

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



**MMA LEGAL
STOK, 43 - 59 PRINCES STREET,
STOCKPORT,
SK1 1RY**

**Date: 11th MAY 2026
Your Ref: 100183
Our Ref: SAR/TEAM/TH
Enquiries to: Tracy Hunter
Direct Line: 0141 211 0667
Email: tracy.hunter3@nhs.scot**

Dear Sir/Madam

**Re: Subject Access Request under the General Data Protection
Regulation**

Patient: GEORGINA LOGAN

Date: 19.08.1954

Thank you for your request received **22ND APRIL 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:

**GARTNAVEL GENERAL HOSPITAL – QUEEN ELIZABETH
UNIVERSITY HOSPITAL – WEST AMBULATORY CARE HOSPITAL – NEW
VICTORIA INFIRMARY – HOSPITAL RECORDS**

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

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

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

- Patient health records, photographs or radiology images
- Video/telephone recordings, including CCTV images

- Witness statements
- Incident reports
- Complaints files
- Emails

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

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

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

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

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

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

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

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

Yours sincerely

SAR Team

ELECTRONIC PATIENT RECORDS

(1)

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:

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

Gartnavel General Hospital
1053 Great Western Road
Glasgow G12 0YN

10/02/2020

Dr DF Spence
Barclay Medical Practice Victoria P
1398 Dumbarton Road
Glasgow
G14 9DR

Dear Dr DF Spence

Re: Georgina Logan
Address: 17 SOLLAS PLACE KNIGHTSWOOD
Glasgow
G13 4NA

CHI Number: 1908546042

Speciality: General Surgery

It would appear from our records that:

- ☒ Your patient has not responded to our recent letters inviting them to arrange an appointment.
- ☐ Your patient has indicated that they no longer require an appointment.
- ☐ Your patient has refused two reasonable offers of appointment.

We therefore assume that your patient no longer needs this appointment. We have removed their name from the waiting list. This is in line with NHS Greater Glasgow and Clyde's Did Not Attend Policy.

If you still wish your patient to be seen, we will require a new referral.

Yours sincerely

Irene Hunter

1908546042
LOGAN
Georgina
17 Sollas Place
Glasgow, Lanarkshire
G13 4NA

19/08/1954

F

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)



Date <u>5/6/25</u> Time _____ of initial height and weight on admission to hospital	Actual	* Patient reported	* If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height <u>149</u> cm	☐	☒	<u>MS</u>
Admission Weight <u>69</u> Kg	☐	☒	

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

Patients reported normal weight 11 stone 10 lb Unable to Recall ☐

Any unplanned weight loss in the last 6 months Yes ☐ how much _____ No ☒ Don't Know ☐

Date	<u>5/6/25</u>							
Time	<u>14:50</u>							
Ward	<u>8B</u>							
Oedema/ Ascities present Y/N	<u>N</u>							
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes	<u>CH</u>							
Weight (kgs)	<u>69.75</u>							
BMI	<u>31.4</u>							

Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days

Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	<u>0</u>							
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	<u>0</u>							
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	<u>0</u>							
Step 4 Overall Risk of Malnutrition TOTAL	<u>0</u>							
Rescreen on	<u>12/6</u>							
Signature	<u>SW/100</u>							

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

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

Assessment Centre COVID-19

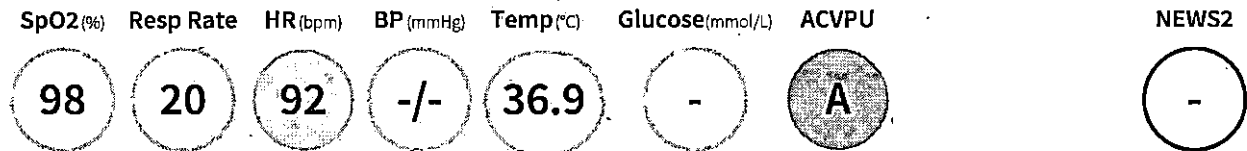
NHS GGC - Barr Street

3 Dec 2021, 17:52

Patient Georgina Logan

CHI 1908546042

Age 67



Situation

CHI

1908546042

Sex

Female

Firstname

Georgina

Lastname

Logan

DOB

19 Aug 1954

PostCode

G13 4NA

Address

17 Sollas Pl
Glasgow
G13 4NA

GP

Dr Desmond Spence

Assessor given name

Rachel

Assessor surname

Green

Assessment Centre

NHS GGC - Barr Street

Background

Living arrangements

Lives with family

Level of independence (Frailty Score) - Pre symptoms

3: Managing well

Capacity

Yes

ACP?

No

DNA CPR?

Unknown

Comorbidities Respiratory

Asthma

Other relevant comorbidities

No

Previous / Current Malignancy	No
Immunodeficiency / Organ Transplant	No
Long term oxygen	No
Home ventilation	No
Home nebulisation	No
Smoking Status	Non Smoker
Does patient Vape?	No
Pregnant	No
Postpartum Last 6 Weeks	No
Allergies	No
Notes	
AF	
Diverticulosis.	

COVID-19	
Onset of First Symptom	1 Dec 2021
Symptoms - Flu like	Cough, Fatigue / Malaise
Symptoms - Respiratory	Shortness of breath (dyspnoea)
Trend	Worse
Able to do activities of daily living	Normal
Fluid intake	Normal
COVID-19 test result	Not Tested
Healthcare worker	No
Co-habit with confirmed or suspected COVID-19	Yes
Co-habitee details	
has been in contact with family who have tested positive for covid-19 2 weeks ago.	
Recent confirmed COVID-19 infected contact	No
Flu vaccine this season	Yes
COVID-19 vaccine	Yes

Notes

unwell for 3 days:

cough- productive of green phlegm

SOB on exertion

says she has been feeling wheezy, has been using saba, is getting relief.

no CP but says it does feel tight

was also concerned about a UTI, says burning when urinating, strong smell, frequency.

A/B Assessment		C Assessment		D Assessment		E Assessment	
SpO2 (On arrival)	98 %	HR	92 bpm	ACVPU	Alert	Temp	36.9 °C
RR	20	Cap refill	Not Performed				
Increased work of breathing	No						
Right lung findings	Not examined						
Left lung findings	Not examined						
O2	Room air						

Assessment Notes

Notes

dipped urine:
leukocytes (++)
GP review
covid swab- consent given
reminded of isolation guidelines and given 'self care at home' leaflet.
going home with treatment and worsening advice.
patient reassured.

Recommend

COVID-19 Presentation?	Unsure
COVID-19 test performed today	Yes
Type of test	Lab-based PCR
Treatment	
amox 5 days	
Disposition	Home
Actions discussed with	Patient
Advice Given	Verbal, Written
Is followup required?	No

Recommend notes

67 year old lady

See pmh and DH—Asthma

Day 3 -cough -wheeze—mild soboe

No pleuritic chest pain

Covid vaccs up to date

Urinary frequency and burning few days ---smelly urine

Exam -well lady ---chatty

speaking freely

Obs -normal

Chest clear ---good AE

Impression - Likely viral exac Asthma --no worrying features ---and UTI

Says would not take trimethoprim or co-amox ----so px Amox 5 days

Will hand urine in to GP next week if no better

Red flags discussed and strong WSG

Covid test

Self-isolation guidance discussed

GP FU as needed with thanks ---assuming neg Covid test

Many thanks

Dr Janice Oliver 3181687

Review Type

Face to face

LOGAN, Georgina (Mrs)

BORN 19-Aug-1954 (71y) GENDER Female

CHI 1908546042

*** COVID-19 Community Assessment Centre Medicines**

Last updated by Woodside CLINICAL28 (WHCCLIN028) 4.5 years ago (v. 1) Show History

! For Community Assessment Centre Use OnlyContent Restricted ☐ No

If the information on this form merits further restriction than that of Highly Sensitive, please select Yes to apply a Privacy Seal

Sensitivity

☐ Sensitive

The information on this form will be viewable by health and care providers with the appropriate access permissions

Assessment Centre

Location

Barr St Centre

Assessor

Dr Janice Oliver 3181687

Role

gp

Medicines Required

Bronchodilators

☐ No

Antibiotics

☒ Yes**Antibiotics**

Amoxicillin

12 Years and Over - Amoxicillin 500mg capsules - ONE three times daily

Clarithromycin

☐

Doxycycline

☐

Lower UTI

☐

Upper UTI \ Pyelonephritis

☐

Acute sore throat/tonsillitis

☐

Steroids

☐ No**Equipment and Sundries**

Peak Flow Meters - Adult and Paediatric

☐ No**Other Medications**

Analgesic/Pyrexia

☐ No

Nausea/Vomiting

☐ No

Additional Notes / Summary

☐**Print**

Assessment Centre COVID-19

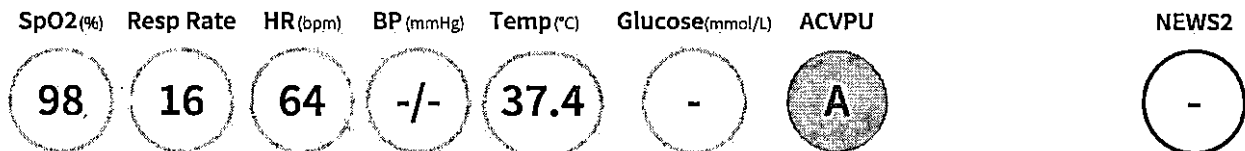
NHS GGC - Barr Street

5 Feb 2021, 17:53

Patient Georgina Logan

CHI 1908546042

Age 66



Situation

CHI	1908546042
Sex	Female
Firstname	Georgina
Lastname	Logan
DOB	19 Aug 1954
PostCode	G13 4NA
Address	17 Sollas Pl Glasgow G13 4NA
Contact number (Mobile is preferred)	07774400790
GP	Dr Desmond Spence
Assessor title	miss
Assessor given name	Lucy
Assessor surname	McKell
Assessment Centre	NHS GGC - Barr Street

Background

Living arrangements	Lives with family
Level of independence (Frailty Score) - Pre symptoms	3. Managing well
Capacity	Yes
ACP?	Unknown
DNA CPR?	Unknown

Comorbidities Respiratory	Asthma
Comorbidities Cardiovascular	Chronic heart failure
Comorbidities Other	Chronic kidney disease
Other relevant comorbidities	No
Previous / Current Malignancy	No
Immunodeficiency / Organ Transplant	No
Long term oxygen	No
Home ventilation	No
Home nebulisation	No
Smoking Status	Ex Smoker
Does patient Vape?	No
Pregnant	No
Postpartum Last 6 Weeks	No
Allergies	No
Notes	
see ECS/KSI	
Awaiting follow up regarding IBS.	

COVID-19	
Onset of First Symptom	3 Feb 2021
Symptoms - Respiratory	Shortness of breath (dyspnoea)
Symptoms - Abdomen	Abdominal pain
Symptoms - Neuro	Headache
Trend	Stable
Able to do activities of daily living	Reduced
Fluid intake	Normal
COVID-19 test result	Negative
Healthcare worker	No
Co-habit with confirmed or suspected COVID-19	No
Recent confirmed COVID-19 infected contact	No
Flu vaccine this season	No
COVID-19 vaccine	No

A/B Assessment		C Assessment		D Assessment		E Assessment	
SpO2 (On arrival)	98 %	HR	64 bpm	ACVPU	Alert	Temp	37.4 °C
RR	16						
Increased work of breathing	No						
O2	Room air						

Assessment Notes
Notes
Awaiting medical assessment

Recommend	
COVID-19 Presentation?	Unsure
COVID-19 test performed today	Yes
Type of test	Lab-based PCR
Treatment	
amoxicillin 500mg tid	
prednisolone 30mg od	
Disposition	Home
Actions discussed with	Patient
Advice Given	Verbal
Is followup required?	No

Recommend notes

66yo

hx of asthma, AF, previous pericarditis

24 hour hx increased wheeze, mild cough, brought up some green phlegm yesterday.

was wheezy this am but settled quickly. feels fine now this evening but more wheeze overall last 2 nights

no chest pain, no fever, no change in taste / smell

mild SOB when wheeze but otherwise fine

o/e

looks well

obs fine

chest - mild scattered wheeze. no creps, good AE

HS 1+2+0 - good volume

abdo soft non tender

imp - ?asthma exac

??covid

test taken

for amox / prednisolone

strict worsening advice given if any worsenniong of sx / feeling more unwell to seek review via 111

My Admission Record



77 to 90 21/1/26

Hospital: QCUH Ward: 9B
 Date of Admission: 20/1/26 Time: 09:00
 Information obtained from: Name: Georgina
 Patient ☒ Relative ☐ Other ☐
 Preferred Name: Georgina
 Age: 71 Telephone Number: 073426644 10
 Consultant: Ms Donance

Name: LOGAN
 Address: Georgina
17 Sollas Place
Glasgow, Lanarkshire
 DoB: 19/08/1954
 CHI: G13 4NA
 Affix patient ID label

H/w OK
 Ted 13
 WSV 17 med

Communication

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

Preferred first contact

Name: George
 Relationship: Husband
 Address: _____
 Telephone: 07760159467
 Is this person aware of your admission?
 Yes ☒ No ☐
 Can we share information with this person?
 Yes ☒ No ☐

Preferred second contact

Name: _____
 Relationship: _____
 Address: _____
 Telephone: _____
 Is this person aware of your admission?
 Yes ☐ No ☐
 Can we share information with this person?
 Yes ☐ No ☐

Presenting Complaint / Diagnosis

Abdo pain and vomiting ? obstruction
 Explained to the patient? Yes ☐ No ☐ Not Applicable ☐
 Do you understand the reason for your admission? Yes ☐ No ☐

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

No known allergies ☒ Dairy

Relevant past medical history

Cramps
Pericarditis
UTI's
L2/L3 lumbar decompression
Dermatolitis
ASTHMA
AF
IBS

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place

Yes ☐ No ☒ If yes, Who asked for a copy? _____

Date they asked for a copy / / Date Obtained / /

Power of Attorney / Guardianship / Adult with Incapacity

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

Yes ☐No ☒**OR**

Does someone have Guardianship?

Yes ☐No ☐If yes, is this for:- Finance ☐ Welfare ☐ Both ☐Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

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

Name:

Address:

1908546042

LOGAN

Georgina

17 Sollas Place

Glasgow, Lanarkshire

19/08/1954

G13 4NA

DoB:

CHI: _____

Affix patient ID label

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:

1. Been an inpatient in a hospital outside Scotland?

Yes

No

2. Received holiday dialysis outside Scotland?

3. Been told that you have CPE?

4. Been in close contact with a person with CPE?

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

Isolate the patient in a side room

Obtain Rectal swab marked 'for CPE'

If patient refuses rectal swab, obtain a stool specimen marked 'for CPE'

and inform the IPCT**MRSA Screening**

Will the patient be an inpatient for more than 23 hours

If **YES** complete the following section

1. Have you ever been told that you have MRSA?

2. Have you been admitted from another hospital/ residential setting or care home?

3. Do you have a wound / skin ulcer or invasive device which you had before admission?

Yes

No

Unsure

If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabsNasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐**Creutzfeldt-Jakob Disease (CJD)**

Have you ever been informed that you are at increased risk of CJD or vCJD?

If **YES** inform the IPCT ☐

Yes

No

Unsure

Name		
Address	1908546042	F
	LOGAN	
	Georgina	19/08/1954
	17 Sollas Place	
	Glasgow, Lanarkshire	
DoB:		G13 4NA
CHI:		
Affix patient ID label		

Lifestyle

Smoking

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

Never smoked ☒

Do you use eCigarettes? Yes ☐ No ☐

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

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

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

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

Drugs

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

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

Alcohol

Do you drink alcohol? Yes ☐ No ☒

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

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

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

Name (Please PRINT): LISA DUNN

Signature: 

Designation: SCN

Date: 20/1/26

My Assessment Record

Name: 

Address: 1908546042
 LOGAN
 Georgina
 17 Sollas Place
 Glasgow, Lanarkshire

DoB: 19/08/1954 F
 CHI: G13 4NA

Affix patient ID label

1. Breathing and Circulation			
Breathing	Admission Presentation	Normal for the patient	Assessment of the patient's breathing
No breathing problems	✓	✓	Asthma
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers	✓	✓	
Oxygen therapy			
Do you have any other symptoms?			
Circulation	Admission Presentation	Normal for the patient	Assessment of the patient's circulation
No circulatory problems	✓	✓	Pericarditis
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			
2. Communication			
	Yes	No	Assessment of the patient's communication needs
Do you have any difficulties communicating your needs?	✓	✓	
Do you have any difficulties with your speech?			
Do you have a Learning Disability?			
Do you have support from a Learning Disability Team?			
Contact details:			

Name: _____
 Address: _____
 1908546042
 LOGAN
 Georgina
 F
 19/08/1954
 DoB: _____
 CHI: _____
 Affix patient ID label

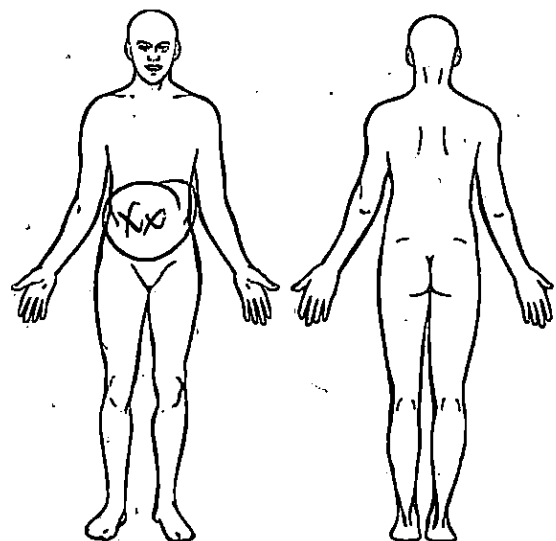
3. Senses

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

Can you describe where and what the pain is like?

Mark current pain on body chart

Have you had treatment / intervention for the pain?



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

Can you describe any chronic pain that you have?

What makes the pain better?

Name			
Address	1908546042	LOGAN	F
	Georgina	17 Sollas Place	19/08/1954
	Glasgow, Lanarkshire		
DoB:		G13 4NA	
CHI:			
Affix patient ID label			

4. Cognitive Status **THINK DELIRIUM**

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

N.B. Think Delirium

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

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

and follow the guidance

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

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

Dairy intolerance

What do you like to eat and drink?

no preferences

What do you not like to eat and drink?

no preference

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

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓	Name:  Address: 1908546042 LOGAN Georgina 19/08/1954 DoB: _____ CHI: _____ Affix patient ID label
Normal diet and fluids		✓	Assessment of the patient's hydration and nutrition needs
Therapeutic diet			
Cultural, ethnic or religious diet			
Texture Modified Diet Please state _____			
Thickened Fluid Please state _____			
Oral Nutritional supplements Preferred flavour _____			
Enteral Nutrition			
Parenteral Nutrition			
Nil by Mouth	✓		
N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS) within 4 hours of admission			
Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓	
Independent (Green)	✓	✓	
Prompting / encouragement / opening packets/cutting up food (Amber)			
Full assistance with eating and drinking (Red)			
Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?			
6. Elimination			
Bladder	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Pass urine with no problems	✓	✓	
Frequently pass urine during the day			
Frequently pass urine overnight			
Sense of urgency when need to pass urine			
Urine retention			

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓	Name: _____ Address: 1908546042 LOGAN F Georgina 19/08/1954 17 Sollas Place Glasgow, Lanarkshire DoB: _____ CHI: _____ Affix patient ID label
Haematuria			
Incontinent			

N.B. If new incontinence report to medical staff to rule out infection or physiological cause

What products do you normally use for this continence issue?

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

Date urinary catheter last changed ____/____/____

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

Bowels

When did your bowels last move? *crushed* 20/1/26

How often in a day/week do you have a bowel movement? Per day Per week

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

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

What products do you normally use for this continence issue?

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

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

Name:

Address:

1908546042
LOGAN
Georgina
17 Sollas Place
Glasgow, Lanarkshire
19/08/1954
G13 4NA

DoB:

CHI:

Affix patient label

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

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

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

Pressure ulcer identified on admission: Yes ☐ No ☒

Pressure Ulcer Grade: _____

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

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

Wound Care	Yes ✓	No ✓	Nam _____ Addr _____ 1908546042 LOGAN Georgina 17 Sollas Place Glasgow, Lanarkshire DoB _____ CHI: _____ Affix patient ID _____
Do you have any wounds? N.B. If yes, complete an assessment chart for wound management		✓	F 19/08/1954 G13 4NA

8. Mobility

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

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

9. Maintaining a Safe Environment

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

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

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

10. Sleep and Rest

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

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11. Social Circumstances

Do you:

- Live alone ☐ Live with family/ friend/ other ☒
 Live in a nursing home ☐ Live in a care home ☐
 Live in residential supported care ☐ Live in student accommodation ☐
 Live in 'homeless' accommodation ☐ Have no fixed abode ☐
 Other please specify _____ ☐

Dependants

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

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

Services

	Yes ✓	No ✓
Do you have support from social work, social services or a care package?		✓
If yes, please provide details:		
If yes, has contact been made to cancel arrangements during admission?		

12. Emotional and Spiritual Care

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

MM

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

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

Healthcare Chaplain informed Yes ☐ N/A ☒

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13. Person Centred Care

What matters and is important to you whilst you are in hospital?

This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

*feeling better
getting home*

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

Informal Support

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

Husband.

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

Name:

Contact Details:

.....

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

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

Yes ☐ No ☐

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

Nam _____
 Adc 1908546042 _____
 LOGAN _____
 Georgina _____
 17 Sollas Place _____
 Dc Glasgow, Lanarkshire _____
 Cl _____
 Affix patient _____
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 G13 4NA _____

Required Support

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

Yes ☐ No ☒

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

Has the carer been advised of the Carers Information Line?

Yes ☐ No ☐ Not appropriate at this time ☒

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?

Yes ☐ No ☒

Are you:

Employed ☐

Unemployed ☐

Self-employed ☐

Retired ☒

Full time education ☐

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

Yes ☐ No ☐ Not applicable ☒

Do you have any money worries?

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

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

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

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

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

If yes when was patient referred ____/____/____

Risk Assessments/Other Documentation

Name:  _____
 Address: 1908546042 _____
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 Georgina 19/08/1954 _____
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Additional NHSGGC Documentation	Required		Required documents completed		Date, Print and Sign when completed
	Yes ✓	No ✓	Yes ✓	No ✓	
Glasgow Assessment and Management of Alcohol (GAMA)					
Generic Pain Scale Assessment Chart					
Abbey Pain Scale (if unable to self report pain)					
4AT and TIME for Detection, Management and Prevention of Delirium	✓		✓		
Getting to Know Me – Relatives to complete					
What Matters to Me					
Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)					
Malnutrition Universal Screening Tool (MUST)	✓		✓		
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan					
Bristol Stool Chart					
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓		✓		
Adult Wound Assessment and Management Chart					
Moving and Handling Assessment	✓		✓		
Falls Risk Assessment	✓		✓		
Bedrail Risk Assessment	✓		✓		

Handwritten:
 20/1/26
 SCN 20/1/26

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
20/1/26 10 ⁰⁰ 20	Admitted with abdo pain and vomiting - ? obstruction.	
	ATW CT scan.	
	was given supps and enema	
	in A+E.	
	Independent with ADL	
	Sips of water at present	

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Clinical Notes (cont.)		
Date and Time	Notes	Print Name, Signature and Designation
	Observations - NEWS stable	
	no iv access or admission	
	Patient stated she has taken her	
	own existing medications this	
	morning. Also states that she	
	has not taken her blood thinner	
	for a while as it was making	
	her feel sick. I stated she	
	should mention this to doctors	
	when discussing her med rec.	seen today
1510	Seen on WIR: CTAP at 1230	
	and/or anal. Offers no complaints	WIR only
1830	CTAP - mild sigmoid	
	diverticulitis. Seen by Mr	
	Reel: ETP, analgesic,	
	Restart apixiban.	WIR only
21/01/26	NEWS currently 2 due to	
03:00	BP low - continue to monitor.	
	Alert + orientated	
	Independent with ADLs.	
	Dairy free diet brought + normal	
	friends.	
	Medications given as per hepna	
	- Has some own tablets on ward	
	but not all.	
	Settled overnight.	
1320	Settled throughout day	→

Name: _____

Address: _____



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19/08/1954

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Georgina

CHI: _____

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Clinical Notes (cont.)

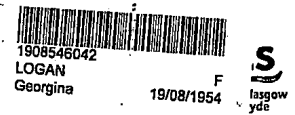
Date and Time	Notes	Print Name, Signature and Designation
	Diet and fluid taken. Spontaneously passing urine. Bowels opened. NEWS as charted. Drugs as per HEPMA. Seen on WIR: CT shows diverticulitis.	
	Fit home when well. —	nommy V.D. SW. V.D.
1730	For t/f to ward 9C. —	nommy V.D. SW. V.D.
21/1/26	Pt t/f to ward 9D. Settled on arrival, alert + orientated.	
1830	Ind. mobile. States skin is intact. Tolerating fluids + dairy free diet. States bowels are active.	
	Obs stable, NEWS = (1) ↓BP. ? d/c home tomorrow.	C. Condon Chk G.L. SW.
22.1.26	Pt Settled. meds as Hepma, fgl. Changed Amitriptyline to 2mg pm. NEWS as charted. meds given as Hepma, ? home tomorrow	Plus on Robertson S
00:10		
1130	Patient fit d/c (H) today. For clinic in 6 weeks. 1 DL, med and dressing given for home. Dressing also redone prior to discharge. Asbury relative to collect. No complaints noted.	Plus on Robertson S R.D. (S) Attila

NHSGGC Bedrail Risk Assessment

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

Patient Name:

CHI Number:



THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT

Use guidance on the reverse of this document when completing this Risk Assessment		DATE	20.1.26	21.1.26					
		TIME	10 ⁰⁰	18.05					
		WARD	2B	90					
		HOSPITAL	QEH	QEH					
SECTION ONE - GENERAL									
1	Is the patient likely to fall, roll, slip or slide from the bed?		Y	N	Y	N	Y	N	Y
2	Has the patient requested the use of bedrails?			✓		✓			
IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED									
SECTION TWO - COGNITIVE AND PHYSICAL STATUS									
3	Is the patient at risk of climbing out of bed?			✓		✓			
4	Is the patient stressed, delirious or restless?			✓		✓			
5	Is the patient small in stature?			✓		✓			
6	Does the patient have an unusually large or small head that might present an entrapment issue?			✓		✓			
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?			✓		✓			
IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE - See Guidance overleaf									
SECTION THREE - COMMUNICATION									
8	Has the patient been consulted regarding the use of bedrails?		✓	✓		✓			
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition		✓	✓		✓			
10	Has the use of bedrails been discussed with relatives/carers?			✓		✓			
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?			✓		✓			
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?		✓	✓		✓			
IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE - See Guidance overleaf									
SECTION FOUR - DECISION MAKING									
13	Will bedrails be used for this patient at the present time?		Y	N	Y	N	Y	N	Y
14	Rationale for use of bedrails: (Please insert code in the box on the right)			✓		✓			
	A - Risk of falling from the bed								
	B - Risk of rolling from the bed								
	C - Risk of slipping from the bed								
	D - Risk of sliding from the bed								
	E - Patient request								
15	Bedrail risk assessment completed by:		L. Murray						
16	Bedrails checked by:		L. Murray						
17	Date		20.1.26 21.1.26						
Any issues relating to the use of bedrails including discussion with family/relatives/carers should be recorded here									

A. Alternatives to bed rails:-

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

C. Safe use and application of bedrails:-

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

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

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

D. Record keeping:-**All of the following should be recorded:-**

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

Bedrail risk assessments should be made as follows:-

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

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Care Plan

Care discussed with patient Unable		☒ Yes	☐ No	☐	If unable, give reason:	
Care discussed with family Unable		☐ Yes	☒ No	☐	If unable, give reason:	
Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature	
20/1/26 ES	independent		20/1/26 ES	no issues		
				5. Hydration and Nutrition		
			20/1/26 ES	fluid and diet fasting		
	2, 3..Communication and senses					
20/1/26 ES	weas glasses					
				6. Elimination		
	4. Cognitive status		20/1/26 ES	independent		
20/1/26 ES	Met					

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Care Plan

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
20/1/26 EO	Independent		20/1/26 EO	nurse call button	
				10. Sleep and Rest	
			20/1/26 EO	encourage	
	8. Mobility				
20/1/26 EO	Independent			12. Privacy, dignity and sexuality	
			20/1/26 EO	NO issues	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

Date: 2011/26

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

1. Signed [Signature] Name Carney Designation Sen
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

USE FOLLOWING CODES:

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

Attach Address

1908546042
LOGAN
Georgina

NHS
Greater Glasgow
and Clyde

Ward:

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

no thanks

[illegible]

Date: 21.1.26

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

1. Signed [Signature] Name Felix Designation AP
2. Signed [Signature] Name hsmity Designation my
3. Signed [Signature] Name JROBERTSON Designation ON

Attach Addres

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Coverage

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Greater Glasgow
and Clyde

Ward: *cp*

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

rs thanks

USE FOLLOWING CODES:

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

[illegible]

Date: 22/1/26

1. Signed: [Signature] Name: SEBASTIAN Designation: ON
2. Signed: [Signature] Name: KULWATH Designation: ON
3. Signed: _____ Name: _____ Designation: _____

NHS
Greater Glasgow
and Clyde

Ward: 90

No thanks

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

[illegible]

4AT and TIME for Detection, Management and Prevention of Delirium

Complete for patients: age 65 and over; patients of any age with an existing cognitive impairment; previous delirium; current hip fracture; or severe illness. These patients are at high risk of delirium.

This should be done on admission; at each transition of care; if SQiD positive; or if any clinical concerns.

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4AT					
(1) Alertness	Ward 2B Date & Time 28/11/16 10:5	Ward 4D Date & Time 28/11/16 18:25	Ward Date & Time	Ward Date & Time	Ward Date & Time
This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating					
Normal (fully alert, but not agitated, throughout the assessment)	0	0	0	0	0
Mild sleepiness for <10 seconds after waking, then normal	0	0	0	0	0
Clearly abnormal	4	4	4	4	4
(2) AMT4					
Ask the patient their Age, Date of Birth, Place (name of hospital) Current Year					
No mistakes	0	0	0	0	0
1 mistake	1	1	1	1	1
2 or more mistakes	2	2	2	2	2
(3) Attention					
Ask the patient "Please tell me the months of the year in backward order, starting at December". To assist, one prompt of "What is the month before December" is permitted.					
Achieves 7 months or more correctly	0	0	0	0	0
Starts but scores < 7 months or refuses to start	1	1	1	1	1
Untestable (cannot participate because too drowsy or inattentive)	2	2	2	2	2
(4) Acute change or fluctuating course					
Evidence of significant change of fluctuation in: alertness, cognition, other mental function (e.g. hallucinations, paranoia) over the past 2 weeks and still present in preceding 24 hrs.					
No	0	0	0	0	0
Yes	4	4	4	4	4
4AT TOTAL SCORE	0	0			
Print initials of assessor	es	Re			
Score >4 This is a possible DELIRIUM +/- COGNITIVE IMPAIRMENT, start 'T' and 'I' of TIME and escalate to medical staff to confirm diagnosis	Score 1-3 This is a possible COGNITIVE IMPAIRMENT, and requires further assessment		Score 0 DELIRIUM or SEVERE COGNITIVE impairment unlikely		

All patients scoring 0-3 are still at high risk of delirium. Use the Triggers listed overleaf to plan care and reassess daily by asking 'Is the patient more confused or drowsy?' This is the single question in delirium (SQiD)

TIME checklist to guide Delirium risk reduction, Identification and Management

The TIME checklist is a joint medical and nursing responsibility.

Affix ID Label



Triggers, Investigate, Manage and Engage		Date 2011/26	Date	Date	Date	Date
		Tick box	Tick box	Tick box	Tick box	Tick box
Triggers	Think possible triggers for delirium					
	Is the patient in pain? Start pain chart, review analgesia and consider need for an aperient	✓				
	Is the patient constipated or at risk of constipation? Commence bowel chart and review daily to assess for constipation, especially if on analgesia. Consider rectal examination	✓ 2011/26				
	Is the patient in urinary retention? Palpate bladder/scan	NO				
	Is the patients oral intake sufficient to prevent dehydration? Encourage hourly fluids, start fluid balance chart	N/A				
	Could any drugs trigger delirium? Doctor to review medication	N/A				
	Blood sugar, high or low?	N/A				
	Is there a history of alcohol intake/drug abuse? Intoxication or withdrawal, start GMAWS/drug misuse guidelines	N/A				
	Does the patient have sensory impairment? Ensure patient is wearing their glasses/hearing aid(s)	✓				
Is the patient immobile? Promote early mobilisation in order to prevent delirium	✓					
Document 4AT score		0				
Does the patient have Delirium? (Yes/No/Unsure) Please Circle		Y <u>9</u> U	Y N U	Y N U	Y N U	Y N U
Investigate	Investigate					
	Record NEWS					
	Screen for infection					
	Take bloods and ensure ECG/appropriate imaging					
Manage	Management: Diagnose causes & Initiate treatment					
	Document diagnosis of delirium					
	Document potential causes of delirium					
	Document treatment plan					
Engage	Engage and Explore					
	If appropriate, explain diagnosis of delirium to patient/ family/ carers and provide delirium leaflet					
	Engage with patient/ family/ carers. Complete "What matters to me"/"Getting to know me" document					
	Does the patient have capacity to consent to care? (Yes/No/Ongoing Assessment)	Y N O	Y N O	Y N O	Y N O	Y N O
If no, complete AWI document						
Print initials of assessor		20				



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FALLS RISK ASSESSMENT

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

**GENERAL SAFETY PRECAUTIONS
TO BE UNDERTAKEN FOR ALL PATIENTS**

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

	Ward: 9B Date: 20.1.26 Time: 10.00	Ward: 90 Date: 21.1.26 Time: 18.05	Ward: Date: Time: -----	Ward: Date: Time: -----	Ward: Date: Time: -----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	complete	Indep			
2. Check walking aid (if required) is in reach and in use.	N/A	NA			
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	✓	In reach			
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	✓	✓			
5. If glasses are worn, check they are available and in use.	✓	✓			
6. If hearing aid/s are worn, check they are working and in use.	N/A	NA			

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).

Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.

****ALL patients in older people's wards must have an interventional plan in place (overleaf)****

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

Highlight risk of fall at the ward safety brief.

FALLS INTERVENTION CHECKLIST

Complete for all patients identified at risk of falling.

Ward:	Ward:	Ward:	Ward:	Ward:
Date:	Date:	Date:	Date:	Date:
Time: -----	Time: -----	Time: -----	Time: -----	Time: -----

BED AND SEATING

Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice.

(Patient care plan 8)

Assess if a low bed is required

(Patient care plan 9)

SAFETY

Complete / update bedrails risk assessment if bedrail in use.

(Patient care plan 9)

Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart.

(Patient care plan 9)

If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.

HEALTH

Complete / Document 4AT – follow THINK DELIRIUM guidelines.

(Patient care plan 4)

Document continence problems and link to care rounding

(Patient care plan 6)

Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns.

(Patient care plan 1)

If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.

COMMUNICATION

Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative.

(Patient care plan -negotiated care)

Update the ward team of the patient's mobility status.

(Patient care plan 8)

Discuss the patient's fall risk at safety briefs and MDT meetings.

(If appropriate)

Consider a referral to the Hospital Falls Service for advice using trackcare.

(If appropriate)

Signature of nurse completing interventional plan / or update

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team
EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

Fluid Balance Chart

 1908548042 LOGAN Georgina 19/08/1954 17 Solas Place Glasgow, Lanarkshire G13 4NA	Hospital: <u>COBAY</u> Ward: <u>9B</u> Date: <u>20/11/16</u>	Reason for Fluid Balance Chart _____ Is patient fluid restricted? Yes ☐ No ☐ If yes how many mls in 24 hours? _____	Does patient require thickened fluids? Yes ☐ No ☐ Stage _____ Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate: 1. Type _____ circle how many daily 1 2 3 2. Type _____ circle how many daily 1 2 3 Signature: _____ Designation: _____
	Fluid balance from previous 24hrs +/- _____		

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input								Output							Running Total OUTPUT	Initials
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type		
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
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10:00																	
11:00																	
12:00																	
13:00																	
14:00																	
15:00																	
16:00																	
17:00																	
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
*Total Intake										*Total Output							

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-



19/08/1954

G13 4NA

SN N smēh

Person is totally independent
(Click here and go to date box)

GGC0026

Continuation Sheet

[illegible]



1908546042

LOGAN
GeorginaF
19/08/1954**MALNUTRITION UNIVERSAL
SCREENING TOOL (MUST)****NHS**
Greater Glasgow
and Clyde

Date: 20.11.26 Time: 10 ⁰⁰	Actual Admission	Patient Reported	Any unplanned weight loss in last six months?
Height	4'10 cm	_____ cm	Yes ☐ No ☒
Weight	69.5 kg	_____ kg	How much _____ kg
		Unable to recall ☐	Previous weight in last six months _____ kg
Obtain accurate height/weight and rescreen as soon as possible. If unable to obtain height/weight - check previous patient record (Clinical Portal/TrakCare) and/or consider alternative measurements i.e ulna length (see chart MI 220398)			Source: Patient ☐ Trak/Portal ☐

Date	20.11.26	21.11.26						
Time	10 ⁰⁰							
Ward	9B	9D						
Oedema/ Ascites present Y/N	N							
Scales Used ST = Standing UW = Unable to weigh. Record reason and document assessment of risk in notes. CH = Chair HT = Hoist	ST	Weight noted						
Weight (kgs)	69.5							
BMI	32.2							
Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days								
Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	0							
Step 2 Weight loss score <5% = 0 (current weight from highest weight recorded in last six months) 5-10% = 1 >10% = 2	0							
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, nutritional intake for > 5 days..... Score 2 Not applicable..... Score 0	0							
Step 4 Overall Risk of Malnutrition TOTAL	0							
Rescreen on:	21.11.26	27.11.26						
Signature	20	21						

Step 5 Management Guidelines	
Overall Risk of Malnutrition	Ensure care plan updated with nutritional requirements, MUST score and actions to be taken to meet patient's nutritional needs.
0	LOW RISK - Repeat screening every 7 days
1 or Greater	MEDIUM/HIGH RISK - Follow the flowchart for MUST 1 or Greater overleaf
2 or Greater - nil by mouth	HIGH RISK - Follow the flowchart for MUST 2 or Greater - nil by mouth overleaf

STEP 5 Management Guidelines

MUST 1 OR Greater

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient /carer normal eating patterns and preferences.
- Use a **Food First Approach**:
 - » Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
 - » Offer full cream milk with and between meals.
 - » Order additional MUST snack daily of patients choice (refer to 'catering' section in nutritional resource manual).
- Encourage family and friends to bring in patient preferred snacks.
- **Complete a food and drink recording chart**, including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a 72 hour period?

