[redacted]

NHS
Ayrshire & Arran

University Hospital Ayr
Dalmellington Road
Ayr

MMA Legal Limited
Stok
43-59 Princes Street
Stockport
SK11RY

Date 14/07/2026
Our Ref MF\3108823299
Your Ref Access to Health Records
Enquires to Maryann
Telephone 01292 616452

E-mail: Maryann.Findlay@aapct.scot.nhs.uk

Dear Sir/Madam

RE: Lee Green,4 Kirkland Road, Darvel, KA17 0JL

I refer to your recent request to myself regarding the above and enclose the relevant documents. I would be grateful if you could return the tear-off slip confirming receipt.

Yours faithfully,

Mr R H Bryden
Head of Health Records Services

Please return to:Maryann,Health Records, University Hospital Ayr,Dalmellington Road,Ayr,KA6 6DX
I acknowledge receipt of the copies of medical records pertaining to: Lee Green 3108823299

Signed: ---------- Date: ----------

Designation: ----------

NHS Ayrshire and Arran Medical Records

Lee James Green

(3108823299)

PATIENT IDENTIFICATION LABELS / ADMISSION FORMS AND OUT PATIENT PROFORMA

File in reserve chronological order behind this card

Write or attach label
HCR No: .....
CHI No: .....
Surname: .....
Forename: ..... Sex: .....
Address: .....
.....
Date of Birth.....

CLINICAL ALERTS AND HAZARDS

IT IS THE RESPONSIBILITY OF THE HEALTH CARE PROFESSIONAL IDENTIFYING A CLINICAL POTENTIAL HAZARD TO RECORD IT

(Please Tick Box On Front Cover Of Caserecord)

Each entry should be signed by the Health Care Professional

KNOWN DRUG ALLERGY / INTOLERANCE	NATURE OF REACTION	DATE	SIGNED
SUSPECTED DRUG ALLERGY / INTOLERANCE	**NATURE OF REACTION**	**DATE**	**SIGNED**

CLINICAL POTENTIAL HAZARDS e.g. Diabetes, Infection Hazard, Mechanical Device in Situ	DATE	SIGNED

SPECIAL NEEDS e.g. Deafness, Blindness etc	DATE	SIGNED

Mr Wilson – Acute Fracture Clinic

Confidential - Clinical Information

Department of Trauma and Orthopaedics
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
01563 825183

www.nhsaaa.net

Dr A Fowdar
Loudoun Medical Practice
Lochore Terrace
Darvel
KA17 0HD

Our Ref: TM/CM
Hospital No:
Clinic Date: 02/09/2025
Date Dictated: 02/09/2025
Date Typed: 02/09/2025
Enquiries to Orthopaedic Secretary
Direct Line: 01563 825183
Ext. Number: 25183
Email:

Dear Dr Fowdar,

LEE GREEN DOB: 31/08/1982 CHI No: 3108823299
B/R 4 KIRKLAND ROAD, DARVEL, AYRSHIRE, KA17 0JL

I saw this 43 year old gentleman in the Fracture Clinic today, one week following a hyperextension injury to his right thumb.

Initial x-rays showed no fracture but possible subluxation of the 1st metacarpophalangeal joint on the right side. This was in keeping with an ulnar collateral ligament injury and he was immobilised in a thumb splint.

On examination today, he has obvious ligament laxity in the ulnar collateral ligament of his right thumb. He has some mild swelling and tenderness over the ulnar collateral ligament area but states that his pain and function has improved since the injury. He has a good range of movement of his thumb and he is distal neurovascularly intact.

He is a right hand dominant smoker with no other significant past medical history.

He works as a Tree Surgeon but has modified his activities and is not using his hand for manual labour. I have encouraged him to avoid strenuous activities in the thumb whilst this heals.

I have updated his x-rays today which show similar position of the joint to previous and I have reviewed these with my Consultant, Mr Wilson, and we have opted to manage him non operatively continuing in the thumb splint.

We will see him back in the Fracture Clinic in 5 weeks' time, by which point he will be 6 weeks post injury.

Yours sincerely

Authorised on 02/09/2025 12:50:41 by Thomas Mullan.

Thomas Mullan
ST1 in Trauma & Orthopaedics
GMC - 8001420

Ophthalmology Department
University Hospital Ayr
Dalmellington Road
Ayr
KA6 6DX

NHS Ayrshire & Arran

Confidential - Clinical Information

CASUALTY CLINIC
MR K MERCHANT ON CALL

www.nhsaaa.net

Dr A Fowdar
Dr Kondol And Partners
Loudoun Medical Centre
Lochore Terrace
Darvel
KA17 0HD

Our Ref: MH/KM
Hospital No:
Clinic Date: 17/04/2020
Date Dictated: 17/04/2020
Date Typed: 20/04/2020
Enquiries to Karen McCristall
Direct Line: 01292 616450
Ext. Number:
Email: karen.mccristall@aapct.scot.nhs.uk

Dear Dr Fowdar,

LEE GREEN DOB: 31/08/1982 CHI No: 3108823299
115 EAST MAIN STREET, DARVEL, AYRSHIRE, KA17 0HA

Diagnosis	Left corneal abrasion
Medication	Oc Chloramphenciol 2 hourly for 5 days Cyclopentolate 1% 3 times a day for 3 days
Follow up	Discharged

I examined this gentleman in the clinic today. On examination there is evidence of a right superior corneal abrasion. I have started him on the above medication and discharged him back to your care but would be happy to see him in the clinic if needed.

Yours sincerely

Authorised on 20/04/2020 15:24:14 by Manjunath Hirae.

Dr Manjunth Hirae
GMC No 6071393
Specialty Doctor in Ophthalmology

INVESTING IN EXCELLENCE

Ophthalmology Department
University Hospital Ayr
Dalmellington Road
Ayr
KA6 6DX

01292 614646
www.nhsaaa.net

NHS Ayrshire & Arran

Confidential - Clinical Information

Casualty Clinic
On Call Consultant - Dr Syrogiannis

Dr A Fowdar
Dr Kondol And Partners
Loudoun Medical Centre
Lochore Terrace
Darvel
KA17 0HD

Our Ref: WR/ET
Hospital No:
Clinic Date: 16/07/2019
Date Dictated: 16/07/2019
Date Typed: 17/07/2019
Enquiries to Ellen Townsend
Direct Line:
Ext. Number: 16023
Email: Ellen.Townsend@aapct.scot.nhs.uk

Dear Dr Fowdar,

LEE GREEN DOB: 31/08/1982 CHI No: 3108823299
115 EAST MAIN STREET, DARVEL, AYRSHIRE, KA17 0HA

Diagnosis: Left small upper lid laceration with left superficial corneal abration

Visual acuity: Right eye -0.1 logMAR, left eye 0.02 logMAR

Treatment: Lid laceration was sutured with one stitch of 5.0 Vicryl under local anaesthetic
Advised to use Chloramphenicol four times a day to the left eye and twice a day to the left lid for one week's time and to get the stitches removed at his GP practice in one week's time

Mr Green gives a history of trauma to the left eye an hour ago when he was taking down a shed and was pulling a bit of wood which has hit the left eye. The eye feels sore but no change in vision.

On examination there is a small laceration of the left upper lid which is mildly deep but not reaching the tarsal plate and no foreign body detected within it. There is bruising of the left upper lid and there is a superficial epithelial defect of the left cornea and conjunctiva superiorly. Anterior chamber examination is normal and fundus examination is normal.

The lid has been cleaned and laceration has been sutured with 5.0 Vicryl under local anaesthesia and patient was advised to use the Chloramphenicol as above with no further review.

Yours sincerely

Authorised on 19/07/2019 12:50:29 by Wedian Noorman Rashid.

Dr Wedian Nooman Rashid
Speciality Ophthalmology Doctor

INVESTING IN VOLUNTEERS

GMC: 7507428

MSK
Musculoskeletal Service

MSK DISCHARGE REPORT

NHS
Ayrshire
& Arran

Patient Name:	Lee Green
Address:	115 East Main Street, Darvel, Ayrshire, KA17 0HA
CHI:	3108823299
GP:	
Consultant:	Dr Fiona Gibson
Referrer Source:	
Referral Date:	
Start Date:	10/04/2018
Discharge Date:	
No. of treatments:	
Discharge Reason:	
Treatment Outcome:	
Therapist:	Gillian Cowan
Location:	OCCUPATIONAL THERAPY DEPT, OUTPATIENT AREA,PURPLE ZONE, CROSSHOUSE HOSPITAL

Dear Dr Gibson

The above patient failed to attend their initial appointment and has therefore been discharged.

Actions for GP/Follow up recommendations:

Referred on to _____(if applicable)

Yours sincerely,
Authorised on 03/05/2018 15:46:16 by Typist Linda Healy, not verified by Consultant.
Gillian Cowan
03/05/2018

Dr A Fowdar
Dr Kondol And Partners
Loudoun Medical Centre
Lochore Terrace
Darvel
KA17 0HD

To: A.FOWDAR

University Hospital Crosshouse Emergency Department
Kilmarnock
Crosshouse Hospital
KA2 0BE
Tel: 01563 827751/827762

DUTY CONSULTANT: DR LISA BLACK

PATIENT DETAILS

Patient Name	Lee Green
CHI Number	3108823299
DOB	31/08/1982
Address	B/R,4 KIRKLAND ROAD,DARVEL,, KA17 0JL
Previous Attendances	No Attendances in Last 12 months:1Total Number of Attendances:19

ATTENDANCE DETAILS

Arrival Date & Time	09/12/2024 17:07
Presenting Complaint	chest pain
Diagnosis	Chest pain
Treatment	Advice
Investigations	
Additional Information	Presented with intermittent episodes of chest pain over past 7 days. No associated palpitations. Obs and examination reassuring, ECG shows NSR, troponin 4. Attempted to call from waiting room to deliver results x2 - no response. No contact number available. As trop normal and ECG reassuring can safely go home.

DISCHARGE DETAILS

Discharge Date & Time	09/12/2024 22:20
Left Department Date & Time	09/12/2024 22:22
	Discharge, no follow up Usual place of residence
Child Protection	None
Adult Protection /Concern Referral?	No

Clinician Seen Eilidh Mulhern,E Mulhern

Ayr Hospital
Emergency Department
Tel: 01292 614578

Emergency Department Discharge Letter

To: A.FOWDAR

Re: Lee Green
115 WEST MAIN STREET,DARVEL,,,
KA17 0HT
DOB: 31/08/1982
ED Attendance No: AYR-19-021479-1
CHI No.: 3108823299

Attendance Details
ate of Attendance: 16/07/2019 **Time of Attendance:** 12:11:00
. resenting Complaint: fb eye **Duty Consultant:** M McNaught
Additional Information: No Attendances in Last 12 months:1 Total Number of Attendances:17

Diagnosis	Penetrating wound of orbit,,
Treatment	Assessed and referred
Investigations	X-Ray,
Discharge ıformation:	
Additional Information	Transferred to suite B Opthalmology for further assessment and management of wood/metal foreign body injury to left eye and eyelid.
Discharged by:	Anne Bryson,Specialty Doctor

If you have any queries about this patient, please contact one of the staff at the above number

Ayr Hospital
Tel: 01292 614615

A&E Discharge Letter

To: A.FOWDAR

Re: Lee Green
115 WEST MAIN STREET,DARVEL,
KA17 0HT
DOB: 31/08/1982
A & E No: AYR-18-006246-1
CHI No.: 3108823299

Attendance Details
ate of Attendance: 09/03/2018 **Time of Attendance:** 16:19:00
. resenting Complaint: part amp-lt finger **Duty Consultant:** N Bartlett
Additional Information: No Attendances in Last 12 months:1 Total Number of Attendances:15

Diagnosis	Incised wound,2nd mcp joint,Left
Treatment	Take home drugs Tetanus booster Wound toilet Wound dressing Wound exploration Assessed and referred
vestigations	X-Ray,
Discharge Information:	Discharge, Usual place of residence follow up arranged, Other referral
Additional Information	laceration to left hand with axe, for surgical wash out and exploration in morning, patient allowed home to attend station 10 tomorrow
Discharged by:	Alice O'Neill,Senior Grade

If you have any queries about this patient, please contact one of the staff at the above number

Ayr Hospital
Tel: 01292 614615

A&E Discharge Letter

To: A.FOWDAR

Re: Lee Green
115 WEST MAIN STREET,DARVEL,
KA17 0HT
DOB: 31/08/1982
A & E No: AYR-18-006246-1
CHI No.: 3108823299

Discharged by: Alice O'Neill,Senior Grade

If you have any queries about this patient, please contact one of the staff at the above number

University Hospital Ayr Dalmellington Road Ayr KA6 6DX Phone: 01292 610 555	**Immediate Discharge Letter** **&** **Prescription**	NHS Ayrshire & Arran

To:	Re:
Dr Kondol and Partners Loudoun Medical Centre Lochore Terrace Darvel KA17 0HD	LEE JAMES GREEN 115 WEST MAIN STREET , , DARVEL , AYRSHIRE , KA17 0HA DOB: 31/08/1982 Hosp. No.: 3108823299 CHI No.: 3108823299

Date of Admission: 10/03/2018
Mode of Admission: Emergency
Admission Reason: hand laceration
Discharge Date: 11/03/2018

Ward: STATION 10-AYR
Consultant: MR NNAMDI OBI (Orthopaedics)
Follow Up:

Diagnoses
Right MCPJ laceration with extensor tendon rupture and injury to MCP joint
( )

Clinical Progress
This 35 year old man presented to A&E following an injury to his left hand whilst chopping logs with an axe. On examination Mr Green had an oblique 3cm laceration dorsally over the MCP joint of the left index finger. He was unable to fully extend the finger and an extensor tendon rupture was suspected. X-rays demonstrated no obvious bony injury. He was admitted for washout and exploration with tendon repair 10/3/18 and bony injury was discovered during this. He was kept overnight for 24 hours IV antibiotics.
He is now considered fit for discharge with fracture clinic follow up and a course of antibiotics. His left index finger is to remain completely immobilised for 4 weeks minimum with further evaluation at fracture clinic 20/3/18.

DR JEAN WIEDMANN (10-MAR-2018 13:02)

Hospital follow up
Follow up in fracture clinic 20/3/18 (Obi)

DR JEAN WIEDMANN (10-MAR-2018 13:02)

Pharmacy
7 day course co-amoxiclav
7 days co-codamol 30/500 for breakthrough analgesia

DR JEAN WIEDMANN (10-MAR-2018 09:45)

Allergy/Intolerance	Reaction
No Known Drug Allergies	

Allergy records are as recorded at time and date of printing.

Discharged by: DR JEAN WIEDMANN

Report generated on: 11/03/2018 20:00

University Hospital Ayr Dalmellington Road Ayr KA6 6DX Phone: 01292 610 555	Immediate Discharge Letter & Prescription	NHS Ayrshire & Arran

To:	Re:
Dr Kondol and Partners Loudoun Medical Centre Lochore Terrace Darvel KA17 0HD	LEE JAMES GREEN 115 WEST MAIN STREET , , DARVEL , AYRSHIRE , KA17 0HA DOB: 31/08/1982 Hosp. No.: 3108823299 CHI No.: 3108823299

Drug	Dose	Route	Frequency	Note	GP to continu	POD	Days Supply
CO-AMOXICLAV 500/125 Tablets	**625 mg**	Oral	THREE times daily - 7am;1pm;10pm		No	N	0
CO-CODAMOL 30/500 Tablets	**2 Tablet**	Oral	FOUR times daily - 7am;1pm;6pm;10pm PRN FOR PAIN	1 x 30 supplied	No	N	0

Additional Medicines Information:

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

Drug	Discontinued / Modified reason
**** Warning - accuracy of information in this section is dependent on details entered by users of the HEPMA system.**** *****Information here may be incomplete and is for guidance only.*****	

Discharged by: DR JEAN WIEDMANN

Report generated on: 11/03/2018 20:00

University Hospital Ayr,
Dalmellington Road,
Ayr,
KA6 6DX
Phone : 01292 610 555

Immediate Discharge Letter & Prescription

Mrs. Carol Wyllie (10/03/18 10:12)

NHS Ayrshire & Arran

Date :10/03/2018 @ 11:09:13 REPRINT

To: Fowdar, Dr. A,
LOUDOUN MEDICAL CENTRE,
LOCHORE TERRACE,
DARVEL,
KA17 0HD

Re: LEE JAMES GREEN
115 WEST MAIN STREET,DARVEL,AYRSHIRE,KA17 0HA

DOB: 31/08/1982
Hosp. No.: 3108823299
CHI No.: 3108823299

Date of Admission: 10/03/2018
Mode of Admission: Emergency Admission
Admission Reason: hand laceration
Discharge Date: 10/03/2018

Ward: STATION 10-AYR
Consultant: MR NNAMDI OBI (Orthopaedics)
Follow-up:

Clinical Progress: This 35 year old man presented to A&E following an injury to his left hand whilst chopping logs with an axe. On examination Mr Green had an oblique 3cm laceration dorsally over the MCP joint of the left index finger. He was unable to fully extend the finger and an extensor tendon rupture was suspected. X-rays demonstrated no obvious bony injury. He was admitted for washout and exploration with tendon repair 10/3/18.
He is now considered fit for discharge with fracture clinic follow up and a course of antibiotics. *last updated 10/03/2018; 9:45 am by DR JEAN WIEDMANN*

Pharmacy: 7 day course co-amoxiclav
7 days co-codamol 30/500 for breakthrough analgesia *last updated 10/03/2018; 9:45 am by DR JEAN WIEDMANN*

Primary Diagnosis: Right MCPJ laceration with extensor tendon rupture

Further patient/drug notes:

Allergy/Intolerance	Reaction
No Known Drug Allergies	

Allergy records are as recorded at time and date of printing

Drug	Dose	Route	Frequency	Days Supply	GP to continue
CO-AMOXICLAV 500/125 Tablets	**625 mg**	Oral	THREE times daily - 7am;1pm;10pm	7	No
CO-CODAMOL 30/500 Tablets	**2 Tablet**	Oral	FOUR times daily - 7am;1pm;6pm;10pm	7	No
	PRN FOR PAIN				

1 x 30 supplied - last updated on 10/03/18 byMRS CAROL WYLLIE

Additional Medicines Information:

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

Drug	Discontinue/Modification reason

*** *Warning* - *accuracy of information in this section is dependent on details entered by users of the HEPMA system.***
****Information here may be incomplete and is for guidance only.****

Discharged by : DR JEAN WIEDMANN **Dispensed by:** **Checked by:**
Grade: Foundation Year 2 **Date:**

Confidential - Clinical Information

Department of Trauma and Orthopaedics
University Hospital Ayr
Dalmellington Road
Ayr
KA6 6DX
01292 610555
01292 614646
www.nhsaaa.net

NHS Ayrshire & Arran

Dr A Fowdar
Dr Kondol And Partners
Loudoun Medical Centre
Lochore Terrace
Darvel
KA17 0HD

Our Ref:	WW/KMM
Hospital No:	
Clinic Date:	19/04/2018
Date Dictated:	19/04/2018
Date Typed:	21/04/2018
Enquiries to	Mrs K McGregor
Direct Line:	
Ext. Number:	Ext 16021
Email:	katy.mcgregor@aapct.scot.nhs.uk

Dear Dr Fowdar,

LEE GREEN DOB: 31/08/1982 CHI No: 3108823299
115 EAST MAIN STREET, DARVEL, AYRSHIRE, KA17 0HA

DIAGNOSIS: Repair of extensor tendon to left index finger – 6 weeks ago
OUTCOME: Discharged to hand therapy

This man had repair of his extensor tendon 6 weeks ago and has his cast removed today. He is able to maintain full extension with no lag but he is very stiff and having trouble initiating flexion.

I have given him simple exercises to begin to get his hand moving and referred him to hand therapy. If there are any problems with his rehabilitation, please do not hesitate to get in touch.

Yours sincerely

Authorised on 23/04/2018 12:10:26 by Miss Gibson's Assistant.

Mr William Wilson
ST5 in Trauma & Orthopaedics
GMC: 7134228

INVESTING IN EXCELLENCE

Confidential - Clinical Information

Department of Trauma and Orthopaedics
University Hospital Ayr
Dalmellington Road
Ayr
KA6 6DX
01292 610555
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www.nhsaaa.net

NHS Ayrshire & Arran

Dr A Fowdar
Dr Kondol And Partners
Loudoun Medical Centre
Lochore Terrace
Darvel
KA17 0HD

Our Ref:	WW/DA
Hospital No:	3108823299
Clinic Date:	22/03/2018
Date Dictated:	22/03/2018
Date Typed:	22/03/2018
Enquiries to	Mrs K McGregor
Direct Line:	
Ext. Number:	16021
Email:	katy.mcgregor@aaaht.scot.nhs.uk

Dear Dr Fowdar,

LEE GREEN DOB: 31/08/1982 CHI No: 3108823299
115 WEST MAIN STREET, DARVEL, AYRSHIRE, KA17 0HA

Procedure: Repair of extensor tendon to left index finger 11.03.18.

Outcome: Full lightweight cast in extension, review in four weeks for cast removal.

This Tree Surgeon had a laceration to his left hand with complete rupture of the extensor tendons to the index finger. He underwent repair by Mr Obi now almost two weeks ago. The wound has healed well with no signs of infection and the sutures were removed today. He has approximately 10° extensor lag today. He is however able to hold the finger in this position. He is neurovascularly intact.

I have placed him in a full lightweight cast in extension and he should remain in this for the next four weeks. I have also referred him to Hand Therapy to begin on the 20th April which will be the day after he comes out of cast.

Yours sincerely

Authorised on 26/03/2018 14:14:19 by Miss Gibson's Assistant.

WILLIAM WILSON
ST5 IN ORTHOPAEDICS
GMC: 7134228

INVESTING IN IMPROVING

Confidential - Clinical Information

Department of Trauma and
Orthopaedics
University Hospital Ayr
Dalmellington Road
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www.nhsaaa.net

STA 0611

NHS
Ayrshire
& Arran

Dr A Fowdar
Dr Kondol And Partners
Loudoun Medical Centre
Lochore Terrace
Darvel
KA17 0HD

Our Ref: /
Hospital No:
Date Dictated: 13/04/2018
Date Typed: 13/04/2018
Enquiries to Miss C Crawford
Direct Line
Ext. Number 14068
Email Christine.Crawford@aapct.scot.nhs.uk

Dear Dr Fowdar,

LEE GREEN **DOB: 31/08/1982** **CHI No: 3108823299**
18 BROWN STREET, NEWMILNS, AYRSHIRE, KA16 9AA

ADMITTED:	**10/03/2018**
DISCHARGED:	**11/03/2018**
TYPE OF ADMISSION:	**EMERGENCY**
DIAGNOSIS:	**LEFT INDEX FINGER LACERATION**
PROCEDURE:	**LEFT INDEX FINGER WASHOUT, EXPLORATION AND TENDON REPAIR**
FOLLOW-UP:	**MISS GIBSON, HAND SURGEON OPA**

Mr Green's admission details are as documented above. Mr Green sustained a laceration to his left hand whilst chopping logs with an axe. An extensor tendon rupture was suspected and he was admitted for washout, exploration and tendon repair. Intra-operatively undisplaced index finger metacarpal neck fracture was noted, non-viable tendon ends debrided and extensor tendon repair undertaken. Post-operative instructions have been explained. He has been transferred to the care of Miss Gibson, orthopaedic hand consultant and will be seen for review in a couple of weeks.

Yours sincerely

Authorised on 15/04/2018 12:10:23 by Nnamdi Obi.

Nnamdi Obi
Consultant Orthopaedic Surgeon, MBBS BSc (Hons) MSc FRCS (Tr & Orth)
GMC: 6104650

Orthopaedic

INVESTING IN VOLUNTEERING

Confidential - Clinical Information

Department of Trauma and Orthopaedics
University Hospital Ayr
Dalmellington Road
Ayr
KA6 6DX
01292 610555
01292 614646
www.nhsaaa.net

NHS Ayrshire & Arran

Dr A Fowdar
Dr Kondol And Partners
Loudoun Medical Centre
Lochore Terrace
Darvel
KA17 0HD

Our Ref:	WW/DA
Hospital No:	3108823299
Clinic Date:	22/03/2018
Date Dictated:	22/03/2018
Date Typed:	22/03/2018
Enquiries to	Mrs K McGregor
Direct Line:	
Ext. Number:	16021
Email:	katy.mcgregor@aaaht.scot.nhs.uk

Dear Dr Fowdar,

LEE GREEN DOB: 31/08/1982 CHI No: 3108823299
115 WEST MAIN STREET, DARVEL, AYRSHIRE, KA17 0HA

Procedure: Repair of extensor tendon to left index finger 11.03.18.

Outcome: Full lightweight cast in extension, review in four weeks for cast removal.

This Tree Surgeon had a laceration to his left hand with complete rupture of the extensor tendons to the index finger. He underwent repair by Mr Obi now almost two weeks ago. The wound has healed well with no signs of infection and the sutures were removed today. He has approximately 10° extensor lag today. He is however able to hold the finger in this position. He is neurovascularly intact.

I have placed him in a full lightweight cast in extension and he should remain in this for the next four weeks. I have also referred him to Hand Therapy to begin on the 20th April which will be the day after he comes out of cast.

Yours sincerely

This document has NOT been verified

WILLIAM WILSON
ST5 IN ORTHOPAEDICS
GMC: 7134228

INVESTING IN EXCELLENCE

STA 0611

NHS
Ayrshire & Arran

Department of Trauma and Orthopaedics
University Hospital Ayr
Dalmellington Road
Ayr
KA6 6DX
01292 610555
01292 614646
www.nhsaaa.net

Confidential - Clinical Information

Dr A Fowdar
Dr Kondol And Partners
Loudoun Medical Centre
Lochore Terrace
Darvel
KA17 0HD

Our Ref:	WW/KMM
Hospital No:	
Clinic Date:	19/04/2018
Date Dictated:	19/04/2018
Date Typed:	21/04/2018
Enquiries to	Mrs K McGregor
Direct Line:	
Ext. Number:	Ext 16021
Email:	katy.mcgregor@aapct.scot.nhs.uk

Dear Dr Fowdar,

LEE GREEN DOB: 31/08/1982 CHI No: 3108823299
115 EAST MAIN STREET, DARVEL, AYRSHIRE, KA17 0HA

DIAGNOSIS: Repair of extensor tendon to left index finger – 6 weeks ago
OUTCOME: Discharged to hand therapy

This man had repair of his extensor tendon 6 weeks ago and has his cast removed today. He is able to maintain full extension with no lag but he is very stiff and having trouble initiating flexion.

I have given him simple exercises to begin to get his hand moving and referred him to hand therapy. If there are any problems with his rehabilitation, please do not hesitate to get in touch.

Yours sincerely

This document has NOT been verified

Mr William Wilson
ST5 in Trauma & Orthopaedics
GMC: 7134228

Orthopaedic

INVESTING IN VOLUNTEERS

To: A.FOWDAR

University Hospital Crosshouse Emergency Department
Kilmarnock
Crosshouse Hospital
KA2 0BE
Tel: 01563 827751/827762

DUTY CONSULTANT: DR JAYNE MCLAREN

PATIENT DETAILS

Patient Name	Lee Green
CHI Number	3108823299
DOB	31/08/1982
Address	B/R,4 KIRKLAND ROAD,DARVEL,, KA17 0JL
Previous Attendances	No Attendances in Last 12 months:2Total Number of Attendances:20

ATTENDANCE DETAILS

Arrival Date & Time	25/08/2025 10:04
Presenting Complaint	r thumb inj
Diagnosis	Minor soft tissue injury Thumb Right
Treatment	Wrist Splint
Investigations	X-Ray,Thumb Right
Additional Information	hyperextended thumb from a piece of wood, xray show nil acute. ? ulna collartral ligament rupture. follow up at next # clinic appointment

DISCHARGE DETAILS

Discharge Date & Time	25/08/2025 15:33
Left Department Date & Time	25/08/2025 12:23
	Discharge, follow up arranged Fracture Clinic Usual place of residence
Child Protection	None
Adult Protection /Concern Referral?	not enough information
Clinician Seen	Michelle Spears,

Confidential - Clinical Information

Department of Trauma and Orthopaedics
University Hospital Ayr
Dalmellington Road
Ayr
KA6 6DX
01292 610555
01292 614646
www.nhsaaa.net

NHS Ayrshire & Arran

Dr A Fowdar
Dr Kondol And Partners
Loudoun Medical Centre
Lochore Terrace
Darvel
KA17 0HD

Our Ref: /
Hospital No:
Date Dictated: 13/04/2018
Date Typed: 13/04/2018
Enquiries to Miss C Crawford
Direct Line
Ext. Number 14068
Email Christine.Crawford@aapct.scot.nhs.uk

Dear Dr Fowdar,

LEE GREEN DOB: 31/08/1982 CHI No: 3108823299
18 BROWN STREET, NEWMILNS, AYRSHIRE, KA16 9AA

ADMITTED:	**10/03/2018**
DISCHARGED:	**11/03/2018**
TYPE OF ADMISSION:	**EMERGENCY**
DIAGNOSIS:	**LEFT INDEX FINGER LACERATION**
PROCEDURE:	**LEFT INDEX FINGER WASHOUT, EXPLORATION AND TENDON REPAIR**
FOLLOW-UP:	**MISS GIBSON, HAND SURGEON OPA**

Mr Green's admission details are as documented above. Mr Green sustained a laceration to his left hand whilst chopping logs with an axe. An extensor tendon rupture was suspected and he was admitted for washout, exploration and tendon repair. Intra-operatively undisplaced index finger metacarpal neck fracture was noted, non-viable tendon ends debrided and extensor tendon repair undertaken. Post-operative instructions have been explained. He has been transferred to the care of Miss Gibson, orthopaedic hand consultant and will be seen for review in a couple of weeks.

Yours sincerely

Authorised on 15/04/2018 12:10:23 by Nnamdi Obi.

Nnamdi Obi
Consultant Orthopaedic Surgeon, MBBS BSc (Hons) MSc FRCS (Tr & Orth)
GMC: 6104650

INVESTING IN VOLUNTEERS

Department of Trauma and Orthopaedics
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE

www.nhsaaa.net

NHS Ayrshire & Arran

Confidential - Clinical Information

MR TANAGHO
ACUTE FRACTURE CLINIC

Dr A Fowdar
Loudoun Medical Practice
Lochore Terrace
Darvel
KA17 0HD

Our Ref: AT/NL
Hospital No:
Clinic Date: 07/10/2025
Date Dictated: 07/10/2025
Date Typed: 10/10/2025
Enquiries to Nanette Lee
Direct Line: 01563-827333
Ext. Number: 27333
Email: nanette.lee@aapct.scot.nhs.uk

Dear Dr Fowdar,

LEE GREEN DOB: 31/08/1982 CHI No: 3108823299
B/R 4 KIRKLAND ROAD, DARVEL, AYRSHIRE, KA17 0JL

Diagnosis: conservatively treated right thumb ulnar collateral ligament injury since 25.08.25
Treatment today: clinical assessment & discharged with advice

Mr Green is a **43** year old tree surgeon who has done well with conservative management. He restored power and stability in the metacarpo-phalangeal joint of the right thumb. I have provided him with a futuro splint to protect his thumb over the next 2 weeks.

Yours sincerely

Authorised on 15/10/2025 10:33:29 by Andy Tanagho.

Mr Andy Tanagho, M.Ch (Orth); FRCS (Tr & Orth)
Consultant Orthopaedic Surgeon
GMC: 7048309

INVESTING IN VOLUNTEERS

PATIENT SERVICES

Trauma Clinic
Emergency Department
Crosshouse Hospital
KA2 OBE
TEL: 01563 521133

Dr A Fowder
Loudoun Medical Centre
Lochore Terrace
DARVEL
KA17 0HD

Date typed	15th September 2009
Clinic Date	16th September 2009
Our ref	CMG/sab/337455
Patient CHI	3108823299
Enquiries to	Sharon Berry, A&E Secretary
Extension	27762
Direct line	01563 827762
Fax	01563 827731
E-mail	Sharon.Berry@aaaht.scot.nhs.uk

Dear Dr Fowder,

LEE GREEN 18 BROWN STREET NEWMILNS 31.08.1982

Diagnosis: Wound to left index finger

This 27 year old gentleman failed to report for the trauma clinic today. No further review is proposed.

Yours sincerely,

Dr Crawford McGuffie, Consultant
Department of Emergency Medicine

Copy: H Mair, ENP, Department of Emergency Medicine, Crosshouse Hospital

ACCIDENT & EMERGENCY

Awarded for excellence

55

Ayrshire and Arran Acute Hospitals NHS Trust

Physiotherapy Discharge Report

Site:	NEWMILNS HC	Referred by	MR MACLEOD
Physiotherapy No:	144114		ORTHOPAEDIC CONSULTANT
Unit No:	337455		CROSSHOUSE HOSPITAL

Name: LEE GREEN

Discharge Reason: **Failed to Attend**

Address: 52 EAST EDITH STREET
DARVEL
KA17 0HT

DOB: 31/08/1982

Treatment: **Rehabilitation**

GP: DR MCCALL
HENRIETTA STREET
GALSTON

Referring Diagnosis: L) KNEE PATELLA ORIF

No. of Treatments: 3

Referral Date: 13/05/2008

Start Date: 02/06/2008

Transfer/ Discharge Date: 09/07/2008

ReviewDate:

Discharge Summary

POOR QUADS CONTROL. FULL EXTENSION, FLEXION 120 DEGREES.
FAILED TO ATTEND ON 27.6.08.

✓
CM

13 AUG 2008

F Holliman

Physiotherapist: MRS F HOLLIMAN

Date Typed: 28/07/2008

PATIENT SERVICES

Crosshouse Hospital
Kilmarnock
KA2 0BE
Tel: 01563 521133
Fax: 01563 827976

CM/MM2/337455
CHI: 3108823299

ORTHOPAEDIC DEPARTMENT – MR C MACLEOD – FRACTURE CLINIC
(Secretary: Linda Hay – Ext: 27896)

Dictated: 29.07.2008 Typed: 04.08.2008

Dr McCall
Galston Medical Practice
Henrietta Street
GALSTON

Dear Dr McCall

LEE GREEN 52 EAST MAIN ST DARVEL DOB 31.08.1982

This young boy didn't attend for his follow-up today. A further appointment is therefore not being arranged.

Yours sincerely

Mr C MacLeod FRCS Ed (Tr & Orth)
CONSULTANT ORTHOPAEDIC SURGEON

Orthopaedic

HOSPITAL SERVICES

Department of Orthopaedics

Crosshouse Hospital
Crosshouse
Kilmarnock KA2 0BE
Telephone: 01563 521133
www.show.scot.nhs.uk/aaaht

Tel: 01563 827896
Fax: 01563 827976
Secretary: linda.hay@aaaht.scot.nhs.uk

CM/LH/337455
CHI: 3108823299

DEPARTMENT OF ORTHOPAEDICS – Mr C MacLeod

Fracture Clinic 24.06.08
Typed 27.06.08

Dr McCall
Galston Medical Practice
5A Henrietta Street
GALSTON

Dear Dr McCall

LEE GREEN, 52 EAT MAIN STREET, DARVEL DOB – 31.08.1982

I reviewed Mr Green in the Clinic today.

He is continuing to work with the physiotherapists to build up his left knee although his left quadriceps remains very wasted and he is going to need quite a bit more work before he is ready to consider getting back to his employment as a Tree Surgeon.

I have emphasized the importance of the rehab programme and will review him back in late July to assess his progress and advise on whether he is likely to manage back to work a short time after that.

Yours sincerely

C MacLeod FRCS Ed (Tr & Orth)
Consultant Orthopaedic Surgeon

Awarded for excellence

HOSPITAL SERVICES

Department of Orthopaedics

Crosshouse Hospital
Crosshouse
Kilmarnock KA2 0BE
Telephone: 01563 521133
www.show.scot.nhs.uk/aaaht

Tel: 01563 827896
Fax: 01563 827976
Secretary: linda.hay@aaaht.scot.nhs.uk

CM/LH/337455
CHI: 3108823299

DEPARTMENT OF ORTHOPAEDICS – Mr C MacLeod

Fracture Clinic 13.05.08
Typed 15.05.08

Dr McCall
Galston Medical Practice
5A Henrietta Street
GALSTON

Dear Dr McCall

LEE GREEN, 52 EAST MAIN STREET, DARVEL DOB – 31.08.1982

I reviewed this young man in the Clinic today.

His check x-ray of the left patella looked satisfactory and the pipestem cast has been removed today.

He has been put in to a Tubigrip and will mobilise with crutches and I have referred him to the Physiotherapists at Newmilns for a mobilisation programme.

I am planning to review him back in June to see how he is progressing.

Yours sincerely

C MacLeod FRCS Ed (Tr & Orth)
Consultant Orthopaedic Surgeon

Awarded for excellence

JMcC/60685

Orthopaedic

STA 0611

#1315

PATIENT SERVICES

Crosshouse Hospital
Kilmarnock
KA2 OBE
Tel: 01563 521133
Fax: 01563 577976

CM/MM2/337455
CHI: 3108823299

ORTHOPAEDIC DEPARTMENT – MR C MACLEOD – FRACTURE CLINIC
(Secretary: Linda Hay – Ext: 2896)

Dictated: 22.04.2008 Typed: 24.04.2008

Dr J McCall
5A Henrietta Street
GALSTON

Dear Dr McCall

LEE GREEN 52 EAST MAIN STREET DARVEL D.O.B 31.08.1982

This gentleman had tension band wiring of his left patella 9 days ago and was seen for wound check today. This was satisfactory and he has gone back in to a Delta cast cylinder today.

We will see him in 3 weeks' time with **plaster off and x-ray of the left patella AP and lateral on arrival.**

Yours sincerely

Mr C MacLeod FRCS Ed (Tr & Orth)
CONSULTANT ORTHOPAEDIC SURGEON

Orthopaedic

JMcC/60685

Patient Services

Clinical Decisions Unit
Crosshouse Hospital
Kilmarnock KA2 OBE

Enquires to: Lorraine Ritchie
Direct Line: 01563 577467/01563 825056
E-mail: Lorraine.Ritchie@aaaht.scot.nhs.uk

Ref No: KF/LR/337455
CHI No: 3108823299

Dictated: 29/04/2008
Typed: 30/04/2008

Dr E Rait
Loudoun Medical Practice
Lochore Terrace
DARVEL
KA17 OHD

Dear Dr Rait

RE LEE GREEN 52 EAST MAINT ST, DARVEL DBO 31/08/82

Date of Admission: **19/04/08**
Date of Discharge: **22/04/08**
Diagnosis: **Chest pain – PE excluded**

This 25 year old man who 6 days before admission had a surgical fixation of his left patella. He was in a cast on the left lower extremity. He stated that he had right sided pain for the past 4 days in the chest which was worse on inspiration. He was coughing some sputum and he did have one episode of haemoptysis. He is a smoker. The Well's criteria for PE came out to a total of 5.5 which put him at moderate risk and he was therefore admitted to the Clinical Decisions Unit to rule out pulmonary embolism.

On examination the patient had a distinct S1 and S2 without any murmurs, gallops or rubs. There were decreased breath sounds in the base of the right lung, there was no chest wall tenderness. The patient was tender in the abdomen, right flank and right lower quadrant. There was no guarding or rebound and he did have bowel sounds. No calf swelling was noted. The chest x-ray showed no consolidation. An ECG was done which showed a sinus rhythm with no acute changes. Bloods were drawn, U&Es were all within normal limits, and the liver enzymes were also within normal limits except for the alkaline phosphatase which was 149. Cholesterol panel showed the overall cholesterol of 3.0, the HDL was 0.71 mmol/l and the rest were within normal limits. The CRP was 171. CBC showed white cell count 10.2 and the D-dimer was 2047. Fragmin was administered and a V/Q scan was performed which was read as negative.

It was thought that this might be a lower respiratory tract infection so the patient was discharged on Augmentin 375mg tid for 7 days and was advised to follow up at his Surgery

Yours sincerely

Ken Fittro
Physician Assistant Certified
Clinical Decisions Unit

Mr D Chung
Consultant in Emergency Medicine

MEDICAL

STA0849

NHS AYRSHIRE & ARRAN

Crosshouse Hospital Discharge

90915.

G.P.

* PLEASE PRINT HEAVILY USING BALL POINT PEN

Patient XH 337455

Surnam GREEN LEE
First Na 52 EAST MAIN STREET
Address DARVEL
KA17 0HT
31/08/1982
DOB:
DR J MCCALL
5A HENRIETTA ST
Unit No: GALSTON
(or date of bir... CHI ... number)

Ward: CDU
Consultant: McGuire
Date of Admission: 19/4/08
Date of Discharge: 22/4/08
(or date of death)
Clinic Appointment: 2/52

Services Arranged: ☐ Home help ___ times week ☐ Meals on wheels ☐ District Nurse ☐ Other
Discharged to: ☐ Home ☐ Stay with relatives ☐ Other hospital ☐ Nursing home ☐ Other ☐ Died

Discharge Diagnosis (if admitted due to an injury, include place of accident & site of injury)	If multiple Day Case admission, list dates of admission
1 Possible LRTI — early	
2 Day 10 post op for # patella	
3	
4	
5	

Operations / Procedures
1 V/Q scan (N)
2
3
4

Discharge Medication (7 days supply will be dispensed unless otherwise stated by doctor)

For Pharmacy use

Drug Name and formulation	Dose	Frequency	Route	Duration (cont/stop)	Quantity and strength	Notes
Coamoxiclav 30/500	2 tabs	4x/day	O	Cont	PCD 60x30/500mg	
Tramadol	50-100mg	4hourly	O	Cont	PCD 10x50mg	
Augmentin	375mg	3x/day	O	Cont	52 21x375mg	Co amoxiclav

pharmacy date 22/4/08 | dispensed by | checked by

Additional Information (e.g. awaiting histology or other results, patients progress)

A finished consultant episode letter will follow.

Signature _____

PRINT NAME d C McGuire Date 22/4/2008

N.B. DISCHARGE MEDICATION IS FOR INFORMATION ONLY. FAXED COPY HAS NOT BEEN CHECKED BY DOCTOR. ON RECEIPT OF HARD COPY, FAXED COPY CAN BE DESTROYED.

Ward Clerkess: _____ / Dictated: _____ / Typed: _____ / Signed: _____ / Mailed: _____

QAD/NP/337455

DIRECT LINE 01563 577885

ORTHOPAEDIC DEPARTMENT

10.10.96

Dr McCall
5A Henrietta Street
GALSTON

Dear Dr McCall

Re: **LEE GREEN c/o 35 BENRIG AVENUE KILMAURS D.O.B. 31.8.82**

This patient was admitted to Hospital as arranged to have arthroscopy of right knee which was carried out on 1.10.96. This showed chondromalacia patellae and lateral release was carried out. He made a satisfactory recovery and discharged home on the following day. He will be reviewed at the Orthopaedic Clinic in 2 weeks time.

Yours sincerely

Q Al-Dadah FRCS
Consultant Orthopaedic Surgeon

STA0849

North Ayrshire and Arran NHS Trust
Crosshouse Hospital Discharge

68551

G.P.

Patient I XH 837455

Surname GREEN
First Na LEE
Address C/O 35 BENRIG AVE
KILMAURS
KA3 2QQ
31/08/1982 M/S
DR.J MCCALL
5A HENRIETTA ST
DOB: GALSTON
Unit No: CHI 3108823299
(or date of birth and address)

Ward: 24
Consultant: Aldadah

Date of Admission: 30/9/96
Date of Discharge: 02/10/96
(or date of death)
Clinic Appointment: 18/10/96

Services Arranged: ☐ Home help ___ times week ☐ Meals on wheels ☐ District Nurse ☐ Other
Discharged to: ☐ Home ☐ Stay with relatives ☐ Other hospital ☐ Nursing home ☐ Other ☐ Died

Discharge Diagnosis (if admitted due to an injury, include place of accident & site of injury)	If multiple Day Case admission, list dates of admission
1 Arthroscopy and lateral release of (R) knee	
2	
3	
4	
5	

Operations / Procedures
1
2
3
4

Discharge Medication (7 days supply will be dispensed unless otherwise stated by doctor)

For Pharmacy use

Drug Name and formulation	Dose	Frequency	Route	Duration (cont/stop)	Quantity and strength	Notes
DIHYDROCODEINE	30mg	Q16 PRN	O		20x30mg	

pharmacy date 2/10/96 | dispensed by CA | checked by AH

Additional Information (e.g. awaiting histology or other results, patients progress)

A finished consultant episode letter will follow.

Signature Bruckner

PRINT NAME BRINKER Date 02/10/19 96

N.B. DISCHARGE MEDICATION IS FOR INFORMATION ONLY. FAXED COPY HAS NOT BEEN CHECKED BY DOCTOR. ON RECEIPT OF HARD COPY, FAXED COPY CAN BE DESTROYED.

Ward Clerkess : _____ / Dictated : _____ / Typed : _____ / Signed : _____ / Mailed : _____

STA0849

North Ayrshire and Arran NHS Trust
Crosshouse Hospital Discharge

68555

G.P.

Pa XH 337455
Su GREEN LEE
Fi C/O 35 BENRIG AVE
A KILMAURS KA3 2DQ
31/08/1982 M/S
DR.J.MCCALI
D 5A HENRIETTA ST
U GALSTON
CHI 3108823299
(or

Ward: 2H
Consultant: MR AL-DADA.

Date of Admission: 30/09/96
Date of Discharge: 2/10/96
(or date of death)
Clinic Appointment:

Services Arranged: ☐ Home help ___ times week ☐ Meals on wheels ☐ District Nurse ☐ Other
Discharged to: ☐ Home ☐ Stay with relatives ☐ Other hospital ☐ Nursing home ☐ Other ☐ Died

Discharge Diagnosis (if admitted due to an injury, include place of accident & site of injury)	If multiple Day Case admission, list dates of admission
1 Knee Pain	
2	
3	
4	
5	

Operations / Procedures
1 ARTHROSCOPY + LATERAL RELEASE
2
3
4

Discharge Medication (7 days supply will be dispensed unless otherwise stated by doctor)

For Pharmacy use

Drug Name and formulation	Dose	Frequency	Route	Duration (cont/stop)	Quantity and strength	Notes
CO-CODAMOL	2tds	stndy	PO	STDY	20	
		"				
		"				

pharmacy date 2/10/96 | dispensed by | checked by

Additional Information (e.g. awaiting histology or other results, patients progress)

A finished consultant episode letter will follow.

Signature

PRINT NAME M.R. KERR Date 2/10/1996

N.B. DISCHARGE MEDICATION IS FOR INFORMATION ONLY. FAXED COPY HAS NOT BEEN CHECKED BY DOCTOR. ON RECEIPT OF HARD COPY, FAXED COPY CAN BE DESTROYED.

Ward Clerkess ___ / Dictated ___ / Typed ___ / Signed ___ / Mailed ___

Crosshouse Hospital

NORTH AYRSHIRE & ARRAN NHS TRUST

Our ref

Your ref

Telephone contact

Crosshouse Hospital
Kilmarnock
Ayrshire
KA2 0BE

Telephone 01563 521133
Facsimile

Dr J S McCall
The Surgery
5A Henrietta Street
Galston
Ayrshire
KA4 8JW

1.10.1996

Dear Dr McCall,

Re. **Master Lee Green** 31/08/82 337455
c/o 35 Benrig Avenue
KILMAURS

Your patient was admitted under the care of Mr Morran on 10/09/96 and discharged home on 13/09/96.

The principal diagnosis was:
Head injury - Transient concussion
Other diagnoses recorded:
Facial injury - Bruising

The patient received no operative treatment.

Drugs on discharge: As listed in the immediate discharge letter.

A full explanation of the diagnosis was given to the patient.

No outpatient follow-up has been arranged.

Neuro obs and skull x-rays and facial x-rays were normal.

Yours sincerely,

CGM/EK

Mr C G Morran
Consultant Surgeon

CHI: 3108823299
Green, Lee ~~West~~
115 ~~East~~ Main Street
Darvel
KA17 0HA
31/08/1982
Dr A Fowdar

STA0211

DATE

17/6/2020
1415

Allergies - none known

PMH - Nil

Medications - Nil

OH - Injury to left eye 2019,

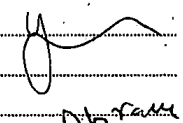
Social - Driver (driving today) smoker, alcohol occasionally.

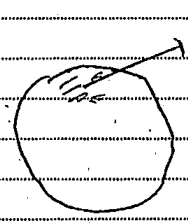
~~Examined~~

VAR - 0.22

VAL 0.22

PH: ~~0.14~~ 0.02





Impr: (L6) Corneal Abrasion

PCAN: 1. Occ. Chloramphenicol 2HN
2. 4- Cyclopentolate 1% 1 gtt

D/C

OPHTHALMIC

Write or attach label

CHI: 3108823299
Green, Lee
115 East Main Street
Darvel
KA17 0HA
31/08/1982
Dr A Fowdar

Dr Syrogiannis.

STA0211

OPHTHALMIC

DATE

16/7/19

Presenting: Dismantling dead, pulled piece of wood, hit left eye.

- Eye lids swollen - A+E sent for x-ray
- Eye feels irritated as if FB present
- Pain on eye movement
- Severe pain temporally superior to the globe.

Allergies/ All known
Meds/ Nil
Med Hx/ Nil
Op Hx/ Nil
Fhx Glaucoma

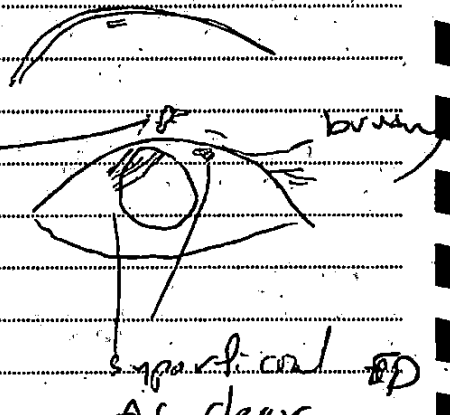
- Socially/ - Driver
- Tree surgeon
- Smoker
- Occasional Alcohol

VaR n/a - 0.1 VaL n/a 0.02

- Not c/o diplopia

Was taking down ashad, while pulling a wood piece & nail in it, it hit the eye & harm eye sore eye & no decay in vision.

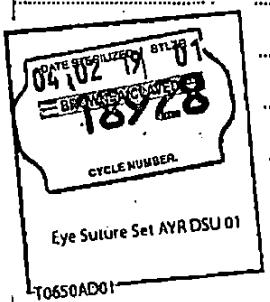
Julie Anderson
Staff Nurse
NMC: 08100915

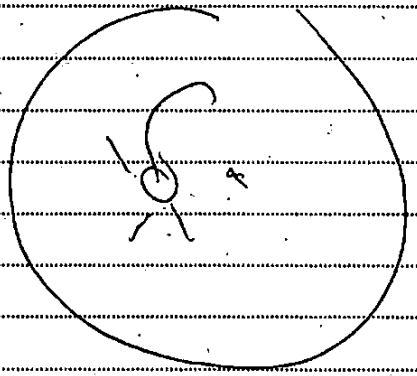


small laceral on LUL, mildly deep, but not reaching tarsal plate no FB within

DATE

Trapezius 1% (b).





OPHTHALMIC
ACHU03235369

Retn –
Rec –
Dis –

1 UL lacerat sutured with
1 stitch of 5/0 Vicryl + LA
advice
chap oint QID / instill eye / 1/24
BD on L/D / 1/24
Stitches removed at hr Cap in 1/24

(D)

Rakhi

337455 TR(MG) 15/9/9-50 RMS

CROSSHOUSE HOSPITAL
EMERGENCY DEPARTMENT

NHS Ayrshire & Arran

A/E No: XH-09-046205-1

CHI No: 3108823299

Date: 10 Sep 2009 Time: 16:20

Consultant: Dr Nicola Weatherup

GP: A Fowder
LOUDOUN MEDICAL CENTRE
LOCHORE TERRACE

Incident Date: 10 Sep 2009
Incident Time: 16:20

Martial Status: Single

Sex: M

GREEN

Lee

Date of Birth: 31 Aug 1982 Age: 27 Years

Address:
16 BROWN STREET
NEWMILNS

KA16 9AA

Next of Kin:
Margaret Mcewan
52 EAST MAIN ST
DARVEL
AYRSHIRE
KA17 0HT

Mother
Home Tel: 01560 321338

Religion: Protestant

Previous Attendance Count: 3

Phone Numbers:

Employer/School

Accompanied By: Work colleague

Special case

Triage Time 16:33 Triage Nurse Linda Baird Triage Group Green

Resp Rate 02 Sat% PFR

Pulse BP / E M V

Allergies: Not Known

BMstix Alcohol Temp Weight

R L

Pain Score (Triage) 4

Pain Score (Discharge)

Triage details
lac to L index finger with chain saw disc

Treatment
High arm sling, Temporary Dressing, Wound cleaned

Special Needs
NONE

Re-assess in 15 30 60 minutes

Against Medical advice I decline the treatment offered. I know this may affect my recovery.

Signed..... Witness..... Witness.....

I give consent for details of my injury to be given to the Police.

Signed.....

Disch A-E clinic Paed Tr # eye ENT Max Facial Ward GP Ward IP

XH-09-046205-1

A/E No. XH-09-046205-1

Drug	Dose	route	time/frequency	signature	quantity/given by
Lignocaine 1%	3ml	SC	17¹⁰	[signature]	[signature] (STAT)
FLUCLOXACILLIN	500mg	ORAL	6HOURLY	Holmes	[signature] (28)
			For 7 days		

DOCTOR / ENP: MAIR Time: 1705

PC: Wound (L) index finger (RHO)

HPC: 27yr old builder cut finger with a chain saw earlier today. No previous injury.

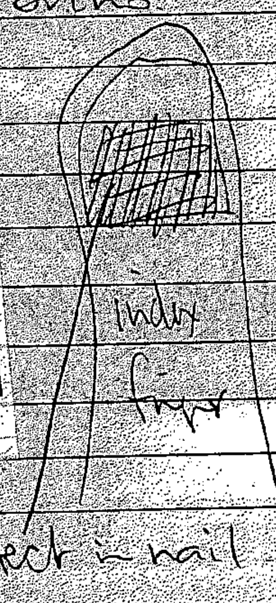
°Allergies °PMH of note °Current meds

ATT covered

OE: Wound over dorsum of nail bed
FROM - C&S intact
Bleeding +++

Plan XRAY (L) index finger - # distal phalanx
Ring block + examine

MP: Large defect in nail bed - bone exposed
Refer ortho
ragged pieces of remaining nail removed
thorough wound toilet
Mepitel dressing
Antibiotics - re ortho
High arm sling
R/V A/E clinic Tues
[signature]



04 09 09 04
026679
CYCLE NUMBER
MEDITRAX Re-order code TT53 Tel: 01454 318373
Dental Facial Set
A/E XH 73
STEAM
Dark = processed
HWD GENERAL
ACHU01806363

Write or attach label

HC
CH
Sur
For GREEN Lee
Add 18 BROWN STREET
KA16 9AA
Dat DOB: 31/08/1982

CHI No: 3108823299

STA 0213

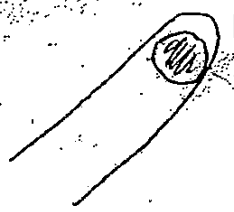
ORTHOPAEDIC

DATE	
10/09/09 18:15	FY2 ORTHO

27 yrs ♂ admitted with injury to left ring finger.

RHD, works as tree surgeon. Recent tetanus. Using electric drill today + went over nail bed of (R) (L) ring finge by accident. Painful + bleeding, lost part of nail. Reviewed by ENP – ring block + washed out, nail particles removed.

O/E



XRay – ~~part~~ insert from saw on distal phalynx

Reviewed by Mr Sreshta.
– For clean dressing + (tt)

Impression: Loss of nail 2° to electric saw.

Plan: Abx 7 days
Return to clinic for dressing change in 7 days.

Alaina
FY2 SOT

CROSSHOUSE HOSPITAL - ACCIDENT AND EMERGENCY DEPARTMENT

XRW A

Triage time: 12:18 Triage nurse MILLIGAN Triage grade Yellow

resp rate		sat O2%	94
PFR		pulse	98
BP	132/70	GCS	
allergy	Not known		
BMstix		breath alcohol	
temp	37.7	urine	
VA	R L	pain score	7
review score		discharge score	
accompanied by:	Mother		

Triage details

c/o left sidedback apin Radiating from chest to flank. Pain on inspiration

treatment

I give consent for details of my injury to be given to the Police.

Signed .....

Against Medical advice I decline the treatment offered. I know this may affect my recovery.

Signed..... Witness..... Witness.....

Surname	GREEN
Forename	LEE
marital status	S
sex	M
A/E No.	08019144
Consultant	Dr D Chung
date/time attendance	19/04/2008 12:14
Date of birth	31/08/1982
age	25
special case	
GP	EA RAIT
address	DARVEL CLINIC 2A EAST DONNINGTON STREET DARVEL AYRSHIRE KA17 0JR
phone	01560320205
address	52 EAST MAIN ST DARVEL AYRSHIRE
alt	N
Post code	KA17 0HT
this problem+total att	2 + 2
Phone	01560 321338
incident: date/time	< 6 hours
next of kin	MARGARET MCEWAN
address	52 EAST MAIN ST DARVEL AYRSHIRE KA17 0HT
relationship	Mother
phone	01560 321338
Occup. religion employer school	Protestant
hospital number	

disch A+E clinic paed tr. # eye ENT max facial ward - OP ward - IP x-ray? Y / N

STA0098

JMcC/61959

Drug	Dose	route	time / frequency	Signature	Given by / quantity
CO-CODAMOL 30/500	2 TABS	O	14 cc		
IBUPROFEN	400mg	PO	1500		

1500

Time: 1250 DOCTOR: MILMORE

25 YO ♂ 6/7 POST-OP FOR SURGICAL FIXATION OF # (L) PATELLA

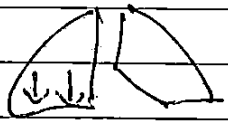
(R) - SIDED PAIN SINCE 2/7 POST-OP
- WORSE ON INSPIRATION
- SPUTUM / 1 x EPISODE HAEMOPTYSIS

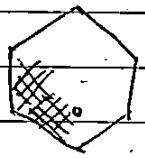
PMH$_x$ - NIL DH$_x$ - ANALGESIA
- NKDA

SH$_x$ - LIVES C MOTHER - SMOKER 20/DAY

O/E (L) LEG IN ABOVE KNEE CAST

CVS HS I + II + 0
- ANKLE OEDEMA ((R) ONLY)

RESP  ↓ A/E (R) BASE
NO CHEST WALL TENDERNESS

SI  - TENDER (R) IF + FLANK
- NO GUARDING/REBOUND
- BS ✓

NO CALF SWELLING

WAN CXR → NO CONSOLIDATION

LIKELY FOR CDU ?PE

MILMORE

A & E/CDU Multidisciplinary Clerking Proforma

SUSPECTED PULMONARY EMBOLUS

Patient ID Details

A&E Num: 08019144
GREEN LEE
52 EAST MAIN ST
DARVEL
KA17 0HT
Male
3/08/1982

Date & Time of arrival in A&E	Date & Time of arrival in CDU
19.4.08	19.4.08.1515

Date & Time left CDU

- ☑ Discharged 22/4/08 1345
- ☐ Admit Medical
- ☐ Admit Surgical
- ☐ Admit other spec.
- ☐ Deceased
- ☐ Other (specify) .....

Triage Category	Trolley/Bed/Chair
Yellow	Trolley

Next of Kin details

Name Margaret McEwan Relationship mum.

Contact No 01560 - 321338.

Alternative name and number

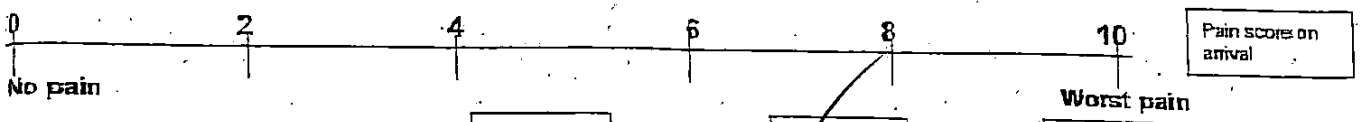
Jim. O'Connell (uncle)

Please ensure that the patient fits the criteria for CDU management as outlined below

Risk Categories (Clinical probability Score-Quantified Wells Criteria)	**Assign patient a probability score using the chart on P.4:** ☐ Low risk – 0-2 ☑ Moderate Risk – 2.5-6 ☐ High Risk - >6
Inclusion Criteria (for CDU management)	☐ Low/moderate risk(score 0 -6) ☐ Conscious and orientated ☐ Pleuritic chest pain and/or dyspnoea and/or haemoptysis ☐ Haemodynamically stable i.e. SaO2 > 92% on air, HR < 120, RR < 25
Exclusion criteria (manage in A&E and refer appropriately if any apply)	☐ High risk (score >6) ☐ Pregnant ☐ Social circumstances requiring admission > 24 hours ☐ Patients currently on Warfarin ☐ Grossly abnormal Chest X-ray ☐ Proven DVT ☐ Pneumonia

Initial Assessment

Pulse	Blood Pressure	Resp. Rate	Temp.	Fio2 (l/min Or %)	Oxygen Saturation	Patient Weight (Kg)



This patient can be managed in: A&E ☐ CDU ☑ AMAU ☐

Unable to send patient to CDU please document why (e.g. no space, patient too ill, etc) .....

Patient's name

A&E Num: 08019144
GREEN LEE
52 EAST MAIN ST
DARVEL
KA17 0HT
Male
31/08/1982
CHI Num:
PAS Num:

Summary of Management Protocol

Presentation	**Suspected Pulmonary Embolism**
Management in A&E	**Observations:** ☐ Temperature; ☐ Pulse; ☐ blood pressure;
	Investigations: ☑ FBC; ☑ U&E's; ☑ D-dimer; ☑ Clotting; ☑ ABG's if Sp02 < 92% on air ☑ 12 lead ECG ☑ Chest X-ray ☑ Intravenous Access +/- fluids if required ☐ Oxygen to maintain if Sp02 < 92 % ☑ Analgesia **Assign patient a probability score using the chart on P.4:** ☐ Low and medium probability patients send to CDU ☐ High probability patients admit to AMAU
Management in CDU	**Observations:** ☑ Pulse; ☑ Blood pressure; ☑ Resp. Rate; ☑ Sp02 hourly **Investigations:** ☐ Troponin (12 hours after the onset of pain) if cardiac cause cannot be excluded) **Please follow pathway for suspected PE and tick the relevant boxes in the pathway.**
Criteria for discharge (after any review)	☑ Pain improved ☑ Pulse and blood pressure within normal limits ☑ Temperature < 37.5°C ☑ Respiratory rate < 20 ☑ Sp02 > 92% on air (not requiring 02) ☑ Normal V/Q scan result ☑ Patient advised of diagnosis and treatment plan ☑ Social circumstances permit discharge ☑ Letter to G.P.
Criteria for admission (at any time)	☐ Social circumstances prevent discharge – social services notified ☐ Unstable patient
Criteria for admission (after final review)	☐ Persisting severe pleuritic chest pain ☐ Significant haemoptysis ☐ High probability of PE on V/Q scan ☐ CT scan positive for PE

XH 337455

GREEN LEE
52 EAST MAIN STREET
DARVEL
KA17 OHT

DR J MCCALL
5A HENRIETTA ST
GALSTON
CHI 3108823299

31/08/1982

PLEASE TICK THE FOLLOWING BOXES AND OBTAIN A PRELIMIN OF THE PATIENT HAVING A PE AND THEN PROCEED TO USE WELL'S CRITERIA IN THE NEXT PAGE

Signs and symptoms (The following signs and symptoms may be present in a patient with PE).

