NHS
Tayside

Respiratory Medicine
Medicine Directorate
Acute Services Division
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

www.nhstayside.scot.nhs.uk

Dr KS MacCallum
Academy Medical Centre
Academy Street
Forfar
DD8 2HA

Date	27/12/2019
Clinic Date	29/11/2019
Your Ref	
Our Ref	DC/PB/ **0408750014**
Enquiries to	Lesley Sandoy
Extension	36457
Direct Line	01382 496457
Email	

Dear Dr MacCallum

Gavin Skretkowicz, 34 St James Road, Forfar, Angus, DD8 1LG DOB: 04/08/1975

Problems: **1. Latent TB infection: contact with smear positive pulmonary tuberculosis (fully sensitive)**
2. Tuberculin skin test 5mm induration
3. Unremarkable chest radiograph

I reviewed Gavin today in clinic. Unfortunately he wasn't able to take his latent TB infection therapy as it seemed to cause side effects which impacted his mental health. He wondered whether it was causing induction of the Venlafaxine he takes (although this is not a recognised problem on the BNF with either Rifampicin or Isoniazid). Nevertheless, he felt unable to carry on taking the treatment and with our knowledge he stopped it a few weeks ago. He feels back to normal now.

I explained to him that his risk of TB with a tuberculin skin test of 5mm induration was above base line but certainly quite low. He and I will accept this very small risk of TB progression over the next couple of years and I will keep an eye on him in outpatients with a chest x-ray in one year's time. He knows to seek help if he has symptoms of active tuberculosis but I think this is going to be extremely unlikely. I have cc'd this letter as usual to Kirsteen Hill our specialist pharmacist to see if she has any other knowledge of non typical reactions with Rifampicin/isoniazid and Venlafaxine or any of his other medications which may have impacted his mental health.

With best wishes

Yours sincerely

Authorised on 17/01/2020 09:45:42 by AMU David Connell.

David Connell
Consultant in Acute and Respiratory Medicine

(P) Kirsteen Hill, Specialist Pharmacist, East Block, Level 4, Ninewells Hospital, DD1 9SY
(P) Margaret Ramsay, Specialist Nurse, Public Health Department, Kings Cross Hospital, Clepington Road, DD3 8EA

NHS
Tayside

Respiratory Medicine
Medicine Directorate
Acute Services Division
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

Tel. 01382 496458
Fax. 01382 496548
www.nhstayside.scot.nhs.uk

Dr KS MacCallum
Academy Medical Centre
Academy Street
Forfar
DD8 2HA

Date	03/11/2019
Clinic Date	29/10/2019
Your Ref	
Our Ref	DC/AM/ **0408750014**
Enquiries to	A McDermott
Extension	36458
Direct Line	01382 496458
Email	

Dear Dr MacCallum

Gavin Skretkowicz, 34 St James Road, Forfar, Angus, DD8 1LG DOB: 04/08/1975

You did not attend the respiratory clinic today. I know you spoke to Margaret before about how the TB medication was having some effects on your health. I know you stopped the medication which is fine but it might be useful to talk things through to see how you are getting on now and to decide of in the future you would need to have any treatment. We will send you another appointment and do let us know in advance if you are unable to attend.

Yours sincerely

Authorised on 11/11/2019 11:20:10 by AMU David Connell.

David Connell
Consultant in Acute and Respiratory Medicine

(P) Margaret Ramsay, Specialist Nurse, Public Health Department, Kings Cross Hospital, Clepington Road, DD3 8EA

NHS
Tayside

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Dr KS MacCallum
Academy Medical Centre
Academy Street
Forfar
DD8 2HA

Date	14/08/2019
Clinic Date	26/07/2019
Your Ref	
Our Ref	RJS/LAS/ **0408750014**
Enquiries to	Lesley Sandøy
Extension	36457
Direct Line	01382 496457
Email	lesley.sandøy@nhs.net

Dear Dr MacCallum

Gavin Skretkowicz, 34 St James Road, Forfar, Angus, DD8 1LG DOB: 04/08/1975

Problems:

1. ***Latent TB infection: contact with smear positive pulmonary tuberculosis (fully sensitive)***
2. ***Tuberculin skin test 5mm induration***
3. ***Unremarkable chest radiograph***

I reviewed Gavin Skretkowicz today in the respiratory clinic. He is a contact with smear positive pulmonary tuberculosis and is a 43 year old care and support worker. He smokes 10-20 cigarettes a day and occasional cannabis. He has otherwise had no previous known exposures to TB and has no symptoms of active TB.

He has a past medical history of hypertension, diabetes and depression. He takes Prazosin 5mg daily, Atorvastatin 20mg daily, Lisinopril 5mg daily, Venlafaxine 225mg daily. He has no known drug allergies.

I have outlined the fact that he has no features of active TB both radiographically and from his symptoms and has a tuberculin skin test which is considered positive under the most recent NICE guidelines for latent TB infection. I explained to him that given his recent significant contact and skin test we should offer him chemoprophylaxis in the form of three months Rifanih 300 two tablets daily along with Pyridoxine 10mg daily. He had some baseline bloods today and LFTs in two weeks time.

We will see him in 8-10 weeks time and I have warned him of the potential side effects he needs to watch out for.

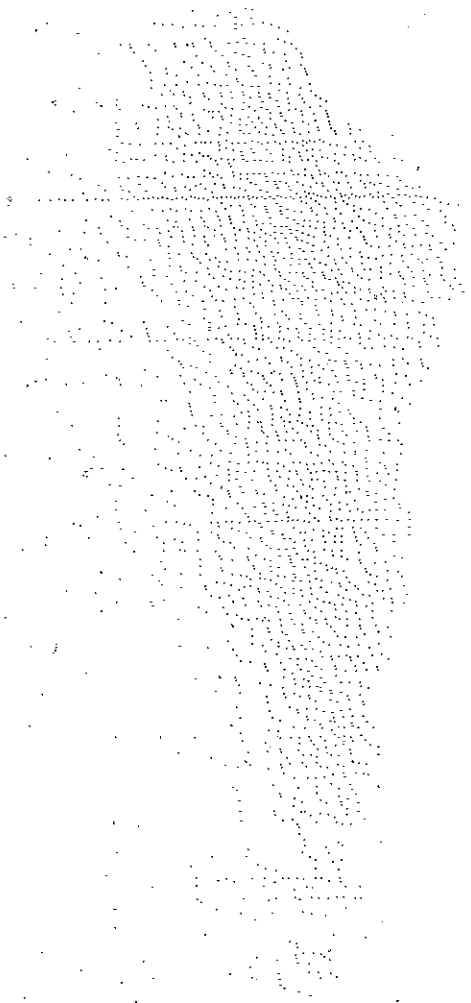
With best wishes.

Yours sincerely

Authorised on 19/08/2019 14:20:13 by AMU David Connell.

David Connell
Consultant in Acute and Respiratory Medicine

(P) Kirsteen Hill, Specialist Pharmacist, East Block, Level 4, Ninewells Hospital, DD1 9SY
(P) Margaret Ramsay, Specialist Nurse, Public Health Department, Kings Cross Hospital, Clepington Road, DD3 8EA



Replace with Patient
Detail Label

RESP. UNIT

DMR101

TB CONTACT REFERRAL DATA SHEET

Surname	Skretowicz	Forename	Gavin	Sex	M	Title	Mr
CHI/DoB		0408750014				Age	43
Address		34 St James Road, Forfar					
Postcode		DD8 1LG					
Phone number							
GP Name		Dr K S MacCallum					
GPAddress		Academy Medical Centre, Academy Street, Forfar DD8 2HA					
GP Phone number							
Relationship to index case		Social acquaintance					
Date contact identified		08.05.19					
Other relevant information							
Details of person referring (from HPT):- Margaret Ramsay							
Date of referral	09.05.19	Date Contact letter sent	09.05.19				
Signature MRamsay Print name MRamsay Designation: Senior Specialist Nurse (Health ProtectionTeam)							

INDEX CASE DETAILS

Hp Zone No 118747	Surname MCNAUGHTON	Forename EDWARD	CHI 1804500070
Status of diagnosis	Pulmonary Smear Positive TB	Date Notified to CPHM	30.04.19
Date of calculated Infective period	December 2018	Date TB treatment commenced	04.05.19

CLINIC ATTENDANCE

Chest Clinic to complete			
Place referred to	Ninewells Hospital Chest Clinic		
Data Sheet Received in Chest Clinic by	Name Designation Date		
Date 1st chest clinic appointment	27/5/19	Date of follow up appointment	
NON-ATTENDANCE AT CLINIC			
1st DNA date		2nd DNA date	
Comments:			

Nurse at Chest Clinic to complete	YES	NO	DON'T KNOW	
Have you had a BCG vaccination? STATES HX HAD TWICE	✓			If yes, Year: AT SCHOOL
If yes is the scar visible? DIFFICULT TO SEE ANY SCAR.			✓	If yes, site:
Have you ever had Tuberculosis?		✓		

Nurse at Chest Clinic to complete		
Health Assessment Questionnaire: Please answer all of the following questions:		
Have you had:	YES	NO
A cough lasting 3 weeks or more? Has been unwell Has cough for months.	✓	
A persistent fever?		✓
Night sweats? Has PTSD – [illegible] for [illegible]	✓	
Loss of appetite?		✓
Unexplained weight loss?		✓
General feeling of tiredness or feeling unwell? normal for patient	✓	
Coughing up blood?		✓
If you have answered 'YES' to any of the above please provide details here:		

TB SCREENING

Nurse at Chest Clinic to complete			
Mantoux test(s) performed		(yes) / no	
Date of 1st test:- 27/5/19	Bleb size:- 6mm	Date of reading:- 30/5/19	Result in mm:- 5mm.
Date of 2nd test:-	Bleb size:-	Date of reading:-	Result in mm:-
Comments: [illegible] test positive [illegible] 26/7/19			
Chest x-ray(s) performed		(yes) / no	
Date of 1st CXR	26/6/19	Date of 2nd CXR	
X-ray report:-		X-ray report:-	
Normal cardiac and mediastinal contours. The lungs are clear. The bony thorax is intact.			
Comments:			
Date of BCG if given:			

OUTCOME

Nurse at Chest Clinic/Paediatric Respiratory Team to complete			
Date screening completed:	10/6/19	Date screening abandoned:	
Any other comments:			

Nurse at Chest Clinic to complete Details of person completing screening outcome:	Signature: William Fry Print Name: WILLIAM FRY Designation: S/N Date: 10/6/19
[illegible] Details of person receiving screening Outcome:	Signature: Print Name: Designation: Date:

CONSENT FOR SCREENING FOR AND IMMUNISATION AGAINST TUBERCULOSIS

CONSENT FOR ADULTS

Full Name: Gavin SKRETKOWICZ Sex M/F: M. DOB: 04/09/75

Address: 34 St James Rd Forfar Postcode: DD8 1LG

GP: Dr Thomas

Address: Academy Practice Forfar.

1. Have you ever had BCG immunisation? (Yes) / No Date: ?

2. Have you had a positive skin test previously? Yes / (No) Date:

   What action was taken? Chest X-ray / Drug treatment

3. Do you suffer from any long term illness? (Yes) / No

   If Yes, give details

   Diabetic #2

4. Are you on any medicines, creams or inhalers: (Yes) / No

   If Yes, give details

   Prasosin 5mg Venlafaxine 2 50mg.

I have received and had an opportunity to read the patient information sheet on screening and immunisation against Tuberculosis and to ask questions of:

I confirm that I understand that to which I have consented

I confirm to having a tuberculin test, BCG vaccination and chest X-ray as required

Signature: [signature] Date: 27/05/19

If not signing for consent, please state reason:

The consultant responsible for this service is Dr A France. The tuberculin testing and BCG vaccination will not necessarily be performed by Dr France.

Witness by: Signature: Date:

FOR OFFICE USE ONLY

PARTICULARS OF TUBERCULIN TEST

Date Given	Type of Tuberculin Test	Batch No	Date Read	Heaf Grade	Mantoux Induration	Mantoux Erythema	+/-	Given By
27/5/15	PPD in 2T / 1/1	[illegible]	30/5/15	5mm	✓	✓	[illegible]	[illegible]

PARTICULARS OF VACCINATION, BCG VACCINE

Date	Expiry Date	Batch No	Site	Centre Given	Given By

Patient's Telephone No.	Time Admitted	A.M./P.M.	Date	Ward/Clinic/ Hosp. ....
Name and Address of Next of Kin		Telephone No.		
Diagnosis/Operation:–				Surname ..... First Name ... Address .....
Weight:	Dentures Yes / No	Valuables in safe Yes / No		G.P. & Address
Spectacles Yes / No	Hearing aid Yes / No	Contact lens Yes / No		

NURSING REPORT

27/6/19 – attended for screening following TB contact states has [illegible]
unable to [illegible] scar, mantoux given [illegible] = 6mm TO return [illegible]
30/6/19 – attended for reading some redness + swelling, [illegible]
CXR carried out to be sent ~~[illegible]~~ onto Dr Cornell [illegible]
Appt booked [illegible] Dr Cornell clinic 26/7/19.

Date	Medicines and (Special Instructions)	Dose	Form	Method of Administration or Site of Application	Times of Administration (24 hour clock)		
27/6/19	Tuberculin PPD RT 23 SSI	0.1 ml	[illegible]	Intradermal			11[illegible]

Please ✓ when medicines are prescribed separately on one of the following:–	Fluid Prescription Sheet .... ☐	DATE	AGE Yrs.	Mths.	Days	Weight g
	Other (Specify) .... ☐					

HOSPITAL	Ward/Dept.	NAME of PATIENT	D. of B.	UNIT No. / MPI No.	CONSUL	COM

THB(MR)32

0408750014

Ward/Clinic/ Hosp............................

Skretkowicz
Gavin

34 ST JAMES ROAD

Forfar
DD8 1LG

KS MacCallum

.... Cons.
C.H.I. No

HISTORY/CONTINUATION SHEET

Surname.....................
First Name..................
Address.....................

........M. State
.........Sex

........UNIT/WARD/DEPT.

G.P. & Address (G.P. Request only)

USE BLOCK LETTERS OR PATIENT LABEL

DATE | Page ....

26 JUL 2019

WHT	BP	P	O2
140 kg	133/83	85	95%

43 →
Carer / Support Worker
Smokes 10-20/d
+ Cannabis

PC

Contact TB

HPC

No known exposure to TB
Friend of RH - has ⊕ TB

No Sx of active TB - trying to lose wt

PMHx

TPP
T2DM
Depression

DHx

Ramipril 5mg
Atorvastatin 20mg
Lisinopril 5mg
Venlafaxine 225mg

SHx

NKDA

Lives c / Lomanite

22184

THB.(MR)3A

DATE

CXR TST Shs
c/ Uncomfortable
Pneumo (-)
Vascular links

∴ LTBI

→ Advised 3/12 Chemopro + B6

Bloods

4/52 Phone

See 8-10/52

29.11.19
Kg
130.7 0/0 97.

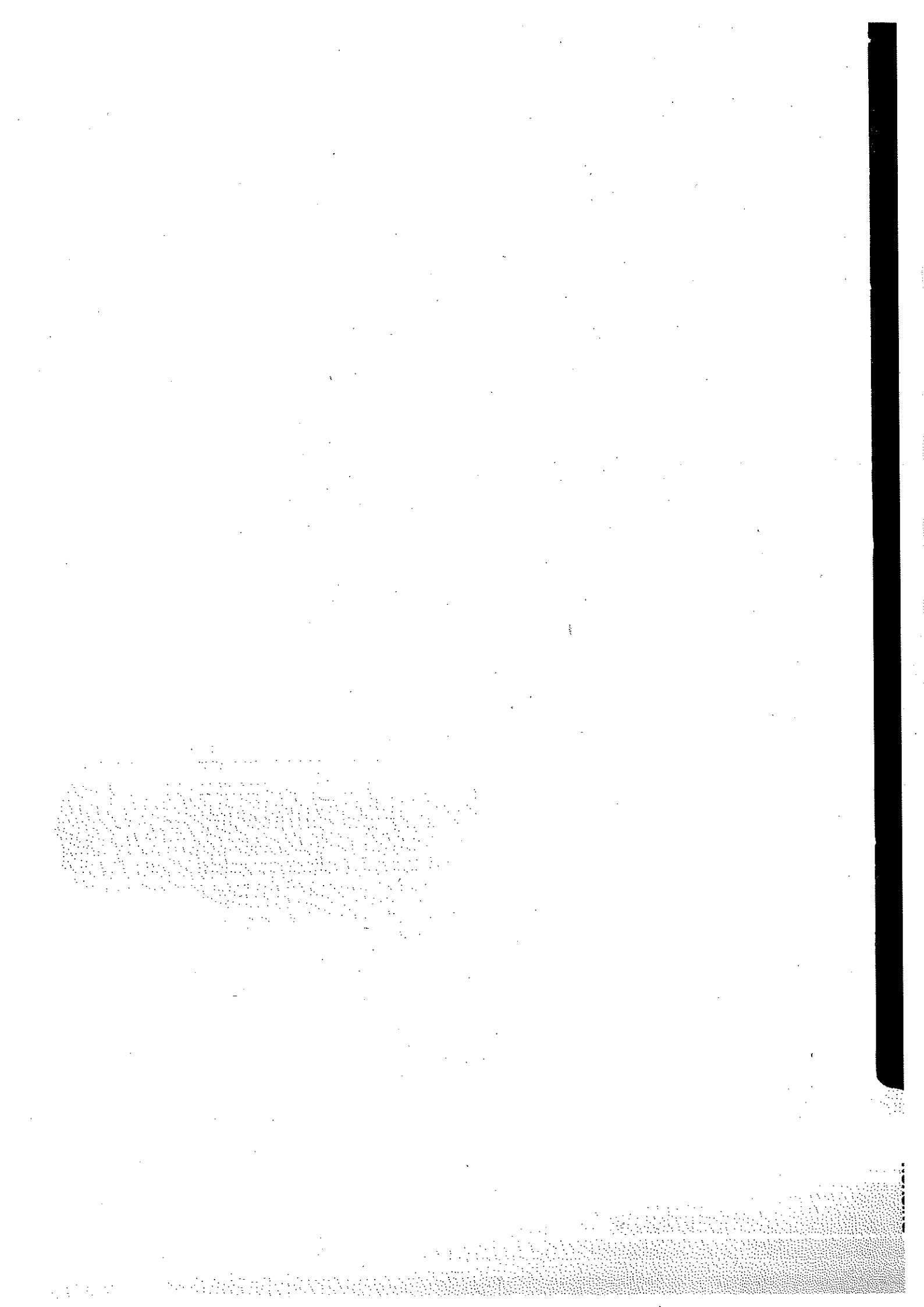
Stopped LTBI due to SEs, 2° MH (? Interaction w/ R + H)

Feeling (N) again

Advised on TB Sx

See 1 yr w/ CXR

[signature]



SAVIN SKREIKOWICZ
CHI 0408750011

DAILY ADULT FLUID MONITORING CHART

Only prescribe IV fluids if oral route is unavailable and for a maximum of 24 hours

Date: 18/12/25 Volumetric Pump Checks: YES ☐ NO ☐ N/A ☐ Med Physics No.________

Reason for Commencing: ______________________ Reason for Discontinuation: ______________

Time	INTAKE (mls)							OUTPUT (mls)							
	Oral	NG/NJ/PEG/PEJ	PN	IV/SC	IV Med	Flush	Running total	Urine	Stool/Stoma	Vomit/Asp	Drain	Drain	Drain	Other	Running total
01:00															
02:00															
03:00															
04:00															
05:00															
06:00															
07:00															
08:00															
09:00															
10:00															
11:00															
12:00															
13:00															
14:00															
Subtotal															

Stop and Check		Y	N	
	Intake (Oral/Enteral+IV) less than 500ml?	Y	N	If Yes to any please action:
	Urine less than 300ml?	Y	N	Daily weight if required________
	Other losses more than 500ml?	Y	N	

Time	Oral	NG/NJ/PEG/PEJ	PN	IV/SC	IV Med	Flush	Running total	Urine	Stool/Stoma	Vomit/Asp	Drain	Drain	Drain	Other	Running total
15:00															
16:00															
17:00															
18:00															
19:00															
20:00				100				360							
21:00				100											
22:00				100											
23:00				100											
00:00															
24hr Totals															

Total Intake:

Total Output:

Codes			
	Nil Orally	=	NBM
	Fasting-Procedure	=	FP
	Offered oral fluids	=	OFF
	Passed urine non measurable	=	PUNM
	Break in administration	=	BA

Fluid Balance:
(Total intake minus Total output)

DAILY ADULT IV FLUID PRESCRIPTION CHART

Only prescribe IV fluids if oral route is unavailable and for a maximum of 24 hours

NHS Tayside

DATE: 18/12/25 WARD:

NAME GAVIN SKRETKOWICZ

DOB/CHI 0408750014

AFFIX PATIENT LABEL

CURRENT WEIGHT:__________

Previous day fluid balance__________

Maintenance Goal Today (including oral intake) __________

(30ml/kg/24hrs) (frail/elderly-20-25ml/kg/24hrs)

Date: Na: K: Cl: Urea: Creat: Hb:

1. Assess Patient	**Hypovolaemic (reassess regularly)**		**Euvolaemic (fasting ≥8hrs)**	**Hypervolaemic (overloaded)**	**Clinical conditions CONSULT SENIOR**
2. Why give fluid?	Resuscitation	Replacement	Maintenance	**Restriction ______ml**	Cardiac dysfunction ☐ Renal/Liver failure ☐ Obstetrics ☐ Head injury ☐ Hyperkalaemia ☐
3. How much? Look at history, weight, U&Es, other fluid intake eg. IV antibiotics	Fluid challenge 250-500ml over 5-15 minutes and reassess	Estimate losses in past 24hrs. Replacement is in addition to maintenance	30ml/kg/24hrs. Subtract other intake. Today's IV needs: =______ml	Fluid restrict. Consider Diuresis	Give 40mmol Potassium/ Litre in maintenance unless K is ≥5.0 or renal function deteriorating
4. Which fluid?	Plasma-Lyte 148 (PL148)/crystalloid/ Blood on BTS	Plasma-Lyte 148 0.9%Sodium Chloride for upper GI losses	0.18%Sodium Chloride/4%Glucose+/-potassium If Na≤132 use PL148	Consult Senior	

NEVER give 0.18%NaCl/4%Gluc/KCL over 100ml/hour: RISK OF HYPONATRAEMIA	**Weight (kg)**	**Maintenance Requirement/24hr** (30 ml/kg/24 hrs)	**Rate (ml/hr)**	**PRESCRIBE ML/HR DO NOT PRESCRIBE 'X HOURLY' BAGS FOR MAINTENANCE**
	35-44	1200 ml	50	
	45-54	1500 ml	65	
	55-64	1800 ml	75	
	65-74	2100 ml	85	
	≥75	2400 ml	100 (max)	

Resuscitation/Replacement Fluid **Still hypotensive after 2000ml of resuscitation fluid? D/w Senior/Critical care**

Fluid +/- additions	**Vol (mls)**	**Rate (mls/hr)**	**After this bag**		**Prescribed by**	**Batch no**	**Start**	**Finish**	**Administered by**
NaCl / NaCl 0.9%	500	250	Stop	Review	G. Perks / G. Perks	25H3 0T4D	01:40		NM / AA
			Stop	Review					
			Stop	Review					
			Stop	Review					
Still hypotensive after 2000ml of resuscitation fluid? D/w Senior/Critical care									
			Stop	Review					
			Stop	Review					
			Stop	Review					
			Stop	Review					

Maintenance Fluid (Max 100ml/hr) includes fluids for patients receiving IV insulin or Subcutaneous fluids

NaCl 0.9% 20mmol KCL	500	100	Continue / Stop	Review	G Perks	25E1 6T4F	04:20		LC / AA
			Continue / Stop	Review					
			Continue / Stop	Review					
			Continue / Stop	Review					
			Continue / Stop	Review					

CLVH - R74 - C02 - S10

Altered Airway Alert (please tick)

Barcode:
Gavin Skrefkowicz
0408750014

RR - 18
Sats - 97
HR - 81
BP - 129/81
T - 36.1

BM - 23
Icef - 4-3

NHS
Tayside

Adult In-Patient Nursing Documentation

✓	Date of Admission: 18-12-25	Time: Time	Initials
✓	NEWS (15mins)	11:00	OI
✓	Blood Glucose (15mins)	11:05	OI
✓	Bloods (60mins)	1115	RH
✓	ECG (60mins)	1130	OC
	Resp Questionnaire +/-Swab (60mins)		

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

User Guidance available on Staffnet

SIGNATURES

This record is a legal document. Your signature indicates that you have reviewed and updated it, and it is a true reflection of the care given by you or delegated by you.

Whenever anyone writes in this record for the first time, they should fill in their details below:

NAME *(please print)*	SIGNATURE & INITIALS	JOB TITLE	WARD
C Marke	C Marke cm	S/N	AMU
Natalie Mossaddaq	N. Moss NM	SN	4

ADDRESSOGRAPH

PATIENT NAME: Shaun Skretkowicz

CHI: 040875 0014

ADDRESS:

TELEPHONE NUMBER:

ADMITTED TO: AMU NWH

DATE: 18-12-25 TIME:

PREFERRED NAME: Shaun

GP NAME:

ADDRESS:

CONTACT NUMBER:

Butterfly Scheme:

Attach sticker if patient / carer consent to opt in.

NEXT OF KIN / KEY CONTACT:

NAME: BRUCE CRAWFORD.

RELATIONSHIP: FATHER

ADDRESS:

CONTACT NUMBER: 07724876352.

*If person has call barring agree preferred method of contact

ALTERNATIVE CONTACT:

NAME:

RELATIONSHIP:

ADDRESS:

CONTACT NUMBER:

*If person has call barring agree preferred method of contact

TRANSFER RECORD

Ward transferred to: _____
Date of transfer: _____
Time of transfer: _____
Consultant: _____

Ward transferred to: _____
Date of transfer: _____
Time of transfer: _____
Consultant: _____

Has patient been placed in a mixed sex bay Yes ☐ No ☐

If yes, state reason

Has Patient (NOK where appropriate) been notified of reason Yes ☐ No ☐

ADMISSION SBAR

SITUATION (Reason for admission /"What has brought you into hospital?")

SOB (MJ) ? DKA

BACKGROUND (Relevant medical history / Has the patient been in hospital in the last 28 days)

T2DM, Essential HTN, Depressive episode

ASSESSMENT (Observations, risk factors, injuries)

OBS Blood

ECG BM's + Ketones

RECOMMENDATION/S (Priorities for Nursing Care Management plan, think...What Matters to Me)

Medical Assessment

NHS | Initial Discharge Communication | NHS

GAVIN SKRETKOWICZ 34 ST JAMES ROAD, FORFAR, DD8 1LG *GP Practice: Academy Medical Centre, Academy Street, Forfar, DD8 2HA*	CHI: 0408750014 Born: 04/08/1975

This letter updates/amends previous communication received in relation to this episode of care

Discharge Details

Admission	18/12/2025	**Discharge**	19/12/2025
Specialty	Diabetes	**Consultant**	Dr Paul Newey (4698443)
From	Ward 4 Ninewells Hospital	**Destination**	Home

Diagnoses

DKA - diabetic ketoacidosis	

Operations/Procedures

Actions Required for Primary Care

Communication to Primary Care

Dear Doctor,

Gavin was admitted to General internal medicine unit of Ninewell Hospital on 18/12/25 with diabetic ketoacidosis (DKA) and was commenced on the DKA protocol. Following stabilization, he has been initiated on long-term insulin therapy, having previously been managed with diet alone.

Gavin has received education and training on insulin administration. Genetic testing and C-peptide levels will be followed up as an outpatient. He is scheduled for review by the Diabetes Nurse Specialist next week to assess progress and ongoing management.

Clear safety-netting and worsening advice was provided prior to discharge. He has also been advised in line with DVLA guidelines. He is therefore discharged back to your care.

Kind regards,

Ward 4

Medications

This prescription has not been reviewed by a Pharmacist

Drug & Formulation	Dose	How to take	How long to take	Supply	Dispensary
Amitriptyline 25mg tablets		TAKE 2 TABLETS AT NIGHT		Own at Home	
Atorvastatin 20mg tablets		1 TABLET ONCE A DAY		Own at Home	
Lisinopril 5mg tablets		1 TABLET ONCE A DAY		Own at Home	
NOVORAPID 100units/1mL FlexPen	6UNITS	6UNITS WITH EVERY MEAL (AT 8AM, 12NOON AND 6PM)		TTO	
Prazosin 500microgram tablets		FOUR TABLETS AT NIGHT AS ADVISED BY CMHT		Own at Home	
Sildenafil 50mg tablets		1 TABLET WHEN REQUIRED		Own at Home	

GAVIN SKRETKOWICZ 34 ST JAMES ROAD, FORFAR, DD8 1LG *GP Practice: Academy Medical Centre, Academy Street, Forfar, DD8 2HA*	CHI: 0408750014 Born: 04/08/1975

TOUJEO 300units/mL SoloStar Pen	18UNITS	TAKE 18UNITS EVERY MORNING		TTO	
Vensir XL 150mg capsules (Morningside Healthcare Ltd)		1 CAPSULE ONCE DAILY (TOTAL DOSE 225MG DAILY) Notes for patient: Please note: Your prescription for Venlafaxine MR capsules has been changed to a different brand of the same drug called Vensir XL capsules as it is more cost effective to prescribe. T		Own at Home	
Vensir XL 75mg capsules (Morningside Healthcare Ltd)		1 CAPSULE ONCE DAILY (TOTAL DOSE 225MG DAILY) Notes for patient: Please note: Your prescription for Venlafaxine MR capsules has been changed to a different brand of the same drug called Vensir XL capsules as it is more cost effective to prescribe. T		Own at Home	

Discontinued Medication

Medication Notes

Allergies

Deleted Allergies

Follow Up Arrangements

Community Diabetic Nurses			Date to be arranged

Final Discharge Comments

Pharmacy

Copy To

Sign Off

	Name	Job Title	Date/Time
Initial Sign Off	Marina Bishay	Clinical fellow	19/12/2025 16:11:44
Pharmacy Sign Off			
Final Sign Off			

NURSING ASSESSMENT – INITIAL ASSESSMENT ON ADMISSION

Communication

Do you speak English Yes ☑ No ☐

If no, what is your first language _____

Interpreter required Yes ☐ No ☑

Do You have speech issues Yes ☐ No ☑

Do you use British Sign Language Yes ☐ No ☑

If yes document details in nursing communication assessment

Power of Attorney

Does someone have Power of Attorney for you Yes ☐ No ☑

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

Is this PoA activated Yes ☐ No ☐

(If yes, check if copy available in notes and if not, obtain a copy & retain in the healthcare record)

Attorney Name: Relationship

Tel No

Attorney Name: Relationship

Tel No

Guardianship Order

Does someone have a Guardianship Order for you Yes ☐ No ☑

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

Is this guardianship currently activated Yes ☐ No ☐

(If yes, check if copy available in notes and if not, obtain a copy & retain in the healthcare record)

Guardian Name: Relationship

Tel No

Guardian Name: Relationship

Tel No

Are there concerns guardianship may be required?

Yes ☐ No ☐

If yes, seek advice from social work.

Disclosure of Information

Do you give consent for full disclosure of information to 1st contact only (e.g. diagnosis / test results) Yes ☑ No ☐

Do you give consent to disclosure of general information to general enquiries / all other relatives, friends e.g. had a good day, doing well Yes ☐ No ☐

Is there anyone you DO NOT wish us to disclose any information to

Yes ☐ No ☑

Please specify:

Own medication brought in	Yes ☐ No ☑	Controlled Drugs Yes ☐ No ☐
Allergies – Please state or denote NIL	N/C D/A	
Name band/Allergy (Alert) band in situ	white Yes ☑ No ☐	**Red name band / allergy (alert) band** – If no, please state agreed process for patient identification and reason for not having one:
Possibility of pregnancy?	Yes ☐ No ☐ N/A ☑	Last Menstrual Period (if applicable):

DNACPR / Anticipatory Care Plan (ACP) / Advanced Directive (AD):

Does the patient have an ACP or AD Yes ☐ No ☑

If Yes, Refer to ACP / AD and discuss with patient when developing care plan.
Retain a copy in the healthcare record if possible.

Does the patient have a current DNACPR Yes ☐ No ☑

If Yes, request the review and update of DNACPR form.

CAPACITY AND CONSENT

Do you have any concerns regarding patient's capacity or ability to make healthcare decisions, including learning disability or mental health conditions
Yes ☐ No ☐
If yes, Please specify

Consider liaison nurse referral to alert of admission

MENTAL STATE	Orientated Yes ☑ No ☐	Confused Yes ☐ No ☐	Distressed Yes ☐ No ☐	Unconscious (GCS ≤ 9) Yes ☐ No ☐

Does the patient have more trouble remembering things that have happened recently than they used to?
Yes ☐ No ☑
Consider if the patient has capacity to consent.
If the patient's ability to consent is in doubt refer to medical staff to assess for AWI.

Is there a concern that the patient is at risk?

1. **Are they unable to safeguard their own wellbeing, property rights or other interests?**	Yes ☐ No ☑
2. **Are they at risk of harm?**	Yes ☐ No ☑
3. **Are they affected by disability, mental disorder, illness, physical or mental infirmity which make them more vulnerable to harm than adults not affected in this way**	Yes ☐ No ☑

If the patient meets all 3 points, follow NHS Tayside Adult Protection and Support process
Tayside Joint Public Health Protection Plan 2019-2021

Home circumstances	Lives alone ☑		Lives with:		
Living Arrangements	Own Home ☑	Sheltered ☐	Care Home ☐	Homeless ☐	Community Alarm ☐ Key pad lock ☐ Stairs ☐ How many?
Care Package	Yes ☐	No ☑	Provider: Care Manager Name:		Frequency:
Family / Informal Carer Support	Details of informal care provided & by whom:				
Financial Inclusion:	Have you got any money worries that might affect how you are feeling? E.g. welfare benefits or debt? Yes ☐ No ☑ If yes, Would the patient like to be referred to an advice service (If no, make patient aware of Advice Centre) If yes, Gain verbal consent and refer to Advice centre. Referral required Yes ☐ No ☑ Referral complete Yes ☐ No ☐				
Employment	Employed ☐ Unemployed ☑ Retired ☐ No paid employment (e.g. unpaid carer) ☐ If unemployed consider employability – refer to Advice Centre for signposting.				

