Subject Access Request Team
Health Records Department
Gartnavel General Hospital
1053 Great Western Road
Glasgow
G12 0YN

NHS
Greater Glasgow and Clyde

MMA Legal,
Stok,
43-59 Princes Street,
Stockport,
SK1 1RY

Date: 22nd May 2026
Your Ref: 100100
Our Ref: SAR/ACCESS/ ZK
Enquiries to: Zaneta
Direct Line: 0141 211 1644
Email: zaneta.kolodiejczyk@nhs.scot

Dear Sir/Madam

Re: Subject Access Request under the General Data Protection Regulation

Patient: SCOTT HUGHES **D.O.B: 20/12/1974**

Thank you for your request received 5th May 2026 in which you seek a copy of your client's personal information.

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

Queen Elizabeth University Hospital, Gartnavel General Hospital, West Ambulatory Care Hospital, Western Infirmary Hospital

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

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

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

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

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

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

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

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

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

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

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

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

Yours sincerely

Subject Access Request Team

ELECTRONIC PATIENT RECORDS

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

Including:

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

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 27/3/17

Attach
2012746039
HUGHES
Scott, S
12 Shafton Road
Glasgow
G13 2NE
M
20/12/1974
Ward:

NHS Greater Glasgow and Clyde

I have evaulated and deemed that the frequency of care delivery over the next work shift, based on the patients' most critical need should be every (please circle) 1hr 2hr 3hr 4hr (6hr)

1. Signed. [signature] Name: [illegible] Designation ...SN.....
2. Signed..... Name: ..... Designation .....
3. Signed..... Name: ..... Designation .....

Individual patient needs: Red mat required: Y (N) Bed Rails: Y / (N)
'Must do's' for me. Ask the patient if there is anything they want specifically done today:

.....

USE FOLLOWING CODE:

O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

			Times	01 00	05 20	09 30																
	1	**Pain: assess and address** If in pain inform registered nurse Y / N or N/A		NA	NA	N																
S	2	**SKIN INSPECTION** Pressure areas checked: Y / N or I (Independent)		I	I	Ind																
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)		INT	INT	INT																
K	3	**KEEP MOVING:** Have you moved or walked Y / N or I (Independent)		I	I	Ind																
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		/	/	B																
		Chiar Assist to walk, stand or tilt (W /ST/ T)		/	/	W																
I	4	**ELIMINATION:** Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine or faeces		I	I	Ind																
N	5	**FOOD, FLUIDS AND NUTRITION:** Is the patient nil by mouth? Y / N (consider mouth care)		N	N	N																
		Encourage the patient to drink? Y / N / N/A		S	S	Y																
		Food, snack or supplement taken Y / N / N/A		S	S	Y																
	6	**ENVIRONMENT: Check:** Is the patients' call buzzer to hand? Is the area clutter free, clean and safe? Doe's the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S		Y	Y	Y																
	7	**INFORMATION: Ask:** Is there anything else I can help you with? Inform patient of the time of return Y/N/O/S		S	S	NT																
	8	**ESCALATION:** Escalate any issues to the Registered Nurse Y / N/A		N/A	N/A	N/A																
		Nurse Initials		[illegible]	[illegible]	SN																

Attach Addressograph Label Ward:

NHS
Greater Glasgow and Clyde

Specialist Pressure Redistributing equipment ordered and in place:

Dynamic Mattress:	
Cushion:	
Orthotic footwear:	
Moving & Handling aids:	
Other:	

Active Care variant sheet – Care Number

1. Pain
2. A/B Skin Inspection
3. A/B/C Keep Moving
4. Elimination
5. Food, Fluid, Nutrition
6. Environment
7. Information
8. Escalation

Date	Time	Number	Variation	Signed

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 26/3/17

Attach Addres 2012746039
HUGHES M
Scott, S 20/12/1974
12 Shafton Road
Glasgow
G13 2NE

Ward: 110

NHS Greater Glasgow and Clyde

I have evaulated and deemed that the frequency of care delivery over the next work shift, based on the patients' most critical need should be every (please circle) 1hr 2hr 3hr 4hr (6hr)

1. Signed ... Name: A. Abraham Designation S/N CN
2. Signed ... Name: ROSE Designation ...
3. Signed ... Name: ... Designation ...

Individual patient needs: Red mat required: Y / (N) Bed Rails: Y / (N)
'Must do's' for me. Ask the patient if there is anything they want specifically done today:

...

USE FOLLOWING CODE:

O = Off the ward **V = Variant** **S = Sleeping** **I = Independent** **NT = No Thanks**

			Times	03 30	09 13	12 50	18 40	19 41	22 8													
	1	**Pain: assess and address** If in pain inform registered nurse **Y / N or N/A**		N	N	P	N	NA	NA													
S	2	**SKIN INSPECTION** Pressure areas checked: **Y / N or I** (Independent)		S	Ind	P	I	I	T													
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)		S	NA	O	N	INT	N													
K	3	**KEEP MOVING:** Have you moved or walked **Y / N or I** (Independent)		INT	Ind	O	I	I	I													
		Bed Right side (30° tilt) – **R** Left side (30° tilt) – **L** Back – **B**		R	/	O	W	/	L													
		Chiar Assist to walk, stand or tilt (**W /ST/ T**)		/	W	O	CH	/	/													
I	4	**ELIMINATION:** Do you need the toilet? **I** = Independent **A** = Assistance given **IC** = patient incontinent of urine or faeces		INT	Ind	O	I	I	I													
N	5	**FOOD, FLUIDS AND NUTRITION:** Is the patient nil by mouth? **Y / N** (consider mouth care)		N	N	O	N	N	N													
		Encourage the patient to drink? **Y / N / N/A**		S	Y	O	Y	Y	Y													
		Food, snack or supplement taken **Y / N / N/A**		S	Y	O	Y	Y	Y													
	6	**ENVIRONMENT: Check:** Is the patients' call buzzer to hand? Is the area clutter free, clean and safe? Doe's the patient have everything they require in safe reach? Is the bed in lowest position? **Y/N/O/S**		Y	Y	O	Y	Y	Y													
	7	**INFORMATION: Ask:** Is there anything else I can help you with? Inform patient of the time of return **Y/N/O/S**		NA	NT	O	N	Y	N													
	8	**ESCALATION:** Escalate any issues to the Registered Nurse **Y / N/A**		NA	NA	O	/	NT	NA													
			Nurse Initials	JD	SM	MR	JK	NM	AA													

Attach Addressograph Label Ward:

NHS
Greater Glasgow and Clyde

Specialist Pressure Redistributing equipment ordered and in place:

Dynamic Mattress:	
Cushion:	
Orthotic footwear:	
Moving & Handling aids:	
Other:	

Active Care variant sheet – Care Number

1. Pain
2. A/B Skin Inspection
3. A/B/C Keep Moving
4. Elimination
5. Food, Fluid, Nutrition
6. Environment
7. Information
8. Escalation

Date	Time	Number	Variation	Signed

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 26/3/A

Attach Add...

2012746039
HUGHES M
Scott, S 20/12/1974
12 Shafton Road
Glasgow
G13 2NE

Ward: 10

NHS Greater Glasgow and Clyde

I have evaulated and deemed that the frequency of care delivery over the next work shift, based on the patients' most critical need should be every (please circle) 1hr 2hr 3hr 4hr 6hr

1. Signed ..... Name: B. Mowbray Designation S.N

2. Signed ..... Name: ..... Designation .....

3. Signed ..... Name: ..... Designation .....

Individual patient needs: Red mat required: Y / N Bed Rails: Y / N
'Must do's' for me. Ask the patient if there is anything they want specifically done today:

.....

USE FOLLOWING CODE:

O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

			Times	06	10 30	15 30	21 30																
	1	**Pain: assess and address** If in pain inform registered nurse Y / N or N/A		N	N	N	O																
S	2	**SKIN INSPECTION** Pressure areas checked: Y / N or I (Independent)		I	Ind	Ind	O																
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)		/	NA	NA	O																
K	3	**KEEP MOVING:** Have you moved or walked Y / N or I (Independent)		I	Ind	X Ind	O																
		Bed Right side (30° tilt) – **R** Left side (30° tilt) – **L** Back – **B**		B	R	B	O																
		Chiar Assist to walk, stand or tilt (W /ST/ T)		/	NA	-	O																
I	4	**ELIMINATION:** Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine or faeces		I	Ind	Ind	O																
N	5	**FOOD, FLUIDS AND NUTRITION:** Is the patient nil by mouth? Y / N (consider mouth care)		N	N	N	O																
		Encourage the patient to drink? Y / N / N/A		Y	Y	Y	O																
		Food, snack or supplement taken Y / N / N/A		Y	Y	Y	O																
	6	**ENVIRONMENT: Check:** Is the patients' call buzzer to hand? Is the area clutter free, clean and safe? Doe's the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S		Y	Y	Y	O																
	7	**INFORMATION: Ask:** Is there anything else I can help you with? Inform patient of the time of return Y/N/O/S		N	NT	NT	O																
	8	**ESCALATION:** Escalate any issues to the Registered Nurse Y / N/A		N	NA	NA	O																
			Nurse Initials		BM	BM																	

Attach Addressograph Label Ward:

NHS
Greater Glasgow and Clyde

Specialist Pressure Redistributing equipment ordered and in place:

Dynamic Mattress:	
Cushion:	
Orthotic footwear:	
Moving & Handling aids:	
Other:	

Active Care variant sheet – Care Number

1. Pain
2. A/B Skin Inspection
3. A/B/C Keep Moving
4. Elimination
5. Food, Fluid, Nutrition
6. Environment
7. Information
8. Escalation

Date	Time	Number	Variation	Signed

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 24/3/17

Attach Ad

2012746039
HUGHES
Scott, S
12 Shafton Road
Glasgow
G13 2NE
M
20/12/1974

Ward: HD

NHS Greater Glasgow and Clyde

I have evaulated and deemed that the frequency of care delivery over the next work shift, based on the patients' most critical need should be every (please circle) 1hr 2hr 3hr 4hr (6hr)

1. Signed ..... Name: ..... Designation S/N
2. Signed ..... Name: ..... Designation .....
3. Signed ..... Name: ..... Designation .....

Individual patient needs: Red mat required: Y / N Bed Rails: Y / N
'Must do's' for me. Ask the patient if there is anything they want specifically done today:

.....

USE FOLLOWING CODE:

O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

			Times	02 30	10 40	14 40	21 40																
	1	**Pain: assess and address** If in pain inform registered nurse Y / N or N/A		N	N	N	N																
S	2	**SKIN INSPECTION** Pressure areas checked: Y / N or I (Independent)		I	I	I	I																
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)			I	I	I																
K	3	**KEEP MOVING:** Have you moved or walked Y / N or I (Independent)		I	I	I	I																
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B			-	-	B																
		Chiar Assist to walk, stand or tilt (W /ST/ T)			-	-	NA																
I	4	**ELIMINATION:** Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine or faeces		I	I	I	I																
N	5	**FOOD, FLUIDS AND NUTRITION:** Is the patient nil by mouth? Y / N (consider mouth care)		N	N	N	N																
		Encourage the patient to drink? Y / N / N/A		Y	Y	Y	Y																
		Food, snack or supplement taken Y / N / N/A		N	Y	Y	Y																
	6	**ENVIRONMENT: Check:** Is the patients' call buzzer to hand? Is the area clutter free, clean and safe? Doe's the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S		Y	Y	Y	Y																
	7	**INFORMATION: Ask:** Is there anything else I can help you with? Inform patient of the time of return Y/N/O/S		N	IT	IT	OT																
	8	**ESCALATION:** Escalate any issues to the Registered Nurse Y / N/A		NA	NA	NA	NA																
			Nurse Initials	NP	KC	K	NC																

Attach Addressograph Label Ward:

NHS
Greater Glasgow and Clyde

Specialist Pressure Redistributing equipment ordered and in place:

Dynamic Mattress:	
Cushion:	
Orthotic footwear:	
Moving & Handling aids:	
Other:	

Active Care variant sheet – Care Number

1. Pain
2. A/B Skin Inspection
3. A/B/C Keep Moving
4. Elimination
5. Food, Fluid, Nutrition
6. Environment
7. Information
8. Escalation

Date	Time	Number	Variation	Signed

Acute Services Division

Hospital / Department QEUH - IMU

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

[redacted]039
HUGHES M
Scott, S 20/12/1974
12 Shafton Road
Glasgow
G13 2NE
Unit/Hospital number

Contents

1. Cannard Falls Risk Assessment Scoring Form
2. Falls Assessment Care Plan
3. Glossary of terms used in risk assessment

Notes: Risk assessment should be completed within 24 hours of admission to each ward.

Acute Wards: Risk assessment and care plan should be reviewed weekly.

Continuing Care Wards: Risk assessment and care plan reviewed monthly.

Referral Criteria for Hospital Falls Prevention Co-ordinator

1. Cannard score of 18+.
2. Second or subsequent fall.
3. Significant Injury caused by a fall. (Significant Injury defined as any fracture, significant bruising or laceration to head or body.)

The patient should be referred with any of the above criteria.

General Safety Precautions

- Ensure patient has buzzer to hand
- Check patient has the manual dexterity and cognitive ability to operate buzzer
- Place personal items within easy reach
- Keep the bed in lowest position possible (use low bed if available)
- DO NOT leave patients with cognitive impairment unattended on commodes, in toilets, baths and showers.
- Patients with poor mobility, who are known not to ask for assistance, should not be left unattended on commodes, toilets, baths and showers.
- If noted that mobility / transfers are unsafe refer to physio / OT for assessment
- If patient wears glasses, ensure they are clean
- Ensure patient's footwear is adequate
- Lock wheels on all wheelchairs, beds, commodes and trolleys when in use
- Provide adequate lighting at night
- Request medication review if appropriate
- Clean up spills immediately
- Orientate patient to the ward environment

Cannard Falls Risk Assessment

(Must be completed within 24 hours of admission to each ward)

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						Date: 24/5/17 Ward:	Date: 24/5/17 Ward: 110	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			0	0					
Sex	Male 1	Female 2				1	1					
Age	13-59 0	60-70 1	71-80 2	81+ 1		0	0					
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0		0	0					
Medication type **	Medication for mental illness & drug / alcohol withdrawal 1	Blood pressure / water tablets 1	Sedatives / Analgesia / Night sedation 1	None of these 0		1	1					
Medical history	Cardiovascular Disease / Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	0	0					
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed / chairbound / wheelchair 1		0	0					
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		0	0					
				TOTAL SCORE		2	2					
				ACTION(S) TAKEN Enter action code(s) from Care Plan below		M	AS BELOW					
SCORE 13+ = HIGH RISK If patient unconscious score as N/A until patient status improves.				NURSE SIGNATURE			NM					

Please see back page for glossary of terms relating to the assessment above.

