit to A/E on 01/11/19

Patient suffered assault and ear was bitten, sutured by Plastics Team (Marie Kearns)

WOUND TYPE & LOCATION; sutures right ear
TISSUE TYPE; well adhered
INFECTION; no signs
EXUDATE; nil
SURROUNDING SKIN; intact
TREATMENT & RATIONALE; all sutures removed
AFTERCARE; patient advised to moisturise/massage, any concerns contact clinic
FOLLOW UP; no f/u required

All care discussed and agreed by SN Poole

10.10am

Date:	12/11/2019	Seen By:	Margaret Kelly	Designation:	Support Worker

DNA for NLC
reappointed

Date:	08/11/2019	Seen By:	Emma Poole	Designation:	Nurse

- End of Report -

Acute Services Division

Surgery and Anaesthetics Directorate

Department: Pre Op Assessment Unit

Specialty: Gynaecology

NHS Greater Glasgow and Clyde

Hospital Name	Glasgow Royal Infirmary

Patient Details		GP Details	
Name	MCLEISH, WENDY	Name	MCGINLEY, ANNE
Address	0/1 51 COXTON PLACE Glasgow Lanarkshire G33 5EJ	Address	Easterhouse Health Centre 9 Auchinlea Road Glasgow
Correspondance Address		Telephone	
Correspondance Postcode		CRN Number	23123532V, 10606785V, ZRV11368851
Telephone		Consent	Yes
Patient Contact Number	07454750438	Sensitivity	Sensitive
CHI Number	2505876061	Consultant Name	EPAS
Sex	Female	Requires Transport	No
Date of Birth	25/05/1987	Religion	None

Next of Kin / Person to Notify	Next of Kin	Person to Notify
Name	JAMES WARD	PARTNER
Address	AS ABOVE	
Landline		
Mobile	07475660161	
Relationship	PARTNER	

Assessor

Amanda Crichton Date Assessed: 11/09/2015

POA First Line

Surgery / Procedure: EVAC
Admission - DSU
TCI Date - 14/09/2015
Fasting information provided

Availability

Patient is not available at short notice

Reason -
Details - DATE ARRANGED.

Examination

Age: 28 Weight (kg): 79 Height (m): 1.57 BMI: 32
BP: 112/77mmHg Pulse: 74/ min Rhythm: Regular SaO2: 96%

Patient has had an anaesthetic before. There is not a family history of anaesthetic problems.

Patient has had surgery before. INDUCED COMA FOR BILATERAL PNEUMONIA, TRACHEOTOMY VENTILATION 2011. RADIAL FIXATION 2009.

Patient is currently taking the following medication:

MIRTAZAPINE 15MGS NOCTE
PROPANOLOL 40MGS TID.

Patient does not have any allergies

Patient does not suffer from heartburn or indigestion. Ranitidine has been dispensed,

Patient does not have any heart conditions

Patient does not have high blood pressure

Patient does not have diabetes. .

Patients best level of fitness is - climbs 1 flight of stairs without stopping.

Patient does not have breathing problems

Patient does not have kidney / liver problems

Patient has not been notified that they are at risk of CJD, vCJD.

Patient is pregnant. Details - .FOR EVAC PROCEDURE.

Patient has Implants / Prosthesis.
Patient has implants
Details - UPPER FRONT 2 VENEERS.

Patient does not require MRSA Screening

Referrals and Type of admission - Recommended Admission pathway		
Type of Admission:	DSU	
Admission Deferred:	No	

Further Details:

INDUCED COMA FOR BILATERAL PNEUMONIA, TRACHEOTOMY VENTILATION 2011.

BENIGN TREMOR, INVESTIGATED. CONTROLLED WITH PROPANOLOL.

BMI 32, RANITIDINE 150MGS X2 DISPENSED AS PER PGD 2015-1205.

There is no further information for this patient.

MCLEISH, Wendy
BORN 25-May-1987 (39y) GENDER Female
CHI 2505876061

Notification Of Concern (Child Protection)

Last updated by Caitlin IRVINE (Caitlin Irvine) 7 years ago (v. 2) Show History

Upon completion of form please email a copy to relevant social work office and notify Child Protection Service (CPS Admin) Team-either by Email (gg-uhb.CPadmin@nhs.net) or telephoning: 0141 451 6605 (Providing CHI Number)

Hospital	Glasgow Royal Infirmary

Sensitivity

Consent Withheld	No	Sensitivity	Sensitive
The information in this form **can** be shared with all health and care providers		The information in this form **will** be viewable by health and care providers across all specialties	

1A. Referrer's Details

Name	Caitlin Irvine		
Tel No	0141 211 5655		
Email	c.irvine3@nhs.net		
Area / Partnership	—		
Acute	Emergency Care & Medical		
HSCP	Glasgow North East		
Corporate / Specialist Services	—		
Other	—		
Job Type	Medical and Dental	Job Title	FY2
Base Location	GRI		

1B. Designated Contact Person (If Different from 1A. Referrer Details) (Please complete as fully as possible)

Name	—
Tel No	—
Email Address	—
Area Partnership	—
Acute	—
HSCP	—
Corporate / Specialist Services	—

Other —

Job Type — Job Title —

MCLEISH, Wendy

Base location —

BORN 25-May-1987 (39y) GENDER Female

CHI 2505876061

2. Referral To (Please complete as fully as possible)

Referral date	01-Nov-2019
Referral Time	11.30
Name of Social Worker spoken to	—
Designation	—
SW Team (Hospital or Area Team)	—
Tel No	—
Additional Information (if any)	—
Is the parent / carer aware of the referral?	Yes
Is the young person aware of this referral?	—
Is this a re-referral from your service?	—

3. Subject Of Referral (Please complete as fully as possible)

Child's Name (Inc Middle Names If Known)	DOB & CHI or EDD	Age	Gender	Child Address	Home Address	Type of Residence
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	—	—

Home Address (Inc Postcode) —

HSCP / Sector of Child / Family —

Ethnicity Details

Ethnicity —

Preferred Language —

Is interpreter required? —

Further Details (inc interpreter) —

Ethnicity Comments —

Child Affected By Disability

Disability —

Communication Assistance Required —

MCLEISH, Wendy
BORN 25-May-1987 (39y) GENDER Female
CHI 2505876061

Child affected by Disability —

Comments

4. Family Details - Siblings / related Children not subject to referral (please complete as fully as possible)

Child's Name (Inc Middle Names If Known)	DOB & CHI or EDD	Age	Gender
—	—	—	—

Home Address (Inc Postcode) —

HSCP Area of Child/Family —

Social Work Information (Please complete as fully as possible)

Child's Name	On CP Register	Current / Previous Registration	CP Indicators
—	—	—	—

5. Family / Principle Carer Details (Please complete as fully as possible)

Name	Aliases	DOB (if known)	Current Address	Relation To Child	Next Of Kin	Do parents have legal reponsibility?
[redacted]		—	—	—	—	—

6. Summary Of Concerns (for all referrals please complete the following)

Primary Risk to Child

Primary Risk to Child: Other (Please specify below)

If Other - Please Specify: Witness to domestic abuse

Suspicion / Risk Factors - Relating to the Carers / Parents

Primary Risk Factors (Parent/Carer): Domestic Abuse

7. Reason For Referral / Request For Services

(Please record reason for concern and how this impacts on child. If applicable, please indicate alleged abuse. Indicate what action, if any, you have taken prior to the referral)

MCLEISH, Wendy
CHI 250587/6061

Wendy attended ED with head injury and bite to her right ear following being assaulted by ex partner [redacted] DOB 25-May-1987 (36y) GENDER Female. Ex-partner occasionally stays with Wendy and [redacted] depending on his work. Wendy presented intoxicated, denies drugs and has minor head injury and ear wound was closed by plastics in ED.
Neighbours called police and police arranged for [redacted] to be picked up by Aunt [redacted]) - Police checked Aunt's details prior to [redacted] being taken to aunts house.

8. Agreed Actions (Actions agreed during phone referral)

Please comment
Discussed with Laura McCourt (Social work - duty social work) - who will arrange follow up. Already informed earlier today by police.

9. Agency Involvement (Please complete as fully as possible)

HEALTH - (This includes GP, Health Visitor, Hospital Staff etc Please Specify)

Name	Designation	Contact Details (Inc Address Tel No & Email Address)
—	—	—

EDUCATION - (This includes Nursery & School Staff - Please Specify)

Nursery / School	Contact Name	Contact Details (Inc Address Tel No & Email Address)
—	—	—

ANY OTHER AGENCIES - (If applicable / known)

Agency Name	Contact Name	Contact Details (Inc Address Tel No & Email Address)
—	—	—

Notification of Concern Acknowledgement

Acknowledgement of Child Welfare/Protection Referral To Social Work Services
Social Work Services use only (Notification to Referrer direct (if email address available) - if not then email to CPS Admin Team by Email (gg-uhb.CPadmin@nhs.net) within 5 working days of date received at Social Work Office)

Date of referral	—		
Referrer Name	—	Designation	—
Base / Location	—	Contact Details	—
Subject of Referral (Child's Name)	—	DOB / CHI or EDD	—

SOCIAL WORK OUTCOMES

Social Work ID —

Request Treated As	—		
Outcome of Referral / Request for Services	—		
Name of Social Worker	—	Designation	—
Address	—	Contact Number	—
Signature (Please Print)	—		
Date Completed	—		

MCLEISH, Wendy
BORN 25-May-1987 (39y) GENDER Female
CHI 2505876061

Print

MCLEISH, Wendy
BORN 25-May-1987 (39y) GENDER Female
CHI 2505876061

Notification Of Concern (Child Protection)

Last updated by Richard STEVENSON (Richard Stevenson) 7 years ago (v. 1) Show History

Upon completion of form please email a copy to relevant social work office and notify Child Protection Service (CPS Admin) Team-either by Email (gg-uhb.CPadmin@nhs.net) or telephoning: 0141 451 6605 (Providing CHI Number)

Hospital	Glasgow Royal Infirmary

Sensitivity

Consent Withheld	No	Sensitivity	Sensitive
The information in this form **can** be shared with all health and care providers		The information in this form **will** be viewable by health and care providers across all specialties	

1A. Referrers Details

Name	Stevenson		
Tel No	2114411		
Email	richard.stevenson@ggc.scot.nhs.uk		
Area / Partnership	North East		
Acute	Emergency Care & Medical		
HSCP	Glasgow North East		
Corporate / Specialist Services	—		
Other	—		
Job Type	Medical and Dental	Job Title	Consultant
Base Location	—		

1B. Designated Contact Person (If Different from 1A. Referrer Details) (Please complete as fully as possible)

Name	—
Tel No	—
Email Address	—
Area Partnership	—
Acute	—
HSCP	—
Corporate / Specialist Services	—

Other	—
Job Type	—
Base Location	—

Job Title —

MCLEISH, Wendy
BORN 25-May-1987 (39y) GENDER Female
CHI 2505876061

2. Referral To (Please complete as fully as possible)

Referral date	16-Aug-2019
Referral Time	12:30
Name of Social Worker spoken to	—
Designation	—
SW Team (Hospital or Area Team)	—
Tel No	—
Additional Information (if any)	Known social worker [redacted]
Is the parent / carer aware of the referral?	No
Is the young person aware of this referral?	No
Is this a re-referral from your service?	No

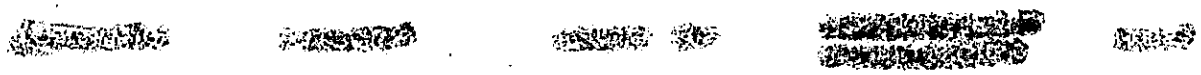
3. Subject Of Referral (Please complete as fully as possible)

Child's Name (Inc Middle Names If Known)	DOB & CHI or EDD	Age	Gender	Child Address	Home Address	Type of Residence
[redacted]	[redacted]	—	[redacted]	[redacted]	[redacted]	[redacted]

Home Address (Inc Postcode)	As above
HSCP / Sector of Child / Family	Glasgow North East

Ethnicity Details

Ethnicity	White Scottish
Preferred Language	English
Is interpreter required?	No
Further Details (inc interpreter)	—
Ethnicity Comments	—





Child Affected By Disability

Disability **MCLEISH, Wendy**
BORN 25-May-1987 (39y) GENDER Female
Communication CHI 2505876061
Assistance
Required

Child affected by Disability —
Comments

4. Family Details - Siblings / related Children not subject to referral (please complete as fully as possible)

Child's Name (Inc Middle Names If Known)	DOB & CHI or EDD	Age	Gender
—	—	—	—

Home Address (Inc Postcode) —

HSCP Area of Child/Family —

Social Work Information (Please complete as fully as possible)

Child's Name	On CP Register	Current / Previous Registration	CP Indicators
[redacted]	Unknown	[redacted]	Parental Alcohol Abuse

5. Family / Principle Carer Details (Please complete as fully as possible)

Name	Aliases	DOB (if known)	Current Address	Relation To Child	Next Of Kin	Do parents have legal reponsibility?
[redacted]	—	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

6. Summary Of Concerns (for all referrals please complete the following)

Risk Indicators

RiskIndicators Domestic Abuse
Neglect
Parental Alcohol Misuse

If Other - Please Specify —

Suspicion / Risk Factors - Relating to the Child (ren)

Child Safety
Emotional Care / Development
Physical Care / Neglect

If Other - Please Specify —

MCLEISH, Wendy

BORN 25 Mar 1987 (39y) GENDER Female
CHI 2505876061

Suspicion / Risk Factors - Relating to the Carers / Parents

Substance Misuse

If Other - Please Specify —

7. Reason For Referral / Request For Services

(Please record reason for concern and how this impacts on child. If applicable, please indicate alleged abuse. Indicate what action, if any, you have taken prior to the referral)

Mother was unfit to be in charge of [redacted] through alcohol; house in disarray; Wendy drinking to excess; unable to locate child

8. Agreed Actions (Actions agreed during phone referral)

Please comment

Police notified. No S/W return contact - notified by telephone.

9. Agency Involvement (Please complete as fully as possible)

HEALTH - (This includes GP, Health Visitor, Hospital Staff etc Please Specify)

Name	Designation	Contact Details (Inc Address Tel No & Email Address)
—	—	—

EDUCATION - (This includes Nursery & School Staff - Please Specify)

Nursery / School	Contact Name	Contact Details (Inc Address Tel No & Email Address)
—	—	—

ANY OTHER AGENCIES - (If applicable / known)

Agency Name	Contact Name	Contact Details (Inc Address Tel No & Email Address)
—	—	—

Notification of Concern Acknowledgement

Acknowledgement of Child Welfare/Protection Referral To Social Work Services
Social Work Services use only (Notification to Referrer direct (if email address available) - if not then email to CPU Admin Team by Email (gg-uhb.CPadmin@nhs.net) within 5 working days of date received at Social Work Office)

Date of referral —



Referrer Name	—	Designation	—
Ba[illegible]	MCLEISH, Wendy	Contact Details	—
Subject of Referral (Child)	BORN 25-May-1987 (39y) GENDER Female CHI 2505876061	DOB / CHI or EDD	—

SOCIAL WORK OUTCOMES

Social Work ID	—		
Request Treated As	—		
Outcome of Referral / Request for Services	—		
Name of Social Worker	—	Designation	—
Address	—	Contact Number	—
Signature (Please Print)	—		
Date Completed	—		

Print

Acute Service Division

Women and Children

Department of EPAS

Specialty:Obstetrics

NHS Greater Glasgow and Clyde

Early Pregnancy Assessment Tool - Version 1.0

Hospital:	Glasgow Royal Infirmary

Patient Details		GP Details	
Name:	MCLEISH, WENDY	**Name:**	MCGINLEY, ANNE
Address:	0/1 51 COXTON PLACE Glasgow Lanarkshire	**Address:**	Easterhouse Health Centre 9 Auchinlea Road Glasgow
Postcode:	G33 5EJ	**Telephone:**	
Correspondence Address 1:			
Correspondence Address 2:			
Correspondence Postcode:			
Telephone:			
Patient Contact Number:	07454750438	**Consent:**	Yes
CHI Number:	2505876061	**Sensitivity:**	Highly Sensitive
CRN:	23123532V, 10606785V, ZRV11368851	**Consultant Name:**	
D.O.B:	25/05/1987	**Form Date:**	27/08/2015
Sex	Female		

Next of Kin / Person to Notify	Next of Kin	Person to Notify
Name		James
Address		s/a
Landline		
Mobile		07475660161
Relationship		partner

Presenting Complaint	
Presenting Complaint:	Follow up scan

Obstetric History			
High risk factors:			
LMP:	22/05/2015	Cycle:	Regular
Date of pregnancy test:		Estimated gestation by LMP :	13+
Parity:	0+0	Last smear:	up to date-nad
Past obstetric history of note:		Date:	Place: Details:
Blood group:		Hb:	
Relevant thrombophilia:			

Additional Obstetric History

High risk factors:			
LMP:		Cycle:	
Date of pregnancy test:		Estimated gestation by LMP :	
Parity:		Last smear:	
Past obstetric history of note:		Date:	Place: Details:
Blood group:		Hb:	
Relevant thrombophilia:			

Relevant Medical History

Past Medical history:	wrist and throat operation - no problems with GA; NKDA.
Smoker: No	Medication:Yes
All Medication:	Propanolol 40mg TID Mitrazipine 15mg OD

Patient Allergy Summary

Ultrasounds

Ultrasound Details

Visit Date:11/09/2015	Ultrasonographer:Jennifer McGill/EMCGUIRE	LMP:22/05/2015

Ultrasound Date:	11/09/2015
Second sac?	No
Membrane seperation?	No
Adnexal mass?	No
Ovarian cyst?	No
Free fluid?	No
RPOC (measure)	Yes
Tenderness elicted	No

Foetus Information

Foetus Number	Heart Activity	Gestation Sac Size	Yolk Sac	CRL
		5.2x3x11.8mm	seen	

Ultrasound Details

Visit Date:03/09/2015	Ultrasonographer:Jennifer McGill (Checked by Donna Bean)	LMP:22/05/2015

Ultrasound Date:	03/09/2015
Second sac?	No
Membrane seperation?	No

Adnexal mass?	No
Ovarian cyst?	No
Free fluid?	No
RPOC (measure)	No
Tenderness elicted	No

Foetus Information

Foetus Number	Heart Activity	Gestation Sac Size	Yolk Sac	CRL
		8.9x10.7x11.5mm	?seen	

Ultrasound Details

Visit Date:27/08/2015	Ultrasonographer:Jennifer McGill	LMP:22/05/2015

Ultrasound Date:	27/08/2015
Menstrual age:	13+
Ultrasound age:	5+
Second sac?	No
Membrane seperation?	No
Adnexal mass?	No
Ovarian cyst?	No
Free fluid?	No
RPOC (measure)	No
Tenderness elicted	No

Foetus Information

Foetus Number	Heart Activity	Gestation Sac Size	Yolk Sac	CRL
		12.7x11.5x8.1mm	seen	

Ultrasound Comments

Date: 11/09/2015	TAS/TVS= Av uterus measures 85.7x42x32.3mm -appearance of collapsing gestation sac and RPOC (AP diameter 17.5mm) at fundus For SERPOC as planned
Date: 03/09/2015	TAS/TVS= AV uterus measures 80.3x53.2x42.2mm -IU gestation sac, yolk sac not clearly seen today (MSD 10.4mm) -areas of SCH surrounding sac -both ovaries and adnexa NAD Non-continuing pregnancy
Date: 27/08/2015	TAS/TVS= AV uterus measures 76.2x51.9x39.2mm -IU gestation sac and yolk sac seen (MSD 10.8mm) -both ovaries seen NAD -difficult scan due to bowel gas -no free fluid seen -no tenderness elicited rescan 1/52 - guarded prognosis

Outcomes

Non continuing pregnancy

Date :03/09/2015			
Explanation and management options discussed:	Yes	Anti D required:	No
Records /CWW informed:	Yes	GP Letter:	Yes
Pre-pregnancy appointment arranged:	No	Management option chosen:	Surgical
Further information:	undecided:- considering management options		
Pre Assessment arranged:	Friday 11/09/15 @ EPAS PRM		
Consent:	Yes		
Date and location of procedure:	Stobhill 14/09/15		
Bloods:	FBC, G&S 11/09/15		
Surgical Management leaflet given:	Yes	Sensitive Disposal Form completed:	Yes
Information leaflet given:	No	Pre-Pregnancy appointment arranged:	No

Intra-uterine pregnancy - uncertain viability

Date: 27/08/2015			
Explanation and emergency contacts given:	Yes		
Further information:			
Information leaflet given:	No	Pre-Pregnancy appointment arranged:	No

Further Details

27/08/15 10.30
Wendy attended EPAS for follow up scan, booking/dating scan last week should IU gestation sac and ?yolk sac. Wendy reports some minimal PVB over the past week, pain free, feels well otherwise:-
-u/s= inconclusive, see report. Findings fully discussed with Wendy and partner.
-for rescan in 1/52 for viability, advised Wendy to self refer or seek medical attention meantime if any concerns.
SM J.McGill

03/09/15 09.00
Planned attendance for rescan, reports PVB over the past week, some clots passed and cramps yesterday, settling today:-
-u/s= non-continuing pregnancy, see report. Findings fully discussed with Wendy and partner, condolences offered.
-discussed management options, Wendy wishing to consider options at home. She will contact EPAS when a decision is made.
-advised to self refer or seek medical attention if any concerns or feels unwell, aware of emergency contact numbers.
SM J.MCGill

03/09/15 14.45
Wendy contacted EPAS, wishing surgical evacuation:-
-SERPOC arranged Stobhill, Mon 14/09/15 @ 08.00hrs, Dr Wong, STO030906.
-Pre-op at EPAS, Fri 11/09/15 @ 12.15hrs.
-self refer or seek medical attention meantime if any concerns.
SM J.McGill

11/09/15 12.15
Wendy attended for SERPOC prep, reports PVB and clots passed at the weekend, Pv loss settled since then:-
-u/s= see report. Findings fully discussed with Wendy.
-keen to go ahead with SERPOC as planned.
-FBC, G&S taken, consent and SD7x2 obtained. Wendy referred to pre-op assessment for review.
-aware of time and place of procedure on Monday, advised to seek medical attention if any concerns over the weekend.
SM J.MCGill

Outcomes & Management

Date	USS Result	HGC Results	Action Plan & Follow Up

11/09/2015	Non-continuing pregnancy		Surgical evacuation

Date	USS Result	HGC Results	Action Plan & Follow Up
03/09/2015	Non-continuing pregnancy		Other
Details	undecided:- considering management options		

Date	USS Result	HGC Results	Action Plan & Follow Up
27/08/2015	Intra-uterine pregnancy - uncertain viability		Repeat U/S

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Nan 2505876061 F
Addr MCLEISH Wendy 25/05/1987
FLAT 3/2
DOB: 312 CUMBERNAULD RD
Glasgow, Lanarkshire G31 3LY
CHI N

1. Triage (Consider Mental Health Triage Assessment - if applicable)

Hospital

Patient Preferred Name:

Date: Time:

Triage Nurse

Transport SAS / Self

2. Presenting Complaint

PC, SOB
Ataxic - 2-3 weeks
Confused +
fall from bed 4/52
No pneumonia

Category Gap Score

3. Observations

Allergies (including food allergies):

No Known allergies ☒ none

Resp. Rate	Sp02	Temperature	Pulse	Blood Pressure
22	96% RA	36.6	90	121/83
GCS	**NEWS Score**	**PEFR**	**Blood Glucose**	**Pain Score**
/15				/10

4. Communication

I.D. band on? (Y) N

Relatives present? (Y) N Partner - James

Relatives / NOK informed? Y / N

Interpreter required? Y / N

5. 4AT and TIME for Detection, Management, and Prevention of Delirium

Complete for patients: age 65 and over; patients of any age with an existing cognitive impairment; previous delirium; current hip fracture; or severe illness. These patients are at high risk of delirium. This should be done on admission; at each transition of care; if SQiD positive; or if any clinical concerns.

mi • 287900 v5.0 • GGC0255

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name: MCLEISH Wendy F
Address: FLAT 3/2 312 CUMBERNAULD RD Glasgow, Lanarkshire G31 3LY
DOB: 25/05/1987
CHI Nu: 2505876061

Named Nurse/Team Leader: Beach R

Assessment Completed by: Name (PLEASE PRINT) Anne MSN (LCPL)

6. Patient Preparation

Prepare patient for examination	☐	IV Cannula (if required)		Y/N
Clothing bag labelled and stored	☐	Blood samples taken		Y/N
GGC RED BAG - with patient	☐	If Yes, list requests		
12 Lead ECG	☑	Cardiac Monitoring		Y/N
X rays performed	☐	Height:	Weight:	

Urinalysis

Leucocytes	Nitrites	Protein	pH
Blood	S.G.	Ketones	Glucose
MSSU/CSU Sent ☐			
HCG specimen if indicated	+ve ☐	-ve ☑	Strip Lot no:

7. Peripheral Vascular Catheter (PVC) Bundle

Reason for PVC Insertion:

☐ IV Fluids

☐ IV Drugs

☑ Suspected haemorrhage

☐ Diagnostic tests

Insertion Date: ___/___/___

Insertion Time: ___:___

Hand hygiene performed immediately before PVC insertion.	☐
Skin antiseptic containing 70% isopropyl alcohol used to cleanse the skin and left to dry.	☐
Aseptic technique maintained throughout insertion procedure.	☐
Sterile, transparent, semi permeable dressing used to cover catheter site.	☐
Size/Colour: _____ Insertion site: ___	
Signature: _____	☐

8. Adult Urethral Urinary Catheter Insertion (Use maintenance care plan as appropriate)

Clinical Indication for Insertion:

Insertion Date: ___/___/___

Insertion Time: ___:___

Signature: _____

Hand hygiene performed immediately before insertion.	☐
Aseptic technique maintained throughout insertion procedure and connection to closed drainage.	☐
Urethral meatus cleansed with saline and lubricant used.	☐
Guage: _____ _____ mls in balloon	

9. General Safety Precautions to be Undertaken by All Patients

Action the following safety precautions on admission to your ward.
Update weekly or on change of condition

Date: 24/3/2?

Time: 15:38

1. Document mobility status in clinical record and complete a moving and handling assessment if appropriate	Supervision unaffected
2. Check walking aid (if required) is in reach and in use.	N/A
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	within reach
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	✓
5. If glasses are worn, check they are available and in use	n/a
6. If hearing aid/s are worn, check they are working and in use.	n/a

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name: 2505876061 F
Address: MCLEISH Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY
DOB:
CHI Nur

10. Risk Assessment

If Yes to any of the 5 questions below complete the falls interventional plan. Whether Yes or No, update this assessment in acute wards, or, at the time of a fall or, upon a change in patient's clinical condition.

	YES	NO	YES	NO
1. Has the patient fallen in the last 6 months - including during this admission?	✓			
2. Does the patient have cognitive impairment or a possible delirium?		✓		
3. Does the patient attempt to walk alone although unsteady or unsafe?	✓			
4. Does the patient or their relative have a fear or anxiety of the patient falling?	✓			
5. Based on your clinical judgement, is this patient at high risk of falling?	✓			
Signature of nurse completing assessment / update	Anna			

11. Screening Tool (Requires escalation/specialist referral/separate Risk Assessments)

Child Protection concern	Y / N / (NA)	Learning Disabilities	Y / N (NA)
Adult Support and Protection	Y / N / (NA)	Patient has appointed Welfare Guardian/Power of Attorney	Y / N / (NA)
>65 years: 4AT/TIME BUNDLE COMPLETE?	Y / N / NA (6)	Patient has Adult with Incapacity Section 47 certificate in place	Y / N / (NA)
Mental Health Triage	Y / N / (NA)	Infection Risk	Y / N / (NA)
Has swallow test been carried out?	Y / N / (NA)	STOPPS completed? Y / N / (NA) Date_____ Time_____ Sign_____	
Sepsis Risk: Systemic inflammatory response syndrome (SIRS) Criteria 2 or more → commence Sepsis Bundle	Y / N / (NA)	Anticipatory Care Planning? (If applicable, complete GAEL chart)	Y / N / (NA)
FRAILTY SCREENING Completed on Trakcare	Y / N (NA)	SUBSTANCE MISUSE FAST SCORE / GMAWS	(Y) / N / NA Unsure

12. Pressure Area Assessment

1 Pressure Damage — Does the person have redness and/or existing damage? Yes / (No)
If YES, prescribe a minimum of 2 HOURLY Active Care to avoid further damage occuring and complete the pressure ulcer intervention plan (PUDRA Chart).