INFECTION CONTROL CLINICAL RISK ASSESSMENT

COMPLETE WITHIN 1 HOUR OF ADMISSION

CARBAPENEMASE PRODUCING ENTEROBACTERIACEAE (CPE) CLINICAL RISK ASSESSMENT

1	Has the patient been transferred from any hospital outside of Scotland Has the patient been transferred from a hospital in a high risk area within Scotland	Yes ☐ No ☑ Yes ☐ No ☑
2	Has the patient been hospitalised outside Scotland in the last 12 months	Yes ☐ No ☑
3	Has the patient had holiday dialysis	Yes ☐ No ☑
4	Has the patient been previously known CPE colonisation/infection Has the patient been identified as a close contact of a known CPE colonisation/infection (If patient has been screened in pre assessment for CPE to be rescreened on admission)	Yes ☐ No ☑ Yes ☐ No ☑

If YES to any of the above questions the following samples should be taken and the patient isolated until negative as per policy:

Rectal swab Yes ☐ No ☐	**RESULT:**	Stool sample (if rectal swab not taken) Yes ☐ No ☐ N/A ☐	**RESULT:**	Patient Isolated Yes ☐ No ☐ (document any risk assess below)	
Other (please state):	**RESULT:**	Other (please state):	**RESULT:**	Other (please state):	**RESULT:**

METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA) CLINICAL RISK ASSESSMENT (IN PATIENT ONLY)

1	Has the patient any previous history of MRSA? (ask patient, check patient information system, labs)	Yes ☐ No ☑
2	Has the patient been admitted from anywhere other than their own home (e.g. prison, homeless hostel, resident in a care home) or transferred from another hospital?	Yes ☐ No ☑
3	Does the patient have any wound(s)/ulcer(s) or indwelling device (e.g. peg tube, urinary catheter) which was inserted before admission?	Yes ☐ No ☑

If **YES** to any of the above questions, samples should be taken and the patient isolated until negative as per policy

For patients admitted / transferred to Vascular, Orthopaedics, Renal and Critical Care (including attached high dependency areas) complete the Clinical Risk Assessment and obtain nasal and perineal swabs)

	RESULT		**RESULT**
☐ Nasal swab		☐ Catheter specimen of urine (CSU)	
☐ Perineal swab		☐ Throat	
☐ Wound (s) – location:		☐ Other – specify:	
☐ Ulcer(s) – location:		☐ Patient Isolated	

IF MRSA POSITIVE: Discuss isolation and decolonisation with Infection Prevention and Control team.

CJD

CJD risk assessment completed (pre op patients only) Yes ☐ No ☑

Diarrhoea

Does patient have unexplained loose stools Yes ☐ No ☑
If Yes, take sample & confirm type (based on Bristol stool chart)

Isolate patient whilst awaiting results. Commence on a fluid/ stool chart

COVID

1	Does the patient have symptoms indicative of COVID?	Yes ☐ No ☑
2	Ensure COVID triage tool complete and COVID screening swabs completed	Yes ☐ No ☑
3	Provide any COVID history of note or risk factors (e.g. travel history, household contact, currently isolating)	

Admission Infection Prevention & Control Measures. Please tick as appropriate:

☐ Standard Infection Control Precautions
☐ Transmission based precautions (Droplet)
☐ Transmission based precautions (Contact)
☐ Transmission based precautions (Airborne)

Patient placement:

☐ Shared Bay Suitable ☐ Risk Assessed & Cohort Bay Suitable ☐ Single Room Required

*If unable to isolate, please document rationale below:

Rationale for isolation / infection risk communicated to patient / NOK ☐

Patient / carer information leaflet given Yes ☐ No ☐

Assessment completed by: **Signature:** **Date:** **Time:**

Sample collection confirmed by: **Signature:** **Date:** **Time:**

INVESTIGATION / TESTS LOG

Date/Time	Investigation / Tests	Results

FRAILTY SCREENING TOOL	COMPLETE WITHIN 6 HOURS OF ADMISSION		
This FRAIL tool supports screening for frailty as an adjunct to clinical judgement. It can be used to screen all adults. Please note - for all people >65 the use of the Clinical Frailty Scale (CFS) is preferred; this FRAIL tool can be used if a CFS is not available.			
FRAILTY SCREENING INDICATED? Yes ☐ No ☐		Yes	No
F	Functional Impairment (new or worsening) e.g. difficulty with self care		
R	Resident in Care Home		
A	Altered Mental State such as delirium and dementia (use of 4AT)		
I	Immobility / Instability – New decline in mobility, difficulty mobilising without help or fall leading up to presentation.		
L	Living at home with support on a daily basis (homecare, one visit or more per day)		
CONSIDERING SAFE PLACEMENT		Yes	No
Clear need for other speciality input e.g. exacerbation of known long term condition such as COPD			
Need for HDU / ITU (including non-invasive ventilation)			
Suspected new stroke or TIA, consider thrombolysis & care in stroke unit			
Head injury with loss of consciousness			
Acute abdominal pain / surgical presentation			
Upper GI bleed			
Chest pain with suspected acute coronary syndrome			
Trauma with suspected fracture			

If **YES** to any considering of safe placement questions above - Prioritise move to non Medicine for the Elderly (MFE) service as appropriate. *Consider MFE or Psychiatry of Old Age liaison advice on parent ward.

If **NO** – Prioritise transfer of care to most appropriate area for example Medicine for the Elderly or Psychiatry of Old Age ward for Older People. For younger people < 65 support and safe placement to be explored in a person centred way.

Has FRAIL criteria been met Yes ☐ No ☐

ACTION TAKEN (Note any onward referral to Acute Frailty Team / OT / PT):

4AT – Please complete if recommended from frailty screening		SCORE
1	**Alertness:** This includes patients who may be markedly drowsy (e.g. difficult to rouse &/ or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep attempt to wake with speech or gentle touch on shoulder. **Ask patient to state their name and address to assist rating** • Normal (fully alert, but not agitated throughout assessment • Mild sleepiness for 10 seconds after waking, then normal • Clearly abnormal	0 0 4
2	**AMT 4: Age, DOB, place name and current year** **AMT score= /4** • No mistakes • 1 mistake • 2 or more mistakes/untestable	0 1 2
3	**Attention:** Ask the patient: "Please tell me the months of the year backwards starting at December" You can assist with 1 prompt of "What is the month before Dec?" • Achieves 7 or more • Starts but score <7 months/refuses to start • Untestable (cannot start because unwell, drowsy, inattentive)	0 1 2
4	**Acute change or fluctuating course:** Evidence of significant change or fluctuation in: alertness, cognition, other mental function (e.g. paranoia, hallucinations arising over last 2 weeks and evident in last 24 hours • No • Yes	0 4
4AT score **4 or above:** possible delirium+/- cognitive impairment: **THINK DELIRIUM - initiate TIME BUNDLE** **1-3:** possible cognitive impairment **0:** delirium or severe cognitive impairment unlikely (but delirium still possible if question 4 information incomplete)		**Total score:**

DELIRIUM / DEMENTIA	
4AT Score: Medical Staff Yes ☐ No ☐	Type: Hypoactive ☐ Hyperactive ☐ Mixed ☐
TIME Bundle started:	Delirium Leaflet given: Yes ☐ No ☐
'Getting to Know Me' in place Yes ☐ No ☐	
DEMENTIA	
Yes ☐ No ☐ Type:	Known to (services / specialist):
ADULTS WITH INCAPACITY (AWI) Certificate Required: ***Ensure care plan completed and discussed with NOK**	Yes ☐ No ☐ Completed ☐
Referral Made: **(POA / Psychiatry Liaison / CAMHS)**	Yes ☐ No ☐

FALLS ASSESSMENT	COMPLETE WITHIN 6 HOURS OF ADMISSION
Are falls the reason for admission Yes ☐ No ☑	Number of falls in the last year (with or without harm):
Were falls medically investigated? Yes ☐ No ☐ N/A ☑	Reason / cause identified:
Is patient afraid of future falls / falling Yes ☐ No ☐ N/A ☑	
Patient's confidence and ability to move about safely:	
Carer's confidence in patient's ability to move about safely:	
Falls leaflet provided: Yes ☐ No ☐ N/A ☑	
Verbal information provided: (Please state)	
Any additional information or risk factors identified (E.g. CVA, cognitive impairment, continence) Yes ☐ No ☐	
Concerns identified, falls action plan completed Yes ☐ No ☑	
Bed Rails Assessment Completed: Yes ☐ No ☐ Bed Rail Risk level: ☐ GREEN (Bedrails may be used) ☐ AMBER (Use Bedrails with Care) ☐ RED (Bedrails not to be used - use other methods) Additional information:	

[redacted]: PRESSURE ULCER RISK ASSESSMENT		COMPLETE WITHIN 6 HOURS OF ADMISSION & DAILY THEREAFTER
MOBILITY:	Independent	Yes ☑ No ☐
CONTINENCE:	Continence concerns	Yes ☐ No ☑
NUTRITION:	Nutrition concerns	Yes ☐ No ☑
SKIN:	Skin integrity concerns	Yes ☐ No ☑

- If any concerns are identified, implement PPURA risk assessment and care round record sheet
- Complete CPR for Feet assessment if at risk

A wound chart is required to document the dressing care plan for any wounds / skin integrity issues in addition to the pressure ulcer record wound

: MALNUTRITION UNIVERSAL SCREENING TOOL

Please note, it is not necessary to complete 'MUST' in the last days of life

COMPLETE WITHIN 6 HOURS OF ADMISSION

DATE:		*Tick relevant box (only use estimated / reported if unable to obtain)*			
Weight (kg):		Adjusted weight (Oedema , ascites, amputation (Kg):	Actual ☐	Estimated ☐	Reported ☐
Height (m):			Actual ☐	Estimate ☐	Reported ☐

Normal reported weight (over past 3-6 months) kg:

BMI SCORE:

Step 1 + Step 2 + Step 3

BMI Score

BMI kg/m²	SCORE
>20 (>30 obese)	= 0
18.5 – 20	= 1
<18.5	= 2

e.g. $\frac{53kg}{1.68m^2}$

(or 53 ÷ 1.68 ÷ 1.68)

=18.8kg/m²

Weight Loss Score

Unplanned weight loss in past 3 – 6 months

%	SCORE
<5%	= 0
5 – 10%	= 1
>10%	= 2

e.g.

- Normal weight = 57kg
- Current wt = 53kg
- Wt loss = 4kg
- % wt loss =
  - (wt loss ÷ normal weight) x 100
  - (4÷57) x 100 = 7%

Acute Disease Effect Score

If patient is acutely ill AND there has been or is likely to be no nutrition intake for >5 days i.e. intestinal obstruction / unconscious.

SCORE = 2

Step 4

Overall Risk of Malnutrition

Add scores together to calculate overall risk

TOTAL MUST SCORE =

Step 5 follow MUST Management Guidelines (available on staffnet)

Immediate Dietetic Referral for patients with;

MUST score ≥2 (High Risk) ☐
Newly diagnosed Irritable Bowel Disease (IBD)
A new diagnosis of coeliac disease or diabetes ☐
Newly inserted oesophageal stents ☐
Pressure Sores Grade 3 or more and deep wounds ☐

Decompensated liver disease ☐
Oral Nutritional supplements ☐
Parenteral Nutrition ☐
An enteral feeding tube in situ ☐

Date	Oedema/ Ascites Y/N	Weight (kg)	Adjusted Wgt (Kg)	Body Mass Index	Step 1 score	Step 2 score	Step 3 score	Step 4 total score	Step 5 Refer to Diet'n Y/N	Care Plan Commenced /Reviewed Y/N	DATIX Y/N	Signature

Repeat a MUST screening weekly

NUTRITION PROFILE: Admission Data

COMPLETE WITHIN 6 HOURS OF ADMISSION

DIETARY REQUIREMENTS *(please tick all that apply)*

Food allergy/intolerance Yes ☐ No ☑

Please specify: _____

Religious, Ethnic or Cultural Yes ☐ No ☐

Please specify: _____

Diabetic ☐
Vegetarian ☐
Vegan ☐
Gluten Free ☐

Energy Dense (High protein / High calorie) ☐

Finger Foods ☐

Texture Modified Diet ☐

IDDSI Level : _____

Other / Food likes & dislikes (please specify):

Diet Kitchen Informed of specific dietary requirements:
Yes ☐ No ☐ No Issues / Risk ☑

ROUTE OF NUTRITIONAL INTAKE (*You may tick more than one*)

Oral	☑	Central Line TPN	☐
NG	☐	Peripheral TPN	☐
Gastrostomy e.g. PEG/RIG/Button	☐	IV Fluids	☐
Naso-jejunal	☐	Subcutaneous fluids	☐
Jejunostomy	☐	Nil by mouth	☐

CAN PATIENT MAKE INDEPENDENT CHOICES ON EATING / DRINK?: Yes ☑ No ☐
If no, complete likes and dislikes form

IS THERE A NEED FOR EQUIPMENT AND / OR ASSISTANCE WITH EATING AND DRINKING? Yes ☐ No ☐

If yes please specify: Plate Guard ☐

Non-slip mat ☐ Adapted Cutlery ☐

Prompting / assistance required ☐

Are there social/environmental mealtime requirements?

Yes ☐ No ☑

ARE THERE ANY CONTRIBUTING FACTORS THAT MAY AFFECT FOOD INTAKE (if yes please specify)

Physical e.g. swallowing problems, vomiting, dementia, sore mouth, oral health assessment completed ☐

Physiological e.g. nausea / constipation, pain ☐

Social e.g. loneliness, isolation, substance use (e.g. alcohol) ☐

Psychological e.g. low mood ☐

Environmental e.g. cooking facilities, ability to prepare food ☐

MENU	FLUIDS	ASSISTANCE REQUIRED	EQUIPMENT / ENVIRONMENTAL & SOCIAL REQUIREMENTS
COMPLETE FOOD RECORD CHART Energy Dense ☐ Level 6 – Soft/bite size ☐ Level 5 – Minced moist ☐ Level 4 – Puree ☐ Level 3 – Liquidised ☐ Normal ☑ Finger Food ☐ Vegetarian ☐ Vegan ☐ Gluten Free ☐ Allergen menu (Specify): Religious or Cultural (Specify):	COMPLETE FLUID BALANCE CHART No oral fluids ☐ Level 4 ☐ Level 3 ☐ Level 2 ☐ Level 1 ☐ Normal ☑ Is a fluid restriction in place? Are they a dialysis patient? If yes please refer to fluid chart for current restriction / seek advise	REQUIRES ASSISTANCE WITH EATING & DRINKING Positioning for eating ☐ Cutting up food /opening packets ☐ Assistance with meal set up ☐ Full assistance ☐ Other (please state) ☐	Yes ☐ No ☐ Equipment Type: Non-slip mat ☐ Plate guard ☐ Adapted cutlery ☐ Drinking equipment e.g. lidded cup, 2 handed cup straw ☐ (specify below) Social/environmental mealtime requirements: Please state:

Profile completed by Name (Print)	Signature:	Date:	Time:
[illegible]	[illegible]	18/12/25	1450

NURSING ASSESSMENT ON ADMISSION

ASSESSMENT

Communication

Do you have any loss of sight ☑ hearing loss ☐ Speech loss ☐ (Stroke / Laryngectomy/Tracheostomy may have communication difficulties)
Do you use glasses / contact lenses ☐ hearing aids ☐ Not with Pt.
Do you have any problems / difficulty in understanding conversation Yes ☐ No ☐
Are there ways we can help with communication, i.e. communication book / cards?

Is referral to SALT required Yes ☐ No ☐
Referral made to SALT (date): ____/____/____ or No Issues / Risk ☐

Pain

Are you in any pain Yes ☐ No ☑ Where is the pain? _____
Severity of pain: mild ☐ moderate ☐ severe ☐
New pain ☐ Long term / persistent pain ☐
How long: hours ☐ days ☐ weeks ☐ months ☐ years ☐
Regular Analgesia Yes ☐ No ☐
Pain score (as per NEWS documentation. Consideration of PAINGO framework): or No Issues / Risk ☑

Respiratory

Do you have any difficulty with your breathing and / or a long term lung condition Yes ☐ No ☐
Do you use inhalers Yes ☐ No ☐
Domiciliary Oxygen Yes ☐ No ☐ If yes, how many litres / minute: ☐
Do you smoke Yes ☑ No ☐

Would you like to stop smoking Yes ☐ No ☐

Patient appears dyspnoeic Yes ☐ No ☐

At risk of deterioration (increasing NEWS) Yes ☐ No ☐

Do you have a Tracheostomy / Laryngectomy Yes ☐ No ☐
Tracheostomy /Laryngectomy care bundle in place Yes ☐ No ☐
Referral made to Airway specialist / ENT on call (date): ____/____/____ or No Issues / Risk ☑

Mobility / Falls

Baseline Mobility: Independent ☑ Uses Walking Aid ☐ Immobile ☐
Mobility on Admission: Independent ☑ Uses Walking Aid ☐ Immobile ☐
Please specify:
Physiotherapy Referral Required: ☐ Yes ☐ No
Falls action plan initiated (see Patient Care Assessment and Admission Record) ☐ Yes ☐ No
or No Issues / Risk ☑

Swallowing

Please note if stroke is suspected follow NHS Tayside Stroke Swallow Screening Protocol
Have you had any difficulties with swallowing: food ☐ liquids ☐
Is patient coughing or choking on oral intake Yes ☐ No ☐
Is patient alert enough to manage oral intake Yes ☐ No ☐
Utilise 'Flowchart/care plan for patients with compromised swallow ' or No Issues / Risk ☐

Hydration / Fluid Management

Do you require any assistance with drinking Yes ☐ No ☐
Do you use any special equipment Yes ☐ No ☐
Do you feel thirsty Yes ☐ No ☐
Nil by mouth Yes ☐ No ☐
Does patient require intravenous fluids Yes ☐ No ☐
Fluid management chart in use Yes ☐ No ☐
Peripheral cannula in situ Yes ☐ No ☐

Peripheral vascular catheter (PVC) Insertion and Maintenance Care Plan required Yes ☐ No ☐
or No Issues / Risk ☑

Oral Hygiene

Do you have a sore mouth Yes ☐ No ☑ Nil by mouth? Yes ☐ No ☐
Do you have dentures/plate Yes ☐ No ☐
What do you usually use to clean your teeth _____
Initiate oral hygiene care plan Yes ☐ No ☐
or No Issues / Risk ☑

ASSESSMENT

Elimination

Are you having any problems with: urinary incontinence ☑ urgency ☐ bowel incontinence ☐
Are these problems new Yes ☐ No ☐
If Yes - commence continence assessment form. If No – Consider contacting continence assessment service
Does patient have an indwelling urinary or supra pubic catheter in situ Yes ☐ No ☐ Please state:
Does patient undertake intermittent self catheterisation Yes ☐ No ☐
Refer to My Urinary Catheter Passport as applicable
Catheter Associated UTI (CAUTI) Insertion and Maintenance Care Plan required Yes ☐ No ☐
Do you require assistance to go to the toilet Yes ☐ No ☐
Do you have a stoma Yes ☐ No ☐ urgency.
Do you require assistance Yes ☐ No ☐
Do you suffer from constipation Yes ☐ No ☐ new problem ☐ long standing problem ☐
When did you last have a bowel motion
How do you usually manage your constipation or No Issues / Risk ☐

Personal Hygiene

Do you usually need help or use special equipment to:
Bathe Yes ☐ No ☑
Shower Yes ☐ No ☑
Dress Yes ☐ No ☑
What help is given / equipment used:

When you are in hospital, would you prefer to have a bath ☐ shower ☐ neither ☐
Referral to OT required Yes ☐ No ☐
Referral made to OT (date): ____ / ____ / ____ or No Issues / Risk ☑

Wound Care

Do you currently have a wound / broken skin Yes ☐ No ☐
Dressing in situ Yes ☐ No ☐
Wound post surgery Yes ☐ No ☐
Admitted with Pressure Ulcer Yes ☐ No ☐
Referral to Specialist Service required Yes ☐ No ☐
Referral made to Specialist Service - specify: _____ Date: ____ / ____ / ____
or No Issues / Risk ☑

Emotional Wellbeing /Spiritual Wellbeing

How are you feeling emotionally? Are you:
Well ☐ Down ☑ Depressed ☐ Anxious ☐ Other ☐ _____ or No Issues / Risk ☐
If identified as down, depressed, anxious or other, refer to medical staff if appropriate.
Consider seeking additional support e.g. Psychiatry of Old Age liaison , general adult psychiatry, wellbeing, chaplaincy if appropriate
Are there any spiritual, religious or pastoral areas you would like us to be aware of Yes ☐ No ☐
If yes, please state area and support offered:
No needs identified ☐

Sleep and rest

Do you usually have trouble sleeping Yes ☐ No ☐
Do you use any particular techniques to help you sleep Yes ☐ No ☐
How do you like to relax reading ☐ listening to music ☐ TV ☐ other: _____
On medication Yes ☐ No ☐
or No Issues / Risk ☐

End of Life Care

Is this relevant to patient Yes ☐ No ☐
Have NOK been made aware / updated on patient's condition Yes ☐ No ☐
Referral to palliative care required Yes ☐ No ☐
Referral made to palliative care (date): ____ / ____ / ____
Have NOK been invited to visit Yes ☐ No ☐

Patient Specific Area

Signature: CMackie. Print Name: CMACKIE
Date: 18/12/25 Time: 1150.

PATIENT FUNDS AND PROPERTY PROCEDURE

Patient Clothing / Belongings List

SECTION A - To be completed by Nursing Staff	
Patient Clothing / Belongings (e.g. pyjamas footwear, outdoor clothing, toiletries, wallet, purse, etc) – please list:	
Accessories (e.g. Laptop, iPad, Keys, mobile phone, etc) – please list:	
Prosthetics (e.g. Hearing Aids, Spectacles, Dentures, Walking Stick, etc)* – please list:	
Money / Jewellery (e.g. Notes, Coins, Bank Cards, Bus Pass, Necklace, Ring, Watch, etc) – please list:	
Compiled by (Signature):	Designation:
Print Name:	Date/Time:

Please ensure dentures / hearing aids stored in a personal named container

Please ensure all personal aids are cleared named

Deceased Patient belongings (ensure stored securely pending transfer to NOK) – please list:	
Compiled by (Signature):	Designation:
Print Name:	Date/Time:

Patient Funds and Property Procedure
Personal Disclaimer Form - Loss of Personal Effects
NHS Tayside will not accept any responsibility for loss or damage to any article/personal belongings unless such article/
personal belongings (including cash) have been handed over and accepted by NHS Tayside, for safe keeping and an official receipt issued

Section A TO BE COMPLETED BY NURSING STAFF

If , for whatever reason, the patient or patient's representative is unable or refusing to complete and sign section B below
at the time of admission inform the patient / representative verbally that they are responsible for their own belongings
and valuables and state below the reason for non completion of Section B.
Sign and date this, and enter a review date in Section C:

Reason:

Signature of Staff Recording _____ Signature of Staff Witness: _____ Date: _____

Section B TO BE COMPLETED BY PATIENT	**Section C**
I have been given the opportunity to read the above statement and *do / do not (*delete as appropriate) wish to take advantage of the facilities provided for safe keeping of my personal belongings. Signature: _____ Date: _____ Print Name: _____ Hospital: _____ Ward: _____ **If signing on behalf of a patient, please enter your relationship with the patient, and your address:** Relationship: _____ Address: _____ _____ Witness to above signature: _____ Print Name: _____ Date: _____	**If section A has been completed and a review is required, please enter review date (should be held every 4 weeks) noting two staff signatures required at each review** (1) Date: _____ Sign: _____ Sign: _____ (2) Date: _____ Sign: _____ Sign: _____ (3) Date: _____ Sign: _____ Sign: _____

Patient's funds and property procedure explained and **PF1 completed**?	☐ YES ☐ NO
Money/property to be handed over on behalf of patient for safekeeping?	☐ YES ☐ NO
(Please refer and follow section 2.2.3 of Patient's Funds and Property procedure)	

Note: When a patient is absent from the ward for treatment (e.g. x-ray, an operation), the safe custody of their property which has not been handed over to NHS Tayside for safe keeping, remains the patient's responsibility. Arrangements may be available whereby property can be handed over to Nursing Staff for safe keeping during such periods. However, please note that due to storage restrictions, it is not possible to store larger items.

DAILY CARE PLAN

Date: 18/12/25

Discussed with patient / carer on: ____ / ____ / ____

	MANAGEMENT / INTERVENTIONS *(Tick appropriate boxes)*		PERSON-CENTRED INTERVENTIONS
Person-Centred Approach	☐ ☐ Patient's personal goals ☐ ☐ Carer / family discussion ☐ ☐ Visitor arrangements ☐ ☐ What Matters to Me	Day	Settled into bay 2 - introduced to staff. DKA Protocol commenced. Lunch given.
		Night	Monitor BMs + ketones IV I
Communication	☐ ☐ Ensure environment conducive to communication ☐ ☐ Call buzzer ☐ ☐ Patient wears glasses ☐ ☐ Patient uses a hearing aid ☐ ☐ Refer to Speech and Language therapy ☐ ☐ Arrange Interpreter service ☐ ☐ Use written communication ☐ ☐ Use communication aid (specify):	Day	Able to make needs known, Call buzzer to hand.
		Night	Able to make needs known
Stressed or Distressed Behaviour	☐ ☐ Reduce stress / distress – specify: ☐ ☐ Identify causes i.e. (constipation, pain, urinary retention. Identify trigger, reduce these where possible ☐ ☐ Consider need for Violence & Aggression Risk Assessment	Day	No signs of stress/ distress.
		Night	Settled in a room, struggles to sleep. Says his mental health is not good and he finds his stay in a hospital hard to
Cognitive Impairment /Delirium	☐ ☐ Inform medical staff of change ☐ ☐ Consider further frailty screen if Previously negative ☐ ☐ If positive for frailty screening, Ensure appropriate assessment undertaken ☐ ☐ Encourage involvement of relatives and carers.	Day	No concerns. Alert and orientated.
		Night	Alert + orientated
Observations	☐ ☐ T,P,R,BP ☐ ☐ Pain score ☐ ☐ Fluid balance ☐ ☐ Weight ☐ ☐ Neuro obs ☑ ☐ Blood Glucose ☐ ☐ Circulation check	Day	NEWS Stable as per EOBS, BM as per DKA Protocol.
		Night	As charted
Symptom Relief	☐ ☐ Pain relief ☐ ☐ PAINGO framework ☐ ☐ Nausea relief ☐ ☐ Other (specify):	Day	Denies pain 1x episode of vomiting. Declined antiemetic.
		Night	1x vomiting. Refused ondansetron even though dose charted.
Respiration / Airway	☐ ☐ Oxygen required ☐ ☐ Nebulisers / Inhalers ☐ ☐ Compromised swallow ☐ ☐ Tracheostomy ☐ ☐ Laryngectomy ☐ ☐ Humidification	Day	Maintaining adequate O2 on room air
		Night	Sat well on Room Air

Section	Actions	Shift	Notes
Nutrition / hydration	☐ MUST rescreen due ☐ MUST care plan ☐ NBM / special diet ☐ Food / fluid chart ☐ Fluid restriction ☐ Parenteral / enteral feeds ☐ Oral supplements ☐ Enteral tube management ☐ Refer to dietitian	Day	Normal diet and fluids as able.
		Night	N D/F, T2DM on Insulin / [illegible]
Pressure Area Care	☐ Reassess daily as per PURA ☐ Use SSKIN Bundle ☐ Document type of pressure Relieving equipment ☐ Record any pressure ulcer on reverse of PURA, Wound Chart, if grade 2 or above – Datix	Day	Independently relieves pressure areas.
		Night	Ind.
Mobility	☐ Complete MH Risk Assessment Form ☐ Ensure required equipment is available ☐ Refer to physiotherapy / OT ☐ Consider activity chart	Day	Independently mobile.
		Night	Ind.
Elimination	☐ Assistance / supervision ☐ Provide equipment ☐ Bristol stool chart ☐ Utilise CAUTI bundle if catheter in situ ☐ Stoma care	Day	Continent, using bottles at bedside.
		Night	Continent.
Falls Risk	☐ Falls Action Plan implemented ☐ Minimum of 2 hourly care rounding initiated ☐ Falls equipment obtained as appropriate ☐ Update safety brief ☐ Assess need for bed rails (Include Risk Level)	Day	Low risk, safety maintained.
		Night	Safety maintained
Wound care	☐ Complete wound assessment chart ☐ Refer to Wound Formulary ☐ Drain care ☐ Refer to Specialist Service: ☐ Tissue Viability ☐ Plastic surgery ☐ Vascular ☐ Dermatology ☐ Podiatry	Day	Reports nil - skin unwitnessed by nursing staff.
		Night	NIL reported
Personal hygiene	☐ Self-care ☐ Basin / shower / bed bath as Preferred by patient ☐ Assistance with 1 / 2 nurse ☐ Oral Hygiene care plan ☐ All care required	Day	Independently meets personal hygiene tasks.
		Night	Ind.
Infection Control	☐ Ensure all invasive devices are documented and managed as per care plans ☐ Ensure appropriate patient placement in ward ☐ Covid Surveillance screening	Day	SICPs observed
		Night	SICPS
IV Fluids / Meds	☐ Fluids / meds ☐ PVC insertion and maintenance ☐ CVC insertion and maintenance ☐ S/C management	Day	1x Green PVC in L ACF, VIP-0
		Night	1 x PVC to (R) hand removed 1 x PVC to (L) ACF - VIP - 0

Day Shift	Night Shift
Signature [illegible] Time 16 05	Signature N. Moss Time 04:40

DAILY CARE PLAN

Date: 19 / 12 / 25

Discussed with patient / carer on: ___ / ___ / ___

	MANAGEMENT / INTERVENTIONS *(Tick appropriate boxes)*		PERSON-CENTRED INTERVENTIONS
Person-Centred Approach	☐ ☐ Patient's personal goals ☐ ☐ Carer / family discussion ☐ ☐ Visitor arrangements ☐ ☐ What Matters to Me	Day	Monitor BMs + ketones, diabetic nurses r/v ✓. home later today
		Night	
Communication	☐ ☐ Ensure environment conducive to communication ☐ ☐ Call buzzer ☐ ☐ Patient wears glasses ☐ ☐ Patient uses a hearing aid ☐ ☐ Refer to Speech and Language therapy ☐ ☐ Arrange Interpreter service ☐ ☐ Use written communication ☐ ☐ Use communication aid (specify):	Day	Able to communicate own needs, nursing buzzer to hand.
		Night	
Stressed or Distressed Behaviour	☐ ☐ Reduce stress / distress – specify: ☐ ☐ Identify causes i.e. (constipation, pain, urinary retention. Identify trigger, reduce these where possible ☐ ☐ Consider need for Violence & Aggression Risk Assessment	Day	Does not appear distressed, settled, sitting on chair @ present.
		Night	
Cognitive Impairment /Delirium	☐ ☐ Inform medical staff of change ☐ ☐ Consider further frailty screen if Previously negative ☐ ☐ If positive for frailty screening, Ensure appropriate assessment undertaken ☐ ☐ Encourage involvement of relatives and carers	Day	Alert and orientated, no cognitive issues
		Night	
Observations	☐ ☐ T,P,R,BP ☐ ☐ Fluid balance ☐ ☐ Pain score ☐ ☐ Weight ☐ ☐ Neuro obs ☐ ☐ Blood Glucose ☐ ☐ Circulation check	Day	NEWS - 0 4 hourly frequency
		Night	
Symptom Relief	☐ ☐ Pain relief ☐ ☐ PAINGO Framework ☐ ☐ Nausea relief ☐ ☐ Other (specify):	Day	No complaint of pain / nausea reported
		Night	
Respiration / Airway	☐ ☐ Oxygen required ☐ ☐ Nebulisers / Inhalers ☐ ☐ Compromised swallow ☐ ☐ Tracheostomy ☐ ☐ Laryngectomy ☐ ☐ Humidification	Day	Maintaining target sts on room air.
		Night	

Nutrition / hydration	☐ MUST rescreen due ☐ MUST care plan ☐ NBM / special diet ☐ Food / fluid chart ☐ Fluid restriction ☐ Parenteral / enteral feeds ☐ Oral supplements ☐ Enteral tube management ☐ Refer to dietitian	Day	Normal diet and fluid intake. BMs as charted.
		Night	
Pressure Area Care	☐ Reassess daily as per PURA ☐ Use SSKIN Bundle ☐ Document type of pressure Relieving equipment ☐ Record any pressure ulcer on reverse of PURA, Wound Chart, if grade 2 or above – Datix	Day	Independent
		Night	
Mobility	☐ Complete MH Risk Assessment Form ☐ Ensure required equipment is available ☐ Refer to physiotherapy / OT ☐ Consider activity chart	Day	Independent
		Night	
Elimination	☐ Assistance / supervision ☐ Provide equipment ☐ Bristol stool chart ☐ Utilise CAUTI bundle if catheter in situ ☐ Stoma care	Day	PU, BO, going to toilet
		Night	
Falls Risk	☐ Falls Action Plan implemented ☐ Minimum of 2 hourly care rounding initiated ☐ Falls equipment obtained as appropriate ☐ Update safety brief ☐ Assess need for bed rails (Include Risk Level)	Day	No falls reported, safety maintained
		Night	
Wound care	☐ Complete wound assessment chart ☐ Refer to Wound Formulary ☐ Drain care ☐ Refer to Specialist Service: ☐ Tissue Viability ☐ Plastic surgery ☐ Vascular ☐ Dermatology ☐ Podiatry	Day	Nil wounds reported.
		Night	
Personal hygiene	☐ Self-care ☐ Basin / shower / bed bath as Preferred by patient ☐ Assistance with 1 / 2 nurse ☐ Oral Hygiene care plan ☐ All care required	Day	Washed independently this am.
		Night	
Infection Control	☐ Ensure all invasive devices are documented and managed as per care plans ☐ Ensure appropriate patient placement in ward ☐ Covid Surveillance screening	Day	SLCPs.
		Night	
IV Fluids / Meds	☐ Fluids / meds ☐ PVC insertion and maintenance ☐ CVC insertion and maintenance ☐ S/C management	Day	1x PVC.
		Night	

Day Shift	Night Shift
Signature [signature] Time 1300	Signature Time

DAILY CARE PLAN

Date: ____ / ____ / ____

Discussed with patient / carer on: ____ / ____ / ____

	MANAGEMENT / INTERVENTIONS *(Tick appropriate boxes)*		PERSON-CENTRED INTERVENTIONS
Person-Centred Approach	☐ Patient's personal goals ☐ Carer / family discussion ☐ Visitor arrangements ☐ What Matters to Me	Day	
		Night	
Communication	☐ Ensure environment conducive to communication ☐ Call buzzer ☐ Patient wears glasses ☐ Patient uses a hearing aid ☐ Refer to Speech and Language therapy ☐ Arrange Interpreter service ☐ Use written communication ☐ Use communication aid (specify):	Day	
		Night	
Stressed or Distressed Behaviour	☐ Reduce stress / distress – specify: ☐ Identify causes i.e. (constipation, pain, urinary retention. Identify trigger, reduce these where possible ☐ Consider need for Violence & Aggression Risk Assessment	Day	
		Night	
Cognitive Impairment /Delirium	☐ Inform medical staff of change ☐ Consider further frailty screen if Previously negative ☐ If positive for frailty screening, Ensure appropriate assessment undertaken ☐ Encourage involvement of relatives and carers	Day	
		Night	
Observations	☐ T,P,R,BP ☐ Fluid balance ☐ Pain score ☐ Weight ☐ Neuro obs ☐ Blood Glucose ☐ Circulation check	Day	
		Night	
Symptom Relief	☐ Pain relief ☐ PAINGO Framework ☐ Nausea relief ☐ Other (specify):	Day	
		Night	
Respiration / Airway	☐ Oxygen required ☐ Nebulisers / Inhalers ☐ Compromised swallow ☐ Tracheostomy ☐ Laryngectomy ☐ Humidification	Day	
		Night	