Falls Assessment Care Plan

Please tick all applicable nursing interventions

	NURSING INTERVENTIONS	Date: Ward:	Date: 24/3/17 Ward: I.D	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:
Action code								
1	Falls prevention and general safety precautions discussed with patient and family.		✓					
2	Move to more observable area of ward to optimise supervision.							
3	Advise patient they may experience dizziness when they mobilise initially.							
4	Requires assistance with mobilisation.							
5	Observe trip hazard due to invasive lines, drains and catheters.							
6	Do not leave the patient unattended when using commode, toilet, in shower or the bathroom area.							
7	If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.							
8	Monitor lying and standing / sitting BP and pulse.							
9	A. Patient requires footwear or podiatry referral. (Date referred: / requested :) B. Request family / carer to provide suitable footwear.							
10	Commence continence assessment, follow Local Guidelines.							
11	Refer to Occupational Therapist.							
12	Select suitable seating (refer to policy).							
13	Non slip mat on chair /floor following advice from therapists.							
14	Refer to Physiotherapist.							
15	Review Transfer techniques.							
16	Request medication review.							
17	Bed/chair monitor in use.							
18	Falls map in use for seven days for patient who has second or subsequent falls.							
19	Bed rails/bumpers to be used (refer to policy).							
20	Patient requires low bed / mattress on the floor (refer to policy.)							
21	Patient requires one to one nursing care.							
22	Refer to Hospital Falls Prevention Co-ordinator (see criteria on front cover).							
23	Other interventions. BUZZER TO HAND		✓					

Review Cannard score weekly / monthly as per policy. Enter action code(s) selected in action taken section on Falls Risk Assessment page above.

Cannard Falls Risk Assessment

Glossary of terms used in risk assessment

SIGHT DEFICIT means patient cannot see well even when wearing glasses or is registered blind.

HEARING DEFICIT means person has hearing problems even with a hearing aid or has hearing problems and does not wear a hearing aid.

BALANCE DEFICIT means person is unable to stand without the support of another person or a walking frame.

MEDICINES FOR SOME MENTAL ILLNESSES include Chlorpromazine (Largactil), Risperidone (Risperdal), Lithium (Camcolit or Priadel), Haloperidol, Chloral hydrate (Welldorm), Clomethiazole (Heminevrin), antidepressants, Diazepam, Lorazepam and Amitriptyline.

CARDIOVASCULAR SYSTEM MEDICATION all antihypertensive medication and inotropes including Captopril, atenolol and many others.

WATER TABLETS (DIURETICS) are such as Bendroflumethiazide, Furosemide and Co-amilofruse.

SEDATIVES / ANALGESIA AT NIGHT include medicines such as Diazepam, Temazepam, Nitrazepam, Chlordiazepoxide and Zopiclone (Zimovane) Morphine PCA, Fentanyl, Tramadol and Oxycontin.

INABILITY TO CO-OPERATE includes failure to use walking aids or putting themselves in situations with a high risk of falling (usually due to mental impairment).

RESTRICTED MOBILITY means the person requires supervision and/or help to walk (i.e. is not safe to walk alone even with an aid).

HESITANT IN INITIATING MOVEMENT means difficulty in starting to walk.

POOR TRANSFER means the person requires help and is not safe to do the following alone - get in or out of bed, on or off a chair, move from chair to standing.

2012746039
HUGHES M
Scott, S 20/12/1974
12 Shafton Road
Glasgow
G13 2NE

Care Plan

NHS
Greater Glasgow and Clyde

Care discussed with patient Unable	☐ Yes	☐ No	☐
Care discussed with family Unable	☐ Yes	☐ No	☐

If unable, give reason:

If unable, give reason:

Date commenced & signature	1. Breathing and circulation	Date discontinued & signature
	as read	
24/3 n		
24/3/17 RM	2, 3. Communication and senses	
	Spoke English	
	4. Cognitive status	
24/3/17 RM	alert + oriented.	

Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
24/3 n		
	5. Hydration and Nutrition	
	(1)	
26/3/17 RM	Fluids + diet	
	6. Elimination	
	(1)	
28/3/17 RM	Mobile to toilet	

Patient Label

Care Plan

NHS Greater Glasgow and Clyde

Date Commenced and Signature	7. Personal Hygiene, oral care, skin care and wound care	Date Discontinued and Signature	Date Commenced and Signature	9. Maintaining a safe environment, Technical Care	Date Discontinued and Signature
	(I)		24/3/17	None cell sputum implant.	
20/3/17 RN	Independent c ADLs				
24/3 RN					
				10. Sleep and Rest	
			24/3/17 RGN	promote sleep	
	8. Mobility				
24/3/17 RGN	(I) Fully mobile			12. Privacy, dignity and sexuality	
			24/3/17 RGN	promote	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	
			R/v 25/3/17 RGN 26/3 R/v RGN		

mi • 285668 Version 1_0 • GCC0127

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

Patient's name: HUGHES Scott, S	Ward: 110
Unit number: 2012746039	Discharge destination: home address
CHI number: 12 Shafton Road Glasgow G13 2NE M 20/12/1974	Estimated Discharge Date (1) 27/3/17
	Estimated Discharge Date (2) / /
	Final date of discharge : / /

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

Time of Discharge:	17.00		
Nurse's signature:		Designation: S/N	Date: 27/3/17

NHS Greater Glasgow and Clyde

Glasgow Assessment and Management of Alcohol

NHS Greater Glasgow and Clyde

Please Attach Patient Label

2012746039
HUGHES
Scott, S
12 Shafton Road
Glasgow
G13 2NE

M
20/12/197
ob:

Postcode:

Alcohol By Volume (ABV%)	Average Units (ABV% x Vol)
Strong Lager 9% (440mls)	4.0 Units
Beer/ Lager 4.5% (Pint/500mls Can/Bottle)	2.2 Units
Wine (e.g.Buckfast) 15% (750mls)	11.0 Units
Wine (Table) 12% (750mls)	9.0 Units
Wine (Table) 12% (175ml glass)	2.1 Units
Alcopops 5% (330mls)	1.5 Units
Spirits 40% (25ml measure)	1.0 Unit
Spirits 40% (¼ bottle 175mls)	7.0 Units
Spirits 40% (Litre)	40.0 Units
Spirits 40% (700mls)	30.0 Units
Cider 4% (Litre)	4.0 Units
Cider 4% (440mls)	1.8 Units
Strong White Cider 8% (Litre)	8.0 Units
Strong White Cider 8% (300ml glass)	2.4 Units

Number of Units = ABV (%) x Volume (litres)

eg A bottle of wine (750mls) which is 12% ABV = 12 x 0.75 = 9 Units
A glass of wine (200mls) which is 12% ABV = 12 x 0.2 = 2.4 Units

Estimated Weekly Alcohol Units :
(Daily Units x Number of Days per Week)

Excessive Weekly Consumption
(♂: >21 units/week; ♀: >14 units/week)

Estimated Date / Time Of Last Drink Thurs ian 24/3/17 (If ≥ 5 Days, Re-consider Alcohol Withdrawal Status)

Presents With (or has Previous History of) Alcohol Related Seizures — Yes ☐ No ☑

Presents With (or has Previous History of) Severe Alcohol Withdrawal — Yes ☐ No ☑

Fast Alcohol Screening Tool - FAST:

Note : 1 drink = 1 unit of alcohol (refer to table above)

1. MEN: How often do you have EIGHT or more drinks on one occasion?
   WOMEN: How often do you have SIX or more drinks on one occasion?

   Never ☐0 Less than monthly ☐1 Monthly ☐2 Weekly ☐3 Daily or almost daily ☑4

2. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

   Never ☐0 Less than monthly ☐1 Monthly ☑2 Weekly ☐3 Daily or almost daily ☐4

3. How often during the last year have you failed to do what was normally expected of you because of drinking?

   Never ☑0 Less than monthly ☐1 Monthly ☐2 Weekly ☐3 Daily or almost daily ☐4

4. In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

   No ☐0 Yes, on one occasion ☐2 Yes, on more than one occasion ☑4

Score of 3 or more: FAST Positive

Total: 10

FAST Positive? Yes ☐ No ☐

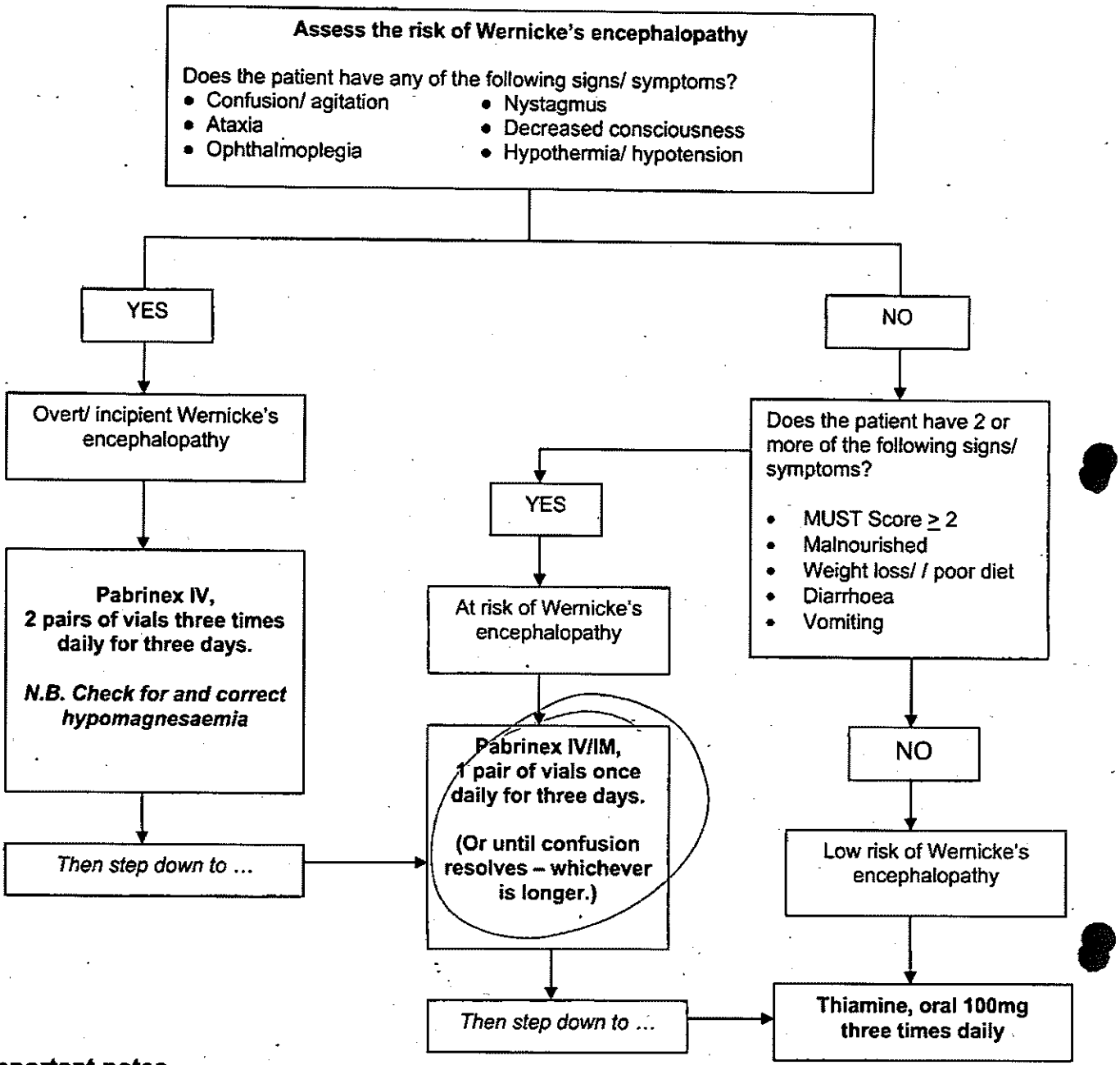
FAST 0-2:	Negative: No action required.
FAST 3-8:	Hazardous Drinking: Advise regarding safe drinking levels and offer information leaflet / advice.
FAST 9-16:	Probable Dependent Drinking: Advice as above and consider referral to Addiction Liaison Service.

PLEASE INSERT IN PATIENT'S CASE RECORD ON COMPLETION OF TREATMENT

STY5332N

Vitamin Prophylaxis and Treatment of Wernicke-Korsakoff Encephalopathy

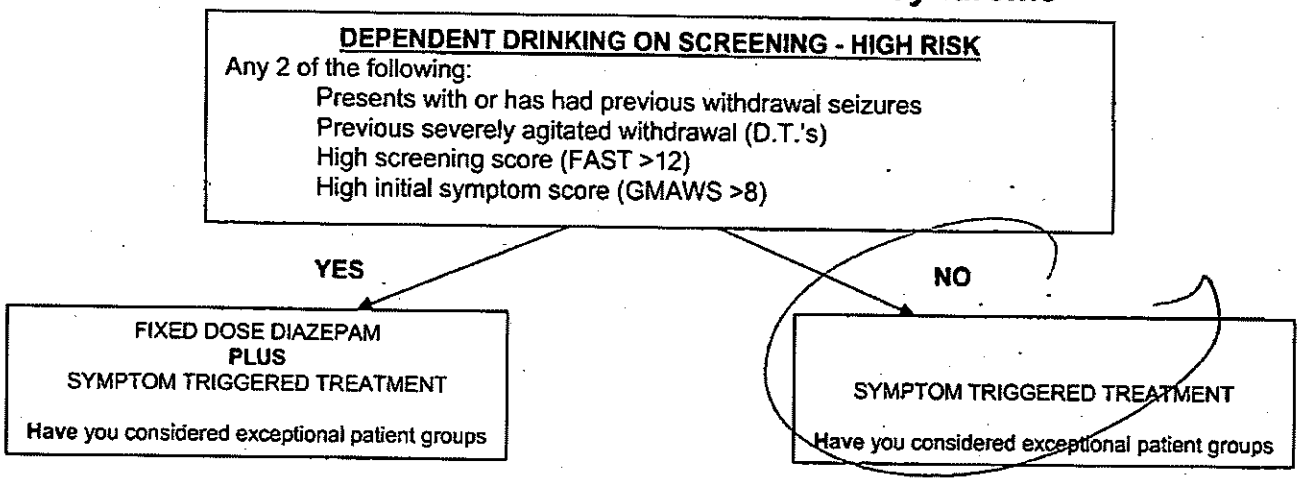
The guidance applies to patients who are chronic alcohol abusers. This includes those who are dependent on alcohol but also those who have a hazardous/ harmful alcohol intake.



Important notes

- Patients with overt/ incipient Wernicke's encephalopathy or 'at risk' of Wernicke's encephalopathy **must** be given Pabrinex® **before** the administration of glucose or nutritional support.
- Intravenous Parbinex® should be administered over 30 minutes
- Anaphylaxis is a rare complication of IV Pabrinex® administration and even more uncommon with IM administration. Monitor patient for wheeze, tachycardia, breathlessness and skin rash. Facilities for the administration of adrenaline and other resuscitation should be available
- Further vitamin supplementation as clinically indicated by responsible medical team in the context of a general nutritional assessment

Management of Alcohol Withdrawal Syndrome



BASELINE TREATMENT REGIME

Fixed Dose oral Diazepam: (for patients unable to tolerate diazepam via the oral route, see below).

Initial 24 hours: **20mg Diazepam 6 hourly**

If no additional symptom triggered treatment, then REDUCE as follows:

15mg Diazepam 6 hourly for 24 hours
10mg Diazepam 6 hourly for 24 hours
5mg Diazepam 6 hourly for 24 hours
5mg Diazepam 12 hourly for 24 hours

Diazepam prescription to be reviewed if patient excessively drowsy.
Maximum of 120mg Diazepam in 24 hours, before requesting senior medical review.
(*Diazepam 120mg not expected to be problematic over 24hrs in uncomplicated patients).