Date	Location of redness/ulcers	Grade of ulcer	Date	Location of redness/ulcers	Grade of ulcer

2 Mobility	Does the person require assistance to mobilise?	(Yes) / No Supervision
3 Continence	Does the person have continence issues with urine and/or faeces	Yes / (No)
4 Nutrition	Does the person appear malnourished and/or unable to eat or drink	Yes / (No)
5 Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?	Yes / (No)
6 Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:	Yes / (No)

13. Record of Intentional Rounding – ask whenever patient is visited but no longer than every 2 hours

1. Think delirium: Is the patient more confused?
2. Comfort: Are you comfortable?
3. Pain: Do you have any pain?
4. Drink/Mouth Care: Would you like a drink?
5. Food: Are you hungry?
6. Continence: Do you need to go to the toilet?
7. Possessions: buzzer, tissues, glasses within reach, water available and relatives at bedside?
8. Is there anything else I can do for you?

Date	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.
24/8/23	15:00		16:00		17:00									

Date	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.

24/8/23 patient arrived AMU, cubicle 11 due 15:50 to new confusion, falls & incontinence. ECG obtained. Awaiting bloods & IV access currently being reviewed by medics – Amire ABDULLAH SJW

2505876061 F
MCLEISH 25/05/1987
Wendy
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire G31 3LY

16:46 reviewed by medics & awaiting plan. Patient's initial temperature on triage 34.6°C presents with shivers. Bair hugger in place present. Temp 35.5°C currently. NEWS score as charted. Bair hugger switched off. Amire ABDULLAH SJW

17:17 IV access insitu. Bloods obtained as well as T/to. Accepted dinner. Awaiting plan & CXR. Supervised. To be passed urine. IV Pabrinex administered as per MCP. Bair hugger switched off. Temp 35.3°C. Amire ABDULLAH SJW

19:00 NEWS scoring of 0 hours. News score as charted. Amire ABDULLAH SJW

20:00 Lying & standing BP carried out as charted. All other observations ok – NEWS 1. Offered tea & food but refused. SJW

2035 patient advised against going outside however has capacity and went outside for fresh air against medical advice. S Smith (SW)

25/8/23 00:05 GMAWS obtained. NEWS as charts. Scoring a 1 (2). BCDJ ready in ward. S Smith (SW) Hudsonnurse

00:10 IV Pabrinex given as prescribed. Pt states usually takes sertraline @ night and lamotrigine bd but not in Hepma, was prescribed for an outward

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name: 2505876061
Address: MCLEISH Wendy F
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
DOB: 25/05/1987
CHI Num G31 3LY

Communication with Relatives	Signatures	Time
Next of Kin: Tel:		

Nursing Notes

Date and Time		Print Name and Signature
25/5/23 0010	medical staff informed	

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name:
Address:

DOB:
CHI Number:

Nursing Notes

Date and Time		Print Name and Signature

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name:

Address:

DOB:

CHI Number:

Nursing Notes

Date and Time		Print Name and Signature

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name: _____

Address: _____

_____

DOB: _____

CHI Number: _____

Pause for Transfer (Please tick when completed)		Tick when completed	N/A	Notes
	Relatives Informed	☐	☐	Information on discussion with relatives
	Cannula	☐	☐	
	Name Band	☐	☐	
	4AT	☐	☐	
	NEWS >7	☐	Always	
Dr.: _____ Page no.: _____				
Prescriptions signed	Infusions	☐	☐	
	Drugs	☐	☐	
	Fluids	☐	☐	
	GMAWS	☐	☐	
GGC RED BAG - with patient		☐	☐	Please note here if any other tasks required prior to transfer
	Belongings (including patients medication)	☐	Always	
	Bed requested, accepted and ward informed/SBAR completed	☐	Always	
	Notes: medical notes, GP letter, PRF	☐	Always	
Investigations	CXR reviewed	☐		
	ECG reviewed	☐	☐	Print name
	Bloods sent	☐	☐	
	Bloods reviewed	☐	☐	
	Patient on 02: cylinder checked	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☐	Information on discussion with relatives
GGC RED BAG - with patient	☐	☐	
Belongings (including patients medication)	☐	Always	
New medications explained	☐	☐	
PVC removed	☐	☐	
Relatives aware of Discharge	☐	☐	Please note here if any other tasks required prior to discharge
Social/Support Services required and contacted	☐	☐	
SAS Transport required and ref. no.	☐	☐	Print name
Other means of transport arranged by nurse	☐	☐	

Document Owner: Pamela Cheung, AAU Team, GRI

Care Rounds Checklist

Date: 25/03/23

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (please circle) 1hr 2hr 3hr (4hr)

1. Signed NMcIntyre Name Neave McIntyre Designation SN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Att: [redacted] Photograph Label
2505876061
MCLEISH
Wendy F
25/05/1987

NHS Greater Glasgow and Clyde

"M... ent if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

			Times	0130	0540	1500	1830	2130													
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		Y	S	N	N	N													
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.		N	S	N	N	N													
S	3	**SKIN INSPECTION** Pressure areas checked:		N	N	N	N	N													
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		/	/	/	/	/													
K	4	**KEEP MOVING** Has the patient moved or walked?		Y	Y	Y	Y	Y													
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		B	B	D	B	B													
		Chair Assist to walk or stand (W/ST)		/	/	N	/	/													
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		I	I	I	I	I													
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?		N	N	N	N	N													
		Drink taken?		Y	S	Y	Y	Y													
		Food, snack, or supplement taken?		N	S	N	Y	Y													
		Has oral hygiene been carried out as per care plan?		N	I	N	N	N													
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		Y	Y	Y	Y	Y													
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.		N	S	NA	NA	N													
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.		NA	NA	NA	NA	NA													
			Care provider / role	NM	NM	NM	NM	NM													

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GGC0098

Care Rounds Checklist

Date: 26/3/23

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (please circle) 1hr 2hr 3hr (4hr)

1. Signed LBrea Name Laura Brea Designation HCSW
2. Signed [illegible] Name [illegible] Designation SCN
3. Signed _____ Name _____ Designation _____

Attach Ad
2505876061
MCLEISH
Wendy
F
25/05/1987

Ward: 46

LA

NHS Greater Glasgow and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

			Times	0800	1400	2000	0200	
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		S	N	N	N	2
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.		S	N	N	N	2
S	3	**SKIN INSPECTION** Pressure areas checked:		N	I	I		1
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		/	–	–	–	–
K	4	**KEEP MOVING** Has the patient moved or walked?		Y	Y	Y		4
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		B	B	F		4
		Chair Assist to walk or stand (W/ST)		/	–	/	–	–
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		I	I	I		1
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?		N	N	N		2
		Drink taken?		S		NT		2
		Food, snack, or supplement taken?		S		NT		2
		Has oral hygiene been carried out as per care plan?		S		N		2
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		Y	Y	Y		4
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.		S	N	NT		2
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.		NA	NA	N		2
		Care provider / role		[illegible]				

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

fm • 278936 v2.1 • CGC0098

LYING / STANDING BLOOD PRESSURE CHART

NHS Greater Glasgow and Clyde

Lying and Standing Blood Pressure (BP) measurement is a key intervention in falls prevention and management. It is best checked in the early morning.

Please check Lying and Standing BP as follows:

1. Lay the patient flat for at least 5 minutes. Take BP and record in 'L' column below.
2. Stand the patient up. Take BP and record in the '0 minutes' column below.
3. Keep patient standing for 3 minutes. Take BP at 1 minute and 3 minutes of standing and record in the appropriate columns below.
4. Record any patient symptoms at each BP measurement and record below. (eg. feels faint, dizziness, light-headedness, nausea, vomiting, unsteadiness, visual disturbance, loss of consciousness).

2505876061 F
MCLEISH 25/05/1987
Wendy
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

BP	Date: 24/3/23				Date: 25/3/23				Date: 25/3/23				Date:				Date:				BP
	Time: 2000				Time: 1017				Time: 1716				Time:				Time:				
	Sign: CT				Sign: H Bullen				Sign: H Bullen				Sign:				Sign:				
	L	S (minutes)			L	S (minutes)			L	S (minutes)			L	S (minutes)			L	S (minutes)			
		0	1	3		0	1	3		0	1	3		0	1	3		0	1	3	
250																					250
240																					240
230																					230
220																					220
210																					210
200																					200
190																					190
180																					180
170																					170
160																					160
150																					150
140												145									140
130		126	128		129				137	130											130
120	116			110		122	122	120			127										120
110																					110
100																					100
90																					90
80					88	85	84	82	82	80	80	89									80
70	72	91	77	76																	70
60																					60
50																					50
SYMPTOMS					NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL									SYMPTOMS

Glasgow Assessment and Management of Alcohol

Please Attach Patient Label

CHI: 2505876061 F
Name: MCLEISH Wendy 25/05/1987
Address
Postcode:

Estimated Weekly Alcohol Units : 2 units
Daily Units x Number of Days per Week)
Excessive Weekly Consumption >14 units/week

Estimated Date / Time Of Last Drink: ~~Sat~~ 3 weeks ago
(If ≥ 5 Days, Re-consider Alcohol Withdrawal Status)

Presents with or has had previous alcohol withdrawal seizures/ severely agitated withdrawal:

YES: ☐ NO: ☐

IS IT ALCOHOL WITHDRAWAL?

Consider alternative diagnoses such as delirium, encephalopathy, traumatic brain injury especially if symptoms atypical or prolonged (≥5 days since last alcohol)

Fast Alcohol Screening Tool - FAST:

Note : 1 drink = 1 unit of alcohol

1. MEN: How often do you have EIGHT or more drinks on one occasion?
   WOMEN: How often do you have SIX or more drinks on one occasion?

   Never ☐0 Less than monthly ☐1 Monthly ☑2 Weekly ☐3 Daily or almost daily ☐4

2. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

   Never ☑0 Less than monthly ☐1 Monthly ☐2 Weekly ☐3 Daily or almost daily ☐4

3. How often during the last year have you failed to do what was normally expected of you because of drinking?

   Never ☑0 Less than monthly ☐1 Monthly ☐2 Weekly ☐3 Daily or almost daily ☐4

4. In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

   No ☑0 Yes, on one occasion ☐2 Yes, on more than one occasion ☐4

Score of 3 or more: FAST Positive

Total 2

FAST Positive?

Yes ☐ No ☑

FAST 0-2:	Negative: No action required.
FAST 3-8:	Hazardous Drinking: Advise regarding safe drinking levels and offer information leaflet / advice.
FAST 9-16:	Probable Dependent Drinking: Advice as above and consider referral to Addiction Liaison Service.

EXCEPTIONAL PATIENT GROUP WITH CO-MORBIDITY?

Be aware of Patients with Co-morbidities presenting with features of Alcohol Withdrawal, especially:

- Patients with evidence of liver disease: especially jaundice, encephalopathy
- Patients with other co-morbidity (ie COPD, pneumonia, cerebrovascular disease, reduced GCS, elderly >70, head Injury; pregnancy)

REFER TO SECTION 3 (PAGE 3) FOR MANAGEMENT ADVICE

PLEASE INSERT IN PATIENT'S CASE RECORD ON COMPLETION OF TREATMENT

Copyright © : This is the property of NHS Greater Glasgow and Clyde. Free to be used across NHS UK. Do not remove logos. Content cannot be amended without permission

Order Number GGC0169

Prophylaxis and Treatment of Wernicke-Korsakoff Syndrome

The guidance applies to all alcohol use disorders; hazardous, harmful and dependent.

ASSESS FOR WERNICKE'S ENCEPHALOPATHY
Does the patient have any of the following signs/ symptoms?

- Confusion
- Ataxia
- Decreased consciousness
- Opthalmoplegia
- Nystagmus
- Hypothermia/ hypotension

YES → Presumptive diagnosis of Wernicke's Encephalopathy (if symptoms otherwise unexplained) **GO TO BOX A**

NO → Assess Risk of Wernicke's Encephalopathy **GO TO BOX B**

BOX A	Day 1-2	Day 3-5	Day 6 onwards
Presumptive Diagnosis of Wernicke's Encephalopathy: This requires URGENT treatment	**Pabrinex IV:** 2 pairs of vials three times a day. **Magnesium** Check Serum Magnesium URGENTLY and give intravenous replacement if deficient.	**Pabrinex IV/IM** 1 pair of vials three times a day	Change to **oral Thiamine** 50mg four times a day **or** continue IV/IM **Pabrinex** at discretion of Medical Team

BOX B	RISK FACTORS for WERNICKE'S	
	Risk Factors	**Severe Risk Factors**
Assessment of Risk of Wernicke's Encephalopathy	Weight loss (MUST=1) Poor diet or vomiting for <5 days Alcoholic Liver Disease Presents with Seizure Age ≤18 or ≥65	Severe Weight loss (MUST≥2) Poor Diet or vomiting for >5 days

No Risk Factors	One Risk factor	Two or more Risk Factors or any single Severe Risk Factor
Oral Thiamine 50mg four times a day	**Pabrinex IV/IM** 1 pair of vials three times a day for **24** hours then change to **oral Thiamine** 50mg four times a day	**Pabrinex IV/IM** 1 pair of vials three times a day for **48** hours then change to **oral Thiamine** 50mg four times a day

Check Magnesium in all patients and correct deficiency

Important notes

- If oral thiamine is indicated but a patient is unable to take medicines by mouth, then consult your ward pharmacist: NG administration may be possible or IM Pabrinex® (1 pair of vials once daily) are alternatives
- Intravenous Pabrinex® should be administered over 30 minutes
- Anaphylaxis is a rare complication of IV Pabrinex® administration and even more uncommon with IM administration. Monitor patient for wheeze, tachycardia, breathlessness and skin rash. Facilities for the administration of adrenaline and other resuscitation should be available.
- Additional vitamin supplementation as clinically indicated by responsible medical team in the context of a general nutritional assessment.
- Discontinuation of oral thiamine should be considered for patients who have been abstinent for 3 months and who have an adequate dietary intake.

Management of Alcohol Withdrawal Syndrome

1. DEPENDENT DRINKING ON SCREENING - HIGH RISK

EXCEPTIONAL PATIENT GROUP WITH CO-MORBIDITY?

- Patients with evidence of liver disease: especially jaundice, encephalopathy
- Patients with other co-morbidity (ie COPD, pneumonia, cerebrovascular disease, reduced GCS, elderly >70, head injury; pregnancy)

YES

NO

1. DEPENDENT DRINKING ON SCREENING - HIGH RISK

Any 2 of the following:

Presents with or has had previous withdrawal seizures or severely agitated withdrawal
High screening score (FAST ≥12)
High initial symptom score (GMAWS ≥4)

YES

FIXED DOSE TREATMENT (Section 2)
PLUS
SYMPTOM TRIGGERED TREATMENT (GMAWS)

NO

SYMPTOM TRIGGERED TREATMENT (GMAWS)

For exceptional patient groups see Section 3

2. FIXED DOSE TREATMENT REGIME: Oral Diazepam (see **Section 5** for patients unable to tolerate oral):

INITIAL DOSE: 20mg Diazepam 6 hourly

REDUCE DOSE: If after 24 hours no additional symptom triggered treatment has been required

OR

If after ≥48 hours of treatment GMAWS less than 4

REDUCING DOSE: (Not to be prescribed 24hrs in advance. Step down only if GMAWS remains less than 4)

15mg Diazepam 6 hourly for 24 hours
10mg Diazepam 6 hourly for 24 hours
5mg Diazepam 6 hourly for 24 hours
5mg Diazepam 12 hourly for 24 hours

3. EXCEPTIONAL PATIENT GROUPS: SYMPTOM TRIGGERED TREATMENT ONLY

- Patients with evidence of liver disease especially jaundice or encephalopathy: use oral **Lorazepam** in a symptom triggered fashion: 1-2 mg (up to 12mg in 24 hours, when senior medical review is required as below)
- Patients with other co-morbidity (i.e. COPD, pneumonia, cerebrovascular disease, reduced GCS, elderly (>70), head injury): use Lorazepam as above **OR** Diazepam at 50% of standard GMAWS dose
- In pregnancy use Diazepam at 50% of standard GMAWS dose with senior medical review if more than 30mg required in 24 hours

REVIEW PRESCRIPTION if patient is excessively drowsy

SENIOR MEDICAL REVIEW (ST3 or above) REQUIRED for diagnostic review and possible adjunctive therapy (Section 4): - If patient requires more than 120mg Diazepam in 24 hours
- If patient still requiring full dose treatment 96 hours after last alcohol ingestion

4. SEVERE WITHDRAWAL (aggressive/ uncontrollable/ dangerous behaviour)[1]

- Intravenous Diazemuls up to 40mg over first 30 minutes (up to 2mg/minute; flumazenil to be available) **(Section 5)**
- Adjunctive therapy with Haloperidol 2-5mg IM in first instance and response assessed **(refer to alcohol withdrawal section in the GGC Therapeutics Handbook regarding Haloperidol and patients with prolonged QTc)**
- Consultation regarding intensive care support may be necessary in extreme situations

5. PATIENTS UNABLE TO TOLERATE ORAL MEDICATION / PARENTERAL BENZODIAZEPINES

- Patients unable to tolerate oral medication may receive parenteral therapy as an alternative at 50% of the oral dose in the first instance, and response assessed
- Intravenous benzodiazepines should be administered by an experienced member of medical (FY2 or above) or nursing staff who have completed the appropriate Competency Training to administer IV sedation

6. MONITORING

- All patients should be closely observed for signs of over-sedation with regular observations
- Exceptional Patient Groups **(Section 3)**, patients with Severe Withdrawal **(Section 4)** and patients requiring parenteral sedation **(Section 5)** require close monitoring (NEWS) ideally with one-to-one nursing care

NHSGGC Guideline for use of Intramuscular Medication for Acutely Disturbed Behaviour in Mental Health and Associated Services

Glasgow Modified Alcohol Withdrawal Scale (GMAWS) **Treatment Option:** GMAWS Only ☐ GMAWS & Fixed Dose ☐

Date	24/3/23		25/3					25/3	25/3	26/3	26/3								
Time	1900	0000	0000	0830	1020	1730	1615	2030	2205	0300	0500								
Tremor 0) No tremor 1) On movement 2) At rest	0	0	0	1	0	0	0	0	0	0	0								
Sweating 0) No sweat visible 1) Moist 2) Drenching sweats	0	0	0	0	0	0	0	0	0	0	0								
Hallucination 0) Not present 1) Dissuadable 2) Not dissuadable	0	0	0	0	0	0	0	0	0	0	0								
Orientation 0) Orientated 1) Vague, detached 2) Disorientated, no contact	0	0	0	0	0	0	0	0	0	0	0								
Agitation 0) Calm 1) Anxious 2) Panicky	0	0	0	0	0	0	0	0	0	0	0								
Score	0	0	0	1	0	0	0	0	0	0	0								
Treatment	Nil	NiL	NiL	10 diaz.	NIL	N/L	NIL	Nil	Nil	Nil	Nil								
Staff Signature	AL	SS	SS	HB HW	HB	HB	HW HB	SS	SS	SD	SD								

2505876061
MCLEISH
Wendy F
FLAT 3/2 25/05/1987
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

Score: (Do not use scoring tool if patient intoxicated, must be at least 8 hours since last drink.)

0 :Repeat Score in 2 hours (Discontinue after scoring on 4 consecutive occasions, except if less than 48hrs after last drink)
1 – 3 :Give 10mg Diazepam: Repeat Score in 2 hours
4 – 8 :Give 20mg Diazepam : Repeat Score in 1 hour
9 – 10 :Give 20mg Diazepam ; Repeat Score in 1 hour

EXCEPTIONAL PATIENT GROUPS: SYTMPTOM TRIGGERED TREATMENT
Patients with evidence of liver disease especially jaundice or encephalopathy: use oral **Lorazepam 1-2 mg**
Patients with other co-morbidity (i.e. COPD, pneumonia, cerebrovascular disease, reduced GCS, elderly (>70), head injury): use Lorazepam as above OR Diazepam at 50% of standard GMAWS dose.
In pregnancy use Diazepam at 50% of standard GMAWS

PATIENTS MAY REQUIRE TO BE WOKEN FOR CONTINUING ASSESSMENT
CO-EXISTING ILLNESS MAY AFFECT SCORE: SEEK MEDICAL ADVICE IF IN DOUBT
FIXED DOSING & SYMPTOM TRIGGERED DOSING MUST BE NO LESS THAN 1 HOUR APART

All patients should have regular observations documented. Patients receiving high doses of Diazepam should be assessed regularly for over sedation. If a patient requires more than 120 mg of diazepam or 12 mg of lorazepam in 24 hrs a senior medical review and consideration of adjunct therapy (Section 4) is required

APPROXIMATE ORAL BENZODIAZEPINE EQUIVALENCE: 10mg Diazepam = 1mg Lorazepam = 25mg Chlordiazepoxide
Patients should not be discharged on regular benzodiazepine

Developed by the Acute Alcohol Screening & Withdrawal Management Guideline Group Chaired by Dr Ewan Forrest, Consultant Physician and Gastroenterologist, GRI
Copyright © : This is the Property of NHS Greater Glasgow and Clyde. Free to be used across NHS UK. Do not remove logos. Content cannot be amended without permission
Published: August 2020
Review Date: January 2023
Version: 5th Edition Amendment

2505876061
MCLEISH
Wendy
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY
F
25/05/1987

P[illegible]ient) Moving and Handling Assessment Form

Person's Name:	Named Nurse: neave mcintyre	Person is totally independent (tick here and go to date box)

1. Gen[illegible]nformation

Body Build		Problems with comprehension, behaviour, co-operation (specify):
Weight	Height	
Kg	cm	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
BMI		
Risk of Falls: Yes ✓	No	

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 / 2 / ≥3	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 / 2 / ≥3	Additional Information:	✓

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N/A
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 / 2 / ≥3	Additional Information:	✓
	Monkey pole			
	Independent bridging			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 / 2 / ≥3	Additional Information:	✓
	Monkey pole			
	Rope ladder			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 / 2 / ≥3	Additional Information / Equipment (eg sliding sheets):	✓
	Other (Please specify)			

7. Sit up over side of bed

	Bed Rest	Assistance	Supervision	Independent
		People: 1 / 2 / ≥3	Additional Information / Equipment (eg rope ladder, swivel cushion):	✓

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair	People: 1 / 2 / ≥3	Additional Information / Equipment (eg sling lifting hoist after risk assess):	✓
Variable / Fixed height bath	Shower trolley			
Bed bath	Bathing hoist (eg Alerti)			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 / 2 / ≥3	Additional Information / Equipment (eg hoist with walking sling dist. Walked)	✓

10. Other Instructions / Observations / Equipment Used

Recent falls unsteady on feet

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:	25/05/23		
Assessor's signature:	N McIntyre		
Proposed Review date:			

Continuation Sheet

1. General Information (Only complete this section if changed from over page)

Body Build		Problems with comprehension, behaviour, co-operation (specify):
Weight	Height	
Kg	cm	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
BMI		
Risk of Falls: Yes	No	

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 / 2 / ≥3	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 / 2 / ≥3	Additional Information:	

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N/A
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 / 2 / ≥3	Additional Information:	
	Monkey pole			
	Person bridges			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 / 2 / ≥3	Additional Information:	
	Monkey pole			
	Rope ladder			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 / 2 / ≥3	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify)			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 / 2 / ≥3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair	People: 1 / 2 / ≥3	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley			
Bed bath	Bathing hoist (eg Alerit)			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 / 2 / ≥3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	4th Assessment	5th Assessment	6th Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

2505876061
MCLEISH
Wendy
F
25/05/1987

CHI: _____
Address: _____
Hospital: _____

NHS Greater Glasgow and Clyde

Insertion criteria: Please complete this section at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☐ **Resuscitation/Chest Pain** ☐ **IV Drugs** ☐ **Fluids** ☐ **Transfusion** ☐

PVC inserted: Day 0	Date: 24/3/23 Hospital: _____ Area: ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☐ _____ Unknown ☐ _____
Insertion site:	R Hand ☐ R Arm ☐ R Foot ☐ L Hand ☐ L Arm ☑ L Foot ☐ Other: _____
Colour of cannula:	Blue ☐ Pink ☑ Green ☐ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: verbal

PVC Maintenance Check	**Does the Patient require this PVC for any of the DRIFT criteria?** Diagnostics Resuscitation/ Chest Pain IV Drugs Fluids Transfusion	**VIP score: (See Chart on back of care plan)** **If ≥ 2 remove PVC and record reason*.**	**Is the PVC dressing intact?**	**If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)**	**Initial**
Day 1 Check 1 Day 25/3/23	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☐ N/A ☑	HB
Day 1 Check 2 Night 25/3/23	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☐ N/A ☑	ES
Day 2 Check 1 Day __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: __/__/__ **Reason for keeping PVC in after 72 hrs/ 3 days:** _____

***Date PVC Removed:** __/__/__

***Reason For Removal:** _____

Modified Visual Infusion Phlebitis (VIP) Score

Modified V.I.P (Visual Infusion Phlebitis) Score	
IV site appears healthy	0
One of the following is evident : slight pain or redness near site	1 Possible first signs. Observe cannula
Two or more of the following are evident: pain, redness, swelling	[illegible]
All of the following are evident: pain, redness, hardening of surrounding tissue	[illegible]
As above including: palpable venous cord	[illegible]
As above including: pyrexia	[illegible]

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and S. aureus bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids ? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → Can I switch my patient from IV to oral antibiotics?

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature ≤ 37.9°C, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE is available reliably** (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST): Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, S. aureus bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abcess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy. Record the intended duration on the medicine kardex

YES

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

NO

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

2505876061 MCLEISH Wendy F 25/05/1987	Hospital: GRI Ward: 46	**Points to consider:** • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

1 Pressure Damage	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan overleaf.

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2 Mobility	Does the person require assistance to mobilise?
3 Continence	Does the person have continence issues with urine and/or faeces?
4 Nutrition	Does the person appear malnourished and/or unable to eat or drink?
5 Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?
6 Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY pressure relieving care interventions and complete the pressure ulcer interventional plan overleaf.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
25/03/23	01:30	n	y	n	n	n	n	4hrly	NM
26/03/23	05:00	n	y	n	n	n	n	4hrly	ES
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	

Complete prevention of pressure ulcer interventional plan overleaf for all patients with redness/pressure damage and for those at risk.

Prevention of Pressure Ulcer Interventional Plan

NHS Greater Glasgow and Clyde

Attach Addressograph

Aim: To incorporate effective pressure ulcer prevention strategies to reduce/eliminate potential for pressure ulcer development.

Outcome: To prevent pressure ulcer development through establishment of effecting work practices in line with SSKINS bundle.