Signs and symptoms	Yes	No	Signs and symptoms	Yes	No
Dyspnoea (or worsening chronic dyspnoea)		✓	Palpitation		✓
Pleuritic chest pain	✓		Sao2<92% on room air		✓
Haemoptysis	✓		Pleural rub		✓
Clinical signs and symptoms of DVT (objectively measured leg swelling and pain with palpation in the deep vein region)		✓	HR>100/min		✓
Cough	✓		RR>25		✓
Others		✓			

Predisposing risk factors for PE

Risk factors	Yes	No	Comments
History of immobilisation (complete bed rest >/= 3 days except for access to toilet	✓		
Recent surgery (within the past 4 weeks, note type of surgery)	✓		
Cancer (within the past 6 months or on palliative care)		✓	
Lower limb problems (trauma or mobility problems eg. Paralysis)	✓		
Pregnancy/puerperium		✓	
Cardiorespiratory disorders (acute MI, Chronic symptomatic illness, irreversible airway disease)		✓	
Thrombophilia (eg. Protein S, Factor V Leiden)		✓	
Strong family history of DVT/PE		✓	
Previous history of objectively diagnosed DVT/PE		✓	
Oestrogen containing contraceptive pill		✓	
Relative risk factors	**Yes**	**No**	**Comments**
IV drug use		✓	
Recent air travel(in last 4 weeks) - > 6 hours in duration		✓	

Physical examination and investigation

	Yes	No	Comments
Heart rate > 100/min		✓	
Respiratory rate > 20/min		✓	
ECG changes (sinus tachycardia, non-specific ST segment changes, right sided strain pattern)		✓	
Pao2 < 10.0 kPa on ABG (on air)		✓	

	Yes	No
PE as likely as or more likely than an alternative diagnosis	✓	

NB: Please proceed to assess the clinical probability for PE using the Well's quantified method on the next page

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Determining the clinical probability of PE (Quantified Well's criteria)

Criteria	Points	accordingly
Clinical signs and symptoms of DVT (objectively measured leg swelling and pain with palpation in the deep vein region)	3	—
Heart rate more than 100 per minute	1.5	—
Immobilisation (bed rest, =/>3 consecutive days except for access to bathroom) OR Surgery in the last 4 weeks	1.5	✓
Previous diagnosed PE or DVT	1.5	—
Haemoptysis	1	✓
...hancy (patients with cancer who are receiving treatment, those in ...n treatment had been stopped within the last 6 months, or those on palliative care)	1	—
PE as likely **as or more likely** than an alternative diagnosis*	3	✓
TOTAL SCORE	5.5	

*It is critical that the physician assess the likelihood of PE v' s other possible causes of the patients' complaints. If in doubt, please consult senior.

Interpretation of Quantified Well's criteria score:

Score (points based on Quantified Well's score)	Probability of PE
...6	Low
	Moderate
	High

FINAL ASSIGNMENT OF CLINICAL PROBABILITY FOR PE
BASED ON THE QUANTIFIED WELL'S CRITERIA:

LOW ☐ MODERATE ☑ HIGH ☐

Quantified Wells score calculated by:

Name: ..... **Signature:** ..... **Date and time:** 19/9/18

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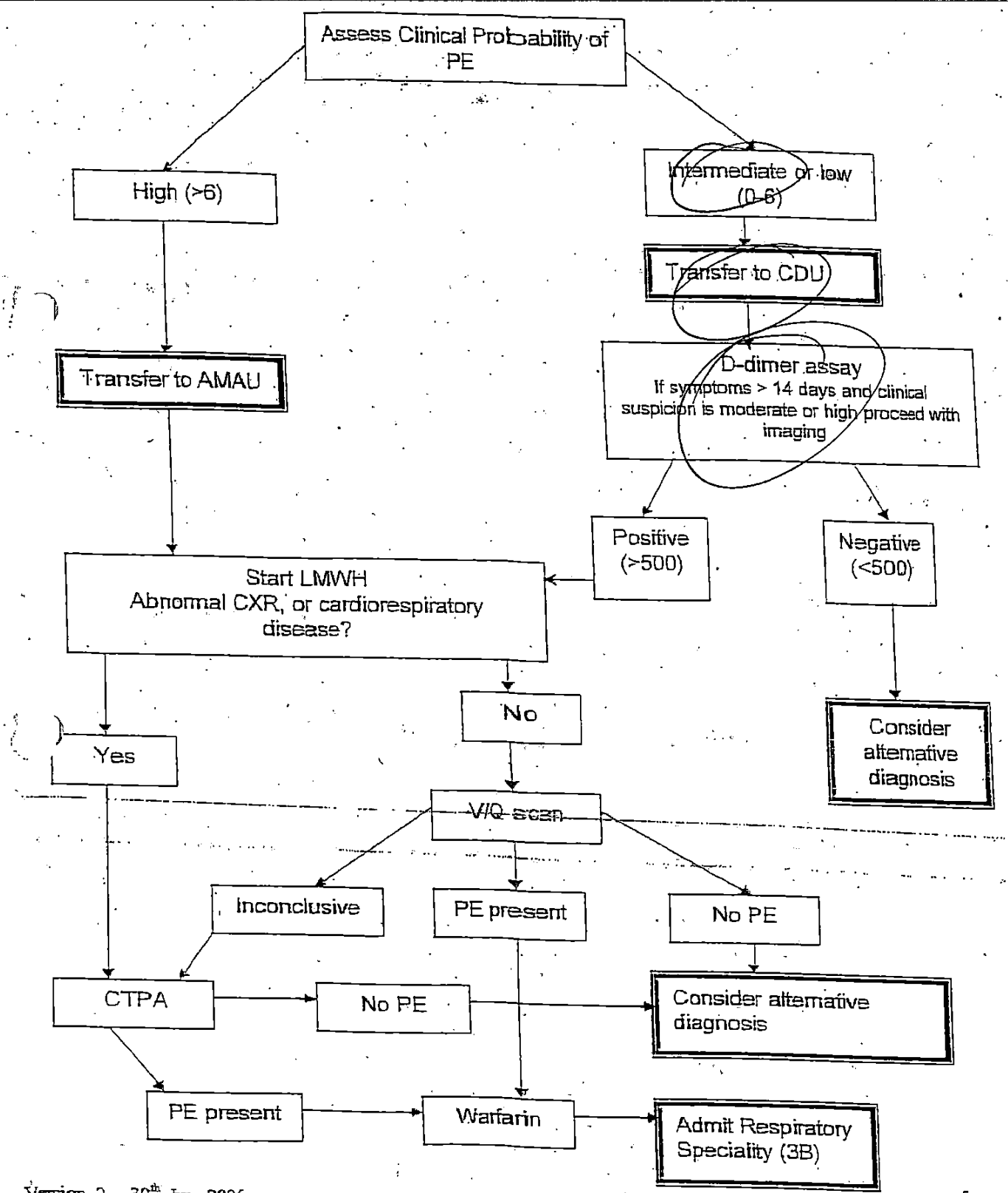
Management Protocol for Suspected Pulmonary Emb

PLEASE PROCEED TO MANAGE THE PATIENT VIA PATHWAY 1 BAS CLINICAL PROBABILITY ASSIGNED BY THE QUANTIFIED WELL'S CRITERIA

Figure 1



A&E Num: 08019144

Patient's name/a

GREEN LEE
52 EAST MAIN ST
DARVEL
KA17 0HT
Male
31/08/1982
CHI Num:
PAS Num:

Medical Notes – Suspected PE

Date and time 19/APR/06

esenting complaint 4/7 Pleuritic Chest Pain
Cough
Today morning 1 episode - Haemaptysis
- Streak of blood in Sputum

st History

Patella Surgery 9/[illegible]/06

Past Medical history		Specify detail:
Previous admissions with ?PE	☐ Yes	☑ No
Previous admissions with proven PE	☐ Yes	☑ No
Previous admission with proven DVT	☐ Yes	☑ No
Previous admissions to CDU	☐ Yes	☑ No
Other – please specify	☐ Yes	☑ No

isk factors – please specify

moker Yes/No
f yes, please undertake assessment CDU)

Others - specify

POD'S
Yes/No

Consent to use POD's
Yes/No

llergies/Intolerance

NIL

History (including OTC/herbal/homeopathic)

Medicine	Dose	Freq	Route
Co-Codamol			
Tramadol			
Lactulose			

Medicine	Dose	Freq	Route

A&E Num: 08019144

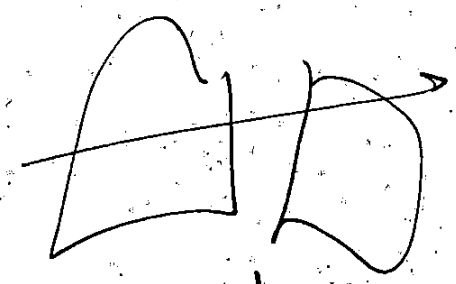
Patient's name/addr

GREEN LEE
52 EAST MAIN ST
DARVEL
KA17 0HT
Male
31/08/1982
CHI Num:
PAS Num:

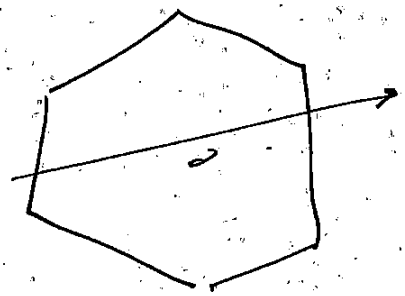
Medical Notes – Continuation Sheet

Examination Findings

obs - Afebrile PR 88/m RR 18/m Sat 99% o/A
Pain Sore 6/10. no Cyanosis

R/S.  B/L Equal AE
no wheeze/crips

CVS S1/S2 no murmur JVP ⇐

 soft
no tender spot
BS (+)

(L) Leg → Above knee cast

Impression/Diagnosis	Management Plan:
R/O PE.	1. ~~[illegible]~~ CDU 2. B/d – D-Dimer - will be (+) < recent surgery 3. W/O 4. Analgesia / Fragmin

Signature ..... Print name ..... Page No. .....
Date 19/Apr/08 Time .....

A&E Num: 08019144

Patient's n

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GREEN LEE
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DARVEL
KA17 OHT

31/08/1982

DR J MCCALL
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Investigations Requests — Suspected PE

PAS Num:

The following investigations could be performed on all those with suspected Pulmonary Embolus(sign when requested)

Investigation	When performed		
	Nurse signature	Time performed	Reason if not performed
ECG			
CXR			
Arterial blood gases			
Troponin (if necessary)			
Clotting screen, Hemer, U's and E's			
V/Q scan			
CTPA			

Investigation results

	Result	Signature	Date/ Time
Hb	15.0	CM	19/4/8 1525
WCC	10.2	CM	
Platelets	304	CM	
N^+	137		
K^+	4.5		
Urea	4.5	Douglas	19/4/08. 1700.
Creatinine	61		
Glucose	5.1		
D-dimer	2047	Douglas.	1725.
PH			
PO2			
PCO2			
Troponin (if done)			

ECG
SR / NII Acute.

Chest X-ray
No focal consolidation.

V/Q scan result
No PTE

CTPA result

Other – Please specify
CRP 171

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Observations Record – Suspected PE

alf measurements (measure each calf circumference 10cm below tibial tuberosity).

Left Calf (cm)	Right Calf (cm)

Unable to measure calf. POP insitu (L) leg.

document pulse, BP, PR, Spo2, pain score, temperature HOURLY or if clinical deterioration.

DATE/TIME														
Fio2 (% or 1/min)														
Pulse														
BP														
Temp														
SpO2														
RR														
Pain Score (/10)														

DATE/TIME														
Fio2 (% or 1/min)														
Pulse														
BP														
Temp														
SpO2														
RR														
Pain Score (/10)														

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Free text page for use by all staff in CHI

Date and time	Comments/notes	Signature
19/4/08. 1530	admitted due to ?PE. Recent # (L) patella, plaster	
	insitu. Coughed up some blood this morning. No	
	calf swelling. Observations stable.	
	Ibuprofen and Cocodamol given for back pain at	
	1500. Await D-Dimer	LDaglas.
19/4/08. 1725.	D-Dimer 2047	LDaglas.
1845	+ Clexane	
	+ Ref patella pertin + physio	
	+ dedyer (R) thigh plaster pain + bruising	
	+ Wells 5.5, moderate. → IV as PTE, V/Q in Mon.	
19/4/08 1800.	Painfree at present. advised Lee to take analgesia routinely.	
	observations stable. S/C Fragmin administered	LDaglas.

CHI 3108823299
GREEN LEE
52 EAST MAIN STREET
DARVEL
KA17 OHT
31/08/1982 Pract 80260
Case Ref 337455

Free text page [for use by all staff in CDU]

Date and time	Comments/notes	Signature
0700	Settled and slept well. No complaints of pain offered. MEWS score 0. Sp2 99% on air.	
20/4/08 1125	s/b Dr Chung · Pain free not SOB · obs - stable. · no new issue Plan ① continue frusemi ② awaiting V/Q.	SR SAHH
20/4/08 1930	Settled evening. Observations stable. Pain now controlled today. Await V/Q scan — Dagleo.	
10pm	Patient requested night sedation. Given Temazepam 10mgs.	
0730	Settled and slept well. No complaints of pain. Temp 37.5°C. MEWS - 0.	

CHI 3108823299
GREEN LEE
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DARVEL
KA17 0HT
31/08/1982 Pract 80260
Case Ref 337455

Free text page (for use by all staff in CDU)

Date and time	Comments/notes	Signature
24-3-08	- CXR UNK	
	- Nursing admit,	
	- V/Q ? PE	
21/4/8 1900	No change to Report Unable to get	
	V/Q Result: Patient was stay overnight as he Has appt tomorrow at Plaster Room	CMcGee
0700	Slept for short spells, suffered pleuritic chest pain overnight although settled with analgesia. Obs stable. Apyrexial. MEW score 0.	
22/4/8	V/Q (N) Bordetella pyrena	? LRTI - early
	Ongoing (R) sided pleuritic pain CXR Some loss of volume (R) LZ	
	Antibiotics Analgesia Advice	(McGuffie)

XH 337455

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52 EAST MAIN STREET
DARVEL
KA17 OHT 31/08/1982.

DR J MCCALL
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CHI 3108823299

Free text page (for use by all staf

Date and time	Comments/notes	Signature
22/4/18 11⁰⁰	R/B Dr McCaffrey's VQ (N) ? LRTI	
	Plan: c/o oral antibiotics discharge	pag

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NHS Ayrshire and Arran – Crosshouse

Clinical Decisions Unit – Discharge Sheet

ease document the patient's journey here:

mitted to Ward(state ward)		Discharged home	✓
eason for admission		Date/Time discharged	22/4/08 1341
me left CDU		Out-patient clinic (specify)	✓

patient is discharged please complete the following checklist BEFORE discharge:

ILITY	INDEPENDENT.
WASHING AND DRESSING	INDEPENDENT.
EATING AND DRINKING	NORMAL DIET + FLUIDS.

DISCHARGE PRESCRIPTION

Date & time written .....

Date and time ready in POD locker .....

PATIENT COUNSELLED ON MEDICATIONS ☐ Yes ☐ No

Is social support required?	☐ Yes	☑ No
W ere a previous package in place?	☐ Yes	☑ No
C revious package be recommenced today?	☐ Yes	☒ No*

* liaise with social work and document outcome .....

Date/time and name of social worker with whom this was discussed .....

Is referral to Rapid Response Team required?	☐ Yes	☑ No
Can transport be arranged today?	☑ Yes	☐ No**

Date/time and name of RRT team member .....

If Yes - mode of transport arranged .....

**If No – assess suitability for taxi use and document outcome .....

Out-patient arrangement made	Yes/No	Signature .....
Discharge advice given to patient	Yes/No	Signature .....
Letter sent to G.P.	Yes/No	Signature .....

NHS Ayrshire & Arran – Crosshouse Hospital

Clinical Decision Unit

Discharge instructions for patients who have undergone investigation of Suspected Pulmonary Embolus.

You have been investigated by the Clinical Decision Unit for the cause of the pain in your chest.

We have specifically looked for a blood clot in your lungs (a pulmonary embolus).

( ) have NOT found a blood clot today and have made a diagnosis of:

..... Chest Infection .....

We would like to return to the CDU in one week for reassessment, at _____am/pm on

/ / 20

Please continue to take any medications that you have been prescribed. A letter will be sent to your GP regarding your investigation and care on the CDU.

You should return to the A&E department if:

( ) **You develop leg swelling or pain**
- **OR if your chest pain worsens**
- **OR if you develop breathlessness**

You can telephone for advice if you are unsure:

CDU: 01563 577467

A&E: 01563 577757

NHS 24: 08454242424

Or contact your G.P.

PATIENT AND INCIDENT DETAILS

Incident number	PA002476140.001
Name	LEE GREEN
Age	25
Date of birth	31/08/1982
Gender	Male
Incident location	108D EAST MAIN STREET DARVEL
Incident post code	KA17 0JB
Incident type	EMG

PRIMARY SURVEY

RESPONSE

AVPU	Alert

AIRWAY

Airway assessment	Clear

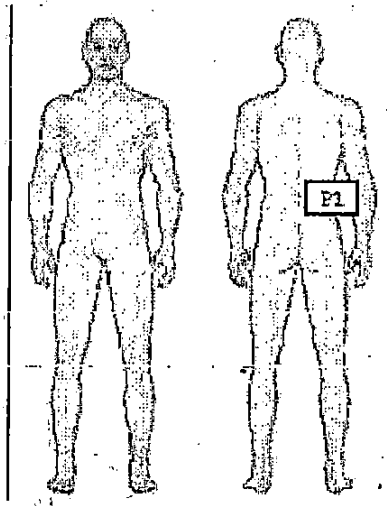
BREATHING

Breathing rate	Fast
Respiratory rate	

CIRCULATION

Pulse rate	Normal
Most peripheral pulse found	Radial
Cap refill rate	
Skin colour	Normal
Skin texture	Dry

INJURIES



AMPDS

Initial code	33C06	4 Transfer/Interfacility, Emergency Response Requested
Final code	33C05	Transfer/Interfacility, Acute Severe Pain

VITAL SIGNS

Time hr : min	Pulse bpm	Resp. rpm	BP mm Hg	Cap refill (secs)	Peak flow %	Blood sugar mmol / l	Temp °C	SpO2 %	GCS Total	RTS	EtCO2 k Pa
11:20	107	24	146 / 89	-	-	-	-	-	15	7.550	-
11:51	97	20	125 / 86	<2 secs	-	-	-	-	15	7.550	-

EYES AND PUPIL SIZE AND REACTION

	Left	Right
Pupil size	Normal	Normal
Pupil reaction	Normal	Normal

AMPLE

Allergies	None
Medication	COCODAMOL ,TRAMADOL
Past history	13/04/08 PT IN HOSPITAL FOR KNEE SURGERY AFTER FALL
Last eaten	>5 hrs
Events prior	PT HAS HAD RIGHT SIDED LUMBAR PAIN FROM TUESDAY 15/04/08 WHICH HAS GRADUALLY GOT WORSE, WAKENING THE PT THROUGH THE NIGHT

DRUGS, GASES AND PAIN RELIEF

Pain before	Drug / gas given	Time given	Dose given	Route	Batch No	Pain after

Hospital use Only | Clinic: Ortho A | Day Date Wed 28/8/96 | Time 2.30 | COA ✕ GP | Hospital No. 337455 | 14. GP112

REQUEST FOR OUT-PATIENT CONSULTATION
THE INFORMATION IN THIS SECTION MUST BE COMPLETED

Appointment Category: Routine ☐ Soon ☐ Urgent ☐

CHI No.

Hospital: CRosshouse Date: 19.8.96

Please arrange for this patient to attend the Orthopaedic Clinic clinic of Dr/Mr Mr. Sammon

PARTICULARS OF PATIENT 'IN BLOCK LETTERS PLEASE'

Patient's Surname: Green Maiden Surname:

First Names: Lee Single/Married/Widowed/Other:

Address: c/o 35 Benrig Avenue Date of Birth: 31.8.82

Kilmaurs Patient's Occupation:

Postal Code: Contact telephone number:

Has the patient attended hospital before? YES/NO If "YES" please state:

Name of Hospital:

Year of Attendance: Hospital No.:

If the patient's name and/or address has/have changed since then please give details:

Can patient attend at short notice? YES/NO

If YES, minimum notice required: days

Name, Address and Telephone number of MEDICAL/DENTAL PRACTITIONER

DR. J.MCBRIDE
KILMAURS CLINIC
EAST PARK DRIVE
KILMAURS.

TEL NO. KILMARNOCK 538585

Please use rubber stamp

I would be grateful for your opinion and advice on the above named patient. A brief outline of history, symptoms and signs is given below:

Thank you for seeing this 14 year old boy. He injured his right knee 6-7 months ago when ice-skating (he ran into a wall) and since then has had problems with it: the knee is painful and locks at times. Occasionally it has also given way. There is no swelling but he is a little tender when applying pressure to the patella. The knee flexes fully but with some resistance but makes the most dreadful crunching noises on extension.

I wonder if he has sustained a meniscal injury and would welcome your advice on further management.

Many thanks.

Yours sincerely,

DR. J.MCBRIDE

Clicking going on for 6 mos
pain. Does not know how long.
Describes 2 incidents that could
like locking..

O/E Marked patello femoral crepitus
pain to Moving patella side to side
not also. ? Chondromalacia

Needs scope

Diagnosis/provisional diagnosis:

X-ray

Present drug treatment and potential special hazards:

X-ray (women of childbearing age). Date of first day of L.M.P.

Relevant X-rays available from: No. (if known)

Signature

355-2104

Dd8373616 3/94 RP(53791)

AYRSHIRE AND ARRAN
HEALTH BOARD

WRITE, IMPRINT OR ATTACH LABEL

GREEN LEE 337455
27 MILRIG CRES
GALSTON
DR NICOLL
HENRIETTA ST

WARD/DEPT
31/08/1982
M/S C/H
A2292

STA0213 Ward/Dept.

ORTHOPAEDIC

DATE		FRACTURE CLINIC (MR FITZGERALD)
28.3.91	SA/SMcG	This boy fell on his left outstretched hand while playing and sustained a greenstick fracture of the left radius. His plaster is loose today and has been changed to a fresh below-elbow plaster. Review in 2 weeks with removal of plaster. Letter to GP.
11.4.91	HBN/SMcG	No tenderness at the fracture site. Left wrist movements are full range and pain free. Discharged from the clinic. Letter to GP.

DATE

XH 337455

GREEN LEE
64 BREWLANDS ST
Surname.. GALSTON
Forename: 31/08/1982 M/S
Address .. DR J MCCALL
HENRIETTA STREET GALSTON
.....
Ward/Dep CHI 3108823299

STA0213

DA

5.5.95 AN/ML Lee Green 337455 Fracture Clinic

This 12 year old boy sustained a greenstick fracture of his right distal radius on 21.4.95, attending A & E the next day. On review today the plaster was in bits and was therefore removed. Examination of the wrist showed no bruising, swelling or tenderness and so he was discharged. Advised to not to take part in contact sports for the next 3 weeks.

cc **Dr McCall, Henrietta Street, GALSTON**

ORTHOPÆDIC

DATE

Surname ..... HCR No. .....

Forer XH 337455

Addr GREEN LEE
C/O 35 BENRIG AVE
KILMAURS

STA0213 War 31/08/1982 M/S
DR.J.MCCALL
THE SURGERY
5A HENRIETTA STREET
CH1 3108823299

DATE

MR ABRAMI'S ORTHOPAEDIC CLINIC
28.08.96 GA/MC LEE GREEN 337455
cc Dr McBride East Park Drive Kilmaurs

14-year-old boy who has been aware of a clicking sensation in his right knee which he says goes out of place and "jams". Vague as to how long he has had these symptoms, but he certainly describes 2 incidents of what sounds like true locking.

On examination: there is marked patello-femoral crepitus. Moving the patella from side to side is uncomfortable but apart from this there is no localising feature to suggest internal derangement. Symptoms began when he struck his knee whilst ice skating. This could be traumatic chondromalacia.

X-ray examination of the knee today is negative. Patient's name to be put on the waiting list for **diagnostic arthroscopy right knee.**

MR AL-DADAH'S ORTHOPAEDIC CLINIC
18 10 96 HBN/AR Lee Green 337455
This boy's right knee feels better. I explained to him regarding his knee problem. Stitches were removed. Wound has healed well. Knee is still swollen. To have a Tubigrip support. I told him to do quadriceps and knee exercises. See again in 2 months' time.

MR AL-DADAH'S ORTHOPAEDIC CLINIC
16 12 96 AGC/AR Lee Green 337455
cc Dr McBride East Park Drive Kilmaurs
This young boy had lateral release of his right knee. Today on review he told me that he is feeling fine. No problems whatsoever. On examination his knee is straight. No effusion. Range of movement is full and pain free. No local tenderness. I have reassured the mother and the boy. Discharged. No further appointment.

ORTHOPAEDIC

DATE

5

THIS CARD IS CONFIDENTIAL—IT MUST NOT BE HANDLED BY PATIENTS OR UNAUTHORISED PERSONS

Code STA0 098

CROSSHOUSE HOSPITAL

Accident/Emergency Department

Name of Examining Doctor [illegible]

A/E Reg. No. 88/5/972

Surname	First Name(s)	Date of Birth	Age	Hospital Case Record Number
GREEN	LEE.	31.8.82	5	

Home Address (Permanent): 27 MILRIG CRES GALSTON.

Tel. No.: 821235

Temporary Address:

Name and Address of own Doctor: DR McCALL GALSTON.

Sex	M. S. W.	Religion	Occupation	Employer/School	Date of Injury	Time	Date of Attendance	Time
M	S	RC	SCHOOLBOY	GALSTON PRIMARY	9.5.88	1[illegible] a.m./p.m.	10.5.88	2[illegible] a.m./p.m.

Source
- Not Accident ☐
- Road Accident ☐
- Home Accident ☐
- Works Accident ☐
- Other Accident ☑

Type of Road Accident
- Pedestrian ☐
- Bicycle ☐
- Motor Cycle ☐
- Motor Car ☐
- Other Vehicles ☐

Method of Referral
- Self Referral ☑
- G.P. Letters/Phone ☐
- 999 call ☐
- Police ☐

Next of Kin: MARGT GREEN

Relationship: MOTHER

Tel. No.: ANY

Present YES/NO

Informed YES/NO

Belongings
- Listed ☐
- Hospital Safe ☐
- Other ☐

Drug Sensitivity

X-Rayed ☑

Administration— Drug (Block letters) Approved Names	Dose	Method of Admin.	Doctor's Signature	Time Given	Given By—Initials

IMMEDIATE DISCHARGE DRUGS

Drug (Block letters) Approved Names	Dose	Method of Admin.	Frequency	Quan. Dispensed	Doctor's Signature

DISPOSAL
- Home—Own G.P. ☐
- Fracture Clinic ☐
- Orthopaedic Clinic ☐
- Other ☐
- Ward 1A ☑
- Transferred ☐
- Return Appt. Date ☐
- Ambulance ☐
- Died ☐
- G.P. Notified ☐
- Police Notified ☐
- Clergy Notified ☐

NURSING NOTES

DATE	
5.88	Head Injury.
	Seen by Doctor 7.10
	To X-Ray 8.30pm
	From X-Ray 8.30pm
	Discharged [illegible]

5

THIS CARD IS CONFIDENTIAL—IT MUST NOT BE HANDLED BY PATIENTS OR UNAUTHORISED PERSONS

Code STA0 098

CROSSHOUSE HOSPITAL

Accident/Emergency Department

Name of Examining Doctor: GATTENS

A/E Reg. No.: 88/5/972.

Surname: GREEN | First Name(s): LEE.

Date of Birth: 31.8.82 | Age: 5. | Hospital Case Record Number:

Home Address (Permanent): 27 MILRIG CRES GALSTON. | Tel. No.: 821235 | Temporary Address:

Name and Address of own Doctor: DR MCCALL GALSTON

Sex	M. S. W.	Religion	Occupation	Employer/School	Date of Injury	Time	Date of Attendance	Time
M	S	RC	SCHOOLBOY	GALSTON PRIMARY	9.5.88	1030 a.m. p.m	10.5.88	2420 a.m. p.m.

Source
- Not Accident ☐
- Road Accident ☐
- Home Accident ☐
- Works Accident ☐
- Other Accident ☑

Type of Road Accident
- Pedestrian ☐
- Bicycle ☐
- Motor Cycle ☐
- Motor Car ☐
- Other Vehicles ☐

Method of Referral
- Self Referral ☑
- G.P. Letters/Phone ☐
- 999 call ☐
- Police ☐

Next of Kin MARGT GREEN
Relationship MOTHER
Tel. No. AMA
Present YES/NO
Informed YES/NO

Belongings
- Listed ☐
- Hospital Safe ☐
- Other ☐

Drug Sensitivity

X-Rayed ☐

DISPOSAL
- Home—Own G.P. ☐
- Fracture Clinic ☐
- Orthopaedic Clinic ☐
- Other ☐
- Ward 1A
- Transferred ☐
- Return Appt. Date ☐
- Ambulance ☐
- Died ☐
- G.P. Notified ☑
- Police Notified ☐
- Clergy Notified ☐

Drug Administration—

Drug (Block letters) Approved Names	Dose	Method of Admin.	Doctor's Signature	Time Given	Given By—Initials

IMMEDIATE DISCHARGE DRUGS

Drug (Block letters) Approved Names	Dose	Method of Admin.	Frequency	Quan. Dispensed	Doctor's Signature

NURSING NOTES

DATE	
10.5.88	Head Injury.
	Seen by Doctor 710
	To A+E 8.30am
	From A+E 8.30am
	Discharged

5

THIS CARD IS CONFIDENTIAL—IT MUST NOT BE HANDLED BY PATIENTS OR UNAUTHORISED PERSONS

Code STA0 098

CROSSHOUSE HOSPITAL

Accident/Emergency Department

Name of Examining Doctor G A Thomas

A/E Reg. No. 88 | 5 | 972.

Surname: GREEN | First Name(s): LEE.

Date of Birth: 31.8.82 | Age: 5. | Hospital Case Record Number:

Home Address (Permanent): 27 MILRIG CRES GALSTON. | Tel. No.: 821235 | Temporary Address:

Name and Address of own Doctor: Dr. McCALL GALSTON.

Sex	M. S. W.	Religion	Occupation	Employer/School	Date of Injury	Time	Date of Attendance	Time
M	S	RC	SCHOOLBOY	GALSTON Primary	9.5.88	1930 a.m. p.m	10.5.88	2020 a.m. p.m.

Source
- Not Accident ☐
- Road Accident ☐
- Home Accident ☐
- Works Accident ☐
- Other Accident ☑

Type of Road Accident
- Pedestrian ☐
- Bicycle ☐
- Motor Cycle ☐
- Motor Car ☐
- Other Vehicles ☐

Method of Referral
- Self Referral ☑
- G.P. Letters/Phone ☐
- 999 call ☐
- Police ☐

Next of Kin: MARGT GREEN

Relationship: Mother

Tel. No.: AMB

Present YES/NO | Informed YES/NO

Belongings
- Listed ☐
- Hospital Safe ☐
- Other ☐

Drug Sensitivity

X-Rayed ☑

Drug Administration— Drug (Block letters) Approved Names	Dose	Method of Admin.	Doctor's Signature	Time Given	Given By—Initials

IMMEDIATE DISCHARGE DRUGS

Drug (Block letters) Approved Names	Dose	Method of Admin.	Frequency	Quan. Dispensed	Doctor's Signature

DISPOSAL
- Home—Own G.P. ☐
- Fracture Clinic ☐
- Orthopaedic Clinic ☐
- Other ☐
- Ward 1A ☐
- Transferred ☐
- Return Appt. Date / Ambulance ☐
- Died ☐
- G.P. Notified ☑
- Police Notified ☐
- Clergy Notified ☐

NURSING NOTES

DATE	
10.5.88	Head Injury.
	Seen by Doctor 7.10
	To X-Ray 8.20pm
	From X-Ray 8.30pm
	Discharged

ATE | CLINICAL NOTES—Each entry to be signed by the examining Doctor.

Fell off bike last night
- ? LOC'd - since then has been drowsy - fully asleep - vomited x 4 today

→

O/E Alert.
Breathing ok Gen Neglect
Pupils unequal - (R) > (L)
Sluggish to light ? dysphasia on left lateral gaze.
- fundi - NAD
Tone/Bulk/Reflexes B T S K A Pl
(R) ↑ ↑ ↑ ↑ ↑ ↓
(L) ↑ ↑ ↑ ↑ ↑ ↓

Skull XR

[signature]

MEDICAL IN CONFIDENCE

Admission Form V3

MEDICAL RECORD

HOSPITAL CODE	HOSPITAL NAME	CASE RECORD NUMBER
XHI	Crosshouse Hospital	XHI337455

ADM. DETAILS

DATE	TIME	TYPE	REASON	ADM/TRANS. FROM	INPAT./DAYCASE	DATE ON W.L.	W.L. TYPE	PATIENT CATEGORY
13/4/2008	13:41:00	36	11	10	Inpatient	//		

WARD	S. FACILITY	SPECIALTY	CONSULTANT	FROM LOCATION	W.G.E
2A	Other (filler code)	Orthopaedics	Mr.Calum MacLeod		

PATIENT

TITLE	SURNAME	FORENAME(1)	(2)	AGE	DATE OF BIRTH	SEX	MARITAL STATUS
	Green	Lee		25	31/8/1982	M	S

ADDRESS 18 Brown Street
Newmilns

ALT/PREV.SURNAME

OCCUPATION

C.H.I. NUMBER 3108823299

POSTCODE KA16 9AA TELEPHONE No.

OCCUPATION(HUSBAND/FATHER)

HEALTH BOARD RESIDENCE

HAVE YOU LIVED IN THIS COUNTRY FOR PAST YEAR?

REF G.P.

NAME
G.P. CODE PRACTICE
CONTRACT No. FH STATUS

ADDRESS
TEL No. POSTCODE

REG

NAME James McCall
G.P. CODE 1342581 PRACTICE GP Practice
CONTRACT No. FH STATUS

ADDRESS 5a Henrietta Street, Galston
TEL No. 01563 820424 POSTCODE KA4 8JW

NOK

NAME

RELATIONSHIP

ADDRESS

DAY PHONE.No. NIGHT PHONE.No.

MISC

RELIGION NK

VISIT REQ. BY CHAPLAIN YES/NO
No

PENSION BOOK No.

Admission

MAIN DIAGNOSIS | SPECIAL WARNINGS
OTHER CONDITIONS (D.G.2)
OTHER CONDITIONS (D.G.3)

SMR04 SMR50

M.H. STATUS | PREVIOUS PSYCH. CARE | CONTRIBUTORY SOCIAL FACTOR

DISCHARGE SUMMARY

Requested by: elizabeth andress 13 Apr 2008 13:41

DATE	TIME	DISCH. TYPE	PATIENT CATEGORY	MANAGEMENT OF PATIENT	SPECIALTY	CONSULTANT CODE
14/4/08						
DISCH./TRANSF. TO	**READY FOR DISCH.**	**HOSPITAL NAME**	**CODE**	**WARD**	**SPECIALTY**	**CONSULTANT CODE**
Home				2A	Ortho	Macleod
SMR04	TYPE OF CARE PROVIDED		ECT-1st TREATMENT DATE		ECT-NUMBER OF TREATMENTS	

DIAGNOSIS AND

MAIN DIAGNOSIS	SPECIAL WARNINGS
OTHER CONDITIONS (D.G.2)	
(D.G.2)	
(D.G.3)	
(D.G.4)	
(D.G.5)	
(D.G.6)	

CHI 3108823299
GREEN LEE
18 BROWN STREET
NEWMILNS
KA16 9AA
31/08/1982 Pract 80260
Case Ref 337455

STA 0213

ORTHOPAEDIC

DATE

ORTHO GPST (MAINWED & MR McLEOD)

13/4/8
12.45

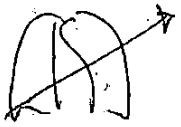
(25) → A&E Referral

PC, (L) knee injury

HPC, Fell over dog outdoors
landed onto (L) knee
Unable to weightbear due to pain
Denies any other bony pain
Last ate/drank ~0930

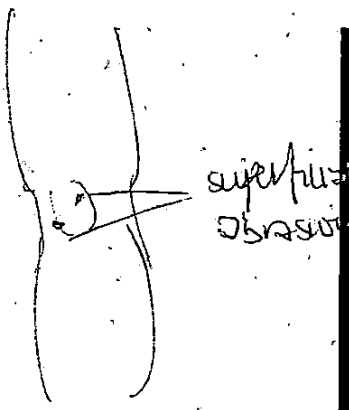
PMHx nil OHx nil NKDA SHx Tree surgeon
Smoker ~15/day
Alcohol ~15U/week

O/E Comfortable
BP 117/74
HR 100 bpm reg
SO_2 100% on A



HSM
Abdo – SNT
BS ✓

(L) knee – swelling +
– superficial abrasions x2 over patella
– tender on palpation
Unable to SLR
Ankle dorsiflexion/plantar flexion intact, NVI intact



superficial abrasions

XRay – # (L) patella – appears comminuted but not displaced ? 3 part

JM-C/74859

DATE

Pn D/W SpR re ? theatre today
- wm RIV xray

↓

for ORIF this afternoon
Remain NBM
IV fluids
Consent | mark

AHMED
GPST (3368)

13/4/00 Ortho

13.40. (25) → fellover dog landing directly on tip of left patella

→ Unable to WB.

Swelling of knee.

Last ate at 9.30 - milky coffee.

Pmh nil.

OE Left knee / Anterior swelling - 2x wound over patella area.

Unable to straight leg raise.

- No contraction of quadriceps.

X → Transverse patella # with comminution

Clinically extensor mechanism not intact.

→ Consent for theatre.

Plan Admit.

Analgesia

Fast for theatre.

Cyl splint

Thomas

CONSENT FOR OPERATION

STA1057

Attach label
XH 337455
HCF GREEN LEE
CHI 18 BROWN STREET
Sur NEWMILNS
KA16 9AA
For
Ad DR J MCCALL 31/08/1982
5A HENRIETTA ST.
GALSTON
CHI 3108823299
Date of ...

I LEE GREEN of .....

..... hereby consent to

* undergo / the submission of my * child SELF / ward

the operation of OPEN REDUCTION & INTERNAL FIXATION LEFT PATELLA

the nature and purpose of which have been explained to me by

~~Dr./~~Mr.* THOMAS

I also consent to such further of alternative operative measures as may be found necessary during the course of the above-mentioned operation and to the administration of general, local or other anaesthetics for any of these purposes.

No assurance has been given to me that the operation will be performed by any particular practitioner. (Not applicable to section 1 (2) patients.)

Date 13/4/8 Signed Lee Green
(Patient/Parent/Guardian)

I confirm that I have explained the nature and purpose of this operation to the patient/parent/guardian.*

Date 13/4/8 Signed .....
(Medical/Dental Practitioner)*

*DELETE AS APPROPRIATE

Note: This form is not to be used for any operation where there is a specific consent form with explanations.

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JMcC/14329

CONSENT FOR OPERATION

4/4/8 NAD NAD NAD
ogw Day 1 post-op (L) patella def
well
Obs stable

CHI 3108823299
GREEN LEE
18 BROWN STREET
NEWMILNS
KA16 9AA
31/08/1982 Pract 80260
Case Ref 337455

P/u cylinder cast today
Physio
(H) are able to mobilise

[redacted]
(3309)

Orthopaedic

Anaesthetic Record

Proposed procedure: ORIF @ patella.

Consent form signed	Y / N
Incapacity form	Y / N
Fasted	Y / N

Elective	
Scheduled Urgent	
Urgent	✓
Emergency	

SASM Consultant:

Informed Y / N

Surr CHI 3108823299
Fore GREEN LEE
Addi 18 BROWN STREET
NEWMILNS
KA16 9AA
31/08/1982 Pract 80260
Case Ref 337455
Ward or Department:

Preoperative assessment: Assessor: Date: Location: ASA Grade:

History
25 ♂ Tripped over dog → # @ patella.

Previous GA: No prev.

FH

CVS: Nil Significant

Resp.: fit + well

Reflux

Other: ϕ neck / back
ϕ liver
ϕ porphyria

Examination
HR
BP 117/74
Weight
Height
BMI

Airway Assessment
Mp I
TMD 76.5
Mouth opening: Good +
Teeth: Some. pk asn

Smoking: 2c/day
Alcohol: Wil reg.
Recreational Drugs

Hb
WCC
Plats
Urea
Creat.
Na
K
ECG
CXR
OTHER

Recent Medication
Nil

c NSAID's

Allergies
NKDA

Discussed:
Fasting ☐
Premed ☐
Induction ☐
Analgesia ☐
Suppositories ☐
Monitoring: ☐

Regional Block: Complications discussed pre-operatively
Failure ☐
Hypotension ☐
Headache ☐
Numbness ☐
Nerve Damage ☐
Patient agrees Y / N
Handout Y / N

Premedication:
Fasting: overnight Time
Light Breakfast
0.9% coffee & milk.
Fluids: Allow still juices / water till:

Usual medicines:
Give all:
Give only:
Give all except:

Drugs: Date: Time:
Ranitidine 150mg 13/4/08 1430

Given at / by: 1430 SVOO

Date: 13.4.08 Operation done: Location: Th 7 Start time: End time: Surgeon(s):

Anaesthetic assistant: SR. Dalrymple

Anaesthetist(s): Grade: Robertson (STI) D/D Dr Martin (Cons @ home)

Remarks: Significant Events / Critical Incidents Hazard Warnings

Uneventful Y/N

Effect of Premed

ANAESTHETIC RECORD

JMcC/70209 STA0093

Cannula	Site	Regional Anaesthetic technique:			
BG	② ACF	Spinal	☐	Full aseptic	☐
A Line		Epidural	☐	Entry site:	
CVP		N. Block	☐	Needle used:	
Insertion Notes		Wound Inf.	☑	Catheter: Y/N	

20mls 0.5% Marcaine to wound (Surgeon)

Anaesthetic / Recovery

Fluid In

	Infusion 1	Vol
①	Hartmann's + NSAID	500
②	Hartmann's	500
③	Hartmann's	500

	Infusion 2	Vol

Events Key

Total	
Blood Loss	
Urine Output	

4/4/8 MR MR McLEOD
0900 Day 1 post-op (L) patella def
well
obs stable

CHI 3108823299
GREEN LEE
18 BROWN STREET
NEWMILNS
KA16 9AA
31/08/1982 Pract 80260
Case Ref 337455

P_n cylinder cast today
Physio
(H) once able to mobilise

GP537(3309)

Orthopaedic

CONSENT FOR OPERATION

STA1057

Attach label
XH 337455
HCF GREEN LEE
CHI 18 BROWN STREET
Sur NEWMILNS
KA16 9AA
For
Ad DR J MCCALL 31/08/1982
5A HENRIETTA ST
GALSTON
CHI 3108823299
Date of ...

I LEE GREEN of .....

.....hereby consent to

* undergo / the submission of my

* child / ward SELF

the operation of OPEN REDUCTION & INTERNAL FIXATION LEFT PATELLA
the nature and purpose of which have been explained to me by

~~Dr./~~Mr.* TOM

I also consent to such further of alternative operative measures as may be found necessary during the course of the above-mentioned operation and to the administration of general, local or other anaesthetics for any of these purposes.

No assurance has been given to me that the operation will be performed by any particular practitioner. (Not applicable to section 1 (2) patients.)

Date 13/4/8 Signed Lee Green
(Patient/Parent/Guardian)

I confirm that I have explained the nature and purpose of this operation to the patient/parent/guardian.*

Date 13/4/8 Signed .....
(Medical/Dental Practitioner)*

*DELETE AS APPROPRIATE

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JMcC/74329

CONSENT FOR OPERATION

HOSPITAL .....

TIME OF ADMISSION/TRANSFER ..... WARD (WARD) 73-75

.....

PREVIOUSLY ATTENDED THIS HOSPITAL YES/NO

IF YES STATE YEAR

ADDRESS (ADDR) 76-135

.....

.....

.....

TEL. No. POSTCODE

RELIGION

NEXT OF KIN (RELATIONSHIP) .....

NAME .....

ADDRESS .....

.....

.....

TEL. No. POSTCODE

FAMILY DOCTOR

NAME .....

ADDRESS .....

.....

.....

TEL. No. POSTCODE

GP CODE (GP) 136-142

PROVISIONAL DIAGNOSIS ON ADMISSION

HOSPITAL CODE (HOSP) 1-5

HOSPITAL CASE REFERENCE No. (CRN) 6-15

SURNAME (SN) 16-35

FIRST FORENAME (FN1) 36-50

SECOND FORENAME (FN2) 51-65

MAIDEN NAME (MN) 66-85

ALTERNATIVE CASE REFERENCE No. (ACRN) 86-95

AGE ..... DATE OF BIRTH (DOB) 96-103

SEX (SEX) 104 MARITAL STATE (MRST) 105

POSTCODE (PC) 106-112

OCCUPATION (OCC) (OCCC) 113-175

HUSBAND'S/PARENT'S OCCUPATION (HPO) (HPOC) 176-238

ADMITTED/TRANSFERRED FROM (ADTF) 239 TYPE OF ADMISSION (TADM) 240

DATE PLACED ON WAITING LIST (DWL) 1-6

DATE OF ADMISSION (DOA) 7-12

DATE OF DISCHARGE (DOD) 13-18

TIME OF DISCHARGE ..... DISCHARGE CODE (DISC) 19

CATEGORY OF PATIENT (CAT) 20 TYPE OF FACILITY (TOF) 21

SPECIALTY (SPEC) 22-25

CONSULTANT'S SURNAME (CONS) 26-45

CONSULTANT'S INITIALS 46-47 CONSULTANT CODE (CONC) 48-54

TO BE COMPLETED BY DOCTOR ON DISCHARGE OF PATIENT

1) MAIN CONDITION (DG1) (DG1C) 55-120

2) OTHER CONDITIONS (DG2) (DG2C) 121-186

3) (DG3) (DG3C) 1-66

4) (DG4) (DG4C) 67-132

5) (DG5) (DG5C) 133-198

6) (DG6) (DG6C) 1-66

1) PRINCIPAL OPERATION (OP1) (OP1C) 67-131

2) OTHER OPERATION (OP2) (OP2C) 132-196

DATE OF PRINCIPAL OPERATION (DOP1) DATE OF PRINCIPAL OPERATION (DOP1) 197-202

ERROR REPORT COMMENT: Data items specified in boxes below are correct (COM)

Enter field abbreviations

Additional notes: 1-60

LOCAL USE (LUSE) 61-66

NATIONAL USE (NUSE) 67-72

KEY TO CODED ITEMS

FULL INSTRUCTIONS FOR COMPLETING THIS FORM ARE CONTAINED IN THE SMR1 MANUAL

SEX (SEX)

1. Male
2. Female
8. Other or NK

MARITAL STATE (MRST)

1. Never Married — Single
2. Married — (Includes Separated)
3. Widowed
8. Other — (Includes Divorced)
9. NK

ADMITTED/TRANSFERRED FROM (ADTF)

1. Home = Usual Address
2. Other N.H.S. Hospital (In-patient, Short Stay or Day Bed Facilities only)
3. Other Unit in This Hospital (In-patient Facilities or Day Bed Units only)
8. Other

TYPE OF ADMISSION (TADM)

0. Deferred Admission
1. Waiting List/Diary/Booked
2. Repeat Admissions
3. Transfer
4. Emergency — Deliberate Self Inflicted Injury or Poisoning
5. Emergency — Road Traffic Accident
6. Emergency — Home Accident (Includes Accidental Poisoning in the Home)
7. Emergency — Other Injury (includes Accidental Poisoning other than in the Home)
8. Emergency — Other (excludes Accidental Poisoning)

DISCHARGE CODE (DISC)

0. 'Irregular' — eg Self Discharge
1. Home
2. Convalescent Hospital or Home
3. Other hospital
4. Local Authority Care
5. Transfer to other specialty in same hospital
6. Died (P.M.)
7. Died (No P.M.)
8. Other

CATEGORY OF PATIENT (CAT)

1. Amenity
2. Paying
3. NHS
7. Special Arrangements

TYPES OF FACILITY (TOF)

1. In-patient Admission
5. 5 Day Ward
6. Day Bed Unit
7. Day Case In-patient Facilities
8. Day Case Other

SPECIALTY (SPEC)

(Read detailed instructions in manual)

01 General Surgery
02 Orthopaedic Surgery
03 ENT Surgery
04 Ophthalmology
05 Urology
06 Neurosurgery
07 Thoracic Surgery (incl. Cardiac Surgery)
08 Plastic Surgery (incl. Maxillo-Facial Surgery and Burns)
11 Orthodontics and Paediatric Dentistry
12 Oral Surgery and Oral Medicine
16 General Medicine
17 Cardiology
18 Metabolic Disease
19 Neurology
21 Gastroenterology
22 Poisons Unit
23 Dermatology
24 Nephrology
25 Rheumatology
26 Rehabilitation Medicine
28 Respiratory Medicine (incl. Respiratory T.B.)
31 Communicable Diseases
32 VD (STD)
33 Diagnostic Radiology
34 Radiotherapy (consultative)
36 Homeopathy
37 Medical Oncology
38 Spinal Paralysis
39 Surgical Paediatrics
40 Medical Paediatrics
41 Pain Control (Anaesthetist)
42 Gynaecology
46 Special/Intensive Care Baby Unit
48 Intensive Therapy Unit
49 Accident and Emergency
50 Geriatric Assessment
51 Geriatric Long Stay
52 Young Chronic Sick
62 Haematology
73 GP (other than Obstetrics)
76 Acute Mixed
98 Other Acute

STA 0090

AYRSHIRE AND ARRAN HEALTH BOARD

MEDICAL IN CONFIDENCE

COPY FOR CASE RECORD

ADMISSION FORM

	HOSP. CODE	PATIENT UNIT No.	PREVIOUS ATTENDANCE	IN/OUT	YEAR
	A1114	337455			

	DATE	TIME	WARD	TYPE	SOURCE	DATE ON WAITING LIST	CONSULTANT	SPECIALTY
Admission Details	10.5.88	2.00	1A	7	8			P.F.D/Surg
Internal Trans.	DATE	TIME	WARD				CONSULTANT	SPECIALTY

PATIENT

TITLE SURNAME	FORENAME	INITIALS	AGE	DATE OF BIRTH	SEX	Ma Sta
GREEN	LEE	L.J.G.	5	31.8.82	M	S

ADDRESS: 27 MILRIG CRES
GALSTON

MAIDEN SURNAME:

OCCUPATION: S/BOY

POST CODE: TELEPHONE No. 821235

OCCUPATION (Husband/Father) CODE:

G.P.

NAME: Dr. NICHOLL
INITIALS:

ADDRESS:
POST CODE: GALSTON.

NEXT OF KIN

NAME: MGT GREEN RELATIONSHIP: MOTHER
ADDRESS: SIA
DAY TELEPHONE No.: A/A NIGHT TELEPHONE No.:

AND / OR

NAME: RETA O'CONNELL RELATIONSHIP: AUNT
ADDRESS: 19 CROSS ST
GALSTON
DAY TELEPHONE No.: NIGHT TELEPHONE No.:

MISCELLANEOUS

	YES	NO
1. Have you/or has your Husband/Wife (if child, your Mother/Father) been living in the UK for the past 12 months? N.B. Absences up to 3 months duration should be disregarded.	✓	
2. Are you/is your Husband/Wife (if child, your Mother/Father) going to live in the UK permanently?		

3. On what date did you/your Husband/Wife (if child, your Mother/Father) arrive in the UK? Enter earliest date

NOT LIABLE ✓ FOR STAGE 2 LIABLE

RELIGION: PROT

VISIT REQUIRED BY CHAPLAIN YES/NO

TYPE OF PENSION 1. 2.

PENSION BOOK No. 1. 2.

DISCHARGE SUMMARY

	DATE	TIME	TYPE	PATIENT CATEGORY	TYPE OF FACILITY	SPECIALTY	CONSULTANT	COD
Discharge Details	11.5.88							
	HOSPITAL			CODE	WARD	SPECIALTY	CONSULTANT	COD
	DISCHARGED/ ~~TRANSFERRED TO~~ HOME.					Paed/Surg	Mr. LIVINGSTONE	

DIAGNOSES & OPERATIONS

PRINCIPAL DIAGNOSIS: Acute Appendicitis CODE

OTHER CONDITIONS

PRINCIPAL OPERATION DATE CODE

OTHER OPERATIONS

NATIONAL OPTION

AYRSHIRE AND ARRAN HEALTH BOARD

STA0213

WRITE, IMPRINT OR ATTACH LABEL

Surname O'BRIEN C/R No.
Forenames Eric Sex
Address D.O.B.
Ward or Dept.

ORTHOPAEDIC

DATE

10/5/83

Admitted for observation following
Head injury

Fell off bicycle yesterday — ? loss of
consciousness + vomiting
Vomited x 4 today. ? drowsy after
Drowsy - keeps falling asleep

Skull XR — NAD
D/w Dr Sear - admit for obs.

PMH Chest infection - smoker + high
nurse.

NKA else of note.
SVD at term

DH Inhaler
Ventolin inhaler.

Allergies - nil

FH/SH Older brother + small sister at home

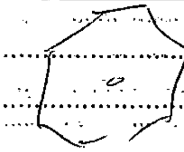
GE Not of note

CE Drowsy. Pallor. Gross Tachy
Bruising below R eye

CVS P 100/m reg
HS I + II +0

Resp Trachea: 0
Lungs A/E +
BS decreased + no added sounds

DATE

Abd  Abd soft [illegible]
 ? KCS
 BS —

CNS Pupils (R) > (L) both reacting to light
? Diplopia on left lateral gaze
Fundi – NAD
Tone / Power [illegible]
Reflexes

	B	T	S	K	A	Plant
(R)	++	++	++	++	++	↓
(L)	++	++	++	++	++	↓

⇒ Imp Skull Xr – NAD

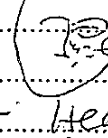
For observation

Dr Sees to see

[signature]

Admission via Cas
History as above fell off bike ?KO'd. Complained of pain above (L) eye Vomited x1 overnight + has spent today sleeping & vomited x3.
No complaint diplopia

O/E alert orientated
PERL
no papilloedema
power / tone L≡R (N) reflexes L≡R (N)
plantars ↓↓
now says diplopia – on (L) & (R) lat gaze.

 Graze

– Head injury
X-ray skull – no fracture
Neuro obs.

[signature]

(2) 5

ARD IS CONFIDENTIAL—IT MUST NOT BE HANDLED BY PATIENTS OR UNAUTHORISED PERSONS

ode STA0098

CROSSHOUSE HOSPITAL

Accident/Emergency Department

A/E Reg. No. 91-3.1451

Name of Examining Doctor MATTHEWSON

Surname	First Name(s)	Date of Birth	Age	Hospital Case Record Number
Green	Lee	31.8.82	8	337455

Home Address (Permanent)	Tel. No.	Temporary Address	Name and Address of own Doctor
27 Milrig Cres Galston	821235	—	DR MCCALL

Sex	M. S. W.	Religion	Occupation	Employer/School	Date of Injury	Time	Date of Attendance	Time
M	S	CE	S/boy	GALSTON PRIMARY	14.3.91	1440 a.m. p.m.	15.3.91	1630 a.m. p.m.

Source
- Not Accident ☐
- Road Accident ☐
- Home Accident ☐
- Works Accident ☐
- Other Accident ☑

Type of Road Accident
- Pedestrian ☐
- Bicycle ☐
- Motor Cycle ☐
- Motor Car ☐
- Other Vehicles ☐

Method of Referral
- Self Referral ☐
- G.P. Letters/Phone ☐
- 999 call ☐
- Police ☐

Next of Kin Margaret SMITH

Relationship Mother

Tel. No.

Present YES/NO Informed YES/NO

Belongings
- Listed
- Hospital Safe
- Other

Drug Sensitivity

X-Rayed ☑

Drug Administration— Drug (Block letters) Approved Names	Dose	Method of Admin.	Doctor's Signature	Time Given	Given By—Initials

IMMEDIATE DISCHARGE DRUGS

Drug (Block letters) Approved Names	Dose	Method of Admin.	Frequency	Quan. Dispensed	Doctor's Signature

DISPOSAL
- Home—Own G.P.
- Fracture Clinic
- Orthopaedic Clinic
- Other #MCFTR
- Ward 28.3.91.
- Transferred
- Return Appt. Date
- Ambulance
- ~~Died~~ P.O.P. onede 16.3.91
- G.P. Notified
- Police Notified
- Clergy Notified

NURSING NOTES

DATE	
	Inj to L WRIST Comes P.O.P CP
	5/-
	5.30 pm

DATE | CLINICAL NOTES—Each entry to be signed by the examining Doctor.

Small cut over forearm, inflamed, Child says 'Its painful to move hand

OE / Non tender, br inflamed pink
° effusion.
Non.

Small lac ~ ½ cm

Greenstick # of ulna radius.

Pain.

3. P.O P. check
Circulation fingers OK.
° Swelling finger.
° Complete.
FOR SLING.

13/9/91

AYRSHIRE AND ARRAN HEALTH BOARD

TA0104

CROSSHOUSE HOSPITAL

CROSSHOUSE
KILMARNOCK KA2 0BE
Telephone (0563) 21133

Accident / Emergency Unit

Consultant in Charge
S. M. H. ZAIDI

Our Ref. 31.382

Date: 15.3.91

Lee Green
27 Milrig Cresc
Galston

Hospital No. 91-3.1451

Dear Dr.

The above named has attended this Department to-day and is suffering from

[illegible]

He/She has been treated as follows—

[illegible]

Clinical examination and inspection of wet films showed

No Bony Injury ☐ Bony injury of the following—

[illegible]

In the meantime the condition will be reviewed by the Radiologist and the Accident and Emergency Surgeon and in the event of a revision of opinion you will be informed and the patient requested if necessary to attend the Department.

Further treatment is recommended as follows—

A review appointment on [illegible]

Yours sincerely,

Accident/Emergency Surgeon.

(2) MR STEVENSON (5)

CARD IS CONFIDENTIAL - IT MUST NOT BE HANDLED BY PATIENTS OR UNAUTHORISED PERSONS

CONSULTANT

Code STA0098

CROSSHOUSE HOSPITAL

Accident/Emergency Department

A/E Reg. No. 95 - 4 - 2834

Name of Examining Doctor FITZSIMMONS

Surname	First Name(s)	Date of Birth	Age	Hospital Case Record Number
Green	Lee	31·8·82	12	337455

Home Address (Permanent)	Tel. No.	Temporary Address	Name and Address of own Doctor
64 Breezland St Galston	820269		Dr McColl Galston

Sex	M. (S./W.)	Religion	Occupation	Employer/School	Date of Injury	Time	Date of Attendance	Time
M	S.	Prot	Student	Lanark	21·4·95	a.m. / p.m.	22·4·95	1035 a.m. / p.m.

Source	Type of Road Accident	Method of Referral
Not Accident ☐	Pedestrian ☐	Self Referral ☑
Road Accident ☐	Bicycle ☐	G.P. Letters/Phone ☐
Home Accident ☐	Motor Cycle ☐	999 call ☐
Works Accident ☐	Motor Car ☐	Police ☐
Other Accident ☑	Other Vehicles ☐	

Next of Kin Margaret Green S/A

Relationship Mother

Tel. No. S/A

Present YES/NO S/A Informed YES/NO

Belongings: Listed ☐ Hospital Safe ☐ Other ☐

Drug Sensitivity

X-Rayed ☑

Drug Administration - Drug (Block letters) Approved Names	Dose	Method of Admin.	Doctor's Signature	Time Given	Given By - Initials

DISPOSAL

- Home - Own G.P. ☑
- Fracture Clinic 5/5/95 ☐
- Orthopaedic Clinic DR Z ☐
- Other ☐
- Ward ☐
- Transferred ☐
- Return Appt. Date / Ambulance ☐

IMMEDIATE DISCHARGE DRUGS

Drug (Block letters) Approved Names	Dose	Method of Admin.	Frequency	Quan. Dispensed	Doctor's Signature

- Died ☐
- G.P. Notified ☐
- Police Notified ☐
- Clergy Notified ☐

NURSING NOTES

DATE

colles pop
Instructions gp

Inj (R) Arm

Injured (R) hand ~~wd~~ while out playing last night

Time seen by Nurse: 1040

~~Time seen by A/E Medical Staff:~~

Time Referred to Specialty:

Specialty: 1050

~~Time sent to Xray:~~

Time returned from Xray:

~~Time Referred by Medical Staff:~~

Time of Discharged/Transferred: 1115

DATE	CLINICAL NOTES - Each entry to be signed by the examining Doctor.
	FITZSIMMONS 11AM
	Pat (R) Barn. thro' whole
	Hyperextension
	Fader distal radius
	Neurovascularly intact
	XR (R) wrist - radial greenstick
	Needs Full POP
	Fabi 2/52

Code 04

Crosshouse Hospital
NORTH AYRSHIRE & ARRAN NHS TRUST

CROSSHOUSE
KILMARNOCK KA2 0BE
Telephone (01563) 521133

Accident/Emergency Unit

Consultant in Charge
S. M. H. ZAIDI

DOB
Our Ref. 31·3·82

Date: 22·4·95

Lee Green
64 Brewland St
Galston

Hospital No. 95-4-2834

Dear Dr. McColl

The above named has attended this Department to-day and is suffering from

R wrist greenstick fx

He/She has been treated as follows -

U/L
Full ROP

Clinical examination and inspection of wet films showed

No Bony Injury ☐ Bony injury of the following -

In the meantime the condition will be reviewed by the Radiologist and the Accident and Emergency Surgeon and in the event of a revision of opinion you will be informed and the patient requested if necessary to attend the Department.

Further treatment is recommended as follows -

Elbow 7/52

A review appointment on .....

Yours sincerely,

Accident/Emergency Surgeon.

MEDICAL IN CONFIDENCE

ADMISSION FORM V2

MEDICAL RECORD

ISSION TAILS

HOSPITAL CODE	HOSPITAL NAME	CASE RECORD NUMBER
A111H	CROSSHOUSE HOSPITAL	XH1-337455

DATE	TIME	TYPE	SOURCE	INPAT./DAYCASE	DATE ON W.L.	PATIENT CATEGORY
30/09/96	11:33	1 WLDB	1 HOME	Inpatient	28/08/96	3 NHS

WARD	SPECIALTY	CONSULTANT
2B	ORTHOPAEDICS	MR -Q- AL-DADAH

PATIENT

TITLE SURNAME	FORENAME	INITIALS	AGE	DATE OF BIRTH	SEX	MARITAL STATUS
MAST GREEN	LEE		14	31/08/1982	M	S

ADDRESS: C/O 35 BENRIG AVE, KILMAURS

ALT./PREV. SURNAME:

OCCUPATION: SCHOOLBOY

POSTCODE: KA3 2GG

TELEPHONE No.: 538715

OCCUPATION (HUSBAND/FATHER): RESEDENTIAL WORKER

REF. G.P.

NAME:

G.P. CODE: MCCALL

PRACTICE: S

CONTRACT No.: 1342581 8026011

ADDRESS: 5A HENRIETTA ST, GALSTON

TELEPHONE No.: 01563 820424 POSTCODE: KA48HN

NEXT OF KIN

NAME: MRS ELLEN HAVLIN

RELATIONSHIP: CARER

ADDRESS: AS ABOVE

DAY PHONE No.:

NIGHT PHONE No.:

AND / OR

NAME:

RELATIONSHIP:

ADDRESS:

DAY PHONE No.:

NIGHT PHONE No.:

MISC.

RELIGION: SEE ABOVE — Ch of Scotland

VISIT REQ. BY CHAPLAIN YES/NO: N

PENSION BOOK No.:

DISCHARGE SUMMARY

DISCHARGE DETAILS

DATE	TIME	DISCH. CODE	PATIENT CATEGORY	TYPE FACILITY	SPECIALTY	CONSULTANT	CODE
2/10/96							

DISCHARGED/ TRANSFERRED TO	HOSPITAL CODE	WARD	SPECIALTY	CONSULTANT	CODE
Home			ORTHO	MR AL-DADAH	

DIAGNOSES

		CODE
MAIN DIAGNOSIS	Chondromalacia Patellae	M224
OTHER CONDITIONS (D.G,2)		
(D.G,3)		
(D.G,4)		
(D.G,5)		
(D.G,6)		

SPECIAL WARNINGS:

AND OPERATIONS

		CODE	DATE
MAIN OPERATION	ARTHROSCOPY EIGHT KNEE LATERAL	N84828460	1 0916
OTHER OPERATION (O.P,2)	RELEASE		
(O.P,3)			
(O.P,4)			

LOCAL USE			NATIONAL USE	

CHI NO = 3108823299

XM 35/455

GREEN LEE
C/O 35 BENRIG AVE
KILMAURS
KA3 2QQ
31/08/1982 M/S
DR.J MCCALL
5A HENRIETTA ST
GALSTON
CHI 3108823299

Surname .....
Forenames ..
Address .....
.....
STA0213 Ward or Dept.

