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

NHS
Greater Glasgow and Clyde

Private

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

Date: 22nd June 2026
Your Ref: 100096
Our Ref: LAT/ACCESS/LB
Enquiries to: Lorna
Direct Line: 0141 201 1644
Email: Lorna.Bower@nhs.scot

Dear Sir/Madam,

Re: Subject Access Request under the General Data Protection Regulation

Patient Nicolas McJury D.O.B 28.10.1966

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

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

Queen Elizabeth University Hospital

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

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

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

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

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

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

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

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

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

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

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

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

Yours sincerely

Legal Aspects Team

ELECTRONIC PATIENT RECORDS

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

Including:

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

Patient name ..

Patient CHI

2810666490
MCJURY M
Nicholas, D · 28/10/1966
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire
G51 3UP

NHS
Greater Glasgow and Clyde

Emergency Care Nursing Documentation

Initial Investigations

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

Communication

	Required?	
GGC Red Bag with Patient (nursing home resident)	Y	N
Language or hearing difficulty	Y	N
Interpreter required	Y	N
what arrangements have been made?		
Relatives / Carer / Next of Kin present	Y	N

name, relationship, location, particular concerns

Signature:

PVC

Circle reason: P R I F T

Diagnostic
Resuscitation
Intravenous Fluids
Transfusion

Insertion Date: 30/8/20 Time: [illegible]

Insertion Side: L R

Insertion Site: Upper arm

Size of PVC: 6.18

Inserted by [illegible] Specialist
Signature

Hand Hygiene Yes ☐

Skin Decontamination 2% chlorhexidine in 70% isopropyl alcohol Yes ☐

Sterile transparent semi-permeable dressing affixed Yes ☐

PVC Reason Explained Yes ☐

Risk Assessments and Screening Tools

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

Pause for Discharge

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

Signature:

Pause for Transfer

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

Signature:

Patient name

Patient CHI

2810666490
MCJURY
Nicholas, D 28/10/196
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire
G51 3UI

NHS
Greater Glasgow and Clyde

Care Rounds Checklist

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

Signed A McDonald Name A _____ Designation SN

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

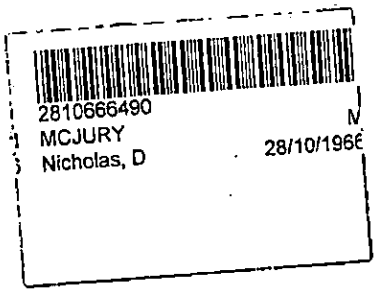
Use the following Codes:
Y = Yes N = No NA = Not Applicable NT = No Thanks S = Sleeping O = Off the ward I - Independent

			Times	09 15									
	1	**THINK DELIRIUM** Is the patient more confused/drowsy than normal? If yes inform registered nurse.		~									
	2	**PAIN: ASSESS AND ADDRESS** Is the patient distressed or in pain?If yes inform registered nurse/ Review analgesia		~									
S	3	**SKIN INSPECTION** Pressure areas checked?		~									
		R = RED D = Discloured PU - Pressure Ulcer INT = Intact M = Moisture		/									
K	4	**KEEP MOVING** Has the patient moved or walked?		Y									
		Bed R =Right side (30°) tilt L =Left side (30°) tilt B =Back Chair W/ST = Assist to walk / stand		B									
		ELIMINATION Does the patient need the toilet?		~									
I	5	I = Independent A - Assistance given IC = Incontinent (urine/ faeces)		~									
		FOOD FLUIDS AND NUTRITION Is the patient nil by mouth?		~									
N	6	Drink taken?		Y									
		Food, snack, or supplements taken?		~									
		Has oral hygiene been carried out as per care plan?		~									
	7	**ENVIRONMENT CHECK** Is the patient's call buzzer to hand? Is the area clutter free clean and safe? Does the patient have everything they require in safe reach? Is the bed in the lowest position?		Y									
	8	**INFORMATION** Is there anything else I can help you with? Inform the patient of the time of return		NT									
	9	**ESCALATION** Is there anything else I can help you with? Inform the patient of the time of return		NA									
		Care provider		A									
		Role		N									

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

Patient name

Patient CHI



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Nursing notes cont.

Date and Time		Name/Signature

Patient nam

Patient CHI

2810666490
MCJURY
Nicholas, D
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire
G51 3UF
28/10/196

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

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Greater Glasgow and Clyde

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

Pressure damage	No RISK ↓	At RISK ↓	Grade 1 – non blanching skin Grade 2,3,4, suspected deep tissue injury (SDTI), ungradable pressure ulcer, Moisture Associate Skin Damage (MASD) ↓	Device Related Pressure Damage i.e. nasogastric, catheters, oxygen tubing ↓
)U MUST ..IECK SKIN at pressure points	Daily skin check	4 hourly positioning Complete SSKINS care plan (below)	2 hourly positioning with skin checks, Complete SSKINS care plan (below)	All devices need a SSKINS care plan (below)

1	PressureDamage	Does the person have Pressure damage; Grade 1, 2, 3, 4, SDTI, Ungradable?
2	Mobility	Does the person require assistance to mobilise or change position?
3	Continence	Does the person have moisture issues, or, continence issues with urine and/or faeces?
4	Nutrition	Does the person appear malnourished and/or unable to eat or drink?
5	Skin	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?
6	Judgement	In your clinical judgement, is this person at risk of developing pressure damage?

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

If NO to all questions, continue Care Rounds Prescribed as assessed for individual need and re-assess daily.
If you have answered YES to any of the questions above, please complete the SSKINS care plan below.

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

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan:	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used: Catheter ☐ Naso gastric ☐ Oxygen mask ☐ Nasal oxygen ☐ Vascular Access Device ☐ Off loading boot ☐ Other:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment: Off loading boot: ☐ Protective product:	• Reposition ____ hourly in bed. • Reposition ____ hourly in chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used: Tilting device ☐ • Knee bend in place ☐ Record reason for no knee bend:	• Does patient have Moisture Associated Skin Damage Yes ☐ • Skin care to be carried out ____ hourly. • Specify products required for increased moisture / continence management: Barrier Cream ☐ Pad / Pants ☐	• Optimise nutrition and hydration. • Refer to MUST	• Provide information in a format appropriate to patient / family/ carer needs : • Specify: Leaflet ☐ Verbal ☐ Not provided record reason:	Date discontinued:

Patient name

Patient CHI

2810666490
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G51 3UF
M
28/10/196

NHS
Greater Glasgow and Clyde

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

Ongoing Care

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

Patient name
Patient CHI

2810666490
MCJURY
Nicholas, D 28/10/1960
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire
G51 3UI

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Greater Glasgow and Clyde

Nursing notes

Date and Time		Name/Signature
30/8/15 . 19:13	brought in by ambulance c chest complaint	
	of SOB HH, transferred to hospital	
	trolley, observations done, sats on	
	air is between 78% - 84%, kept on	
	venturi mask c O2 at 60%, sats	
	now at 93-94%. ——	[signature]
20:15	obs as charts patient	
	given Abx. states is having	
	hallucinations. escalated to medical	
	staff given cup of tea	A MacDonald
	pad changed to ...	[signature]
2110	For	

My Admission Record

NHS Greater Glasgow and Clyde

2810666490
MCJURY M
Nicholas, D 28/10/1966

Hospital: QEUH Ward: ARU5
Date of Admission: 30/8/28 Time:
Information obtained from: Name:
Patient ☑ Relative ☐ Other ☐ _____
Preferred Name:
Age: 58 Telephone Number:
Consultant:

Communication

What is your first language? English
Do you require an interpreter? Yes ☐ No ☑
If yes, provide details of arrangements made _____
Do you use British Sign Language (BSL)? Yes ☐ No ☑
Do you need someone to help you to communicate? Yes ☐ No ☑ If yes, who _____

Preferred first contact	**Preferred second contact**
Name: Martha	Name:
Relationship: Mother	Relationship:
Address:	Address:
Telephone: 0146482398	Telephone:
Is this person aware of your admission? Yes ☑ No ☐	Is this person aware of your admission? Yes ☐ No ☐
Can we share information with this person? Yes ☑ No ☐	Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

SOB, General Unwell, Fever and Cough

Explained to the patient? Yes ☑ No ☐ Not Applicable ☐
Do you understand the reason for your admission? Yes ☑ No ☐

Allergies / Sensitivities (Record food allergies in the Hydration and Nutrition section)

No known allergies ☑

Relevant past medical history

Prev IVDU, Prev DVT, Alc KS, Undiagnosed COPD
Buprenorphine, Rivaroxaban

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place
Yes ☐ No ☐ If yes, Who asked for a copy? _____
Date they asked for a copy __/__/__ Date Obtained __/__/__

Power of Attorney / Guardianship / Adult with Incapacity

Name:
Addres: 2810666490
MCJURY
Nicholas, D M
FLAT 1/2
DoB: 28/10/1966
CHI: 820 GOVAN ROAD
Glasgow, Lanarkshire
Affix p G51 3UP

Does someone have Power of Attorney (POA) for you?

Yes ☐ No ☐

OR

Does someone have Guardianship?

Yes ☐ No ☐

If yes, is this for:- Finance ☐ Welfare ☐ Both ☐

Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

Please obtain a copy and place in the patient's notes

Who asked for a copy?_____ Date they asked for a copy __/__/__ Date Obtained __/__/__

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

N.B. If you think the patient may lack capacity inform Medical Staff to assess and, if required, consider the need for an 'Adult with Incapacity' Section 47

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:	Yes	No
1. Been an inpatient in a hospital outside Scotland?	☑	☐
2. Received holiday dialysis outside Scotland?	☐	☑
3. Been told that you have CPE?	☐	☑
4. Been in close contact with a person with CPE?	☐	☑

If the answer is yes to **ANY** of the questions in this section, you must

- Isolate the patient in a side room ☐
- Obtain Rectal swab marked 'for CPE' ☐
- If patient refuses rectal swab, obtain a stool specimen marked 'for CPE' ☐
- **and inform the IPCT** ☐

MRSA Screening

	Yes	No	Unsure
Will the patient be an inpatient for more than 23 hours	☐	☐	☐
If **YES** complete the following section			
1. Have you ever been told that you have MRSA?	☐	☑	☐
2. Have you been admitted from another hospital/ residential setting or care home?	☐	☑	
3. Do you have a wound / skin ulcer or invasive device which you had before admission?	☐	☑	☐

If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabs

Nasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐

Creutzfeldt-Jakob Disease (CJD)

	Yes	No	Unsure
Have you ever been informed that you are at increased risk of CJD or vCJD?	☐	☐	☐

If **YES inform the IPCT** ☐

Name: 2810666490
Addres: MCJURY
Nicholas, D
FLAT 1/2
820 GOVAN ROAD
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M
28/10/1966
DoB:
CHI:
Affix patient ID label

Lifestyle

Smoking

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

Never smoked ☐

Do you use eCigarettes? Yes ☑ No ☐

If a smoker, the NHSGGC Smokefree policy has been explained and Nicotine Replacement Therapy (NRT) has been offered

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why:_____

Do you want to talk to someone about your smoking? Yes ☐ No ☐

If yes, refer to Smokefree Services (Trakcare) Date referred: ___/___/___

Drugs

Do you use recreational or illicit drugs or are you receiving opiate replacement therapy (ORT / Methadone / Suboxone)? Yes ☑ No ☐

If yes, please specify and refer to the NHSGGC Guidelines for the Management of Drug Users in Glasgow and Clyde Acute Hospitals Espond

Alcohol

Do you drink alcohol? Yes ☐ No ☑

How often do you have more than 6 units of alcohol on one occasion:

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

NB: If daily or almost daily commence the Glasgow Assessment and Management of Alcohol (GAMA), complete FAST Tool and take further action as per guidance.

Name (Please PRINT): S Macdally Signature: SMacD

Designation: SN Date: 30/8/18

My Assessment Record

Name: _____

Addres: 
2810666490
MCJURY M
Nicholas, D 28/10/1966
DoB: FLAT 1/2
CHI: 820 GOVAN ROAD
Glasgow, Lanarkshire
Affix pa G51 3UP

1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems			
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy	✓	✓	
Do you have any other symptoms?			

Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems	✓	✓	
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

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

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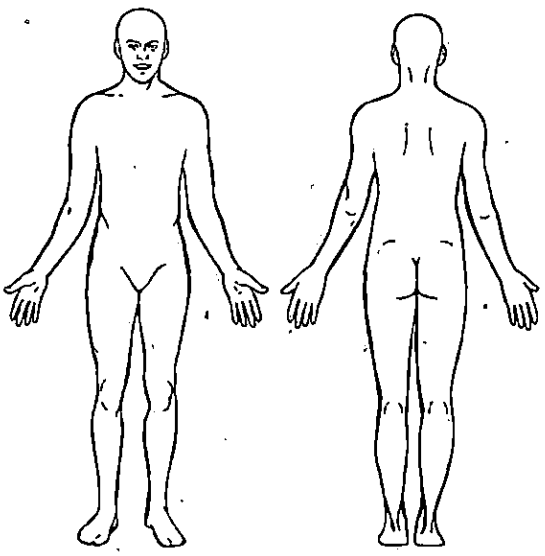
M
28/10/1966

3. Senses

Vision	**Yes** ✓	**No** ✓	Assessment of the patient's vision
Do you have any problems with your vision?	✓		
Do you wear glasses?	✓		Distance ☐ Reading ☐ Both ☐
Do you have your glasses with you?		✓	
Do you wear contact lenses?			
Do you have your lenses with you?			
Do you wear a prosthesis?			
Hearing	**Yes** ✓	**No** ✓	Assessment of the patient's hearing
Do you have any problems with your hearing?		✓	
Do you have any hearing loss?			
Do you use a hearing aid?			
Do you have your hearing aid(s) with you?			
Pain	**Yes** ✓	**No** ✓	Assessment of the patient's pain
Do you have pain?		✓	

Can you describe where and what the pain is like?

Mark current pain on body chart



Have you had treatment / intervention for the pain?

N.B. Complete generic pain assessment chart. If unable to self report complete Abbey Pain Scale.

Can you describe any chronic pain that you have?

What makes the pain better?

Name
Addre 2810666490
MCJURY M
Nicholas, D 28/10/1966
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CHI: Glasgow, Lanarkshire
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Affix patient ID label

4. Cognitive Status THINK DELIRIUM

	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's cognitive status
Alert and orientated	✓	✓	
Impaired conscious level			
Confused			
Dementia			
Stressed / Distressed			

N.B. Think Delirium

Complete 4AT for all patients 65 and over, AND for patients of any age with one or more of the following:

- existing cognitive impairment
- previous delirium
- current hip fracture
- severe illness

and follow the guidance

N.B. 'Getting to Know Me' and 'What Matters to Me' should be completed for all patients with dementia, cognitive impairment or complex needs

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

None

What do you like to eat and drink?

No fussy

What do you not like to eat and drink?

Tea, Juice, Coffee

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

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓
Normal diet and fluids	✓	✓
Therapeutic diet		
Cultural, ethnic or religious diet		
Texture Modified Diet Please state _____		
Thickened Fluid Please state _____		
Oral Nutritional supplements Preferred flavour _____		
Enteral Nutrition		
Parenteral Nutrition		
Nil by Mouth		

Nai
Adc 2810666490
MCJURY M
Nicholas, D 28/10/1966
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CH G51 3UP
Affix patient ID label

Assessment of the patient's hydration and nutrition needs

N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharnygeal Swallow Symptoms (STOPSS) within 4 hours of admission

Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓
Independent (Green)	✓	✓
Prompting / encouragement / opening packets/cutting up food (Amber)		
Full assistance with eating and drinking (Red)		

Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?

6. Elimination

Bladder	Admission Presentation ✓	Normal for the patient ✓
Pass urine with no problems	✓	✓
Frequently pass urine during the day		
Frequently pass urine overnight		
Sense of urgency when need to pass urine		
Urine retention		

Assessment of the patient's elimination needs

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓
Haematuria		
Incontinent		

Name: _____
Address: _____
_____
_____
DoB: 28/10/1966 M
CHI: 2810666490
Affix pat MCJURY, Nicholas, D
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire
G51 3UP

N.B. If new incontinence report to medical staff to rule out infectio[illegible]ological cause

What products do you normally use for this continence issue?

No urinary catheter ☐ Urinary catheter in situ: Urethral ☐ Suprapubic ☐

Date urinary catheter last changed ___/___/___

N.B. If Urinary Urethral Catheter (UCC) in situ commence NHSGGC Adult UCC Insertion and Maintenance Care Plan

Bowels

When did your bowels last move? 30/8/18

How often in a day/week do you have a bowel movement? Per day 2-3 Per week ☐

Do you use any medication e.g. laxative to help your bowels move? Yes ☐ No ☑

Bowel Habit	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Regular	✓	✓	
Constipated			
Diarrhoea / loose stools			
Blood in stools			
Incontinent			

What products do you normally use for this continence issue?

N.B. if concerned about bowel patterns (e.g. infrequent movement or frequent loose stools) consider using the Bristol Stool Chart

Stoma	Yes ✓	No ✓	Assessment of the patient's needs in relation to their stoma
Do you have a stoma?		✓	
Do you require assistance with your stoma care?		✓	
Have you brought any of your stoma products with you?		✓	

Na
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FLAT 1/2
Do 820 GOVAN ROAD
CH Glasgow, Lanarkshire G51 3UP
Affix patient ID label

7. Personal Hygiene, Oral Health, Skin Care and Wound Care

Personal Hygiene	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's personal hygiene needs
Independent	✓	✓	
Requires assistance with washing and dressing			
Oral Health	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's oral health needs
No problems	✓	✓	
Sore mouth / mucositis / ulcer			
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)			
Dental work	**Yes** ✓	**No** ✓	Description of any dental work
Do you wear dentures?		✓	
Do you have your dentures with you?			
Are your dentures a good fit?			
Do you have any other dental work that we need to be aware of?			
Skin Care	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's skin care needs
No problems	✓	✓	
Skin broken			
Skin oedematous			
Skin discoloured / red		✓	

N.B. Complete PUDRA for all patients within 8 hours of admission

Pressure ulcer identified on admission: Yes ☐ No ☑

Pressure Ulcer Grade: _____

Pressure Ulcer Site: _____ **Adult wound assessment and management chart required**

N.B If Grade 2 pressure damage on ankle or below refer to Podiarty via TrakCare

Wound Care	Yes ✓	No ✓
Do you have any wounds? **N.B. If yes, complete an assessment chart for wound management**		

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CHI: ___
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Affix patient ID ___ G51 3UP

8. Mobility

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

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

9. Maintaining a Safe Environment

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

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

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

10. Sleep and Rest

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

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11. Social Circumstances

Do you:

Live alone ☑ Live with family/ friend/ other ☐

Live in a nursing home ☐ Live in a care home ☐

Live in residential supported care ☐ Live in student accommodation ☐

Live in 'homeless' accommodation ☐ Have no fixed abode ☐

Other please specify_____ ☐

Dependants	**Yes** ✓	**No** ✓
Do you have any dependants?		✓
Do you support anyone (e.g. partner, children, relatives, animals)?		✓
Do they need support from someone else whilst you are in hospital?		✓
Would someone else be able to provide this support when you are in hospital? If yes, who?		

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☑ Referred ☐

Services	**Yes** ✓	**No** ✓
Do you have support from social work, social services or a care package?		✓

If yes, please provide details:

If yes, has contact been made to cancel arrangements during admission?

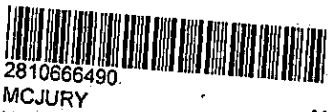
12. Emotional and Spiritual Care

Do you have a religion or beliefs that we can help you observe while you are in hospital? ✓

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

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

Healthcare Chaplain informed Yes ☐ N/A ☑

Name: 
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13. Person Centred Care

What matters and is important to you whilst you are in hospital?
This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

Nurses

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

Informal Support

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

Nurses

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

Name: .....

Contact Details: .....

.....

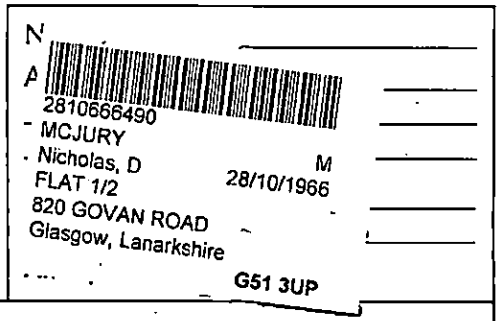
.....

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

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

Yes ☐ No ☑

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



Required Support

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

Yes ☐ No ☑

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

Has the carer been advised of the Carers Information Line?

Yes ☐ No ☐ Not appropriate at this time ☑

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?

Yes ☐ No ☐

Are you:

Employed ☐ Unemployed ☑

Self-employed ☐ Retired ☐

Full time education ☐

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

Yes ☐ No ☐ Not applicable ☑

Do you have any money worries?

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

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

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

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

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

If yes when was patient referred ___/___/___

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Risk Assessments/Other Documentation

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

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
23:00	Patient admitted with SOB,	
30/8/25	NEWS 6 FY1 has been informed	
	about this. Await plan. O2 at	
	present Sat 91 on 15/ltr	
	O2 therapy.	
31/08/25	Patient on 2 VM 60%. Sats 91%	
5:00	Put hem° on Trama mask 15L. Predn	

Name [redacted]
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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
	advised he is on scale 2. Mean Num of to 35% VM. SpO2 was 85 - 88. Patient was taking mask off time to time. Medics signed the News chart for scale 2. Patient stats stable on 40% VM. Medics are happy with it. News as per chart. Patient drinking well but needs assistance. IUF running. He is pannus. Seen by medics	
	Imp: - Severe CAP	
	- CURB-2	
	- septic on arrival	
	plan: ① IV amox ✓ + oral clari ✓	
	② Sputum C+S ☐	
	③ BCs	
	④ check Urine legionella Ag ☐	
	⑤ Accept sats 88-92% (pre CO_2 on gases)	
	⑥ F/U CXR 6/52 req. V.	
	⑦ BBV screen.	
	⑧ IUF ✓	
	Patient unable to provide sputum sample as he takes off mask that drop his sats. Patient used bottles and urine was all over bed. Advised next time we will not	Allahuyia

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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
	Cont	
31/08/25	Help hum? need sample too.	Pullalu Yas
4:00		
31/08/25	NEWS 2, on OE therapy via	
	VM. non-compliant at times with	
	O2 mask. Having regular	
	nebulisation. Seen by consultant	
	IMP: Right sided pneumonia	
	probable aspiration	
	PLAN: continue IV amox	
	and clarithromycin	
	could swap (✓)	Chaffety SpR
1/9/25	All care as planned.	
02:15	NEWS = (2) 6litres VM.	
	Risk assessments checked.	
	D+F as managed.	
	Medication charted as per kepma.	
	PU using urinals overnight ~~so~~	
	~~yesterday~~.	
	Imp- (R) sided pneumonia probable	
	aspiration.	
	Plan- IV amox / clari.	
	POCT ☑(-ve)	J DUFFY
	Complaining of pain overnight.	
	PRN analgesia given.	
1/9/25	For t/f to GA.	
0835	Care taken over at 730am.	Chaffety
	Mobilising with AOL Passing	SpR

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☑

Please tick ✔ appropriate directorate

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Date & Time		Signature, Print Name & Designation
1/9/25	urine via bottles. On 4L O^2.	
(continued)	Patient requiring espanor prescribed - to clarify with medics before t/f.	Chafferty [illegible] STN
1/9/25 1545	Patient Admitted to ward 6A Refused skin check and positional change, NEWS=3 BP↓ 4litre NC on Scale 2 Covid ~~[illegible]~~ sample negative treated for ?aspirational pneumonia (Right Sided) given rest of espanonal 10mg, pt has been verbally aggressive to staff refusing turns and skin checks given IV Amox and oral ABX	[signature] BETH TINLAY SN
2/9/25 0025	A - Observations checked. B - Charts reviewed. C - Pt settled overnight. IVABX given maintaining sats on 3L of O_2. For medic R/O today, pt still refusing skin checks no concerns. D - nil new	Jucc SN Fincanell
2/9/25 13:00	(A) NEWS AS PER CHART (B) [illegible] (C) IV ANTIBIOTICS CONTINUE - ? [illegible] [illegible] [illegible] REMAINS ON 1 CO_2 (D) NO OTHER ISSUES TO REPORT PRESENTLY	[signature]

83949 GGC0072

Date & Time		Signature, Print Name & Designation
3/9/25	A- Observations charted	
0130	B- Charts reviewed	
	C- Pt Settled overnight no concerns	
	? WOAT today with medics	Lucc SD
	D- nil	LMcConnell
3/9/25	A NEWS AS PER CHART	
14:00	B REVIEW OF PATIENT	
	C IV AMOXICILLIN COMPLETED AS PER	
	HEPMA - NO CONSENT ON O2 ?	
	REVIEW SOON :	
	D NO CONCERNS TO DISCHARGE TODAY	SYS Surrey
4/9/25	A- Observations charted	CB
0428	B Charts reviewed	
	C- Pt Settled IV ABX given no	
	new concerns	Lucc SD
	D- nil	LMcConnell
4/9/25	A= Patient no longer Scale 2 SpO2 97%	
1426	on per medics	
	B= All bedside notes updated and	
	Reviewed. (Refused skin check)	
	C= Patient IVOSED ? Home tomorrow	Beth Tinnion
	D= ~~Nil~~ had controlled Drug.	BETH TINNION
5/9/25	A- Observations charted	
	B- Charts reviewed	
	C- Meds given as per Hepma	
	pt Settled no new concerns	Lucc SD
	D- nil	LMcConnell
1100-	Settled morning, pt wishes shower	
	prior to discharge.	
-	Oral fluids + diet taken	
-	Observations stable	
-	Subcoxone given as per Hepma	
-	For discharge home today	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐ NURSING ☑

Please tick ✔ appropriate directorate

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Date & Time		Signature, Print Name & Designation
-	Family will collect. No medications	
	required	A. CARRICK SN
-	Cannula removed.	A. C. C

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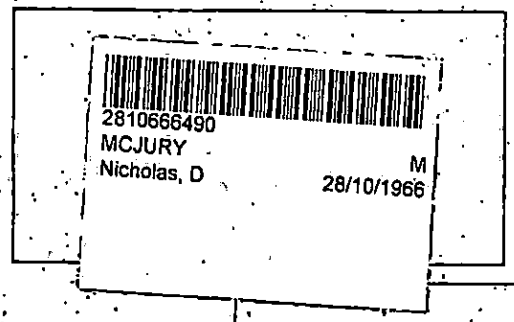

6A ADMISSION CHECKLIST

Admission date 1/9/25

	Initials
Check MAR Complete	BT
Name Band	BT
News	BT
PVC /CVC	BT
Care Rounding	BT
Care Plan	
PUDRA	BT
FALLS	BT
BEDRAILS	BT
4AT	NA
FLUID CHART	BT
MUST	BT
FOOD CHART	NA
STOOL CHART	BT
WOUND CHART	NA
DIABETIC CHART	NA
INFECTION CONTROL DOOR BARRIER/CAREPLAN	NA
WHAT MATTERS TO ME WHITE BOARD	BT

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NHS Greater Glasgow and Clyde

NHSGGC Bedrail Risk Assessment

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

Patient Nar

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT

CHI Numb

	Use guidance on the reverse of this document when completing this Risk Assessment								
		DATE	30/8/25		1/9/25				
		TIME	22:58		15:39				
		WARD	ARMS		6A				
		HOSPITAL	QEUH		QEUH				
	SECTION ONE – GENERAL		Y	N	Y	N	Y	N	Y	N
1	Is the patient likely to fall, roll, slip or slide from the bed?			✓		✓				
2	Has the patient requested the use of bedrails?		✓		✓					
	IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED									
	SECTION TWO – COGNITIVE AND PHYSICAL STATUS									
3	Is the patient at risk of climbing out of bed?			✓		✓				
4	Is the patient stressed, delirious or restless?			✓		✓				
5	Is the patient small in stature?			✓		✓				
6	Does the patient have an unusually large or small head that might present an entrapment issue?			✓		✓				
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?			✓		✓				
	IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
	SECTION THREE – COMMUNICATION									
8	Has the patient been consulted regarding the use of bedrails?		✓		✓					
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition		✓		✓					
10	Has the use of bedrails been discussed with relatives/carers?			✓		✓				
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?			✓		✓				
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?			✓		✓				
	IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
	SECTION FOUR – DECISION MAKING		Y	N	Y	N	Y	N	Y	N
13	Will bedrails be used for this patient at the present time?		✓			✓				
14	Rationale for use of bedrails: (Please insert code in the box on the right)									
	A – Risk of falling from the bed									
	B – Risk of rolling from the bed									
	C – Risk of slipping from the bed									
	D – Risk of sliding from the bed									
	E – Patient request		✓							
15	Bedrail risk assessment completed by:		QM		[illegible]					
16	Bedrails checked by:		[illegible]		[illegible]					
17	Date		7/9/25		1/9/25					

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

A. Alternatives to bed rails:-

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

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

Is patient:-

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

C. Safe use and application of bedrails:-

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

D. Record keeping:-

All of the following should be recorded:-

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

Bedrail risk assessments should be made as follows:-

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

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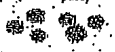
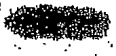
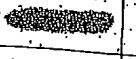
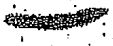
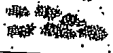
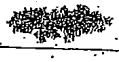
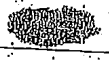
BOWEL MOVEMENT RECORD

NHS Greater Glasgow and Clyde

Name: ..... CHI: ..... Date Commenced: 1/9/25

Date	Time	Colour/ Size S – small M – medium L – large	Type 1 Separate hard lumps like nuts (hard to pass) 	Type 2 Sausage shaped but lumpy 	Type 3 Like a sausage but with cracks on surface 	Type 4 Like a sausage or snake, smooth and soft 	Type 5 Soft blobs with clear-cut edges (passed easily) 	Type 6 Fluffy pieces with ragged edges, a mushy stool 	Type 7 Watery, no solid pieces (entirely liquid) 	Staff Initials

Adapted from the Bristol Stool Scale developed by KW Heaton and SJ Lewis at the University of Bristol, 1997

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MCJURY 28/10/1966
Nicholas, D.