EXCEPTIONAL PATIENT GROUPS:

- Elderly patients
- Head injury
- Patients with evidence of liver disease: especially jaundice, encephalopathy
- Patients with other significant co-morbidity (i.e. COPD, pneumonia, cerebrovascular disease, reduced GCS)

Consider the use of oral Lorazepam in these exceptional patient groups in a symptom triggered fashion: 1-2 mg (to a maximum of 12mg in 24 hours before requesting senior medical review).
Note: Lorazepam has a slower onset of peak effect but ultimately has a more rapid elimination

SEVERE WITHDRAWAL (aggressive/ uncontrollable/ dangerous behaviour)

- Intravenous diazemuls up to 40mg over first 30 minutes (up to 2mg/minute; flumazanil to be available)
- Adjunctive therapy with Haloperidol 5-10mg IV or IM (smaller doses unlikely to be effective)

PATIENTS UNABLE TO TOLERATE ORAL MEDICATION

- Patients unable to tolerate oral medication may receive intravenous therapy (diazemuls or lorazepam) as an alternative at 50% of the oral dose in the first instance, and response assessed

INTRAVENOUS BENZODIAZEPINES

- It is recommended that intravenous benzodiazepines are administered by an experienced member of medical staff (FY2 or above)
- If nursing staff administer intravenous benzodiazepines they MUST have completed the appropriate Competency Training to administer IV sedation

MONITORING

- All patients should be closely observed for signs of over-sedation with regular observations
- Exceptional Patient Groups (see above), patients with Severe Withdrawal and patients requiring Intravenous or Intramuscular Sedation require close monitoring (NEWS) ideally with one-to-one nursing care
- Consultation regarding intensive care support may be necessary in extreme situations

APPROXIMATE ORAL BENZODIAZEPINE EQUIVALENCE

10mg Diazepam = 1mg Lorazepam = 30mg Chlordiazepoxide

Patients should not be discharged on regular benzodiazepine unless there is a confirmed arrangement with the Community Addiction Services. Chlordiazepoxide is the recommended benzodiazepine for community use.

Glasgow Modified Alcohol Withdrawal Scale (GMAWS)

Treatment Option: GMAWS Only ☐ GMAWS & Fixed Dose ☐

Date	24/8/17	24/8/17	ARE	110		25/8											26/8		
Time	0830	1100	KGW	1845	2144	2000	4AM	6AM	0800	1000	1200	1430	1700	1900	2100	2300	1AM	4AM	6AM
Tremor 0) No tremor 1) On movement 2) At rest	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sweating 0) No sweat visible 1) Moist 2) Drenching sweats	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
Hallucination 0) Not present 1) Dissuadable 2) Not dissuadable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Orientation 0) Orientated 1) Vague, detached 2) Disorientated, no contact	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Agitation 0) Calm 1) Anxious 2) Panicky	1	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0
Score	1	0	0	0	0	0	0	0	1	0	0	2	0	0	0	0	0	0	0
Treatment	10 mg	Nil		10mg	None	Nil	Nil	Nil	10 mg	NIL	NIL	10 mg	10 mg	NIL	Nil	10 mg	Nil	Nil	Nil
Staff Signature	KC	KC	h	NM	NM	RM	AM	DM	JK	NM	NM	NM	NM	NM	RM		RM	AM	RM

Score: (Do not use scoring tool if patient intoxicated, must be at least 8 hours since last drink.)

0 : Repeat Score in 2 hours (Discontinue after scoring on 4 consecutive occasions, except if less than 48hrs after last drink)

1 – 3 : Give 10mg Diazepam: Repeat Score in 2 hours

4 – 8 : Give 20mg Diazepam : Repeat Score in 1 hour

9 - 10 : Give 20mg Diazepam : Repeat Score in 1 hour, and discuss with medical staff regarding management of severe withdrawal as per guideline (see page 3)

PATIENTS MAY REQUIRE TO BE WOKEN FOR CONTINUING ASSESSMENT

CO-EXISTING ILLNESS MAY AFFECT SCORE: SEEK MEDICAL ADVICE IF IN DOUBT

FIXED DOSING & SYMPTOM TRIGGERED DOSING MUST BE NO LESS THAN 1 HOUR APART

All patients should have regular observations documented. Patients receiving high doses of Diazepam should be assessed regularly for over sedation. Regular NEWS – Frequency 1-4hrs. (GCS, Respiration rate. Oxygen sat^{n}, Pulse, Blood Pressure)

Developed by the Acute Alcohol Screening & Withdrawal Management Guideline Group
Chaired by Dr Ewan Forrest, Consultant Physician and Gastroenterologist, GRI

Published April 2011
Review Date April 2016

Version 4

NHS Greater Glasgow and Clyde

Glasgow Assessment and Management of Alcohol

NHS Greater Glasgow and Clyde

Please Attach Patient Label

CHI: 2012746039

Name: HUGHES Scott, S M 20/12/1974

Addres 12 Shafton Road Glasgow G13 2NE

Postcode:

Alcohol By Volume (ABV%)	Average Units (ABV% x Vol)
Strong Lager 9% (440mls)	4.0 Units
Beer/ Lager 4.5% (Pint/500mls Can/Bottle)	2.2 Units
Wine (e.g.Buckfast) 15% (750mls)	11.0 Units
Wine (Table) 12% (750mls)	9.0 Units
Wine (Table) 12% (175ml glass)	2.1 Units
Alcopops 5% (330mls)	1.5 Units
Spirits 40% (25ml measure)	1.0 Unit
Spirits 40% (¼ bottle 175mls)	7.0 Units
Spirits 40% (Litre)	40.0 Units
Spirits 40% (700mls)	30.0 Units
Cider 4% (Litre)	4.0 Units
Cider 4% (440mls)	1.8 Units
Strong White Cider 8% (Litre)	8.0 Units
Strong White Cider 8% (300ml glass)	2.4 Units

Number of Units = ABV (%) x Volume (litres)

eg A bottle of wine (750mls) which is 12% ABV = 12 x 0.75 = 9 Units
A glass of wine (200mls) which is 12% ABV = 12 x 0.2 = 2.4 Units

Estimated Weekly Alcohol Units : 24-3-1+
(Daily Units x Number of Days per Week)

Excessive Weekly Consumption
(♂: >21 units/week; ♀: >14 units/week)

Estimated Date / Time Of Last Drink 48hrs (If ≥ 5 Days, Re-consider Alcohol Withdrawal Status)

Presents With (or has Previous History of) Alcohol Related Seizures Yes ☐ No ☑

Presents With (or has Previous History of) Severe Alcohol Withdrawal Yes ☐ No ☑

Fast Alcohol Screening Tool - FAST:

Note : 1 drink = 1 unit of alcohol (refer to table above)

1. MEN: How often do you have EIGHT or more drinks on one occasion?
   WOMEN: How often do you have SIX or more drinks on one occasion?

   Never ☐0 Less than monthly ☐1 Monthly ☐2 Weekly ☐3 Daily or almost daily ☑4

2. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

   Never ☐0 Less than monthly ☐1 Monthly ☑2 Weekly ☐3 Daily or almost daily ☐4

3. How often during the last year have you failed to do what was normally expected of you because of drinking?

   Never ☐0 Less than monthly ☑1 Monthly ☐2 Weekly ☐3 Daily or almost daily ☐4

4. In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

   No ☐0 Yes, on one occasion ☑2 Yes, on more than one occasion ☐4

Score of 3 or more: FAST Positive

Total 9

FAST Positive?

Yes ☐ No ☐

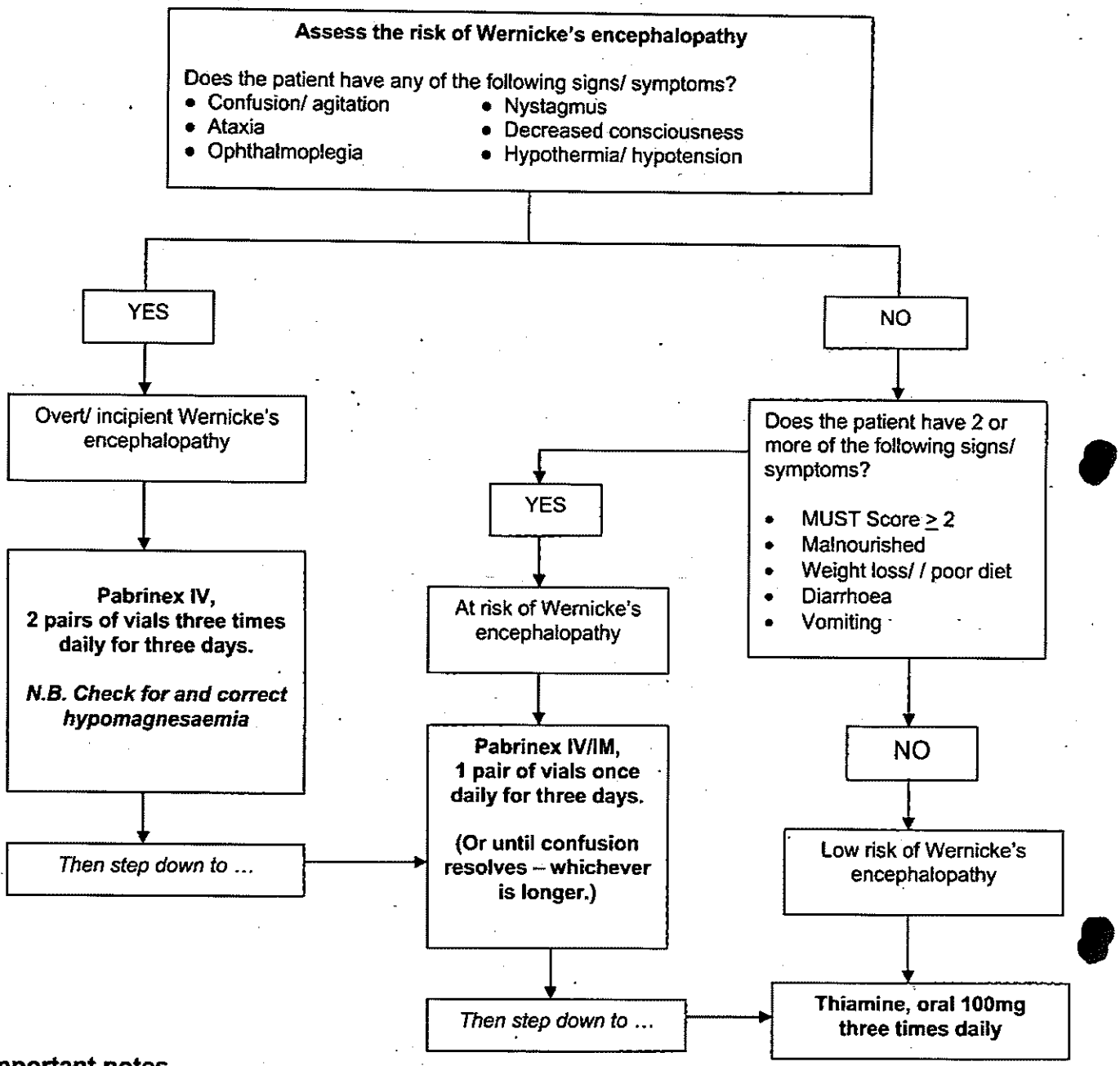
FAST 0-2:	Negative: No action required.
FAST 3-8:	Hazardous Drinking: Advise regarding safe drinking levels and offer information leaflet / advice.
FAST 9-16:	Probable Dependent Drinking: Advice as above and consider referral to Addiction Liaison Service.

PLEASE INSERT IN PATIENT'S CASE RECORD ON COMPLETION OF TREATMENT

STY5332N

Vitamin Prophylaxis and Treatment of Wernicke-Korsakoff Encephalopathy

The guidance applies to patients who are chronic alcohol abusers. This includes those who are dependent on alcohol but also those who have a hazardous/ harmful alcohol intake.



Important notes

- Patients with overt/ incipient Wernicke's encephalopathy or 'at risk' of Wernicke's encephalopathy **must** be given Pabrinex® **before** the administration of glucose or nutritional support.
- Intravenous Parbinex® should be administered over 30 minutes
- Anaphylaxis is a rare complication of IV Pabrinex® administration and even more uncommon with IM administration. Monitor patient for wheeze, tachycardia, breathlessness and skin rash. Facilities for the administration of adrenaline and other resuscitation should be available
- Further vitamin supplementation as clinically indicated by responsible medical team in the context of a general nutritional assessment

Management of Alcohol Withdrawal Syndrome

DEPENDENT DRINKING ON SCREENING - HIGH RISK

Any 2 of the following:

- Presents with or has had previous withdrawal seizures
- Previous severely agitated withdrawal (D.T.'s)
- High screening score (FAST >12)
- High initial symptom score (GMAWS >8)

YES

FIXED DOSE DIAZEPAM
PLUS
SYMPTOM TRIGGERED TREATMENT

Have you considered exceptional patient groups

NO

SYMPTOM TRIGGERED TREATMENT

Have you considered exceptional patient groups

BASELINE TREATMENT REGIME

Fixed Dose oral Diazepam: (for patients unable to tolerate diazepam via the oral route, see below).

Initial 24 hours: **20mg Diazepam 6 hourly**

If no additional symptom triggered treatment, then REDUCE as follows:

15mg Diazepam 6 hourly for 24 hours
10mg Diazepam 6 hourly for 24 hours
5mg Diazepam 6 hourly for 24 hours
5mg Diazepam 12 hourly for 24 hours

Diazepam prescription to be reviewed if patient excessively drowsy.
Maximum of 120mg Diazepam in 24 hours, before requesting senior medical review.
(*Diazepam 120mg not expected to be problematic over 24hrs in uncomplicated patients).

EXCEPTIONAL PATIENT GROUPS:

- Elderly patients
- Head injury
- Patients with evidence of liver disease: especially jaundice, encephalopathy
- Patients with other significant co-morbidity (i.e. COPD, pneumonia, cerebrovascular disease, reduced GCS)

Consider the use of oral Lorazepam in these exceptional patient groups in a symptom triggered fashion: 1-2 mg (to a maximum of 12mg in 24 hours before requesting senior medical review).
Note: Lorazepam has a slower onset of peak effect but ultimately has a more rapid elimination

SEVERE WITHDRAWAL (aggressive/ uncontrollable/ dangerous behaviour)

- Intravenous diazemuls up to 40mg over first 30 minutes (up to 2mg/minute; flumazanil to be available)
- Adjunctive therapy with Haloperidol 5-10mg IV or IM (smaller doses unlikely to be effective)

PATIENTS UNABLE TO TOLERATE ORAL MEDICATION

- Patients unable to tolerate oral medication may receive intravenous therapy (diazemuls or lorazepam) as an alternative at 50% of the oral dose in the first instance, and response assessed

INTRAVENOUS BENZODIAZEPINES

- It is recommended that intravenous benzodiazepines are administered by an experienced member of medical staff (FY2 or above)
- If nursing staff administer intravenous benzodiazepines they MUST have completed the appropriate Competency Training to administer IV sedation

MONITORING

- All patients should be closely observed for signs of over-sedation with regular observations
- Exceptional Patient Groups (see above), patients with Severe Withdrawal and patients requiring Intravenous or Intramuscular Sedation require close monitoring (NEWS) ideally with one-to-one nursing care
- Consultation regarding intensive care support may be necessary in extreme situations

APPROXIMATE ORAL BENZODIAZEPINE EQUIVALENCE

10mg Diazepam = 1mg Lorazepam = 30mg Chlordiazepoxide

Patients should not be discharged on regular benzodiazepine unless there is a confirmed arrangement with the Community Addiction Services. Chlordiazepoxide is the recommended benzodiazepine for community use.