YES

NO

Is the patients intake 'normal' or improved for them?

Complete the Above Steps

YES

NO

Is the patient dying?

- Encourage higher calorie menu choices indicated with ☉
- Continue with food and drink recording chart for 4 days, and if no improvement in intake, rescreen

YES

NO

- Discontinue food and fluid chart, documenting reason in nursing notes.
- Continue with 'food first' approach as above.
- Rescreen at least every 7 days.

- Discontinue food and drink recording chart.
- Stop screening.
- Offer food and fluid as appropriate.

- Continue with food and drink recording chart.
- Screen at least every 7 days.
- Consider referral to dietetics via Trakcare.

MUST 2 OR Greater - Nil by Mouth

- Refer to Speech and Language Therapy according to STOPSS pathway.
 - Consider passing NG tube and commencing NG starter regime where clinically indicated (medical and patient agreement is required)
 - Refer to Dietetics.
- N.B Not all NBM patients will require referral to Dietetics/SLT such as those at end of life or those undergoing procedures requiring NBM.
- Some patients who are long term NBM with alternative feeding in place should be discussed with local Dietitians and Nutrition Nurse teams.

DISCHARGE

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

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

180854042
LOGAN F
Georgia 18/08/1954
17 Solias Place
Glasgow, Lanarkshire
G13 4NA

	Date	Ward	Time
Admitted			
Transferred	2/11	90	?
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	
Signature:	
Print Name:	
Dr/ANP initials ONLY:	
Date:	

Sp02 Scale 2 Target 88-92%	
Signature:	
Print Name:	
Dr/ANP Initials ONLY:	
Date:	

Patient on home oxygen Y ☐ N ☐

If yes, add details of oxygen therapy

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

■ all right
▲ all reaction
♦ no reaction
● eyes closed

Pupil Size (mm)

1 2 3 4 5 6 7 8

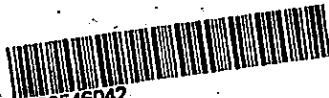
Glasgow Coma Scale[illegible]

19054E042
LOGAN
Georgina

Pain Function Score	
A	No limitations, activity unrestricted by pain or settles quickly
B	Mild limitations, mild activity restrictions
C	Moderate limitations, but reluctant to continue because of pain. Seek Advice
D	Severe limitations, unable to or refuse to continue because of pain. Unrest Begins Documented

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	40

Pressure Ulcer Daily Risk Assessment (PUDRA)



1908546042
LOGAN
Georgina
17 Sallas Place
Glasgow, Lanarkshire

19/08/1954
G13 4NA

Hospital:

Q&W

Ward:

9B

Points to consider:

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

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

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

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

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

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Check Skin	Signature
20/1/26	10:00	N	N	N	N	N	N	4 hrly	eo
20/1/26	03:30	N	N	N	N	N	N	6 hrly	eo
20/1/26	18:05	N	N	N	N	N	N	4 hrly	eo
20/1/26	08:00	N	N	N	N	N	N	4 hrly	eo
/ /	:							hrly	
/ /	:							hrly	
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/ /	:							hrly	
/ /	:							hrly	

Patient Centred SSKINS care plan

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

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

Attach Addressograph

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

no cannula
in TIF 10 18

Na  Ad 1906546042 LOGAN CI Georgina F 17 Solas Place 19/08/1954 DI Glasgow, Lanarkshire H G13 4NA	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
As above and including: palpable venous cord	4	Seek further advice		
As above and including: pyrexia	5			

Insertion details: Date: ____/____/____ (Day 1) Time: ____:____	Where inserted: ☐ ED ☐ Theatre ☐ ITU/HDU ☐ Ward _____ ☐ Unknown	Insertion site: ☐ Hand ☐ Arm Other _____	Side: ☐ Left ☐ Right	Size of cannula: ☐ 26G Purple ☐ 24G Yellow ☐ 18G Green ☐ 23G Blue ☐ 16G Grey ☐ 20G Pink ☐ 14G Orange	Inserted by: Print: _____ Signature: _____ Designation: _____
Clinical indication: ☐ Diagnostics ☐ Resuscitation ☐ IV medications ☐ Fluids ☐ Transfusion					
Insertion criteria: Hand hygiene performed ☐ Yes ☐ No	Skin decontamination (2% chlorhexidine in 70% isopropyl alcohol) ☐ Yes ☐ No	Sterile transparent semi-permeable dressing affixed ☐ Yes ☐ No	PVC explained to patient/carer ☐ Yes ☐ No		
DRIFT PVCs are associated with an increased risk of phlebitis, thrombosis, infection and S.aureus bacteraemia.					
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?					
			Local infection • Erythema / inflammation • Exudate • Hot to touch • Pain/tenderness	Systemic Infection • Hypotension • Tachycardia • Pyrexia	

	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 $\leq 37.9^{\circ}\text{C}$, 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. aureus 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		

Write or affix label

Name: _____

Address: _____

CHI: _____

DOB: _____

Hospital & Ward: _____

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

Maintenance – to be completed twice daily (Observe for signs and symptoms of local or systemic infection)													
Date	Need for PVC reviewed today?		Any sign of PVC site infection?		Is the dressing intact?		Before / after PVC procedures; hand hygiene performed?		PVC patent?		What has been done?		Sign: Print: Designation:
	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	
Day 1 Insertion Date _/_/___	☐ 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	☐ Left in situ ☐ Redressed ☐ 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: _____
--------------------	---	---------------------------------------	--	---	--------------

Discharge Checklist

Patient's name: 
 1908546042
 CHI number: LOGAN F
 Georgina 19/08/1954
 17 Sollas Place
 Glasgow, Lanarkshire
 G13 4NA

Ward: 9B. → 9D

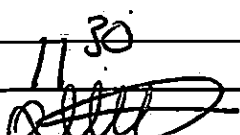
Discharge destination:

Home

Estimated Discharge Date (1) 23/01/26

Estimated Discharge Date (2) / /

Final date of discharge: 22/1/26

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓		JR	
Relative/carer informed	✓		JR	
Relative/carer involved in discharge planning discussions		✓	JR	
Others informed: Care Home				
Transport arranged				
Own transport (preferred option)	✓		JR	
Ambulance: 1 man/ 2 man am/pm		✓	JR	
Other: Flight, Air ambulance etc.				
Discharge medication				
Immediate Discharge Letter completed	✓			
Compliance aids e.g. Dossette Box (involve pharmacist)	✓		JR	
Medication received	✓		JR	
Medication explained to patient and/or relative/carer	✓		JR	
Own medication returned to patient	✓		JR	
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)	✓			
Informed of discharge				
Social work/ Other agencies		✓	JR	
Homecare		✓	JR	
Homecare request form completed?		✓	JR	
Discharge lounge handover completed?		✓	JR	
Physiotherapist		✓	JR	
Occupational Therapist		✓	JR	
Dietitian		✓	JR	
Speech and Language Therapist		✓	JR	
Clinical Nurse specialist		✓	JR	
Liaison/ District Nurse/Practice Nurse		✓	JR	
Other discharge items				
Access arrangements (e.g. keys, door entry)	✓		JR	
Patients clothing available for day of discharge	✓		JR	
Valuables e.g. cashier		✓	JR	
Intravenous cannula removed	✓		JR	
Equipment ordered (inc. walking aids) in place for discharge		✓	JR	
Part 2 Discharge letter - Required		✓	JR	
- Completed		✓	JR	
Outpatient clinic appointment				
Arranged	✓		JR	clinic
To follow		✓	JR	6 weeks
If unknown at time of discharge state reason				
Additional information / leaflets / factsheets				
Time of Discharge:				
Nurse's signature: 				
Designation:				
Date:				22/1/26

My Admission Record



77 to 90 21/1/26

Hospital: Q&A Ward: 9B
 Date of Admission: 20/1/26 Time: 09:00
 Information obtained from: Name: Georgina
 Patient ☒ Relative ☐ Other ☐
Preferred Name: Georgina
 Age: 71 Telephone Number: 07342664410
 Consultant: MS Downance

Name: Georgina
 Address: 1908546042
LOGAN F
Georgina 19/08/1954
17 Solas Place
Glasgow, Lanarkshire
 DoB: G13 4NA
 CHI:
 Affix patient ID label

H/V OK
 Ted 13
 WSV 13 med

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

Preferred first contact	Preferred second contact
Name: <u>George</u> Relationship: <u>Husband</u> Address: <u></u> Telephone: <u>07760159467</u> Is this person aware of your admission? Yes ☒ No ☐ Can we share information with this person? Yes ☒ No ☐	Name: <u></u> Relationship: <u></u> Address: <u></u> Telephone: <u></u> Is this person aware of your admission? Yes ☐ No ☐ Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis
Abdo pain and vomiting ? obstruction
 Explained to the patient? Yes ☐ No ☐ Not Applicable ☐
 Do you understand the reason for your admission? Yes ☐ No ☐

Allergies / Sensitivities (Record food allergies in the Hydration and Nutrition section)
 No known allergies ☒ Dairy

Relevant past medical history
Cr6hns Dysenteric colitis
Pericarditis ASTHMA
UTI Af
L2/L3 lumbar decompression IBS
 On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place
 Yes ☐ No ☒ If yes, Who asked for a copy?
 Date they asked for a copy /// Date Obtained ///

Power of Attorney / Guardianship / Adult with Incapacity

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

Yes ☐ No ☒**OR**

Does someone have Guardianship?

Yes ☐ No ☐If yes, is this for:- Finance ☐ Welfare ☐ Both ☐Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

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

Name: _____

Address: _____

1908546042

LOGAN

Georgina

17 Sollas Place

Glasgow, Lanarkshire

19/08/1954

F

DoB: _____

CHI: _____

G13 4NA

Affix patient ID label

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:

1. Been an inpatient in a hospital outside Scotland?

Yes

No

2. Received holiday dialysis outside Scotland?

3. Been told that you have CPE?

4. Been in close contact with a person with CPE?

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

Isolate the patient in a side room

Obtain Rectal swab marked 'for CPE'

If patient refuses rectal swab, obtain a stool specimen marked 'for CPE'

and inform the IPCT**MRSA Screening**

Will the patient be an inpatient for more than 23 hours

If **YES** complete the following section

1. Have you ever been told that you have MRSA?

2. Have you been admitted from another hospital/ residential

setting or care home?

3. Do you have a wound / skin ulcer or invasive device which you had before admission?

Yes

No

Unsure

☒☐☐☐☒☐☐☒☐☐☒☐If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabsNasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐**Creutzfeldt-Jakob Disease (CJD)**

Have you ever been informed that you are at increased risk of CJD or vCJD?

Yes

No

Unsure

☐☒☐If **YES** inform the IPCT ☐

Name

Address

1908546042
LOGAN
Georgina
17 Sollas Place
Glasgow, Lanarkshire

19/08/1954

DoB:

G13 4NA

CHI:

Affix patient ID label

Lifestyle**Smoking**Are you a: smoker ☐ ex-smoker ☐ when did you stop? _____Never smoked ☒Do you use eCigarettes? Yes ☐ No ☐

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

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

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

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

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

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

AlcoholDo you drink alcohol? Yes ☐ No ☒

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

Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐**NB: If daily or almost daily commence the Glasgow Assessment and Management of Alcohol (GAMA), complete FAST Tool and take further action as per guidance.**

Name (Please PRINT): LISA DUNN

Signature: 

Designation: SCN

Date: 20/1/26

My Assessment Record

Name: 
 Address: 1908546042
 LOGAN
 Georgina
 17 Sollas Place
 Glasgow, Lanarkshire
 DoB: 19/08/1954
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1. Breathing and Circulation

Breathing	Admission Presentation	Normal for the patient	Assessment of the patient's breathing
No breathing problems	✓	✓	Asthma
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers	✓	✓	
Oxygen therapy			
Do you have any other symptoms?			
Circulation	Admission Presentation	Normal for the patient	Assessment of the patient's circulation
No circulatory problems	✓	✓	Pneumonia
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

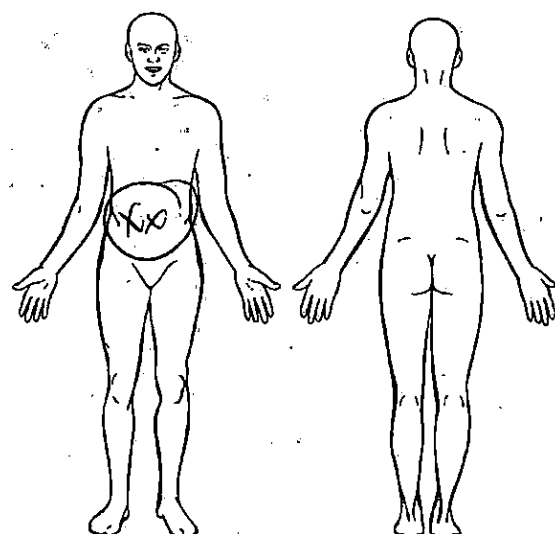
2. Communication

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

Name: _____
 Address: _____
 1908546042
 _____ LOGAN
 _____ Georgina
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3. Senses		
Vision	Yes ✓	No ✓
Do you have any problems with your vision?	✓	
Do you wear glasses?	✓	
Do you have your glasses with you?	✓	
Do you wear contact lenses?		
Do you have your lenses with you?		
Do you wear a prosthesis?		
Hearing	Yes ✓	No ✓
Do you have any problems with your hearing?		✓
Do you have any hearing loss?		
Do you use a hearing aid?		
Do you have your hearing aid(s) with you?		
Pain	Yes ✓	No ✓
Do you have pain?	✓	
Can you describe where and what the pain is like? Have you had treatment / intervention for the pain? N.B. Complete generic pain assessment chart. If unable to self report complete Abbey Pain Scale. Can you describe any chronic pain that you have? What makes the pain better?		

Mark current pain on body chart



Name  _____
 Address 1908546042 _____
 LOGAN _____ F _____
 Georgina _____ 19/08/1954 _____
 17 Sollas Place _____
 Glasgow, Lanarkshire _____
 DoB: _____ G13 4NA _____
 CHI: _____
 Affix patient ID label _____

4. Cognitive Status **THINK DELIRIUM**

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

N.B. Think Delirium

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

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

and follow the guidance.

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

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

Dairy intolerance

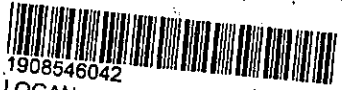
What do you like to eat and drink?

no preferences

What do you not like to eat and drink?

no preference

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

Diet and Fluids	Admission Presentation	Normal for the patient	Name:  Address: 1908546042 LOGAN Georgina 19/08/1954 F DoB: CHI: Affix patient ID label
Normal diet and fluids		✓	Assessment of the patient's hydration and nutrition needs
Therapeutic diet			
Cultural, ethnic or religious diet			
Texture Modified Diet Please state _____			
Thickened Fluid Please state _____			
Oral Nutritional supplements Preferred flavour _____			
Enteral Nutrition			
Parenteral Nutrition			
Nil by Mouth	✓		
N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS) within 4 hours of admission			
Assistance with eating and drinking	Admission Presentation	Normal for the patient	
Independent (Green)	✓	✓	
Prompting / encouragement / opening packets/cutting up food (Amber)			
Full assistance with eating and drinking (Red)			
Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?			
6. Elimination			
Bladder	Admission Presentation	Normal for the patient	Assessment of the patient's elimination needs
Pass urine with no problems	✓	✓	
Frequently pass urine during the day			
Frequently pass urine overnight			
Sense of urgency when need to pass urine			
Urine retention			

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓	Name:  Address: 1908546042 LOGAN Georgina 17 Sollas Place Glasgow, Lanarkshire DoB: 19/08/1954 CHI: G13 4NA Affix patient ID label
Haematuria			
Incontinent			

N.B. If new incontinence report to medical staff to rule out infection or physiological cause

What products do you normally use for this continence issue?

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

Date urinary catheter last changed ____/____/____

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

Bowels

When did your bowels last move? *contin* *20/1/26*

How often in a day/week do you have a bowel movement? Per day Per week

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

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

What products do you normally use for this continence issue?

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

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

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 Glasgow, Lanarkshire
 DoB: _____
 CHI: _____
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 G13 4NA

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

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

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

Pressure ulcer identified on admission: Yes ☐ No ☒

Pressure Ulcer Grade: _____

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

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

Wound Care	Yes ✓	No ✓	Nam _____ Addr _____ 1908546042 LOGAN Georgina 17 Sollas Place Glasgow, Lanarkshire DoB _____ CHI: _____ Affix patient's name _____
Do you have any wounds? N.B. If yes, complete an assessment chart for wound management		✓	F 19/08/1954 G13 4NA

8. Mobility

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

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

9. Maintaining a Safe Environment

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

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

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

10. Sleep and Rest

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

N:  _____
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 Glasgow, Lanarkshire
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 Affix patient ID label

11. Social Circumstances

Do you:

- Live alone ☐ Live with family/ friend/ other ☒
 Live in a nursing home ☐ Live in a care home ☐
 Live in residential supported care ☐ Live in student accommodation ☐
 Live in 'homeless' accommodation ☐ Have no fixed abode ☐
 Other please specify _____ ☐

Dependants

Yes No
✓ ✓

Do you have any dependants?

Do you support anyone (e.g. partner, children, relatives, animals)?

Do they need support from someone else whilst you are in hospital?

Would someone else be able to provide this support when you are in hospital?
 If yes, who?

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

Services

Yes No
✓ ✓

Do you have support from social work, social services or a care package?

If yes, please provide details:

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

12. Emotional and Spiritual Care

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

~

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

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

Healthcare Chaplain informed Yes ☐ N/A ☒

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13. Person Centred Care

What matters and is important to you whilst you are in hospital?

This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

*feeling better
getting home*

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

Informal Support

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

Husband

1B. If the person who helps is not a preferred contact please ensure their details are listed below.

Name:

Contact Details:

.....

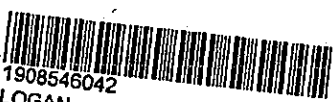
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How do you want the people who matter to you to be involved in your care?

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

Yes ☐ No ☐

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

Name 
 Address 1908546042
 LOGAN
 Georgina
 17 Sollas Place
 Glasgow, Lanarkshire
 Date 19/08/1954
 City
 Affix patient ID G13 4NA

Required Support

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

Yes ☐ No ☒

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

Has the carer been advised of the Carers Information Line?

Yes ☐ No ☐ Not appropriate at this time ☒

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?

Yes ☐ No ☒

Are you:

Employed ☐

Unemployed ☐

Self-employed ☐

Retired ☒

Full time education ☐

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

Yes ☐ No ☐ Not applicable ☒

Do you have any money worries?

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

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

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

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

Yes ☐ No ☐ Not applicable ☐

Not appropriate to ask at this time ☒

If yes when was patient referred ____ / ____ / ____

Risk Assessments/Other Documentation

Name:  —
 Address: 1908546042 —
 LOGAN F —
 Georgina 19/08/1954 —
 17 Solas Place
 DoB: Glasgow, Lanarkshire —
 CHI: G13 4NA —
 Affix patient ID label

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

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
20/1/26 10 ⁰⁰ 20	Admitted with abdo pain and vomiting - ? obstruction.	
	ATW CT scan.	
	was given supps and enema in A+E.	
	Independent with ADLs	
	Sips of water at present.	

N 

A 1908546042
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Georgina
17 Sollas Place
Glasgow, Lanarkshire
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Clinical Notes (cont.)		
Date and Time	Notes	Print Name, Signature and Designation
	observations - news stable	
	no iv access on admission	
	Patient stated she has taken her	
	own crning medications this	
	morning. Also states that she	
	has not taken her blood thinner	
	for a while as it was making	
	her feel sick. I stated she	
	should mention this to doctors	
	when discussing her med rec.	seen today
1510	Seen on WIR: CTAP at 1230	
	and analgesia. Offers no complaints	RMH/4 CN. R
1830	CTAP - mild sigmoid	
	diverticulitis. Seen by MS	
	Reel: ETP, analgesia,	
	Restart apixiban.	RMH/4 CN
21/01/26	news currently 2 due to	
03:00	BP low - continue to monitor.	
	Alex + analgesia.	
	Independent with ADLs.	
	Dairy free diet brought + normal	
	foods.	
	Medications given as per hepma	
	- Has some own tablets on ward	
	but not all.	
	Settled overnight.	21/01/26
1320	Settled throughout day	→

Name: _____
 Address: _____
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 LOGAN
 Georgina
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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
	Diet and fluid taken. Spontaneously passing urine. Bowels opened. NEWS as charted. Drugs as per HEMPA. Seen on WIR. CT shows diverticulitis. At home when well. —	Norman V.D.
1730	For t/f to ward 9C. —	Norman V.D.
21/1/26	Pt t/f to ward 9D. Settled on arrival, alert + orientated. Ind. mobile. States skin is intact. Tolerating fluids + dairy. Free diet. U	
1830	States bowels are active. Obs stable, NEWS = ① & BP. ? d/c home tomorrow.	C Gordon
22.1.26	Pt Settled. meds as Hempa, fyi Changed Amitripty to 2mg pm. NEWS as charted. meds given as Hempa, ? home tomorrow	John OR
00:16	1130 Patient for d/c ④ today. for clinic in 6 weeks. 1 DL, med and dressings given for home. Dressings also redone prior to discharge. Anxiety relative to collect. No complaints noted.	Robertson S
		5

NHSGGC Bedrail Risk Assessment

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

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT



1908546042
LOGAN
Georgina

19/08/1954



Patient Name:

CHI Number:

Use guidance on the reverse of this document when completing this Risk Assessment		DATE	20.1.26	21.1.26					
		TIME	10 ⁰⁰	18.05					
		WARD	3B	90					
		HOSPITAL	WGH	GEU					
SECTION ONE - GENERAL									
1	Is the patient likely to fall, roll, slip or slide from the bed?		Y	N	Y	N	Y	N	Y
2	Has the patient requested the use of bedrails?			✓		✓			
IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED									
SECTION TWO - COGNITIVE AND PHYSICAL STATUS									
3	Is the patient at risk of climbing out of bed?			✓		✓			
4	Is the patient stressed, delirious or restless?			✓		✓			
5	Is the patient small in stature?			✓		✓			
6	Does the patient have an unusually large or small head that might present an entrapment issue?			✓		✓			
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?			✓		✓			
IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE - See Guidance overleaf									
SECTION THREE - COMMUNICATION									
8	Has the patient been consulted regarding the use of bedrails?		✓	✓		✓			
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition		✓	✓		✓			
10	Has the use of bedrails been discussed with relatives/carers?			✓		✓			
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?			✓		✓			
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?		✓			✓			
IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE - See Guidance overleaf									
SECTION FOUR - DECISION MAKING									
13	Will bedrails be used for this patient at the present time?			✓		✓			
14	Rationale for use of bedrails: (Please insert code in the box on the right)								
	A - Risk of falling from the bed								
	B - Risk of rolling from the bed								
	C - Risk of slipping from the bed								
	D - Risk of sliding from the bed								
	E - Patient request								
15	Bedrail risk assessment completed by:		Wahny	✓		✓			
16	Bedrails checked by:		Wahny						
17	Date		20.1.26	21.1.26					
Any issues relating to the use of bedrails including discussion with family/relatives/carers should be recorded here									

A. Alternatives to bed rails:-

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

C. Safe use and application of bedrails:-

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

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

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

D. Record keeping:-

All of the following should be recorded:-

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

Bedrail risk assessments should be made as follows:-

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

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19/08/1954

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Care Plan

Care discussed with patient		☒ Yes	☐ No	☐	If unable, give reason:	
Unable						
Care discussed with family		☐ Yes	☒ No	☐	If unable, give reason:	
Unable						
Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature	
20/1/26 eo	independent		20/1/26 eo	no issues		
				5. Hydration and Nutrition		
			20/1/26 eo	fluids and diet - fasting		
	2. 3. Communication and senses					
20/1/26 eo	nears glasses					
				6. Elimination		
	4. Cognitive status		20/1/26 eo	independent		
20/1/26 eo	Alert					

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Care Plan

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
20/1/26 EO	Independent		20/1/26 EO	nurse call buzzer	
				10. Sleep and Rest	
			20/1/26 EO	encourage	
	8. Mobility				
20/1/26 EO	Independent			12. Privacy, dignity and sexuality	
			20/1/26 EO	NO issues	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

Date: 2011/26

1. Signed [Signature] Name Conny Designation: Sen
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

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

19/08/1954

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

no thanks

[illegible]

Date: 21.1.26

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

1. Signed [Signature] Name Indelix Designation AP
2. Signed [Signature] Name hsmity Designation my
3. Signed [Signature] Name JROBERTSON Designation PN

USE FOLLOWING CODES:

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

Attach Addres

1908546042

LOGAN

LOGAN
Coopering

Georgina
17 Sallas Place

Glasgow, Lanarkshire

19/08/1954

G13 4NA

NHS

**Greater Glasgow
and Clyde**

Ward: *cp*

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

no thanks

		Time	0700	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	2400
1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
3	SKIN INSPECTION Pressure areas checked: Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
4	KEEP MOVING Has the patient moved or walked? Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B Chair Assist to walk or stand (W/ST)	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth? Drink taken? Food, snack, or supplement taken? Has oral hygiene been carried out as per care plan?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
7	ENVIRONMENT Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
9	ESCALATION Escalate any issues to the registered nurse and document overleaf.	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Care provider / role																				

Date: 22/1/26

1. Signed [Signature] Name Seabrook Designation ON
2. Signed [Signature] Name Kuwait Designation [Signature]
3. Signed _____ Name _____ Designation _____

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

Ward: 90

No thanks

[illegible]

Care Rounds Variance Sheet

Attach Addressograph Label



Ward:

Codes

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

N.B. Record what and to whom escalated.

[illegible]

4AT and TIME for Detection, Management and Prevention of Delirium

Complete for patients: age 65 and over; patients of any age with an existing cognitive impairment; previous delirium; current hip fracture; or severe illness. These patients are at high risk of delirium.

This should be done on admission; at each transition of care; if SQiD positive; or if any clinical concerns.

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4AT	Ward <u>9B</u> Date & Time <u>20/11/16</u> <u>10:55</u>	Ward <u>9D</u> Date & Time <u>21/11/16</u> <u>18:05</u>	Ward _____ Date & Time _____	Ward _____ Date & Time _____	Ward _____ Date & Time _____
(1) Alertness This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating					
Normal (fully alert, but not agitated, throughout the assessment)	0	0	0	0	0
Mild sleepiness for <10 seconds after waking, then normal	0	0	0	0	0
Clearly abnormal	4	4	4	4	4
(2) AMT4 Ask the patient their Age, Date of Birth, Place (name of hospital) Current Year					
No mistakes	0	0	0	0	0
1 mistake	1	1	1	1	1
2 or more mistakes	2	2	2	2	2
(3) Attention Ask the patient "Please tell me the months of the year in backward order, starting at December". To assist, one prompt of "What is the month before December" is permitted.					
Achieves 7 months or more correctly	0	0	0	0	0
Starts but scores < 7 months or refuses to start	1	1	1	1	1
Unstable (cannot participate because too drowsy or inattentive)	2	2	2	2	2
(4) Acute change or fluctuating course Evidence of significant change of fluctuation in: alertness, cognition, other mental function (e.g. hallucinations, paranoia) over the past 2 weeks and still present in preceding 24 hrs.					
No	0	0	0	0	0
Yes	4	4	4	4	4
4AT TOTAL SCORE	0	0			
Print initials of assessor	es	Be			
Score >4 This is a possible DELIRIUM +/- COGNITIVE IMPAIRMENT, start 'T' and 'I' of TIME and escalate to medical staff to confirm diagnosis	Score 1-3 This is a possible COGNITIVE IMPAIRMENT, and requires further assessment				
Score 0 DELIRIUM or SEVERE COGNITIVE impairment unlikely					

All patients scoring 0-3 are still at high risk of delirium. Use the Triggers listed overleaf to plan care and reassess daily by asking 'Is the patient more confused or drowsy?' This is the single question in delirium (SQiD)

TIME checklist to guide Delirium risk reduction, Identification and Management

The TIME checklist is a joint medical and nursing responsibility.

Affix ID Label

Triggers, Investigate, Manage and Engage		Date 20/11/26	Date	Date	Date	Date
		Tick box	Tick box	Tick box	Tick box	Tick box
Triggers	Think possible triggers for delirium					
	Is the patient in pain? Start pain chart, review analgesia and consider need for an aperient	✓				
	Is the patient constipated or at risk of constipation? Commence bowel chart and review daily to assess for constipation, especially if on analgesia. Consider rectal examination	✓ 20/11/26				
	Is the patient in urinary retention? Palpate bladder/scan	NO				
	Is the patients oral intake sufficient to prevent dehydration? Encourage hourly fluids, start fluid balance chart	✓				
	Could any drugs trigger delirium? Doctor to review medication	NA				
	Blood sugar, high or low?	NA				
	Is there a history of alcohol intake/drug abuse? Intoxication or withdrawal, start GMAWS/drug misuse guidelines	NA				
	Does the patient have sensory impairment? Ensure patient is wearing their glasses/hearing aid(s)	✓				
Is the patient immobile? Promote early mobilisation in order to prevent delirium	✓					
	Document 4AT score	0				
	Does the patient have Delirium? (Yes/No/Unsure) Please Circle	Y <u>NO</u>	YNU	YNU	YNU	YNU
Investigate	Investigate					
	Record NEWS					
	Screen for infection					
	Take bloods and ensure ECG/appropriate imaging					
Manage	Management: Diagnose causes & initiate treatment					
	Document diagnosis of delirium					
	Document potential causes of delirium					
	Document treatment plan					
Engage	Engage and Explore					
	If appropriate, explain diagnosis of delirium to patient/ family/ carers and provide delirium leaflet					
	Engage with patient/ family/ carers. Complete "What matters to me"/"Getting to know me" document					
	Does the patient have capacity to consent to care? (Yes/No/Ongoing Assessment)	Y NO	Y NO	Y NO	Y NO	Y NO
	If no, complete AWI document					
	Print initials of assessor	ED				



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FALLS RISK ASSESSMENTTo Be Completed For All Patients Within 24 Hrs of Admission
and on Transfer to Another Ward**GENERAL SAFETY PRECAUTIONS
TO BE UNDERTAKEN FOR ALL PATIENTS**Action the following safety precautions on admission to your ward.
Update weekly or on change of condition.

	Ward: 98 Date: 20.1.26 Time: 10.00	Ward: 90 Date: 21.1.26 Time: 18.05	Ward: Date: Time: -----	Ward: Date: Time: -----	Ward: Date: Time: -----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	complete	Indep			
2. Check walking aid (if required) is in reach and in use.	N/A	NA			
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	✓	In reach			
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	✓	✓			
5. If glasses are worn, check they are available and in use.	✓	✓			
6. If hearing aid/s are worn, check they are working and in use.	N/A	NA			

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).

Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.

ALL patients in older people's wards must have an interventional plan in place (overleaf)

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

Highlight risk of fall at the ward safety brief.

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Patient Moving and Handling Assessment Form

Person's Name:		Named Nurse:		Person is totally independent (tick here and go to date box)	
1. General Information					
Body Build		Problems with comprehension, behaviour, co-operation (specify):			
Weight	Height				
Kg	cm				
BMI		Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):			
Risk of Falls: Yes ☐ No ☒					
2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)					
Hoist	Standard	Walking Aid	Assistance		Supervision Independent
Model		Aid Type	People: 1	2	>3
Sling type		Additional Information / Equipment:			
Sling Size					
3. Toileting					
Hoist	Standard	Walking Aid	Assistance		Supervision Independent
See No 2 Sit to Stand Transfers for details	see 'sit to stand transfers'	People: 1	2	>3	Additional Information:
4. Move on / off bed pan					
Hoist	Manoeuvre	Assistance		Supervision	N/A
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1	2	>3	Additional Information:
	Monkey pole				
	Independent bridging				
5. Move up / down bed					
Hoist	Handling Aids	Assistance		Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1	2	>3	Additional Information:
	Monkey pole				
	Rope ladder				
6. Lateral Transfer to / from trolley / bed					
Hoist	Handling Aids	Assistance		Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1	2	>3	Additional Information / Equipment (eg sliding sheets):
	Other (Please specify)				
7. Sit up over side of bed					
	Bed Rest	Assistance		Supervision	Independent
		People: 1	2	>3	Additional Information / Equipment (eg rope ladder, swivel cushion):
8. Into Bath or Shower					
Equipment	Handling Aid	Assistance		Supervision	Independent
Shower	Shower chair	People: 1	2	>3	Additional Information / Equipment (eg sling lifting hoist after risk assess):
Variable / Fixed height bath	Shower trolley				
Bed bath	Bathing hoist (eg Aleno)				
9. Walking					
No Walking	Walking Aid	Assistance		Supervision	Independent
	see 'sit to stand transfers'	People: 1	2	>3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)
10. Other Instructions / Observations / Equipment Used					
Recording Symbol:		1st Assessment	2nd Assessment	3rd Assessment	
/ Forward slash		X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star		
Date Assessed:	20/1/26				
Assessor's signature:	<i>[Signature]</i>				
Proposed Review date:	27/1/26				

Continuation Sheet

1. General Information (Only complete this section if changed from over page)											
Body Build				Problems with comprehension, behaviour, co-operation (specify):							
Weight		Height		Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):							
Kg		cm									
BMI											
Risk of Falls: Yes ☐ No ☐											
2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)											
Hoist	Standaid	Walking Aid	Assistance			Supervision	Independent				
Model		Aid Type	People: 1	2	>3	Additional Information / Equipment:					
Sling type											
Sling Size											
3. Toileting											
Hoist	Standaid	Walking Aid	Assistance			Supervision	Independent				
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1	2	>3	Additional Information:					
4. Move on / off bed pan											
Hoist	Manoeuvre	Assistance			Supervision	N/A					
See No 2 Sit to Stand Transfers for details		Roll patient	People: 1	2	>3	Additional Information:					
		Monkey pole									
		Person bridges									
5. Move up / down bed											
Hoist	Handling Aids	Assistance			Supervision	Independent					
See No 2 Sit to Stand Transfers for details		Sliding sheets	People: 1	2	>3	Additional Information:					
		Monkey pole									
		Rope ladder									
6. Lateral Transfer to / from trolley / bed											
Hoist	Handling Aids	Assistance			Supervision	Independent					
See No 2 Sit to Stand Transfers for details		Rigid Transfer Board	People: 1	2	>3	Additional Information / Equipment (eg sliding sheets):					
		Other (Please specify)									
7. Sit up over side of bed											
Bed Rest		Assistance			Supervision	Independent					
		People: 1	2	>3	Additional Information / Equipment (eg rope ladder, swivel cushion):						
8. Into Bath or Shower											
Equipment	Handling Aid	Assistance			Supervision	Independent					
Shower	Shower chair	People: 1	2	>3	Additional Information / Equipment (eg sling lifting hoist after risk assess):						
Variable / Fixed height bath	Shower trolley										
Bed bath	Bathing hoist (eg Alenti)										
9. Walking											
No Walking	Walking Aid	Assistance			Supervision	Independent					
see 'sit to stand transfers'		People: 1	2	>3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)						
10. Other Instructions / Observations / Equipment Used											
		4th Assessment			5th Assessment			6th Assessment			
Recording Symbol:		/ Forward slash			X Where a forward slash exists, add a back slash to make a cross			* Where a slash or cross exists add slashes to make a star			
Date Assessed:											
Assessor's signature:											
Proposed Review date:											



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19/08/1954

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS
Greater Glasgow
and Clyde

Date: 20/1/26 Time: 10 ⁰⁰	Actual Admission	Patient Reported	Any unplanned weight loss in last six months?
Height	4'10 cm	_____ cm	Yes ☐ No ☒
Weight	69.5 kg	_____ kg	How much _____ kg
		Unable to recall ☐	Previous weight in last six months _____ kg
Obtain accurate height/weight and rescreen as soon as possible. If unable to obtain height/weight – check previous patient record (Clinical Portal/TrakCare) and/or consider alternative measurements i.e ulna length (see chart MI 220398)			Source: Patient ☐ Trak/Portal ☐

Date	20/1/26	21.1.26						
Time	10 ⁰⁰							
Ward	9B	9D						
Oedema/ Ascites present Y/N	N							
Scales Used ST = Standing UW = Unable to weigh. Record reason and document assessment of risk in notes. CH = Chair HT = Hoist	ST	Weight noted						
Weight (kgs)	69.5							
BMI	32.2							
Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days								
Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	0							
Step 2 Weight loss score <5% = 0 (current weight from highest weight recorded in last six months) 5-10% = 1 >10% = 2	0							
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, nutritional intake for > 5 days..... Score 2 Not applicable..... Score 0	0							
Step 4 Overall Risk of Malnutrition TOTAL	0							
Rescreen on:	27.1.26							
Signature	20	21						