Nutrition / hydration	☐ MUST rescreen due ☐ MUST care plan ☐ NBM / special diet ☐ Food / fluid chart ☐ Fluid restriction ☐ Parenteral / enteral feeds ☐ Oral supplements ☐ Enteral tube management ☐ Refer to dietitian	Day	
		Night	
Pressure Area Care	☐ Reassess daily as per PURA ☐ Use SSKIN Bundle ☐ Document type of pressure Relieving equipment ☐ Record any pressure ulcer on reverse of PURA, Wound Chart, if grade 2 or above – Datix	Day	
		Night	
Mobility	☐ Complete MH Risk Assessment Form ☐ Ensure required equipment is available ☐ Refer to physiotherapy / OT ☐ Consider activity chart	Day	
		Night	
Elimination	☐ Assistance / supervision ☐ Provide equipment ☐ Bristol stool chart ☐ Utilise CAUTI bundle if catheter in situ ☐ Stoma care	Day	
		Night	
Falls Risk	☐ Falls Action Plan implemented ☐ Minimum of 2 hourly care rounding initiated ☐ Falls equipment obtained as appropriate ☐ Update safety brief ☐ Assess need for bed rails (Include Risk Level)	Day	
		Night	
Wound care	☐ Complete wound assessment chart ☐ Refer to Wound Formulary ☐ Drain care ☐ Refer to Specialist Service: ☐ Tissue Viability ☐ Plastic surgery ☐ Vascular ☐ Dermatology ☐ Podiatry	Day	
		Night	
Personal hygiene	☐ Self-care ☐ Basin / shower / bed bath as Preferred by patient ☐ Assistance with 1 / 2 nurse ☐ Oral Hygiene care plan ☐ All care required	Day	
		Night	
Infection Control	☐ Ensure all invasive devices are documented and managed as per care plans ☐ Ensure appropriate patient placement in ward ☐ Covid Surveillance screening	Day	
		Night	
IV Fluids / Meds	☐ Fluids / meds ☐ PVC insertion and maintenance ☐ CVC insertion and maintenance ☐ S/C management	Day	
		Night	
	Day Shift Signature _____ Time _____		Night Shift Signature _____ Time _____

DAILY CARE PLAN

Date: ____ / ____ / ____

Discussed with patient / carer on: ____ / ____ / ____

	MANAGEMENT / INTERVENTIONS *(Tick appropriate boxes)*	PERSON-CENTRED INTERVENTIONS	
Person-Centred Approach	☐ Patient's personal goals ☐ Carer / family discussion ☐ Visitor arrangements ☐ What Matters to Me	**Day**	
		Night	
Communication	☐ Ensure environment conducive to communication ☐ Call buzzer ☐ Patient wears glasses ☐ Patient uses a hearing aid ☐ Refer to Speech and Language therapy ☐ Arrange Interpreter service ☐ Use written communication ☐ Use communication aid (specify):	**Day**	
		Night	
Stressed or Distressed Behaviour	☐ Reduce stress / distress – specify: ☐ Identify causes i.e. (constipation, pain, urinary retention. Identify trigger, reduce these where possible ☐ Consider need for Violence & Aggression Risk Assessment	**Day**	
		Night	
Cognitive Impairment /Delirium	☐ Inform medical staff of change ☐ Consider further frailty screen if Previously negative ☐ If positive for frailty screening, Ensure appropriate assessment undertaken ☐ Encourage involvement of relatives and carers	**Day**	
		Night	
Observations	☐ T,P,R,BP ☐ Fluid balance ☐ Pain score ☐ Weight ☐ Neuro obs ☐ Blood Glucose ☐ Circulation check	**Day**	
		Night	
Symptom Relief	☐ Pain relief ☐ PAINGO framework ☐ Nausea relief ☐ Other (specify):	**Day**	
		Night	
Respiration / Airway	☐ Oxygen required ☐ Nebulisers / Inhalers ☐ Compromised swallow ☐ Tracheostomy ☐ Laryngectomy ☐ Humidification	**Day**	
		Night	

Nutrition / hydration	☐ MUST rescreen due ☐ MUST care plan ☐ NBM / special diet ☐ Food / fluid chart ☐ Fluid restriction ☐ Parenteral / enteral feeds ☐ Oral supplements ☐ Enteral tube management ☐ Refer to dietitian	Day	
		Night	
Pressure Area Care	☐ Reassess daily as per PURA ☐ Use SSKIN Bundle ☐ Document type of pressure Relieving equipment ☐ Record any pressure ulcer on reverse of PURA, Wound Chart, if grade 2 or above – Datix	Day	
		Night	
Mobility	☐ Complete MH Risk Assessment Form ☐ Ensure required equipment is available ☐ Refer to physiotherapy / OT ☐ Consider activity chart	Day	
		Night	
Elimination	☐ Assistance / supervision ☐ Provide equipment ☐ Bristol stool chart ☐ Utilise CAUTI bundle if catheter in situ ☐ Stoma care	Day	
		Night	
Falls Risk	☐ Falls Action Plan implemented ☐ Minimum of 2 hourly care rounding initiated ☐ Falls equipment obtained as appropriate ☐ Update safety brief ☐ Assess need for bed rails (Include Risk Level)	Day	
		Night	
Wound care	☐ Complete wound assessment chart ☐ Refer to Wound Formulary ☐ Drain care ☐ Refer to Specialist Service: ☐ Tissue Viability ☐ Plastic surgery ☐ Vascular ☐ Dermatology ☐ Podiatry	Day	
		Night	
Personal hygiene	☐ Self-care ☐ Basin / shower / bed bath as Preferred by patient ☐ Assistance with 1 / 2 nurse ☐ Oral Hygiene care plan ☐ All care required	Day	
		Night	
Infection Control	☐ Ensure all invasive devices are documented and managed as per care plans ☐ Ensure appropriate patient placement in ward ☐ Covid Surveillance screening	Day	
		Night	
IV Fluids / Meds	☐ Fluids / meds ☐ PVC insertion and maintenance ☐ CVC insertion and maintenance ☐ S/C management	Day	
		Night	
	Day Shift Signature _____ Time _____	Night Shift Signature _____ Time _____	

DAILY CARE PLAN

Date: ____ / ____ / ____

Discussed with patient / carer on: ____ / ____ / ____

	MANAGEMENT / INTERVENTIONS *(Tick appropriate boxes)*		PERSON-CENTRED INTERVENTIONS
Person-Centred Approach	☐ Patient's personal goals ☐ Carer / family discussion ☐ Visitor arrangements ☐ What Matters to Me	Day	
		Night	
Communication	☐ Ensure environment conducive to communication ☐ Call buzzer ☐ Patient wears glasses ☐ Patient uses a hearing aid ☐ Refer to Speech and Language therapy ☐ Arrange Interpreter service ☐ Use written communication ☐ Use communication aid (specify):	Day	
		Night	
Stressed or Distressed Behaviour	☐ Reduce stress / distress – specify: ☐ Identify causes i.e. (constipation, pain, urinary retention. Identify trigger, reduce these where possible ☐ Consider need for Violence & Aggression Risk Assessment	Day	
		Night	
Cognitive Impairment /Delirium	☐ Inform medical staff of change ☐ Consider further frailty screen if Previously negative ☐ If positive for frailty screening, Ensure appropriate assessment undertaken ☐ Encourage involvement of relatives and carers	Day	
		Night	
Observations	☐ T,P,R,BP ☐ Fluid balance ☐ Pain score ☐ Weight ☐ Neuro obs ☐ Blood Glucose ☐ Circulation check	Day	
		Night	
Symptom Relief	☐ Pain relief ☐ PAINGO Framework ☐ Nausea relief ☐ Other (specify):	Day	
		Night	
Respiration / Airway	☐ Oxygen required ☐ Nebulisers / Inhalers ☐ Compromised swallow ☐ Tracheostomy ☐ Laryngectomy ☐ Humidification	Day	
		Night	

Nutrition / hydration	☐ MUST rescreen due ☐ MUST care plan ☐ NBM / special diet ☐ Food / fluid chart ☐ Fluid restriction ☐ Parenteral / enteral feeds ☐ Oral supplements ☐ Enteral tube management ☐ Refer to dietitian	Day	
		Night	
Pressure Area Care	☐ Reassess daily as per PURA ☐ Use SSKIN Bundle ☐ Document type of pressure Relieving equipment ☐ Record any pressure ulcer on reverse of PURA, Wound Chart, if grade 2 or above – Datix	Day	
		Night	
Mobility	☐ Complete MH Risk Assessment Form ☐ Ensure required equipment is available ☐ Refer to physiotherapy / OT ☐ Consider activity chart	Day	
		Night	
Elimination	☐ Assistance / supervision ☐ Provide equipment ☐ Bristol stool chart ☐ Utilise CAUTI bundle if catheter in situ ☐ Stoma care	Day	
		Night	
Falls Risk	☐ Falls Action Plan implemented ☐ Minimum of 2 hourly care rounding initiated ☐ Falls equipment obtained as appropriate ☐ Update safety brief ☐ Assess need for bed rails (Include Risk Level)	Day	
		Night	
Wound care	☐ Complete wound assessment chart ☐ Refer to Wound Formulary ☐ Drain care ☐ Refer to Specialist Service: ☐ Tissue Viability ☐ Plastic surgery ☐ Vascular ☐ Dermatology ☐ Podiatry	Day	
		Night	
Personal hygiene	☐ Self-care ☐ Basin / shower / bed bath as Preferred by patient ☐ Assistance with 1 / 2 nurse ☐ Oral Hygiene care plan ☐ All care required	Day	
		Night	
Infection Control	☐ Ensure all invasive devices are documented and managed as per care plans ☐ Ensure appropriate patient placement in ward ☐ Covid Surveillance screening	Day	
		Night	
IV Fluids / Meds	☐ Fluids / meds ☐ PVC insertion and maintenance ☐ CVC insertion and maintenance ☐ S/C management	Day	
		Night	
	Day Shift Signature _____ Time _____		Night Shift Signature _____ Time _____

DAILY CARE PLAN

Date: ____ / ____ / ____

Discussed with patient / carer on: ____ / ____ / ____

	MANAGEMENT / INTERVENTIONS *(Tick appropriate boxes)*		PERSON-CENTRED INTERVENTIONS
Person-Centred Approach	☐ Patient's personal goals ☐ Carer / family discussion ☐ Visitor arrangements ☐ What Matters to Me	**Day**	
		Night	
Communication	☐ Ensure environment conducive to communication ☐ Call buzzer ☐ Patient wears glasses ☐ Patient uses a hearing aid ☐ Refer to Speech and Language therapy ☐ Arrange Interpreter service ☐ Use written communication ☐ Use communication aid (specify):	**Day**	
		Night	
Stressed or Distressed Behaviour	☐ Reduce stress / distress – specify: ☐ Identify causes i.e. (constipation, pain, urinary retention. Identify trigger, reduce these where possible ☐ Consider need for Violence & Aggression Risk Assessment	**Day**	
		Night	
Cognitive Impairment /Delirium	☐ Inform medical staff of change ☐ Consider further frailty screen if Previously negative ☐ If positive for frailty screening, Ensure appropriate assessment undertaken ☐ Encourage involvement of relatives and carers	**Day**	
		Night	
Observations	☐ T,P,R,BP ☐ Fluid balance ☐ Pain score ☐ Weight ☐ Neuro obs ☐ Blood Glucose ☐ Circulation check	**Day**	
		Night	
Symptom Relief	☐ Pain relief ☐ PAINGO Framework ☐ Nausea relief ☐ Other (specify):	**Day**	
		Night	
Respiration / Airway	☐ Oxygen required ☐ Nebulisers / Inhalers ☐ Compromised swallow ☐ Tracheostomy ☐ Laryngectomy ☐ Humidification	**Day**	
		Night	

Nutrition / hydration	☐ MUST rescreen due ☐ MUST care plan ☐ NBM / special diet ☐ Food / fluid chart ☐ Fluid restriction ☐ Parenteral / enteral feeds ☐ Oral supplements ☐ Enteral tube management ☐ Refer to dietitian	Day	
		Night	
Pressure Area Care	☐ Reassess daily as per PURA ☐ Use SSKIN Bundle ☐ Document type of pressure Relieving equipment ☐ Record any pressure ulcer on reverse of PURA, Wound Chart, if grade 2 or above – Datix	Day	
		Night	
Mobility	☐ Complete MH Risk Assessment Form ☐ Ensure required equipment is available ☐ Refer to physiotherapy / OT ☐ Consider activity chart	Day	
		Night	
Elimination	☐ Assistance / supervision ☐ Provide equipment ☐ Bristol stool chart ☐ Utilise CAUTI bundle if catheter in situ ☐ Stoma care	Day	
		Night	
Falls Risk	☐ Falls Action Plan implemented ☐ Minimum of 2 hourly care rounding initiated ☐ Falls equipment obtained as appropriate ☐ Update safety brief ☐ Assess need for bed rails (Include Risk Level)	Day	
		Night	
Wound care	☐ Complete wound assessment chart ☐ Refer to Wound Formulary ☐ Drain care ☐ Refer to Specialist Service: ☐ Tissue Viability ☐ Plastic surgery ☐ Vascular ☐ Dermatology ☐ Podiatry	Day	
		Night	
Personal hygiene	☐ Self-care ☐ Basin / shower / bed bath as Preferred by patient ☐ Assistance with 1 / 2 nurse ☐ Oral Hygiene care plan ☐ All care required	Day	
		Night	
Infection Control	☐ Ensure all invasive devices are documented and managed as per care plans ☐ Ensure appropriate patient placement in ward ☐ Covid Surveillance screening	Day	
		Night	
IV Fluids / Meds	☐ Fluids / meds ☐ PVC insertion and maintenance ☐ CVC insertion and maintenance ☐ S/C management	Day	
		Night	
	Day Shift Signature _____ Time _____		Night Shift Signature _____ Time _____

DAILY CARE PLAN

Date: ____ / ____ / ____

Discussed with patient / carer on: ____ / ____ / ____

	MANAGEMENT / INTERVENTIONS *(Tick appropriate boxes)*	PERSON-CENTRED INTERVENTIONS	
Person-Centred Approach	☐ ☐ Patient's personal goals ☐ ☐ Carer / family discussion ☐ ☐ Visitor arrangements ☐ ☐ What Matters to Me	**Day**	
		Night	
Communication	☐ ☐ Ensure environment conducive to communication ☐ ☐ Call buzzer ☐ ☐ Patient wears glasses ☐ ☐ Patient uses a hearing aid ☐ ☐ Refer to Speech and Language therapy ☐ ☐ Arrange Interpreter service ☐ ☐ Use written communication ☐ ☐ Use communication aid (specify):	**Day**	
		Night	
Stressed or Distressed Behaviour	☐ ☐ Reduce stress / distress – specify: ☐ ☐ Identify causes i.e. (constipation, pain, urinary retention. Identify trigger, reduce these where possible ☐ ☐ Consider need for Violence & Aggression Risk Assessment	**Day**	
		Night	
Cognitive Impairment /Delirium	☐ ☐ Inform medical staff of change ☐ ☐ Consider further frailty screen if Previously negative ☐ ☐ If positive for frailty screening, Ensure appropriate assessment undertaken ☐ ☐ Encourage involvement of relatives and carers	**Day**	
		Night	
Observations	☐ ☐ T,P,R,BP ☐ ☐ Fluid balance ☐ ☐ Pain score ☐ ☐ Weight ☐ ☐ Neuro obs ☐ ☐ Blood Glucose ☐ ☐ Circulation check	**Day**	
		Night	
Symptom Relief	☐ ☐ Pain relief ☐ ☐ PAINGO Framework ☐ ☐ Nausea relief ☐ ☐ Other (specify):	**Day**	
		Night	
Respiration / Airway	☐ ☐ Oxygen required ☐ ☐ Nebulisers / Inhalers ☐ ☐ Compromised swallow ☐ ☐ Tracheostomy ☐ ☐ Laryngectomy ☐ ☐ Humidification	**Day**	
		Night	

Nutrition / hydration	☐ MUST rescreen due ☐ MUST care plan ☐ NBM / special diet ☐ Food / fluid chart ☐ Fluid restriction ☐ Parenteral / enteral feeds ☐ Oral supplements ☐ Enteral tube management ☐ Refer to dietitian	Day	
		Night	
Pressure Area Care	☐ Reassess daily as per PURA ☐ Use SSKIN Bundle ☐ Document type of pressure Relieving equipment ☐ Record any pressure ulcer on reverse of PURA, Wound Chart, if grade 2 or above – Datix	Day	
		Night	
Mobility	☐ Complete MH Risk Assessment Form ☐ Ensure required equipment is available ☐ Refer to physiotherapy / OT ☐ Consider activity chart	Day	
		Night	
Elimination	☐ Assistance / supervision ☐ Provide equipment ☐ Bristol stool chart ☐ Utilise CAUTI bundle if catheter in situ ☐ Stoma care	Day	
		Night	
Falls Risk	☐ Falls Action Plan implemented ☐ Minimum of 2 hourly care rounding initiated ☐ Falls equipment obtained as appropriate ☐ Update safety brief ☐ Assess need for bed rails (Include Risk Level)	Day	
		Night	
Wound care	☐ Complete wound assessment chart ☐ Refer to Wound Formulary ☐ Drain care ☐ Refer to Specialist Service: ☐ Tissue Viability ☐ Plastic surgery ☐ Vascular ☐ Dermatology ☐ Podiatry	Day	
		Night	
Personal hygiene	☐ Self-care ☐ Basin / shower / bed bath as Preferred by patient ☐ Assistance with 1 / 2 nurse ☐ Oral Hygiene care plan ☐ All care required	Day	
		Night	
Infection Control	☐ Ensure all invasive devices are documented and managed as per care plans ☐ Ensure appropriate patient placement in ward ☐ Covid Surveillance screening	Day	
		Night	
IV Fluids / Meds	☐ Fluids / meds ☐ PVC insertion and maintenance ☐ CVC insertion and maintenance ☐ S/C management	Day	
		Night	
	Day Shift Signature _____ Time _____		Night Shift Signature _____ Time _____

DISCHARGE PLAN

Planned patient discharge date: 19/12/25	Actual patient discharge date: 19/12/25 *(If delay please specify reason)*
Patient informed of date Yes ☑ No ☐ N/A ☐ Date 19/12/25 Initials of nurse COFO	Relative/carer informed of date Yes ☐ No ☐ N/A ☐ Who was informed: Date Initials of nurse

Patient Discharge Destination

Complete referral/s to Hospital Discharge Team / District Nurse / AHP or similar (if applicable) Please specify below:-

Date Initials of nurse

Transport Plan agreed and arrangements made to date and progress

Yes ☐ No ☐ N/A ☐

Please specify:-

Adult available to escort home if using own/public transport? Yes ☑ No ☐ N/A ☐

Please specify:- own way home

Date 19/12/25 Initials of nurse COF

Does the patient have any ongoing nutritional care needs Yes ☐ No ☐ N/A ☑ Has this been communicated to carers /relevant agencies Yes ☐ No ☐ N/A ☑ This information has been recorded on the discharge plan continuation sheet Yes ☐ No ☐ N/A ☑ Does patient currently have an infection / colonisation / history of positive culture e.g. MRSA, VRE, CDI, CPE, Norovirus, Covid etc Yes ☐ No ☐ N/A ☑ Please specify:-	Does the patient / carer understand the treatment they received Yes ☑ No ☐ N/A ☐ Healthcare /self-care /advice and information /speciality care plan given to patient and /or carer Yes ☑ No ☐ N/A ☐ state what type(s): diabetic Are staff /carers appropriately trained Yes ☑ No ☐ N/A ☐ Carer support referral postcard given Yes ☐ No ☐ N/A ☐ Date Initials of nurse

Medications ordered and sent to pharmacy Date Initials of nurse

Delivered to ward Date Initials of nurse

Dressings / catheter / equipment required Yes ☑ No ☐ N/A ☐

Specify: insulin, needles, libre

Supply ordered Yes ☐ No ☑ Date Initials of nurse

Patient's home is suitable for them to return to? I.e./ heating on / food in fridge / suitable for mobility requirements / equipment needs Yes ☑ No ☐ N/A ☐

Please specify:-

Does patient require a relative/ carer to be present at home on discharge Yes ☐ No ☐ N/A ☑

Please specify:-

Patient has key / access to inside of their home Yes ☑ No ☐ N/A ☐

Please specify:-

Patient has clothing and footwear for discharge that is appropriate for the weather conditions Yes ☑ No ☐ N/A ☐

DNA CPR	**Does patient have a new DNA CPR during this admission** Yes ☐ No ☐ N/A ☑ If yes, copy of DNA CPR Form given to patients Yes ☐ No ☐ If yes, has NOK been informed of DNA CPR status Yes ☐ No ☐ Please specify:-
COVID	**COVID STATUS (please circle):** POSITIVE / RECOVERED / CONTACT / NEGATIVE Isolation Required until:_____ EDD Updated with COVID information Yes ☐ No ☐ N/A ☐ Health Protection Team notified is self isolation required: Yes ☐ No ☐ N/A Date(s) of most recent negative test:
Financial Inclusion:	Have you got any money worries that might affect how you are feeling? e.g. welfare benefits or debt If yes, Would the patient like to be referred to an advice service (If no, make patient aware of Advice Centre) If yes, Gain verbal consent and refer to Advice centre. Referral completed ☐
Employment	Employed / Unemployed / Retired / No paid employment (e.g. unpaid carer) *If unemployed consider employability – refer to Advice Centre for signposting.

Please specify:-

If any issues highlighted from any of the information obtained during the admission or as part of the discharge plan: Please describe plan and interventions required for effective and safe discharge including any conversations you have with the patient/carer on Discharge Plan Continuation sheet If a referral to Social Work, Enablement Team, or District Nurse are required, please complete the Social work/District Nurse Referral Form.
For patients with Learning Disability/ Dementia consider holding a pre-discharge multidisciplinary meeting

PREPARATION FOR DISCHARGE e.g. complex discharge, case conference etc

DATE & TIME		SIGN & PRINT
19/12/25	Dietetic nurses came to see and happy with education given EDD completed. happy to go home.	

Version 1

ℝ Practice Encounter Report

Gavin Charles Skretkowicz 04/08/1975 Male NHS: 970.87.685 CHI: 0408750014

Many Thanks for seeing Dr C Thomas

Address and Telephone numbers

34 St James Road Forfar DD8 1LG
Mobile phone 07984 270423
Email gavskretkowicz@goolemail.com

Significant Medical History

26/02/2021 Consent given for communication by email Mrs Denise Eggie
29/05/2019 Essential hypertension Dr Caroline Thomas
24/04/2017 Type 2 diabetes mellitus Dr Matthew Adam
02/06/2014 [X]Post - traumatic stress disorder Dr Matthew Adam
30/07/2004 Fracture of ankle left
Dr Matthew Adam
01/06/2000 [X]Depressive episode Dr Matthew Adam
08/02/1998 Overdose of drug Dr Matthew Adam
01/01/1984 Fostered Dr Matthew Adam
02/03/1982 Fracture of humerus left Dr Matthew Adam

Current Repeat Medication

CMS Item Vensir XL 75mg capsules (Morningside Healthcare Ltd) Until: 24/09/2026 CMS last disp.: 17/11/2025 Dispensed: 2 maximum 7 every 56 days Supply: (392) capsule 1 CAPSULE ONCE DAILY (TOTAL DOSE 225MG DAILY)
Notes for patient: Please note: Your prescription for Venlafaxine MR capsules has been changed to a different brand of the same drug called Vensir XL capsules as it is more cost effective to prescribe. The strength and dose remains the same therefore you should notice no difference in your treatment. Dr Caroline Thomas
CMS Item Atorvastatin 20mg tablets Until: 24/09/2026 CMS last disp.: 17/11/2025 Dispensed: 2 maximum 7 every 56 days Supply: (392) tablet 1 TABLET ONCE A DAY Dr Caroline Thomas
CMS Item Lisinopril 5mg tablets Until: 24/09/2026 CMS last disp.: 17/11/2025 Dispensed: 2 maximum 7 every 56 days Supply: (392) tablet 1 TABLET ONCE A DAY Dr Caroline Thomas
CMS Item Amitriptyline 25mg tablets Until: 24/09/2026 CMS last disp.: 17/11/2025 Dispensed: 2 maximum 7 every 56 days Supply: (784) tablet TAKE 2 TABLETS AT NIGHT Dr Caroline Thomas
CMS Item Prazosin 500microgram tablets Until: 24/09/2026 CMS last disp.: 09/12/2025 Dispensed: 2 maximum 7 every 56 days Supply: (1568) tablet FOUR TABLETS AT NIGHT AS ADVISED BY CMHT Dr Caroline Thomas
CMS Item Vensir XL 150mg capsules (Morningside Healthcare Ltd) Until: 24/09/2026 CMS last disp.: 09/12/2025 Dispensed: 2 maximum 7 every 56 days Supply: (392) capsule 1 CAPSULE ONCE DAILY (TOTAL DOSE 225MG DAILY)
Notes for patient: Please note: Your prescription for Venlafaxine MR capsules has been changed to a different brand of the same drug called Vensir XL capsules as it is more cost effective to prescribe. The strength and dose remains the same therefore you should notice no difference in your treatment. Dr Caroline Thomas
Repeat Sildenafil 50mg tablets Last issued: 04/03/2025 Issued: 1 maximum 1 allowed Supply: (4) tablet 1 TABLET WHEN REQUIRED Dr Caroline Thomas

Acutes issued in past 3 months

No data recorded.

Allergies and Intolerances

No data recorded.
No data recorded.

Referrals and Requests in last 3 months

No data recorded.

Tests in last 3 months

18/12/2025 Oxygen saturation at periphery 99 % Dr Caroline Thomas
18/12/2025 Surgery consultation Dr Caroline Thomas
18/12/2025 Consultation not feeling right for last month, excessive thirst ++, polyuria over 3 litres daily, weight loss 10 kg since last diabetic review, vomiting in the mornings, no abdo pain, TATT, wolly head at times, urine ketones ++++, blood ketones 3.1, BM 24.5, ketoacidosis, admit via AMU Dr Caroline Thomas
18/12/2025 Oxygen saturation at periphery 99 % Dr Caroline Thomas
18/12/2025 O/E - pulse rate 87 beats/min Dr Caroline Thomas
18/12/2025 09:24.00 BP 129 / 94 taken Sitting Cuff: Standard recall due: O/E - blood pressure reading Dr Caroline Thomas
18/12/2025 Surgery consultation Mrs Kim Birse
18/12/2025 Administration Gav attended for diabetic annual appointment I will rearrange this for later. Mrs Kim Birse
16/12/2025 Administration Mrs Kim Birse - No Data Recorded

Immunisations

05/12/2022 COVPFIZER Stage: 1 Given Due 05/12/2022 Batch: GD6800 C-19 Comirnaty (Forfar Vaccination Centre)
05/12/2022 FLUQIVC Stage: 1 Given Due 05/12/2022 Batch: 440151A FLU - Seqirus UK (Forfar Vaccination Centre)
12/11/2021 COVPFIZER Stage: 1 Given Due 12/11/2021 Batch: FK0596 C-19 Booster Pfizer (Reid Hall)
12/11/2021 FLUQIVC Stage: 1 Given Due 12/11/2021 Batch: 3079181A FLU - Flucelvax Tetra (QIVc) (Reid Hall)
04/05/2021 COVOXFORD Stage: 2 Given Routine Measure Due 04/06/2021 Batch: PW40041 C-19 AstraZeneca (By D Eggie 13231) Dr Caroline Thomas
26/02/2021 COVOXFORD Stage: 1 Given Routine Measure Due 26/03/2021 Batch: PV46669 C-19 AstraZeneca (By D Eggie 13231) Dr Caroline Thomas
05/10/2020 FLU Stage: 1 Given Routine Measure Due 05/10/2021 Batch: P100251946 exp 06/2021 Mrs Kim Birse
02/11/2019 FLU Stage: 1 Given Due Batch: P100119212 FLUCELVAX TETRA 0.5ML LEFT ARM SEQUIRUS EXP 06/2020 Dr Federated User

29/09/1988 BCG Stage: 0 Given Routine Measure Due
31/03/1987 IGTETANUS Stage: 0 Given Routine Measure Due
01/04/1981 POLIO Stage: B Given Routine Measure Due 01/04/1991
01/04/1981 TETANUS Stage: B Given Routine Measure Due 01/04/1991
01/04/1981 PERTUSSIS Stage: B Given Routine Measure Due
01/04/1981 DIPHTHERIA Stage: B Given Routine Measure Due 01/04/1991

BP

18/12/2025 09:24.00 BP 129 / 94 taken Sitting Cuff: Standard recall due: O/E - blood pressure reading Dr Caroline Thomas
28/02/2025 11:56.00 BP 135 / 87 taken Sitting Cuff: Standard recall due: O/E - blood pressure reading Miss Sarah Clark

06/08/2024 09:36.00 BP 116 / 86 taken Sitting Cuff: Standard recall due: O/E - blood pressure reading p81 127/87 p78 Mrs Kim Birse

Smoking

06/08/2024 Smoker Cigarettes: 15 Cigarette smoker Mrs Kim Birse

Alcohol

06/08/2024 Current drinker Alcohol consumption has 1 glass of cider if he goes out for a meal Mrs Kim Birse

Weight

28/02/2025 Weight: 140.6 kgs BMI: 40.7 O/E - weight Miss Sarah Clark

Height

06/08/2024 Height: 1.858 metres O/E - height Mrs Kim Birse

Blood Group

No data recorded.

Current Consultation:

18/12/2025 Surgery consultation Dr Caroline Thomas

18/12/2025 Consultation not feeling right for last month, excessive thirst ++, polyuria over 3 litres daily, weight loss 10 kg since last diabetic review, vomiting in the mornings, no abdo pain, TATT, wolly head at times, urine ketones ++++, blood ketones 3.1, BM 24.5, ketoacidosis, admit via AMU Dr Caroline Thomas

18/12/2025 Oxygen saturation at periphery 99 % Dr Caroline Thomas

18/12/2025 O/E - pulse rate 87 beats/min Dr Caroline Thomas

18/12/2025 09:24.00 BP 129 / 94 taken Sitting Cuff: Standard recall due: O/E - blood pressure reading Dr Caroline Thomas

18/12/2025 Surgery consultation Mrs Kim Birse

18/12/2025 Administration Gav attended for diabetic annual appointment I will rearrange this for later. Mrs Kim Birse

16/12/2025 Administration Mrs Kim Birse - No Data Recorded

16/12/2025 Administration Miss Kirsty Alalibo - No Data Recorded

27/08/2025 Administration Mrs Lynn Ferrar

27/08/2025 Diabetes monitoring 2nd letter Seen by: Clinician: Mrs Lynn Ferrar

21/07/2025 Administration Miss Rebecca Hardie - No Data Recorded

21/07/2025 Administration Ms Morag Grant

21/07/2025 Diabetes monitoring 1st letter Seen by: Clinician: Ms Morag Grant ANNUAL & MENTAL HEALTH

Date and Time: 19/12/25

Nurse Signature: N. Moss

Ward 4 Patient Transfer Sheet
Ninewells Hospital

[ ] Gen Med
[ ] Diabetes
[ ] Other: _____

Situation

Patient Name, Age, Chi
Reason for Admission

Patient Name: Gavin Stretkavicz	Chi:		Age: 50
Reason For Admission	Unwell for last month ↑BMs ↑ketones, DKA protocol weight loss, vomiting		

Background

Past Medical History
Social History + POC
Baseline Mobility
Elimination
DNACPR
Venalink

Past Medical History	Non-insulin dep. diabetic ↑2DM, essential hypotension, depression			
Social History	alone @ home	Package of Care		
DNACPR	Next of Kin	unverified ?adopted	Elimination	continent
Venalink	Baseline Mobility	Ind.		

Assessment

Nutrition and Fluid Balance
MUST
PUP
Skin Integrity
Current Mobility
Falls Risk
NEWS
AWI
Infection Control
Investigations

Nutrition/Fluid Balance	MUST	PUP	Skin Integrity	
N D+F			intact	
Current Mobility	**Falls Risk**	**NEWS**	**AWI**	**Infection Control**
Ind.				

Investigations	

Recommendation

Plan
IV Fluids and Antibiotics
Interventions
MDT

MDT Involvement	Physiotherapist Y/N	Occupational Therapist Y/N	Dietitian Y/N	Discharge Team Y/N

Intravenous Fluids	Intravenous Antibiotics
IVI	

Plan	On insulin monitor BMs + ketones DSN A/V for insulin + education ☐ - issue Freestyle Libre ☐

Acute Medical Unit
Ninewells Hospital

Patient Name:

CHI Number:

Patient Clothing / Belongings List

Item Names	Quantity	Item Names	Quantity	Item Names	Quantity
Bag		Hoodie		Sweater	
Belt		Jacket		T-Shirt	
Bra		Jeans		Tank top	
Blouse		Jogging Bottoms		Tights	
Boots		Jumper		Trousers	
Braces		Night Dress		Toilet Bag	
Blazer		Pants		Top	
Cardigan		Purse		Tie	
Coat		Pyjamas		Track Suite	
Dress		Scarf		Trainers	
Dressoing gown		Sandals		Towels	
Fleece		Shirt		Under Shirt	
Gloves		Skirt		Vest top	
Hat		Shoes		Wallet	
Hand Bag		Short			
Hand Towels		Slippers			
Handkerchief		Socks			
House Coat		Sweat shirt			

Accessories

Laptop		Tablet/IPad		Electric shaver	
Mobile Phone		Keys		Chargers	

Prosthetics:

Community alarm		Hearing Aids		Sun glasses	
Crutches		Spectacles			
Dentures Top Set		Walking Stick			
Dentures Bottom Set		Wheelchair			
False Limbs		Zimmer			

Money:

Notes	£	Coins		
Bank Cards		Bus Pass		

Jewellery:

Beads Necklaces		Earrings Silver		Rings Silver	
Bead bracelets		Necklace yellow metal		Watch	
Bracelets yellow metal		Necklace silver			
Bracelets Silver		Rings yellow metal			
Earrings yellow metal					

Staff Signature:

Date: / /

Bay/Side Room_____ Bed_____

RAPIDPoint® 500e

VENOUS SAMPLE
18 . 12 . 2025 11:17
System ID 0500-62207

Patient ID	0408750014
Lst Name	SKRETKOWICZ
1st Name	GAVIN
Operator	HAXR

ACID/BASE 37.0 °C

H^+	49.4	nmol / L
pCO_2	4.01	kPa
pO_2	6.29	kPa
HCO_3^-act	14.7	mmol / L
BE(B)	- 9.8	mmol / L

CO-OXIMETRY

tHb	197	g / L
sO_2	88.9	%
FO_2Hb	85.1	%
FCOHb	4.2	%
FMetHb	0.1	%
FHHb	10.6	%

CORRECTED 37.0 °C

pH(T)	7.306	
pCO_2(T)	4.01	kPa
pO_2(T)	6.29	kPa

ELECTROLYTES

Na^+	136.1	mmol / L
K^+	4.49	mmol / L
Ca^{++}	1.23	mmol / L
Cl^-	100	mmol / L

METABOLITES

Glu	25.5	mmol / L
Lac	1.44	mmol / L

Temperature 37.0 °C

RAPIDPoint® 500e

VENOUS SAMPLE
18 . 12 . 2025 23:57
System ID 0500-62207

Patient ID	0408750014
Lst Name	SKRETKOWICZ
1st Name	GAVIN
Operator	EDGEL

ACID/BASE 37.0 °C

H^+	40.1	nmol / L
pCO_2	4.38	kPa
pO_2	7.14	kPa
HCO_3^-act	19.7	mmol / L
BE(B)	- 4.0	mmol / L

CO-OXIMETRY

tHb	175	g / L
sO_2	89.3	%
FO_2Hb	87.2	%
FCOHb	2.4	%
FMetHb	0.0	%
FHHb	10.4	%

CORRECTED 37.0 °C

pH(T)	7.396	
pCO_2(T)	4.37	kPa
pO_2(T)	7.13	kPa

ELECTROLYTES

Na^+	137.5	mmol / L
K^+	4.11	mmol / L
Ca^{++}	1.17	mmol / L
Cl^-	108	mmol / L

METABOLITES

Glu	13.7	mmol / L
Lac	1.50	mmol / L

Temperature 37.0 °C

F_iO_2 21.0 %

NHS TAYSIDE

24 HOUR SKIN* and Care Round** Record Sh

Ward........................ Hospital ....