DATE

Admission for arthroscopy (R) knee.

PMH: nil of note
°DM °asthma

Drugs Ø

NKA

O/E: Well.

cvs / Resp / abdomen / CNS - NAD

(R) knee: °effusion / swelling
FROM
°tenderness
no marked retropatellar grating or discomfort on patellar movements

Plan: Consent
Routine bloods ✓

Brucker

ORTHOPAEDIC

MR AL-DADAH'S WARD ROUND NOTES

2.10.96 QAD/NP LEE GREEN

This young man had arthroscopy and lateral release yesterday. Today he feels better. Drain removed. Can go home today and review at the Clinic in 2 weeks time.

DATE

CONSENT FOR OPERATION

STA1057

XH 337455
GREEN LEE
C/O 35 BENRIG AVE
KILMAURS

31/08/1982 M/S
DR.J MCCALL
THE SURGERY
5A HENRIETTA STREET
CHI 3108823299

I MARGARET ~~GREEN~~ GREEN of 64 BREWLAND ST. GALSTON hereby consent to

* ~~undersigned~~ the submission of my * child LEE ~~ward~~

the operation of (R) Knee arthroscopy

the nature and purpose of which have been explained to me by

Dr./~~Mr.~~* WHITE

I also consent to such further or alternative operative measures as may be found necessary during the course of the above-mentioned operation and to the administration of general, local or other anaesthetics for any of these purposes.

No assurance has been given to me that the operation will be performed by any particular practitioner. (Not applicable to Section 1 (2) patients).)

Date 30/9/96 Signed M Green
(~~Patient~~/Parent/~~Guardian~~)*

I confirm that I have explained the nature and purpose of this operation to the patient/parent/guardian.*

Date 30/9/96 Signed
(Medical/~~Dental~~ Practitioner)*

*DELETE AS APPROPRIATE

Note: This form is not to be used for any operation where there is a specific consent form with explanations.

Any deletions, insertions or amendments to the form are to be made before the explanation is given and the form submitted for signature.

CONSENT FOR OPERATION

ANAESTHETIC RECORD

STA0093

XH 337455

GREEN LEE
C/O 35 BENRIG AVE
KILMAURS

Su
Fe 31/08/1982 M/S
Ad DR.J MCCALL
THE SURGERY
5A HENRIETTA STREET
CHI 3108823299
W

No: .....
.....
B.: .....
.....
.....

PROPOSED PROCEDURE | ELECTIVE / EMERGENCY | Wt. | BP

PRE-OPERATIVE ASSESSMENT

Ear op. 82.

RECENT DRUG THERAPY: Nil.

ALLERGIES: TETANUS

PREMEDICATION: TEMAZEPAM 20mg DATE: 1/10/96 TIME: 11 30

TIME	INIT.
11.20	BB

MONITORING

- ECG ☑
- BP ☑
- PULSE ☑
- O_2 ☑
- CO_2 ☐
- CVP ☐
- TEMP ☐
- NMT ☐
- CFM ☐

ANAESTHETIC TECHNIQUE

INJECTION R/L (5)#20 INFUSION(S) R L

INDUCTION PRE O_2 ☐ CRICOID ☐ INHAL ☐ IV ☑

AIRWAY ORAL ☐ NASAL ☐

INTUBATION ORAL ☐ NASAL ☐ CUFF ☐ SIZE Lma 3.0 TYPE

SPRAY ☐ PACK ☐

RESPIRATION SPONT ☑ IPPV ☐ VENTILATOR ☐

POSTION ON TABLE

LOCAL ANAESTHESIA

- SPINAL ☐
- EPIDURAL ☐
- NERVE BLOCK ☐

5ml 0.5% Bupivacaine See ope (R) knee

DRUGS GIVEN

DATE OF OP.	OPERATION PERFORMED	SURGEON	ANAESTHETIST
11/1/96	(R) knee arthroscopy + lateral release.	Abdddh	Wilson/Sivis

POST OP. INSTRUCTIONS

O2 @ 4l/m until fully awake
Analgesia as per kardex

NOTES/COMMENTS

Codeine Phosphate 15mg IM at 2pm.

ANAESTHETIC RECORD

Propofol 160
Fentanyl 75
Midazolam

TIME 13 14

220 210
200 200
180 180
160 160
140 140
120 120
100 100
80 80
60 60
40 40
20 20

CVP 100 99
CI 02 To 1 45 48
To 2

	FLUID IN				FLUID OUT		
	DRIP 1	VOL.	DRIP 2	VOL.	URINE	BLOOD	
	TOTALS						

NAME XH 337455 C/S NO.

ADDRESS GREEN LEE
C/O 35 BENVIG AVE
KILMAURS
KA3 200 M/S
31/08/1982
DR.J MCCALL
5A HENRIETTA ST
GALSTON
CHI 3108823299

DATE 1/10/96

OCCUPATION

PRE OP DIAGNOSIS:-

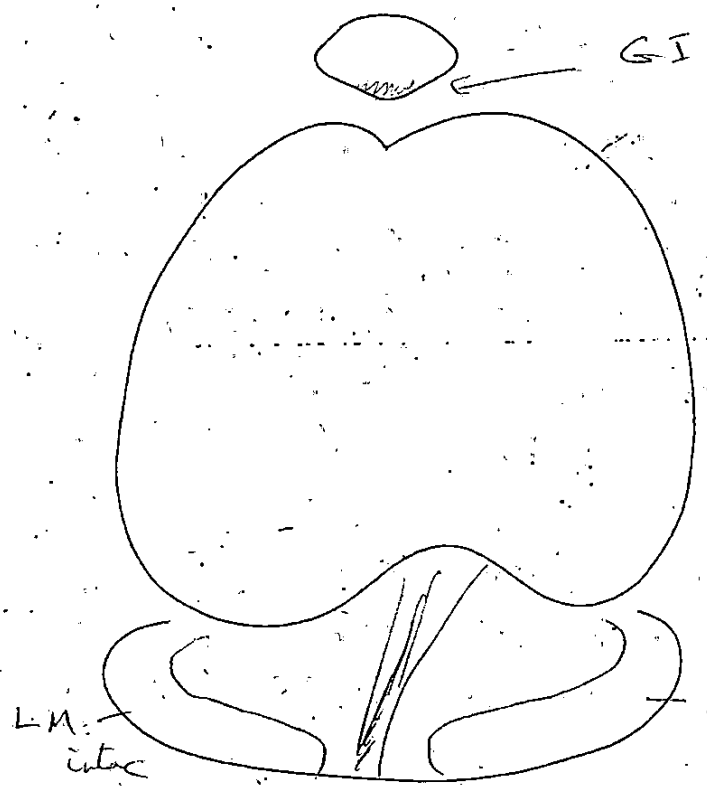
HISTORY OF INJURY:- (SPORT) WORK HOME OTHER

PREVIOUS SURGERY No

LITIGATION

----oooOooo----

SURGEON AL-DADAM ANAESTHETIST DR THOMSON



Chondromalcia Patellae. About 1/2 of the Patella is sitting lateral to edge of lateral epicondyle.

↓

lateral release one Redivac

POST OP!

GO.

CONFIDENTIAL

Form STA0186

THEATRE CHECK SHEET

PART 1 Name, number and ward to be completed by the Medical Secretary when a patient is sent for. The form is then inserted in the Case Sheet. The form then goes to theatre with the Theatre List and the date is filled in and the appropriate theatre indicated.

The sheet will be taken to the ward when the patient is to be collected for operation.

Patient's Name ..... LEE GREEN ..... Date of Birth ..... 31 08 82 Hospital Number 337455

From Ward ..... 2B ..... Date ..... TUES 01 10 96 To Theatre 7

Proposed Operation ..... ARTHROSCOPY RIGHT KNEE

PART 11 To be completed by the Ward Sister/Charge Nurse or her deputy and to accompany the patient to theatre, where it should be counter-signed in reception.

CHECKED : Identity Bracelet ..... CHECKED ..... Pre-Medication ..... GIVEN

Consent Form(s) ..... SIGNED ..... Removal of Dentures, etc. ..... NONE

X-Rays ..... PRESENT ..... Case Record ..... PRESENT

Nursing Notes ..... PRESENT

NKA

Theatre Blood X Matched Check .....

Signed ..... D Robertson

Ward 2B

Theatre ..... Hamberk

PART 111 Operation ..... RR D Steed

arthroscopy (R) knee + lateral release

Drainage/Packs ..... One Redivac

Post-Op Directions .....

Date 1/10/96

Time .....

Signature of Surgeon

CROSSHOUSE HOSPITAL - ACCIDENT AND EMERGENCY DEPARTMENT

Ob's 8

Triage time: 11:51 Triage nurse: THOMSON Triage group: Orange

resp rate	19	sat O_2%	100	PFR	
pulse	100	BP	117/74	GCS	15
allergy	Not known				
BMstix		breath alcohol		temp	36.5
urine					

Triage details

999 call : (L) knee injury - ? # - Entonox dependant on arrival

VA	R	L	
pain score	9		
review score			
discharge score			

accompanied by: Friend

treatment

I give consent for details of my injury to be given to the Police.

Signed .....

Against Medical advice I decline the treatment offered. I know this may affect my recovery.

Signed..... Witness..... Witness .....

Surname	GREEN
Forename	LEE
marital status	S
sex	M
A/E No.	08018060
Consultant	Dr A Lannigan
date/time attendance	13/04/2008 11:48
Date of birth	31/08/1982
age	25

Address: 18 BROWN ST
NEWMILNS
AYRSHIRE

alt: N

Post code: KA16 9AA

special case

this problem+total att: + 0

GP: EA RAIT
address
DARVEL CLINIC
2A EAST DONNINGTON STREET
DARVEL
AYRSHIRE
KA17 0JR
phone
01560320205

Phone

Occup
religion
employer
school

incident: date/time: < 6 hours

hospital number

next of kin
address

relationship
phone

disch | A+E clinic | paed tr. | # | eye | ENT | max facial | ward - OP | ward - IP | x-ray? Y / N

24

STA0098

JMcC/61959

Drug	Dose	route	time / frequency	Signature	Given by / quantity
MORPHINE	3mg	IV	12 03 pm	Anderson.	AS
MORPHINE	4mg	IV	12 40 pm	[illegible]	AS.

Time: 11 50 am DOCTOR: Anderson. SpR G.M.

25/o

injured running fell on (L) knee pain

PMHx: nil DHx: nil, NKDA. FH – unable

Hx (L) Knee
— swelling
tender medial patella
MVC

Morphine

XR (L) Knee — patella #
(? transverse)
unable to SLR

Pain → METHO (12 40) re ? DRIP

Anderson
SpR G.M

Write or attach label

CHI 3108823299
GREEN LEE
18 BROWN STREET
NEWMILNS
KA16 9AA
31/08/1982 Pract 80260
Case Ref 337455

NURSING NOTES

DATE	
13102/08	999 Call: Trip and fall hitting (L) knee of a concrete slab Painful knee - requiring extensor therapy ? movement in knee David Thomson

DATE

MEDICAL IN CONFIDENCE

Admission Form V3

MEDICAL RECORD

HOSPITAL CODE	HOSPITAL NAME	CASE RECORD NUMBER
XHI	Crosshouse Hospital	XHI337455

ADM. DETAILS

DATE	TIME	TYPE	REASON	ADM/TRANS. FROM	INPAT./DAYCASE	DATE ON W.L.	W.L. TYPE	PATIENT CATEGORY
13/4/2008	13:41:00	36	11	10	Inpatient	//		

WARD	S. FACILITY	SPECIALTY	CONSULTANT	FROM LOCATION	W.G.E
2A	Other (filler code)	Orthopaedics	Mr Calum MacLeod		

PATIENT

TITLE	SURNAME	FORENAME(1)	(2)	AGE	DATE OF BIRTH	SEX	MARITAL STATUS
	Green	Lee		25	31/8/1982	M	S

ADDRESS 18 Brown Street
Newmilns

ALT/PREV.SURNAME

OCCUPATION

C.H.I. NUMBER 3108823299

POSTCODE KA16 9AA TELEPHONE No.

OCCUPATION(HUSBAND/FATHER)

HEALTH BOARD RESIDENCE

HAVE YOU LIVED IN THIS COUNTRY FOR PAST YEAR?

REF G.P.

NAME
G.P. CODE PRACTICE
CONTRACT No. FH STATUS

ADDRESS
TEL No. POSTCODE

REG

NAME James McCall
G.P. CODE 1342581 PRACTICE GP Practice
CONTRACT No. FH STATUS

ADDRESS 5a Henrietta Street, Galston
TEL No. 01563 820424 POSTCODE KA4 8JW

NAME

RELATIONSHIP

ADDRESS

DAY PHONE.No. NIGHT PHONE.No.

MISC

RELIGION NK

VISIT REQ. BY CHAPLAIN YES/NO
No

PENSION BOOK No.

Admission

MAIN DIAGNOSIS	SPECIAL WARNINGS
OTHER CONDITIONS (D.G.2)	
OTHER CONDITIONS (D.G.3)	

SMR04 SMR50

M.H. STATUS	PREVIOUS PSYCH. CARE	CONTRIBUTORY SOCIAL FACTOR

DISCHARGE SUMMARY

Requested by: elizabeth andress 13 Apr 2008 13:41

DATE	TIME	DISCH. TYPE	PATIENT CATEGORY	MANAGEMENT OF PATIENT	SPECIALTY	CONSULTANT CODE
14/4/08						
DISCH./TRANSF. TO	**READY FOR DISCH.**	**HOSPITAL NAME**	**CODE**	**WARD**	**SPECIALTY**	**CONSULTANT CODE**
Home				2A	Ortho	Macleod
SMR04	TYPE OF CARE PROVIDED		ECT-1st TREATMENT DATE		ECT-NUMBER OF TREATMENTS	

DIAGNOSIS AND

MAIN DIAGNOSIS	SPECIAL WARNINGS
OTHER CONDITIONS (D.G.2)	
(D.G.2)	
(D.G.3)	
(D.G.4)	
(D.G.5)	
(D.G.6)	

CHI 3108823299
GREEN LEE
18 BROWN STREET
NEWMILNS
KA16 9AA
31/08/1982 Pract 80260
Case Ref 337455

STA 0213

DATE
13/4/8
12.45

ORTHO GPST7 (M.AHMED ⇒ MR McLEOD)

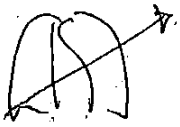
(25) ⇒ A&E Referral

PC: (L) knee injury

HPC: Fell over dog outdoors
landed onto (L) knee
unable to weightbear due to pain
denies any other body pain
last ate/drank ~0930

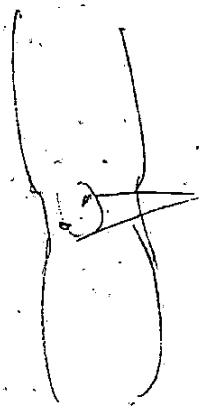
PMHx: nil OHx: nil NKDA SHx: Tree surgeon
Smoker ~15/day
Alcohol ~15 u/week

O/E Comfortable
BP 117/74
HR 100 bpm reg
SO_2 100% on RA



HSL
Abdo – snt
BS ✓

(L) knee – swelling +
– superficial abrasions x2 over patella
– tender on palpation



Unable to SLR
Ankle dorsiflexion/plantar flexion intact, NVI intact

Xray – # (L) patella – appears comminuted but not displaced ? 3 part

ORTHOPAEDIC

JMcC/74859

4/4/8 NR NR McLEOD
ogw Day 1 post-op (L) patellar def
well
Obs stable

CHI 3108823299
GREEN LEE
18 BROWN STREET
NEWMILNS
KA16 9AA
31/08/1982 Pract 80260
Case Ref 337455

P/n cylinder cast today
Physio
(H) able to mobilise

[redacted]
GP57(3309)

Orthopaedic

CONSENT FOR OPERATION

STA1057

Attach label
XH 337455
HCF GREEN LEE
CHI 18 BROWN STREET
Sur NEWMILNS
For KA16 9AA
Ad DR J MCCALL 31/08/1982
5A HENRIETTA ST
GALSTON
Date of ... CHI 3108823299

I LEE GREEN of .....

.....hereby consent to

* undergo / the submission of my — * child / ward SELF

the operation of OPEN REDUCTION & INTERNAL FIXATION LEFT PATELLA
the nature and purpose of which have been explained to me by

~~Dr./~~Mr.* TOM

I also consent to such further of alternative operative measures as may be found necessary during the course of the above-mentioned operation and to the administration of general, local or other anaesthetics for any of these purposes.

No assurance has been given to me that the operation will be performed by any particular practitioner. (Not applicable to section 1 (2) patients.)

Date 13/4/8 Signed Lee Green
(Patient/Parent/Guardian)

I confirm that I have explained the nature and purpose of this operation to the patient/parent/guardian.*

Date 13/4/8 Signed .....
(Medical/Dental Practitioner)*

*DELETE AS APPROPRIATE

Note: This form is not to be used for any operation where there is a specific consent form with explanations.

Any deletions, insertions or amendments to the form are to be made before the explanation is given and the form submitted for signature.

JMcC/74329

CONSENT FOR OPERATION

Time

Recovery

Postoperative instructions

Routine monitoring & care ☑

O_2 ....4....l/min for.....hrs ☑ until awake + stable

Humidified O_2, % as required to maintain O_2 Sat > 95% ☐

Morphine 1mg/ml iv up to ~~10mg~~ 20mg as required for pain in recovery (YES) Signed.....

Ondansetron 4mg iv in recovery if required for nausea (YES) Signed.....

iv fluids as charted ☐ Special instructions

Drug therapy as charted ☑

16⁵⁰ 3mg IV Morphine given K Palmer
16⁵⁵ 3mg IV Morphine given K Palmer
17⁰² 2mg IV Morphine given K Palmer
= 10mg

17²⁷ 2.5mg IV Morphine
17³² 2.5mg IV Morphine
= 5mg

Cyclizine 50mg d/IV/im if req. for PONV

Reviewed by

NOTES

DATE	
	Recephen.
14.55	Colour good. IV infusing. pread
1641	Recovery: Awake and drowsy. Nursed on left side.
	Colour good. O_2 at 4l. IV infusing.
	Splint remains in place. Vital signs as charted pread
	Diclofenac 75 mgp IV
	Paracetamol 1g IV
	Morphine 10mgp IV } Given in Theatre
	Ondansetron 4 mgp IV
1645	Complaining of pain. IV Morphine given as charted pread
	Shivering. Extra blankets on. Temp 37.0°c. pread
17⁰⁰	Toes cool and perfusing. CSM intact. pread
17⁰⁵	Leg elevated on pillow. Continues to complain of pain. pread
17¹⁰	Morphine 10 mgp IV given in Recovery pread
17²⁵.	Reviewed by Dr. Robertson. May have further IV Morphine
	in recovery and return to ward (IV morphine prescribed
	in kardex). pread
1735.	Further 5mgp IV Morphine given in Recovery pread
1745.	Pain appears to have eased slightly. Patient concerned bandage/
	dressing may be tight. Vital signs as charted.
	Foot remains as before. IVI and O_2 cannulae.
	May return to ward. pread.

Time

Recovery

Postoperative instructions

Routine monitoring & care ☑

O_2 ....4....l/min for.....hrs ☑ until awake + stable

Humidified O_2 % as required to maintain O_2 Sat > 95% ☐

Morphine 1mg/ml iv up to ~~10mg~~ 20mg as required for pain in recovery (YES) Signed HCL

Ondansetron 4mg iv in recovery if required for nausea (YES) Signed HCL

iv fluids as charted ☐ Special instructions

Drug therapy as charted ☑

16^{50} 3mg IV Morphine given K Palmer
16^{55} 3mg IV Morphine given K Palmer
17^{02} 2mg IV Morphine given K Palmer
17^{10} 2mg IV Morphine given K Palmer
= 10mg

17^{27} 2.5mg IV Morphine
17^{32} 2.5mg IV Morphine
= 5mg

Cyclizine 50mg d/IV/im if req. for PONV HCL

Reviewed by

NOTES

DATE	
	Reception.
14.55	Colour good. M infusing. cpeed
1641	Recovery. Awake and drowsy. Nursed on left side.
	Colour good. O_2 at 4l. IVI infusing.
	Splint remains in place. Vital signs as charted cpeed
	Diclofenac 75 mgp IV
	Paracetamol 1g IV
	Morphine 10 mgp IV } Given in Theatre
	Ondansetron 4 mgp IV
1645	Complaining of pain. IV Morphine given as charted cpeed
	Shivering. Extra blankets on. Temp 37.0°C. cpeed
17^{00}	Toes cool and perfusing. CSM intact. cpeed
17^{05}	Leg elevated on pillow. Continues to complain of pain. cpeed
17^{10}	Morphine 10 mgp IV given in Recovery cpeed
17^{25}	Reviewed by Dr. Robertson. May have further IV Morphine
	in recovery and return to ward (IV morphine prescribed
	in kardex). cpeed
1735	Further 5mgp IV Morphine given in Recovery cpeed
1745	Pain appears to have eased slightly. Patient concerned bandage/
	dressing may be tight. Vital signs as charted.
	Foot remains as before. IVI and O_2 continues.
	May return to ward. cpeed

Cannula	Site	Regional Anaesthetic technique:			
RG	(L) ACF	Spinal	☐	Full aseptic	☐
A Line		Epidural	☐	Entry site:	
CVP					
Insertion Notes		N. Block	☐	Needle used:	
		Wound Inf.	☑	Catheter:	Y/N

20mls 0.5% Marcaine to wound (Surgeon)

Anaesthetic / Recovery

Fluid In

	Infusion 1	Vol
①	Hartmann's + NSAID	500
②	Hartmann's	500
③	Hartmann's	500

	Infusion 2	Vol

Events Key

Total	
Blood Loss	
Urine Output	

Monitoring	
ECG	✓
NIBP	✓
SpO_2	✓
$ETCO_2$	✓
ET Agent	✓
F_iO_2	✓
NMT	
Temp. Strip	✓
Urine Cath.	
CVP	
IBP	
Boots	
Fluid Warmer	✓
Warm Mattress	
Bair Hugger	✓

Machine Check
Anaesthetic room ☑
Theatre ☐

Circuit
Circle ☑ Bain ☐
Tpiece ☐ HME ☐

Ventilation
IPPV: Pressure Cont ☐
Volume Cont ☐
Spont Respiration ☑
Press Support ☐

Induction: Intravenous ☑ Gas ☐
Pre O_2 ☑ RSI ☐

Face Mask ☐
Airway: Oral ☐ Nasal ☐
LMA: Size 5 Type Ker
ETT: Size..... Cuff ☐
Type.....
Throat Pack In ☐ Out ☐

Laryngoscopy Grade.....
Laryngoscopy Notes

Position Supine
Pressure Care ☑
Eye Care tape ☑
Thromboprophylaxis ☐
Antibiotic Cefuroxime
Dose 1.5g
Time pre Varnique inflat

Time	1500		1530		1600		1630							
Fentanyl	50		+50											
Propofol	200													
Diclofenac	75mg	in ①												
Paracetamol		1g												
Morphine			2+2		1		3		2					
Ondansetron									4					
	Pack													
Fluids		①		②		③								
SpO_2	100	100	100	100	100	100	100		Sed 2	2	1	2	1	1	1	1	1	5
$ETCO_2$		6.7	7.0	7.4	7.5	7.3	7.9		SpO_2	100	100	100	100	100	100	100		
ET Agent		2.2	2.1	2.1	1.8	1.9	1.7		O_2	4	8	8	8	8	8	4	4	
F_iO_2		.48	.46	.46	.40	.36	.37		Pain	2	2	2	2	2	2	2	1	5
RR		9	12	10	11	13	10		Resp		14	14	12	15	15	13	12	
TV		230	245	240	340	355	370											
Temp Strip				38		37												
Blood Loss																		
Urine Output																		

O_2 ☑ N_2O ☑ Air ☐ Sev ☑ Des ☐ so ☐ Halo ☐ Others ☐

220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30

knife to skin

1644 1651 1657 1701 1711 1724 1731 1740

T 37.0°C

Recovery

12.7

Anaesthetic Record

Proposed procedure: ORIF @ patella	Elective		CHI 3108823299
	Scheduled Urgent	•	GREEN LEE
	Urgent	✓	18 BROWN STREET
	Emergency		NEWMILNS
Consent form signed Y / N	SASM Consultant:		KA16 9AA
Incapacity form Y / N			31/08/1982 Pract 80260
Fasted Y / N	Informed Y / N		Case Ref 337455

Preoperative assessment: Assessor: Date: Location: ASA Grade:

History

25 ♂ Tripped over dog → # @ patella

Previous GA: No prev.

FH:

CVS: Nil Significant

Resp.: fit + well

Reflux:

Other: ϕ neck / back
ϕ liver
ϕ porphyria

Examination

HR:

BP: 117/74

Weight:

Height:

BMI:

Airway Assessment

Mp I
TMD 7 6.5

Mouth opening: Good + prevuisia

Teeth: Some. Ok own

Smoking: 2c/day

Alcohol: Wil beg.

Recreational Drugs:

Hb	
WCC	
Plats	
Urea	
Creat.	
Na	
K	
ECG	
CXR	
OTHER	

Recent Medication

Nil

ck NSAID's

Allergies

NKDA

Discussed:		Regional Block: Complications discussed pre-operatively	
Fasting	☐	Failure	☐
Premed	☐	Hypotension	☐
Induction	☐	Headache	☐
		Numbness	☐
Analgesia	☐	Nerve Damage	☐
Suppositories	☐	Patient agrees	Y / N
Monitoring:	☐	Handout	Y / N

Premedication:

Fasting: overnight Time

Light Breakfast

0.930 coffee & milk.

Fluids: Allow still juices / water till:

Usual medicines:

Give all:

Give only:

Give all except:

Drugs: Date: Time:

Ranitidine 150mg 13/4/08 1330

Given at / by: 1430 SVO

Date: 13.4.08 Operation done: Location: Th 7 Start time: End time: Surgeon(s):

Anaesthetic assistant: Sr. Dalrymple

Anaesthetist(s): Grade: Robertson (SpT) D/D Dr Martin (Cons @ home)

Remarks: Significant Events / Critical Incidents Hazard Warnings

Uneventful Y/N

Effect of Premed

ANAESTHETIC RECORD

JMcC/70209 STA0093

NHS Ayrshire & Arran

OPERATIVE CARE PLAN

Surna .....
Foren CHI 3108823299
GREEN LEE
Addre 18 BROWN STREET
NEWMILNS
..... KA16 9AA
Ward 31/08/1982 Pract 80260
Case Ref 337455

Ward 2A Date 13-04-08 Theatre 7

Proposed Operation Patellar Wiring (L) Side

Pre-Medication Time Given 1430 Ranitidine

Fasted from: Time Coffee 0930

Paediatrics Last feed / drink .....

Last Immunisation .....

Identified Allergies: Specify NKA

CHECK 1 Pre op

Surgical site marking and patient verification

- ☐ **Check patient identity**
- ☐ **Check reliable documentation/results**
- ☐ **Images to ascertain intended surgical site**
- ☐ **Intended site marked with an arrow using indelible pen**
- ☐ **Decision not to mark – state reason below.**

.....

Signature confirming surgical check complete

In the event of this section being incomplete – Reception Nurse to communicate with Theatre to establish action to be taken.

Operating Surgeon

Signature .....

Print .....

CHECK 2 - 3 Surgical site marking and patient verification	**Ward/DSU**			**R/Recovery**			**Anaesthetic**		
	Yes	**No**	**N/A**	**Yes**	**No**	**N/A**	**Yes**	**No**	**N/A**
Identification Bracelet				✓			✓		
Consent Form signed				✓			✓		
AWI Consent if applicable						✓			✓
Operation Site marked clearly				✓			✓		
Bone bank consent form					✓			✓	
Dentures removed						✓			✓
Caps/Crowns/Loose teeth: Specify					✓			✓	
Nail Polish/Jewellery/Make-up: Removed				✓			✓		
Rings taped/Body Piercing						✓			✓
Pad or Tampon					✓			✓	
Catheter in situ					✓			✓	
Pre-op Shower				✓			✓		
Skin Prep/Shaved: If required					✓			✓	
Paper Pants				✓			✓		
Patient's Label included				✓			✓		
Hearing Aid					✓			✓	
Inhalers					✓			✓	
Pillows extra: Number 2				✓			✓		
B.H.C.G. (Pregnancy Test)					✓			✓	
Urinalysis					✓			✓	
Case Notes					✓			✓	
X Rays/Images					✓			✓	
Pathology/Lab results					✓			✓	
Haemoglobin					✓			✓	
Blood X matched					✓			✓	
E.C.G. if applicable						✓			✓
Other: Specify									

Any other relevant information: (e.g. high risk or changes to general health) .....

.....

Ward Nurse *(signature)* ..... Print .....

Rec-Recovery Nurse *(signature)* ..... Print .....

Anaesthetic Nurse *(signature)* ..... Print T. DALRYMPLE

ANAESTHETIC CARE GIVEN

Pulse 68 Temp ..... BP 130/75 SPo2 99

G.A.	✓	Rapid Sequence	
L.M.A.	1gel	Size	5
ET Tube		Size	
Face Mask			
Throat Pack			
Throat Pack removed			
N.G. Tube			
Antibiotics Given	✓		

Spinal			
Epidural			
Combined Spinal/Epidural			
Local Anaesthetic			
Nerve Block			
Eyes Taped	✓	Gel	

eyeguards

Infusion Device

PCA	
TIVA	
Baxter Colleague	
Alaris	
Other	
INVASIVE MONITORING	
IBP	CVP

Patient Positioning

Supine	✓	**RIGHT ARM**	
Prone		On board	
Lithotomy		At side	
Trendelenburg		Across chest	✓
Rev-Trendelenburg		Other	
Jack Knife		**LEFT ARM**	
Right lateral		On board	
Left lateral		At side	
Traction Table		Across chest	✓
Lloyd Davis		Other	
Deck Chair			

Diathermy Application

Bi-polar	
Mono-polar Diathermy site	
Thigh	
Buttock	
Abdomen	
Chest	
Other	
Diathermy Pad applied correctly and checked	

TOURNIQUET

Arm right		Arm left	
Leg right		Leg left	✓
Digit right		Digit left	
Time on right		Time on left	15'
Total Tourniquet time right		Total Tourniquet time left	1hr 14m

PERI-OPERATIVE CARE

Patient protection safety

Arm supports	✓	Sand bag	
Pelvic support i.e. padding		Shoulder vac pac (beanbag)	
Lateral support i.e. padding		Shoulder/arm traction	
Padding bony prominences	✓	Bair Hugger	✓
Heel rest	✓	Thermo-hat	
Head ring		Fluid warmer	✓
Prone head ring		Core temp probe	
Stirrups		Gel mattress	
Pillows		Other: State.....	

Evaluation pre and post-operative

Pre op		Post op
✓	Pressure area checked	
	Diathermy site checked	
✓	Tourniquet site checked	

DVT Prophylaxis

Dextran 70	
Fragmin (LMWH)	
Ted stockings	
Pre-op aspirin/Clopidogrel	
Flowtron leggings	

Time on			Time off		
Limb + machine function checks	1 hr	2 hr	3 hr	4 hr	5 hr

Skin Prep solution used ..... Videne .....

Given by (Name) .....

Specimens taken:

Yes ☐ No ☐ Bacteriology ☐ Pathology ☐

Other Hospital ☐ Bone bank ☐ State total (in box) ☐ (except bone bank)

Signature nurse receiving specimens from scrub person .....

Blood loss measured Yes ☐ No ☐ Total ☐

Patient Catheterised in Theatre Nurse ☐ Doctor ☐ Catheter size ☐ mls in balloon ☐

Skin closure 3/0 Monocryl	Wound drainage —
Dressing Mepore Blue Sensi Wound + Cover	Local anaesthetic infiltration 0.5% Marcain 20ml

Identified problem	Nursing intervention	Outcome

Check 4

Surgical site marking and patient verification **Theatre:**	**Signature of Operating Surgeon or Senior Member of Theatre Team to confirm check completed**	**Surgeon only to complete and sign if discrepancy has been identified**
Surgical, Anaesthetic and Theatre team prior to commencement of surgery **should pause for verbal briefing to confirm the following** ☐ **Correct patient** ☐ **Consent form correct and signed by patient and clinician** ☐ **Proposed operation** ☐ **Operation site marked** ☐ **Availability of required image studies plus pathology results**	**Sign**..... **Print**..... **Time**..... **Date**.....	**Nature of discrepancy**..... .... **Decision taken**..... .... **Sign.**..... **Print**..... When there is a discrepancy, a senior member of staff will follow the adverse incident policy.

DAY SURGERY ESCORT DETAILS

Name..... Address.....

..... Telephone No.....

Time into recovery..... **Conscious state**.....

Time conscious..... **Operation site**.....

Oxygen Therapy..... **Hudson Mask**.....

Nasal Cannula.....

Time transfer..... **Nurse Signature**.....

PROGRESSIVE RECOVERY

Seen by Surgeon YES / NO Anaesthetist YES / NO

Wound Check: Time..... Comments .....

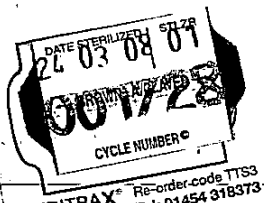
DISCHARGE DETAILS

Post-op Phone Call	Yes ☐	No ☐	Post-op instructions	Yes ☐	No ☐
Observations stable	Yes ☐	No ☐	GP letter given	Yes ☐	No ☐
Tolerating oral fluids	Yes ☐	No ☐	Follow up appointment given	Yes ☐	No ☐
Venflon removed	Yes ☐	No ☐	Community call arranged	Yes ☐	No ☐
Wound site satisfactory	Yes ☐	No ☐	Discharge medication given	Yes ☐	No ☐
Passed Urine	Yes ☐	No ☐			

Date of Discharge ..... Time of Discharge .....

Nurse's Signature .....

T.s.s.u instrument labels

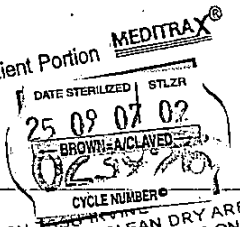


MEDITRAX® Re-order code TTS3 Tel: 01454 318373

Bone Holding Forcep
XH 04

STEAM
Dark = processed

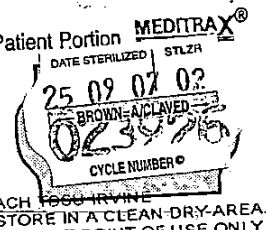
Orthopaedic
ACHU01531491



ACH ~~TSSU IRVINE~~
STORE IN A CLEAN DRY AREA
OPEN AT POINT OF USE ONLY
In accordance with Article 12
K Wire

XH Theatre 7 Supps

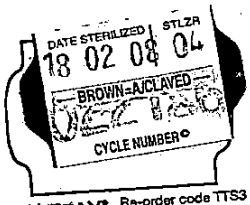
25/09/2007 25/09/2008 ACHB01454414



ACH ~~TSSU IRVINE~~
STORE IN A CLEAN DRY AREA
OPEN AT POINT OF USE ONLY
In accordance with Article 12
K Wire

XH Theatre 7 Supps

25/09/2007 25/09/2008 ACHB01454411

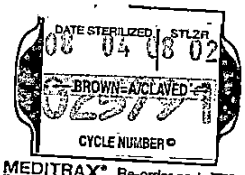


MEDITRAX® Re-order code TTS3 Tel: 01454 318373

Synthes Wire XH01

STEAM
Dark = processed

Orthopaedic
ACHU01517504

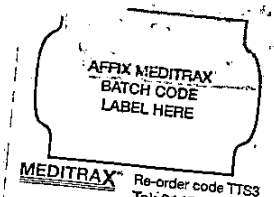


MEDITRAX® Re-order code TTS3 Tel: 01454 318373

Foot Set XH 06

STEAM
Dark = processed

Orthopaedic
ACHU01537411



MEDITRAX® Re-order code TTS3 Tel: 01454 318373

Stryker Cordless
Driver 3 XH 01

STEAM
Dark = processed

Orthopaedic
ACHU01534319

PLACE OR ATTACH LABEL

S
F
CHI 3108823299
GREEN LEE
18 BROWN STREET
NEWMILNS
KA16 9AA
31/08/1982 Pract 80260
Case Ref 337455

STA0215

DATE	SURGEON	ANAESTHETIST
PR 13/4/98	Thomas	Robertson

ASSISTANT

OPERATION PERFORMED

Tension Band Wiring of Left Patella

DESCRIPTION OF PROCEDURE

GA Tourniquet applied - Betadine prep + draped free

Midline incision

identified cleared + reduced. - (Displaced # min articular surface)

- medial attention allowed assessment of articular surface - good reduction

2 x 2mm K wires.

figure of 8. wire tensioned.

Check films printed.

- Wound closed. irrigated with saline.

- Mepore / Blue roll / wool / crepe / Bucks splint

Post Op

(1) CSM

(2) Analgesia + ICE

(3) Plaster Cast made

(K) Non-W Wire Arm

(I) # Clinic 1/52

DRAINS ..... PACKS.....

SPECIAL INSTRUCTIONS TO WARD

Signature .....

Thomas

OPERATION

JMcC/63195

Req: 40260

Date: 13-04-08 | Theatre: 7

PATIENT | Sex M | F

PROCEDURE

Speciality: Trauma | Surgery Class: 2

OPCS 4 Code

CASE FORM

CHI 3108823299
GREEN LEE
18 BROWN STREET
NEWMILNS
KA16 9AA
31/08/1982 Pract 80260
Case Ref 337455

Consultant: Macleod | Admit Type: 4

Ward: 2A | Admit Date: 13-04-08

Custom | Op Type: 5

Procedure

Delays

Actual Procedure: Tension Band Wiring Of Left Patella

Post-op directions: Analgesia
C3 in
Elevate Ice
Pressure Care Nurse

Follow-up instructions: # Clinic 1/52 X-ray

Sign: ..... Date: 13/4/08

CASE FORM

Counts and Dressings

Scrub Nurse Check	Sign: J Little	PRINT	
Final Check	Sign: [illegible]	PRINT	Kallan.
Tray out Check	Sign: [illegible]	PRINT	K Robb

TIMES

Sent for	1445	Patient available	1455	Anaesthetic begin	1505
Pt. in theatre	1512	Surgery starts	1520	Surgery stops	1635
Pt. out theatre		Clean up starts		Recovery in	1641
Clean up stop		Recovery out	1745	DS Disc.	

STAFF

MEDICAL		NURSING			
Actual Surgeon	M Thomas	Anaesthetic Nurse	T Little	Circulating Nurse	K Robb
1st Assistant	Dr	Scrub Nurse	J Little	Circulating Nurse	Kallan
2nd Assistant		Scrub Nurse		Circulating Nurse	Malenor
Anaesthetist 1	Dr Robertson	Scrub Nurse		Circulating Nurse	
Anaesthetist 2		ODP		ODP	
Aux		Aux		Other	

ANAESTHETIC

Type: 1 | ASA: T E | Controlled Drugs: Fentanyl Morphine

PACU

Recovered by 1. Opheach 2. K Palmer

Released to: 1

ADMISSION TYPE
1. 23 hour
2. Day Surgery
3. Elective In Patient
4. Emergency In Patient

SURGERY CLASS
1. Minor
2. Intermediate
3. Major
4. Supercomplex

OPERATION TYPE
1. Elective in hrs.
2. Elective out hrs.
3. Emergency in hrs.
4. Emergency out hrs.
5. Emergency Weekend/PH's
6. Elective Weekend/PH's

REASON FOR DELAY
1. Patient not ready
2. Lack nursing staff on ward
3. Patient not in specified ward

ANAESTHETIC TYPE
1. General
2. Epidural
3. General Epidural
4. Local anaesthetic
5. No anaesthetic
6. Sedation
7. Spinal
8. Spinal Sedation
9. Nerve Block

RELEASED TO
1. Ward
2. I.T.U.
3. H.D.U.
4. D.S.U.
5. 23 hour
6. Other

Key: 43265

Date: 13-04-08 | Theatre: 7

PATIENT | Sex M | F

PROCEDURE

Speciality: Trauma | Surgery Class: 2

OPCS 4 Code

CASE FORM

CHI 3108823299
GREEN LEE
18 BROWN STREET
NEWMILNS
KA16 9AA
31/08/1982 Pract 80260
Case Ref 337455

Consultant: Macleod | Admit Type: 4

Ward: 2A | Admit Date: 13-04-08

Custom | Op Type: 5

Procedure

Delays

Actual Procedure: Tension Band wiring Of Left Patella

Post-op directions: Analgesia
Cam
Cryotherapy
Pressure Cast Care

Follow-up instructions: # Clinic 1/52 X-ray

Sign: ..... Date: 13/4/08

ADMISSION TYPE
1. 23 hour
2. Day Surgery
3. Elective In Patient
4. Emergency In Patient

SURGERY CLASS
1. Minor
2. Intermediate
3. Major
4. Supercomplex

OPERATION TYPE
1. Elective in hrs.
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5. Emergency Weekend/PH's
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REASON FOR DELAY
1. Patient not ready
2. Lack nursing staff on ward
3. Patient not in specified ward

ANAESTHETIC TYPE
1. General
2. Epidural
3. General Epidural
4. Local anaesthetic
5. No anaesthetic
6. Sedation
7. Spinal
8. Spinal Sedation
9. Nerve Block

CASE FORM

Counts and Dressings

Scrub Nurse Check Sign: ..... PRINT: .....
Final Check Sign: ..... PRINT: Kallaway
Tray out Check Sign: ..... PRINT: K Robb

TIMES

Sent for	1445	Patient available	1455	Anaesthetic begin	1505
Pt. in theatre	1512	Surgery starts	1520	Surgery stops	1635
Pt. out theatre		Clean up starts		Recovery in	1641
Clean up stop		Recovery out	1745	DS Disc.	

STAFF

MEDICAL	NURSING				
Actual Surgeon	M Thomas	Anaesthetic Nurse	J Little	Circulating Nurse	K Robb
1st Assistant	Dr	Scrub Nurse	J Little	Circulating Nurse	Kallaway
2nd Assistant		Scrub Nurse		Circulating Nurse	J Malone
Anaesthetist 1	Dr Robertson	Scrub Nurse		Circulating Nurse	
Anaesthetist 2		ODP		ODP	
Aux		Aux		Other	

ANAESTHETIC

Type: I | ASA: T E | Controlled Drugs: Fentanyl Morphine

PACU

Recovered by 1. Spheech 2. K Palmer

Released to: 1

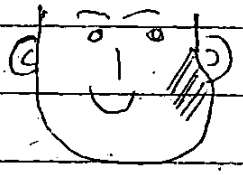
RELEASED TO
1. Ward
2. I.T.U.
3. H.D.U.
4. D.S.U.
5. 23 hour
6. Other

DATE | CLINICAL NOTES—Each entry to be signed by the examining Doctor.

0/9/96 14 yr O↗

punched (R) side face ~~knife~~ → collapsed ? LOC few mins no vault trip but felt ear sat as if bleeding. v. dizzy & unsteady on feet. Headache has had ½ bottle ~~drowned~~ ~~in~~ cider.

O/E alert GCS 15/15 PERLA.
P 105 reg BP 140/80
° subcon haem
blood in (R) audy canal.
(R) ear (N).
large haematoma over (R) side face/jaw tender. firm.



good jaw movements
jaw opening appt restriction.

neuro PL ↓↓ hearing OK.
Reflexes (N)
moving all 4 limbs.

Plan, SXR
Refer surgeons ? basal skull ff ~~grunt~~
↳ WdSB

MR STEVENSON

THIS CARD IS CONFIDENTIAL—IT MUST NOT BE HANDLED BY PATIENTS OR UNAUTHORISED PERSONS

CONSULTANT

Code. STA0098

CROSSHOUSE HOSPITAL

Accident/Emergency Department

A/E Reg. No. 96-9-1485.

Name of Examining Doctor DR MCCALL

Surname	First Name(s)	Date of Birth	Age	Hospital Case Record Number
GREEN.	LEE.	31.8.82	14	

Home Address (Permanent): 35 Bennigg Ave Kilmarks

Tel. No. 538715.

Temporary Address

Name and Address of own Doctor: DR. MCCALL.

Sex	M.	Religion	Occupation	Employer/School	Date of Injury	Time	Date of Attendance	Time
M.	(S.) W.	C/S	SCHOOL.		10.9.96.	a.m. p.m	10.9.96	2040 a.m. p.m

Source
- Not Accident ☐
- Road Accident ☐
- Home Accident ☐
- Works Accident ☐
- Other Accident ☐

Type of Road Accident
- Pedestrian ☐
- Bicycle ☐
- Motor Cycle ☐
- Motor Car ☐
- Other Vehicles ☐

Method of Referral
- Self Referral ☑
- G.P. Letters/Phone ☐
- 999 call ☐
- Police ☐

Next of Kin: MRS Green.
22 BRENLANDS ST
EALSTON
Relationship: MOTHER
Tel. No.: 820265.
Present ~~YES~~/NO
Informed ~~YES~~/NO

Belongings
- Listed
- Hospital Safe
- Other

Drug Sensitivity

X-Rayed ☑

DISPOSAL
- Home—Own G.P.
- Fracture Clinic
- Orthopaedic Clinic
- Other
- Ward 5B
- Transferred
- Return Appt. Date
- Ambulance

Drug Administration— Drug (Block letters) Approved Names	Dose	Method of Admin.	Doctor's Signature	Time Given	Given By—Initials

IMMEDIATE DISCHARGE DRUGS

Drug (Block letters) Approved Names	Dose	Method of Admin.	Frequency	Quan. Dispensed	Doctor's Signature

- Died
- G.P. Notified
- Police Notified
- Clergy Notified

NURSING NOTES

11.33

DATE	
10/9/96	PAR IAR DNT. - punched on (L) side face. Large swelling infront of (L) ear. Not R/O. But feels vision is distorted Canvassed re neuro-obs. chart. SN. Had taken approx. 1/2 bottle Diamond White. SN.

Time seen by Nurse: 2045.

Time seen by Medical Staff:

Time Discharged: 21.45.

Time of Discharge/Transferred:

S CARD IS CONFIDENTIAL—IT MUST NOT BE HANDLED BY PATIENTS OR UNAUTHORISED PERSONS

Code STA 0098

CROSSHOUSE HOSPITAL

Accident/Emergency Department

A/E Reg. No. 887 2025

Name of Examining Doctor CUNNINGHAM

Surname Aiken | First Name(s) Lee

Date of Birth 31.8.82 | Age 5 | Hospital Case Record Number 337455

Home Address (Permanent) 27 Mulroy Cres Yoker ston | Tel. No. 821235 | Temporary Address

Name and Address of own Doctor Dr McWhirter Yoker ston

Sex	M.	S.	W.	Religion	Occupation	Employer/School	Date of Injury	Time	Date of Attendance	Time
M.		S.		Pres	Schoolboy	Yoker ston	~~Yoker ston~~ 24 7 88	2040 a.m. p.m.	24.7.88	2100 a.m. p.m.

Source
- Not Accident ☐
- Road Accident ☐
- Home Accident ☐
- Works Accident ☐
- Other Accident ☑

Type of Road Accident
- Pedestrian ☐
- Bicycle ☐
- Motor Cycle ☐
- Motor Car ☐
- Other Vehicles ☐

Method of Referral
- Self Referral ☑
- G.P. Letters/Phone ☐
- 999 call ☐
- Police ☐

Next of Kin Mgt Aiken STA

Relationship Mother

Tel. No. N/A

Present ~~YES/NO~~ NO Informed YES/NO

Belongings
- Listed [
- Hospital Safe [
- Other [

Drug Sensitivity

38585 X-Rayed ☐

Drug Administration— Drug (Block letters) Approved Names	Dose	Method of Admin.	Doctor's Signature	Time Given	Given By—Initials

IMMEDIATE DISCHARGE DRUGS

Drug (Block letters) Approved Names	Dose	Method of Admin.	Frequency	Quan. Dispensed	Doctor's Signature

DISPOSAL
- Home—Own G.P. [
- Fracture Clinic [
- Orthopaedic Clinic [
- Other EYE. [
- Ward [
- Transferred [
- Return Appt. Date 28/7 [
- Ambulance [
- Died [
- G.P. Notified [
- Police Notified [
- Clergy Notified [

NURSING NOTES

DATE	
	Lac. Head & Nose Sut
27/7	Returned with GP letter
	SEEN BY Dr. 9.15
	TO 9.20
	ED 9.35
	DISPOSED OF

DATE	CLINICAL NOTES—Each entry to be signed by the examining Doctor.
24/7	Fell from bike. laceration T shape to forehead No loss of consciousness or vomiting. Sutured 5X 5/0 ethilon ATT – mother coming to Dept Nose tender – not Xrayed in view of radiation to eyes → Skull Xray No bony injury Mother says he had preschool booster Allow home with head injury card DC
14/8.	Returned with GP letter Yesterday his mother noticed a squint Never been seen before O/E. full range eye movements alert + orientated no diplopia moving all 4 limbs – eye clinic appt. DScott.

MEDICAL IN CONFIDENCE

ADMISSION FORM V2

MEDICAL RECOR

HOSPITAL CODE	HOSPITAL NAME	CASE RECORD NUMBER
A111H	CROSSHOUSE HOSPITAL	XHI-337455

ADMISSION DETAILS

DATE	TIME	TYPE	SOURCE	INPAT./DAYCASE	DATE ON W.L.	PATIENT CATEGORY
10/09/96	21:55	7 EM-OI	1 HOME	Inpatient		3 NHS

WARD	SPECIALTY	CONSULTANT
5B	GENERAL SURGERY	MR C MORRAN

PATIENT

TITLE SURNAME	FORENAME	INITIALS	AGE	DATE OF BIRTH	SEX	MARITAL STATUS
MAST GREEN	LEE		14	31/08/1982	M	S

ADDRESS: C/O 35 BENRIG AVE, KILMAURS

ALT./PREV. SURNAME:

OCCUPATION: S/BOY

POSTCODE: KA3 2QQ

TELEPHONE No.: 538715

OCCUPATION (HUSBAND/FATHER): N/A

REF. G.P.

NAME: G.P. CODE: MCCALL 1342581

PRACTICE: S 8026011

CONTRACT No.:

ADDRESS: 5A HENRIETTA ST, GALSTON

TELEPHONE No.: 01563 820424 POSTCODE: KA48HN

NEXT OF KIN

NAME: MRS MARGARET GREEN

RELATIONSHIP: MOTHER

ADDRESS: 64 BREWLANDS STREET, GALSTON

DAY PHONE No.:

NIGHT PHONE No.: 820249

AND / OR

NAME:

RELATIONSHIP:

ADDRESS:

DAY PHONE No.:

NIGHT PHONE No.:

MISC.

RELIGION:

VISIT REQ. BY CHAPLAIN YES/NO:

PENSION BOOK No.:

DISCHARGE SUMMARY

DISCHARGE DETAILS

DATE	TIME	DISCH. CODE	PATIENT CATEGORY	TYPE FACILITY	SPECIALTY	CONSULTANT	CODE
13.9.96							

DISCHARGED/ TRANSFERRED TO	HOSPITAL	CODE	WARD	SPECIALTY	CODE	CONSULTANT	CODE
Home				Surg.		Mr Morran	

DIAGNOSES

		CODE	SPECIAL WARNINGS
MAIN DIAGNOSIS	Head Inj	S099	
OTHER CONDITIONS (D.G,2)		4044	
(D.G,3)		Z045	
(D.G,4)			
(D.G,5)			
(D.G,6)			

AND OPERATIONS

	CODE	DATE
MAIN OPERATION		
OTHER OPERATION (O.P,2)		
(O.P,3)		
(O.P,4)		

LOCAL USE			NATIONAL USE	

CHI NO = 3108823299

MEDICAL IN CONFIDENCE

ADMISSION FORM V2

MEDICAL REC

ADMISSION DETAILS

HOSPITAL CODE	HOSPITAL NAME	CASE RECORD NUMBER
A111H	CROSSHOUSE HOSPITAL	XHI-337455

DATE	TIME	TYPE	SOURCE	INPAT./DAYCASE	DATE ON W.L.	PATIENT CATEGORY
10/09/96	21:55	7 EM-OI	1 HOME	Inpatient		3 NHS

WARD	SPECIALTY	CONSULTANT
5B	GENERAL SURGERY	MR C MORRAN

PATIENT

TITLE SURNAME	FORENAME	INITIALS	AGE	DATE OF BIRTH	SEX	MAR STAT
MAST GREEN	LEE		14	31/08/1982	M	S

ADDRESS: C/O 35 BENRIG AVE, KILMAURS

ALT./PREV. SURNAME:

OCCUPATION: S/BOY

POSTCODE: KA3 2QQ

TELEPHONE No.: 538715

OCCUPATION (HUSBAND/FATHER): N/A

REF. G.P.

NAME: MCCALL

G.P. CODE: 1342581

PRACTICE: S 8026011

CONTRACT No.:

ADDRESS: 5A HENRIETTA ST, GALSTON

TELEPHONE No.: 01563 820424 POSTCODE: KA48HN

NEXT OF KIN

NAME: MRS MARGARET GREEN

RELATIONSHIP: MOTHER

ADDRESS: 64 BREWLANDS STREET, GALSTON

DAY PHONE No.:

NIGHT PHONE No.: 820249

AND / OR

NAME:

RELATIONSHIP:

ADDRESS:

DAY PHONE No.:

NIGHT PHONE No.:

MISC.

RELIGION:

VISIT REQ. BY CHAPLAIN YES/NO:

PENSION BOOK No.:

DISCHARGE SUMMARY

DISCHARGE DETAILS

DATE	TIME	DISCH. CODE	PATIENT CATEGORY	TYPE FACILITY	SPECIALTY	CONSULTANT	CODE
13.9.96							

DISCHARGED/ TRANSFERRED TO	HOSPITAL CODE	WARD	SPECIALTY	CONSULTANT	CODE
Home			Surg	Mr Morran	

DIAGNOSES AND OPERATIONS

		CODE	SPECIAL WARNINGS
MAIN DIAGNOSIS	Head Inj	S099	
OTHER CONDITIONS (D.G,2)		L044	
(D.G,3)		Z045	
(D.G,4)			
(D.G,5)			
(D.G,6)			

	CODE	DATE
MAIN OPERATION		
OTHER OPERATION (O.P,2)		
(O.P,3)		
(O.P,4)		

LOCAL USE			NATIONAL USE	

CHI NO = 3108823299

AYRSHIRE AND ARRAN
HEALTH BOARD

WRITE IMPRINT OR ATTACH LABEL

GREEN LEE 337455
2 MILRIG CR. WARD
GALSTON DEPT
31.8.82 M/S C/H
DR. N COLL GALSTON

STA0149 | Ward or Dept.

Otolaryngology

DATE

18.9.92 AA for Repeat myringotomy + insertion of grommets

HPC Recurrent earache.
Last grommets became blocked + fell out.

Fit + healthy generally

PMH 1. Earache do above → grommets 1991.
Nil else of note ○ Asth / Epilepsy / TB / RF
Ten babies. Vaccinations up to date

DH Nil
Allergic to tetanus

SH Schoolboy

Systems - All → NAD

OE Tymp dull ○
pink. Afebrile

CVS P 70, reg HS I/II no murmurs
Resp Chest clear
Abdo Soft. NAD
CNS Grossly intact (except ears)

Imp Fit 10yr old ○ for myringotomy + grommets

Consent from mother ✓ KAG
(4y)

DATE
1/11/92

Fam. Hx
Cough & Allergy
Skin Test - Negative

AYRSHIRE AND ARRAN
HEALTH BOARD

CONSENT FOR OPERATION

STA1057

WRITE IMPRINT OR ATTACH LABEL

GREEN LEE 337455
27 MILRIG CRES
GALSTON.
DR NICOLL
HENRIETTA ST

WARD/DEPT 17
31/08/1982
M/S C/H
A2292

Ward or Dept: .....

I MARGARET A GREEN of 27 Milrig Crescent Galstn. hereby consent to

~~undergo~~ the submission of my child Lee ward

the operation of MYRINGOTOMY + insertion of grommets.

the nature and purpose of which have been explained to me by

Dr./~~Mr.~~ SHM

I also consent to such further or alternative operative measures as may be found necessary during the course of the above-mentioned operation and to the administration of general, local or other anaesthetics for any of these purposes.

No assurance has been given to me that the operation will be performed by any particular practitioner. (Not applicable to Section 1 (2) patients.)

Date 18.9.92 Signed X M A Green
(Patient/Parent/Guardian)*

I confirm that I have explained the nature and purpose of this operation to the patient/parent/guardian.*

Date 18.9.92 Signed KAR
(Medical/Dental Practitioner)*

*DELETE AS APPROPRIATE

Note: This form is not to be used for any operation where there is a specific consent form with explanations.

Any deletions, insertions or amendments to the form are to be made before the explanation is given and the form submitted for signature.

CONSENT FOR OPERATION

AYRSHIRE AND ARRAN HEALTH BOARD

ANAESTHETIC RECORD

STA0093

WRITE, IMPRINT OR ATTACH LABEL

GREEN LEE 337455
27 MILRIG CRES
GALSTON
DR NICOLL
HENRIETTA ST

WARD/DEPT
31/08/1982
M/S C/H
A2292

Ward or Dept:

PROPOSED PROCEDURE: Rep. Myr / Revis. Cannula

ELECTIVE / EMERGENCY

Wt. 33kgs

BP:

PRE-OPERATIVE ASSESSMENT

CXR for recon 2/91
Chest clear

RECENT DRUG THERAPY: Nil

ALLERGIES: ~~NKA~~ TETANUS

PREMEDICATION — DATE: 19/9/92 — TIME:

VALLECAN FORTE SYRUP 15ml orally
ATROPINE 0.6mg

EMLA CREAM TO (L) HAND

TIME	INIT.
7 AM	C.C

MONITORING

- ECG ☑
- BP ☐
- SPULSE O2 ☑
- O_2 ☐
- CO_2 ☐
- CVP ☐
- TEMP ☐
- NMT ☐
- CFM ☐

ANAESTHETIC TECHNIQUE

INJECTION R/L (L) Rad 22/hr — INFUSION(S) R / L

INDUCTION — PRE O_2 ☐ — CRICOID ☐ — INHAL ☐ — IV ☑

AIRWAY — ORAL ☐ — NASAL ☐

INTUBATION — ORAL ☐ — NASAL ☐ — CUFF ☐ — SIZE — TYPE

SPRAY ☐ — PACK ☐

RESPIRATION — SPONT ☑ — IPPV ☐ — VENTILATOR

POSITION ON TABLE

LOCAL ANAESTHESIA

- SPINAL ☐
- EPIDURAL ☐
- NERVE BLOCK ☐

DRUGS GIVEN

DATE OF OP.	OPERATION PERFORMED	SURGEON	ANAESTHETIST
19/9/92	ENT Ear	R. Syfe	

POST OP. INSTRUCTIONS

Routine Post Ear Recon

NOTES/COMMENTS

ANAESTHETIC RECORD

Patient	80											
Patient	20											
Dr Imo/	epfleme											
TIME												
	220											220
	200											200
	180											180
	160											160
	140											140
	120											120
	100											100
	80											80
	60											60
	40											40
	20											20
	CVP											
	T° 1											
	T° 2											

	FLUID IN				FLUID OUT		
	DRIP 1	VOL.	DRIP 2	VOL.	URINE	BLOOD	
	TOTALS						

CONFIDENTIAL

Form STA0186

AYRSHIRE AND ARRAN HEALTH BOARD

THEATRE CHECK SHEET

PART 1 Name, number and ward to be completed by the Medical Secretary when a patient is sent for. The form is then inserted in the Case Sheet. The form then goes to theatre with the Theatre List and the date is filled in and the appropriate theatre indicated.

The sheet will be taken to the ward when the patient is to be collected for operation.

Patient's Name: Lee Green Date of Birth: 31.8.82 Hospital Number: 337455

From Ward: 1a Date: 19.9.92 To Theatre: 2

Proposed Operation: Rep Myr/Re-Insertion Grommets

PART 11 To be completed by the Ward Sister/Charge Nurse or her deputy and to accompany the patient to theatre, where it should be counter-signed in reception.

CHECKED : Identity Bracelet: checked ✓ Pre-Medication: given ✓

Consent Form(s): signed Removal of Dentures, etc.: NONE ✓

X-Rays: NONE ✓ Case Record: present ✓

Nursing Notes: Passed

allergic to tetanus immoc.

no loose teeth.

Theatre Blood X Matched Check:

Signed: a Shc

Ward: 2 N

Theatre: Ekeh

Webb MacNeil

PART 111 Operation: Bil. Myr

Drainage/Packs:

Post-Op Directions:

Date: 19.9.92

Time:

Signature of Surgeon

AYRSHIRE AND ARRAN
HEALTH BOARD

GREEN LEE 337455
27 MILRIG CRES
GALSTON.
DR NICOLL
HENRIETTA ST

WARD/DEPT
31/08/1982
M/S C/H
A2292

STA0215

Ward/Dept

DATE SURGEON ANAESTHETIST

19.9.92

ASSISTANT

OPERATION PERFORMED

DESCRIPTION OF PROCEDURE

DRAINS..... PACKS.....

SPECIAL INSTRUCTIONS TO WARD

Signature.....

OPERATION

AYRSHIRE AND ARRAN HEALTH BOARD

STA 0217

WRITE, IMPRINT OR ATTACH LABEL

GREEN LEE 337455
27 MILRIG CRES
GALSTON
DR NICOLL
HENRIETTA ST
Ward or Dept.....

WARD/DEPT
31/08/1982
M/S C/H
A2292

OTOLARYNGOLOGY

DATE

14.8.91 Ears Sleeve
Request Regd. Accounts ←
Feb. 1 82 1285

DATE

MEDICAL IN CONFIDENCE

ADMISSION FORM

MEDICAL RECOI

	HOSP. CODE	HOSPITAL NAME					PATIENT CATEGORY	UNIT No.
	A111H	CROSSHOUSE HOSPITAL					N.H.S.	XHI-337455
DMISSION DETAILS	DATE	TIME	WARD	TYPE	SOURCE	DATE ON WAITING LIST	CONSULTANT	SPECIALITY
	10/02/91	1350	1A	W/L	HOME	27/06/90	R S SINGH	ENT

	TITLE SURNAME	FORENAME	INITIALS	AGE	DATE OF BIRTH	SEX	MAR. STAT.
PATIENT	MAST GREEN	LEE		8	31/08/1982	M	SI

ADDRESS
27 MILRIG CRES
GALSTON

POST CODE: KA4 8NF
TELEPHONE No.: 821235

ALT/PREV SURNAME

OCCUPATION: CHILD
CODE: 666

OCCUPATION (Husband/Father): HOUSEWIFE
CODE

G.P.
NAME: DR NICOLL
INITIALS
ADDRESS: GALSTON
POST CODE
TELEPHONE No.

NEXT OF KIN
NAME: MARGARET
RELATIONSHIP: MOTHER
ADDRESS: AS ABOVE
DAY TELEPHONE No.
NIGHT TELEPHONE No.

AND / OR
NAME: MARGARET O'CONNELL
RELATIONSHIP: GRAN
ADDRESS: 64 BREWLANDS ST
GALSTON
DAY TELEPHONE No.: 820269
NIGHT TELEPHONE No.

MISC.
RELIGION: C/S
VISIT REQUIRED BY CHAPLAIN YES/NO: YES

TYPE OF PENSION 1. 2.
PENSION BOOK No. 1. 2.