Glasgow Modified Alcohol Withdrawal Scale (GMAWS)

Treatment Option: GMAWS Only ☐ GMAWS & Fixed Dose ☐

Date	26/3	26/3	26/3	26/3	26/3	27/3		27/3											
Time	08.00	1100	1800	1945	2240	0100	0400	0845	1210										
Tremor 0) No tremor 1) On movement 2) At rest	0	0	0	0	0	0	0	0	0										
Sweating 0) No sweat visible 1) Moist 2) Drenching sweats	1	0	1	0	0	0	0	0	0										
Hallucination 0) Not present 1) Dissuadable 2) Not dissuadable	0	0	0	0	0	0	0	0	0										
Orientation 0) Orientated 1) Vague, detached 2) Disorientated, no contact	0	0	0		0	0	0	0	0										
Agitation 0) Calm 1) Anxious 2) Panicky	1	0	1	1	0	0	0	1	0										
Score	2	0	2	1	[illegible]	0	0	1	0										
Treatment	10 mg	NIL	10 mg	10 mg	0	NA	NA	10mg	NIL										
Staff Signature	JC	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]										

Score: (Do not use scoring tool if patient intoxicated, must be at least 8 hours since last drink.)

0 : Repeat Score in 2 hours (Discontinue after scoring on 4 consecutive occasions, except if less than 48hrs after last drink)

1 – 3 : Give 10mg Diazepam: Repeat Score in 2 hours

4 – 8 : Give 20mg Diazepam : Repeat Score in 1 hour

9 - 10 : Give 20mg Diazepam : Repeat Score in 1 hour, and discuss with medical staff regarding management of severe withdrawal as per guideline (see page 3)

PATIENTS MAY REQUIRE TO BE WOKEN FOR CONTINUING ASSESSMENT

CO-EXISTING ILLNESS MAY AFFECT SCORE: SEEK MEDICAL ADVICE IF IN DOUBT

FIXED DOSING & SYMPTOM TRIGGERED DOSING MUST BE NO LESS THAN 1 HOUR APART

All patients should have regular observations documented. Patients receiving high doses of Diazepam should be assessed regularly for over sedation.
Regular NEWS – Frequency 1-4hrs. (GCS, Respiration rate. Oxygen sat^{n}, Pulse, Blood Pressure)

Developed by the Acute Alcohol Screening & Withdrawal Management Guideline Group
Chaired by Dr Ewan Forrest, Consultant Physician and Gastroenterologist, GRI

Published April 2011
Review Date April 2016

Version 4

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

2012746039 M
HUGHES 20/12/1974
Scott, S
12 Shafton Road
Glasgow G13 2NE

	Date	Ward
Admitted		
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

See NEWS Actions Reference Tool for local escalation policy

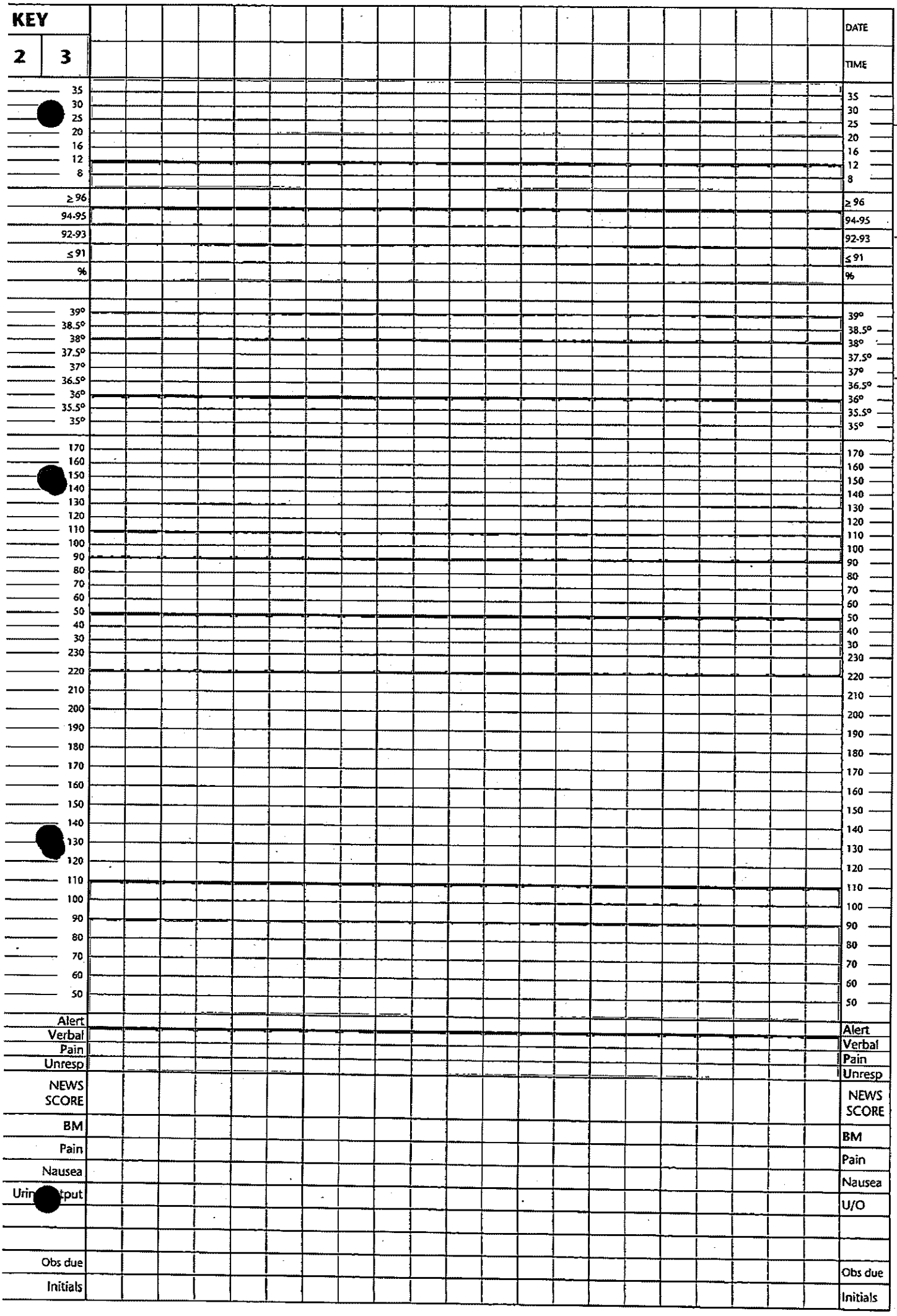
NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more **or** 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.

DATE:	23/3/17		24/3				10		24/3	25/3		26/3	26/3					
TIME:	19 10.		03 50	06 20	11 00	14 45	17	18:45	95	11:45	20:45	2am	10 40	19 45				
Resp. Rate (Mark: •)	17	•	17	17	18	18	16	•18	•	•	•	•	•	15				
SpO₂ (Enter Value)	97	97	96	97	100	100	100	97	98	98	99	96	96	98				
Any Sup'l O₂ % / Room air	A		A		A	A	(A)	(A)	A	(A)		A	(A)	A				
Temp. (Mark: X)	35.9	×	36.4	×	37.4	36.5	×	37.3	•	36.5	•	•	36.4	36.3 °C				
Pulse (Mark: •)	114	107	96	78	95	96	98	•97	94	•83	96	•	98	92				
Blood Pressure (Mark: ⌃⌄)	119/66	117/72	114/69	124/79	127/96	139/92	133/85	142/91	↕	123/72	142/86	↕	140/90	142/93				
Conscious Level (Alert/Verbal/Pain/Unresp)	A	A	A	A	A	A	✓	(A)	A	(A)	A	A	(A)	A				
Total NEWS (with all obs)	3	1	2	0	1	1	1	1	(0)	(2)	\	\	1	1				
BM														NA				
Pain	N	N	N	N	N	N	0	0	0	0	0	0	0	0/0				
Nausea	N	N	N	N	N	N	0	0	0	0	0	0	0	0/3				
Urine output	PU	Y	NPU	Y	PU	PU	✓	✓	✓	✓	✓	✓	PU	PU				
Obs due	22°°	4	4	4	4°	4°	21/10	4°	4	4°	4	4	4°	8				
Initials	KC	[illegible]	JJ	MO	KC	KC	[illegible]	MN	M	MN	[illegible]	[illegible]	MO	[illegible]				

DATE / TIME / Resp. Rate (35, 30, 25, 20, 16, 12, 8) / SpO₂ (≥96, 94-95, 92-93, ≤91, %) / Temp. (39°–35°) / Pulse (170–30) / Blood Pressure (230–50) / NEWS SCORE / BM / Pain / Nausea / U/O / Obs due / Initials

NEWS

0	1


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Glasgow Coma Scale

Pupil size (mm)

Neurological Observations

Section	Category	Item	Score	Notes
Date:				
Time:				
COMA SCALE	E – Eyes open	Spontaneously	4	Eyes closed by swelling = C
		To speech	3	
		To pain	2	
		None	1	
	V – Best Verbal response	Orientated	5	Endotracheal tube or tracheostomy = T
		Confused	4	
		Inappropriate words	3	
		Incomprehensible sounds	2	
		None	1	
	M – Best motor response	Obeys	6	Usually record the best arm response
		Localises	5	
		Flexion - withdrawal	4	
		Flexion - abnormal	3	
		Extension to pain	2	
		None	1	
		TOTAL SCORE		
PUPILS	R	Size		+ reacts - no reaction c. eyes closed
		Reaction		
	L	Size		
		Reaction		
LIMB MOVEMENT	ARMS	Normal power		Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness		
		Severe weakness		
		Spastic flexion		
		Extension		
		No response		
	LEGS	Normal power		
		Mild weakness		
		Severe weakness		
		Spastic flexion		
		Extension		
		No response		

Pain Score

Ask the patient to rate his/her pain by choosing a number between 0 and 10. Use the diagram below to assist the patient. If patient's pain is chronic, use generic tool. If patient is unable to communicate, use observational tool.

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

Nausea and Vomiting	
0	= None
1	= Mild (*Not distressing – no retching/vomiting*)
2	= Moderate (*Troublesome – occasional retching/vomiting*)
3	= Severe (*Distressing – frequent retching/vomiting*)

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

Acute Services Division

Nursing Admission & Assessment

1. Admission

NHS Greater Glasgow and Clyde

Name: .....
Address:.. 2012746039
HUGHES
.....Scott, S
DoB:.....12 Shafton Road
Glasgow
CHI num
G13 2NE
M
20/12/1974

Hospital: QEUH	Ward: 1AU
Date of admission: 24/3/17	Time: 0200
Admitting Consultant:	Admitting Nurse: Mena
Expected date of discharge: / /	

1. Patient Details

Preferred name:	Next of Kin (NoK): Michelle McGarrity
Age: 42	Relationship: PARTNER
Religion:	NoK Address: SAME -
Telephone:	
GP: Dr. D Taylor	NoK Telephone: 07507571684
GP address: Anniesland Medical Practice, 46 Munro Place, Glasgow, G13 2UP	NoK Aware of admission: ☑ Yes ☐ No
	Consent for information to be given to relative/carer/friend: ☑ Yes ☐ No Nominated relative/carer/friend contact:
GP telephone:	Telephone - Day: Telephone - Evening:

Is the patient a carer? ☐ Yes ☑ No If 'Yes' refer to Duty Social Worker if required: ☐ Referred ☑ Not required

Does the patient have an appointed Welfare Guardian / Power of Attorney? ☐ Yes ☐ No ☑ N/A

a. If 'Yes' please provide – Name: ..... Relationship: .....

Contact telephone number: .....

b. If 'Yes' does the patient have an 'Adult with Incapacity Section 47' certificate in place? ☐ Yes ☐ No

If 'Yes' obtain a copy and file with patient notes.

If 'No' to 'b' please inform medical staff. Name of doctor informed: .....

2. Presenting Complaint / Diagnosis

Have treatment / investigations: Worsening Epilepsy + Jaundice
Deranged LFTs

Why does the patient think they are in hospital? *Use patients own words:*

3. Allergies (including food allergies)

No known allergies: ☑

4. Observations

Cannard	Waterlow	MUST	Pulse	BP	Resp	SaO_2	Temp
			114	119/88	19	97	35.9
Urinalysis:			BM	NEWS Score	Weight Patient reported for weight /Actual	Height Patients reported height / Actual	BMI
				(3)			

5. Current Medication

AB Kardup.

6. Relevant Past Medical History

Alcohol liver Disease
Acute Pancreatitis -
ALC x 5.

7. Risk Assessment

MUST Screening Tool

1. Is the patient's BMI:
   - > 20 .....Score 0
   - 18.5-20 .....Score 1
   - <18.5 .....Score 2
   - **Score** ☐
2. Has the patient had unplanned weight loss in the past 3-6 months?
   - < 5% .....Score 0
   - 5-10% .....Score 1
   - >10% .....Score 2
   - **Score** ☐
3. If the patient is acutely unwell and there has been or is likely to be no food intake for > 5 days:
   - Score = 2
   - Not applicable: Score = 0
   - **Score** ☐

MUST Score: ☐

If score 1 or more, complete full Nutrition Profile

Swallow Risk Assessment

Has the patient had, or is suspected of having, a stroke, a TIA or is suspected of having a swallowing difficulty? ☐ Yes ☐ No

If YES complete a STOPSS screening tool.

STOPSS completed ☐ Yes ☐ No

Name: .....

Address: .....

.....

DoB: .....

CHI number: .....

Affix patient data label

8. Cognitive Impairment / Delirium

Think Delirium

Do 4AT on all patients over 65 yrs

and

on patients of any age with one or more of the following:

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

9. MRSA Screening / CJD / Healthcare outside Scotland

Will the patient be an inpatient >23 hours? ☐ Yes ☑ No If 'Yes' complete the following section.

1. Has the patient ever had a previous positive MRSA result? ☐ Yes ☐ No ☐ Not known
2. Has the patient been admitted from a Care Home/ institutional setting or another hospital? ☐ Yes ☐ No ☐ Not known
3. Does the patient have a wound / ulcer or invasive device which was present prior to this admission? ☐ Yes ☐ No ☐ Not known

If **'Yes'** to any of the above questions **OR** if the patient is admitted to a 'high impact speciality' e.g. **Orthopaedics, Vascular, Renal Unit, Critical Care – then obtain MRSA Swabs:**

☐ **Nasal** ☐ **Perineum** ☐ **Other - Specify:** ☐ **Patient refused**

CJD: **Has the patient ever been contacted by Public Health and told that they are possibly at risk of CJD:**

☐ Yes ☐ No If 'Yes' contact Infection Control Team. Infection Control Team contacted: ☐

Healthcare outside Scotland

Has the patient been transferred from, or received health care in, a hospital outside of Scotland in the last 12 months:

☐ Yes ☑ No If 'Yes obtain rectal swab and send to microbiology for CPE screen.

Rectal swab taken ☐ Patient refused ☐

10. Lifestyle

Smoking:

Are you a smoker ☑ ex-smoker ☐ never smoked ☐

If ex-smoker when did they stop? .....

If smoker how many cigarettes per day.....