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____

2505876061 F
MCLEISH 25/05/1987
Wendy

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date_____ Time_____ of initial height and weight on admission to hospital *Pt report*		Actual	*Patient reported	*If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height	52 cm	☐	☐	
Admission Weight	14 stone kg	☐	☐	

*Obtain accurate height/weight and rescreen as soon as possible

Patients reported normal weight _____ Unable to Recall ☐

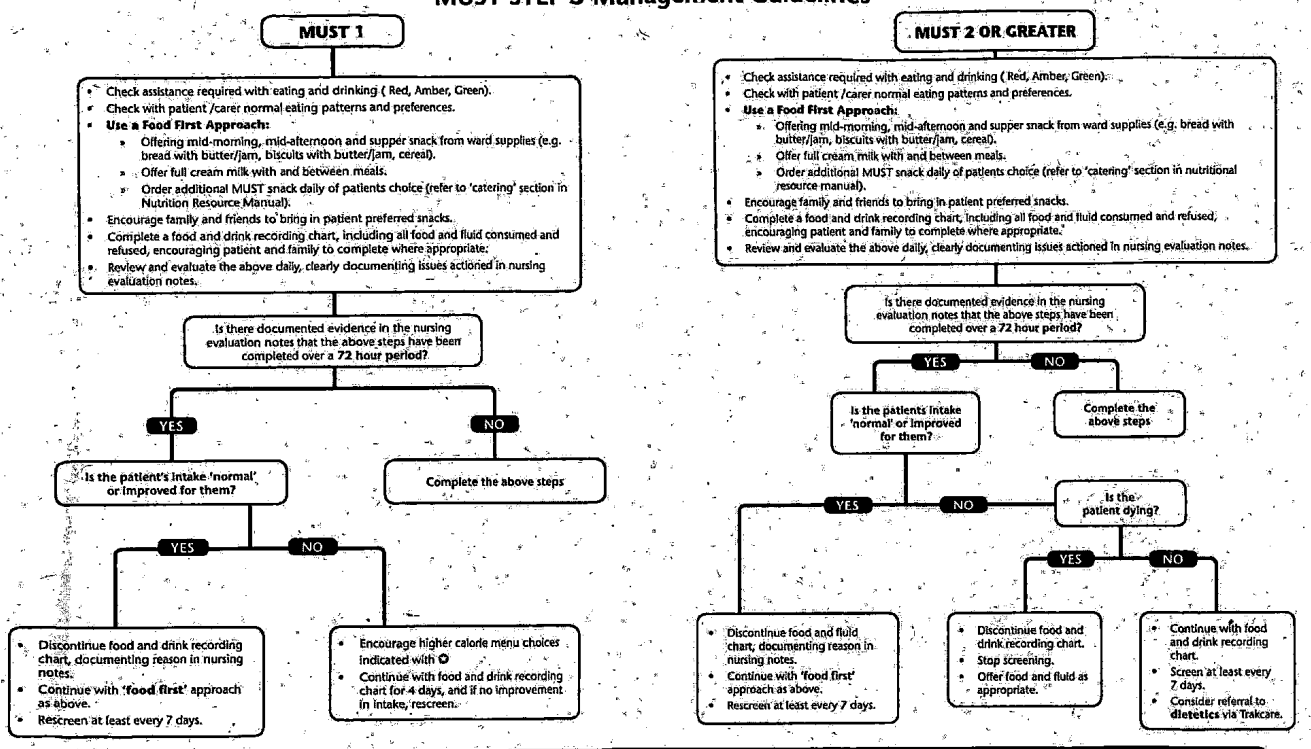
Any unplanned weight loss in the last 6 months Yes ☐ how much_____ No ☐ Don't Know ☐

Date								
Time								
Ward								
Oedema/ Ascities present Y/N								
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes								
Weight (kgs)								
BMI								
Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days								
Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2								
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2								
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0								
Step 4 Overall Risk of Malnutrition TOTAL								
Rescreen on								
Signature								

Step 5 Management Guidelines (excludes patients who are Nil by Mouth)

Overall Risk of Malnutrition	Ensure plan of care for specific nutritional requirements, MUST score and plans to improve / increase nutritional intake are documented in the patients care plan
0	**LOW RISK** - Repeat screening every 7 days
1	**MEDIUM RISK** - Follow the flowchart for MUST 1 overleaf
2 or greater	**HIGH RISK** - Follow the flowchart for MUST 2 or greater overleaf

MUST STEP 5 Management Guidelines



DISCHARGE

If the patient is due for discharge and concerns remain regarding their oral intake, provide NHSGGC "*Eating to Feel Better" booklet discussing the reason why the information is being given e.g. reduced appetite and / or weight loss before or during hospital admission.

www.nhsggc.org.uk/patients-and-visitors/information-for-patients/food-in-hospital/discharge-from-hospital/

mi • 285884 v3.0 • GCC0250

NHSGGC Bedrail Risk Assessment

2505876061
MCLEISH
Wendy
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY
F
25/05/1987
IHS
ter Glasgow
nd Clyde

This Risk Assessment Tool is an aide memoire for staff. It should be used in conjunction with the Bedrail Guidance (see reverse) and Guidelines for Falls Prevention and Management (Adults).

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT

Patient Name:

CHI Number:

	Use guidance on the reverse of this document when completing this Risk Assessment								
		DATE	24/3/23		25/3/23				
		TIME	17.17		01.30				
		WARD	ANDM		46				
		HOSPITAL	CRH		GRI				
	SECTION ONE – GENERAL		Y	N	Y	N	Y	N	Y	N
1	Is the patient likely to fall, roll, slip or slide from the bed?			✓		✓				
2	Has the patient requested the use of bedrails?			✓		✓				
	IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED									
	SECTION TWO – COGNITIVE AND PHYSICAL STATUS									
3	Is the patient at risk of climbing out of bed?			✓	✓					
4	Is the patient stressed, delirious or restless?			✓		✓				
5	Is the patient small in stature?			✓		✓				
6	Does the patient have an unusually large or small head that might present an entrapment issue?			✓		✓				
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?		✓			✓				
	IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
	SECTION THREE – COMMUNICATION									
8	Has the patient been consulted regarding the use of bedrails?		✓		✓					
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition		✓		✓					
10	Has the use of bedrails been discussed with relatives/carers?		✓		✓					
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?			✓		✓				
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?		✓			✓				
	IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
	SECTION FOUR – DECISION MAKING		Y	N	Y	N	Y	N	Y	N
13	Will bedrails be used for this patient at the present time?			✓	✓					
14	Rationale for use of bedrails: (Please insert code in the box on the right)									
	A – Risk of falling from the bed									
	B – Risk of rolling from the bed									
	C – Risk of slipping from the bed									
	D – Risk of sliding from the bed									
	E – Patient request									
15	Bedrail risk assessment completed by:		[redacted]		[redacted]					
16	Bedrails checked by:		[redacted]		[redacted]					
17	Date		24/3/23		25/3/23					

Any issues relating to the use of bedrails including discussion with family/relatives/carers should be recorded here

One side of bedrail in use

A. Alternatives to bed rails:-

- Move the patient to a more observable area
- Increase patient observation
- Ensure the bed is returned to the lowest height appropriate to the patient needs, after care delivery
- Ensure patient needs are anticipated e.g. drinks are accessible, regular toileting, call bell to hand
- Nursing patient on mattress on the floor should be the last resort, and safety checks should be made for hot pipes, trailing wires, electrical sockets etc
- A generic moving and handling assessment must be carried out for staff caring for patients nursed on mattress on the floor.
- Contact Hospital Falls team for advice where appropriate

B. If bedrails are to be used, please consider the following:-

Is patient:-

- Stressed, delirious or restless
- At risk of entrapment
- At risk of climbing over the top of the bed rail
- At risk of being psychologically affected by the use of the bed rail

C. Safe use and application of bedrails:-

- If bedrail is fitted and there is a gap between the lower rail and the mattress then a bedrail should not be used
- If the gap between the bars on the bedrail is greater than 12cm then a bedrail should not be used
- If the bedrail moves away from the side of the mattress then a bedrail should not be used
- If the gap between the bedrail and the headboard is between 6cm and 25cm then a bedrail should not be used
- If the gap between the bedrail and the footboard is between 6cm and 25cm then a bedrail should not be used
- If the bedrail has not been fitted correctly then the bedrail should not be used
- If the bedrail is not secure then the bedrail should not be used
- If the bedrail is not compatible with the frame it will be fitted to then a bedrail should not be used
- If the bedrail is not in good working order then the bedrail should not be used

D. Record keeping:-

All of the following should be recorded:-

- Date and time of assessment
- Bedrail information leaflet given to patient and-or next of kin
- Rationale for decision in care plan or in AWI treatment plan
- Where bedrails are considered appropriate and patient has declined their use
- Any other actions implemented
- Care planning should be reviewed and updated as per record keeping standards

Bedrail risk assessments should be made as follows:-

- On admission
- If patient's condition changes or fall / suspected fall from bed
- Daily/weekly depending on the patient's status

2505876061
MCLEISH F
Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs of Admission and on Transfer to Another Ward

NHS Greater Glasgow and Clyde

GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

Action the following safety precautions on admission to your ward. Update weekly or on change of condition.

	Ward: AMU Date: 24/3/23 Time: 19:00	Ward: 46 Date: 25/03/23 Time: 01:30	Ward: Date: Time: --:--	Ward: Date: Time: --:--	Ward: Date: Time: --:--
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	Independent ~~Supervision~~	Independent Supervision			
2. Check walking aid (if required) is in reach and in use.	N/A	N/A			
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	within reach	in reach in use			
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	✓	Yes			
5. If glasses are worn, check they are available and in use.	N/A	N/A			
6. If hearing aid/s are worn, check they are working and in use.	N/A	N/A			

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).
Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.
ALL patients in older people's wards must have an interventional plan in place (overleaf)

Tick Yes or No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has the patient fallen in the last 6 months – including during this admission?	✓		✓							
2. Does the patient have cognitive impairment or a possible delirium?		✓		✓						
3. Does the patient attempt to walk alone although unsteady or unsafe?	✓		✓							
4. Does the patient or their relative have a fear or anxiety of the patient falling?	✓		✓							
5. Based on your clinical judgement, is this patient at high risk of falling?	✓		✓							
Signature of nurse completing assessment / update	[signature]		[signature]							

Highlight risk of fall at the ward safety brief.

2505876061
MCLEISH F
Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

FALLS INTERVENTION CHECKLIST

NHS Greater Glasgow and Clyde

Complete for all patients identified at risk of falling.

	Ward: RNM Date: 24/3/23 Time: 17.17	Ward: 16 Date: 25/8/23 Time: ----	Ward: Date: Time:	Ward: Date: Time:	Ward: Date: Time:
BED AND SEATING					
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)	Safe height				
Assess if a low bed is required (Patient care plan 9)	N/A				
SAFETY					
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)	complete				
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)	Rnd				
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.	Buzzer at hand				
HEALTH					
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)	N/A				
Document continence problems and link to care rounding (Patient care plan 6)	ongoing				
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)	N/A				
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.	N/A				
COMMUNICATION					
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)	N/A				
Update the ward team of the patient's mobility status. (Patient care plan 8)	Handover				
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)	Attended				
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)	N/A				
Signature of nurse completing interventional plan / or update	[redacted]				

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team
EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

2505676061
MCLEISH F
Wendy 25/05/1987
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

	Date	Ward	Time
Admitted	24/3/23	AMU	18:12
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP initials ONLY:	Dr/ANP initials ONLY:	
Date:	Date:	

Document all actions and interventions

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
	Low Clinical Risk	Medium Clinical Risk	High Clinical Risk
Min 12 Hourly Observations	Min 4 Hourly Observation	Min Hourly Observations	Continuous Monitoring
	Inform Registered Nurse	Urgent Assessment by Medical Team	Urgent Assessment by Senior Medical Team
	Agree Frequency of Observation Required	ACE Response in Medical Notes	ACE Response in Medical Notes
		Think Sepsis If Suspicion of Infection	Consider 2222

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes

Discontinuation of NEWS

Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Signed.....

Medical: .....

Date:.....

Glasgow Coma Scale

Pupil Reaction and size: s = sluggish, + = reaction, - = no reaction, c = eyes closed. Pupil Size (mm): 1 2 3 4 5 6 7 8

| | Date | | |

NEWS 2 Key | 1 | 2 | 3

Date 24/3/2023 | Time 13:12

2505876081
MCLEISH
Wendy
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY
F
25/05/1987

A + B Respirations Breaths/min

≥25	3
21-24	2
12-20	0
9-11	1
≤8	3

A + B SpO2 Scale 1 Oxygen saturation (%)

≥96	0
94-95	1
92-93	2
≤91	3

SpO2 Scale 2 Hypercapnic target range 88 - 92%

Only use scale 2 under direction of qualified clinician

≥97 on O2	3
95-96% on O2	2
93-94% on O2	1
≥93 on air	0
88-92	0
86-87	1
84-85	2
≤83	3

Air or oxygen?

Air (A) or O2 device*	0
O2 L/min 2	2

C Blood Pressure mmHg

(Score uses systolic BP only)

≥220	3
201-219	0
181-200	0
161-180	0
141-160	0
121-140	0
111-120	0
101-110	1
91-100	2
81-90	3
71-80	3
61-70	3
51-60	3
≤50	3

C Pulse Beats/min

≥131	3
121-130	2
111-120	2
101-110	1
91-100	1
81-90	0
71-80	0
61-70	0
51-60	0
41-50	1
31-40	2
≤30	3

D Any changes in neuro response, do CCS. Immediate medical review. Check Blood Glucose. Think Delirium.

A Alert	0
C New Confusion	3
V Verbal	3
P Pressure	3
U Unresponsive	3

E Temperature

≥39	2
38.1-39.0	1
37.1-38.0	0
36.1-37.0	0
35.1-36.0	1
≤35.0	3

NEWS Total

Abbreviations for recording oxygen device

A	Room Air
N	Nasal Cannulae
SM	Simple Mask
V	Venturi Mask and % eg V24
NIV	Non Invasive Ventilation
IV	Invasive Ventilation
T	Tracheostomy
CP	CPAP Mask
HFN	High Flow Nasal Oxygen
NEB	Nebuliser
RM	Reservoir Mask (Emergency use only)

2505876081
MCLEISH
Wendy
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY
F
25/05/1987

Blood glucose	2.0
Pain / Infection score	DA
Time Pt last passed urine	10.20
Fluid balance chart indicated Y/N	N
CCS initiated Y/N	N
Time NEWS due	23.00
Escalation criteria Y / N	N
Initials	AB

NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

1. Give oxygen to target saturation >94% (COPD 88-92%)
2. IV fluids up to 20ml/kg
3. Take blood cultures
4. Measure lactate and FBC
5. Give IV antibiotics
6. Monitor urine output and fluid balance chart

THINK ACE

A	Action: Working diagnosis (consider SEPSIS). Consider frequency of observations. Management plan. Set review time. Document.
C	Communicate: Inform nurse of plan. Inform senior medic if necessary. Document the discussion.
E	Escalate: Document the treatment escalation plan. Should include need for next level of care & consideration of resuscitation status.

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

2505876061
MCLEISH
Wendy
126 LIBERTON ST
Glasgow, Lanarkshire
G33 2HJ
F
25/05/1987

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y ☐ N ☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP initials ONLY:	Dr/ANP initials ONLY:	
Date:	Date:	

Document all actions and interventions

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
	Low Clinical Risk	Medium Clinical Risk	High Clinical Risk
Min 12 Hourly Observations	Min 4 Hourly Observation	Min Hourly Observations	Continuous Monitoring
	Inform Registered Nurse	Urgent Assessment by Medical Team	Urgent Assessment by Senior Medical Team
	Agree Frequency of Observation Required	ACE Response in Medical Notes	ACE Response in Medical Notes
		Think Sepsis if Suspicion of Infection	Consider 2222

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes

Discontinuation of NEWS

Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Signed .....

Medical: .....

Date: .....

| | | |

17

WENDY MCLEISH

NEWS 2 Key	1	2	3

| Date | 2020 | 1/11 | 8/12 | | | | | 9/12 | | | | |

Glasgow Coma Scale

| | | |

Care Rounds Checklist

Date: 9/12/20

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (please circle) 1hr 2hr 3hr 4hr

1. Signed [signature] Name Laura Daw Designation SN
2. Signed N. Finnigan Name N. Finnigan Designation SN
3. Signed _____ Name _____ Designation _____

Attach Addr

2505876081
MCLEISH
Wendy
F
25/05/1987

NHS Greater Glasgow and Clyde

Ward:

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

No Thanks

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	0145	0300	0330	0800	1330	1810												
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N												
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N												
S	3	**SKIN INSPECTION** Pressure areas checked:	N	N	N	NT	NT	N												
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	-	-	/	/	/	/												
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y	Y												
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	R	R	B	I	I	I												
		Chair Assist to walk or stand (W/ST)	I	W	SS	I	I	I												
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	I	I	I	I	I												
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N												
		Drink taken?	S	Y	Y	Y	Y	I												
		Food, snack, or supplement taken?	S	NT	Y	Y	Y	I												
		Has oral hygiene been carried out as per care plan?	I	-	I	I	I	I												
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y												
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	S	NT	N	NT	NT	N												
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA	NA												
		Care provider / role	SN	SN	SN	PN	PN	PN												

Care Rounds Variance Sheet

Attach Addressograph Label
Ward:

NHS Greater Glasgow and Clyde

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GGC0098

Care Rounds Checklist

Date: 8/12/20

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (please circle) 1hr 2hr 3hr 4hr

1. Signed _____ Name Emerald Designation SN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attach 2505876081 F MCLEISH Wendy 25/05/1987

Ward:

NHS Greater Glasgow and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

			LS																		
		Times	90	2230																	
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	2	2																	
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	2	2																	
S	3	**SKIN INSPECTION** Pressure areas checked:	1	2T																	
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	1	-																	
K	4	**KEEP MOVING** Has the patient moved or walked?	1	2																	
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	1	B																	
		Chair Assist to walk or stand (W/ST)	1	-																	
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	1	2																	
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	2	2																	
		Drink taken?	4	1																	
		Food, snack, or supplement taken?	4	2																	
		Has oral hygiene been carried out as per care plan?	2	-																	
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	4	1																	
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	2T	2T																	
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.																			
		Care provider / role		SN																	

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GGC0098

Fluid Balance Chart

2505876061 F
MCLEISH 25/05/1987
Wendy

Hospital: Crumlin
Ward: 50 Resp
Date: 9.12.20

Reason for Fluid Balance Chart: Observation
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____

Fluid balance from previous 24hrs
+/- _____

Does patient require thickened fluids?
Yes ☐ No ☐ Stage _____

Is the patient on an oral supplement? Yes ☐ No ☐ If YES please Indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: SCA

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00										PU							
02:00																	
03:00																	
04:00																	
05:00										PU							
06:00																	
07:00	Breakfast	200							200								
08:00																	
09:00																	
10:00	Juice	150							350	PU							
11:00																	
12:00	Lunch	200							550								
13:00																	
14:00																	
15:00																	
16:00																	
17:00																	
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
								*Total Intake							*Total Output		

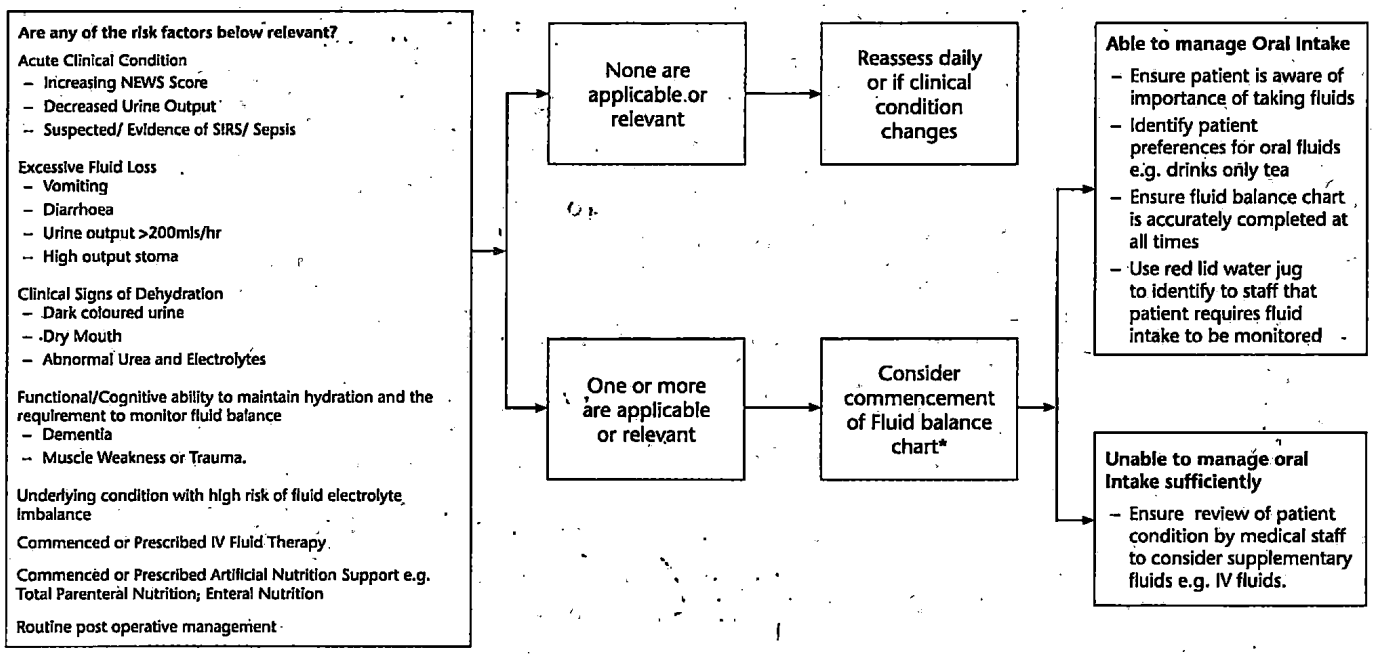
*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS • EDU • 237971-2

Fluid Balance Chart

Na 2505876051
Dc MCLEISH
Wendy F
C 126 LIBERTON ST 25/05/1987
Glasgow, Lanarkshire
A G33 2HJ

Hospital: QEU
Ward: 50
Date: 8/12/20

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids? Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume	INPUT							OUTPUT	
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
08:00																	
09:00																	
10:00																	
11:00																	
12:00																	
13:00																	
14:00																	
15:00																	
16:00																	
17:00																	
18:00	Water 100									UTT							
19:00																	
20:00																	
21:00	Stuff (Lofycad)																
22:00																	
23:00																	
								*Total Intake	[redacted]						*Total Output	[redacted]	

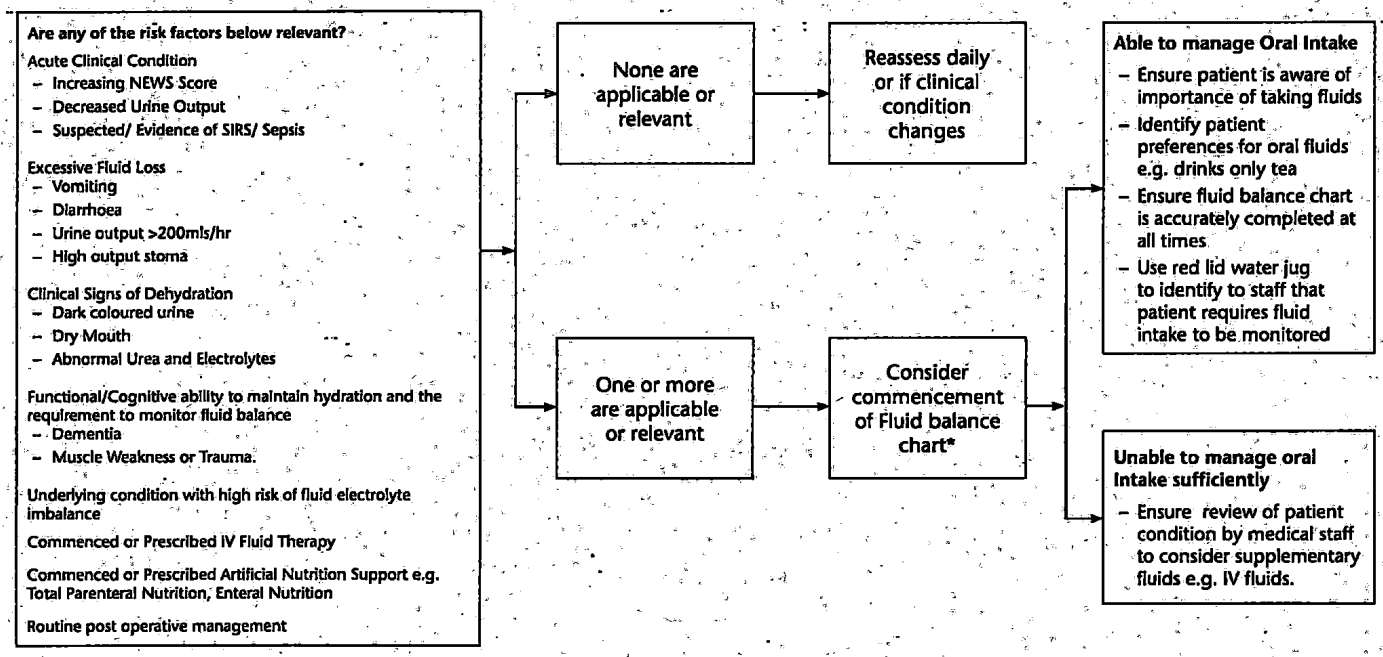
*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS • EDU • 237971-2

2505676061
MCLEISH
Wendy
F
25/05/1987

PATIENT DETAILS:
NAME:
DOB:
UN:

Date	No	Problem/Need	Patient Goal/Nursing Outcome	Action	Eval. date	Sig.
8/12	1.	Orientation. 4AT AMT:	▪Familiarise patient with new surroundings. ▪Detect signs of new/increasing confusion. ▪Treat cause(s) of confusion.	▪Introduce yourself and other staff on admission. ▪Show patient ward layout as soon as mobile. ▪Observe for changes in mental state-consider behaviour chart. ▪Carry out relevant investigations. ▪Commence TIME bundle.		
	2.	Observations.	▪Record NEWS. ▪Detect abnormalities and escalate as per deteriorating patient protocol.	▪Ensure appropriate baseline observations are obtained, then repeated as indicated on NEWS chart. ▪Ensure frequency of recordings is marked on observation chart and reviewed following each NEWS score. ▪Use variance section on back page if required.		
	3.	Hydration and Nutrition.	Ensure fluid and nutrition requirements are met.	▪Complete MUST ▪If problems are detected: ▪Refer to dietician ☐ date: ▪If patient requires special diet, ensure this is ordered and available ☐ date: ▪Assess RAG status ☐ date: ▪Consider 3 day food chart ☐ date:		

Date	No	Problem/Need	Patient Goal/Nursing Outcome	Action	Eval date	Sig
8/12	4.	Elimination.	▪Maintain normal elimination where possible and assess need for appropriate intervention where required.	▪Bristol Stool Chart ☐ ▪Urinary Catheter Care Plan ☐ ▪Maintain privacy and dignity at all times. ▪Promote hand hygiene following use of toilet.		
	5.	Mobility.	▪Optimise mobility.	▪Assess and record baseline mobility on M+H assessment. ▪If potential for improvement, refer to physio: Referred to physio: ☐ Date:		
	6.	Patient Hygiene.	☐ Independent with ADLs.	▪Provide any supplies required and inform of options for washing		
			☐ Requires some assistance with ADLs.	▪Assess patient and offer either: ▪Assisted wash at bedside or, ▪Assisted shower / bath.		
			☐ Requires all care	▪Provide bed-bath and oral hygiene with two nurses.		
	7.	Oral Hygiene	☐ Independent with ADLs.	▪Provide any supplies		
			☐ Requires some assistance with ADLs.	▪Assist with tooth brushing/denture cleaning/mouth care as require. Delete as appropriate.		
			☐ Requires all care	▪Ensure 2-3 hour mouth care is completed using pink sponges and appropriate cleansing agent. ▪Apply lubricant to lips.		