Step 5 Management Guidelines	
Overall Risk of Malnutrition	Ensure care plan updated with nutritional requirements, MUST score and actions to be taken to meet patient's nutritional needs.
0	LOW RISK - Repeat screening every 7 days
1 or Greater	MEDIUM/HIGH RISK - Follow the flowchart for MUST 1 or Greater overleaf
2 or Greater - nil by mouth	HIGH RISK - Follow the flowchart for MUST 2 or Greater - nil by mouth overleaf

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	Date	Ward	Time
Admitted			
Transferred	2/1	90	7
Transferred			
Transferred			
Transferred			

SpO2 Scale 1 Target >96%	SpO2 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: _____	

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
Min 12 Hourly Observations	Low Clinical Risk Min 4 Hourly Observation	Medium Clinical Risk Min Hourly Observations	High Clinical Risk 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

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

Signed _____

Medical: _____

Date: _____

Pupil Reaction and size

● = sluggish
● = reaction
○ = no reaction
○ = eyes closed

Pupil Size (mm)

1 2 3 4 5 6 7 8

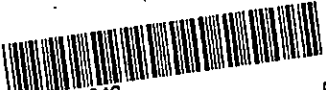
	Glasgow	Coma	Scale
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100	4	3	7

Date:	11/11	11/10	11/09	11/08	11/07	11/06	11/05	11/04	11/03	11/02	11/01	10/31	10/30	10/29	10/28	10/27	10/26	10/25	10/24	10/23	10/22	10/21	10/20	10/19	10/18	10/17	10/16	10/15	10/14	10/13	10/12	10/11	10/10	10/09	10/08	10/07	10/06	10/05	10/04	10/03	10/02	10/01	09/30	09/29	09/28	09/27	09/26	09/25	09/24	09/23	09/22	09/21	09/20	09/19	09/18	09/17	09/16	09/15	09/14	09/13	09/12	09/11	09/10	09/09	09/08	09/07	09/06	09/05	09/04	09/03	09/02	09/01	08/31	08/30	08/29	08/28	08/27	08/26	08/25	08/24	08/23	08/22	08/21	08/20	08/19	08/18	08/17	08/16	08/15	08/14	08/13	08/12	08/11	08/10	08/09	08/08	08/07	08/06	08/05	08/04	08/03	08/02	08/01	07/31	07/30	07/29	07/28	07/27	07/26	07/25	07/24	07/23	07/22	07/21	07/20	07/19	07/18	07/17	07/16	07/15	07/14	07/13	07/12	07/11	07/10	07/09	07/08	07/07	07/06	07/05	07/04	07/03	07/02	07/01	06/30	06/29	06/28	06/27	06/26	06/25	06/24	06/23	06/22	06/21	06/20	06/19	06/18	06/17	06/16	06/15	06/14	06/13	06/12	06/11	06/10	06/09	06/08	06/07	06/06	06/05	06/04	06/03	06/02	06/01	05/31	05/30	05/29	05/28	05/27	05/26	05/25	05/24	05/23	05/22	05/21	05/20	05/19	05/18	05/17	05/16	05/15	05/14	05/13	05/12	05/11	05/10	05/09	05/08	05/07	05/06	05/05	05/04	05/03	05/02	05/01	04/30	04/29	04/28	04/27	04/26	04/25	04/24	04/23	04/22	04/21	04/20	04/19	04/18	04/17	04/16	04/15	04/14	04/13	04/12	04/11	04/10	04/09	04/08	04/07	04/06	04/05	04/04	04/03	04/02	04/01	03/31	03/30	03/29	03/28	03/27	03/26	03/25	03/24	03/23	03/22	03/21	03/20	03/19	03/18	03/17	03/16	03/15	03/14	03/13	03/12	03/11	03/10	03/09	03/08	03/07	03/06	03/05	03/04	03/03	03/02	03/01	02/29	02/28	02/27	02/26	02/25	02/24	02/23	02/22	02/21	02/20	02/19	02/18	02/17	02/16	02/15	02/14	02/13	02/12	02/11	02/10	02/09	02/08	02/07	02/06	02/05	02/04	02/03	02/02	02/01	01/31	01/30	01/29	01/28	01/27	01/26	01/25	01/24	01/23	01/22	01/21	01/20	01/19	01/18	01/17	01/16	01/15	01/14	01/13	01/12	01/11	01/10	01/09	01/08	01/07	01/06	01/05	01/04	01/03	01/02	01/01	12/31	12/30	12/29	12/28	12/27	12/26	12/25	12/24	12/23	12/22	12/21	12/20	12/19	12/18	12/17	12/16	12/15	12/14	12/13	12/12	12/11	12/10	12/09	12/08	12/07	12/06	12/05	12/04	12/03	12/02	12/01	11/30	11/29	11/28	11/27	11/26	11/25	11/24	11/23	11/22	11/21	11/20	11/19	11/18	11/17	11/16	11/15	11/14	11/13	11/12	11/11	11/10	11/09	11/08	11/07																																																																																																																																																																																																																																																																																																																																																																																																																															
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1908546042
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13108/1954
LOGAN
Georgia

Pain Score		Pain Function Score	
Ask the patient to rate his/her pain by using numerical scale 0 to 10. Use the chart below to assess 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	
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, attempts but unable to continue because of pain. Seek Advice			

Pressure Ulcer Daily Risk Assessment (PUDRA)

 1908546042 LOGAN Georgina 17 Sollas Place Glasgow, Lanarkshire 19/08/1954 G13 4NA	Hospital: <i>Q&W</i> Ward: <i>9B</i>	Points to consider: • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes
--	--	--

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

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

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

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

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Check Skin	Signature
20/1/26	10:00	N	N	N	N	N	N	4 hrly	eo
20/1/26	03:30	N	N	N	N	N	N	4 hrly	<i>[Signature]</i>
20/1/26	18:05	N	N	N	N	N	N	4 hrly	<i>[Signature]</i>
20/1/26	08:00	N	N	N	N	N	N	4 hrly	<i>[Signature]</i>
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	

Patient Centred SSKINS care plan

Aim: to provide effective pressure ulcer prevention strategies to reduce/eliminate potential for pressure ulcer development.
NB. Avoid patients lying on back/sitting for prolonged episodes, a total change of position is required, standing only is not sufficient

Attach Addressograph

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

Discharge Checklist

Patient's name: 
1908546042
LOGAN F
CHI number: Georgina 19/08/1954
17 Sollas Place
Glasgow, Lanarkshire
G13 4NA

Ward: 9B → 9D

Discharge destination:
Home

Estimated Discharge Date (1) 23/01/26

Estimated Discharge Date (2) / /

Final date of discharge: 22/1/26

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓		JR	
Relative/carer informed	✓		JR	
Relative/carer involved in discharge planning discussions		✓	JR	
Others informed: Care Home				
Transport arranged				
Own transport (preferred option)	✓		JR	
Ambulance: 1 man/ 2 man am/pm		✓	JR	
Other: Flight, Air ambulance etc.				
Discharge medication				
Immediate Discharge Letter completed	✓		JR	
Compliance aids e.g. Dosette Box (involve pharmacist)	✓	✓	JR	
Medication received	✓		JR	
Medication explained to patient and/or relative/carer	✓		JR	
Own medication returned to patient	✓	✓	JR	
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)	✓		JR	
Informed of discharge				
Social work/ Other agencies		✓	JR	
Homecare		✓	JR	
Homecare request form completed?		✓	JR	
Discharge lounge handover completed?		✓	JR	
Physiotherapist		✓	JR	
Occupational Therapist		✓	JR	
Dietitian		✓	JR	
Speech and Language Therapist		✓	JR	
Clinical Nurse specialist		✓	JR	
Liaison/ District Nurse/Practice Nurse		✓	JR	
Other discharge items				
Access arrangements (e.g. keys, door entry)	✓		JR	
Patients clothing available for day of discharge	✓		JR	
Valuables e.g. cashier		✓	JR	
Intravenous cannula removed	✓		JR	
Equipment ordered (inc. walking aids) in place for discharge		✓	JR	
Part 2 Discharge letter - Required		✓	JR	
- Completed		✓	JR	
Outpatient clinic appointment				
Arranged	✓		JR	clinic
To follow		✓	JR	6 weeks
If unknown at time of discharge state reason				
Additional information / leaflets / factsheets				
Time of Discharge:				
Nurse's signature: 			Designation: JR	Date: 22/1/26

Pressure Ulcer Daily Risk Assessment (PUDRA)



1908546042
LOGAN F
Georgina 19/08/1954
17 Sollas Place
Glasgow, Lanarkshire
G13 4NA

Hospital:

GGH

Ward:

SDN

Points to consider:

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

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

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

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

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

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Check Skin	Signature
12/9/25	09:50	N	N	N	N	N	N	4 hrly	[Signature]
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
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/ /	:							hrly	
/ /	:							hrly	

1908545042
LOGAN F
Georgina 19/08/1954
17 Sollas Place
Glasgow, Lanarkshire
G13 4NA

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%
Signature:
Print Name:
Dr/ANP initials ONLY:
Date:

Sp02 Scale 2 Target 88-92%
Signature:
Print Name:
Dr/ANP initials ONLY:
Date:

Patient on home oxygen Y ☐ N ☐
If yes, add details of oxygen therapy

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:

[illegible]

My Admission Record



Hospital: QEUEH Ward: IAU
 Date of Admission: 4/6/25 Time: 2030
 Information obtained from: Name: _____
 Patient ☒ Relative ☐ Other ☐
Preferred Name: _____
 Age: 70 Telephone Number: _____
 Consultant: _____

Name: _____
 Address: _____
 1908546042
 LOGAN F
 Georgina 19/08/1954
 17 Sollas Place
 Glasgow, Lanarkshire G13 4NA
 DoB: _____
 CHI: _____
 Affix pi: _____

2230 - 131/72 99%
 91 57
 36.5
 RR 19

Communication

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

Preferred first contact

Name: George Logan
 Relationship: HUSBAND
 Address: _____
 Telephone: 07760189467
 Is this person aware of your admission? Yes ☐ No ☐
 Can we share information with this person? Yes ☐ No ☐

Preferred second contact

Name: _____
 Relationship: _____
 Address: _____
 Telephone: _____
 Is this person aware of your admission? Yes ☐ No ☐
 Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

Known Crohns having approx 11 episodes loose stools a day
 Explained to the patient? Abdo pain Yes ☐ No ☐ Not Applicable ☐
 Do you understand the reason for your admission? Yes ☐ No ☐

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

No known allergies ☐ Co-amoxiclav

Relevant past medical history

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

Power of Attorney / Guardianship / Adult with Incapacity

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

Yes ☐No ☒**OR**

Does someone have Guardianship?

Yes ☐No ☒If yes, is this for: Finance ☐ Welfare ☐ Both ☐Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

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

Name: _____

Addr: _____



1908546042

LOGAN

Georgina

17 Solias Place

Glasgow, Lanarkshire

19/08/1954

G13 4NA

Affix p

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:

1. Been an inpatient in a hospital outside Scotland?

Yes ☐No ☒

2. Received holiday dialysis outside Scotland?

☐☒

3. Been told that you have CPE?

☐☒

4. Been in close contact with a person with CPE?

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

Isolate the patient in a side room

☐

Obtain Rectal swab marked 'for CPE'

☐

If patient refuses rectal swab, obtain a stool specimen marked 'for CPE'

☐**and inform the IPCT**☐**MRSA Screening**

Will the patient be an inpatient for more than 23 hours

Yes ☐No ☐Unsure ☒If **YES** complete the following section

1. Have you ever been told that you have MRSA?

☐☒☐

2. Have you been admitted from another hospital/ residential setting or care home?

☐☒☐

3. Do you have a wound / skin ulcer or invasive device which you had before admission?

☐☒☐If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabsNasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐**Creutzfeldt-Jakob Disease (CJD)**

Have you ever been informed that you are at increased risk of CJD or vCJD?

Yes ☐No ☒Unsure ☐If **YES** inform the IPCT ☐

Name: _____
 Address: _____
 1908546042
 LOGAN
 Georgina
 17 Sollas Place
 Glasgow, Lanarkshire
 DoB: _____
 CHI: _____
 Affix patient ID label

19/08/1954
 F
 G13 4NA

Lifestyle

Smoking

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

Never smoked ☒

Do you use eCigarettes? Yes ☐ No ☐

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

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

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

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

Drugs

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

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

Alcohol

Do you drink alcohol? Yes ☐ No ☒

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

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

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

Name (Please PRINT): Shannon Twomey

Signature: _____

Designation: Staff Nurse.

Date: 4/6/25

My Assessment Record

Name: _____
 Address: 
 1908546042
 LOGAN F
 Georgina 19/08/1954
 17 Sollas Place
 Glasgow, Lanarkshire
 DoB: _____
 CHI: _____ G13 4NA
 Affix _____

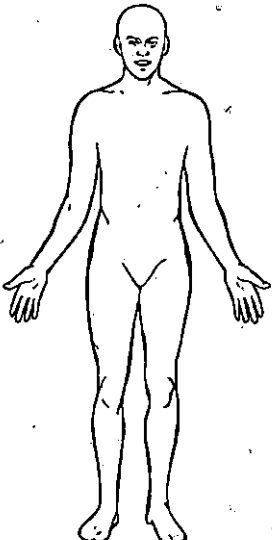
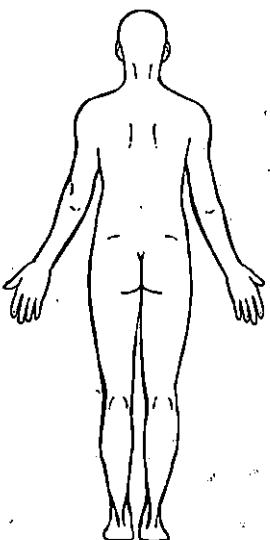
1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems			asthma
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers	✓	✓	
Oxygen therapy			
Do you have any other symptoms?			
Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems	✓	✓	
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

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

N: _____
 A: _____
 1908546042
 LOGAN
 Georgina
 17 Sollas Place
 Glasgow, Lanarkshire
 G13 4NA
 19/08/1954
 F: _____
 C: _____
 Anna _____

3. Senses			
Vision	Yes ✓	No ✓	Assessment of the patient's vision
Do you have any problems with your vision?	✓		Distance ☐ Reading ☒ Both ☐
Do you wear glasses?	✓		
Do you have your glasses with you?	✓		
Do you wear contact lenses?			
Do you have your lenses with you?			
Do you wear a prosthesis?			
Hearing	Yes ✓	No ✓	Assessment of the patient's hearing
Do you have any problems with your hearing?		✓	
Do you have any hearing loss?		✓	
Do you use a hearing aid?		✓	
Do you have your hearing aid(s) with you?		✓	
Pain	Yes ✓	No ✓	Assessment of the patient's pain
Do you have pain?		✓	
Can you describe where and what the pain is like?			
Mark current pain on body chart			
 			
Have you had treatment / intervention for the pain?			
N.B. Complete generic pain assessment chart. If unable to self report complete Abbey Pain Scale.			
Can you describe any chronic pain that you have?			
What makes the pain better?			

N
A
— 1908546042
— LOGAN, F
— Georgina 19/08/1954
D 17 Sallas Place
C Glasgow, Lanarkshire
A G13 4NA

4. Cognitive Status **THINK DELIRIUM**

	Admission Presentation	Normal for the patient	Assessment of the patient's cognitive status
Alert and orientated	✓	✓	4AT=0
Impaired conscious level			
Confused			
Dementia			
Stressed / Distressed			

N.B. Think Delirium

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

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

and follow the guidance

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

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

dairy

What do you like to eat and drink?

What do you not like to eat and drink?

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

Diet and Fluids	Admission Presentation	Normal for the patient	 1908546042 LOGAN Georgina 17 Sollas Place Glasgow, Lanarkshire 19/08/1956 G13 4NA Affix patient ID label
Normal diet and fluids	✓	✓	
Therapeutic diet			
Cultural, ethnic or religious diet			
Texture Modified Diet Please state _____			Assessment of the patient's hydration and nutrition needs
Thickened Fluid Please state _____			<i>NDF - No dairy</i>
Oral Nutritional supplements Preferred flavour _____			
Enteral Nutrition			
Parenteral Nutrition			
Nil by Mouth			
N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS) within 4 hours of admission			
Assistance with eating and drinking	Admission Presentation	Normal for the patient	
Independent (Green)	✓	✓	
Prompting / encouragement / opening packets/cutting up food (Amber)			
Full assistance with eating and drinking (Red)			
Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?			
6. Elimination			
Bladder	Admission Presentation	Normal for the patient	Assessment of the patient's elimination needs
Pass urine with no problems	✓	✓	
Frequently pass urine during the day			
Frequently pass urine overnight			
Sense of urgency when need to pass urine			
Urine retention			

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓	Name: _____ Address: _____ 1908546042 LOGAN Georgina 17 Sollas Place Glasgow, Lanarkshire DoB: _____ CHI: _____ Affiliations: _____ 19/08/1954 G13 4NA
Haematuria			
Incontinent			

N.B. If new incontinence report to medical staff to rule out infection or physiological cause

What products do you normally use for this continence issue?

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

Date urinary catheter last changed ____/____/____

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

Bowels

When did your bowels last move?

W 3/6/25

How often in a day/week do you have a bowel movement? Per day Per week

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

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

What products do you normally use for this continence issue?

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

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

Na _____
 Ad 1908546042 _____
 LOGAN _____
 Georgina F _____
 17 Sollas Place 19/08/1954 _____
 D, Glasgow, Lanarkshire _____
 Cl G13 4NA _____
 Affix patient ID label

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

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

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

Pressure ulcer identified on admission: Yes ☐ No ☒

Pressure Ulcer Grade: _____

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

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

Wound Care	Yes ✓	No ✓	Name: 1908546042 Add: LOGAN Georgina 19/08/1954 17 Sollas Place Glasgow, Lanarkshire DoB: G13 4NA CHI: Affix patient ID label
Do you have any wounds? N.B. If yes, complete an assessment chart for wound management		✓	

8. Mobility

Mobility	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's mobility needs 1ND
Fully mobile and independent	✓	✓	
Unsteady when walking			
Do you use a mobility aid	Yes ☐	No ☐	
Do you have your mobility aid with you?	Yes ☐	No ☐	

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

9. Maintaining a Safe Environment

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

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

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

10. Sleep and Rest

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



1908546042

LOGAN

Georgina

17 Sallas Place

Glasgow, Lanarkshire

19/08/1954

G13 4NA

11. Social Circumstances

Do you:

Live alone

☒

Live with family/ friend/ other

☐

Live in a nursing home

☐

Live in a care home

☐

Live in residential supported care

☐

Live in student accommodation

☐

Live in 'homeless' accommodation

☐

Have no fixed abode

☐

Other please specify

☐**Dependants**

Yes

No

Do you have any dependants?

☒☒

Do you support anyone (e.g. partner, children, relatives, animals)?

☒☒

Do they need support from someone else whilst you are in hospital?

☒☒

Would someone else be able to provide this support when you are in hospital?

☒☒

If yes, who?

If no support available contact Duty Social Worker

Duty Social Worker Required ☐Not required ☐Referred ☐**Services**

Yes

No

Do you have support from social work, social services or a care package?

☒☒

If yes, please provide details:

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

☐☒**12. Emotional and Spiritual Care**

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

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

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

Healthcare Chaplain informed

Yes ☐N/A ☐

Name: _____
 Adc _____
 1908546042
 LOGAN
 DoB Georgina 19/08/1954
 CHI 17 Solias Place
 Affix Glasgow, Lanarkshire G13 4NA

13. Person Centred Care

What matters and is important to you whilst you are in hospital?

This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

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

Informal Support

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

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

Name:

Contact Details:

.....

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

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

Yes ☐ No ☐

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

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Ad		
	1908546042	
	LOGAN	F
	Georgina	19/08/1954
Do	17 Sollas Place	
CH	Glasgow, Lanarkshire	
Aff		G13 4NA

Required Support

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

Yes ☐ No ☐

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

Has the carer been advised of the Carers Information Line?

Yes ☐ No ☐ Not appropriate at this time ☐

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?

Yes ☐ No ☐

Are you:

Employed ☐

Unemployed ☐

Self-employed ☐

Retired ☐

Full time education ☐

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

Yes ☐ No ☐ Not applicable ☐

Do you have any money worries?

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

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

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

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

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

If yes when was patient referred ____/____/____

N
A 1908546042
— LOGAN
— Georgina 19/08/1954
D 17 Sollas Place
C Glasgow, Lanarkshire G13 4NA
All

Risk Assessments/Other Documentation

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

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
4/6/25 21:00	patient admitted to LAU with known chrons and having approx 11 episodes loose stools a day; ↑ abdo pain.	
	patient independently mobile	
	patient States Slan is intact	



1908546042
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 17 Sollas Place
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 Af patient ID label

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
	Patient takes normal diet and fluids.	
	Call buzzer explained and within reach.	
	awaiting medical R/V	Staff Nurse Shannonway
04/06/25	PATIENT ALERT AND ORIENTED	KERRI MORAN
2330	NEWS SCORE 1 HR 91	STUDENT
05/06/25	PATIENT COMPLAINED OF FEELING NAUSEOUS OVERNIGHT ASKED MEDICS TO PRESCRIBE ANTIEMETIC & GIVEN AS PER HGMN AROUND 0341. AFTER MORNING OBS. PATIENT DISCLOSED THAT SHE TOOK HER OWN PREGABLIN AT AROUND 0300. PT DID NOT DISCLOSE ANY PAIN DURING OBS. AT 0250 NEWS SCORE 0. MEDICAL PLAN (1) STOOL SAMPLE + CULTURES (2) STOOL CHART (3) FBC, CRP, U ² , COAG, LFTS (4) HAEMATINICS + IRON STUDIES (5) CONSIDER. COLONOSCOPES + COLONOSCOPY (6) USS ABDOM + PELVIS. (7) MGO REC.	KERRI MORAN STUDENT (20) OBSTETRICIAN
05/06/25	PATIENT STATED THAT SHE WAS UNABLE TO WAIT ANY LONGER	

Name _____
 Address _____
 1908546042
 LOGAN
 Georgina
 17 Solus Place
 Glasgow, Lanarkshire
 DoB: _____
 CHI: _____
 19/08/1954
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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
05/06/25 0705	FOR PAIN RELIEF DESPITE NOT ALERTING NURSING STAFF OF CONTINUED PAIN OR DISCOMFORT	Kelli Mowbray Rn (STN) Bill Tompkins Rn
05/06/25, 11:34	Alert + oriented, independently mobilizing Stool culture sent, Abx CT abd/pelvis, Urine to be sent. Had due meds. Given Buprenorphine patch 20ug, on left abdomen. SB consultant; 9 miles chon's /diverticulosis (P) - CT abd/pelvis - Check urine MLEs if - dip +ve Stool culture + fecal calpro tein	Melissa ms low
11:55	Fecal C+S + calprotectin is sent	
5/6/25 12:05	Patient Newell - Eating SOUP & sandwich for lunch NO NEW CONCERNS AT PRESENT Greened for bed in 8B	STN E. Green
5/6/25 14:20	Patient admitted to ward 8B, Newell is chon's Alert + oriented to ward Sent Chon M STN Abx CT Abdo + pelvis N.I. re 1 day	J. Green RN

Gynaecology Department**Gynaecology Emergency Dept – Admission Document**Date 11/6/25Consultant on call: DR. DATSONTime Seen: 12.10Triage Nurse: JOAN WARREN (HCSW)

Name	
Address	1908546042 LOGAN Georgina 17 Sollas Place Glasgow, Lanarkshire G13 4N
D.O.B	19/08/195
Age	<u>70</u>
Telephone	<u>07760159467</u>
Occupation	<u>RETIRED</u>

GP	P	Dr. RP Murphy 1398 Dumbarton Road Glasgow G14 9DR
Name		
Address		
Telephone		

Emergency Contact	
Name	<u>GEORGE LOGAN</u>
Address	<u>AS ABOVE</u>
Telephone	<u>07760159467</u>
Relationship	<u>HUSBAND</u>
Comments	

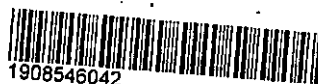
Triage Notes			
R	BP	<u>111/56</u>	P <u>52</u> T <u>36.2</u>
BM	SpO2	<u>97%</u>	
Urine: Leuco	Prot	Blood	
Ket	Gluc	Nitrites	
MSSU sent:			
Pregnancy Test Result:			
Height-			
Weight-	(If required)		
BMI-			

Clinical Assessment	
Presenting complaint	<u>? PVB (PMS)</u>
Source of referral	<u>88</u>
LMP	<u>1/1 N/A</u>
Allergies:	<u>AMOXICLAVIN</u>

Gynaecology Department

Emergency Dept. Admission Document

Date 11/04/25



1908546042

LOGAN

Georgina

19/08/195

Patient name: _____

Hospital number _____

Time Seen: 12:30

Presenting complaint:

70♀ - current IP 86.

- admitted with diarrhoea

- ? Passing faeces PV + episode PrB

& complex ⊕ ovarian cyst on CT abd

History of presenting complaint:

reports long hx of abdominal pain.

Last week episode of fresh Pr bleeding - states had small amount of pad also having diarrhoea and ~~more than~~ ^{passed faeces PV} ~~more than~~ ^{had just inserted pessary before bleeding happened.} states was being tx through, nil further episodes. Reports longstanding Lth Pr. nil weight loss, nil bloating. Reports ↓ appetite.

Past Obstetric/Gynaecology History:

Parity: G4 P4

Contraception: nil

Date of Last Smear: ? Thinks 10 yrs ago (N)

Result: _____

~~was~~ ^{past}

Age of menopause - 50 y/o.

Past Medical/Surgical History:

cholecystectomy

AF

Crohn's

IBS

Asthma

pericarditis

Diverticulosis

spinal surgery

prev. uretic stent

Family History:

hx lung + breast ca.

Social History:

o non smoker

only eth.

o cover 27 yrs (retired)

Medication:

Two sources are required

Medication	Dose	Frequency	Comment
Apixaban			
Regabain			
metocarbamol			
omeprazole			
atenolol			
bupropion			
ropinrole			
levodopa			

Allergies:

Dosette box used:

CO-amoxiclav + trimethoprim

Examination:

O/E: Whitish discolouration of vulval skin and loss of labial architecture - appearances consistent c lichen sclerosis.

Attempted spec - unable to tolerate due to discomfort.

Scan findings:

TUS - (L) complex adnexal cyst noted measuring $51.4 \times 34 \times 24.7$ mm.

Slightly thickened endometrium at fundus 7.31mm.

Blood results:

Clinical Impression:

- ① Complex ② adrenal cyst as before, persistent for at least 11 years with min change in size. CA125 15.
 ③ FU scan in 1 year to assess for interval scan.
- ② PVB? faeculent discharge - on questioning had small amount fresh red PVB on inserting clonimazole pessary - likely local trauma. Then awoke to find faecal matter on pad - suspect episode of faecal incontinence rather than PVB. Slightly thickened endometrium 7.3mm - unable to tolerate spec/pipelle but think this is incidental finding rather than true PVB.

Doctors Signature _____

Designation _____

Print Name _____

Management plan:

Can reassess appearances at FU scan in 1 yr.

Follow-up Plan:

Requires Admission: ☐ Yes ☐ No

Admitted to: _____

Outpatient Clinic Letter completed: ☐ Yes ☐ No

① Dermovate ointment: od for 4/52 then every other day 4/52 then twice weekly 4/52.
 Dermol as soap sub.
 One Stop Clinic 1 year

Once Only Prescriptions

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

1908546042
LOGAN
Georgina
17 Solfas Place
Glasgow, Lanarkshire
19/08/1954
G13 4NA

33949. GGC0072

Date & Time		Signature, Print Name & Designation
	Patient had due medications administered as per HEPMA. Patient blood was noted to be hypotensive, thus blood pressures were monitored. Patient was assisted with needs as per request. Patient slept well. There was noted to be sound with no issues.	
8/6/25 7:52	Observations stable. Medications as per Hepma. Independent with all ADLs. Settled overnight.	Spodern SN
9/6/25 14:40	Observations as per news chart. Medications given as per Hepma. Independently mobile remains on PR. Discuss outpatient appointments between cardiology & urology. Patient not keen for cardiac surgery but ^{error: cardiology} only happy to see pt after see urology input. Home soon if only cardiac concerns error.	Spodern SN
6/25 15:10	Observations as per news chart. Medications given as per Hepma. Independently mobile. Awaiting stool cultures x2. CT Abdo ok . PIC blown at CT, new one inserted. NO new issues.	Spodern SN NFERNS SN
10/6/25 01:35	Observations stable. Medications as per Hepma. Independent with all ADLs. No new concerns.	Spodern SN
10/6/25 13:45	Observations as charted. NFWs=1. Medications as per Hepma. L° ACR, Ind with ADLs. AW ☐ ☐ Stool cultures. Pt settled at present.	NFERNS SN NFERNS

1908546042
LOGAN F
Georgina 19/08/1954
17 Sollas Place
Glasgow, Lanarkshire
G13 4NA

33949 GGC0072

NHSGGC Bedrail Risk Assessment

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

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT



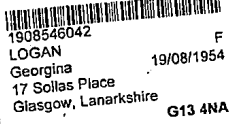
1908546042
LOGAN
Georgina
17 Sollas Place
Glasgow, Lanarkshire
G13 4NA

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19/08/1954
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Glasgow
rde

Patient Name:

CHI Number:

Use guidance on the reverse of this document when completing this Risk Assessment		DATE	4/6/25	5/6/25					
		TIME	2100	1430					
		WARD	1A0	8B					
		HOSPITAL	QEUH	QEUH					
SECTION ONE - GENERAL									
1	Is the patient likely to fall, roll, slip or slide from the bed?		Y	N	Y	N	Y	N	Y
2	Has the patient requested the use of bedrails?		Y	N	Y	N	Y	N	Y
IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED									
SECTION TWO - COGNITIVE AND PHYSICAL STATUS									
3	Is the patient at risk of climbing out of bed?								
4	Is the patient stressed, delirious or restless?								
5	Is the patient small in stature?								
6	Does the patient have an unusually large or small head that might present an entrapment issue?								
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?								
IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE - See Guidance overleaf									
SECTION THREE - COMMUNICATION									
8	Has the patient been consulted regarding the use of bedrails?								
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition								
10	Has the use of bedrails been discussed with relatives/carers?								
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?								
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?								
IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE - See Guidance overleaf									
SECTION FOUR - DECISION MAKING									
13	Will bedrails be used for this patient at the present time?		Y	N	Y	N	Y	N	Y
14	Rationale for use of bedrails: (Please insert code in the box on the right)		Y	N	Y	N	Y	N	Y
	A - Risk of falling from the bed								
	B - Risk of rolling from the bed								
	C - Risk of slipping from the bed								
	D - Risk of sliding from the bed								
	E - Patient request								
15	Bedrail risk assessment completed by:		ST						
16	Bedrails checked by:		ST						
17	Date		4/6/25	5/6/25					
Any issues relating to the use of bedrails including discussion with family/relatives/carers should be recorded here									



NHS
Greater Glasgow
and Clyde

CHI:

Date Commenced: 05/06/25

[illegible]

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

Date: 4/6/25

Attach A



NHS
Greater Glasgow
and Clyde

Ward:

G13 4NA

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

[illegible]

Date: 5/6/25

1hr 2hr 3hr 4hr

1. Signed [Signature] Name E. E. [Signature] Designation SP
2. Signed J. Gunter Name J. Gunter Designation SP
3. Signed _____ Name _____ Designation _____

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

1908546042
LOGAN F
Georgina 19/08/1954
17 Sollas Place
Glasgow, Lanarkshire
G13 4NA

No Thanks.

NHS
Greater Glasgow
and Clyde

[illegible]

Care Rounds Variance Sheet

Attach Addressograph Label



Ward:

Codes

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

N.B. Record what and to whom escalated.

[illegible]

Date: 6/6/25

Attach Addr

NHS
Greater Glasgow
and Clyde

Ward:

USE FOLLOWING CODES:

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

No Thanks

[illegible]

Date: 7/6/28

Attached
 1908546042
 LOGAN
 Georgina
 17 Solias Place
 Glasgow, Lanarkshire
 Ward:
 8R

F
 19/08/1954
 G13 4NA

NHS
Greater Glasgow
and Clyde

'Must ~~identify their most important issues~~ be patient if there is anything they want specifically done today:

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

[illegible]

Date: 8/6/25

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

1. Signed Sforner Name SFOSTGR Designation SN

2. Signed _____ Name _____ Designation _____

3. Signed _____ Name _____ Designation _____

USE FOLLOWING CODES:

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

Attach Addr:



1908546042

LOGAN

LOGAN
Georgina

Georgina
17 Selles Place

17 Sollas Place
Glasgow, Lanarkshire

F
19/08/1954

G13 4NÀ

NHS
Greater Glasgow
and Clyde

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

		Times	00	05	10	15	20	25	30	35	40	45	50	55
1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	S	N				N							
2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.	S	N				N							
S	3 SKIN INSPECTION Pressure areas checked:	S	N				I							
	Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	/	/				/							
K	4 KEEP MOVING Has the patient moved or walked?	S	incl				I							
	Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	/	B				/							
	Chair Assist to walk or stand (W/ST)	/	B				/							
I	5 ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	S	N				I							
N	6 FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?	N	N				N							
	Drink taken?	S	I				I							
	Food, snack, or supplement taken?	S	I				I							
	Has oral hygiene been carried out as per care plan?	S	/				I							
7	ENVIRONMENT Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y				Y							
8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.	S	N				N							
9	ESCALATION Escalate any issues to the registered nurse and document overleaf.	NA	NA				NA							
	Care provider / role	SC	AS				SC							

Date: 9/6/25

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

1. Signed [Signature] Name STOSTER Designation SN
2. Signed [Signature] Name S. G. KURE Designation CN
3. Signed _____ Name _____ Designation _____

USE FOLLOWING CODES:

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



1908546042

LOGAN

Georgina

17 Sollas Place

Glasgow, Lanarkshire

F
19/08/1954

G13 4NA

1. **ANALYSIS OF THE DATA**

Ward: 8B



**Greater Glasgow
and Clyde**

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

no thanks

[illegible]

Date: 10/6/25

1. Signed S Foster Name SFOSTER Designation SN
2. Signed amymmh Name Amey Murdoch Designation SN
3. Signed Zad Name Lucy Atherton Designation SN

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

Ward: 8B

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

NHS
Greater Glasgow
and Clyde

[illegible]

Date: 11/6/25

1. Signed Zak Name Leo Atherton Designation SW
2. Signed on Name onlined Designation on
3. Signed _____ Name _____ Designation _____

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

19/08/195

Ward: 8B

No Thanks.

[illegible]

1908546042
LOGAN
Georgina
17 Solias Place
Glasgow, Lanarkshire
G13 4NA

19/08/1954
F

Care Plan

Care discussed with patient Unable ☐ Yes ☐ No ☐		If unable, give reason:			
Care discussed with family Unable ☒ Yes ☐ No ☐		If unable, give reason:			
Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
10/6/25	News as per News Score	Zale Lisa Atherton	10/6/25	See Board In Room	Zale Lisa Atherton
				5. Hydration and Nutrition	
			10/6/25	See Must Chart	Zale Lisa Atherton
	2, 3. Communication and senses				
10/6/25	Use bed lights as likes room dark	Zale Lisa Atherton			
				6. Elimination	
	4. Cognitive status		10/6/25	See News Chart for Bowel Activity	Zale Lisa Atherton
10/6/25	Patient aware of environment and her needs	Zale Lisa Atherton			



1908549042

LOGAN
Georgina

19/08/1954

Care Plan

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
10/6/25	See Podra See Pvc Chart	Zals Lisa Atherton	10/6/25	Ensure Nurse Call System at hand. Visually inspected	Lisa Atherton Zals
				10. Sleep and Rest	
			10/6/25	Good Sleep Normal for this patient	Lisa Atherton Zals
	8. Mobility				
10/6/25	See moving & handling Chart	Zals	10/6/25	12. Privacy, dignity and sexuality	
	See Bed rail Chart	Lisa Atherton		No issues with this door being open and people popping in	Lisa Atherton Zals
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	
			10/6/25	Care discussed with patient patient able to participate	Lisa Atherton Zals

4AT and TIME for Detection, Management and Prevention of Delirium

Complete for patients: age 65 and over; patients of any age with an existing cognitive impairment; previous delirium; current hip fracture; or severe illness. These patients are at high risk of delirium.

This should be done on admission; at each transition of care; if SQiD positive; or if any clinical concerns.

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4AT					
(1) Alertness	Ward 1AU Date & Time 4/6/25 2:30	Ward 2B Date & Time 5/6/25 14:45	Ward Date & Time	Ward Date & Time	Ward Date & Time
This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating					
Normal (fully alert, but not agitated, throughout the assessment)	0	0	0	0	0
Mild sleepiness for <10 seconds after waking, then normal	0	0	0	0	0
Clearly abnormal	4	4	4	4	4
(2) AMT4					
Ask the patient their Age, Date of Birth, Place (name of hospital) Current Year					
No mistakes	0	0	0	0	0
1 mistake	1	1	1	1	1
2 or more mistakes	2	2	2	2	2
(3) Attention					
Ask the patient "Please tell me the months of the year in backward order, starting at December". To assist, one prompt of "What is the month before December" is permitted.					
Achieves 7 months or more correctly	0	0	0	0	0
Starts but scores < 7 months or refuses to start	1	1	1	1	1
Untestable (cannot participate because too drowsy or inattentive)	2	2	2	2	2
(4) Acute change or fluctuating course					
Evidence of significant change of fluctuation in: alertness, cognition, other mental function (e.g. hallucinations, paranoia) over the past 2 weeks and still present in preceding 24 hrs.					
No	0	0	0	0	0
Yes	4	4	4	4	4
4AT TOTAL SCORE	0	0			
Print initials of assessor	St	SMH			
Score >4 This is a possible DELIRIUM +/- COGNITIVE IMPAIRMENT, start 'A' and 'I' of TIME and escalate to medical staff to confirm diagnosis	Score 1-3 This is a possible COGNITIVE IMPAIRMENT, and requires further assessment		Score 0 DELIRIUM or SEVERE COGNITIVE impairment unlikely		

All patients scoring 0-3 are still at high risk of delirium. Use the Triggers listed overleaf to plan care and reassess daily by asking 'Is the patient more confused or drowsy?' This is the single question in delirium (SQiD)

TIME checklist to guide Delirium risk reduction, Identification and Management

The TIME checklist is a joint medical and nursing responsibility.