Care Plan

NHS
Greater Glasgow and Clyde

Care discussed with patient ☐ Yes ☐ No ☐ Unable	If unable, give reason:		
Care discussed with family ☐ Yes ☐ No ☐ Unable	If unable, give reason:		

Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
30/8/18 gm	As per news chart		30/8/18 gm	To be filled	
	Undiagnosed COPD				
			30/8/18 gm	5. Hydration and Nutrition	
				Normal DTF	
30/8/18 gm	2, 3. Communication and senses				
	Clear No problem				
			30/8/18 gm	6. Elimination	
30/8/18 GL	4. Cognitive status				
	Alert + Oriented				

Patient Label

Care Plan

NHS Greater Glasgow and Clyde

Date Commenced and Signature	7. Personal Hygiene, oral care, skin care and wound care	Date Discontinued and Signature	Date Commenced and Signature	9. Maintaining a safe environment, Technical Care	Date Discontinued and Signature
30/8/25 GM	AOx1		30/8/25 GM	To be Allocated	
1/9/25	Patient Refused skin check on work				
				10. Sleep and Rest	
			30/8/25 GM	Promote	
30/8/25 GM	8. Mobility				
	Bedrest			12. Privacy, dignity and sexuality	
			30/8/25 GM	Promote	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	
			30/8/25 G	None	

Care Rounds Checklist

Date: 30/8/25

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

1. Signed _____ Name JMacKella Designation SN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attach Addressog

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M
28/10/1966

NHS eater Glasgow and Clyde

Ward: RHU8

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

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

			Times	12	06																
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		N																	
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.		N																	
S	3	**SKIN INSPECTION** Pressure areas checked:		I																	
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		R																	
K	4	**KEEP MOVING** Has the patient moved or walked?		N																	
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		B																	
		Chair Assist to walk or stand (W/ST)		W																	
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		A																	
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?		N																	
		Drink taken?		Y																	
		Food, snack, or supplement taken?		Y																	
		Has oral hygiene been carried out as per care plan?		I																	
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		Y																	
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.		N																	
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.		N																	
			Care provider / role	JM																	

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 31-08-25

Attach Ad 2810666490 M
MCJURY 28/10/1966
Nicholas, D
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire G51 3UP

Ward: ARU5

NHS Greater Glasgow and Clyde

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

1. Signed [signature] Name Gillian Yule Designation SN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

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

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

		Times	01	06	10	14	18	22
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	W
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N
S	3	**SKIN INSPECTION** Pressure areas checked:	Y	Y	NT	NT	VT	Y
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	INT	INT	—	—	—	INT
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y	Y
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	L	R	B	B	B	R
		Chair Assist to walk or stand (W/ST)	12pl	12pl	—	—	—	—
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	A BTL	A BTL	A BTL	NT	BTL	Bottle
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	Y	Y	N	N	N	N
		Drink taken?	Y	N	Y	Y	Y	Y
		Food, snack, or supplement taken?		N	N	Y	Y	
		Has oral hygiene been carried out as per care plan?	NT	NT	NT	NT	NT	NT
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NA	NT	NT	NT	NT	WT
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NT	NT	N	N	NA	NA
		Care provider / role	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	RG

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 1/9/25

Attach Ac

2810666490
MCJURY N
Nicholas, D 28/10/196
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire
G51 3UF

Ward: ARUS

NHS Greater Glasgow and Clyde

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

1. Signed [signature] Name J DUFFY Designation SN
2. Signed [signature] Name BETH TINIAY Designation SN
3. Signed _____ Name _____ Designation _____

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

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

			Times	02:30	07:00	09:30	14:00	20:00	22:00
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		N	O	N	N	N	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.		Y	O	N	Y	N	N
S	3	**SKIN INSPECTION** Pressure areas checked:		N	O	NT	Patient refused	N	N
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		-	O	I	/	I	I
K	4	**KEEP MOVING** Has the patient moved or walked?		Y	Y	Y	Y	Y	Y
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		B	O	B	B	B	B
		Chair Assist to walk or stand (W/ST)		T	O	Hoist	/	/	/
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		M	A	Bottle	Bottles	Bottle	
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?		N	O	N	N	N	N
		Drink taken?		N	O	Y	Y	Y	Y
		Food, snack, or supplement taken?		N	O	Y	Y	/	/
		Has oral hygiene been carried out as per care plan?		N	O	I	I	/	/
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		Y	Y	Y	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.		N	N	NT	NT	/	/
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.		NA	NA	NA	NA	/	/
		Care provider / role		RN	CA	RN	CA	RN	RN

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name
1/9/25	15:22	8	> Patient Refused skin check so 2hourly until patient allows staff to check	BETH TINLAY RGN

Care Rounds Checklist

Date: 2/9/25

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

1. Signed [signature] Name [illegible] Designation [illegible]
2. Signed [signature] Name [illegible] Designation [illegible]
3. Signed _____ Name _____ Designation _____

Attach label

2810666490
MCJURY M
Nicholas, D 28/10/1966
FLAT 1/2
820 GOVAN ROAD
Ward: Glasgow, Lanarkshire
6A G51 3UP

NHS Greater Glasgow and Clyde

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

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

		Times	00 15	00 15	01 30	06 30	08 30	10 30	13 00	15 30	18 00	21 00	22 45
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	L	Y	N	2	2	2	2	2	L	2
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	L	N	N	2	2		2	2	N	2
S	3	**SKIN INSPECTION** Pressure areas checked:	Y	L	Y	Y	2	N	2	2	2	N	1
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	I	I	-	I	—	I	I	I	I	I	I
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	B	B	B	R	B	B	B	B	B	L	B
		Chair Assist to walk or stand (W/ST)	—	/			—	I	I	I	I	I	/
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	BN	L	BN	BN	N	2	I	I	I	I	I
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	L	N	N	Y	2	2	2	2	N	2
		Drink taken?	N	Y	N	N	N	N	Y	I	I	N	Y
		Food, snack, or supplement taken?	N	L	N	N	N	N	Y	I	I	Y	Y
		Has oral hygiene been carried out as per care plan?	—	L	N	N	N	2	I	I	I	I	I
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	N	/	N	N	N	2	N	2	N	N	N
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	/	N	N	N	2	N	2	N	N	N
		Care provider / role	[illegible]										

Care Rounds Variance Sheet

Attach Addressograph Label Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name
02/9/25	10:50	8	Patient declined a wash this morning	
			will buzz when ready	C. WILSON

Care Rounds Checklist

Date: 3/9/25

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

1. Signed JMcq Name Jmcconnell Designation Dr
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

2810666490
MCJURY M
Nicholas, D 28/10/1966
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire
G51 3UP

NHS Greater Glasgow and Clyde

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

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

			Times	30 35	02 40	04 40	06 45	09 00	11 30	13 10	16 15	18 45	20 00								
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		N	N	N	N	N	N	N	N	N	N								
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.		N	N	N	N	N	N	N	N	N	N								
S	3	SKIN INSPECTION Pressure areas checked:		S	I	I	S	N	NT	NT	N	N	NT								
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		✓	✓	–	✓	I	I	✓	–	I	✓								
K	4	KEEP MOVING Has the patient moved or walked?		I	Y	Y	Y	Y	Y	Y	Y	Y	Y								
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		B	L	L	B	B	B	R	SIT	R	B								
		Chair Assist to walk or stand (W/ST)		✓	W	W	✓	–	–	–	–	–	✓								
I	5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		I	I	I	I	I	I	I	I	I	I								
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?		N	N	N	N	N	N	N	N	N	N								
		Drink taken?		I	Y	Y	I	I	Y	I	I	I	Y								
		Food, snack, or supplement taken?		I	✓	✓	I	I	N	I	I	I	I								
		Has oral hygiene been carried out as per care plan?		I	✓	✓	I	I	N	I	I	I	I								
	7	ENVIRONMENT Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y								
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.		S	–	–	S	N	NT	NT	N	N	NT								
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.		NA	–	–	NA	N	NA	NA	N	N	NA								
			Care provider / role	DC	MC	MC	MW	MW	DC	LL	MW	MW	MW								

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name
3/9/25	11:30	3	patient offered Skin Check but declined	

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Care Rounds Checklist

Date: 5/9/25

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

1. Signed [signature] Name [signature] Designation Dr
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

2810666490
MCJURY M
Nicholas, D 28/10/1966
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire
G51 3UP

NHS Greater Glasgow and Clyde

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

N / -

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

		Times	20 05	04 40	08 10
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N
S	3	**SKIN INSPECTION** Pressure areas checked:	NN	I	I
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	Int	I	—
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	B	I	I
		Chair Assist to walk or stand (W/ST)	—	—	✓
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	A	I	I
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N
		Drink taken?	S	N	I
		Food, snack, or supplement taken?	S	N	I
		Has oral hygiene been carried out as per care plan?	S	—	I
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	N	N
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NT	NA	NA
		Care provider / role	RN	ORN	ORN

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

Patient's na 2810666490 MCJURY M CHI numbe Nicholas, D 28/10/1966 FLAT 1/2 820 GOVAN ROAD Glasgow, Lanarkshire G51 3UP	Ward: ARM 5 Discharge destination: (H) Estimated Discharge Date (1) 7 / 9 / 25 Estimated Discharge Date (2) / / Final date of discharge : / /

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓		AC	
Relative/carer informed	✓		AC	
Relative/carer involved in discharge planning discussions				
Others informed: Care Home				
Transport arranged				
Own transport (preferred option)	✓		AC	
Ambulance: 1 man/ 2 man am/pm				
Other: Flight, Air ambulance etc.				
Discharge medication				
Immediate Discharge Letter completed	✓		AC	
Compliance aids e.g. Dossette Box (involve pharmacist)		✓	AC	
Medication received		✓	AC	
Medication explained to patient and/or relative/carer		✓	AC	
Own medication returned to patient		✓	AC	
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)		✓	AC	
Informed of discharge				
Social work/ Other agencies				
Homecare				
Homecare request form completed?				
Discharge lounge handover completed?				
Physiotherapist				
Occupational Therapist				
Dietitian				
Speech and Language Therapist				
Clinical Nurse specialist				
Liaison/ District Nurse/Practice Nurse				
Other discharge items				
Access arrangements (e.g. keys, door entry)	✓		AC	
Patients clothing available for day of discharge	✓		AC	
Valuables e.g. cashier		✓	AC	
Intravenous cannula removed	✓		AC	
Equipment ordered (inc. walking aids) in place for discharge				
Part 2 Discharge letter - Required	✓		AC	
- Completed	✓		AC	
Outpatient clinic appointment				
Arranged		✓	AC	
To follow				
If unknown at time of discharge state reason				
Additional information / leaflets / factsheets				

Time of Discharge: 1130			
Nurse's signature: C. Cle	Designation: SN	Date: 5/9/25	

2810666490
MCJURY
Nicholas, D 28/10/196
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire
G51 3UI

FALLS RISK ASSESSMENT

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

NHS Greater Glasgow and Clyde

GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

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

	Ward: ARU8 Date: 30/8/12 Time: 22.00	Ward: 6A Date: 1/9/12 Time: 15.40	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	Bedrest	Bedrest			
2. Check walking aid (if required) is in reach and in use.	Bedrest	Bedrest			
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	In hand	Yes			
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	None	Yes			
5. If glasses are worn, check they are available and in use.	None	N/A			
6. If hearing aid/s are worn, check they are working and in use.	None	N/A			

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).
Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.
ALL patients in older people's wards must have an interventional plan in place (overleaf)

Tick Yes or No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has the patient fallen in the last 6 months – including during this admission?	✓		✓							
2. Does the patient have cognitive impairment or a possible delirium?		✓		✓						
3. Does the patient attempt to walk alone although unsteady or unsafe?		✓		✓						
4. Does the patient or their relative have a fear or anxiety of the patient falling?		✓		✓						
5. Based on your clinical judgement, is this patient at high risk of falling?		✓								
Signature of nurse completing assessment / update	[signature]		[signature] 8/9/12							

Highlight risk of fall at the ward safety brief.

2810566490
MCJURY M
Nicholas, D 28/10/1986
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire
G51 3UP

FALLS INTERVENTIO.. CHECKLIST

NHS Greater Glasgow and Clyde

Complete for all patients identified at risk of falling.

	Ward: 6A Date: 1/9/25 Time: 15:48	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----
BED AND SEATING					
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)	Yes				
Assess if a low bed is required (Patient care plan 9)	N/A				
SAFETY					
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)	No				
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)	2hrly				
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.	Yes				
HEALTH					
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)	N/A				
Document continence problems and link to care rounding (Patient care plan 6)	Yes				
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)	No				
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.	Yes				
COMMUNICATION					
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)	No				
Update the ward team of the patient's mobility status. (Patient care plan 8)	Yes				
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)	No				
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)	Yes				
Signature of nurse completing interventional plan / or update	[signature]				

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

EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

Pe[illegible]nt) Moving and Handling Assessment Form

2810666490
MCJURY
6 Nicholas, D 28/10/196
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire
G51 3U

Person's Name:	Named Nurse:	Person is totally independent (tick here and go to date box)

1. Gene[illegible]

Body Build		
Weight	Height	
Kg	cm	
BMI		

Risk of Falls: Yes ☐ No ☐

Problems with comprehension, behaviour, co-operation (specify):

Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 / 2 X ≥3	Additional Information / Equipment:	
Sling type		Bedrest			
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 2 X ≥3	Additional Information:	

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N/A
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 / 2 ≥3	Additional Information:	X
	Monkey pole			
	Independent bridging			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets X	People: 1 / 2 X ≥3	Additional Information:	
	Monkey pole			
	Rope ladder			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board X	People: 1 / 2 X ≥3	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify)			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 / 2 X ≥3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower X	Shower chair	People: 1 / 2 X ≥3	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley			
Bed bath X	Bathing hoist (eg Alenti)			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
X	see 'sit to stand transfers'	People: 1 / 2 ≥3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	
	Bedrest			

10. Other Instructions / Observations / Equipment Used

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star.
Date Assessed:	30/8/25	1/9/25	
Assessor's signature:			
Proposed Review date:		8/9/25	

Continuation Sheet

1. General Information (Only complete this section if changed from over page)

Body Build		Problems with comprehension, behaviour, co-operation (specify):
Weight	Height	
Kg	cm	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
BMI		
Risk of Falls: Yes	No	

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 2 ≥3	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 2 ≥3	Additional Information:	

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N/A
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 2 ≥3	Additional Information:	
	Monkey pole			
	Person bridges			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 2 ≥3	Additional Information:	
	Monkey pole			
	Rope ladder			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 2 ≥3	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify)			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 2 ≥3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair	People: 1 2 ≥3	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley			
Bed bath	Bathing hoist (eg Aleni)			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 2 ≥3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	4th Assessment	5th Assessment	6th Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

2810666490
MCJURY
6 Nicholas, D 28/10/1961
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire
G51 3UI

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date 2/9/25 Time 1545 of initial height and weight on admission to hospital		Actual	*Patient reported	*If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height	5ft 8inch	☐	☑	*Pt on Bedrest*
Admission Weight	110.3 Kg	☑	☐	

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

Patients reported normal weight _____ Unable to Recall ☑

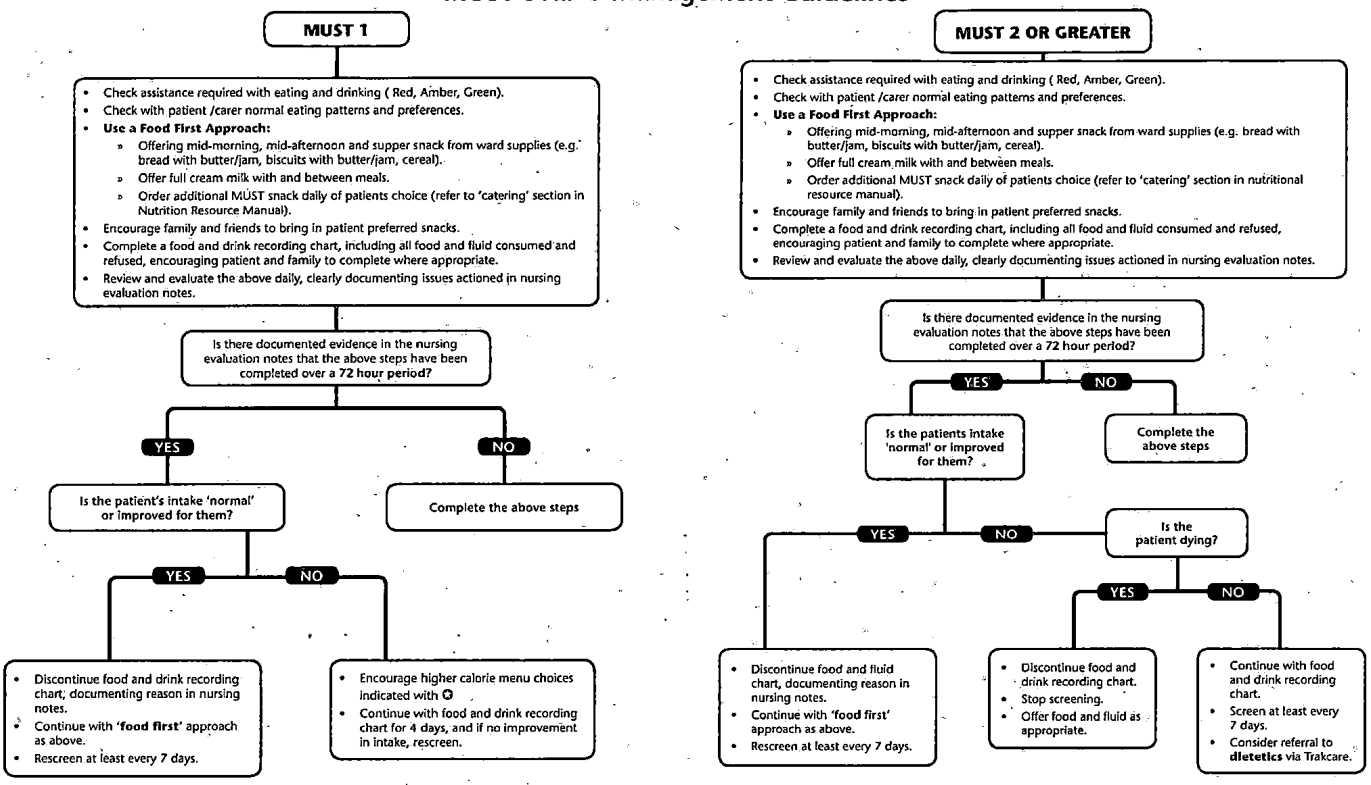
Any unplanned weight loss in the last 6 months Yes ☐ how much_____ No ☐ Don't Know ☑

Date	1/9/25	2/9/25	8/9/25					
Time	1546	12:05	1353					
Ward	6A	6A	6A					
Oedema/ Ascities present Y/N			N					
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes	UW *due pt on Bedrest	D E*	CH					
Weight (kgs)	*	E*	110.3					
BMI		NW E	37					
Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days								
Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2		D E T 9 O A B	0					
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2		B D O	0					
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0			0					
Step 4 Overall Risk of Malnutrition TOTAL			0				✓	
Rescreen on	2/9/25		11/9/25					
Signature								

Step 5 Management Guidelines (excludes patients who are Nil by Mouth)

Overall Risk of Malnutrition	Ensure plan of care for specific nutritional requirements, MUST score and plans to improve / increase nutritional intake are documented in the patients care plan
0	**LOW RISK** - Repeat screening every 7 days
1	**MEDIUM RISK** - Follow the flowchart for MUST 1 overleaf
2 or greater	**HIGH RISK** - Follow the flowchart for MUST 2 or greater overleaf

MUST STEP 5 Management Guidelines



DISCHARGE

If the patient is due for discharge and concerns remain regarding their oral intake, provide NHSGGC "*Eating to Feel Better" booklet discussing the reason why the information is being given e.g. reduced appetite and / or weight loss before or during hospital admission.

www.nhsggc.org.uk/patients-and-visitors/information-for-patients/food-in-hospital/discharge-from-hospital/

mi • 285884 v3.0 • GGC0250

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

2810666490
MCJURY M
Nicholas, D 28/10/1966
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire
G51 3UP

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

SpO2 Scale 1 Target >96%	SpO2 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature: [signature]	If yes, add details of oxygen therapy
Print Name:	Print Name: MACMILLAN	
Dr/ANP Initials ONLY:	Dr/ANP Initials ONLY:	
Date:	Date: 31/08/25	

Document all actions and interventions

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
	Low Clinical Risk	Medium Clinical Risk	High Clinical Risk
Min 12 Hourly Observations	Min 4 Hourly Observation	Min Hourly Observations	Continuous Monitoring
	Inform Registered Nurse	Urgent Assessment by Medical Team	Urgent Assessment by Senior Medical Team
	Agree Frequency of Observation Required	ACE Response in Medical Notes	ACE Response in Medical Notes
		Think Sepsis if Suspicion of Infection	Consider 2222

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

Discontinuation of NEWS

Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Signed ....

Medical: ....

Date: ....

Glasgow Coma Scale

Pupil Reaction and size.
s = sluggish
+ = reaction
- = no reaction
c = eyes closed

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

Section	Item	Score	11/1 11.00
EYES (Eyes closed by swelling = NT)	Spontaneously	4	●
	To sound	3	
	To pressure	2	
	None	1	
	Non testable	NT	
VERBAL (Endotracheal tube or tracheostomy = NT)	Orientated	5	●
	Confused	4	
	Words	3	
	Sounds	2	
	None	1	
	Non testable	NT	
MOTOR (Always record the best response)	Obeys command	6	●
	Localising pressure	5	
	Normal flexion	4	
	Abnormal flexion	3	
	Extension	2	
	None	1	
	Non testable	NT	
TOTAL			15
PUPIL	Right size:		4
	Right reaction:		+
	Left size:		4
	Left reaction:		+
ARMS (Record right (R) and left (L) separately if there is a difference between the two sides)	Normal power		●
	Mild weakness		
	Severe weakness		
	Spastic flexion		
	Extension		
	No response		
LEGS (Record right (R) and left (L) separately if there is a difference between the two sides)	Normal power		●
	Mild weakness		
	Severe weakness		
	Spastic flexion		
	Extension		
	No response		

2810666490
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Pain Function Score

- A No limitations, activity unrestricted by pain or settles quickly
- B Mild limitations, mild activity restrictions
- C Moderate limitations, attempts but reluctant to continue because of pain. **Seek Advice**
- D Severe limitations, unable to or refuse to perform because of pain. **Urgent Review Required**

Pain Score

Ask the patient to rate his/her pain by using numerical scale 0 to 10. Use the chart below to assist the patient. If the patient is unable to communicate, use alternative pain scoring tools.

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

NEWS 2 Key | 1 | 2 | 3

Parameter	Range	Score	Example
Date			1/11
Time			11.00
A + B Respirations Breaths/min	≥25	3	
	21-24	2	
	12-20	0	•
	9-11	1	
	≤8	3	
A + B SpO2 Scale 1 Oxygen saturation (%)	≥96	0	97
	94-95	1	
	92-93	2	
	≤91	3	
SpO2 Scale 2 Oxygen saturation (%) Use Scale 2 if target range is 88-92% e.g. in chronic hypercapnic respiratory failure. Only use scale 2 under direction of qualified clinician	≥97 on O2	3	
	95-96% on O2	2	
	93-94% on O2	1	
	≥93 on air	0	
	88-92	0	
	86-87	1	
	84-85	2	
	≤83	3	
Air or oxygen?	Air (A) or O2 device	0	A
	O2 L/min	2	
C Blood Pressure mmHg (Score uses systolic BP only)	≥220	3	
	201-219	0	
	181-200	0	
	161-180	0	
	141-160	0	
	121-140	0	
	111-120	0	
	101-110	1	
	91-100	2	
	81-90	3	
	71-80	3	
	61-70	3	
	51-60	3	
	≤50	3	
C Pulse Beats / min	≥131	3	
	121-130	2	
	111-120	2	
	101-110	1	
	91-100	1	
	81-90	0	
	71-80	0	•
	61-70	0	
	51-60	0	
	41-50	1	
	31-40	3	
	≤30	3	
D Any changes in neuro response, do GCS. Immediate medical review. Check Blood Glucose. Think Delirium.	A Alert	0	•
	C New Confusion	3	
	V Verbal	3	
	P Pressure	3	
	U Unresponsive	3	
E Temperature	≥39	2	
	38.1-39.0	1	
	37.1-38.0	0	
	36.1-37.0	0	•
	35.1-36.0	1	
	≤35.0	3	
NEWS Total			0
Blood glucose			7.0
Pain / function score			OA
Time Pt last passed urine			10.20
Fluid balance chart indicated Y/N			N
GCS indicated Y/N			N
Time NEWS due			23.00
Escalation of care Y/N			N
Initials			AB

NEWS Total 9 7 4 6 5 5 5 4 3 2 2 2 2 5 (2) | (2) 2 3 4 2 4 3 0 0 0 1 1

Abbreviations for recording oxygen device

A	Room Air
N	Nasal Cannulae
SM	Simple Mask
V	Venturi Mask and % eg. V24
NIV	Non Invasive Ventilation
IV	Invasive Ventilation
T	Tracheostomy
CP	CPAP Mask
HFN	High Flow Nasal Oxygen
NEB	Nebuliser
RM	Reservoir Mask (Emergency use only)

2810666490 MCJURY Nicholas, D FLAT 1/2 820 GOVAN ROAD Glasgow, Lanarkshire G51 3UP 28/10/1966 M

2810666490 MCJURY Nicholas, D 28/10/1966 M

NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

1. Give oxygen to target saturation >94% (COPD 88-92%)
2. IV fluids up to 20ml/kg
3. Take blood cultures
4. Measure lactate and FBC
5. Give IV antibiotics
6. Monitor urine output and fluid balance chart

Think ACE

A Action: Working diagnosis (consider SEPSIS). Consider frequency of observations. Management plan. Set review time. Document.