Written by:
30/05/20Review date:

Cannula

2505876061
MCLEISH
Wendy
126 LIBERTON ST
Glasgow, Lanarkshire
G33 2HJ

Female
25/05/1987

Write or affix patient label

Name: _____ CHI: _____

DOB: _____ Address: _____

Ward: _____ Hospital: _____

NHS Greater Glasgow and Clyde

Insertion criteria: Please complete this section at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☐ Resuscitation/Chest Pain ☐ IV Drugs ☑ Fluids ☑ Transfusion ☐

PVC inserted: Day 0	Date: 6.12.20 Hospital: GRI Area: ED ☐ Theatre ☑ ITU/HDU ☐ Ward ☐ _____ Unknown ☐
Insertion site:	R Hand ☐ R Arm ☑ R Foot ☐ L Hand ☐ L Arm ☐ L Foot ☐ Other: _____
Colour of cannula:	Blue ☐ Pink ☑ Green ☐ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: Verbal

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? (Diagnostics, Resuscitation/ Chest Pain, IV Drugs, Fluids, Transfusion)	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day 9/11/20	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☐ N/A ☑	nl
Day 1 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: ___/___/___ Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: ___/___/___

*Reason For Removal: _____

Modified Visual Infusion Phlebitis (VIP) Score

Modified V.I.P (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phlebitis : Observe cannula
One of the following is evident : slight pain or redness near site	1	Possible first signs : Observe cannula
Two or more of the following are evident: pain, redness, swelling	2	Early stage of phlebitis : Remove & resite cannula
All of the following are evident: pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: Remove & resite cannula Seek further advice
As above including: palpable venous cord	4	
As above including: pyrexia	5	

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and S. aureus bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids ? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → Can I switch my patient from IV to oral antibiotics?

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature ≤ 37.9°C, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE** is available reliably (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, S. aureus bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abcess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy.
Record the intended duration on the medicine kardex

YES

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

NO

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

2505876061 MCLEISH Wendy F 126 LIBERTON ST 25/05/1987 ography Glasgow, Lanarkshire G33 2HJ	Hospital: GRI Ward: 50	**Points to consider:** • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

1 Pressure Damage	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan overleaf.

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2 Mobility	Does the person require assistance to mobilise?
3 Continence	Does the person have continence issues with urine and/or faeces?
4 Nutrition	Does the person appear malnourished and/or unable to eat or drink?
5 Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?
6 Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY pressure relieving care interventions and complete the pressure ulcer interventional plan overleaf.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
6/12/20	18:45	N	N	N	N	N	N	4 hrly	
9/12/20	01:45	N	N	N	N	N	N	4 hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	

Complete prevention of pressure ulcer interventional plan overleaf for all patients with redness/pressure damage and for those at risk.

Prevention of Pressure Ulcer Interventional Plan

NHS Greater Glasgow and Clyde

Attach Addressograph

Aim: To incorporate effective pressure ulcer prevention strategies to reduce/eliminate potential for pressure ulcer development.

Outcome: To prevent pressure ulcer development through establishment of effecting work practices in line with SSKINS bundle.

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____

2505876061
MCLEISH F
Wendy 25/05/1987
126 LIBERTON ST
Glasgow, Lanarkshire
G33 2HJ

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date 9/12/20 Time 07:08 of initial height and weight on admission to hospital		Actual	*Patient reported	*If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height	5ft 2 cm	☐	☑	
Admission Weight	80.4 Kg	☑	☐	

*Obtain accurate height/weight and rescreen as soon as possible

Patients reported normal weight _____ Unable to Recall ☐

Any unplanned weight loss in the last 6 months Yes ☐ how much_____ No ☐ Don't Know ☐

Date	09/12/20							
Time	07:08							
Ward	53							
Oedema/ Ascities present Y/N	N							
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes	CH							
Weight (kgs)	80.4							
BMI	32.6							
Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days								
Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	0							
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	0							
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	0							
Step 4 Overall Risk of Malnutrition TOTAL	0							
Rescreen on	16/12/20							
Signature	SM							

Step 5 Management Guidelines (excludes patients who are Nil by Mouth)

Overall Risk of Malnutrition	Ensure plan of care for specific nutritional requirements, MUST score and plans to improve / increase nutritional intake are documented in the patients care plan
0	LOW RISK - Repeat screening every 7 days
1	MEDIUM RISK - Follow the flowchart for MUST 1 overleaf
2 or greater	HIGH RISK - Follow the flowchart for MUST 2 or greater overleaf

MUST STEP 5 Management Guidelines

MUST 1

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient /carer normal eating patterns and preferences.
- **Use a Food First Approach:**
  - Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
  - Offer full cream milk with and between meals.
  - Order additional MUST snack daily of patients choice (refer to 'catering' section in Nutrition Resource Manual).
- Encourage family and friends to bring in patient preferred snacks.
- Complete a food and drink recording chart, including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a 72 hour period?

NO → Complete the above steps

YES → Is the patient's intake 'normal' or improved for them?

YES
- Discontinue food and drink recording chart, documenting reason in nursing notes.
- Continue with 'food first' approach as above.
- Rescreen at least every 7 days.

NO
- Encourage higher calorie menu choices indicated with ✪
- Continue with food and drink recording chart for 4 days, and if no improvement in intake, rescreen.

MUST 2 OR GREATER

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient /carer normal eating patterns and preferences.
- **Use a Food First Approach:**
  - Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
  - Offer full cream milk with and between meals.
  - Order additional MUST snack daily of patients choice (refer to 'catering' section in nutritional resource manual).
- Encourage family and friends to bring in patient preferred snacks.
- Complete a food and drink recording chart, including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a 72 hour period?

NO → Complete the above steps

YES → Is the patients intake 'normal' or improved for them?

YES
- Discontinue food and fluid chart, documenting reason in nursing notes.
- Continue with 'food first' approach as above.
- Rescreen at least every 7 days.

NO → Is the patient dying?

YES
- Discontinue food and drink recording chart.
- Stop screening.
- Offer food and fluid as appropriate.

NO
- Continue with food and drink recording chart.
- Screen at least every 7 days.
- Consider referral to dietetics via Trakcare.

DISCHARGE

If the patient is due for discharge and concerns remain regarding their oral intake, provide NHSGGC "*Eating to Feel Better" booklet discussing the reason why the information is being given e.g. reduced appetite and / or weight loss before or during hospital admission.

www.nhsggc.org.uk/patients-and-visitors/information-for-patients/food-in-hospital/discharge-from-hospital/

mi • 288984 v3.0 • CCC0250

2505876051
MCLEISH
Wendy
126 LIBERTON ST
Glasgow, Lanarkshire
25/05/1987
F

NHSG ment

NHS Greater Glasgow and Clyde

This Ris... emoire for staff. It should be used in conjunction with the Bedrail Guidance
(see rev... revention and Management (Adults).

Patient Name:

THIS D... G33 2HJ **ACE THE NEED FOR CLINICAL JUDGEMENT**

CHI Number:

Use guidance on the ...erse of this document when completing this Risk Assessment	DATE	8/12/20						
	TIME	1545						
	WARD	SD						
	HOSPITAL	QEU						

	SECTION ONE – GENERAL	Y	N	Y	N	Y	N	Y	N
1	Is the patient likely to fall, roll, slip or slide from the bed?	/							
2	Has the patient requested the use of bedrails?	/							
	IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED								
	SECTION TWO – COGNITIVE AND PHYSICAL STATUS								
3	Is the patient at risk of climbing out of bed?		/						
4	Is the patient stressed, delirious or restless?		/						
5	Is the patient small in stature?		/						
6	Does the patient have an unusually large or small head that might present an entrapment issue?		/						
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?		/						
	IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf								
	SECTION THREE – COMMUNICATION								
8	Has the patient been consulted regarding the use of bedrails?	/							
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition	/							
10	Has the use of bedrails been discussed with relatives/carers?	/							
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?	/	\						
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?	/							
	IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf								
	SECTION FOUR – DECISION MAKING	Y	N	Y	N	Y	N	Y	N
13	Will bedrails be used for this patient at the present time?	/							
14	Rationale for use of bedrails: (Please insert code in the box on the right)								
	A – Risk of falling from the bed	/							
	B – Risk of rolling from the bed	/							
	C – Risk of slipping from the bed	/							
	D – Risk of sliding from the bed	/							
	E – Patient request								
15	Bedrail risk assessment completed by:	CM							
16	Bedrails checked by:	CM							
17	Date	8/12/20							

Any issues relating to the use of bedrails including discussion with family/relatives/carers should be recorded here

A. Alternatives to bed rails:-

- Move the patient to a more observable area
- Increase patient observation
- Ensure the bed is returned to the lowest height appropriate to the patient needs, after care delivery
- Ensure patient needs are anticipated e.g. drinks are accessible, regular toileting, call bell to hand
- Nursing patient on mattress on the floor should be the last resort, and safety checks should be made for hot pipes, trailing wires, electrical sockets etc
- A generic moving and handling assessment must be carried out for staff caring for patients nursed on mattress on the floor.
- Contact Hospital Falls team for advice where appropriate

B. If bedrails are to be used, please consider the following:-

Is patient:-

- Stressed, delirious or restless
- At risk of entrapment
- At risk of climbing over the top of the bed rail
- At risk of being psychologically affected by the use of the bed rail

C. Safe use and application of bedrails:-

- If bedrail is fitted and there is a gap between the lower rail and the mattress then a bedrail should not be used
- If the gap between the bars on the bedrail is greater than 12cm then a bedrail should not be used
- If the bedrail moves away from the side of the mattress then a bedrail should not be used
- If the gap between the bedrail and the headboard is between 6cm and 25cm then a bedrail should not be used
- If the gap between the bedrail and the footboard is between 6cm and 25cm then a bedrail should not be used
- If the bedrail has not been fitted correctly then the bedrail should not be used
- If the bedrail is not secure then the bedrail should not be used
- If the bedrail is not compatible with the frame it will be fitted to then a bedrail should not be used
- If the bedrail is not in good working order then the bedrail should not be used

D. Record keeping:-

All of the following should be recorded:-

- Date and time of assessment
- Bedrail information leaflet given to patient and-or next of kin
- Rationale for decision in care plan or in AWI treatment plan
- Where bedrails are considered appropriate and patient has declined their use
- Any other actions implemented
- Care planning should be reviewed and updated as per record keeping standards

Bedrail risk assessments should be made as follows:-

- On admission
- If patient's condition changes or fall / suspected fall from bed
- Daily/weekly depending on the patient's status

ific (Inpatient) Moving and Handling Assessment Form

2505876061
MCLEISH
Wendy
126 LIBERTON ST
Glasgow, Lanarkshire
G33 2HJ

F
25/05/198

Named Nurse: Gmcnab

Person is totally independent (tick here and go to date box) ✓

Problems with comprehension, behaviour, co-operation (specify):

Weight: Kg
Height: cm
BMI

Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):

Risk of Falls: Yes | No

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 / 2 / >3	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 / 2 / >3	Additional Information:	

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N/A
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 / 2 / >3	Additional Information:	
	Monkey pole			
	Independent bridging			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 / 2 / >3	Additional Information:	
	Monkey pole			
	Rope ladder			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 / 2 / >3	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify)			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 / 2 / >3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair	People: 1 / 2 / >3	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley			
Bed bath	Bathing hoist (eg Alerti)			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 / 2 / >3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:	8/10/20		
Assessor's signature:			
Proposed Review date:	ongoing		

Continuation Sheet

1. General Information (Only complete this section if changed from over page)

Body Build		Problems with comprehension, behaviour, co-operation (specify):
Weight	Height	
Kg	cm	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
BMI		
Risk of Falls: Yes	No	

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 2 ≥3	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 2 ≥3	Additional Information:	

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N/A
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 2 ≥3	Additional Information:	
	Monkey pole			
	Person bridges			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 2 ≥3	Additional Information:	
	Monkey pole			
	Rope ladder			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 2 ≥3	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify)			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 2 ≥3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair	People: 1 2 ≥3	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley			
Bed bath	Bathing hoist (eg Aleas)			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 2 ≥3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	4th Assessment	5th Assessment	6th Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

2505876051
MCLEISH
Wendy
126 LIBERTON ST
Glasgow, Lanarkshire
G33 2H.
25/05/198

FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs of Admission and on Transfer to Another Ward

NHS Greater Glasgow and Clyde

GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

Action the following safety precautions on admission to your ward. Update weekly or on change of condition.

	Ward: 50 Date: 8/12/20 Time: 1845	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).					
2. Check walking aid (if required) is in reach and in use.					
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	✓				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	✓				
5. If glasses are worn, check they are available and in use.					
6. If hearing aid/s are worn, check they are working and in use.					

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).
Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.
ALL patients in older people's wards must have an interventional plan in place (overleaf)

Tick Yes or No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has the patient fallen in the last 6 months – including during this admission?		✓								
2. Does the patient have cognitive impairment or a possible delirium?		✓								
3. Does the patient attempt to walk alone although unsteady or unsafe?		✓								
4. Does the patient or their relative have a fear or anxiety of the patient falling?		✓								
5. Based on your clinical judgement, is this patient at high risk of falling?		✓								
Signature of nurse completing assessment / update	OM									

Highlight risk of fall at the ward safety brief.

Patient Details	FALLS INTERVENTION CHECKLIST	NHS Greater Glasgow and Clyde

Complete for all patients identified at risk of falling.

	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----
BED AND SEATING					
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)					
Assess if a low bed is required (Patient care plan 9)					
SAFETY					
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)					
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)					
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.					
HEALTH					
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)					
Document continence problems and link to care rounding (Patient care plan 6)					
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)					
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.					
COMMUNICATION					
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)					
Update the ward team of the patient's mobility status. (Patient care plan 8)					
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)					
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)					
Signature of nurse completing interventional plan / or update					

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team

Care Rounds Checklist

Date: 1/11/19

Attach Addr
2505876061
MCLEISH, Wendy X F 25/05/1987
128 LIBERTON ST
Glasgow, Lanarkshire
G33 2HJ
Ward: 46

NHS Greater Glasgow and Clyde

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (please circle) 1hr 2hr 3hr 4hr

1. Signed MMcMahan Name MCEWAN Designation S/N
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward O I = Independent

			Times	X																
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		N																
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.		Y																
S	3	**SKIN INSPECTION** Pressure areas checked:		N																
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)																		
K	4	**KEEP MOVING** Has the patient moved or walked?		I																
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B																		
		Chair Assist to walk or stand (W/ST)		I																
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		I																
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?		N																
		Drink taken?		Y																
		Food, snack, or supplement taken?		Y																
		Has oral hygiene been carried out as per care plan?		MA																
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		Y																
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.		Y																
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.		MM																
		Care provider / role		MM																

Care Rounds Variance Sheet

Attach Addressograph Label
Ward:

NHS Greater Glasgow and Clyde

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GGC0098

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan



Write or aff. 2505876081
Name: MCLEISH Wendy F
DOB: 25/05/1987
Ward: 4b

NHS Greater Glasgow and Clyde

Insertion criteria: Please complete this section at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☑ Resuscitation/Chest Pain ☐ IV Drugs ☐ Fluids ☐ Transfusion ☐

PVC Inserted: Day 0	Date: 1/11/19 Hospital: GRI Area: ED ☑ Theatre ☐ ITU/HDU ☐ Ward ☐ _____ Unknown ☐ _____
Insertion site:	R Hand ☐ R Arm ☑ R Foot ☐ L Hand ☐ L Arm ☐ L Foot ☐ Other: _____
Colour of cannula:	Blue ☐ Pink ☑ Green ☐ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: _____

PVC Maintenance Check	**Does the Patient require this PVC for any of the DRIFT criteria?** (Diagnostics, Resuscitation/ Chest Pain, IV Drugs, Fluids, Transfusion)	**VIP score. (See Chart on back of care plan)** If ≥ 2 remove PVC and record reason*.	**Is the PVC dressing intact?**	**If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)**	**Initial**
Day 1 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 1 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: ___/___/___ Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: ___/___/___

*Reason For Removal: _____

Modified Visual Infusion Phlebitis (VIP) Score

Modified V.I.P (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phlebitis : Observe cannula
One of the following is evident : slight pain or redness near site	1	Possible first signs : Observe cannula
Two or more of the following are evident: pain, redness, swelling	2	Early stage of phlebitis : Remove & resite cannula
All of the following are evident: pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: Remove & resite cannula
As above including: palpable venous cord	4	Seek further advice
As above including: pyrexia	5	

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and S. aureus bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids ? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → Can I switch my patient from IV to oral antibiotics?

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature ≤ 37.9°C, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE** is available reliably (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, S. aureus bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abcess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy. Record the intended duration on the medicine kardex

YES

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

NO

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name	2505876061 MCLEISH Wendy F
Address	126 LIBERTON ST 25/05/1987 Glasgow, Lanarkshire
CHI No.	G33 2HJ
DoB	

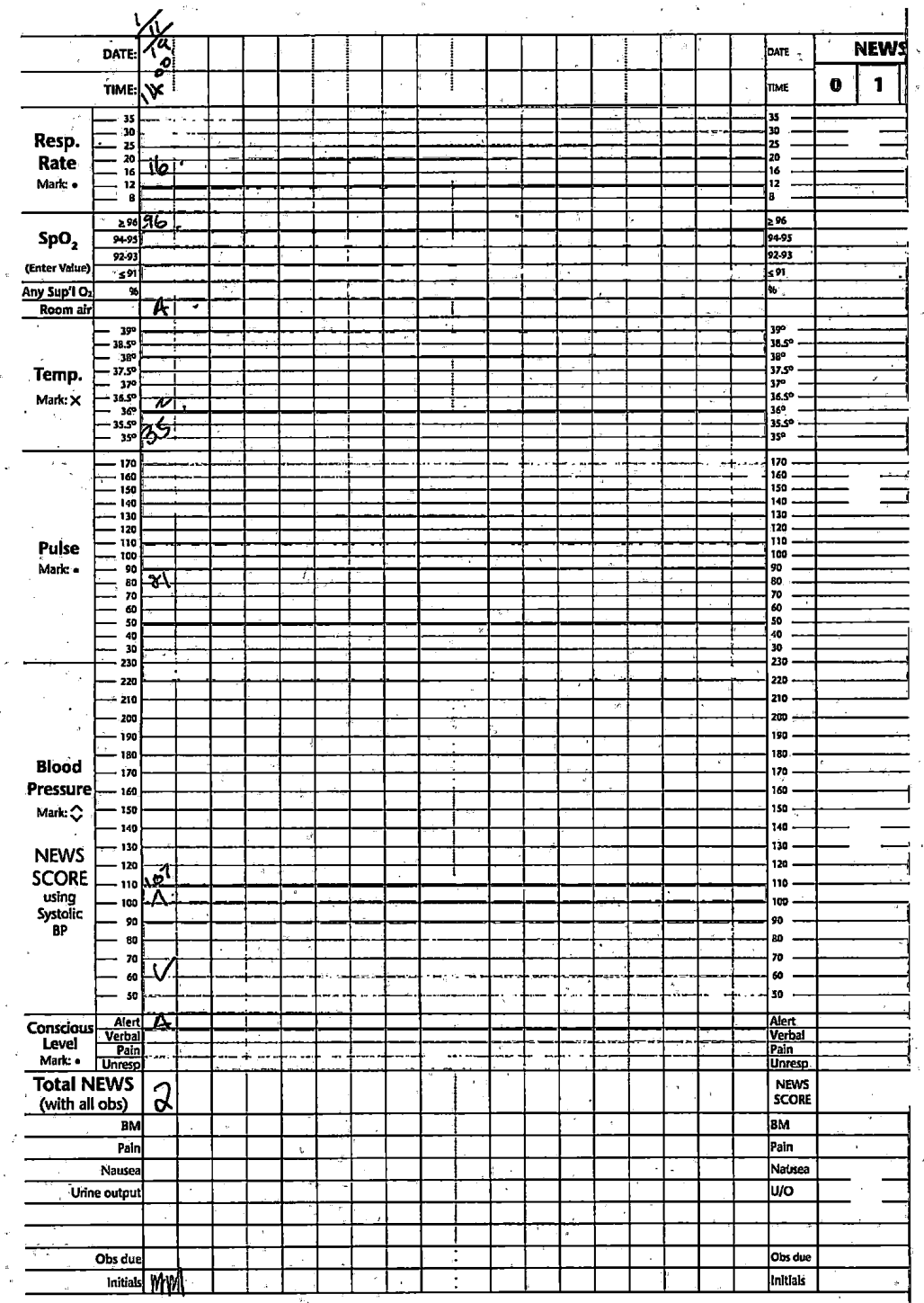
	Date	Ward
Admitted		
Transferred		
Transferred		

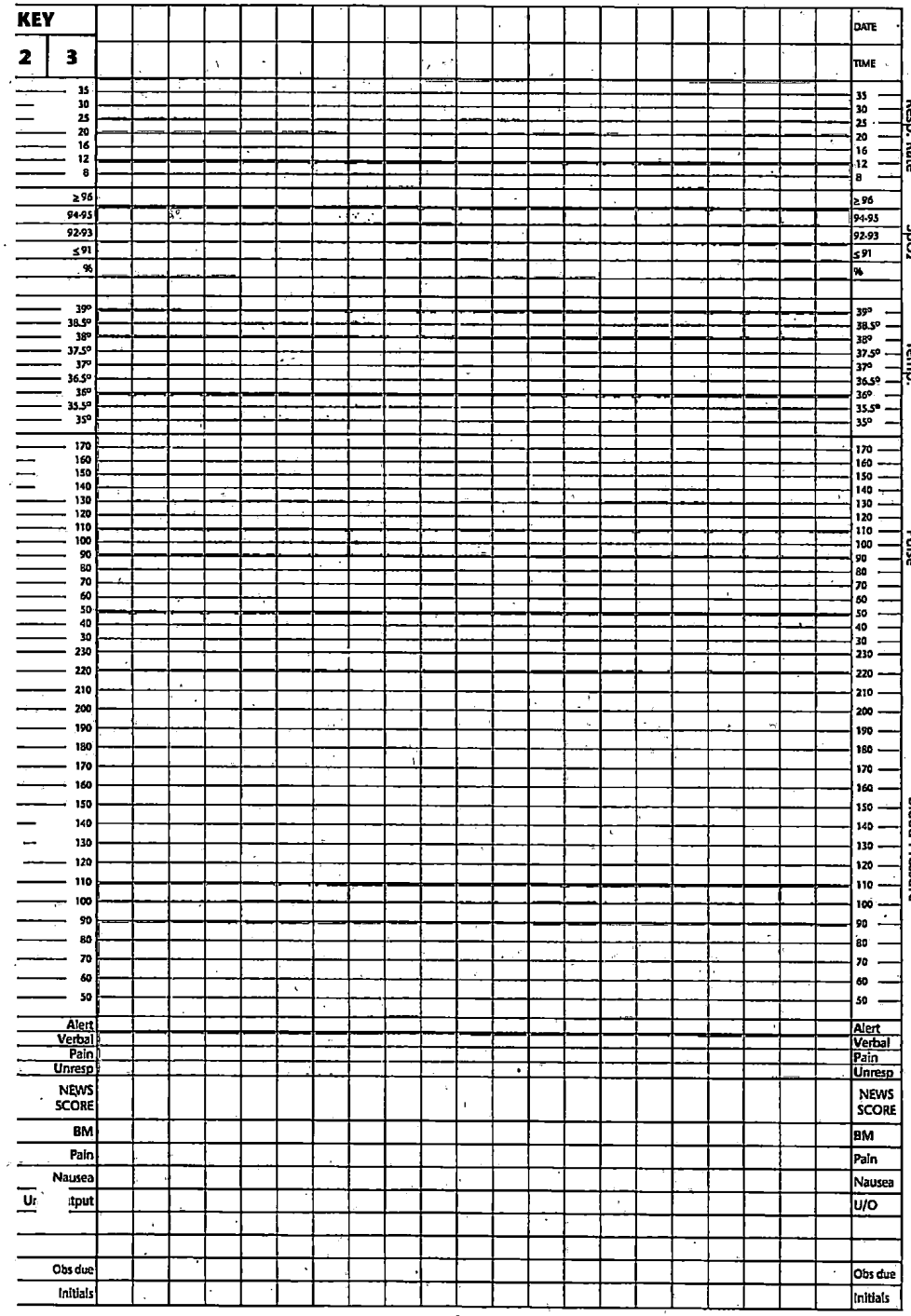
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.


DATE:
TIME:
NEWS
0 1
Resp. Rate
Mark: •
SpO2
(Enter Value)
Any Sup'l O2
Room air
Temp.
Mark: ×
Pulse
Mark: •
Blood Pressure
Mark:
NEWS SCORE using Systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
BM
Pain
Nausea
Urine output
Obs due
Initials


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Glasgow Coma Scale

Pupil size (mm): 1 2 3 4 5 6 7 8

Neurological Observations

Date:					0																					
Time:					14																					
COMA SCALE	E Eyes open	Spontaneously	4																							Eyes closed by swelling = C
		To speech	3																							
		To pain	2																							
		None	1																							
	V Best Verbal response	Orientated	5																							Endotracheal tube or tracheostomy = T
		Confused	4																							
		Inappropriate words	3																							
		Incomprehensible sounds	2																							
		None	1																							
	M Best motor response	Obeys	6																							Usually record the best arm response
		Localises	5																							
		Flexion - withdrawal	4																							
		Flexion - abnormal	3																							
		Extension to pain	2																							
		None	1																							
	TOTAL SCORE				15																					
PUPILS	R	Size			4																					+ reacts – no reaction C eyes closed
		Reaction			+																					
	L	Size			4																					
		Reaction			+																					
LIMB MOVEMENT	ARMS	Normal power																								Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness																								
		Severe weakness																								
		Spastic flexion																								
		Extension																								
		No response																								
	LEGS	Normal power																								
		Mild weakness																								
		Severe weakness																								
		Spastic flexion																								
		Extension																								
		No response																								

Pain Score

Ask the patient to rate his/her pain by choosing a number between 0 and 10. Use the diagram below to assist the patient. If patient's pain is chronic, use generic tool. If patient is unable to communicate, use observational tool.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Severe Pain			

Nausea and Vomiting	
0	= None
1	= Mild (*Not distressing – no retching/vomiting*)
2	= Moderate (*Troublesome – occasional retching/vomiting*)
3	= Severe (*Distressing – frequent retching/vomiting*)

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

MEDICINE | PRESCRIPTION FORM

Hospital Name: GRI

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐

Date _____ Name (Print) _____

Discharge Prescription Prepared & Reconciled YES ☐

Date _____ Name (Print) _____

Date and time this form prepared:	Sheet No	2nd Prescription in use
__/__/__ Time: ____	____	YES ☐ NO ☐

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the symptomatic relief policy & local protocol:

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name _____ Tel No. _____

Address _____

Compliance Aid Details _____

Patient consent to share discharge information Y/N

Print & Sign _____

PATIENT DETAILS

2505876061

MCLEISH
Wendy
126 LIBERTON ST
Glasgow, Lanarkshire G33 2HJ

F
25/05/1987

Height:

Weight:

Surface area:

Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

TARGET OXYGEN SATURATIONS

Please CIRCLE a target saturation and prescribe oxygen on the Regular Prescription section.