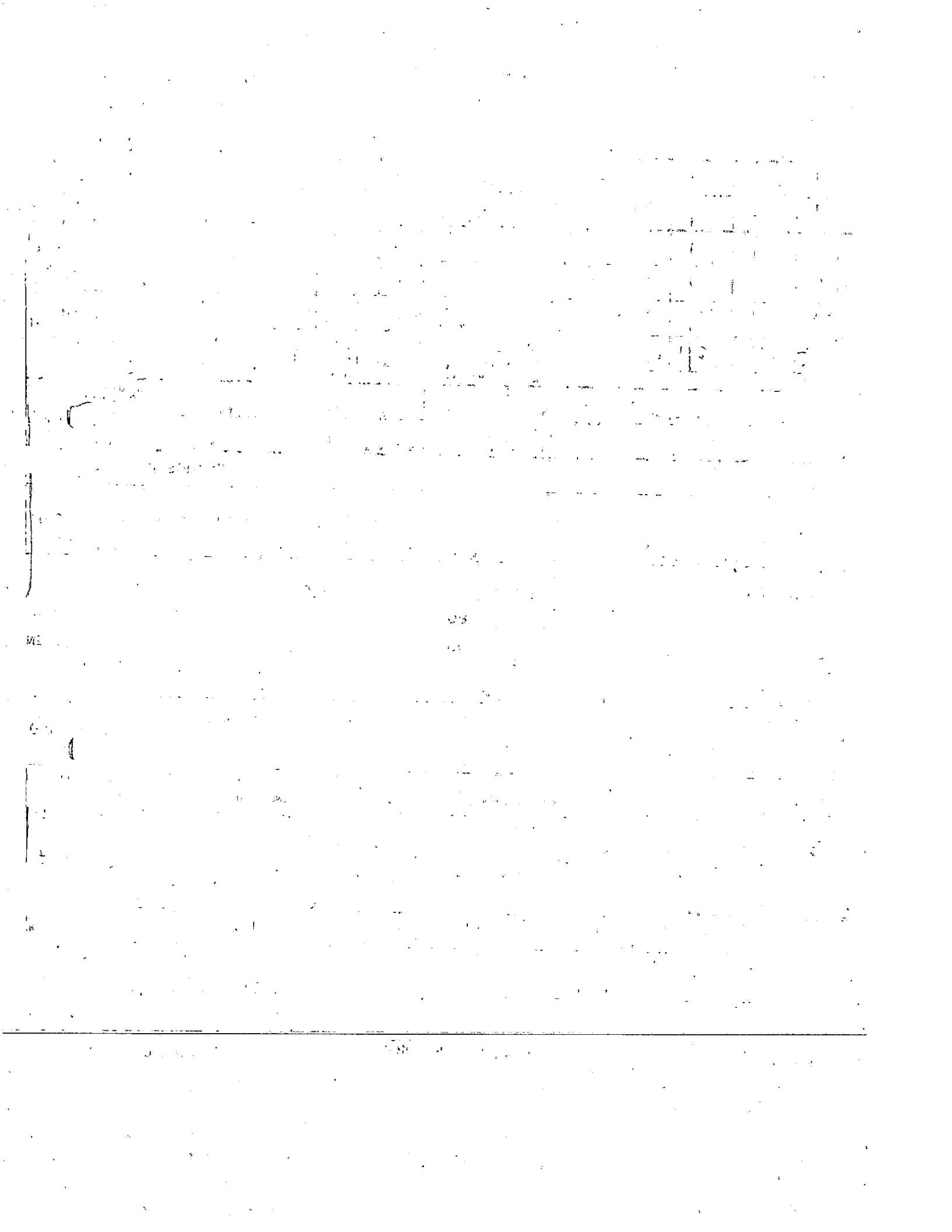
DISCHARGE SUMMARY

DISCHARG DETAILS	DATE	TIME	TYPE	PATIENT CATEGORY	TYPE OF FACILITY	SPECIALITY	CONSULTANT	C
	12-2-91							
	DISCHARGED/ TRANSFERRED TO:-	HOSPITAL	CODE	WARD	SPECIALITY		CONSULTANT	C
	Home			1A	ENT Padd		Singh	

DIAGNOSIS & OPERATIONS

	PRINCIPAL DIAGNOSIS	CODE	PRINCIPAL OPERATION	DATE	CODE
	(R) SEROUS OTITIS MEDIA	F 3814	BIL. MYRINGOTOMY + INSERTION (R) GROMMET	1 1 0 2 9 1	D 1 5 2 9 4
	OTHER CONDITIONS		OTHER OPERATIONS		E 1 3 2 9 4
			BIL. ANTRAL WASHOUT		
			NATIONAL OPTION		
			LOCAL OPTION		

L FRASER 13:52:31 10 FEB 1991



AYRSHIRE AND ARRAN HEALTH BOARD

STA 0217

WRITE, IMPRINT OR ATTACH LABEL

GREEN TCE 33/455
27 MILRIG CR. WARD
GALSTON DEPT.
31.8.82 M/S C/H
DR. NICOLL GALSTON
Name of Dept.

DATE

OTOLARYNGOLOGY

10/4/84 8½ yrs ♂ RH for bilat myringotomy + insertion of grommets, + adenoidectomy sinus wash - art

HPC long history of problems ? ears - since early childhood. Recurrent ear infections + sinusitis + fluctuating hearing loss - probable serous otitis media.

PMH Asthmatic tendencies - never definitely diagnosed.
ODM OTB OT OCF Epilepsy - No major illnesses
NO previous surgery.

DH NKH regularly
No allergies known of

FHOH Lives ? family (parents, 2 sibs)
Older brother } both well
Younger sister }
At school, mainly H; no major problems

OH Reasonably clean 8½ yr old
Yellow/brown nodes (nicotine) dishevelled

CNS ? Some nystagmus
TMS ? TM ? TO otherwise

Resp Trachea ? PN. RS (R) = (L)
AE (R) = (L)
BS resonant
Infrequent occas soft rhonchi ? cough
tend to clear on coughing. Exp. not prolonged
No crepts.

DATE

Inj^n sites for procedure

Consent obtained for
notes

SHO

8/8/91 Pyrexial 38° this morning
Monitor temp + will review in pm
If settled probably for home
CMClean (SHO)

12/2/91 37.9°C
feels well
Ears R TM ✓ normal - no pus not inflamed
L TM ✓
Throat - slightly red + inflamed
Mum keen for discharge
→ Discharge
Will contact GP should Temp not settle in
24 - 48 hrs.
Chris 6152

SHO

AYRSHIRE AND ARRAN HEALTH BOARD

ANAESTHETIC RECORD

STAO

WRITE, IMPRINT OR ATTACH LABEL

Surname: .....

GREEN LEE
27 MTLRIG CR.
GALSTON
31.8.82 M/S
DR. NICOLL GALSTON

337455
WARD .....
DEPT .....
C/H .....

PROPOSED PROCEDURE B.T. Myr. + grommets / B.A.N.O.

ELECTIVE / EMERGENCY | Wt. 25kgs | BP.

PRE-OPERATIVE ASSESSMENT

Asthmatic

RECENT DRUG THERAPY	ALLERGIES	PREMEDICATION 11.2.91 DATE	TIME
Ventolin & Inhal.	nil	Emla cream. both hands.	
		Valium Forte 5mg. 85mgs. - oral.	12.30
		Glycopyrrolate 0.2mg. - oral.	

TIME	INIT.
12.30pm	gp

MONITORING		ANAESTHETIC TECHNIQUE							
ECG	☑	INJECTION R/L			INFUSION (S) R L				
BP	☑	INDUCTION	PRE O_2 ☐	CRICOID ☐	INHAL ☐	IV ☐			
PULSE	☑	AIRWAY	ORAL ☐	NASAL ☐					
O_2	☑	INTUBATION	ORAL ☑	NASAL ☐	CUFF ☐	SIZE 6.5	TYPE Rae		
CO_2	☐		SPRAY ☐	PACK ☑					
CVP	☐	RESPIRATION	SPONT ☑ Bain	IPPV ☐	VENTILATOR				
TEMP	☐								
NMT	☐	POSITION ON TABLE	S - R.L.						
CFM	☐								

LOCAL ANAESTHESIA		DRUGS GIVEN
SPINAL	☐	S.T.8. 125mgs.
EPIDURAL	☐	Co-Co 4.
NERVE BLOCK	☐	

DATE OF OP.	OPERATION PERFORMED	SURGEON	ANAESTHETIST
11.2.91	B/L. Myr. + grommets (CR) B.A.N.O.	Slavid.	Sudhir Chakravarty

POST OP. INSTRUCTIONS	NOTES/COMMENTS
Routine Care Please. Slavid.	

ANAESTHETIC RECORD

TIME											
	220										220
	200										200
	180										180
	160										160
	140										140
	120										120
	100										100
	80										80
	60										60
	40										40
	20										20
	CVP										
	T° 1										
	T° 2										

	FLUID IN				FLUID OUT		
	DRIP 1	VOL.	DRIP 2	VOL.	URINE	BLOOD	
	TOTALS						

AYRSHIRE AND ARRAN
HEALTH BOARD

CONSENT FOR OPERATIO

STA 1057

WRITE, IMPRINT OR ATTACH LABEL

GREEN LEE 337455
27 MILRIG CR. WARD
GALSTON DEPT
31.8.82 M/S C/H
DR.NICOLL GALSTON

Ward or Dept: .....

I Margaret Green .....

..... hereby consent to

* undergo— / the submission of my * child Lee Green / -ward-

the operation of Bilateral myringotomy & grommets + maxillary sinus washout

the nature and purpose of which have been explained to me by

Dr./Mr.* J. McCauley

I also consent to such further or alternative operative measures as may be found necessary during the course of the above-mentioned operation and to the administration of general, local or other anaesthetics for any of these purposes.

No assurance has been given to me that the operation will be performed by any particular practitioner. (Not applicable to Section 1 (2) patients.)

Date 10/2/91 Signed M Lynn Green
(Patient/Parent/Guardian)*

I confirm that I have explained the nature and purpose of this operation to the patient/parent/guardian.*

Date 10/2/91 Signed J. McCauley
(Medical/Dental Practitioner)*

*DELETE AS APPROPRIATE

Note: This form is not to be used for any operation where there is a specific consent form with explanations.

Any deletions, insertions or amendments to the form are to be made before the explanation is given and the form submitted for signature.

CONSENT FOR OPERATION

AYRSHIRE AND ARRAN HEALTH BOARD

STA0215

Write—Imprint or attach Label

GREEN LEE 337455
27 MILRIG CRES
GALSTON
DR NICOLL
HENRIETTA ST

WARD/DEPT
31/08/1982
M/S C/H
A2292

Ward/Dept.....

OPERATION

DATE 11.2.91

SURGEON Dr Shanks

ANAESTHETIST Dr Kothari

ASSISTANT

OPERATION PERFORMED

1. Bilat. Myringotomies

DESCRIPTION OF PROCEDURE

(R) TM wax crust past. thickened & inflammed (mild)

→ Fluid ++

x Shepard Grommet inserted (R)

(L) - Dry (No G)

2. BAWD

ostia patent
Clear return.

DRAINS..... PACKS.....

SPECIAL INSTRUCTIONS TO WARD

Signature EM Shanks

CONFIDENTIAL Form STA0186

1/02

AYRSHIRE AND ARRAN HEALTH BOARD

THEATRE CHECK SHEET

PART I Name, number and ward to be completed by the Medical Secretary when a patient is sent for. The form is then inserted in the Case Sheet. The form then goes to theatre with the Theatre List and the date is filled in and the appropriate theatre indicated.

The sheet will be taken to the ward when the patient is to be collected for operation.

Patient's Name Lee Green Date of Birth 31.8.82 Hospital Number 337455

From Ward 1A Date 11.2.91 To Theatre 2

Proposed Operation Bilateral Myringotomy/Grommets/BAWO

PART II To be completed by the Ward Sister/Charge Nurse or her deputy and to accompany the patient to theatre, where it should be counter-signed in reception.

CHECKED: Identity Bracelet CHECKED ✓ Pre-Medication GIVEN ✓

Consent Form(s) SIGNED ✓ Removal of Dentures, etc. Own Teeth.

X-Rays ✓ Case Record PRESENT

Nursing Notes PRESENT

ALLERGY — TETANUS INJ.

DO LOOSE TEETH

Theatre Blood X Matched Check

Signed Jean Tolland

Ward 1B

(Both eyes appear inflamed)

Theatre Dr Gilchrist L Davies. Rcp.

PART III Operation Bil. Myrt ® Grommet / BAWO

Drainage/Packs —

Post-Op Directions Usual obs

Date 11.2.91

Time 2.40pm

EM Shanks

Signature of Surgeon

WRITE, IMPRINT OR ATTACH LABEL

Surname GREEN HCR No.

Forenames LEE Sex

Address D.O.B.

Ward or Dept.

STA0172

SURGICAL

DATE

10/3/96 EA via A&E ? head injury

HPC Punched area on (L) head. Fell to floor but rose immediately. Reports short lasting visual disturbance for 30 mins after blow. No neuro symptoms since. Had ½ bottle cider (150ml)

PMH. Gromits @ age 6.
R tib avulsion
Knee locks - right. Arthroscopy arranged
asthma ? dist ? epil

SH NAD

SH In 3 L yr at school.
Lives at Kilmarnock with
One smoker
One drinker

DH No medication
No known allergies

SE. Resp. Cough every winter. Rings of green sputum
Wheezy " "

CVS "
GIT "
GUS "
CNS "

O/E. CVS HR 76 reg HS I+II+0
Resp Chest clear. Sounds basic, nil added
Abdo Soft non tender ^ masses ? organomegaly
CNS PERLA
Visual fields normal.

DATE	
	Head. Swollen + tender over (L) face
	Plan. Bloods FBC UrE's
	Observe
	P Ibuleve PO
12/9/96	CCM - WR
	- Orthopantogram ✓
	S. Tuite JHO
13/9/96	CCM - WR
	- XR - (L)
	- Soft tissue injury - Home today
	S. Tuite JHO

WRITE IMPRINT OR ATTACH LABEL

XH 337455

Surname....	GREEN LEE
Forenames.	C/O 35 BENRIG AVE
Address.....	KILMAURS
	KA3 2QQ
	31/08/1982 M/S
	DR.J MCCALL
	5A HENRIETTA ST
Ward or Di	CALSTON
	CHI 3108823299

STA0172

DATE

SURGICAL

DATE

XH 337455

Surname..... GREEN LEE
Forenames.. C/O 35 BENRIG AVE
..... KILMAURS
..... KA3 200
Address .... 31/08/1982 M/S
..... DR.J MCCALL
..... 5A HENRIETTA ST
Ward/Dept. CALSTON
CHI 3108823299

STA0215

DATE	SURGEON	ANAESTHETIST

ASSISTANT

OPERATION PERFORMED

DESCRIPTION OF PROCEDURE

OPERATION

DRAINS..... PACKS.....

SPECIAL INSTRUCTIONS TO WARD

Signature .....

AYRSHIRE AND ARRAN HEALTH BOARD

Code ST

CROSSHOUSE HOSPITAL

CROSSHOUSE
KILMARNOCK KA2 0BE
Telephone (0563) 21133

Accident / Emergency Unit

Consultant in Charge
S. M. H. ZAIDI

Our Ref.

Date: 24/7/88

Lee Yuen
27 Nursing Ave
Kaitaia

Hospital No. 88 7 2025

Dear Dr. Mr Whurter

The above named has attended this Department to-day and is suffering from

fell from bike
laceration to head

He/She has been treated as follows—

Sutured sx s/o eruka
ATT - before school

Clinical examination and inspection of wet films showed

No Bony Injury ☑ Bony injury of the following—

Nil

In the meantime the condition will be reviewed by the Radiologist and the Accident and Emergency Surgeon and in the event of a revision of opinion you will be informed and the patient requested if necessary to attend the Department.

Further treatment is recommended as follows—

Tender wee - not xrayed because of high radiation to eyes - please send to ENT if a problem in 10 days

A review appointment on .....

Yours sincerely,

Please remove sutures (5) day thanks DCL

Accident/Emergency Surgeon.

CROSSHOUSE HOSPITAL

Code STA0211

GREEN LEF
27 MILRIG CR.
GAILSTON
31.8.92 M/S
DR.MICOLL GALSTON

33/455
WARD
DEPT
C/H

DATE

28/7/88 Minor blunt injury to R eye s/p assault by Grandmother with Squash racket (2) yesterday

L+X Bruised nose

O/E N A D.

OPHTHALMIC

DATE

Dr. J.L. ROBERTSON
Dr. T.W. McWHIRTER
Dr. J.S. McCALL
Dr. JAMES McWHIRTER
Dr. W.S. NICOLL

Consulting Rooms –
5A HENRIETTA STREET
GALSTON - AYRSHIRE
KA4 8HW
Tel: Galston (0563) 820424

27. JUL. 1988

Dear Dr

Lee Green 31.8.82
27 Mining Cres.
Galston

This child was seen on
24.7.88 at A & E where
a foreign body in his right eye
& injured his hand
Suturing was required
in connection of his
forehead which had
sustained
He has known
damaged as regards his
the last 24 hours &
Thanks to you for

SR
MC
8/3

Hospital use Only	Clinic	Day Date	Time	Hospital No.	GP112
	PAED/ENT MR SINGH	WED 27/6/90	9.30am	337455	

REQUEST FOR OUT-PATIENT CONSULTATION

Hospital ..Crosshouse..... Date..10.04.90

Urgent Appointment Required YES/NO

PARTICULARS OF PATIENT IN BLOCK LETTERS PLEASE

Please arrange for this patient to attend the .....ENT..... clinic of Dr/Mr .....Singh.....

Patient's Surname .....GREEN..... Maiden Surname .....

First Names .....Lee..... Single/Married/Widowed/Other

Address .....27 Milrig Crescent..... Date of Birth ...31.08.82.....

.....GALSTON..... Patient's Occupation .....

Postal Code ...KA4 8NF..... Telephone Number .....

Has the patient attended hospital before YES/NO if "YES" please state:

Name of Hospital .....Crosshouse.....

Year of Attendance .....1988..... Hospital No ....337455.....

If the patient's name and/or address has/have changed since then please give details:

.....

.....

.....

.....

.....

Name, Address and Telephone Number of MEDICAL/DENTAL PRACTITIONER

Dr James McWhirter
5A Henrietta Street
GALSTON

Please use rubber stamp

I would be grateful for your opinion and advice on the above named patient. A brief outline of history, symptoms and signs is given below:

This 7 year old boy suffers from recurrent ear infections. He has had several episodes recently requiring treatment with antibiotics. In view of the recurrent nature of this, I would be grateful for your opinion.

Diagnosis/provisional diagnosis: .....

Present drug treatment and potential special hazards: .....

X-ray (women of childbearing age). Date of first day of L.M.P. .....

Relevant X-rays available from: ..... No. (if known).....

Signature .....

Dd 8128515 11.5M pads 6/88 (25364)

AYRSHIRE AND ARRAN HEALTH BOARD

STA0201

WRITE, IMPRINT OR ATTACH LABEL

GREEN LEE 337455
27 MILRIG CR. WARD
GALSTON DEPT
31.8.92 M/S C/H
DR. N.I.COLL GALSTON

INFECTIOUS DISEASES:

Measles
German Measles
Mumps
Whooping Cough
Scarlet Fever
Diphtheria
Chicken Pox

INOCULATIONS:

Polio
D.P.T.

BLEEDING TENDENCY:

Date

HISTORY:

27/6/90

Earaches - 1 - every 2 weeks -
Deafness - L
Sore throat +
Cough + Postnasal dripping
Sore throat - tonsils - L

File - 821285.

EXAMINATION:

General

Mouth and Pharynx

Tsils

Neck -

Ears Glue ear +

Nose -

Postnasal Space -

Larynx

R.

L.

TREATMENT:

1. Aug. + Bd. Keys - grommets +
2. Statim

OTOLARYNGOLOGY

DATE

2/13/91

Ear inf (L) on & off

(R) Ca in situ

TM ~

(L) TM. Mild Catarrh.

Observe

3/12

Appl.

26.6.91 (R) ear inf - (R) otalgia

(R) Ca in situ - Block.

TM - Hyperemia + Retracted.

(L) TM - Dull.

August

6/52

Appl.

14/8/91 Ear inf - Twice

(R) Ca in situ resolved

Dry

TM - Clear -

(L) TM - Dull

Impedance Plan

MEDICAL IN CONFIDENCE

ADMISSION FORM V2

MEDICAL RECO

HOSPITAL CODE: A414H	HOSPITAL NAME: CRAIGHOUSE HOSPITAL					CASE RECORD NUMBER: XHT1237455	
ADMISSION DETAILS — DATE: 18/09/92	TIME: 13:45	TYPE: 1 WLDR	SOURCE: 1 HOME	INPAT/DAYCASE: Inpatient	DATE ON W.L: 14/08/91	PATIENT CATEGORY: 2 NHS	
WARD: 10	SPECIALTY: ENT SURGERY	CONSULTANT: MR S SINGH					

PATIENT

TITLE	SURNAME	FORENAME	INITIALS	AGE	DATE OF BIRTH	SEX	MARITAL STATUS
	MASTEGREEN	LEE		10	31/08/1982	M	

ADDRESS: 27 MILRIG CRES, GALSTON

ALT/PREV SURNAME:

OCCUPATION:

POSTCODE: KA4 8NF

TELEPHONE No.: 821235

OCCUPATION (HUSBAND/FATHER): SCHOOLBOY

REF. G.P.

NAME: G.P. CODE MCCALL A2224 — PRACTICE S 8026011 — CONTRACT No.

ADDRESS: THE SURGERY, HENRIETTA STREET, GALSTON

TELEPHONE No.: 0563 820424 — POSTCODE: KA4 9QN

NEXT OF KIN

NAME: MARGARET GREEN — RELATIONSHIP: MOTHER

ADDRESS: AS ABOVE

DAY PHONE No.:

NIGHT PHONE No.:

AND / OR

NAME: MARGARET OCONNELL — RELATIONSHIP: GRANDMOTHE

ADDRESS: 64 BREWLANDS ST, GALSTON

DAY PHONE No.:

NIGHT PHONE No.:

MISC.

RELIGION: Ch. of Scotland

VISIT REQ. BY CHAPLAIN YES/NO: Y

PENSION BOOK No.:

DISCHARGE SUMMARY

DISCHARGE DETAILS

DATE	TIME	DISCH CODE	PATIENT CATEGORY	TYPE FACILITY	SPECIALTY	CONSULTANT	CODE
19.9.92							

HOSPITAL CODE: | WARD: | SPECIALTY: Paed ENT. | CONSULTANT: Mr. Singh | CODE:

DISCHARGED/ ~~TRANSFERRED TO~~: HOME

DIAGNOSES AND OPERATIONS

		CODE	SPECIAL WARNINGS
MAIN DIAGNOSIS	Bil Sclerosing otitis Media	13814	
OTHER CONDITIONS (D.G,2)			
(D.G,3)			
(D.G,4)			
(D.G,5)			
(D.G,6)			

		CODE	DATE
MAIN OPERATION	Bil Myr	D153941	19/09/92
OTHER OPERATION (O.P,2)			
(O.P,3)			
(O.P,4)			

LOCAL USE: | NATIONAL USE:

CAMPBELL 14:23:30 18 SEP 1992

NHS Ayrshire & Arran

OPERATIVE CARE PLAN

Surna .....
Foren CHI 3108823299
GREEN LEE
Addre 18 BROWN STREET
NEWMILNS
..... KA16 9AA
Ward 31/08/1982 Pract 80260
Case Ref 337455

Ward 2A Date 13-04-08 Theatre 7

Proposed Operation Patella Wiring (L) Side

Pre-Medication Time Given 1430 Ranitidine

Fasted from: Time Coffee 0930

Paediatrics Last feed / drink .....

Last Immunisation .....

Identified Allergies: Specify NKA

CHECK 1 Pre op

Surgical site marking and patient verification

- ☐ Check patient identity
- ☐ Check reliable documentation/results
- ☐ Images to ascertain intended surgical site
- ☑ Intended site marked with an arrow using indelible pen
- ☐ Decision not to mark – state reason below

.....

Signature confirming surgical check complete

In the event of this section being incomplete – Reception Nurse to communicate with Theatre to establish action to be taken.

Operating Surgeon

Signature .....

Print .....

CHECK 2 - 3 Surgical site marking and patient verification	Ward/DSU			R/Recovery			Anaesthetic		
	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
Identification Bracelet				✓			✓		
Consent Form signed				✓			✓		
AWI Consent if applicable						✓			✓
Operation Site marked clearly				✓			✓		
Bone bank consent form					✓			✓	
Dentures removed						✓			✓
Caps/Crowns/Loose teeth: Specify					✓			✓	
Nail Polish/Jewellery/Make-up: Removed				✓			✓		
Rings taped/Body Piercing						✓			✓
Pad or Tampon					✓			✓	
Catheter in situ					✓			✓	
re-op Shower				✓			✓		
kin Prep/Shaved: If required					✓			✓	
Paper Pants				✓			✓		
Patient's Label included				✓			✓		
Hearing Aid					✓			✓	
Inhalers					✓			✓	
Pillows extra: Number 2				✓			✓		
B.H.C.G. (Pregnancy Test)					✓			✓	
Urinalysis					✓			✓	

Case Notes					✓			✓	
X Rays/Images					✓			✓	
Pathology/Lab results					✓			✓	
Haemoglobin					✓			✓	
Blood X matched					✓			✓	
E.C.G. if applicable						✓			✓
Other: Specify									

Any other relevant information: (e.g. high risk or changes to general health) .....

.....

Ward Nurse *(signature)* ..... Print .....

Rec-Recovery Nurse *(signature)* ..... Print .....

Anaesthetic Nurse *(signature)* ..... Print T DALRYMPLE

ANAESTHETIC CARE GIVEN

Pulse 68 Temp ..... BP 130/75 SPo2 99

G.A.	✓	Rapid Sequence	
L.M.A.	4th	Size	5
ET Tube		Size	
Face Mask			
Throat Pack			
Throat Pack removed			
N.G. Tube			
Antibiotics Given	✓		

Spinal			
Epidural			
Combined Spinal/Epidural			
Local Anaesthetic			
Nerve Block			
Eyes Taped	✓	Gel	

eyepad

Infusion Device

PCA	
TIVA	
Baxter Colleague	
Alaris	
Other	
INVASIVE MONITORING	
IBP	CVP

Patient Positioning

Supine	✓	**RIGHT ARM**	
Prone		On board	
Lithotomy		At side	
Trendelenburg		Across chest	✓
Rev-Trendelenburg		Other	
Jack Knife		**LEFT ARM**	
Right lateral		On board	
Left lateral		At side	
Traction Table		Across chest	✓
Lloyd Davis		Other	
Deck Chair			

Diathermy Application

Bi-polar	
Mono-polar Diathermy site	
Thigh	
Buttock	
Abdomen	
Chest	
Other	
Diathermy Pad applied correctly and checked	

TOURNIQUET

Arm right		Arm left	
Leg right		Leg left	✓
Digit right		Digit left	
Time on right		Time on left	1519
Total Tourniquet time right		Total Tourniquet time left	18

1hr 14m

PERI-OPERATIVE CARE

Patient protection safety

Arm supports	✓	Sand bag	
Pelvic support i.e. padding		Shoulder vac pac (beanbag)	
Lateral support i.e. padding		Shoulder/arm traction	
Padding bony prominences	✓	Bair Hugger	✓
Heel rest	✓	Thermo-hat	
Head ring		Fluid warmer	✓
Prone head ring		Core temp probe	
Stirrups		Gel mattress	
Pillows		Other: State.....	

Evaluation pre and post-operative

Pre op		Post op
✓	Pressure area checked	
	Diathermy site checked	
✓	Tourniquet site checked	

Skin Prep solution used ..... Videne

Given by (Name) .....

DVT Prophylaxis

Dextran 70	
Fragmin (LMWH)	✓
Ted stockings	
Pre-op aspirin/Clopidogrel	
Flowtron leggings	

Time on			Time off		
Limb + machine function checks	1 hr	2 hr	3 hr	4 hr	5 hr

Specimens taken:

Yes ☐ No ☐ Bacteriology ☐ Pathology ☐

Other Hospital ☐ Bone bank ☐ State total (in box) ☐ (except bone bank)

Signature nurse receiving specimens from scrub person .....

Blood loss measured Yes ☐ No ☐ Total ☐

Patient Catheterised in Theatre Nurse ☐ Doctor ☐ Catheter size ☐ mls in balloon ☐

Skin closure 3/0 Monocryl	Wound drainage —
Dressing Mepore Blue Sues	Local anaesthetic infiltration 0.5% Marcaine 20ml

Wound Care

Identified problem	Nursing intervention	Outcome

Check 4

Surgical site marking and patient verification Theatre:	**Signature of Operating Surgeon or Senior Member of Theatre Team to confirm check completed**	**Surgeon only to complete and sign if discrepancy has been identified**
Surgical, Anaesthetic and Theatre team prior to commencement of surgery **should pause for verbal briefing to confirm the following** ☐ **Correct patient** ☐ **Consent form correct and signed by patient and clinician** ☐ **Proposed operation** ☐ **Operation site marked** ☐ **Availability of required image studies plus pathology results**	**Sign**..... **Print**..... **Time**..... **Date**.....	**Nature of discrepancy**..... .... **Decision taken**..... .... **Sign.**..... **Print**..... When there is a discrepancy, a senior member of staff will follow the adverse incident policy.

DAY SURGERY ESCORT DETAILS

Name..... Address.....

..... Telephone No.....

Time into recovery..... **Conscious state**.....

Time conscious..... **Operation site**.....

Oxygen Therapy..... **Hudson Mask**.....

Nasal Cannula.....

Time transfer..... **Nurse Signature**.....

PROGRESSIVE RECOVERY

Seen by Surgeon YES / NO Anaesthetist YES / NO

Wound Check: Time..... Comments .....

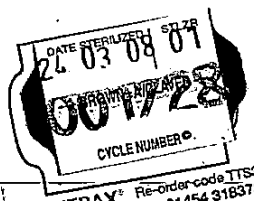
DISCHARGE DETAILS

Post-op Phone Call	Yes ☐	No ☐	Post-op instructions	Yes ☐	No ☐
Observations stable	Yes ☐	No ☐	GP letter given	Yes ☐	No ☐
Tolerating oral fluids	Yes ☐	No ☐	Follow up appointment given	Yes ☐	No ☐
Venflon removed	Yes ☐	No ☐	Community call arranged	Yes ☐	No ☐
Wound site satisfactory	Yes ☐	No ☐	Discharge medication given	Yes ☐	No ☐
Passed Urine	Yes ☐	No ☐			

Date of Discharge ..... Time of Discharge .....

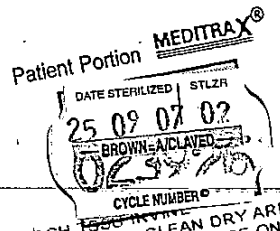
Nurse's Signature .....

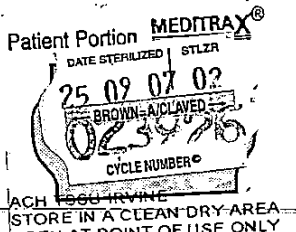
T.s.s.u instrument labels

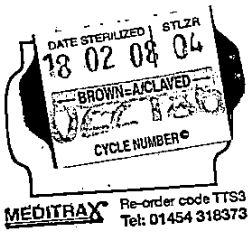


Bone Holding Forcep
XH 04

Orthopaedic
ACHU01531491

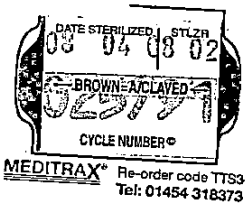






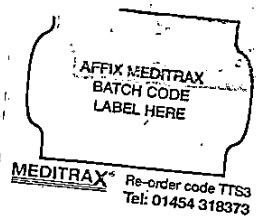
Synthes Wire XH01

Orthopaedic
ACHU01517504



Foot Set XH 06

Orthopaedic
ACHU01537411



Stryker Cordless
Driver 3 XH 01

Orthopaedic
ACHU01534319

PLEASE ATTACH LABEL

S CHI 3108823299
F GREEN LEE
18 BROWN STREET
NEWMILNS
KA16 9AA
31/08/1982 Pract 80260
Case Ref 337455

STA0215

DATE	SURGEON	ANAESTHETIST
PR 13/4/18	Thomas	Robertson

ASSISTANT

OPERATION PERFORMED

Tension Band Wiring of Left Patella

DESCRIPTION OF PROCEDURE

GA Tourniquet applied - Betadine prep - draped free

Midline incision

identified cleared + reduced. - (Distal pole # minor articular impression)

- medial arthrotomy allowed assessment of articular surface - good reduction

2x 2mm K wires.

figure of 8. wire tightened.

Check films printed.

- Wound closed. Right monocryl skin.

- Vaseline / Blue nobo / wool / crepe / Bucksaw splint

Post Op

(1) C/S

(2) Paracetamol + Ice

(3) Plaster Cast Mobile

(4) Non-W Wt Bears

(5) # Clinic 1/52

DRAINS ..... PACKS.....

SPECIAL INSTRUCTIONS TO WARD

Signature .....

Thomas

OPERATION.

JMcC/63195

AYRSHIRE AND ARRAN
HEALTH BOARD

STA0215

...int or attach Label

S/ ..... HCR No.....

(.....

Address .....

.....

Ward/Dept.....

GREEN LEE
27 MILRIG CR.
GALSTON
31-8-82 M/S
DR. NICOLL GALSTON

357455
WARD
DEPT
C/H

DATE	SURGEON	ANAESTHETIST

ASSISTANT

OPERATION PERFORMED

DESCRIPTION OF PROCEDURE

DRAINS..... PACKS.....

SPECIAL INSTRUCTIONS TO WARD

Signature.....

OPERATION

CROSSHOUSE HOSPITAL

Code STA0172

LEE GREEN

5

DATE

10/5/18 Appears well.

Normal vitals

Slight grafting RT Eye to outer canthus

Xray - ok

Signed Nina Green

Obs overnight

SURGICAL

DATE

CROSSHOUSE HOSPITAL

GREEN LEE
27 MILRIG CR.
GALSTON
31.8.42 M/S
DR. NICOLL GALSTON

33/455
WARD
DEPT
C/H

FORM STA0172

DATE	

SURGICAL

DATE

CROSSHOUSE HOSPITAL

Write – Imprint or attach Label

GREEN LEE 33/455
27 MILRIG CR. WARD
GALSTON DEPT
31.8.92 M/S C/H
DR.NICOL L GALSTON

Consultant.....

Ward/Dept.....

Date	CONTINUATION SHEET

MEDICAL PAEDIATRICS

Date

NORTH AYRSHIRE
DISTRICT GENERAL HOSPITAL

Write – Imprint or attach Label

Surname ..... Hosp. No. .....

GREEN I HE
27 MILRTG CR.
GALSTON
31.8.82 M/S
DR. NICOL GALSTON.

337455
WARD
DEPT
C/H

Consultant: .....

Household	Fevers, etc.	Age	Imm.	PREVIOUS AND FAMILY HISTORY	Bth. Wt.
Children:	Diph.				P. Wt.
	Pertussis				P. Ht.
	Tetanus				
	Measles				
	Polio				
	Rubella				
	Mumps				
Adults:	Ch. Pox				
	Sc. Fever				
	B. C. G.			FEEDING	
Rooms:					

Date | Urine

MEDICAL PAEDIATRICS

Date	Urine

NORTH AYRSHIRE
DISTRICT GENERAL HOSPITAL

Consultant .....

Write – Imprint or attach Label

Surname ..... Hosp. No. .....

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

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

Address .....

.....

Ward/Dept. .....

Household	Fevers, etc.	Age	Imm.	PREVIOUS AND FAMILY HISTORY	Bth. Wt.
Children:	Diph.				P. Wt.
	Pertussis				P. Ht.
	Tetanus				
	Measles				
	Polio				
	Rubella				
	Mumps				
Adults:	Ch. Pox				
	Sc. Fever			FEEDING	
	B. C. G.				
Rooms:					

Date

Urine

MEDICAL PAEDIATRICS

Date	Urine

AYR HOSPITAL
EMERGENCY DEPARTMENT

NHS Ayrshire & Arran

A/E No: AYR-18-006246-1

CHI No: 3108823299

Date: 09 Mar 2018 **Time:** 16:19

Consultant: Nicola Bartlett

GREEN

Lee

GP
A FOWDAR

LOUDOUN MEDICAL CENTRE
LOCHORE TERRACE
DARVEL

Incident Date: 09 Mar 2018
Incident Time: 16:19

Marital Status: Single

Date of Birth: 31 Aug 1982 **Age:** 35 Years

Sex: M

Address:
115 WEST MAIN STREET
DARVEL

KA17 0HT

re modify

Next of Kin:
Margaret Mcewan
115 WEST MAIN STREET
DARVEL
KA17 0HT

Mother

Ethnicity: Scottish

Religion: Protestant

Attendances in last 12mths 0

Total Cross Site Attendances Count 14

Phone Numbers:

Mobile: 07748032073

Special case :

Employer/School
tree surgeon Not at School

Accompanied By:
Unaccompanied

Waterlow Score :

Triage Time 16:31 **Triage Nurse** Kathryn Smith **Triage Group** Orange

Resp Rate **02 Sat%** **PFR**

Pulse **BP** /

E **M** **V**

Allergies: Not Known

BMstix **Alcohol** **Temp** **Weight**

R L

Pain Score Triage 10

Pain Score Discharge

Triage details
Left index finger injury - hit with axe, pt describes partial amputation type injury. Well bandaged at triage, wound not visualised.

Treatment
Analgesia outwith PGD

Special Needs
NONE

Re-assess in 15 30 60 minutes

Against Medical advice I decline the treatment offered. I know this may affect my recovery.

Signed..... Witness..... Witness.....

I Hereby Consent To My Self/Child Having

Signed.....

Disch A+E clinic Paed Tr. Fracture Clinic Eye ENT Max Facial Ward OP Ward IP

3108823299

Forename: Lee Surname: GREEN Date : 09 Mar 2018 A/E No. AYR-18-006246-1

Drug	Dose	route	time/frequency	signature	quantity/given by
Co-codamol 30/500	2 TAB	PO	16:30		[illegible] @ 1640.
ORAMORPH	5 MG	PO	if required.		
Tetnus booster (revaxis)	1cpp	IM	17:20.		[illegible]
Co-Amoxiclav	625mg	P/O	3 TABS TDA		[illegible]
co-codamol 30/500	2tab	P/O	6 tabs TDA		[illegible]

Clinical indication:
IV
Urgency
Blood products

- Clean field
- Hand hygiene
- Skin antisepsis
- No touch critical parts
- Dressing dated/timed

PVC Insertion Bundle

	Size/Colour	Location	Initials
PVC1			
PVC2			

Diagnostic Procedures	Device	Flow Rate l/min	% O2 for Venturi	Target SpO2	Prescribed by	Stopped by	Started by
Oxygen / Other							
Changed to							

DOCTOR / ENP: O'Neill Time: 16:44

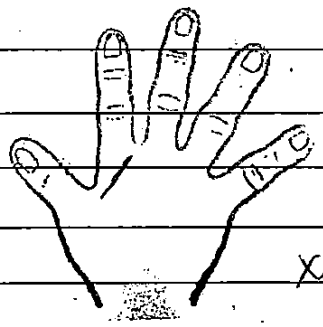
Cut to base of left index finger c axe at approx 15:30. → cutting c axe. "feels finger no longer attached". pain ++. still able to flex + extend finger

PMH - nil NKDA.

no tetnus boosters since school.

Rt hand dominant.

Last ate 13:00 (approx).



3-4cm laceration

cRT <2sec, no sensory disturbance to index finger

↓ flexion, ↓ ROM in index?

↓ pulp tenancy tendons on flexion.

xray → no underlying # identified.

Discussed c ortho ? exam ward wash out + explore, tetnus booster

Dead - Have you notified :- NOK? ☐ GP? ☐ Fiscal? ☐ Police? ☐ Letter? ☐

I give consent for details of my injury to be given to the Police.

Signed.....

ED Dr Xray report

HCI *AYR-18-006245-1*
CHI DOB: 31/08/1982
Sun GREEN Lee
For 115 WEST MAIN STREET, DARVEL
Add KA17 0HT
Dat *3108823299*
STA0213

DATE

09/03/18
18:00

FY2 WIEDMANN - ORTHO ON CALL

(35) Laceration to (L) hand following injury with Axe

Background: (2) knee ORIF

Medications: Nil regular
NKDA

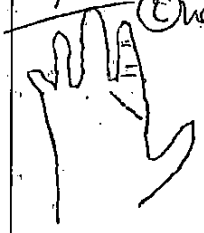
SH: Tree surgeon
Rt hand dominant

Alcohol - 1 litre cider/day
Smokes - 20/day for 20yrs

Chopping wood with axe when injured (L) hand. Pain ++ Intact sensation. Occurred around 15:30. Unable to move finger well.

white area visible tendon ?

O/E (L) hand



laceration 3-4 cm at MCP joint index finger
cap refill < 2 secs
No sensory disturbance
Able to flex finger weakly
Unable to extend finger at all
No pain wrist

X-ray - no obvious #

D/W Registrar William Wilson.

Plan → tetanus
→ co-amoxiclav - oral
→ Bring back tomorrow for possible exploration + wash out.
→ Fast from midnight
→ bloods

FY2 #1097

ORTHOPAEDIC

STA0213

DATE	
10/3/18 0900	WR OBI/FY2 WIEDMANN Laceration over (L) ~~hand~~ index finger MCP joint reviewed. Neurovascularly intact. Suspected extensor tendon rupture +/- MCP joint injury. Risks + benefits explained regarding theatre/surgery + tendon rupture repair explained. Mr Green agrees + understands. Abx cover. FY2 #1092
11/3/18 0904	WR OBI/FY2 WIEDMANN Explained that tendon repair quite right. Injury went into joint - appeared stable. Washed out. Will discuss with Miss Gibson - hand surgeon tomorrow + will update him in terms of the plan. Otherwise plan for (D) today with oral Abx 07748032073 - contact num. NEWS=0 Feels much improved. FY2 #1097

Write or attach label

HCR No: .....

CHI No: .....

Surname: .....

Forename: .....Sex: .....

Address: .....

.....

Date of Birth: .....

STA0213

DATE	WARD ROUND – MR OBI
	LEE GREEN 3108823299
10/03/18	**DIAGNOSIS: LEFT INDEX FINGER LACERATION + EXTENSOR TENDON INJURY** **MANAGEMENT: FOR EXPLORATION AND WASHOUT +/- REPAIR IN THEATRE** This 35 year old right hand dominant self employed tree surgeon struck his left hand with an axe in his yard yesterday. He was seen in the ED, tetanus booster given. He is otherwise fit and well. Clinically he is unable to extend the MCPJ, no distal neurovascular deficit. I have explained that we need to explore this, debride any devitalised tissue and repair the extensor tendon. He was aware of the risks of weakness, re-rupture, stiffness and nerve or vessel damage. NO/CC
	WARD ROUND – MR OBI **LEE GREEN 3108823299**
11/03/18	**DIAGNOSIS: LEFT INDEX FINGER METACARPAL OPEN FRACTURE WITH EXTENSOR TENDON INJURY – WASHOUT EXTENSOR TENDON REPAIR** Mr Green is one day post op. He is comfortable at rest. Intraoperative findings were explained in that the axe had caused the laceration of the extensor tendons to his left index finger in addition to breaching the joint capsule and fracturing the metacarpal neck. It was thoroughly irrigated and debrided, capsule closed, tendons approximated. There was some tightness at the tendons post repair. He is on oral antibiotics and may be discharged today. He is aware that I will discuss his case with my colleague Miss Gibson who is a hand surgeon regarding the nature of the injury, repair and ongoing management. I will update him following the outcome of that discussion. NO/CC

ORTHOPAEDIC

STA0213

DATE

2213.SQ

NHS Ayrshire & Arran

Lee GREEN CHI 3108823299

Write or attach label

HCR No: .....
CHI No: .....
Surname: .....
Forename: ..... Sex: .....
Address: .....
.....
Date of Birth: .....

DATE

SURGEON

Mr Obi

ASSISTANT

Miss Wilson

ANAESTHETIST **Dr Parrish**

10/03/18

OPERATION PERFORMED

Left index finger wound exploration, debridement + extensor tendon repair

DESCRIPTION OF PROCEDURE

Indication – Self-employed tree surgeon, traumatic blunt axe axe wound at work yesterday. No active extension at left index finger MCPJ and overlying ~4cm oblique wound. Supine + armboard, TT – 106mins at 250mmHg, IV antibiotics – 1.5g Cefuroxime. Aqueous betadine prep, upper limb drapes.

Procedure

Findings : ~4cm oblique laceration over Left index finger MCPJ. Extensor digitorum and indicis proximal ends frayed, foreign material in wound, dorsal capsule lacerated, oblique fracture to metacarpal neck. Old scars zone 6/7 dorsally.

Foreign material removed. Wound debrided, devitisalised tissue and non-viable tendon ends excised. Fracture site accessed, opened, bone curretaged. 1L 0.9% NaCl washout to capsule, fracture site and soft tissues. Fracture appeared stable – therefore no internal fixation undertaken. Tendon ends opposed, 4 strand Kessler repair through each with 4/0 prolene. Dorsal reinforcement with 6/0 prolene. 0.9% NaCl washout. Some residual tension on assessing through range post tendon repair, however repair given nature of injury felt to be acceptable.

Closure – 4/0 ethilon, inadine, blue gauze, wool, crepe, splinted in extension.

1. Routine neurovascular observations
2. 24 hours IV abx
3. Aim home tomorrow with 7/7 oral abx
4. Fracture clinic FU for wound check 20/3/18
5. 6 weeks in splint, extensor tendon rehab

DRAINS ..... PACKS .....

SPECIAL INSTRUCTIONS TO WARD

NO/CC

Signature .....

OPERATION

DRS 5964

RECOVERY ROOM INSTRUCTIONS

CHI: 3108823299
Green, Lee
115 West Main Street
Darvel
KA17 0HA
31/08/1982
Dr A Fowdar

Date: 10/3/18 **Anaesthetist:** Dr Parrish

Surgeon: Mr Obi **Anaesthetic:** General

Operation: Exploration + washout + extensor tendon repair.

Theatre No: 4 Time on entering recovery: 1142.

Condition on entering recovery asleep, breathing spontaneously via i-gel + circuit. SpO2 100%.

Airway i-gel expelled in Recovery

Laryngeal mask

E.T.T. x

IV Fluids: discontinued

Peripheral (R) hand

Arterial Line x

CVP x

Naso-gastric x

Oxygen therapy: 9L via circuit → Room Air (would not tolerate O_2).

Drains: x Catheters x Packs: x Stomas x Dressings inadine blue swaps wool crepe backslab.

Drugs given in recovery: Controlled in red.

1	7
2	8
3	9
4	10
5	11
6	12

Condition on leaving recovery.

Patient easily rousable and maintaining airway	(Y)/ N	Oxygen prescribed	Y /(NA)
Respiratory Rate 10-20 per minute	(Y)/ N	IV Fluids prescribed	Y /(NA)
Cardiovascular system stable	(Y)/ N	Wound drain satisfactory	Y /(NA)
Peripheral perfusion adequate	(Y)/ N	Temperature >36	(Y) N
Pain controlled/analgesia prescribed	(Y) N	Discharge NEWS Score 1	HR ↑
Emesis/nausea controlled/prescribed	(Y) N		

Comments: Temp 35.7°C, warm blanket applied. Dressing intact. Patient very unsettled once first awakee, this settled with re-assurrance. Anaesthetist reviewed patient and suggested to remove O_2 mask ~~an~~ which also helped settle patient. Patient comfortable, arm feels heavy from tourniquet however no complaints of pain, Post-op instructions documented. No concerns.

Time of Discharge 1232. Nurse signature SRobertson.

~~CSM sabbi~~ CSM satisfactory.

Ayr Hospital - Orthopaedic Department
ost-Operative Instruction Sheet

AYR-18-006246-1
DOB: 31/08/1982
GREEN Lee
115 WEST MAIN STREET, DARVEL
KA17 0HT
3108823299

Consultant: MR OBI

Diagnosis: Laceration left index MCPJ

Operation: Exploration + washout + extensor tendon repair

Date	Instruction	Signature
10/3/18		

1. **Remove Drains:** 24 hours 48 hours (No Drains)

2. **Position in Bed:** Supine

3. **Antibiotic Prophylaxis:** Antibiotic..... Cefuroxime

   1 Dose (*given*) (*Trauma*) 2 Further Dose (*elective*) Other Durⁿ.(specify).....

4. **DVT Prophylaxis:** AVI Aspirin TED's Fragmin Warfarin

   Rivaroxaban *Time of 1st dose*..... N/A

5. **Mobilisation:** a.) **When:** Immed. 24H 48H Other(Specify)... 4 weeks minimum → as per clinic review

   b.) **Weight Bearing:** Full Partial Touch (Non)

   c.) **Aids:** (As Reqd.) Zimmer Crutches Sticks Other

6. **Removal of Sutures:** Not reqd.

   Time: 5d 7d 10d (12d) 14d

   Place: Ward D/N Clinic

Further Instructions: *(N.B. Please affix implant stickers to backside of this form)*

Continue 2/52 of cefuroxime
Splint until # clinic review

Discharge: tomorrow after ward round (11/3/18 MR OBI)
On:
When:

Follow-Up		
Clinic	Day	No. Weeks / Date
(# Clinic)	Mon	20/3/18
Review Clinic Ayr	(Tue)	
EACH	Wed	X-Ray On-Arrival?
Arran Clinic	Thu	Yes / (No)
Hand Clinic	Fri	
Telephone Review		

Post-op X-rays ?	Yes	(No)
When required?		
X-ray to request		
Signature *Required.*		MR OBI SR

AYR-18-006246-1

DOB: 31/08/1982
GREEN Lee
115 WEST MAIN STREET, DARVEL
KA17 0HT

3108823299

NHS Ayrshire and Arran

Pre Operative Correct Site and Patient verification

Station..... LD Date..... 16/3/18 Theatre.....

Proposed Operation..... LEFT KNEE WASH OUT. FASCIOTOMY.....

Prescribed Pre medication: Time given. N/A .....Fasted from: time. midnight.

Check 1

- ☑ Check patient identity
- ☑ Check all relevant documentation/results
- ☑ Images to ascertain intended surgical site
- ☐ Intended site marked with indelible pen
- ☐ Decision not to mark - state reason below

Surgeon

In the event of this section being incomplete-Reception nurse to communicate with theatre staff to establish action to be taken

Signature.....

Print.....

Check 2-3	Station/DSU			Rec/Recovery			Theatre		
	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
Operation site marked	✓			✓			✓		
Case notes/profile	✓			✓			✓		
Identification bracelet	✓			✓			✓		
Consent form signed	✓			✓			✓		
AWI consent signed			✓			✓			✓
Patients labels included	✓			✓			✓		
X-Rays/Images		✓			✓			✓	
Lab results / Bloods			✓	✓			✓		
INR Coag Status			✓			✓			✓
Blood X matched			✓			✓			✓
E.C.G if applicable			✓			✓			✓
Pregnancy test if applicable			✓			✓			✓
Urinalysis abnormalities		✓			✓			✓	
Allergies		✓			✓			✓	
Caps/crowns/loose teeth/Dentures		✓			✓			✓	
Catheter in situ		✓			✓			✓	
Hearing aids		✓			✓				
Rings taped/piercings taped		✓				✓			✓
Jewellery/Contact lenses		✓			✓			✓	
Internal metalwork Site: (L) KNEE	✓			✓			✓		
Pre op shower			✓						
Nail polish			✓						
Paper pants	✓								
Pad/tampon			✓						

Any other relevant information.....

	Dose given			Time given		
Anticoagulants - LMWH						
other						

Station Nurse(signature) ..... Print. M. MURDOCH Designation. SN

Reception Nurse(signature) S Robertson Print. Sophie Robertson Designation. SN

Anaesthetic Nurse(signature)..... Print..... Designation.....

NHS Ayrshire and Arran
Day Surgery Unit/Ward
Pre operative, Correct Site and Patient verification

Check 4 Surgical marking and patient verification Theatre:	Signature of Operating Surgeon or Senior member of Theatre team to confirm check was conducted	Surgeon to complete sign if discrepancy has been identified
Surgical, Anaesthetic and Theatre team prior to commencement of surgery **should pause for verbal briefing to confirm the following** ☐ Correct Patient ☐ Consent form correct and signed by the patient and clinician ☐ Correct operation ☐ Operation site marked ☐ Availability of required image studies plus pathology results especially those confirming malignancy	**Sign** ..... **Print** ..... **Designation** ..... **Time** 9.51 **Date** 10/3/18	**Nature of discrepancy** .... **Decision taken** .... **Sign**..... **Print**..... **Designation**..... When there is a discrepancy, a senior member of staff will follow the adverse incident policy

- If failure of any pre operative check occurs, the surgeon in charge must assess the situation and either return the patient to the ward/day surgery area or note and sign a decision to proceed at risk.
- If the patient is returned to the ward/day surgery area, a patient safety incident report form must be completed in line with local governance procedures.
- A senior member of staff must offer an explanation and apology.
- If surgery is carried out at the incorrect site, a full root cause analysis of events is recommended.

NHS
Ayrshire & Arran

DOB: 31/08/1982
GREEN Lee
115 WEST MAIN STREET, DARVEL
KA17 0HT

Consent for Operation

PROCEDURE: EXPLORATION LEFT HAND WOUND + REPAIR EXTENSOR TENDONS TO INDEX FINGER +/- PINNED

PURPOSE OF PROCEDURE: Wound

SIDE OF PROCEDURE: LEFT / RIGHT / BOTH / NOT APPLICABLE

A: Statement of health professional

I confirm I am a health professional with an **appropriate knowledge of the proposed procedure** as specified in the Board's consent policy. I have explained the procedure to the patient. In particular, I have explained:

a) ☑ the proposed approach

b) ☑ the intended benefits of the procedure

c) ☑ the possible risks of the procedure (including those specific to the patient).

d) ☐ the benefits and risks of any alternative treatments (including no treatment) and any particular concerns of the patient.

e) any additional procedures that might become necessary during surgery. Commonly this would include:

☐ Blood transfusion ☐ Other procedure (please state)

.....

.....

.....

NB. If blood transfusion is declined, please also complete a refusal of blood transfusion form.

I have provided an information leaflet to explain the benefits and risks of, and alternatives to the proposed treatment.

Yes ☐ Leaflet title: ..... Leaflet version no.: .....

No ☑ It is the health professional's responsibility to document the benefits, risks and alternatives explained to the patient.

Infection
Nerve / Vessel Damage
Stiffness
Failure of repair / re-rupture

☑ In my view, this patient has capacity at this time to consent to this procedure.

Where the clinician has doubts about capacity, please refer to the consent policy for guidance on Adults with Incapacity, and section 47 certificate of incapacity.

Consultant or other responsible health professional

It is the responsibility of the doctor undertaking the procedure to personally seek patient consent. In the unusual event that this is not practical, the responsibility can be delegated to another professional, but that individual must be suitably trained and qualified, have sufficient knowledge of the proposed investigation or treatment, understand the risks involved and act in accordance with the Board's consent policy.

As the health professional explaining this procedure, please confirm:

☑ I am fully familiar with the procedure, its risks, benefits and alternatives.

Signed (health professional): ..... Date: 10/3/18

Name (PRINT): Wallis Time (24 hr): .....

Designation: ST1 GMC/GDC/NMC number: 7136128

NHS
Ayrshire
& Arran

Consent for Operation

CHI: 3108823299
Green, Lee
115 West Main Street
Darvel
KA17 0HA
31/08/1982
Dr A Fowdar
Sex:

B. Consent of patient, parent or guardian

I understand the information given to me, including the risks, benefits and alternatives to this operation. The information has been discussed with me, and my questions have been answered in a way I could understand. I accept that the doctor has told me:

- ☑ my expected outcome and the risks of having the operation.
- ☑ the benefit this operation may bring to me, but also that this cannot be guaranteed even though performed with professional care.
- ☑ other relevant treatment options and their associated risks.
- ☑ that an appropriately qualified doctor, undergoing further training, may perform the operation.
- ☑ that I have the right to change my mind at any time before the operation, including after I have signed this form.

If an emergency occurs, I may require other procedures, but these will only be carried out to save my life or to prevent serious harm to my health. I have listed below any procedures that **I do not wish to be carried out without further discussion:**

☐ Blood transfusion ☐ Other procedure (please state)

.....

.....

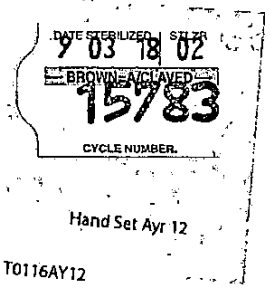
NB. If blood transfusion is declined, please also complete a refusal of blood transfusion form.

I understand the benefits, risks and alternatives that have been explained to me, and I agree to the operation.

Signed (patient/parent/guardian): ..... Date: 10/3/18.

Name of patient/parent/guardian (PRINT): .....

atient: .....



Orthopaedic
ACHU03110098

C. Confirmation of consent (for use on day before or day of surgery)

Confirmation of consent is only mandatory, when the original consent was signed by the patient >84 days before the date of the operation.

On behalf of the team treating the patient, I have confirmed with the patient that he/she has no further questions and wishes the procedure to go ahead.

Consultant or other responsible health professional

Signed (health professional): ..... Date: .....

Name (PRINT): ..... Time (24 hr): .....

Designation: ..... GMC/GDC/NMC number: .....

Patient

Signed (patient/parent/guardian): ..... Date: .....

Name of patient/parent/guardian (PRINT): .....

Relationship to patient: .....

Anaesthetic Record

Elective	
Scheduled Urgent	
Urgent	
Emergency	✓

Proposed procedure:

(L) hand flexor + tendon repairs.

Consent form signed	Y / N
Incapacity form	Y / N
Fasted	Y / N
SASM Consultant:	
Informed	Y / N

Write or attach label

HC
CH CHI: 3108823299
Sur Green, Lee
For 115 West Main Street
Ad Darvel
..... KA17 0HA
Dal 31/08/1982
Dr A Fowdar

Preoperative Assessment: Assessor: D. PARRISH Date: 10/05/18 Location: RAH ASA Grade: 2

History

Previous GA: No issues.

FH: nil.

CVS: nil

Exercise Tolerance: good.

Resp: good AE. chest clear.

Reflux: No

Smoking: YES

Alcohol & Recreational Drugs: YES YES - CANABUS.

Recent Medication

2

Allergies: none known.

Examination

Mouth opening: good

Teeth: ORL.

HR

BP

Weight

Height

BMI

Hb

WCC

Plats

Urea

Creat.

Na

K

ECG

CXR

OTHER:

Discussed:

Fasting	☑	Failure	☐
Premed	☐	Hypotension	☐
Induction	☑	Headache	☐
Analgesia	☑	Numbness	☐
Suppositories	☐	Urine Retention	☐
Monitoring:	☑	Nerve Damage	☐
Other		L.A. Toxicity	☐
		Patient agrees	Y / N
		Handout	Y / N
		Other	

Regional Block: Complications discussed pre-operatively

Preoperative Instructions

Fasting: Time
As Protocol ☐
Light breakfast
Fluids - allow:
still juices / water till:

Usual Medicines: Unless otherwise instructed give all medicines except insulin, oral hypoglycaemics and anticoagulants.
Give all except:
Give only:

Premedication drugs: Date Time
Signed:
Given at / by

Operation done:

Date: 10.03.18. Location: TH4 SM. Start time: End time:

Surgeon(s): MR OBI

Anaesthetic Assistant: Andy Smith.

Anaesthetist(s): DR PARRISH

Grade: CONSULTANT GMC No. 6109597

Remarks

Uneventful ☐ Significant events / Critical incidents Hazard warnings

Effect of premed

STA0093

ANAESTHETIC RECORD

Monitoring				Checks				Ventilation		Access		Induction
ECG	✓	Boots		Anaesthetic Machine				Circuit		Site of Cannula	Size	IV.....Gas.....Pre O_2 RSI.....
NIBP	✓	Fluid Warmer	✓	Anaes room	✓	Theatre	✓	Circle	✓	Rt.	18G	Face Mask Anaesthetic
SpO_2	✓	Warm Air		Position:				Bain		.....	.....	Airway Oral.....Nasal.....
$ETCO_2$	✓	Padded Mat		Supine.				T Piece		.....	.....	LMA: Size.....Type.....
F_iO_2	✓	TED Stocks		Pressure Care			✓	HME Filter		A Line	Site	ETT: Size.....Cuff.....
NMT		Tourniquet Press. Time		Eye Care			✓	Ventilation				Type.....
ET Agent	✓			Throat Pack	In	Out		Pressure Cont		CVP	Site	Laryngoscopy grade.....
Temp.				Thromboprophylaxis				Volume Cont				Notes:
Urine Cath.				Antibiotic	Dose	Time		Spont. Resp.		Insertion Notes:		
CVP				Cefuroxime	1.5g			Press Sup.	✓			
IBP								Manual IPPV				

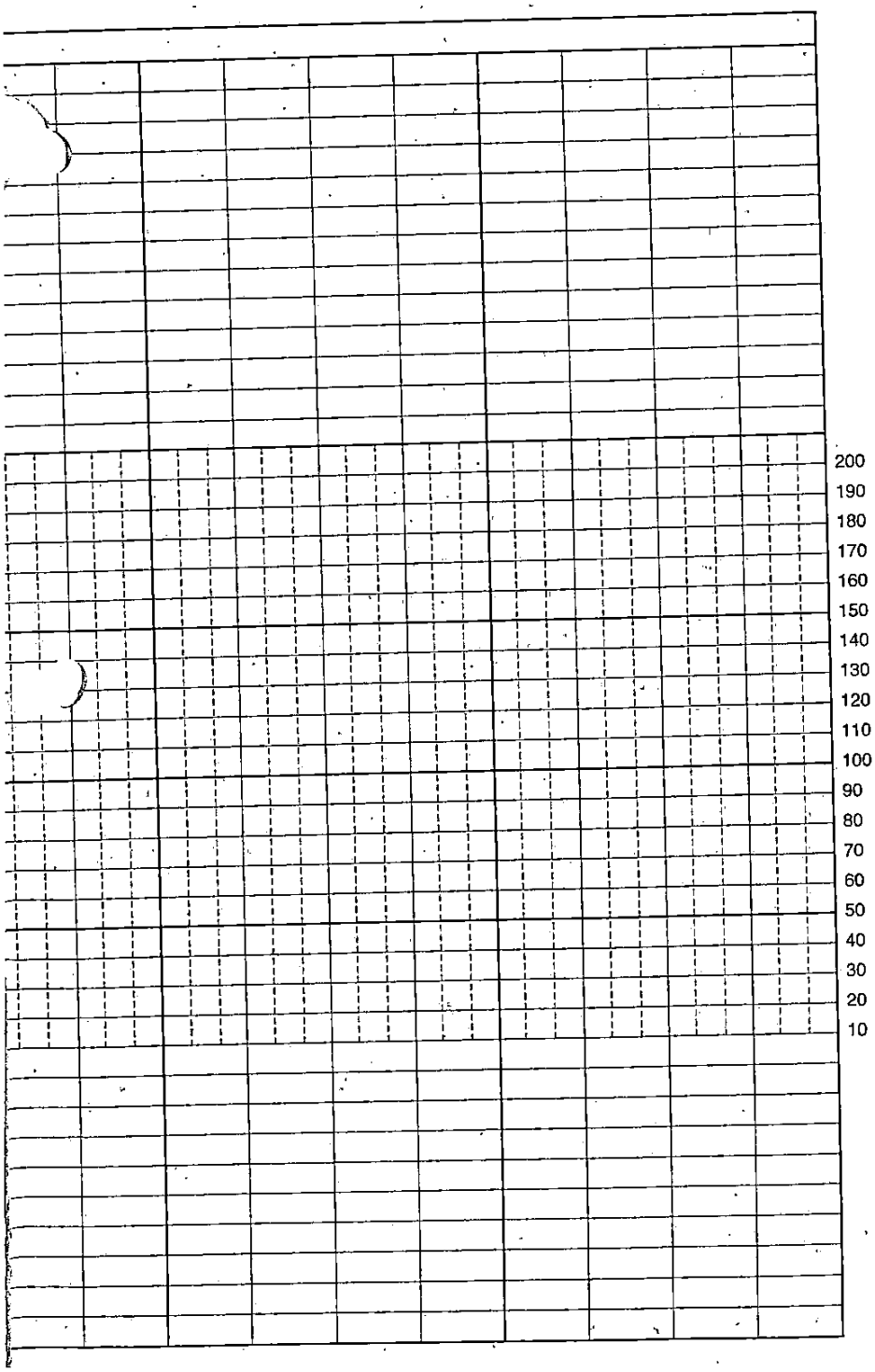
Drugs	Time	9:30	10.	30	11	30	12	30
ONDANSETRON		8mg						
FENTANYL		100µg						
PROPOFOL		250mg		+100				
KETAMINE						50mg		
OXYCODONE							10mg	

		9:30	10.	30	11	30	12	30
S_pO_2		99	99	99	99	99	99	99
$ETCO_2$		6.1	5.3	5.6	5.6	5.3	5.4	5.4
ET Agent		2.0	2.3	2.4	2.4	2.4	2.4	2.4
f_iO_2		0.42	0.4	0.4	0.4	0.4	0.4	0.4
Fluids		(1)						
Blood Loss								
Urine Output								

O_2 ☑ N_2O ☐ Air ☑ Sev ☑ Des ☐ Iso ☐ Halo ☐ Others ☐

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

Regional & Local Anaesthetic Techniques		Notes & Events
Spinal ☐	Notes	
Epidural ☐		
N. Block.....		
Wound Infiltration ☐		
Full Aseptic ☐		
Entry Site:.....		
Needle Used:.....		
Catheter: Y / N		



	Fluid In	Vol.
(1)	CSL	1000 l

Events	Time

Blood Loss	

Postoperative Instructions:

Reviewed by

Routine monitoring & care

O_2 4 l/min till awake or.....hrs

Humidified O_2 % as required to maintain O_2 Sat > 95%

~~Morphine~~ Oxycodone 1mg/ml IV up to 10mg as required for pain in recovery YES Signed.....