C Communicate: Inform nurse of plan. Inform senior medic if necessary. Document the discussion.

E Escalate: Document the treatment escalation plan. Should include need for next level of care & consideration of resuscitation status.

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Affix Patient ID

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature: U. Wilson	Signature:	If yes, add details of oxygen therapy
Print Name: URSULA WILSON	Print Name:	
Dr/ANP initials ONLY: UW	Dr/ANP initials ONLY:	
Date: 16/09/25	Date:	

Document all actions and interventions

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
	Low Clinical Risk	Medium Clinical Risk	High Clinical Risk
Min 12 Hourly Observations	Min 4 Hourly Observation	Min Hourly Observations	Continuous Monitoring
	Inform Registered Nurse	Urgent Assessment by Medical Team	Urgent Assessment by Senior Medical Team
	Agree Frequency of Observation Required	ACE Response in Medical Notes	ACE Response in Medical Notes
		Think Sepsis if Suspicion of Infection	Consider 2222

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

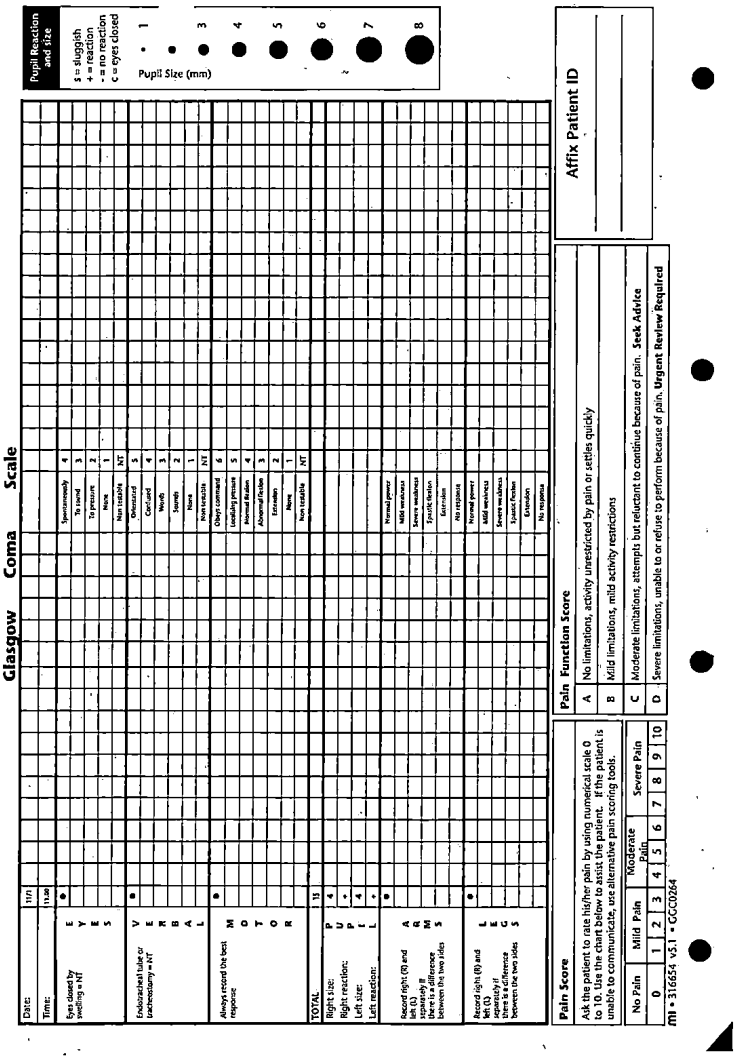
Discontinuation of NEWS

Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Signed.....

Medical: .....

Date: .....



NEWS 2 Key	1	2	3

Date	1/11	4/9	4/9	4/9
Time	11.00	10 20	18 45	22 40

A + B Respirations Breaths/min

	Example	4/9 10:20	4/9 18:45	4/9 22:40	Range	Score
					≥25	3
					21-24	2
	•	•	•	•	12-20	0
					9-11	1
					≤8	3

A + B SpO2 Scale 1 Oxygen saturation (%)

	Example	4/9 10:20	4/9 18:45	4/9 22:40	Range	Score
	97	97	96	96	≥96	0
					94-95	1
					92-93	2
					≤91	3

SpO2 Scale 2 Oxygen saturation (%) Use Scale 2 if target range is 88-92% e.g. in chronic hypercapnic respiratory failure

Only use scale 2 under direction of qualified clinician

Range	Score
≥97 on O2	3
95-96% on O2	2
93-94% on O2	1
≥93 on air	0
88-92	0
86-87	1
84-85	2
≤83	3

Air or oxygen?

	Example	4/9 10:20	4/9 18:45	4/9 22:40	Range	Score
	A	A	NC 2L	A	Air (A) or O2 device	0
					O2 L/min 2	2

C Blood Pressure mmHg (Score uses systolic BP only)

	Example	4/9 10:20	4/9 18:45	4/9 22:40	Range	Score
					≥220	3
					201-219	0
					181-200	0
					161-180	0
					141-160	0
	↑		∧	∧	121-140	0
					111-120	0
		∧			101-110	1
					91-100	2
					81-90	3
	↓				71-80	3
		∨	∨	∨	61-70	3
					51-60	3
					≤50	3

C Pulse Beats / min

	Example	4/9 10:20	4/9 18:45	4/9 22:40	Range	Score
					≥131	3
					121-130	2
					111-120	2
					101-110	1
					91-100	1
					81-90	0
	•	•	•	•	71-80	0
					61-70	0
					51-60	0
					41-50	1
					31-40	3
					≤30	3

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

	Example	4/9 10:20	4/9 18:45	4/9 22:40	Range	Score
	•	•	•	•	A Alert	0
					C New Confusion	3
					V Verbal	3
					P Pressure	3
					U Unresponsive	3

E Temperature

	Example	4/9 10:20	4/9 18:45	4/9 22:40	Range	Score
					≥39	2
					38.1-39.0	1
					37.1-38.0	0
	•	•	•	•	36.1-37.0	0
					35.1-36.0	1
					≤35.0	3

	Example	4/9 10:20	4/9 18:45	4/9 22:40
NEWS Total	0	1	2	0
Blood glucose	7.0	/	/	/
Pain / function score	OA	0/A	0/A	0A
Time Pt last passed urine	10.20	PU	PU	PU
Fluid balance chart indicated Y/N	N	N	N	N
GCS indicated Y/N	N	N	N	N
Time NEWS due	23.00	14 20	22 45	00 40
Escalation of care Y / N	N	N	N	N
Initials	AB	[illegible]	[illegible]	[illegible]

Affix Patient ID

Abbreviations for recording oxygen device

A	Room Air
N	Nasal Cannulae
SM	Simple Mask
V	Venturi Mask and % eg. V24
NIV	Non Invasive Ventilation
IV	Invasive Ventilation
T	Tracheostomy
CP	CPAP Mask
HFN	High Flow Nasal Oxygen
NEB	Nebuliser
RM	Reservoir Mask (Emergency use only)

Affix Patient ID

NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

1. Give oxygen to target saturation >94% (COPD 88-92%)
2. IV fluids up to 20ml/kg
3. Take blood cultures
4. Measure lactate and FBC
5. Give IV antibiotics
6. Monitor urine output and fluid balance chart

Think AGE

A Action: Working diagnosis (consider SEPSIS). Consider frequency of observations. Management plan. Set review time. Document.

C Communicate: Inform nurse of plan. Inform senior medic if necessary. Document the discussion.

E Escalate: Document the treatment escalation plan. Should include need for next level of care & consideration of resuscitation status.

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

2810666490 MCJURY Nicholas, D FLAT 1/2 820 GOVAN ROAD Glasgow, Lanarkshire 28/10/196 G51 3UF	Hospital: QEUH Ward: ARM 5/6A	Points to consider: • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes.

Pressure damage	No RISK ↓	At RISK ↓	Grade 1 – non blanching skin Grade 2,3,4, suspected deep tissue injury (SDTI), ungradable pressure ulcer, Moisture Associate Skin Damage (MASD) ↓	Device Related Pressure Damage i.e. nasogastric, catheters, oxygen tubing ↓
YOU MUST CHECK SKIN at pressure points	Daily skin check	4 hourly positioning Complete SSKINS care plan (Overleaf)	2 hourly positioning with skin checks, Complete SSKINS care plan (overleaf)	All devices need a SSKINS care plan (overleaf)

1	PressureDamage	Does the person have Pressure damage; Grade 1, 2, 3, 4, SDTI, Ungradable?
2	Mobility	Does the person require assistance to mobilise or change position?
3	Continence	Does the person have moisture issues, or, continence issues with urine and/or faeces?
4	Nutrition	Does the person appear malnourished and/or unable to eat or drink?
5	Skin	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?
6	Judgement	In your clinical judgement, is this person at risk of developing pressure damage?

Date	Location of pressure damage	Grade of ulcer	Date	Location of pressure damage	Grade of ulcer
30/8/25	Sacrum	Red	/ /		
/ /			/ /		
/ /			/ /		

If NO to all questions, continue Care Rounds Prescribed as assessed for individual need and re-assess daily.
If you have answered YES to any of the questions above, please complete the SSKINS care plan overleaf.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Check Skin	Signature
30/8/25	22:00	N	Y	N	N	N	N	4 hrly	
31/8/25	02:00	N	Y	N	N	N	N	4 hrly	
1/9/25	02:30	N	Y	N	N	N	N	4 hrly	
1/9/25	15:30	(Patient	Refused	skin	check)			4 hrly	
2/9/25	14:00	N	N	N	N	N	N	4 hrly	
3/9/25	14:30	N	N	N	N	N	N	4 hrly	
4/9/25	:	(Patient	Refused					4 hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	

Patient Centred SSKINS care plan

Aim: to provide effective pressure ulcer prevention strategies to reduce/eliminate potential for pressure ulcer development.

NB. Avoid patients lying on back/sitting for prolonged episodes, a total change of position is required, standing only is not sufficient

Attach Addressograph

NHS Greater Glasgow and Clyde

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan:	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used: Catheter ☐ Naso gastric ☐ Oxygen mask ☐ Nasal oxygen ☐ Vascular Access Device ☐ Off loading boot ☐ Other:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment: Off loading boot: ☐ Protective product:	• Reposition ____ hourly in bed. • Reposition ____ hourly in chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used: Tilting device ☐ • Knee bend in place ☐ Record reason for no knee bend:	• Does patient have Moisture Associated Skin Damage Yes ☐ • Skin care to be carried out ____hourly. • Specify products required for increased moisture / continence management: Barrier Cream ☐ Pad / Pants ☐	• Optimise nutrition and hydration. • Refer to MUST	• Provide information in a format appropriate to patient / family/ carer needs : • Specify: Leaflet ☐ Verbal ☐ Not provided record reason:	Date discontinued: ____
Date Reviewed:	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used: Catheter ☐ Naso gastric ☐ Oxygen mask ☐ Nasal oxygen ☐ Vascular Access Device ☐ Off loading boot ☐ Other:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment: Off loading boot: ☐ Protective product:	• Reposition ____ hourly in bed. • Reposition ____ hourly in chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used: Tilting device ☐ • Knee bend in place ☐ Record reason for no knee bend:	• Does patient have Moisture Associated Skin Damage Yes ☐ • Skin care to be carried out ____hourly. • Specify products required for increased moisture / continence management: Barrier Cream ☐ Pad / Pants ☐	• Optimise nutrition and hydration. • Refer to MUST	• Provide information in a format appropriate to patient / family/ carer needs : • Specify: Leaflet ☐ Verbal ☐ Not provided record reason:	Date discontinued: ____

Name:	2810666490 MCJURY M
Address:	Nicholas, D 28/10/1966 FLAT 1/2 820 GOVAN ROAD Glasgow, Lanarkshire
CHI:	
DOB:	
Hospital #	G51 3UP

Peripheral Venous Cannula (PVC) Insertion & maintenance

Please complete insertion details for each PVC inserted

Care & maintenance to be undertaken & documentation completed **twice** each day.

Modified Visual Infusion Phlebitis (VIP) Score		
PVC site appears healthy	0	No phlebitis: Continue care and maintenance
Either slight pain or redness near site	1	Possible first signs: Observe PVC site
Two or more: pain / redness / swelling	2	Early stage of phlebitis: **Remove and resite** PVC
All: pain / redness / hardening of surrounding area	3	Phlebitis/thrombophlebitis: **Remove and resite** PVC **Seek further advice**
As above and including: palpable venous cord	4	
As above and including: pyrexia	5	

NHS Greater Glasgow and Clyde

Insertion details: Date: 22/08/25 (Day 1) Time: ___:___	**Where inserted:** ☒ ED ☐ Theatre ☐ ITU/HDU ☐ Ward ___ ☐ Unknown	**Insertion site:** ☐ Hand ☒ Arm Other ___	**Side:** ☐ Left ☒ Right	**Size of cannula:** ☐ 26G Purple ☐ 24G Yellow ☒ 18G Green ☐ 23G Blue ☐ 16G Grey ☐ 20G Pink ☐ 14G Orange	**Inserted by:** Print: ___ Signature: ___ Designation: ___
Clinical indication:	☐ **Diagnostics**	☐ **Resuscitation**	☐ **IV medications**	☐ **Fluids**	☐ **Transfusion**
Insertion criteria:	Hand hygiene performed ☐ Yes ☐ No	Skin decontamination (2% chlorhexidine in 70% isopropyl alcohol) ☐ Yes ☐ No	Sterile transparent semi-permeable dressing affixed ☐ Yes ☒ No	PVC explained to patient/carer ☐ Yes ☐ No	

DRIFT PVCs are associated with an increased risk of phlebitis, thrombosis, infection and S.aureus bacteraemia.

Signs of local or systemic infection

Justify the need for your patient to have a PVC using the DRIFT mnemonic.
- ✓ **D**iagnostics - Does the patient need the PVC for a diagnostic procedure e.g. CT scan
- ✓ **R**esuscitation - Is the patient at risk of cardiac or respiratory arrest?
- ✓ **I**ntravenous (IV) - Does the patient require intravenous (IV) medication? Could these be switched to another route?
- ✓ **F**luids - Does the patient require IV fluids? Could this be switched or oral fluids?
- ✓ **T**ransfusion - Does the patient require a transfusion of blood products?

Local infection
- Erythema / inflammation
- Exudate
- Hot to touch
- Pain/tenderness

Systemic Infection
- Hypotension
- Tachycardia
- Pyrexia

Adult IVOST Guideline:

Paediatric IVOST Guideline:

Always refer to full IV route to Oral route Switch Therapy (IVOST) guidelines

IV → Oral Antibiotic Switch Therapy (IVOST) Guideline

Review need for IV antibiotics daily
Can antibiotic therapy be stopped? (eg: alternative diagnosis)?
If ongoing antibiotics required - document patient progress/IVOST plan within 72 hours

Switch to oral when:

a **CLINICAL IMPROVEMENT** in signs of infection eg: temperature ≤37.9°C, reduction in the NEWS score, improving SEPSIS

a **ORAL ROUTE** is available reliably (eating/drinking no concerns regarding absorption)

a **UNCOMPLICATED INFECTION** i.e. specialist advice not required prior to IVOST: Infection requiring specialist advice includes CNS infection, Cystic fibrosis, S. aureas bacteraemia (minimum 14 days IV), Endocarditis, Vascular graft or bone/joint infection, Undrainable deep abscess.

DO NOT use CRP in isolation to assess IVOST suitability as does not reflect severity of illness

Record the stop date on HEPMA

If IVOST criteria met → Switch to oral
Review MICROBIOLOGY results and NARROW THE SPECTRUM based on cultures
IF not responsive MICROBIOLOGY switch to oral as outlined below

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MCJURY M
Nicholas, D 28/10/1966
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire
G51 3UP

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

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Maintenance – to be completed twice daily (Observe for signs and symptoms of local or systemic infection)

Date	Need for PVC reviewed today?		Any sign of PVC site infection?		Is the dressing intact?		Before / after PVC procedures; hand hygiene performed?		PVC patent?		What has been done?		Sign: Print: Designation:
	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	
Day 1 Insertion Date 30/08/25	☐ Yes ☐ No	☑ Yes ☐ No	VIP ____	VIP 0	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☑ Left in situ ☐ Redressed ☐ Removed	Day Night ay
Day 2 31/08/25	☐ Yes ☐ No	☑ Yes ☐ No	VIP ____	VIP 0	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☑ Left in situ ☐ Redressed ☐ Removed	Day Night JOUHH
Day 3 1/9/25	☑ Yes ☐ No	☑ Yes ☐ No	VIP 0	VIP 0	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Left in situ ☐ Redressed ☐ Removed	☑ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 4 2/9/25	☑ Yes ☐ No	☑ Yes ☐ No	VIP 0	VIP 0	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Left in situ ☐ Redressed ☐ Removed	☑ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 5 3/9/25	☑ Yes ☐ No	☐ Yes ☐ No	VIP 0	VIP ____	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 6 4/9/25	☑ Yes ☐ No	☑ Yes ☐ No	VIP 0	VIP 0	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 7	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Removed	Day Night

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

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

Patient name

Patient CHI

2810666490
M MCJURY
6 Nicholas, D 28/10/196
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire
P G51 3U

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Emergency Care Nursing Documentation

Initial Investigations

Patient prepared for exam - clothing bagged				(Y)	N
NEWS Chart	(Y)	N	X-rays	Y	N
ID band	(Y)	N	Pain Score	Y	N
Peak Flow	Y	(N)	Please specify		
12-lead ECG	(Y)	N	Urinalysis	Y	N
IV access	(Y)	N			
Blood samples	(Y)	N	Positive findings		
Blood Gas	(Y)	N	B-HCG	Y	N

Signature: MCJWEIR

Communication

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

Signature: MCJWEIR

Risk Assessments and Screening Tools

	SEPSIS	Y	(N)	GMAWS	(Y) (N)
	FAST	Y	(N)	Adult Support and Protection	Y (N)
Time:	Swallow Testing	Y	(N)	Mental Health Triage Assessment	Y (N)
	Falls Risk (clinical judgement)	Y	(N)	Child Protection Concerns	Y (N)
	4AT Assessment	Y	(N)	Frailty Assessment	Y (N)
				Public Protection (NOC)	Y (N)

Signature:

Pause for Discharge or Transfer

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

Signature:

Patient name

Patient CHI

2810666490
M MCJURY
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P G51 3U

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Greater Glasgow and Clyde

Care Rounds Checklist

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

Signed VStrang Name VSTRANG Designation SN

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

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

			Times	08:00										
	1	**THINK DELIRIUM** Is the patient more confused/drowsy than normal? If yes inform registered nurse.	Y											
	2	**PAIN: ASSESS AND ADDRESS** Is the patient distressed or in pain? If yes inform registered nurse.	N											
S	3	**SKIN INSPECTION** Pressure areas checked?	Y											
		R = RED D = Discloured PU = Pressure Ulcer INT = Intact M = Moisture	INT											
K	4	**KEEP MOVING** Has the patient moved or walked?	Y											
		Bed R =Right side (30°) tilt L =Left side (30°) tilt B =Back Chair W/ST = Assist to walk / stand	B											
		ELIMINATION Does the patient need the toilet?	Y											
I	5	I = Independent A - Assistance given IC = Incontinent (urine/ faeces)	IC											
N	6	**FOOD FLUIDS AND NUTRITION** Is the patient nil by mouth?	N											
		Drink taken?	✓											
		Food, snack, or supplements taken?	✓											
		Has oral hygiene been carried out as per care plan?	✓											
	7	**ENVIRONMENT CHECK** Is the patient's call buzzer to hand? Is the area clutter free clean and safe? Does the patient have everything they require in safe reach? Is the bed in the lowest position?	Y											
	8	**INFORMATION** Is there anything else I can help you with? Inform the patient of the time of return	Y											
	9	**ESCALATION** Is there anything else I can help you with? Inform the patient of the time of return	Y											
		Care provider	SN											
		Role	SN											

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

Patient name

Patient CHI

2810666490
MCJURY
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Nursing notes cont.

Date and Time	Name/Signature

Patient name

Patient CHI

2810666490
M MCJURY M
6 Nicholas, D 28/10/1966
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire
P G51 3UP

Hospital:

Ward:

Points to consider:

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

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PUDRA

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

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

2	**Mobility**	Does the person require assistance to mobilise or change position (inappropriate for age)?
3	**Continence**	Does the person have continence issues with urine and/or faeces (inappropriate for age)?
4	**Nutrition**	Does the person appear malnourished and/or unable to eat or drink/ PYMS score>2?
5	**Skin**	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?
6	**Judgement**	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

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

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

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

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

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

Patient name

Patient CHI

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Ongoing Care

	4 Hours	5 Hours	6 Hours	7 Hours	8 Hours	9 Hours	10 Hours	11 Hours	12 Hours
Time									
Nursing notes updated including (NEWS, MEWS,PEWS)									
FFN (provide details)									
VI/IVABs									
Routine Medications prescribed and administered									
Falls risk assessment									
Skin assessed and supported (PURDRA)									
Analgesia assessment									
Nurse call system in place									
SBAR commenced									
Patient/ relatives updated									
Elimination needs met (does the patient know where toilet is)									
If patient not in cubicle space think about patients dignity requirements eg hearing aids, mobility aids, glasses, interpreter									
STOPPS completed									

Patient name

Patient CHI

2810666490
MCJURY M
Nicholas, D 28/10/1956
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Greater Glasgow and Clyde

Nursing notes

Date and Time		Name/Signature
30/07/25	Standby to Resus ✓ GCS taken	
2345	street valium & gabapentin. Given Naloxone by SAS. GCS 14 on arrival. ——— lucywell ON.	
02-50	Patient repositioned unwell obs charted passed urine into bottle patient for IV by med HDU. ✓ Strangon (5)	
0500.	Care taken over by dayShift. Obs as charted.	KTopping SSN.
10°°.	Attempted to phone ARU (1) NIC (82344) no answer. Informed by ARU (1) Ward clerk that bed is not available at present - states approx 20 minutes as room is getting cleared now. Rpt obs obtained. NEWS (4). GCS (13). ———	HKGITH SN
10°5.	Contacted demand & capity. They have informed resus nurse in charge that bed will be ready in 10 minutes.	HKGITH SN

My Admission Record

NHS Greater Glasgow and Clyde

2810666490
MCJURY N
Nicholas, D 28/10/1966
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire
G51 3UF
Affix patient ID label

Hospital: QEUH Ward: ARU1
Date of Admission: 31/07/25 Time: 1080
Information obtained from: Name:
Patient ☒ Relative ☐ Other ☐ _____
Preferred Name:
Age: 58 Telephone Number:
Consultant:

Communication

What is your first language? English
Do you require an interpreter? Yes ☐ No ☒
If yes, provide details of arrangements made _____
Do you use British Sign Language (BSL)? Yes ☐ No ☒
Do you need someone to help you to communicate? Yes ☐ No ☒ If yes, who _____

Preferred first contact	**Preferred second contact**
Name: Mama	Name: Rita S
Relationship:	Relationship: Sister
Address:	Address:
Telephone:	Telephone: 07713950808
Is this person aware of your admission?	Is this person aware of your admission?
Yes ☐ No ☐	Yes ☒ No ☐
Can we share information with this person?	Can we share information with this person?
Yes ☐ No ☐	Yes ☒ No ☐

Presenting Complaint / Diagnosis

?SEIZURES / ↓GCS / STREET WALKER

Explained to the patient? Yes ☐ No ☐ Not Applicable ☐
Do you understand the reason for your admission? Yes ☐ No ☐

Allergies / Sensitivities (Record food allergies in the Hydration and Nutrition section)

No known allergies ☐ NKDA

Relevant past medical history

IVDU
?Undiagnosed COPD

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place
Yes ☐ No ☒ If yes, Who asked for a copy? _____
Date they asked for a copy __/__/__ Date Obtained __/__/__

Power of Attorney / Guardianship / Adult with Incapacity

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MCJURY
Nicholas, D
28/10/196
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire
G51 3UF

Does someone have Power of Attorney (POA) for you?

Yes ☐ No ☒

OR

Does someone have Guardianship?

Yes ☐ No ☒

If yes, is this for:- Finance ☐ Welfare ☐ Both ☐

Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

Please obtain a copy and place in the patient's notes

Who asked for a copy?_____ Date they asked for a copy __/__/__ Date Obtained __/__/__

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

N.B. If you think the patient may lack capacity inform Medical Staff to assess and, if required, consider the need for an 'Adult with Incapacity' Section 47

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:	Yes	No
1. Been an inpatient in a hospital outside Scotland?	☐	☒
2. Received holiday dialysis outside Scotland?	☐	☒
3. Been told that you have CPE?	☐	☒
4. Been in close contact with a person with CPE?	☐	☒

If the answer is yes to **ANY** of the questions in this section, you must

- Isolate the patient in a side room ☐
- Obtain Rectal swab marked 'for CPE' ☐
- If patient refuses rectal swab, obtain a stool specimen marked 'for CPE' ☐
- **and inform the IPCT** ☐

MRSA Screening

	Yes	No	Unsure
Will the patient be an inpatient for more than 23 hours	☒	☐	☐
If **YES** complete the following section			
1. Have you ever been told that you have MRSA?	☐	☒	☐
2. Have you been admitted from another hospital/ residential setting or care home?	☐	☒	
3. Do you have a wound / skin ulcer or invasive device which you had before admission?	☐	☒	☐

If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabs

Nasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐

Creutzfeldt-Jakob Disease (CJD)

	Yes	No	Unsure
Have you ever been informed that you are at increased risk of CJD or vCJD?	☐	☒	☐

If **YES inform the IPCT** ☐

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1 MCJURY
3 Nicholas, D 28/10/196
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Affix patient ID label

Lifestyle

Smoking

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

Never smoked ☐

Do you use eCigarettes? Yes ☐ No ☐

If a smoker, the NHSGGC Smokefree policy has been explained and Nicotine Replacement Therapy (NRT) has been offered

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

Do you want to talk to someone about your smoking? Yes ☐ No ☐

If yes, refer to Smokefree Services (Trakcare) Date referred: ___/___/___

Drugs

Do you use recreational or illicit drugs or are you receiving opiate replacement therapy (ORT / Methadone / Suboxone)? Yes ☒ No ☐

If yes, please specify and refer to the NHSGGC Guidelines for the Management of Drug Users in Glasgow and Clyde Acute Hospitals

_____

_____

Alcohol

Do you drink alcohol? Yes ☒ No ☐

How often do you have more than 6 units of alcohol on one occasion:

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

NB: If daily or almost daily commence the Glasgow Assessment and Management of Alcohol (GAMA); complete FAST Tool and take further action as per guidance.