(94–98%) | 88–92% (e.g. in hypercapnic respiratory failure) | Other (please specify)

On Home Oxygen? Yes / No _____ L/min

DATE: 8-12-2020 PRESCRIBER (PRINT & SIGN): FYI M. Mostofa

	DATE / MONTH																							
	RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)																							
IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N																								
ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N																								
SIGNATURE OF ASSESSOR																								
ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N																								

Parenteral Drugs : Regular Prescription

					Patient's own Medicine	For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	**A** DRUG	DOSE / ROUTE / DATE	STOPPED DATE: INITIALS:	PRESCRIBER (PRINT & SIGN)	Other time					
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			0700-0900					
					1200-1400					
					1500-1800					
					2200-2400					
					Other time					
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	**B** DRUG	DOSE / ROUTE / DATE	STOPPED DATE: INITIALS:	PRESCRIBER (PRINT & SIGN)	Other time					
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			0700-0900					
					1200-1400					
					1500-1800					
					2200-2400					
					Other time					
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	**C** DRUG	DOSE / ROUTE / DATE	STOPPED DATE: INITIALS:	PRESCRIBER (PRINT & SIGN)	Other time					
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			0700-0900					
					1200-1400					
					1500-1800					
					2200-2400					
					Other time					

REVIEW THE NEED FOR IV ANTIBIOTIC DAILY. SWITCH TO ORAL THERAPY AS SOON AS POSSIBLE (SEE IVOST POLICY)

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

D DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

E DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

F DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

G DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE → 8 9
MONTH → 12 12

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

H
BEFORE ADMISSION ☑
NEW DOSE ☐
NEW MEDICATION ☐
DRUG: Mirtazapine
DOSE: 45 mg | ROUTE: PO | DATE: 8/12
STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): Fyi M. Restiva
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 (3) | Other time

J
BEFORE ADMISSION ☑
NEW DOSE ☐
NEW MEDICATION ☐
DRUG: Cerelle
DOSE: 75 mg (am) | ROUTE: po | DATE: 8/12
STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): [illegible] Tkachuk
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: (Oesogastral)
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

K
BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐
DRUG:
DOSE: | ROUTE: | DATE:
STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

2505876051
MCLEISH
Wendy
F
25/05/1987

L
BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐
DRUG:
DOSE: | ROUTE: | DATE:
STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

M DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

N DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

P DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

R DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

S DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

T DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

V DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

W DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

X DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

CC DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

DD DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

EE DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY.

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

FF DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

All Routes: As Required Prescriptions

Patient's Own Medicine

| | | |

Patient's Own Medicine

| | | |

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

Warning: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed by a doctor.

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).
2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).
3. Print & Sign your full name clearly against each prescription entry.
4. Time should be recorded in 24hr format e.g. 0600, 1800.
5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.
6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.
7. The following metric unit abbreviations must be used –

Milligram = mg — Gram = g
Millilitre = ml — Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

8. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - intrathecal must be written in full.

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.
2. Insert initials in the relevant date column and time row each time a drug is administered.
3. Check that all drugs prescribed at a certain time have been administered.
4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

(3) Patient refused
(4) Drug not available
(5) Nil by mouth/fasting
(6) Patient unavailable
(7) Patient asleep
(8) Time varied on doctor's instructions
(9) Dose withheld on doctor's instructions
(10) Nausea/vomiting
(11) Unable to swallow
(12) No intravenous access
(13) Patient Self-Administration of Medicine
(14) Other - Record in nursing notes
(15) Prescription clarification required

Cat. No. 40995 Ver 4, 09/2010 GGC029

MEDICINE

PRESCRIPTION FORM

Hospital Name: .....

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐

Date _____ Name (Print) _____

Discharge Prescription Prepared & Reconciled YES ☐

Date _____ Name (Print) _____

Date and time this form prepared:	Sheet No	2nd Prescription in use
__/__/__ Time: _____	.....	YES ☐ NO ☐

DOCTOR'S DECLARATION (If required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the symptomatic relief policy & local protocol:

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name _____ Tel No. _____

Address _____

Compliance Aid Details _____

Patient consent to share discharge information Y/N

Print & Sign _____

PATIENT DETAILS

H 2505876061
D MCLEISH F
Wendy 25/05/1987
D
C

Height:

Weight:

Surface area:

Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
	PERMETHRIN						
01/11/19	~~PIMETHICONE~~	x1	TOP	13''	[signature]	[signature]	1324
01/11/19	CO-AMOXICLAV	1.2g	IV	1700	[signature] OMeara	[signature]	1715

TARGET OXYGEN SATURATIONS

Please CIRCLE a target saturation and prescribe oxygen on the Regular Prescription section.

94 – 98%	88– 92% (e.g. in hypercapnic respiratory failure)	Other (please specify)

On Home Oxygen? Yes / No _____ L/min

DATE: ____/____/____ PRESCRIBER (PRINT & SIGN): _____

	DATE →																							
	MONTH →																							

RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)

IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N																								
ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N																								
SIGNATURE OF ASSESSOR																								
ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1600 DRUG ROUND WITH Y OR N																								

Parenteral Drugs : Regular Prescription

Patient's Own Medicine

BEFORE ADMISSION ☐ **NEW DOSE** ☐ **NEW MEDICATION** ☐

A DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time																								
0700-0900																								
1200-1400																								
1600-1800																								
2200-2400																								
Other time																								

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐ **NEW DOSE** ☐ **NEW MEDICATION** ☐

B DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time																								
0700-0900																								
1200-1400																								
1600-1800																								
2200-2400																								
Other time																								

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐ **NEW DOSE** ☐ **NEW MEDICATION** ☐

C DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time																								
0700-0900																								
1200-1400																								
1600-1800																								
2200-2400																								
Other time																								

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

REVIEW THE NEED FOR IV ANTIBIOTIC DAILY. SWITCH TO ORAL THERAPY AS SOON AS POSSIBLE (SEE IVOST POLICY)

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

D DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

E DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

F DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

G DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE / MONTH

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

H

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DRUG: Co-Amoxiclav PV

DOSE: 625mg | ROUTE: O | DATE: 01/11/11

PRESCRIBER (PRINT & SIGN):

STOPPED — DATE: | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: 7/7.

J

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DRUG: Chloramphenicol

DOSE: x1 | ROUTE: TOP | DATE: 01/11/11

PRESCRIBER (PRINT & SIGN):

STOPPED — DATE: | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: To @ ear mornl

K

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DRUG:

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN):

STOPPED — DATE: | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

L

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DRUG:

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN):

STOPPED — DATE: | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

M DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

N DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

P DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

R DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE
MONTH

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

S DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

T DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

V DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

W DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

X DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1500-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1500-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1500-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1500-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
City:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
City:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
City:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
City:
Date:
Assessed by:
Ordered from Pharm.

. The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

All Routes: As Required Prescriptions

1/1/19

Patient's Own Medicine

LL
DRUG: Paracetamol
DOSE: 1g | ROUTE: O | INDICATION: Pain
PRESCRIBER (PRINT & SIGN): Lie | MAX.FREQ.: Qds | DATE: 01/1/19
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
STOPPED DATE: | INITIALS:
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DATE																															
TIME	1																														
DOSE	1g																														
GIVEN BY	MM																														

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

MM
DRUG:
DOSE | ROUTE | INDICATION
PRESCRIBER (PRINT & SIGN) | MAX.FREQ. | DATE:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
STOPPED DATE: | INITIALS:
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DATE																															
TIME																															
DOSE																															
GIVEN BY																															

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

NN
DRUG:
DOSE | ROUTE | INDICATION
PRESCRIBER (PRINT & SIGN) | MAX.FREQ. | DATE:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
STOPPED DATE: | INITIALS:
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DATE																															
TIME																															
DOSE																															
GIVEN BY																															

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

PP
DRUG:
DOSE | ROUTE | INDICATION
PRESCRIBER (PRINT & SIGN) | MAX.FREQ. | DATE:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
STOPPED DATE: | INITIALS:
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DATE																															
TIME																															
DOSE																															
GIVEN BY																															

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

BEFORE ADMISSION ☐	RR	DRUG			STOPPED DATE:	DATE																									Patient's Own Medicine For Use Y/N
NEW DOSE ☐		DOSE	ROUTE	INDICATION	INITIALS:	TIME																										Qty:
NEW MEDICATION ☐		PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DATE:	DOSE																										Date:
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				GIVEN BY																										Assessed by:
																																Ordered from Pharm.
BEFORE ADMISSION ☐	SS	DRUG			STOPPED DATE:	DATE																										For Use Y/N
NEW DOSE ☐		DOSE	ROUTE	INDICATION	INITIALS:	TIME																										Qty:
NEW MEDICATION ☐		PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DATE:	DOSE																										Date:
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				GIVEN BY																										Assessed by:
																																Ordered from Pharm.
BEFORE ADMISSION ☐	TT	DRUG			STOPPED DATE:	DATE																										For Use Y/N
NEW DOSE ☐		DOSE	ROUTE	INDICATION	INITIALS:	TIME																										Qty:
NEW MEDICATION ☐		PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DATE:	DOSE																										Date:
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				GIVEN BY																										Assessed by:
																																Ordered from Pharm.
BEFORE ADMISSION ☐	VV	DRUG			STOPPED DATE:	DATE																										For Use Y/N
NEW DOSE ☐		DOSE	ROUTE	INDICATION	INITIALS:	TIME																										Qty:
NEW MEDICATION ☐		PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DATE:	DOSE																										Date:
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				GIVEN BY																										Assessed by:
																																Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Name _____

CHI No _____

Drug Allergies / Sensitivities **None Known** ☑ **Yes** ☐ **(provide details below)**

_____

_____

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

Warning: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed by a doctor.

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).
2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).
3. Print & Sign your full name clearly against each prescription entry.
4. Time should be recorded in 24hr format e.g. 0600, 1800.
5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.
6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.
7. The following metric unit abbreviations must be used –

Milligram = mg — Gram = g
Millilitre = ml — Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

8. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - Intrathecal must be written in full.

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.
2. Insert initials in the relevant date column and time row each time a drug is administered.
3. Check that all drugs prescribed at a certain time have been administered.
4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

(3) Patient refused	(7) Patient asleep	(11) Unable to swallow	(14) Other - Record in nursing notes
(4) Drug not available	(8) Time varied on doctor's instructions	(12) No intravenous access	(15) Prescription clarification required
(5) Nil by mouth/fasting	(9) Dose withheld on doctor's instructions	(13) Patient Self-Administration of Medicine	
(6) Patient unavailable	(10) Nausea/vomiting		

Cat. No. 46595 Ver 4. 09/2010 GGC0029

Inpatient prescription & administration record for Wendy McLeish (2505876061) Admission: 24/03/2023 => 26/03/2023

01:00
28/03/23

Patient Demographics

MCLEISH Wendy (2505876061)
DOB: 25/05/1987
Flat 3/2, 312 Cumbernauld Rd,
Glasgow,
Lanarksh,
G31 3LY

Admitted: 24/03/2023 13:12
Discharged: 26/03/2023 18:05

Transfer history

Admission	2023-03-24 13:12:00	RAAU GRI AAU
Transfer	2023-03-25 01:00:00	R46 GRI WARD 46

Responsible Consultant history

Assigned No Consultant	24/03/23	13:12
Laura Mcgregor	25/03/23	01:00
Christine Aiken	25/03/23	09:46

Allergy

Admission Allergy Check performed by: Paul Lyons
Current recorded allergy (reaction): Allergy Status Undetermined

GABAPENTIN 100 mg Capsules

☒ 25/03/23 12:00 100 mg THREE TIMES DAILY 7am:12pm:10pm (Oral) — Christine Aiken

25/03/23	12:00	25/03/2023	12:28	Heather Bullen
25/03/23	22:00	25/03/2023	22:27	Emma Bawle
26/03/23	07:00	26/03/2023	08:30	Julie Caldwell
26/03/23	12:00	26/03/2023	12:57	Julie Caldwell

LAMOTRIGINE 25 mg Tablets

☒ 25/03/23 07:00 75 mg ONCE DAILY MORNING 7am (Oral) — Paul Lyons

25/03/23	07:00	25/03/2023	08:32	Heather Bullen
26/03/23	07:00	26/03/2023	08:30	Julie Caldwell

PABRINEX High Potency Intravenous Infusion

☒ 24/03/23 22:00 2 Pair of ampoules THREE TIMES DAILY 7am:12pm:10pm (Intravenous Intermittent Infusion) — Paul Lyons

24/03/23	22:00	24/03/2023	21:55	Colette Taylor/ Sharlene Smith
25/03/23	07:00	25/03/2023	09:29	Heather Bullen/ Jannat Latif
25/03/23	12:00	25/03/2023	13:50	Heather Bullen/ Jannat Latif
25/03/23	22:00	25/03/2023	22:51	Emma Bawle/ Annemarie Smith
26/03/23	07:00	26/03/2023	08:34	Julie Caldwell/ Donna Marie McGowan

Discontinued on: 26/03/2023 10:44 by: Lorena Mihaita . Reason: Condition Resolving/Resolved

☒ 24/03/23 16:19 2 Pair of ampoules (Intravenous Intermittent Infusion) — Paul Lyons

24/03/23	16:19	24/03/2023	17:16	Kathleen Shannon/ Rachael Watson

SERTRALINE 50 mg Tablets

☒ 25/03/23 07:00 50 mg ONCE daily at 7am (Oral) — Paul Lyons

25/03/23	07:00	25/03/2023	08:28	Heather Bullen
26/03/23	07:00	26/03/2023	08:30	Julie Caldwell

THIAMINE 50 mg Tablets

☒ 26/03/23 12:00 50 mg FOUR TIMES DAILY 7am:12pm:5pm:10pm (Oral) — Lorena Mihaita

26/03/23	12:00	26/03/2023	12:57	Julie Caldwell

Discontinued on: 26/03/2023 16:28 by: Lorena Mihaita . Reason: Condition Resolving/Resolved

Diazepam Tablets - GMAWS PRN Regimen AS CHARTED as required

☒ 24/03/23 16:19 1 Dose (Oral) AS PER GMAWS CHART — Paul Lyons

DIHYDROCODEINE 30 mg Tablets as required

☒ 24/03/23 17:20 60 mg FOUR TIMES DAILY 7am:12pm:5pm:10pm (Oral) FOR PAIN — Paul Lyons

60.00 mg	24/03/2023	19:38	Kathleen Shannon	
60.00 mg	25/03/2023	08:34	Heather Bullen	

Key: Prescription details | Recorded as "Admitted On" | Prescribed as "Self Administer" | Discontinuation details | HEPMA Prescription additional notes | HEPMA Patient admission notes (admission specific) | HEPMA Patient retained notes (not specific to admission)

The information contained in this document is privileged and confidential. This document must not be copied or distributed without prior authorisation. Any unauthorised disclosure of the information contained in this document is prohibited and may be unlawful. The information contained within this document is only valid at the time of its creation - the HEPMA team cannot be held responsible for changes subsequent to this document's creation.

Please ensure this document is destroyed after use.

Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, NHS Ayrshire & Arran and NHS Greater Glasgow & Clyde

HEPMA MAP v1.0

DIHYDROCODEINE 30 mg Tablets as required *(Continued)*

60.00 mg	25/03/2023	16:20	Heather Bullen	
60.00 mg	25/03/2023	22:28	Emma Bawle	
60.00 mg	26/03/2023	09:29	Julie Caldwell	
60.00 mg	26/03/2023	12:57	Julie Caldwell	

SALBUTAMOL 100 micrograms (MDI) per metered dose as required

☒ 24/03/23 17:22 200 microgram (Inhalation) FOR BREATHLESSNESS — Paul Lyons

SRP PEPTAC Oral Liquid as required

☒ 25/03/23 11:38 10 mL (Oral) Heartburn/GORD for 1 dose(s) — Heather Bullen

10.00 mL	25/03/2023	11:39	Heather Bullen

Key: Prescription details; Recorded as "Admitted On"; Prescribed as "Self Administer"; Discontinuation details; HEPMA Prescription additional notes; HEPMA Patient admission notes (admission specific); HEPMA Patient retained notes (not specific to admission)

The information contained in this document is privileged and confidential. This document must not be copied or distributed without prior authorisation. Any unauthorised disclosure of the information contained in this document is prohibited and may be unlawful. The information contained within this document is only valid at the time of its creation - the HEPMA team cannot be held responsible for changes subsequent to this document's creation.

Please ensure this document is destroyed after use.

Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, NHS Ayrshire & Arran and NHS Greater Glasgow & Clyde

HEPMA MAP v1.0

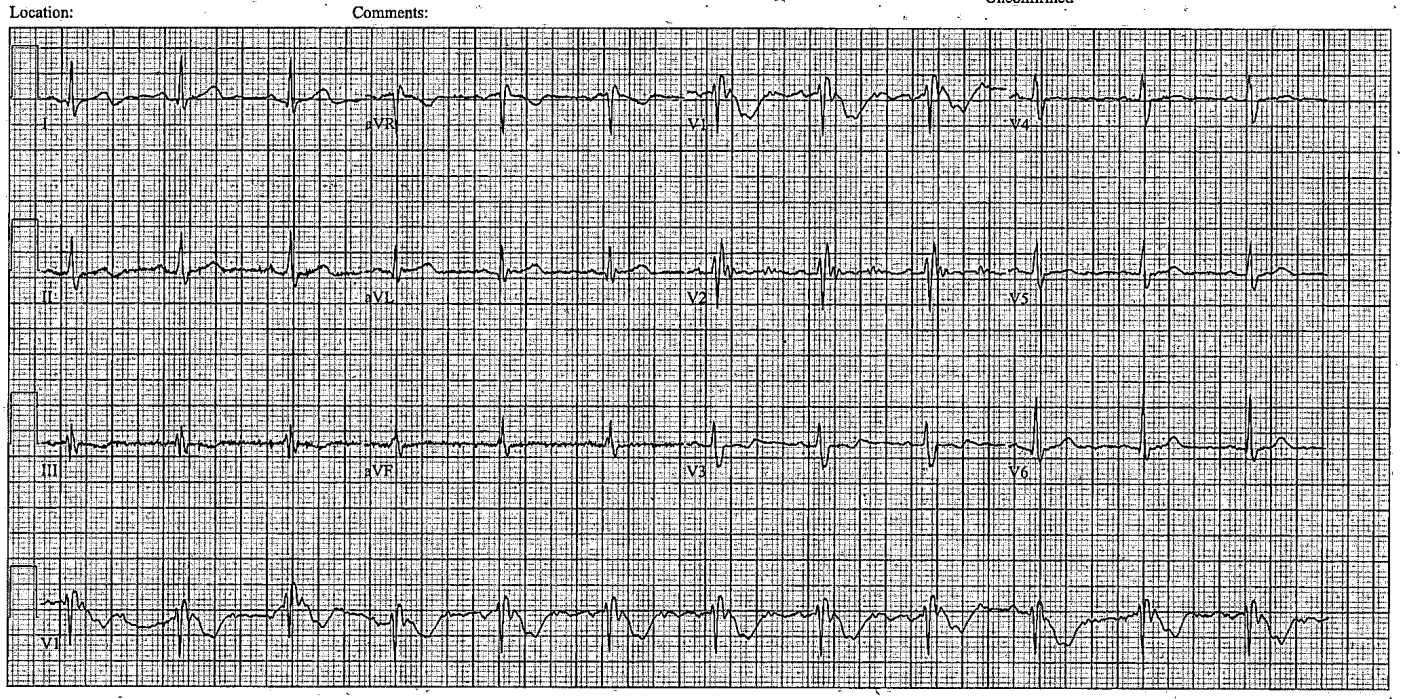
McLeish, Wendy ID:250587606 20-DEC-2025 23:51:24 GREATER GLASGOW SITE-GRAE ROUTINE RECORD

25-MAY-1987 (38 yr)	Vent. rate	72	BPM	Normal sinus rhythm
Female	PR interval	158	ms	Incomplete right bundle branch block
	QRS duration	106	ms	Borderline ECG
Room:	QT/QTc	382/418	ms	
Loc:201	P-R-T axes	20 28	7	

Technician: rebecca
Test ind:

Unconfirmed

Location: Comments:



25mm/s 10mm/mV 150Hz 9.0.10 12SL 243 CID: 1509 SID: 3309171 EID:13 EDT: ORDER:

McLeish, Wendy ID:250587606 20-DEC-2025 23:51:00 GREATER GLASGOW SITE-GRAE ROUTINE RECORD

25-MAY-1987 (38 yr)
Female

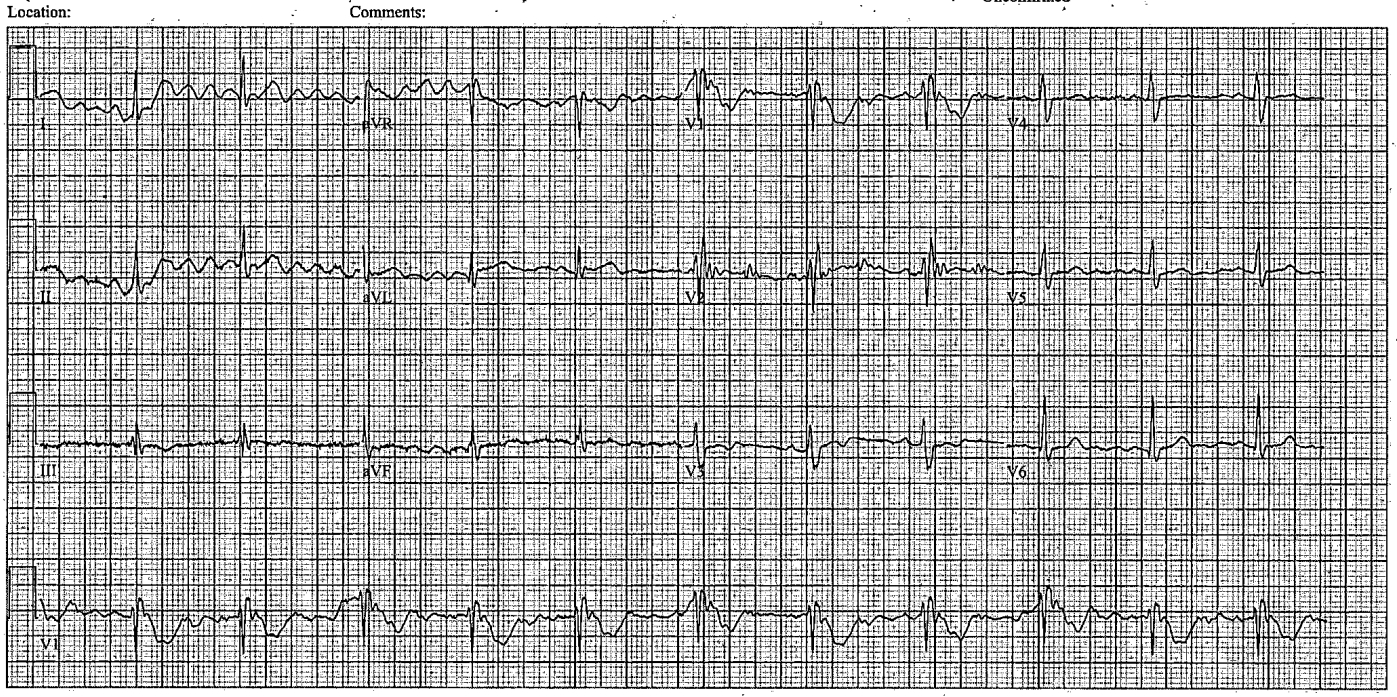
Room:
Loc:201

Vent. rate	69	BPM
PR interval	158	ms
QRS duration	108	ms
QT/QTc	410/439	ms
P-R-T axes	20 32	12

Undetermined rhythm
Incomplete right bundle branch block
Borderline ECG

Technician: rebecca
Test ind:

Location: Comments: Unconfirmed



25mm/s 10mm/mV 150Hz 9.0.10 12SL 243 CID: 1509

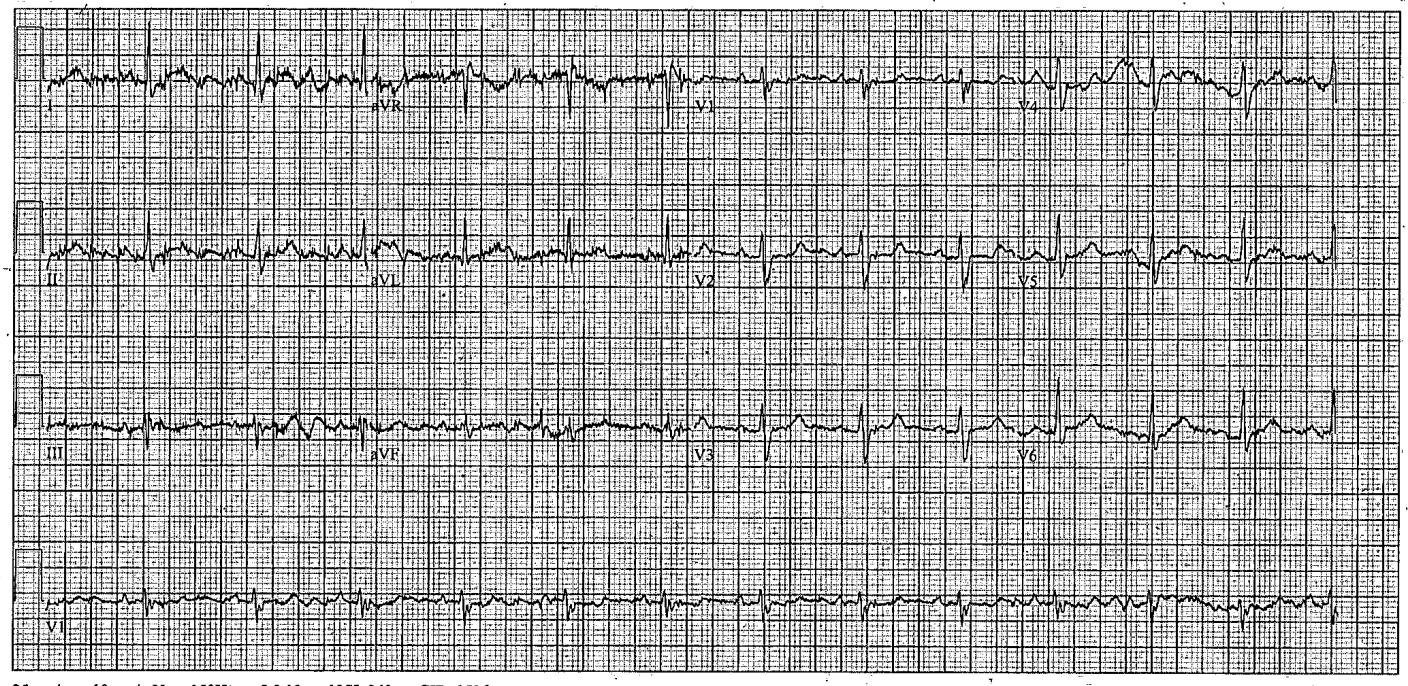
SID: 3309171 EID:13 EDT: ORDER:

McLeish, Wendy ID:2505876061 12-SEP-2025 14:25:46 GREATER GLASGOW SITE-GRAE ROUTINE RECORD

25-MAY-1987 (38 yr)	Vent. rate	78	BPM	Normal sinus rhythm
Female	PR interval	178	ms	Normal ECG
	QRS duration	96	ms	
Room:	QT/QTc	398/453	ms	
Loc:201	P-R-T axes	58 7	32	

Technician: pq
Test ind:

Location: Comments: Unconfirmed



25mm/s 10mm/mV 150Hz 9.0.10 12SL 243 CID: 1506 SID: 3309171 EID:13 EDT: ORDER:

McLeish, Wendy ID:2505876061 12-SEP-2025 14:24:39 GREATER GLASGOW SITE-GRAE ROUTINE RECORD

25-MAY-1987 (38 yr)
Female

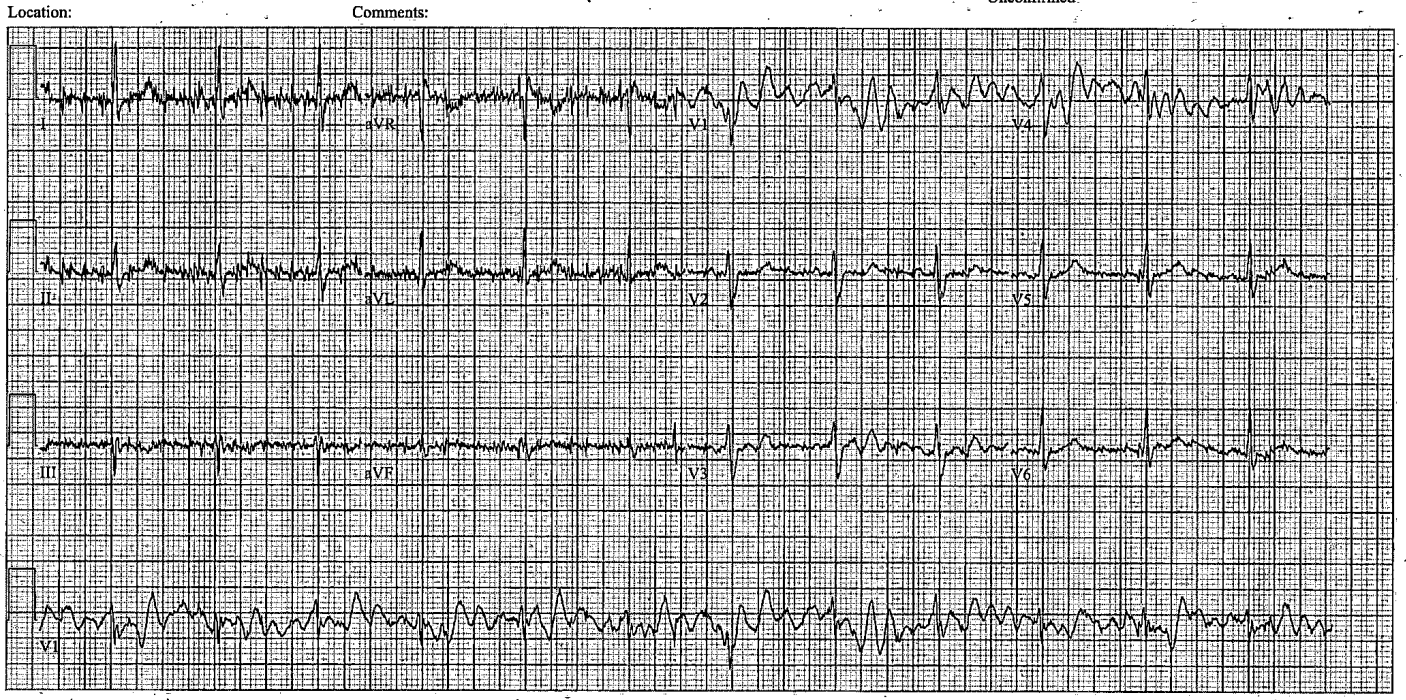
Room:
Loc:201

Vent. rate	75	BPM
PR interval	144	ms
QRS duration	94	ms
QT/QTc	378/422	ms
P-R-T axes	-7 -1	18

Normal sinus rhythm
T wave abnormality, consider anterior ischemia
Abnormal ECG

Technician: pq
Test ind:

Location: Comments: Unconfirmed



25mm/s 10mm/mV 150Hz 9.0.10 12SL 243 CID: 1506

SID: 3309171 EID:13 EDT: ORDER:

McLeish, Wendy ID:2505876061 25-FEB-2025 21:58:19 GREATER GLASGOW SITE-GRAE ROUTINE RECORD

25-MAY-1987 (37 yr)
Female

Room:
Loc:201

Vent. rate	81	BPM
PR interval	172	ms
QRS duration	110	ms
QT/QTc	384/446	ms
P-R-T axes	30 1 2	

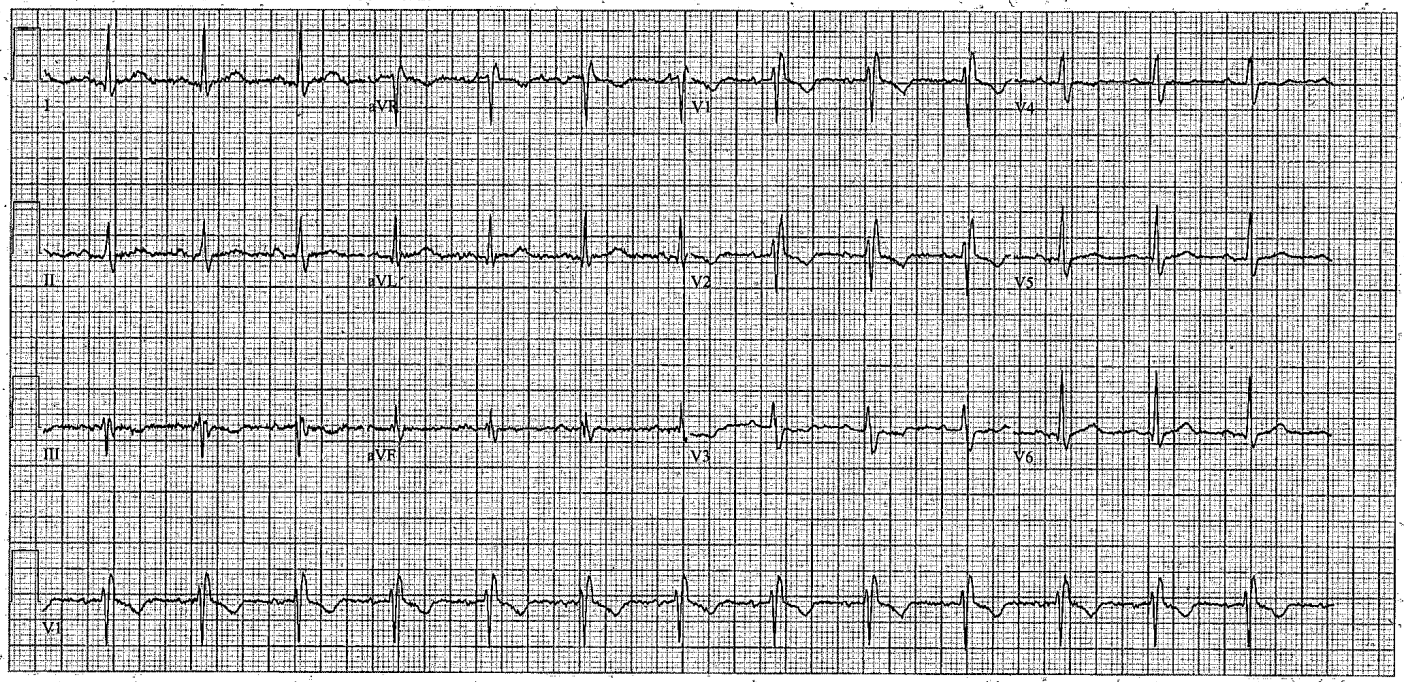
Normal sinus rhythm
Incomplete right bundle branch block
ST & T wave abnormality, consider anterior ischemia
Abnormal ECG

Technician: hf
Test ind:

Location:

Comments:

Unconfirmed



25mm/s 10mm/mV 150Hz 9.0.10 12SL 243 CID: 1507

SID: 3309171 EID:13 EDT: ORDER:

McLeish, Wendy ID:2505876061 24-MAR-2023 16:20:54 GREATER GLASGOW SITE-GRAAU ROUTINE RECORD

25-MAY-1987 (35 yr)
Female

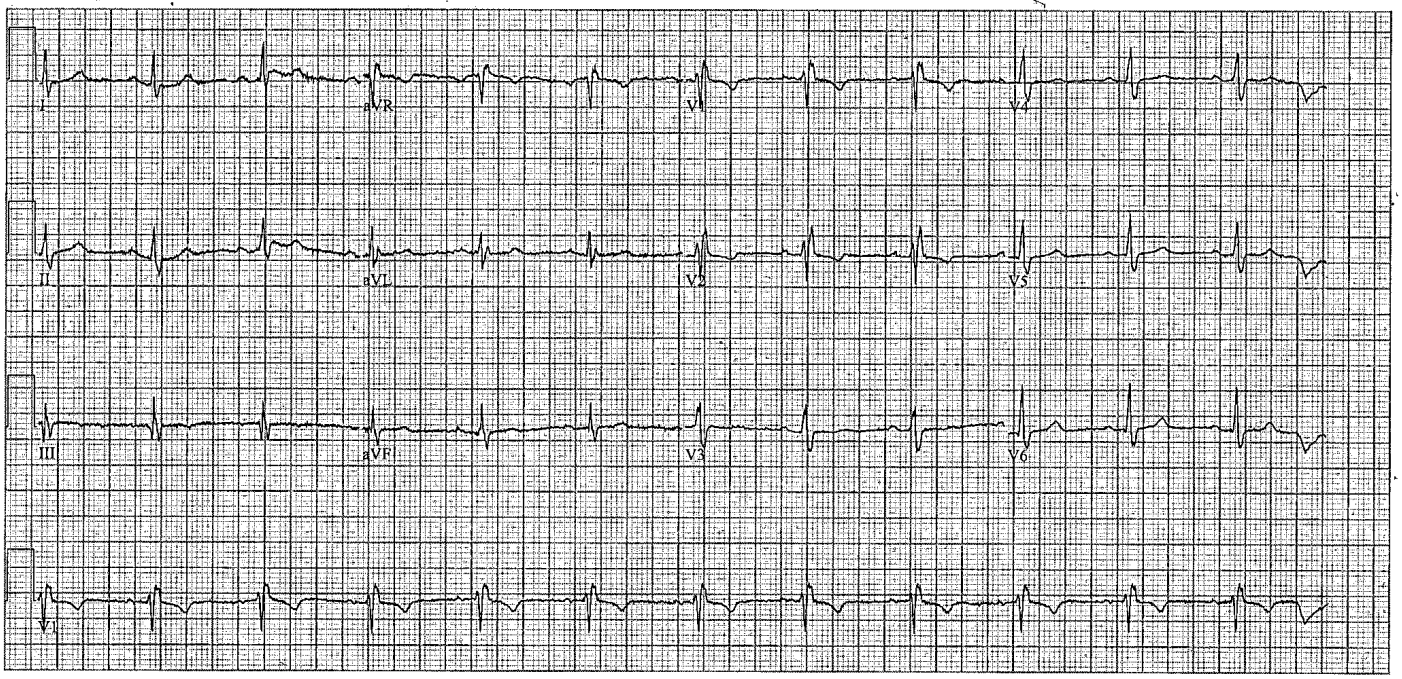
Room:
Loc:202

Vent. rate	71	BPM
PR interval	162	ms
QRS duration	108	ms
QT/QTc	384/417	ms
P-R-T axes	26 35	21

Normal sinus rhythm
Incomplete right bundle branch block
Borderline ECG

Technician:
Test ind: -

Unconfirmed



25mm/s 10mm/mV 150Hz 9.0.10 12SL 241 CID: 0

SID: 3309171 EID: EDT: ORDER:

McLeish, Wendy ID:2505876061 24-MAR-2023 16:19:51 GREATER GLASGOW SITE-GRAAU ROUTINE RECORD

25-MAY-1987 (35 yr)
Female

Room:
Loc:202

Vent. rate	116	BPM
PR interval	304	ms
QRS duration	108	ms
QT/QTc	290/403	ms
P-R-T axes	* 42	183

Undetermined rhythm
Incomplete right bundle branch block
Nonspecific ST and T wave abnormality
Abnormal ECG

Technician:
Test ind:

Unconfirmed



25mm/s 10mm/mV 150Hz 9.0.10 12SL 241 CID: 0

SID: 3309171 EID: EDT: ORDER:

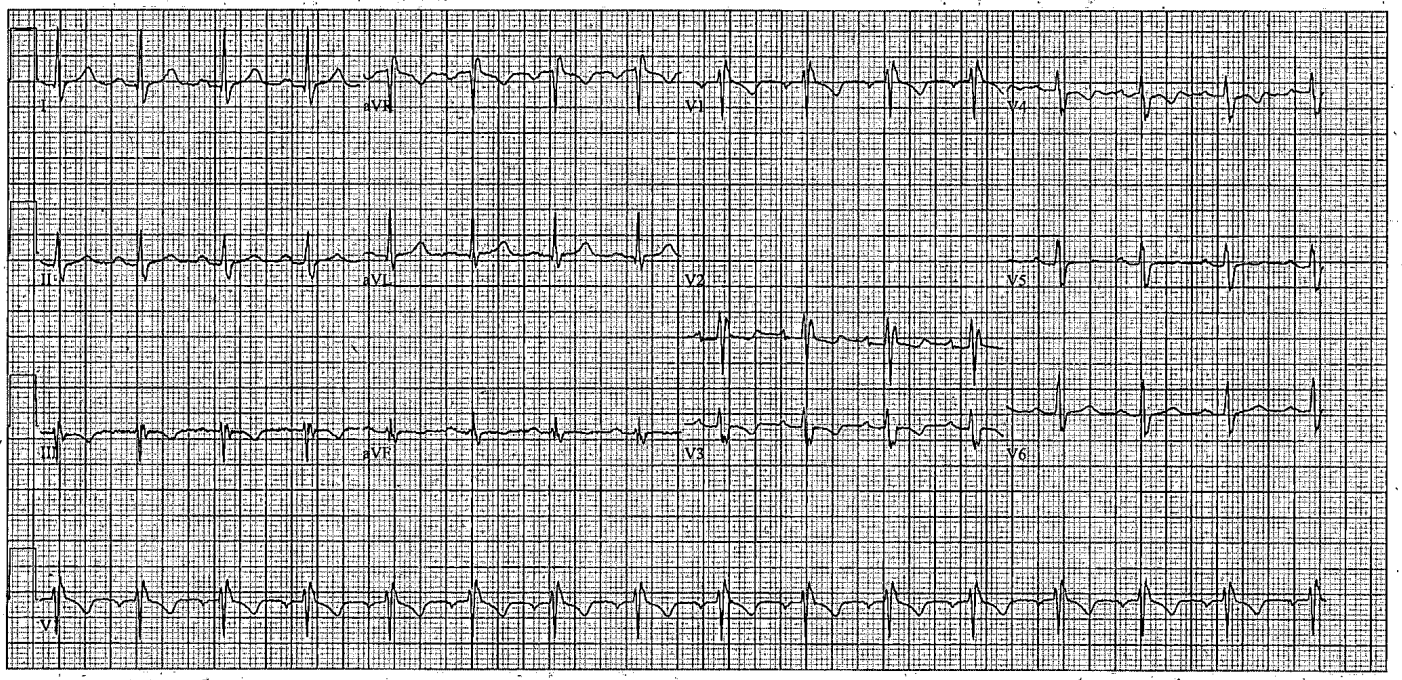
McLeish, Wendy ID:2505876061 11-JAN-2023 13:29:57 GREATER GLASGOW SITE-GRAAU ROUTINE RECORD

25-MAY-1987 (35 yr)	Vent. rate	92	BPM	Normal sinus rhythm
Female	PR interval	178	ms	Incomplete right bundle branch block
	QRS duration	110	ms	T wave abnormality, consider anterior ischemia
Room:	QT/QTc	370/457	ms	Abnormal ECG
Loc:202	P-R-T axes	35 -7	5	

Technician:
Test ind:

Referred by: GRI AAU STAFF Unconfirmed

COMMENTS: COMMENTS:



25mm/s 10mm/mV 150Hz 9.0.10 12SL 241 HD CID: 137 SID: 3309171 EID: EDT: ORDER:

McLeish, Wendy ID:2505876061 08-DEC-2020 15:13:53 GREATER GLASGOW SITE-GRAE ROUTINE RECORD

25-MAY-1987 (33 yr)
Female

Room:
Loc:201

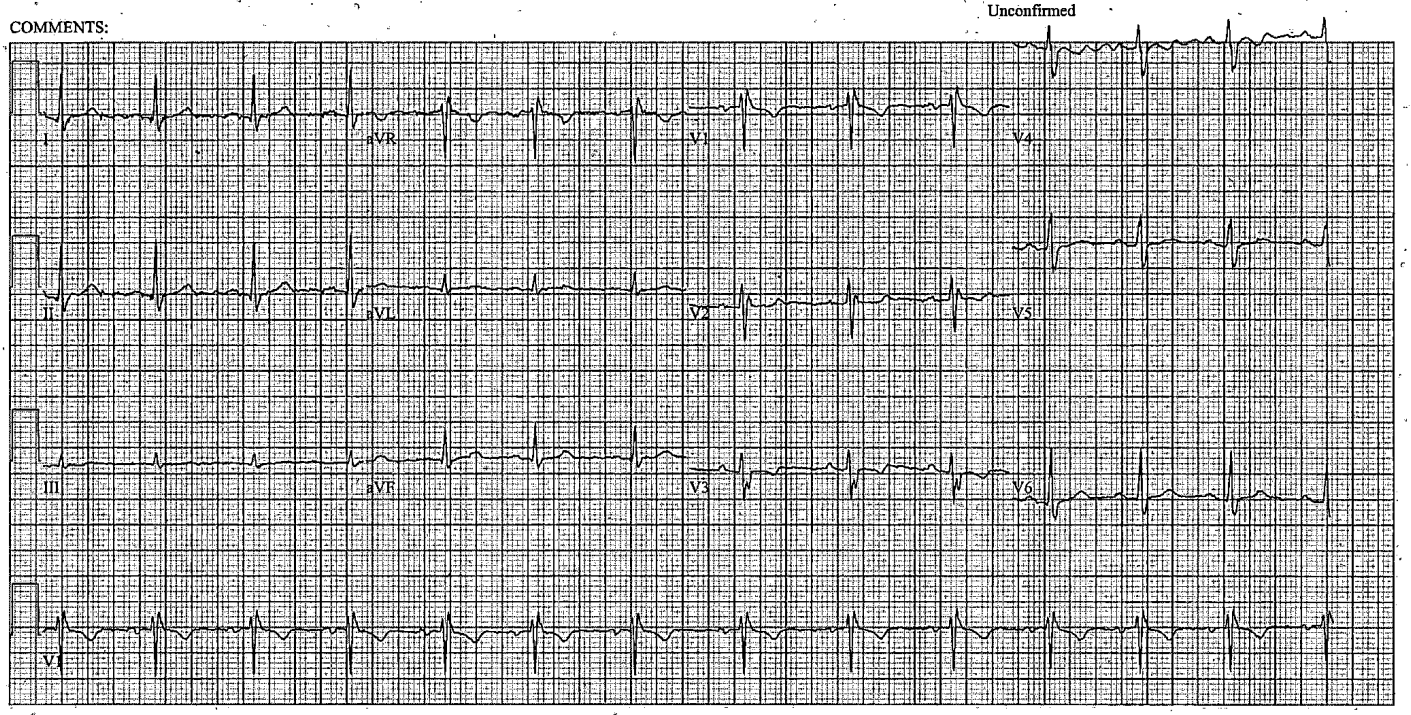
Vent. rate	79	BPM
PR interval	170	ms
QRS duration	104	ms
QT/QTc	360/412	ms
P-R-T axes	30 40	37

Normal sinus rhythm
Incomplete right bundle branch block
Borderline ECG

Technician:
Test ind:

COMMENTS:

Unconfirmed



25mm/s 10mm/mV 100Hz 9.0.10 12SL 241 HD CID: 118 SID: 3309171 EID: EDT: ORDER:

MCLEISH, WENDY ID:2505876061 09-AUG-2013 17:20:11 GREATER GLASGOW SITE-GRAAU ROUTINE RECORD

25-MAY-1987 (26 yr)
Female

Room:
Loc:202

Vent. rate	82	BPM
PR interval	198	ms
QRS duration	100	ms
QT/QTc	380/443	ms
P-R-T axes	69 14	27

Normal sinus rhythm
Incomplete right bundle branch block
Borderline ECG

Technician:GRI 203
Test ind:

Referred by: UNCONFIRMED ECG REPORT Sys Admin 2



25mm/s 10mm/mV 150Hz 7.1.1 12SL 237 CID: 1

SID: 3309171 EID:21002 EDT: 14:57 14-AUG-2013 ORDER:

McLeish, Wendy
Female
25/05/1987 (38 Years)

Location: 201

Technician ID: rebecca

Vent. rate	72	BPM
PR interval	158	ms
QRS duration	106	ms
QT/QTc Baz	382/418	ms
P-R-T axes	20 28 7	

Patient ID: 2505876061
Normal sinus rhythm
Incomplete right bundle branch block
Borderline ECG

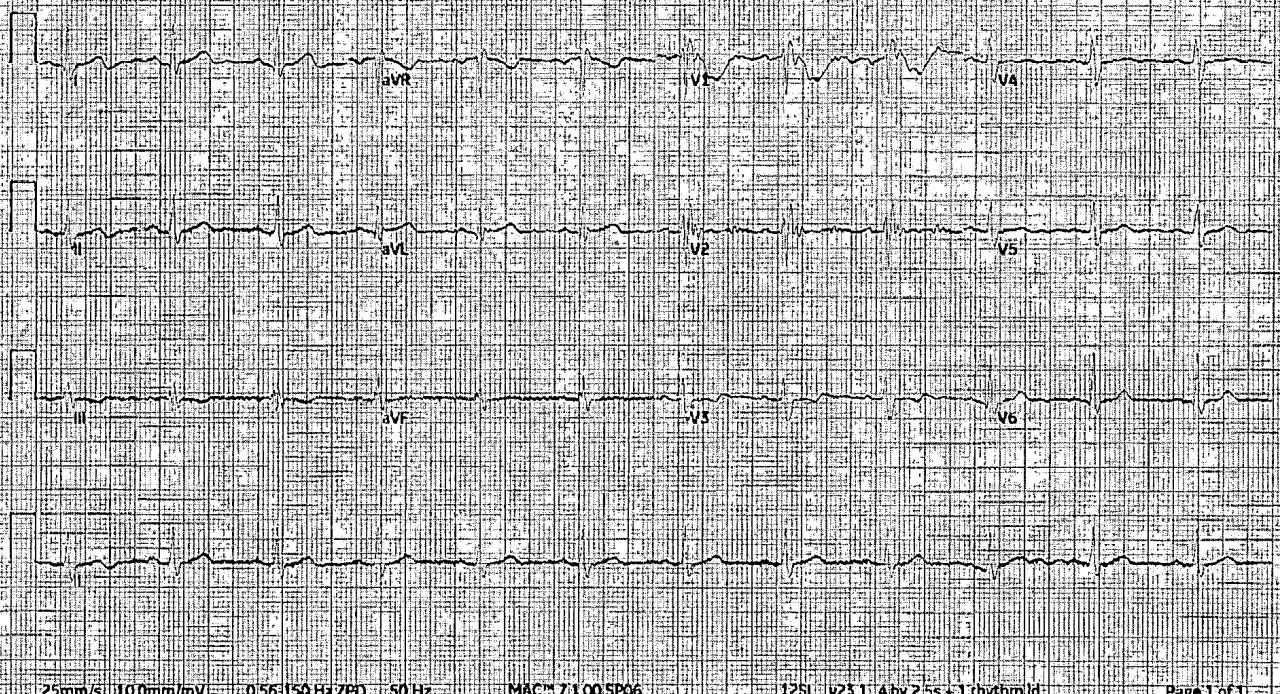
20.12.2025 23:51:24
GRI A&E

2505876061
MCLEISH
Wendy
257 TODD STREET
Glasgow, Lanarkshire
G31 3SF

F
25/05/1987

Location:
Comments: 0/1

Unconfirmed



25mm/s 10.0mm/mV 0.56-150 Hz ZPD 50 Hz MAC™ 7 1.00.SP06 12SL v23.1 4 by 2.5s + 1 rhythm ld

Vital Signs™ 226 166 05

McLeish, Wendy
Female
25.05.1987 (38 Years)

Location: 201

Technician ID: pq

Vent. rate	75	BPM
PR interval	144	ms
QRS duration	94	ms
QT/QTc-Baz	378/422	ms
P-R-T axes	-7 -1 18	

Patient ID: 2505876061

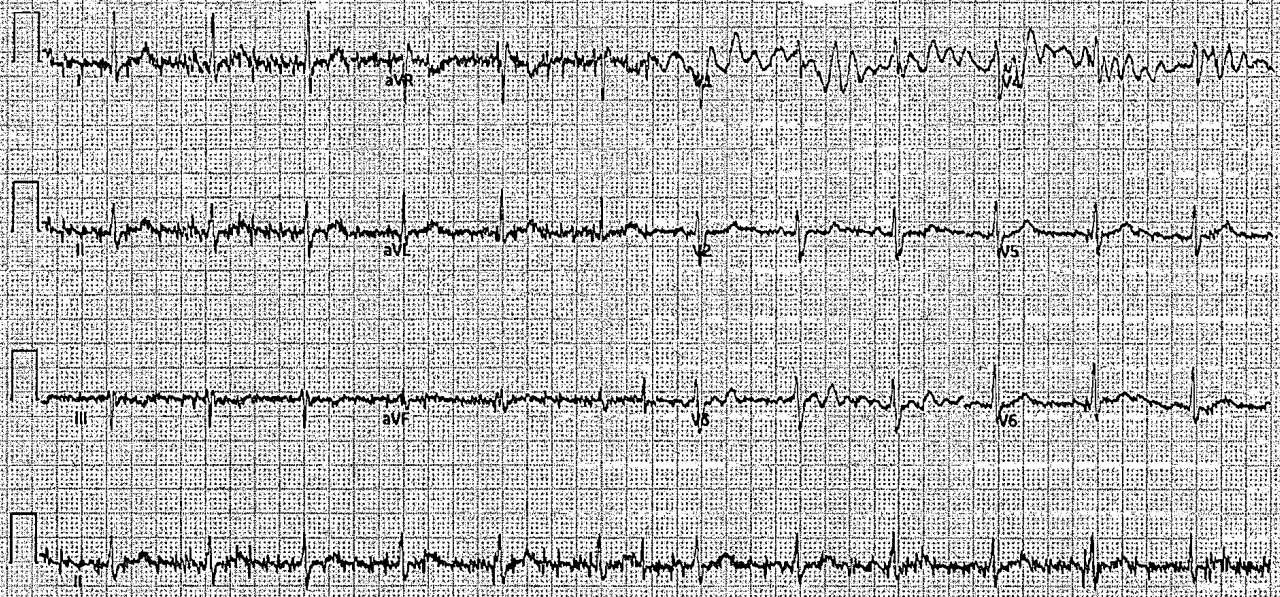
Normal sinus rhythm
T wave abnormality, consider anterior ischemia
Abnormal ECG

2505876081
MCLEISH F
Wendy 25/05/1987

12.09.2025 02:24:39 PM
A&E

Location:
Comments:

Unconfirmed



25mm/s 10.0mm/mV 0.56-150 Hz ZPD 50 Hz MAC™ 7 1.00 SP07 12SL v23.1 4 by 2.5s + 1 rhythm Id

Vital Signs™ 226 166 05

McLeish, Wendy **Patient ID: 2505876061** **12.09.2025 02:25:46 PM**

Female
25.05.1987 (38 Years)

Vent. rate	78	BPM
PR interval	178	ms
QRS duration	96	ms
QT/QTc-Baz	398/453	ms
P-R-T axes	58 7 32	

Normal sinus rhythm
Normal ECG

A&E

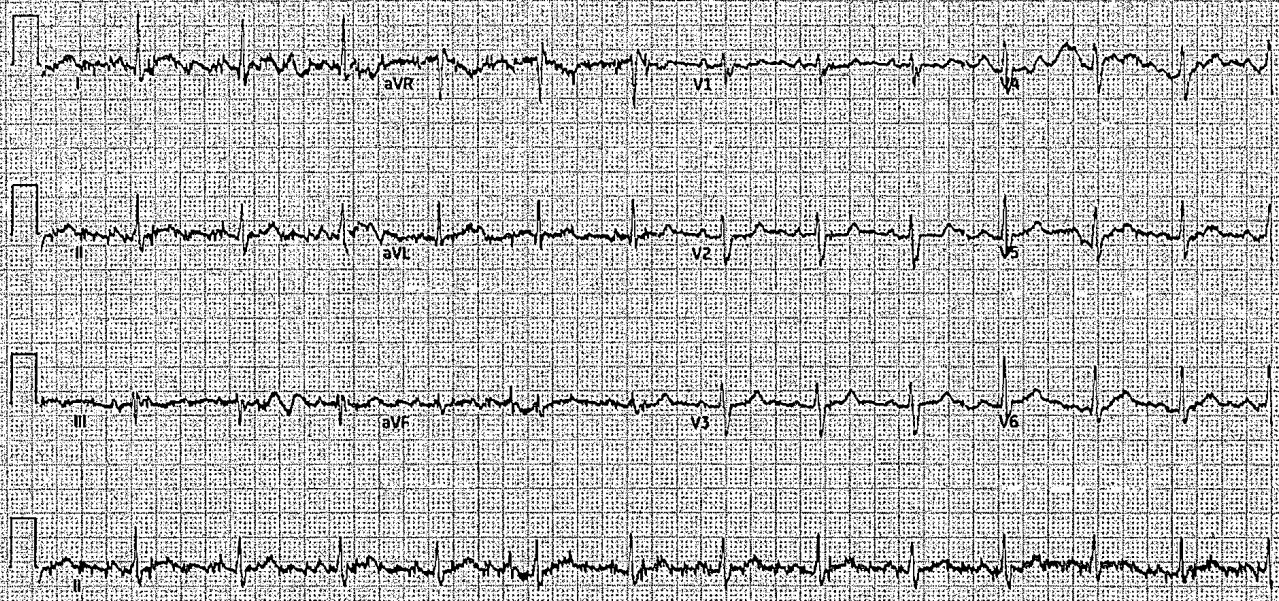
Location: 201

Technician ID: pq

Location:
Comments:

2505876061 F
MCLEISH 25/05/1987
Wendy
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY

Unconfirmed



25mm/s 10.0mm/mV 0.56-150 Hz ZPD 50 Hz MAC™ 7 1.00 SP07 12SL v23.1 4 by 2.5s + 1 rhythm ld Page 1 of 1

McLeish, Wendy

Patient ID: 2505876061

25.02.2025 21:58:19

A&E

Vent. rate	81	BPM
PR interval	172	ms
QRS duration	110	ms
QT/QTc-Baz	384/446	ms
P-R-T axes	30 1 2	

Normal sinus rhythm
Incomplete right bundle branch block
ST & T wave abnormality, consider anterior ischemia
Abnormal ECG

Location: 201

Technician ID: hf

No change from prev.