Affix ID Label

Triggers, Investigate, Manage and Engage		Date	Date	Date	Date	Date
Triggers	Think possible triggers for delirium	Tick box	5/6/25			
	Is the patient in pain? Start pain chart, review analgesia and consider need for an aperient		N			
	Is the patient constipated or at risk of constipation? Commence bowel chart and review daily to assess for constipation, especially if on analgesia. Consider rectal examination		N			
	Is the patient in urinary retention? Palpate bladder/scan		N			
	Is the patients oral intake sufficient to prevent dehydration? Encourage hourly fluids, start fluid balance chart		N			
	Could any drugs trigger delirium? Doctor to review medication		N			
	Blood sugar, high or low?		N/A			
	Is there a history of alcohol intake/drug abuse? Intoxication or withdrawal, start GMAWS/drug misuse guidelines		N			
	Does the patient have sensory impairment? Ensure patient is wearing their glasses/hearing aid(s)		Glasses			
	Is the patient immobile? Promote early mobilisation in order to prevent delirium		N			
Document 4AT score			0			
Does the patient have Delirium? (Yes/No/Unsure) Please Circle		Y N U	Y N U	Y N U	Y N U	Y N U
Investigate	Investigate					
	Record NEWS		0			
	Screen for infection		✓			
	Take bloods and ensure ECG/appropriate imaging		✓			
Manage	Management: Diagnose causes & initiate treatment					
	Document diagnosis of delirium		N/A			
	Document potential causes of delirium		✓			
	Document treatment plan		✓			
Engage	Engage and Explore					
	If appropriate, explain diagnosis of delirium to patient/ family/ carers and provide delirium leaflet		OA			
	Engage with patient/ family/ carers. Complete "What matters to me"/"Getting to know me" document		OA			
	Does the patient have capacity to consent to care? (Yes/No/Ongoing Assessment)	Y N O	Y N O	Y N O	Y N O	Y N O
If no, complete AWI document			NA			
Print initials of assessor			SHJ JIM			

Discharge Checklist

Patient's name: 
 1908546042
 CHI number: LOGAN F
 Georgina 19/08/1954
 17 Sollas Place
 Glasgow, Lanarkshire
 G13 4NA

Ward: *8B*Discharge destination: *Home*Estimated Discharge Date (1) *1 / 1*Estimated Discharge Date (2) *1 / 1*Final date of discharge: *11 / 6 / 25*

Checklist	Yes	N/A	Initials	Comments
Patient informed	☒			
Relative/carer informed		☒		
Relative/carer involved in discharge planning discussions		☒		
Others informed: Care Home		☒		
Transport arranged				
Own transport (preferred option)	☒			
Ambulance: 1 man/ 2 man am/pm		☒		
Other: Flight, Air ambulance etc.		☒		
Discharge medication				
Immediate Discharge Letter completed	☒			
Compliance aids e.g. Dosette Box (involve pharmacist)	☒			<i>Discharge</i>
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		☒		
Homecare		☒		
Homecare request form completed?		☒		
Discharge lounge handover completed?		☒		
Physiotherapist		☒		
Occupational Therapist		☒		
Dietitian		☒		
Speech and Language Therapist		☒		
Clinical Nurse specialist		☒		
Liaison/ District Nurse/Practice Nurse		☒		
Other discharge items				
Access arrangements (e.g. keys, door entry)	☒			
Patients clothing available for day of discharge	☒			
Valuables e.g. cash		☒		
Intravenous cannula removed	☒			
Equipment ordered (inc. walking aids) in place for discharge				
Part 2 Discharge letter - Required				
- Completed	☒			
Outpatient clinic appointment				
Arranged				
To follow	☒			<i>up</i>
If unknown at time of discharge state reason				
Additional information / leaflets / factsheets				
Time of Discharge: <i>16:00</i>				
Nurse's signature: <i>[Signature]</i>			Designation: <i>DN</i>	Date: <i>11/6/25</i>



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FALLS RISK ASSESSMENT

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



GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

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

	Ward: 1AU Date: 4/6/25 Time: 20:00	Ward: 8B Date: 5/6/25 Time: 14:30	Ward: Date: Time: -----	Ward: Date: Time: -----	Ward: Date: Time: -----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	yes	Y			
2. Check walking aid (if required) is in reach and in use.	N/A	N/A			
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	yes	Y			
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	yes	Y			
5. If glasses are worn, check they are available and in use.	yes	Y			
6. If hearing aid/s are worn, check they are working and in use.	N/A	N/A			

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).

Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.

****ALL patients in older people's wards must have an interventional plan in place (overleaf)****

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

Highlight risk of fall at the ward safety brief.



1908546042

LOGAN

Georgina

17 Sollas Place
Glasgow, Lanarkshire

19/08/1954

G13 4NA

Patient) Moving and Handling Assessment Form

Person Name:	1908546042 LOGAN Georgina 17 Sollas Place Glasgow, Lanarkshire		Named Nurse:		Person is totally independent (tick here and go to date box)	☒
--------------	--	--	--------------	--	---	-------------------------------------

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

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)					
Hoist	Standard	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 2 >3	Additional Information / Equipment:	
Sling type					
Sling Size					

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

4. Move on / off bed pan					
Hoist	Manoeuvre	Assistance	Supervision	N/A	
See No 2 Sit to Stand Transfers for details		Roll patient Monkey pole Independent bridging	People: 1 2 >3	Additional Information:	

5. Move up / down bed					
Hoist	Handling Aids	Assistance	Supervision	Independent	
See No 2 Sit to Stand Transfers for details		Sliding sheets Monkey pole Rope ladder	People: 1 2 >3	Additional Information:	

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

7. Sit up over side of bed					
Bed Rest		Assistance	Supervision	Independent	
		People: 1 2 >3	Additional Information / Equipment (eg rope ladder, swivel cushion):		

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

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

10. Other Instructions / Observations / Equipment Used					

	1st Assessment		2nd Assessment		3rd Assessment	
Recording Symbol:	/	Forward slash	X	Where a forward slash exists, add a back slash to make a cross	*	Where a slash or cross exists add slashes to make a star
Date Assessed:	4/6/25		11/6/25			
Assessor's signature:			am			
Proposed Review date:	11/6/25		18/6/25			

Continuation Sheet

[illegible]

Pressure Ulcer Daily Risk Assessment (PUDRA)

 1908546042 LOGAN: F Georgina 17 Sollas Place Glasgow, Lanarkshire 19/08/1954 G13 4NA	Hospital: QEUW Ward: 1A	Points to consider: - Use within 8 hrs of admission to care area - Re-assess daily and more frequently if a person's condition changes
---	--	--

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

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

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

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

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Check Skin	Signature
4/6/25	21:00	N	N	N	N	N	N	4 hrly	ST
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	

Patient Centred SSKINS care plan

Aim: to provide effective pressure ulcer prevention strategies to reduce/eliminate potential for pressure ulcer development.
NB. Avoid patients lying on back/sitting for prolonged episodes, a total change of position is required, standing only is not sufficient

Attach Addressograph

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

Pressure Ulcer Daily Risk Assessment (PUDRA)

 1908546042 LOGAN F Georgina 17 Sollas Place Glasgow, Lanarkshire 19/08/1954 G13 4NA	Hospital: QEHM Ward: 8B	Points to consider: • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes
--	--	--

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

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

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

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

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

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
5/6/25	14:40	N	N	N	N	N	N	4 hrly	Sawyer
6/6/25	02:00	N	N	N	N	N	N	4 hrly	NS
7/6/25	01:00	N	N	N	N	N	N	4 hrly	NS
8/6/25	00:28	N	N	N	N	N	N	4 hrly	Spicer
9/6/25	00:30	N	N	N	N	N	N	4 hrly	Spicer
10/6/25	01:00	N	N	N	N	N	N	4 hrly	Spicer
11/6/25	00:00	N	N	N	N	N	N	4 hrly	CAO
/ /	:							__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



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



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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
As above and including: palpable venous cord	4	Seek further advice
As above and including: pyrexia	5	

Insertion details: Date: <u>9/8/22</u> (Day 1) Time: _____	Where inserted: ☐ ED ☐ Theatre ☐ ITU/HDU ☐ Ward _____ ☐ Unknown	Insertion site: ☒ Hand ☐ Arm Other: _____	Side: ☒ Left ☐ Right	Size of cannula: ☐ 26G Purple ☐ 18G Green ☐ 24G Yellow ☐ 16G Grey ☒ 23G Blue ☐ 14G Orange ☐ 20G Pink	Inserted by: Print: _____ Signature: _____ Designation: _____
Clinical indication:	☒ Diagnostics	☐ Resuscitation	☐ IV medications	☐ Fluids	☐ Transfusion
Insertion criteria:	Hand hygiene performed ☐ Yes ☐ No	Skin decontamination (2% chlorhexidine in 70% isopropyl alcohol) ☐ Yes ☐ No	Sterile transparent semi-permeable dressing affixed ☐ Yes ☐ No	PVC explained to patient/carer ☐ Yes ☐ No	
DRIFT PVCs are associated with an increased risk of phlebitis, thrombosis, infection and S.aureus bacteraemia.			Signs of local or systemic infection		
Justify the need for your patient to have a PVC using the DRIFT mnemonic. ✓ 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 to oral fluids? ✓ Transfusion - Does the patient require a transfusion of blood products?			Local infection - Erythema / inflammation - Exudate - Hot to touch - Pain/tenderness		Systemic infection - Hypotension - Tachycardia - Pyrexia

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 $\leq 37.9^{\circ}\text{C}$, 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. aureus 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

Adult IVOST
Guideline:



Paediatric IVOST
Guideline:



Write or affix label

Name:
Address:
CHI:
DOB:
Hospital & Ward:

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

Maintenance – to be completed twice daily (Observe for signs and symptoms of local or systemic infection)													
Date	Need for PVC reviewed today?		Any sign of PVC site infection?		Is the dressing intact?		Before / after PVC procedures; hand hygiene performed?		PVC patent?		What has been done?		Sign: Print: Designation:
	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	
Day 1 Insertion Date 9/6/25	☒ Yes ☐ No	☒ Yes ☐ No	VIP 0	VIP 0	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Left in situ ☐ Redressed ☐ Removed	☒ Left in situ ☐ Redressed ☐ Removed	Day <i>Shi CN</i> Night <i>Shi CN</i>
Day 2 10/6/25	☒ Yes ☐ No	☒ Yes ☐ No	VIP 0	VIP 0	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Left in situ ☐ Redressed ☐ Removed	☒ Left in situ ☐ Redressed ☐ Removed	Day <i>Shi CN</i> Night <i>L. Ash Lisa. Attah SN</i>
Day 3 11/6/25	☒ Yes ☐ No	☒ Yes ☐ No	VIP 0	VIP 0	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Left in situ ☐ Redressed ☐ Removed	☒ Left in situ ☐ Redressed ☐ Removed	Day <i>Shi CN</i> 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	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
PVCs should be removed on day 7. Reassess ongoing needs and vessel health for most appropriate vascular access device. Date removed <u> </u> / <u> </u> / <u> </u>													
Reason for removal		☐ Site infection		☐ Infiltration		☐ Extravasation		☐ End of treatment		Other:			

 1908546042 LOGAN, F 19/08/1954 17 Solias Place Glasgow, Lanarkshire G13 4NA		Peripheral Venous Cannula (PVC) Insertion & maintenance Please complete insertion details for each PVC inserted Care & maintenance to be undertaken & documentation completed twice each day.		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="3">Modified Visual Infusion Phlebitis (VIP) Score</th> </tr> <tr> <td>PVC site appears healthy</td> <td>0</td> <td>No phlebitis: Continue care and maintenance</td> </tr> <tr> <td>Either slight pain or redness near site</td> <td>1</td> <td>Possible first signs: Observe PVC site</td> </tr> <tr> <td>Two or more: pain / redness / swelling</td> <td>2</td> <td>Early stage of phlebitis: Remove and resite PVC</td> </tr> <tr> <td>All: pain / redness / hardening of surrounding area</td> <td>3</td> <td>Phlebitis/thrombophlebitis: Remove and resite PVC</td> </tr> <tr> <td>As above and including: palpable venous cord</td> <td>4</td> <td>Seek further advice</td> </tr> <tr> <td>As above and including: pyrexia</td> <td>5</td> <td></td> </tr> </table>				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	As above and including: palpable venous cord	4	Seek further advice	As above and including: pyrexia	5	
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Insertion details: Date: <u>2/2/22</u> (Day 1) <u>1</u> Time: <u>7</u>		Where inserted: ☐ ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☒ Unknown		Insertion site: ☐ Hand ☐ Arm Other: _____		Side: ☐ Left ☐ Right		Size of cannula: ☐ 26G Purple ☐ 18G Green ☐ 24G Yellow ☐ 16G Grey ☐ 23G Blue ☐ 14G Orange ☐ 20G Pink		Inserted by: <u>?</u> Print: _____ Signature: _____ Designation: _____																		
Clinical indication: ☐ Diagnostics ☐ Resuscitation ☐ IV medications ☐ Fluids ☐ Transfusion		Insertion criteria: Hand hygiene performed ☐ Yes ☐ No <u>?</u> Skin decontamination (2% chlorhexidine in 70% isopropyl alcohol) ☐ Yes ☐ No <u>?</u> Sterile transparent semi-permeable dressing affixed ☐ Yes ☐ No <u>?</u> PVC explained to patient/carer ☐ Yes ☐ No <u>?</u>																										
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?						<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th>Signs of local or systemic infection</th> </tr> <tr> <td> Local infection • Erythema / inflammation • Exudate • Hot to touch • Pain/tenderness </td> </tr> <tr> <td> Systemic Infection • Hypotension • Tachycardia • Pyrexia </td> </tr> </table>						Signs of local or systemic infection	Local infection • Erythema / inflammation • Exudate • Hot to touch • Pain/tenderness	Systemic Infection • Hypotension • Tachycardia • Pyrexia														
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		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 $\leq 37.9^{\circ}\text{C}$, 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. aureus 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									
--	--	--	--	--	--	--	--	--	--	---	--

Write or affix label

Name:
Address:
CHI:
DOB:
Hospital & Ward:

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

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

Date	Need for PVC reviewed today?		Any sign of PVC site infection?		Is the dressing intact?		Before / after PVC procedures; hand hygiene performed?		PVC patent?		What has been done?		Sign: Print: Designation:
	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	
Day 1 Insertion Date 5/1	☐ 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 5/16/25	☒ 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 <i>SN / IM / B. Gerson</i> Night
Day 3 6/1	☐ 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
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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	☐ Left in situ ☐ Redressed ☐ Removed	Day Night

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

5/16/25

Reason for removal ☐ Site infection ☐ Infiltration ☐ Extravasation ☐ End of treatment Other: *Not in situ*

[illegible][illegible][illegible][illegible][illegible]

C Blood Pressure mmHg

Score uses Systolic BP only.

Systolic BP Range (mmHg)	Frequency
220	3
201-219	0
181-200	0
161-180	0
141-160	0
121-140	0
111-120	0
101-110	1
91-100	2
81-90	3
71-80	3
61-70	3
51-60	3
≤50	3

C Pulse Beats / min

Time	Pulse (Beats/min)
0	133
1	131
2	129
3	127
4	125
5	123
6	121
7	119
8	117
9	115
10	113

[illegible]

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[illegible]

Blood glucose	7.0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	52
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NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

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

Think ACE	
A	Action: Working diagnosis (consider SEPSIS). Consider frequency of observations. Management plan. Set review time. Document.
C	Communicate: Inform nurse of plan. Inform senior medic if necessary. Document the discussion.
E	Escalate: Document the treatment escalation plan. Should include need for next level of care & consideration of resuscitation status.

19085456042 F
LOGAN
Georgina
17 Sollas Place
Glasgow, Lanarkshire
G13 4NA

Abbreviations for recording oxygen device

A	Room Air
N	Nasal Cannulae
SM	Simple Mask
V	Venturi Mask and 9% 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)

1908546042
LOGAN
Georgina
17 Solais Place
Glasgow, Lanarkshire
19/08/1954
F
G13 4NA

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1908545042 F
LOGAN
Georgina 19/08/1954
17 Solias Place
Glasgow, Lanarkshire
G13 4NA

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	
Signature:	
Print Name:	
Dr/ANP Initials ONLY:	
Date:	

Sp02 Scale 2 Target 88-92%	
Signature:	
Print Name:	
Dr/ANP initials ONLY:	
Date:	

Patient on home oxygen Y ☐ N ☐
If yes, add details of oxygen therapy

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: _____

[illegible]

Patient name

Patient CHI

 1908546042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA	
19/08/1954	



Emergency Care Nursing Documentation

Presenting complaint - and relevant past medical history including allergies

Date and Time		Name/Signature
04.01.23 1540	? Flare up of diverticulitis	SN H. ROPER

Nursing notes - on admission

Date and Time		Name/Signature
04.01.23 1540	In cubicle, in gown. Monitors attached. NEWS (1) Nameband Consulted by DR	SN H. ROPER

Triage

Patient prepared for exam - clothing bagged	☒	☐	
NEWS Chart	☒	☐	X-rays ☐ ☐
ID band	☒	☐	
Peak Flow	☐	☒	Please specify
12-lead ECG	☐	☐	Urinalysis ☐ ☐
IV access	☐	☐	
Blood samples	☐	☐	Positive findings
Blood Gas	☐	☐	B-HCG ☐ ☐

Communication

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

Risk Assessments and Screening Tools

SEPSIS	☐	☐	GMAWS	☐	☐
FAST	☐	☐	Adult Support and Protection	☐	☐
Swallow Testing	☐	☐	Mental Health Triage Assessment	☐	☐
Falls Risk (clinical judgement)	☐	☐	Child Protection Concerns	☐	☐
Signature:					

Patient name ..

Patient CHI



Care Rounds Checklist

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

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Use the following Codes:

Y = Yes **N** = No **NA** = Not Applicable **NT** = No Thanks **S** = Sleeping **O** = Off the ward **I** = Independent

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

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

Patient CHI

N | S
Greater Glasgow
and Clyde

[illegible]

Date and Time		Name/Signature

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

Signature: _____

Patient name

Patient CHI

or use sticker

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



PUDRA

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

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

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

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

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

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

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

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

Patient name

Patient CHI

or use sticker

4AT assessment - for delirium and cognitive impairment

(1) ALERTNESS This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.		Circle Score
Normal (alert, but not agitated, through assessment)		0
Mild sleepiness (<10 secs) after waking, then normal		0
Clearly abnormal		4
(2) AMT4 Age, date of birth, place (name of the hospital/building), current year.		Circle Score
No mistakes		0
1 mistake		1
2 or more mistakes/untestable		2
(3) ATTENTION Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.		Circle Score
wAchieves 7 months or more correctly		0
Starts but scores <7 months / refuses to start		1
Untestable (cannot start, unwell, drowsy, inattentive)		2
(4) ACUTE CHANGE OR FLUCTUATING COURSE Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs.		Circle Score
No		0
Yes		4
4 or more possible delirium + /- cognitive impairment 1-3 possible cognitive impairment 0 delirium or severe cognitive impairment unlikely (but delirium still possible if (4) information incomplete)		TOTAL

Frailty Assessment Tool (Healthcare Improvement Scotland)

Step 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?			circle Y or N	
F	Functional impairment	(new or worsening) eg difficulty with self care	Y	N
R	Resident	in a care home	Y	N
A	Altered mental state	such as delirium or dementia (4AT Assessment)	Y	N
I	Immobility/instability	decline in mobility, difficulty mobilising without help, fall leading to presentation	Y	N
L	Living at home with support	on a daily basis (homecare, one visit or more per day)	Y	N
If YES to any of the criteria in Step 1 move to Step 2				
Step 2 Would this person be better managed by another speciality team at present?			circle Y or N	
Clear need for other speciality input eg exacerbation of known long-term condition such as COPD			Y	N
Need for HDU/ITU (including non-invasive ventilation)			Y	N
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit			Y	N
Head injury with loss of consciousness			Y	N
Acute abdominal pain/ surgical presentation			Y	N
Upper GI Bleed			Y	N
Chest pain with suspected acute coronary syndrome			Y	N
Trauma with suspected fracture			Y	N
Are any of the criteria met?				
If YES to any criteria in Step 2: Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.				
If YES to any criteria in Step 1 and NO to ALL criteria in STEP 2: Prioritise transfer of care to specialist geriatric assessment service.				

T/F 9d 05/01/23

My Admission Record



Ne 1908545042
 AC LOGAN
 Georgina
 17 SOLLAS PLACE
 KNIGHTSWOOD
 D Glasgow, Lanarkshire
 C G13 4NZ
 Affix patient ID label

Hospital: QGH Ward: 9B
 Date of Admission: 4/1/23 Time: 1850
 Information obtained from: Name: Georgina
 Patient ☒ Relative ☐ Other ☐
 Preferred Name: Georgina
 Age: 68 Telephone Number: 073426644 10
 Consultant: Mr Glen

WSU - ☒ trace blood
 TcdS - ☒

Communication

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

Preferred first contact

Name: George
 Relationship: Husband
 Address: _____
 Telephone: 07760159467
 Is this person aware of your admission? Yes ☒ No ☐
 Can we share information with this person? Yes ☒ No ☐

Preferred second contact

Name: _____
 Relationship: _____
 Address: _____
 Telephone: _____
 Is this person aware of your admission? Yes ☐ No ☐
 Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

Recent discharge with DVT/PE
? similar pain
 Explained to the patient? Yes ☐ No ☐ Not Applicable ☐
 Do you understand the reason for your admission? Yes ☐ No ☐

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

No known allergies ☒

Relevant past medical history

Pericarditis
low Blood pressure
Angina

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

Power of Attorney / Guardianship / Adult with Incapacity

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

Yes ☐No ☒**OR**

Does someone have Guardianship?

Yes ☐No ☒If yes, is this for:- Finance ☐ Welfare ☐ Both ☐Which are currently in action? Finance ☐ Welfare ☐ Bt ☐ Nil ☐

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

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

Name: _____

Address: _____

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:

Yes

No

1. Been an inpatient in a hospital outside Scotland?

☐☒

2. Received holiday dialysis outside Scotland?

☐☒

3. Been told that you have CPE?

☐☒

4. Been in close contact with a person with CPE?

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

Isolate the patient in a side room

☐

Obtain Rectal swab marked 'for CPE'

☐

If patient refuses rectal swab, obtain a stool specimen marked 'for CPE'

☐**and Inform the IPCT**☐**MRSA Screening**

Yes

No

Unsure

Will the patient be an inpatient for more than 23 hours

☒☐☐If **YES** complete the following section

1. Have you ever been told that you have MRSA?

☐☒☐

2. Have you been admitted from another hospital/ residential setting or care home?

☐☒☐

3. Do you have a wound / skin ulcer or invasive device which you had before admission?

☐☒☐If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabsNasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐**Creutzfeldt-Jakob Disease (CJD)**

Yes

No

Unsure

Have you ever been informed that you are at increased risk of CJD or vCJD?

☐☒☐If **YES** inform the IPCT ☐

Name: _____
Addr _____
1908546042
LOGAN, J
Georgina 19/08/195
DoB: 17 SOLLAS PLACE
CHI: KNIGHTSWOOD
Affix: Glasgow, Lanarkshire
G13 4N/

Lifestyle

Smoking

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

Never smoked ☒

Do you use eCigarettes? Yes ☐ No ☐

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

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

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

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

Drugs

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

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

Alcohol

Do you drink alcohol? Yes ☐ No ☒

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

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

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

Name (Please PRINT): Laura Oumy

Signature: [Signature]

Designation: sen

Date: 4/1/23

My Assessment Record

Nr _____
 Ad _____
 1908546042
 LOGAN
 Georgina
 17 SOLLAS PLACE
 KNIGHTSWOOD
 Glasgow, Lanarkshire
 G13 4NJ
 19/08/1951
 Do _____
 CH _____
 Affi _____

1. Breathing and Circulation

Breathing	Admission Presentation	Normal for the patient	Assessment of the patient's breathing
No breathing problems	✓	✓	
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers	✓	✓	
Oxygen therapy			
Do you have any other symptoms?			
Circulation	Admission Presentation	Normal for the patient	Assessment of the patient's circulation
No circulatory problems			pericarditis
Chest pain at rest			
Chest pain on exertion			
Angina	✓	✓	
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

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

Name: _____
 Address: _____
 1908546042
 LOGAN: _____ F
 Georgina 19/08/1954
 DoB: 17, SOLLAS PLACE
 CHI: KNIGHTSWOOD
 Glasgow, Lanarkshire G13 4NA
 Affix p _____

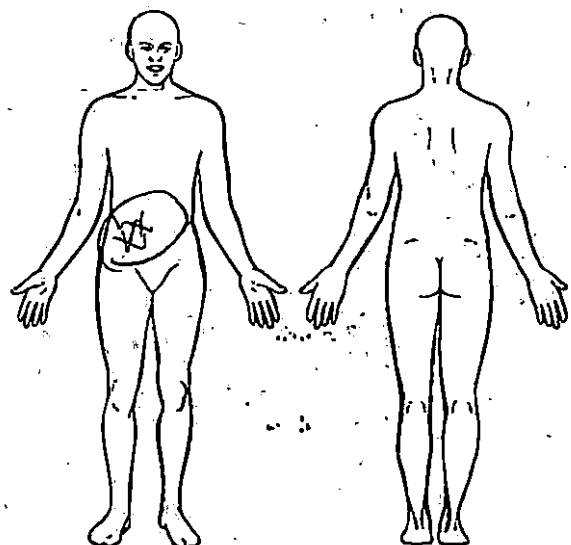
3. Senses

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

Can you describe where and what the pain is like?

Mark current pain on body chart

Have you had treatment / intervention for the pain?



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

Can you describe any chronic pain that you have?

What makes the pain better?

Name: _____
 Address: _____
 1908546042
 DoB: LOGAN 19/08/1954
 CHI: Georgina 17 SOLLAS PLACE
 Affix: KNIGHTSWOOD
 Glasgow, Lanarkshire G13 4NA

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

N.B. Think Delirium

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

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

and follow the guidance

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

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

nil

What do you like to eat and drink?

What do you not like to eat and drink?

*curry
eggs
some dairy products*

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

Diet and Fluids	Admission Presentation	Normal for the patient	Name: _____ Address: _____ 1908546042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire 19/08/1954 F G13 4NA
Normal diet and fluids	✓	✓	Assessment of the patient's hydration and nutrition needs
Therapeutic diet			
Cultural, ethnic or religious diet			
Texture Modified Diet Please state _____			
Thickened Fluid Please state _____			
Oral Nutritional supplements Preferred flavour _____			
Enteral Nutrition			
Parenteral Nutrition			
Nil by Mouth			
N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS) within 4 hours of admission			
Assistance with eating and drinking	Admission Presentation	Normal for the patient	
Independent (Green)	✓	✓	
Prompting / encouragement / opening packets/cutting up food (Amber)			
Full assistance with eating and drinking (Red)			
Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?			
6. Elimination			
Bladder	Admission Presentation	Normal for the patient	Assessment of the patient's elimination needs
Pass urine with no problems	✓	✓	
Frequently pass urine during the day			
Frequently pass urine overnight			
Sense of urgency when need to pass urine			
Urine retention			

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓	No Ad  1908546042 LOGAN Georgina 17 SOLIAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire DoB CHI Affix patient ID label
Haematuria			
Incontinent			

N.B. If new incontinence report to medical staff to rule out infection or physiological cause

What products do you normally use for this continence issue?

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

Date urinary catheter last changed ____/____/____

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

Bowels

When did your bowels last move?

Regular

How often in a day/week do you have a bowel movement? Per day Per week

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

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

What products do you normally use for this continence issue?

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

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

Name: _____

Address: _____



1908546042

LOGAN

Georgina

19/08/195

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

G13 4NA

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

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

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

Pressure ulcer identified on admission: Yes ☐ No ☒

Pressure Ulcer Grade: _____

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

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

Wound Care	Yes ✓	No ✓	Na Ad: 1908546042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire Do CH Affix patient ID label
Do you have any wounds? N.B. If yes, complete an assessment chart for wound management		✓	19/08/1954 G13 4NA

8. Mobility

Mobility	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's mobility needs
Fully mobile and independent	✓	✓	<i>Walking Steady</i>
Unsteady when walking			
Do you use a mobility aid	Yes ☐	No ☒	
Do you have your mobility aid with you?	Yes ☐	No ☒	

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

9. Maintaining a Safe Environment

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

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

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

10. Sleep and Rest

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

Nam 1908546042
 Add LOGAN
 Georgina
 17 SOLLAS PLACE
 KNIGHTSWOOD
 Glasgow, Lanarkshire
 DoB
 CHI: 19/08/195
 G13 4N
 Affix patient ID label

11. Social Circumstances

Do you:

- Live alone ☒ Live with family/ friend/ other ☐
 Live in a nursing home ☐ Live in a care home ☐
 Live in residential supported care ☐ Live in student accommodation ☐
 Live in 'homeless' accommodation ☐ Have no fixed abode ☐
 Other please specify ☐

Dependants

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

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

Services

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

If yes, please provide details:

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

12. Emotional and Spiritual Care

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

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

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

Healthcare Chaplain informed Yes ☐ N/A ☒

Name			
Address	1908546042		
Sex	F	LOGAN,	
Age	4	Georgina	19/08/195
DoB	17 SOLLAS PLACE		
CHI	KNIGHTSWOOD		
	Glasgow, Lanarkshire		
Affix patient ID label	G13 4N/		

13. Person Centred Care

What matters and is important to you whilst you are in hospital?

This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

ml

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

Informal Support

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

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

Name:

Contact Details:

.....
.....

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

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

Yes ☐ No ☐

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

Name: _____



1908546042

LOGAN

Georgina 19/08/195

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

G13 4N/

Required Support

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

Yes ☐ No ☒

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

Has the carer been advised of the Carers Information Line?

Yes ☐ No ☐ Not appropriate at this time ☒

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?

Yes ☐ No ☐

Are you:

Employed ☐

Unemployed ☐

Self-employed ☐

Retired ☒

Full time education ☐

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

Yes ☐ No ☐ Not applicable ☒

Do you have any money worries?

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

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

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

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

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

If yes when was patient referred ____/____/____

Name: 
 Address: 1908546042
 LOGAN
 Georgina 19/08/1954
 17 SOLLAS PLACE
 KNIGHTSWOOD
 Glasgow, Lanarkshire
 DoB:
 CHI:
 Affix patient ID label G13 4NA

Risk Assessments/Other Documentation

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

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
4/1/23 19 ⁰⁰	Admitted via A&E with increased abdo pain - recent discharge with diarrhoea fluid and diet as able observations - NEWS stable Await Hepria for analgesia	

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 4 Georgina 19/08/1954
 17 SOLLAS PLACE
 KNIGHTSWOOD
 Glasgow, Lanarkshire
 G13 4NA
 A patient ID number

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
	Commenced on Abx - await Gent prescription	SCW
5/1/23	Patient had settled night	
03:00	Independent with ADLs	
	Analgesia as per hepma	
	IVABX as per hepma	
	Still awaiting gent being prescribed - Fyl aware as was admitted on dls.	
	Wound stable.	
	Reports passing urine although states not drinking enough - ORAL fluids encouraged.	
	Otherwise settled	K. Blw / SW
5/1/23	Cannula fixed with night shift - requested visiting at this time.	
1020	Full again ahead to desite cannula -	
	7am antibiotics started to be given	
	NEWS 1	
	SIB Mr Glen - current management	
	used red rock blood	
	Stress bands, watched	
	and no flatus	McCarthy

Name _____
 Address _____
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 D. _____
 C. _____
 Affix patient... _____
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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
5/1/23	pressed.	
10 ²⁰ cont.	Uncomplaning with DTF as to bed rest	W. A. J. M. V. All Caretakers
05/01/23	Patient arrived on road 91	
1415	Oral fluids given	J. Forrester
	Settled in room	JH
	obs stable	
	meds given	
6/1/23	Slept well.	X. B. M.
	Home today	X. B. M.
6.1.23	WR: For phosphate enema.	
1430	Pt. currently administering enema indep.	
	News Charted.	
	meds per hepma.	
	Indep. with adls.	
	PRN anti emetic for nausea. Settled day.	
	NO bowel mvemnts.	S. Ban
7/1/23	Complaining of pain after enema required creamph which was given.	
0730	Revised Suppositories and dithydrocodol.	
	Mobile & independent.	
	NEWS - 2 B p 97/1/1	
	medication taken as per plan	

CLINICAL NOTES - MEDICAL
NURSING

Please tick ✓ appropriate directorate



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Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

19/08/1954

G13 4NA

Date & Time		Signature, Print Name & Designation
7/1/23	Pres of fluids as able	CE CypP
0230	Plt Plt in ward - aware BNO	
1140	and that pt declined supps.	
	Plt states will try them today	
	Plt takes able independent	
	with ADP. Not at chared	
	No further complaints.	
	Patient suitable for boarding per	
07/01/23	Mr PARR	
1730	Bed allocated at GGH ward 3C	
	Handover given	
	Patient informed	JHore
	Transport arranged.	JHorester SN
8/1/23	Medications taken as prescribed.	
0230	Two of meds and inhaler unable to	
	be given as no stock in the ward.	
	Called a couple of wards to inquire	
	the meds but none of the wards	
	have it. ordered the meds on the internet.	
	Georgina has been settled and appeared	
	to be sleeping at present. Care rounding	
	carried out and documented.	SEH
8/1/23	Independent with own	
1030	personal care & Dressing	
	Observations Charted	
	Medications administered	
	as per hepma	
	Bowels inactive at time of	
	Repat - laxatives taken	CSN(S)

Date & Time		Signature, Print Name & Designation
8/1/23	patient for transfer Back to surgical ward @	
1140	Deen —————	C SN(S)
	patient's husband informed of transfer Back to a	
	Deen —————	C SN(S)
8.1.23	PT TIF to ward 9D, off ward	
1805	at present with partner.	
	Obs as charted. Voiding	
	urine - nil concerns reported.	
	Glycerate supps given - pt	
	self administers - reports no	
	bowel activity for over one	
	Week. —————	K Hills SN
9/1/23	Settled evening	
0300	Independent toilet	
	Bowel's incase - Supps given	
	NEWS = (2) B p 4/53	
	Medication taken as per	
	Home.	
	Managing diet & fluids	
	CS chole —————	Chysp
		(S SN)
9.1.23	Ward rand-awaited	
015	patient independently mobile	
	Independent with hygiene	
	voiding urine. Nil reported	
	PR as yet. Managing oral	
	fluids. Oral diet taken.	
	Obs as NEWS chart. All	
	mods as home. —————	K Hills SN
2015	Settled evening, ward rand	
	plan - commenced on	
	mebeverine, pt worried about	K Hills SN

☒

19/08/1954

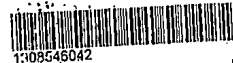
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NHSGGC Bedrail Risk Assessment

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

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT

Use guidance on the reverse of this document when completing this Risk Assessment		DATE	4/11/13	TIME	18:55	WARD	4B	HOSPITAL	Queen's
SECTION ONE - GENERAL									
1	Is the patient likely to fall, roll, slip or slide from the bed?								
2	Has the patient requested the use of bedrails?								
IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED									
SECTION TWO - COGNITIVE AND PHYSICAL STATUS									
3	Is the patient at risk of climbing out of bed?								
4	Is the patient stressed, delirious or restless?								
5	Is the patient small in stature?								
6	Does the patient have an unusually large or small head that might present an entrapment issue?								
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?								
IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE - See Guidance overleaf									
SECTION THREE - COMMUNICATION									
8	Has the patient been consulted regarding the use of bedrails?								
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition								
10	Has the use of bedrails been discussed with relatives/carers?								
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?								
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?								
IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE - See Guidance overleaf									
SECTION FOUR - DECISION MAKING									
13	Will bedrails be used for this patient at the present time?								
14	Rationale for use of bedrails: (Please insert code in the box on the right)								
	A - Risk of falling from the bed								
	B - Risk of rolling from the bed								
	C - Risk of slipping from the bed								
	D - Risk of sliding from the bed								
	E - Patient request								
15	Bedrail risk assessment completed by:								
16	Bedrails checked by:								
17	Date								
Any issues relating to the use of bedrails including discussion with family/relatives/carers should be recorded here									



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G13 4NL

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LOGAN, Georgina
19/08/1951
17, SOLLIAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire
G13 4NJ

Care Plan

Care discussed with patient Unable		☐ Yes ☐ No ☐	If unable, give reason:		
Care discussed with family Unable		☐ Yes ☐ No ☐	If unable, give reason:		
Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
4/1/23 eo	Independent		4/1/23 eo	NO issues	
				5. Hydration and Nutrition	
			4/1/23 eo	fluid and diet	
	2, 3. Communication and senses				
4/1/23 eo	NO issues				
				6. Elimination	
	4. Cognitive status		4/1/23 eo	Independent	
4/1/23 eo	Alert		6/1/25	Phosphate - aware	
			200	Supervising	
				BVO 9 days	



1808548042
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19/08/1995

Care Plan

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
4/1/22 EO	Independent		4/1/22 EO	no issues	
				10. Sleep and Rest	
			4/1/22 EO	encourage	
	8. Mobility				
4/1/22 EO	Independent			12. Privacy, dignity and sexuality	
			4/1/22 EO	no issues	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

Date: 4/1/23

1. Signed [Signature] Name Wenling Designation CN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

ni

[illegible]

Care Rounds Variance Sheet

Attach Addressograph Label



Ward:

Codes

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

N.B. Record what and to whom escalated.