Name (Please PRINT): Y Hamilton Signature:

Designation: SN Date: 31/7/2025

My Assessment Record

2810666490
MCJURY M
Nicholas, D 28/10/1966
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire
G51 3UP

1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems			
Breathless at rest	✓	✓	
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			

Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems	✓	✓	
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

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

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Nicholas, D M
28/10/1966
FLAT 1/2
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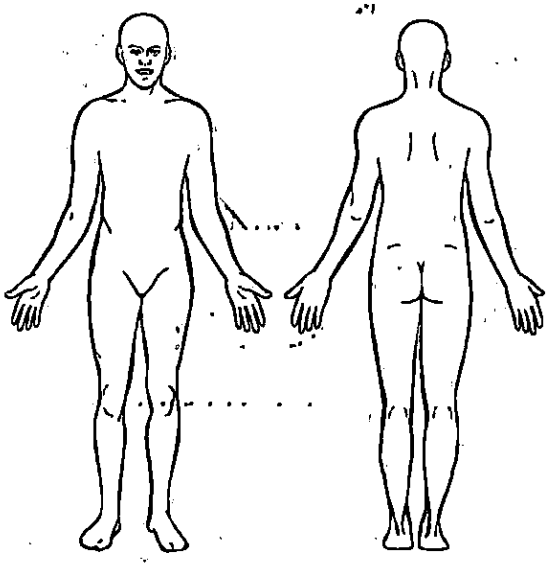
3. Senses

Vision	**Yes** ✓	**No** ✓	Assessment of the patient's vision
Do you have any problems with your vision?		✓	
Do you wear glasses?			Distance ☐ Reading ☐ Both ☐
Do you have your glasses with you?			
Do you wear contact lenses?			
Do you have your lenses with you?			
Do you wear a prosthesis?			
Hearing	**Yes** ✓	**No** ✓	Assessment of the patient's hearing
Do you have any problems with your hearing?		✓	
Do you have any hearing loss?			
Do you use a hearing aid?			
Do you have your hearing aid(s) with you?			
Pain	**Yes** ✓	**No** ✓	Assessment of the patient's pain
Do you have pain?		✓	

Can you describe where and what the pain is like?

Mark current pain on body chart



Have you had treatment / intervention for the pain?

N.B. Complete generic pain assessment chart. If unable to self report complete Abbey Pain Scale.

Can you describe any chronic pain that you have?

What makes the pain better?

Preferred flavour		
Enteral Nutrition		

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G51 3UI

Affix patient ID label

4. Cognitive Status THINK DELIRIUM

	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's cognitive status
Alert and orientated	✓	✓	
Impaired conscious level			
Confused			
Dementia			
Stressed / Distressed			

N.B. Think Delirium

Complete 4AT for all patients 65 and over, AND for patients of any age with one or more of the following:

- existing cognitive impairment
- previous delirium
- current hip fracture
- severe illness

and follow the guidance

N.B. 'Getting to Know Me' and 'What Matters to Me' should be completed for all patients with dementia, cognitive impairment or complex needs

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

NIL

What do you like to eat and drink?

VARIED DIET

What do you not like to eat and drink?

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

NHSGGC Bedrail Risk Assessment

2810666490
MCJURY M
Nicholas, D 28/10/1966
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire
G51 3UP

NHS Glasgow & Clyde

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

Patient Name:

CHI Number:

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT

Use guidance on the reverse of this document when completing this Risk Assessment								
	DATE	31/7/25						
	TIME	1200						
	WARD	ARUS						
	HOSPITAL	QEUH						

	SECTION ONE – GENERAL	Y	N	Y	N	Y	N	Y	N
1	Is the patient likely to fall, roll, slip or slide from the bed?		✓						
2	Has the patient requested the use of bedrails?		✓						
	IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED								
	SECTION TWO – COGNITIVE AND PHYSICAL STATUS								
3	Is the patient at risk of climbing out of bed?		✓						
4	Is the patient stressed, delirious or restless?		✓						
5	Is the patient small in stature?		✓						
6	Does the patient have an unusually large or small head that might present an entrapment issue?		✓						
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?		✓						
	IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf								
	SECTION THREE – COMMUNICATION								
8	Has the patient been consulted regarding the use of bedrails?	✓							
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition	✓							
10	Has the use of bedrails been discussed with relatives/carers?		✓						
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?		✓						
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?		✓						
	IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf								

	SECTION FOUR – DECISION MAKING	Y	N	Y	N	Y	N	Y	N
13	Will bedrails be used for this patient at the present time?		✓						
14	Rationale for use of bedrails: (Please insert code in the box on the right)								
	A – Risk of falling from the bed								
	B – Risk of rolling from the bed								
	C – Risk of slipping from the bed								
	D – Risk of sliding from the bed								
	E – Patient request								
15	Bedrail risk assessment completed by:								
16	Bedrails checked by:								
17	Date	31/7/25							

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

Care Rounds Checklist

Date: 31/7/2015

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

1. Signed _____ Name Y Hamilton Designation SIN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attach A
2810666490
MCJURY
Nicholas, D
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire
G51 3UF
Ward:
28/10/1961

NHS Greater Glasgow and Clyde

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

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

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

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

2810666490 MCJURY Nicholas, D FLAT 1/2 820 GOVAN ROAD Glasgow, Lanarkshire G51 3UF M 28/10/1968	**Hospital:** QEUH **Ward:** ARU1	**Points to consider:** • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

Pressure damage	No RISK ↓	At RISK ↓	Grade 1 – non blanching skin Grade 2,3,4, suspected deep tissue injury (SDTI), ungradable pressure ulcer, Moisture Associate Skin Damage (MASD) ↓	Device Related Pressure Damage i.e. nasogastric, catheters, oxygen tubing ↓
YOU MUST CHECK SKIN at pressure points	Daily skin check	4 hourly positioning Complete SSKINS care plan (Overleaf)	2 hourly positioning with skin checks, Complete SSKINS care plan (overleaf)	All devices need a SSKINS care plan (overleaf)

1	PressureDamage	Does the person have Pressure damage; Grade 1, 2, 3, 4, SDTI, Ungradable?
2	Mobility	Does the person require assistance to mobilise or change position?
3	Continence	Does the person have moisture issues, or, continence issues with urine and/or faeces?
4	Nutrition	Does the person appear malnourished and/or unable to eat or drink?
5	Skin	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?
6	Judgement	In your clinical judgement, is this person at risk of developing pressure damage?

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

If NO to all questions, continue Care Rounds Prescribed as assessed for individual need and re-assess daily.
If you have answered YES to any of the questions above, please complete the SSKINS care plan overleaf.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Check Skin	Signature
31/7/25	1200	NO	NO	NO	NO	NO	NO	4hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	

Patient Centred SSKINS care plan

Aim: to provide effective pressure ulcer prevention strategies to reduce/eliminate potential for pressure ulcer development

NB. Avoid patients lying on back/sitting for prolonged episodes, a total change of position is required, standing only is not sufficient

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M
28/10/196[illegible]
[illegible]graph

NHS Greater Glasgow and Clyde

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan:	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used: Catheter ☐ Naso gastric ☐ Oxygen mask ☐ Nasal oxygen ☐ Vascular Access Device ☐ Off loading boot ☐ Other:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment: Off loading boot: ☐ Protective product:	• Reposition ____ hourly in bed. • Reposition ____ hourly in chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used: Tilting device ☐ • Knee bend in place ☐ Record reason for no knee bend:	• Does patient have Moisture Associated Skin Damage Yes ☐ • Skin care to be carried out ____ hourly. • Specify products required for increased moisture / continence management: Barrier Cream ☐ Pad / Pants ☐	• Optimise nutrition and hydration. • Refer to MUST	• Provide information in a format appropriate to patient / family/ carer needs : • Specify: Leaflet ☐ Verbal ☐ Not provided record reason:	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used: Catheter ☐ Naso gastric ☐ Oxygen mask ☐ Nasal oxygen ☐ Vascular Access Device ☐ Off loading boot ☐ Other:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment: Off loading boot: ☐ Protective product:	• Reposition ____ hourly in bed. • Reposition ____ hourly in chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used: Tilting device ☐ • Knee bend in place ☐ Record reason for no knee bend:	• Does patient have Moisture Associated Skin Damage Yes ☐ • Skin care to be carried out ____ hourly. • Specify products required for increased moisture / continence management: Barrier Cream ☐ Pad / Pants ☐	• Optimise nutrition and hydration. • Refer to MUST	• Provide information in a format appropriate to patient / family/ carer needs : • Specify: Leaflet ☐ Verbal ☐ Not provided record reason:	Date discontinued: _____

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Nicholas, D 28/10/195[illegible]

Peripheral Venous Cannula (PVC) Insertion & maintenance

Please complete insertion details for each PVC inserted

Care & maintenance to be undertaken & documentation completed **twice** each day.

Modified Visual Infusion Phlebitis (VIP) Score		
PVC site appears healthy	0	No phlebitis: Continue care and maintenance
Either slight pain or redness near site	1	Possible first signs: Observe PVC site
Two or more: pain / redness / swelling	2	Early stage of phlebitis: Remove and resite PVC
All: pain / redness / hardening of surrounding area	3	Phlebitis/thrombophlebitis: Remove and resite PVC Seek further advice
As above and including: palpable venous cord	4	
As above and including: pyrexia	5	

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Insertion details: Date: 31/7/25 (Day 1) 7 Time: ___:___	**Where inserted:** ☐ ED ☐ Theatre ☐ ITU/HDU ☐ Ward ___ ☐ Unknown	**Insertion site:** ☐ Hand ☐ Arm Other ___	**Side:** ☐ Left ☐ Right	**Size of cannula:** ☐ 26G Purple ☐ 24G Yellow ☐ 18G Green ☐ 23G Blue ☐ 16G Grey ☐ 20G Pink ☐ 14G Orange	**Inserted by:** Print: 7 Signature: ___ Designation: ___
Clinical Indication:	☐ Diagnostics	☐ Resuscitation	☐ IV medications	☐ Fluids	☐ Transfusion
Insertion criteria:	Hand hygiene performed ☐ Yes ☐ No	Skin decontamination (2% chlorhexidine in 70% isopropyl alcohol) ☐ Yes ☐ No	Sterile transparent semi-permeable dressing affixed ☐ Yes ☐ No	PVC explained to patient/carer ☐ Yes ☐ No	

DRIFT PVCs are associated with an increased risk of phlebitis, thrombosis, infection and S.aureus bacteraemia.

Justify the need for your patient to have a PVC using the DRIFT mnemonic.
- ✓ **D**iagnostics - Does the patient need the PVC for a diagnostic procedure e.g. CT scan
- ✓ **R**esuscitation - Is the patient at risk of cardiac or respiratory arrest?
- ✓ **I**ntravenous (IV) - Does the patient require intravenous (IV) medication? Could these be switched to another route?
- ✓ **F**luids - Does the patient require IV fluids? Could this be switched or oral fluids?
- ✓ **T**ransfusion - Does the patient require a transfusion of blood products?

Signs of local or systemic infection

Local Infection
- Erythema / inflammation
- Exudate
- Hot to touch
- Pain/tenderness

Systemic Infection
- Hypotension
- Tachycardia
- Pyrexia

Adult IVOST Guideline:

Paediatric IVOST Guideline:

Always refer to full IV route to Oral route Switch Therapy (IVOST) guidelines

IV → Oral Antibiotic Switch Therapy (IVOST) Guideline

Review need for IV antibiotics daily

Can antibiotic therapy be stopped? (eg: alternative diagnosis)?

If ongoing antibiotics required - document patient progress/IVOST plan within 72 hours

↓

Switch to oral when:

a **CLINICAL IMPROVEMENT** in signs of infection eg: temperature ≤37.9°C, reduction in the NEWS score, improving SEPSIS

a **ORAL ROUTE** is available reliably (eating/drinking no concerns regarding absorption)

a **UNCOMPLICATED INFECTION** i.e. specialist advice not required prior to IVOST: Infection requiring specialist advice includes CNS infection, Cystic fibrosis, S. aureas bacteraemia (minimum 14 days IV), Endocarditis, Vascular graft or bone/joint infection, Undrainable deep abscess.

DO NOT use CRP in isolation to assess IVOST suitability as does not reflect severity of illness

Record the stop date on HEPMA

↓

If IVOST criteria met → Switch to oral

Review MICROBIOLOGY results and NARROW THE SPECTRUM based on cultures

IF not responsive MICROBIOLOGY switch to oral as outlined below

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

Maintenance – to be completed twice daily (Observe for signs and symptoms of local or systemic infection)

Date	Need for PVC reviewed today?		Any sign of PVC site infection?		Is the dressing intact?		Before / after PVC procedures; hand hygiene performed?		PVC patent?		What has been done?		Sign: Print: Designation:
	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	
Day 1 Insertion Date 31/7/25	☑ Yes ☐ No	☐ Yes ☐ No	VIP 0	VIP ____	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 2	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 3	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 4	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 5	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 6	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 7	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Removed	Day Night

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

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

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

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Glasgow, Lanarkshire
G51 3U

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name: J.Law	
Dr/ANP Initials ONLY:	Dr/ANP Initials ONLY: JL	
Date:	Date: 31/7	

Document all actions and interventions

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
	Low Clinical Risk	Medium Clinical Risk	High Clinical Risk
Min 12 Hourly Observations	Min 4 Hourly Observation	Min Hourly Observations	Continuous Monitoring
	Inform Registered Nurse	Urgent Assessment by Medical Team	Urgent Assessment by Senior Medical Team
	Agree Frequency of Observation Required	ACE Response in Medical Notes	ACE Response in Medical Notes
		Think Sepsis if Suspicion of Infection	Consider 2222

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

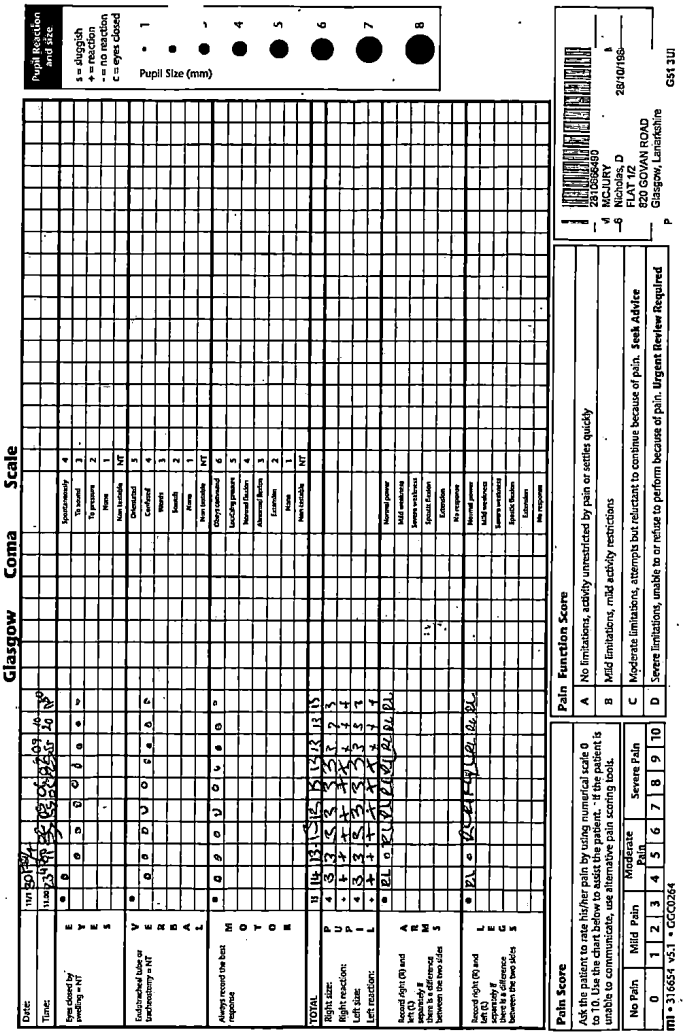
Discontinuation of NEWS

Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Signed.....

Medical: .....

Date: .....



Pain Score

Ask the patient to rate his/her pain by using numerical scale 0 to 10. Use the chart below to assist the patient. If the patient is unable to communicate, use alternative pain scoring tools.

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

Pain Function Score

A	No limitations, activity unrestricted by pain or settles quickly
B	Mild limitations, mild activity restrictions
C	Moderate limitations, attempts but reluctant to continue because of pain. **Seek Advice**
D	Severe limitations, unable to or refuse to perform because of pain. **Urgent Review Required**

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mi • 316654 v5.1 • GCC0264

NEWS 2 Key	1	2	3

Date	1/11		31/7					31/07	31/07			
Time	11.00	2345	0031	[illegible]	0600	[illegible]	0500	0905	1020	1130		

A + B Respirations Breaths/min											Range	Score
											≥25	3
											21-24	2
											12-20	0
											9-11	1
											≤8	3

A + B SpO2 Scale 1 Oxygen saturation (%)											Range	Score
	97	97		96	90						≥96	0
											94-95	1
											92-93	2
											≤91	3

SpO2 Scale 2 Oxygen saturation (%) Use Scale 2 if target range is 88-92% eg. in chronic hypercapnic respiratory failure. Only use scale 2 under direction of qualified clinician											Range	Score
											≥97 on O2	3
							95				95-96% on O2	2
											93-94% on O2	1
						92					≥93 on air	0
									92	92	88-92	0
								82			86-87	1
											84-85	2
											≤83	3

Air or oxygen?												
	A			N	NC	NC	N	A	1L	1LN	Air (A) or O2 device	0
		IV		2L	2L	2L	1L		NC	NC	O2 L/min 2	2

C Blood Pressure mmHg (Score uses systolic BP only)											Range	Score
											≥220	3
											201-219	0
											181-200	0
											161-180	0
											141-160	0
											121-140	0
							115				111-120	0
											101-110	1
											91-100	2
							83				81-90	3
											71-80	3
											61-70	3
											51-60	3
											≤50	3

C Pulse Beats / min											Range	Score
											≥131	3
											121-130	2
											111-120	2
											101-110	1
											91-100	1
		84									81-90	0
							79				71-80	0
											61-70	0
											51-60	0
											41-50	1
											31-40	3
											≤30	3

D Any changes in neuro response, do GCS. Immediate medical review. Check Blood Glucose. Think Delirium.	Level	Score
	A Alert	0
	C New Confusion	3
	V Verbal	3
	P Pressure	3
	U Unresponsive	3

E Temperature	Range	Score
	≥39	2
	38.1-39.0	1
	37.1-38.0	0
	36.1-37.0	0
	35.1-36.0	1
	≤35.0	3

NEWS Total	0	6		5	5	5	4	4	5	5
Blood glucose	7.0						/			
Pain / function score	OA									
Time Pt last passed urine	10.20					[illegible]	[illegible]			
Fluid balance chart indicated Y/N	N	N		N	N	N	N	N	N	N
GCS indicated Y/N	N	Y		Y	Y	Y	Y	Y	Y	Y
Time NEWS due	23.00									2°
Escalation of care Y/N	N	Y		N	N	N	N			N
Initials	AB	LW		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	D

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Abbreviations for recording oxygen device

A	Room Air
N	Nasal Cannulae
SM	Simple Mask
V	Venturi Mask and % eg. V24
NIV	Non Invasive Ventilation
IV	Invasive Ventilation
T	Tracheostomy
CP	CPAP Mask
HFN	High Flow Nasal Oxygen
NEB	Nebuliser
RM	Reservoir Mask (Emergency use only)

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NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

1. Give oxygen to target saturation >94% (COPD 88-92%)
2. IV fluids up to 20ml/kg
3. Take blood cultures
4. Measure lactate and FBC
5. Give IV antibiotics
6. Monitor urine output and fluid balance chart

Think ACE

A Action: Working diagnosis (consider SEPSIS). Consider frequency of observations. Management plan. Set review time. Document.

C Communicate: Inform nurse of plan. Inform senior medic if necessary. Document the discussion.

E Escalate: Document the treatment escalation plan. Should include need for next level of care & consideration of resuscitation status.

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

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

Patient Note		**Outpatient Note**
Date/Time: 15-Aug-2025 11:07	**Created By:** Independent Nurse Prescriber South Alcohol & Drug Recovery Service Gorbals Health Centre - Caroline Notman	**Role:** Nurse - GGC
Specialty: Acute Specialties GGC	**Organisation:**	Sensitive
Note:		
Patient no longer prescribed Buvidal.		

Patient Note		**Other**
Date/Time: 20-Mar-2025 16:05	**Created By:** Senior Addiction Nurse - Jennifer Brown8	**Role:** Nurse - GGC
Specialty: Acute Specialties GGC	**Organisation:**	Sensitive
Note:		
Patient commenced on Buprenorphine prolonged release injection (Buvidal). No other OST to be prescribed until further notice. Contact South ADRS for further details 0141 420 8100.		

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Queen Elizabeth University Hospital

CHI: 2810666490

Total Att: 0

12 Mth Att: 0

Title:

MCJURY

Nicholas

DOB **28/10/1966** Age: **56y**

Sex: **Male**

Flat 2/1
820 Govan Road
Glasgow
G51 3UP
01414452395

No mobile

Next of kin: **ALISON, Martha**
Relationship: **Mother**
01414452395

GP: **BS Chita**
0141 427 2504

Attendance Date: **25/02/2023** Arrival Time: **15:33**

Registration Time: **15:33** Date of Incident: **25/02/2023**

Major Incident Desc:

Reason for Attendance: **Right arm injury - Plaster put on in southampton**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **Not Recorded** Pain Score:

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

Presenting Complaint: **Wrist Injury**

Observation Date: **25/02/2023 18:07** Nurse name: **Dr Ioannis Traiforos**

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

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **"Plaster cast in situ for #wrist. Under care of Southampton general- no documentation from hospital. States cast has been in place for 2/52- right wrist. "**

Child Assessment Questionnaire

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

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

X-Ray and Other Reports to be filed on this side (if the patient is not being admitted)

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

Date	25-2-23	CLINICAL NOTES
	Seen by (Dr) G-Curran ESP	Time seen 1910

RL

(R) arm #

WA

States was assaulted 2/52 ago in Swinhampton sustained midshaft tha # plaster in situ

meds allergies NKDA

% Plaster on (R) arm. NV-intact

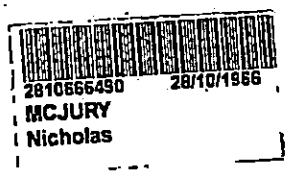
NV-intact.

no c/o about plaster

advised will refer to virtual # Clinic & doctor will call for f/u 100 ap.

2810666490 28/10/1966
MCJURY
Nicholas

Date	CLINICAL NOTES



Discharge Codes (Please CIRCLE) 1. Admission 2. Discharge 3. Refer to GP 4. Transfer to other (see below) 5. Died 6. Refer to OP Clinic (see below) 7. Irregular Discharge 8. D.O.A.	Discharge date	
	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged	Not arranged	To be arranged

Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

QEUH EMERGENCY DEPARTMENT
STANDBY NOTIFICATION / HANDOVER

NHS Greater Glasgow and Clyde

Date Time 2203

Crew Radio Callsign S665

initial notes patient sticker

96 ISL

Age 58 (M) / F

and other info

RR	Sat's	HR	BP	GCS	Temp	BM
28	64 RA	110	116/78	15	39.7	8.8

Time of Onset

Transport road / air * EMRS? Y/N

*Helicopter transfers to QEUH roof? call 19342, activate helipad, note time of call.

HH:MM

Mechanism Inf - DIB

Main complaint Self DIC hosp 2/52 ago

Injuries

Information NEWS 11

Signs

Symptoms

FAST +ve? CHI? (name/DoB?)

Treatment given

Time to arrival

ETA

further information e.g. instructions to crew

Further Cascade

	tick	Time of call
Code Red 2222		
Trauma Call 2222		
Stroke Team 83234		

	tick	Time of call
ICU 83081		
ENT 82782/Switch OOHs		
Vascular 82758/Switch OOHs		

IAU 82338
PAEDS ED 84055 / 84585
Helipad Activation 19342
Ambulance Airdesk 0141 810 6110
Ambulance Control 0141 510 6106

Seen by	Resus consultant	Circle resus interventions below			
Pre-Hospital	Trauma Call	EMRS	Code RED	Major Haem	Ventilated
Central Line	Arterial Line	Inotropes	RSI	CPR	Thrombolysis (Stroke)

Printed: 30/08/2025 19:27:28

Patient Sample Report

Status: **ACCEPTED**
Analyzed: 30/08/2025 19:27:14
Sample Type: **Venous**
Sample Number:
Operator ID: MART-RYAN LLORENTE0

Patient

ID:	2810666490
Last Name:	**MCJURY**
First Name:	**NICHOLAS**
Gender/Age:	Male, 58 years
Birth Date:	28/10/1966

Cartridge

Lot No.:	250603B
S/N:	000000000501197785
Exp. Date:	11/09/2025

Analyzer

Model:	GEM® *Premier 5000*
Area:	AH_L0ED_B
Name:	ED-MAJ-IN
S/N:	17030619

Results

				Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)							
cH	30.2	nmol/L	[	--	--	--	--]
pCO_2	4.6	kPa	[	--	--	--	--]
pO_2	8.4	kPa	[	--	--	--	--]
Na^+	↓ 121	mmol/L	[	--	133	146	--]
K^+	5.0	mmol/L	[	--	3.5	5.3	--]
Cl^-	107	mmol/L	[	--	95	108	--]
Ca^{++}	↓ 1.09	mmol/L	[	--	1.15	1.27	--]
Hct	39	%	[	--	--	--	--]
Glu	↑ 9.3	mmol/L	[	--	3.5	6.0	--]
Lac	↑ 3.4	mmol/L	[	--	0.6	2.2	--]
CO-Oximetry							
tHb	incalc	g/L	[	--	--	--	--]
O_2Hb	incalc	%	[	--	95.0	98.0	--]
COHb	incalc	%	[	--	0.5	1.5	--]
MetHb	incalc	%	[	--	0.5	1.5	--]
HHb	incalc	%	[	--	0.0	5.0	--]
sO_2	incalc	%	[	--	95.0	98.0	--]
Derived							
BE(B)	5.0	mmol/L	[	--	--	--	--]
HCO_3^-(c)	27.8	mmol/L	[	--	--	--	--]
Hct(c)	incalc	%	[	--	--	--	--]

↑↓ Outside Reference Range

Other Information

Operator Entered

Temp	37.0	°C

NHS GGC Hospitals, Admission Document

NHS Greater Glasgow and Clyde

Affix Label

CHI: 2810666490

Queen Elizabeth University Hospital

Total Att: 2

12 Mth Att: 1

Title: **MR**

MCJURY **Nicholas Dominica**

DOB: **28/10/1966** Age: **58y** Sex: **Male**

FLAT 1/2
820 GOVAN ROAD
Glasgow
Lanarkshire
G51 3UP
01414452395

Next of kin: **ALISON, Martha**
Relationship: **Mother**
07810702648

GP: **RM Mair**
0141 882 4567

Attendance Date: **30/08/2025** Arrival Time: **19:08**

Registration Time: **19:08** Date of Incident: **30/08/2025**

Major Incident Desc:

Reason for Attendance: **standby**

Affix Label

Nursing Assessment

Alerts: **Not Recorded** Allergies: **Not Recorded** Pain Score:

Triage Category: **1** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **30/08/2025 19:14** Nurse name: **Nurse Mart Ryan Llorente**

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

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **medstandby, SOB+++**

Patient ID label

2810666490 28/10/1966
MCJURY
Nicholas Dominica

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

30/08/25

58m PC: sob

hpc: 2/7 hx of feeling generally unwell. Fever, sob, and cough.

No expectorate

Took street valium and pregabalin yesterday

Reports vomited and diarrhoea.

No cp/palpitations

No abdo pain

No urinary symptoms.

No headaches/head injury/limb weakness

Pmh: prev IVDU
prev DVT
alc XS
?undiagnosed COPD.

Dhx: Buprenorphine
rivaroxaban.

allergies: nkda

Shx: lives with mum. vapes, denies alcohol

O/E. SPO2 95% on 60% venturi
RR 25
HR 103
BP 120/70.
T. 38.4

Patient ID label

2810666490 28/10/1966
MCJURY
Nicholas Dominica

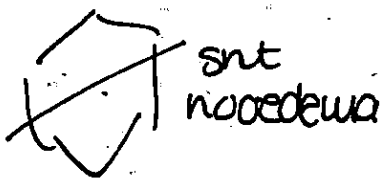
Date	Emergency Department Notes	
	Seen by ~~(Doctor)~~	Time seen

alert. GCS 15 15
PERL
mavingall4limbs.

HS 1+1 1+0
reg pulse
calves nt
no oedema
wnl.