Location:
Comments:

2505876061
MCLEISH
Wendy
FLAT 3/2
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3L

F
25/05/1987

Unconfirmed



25mm/s 10.0mm/mV 0.56-150 Hz ZPD 50 Hz MAC™ 7 1.00 SP07 12SL v23.1 4 by 2.5s + 1 rhythm ld

MCLEISH, WENDY ID: 2505876061 24-Mar-2023 16:20:54 ACUTE ASSESSMENT UNIT GRI

35years
Female

Vent. rate 71 bpm
PR interval 162 ms
QRS duration 108 ms
QT/QTc 384/417 ms
P-R-T axes 36 35 21

normal sinus rhythm
complete right bundle branch block
Borderline ECG

Loc: 202

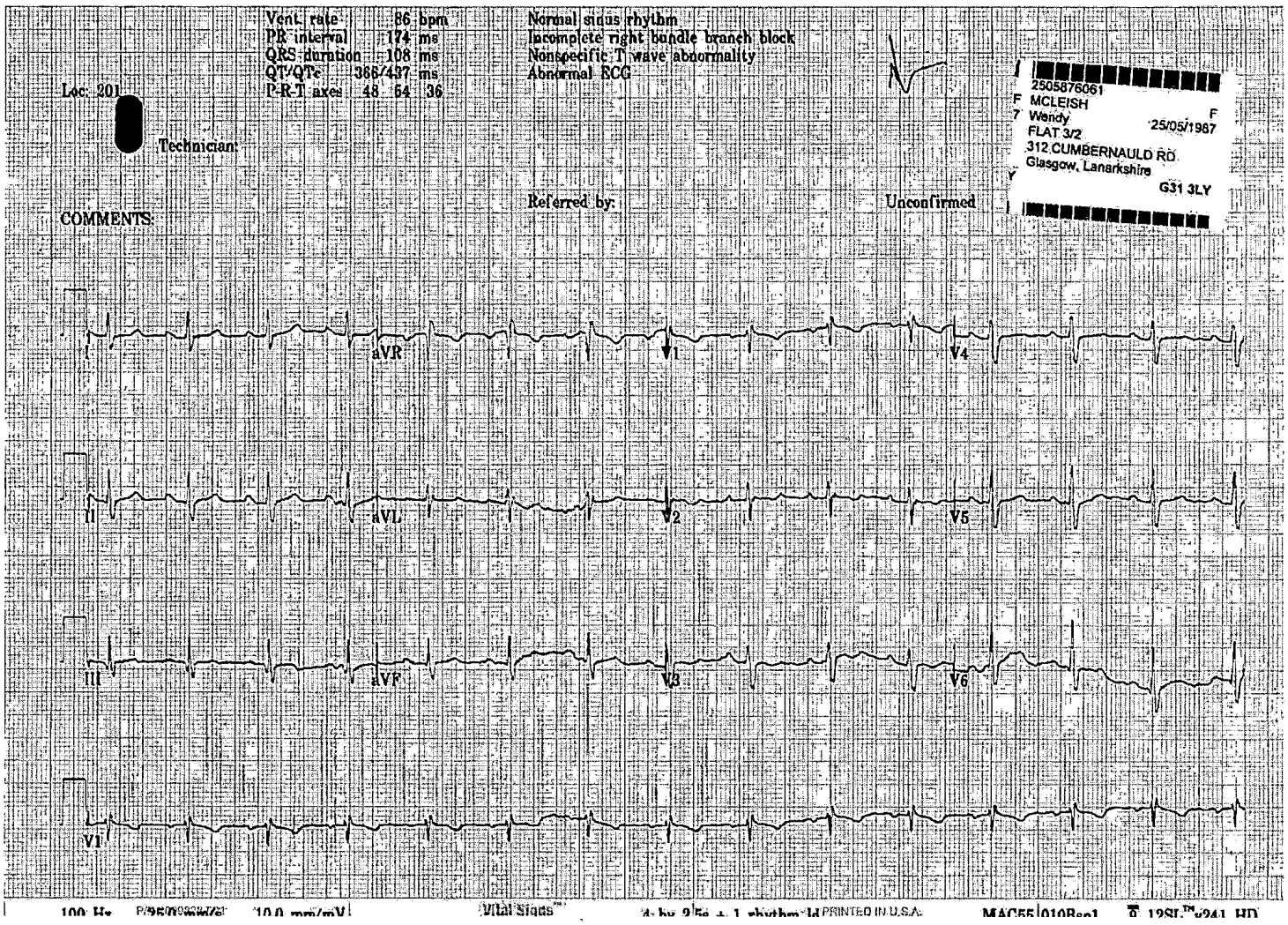
Technician:

2505876061
MCLEISH
Wendy F
FLAT 3/2 25/05/1987
312 CUMBERNAULD RD
Glasgow, Lanarkshire,
G31 3LY

Unconfirmed

aVR V1 V4
aVL V2 V5
aVF V3 V6

150 Hz 25.0 mm/s 10.0 mm/mV
P/N 2009028-021
Vital Signs 4 by 2.5s + 1 rhythm -Id
MAC55 010B
PRINTED IN U.S.A.


Vent. rate 86 bpm
PR interval 174 ms
QRS duration 108 ms
QT/QTc 366/437 ms
P-R-T axes 48 64 36
Normal sinus rhythm
Incomplete right bundle branch block
Nonspecific T wave abnormality
Abnormal ECG
Loc: 201
Technician
2505876061
F MCLEISH
7 Wendy F
FLAT 3/2 25/05/1987
312 CUMBERNAULD RD
Glasgow, Lanarkshire
G31 3LY
Referred by:
Unconfirmed
COMMENTS:
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
VI
100 Hz
10.0 mm/mV
Vital Signs
PRINTED IN U.S.A.

McLeish, Wendy 2505876061 8-Dec-2020 15:13:53 GLASGOW ROYAL INFIRMARY ED

25-May-1987
Female

Vent. rate 70 bpm
PR interval 170 ms
QRS duration 104 ms
QT/QTc 360/412 ms
P-R-T axes 30 40 47

Normal sinus rhythm
Incomplete right bundle branch block
Borderline ECG

INFERIOR INFARCT ACUTE
NO DATA

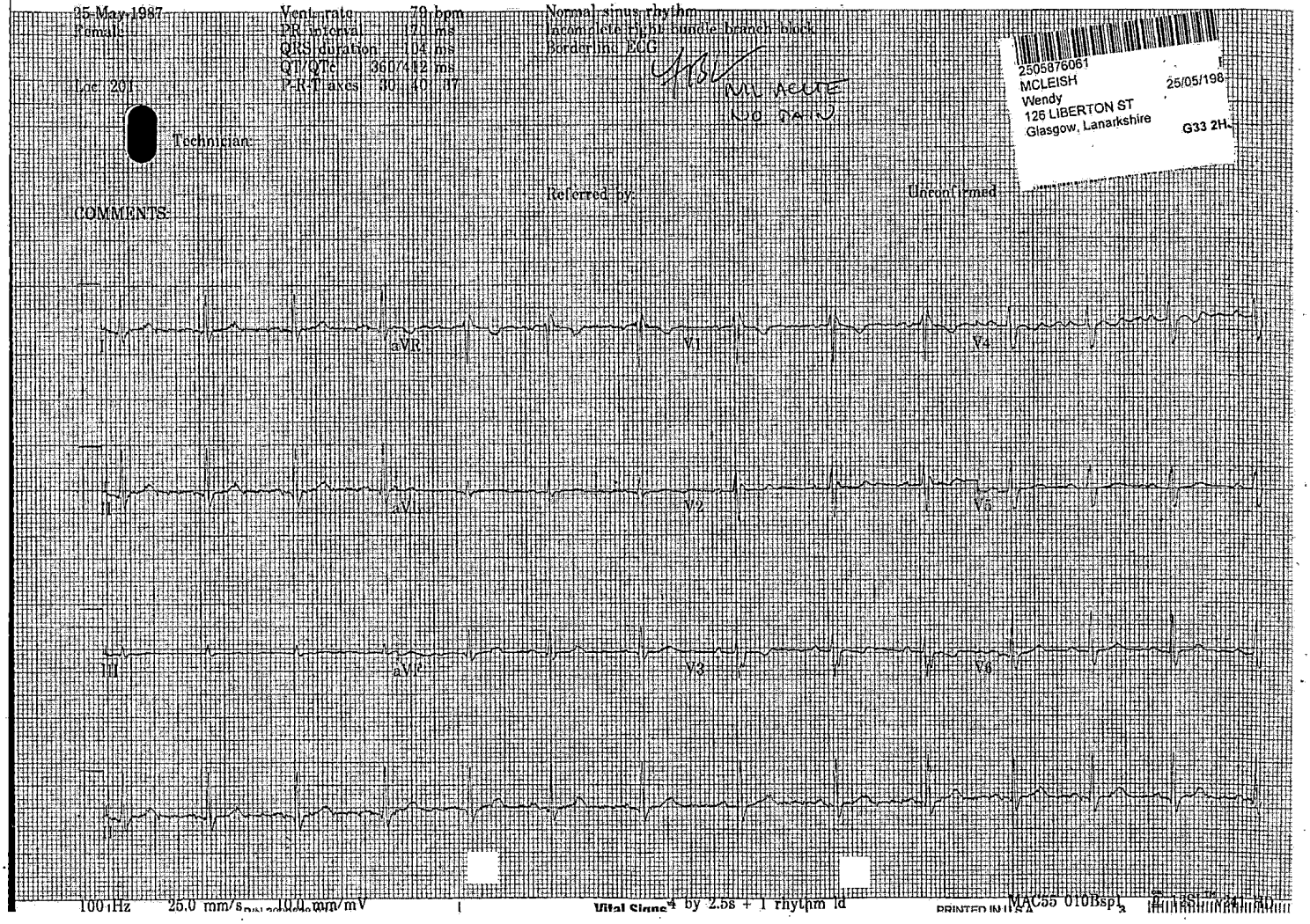
2505876061
MCLEISH 25/05/198
Wendy
126 LIBERTON ST
Glasgow, Lanarkshire G33 2H

Loc: 20I

Technician:

Referred by: Unconfirmed

COMMENTS:



100 1Hz 25.0 mm/s 10.0 mm/mV Vital Signs 4 by 2.5s + 1 rhythm ld PRINTED IN U.S.A. MAC55 010Bspl

Glasgow Royal Infirmary
Echocardiogram Report

NHS Greater Glasgow and Clyde

Patient Name **McLeish, Wendy** Date of Birth **25/05/1987** Patient Id **2505876061** Sex **Female** **Referred from** Dr Angela Wright.	Date of Exam **21/11/2024** Sonographer **Lea, James** Ref. Doc **Dr Angela Wright** Ward/Dept. **ECG** **Indication:** 37 yr old female. previous echo for resp failure. recent CT showed enlarged pulmonary vessels suggestive of PH. ECHO to assess. ? PH.

2D		M-Mode		Doppler	
IVSd	0.7 cm	TAPSE	3.3 cm	LVOT Vmax	1.2 m/s
LVIDd	3.9 cm			LVOT Vmean	0.8 m/s
LVIDd Index	2.2 cm/m²			LVOT maxPG	6 mmHg
EDV(Teich)	65 ml			LVOT meanPG	3 mmHg
LVPWd	0.7 cm			LVOT Env.Ti	289.2 ms
LVd Mass	76.2 g			LVOT VTI	22.2 cm
LVd Mass Index	43.1 g/m²			LVSV Dopp	66 ml
LVd Mass (ASE)	72.5 g			LVSI Dopp	37.2 ml/m²
LVd Mass Ind (ASE)	40.9 g/m²			AV Vmax	1.3 m/s
RWT	0.36			AV Vmean	0.9 m/s
RV basal	4.7 cm			AV maxPG	7 mmHg
RV mid	4.1 cm			AV meanPG	4 mmHg
RV length	7.7 cm			AV Env.Ti	319.7 ms
LVOT Diam	1.9 cm			AV VTI	29.2 cm
LA Diam	3.9 cm			AVA Vmax	2.69 cm²
Ao Arch Diam	2.2 cm			AV EOA I Vmax	1.52 cm²/m²
Ao Arch Diam Indexed	0.014 cm/m			AVA (VTI)	2.26 cm²
LVLd A4C	7.5 cm			AV/LVOT	1.31
LVEDV MOD A4C	83.6 ml			DVI	0.76
LVLs A4C	5.9 cm			MV E Vel	0.9 m/s
LVESV MOD A4C	20.3 ml			MV DecT	187 ms
LVEF MOD A4C	76 %			MV Dec Slope	4.8 m/s²
SV MOD A4C	63.35 ml			MV A Vel	0.8 m/s
LVLd A2C	7.7 cm			MV E/A Ratio	1.2
LVEDV MOD A2C	82.7 ml			E' Sept	12.4 cm/s
LVLs A2C	6.4 cm			E' Lat	14.9 cm/s
LVESV MOD A2C	34.3 ml			E' Avg	13.7 cm/s
LVEF MOD A2C	58.49 %			E/E' Avg	6.6
SV MOD A2C	48.38 ml			PV Vmax	1.15 m/s
EF Biplane	67 %			PV Vmean	0.85 m/s
LVEDV MOD BP	83 ml			PV maxPG	5 mmHg
LVESV MOD BP	27 ml			PV meanPG	3.17 mmHg
SV Biplane	56 ml			TR Vmax	2.1 m/s
				TR maxPG	18 mmHg

Print Date: 26/11/2024

LVEDVInd MOD BP	46.87 ml/m²		
LVESVInd MOD BP	15.38 ml/m²		
LA Area	17.2 cm²		
RA Area	23.6 cm²		

Echo Summary

ECG -SR ~65bpm
Study Quality - Adequate

Normal LV cavity size and wall thickness with all regions contracting well. Ejection fraction by Simpsons Biplane- 67%
Normal E/E ratio.
Septal flatting in Diastole consistent with RV volume overload

Dilated RV dimension at the basal to mid level. Good systolic function c/w TAPSE.

Dilated RA by area, normal LA.
IAS appears intact by colour flow assessment.

Mildly thickened anterior mitral valve leaflet good leaflet mobility.and trace MR.

Tri-leaflet aortic valve with good cusp separation and normal Doppler flows.
Normal aortic arch appearance and dimension
Normal pulmonary valve appearance. Trivial PR noted on CFD.

Normal tricuspid valve appearance with good leaflet mobility and trivial TR with a PASP estimated at 18mmHg

Unable tot obtain subcostal images, IVC not visualised.

Conclusion

Normal LV cavity size and wall thickness with all regions contracting well. Ejection fraction by Simpsons Biplane- 67%
Septal flattening in diastole consistent with RV volume overload

Dilated RV dimensions and dilated RA by area, suggestive of pulmonary hypertension.

No signiificant valvular abnormalities visualised

Reported By: JL / AP

Glasgow Royal Infirmary

NHS Greater Glasgow and Clyde

Department of Respiratory Medicine
6 Minute Walk Test

Name: Wendy McLeish CHI: 2505876061

Consultant: Dr Wright Date: 28/11/2024

Physiologist: Fergus Wilkie

Time (min)	SpO2 (%)	Heart rate (bpm)	BORG (x/10)
Rest	98	57	1
1	98	62	
2	98	79	
3	98	79	6
4	99	80	
5	98	80	
6	99	79	8
Recovery			
0:30	98	73	
1:00	99	60	
1:30	99	57	
2:00	99	58	
2:30			
3:00			

Total distance walked: 300 **metres**

Comments:

Quite unsteady on feet. Steady pace maintained with no stops.
Patient did not desaturate by >4% to less than 90%.

Signed: Fergus Wilkie

Signed: Gavin Sneddon

XR Chest

Performed	11-Mar-2026 12:01	Received	11-Mar-2026 13:01
Reported	11-Mar-2026 12:59	Order Number	G107H43307363
Status	Final	Source System	MiSys

XR Chest Final
Wendy McLeish
Clinical History :

R sided chest wall pain and productive cough. CXR ? CAP

XR Chest :
Comparison is made with the previous film of 19/09/2025.No pneumothorax or pleural effusion. Normal heart and mediastinal contour. The lungs are clear and the bony thorax is intact.

Reported by: Dr Colin Noble
Verified by: Dr Colin Noble

XR Chest

Performed	19-Sep-2025 14:06	Received	15-Oct-2025 13:53
Reported	15-Oct-2025 13:51	Order Number	G107H42693255
Status	Final	Source System	MiSys

XR Chest Final
Wendy McLeish
Clinical History :

Looks like assaulted, chest pain RO PTX

XR Chest :
Comparison is made with the previous film of 16/04/2025.Normal heart and mediastinal contour. No pneumothorax or pleural effusion. The lungs are clear and the bony thorax is intact.

Reported by: Dr Colin Noble
Verified by: Dr Colin Noble

CT Head

Performed	19-Sep-2025 14:00	Received	19-Sep-2025 15:31
Reported	19-Sep-2025 15:29	Order Number	G107H42692255
Status	Final	Source System	MiSys

CT Head Final
Wendy McLeish
Clinical History :

Bilateral panda eyes and haematoma/ contusion to forehead, says bitten by dog but looks like assault. ? intracranial injury

CT Head : no fracture of the skull vault or base.
Unenhanced volume study. No intra or extra-axial haemorrhage. Normal brain parenchyma, ventricular system and peripheral CSF spaces. No fracture of the skull vault or base. No facial bone fracture.
Severe, bilateral periorbital soft tissue swelling confluent across the glabella and lower forehead. No discrete collection. No post septal orbital changes.

Reported by: Dr Claire McArthur
Verified by: Dr Claire McArthur

CT Facial bones

Performed	19-Sep-2025 13:59	Received	19-Sep-2025 15:45
Reported	19-Sep-2025 15:43	Order Number	G107H42693253
Status	Final	Source System	MiSys

CT Facial bones Final
Wendy McLeish
Clinical History :

Bilateral panda eyes and haematoma/ contusion to forehead, says bitten by dog but looks like assault. ? intracranial injury

CT Facial bones :
This study has been reported with the CT head of 19/09/2025 no separate images in this PACs entry, please refer to the report of that study.

Reported by: Dr Laura Thomson
Verified by: Dr Laura Thomson

XR Chest

Performed	16-Apr-2025 00:12	Received	16-Apr-2025 08:05
Reported	16-Apr-2025 08:03	Order Number	G107H42135800
Status	Final	Source System	MiSys

XR Chest Final
Wendy McLeish
Clinical History :

prev CAP
recent finished abx.
right post lung pain
?recurrence of CAP

XR Chest :
Comparison is made with the previous film of 05/02/2024. The heart size is at the upper limit of normal. The central pulmonary arteries are slightly prominent. New minor atelectasis at the right base which could relate to infection. No other new focal lung pathology. No evidence of cardiac failure. No pneumothorax or pleural effusion. The bony thorax is intact.

Reported by: Dr Colin Noble
Verified by: Dr Colin Noble

CT Angiogram pulmonary

Performed	30-Jan-2025 09:40	Received	30-Jan-2025 11:24
Reported	30-Jan-2025 11:22	Order Number	G107H41670018
Status	Final	Source System	MiSys

CT Angiogram pulmonary Final
Wendy McLeish
Clinical History :
37 yr old female. previous ecmo for resp failure. PH on echo and hrct. For CTPA - chronic PE? Not a Wednesday please.

CT Angiogram pulmonary :
Comparison made to HRCT dated 13/08/23.
Pulmonary arterial phase contrast study. Good contrast opacification.

No pulmonary embolus.
No focal consolidation. Longstanding right middle lobe bronchiectasis.
A 6 mm right lower lobe nodule in-keeping with an benign intrapulmonary lymph node.

Right ventricular dilation, flattening of the interventricular septum and contrast reflux into the IVC is consistent with a degree of right heart failure.

No lymphadenopathy.
The visualised solid upper abdominal organs are unremarkable on this non-dedicated scan.
No acute skeletal abnormality.

Impression: No pulmonary embolus. Evidence to suggest right heart failure.

Reported by: Dr Yu Jing Lee (SpR) and Dr Ross MacDuff
Verified by: Dr Ross MacDuff

CT Spine cervical

Performed	09-Apr-2024 15:19	Received	09-Apr-2024 16:08
Reported	09-Apr-2024 16:06	Order Number	G107H40816435
Status	Final	Source System	MiSys

CT Head Final
Wendy McLeish
Clinical History :

RTC sat eve. Ongoing headache since. vomit x5. Midline c spine tenderness C4. GCS15 No neurology

CT Head :

Unenhanced CT head. Comparison to previous CT dated 26/03/2023. No acute infarct, space-occupying lesion or intracranial haemorrhage. Unremarkable CSF spaces and ventricles with no hydrocephalus. Unremarkable bony skull vault.

Conclusion: No acute intracranial findings, in particular no haemorrhage.

CT Spine cervical :

Unenhanced CT of the cervical spine. No acute cervical spine fracture. Loss of the usual lordosis with straightening of the cervical spine but otherwise unremarkable vertebral alignment and preserved intervertebral disc height. Unremarkable imaged lung apices and soft tissue structures of the neck.

Conclusion: No acute cervical spine fracture. Please note ligamentous injury is not excluded on CT.

Reported by: Dr Patrick Baker (SpR) and Dr Christopher Nicholas
Verified by: Dr Christopher Nicholas

CT Head

Performed	09-Apr-2024 15:19	Received	09-Apr-2024 16:08
Reported	09-Apr-2024 16:06	Order Number	G107H40816270
Status	Final	Source System	MiSys

CT Head Final
Wendy McLeish
Clinical History :

RTC sat eve. Ongoing headache since. vomit x5. Midline c spine tenderness C4. GCS15 No neurology

CT Head :

Unenhanced CT head. Comparison to previous CT dated 26/03/2023. No acute infarct, space-occupying lesion or intracranial haemorrhage. Unremarkable CSF spaces and ventricles with no hydrocephalus. Unremarkable bony skull vault.

Conclusion: No acute intracranial findings, in particular no haemorrhage.

CT Spine cervical :

Unenhanced CT of the cervical spine. No acute cervical spine fracture. Loss of the usual lordosis with straightening of the cervical spine but otherwise unremarkable vertebral alignment and preserved intervertebral disc height. Unremarkable imaged lung apices and soft tissue structures of the neck.

Conclusion: No acute cervical spine fracture. Please note ligamentous injury is not excluded on CT.

Reported by: Dr Patrick Baker (SpR) and Dr Christopher Nicholas
Verified by: Dr Christopher Nicholas

XR Ankle Rt

Performed	25-Mar-2024 09:57	Received	25-Mar-2024 10:35
Reported	25-Mar-2024 10:33	Order Number	G107H40765162
Status	Final	Source System	MiSys

XR Ankle Rt Final
Wendy McLeish
Auto reported

For autosign off in TrakCare
A radiological report will not be issued for this examination. The referrer (or a more experienced clinical colleague) will interpret and evaluate the outcome of this examination and document this outcome in the patient's case notes within an appropriate time-scale. Should the referrer wish advice or a formal report please contact the Radiology Department. Reference: Procedure 10, Evaluation of Medical Exposure, Ionising Radiation (Medical Exposure) Regulations IR(ME) R 2017

Reported by: Auto Reporting
Verified by: Auto Reporting

XR Ankle Rt

Performed	26-Feb-2024 11:30	Received	26-Feb-2024 11:53
Reported	26-Feb-2024 11:51	Order Number	G107H40661565
Status	Final	Source System	MiSys

XR Ankle Rt Final
Wendy McLeish
Auto reported

For autosign off in TrakCare
A radiological report will not be issued for this examination. The referrer (or a more experienced clinical colleague) will interpret and evaluate the outcome of this examination and document this outcome in the patient's case notes within an appropriate time-scale. Should the referrer wish advice or a formal report please contact the Radiology Department. Reference: Procedure 10, Evaluation of Medical Exposure, Ionising Radiation (Medical Exposure) Regulations IR(ME) R 2017

Reported by: Auto Reporting
Verified by: Auto Reporting

XR Chest

Performed	05-Feb-2024 10:27	Received	06-Feb-2024 14:40
Reported	06-Feb-2024 14:38	Order Number	G107H40582877
Status	Final	Source System	MiSys

XR Chest Final
Wendy McLeish
Clinical History :

cough with blood streaks in sputum. chest clear. ? abnormality

XR Chest :
Comparison is made with the previous film of 24/03/2023.Normal heart and mediastinal contour. The lungs are clear and the bony thorax is intact.