If smoker, or recent ex-smoker, would they like to use nicotine replacement therapy to prevent withdrawal discomfort while in hospital? ☐ Yes ☐ No

If smoker, would they like to stop now with the support from stop smoking service? ☐ Yes ☐ No

If Yes refer to Smoking Cessation Service

Drugs: Does the patient use recreational drugs? ☐ Yes ☐ No If 'Yes' specify:

Alcohol (Men): How often do you have **8** or more drinks on one occasion:

☐ Never ☐ Less than monthly

☐ Monthly ☐ Weekly ☑ Daily or almost daily

If 'Monthly' or more then complete FAST Tool.

Alcohol (Women): How often do you have **6** or more drinks on one occasion:

☐ Never ☐ Less than monthly

☐ Monthly ☐ Weekly ☐ Daily or almost daily

If 'Monthly' or more then complete FAST Tool.

11. Admission Documentation Completed By

Name (Please PRINT): M Doran	Signature: M Doran
Designation: S/N	Date: 22/3/17

Acute Services Division

Nursing Admission & Assessment

2. Assessment

Hospital: QEUH	Ward: IAU
Date of Assessment: 24/3/19	Time: 0200

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

1. Breathing and Circulation

Breathing:

- [x] No symptoms or history of respiratory problems
- [ ] Dyspnoeic at rest
- [ ] Dyspnoeic on minimal exertion
- [ ] Dyspnoeic on maximum exertion
- [ ] Productive / non-productive cough evident
- [ ] Normally receives oxygen therapy

If 'Yes' provide details:

Circulation:

- [x] No symptoms
- [ ] known high blood pressure
- [ ] known angina
- [ ] current chest pain

Problem identified: [ ] Yes [ ] No If 'Yes' please describe

	Initial

2. Communication

Assessment of ability to communicate:

What language does the patient speak?:

..... English .....

Interpreter: Required [ ] Not required [ ]

If required, provide details and arrangement made:

.....

.....

Does the patient have:

a. Speech difficulties? [ ] Yes [x] No

b. A learning disability e.g. Down's Syndrome?
[ ] Yes [x] No

If 'Yes' please specify:

.....

If 'Yes' contact Liaison Learning Disability Team.
Liaison Learning Disability Team contacted:
[ ] Yes [x] No

c. A learning difficulty e.g. dyslexia, dyspraxia?
[ ] Yes [ ] No

If 'Yes' please specify:

.....

3. Senses

Senses:

Eyesight

- [x] Normal vision
- [ ] Glasses – [ ] Distance [ ] Reading
- [ ] Prosthesis – [ ] Left [ ] Right
- [ ] Contact lenses
- [ ] Registered blind

Hearing

- [x] Normal
- [ ] Hearing impaired
- [ ] Hearing aid – [ ] Left [ ] Right

4. Cognitive Status

Cognitive Status:

- [x] Orientated
- [ ] Confused
- [ ] Distressed
- [ ] Aggressive /Abusive
- [ ] Known dementia
- [ ] Unconcious

Problem identified: [ ] Yes [ ] No If 'Yes' please describe

	Initial

5. Hydration and Nutrition

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

MUST Score: ..... **If score is 1 or more, complete a Nutrition Profile.**

Nutrition Profile completed ☐ Yes ☐ No
If 'Yes' do not complete sections 5a to 5d.

- **If score is 0, reassess / screen patient in 7 days.**
- **Complete sections 5a to 5d.**

Date of reassessment: / /

5a 1. Food likes / dislikes:

Nil Specific

5a 2. Fluid likes / dislikes:

5c. Help needed with eating and drinking:
☐ Yes ☒ No
If 'Yes' provide details:

5b. Cultural or religious diet needed (e.g. vegetarian, vegan, halal, kosher etc):
☐ Yes ☒ No
If 'Yes' specify diet needed:

5d. Texture Modified Diet needed?
☐ Yes ☒ No
If 'Yes' specify texture: A☐ B☐ C☐ D☐ E☐
Thickened Fluids required? ☐ Yes ☐ No
If 'Yes' specify stage required: 1☐ 2☐ 3☐

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial KD

6. Elimination

Continent:
☑ Bladder
☑ Bowel

Incontinent:
☐ Bladder
☐ Bowel

NHS GGC Stool Chart commenced:
☐ Required ☐ Not required

Long-term urinary catheter in situ? ☐ Yes ☐ No
If Yes is it urethral ☐ suprapubic ☐

If 'Yes' – Size: ..... fg Make: .....
Date catheter last changed: / /

Continence assessment commenced:
☐ Yes ☐ No ☐ Not applicable

Containment products in use? Please specify:

☑ Bowels regular
☐ Constipated
☐ Diarrhoea / loose stools

Stoma: ☐ Yes ☐ No
If 'Yes' please specify and list appliances used:

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial MO

7. Personal Hygiene, Oral Health and Skin Assessment

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Personal hygiene:

☑ Self-caring and independent
☐ Requires assistance

Specify assistance if required:

Oral health:

Self-caring and independent	☑ Yes	☐ No
Does the patient have a sore mouth	☐ Yes	☑ No
Does the patient have a non healing mouth ulcer	☐ Yes	☑ No

If the patient has a sore mouth or non healing mouth ulcer, refer to dentist (See StaffNet for dentist referral pathway).

Dentures:

Does the patient wear a denture plate?
☐ Yes ☑ No

If yes complete the following:
☐ Full set ☐ Upper set ☐ Lower set
☐ Dentures with patient on admission

Skin assessment:

☑ Skin healthy with no evidence of damage
☐ Skin broken ☐ Skin oedematous ☐ Skin discoloured ☐ Skin clammy
If 'Yes' to any of the above, describe skin condition:

Wound Assessment Chart completed: ☐ Yes ☐ No ☐ Not applicable

Pressure ulcer evident: ☐ Yes ☐ No
If 'Yes' please identify Grade and record on Pressure Ulcer record sheet – Grade: .....

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Reports intact

Initial MK

8. Mobility

Patient fully mobile / independent? ☑ Yes ☐ No If 'No' complete Moving and Handling Assessment.

☐ Limited mobility

☐ Mobile with aid – Specify:

☐ Prosthesis – Specify:

Moving and Handling Plan commenced:
☐ Yes ☐ No

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial

9. Maintaining a Safe Environment

Pain status:

Does the patient have pain? ☐ Yes ☑ No
If 'Yes' record Pain Score on NEWS chart.

What makes their pain better? Please provide brief details:

Bed rail assessment completed: ☐ Yes ☑ No

Bed rails required:
☐ Required ☐ Not required

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial

10. Sleep and Rest

Sleep habits:

☐ Less than 8 hours ☐ Afternoon nap
☐ Morning nap

Sleep difficulties:

☐ None ☐ Disturbed
☐ Early wakening e.g. nocturia, insomnia

Medication required: ☐ Yes ☐ No

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

	Initial

11. Social Circumstances

☐ Employed ☐ Unemployed ☐ Retired
☐ Health problems at work
☐ Lives alone
☑ Lives with Family PARTNER.
☐ Friend
☐ Dependants
☐ Other: ☐ Nursing Home ☐ Residential

Current Care / Support arrangements:

☐ Social Services

Unpaid carer ☐ Yes ☐ No
If Yes are they Partner / Friend / Son / Daughter
What kind of care do they provide?:

☐ Private Carers
☐ None

If support services in place, please provide details:

Does the patient have any money worries? ☐ Yes ☐ No
If Yes would the patient like to be referred to a money advice service that can offer confidential advice / support?
☐ Yes ☐ No
If Yes please identify date patient referred: ...../...../.....
Would the patient like a referral to a service that can support them with employment / education/training/skills /volunteering
☐ Yes ☐ No
If Yes please identify date patient referred: ...../...../.....

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

	Initial

12. Privacy, Dignity and Sexuality

Does the patient have issues related to privacy, dignity and/or sexuality that are relevant to admission? ☐ Yes ☑ No	If 'Yes' please provide brief details:

13. Spiritual Care

Is there anything with regard to faith or culture that we can support the patient with during their stay in hospital (e.g. prayer, meditation)? ☐ Yes ☑ No	If 'Yes' please provide brief details:
Is there anything causing the patient a lot of anxiety at the time of admission that staff should be aware of? ☐ Yes ☑ No	If 'Yes' please provide brief details:
Ask the patient: "Would you like the ward staff to arrange for a Hospital Chaplain to visit you while in hospital?" ☐ Yes ☐ No ☑ Not at this time	If 'Yes' please specify faith group:

14. Anticipatory Care

(This section is for patients thought to be in the last year of life, where appropriate and relevant)

Appropriate ☐ Not appropriate ☐

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Is the **patient** aware of their:
Diagnosis? ☐ Yes ☐ No
Prognosis? ☐ Yes ☐ No

Is the **patient's family** aware of their:
Diagnosis? ☐ Yes ☐ No
Prognosis? ☐ Yes ☐ No

Preferred place of care:
Home: ☐ Hospital ☐ Hospice ☐

Preferred place of death:
Home: ☐ Hospital ☐ Hospice ☐

Current treatment – please identify (e.g. chemotherapy/ radiotherapy):

Other agencies involved in patient's care – please identify (e.g.) Marie Curie, MacMillan Nurses):

DNACPR order in place: ☐ Yes ☐ No
If 'Yes' are the patient's family and next of kin aware? ☐ Yes ☐ No

15. Admission Assessment Completed By

Name (Please PRINT): Mr Dorn

Signature: M Dorn

Designation: S/N

Date: 24/3/17

Clinical Notes

Date and Time	Notes	Name, Signature and Designation
	42 y/o referred with ? jaundice	
	and Deranged LFTs	
	Settled in Bay - Seen By medics	
	for chest xray, Liver U/S.	
	Liver Screen Bloods with	
	Amylase; FAST And GMANS.	
	W/H ABx Until XRAY Chest.	
	DN Neuro RE Anti Epileptics	Mdorn

Clinical Notes continue on next page

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Clinical Notes (continued)

Date and Time	Notes	Name, Signature and Designation
24/3/17. 0230	written up for IV PARACETAMOL	
	new. Given Blanket and	
	opened gown. Son in Attendance	S/N Malin
0650	Settled night appears to have	
	slept well. Nil complaints offered	S/N Malin
1120	Patient settled. Observations stable.	
	Medications as per kardex. Independantly	
	Mobile & ADLs. Tolerating adequate	
	diet and fluids. Ward round: AUD,	
	continue c paracetamol and GTN PRN.	
	Await liver u/s, for gastro bed.	
	No complaints offered at present.	Mollison SN.
1440	Patient for t/f am 3. liver u/s.	
	at 2.45pm.	Mollison SN.

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐ NURSING ☑

Please tick ✔ appropriate directorate

2012746039
HUGHES M
Scott, S 20/12/1974
12 Shafton Road
Glasgow
G13 2NE

Date & Time		Signature, Print Name & Designation
WR	gmaws/pabrinex	
	alt.	
	Rpt LFTs.	
1800	Electronic W10 11D.	[signature]
	Pt admitted to ward 11D.	
24/3/17	NEWS 7 - P97.	
1915	Scored 1 on GMAWS - slightly	
	anxious. 10mg diazepam given.	N MARTIN S/N.
24/3	Medication as per	
8am	Kardex observations and	
	active care as	
	charted. GMAWS continues	
	and not scoring	RGN B. [signature]
25/3	Independent of ADL,	
11.15	observation as charted.	
	continue Pabrinex +	
	GMAWS, Diet and fluids	
	taken. No complaints	J King
	appeared.	S/N.
26/3	Medications as per Kardex.	
4 00	Active care & GMAWS as	
	charted. settled overnight.	
	Continue with pabrinex.	RGN B [signature]
26/3/17 @ 13.15	Settled day so far, independent with adls	
	Food + fluids taken.	
	All medications as per	
	kardex.	
	Observations as charted.	

83949 GGC0072

Date & Time		Signature, Print Name & Designation
	IV pabrinex continues as prescribed.	
	Passing urine spontaneously.	
	Pabrinex care as charted.	M SMAIL RGN M(S)M
27/3/17	settled and slept really well	
0410	Eating + drinking. fully mobile	
	observable NEWS 1 for pulse 92.	
	otherwise ok. IV pabrinex given.	
	diazepam as needed or per	
	GMFWS.	Jennifer
27/3/17	Patient independent with all care	SN/RGN
17.00	needs. Active care as charted.	
	Medications given as per kardex	
	No longer scoring on GMFWS	
	Seen by medical team and fit	
	for discharge. Given TOLS	
	and discharge medications.	
	Discharged from ward.	

Write or affix label

Name: HUGHES
Address: Scott, S
2012746039 M
CHI: 12 Shafton Road
DOB: 20/12/1974
Hospital: Glasgow G13 2NE

Peripheral Vascular Cannula(PVC) Insertion & Maintenance

NHS Greater Glasgow and Clyde

Modified V.I.P (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phlebitis : Observe cannula
One of the following is evident : slight pain or redness near site	1	Possible first signs : Observe cannula
Two or more of the following are evident: pain,redness,swelling	2	Early stage of phlebitis - Remove & resite cannula
All of the following are evident: pain,redness,hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis Remove & resite cannula Seek further advice
As above including: palpable venous cord	4	
As above including :pyrexia	5	

Insertion – Complete all sections

PVC inserted ED Theatre Ward IAU	Date inserted 24/3	Insertion site (L) ARM	Colour of PVC	Inserted by: Name & Designation *(only if inserted in ward)*
Clinical indication	IV Fluids/IV Medication ☐	Urgent access ☐	Interventional procedures ☐	Other Please state:
Insertion Criteria (If no: please explain in comments below)	Clean field used Yes ☐ No ☐ Unknown ☐	Hand hygiene Yes ☐ No ☐ Unknown ☐	Skin asepsis Yes ☐ No ☐ Unknown ☐	Dressing affixed Yes ☐ No ☐ Unknown ☐

Non touch technique (do not re- contaminate cleaned skin) Yes ☐ No ☐ Unknown ☐

Maintenance – To be completed daily

PVC 1	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation Record VIP score	The PVC dressing is intact	The PVC has been inserted less than 72 hours	Hand hygiene before & after all procedures	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 2 25/3/17	Yes ☑ No ☐	V.I.P: 0	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Left in situ ☐ Removed ☑	GH
Day 3 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After day 3 consider removal, if there is still a clinical reason justify rationale for PVC to remain in situ.							
Day 4 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

Date removed_____ Reason for PVC removal_____ Reason PVC in greater than 72 hours_____

Date & time	PVC no.	Comments	Signature

CHI:	Modified V.I.P (Visual Infusion Phlebitis) Score		
	IV site appears healthy	0	No phlebitis : Observe cannula
	One of the following is evident : slight pain or redness near site	1	Possible first signs : Observe cannula
	Two or more of the following are evident: pain,redness,swelling	2	Early stage of phlebitis : Remove & resite cannula
	All of the following are evident: pain,redness,hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: Remove & resite cannula Seek further advice
	As above including: palpable venous cord	4	
	As above including :pyrexia	5	

Insertion – Complete all sections

PVC inserted ED Theatre Ward_____	Date inserted	Insertion site	Colour of PVC	Inserted by: Name & Designation *(only if inserted in ward)*
Clinical indication IV Fluids/IV Medication ☐	Urgent access ☐	Interventional procedures ☐	Other Please state:	
Insertion Criteria (If no: please explain in comments below) Clean field used Yes ☐ No ☐ Unknown ☐	Hand hygiene Yes ☐ No ☐ Unknown ☐	Skin asepsis Yes ☐ No ☐ Unknown ☐	Dressing affixed Yes ☐ No ☐ Unknown ☐	Non touch technique (do not re- contaminate cleaned skin) Yes ☐ No ☐ Unknown ☐

Maintenance – To be completed daily

PVC 2	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation Record VIP score	The PVC dressing is intact	The PVC has been inserted less than 72 hours	Hand hygiene before & after all procedures	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 2 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After day 3 consider removal, if there is still a clinical reason justify rationale for PVC to remain in situ.							
Day 4 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

Date & time	PVC no.	Comments	Signature

Date removed_____ Reason for PVC removal_____ Reason PVC in greater than 72 hours_____

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

2012746039 HUGHES M Scott, S 20/12/1974 12 Shafton Road Glasgow G13 2NE	Hospital: Ward:	Points to consider: • Use within 6 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

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

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

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

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

If NO to all statements, continue Active Care Prescribing as assessed for individual need and re-assess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
23/3/17	02:00	N	N	N	N	N	N	6 hrly	NBO
24/3/17	18:45	N	N	N	N	N	N	6 hrly	NM
24/3/17	06:00	N	N	N	N	N	N	6 hrly	NM
26/3/17	00:20	N	N	N	N	N	N	6 hrly	NM
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	

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

Prevention of Pressure Ulcer Interventional Plan

NHS Greater Glasgow and Clyde

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

Outcome: To prevent pressure ulcer development through establishment of effecting work practices in line with SSKINS bundle.