CXR: ↑opacity
Right mid zone
? aspiration

Bloods



Differential Diagnosis/Problem List

? CAP
! aspiration

NEWS ☐ 0-7
RED FLAG ☐ (Tick)
SEPSIS ☐
CURB 65 ☐

Done/ completed	Immediate Managment Plan.
	Bloods + Blood cultures
	ECG
	CXR
	N fluids
	analgesia - given by SAS (paracetamol)
	POCT
	admit.

Signature: Designation: Page No:

GDRUBSCU RMP.

PLEASE DO NOT WRITE HERE

In-Patient Admission Notes

Patient ID label

2810666490 28/10/1966
MCJURY
Nicholas Dominica

Seen By: MACLEAN (STB) Print: Time Seen: 0110 Pg. No: 85823

PRF Reviewed Yes / No

Presenting Complaint(s)	
Presenting complaint	SOB
History of presenting complaint	58 ♂ ED referral Unwell last 1/7 - cough ° haemoptysis - SOB - fever States recently fell down stairs → Ⓡ chest * back pain Recent self d/c ARUI following overdose

Past Medical History / Review of portal
Ex-IVDU Prev DVT Substance misuse - alcohol/pregabalin/street valium

Systemic Enquiry

Patient ID label

MEDICINES RECONCILIATION – Acceptable to staple fully completed Emed Rec

Source of medication history (>1 source preferred)
☑ Patient/Relative/carer ☐ GP Phone call ☑ ECS
☐ Patient own drugs ☐ Com. Pharmacist ☐ GP letter/summary
☐ Repeat Prescription

Other (please specify)

Admission Medicines			Plan for Medicines (Dr complete)				Comments Reason for alteration
Name	Dose	Freq	Continue	Amend	Withhold	Stop	
BUPRENORPHINE							
RIVAROXABAN	20mg	OD					

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

Pharmacy review	Comments

Compliance aid : ☐ Yes ☐ No	Community pharmacist Phone
Reviewed by : Designation : Date :	

Patient ID label

Social History \ Family History

Smoking History

Ex-smoker/(Smoker) ~10 cpd _____ yrs ☐ Never smoked

Alcohol History

_____ Units/week FAST score if excess _____

Previous excess

Recreational Drugs **Driving Status**

Street valium

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

lives w/ mother

General Examination

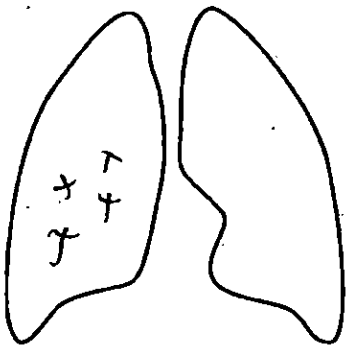
Temp:	RR:
Pulse:	CBG:
SpO_2:	Weight:
BP:	Urinalysis:

General Appearance:

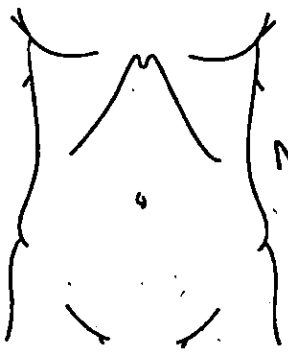
Agitated
disorientated
flushed

Respiratory

Decent AE
Coarse crackles (R) side



Gastrointestinal System



Soft
Non-tender
° masses
BS ✓

Cardiovascular

Pulse ~90 reg
HS 1 + II + 0
Chronic venous changes lower legs

Locomotor

Patient ID label

Neurological system

GCS: 14/15 E: 4/4 M: 6/6 V: 4/5

AMT 4 = age, DOB, place, year

AMT score ____ /4

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

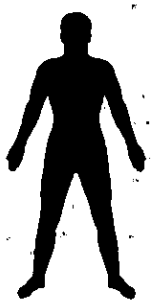
Pupils/fundoscopy:

Cerebellar and extrapyramidal:

Cranial Nerves:

Neck:

Reflexes:



	RUL	LUL	RLL	LLL
Tone				
Power				
Co-ordination				
Sensation				

Plantars: R L

Skin/Other

Patient ID label

Key Results

CXR

Extensive (R) sided consolidation

ECG

SR 79 bpm

(Differential) diagnosis

Severe CAP

- CURB 2
- Septic on arrival

NEWS ☐

Red Flag ☐

Sepsis ☐

CURB 65 ☐

Management Plan

① IV cefo amox + oral clari

② Sputum Cts

③ BCs ✓

④ Check urine legionella Ag

⑤ Accept sats 88-92% (pNBV TCO_2 on gases)

⑥ F/u CXR bl52 - Negv

⑦ BBV screen ⑧ IVF

☐ Thromboprophylaxis assessed ☐ Medicine Reconciliation ☐ 4AT/TIME
☐ Antimicrobial

Signature:

PRINT NAME MACLEAN

PRINT GRADE ST6 Page: 85623

Patient ID label

Resuscitation Decision
Resuscitation status: FOR RESUSCITATION / DNA CPR (please circle)
If DNA CPR → Complete appropriate form

Senior Medical review

☐ Thromboprophylaxis assessed ☐ Medicine Reconciliation ☐ 4AT/TIME
☐ Antimicrobial ☐ DNACPR ☐ AWI if appropriate

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

Patient ID label

Medical patient thromboprophylaxis decision aid – ENSURE BLACK BOX COMPLETED

Is the patient bed-bound or expected to have reduced mobility relative to normal for ≥2 days

☐ Yes ☐ No

Does the patient have any of the following risk factors? Tick if apply

Active cancer or cancer treatment		Use of oestrogen containing contraceptive	
Age> 60		Hormone replacement therapy	
Dehydration		Pregnancy or <6 weeks post partum (seek specialist advice)	
Known thrombophillia		Critical care admission	
BMI >30		Varicose veins with phlebitis	
Personal/1st degree relative history of VTE		Current significant medical condition e.g. infection, inflammation, cardio resp disease	
Hip fracture			

- No thromboprophylaxis
- Reassess (every 72 hours minimum)and document
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)

☐ Yes ☐ No

Does the patient have any of the following contraindications? Tick if apply

Active bleeding		Untreated inherited bleeding disorder	
Acquired bleeding disorder		Thrombocytopaenia <75 x109/l	
Thyroid, spinal, posterior eye or neurosurgery		Other procedure with high bleeding risk (discuss with senior)	
Concurrent use of anticoagulants e.g. warfarin with INR>2		Uncontrolled hypertension (>230/120)	
Acute stroke		Varicose veins	
Recent (<4 hours) or expected (within 12 hours) lumbar puncture, epidural or spinal anaesthetic			
Other - Document			

- Discuss with senior clinical staff regarding thromboprophylaxis
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)
- Consider mechanical prophylaxis unless contraindicated
- Reassess (every 72 hours minimum)and document

☐ No ☐ Yes

Enoxaparin 40mg (reduce to 20mg if weighs < 50kg or eGFR <30)

- Reassess every 72 hours minimum
- Ensure patient informed (see information leaflet)

Patient informed ☐ Yes ☐ N/A
(only n/a if due to cognitive impairment or similar)
If N/A why? _____
Assessed by _____
Date _____

Patient ID label

Results

Date		30/08/25							
Time		1921							
Parameter	Ref Range								
Hb	Male: 130-180 Female: 110-165	125							
WCC	4.0 - 11.0	4.7							
Plts	150 - 450	181							
MCV	80 - 100	92.1							
Neut	2.0 - 7.5	3.8							
PT	9.0 - 13.0								
APFT	27.0 - 38.0								
Fibrinogen	1.7 - 4.0								
INR	( )								
Thromb T	11-15 secs								
D-Dimer	0 - 250								
Na+	133 - 146	138							
K+	3.5 - 5.3	4.2							
Cl-	95 - 108	102							
HCO3-	22 - 29	29							
Urea	2.5 - 7.8	9.8							
Creat	40 - 130	93							
eGFR		>60							
Glucose	3.5 - 6.0								
Protein	60 - 80								
Albumin	35 - 50	33							
AlkP	30 - 130	53							
Bil	<20	22							
ALT	<50	73							
AST	<40	147							
GGT	Male: <70 Female: <40								
ESR	Male: 1 -10 Female: 1 - 12								
CRP	<10	(406)							
Troponin hs I	Male: 0 - 34 Female 0 - 16								
CK	Male: 40 - 230 Female: 25 - 200								
Corr Ca++	2.20 - 2.60								
PO4-	0.8 - 1.5								
Mg++	0.70 - 1.00								
Alcohol									
Paracetamol	<100 @4 hr								
Salicylate									
AST	<40								
Amylase	<100								
LDH	170 - 380								
Folate									
B12	200 - 900								
Ferritin	Male: 20 - 300 Female: 15 - 200								
TSH	0.35 - 5.00								
Free T4	9.0 - 21.0								
Digoxin	0.5 – 2.0								

Patient ID label

Post Take Ward Round IAU/ARU 5

Consultant: Afnason Date: _____ Time: _____

Summary

HAS HAD A COUGH AND FEVER FOR A FEW DAYS BUT ON 29/8/25 TOOK STREET VALIUM THEN COLLAPSED WITH VOMITING

NO KNOWN UNDERLYING LUNG PROBLEMS

NOW REDUCED AIR ENTRY RIGHT LUNG

Temp:	37
Pulse:	88
BP:	165/72
SpO_2:	89%
FiO2:	35%
RR:	14

Diagnosis: DESATURATING

CXR - RIGHT SIDED PNEUMONIC CHANGE

Plan:

CRP > 400

Inv RIGHT SIDED PNEUMONIA PROBABLE ASPIRATION

CONTINUE IV AMOXICILLIN + CLARITHROMYCIN

COVID SWAB

Recommended Destination: GIM

Suitable to board if required ☐ Yes ☐ No

Expected Date of Discharge: 3/9/25

Signature: [signature]

Designation: CMS

Bleep Number: 86146

Pa
2810666490
MCJURY
Nicholas, D M
FLAT 1/2 28/10/1966
820 GOVAN ROAD
Glasgow, Lanarkshire
G51 3UP

Continuation Sheet

Date: Time

13:33
2/9/2025

Jasmine Shuttor - FY1

ATSP re distressed.

Mr. McJury noted that he was given only 8mg of his Espranor ; normal dose 18mg daily. Complained of discomfort & withdrawing. Said that he takes his meds daily from Harmony Row Pharmacy, Govan.

→ Called the pharmacy @ 0141 445 5135 clarified dose & prescribed the right dose. (18 mg OD)

Jf.

2/9/25
10 40.

STS MNCH WR

580→ BG: Prev DVT
Prev IVDU
Alcohol. XS

A/W ®CAP + vomiting

1) ®CAP -
- On IV amox/clari D3.
- CRP 400 WCC 4·7.

Improving - Sats 93% 1L
Afeb.

Plan/ Update bloods.
If CRP ↓ → PO abx.
Wean O_2 as able

GL MNCH
STS.

02/9/28
14:33

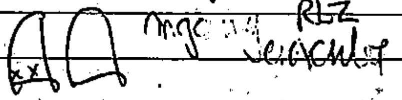
FY1 Jasmine Shuttor

Mr McJury refused bloods today.

Jf

Pat
2810666490
MCJURY M
Nicholas, D 28/10/1966
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire
G51 3UP

Continuation Sheet

Date: Time	
07/09/25	Daily R/V C. Sutherland FY2
	58♂ adm 30/08 w/ (R) CAP
	No updated bloods since admission - pt has refused. Also refusing obs, but now OA and last NEWS (0).
	Today NEWS 0
	Chest improving. Less SOB and R sided chest pain from admission better. Refused bloods again. I explained clinically could IVOST but he says not today.
	
	Plan (1) Bloods + IVOST mane (2) ?H ~~Friday~~ Thursday / Friday
	[signature] FY2
4/9/25 08.25 [illegible]	Pleural [illegible] Cons / As noted Sepsis / Rt CAP / T1 RF
	On Buprenorphine (Hx [illegible] to alcohol & drugs [illegible] years
	SOB on minimal exertion / frequent episodes of overnight expectoration in the community
	Feels "[illegible]" + deconditioned + wobbly on his feet
	SO2 → 88% (A) Rt lung [illegible]
	HS [illegible]
	Abdominal obesity / [illegible] NT.
	Chronic venous insufficiency
	No peripheral oedema →

Patient ID label

Continuation Sheet

Date: Time	
	Plan: IVOST to Amb + Clinic (SH)
	BNP + Echo.
	Rpt FBC U&E CRP Mg PO4 Vasculitis
	screen
	PT + OT
	Refer to respiratory for chronic
	SOB + ?? expediently
	SpO_2 >, 94%.
	TBD likely home.
	CXR in 6 weeks
	HRCT in 2 weeks
	for bronchiectasis
04/09/25	K. Wilson FY1
10:42	- OP High res CT requested for 2/52 on Trakcare.
04/09/25	K. Wilson FY1.
11:23	- Pt refusing bloods as ~~has~~ feels poor access. I explained we can't monitor infection markers etc but pt says happy w/ this + feels he is getting better w/ current treatment - seen improvement in SOB.
	- Plan: NEWS 1
	1) IVOST this morning BP 110/70
	2) Resp ref done O_2 97% RA
	3) High res CT ~~been~~ requested 2/52 HR 78

Patient ID label

Continuation Sheet

Date: Time	
	Update resp on call
04/09/25 13:05	They think this is most appropriate for GP to follow up in 6-8 weeks once acute episode has resolved to perform spirometry. Can get XR organised by hospital to ensure infective resolution in 6-8 weeks post-discharge.
05/09/25 09:30	Daily RIV E. Sutherland FU2
	58♂ adm 30/08 w/ severe CAP IVOSTed abx yesterday - completed 5/7 total
	Has chronic SOB and was not seen GP for this... was for ppt bloods + RNP but patient persistently refusing. Ofw resp as above. More appropriate for GP to follow up once acute episode resolved.
	NEWS 0
	Pt feels well. Cough resolved. Not SOB. Discussed above with him re ongoing plan. In agreement w/ ongoing statement given
	Plan: ① Home ↳ to re-attend GP 6-8 weeks re. long term SOB ↳ High res CT chest as OP 2/12
	FU2
	* Picus cup approx M W F. We will give supply until Monday am, phone community pharmacy to update and put in IPL.

2810666490 28/10/1966
MCJURY
Nicholas Dominica

Nursing Documentation

Done/ Time	

Once only prescriptions (inlcuding tetanus prophylaxis)

Date Given	Drug (Block Capitals)	Dose	Method of administration	Time of administration	Signature	Given by
30/08	amoxicillin	1g	IV	20:10		AM
30/08.	clarithromycin	500mg	PO	20:10		

Discharge prescription packs

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

DISCHARGE CODES: Please Circle				Time Ready to Depart	
1. Admission	2. Discharge	3. Refer to G.P.	4. Transfer to other hospital (see below)		
5. Died	6. Refer to O.P. Clinic (see below)	7. Irregular Discharge	8. D.O.A.	Discharge Time	

Ward No. (If admitted)	Transfer to Hospital	Consultant (if admitted)

Outpatient clinic specialty						Admission or specialty clinic consultant		
Clinic Referred to	AE	OP DVT	DME Falls	TIA	Medical	Surgical	First Seizure	Others Specify

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐ NURSING ☐

Please tick ✔ appropriate directorate

2810666490
MCJURY M
Nicholas, D 28/10/1966
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire
G51 3UP

Date & Time	K. Wilson FYI.	Signature, Print Name & Designation
05/09/25		
10:30	Spoke w/ ward pharmacist re pt buprenorphine px we are unable to dispense buprenorphine - advised give pt today's dose + corrected care pharmacy to make them aware he has had today's. I also was unable to amend ICR so discontinued the primary + resubscribed.	
	- Comm. pharmacy advised no prescription in place.	
	- GP also don't prescribe this - provided me w/ details of drug support worker Patricia Crowes. AIW pharmacy have - Explained to patient we can't supply buprenorphine + trying to get prescription in place.	
	K Wilson	
05/09/25 12:30	K. Wilson FYI.	
	- Phonecall w/ duty worker from Drug Support Team - confirmed pharmacy have correct prescription of buprenorphine + this will be available for pt to collect tomorrow morning. Charge nurse Gillian will phone community team to inform pt.	
		K Wilson

83949 GCC0072

NICHOLAS MCJURY

Scottish Ambulance Service

Age/Gender:	58 Years, 10 Months, 2 Days, Male	**Incident Date:**	30/08/2025 17:54:00
DOB:	28/10/1966	**ePCR Number:**	49-2-300825-175440
Address:	FLAT 1/2 820 GOVAN ROAD LINTHOUSE GLASGOW G51 3UP	**Incident Number:**	CR012389198
CHI Number:	-	**Incident Type:**	EMG
Ethnicity:	White Scottish	**Incident Location:**	FLAT 1/2 820 GOVAN ROAD LINTHOUSE GLASGOW, G51 3UP

PATIENT INFO

Next Of Kin

Forename:	MARTHA	**Surname:**	ALLISON
Telephone Number:	07810702648	**Relationship To Patient:**	Parent

ADDITIONAL COMMENTS

Presenting Complaint:	BREATHING PROBLEMS

Timestamp	Additional Comment	Crew Name
30/08/2025 19:38:00	999 Call for 58yom... HX... Pt has had worsening DIB and increased WOB over last 2 weeks, pt was admitted to hospital 2 weeks ago for an overdose and fluid in lungs- pt self discharged against medical advice before recieving treatment. Pts family state to crew there has been significant decline over last few days- pt has also been falling regularly due worsening mobility, pt states to crew has been taking street valium and pregabalin daily. Crew unable to gain full hx of presenting complaint or pts pmhx due to pt/family not knowing... O/A... Pt lying in bed, cyanosed, mottling on stomach, increased WOB, and appears aggitated, family present... O/E... All obs as noted, GCS-15 throughout but pt very aggitated/not fully compliant. Initial sats 64% on air > 98%- pt desaturating to low 70% off of high flow, pts colour improved after administration of o2. Chest- dull/reduced air entry throughout. Drugs administered as noted... Pre alert accepted to QEUH Resus, uneventful transfer, pt stable on route.	

ACVPU

Options:	Alert

CATASTROPHIC HAEMORRHAGE

Catastrophic Haemorrhage:	No

AIRWAY

Assessment:	Clear

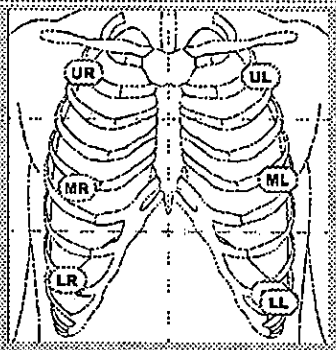
BREATHING

Breathing Adequately:	Yes	**Initial Respiratory Rate:**	28
Initial SpO2:	64	**Initial SpO2 On Air:**	Yes
Oxygen Given:		Yes	

Chest Examination

Chest Signs/Sounds:	Cough

Anterior

Dullness, Normal Breath Sounds, Reduced Air Entry	UR		UL	Dullness, Normal Breath Sounds, Reduced Air Entry
Dullness, Normal Breath Sounds, Reduced Air Entry	MR		ML	Dullness, Normal Breath Sounds, Reduced Air Entry
Dullness, Normal Breath Sounds, Reduced Air Entry	LR		LL	Dullness, Normal Breath Sounds, Reduced Air Entry

CIRCULATION

Pulse Rate:	**114**	**Rhythm:**	**Reg**
Most Distal Pulse Found:	**Radial**	**Cap Refill:**	**<=2 Secs**
Central Peripheral:	**Peripheral**	**Arm:**	**Right**
Systolic Pressure:	**107**	**Diastolic Pressure:**	**75**
ECG:		**3 Lead**	

Rhythm

Rhythm:	**Sinus Tachy**

Skin

Appearance:	**Pale**	**Skin Texture:**	**Sweaty**
Skin Temperature:		**Warm**	

DISABILITY

Initial GCS:

Timestamp	Eyes Value	Eyes Score	Voice Value	Voice Score	Motor Value	Motor Score	Final Score
30/08/2025 19:23:00	Spontaneously	4	Orientated	5	Obeys Commands	6	15

Eyes

Pupils Equal And Reactive To Light (Pearl):	**Yes**

Blood Glucose

Blood Sugar Value (MMOL/L):	**8.8**

OBSERVATIONS

Observations Assessment

Timestamp	Pulse	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	Temp	BM	ECG	P(L) R)	PEF	Crew
30/08/2025 18:14	114	28	107/75	64	<=2 Secs	15	Alert		39.7	8.8	Sinus Tachy			E9881817
30/08/2025 18:24	107	28	131/79	94	<=2 Secs	15	Alert		39.4	8.8	Sinus Tachy			E9881817
30/08/2025 18:44	101	28	116/78	96	<=2 Secs	15	Alert		39.4	8.8	Sinus Tachy			E9881817
30/08/2025 19:05	98	28	112/78	96	<=2 Secs	15	Alert		39.4	8.8	Sinus Tachy			E9881817

GCS

Timestamp	Eyes Value	Eyes Score	Voice Value	Voice Score	Motor Value	Motor Score	Final Score
30/08/2025 18:14	Spontaneously	4	Orientated	5	Obeys Commands	6	15
30/08/2025 18:24	Spontaneously	4	Orientated	5	Obeys Commands	6	15
30/08/2025 18:44	Spontaneously	4	Orientated	5	Obeys Commands	6	15
30/08/2025 19:05	Spontaneously	4	Orientated	5	Obeys Commands	6	15

NEWS Score

Timestamp	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
30/08/2025 18:14	28 (3)	64 (3)	-	0	107 (1)	114 (2)	Alert (0)	39.7 (2)	11
30/08/2025 18:24	28 (3)	94 (1)	-	2	131 (0)	107 (1)	Alert (0)	39.4 (2)	9
30/08/2025 18:44	28 (3)	96 (0)	-	2	116 (0)	101 (1)	Alert (0)	39.4 (2)	8
30/08/2025 19:05	28 (3)	96 (0)	-	2	112 (0)	98 (1)	Alert (0)	39.4 (2)	8

AMPLE

Allergies:	**Unknown**

Overdose

How Many:	**1**	**When:**	**2 WEEKS AGO**

Suicide Attempts

Other:	**Unknown**

Last Eaten

Last Eaten:	**Unknown**

Events Prior

Events Prior:	**SEE ADDITIONAL COMMENTS**

DRUGS

Drugs Table

Timestamp	Drug	Expiry	Quantity	Route	Pain Before	Pain After	Source	Crew
30/08/2025 18:17	Oxygen		15 ltrs	INH			MANUAL	E9881817
30/08/2025 18:40	Paracetamol	02/2028	1 g	OR			MANUAL	E9881817

CLOSE REPORT

Clinical Response Feedback

On-Scene Clinical Findings	**Emergency**

CONVEYANCE

Transport To Hospital	**Emergency Driving**	**Pre-Alert**	**Yes**
Destination Hospital		**QUEEN ELIZABETH UNIVERSITY HOSPITAL**	

INCIDENT INFORMATION

Dispatch

Dispatch Code	**23D03A**	**Dispatch Description**	**Accidental Overdose - Changing colour**

Incident Log

Status Time	Status	Callsign	Reason	Hospital
17:52:25	Call Received Time	GGE5665		
17:52:25	Call Received Time	GGW3203		
17:52:25	Call Received Time	GGE5475		
17:54:50	Mobile	GGE5665		
17:54:58	Mobile	GGE5475		
18:05:06	At Scene	GGE5665		
18:59:00	Leave Scene	GGE5665		QUEEN ELIZABETH UNIVERSITY HOSPITAL
19:03:09	At Hospital	GGE5665		

CREW INFORMATION

Additional Crew

Crew ID	Crew Grade
E9881817	Ambulance Technician (AT)
E9882942	Ambulance Technician (AT)

NICHOLAS MCJURY

Scottish Ambulance Service

Age/Gender:	58 Years, 9 Months, 2 Days	**Incident Date:**	30/07/2025 22:24:00
DOB:	28/10/1966	**ePCR Number:**	56-2-300725-222426
Address:	1/2820 Govan road ,	**Incident Number:**	CR012296989
CHI Number:	2810666490	**Incident Type:**	EMG
Ethnicity:	-	**Incident Location:**	FLAT 21 620 HILLPARK DRIVE NEWLANDS GLASGOW, G43 2PZ

PATIENT INFO

Capacity Assessed

Time Critical Condition - Unable to assess Capacity

ADDITIONAL COMMENTS

Presenting Complaint:	overdose

Timestamp	Additional Comment	Crew Name
30/07/2025 23:32:00	999 call... 58yom... pt has taken a unknown amount of street valium and pregablin... At 2220hrs, pt has had a witnessed, 2 mins seizure, during which he vomited ?haematemesis... pt has then became unresponsive and sister called 999... o/a pt lying on floor, gcs 6 (e1v1m4)... pt cyanosed in colour... O/e all obs as recorded... auscultation chest, gargling to left fields, right fields clear.. ?espiration... ECG, sinus rythmn.. Pupils pinpoint... Administered high flow 02... Administered narcan (im - see drugs)... GCS and obs began to improve...	-
30/07/2025 23:44:00	See further obs during monitoring and transport... Pt prealerted to QEUH	-

ACVPU

Options:	Unresponsive

CATASTROPHIC HAEMORRHAGE

Catastrophic Haemorrhage:	No

AIRWAY

Assessment:	At Risk

Treatment

Treatment Options:	Positioning	**Successful?:**	Yes

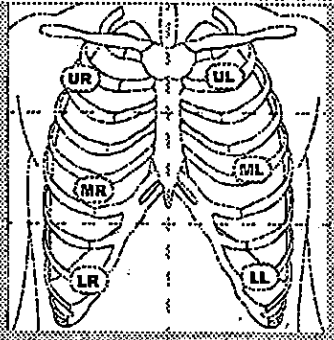
BREATHING

Breathing Adequately:	No	**Initial Respiratory Rate:**	14
Initial SpO2:	83	**Initial SpO2 On Air:**	Yes
Oxygen Given:		Yes	

Chest Examination

Anterior

Normal Breath Sounds, Normal Air Entry	UR	UL	Creps/Crackles, Reduced Air Entry
Normal Breath Sounds, Normal Air Entry	MR	ML	Creps/Crackles, Reduced Air Entry
Normal Breath Sounds, Normal Air Entry	LR	LL	Creps/Crackles, Reduced Air Entry



CIRCULATION

Pulse Rate:	87	**Rhythm:**	Reg
Most Distal Pulse Found:	Radial	**Cap Refill:**	>2 Secs
Central Peripheral:	Peripheral	**Arm:**	Right
Systolic Pressure:	144	**Diastolic Pressure:**	107
ECG:		12 Lead	

Rhythm

Rhythm:	Sinus Rhythm

Skin

Appearance:	Normal	**Skin Texture:**	Dry
Skin Temperature:		Warm	

DISABILITY

Eyes

Left Pupil Size (Mm):	1	**Right Pupil Size (Mm):**	1

Blood Glucose

Blood Sugar Value (MMOL/L):	6.7

OBSERVATIONS

Observations Assessment

Timestamp	Pulse	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	Temp	BM	ECG	P(L | R)	PEF	Crew
30/07/2025 22:35	87	14	144/107	83	>2 Secs	6	Unresponsive		36.3	6.7	Sinus Rhythm	1|1		
30/07/2025 22:48	81	16	136/100	98	>2 Secs	8	Pain				Sinus Rhythm			
30/07/2025 22:55	84	18	144/99	100	>2 Secs	12	Voice							
30/07/2025 23:26	80	17	108/82	99	>2 Secs	13	Acute Confusion				Sinus Rhythm			