SKIN Chart required Y N (circle)

MATTRESS TYPE- High Specification Foam ☐

Invacare Active ☐ Other state ______________

Pressure Ulcer Treatment Plan A B C (circle)

PATIENT DETAILS

(Affix Label)

NAME Qav Skeetkowcz

CHI

DOB 0408750014.

Date/s 18/12/15 Mark each box with TICK or N/A or I (intervention) If Intervention given rec

Care Round	TIME	12		14		16										
Are you comfortable? Anything you need? e.g toilet / drink or snack/ oral supplement / painkillers etc. (update nursing charts as required)		✓		✓		✓										
Nurse call system/ drink/ tissues etc within reach?		✓		✓		✓										
Is this patient more confused, agitated, sleepy or withdrawn **(THINK DELIRIUM)**																

CARE ROUND

Re-position frequency required .... hourly Maximum Seating Time

Pressure Relief	TIME															
Check any powered mattress is working																
Mobilise/ Reposition Code (State CODE in box)																
Check **ALL** pressure areas- incude heels and toes																
Heel protectors in place/ correct seating and cushion (if applicable)																
Check antiembolic stockings are prescribed on the TPAR and review need **daily**																
If antiembolic stockings prescribed check heels and toes **8 hourly**																
Skin is free from wetness or incontinence																
Dry skin is moistened with emollients																
Initials		[illegible]		[illegible]		[illegible]										

SKIN CHART

CODES

W	Patient Walking	L	Left lateral 30 degree tilt	R	Right lateral 30 degree tilt	P	Prone (front)	B
C	Sitting in chair	CP	Pressure relieved in chair	A	Asleep	BA	Angle of Bed changed	T
N/C	Patient declined	M	Mealtime	O	Off ward	S	Stand	PT/ O

* Follow NHST Policy for the prevention and management of pressure ulcers. For Variance in any section, document care and progress in the record

** Agree with the patient when the next care intervention is due and encourage to contact nurse beforehand if required.

ADULT INSULIN PRESCRIPTION AND ADMINISTRATION RECORD (IPAR)

Affix Patient Label

DATE: 18/12/25
Ward: AMY
Hospital: NWS.
Chart No.

GAVIN SKERETHOWICZ

NHS Tayside

BARCODE

Prescribing subcutaneous insulin

DO NOT USE abbreviations 'U' or 'IU' when prescribing insulin.

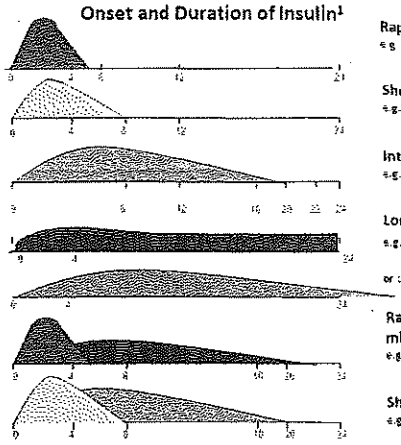
If the usual insulin regimen is unknown, do not omit insulin, but use a suitable substitute until insulin details are established use the diagram opposite to guide a suitable alternative preparation e.g.

- Prescribe once daily or twice daily isophane in the elderly
- Use short-acting/intermediate mixture twice daily in others
- Calculate dose as 0.3 units/kg/24hrs for those at risk of hypoglycaemia, 0.5 units/kg/24hrs if insulin resistant

Review monitoring results daily and adjust insulin if required to optimise blood glucose control to avoid hypoglycaemia and hyperglycaemia.

Only prescribe intravenous insulin in acutely unwell or fasting patients, or those who are unable to tolerate oral intake.

Onset and Duration of Insulin[1]



[1] Schemaic adapted and reproduced with permission from figure 2.2 Sreenan AJ and Bailey CJ. Type 2 Diabetes in Practice. The Royal Society of Medicine Press, London 2001 ISBN: 1853154622

Routine Subcutaneous Insulin Prescription Insulin device for self use.....

Start Date	Name of Insulin Preparation [in CAPITALS]	Dose	Time of Administration e.g. before breakfast e.g. at 22.00 hours	Prescribed by	Discontinued by Sign, date and draw a line through prescription
18/12	TOUJEO.	18 units	Morning (8am)		
18/12	NOVORAPID	6 units	Before breakfast		
18/12	NOVORAPID	6 units	Before lunch		
18/12	NOVORAPID	6 units	Before dinner.		
		units			
		units			
		units			
		units			
		units			
		units			
		units			
		units			
		units			
		Self-managed by Continuous Subcutaneous Insulin Infusion (CSII) Pump			

ONCE ONLY 'STAT' INSULIN DOSE PRESCRIPTION Caution: use with care - STAT doses of rapid acting insulin can precipitate hypoglycaemia

Date	Name of Insulin Preparation	Dose in Units	Time e.g. 09.00 hours	Prescribed by	Administered by	Time given	Reason for STAT dose
18/12	TOUJEO	18 units	14:10		NB/RB	1525	
19/12	NOVORAPID	6 units	0630	SJWEBSTER (0600)	NM/LC	07:00	
19/12	NOVORAPID	10 units	12:15	(Matild)	Self admn.	1215	
		units					
		units					
		units					

Insulin Administration, Blood Glucose and Ketone Monitoring Record

See guidelines for hyperglycaemia and hypoglycaemia on reverse.

(BG Blood Glucose)

DATE	BREAKFAST	LUNCH	EVENING MEAL	SUPPERTIME
TIME:				
Ketone: urine/blood				
BG mmol/L			15.3	
HbA1c mmol/L				
Insulin name and dose in units	Novorapid units With units	units units	Novorapid units Withheld due units	units units
Given by			to VE11 NB.	
Hypoglycaemia treatment BG rechecked by				
18/12/25	BREAKFAST	LUNCH	EVENING MEAL	SUPPERTIME
TIME:	05:30 0900	1200 1330		
Ketone: urine/blood	2.9 1.9	1.9 2.1 1.4		
BG mmol/L	14.4 20.1	18.4 15.4 15.4		
HbA1c mmol/L				
Insulin name and dose in units	Tresiba 18 units Novorapid 6 units	units units	units units	units units
Given by	IOP / ✗			
Hypoglycaemia treatment BG rechecked by				
	BREAKFAST	LUNCH	EVENING MEAL	SUPPERTIME
TIME:				
Ketone: urine/blood				
BG mmol/L				
HbA1c mmol/L				
Insulin name and dose in units	units units	units units	units units	units units
Given by				
Hypoglycaemia treatment BG rechecked by				
DATE	BREAKFAST	LUNCH	EVENING MEAL	SUPPERTIME
TIME:				
Ketone: urine/blood				
BG mmol/L				
HbA1c mmol/L				
Insulin name and dose in units	units units	units units	units units	units uni
Given by				
Hypoglycaemia treatment BG rechecked by				

KEY PERFORMANCE INDICATORS: Improvement is required if any of the questions below are answered NO

Insulin Prescribing:

1. Is insulin preparation prescribed using capital letters? Yes/No
2. Is insulin prescribed in the main prescription document? Yes/No
3. Is insulin dose prescribed <u>without abbreviation</u> 'u' or 'iu'? Yes/No
4. Has insulin been administered at each time prescribed? Yes/No

Hypoglycaemia Management (in the event of BG < 4mmol/L)

1. Is treatment for hypoglycaemia available in the ward? Yes/No
2. Was the appropriate treatment given to patient? Yes/No
3. Was blood glucose rechecked in 15 minutes? Yes/No
4. Has diabetes management and medication been reviewed? Yes/No

	BREAKFAST			LUNCH			EVENING MEAL			SUPPERTIME		
TIME:												
Ketone urine/blood												
BG mmol/L												
BG < 4mmol/L												
Insulin name and dose in units			units			units			units			units
			units			units			units			units
Given by												
Hypoglycaemia treatment BG rechecked by												

DATE	BREAKFAST			LUNCH			EVENING MEAL			SUPPERTIME		
TIME:												
Ketone urine/blood												
BG mmol/L												
BG < 4mmol/L												
Insulin name and dose in units			units			units			units			units
			units			units			units			units
Given by												
Hypoglycaemia treatment BG rechecked by												

DATE	BREAKFAST			LUNCH			EVENING MEAL			SUPPERTIME		
TIME:												
Ketone urine/blood												
BG mmol/L												
BG < 4mmol/L												
Insulin name and dose in units			units			units			units			units
			units			units			units			units
Given by												
Hypoglycaemia treatment BG rechecked by												

DATE	BREAKFAST			LUNCH			EVENING MEAL			SUPPERTIME		
TIME:												
Ketone urine/blood												
BG mmol/L												
BG < 4mmol/L												
Insulin name and dose in units			units			units			units			units
			units			units			units			units
Given by												
Hypoglycaemia treatment BG rechecked by												

Subcutaneous Insulin Administration in Hospital Guideline

THINK: Does this patient self-administer insulin at home and/or will be self-administering insulin on discharge from hospital?

No → **LEVEL 1: Nurse administered**
ACT: Nurse administers insulin as prescribed with an insulin syringe and vial of insulin

Yes ↓

CHECK: Is this patient currently well enough to self-administer subcutaneous insulin safely using an insulin device/ syringe?

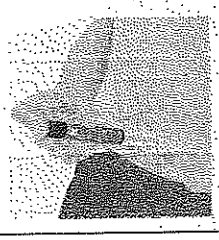
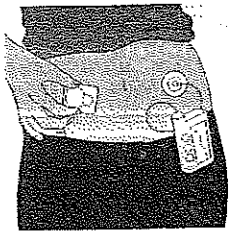
No → **LEVEL 1: Nurse administered**
ACT: Nurse administers insulin as prescribed with an insulin syringe and vial of insulin

Yes ↓

CHECK: Assess self-administration of subcutaneous insulin under nurse supervision/ observation - is this patient currently competent to safely administer insulin without supervision?

No → **LEVEL 2: Supervised self-administration**
ACT: Facilitate self-administration of insulin as prescribed under nurse supervision/observation

Yes → **LEVEL 3: Self administration**
ACT: Facilitate self-administration of prescribed insulin

LEVELS	Checklists
Level 1 **Nurse administered** 	• Monitor blood glucose using quality controlled hospital meter • Ensure prescribed Insulin is on the main drug chart and on the appropriate insulin prescription chart • Use an insulin syringe and a vial of insulin * see overleaf • Review glycaemic control daily with medical staff to assess efficacy of management • At discharge: ➢ Arrange appropriate support for insulin administration /refer to district nursing service ➢ Supply insulin syringes, prescribed insulin in a vial and appropriate sharps disposal
Level 2 **Supervised self-administration** 	• Monitor blood glucose using quality controlled hospital meter • Ensure prescribed Insulin is on the main drug kardex and on the appropriate insulin prescription chart • Provide sharps disposal unit and a safe repository for insulin storage in patient own drug (POD) locker • Observe and document all insulin administration • Review glycaemic control daily with medical staff to assess efficacy of management • Refer to Diabetes Specialist Nurse for education and follow up as required • Complete nurse patient partnership agreement overleaf • At discharge: ➢ Arrange ongoing support, supply pen needles, inform Diabetes Specialist Nurse Team
Level 3 **Self administration** 	Review daily, more often if clinically indicated. • Check the patient is currently well enough to self-administer insulin • Monitor blood glucose using quality controlled hospital meter • Review insulin management if blood glucose levels are not within 4 – 12 mmol/L. • Ensure prescribed Insulin is on the main drug kardex and on the appropriate insulin prescription chart • Provide sharps disposal unit and a safe repository for insulin storage in POD locker • Document all insulin administration • For antenatal women: Is blood ketone level < 0.6 mmol/L? • Complete nurse patient partnership agreement overleaf
LEVEL 3 **CSII** 	Continuous subcutaneous Insulin Infusion (CSII) is self managed by the patient Mealtime insulin/carbohydrate (CHO) ratio is .....units/.....grams CHO ➢ The following should available for use in hospital: • A vial of prescribed insulin • Infusion sets and reservoirs for insulin pump • Spare batteries for insulin pump (supplied by pump manufacturer) • Blood ketone monitoring • Contact details for the diabetes team • Basal insulin and appropriate device incase conversion to subcutaneous insulin is necessary • Rapid acting insulin and appropriate device in the event of conversion to subcutaneous insulin ➢ Complete nurse patient partnership agreement overleaf

Practical advice for administration of subcutaneous insulin

- Insulin pen devices and Continuous Subcutaneous Insulin Infusion pumps (CSII) are designed for 'self use' only.
- *Pen needles with automatic protective shields are available for use to reduce risk of needle stick injury.
- *Nurses should not administer insulin using an insulin device due to the risk of needle stick injury unless insulin safety pen needle is used.
- Do not extract insulin from prefilled insulin devices and cartridges with a syringe. This will damage the plunger mechanism. Also, if insulin is extracted from a pen device containing high strength insulin preparations (U200 per m/L and U300 per mL preparations) will lead to significant overdose.
- Patient's own insulin should be appropriately labelled with their name, DOB and CHI.
- Insulin pen needles and syringes should be used once only and disposed of in a sharps box.
- Cartridges are not interchangeable with different pen devices.
- Patient education must be facilitated if insulin device or insulin preparation is changed as devices often differ.
- **Refer to Diabetes Nurse Team as required**

Storage of insulin

- Identification of a safe insulin storage and sharps disposal is the responsibility of the registered nurse.
- Specific storage guidelines for each insulin preparation are available in the product package insert.
- 'In-use' prefilled insulin pen devices and cartridges can be stored at room temperature / in POD locker for a maximum of 28 days.
- Always document 'date of first use' on insulin vials and discard after 28 days.
- **Do not store 'in use' insulin devices in ward fridge** (there is a risk of cross infection if pens or devices are inadvertently used for more than one patient).
- Store **unopened** vials, pen devices and cartridges in the ward medicine fridge ($2-8\ ^{0}C$).

Nurse Patient Partnership for Insulin Administration

Once a patient has been identified as being suitable to self-administer insulin at either Level 2 or 3 then agreement with the patient on roles and responsibilities and consent must be obtained.

Roles and Responsibilities

1. Insulin preparation, doses and times will be prescribed on the hospital drug prescription record and insulin prescription chart by us and agreed with yourself.
2. You will be responsible for administration of your insulin and for telling the nurse when and what you have taken to allow an accurate update of your records.
3. You will inform us if you are unsure, or have any problems with your insulin.
4. You will keep your insulin in a safe place, in a patient own drug (POD) locker.
5. You will be responsible for disposal of sharps/needles in a sharps disposal unit.
6. We will ensure a sharps disposal unit is available and witness disposal if appropriate.
7. We will measure your blood glucose regularly, and if you request it, using the hospital meter system.
8. We will be responsible for recording the insulin you have taken along with your blood glucose levels.
9. We will both ensure a supply of appropriate insulin is available in hospital, on discharge or transfer to another ward.
10. We will assess and discuss your ability to self administer daily.
11. Please record Level of Administration (level 1, 2, 3, 3CSII) on the Ongoing Record of Care under Additional Care Need or equivalent care planning documentation. This should be evaluated accordingly if the condition of the patient changes i.e. if they develop delirium/confusion or problems with dexterity, review Level of Administration.

Nursing and Medical staff should continue to monitor and evaluate the appropriate level of insulin administration and document in the patient record.

ıg and Managing Glycaemic Control for Adult In-patients with Diabetes

ıl is 6 -10 mmol/L with 4-12 mmol/L being acceptable (Joint British Diabetes Society). Blood ketone levels above 0.6 is 0 - 8 mmol/L). Ketosis can occur at any BG level. Check ketones at diagnosis of diabetes and in patients who are ant women who are acutely unwell irrespective of BG level.

caemia

motic symptoms of diabetes,
d to Diabetic Ketoacidosis

lietary indiscretion
dose

/injection site

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r to testing

ketosis
ılin Infusion (CSII) check
s site.

ıedication and clinical status
ınsider increase in fluid and insulin
·med ketone free
·apy is prescribed
: change
required
rent/carer
n as required

Management of Hypoglycaemia

SITUATION

Blood glucose (BG) level <4mmol/L is a potentially dangerous side effect of insulin therapy and hypoglycaemic agents e.g. gliclazide, glipizide, glimepiride, glibenclamide. Hypoglycaemia is harmful and should be avoided. Prompt treatment is required in the event of hypoglycaemia – see below

BACKGROUND

THINK of the causes of low blood glucose levels, such as:

- Inadequate carbohydrate food intake
- Too much insulin and/or oral hypoglycaemic medication
- Reduction or withdrawal of steroid therapy
- Insulin absorption problem e.g. technique/administration/injection site
- Increased activity
- Renal or hepatic impairment or pancreatic insufficiency

ASSESSMENT

CHECK to identify the reason for hypoglycaemia:

- Assess pattern of BG levels e.g. over previous 48 hours
- Assess recent nutritional intake
- Identify the drugs prescribed that may precipitate hypoglycaemia
- Check insulin/medication prescription, dose, time of administration, food intake, activity
- Check for factors which may affect insulin absorption
- Check ability to self-manage medication if appropriate
- Increase frequency of BG monitoring following treatment change
- Check that patients prescribed insulin are educated in hypoglycaemia recognition and treatment

RECOMMENDATION

ACT immediately to treat hypoglycaemia with 15 - 20 grams of quick acting carbohydrate

- If patient is able to swallow – administer 15g of quick acting glucose e.g. 60 mL of Glucojuice
- If patient is confused or drowsy but able to swallow: administer 1-2 tubes of glucose gel
- If patient is unconscious/unable to swallow: administer IV Glucose 10% 150ml or 20% 75ml or 1mg IM Glucagon (adults)
- Note: Glucagon is not suitable in malnourished patients, in those with severe liver disease, in those treated with oral hypoglycaemic agents
- Provide complex carbohydrate snack promptly e.g. wholemeal bread/toast
- Observe and chaperone patient until recovery is complete
- Recheck BG in 15 minutes and repeat treatment if necessary
- Do not omit insulin: review and alter the insulin dose/oral hypoglycaemic medication administered before the episode of hypo if required
- Take appropriate action to prevent further hypoglycaemia
- Inform and agree any medication changes with patient/parent/carer
- Refer to the Diabe[illegible] Team for advice as required

HOSPITAL: Ninewells Hospital

WARD: AMU

WRITE OR ATTACH LABEL	
Surname	Skretkowicz Sex M
Forename	Gavin
DOB and CHI	04087500141

THB (MR)610

Personal Safety Risk Assessment

This risk assessment must be completed with ALL patients that have been identified as 'High Risk'.

Safety risk	Tick if applicable
Patient is ambulant but clinically unstable	
Patient is mentally incapable of making sound judgements	
Patient has a current Adults with incapacity form in place	
Patient is a current smoker	✓
Patient has history of alcohol or substance misuse	
Patient has history of wandering	
Previous history of becoming a Missing Patient	
Patient under 16 in an adult ward	
Concern for Patient safety	

Appropriate preventative measures must be taken to maintain the patient's safety, for example (this list is not exhaustive);

- Nurse patient in a **high observation area** within the ward.
- Continuous supervision - consider **cohort nursing** if there are several high-risk patients and allocate staff to observe patients continuously and record observations in patient record
- Consider requesting additional staff to ensure patient safety
- Identify high-risk patients to clinical team during **safety briefings,** and safety huddles both within Directorate and wider Hospital wide huddles
- Invite **unrestricted/open visiting** to provide patient with familiar company/diversion/reassurance
- If appropriate, consider **patient referral** to NHS Tayside Substance Misuse Services.
- Review **medications**
- Ensure **patient identity bracelet** is correct and in place at all times.

Observation Policy - allocate a nurse for an allocated time period, to regularly check on the patient in between duties (specify the time interval below) and record observations in nursing records. If patient does go missing, this allows the time frame to be known.
Establish the patients' normal routine outside hospital and identify particular drivers/triggers for leaving the ward e. g normally walks dog at 8 pm so tries to leave ward at 8 pm

Record any other measures taken

The information provided overleaf (page 1)must be reviewed as appropriate to patient's clinical condition. This must be documented within the record of on-going care and indicated as RED on traffic lights (as applicable).
Discuss risk and planned preventative interventions with patients 1st contact.

Date Discussed: _____

Initials of Nurse: _____ Date/Time: _____

Smoking / Substance Misuse

If patient is a smoker

- Advise patient of the NHS Tayside Smoking Policy
- Offer Smoking Information Leaflet
- Follow Smoker In-Patient Pathway if patient wishes to stop smoking
- Offer "Pharmacy Stop Smoking" referral form on discharge (if applicable)

If patient does not wish to stop smoking/continue substance misuse ask the patient/patient's representative to complete disclaimer below.

Section A TO BE COMPLETED BY NURSING STAFF

If the patient or patient's representative at the time of admission is unable or refusing to complete and sign section B below, for whatever reason, inform the patient/representative verbally that they are responsible for their actions and consequences thereform and state below the reason for non completion.

Reason: _____

Signature of Staff Recording _____ Date _____

Signature of Staff Witness: _____ Date: _____

Section B TO BE COMPLETED BY PATIENT

I have been advised NHS Tayside will not accept any responsibility if I choose to leave the hospital grounds and I accept full responsibility for my actions and any consequences as a result of doing so for example if I become ill, have an accident, miss treatment or tests

Patient Signature*** _____ Date: 10/12/25

Print Name: _____

***If signing on behalf of a patient, please enter your relationship with the patient, and your address:**

Relationship: _____

Address: _____

Witness to above signature: _____

Print Name: _____ Date:- _____

JOINT ACTION INFORMATION CHECK LIST FOR PERSONAL SAFETY

Part 1 - To be completed within 24 hours of admission

Ward/Department _____
Name of 1st Contact _____
Address _____
_____
_____
Tel No _____
Relationship _____

WRITE OR ATTACH LABEL

Surname.....Sex.....

Forename.....

DOB and CHI.....

Nickname	
Description of Patient: ▪ Build ▪ Approx Height	
Distinguishing features e.g. ▪ Facial hair ▪ Hair Colour ▪ Hair Type ▪ Eye Colour ▪ Complexion ▪ Marks / Scars ▪ Tattoos	
Spoken Language/Nationality	
Any Likely destinations/familiar haunts?	Specify :
Does Patient have a mobile phone ▪ Mobile Number ▪ Network ▪ Type of Phone	
Does patient have money/bank card with them?	Y N
Current Diagnosis Relevant Past Medical History	
Any Altered Mental state/ or likelihood of violent behaviour?	Specify:
Does the patient take any Medication that is likely to place them at risk?	Specify:
Any alcohol/drug dependency?	Specify:

Part 2 – To be completed ONLY if patient goes missing

Date & Time noted to be missing	
Area searched?	
Attempt made to contact patient via their mobile phone	
Clothes last seen wearing (Consult other patients)	
Has any other clothing been taken	
Has any other property been taken e.g. ▪ Mobile phone ▪ Wallet / money ▪ Bags ▪ Equipment	
Contact the following as soon as patient is N[illegible]d to be missing ▪ Wards in the vicinity ▪ Bleep holder ▪ Security ▪ Medical staff ▪ 1st Contact (if not, specify reasons)	
Record details in nursing record	
Police (if initial search fails)	Time contacted:
Identify key risks / special information to the police ▪ High risk medication ▪ Missed medication ▪ IV device in situ ▪ History of behavioural concerns ▪ Legal status if applicable ▪ Child Protection Concern ▪ History of Missing patient previously - circumstances of previous events	
Any additional relevant information	

Initials of Nurse: _____ Date/Time: _____

If a patient goes missing or is absent from the ward, please refer to the "NHS Tayside Adult Missing Patient Policy" and follow stages 1 – 7 as appropriate.

Please photocopy both sides of the Joint action Information Checklist and give to Police

Integrated Care Pathway for Diabetic Ketoacidosis in Adults*
Intravenous Insulin Prescription

Name DOB CHI
GAVIN SKRETKOWICZ
0408 750 014

IV INSULIN PRESCRIPTION
Add 50 units of soluble insulin (e.g. Actrapid) in 49.5 ml sodium chloride 0.9% (1 unit/ml). Infuse using a syringe driver. Start insulin infusion at 6 units/hour in 1st hour

***Adjust the insulin rate if necessary to maintain blood glucose (BG) level 9-14 mmol/L. Do not reduce the insulin rate below 2 units per hour.
If BG continues to fall, consider increasing the glucose infusion rate (e.g. 150 -200 ml/hour). If blood glucose remains < 4mmol/L thereafter, reduce insulin rate to 1 unit per hour. Confirm with senior medical staff.

'Standard' IV insulin scale for DKA:		***Adjust IV insulin scale to:	
Blood glucose mmol/L	**IV insulin** units per hour	**Blood glucose** mmol/L	**IV insulin** units per hour
> 14	**6 units**	**> 14**	units
9 – 14	**3 units**	**9 – 14**	units
< 9	**2 units**	**< 9**	units

Prescribed by: (NMP) RHAXTON
Bleep: 41023
Date 18/12/25 Time 1125

Prescribed by:
Bleep:
Date Time

DATE 18/12/25 Time	Insulin infusion rate per hour	Insulin infused in one hour	Total insulin infused in ml	Volume remaining in syringe	Blood glucose mmol/L	Ketones mmol/L	IV glucose infusing ml/hr	Cannula check	Initials
11:35	6units	— units	— mL	44mls.	23.	4.3	—	4	MB.
1235	6units	6 units	6 mL	38.82ml	21.1	—	—	4	cm/MB
1525	6units	9 units	11 mL	33.85ml	25.3	3.5	—	4	MB
14.20	6units	6 units	17 mL	27.82ml	20.0	—	—	4	cm/MB.
1530	6units	6 units	23 mL	21.60ml	16.3	1.5	—	4.	cm/MB
1630	6units	6 units	29. mL	15.14ml	15.3	—	—	4	MB/cm
1723	3units	6 units	mL	12.	12.3	1.2	—	4	cm/MB.
1845	3units	3 units	mL	7.11mls	13.2	—	—	4	MB.
Commence IV glucose 10% with 20 mmol potassium chloride at 100 ml/hr when BG falls to ≤ 14 mmol/L & reduce rate of 0.9% sodium chloride ± potassium chloride accordingly by 100ml									
1930	3units	3 units	mL		12.7	2.0	—	4.	cm
2030	↑6units	↑6 units	mL	1.3H	16.4	1.5	—	4	PH
18/12/25		units	mL						
2113	6units	6 units	mL	50mls	15.14	1.3	—	4	EE/PH
2230	6units	12 units	mL	38	14.8	1.2		4	PH
2336	↓3 Units	18 units	mL	32	13.8	1.0	—	4	PH
		units	mL						
		units	mL						
Commence IV glucose 10% with 20 mmol potassium chloride at 100 ml/hr when BG falls to ≤ 14 mmol/L & reduce rate of 0.9% sodium chloride ± potassium chloride accordingly by 100ml									
		units	mL						
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		units	mL						

Continue IV insulin until ketone free, bicarbonate is within target range (or has plateaued) and the patient is tolerating fluid and diet.
Stop IV insulin after two injections of s/cut insulin (including basal insulin for patients on multiple daily injections).

*If patient is < **16 years old** refer to **Paediatric Team** http://www.bsped.org.uk/professional/guidelines/docs/DKAGuideline.pdf

DIABETIC KETOACIDOSIS (DKA)

DKA is a life threatening complication of diabetes caused by a shortage of insulin. The causes of DKA include new onset type 1 diabetes, insulin omission/insufficiency, acute illness, sepsis and myocardial infarction. A lack of insulin leads to elevated blood glucose (BG) levels, increased fat metabolism and protein degradation which leads to ketone production and acidosis.

Supplementary Notes

1. **Bicarbonate:** Avoid use of bicarbonate in the management of DKA. There is no evidence of benefit.
2. **Potassium Replacement:** Potassium chloride (KCl) should not normally be administered at a rate of greater than 20 mmol/hour.
3. **Phosphate** if measured is often low in DKA due to fasting. Consider IV replacement only if longstanding poor nutrient intake e.g. significant alcohol history/eating disorders or if there are concerns about respiratory muscle function.
4. **White Blood Cell** (WBC) count is often raised in DKA and is not always indicative of infection. Antibiotics should only be administered if there is clear evidence of an infection.
5. **Blood Glucose:** Commence IV 10% glucose when blood glucose falls below 14 mmol/L. Thereafter, if BG is > 14 mmol/L do not stop glucose, but instead adjust the insulin rate to maintain BG level between 9-14 mmol/L.
6. **Cerebral oedema:** Monitoring for signs of cerebral oedema should start from time of admission and continue for at least 12 hours. Children and adolescents are at highest risk of cerebral oedema. Signs and symptoms include headaches or reduced conscious level. Call for Consultant input if there is suspicion of cerebral oedema or the patient is not improving as expected within 4 hours of admission. Treatment of cerebral oedema: IV mannitol (100mls of 20% over 20 minutes) or dexamethasone 8 mg (discuss with consultant). Check arterial blood gases. Refer to ICU. Consider CT scan to confirm findings.
7. **Laboratory glucose testing:** Finger prick BG measurements are less accurate than laboratory samples, especially at high glucose levels. Check laboratory glucose every 2 hours if finger prick BG is > 20 mmol/L.
8. **Insulin management:** IV insulin should be started at 6 units/hour. Avoid a fall in BG of > 5 mmol/L per hour as a more rapid fall may be associated with the development of cerebral oedema. Continue the patient's 'usual' basal long acting s/cut insulin (Lantus/Levemir) along with IV insulin. This will reduce risk of insulin omission and aid safe transfer from IV to s/cut insulin.

DKA MANAGEMENT AUDIT	YES	NO	N/A
IV FLUID REPLACEMENT			
1. 1000ml 0.9% sodium chloride in first hour	☐	☐	☐
2. 2000ml 0.9% sodium chloride by 2 hours	☐	☐	☐
3. 3000ml 0.9% sodium chloride by 4 hours	☐	☐	☐
MONITORING			
4. U&E's and bicarbonate at hour 2	☐	☐	
5. U&E's and bicarbonate at hour 4	☐	☐	
POTASSIUM REPLACEMENT	☐	☐	☐
INSULIN			
6. 'Usual' S/Cut basal insulin continued daily	☐	☐	☐

AUDIT NOTES

Key targets have been identified to measure compliance with the DKA protocol. Please complete for each patient.

Aggressive IV fluid replacement may not be applicable (N/A) in patients with cardiac or renal co-morbidities

N/A if patient is anuric or potassium > 5 mmol/L

N/A if person is not normally prescribed basal insulin

PATIENT EDUCATION AND FOLLOW UP:

Additional information:

- Blood glucose meter and test strips ☐
- Ketone testing kit and strips ☐
- 'Sick day rules' and DKA information leaflet ☐
- Eye screening within previous 12 months ☐
  (For information/ appointments phone ext 33956 / 34609)
- Contact details for Diabetes Specialist Nurses ☐
- Follow up appointment ☐

Reviewed by: Date: Contact detail:

If in doubt about follow up, send a copy of discharge summary to Diabetes Secretary, Strathmore Diabetes Centre, Ninewells Hospital Dundee or appropriate Regional Diabetes Clinic. For patients admitted over a weekend/public holiday and who are suitable for discharge from hospital without direct contact from the Diabetes Team please request follow up by emailing Tay-UHB.diabendoreferrals@nhs.net

CONTACT DETAILS FOR OUT-PATIENT DIABETES SPECIALIST NURSES Mon–Fri 9.00 – 17.00 hrs (24 hr answering machine available)
Ninewells tel. 01382 632293 Perth Royal Infirmary tel. 01738 473476. Diabetes Specialist Nurse Led Drop In Clinic Strathmore Diabetes Centre, Ninewells every Wednesday 10.30 -12.30 – no appointment is required.
Diabetes information www.diabetes-healthnet.ac.uk DKA online learning http://medblogs.dundee.ac.uk/files/endocrinology/DKA/

*If patient is < **16 years old** refer to **Paediatric Team** http://www.bsped.org.uk/professional/guidelines/docs/DKAGuideline.pdf

Integrated Care Pathway (ICP) for the Management of Diabetic Ketoacidosis (DKA) in Adults*

DATE: 18/12/25 Time of admission: 1105 hrs

NAME DOB CHI
GAVIN SKRETKOWICZ
Ward AMU
Hospital NWH

NHS Tayside

The definition of DKA is: uncontrolled or new presentation of diabetes with:

- Elevated blood ketones > 3 mmol/L, or urinary ketones > +++
- Metabolic acidosis: bicarbonate < 18 mmol/L or pH <7.3 on venous blood
- Usually accompanied by hyperglycaemia

Patients should be managed in the Medical High Dependency Unit

INITIAL DKA MANAGEMENT

BLOOD MONITORING

Check **urea & electrolytes, glucose & venous bicarbonate** on admission

Recheck at 1 hour ☑ 2 hours ☑ 4 hours ☐ 8 hours ☐

Check **HbA1c** ☐

Check finger prick **glucose hourly & blood ketones 4 hourly**

INTRAVENOUS (IV) FLUIDS (0-4 hours)

Start IV fluids **within 30 minutes** of admission

Use pre-printed fluid prescription chart overleaf

NB: *Reduce fluid volume in patients with chronic kidney disease (CKD) stage 4/5, cardiac failure or raised intracranial pressure. Individual assessment will be required.*

POTASSIUM REPLACEMENT

Prescribe potassium chloride in 500 ml 0.9% sodium chloride:

If plasma potassium > 5 mmol/L or anuric no potassium chloride

If plasma potassium 3.5 – 5 mmol/L add 10 mmol potassium chloride

If plasma potassium < 3.5 mmol/L add 20 mmol potassium chloride

Avoid infusion rates of potassium chloride > 20 mmol/hour

Seek senior medical advice if necessary.

Continue potassium replacement in 0.9% sodium chloride until target potassium value is maintained.

ONCE BLOOD GLUCOSE FALLS TO ≤14 mmol/L:

Commence **IV glucose 10% with 20 mmol potassium chloride** at 100 ml/hr

and reduce rate of 0.9% sodium chloride ± potassium chloride by 100ml/hr e.g. from 500 to 400 ml/hr

INSULIN MANAGEMENT

Start IV insulin infusion **within the 1st hour** of admission at **6 units/hour** using the IV insulin prescription on page 3

Adjust insulin rate to maintain BG 9 – 14 mmol/L

Prescribe IV insulin on TPAR ☐

Continue 'usual' subcutaneous long acting **basal insulin** (e.g. Lantus, Levemir, Insulatard, Humulin I) ☐

Prescribe subcutaneous basal insulin on TPAR ☐

Consider the following:

Cardiac Monitoring	☐	ECG	☐
Chest X-Ray	☐	Blood Cultures	☐
MSSU	☐	DVT prophylaxis	☐
Pregnancy Test	☐	Pregnancy test result.....	