[illegible]

Date: 5/1/23

At 
1908546042 F
= LOGAN 19/08/1954
1 Georgina
Wa 17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire G13 4NA

1. Signed K-BL Name K-BL Designation SN
2. Signed Im Name Imorgan 4 Designation 4
3. Signed Shim Name Shim Designation SIN

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

[illegible]

Date: 6/1/23

1. Signed [Signature] Name Stevenson Designation SN
2. Signed [Signature] Name OStevenson Designation SN
3. Signed [Signature] Name Chapman Designation SN

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

Ward: 90

NHS
Greater Glasgow
and Clyde

[illegible]

Date: 8-1-23

1. Signed [Signature] Name Salma Gamie Designation SN
2. Signed [Signature] Name Lama Hills Designation SN
3. Signed [Signature] Name CHYSS Designation SN

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

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Glasgow, Lanarkshire

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

NHS
Greater Glasgow
and Clyde

[illegible]

4AT and TIME for Detection, Management and Prevention of Delirium

Complete for patients: age 65 and over; patients of any age with an existing cognitive impairment; previous delirium; current hip fracture; or severe illness. These patients are at high risk of delirium.

This should be done on admission; at each transition of care; if SQiD positive; or if any clinical concerns.



4AT		Ward 98	Ward 92	Ward	Ward	Ward
		Date & Time	Date & Time	Date & Time	Date & Time	Date & Time
(1) Alertness This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating		4/11/23 19:55	7/11/23 08:10			
Normal (fully alert, but not agitated, throughout the assessment)		0	0	0	0	0
Mild sleepiness for <10 seconds after waking, then normal		0	0	0	0	0
Clearly abnormal		4	4	4	4	4
(2) AMT4 Ask the patient their Age, Date of Birth, Place (name of hospital) Current Year						
No mistakes		0	0	0	0	0
1 mistake		1	1	1	1	1
2 or more mistakes		2	2	2	2	2
(3) Attention Ask the patient "Please tell me the months of the year in backward order, starting at December". To assist, one prompt of "What is the month before December" is permitted.						
Achieves 7 months or more correctly		0	0	0	0	0
Starts but scores < 7 months or refuses to start		1	1	1	1	1
Untestable (cannot participate because too drowsy or inattentive)		2	2	2	2	2
(4) Acute change or fluctuating course Evidence of significant change of fluctuation in: alertness, cognition, other mental function (e.g. hallucinations, paranoia) over the past 2 weeks and still present in preceding 24 hrs.						
No		0	0	0	0	0
Yes		4	4	4	4	4
4AT TOTAL SCORE		0	0			
Print initials of assessor		eo	JH			
Score >4 This is a possible DELIRIUM +/- COGNITIVE IMPAIRMENT, start 'T' and 'I' of TIME and escalate to medical staff to confirm diagnosis		Score 1-3 This is a possible COGNITIVE IMPAIRMENT, and requires further assessment.		Score 0 DELIRIUM or SEVERE COGNITIVE impairment unlikely		

All patients scoring 0-3 are still at high risk of delirium. Use the Triggers listed overleaf to plan care and reassess daily by asking 'Is the patient more confused or drowsy?' This is the single question in delirium (SQiD)

TIME checklist to guide Delirium risk reduction, Identification and Management

The TIME checklist is a joint medical and nursing responsibility.

Triggers, Investigate, Manage and Engage		Date	Date	Date	Date	Date
Triggers	Think possible triggers for delirium	Tick box	Tick box	Tick box	Tick box	Tick box
	Is the patient in pain? Start pain chart, review analgesia and consider need for an aperient					
	Is the patient constipated or at risk of constipation? Commence bowel chart and review daily to assess for constipation, especially if on analgesia. Consider rectal examination					
	Is the patient in urinary retention? Palpate bladder/scan					
	Is the patient's oral intake sufficient to prevent dehydration? Encourage hourly fluids, start fluid balance chart					
	Could any drugs trigger delirium? Doctor to review medication					
	Blood sugar, high or low?					
	Is there a history of alcohol intake/drug abuse? Intoxication or withdrawal, start GMAWS/drug misuse guidelines					
	Does the patient have sensory impairment? Ensure patient is wearing their glasses/hearing aid(s)					
	Is the patient immobile? Promote early mobilisation in order to prevent delirium					
Document 4AT score						
Does the patient have Delirium? (Yes/No/Unsure) Please Circle		Y N U	Y N U	Y N U	Y N U	Y N U
Investigate	Investigate					
	Record NEWS					
	Screen for infection					
	Take bloods and ensure ECG/appropriate imaging					
Manage	Management: Diagnose causes & initiate treatment					
	Document diagnosis of delirium					
	Document potential causes of delirium					
	Document treatment plan					
Engage	Engage and Explore					
	If appropriate, explain diagnosis of delirium to patient/ family/ carers and provide delirium leaflet					
	Engage with patient/ family/ carers. Complete "What matters to me"/"Getting to know me" document					
	Does the patient have capacity to consent to care? (Yes/No/Ongoing Assessment)	Y N O	Y N O	Y N O	Y N O	Y N O
	If no, complete AWI document					
Print Initials of assessor						



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FALLS RISK ASSESSMENT

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



GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

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

	Ward: <i>2B</i> Date: <i>4/1/23</i> Time: <i>18:50</i>	Ward: <i>9d</i> Date: <i>05/01/23</i> Time: <i>16:15</i>	Ward: _____ Date: _____ Time: _____	Ward: _____ Date: _____ Time: _____	Ward: _____ Date: _____ Time: _____
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	<i>complete</i>	<i>I</i>			
2. Check walking aid (if required) is in reach and in use.	<i>N/A</i>	<i>NA</i>			
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	<i>✓</i>	<i>✓</i>			
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	<i>✓</i>	<i>✓</i>			
5. If glasses are worn, check they are available and in use.	<i>✓</i>	<i>✓</i>			
6. If hearing aid/s are worn, check they are working and in use.	<i>N/A</i>	<i>NA</i>			

RISK ASSESSMENT

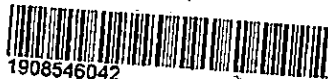
If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).

Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.

****ALL patients in older people's wards must have an interventional plan in place (overleaf)****

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

Highlight risk of fall at the ward safety brief.



1908546042

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4 Georgina

17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire

19/08/195

Patient) Moving and Handling Assessment Form

Pers/ Nam	G13 4N/		Named Nurse:	C L Martin		Person is totally independent (tick here and go to date box)	X
1. General		Problems with comprehension, behaviour, co-operation (specify):					
Body Build		Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):					
Weight	Height						
Kg	cm						
BMI							
Risk of Falls:		Yes ☐ No ☒					
2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)							
Hoist	Standaid	Walking Aid	Assistance		Supervision	Independent	
Model		Aid Type	People: 1	2	>3	Additional Information / Equipment:	
Sling type							
Sling Size							
3. Toileting							
Hoist	Standaid	Walking Aid	Assistance		Supervision	Independent	
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1	2	>3	Additional Information:	
4. Move on / off bed pan							
Hoist	Manoeuvre	Assistance		Supervision	N/A		
See No 2 Sit to Stand Transfers for details		Roll patient	People: 1	2	>3	Additional Information:	
		Monkey pole					
		Independent bridging					
5. Move up / down bed							
Hoist	Handling Aids	Assistance		Supervision	Independent		
See No 2 Sit to Stand Transfers for details		Sliding sheets	People: 1	2	>3	Additional Information:	
		Monkey pole					
		Rope ladder					
6. Lateral Transfer to / from trolley / bed							
Hoist	Handling Aids	Assistance		Supervision	Independent		
See No 2 Sit to Stand Transfers for details		Rigid Transfer Board	People: 1	2	>3	Additional Information / Equipment (eg sliding sheets):	
		Other (Please specify)					
7. Sit up over side of bed							
Bed Rest		Assistance		Supervision	Independent		
		People: 1	2	>3	Additional Information / Equipment (eg rope ladder, swivel cushion):		
8. Into Bath or Shower							
Equipment	Handling Aid	Assistance		Supervision	Independent		
Shower	Shower chair	People: 1	2	>3	Additional Information / Equipment (eg sling lifting hoist after risk assess):		
Variable / Fixed height bath	Shower trolley						
Bed bath	Bathing hoist (eg Alenti)						
9. Walking							
No Walking	Walking Aid	Assistance		Supervision	Independent		
see 'sit to stand transfers'		People: 1	2	>3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)		
10. Other Instructions / Observations / Equipment Used							
Recording Symbol:		1st Assessment		2nd Assessment		3rd Assessment	
		/ Forward slash		X Where a forward slash exists, add a back slash to make a cross		* Where a slash or cross exists add slashes to make a star	
Date Assessed:		4/11/23		7/11/23			
Assessor's signature:		[Signature]		[Signature]			
Proposed Review date:		11/11/23		14/11/23			

Continuation Sheet

1. General Information (Only complete this section if changed from over page)											
Body Build				Problems with comprehension, behaviour, co-operation (specify): Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):							
Weight		Height									
Kg		cm									
BMI											
Risk of Falls: Yes ☐ No ☐											
2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)											
Hoist	Standard	Walking Aid	Assistance			Supervision			Independent		
Model		Aid Type	People: 1	2	≥3	Additional Information / Equipment:					
Sling type											
Sling Size											
3. Toileting											
Hoist	Standard	Walking Aid	Assistance			Supervision			Independent		
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1	2	≥3	Additional Information:					
4. Move on / off bed pan											
Hoist	Manoeuvre	Assistance			Supervision			N/A			
See No 2 Sit to Stand Transfers for details		Roll patient	People: 1	2	≥3	Additional Information:					
		Monkey pole									
		Person bridges									
5. Move up / down bed											
Hoist	Handling Aids	Assistance			Supervision			Independent			
See No 2 Sit to Stand Transfers for details		Sliding sheets	People: 1	2	≥3	Additional Information:					
		Monkey pole									
		Rope ladder									
6. Lateral Transfer to / from trolley / bed											
Hoist	Handling Aids	Assistance			Supervision			Independent			
See No 2 Sit to Stand Transfers for details		Rigid Transfer Board	People: 1	2	≥3	Additional Information / Equipment (eg sliding sheets):					
		Other (Please specify)									
7. Sit up over side of bed											
Bed Rest		Assistance			Supervision			Independent			
		People: 1	2	≥3	Additional Information / Equipment (eg rope ladder, swivel cushion):						
8. Into Bath or Shower											
Equipment	Handling Aid	Assistance			Supervision			Independent			
Shower	Shower chair	People: 1	2	≥3	Additional Information / Equipment (eg sling lifting hoist after risk assess):						
Variable / Fixed height bath	Shower trolley										
Bed bath	Bathing hoist (eg Alenti)										
9. Walking											
No Walking	Walking Aid	Assistance			Supervision			Independent			
see 'sit to stand transfers'		People: 1	2	≥3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)						
10. Other Instructions / Observations / Equipment Used											
		4 th Assessment			5 th Assessment			6 th Assessment			
Recording Symbol:		/ Forward slash			X Where a forward slash exists, add a back slash to make a cross			* Where a slash or cross exists add slashes to make a star			
Date Assessed:											
Assessor's signature:											
Proposed Review date:											

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19/08/195

G13 4NA

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)



Date <u>4/1/23</u> Time <u>1850</u> of initial height and weight on admission to hospital	Actual	* Patient reported	* If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height <u>4-11</u> cm	☐	☒	
Admission Weight <u>69-10</u> kg	☒	☐	

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

Patients reported normal weight ☐ Unable to Recall ☐

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

Date	<u>4/1/23</u>	<u>05/01/23</u>	<u>08-1-23</u>				
Time	<u>1850</u>	<u>1415</u>	<u>1500</u>				
Ward	<u>9B</u>	<u>9A</u>	<u>9D</u>				
Oedema/ Ascities present Y/N	<u>N</u>	<u>N</u>	<u>-</u>				
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes	<u>ST</u>	<u>WajL</u> <u>not a</u>	<u>CH</u>				
Weight (kgs)	<u>69.10</u>	<u>1</u>	<u>69.50</u>				
BMI	<u>30.6</u>	<u>1</u>	<u>30.8</u>				

Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days

Step 1 BMI Score >20 = 0 10.5-20 = 1 <18.5 = 2	<u>0</u>	<u>1</u>	<u>0</u>				
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	<u>0</u>	<u>1</u>	<u>0</u>				
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	<u>0</u>	<u>1</u>	<u>1</u>				
Step 4 Overall Risk of Malnutrition TOTAL	<u>0</u>	<u>1</u>	<u>0</u>				
Rescreen on	<u>4/1/23</u>	<u>11/01/23</u>	<u>15-1-23</u>				
Signature	<u>LO</u>	<u>SR</u>	<u>EB</u>				

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

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

MUST STEP 5 Management Guideline

MUST 1

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient /carer normal eating patterns and preferences.
- Use a **Food First Approach**:
 - Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
 - Offer full cream milk with and between meals.
 - Order additional MUST snack daily of patients choice (refer to 'catering' section in Nutrition Resource Manual).
- Encourage family and friends to bring in patient preferred snacks.
- Complete a food and drink recording chart, including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a 72 hour period?

YES

Is the patient's Intake 'normal' or improved for them?

YES

- Discontinue food and drink recording chart, documenting reason in nursing notes.
- Continue with 'food first' approach as above.
- Rescreen at least every 7 days.

NO

- Encourage higher calorie menu choices indicated with ⓪
- Continue with food and drink recording chart for 4 days, and if no improvement in intake, rescreen.

NO

Complete the above steps

MUST 2 OR GREATER

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient /carer normal eating patterns and preferences.
- Use a **Food First Approach**:
 - Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
 - Offer full cream milk with and between meals.
 - Order additional MUST snack daily of patients choice (refer to 'catering' section in nutritional resource manual).
- Encourage family and friends to bring in patient preferred snacks.
- Complete a food and drink recording chart, including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a 72 hour period?

YES

Is the patients intake 'normal' or improved for them?

YES

- Discontinue food and fluid chart, documenting reason in nursing notes.
- Continue with 'food first' approach as above.
- Rescreen at least every 7 days.

NO

Is the patient dying?

YES

- Discontinue food and drink recording chart.
- Stop screening.
- Offer food and fluid as appropriate.

NO

- Continue with food and drink recording chart.
- Screen at least every 7 days.
- Consider referral to dietitians via Trakcare.

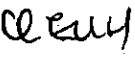
Complete the above steps

DISCHARGE

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

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

Pressure Ulcer Daily Risk Assessment (PUDRA)

 1908546042 LOGAN F Georgina 19/08/1954 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA	Hospital:  Ward: 	Points to consider: • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes
--	--	--

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

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

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

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

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

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
4/1/23	18:40	N	N	N	N	N	N	4 hrly	ED
5/1/23	08:00	N	N	N	N	N	N	4 hrly	WJ
6/1/23	00:00	N	N	N	N	N	N	4 hrly	WJ
7/1/23	01:00	N	N	N	N	N	N	4 hrly	WJ
8/1/23	08:30	N	N	N	N	N	N	4 hrly	WJ
9/1/23	11:00	N	N	N	N	N	N	4 hrly	WJ
10/1/23	00:00	N	N	N	N	N	N	4 hrly	WJ
/ /	:							__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

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



Attach Addressograph

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

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

Adult Peripheral Vascular Cannula

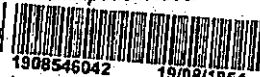
Insertion and Maintenance
Care Plan

Write or affix patient label

Name

DC

We



1908546042

LOGAN

Georgina

19/08/1954

CHI:

Address:

Hospital:



Insertion criteria: Please complete this section at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☐

Resuscitation/Chest Pain ☐

IV Drugs ☐

Fluids ☐

Transfusion ☐

PVC inserted: Day 0	Date: <u>4/1/23</u> Hospital: <u>Queen</u>
	Area: ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☐ Unknown ☒
Insertion site:	R Hand ☒ R Arm ☐ R Foot ☐ L Hand ☐ L Arm ☒ L Foot ☐ Other: _____
Colour of cannula:	Blue ☐ Pink ☒ Green ☐ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: _____

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? Diagnostics Resuscitation/ Chest Pain IV Drugs Fluids Transfusion	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day <u>1/1/23</u>	Yes ☒ No ☐ If No, remove PVC and record date and reason*.	VIP: <u>0</u>	Yes ☒ No ☐	Yes ☐ No ☒ N/A ☒	<u>JK</u>
Day 1 Check 2 Night: <u> / / </u>	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: <u> </u>	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day <u> / / </u>	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: <u> </u>	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night <u> / / </u>	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: <u> </u>	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day <u> / / </u>	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: <u> </u>	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night <u> / / </u>	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: <u> </u>	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: / / Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: 5/1/23 777

*Reason For Removal: _____

Modified Visual Infusion Phlebitis (VIP) Score

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

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and *S. aureus* bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids ? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → Can I switch my patient from IV to oral antibiotics?

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature $\leq 37.9^{\circ}\text{C}$, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE** is available reliably (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, *S. aureus* bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abscess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy. Record the intended duration on the medicine kardex

YES

NO

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

TRANSFER SBAR

Patient Name: <u>Georgina Logan</u> Age: <u>(68)</u>	COVID Screened: _____ DNR/AWT STATUS: _____
Admitted with: <u>Left iliac phospha pain</u> <u>Acute Diverticular</u> PMH: <u>Renal Colic, Depression</u> <u>AF, chronic Anxiety IBS</u> <u>Asthma pericarditis</u>	Current treatment: <u>- Bowels inactive 9 days</u> <u>- Supps/enemas given</u> <u>↑ laxatives</u>
Mobility: Normal level - _____ Current level - <u>Independent</u>	Skin condition: Wounds? _____ Dressing regime - <u>Skin Intact</u>
Continence: Normal - <u>Continent</u> Current - _____ <u>Pressure areas Intact</u>	Diet and fluids: Texture: _____ Fluids: <u>NDF</u> Supplements? _____
NEWS: O2 therapy? _____ Target sats: _____	Social circumstances: <u>Lives w husband</u>
Investigations carried out: _____	Investigations to be carried out: _____
<u>* Butrans patch x2 10 insitu *</u>	

Disch



Patient's name: 1908543042
 LOGAN
 Georgina
 17 SOLLAS PLACE
 KNIGHTSWOOD
 Glasgow, Lanarkshire
 G13 4NA
 Apply addressograph label

19/08/1954

Ward: 9A

Discharge destination: HOME

Estimated Discharge Date (1): 1 / 1

Estimated Discharge Date (2): 1 / 1

Final date of discharge: 10 / 1 / 23

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓		KN	
Relative/carer informed	✓		KN	
Relative/carer involved in discharge planning discussions				
Others informed: Care Home				
Transport arranged				
Own transport (preferred option)	✓		KN	
Ambulance: 1 man/ 2 man am/pm				
Other: Flight, Air ambulance etc.				
Discharge medication				
Immediate Discharge Letter completed	✓		KN	
Compliance aids e.g. Dosette Box (involve pharmacist)				
Medication received	✓		KN	
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				
Homecare				
Homecare request form completed?				
Discharge lounge handover completed?				
Physiotherapist				
Occupational Therapist				
Dietitian				
Speech and Language Therapist				
Clinical Nurse specialist				
Liaison/ District Nurse/Practice Nurse				
Other discharge items				
Access arrangements (e.g. keys, door entry)				
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				
Outpatient clinic appointment				
Arranged				
To follow				
If unknown at time of discharge state reason				
Additional information / leaflets / factsheets				
Time of Discharge:				
Nurse's signature:			Designation:	Date: / /

1908546042
LOGAN
Georgina
17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire
19/08/1954
G13 4NA

	Date	Ward	Time
Admitted			
Transferred	05/01/21	9d	14:15
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%
Signature:
Print Name:
Dr/ANP Initials ONLY:
Date:

Sp02 Scale 2 Target 88-92%
Signature: _____
Print Name: _____
Dr/ANP Initials ONLY: _____
Date: _____

Patient on home oxygen Y ☐ N ☐
If yes, add details of oxygen therapy

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:

Date:	Unit
Time:	Unit
Eyes closed by reading a VRT	E Y E
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	G H
	I J
	K L
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	O P
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[illegible][illegible]

A + B SpO2 Scale 1 Oxygen saturation (%)	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546</
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[illegible][illegible]

C Blood Pressure mmHg

(Score uses systolic BP)

Time	Systolic BP (mmHg)
134	134
144	144
102	102
105	105
106	106
107	107
108	108
109	109
110	110
111	111
112	112
113	113
114	114
115	115
116	116
117	117
118	118
119	119
120	120
121	121
122	122
123	123
124	124
125	125
126	126
127	127
128	128
129	129
130	130
131	131
132	132
133	133
134	134
135	135
136	136
137	137
138	138
139	139
140	140
141	141
142	142
143	143
144	144
145	145
146	146
147	147
148	148
149	149
150	150

Time (min)	Pulse (beats/min)
10	70
20	100
30	90
40	100
50	90
60	100
70	90
80	100
90	90
100	100
110	60
120	60
130	60

[illegible]

Temperature	23.9	2
38.1-39.0	1	
37.1-38.0	0	
36.1-37.0	0	
35.1-36.0	1	
≤35.0	1	

[illegible][illegible]

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.

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19/08/1954

Abbreviations for recording oxygen device

A	Room Air
N	Nasal Cannulae
SM	Simple Mask
V	Venturi Mask and 96 eg. V24
NiV	Non Invasive Ventilation
IV	Invasive Ventilation
T	Tracheostomy
CP	CPAP Mask
HFN	High Flow Nasal Oxygen
NEB	Nebuliser
Rm	Reservoir Mask (Emergency use only)

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Date: 7/1/23

1. Signed [Signature] Name Chusker Designation SN
2. Signed [Signature] Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

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

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Glasgow, Lanarkshire

Ward: 9

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

NHS
Greater Glasgow
and Clyde

[illegible]

My Admission Record



1908546042	
F	LOGAN
34	Georgina
17 SOLLAS PLACE	
KNIGHTSWOOD	
Glasgow, Lanarkshire	
IA	G13 4P

Hospital: QEUTH Ward: QB
 Date of Admission: 21/1/23 Time: 03.00
 Information obtained from: Name: _____
 Patient ☒ Relative ☐ Other ☐ _____
 Preferred Name: Gina
 Age: 68 Telephone Number: 07342664410
 Consultant: Park

*Leo, nites
 placed in SW
 Tedso*

Communication

What is your first language? ENGLISH

Do you require an interpreter? Yes ☐ No ☒

If yes, provide details of arrangements made _____

Do you use British Sign Language (BSL)? Yes ☐ No ☒

Do you need someone to help you to communicate? Yes ☐ No ☒ If yes, who _____

Preferred first contact

Name: GEORGE LOGAN

Relationship: HUSBAND

Address: AS ABOVE

Telephone: 07760159469

Is this person aware of your admission? Yes ☒ No ☐

Can we share information with this person? Yes ☒ No ☐

Preferred second contact

Name: _____

Relationship: _____

Address: _____

Telephone: _____

Is this person aware of your admission? Yes ☐ No ☐

Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

? Renal Colic

Explained to the patient? Yes ☒ No ☐ Not Applicable ☐

Do you understand the reason for your admission? Yes ☒ No ☐

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

No known allergies ☐

**Plastic *Latex *Clarithromycin *Trimethoprim *Co-amoxiclav*

Relevant past medical history

- Renal calculi
- Depression
- Crohn's
- A.F
- Anxiety
- Diverticulosis
- IBS
- Asthma
- Pericarditis

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place

Yes ☐ No ☒ If yes, Who asked for a copy? _____

Date they asked for a copy / / Date Obtained / /

Power of Attorney / Guardianship / Adult with Incapacity

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

Yes ☐ No ☒**OR**

Does someone have Guardianship?

Yes ☐ No ☒If yes, is this for:- Finance ☐ Welfare ☐ Both ☐Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☒

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

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

Name

Address



1908546042

F

LOGAN

34

Georgina

19/08/19

Do

17 SOLLAS PLACE

City

KNIGHTSWOOD

Ch

Glasgow, Lanarkshire

IA

Affix patient ID mark

G13 4A

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:

1. Been an inpatient in a hospital outside Scotland?

Yes

No

☐☒

2. Received holiday dialysis outside Scotland?

☐☒

3. Been told that you have CPE?

☐☒

4. Been in close contact with a person with CPE?

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

Isolate the patient in a side room

☐

Obtain Rectal swab marked 'for CPE'

☐

If patient refuses rectal swab, obtain a stool specimen marked 'for CPE'

☐**and inform the IPCT**☐**MRSA Screening**

Will the patient be an inpatient for more than 23 hours

Yes

No

Unsure

☒☐☐If **YES** complete the following section

1. Have you ever been told that you have MRSA?

☐☒☐

2. Have you been admitted from another hospital/ residential setting or care home?

☐☒☐

3. Do you have a wound / skin ulcer or invasive device which you had before admission?

☐☒☐If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabsNasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐**Creutzfeldt-Jakob Disease (CJD)**

Have you ever been informed that you are at increased risk of CJD or vCJD?

Yes

No

Unsure

☐☒☐If **YES** inform the IPCT ☐

Name:

1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

A

19/08/19:

G13 4N

Lifestyle**Smoking**Are you a: smoker ☐ ex-smoker ☐ when did you stop? _____Never smoked ☒Do you use eCigarettes? Yes ☐ No ☒

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

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

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

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

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

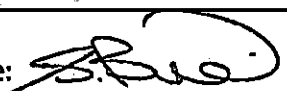
If yes, please specify and refer to the NHSGCC Guidelines for the Management of Drug Users in Glasgow and Clyde Acute Hospitals

AlcoholDo you drink alcohol? Yes ☐ No ☒

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

Never ☒ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐**NB: If daily or almost daily commence the Glasgow Assessment and Management of Alcohol (GAMA), complete FAST Tool and take further action as per guidance.**

Name (Please PRINT): SARABIRD

Signature: 

Designation: STAFF NURSE

Date: 2/1/23

My Assessment Record


 1908546042
 LOGAN
 Georgina
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 KNIGHTSWOOD
 Glasgow, Lanarkshire
 19/08/19
 G13 4N

1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems	✓	✓	
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			
Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems	✓	✓	A.F.
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

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

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 -F LOGAN
 j4 Georgina 19/08/19
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 A G13 4N

3. Senses

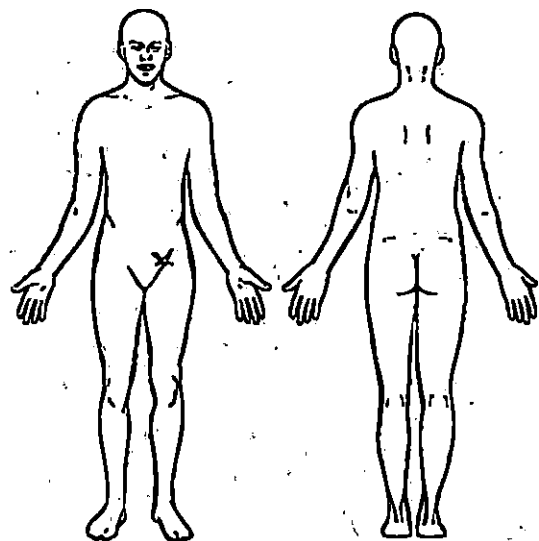
Vision	Yes ✓	No ✓	Assessment of the patient's vision
Do you have any problems with your vision?	✓		Distance ☐ Reading ☐ Both ☒
Do you wear glasses?	✓		
Do you have your glasses with you?	✓		
Do you wear contact lenses?		✓	
Do you have your lenses with you?		✓	
Do you wear a prosthesis?		✓	
Hearing	Yes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

Can you describe where and what the pain is like?

STABBING PAIN

Mark current pain on body chart

Have you had treatment / intervention for the pain?



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

Can you describe any chronic pain that you have?

What makes the pain better?

ANALGESIA

Name: _____

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 E 17 SOLLAS PLACE
 C KNIGHTSWOOD
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4. Cognitive Status **THINK DELIRIUM**

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

N.B. Think Delirium

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

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

and follow the guidance

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

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

DAIRY PRODUCTS.

What do you like to eat and drink?

What do you not like to eat and drink?

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

Diet and Fluids	Admission Presentation	Normal for the patient	Name:  1908546042 F LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4N 19/08/19
Normal diet and fluids	✓	✓	
Therapeutic diet			
Cultural, ethnic or religious diet			
Texture Modified Diet Please state _____			Assessment of the patient's hydration and nutrition needs
Thickened Fluid Please state _____			
Oral Nutritional supplements Preferred flavour _____			
Enteral Nutrition			
Parenteral Nutrition			
Nil by Mouth			
N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS) within 4 hours of admission			
Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓	
Independent (Green)	✓	✓	
Prompting / encouragement / opening packets/cutting up food (Amber)			
Full assistance with eating and drinking (Red)			
Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?			
6. Elimination			
Bladder	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Pass urine with no problems	✓	✓	
Frequently pass urine during the day			
Frequently pass urine overnight			
Sense of urgency when need to pass urine			
Urine retention			

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓	 1908548042 F LOGAN 54 Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4N AA
Haematuria			
Incontinent			

N.B. If new incontinence report to medical staff to rule out infection or physiological cause

What products do you normally use for this continence issue?

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

Date urinary catheter last changed ___/___/___

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

Bowels

When did your bowels last move? 5 or 6 DAYS

How often in a day/week do you have a bowel movement? Per day Per week

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

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

What products do you normally use for this continence issue?

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

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

Name: _____
 Address: _____
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 F LOGAN
 34 Georgina 19/08/19
 DoB: 17 SOLLAS PLACE
 CHI: KNIGHTSWOOD
 Glasgow, Lanarkshire
 Affix: ^{IA} G13 4N

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

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

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

Pressure ulcer identified on admission: Yes ☐ No ☐

Pressure Ulcer Grade: _____

Pressure Ulcer Site: _____

Adult wound assessment and management chart required

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

Wound Care	Yes ✓	No ✓	Name: _____ Ad:  _____ 1908546042 F LOGAN F 54 Georgina 19/08/1954 Do: _____ CH: _____ Affi: _____
Do you have any wounds? N.B. If yes, complete an assessment chart for wound management		✓	

8. Mobility

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

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

9. Maintaining a Safe Environment

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

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

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

10. Sleep and Rest

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

Name: _____

Adc:  1808546042

F: LOGAN

DoB: 19/08/19: _____

CHI: Georgina

Aff: 17 SOLLAS PLACE

Glasgow, Lanarkshire

JA G13 4A

11. Social Circumstances

Do you:

- Live alone ☒ Live with family/ friend/ other ☐
- Live in a nursing home ☐ Live in a care home ☐
- Live in residential supported care ☐ Live in student accommodation ☐
- Live in 'homeless' accommodation ☐ Have no fixed abode ☐
- Other please specify _____ ☐

Dependants

Yes ☒ No ☒

Do you have any dependants?

Do you support anyone (e.g. partner, children, relatives, animals)?

Do they need support from someone else whilst you are in hospital?

Would someone else be able to provide this support when you are in hospital?
If yes, who?

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

Services

Yes ☒ No ☒

Do you have support from social work, social services or a care package?

If yes, please provide details:

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

12. Emotional and Spiritual Care

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

NIL

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

NO

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

Healthcare Chaplain informed Yes ☐ N/A ☐

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C	KNIGHTSWOOD	
	Glasgow, Lanarkshire	
AIA	G13 4NA	
PATIENT ID LABEL		

3. Person Centred Care

What matters and is important to you whilst you are in hospital?

This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

GETTING HOME

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

Informal Support

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

HUSBAND

(SEPARATED, N.O.K. ON FRIENDLY TERMS)

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

Name:

Contact Details:

.....

.....

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

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

Yes ☐

No ☒

If yes, has the help or support listed above been confirmed with the patient's family/ friends?

(please tick)

Yes ☐

No ☒

Name: _____



1908546042

F LOGAN

F

34 Georgina

19/08/1954

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

IA

G13 4NA

Required Support

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

Yes ☐

No ☒

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

Has the carer been advised of the Carers Information Line?

Yes ☐

No ☒

Not appropriate at this time ☐

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?

Yes ☐

No ☒

Are you:

Employed

☐

Unemployed

☐

Self-employed

☐

Retired

☒

Full time education

☐

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

Yes ☐

No ☐

Not applicable ☒

Do you have any money worries?

Yes ☐

No ☐

Not appropriate to ask at this time ☒

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

Yes ☐

No ☐

If yes when was patient referred ____/____/____

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

Yes ☐

No ☐

Not applicable ☐

Not appropriate to ask at this time ☒

If yes when was patient referred ____/____/____

Name: _____
 Address: _____

 DoB: _____
 CHI: _____
 Affix patient ID label

Risk Assessments/Other Documentation

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

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
21/1/23	Patient admitted to ward	
03.30am	GB. with ? renal colic.	
	vital signs as charted.	
	Orientated to ward	
	environment. now S O	
	Plan - IV antibiotics, IV fluids	
	CTAP, Analgesia	J Bud

Name: _____
 Address: _____

 DoB: _____
 CHI: _____
 Affix patient ID label

Clinical Notes (cont.)		
Date and Time	Notes	Print Name, Signature and Designation
2/1/23 1530	Meds as charted on Hepma. Obs stable as charted. Independent with personal care. For CT & scan @ 12 ³⁰ needs pink venflon IV Commenced on IV fluids. Diet & fluids taken.	useee
1800	CT - Scan - diverticulitis IVs 2/1/23	useee
02/01/23 2100	Patient stable, obs as charted. NEWS-0, independent with mobility and personal care. Has been IVOST'D, for ? home tomorrow. To be transferred to ward 9C, bed available.	Kosgei SN
02/1/23 1-25	Patient transferred from 9B. NEWS-0, Independent with ADL's. IVABx given as prescribed. IVF running. & hungry. Voiding none. Settled night.	87
	No new issues to report.	8 Sebastian
03/01/23 1500	Settled day. NEWS = 1. Meds given as per Hepma. Contd IVABX. Indep with ADL and personal care. Voiding.	

Affix patient ID label

Date: 3/1/23

1. Signed [Signature] Name Δ Sebasna Designation SN
2. Signed [Signature] Name FREYA BUTCH Designation sn
3. Signed _____ Name _____ Designation _____

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

NHS
Greater Glasgow
and Clyde

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

[illegible]

NHSGGC Bedrail Risk Assessment

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

Patient Name:

CHI Number:



THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT

Use guidance on the reverse of this document when completing this Risk Assessment

DATE	21/23	31/23		
TIME	0900	1-00		
WARD	4B	4C		
HOSPITAL	QEUH	QUBH		

SECTION ONE - GENERAL

1	Is the patient likely to fall, roll, slip or slide from the bed?								
2	Has the patient requested the use of bedrails?								

IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED

SECTION TWO - COGNITIVE AND PHYSICAL STATUS

3	Is the patient at risk of climbing out of bed?								
4	Is the patient stressed, delirious or restless?								
5	Is the patient small in stature?								
6	Does the patient have an unusually large or small head that might present an entrapment issue?								
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?								

IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE - See Guidance overleaf

SECTION THREE - COMMUNICATION

8	Has the patient been consulted regarding the use of bedrails?								
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition								
10	Has the use of bedrails been discussed with relatives/carers?								
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?								
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?								

IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE - See Guidance overleaf

SECTION FOUR - DECISION MAKING

13	Will bedrails be used for this patient at the present time?								
14	Rationale for use of bedrails: (Please insert code in the box on the right)								
	A - Risk of falling from the bed								
	B - Risk of rolling from the bed								
	C - Risk of slipping from the bed								
	D - Risk of sliding from the bed								
	E - Patient request								
15	Bedrail risk assessment completed by:								
16	Bedrails checked by:								
17	Date	21/23	31/23						

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

Patient Label

Care Plan

Care discussed with patient Unable		☒ Yes	☐ No	☐	If unable, give reason:	
Care discussed with family Unable		☐ Yes	☐ No	☐	If unable, give reason:	
Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature	
21/1/23 S. B. [Signature]	Monitor vital signs			N/A		
			21/1/23	5. Hydration and Nutrition		
				Normal diet and fluids		
21/1/23 S. B. [Signature]	2, 3. Communication and senses					
	Communicates freely					
21/1/23 S. B. [Signature]	4. Cognitive status		21/1/23	6. Elimination		
	GCS 15/15			Normal		

Patient Label

Care Plan

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
21/1/23 S.B.	Independent				
			21/1/23 S.B.	10. Sleep and Rest	
				No Issues	
21/1/23 S.B.	8. Mobility				
	Independent		21/1/23 S.B.	12. Privacy, dignity and sexuality	
				No Issues	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

FALLS RISK ASSESSMENT

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

**GENERAL SAFETY PRECAUTIONS
TO BE UNDERTAKEN FOR ALL PATIENTS**

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

Ward: 9B	Ward: 9C	Ward:	Ward:	Ward:
Date: 21/23	Date: 21/23	Date:	Date:	Date:
Time: 03.00	Time: 01.00	Time:	Time:	Time:
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	✓	✓		
2. Check walking aid (if required) is in reach and in use.	✓	✓		
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	✓	✓		
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	✓	✓		
5. If glasses are worn, check they are available and in use.	✓	✓		
6. If hearing aid/s are worn, check they are working and in use.	✓	✓		

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).

Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.