GCS

Timestamp	Eyes Value	Eyes Score	Voice Value	Voice Score	Motor Value	Motor Score	Final Score
30/07/2025 22:35	No Response	1	No Response	1	Flexion Withdrawal To Pain	4	6
30/07/2025 22:48	To Pain	2	Incomprehensible Words	2	Flexion Withdrawal To Pain	4	8
30/07/2025 22:55	Spontaneously	4	Inappropriate Words	3	Localised Pain	5	12
30/07/2025 23:26	Spontaneously	4	Inappropriate Words	3	Obeys Commands	6	13

NEWS Score

Timestamp	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
30/07/2025 22:35	14 (0)	83 (3)	-	2	144 (0)	87 (0)	Unresponsive (3)	36.3 (0)	8

AMPLE

Allergies:	None

Medication

Medication:	rivaroxaban

Other

Other:	IVDU

Last Eaten

Last Eaten:	Unknown

THN

Take Home Naloxone Supply

THN Provided To:	Friend/family	**THN Supply:**	First Supply

DRUGS

Drugs Table

Timestamp	Drug	Expiry	Quantity	Route	Pain Before	Pain After	Source	Crew
30/07/2025 22:38	Oxygen		15 ltrs	INH			MANUAL	E9887270
30/07/2025 22:45	Naloxone (Narcan)	11/2026	400 mcg	IM			MANUAL	E9887270
30/07/2025 22:52	Naloxone (Narcan)	11/2026	400 mcg	IM			MANUAL	E9887270

CLOSE REPORT

Clinical Response Feedback

On-Scene Clinical Findings	**Emergency**

CONVEYANCE

Transport To Hospital	**Emergency Driving**	**Pre-Alert**	**Yes**
Destination Hospital		**QUEEN ELIZABETH UNIVERSITY HOSPITAL**	

INCIDENT INFORMATION

Dispatch

Dispatch Code	**23D02A**	**Dispatch Description**	**Accidental Overdose and Unconscious**

Incident Log

Status Time	Status	Callsign	Reason	Hospital
22:22:30	Call Received Time	LVD4655		
22:24:32	Mobile	LVD4655		
22:24:47	Call Received Time	LVD4655		
22:27:30	At Scene	LVD4655		
23:19:35	Leave Scene	LVD4655		QUEEN ELIZABETH UNIVERSITY HOSPITAL

CREW INFORMATION

Additional Crew

Crew ID	Crew Grade
E9887746	
E9887270	

NHS GGC Hospitals, Admission Document

NHS Greater Glasgow and Clyde

Affix Label

CHI: 2810666490

Queen Elizabeth University Hospital

Total Att: 1

12 Mth Att: 0

Title: MR

MCJURY **Nicholas Dominica**

DOB: **28/10/1966** Age: **58y** Sex: **Male**

FLAT 1/2
820 GOVAN ROAD
Glasgow
Lanarkshire
G51 3UP
01414452395

Next of kin: **ALISON, Martha**
Relationship: **Mother**
01414452395

GP: **RM Mair**
0141 882 4567

Rita (Sister)
07713950808

Attendance Date: **30/07/2025** Arrival Time: **23:36**

Registration Time: **23:36** Date of Incident: **30/07/2025**

Major Incident Desc:

Reason for Attendance: **Medical Stand by**

Affix Label

Nursing Assessment

Alerts: **Not Recorded** Allergies: **Not Recorded** Pain Score:

Triage Category: **1** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **30/07/2025 23:40** Nurse name: **Nurse Lucy Weir**

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

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **reduced gcs - taken street valium.**

Patient ID label

Date	Emergency Department Notes	
	Ambulance Proforma reviewed Yes / No Seen by (Doctor) J.LIUST4EM	Time seen
8/7/25	58 o⁷ PRE ALERT PC / ?Seizures HPC / Per PRE SAS - took pregabalin + street valium Heard by ?partner to collapse in bathroom Increased rigidity + ? seizure activity at home W/ SAS - GCS reduced, given 800 mcg naloxone → GCS improved Vomited w/ SAS ? aspiration O/E / A Patent B Fine ole SpO2 80% RA → 4l + NR → 94% C HS heard ECG NKR D GCS E3M6V4 BM E Mottle Abdo distended SNT	

Patient ID label

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen

PMH
IVDU

SH
Previously in England
Previously imprisoned

DH
Rivaroxaban
? stop

Differential Diagnosis/Problem List

Drug toxicity
? Aspiration

NEWS ☐ 0-7
RED FLAG ☐ (Tick)
SEPSIS ☐
CURB 65 ☐

Done/ completed	Immediate Managment Plan
	Bloods
	CXR
	Period of Observation
	Ward Med Reg for floor O/N – to be seen daily
	– Not suitable for ward at present but improving slowly
	– No HDU beds

Signature: Designation: STR Page No:

Printed: 30/07/2025 23:54:00

Patient Sample Report

Status: **ACCEPTED**
Analyzed: 30/07/2025 23:53:48
Sample Type: **Venous**
Sample Number:
Operator ID: SOPHIE BERNKLOW0

Patient

ID:	2810666490
Last Name:	MCJURY
First Name:	NICHOLAS
Gender/Age:	Male, 58 years
Birth Date:	28/10/1966

Cartridge

Lot No.:	250407D
S/N:	00000000501144899
Exp. Date:	10/08/2025

Analyzer

Model:	GEM® *Premier 5000*
Area:	AH_L0ED_B
Name:	ED-MAJ-IN
S/N:	17030619

Results

			Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)						
cH	51.9	nmol/L	[--	–	–	--]
pCO_2	9.0	kPa	[--	–	–	--]
pO_2	6.7	kPa	[--	–	–	--]
Na^+	↓ 132	mmol/L	[--	133	146	--]
K^+	↑ 6.0	mmol/L	[--	3.5	5.3	--]
Cl^-	100	mmol/L	[--	95	108	--]
Ca^{++}	1.17	mmol/L	[--	1.15	1.27	--]
Hct	46	%	[--	–	–	--]
Glu	↑ 7.9	mmol/L	[--	3.5	6.0	--]
Lac	1.3	mmol/L	[--	0.6	2.2	--]
CO-Oximetry						
tHb	146	g/L	[--	–	–	--]
O_2Hb	↓ 74.8	%	[--	95.0	98.0	--]
COHb	↑ 1.6	%	[--	0.5	1.5	--]
MetHb	1.0	%	[--	0.5	1.5	--]
HHb	↑ 22.6	%	[--	0.0	5.0	--]
sO_2	↓ 76.8	%	[--	95.0	98.0	--]
Derived						
BE(B)	2.6	mmol/L	[--	–	–	--]
$HCO_3^-(c)$	31.5	mmol/L	[--	–	–	--]
Hct(c)	44	%	[--	–	–	--]

↑↓ Outside Reference Range

Other Information

Operator Entered		
Temp	37.0	°C

Printed: 31/07/2025 03:07:46

Patient Sample Report

Status: **ACCEPTED**
Analyzed: 31/07/2025 03:07:32
Sample Type: **Arterial**
Sample Number:
Operator ID: GEMMA DAVIDSON0

Patient

ID:	2810666490
Last Name:	MCJURY
First Name:	NICHOLAS
Gender/Age:	Male, 58 years
Birth Date:	28/10/1966

Cartridge

Lot No.:	250407D
S/N:	00000000501144899
Exp. Date:	10/08/2025

Analyzer

Model:	GEM® *Premier 5000*
Area:	AH_L0ED_B
Name:	ED-MAJ-IN
S/N:	17030619

Results

			Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)						
cH	↑ 46.9	nmol/L	[--	36.0	44.0	--]
pCO_2	↑ 7.1	kPa	[--	4.6	6.0	--]
pO_2	↓ 9.7	kPa	[--	10.5	14.0	--]
Na^+	↓ 131	mmol/L	[--	133	146	--]
K^+	5.0	mmol/L	[--	3.4	6.0	--]
Cl^-	101	mmol/L	[--	95	108	--]
Ca^{++}	1.18	mmol/L	[--	1.15	1.27	--]
Hct	46	%	[--	–	–	--]
Glu	↑ 7.7	mmol/L	[--	3.5	6.0	--]
Lac	0.9	mmol/L	[--	0.6	2.2	--]
CO-Oximetry						
tHb	144	g/L	[--	–	–	--]
O_2Hb	↓ 92.8	%	[--	95.0	98.0	--]
COHb	1.5	%	[--	0.5	1.5	--]
MetHb	1.2	%	[--	0.5	1.5	--]
HHb	4.4	%	[--	0.0	5.0	--]
sO_2	95.5	%	[--	95.0	98.0	--]
Derived						
BE(B)	0.9	mmol/L	[--	–	–	--]
$HCO_3^-(c)$	27.9	mmol/L	[--	–	–	--]
Hct(c)	43	%	[--	–	–	--]

↑↓ Outside Reference Range

Other Information

Operator Entered		
Temp	37.0	°C

In-Patient Admission Notes

2810666490
MCJURY
Nichols, D
28/10/1966
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire
G51 3UF

Seen By: Beth Burrus FY2 Print:
31/07
Time Seen: 1120 Pg. No:
PRF Reviewed Yes / No

Presenting Complaint(s)	
Presenting complaint	? Seizures
History of presenting complaint	(58♂) ~~[illegible]~~ Took pregabalin + street valium. Found collapsed in bathroom by partner With SAS, GCS ↓, naloxone 800mg given. Further 400mg in A+E. Unable to get much history Will review later + call partner. 1300 – BBURRUS Nicholas self discharged while Drs away at lunch. Refused to wait Signed self discharge paper.

Past Medical History / Review of portal
Alcohol XS Prev [illegible]IVDU Prev DVT Letter from psych reports MRI in Southampton that may show lung cancer.

Systemic Enquiry

2810666490
MCJURY
Nicholas, D 28/10/1961
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire
G51 3UF

MEDICINES RECONCILIATION – Acceptable to staple fully completed Emed Rec

Source of medication history (>1 source preferred)
☐ Patient/Relative/carer ☐ GP Phone call ☐ ECS
☐ Patient own drugs ☐ Com. Pharmacist ☐ GP letter/summary
☐ Repeat Prescription

Other (please specify)

Admission Medicines			Plan for Medicines (Dr complete)				Comments Reason for alteration
Name	Dose	Freq	Continue	Amend	Withhold	Stop	

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

Pharmacy review	Comments
Compliance aid : ☐ Yes ☐ No	Community pharmacist Phone
Reviewed by : Designation :	Date :

Patient ID label

Social History \ Family History

Smoking History

Ex-smoker/Smoker _____ cpd _____ yrs ☐ Never smoked

Alcohol History

_____ Units/week FAST score if excess _____

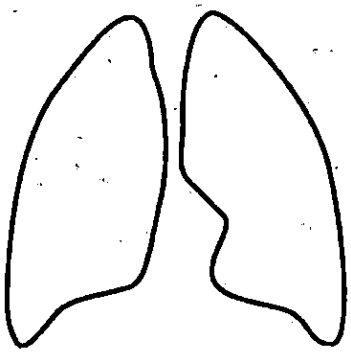
Recreational Drugs **Driving Status**

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

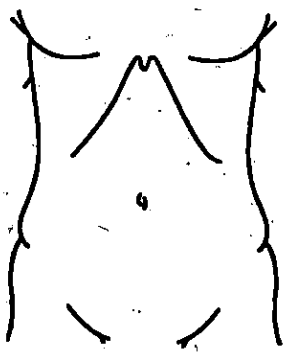
General Examination	
Temp:	RR:
Pulse:	CBG:
SpO_2:	Weight:
BP:	Urinalysis:

General Appearance:

Respiratory



Gastrointestinal System



Cardiovascular

Locomotor

Patient ID label

Neurological system

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

AMT 4 = age, DOB, place, year

AMT score ____ /4

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

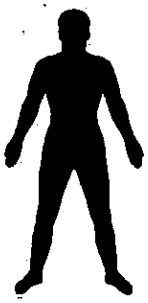
Pupils/fundoscopy:

Cerebellar and extrapyramidal:

Cranial Nerves:

Neck:

Reflexes:



	RUL	LUL	RLL	LLL
Tone				
Power				
Co-ordination				
Sensation				

Plantars: R L

Skin/Other

2810666490
MCJURY M
Nicholas, D 28/10/1966
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire
G51 3UP

Key Results

CXR

nil acute

ECG

(Differential) diagnosis

NEWS ☐

Red Flag ☐

Sepsis ☐

CURB 65 ☐

Management Plan

☐ Thromboprophylaxis assessed ☐ Medicine Reconciliation ☐ 4AT/TIME
☐ Antimicrobial

Signature: PRINT NAME

PRINT GRADE Page:

Patient ID label

Resuscitation Decision
Resuscitation status: FOR RESUSCITATION / DNA CPR **(please circle)**
If DNA CPR → Complete appropriate form

Senior Medical review

☐ Thromboprophylaxis assessed	☐ Medicine Reconciliation	☐ 4AT/TIME
☐ Antimicrobial	☐ DNACPR	☐ AWI if appropriate

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

Patient ID label

Medical patient thromboprophylaxis decision aid – ENSURE BLACK BOX COMPLETED

Is the patient bed-bound or expected to have reduced mobility relative to normal for ≥2 days

☐ Yes

☐ No

- No thromboprophylaxis
- Reassess (every 72 hours minimum)and document
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)

Does the patient have any of the following risk factors? Tick if apply			
Active cancer or cancer treatment		Use of oestrogen containing contraceptive	
Age> 60		Hormone replacement therapy	
Dehydration		Pregnancy or <6 weeks post partum (seek specialist advice)	
Known thrombophillia		Critical care admission	
BMI >30		Varicose veins with phlebitis	
Personal/1st degree relative history of VTE		Current significant medical condition e.g. infection, inflammation, cardio resp disease	
Hip fracture			

☐ Yes

☐ No

Does the patient have any of the following contraindications? Tick if apply			
Active bleeding		Untreated inherited bleeding disorder	
Acquired bleeding disorder		Thrombocytopaenia <75 x109/l	
Thyroid, spinal, posterior eye or neurosurgery		Other procedure with high bleeding risk (discuss with senior)	
Concurrent use of anticoagulants e.g. warfarin with INR>2		Uncontrolled hypertension (>230/120)	
Acute stroke		Varicose veins	
Recent (<4 hours) or expected (within 12 hours) lumbar puncture, epidural or spinal anaesthetic			
Other - Document			

- Discuss with senior clinical staff regarding thromboprophylaxis
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)
- Consider mechanical prophylaxis unless contraindicated
- Reassess (every 72 hours minimum)and document

☐ No

☐ Yes

Enoxaparin 40mg (reduce to 20mg if weighs < 50kg or eGFR <30)

- Reassess every 72 hours minimum
- Ensure patient informed (see information leaflet)

Patient informed ☐ Yes ☐ N/A
(only n/a if due to cognitive impairment or similar)
If N/A why? _____
Assessed by _____
Date _____

Results

Date / Time									
Parameter	Ref Range								
Hb	Male: 130-180 Female: 110-165								
WCC	4.0 - 11.0								
Plts	150 - 450								
MCV	80 - 100								
Neut	2.0 - 7.5								
PT	9.0 - 13.0								
APTT	27.0 - 38.0								
Fibrinogen	1.7 - 4.0								
INR	( )								
Thromb T	11-15 secs								
D-Dimer	0 - 250								
Na+	133 - 146								
K+	3.5 - 5.3								
Cl-	95 - 108								
HCO3-	22 - 29								
Urea	2.5 - 7.8								
Creat	40 - 130								
eGFR									
Glucose	3.5 - 6.0								
Protein	60 - 80								
Albumin	35 - 50								
AlkP	30 - 130								
Bil	<20								
ALT	<50								
AST	<40								
GGT	Male: <70 Female: <40								
ESR	Male: 1 -10 Female: 1 - 12								
CRP	<10								
Troponin hs I	Male: 0 - 34 Female 0 - 16								
CK	Male: 40 - 230 Female: 25 - 200								
Corr Ca++	2.20 - 2.60								
PO4-	0.8 - 1.5								
Mg++	0.70 - 1.00								
Alcohol									
Paracetamol	<100 @4 hr								
Salicylate									
AST	<40								
Amylase	<100								
LDH	170 - 380								
Folate									
B12	200 - 900								
Ferritin	Male: 20 - 300 Female: 15 - 200								
TSH	0.35 - 5.00								
Free T4	9.0 - 21.0								
Digoxin	0.5 – 2.0								

2810666490
MCJURY M
Nicholas, D 28/10/1966
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire
G51 3UP

Post Take Ward Round IAU/ARU

Consultant: _____ Date: _____ Time: _____

Summary

Temp:

Pulse:

BP:

SpO_2:

FiO2:

RR:

Diagnosis:

Plan:

Recommended Destination: _____

Suitable to board if required ☐ Yes ☐ No

Expected Date of Discharge: _____

Signature: _____

Designation: _____

Bleep Number: _____

Patient ID label

Continuation Sheet

Date: Time

31/7
0852

SIS Norton

RV GCS 15 - SOBearing + angry

States no hisby of COPD
↳ Sig. Wheezy + emphysema on Previous CT

ABG Ht 43.9
CO_2 6.7 (no O_2)
pO_2 8.2

CXR - Nil focal

Imp/ likely underlying COPD

Plan/ Neb
Pred
Mg

Sats 88-92%

Patient ID label

Continuation Sheet	
Date: Time	

Patient ID label

Continuation Sheet

Date: Time

Printed: 31/07/2025 08:49:23

Patient Sample Report

Status: **ACCEPTED**
Analyzed: 31/07/2025 08:49:11
Sample Type: **Arterial**
Sample Number:
Operator ID: DEBORAH MAIR1

Patient

ID:	2810666490
Last Name:	MCJURY
First Name:	NICHOLAS
Gender/Age:	Male, 58 years
Birth Date:	28/10/1966

Cartridge

Lot No.:	250407D
S/N:	00000000501144899
Exp. Date:	10/08/2025

Analyzer

Model:	GEM® *Premier 5000*
Area:	AH_L0ED_B
Name:	ED-MAJ-IN
S/N:	17030619

Results

			Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)						
cH	43.9	nmol/L	--	36.0	44.0	--
pCO_2	↑ 6.7	kPa	--	4.6	6.0	--
pO_2	↓ 8.2	kPa	--	10.5	14.0	--
Na^+	↓ 129	mmol/L	--	133	146	--
K^+	5.2	mmol/L	--	3.4	6.0	--
Cl^-	100	mmol/L	--	95	108	--
Ca^{++}	1.17	mmol/L	--	1.15	1.27	--
Hct	45	%	--	--	--	--
Glu	↑ 7.4	mmol/L	--	3.5	6.0	--
Lac	1.2	mmol/L	--	0.6	2.2	--
CO-Oximetry						
tHb	142	g/L	--	--	--	--
O_2Hb	↓ 91.8	%	--	95.0	98.0	--
COHb	↑ 1.6	%	--	0.5	1.5	--
MetHb	1.2	%	--	0.5	1.5	--
HHb	↑ 5.5	%	--	0.0	5.0	--
sO_2	↓ 94.3	%	--	95.0	98.0	--
Derived						
BE(B)	1.8	mmol/L	--	--	--	--
HCO_3^-(c)	28.2	mmol/L	--	--	--	--
Hct(c)	43	%	--	--	--	--

↑↓ Outside Reference Range

Other Information

Operator Entered

Temp	37.0	°C

Patient ID label

Continuation Sheet	
Date: Time	

Patient ID label

2810566490
MCJURY
Nicholas, D
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire
28/10/196[illegible]
G51 3U[illegible]

Nursing Documentation

Done/ Time	

Once only prescriptions (inlcuding tetanus prophylaxis)

Date Given	Drug (Block Capitals)	Dose	Method of administration	Time of administration	Signature	Given by
	SALBUTAMOL / IPRATROPIUM	5mg/500 mcg	NEB	00:30		VS
	NALOXONE	400mcg	IV	0500		
31/7	Salbutamol / Ipratropium	5/500mcg	NEB			
	Magnesium Sulfate	2g	IV	0745		
	~~Prednisolone~~	~~40mg~~	~~PO~~			
	Hydrocortisone	100mg	IV	0950		

Discharge prescription packs

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

DISCHARGE CODES: Please Circle

1. Admission 2. Discharge 3. Refer to G.P. 4. Transfer to other hospital (see below)
5. Died 6. Refer to O.P. Clinic (see below) 7. Irregular Discharge 8. D.O.A.

Time Ready to Depart	
Discharge Time	

Ward No. (If admitted)	Transfer to Hospital	Consultant (if admitted)

Outpatient clinic specialty						Admission or specialty clinic consultant		
Clinic Referred to	AE	OP DVT	DME Falls	TIA	Medical	Surgical	First Seizure	Others Specify

QEUH EMERGENCY DEPARTMENT STANDBY NOTIFICATION / HANDOVER

NHS Greater Glasgow and Clyde

Date 30/7/25 Time 2325

Crew Radio Callsign

Initial notes patient sticker

Age 58 M/F

2nd other info

RR	Sat's	HR	BP	GCS	Temp	BM
14	82% on RA 98% on 15L	87	144/107	6 ↓ 12	36.3	6.7

Time of Onset HH:MM

Transport road / air* EMRS? Y/N *Helicopter transfers to QEUH roof? call 19342, activate helipad, note time of call. HH:MM

Mechanism OD Sheet valium/pregabalin

Main complaint 2 min seizure → vomiting

Injuries

Information 800 mcg Naloxone

Signs

Symptoms

FAST +ve? CHI? (name/DoB?)

Treatment given

Time to arrival

ETA HH:MM 14

further information e.g. instructions to crew

Further Cascade

	tick	Time of call
Code Red 2222		
Trauma Call 2222		
Stroke Team 83234		

ICU 83081
ENT 82782/Switch OOHs
Vascular 82758/Switch OOHs

	tick	Time of call

IAU 82338
PAEDS ED 84055 / 84585
Helipad Activation 19342
Ambulance Airdesk 0141 810 6110
Ambulance Control 0141 510 6106

Seen by

Resus consultant

Circle resus interventions below

Pre Hospital | Trauma Call | EMRS | Code Red | Major Incident | Verbal

Central Line	Arterial Line	Inotropes	RSI	CPR	Thrombolysis (Stroke)
Intubated No Drugs	Chest drain	Blood	TXA	CT	Manipulation Reduction
USS	Biers Block	NOF Block	Sedation	NIV	PLE

2810666490 28/10/1966
MCJURY
Nicholas Dominica

NHS
Greater Glasgow and Clyde

Hospital QEUH

I hereby certify that I am being discharged from this hospital on my own responsibility.

Signed N. M Jury

Witness S/N

I hereby agree to relieve the Health Board of all responsibility in connection with the discharge of ..... from hospital.

Signed.....

Relationship.....

Address .....

Witness .....

Note: A permanent form of writing instrument should be used in completing this form.

STY5017N

Care Rounds Checklist

Date: 4/9/25

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

1. Signed [signature] Name [signature] Designation [illegible]
2. Signed [signature] Name KETH TWICKY Designation JN
3. Signed ______ Name ______ Designation ______

2810666490
MCJURY
Nicholas, D 28/10/196
FLAT 1/2
820 GOVAN ROAD
Glasgow, Lanarkshire
G51 3UI

NHS Greater Glasgow and Clyde

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

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

		Times	00 00	02 55	04 50	07 00	08 20	11 50	12 20	16 30	20 10									
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N	N	N	N									
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N	N	N	N									
S	3	**SKIN INSPECTION** Pressure areas checked:	S	NT	I	I	I	Y	Y	NT	NT									
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	/	/	/	/	N	INT	INT	–	/									
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y	Y	Y	Y	Y									
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	B	B	L	B	S,Y	Ch	L/H	SIV	B									
		Chair Assist to walk or stand (W/ST)	/	/	W	/	\	W/ST	/	–	/									
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	BOHG	BoHle	ETU	BOHS	I	Bot	I	I	I									
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N	N	N	N									
		Drink taken?	I	Y	Y	I	I	Y	I	Y	Y									
		Food, snack, or supplement taken?	I	I	/	I	I	Y	I	Y	I									
		Has oral hygiene been carried out as per care plan?		I	/	I	I	Y	I	N										
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y	Y	Y	Y									
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	/	NT	NT	N	NT	NT	NT									
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	ne	ne	/	ne	NA	NA	NA	NA	ne									
		Care provider / role	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]									

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GGC0098

VIRTUAL FRACTURE CLINIC

Patient Name: 2810666490 MCJURY Nicholas M 28/10/1966
Address: Flat 2/1 820 Govan Road Glasgow
CHI: G51 3UP

CLINIC DATE: 26/2/23

CONSULTANT: Mr Spence

DATE OF INJURY:

Contact No.

CLINICAL ASSESSMENT

MECHANISM OF INJURY:

PROVISIONAL DIAGNOSIS:

CONSULTANT DIAGNOSIS:
L midshaft clav # (Q1) - in plaster
Rem England

TREATMENT PLAN:
Con 1/52

CONSULTANT'S SIGNATURE:

OUTCOME

VIRTUAL DISCHARGE: ☐ RETURN APPOINTMENT: ☐ QEUH ☐ ~~WACH~~ ☐ VACH ☐

1 wk ☑ 2 wks ☐ 3 wks ☐ 4 wks ☐ 5 wks ☐ 6 wks ☐

GENERIC FRACTURE CLINIC: ☐ *SPECIALTY FRACTURE CLINIC: ☐ NURSE-LEAD DRESSING/ PLASTER CLINIC: ☐ PHYSIO REFERRAL: ☐

*SPECIFY SPECIALTY:

FOLLOW UP APPOINTMENT DATE & TIME: Monday 6 March 2pm Con & Cling QEUH

PATIENT CONTACTED - APPOINTMENT & TIME CONFIRMED? YES ☑ ~~NO~~ ☐ VOICEMAIL MESSAGE? ☐

APPOINTMENT TO BE CONFIRMED BY LETTER? YES ☐ ~~NO~~ ☐

AUTHORISATION

NURSE: (please print)	S. Buchanan	DESIGNATION:	Sister
SIGNATURE:	S Buchanan	DATE:	27/2/23

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

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

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

Date Completed: 02/09/2025

Consultant: Dr Andrew Saunders

RM Mair
Dr Mair & Partners
1600-1604 Paisley Road West
Ibrox
Glasgow
Glasgow
G52 3QN

Dear RM Mair

Re: **McJury Nicholas Dominica** DOB: **28/10/1966** CHI: **2810666490**
FLAT 1/2
Glasgow G51 3UP

Attended on: **30/08/2025 at 19:08 hrs.** Departed on: **30/08/2025 at 21:31 hrs.**
Discharge Type: **02 - Admitted** Destination: **Admission to this Hospital**
Previous ED Attendance in last 12 months: **1**

Presenting complaint
standby

Nursing Assessment:
medstandby, SOB+++

Investigations in ED:

1. XR Chest
2. Urea and Electrolytes
3. Bicarbonate
4. LFT
5. Glucose
6. CRP
7. Full Blood Count
8. Coagulation screen
9. Sample in Blood Culture Bottles
10. Lactate

Diagnosis:

Diagnosis	Side	Site
Unspecified Acute Lower Respiratory Infection		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:
Admitted

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

Yours sincerely,
Gemma Davidson
Nurse

Copies to:
1. RM Mair (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

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

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 25/02/2023

Consultant: Dr Malcolm Gordon

BS Chita
Drs Chita & Hayes
Ibroxholm Medical Centre
532 Paisley Road West
Glasgow
Glasgow
G51 1RN

Dear BS Chita

Re: **McJury Nicholas** DOB: **28/10/1966** CHI: **2810666490**
Flat 2/1
Glasgow G51 3UP

Attended on: **25/02/2023 at 15:33 hrs.** Departed on: **at hrs.**
Discharge Type: **01c - Discharge with referral** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
Right arm injury - Plaster put on in southampton

Nursing Assessment:
Plaster cast in situ for #wrist. Under care of Southampton general- no documentation from hospital. States cast has been in place for 2/52- right wrist.