CVP line e.g. if elderly, cardiac failure, or CKD 4/5 ☐

Catheter if oliguric (or evidence of renal/cardiac failure) ☐

NG Tube (if protracted vomiting &/or unprotected airway) ☐

Screen for MI (if > 40 years or significant risk) ☐

Antibiotics only if infection is strongly suspected or proven ☐

ONGOING MANAGEMENT (see supplementary notes overleaf) COMPLETE AUDIT OF KEY TARGETS page 4

IV FLUID MANAGEMENT ≥ 4 hours

a) Reduce rate of 0.9% sodium chloride ± potassium chloride to 250 ml/hour or,

b) If glucose 10% + potassium chloride is infusing at 100 mls/hr then reduce the rate of 0.9% sodium chloride ± potassium chloride to 150 mls/hr

INSULIN MANAGEMENT

Continue IV insulin until ketone free, bicarbonate is within target range (or has plateaued) and the patient is tolerating fluid and diet.

Discuss transfer to subcutaneous (s/cut) insulin with the Diabetes Team/Senior Physician

Start pre-meal s/cut insulin at a suitable mealtime.

Stop IV insulin after two injections of s/cut insulin (including basal insulin for patients on multiple daily injections).

TARGET BLOOD CONCENTRATIONS

Potassium 4.0 - 5.0 mmol/L

Bicarbonate 22 – 29 mmol/L

Glucose 9 – 14 mmol/L

Blood ketones < 0.6 mmol/L

REFER TO DIABETES TEAM:

Diabetes Registrar: bleep 5416 ☐

Diabetes Specialist Nurse:

- NW bleep 4872 or Ext 36009 ☐
- PRI bleep 5288 or Ext 13476 ☐

*If patient is < **16 years old** refer to **Paediatric Team** http://www.bsped.org.uk/professional/guidelines/docs/DKAGuideline.pdf

Integrated Care Pathway for the Management of DKA

Blood results and intravenous fluid prescription

Name GAVIN SKRETKOWICZ

DOB CHI 0408750014

Blood results	Normal Range ...:...hrs	O/A 11...15hrs	1hr ...:...hrs	2hrs 1332hrs	4hrs ...:...hrs	8 hrs ...:...hrs	...:...hrs	...:...hrs
Sodium	135 – 147 mmol/L	136·1						
Potassium	3.5 - 5.0 mmol/L	4·49						
Urea	3.3 - 6.6 mmol/L							
Creatinine	44 - 80 µmol/L							
eGFR								
Amylase	0 – 100 U/L							
pH				7·36				
Bicarbonate	22 - 29 mmol/L	14·7						
Lactate	0.7 - 1.8 mmol/L	1·44						
Glucose	3.3 - 5.8 mmol/L	25·5		29.4				
HbA1c								

INITIAL INTRAVENOUS FLUID 0 - 4 hours following admission

	DATE	Intravenous Fluid Prescription	Prescribed by	Volume	Duration	Rate ml/hr	Serial No. Batch No.	Admin. By Witnessed by	Start time	Finish time
1	18/12/25	Sodium chloride 0.9%	BHAXTON (NMP)	500ml	30 minutes	1000	25J03 T4H	RM 01	1125	1200
2	18/12/25	Sodium chloride 0.9%	BHAXTON (NMP)	500ml	30 minutes	1000	25J03 T4H	NB 01	1200	12[illegible]
3	18/12/25	Sodium chloride 0.9% with ....10.... mmol potassium chloride	BHAXTON (NMP)	500ml	30 minutes	1000	24L06 T4G	NB RB	12·30	1300
4	18/12/25	Sodium chloride 0.9% with .....10.... mmol potassium chloride	[illegible]	500ml	30 minutes	1000	24L06 T4G	NB CD.	1300	1330
5	18/12/25	Sodium chloride 0.9% with .....10.... mmol potassium chloride	[illegible]	500ml	1 hour	500**	24L06 T4G	NB RB	13·30	14·40
6	18/12/25	Sodium chloride 0.9% with .....10..... mmol potassium chloride	[illegible]	500ml	1 hour	500**	24L04 T4G	NB RB	14·40	1551
		Glucose 10% with 20 mmol potassium chloride		500ml	5 hours	100**				

**Start IV glucose 10% with 20 mmol potassium chloride at 100ml/hr when BG falls to ≤ 14 mmol/L and reduce rate of sodium chloride 0.9% ± potassium chloride accordingly by 100ml. Seek senior medical advice if required.

ONGOING INTRAVENOUS FLUID ≥ 4 hours

	DATE	Intravenous Fluid Prescription	Prescribed by	Volume	Duration	Rate ml/hr	Serial No. Batch No.	Admin. By Witnessed by	Start time	Finish time
7	18/12/25	Sodium chloride 0.9% with .10..... mmol potassium chloride	A·Gupta	500ml	60 mins	~~1000~~ 500	24L04 T4G	NB RB	16·10	17[illegible]0
8	18/12/25	Sodium chloride 0.9% with .....10... mmol potassium chloride	A·Gupta	500ml	60 mins	~~1000~~ 500	24L04 T4G	NB RB	1725	1840
9	18/12/25	Glucose 10% with 20mmol potassium chloride	A·Gupta	500ml	5 hrs	100	24588[illegible]01	NB CR	1850	
10	18/12/25	GLUCOSE 10% WITH 20mmol KCl.	[illegible]	500ml	4.	150.	V			
		0·9% NaCl	[illegible]	500ml	8 HRS	[illegible]				

IV FLUID MANAGEMENT ≥ 4 hours: Review phlebotomy results and assess individually. Seek senior medical advice if required.

Standard management: a) Reduce rate of sodium chloride 0.9% ± potassium chloride to 250 ml/hour or,
b) If 10% glucose with potassium chloride infusion is running at 100 mls/hr then reduce rate of 0.9% sodium chloride ± potassium chloride to 150 mls/hr

*If patient is < **16 years old** refer to **Paediatric Team** http://www.bsped.org.uk/professional/guidelines/docs/DKAGuideline.pdf

NHS

Initial Discharge Communication

NHS

GAVIN SKRETKOWICZ 34 ST JAMES ROAD, FORFAR, DD8 1LG *GP Practice: Academy Medical Centre, Academy Street, Forfar, DD8 2HA*	CHI: 0408750014 Born: 04/08/1975

This letter updates/amends previous communication received in relation to this episode of care

Discharge Details

Admission	18/12/2025	**Discharge**	
Specialty	Diabetes	**Consultant**	Dr Paul Newey (4698443)
From	Ward 4 Ninewells Hospital	**Destination**	Home

Diagnoses

DKA - diabetic ketoacidosis

Operations/Procedures

Actions Required for Primary Care

Communication to Primary Care

Dear Doctor,

Gavin was admitted to General internal medicine unit of Ninewell Hospital on 18/12/25 with diabetic ketoacidosis (DKA) and was commenced on the DKA protocol. Following stabilization, he has been initiated on long-term insulin therapy, having previously been managed with diet alone.

Gavin has received education and training on insulin administration. Genetic testing and C-peptide levels will be followed up as an outpatient. He is scheduled for review by the Diabetes Nurse Specialist next week to assess progress and ongoing management.

Clear safety-netting and worsening advice was provided prior to discharge. He has also been advised in line with DVLA guidelines. He is therefore discharged back to your care.

Kind regards,

Ward 4

Medications

This prescription has not been reviewed by a Pharmacist

Drug & Formulation	Dose	How to take	How long to take	Supply	Dispensary
Amitriptyline 25mg tablets		TAKE 2 TABLETS AT NIGHT		Own at Home	
Atorvastatin 20mg tablets		1 TABLET ONCE A DAY		Own at Home	
Lisinopril 5mg tablets		1 TABLET ONCE A DAY		Own at Home	
NOVORAPID 100units/1mL FlexPen	6UNITS	6UNITS WITH EVERY MEAL (AT 8AM, 12NOON AND 6PM)		TTO	
Prazosin 500microgram tablets		FOUR TABLETS AT NIGHT AS ADVISED BY CMHT		Own at Home	
Sildenafil 50mg tablets		1 TABLET WHEN REQUIRED		Own at Home	

GAVIN SKRETKOWICZ 34 ST JAMES ROAD, FORFAR, DD8 1LG *GP Practice: Academy Medical Centre, Academy Street, Forfar, DD8 2HA*	CHI: 0408750014 Born: 04/08/1975

TOUJEO 300units/mL SoloStar Pen	18UNITS	TAKE 18UNITS EVERY MORNING		TTO
Vensir XL 150mg capsules (Morningside Healthcare Ltd)		1 CAPSULE ONCE DAILY (TOTAL DOSE 225MG DAILY) Notes for patient: Please note: Your prescription for Venlafaxine MR capsules has been changed to a different brand of the same drug called Vensir XL capsules as it is more cost effective to prescribe. T		Own at Home
Vensir XL 75mg capsules (Morningside Healthcare Ltd)		1 CAPSULE ONCE DAILY (TOTAL DOSE 225MG DAILY) Notes for patient: Please note: Your prescription for Venlafaxine MR capsules has been changed to a different brand of the same drug called Vensir XL capsules as it is more cost effective to prescribe. T		Own at Home

Discontinued Medication

Medication Notes

Allergies

Deleted Allergies

Follow Up Arrangements

Community Diabetic Nurses			Date to be arranged

Final Discharge Comments

Pharmacy

Copy To

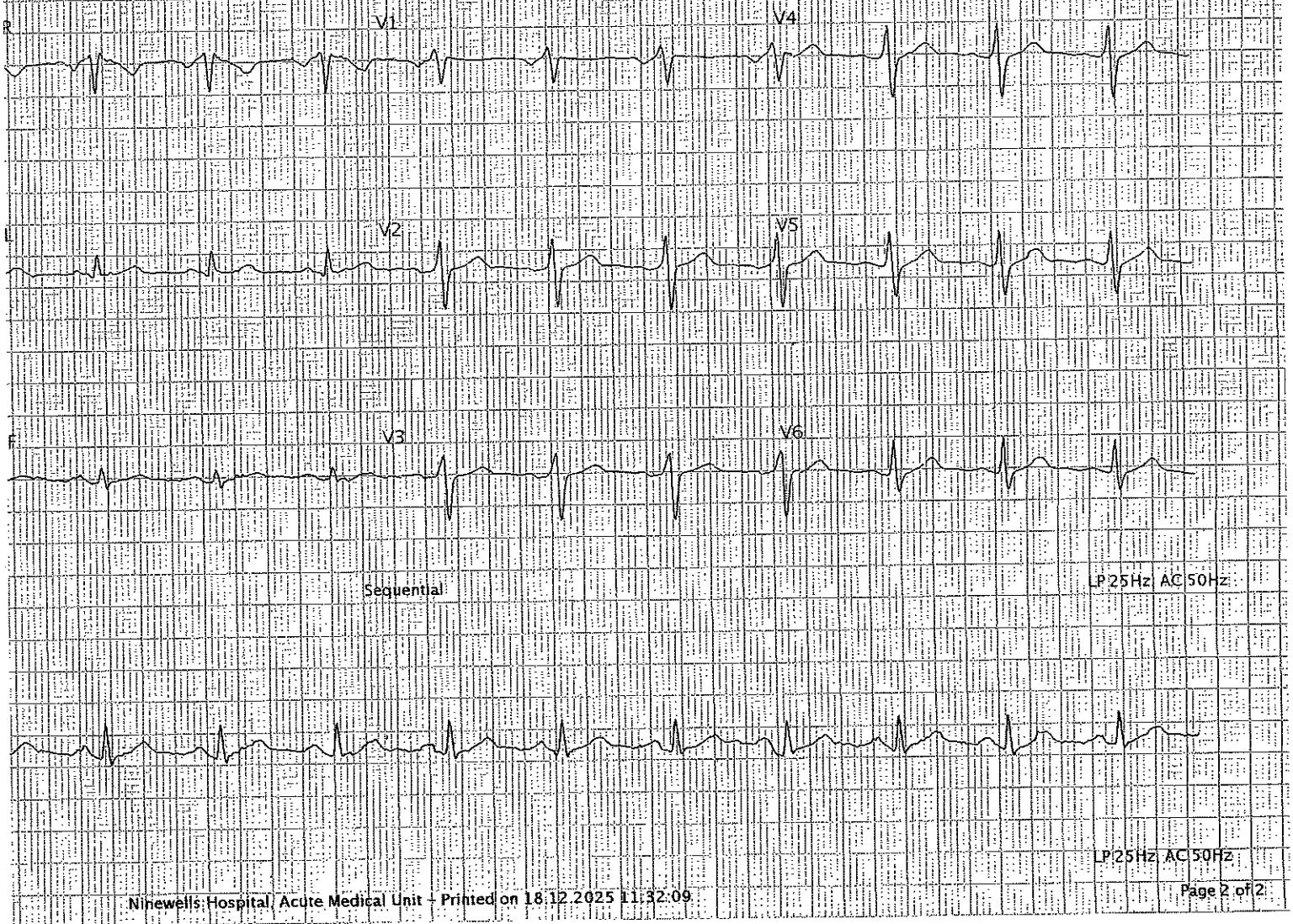
Sign Off

	Name	Job Title	Date/Time
Initial Sign Off	Marina Bishay	Clinical fellow	19/12/2025 16:11:44
Pharmacy Sign Off			
Final Sign Off			

18.12.2025 11:31:56
[redacted]ndard 12-Lead

HR	84 bpm	RR	716 ms	Interpretation too long to fit, please see separate page
		P	120 ms	
		PR	147 ms	Unconfirmed report
P axis	13 °	QRS	91 ms	
QRS axis	7 °	QT	352 ms	
T axis	21 °	QTcB	416 ms	

Abnormal



Ninewells Hospital, Acute Medical Unit - Printed on 18.12.2025 11:32:09

D Art. No. 2.157.050 CE 0044 LOT 0912

18.12.2025 11:31:56
Standard 12-Lead

Cover page

CareFirst ID / CHI
JAVIN
SKRETKOWICZ
040857 50014

Data Protection
Patient File Access Log

ANGUS
Health & Social Care
Partnership

(1)

Offered access to GDPR Privacy Notice: Yes / No Date: 27/11/25

Privacy Notice: READ / DECLINED

DATE	STAFF NAME	PURPOSE FOR ACCESS TO FILE (PLEASE TICK)				
		Writing Contacts	Filing Information	Accessing Information	File Audit	Other
27/11/25	Shona Deans	✓				

Received - 3.1.25 Appt: 21.01.25 @ 1.30pm F.D.

Barcode:

- Urgent

TRAK 03.01.25 SCANNED (2)

NHS Tayside

Medical In Confidence

MSK Outpatients Referral

Name: GAVIN SKRETKOWICZ	CHI: 0408750014
Address: 34 ST JAMES ROAD FORFAR DD8 1LG	GP: ACADEMY
	Consultant: For clinical review: Y/N Date:
Patient Tel No: 07984 270423	NOK and Tel:
Date of referral: 31/12/24	Falls Pathway Discussed: Y/N Initiated: Y/N

HPC/Reason for Referral

3-4/12 Hx of worsening Lsp pain with bilateral full-length radicular-type leg pain (R>L)

- No clear PNs, numbness, CES - ?R leg weaker but historic weakness following previous fracture
- Started with twisting-type movement in flexed position whilst holding dog in place at vets
- Not been assessed in person by anyone for this issue, GP prescribed codeine in November
- PMH includes mental health issues, does not work due to this
- Please assess and advise as able, thank you

PMH:	DH: Anticoagulants/ Steroids/ Chemotherapy/ Radiotherapy NSAIDS/Analgesia: Other relevant:

Any precautions/ Special instructions/ Weight bearing status:

Referrer (Print): Lewis Smart	Signature: X	Grade: B7
Assessing PT (Print):	Signature:	Grade:

Barcode:

NHS TAYSIDE PHYSIOTHERAPY LUMBER SPINE ASSESSMENT

NHS Tayside

Patient Name:	GAVIN SKRETKOWICZ	**CHI:**	0408750014		
Date:	21/1/25	**PT Sign:**	Fiona Deans	**Band:**	B7
Page No:	(3)		Fiona Deans		

Verbal consent obtained for ongoing physiotherapy assessment and treatment: verbally ✓

Patient Tel No: See other form **NOK and Tel No:** ?

Compensation: Y / N

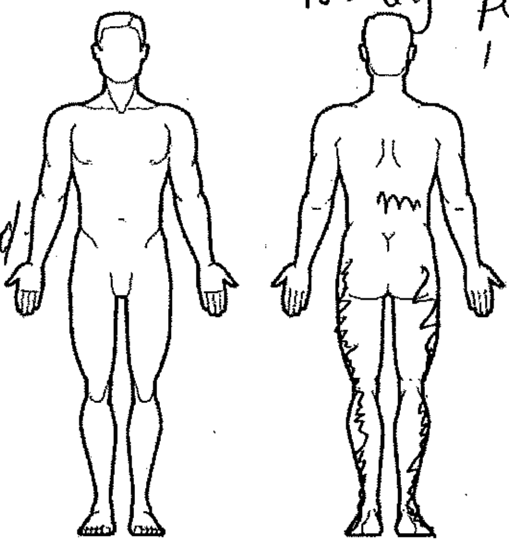
Falls Pathway - Over 65:	**2 or more falls in past 12 months:**	**Proceed to Falls Pathway:**
Y / N	Y / N	Y / N

History of Presenting Condition:
Was holding dog at vet ~ 5/12 ago - felt pain in lower back, developed (R) leg pain few days later then started alternating between legs. Bought a mattress 10 days ago which has helped.

N (L) leg pain for 1 week

Pain:
Intensity
0 ____4____ 10

Intermittent/Constant (Constant circled)



Aggravation Standing, leaning forward

Alleviation

24hr Pattern

Sleep *Prevents* *Interrupts* (Interrupts circled)

Surface *Hard* *Med* *Soft* *Ortho*

Past Medical History: Type II - Diet, Depression/PTSD
Heart *Epilepsy* *Chest* *Diabetic* (circled) *Hx of Ca* *Thyroid* *Osteoporosis* *Other:* Hypertension, Chronic back pain
(L) foot over 10 yrs ago - feet can give way. Favours (R) leg

Drug History: *Anticoagulants* *Steroids* *Chemotherapy* *Radiotherapy*
NSAIDS/ Analgesia: Lisinopril, Atorvastatin
Other relevant: Levemir, Paracetamol, Amitriptyline, Co-codamol

Social History:
Doesn't work due to PTSD
Walking dog
Uses VR set for ex
Sick Leave Y/N
Paddle boarding in summer
Has a carer for father who had MND

Previous Treatment of Injury:

Investigations: Y/N

PT Signature	PT Name	PT Grade

Patient Name: GAVIN SKRETKOWICZ **CHI:** 0408750014 **Page No:** 2

Date: 21/11/23 **PT Sign:** Fiona Deans Fiona Deans **Band:** 7

Posture Sitting: Good (Fair) Poor **Standing:** Good (Fair) Poor **Lordosis:** Increased (Decreased) NL

Shift: Right Left (NL) **PSIS:** Right Elevated Left Elevated (NL)

Pre-Test Symptoms/Pain:

Movement	Range	Comments
Flexion	Knees	pulling S/L
Extension	1/2	↑P
Right Side Flexion	1/2	↑P
Left Side Flexion	1/2	↑P
Flexion in Lying	P S/L	
Extension in Lying	NIT	

Motor	R	L
L2,3 *Psoas*	✓	✓
L3 *Quads*	✓	✓
L4 *Dorsiflexors*	✓	✓
L4,5 *EHL*	✓	✓
L5, S1 *Evertors*	✓	✓
S1,2 *Hamstrings*	✓	✓
S1,2 *Gastrocs*	✓	✓
L3 *Knee Reflex*	✓	✓
L5, S1 *Ankle Reflex*	✓	✓

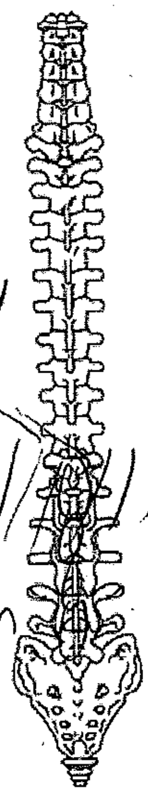
Sensation	R	L
L1	✓	✓
L2	✓	✓
L3	✓	✓
L4	✓	✓
L5	✓	✓
S1	✓	✓
S2	✓	✓

Tests	R	L	Comments
SLR	-ve	-ve	
Slump	NIT		
Femoral Nerve	-ve	-ve	
Babinski	NIT		

Other Tests:

Hip ROM ✓
Balance single leg ✓ (L)
Chair squats

Palpation



Muscular discomfort

Pain on palpation L SP

Clinical Impression:

Chronic low back pain flare up 5/12 ago with episodes of leg pain which have settled. no red flags/neuro
– discussed ↑ing activity, offered referral to pt management
Ex's as per physio tools, postural, positioning advice
Open next until mid March

THB(MR)988 Physiotherapy, NHS Tayside Date Developed: 23/01/2023

PT Signature	PT Name	PT Grade

Patient Name: GAVIN SKRETKOWICZ **CHI:** 0408750014 **Page no:** 5

Patient Expectations:

1. Advice how to manage back pain
2. Worried that he had damage disc / nerves
3.
4.

Treatment options discussed/ agreed:

Date	Problem	Plan
2/1/25	1 Flare of chronic back pain → recent flare up with referred leg pain	1. Ex's Encourage walking Posture and advice

	Objective/ Goals	Timescale	Achieved
2/1/25 1	self managing	1 session	1/4/25 D/C, no further contact

PT Signature	PT Name	PT Grade
Fiona Deans	FIONA DEANS	B7

Barcode:

NHS Tayside

RED/OTHER FLAG SPINAL SCREENING SHEET

Patients Name: GAVIN SKRETKOWICZ CHI: 060875 0014 (6)

RED FLAGS	YES	NO
Cauda Equina Syndrome: Saddle anaesthesia		
Cauda Equina Syndrome: Altered bladder control		✓
Cauda Equina Syndrome: Bowel incontinence		✓
If YES to any of the above questions refer to Cauda Equina Guidance		✓
Gait disturbance		✓
Weakness or sensory loss involving more than one myotome or dermatome (cervical spine)		✓
Dizziness Diplopia Drop Attacks Dysarthria Dysphagia		✓
Widespread neurological deficit		✓
Past history of cancer		✓
Unexplained weight loss over 3-6 months		✓
Severe unremitting night pain or unable to lie supine		✓
Constant non-mechanical pain		✓
Major loss of lumbar flexion		✓
Thoracic pain		✓
Age under 20, over 55 years of age at onset		✓
TB, immunosupression, HIV disease or IV drug user		✓
History or recent trauma		✓
Long-term steroid use, premature menopause, disease modifying anti-rheumatic drugs		✓
Osteoporosis		✓
Back pain associated with prolonged early morning stiffness		✓

CLINICAL IMPRESSION:_____

_____

_____

PT Name/Grade printed : VIOLA DEANS B7 PT Signature Viola Deans

Date: 21/1/25

ELECTRONICALLY
HELD
HEALTH RECORDS

Tayside Out of Hours Service OOH Call Incident Report

Call number:	**32075**	Receive Date:	**24-Feb-2013 10:38**
Patient's Name:	**Gavin Skretkowicz**		
Date of birth:	**4-Aug-1975 (37 years)**	Gender:	**M**
Address:	**1 Knowes Loan** **Barry** **Carnoustie DD7 7RF**	Current Address:	**34 St. James Road** **Forfar DD8 1LG**
Return Contact No:			
Tel No:			
Mobile No:			
Priority:	**Routine**	Call Origin:	**NHS24**
Received:	**24-Feb-2013 10:38**	Calltype:	**Attend**
Advised:	**10:53**	Arrived PCC:	
Cons start:	**24-Feb-2013 12:01**	Cons End:	**24-Feb-2013 12:09**
Consulting Doctor:	**Peter Croll**	Own doctor:	**Alasdair Easton**

Reported Condition:

GENERAL WEAKNESS - 4 DAYS

Consultation details:

History -	**Unwell past few days, c/o back pain, weakness, feels hot and cold. Nausea and occassional vomiting**
Examination -	**BP 137/78 P76 Temp 36.9. Appears pale, perspiring. Occasional cough, equal air entry over both lung fields, no creps or wheeze heard. No rash or spots. Managing to take diet and fluids. No acute pain or discomfort, fully alert. Urine concentrated urinalysis: +ve ketone +ve blood +ve protein. Bilateral renal angle discomfort and across lumbar region of back.**
Diagnosis -	**? uti ? flu**
Treatment -	**Urinalysis sent to lab, pt commenced on trimethoprim and advised to see GP for review for urine results Tues. Review sooner if symptoms cause further concerns**

Prescriptions:

trimethoprim tablets 200mg as directed 14.00

Followups:

None

Clinical Codes:

K190. Urinary tract infection

NHS24 details:

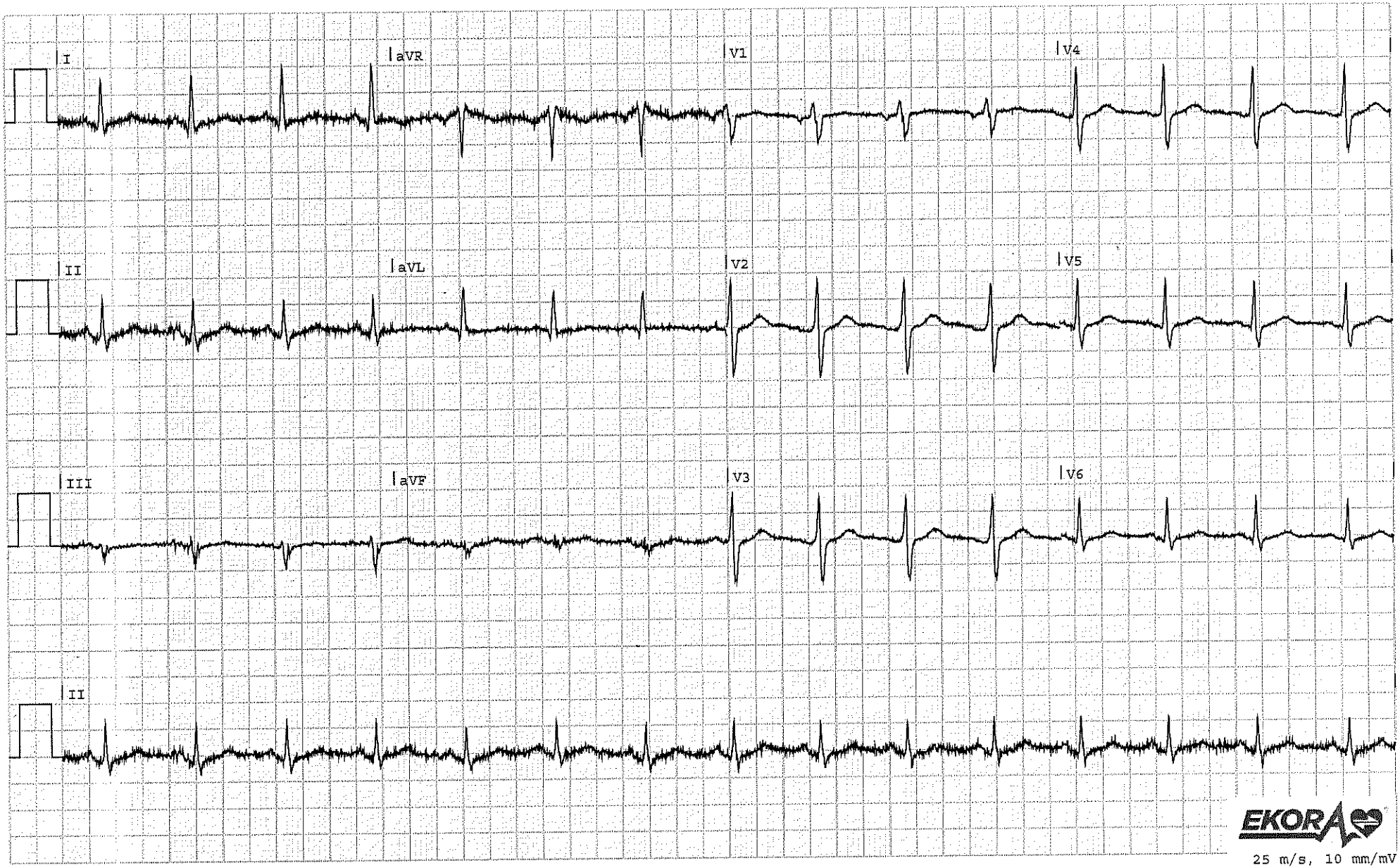
Triage NHS24 -	**This call will be transferred directly to a nurse via serious and urgent telephony route.** **Advise the caller that if they get cut off you will call them back immediately.**
NHS24 Comments -	**SAYS BODY IS ACHING. THINKS HAS CHEST INFECTION AS COUGHING UP GREEN PHLEGM. SKIN FEELS SENSITIVE. HEAD IS SORE AND HAS BEEN SICK WHEN COUGHING. ALSO HAS HAD DIARRHOEA SINCE THURSDAY. ((Non-Clinical User) (Edinburgh))**
Disposition -	**Contact GP Practice within 4 Hours (as soon as possible)**

*** UNCONFIRMED AUTOMATED ANALYSIS ***

Name : Skretkowicz Gavin
CHI : 0408750014
Date : 16/05/2019
Time : 09:05:41
Site : Academy_Street_Medical_Centre

Heart Rate : 90 bpm
PR int : 128 ms
QRS dur : 108 ms
QT/QTc : 362/409 ms
P-R-T axis : 20 -1 45

Summary : ** borderline ECG **
Rhythm : Sinus rhythm
Analysis : -



Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?	**REFERRAL LETTER** MEDICAL IN CONFIDENCE	**Unique Care Pathway Number** 101018802351U

REFERRAL TO

Medical HypertensionA1V TAY General Referral	———	**Consultant / receiving practitioner** and/or **specialty clinic**
Ninewells Hospital Dundee DD1 9SY	———	**Hospital** and **hospital address** Hospital unit no. T101H Email address -

Date of Referral (set by referrer)	29-May-2019	**Armed Forces Personnel, Immediate Families & Veterans**	**Impairment (s)**
Date referral was submitted	29-May-2019	☐ On active service	☐ Learning
Urgency of referral	Routine	☐ Condition related to service	☐ Visual
		☐ Immediate family member	☐ Hearing

Miscellaneous
Interpreter Required: No
Details of "Other" Language: None

PATIENT DETAILS		**Patient's address**
Surname	SKRETKOWICZ	34 ST JAMES ROAD FORFAR DD8 1LG
Forename (s)	GAVIN	
Title	MR	
Sex	Male	
Date of birth	04-Aug-1975	Contact number(s)
CHI no.	0408750014	Voice: 07984270423

REGISTERED GP DETAILS				**Practice address**
Name	Dr Kay Maccallum			ACADEMY STREET FORFAR ANGUS
GMC code	3107371	GP code	72249	Contact number(s)
Practice name	Academy Medical Centre			
Practice code	13231			

	Voice: 01307462316

REFERRING PRACTITIONER DETAILS			
Name	Dr. Caroline Thomas		
GMC code	4047968	GP code	76155
Practice name	Academy Medical Centre (13231)		
Practice code	13231		

Practice address
Academy Street Forfar
Contact number(s)
Voice: 01307 462316

Periods of Future Unavailability	None provided.

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: New hypertension

Comment: I would be grateful if you could review this new hypertensive 43 year old gentleman who has been type 2 diabetic now for 3 years, is diet controlled at present with last HbA1C of 43. Unfortunately his BMI is 43 with a weight of 145.8kg and his ASSIGN score is 31 and due to extremely low HDL 0.68 and his diabetes I started him on Lisinopril 5mg and Atorvastatin 20mg. He is motivated now to address his diet issues and weight issues and as he is very young is keen to discuss with yourself whether you feel that he would need to be seen to exclude any secondary causes or whether his weight is the main contributing factor, which obviously is significant. I am monitoring his U+Es having started his Lisinopril and if you feel that his weight needs to be addressed initially before potentially being seen by yourself at all in the future please let me know. Kind regards

Examinations and Investigations

Heavy smoker - 20-39 cigs/day:	Smoking status on date of event: Smoker. NOTES: ..	14-Aug-2018
Non-drinker alcohol:	Drinking status on eventdate: Life teetotaler.	14-Aug-2018
30 mins/day of at least mod intensty physc activity >=5 week:		14-Aug-2018

Most recent height, weight, BMI and Blood Pressure

Height:	1.84	m	Recorded Date: None provided
Weight:	145.8	Kg	Recorded Date: None provided
BMI:	43	Kg/m^2	Recorded Date: None provided
Blood Pressure:	131/95	mmHg	Recorded Date: None provided

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset
Essential hypertension	-	First ever	-	29-May-2019
Type 2 diabetes mellitus	-	Continuing	-	24-Apr-2017
Type 2 diabetes mellitus	-	Continuing	[TRUNCATED]Discussed diagnosis, aims and management of Type 2 diabetes. No known FH. He feels he can make some changes to his lifestyle through diet and increasing activity as able. HbA1c 44. EMU re	24-Apr-2017
Capable of work on work capability	-	New event	-	02-Jan-2017

assessment criteria				
[X]Post - traumatic stress disorder	-	Continuing	-	02-Jun-2014
[X]Post - traumatic stress disorder	-	Continuing	-	02-Jun-2014
[X]Depressive episode	-	Continuing	-	14-Apr-2014
Fracture of ankle	-	Continuing	left	30-Jul-2004
[X]Depressive episode	-	Continuing	-	01-Jun-2000
Overdose of drug	-	Continuing	-	08-Feb-1998
Fostered	-	Continuing	-	01-Jan-1984
Fracture of humerus	-	Continuing	left	02-Mar-1982

Past procedures

Description	Laterality	Modifier	Date performed
Medication changed	-	Continuing	21-Sep-2018
Drug changed to cost effective alternative	-	Continuing	21-Sep-2018
Medication review done by pharmacy technician	-	Continuing	21-Sep-2018
Lifestyle counselling	-	Continuing	14-Aug-2018
Referral to pharmacist	-	Continuing	30-Jul-2018
Referral to pharmacist	-	Continuing	11-Jul-2018
Excision of lesion of skin NEC	-	Continuing	21-Jul-1998

Current and recent medication

Current repeat medication

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration
Lisinopril 5mg tablets	68571020	tablet	1 TABLET ONCE A DAY	-	29-May-2019	-
Atorvastatin 20mg tablets	83944020	tablet	1 TABLET ONCE A DAY	-	29-May-2019	-
Vensir XL 75mg capsules (Morningside Healthcare Ltd)	96355020	capsule	1 CAPSULE ONCE DAILY (TOTAL D[more]	-	21-Sep-2018	-
Vensir XL 150mg capsules (Morningside Healthcare Ltd)	96357020	capsule	1 CAPSULE ONCE DAILY (TOTAL D[more]	-	21-Sep-2018	-
Prazosin 1mg tablets	66154020	tablet	TAKE 5 TABS	-	14-Aug-2018	-

			(5MG) AT NIGHT TIME			

Recent acute medication (last 30 days)

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration
Avamys 27.5micrograms/dose nasal spray (GlaxoSmithKline UK Ltd)	96413020	dose	ONE SPRAY INTO EACH NOSTRIL DAILY	-	08-May-2019	-

Clinical warnings

Additional relevant information
Administrative information

Referred By:Registered GP

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

NHS
Tayside

CF Thomas
13231/1
Academy Medical Centre
Academy Street
Forfar
Forfar
DD8 2HA

30/05/2019

Dear Dr Thomas

Thank you for your referral. He almost certainly has morbid obesity driven hypertension. I have appointed him to our new patient clinic but weight loss is the absolute priority both for his hypertension/dyslipidemia as well as his Diabetes. please refer him to a Weight management Service if possible

CARDIOVASCULAR RISK CLINIC CONTINUE MEDS

Patient Name: Gavin Charles Skretkowicz

CHI Number: 0408750014

Referral Date: 29/05/2019

Yours sincerely

Professor Jacob George

NHS
Tayside

Respiratory Medicine
Medicine Directorate
Acute Services Division
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

01382 496457
01382 496548
www.nhstayside.scot.nhs.uk

Dr KS MacCallum
Academy Medical Centre
Academy Street
Forfar
DD8 2HA

Date	14/08/2019
Clinic Date	26/07/2019
Your Ref	
Our Ref	RJS/LAS/ **0408750014**
Enquiries to	Lesley Sandøy
Extension	36457
Direct Line	01382 496457
Email	lesley.sandøy@nhs.net

Dear Dr MacCallum

Gavin Skretkowicz, 34 St James Road, Forfar, Angus, DD8 1LG DOB: 04/08/1975

Problems:

1. ***Latent TB infection: contact with smear positive pulmonary tuberculosis (fully sensitive)***
2. ***Tuberculin skin test 5mm induration***
3. ***Unremarkable chest radiograph***

I reviewed Gavin Skretkowicz today in the respiratory clinic. He is a contact with smear positive pulmonary tuberculosis and is a 43 year old care and support worker. He smokes 10-20 cigarettes a day and occasional cannabis. He has otherwise had no previous known exposures to TB and has no symptoms of active TB.