****ALL patients in older people's wards must have an interventional plan in place (overleaf)****

	Tick Yes or No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has the patient fallen in the last 6 months – including during this admission?			✓		✓						
2. Does the patient have cognitive impairment or a possible delirium?			✓		✓						
3. Does the patient attempt to walk alone although unsteady or unsafe?			✓		✓						
4. Does the patient or their relative have a fear or anxiety of the patient falling?			✓		✓						
5. Based on your clinical judgement, is this patient at high risk of falling?			✓		✓						
Signature of nurse completing assessment / update			<i>P. B.</i>		<i>80</i>						

Highlight risk of fall at the ward safety brief.

FALLS INTERVENTION CHECKLIST

Complete for all patients identified at risk of falling.

Ward: 9B	Ward:	Ward:	Ward:	Ward:
Date: 2/1/23	Date:	Date:	Date:	Date:
Time: 03:00	Time: -----	Time: -----	Time: -----	Time: -----

BED AND SEATING

Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice.

(Patient care plan 8)

Assess if a low bed is required

(Patient care plan 9)

SAFETY

Complete / update bedrails risk assessment if bedrail in use.

(Patient care plan 9)

Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart.

(Patient care plan 9)

If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.

HEALTH

Complete / Document 4AT

– follow THINK DELIRIUM guidelines.

(Patient care plan 4)

Document continence problems and link to care rounding

(Patient care plan 6)

Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns.

(Patient care plan 1)

If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.

COMMUNICATION

Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative.

(Patient care plan -negotiated care)

Update the ward team of the patient's mobility status.

(Patient care plan 8)

Discuss the patient's fall risk at safety briefs and MDT meetings.

(If appropriate)

Consider a referral to the Hospital Falls Service for advice using trackcare.

(If appropriate)

Signature of nurse completing interventional plan / or update

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

EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

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Glasgow, Lanarkshire
G13 4NA

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)



Date <u>21/1/23</u> Time <u>03.00</u> of initial height and weight on admission to hospital	Actual	* Patient reported	* If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height <u>1.810m</u>	☐	☒	
Admission Weight <u>169.55g</u>	☐	☒	

* Obtain accurate height/weight and rescreen as soon as possible
 Patients reported normal weight _____ Unable to Recall ☐
 Any unplanned weight loss in the last 6 months Yes ☐ how much _____ No ☐ Don't Know ☐

Date	<u>21/1/23</u>						
Time	<u>03.00</u>						
Ward	<u>9B</u>						
Oedema/ Ascities present Y/N	<u>N</u>						
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes							
Weight (kgs)	<u>115.00</u>						
BMI	<u>32</u>						

Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days

Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	<u>0</u>						
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	<u>0</u>						
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food Intake for > 5 days.....Score 2 Not applicable.....Score 0	<u>0</u>						
Step 4 Overall Risk of Malnutrition TOTAL	<u>0</u>						
Rescreen on							
Signature	<u>[Signature]</u>						

Step 5 Management Guidelines (excludes patients who are Nil by Mouth)	
Overall Risk of Malnutrition	Ensure plan of care for specific nutritional requirements, MUST score and plans to improve / increase nutritional intake are documented in the patients care plan
0	LOW RISK - Repeat screening every 7 days
1	MEDIUM RISK - Follow the flowchart for MUST 1 overleaf
2 or greater	HIGH RISK - Follow the flowchart for MUST 2 or greater overleaf

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan



1908548042
LOGAN
Georgina
17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire

19/08/1954

F CHI: _____
Address: _____
Hospital: _____



G13 4NA

Insertion criteria: Please complete this section at time of Insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☐ Resuscitation/Chest Pain ☐ IV Drugs ☐ Fluids ☐ Transfusion ☐

PVC Inserted: Day 0 23.27 CW	Date: 21.23	Hospital: QCT
Area: ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☒ Unknown ☐		
Insertion site:	R Hand ☐ R Arm ☒ R Foot ☐ L Hand ☐ L Arm ☐ L Foot ☐ Other: _____	
Colour of cannula:	Blue ☐ Pink ☒ Green ☐ White ☐ Grey ☐ Orange ☐	
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: _____	

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? Diagnostics Resuscitation/ Chest Pain IV Drugs Fluids Transfusion	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day 21.23	Yes ☐ No ☒ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☒ No ☐	Yes ☐ No ☐ N/A ☒	87
Day 1 Check 2 Night ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: ____/____/____ Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: **21.23**

*Reason For Removal: **Discharged**

Modified Visual Infusion Phlebitis (VIP) Score

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

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and *S. aureus* bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic:

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → **Can I switch my patient from IV to oral antibiotics?**

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature $\leq 37.9^{\circ}\text{C}$, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE** is available reliably (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, *S. aureus* bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abscess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy.
Record the Intended duration on the medicine kardex

YES

NO

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

Person Specific (Inpatient) Moving and Handling Assessment Form

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

1. General Information

Body Build		Problems with comprehension, behaviour, co-operation (specify):
Weight	Height	
11 stone Kg BMI 32	4 Ft 10 cm	
		Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):

Risk of Falls: Yes ☐ No ☒

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

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

3. Toileting

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

4. Move on / off bed pan

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

5. Move up / down bed

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

6. Lateral Transfer to / from trolley / bed

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

7. Sit up over side of bed

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

8. Into Bath or Shower

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

9. Walking

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

10. Other Instructions / Observations / Equipment Used

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:	2/12/23	3/1/23	
Assessor's signature:	S.B.	87	
Proposed Review date:	4/1/23	10/1/23	

Continuation Sheet

[illegible]

Pressure Ulcer Daily Risk Assessment (PUDRA)

 1908546042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA	Hospital: GECH Ward: 9B	Points to consider: • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes
---	--	--

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

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

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

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

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

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
02/01/23	08:00	N	N	N	N	N	N	4 hrly	SB
02/01/23	14:00	N	N	N	N	N	N	4 hrly	SB
02/01/23	07:55	N	N	N	N	N	N	4 hrly	FB
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
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/ /	:							__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

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



Attach Addressograph

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

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

Discharge Checklist

Patient's name:	Ward: 9C			
CHI number:	Discharge destination: HOME			
Apply addressograph label	Estimated Discharge Date (1) 1 / 1			
	Estimated Discharge Date (2) 1 / 1			
	Final date of discharge : 3 / 1 / 23			
Checklist	Yes	N/A	Initials	Comments
Patient informed	✓		FB	
Relative/carer informed	✓		FB	
Relative/carer Involved in discharge planning discussions		✓		
Others informed: Care Home		✓		
Transport arranged				
Own transport (preferred option)	✓		FB	
Ambulance: 1 man/ 2 man am/pm		✓		
Other: Flight, Air ambulance etc.		✓		
Discharge medication				
Immediate Discharge Letter completed	✓		FB	
Compliance aids e.g. Dosette Box (involve pharmacist)		✓		
Medication received	✓		FB	
Medication explained to patient and/or relative/carer	✓		FB	
Own medication returned to patient		✓		
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)		✓		
Informed of discharge				
Social work/ Other agencies		✓		
Homecare		✓		
Homecare request form completed?		✓		
Discharge lounge handover completed?		✓		
Physiotherapist		✓		
Occupational Therapist		✓		
Dietitian		✓		
Speech and Language Therapist		✓		
Clinical Nurse specialist		✓		
Liaison/ District Nurse/Practice Nurse		✓		
Other discharge items				
Access arrangements (e.g. keys, door entry)	✓			
Patients clothing available for day of discharge	✓		FB	
Valuables e.g. cash	✓		FB	
Intravenous cannula removed	✓			
Equipment ordered (inc. walking aids) in place for discharge		✓		
Part 2 Discharge letter - Required		✓		
- Completed		✓		
Outpatient clinic appointment				
Arranged		✓		
To follow		✓		
If unknown at time of discharge state reason		✓		
Additional information / leaflets / factsheets		✓		
Time of Discharge: 1730				
Nurse's signature: FB	Designation: SN	Date: 3 / 1 / 23		

ELECTRONIC PATIENT RECORDS

2

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:

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

NEWS 2 Key 1 2 3

Date 1/11 11:00

A + B
Respirations
Breaths/min

A + B
SpO2 Scale, 1
Oxygen saturation (%)

SpO2 Scale 2
Oxygen saturation (%)
Use Scale 1 (Range 95-100) for patients on oxygen therapy
Use Scale 2 (Range 90-100) for patients on oxygen therapy
Only use scale 2 under direction of qualified clinician

Air or oxygen?

C
Blood Pressure: mmHg
Note uses systolic BP only

C
Pulse
Beats / min

D
Any changes in neuro response, GCS, immediate medical review. Check blood glucose. Think Delirium.

Temperature

NEWS Total

Blood glucose 7.0

Pain / function score 04

Time Pt last passed urine 10:20

Fluid balance chart Indicated Y/N

GCS indicated Y/N

Time NEWS due 23:00

Escalation of care Y/N

Initials

Affix Patient ID
180345642
LOGAN
Georgina
190318

Abbreviations for recording oxygen device

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

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Glasgow, Lanarkshire
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G13.4B

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 F&C
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.

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Glasgow, Lanarkshire
G13 4N
19/08/19

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

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

Document all actions and interventions

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

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

Discontinuation of NEWS
Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations
Signed: _____
Medicals: _____
Date: _____

Glasgow Coma Scale

Pupil Reaction and Size
 0 = sluggish
 1 = no reaction
 2 = no reaction
 3 = eye closed
 Pupil Size (mm)
 1 2 3 4 5 6 7 8

NEWS
 NEWS 0
 NEWS 1-4
 NEWS 5-6 or 3 in one parameter
 NEWS 7 or more

Pain Score
 Add the patient to rate higher pain by using numerical scale 0-10. If the patient is unable to communicate, use alternative pain scoring tools.
 No Pain 0 1 2 3 4 5 6 7 8 9 10
 Mild Pain
 Moderate Pain
 Severe 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

MI - 316654 v5.1 - GGC0264

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 KNIGHTSWOOD
 Glasgow, Lanarkshire. G13 4NA

Emergency Care Nursing Documentation

Presenting complaint - and relevant past medical history including allergies

Date and Time		Name/Signature
15/11/2020	central chest Pain -	<i>[Signature]</i>
1530	radiating to lower back.	SN SHREENAN

Nursing notes - on admission

Date and Time		Name/Signature
5/11/2020	changed into gown.	
1530	obs obtained.	
	ecg obtained	<i>[Signature]</i>
	Patient believes	SN SHREENAN
	could have uti -	
	await sample.	

Triage

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

Communication

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

Risk Assessments and Screening Tools

SEPSIS	☐ Y	☐ N	GMAWS	☐ Y	☐ N
FAST	☐ Y	☐ N	Adult Support and Protection	☐ Y	☐ N
Swallow Testing	☐ Y	☐ N	Mental Health Triage Assessment	☐ Y	☐ N
Falls Risk (clinical judgement)	☐ Y	☐ N	Child Protection Concerns	☐ Y	☐ N

Signature:

Patient name

Patient CHI

or use sticker

Care Rounds Checklist

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

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Use the following Codes:

Y = Yes **N** = No **NA** = Not Applicable **NT** = No Thanks **S** = Sleeping **O** = Off the ward **I** = Independent

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

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

Patient name

Patient CHI

or use sticker

Hospital:

Ward:

Points to consider:

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



PUDRA

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

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

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

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

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

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

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

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

Patient CHI

NHS
Greater Glasgow
and Clyde

[illegible]

Date and Time		Name/Signature

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

[illegible]

Patient name

Patient CHI

or use sticker

4AT assessment - for delirium and cognitive impairment

(1) ALERTNESS This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.		Circle Score
Normal (alert, but not agitated, through assessment)		0
Mild sleepiness (<10 secs) after waking, then normal		0
Clearly abnormal		4
(2) AMT4 Age, date of birth, place (name of the hospital/building), current year.		
No mistakes		0
1 mistake		1
2 or more mistakes/untestable		2
(3) ATTENTION Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.		
wAchieves 7 months or more correctly		0
Starts but scores <7 months / refuses to start		1
Untestable (cannot start, unwell, drowsy, inattentive)		2
(4) ACUTE CHANGE OR FLUCTUATING COURSE Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs.		
No		0
Yes		4
4 or more possible delirium + /- cognitive impairment 1-3 possible cognitive impairment 0 delirium or severe cognitive impairment unlikely (but delirium still possible if (4) information incomplete)		TOTAL

Frailty Assessment Tool

(Healthcare Improvement Scotland)

Step 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?		circle Y or N	
F	Functional Impairment (new or worsening) eg difficulty with self care	Y	N
R	Resident in a care home	Y	N
A	Altered mental state such as delirium or dementia (4AT Assessment)	Y	I
I	Immobility/Instability decline in mobility, difficulty mobilising without help, fall leading to presentation	Y	N
L	Living at home with support on a daily basis (homecare, one visit or more per day)	Y	N
If YES to any of the criteria in Step 1 move to Step 2			
Step 2 Would this person be better managed by another speciality team at present?		circle Y or N	
Clear need for other specialty input eg exacerbation of known long-term condition such as COPD		Y	N
Need for HDU/ITU (Including non-invasive ventilation)		Y	N
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit		Y	N
Head Injury with loss of consciousness		Y	N
Acute abdominal pain/ surgical presentation		Y	N
Upper GI Bleed		Y	N
Chest pain with suspected acute coronary syndrome		Y	N
Trauma with suspected fracture		Y	N
Are any of the criteria met?			
If YES to any criteria in Step 2: Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.			
If YES to any criteria in Step 1 and NO to ALL criteria in STEP 2: Prioritise transfer of care to specialist geriatric assessment service.			

My Admission Record



46

Hospital: DEUN Ward: ARU2
 Date of Admission: 15/11/20 Time: 2005
 Information obtained from: Name: RUCPT
 Patient ☒ Relative ☐ Other ☐
 Preferred Name: "GINA"
 Age: 66 Telephone Number: 0141 9523728
 Consultant:


 1908546042
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 Georgina
 17 SOLLAS PLACE
 KNIGHTSWOOD
 Glasgow, Lanarkshire
 19/08/195
 G13 4NA
 Dr. DF Spence
 Barclay Medical Practice Victoria P
 1398 Dumbarton Road
 Glasgow
 G14 9DR

LOUIA DUXION

Communication

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

Preferred first contact

Name: GEORGE LOGAN
 Relationship: HUSBAND
 Address:
 Telephone: 07774400790
 Is this person aware of your admission?
 Yes ☒ No ☐
 Can we share information with this person?
 Yes ☒ No ☐

Preferred second contact

Name:
 Relationship:
 Address:
 Telephone:
 Is this person aware of your admission?
 Yes ☐ No ☐
 Can we share information with this person?
 Yes ☐ No ☐

Presenting Complaint / Diagnosis

CHEST PAIN - ? PERICARDITIS SMALL PERICARDIAL EFFUSION
 Explained to the patient? Yes ☐ No ☐ Not Applicable ☐
 Do you understand the reason for your admission? Yes ☐ No ☐

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

No known allergies ☐ NKDA

Relevant past medical history

IBS RENAL STONES DIVERTICULITIS
ASTHMA UTERINE STENT AF
CHOLECYSTECTOMY PERICARDITIS

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place

Yes ☐ No ☒ If yes, Who asked for a copy? _____
 Date they asked for a copy / / Date Obtained / /

Power of Attorney / Guardianship / Adult with Incapacity

Name: _____



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Glasgow, Lanarkshire

G13 4NA

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

Yes ☐No ☒**OR**

Does someone have Guardianship?

Yes ☐No ☒If yes, is this for:- Finance ☐Welfare ☐Both ☐Which are currently in action? Finance ☐Welfare ☐Both ☐Nil ☐

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

N.B. If you think the patient may lack capacity inform Medical Staff to assess and, if required, consider the need for an 'Adult with Incapacity' Section 47**Carbapenemase-producing enterobacteriaceae (CPE)**

Have you ever:

1. Been an inpatient in a hospital outside Scotland?

Yes ☐No ☒

2. Received holiday dialysis outside Scotland?

☐☒

3. Been told that you have CPE?

☐☒

4. Been in close contact with a person with CPE?

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

Isolate the patient in a side room

☐

Obtain Rectal swab marked 'for CPE'

☐

If patient refuses rectal swab, obtain a stool specimen marked 'for CPE'

☐**and inform the IPCT**☐**MRSA Screening**

Will the patient be an inpatient for more than 23 hours?

Yes ☐No ☐Unsure ☒If **YES** complete the following section

1. Have you ever been told that you have MRSA?

☐☒☐

2. Have you been admitted from another hospital/ residential setting or care home?

☐☒☐

3. Do you have a wound / skin ulcer or invasive device which you had before admission?

☐☒☐If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabsNasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐**Creutzfeldt-Jakob Disease (CJD)**

Have you ever been informed that you are at increased risk of CJD or vCJD?

Yes ☐No ☒Unsure ☐If **YES** inform the IPCT ☐

Name: 
 1908546042
 LOGAN
 Georgina
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 Glasgow, Lanarkshire
 19/08/195 F
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Lifestyle

Smoking

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

Never smoked ☒

Do you use eCigarettes? Yes ☐ No ☐

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

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

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

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

Drugs

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

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

Alcohol

Do you drink alcohol? Yes ☐ No ☒

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

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

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

Name (Please PRINT): *RUCPE*

Signature: *[Signature]*

Designation: *SN*

Date: *15/11/20.*

My Assessment Record

N			
A	1908546042		
	LOGAN		F
	Georgina	19/08/195	
D			
C			
AI			

1. Breathing and Circulation

Breathing	Admission Presentation	Normal for the patient	Assessment of the patient's breathing
No breathing problems		✓	LHX ASTHMA
Breathless at rest	✓		
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers	✓	✓	
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			
Circulation	Admission Presentation	Normal for the patient	Assessment of the patient's circulation
No circulatory problems		✓	PREVIOUS PERICARDITIS, AF
Chest pain at rest	✓		
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

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



1908546042

LOGAN

F

4 Georgina

19/08/1954

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

G13 4NA

A111A patient ID label

3. Senses

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

Can you describe where and what the pain is like?

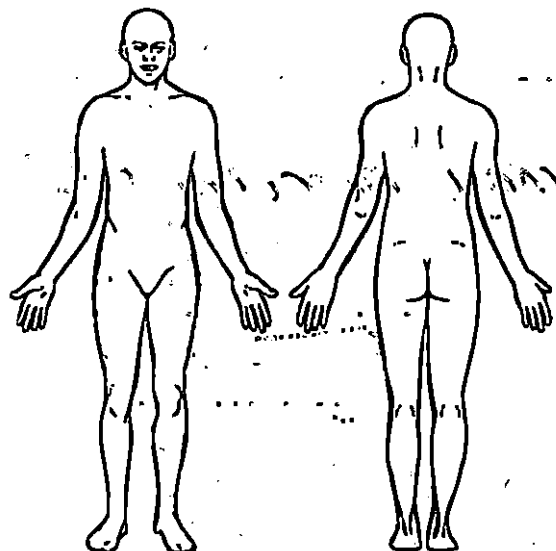
Mark current pain on body chart

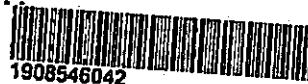
Have you had treatment / intervention for the pain?

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

Can you describe any chronic pain that you have?

What makes the pain better?





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4. Cognitive Status**THINK DELIRIUM**

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

N.B. Think Delirium

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

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

and follow the guidance

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

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

What do you like to eat and drink?

SMALL AMOUNTS

KNOWS WHAT
FOODS CAN TOLERATE
EATS

What do you not like to eat and drink?

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

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓	 1908546042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire 19/08/1954 G13 4NA
Normal diet and fluids	✓	✓	
Therapeutic diet			
Cultural, ethnic or religious diet			
Texture Modified Diet Please state _____			
Thickened Fluid Please state _____			
Oral Nutritional supplements Preferred flavour _____			
Enteral Nutrition			
Parenteral Nutrition			
Nil by Mouth			
N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS) within 4 hours of admission			Assessment of the patient's hydration and nutrition needs
Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓	
Independent (Green)	✓	✓	
Prompting / encouragement / opening packets/cutting up food (Amber)			
Full assistance with eating and drinking (Red)			
Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?			
6. Elimination			
Bladder	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Pass urine with no problems	✓	✓	
Frequently pass urine during the day			
Frequently pass urine overnight			
Sense of urgency when need to pass urine			
Urine retention			

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓	 1908546042 LOGAN Georgina 19/08/1954
Haematuria			
Incontinent			

N.B. If new Incontinence report to medical staff to rule out infection or physiological cause

What products do you normally use for this continence issue?

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

Date urinary catheter last changed ____/____/____

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

Bowels

When did your bowels last move?

How often in a day/week do you have a bowel movement? Per day Per week

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

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

What products do you normally use for this continence issue?

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

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

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 4 Georgina 19/08/195_____
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7. Personal Hygiene, Oral Health, Skin Care and Wound Care

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

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

Pressure ulcer identified on admission: Yes ☐ No ☒

Pressure Ulcer Grade: _____

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

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

Wound Care	Yes ✓	No ✓	 1908546042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA 19/08/195
Do you have any wounds? N.B. If yes, complete an assessment chart for wound management.			

8. Mobility			
Mobility	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's mobility needs
Fully mobile and independent	✓	✓	OCCASIONALLY USES STICK WHEN UNWELL
Unsteady when walking			
Do you use a mobility aid	Yes ☐	No ☐	
Do you have your mobility aid with you?	Yes ☐	No ☐	

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

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

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

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

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



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11. Social Circumstances

Do you:

Live alone ☐Live with family/ friend/ other ☒Live in a nursing home ☐Live in a care home ☐Live in residential supported care ☐Live in student accommodation ☐Live in 'homeless' accommodation ☐Have no fixed abode ☐Other please specify _____ ☐**Dependants**Yes
✓No
✓

Do you have any dependants?

Do you support anyone (e.g. partner, children, relatives, animals)?

Do they need support from someone else whilst you are in hospital?

Would someone else be able to provide this support when you are in hospital?
If yes, who?

If no support available contact Duty Social Worker

Duty Social Worker Required ☐Not required ☐Referred ☐**Services**Yes
✓No
✓

Do you have support from social work, social services or a care package?

If yes, please provide details:

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

12. Emotional and Spiritual Care

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

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

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

Healthcare Chaplain informed

Yes ☐N/A ☐

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13. Person Centred Care

What matters and is important to you whilst you are in hospital?

This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

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

Informal Support

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

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

Name:

Contact Details:

.....

.....

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

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

Yes ☐ No ☐

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

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Required Support

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

Yes ☐ No ☐

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

Has the carer been advised of the Carers Information Line?

Yes ☐ No ☐ Not appropriate at this time ☒

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?

Yes ☐ No ☐

Are you:

Employed ☐

Self-employed ☐

Full time education ☐

Unemployed ☐

Retired ☒

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

Yes ☐ No ☐ Not applicable ☒

Do you have any money worries?

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

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

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

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

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

If yes when was patient referred ____/____/____



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Affix patient ID label

Risk Assessments/Other Documentation

Additional NHSGCC Documentation	Required		Required documents completed		Date, Print and Sign when completed
	Yes ✓	No ✓	Yes ✓	No ✓	
Glasgow Assessment and Management of Alcohol (GAMA)		✓			
Generic Pain Scale Assessment Chart		✓			
Abbey Pain Scale (if unable to self report pain)		✓			
4AT and TIME for Detection, Management and Prevention of Delirium - - -		✓			
Getting to Know Me - Relatives to complete.		✓			
What Matters to Me		✓			
Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)		✓			
Malnutrition Universal Screening Tool (MUST)	✓				
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan		✓			
Bristol Stool Chart		✓			
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓		✓		DM 15/11/20
Adult Wound Assessment and Management Chart		✓			
Moving and Handling Assessment	✓		✓		DM 15/11/20
Falls Risk Assessment	✓		✓		DM 15/11/20
Bedrail Risk Assessment	✓		✓		DM 15/11/20

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
15/11/20 2025	ADMISSION FROM A&E - PRESENTS	
	REQUEST PAIN	
IMP	PERICARDITIS	
	→ SMALL PERICARDIAL EFFUSION	
PLAN	- ANALGESIA	
	- BLOODS INCL DDIMER	
	- WEEKLY CARDO RLV B	

Name: _____

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- Georgina

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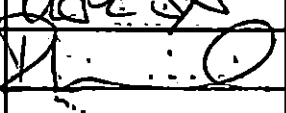
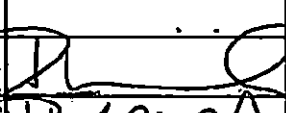
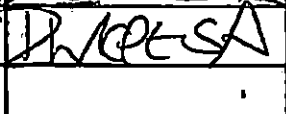
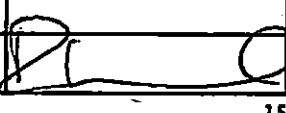
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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
	DEPARTMENTAL ECHO. —	
0035	S/R MEDICAL STAFF	
Imp —	CHEST PAIN ? PERICARDITIS —	
	BUSIDE ECHO SIGNS SMALL PERICARDIAL EFFUSION	
—	TROP ? 20 PERICARDITIS ? UTI ? COVID	
—	WGT LOSS	
PLAN —	RPT TROP + ECG	
—	DEPARTMENTAL ECHO	
—	ANALGESIA: START COLEUICINE	
—	MSU	
—	COVID 19 SWAB □	
—	CHASE @ FIT RESULT, MAY NEED FURTHER 1x FOR WGT LOSS	
16/11/20 0500	SLEPT ONLY FOR SHORT SPELLS	
	INDEPENDANT TO TOILET	
	OBSERVATIONS AS QUALITY	
11 v SPL AT —	GIVEN PARACETAMOL AS	
	TEMP CLIMBING	
—	MOVING INDEPENDANTLY IN BED	
—	REPEAT TROP LA	
0525	NEWS THIS 3 BP 91/68 & SPO2 95%	
—	FEEUNG NAUSEATED, REQUESTING ANTIEMETICS	
	ANALITING MEDICS	

Name: _____

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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
	UNABLE TO DO COVID SWAB	
	DUE TO NAUSEA. —	DL
	- IV CINDANSETRON GIVEN. —	
16/11/20	Shown and assessed independently	
0930	Declined breakfast. FULFILL TOHERMICK	
	Emergency room to toilet	
	says she may have UTI, Bar	
	keet at busick	
	NEWS CURRENTLY 3, SPOD 45/10K	
	RU BP 92/48, RHYTHMIC	
	CARE NOUNCING COME OUT N°	W1300N
	ALL COMPLAINTS UOICEL	
16/11/20	S/S LANCULOCH	
12:00	1MD DYSOCHIA	
	Ø PERICARDITIS ON ECHO	
	FOR POTAL AND SIMON SULLGEDI	W1300N
	↳ SPOKE 2 COLONS HOME WHEN EATING	
	AND LANCING, WHICH 'PATIENT'	W1300N
	IS NOT AT THE MOMENT —	
16/11/20	SEEN AFTERNOON, IS STILL NOT EATING	
16:50	ONCE FULFILL TOHERMICK —	W1300N
	CARE NOUNCING COME OUT N°	
	ALL COMPLAINTS UOICEL	
	WASH TX BLOCK, PROT AND NITROGL	W1300N
	DOCTOR RUOCH —	
16/11/20	FOR TRANSFER TO URMER SCI. SPOKE UP TO URMER	W1300N
18:45	PATIENT WILL INFORM NUR	

CLINICAL NOTES - MEDICAL
NURSING
☐
☒

Please tick ✓ appropriate directorate



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Date & Time		Signature, Print Name & Designation
17/11/20	Transferred to SD. Obs stable	
0130	as charted. meds as per kardex. States & in interest. Normal diet & fluids. NO concerns overnight. Indop in ADLS.	K. Starnac K. Starnac S/N
1125	Patient independant with ADLS. PRN lactulose requested & prescribed. All other meds taken as prescribed.	
	Continues bowel per ? card.	
	Patient in some discomfort with constipation pain & UTI. Analgesia offered.	
	Anticipating medical review	C. J. S/N C. J. STEVENS
18/11/20	Settled. meds as per kardex. Obs stable	
0330	as charted. Indop with ADLS. Covid - VE. NO concerns overnight.	K. Starnac K. Starnac S/N
18/11/20	Patient settled no concerns.	
1245	Independent with ADLS. News stable as charted.	
	Medication administered as per Kardex. Diet and fluids taken.	
	Form home today await IDL and meds.	D. McLaughlin D. McLAUGHLIN
1840	Patient discharged with IDL and meds, own transport.	D. McLaughlin S/N D. McLAUGHLIN

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

NHSGGC Bedrail Risk Assessment

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

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT



Patient Name: LOGAN, Georgina
CHI Number: 17 SOLLAS PLACE
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Use guidance on the reverse of this document when completing this Risk Assessment		DATE	15/11/20	TIME	16:15	WARD	17/11/2	HOSPITAL	17/11/2
SECTION ONE - GENERAL									
1	Is the patient likely to fall, roll, slip or slide from the bed?								
2	Has the patient requested the use of bedrails?								
IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED									
SECTION TWO - COGNITIVE AND PHYSICAL STATUS									
3	Is the patient at risk of climbing out of bed?								
4	Is the patient stressed, delirious or restless?								
5	Is the patient small in stature?								
6	Does the patient have an unusually large or small head that might present an entrapment issue?								
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?								
IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE - See Guidance overleaf									
SECTION THREE - COMMUNICATION									
8	Has the patient been consulted regarding the use of bedrails?								
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition								
10	Has the use of bedrails been discussed with relatives/carers?								
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?								
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?								
IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE - See Guidance overleaf									
SECTION FOUR - DECISION MAKING									
13	Will bedrails be used for this patient at the present time?								
14	Rationale for use of bedrails: (Please insert code in the box on the right)								
	A - Risk of falling from the bed								
	B - Risk of rolling from the bed								
	C - Risk of slipping from the bed								
	D - Risk of sliding from the bed								
	E - Patient request								
15	Bedrail risk assessment completed by:								
16	Bedrails checked by:								
17	Date								
Any issues relating to the use of bedrails including discussion with family/relatives/carers should be recorded here									

Date: 16/11/20

1. Signed [Signature] Name KHOE Designation SV
2. Signed UL Name WUON Designation C
3. Signed _____ Name _____ Designation _____

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

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

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NHS

Greater Glasgow

95 and Clyde

Ward:

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

[illegible]

Date: 7/1/20

1. Signed E. J. Starnore Name E. J. Starnore Designation SN

2. Signed _____ Name _____ Designation _____

3. Signed _____ Name _____ Designation _____

USE FOLLOWING _____ Name _____ Designation _____

Georgina Logan

Ward;

NHS
Greater Glasgow
and Clyde

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

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

[illegible]

Care Rounds Checklist

Date: 18/11/20

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

1. Signed [Signature] Name K. Starnore Designation S/N

2. Signed _____ Name _____ Designation _____

3. Signed _____ Name _____ Designation _____

USE FOLLOWING _____

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Georgina
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Glasgow, Lanarkshire
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NHS
Greater Glasgow
and Clyde

USE FOLLOWING CODES:

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

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

[illegible]

4AT and TIME for Detection, Management and Prevention of Delirium

Complete for patients: age 65 and over; patients of any age with an existing cognitive impairment; previous delirium; current hip fracture; or severe illness. These patients are at high risk of delirium.

This should be done on admission; at each transition of care; if SQiD positive; or if any clinical concerns.

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4AT	Ward <u>2</u> Date & Time <u>16/11/20</u> <u>1035</u>	Ward _____ Date & Time	Ward _____ Date & Time	Ward _____ Date & Time	Ward _____ Date & Time
(1) Alertness This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating					
Normal (fully alert, but not agitated, throughout the assessment)	0	0	0	0	0
Mild sleepiness for <10 seconds after waking, then normal	0	0	0	0	0
Clearly abnormal	4	4	4	4	4
(2) AMT4 Ask the patient their Age, Date of Birth, Place (name of hospital) Current Year					
No mistakes	0	0	0	0	0
1 mistake	1	1	1	1	1
2 or more mistakes	2	2	2	2	2
(3) Attention Ask the patient "Please tell me the months of the year in backward order, starting at December". To assist, one prompt of "What is the month before December" is permitted.					
Achieves 7 months or more correctly	0	0	0	0	0
Starts but scores < 7 months or refuses to start	1	1	1	1	1
Untestable (cannot participate because too drowsy or inattentive)	2	2	2	2	2
(4) Acute change or fluctuating course Evidence of significant change of fluctuation in: alertness, cognition, other mental function (e.g. hallucinations, paranoia) over the past 2 weeks and still present in preceding 24 hrs.					
No	0	0	0	0	0
Yes	4	4	4	4	4
4AT TOTAL SCORE	0				
Print initials of assessor	<u>JS</u>				
Score >4 This is a possible DELIRIUM +/- COGNITIVE IMPAIRMENT, start 'T' and 'I' of TIME and escalate to medical staff to confirm diagnosis	Score 1-3 This is a possible COGNITIVE IMPAIRMENT, and requires further assessment				
Score 0 DELIRIUM or SEVERE COGNITIVE impairment unlikely					

All patients scoring 0-3 are still at high risk of delirium. Use the Triggers listed overleaf to plan care and reassess daily by asking 'Is the patient more confused or drowsy?' This is the single question in delirium (SQiD)

TIME checklist to guide Delirium risk reduction, Identification and Management

The TIME checklist is a joint medical and nursing responsibility.

Alix ID Label

Triggers, Investigate, Manage and Engage		Date	Date	Date	Date	Date
Triggers	Think possible triggers for delirium	Tick box	Tick box	Tick box	Tick box	Tick box
	Is the patient in pain? Start pain chart, review analgesia and consider need for an aperient					
	Is the patient constipated or at risk of constipation? Commence bowel chart and review daily to assess for constipation, especially if on analgesia. Consider rectal examination					
	Is the patient in urinary retention? Palpate bladder/scan					
	Is the patient's oral intake sufficient to prevent dehydration? Encourage hourly fluids, start fluid balance chart					
	Could any drugs trigger delirium? Doctor to review medication					
	Blood sugar, high or low?					
	Is there a history of alcohol intake/drug abuse? Intoxication or withdrawal, start GMAWS/drug misuse guidelines					
	Does the patient have sensory impairment? Ensure patient is wearing their glasses/hearing aid(s)					
	Is the patient immobile? Promote early mobilisation in order to prevent delirium					
	Document 4AT score					
	Does the patient have Delirium? (Yes/No/Unclear) Please Circle	Y N U	Y N U	Y N U	Y N U	Y N U
Investigate	Investigate					
	Record NEWS					
	Screen for infection					
	Take bloods and ensure ECG/appropriate imaging					
Manage	Management: Diagnose causes & Initiate treatment					
	Document diagnosis of delirium					
	Document potential causes of delirium					
	Document treatment plan					
Engage	Engage and Explore					
	If appropriate, explain diagnosis of delirium to patient/ family/ carers and provide delirium leaflet					
	Engage with patient/ family/ carers. Complete "What matters to me"/"Getting to know me" document					
	Does the patient have capacity to consent to care? (Yes/No/Ongoing Assessment)	Y N O	Y N O	Y N O	Y N O	Y N O
	If no, complete AWI document					
	Print Initials of assessor					

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FALLS RISK ASSESSMENT

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



GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

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

Ward: <u>ARL2</u>	Ward: <u>SD</u>	Ward: _____	Ward: _____	Ward: _____
Date: <u>5/11/20</u>	Date: <u>10/11/20</u>	Date: _____	Date: _____	Date: _____
Time: <u>20:30</u>	Time: <u>14:15</u>	Time: _____	Time: _____	Time: _____
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	☒	☒	☐	☐
2. Check walking aid (if required) is in reach and in use.	<u>N/A</u>	<u>N/A</u>	☐	☐
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	☒	☒	☐	☐
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	☒	☒	☐	☐
5. If glasses are worn, check they are available and in use.	☒	☒	☐	☐
6. If hearing aid/s are worn, check they are working and in use.	<u>N/A</u>	<u>N/A</u>	☐	☐

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).

Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.

****ALL patients in older people's wards must have an interventional plan in place (overleaf)****

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

Highlight risk of fall at the ward safety brief.

Infection Prevention and Control Care Checklist – Respiratory virus

This Care checklist should be used with patients who are suspected of or are known to have a respiratory virus e.g. rhinovirus, human metapneumovirus, coronavirus, while the patient is considered infectious and then signed off at end of the isolation period / discharge. Each criteria should be ticked ✓ in place or X if not, the checklist should be then initialled after completion, daily.