Investigations in ED:
1. XR Radius and ulna Rt

Diagnosis:

Diagnosis	Side	Site
Closed Fracture of Upper End of Ulna		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:

pt attended miu today just returned from southhampton states was assaulted 2/62 previous has plaster cast on right arm, xray shows # to mid shaft ulna. nv intact. referral to virtual # clinic

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Jill Gillian Curran
Nurse

Copies to:

1. BS Chita (GP)

School Address:

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF
Main Switchboard: 0141 201 1100
Department: Endocrinology Osteoporosis
Contact Tel: 0141 451 6097
Enquiries to: ggc.endoosteonursesqeuh@ggc.scot.nhs.uk
Letter Date: 11/09/2024
Reference: KJ/LP
Dictated Date: 10/09/2024
Transcribed Date: 10/09/2024

Dr. RM Mair
Dr Mair & Partners
1600-1604 Paisley Road West
Ibrox
Glasgow
G52 3QN

Dear Dr,

Nicholas McJury; D.O.B: 28/10/1966; CHI: 2810666490
FLAT 1/2, 820 GOVAN ROAD, Glasgow, Lanarkshire, G51 3UP

This patient did not attend for their DXA appointment. Due to pressure on our service I have not offered a further appointment. Should they wish to attend in the future please refer them via the DADS patient pathway.

Sister Kay Johnstone

Clinical Nurse Specialist

Electronically Signed: Nurse Kay Johnstone, Nurse Practitioner

cc. kj

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

Dr. RM Mair
Dr Mair & Partners
1600-1604 Paisley Road West
Ibrox
Glasgow
G52 3QN

Main Switchboard:	0141 201 1100
Department:	Respiratory
Contact Tel:	0141 451 6159
Enquiries to:	Liz Porteous
Letter Date:	19/06/2023
Reference:	EM/LP
Dictated Date:	12/06/2023
Transcribed Date:	13/06/2023

Dear Dr Mair,

Nicholas McJury; D.O.B: 28/10/1966; CHI: 2810666490
FLAT 1/2, 820 GOVAN ROAD, Glasgow, Lanarkshire, G51 3UP

I have been informed this gentleman, who is currently on the waiting list for an urgent respiratory appointment, failed to attend for a CT thorax on 28 May 2023 and the request has been discontinued.

We will keep him on the waiting list for review at clinic and take things from there.

Yours sincerely

DR EVELYN MILLAR
Consultant in Respiratory Medicine

Electronically Signed: Dr Evelyn Millar, Consultant

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF
0141 201 1100

Dr. RM Mair
Dr Mair & Partners
1600-1604 Paisley Road West
Ibrox
Glasgow
G52 3QN

Main Switchboard:	
Department:	Respiratory
Contact Tel:	0141 451 6159
Enquiries to:	Liz Porteous
Letter Date:	16/08/2023
Reference:	EM/LP
Dictated Date:	15/08/2023
Transcribed Date:	16/08/2023

Dear Dr. RM Mair,

Nicholas McJury; D.O.B: 28 Oct 1966; CHI: 2810666490
FLAT 1/2, 820 GOVAN ROAD, Glasgow, Lanarkshire, G51 3UP

Attendance: Specialty - Respiratory Medicine; Clinic - SUEMRE5-DR MILLAR CHEST WEDNESDAY AM
Date and Time of Appointment - 16/08/2023 10:30

Clinical Comments:
I tried to call this gentleman on 15 August, in lieu of his scheduled clinic appointment. I phoned the landline (there was no mobile number supplied) and his mother answered. She informed me he is in prison in England, which is probably why he did not attend for a CT which we had organized. She would not disclose anything further and said he is likely to be away for some time and was under the impression he had a scan in England.

I will take him off our waiting list.

Yours sincerely

DR EVELYN MILLAR
Consultant in Respiratory Medicine

Electronically Signed: Dr Evelyn Millar, Consultant

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF
0141 201 1100

Dr. RM Mair
Dr Mair & Partners
1600-1604 Paisley Road West
Ibrox
Glasgow
G52 3QN

Main Switchboard:	
Department:	Trauma & Orthopaedics
Contact Tel:	
Enquiries to:	
Letter Date:	06/03/2023
Reference:	MK/GG
Dictated Date:	08/03/2023
Transcribed Date:	09/03/2023

Dear Dr. RM Mair,

Nicholas McJury; D.O.B: 28 Oct 1966; CHI: 2810666490
FLAT 1/2, 820 GOVAN ROAD, Glasgow, Lanarkshire, G51 3UP

Attendance: Specialty - Orthopaedics ; Clinic - SUOROR2-QEUH GENERIC ORTHO FRACTURE CLINIC
Date and Time of Appointment - 06/03/2023 14:00

Clinical Comments:
Diagnosis: Fracture right dominant midshaft ulna.

Date of Injury: Approximately eight weeks' ago.

Treatment: Conservative.

Your patient was reviewed today in the clinic. He sustained this injury whilst in Southampton approximately two months' ago. He was treated in a cast. He attended the Emergency Department on 25/02/2023.

On examination today out of cast, he has a good range of pronation and supination and this is pain free. He is ever so slightly tender over the fracture on stressing it, otherwise his arm is neurovascularly intact and reasonably functional.

Plan: I said he can stay out of the cast so long as he is sensible. I will review him in six weeks' time and get a further x-ray just to check this has gone on to heal.

Yours sincerely

Mr Michael Kelly

Consultant Orthopaedic Surgeon

Electronically Signed: Mr Michael Kelly, Consultant

cc.

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
Fracture Liaison Service
0141 451 6097

Consultants
Dr A Gallagher & Dr M Talla

Osteoporosis Nurse Specialists
Kay Johnstone, Angela Collie, Margaret French, Mayrine Fraser and Leigh Robertson

CHI: 2810666490

01 Mar 2023

Regarding Nicholas McJury, born 28 Oct 1966 (CHI 2810666490)

Dear Dr,

Your patient has been assessed for osteoporosis / fracture risk on **01 Mar 2023** following presentation to hospital with a fracture. This fracture was identified from a radiology report or medical records and this patient has not been seen in person by the Fracture Liaison Service. A report from this assessment is attached.

An appointment for full assessment by the Fracture Liaison Service, including DXA scan, will be now arranged.

Follow up

A DXA scan will be scheduled for your patient

Yours sincerely,

Kay Johnstone
Osteoporosis Nurse Specialist

Assessment report

Date:	01 Mar 2023
Fracture history:	Radius/Ulna (Right) (aged 56)
Risk factors:	Previous fragility fracture
Recommended treatment:	None
Recommended investigations:	None
Future DXA Scans: *(to be arranged by GP)*	To be decided based on outcome of patient's next steps
Recommended lifestyle changes:	None
Comments:	This patient's fracture history was obtained through radiology or virtual fracture clinic reports; they have not been seen in person by the fracture liaison service.

CHI: 2810666490

Department of Trauma & Orthopaedics
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

Appointments: **0141 347 8347**
Fracture Clinic: **0141 452 2908**

Virtual Fracture Clinic

Clinic Date: 26/02/2023
Typed: 28/02/2023

Dr BS Chita
Drs Chita and Hayes
Ibroxholm Medical Centre
532 Paisley Road West
Glasgow
G51 1RN

Dear Dr Chita

Mr Nicholas McJury ~ DOB: 28/10/1966 ~ CHI:2810666490;
Flat 2/1 820 Govan Road Glasgow G51 3UP

Your patient was recently followed up at the Virtual Fracture Clinic at Queen Elizabeth University Hospital. The following details were recorded:

Bodily site:	Left As follows: left mid shaft ulnar fracture (old) - in plaster from England
Injury Type:	Fracture
Management plan:	Fracture clinic
Patient contacted	Phone
Site:	QEUH
Outcome:	# Clinic
Nurses notes:	Nurse present at Virtual Fracture Clinic: 27/02/2023 15:55 Susan Buchanan Patient has a plaster from England in situ and to remain in same until being reviewed on Monday 6th March, 2pm, Generic # Clinic, at the QEUH. Contacted patient's partner today and the above was discussed. Pain relief and elevation also discussed. Appointment letter in post today. Patient will attend the above appointment.

Yours Sincerely,

Mr Simon Spencer
Consultant Orthopaedic Surgeon

Final Discharge Letter

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF
0141 201 1100

Dr. M Simpson
Yellow Practice
Govan Health Centre
5 Drumoyne Road
Glasgow
G51 4BJ

Main Switchboard:	
Department:	General Medicine
Contact Tel:	0141 451 6181
Enquiries to:	
Letter Date:	18/11/2025
Reference:	PK/GT
Dictated Date:	29/10/2025
Transcribed Date:	30/10/2025

Dear Dr. M Simpson,

Nicholas Dominica McJury; D.O.B: 28/10/1966; CHI: 2810666490
FLAT 1/2, 820 GOVAN ROAD, Glasgow, Lanarkshire, G51 3UP

Admission: Specialty - General Medicine; Ward - QEUH Ward 6A Short Stay
Consultant - Dr Petros Karsaliakos; Date of Admission - 30/08/2025
Date of Discharge - 05/09/2025; Discharged to - Private Residence - no additional detail added

Clinical Comments:
FDL for the IDL of the 5th September 2025

I have reviewed the IDL and the contents are accurate. There is a chest x-ray in 6 weeks' time and a CT thorax in 2 months' time pending for this gentleman in the community.

Yours sincerely,

Petros Karsaliakos

Consultant General Medicine

Electronically Signed: Dr Petros Karsaliakos, Consultant

cc.

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No
Consent for Sharing Withheld: No

ROBERT MAIRDr Mair & Partners,1600-1604 Paisley Road West,Ibrox, Glasgow, G52 3QN

Main Switchboard:
Date of Completion: 05-Sep-2025

Dear ROBERT MAIR,

Name	CHI	DoB	Address
Nicholas McJury	**2810666490**	**28-Oct-1966**	**FLAT 1/2, 820 GOVAN ROAD, Glasgow, Lanarkshire, G51 3UP**

Admitted	Type	Discharged	Destination
30-Aug-2025 21:31	IP	05-Sep-2025	

Specialty	Consultant	Ward	Telephone
General Medicine	Karsaliakos	QEUH Ward 6A Short Stay	

Primary Diagnosis
Community acquired pneumonia (SNOMED Code: 385093006)

Secondary Diagnosis
There is no data to display.

Significant Operations / Procedures:
There is no data to display.

Last Discharge Review: Keryn Wilson (Keryn Wilson - FY1) on 05 Sep 2025 10:13

Discharge Medication:

Active Drug Name	Route	Dose	Disp	Reason	Further Details	ECS	Since Admission
Buprenorphine 2mg oral lyophilisates sugar free	oral	1 tablet once daily in the morning	No	Community Pharmacist to Supply	**Drug Details:** Total daily dose: 18mg mane		Added Amended
Buprenorphine 8mg oral lyophilisates sugar free	oral	2 tablets once daily in the morning	No	Community Pharmacist to Supply			Added Amended
Rivaroxaban 20mg tablets	oral	1 tablet once daily	No	Patient's own drugs at home			Added

"Added" means this medicine was added to the Clinical Portal record after admission. It does not necessarily mean this medicine was started by the hospital.

Dispensing Comments
There is no data to display.

Withheld Medication:

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

Stopped Medication:

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

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

Clinical Comments:	Dear Doctor, Nicholas McJury was admitted to QEUH on 30/08/25 with a 2/7 history of fever, shortness of breath and cough. Impression: Community acquired pneumonia. Investigations: CXR- Right sided consolidation Bloods on admission:

	CRP 406 WCC 4.7 Neutrophils 3.8 Lactate 2.7 Hb 125 AST 147 ALT 73 ALP 52 Mr McJury was treated with 5/7 antibiotics. Please note we were unable to monitior his bloods as patient refused repeat bloods multiple times. We had hoped to do a BNP. He is now clinically improving- cough has resolved and improving SOB. Worsening advice given. Mr McJury also reported chronic shortness of breath on exertion and frequent episodes of purulent sputum in the community. We discussed with respiratory who felt GP follow up in 6-8 weeks is most appropriate and we have informed Mr McJury of this. We have also arranged a follow up CXR in 6 weeks and high resolution CT in 2/12. Plan: 1. GP please follow up ongoing chronic symptoms 2. OP CXR 6/52 3. OP High res CT 2/12 Many thanks for your ongoing care, Ward 6a QEUH
Discharge Comments:	
Follow Up:	Yes GP to follow up
Results Awaited:	Yes CXR 6/52 HRCT 2/12
Pharmacist Comments:	

Final Discharge Letter to Follow:	Yes

Yours sincerely,

Keryn WILSON

Prescription Review
Checked by: Keryn WILSON (FY1)
Discharged by: Keryn WILSON (FY1)

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No
Consent for Sharing Withheld: No

ROBERT MAIRDr Mair & Partners,1600-1604 Paisley Road West,Ibrox, Glasgow, G52 3QN

Main Switchboard:
Date of Completion: 31-Jul-2025

Dear ROBERT MAIR,

Name	CHI	DoB	Address
Nicholas McJury	**2810666490**	**28-Oct-1966**	**FLAT 1/2, 820 GOVAN ROAD, Glasgow, Lanarkshire, G51 3UP**

Admitted	Type	Discharged	Destination
31-Jul-2025 10:44	IP	31-Jul-2025	

Specialty	Consultant	Ward	Telephone
Respiratory Medicine	Thomson	QEUH ARU1 Respiratory	

Primary Diagnosis
There is no data to display.

Secondary Diagnosis
There is no data to display.

Significant Operations / Procedures:
There is no data to display.

Last Discharge Review: Benjamin Clarke (Benjamin Clarke - FY1) on 31 Jul 2025 13:06

Discharge Medication:

Active Drug Name	Route	Dose	Disp	Reason	Further Details	ECS	Since Admission
There is no data to display.							

"Added" means this medicine was added to the Clinical Portal record after admission. It does not necessarily mean this medicine was started by the hospital.

Dispensing Comments
There is no data to display.

Withheld Medication:

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

Stopped Medication:

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

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

Clinical Comments:	Dear Doctor, Nicholas McJury was admitted to the QEUH on the 31/7/25 due to possible seizures in the community. He was noted to have collapsed at home following taking pregabalin and street Valium. Initially with a reduced GCS he was taken by the SAS to hospital. Upon arrival it was felt he possibly had a LRTI and a collapse secondary to drug misuse. He then proceeded to, against medical advice, sign himself out of hospital. He had the capacity to make this decision. Many thanks for your ongoing care ARU1
Discharge Comments:	
Follow Up:	No
Results Awaited:	No
Pharmacist Comments:	

Final Discharge Letter to Follow:	Yes

Yours sincerely,

Benjamin CLARKE

Prescription Review
Discharged by: Benjamin CLARKE (FY1)

Letter to Patient:

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

Nicholas McJury
FLAT 1/2
820 GOVAN ROAD
Glasgow
Lanarkshire
G51 3UP

Main Switchboard:	0141 201 1100
Department:	General Medicine
Contact Tel:	0141 451 6181
Enquiries to:	georgia.thomson@nhs.scot
Letter Date:	18/11/2025
Reference:	PK/GT
Dictated Date:	01/11/2025
Transcribed Date:	05/11/2025

Dear Mr McJury,

This letter is to inform you that to my understanding you did not attend your CT scan of chest appointment on the 16th October 2025 in Queen Elizabeth University Hospital. In case you want this to be rebooked please contact us on 0141 451 6181 and this will be rebooked for you.

Yours sincerely,

Petros Karsaliakos

Consultant General Medicine

Electronically Signed: Dr Petros Karsaliakos, Consultant

cc.

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
Fracture Liaison Service
0141 451 6097

Consultants
Dr A Gallagher & Dr M Talla

Osteoporosis Nurse Specialists
Kay Johnstone, Angela Collie,
Margaret French, Mayrine Fraser
and Leigh Robertson

CHI: 2810666490

01 Mar 2023

Nicholas McJury
Flat 2/1
820 Govan Road
Glasgow
G51 3UP

Dear Mr Nicholas McJury,

We recommend a bone density (DXA) scan to people over the age of 50 who have had a fragility fracture. In due course, you will receive an appointment for a bone density (DXA) scan. The scan tells us if you have a higher risk of more fractures due to osteoporosis (reduced bone strength).

Your appointment will take around 30 minutes. It is not unpleasant and does not involve going into a 'tunnel'. Instead you will be asked to lie on a flat x-ray table while a machine measures your hip and back using very small doses of x-rays.

After your scan we will inform you and your GP of your results and, if necessary, recommend treatment to reduce your risk of future fractures by strengthening your bones.

For more information and advice:

- Visit the Royal Osteoporosis Society (ROS) website theros.org.uk
- Read about new osteoporosis diagnoses: http://theros.org.uk/information-and-support/osteoporosis/newly-diagnosed/
- Email nurses@theros.gov.uk
- Freephone ROS: 0808 800 0035
- Contact our Osteoporosis Specialist Nurses directly on 0141 451 6097

If you do not want a DXA scan, or if the scheduled appointment is unsuitable, please contact us on 0141 451 6097.

Yours sincerely,

Kay Johnstone
Osteoporosis Nurse Specialist

CHI: 2810666490

Assessment report

Date:	01 Mar 2023
Fracture history:	Radius/Ulna (Right) (aged 56)
Risk factors:	Previous fragility fracture
Recommended treatment:	None
Recommended investigations:	None
Future DXA Scans: *(to be arranged by GP)*	To be decided based on outcome of patient's next steps
Recommended lifestyle changes:	None
Comments:	

Follow up

A DXA scan will be scheduled for you

CHI: 2810666490

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Gastroenterology GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Queen Elizabeth University Hospital 1345 Govan Road Glasgow G51 4TF	——	**Hospital** and **hospital address** Hospital location code. G405H Email address

Urgency of referral Urgent
Date of referral 19-Jun-2026 **Date sent** 19-Jun-2026

PATIENT DETAILS

Surname	MCJURY
Forename(s)	NICHOLAS
Title	MR
Sex	Male
Date of birth	28-Oct-1966
CHI no.	2810666490
Area of Residence	

Patient's address

FLAT 1-2
820 GOVAN ROAD
GLASGOW
G51 3UP

Contact number(s)

Voice: 0141 445 2395
Voice: 07881377871

101040323681Y

Unique Care Pathway Number: 101040323681Y

REGISTERED GP DETAILS

Name	Dr Marianne Simpson		
GMC code	4414588	GP code	03441
Practice name	Yellow Practice		
Practice code	52330		

Practice address

GOVAN HEALTH CENTRE
5 DRUMOYNE ROAD
GLASGOW
G51 4BJ

Contact number(s)

Voice: 04145318490

REFERRING GP DETAILS

Name	Dr. Robert Shaw		
GMC code	6071667	GP code	05487
Practice name	Yellow Practice (52330)		
Practice code	52330		

Practice address

Govan Health Centre
5 Drumoyne Road
Glasgow
G51 4BJ

Contact number(s)

Voice: 0141 531 8490

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: ?cirrhotic liver disease ?beginning to decompensate

Comment: Dear Team

This gentleman presents in a rather unusual situation in that he informs me it is universally impossible to obtain blood samples and has been for decades other than via using central venous access.

He presents today with a 2 month deterioration in his general wellbeing alongside the new development of puffy hands, face and increasing chronic lower limb oedema.

On examination I suspect he is ascitic.

He looks pale.

There is a history of polysubstance use ongoing until relatively recently. I understand there is a history of hepatitis C with evidence of clearance (I do not know if this was spontaneous or following treatment) but it does not appear to me that there has been any form of assessment of his liver either by USS or Fibroscan at any point.

My suspicion here is that he has undiagnosed cirrhotic liver disease and is in the early stages of decompensation.

I appreciate it is highly unusual for such a referral to be made without blood test results but I am unsure what else to do other than to ask that he be seen at your clinic as soon as is practicable.

Many thanks
Bob Shaw
GP Partner

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

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

Description	Comment	Date of onset	Date recorded
Community acquired pneumonia	(Right)	05-Sep-2025	05-Sep-2025
[D]Collapse	secondary to overdose street valium/pregabalin	31-Jul-2025	31-Jul-2025
Injecting drug user	Intravenous drug user	17-May-2023	17-May-2023
[X] Reactive depression NOS	-	17-May-2023	17-May-2023
Heroin dependence	-	17-May-2023	17-May-2023
Long-term drug misuser	-	17-Apr-2023	17-Apr-2023
Fracture of ulna NOS	Closed fracture of Upper End of Ulna	25-Feb-2023	25-Feb-2023
[D]Pulmonary nodule	-	15-Jan-2023	15-Jan-2023
Suicidal ideation	-	29-Nov-2022	29-Nov-2022
Chronic viral hepatitis C	-	27-Jul-2016	27-Jul-2016
Cellulitis of leg	-	27-Jul-2016	27-Jul-2016
Myoneural disorder NOS	[YEAR OF EVENT 2016]	01-Jan-2016	01-Jan-2016
Acute rheumatic fever	[YEAR OF EVENT 2016]	01-Jan-2016	01-Jan-2016
Acute kidney injury stage 3	[YEAR OF EVENT 2016]	01-Jan-2016	01-Jan-2016
Fracture of nasal bones	manipulated under local anaesthesia	26-Jul-2015	26-Jul-2015
[V]Hepatitis C carrier	-	08-Apr-2012	08-Apr-2012
Upper respiratory tract infection NOS	-	08-Oct-2010	08-Oct-2010
Pleural effusion NOS	-	06-Aug-2010	06-Aug-2010
Cellulitis of leg	-	09-Jan-2009	09-Jan-2009
Deep vein phlebitis and thrombophlebitis of the leg	-	24-Feb-2006	24-Feb-2006
[X] Reactive depression NOS	-	20-May-2005	20-May-2005

H/O: Deep Vein Thrombosis	-	27-Jan-2003	27-Jan-2003
H/O: Deep Vein Thrombosis	[YEAR OF EVENT 2002]	01-Jan-2002	01-Jan-2002
H/O: Bell's palsy	[YEAR OF EVENT 1992]	01-Jan-1992	01-Jan-1992

Past procedures (High and medium priority - all)

Description	Date performed	Date recorded
Drug addiction detoxification therapy - methadone	17-May-2023	17-May-2023
Haemodialysis NEC	19-Jul-2016	19-Jul-2016

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Rivaroxaban 20mg tablets	28	tablet	1 Tab Daily	-	05-Jan-2026	01-Jun-2026
Buprenorphine 8mg oral lyophilisates sugar free	0.001	tablet	20MG DAILY - SUPPLIED BY ADRS	-	05-Jan-2026	05-Jan-2026

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Pregabalin 150mg capsules	56	capsule	1 TWICE A DAY	-	02-Jun-2026	02-Jun-2026
Co-codamol 30mg/500mg tablets	112	tablet	2 TWICE A DAY	-	02-Jun-2026	02-Jun-2026
Co-codamol 30mg/500mg tablets	112	tablet	2 TWICE A DAY	-	29-Apr-2026	29-Apr-2026
Pregabalin 150mg capsules	56	capsule	1 TWICE A DAY	-	30-Mar-2026	30-Mar-2026
Co-codamol 30mg/500mg tablets	112	tablet	2 TWICE A DAY	-	30-Mar-2026	30-Mar-2026
Co-codamol 30mg/500mg tablets	112	tablet	2 TWICE A DAY	-	02-Mar-2026	02-Mar-2026
Pregabalin 150mg capsules	56	capsule	1 TWICE A DAY	-	02-Mar-2026	02-Mar-2026
Co-codamol 30mg/500mg tablets	112	tablet	2 TWICE A DAY	-	30-Jan-2026	30-Jan-2026
Pregabalin 150mg capsules	56	capsule	1 TWICE A DAY	-	30-Jan-2026	30-Jan-2026
Co-codamol 30mg/500mg tablets	112	tablet	2 TWICE A DAY	-	05-Jan-2026	05-Jan-2026
Pregabalin 150mg capsules	56	capsule	1 TWICE A DAY	-	05-Jan-2026	05-Jan-2026
Rivaroxaban 20mg tablets	28	tablet	1 Tab Daily	-	05-Jan-2026	05-Jan-2026

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

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

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Respiratory Medicine GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Queen Elizabeth University Hospital 1345 Govan Road Glasgow G51 4TF	——	**Hospital** and **hospital address** Hospital location code. G405H Email address

Urgency of referral Routine
Date of referral 15-Mar-2023 **Date sent** 15-Mar-2023

PATIENT DETAILS

Surname	McJury
Forename(s)	Nicholas
Title	Mr
Sex	Male
Date of birth	28-Oct-1966
CHI no.	2810666490
Area of Residence	-

Patient's address

1-2
820 Govan Road
Glasgow
Glasgow
G51 3UP

Contact number(s)

Voice: 445 2395

101029035137K

Unique Care Pathway Number: 101029035137K

REGISTERED GP DETAILS

Name	Dr Robert Mair		
GMC code	3257623	GP code	01821
Practice name	Dr Mair & Partners (18967)		
Practice code	52241		

Practice address

1600 Paisley Road West
Cardonald
Glasgow
G52 3QN

Contact number(s)

Voice: 0141 882 4567
Facsimile: 0141 342 3448

REFERRING GP DETAILS

Name	Dr Louise Pettigrew		
GMC code	4321273	GP code	02178
Practice name	Dr Mair & Partners (18967)		
Practice code	52241		

Practice address

1600 Paisley Road West
Cardonald
Glasgow
G52 3QN

Contact number(s)

Voice: 0141 882 4567

Facsimile: 0141 342 3448

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: irregular nodule righ tlung

Comment: Many thanks for seeing this 56 year old man who had a CT thorax in Southampton in January following an assault. This showed widespread emphysematous changes and an irregular 11mm nodule in the right lower lobe, further review was recommended. He ha s now moved back to Glasgow. He has a significant past medical history including PE and opiate misuse

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

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

No current medications recorded

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Pregabalin Capsules 300 mg	56	56 capsule	ONE TO BE TAKEN TWICE A DAY	-	27-Feb-2023	27-Feb-2023
Tramadol Hydrochloride Capsules 50 mg	112	112 capsule	ONE TO BE TAKEN FOUR TIMES A DAY	-	27-Feb-2023	27-Feb-2023
Rivaroxaban Tablets 20 mg	28	28 tablet	1 Tab Daily	-	27-Feb-2023	27-Feb-2023

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

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

Referred By:Referring GP

Electronic Attachment Present:No

Social circumstances

Ethnic Origin: (White) Scottish

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

Patient name: .....

Date of birth: 28/10/1966 .....

CHI No 2810666490 MCJURY Nicholas Dominica .....

Affix potient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg) ..... Height (cm) .....

Prescription details									Administration details				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments
31/08	0140	HARTMANNS	500	IV	4°		[signature]		31/08/20	3	CH		25E08TMC 04/2027
31/08		HARTMANNS	500	IV	4°		[signature]		31/08	10 20	CB		
31/08		HARTMANNS	500	IV	4°		[signature]		31/08	18 40	CB		

*Prescriber should sign this box if the fluid/additive is no longer required.

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow (drops/min) = Volume of fluid (ml) x 20 / Duration of admin (min)

NB: 1ml = 20 drops (for a standard giving set)

Example:

500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

Patient name:.....

Date of birth:.....

CHI No:.....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details - continued									Administration details - continued				
Date	Time	Name of fluid Name of additive	Volume (ml) Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments

*Prescriber should sign this box if the fluid/additive is no longer required.