He has a past medical history of hypertension, diabetes and depression. He takes Prazosin 5mg daily, Atorvastatin 20mg daily, Lisinopril 5mg daily, Venlafaxine 225mg daily. He has no known drug allergies.

I have outlined the fact that he has no features of active TB both radiographically and from his symptoms and has a tuberculin skin test which is considered positive under the most recent NICE guidelines for latent TB infection. I explained to him that given his recent significant contact and skin test we should offer him chemoprophylaxis in the form of three months Rifanih 300 two tablets daily along with Pyridoxine 10mg daily. He had some baseline bloods today and LFTs in two weeks time.

We will see him in 8-10 weeks time and I have warned him of the potential side effects he needs to watch out for.

With best wishes.

Yours sincerely

Authorised on 19/08/2019 14:20:13 by AMU David Connell.

David Connell
Consultant in Acute and Respiratory Medicine

(P) Kirsteen Hill, Specialist Pharmacist, East Block, Level 4, Ninewells Hospital, DD1 9SY
(P) Margaret Ramsay, Specialist Nurse, Public Health Department, Kings Cross Hospital, Clepington Road, DD3 8EA

Respiratory Medicine
Medicine Directorate
Acute Services Division
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

Tel. 01382 496458
Fax. 01382 496548
www.nhstayside.scot.nhs.uk

Dr KS MacCallum
Academy Medical Centre
Academy Street
Forfar
DD8 2HA

Date	03/11/2019
Clinic Date	29/10/2019
Your Ref	
Our Ref	DC/AM/ **0408750014**
Enquiries to	A McDermott
Extension	36458
Direct Line	01382 496458
Email	

Dear Dr MacCallum

Gavin Skretkowicz, 34 St James Road, Forfar, Angus, DD8 1LG DOB: 04/08/1975

You did not attend the respiratory clinic today. I know you spoke to Margaret before about how the TB medication was having some effects on your health. I know you stopped the medication which is fine but it might be useful to talk things through to see how you are getting on now and to decide of in the future you would need to have any treatment. We will send you another appointment and do let us know in advance if you are unable to attend.

Yours sincerely

Authorised on 11/11/2019 11:20:10 by AMU David Connell.

David Connell
Consultant in Acute and Respiratory Medicine

(P) Margaret Ramsay, Specialist Nurse, Public Health Department, Kings Cross Hospital, Clepington Road, DD3 8EA

Respiratory Medicine
Medicine Directorate
Acute Services Division
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

www.nhstayside.scot.nhs.uk

Dr KS MacCallum
Academy Medical Centre
Academy Street
Forfar
DD8 2HA

Date	27/12/2019
Clinic Date	29/11/2019
Your Ref	
Our Ref	DC/PB/ **0408750014**
Enquiries to	Lesley Sandoy
Extension	36457
Direct Line	01382 496457
Email	

Dear Dr MacCallum

Gavin Skretkowicz, 34 St James Road, Forfar, Angus, DD8 1LG DOB: 04/08/1975

Problems: **1. Latent TB infection: contact with smear positive pulmonary tuberculosis (fully sensitive)**
2. Tuberculin skin test 5mm induration
3. Unremarkable chest radiograph

I reviewed Gavin today in clinic. Unfortunately he wasn't able to take his latent TB infection therapy as it seemed to cause side effects which impacted his mental health. He wondered whether it was causing induction of the Venlafaxine he takes (although this is not a recognised problem on the BNF with either Rifampicin or Isoniazid). Nevertheless, he felt unable to carry on taking the treatment and with our knowledge he stopped it a few weeks ago. He feels back to normal now.

I explained to him that his risk of TB with a tuberculin skin test of 5mm induration was above base line but certainly quite low. He and I will accept this very small risk of TB progression over the next couple of years and I will keep an eye on him in outpatients with a chest x-ray in one year's time. He knows to seek help if he has symptoms of active tuberculosis but I think this is going to be extremely unlikely. I have cc'd this letter as usual to Kirsteen Hill our specialist pharmacist to see if she has any other knowledge of non typical reactions with Rifampicin/isoniazid and Venlafaxine or any of his other medications which may have impacted his mental health.

With best wishes

Yours sincerely

Authorised on 17/01/2020 09:45:42 by AMU David Connell.

David Connell
Consultant in Acute and Respiratory Medicine

(P) Kirsteen Hill, Specialist Pharmacist, East Block, Level 4, Ninewells Hospital, DD1 9SY
(P) Margaret Ramsay, Specialist Nurse, Public Health Department, Kings Cross Hospital, Clepington Road, DD3 8EA

Ward/Clinic		CHI	0408750014
Hospital	Whitehills Health and Community Care Centre	Surname	SKRETKOWICZ
Clinician	Lynn Gilbert	First Name	GAVIN
Specialty	GENERAL NURSING	Address	34 ST JAMES ROAD FORFAR DD8 1LG
Date	12/10/2021	GP/Address	Academy Medical Centre Academy Street Forfar DD8 2HA

Dear Doctor,

The above patient was reviewed today; please accept this brief communication.

Provisional/Diagnosis is: BP

Comment/Recommendations:

Attended CTC today for blood pressure, a couple fell under amber range. GP to follow up.

Follow up by clinic required: No

Specific Monitoring Required: No

Lynn Gilbert | Staff Nurse | Tel:01307475209
Ninewells Switch Board Tel:01382 660111

Ward/Clinic	CTC	CHI	0408750014
Hospital	Whitehills Health and Community Care Centre	Surname	SKRETKOWICZ
Clinician	Alison Wynn	First Name	GAVIN
Specialty	GENERAL NURSING	Address	34 ST JAMES ROAD FORFAR DD8 1LG
Date	29/04/2022	GP/Address	Academy Medical Centre Academy Street Forfar DD8 2HA

Dear Doctor,

The above patient was reviewed today; please accept this brief communication.

Provisional/Diagnosis is: Pt attended CTC at WHCCC today for BP check. BP was in the amber parameters as recorded in Vision.

Comment/Recommendations: GP to follow up.

Follow up by clinic required: No

Specific Monitoring Required: No

Alison Wynn | Healthcare Support Worker | Tel:01307 475209
Ninewells Switch Board Tel:01382 660111

Tayside Out of Hours Service OOH Call Incident Report

Call number:	**17928**	Receive Date:	**15-Nov-2025 15:50**
Patient's Name:	**Gavin Skretkowicz**		
Date of birth:	**4-Aug-1975 (50 years)**	Gender:	**M**
Address:	**34 St James Road Forfar DD8 1LG**	Current Address:	**34 St James Road Forfar DD8 1LG**
Return Contact No:			
Tel No:			
Mobile No:			
Priority:	**Routine**	Call Origin:	**NHS24**
Received:	**15-Nov-2025 15:50**	Calltype:	**NHS24 Advised (Info Only)**
Advised:	**16:12**	Arrived PCC:	
Final Cons start:		Final Cons End:	
Consulting Doctor:		Own doctor:	**Alasdair Easton**

CHI Number:
0408750014

Reported Condition:
? INFECTION RIGHT MIDDLE FINGER NEAR NAIL - OVER 7 DAYS

NHSD details:

Received By - **Mark Carballo (Nhs 24) (Callhandler) (Cardona**
Triage Start Time - **15-Nov-2025 15:50**
Triage End Time - **15-Nov-2025 16:13**

Clinical Summary -**Clinical summary created by: Mark Carballo (Nhs 24) (Callhandler) () [15/11/2025 15:50:09]**
Reason for call: ? INFECTION RIGHT MIDDLE FINGER NEAR NAIL - OVER 7 DAYS
Confirmed symptom(s): Finger deformity
Symptom(s) not found: No current fever
Risk factor(s) not found: Patient not resident in a Care Home No travel outside Europe in last 21 days or to an affected country
20251115T161318.053 GMT Elaine Hay (NHS 24):INFECTED MIDDLE FINGER R HAND UNDER NAIL BED RADIATING TO IST JOINT , TIP LOOKS VERY RED , SOME PUS DRAINED , NO TRACKING, FEVER OR NAUSUA . THROPBBING PAIN ., DIABETIC DIET CONTROLLED . RECENT DENTAL TOOTHACHE AND TREATMENT , STILL SOME DISCOMFORT BUT NO OBVIOUS NEW SYMPTOMS . OUTCOME CONTACT PHARMACIST /WORSENING STATEMENT
20251115T160900.537 GMT Mark Carballo (NHS 24):TYPE 2 DIABETIC
20251115T160900.495 GMT Mark Carballo (NHS 24):MANAGED TO GET PUS OUT FINGER - FEELS INFECTION TRAVELING DOWN FINGER. RED AND HTT Outcome: Pt advised to contact Pharmacist - for information only

Questions -

Algorithm: Keyword Search

Keyword 1:

[X] Fingers

Keyword selected
[X] Fingers

Algorithm: Risk Assessment

Is this call from a Nursing or Care Home?
--NO

Do you have fever?
--NO

Have you been outside Europe in the last 21 days?
--NO

Algorithm: Initial Assessment

Are you/person about whom you are calling so unwell that you/person cannot stand at all e.g. walk to the toilet or sit up unaided without falling back down?
--NO

Algorithm: Protocols Used

Guideline used
[X] Finger 47

Algorithm: Finger 47

Select the additional marker of the keyword that defines the caller's complaint: (select one)
[X] No injury

Select the additional marker of the keyword that defines the caller's complaint: (Select one)
[X] Deformity

Algorithm: Protocols Used

Last Guideline used in the recommendation
[X] Finger 47

Algorithm: Pharmacy

Do you know the Pharmacy you are attending?
--NO

Disposition Contact Pharmacist

Followups:

None

GAVIN SKRETKOWICZ [04/08/1975] ID: 0408750014

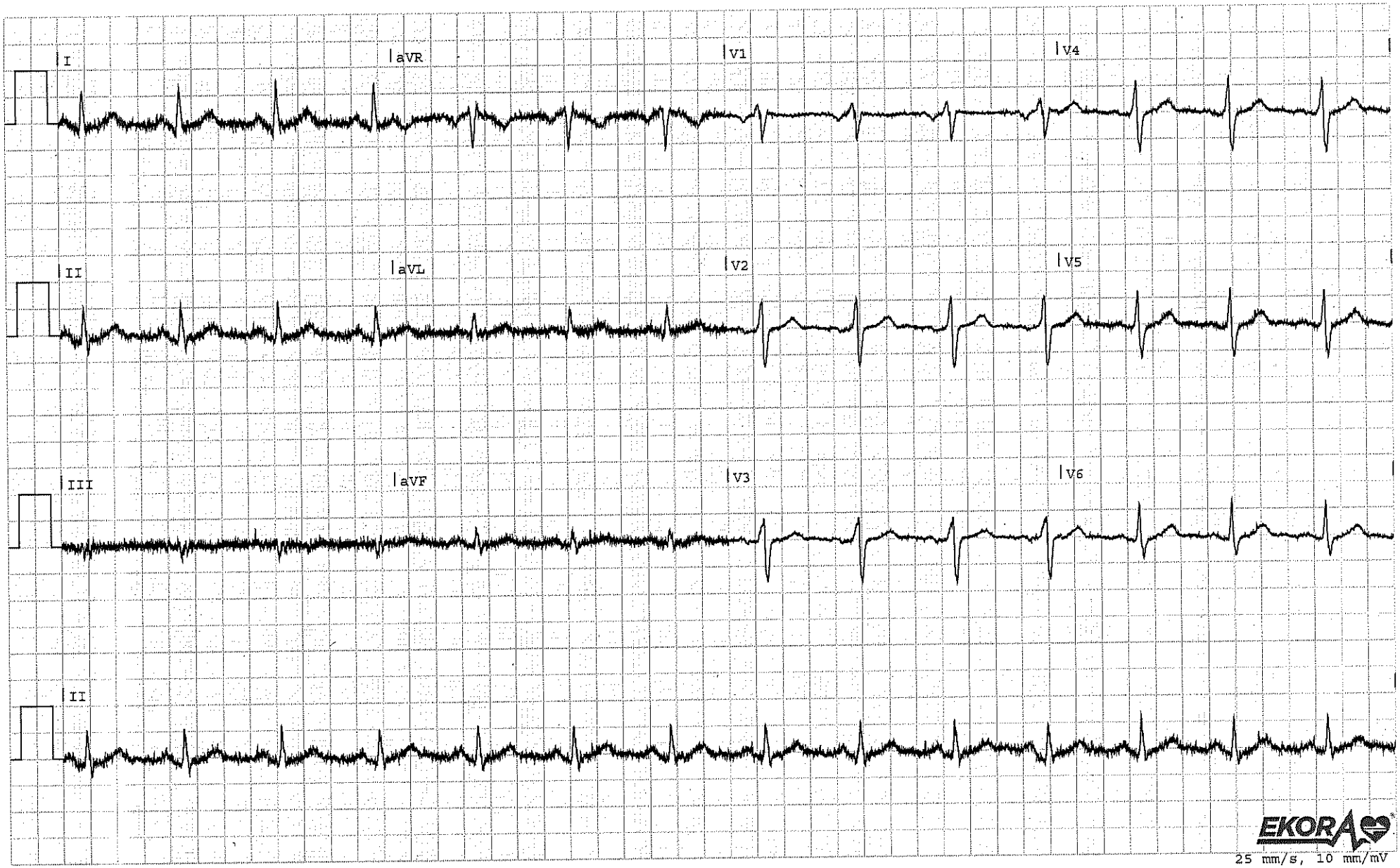
18/12/2025 11:31:56

Vent rate	84 bpm
PR int	147 ms
QRS dur	91 ms
QT/QTc	352/416 ms
P-R-T axes	13 7 21

Abnormal ECG
Complex(es) with aberrant intraventricular conduction, Sinus rhythm
Left atrial abnormality, Normal electrical axis, Consider right ventricular hypertrophy, ST-T abnormality, consider, septal ischemia or left ventricular strain, Nonspecific ST abnormality (elevation)

UNCONFIRMED AUTOMATED INTERPRETATION

NHS Tayside



Performed at : Unknown_Location

EPR Clinical Note

NHS Tayside

GAVIN SKRETKOWICZ
0408750014

Referral — 18/12/2025 09:13

Time	18/12/2025 09:13	Source	GP	Mode	
Received by	OR	Referer	GP	Contact	
Reason	?DKA			Plan	Admit

Unwell for last month (increased urine output), feeling tired, very thirsty. Vomiting every morning for last 1 month. NO abdo pain:
Ketones 3.1, BM 24.5
Obs ok

DM
bloods, VBG, If meets DKA criteria, then start DKA protocol, Diabetes Team review, monitor BMs and ketones, urine dipstick +/- culture, ECG

Dr Olumide Rowaiye on 18/12/2025 at 09:17

Progress Note — 18/12/2025 11:35

Date	18/12/2025 11:35	Clinician	Mrs Rachael Haxton	Escalation	

AMU Triage

50M

T2DM - diet controlled

Vomiting, no diarrhoea
1 month of Polyuria, polydipsia
Lost 10kg since February
No abdo pain
Smoker
No alcohol

Ketone 4.3
BG 23

VBG: pH 7.30, HCO3 14.7, K+ 4.49, Gluc 25.5, Lact 1.44

Plan	Start DKA protocol Bloods sent Repeat bloods in 1 hour Accurate fluid balance Dr Urquhart reviewing at present - admit to AMU

rhaxton1 on 18/12/2025 at 11:35

Initial Plan / Consultant Review — 18/12/2025 11:43

Date	18/12/2025 11:43	Clinician	Dr Lynn Urquhart	Escalation	

type 2 DM diet controlled for 7 years
past month developed significant osmotic symptoms with weight loss
non drinker
not on and sglt1

sugars and ketones raised just acidotic bicarb 15

o/e abdo soft
doesn't look too dry

imp: now behaving like type 1
? cause
? pancreatic lesion

Plan	dka protocol ct abdo diabetes team

Dr Lynn Urquhart on 18/12/2025 at 11:43

EKORA

Medicines Reconcilliation					19/12/2025 11:51
Date	18/12/2025 12:03	Last Edit by	Mrs Leigh Cartney	Verified by	Mrs Leigh Cartney
Sources	Electronic				
Compliance Aid	No	Comm Pharmacy			
Supply of all regular meds at home. Nil OTC					

Drug	Instruction	Comment	Action
Amitriptyline 25mg tablets 784 tablet	TAKE 2 TABLETS AT NIGHT	2200	Continue
Atorvastatin 20mg tablets 392 tablet	1 TABLET ONCE A DAY	0800	Continue
Lisinopril 5mg tablets 392 tablet	1 TABLET ONCE A DAY	0800	Continue
Prazosin 500microgram tablets 1568 tablet	FOUR TABLETS AT NIGHT AS ADVISED BY CMHT	?2.5*2 2200	Continue
Sildenafil 50mg tablets 4 tablet	1 TABLET WHEN REQUIRED		Hold
Vensir XL 150mg capsules (Morningside Healthcare Ltd) 392 capsule	1 CAPSULE ONCE DAILY (TOTAL DOSE 225MG DAILY) Notes for patient: Please note: Your prescription for Venlafaxine MR capsules has been changed to a different brand of the same drug called Vensir XL capsules as it is more cost effective to prescribe. The strength and dose remains the same therefore you should notice no difference in your treatment.	0800	Continue
Vensir XL 75mg capsules (Morningside Healthcare Ltd) 392 capsule	1 CAPSULE ONCE DAILY (TOTAL DOSE 225MG DAILY) Notes for patient: Please note: Your prescription for Venlafaxine MR capsules has been changed to a different brand of the same drug called Vensir XL capsules as it is more cost effective to prescribe. The strength and dose remains the same therefore you should notice no difference in your treatment.	0800	Continue

Allergies
There were no allergies recorded

Completion History			
Dr Rejin Pradeep-Kumar	18/12/2025 12:03:56	Mrs Leigh Cartney	18/12/2025 12:03:56

Mrs Leigh Cartney on 19/12/2025 at 11:51

EKORA

Specialist Review					18/12/2025 14:15
Date	18/12/2025 14:15	Clinician	Dr Rachel Siow	Escalation	

Endocrine Review
Consultant On - Call Dr. P. Newey

50M:
From Forfar
T2DM since 2017, never on anti-diabetic meds - HbA1c 45 in2024, 53 in Feb 2025
1/12 of osmotic symptoms - polydipsia (drinking 4-6L throughout day and overnight), Polyuria, Balanitis, and poor healing wounds in hands and dental abscess), 10kg unintentional weight loss
Reports visual changes but states actually improved in recent weeks, no longer requiring
Reports brain fog and forgetfulness
Nil chest or abdominal pain - Nil complaint of post meal RUQ pain.

PMH:
HTN - 2019 , T2DM - 2017, PTSD - 2014

Social Hx:
Lives alone
Unemployed due to mental health
Smoker since aged 12yrs
Nil alcohol use at all

FH:
Adopted so unable to comment on FHx

Discussed the difference between Type 1 and Type 2 Diabetes and brief overview of physiology and how this to relates to different types of treatment

Renal function and formal lab bloods still awaited

Initial blood gas
pH 7.31; pCO2 4.0; Bicarb 15; BE -10; K+ 4.5; Glucose * 25.5

Blood gas @13:30
pH 7.36; pCO2 3.7; pO2 9.7; Bicarb 15; BE -9; Na 133; K+ 5.1; Glucose 29.4

NEWS: BP:133/84 | HR:76bpm | RR:14/min | O2:96% [RA] | T:36.2C | 18/12/2025 12:05
Resp: Chest clear
CVS: HS pure
Abdo SNT and BS present
Feet - dry cracked heels, no wounds/broken skin/ ulcers

Understands all the above information and plan detailed below
Patient discussed with Dr. P Newey - In agreement with plan.

Plan	Cont VRII Stat dose Toujeo Next VBG due at 16:30 - if Bicarb > 17.0 and ketones < 1.0 can stop DKA protocol and commence Novorapid with meals Worthwhile continuing IVF for few hours after discontinuing, as likely dehydrated Next set of bloods should include C-peptide, Anti GAD antibodies Can come to W4/SSM under Diabetes (Paul Newey) DSN review tomorrow for insulin education and issue Freestyle Libre He is very eager to get home as soon as able, but willing to stay - we have said late tomorrow, is possible but over the weekend may be more realistic

rsiow on 18/12/2025 at 16:40

Progress Note					18/12/2025 17:40
Date	18/12/2025 17:40	Clinician	Dr Fathima-Sumaiya Rizaam	Escalation	

16:30 VBG
Bicarb 17.3
Ketones 1.2

Plan	Continue with DKA protocol Repeat VBG at 9pm

frizaam on 18/12/2025 at 17:40

Progress Note					18/12/2025 21:07
Date	18/12/2025 21:07	Clinician	Dr Michael Iwaniec	Escalation	

current BMs 16.4
ketones 1.5

Plan	continue another round of DKA stepdown once ketones < 1 as per Endocrine plan repeat VBG at 23:00 ward 4 once off DKA

miwaniec on 18/12/2025 at 21:07

Progress Note — 19/12/2025 00:05

Date	19/12/2025 00:05	Clinician	Dr Perks	Escalation	

Ketones 1
Repeat VBG = pH 7.396
Bicarb 20
K 4.1

Endo plan:
Bicarb > 17.0 and ketones < 1.0 can stop DKA protocol and commence Novorapid with meals

Plan
Stop DKA protocl as per endo plan
IV fluids
Has novorapid prescribed already
Continue to monitor BG + ketones 4 hourly

miwaniec on 19/12/2025 at 00:05

Progress Note — 19/12/2025 01:38

Date	19/12/2025 01:38	Clinician	Dr. Dominic Lee	Escalation	

Gavin has arrived to Ward 4 and is exceptionally nauseous with several episodes of vomiting
This is likely due to his DKA

Normal QTc
For ondansetron

Dr. Dominic Lee on 19/12/2025 at 01:38

Progress Note — 19/12/2025 06:43

Date	19/12/2025 06:43	Clinician	Mrs Simone Webster	Escalation	

S- ATSP as BG 14.4 mmols and blood ketones 2.9mmols
B- Treated for DKA on background of T2DM. PMH as noted above.
A= NEWS 0 at last check; BP:124/80 | HR:68bpm | RR:17/min | O2:97% [RA] | T:36.8C | 19/12/2025 5:34. One episode of vomiting overnight, eased after receiving ondansetron. IV fluids in situ at 100ml/hr. Now managing oral fluids and some shortbread to eat. No abdominal pain reported.
VBG taken:
pH 7.334
Bicarb 16.8
BE -7.7

Plan
R- discussed with CCU/renal ST Kabir - advises to continue IV fluids, give morning dose novorapid 6 units now followed by breakfast. Recheck bloods glucose and ketones one hour following this. Contact him if no improvement. Stat dose novorapid prescribed for now. Gavin updated and agreeable with plan but appears very fed up. Requires urgent DSN review today as keen to get home.

sjwebster on 19/12/2025 at 06:43

Ward Round — 19/12/2025 10:49

Date	19/12/2025 10:49	Clinician	Newey	Escalation	

Patient alert this mane. Sitting in chair.
Looking and feeling much better.
Not drinking as much and urinary frequency has reduced.
Fatigued but osmotic symptoms much improved.
Anxiety with being in hospital - Complex PTSD.
Private individual - does not like hospital environment
Extremely keen to go home

Managed to eat this mane.

Insulin:
Toujeo 18 units given this mane
Novorapid 6 units

09:00am
BMs 20.1
Ketones 1.9

Micro
Urine culture - Nil significant bacturia.

NEWS: BP:124/80 | HR:68bpm | RR:17/min | O2:97% [RA] | T:36.8C | 19/12/2025 5:34
Moist membrane
pulse regular
looks well

Plan
1) Needs DSN review for education
2) Continue to monitor BMs and ketones
3) Chase genetic testing/ C- peptide as an OP
4) Assuming BMs and ketones okay home later today after education
5) will need DSN follow up early next week
6) Needs worsening advice for weekend
7) Will arrange for Diabetes Clinic F/U - I will email

rsiow on 19/12/2025 at 13:23

Pharmacy					19/12/2025 11:53
Date	19/12/2025 11:53	Review by	Mrs Leigh Cartney		
Prazosin 500microgram tabs prescribed prior to admission (4 tablets at night -2mg) , not prescribed on hepma. Please review					

lcartney on 19/12/2025 at 11:53

Specialist Review					19/12/2025 12:22
Date	19/12/2025 12:22	Clinician	Mr Rory Fergus	Escalation	

Diabetes Nurse Review:
Type 2 Diabetes
Admitted with hyperglycaemia and ketones
Commenced on basal bolus regime of insulin

Reporting history of osmotic symptoms prior to admission
Awaiting updated HbA1c
Currently on Toujeo 18units once daily and Novorapid 6units before meals

Glucose levels continue above 12mmol/l
Ketones currently 1.9mmol/l. down trending

Education provided today on:
Blood glucose and ketone monitoring
Insulin administration technique and pen device set up
Insulin storage
Hypoglycaemia treatment and management
Ketone management
DVLA guidelines

Provided with Libre for on going monitoring at home

Plan	Please supervise Gavin administering own insulin at lunchtime Increased dose of Novorapid prescribed for lunchtime to help clear ketones DSN follow up on discharge

rfergus on 19/12/2025 at 12:22

Progress Note					19/12/2025 16:08
Date	19/12/2025 16:08	Clinician	Dr Rachel Siow	Escalation	

Returned to r/v patient.
Has received DSN education as above.
Patient expressing wish to leave - Discussed ideally would like to keep him in hospital until ketones have cleared to at least below one and to ensure continued downward trend.
Explained importance of this however he has capacity and is requesting discharge accepting of the risks.
Patient has retained information provided by DSNs and has all equipment needed for discharge - Appropriate knowledge of BM and ketone monitoring.
NS reports patient has been able to safely administer his own insulin.

Received STAT dose Novorapid 10 unit at 12:15pm
Last check post lunch at 13:30pm
BMs 15.4
Ketones 1.4

Plan	1) DSN will contact next week to ensure patient managing. 2) Willl arrange for F/U Diabetes Clinic review in 3 months time - I will email. 3) CTAP not indicated at present. 4) Safety advice given.

rsiow on 19/12/2025 at 17:17

NHS
Tayside

Endocrinology/Diabetology Department
Medicine Directorate
Acute Services Division
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

www.nhstayside.scot.nhs.uk

Dr JL Denholm
Academy Medical Centre
Academy Street
Forfar
DD8 2HA

Date	19/12/2025
Your Ref	
Our Ref	RF/LSM/ **0408750014**
Enquiries to	Diabetes Secretary
Extension	58640
Direct Line	01382 660111
Email	

Dear Dr Denholm

Gavin Skretkowicz, 34 St James Road, Forfar, Angus, DD8 1LG DOB: 04/08/1975

The above named patient has undertaken the Abbott Libre Academy online training and has been provided with FreeStyle Libre®2 Plus flash glucose monitoring educational literature, a FreeStyle Libre®2 Plus starter kit containing a Libre®2 Plus reader and one sensor.

Each sensor lasts 15 days.

Patient has agreed to the following:

- Carry out blood glucose monitoring as required and scan interstitial glucose no fewer than 6 times daily.
- Share downloaded data from FreeStyle Libre monitoring device for discussion at clinical reviews.
- Register with 'MyDiabetesMyWay'
- Have access to LibreView and agree to share data with the Diabetes Team.
- Ensure that sensors are worn and used in accordance with Abbott manufacturer guidelines.

Please can you prescribe sensors for future use: **Abbott FreeStyle Libre®2 Plus Sensors.**

Ongoing use will be assessed by a secondary care diabetes specialist. Individuals should receive no more than 25 sensors per annum (unless there are exceptional circumstances).

The patient will continue to require blood glucose test strips for Bolus advice, to comply with sick-day rules and DVLA guidelines.

If you have any queries around this patient's use of Freestyle Libre please contact tay.admindiabetes@nhs.scot

For further information regarding Flash Glucose Monitoring can be found on the Diabetes MCN website www.diabetes-healthnet.ac.uk

Yours sincerely

Authorised on 19/12/2025 15:06:55 by Typist Diabetes Lorraine Smith Morrison, not verified by Consultant.

Rory Fergus
Diabetes Nurse Specialist

GAVIN SKRETKOWICZ 34 ST JAMES ROAD, FORFAR, DD8 1LG *GP Practice: Academy Medical Centre, Academy Street, Forfar, DD8 2HA*	CHI: 0408750014 Born: 04/08/1975

This letter updates/amends previous communication received in relation to this episode of care

Discharge Details

Admission	18/12/2025	**Discharge**	19/12/2025
Specialty	Diabetes	**Consultant**	Dr Paul Newey (4698443)
From	Ward 4 Ninewells Hospital	**Destination**	Home

Diagnoses

DKA - diabetic ketoacidosis

Operations/Procedures

Actions Required for Primary Care

Communication to Primary Care

Dear Doctor,

Gavin was admitted to General internal medicine unit of Ninewell Hospital on 18/12/25 with diabetic ketoacidosis (DKA) and was commenced on the DKA protocol. Following stabilization, he has been initiated on long-term insulin therapy, having previously been managed with diet alone.

Gavin has received education and training on insulin administration. Genetic testing and C-peptide levels will be followed up as an outpatient. He is scheduled for review by the Diabetes Nurse Specialist next week to assess progress and ongoing management.

Clear safety-netting and worsening advice was provided prior to discharge. He has also been advised in line with DVLA guidelines. He is therefore discharged back to your care.

Kind regards,

Ward 4

Medications

This prescription has not been reviewed by a Pharmacist

Drug & Formulation	Dose	How to take	How long to take	Supply	Dispensary
Amitriptyline 25mg tablets		TAKE 2 TABLETS AT NIGHT		Own at Home	
Atorvastatin 20mg tablets		1 TABLET ONCE A DAY		Own at Home	
Lisinopril 5mg tablets		1 TABLET ONCE A DAY		Own at Home	
NOVORAPID 100units/1mL FlexPen	6UNITS	6UNITS WITH EVERY MEAL (AT 8AM, 12NOON AND 6PM)		TTO	
Prazosin 500microgram tablets		FOUR TABLETS AT NIGHT AS ADVISED BY CMHT		Own at Home	
Sildenafil 50mg tablets		1 TABLET WHEN REQUIRED		Own at Home	

TOUJEO 300units/mL SoloStar Pen	18UNITS	TAKE 18UNITS EVERY MORNING		TTO	
Vensir XL 150mg capsules (Morningside Healthcare Ltd)		1 CAPSULE ONCE DAILY (TOTAL DOSE 225MG DAILY) Notes for patient: Please note: Your prescription for Venlafaxine MR capsules has been changed to a different brand of the same drug called Vensir XL capsules as it is more cost effective to prescribe. T		Own at Home	
Vensir XL 75mg capsules (Morningside Healthcare Ltd)		1 CAPSULE ONCE DAILY (TOTAL DOSE 225MG DAILY) Notes for patient: Please note: Your prescription for Venlafaxine MR capsules has been changed to a different brand of the same drug called Vensir XL capsules as it is more cost effective to prescribe. T		Own at Home	

Discontinued Medication

Medication Notes

Allergies

Deleted Allergies

Follow Up Arrangements

Community Diabetic Nurses			Date to be arranged

Final Discharge Comments

Admission mild DKA (HC03 15), ketones > 4
HbA1c 148mmol/l on admission indicating persistent marked hyperglycaemia over weeks prior to admisison
Commenced basal bolus insulin with DSN follow up
Found hospital environment difficult and was extremly keen for early discharge
Will require diabetes OPD follow up

Pharmacy

Copy To

Sign Off

	Name	Job Title	Date/Time
Initial Sign Off	Marina Bishay	Clinical fellow	19/12/2025 16:11:44
Pharmacy Sign Off			
Final Sign Off	Paul Newey	Consultant	29/12/2025 12:45:01

Ward/Clinic		CHI	0408750014
Hospital	Ninewells Hospital	Surname	SKRETKOWICZ
Clinician	Graeme Gibb	First Name	GAVIN
Specialty	ENDOCRINOLOGY & DIABETES	Address	34 ST JAMES ROAD FORFAR DD8 1LG
Date	22/12/2025	GP/Address	Academy Medical Centre Academy Street Forfar DD8 2HA

Dear Doctor,

Provisional/Diagnosis is: Type 2 diabetes, commenced insulin as an inpatient. Provided with 4sure smart duo meter

Comment/Recommendations: Please prescribe 4SURE GLUCOSE TEST STRIPS, 4SURE KETONE TEST STRIPS, MICIRDOT PLUS LANCETS AND BD VIVA 4MM PEN NEEDLES.

Follow up by clinic required: No

Specific Monitoring Required: No

Graeme Gibb | Diabetes Specialist Nurse | Tel:01382 632293
Ninewells Switch Board Tel:01382 660111

Name: SKRETKOWICZ GAVIN CHI: 0408750014 Clinic Date: 22/12/2025

Ward/Clinic:

Further comment/Recommendations:

I am not a non medical prescriber.

Graeme Gibb | Diabetes Specialist Nurse | Tel:01382 632293
Ninewells Switch Board Tel:01382 660111

NHS
Tayside

JL Denholm
Academy Medical Centre
Academy Street
Forfar
DD8 2HA

05/01/2026

Dear Colleague

Please see the following outcome from the vetting process.

Patient Name: Gavin Charles Skretkowicz
CHI Number: 0408750014
Referral Date: 22/12/2025

Referral Source: Other (includes Armed Forces)

Referral Priority was: Routine
Vetted Priority is: Routine

N & D ADULT ROUTINE
Vetted By: Dietetics

Please note: If the vetting outcome is Redirecting Referral then the vetted by specialty will show as the redirected to specialty and not the specialty originally referred to.