Paracetamol 1g IV in recovery if required for pain YES Signed.....

Ondansetron 4mg IV in recovery if required for nausea YES Signed.....

Cyclizine 50mg IV in recovery if required for nausea YES Signed.....

IV fluids as charted ☐ Special instructions

Drug therapy as charted

Sign off completed chart

Time	Recovery Notes	Drugs

GREEN, LEE ID:3108823299 09-DEC-2024 18:49:16 NHS AYRSHIRE & AARAN-ED C ROUTINE RECORD

41 YUG 1982 (42 yr)
Male
Room:
Loc:107

Vent. rate	84	BPM	Normal sinus rhythm with sinus arrhythmia
PR interval	152	ms	Normal ECG
QRS duration	92	ms	No previous ECGs available
QT/QTc	360/425	ms	
P-R-T axes	63 19	39	

Technician:
Test ind:

location: comments: comments: Unconfirmed

I aVR V1 V4

II aVL V2 V5

III aVF V3 V6

VI

II

V5

25mm/s 10mm/mV 50Hz 9.0.10 12SL 243 CID: 603 SID: 561167 EID: 13 EDT: ORDER:

UREA AND ELECTROLYTES Cumulative

Number	**LATEST 3 of 3**	2 of 3	1 of 3	Ref. Range (Units)
Collected	**09-Dec-24 20:20**	23-Aug-21 10:10	09-Mar-18 00:00	
Source	Revive	Revive	Revive	
Urea	4.6	4.4	4.5	2.5-7.8 (mmol/L)
Creatinine	80	85	83	50-120 (µmol/L)
Sodium	139	139	141	133-146 (mmol/L)
Potassium	4.0	4.1	3.8	3.5-5.3 (mmol/L)
Chloride	103	101	104	95-108 (mmol/L)
eGFR result/1.73m2	>60	>60	>60	60-61 (mL/min)

Graph No tests selected

* Abnormal ** Critically Abnormal § Units or Reference Range differs

TROPONIN T (HS)

Patient ID	3108823299:OHCP	**Patient Name**	GREEN, Lee
Sex	Male	**Date Of Birth**	31-Aug-1982
Collected	09-Dec-2024 20:20	**Order Number**	0024B654958
Ordering Provider	Unknown Clinician	**Status**	Final

Test Name	Result	Ref. Range (Units)	Abnormality	Status
Troponin T (HS)	4	0-13 (ng/L)		Final

* Abnormal, ** Critically Abnormal

FULL BLOOD COUNT Cumulative

Number	**LATEST 3 of 3**	2 of 3	1 of 3	Ref. Range (Units)
Collected	**09-Dec-24 20:20**	23-Aug-21 10:10	09-Mar-18 00:00	
Source	Revive	Revive	Revive	
RBC	5.02	5.55	4.71	4.32-5.66 (10^{12}/L)
Monocytes	0.6	0.6	0.9	0.2-0.9 (10^{9}/L)
Haemoglobin	160	*** 180**	149	133-176 (g/L)
White Cell Count	*** 10.3**	9.5	*** 11.3**	3.7-9.5 (10^{9}/L)
Platelets	308	297	266	150-400 (10^{9}/L)
Haematocrit	0.43	0.50	0.41	0.39-0.5 (%)
MCV	86	90	87	82-98 (fL)
MCH	31.9	32.4	31.6	27.3-32.6 (pg)
MCHC	*** 370**	*** 362**	*** 363**	316-349 (g/L)
Neutrophils	*** 6.9**	6.1	*** 8.6**	1.5-6.5 (10^{9}/L)
Lymphocytes	2.5	2.2	1.7	1.1-5 (10^{9}/L)
Eosinophils	0.1	0.5	0.1	0.1-0.7 (10^{9}/L)
Basophils	0.1	0.1	0	0-0.1 (10^{9}/L)

Graph No tests selected

* Abnormal ** Critically Abnormal § Units or Reference Range differs

GLUCOSE

Patient ID	3108823299:OHCP	**Patient Name**	GREEN, Lee
Sex	Male	**Date Of Birth**	31-Aug-1982
Collected	23-Aug-2021 10:10	**Order Number**	0021B355980
Ordering Provider	Dr Ajay Fowder	**Status**	Final

Test Name	Result	Ref. Range (Units)	Abnormality	Status
Glucose	4.9	3.3-6 (mmol/L)		Final

* Abnormal, ** Critically Abnormal

C-REACTIVE PROTEIN Cumulative

Number	**LATEST 2 of 2**	1 of 2	Ref. Range (Units)
Collected	**23-Aug-21 10:10**	09-Mar-18 00:00	
Source	Revive	Revive	
CRP	<5	<5	2-10 (mg/L)
Graph	No tests selected		

* Abnormal ** Critically Abnormal § Units or Reference Range differs

URINE CULTURE

Patient ID	3108823299:OHCP	**Patient Name**	GREEN, Lee
Sex	Male	**Date Of Birth**	31-Aug-1982
Collected	23-Aug-2021 10:45	**Status**	Final
Received	24-Aug-2021 09:36	**Ordering Provider**	Dr Ajay Fowder
Reported	24-Aug-2021 09:36	**Order Number**	0021M252107
Source System	Revive		

Culture

**********Microbiology results should be viewed on Review or PMS to prevent misinterpretation.** Microbiology reports do not format correctly on Clinical Portal or Revive. Antimicrobial susceptibilities may appear out of alignment. Comments relevant to this sample may appear in a different tab.**********

No growth

Organisms (0)

XR Finger Middle Rt

Patient ID	3108823299:OHCP	**Patient Name**	GREEN, Lee
Sex	Male	**Date Of Birth**	31-Aug-1982
Performed	10-Mar-2026 14:59	**Order Number**	AA15164509001
Ordering Provider	Hunter (ANP Loudoun)	**Status**	Final

General

Final

: Patient Name: Lee, Green
: Patient Address: 4 B/R , KA17 0JL
: DOB: 31/08/1982
: Patient ID: 3108823299
: Accession Number: AA15164509001
: Referring Cons: Lisa Hunter (ANP Loudoun)
: Referring Dept: GP
: Visit Type: GP
: Site: University Hospital Crosshouse

: 51645090 10/03/2026 XR Finger Middle Rt
: _

: Clinical Indications
: NMR under supervision of Dr Louden - 43 year year old with lump on his right middle finger for around 1 year. Growing in size and pain. Works with chainsaw and right handed so this is causing some issues at work. Firm, lump appreciated. ?Bone spur

: Report
: No significant bone or joint abnormality. No radiopaque foreign body.

: Singh, H (Cons Radiologist 7134306)

: Reported by: Dr Henna Singh (Radiologist)
Reported By: Henna Singh
Released By: Henna Singh

XR Thumb Rt

Patient ID	3108823299:OHCP	**Patient Name**	GREEN, Lee
Sex	Male	**Date Of Birth**	31-Aug-1982
Performed	02-Sep-2025 11:33	**Order Number**	AA15143873001
Ordering Provider	Dr William Wilson	**Status**	Final

General

Final

:
:
:
: Report
: To comply with the Ionising Radiation (Medical Exposure) Regulations 2017, this examination requires a report. Under certain instances the referring clinician has agreed to record their evaluation in the patient's clinical notes, thus complying with these regulations. If such evaluation is not possible the referring clinician must request a radiologist's report through the Diagnostic Imaging Manager.
:
: Medical Imaging Department
:
: Reported by: AUTO REPORT
Reported By:AUTO REPORT
Released By:AUTO REPORT

XR Thumb Rt

Patient ID	3108823299:OHCP	**Patient Name**	GREEN, Lee
Sex	Male	**Date Of Birth**	31-Aug-1982
Performed	25-Aug-2025 11:27	**Order Number**	AA15143165701
Ordering Provider	Jayne McLaren	**Status**	Final

General Final

: Patient Name: Lee, Green
: Patient Address: 115 East Main Street, KA17 0HA
: DOB: 31/08/1982
: Patient ID: 3108823299
: Accession Number: AA15143165701
: Referring Cons: Jayne McLaren (Cons)
: Referring Dept: XH ED
: Visit Type: A\T\E
: Site: University Hospital Crosshouse

: 51431657 25/08/2025 XR Thumb Rt
: _

: Clinical Indications
: hyperextend thumb when a piece of timber fell. tender over phalanx and 1st Mc. ?# NMR1MSK

: Report

: Right thumb

: There is the appearance of mild radial subluxation of the proximal phalanx and at the metacarpophalangeal joint which raises suspicion of an ulnar collateral ligament injury.
: No fracture is seen.

: Frew, N (Rep.Radiographer RA49336)

: Reported by: Natalie Frew (Reporting Radiographer)
Reported By: Natalie Frew
Released By: Natalie Frew

General

Performed
16-Jul-2019 12:57
Ordering Provider
(Medica) Jones
Order Number
A103755585301
Status
Final

Final**General**

:
: 16 July 2019, 12:57:00
: 16 July 2019, 12:57:00
:
: RADIOLOGY REPORT
: CHI NUMBER: 3108823299 Examination Number: 37555853 Examination Date: 16/07/2019
: Name: Green, Lee DOB: 31/08/1982
: Address: 115 East Main Street, , Darvel, KA17 0HA -- CC: -
: Referring Department / Location: Ayr A&E
:
:
:
:
:
: Referring Consultant: Dr M McNaught Clinical Specialty: Accident & Emergency
: Date Dictated: 04/08/2019 Typed by: None
: Examination: XR Orbits
:
: Clinical Indication
:
: Pentrating eye injury, nail. ? any metal fragments
:
:
: Report:
: Date of Examination: 16/7/2019
:
: Name of Procedure and Technique: Orbits
:
: Findings: No bony injury. No radiopaque foreign body demonstrated within the orbits.
:
: Report Date: 4/8/2019
:
: Reporting Radiographer : Amanda Jones
:
: RA31716 : Medica Reporting Ltd
:
:
: Dictating Radiologist / Clinical Specialist (Medica) Jones, A (RA31716)
:
: Verified by: (Medica) Jones, A (RA31716)
Reported By: A (RA31716) (Medica) Jones
Released By: A (RA31716) (Medica) Jones
Released On: 05/08/2019 08:09

Report History

1. **Final Report** from **Revive**7 years ago

Access History

General

Performed
09-Mar-2018 16:54
Ordering Provider
Blower.Caroline (Con Radiographer)
Order Number
A103611555801
Status
Final

Final**General**

```
:
: 09 March 2018, 16:54:00
: 09 March 2018, 17:05:00
:
: RADIOLOGY REPORT
: CHI NUMBER: 3108823299   Examination Number: 36115558   Examination Date:
09/03/2018
: Name:   GREEN, LEE James  DOB:  31/08/1982
: Address:  115 WEST MAIN STREET, , DARVEL, KA17 0HT -- CC: -
: Referring Department / Location: Ayr A&E
:
:
:
:
:
: Referring Consultant:   Bartlett, Nicola (Consultant)        Clinical
Specialty:   Accident & Emergency
: Date Dictated: 10/03/2018                    Typed by:  None
: Examination:  XR Hand Lt, XR Finger Index Lt
:
: Clinical Indication
:
: laceration to base of left index finger from axe, ? #
:
:
: Report:
: Artefact from bandage noted.
: There is irregularity at the index finger metacarpal head which may
represent a sesamoid bone however an un-displaced fracture is not entirely
excluded and if there is ongoing clinical concern repeat images without the
artefact are suggested for better evaluation.
:
: Dictating Radiologist / Clinical Specialist    Blower.Caroline (Con
Radiographer)
:
: Verified by: Blower.Caroline (Con Radiographer)
Reported By: Blower.Caroline (Con Radiographer)
Released By: Blower.Caroline (Con Radiographer)
Released On: 12/03/2018 09:12
```

Report History

1. **Final Report** from **Revive** 8 years ago

Access History

Patient ID	3108823299:OHCP	**Patient Name**	GREEN, Lee
Sex	Male	**Date Of Birth**	31-Aug-1982
Performed	20-Dec-2016 13:16	**Order Number**	AA13483996001
Ordering Provider	(Medica) Dr S Forbat	**Status**	Final

General

Final

:
: 20 December 2016, 13:16:00
: 20 December 2016, 13:21:00
:
: RADIOLOGY REPORT
: CHI NUMBER: 3108823299 Examination Number: 34839960 Examination Date: 20/12/2016
: Name: Green, Lee DOB: 31/08/1982
: Address: 115 West Main Street, Darvel, Ayrshire, KA17 0HA -- CC: -
: Referring Department / Location: KONDOL ANTONI
: DARVEL CLINIC
: LOCHORE TERRACE
: DARVEL
: AYRSHIRE
: KA17 0HD
: Referring Consultant: GP Requestor
: Date Dictated: 23/12/2016 Typed by: (Medica) Dr S Forbat
: Examination: XR Chest
:
: Clinical Indication
:
:
:
:
: Report:
: Clinical history.
: 4 months of dry cough. 30 years history of smoking. Chest clear.
:
: The heart size is normal.
: The lungs are clear.
: The mediastinal contours are within normal limits.
:
:
: Dictating Radiologist / Clinical Specialist (Medica) Dr S Forbat GMC 3067985
:
: Verified by: (Medica) Dr S Forbat
Reported By: (Medica) Dr S Forbat
Released By: (Medica) Dr S Forbat
Released On: 21/02/2017 14:30

Our purpose

Working together to achieve the healthiest life possible for everyone in Ayrshire and Arran

NHS Ayrshire & Arran

Nan

DOB: 31/08/1982

CHI GREEN Lee
115 WEST MAIN STREET, DARVEL
KA17 0HT

PATIENT PROFILE

Please complete below when patient is admitted or transferred to your clinical area

	Admission		Transfer 1		Transfer 2		Transfer 3	
Hospital	AYR							
Ward	5T10							
Consultant	OBI							
Date / Time	10/3/18 0805							
Relative Informed	(Yes)	No	Yes	No	Yes	No	Yes	No
ID Band in situ	(Yes)	No	Yes	No	Yes	No	Yes	No
Completed By - Signature	[signature]							

The Patient Profile can be used for patients with ongoing regular treatment i.e. for a course of therapy or weekly blood transfusion, however if there is a gap of more than 6 weeks since last attendance repeat lifestyle assessment (p15).

If the patient is readmitted into UHC or UHA an additional MRSA/CRA (p20) must be completed. Additional forms can be obtained from the infection control AthenA site.

This profile can also be used for readmission within 3 days.
Please remember to review earlier risk assessments.

Property handed over for safe keeping

PLACE VALUABLES STICKER HERE

Our values

Caring Safe Respectful

Clinical Team Signatures

All staff completing the documentation **must** complete this section

Write or attach label
HCR No:
CHI No:
Surname:
Forename: Sex:
Address:
Date of Birth

Name (BLOCK CAPS)	Profession	Ward/ Page No	Signature	Initials
MICHELLE MURDOCH	SN	STN		MM
J. FRANCIS	SN	ST10		JF
V. JAMIESON	SN	ST10	V. Jamieson	VJ
KAITLYN VAIR	STN	#Clinic		KV

Colour codes for sections within

Risk Assessment	Lifestyle Assessment
Personal Details	Patient/Family Communication
Care Plans	MDT, Discharge Plan
Ward Round Instructions	Nursing Care Evaluation
MDT Communication	

SCN - Senior Charge Nurse DCN - Deputy Charge Nurse RN - Registered Nurse AHP - Allied Health Professional
STN - Student Nurse HCA - Health Care Assistant HCSW - Health Care Support Worker

Abbreviations

This abbreviation list has been approved for use by NHS Ayrshire & Arran

ANP	Advanced Nurse Practitioner	ICES	Intermediate Care and Enablement Services
ABG	Arterial Blood Gas	ICU	Intensive Care Unit
BM	Blood Glucose Monitoring	IM	Intramuscular
BMI	Body Mass Index	INR	International Normalised Ratio
BO	Bowels Open	IV	Intravenous
BP	Blood Pressure	LFTs	Liver Function Tests
CABG	Coronary Artery Bypass Graft	L+S BP	Lying and Standing Blood Pressure
CAU	Combined Assessment Unit	MAR	Medication Administration Record
CCU	Coronary Care Unit	MEWS	Modified Early Warning Score
CDI	Clostridium Difficile Infection	MHC	Medical High Care
CDU	Clinical Decisions Unit	MI	Myocardial Infarction
CHI	Community Health Index	MRI	Magnetic Resonance Imaging
CKD	Chronic Kidney Disease	MRSA	Methicillin Resistant Staphylococcus Aureus
CLD	Criteria Led Discharge	MSSU	Mid Stream Specimen of Urine
CLDT	Community Learning Disability Team	MUST	Malnutrition Universal Screening Tool
COPD	Chronic Obstructive Pulmonary Disease	NAD	No Abnormalities Detected
CPR	Cardio Pulmonary Resuscitation	NBM	Nil By Mouth
CRP	C - Reactive Protein	NG	Nasogastric
CSU	Catheter Specimen of Urine	NOF	Neck of Femur
CSW	Clinical Support Worker	O2	Oxygen
CT	Computerised Tomography	OT	Occupational Therapist
CVC	Central Venous Catheter	PEG	Percutaneous Endoscopic Gastrostomy
DOB	Date of Birth	PICC	Peripherally Inserted Central Catheter
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation	PMH	Past Medical History
ECG	Electrocardiogram	PN	Parental Nutrition
ED	Emergency Department	PVC	Peripheral Vascular Catheter
EDD	Estimated Date of Discharge	SP02	Saturation of Peripheral Oxygen
ERCP	Endoscopic Retrograde Cholangiopancreatography	SBAR	Situation Background Assessment Recommendations
ERT	Emergency Response Team	SC	Subcutaneous
ESBL	Extended Spectrum Beta Lactamase	SLT	Speech and Language Therapy
ESR	Erythrocyte Sedementation Ratio	TFTs	Thyroid Function Tests
FBC	Full Blood Count	USS	Ultra Sound Scan
GP	General Practitioner	U&Es	Urea and Electrolytes
H@N	Hospital at Night	UTI	Urinary Tract Infection
HAI	Healthcare Associated Infection	WCC	White Cell Count
HDU	High Dependency Unit	WZF	Wheeled Zimmer Frame

Personal Details

Prefers to be known as: LEE	Age: 35
Receiving Consultant: MR OBI	Allocated Consultant:
From where: HOME	Accompanied by:
Emergency ☑ Elective ☐	Patients telephone number:
	Patients mobile number:

Write or attach label

HCR No:.....
CHI No:.....
Surname:.....
Forename:..... Sex:.....
Address:.....
.....
Date of Birth.....

GP Name: _____
GP Address: _____
_____

Reason for Admission	Next of Kin/First contact/Significant other
LACERATION LEFT HAND ? TENDON DAMAGE FOR EXPLORATION + WASHOUT.	Name: MARGARET MCEWAN Address: Relationship to patient: MUM Contact No(s) Home: 07514234594 Mobile: Aware of admission Yes ☐ No ☑ Contact overnight Yes ☐ No ☑ Consent to share information with significant other listed: Yes ☑ No ☐
Patients Account of Reason for Admission	**Second contact/significant other**
HIT HAND WITH AXE AT WORK 9/3/18.	Name: Address: Relationship to patient: Contact No(s) Home: Mobile: Aware of admission Yes ☐ No ☐ Contact overnight Yes ☐ No ☐
Specific Alerts	**Specific Alerts**
Previous known MRSA Yes ☐ No ☑ Ensure risk assessment completed Clostridium Difficile Yes ☐ No ☑ ESBL Yes ☐ No ☑ Other infectious conditions? Yes ☐ No ☑ Specify:	Drug Allergies: Other allergies (food, latex, etc) None known ☑

Observation on admission		+ ++ +++ ++++	+ ++ +++	+ ++ +++ ++++	+ ++ +++	-ve +ve
Urinalysis	NAD ☐	Protein Trace	Blood Trace	Glucose Trace	Leucocytes Trace	Nitrates
MSSU collected?			Yes ☐	No ☐	Date.....	

Glucometer Reading: Yes ☐ No ☐ Result:.....	Date Last Menstrual Period (if appropriate)	Pregnancy Test (if appropriate) +ve ☐ -ve ☐

Pain Score	low						severe				
	0	1	2	3	4	5	6	7	8	9	10
For patients with cognitive impairment please refer to Abbey pain scale											

Previous medical, surgical and mental health history

Details	Date (if Known)	Details	Date (if Known)
ORIF (L) KNEE			

Medications

Any important information regarding medications.....

Own medication retained on ward Yes ☐ No ☐ Where stored.....

Have the medications been returned to relatives? Yes ☐ No ☐ ☐ N/A

Please complete below when patient is admitted or transferred to your clinical area

	Ward:		Ward:		Ward:	
Verbal information given to patient and / or relatives:	Date:		Date:		Date:	
	Yes	N/A	Yes	N/A	Yes	N/A
Call buzzer If patients unable to use buzzer ensure this is reflected in care planning	✓					
Toilets / Bathroom	✓					
Explained Protected Mealtimes	✓					
Visiting times	✓					
Hand hygiene	✓					
Valuables	✓					
Smoking		✓				
Patient Discharge Booklet given		✓				
Other						
Sign	mm	mm				

Patient's Property - Where possible send belongings home with family

You are asked to keep belongings/valuables to a minimum whilst in hospital. You are responsible for property belonging to you not handed over for safe custody. This includes cash, spectacles, hearing aids, dentures and other personal items and valuables. Valuables should be sent home at first opportunity or given to the nurse if this is not possible.

Valuables handed over for safe keeping will be sent to the cashier's office and a receipt will be issued. If patient lacks capacity please ensure relevant documentation is completed for belongings and valuables.

Signature of Patient / Significant Other: x Lee Green Date 10/3/18

Property handed over for Safe Keeping: Yes ☐ No ☐ Sticker on front page: Yes ☐ No ☐

Date taken to Cashier:_____ Cash & Valuables Ref No:_____ Date Returned:_____

Personal Details

Cognitive assessment	Circle		
To be completed on all patients over 65 or if appropriate or if the patient has suspected delirium Ask the patient the following questions: (4AT)	1st Assessment	Further Assessment	Further Assessment
	Date	Date	Date
1. ALERTNESS This includes patients who may be markedly drowsy (eg. Difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gently touch on shoulder. Ask the patient to state their name and address to assist rating			
Normal (fully alert), but not agitated, throughout assessment)	0	0	0
Mild sleepiness for <10 seconds after waking, then normal	0	0	0
Clearly abnormal	4	4	4
2. AMT4 Age, date of birth, place (name of the hospital or building), current year.			
No mistakes	0	0	0
1 mistake	1	1	1
2 or more mistakes/untestable	2	2	2
3. ATTENTION Ask the patient "Please tell me the months of the year in backwards order, starting at December". To assist initial understanding one prompt of "what is the month before December?' is permitted.			
Months of the year backwards, Achieves 7 months or more correctly	0	0	0
Starts but scores <7 months / refuses to start	1	1	1
Untestable (cannot start because unwell, drowsy, inattentive)	2	2	2
4. ACUTE CHANGE OF FLUCTUATING COURSE Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. Paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs			
No	0	0	0
Yes	4	4	4
4 or above: possible delirium +/-cognitive impairment: refer to algorithm 1-3: possible cognitive impairment 0: delirium or cognitive impairment unlikely (but delirium still possible if question 4 information incomplete)			
If 4AT of 4 or above commence Time Bundle			
4AT SCORE			
SIGN			

If you have concerns regarding capacity, please refer to algorithm and dementia/delirium care plan.

If no 4AT carried out please document reason eg Patient unconscious.....

Informed Consent and Capacity

While undertaking the patient's clinical assessment, if you have any concerns regarding the patient's capacity and ability to make healthcare decisions refer to medical staff for **assessment and treatment plan** under the Adults With Incapacity (Scotland) Act 2000 and document your actions within the nursing notes. Refer to the Consent policy for further guidance.

Information about the patient can be obtained from relatives and carers including legal guardians (e.g. guardianship through the social work department)

Relatives and carers cannot make decisions for patients except in certain circumstances where they hold Welfare Guardianship or Power of Attorney extending to health care decisions under the Adults With Incapacity (Scotland) Act 2000.

	Yes	No			Names
Advanced Statement	☐	☐			.....
Power of Attorney details	☐	☐	Financial ☐	Welfare ☐	.....
Guardianship details	☐	☐	Financial ☐	Welfare ☐	.....
"Getting to know me" in use	☐	☐			.....

If yes to any of the above obtain a copy of the relevant document.

If diagnosis of dementia is confirmed please ensure appropriate documentation / care plans are initiated

Personal Details

Adult Support and Protection – 3 point criteria

An adult who:

- Are unable to safeguard their own well-being, property, rights or other interests
- Are at risk of harm; and
- Because they are affected by disability, mental disorder, illness or physical or mental infirmity are more vulnerable to being harmed than adults who are not so affected.

Harm includes:

- All harmful conduct and in particular:
- Conduct which causes physical harm;
- Conduct which causes psychological harm (for example by causing fear, alarm or distress);
- Financial harm
- Conduct which causes self-harm

If you have a concern about an adult who you believe is or may be at risk of harm complete an ASP/Concern referral.

ASP / Concern referral submitted Yes ☐ No ☑

All referral information can be found on AthenA Adult Support and Protection site.

Consent to display limited information

Patient consents to display of CHI number and limited personal information about care (e.g. bedrails, diet, mobility, "forget me not") on a chart at the bedside and whiteboard etc.

Consent given: Yes ☑ No ☐ By whom: Patient ☑ Relative/Carer ☐

If the patient has declined to consent to information being displayed at the bed space please provide information here .....

Nurse Initials MM Date 10/3/18

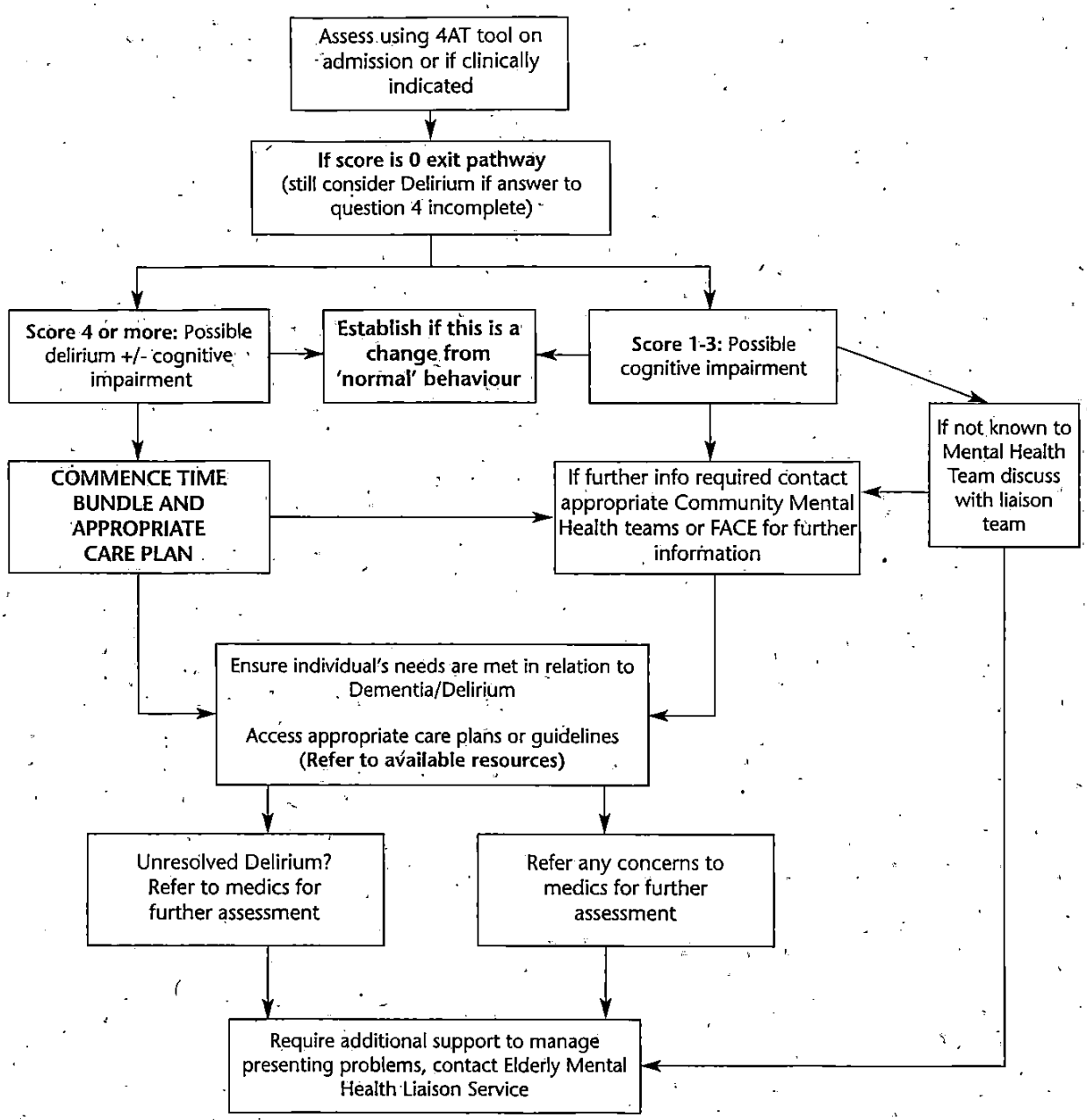
Useful Contacts:

To support your plan of care for this patient you might find it helpful to contact the relevant liaison service below:

Learning Disability Liaison Nurse Specialist:	01294 323560 (north) 01292 614910 (south) 01563 578574 (east)
Mental Health Liaison Nurses (Elderly Services)	01292 513007
Psychiatric Liaison Nurse (Adult general hospitals)	01563 826120
Advocacy Services	01294 608664 (north) 01292 264396 (south) 01563 574442 (east)
Hospital Social work team	Hospital site contacts through switchboard.

Additional relevant information (including details of the relevant liaison service contacted)

Nursing Assessment and Management of Cognitive Impairment



<u>Useful Contact numbers</u>

<u>If patient has diagnosis of dementia and lives:</u>
Nursing/Care Home: Contact **Elderly Mental Health Care Home Liaison Nurse** who will be able to provide background information regarding patient and support discharge arrangements.

Telephone no:.....

At home: Contact **Community Mental Health Team** as patient likely to be known to them>they may offer advice and/or background info.

Telephone no:.....

If patient does not have a diagnosis of dementia but further advice/support req'd whilst an in-patient, contact: **Elderly Mental Health Liaison service**

Telephone no:.....

If patient is known to any of the Mental Health Teams please inform when fit for home/discharge plans.

<u>Useful Available Resources</u>

Access if available:

Getting to Know Me - hand held document used by patients

Dementia Care Plan - for pts with a diagnosis of dementia

Delirium Care Plan - for pts displaying symptoms indicative of delirium

Identification and Management of Delirium in the Elderly - can be found on back of Delirium Care Plan

Behavioural and Psychological Symptoms associated with Dementia - a guide to cause and management in behaviour that challenges in delivery of care of patients with dementia

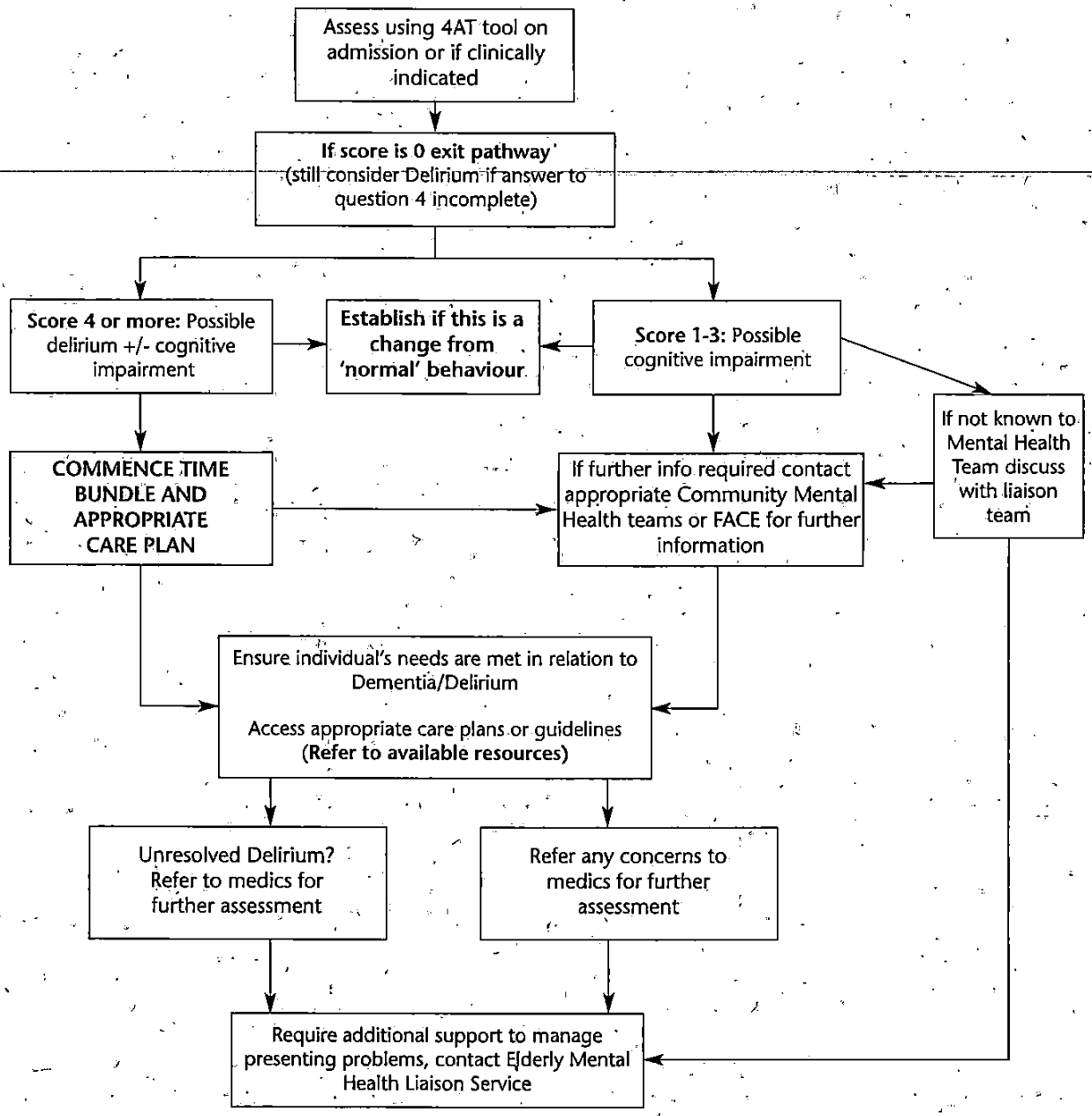
Abbey Pain Scale - pain tool that should be used for pts with dementia and/or who cannot verbalise

Time Bundle - Time Bundle for patients with 4AT of 4 or more

All of the above resources can be accessed through Athena or in Dementia Resource Folder if available.

Personal Details

Nursing Assessment and Management of Cognitive Impairment



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Additional relevant information (including details of the relevant liaison service contacted)

Personal Details

Person-centred care is where the patient is an equal partner with the health or care professional and where both parties work together to make an assessment, identify options for and the delivery of the most appropriate care. The care provided is holistic and the 'whole person' sits at the centre of the care package, which may be delivered by a range of health and social care professionals.

To promote person-centred care our focus is changing from asking 'What's the matter with you' to asking 'What matters to you'. We can do this by reliably covering the five 'Must do with me' elements of care with patients and/or their families and carers. This will help to ensure all of the interactions between people using our services and the staff delivering them are person-centred and are characterised by listening, dignity, compassion and respect.

5 Must do's. These can be answered by patient/family/carers

What is important or matters to you?

What are the most important things for you that we can help you with/ do for you while you are here? e.g; *'that my wife/husband can be present when the consultant talks to me'; 'that I can choose my meal rather than someone else choosing it for me'; 'that my pet has been taken care of'; 'that my medication is given at the right time';*

.....

.....

.....

.....

Who matters to you?

Who are the most important people to you and how would you like them involved in your care? eg. family, friend, chaplain, minister, priest.

.....

.....

.....

.....

What information do you need?

eg when will the doctor see me'; 'visiting times'; 'meal times'; 'Can I smoke'; 'can I get out of the bed'; 'can I wear outdoor clothes in the ward'; 'what is the name of my nurse'; 'what can and can't I do'; 'how to contact relatives'; 'if mobiles can be used'; 'how to use Hospedia;'

.....

.....

.....

.....

Do you require any assistance to understand information e.g. Family / other Yes ☐ No ☐

Leaflets / written: Yes ☐ No ☐

Personalised Contact

As much as possible, try to be flexible about the timing of interventions to meet the patients personal needs. *Example questions of this could be, Would it be ok if we check on you every 1-2 hours to check you are ok or if you need anything?* .....

.....

.....

Nothing about you without you

Whilst you are in the ward we will involve you in any decisions regarding your care and discuss any referrals with you.

Nurse Initials ..... Date .....

Home Circumstances

Home circumstances on admission

Do you have a carer: Yes ☐ No ☐
If yes: Family ☐ Private ☐
Do you live:-
Alone Yes ☐
With dependent partner ☐
With independent partner / family ☐
Does carer require additional support ☐
(Consider referral to social work) ☐
Are you a carer? Yes ☐ No ☐
Who for:
Children ☐ Elderly relative ☐ Other ☐

Please specify: .....
Who is caring for them currently?
Family ☐ Social Worker ☐
Nursing Home ☐ Neighbour ☐
Respite Centre ☐ Other ☐
Please specify:

Describe Family Living Arrangements

Type of House .....
Steps at entrance ☐ How many? .....
Stairs inside ☐ How many? .....
Toilet: Upstairs ☐ Downstairs ☐
Bedroom: Upstairs ☐ Downstairs ☐
Banister ☐ Others .....
.....

Comments

Community Services in Use			Frequency	Informed of Admission		Informed By / Comments
Home Care provided	Yes ☐	No ☐		Yes ☐	No ☐	
Meals on Wheels	Yes ☐	No ☐		Yes ☐	No ☐	
Sheltered Housing	Yes ☐	No ☐		Yes ☐	No ☐	
Day Hospital	Yes ☐	No ☐		Yes ☐	No ☐	
Community Nurse	Yes ☐	No ☐		Yes ☐	No ☐	
Community Psychiatric Nurse	Yes ☐	No ☐		Yes ☐	No ☐	
Learning Disability Nurse	Yes ☐	No ☐		Yes ☐	No ☐	
Visited by Specialist Nurse	Yes ☐	No ☐		Yes ☐	No ☐	
Specify:						

Functional Assessment of Medication Use: **Complete for all patients**

Pre-Admission Status		
Independent ☐	Prompting required ☐	Assistance required ☐
Level ..... MAR Chart ☐	Compliance aid ☐	.....
On Admission Initial Assessment		
Independent ☐	Prompting required ☐	Assistance required ☐
Level ..... MAR Chart ☐	Compliance aid ☐	.....

Do community nurses assist in medicine administration? Yes ☐ No ☐

If Yes, please provide details e.g. insulin administration .....

.....

Nurse Initials: ..... Date: .....
Nurse Initials: ..... Date: .....
Nurse Initials: ..... Date: .....
Nurse Initials: ..... Date: .....

Remember to re-assess patient needs and service requirements pre-discharge

Multi-Disciplinary Discharge Plan

To ensure safe and timeous discharge planned in partnership with the patient/carer and staff.

PATIENTS SHOULD BE CONSIDERED FOR CRITERIA LED DISCHARGE IF USED APPLY STICKER TO MDT DISCHARGE SUMMARY.

Write or attach label

HCR No:.....
CHI No:.....
Surname:.....
Forename:..... Sex:.....
Address:.....
.....
Date of Birth.....

Estimated discharge date:..... Medically fit date:..... Ready for discharge: .....

Date & Time	Reason for EDD change	New EDD	Initials

Discharge planning should be commenced on the day of admission

Date		Yes	No	N/A	Int
	Does the patient require a discharge planning meeting?				
	If yes to the above contact patient, family, social work and members of the MDT Record date of meeting...../Outcome.....				
	Discuss, document and agree discharge plan with patient, relatives, carers and MDT				
	Equipment needed. **Please document on checklist over page.**				
	Does the patient have house keys Key safe number:				
	Does the patient have appropriate clothing for discharge				
	Does the patient require a **Fit Note**				
	Has the patient been given a **Fit Note**				
	Does the patient require a home visit or environment assessment				
	Continuing care at home	Yes	No	N/A	Int
	Referred to ICES ☐ Homecare ☐ Occupational Therapy ☐ Physiotherapy ☐				
	Homecare referral type New referral ☐ Increase ☐ Restart ☐				
	Level of Homecare Package				
	Homecare confirmed by..... Start Date & Time.....				
	Community nurse referral made ☐ Referred to Podiatry ☐				
	Discharge Medication/Aids	Yes	No	N/A	Int
	Order discharge prescription **(Consider Blister pack or MAR chart)**				
	Discharge prescription is on the ward				
	7 day supply of dressing, continence aids, catheters or stoma products (new patients must be given a 7 day supply and refer to district nurse for re-assessment)				
	Nutritional Supplements/Enteral Feed/Thickener: new patients must be given a 7 day supply				
	Transport **Those able to make their own travel arrangements should be encouraged to do so**	Yes	No	N/A	Int
	Own transport arrangements:				
	Hospital transport booked. Ambulance ☐am ☐pm **Reference No:**				
	Discharge Lounge	Yes	No	N/A	Int
	Is the patient suitable for the discharge lounge (Ext XH 26467 / 8) (Ayr 17078)				
	Plans in place to facilitate morning discharge				
	If no document why				

MDT Discharge Plan

	Final checklist Please complete all sections of this checklist on discharge	Yes	No	N/A	Int
	Cannula removed				
	Patients own medication returned				
	Discharge prescription given and explained to patient/carer				
	Clinic follow up arrangements given. (Please record in discharge summary)				
	7-days dressing supply provided				
	Patients property packed and valuables returned				
	If DNACPR keep copy in patients notes and send original home				
	Send home "Getting to Know Me" document if appropriate				
	Anticipatory Care Pathway or any other relevant community plan/pathway?				
	Inform family/NOK/carer when patient leaves the ward (If appropriate)				
	If appropriate the patient and their carer are provided with the NHS Preventing Pressure Ulcers: A guide for Adults at risk of Pressure Ulcers leaflet.				

MDT Discharge Plan

Equipment needs; essential equipment should be in place for discharge				
Equipment type	Date Requested	Arranged by	Expected delivery date	Delivery confirmed
Physio (specify)				
OT (specify)				
Commode				
Community electric profiling bed frame				
Pressure Reducing Mattress*				
Chair Cushion				
Foot protectors				
Wheelchair				
Oxygen Cylinder and/or Concentrator				
Enteral Feeding Equipment				
Community alarm				
Key safe				
Other (specify)				

* Please call the district nurse to discuss before ordering.

Multi-Disciplinary Discharge Summary

Date & Time	This should include reference to SSA, 24hr continuing care or rehab	Initials

MDT Discharge Plan

MDT Discharge Plan

Multi-Disciplinary Discharge Summary

Date & Time	This should include reference to SSA, 24hr continuing care or rehab	Initials

Lifestyle Assessment/Usual Ability

Please add date, time & signature when you update the Lifestyle Assessment

Date/time..... Sign.....

Date/time..... Sign.....

Date/time..... Sign.....

Write or attach label

HCR No:.....
CHI No:.....
Surname:.....
Forename:..... Sex:.....
Address:.....
.....
Date of Birth.....

Pre-admission Status

Communicating

Any specific communication needs:

Speaking	Yes ☐	No ☐
Reading	Yes ☐	No ☐
Writing	Yes ☐	No ☐
Glasses	Yes ☐	No ☐
Contact Lenses	Yes ☐	No ☐

Hearing aid - Left ☐ with Patient ☐

Hearing aid - Right ☐ with Patient ☐

Initial assessment

Detail Presenting Problems/Risk/Needs

Interpreter required** Yes ☐ No ☐

Breathing

Do you normally have any issues with breathing?

Yes ☐ No ☐

If yes, please describe.....

.....

Equipment / aids - circle all that apply: Inhalers / oxygen -concentrator / cylinder / nebulisers / tracheostomy.

Do you smoke? Yes ☐ No ☐

If so how many.....

All smokers *must* be referred to Fresh Air-shire for discussion about smoking management whilst in hospital; this will include being advised about the current smoking policy. Please attach a patient sticker to referral card and place it in the Fresh Air-shire referral box on the ward. For any queries please phone Fresh Air-shire on 08007 839132.

Please tick when this referral has been made ☐

Date & time of referral.....

Detail Presenting Problems/Risk/Needs

Patient wishes nicotine replacement therapy?

Yes ☐ No ☐

Should a patient insist on leaving the ward for a cigarette, a smoking disclaimer must be completed.

Smoking disclaimer signed Yes ☐ No ☐

Mobilising/Falls Risk Assessment

Does the patient normally have a reduced functional ability	Yes ☐	No ☐
Walking aids	Yes ☐	No ☐
Pain.	Yes ☐	No ☐
Foot Problems	Yes ☐	No ☐
Poor balance	Yes ☐	No ☐
Uncoordinated movements	Yes ☐	No ☐
Medication that could increase risk	Yes ☐	No ☐
Falls History	Yes ☐	No ☐
Cognitive Impairment	Yes ☐	No ☐
Sensory Problems	Yes ☐	No ☐
Is patient at risk of falling from bed?	Yes ☐	No ☐

Detail Presenting Problems/Risk/Needs

Is the patient at risk of falls?* Yes ☐ No ☐

* Consider increasing frequency of care and comfort rounding
* Consider higher level supervision policy
** Language Line 0845 310990 ID No L28656

Lifestyle Assessment

Lifestyle		Yes	No
Driving Status	Do you Drive	☐	☐
Physical Activity	How many days per week do you usually undertake a total of 30 minutes or more exercise? 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ NA☐ If less than 5 days, does this equal more than 2½ hours of activity a week	☐	☐
Alcohol Use	Units per week _____ Suitable for alcohol brief intervention? ☐ Not applicable Currently in Treatment? ☐ Not applicable Refer to alcohol liaison team? ☐ Not applicable	☐ ☐ ☐	☐ ☐ ☐
Substance misuse	Substance misuse issues/? If yes give details: Currently in treatment? ☐ Not applicable Refer to substance misuse? ☐ Not applicable	☐ ☐ ☐	☐ ☐ ☐

Pre Admission Status	Initial assessment
Eating and Drinking	**Detail Presenting Problems/Risk/Needs**
Date..... Time..... Does the patient need assistance in carrying out their own basic oral care? Yes☐ No☐ Does the patient have dentures? Yes☐ No☐ Top☐ Bottom☐ Partial☐ With Patient☐ Is the patient suffering from mouth pain? Yes☐ No☐	
Patient on nutritional supplements / enteral feed at home? Yes☐ No☐ Type: _____ Amount _____ Frequency _____ kitchen notified Yes☐ No☐ Any changes in eating pattern/appetite? Yes☐ No☐ Specify: _____ Support required for eating/drinking? Yes☐ No☐ Equipment required to support eating /drinking Yes☐ No☐ *Likes* _____ *Dislikes* _____ Long term swallowing ability impaired (Consider referral to SLT) Yes☐ No☐ Modified Diet/Fluids Texture..... Stage..... Consent to therapeutic diet (Cultural/Ethic/Religious requirements) Yes☐ No☐ Complete MUST Screening on page 20.	
Eliminating	**Detail Presenting Problems/Risk/Needs**
Normal bowel habit Yes☐ No☐ When did your bowels last move? ..... Any problems passing urine? Yes☐ No☐ Does the patient have a urinary catheter in situ Yes☐ No☐ Date of catheter insertion _____ Long term catheter? Yes☐ No☐ Complete continence assessment if required Refer to Adult Continence Assessment Pathway algorithm	If YES apply the Catheter Care Bundle Referral Date: _____

Write or attach label
HCR No:
CHI No:
Surname:
Forename: Sex:
Address:
Date of Birth

Pre Admission Status	Initial assessment
Personal Cleansing & Dressing	**Detail Presenting Problems/Risk/Needs**
Is patient normally independent? Yes ☐ No ☐ What type of assistance is required by the patient (please consider patient preferences)	
Skin Condition PPURA	**Detail Presenting Problems/Risk/Needs Preliminary Pressure Ulcer Risk Assessment (PPURA)**
Date Time **Mobility** Patient is fully mobile without equipment / assistance Yes ☐ No ☐ **Continence** Patient is fully continent Yes ☐ No ☐ **Nutrition** Patient appears to be well nourished and able to eat and drink Yes ☐ No ☐ **Skin** Skin is healthy and intact Yes ☐ No ☐	Assess condition of skin, any wounds / lesions / stomas If No to any questions undertake Waterlow Assessment and apply the SSKIN bundle if indicated. If all answers Yes complete a daily PPURA see page 18
Spiritual or religious needs	**Detail Presenting Problems/Risk/Needs**
Faith or Life Stance? Do you have any spiritual or religious needs whilst in hospital? *(please state)* Yes ☐ No ☐ Do you wish your details passed to the hospital Chaplaincy Service? Yes ☐ No ☐ Do you wish your own Minister/Priest contacted Yes ☐ No ☐ If yes complete name & telephone number Name..... Tel No..... Specify needs or cultural practices that place limitations on the patient's care *(please state)*	

Preliminary Pressure Ulcer Risk Assessment (PPURA)

Complete or attach addressograph	
HCR No:	
CHI No:	
Surname:	
Forename:	Sex:
Address:	

Points to consider

- Use within 6 hours of admission to care area
- Use daily if the person is identified to be 'not at risk'
- People who are overweight may not be well nourished
- Please sign after each check

Mobility:	Person is fully mobile without equipment/assistance
Continence:	Person is fully continent
Nutrition:	Person appears well nourished and able to eat and drink
Skin:	Persons pressure areas are healthy, with no signs of redness, discolouration, including bruising or ulceration.

Record your answer in the grid below **Y** – Yes or **N** – No
If the answer is **Yes** to all statements use this chart daily
If the answer is **No** to any statement undertake a full pressure ulcer risk assessment and consider any other relevant assessment

Date	Time	Mobility	Continence	Nutrition	Skin inspected	Is a full pressure ulcer risk assessment required?	Signature

Patient Risk Assessment

Write or attach label
HCR No:
CHI No:
Surname:
Forename: Sex:
Address:
Date of Birth

After completing the Individual Person Centred Lifestyle Assessment please now decide which risk assessments your patient needs.

In some circumstances your professional judgement may decide that this patient is exempt from a particular mandatory assessment. You must clearly document the reason for this decision.

Identify relevant assessment tools and tick the box to confirm assessment tool activated.

Yes	N/A		
☑	☐	MRSA	mandatory
☐	☑	Nutrition - MUST	mandatory
☐	☑	Oral Health	initial rapid assessment questions mandatory if clinically indicated
☐	☑	Pressure Area Care - Waterlow	Mandatory if PPURA indicates needs
☐	☑	4AT	all patients over 65 or if patient has a suspected delirium
☐	☑	Bedrails	mandatory
☐	☐	Moving and Handling	mandatory
☐	☐		

You may use your professional judgement to decide which assessment tools are most relevant to your patient. It may not be necessary to complete all risk assessments for every patient.

Not Completed		Reason Why
☐	MRSA	
☑	Nutrition - MUST	
☑	Oral Health	
☑	Pressure Area Care - Waterlow	
☑	Falls	
☑	Bedrails	
☑	Moving and Handling	
☑	4AT	Not complete as patient 35 years old and only 1 hr stay.

It will be necessary to re-assess the requirement for completion of the above risk assessments during the patients stay

Nurse Initials: MM Date: 10/3/18

NHS Ayrshire & Arran

Complete or attach addressograph

HCR No:.....

CHI No: .....

Surname:.....

Forename:.....Sex: .....

Address: .....

Infection Prevention & Control Assessment

⚠ You MUST CHECK PMS for details where you see this symbol

Risk Assessment

MRSA Clinical Risk Assessment (CRA) You MUST CHECK PMS for details where you see this symbol ⚠ ALL PATIENTS MUST HAVE CRA COMPLETE FOR PRE-EMPTIVE ISOLATION PURPOSES			
	Yes	No	Action to be taken
Has the patient had any **previous history of MRSA** colonisation or MRSA infection at any time in the past? ⚠ **CHECK PMS**			**After checking PMS ⚠ if you have answered NO to all** three of the questions **then** no further action is required in all non-high risk areas **If you have answered 'Yes' to any** of the three questions or your ward is one of the high risk specialties detailed above you **MUST** • Swab **nose and perineum** (& wound or device where applicable) for MRSA **If you have answered 'Yes' to any of the three questions regardless of specialty** • Manage patient as if MRSA positive (refer to MRSA Policy) **Date swabs obtained**..... **Print name**.....
The patient currently **resident in a care home or institutional setting** (i.e. prison, homeless hostel) or **transferred from another hospital (including those within Ayrshire)?**			
Does the patient **have a wound/ulcer or indwelling medical device** which was present before admission to this hospital?			

Gastro intestinal risk assessment for CID, norovirus and other gastro-intestinal infections			
	Yes	No	Action to be taken
Is the patient presenting at admission with diarrhoeal stool (Bristol stool chart 5, 6, 7) and/or vomiting			If **YES – implement Transmission Based Precautions and isolate patient.** Initiate weekly Bristol stool chart. Send sample to the laboratory. **Date sample sent**..... **Print name**.....
Has been transferred from any ward/nursing home with suspected or confirmed cases of norovirus.			

Multi drug resistant organism e.g. Carbapenemase-producing Enterobacteriaceae (CPE)			
	Yes	No	Action to be taken
Has the patient been • transferred from a hospital outside Scotland • hospitalised outside Scotland in the last 12 months? • Received holiday dialysis outside Scotland • Been a close contact with a person who has been colonised or infected with CPE			**After checking PMS ⚠ if you have answered NO to all** the questions then there is no further action to be taken. If you have answered **YES** to any of the questions you **MUST** screen the patient this includes • Swabs from the **rectum** (& wound or device where applicable) • Manage patient as if CPE positive (refer to CPE Policy) • Inform a member of the Infection Prevention and Control team **NOTE:-IN THE INVESTIGATIONS BOX ON THE LABORATORY REQUEST FORM YOU MUST REQUEST "CPE SCREENING".** **Date swab obtained**..... **Print name**.....
⚠ Has the patient been previously positive for CPE at any body site? **(Check case notes and lab results in addition to PMS)**			

For further advice if required contact the Infection Prevention & Control Team (ext 25765) or the on-call Consultant Microbiologist (via switchboard).

NHS Ayrshire & Arran

Nutritional Screening 'Malnutrition Universal Screening Tool' ('MUST')

Food Fluid and Nutrition

Write or attach label
HCR No:
CHI No:
Surname:
Forename: Sex:
Address:
Date of Birth

Step 1: Measure height and weight to get a BMI score.

Step 2: Note percentage unplanned weight loss and score.

Step 3: Establish acute disease effect and score.

Step 4: Add scores from steps 1, 2 and 3 together to obtain overall risk of malnutrition.

Step 5: Follow the management guidance appropriate to the risk category and commence the corresponding care plan.

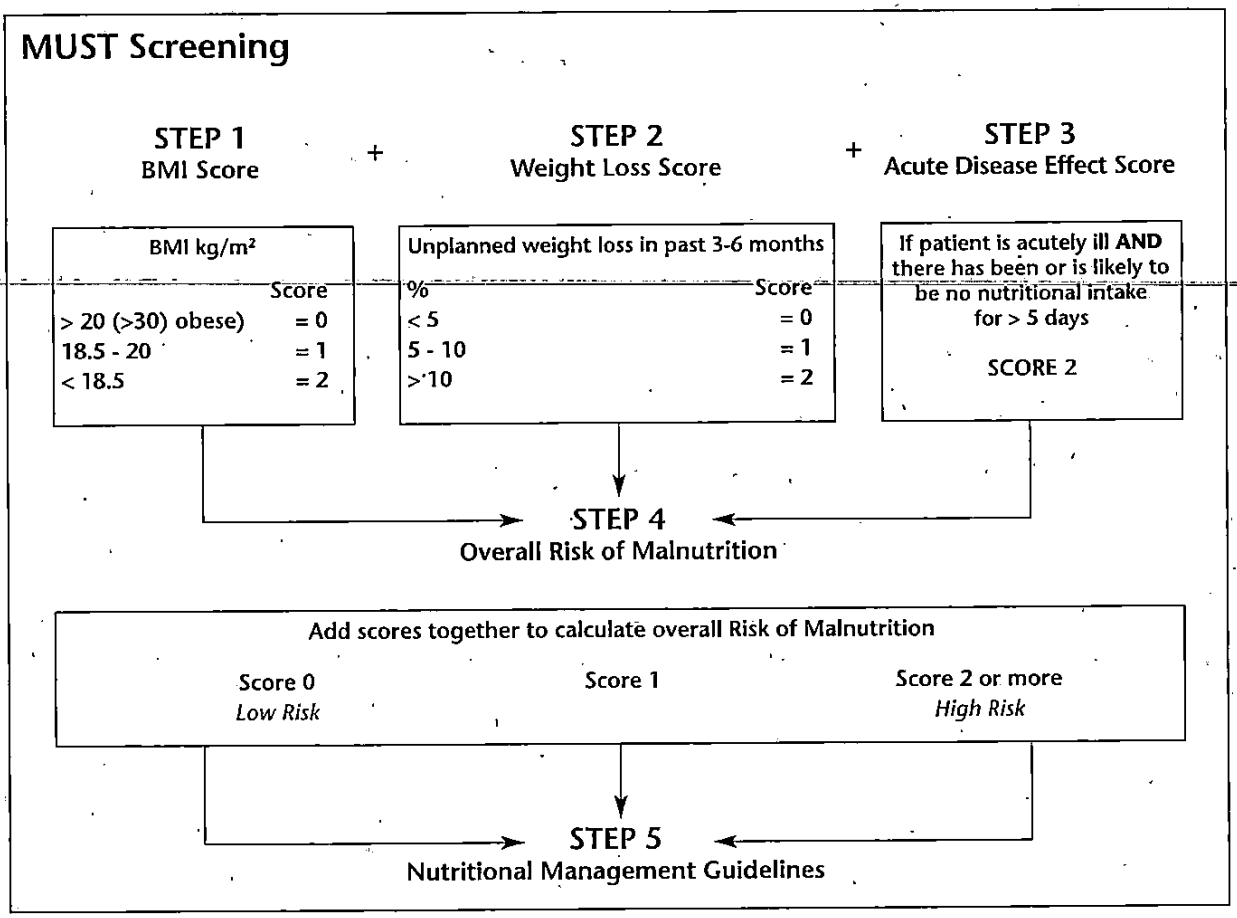
Screening Results

Please indicate if measurements are Measured (M), Reported (R) or Estimated (E)

Date					
Time					
Ward					
Height (metres) (M) (R) (E)	m	m			
Current weight (Kg) (M) (R) (E)	Kg ( )	Kg ( )	Kg ( )	Kg ( )	Kg ( )
BMI					
Is patient within obese category?					
Usual weight (Kg)	Kg				
Signature					
MUST					
Step 1: BMI Score >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					
Step 3: Acute Disease Effect Score If patient is acutely ill **and** there has been or is likely to be no nutritional intake for>5 days.....Score 2 Not applicable .....Score 0					
Step 4: Overall Risk of Malnutrition Total:					
Step 5:	0 = Low Risk	1 = Medium Risk	2 or more = High Risk		

Referrals	Consent for referral obtained	Date referred	Signature
Dietician	☐		
Speech and Language Therapy	☐		

MUST Screening



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Nutritional Management Guidelines:

MUST Score 0	MUST Score 1	MUST Score 2 or more
Low risk - *Routine Clinical Care* • Commence and implement the Low Risk Care Plan • Monitor and review care plan • Repeat screening as below: Acute..... weekly Continuing Care..... monthly	Medium risk - *Observe* • Commence and implement the Medium Risk Care Plan • Monitor and document dietary intake whilst in ward/department on a Food Record Chart • Encourage oral intake • Assist patient to choose appropriate meals/snacks and offer milk or suitable alternative to drink with and between meals. • Provide nutrition information leaflet to patient. • Monitor and review care plan • Repeat screening weekly or when next in department.	High risk - *Treat** • Commence and implement the High Risk Care Plan • Refer to Dietitian, include MUST score • Continue to monitor dietary intake. • Offer maximum encouragement. • Monitor and review care plan • Repeat screening weekly or when next in department. • Consider use of red tray/jug *Unless detrimental or no benefit is expected from nutritional support e.g. imminent death. Use own judgement and document rationale for not treating.

- For low risk patients implement interventions in the **green** section of the care plan, as appropriate.
- For medium risk patients implement interventions in the **green** and sections of the care plan.
- For high risk patients implement interventions in the **green,** and **red** sections of the care plan.
- Always use your own professional judgement when screening patients and making referrals.
- Consider initial admission information relating to eating and drinking needs and preferences.
- When completing Step 2 always compare the most recent weight with the 'usual' weight (or use the initial weight taken on admission if necessary) and not the previous weeks weight.

NHS Ayrshire & Arran

Malnutrition Universal Screening Tool ('MUST') Multidisciplinary Care Plan

Write or attach label

HCR No:.....
CHI No:.....
Surname:.....
Forename:..... Sex:.....
Address:.....
.....
Date of Birth.....

Patient Problem
Nutritional screening has identified the patient as being Low ☒ Medium ☐ High ☐ Risk of malnutrition
Patient identified as having other nutritional problems e.g. obesity, chewing certain foods (specify)

Goal
To meet patients nutritional and fluid requirements

Date	Time	Intls	Planned Nursing Interventions/Support	End Date	Intls
			Low Risk Care Plan		
			Assistance required (specify) e.g. helping, prompting, cutting up food, opening packets:-		
			Individual / therapeutic dietary requirements (specify) e.g. likes/dislikes religious/ethical/cultural:-		
			Modified eating equipment (specify) e.g. cutlery.		
			Assist patient to select appropriate meals from menu card.		
			Ensure fresh drinking water is offered regularly and available at all times, where clinically appropriate.		
			Consider patients positioning and support oral hygiene, if required.		
			Ensure patients nutritional needs recorded on nutrition board.		
			Monitoring and review care plan **repeat screening weekly** (monthly continuing care)..		
			Medium Risk Care Plan (complete low risk section also)		
			Commence food chart for a minimum of 3 days. Only discontinue if/when dietary intake is adequate.		
			If intake is insufficient, offer patient milk to drink with / and between meals and suitable additional snacks.		
			Record accurate fluid intake / output on fluid balance chart until established that oral intake is adequate. If intake per 24 hours is inadequate consider IV/SC fluids.		
			Monitor and review care plan and **repeat screening weekly.**		
			RED TRAY Yes ☐ No ☐ RED JUG Yes ☐ No ☐		
			High Risk Care Plan (complete low and medium risk section also)		
			Refer to Dietitian, ensuring the MUST score is included.		
			Discontinue food chart only when advised by Dietitian.		
			Administer and monitor enteral feed via NG/PEG route as per local guidelines.		
			Monitor and review care plan and **repeat screening weekly.**		
			This care plan has been discussed and agreed with the patient as appropriate.		