Attach Addressograph

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCONTINENCE / MOISTURE	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of initial plan:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐	Date discontinued: _____

Previous Patient Notes for Neurology (newest at the top).

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

Patient Note		**Remote Consultation**
Date/Time: 11-May-2026 22:46	**Created By:** STR - Mohamed Taha	**Role:** Doctor - GGC
Specialty: Neurology	**Organisation:**	Sensitive

Note:

OOH on call from IAU in QEUH
admitted for LRTI but also reports increased seizure frequency of 2-3 a week.
Still reports of poor adherence - not stated to me exactly how much he misses the tablets per week, in addition issues of increased ETOH both vodka and 4 pints of bear.
Plan
no change of ASM
counsel about ETOH and Poor adherence.

Patient Note		**Remote Consultation**
Date/Time: 21-Mar-2024 14:47	**Created By:** Epilepsy Clinical Nurse Specialist - Eleanor Arthur	**Role:** Nurse - GGC
Specialty: Neurology	**Organisation:**	Sensitive

Note:

Telephone appt today. Spoke with Mr Hughes for first time. Previously reviewed by my colleague Susan Sanders, ESN (retired). Medication - Brivaracetam 75mg night only. Had x1 "big" seizure few months ago and some "minors" where he feels funny and told he looks switched off for about 1 minute. Often forgets medication. Discussed medication, compliance, seizure triggers, risks of seizures including small risk of SUDEP and loss of life. Has bus pass. See GP letter.

Patient Note		**Outpatient Note**
Date/Time: 05-Apr-2023 14:38	**Created By:** Clinical Nurse Specialist - Susan Sanders	**Role:** Nurse - GGC
Specialty: Neurology	**Organisation:**	Sensitive

Note:

Telephone consultation. Known to Dr Stephen. Current meds Brivaracetam 50mgs at night. Tolerating fairly well at present. Seizures not as bad as previously. Does not wish to make any further increase to Brivaracetam dose at present.

Patient Note		**Outpatient Note**

Date/Time: 20-Jul-2021 14:09	**Created By:** Clinical Nurse Specialist - Susan Sanders	**Role:** Nurse - GGC
Specialty: Neurology	**Organisation:**	Sensitive

Note:

Telephone consultation. Known to Dr Stephen. Current meds- Topiramate 50mgs at night. Dose increased last week due to seizure activity. Is finding the dose difficult to tolerate but will persevere a bit longer. States that he often has problematic side effects on AED's.

Previous Patient Notes for (newest at the top).

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

Patient Note		**Historical Note**
Date/Time: 12-Apr-2017 10:43	**Created By:** Consultant - Rahat Maitland	**Role:**
Specialty:	**Organisation:**	Sensitive
Note:		
IDL reviewed-nil to add to an FDL		

Patient Note		**Historical Note**
Date/Time: 06-Jan-2016 15:59	**Created By:** Acute Addiction Liaison Nurse - Jenny Brown1	**Role:**
Specialty:	**Organisation:**	Sensitive
Note:		
FAST 10		

NHS GGC Hospitals, Admission Document

NHS

Queen Elizabeth University Hospital

CHI: 2012746039

Total Att: 16

12 Mth Att: 1

Title: MR

HUGHES **Scott Sean**

DOB: **20/12/1974** Age: **51y** Sex: **Male**

FLAT 7-6
39 LINKWOOD CRES
Glasgow
Lanarkshire
G15 7EP
07787255019

Next of kin: **HUGHES, Kyle**
Relationship: **Son**

GP: **A Martin**
0141 211 6100

Needs edit

Attendance Date: **11/05/2026** Arrival Time: **17:14**

Registration Time: **17:14** Date of Incident: **11/05/2026**

Major Incident Desc:

Reason for Attendance: **IAU - OWN TRANSPORT CHRONIC CHEST PAIN WORSENING, EPISODES AT REST HX EPILPESY PT REPORTS INCREASE IN SEIZURES + HEADACHES THIS WEEK. ALCOHOL DEPENDENCE LAST DRINK 2PM. OBS STABLE**

Reason for attendance:

Nursing Assessment

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

Triage Category: **2** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **11/05/2026 17:51** Nurse name: **Nurse Sarah Logan1**

RR	18	bpm
Oxygen	21	%
Air or O2		
SpO2	100	%
HR	77	bpm
BP	116/95	mmHg
CRT		
MAP	102	mmHg
AVPU		
Temp	36.7	C
EWS Total		

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

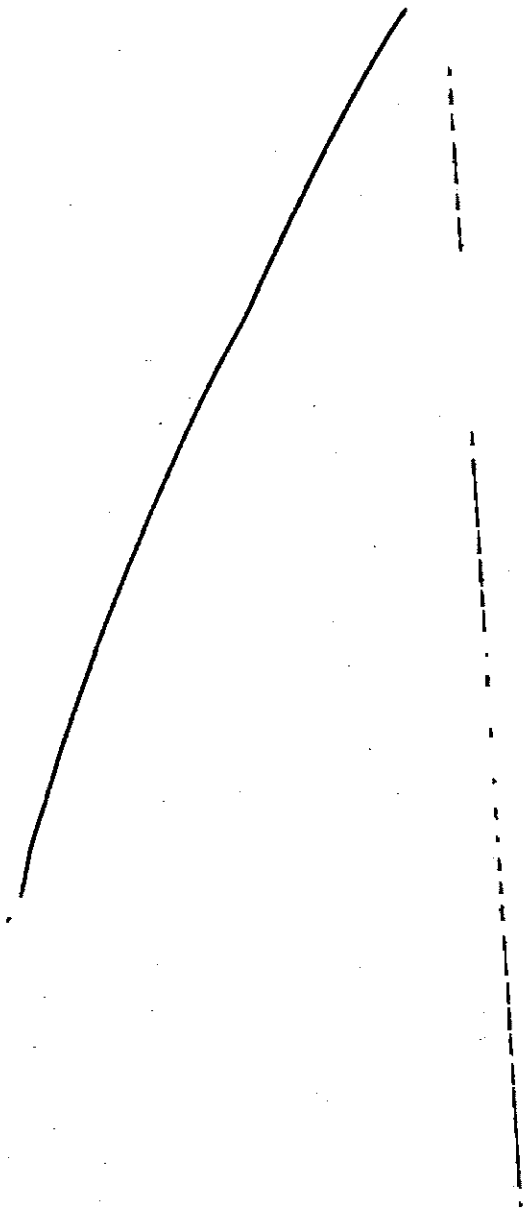
GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **"WORSENING CHEST PAIN. REPORTS PAIN AT REST. STATES 6/10 AT PRESENT. KNOWN ALC XS. DRINKING TODAY. LAST DRINK APPROX 2PM. "**

Patient ID label

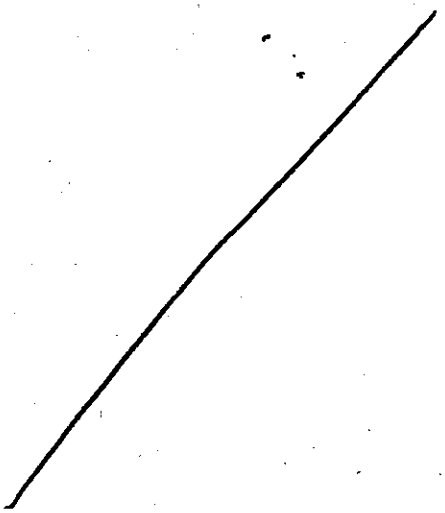
Date	Emergency Department Notes	
	Ambulance Proforma reviewed Yes / No Seen by (Doctor)	Time seen



Patient ID label

2012746039
HUGHES
Scott, S
FLAT 7-6
39 LINKWOOD CRES
Glasgow, Lanarkshire
G15 7EP

M
20/12/1974

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen
		

Differential Diagnosis/Problem List

NEWS ☐ 0-7

RED FLAG ☐ (Tick)

SEPSIS ☐

CURB 65 ☐

Done/ completed	Immediate Managment Plan

Signature: Designation: Page No:

07

PLEASE DO NOT WRITE HERE

In-Patient Admission Notes

2012746039
HUGHES M
Scott, S 20/12/1974
FLAT 7-6
39 LINKWOOD CRES
Glasgow, Lanarkshire
G15 7EF

Seen By: Print: ZJ. SHG. Time Seen: Pg. No:
PRF Reviewed Yes / No

Presenting Complaint(s)	
Presenting complaint	Cough / chest pain / ↑ seizure freq-cy.
History of presenting complaint	Having chest pain sharp in nature across the chest worse with inspiration. Chronic cough. No change in volume/purulence. Having ↑ SOB associated with nasal polyp/mass – referral to ENT by GP. ↑ seizure frequency 2–3/week. 'Grand mal' seizure last 3–4 mins in bed, witnessed by partner. Described confusion post ictal at each generalised. Has worked on improved compliance but STILL missing dose of AED

Past Medical History / Review of portal
Mild/moderate coronary artery calcification. Apical moderate emphysema. Foci of calcification in kidneys (Medullary sponge kidney) Epilepsy. (previously on various AEDs)

Systemic Enquiry
No new symptoms / change of bowel habit.

2012746039
HUGHES
Scott, S — M
20/12/1974
FLAT 7-6
39 LINKWOOD CRES
Glasgow, Lanarkshire
G15 7EP

MEDICINES RECONCILIATION – Acceptable to staple fully completed Emed Rec

Source of medication history (>1 source preferred)

☐ Patient/Relative/carer ☐ GP Phone call ☐ ECS
☐ Patient own drugs ☐ Com. Pharmacist ☐ GP letter/summary
☐ Repeat Prescription

Other (please specify)

Admission Medicines			Plan for Medicines (Dr complete)				Comments Reason for alteration
Name	Dose	Freq	Continue	Amend	Withhold	Stop	
Naproxen	500mg	BD	✓				
Dihydrocodeine	30mg	PRN	✓				
Trelegy 92/55/22	1 puff	OD	✓				
Salbutamol DPI	1-2 puff	PRN	✓				
Atorvastatin	80mg	ON	✓				
[illegible]	15mg	ON	✓				
Clinitas carbomer	OU	QDS	✓				
Mometasone	2 sp	OD	✓				

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

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

P 2012746039
HUGHES M
Scott, S 20/12/1974
FLAT 7-6
39 LINKWOOD CRES
Glasgow, Lanarkshire
G15 7EP

Social History \ Family History

Smoking History

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

Alcohol History

_____ Units/week FAST score if excess _____

4 pints per day + 4 x vodka.

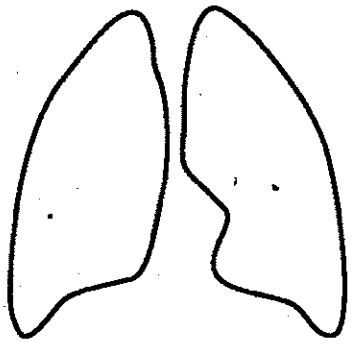
Recreational Drugs **Driving Status** Does not drive.

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

Lives with partner. Does not work.

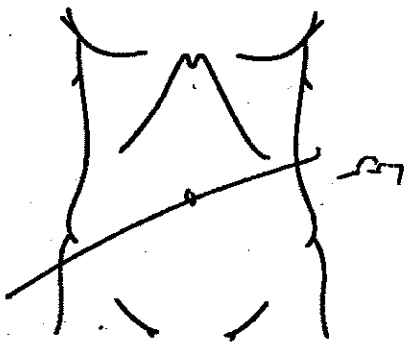
General Examination		General Appearance:
Temp:	RR:	
Pulse:	CBG:	
SpO_2:	Weight:	
BP:	Urinalysis:	

Respiratory



Scattered crep.

Gastrointestinal System



Scar

Cardiovascular

Hypertn.

Locomotor

2012746039 M
HUGHES 20/12/1974
Scott, S

Neurological system

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

AMT 4 = age, DOB, place, year

AMT score 4/4

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

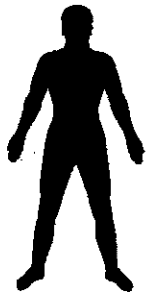
Pupils/fundoscopy:

Cerebellar and extrapyramidal:

Cranial Nerves:

Neck:

Reflexes:



	RUL	LUL	RLL	LLL
Tone				
Power	5	5	5	5
Co-ordination				
Sensation				

Plantars: R L

Skin/Other

2012746039
HUGHES
Scott, S
M
20/12/1974

Key Results

CXR

ECG

NSR. No ischemic chg.

(Differential) diagnosis

Chest pain ?. infection
? pneumothorax.

↑ seizure (known epilepsy)

Alcohol excess

NEWS ☐
Red Flag ☐
Sepsis ☐
CURB 65 ☐

Management Plan

- CT head (verbal)
- CXR (verbal)
- Monitor seizure chart.
- GMAWS.
- ABU Hg/ Cg
- Smoking cessation advice given
- Alcohol improvement explained

Pt is not keen for hospital admission but has agreed to stay in hospital for CT head.

Will likely need d/w neurology before d/c

Next appt 2/6/16 with neurology.

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

Signature: [signature]

PRINT NAME ZHEN MUNDLE

PRINT GRADE ST6

Page:

Patient ID label

Resuscitation Decision

Resuscitation status: FOR RESUSCITATION / DNA CPR (please circle)

If DNA CPR → Complete appropriate form

Senior Medical review

11/5/26 JIHANDAR (CT2)
22:45

→ D/W NEURO (on CALL)

- Agrees ↑ seizure frequency likely 2o To main factors.
  - i- poor compliance
  - ii- Alcohol xs.
- So, we should work on these reversible factors, rather than doing anything to the meds.
- will be seen @ Neuroclinic 02/06/26.

Mention this in EDL.