Inpatient prescription & administration record for Nicholas Dominica McJury (2810666490) Admission: 30/08/2025 => 05/09/2025

00:01
08/09/25

Patient Demographics

MCJURY Nicholas Dominica (2810666490)
DOB: 28/10/1966
Flat 1/2, 820 Govan Road,
Glasgow,
Lanarksh,
G51 3UP

Admitted: 30/08/2025 21:41
Discharged: 05/09/2025 12:54

Transfer history

Admission	2025-08-30 19:08:00	QED QEUH ED
Transfer	2025-08-30 21:41:00	QARU5 QEUH ARU5
Transfer	2025-09-01 10:00:00	Q6AS QE 6A SSW

Responsible Consultant history

Assigned No Consultant	30/08/25	21:41
Durga Ghosh	01/09/25	10:00
Petros Karsaliakos	05/09/25	11:52

Allergy

Admission Allergy Check performed by: Alexander Maclellan
Current recorded allergy (reaction): No Known Drug Allergies

AMOXICILLIN 500 mg Capsules

☒ 04/09/25 12:00 500 mg THREE times daily - 7am;12pm;10pm (Oral) — Keryn Wilson

04/09/25	12:00	04/09/2025	13:03	Beth Tinlay
04/09/25	22:00	04/09/2025	21:56	Jasmine McConnell

AMOXICILLIN 1000 mg (1g) Injection

☒ 31/08/25 07:00 1,000 mg THREE TIMES DAILY 7am:12pm:10pm (Intravenous Slow Bolus Injection) — Alexander Maclellan

31/08/25	07:00	31/08/2025	06:31	Jade Dee Duffy/ Eva Maclean
31/08/25	12:00	31/08/2025	12:09	Cindy Bilog/ Daniel McConville
31/08/25	22:00	31/08/2025	21:45	Aoife Burke/ Abosede Hellen Ninalowo
01/09/25	07:00	01/09/2025	06:25	Jade Dee Duffy/ Abosede Hellen Ninalowo
01/09/25	12:00	01/09/2025	13:37	Beth Tinlay/ Jaspreet Kaur
01/09/25	22:00	01/09/2025	22:16	Jasmine McConnell/ Gillian Milligan
02/09/25	07:00	02/09/2025	06:19	Jasmine McConnell/ Zeus Kelso
02/09/25	12:00	02/09/2025	12:32	Stephen McBrearty/ Mistura Yusuf
02/09/25	22:00	02/09/2025	22:36	Jasmine McConnell/ Zeus Kelso
03/09/25	07:00	03/09/2025	06:18	Gillian Milligan/ Zeus Kelso
03/09/25	12:00	03/09/2025	12:47	Stephen McBrearty/ Olamide Ogunniran
03/09/25	22:00	03/09/2025	22:00	Jasmine McConnell/ Zeus Kelso
04/09/25	07:00	04/09/2025	06:36	Zeus Kelso/ Jasmine McConnell

Discontinued on: 04/09/2025 10:17:00 by: Keryn Wilson . Reason: Formulation/Route Change

Buprenorphine lyophilisate (Espranor) 2 mg Sublingual Tablet

☒ 01/09/25 14:59 2 mg every 24 HOURS (Oral) — Nurul Shukor

01/09/25	14:59			Beth Tinlay	Other - see patient nursing notes

☒ 02/09/25 10:00 2 mg ONCE daily at 10am (Oral) — Nurul Shukor

02/09/25	10:00	02/09/2025	09:19	Stephen McBrearty/ Rhona Cameron
03/09/25	10:00	03/09/2025	09:28	Stephen McBrearty/ Nikki Hynd
04/09/25	10:00	04/09/2025	09:29	Beth Tinlay/ Stephen McBrearty
05/09/25	10:00	05/09/2025	09:45	Allison Carrick/ Olamide Ogunniran

☒ 01/09/25 15:11 2 mg (Oral) — Nurul Shukor

01/09/25	15:11	01/09/2025	15:16	Beth Tinlay/ Mistura Yusuf

Buprenorphine lyophilisate (Espranor) 8 mg Sublingual Tablet

☒ 31/08/25 10:05 16 mg (Oral) — Andrew Fraser

31/08/25	10:05	31/08/2025	10:13	Cindy Bilog/ Laura Anderson

☒ 01/09/25 08:45 8 mg (Oral) — Kevin Creavin

01/09/25	08:45	01/09/2025	08:47	Chloe Lafferty/ Celine McLaughlin

Key: Prescription details | Recorded as "Admitted On" | Prescribed as "Self Administer" | Discontinuation details | HEPMA Prescription additional notes | HEPMA Patient admission notes (admission specific) | HEPMA Patient retained notes (not specific to admission)

Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, NHS Ayrshire & Arran and NHS Greater Glasgow & Clyde

HEPMA MAP v1.0

Buprenorphine lyophilisate (Espranor) 8 mg Sublingual Tablet *(Continued)*

☒ 01/09/25 14:58 16 mg every 24 HOURS (Oral) Nurul Shukor

01/09/25	14:58			Beth Tinlay	Other - see patient nursing notes

☒ 02/09/25 10:00 16 mg ONCE daily at 10am (Oral) Nurul Shukor

02/09/25	10:00	02/09/2025	09:19	Stephen McBrearty/ Rhona Cameron
03/09/25	10:00	03/09/2025	09:28	Stephen McBrearty/ Nikki Hynd
04/09/25	10:00	04/09/2025	09:29	Beth Tinlay/ Stephen McBrearty
05/09/25	10:00	05/09/2025	09:45	Allison Carrick/ Olamide Ogunniran

☒ 01/09/25 15:10 8 mg (Oral) Nurul Shukor

01/09/25	15:10	01/09/2025	15:16	Beth Tinlay/ Mistura Yusuf

CLARITHROMYCIN 500 mg Tablets

☒ 31/08/25 07:00 500 mg TWICE daily at 7am and 10pm (Oral) Alexander Maclellan

31/08/25	07:00	31/08/2025	09:12	Cindy Bilog
31/08/25	22:00	31/08/2025	21:15	Jade Dee Duffy
01/09/25	07:00	01/09/2025	07:48	Chloe Lafferty/ Celine McLaughlin
01/09/25	22:00	01/09/2025	21:19	Jasmine McConnell
02/09/25	07:00	02/09/2025	09:22	Stephen McBrearty
02/09/25	22:00	02/09/2025	21:37	Jasmine McConnell
03/09/25	07:00	03/09/2025	08:29	Stephen McBrearty
03/09/25	22:00	03/09/2025	21:19	Jasmine McConnell
04/09/25	07:00	04/09/2025	08:21	Beth Tinlay

04/09/25 22:00 500 mg TWICE daily at 7am and 10pm (Oral) Keryn Wilson

04/09/25	22:00	04/09/2025	21:56	Jasmine McConnell

Naproxen 500 mg Enteric Coated Tablets

☒ 31/08/25 17:00 500 mg TWICE daily at 7am and 5pm (Oral) Andrew Fraser

31/08/25	17:00	31/08/2025	16:29	Cindy Bilog
01/09/25	07:00	01/09/2025	07:51	Chloe Lafferty/ Celine McLaughlin
01/09/25	17:00	01/09/2025	17:41	Beth Tinlay
02/09/25	07:00	02/09/2025	09:21	Stephen McBrearty
02/09/25	17:00	02/09/2025	16:53	Stephen McBrearty
03/09/25	07:00	03/09/2025	08:28	Stephen McBrearty
03/09/25	17:00	03/09/2025	16:44	Stephen McBrearty
04/09/25	07:00	04/09/2025	08:22	Beth Tinlay
04/09/25	17:00	04/09/2025	17:37	Beth Tinlay
05/09/25	07:00	05/09/2025	08:31	Allison Carrick

☒ 31/08/25 09:57 500 mg (Oral) Andrew Fraser

31/08/25	09:57	31/08/2025	10:15	Cindy Bilog

Paracetamol 500 mg Tablets

☒ 31/08/25 07:00 1,000 mg FOUR times daily - 7am;12pm;5pm;10pm (Oral) Alexander Maclellan

31/08/25	07:00	31/08/2025	09:10	Cindy Bilog	
31/08/25	12:00			Cindy Bilog	Refused by Patient
31/08/25	17:00	31/08/2025	16:29	Cindy Bilog	
31/08/25	22:00	31/08/2025	21:15	Jade Dee Duffy	
01/09/25	07:00	01/09/2025	07:48	Chloe Lafferty/ Celine McLaughlin	
01/09/25	12:00	01/09/2025	13:05	Beth Tinlay	
01/09/25	17:00	01/09/2025	17:39	Beth Tinlay	
01/09/25	22:00	01/09/2025	21:19	Jasmine McConnell	
02/09/25	07:00	02/09/2025	09:22	Stephen McBrearty	
02/09/25	12:00	02/09/2025	12:06	Stephen McBrearty	
02/09/25	17:00	02/09/2025	16:53	Stephen McBrearty	
02/09/25	22:00	02/09/2025	21:26	Jasmine McConnell	
03/09/25	07:00	03/09/2025	08:29	Stephen McBrearty	
03/09/25	12:00	03/09/2025	12:32	Stephen McBrearty	
03/09/25	17:00	03/09/2025	16:44	Stephen McBrearty	
03/09/25	22:00	03/09/2025	21:19	Jasmine McConnell	
04/09/25	07:00	04/09/2025	08:21	Beth Tinlay	
04/09/25	12:00	04/09/2025	13:03	Beth Tinlay	
04/09/25	17:00	04/09/2025	17:36	Beth Tinlay	
04/09/25	22:00	04/09/2025	21:56	Jasmine McConnell	
05/09/25	07:00	05/09/2025	08:30	Allison Carrick	
05/09/25	12:00	05/09/2025	12:41	Allison Carrick	

Rivaroxaban 20 mg Tablets

Rivaroxaban 20 mg Tablets *(Continued)*

☒ 31/08/25 07:00 20 mg ONCE DAILY MORNING 7am (Oral) Alexander Maclellan

31/08/25	07:00	31/08/2025	09:09	Cindy Bilog	
01/09/25	07:00	01/09/2025	07:47	Chloe Lafferty/ Celine McLaughlin	
02/09/25	07:00			Stephen McBrearty	Drug unavailable
03/09/25	07:00	03/09/2025	08:29	Stephen McBrearty	
04/09/25	07:00	04/09/2025	08:18	Beth Tinlay	
05/09/25	07:00	05/09/2025	08:30	Allison Carrick	

Salbutamol 5 mg in 2.5mL Nebuliser Solution

☒ 31/08/25 07:00 5 mg FOUR TIMES DAILY 7am:12pm:5pm:10pm (Nebulised) Alexander Maclellan

31/08/25	07:00	31/08/2025	09:15	Cindy Bilog	
31/08/25	12:00	31/08/2025	12:09	Cindy Bilog	
31/08/25	17:00	31/08/2025	16:29	Cindy Bilog	
31/08/25	22:00	31/08/2025	21:18	Jade Dee Duffy	
01/09/25	07:00	01/09/2025	07:50	Chloe Lafferty/ Celine McLaughlin	
01/09/25	12:00	01/09/2025	13:06	Beth Tinlay	
01/09/25	17:00	01/09/2025	17:39	Beth Tinlay	
01/09/25	22:00			Jasmine McConnell	Refused by Patient
02/09/25	07:00	02/09/2025	09:21	Stephen McBrearty	
02/09/25	12:00	02/09/2025	12:06	Stephen McBrearty	
02/09/25	17:00	02/09/2025	16:53	Stephen McBrearty	
02/09/25	22:00	02/09/2025	21:37	Jasmine McConnell	
03/09/25	07:00	03/09/2025	08:28	Stephen McBrearty	
03/09/25	12:00	03/09/2025	12:32	Stephen McBrearty	
03/09/25	17:00	03/09/2025	16:44	Stephen McBrearty	
03/09/25	22:00	03/09/2025	21:19	Jasmine McConnell	
04/09/25	07:00	04/09/2025	08:21	Beth Tinlay	
04/09/25	12:00	04/09/2025	13:03	Beth Tinlay	
04/09/25	17:00	04/09/2025	17:37	Beth Tinlay	
04/09/25	22:00	04/09/2025	21:56	Jasmine McConnell	
05/09/25	07:00			Allison Carrick	Refused by Patient
05/09/25	12:00	05/09/2025	12:41	Allison Carrick	

Dihydrocodeine 30 mg Tablets as required

☒ 01/09/25 02:38 30 mg FOUR TIMES DAILY 7am:12pm:5pm:10pm (Oral) FOR PAIN Kevin Creavin

30.00	01/09/2025	02:43	Jade Dee Duffy	

Key: Prescription details | Recorded as "Admitted On" | Prescribed as "Self Administer" | Discontinuation details | HEPMA Prescription additional notes | HEPMA Patient admission notes (admission specific) | HEPMA Patient retained notes (not specific to admission)

Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, NHS Ayrshire & Arran and NHS Greater Glasgow & Clyde

HEPMA MAP v1.0

McJury, Nicholas ID:2810666490 30-JUL-2025 23:46:04 GREATER GLASGOW SITE-QEED ROUTINE RECORD

28-OCT-1966 (58 yr)
Male

Room:
Loc:1301

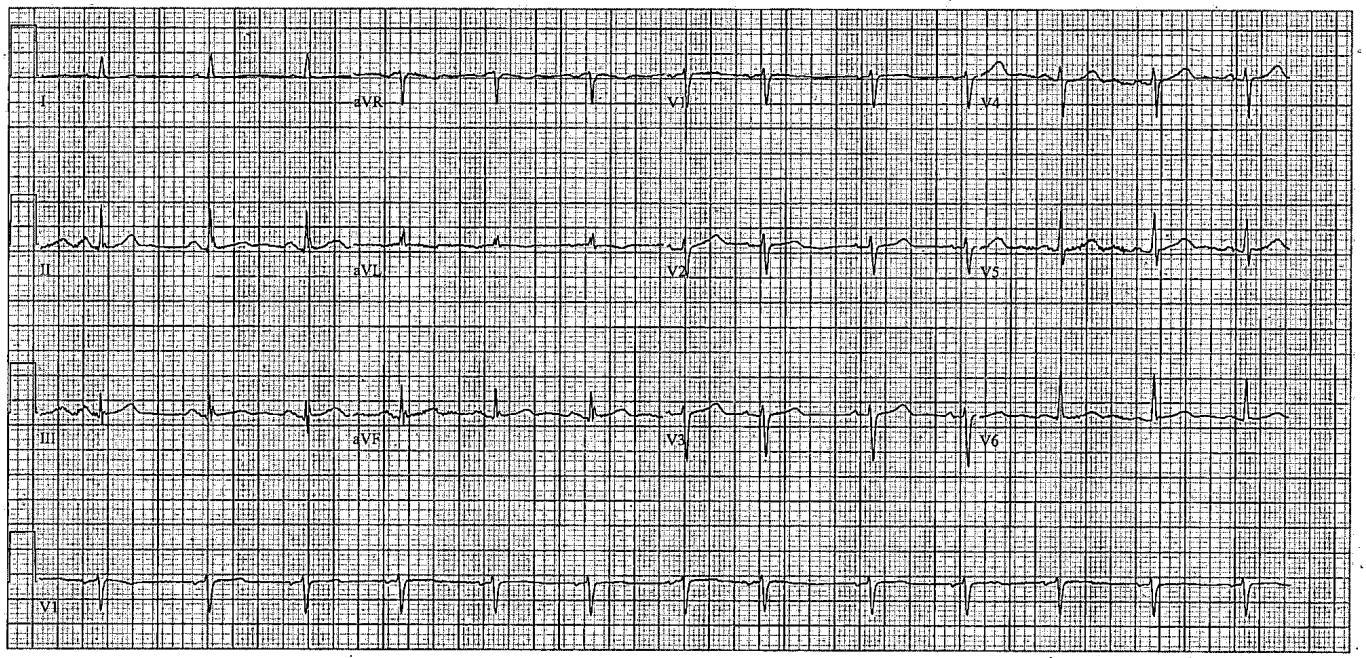
Vent. rate	79	BPM
PR interval	140	ms
QRS duration	78	ms
QT/QTc	376/431	ms
P-R-T axes	76 49	80

Sinus rhythm with premature atrial complexes
Otherwise normal ECG

Technician: soriba
Test ind:

Unconfirmed

Comments:



25mm/s 10mm/mV 100Hz 9.0.10 12SL 243 CID: 1036

SID: 3064115 EID:13 EDT: ORDER:

McJury, Nicholas ID:2810666490 30-JUL-2025 23:44:55 GREATER GLASGOW SITE-QEED ROUTINE RECORD

28-OCT-1966 (58 yr)
Male

Room:
Loc:1301

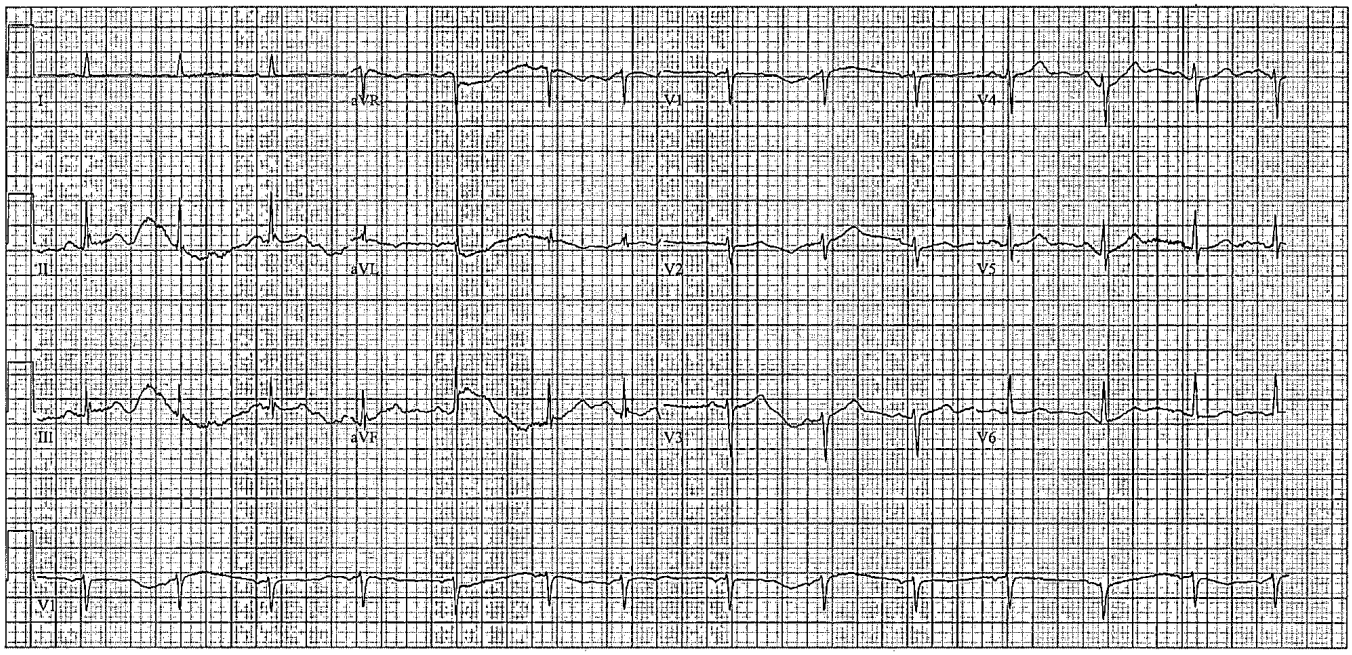
Vent. rate	82	BPM
PR interval	140	ms
QRS duration	72	ms
QT/QTc	374/436	ms
P-R-T axes	81 57	72

Sinus rhythm with premature atrial complexes
Anterior infarct , age undetermined
Abnormal ECG

Technician: soriba
Test ind:

Unconfirmed

Comments:



25mm/s 10mm/mV 100Hz 9.0.10 12SL 243 CID: 1036

SID: 3064115 EID:13 EDT: ORDER:

McJury, Nicholas
Male
28.10.1966 (58 Years)

Location: 1301

Technician ID: soriba

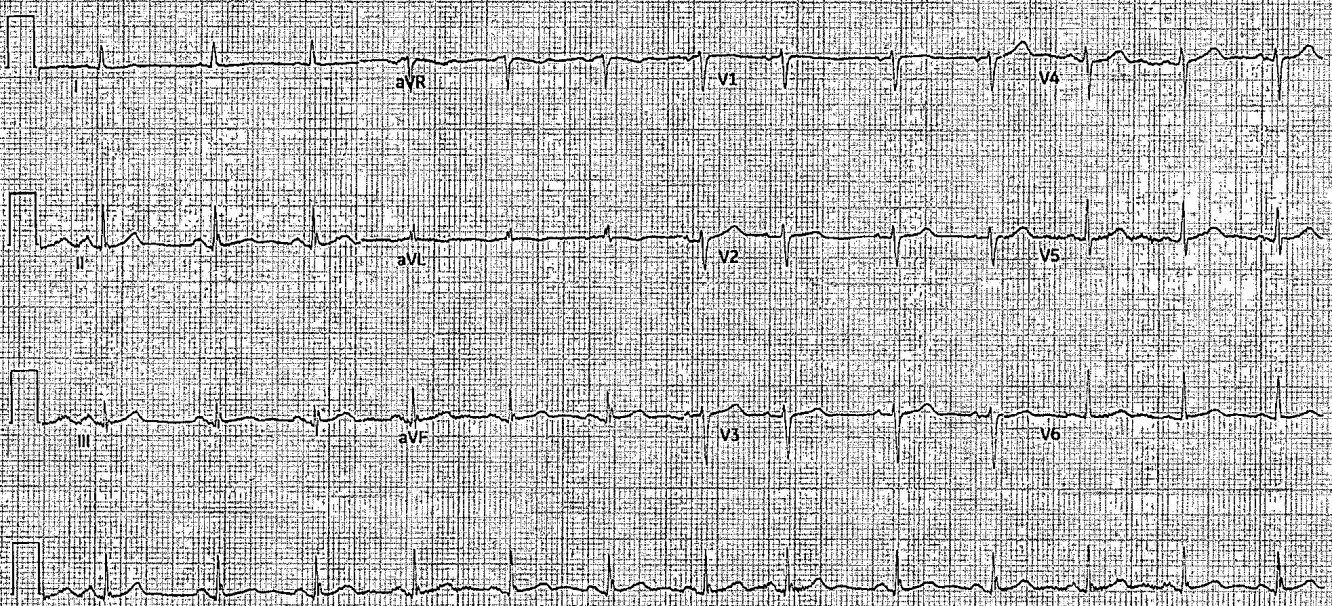
Vent. rate	79
PR interval	140 ms
QRS duration	78 ms
QT/QTc-Baz	376/431 ms
P-R-T axes	76 49 80

Patient ID: 2810666490
Sinus rhythm with premature atrial complexes
Otherwise normal ECG

30.07.2025 23:46:04
QEUH ED

Comments:

Unconfirmed



25mm/s 10.0mm/mV 0.56-100 Hz ZPD 50 Hz MAC™ 7 1.00 SP06 12SL v23:1 4 by 2.5s + 1 rhythm Id

McJury, Nicholas
Male
28.10.1966 (58 Years)
Location: 1301

Vent. rate	8	[redacted]
PR interval	14	ms
QRS duration	72	ms
QT/QTc-Baz	374/436	ms
P-R-T axes	81 57 72	

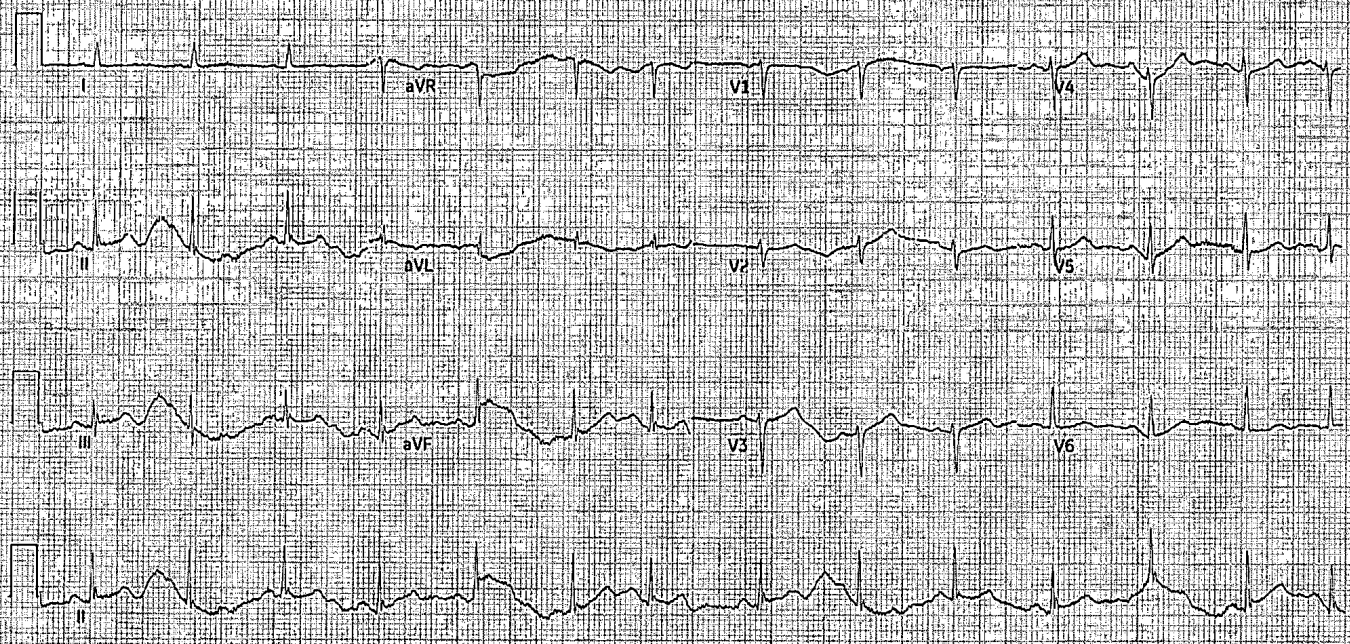
Patient ID: 2810666490 [redacted]
Sinus rhythm with premature atrial complexes
Anterior infarct , age undetermined
Abnormal ECG

30.07.2025 23:44:55
QEUH ED

Technician ID: soriba

Comments:

Unconfirmed



25mm/s 10.0mm/mV 0.56-100 Hz ZPD 50 Hz MAC™ 7 100 SP06 12SL v23 1 4 by 2.5s + 1 rhythm Id

XR Pelvis

Performed	03-Dec-2025 13:09	Received	23-Jan-2026 17:23
Reported	23-Jan-2026 17:21	Order Number	G405H42960360
Status	Final	Source System	MiSys

XR Pelvis Final
Nicholas Dominica McJury
Clinical History: hip pain

03/12/2025, 13:12, XR Pelvis
No previous imaging for comparison. Very mild osteoarthritic changes at both hips. Remaining pelvis and SI joints are normal.

Oliver Smith
Reporting Radiographer
HCPC: RA78819
Axon Diagnostics
clinicalqueries@axondiagnostics.com

Reported by: AXON Reporting
Verified by: AXON Reporting

XR Chest

Performed	30-Jul-2025 23:45	Received	09-Oct-2025 11:37
Reported	09-Oct-2025 11:35	Order Number	G405H42509354
Status	Final	Source System	MiSys

XR Chest Final
Nicholas Dominica McJury
Clinical History :

overdose, new oxygen requirement, ongoing cough and noisy breathing, ?infection, ?fluid

XR Chest :
Rotated AP film. Heart size and mediastinal contours cannot be accurately assessed.
The lungs are clear of active disease.
No significant focal lung lesion identified.

Reported by: Dr Sean Kelly
Verified by: Dr Sean Kelly

XR Radius and ulna Rt

Performed	25-Feb-2023 18:13	Received	27-Feb-2023 08:39
Reported	27-Feb-2023 08:37	Order Number	G405H39398564
Status	Final	Source System	MiSys

XR Radius and ulna Rt Final
Nicholas McJury
Clinical History :

moved up from England. fracture of wrist. plaster on. xray for fracture clinic please

XR Radius and ulna Rt :
Transverse fracture is seen through the midshaft of the right ulna.
Callus formation consistent with ongoing fracture healing is seen.

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

Report by Graham Johnstone reporting radiographer.

Reported by: Graham Johnstone
Verified by: Graham Johnstone