Comment Referral received from Diabetes Specialist Nurse, accepted to waiting list and has now been appointed.

Yours sincerely

On behalf of NHS Tayside
Diabetes Dietitians

Tayside Out of Hours Service OOH Call Incident Report

Call number:	**43414**	Receive Date:	**12-Jan-2026 19:06**
Patient's Name:	**Gavin Skretkowicz**		
Date of birth:	**4-Aug-1975 (50 years)**	Gender:	**M**
Address:	**34** **ST JAMES ROAD** **FORFAR DD8 1LG**	Current Address:	**34** **ST JAMES ROAD** **FORFAR DD8 1LG**
Return Contact No:			
Tel No:			
Mobile No:			
Priority:	**Routine**	Call Origin:	**Police**
Received:	**12-Jan-2026 19:06**	Calltype:	**Advice**
Advised:	**:**	Arrived PCC:	
Final Cons start:	**12-Jan-2026 19:12**	Final Cons End:	**12-Jan-2026 19:32**
Consulting Doctor:	**Stephen Pegg**	Own doctor:	**Caroline Thomas**

CHI Number:
0408750014

Reported Condition:
Symptoms: patient telephone police reporting persons unknown in his house - on arrival he is alone and advises he has not taken his insulin for 2 weeks - own gp contacted and advised police to telephone for an ambulance - ambulance has since been re-directed and eta 3hours - request speak to gp please

Final Consultation details:

Consultation Start - **12-Jan-2026 19:12**

Consultation Finish - **12-Jan-2026 19:32**

Consulting Clinician - **Pegg, Stephen**

History - **Police officer seeks advise. She advises that patient has called the Police earlier to report that there were intruders in his house. Police have arrived and reports that there are no sign of any intruders. Police officer reports that patient seems confused and states that he has not taken his insulin for 2 weeks. Police officer called own GP who advised that they had no capacity to see patient and advised them to call an ambulance. Officer then called SAS who agreed to respond but she has now been waiting for 2 hours and SAS have advised that it will be at least another 3 hours before they have a vehicle available. Officer asking if we can see patient - advised that we are happy to do so but patient is refusing to attend. Police officer does not think that patient seems unwell and is freely mobile about the house.**

Examination - **.**

Diagnosis - **Confusion**

Treatment - **Discussed - probably little else to suggest other then waiting for SAS. Advised that if patient seems well there may be little to be gained by waiting for SAS to arrive, but it is up them if they choose to wait or not.**

Clinical Codes - **R009. Confusion**

Followups:

No Follow Up

Clinical Codes Summary (All Consultations):

R009. Confusion

Case Questions:

Chaperone Assisted

Chaperone Assisted	**No**

GAVIN SKRETKOWICZ [04/08/1975] ID: 0408750014

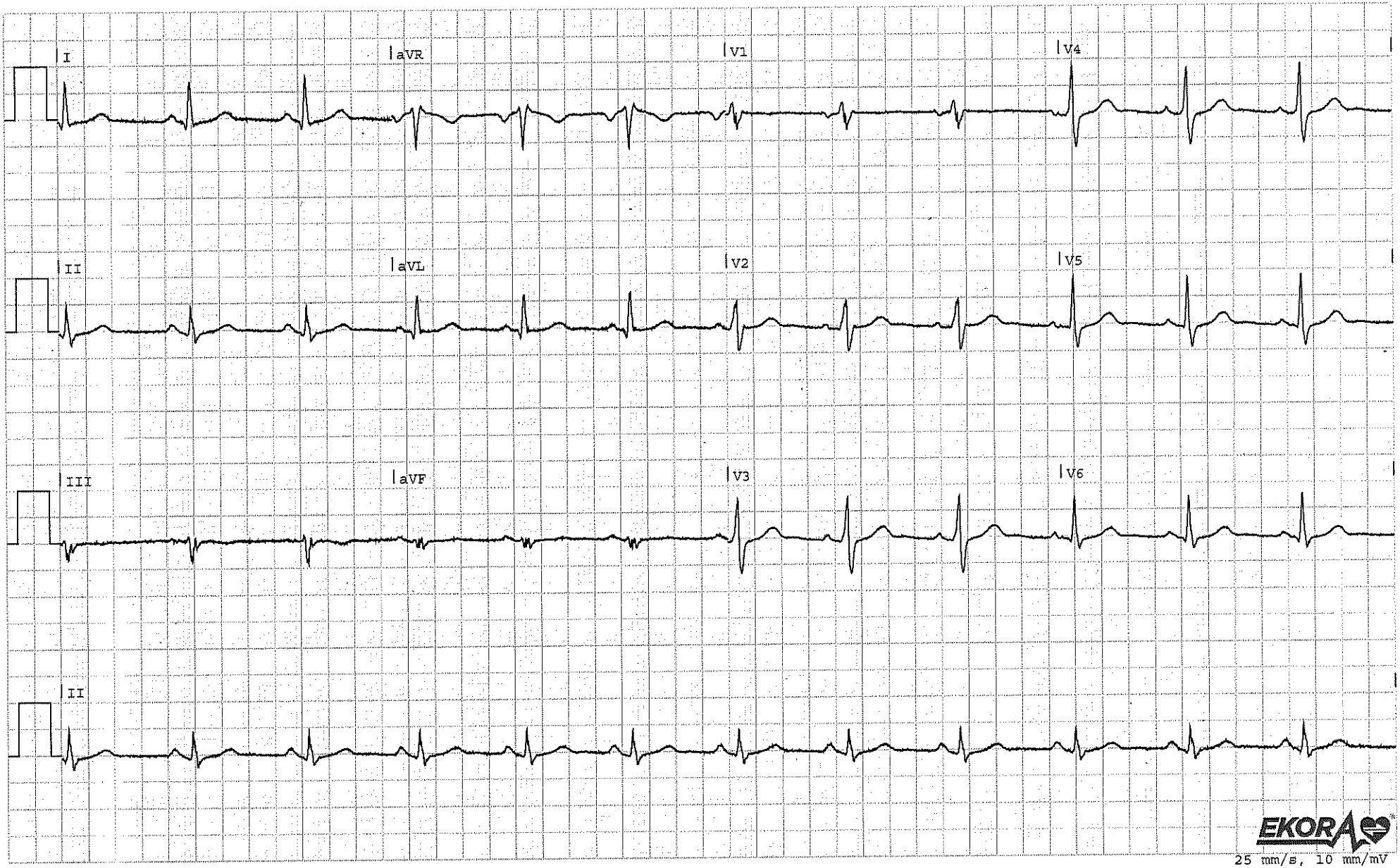
16/01/2026 14:51:24

Vent rate	72 bpm
PR int	144 ms
QRS dur	119 ms
QT/QTc	395/434 ms
P-R-T axes	26 -14 14

Otherwise normal ECG
Sinus rhythm
Leftward electrical axis

UNCONFIRMED AUTOMATED INTERPRETATION

NHS Tayside



Performed at : Unknown_Location

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?	**ADVICE REQUEST** MEDICAL IN CONFIDENCE	**Unique Care Pathway Number** 1010395910881

REQUESTED OF		
DiabetesA82 Tay Advice Protocol v1.2	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Stracathro Hospital By Brechin DD9 7QA	——	**Hospital** and **hospital address** Hospital unit no. T312H Email address -

Date of Request (set by referrer)	08/04/2026	**Armed Forces Personnel, Immediate Families & Veterans**	**Remote Consulting** Patient can manage:
Date request was submitted	08/04/2026	☐ On active service ☐ Condition related to service ☐ Immediate family member	Video consultation: Not Known Telephone consultation: Yes
Urgency of request	Advice		

PATIENT DETAILS		**Patient's address**
Surname	SKRETKOWICZ	34 ST JAMES ROAD FORFAR DD8 1LG
Forename (s)	GAVIN	
Title	MR	
Sex	Male	
Date of birth	04/08/1975	Contact number(s)
CHI no.	0408750014	Voice: 07984 270423 E-mail: gavskretkowicz@goolemail.com

REGISTERED GP DETAILS				**Practice address**
Name	Dr James Denholm			ACADEMY STREET FORFAR ANGUS
GMC code	4177591	GP code	72681	
Practice name	Academy Medical Centre			
Practice code	13231			Contact number(s)

	Voice: 01307462316

REFERRING PRACTITIONER DETAILS			
Name	Dr. Caroline Thomas		
GMC code	4047968	GP code	76155
Practice name	Academy Medical Centre (13231)		
Practice code	13231		

Practice address
Academy Street Forfar
Contact number(s)
Voice: 01307 462316

Periods of Future Unavailability	None provided.

Additional Support Needs	No known ASN requirements.

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Advice requested

Description: ?stop insulin

Comment: I would be extremely grateful for your advice with regards to this 50 year old gentleman who is diagnosed with type 2 diabetes in 2017. He remained a diet controlled diabetic up until his admission in December last year with DKA where he was treated following the DKA protocol. His admission HbA1c was 148 having been 53 when last checked in February 2025. He was discharged on long term insulin but unfortunately he became quite delusional and was admitted to Carseview and stayed there for several weeks from 13/01/26. He continued to received his insulin whilst he was an inpatient.

Since his discharge from there, he has stopped all his insulin and I was in touch with him last week advising that was feeling great, his diet was good and he wished for his insulin to be discontinued on his repeats. Obviously I spoke to him on the phone as I was concerned that he should continue with his insulin. He advised me he would compromise with taking his long lasting insulin. On asking him, he is still checking his BMs regularly and tells me that they were between 7 and 8 which was why he wanted to stop with his insulin.

I persuaded him to come in as he is still quite paranoid for up to date HbA1c which having been 114 in January when was admitted, it is currently 45. I am therefore at a loss as to how best to continue with this gentleman's diabetic medication as his diabetes is now back in remission and therefore he could indeed stop his insulin.

This is extremely unusual and therefore I would be extremely grateful for any of your expert advice going forward.

Kind regards.

Yours sincerely

Dr C Thomas

Examinations and Investigations

Cigarette smoker:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 15.	//
Alcohol consumption:	Drinking status on eventdate: Current drinker. NOTES: has 1 glass of cider if he goes out for a meal.	//
Exercise grading:	paddle boarding walking	//

Most recent height, weight, BMI and Blood Pressure

Height:	1.858	m	Recorded Date: None provided
Weight:	140.6	Kg	Recorded Date: None provided
BMI:	40.7	Kg/m^2	Recorded Date: None provided
Blood Pressure:	129/94	mmHg	Recorded Date: None provided

Reason for referral

Care type requested: Advice

Expected outcome: Advice

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset
[X]Persistent delusional disorders	-	First ever	-	02/02/2026
Diabetes mellitus with ketoacidosis	-	First ever	-	18/12/2025
Essential hypertension	-	First ever	-	29/05/2019
Type 2 diabetes mellitus	-	Continuing	-	24/04/2017
[X]Post - traumatic stress disorder	-	Continuing	-	02/06/2014
Fracture of ankle	-	Continuing	left	30/07/2004
[X]Depressive episode	-	Continuing	-	01/06/2000
Overdose of drug	-	Continuing	-	08/02/1998
Fostered	-	Continuing	-	01/01/1984
Fracture of humerus	-	Continuing	left	02/03/1982

Past procedures

Description	Laterality	Modifier	Date performed
Post hospital dischrge med reconciliation with medical notes	-	-	04/02/2026
Discharged from hospital	-	Continuing	02/02/2026
Post hospital dischrge med reconciliation with medical notes	-	-	30/12/2025
Discharged from hospital	-	Continuing	19/12/2025
Discharged from hospital	-	Continuing	19/12/2025

Current and recent medication

Current repeat medication

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration
Folic acid 5mg tablets	59305020	tablet	TAKE ONE TABLET ONCE A DAY T[more]	-	04/02/2026	-
Trazodone 50mg capsules	67151020	capsule	TAKE ONE CAPSULE AT NIGHT	-	04/02/2026	-
Aripiprazole 15mg tablets	87946020	tablet	TAKE ONE TABLET ONCE A DAY	-	04/02/2026	-
NovoRapid FlexPen 100units/ml solution for injection 3ml pre-filled pens (Novo Nordisk Ltd)	79182020	pre-filled disposable injection	TO BE ADMINISTERED AT 8AM, 12 [more]	-	30/12/2025	-
Toujeo 300units/ml solution for injection 1.5ml pre-filled SoloStar pens (Sanofi)	53110021	pre-filled disposable injection	TO BE ADMINSTERED IN THE MOR [more]	-	30/12/2025	-
	09168022	kit		-	23/12/2025	-

FreeStyle Libre 2 Plus Sensor (Abbott Laboratories Ltd)			USE AS DIRECTED. CHANGE EVERY [more]			
Viva hypodermic insulin needles for pre-filled / reusable pen injectors screw on 4mm/32gauge (embecta UK Ltd)	65852021	needle	USE WITH INSULIN PENS. SINGLE[more]	-	23/12/2025	-
Microdot Plus lancets 0.3mm/30gauge (Cambridge Sensors Ltd)	77965021	lancet	USE AS DIRECTED TO PRICK FING [more]	-	23/12/2025	-
4SURE beta-ketone testing strips 4S-810-4183401-001 (Nipro Diagnostics (UK) Ltd)	82090021	strip	TO BE USED WITH 4SURE SMART D [more]	-	23/12/2025	-
4SURE testing strips (Nipro Diagnostics (UK) Ltd)	81930021	strip	TO BE USED WITH 4SURE SMART D [more]	-	23/12/2025	-
Lisinopril 5mg tablets	68571020	tablet	1 TABLET ONCE A DAY	-	29/05/2019	-

Recent acute medication (last 30 days)

No recent acute medications recorded

Clinical warnings

Additional relevant information

Administrative information

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

NHS
Tayside

CF Thomas
Academy Medical Centre
Academy Street
Forfar
DD8 2HA

10/04/2026

Dear Colleague

Please see the following outcome from the vetting process.

Patient Name: Gavin Charles Skretkowicz
CHI Number: 0408750014
Referral Date: 08/04/2026

Referral Source: General Practitioner

Referral Priority was: Advice
Vetted Priority is: Back to Referrer

ADVICE TO REFERRER
Vetted By: Diabetes

Please note: If the vetting outcome is Redirecting Referral then the vetted by specialty will show as the redirected to specialty and not the specialty originally referred to.

Comment (Please add comments below for the referrer as required)

Thanks. He had an appointment to see me last week but did not attend.

Given this HBA1c, and the fact that his prior decompensation/DKA was on the background of no diabetes medication, then i'd suggest:
1) Stop the insulin
2) Start Metformin MR (ideally 1g bd) and Dapagliflozin.
3) Give sick day rule advice re both - esp Dapa
4) Ask him to monitor his CBG twice a week and seek input if CBG >10

NHS
Tayside

Yours sincerely
Dr Ewan Pearson

Endocrinology/Diabetology Department
Medicine Directorate
Acute Services Division
NHS Tayside
Whitehills Health & Community Care Centre
51 Station Road
Forfar
DD8 3DY

www.nhstayside.scot.nhs.uk

Private & Confidential
Gavin Skretkowicz
34 St James Road
Forfar
Angus
DD8 1LG

Date	14/04/2026
Your Ref	
Our Ref	EP/MC/ **0408750014**
Enquiries to	Marianne Cowie
Extension	65038
Direct Line	01356 665038
Email	marianne.cowie@nhs.scot

Dear Gavin Skretkowicz

Gavin Skretkowicz, 34 St James Road, Forfar, Angus, DD8 1LG DOB: 04/08/1975

You had an appointment to see me in the Diabetes clinic today. This was to follow up from your hospital stay a few months ago. At that time we started you on Insulin and I would be very keen to see you to revisit whether or not you still need Insulin or whether or not we can be using some different treatments to help you go on top of your diabetes. I will send through a further appointment and I would encourage you to attend. If you do not want to come please let us know. If you would like a discussion around coming off the Insulin and starting some alternative drugs between now and your follow up appointment please do phone our diabetes nurses on 01382 632293.

I look forward to seeing you soon. Many thanks.

Yours sincerely

Authorised on 20/04/2026 13:18:17 by Ewan Pearson.

Ewan Pearson
Professor in Diabetes

(D) Dr JL Denholm, Academy Medical Centre, Academy Street, Forfar, DD8 2HA

Patient name: **GAVIN SKRETKOWICZ**
Hospital number: **0408750014**

Tayside Diagnostic Services

Printed by amrobertson2 (Ann Robertson (non-referrer)) at 21 Jul 2026 10:15

Patient name:	**GAVIN SKRETKOWICZ**	CHI Number:	**0408750014**	Sex:	**Male**
Date of birth:	**04 Aug 1975**				
Address:	**34 St James Road, Forfar DD8 1LG**				

Report 1/5

Reported	Specialty	Location	Clinician
02 Apr 2026 15:16	Blood Sciences	T13231-ACADEMY MEDICAL CENTRE	Dr Caroline THOMAS (GP) (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 01 Jun 2026 06:59

CLINICAL DETAILS :
paranoid, stopped taking insulin 5-6 weeks ago, advising BMs regularly between 7 and 8, previous DKA

Sample 26B10095213 (Blood) Collected 02 Apr 2026 08:56 Received 02 Apr 2026 12:25

CREATININE AND ELECTROLYTES

Sodium		144	mmol/L	133 - 146
Potassium		4.8	mmol/L	3.5 - 5.3

SLIGHTLY HAEMOLYSED

Creatinine (Enzymatic)		79	umol/L	62 - 106
eGFR result (EPI)		>90	mL/min/1.73m*2	

This eGFR is consistent with category G1 - Normal
eGFR

C-REACTIVE PROTEIN

C-reactive protein		7.0	mg/L	0 - 10

HAEMOGLOBIN A1C

Haemoglobin A1c (IFCC)		45	mmol/mol	<48

FULL BLOOD COUNT

Haemoglobin		179	g/L	130 - 180
White Cell Count		10.6	10*9/L	4.0 - 11.0
Platelets		257	10*9/L	150 - 400
RBC		5.63	10*12/L	4.5 - 6.0
Haematocrit	*	**0.556**		0.40 - 0.52
MCV		98.8	fL	85 - 105
MCH		31.8	pg	27 - 32
MCHC		322	g/L	320 - 360
Neutrophils	*	**7.7**	10*9/L	2.0 - 7.5
Lymphocytes		2.1	10*9/L	1.5 - 4.0
Monocytes		0.6	10*9/L	0.2 - 0.8
Eosinophils		0.2	10*9/L	0.0 - 0.4
Basophils		0.1	10*9/L	0.0 - 0.1

Report 2/5

Reported	Specialty	Location	Clinician
10 Feb 2026 11:15	Blood Sciences	NW WARD AMU	Dr Helen ELDER (General Medicine) (General Medicine)

Filed by **helder** (Helen Elder (medical)) at 16 Mar 2026 15:58

CLINICAL DETAILS :
Patient on IVIG: No
Presentation with DKA. Please complete zinc transporter and IA2.

LAB COMMENTS :
Anti-GAD and anti-IA2 Abs requested for serological investigation of diabetes are performed at Immunology Royal Devon and Exeter Hospital.
Important - a negative TTG result is only valid for out ruling coeliac disease if this individual is eating gluten containing foods twice a day, for the previous 6 weeks.

Patient name: **GAVIN SKRETKOWICZ**
Hospital number: **0408750014**

Sample I253259930 (SERUM) Collected 18 Dec 2025 16:43 Received 18 Dec 2025 17:39

Anti-GAD Antibodies

Anti-GAD Abs (DIABETES only)	Negative	

GAD positivity threshold:11 U/mL or above. This is based on 97.5 centile based on 500 non-diabetic subjects.

IgA Tissue Transglutaminase Ab

IgA Tissue Transglutaminase	0.7	u/ml	0 - 4

Anti-IA2 Antibodies

Anti-IA-2 Antibodies	Negative

IA-2 positivity threshold: 7.5 U/mL or above. This is based on 97.5 centile of 1000 non-diabetic subjects.

Zinc Transporter 8 Ab

Zinc Transporter 8 Ab	Negative

ZNT8 positivity threshold: 10 U/mL or above (Age 30 Years or above). This is based on 97.5 centile of 1650 non-diabetic subjects.

Report 3/5

Reported	Specialty	Location	Clinician
21 Jan 2026 16:06	Radiology	CARSEVIEW MULBERRY UNIT	Dr Hani ZAKRI (GAP) (Mental Illness)

Filed by **sunquest** (Sunquest Administrator) at 01 Jun 2026 05:13

Sample 10055177 (TYPE UNSPECIFIED) Collected 21 Jan 2026 14:00 Received 21 Jan 2026 14:00

CT Head

Clinical History :
First presentation of grossly delusional psychosis at age 50; no prior relevant presentations. Very poorly controlled insulin-dependent T2DM. Requesting CT head to screen for organic causes please -- ?evidence of past infarct / ?mass lesion
ENTERED BY: Alexander Palmer (medical)
BLEEP: 01382 660111
CT Head :
Ventricles, basal cisterns, cerebral sulci are normal and symmetrical. No expansile mass.
No area of significantly abnormal attenuation.
OPINION: CT brain within normal limits for age.
DR TOM W TAYLOR / GOWF

Report 4/5

Reported	Specialty	Location	Clinician
16 Jan 2026 22:35	Blood Sciences	CARSEVIEW MULBERRY UNIT	Dr Hani ZAKRI (GAP) (Mental Illness)

Filed by **ailaing** (Alexander Laing (medical)) at 16 Jan 2026 23:11

CLINICAL DETAILS :
Admission bloods for a psych. admission, poorly controlled DM.

Sample C263320380 (Blood) Collected 16 Jan 2026 12:42 Received 16 Jan 2026 18:27

C-REACTIVE PROTEIN			
C-REACTIVE PROTEIN	6.9	mg/L	0.0 - 10.0
CHOLESTEROL			
TOTAL CHOLESTEROL	FREQUENCY OF TEST NOT JUSTIFIED.	mmol/L	
PROLACTIN			
PROLACTIN	37	mU/L	0 - 350
Urea & Electrolytes			
SODIUM	142	mmol/L	133 - 146
POTASSIUM	4.8	mmol/L	3.5 - 5.3
UREA	7.6	mmol/L	2.5 - 7.8
CREATININE	72	umol/L	62 - 106
AKI			
AKI	Not detected: May not exclude AKI in all cases		

Patient name: **GAVIN SKRETKOWICZ**
Hospital number: **0408750014**

Liver Function Tests (LFT)

ALT	41	U/L	5 - 55
BILIRUBINS	10	umol/L	0 - 21
ALKALINE PHOSPHATASE	110	U/L	30 - 130
ALBUMIN	41	g/L	35 - 50

ESTIMATED GFR

ESTIMATED GFR	GT60	mL/min

eGFR should not be used to assess renal function for any drug dosing in over 75s or extremes of BMI and for DOAC dosing in those with an eGFR less than 60ml/min.

CKD Stage

CKD Stage	IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA .

GLUCOSE

GLUCOSE (preserved tube)	FLUORIDE OXALATE (GREY TOP) REQUIRED	mmol/L

HbA1c (IFCC)

HbA1c IFCC	* **114**	mmol/mol	>Below 48

Report 5/5

Reported	Specialty	Location	Clinician
16 Jan 2026 19:15	Blood Sciences	CARSEVIEW MULBERRY UNIT	Dr Hani ZAKRI (GAP) (Mental Illness)

Filed by **ailaing** (Alexander Laing (medical)) at 16 Jan 2026 19:49

CLINICAL DETAILS :
Admission bloods for a psych. admission, poorly controlled DM.

LAB COMMENTS :
Borderline B12 ?significance. May represent true deficiency. Suggest correlate with clinical and laboratory features. (NB levels can be falsely low in Folate deficiency, pregnancy and patients on oral contraceptives).

Sample H263320380 (EDTA) Collected 16 Jan 2026 12:42 Received 16 Jan 2026 18:27

FBC

Hb		173	g/L	130 - 180
WBC		10.1	x10^9/L	4.0 - 11.0
PLT		256	x10^9/L	150 - 400
RBC		5.12	x10^12/L	4.5 - 6.0
HCT	*	**0.521**		0.40 - 0.52
MCV		101.8	fl	85 - 105
MCH	*	**33.9**	pg	27 - 32
MCHC		333	g/L	320 - 360
NE#	*	**7.6**	x10^9/L	2.0 - 7.5
LY#		1.7	x10^9/L	1.5 - 4.0
MO#		0.6	x10^9/L	0.2 - 0.8
EO#		0.04	x10^9/L	0.0 - 0.4
BA#		0.0	x10^9/L	0.0 - 0.1

B12/FOLATE

B12	*	**185**	ng/l	200 - 940

Results may be unreliable if sample older than 48h

Serum Folate		11.0	ug/l	3.1 - 17.5

End of reports

Patient name: **GAVIN SKRETKOWICZ**
Hospital number: **0408750014**

Tayside Diagnostic Services

Printed by amrobertson2 (Ann Robertson (non-referrer)) at 21 Jul 2026 10:16

Patient name:	**GAVIN SKRETKOWICZ**	CHI Number:	**0408750014**	Sex:	**Male**
Date of birth:	**04 Aug 1975**				
Address:	**34 St James Road, Forfar DD8 1LG**				

Report 1/21

Reported	Specialty	Location	Clinician
29 Jul 2019 16:00	Microbiology	NW OP EAST BLOCK	David CONNELL (Respiratory) (General Medicine)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 05:09

CLINICAL DETAILS :
HIV Risk level: Average
HIV testing Reason: No symptoms
Latent TB for treatment

Sample 19V015501 (Venous blood) Collected 26 Jul 2019 15:51 Received 27 Jul 2019 09:10

Hepatitis B (HBsAg) screen:

Hepatitis B (HBsAg) screen	Negative	

Hepatitis C IgG screen:

Hepatitis C IgG screen	Negative	

HIV1&2 Antigen/Antibody:

HIV1&2 Antigen/Antibody	Negative	

Hepatitis B core antibody:

Hepatitis B core antibody	Negative	

Hepatitis B surface antibody:

Hepatitis B surface antibody	0	mIU/ml

Report 2/21

Reported	Specialty	Location	Clinician
26 Jul 2019 17:10	Blood Sciences	NW OP EAST BLOCK	David CONNELL (Respiratory) (General Medicine)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 05:09

CLINICAL DETAILS :
Latent TB for treatment

Sample H197243372 (EDTA) Collected 26 Jul 2019 15:51 Received 26 Jul 2019 16:24

FBC

Hb		155	g/L	130 - 180
WBC		10.6	x10^9/L	4.0 - 11.0
PLT		222	x10^9/L	150 - 400
RBC	*	**4.19**	x10^12/L	4.5 - 6.0
HCT		0.453		0.40 - 0.52
MCV	*	**108.2**	fl	85 - 105
MCH	*	**37.0**	pg	27 - 32
MCHC		342	g/L	320 - 360
NE#		7.1	x10^9/L	2.0 - 7.5
LY#		2.8	x10^9/L	1.5 - 4.0
MO#		0.6	x10^9/L	0.2 - 0.8
EO#		0.14	x10^9/L	0.0 - 0.4
BA#		0.1	x10^9/L	0.0 - 0.1

Patient name: **GAVIN SKRETKOWICZ**
Hospital number: **0408750014**

Report 3/21

Reported	Specialty	Location	Clinician
26 Jul 2019 17:09	Blood Sciences	NW OP EAST BLOCK	David CONNELL (Respiratory) (General Medicine)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 05:09

CLINICAL DETAILS :
Latent TB for treatment

Sample C197243372 (Blood) Collected 26 Jul 2019 15:51 Received 26 Jul 2019 16:24

Urea & Electrolytes			
SODIUM	140	mmol/L	133 - 146
POTASSIUM	4.3	mmol/L	3.5 - 5.3
UREA	7.4	mmol/L	2.5 - 7.8
CREATININE	82	umol/L	62 - 106
AKI			
AKI	Not detected: May not exclude AKI in all cases		
Liver Function Tests (LFT)			
ALT	52	U/L	5 - 55
BILIRUBINS	8	umol/L	0 - 21
ALKALINE PHOSPHATASE	93	U/L	30 - 130
ALBUMIN	41	g/L	35 - 50
ESTIMATED GFR			
ESTIMATED GFR	GT60	mL/min	
CKD Stage			
CKD Stage	IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA .		

Report 4/21

Reported	Specialty	Location	Clinician
08 Jun 2019 21:17	Radiology	NW OP CHEST CLINIC	David CONNELL (Respiratory) (General Medicine)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:27

Sample 7213559 (TYPE UNSPECIFIED) Collected 30 May 2019 10:52 Received 30 May 2019 10:52

XR Chest

Clinical History :
TB contact, positive Mantoux
?evidence of TB
ENTERED BY: Gillian Hernandez (NMR199)
BLEEP: 33141
Examination: X-ray chest
Findings: Normal cardiac and mediastinal contours. The lungs are clear. The bony thorax is intact.
Report Date: 8th June 2019
Dr Ishmael Chasi
Medica Reporting Ltd
GMC Ref: 5198376
DR ISHMAEL CHASI (MEDICA) / ICHASI

Report 5/21

Reported	Specialty	Location	Clinician
06 Jun 2019 12:57	Blood Sciences	T13231-ACADEMY MEDICAL CENTRE	Patricia STEWART (Practice Nurse) (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 06:20

CLINICAL DETAILS :
started on Lisinopril

Sample C197130998 (Blood) Collected 06 Jun 2019 08:12 Received 06 Jun 2019 12:16

Patient name: **GAVIN SKRETKOWICZ**
Hospital number: **0408750014**

Creatinine and Electrolytes			
SODIUM	137	mmol/L	133 - 146
POTASSIUM	4.7	mmol/L	3.5 - 5.3
CREATININE	80	umol/L	62 - 106
AKI			
AKI	Not detected: May not exclude AKI in all cases		
ESTIMATED GFR			
ESTIMATED GFR	GT60	mL/min	
CKD Stage			
CKD Stage	IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA .		

Report 6/21

Reported	Specialty	Location	Clinician
16 May 2019 13:56	Blood Sciences	T13231-ACADEMY MEDICAL CENTRE	Dr Caroline THOMAS (GP) (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 06:18

CLINICAL DETAILS :
hypertension workup

Sample C197084302 (Blood) Collected 16 May 2019 09:26 Received 16 May 2019 13:01

CHOLESTEROL			
TOTAL CHOLESTEROL	* **5.16**	mmol/L	0.00 - 5.00
TOTAL CHOL/HDL-CHOL			
HDL-CHOLESTEROL	0.68	mmol/L	0.60 - 2.50
TOTAL CHOL/HDL-CHOL	7.50		
Creatinine and Electrolytes			
SODIUM	140	mmol/L	133 - 146
POTASSIUM	4.2	mmol/L	3.5 - 5.3
CREATININE	74	umol/L	62 - 106
AKI			
AKI	Not detected: May not exclude AKI in all cases		
ESTIMATED GFR			
ESTIMATED GFR	GT60	mL/min	
CKD Stage			
CKD Stage	IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA .		
GLUCOSE			
GLUCOSE (preserved tube)	* **10.1**	mmol/L	3.3 - 5.8

Report 7/21

Reported	Specialty	Location	Clinician
16 May 2019 13:23	Blood Sciences	T13231-ACADEMY MEDICAL CENTRE	Dr Caroline THOMAS (GP) (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 06:18

CLINICAL DETAILS :
hypertension workup

Sample H197084302 (EDTA) Collected 16 May 2019 09:26 Received 16 May 2019 13:01

FBC				
Hb		158	g/L	130 - 180
WBC		9.0	x10^9/L	4.0 - 11.0
PLT		239	x10^9/L	150 - 400
RBC	*	**4.47**	x10^12/L	4.5 - 6.0
HCT		0.479		0.40 - 0.52
MCV	*	**107.2**	fl	85 - 105
MCH	*	**35.3**	pg	27 - 32
MCHC		329	g/L	320 - 360
NE#		6.3	x10^9/L	2.0 - 7.5

Patient name: **GAVIN SKRETKOWICZ**
Hospital number: **0408750014**

LY#	2.1	x10^9/L	1.5 - 4.0
MO#	0.4	x10^9/L	0.2 - 0.8
EO#	0.22	x10^9/L	0.0 - 0.4
BA#	0.1	x10^9/L	0.0 - 0.1

Report 8/21

Reported	Specialty	Location	Clinician
02 Apr 2019 12:07	Blood Sciences	T13231-ACADEMY MEDICAL CENTRE	Nurse M MURRAY (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 06:16

CLINICAL DETAILS :
diabetic 6m review

Sample C196985231 (Blood) Collected 01 Apr 2019 11:30 Received 01 Apr 2019 17:36

Creatinine and Electrolytes

SODIUM	141	mmol/L	133 - 146
POTASSIUM	4.5	mmol/L	3.5 - 5.3
CREATININE	70	umol/L	62 - 106

AKI

AKI	Not detected: May not exclude AKI in all cases		

ESTIMATED GFR

ESTIMATED GFR	GT60	mL/min	

CKD Stage

CKD Stage	IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA .		