CXR — Nil acute

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

APPROVED: APR 25
REVIEW DATE: APR 28

NHS Greater Glasgow and Clyde

Glasgow Assessment and Management of Alcohol

NHS Greater Glasgow and Clyde

Please Attach Patient Label
CHI: 2012746039
Name: HUGHES
Scott, S
DoB: 20/12/1974 M
Address: FLAT 7-6
39 LINKWOOD CRES
Glasgow, Lanarkshire
Postcode: G15 7EF

GUIDE TO ALCOHOL UNITS	
Alcohol By Volume (ABV%)	Approximate Units
Strong Lager 9% (440mls)	4 Units
Beer/ Lager 4% (Pint /Can)	2 Units x4
Wine (e.g.Buckfast) 15% (750mls)	11 Units
Wine (Table) 12% (750mls)	9 Units
Alcopops 5% (330mls)	2 Units
Spirits 40% (Litre)	40 Units
Spirits 40% (700mls) x4 vodka's	28 Units
Cider 4% (Litre)	4 Units
Cider 4% (440mls)	2 Units
White Cider 8% (Litre)	8 Units

Estimated Weekly Alcohol Units: 50 **Estimated Date / Time Of Last Drink:** 8pm 11/05

(Daily Units x Number of Days per Week) (If ≥ 5 Days, Re-consider Alcohol Withdrawal Status

Presents with or has had previous alcohol withdrawal seizures or severely agitated withdrawal within 6 months: YES: ☐ NO: ☐

IS IT ALCOHOL WITHDRAWAL?

Consider alternative diagnoses such as delirium, encephalopathy, traumatic brain injury especially if symptoms atypical or prolonged (≥5 days since last alcohol)

Fast Alcohol Screening Tool - FAST:

1. MEN: How often do you have EIGHT or more units on one occasion?
   WOMEN: How often do you have SIX or more units on one occasion?
   Never ☐0 Less than monthly ☐1 Monthly ☐2 Weekly ☐3 Daily or almost daily ☑4
2. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
   Never ☐0 Less than monthly ☐1 Monthly ☐2 Weekly ☑3 Daily or almost daily ☐4
3. How often during the last year have you failed to do what was normally expected of you because of drinking?
   Never ☐0 Less than monthly ☐1 Monthly ☐2 Weekly ☑3 Daily or almost daily ☐4
4. In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?
   No ☐0 Yes, on one occasion ☐2 Yes, on more than one occasion ☑4

Score of 3 or more: FAST Positive

Total 14

FAST Positive? Yes ☑ No ☐

FAST 0-2: Negative: No action required.
FAST 3-4: Hazardous Drinking: Advise safe drinking levels and offer information leaflet / advice.
FAST 5-16: Probable Dependent Drinking: Advice as above and consider referral to Addiction Liaison Service.

EXCEPTIONAL PATIENT GROUP WITH CO-MORBIDITY?

Be aware of Patients with Co-morbidities presenting with features of Alcohol Withdrawal, especially:

- Patients with evidence of advanced liver disease (cirrhosis) especially with jaundice (bilirubin >80μmol/l), coagulopathy (INR/ Prothrombin time ratio >1.5) or history of hepatic encephalopathy
- Patients with other co-morbidity (ie COPD, pneumonia, cerebrovascular disease, reduced GCS, elderly >70, head injury; pregnancy)

REFER TO SECTION 3 (PAGE 3) FOR MANAGEMENT ADVICE

PLEASE INSERT IN PATIENT'S CASE RECORD ON COMPLETION OF TREATMENT

Order Number GGC0169

Glasgow Modified Alcohol Withdrawal Scale (GMAWS)

Treatment Option: GMAWS Only ☐ GMAWS & Fixed Dose ☐

Date	11/05																		
Time	2110																		
Tremor 0) No tremor 1) On movement 2) At rest	0																		
Sweating 0) No sweat visible 1) Moist 2) Drenching sweats	0																		
Hallucination 0) Not present 1) Dissuadable 2) Not dissuadable	0																		
Orientation 0) Orientated 1) Vague, detached 2) Disorientated, no contact	0																		
Agitation 0) Calm 1) Anxious 2) Panicky	0																		
Score	0																		
Treatment	nil																		
Staff Signature	MO																		

Score: (Do not use scoring tool if patient intoxicated, must be at least 8 hours since last drink.)

0 :Repeat Score in 2 hours (Discontinue after scoring on 4 consecutive occasions, except if less than 48hrs after last drink)
1 – 3 :Give 10mg Diazepam: Repeat Score in 2 hours
4 – 8 :Give 20mg Diazepam : Repeat Score in 1 hour
9 – 10 :Give 20mg Diazepam: Repeat Score in 1 hour, discuss with medical staff; may need adjunctive treatment (see Section 4).

EXCEPTIONAL PATIENT GROUPS: SYTMPTOM TRIGGERED TREATMENT
Patients with evidence of advanced liver disease and liver dysfunction: jaundice (bilirubin >80μmol/l), coagulopathy (INR/ Prothrombin time ratio >1.5) or history of hepatic encephalopathy: use Lorazepam 1-2mg
Patients with other co-morbidity (i.e. COPD, pneumonia, cerebrovascular disease, reduced GCS, elderly (>70), head injury): use Lorazepam as above OR Diazepam at 50% of standard GMAWS dose.
In pregnancy use Diazepam at 50% of standard GMAWS

PATIENTS MAY REQUIRE TO BE WOKEN FOR CONTINUING ASSESSMENT

CO-EXISTING ILLNESS MAY AFFECT SCORE: SEEK MEDICAL ADVICE IF IN DOUBT

FIXED DOSING & SYMPTOM TRIGGERED DOSING MUST BE NO LESS THAN 1 HOUR APART

All patients should have regular observations documented. Patients receiving high doses of Diazepam should be assessed regularly for over sedation. If a patient requires more than 120 mg of diazepam or 12 mg of lorazepam in 24 hrs a senior medical review and consideration of adjunct therapy (Section 4) is required

APPROXIMATE ORAL BENZODIAZEPINE EQUIVALENCE: 10mg Diazepam = 1mg Lorazepam = 25mg Chlordiazepoxide

PATIENTS SHOULD NOT BE DISCHARGED ON REGULAR BENZODIAZEPINE

Developed by the Acute Alcohol Screening & Withdrawal Management Guideline Group Chaired by Prof Ewan Forrest, Consultant Physician and Gastroenterologist, GRI

Published:
Review Date:
Version: Edition Amendment

Prophylaxis and Treatment of Wernicke-Korsakoff Syndrome

The guidance applies to all alcohol use disorders; hazardous, harmful and dependent.

ASSESS FOR WERNICKE'S ENCEPHALOPATHY
Does the patient have any of the following signs/ symptoms?

- Confusion
- Nystagmus
- Ataxia
- Opthalmoplegia
- Otherwise unexplained decreased consciousness, hypothermia or hypotension

SYMPTOMS MAY EVOLVE AFTER ADMISSION; continued assessment required

YES

Presumptive diagnosis of Wernicke's Encephalopathy

This requires URGENT treatment

Days 1-3

IV VITAMINS B&C SOLUTION FOR INFUSION: 2 pairs of vials (provides 500mg thiamine) three times a day.
Magnesium: Check Serum Magnesium URGENTLY and give intravenous replacement if deficient.

Days 4-5

Reassess diagnosis of Wernicke's Encephalopathy
If no alternative cause, continue **IV VITAMINS B&C SOLUTION FOR INFUSION :** 1 pair of vials (provides 250mg thiamine) three times a day

Day 6 onwards

Change to **oral Thiamine** 50mg four times a day **or** continue IV Vitamins B&C solution for infusion at the discretion of Medical Team or the advice of Alcohol Liaison team

NO

Assess Risk of Wernicke's Encephalopathy

Risk Factors

Weight loss (MUST≥1)
Minimal oral intake for >3 days
Vomiting for >2 days
Alcohol-related Liver Disease
Presents with Seizure
Age ≤18 or ≥65
Previous Wernicke's Encephalopathy
Unexplained peripheral neuropathy

Risk Factors Present

IV VITAMINS B&C SOLUTION FOR INFUSION : 1 pair of vials (provides 250mg thiamine) three times a day for **48** hours then change to **oral Thiamine** 50mg four times a day

No Risk Factors

Oral Thiamine 50mg four times a day

INTRAVENOUS (IV) THIAMINE PREPARATIONS

Thiamine is ideally administered using an IV high strength multivitamin preparation ('Vitamins B & C solution for infusion' on HEPMA).
If the multivitamin preparation is not available, consult the GGC supply problem page for further advice: https://scottish.sharepoint.com/sites/GGC-ClinicalInfo/SitePages/Medicines-Supply-Problems-and-Shortage.aspx?csf=1&web=1&e=cdjivl&CID=d6557ffd-30ac-4559-9f99-ee3b00812d6e

CHECK MAGNESIUM IN ALL PATIENTS AND CORRECT DEFICIENCY
BOTH Magnesium and Thiamine are co-factors for the enzyme function required to prevent Wernicke's Encephalopathy

PATIENTS WITH ALCOHOL USE DISORDER MAY HAVE OTHER NUTRITIONAL DEFICIENCIES WHICH SHOULD BE ASSESSED AND SUPPLEMENTED

Important notes

- If a patient cannot swallow oral thiamine consider NG administration or intravenous 'Vitamins B & C solution for infusion'. Consult ward pharmacist for advice on NG administration.
- Intravenous 'Vitamins B & C solution for infusion' should be administered over 30 minutes.
- Anaphylaxis is a rare complication of 'Vitamins B & C solution for infusion' administration. Monitor patient for wheeze, tachycardia, breathlessness and skin rash. Resuscitation facilities should be available.
- Discontinuation of oral thiamine should be considered for patients who have been abstinent for 6 weeks and who have established an adequate dietary intake.
- In at risk patients re-admitted within 7 days of a previous admission when intravenous replacement with thiamine or a vitamins B&C solution was given, continued oral therapy can be given rather than a further course of intravenous thiamine.

Management of Alcohol Withdrawal Syndrome

1. SUSPECTED DEPENDENT DRINKING (FAST ≥5)

EXCEPTIONAL PATIENT GROUP WITH CO-MORBIDITY?

- Patients with evidence of advanced liver disease (cirrhosis)
- Patients with other co-morbidity (ie COPD, pneumonia, cerebrovascular disease, reduced GCS, elderly >70, head injury; pregnancy)

See Section 3

YES

NO

RISK OFSEVERE ALCOHOL WITHDRAWAL

Any 2 of the following:

- Presents with or has had previous withdrawal seizures or severely agitated withdrawal **within 6 months**
- High screening score (FAST ≥12)
- High initial symptom score (GMAWS ≥4)

YES

FIXED DOSE TREATMENT (Section 2) PLUS SYMPTOM TRIGGERED TREATMENT (GMAWS)

NO

SYMPTOM TRIGGERED TREATMENT (GMAWS)

2. FIXED DOSE TREATMENT REGIME: Oral Diazepam (see **Section 5** for patients unable to tolerate oral):
INITIAL DOSE: 20mg Diazepam 6 hourly
REDUCE DOSE: If after 24 hours no additional symptom triggered treatment has been required
OR
If after ≥48 hours of treatment GMAWS less than 4

REDUCING DOSE: (Do not prescribe in advance; only step down dose if GMAWS remains less than 4)
15mg Diazepam 6 hourly for 24 hours
10mg Diazepam 6 hourly for 24 hours
5mg Diazepam 6 hourly for 24 hours
5mg Diazepam 12 hourly for 24 hours

3. EXCEPTIONAL PATIENT GROUPS: SYMPTOM TRIGGERED TREATMENT ONLY

- All patients with evidence of advanced liver disease (cirrhosis) should have symptom triggered treatment only. Patients with evidence of liver dysfunction: jaundice (bilirubin >80µmol/l), coagulopathy (INR/ Prothrombin time ratio >1.5) or history of hepatic encephalopathy: use symptom triggered Lorazepam: 1-2 mg
- Patients with COPD, pneumonia, cerebrovascular disease, reduced GCS, elderly (>70), head injury: use Lorazepam as above **OR** Diazepam at 50% of standard GMAWS dose
- In pregnancy use Diazepam at 50% of standard GMAWS dose with senior medical review if more than 30mg required in 24 hours

REVIEW PRESCRIPTION if patient is excessively drowsy
SENIOR MEDICAL REVIEW (FY2 or above) REQUIRED for diagnostic review and possible adjunctive therapy (Section 4):
- If patient requires more than 120mg Diazepam (or 12mg lorazepam) in 24 hours
- If patient still requiring full dose treatment 96 hours after last alcohol ingestion

4. SEVERE WITHDRAWAL (aggressive/ uncontrollable/ dangerous behaviour; high benzodiazepine requirement).

- Reassess diagnosis and consider alternative causes of severe symptoms.
- CONSIDER **Lorazepam**, 1-2mg IM (or IV) and/or adjunctive therapy with **Haloperidol** 2.5 – 5mg IM: assess response (note contraindications to Haloperidol such as prolonged QTc: see GGC Handbook).
- If continued severe behavioural disturbance, refer to local guidelines for escalation of treatment.

5. PARENTERAL BENZODIAZEPINES

- If unable to tolerate oral medication, parenteral therapy at 50% of the oral dose can be given and response assessed.
- Intravenous benzodiazepines should be administered by staff with suitable competencies.

6. MONITORING

- All patients should be closely observed for signs of over-sedation with regular observations
- Consider escalation to High Dependency/ Critical Care management for Exceptional Patient Groups **(Section 3)**, patients with Severe Withdrawal **(Section 4)** and patients requiring parenteral sedation **(Section 5)**.

NHSGGC Adult In-Patient National Early Warning Score (NEWS)

NHS Greater Glasgow and Clyde

2012746039
HUGHES M
Scott, S 20/12/1974
FLAT 7-6
39 LINKWOOD CRES
Glasgow, Lanarkshire
G15 7EP

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

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

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed.....

Medical:.....

Date:.....