Risk Assessment

Following assessment the Speech and Language Therapist will recommend which texture is suitable for the Individual	
Modified Food Consistency	
Texture B Thin Puree	Smooth consistency with no lumps Can be poured Will slowly drop through prongs of a fork **Thick enough to stand a light plastic teaspoon in**
Texture C Thick Puree	Smooth, moist consistency with no lumps and should not be sticky on palate Cannot be poured Holds its shape on the plate when scooped **No separation of fluids**
Texture D Pre-mashed	Mashed or finely minced before serving Very soft, tender and moist Needs very little chewing **No mixed textures or separation of fluids**
Texture E Fork Mashable	Food must be able to be mashed with a fork Soft, tender and moist Needs some chewing **Meat must be very soft and tender, or minced in thick sauce**
Modified Fluid Consistency	
Stage 1 **Syrup consistency**	Use 1 level scoop of Nutilis Clear in a 200ml drink • This leaves a thin coat on the back of a spoon
Stage 2 **Custard consistency**	Use 2 level scoops of Nutilis Clear in a 200ml drink • This leaves a thick coat on the back of a spoon
Stage 3 **Pudding consistency**	Use 3 level scoops of Nutilis Clear in a 200ml drink • This needs to be taken with a spoon • This will be too thick to drink from a cup

Please record any Therapeutic/Special Diet/Fluids

Texture/Stage/Type (include diabetic, gluten free etc)	Date commenced	Comments	Date discontinued

Please Record if Patient on / Commenced on Supplements
If on supplements please commence supplement monitoring chart

Supplement	Frequency	Any preferences / dislikes	Supplement Chart	On Nutrition Board	Stopped

Any additional interventions (free text)

Further information can be found in the Dietetic Treatment Record

Oral Health Risk Assessment

Rapid Assessment Questions		Circle which is appropriate		Suggested outcome/actions if "Yes" circled
Does the patient need assistance in carrying out their own basic oral care?		Yes	No	If you have answered yes to any of these questions please complete full oral health risk assessment below and review 4-weekly.
Does the patient need assistance taking care of their dentures?		Yes	No	
Is the patient suffering from mouth pain?		Yes	No	
What is your normal mouth care routine at home? (for initial assessment only)				Details
Are you having any problems with your teeth or mouth?				Details
Patient Assessment		Circle which is appropriate		Suggested outcome/actions if "Yes" circled
Smoking habits	Smoker? (which may increase risk of gum disease and oral cancer?	Yes	No	Note amount per day on profile Consider smoking cessation
Dexterity problems	Having difficulty holding toothbrush?	Yes	No	May need supervision/help with mouth care Consider OT adaptation
Cognitive function	Evidence of short-term memory loss and/or confusion?	Yes	No	May need supervision/help with mouth care
Oral Assessment - use tongue compressor and pen torch to examine oral cavity		Circle which is appropriate		Suggested nursing care If "Yes" circled
Lips	Dry/cracked?	Yes	No	Apply an emollient e.g. lubricating gel
Tongue	Dry/coated?	Yes	No	Clean with soft toothbrush and toothpaste Offer frequent fluids
	Evidence of ulceration/soreness?	Yes	No	If yes, refer to Public Dental Services (PDS)* or advise patient to contact their dentist on discharge
Gums / soft tissue	Evidence of soreness, ulceration, bleeding gums or whiteness?	Yes	No	If yes, refer to PDS* or advise patient to contact their dentist on discharge
Saliva	Dry mouth? (xerostomia) could be side-effect of medication e.g. antidepressants, anticonvulsants etc.	Yes	No	Offer frequent fluids and/or iced water If symptoms persistent refer to dentist
Teeth	Natural top teeth?	Yes	No	Encourage independence with cleaning teeth night and morning. Use toothbrush and fluoride toothpaste (see Basic Oral Care Guidelines for concentration of fluoride)
	Natural lower teeth?	Yes	No	
	Evidence of plaque / debris?	Yes	No	Supervise/help with oral care Use toothbrush and fluoride toothpaste
Dentures	Top denture?	Yes	No	Supervise/help with cleaning dentures night and morning with mild soap and water; rinse dentures after meals. Clean teeth as above Remove dentures at night and leave to soak in water with Milton
	Lower denture?	Yes	No	
	Dentures and natural teeth?	Yes	No	
Pain	When eating/drinking?	Yes	No	If yes, refer to PDS* or advise patient to contact their dentist on discharge
	Caused by teeth/dentures?	Yes	No	
Swallowing	Difficulty with swallowing?	Yes	No	Supervise/help with cleaning teeth and/or dentures and oral cavity after each meal
Nutrition	NBM / Fluid/dietary intake poor?	Yes	No	May require 2 hourly mouth care Check whether oral problems contributing
	Dehydrated?	Yes	No	
	On energy-dense diet or prescribed supplements/snacks?			Consider high fluoride toothpaste if have natural teeth (2800ppm F)

Signed:.....

Date and Time:.....

* Dental Services Helpline: 01563 507 950

For urgent care or advice on weekdays

NHS 24: 111

For dental emergencies out-of-hours

Oral Hygiene - Care Plan

Write or attach label
HCR No:.....
CHI No:.....
Surname:.....
Forename:..... Sex:.....
Address:.....
.....
Date of Birth.....

Risk Assessment

Pre Admission Status					
Patient has undergone oral assessment and requires assistance with regular mouth care					
Goal					
For oral cavity to be clean, pink, moist and comfortable					
Date	**Time**	**Intls**	**Planned Nursing Interventions**	**Discontinued Date/Time**	**Initials**
			Dental Referral		
			• If patient hasn't seen a dentist • If patient suffers from mouth pain • If evidence of ulceration/soreness on tongue • If evidence of ulceration, bleeding gums or whiteness in gums/soft tissues		
			Oral Care		
			If patient is able, prompt by providing adequate opportunity and support to carry out oral care.		
			If patient is dependent, ensure mouth care is offered and provided at regular intervals.		
			If patient has dentures supervise/help with cleaning them night and morning with mild soap and water; rinse dentures after meals. Dentures should be left out and soaked in sodium hypochlorite overnight or for at least 20 minutes, before rinsing and leaving in plain water for the rest of the time. Metal-based dentures should be soaked in chlorhexidine mouthwash.		
			Other Issues		
			If lips are dry apply emollient e.g. lubricating gel.		
			If tongue is dry and coated clean with soft toothbrush and toothpaste and offer frequent fluids.		
			If patient suffers from dry mouth offer frequent fluids and/or iced water. If symptoms persist refer to dentist.		
			If patient has difficulty swallowing you should supervise/help with cleaning teeth and/or dentures and oral cavity after each meal.		
			If patient is nil by mouth or has poor fluid or dietary intake or is dehydrated they may require 2-hourly mouthcare. Check whether oral problems contributing.		
			If patient is on an energy dense diet or prescribed supplements/snacks consider high fluoride toothpaste if have natural teeth.		
			This care plan has been discussed and agreed with the patient as appropriate.		

NHS Ayrshire & Arran

Adapted Waterlow Pressure Area
- Risk Assessment Chart

More than one score can be used in each section

Complete assessment according to PPURA or if there is a change in individual's condition and repeat regularly according to local protocol

Write or attach label

HCR No:.....
CHI No:.....
Surname:.....
Forename:..... Sex:.....
Address:.....
.....
Date of Birth.....

		Date									
		Time									
Sex											
Male 1	Female 2										
Age											
14 - 49	1										
50 - 64	2										
65 - 74	3										
75 - 80	4										
81+	5										
Build/Weight for Height (BMI=weight in Kg/height in m²)											
Average - BMI 20-24.9	0										
Above average - BMI 25-29.9	1										
Obese - BMI > 30	2										
Below average - BMI < 20	3										
Continence											
Complete/catheterised	0										
Urinary Incontinence	1										
Faecal incontinence	2										
Urinary and faecaly incontinent	3										
Skin Type - Visual Risks Area											
Healthy	0										
Tissue paper (thin/fragile)	1										
Dry (appears flaky)	1										
Oedamatous (puffy)	1										
Clammy (moist to touch) pyrexia	1										
Discoloured/Bruising/Grade 1	2										
Broken (established ulcer) Grade 2 - 4	3										
Mobility											
Fully mobile	0										
Restless/fidgety	1										
Apathetic (sedated/depressed/reluctant to move)	2										
Restricted (restricted by severe pain or disease)	3										
Bedbound (unconscious/unable to change position/traction)	4										
Chairbound (unable to leave chair without assistance)	5										
Special Risks - Tissue Malnutrition											
Multiple organ failure/terminal cachexia	8										
Single organ failure e.g. cardiac, renal, respiratory	5										
Peripheral vascular disease	5										
Anaemia = Hb < 8	2										
Smoking	1										
Special Risks - Neurological Deficit											
Diabetes/MS/CVA/motor/sensory/paraplegia *Max 6*	4-6										
Special Risks - Surgery/Trauma											
On table > 2 hours (up to 48 hours post op)	5										
On table for up to 6 hours (up to 48 hours post op) provided the rate of recovery is normal)	5										
Orthopaedic/below waist/spinal	8										
Special Risks - Medication											
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*	4										
	Total Score										
	Initials										

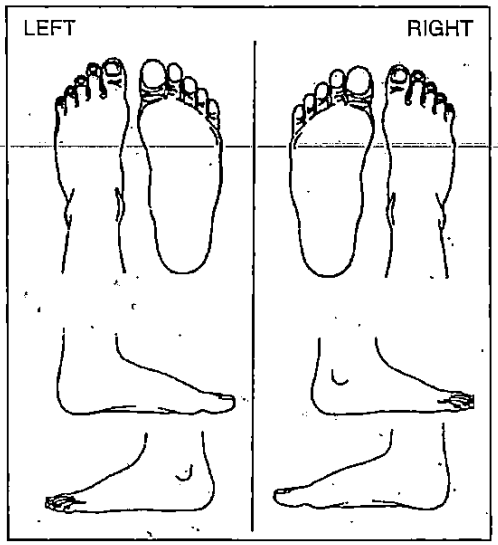
<10 Low Risk - Reassess weekly
10+ At Risk - Reassess twice weekly
15+ High Risk - Reassess on alternate days
20+ Very High Risk - Assess daily

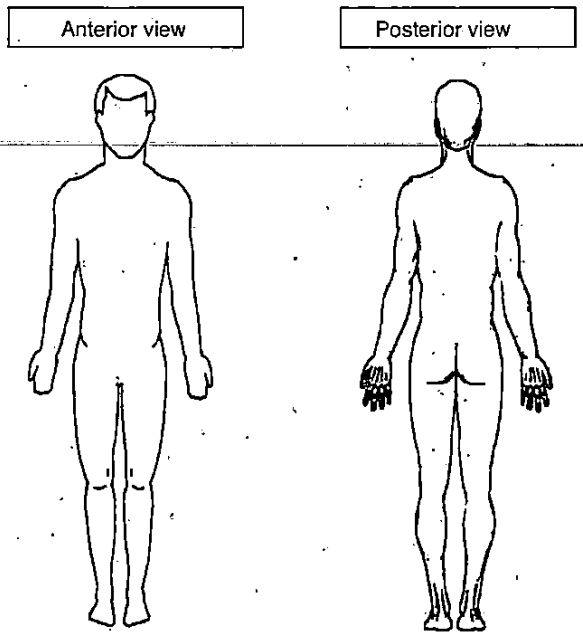
- The Waterlow **must be reassessed** if the patient's condition changes /deteriorates and the plan of care should be reviewed at that point.
- For patients who are in long term care, provided their condition is stable after one week of admission the Waterlow can be reassessed weekly/monthly

Risk Assessment

Pressure Ulcer Record

Indicate by circling, numbering and dating all pressure damage on diagrams, then complete box below. Initiate SSKIN care plan/wound assessment chart.





Date	Number of ulcer	Location of ulcer	Grade of ulcer	Datix Insert reference Grade 2-4	Logged on safety cross Grade 1-4	Signature	Print name

<u>Scottish Adapted European Pressure Ulcer Advisory Panel) EPUAP - Pressure Ulcer Grading Tool - 2014</u>

GRADE 1 Intact skin with non blanchable redness, usually over a bony prominence. Darker skin tones may not have visible blanching but the colour may differ from the surrounding skin. The area may be painful, firmer, softer, warmer or cooler than the surrounding tissue.

GRADE 2 Loss of epidermis/dermis presenting as a shallow open ulcer with red/pink wound bed without slough or bruising. May also present as a blister.

GRADE 3 Subcutaneous fat may be visible but bone tendon or muscle is not visible or palpable. Slough may be present but does not obscure the depth of tissue loss. Often includes undermining or tunnelling

GRADE 4 Extensive destruction with exposed or palpable bone, tendon or muscle. Slough may be present but does not obscure the depth of tissue loss. Often includes undermining or tunnelling.

DEEP TISSUE INJURY Epidermis is intact but the area appears purple or maroon or is a blood filled blister over a dark wound bed. Over time the skin will degrade and develop into deeper tissue loss.

UNGRADABLE: Full thickness skin loss where the depth of the ulcer is completely obscured by slough/necrosis. Until enough slough or necrotic tissue is removed to expose the base of the wound the true depth cannot be determined. It may be a grade 3 or 4 once debrided.

All acquired pressure ulcers graded 2 - 4 must be reported via Datix.
Refer to podiatry for at risk feet.

Slips Trips & Falls Assessment Tool

Date of admission: ...../...../.....

Please assess ALL patients with a history of falls or over 65 years or if clinically indicated
Each category must be filled in
If the patient does not meet any of the criteria, N/A to be entered in box
You can have more than one score for some categories

Write or attach label

HCR No:.....
CHI No:.....
Surname:.....
Forename:..... Sex:.....
Address:.....
.....
Date of Birth.....

	Ward Name: Assessment Date and Time of Day	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:
ITEM	**SCORE**	**SCORE**	**SCORE**	**SCORE**	**SCORE**	**SCORE**
GENDER	1 = Male 2 = Female					
AGE	1 = 16-70 years 2 = 71-80 years 3 = 81 + years					
GAIT/MANNER OF WALKING (with usual aid)	1 = Hesitant 3 = Unsteady / Falls back / Unable to walk					
COGNITION	3 = Any degree of disorientation					
SENSORY	1 = Poor hearing 1 = Poor sight 2 = Poor balance 2 = Uncoordinated limb movement or loss of sensation in lower limb					
FALL HISTORY	1 = Fall(s) in street 1 = Fall(s) in the ward 1 = Fall(s) at home					
MEDICATIONS (see over for examples)	1 = Sedation/analgesics 1 = Tranquillisers 1 = Cardiovascular drugs 1 = Bladder medication					
MEDICAL HISTORY (see over for examples)	1 = Altered endocrine/electrolyte balance 1 = Neurological Disorders 1 = Other (i.e. arrhythmias, blackouts etc) 1 = Incontinent of urine and/or faeces					
ACTIVITY AND MOBILITY	1 = Independently mobile with or without usual aid 2 = Needs assistance and/or supervision with transfers or mobility 2 = Needs the assistance of 1-2 people to transfer to toilet/commode 3 = Bed/chair bound but moves/rolls unsafely					
	TOTAL					
Level of Risk	LOW (L) = 6-8 / MEDIUM (M) = 9-12 / HIGH (H) = 13+					
Initials						
Print Name						
Designation						

Slips Trips & Falls - Assessment Tool

What happens once you have a score?

- If the patient has scored>6 the appropriate actions should be implemented using the Slips, Trips and Falls care plan
- For low risk patients follow actions in the green section only of the action list
- For medium risk patients follow actions in the green and yellow sections of the action list
- For high risk patients follow actions in the green, yellow and red sections of the action list

Re Assessment Occurs

- Weekly
- When the patient's condition changes (i.e. patient falls/post surgery/change in medication/cognitive state changes)

If the patient has a slip, trip or fall whilst an in-patient, a Datix should be completed and it should also be recorded here.

Slip, Trip or Falls Record (Please complete after each incident)

Date	Time of Day	Location	Injuries?	Circumstances	Datix Number

Medication examples:

SEDATION/ ANALGESICS	TRANQUILLISERS/ ANTIDEPRESSANTS	CARDIOVASCULAR DRUG (those that reduce BP)	BLADDER MEDICATION
• Nitrazepam • Temazepam • Tramadol • Co-codamol	• Risperidone • Haloperidol • Amitryptyline • Alcohol	• Atenolol • Isosorbide Mononitrate • Digoxin • GTN • Diltiazem • Diuretics • Ace-inhibitors	• Doxazosin • Oxybutynin • Tamsulosin (Flomax)

Medical history examples:

Examples of **Altered endocrine/electrolyte balance**	Examples of **Neurological Disorders**	Examples of **"Other"**
• Diabetes • Hyponatraemia • Low calcium • Low potassium	• Parkinson's Disease • Stroke • Head Injury	• Arrhythmias • Osteoporosis • Postural hypo/hypertension • Peripheral Neuropathy • Intermittent heart block • Epilepsy

Falls for All Bundle

Please complete for all patients on admission

Write or attach label
HCR No:.....
CHI No:.....
Surname:.....
Forename:..... Sex:
Address:.....
Date of Birth

1. 5Q's
   a. Has the patient fallen in the last 6 months – including during this admission? Yes ☐ No ☐
   b. Does that patient have cognitive impairment or possible delirium? Yes ☐ No ☐
   c. Does that patient attempt to walk alone although unsteady or unsafe? Yes ☐ No ☐
   d. Does the patient or their relative/s have fear or anxiety, Re falling? Yes ☐ No ☐
   e. Based on your clinical judgement, is this patient at high risk of falling? Yes ☐ No ☐

If yes to any of the above, the patient is deemed as a vulnerable patient and should be commenced on the more vulnerable falls bundle (recording of this is included in care and comfort rounding or alternatively should be recorded in the patients records).

Initials:.....

Date:.....

Time:.....

Slips Trips & Falls - Care Plan

(To be used in conjunction with the falls for all bundle)

Problem Number:

Write or attach label
HCR No:
CHI No:
Surname:
Forename: Sex:
Address:
Date of Birth

Patient Problem/Need
Patient is considered to be at risk of falling

Goal
To promote and maintain patient safety and reduce the risk of falls

Date	Time	Initial	Planned Nursing Interventions	Discontinued Date/Time	Initial
			Orientate patient and family/carers to ward environment on admission and each shift.		
			Ensure buzzer within reach.		
			Explain importance about calling for help when needed.		
			Ensure that bedside table and key belongings are within easy reach.		
			Ensure patient wears appropriate clothing and footwear.		
			Ensure that patient is wearing spectacles if appropriate.		
			Discuss with family/carers how to assist with interventions.		
			Ensure that patient/family receives an explanation of risk and the measures in place to minimise this risk and document outcome.		
			Ensure that standard bed frame is used and left in a low position with brakes on.		
			Select a chair that is the appropriate height and design for the patient (seek guidance from Physio and OT).		
			When in use ensure that chair/commode brakes are secure.		
			Ensure that area is illuminated appropriately at night time.		
			Liaise with medical team re: medication review.		
			Consider referral to Physiotherapy, Occupational Therapy, Social Work.		
			Monitor lying and standing blood pressure.		
			Supervise patient when transferring as per moving and handling risk assessment.		
			Supervise patient when mobilising as per moving and handling risk assessment.		

			Offer toileting facilities as appropriate.		
			Ensure that patient is cared for in an area proximal to toilet facilities, if possible.		
			Encourage family, if present, to sit with patient (as appropriate).		
			Encourage family/carers to report to nursing station when ending their visit.		
			Consider appropriate equipment in liaison with Physio and / or OT.		
			Ensure yellow sticker is inserted into patient's notes after each fall.		
			Patients who may be confused or have had repeated falls where possible should be cared for in an area within the ward that is within easy view of nursing staff.		
			Check on patient every 15 minutes.		
			Consider a higher level of supervision of the patient.		
			Consider the use of a low level variable height bed.		
			Above care plan has been discussed and agreed with the patient and / or family / carer		

NHS Ayrshire & Arran

Bedrails Risk Assessment

Date of admission:.....

Write or attach label
HCR No:.....
CHI No:.....
Surname:.....
Forename:..... Sex:.....
Address:.....
.....
Date of Birth.....

Please assess ALL patient on admission to your ward/departments

- Each statement must be answered - Circle answer
- Complete Risk Assessment in conjunction with Bedrails Algorithm overleaf
- Refer to Guidelines - Safe Use of Bedrails in In-patient Settings & Falls Prevention
- Ensure that you are aware of the safety requirements when using a bedrail, you have undertaken a visual check of the bedrail and that you are satisfied that there are not obvious areas of faults

Re Assessment Occurs

- Weekly
- When the patient's condition changes (i.e. patient falls/post surgery/change in medication/cognitive state changes)

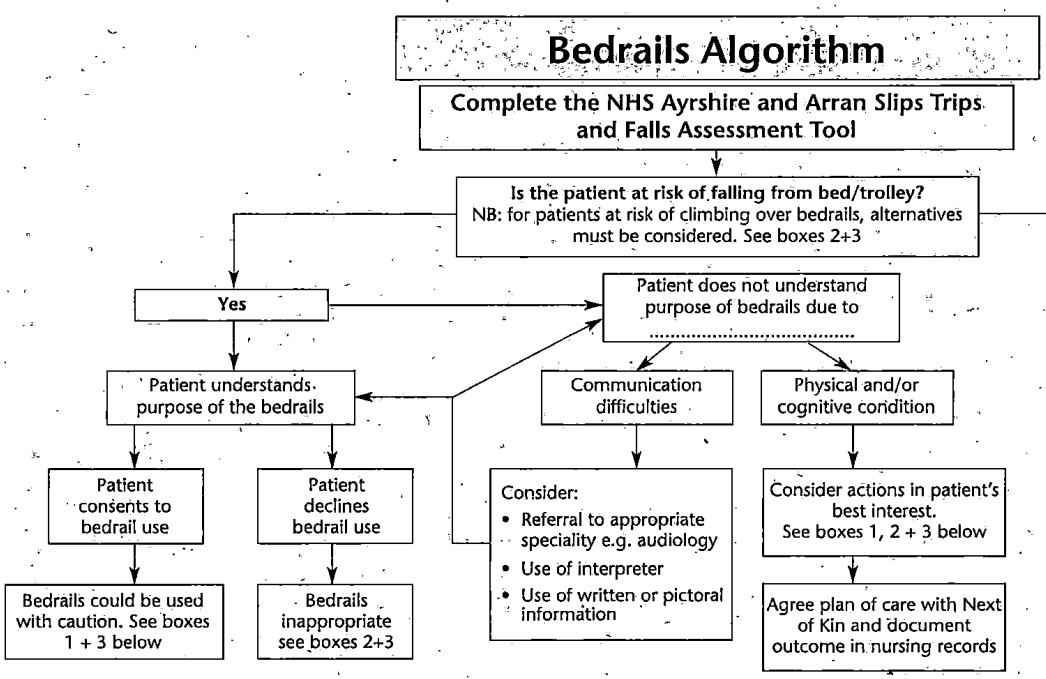
Ensure clear identification of a change in use of bedrails within documentation and at bed space if consent obtained from patient

Risk Factors	Ward: Date: Time:	Ward: Date: Time:	Ward: Date: Time:	Ward: Date: Time:
1. Is the patient at risk of **falling** from bed?	YES / NO	YES / NO	YES / NO	YES / NO
2. Is the patient at risk of **intentionally** climbing over the bedrails?	YES / NO	YES / NO	YES / NO	YES / NO
3. Is the patient at risk of **unintentionally** falling from the bed/trolley?	YES / NO	YES / NO	YES / NO	YES / NO
4. Does the patient **understand** the purpose of the bedrails? Consider communication difficulties and physical/Cognitive condition.	YES / NO / NA	YES / NO / NA	YES / NO / NA	YES / NO / NA
5. Does the patient **consent** to the use of bedrails?	YES / NO / NA	YES / NO / NA	YES / NO / NA	YES / NO / NA
Has the Bedrails Algorithm been followed?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
According to the Bedrails Algorithm are bedrails required / appropriate?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Bumpers required	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Initials				

If Yes, commence a Safe Use of Bedrails Care Plan. If No, state reason why bedrails are not required.

RISK ASSESSMENT

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 their use on the patient
- Ensure bed returned to lowest height after care delivery
- Use of the Dynamic mattress increases the height of the bed

2. Alternatives to bed rails

- Use of variable height bed
- Additional mattress/crash mat beside bed
- Close observation of patient
- 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, electric sockets etc. Manual handling risk assessment for staff must be undertaken

3. Remember to document in nursing records:

- Date and time assessment made
- Rationale for decision made in care plan
- Actions taken, including discussion with Next of Kin
- Care planning

Assessment should be made:

- On admission
- If patient's condition changes
- Weekly

Safe Use of Bed Rails - Care Plan

Write or attach label
HCR No:.....
CHI No:.....
Surname:.....
Forename:..... Sex:.....
Address:.....
.....
Date of Birth.....

Patient Problem/Need
The patient is at risk of falling out of bed due to (e.g. cognitive or physical condition)

Goal
To promote and maintain patient safety and reduce the risk of falling out of bed

Date	Time	Initial	Planned Nursing Interventions	Discontinued Date/Time	Initial
			Ensure assessment is made on admission, when patient's condition changes, and weekly as a minimum.		
			Ensure rationale for decision made re; the use of bedrails is clearly documented.		
			Consider psychological effects of bedrail usage on patient and where appropriate ensure the patient's consent to their use.		
			Ensure risk of entrapment is minimised by careful positioning of patient prior to operating bedrails.		
			If detachable bedrails used, ensure the gap between the top end bedrail and head of bed is less than 6cm or more than 25cm.		
			If detachable bedrails used, ensure the gap between the bottom end of bedrail and foot of bed is more than 25cm.		
			Continually monitor risk of patient climbing over the top of bedrails and assess the use of bedrails as necessary.		
			Discuss with the patient, the need to share information with other nurses and health care workers re; the use of bedrails, and document within the nursing documentation whether the patient consents to display information at the bed space.		
			Provide Falls/Use of Bedrails information leaflet to patient. Where the patient is incapacitated, ensure that relative/carer is given a leaflet and information about the assessment for bedrails is provided.		
			Ensure all actions, including discussions with relative/ carer are documented.		
			Refer to the Safe Use of Bedrails in Adult In-Patient Settings Guideline for further guidance on the management of bedrails.		
			Re-assess the need for bedrail use at least weekly or as the patient's condition indicates and document on the risk assessment chart.		
			This care plan has been discussed and agreed with the patient as appropriate.		

Risk Assessment

Moving & Handling
Patient Risk Assessment

Write or attach label

HCR No:.....
CHI No:.....
Surname:.....
Forename:..... Sex:.....
Address:.....
.....
Date of Birth.....

All Patients:

Sliding aids **must** be used bed to trolley/bed unless the patient transfers independently
A hoist **must** be used if assistance is required from the floor
A hoist **must** be used for bathing unless independently mobile
Hoists are for lifting patients and must not be used for transport between rooms

Special Alerts: **Date:**						
Overweight / Obese (BMI definition)						
Very tall (>185cm in height)						
Restricted use of limbs						
Poor standing ability						
Sedation or lethargy						
Irrational behaviour / confusion						
Unable to co-operate						
Acute pain						

Assessment of Risk:

Low Risk: Independently mobile / supervision only required. Aids required should be specified in care plan

Moderate Risk: Requires physical assistance from one or more handlers. Is able to stand or partially bear weight and has no more than one special alert.

High Risk: (a) Is unable to bear weight and requires assistance.
(b) 2 or more special alerts present and requires assistance.

Aids, equipment and a minimum of 2 handlers recommended to move a patient.

Specify Level of Risk

Date:						
LOW RISK						
MODERATE RISK						
HIGH RISK						
Assessor's Initials						

If a hoist or standing aid is required please specify:

Sling type:		**Size:**		**Manufacturer:**	

Additional Comments:

MOVING AND HANDLING CARE PLAN

Date:							
1. Moving in bed:							
a) Independent	a)						
b) Handlers and sliding sheets required to move in bed - specify number of handlers in grid	b)						
c) Specify any additional equipment required in grid	c)						
2. Sitting to Standing:							
a) Independent	a)						
b) Requires assistance from sit/stand to sit? Specify number of handlers in grid	b)						
c) Also requires aids. Specify equipment in grid	c)						
4. Transfers: (chair / wheelchair / commode / toilet / bed)							
a) Independent or with minimal supervision	a)						
b) Assistance required from handlers specify number of handlers in grid.	b)						
c) Equipment required - specify equipment in grid	c)						
4. Adjusting Clothing							
a) Independent or minimal supervision	a)						
b) Can use support/grab rails while assistance is given with clothing	b)						
c) Requires support from Handler(s) while another assists with clothing	c)						
d) Requires equipment, specify equipment in grid	d)						
5. Repositioning in chair / wheelchair:							
a) Independent or minimal supervision	a)						
b) Assistance from handler(s), specify number in grid	b)						
c) Specify other aids or equipment required in grid	c)						
6. Mobilising:	Documented in Mobility Care Plan						
Assessors initials							

If it is decided to stand, transfer or mobilise a patient requiring assistance of more than 2 handlers, without equipment, a detailed assessment outlining the decision making process must be documented in the mobility careplan.

Mobilising - Care Plan

Write or attach label

HCR No:.....
CHI No:.....
Surname:.....
Forename:..... Sex:.....
Address:.....
.....
Date of Birth.....

Patient Problem/Need
Patient has restricted mobility/mobility is deteriorating due to.....
Goal
To optimise ability to mobilise safely and maintain independence as much as possible

Date	Time	Initial	Planned Nursing Interventions	Discontinued Date/Time	Initial
			Refer to moving and handling risk assessment tool and plan care accordingly.		
			Mobilise/transfer with assistance of one/two handlers.		
			Mobilise/transfer with supervision.		
			Mobilising with appropriate handling equipment and/or aids, please state:-		
			• Walking stick one/two		
			• Tripod/quad		
			• Zimmer frame/rolator		
			• Wheel chair		
			• Hoist aid (specify equipment used)		
			• Other (please specify)		
			Refer to physiotherapist and action specialist requirements.		
			This care plan has been discussed and agreed with the patient and/or carer/relative as appropriate.		

Referrals to Multidisciplinary Team During Admission

Date	Initials of staff making referral	Referrals	Contact Number/ Page	Date Reviewed	Initials
		Alcohol Liaison Team			
		Community Learning Disability Team			
		Community Mental Health Team			
		Community Mental Health Team Elderly			
		Community Nurse			
		Community Psychiatric Liaison Team			
		Community Psychiatric Liaison Team Elderly			
		Dental			
		Diabetic Team			
		Dietitian			
		Discharge Co-ordinator			
		Fresh Air-shire			
		Home Care Organiser			
		Intermediate Care and Enablement Services			
		Occupational Therapist			
		Palliative Care Team			
		Pain Team			
		Pharmacist			
		Physiotherapist			
		Podiatrist			
		Psychiatric Liaison Team			
		Speech and Language Therapist			
		Social Worker			
		Specialist Nurse			
		Tissue Viability			
		Other - please specify			

Care Plans and Monitoring Charts Evaluation

Write or attach label

HCR No:.....
CHI No:.....
Surname:.....
Forename:..... Sex:.....
Address:.....
.....
Date of Birth.....

Code	Care Plan / Monitoring Chart	Code	Additional specific care plans / monitoring Charts
A	Admitted as an emergency	1	
B	Breathing	2	
C	Catheter	3	
D	Cleansing and dressing	4	
E	Elimination	5	
F	Falls	6	
G	Bedrails	7	
H	Mobilising	8	
J	Communication	9	
K	Pre - operative	10	
L	Post - operative	11	
M	Wound Management	12	
N	Pressure area care	13	
O	Oral Hygiene	14	
P	Pain Management	15	
R	MUST - Eating and Drinking	16	
S	Emotional Wellbeing/Anxiety	17	
T	MRSA	18	
V	MEWS	19	
W	Fluid Balance Chart	20	
X	PVC Chart	21	
Y	Investigations		
Z	Cognitive impairment		

Initial Presentation and Plan

Write or attach label

HCR No:.....
CHI No:.....
Surname:.....
Forename:..... Sex:.....
Address:.....
.....
Date of Birth.....

Ward _____

Date & Time	Immediate presenting history (inc GP, ED or clinic)	Initials
	Medical/ANP Initial Plan	

Ward Round Instructions / Goals of Care

Write or attach label

HCR No:.....
CHI No:.....
Surname:.....
Forename:..... Sex:.....
Address:.....
.....
Date of Birth.....

Ward _____

Date & Time	Ward Round Instructions	CLD	EDD	Initials

Ward _____

Ward Round Instructions

Date & Time	Ward Round Instructions	CLD	EDD	Initials

Write or attach label

HCR No:.....

CHI No:.....

Surname:.....

Forename:..... Sex:.....

Address:.....

.....

Date of Birth.....

Ward _____

Date & Time	Ward Round Instructions	CLD	EDD	Initials

Ward Round Instructions

Ward Round Instructions

Ward _____

Date & Time	Ward Round Instructions	CLD	EDD	Initials

Write or attach label

HCR No:
CHI No:
Surname:
Forename: Sex:
Address:
Date of Birth

Ward 5TTO

Date & Time	Care plan Code	Nursing Evaluation	Initials
10/3/18		C/A attended A&E 9/3/18 advised to	
1400		return to ward fasted today for	
		exploration + washout —	
		Returned from theatre around 12.45hrs	
		following exploration + washout + extensor	
		tendon repair under GA. Fully awake on	
		return to ward, NEWS 1 due to	
		tachycardia. Has had some diet and	
		fluids, still to pass urine ☐ —	MM
		Post-op instructions :- ~~hand in back~~ elevation	
		~~slab to remain 4 weeks~~, R.O.S 12-14 days	
		at #clinic ?? for splint backslab insitu	
		at present time, 24hrs worth of cefuroxime	
		then none, #clinic 20/3/18 —	MM
11/3/18 0600	E	States passing urine with nil	
		issues.	
	G	Backslab left clean as per patient	
		request	
	H	Independently mobile.	
	M	Backslab insitu.	
	P	Denies any pain	
	R	Managing diet & fluids	
	V	NEWS stable	
11/3/18	J.	Washed independently	
09.00		this morning	JO
	E.	No issues stated to	
		staff on passing	
		urine.	JO
	H.	Independently mobile	
		around ward area.	JO

Nursing Care Evaluation

Nursing Care Evaluation

Ward _____

Date & Time	Care plan Code	Nursing Evaluation	Initials
	M.	Backslab in situ, no staining noted.	JD
	N.	Pressure areas are intact.	JD
	J.	Patient awaiting r/v from consultant avait decision on discharge/ ☐ Discharge letter ☑ Transport ☑ Meds given, ☐ patient aware to return to fracture clinic. Happy with all informatio given.	JD

Write or attach label

CHI 3108823299
GREEN LEE
18 BROWN STREET,
NEWMILNS,
KA16 9AA
31/08/1982 Ptact 80260
Case Ref 337455

ORTHO
REV

Ward Plaster room

Date & Time	Care plan Code	Nursing Evaluation	Initials
22.3.18			
0930	M	Wound reviewed by Mr Wilson. Sutures removed, wound OK. Mepore applied and cast.	KY/MT

Nursing Care Evaluation

Ward _____

Nursing Care Evaluation

Date & Time	Care plan Code	Nursing Evaluation	Initials

Write or attach label

HCR No:.....

CHI No:.....

Surname:.....

Forename:..... Sex:.....

Address:.....

.....

Date of Birth.....

Ward _____

Date & Time	Care plan Code	Nursing Evaluation	Initials

Nursing Care Evaluation Form

Ward _____

Nursing Care Evaluation

Date & Time	Care plan Code	Nursing Evaluation	Initials

Write or attach label

HCR No:.....
CHI No:.....
Surname:.....
Forename:..... Sex:.....
Address:.....
.....
Date of Birth.....

Ward _____

Date & Time	Care plan Code	Nursing Evaluation	Initials

Nursing Care Evaluation

Ward _____

Nursing Care Evaluation

Date & Time	Care plan Code	Nursing Evaluation	Initials

Write or attach label

HCR No:.....
CHI No:.....
Surname:.....
Forename:..... Sex:.....
Address:.....
.....
Date of Birth.....

Ward_____

Date & Time	Care plan Code	Nursing Evaluation	Initials

Nursing Care Evaluation

Ward _____

Nursing Care Evaluation

Date & Time	Care plan Code	Nursing Evaluation	Initials

Write or attach label

HCR No:.....

CHI No:.....

Surname:.....

Forename:..... Sex:.....

Address:.....

.....

Date of Birth.....

Ward_____

Date & Time	Care plan Code	Nursing Evaluation	Initials

Nursing Care Evaluation

Ward _____

Nursing Care Evaluation

Date & Time	Care plan Code	Nursing Evaluation	Initials

Multi-professional Communication Sheet

Write or attach label

HCR No:.....

CHI No:.....

Surname:.....

Forename:..... Sex:.....

Address:.....

.....

Date of Birth.....

Ward.....

Date & Time	Communication and significant information discussed with multi professional team	Initials

Multiprofessional Communication Sheet

Multiprofessional Communication Sheet

Ward _____

Date & Time	Communication and significant information discussed with multi professional team	Initials

Multiprofessional Communication Sheet

Write or attach label

HCR No:.....
CHI No:.....
Surname:.....
Forename:..... Sex:.....
Address:.....
.....
Date of Birth.....

Ward _____

Date & Time	Communication and significant information discussed with multi professional team	Initials

Multiprofessional Communication Sheet

Ward _____

Date & Time	Communication and significant information discussed with multi professional team	Initials

Patient / Family / Carer Communication Sheet

Write or attach label

HCR No:.....

CHI No:.....

Surname:.....

Forename:..... Sex:.....

Address:.....

.....

Date of Birth.....

Ward_____

Date & Time	Communication and significant information discussed with patient / family / carers. This may include relevant telephone communication	Initials

Patient / Family / Carer Communication

Ward _____

Patient / Family / Carer Communication

Date & Time	Communication and significant information discussed with patient / family / carers. This may include relevant telephone communication	Initials

Previous medical, surgical and mental health history

Details	Date (if Known)	Details	Date (if Known)
ORIF (L) KNEE			

Medications

Any important information regarding medications.....

Own medication retained on ward Yes ☐ No ☐ Where stored.....

Have the medications been returned to relatives? Yes ☐ No ☐ ☐ N/A

Please complete below when patient is admitted or transferred to your clinical area

Verbal information given to patient and / or relatives:	Ward: Date: Yes	Ward: Date: N/A	Ward: Date: Yes	Ward: Date: N/A	Ward: Date: Yes	Ward: Date: N/A
Call buzzer If patients unable to use buzzer ensure this is reflected in care planning	✓					
Toilets / Bathroom	✓					
Explained Protected Mealtimes	✓					
Visiting times	✓					
Hand hygiene	✓					
Valuables	✓					
Smoking		✓				
Patient Discharge Booklet given		✓				
Other.....						
Sign	MM	MM				

Patient's Property - Where possible send belongings home with family

You are asked to keep belongings/valuables to a minimum whilst in hospital. You are responsible for property belonging to you not handed over for safe custody. This includes cash, spectacles, hearing aids, dentures and other personal items and valuables. Valuables should be sent home at first opportunity or given to the nurse if this is not possible.

Valuables handed over for safe keeping will be sent to the cashier's office and a receipt will be issued. If patient lacks capacity please ensure relevant documentation is completed for belongings and valuables.

Signature of Patient / Significant Other: x [signature] Date 10/3/18

Property handed over for Safe Keeping: Yes ☐ No ☐ Sticker on front page: Yes ☐ No ☐

Date taken to Cashier:_____ Cash & Valuables Ref No:_____ Date Returned:_____

Personal Details

Personal Details

Cognitive assessment	Circle		
To be completed on all patients over 65 or if appropriate or if the patient has suspected delirium Ask the patient the following questions: (4AT)	1st Assessment	Further Assessment	Further Assessment
	Date	Date	Date
1. ALERTNESS This includes patients who may be markedly drowsy (eg. Difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gently touch on shoulder. Ask the patient to state their name and address to assist rating			
Normal (fully alert), but not agitated, throughout assessment)	0	0	0
Mild sleepiness for <10 seconds after waking, then normal	0	0	0
Clearly abnormal	4	4	4
2. AMT4 Age, date of birth, place (name of the hospital or building), current year.			
No mistakes	0	0	0
1 mistake	1	1	1
2 or more mistakes/untestable	2	2	2
3. ATTENTION Ask the patient "Please tell me the months of the year in backwards order, starting at December". To assist initial understanding one prompt of "what is the month before December?' is permitted.			
Months of the year backwards, Achieves 7 months or more correctly	0	0	0
Starts but scores <7 months / refuses to start	1	1	1
Untestable (cannot start because unwell, drowsy, inattentive)	2	2	2
4. ACUTE CHANGE OF FLUCTUATING COURSE Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. Paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs			
No	0	0	0
Yes	4	4	4
4 or above: possible delirium +/-cognitive impairment: refer to algorithm 1-3: possible cognitive impairment 0: delirium or cognitive impairment unlikely (but delirium still possible if question 4 information incomplete)			
If 4AT of 4 or above commence Time Bundle			
4AT SCORE			
SIGN			
If you have concerns regarding capacity, please refer to algorithm and dementia/delirium care plan.			
If no 4AT carried out please document reason eg Patient unconscious.....			

Informed Consent and Capacity

While undertaking the patient's clinical assessment, if you have any concerns regarding the patient's capacity and ability to make healthcare decisions refer to medical staff for **assessment and treatment plan** under the Adults With Incapacity (Scotland) Act 2000 and document your actions within the nursing notes. Refer to the Consent policy for further guidance.

Information about the patient can be obtained from relatives and carers including legal guardians (e.g. guardianship through the social work department)

Relatives and carers cannot make decisions for patients except in certain circumstances where they hold Welfare Guardianship or Power of Attorney extending to health care decisions under the Adults With Incapacity (Scotland) Act 2000.

	Yes	No			Names
Advanced Statement	☐	☐			.....
Power of Attorney details	☐	☐	Financial ☐	Welfare ☐	.....
Guardianship details	☐	☐	Financial ☐	Welfare ☐	.....
"Getting to know me" in use	☐	☐			.....

If yes to any of the above obtain a copy of the relevant document.

If diagnosis of dementia is confirmed please ensure appropriate documentation / care plans are initiated

Adult Support and Protection – 3 point criteria

An adult who:

- Are unable to safeguard their own well-being, property, rights or other interests
- Are at risk of harm; and
- Because they are affected by disability, mental disorder, illness or physical or mental infirmity are more vulnerable to being harmed than adults who are not so affected.

Harm includes:

- All harmful conduct and in particular:
- Conduct which causes physical harm;
- Conduct which causes psychological harm (for example by causing fear, alarm or distress);
- Financial harm
- Conduct which causes self-harm

If you have a concern about an adult who you believe is or may be at risk of harm complete an ASP/Concern referral.

ASP / Concern referral submitted Yes ☐ No ☑

All referral information can be found on AthenA Adult Support and Protection site.

Consent to display limited information

Patient consents to display of CHI number and limited personal information about care (e.g. bedrails, diet, mobility, "forget me not") on a chart at the bedside and whiteboard etc.

Consent given: Yes ☑ No ☐ By whom: Patient ☑ Relative/Carer ☐

If the patient has declined to consent to information being displayed at the bed space please provide information here .....

.....

Nurse Initials mm Date 10/3/18

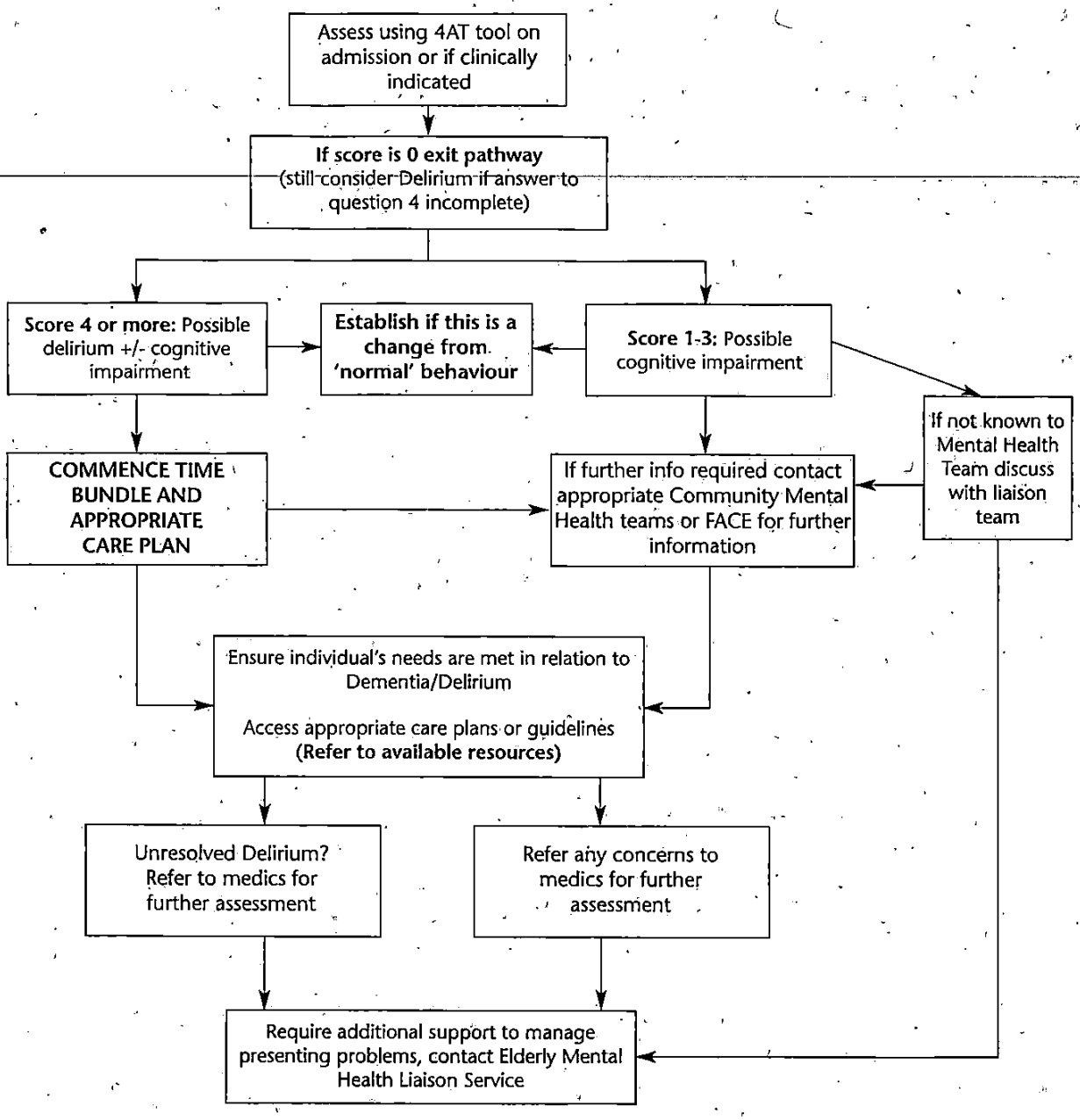
Useful Contacts:

To support your plan of care for this patient you might find it helpful to contact the relevant liaison service below:

Learning Disability Liaison Nurse Specialist:	01294 323560 (north) 01292 614910 (south) 01563 578574 (east)
Mental Health Liaison Nurses (Elderly Services)	01292 513007
Psychiatric Liaison Nurse (Adult general hospitals)	01563 826120
Advocacy Services	01294 608664 (north) 01292 264396 (south) 01563 574442 (east)
Hospital Social work team	Hospital site contacts through switchboard.

Additional relevant information (including details of the relevant liaison service contacted)

Nursing Assessment and Management of Cognitive Impairment



Useful Contact numbers

If patient has diagnosis of dementia and lives:

Nursing/Care Home: Contact **Elderly Mental Health Care Home Liaison Nurse** who will be able to provide background information regarding patient and support discharge arrangements.

Telephone no:.....

At home: Contact **Community Mental Health Team** as patient likely to be known to them>they may offer advice and/or background info.

Telephone no:.....

If patient does not have a diagnosis of dementia but further advice/support req'd whilst an in-patient, contact: **Elderly Mental Health Liaison service**

Telephone no:.....

If patient is known to any of the Mental Health Teams please inform when fit for home/discharge plans.

Useful Available Resources

Access if available:

Getting to Know Me - hand held document used by patients

Dementia Care Plan - for pts with a diagnosis of dementia

Delirium Care Plan - for pts displaying symptoms indicative of delirium

Identification and Management of Delirium in the Elderly - can be found on back of Delirium Care Plan

Behavioural and Psychological Symptoms associated with Dementia - a guide to cause and management in behaviour that challenges in delivery of care of patients with dementia

Abbey Pain Scale - pain tool that should be used for pts with dementia and/or who cannot verbalise

Time Bundle - Time Bundle for patients with 4AT of 4 or more

All of the above resources can be accessed through Athena or in Dementia Resource Folder if available.

NHS Ayrshire & Arran

Intermediate Care Profile
(Anticipated stay <3 days)

V [barcode] EL

Surnar CHI 3108823299
Forena GREEN LEE
Address 18 BROWN STREET
NEWMILNS
KA16 9AA
31/08/1982 Pract 80260
Ward or. Case Ref 337455

Date of Admission 13/4/08 Time 14:00

Type of Admission: Emergency ☑ Elective ☐

Admitted From A E

Age 25 Religion NOT RELIGIOS

Marital Status SINGLE

GP Consultant

Next of Kin

Aware of Admission YES ☑ NO ☐

Name Margaret M'Eman

Relationship Mother

Address 52 East Main St
Darvel

Contact No: 01560 321338

Summary of Presenting Condition

(L) Patella #

Alternative Next of Kin

Aware of Admission YES ☐ NO ☐

Name

Relationship

Address

Contact No:

Previous Health Problems

NIL of note

Medicications Used at Home

Drug	Dosage

Stored in Ward YES ☐ NO ☐ Initials

Returned to Patient ☐ Relative ☐ Initials

Allergies

NKA

MRSA Screening Required

YES ☑ NO ☐

Swabs Taken 13/4/08 Initials C. an

Date	Investigations / Procedures	Patient Informed of Result
13/4/08	MRSA nasal Screen	

DRS5222

Observations on Admission

Temp	Pulse	Resp	BP	Sp O^2	LMP

Urinalysis

MSSU Obtained YES ☐ NO ☐

If obtained: Date

Smoker YES ☑ NO ☐

Number per Day 20 per day

Alcohol Intake

OCCASIONAL ALCOHOL

Dentures YES ☐ NO ☑

Upper Lower Partial Crowns

Communication

Vision: any problems YES ☐ NO ☑

Spectacles YES ☐ NO ☑

Hearing: any problems YES ☐ NO ☑

Speech Difficulty YES ☐ NO ☑

Elimination

Bladder: any problems YES ☐ NO ☑

Bowel: any problems YES ☐ NO ☑

Moving & Handling Assessment Requirement YES ☑ NO ☐ Signature

Nutrition Assessment Required YES ☐ NO ☑ Signature

Waterlow Assessment Required YES ☐ NO ☑ Signature

Property Retained by Patient

I understand articles / valuables retained by me are my own responsibility

Signature of Patient / Next of Kin * Lee Gavin

Date 13/4/08

Property taken for Safe-keeping

Cash & Valuables Ref.

Date Returned

Anticipated Discharge

Complicated ☐ Uncomlicated ☑

Transport Available YES ☑ NO ☐

Signature of Admitting Nurse

Print Name	IN	Grade	Signature	Print Name	IN	Grade	Signature
J BROWN		D	BBro				
DAWN MOIR	DM	SN	DMoi				
K A WATSON	KAW	S/N	KAWatson				

BEL
Su CHI 3108823299
GREEN LEE
Fo 18 BROWN STREET
Ad NEWMILNS
KA16 9AA
31/08/1982 Pract 80260
We Case Ref 337455

NHS Ayrshire & Arran

ACTIVITY OF LIVING

MAINTAINING SAFE ENVIRONMENT

Identify Problems / Needs Patient requires Surgical Nursing

	Date

Goal / Aim: To reduce anxiety and promote understanding

Date	Time	Initials	Nursing Actions	Discontinued Date / Time	Initials
13/4/08	1400	SB	Orientate to ward / staff / environment	14/04/08	KMcL
			Discuss management & nursing care plan with patient		
			Ensure patient understands pre operative and post		
			operative management		
			Allow patient time to voice fears and reiterate		
			information as necessary		
			Ensure family have contact number		
			Ensure patient and family have some indication		
			when surgery will take place		
13/4/08	1400	SB	Ensure patient and relatives are aware of visiting arrangements		
13/4/08	1400	SB	With patients consent inform relatives of patients management		
			Arrange meetings with consultant where requested		
			Where possible discuss possible transfer to		
			High Dependency Unit		
			Intensive Care Unit		
			Assess discharge needs with patient & family		

Date	Time	Initials	Nursing Actions	Discontinued Date / Time	Initials

SUMMATIVE ASSESSMENT **ACHIEVED** ☐ **DISCONTINUED** ☑

Comments

4/04/08
KHW

Ayrshire and Arran Acute Hospitals NHS Trust

WRITE IMPRINT OR ATTACH LABEL

CHI 3108823299
GREEN LEE
18 BROWN STREET
NEWMILNS
KA16 9AA
31/08/1982 Pract 80260
Case Ref 337455

ACTIVITY OF LIVING

Identify Problems/Needs

Date

_Pre operative minor orthopaedic

Goal / Aim: Observe and monitor patients activities of living

Date	Time	Initials	Nursing Actions	Discontinued Date / Time	Initials
13/4/08	1400	SB	Monitor and document baseline observations on admission	14/04/08	KAW
13/4/08	1400	SB	Maintain safe effective intravenous access as per protocol		
13/4	1400	SB	Give intravenous fluids as prescribed/protocol		
			Monitor input and output on fluid balance chart		
			Collect specimen of urine for ward test		
13/4	1400	SB	Obtain nasal swab for MRSA screen		
13/4	1400	SB	Monitor/observe/dress wound/fracture site as instructed		
		SB	Monitor CSM as instructed		
			Give prescribed medications and monitor effect		
13/4	1400	SB	Fast until otherwise instructed by medical staff		
13/4	1400	SB	Ensure correct identity bracelet in situ		
			Remove prosthesis as necessary		
13/4	1400	SB	Check patient has fasted adequately		
13/4	1400	SB	Check patient has given informed written consent where appropriate		
			Check for any specific instructions from anaesthetist and Carry out as instructed		

Ayrshire and Arran Acute Hospitals NHS Trust

W ATTACH LABEL

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S GREEN LEE
F 18 BROWN STREET
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KA16 9AA.
31/08/1982 Pract 80260
Case Ref 337455

ACTIVITY OF LIVING

Identify Problems/Needs

Date

_Post operative minor orthopaedic

Goal / Aim: Observe and monitor patients activities of living

Date	Time	Initials	Nursing Actions	Discontinued Date / Time	Initials
13/4/08	18⁰⁰	BB	Monitor and record vital signs on return from theatre	14/04/08	KAW
13/4/08	18⁰⁰	BB	Record vital signs ¼ hourly		
13/4/08	18⁰⁰	BB	½ hourly		
			hourly		
			2 hourly		
			4 hourly		
			Twice daily		
			Daily		
			Introduce diet and fluids as tolerated		
13/4/08	18⁰⁰	BB	Maintain safe effective intravenous access as per protocol		
13/4/08	18⁰⁰	BB	Give intravenous fluids as prescribed		
			Monitor input/output on fluid balance chart		
13/4/08	18⁰⁰	BB	Administer oxygen therapy as prescribed		
			Give all prescribed medications and monitor effect		
13/4/08	18⁰⁰	BB	Monitor wound site and C.S.M and dress as instructed		
			Refer to physiotherapist and assist in mobility management		
			Mobilise as condition indicates (refer to moving and handling Chart)		
			Report any deviation from the normal to medical staff and act on their instruction		

NHS Ayrshire & Arran

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For GREEN LEE
Ad 18 BROWN STREET
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31/08/1982 Pract 80260
Case Ref 337455

Nursing Evaluation Form

Goal /Aim

Date	Time	Nursing evaluation	Review Date and Time	Sign
13/4/08	1400	Emergency admission to 2A with. Left patella #. Observations stable on admission, MRSA nasal Screen obtained also. I.V fluids running as charted as patient fasting Since 930 am. Fasting for theatre at present, for Surgery this afternoon as Soon as theatre Space available		BR
13/4/08	1900	Returned from theatre after having tension band wiring to (L) patella. Post operative observations stable, 4L O2 via hudson Mask in situ. Patient has had Morphine 25mgs between theatre and recovery, patient is drowsy but easily rousable to voice. Limb elevated CSM intact to (L) foot. Post operative instructions		

Date	Time	Nursing evaluation	Review Date and Time	Sign
13/4/08	1900	are for elevation; Monitor CSM. To attend for pupistem cast tomorrow		SVS
		To remain on IV fluids Until awake and able to tolerate diet and fluids.		SVS
14/4/08	0600	Patients observations as per chart. 4Ltrs O2 discontinued Sats 98%. Patient tolerating fluids well. IV fluids discontinued. Passing urine spontaneously. Appears to have slept for long spells overnight.		DMo
	0700	Patient vomited this morning antiemetic given @ IM as prescribed		DMo
14/04/08	1530	Patient ready for discharge home today Obs Satisfactory Diet + fluids taken. Mobilised by physio using crutches Attended plaster room for pupe Stem cast applied D/D ordered Patient collected from pharmacy OPA made + given to patient No complaints made		KMcJ

MEDICINES TO BE GIVEN ONCE (BLOCK CAPITALS)

PHARM.	TO BE GIVEN		APPROVED NAME OF MEDICINE	DOSE	ROUTE (See Key)	DOCTOR'S SIGNATURE	GIVEN BY	TIME GIVEN
	DATE	TIME						

SHEET No. .....

MEDICINE PRESCRIPTION SHEET

Key: O ORAL | SL SUBLINGUAL | PR PER RECTUM | IM INTRAMUSCULAR | ID INTRADERMAL | PV PER VAGINA | IV INTRAVENOUS | INH INHALATION | IT INTRATHECAL | SC SUBCUTANEOUS | NEB NEBULISED

CHI 3108823299
GREEN LEE
18 BROWN STREET
NEWMILNS
KA16 9AA
31/08/1982 Pract 80260
Case Ref 337455

31/8/82

Department .....

KNOWN SENSITIVITY	
1.	2.
SUSPECTED ADVERSE REACTION	
MEDICINE	ADVERSE EFFECT
1.	
2.	

MEDICINES TO BE GIVEN REGULARLY (BLOCK CAPITALS)

PHARM.	Date Commenced	APPROVED NAME OF MEDICINE	DOSE	TIMES OF ADMINISTRATION: 6am	8am	10am	12md	2pm	6pm	8pm	10pm	12mn	OTHER	ROUTE (See Key)	OTHER INSTRUCTIONS	DOCTOR'S SIGNATURE	DISCONTINUED: DATE	INITIAL
	A 13/4/8	PARACETAMOL	1g		✓		✓		✓		✓			ORAL/IV				
	B 13/4	MORPHINE	5-10mg		2°		PRN							IV/SC				
	C 13/4	CYCLIZINE	50mg		8°		PRN							IV/IM/ORAL				
	D 13/4	TRAMADOL	50-100mg		4-6°		PRN							ORAL				
	E 13/4	Diclofenac	50mg		✓				✓		✓			ORAL				
	F																	
	G																	
	H																	
	I																	
	J																	
	K																	
	L																	
	M																	
	N																	
	O																	
	P																	
	R																	
	S																	
	T																	
	V																	

JMcC/60565

STA 0235

NHS Ayrshire & Arran

PAIN SCORING CHART

Write or attach label

CHI 3108823299
GREEN LEE
18 BROWN STREET
NEWMILNS
KA16 9AA
31/08/1982 Pract 80260
Case Ref 337455
Date of Birth

Pain Score must be assessed on each drug round, documented and initialled accordingly.

Date	11/8/08																													
Time	08 BC	1-20 BC																												
PAIN																														
3																														Severe
2																														Moderate
1	✓	✓																												Mild
0																														No pain
SEDATION																														
3																														Unconscious
2																														Asleep / difficult to rouse
1																														Asleep / drowsy / easy to rouse
0	✓	✓																												Awake
NAUSEA																														
3																														Severe nausea +/- frequent vomiting
2																														Moderate nausea +/- occasional vomiting
1	✓	✓																												Mild nausea - no vomiting
0	✓																													No nausea - no vomiting
BOWELS MOVED																														
YES																														
NO	✓	✓																												
ACTION TAKEN																														Refer to Acute Pain team analgesia guidelines. e.g. Regular analgesia given or PRN analgesia given, patient refused. Any problems please page the Acute Pain Team on: 3305 (Crosshouse Hospital) or 6181 (Ayr Hospital)
	Nil Charted																													
Initials	[illegible]	[illegible]																												Please initial at each assessment

STA 4134 JMcC73774

NHS Ayrshire & Arran

PAIN SCORING CHART

Pain Score must be assessed on each drug round, documented and initialled accordingly.

HCR N
CHI N CHI 3108823299
Surnai GREEN LEE
Forenı 19 BROWN STREET
Addre NEWMILNS
KA16 9AA
31/08/1982 Pract 80260
Case Ref 337455
Date of Birth .....

Date																															
Time																															
PAIN																															
3																															Severe
2																															Moderate
1																															Mild
0																															No pain
SEDATION																															
3																															Unconscious
2																															Asleep / difficult to rouse
1																															Asleep / drowsy / easy to rouse
0																															Awake
NAUSEA																															
3																															Severe nausea +/- frequent vomiting
2																															Moderate nausea +/- occasional vomiting
1																															Mild nausea - no vomiting
0																															No nausea - no vomiting
BOWELS MOVED																															
YES																															
NO																															
ACTION TAKEN																															
																															Refer to Acute Pain team analgesia guidelines. e.g. Regular analgesia given or PRN analgesia given, patient refused. Any problems please page the Acute Pain Team on: 3305 (Crosshouse Hospital) or 6181 (Ayr Hospital)
Initials																															Please initial at each assessment

STA 4134 JMcC/73774

SI

CHI 3108823299
GREEN LEE
18 BROWN STREET
NEWMILNS
KA16 9AA
31/08/1982 Pract 80260
Case Ref 337455

MEDICINE RECORDING SHEET

Enter code in box and initial when medicine is taken.

If medicine refused record (A) If patient unable to swallow record A

If patient absent record A If medicine not available record A

Date	6 a.m	8 a.m	10 a.m	12 m.d	2 p.m	6 p.m	8 p.m	10 p.m	12 m.n	Other Administrations
3/4/08								A D50 E DM		
	Init.									
4	C @ 0645	A @ 0700 AM	(A)	E	D100 @ 09 45					D100 at 03 45 ME.
4	Init.	OM	KMJ		KMJ					
28					A	E				
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

Date	6 a.m	8 a.m	10 a.m	12 m.d	2 p.m	6 p.m	8 p.m	10 p.m	12 m.n	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

STA 0236

MEDICINE RECORDING SHEET

Name .....

Age .....

Consultant .....

Hospital .....

Enter code in box and initial when medicine is taken.