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Date Isolation commenced: 16/11/20

		Date: 16/11/18					
		Daily check (✓/X)					
Patient Placement / Assessment of risk	Patient Placement/ Assessment of Risk						
	Patient isolated in a single room with en suite facilities / own commode. If a single room is not available, an IPCT risk assessment is completed daily. Stop isolation when patient is 48hrs asymptomatic of respiratory symptoms. (Re Isolation: if patient is ventilated or part of an ongoing incident, seek advice from a consultant microbiologist).	✓	✓				
	Place yellow isolation sign on the door to the isolation room	✓	✓				
Standard Infection Control & Transmission Based Precautions	Door to isolation room is closed when not in use. If for any reason this is not appropriate then an IPCT risk assessment is completed (Appendix 1).	✓	✓				
	Hand Hygiene (HH)						
	All staff must use correct 5 step technique for hand hygiene at 5 key moments	✓	✓				
	HH facilities are offered to patient after using the toilet or during coughing/sneezing episodes and prior to mealtimes etc. (clinical wash hand basin/ wipes where applicable)	✓	✓				
	Personal Protective Clothing (PPE)						
	Disposable gloves and yellow apron are worn for all direct contact with the patient and their equipment/environment, removed before leaving the isolation area and discarded as clinical waste. HH must follow removal of PPE.	✓	✓				
	Staff should risk assess the need for face protection i.e. goggles/mask where they feel there is a risk of body fluid splashing onto the face or staff are within 1 metre of the patient.	✓	✓				
	Staff are wearing appropriately fitting FFP3 masks during Aerosol Generating Procedures (AGPs). (See Table 1 below for list of AGPs)	✓	✓				
	Visitors participating in patient care should be offered appropriate PPE:	✓	✓				
	Safe Management of Care Equipment						
	Single-use items are used where possible or equipment is dedicated to patient while in isolation.	✓	✓				
	There are no non-essential items in room e.g. Excessive patient belongings	✓	✓				
	Twice daily decontamination of the patient equipment by HCW is in place using 1,000 ppm solution of chlorine based detergent.	✓	✓				
	Safe Management of Care Environment						
	Twice daily clean of isolation room is completed by Domestic services, using a solution of 1,000 ppm chlorine based detergent. A terminal clean will be arranged on day of discharge/ end of isolation.	✓	✓				
Laundry and Clinical/Healthcare waste							
All laundry is placed in a water soluble bag, then into a clear plastic bag (brown bag in mental health areas), then into a laundry bag	✓	✓					
Clean linen must not be stored in the isolation room.	✓	✓					
All waste should be disposed of in the isolation room as clinical waste	✓	✓					
Information for patients/carer	Information for patients and their carers						
	The patient has been given information on their infection/ isolation and provided with a patient information leaflet (PIL) if available	✓	✓				
	If taking soiled clothing home, carers have been issued with a Washing Clothes at Home PIL. (NB. Personal laundry into a water soluble bag, then a patient clothing bag before being given to carer to take home)	✓	✓				
HCW Daily Initial: KS							

Date Isolation ceased/ Terminal Clean Requested: 17/11/20 Signature: [Signature] Date: 17/11

Table 1

List of AGPs

- Intubation, extubation and related procedures e.g. Manual Ventilation, open suctioning
- Tracheostomy/tracheotomy procedures
- Bronchoscopy
- Surgery and post mortem procedures in which high speed devices are used to open respiratory tract
- Dental procedures
- Non-invasive ventilation (NIV) e.g. Bi-level positive airway pressure ventilation (BiPAP), continuous positive airway pressure ventilation (CPAP)
- Hi-frequency oscillatory ventilation
- Induction of sputum



Patient) Moving and Handling Assessment Form

Person's Name: LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire	1908546042	19/08/195	Named Nurse: <i>R. Nott</i>	Person is totally independent (tick here and go to date box)	☒
	G13 4NA				
Problems with comprehension, behaviour, co-operation (specify):					
Weight Kg BMI		Height cm			
Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):					
Risk of Falls: Yes ☐ No ☒					
2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)					
Holst	Standard	Walking Aid	Assistance		Supervision
Model		Aid Type	People: 1	2	≥3
Sling type	Additional Information / Equipment:				
Sling Size					
3. Toileting					
Holst	Standard	Walking Aid	Assistance		Supervision
See No 2 Sit to Stand Transfers for details	see 'sit to stand transfers'		People: 1	2	≥3
Additional Information:					
4. Move on / off bed pan					
Holst	Manoeuvre	Assistance		Supervision	N/A
See No 2 Sit to Stand Transfers for details	Roll patient Monkey pole Independent bridging	People: 1	2	≥3	Additional Information:
5. Move up / down bed					
Holst	Handling Aids	Assistance		Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets Monkey pole Rope ladder	People: 1	2	≥3	Additional Information:
6. Lateral Transfer to / from trolley / bed					
Holst	Handling Aids	Assistance		Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board Other (Please specify)	People: 1	2	≥3	Additional Information / Equipment (eg sliding sheets):
7. Sit up over side of bed					
	Bed Rest	Assistance		Supervision	Independent
		People: 1	2	≥3	Additional Information / Equipment (eg rope ladder, swivel cushion):
8. Into Bath or Shower					
Equipment	Handling Aid	Assistance		Supervision	Independent
Shower	Shower chair	People: 1	2	≥3	Additional Information / Equipment (eg sling lifting hoist after risk assess):
Variable / Fixed height bath	Shower trolley				
Bed bath	Bathing hoist (eg Alenti)				
9. Walking					
No Walking	Walking Aid	Assistance		Supervision	Independent
	see 'sit to stand transfers'	People: 1	2	≥3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)
10. Other Instructions / Observations / Equipment Used					
Recording Symbol:		1st Assessment	2nd Assessment	3rd Assessment	
		/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star	
Date Assessed:		15/11/20	16/11/20		
Assessor's signature:		<i>[Signature]</i>	<i>[Signature]</i>		
Proposed Review date:		1/52	1/52		

Continuation Sheet

[illegible]



1908546042

LOGAN

4 Georgina

19/08/1954

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

G13 4NA

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS
Greater Glasgow
and Clyde

Date <u>17/11/20</u> Time <u>12:00pm</u> of initial height and weight on admission to hospital	Actual	* Patient reported	* If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height <u>125</u> cm	☐	☐	
Admission Weight <u>—</u> Kg	☐	☐	

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

Patients reported normal weight _____ Unable to Recall ☒

Any unplanned weight loss in the last 6 months Yes ☒ how much 1 stone No ☐ Don't Know ☐

Date	<u>17/11</u>						
Time	<u>12:00</u>						
Ward	<u>8D</u>						
Oedema/ Ascities present Y/ <u>N</u>							
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes	<u>CH</u>						
Weight (kgs)	<u>67.17</u>						
BMI	<u>42.9</u>						

Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days

Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	<u>0</u>						
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	<u>0</u>						
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	<u>0</u>						
Step 4 Overall Risk of Malnutrition TOTAL	<u>0</u>						
Rescreen on	<u>24/11/20</u>						
Signature	<u>AMW</u>						

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

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

Pressure Ulcer Daily Risk Assessment (PUDRA)

 1808546042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA 19/08/195	Hospital: Qenu: Ward: ALU2	Points to consider: • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes
--	-------------------------------------	--

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

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

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

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

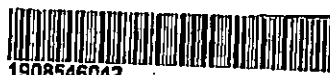
If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
15/11/20	20:35	NO	NO	NO	NO	NO	NO	4 hrly	[Signature]
16/11/20	08:00	N	N	N	N	N	N	1 hrly	[Signature]
16/11/20	19:15	N	N	N	N	N	N	4 hrly	[Signature]
17/11/20	01:00	N	N	N	N	N	N	4 hrly	[Signature]
18/11/20	01:00	N	N	N	N	N	N	4 hrly	[Signature]
/ /	:							__ hrly	
/ /	:							__ hrly	
/ /	:							__ hrly	
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/ /	:							__ 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.

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan



1908546042

LOGAN
Georgina
17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire

CHI: _____
Address: _____
Hospital: _____



Insertion criteria

G13 4NA

Justification at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☒ Resuscitation/Chest Pain ☒ IV Drugs ☐ Fluids ☐ Transfusion ☐

PVC inserted: Day 0	Date: <u>15/11/20</u> Hospital: _____
	Area: ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☐ Unknown ☐
Insertion site:	R Hand ☐ R Arm ☐ R Foot ☐ L Hand ☐ L Arm ☒ L Foot ☐ Other: _____
Colour of cannula:	Blue ☐ Pink ☒ Green ☐ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: <u>INSERTED IN A&C</u>

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? Diagnostics Resuscitation/ Chest Pain IV Drugs Fluids Transfusion	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day <u>16/11/20</u>	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: <u>0</u>	Yes ☒ No ☐	Yes ☐ No ☐ N/A ☒	<u>W</u>
Day 1 Check 2 Night <u>16/11/20</u>	Yes ☒ No ☐ If No, remove PVC and record date and reason*.	VIP: <u>0</u>	Yes ☒ No ☐	Yes ☐ No ☐ N/A ☒	<u>W</u>
Day 2 Check 1 Day <u>17/11/20</u>	Yes ☒ No ☐ If No, remove PVC and record date and reason*.	VIP: <u>0</u>	Yes ☒ No ☐	Yes ☐ No ☐ N/A ☒	<u>W</u>
Day 2 Check 2 Night <u>17/11/20</u>	Yes ☒ No ☐ If No, remove PVC and record date and reason*.	VIP: <u>0</u>	Yes ☒ No ☐	Yes ☐ No ☐ N/A ☒	<u>W</u>
Day 3 Check 1 Day <u>18/11/20</u>	Yes ☒ No ☐ If No, remove PVC and record date and reason*.	VIP: <u>0</u>	Yes ☒ No ☐	Yes ☐ No ☐ N/A ☒	<u>W</u>
Day 3 Check 2 Night ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: ____/____/____ Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: 18/11/20
*Reason For Removal: Discharged

Modified Visual Infusion Phlebitis (VIP) Score

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

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and *S. aureus* bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → ~~Can I switch my patient from IV to oral antibiotics?~~

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature $\leq 37.9^{\circ}\text{C}$, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE** is available reliably (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, *S. aureus* bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abscess.

~~CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves~~

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy.
Record the intended duration on the medicine kardex

YES

NO

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

Discharge Checklist

Patient: 
 CHI 1908548042 F
 LOGAN
 Georgina
 17 SOLLAS PLACE
 KNIGHTSWOOD
 Glasgow, Lanarkshire
 19/08/1954
 G13 4NA

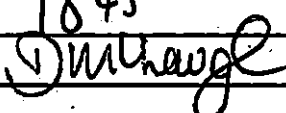
Ward: 80

Discharge destination: QEUH

Estimated Discharge Date (1) 18 / 11 / 20

Estimated Discharge Date (2) / /

Final date of discharge: 18 / 11 / 20

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓		DM	
Relative/carer informed		✓	DM	
Relative/carer involved in discharge planning discussions		✓	DM	
Others informed: Care Home		✓	DM	
Transport arranged				
Own transport (preferred option)	✓		DM	
Ambulance: 1 man/ 2 man am/pm		✓	DM	
Other: Flight, Air ambulance etc.		✓	DM	
Discharge medication				
Immediate Discharge Letter completed	✓		DM	
Compliance aids e.g. Dosette Box (Involve pharmacist)		✓	DM	
Medication received	✓		DM	
Medication explained to patient and/or relative/carer	✓		DM	
Own medication returned to patient	✓		DM	
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)		✓	DM	
Informed of discharge				
Social work/ Other agencies		✓	DM	
Homecare		✓	DM	
Homecare request form completed?		✓	DM	
Discharge lounge handover completed?		✓	DM	
Physiotherapist		✓	DM	
Occupational Therapist		✓	DM	
Dietitian		✓	DM	
Speech and Language Therapist		✓	DM	
Clinical Nurse specialist		✓	DM	
Liaison/ District Nurse/Practice Nurse		✓	DM	
Other discharge items				
Access arrangements (e.g. keys, door entry)		✓	DM	
Patients clothing available for day of discharge		✓	DM	
Valuables e.g. cashier		✓	DM	
Intravenous cannula removed		✓	DM	
Equipment ordered (inc. walking aids) in place for discharge		✓	DM	
Part 2 Discharge letter - Required		✓	DM	
- Completed		✓	DM	
Outpatient clinic appointment				
Arranged		✓	DM	
To follow		✓	DM	
If unknown at time of discharge state reason		✓	DM	
Additional Information / leaflets / factsheets		✓	DM	
Time of Discharge: 1845				
Nurse's signature: 				
Designation: SN				
Date: 18/11/20.				

My Admission Record



1908546042	F: _____
LOGAN	19/08/1954
Georgina	
17 SOLLAS PLACE	
KNIGHTSWOOD	
Glasgow, Lanarkshire	G13 4NA
A	

Hospital: QEH Ward: 9B
 Date of Admission: 20/07/20 Time: 1945
 Information obtained from: Name: Gina
 Patient ☒ Relative ☐ Other ☐
Preferred Name:
 Age: _____ Telephone Number: 07774400790
 Consultant: Watson

Communication

What is your first language? English

Do you require an interpreter? Yes ☐ No ☐

If yes, provide details of arrangements made _____

Do you use British Sign Language (BSL)? Yes ☐ No ☐

Do you need someone to help you to communicate? Yes ☐ No ☐ If yes, who _____

Preferred first contact	Preferred second contact
Name: <u>George Logan</u> Relationship: <u>Husband</u> Address: _____ Telephone: _____ Is this person aware of your admission? Yes ☐ No ☐ Can we share information with this person? Yes ☐ No ☐	Name: _____ Relationship: _____ Address: _____ Telephone: _____ Is this person aware of your admission? Yes ☐ No ☐ Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

Constipation 6/7

Explained to the patient? Yes ☐ No ☐ Not Applicable ☐

Do you understand the reason for your admission? Yes ☐ No ☐

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

No known allergies ☐ Latex plastics (stents)

Relevant past medical history

Urteric Stent Asthma
Diverticulosis AF
Cholecystectomy Chen's

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

Power of Attorney / Guardianship / Adult with Incapacity

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

Yes ☐No ☒**OR**

Does someone have Guardianship?

Yes ☐No ☒If yes, is this for:- Finance ☐ Welfare ☐ Both ☐Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

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

1908546042
LOGAN
Georgina
17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire
G13 4NA

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:

1. Been an inpatient in a hospital outside Scotland?

Yes ☐No ☒

2. Received holiday dialysis outside Scotland?

☐☒

3. Been told that you have CPE?

☐☒

4. Been in close contact with a person with CPE?

☐☒If the answer is yes to **ANY** of the questions in this section, you mustIsolate the patient in a side room ☐Obtain Rectal swab marked 'for CPE' ☐If patient refuses rectal swab, obtain a stool specimen marked 'for CPE' ☐**and inform the IPCT** ☐**MRSA Screening**

Will the patient be an inpatient for more than 23 hours

Yes ☒No ☐Unsure ☐If **YES** complete the following section

1. Have you ever been told that you have MRSA?

☐☒☐

2. Have you been admitted from another hospital/ residential setting or care home?

☐☒☐

3. Do you have a wound / skin ulcer or invasive device which you had before admission?

☐☒☐If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care - obtain MRSA swabsNasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐**Creutzfeldt-Jakob Disease (CJD)**

Have you ever been informed that you are at increased risk of CJD or vCJD?

Yes ☐No ☒Unsure ☐If **YES** inform the IPCT ☐

N:		
Ac	1908546042	
—	LOGAN	F
—	Georgina	19/08/195
D:	17 SOLLAS PLACE	
CI	KNIGHTSWOOD	
Af	Glasgow, Lanarkshire	G13 4NA

Lifestyle

Smoking

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

Never smoked ☒

Do you use eCigarettes? Yes ☐ No ☐

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

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

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

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

Drugs

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

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

Alcohol

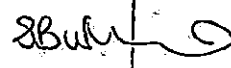
Do you drink alcohol? Yes ☐ No ☒

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

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

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

Name (Please PRINT): S. BRITTON

Signature: 

Designation: STAFF NURSE

Date: 20.10.20

My Assessment Record



1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

19/08/1954

G13 4NA

1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems			
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers	✓	✓	
Oxygen therapy			
Do you have any other symptoms?			
Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems			
Chest pain at rest			
Chest pain on exertion			
Angina	✓	✓	
Do you take medication for symptoms of angina?	✓	✓	
Hypertension			
Do you have any other symptoms?			

2. Communication

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

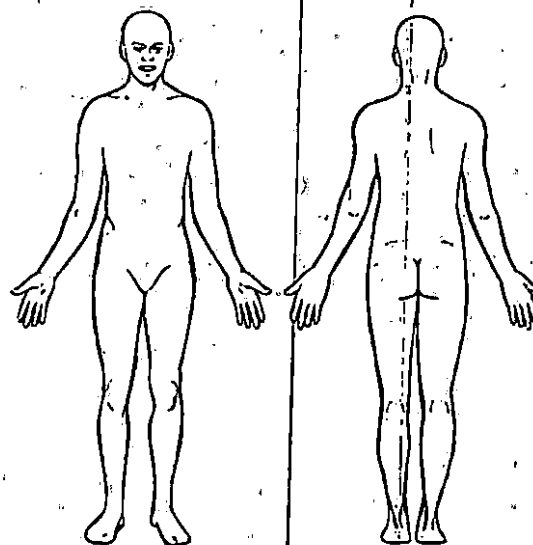
1908546042
LOGAN
Georgina
19/08/1954

patient ID label

3. Senses

Vision	Yes ✓	No ✓	Assessment of the patient's vision
Do you have any problems with your vision?			Distance ☒ Reading ☐ Both ☐
Do you wear glasses?	✓		
Do you have your glasses with you?			
Do you wear contact lenses?			
Do you have your lenses with you?			
Do you wear a prosthesis?			
Hearing	Yes ✓	No ✓	Assessment of the patient's hearing
Do you have any problems with your hearing?			
Do you have any hearing loss?			
Do you use a hearing aid?		✓	
Do you have your hearing aid(s) with you?			
Pain	Yes ✓	No ✓	Assessment of the patient's pain
Do you have pain?	✓		Can you describe where and what the pain is like? Have you had treatment / intervention for the pain? N.B. Complete generic pain assessment chart. If unable to self report complete Abbey Pain Scale. Can you describe any chronic pain that you have? What makes the pain better?

Mark current pain on body chart



N: _____
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 Georgina
 D: _____
 C: _____
 A: _____
 19/08/1954

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

N.B. Think Delirium

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

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

and follow the guidance

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

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

Dairy products

What do you like to eat and drink?

Tea

What do you not like to eat and drink?

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

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓	 1908546042 LOGAN Georgina F 19/08/1954	
Normal diet and fluids	✓	✓	Assessment of the patient's hydration and nutrition needs	
Therapeutic diet				
Cultural, ethnic or religious diet				
Texture Modified Diet Please state _____				
Thickened Fluid Please state _____				
Oral Nutritional supplements Preferred flavour _____				
Enteral Nutrition				
Parenteral Nutrition				
Nil by Mouth				
N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS) within 4 hours of admission				
Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓		
Independent (Green)	✓	✓		
Prompting / encouragement / opening packets/cutting up food (Amber)				
Full assistance with eating and drinking (Red)				
Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?				
6. Elimination				
Bladder	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs	
Pass urine with no problems	✓	✓		
Frequently pass urine during the day				
Frequently pass urine overnight				
Sense of urgency when need to pass urine				
Urine retention				

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓	 1908546042 LOGAN Georgina 19/08/1954 F ATTIX patient ID 1000
Haematuria			
Incontinent			

N.B. If new incontinence report to medical staff to rule out infection or physiological cause

What products do you normally use for this continence issue?

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

Date urinary catheter last changed ____/____/____

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

Bowels

When did your bowels last move? *last Wednesday*

How often in a day/week do you have a bowel movement? Per day Per week

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

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

What products do you normally use for this continence issue?

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

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

Name: _____



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

Personal Hygiene	Admission Presentation	Normal for the patient	Assessment of the patient's personal hygiene needs
Independent	✓	✓	
Requires assistance with washing and dressing			
Oral Health	Admission Presentation	Normal for the patient	Assessment of the patient's oral health needs
No problems	✓	✓	
Sore mouth / mucositis / ulcer			
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)			
Dental work	Yes	No	Description of any dental work
Do you wear dentures?	✓		
Do you have your dentures with you?	✓		
Are your dentures a good fit?	✓		
Do you have any other dental work that we need to be aware of?			
Skin Care	Admission Presentation	Normal for the patient	Assessment of the patient's skin care needs
No problems	✓	✓	
Skin broken			
Skin oedematous			
Skin discoloured / red			
N.B. Complete PUDRA for all patients within 8 hours of admission			
Pressure ulcer identified on admission: Yes ☐ No ☒			
Pressure Ulcer Grade: _____			
Pressure Ulcer Site: _____ Adult wound assessment and management chart required			
N.B If Grade 2 pressure damage on ankle or below refer to Podiatry via TrakCare			

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

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8 Mobility

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

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

9 Maintaining a Safe Environment

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

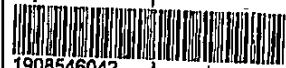
Safety	Yes ✓	No ✓	Assessment of the patient's ability to maintain a safe environment
Is the patient at risk of falling, rolling, slipping or sliding from the bed?		✓	
Would you like bedrails to be used while in hospital?	✓		

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

10. Sleep and Rest

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

Getting better.

		
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11. Social Circumstances

Do you:		
Live alone ☐	Live with family/ friend/ other ☒	
Live in a nursing home ☐	Live in a care home ☐	
Live in residential supported care ☐	Live in student accommodation ☐	
Live in 'homeless' accommodation ☐	Have no fixed abode ☐	
Other please specify _____ ☐		

Dependants

	Yes ✓	No ✓
Do you have any dependants?		✓
Do you support anyone (e.g. partner, children, relatives, animals)?		✓
Do they need support from someone else whilst you are in hospital?		✓
Would someone else be able to provide this support when you are in hospital? If yes, who?		✓
If no support available contact Duty Social Worker		
Duty Social Worker Required ☐ Not required ☒ Referred ☐		

Services

	Yes ✓	No ✓
Do you have support from social work, social services or a care package?		✓
If yes, please provide details:		
If yes, has contact been made to cancel arrangements during admission?		

12. Emotional and Spiritual Care

Do you have a religion or beliefs that we can help you observe while you are in hospital?	
Is there anything else with regards to your values, religion or culture that we can support you with during your stay in hospital (e.g. prayer meditation)?	
Would you like to talk to someone (e.g. Hospital Healthcare Chaplain) about you, your loved ones, your values and beliefs, or any worries you have? Yes ☐ No ☐	
Healthcare Chaplain informed Yes ☐ N/A ☒	

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Required Support

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

Yes ☐

No ☒

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

Has the carer been advised of the Carers Information Line?

Yes ☐

No ☐

Not appropriate at this time ☐

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?

Yes ☐

No ☐

Are you:

Employed

☐

Unemployed

☐

Self-employed

☐

Retired

☒

Full time education

☐

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

Yes ☐

No ☐

Not applicable ☐

Do you have any money worries?

Yes ☐

No ☐

Not appropriate to ask at this time ☒

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

Yes ☐

No ☐

If yes when was patient referred

___/___/___

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

Yes ☐

No ☐

Not applicable ☒

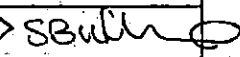
Not appropriate to ask at this time ☐

If yes when was patient referred ___/___/___

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Risk Assessments/Other Documentation

Additional NHSGGC Documentation	Required		Required documents completed		Date, Print and Sign when completed
	Yes ✓	No ✓	Yes ✓	No ✓	
Glasgow Assessment and Management of Alcohol (GAMA)		/		/	 S BRIFTON 20/10/2020
Generic Pain Scale Assessment Chart		/		/	
Abbey Pain Scale (if unable to self report pain)		/		/	
4AT and TIME for Detection, Management and Prevention of Delirium	/		/		
Getting to Know Me – Relatives to complete		/		/	
What Matters to Me		/		/	
Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)		/		/	
Malnutrition Universal Screening Tool (MUST)	✓		/		
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan		/		/	
Bristol Stool Chart	/		/		
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓		/		
Adult Wound Assessment and Management Chart		/		/	
Moving and Handling Assessment	/		/		
Falls Risk Assessment	✓		/		
Bedrail Risk Assessment	/	/	/		

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
20.10.20	Patient received in ward 9B	
20/10/20	From SNF clinic following admission with constipation. Bowels inactive for 6/7 days - Normally active 6 x daily and loose	
	Plan: Analgesia	
	Enema & laxatives	

Name:



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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
	Diet & Fluids	
	Unanalysis	
	Alert & oriented on Admission	
	Mobile & independent. Normally	
	mobile with walking stick for	
	distances	
	Skin intact. Reports allergy to plasmas	
	Redness to arm crook noted from	
	corner Bag on Arrival	
	Requesting Bed rails. Risk assessment	
	complete.	
	For fluid Balance & unanalysis	
	News 0. MUST 2 - For food chart ✓	
	No PVC insert.	
	Active care known.	
	Orientated to room & Nurse call	S. BRYTON SN
	system	S. Bule
2315	Patient unable to tolerate Phosphate	
	enema - Flareus Passed	
	laxido Administered	
	Patient then vomiting at 2300	
	300ml bilious / food content.	S. BRYTON SN
	5 evening medications due to this	S. Bule
21.10.20	Patient unable to	
Nocté	lie on bed as	
	feeling uncomfortable.	
	Chose to	

Name: _____
 Address: _____

 DoB: _____
 CHI: _____
 Affix patient ID label

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
	sit on chair @ bedside. Settled @ this time when observed.	W. J. S. (S) K. J. S. (S)
1440	patient has been settled today, complaining of leg cramps. patient refusing some meds as feeling nauseous. anticonvulsant given with good effect urine dipped - bilirubin + nitrates. Neuro stable. Seen on ward round plan is for CTWOB, + Wt. patient's bulimic patch due changed tomorrow. a. h. m. p. h. S. N.	
1640	patient for transfer to 4D. await porter for transfer. a. h. m. p. h. S. N.	
1910	patient had temp 38 at 1745 paracetamol given for this, rechecked at 1900 temp 38.3 - ibuprofen given - full taking blood cultures. with monitor. ? for IV abx.	a. h. m. p. h. S. N. A. h. m. p. h. S. N.

CLINICAL NOTES - MEDICAL
NURSING
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Please tick ☒ appropriate directorate

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Date & Time		Signature, Print Name & Designation
21/10/20	Transferred to 9D earlier this evening. NEWS 1, as charted - as slightly hypotensive. Tolerating fluids and diet. Continues on IV fluids. After current bag of Hartmann's, not for more fluids unless clinically indicated. Medications given as per Kardex, ordered some medications. Urinalysis showed positive for nitrates, protein, blood and leucocytes. Sent urine culture. For CT KUB tomorrow at 9.40. Passing urine spontaneously, bowels opened. Analgesia given as per Kardex. Patient seems more settled after receiving analgesia. No issues at present.	C. Harris SN Pats Harris
04.00	Settled night, no concerns at present. IV fluids continue due to hypotension.	C. Harris SN Pats Harris
22/10/20	MR: MA Manni Commence Oral Co-Amoxiclav for CT KUB today. Independent With personal Care Showered Fluid & Diet as able Voiding urine BNS Independently mobile Self positional Changes News 3 BP ↓ SpO2 95% on Room Air Full aware IV fluids commenced	

Date & Time		Signature, Print Name & Designation
22/10/20 cont	Meds as Kardex Borec Patch Renewed	
	Oral AB Commenced	
	Attended for CT KUB ALW Results	J Galacher SN
19 ³⁰	Attended CT - cholecystitis C10	
	IVAB. IVI for AKI. Temp 38.1	OBMAN
	FYI note	OBMAN
22/10/20	NEWS 3, as charted - hypotensive	
23 ⁵⁰	Tolerating fluids and diet. Continues on IV fluids and IV antibiotics.	
	Pyrexial at 38.6°C - informed FYI.	
	Medications given as per Kardex.	
	Settled evening so far, no issues at present.	C. Hamis SN
06 ⁰⁵	Analgesia as per Kardex. NEWS 3, as charted - hypotensive and 95% SpO2. Fairly settled night, no issues at present.	C. Hamis SN
23/10	WE: Continue IVAB	
1150	Incl with personal care	
	Taking fluid & diet	
	Voiding urine. BNO, feels constipated	
	Incl mobile	
	NEWS: 2 (hypotensive)	
	IVAB given. IV fluids continue.	
	Analgesia as per Kardex	OBMAN
	Settled AM	OBMAN
1800	Slept well - no complaints	
	Voided	
21/10/20	Settled night	
06 ¹²	NEWS 5 Charted	
	IVs IVAB continue	
	Chromomorph x1.	
	Mechile to Pacer	

CLINICAL NOTES - MEDICAL
NURSING
☐
☒

Please tick ✓ appropriate directorate



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Date & Time		Signature, Print Name & Designation
	Settled at present.	Chile 42
26.10.20	Seen by medical staff on ward round.	
11.30 am	continue IV fluids and IV antibiotics.	
	WSU - nitrokes.	
	Independent with hygiene	
	Taking very little fluid and diet.	
	On food chart.	
	Encouraged to drink more	
	Bowels inactive	
	Passing urine.	
	Very lethargic. Complaining of	
	feeling seedy - not specific	
	Remained in bed most of morning	
	Observations as charted NEWS 0	
	IV fluids continue as per regime	
	IV antibiotics as prescribed.	JM O'Callaghan
17.40	Gentamicin not yet given as not	JM O'Callaghan
	prescribed - no levels taken. FYI will	
	take bloods.	
	Not prescribed dexone - FYI informed.	
	Will review notes and prescribe if	
	appropriate.	JM O'Callaghan
19.00	Dexone given Analgesia required	JM O'Callaghan
	Gentamicin now in progress	JM O'Callaghan
20.10.20	Settled night	
06.2	News 3 entered	
	IV + WAB continue	
	Up to toilet	
	No ch nausea.	

Date & Time		Signature, Print Name & Designation
	Bowels inactive.	
	Oral fluids taken	
	Seated at present	Giller 4 th
25/10/20	Seen by medical staff as ward visit -	
16 ⁴⁰	IV fluids to be discontinued.	
	IV antibiotics to continue. Gentamicin switched to temocillin.	
	Independent with hygiene.	
	Taking fluid and a little diet - on food chart.	
	Passing urine.	
	Bowels active small amount.	
	Mobilising around room.	
	Observations as charted NEWS 0.	
	IV antibiotics as prearranged.	
	Pressure areas intact.	JM'GART
1900	Bedden pm NEWS 0.	JM'GART
26/10/20	Seated night	
03 ³⁰	WAB continue.	
	Benzepam 10 mg pain.	
	Mobile to toilet.	
	News 0 observed.	
	Bowels active for small amount.	
	Seated at present	Giller 4 th
1100	Pt. p/b NR today - IVPT and	
	? H late if pt call. Pt	
	for OP note. Pt aware	
	of plan. Pt independent	
	with AAS. Mnt of 0. Pt	(JMG)
	not complaining.	(JMG)

NHSGGC Bedrail Risk Assessment

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

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT

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Use guidance on the reverse of this document when completing this Risk Assessment		DATE	2010	21/10				
		TIME	2030	2015				
		WARD	9B	9D				
		HOSPITAL	QETAH	QETAH				
SECTION ONE - GENERAL								
1	Is the patient likely to fall, roll, slip or slide from the bed?	Y	N	Y	N	Y	N	Y
2	Has the patient requested the use of bedrails?	✓	✓	✓	✓			
IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED								
SECTION TWO - COGNITIVE AND PHYSICAL STATUS								
3	Is the patient at risk of climbing out of bed?		✓		✓			
4	Is the patient stressed, delirious or restless?		✓		✓			
5	Is the patient small in stature?		✓		✓			
6	Does the patient have an unusually large or small head that might present an entrapment issue?		✓		✓			
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?		✓		✓			
IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE - See Guidance overleaf								
SECTION THREE - COMMUNICATION								
8	Has the patient been consulted regarding the use of bedrails?	✓	✓	✓	✓			
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition	✓	✓	✓	✓			
10	Has the use of bedrails been discussed with relatives/carers?	✓	✓	✓	✓			
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?	✓	✓	✓	✓			
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?	✓	✓	✓	✓			
IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE - See Guidance overleaf								
SECTION FOUR - DECISION MAKING								
13	Will bedrails be used for this patient at the present time?	✓	✓	✓	✓			
14	Rationale for use of bedrails: (Please insert code in the box on the right)							
	A - Risk of falling from the bed							
	B - Risk of rolling from the bed							
	C - Risk of slipping from the bed							
	D - Risk of sliding from the bed							
	E - Patient request	✓	✓	✓	✓			
15	Bedrail risk assessment completed by:	SB	CH					
16	Bedrails checked by:	SB	CH					
17	Date	2010	21/10					
Any issues relating to the use of bedrails including discussion with family/relatives/carers should be recorded here								

A. Alternatives to bed rails:-

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

C. Safe use and application of bedrails:-

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

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

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

D. Record keeping:-

All of the following should be recorded:-

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

Bedrail risk assessments should be made as follows:-

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

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Care Plan

Care discussed with patient Unable		☒ Yes	☐ No	☐	If unable, give reason:	
Care discussed with family Unable		☐ Yes	☐ No	☐	If unable, give reason:	
Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature	
20/10/20. 2025 S. B. [Signature]	Known Asthma & AF Record observations as per News.		20/10/20 S. B. [Signature]	N/A		
				5. Hydration and Nutrition		
				Avoids Dairy products		
				Prefers tea, dislikes water		
	2, 3. Communication and senses					
	Wears glasses for distances					
				6. Elimination		
	4. Cognitive status			Normally loose stools		
	Alert & Orientated			recent urinary incontinence		
				Independent		
				For laxatives & Enemas		

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Care Plan

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
26/10/20	Independent			Alert & oriented	
				Nurse call system given	
				10. Sleep and Rest	
				States she does not sleep	
	8. Mobility				
	Uses stick for distances			12. Privacy, dignity and sexuality	
	otherwise independent			To be respected at all	
				times	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

Date: 20/10/20

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

1. Signed SBurton Name SBurton Designation SN

2. Signed _____ Name _____ Designation _____

3. Signed _____ Name _____ Designation _____



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USE FOLLOWING CODES:

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

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

[illegible]

Attach Addressograph Label



Ward:

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

[illegible]

Date: 21/10/20

1. Signed SBurton Name SBurton Designation SN
2. Signed AHumphrey Name AHumphrey Designation S/N
3. Signed CHawis Name CHawis Designation SN

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

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T/E 9.0 G13.4NA

NHS
Greater Glasgow
and Clyde

[illegible]

Attach Addressograph Label



Ward:

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

[illegible]

Care Rounds Checklist

Date: 22/10/20

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

1. Signed Chavis Name C. Chavis Designation SN
2. Signed Byrd Name Byrd Designation SN
3. Signed Chavis Name Chavis Designation SN

Attach Ad



1908546042

LOGAN

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Dana

Georgina

17 SOL LAS PLAS

17 SOLLAS PLACE
MANHATTAN, N.Y. 10022

KNIGHTSWOOD

Monday

Ward: 90

19/08/1954

G13 4NA

NHS
Greater Glasgow
and Clyde

USE FOLLOWING CODES:

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

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

[illegible]

Date: 23/10/20

1. Signed CHAMIS Name C. Hamis Designation SN
2. Signed Leh Name Leh M. Kafe Designation STN
3. Signed CHAMIS Name CHAMIS Designation SL

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

G13 4NA

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Greater Glasgow
and Clyde

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

[illegible]

Date: 24/10/20 -

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

1. Signed [Signature] Name ASIA Designation JL
2. Signed [Signature] Name Barz Designation [Signature]
3. Signed [Signature] Name ASIA Designation [Signature]

Attach Addressograph Label



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Georgina

Ward: 17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire

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'Must' G13 4NA there is anything they want specifically done today:

USE FOLLOWING CODES:

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

[illegible]

Attach Addressograph Label



Ward:

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

[illegible]

Date: 25/10/20

1. Signed [Signature] Name CHIA Designation IN
2. Signed [Signature] Name IMC AFFENY Designation ON
3. Signed [Signature] Name CHIA Designation IN

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

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

[illegible]

Ward:

Codes

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

N.B. Record what and to whom escalated.

[illegible]

Date: 26/10/20

1. Signed [Signature] Name Alvin Designation SL
2. Signed [Signature] Name Rhannon Coats Designation DR
3. Signed _____ Name _____ Designation _____

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

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and Clyde

[illegible]

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

Codes

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

N.B. Record what and to whom escalated.

[illegible]

4AT and TIME for Detection, Management and Prevention of Delirium

Complete for patients: age 65 and over; patients of any age with an existing cognitive impairment; previous delirium; current hip fracture; or severe illness. These patients are at high risk of delirium.

This should be done on admission; at each transition of care; if SQiD positive; or if any clinical concerns.

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4AT		Ward <u>9B</u>	Ward <u>9D</u>	Ward _____	Ward _____	Ward _____
		Date & Time <u>20/08/2015</u>	Date & Time <u>21/08/2015</u>	Date & Time _____	Date & Time _____	Date & Time _____
(1) Alertness This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating						
Normal (fully alert, but not agitated, throughout the assessment)		0	0	0	0	0
Mild sleepiness for <10 seconds after waking, then normal		0	0	0	0	0
Clearly abnormal		4	4	4	4	4
(2) AMT4 Ask the patient their Age, Date of Birth, Place (name of hospital) Current Year						
No mistakes		0	0	0	0	0
1 mistake		1	1	1	1	1
2 or more mistakes		2	2	2	2	2
(3) Attention Ask the patient "Please tell me the months of the year in backward order, starting at December". To assist, one prompt of "What is the month before December" is permitted.						
Achieves 7 months or more correctly		0	0	0	0	0
Starts but scores < 7 months or refuses to start		1	1	1	1	1
Untestable (cannot participate because too drowsy or inattentive)		2	2	2	2	2
(4) Acute change or fluctuating course Evidence of significant change of fluctuation in: alertness, cognition, other mental function (e.g. hallucinations, paranoia) over the past 2 weeks and still present in preceding 24 hrs.						
No		0	0	0	0	0
Yes		4	4	4	4	4
4AT TOTAL SCORE		0	0			
Print initials of assessor		<u>SD</u>	<u>CH</u>			
Score >4 This is a possible DELIRIUM +/- COGNITIVE IMPAIRMENT, start 'T' and 'I' of TIME and escalate to medical staff to confirm diagnosis		Score 1-3 This is a possible COGNITIVE IMPAIRMENT, and requires further assessment				
		Score 0 DELIRIUM or SEVERE COGNITIVE impairment unlikely				

All patients scoring 0-3 are still at high risk of delirium. Use the Triggers listed overleaf to plan care and reassess daily by asking 'Is the patient more confused or drowsy?' This is the single question in delirium (SQiD)

TIME checklist to guide Delirium risk reduction, Identification and Management

The TIME checklist is a joint medical and nursing responsibility.