Reported by: Dr Colin Noble
Verified by: Dr Colin Noble

XR Ankle Rt

Performed	05-Feb-2024 10:17	Received	05-Feb-2024 10:29
Reported	05-Feb-2024 10:27	Order Number	G107H40582812
Status	Final	Source System	MiSys

XR Ankle Rt Final
Wendy McLeish
Auto reported

For autosign off in TrakCare
A radiological report will not be issued for this examination. The referrer (or a more experienced clinical colleague) will interpret and evaluate the outcome of this examination and document this outcome in the patient's case notes within an appropriate time-scale. Should the referrer wish advice or a formal report please contact the Radiology Department. Reference: Procedure 10, Evaluation of Medical Exposure, Ionising Radiation (Medical Exposure) Regulations IR(ME) R 2017

Reported by: Auto Reporting
Verified by: Auto Reporting

XR Ankle Rt

Performed	28-Jan-2024 08:54	Received	02-Feb-2024 14:47
Reported	02-Feb-2024 14:45	Order Number	G107H40555061
Status	Final	Source System	MiSys

XR Ankle Rt Final
Wendy McLeish
Clinical History :

inversion injury right ankle swollen pain to medial and lateral aspect non weight br. ?#

XR Ankle Rt :
No previous imaging for comparison.

Ankle joint effusion and soft tissue swelling.

Appearances suggest a minimally displaced fracture of the anterolateral aspect of the distal tibia (tillaux type fracture). No overt talar shift. There is also the impression of possible posterior propagation of the fracture to the posterior cortex on the lateral projection. If required CT can be performed to further assess.

No other acute fractures seen.

Code N: No note: No sticky note available. Referrer's interpretation is unknown.

Reported by: Dr Paulina Kosk (SpR) and Dr Kenneth Lupton
Verified by: Dr Kenneth Lupton

CT Chest high resolution

Performed	13-Aug-2023 18:16	Received	14-Aug-2023 15:07
Reported	14-Aug-2023 15:05	Order Number	G107H39887007
Status	Final	Source System	MiSys

CT Chest high resolution Final
Wendy McLeish
Clinical History :

36 yr old female. CT March 2023 identified new GGO - liklely pneumonitis from intercurrent infection. Interval advised. thanks

CT Chest high resolution :
Supine inspiratory volume acquisition. Comparison is made with the previous CT of 26/03/2023. No major findings within the lower neck or the axillae. No focal abnormality within either breast. No mediastinal masses and no significant intrathoracic lymphadenopathy. No new cardiac findings. The central pulmonary arteries are of slightly large calibre which could indicate pulmonary arterial hypertension. Normal calibre thoracic aorta. There are bilateral paracardiac fat pads. Postinflammatory scarring with associated traction bronchiectasis in the right middle lobe is static. The patchy ground-glass attenuation in the lower lobes, lingula and posterior segment of the right upper lobe has improved but not resolved . No focal consolidation and no intrapulmonary mass lesion. No evidence of diffuse interstitial lung disease. No significant pleural fluid or thickening. Normal oesophagus and proximal stomach. No incidental findings within the upper abdomen. No major skeletal pathology.

Summary: Interval improvement in the nonspecific bilateral ground-glass attenuation.

Reported by: Dr Colin Noble
Verified by: Dr Colin Noble

CT Chest high resolution

Performed	26-Mar-2023 14:09	Received	28-Mar-2023 11:20
Reported	28-Mar-2023 11:18	Order Number	G107H39260816
Status	Final	Source System	MiSys

CT Chest high resolution Final
Wendy McLeish
Clinical History :

35 yr old female. previous ECMO in 2012 for severe CAP and resp failure. recurrent infections over last 12 months with radiological change. creps at left base. bronchiectasis? Pt requesting GRI only please due to transport

CT Chest high resolution :

Supine inspiratory volume HRCT.

The only prior CT available for comparison is that of 27/11/11. Interval chest radiographs reviewed.

There is some contracture and scarring of the medial segment right middle lobe with traction bronchiectasis within and this is clearly very chronic (key image). There is similar less pronounced subsegmental traction bronchiectasis in the adjacent anterior segment right upper lobe. There is similar mild subsegmental traction bronchiectasis in the inferior segment left upper lobe (key image).

There are scattered regions of GGO bilaterally in all lobes mainly peribronchovascular, no cavitation or effusion. No significant emphysema and no evidence of an active IPF.

No focal pulmonary or bronchial mass, no hilar or mediastinal adenopathy. No cardiovascular or other incidental abnormality apparent.

Comment - The traction scarring and associated bronchiectasis looks long established and could well be sequelae of the severe pulmonary injury she suffered in 2011. The small regions of scattered GGO look more like current active process and I suspect intercurrent COVID-19 or influenza. Follow-up should help clarify.

Reported by: Dr Giles Roditi
Verified by: Dr Giles Roditi

CT Head

Performed	26-Mar-2023 14:02	Received	26-Mar-2023 14:33
Reported	26-Mar-2023 14:31	Order Number	G107H39499025
Status	Final	Source System	MiSys

CT Head Final
Wendy McLeish
Clinical History :

Patient presents with vertigo, urinary incontinence, and confusion. ?Normal pressure hydrocephalus ?cerebellar syndrome
Presented w LOC, found on floor by partner with amnesia of events. Resolved poor coordination
) on 26-Mar-2023 at 12:17)

CT Head :
Comparison to previous MRI dated 08/12/2021 and CT dated 08/12/2020.
Unenhanced acquisition.

No acute intracranial haemorrhage or collection.
No evidence of acute or established major vessel territory infarction.
No evidence of altered pressure state with no hydrocephalus.

No evidence of head injury or skull fracture.

Please note CT is suboptimal to assess posterior fossa structures and MRI is advised if ongoing clinical concern.

Reported by: Dr Leanne Alexander (SpR) and Dr Adam Berg
Verified by: Dr Adam Berg

XR Chest

Performed	24-Mar-2023 17:34	Received	27-Mar-2023 10:45
Reported	27-Mar-2023 10:45	Order Number	G107H39496962
Status	Final	Source System	MiSys

XR Chest Final
Wendy McLeish
This attendance is part of a series
Please see the report for event
(url=cris:E-37336065|37336065)
26-Mar-2023 14:09
CT Chest high resolution (CHRC)

Reported by: Dr Giles Roditi
Verified by: Dr Giles Roditi

XR Chest

Performed	11-Jan-2023 15:20	Received	18-Jan-2023 10:30
Reported	18-Jan-2023 10:28	Order Number	G107H39237398
Status	Final	Source System	MiSys

XR Chest Final
Wendy McLeish
Clinical History :

SOB and pleuritic CP. Cough and no response to antibiotics/steroids. ?infective changes

XR Chest :
Comparison is made with the previous film of 06/12/2016. Underinspired film. There is minor linear atelectasis in the left lower zone. No other focal lung pathology. Normal heart and mediastinal contour. No pneumothorax or pleural effusion. The bony thorax is intact. I note HRCT thorax has been requested.

Reported by: Dr Colin Noble
Verified by: Dr Colin Noble

XR Chest

Performed	17-Nov-2022 12:48	Received	17-Nov-2022 23:20
Reported	17-Nov-2022 23:18	Order Number	G107H39063603
Status	Final	Source System	MiSys

XR Chest Final
Wendy McLeish
Clinical History :

persistent cough - ongoing left basal changes post-consolidation on 19th Oct - discussed with respiraotry who advised further repeat x-ray please 4-6 weeks later (from date commencing 16th November)

XR Chest :
Compared to 19/10/2022 there has been further clearance of the left lower zone.
Appearances in keeping with slowly resolving infective/inflammatory change.
There are no additional significant new or suspicious findings.

Reported by: Dr Sean Kelly
Verified by: Dr Sean Kelly

XR Chest

Performed	19-Oct-2022 10:09	Received	01-Nov-2022 08:30
Reported	01-Nov-2022 08:28	Order Number	G107H38959815
Status	Final	Source System	MiSys

XR Chest Final
Wendy McLeish
Clinical History :
repeat CXR in 4-6 weeks please as per previous report. bibasal opacification L>R. ?resolution of infection.

Chest x-ray
Comparison 14 September 2022
Mediastinum unremarkable
Asymmetry left base has improved but not resolved
Recommend further followup
Dr R Davies Medica Reporting
GMC 3588040

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

Reported by: Dr Russell Davies
Verified by: Dr Russell Davies

XR Chest

Performed	14-Sep-2022 11:51	Received	15-Sep-2022 07:27
Reported	15-Sep-2022 07:25	Order Number	G107H38844811
Status	Final	Source System	MiSys

XR Chest Final
Wendy McLeish
Clinical History :

chronic cough 4 weeks clear sputum with exertional SOB. wheeze all zones on auscultation, nil focal creps. CXR pelase to assess for focal mass / consolidation

XR Chest :
Compared to 06/12/2016 there is subtle increased air space opacification of both lung bases particularly the left which are in keeping with possible infection.
The remainder of lung fields are clear.
A fully inspired centred PA film in 4-6 weeks time following any treatment deemed necessary is advised to assess clearance.

Reported by: Dr Sean Kelly
Verified by: Dr Sean Kelly

CT Head

Performed	08-Dec-2020 16:10	Received	08-Dec-2020 17:12
Reported	08-Dec-2020 17:10	Order Number	G107H36779759
Status	Final	Source System	MiSys

CT Head Final
Wendy McLeish
Clinical History :

sudden collapse with ?seizure today. alert orientated on arrival. had subsequent seizure in department, not known epileptic. bloods normal. been having headaches recently ?bleed ? tumour

CT Head :
Unenhanced scan.

Normal appearance of the brain parenchyma and CSF spaces. No intracranial haemorrhage. No space-occupying lesion. No fracture. Mucosal thickening within the right maxillary sinus.

Conclusion: no acute findings.

Reported by: Dr John Joseph (SpR) and Dr Mark McCleery
Verified by: Dr Mark McCleery

NM Lung Ventilation SPECT

Performed	07-Dec-2016 09:06	Received	07-Dec-2016 16:09
Reported	07-Dec-2016 16:07	Order Number	G107H32119743
Status	Final	Source System	MiSys

NM Lung Ventilation SPECT Final
Wendy McLeish
Clinical History : 27 weeks gestation. shortness of breath and chest and back pain. bloods normal. chest x ray normal. on clexane. ??PE

NM Lung Ventilation SPECT : Technegas ventilation study

NM Lung Perfusion SPECT : Matched non-segmental perfusion defect in the left upper lobe posteriorly. Allowing for gravity-dependent distribution of MAA, perfusion was otherwise normal to both lungs. There are no mismatched segmental or subsegmental perfusion defects.

Conclusions: The findings do not support a diagnosis of pulmonary embolism.

Reported by: Dr James Neilly
Verified by: Dr James Neilly

NM Lung Perfusion SPECT

Performed	07-Dec-2016 09:06	Received	07-Dec-2016 16:09
Reported	07-Dec-2016 16:07	Order Number	G107H32119746
Status	Final	Source System	MiSys

NM Lung Ventilation SPECT Final
Wendy McLeish
Clinical History : 27 weeks gestation. shortness of breath and chest and back pain. bloods normal. chest x ray normal. on clexane. ??PE

NM Lung Ventilation SPECT : Technegas ventilation study

NM Lung Perfusion SPECT : Matched non-segmental perfusion defect in the left upper lobe posteriorly. Allowing for gravity-dependent distribution of MAA, perfusion was otherwise normal to both lungs. There are no mismatched segmental or subsegmental perfusion defects.

Conclusions: The findings do not support a diagnosis of pulmonary embolism.

Reported by: Dr James Neilly
Verified by: Dr James Neilly

XR Chest

Performed	06-Dec-2016 09:06	Received	06-Dec-2016 12:04
Reported	06-Dec-2016 12:02	Order Number	G107H32117424
Status	Final	Source System	MiSys

XR Chest Final
Wendy McLeish
Clinical History :

27/40 gestation. 2 week Hx SOB on exertion and 1x ep haemoptysis. ?PE, ?pneumonia.
Please screen bump.

Pb rubber applied ++

XR Chest :

Comparison is made to previous radiograph of 11/02/15.

Lungs are clear. Normal cardiac and mediastinal contours..

Normal bony thorax.

Reported by: Dr Umme Sara Zishan (SpR)
Verified by: Dr Umme Sara Zishan (SpR)

XR Chest

Performed	11-Feb-2015 15:44	Received	18-Feb-2015 09:54
Reported	18-Feb-2015 09:52	Order Number	G107H29953716
Status	Final	Source System	MiSys

XR Chest Final
Wendy McLeish
Clinical History : 4 weeks cough and right chest wall pain. Clinically well.

XR Chest :

The heart is not enlarged and mediastinal contours are normal. Lungs clear, no evidence of new pathology when compared to 09/08/2013.

Reported by: Dr Giles Roditi
Verified by: Dr Giles Roditi

XR Chest

Performed	09-Aug-2013 19:35	Received	11-Aug-2013 13:09
Reported	11-Aug-2013 12:47	Order Number	G107H28218009
Status	Final	Source System	MiSys

XR Chest Final
Wendy McLeish
Clinical History :
Previous pneumonia. Chest pain.

XR Chest :
Comparison is made previous examination from March.

Heart is not enlarged. Mediastinal contours are unremarkable. Lungs are clear.

Reported by: Dr Cindy Chew
Verified by: Dr Cindy Chew

US Abdomen

Performed	21-Sep-2012 09:12	Received	21-Sep-2012 11:13
Reported	21-Sep-2012 10:51	Order Number	G107H27244305
Status	Final	Source System	MiSys

US Abdomen Final
Wendy McLeish
Clinical History : ? Gallstones.

US Abdomen : Difficult examination due to high position of liver.

The gallbladder appears normal no stones demonstrated. Normal calibre common duct with no intrahepatic duct dilatation.

The liver appears normal in shape, size and echotexture, no focal lesion demonstrated.Portal vein appears patent with no reversal of flow. The spleen is not enlarged. No free fluid seen within the abdomen.

Normal ultrasound appearance of the head of pancreas; the body and tail obscured by overlying bowel gas.

Normal ultrasound appearance of both kidneys and aorta.

This examination has been reported by Mairi Devine, Sonographer.

Reported by: Mairi Devine (Sonographer)
Verified by: Mairi Devine (Sonographer)

XR Chest

Performed	26-Mar-2012 15:55	Received	05-Apr-2012 11:43
Reported	05-Apr-2012 11:18	Order Number	G107H26757867
Status	Final	Source System	MiSys

XR Chest Final
Wendy McLeish
Clinical History :
Right upper lobe pneumonia with ITU admission. Resolution?

XR Chest :
Comparison is made to the previous chest x-rays.
There has been resolution of the previous new pneumonic changes. There remains a little linear atelectasis in the right mid zone in keeping with post inflammatory scarring.

Reported by: Dr Laura Thomson (SpR)
Verified by: Dr Laura Thomson (SpR)

XR Chest

Performed	23-Dec-2011 16:29	Received	28-Dec-2011 14:43
Reported	28-Dec-2011 14:21	Order Number	G107H26490673
Status	Final	Source System	MiSys

XR Chest Final
Wendy McLeish
Clinical History : NG tube in situ - check position.

XR Chest :

AP erect ward film. NGT appears in satisfactory position in this patient with tracheostomy in situ. There is continuing bilateral basal consolidation.

Reported by: Dr Giles Roditi
Verified by: Dr Giles Roditi

US Abdomen and pelvis

Performed	22-Dec-2011 11:27	Received	22-Dec-2011 12:25
Reported	22-Dec-2011 12:03	Order Number	G107H26482206
Status	Final	Source System	MiSys

US Abdomen and pelvis Final
Wendy McLeish
Clinical History : CAP ITU admission. ECMO. Patient now jaundiced, liver enzymes deranged, ? cause.

US Abdomen and pelvis :

Technically limited examination due to marked tremor causing movement artefacts and degraded image. As best seen, normal appearance of the liver, gallbladder, biliary tree, both kidneys and spleen. Pancreas was obscured. No free fluid.

Reported by: Frith Noble
Verified by: Frith Noble

XR Chest

Performed	17-Dec-2011 16:19	Received	21-Dec-2011 17:58
Reported	21-Dec-2011 17:36	Order Number	G107H26470887
Status	Final	Source System	MiSys

XR Chest Final
Wendy McLeish
Clinical History : Tracheostomy in place, deteriorating respiratory function with raised inflammatory markers.

XR Chest :

AP erect ward film. Tracheostomy tube in situ, NGT is looped in stomach fundus region as before. There is persistent consolidative shadowing medially in the right lung partly obscuring the hilum with some further patchy consolidation in the left mid zone though this is fairly similar to the film of 12/12/11.

Reported by: Dr Giles Roditi
Verified by: Dr Giles Roditi

XR Chest

Performed	12-Dec-2011 19:23	Received	14-Dec-2011 10:00
Reported	14-Dec-2011 09:38	Order Number	G107H26455641
Status	Final	Source System	MiSys

XR Chest Final
Wendy McLeish
Clinical History :
Pneumonia. NG tube placement.

XR Chest :
The tracheostomy is noted, tip is projected level of clavicles. NG tube is noted tip projected under left hemidiaphragm.
Focal consolidation is still demonstrated at the left lung and right upper lobe. Things have improved from previous examination dated 29/11/2011.

Reported by: Dr Cindy Chew
Verified by: Dr Cindy Chew

US Thorax and pleural cavity

Performed	30-Nov-2011 13:04	Received	30-Nov-2011 15:10
Reported	30-Nov-2011 14:48	Order Number	G107H26421760
Status	Final	Source System	MiSys

US Thorax and pleural cavity Final
Wendy McLeish
Clinical History :
Worsening respiratory failure. Significant pulmonic changes on the right ? Loculation? Empyema.

US Thorax and pleural cavity :

Portable ultrasound chest in ITU.

Ultrasound confirms a small right-sided simple pleural effusion, of maximal depth posteromedially. No echogenic material, loculations or debris is seen on ultrasound to suggest an empyema.

Findings discussed with the referring team at the time of scanning.

Reported by: Dr Patricia Deonarine (SpR) and Dr Colin Noble
Verified by: Dr Patricia Deonarine (SpR)

XR Chest

Performed	29-Nov-2011 01:56	Received	01-Dec-2011 13:16
Reported	01-Dec-2011 12:54	Order Number	G107H26417221
Status	Final	Source System	MiSys

XR Chest Final
Wendy McLeish
Clinical History : Increasing oxygen requirements with diminished expansion right lung - exclude pneumothorax.

XR Chest :

AP erect. ETT, NGT and right subclavian CVC appear in satisfactory unaltered positions. There is extremely dense consolidation of the right lung with fluid capping the apex as before. Quite dense consolidation in the left mid and lower zones persists with only the left apex spared. Allowing for differences in technical factors there appears to be have been little change when compared with 27/11/11.

Reported by: Dr Giles Roditi
Verified by: Dr Giles Roditi

CT Thorax

Performed	27-Nov-2011 12:05	Received	27-Nov-2011 13:39
Reported	27-Nov-2011 13:12	Order Number	G107H26412588
Status	Final	Source System	MiSys

CT Thorax Final
Wendy McLeish
Clinical History :
Community-acquired pneumonia that does not improve despite antibiotics. Patient in ITU and ventilated. Pyrexial and raised markers. ? Empyema ? Any other underlying cause for lack of response to treatment

CT Thorax : Volume acquisition through the thorax post intravenous contrast. No previous imaging available for comparison.

NG tube, ET tube and right subclavian line noted in situ in satisfactory position.
There is extensive consolidation with air bronchograms in both lungs affecting the entirety of the right lung and the lingula and basal segments of the left lower lobe. Focal areas of pulmonary consolidation also seen in the left upper apical segment. Bilateral pleural effusions are also present, maximum depth of fluid on the right posterior basal pleura 4cm, left posterior basal pleura 1cm. No evidence of empyema. No evidence of pulmonary embolus in this non dedicated scan. There is evidence of right heart strain with aorta:pulmonary trunk ratio of 2.3:3.4, enlarged right atrium and contrast seen in the hepatic veins. No evidence of pneumothorax.
Small volume reactive mediastinal and axillary lymphadenopathy. Unremarkable upper abdominal organs allowing for scan phase. Unremarkable bony skeleton.

Conclusion: Extensive bilateral consolidation and small pleural effusions, right larger than left. Evidence of developing pulmonary hypertension and right heart strain.

Reported by: Dr Sophia Sakellariou (SpR) and Dr John Shand
Verified by: Dr John Shand

XR Chest

Performed	27-Nov-2011 07:37	Received	27-Nov-2011 13:47
Reported	27-Nov-2011 13:19	Order Number	G107H26412361
Status	Final	Source System	MiSys

XR Chest Final
Wendy McLeish
Clinical History :
Worsening respiratory failure with right bronchial breathing.

XR Chest :
There is complete consolidation of the right lung and the lower two thirds of the left lung. The ET tube in the mid trachea, nasogastric tube is in the stomach and a right subclavian line is probably within the SVC. The left sided changes are progressing slightly when compared to 24 November 2011.

Reported by: Dr John Shand
Verified by: Dr John Shand

XR Chest

Performed	24-Nov-2011 02:31	Received	30-Nov-2011 17:14
Reported	30-Nov-2011 16:52	Order Number	G107H26404050
Status	Final	Source System	MiSys

XR Chest Final
Wendy McLeish
Clinical History :
Increasing oxygen requirements.

XR Chest :
There is complete consolidation of the right lung with partial consolidation of the left lung. The radiological appearance of the lungs is deteriorating compared to the previous examination 21 November 2011. ET tube is in the trachea, right subclavian line to the SVC and the nasogastric tube is coiled in the stomach.

Reported by: Dr John Shand
Verified by: Dr John Shand

XR Chest

Performed	21-Nov-2011 11:05	Received	21-Nov-2011 12:37
Reported	21-Nov-2011 12:15	Order Number	G107H26392912
Status	Final	Source System	MiSys

XR Chest Final
Wendy McLeish
Clinical History :
Intubation, pneumonia, central line, NG tube.

XR Chest :
Portable supine examination, the patient is rotated.

The tip of the central line lies low, probably in the right atrium. Ideally it should be withdrawn. ET and NG tubes are appropriately sited. As on previous examinations there is bilateral consolidative changes with air bronchograms, worse on the right with increasing consolidation at the right base and left mid zone, compared with the study performed 24 hours previously.

Reported by: Dr Christopher Smith (SpR)
Verified by: Dr Christopher Smith (SpR)

XR Chest

Performed	20-Nov-2011 21:00	Received	22-Nov-2011 10:21
Reported	22-Nov-2011 09:59	Order Number	G107H26391546
Status	Final	Source System	MiSys

XR Chest Final
Wendy McLeish
Clinical History : Short of breath. Right-sided chest pain. Dry cough.

XR Chest :
There is consolidation of the right upper lobe confined inferiorly by the horizontal fissure. Opacification is also demonstrated around the hilum inferior to the horizontal fissure.

The linear shadowing is demonstrated in the left mid zone suggestive of a linear atelectasis. Otherwise the left lung field is clear.

Findings are likely to represent a right upper lobe and (to a lesser extent) right middle lobe pneumonia.

Reported by: Dr Joanna Powell (SpR)
Verified by: Dr Joanna Powell (SpR)

XR Thumb Rt

Performed	18-Apr-2010 04:21	Received	20-Apr-2010 09:32
Reported	20-Apr-2010 09:06	Order Number	G107H13739065
Status	Final	Source System	MiSys

XR Thumb Rt Final
Wendy McLeish
Clinical History : Laceration on glass to distal phalanx palmar aspect. ? Foreign body.

XR Thumb Rt , XR Foreign body demonstration :

The thumb has been dressed. A tiny fleck of radio-opacity is seen in the palmar aspect of the right thumb, which is likely to reflect retained glass.

XR Finger index Rt :

No acute bone injury is seen.

Reported by: DR G MACKAY and BLANK CLINICIAN
Verified by: DR G MACKAY

XR Foreign body demonstration

Performed	18-Apr-2010 04:21	Received	20-Apr-2010 09:32
Reported	20-Apr-2010 09:32	Order Number	G107H13739067
Status	Final	Source System	MiSys

XR Thumb Rt Final
Wendy McLeish
Clinical History : Laceration on glass to distal phalanx palmar aspect. ? Foreign body.

XR Thumb Rt , XR Foreign body demonstration :

The thumb has been dressed. A tiny fleck of radio-opacity is seen in the palmar aspect of the right thumb, which is likely to reflect retained glass.

XR Finger index Rt :

No acute bone injury is seen.

Reported by: DR G MACKAY and BLANK CLINICIAN
Verified by: DR G MACKAY

XR Finger index Rt

Performed	18-Apr-2010 04:21	Received	20-Apr-2010 09:32
Reported	20-Apr-2010 09:06	Order Number	G107H13739066
Status	Final	Source System	MiSys

XR Thumb Rt Final
Wendy McLeish
Clinical History : Laceration on glass to distal phalanx palmar aspect. ? Foreign body.

XR Thumb Rt , XR Foreign body demonstration :

The thumb has been dressed. A tiny fleck of radio-opacity is seen in the palmar aspect of the right thumb, which is likely to reflect retained glass.

XR Finger index Rt :

No acute bone injury is seen.

Reported by: DR G MACKAY and BLANK CLINICIAN
Verified by: DR G MACKAY

XR Wrist Rt

Performed	19-Aug-2009 10:02	Received	20-Aug-2009 09:27
Reported	20-Aug-2009 09:27	Order Number	G107H13150614
Status	Final	Source System	MiSys

XR Wrist Rt Final
Wendy McLeish
A radiological report will not be issued for this examination. The referrer (or a more experienced clinical colleague) will interpret and evaluate the outcome of this examination and document this outcome in the patient's case notes within an appropriate time-scale. Reference: Procedure 10, Evaluation of Medical Exposure, Ionising Radiation Medical Exposures Regulations IRM(E) R 00

Reported by: AUTO REPORTING and BLANK RADIOL
Verified by: AUTO REPORTING

XR Wrist Rt

Performed	15-Jul-2009 10:47	Received	15-Jul-2009 17:07
Reported	15-Jul-2009 17:07	Order Number	G107H13078455
Status	Final	Source System	MiSys

XR Wrist Rt Final
Wendy McLeish
A radiological report will not be issued for this examination. The referrer (or a more experienced clinical colleague) will interpret and evaluate the outcome of this examination and document this outcome in the patient's case notes within an appropriate time-scale. Reference: Procedure 10, Evaluation of Medical Exposure, Ionising Radiation Medical Exposures Regulations IRM(E) R 00

Reported by: AUTO REPORTING and BLANK RADIOL
Verified by: AUTO REPORTING

XR Wrist Rt

Performed	09-Jul-2009 01:06	Received	09-Jul-2009 12:55
Reported	09-Jul-2009 11:36	Order Number	G107H13066710
Status	Final	Source System	MiSys

XR Wrist Rt Final
Wendy McLeish
Clinical History : No clinical history.

XR Wrist Rt :

There is moderate residual deformity of the distal radius fracture after application of plaster.

Reported by: DR J FRENCH (LOCUM) and BLANK RADIOL
Verified by: DR J FRENCH (LOCUM)

XR Wrist Rt

Performed	09-Jul-2009 00:20	Received	09-Jul-2009 12:55
Reported	09-Jul-2009 11:34	Order Number	G107H13066691
Status	Final	Source System	MiSys

XR Wrist Rt Final
Wendy McLeish
Clinical History : RTA trauma. Pain distal radius.

XR Wrist Rt :

There is a displaced fracture of the distal radius with some comminution.

Reported by: DR J FRENCH (LOCUM) and BLANK RADIOL
Verified by: DR J FRENCH (LOCUM)