Pupil Reaction and size
s = sluggish
+ = reaction
- = no reaction
c = eyes closed
Pupil Size (mm) 1 2 3 4 5 6 7 8

Glasgow Coma Scale

Date:
Time:
1/1
51.00

EYES	Eyes closed by swelling = NT	Spontaneously	4
		To sound	3
		To pressure	2
		None	1
		Not testable	NT
VERBAL	Endotracheal tube or tracheostomy = NT	Orientated	5
		Confused	4
		Words	3
		Sounds	2
		None	1
		Not testable	NT
MOTOR	Always record the best response	Obeys command	6
		Localising pressure	5
		Normal flexion	4
		Abnormal flexion	3
		Extension	2
		None	1
		Not testable	NT
TOTAL	15		
PUPILS	Right size:	4	
	Right reaction:	+	
	Left size:	4	
	Left reaction:	+	
ARMS	Record right (R) and left (L) separately if there is a difference between the two sides	Normal power	
		Mild weakness	
		Severe weakness	
		Spastic flexion	
		Extension	
		No response	
LEGS	Record right (R) and left (L) separately if there is a difference between the two sides	Normal power	
		Mild weakness	
		Severe weakness	
		Spastic flexion	
		Extension	
		No response	

2012746039
HUGHES M
Scott, S 20/12/1974
FLAT 7-6
39 LINKWOOD CRES
Glasgow, Lanarkshire G15 7EP

Pain Function Score

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

Pain Score

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

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

mi • 316454 v5.2 GGC0264

NEWS 2 Key	1	2	3

Parameter	Key	Entry
Date	1/11	1/5
Time	11.00	9.45

A + B Respirations Breaths/min	Key	Entry	Range	Score
			≥25	3
			21-24	2
	•	18	12-20	0
			9-11	1
			≤8	3

A + B SpO2 Scale 1 Oxygen saturation (%)	Key	Entry	Range	Score
	97	100	≥96	0
			94-95	1
			92-93	2
			≤91	3

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

Air or oxygen?	Key	Entry	Range	Score
	A	A	Air (A) or O2 device*	0
			O2 L/min 2	2

C Blood Pressure mmHg (Score uses systolic BP only)	Entry	Range	Score
		≥220	3
		201–219	0
		181–200	0
		161–180	0
		141–160	0
	116	121–140	0
	A	111–120	0
	V	101–110	1
	95	91–100	2
		81–90	3
		71–80	3
		61–70	3
		51–60	3
		≤50	3

C Pulse Beats / min	Key	Entry	Range	Score
			≥131	3
			121-130	2
			111-120	2
			101-110	1
			91-100	1
		77	81-90	0
	•		71-80	0
			61-70	0
			51-60	0
			41-50	1
			31-40	3
			≤30	3

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

E Temperature	Key	Entry	Range	Score
			≥39	2
		36.7	38.1-39.0	1
			37.1-38.0	0
	•		36.1-37.0	0
			35.1-36.0	1
			≤35.0	3

Item	Key	Entry
NEWS Total	0	0
Blood glucose	7.0	NA
Pain / function score	OA	8
Time Pt last passed urine	10.20	15 30
Fluid balance chart indicated Y/N	N	N
GCS indicated Y/N	N	N
Time NEWS due	23.00	21 45
Escalation of care Y / N	N	N
Initials	AB	8

Abbreviations for recording oxygen device

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

2012746039
HUGHES
Scott, S 20/12/1974 M
FLAT 7-6
39 LINKWOOD CRES
Glasgow, Lanarkshire G15 7EP

2012746039
HUGHES
Scott, S 20/12/1974 M
FLAT 7-6
39 LINKWOOD CRES
Glasgow, Lanarkshire G15 7EP

NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

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

Think ACE

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

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

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

Name: Write or affix label
2012746039
Address: HUGHES M
CHI: Scott, S 20/12/1974
DOB: FLAT 7-6
Hospital 39 LINKWOOD CRES
Glasgow, Lanarkshire
G15 7EP

Peripheral Venous Cannula (PVC) Insertion & maintenance

Please complete insertion details for each PVC inserted

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

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

NHS Greater Glasgow and Clyde

Insertion details:	Where inserted:	Insertion site:	Side:	Size of cannula:	Inserted by:
Date: 11/5/26	☐ ED ☐ Theatre ☐ ITU/HDU	☐ Hand	☐ Left	☐ 26G Purple	Print: MN
(Day 1)	☐ Ward MAU	☑ Arm	☐ Right	☐ 24G Yellow ☐ 18G Green	Signature:
Time: 18:00	☐ Unknown	Other		☐ 23G Blue ☐ 16G Grey	Designation: CN
				☑ 20G Pink ☐ 14G Orange	

Clinical indication:	☐ Diagnostics	☑ Resuscitation	☐ IV medications	☐ Fluids	☐ Transfusion

Insertion criteria:	Hand hygiene performed	Skin decontamination (2% chlorhexidine in 70% isopropyl alcohol)	Sterile transparent semi-permeable dressing affixed	PVC explained to patient/carer
	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No

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

Justify the need for your patient to have a PVC using the DRIFT mnemonic.
- ✓ Diagnostics - Does the patient need the PVC for a diagnostic procedure e.g. CT scan
- ✓ Resuscitation - Is the patient at risk of cardiac or respiratory arrest?
- ✓ Intravenous (IV) - Does the patient require intravenous (IV) medication? Could these be switched to another route?
- ✓ Fluids - Does the patient require IV fluids? Could this be switched or oral fluids?
- ✓ Transfusion - Does the patient require a transfusion of blood products?

Signs of local or systemic infection

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

Systemic Infection
- Hypotension
- Tachycardia
- Pyrexia

Adult IVOST Guideline:

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

IV → Oral Antibiotic Switch Therapy (IVOST) Guideline

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

Switch to oral when:
- a **CLINICAL IMPROVEMENT** in signs of infection eg: temperature ≤37.9°C, reduction in the NEWS score, improving SEPSIS
- a **ORAL ROUTE** is available reliably (eating/drinking no concerns regarding absorption)
- a **UNCOMPLICATED INFECTION** i.e. specialist advice not required prior to IVOST: Infection requiring specialist advice includes CNS infection, Cystic fibrosis, S. aureas bacteraemia (minimum 14 days IV), Endocarditis, Vascular graft or bone/joint infection, Undrainable deep abscess.

DO NOT use CRP in isolation to assess IVOST suitability as does not reflect severity of illness
Record the stop date on HEPMA

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

Paediatric IVOST Guideline:

Write or affix label

Name:

Address:

CHI:

DOB:

Hospital & Ward:

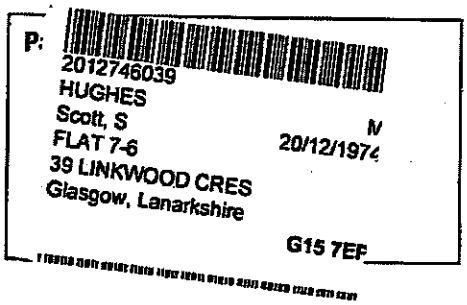
PVCs should be removed as soon as no longer clinically indicated.

NHS Greater Glasgow and Clyde

Maintenance – to be completed twice daily (Observe for signs and symptoms of local or systemic infection)													
Date	Need for PVC reviewed today?		Any sign of PVC site infection?		Is the dressing intact?		Before / after PVC procedures; hand hygiene performed?		PVC patent?		What has been done?		Sign: Print: Designation:
	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	
Day 1 Insertion Date __/__/__	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 2	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 3	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 4	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 5	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 6	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 7	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Removed	Day Night

PVCs should be removed on day 7. Reassess ongoing needs and vessel health for most appropriate vascular access device. Date removed __/__/__					
Reason for removal	☐ Site infection	☐ Infiltration	☐ Extravasation	☐ End of treatment	Other:

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



Medical patient thromboprophylaxis decision aid – ENSURE BLACK BOX COMPLETED

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

☐ Yes

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

☐ Yes

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

☐ No

☐ No

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

☐ No

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

☐ Yes

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

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

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

Pati
2012746039
HUGHES
Scott, S
M
20/12/1974

Results

Date / Time		11/5/14							
Parameter	Ref Range								
Hb	Male: 130-180 Female: 110-165	151							
WCC	4.0 - 11.0	12.4							
Plts	150 - 450	257							
MCV	80 - 100	93.4							
Neut	2.0 - 7.5	8.9							
PT	9.0 - 13.0								
APTT	27.0 - 38.0								
Fibrinogen	1.7 - 4.0								
INR	( )								
Thromb T	11-15 secs								
D-Dimer	0 - 250								
Na+	133 - 146	140							
K+	3.5 - 5.3	4.1							
Cl-	95 - 108	101							
HCO3-	22 - 29								
Urea	2.5 - 7.8	4.3							
Creat	40 - 130	79							
eGFR		>60							
Glucose	3.5 - 6.0								
Protein	60 - 80								
Albumin	35 - 50	44							
AlkP	30 - 130	116							
Bil	<20	6							
ALT	<50	51							
AST	<40	76							
GGT	Male: <70 Female: <40								
ESR	Male: 1-10 Female: 1 - 12								
CRP	<10	4							
Troponin hs I	Male: 0 - 34 Female 0 - 16								
CK	Male: 40 - 230 Female: 25 - 200								
Corr Ca++	2.20 - 2.60								
PO4-	0.8 - 1.5								
Mg++	0.70 - 1.00								
Alcohol									
Paracetamol	<100 @4 hr								
Salicylate									
AST	<40								
Amylase	<100								
LDH	170 - 380								
Folate									
B12	200 - 900								
Ferritin	Male: 20 - 300 Female: 15 - 200								
TSH	0.35 - 5.00								
Free T4	9.0 - 21.0								
Digoxin	0.5 – 2.0								

2012746039
HUGHES
Scott, S
M
20/12/1974

Post Take Ward Round IAU/ARU

Consultant: _____ Date: _____ Time: _____

Summary

Temp:

Pulse:

BP:

SpO_2:

FiO2:

RR:

Diagnosis:

Plan:

Recommended Destination: _____

Suitable to board if required ☐ Yes ☐ No

Expected Date of Discharge: _____

Signature: _____

Designation: _____

Bleep Number: _____

Patient ID label

Continuation Sheet

Date: Time

Patient ID label

2012746039.

Continuation Sheet

Date: Time	

Patient ID label

Continuation Sheet

Date: Time	

Patient ID label

2012746039

Continuation Sheet

Date: Time	

Patient ID label

Nursing Documentation

Done/ Time	

Once only prescriptions (inlcuding tetanus prophylaxis)

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

Discharge prescription packs

Date Given	Drug (Block Capitals)	Dose	Method of administration	Frequency	Signature	Given by
11/05/26	AMOXICILLIN (5 DAYS).	500mg	PO	TDS		MO

DISCHARGE CODES: Please Circle

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

Time Ready to Depart								
Discharge Time								
Ward No. (If admitted)		Transfer to Hospital				Consultant (if admitted)		
Outpatient clinic specialty						Admission or specialty clinic consultant		
Clinic Referred to	AE	CP DVT	DME Falls	TIA	Medical	Surgical	First Seizure	Others Specify

2012746039

11 55 oct 3D Line

Acute Services Division

Glasgow Ophthalmology Acute Referral Centre

NHS Greater Glasgow and Clyde

Date: 14/02/26	Time: 11:45
GP Details Dr. A Martin Garscadden Burn Medical Practic Drumchapel Health Centre 80/90 Kinfauns Drive Glasgow G15 7TS	**Patient Details** 2012746039 HUGHES M Scott, S 20/12/1974 FLAT 7-6 39 LINKWOOD CRES Glasgow, Lanarkshire G15 7EP
	Patient Tel No:

Outcome			Instruct patient to take this sheet to Reception for all PCC Appointments ≤ 2/52
≤ 2/52 GGH Primary Care Clinic	days	weeks	
Clinic (>2/52)	weeks	months	**Follow Up Hospital**
Admit			Local
Discharge			Other

Follow Up Specialty	Follow Up Consultant:			
General		Medical Retina	Macula	* Not GRI/SGH
Cornea	* Not GRI		Diabetic	
Oculoplastics			Uveitis	* GGH Only
Glaucoma		Surgical Retina (VR)		* GGH Only
Motility	* Not GRI/SGH	Neuro-ophthalmology (Not suitable for PCCS without Consultant approval)		* SGH Only
Chalazian (Nurse)		Minor Ops (Doctor)		* NVH/SGH Only
Oncology	* GGH Only	OTHER (Please specify):		

Follow Up Investigations			
Refraction		Orthoptics	
Fields		Other	

Designed by Medical Illustration Services reference 251373

Glasgow Ophthalmology Telephone Triage

Date: 13/2	Time:	Referrer:	Optom ☑
Patient Name: Scott hill		Postcode:	GP ☐
Date of Birth/CHI: 2012746039			Patient ☐
Telephone No:			Other ☐

51

Concerns VA Right VA Left

ant uveitis (new) 6/6 6/9
· pain + tender LE few days.
cells in Ant chamber. 17/19

Surgery ☐	Date:	Operation:	
IVT ☐	Date:		
Other ☐			

Symptoms

Duration of Symptoms	<24 Hours	≥24 Hours	>48 Hours
	☐	☐	☐

Loss or Deterioration of Vision	☐	Is the eye red looking?	☐
Is the patient photophobic?	☐	Any discharge?	☐
Flashing lights/increased floaters?	☐	Any known trauma?	☐

Pain Score 1 2 3 4 5 6 7 8 9 10

Previous Ocular History

Action Plan

Advice Given/Concern Resolved?	Yes ☐	No ☐

Advice Provided:

Appointment Required?	Yes ☐		No ☐	
Appointment Made:	Yes ☐	No ☐	Date	Time
Today ☐	48Hrs ☐		14/2	9NS
24Hrs ☐	Non-Emergency ☐			
Referred to Optom/GP ☐				11.45

Covid-19 Survey	Yes	No
Shielding?	☐	☐
Self-Isolating?	☐	☐
Fever	☐	☐
New Continuous Cough	☐	☐
Loss of taste/smell	☐	☐

Mobility Issues:

	Yes	No
Transfer	☐	☐
Slit Lamp Examination	☐	☐
Interpreter	☐	☐

Signature: Notes:

Y.D

OPTOMETRIST GENERALOPHTHALMIC REFERRAL FORM
PLEASE SEND TO

NHS
Greater Glasgow and Clyde

☐ Inverclyde Royal Hospital ☐ Royal Alexandra Hospital ☐ Vale of Leven Hospital

☑ Gartnavel General Hospital ☐ Glasgow Royal Infirmary ☐ Stobhill Hospital

☐ Royal Hospital for Sick Children ☐ Southern General Hospital ☐ Victoria Infirmary

Patient Details	**General Practitioner Details**	**Optometry Practice Details**
Mr Scott Hughes 76 Linkwood Crescent Glasgow G15 7EP CHI 2012746039 DOB 20/12/1974 Ethnic Background Telephone No M: 07787255019	Practice Murray Opticians Address 22 Dunkenny Rd Glasgow G15 8NB Telephone No 0141 944 6627	Practice Drumchapel Health Centre Address Drumchapel Health Centre 80-90 Kinfauns Drive Glasgow G15 7TS Optometrist Name Ahmed Umair Qazi Optometrist Signature Date of referral Friday 13 February 2026 Telephone No

TYPE OF REFERRAL ☑ Acute Red Eye ☐ Cyst / Infection ☐ Sudden Vision Loss ☐ ARMD ☐ Cataract ☐ Glaucoma ☐ Retinal ☐ Corneal ☐ Neurological ☐ Oculoplastic (Lids/Lacrimal) ☐ Squint ☐ Paediatric
Other, please specify

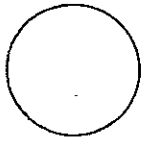
Unaided VA	Sph	Cyl	Axis	Prism	Base	VA	Add	Near VA
Left 6/6								
Left 6/9								

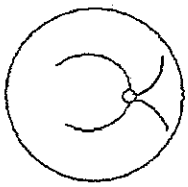
Primary Patient Complaint	Primary / Provisional Diagnosis: anterior uveitis
pain in LE only onset 5/7, tender to touch. no redness, no problem with vision	Secondary Diagnosis / Other Conditions: Blepharitis demodex
Duration of Signs / Symptoms	Past Ocular History:

Additional Information / Clinical Findings: No llimbal redness noticed today however, there were few white cells seen in the anterior chamber, no flare.	IOP **Applanation** mmHg	Attached files **Fields** ☐ **Photograph** ☐ **OCT** ☐

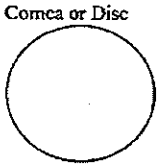
	R L 1 17 19 2 **Pachymetry**	**Medical Fields** ☐ **Other**.....
Repeat fields Y/N	Dilated Fundoscopy Y/N	

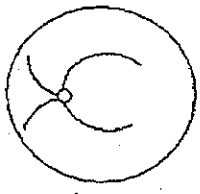
Cornea or Disc





Cornea or Disc





FOR ATTENTION OF GENERAL PRACTITIONER

☐ **FOR ACTION** — Referral to Ophthalmology completed by Optometrist. Please send past medical history and drug history via SCI Gateway to the Hospital indicated above.

☐ **FOR INFORMATION ONLY** — No action required. Patient referred as emergency to Eye Casualty by Optometrist.