If medicine refused record (A) If patient unable to swallow record ~~A~~

If patient absent record ~~A~~ If medicine not available record ~~A~~

Date	6 a.m	8 a.m	10 a.m	12 m.d	2 p.m	6 p.m	8 p.m	10 p.m	12 m.n	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

JMcC/60566

Date	6 a.m	8 a.m	10 a.m	12 m.d	2 p.m	6 p.m	8 p.m	10 p.m	12 m.n	Other Administration
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

STA 0236

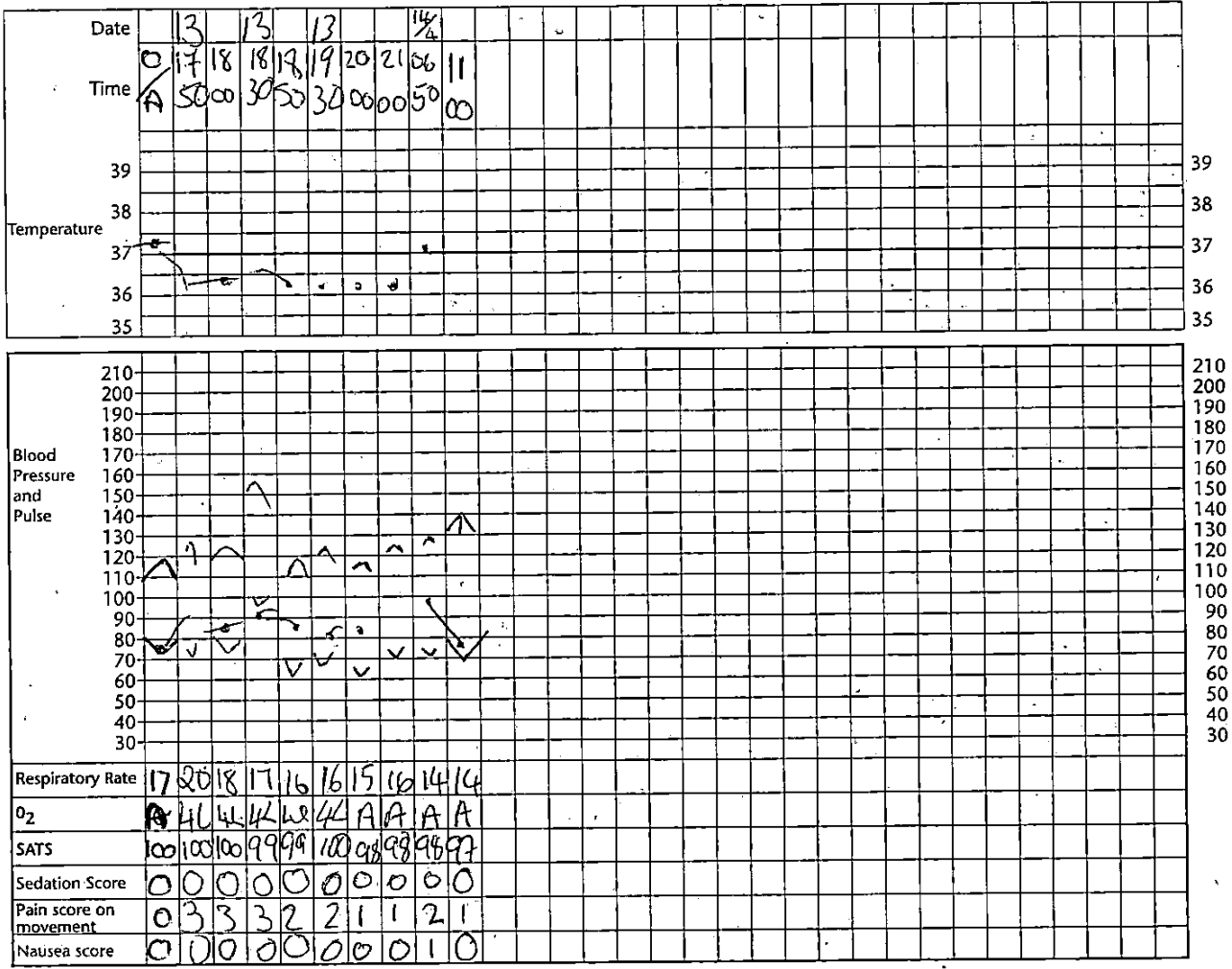
NHS Ayrshire & Arran

Surnar .....
Foren .....
CHI 3108823299
..... GREEN LEE .....
Addre 18 BROWN STREET .....
NEWMILNS
KA16 9AA
..... 31/08/1982 Pract 80260 .....
Ward/ Case Ref 337455 .....

TPR, BP, Pain, Sedation, Nausea & Mews Chart

If MEWS Discontinued, record reason in medical notes

Commencement date: / / Ward: 2N MEWS Discontinued Date: DR:



MEWS Score Record

Heart Rate	0	0	0	0	0	0	0	0	0	0
BP (systolic)	0	0	0	0	0	0	0	0	0	0
Resps	0	0	0	0	0	0	0	0	0	0
Temp	0	0	0	0	0	0	0	0	0	0
SpO2	0	0	0	0	0	0	0	0	0	0
Urine Output	0	0	[illegible]	[illegible]	[illegible]	0	0	0	0	0
CNS	0	0	0	0	0	0	0	0	0	0
Mews Total	0	0	0	0	0	0	0	0	0	0

Pain Score
0 = No pain at rest; No pain on movement.
1 = No pain at rest; Slight pain on movement.
2 = Intermittent pain at rest; Moderate pain on movement.
3 = Continuous pain at rest; Severe pain on movement.
4 = Asleep; pain not assessed.

Sedation Score
0 = None (patient alert).
1 = Mild (occasionally drowsy, easy to rouse).
2 = Moderate (frequently drowsy, easy to rouse).
3 = Severe (somnolent, difficult to rouse).
4 = Normal sleep, easily roused.

Nausea Score
0 = No nausea.
1 = Mild.
2 = Moderate.
3 = Severe.
4 = Asleep.

MEWS Score

Score	3	2	1	0	1	2	3
Heart Rate		<40	41-50	51-100	101-110	111-130	>130
BP (systolic)	<70	71-80	81-100	101-179	180-199	>200	
Resps		<8		8-20	21-25	26-30	>30
Temp		<35		35.1-37.9		>38	
SpO2	<80	<90 on oxygen	<90 on air				
Urine Output	<80ml in 4hr (Cath)						<150ml in 6hr (Non Cath)
CNS	Unresp	Pain	Verbal	Alert		New Agitated/Confused	

STA4202PS

MODIFIED EARLY WARNING SCORE (MEWS) OBSERVATION CHART

Patient Addressograph

Consultant:

Patient's Weight:

A MEWS Score must be calculated every time patient observations are recorded unless the patient is recieving pallative care only. If MEWS Score 4 or more then call the appropriate doctor/nurse using the guidline below. Increased frequency of observations (minimum hourly) should be commenced and a note of action taken by the nurse should be documented in the MEWS Action Sheet. A detailed report in the medical notes using the MEWS Assessment Casenote Record should be completed by the first responder.

MEWS 4 or More or concern with condition

MEWS 6 or More or rapid deterioration

CALL FY1 OR HOSPITAL AT NIGHT TEAM

Dr unable to attend within 30mins or MEWS increased by 2

Call appropriate SHO or HAN TEAM

Dr unable to attend within 20mins or MEWS increased by 2

Discuss with Consultant - refer to HDU/ITU

HOW TO CALCULATE MEWS SCORE

- **Do Not add Pain Score to MEWS Score**
- **All MEWS Scores must be completed by suitably trained nursing staff**
- **Complete ALL vital signs and record MEWS Score in highlighted area**

MEDICAL/HaN GUIDLINES

If RR >25	**Review patient/CXR+/-ABGS/PEF – Definitive Therapy**
If SpO2 <80	**Ensure accuracy** **Review patient – prescribe oxygen/ABGs**
If Sys BP<100	**Review monitoring** *(cardiac/oximetry/urine output etc)* **IV access** **Review patient/drug cardex**
Consider	**IV fluid bolus – reassess** **TREAT UNDERLYING CAUSE**
If HR >130	**IV access/Review Patient** – *Consider ECG/U&E's*
If unresponsive	**Assess airway/BM/GCS**

PAIN ASSESSMENT & MANAGEMENT GUIDLINES

How to score pain: Score current pain on movement

0 NONE	– **Continue to assess pain withevery set of observations (At least daily)**
1 MILD	– **Prescribe simple analgesia at regular intervals. Score pre/post admiNistration of analgesia**
2 MODERATE	– **Consider adding weak opiod PRN. Assess score 4 hourly**
3 SEVERE	– **Add strong opoid and refer to APN. Assess score 2-4 hourly**

PERSISTENT PAIN – REFER TO ACUTE PAIN TEAM OR ON CALL ANAESTHETIST OUT OF HOURS

NAUSEA SCORE

1 MILD	– **Consider anti-emetic**
2 MOD	– **Administer anti-emetic**
3 SEVERE	– **Consider Doctor**

SEDATION SCORE

1 MILD	– **Record 4 hourly**
2 MOD	– **Assess GCS/Use of sedatives**
3 SEVERE	– **Withhold sedatives & Contact Dr**

NHS Ayrshire & Arran

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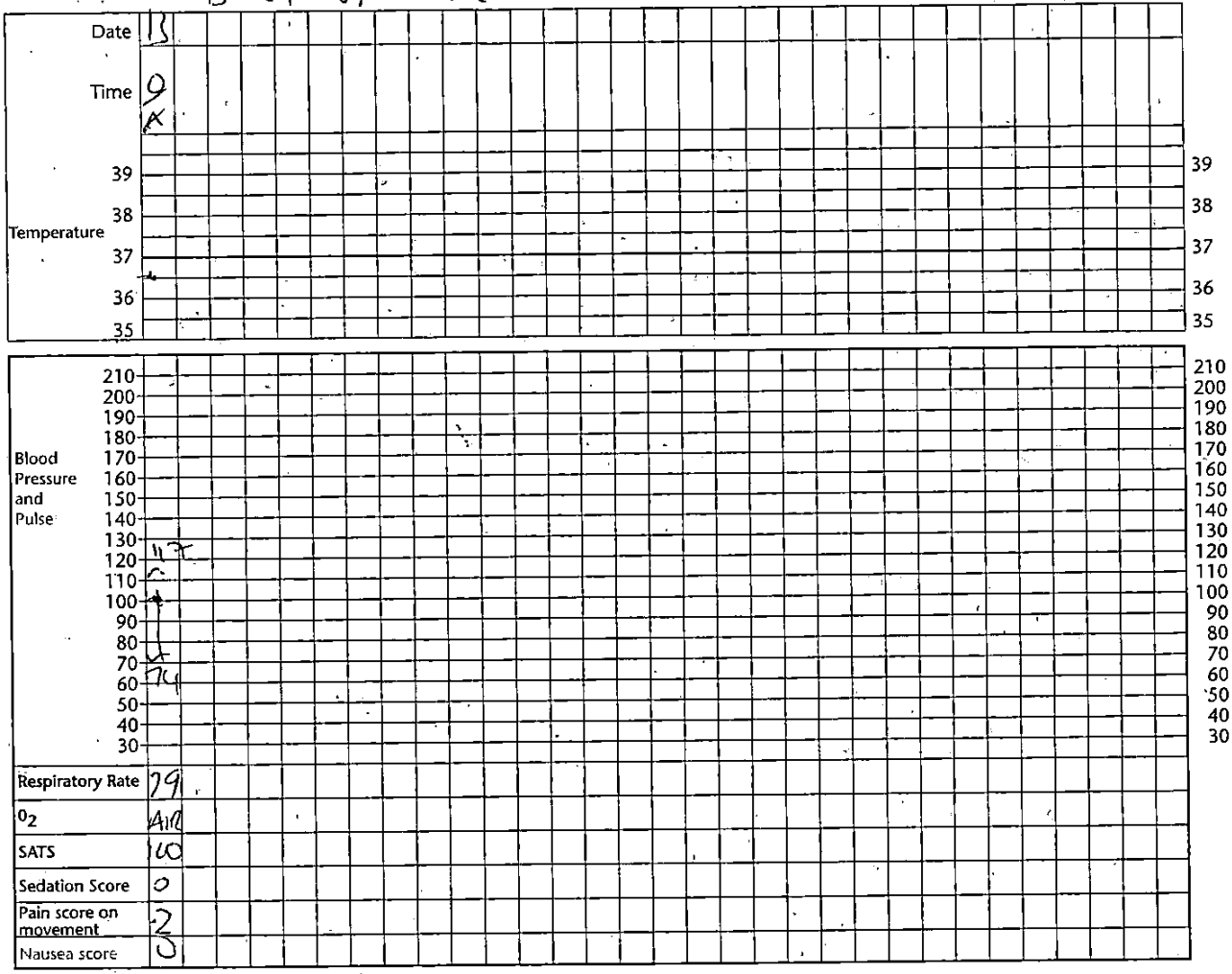
TPR, BP, Pain, Sedation, Nausea & Mews Chart

If MEWS Discontinued, record reason in medical notes

Commencement date: 13 / 04 / 09 Ward: AAU MEWS Discontinued Date: DR:



MEWS Score Record

Heart Rate																								
BP (systolic)																								
Resps																								
Temp																								
SpO2																								
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Nausea Score
0 = No nausea.
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3 = Severe.
4 = Asleep.

MEWS Score

Score	3	2	1	0	1	2	3
Heart Rate	<40	41-50	51-100	101-110	111-130	>130	
BP (systolic)	<70	71-80	81-100	101-179	180-199	>200	
Resps	<8		8-20	21-25	26-30	>30	
Temp	<35		35-37.9		>38		
SpO2	<80	<90 on oxygen	<90 on air				
Urine Output	<80ml in 4hr (Cath)						<150ml in 6hr (Non Cath)
CNS	Unresp	Pain	Verbal	Alert	New Agitated/Confused		

STA4202PS

MODIFIED EARLY WARNING SCORE (MEWS) OBSERVATION CHART

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MEWS 6 or More or rapid deterioration

HOW TO CALCULATE MEWS SCORE

- **Do Not add Pain Score to MEWS Score**
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MEDICAL/HaN GUIDLINES

If RR ≥25	**Review patient/CXR+/-ABGS/PEF – Definitive Therapy**
If SpO2 <80	**Ensure accuracy** **Review patient – prescribe oxygen/ABGs**
If Sys BP<100	**Review monitoring** *(cardiac/oximetry/urine output etc)* **IV access** **Review patient/drug cardex**
Consider	**IV fluid bolus – reassess** **TREAT UNDERLYING CAUSE**
If HR >130	**IV access/Review Patient** – *Consider ECG/U&E's*
If unresponsive	**Assess airway/BM/GCS**

PAIN ASSESSMENT & MANAGEMENT GUIDLINES

How to score pain: Score current pain on movement

0 NONE	– Continue to assess pain withevery set of observations (At least daily)
1 MILD	– Prescribe simple analgesia at regular intervals. Score pre/post admiNistration of analgesia
2 MODERATE	– Consider adding weak opiod PRN. Assess score 4 hourly
3 SEVERE	– Add strong opoid and refer to APN. Assess score 2-4 hourly

PERSISTENT PAIN – REFER TO ACUTE PAIN TEAM OR ON CALL ANAESTHETIST OUT OF HOURS

NAUSEA SCORE

1 MILD	– Consider anti-emetic
2 MOD	– Administer anti-emetic
3 SEVERE	– Consider Doctor

SEDATION SCORE

1 MILD	– Record 4 hourly
2 MOD	– Assess GCS/Use of sedatives
3 SEVERE	– Withhold sedatives & Contact Dr

CHI 3108823299
GREEN LEE
18 BROWN STREET
NEWMILNS
KA16 9AA
31/08/1982 Pract 80260
Case Ref 337455

REQUESTS FOR PLASTER ROOM

SN — San

SECTION 1

1. **WARD:** 2A **WHO IS SPEAKING:** Watson **DATE/TIME:** 14/4/08

2. **PATIENT INFO:** name: Lee green unit no: 337455 consultant: Mr MAClead

3. **DIAGNOSIS:** _____

4. **PRESENT TREATMENT + ANY INFO:** Buchanan Splint

5. **TREATMENT REQUESTED:** Pipestem cast applied

6. **BY WHOM:** _____ **MODE OF TRANSPORT:** Trolley

SIGNATURE: Lyn Cully

SECTION 2

1. **CAST APPLICATION:** Pipestem D/cast applied

2. **WALKING AID:** As instructed by Dr/Physio

3. **MOBILISATION:** As above

4. **EDUCATION:** Patient given instruction sheet

5. **FOLLOW UP:** O.P.D. as ater

SIGNATURE: Isobel Hamilton/ SD Simon

NHS Ayrshire & Arran

Fluid and Low Risk Infusion Therapy Recording Chart

Ward/Dept .....

Consultant .....

Write or attach label

HC
CH CHI 3108823299
SU GREEN LEE
FO 18 BROWN STREET
AD NEWMILNS
KA16 9AA
31/08/1982 Pract 80260
Case Ref 337455
Date of Birth .....

		Fluid (use block letters) Electrolyte/additive 3	Vol (ml) mmols 4	Route of Admin. 5	Duration Rate 6	Pump Yes / No 7	Mon Time every (hrs / mins) 8	Signatures 9	Batch Nos 10	Given by Added by 11	Start Time 12
A	13/4	Na Cl 0.9%	500	IV	4°	NO			08C04T1X		1335
B	13/4	Na Cl 0.9%	500	IV	4°				07L23E1F	K Palmer	1705
C		Na Cl 0.9%	500	IV	4°						
D		Na Cl 0.9%									
E		DEXTROSE 5%	500	IV	4°						
F		Na Cl 0.9%	500	IV	4°						
G											
H											
I											
J											
K											
L											

Use this chart of infusions of Fluids, Electrolytes (less than 40 mmol per litre potassium chloride), Blood, Blood Products and T.P.N.
If a volumetric pump is used the monitoring section on the reverse must be completed.

STA4015

JMcC/73767

If a volumetric pump is used for any infusion on the previous page, the infusion ID should be noted on the chart below and the monitoring details completed at intervals specified by the prescriber of the infusion.

The **INFUSION CHECKS** box should be ticked to indicate that the following checks have been made: **Pump Rate, Infusion site, Vol. remaining in bag is approx. as expected, patient's condition.**

INF I.D. 1	VOL. PUMP MAKE 2	SERIAL NUMBER 3	DATE 4	TIME 5	VOL. INFUSED (from pump) 6	INFUSION CHECKS 7	SIGNED 8

PATIENT ADMISSION RECORD - DISCHARGE PATIENT RECORD DATA REPORT

CRN/Unit.....: 337455
Surname.....: GREEN
Forename.....: LEE
Admit Date....: 30/09/1996 Projected Discharge Date:01/10/1996
Discharge Date:: 02/10/1996 Discharge Code: 1
Total Days....: 2 Discharge Ward: 2A
Discharged To.: Discharge DX: PAIN RIGHT KNEE
Relative Informed: Y Date: 02/10/1996 Relationship: CARER
Referred To Liaison Nurse.....: / /
GP Letter Sent.....: / /

PATIENT INFORMED:
mr green informed

COMMUNITY NURSE INFORMED:
NONE

HEALTH EDUCATION INFORMATION:
NONE

ATMENTS/DRESSINGS FOLLOWING DISCHARGE:
dresiing to remain in situ until return to clinic

EQUIPMENT AND APPLIANCES REQUIRED:
NONE

SOCIAL CIRCUMSTANCES/SERVICES NEEDS (i.e. Home Help/Worker):
NONE

TRANSPORTATION ARRANGEMENTS:
own transport

VALUABLES RETURNED:
NONE

SPECIAL NEEDS IDENTIFIED:
NONE

MEDICATIONS TAKEN HOME/DRUG & DIET INSTRUCTIONS:
discarge drugs given and explained on discharge

OUTPATIENT APPOINTMENTS:
NONE

OTHER:
gp letter to be given on discharge

I Have Read And Understand The Instructions As Presented Above
Patient Signature: Date: Time:

Discharge Nurse Signature: Date: Time:

M Alexander 2/10/96 6pm
Bruce Chambers

(D)

PATIENT ADMISSION RECORD - PATIENT RECORD DATA REPORT

CRN/Unit Number.....:337455
CHI Number.....: 0
Surname.....:GREEN
Forename.....:LEE
Maiden Name.....:
Date Of Birth...:31/08/1982
Age: (Years:014 Months:00 Days:30)
Sex.....:M Pref/Name:LEE
Secondary DX:
Consultant:MR FITZGERALD
Allergies: Food: N Drug: Y Other: N

Address:C/O 35 BENRIG AVE
KILMAURS

City...:
Postcode:KA3 2QQ Phone:538715
Language Spoken:.ENGLISH
Religion: PROTEST.
Occupation:SCHOOLBOY

Pre Admission.:N Admit Type:W/L
Pre-Admit Date: / / Time:00:00
Pre-Admit Ward: Bed:
Pre-Assessment: Adm. Hx:
Proj. Adm Date: / / Time:00:00
Admit Date....:30/09/1996 Time:11:23
Admit Ward....:2B Bed:000005
Prime Admit Dx:PAINFUL R KNEE

Pat. Type.....:ORTHOPAEDIC
Patient On Pass::N
Named Nurse..:S/N O ROURKE
Adm Nurse/Clrk..:GRAHAM, F

Marital Status.:.SINGLE
Understands....:.ENGLISH
Nationality....:BRITISH
Special Considerations:

ADMISSION DETAILS:

Temp: 36.3 Pulse: 60 Resp: 16 B.P.: 100/70 Hght: 0 '0 " Wgt: 0
Urinalysis..: N
Operative Procedures: (R) arthroscopy + lateral release 1/10/96

Medications Prior To Admission:N Prior Med. Hx:Y
Patient Spoken To - Dr. Name: BRINCKER Date: 30/09/1996 Time: 00:00
Reason for Admission As Stated By Patient:
PAINFUL KNEE
Relative Notified Of Admission: Y
Relative/Friend Understanding Of Reason For Admission:
AS ABOVE
Relative Spoken To -
Relation:CARER Dr/Nurse Name: Date: / / Time:00:00
Admit Ward...: 2B Current Ward.: 2B
Admit Bed....: 000005 Current Bed..: 000005
Property/ Valuables: .IN OWN POSSESSION
Clothing.....: RETAINED BY PATIENT
Hospital Info. Book Given.: N Identification Band: Y
Projected Discharge Date: 01/10/1996 Discharge Code:
Clergy Visit.....: N Research Patient Code: 0

NEXT OF KIN DETAILS:
Surname...: GREEN Forename..: MARGARET
Relation..: MOTHER
Address...: 64 BREWLANDS STREET
GALSTON

Postcode..:
Home Phone: 820269 Work: Extension:

PATIENT ADMISSION RECORD - PATIENT RECORD DATA REPORT

PATIENT.....: GREEN, LEE
CURRENT WARD...: 2B
CURRENT BED....: 000005

EMERGENCY CONTACT DETAILS:
Surname...: GREEN Forename..: MARGARET
Relation..: MOTHER
Address...: 64 BREWLANDS STREET
GALSTON

Postcode..:
e Phone: 820269 Work: Extension:

GENERAL PRACTITIONER DETAILS:
Surname...: MCCALL Forename: JAMES , S
Address...:
THE SURGERY
GALSTON
Postcode..: KA4 8JW

CONSULTANT/MR. 1 DETAILS:
Surname...: MR FITZGERALD Forename:
Admit Clerk:

CONSULTANT/MR. 2 DETAILS:
Surname...: Forename:

ALLERGIES:
Food Allergies
None

Drug Allergies
TETANUS TOXOID

Other Allergies
None

PATIENT ADMISSION RECORD - PATIENT RECORD DATA REPORT

PATIENT.....: GREEN, LEE
CURRENT WARD...: 2B
CURRENT BED....: 000005

Prior Medical History		
Date	Reason	Hospital / Physician
01/01/1901	GROMMETS	
01/09/1996	HEAD INJURY	
01/01/1992	MYRINGOTOMY	

NOTE: Dates of 01/01/01 indicate actual date is unknown.
Dates of 01/01 and year indicate only the year was known.

NO PRIOR MEDICATION HISTORY ON FILE

ANY OTHER RELEVANT INFORMATION:

XH 337455

Su GREEN LEE
C/O 35 BENRIG AVE
Fo KILMAURS
.... 31/08/1982 M/S
DR.J MCCALL
Ad THE SURGERY
5A HENRIETTA STREET
..... CH1 3108823299
FAN .... Ward/Dept. 2B

NURSING ASSESSMENT

Date of admission: 30-9-96 Time:

Type of admission: Arranged

Accompanied by:

From where:

PATIENT'S OCCUPATION: School Boy

MARITAL STATUS:

Dependants - children Ages:

- others

Living alone?

(1) NO - with whom?

(2) YES - any supportive help?

RELIGION: Prot

Seen by Minister/Priest

NEXT OF KIN:

Relationship:

Address:

Home phone no.:

Work phone no.:

ALTERNATIVE NEXT OF KIN:

Relationship:

Address:

Phone no.:

REASON FOR THIS ADMISSION

Arthroscopy ® Knee

PATIENT'S ACCOUNT OF ILLNESS

SPECIAL VISITING NEEDS

PREVIOUS HEALTH PROBLEMS

GROMETS
Head injury Sept'96
myringotomy '92

SPECIAL NEEDS AT HOME

- housing
- social
- other

DRUGS USED BEFORE ADMISSION

none

ALLERGIES

NKA

* Tetanus toxoid *

TAKEN FOR SAFEKEEPING	RETURNED

Property checked YES / NO

Valuables in hospital safe YES / NO

NURSING ASSESSMENT

1. **Capable of self care** YES / NO

2. **Communicating**
   Vision - any problems?
   - spectacles?
   - contact lenses?
   Hearing - any problems?
   - hearing aid?
   - battery type?

Speech difficulty YES / NO

3. **Mobility** - independent?
   - with assistance?
   - remarks.

4. **Eating and drinking**
   - appetite?
   - special diet?
   - dislikes?
   - assistance needed YES / NO

5. **Personal cleaning and dressing**
   - independent?
   - with assistance?
   - remarks.

6. **Bladder and Bowels** - any problems?
   - special needs?

7. **Sleeping** - pattern
   - what helps?

8. **Recreational interests**

9. **Other relevant information**

Independent

GENERAL APPEARANCE/CONDITION

Well looking Boy

GENERAL OBSERVATIONS

T 37 P 60 R B/P 100/70

Height: Weight: Norton score:

Urine:

SKIN INSPECTION

ORAL INSPECTION

Condition of mouth:
Condition of teeth:

Dentures: Upper Lower Partial

Crown:

Any problems?

DISCHARGE/FUTURE PLANS	Date ordered	Date given	Sign
Education of condition/ limitations/ rehabilitation (a) Patient (b) Relatives			
Discharge medications			
Warfarin Steroid/ Tetanus card			
Transport home			
Out-patient appointment			
Walking stick/crutches			
Dressings:			
Other:			
Community nursing			
Home help			
Meals on wheels			
Social worker			
Physiotherapy			
Occupational Therapy			
Speech Therapy			
Geriatric waiting list			
Sheltered housing			
Other:			

FAN1286

NURSING NOTES

Sur GREEN LEE XH 337455
C/O 35 BENRIG AVE
For KILMAURS
31/08/1982 M/S
DR J MCCALL
THE SURGERY
Ad 5A HENRIETTA STREET
CHI 3108823299
Ward/Dept. 28

DATE	
30.9.96	Arranged admission to ward for theatre tomorrow. FGraham
	Consent form to be signed later when mother comes to visit. ✓ FGraham
PM	Consent form signed by mother. Please fast overnight for theatre in AM DCallaghan
1.10.96	Fasted. Premed due 11.30a. DStead
	1340 Reception. Colour good. DStead
	1425 Recovery. Orally conscious. O2 41/t commenced. Dressing clean and dry, foot warm to touch. One redivac drain patent with minimal drainage. obs charted.
1400	Codeine 60mg IM in theatre.
1425	Sleeping
1450	Dressing remains clean and dry, drainage minimal obs satisfactory. O2 discontinued Returned to ward. MMitchell
4pm	Patient orentated and alert. Observations stable. No staining to knee dressing. Minimal drainage in redivac drain
2/10 a.m.	Redivac drain removed. Swab in CJackson drain. Drain site clean and dry. CJackson

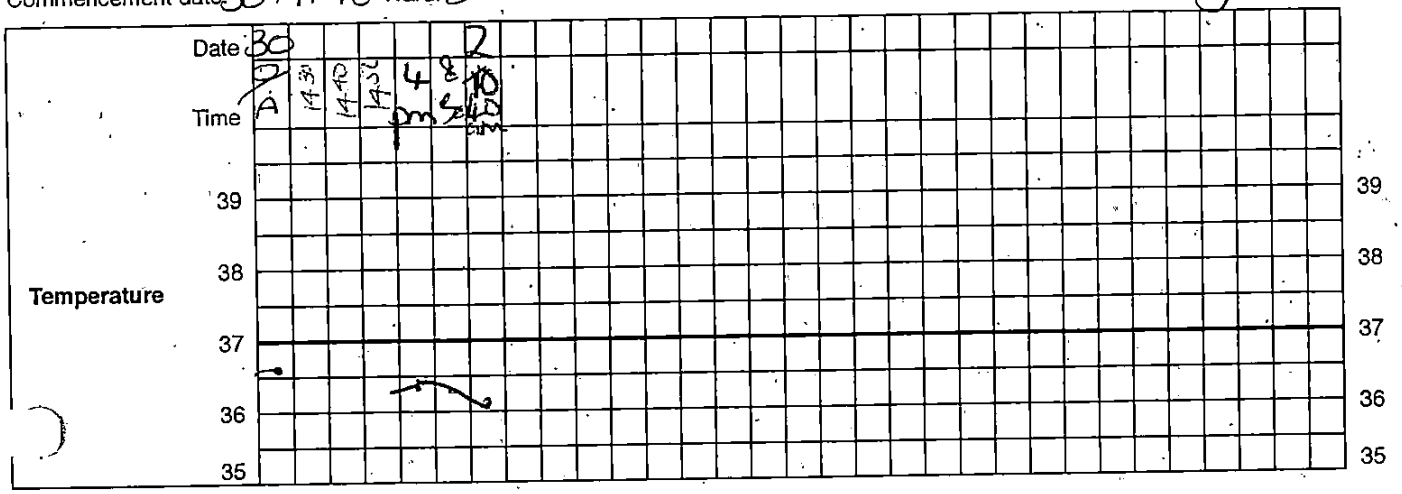
DATE

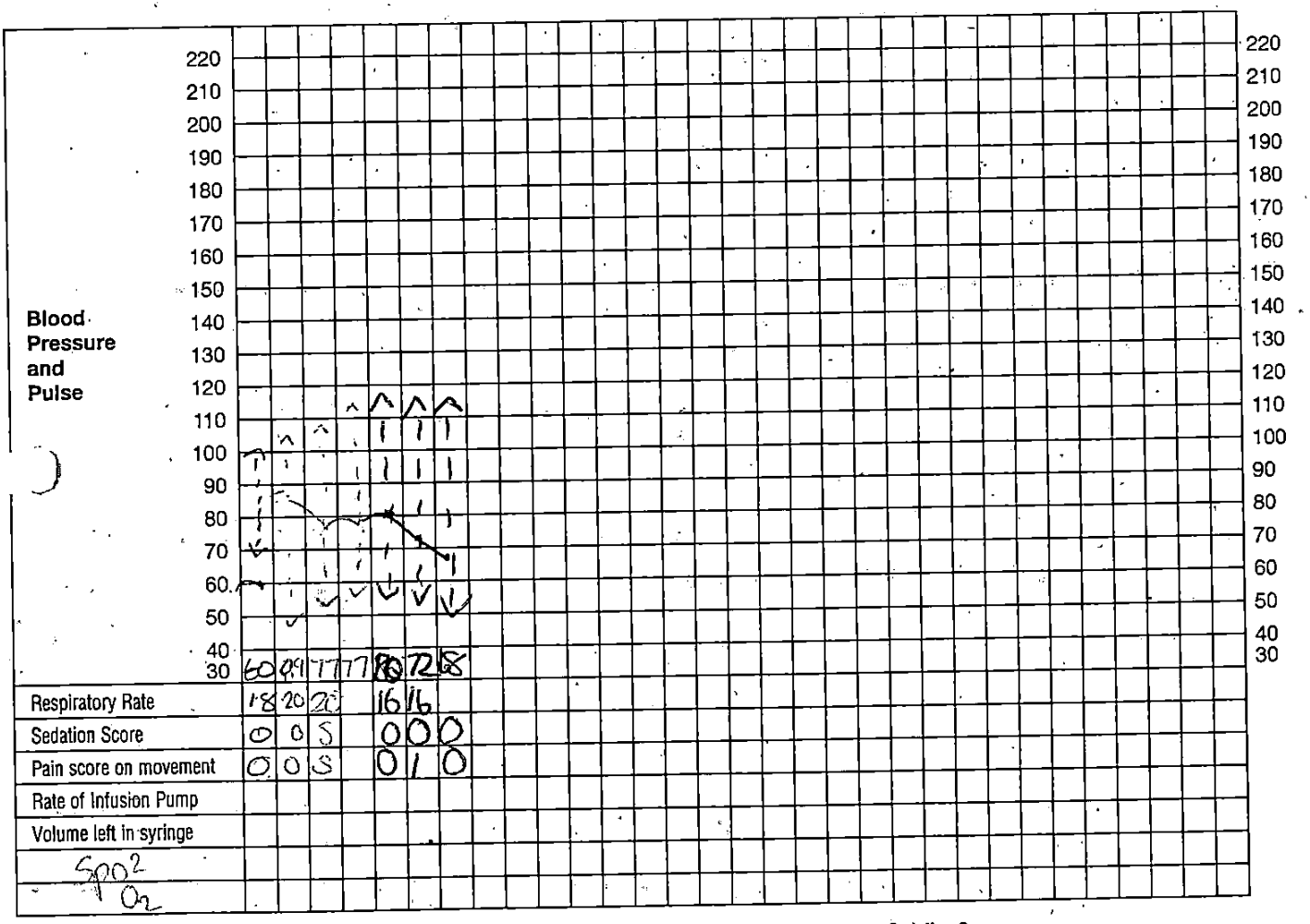
North Ayrshire & Arran
NATIONAL HEALTH SERVICE TRUST

Sur
For GREEN LEE
C/O 35 BENRIG AVE
KILMAURS
Add 31/08/1982 M/S
DR.J MCCALL
THE SURGERY
War 5A HENRIETTA STREET
CH1 3108823299
XH 337455

T.P.R., B.P. & Pain Chart

Commencement date: 30-9-96 Ward: 2B Named Nurse: Consultant: mr Fitzgerald





Pain Score
0 = No pain at rest; No pain on movement.
1 = No pain at rest; Slight pain on movement.
2 = Intermittent pain at rest;Moderate pain on movement.
3 = Continuous pain at rest; Severe pain on movement.
S = Asleep, pain not assessed.

Sedation Score
0 = None (patient alert).
1 = Mild (occasionally drowsy, easy to rouse).
2 = Moderate (frequently drowsy, easy to rouse).
3 = Severe (somnolent, difficult to rouse).
S = Normal sleep, easily roused.

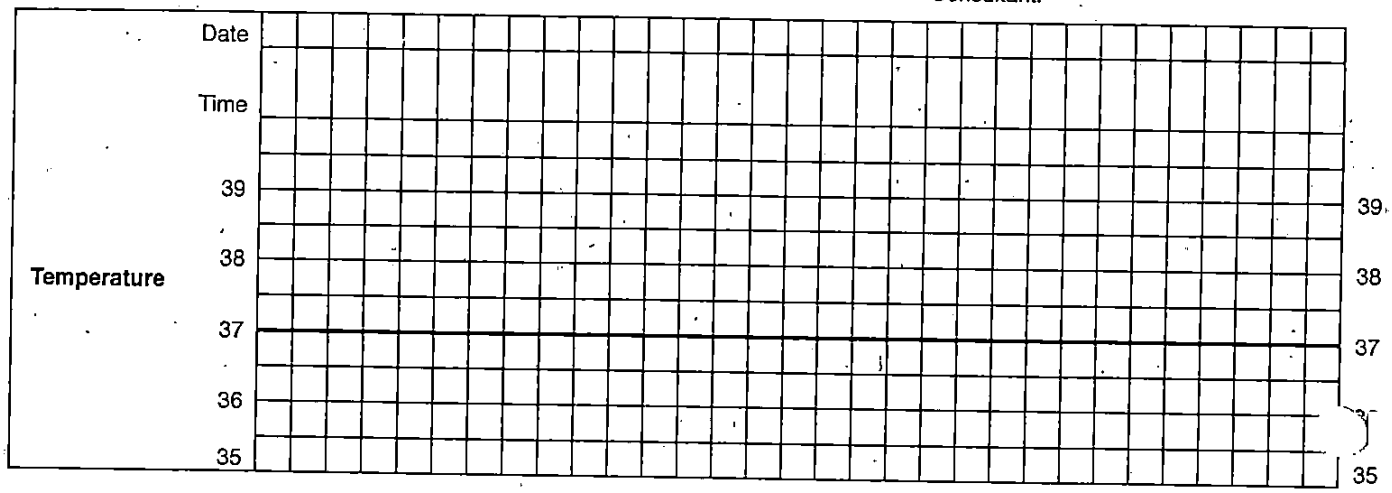
For analgesia advice call .....Bleep.....Phone .....

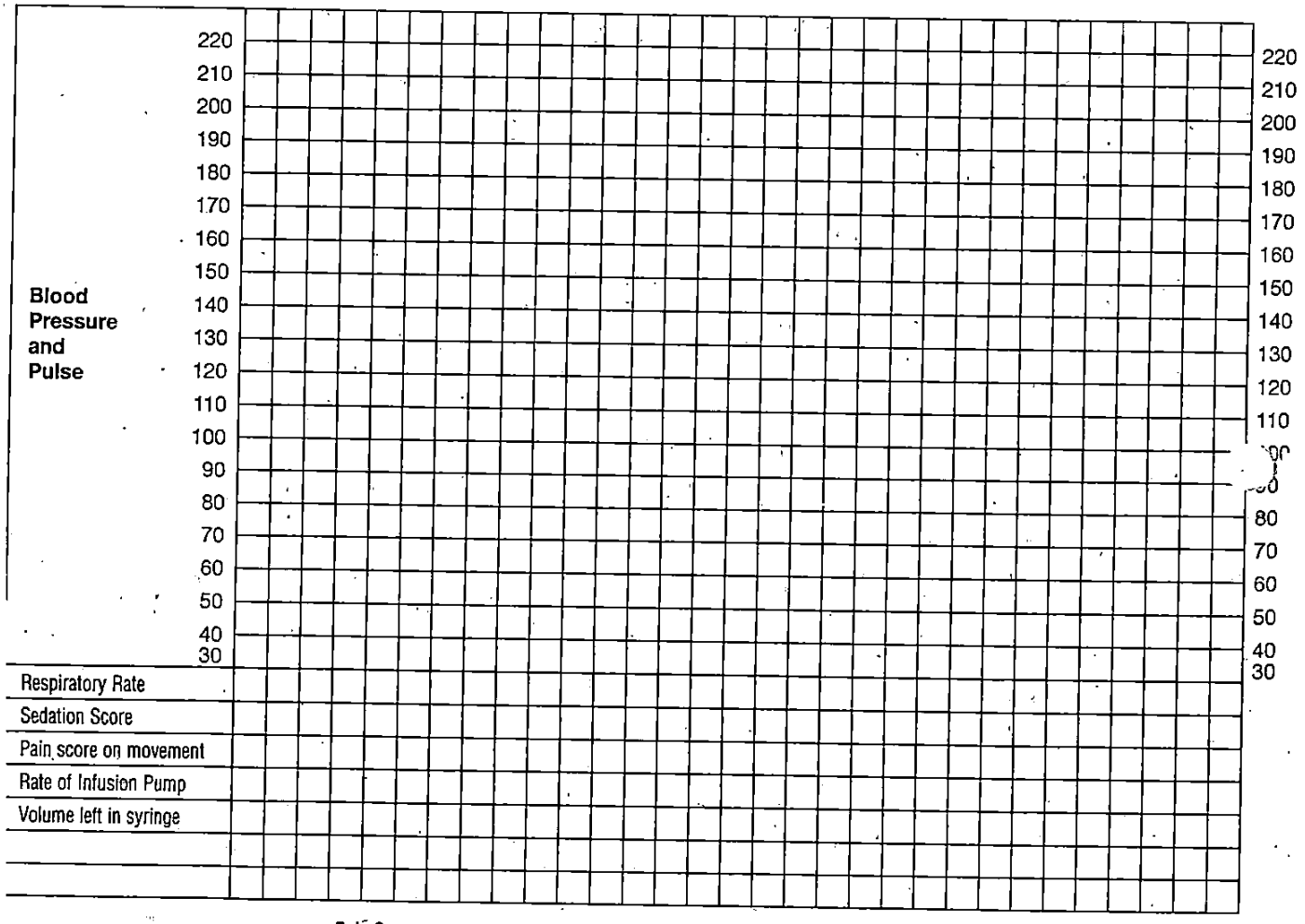
North Ayrshire & Arran
NATIONAL HEALTH SERVICE TRUST

Surname ..... Hosp. No. .....
Forenames ..... Sex .....
..... D.O.B. .....
Address .....
.....
Ward/Dept. .....

T.P.R., B.P. & Pain Chart

Commencement date: / / Ward: Named Nurse: Consultant:





Respiratory Rate
Sedation Score
Pain score on movement
Rate of Infusion Pump
Volume left in syringe

Pain Score

0 = No pain at rest; No pain on movement.
1 = No pain at rest; Slight pain on movement.
2 = Intermittent pain at rest;Moderate pain on movement.
3 = Continuous pain at rest; Severe pain on movement.
S = Asleep, pain not assessed.

Sedation Score

0 = None (patient alert).
1 = Mild (occasionally drowsy, easy to rouse).
2 = Moderate (frequently drowsy, easy to rouse).
3 = Severe (somnolent, difficult to rouse).
S = Normal sleep, easily roused.

For analgesia advice call ..... Bleep ..... Phone .....

MEDICINES TO BE GIVEN ONCE (BLOCK CAPITA)

PHARM.	TO BE GIVEN		APPROVED NAME OF MEDICINE	DOSE	ROUTE (see key)	DOCTOR'S SIGNATURE	GIVEN BY	TIME GIVEN
	DATE	TIME						

SHEET No. .....

MEDICINE PRESCRIPTION SHEET

KEY: O ORAL; IM INTRAMUSCULAR; IV INTRAVENOUS; SC SUBCUTANEOUS; SL SUBLINGUAL; ID INTRADERMAL; INH INHALATION; NEB NEBULISED; PR PER RECTUM; PV PER VAGINA; IT INTRATHECAL

XH 337455
GREEN LEE
C/O 35 BENRIG AVE
KILMAURS

31/08/1982 M/S
DR.J MCCALL
THE SURGERY
5A HENRIETTA STREET
CH1 3108823299

CR No. .....
Sex .....
D.o.B. .....
.....
d/Dept. .....

KNOWN SENSITIVITY	
1.	2.

SUSPECTED ADVERSE REACTION	
MEDICINE	ADVERSE EFFECT
1.	
2.	

MEDICINES TO BE GIVEN REGULARLY (BLOCK CAPITALS)

Code STA0235

PHARM.	Date Commenced	APPROVED NAME OF MEDICINE	DOSE	TIMES OF ADMINISTRATION: 6 am	8 am	10 am	12 md	2 pm	6 pm	8 pm	10 pm	12 mn	OTHER	ROUTE (see key)	OTHER INSTRUCTIONS	DOCTOR'S SIGNATURE	DISCONTINUED: DATE	INITIAL
A	1/10/96	DIAMORPHINE	30mg	4 hourly c [illegible] for pain										O				
B		PARACETAMOL	1g	✓			✓		✓		✓			O				
C	9/10/96	MORPHINE	5mg		4-6		hourly	for	pain					IM				
D	9/10/96	STEMETIL	12.5mg		6-8		hourly	for	nausea					IM				
E																		
F																		
G																		
H																		
I																		
J																		
K																		
L																		
M																		
N																		
O																		
P																		
R																		
S																		
T																		
V																		

XH 337455

SHEET No..... GREEN LEE
Name . C/O 35 BENRIG AVE
KILMAURS
Age .... 31/08/1982 M/S
Consult DR.J MCCALL
Hospital THE SURGERY
5A HENRIETTA STREET
CH1 3108823299

MEDICINE RECORDING SHEET

Enter code in box and initial when medicine is taken.
If medicine refused record (A) If patient unable to swallow record A
If patient absent record A If medicine not available record A

ate	6a.m.	8a.m.	.....	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
1/10/96						(A)			(B)	A (2) 9.45pm
	Init.					MS			VC	CD.
2/10/96		B		(B)						
	Init.	OL		2						
	Init.									
	Init.									
	Init.									
	Init.									

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

MEDICINE RECORDING SHEET

Name .....

Age .....

Consultant .....

Hospital.....

Enter code in box and initial when medicine is taken.

If medicine refused record (A) If patient unable to swallow record A

If patient absent record A If medicine not available record A

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

STA 9226

tient Name: GREEN, LEE Patient Number: 337455 Bed Number: 000027

OUTCOME - CONTINUING GOAL, REVIEWED ON: 01/10/1996 TIME: 20:34 USER: MARIE ALEXANDER
instructed by mr aldadah

OUTCOME - CONTINUING GOAL, REVIEWED ON: 02/10/1996 TIME: 04:19 USER: JEAN MCAULEY
minimal drainage via redi vac

OUTCOME - CONTINUING GOAL, REVIEWED ON: 02/10/1996 TIME: 11:31 USER: JANET MCLAUGHLAN
redivac to be removed

OUTCOME - ACHIEVED GOAL, DATE: 02/10/1996 TIME: 11:32 USER: JANET MCLAUGHLAN
redivac has been removed

tient Name: GREEN, LEE Patient Number: 337455 Bed Number: 000027

OUTCOME - CONTINUING GOAL, REVIEWED ON: 01/10/1996 TIME: 03:59 USER: MARGARET STORER
fasted for theatre

OUTCOME - CONTINUING GOAL, REVIEWED ON: 01/10/1996 TIME: 20:30 USER: MARIE ALEXANDER
returned from theatre csm satisfactory nil staining vital
signs stable has tolertated diet and fluids has passed uri

OUTCOME - CONTINUING GOAL, REVIEWED ON: 01/10/1996 TIME: 20:32 USER: MARIE ALEXANDER
urine passed

OUTCOME - CONTINUING GOAL, REVIEWED ON: 02/10/1996 TIME: 04:19 USER: JEAN MCAULEY
comfortable post op night dressing clean and dry

OUTCOME - CONTINUING GOAL, REVIEWED ON: 02/10/1996 TIME: 11:31 USER: JANET MCLAUGHLAN
observations stable,redivac to be removed

OUTCOME - CONTINUING GOAL, REVIEWED ON: 02/10/1996 TIME: 12:12 USER: JANET MCLAUGHLAN
seen by dr.may be discharged if mobility satisfactory

OUTCOME - CONTINUING GOAL, REVIEWED ON: 02/10/1996 TIME: 17:39 USER: MARIE ALEXANDER
mobility satisfactory pm to be discharged today

lentified Needs 2 DATE: 01/10/1996 USER: MA
EDIVAC DRAINAGE/POTENTIAL OF WOUND HAEMATOMA

OUTCOME ACHIEVED, DATE: 02/10/1996 USER: MARIE ALEXANDER
TO MINIMISE RISK OF HAEMATOMA

STATUS: DE-ACTIVE
REDIVAC DRAIN IN SITU AND FUNCTIONING PROPERLY

STATUS: DE-ACTIVE
OBSERVE AND RECORD AMOUNT OF DRAINAGE.....FREQUENCY

STATUS: DE-ACTIVE
REMOVE DRAIN USING ASEPTIC TECHNIQUE AFTER.....HOURS ACCORDING TO SURGEONS INSTRUCTIONS

STATUS: DE-ACTIVE
OBSERVE DRAIN SITE FOR FURTHER LEAKAGE AND RECORD SAME.....FREQUENCY

OUTCOME - CONTINUING GOAL, REVIEWED ON: 01/10/1996 TIME: 20:32 USER: MARIE ALEXANDER
redivac drainage minimal to be removed tomorrow
dressing to remain intact to be mobilised to morrow as instr

[More]

ient Name: GREEN, LEE Patient Number: 337455 Bed Number: 000027

ntified Needs 1 DATE: 30/09/1996 USER: FG
ient requires pre-operative care for minor/major Orthopaedic surgery

OUTCOMES CONTINUING, NEXT REVIEW: 02/10/1996 USER: FIONA GRAHAM
The Patient will achieve a satisfactory clinical outcome

[0466/2C] The Primary/Associate nurse will speak to patient pre-op, giving information on Primary nursing and general information regarding their plan of care

[0466/2C] A Primary nurse information sheet will be left for the patient/relatives to read

[0466/2C] The Primary nurse will be identified on each bed/room or nursing profile

[0466/2C] A plan of care will be established by the Primary/Associate nurse within 24 hours of admission

[0466/2C] The Primary/Associate nurse will liaise with members of the multi-disciplinary team regarding the patients treatment and nursing care

[0465/2C] The patient will be treated with courtesy and competency, respecting their privacy and dignity at all times and treating all matters concerning them in the strictest of confidence

Patient will be assessed by Primary/associate nurse as to their psychological and emotional well being throughout their stay in ward

Patient/relatives will be invited to share their views and feelings with Primary/associate nurse

Ensure patient has signed a consent form for the proposed surgery

Ensure patient has fasted as per Anaethetists instructions

Patient should have a pre-op wash, remove jewellery, make-up or prosthesis and don a white gown

The Primary/Associate nurse with another registered nurse will administer prescribed premedication checking correct patient and signed consent

Patient is then safely and effectively transferred with nurse to reception area after checking correct identity

The Primary/associate nurse will monitor the patients vital signs post operatively

[0461/2C] Primary/associate nurse will observe patients wound for signs of inflammation/exudate and redress as necessary

[More]

atient Name: GREEN, LEE Patient Number: 337455 Bed Number: 000027

Primary/associate nurse will observe colour, circulation and movement of operated limb and report any deviation to Medical staff

Elevate operated limb as instructed by Medical staff

Consult patients observation charts for any information required to assist in patient care

The Primary/associate nurse will administer prescribed oxygen therefore maintaining adequate oxygenation

Primary/associate nurse will ensure correct rate, flow and route of oxygen as prescribed and safety precautions are adhered to

Patient will have clear fluids, light diet progressing to normal diet as advised by Primary/associate nurse, thus preventing dehydration

The Primary/associate nusre will monitor patients urinary output, ensuring patient has passed urine post-op

I.V. infusion in progress as prescribed and regime adhered to

Observe cannula site for inflammation/leakage

[T/1081] Each patient will be assessed within 2 hours of admission for pressure area risk using Waterlow (or agreed alternative) scoring system

[T/1081] An individual care plan will be made for each patient within 24 hours of admission

[T/1081] The care plan (and any other relevant documentation) will be updated regularly according to the needs of the patient and following local protocols

[T/1081] The patient will be treated according to North Ayrshire and Arran NHS trusts pressure management protocols

[T/1081] Each patient and/or carer is fully informed of the need for the plan of care

The Primary/associate nurse agrees a regime for personal cleanliness/oral hygiene

The patient will be instructed by Physiotherapist on mobility following surgery, nursing staff will assist patient thereafter with appropriate aids

The Primary/associate nurse will ensure patient is discharged in a safe and effective manner and have an OPA for review by Consultant if requested

[More]

PATIENT ADMISSION RECORD - PATIENT RECORD DATA REPORT

CRN/Unit Number.....:337455
CHI Number.....: 0
Surname.....:GREEN
Forename.....:LEE
Maiden Name.....:
Date Of Birth...:31/08/1982
Age: (Years:014 Months:00 Days:11)
Sex.....:M Pref/Name:
Secondary DX:
Consultant:MR MORRAN
Allergies: Food: N Drug: N Other: N

Address:C/O 35 BENRIG AVE
KILMAURS

City...:
Postcode:KA3 2QQ Phone:538715
nguage Spoken:.ENGLISH
ligion: PROTEST.
Occupation:MOTHER

Pre Admission.:N Admit Type:.ELE
Pre-Admit Date: / / Time:00:00
Pre-Admit Ward: Bed:
Pre-Assessment: Adm. Hx:
Proj. Adm Date: / / Time:00:00
Admit Date....:10/09/1996 Time:21:55
Admit Ward....:5B Bed:000014
Prime Admit Dx:.....

Pat. Type.....:GEN SURGERY
Patient On Pass::N
Named Nurse..:TEAM C
Adm Nurse/Clrk..:MCNALLY, J

Marital Status.:.SINGLE
Understands....:.ENGLISH
Nationality....:BRITISH
Special Considerations:

ADMISSION DETAILS:

Temp: 36.7 Pulse: 83 Resp: 20 B.P.: 117/80 Hght: 0 '0 " Wgt: 0
Urinalysis..: N
Operative Procedures: .....

Medications Prior To Admission:N Prior Med. Hx:Y
Patient Spoken To - Dr. Name: Date: / / Time: 00:00
Reason for Admission As Stated By Patient:
PUNCHED ON SIDE OF FACE
Relative Notified Of Admission:
Relative/Friend Understanding Of Reason For Admission:
AWARE
Relative Spoken To -
Relation:MOTHER Dr/Nurse Name: Date: / / Time:00:00
mit Ward...: 5B Current Ward.: 5B
nit Bed....: 000014 Current Bed..: 000014
Property/ Valuables: .IN OWN POSSESSION
Clothing.....: RETAINED BY PATIENT
Hospital Info. Book Given.: N Identification Band: Y
Projected Discharge Date: / / Discharge Code:
Clergy Visit.....: Research Patient Code: 0

NEXT OF KIN DETAILS:
Surname...: GREEN Forename..: MARGARET , 8
Relation..: MOTHER
Address...: 64 BREWLANDS STREET
GALSTON

Postcode..:
Home Phone: Work: Extension:

PATIENT ADMISSION RECORD - PATIENT RECORD DATA REPORT

PATIENT.....: GREEN, LEE
CURRENT WARD...: 5B
CURRENT BED....: 000014

EMERGENCY CONTACT DETAILS:
Surname...: Forename..:
Relation..:
Address...:

Postcode..:
ıe Phone: Work: Extension:

GENERAL PRACTITIONER DETAILS:
Surname...: MCCALL Forename: JAMES , S
Address...:
THE SURGERY
GALSTON
Postcode..: KA4 8JW

CONSULTANT/MR. 1 DETAILS:
Surname...: MR MORRAN Forename:
Admit Clerk:

CONSULTANT/MR. 2 DETAILS:
Surname...: Forename:

LERGIES:
Food Allergies
None

Drug Allergies
None

Other Allergies
None

PATIENT ADMISSION RECORD - PATIENT RECORD DATA REPORT

PATIENT.....: GREEN, LEE
CURRENT WARD...: 5B
CURRENT BED....: 000014

Prior Medical History		
Date	Reason	Hospital / Physician
01/01/1901	GROMETS	

NOTE: Dates of 01/01/01 indicate actual date is unknown.
Dates of 01/01 and year indicate only the year was known.

NO PRIOR MEDICATION HISTORY ON FILE

ANY OTHER RELEVANT INFORMATION:

NORTH AYRSHIRE AND ARRAN NHS TRUST - CROSSHOUSE HOSPITAL
PATIENT CARE PLAN - 5B

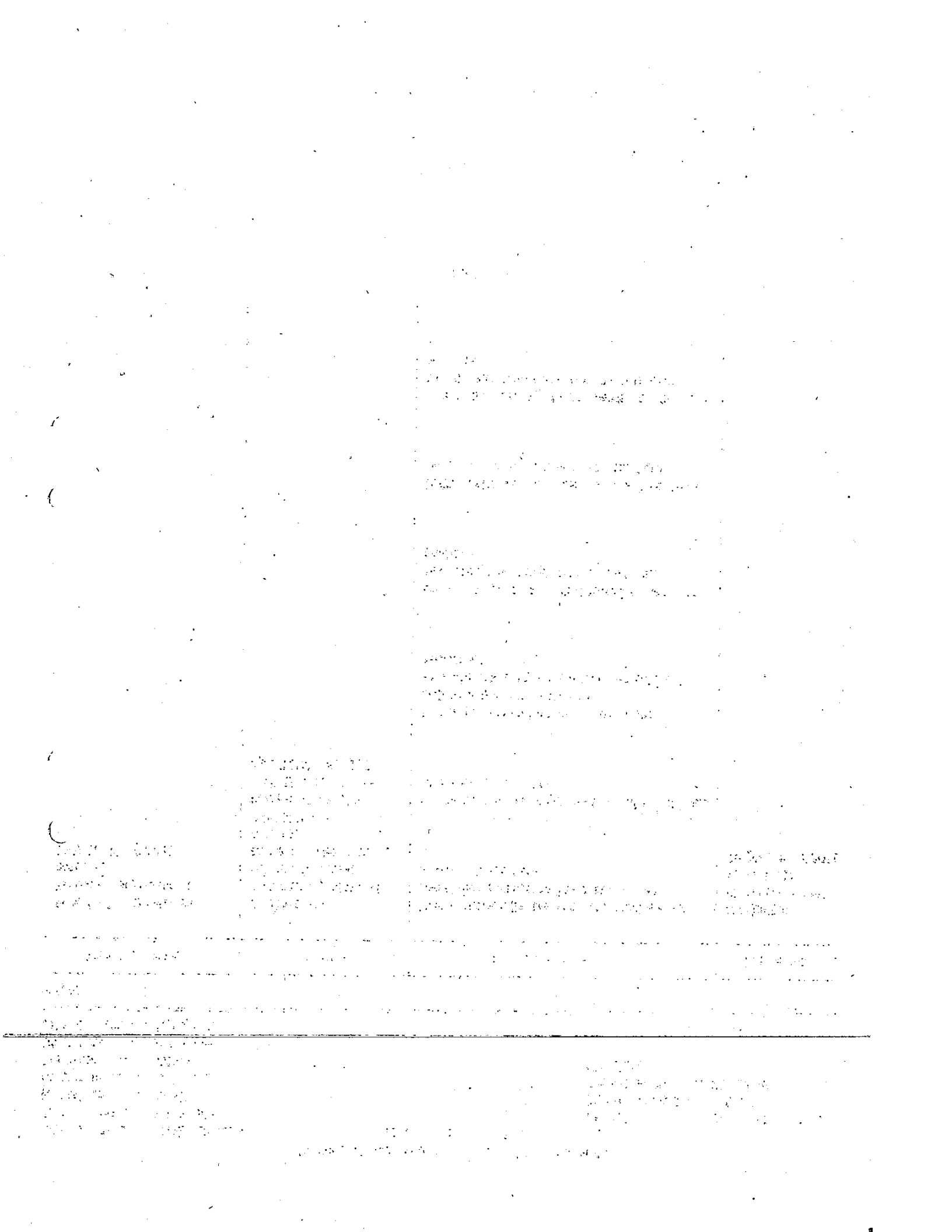
DATE: 11/09/1996 TIME: 12:16:06
Patient Name .... GREEN, LEE
Patient No 337455
Patient DX ....
Bed Number 000014
Admit Date 10/09/1996
Date of Birth ... 31/08/1982

Patient Age/Sex ... 014/00/11 / Male
Primary/Named Nurse. TEAM C
Consultant Name.... MR MORRAN
Signature
.....

00EE9C

Identfied Needs	Outcomes	Planned Care	Evaluation
PROB # 01 11/09/1996 Emergency admission to hospital JACQUELINE MCNALLY	To achieve a satisfactory clinical outcome following emergency admission to hospital CONTINUING REVIEW: 12/09/1996 SELECTED: 11/09/1996 JACQUELINE MCNALLY	Ensure patient is treated with courtesy and competency respecting their privacy and dignity at all times Ensure patient is orientated to ward,staff and environment where possible Ensure patient/relatives receive some understanding for reason for admission,immediate treatment and future management Ensure information is reitorated as necessary and arrange meetings with doctors where required Ensure relatives are aware of visiting times and have a contact number for the ward Addmit and assess patients needs on admission to ward and compensate for any self care deficits	CONTINUING REV'D:11/09/1996 TIME: 12:14 JACQUELINE MCNALLY

[MORE]



Identified Needs	Outcomes	Planned Care	Evaluation
		Record routine urinalysis	
		Inform doctor of any deficits from normal and assist with medical intervention	
		Patient will be fasted until otherwise informed by Medical staff to reduce the chances of aspiration if surgery is necessary and to rest gastrointestinal tract thus avoiding exacerbation of symptoms	
		Give prompt analgesia as prescribed and monitor effect	
		Administer anti-emetic as prescribed and monitor effect	
		Give intravenous fluids where prescribed at correct rate, monitor for signs of extravasation	
		As condition improves, discuss relevant discharge needs	

[MORE]

Identified Needs	Outcomes	Planned Care	Evaluation

PATIENT ADMISSION RECORD - DISCHARGE PATIENT RECORD DATA REPORT

CRN/Unit.....: 337455
Surname.....: GREEN
Forename.....: LEE

Admit Date....: 10/09/1996 Projected Discharge Date: / /
Discharge Date: 13/09/1996 Discharge Code: 1
Total Days....: 3 Discharge Ward: 5B
Discharged To.: Discharge DX: .....
Relative Informed: Y Date: 13/09/1996 Relationship: CARER
Referred To Liaison Nurse.....: / /
GP Letter Sent.....: / /

PATIENT INFORMED:
TOLD OF PLANNED DISCHARGE.

COMMUNITY NURSE INFORMED:
NONE

HEALTH EDUCATION INFORMATION:
HEAD INJURY CARD GIVEN.

TREATMENTS/DRESSINGS FOLLOWING DISCHARGE:
NONE

EQUIPMENT AND APPLIANCES REQUIRED:
NONE

SOCIAL CIRCUMSTANCES/SERVICES NEEDS (i.e. Home Help/Worker):
NONE

TRANSPORTATION ARRANGEMENTS:
OWN TRANSPORT ARRANGED.

VALUABLES RETURNED:
NONE

SPECIAL NEEDS IDENTIFIED:
NONE

MEDICATIONS TAKEN HOME/DRUG & DIET INSTRUCTIONS:
NONE

OUTPATIENT APPOINTMENTS:
NO FOLLOW UP.

OTHER:
NONE

I Have Read And Understand The Instructions As Presented Above
Patient Signature: Date: Time:

Discharge Nurse Signature: Date: Time:

Printed after discharge

PATIENT ADMISSION RECORD - DISCHARGE PATIENT RECORD DATA REPORT

CRN/Unit.....: 337455
Surname.....: GREEN
Forename.....: LEE
Admit Date....: 10/09/1996 Projected Discharge Date: / /
Discharge Date: 13/09/1996 Discharge Code: 1
Total Days....: 3 Discharge Ward: 5B
Discharged To.: Discharge DX: .....
Relative Informed: Y Date: 13/09/1996 Relationship: CARER
Referred To Liaison Nurse.....: / /
GP Letter Sent.....: / /

PATIENT INFORMED:
TOLD OF PLANNED DISCHARGE.

COMMUNITY NURSE INFORMED:
NONE

HEALTH EDUCATION INFORMATION:
HEAD INJURY CARD GIVEN.

TREATMENTS/DRESSINGS FOLLOWING DISCHARGE:
NONE

EQUIPMENT AND APPLIANCES REQUIRED:
NONE

SOCIAL CIRCUMSTANCES/SERVICES NEEDS (i.e. Home Help/Worker):
NONE

TRANSPORTATION ARRANGEMENTS:
OWN TRANSPORT ARRANGED.

VALUABLES RETURNED:
NONE

SPECIAL NEEDS IDENTIFIED:
NONE

MEDICATIONS TAKEN HOME/DRUG & DIET INSTRUCTIONS:
NONE

OUTPATIENT APPOINTMENTS:
NO FOLLOW UP.

OTHER:
NONE

I Have Read And Understand The Instructions As Presented Above
Patient Signature: Date: Time:

Discharge Nurse Signature: Date: Time:

printed after discharge

PATIENT ADMISSION RECORD - DISCHARGE PATIENT RECORD DATA REPORT

CRN/Unit.....: 337455
Surname.....: GREEN
Forename.....: LEE
Admit Date.....: 10/09/1996 Projected Discharge Date: / /
Discharge Date: 13/09/1996 Discharge Code: 1
Total Days....: 3 Discharge Ward: 5B
Discharged To.: Discharge DX: .....
Relative Informed: Y Date: 13/09/1996 Relationship: CARER
Referred To Liaison Nurse.....: / /
GP Letter Sent.....: / /

PATIENT INFORMED:
TOLD OF PLANNED DISCHARGE.