HbA1c (IFCC)

HbA1c IFCC	43	mmol/mol	

Report 9/21

Reported	Specialty	Location	Clinician
15 Aug 2018 14:44	Blood Sciences	T13231-ACADEMY MEDICAL CENTRE	Patricia STEWART (Practice Nurse) (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 06:03

CLINICAL DETAILS :
diabetic annual also annual MentalHealth

Sample C186483659 (Urine) Collected 14 Aug 2018 11:59 Received 14 Aug 2018 19:20

URINE ALBUMIN/CREATININE RATIO

URINARY MICRO ALBUMIN	3	mg/L	0 - 30
URINE ALBUMIN/CREATININE	0.2	mg/mmol Creat	0.0 - 2.5

Report 10/21

Reported	Specialty	Location	Clinician
15 Aug 2018 12:22	Blood Sciences	T13231-ACADEMY MEDICAL CENTRE	Patricia STEWART (Practice Nurse) (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 06:03

CLINICAL DETAILS :
On T4?: No
diabetic annual also annual MentalHealth

Sample C186483658 (Blood) Collected 14 Aug 2018 11:59 Received 14 Aug 2018 19:10

CHOLESTEROL

TOTAL CHOLESTEROL	4.67	mmol/L	0.00 - 5.00

Creatinine and Electrolytes

SODIUM	140	mmol/L	133 - 146
POTASSIUM	4.1	mmol/L	3.5 - 5.3
CREATININE	77	umol/L	62 - 106

Patient name: **GAVIN SKRETKOWICZ**
Hospital number: **0408750014**

AKI			
AKI	Not detected: but may not exclude AKI in all cases		
ESTIMATED GFR			
ESTIMATED GFR	GT60	mL/min	
CKD Stage			
CKD Stage	IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA .		
TOTAL CHOL/HDL-CHOL			
HDL-CHOLESTEROL	0.79	mmol/L	0.60 - 2.50
TOTAL CHOL/HDL-CHOL	5.90		
TSH			
TSH	1.12	mU/L	0.4 - 4.0
HbA1c (IFCC)			
HbA1c IFCC	40	mmol/mol	

Report 11/21

Reported	Specialty	Location	Clinician
23 Mar 2018 13:54	Blood Sciences	T13231-ACADEMY MEDICAL CENTRE	Patricia STEWART (Practice Nurse) (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 06:55

CLINICAL DETAILS :
diabetic 6m review haematuria

Sample C186164526 (Blood) Collected 22 Mar 2018 14:13 Received 22 Mar 2018 17:28

Creatinine and Electrolytes			
SODIUM	142	mmol/L	133 - 146
POTASSIUM	4.8	mmol/L	3.5 - 5.3
CREATININE	74	umol/L	62 - 106
AKI			
AKI	Not detected: but may not exclude AKI in all cases		
ESTIMATED GFR			
ESTIMATED GFR	GT60	mL/min	
CKD Stage			
CKD Stage	IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA .		
HbA1c (IFCC)			
HbA1c IFCC	40	mmol/mol	

Report 12/21

Reported	Specialty	Location	Clinician
23 Mar 2018 13:29	Microbiology	T13231-ACADEMY MEDICAL CENTRE	Patricia STEWART (Practice Nurse) (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 06:55

CLINICAL DETAILS :
Symptoms of UTI?: No
Test reason: OTHER REASON FOR TESTING
Test reason: haematuria
Antibiotic Therapy: NK
Antibiotic allergies: NK
eGFR value (last 3 mths): NK
diabetic 6m review haematuria

Sample 18B215984 (Midstream Urine) Collected 22 Mar 2018 14:13 Received 22 Mar 2018 17:08

Urine Culture:

No Significant Bacteriuria

Report 13/21

Reported	Specialty	Location	Clinician
17 Jul 2017 18:05	Blood Sciences	T13231-ACADEMY MEDICAL CENTRE	Dr Matthew ADAM (GP) (General Practice)

Patient name: **GAVIN SKRETKOWICZ**
Hospital number: **0408750014**

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 06:41

CLINICAL DETAILS :
Annual Diabetic review also commenced Atorvastatin for diabetes

Sample C175616481 (Urine) Collected 17 Jul 2017 13:56 Received 17 Jul 2017 16:50

URINE ALBUMIN/CREATININE RATIO

URINARY MICRO ALBUMIN	8	mg/L	0 - 30
URINE ALBUMIN/CREATININE	1.7	mg/mmol Creat	0.0 - 2.5

Report 14/21

Reported	Specialty	Location	Clinician
13 Jul 2017 09:24	Blood Sciences	T13231-ACADEMY MEDICAL CENTRE	Dr Matthew ADAM (GP) (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 06:41

CLINICAL DETAILS :
On T4?: No
Annual Diabetic review also commenced Atorvastatin for diabetes

Sample C175606436 (Blood) Collected 12 Jul 2017 10:56 Received 12 Jul 2017 18:38

CHOLESTEROL			
TOTAL CHOLESTEROL	* **5.36**	mmol/L	0.00 - 5.00
Creatinine and Electrolytes			
SODIUM	139	mmol/L	133 - 146
POTASSIUM	4.3	mmol/L	3.5 - 5.3
CREATININE	80	umol/L	62 - 106
AKI			
AKI	Not detected: but may not exclude AKI in all cases		
Liver Function Tests (LFT)			
ALT	46	U/L	5 - 55
BILIRUBINS	9	umol/L	0 - 21
ALKALINE PHOSPHATASE	105	U/L	30 - 130
ALBUMIN	40	g/L	35 - 50
ESTIMATED GFR			
ESTIMATED GFR	GT60	mL/min	
CKD Stage			
CKD Stage	IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA .		
TOTAL CHOL/HDL-CHOL			
HDL-CHOLESTEROL	0.79	mmol/L	0.60 - 2.50
TOTAL CHOL/HDL-CHOL	6.70		
TSH			
TSH	1.42	mU/L	0.4 - 4.0
HbA1c (IFCC)			
HbA1c IFCC	40	mmol/mol	

Report 15/21

Reported	Specialty	Location	Clinician
12 Jul 2017 18:55	Blood Sciences	T13231-ACADEMY MEDICAL CENTRE	Dr Matthew ADAM (GP) (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 06:41

CLINICAL DETAILS :
On T4?: No
Annual Diabetic review also commenced Atorvastatin for diabetes

Sample H175606436 (EDTA) Collected 12 Jul 2017 10:56 Received 12 Jul 2017 18:38

Patient name: **GAVIN SKRETKOWICZ**
Hospital number: **0408750014**

FBC

Hb		170	g/L	130 - 180
WBC		9.2	x10^9/L	4.0 - 11.0
PLT		236	x10^9/L	150 - 400
RBC		4.83	x10^12/L	4.5 - 6.0
HCT		0.513		0.40 - 0.52
MCV	*	**106.3**	fl	85 - 105
MCH	*	**35.2**	pg	27 - 32
MCHC		331	g/L	320 - 360
NE#		5.9	x10^9/L	2.0 - 7.5
LY#		2.5	x10^9/L	1.5 - 4.0
MO#		0.6	x10^9/L	0.2 - 0.8
EO#		0.18	x10^9/L	0.0 - 0.4
BA#		0.0	x10^9/L	0.0 - 0.1

Report 16/21

Reported	Specialty	Location	Clinician
25 Apr 2017 18:02	Blood Sciences	T13231-ACADEMY MEDICAL CENTRE	Nurse M MURRAY (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 06:37

CLINICAL DETAILS :
ACR Levels, new diabetic.

Sample C175429679 (Urine) Collected 25 Apr 2017 12:14 Received 25 Apr 2017 16:35

URINE ALBUMIN/CREATININE RATIO

URINARY MICRO ALBUMIN	4	mg/L	0 - 30
URINE ALBUMIN/CREATININE	0.3	mg/mmol Creat	0.0 - 2.5

Report 17/21

Reported	Specialty	Location	Clinician
31 Mar 2017 18:18	Blood Sciences	T13231-ACADEMY MEDICAL CENTRE	Eleanor McINTOSH (PN) (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 06:36

CLINICAL DETAILS :
previous raised fasting glucose 6.9

Sample C175377074 (Blood) Collected 31 Mar 2017 11:37 Received 31 Mar 2017 17:00

GLUCOSE TOLERANCE TEST

Dynamic Function Test

GLUCOSE TOLERANCE TEST
Spm Nos.:C175377074 C170910531
Times : 0' 120'
GLUCOSE. 7.2 6.5

Report 18/21

Reported	Specialty	Location	Clinician
17 Mar 2017 16:33	Blood Sciences	T13231-ACADEMY MEDICAL CENTRE	Dr Matthew ADAM (GP) (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 06:35

CLINICAL DETAILS :
Random glucose 8.3, repeat fasted

Sample C175344126 (Blood) Collected 17 Mar 2017 09:16 Received 17 Mar 2017 12:27

CHOLESTEROL

TOTAL CHOLESTEROL	*	**5.06**	mmol/L	0.00 - 5.00

SAMPLE IS

Patient name: **GAVIN SKRETKOWICZ**
Hospital number: **0408750014**
:

SAMPLE IS		(FASTING)	.	
URATE				
URATE	*	**486**	umol/L	200 - 430
TOTAL CHOL/HDL-CHOL				
HDL-CHOLESTEROL		0.71	mmol/L	0.60 - 2.50
TOTAL CHOL/HDL-CHOL		7.10	.	
LDL-CHOLESTEROL (CALCULATED)				
TRIGLYCERIDES	*	**2.53**	mmol/L	0.00 - 2.30
LDL-CHOL. (CALCULATED)	*	**3.21**	mmoL/L	0 - 2.60
GLUCOSE				
GLUCOSE (preserved tube)	*	**6.9**	mmol/L	3.3 - 5.8
HbA1c (IFCC)				
HbA1c IFCC		44	mmol/mol	

Report 19/21

Reported	Specialty	Location	Clinician
15 Feb 2017 15:08	Blood Sciences	T13231-ACADEMY MEDICAL CENTRE	Dr Matthew ADAM (GP) (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 06:33

```
CLINICAL DETAILS :
PV repeated: within 30 days
On T4?: Yes
Vague symptoms, eye shocks and headaches, patient thinks
Paroxetine related, ? psychosocial.
```

Sample H175271591 (EDTA) Collected 15 Feb 2017 09:08 Received 15 Feb 2017 12:50

FBC				
Hb		173	g/L	130 - 180
WBC		11.0	x10^9/L	4.0 - 11.0
PLT		275	x10^9/L	150 - 400
RBC		4.73	x10^12/L	4.5 - 6.0
HCT		0.507		0.40 - 0.52
MCV	*	**107.1**	fl	85 - 105
MCH	*	**36.5**	pg	27 - 32
MCHC		341	g/L	320 - 360
NE#		7.0	x10^9/L	2.0 - 7.5
LY#		3.0	x10^9/L	1.5 - 4.0
MO#		0.6	x10^9/L	0.2 - 0.8
EO#		0.29	x10^9/L	0.0 - 0.4
BA#		0.1	x10^9/L	0.0 - 0.1
Plasma Viscosity				
PV		1.68	mPa.s.	1.5 - 1.72

Report 20/21

Reported	Specialty	Location	Clinician
15 Feb 2017 13:46	Blood Sciences	T13231-ACADEMY MEDICAL CENTRE	Dr Matthew ADAM (GP) (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 06:33

```
CLINICAL DETAILS :
PV repeated: within 30 days
On T4?: Yes
Vague symptoms, eye shocks and headaches, patient thinks
Paroxetine related, ? psychosocial.
```

Sample C175271591 (Fluoride Oxalate) Collected 15 Feb 2017 09:08 Received 15 Feb 2017 12:50

GLUCOSE				
GLUCOSE (preserved tube)	* **8.3**		mmol/L	3.3 - 5.8
C-REACTIVE PROTEIN				
C-REACTIVE PROTEIN	6		mg/L	0 - 10

Patient name: **GAVIN SKRETKOWICZ**
Hospital number: **0408750014**

Creatinine and Electrolytes			
SODIUM	139	mmol/L	133 - 146
POTASSIUM	4.7	mmol/L	3.5 - 5.3
CREATININE	80	umol/L	62 - 106
AKI			
AKI	Not detected: but may not exclude AKI in all cases		
Liver Function Tests (LFT)			
ALT	34	U/L	5 - 55
BILIRUBINS	8	umol/L	0 - 21
ALKALINE PHOSPHATASE	103	U/L	30 - 130
ALBUMIN	38	g/L	35 - 50
Bone Group			
CALCIUM	2.14	mmol/L	2.10 - 2.55
CALCIUM (CORRECTED)	2.16	mmol/L	2.10 - 2.55
ESTIMATED GFR			
ESTIMATED GFR	GT60	mL/min	
CKD Stage			
CKD Stage	IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA .		
TSH			
TSH	2.70	mU/L	0.4 - 4.0

Report 21/21

Reported	**Specialty**	**Location**	**Clinician**
26 Feb 2013 08:10	Microbiology	T10638-CARNOUSTIE MEDICAL GROU - NOT GIVEN (Not Specified)	

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 06:23

CLINICAL DETAILS :
?Urinary Tract Infection.

Sample 13B262136 (Urine - Unspecified) Collected 24 Feb 2013 12:00 Received 25 Feb 2013 12:42

Urine Culture:

No Growth

End of reports

Medication Administration Profile

Type of Report: Since Admission
Requested By: AROBER8
Current Status: Discharged

Patient: **SKRETKOWICZ, GAVIN CHARLES**
Hospital No: 0408750014 National No: 040 875 0014
Date of Birth: 4-Aug-1975
Allergies: ***No known drug allergies***

Weight: kg
Height: cm
Body Surface: sq m

Admitted On: 18-Dec-2025
Discharged On: 19-Dec-2025 Patient Note(s) exist

Sensitivities:

Episode History:

Consultant:	Helen Elder	from	18-Dec-2025	10:55	to	19-Dec-2025	01:25
Consultant:	Iqbal Malik	from	19-Dec-2025	01:26	to	19-Dec-2025	07:47
Consultant:	Paul Newey	from	19-Dec-2025	07:48	to	19-Dec-2025	17:31

Transfer History:

Admitted to Ward:	NWH AMU TRIAGE	on	18-Dec-2025	at	10:55
Transferred to Ward	NWH AMU	on	18-Dec-2025	at	11:44
Transferred to Ward	NWH WARD 4	on	19-Dec-2025	at	01:26

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

DRUG DOSE,ROUTE & FREQUENCY/INTERVAL/RATE *VERIFIER*	18-Dec-2025 Thursday	19-Dec-2025 Friday					
AMITRIPTYLINE 25mg Tablets 50 mg Oral 1X22 Rejin Pradeep-Kumar Start Date/Time 18-Dec-2025 22:00	! 22:51 PMASHE						
ATORVASTATIN 20mg Tablets 20 mg Oral 1X08 Rejin Pradeep-Kumar Start Date/Time 19-Dec-2025 08:00		! 10:53 CORELLA					
LISINOPRIL 5mg Tablets 5 mg Oral 1X08 Rejin Pradeep-Kumar Start Date/Time 19-Dec-2025 08:00		! 10:54 CORELLA					

Medication Administration Profile

Type of Report: Since Admission
Requested By: AROBER8
Current Status: Discharged

Admitted On: 18-Dec-2025
Discharged On: 19-Dec-2025 Patient Note(s) exist

Patient: **SKRETKOWICZ, GAVIN CHARLES**
Hospital No: 0408750014 National No: 040 875 0014
Date of Birth: 4-Aug-1975
Allergies: ***No known drug allergies***

Weight: kg
Height: cm
Body Surface: sq m

Sensitivities:

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

DRUG DOSE,ROUTE & FREQUENCY/INTERVAL/RATE *VERIFIER*	18-Dec-2025 Thursday	19-Dec-2025 Friday					
VENLAFAXINE 150mg Modified-Release Capsules 150 mg Oral 1X08 Rejin Pradeep-Kumar Start Date/Time 19-Dec-2025 08:00		! 10:55 CORELLA					
VENLAFAXINE 75mg Modified-Release Capsules 75 mg Oral 1X08 Rejin Pradeep-Kumar Start Date/Time 19-Dec-2025 08:00		! 10:55 CORELLA					
TOUJEO 300units/mL SoloStar Pen - AS PER PAPER CHART 1 Dose(s) SC Bolus 1X08 Rachel Siow Start Date/Time 19-Dec-2025 08:00		! 10:51 CORELLA					
NOVORAPID 100units/1mL FlexPen - AS PER PAPER CHART 1 Dose(s) SC Bolus 3X08/12/18 Simone Webster (NMP) Start Date/Time 19-Dec-2025 12:00		! 13:15 CORELLA					

Medication Administration Profile

Type of Report: Since Admission
Requested By: AROBER8
Current Status: Discharged

Patient: **SKRETKOWICZ, GAVIN CHARLES**
Hospital No: 0408750014 National No: 040 875 0014
Date of Birth: 4-Aug-1975
Allergies: ***No known drug allergies***

Weight: kg
Height: cm
Body Surface: sq m

Admitted On: 18-Dec-2025
Discharged On: 19-Dec-2025 Patient Note(s) exist

Sensitivities:

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

DRUG DOSE,ROUTE & FREQUENCY/INTERVAL/RATE *VERIFIER*	18-Dec-2025 Thursday	19-Dec-2025 Friday					
TOUJEO 300units/mL SoloStar Pen - AS PER PAPER CHART 1 Dose(s) SC Bolus STAT Rachel Siow Start Date/Time 18-Dec-2025 13:59 Stop Date/Time: 18-Dec-2025 15:29	! 15:28 ABURKE RBANKS1 <MOD> ABURKE						
NOVORAPID 100units/1mL FlexPen - AS PER PAPER CHART 1 Dose(s) SC Bolus STAT Simone Webster (NMP) Start Date/Time 19-Dec-2025 06:46 Stop Date/Time: 19-Dec-2025 06:47		! 06:46 [Other (See HEPMA CORELLA <MOD> CORELLA					
INSULIN (VARIABLE RATE) Infusion - AS PER PAPER CHART 1 Dose IV Con Inf PRN SEE PAPER CHART Rachael Haxton (NMP) Start Date/Time 18-Dec-2025 12:00 Stop Date/Time: 19-Dec-2025 06:44	! 12:00 ABURKE LHARDE ! 21:18 PMASHE EIGHOD	!% 06:44 [Drug discontinued SWEBST <DIS> SWEBST					

Medication Administration Profile

Type of Report: Since Admission
Requested By: AROBER8
Current Status: Discharged

Patient: **SKRETKOWICZ, GAVIN CHARLES**
Hospital No: 0408750014 National No: 040 875 0014
Date of Birth: 4-Aug-1975
Allergies: ***No known drug allergies***

Weight: kg
Height: cm
Body Surface: sq m

Admitted On: 18-Dec-2025
Discharged On: 19-Dec-2025 Patient Note(s) exist

Sensitivities:

Key: ! - denotes unverified order at the time of charting or administration. * - denotes charting was overridden ? - denotes witnessable administration not witnessed. [@@] - denotes patient was/is on Short Term Leave. [+] - Order Notes exist ⅘ - Part Dose (see PAC) <MOD> - Order Modified <DIS> - Order Discontinued <STOPPED> - Order Stopped <RES> - Order Resumed <SUS> - Order Suspended RS - Result <TASK> - Order Suspended (task non-completion) AC - Recommended Action

DRUG DOSE,ROUTE & FREQUENCY/INTERVAL/RATE *VERIFIER*	18-Dec-2025 Thursday	19-Dec-2025 Friday					
PEPTAC PEPPERMINT Oral Sugar Free Suspension 10 mL Oral EH08 PRN FOR INDIGESTION Rachel Siow Start Date/Time 18-Dec-2025 14:02 Modify Reason: Change to PRN							
ONDANSETRON 4mg/2mL Injection 4 mg IV S Bolus EH08 PRN FOR NAUSEA / VOMITING Rachel Siow Start Date/Time 18-Dec-2025 14:22							
ONDANSETRON 4mg/2mL Injection 4 mg IV S Bolus EH06-08H PRN FOR NAUSEA / VOMITINGMAX 3 daily Dominic Lee Start Date/Time 19-Dec-2025 01:38 Stop Date/Time: 19-Dec-2025 01:38		!% 01:38 [Drug discontinued DLEE1 <DIS> DLEE1					

Medication Administration Profile

Patient: **SKRETKOWICZ, GAVIN CHARLES**
Hospital No: 0408750014 National No: 040 875 0014
Date of Birth: 4-Aug-1975
Allergies: ***No known drug allergies***

Weight: kg
Height: cm
Body Surface: sq m

Date of Report: 21-Jul-2026 at 10:21
Type of Report: Since Admission
Requested By: AROBER8
Current Status: Discharged

Admitted On: 18-Dec-2025
Discharged On: 19-Dec-2025 Patient Note(s) exist

Sensitivities:

Patient Notes

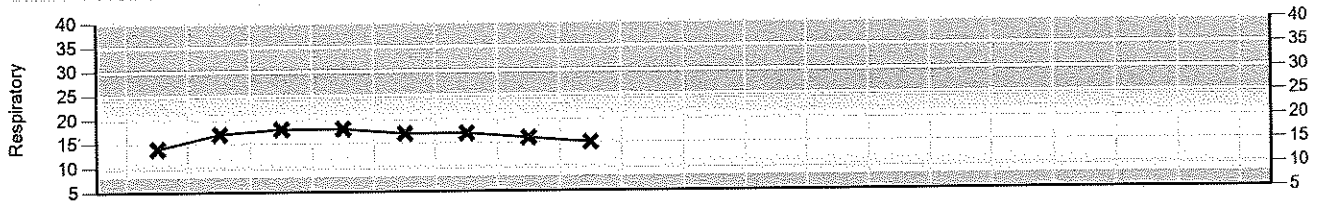
Note to Nurse

Novorapid

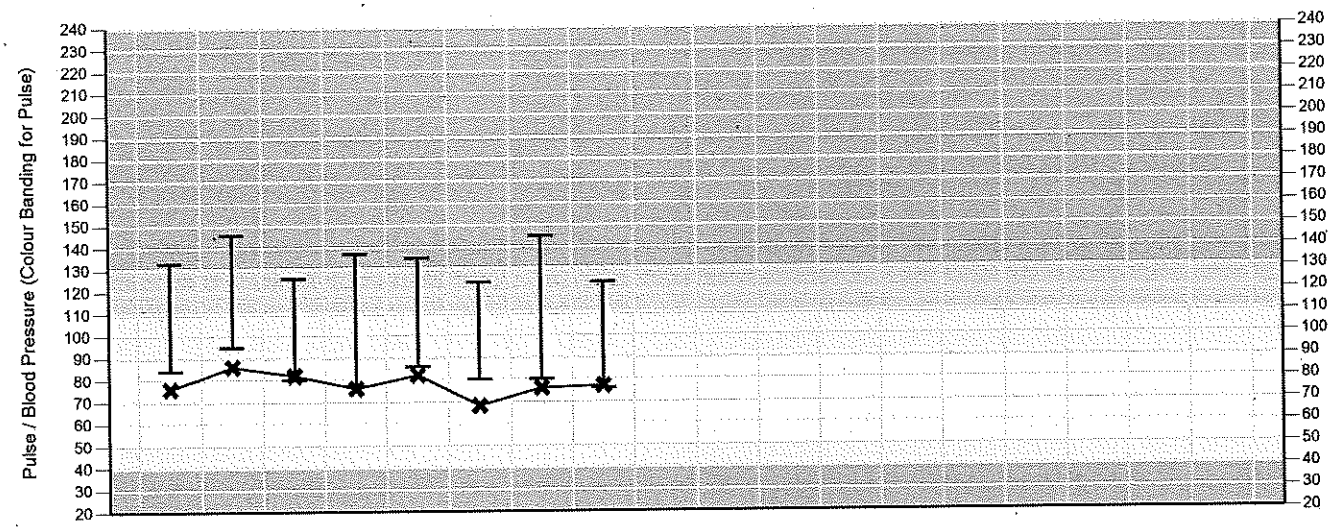
Added by: Celia Garcia-Ferres Orella on 19-Dec-2025 at 11:00

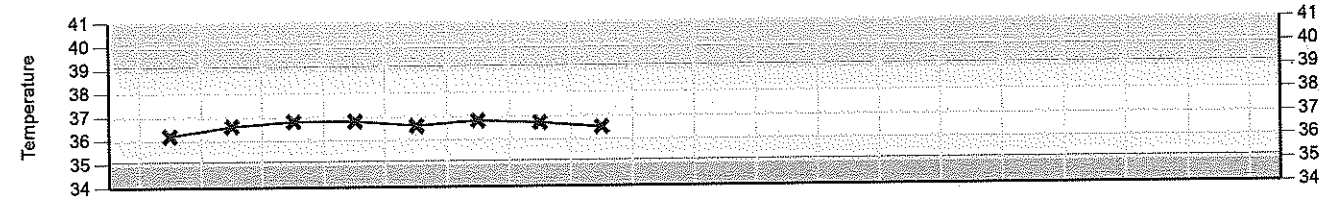
Novorapid stat given by nightshift not charted

Date	18/12	18/12	18/12	19/12	19/12	19/12	19/12	19/12
Time	12:05	14:19	17:53	00:09	01:57	05:34	11:08	15:13
NEWS	0	0	0	0	0	0	0	0



SpO2 Scale	1	1	1	1	1	1	1	1
O2 Sat	96	96	98	96	97	97	98	99
O2 Device	RA	RA	RA	RA	RA	RA	RA	RA
O2 (L/min)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
FRIO2%								





EWS 1 2 3 ◆ SBP Informs EWS ✕ Value Contributes to EWS ♥ Irregular Heart Rate ▲ Value out of range Keys to Codes Overleaf

Ward	AMUE				NW04			
Resp	14	17	18	18	17	17	16	15
SpO2 Scale	1	1	1	1	1	1	1	1
O2 Sat	96	96	98	96	97	97	98	99
O2 Device	RA	RA	RA	RA	RA	RA	RA	RA
O2 (L/min)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
FRIO2%								
Lying SBP	133	146	126	137	135	124	145	124
Lying DBP	84	95	80	77	86	80	80	76
MAP (Lying)	100	112	95	97	102	95	102	92
Standing SBP								
Standing DBP								
Pulse (p/m)	76	86	82	76	82	68	76	77
Cardiac Rhythm								
Consciousness	A	A	A	A	A	A	A	A
Temp	36.2	36.6	36.8	36.8	36.6	36.8	36.7	36.5
Blood Glucose								
Pain Score	0	0	0	0	0	0	0	0
Nausea	0	2	0	0	0	0	0	0
Sedation	0	0	0	0	0	0	0	0
User	AB	VD	AB	PM	NC	NC	CG	CG
Obs type	FULL	FULL	FULL	FULL	FULL	FULL	FULL	FULL
Notes								
NEWS	0	0	0	0	0	0	0	0

Notes

NEWS Regime History

1 **NEWS2 (SpO2 Scale 1)**

Start Date: 18/12/2025 10:55 End Date:

Respiration Rate	<=8 (3)	9-11 (1)	12-20 (0)	21-24 (2)	25+ (3)		
Oxygen Saturations	<=91 (3)	92-93 (2)	94-95 (1)	96+ (0)			
Oxygen Device	Air (0)	Nasal Cannula (2)	Simple Mask (2)	Venturi 24% (2)	Venturi 28% (2)	Venturi 31% (2)	Venturi 35% (2)
Oxygen Device	Venturi 40% (2)	Venturi 60% (2)	Humidified O2 28% (2)	Humidified O2 35% (2)	Humidified O2 40% (2)		
Lying Systolic Blood Pressure	<=90 (3)	91-100 (2)	101-110 (1)	111-219 (0)	220+ (3)		
Heart Rate	<=40 (3)	41-50 (1)	51-90 (0)	91-110 (1)	111-130 (2)	131+ (3)	
ACVPU	Alert (0)	New Confusion (3)	Voice (3)	Pain (3)	Unresponsive (3)		
Temperature	<=35.00 (3)	35.10-36.00 (1)	36.10-38.00 (0)	38.10-39.00 (1)	39.10+ (2)		

Key to Codes

ACVPU NEWS2	
A	Alert
C	New Confusion
V	Voice
P	Pain
U	Unresponsive

Cardiac Rhythm	
SR	Sinus Rhythm
SB	Sinus Bradycardia
ST	Sinus Tachycardia
SA	Sinus Arrhythmia
AF	Atrial Fibrillation
AFLT	Atrial Flutter
SVT	Supraventricular Tachycardia
VT	Ventricular Tachycardia
CHB	Complete Heart Block
1HB	1st Degree Heart Block
21HB	2:1 Heart Block
WENK	Wenkebach
AE	Atrial ectopics
VE	Ventricular ectopics
PR	Paced Rhythm
BIG	Bigeminy
TRIG	Trigeminy

Generic Reasons Measure Not Taken	
ACC	Access Issue
NAS	Nursing Assessment
PDEC	Patient Declined
PDIS	Patient Distressed
PROC	Procedure/protocol based

Pain Score	
0	0 = No Pain
1	1 = Mild Pain
2	2 = Moderate Pain
3	3 = Severe Pain

Nausea	
0	No nausea and vomiting
1	Nausea only
2	Vomiting once
3	Vomiting more than once

O2 Device List NEWS2	
RA	Air
NC	Nasal Cannula
FM	Simple Mask
V24	Venturi 24%
V28	Venturi 28%
V31	Venturi 31%
V35	Venturi 35%
V40	Venturi 40%
V60	Venturi 60%
H28	Humidified O2 28%
H35	Humidified O2 35%
H40	Humidified O2 40%
H60	Humidified O2 60%
NRM	Reservoir Mask
TM	Tracheostomy Mask
CPAP	CPAP
NIV	NIV
HHHF	Hi-Flow
AVO	Airvo
OTH	Other

Reason for Observations not taken	
PA	Patient Absent
PR	Patient Refused
PC	Parent/Carer refused
PD	Patient Distressed

Sedation Score	
0	None (patient alert)
1	Mild (occasionally drowsy, easy to rouse)
S	Moderate (frequently drowsy, Sleeping and rousable)
U	Unrousable

ID:	**CHI: 0408750014**	
Patient Name:	**Skretkowicz, Gavin Charles**	
Admitted:	**18 December 2025**	
DOB:	**04 August 1975**	**50y**
Gender:	**Male**	

NHS Tayside

Daily Pressure Ulcer Risk Assessment (D-PURA)

Recorded Date	Assessment Record By
18/12/25 12:06	aburke3

SKIN intact and no evidence of redness and/or existing pressure damage	Yes
Can the person mobilise independently	Yes
Is the person continent? (Incontinence can impair skin integrity)	Yes
Appears well nourished, able to eat and drink?	Yes
Is the skin free from purple discolouration/deep tissue damage? (Dry skin impairs skin integrity)	Yes
Is the person free from special risks or additional factors that would affect the persons risk of pressure damage e.g. diabetes, major surgery, neurological or cognitive impairment, PVD?	Yes
Has the patient or family member received a copy of the pressure ulcer prevention leaflet	No

State Reason
None available

If answer to at least one statement is NO, but you feel within your clinical judgement, that the patient is NOT at risk record the reasons for not commencing SSKIN bundle?	False
Buttocks (Left)	**False**
Buttocks (Right)	**False**
Elbow (Left)	**False**
Elbow (Right)	**False**
Ear (Left)	**False**
Ear (Right)	**False**
Sacrum (Bottom)	**False**
Hip (Left)	**False**

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NHS Tayside

Hip Right	False
Spine	False
Shoulder Left	False
Shoulder Right	False
Heel Left	False
Heel Right	False
Occipital Area	False
Toes Left	False
Toes Right	False
Other	

End of Report

Hospital Number:	CHI: 0408750014
Patient Name:	Skretkowicz, Gavin Charles
Admitted:	18 December 2025
DOB:	04 August 1975 50y
Gender:	Male

NHS Tayside

Falls Assessment

Recorded Date/Time	**18/12/2025 12:06**
Recorded By	**aburke3**
Patient age	Under 65
Does the patient have any of the following risks?	
Does the patient have any of the following risks?	
Falls_Risks_sub	None of the above
Other falls risk information	
Falls history. Fear of falling	
How many falls in the last year?	
Was fall associated with symptoms, such as light headedness, dizziness, Loss of consciousness?	
Patient/ carer identify any fears about falls?	
Concerns:	
Age-increased risk (65+ years). Assess injury risk.	
Is the patient prescribed anti- coagulant or blood thinning medication (warfarin, clopidogrel, Direct Oral Anticoagulant(DOAC))?	
Additional information	
Does the patient have a history of fracture aged 50+ or known osteoporosis?	
List of medications. Lying and standing BP	
Is the patient prescribed 4 or more medications?	
Additional information on prescribed medication	
Has pharmacy falls risk medication been reviewed and documented?	
Why not?	
Is the patient prescribed new night sedation?	
Lying and standing BP and manual pulse checked?	
Reason BP and manual pulse not taken?	
Location (bed/toilet)	

NHS Tayside

Falls Assessment

Patient orientated to bed area. Toilet and ward environment?	
Reason why not?	
Strength, mobility and balance. Senses (ears and eyes)	
Is the patient able to mobilise independently?	
Additional information regarding mobility	
Patient mobility status	
Information on number of staff required to mobilise, aids used, equipment required, etc	
Has the patient any sensory risk?	
Details	
Does the patient have/use?	
ABC.... Falls medical assessment. Assess mental state.	
Has the patient evidence of any of the following:	
Additional information /evidence	
Has the 4AT been performed?	
4AT score	
Please give reason for not entering 4AT score	
Footwear and foot care	
Is the patient's footwear well-fitting and does it have a good grip on the sole?	
Are there any concerns with the patient's feet and/or lower limbs that may affect mobility? e.g. peripheral neuropathy to the feet	
Additional information for footwear and foot care	
Environment.	
Environment checked to maintain patient safety?	
Inpatient Falls information leaflet given to	
Falls_leaflet_sub	
Reason why not given	
Risk reduction strategies	
Strategies in use:	
Any additional information?	

NHS Tayside

Falls Assessment

Acknowledgement	
I acknowledge that I will implement all identified strategies including bed safety rail safe decision	True

Hospital Number:	CHI: 0408750014
Patient Name:	Skretkowicz, Gavin Charles
Admitted:	18 December 2025
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Gender:	Male

NHS Tayside

Nutrition Profile

Recorded Date/Time	18/12/2025 12:07
Recorded By	aburke3
Likes	
Dislikes	
Special Dietary Requirements?	No
Religious, Ethnic or Cultural	No
Details	
Cultural requirements	
Other dietary requirement details	
Food allergy / Intolerance	
Details	
Texture Modified	
Thickened Liquids	
Known renal patient – CKD eGFR <30	
Patient on dialysis	
Fluid restriction	
Dietary requirements - notes and comments	
Are ther any contributing factors that may affect food intake?	No
Physical e.g Swallowing/oral problems/sore mouth/dementia	No
Details (Physical)	
Physiological e.g. Nausea/constipation problems/pain	No
Details (Physiological)	
Psychological e.g. low mood	No
Details (Psychological)	
Social carer support/input	No
Details (Social)	
Environmental	False
Details e.g. Cooking facilities/ability to prepare food/personal preferences:	No
Is the Patient taking Oral Nutritional supplements?	No
Current Oral Nutritional Supplement	

Hospital Number:	CHI: 0408750014	
Patient Name:	Skretkowicz, Gavin Charles	
Admitted:	18 December 2025	
DOB:	04 August 1975	50y
Gender:	Male	

NHS Tayside

Nutrition Profile

Route of Nutritional Intake	Oral– Eating and Drinking
Oral Health Assessment completed?	NA
Was swallow Screening Test undertaken?	NA
Patient referred to Speech and Language Therapy?	NA
'Your food and drink in Hospital' given on admission?	NA
Can patient make menu choices independently?	Yes
Complete 'Getting to Know Me'	
Is there a need for equipment and/or assistance with eating and drinking?	No
Equipment	
Other equipment	
Ward	Acute Medical Unit - NW

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NHS Tayside

MUST Assessment

Recorded	Current Weight	Previous Weight 3- 6 months ago	Weight change (%)	Weight loss planned?	Height (cm)	BMI	No nutritional intake > 5 days	Total score	Risk category
18/12/25 12:07 by aburke3	**Not possible to calculate BMI for this patient using weight and height.**								
	Reason: acute admission								
	Overweight / acceptable weight. No recent weight loss reported. Clothes / jewellery fit well								
	None of the above								

ID:	CHI: 0408750014
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Gender:	Male

NHS Tayside

MUST Assessment

Hospital Number: CHI: 0408750014
Patient Name: Skretkowicz, Gavin Charles
Admitted: 18/12/2025 10:55
DOB: 04 - Aug - 1975
Gender: Male

NHS Tayside

Patient IV Lines

Type	Inserted By	Site	Inserted	Present on Adm.	Cannula Colour	Attempts	Reason for Insertion			
Peripheral Cannula	Unknown	Left anti-cubital fossa	18/12/2025 12:07	Yes inserted in Triage	Green (18)		medication(IV/SC)			
	Hand Hygiene	**Gloves**	**Skin Prep**	**ANTT**	**Needle-free connector**		**Dressing**	**Sharps Disposal**	**Comment**	
	n/a	n/a	n/a	n/a	n/a		n/a	n/a		

REVIEWS

Recorded	Recorded By	Site Inspected	VIP Score	Hand hygiene	Cont Clinical Indication	Dressing Clean /Dry Intact	Admin set Attached	Dressing Change	Needle free device cleaned	Lumen Flushed
19/12/2025 05:35	ncykiermoss eddaq	✓	[redacted]	✓	✓	✓	✓	✗	✓	✓