COMMUNITY NURSE INFORMED:
NONE

HEALTH EDUCATION INFORMATION:
HEAD INJURY CARD GIVEN.

TREATMENTS/DRESSINGS FOLLOWING DISCHARGE:
NONE

EQUIPMENT AND APPLIANCES REQUIRED:
NONE

SOCIAL CIRCUMSTANCES/SERVICES NEEDS (i.e. Home Help/Worker):
NONE

TRANSPORTATION ARRANGEMENTS:
OWN TRANSPORT ARRANGED.

VALUABLES RETURNED:
NONE

SPECIAL NEEDS IDENTIFIED:
NO

MEDICATIONS TAKEN HOME/DRUG & DIET INSTRUCTIONS:
NONE

OUTPATIENT APPOINTMENTS:
NO FOLLOW UP.

OTHER:
NONE

I Have Read And Understand The Instructions As Presented Above
Patient Signature: Date: Time:

Discharge Nurse Signature: Date: Time:

printed a/f b/f discharge

tient Name: GREEN, LEE Patient Number: 337455 Bed Number: 000014

lentified Needs 1 DATE: 11/09/1996 USER: JMN
ergency admission to hospital

OUTCOME ACHIEVED, DATE: 13/09/1996 USER: JACQUELINE MCNALLY
To achieve a satisfactory clinical outcome following emergency admission to hospital

STATUS: DE-ACTIVE
Ensure patient is treated with courtesy and competency respecting their privacy and dignity at all times

STATUS: DE-ACTIVE
Ensure patient is orientated to ward,staff and environment where possible

STATUS: DE-ACTIVE
Ensure patient/relatives receive some understanding for reason for admission,immediate treatment and future management

STATUS: DE-ACTIVE
Ensure information is reitorated as necessary and arrange meetings with doctors where required

STATUS: DE-ACTIVE
Ensure relatives are aware of visiting times and have a contact number for the ward

STATUS: DE-ACTIVE
Addmit and assess patients needs on admission to ward and compensate for any self care deficits

STATUS: DE-ACTIVE
Record routine urinalysis

STATUS: DE-ACTIVE
Inform doctor of any deficits from normal and assist with medical intervention

STATUS: DE-ACTIVE
Patient will be fasted until otherwise informed by Medical staff to reduce the chances of aspiration if surgery is necessary and to rest gastrointestinal tract thus avoiding exacerbation of symptoms

STATUS: DE-ACTIVE
Give prompt analgesia as prescribed and monitor effect

STATUS: DE-ACTIVE
Administer anti-emetic as prescribed and monitor effect

STATUS: DE-ACTIVE
Give intravenous fluids where prescribed at correct rate, monitor for signs of extravasation

[More]

ıtient Name: GREEN, LEE Patient Number: 337455 Bed Number: 000014

STATUS: DE-ACTIVE
As condition improves, discuss relevant discharge needs

OUTCOME - CONTINUING GOAL, REVIEWED ON: 11/09/1996 TIME: 12:14 USER: JACQUELINE MCNALLY

OUTCOME - ACHIEVED GOAL, DATE: 13/09/1996 TIME: 13:42 USER: ANN L HARVEY
NO FRACTURES SWELLING REDUCING.

NORTH AYRSHIRE AND ARRAN
NHS TRUST

Surname ..... Hosp. No. .....

Forenames .....

Address ..... Sex .....

.....

Date of Birth .....

Date of Admission .....

'Phone No. .....

Ward .....

PATIENT PROFILE

Date of Admission 10.9.96

Type of Admission 10.20 pm

Time of Admission Emergency

Accompanied by Mum

Marital Status Single

Patient Occupation Schoolboy

Religion Prot

Patient likes to be known as Lee

Reason for Admission:

Head injury

Patient's Account of Illness: Got punched on side of face - not unconscious.

Previous Health Problems:

Sprains ? '88

Consultant Mrs Moran

GP Name & Address .....

.....

Next of Kin: Name .....

Relationship .....

Address ..... 6 Green Street

.....

'Phone No. Home ..... Work .....

ALTERNATIVE NEXT OF KIN:

Name .....

Relationship .....

Address .....

.....

'Phone No. Home ..... Work .....

Drugs used prior to admission:

None

Allergies:

Note Known

Investigation performed whilst an in-patient

Date .....

SIGNATURE OF NURSE ..... DESIGNATION .....

DATE ..... TIME .....

ADMISSION OBSERVATIONS

PERL

Pulse	Temperature	Respirations
83	36⁷	18
Blood Pressure	**Weight**	**Height / Build**
117/80		
Urinalysis	**Pain Score**	
NAD.		

General appearance

Fit looking young man.

Skin inspection including Waterlow score

Clear and intact — swollen (L) jaw.

Oral inspection

Own teeth.

Family status and dependants

Lives in childrens unit (Kelmarsh)

Family's perception of patient's illness

Noted present at admission

Significant personal problems	VALUABLES:
Housing	
Social / Community Services	CLOTHING:

SIGNATURE OF NURSE ..... Primary Nurse _____

DESIGNATION ..... DATE ..... Associate Nurse _____

NORTH AYRSHIRE AND ARRAN
NHS TRUST

Surname ..... Hosp. No. .....

Forenames .....

Address ..... Sex .....

.....

Date of Birth .....

Date of Admission .....

'Phone No. .....

Ward .....

ACTIVITIES OF LIVING

ROUTINE

PROBLEMS: Actual (A)
Potential (P)

1.	Maintaining a safe environment: Buzzer system explained
2.	Breathing:
3.	Controlling body temperature: Apyrexial
4.	Eating and drinking: No problems
5.	Eliminating: No problems

SIGNATURE OF NURSE .....

DESIGNATION ..... DATE .....

ACTIVITIES OF LIVING (Cont'd...)

ROUTINE

PROBLEMS: Actual (A)
Potential (P)

6.	Communicating:
	No problems
7.	Mobilising:
	Independent
8.	Personal cleansing and dressing:
	Independent
9.	Working and recreation:
	schoolboy
10.	Sleeping:
	No problems
11.	Expressing sexuality:
	Not discussed
12.	Dying:
	Not discussed

SIGNATURE OF NURSE .....

DESIGNATION ..... DATE .....

NORTH AYRSHIRE AND ARRAN
NHS TRUST

Surname ..... Hosp. No. .....

Forenames .....

Address ..... Sex .....

.....

Date of Birth .....

Date of Admission .....

'Phone No. .....

Ward .....

ACTIVITIES OF LIVING

ROUTINE

PROBLEMS: Actual (A)
Potential (P)

1.	Maintaining a safe environment:
2.	Breathing:
3.	Controlling body temperature:
4.	Eating and drinking:
5.	Eliminating:

SIGNATURE OF NURSE .....

DESIGNATION ..... DATE .....

ACTIVITIES OF LIVING (Cont'd...)

ROUTINE

PROBLEMS: Actual (A)
Potential (P)

6. Communicating:
7. Mobilising:
8. Personal cleansing and dressing:
9. Working and recreation:
10. Sleeping:
11. Expressing sexuality:
12. Dying:

SIGNATURE OF NURSE .....

DESIGNATION ..... DATE .....

NORTH AYRSHIRE AND ARR
NHS TRUST

ADDRESSOGRAPH

WOUND ASSESSMENT CHART

		LOCATION					LOCATION					LOCATION					LOCATION					LOCATION				
	DATE:																									
TYPE OF WOUND	Unbroken - blanching.	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	Unbroken - non-blanching.	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
	Broken superficial.	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	Broken shallow.	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
	Cavity wound: a) wide	5a	5a	5a	5a	5a	5a	5a	5a	5a	5a	5a	5a	5a	5a	5a	5a	5a	5a	5a	5a	5a	5a	5a	5a	5a
	Cavity wound: b) sinus	5b	5b	5b	5b	5b	5b	5b	5b	5b	5b	5b	5b	5b	5b	5b	5b	5b	5b	5b	5b	5b	5b	5b	5b	5b
TISSUE STATUS	Epithelialising.	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	Granulating.	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
	Sloughy.	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	Necrotic.	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
SIZE OF WOUND	Length in centimetres.																									
	Width in centimetres.																									
	Depth in centimetres.																									
ODOUR	None.	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	Some.	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
	Offensive.	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
PAIN	None.	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	Only at dressing change.	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
	Intermittent.	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	Continuous.	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
INFECTION	None.	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	Suspected.	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
	Confirmed.	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	Swab sent for C + S (date).																									
	Organism isolated (yes/no).																									
WOUND ASSESSED BY (Signature):																										

CURE CARE PLAN

WATE[illegible]OV[illegible]RESSURE SORE PREVENTION/[illegible]EATM[illegible]NT POLICY

RING SCORE IN TABLE, ADD TOTAL SEVERAL SCORES PER CATEGORY CAN BE USED

DATE																					
BUILD/WEIGHT FOR HEIGHT	*	*	*	*	*	SKIN TYPE VISUAL RISK AREAS	*	*	*	*	*	SEX AGE	*	*	*	*	*	SPECIAL RISKS	*	*	*	*	*
AVERAGE	0	0	0	0	0	HEALTHY	0	0	0	0	0	MALE	1	1	1	1	1	TISSUE MALNUTRITION	*	*	*	*	*
ABOVE AVERAGE	1	1	1	1	1	TISSUE PAPER	1	1	1	1	1	FEMALE	2	2	2	2	2						
OBESE	2	2	2	2	2	DRY	1	1	1	1	1	14-49	1	1	1	1	1	e.g.TERMINAL CACHEXIA	8	8	8	8	8
BELOW AVERAGE	3	3	3	3	3	OEDEMATOUS	1	1	1	1	1	50-64	2	2	2	2	2	CARDIAC FAILURE	5	5	5	5	5
						CLAMMY (TEMP)	1	1	1	1	1	65-74	3	3	3	3	3	PERIPHERAL VASCULAR DISEASE	5	5	5	5	5
CONTINENCE	*	*	*	*	*	DISCOLOURED	2	2	2	2	2	75-80	4	4	4	4	4	ANAEMIA	2	2	2	2	2
						BROKEN/SPOT	3	3	3	3	3	80+	5	5	5	5	5	SMOKING	1	1	1	1	1
COMPLETE/ CATHETERISED	0	0	0	0	0	MOBILITY	*	*	*	*	*	APPETITE	*	*	*	*	*						
OCCASION INCONT.	1	1	1	1	1													NEUROLOGICAL DEFICIT	*	*	*	*	*
CATH/ INCONTINENT OF FAECES	2	2	2	2	2	FULLY	0	0	0	0	0	AVERAGE	0	0	0	0	0	e.g.DIABETES, MS, CVA	4	4	4	4	4
						RESTLESS	1	1	1	1	1	POOR	1	1	1	1	1	MOTOR/SENSORY;	5	5	5	5	5
DOUBLY INCONT.	3	3	3	3	3	APATHETIC	2	2	2	2	2	N.G. TUBE/ FLUIDS ONLY	2	2	2	2	2	PARAPLEGIA	6	6	6	6	6
						RESTRICTED	3	3	3	3	3							MAJOR SURGERY/ TRAUMA	*	*	*	*	*
						INERT/TRACTION	4	4	4	4	4	NBM/ANOREXIC	3	3	3	3	3						
						CHAIRBOUND	5	5	5	5	5							ORTHOPAEDIC - BELOW WAIST/SPINAL	5	5	5	5	5
																		ON TABLE > 2 HOURS	5	5	5	5	5
																		MEDICATION	*	*	*	*	*
																		STEROIDS, CYTOTOXICS, HIGH DOSE ANTI-INFLAMMATORY	4	4	4	4	4

SCORE:

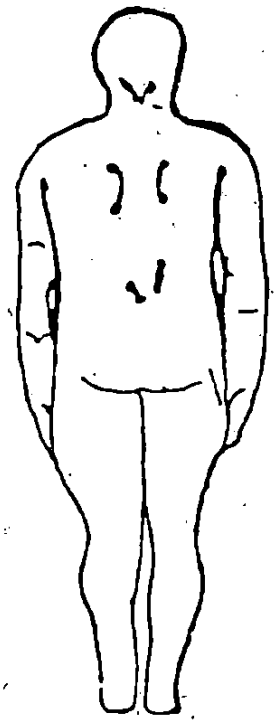
10+ AT RISK 15+ HIGH RISK

20+ VERY HIGH RISK

SCORE ON ADMISSION	CATEGORY	FREQUENCY OF ASSESSMENT
UNDER 10	LOW RISK	IF PATIENT'S GENERAL CONDITION CHANGES.
10 - 14	AT RISK	WEEKLY - BUT MORE FREQUENTLY DEPENDING ON PATIENT'S GENERAL CONDITION.
15 - 19	HIGH RISK	ALTERNATE DAYS - DEPENDING ON PATIENT'S GENERAL CONDITION.
OVER 20	VERY HIGH RISK	DAILY.

PRESSURE AREA INFORMATION

SCALE RATING: .....



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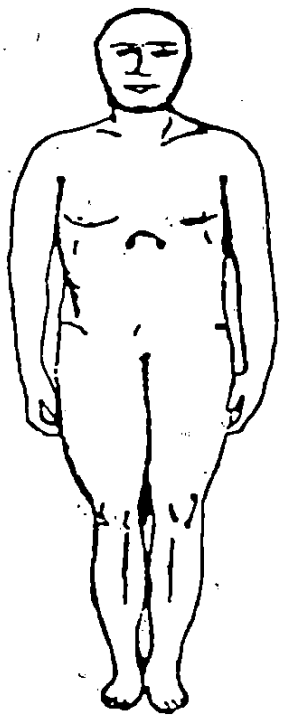


F

FAN1286

Surname Green Hosp. No.
Forenames Lee Sex
D.O.B.
Address
Ward/Dept S5

NURSING NOTES

10.9.96

DATE	
	E/A from A+E with history of being punched on the left jaw - not unconscious but knocked to the ground. (L) side of face very swollen - patient uncomplaining. Observations satisfactory. Awaiting to be seen by Doctor.
am	Settled since admission
	S/B Dr Anderson for free fluids APhelps
	Patient seen by Mr Morran. To remain on free fluids only. To have more facial X-rays today.
	Self-caring in personal hygiene.
	Observations stable JMMalby
	Settled evening. Uncomplaining of pain. Observations as charted. X-rays carried out. Awaiting medical staff to review. Tolerating fluids. Remains food fasting. AMills
12.9.96	Settled night APhelps
Am	Self caring this morning, tolerating diet & fluids. Seen by mr maran. awaiting review of xc-rays. observations within normal limits. V. Cee.
pm	Patient still awaiting review of X-rays. Tolerating diet and fluids well. Observations stable. Patient's mood low due to stay in hospital JMMalby

DATE	
	Slept soundly Aphasia
	Seen by Mr Duncan, no fractures noted on x-ray. Discharged home head injury instructions given No Surgical follow up. attorney

5/86

AYRSHIRE AND ARRAN HEALTH BOARD

NEUROLOGICAL OBSERVATION CHART

Surname ..... Hosp. No. .....
Forenames ..... Sex .....
..... D. O. B. .....
Address .....
Ward/Dept. .....

			DATE	10.9.96				DATE
			TIME	10/4	11/4	2am	5	8	8pm	TIME
COMA SCALE	Eyes open	Spontaneously		✓	✓	✓	✓	1		Eyes closed by swelling = C
		To speech						A		
		To pain						B		
		None						5		
	Best verbal response	Orientated		✓	✓	✓	✓	E		Endotracheal tube or tracheostomy = T
		Confused						N		
		Inappropriate words						T		
		Incomprehensible sounds								
		None								
	Best motor response	Obey commands		✓	✓	✓	✓			Normally the best arm response should be recorded
		Localise pain								
		Flexion to pain								
		Extension to pain								
		None								

Pupil scale (m.m.): 1, 2, 3, 4, 5, 6, 7, 8

Blood Pressure and Pulse Rate / Respiration: 240, 230, 220, 210, 200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40, 30, 20, 10

Temperature °C: 40, 39, 38, 37, 36, 35, 34, 33, 32, 31, 30

PUPILS								
Right	Size		3	3	4	3		+ reacts
	Reaction		+	+	+	+		— no reaction
Left	Size		3	3	4	3		c. eye closed
	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							

AYRSHIRE AND ARRAN HEALTH BOARD

NEUROLOGICAL OBSERVATION CHART

Surname ..... Hosp. No. .....

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

..... D. O. B. .....

Address .....

Ward/Dept. .....

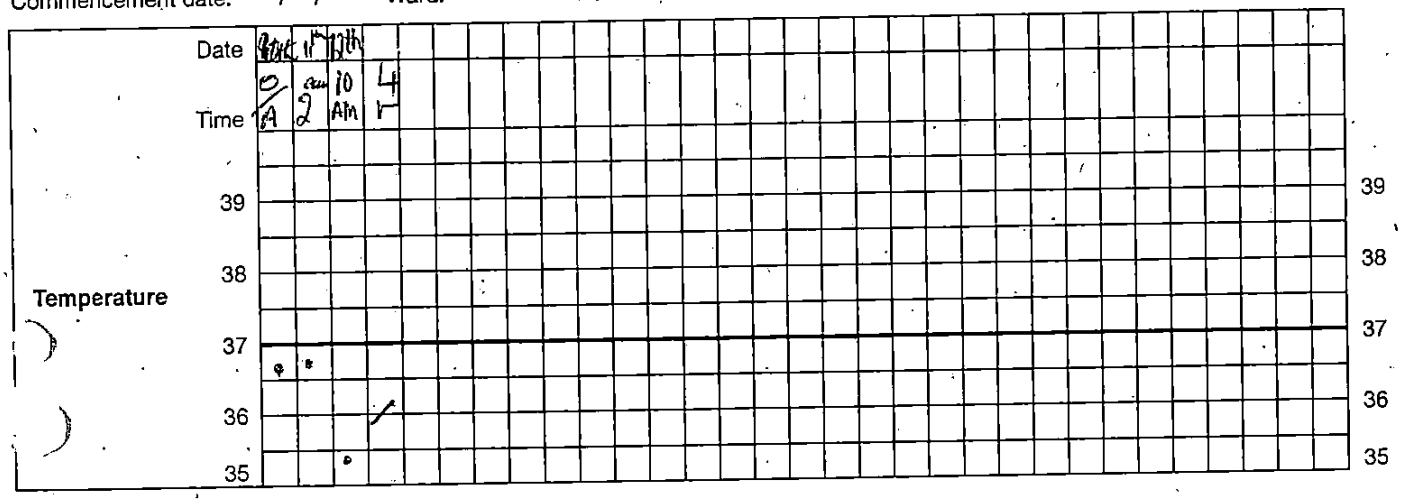
			DATE	DATE
			TIME	TIME
COMA SCALE	Eyes open	Spontaneously		Eyes closed by swelling = C
		To speech		
		To pain		
		None		
	Best verbal response	Orientated		Endotracheal tube or tracheostomy = T
		Confused		
		Inappropriate words		
		Incomprehensible sounds		
		None		
	Best motor response	Obey commands		Normally the best arm response should be recorded
		Localise pain		
		Flexion to pain		
		Extension to pain		
		None		
Pupil scale (m.m.)	1	240		
		230		40
	2	220		39
		210		38
		200		37
	3	190		36
		180		35 Temperature
		170		34 °C
	4	160	Blood	33
		150	Pressure	32
		140	and	31
	5	130	Pulse	30
		120	Rate	
	6	110		
		100		
		90		
	7	80		
		70		
		60		
	8	50		
		40		
		30		
		20	Respiration	
		10		
PUPILS		Right	Size	+ reacts
			Reaction	— no reaction
		Left	Size	c. eye closed
			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		

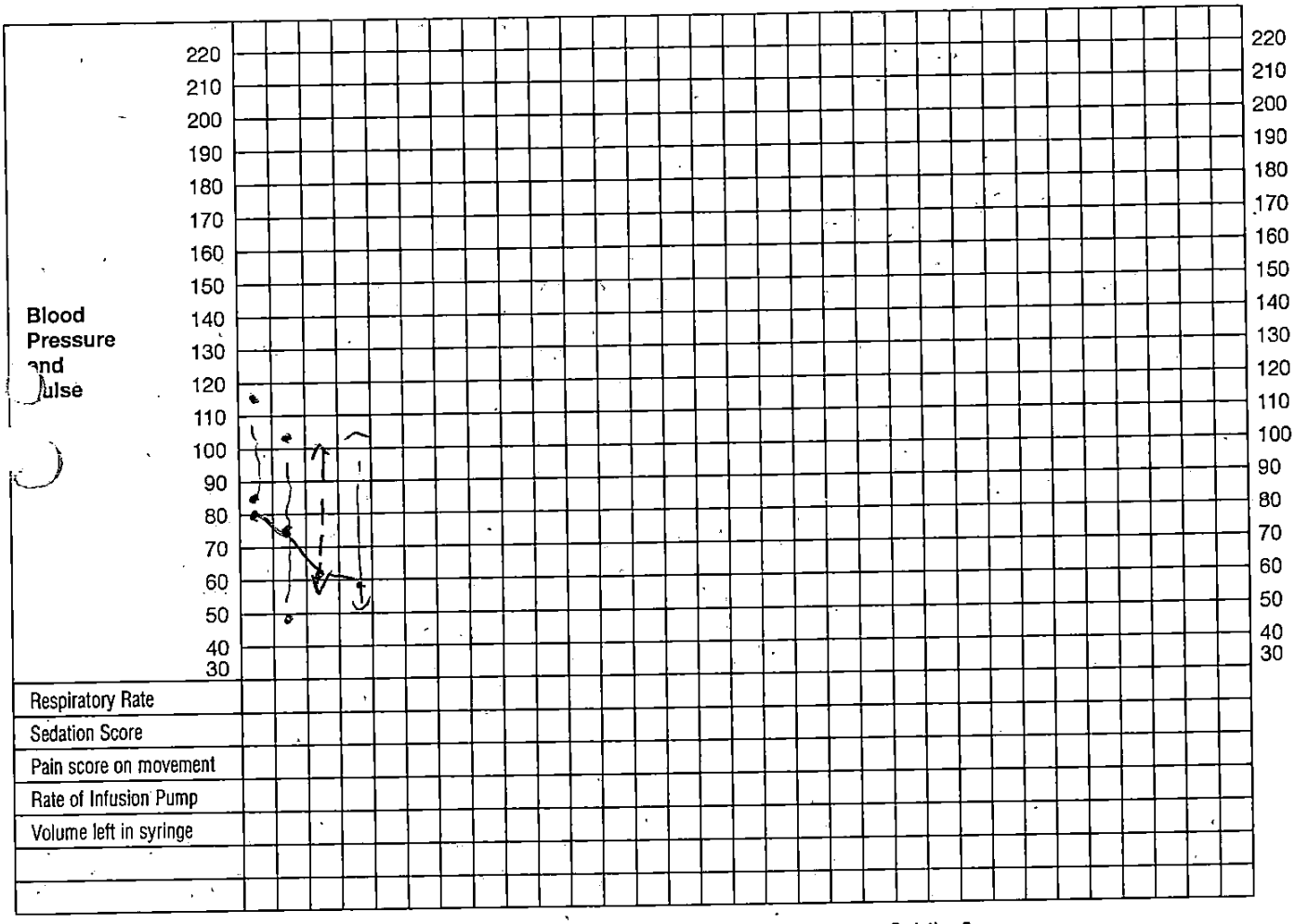
North Ayrshire & Arran
NATIONAL HEALTH SERVICE TRUST

Surname ..... Hosp. No. .....
Forenames ..... Sex .....
..... D.O.B. .....
Address .....
.....
Ward/Dept. .....

T.P.R., B.P. & Pain Chart

Commencement date: / / Ward: Named Nurse: Consultant:





Pain Score

0 = No pain at rest; No pain on movement.
1 = No pain at rest; Slight pain on movement.
2 = Intermittent pain at rest;Moderate pain on movement.
3 = Continuous pain at rest; Severe pain on movement.
S = Asleep, pain not assessed.

Sedation Score

0 = None (patient alert).
1 = Mild (occasionally drowsy, easy to rouse).
2 = Moderate (frequently drowsy, easy to rouse).
3 = Severe (somnolent, difficult to rouse).
S = Normal sleep, easily roused.

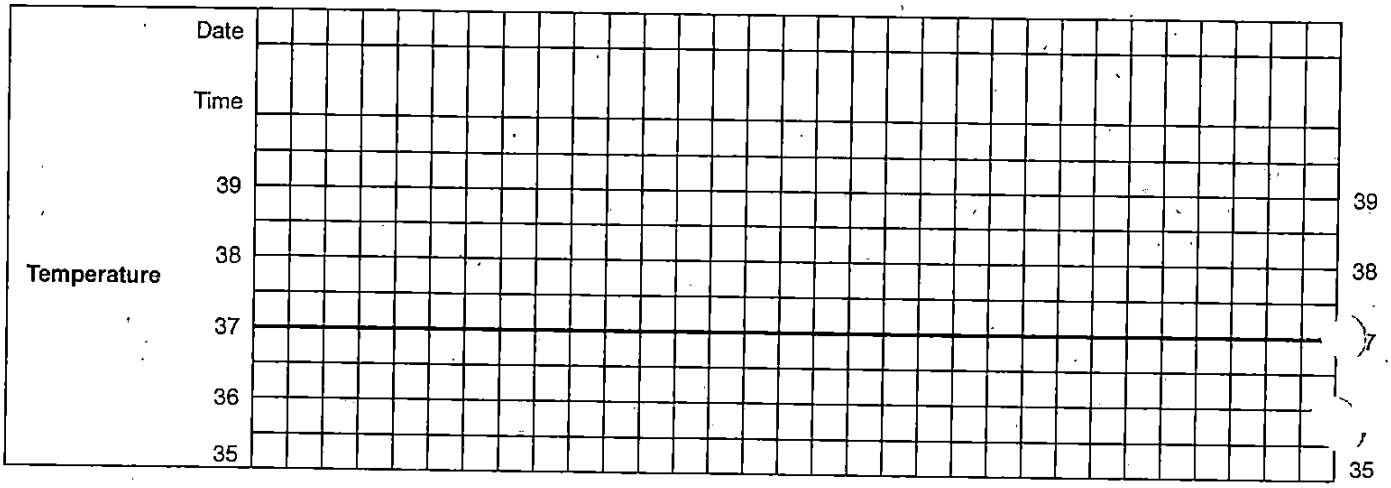
For analgesia advice call ..... Bleep ..... Phone .....

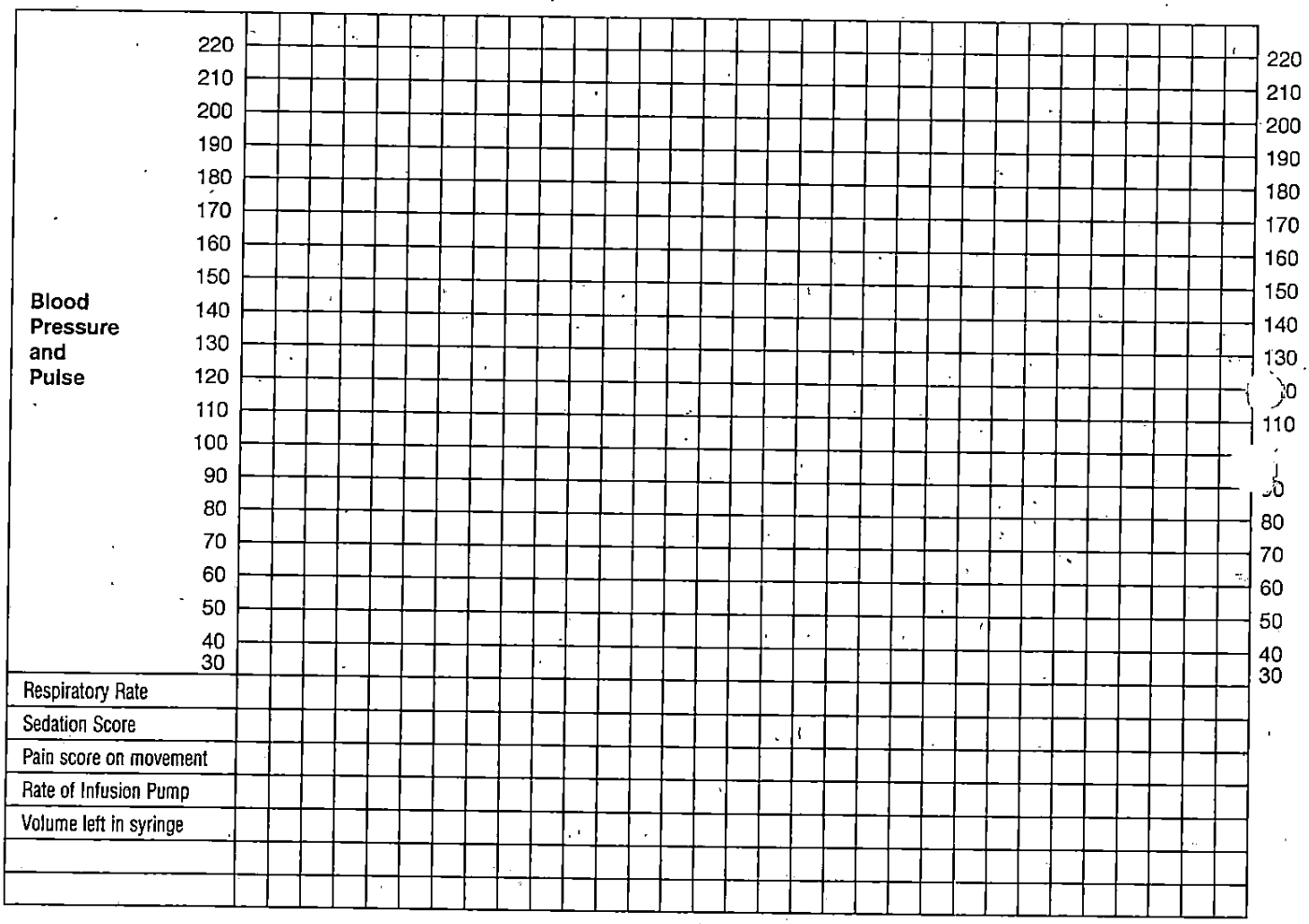
North Ayrshire & Arran
NATIONAL HEALTH SERVICE TRUST

Surname ..... Hosp. No. .....
Forenames ..... Sex .....
..... D.O.B. .....
Address .....
.....
Ward/Dept. .....

T.P.R., B.P. & Pain Chart

Commencement date: / / Ward: Named Nurse: Consultant:





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1 = Mild (occasionally drowsy, easy to rouse).
2 = Moderate (frequently drowsy, easy to rouse).
3 = Severe (somnolent, difficult to rouse).
S = Normal sleep, easily roused.

For analgesia advice call ..... Bleep ..... Phone .....

MEDICINES TO BE GIVEN ONCE (BLOCK CAPITALS)

PHARM.	TO BE GIVEN		APPROVED NAME OF MEDICINE	DOSE	ROUTE (see key)	DOCTOR'S SIGNATURE	GIVEN BY	TIME GIVEN
	DATE	TIME						

SHEET No. .....

MEDICINE PRESCRIPTION SHEET

KEY: O ORAL; IM INTRAMUSCULAR; IV INTRAVENOUS; SC SUBCUTANEOUS; SL SUBLINGUAL; ID INTRADERMAL; INH INHALATION; NEB NEBULISED; PR PER RECTUM; PV PER VAGINA; IT INTRATHECAL

Write, Imprint or attach label

Surname .....HCR No. .....

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

.....D.O.B. .....

Address .....

.....Ward/Dept.....

KNOWN SENSITIVITY

1.	2.

SUSPECTED ADVERSE REACTION

MEDICINE	ADVERSE EFFECT
1.	
2.	

MEDICINES TO BE GIVEN REGULARLY (BLOCK CAPITALS)

PHARM.	Date Commenced	APPROVED NAME OF MEDICINE	DOSE	TIMES OF ADMINISTRATION									OTHER		ROUTE (see key)	OTHER INSTRUCTIONS	DOCTOR'S SIGNATURE	DISCONTINUED	
				6 am	8 am	10 am	12 md	2 pm	6 pm	8 pm	10 pm	12 mn						DATE	INITIAL
	A																		
	B																		
	C																		
	D																		
	E																		
	F																		
	G																		
	H																		
	I																		
	J																		
	K																		
	L																		
	M																		
	N																		
	O																		
	P																		
	R																		
	S																		
	T																		
	V																		

STA 0235

SHEET No.....

MEDICINE RECORDING SHEET

Name .....

Age .....

Consultant .....

Hospital.....

Enter code in box and initial when medicine is taken.

If medicine refused record Ⓐ If patient unable to swallow record A

If patient absent record A If medicine not available record A

ate	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

SHEET No.....

MEDICINE RECORDING SHEET

Name .....

Age .....

Consultant .....

Hospital.....

Enter code in box and initial when medicine is taken.

If medicine refused record Ⓐ If patient unable to swallow record Ⓐ

If patient absent record Ⓐ If medicine not available record Ⓐ

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

OBSERVATION CHART

FAN 058

NAME Lee Grace

RECORD No.

DATE

TIME 3/5 3/5 12

COMA SCALE

Eyes open	Spontaneously	4
	To speech	3
	To pain	2
	None	1
Best verbal response	Orientated	5
	Confused	4
	Inappropriate words	3
	Incomprehensible sounds	2
	None	1
Best motor response	Obey commands	6
	Localise pain	5
	Withdrawal to pain	4
	Abnormal flexion to pain	3
	Extension to pain	2
	None	1

Eyes closed by swelling = C

Endotracheal tube or tracheostomy = T

Usually recorded the best arm response

Pupil scale mm: 1 2 3 4 5 6 7 8

Blood pressure and Pulse rate: 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30

Respiration: 20 10

Temperature °C: 40 39 38 37 36 35 34 33 32 31 30

PUPILS				
right	Size	3	3	
	Reaction	+	+	
left	Size	3	3	
	Reaction	+	+	

+ reacts
– no reaction
c. eye closed

LIMB MOVEMENT

ARMS	Normal power	6
	Mild weakness	
	Severe weakness	
	Spastic flexion	
	Extension	
	No response	
LEGS	Normal power	6
	Mild weakness	
	Severe weakness	
	Extension	
	No response	

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

FILING ONLY DO NOT USE THIS SPACE

5/123720
REEN LEE
5 BENRIG AVE
ILMAURS

31 AUG 1982 M

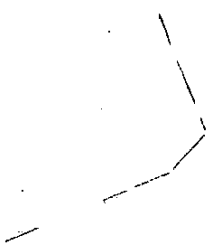
R96/56631J

CROSSHOUSE HOSPITAL
CAS
ACC & EM
Mr. Stevenson J.

KULL (10 SEP 1996)

---

o vault fracture is demonstrated.



5/123720
REEN LEE
5 BENRIG AVE
ILMAURS

31 AUG 1982 M

R96/56792R

CROSSHOUSE HOSPITAL
5B
SURGERY
Mr. Morran C.G.

.P.T. (11 SEP 1996)

---

o bone injury is demonstrated.

AYRSHIRE AND ARRAN HEALTH BOARD

PAEDIATRIC NURSING ASSESSMENT

10yrs.

SURNAME GREEN LEE HOSP NO 332455
27 MILRIG CRES WARD/DEPT
GALSTON 31/08/1982
DR NICOLL M/S C/H
HENRIETTA ST A2292 DEPT.

DATE OF ADMISSION: 18.9.92 TIME: 2pm

TYPE OF ADMISSION: Arranged

ACCOMPANIED BY: Mother.

FROM WHERE: Home. Mum

LIVES WITH?: Brother 13

BROTHERS/SISTERS: Sister AGE: 4yrs.

REASON FOR THIS ADMISSION

Repeat Myringotomy
~~Insertion of Grommets~~ 19/9/92

RELIGION: C of S

NEXT OF KIN: Margaret Lyon

RELATIONSHIP: Mother

ADDRESS: AIA

HOME PHONE NO: 82123 S.

WORK PHONE NO:

ALTERNATIVE NEXT OF KIN:

RELATIONSHIP:

ADDRESS:

PHONE NO:

ENT/GUARDIAN ACCOUNT OF THIS ILLNESS

Coughs. Painful. Ear.

SPECIAL NEEDS:

SOCIAL
LANGUAGE
OTHER EG. A SPECIAL NAME

PREVIOUS HEALTH PROBLEMS

Myringotomies
Grommets.

DRUG THERAPY AT TIME OF ADMISSION

✓

TAKEN FOR SAFE-KEEPING ☐ RETURNED ☐

DRUG/FOOD OTHER ALLERGIES: glass.

✗ Tetanus immunisation.

BLEEDING TENDENCIES:

NO.

INFECTIOUS DISEASES:	YES	NO	RECENT CONTACT
MEASLES	☐	☑	☐
MUMPS	☐	☑	☐
RUBELLA	☐	☑	☐
PERTUSSIS	☐	☑	☐
CHICKEN POX	☐	☑	☐ NO.
SCARLET FEVER	☐	☑	☐
TUBERCULOSIS	☐	☑	☐
POLIO	☐	☑	☐
OTHER	☐	☐	☐

INNOCULATIONS: PLEASE TICK

POLIO	TETANUS	WHOOPING COUGH	DIPTHERIA
(1)	(1)	(1)	(1)
(2)	(2) up to	(2)	(2)
(3)	(3) date.	(3)	(3)
(4)	(4)		

BOOSTER

MEASLES BCG
RUBELLA OTHERS
RECENT COUGH/COLD NO.

CLOTHES CHECKED: RETAINED ☐ SENT HOME ☑

VALUABLES: RETAINED ☐ SENT HOME ☐

ADMISSION DETAILS TAKEN BY:

18-9-92

SIGNATURE A Shaw DATE

ANY SPECIAL VISITING NEEDS:

FAN1487

2 Communicating:

Vision — any problems?
spectacles? yes for reading.
contact lenses?

Hearing — any problems? dull.
hearing-aid?
battery type?

Speech difficulty — YES
— NO ✓

3. Mobility

— independent? ✓
— with assistance?
— remarks?

4. Eating and Drinking?

appetite? — good.
special diet? —
dislikes? —
assistance needed —

5. Personal cleaning and dressing

— independent? ✓
— with assistance?
— remarks

6. Bladder and Bowels

— any problems? none
— special needs?

7. Sleeping — pattern: 9PM. — 7AM.
What helps?

8. Recreational Interests

9. Other Relevant Information

GENERAL OBSERVATIONS

Temp. 36 Pulse 80 Resps. 20 B/P
Height: Weight:
Skin inspection: normal bruising on legs.
Hair inspection:
Urinalysis:
Oral inspection:
— condition of mouth
— condition of teeth
Dentures: Crowns:
Problems:
no loose teeth

GENERAL INFORMATION **SIGNATURE/DATE**

— re visiting times a Sia
— re resident parents
— doctor/parent 18.9.92

ASSESSMENT MADE BY:

Discharge/Future Plans	*Date Ord.*	*Date Gvn.*	*Signature*
Education of condition	19/9		JF
Patient rehabilitation			
Discharge medication			
Tetanus card			
Transport home			
Out-Patient appointment	19/9		JF
Crutches/walking aids			
Dressings			
Steroids			
Community Nursing			
Social Worker			
Physiotherapy			
Occupational Therapy			
Speech Therapy			
Others:			

DISCHARGE INFORMATION
GIVEN BY:

AYRSHIRE AND ARRAN HEALTH BOARD

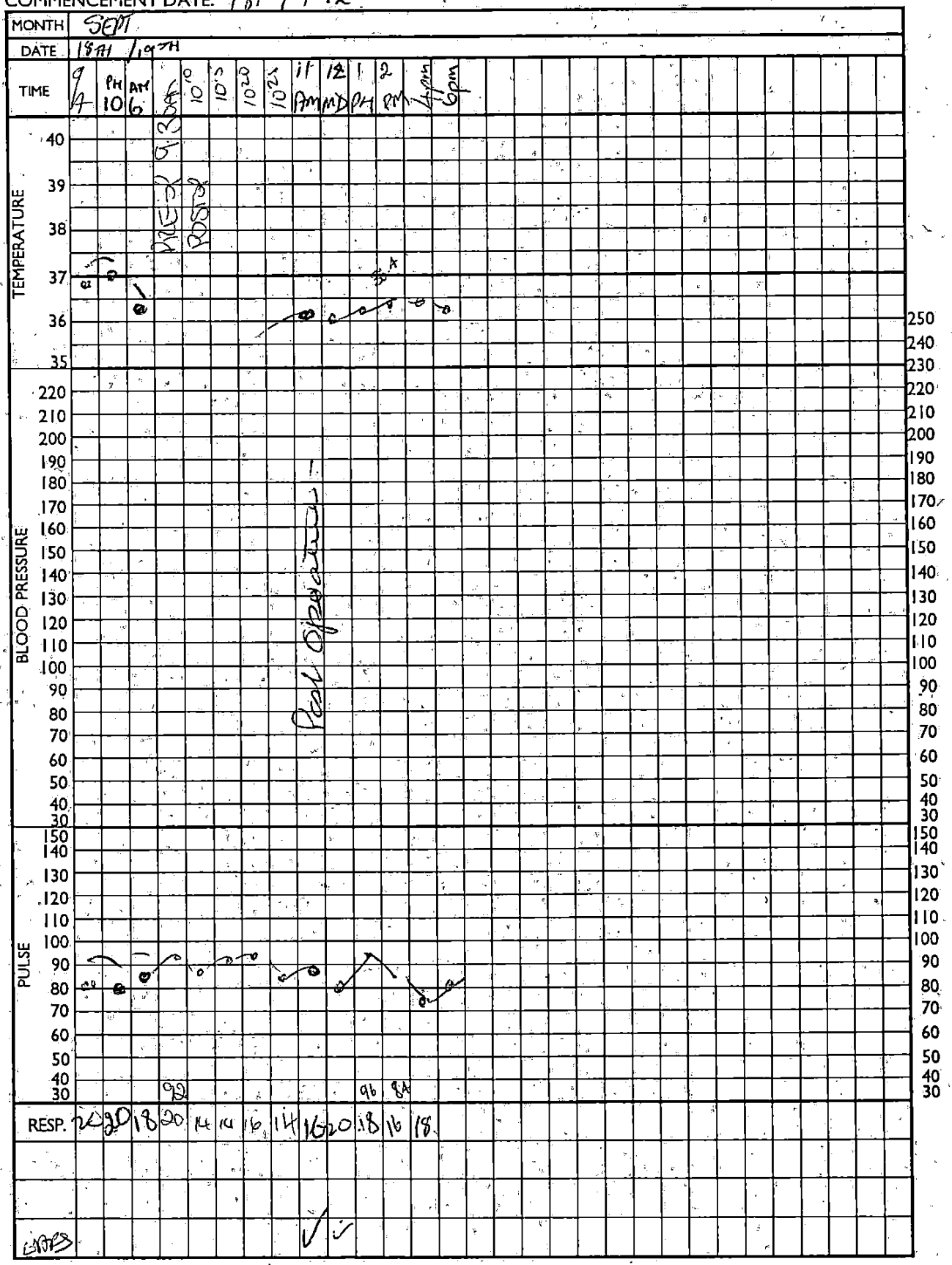
T.P.R & B.P. CHART

Surname GREEN LEE Hosp. No. 337455

27 MILRIG CRES
GALSTON
DR NICOLL
HENRIETTA ST

WARD/DEPT
31/08/1982
M/S C/H
A2292

COMMENCEMENT DATE: 18/9/92 FAN0486 Ward/Dept.



AYRSHIRE AND ARRAN HEALTH BOARD

T.P.R & B.P. CHART

Surname ..... Hosp. No. .....

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

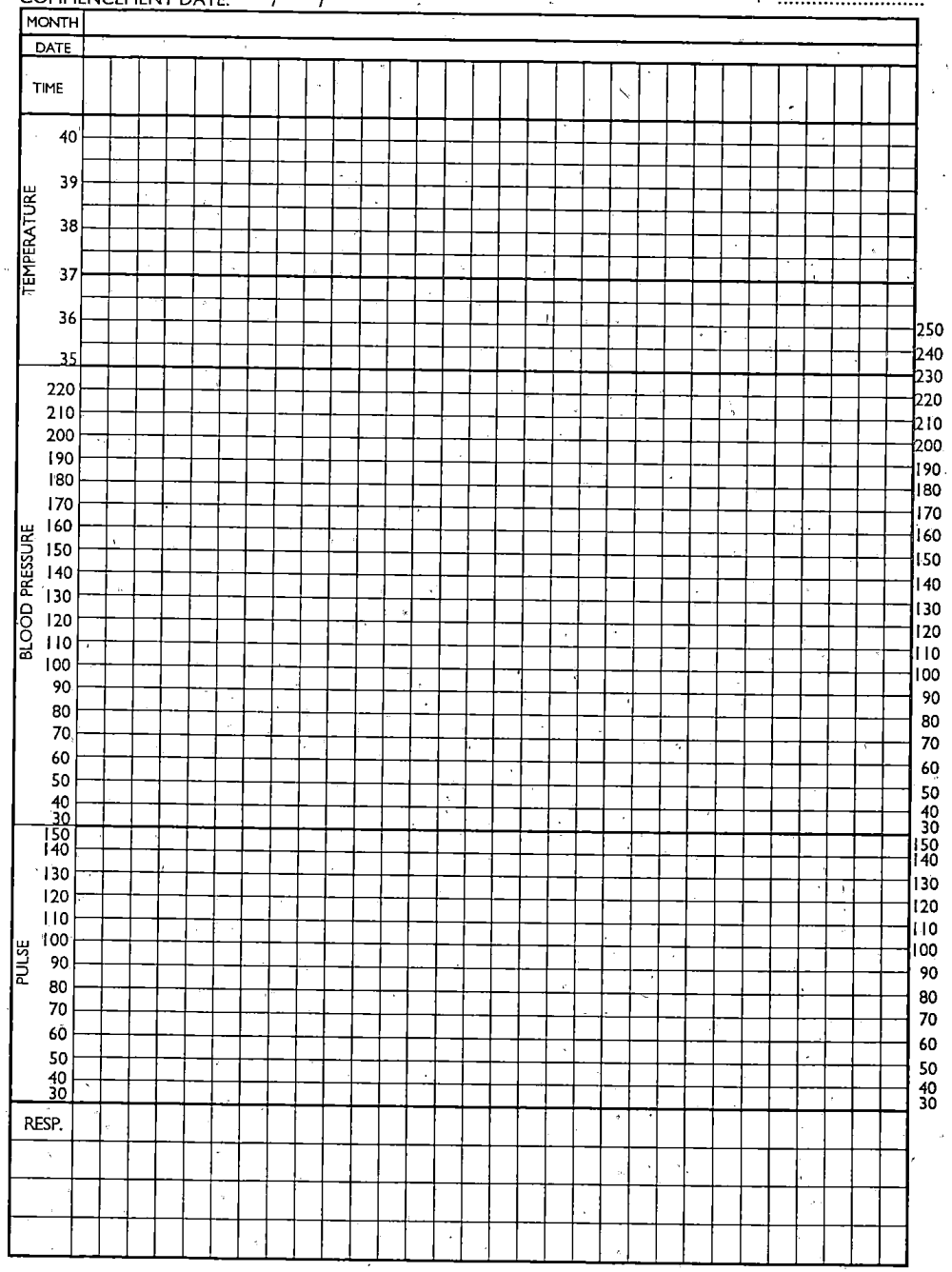
..... D.O.B. .....

Address .....

.....

FAN0486 Ward/Dept. .....

COMMENCEMENT DATE: / /



FAN1286

AYRSHIRE AND ARRAN HEALTH BOARD

GREEN LEE 337455 Hosp No. .....
27 MILRIG CRES
GALSTON
DR NICOLL
HENRIETTA ST
Address .....
WARD/DEPT .....
31/08/1982
M/S C/H .....
A2292 .....

NURSING NOTES

Ward/Dept. .....

DATE	
19-9-92	Arranged admission for repeat myringotomy & insertion of grommets. Please fast & prepare. S/B S/O Sp. Consent obtained. S/B anaesthetist pre med due 7.00 AM.
19-9-92	Fasted & prepared for theatre. c-c
9.30am	Reception, obsv good, observations charted BP ok
	10.10 Recovery: Awake, sensible
	Obsv good. O_2 given
	no signs of bleeding
	Obs. charted SR
	10.25 Awake Obsv + Obsv. stable
	O_2 disc.
	no signs of bleeding
	may return to ward dressing
	Awake on return to ward. Ot theatre book. Bilateral Myringotomy. NO grommets. Post op wash given. Mouth given.
pm	Post operative observations satisfactory. Tolerated diet at tea-time ? Comp.
	Patient discharged from this evening

DATE

MEDICINES TO BE GIVEN ONCE ONLY (BLOCK CAPITALS)

PHARM.	TO BE GIVEN		APPROVED NAME OF MEDICINE	DOSE	ROUTE (see key)	DOCTOR'S SIGNATURE	GIVEN BY	TIME GIVEN
	DATE	TIME						

SHEET No. .....

MEDICINE PRESCRIPTION SHEET

GREEN LEE 337455
27 MILRIG CRES WARD/DEPT .....
GALSTON 31/08/1982 .....
DR NICOLL M/S C/H .....
HENRIETTA ST A2292 .....
..... Ward/Dept. .....

KNOWN SENSITIVITY	
1.	2.
SUSPECTED ADVERSE REACTION	
MEDICINE	ADVERSE EFFECT
1.	
2.	

KEY:
O ORAL
IM INTRAMUSCULAR
IV INTRAVENOUS
SC SUBCUTANEOUS
SL SUBLINGUAL
ID INTRADERMAL
INH INHALATION
NEB NEBULISED
PR PER REC
PV PER VAG
IT INTRATHECAL

MEDICINES TO BE GIVEN REGULARLY (BLOCK CAPITALS)

Code STA0235

PHARM.	Date Commenced	APPROVED NAME OF MEDICINE	DOSE	TIMES OF ADMINISTRATION									OTHER		ROUTE (see key)	OTHER INSTRUCTIONS	DOCTOR'S SIGNATURE	DISCONTINUED	
				6 am	8 am	10 am	12 md	2 pm	6 pm	8 pm	10 pm	12 mn						DATE	INITIAL
	A																		
	B																		
	C																		
	D																		
	E																		
	F																		
	G																		
	H																		
	I																		
	J																		
	K																		
	L																		
	M																		
	N																		
	O																		
	P																		
	R																		
	S																		
	T																		
	V																		

SHEET

GREEN LEE 337455
27 MILRIG CRES
GALSTON
DR NICOLL
HENRIETTA ST

WARD/DEPT
31/08/1982
M/S C/H
A2292

Hospital.....

MEDICINE RECORDING SHEET

Enter code in box and initial when medicine is taken.

If medicine refused record (A) If patient unable to swallow record A

If patient absent record A If medicine not available record A

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

STA 0236

SHEET No.....

MEDICINE RECORDING SHEET

Name .....

Age .....

Consultant .....

Hospital.....

Enter code in box and initial when medicine is taken.

If medicine refused record Ⓐ If patient unable to swallow record Ⓐ

If patient absent record Ⓐ If medicine not available record Ⓐ

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

STA 0226

AYRSHIRE AND ARRAN HEALTH BOARD

PAEDIATRIC NURSING ASSESSMENT

S GREEN LEE 337455 HOSP. NO.....
F 27 MILRIG CRES
GALSTON
DR NICOLL
HENRIETTA ST
WARD/DEPT
31/08/1982
M/S C/H
A2292

DATE OF ADMISSION: 10/2/91 TIME: 1.30pm
TYPE OF ADMISSION: Arranged
ACCOMPANIED BY: Mother
FROM WHERE: Galston
LIVES WITH?: Mother
BROTHERS/SISTERS: 1 + 1 AGE: —

RELIGION: C of Scotland
NEXT OF KIN: Margaret Green
RELATIONSHIP: Mother
ADDRESS: 27 Milrig Cres. Galston
HOME PHONE NO: 821235
WORK PHONE NO:
ALTERNATIVE NEXT OF KIN: Margaret O'connel
RELATIONSHIP: Grandmother
ADDRESS: 64 Braidland St. Galston
PHONE NO: 820269

REASON FOR THIS ADMISSION
Bilateral Myringotomy. Insertion of grommets + sinuses washout 11-2-91

PARENT/GUARDIAN ACCOUNT OF THIS ILLNESS

SPECIAL NEEDS:
SOCIAL
LANGUAGE
OTHER EG. A SPECIAL NAME

PREVIOUS HEALTH PROBLEMS
Concussion - 2 years ago.

DRUG THERAPY AT TIME OF ADMISSION
Mxcodume

TAKEN FOR SAFE-KEEPING ☐ RETURNED ☐

DRUG/FOOD OTHER ALLERGIES:
Tetanus

BLEEDING TENDENCIES: NO.

INFECTIOUS DISEASES:	YES	NO	RECENT CONTACT
MEASLES	☐	☑	☐
MUMPS	☐	☑	☐
RUBELLA	☐	☑	☐
PERTUSSIS	☐	☑	☐
CHICKEN POX	☐	☑	☐
SCARLET FEVER	☐	☑	☐
TUBERCULOSIS	☐	☑	☐
POLIO	☐	☑	☐
OTHER	☐	☑	☐

INNOCULATIONS: PLEASE TICK

POLIO	TETANUS	WHOOPING COUGH	DIPTHERIA
(1)	(1)	(1)	(1)
(2)	(2)	(2)	(2)
(3)	(3)	(3)	(3)
(4)	(4)		

Up to date
BOOSTER

MEASLES
RUBELLA
RECENT COUGH/COLD
BCG
OTHERS

CLOTHES CHECKED: RETAINED ☑ SENT HOME ☐
VALUABLES: RETAINED ☑ SENT HOME ☐

ADMISSION DETAILS TAKEN BY:

SIGNATURE Jane McDonald DATE 10/2/91

ANY SPECIAL VISITING NEEDS:

FAN1487

2 Communicating:

Vision — any problems?
spectacles? Reading - Longsighted
contact lenses?

Hearing — any problems? NO.
hearing aid?
battery type?

Speech difficulty — YES
NO

3. Mobility

— independent? YES.
— with assistance?
— remarks?

4. Eating and Drinking?

appetite? — GOOD
special diet? — NO
dislikes? —
assistance needed — NO.

5. Personal cleaning and dressing

— independent? YES
— with assistance?
— remarks

6. Bladder and Bowels

— any problems?
— special needs?

7. Sleeping — pattern:

What helps? NO.

8. Recreational Interests

TV. Cartoons.

9. Other Relevant Information

GENERAL OBSERVATIONS

Temp. 36.8°C Pulse 90 Resps. 16 B/P
Height: Weight: 28kg.
Skin inspection: GOOD.
Hair inspection: CLEAN
Urinalysis:
Oral inspection:
— condition of mouth GOOD
— condition of teeth GOOD.
Dentures: — Crowns: —
Problems:
Scratch on chin.

GENERAL INFORMATION
— re visiting times
— re resident parents
— doctor/parent

SIGNATURE/DATE
JMcDonald

ASSESSMENT MADE BY:

Discharge/Future Plans	*Date Ord.*	*Date Gvn.*	*Signature*
Education of condition			
Patient rehabilitation			
Discharge medication			
Tetanus card			
Transport home			
Out-Patient appointment			
Crutches/walking aids			
Dressings			
Steroids			
Community Nursing			
Social Worker			
Physiotherapy			
Occupational Therapy			
Speech Therapy			
Others:			

DISCHARGE INFORMATION GIVEN BY:

FANO 486

AYRSHIRE AND ARRAN HEALTH BOARD

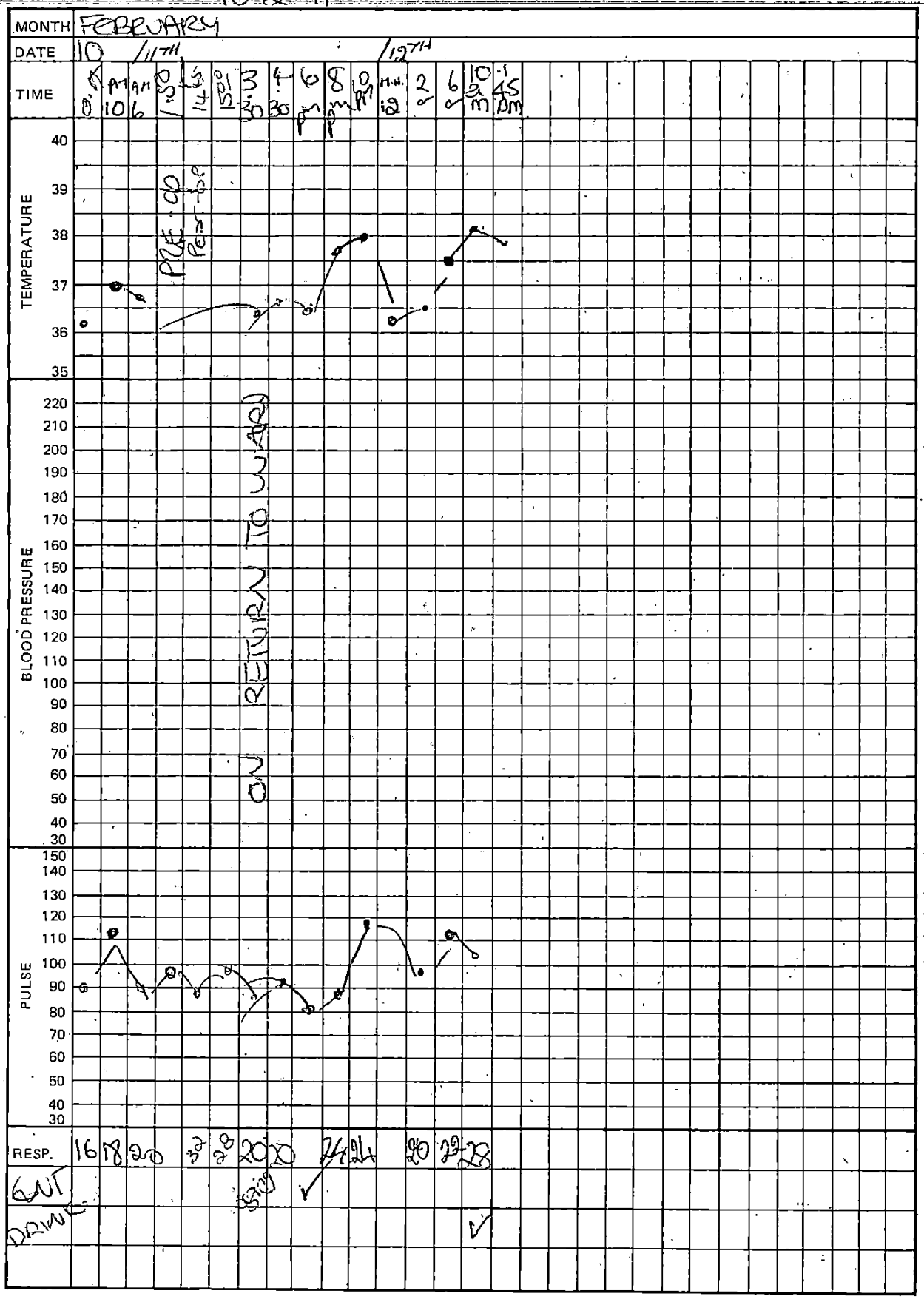
T.P.R. & B.P. CHART

GREEN LEE 337455
27 MILRIG CRES
GALSTON
DR NICOLL
HENRIETTA ST

WARD/DEPT
31/08/1982
M/S C/H
A2292

COMMENCEMENT DATE: 10/2/91

Ward/Dept. 1A



AYRSHIRE AND ARRAN HEALTH BOARD

T.P.R. & B.P. CHART

Surname ..... Hosp. No. .....

GREEN LEE 337455
27 MILRIG CRES WARD/DEPT
GALSTON 31/08/1982
DR NICOLL M/S C/H
HENRIETTA ST A2292

COMMENCEMENT DATE: / /

Ward/Dept. .....

MONTH

DATE

TIME

TEMPERATURE
40
39
38
37
36
35

BLOOD PRESSURE
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30

PULSE
150
140
130
120
110
100
90
80
70
60
50
40
30

250
240
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30

RESP.

FAN12 86

AYRSHIRE AND ARRAN HEALTH BOARD

NURSING NOTES

Surname GREEN LEE 337455
1 27 MILRIG CRES
GALSTON
DR NICOLL
A HENRIETTA ST

WARD/DEPT
31/08/1982
M/S C/H
A2292

Ward/Dept. 1A

DATE	
10/2/91.	Arranged admission for theatre please fast + prepare. Consent obtained. S/S anaesthetist, pre med due 12.30pm
11.2.91	Settled & slept well. Observations satisfactory. Early breakfast given. Fasted & prepared for theatre. 1.50 pm Reception. Obs now normal. 2 hrs 14.45 Recovery: unconscious. Colour good. O2 given no signs of bleeding. Obs charted NR CD.
3.10 pm	Conscious : 3.20 pm Condition stable : to ward RDavies
3.30 pm	Returned to ward following B.lateral myringotomy insertion grommet to left ear. BAWD. Observations satisfactory. Drink taken. UGrant
pm	Observations satisfactory. Slept most of afternoon resting.
12-2-91	Slept well. low grade pyrexia this a.m. UGrant c.c Seen by ENT SHO, to remain until after lunch, if apyrexial

DATE

Pain may go home infant seen by DR. Ristvic home today recheck back at clinic on 6/52.

Infant

M___CINES TO BE GIVEN ONCE ONLY (BLOCK CAPI)

PHARM.	TO BE GIVEN		APPROVED NAME OF MEDICINE	DOSE	ROUTE (see key)	DOCTOR'S SIGNATURE	GIVEN BY	TIME GIVEN
	DATE	TIME						

SHEET No. .....

MEDICINE PRESCRIPTION SHEET

KEY: **O** ORAL **IM** INTRAMUSCULAR **IV** INTRAVENOUS **SC** SUBCUTANEOUS **SL** SUBLINGUAL **ID** INTRADERMAL **INH** INHALATION **NEB** NEBULISED **PR** PER RECTUM **PV** PER VAGINA **IT** INTRATHECAL

Write, Imprint, or attach label

GREEN LEE 337455
27 MILRIG CRES WARD/DEPT
GALSTON 31/08/1982
DR NICOLL M/S C/H
HENRIETTA ST A2292

KNOWN SENSITIVITY
1. 2.

SUSPECTED ADVERSE REACTION

MEDICINE	ADVERSE EFFECT
1.	
2.	

MEDICINES TO BE GIVEN REGULARLY (BLOCK CAPITALS)

Code STA0235

PHARM.	Date Commenced	APPROVED NAME OF MEDICINE	DOSE	TIMES OF ADMINISTRATION 6 am	8 am	10 am	12 md	2 pm	6 pm	8 pm	10 pm	12 mn	OTHER		ROUTE (see key)	OTHER INSTRUCTIONS	DOCTOR'S SIGNATURE	DISCONTINUED DATE	INITIAL
	A 11.2.91	Omnopon	5 mgs.					6	daily	PRN					i-m.		JH. ICU		
	B																		
	C																		
	D																		
	E																		
	F																		
	G																		
	H																		
	I																		
	J																		
	K																		
	L																		
	M																		
	N																		
	O																		
	P																		
	R																		
	S																		
	T																		
	V																		

SHEET No.....

GREEN LEE 337455
27 MILRIG CRES WARD/DEPT
GALSTON ~~31/08/1982~~
DR NICOLL M/S C/H
HENRIETTA ST A2292

MEDICINE RECORDING SHEET

Enter code in box and initial when medicine is taken.

If medicine refused record (A) If patient unable to swallow record A

If patient absent record A If medicine not available record A

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

STA 023F

SHEET No.....

GREEN LEE 337455
27 MILRIG CRES
GALSTON
DR NICOLL
HENRIETTA ST

WARD/DEPT
31/08/1982
M/S C/H
A2292

MEDICINE RECORDING SHEET

Enter code in box and initial when medicine is taken.

If medicine refused record (A) If patient unable to swallow record A

If patient absent record A If medicine not available record A

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

STA 0236