Triggers, Investigate, Manage and Engage		Date	Date	Date	Date	Date
Triggers	Think possible triggers for delirium	Tick box	Tick box	Tick box	Tick box	Tick box
	Is the patient in pain? Start pain chart, review analgesia and consider need for an aperient					
	Is the patient constipated or at risk of constipation? Commence bowel chart and review daily to assess for constipation, especially if on analgesia. Consider rectal examination					
	Is the patient in urinary retention? Palpate bladder/scan					
	Is the patient's oral intake sufficient to prevent dehydration? Encourage hourly fluids, start fluid balance chart					
	Could any drugs trigger delirium? Doctor to review medication					
	Blood sugar, high or low?					
	Is there a history of alcohol intake/drug abuse? Intoxication or withdrawal, start CMAWS/drug misuse guidelines					
	Does the patient have sensory impairment? Ensure patient is wearing their glasses/hearing aid(s)					
	Is the patient immobile? Promote early mobilisation in order to prevent delirium					
	Document 4AT score					
	Does the patient have Delirium? (Yes/No/Unsure) Please Circle	Y N U	Y N U	Y N U	Y N U	Y N U
Investigate	Investigate					
	Record NEWS					
	Screen for infection					
	Take bloods and ensure ECG/appropriate imaging					
Manage	Management: Diagnose causes & initiate treatment					
	Document diagnosis of delirium					
	Document potential causes of delirium					
	Document treatment plan					
Engage	Engage and Explore					
	If appropriate, explain diagnosis of delirium to patient/ family/ carers and provide delirium leaflet					
	Engage with patient/ family/ carers. Complete "What matters to me"/"Getting to know me" document					
	Does the patient have capacity to consent to care? (Yes/No/Ongoing Assessment)	Y N O	Y N O	Y N O	Y N O	Y N O
	If no, complete AWI document					
	Print initials of assessor					

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FALLS RISK ASSESSMENT

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



GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

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

Ward: 9B Date: 20.10.20 Time: 19.45	Ward: 9D Date: 21/10/20 Time: 20.15	Ward: Date: Time: -----	Ward: Date: Time: -----	Ward: Date: Time: -----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	✓	Yes		
2. Check walking aid (if required) is in reach and in use.	✓	Yes		
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	✓	Yes		
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	✓	Yes		
5. If glasses are worn, check they are available and in use.	✓	Yes		
6. If hearing aid/s are worn, check they are working and in use.	N/A	N/A		

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).

Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.

ALL patients in older people's wards must have an interventional plan in place (overleaf)

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

Highlight risk of fall at the ward safety brief.

FALLS INTERVENTION CHECKLIST

Complete for all patients identified at risk of falling.

Ward:	Ward:	Ward:	Ward:	Ward:
Date:	Date:	Date:	Date:	Date:
Time: -----	Time: -----	Time: -----	Time: -----	Time: -----

BED AND SEATING

Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice.
(Patient care plan 8)

Assess if a low bed is required (Patient care plan 9)

SAFETY

Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)

Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)

If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.

HEALTH

Complete / Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)

Document continence problems and link to care rounding (Patient care plan 6)

Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)

If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.

COMMUNICATION

Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)

Update the ward team of the patient's mobility status. (Patient care plan 8)

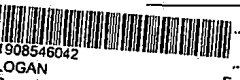
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)

Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)

Signature of nurse completing interventional plan / or update

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team
EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

Fluid Balance Chart

 1908546042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA 19/08/1954 F	Hospital: <u>Q&A</u> Ward: <u>9B</u> Date: <u>20/10/20</u>	Reason for Fluid Balance Chart <u>Constipation</u> Is patient fluid restricted? Yes ☐ No ☐ If yes how many mls in 24 hours? _____ Fluid balance from previous 24hrs +/- _____	Does patient require thickened fluids? Yes ☐ No ☐ Stage _____ Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate: 1. Type _____ circle how many daily 1 2 3 2. Type _____ circle how many daily 1 2 3 Signature: _____ Designation: _____																
ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT																			
Time	Input								Output										
	Oral Fluids		Enteral		IV / Other				Running Total	Urine	Gastric /	Bowel	Type	Type	Type	Running Total	Initials		
	Type	Volume	Type	Volume	Type	Volume	Type	Volume	INPUT		Vomit					OUTPUT			
00:00																			
01:00																			
02:00																			
03:00																			
04:00																			
05:00																			
06:00																			
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18:00																			
19:00	✓																		
20:00	4.00	Tea							4.00		50								
21:00																			
22:00											300								
23:00																			
*Total Intake									1.00	*Total Output									350

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

Fluid Balance Chart

 1908546042 LOGAN F Georgina 19/08/1954 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA	Hospital: <u>Acute</u>	Reason for Fluid Balance Chart _____	Does patient require thickened fluids? Yes ☐ No ☒ Stage _____																	
	Ward: <u>9B</u>	Is patient fluid restricted? Yes ☐ No ☐	Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:																	
	Date: <u>21/10/20</u>	If yes how many mls in 24 hours? _____	1. Type _____ circle how many daily 1 2 3																	
	<u>TIF 919</u>	Fluid balance from previous 24hrs +/- _____	2. Type _____ circle how many daily 1 2 3																	
Signature: _____ Designation: _____																				
ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT																				
Time	Input				Output										Running Total OUTPUT	Initials				
	Oral Fluids		Enteral		IV / Other				Running Total INPUT		Urine	Gastric / Vomit	Bowel	Type			Type	Type		
	Type	Volume	Type	Volume	Type	Volume	Type	Volume												
00:00																				
01:00																				
02:00																				
03:00																				
04:00																				
05:00																				
06:00	<u>100</u>					<u>100</u>			<u>100</u>		<u>200</u>	<u>200</u>					<u>400</u>			
07:00																				
08:00																				
09:00																				
10:00																				
11:00																				
12:00																				
13:00																				
14:00																				
15:00																				
16:00																				
17:00																				
18:00																				
19:00						<u>WF 500</u>			<u>500</u>											
20:00						<u>IVF commenced</u>														
21:00																				
22:00											<u>200</u>						<u>600</u>			
23:00																				
*Total Intake									<u>1700</u>	*Total Output									<u>600</u>	

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/- 0

Fluid Balance Chart

 1908548042 LOGAN F Georgina 19/08/1954 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA	Hospital: <u>REOM</u>	Reason for Fluid Balance Chart _____	Does patient require thickened fluids? Yes ☐ No ☐ Stage _____
	Ward: <u>9D</u>	Is patient fluid restricted? Yes ☐ No ☐	Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
	Date: <u>22/10/20</u>	If yes how many mls in 24 hours? _____	1. Type _____ circle how many daily 1 2 3 2. Type _____ circle how many daily 1 2 3
	Fluid balance from previous 24hrs +/- _____		Signature: _____ Designation: _____

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input				IV / Other				Running Total INPUT	Output			Running Total OUTPUT	Initials	
	Oral Fluids		Enteral		Type	Volume	Type	Volume		Urine	Gastric / Vomit	Bowel			Type
00:00															
01:00															
02:00															
03:00															
04:00															
05:00															
06:00															
07:00															
08:00	100				500	IV1			500						
09:00										400				400	CB
10:00															
11:00															
12:00															
13:00	200				200				200	200	IT				
14:00															
15:00	100				400	IV1			1200						
16:00					200	IVM			1400						
17:00															
18:00										200				600	CB
19:00															
20:00															
21:00															
22:00	100				IV1	300			1700	200				800	SL
23:00									1800						
*Total Intake									1800	*Total Output			800	CB	

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/- 1000ml

Fluid Balance Chart

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F
19/08/1954
G13 4NA

Hospital: QECH
Ward: 90
Date: 23/10/20

Reason for Fluid Balance Chart
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours?

Fluid balance from previous 24hrs
+/-

Does patient require thickened fluids?

Yes ☐ No ☐ Stage

Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:

1. Type circle how many daily 1 2 3

2. Type circle how many daily 1 2 3

Signature: Designation:



ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input				Enteral				IV / Other				Running Total INPUT	Output				Running Total OUTPUT	Initials	
	Oral Fluids													Urine	Gastric / Vomit	Bowel	Type			Type
	Type	Volume	Type	Volume	Type	Volume	Type	Volume												
00:00																				
01:00					IV PB	100						100								
02:00																				
03:00																				
04:00																				
05:00																				
06:00																				
07:00					Normal	300						400							h	
08:00					200	100						600								
09:00	200	Juice										800	pucl							
10:00																				
11:00																				
12:00																				
13:00	100	Juice										900	NPO					-	DB	
14:00																				
15:00																				
16:00	100				500	IV						1500								
17:00					200	IV PB						1700								
18:00					100	IV PB						1800	350					350	~	
19:00																				
20:00																				
21:00	200											2000								
22:00																				
23:00					IV PB							2200	200					550		
*Total Intake													2400	*Total Output				550	*24 hr Fluid Balance +/-	

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

Fluid Balance Chart

Name:  1908546042 F LOGAN Georgina 19/08/1954	Hospital: <u>QUEEN</u>	Reason for Fluid Balance Chart _____	Does patient require thickened fluids? Yes ☐ No ☐ Stage _____
	Ward: <u>9D</u>	Is patient fluid restricted? Yes ☐ No ☐	Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate: 1. Type _____ circle how many daily 1 2 3 2. Type _____ circle how many daily 1 2 3
	Date: <u>24/10/20</u>	If yes how many mls in 24 hours? _____	Signature: _____ Designation: _____
		Fluid balance from previous 24hrs +/- _____	

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input				IV / Other				Running Total INPUT	Output			Running Total OUTPUT	Initials
	Oral Fluids Type	Volume	Enteral Type	Volume	Type	Volume	Type	Volume		Urine	Gastric / Vomit	Bowel		
00:00														
01:00														
02:00														
03:00														
04:00									500					
05:00									700					
06:00														
07:00														
08:00	NIL									100			100	
09:00														
10:00														
11:00	50								750	PU 750				
12:00	50								1000					
13:00	200								1200	PU 750				
14:00														
15:00														
16:00	200								1400	300			450	
17:00	100								1500	100			550	
18:00														
19:00									1800					
20:00	100								1900	200			750	
21:00									2000					
22:00									2100					
23:00	150								2250	250			1000	
*Total Intake										*Total Output				

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

Fluid Balance Chart

 1908548042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA 19/08/1954 F	Hospital: <u>GEWH</u> Ward: <u>9D</u> Date: <u>25/10/20</u>	Reason for Fluid Balance Chart _____ Is patient fluid restricted? Yes ☐ No ☐ If yes how many mls in 24 hours? _____ Fluid balance from previous 24hrs +/- _____	Does patient require thickened fluids? Yes ☐ No ☐ Stage _____ Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate: 1. Type _____ circle how many daily 1 2 3 2. Type _____ circle how many daily 1 2 3 Signature: _____ Designation: _____													
ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT																
Time	Input				Output											
	Oral Fluids		Enteral		IV / Other		Running Total	Urine	Gastric /	Bowel	Type	Type	Type	Running Total	Initials	
	Type	Volume	Type	Volume	Type	Volume	INPUT		Vomit					OUTPUT		
00:00																
01:00																
02:00																
03:00																
04:00																
05:00																
06:00							700	300					300	GM		
07:00	200						900									
08:00																
09:00								150					150			
10:00							1050									
11:00	150						1200									
12:00	150						1350									
13:00	150						1500	200					850			
14:00																
15:00																
16:00																
17:00																
18:00																
19:00																
20:00																
21:00																
22:00																
23:00																
*Total Intake								*Total Output								

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-



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G13 4NA

19/08/1954

Guidance:

If the patient is at risk of dehydration please record drinks on a Fluid Balance Chart.

Record ALL food, drink and supplements that the patient eats and drinks.

Make sure the type and amount of the food, drink or supplement is accurate e.g. 3 spoonfuls of lentil soup, 1 cup of full fat milk.

It is important to record if the patient refuses food, drink or supplement and the reason why e.g. no appetite, didn't like, feeling sick.

Patients, friends, relatives, volunteers can write on this chart.

The information documented on this chart should be reviewed and evaluated daily by a Registered Nurse. Any changes should be noted in the patients care plan.

Food and Drink Recording Chart

Reason for recording intake: _____

Date: 23/10/20	Day Number:
Food and Drink Intake	
Breakfast: refused breakfast	
Snack:	
Lunch: 1/2 bowl soup	
Snack: crisps	
Evening Meal: chicken breast in peppercorn sauce	
Supper:	
Overnight:	
Is the patients intake 'normal' or improved for them? Yes ☐ No ☐ Unsure ☐	
Continue: ☐ Discontinue: ☐	
Rationale: _____	
Signed: _____	Print: _____

Date: 24.10.20	Day Number:
Food and Drink Intake	
Breakfast: Refused	
Snack:	
Lunch: Small portion of baked egg	
Snack:	
Evening Meal: mince 1/2	
Supper: 1/2 cup tea 1/4 Mars Bar 2 extra biscuits	
Overnight:	
Is the patients intake 'normal' or improved for them? Yes ☐ No ☐ Unsure ☐	
Continue: ☐ Discontinue: ☐	
Rationale: _____	
Signed: _____	Print: _____

Food and Drink Recording Chart

Reason for recording intake: Weight loss

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Guidance:

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Record ALL food, drink and supplements that the patient eats and drinks.

Make sure the type and amount of the food, drink or supplement is accurate e.g. 3 spoonfuls of lentil soup, 1 cup of full fat milk.

It is important to record if the patient refuses food, drink or supplement and the reason why e.g. no appetite, didn't like, feeling sick.

Patients, friends, relatives, volunteers can write on this chart.

The information documented on this chart should be reviewed and evaluated daily by a Registered Nurse. Any changes should be noted in the patients care plan.

Date: <u>21.10.20</u>	Day Number:
Food and Drink Intake	
Breakfast:	
Snack:	
Lunch:	
Snack:	
Evening Meal:	
Supper:	
Overnight:	
Is the patients intake 'normal' or improved for them? Yes ☐ No ☐ Unsure ☐	
Continue: ☐ Discontinue: ☐	
Rationale: _____	
Signed: _____ Print: _____	

Date: <u>22/10/20</u>	Day Number:
Food and Drink Intake	
Breakfast: <u>x2 spoon cornflakes</u>	
Snack:	
Lunch: <u>x3 spoon soup</u> <u>x3 bites stew</u>	
Snack:	
Evening Meal: <u>ham salad (1/4)</u>	
Supper:	
Overnight:	
Is the patients intake 'normal' or improved for them? Yes ☐ No ☐ Unsure ☐	
Continue: ☐ Discontinue: ☐	
Rationale: _____	
Signed: _____ Print: _____	



1908546042

LOGAN

Georgina

19/08/1951

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

G13 4NA

Food and Drink Recording Chart

Reason for recording intake: _____

Guidance:

If the patient is at risk of dehydration, please record drinks on a Fluid Balance Chart.

Record ALL food, drink and supplements that the patient eats and drinks.

Make sure the type and amount of the food, drink or supplement is accurate e.g. 3 spoonfuls of lentil soup, 1 cup of full fat milk.

It is important to record if the patient refuses food, drink or supplement and the reason why e.g. no appetite, didn't like, feeling sick.

Patients, friends, relatives, volunteers can write on this chart.

The information documented on this chart should be reviewed and evaluated daily by a Registered Nurse. Any changes should be noted in the patients care plan.

Date: 25.10.20	Day Number: 3
Food and Drink Intake	
Breakfast: 3x spoonfuls via crumpies. cup of tea	
Snack:	
Lunch: Full bowl minestrone Couple spoonfuls mashed potato	
Snack:	
Evening Meal: chicken curry - 3/4. cheesecake - all	
Supper: 1/2 cup TEA (100ml)	
Overnight:	
Is the patients intake 'normal' or improved for them?	
Yes ☐ No ☐ Unsure ☐	
Continue: ☐ Discontinue: ☐	
Rationale: _____	
Signed: _____ Print: _____	

Date: 26.10	Day Number: 4
Food and Drink Intake	
Breakfast:	
Snack:	
Lunch: 1/2 bowl of soup crackers and butter 3/4 of baked potato	
Snack:	
Evening Meal:	
Supper:	
Overnight:	
Is the patients intake 'normal' or improved for them?	
Yes ☐ No ☐ Unsure ☐	
Continue: ☐ Discontinue: ☐	
Rationale: _____	
Signed: _____ Print: _____	

Patient Address Label

Guidance:

If the patient is at risk of dehydration please record drinks on a Fluid Balance Chart.

Record ALL food, drink and supplements that the patient eats and drinks.

Make sure the type and amount of the food, drink or supplement is accurate e.g. 3 spoonfuls of lentil soup, 1 cup of full fat milk.

It is important to record if the patient refuses food, drink or supplement and the reason why e.g. no appetite, didn't like, feeling sick.

Patients, friends, relatives, volunteers can write on this chart.

The information documented on this chart should be reviewed and evaluated daily by a Registered Nurse. Any changes should be noted in the patients care plan.

Food and Drink Recording Chart

Reason for recording intake: _____

Date:	Day Number:
Food and Drink Intake	
Breakfast:	
Snack:	
Lunch:	
Snack:	
Evening Meal:	
Supper:	
Overnight:	
Is the patients intake 'normal' or improved for them?	
Yes No Unsure	
Continue: Discontinue:	
Rationale: _____	
Signed: _____ Print: _____	

Date:	Day Number:
Food and Drink Intake	
Breakfast:	
Snack:	
Lunch:	
Snack:	
Evening Meal:	
Supper:	
Overnight:	
Is the patients intake 'normal' or improved for them?	
Yes No Unsure	
Continue: Discontinue:	
Rationale: _____	
Signed: _____ Print: _____	

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19/08/1954

Named Nurse:

S. BUFTON

Person is totally independent
(tick here and go to data box)

GGC0026

Continuation Sheet

1. General Information (Only complete this section if changed from over page)										
Body Build			Problems with comprehension, behaviour, co-operation (specify):							
Weight		Height		Handling constraints, e.g. dexterity, weakness, pain, skin lesions, infusions (specify):						
Kg		cm								
BMI										
Risk of Falls: Yes ☐ No ☐										
2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)										
Hoist	Standard	Walking Aid	Assistance			Supervision		Independent		
Model:		Aid Type	People: 1	2	>3	Additional Information / Equipment:				
Sling type										
Sling Size										
3. Toileting										
Hoist	Standard	Walking Aid	Assistance			Supervision		Independent		
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1	2	>3	Additional Information:				
4. Move on / off bed pan										
Hoist	Manoeuvre	Assistance			Supervision		N/A			
See No 2 Sit to Stand Transfers for details		Roll patient	People: 1	2	>3	Additional Information:				
		Monkey pole								
		Person bridges								
5. Move up / down bed										
Hoist	Handling Aids	Assistance			Supervision		Independent			
See No 2 Sit to Stand Transfers for details		Sliding sheets	People: 1	2	>3	Additional Information:				
		Monkey pole								
		Rope ladder								
6. Lateral Transfer to / from trolley / bed										
Hoist	Handling Aids	Assistance			Supervision		Independent			
See No 2 Sit to Stand Transfers for details		Rigid Transfer Board	People: 1	2	>3	Additional Information / Equipment (eg sliding sheets):				
		Other (Please specify)								
7. Sit up over side of bed										
Bed Rest		Assistance			Supervision		Independent			
		People: 1	2	>3	Additional Information / Equipment (eg rope ladder, swivel cushion):					
8. Into Bath or Shower										
Equipment	Handling Aid	Assistance			Supervision		Independent			
Shower	Shower chair	People: 1	2	>3	Additional Information / Equipment (eg sling lifting hoist after risk assess):					
Variable / Fixed height bath	Shower trolley									
Bed bath	Bathing hoist (eg Atena)									
9. Walking										
No Walking	Walking Aid	Assistance			Supervision		Independent			
see 'sit to stand transfers'		People: 1	2	>3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)					
10. Other Instructions / Observations / Equipment Used										
		4 th Assessment		5 th Assessment		6 th Assessment				
Recording Symbol:	/	Forward slash		X	Where a forward slash exists, add a back slash to make a cross		*	Where a slash or cross exists add slashes to make a star		
Date Assessed:										
Assessor's signature:										
Proposed Review date:										



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17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

19/08/1954

G13 4NA

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS
Greater Glasgow
and Clyde

Date <u>20/10</u> Time <u>2030</u> of initial height and weight on admission to hospital		Actual	* Patient reported	* If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height	<u>4ft 10¹¹</u> cm	☐	☒	
Admission Weight	<u>105.71</u> Kg	☐	☒	

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

Patients reported normal weight 125st Unable to Recall ☐

Any unplanned weight loss in the last 6 months Yes ☒ how much 1 1/2 stone No ☐ Don't Know ☐

Date	20/10	22/10	25/10					
Time	2030	0800	1030					
Ward	9B	9D	9D					
Oedema/ Ascites present Y/N	N	N	N					
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes	ST	weight not	CH					
Weight (kgs)	68.6	68.6	70.4					
BMI	30.5	30	32					

Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days

Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	0	0	0					
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	2	2	0					
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	0	0	0					
Step 4 Overall Risk of Malnutrition TOTAL	2	2	0					
Rescreen on	23/10	27/10	01/11					
Signature	sb	JB	AME					

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

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

NHSGGC NEWS – National Early Warning Score



1908546042	F
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Georgina	
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KNIGHTSWOOD	
Glasgow, Lanarkshire	G13 4NA

	Date	Ward	Time
Admitted	20.10.20	SIAU	1520
Transferred	20.10.20	9B	2025
Transferred			
Transferred			
Transferred			

SpO2 Scale 1 Target >96%	SpO2 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 Min 12 Hourly Observations	Low Clinical Risk Min 4 Hourly Observation Inform Registered Nurse Agree Frequency of Observation Required	Medium Clinical Risk Min Hourly Observations Urgent Assessment by Medical Team ACE Response in Medical Notes Think Sepsis If Suspicion of Infection	High Clinical Risk Continuous Monitoring Urgent Assessment by Senior Medical Team ACE Response in Medical Notes Consider 2222

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

Discontinuation of NEWS Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations Signed..... Medical: Date:	
---	--

NHSGGC NEWS – National Early Warning Score



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 Glasgow, Lanarkshire
 19/08/1954
 G13 4NA

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

CONT.

SpO2 Scale 1
 Target >96%

Signature: _____

Print Name: _____

Dr/ANP initials ONLY: _____

Date: _____

SpO2 Scale 2
 Target 88-92%

Signature: _____

Print Name: _____

Dr/ANP initials ONLY: _____

Date: _____

Patient on home oxygen Y ☐ N ☐

If yes, add details of oxygen therapy

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed:

Medical:

Date:

D 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	• 36.1											≥39	2										
		38.1-39.0	1																				
		37.1-38.0	0																				
		36.1-37.0	0																				
		35.1-36.0	1																				
												≤35.0	3										

NEWS Total	0	0										
------------	---	---	--	--	--	--	--	--	--	--	--	--

Blood glucose	7.0	/										
Pain / function score	0A	0A										
Time Pt last passed urine	10.20	09.00										
Fluid balance chart indicated Y/N	N	N										
GCS indicated Y/N	N	N										
Time NEWS due	23.00	16.00										
Escalation of care Y / N	N	N										
Initials	AB	RC										

ELEVATED NEWS2 ≥ 4 THINK SEPSIS Apply SEPSIS 6 within 1 hour	
1.	Give oxygen to target saturation >94% (COPD 88-92%)
2.	IV fluids up to 20ml/kg
3.	Take blood cultures
4.	Measure lactate and FBC
5.	Give IV antibiotics
6.	Monitor urine output and fluid balance chart

Think AGE	
A	Action: Working diagnosis (consider SEPSIS). Consider frequency of observations. Management plan. Set review time. Document.
C	Communicate: Inform nurse of plan. Inform senior medic if necessary. Document the discussion.
E	Escalate: Document the treatment escalation plan. Should include need for next level of care & consideration of resuscitation status.

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Glasgow, Lanarkshire		
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[illegible]

Pupil Reaction

s = sluggish
+ = reaction
- = no reaction
c = eyes closed

Pupil Size (mm)

1
2
3
4
5
6
7
8

Pressure Ulcer Daily Risk Assessment (PUDRA)

 1908546042 LOGAN Georgina F 19/08/1954	Hospital: QEUTH Ward: 9B T/F 9D	Points to consider: • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes
1 Pressure Damage Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan overleaf.		

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

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

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

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

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
20/10/20	20:40	N	N	N	N	N	N	4 hrly	SB
21/10/20	08:00	N	N	N	N	N	N	4 hrly	gh
21/10/20	20:15	N	N	N	N	N	N	4 hrly	CH
22/10/20	00:30	N	N	N	N	N	N	4 hrly	CH
23/10/20	00:20	N	N	N	N	N	N	4 hrly	CH
24/10/20	09:00	N	N	N	Y	N	N	4 hrly	CH
25/10/20	08:15	N	N	N	Y	N	N	4 hrly	CH
/ /	:							__ 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



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 effective work practices in line with SSKINS bundle.

Attach Addressograph

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan: <i>26.10.20</i>	Check: • Pressure areas <i>L⁰</i> hourly. • Skin under medical devices _____ hourly. • Specify medical devices used: _____	Specify: • Mattress: <i>good foam</i> • 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: <i>INDEPENDENT</i>	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used: _____	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment: _____	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used: _____	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management: _____	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used: _____	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment: _____	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used: _____	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management: _____	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

1908546042
LOGAN
Georgina
17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire

19/08/1954

F CHI:

Address:

Hospital:



G13 4NA

Insertion criteria

Complete this section at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☐

Resuscitation/Chest Pain ☐

IV Drugs ☐

Fluids ☐

Transfusion ☐

PVC inserted: Day 0	Date: 21 / 10 / 20	Hospital: GEH
	Area: ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☒ 9D Unknown ☐	
Insertion site:	R Hand ☐ R Arm ☒ R Foot ☐ L Hand ☐ L Arm ☐ L Foot ☐ Other: _____	
Colour of cannula:	Blue ☒ Pink ☐ Green ☐ White ☐ Grey ☐ Orange ☐	
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: _____	

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? Diagnostics Resuscitation/ Chest Pain IV Drugs Fluids Transfusion	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day 21 / 10 / 20	Yes ☒ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☒ No ☐	Yes ☐ No ☒ N/A ☐	OB
Day 1 Check 2 Night / /	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day / /	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night / /	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day / /	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night / /	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: / / Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: / /

*Reason For Removal: _____

Modified Visual Infusion Phlebitis (VIP) Score

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

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and *S. aureus* bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids ? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → Can I switch my patient from IV to oral antibiotics?

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature $\leq 37.9^{\circ}\text{C}$, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE** is available reliably (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, *S. aureus* bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abscess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy.
Record the intended duration on the medicine kardex

YES

NO

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

Write or affix

Name:

DOB:

Ward:

1908546042

LOGAN

Georgina

19/08/1954



Insertion criteria: Please complete this section at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☐	Resuscitation/Chest Pain ☐	IV Drugs ☒	Fluids ☐	Transfusion ☐
PVC inserted: Day 0	Date: 23/10/20	Hospital: QEUN		
	Area: ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☒ Unknown ☐			
Insertion site:	R Hand ☒ R Arm ☐ R Foot ☐			
	L Hand ☐ L Arm ☐ L Foot ☐ Other: ☐			
Colour of cannula:	Blue ☐ Pink ☒ Green ☐ White ☐ Grey ☐ Orange ☐			
Explanation and PVC leaflet provided to patient/ carer	Yes ☒ No ☐ If No, state reason:			

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? Diagnostics Resuscitation/ Chest Pain IV Drugs Fluids Transfusion	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day 24/10/20	Yes ☒ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☒ No ☐	Yes ☐ No ☒ N/A ☒	JV
Day 1 Check 2 Night 24/10/20	Yes ☐ No ☒ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☐ No ☒	Yes ☐ No ☒ N/A ☒	C
Day 2 Check 1 Day 25/10/20	Yes ☒ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☒ No ☐	Yes ☐ No ☒ N/A ☐	JV
Day 2 Check 2 Night 26/10/20	Yes ☒ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☐ No ☒	Yes ☒ No ☐ N/A ☐	RC
Day 3 Check 1 Day / /	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP:	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night / /	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP:	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: / / Reason for keeping PVC in after 72 hrs/ 3 days:

*Date PVC Removed: 26/10/20

*Reason For Removal: Cannula not intact - falling out

Modified Visual Infusion Phlebitis (VIP) Score

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

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and *S. aureus* bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids ? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → Can I switch my patient from IV to oral antibiotics?

Review need for IV antibiotics DAILY:

Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature $\leq 37.9^{\circ}\text{C}$, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE** is available reliably (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, *S. aureus* bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abscess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy. Record the intended duration on the medicine kardex

YES

NO

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

Discharge Checklist


 1908546042
 LOGAN F I
 (Georgina - 19/08/1954
 17 SOLLAS PLACE
 KNIGHTSWOOD
 Glasgow, Lanarkshire
 G13 4NA 2ph label

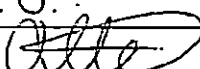
Ward: 9D

Discharge destination: HOME

Estimated Discharge Date (1) 1 1

Estimated Discharge Date (2) 1 1

Final date of discharge: 26/10/20

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓		J	
Relative/carer informed	✓		J	
Relative/carer involved in discharge planning discussions		✓	J	
Others informed: Care Home		✓	J	
Transport arranged				
Own transport (preferred option)	✓		J	
Ambulance: 1 man/ 2 man am/pm		✓	J	
Other: Flight, Air ambulance etc.		✓	J	
Discharge medication				
Immediate Discharge Letter completed	✓		J	
Compliance aids e.g. Dosette Box (involve pharmacist)		✓	J	
Medication received	✓		J	
Medication explained to patient and/or relative/carer	✓		J	
Own medication returned to patient		✓	J	
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)		✓	J	
Informed of discharge				
Social work/ Other agencies		✓	J	
Homecare		✓	J	
Homecare request form completed?		✓	J	
Discharge lounge handover completed?		✓	J	
Physiotherapist		✓	J	
Occupational Therapist		✓	J	
Dietitian		✓	J	
Speech and Language Therapist		✓	J	
Clinical Nurse specialist		✓	J	
Liaison/ District Nurse/Practice Nurse		✓	J	
Other discharge items				
Access arrangements (e.g. keys, door entry)	✓		J	
Patients clothing available for day of discharge	✓		J	
Valuables e.g. cashier		✓	J	
Intravenous cannula removed	✓		J	
Equipment ordered (inc. walking aids) in place for discharge		✓	J	
Part 2 Discharge letter - Required		✓	J	
- Completed		✓	J	
Outpatient clinic appointment				
Arranged		✓	J	
To follow		✓	J	
If unknown at time of discharge state reason		✓	J	
Additional information / leaflets / factsheets		✓	J	
Time of Discharge: 1.5.30				
Nurse's signature: 				
Designation: 2				
Date: 26/10/20				

My Admission Record



Hospital: QEUH Ward: 1K
 Date of Admission: 12/9/20 Time: 2100
 Information obtained from: Name: _____

Patient ☒ Relative ☐ Other ☐ _____

Preferred Name:

Age: 65 Telephone Number: 07774400790
 Consultant: Mr Dades

Nan	
Adc	1908546042
	LOGAN
	Georgina
	17 SOLLAS PLACE
Do	KNIGHTSWOOD
CH	Glasgow, Lanarkshire
Affix patient ID label:	G13 4NA

Communication

What is your first language? English

Do you require an interpreter? Yes ☐ No ☒

If yes, provide details of arrangements made _____

Do you use British Sign Language (BSL)? Yes ☐ No ☐

Do you need someone to help you to communicate? Yes ☐ No ☐ If yes, who _____

Preferred first contact

Name: George Logan
 Relationship: _____
 Address: _____

Telephone: 07437685618

Is this person aware of your admission?

Yes ☒ No ☐

Can we share information with this person?

Yes ☒ No ☐

Preferred second contact

Name: _____
 Relationship: _____
 Address: _____

Telephone: _____

Is this person aware of your admission?

Yes ☐ No ☐

Can we share information with this person?

Yes ☐ No ☐

Presenting Complaint / Diagnosis

Haematuria - Stent pain

Explained to the patient? Yes ☒ No ☐ Not Applicable ☐

Do you understand the reason for your admission? Yes ☒ No ☐

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

No known allergies ☒

Relevant past medical history

Asthma, AF, Diverticulosis/crohns.
cholecystectomy
Decompressed spinal cord.

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place

Yes ☐ No ☒ If yes, Who asked for a copy? _____

Date they asked for a copy / / Date Obtained / /

Power of Attorney / Guardianship / Adult with Incapacity

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

Yes ☐ No ☒**OR**

Does someone have Guardianship?

Yes ☐ No ☒If yes, is this for:- Finance ☐ Welfare ☐ Both ☐Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

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

Name.  _____
Addre. 1908546042 _____
LOGAN _____ F _____
Georgina 19/08/1954 _____
17 SOLLAS PLACE
DoB: KNIGHTSWOOD _____
CHI: Glasgow, Lanarkshire _____
G13 4NA _____
Affix patient ID label.

MRSA Screening - Complete if the patient will be an inpatient for >23hrs

1. Have you ever previously had MRSA? Yes ☐ No ☒ Not known ☐
2. Have you been admitted from another hospital or care home? Yes ☐ No ☐
3. Do you have a wound / skin ulcer or invasive device which you had before admission?
Yes ☐ No ☐ Not known ☐

If yes, to any of the above questions OR if the patient is admitted into a 'high impact specialty' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care - obtain MRSA swabs

Creutzfeldt-Jakob Disease (CJD)

Have you ever been notified that you are at increased risk of CJD or vCJD for public health purposes?

Yes ☐ No ☒ Not known ☐

If yes, contact Infection Control Team. Infection Control Team Informed ____/____/____

Healthcare outside Scotland

Have you ever been told that you are carbapenemase-producing enterobacteriaceae (CPE) positive?

Yes ☐ No ☒

In the past 12 months have you:

1. Been an inpatient in a hospital outside Scotland? Yes ☐ No ☒
2. Received holiday dialysis outside Scotland? Yes ☐ No ☒
3. Been a close contact of a person who has been colonised or infected with CPE?
Yes ☐ No ☒

If the answer is yes to any of the questions in this section, isolate the patient and contact the Infection Control Team for advice and undertake the following screen:

Rectal swab obtained ☐ Patient refused rectal swab, stool specimen obtained ☐



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Lifestyle

Affix patient ID label

SmokingAre you a: smoker ☐ ex-smoker ☐ when did you stop? _____Never smoked ☒Do you use eCigarettes? Yes ☐ No ☐

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

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

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

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

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

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

AlcoholDo you drink alcohol? Yes ☐ No ☒

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

Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐**NB: If daily or almost daily commence the Glasgow Assessment and Management of Alcohol (GAMA), complete FAST Tool and take further action as per guidance.**

Name (Please PRINT): J RITCHIE

Signature:

Designation: S/N.

Date: 12/9/20

My Assessment Record



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19/08/1954

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1. Breathing and Circulation

Affix patient ID label

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems			Asthma
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers	✓	✓	
Oxygen therapy			
Do you have any other symptoms?			
Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems			A.F.
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

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



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3. Senses

Affix patient ID label

VisionYes
✓No
✓

Assessment of the patient's vision

Do you have any problems with your vision?

✓

Do you wear glasses?

✓

Do you have your glasses with you?

✓

Do you wear contact lenses?

✓

Do you have your lenses with you?

✓

Do you wear a prosthesis?

✓

Distance ☒ Reading ☒ Both ☐**Hearing**Yes
✓No
✓

Assessment of the patient's hearing

Do you have any problems with your hearing?

✓

Do you have any hearing loss?

✓

Do you use a hearing aid?

✓

Do you have your hearing aid(s) with you?

PainYes
✓No
✓

Assessment of the patient's pain

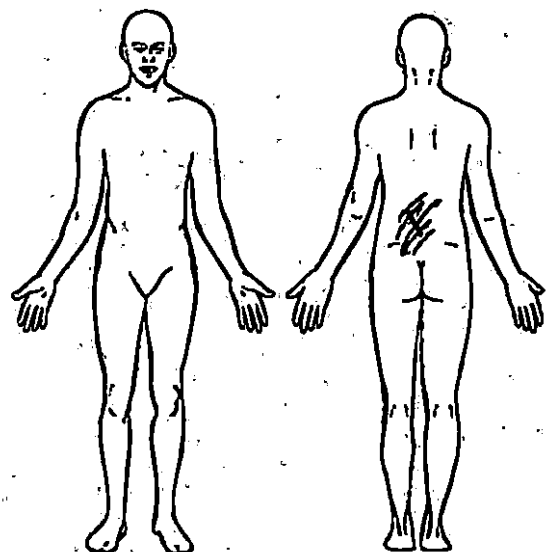
Do you have pain?

✓

Can you describe where and what the pain is like?

Mark current pain on body chart

Have you had treatment / intervention for the pain?

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

Can you describe any chronic pain that you have?

What makes the pain better?



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4. Cognitive Status		THINK DELIRIUM	Affix patient ID label
	Admission Presentation	Normal for the patient	Assessment of the patient's cognitive status
	✓	✓	
Alert and orientated	✓	✓	
Impaired conscious level			
Confused			
Dementia			
Stressed / Distressed			

N.B. Think Delirium

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

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

and follow the guidance

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

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

Dairy.

What do you like to eat and drink?

What do you not like to eat and drink?

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

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓	 1908546042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA 19/08/1954 Affix patient ID label
Normal diet and fluids			
Therapeutic diet	✓	✓	
Cultural, ethnic or religious diet			
Texture Modified Diet Please state _____			
Thickened Fluid Please state _____			
Oral Nutritional supplements Preferred flavour _____			
Enteral Nutrition			
Parenteral Nutrition			<i>No dairy.</i>
Nil by Mouth			
N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS) within 4 hours of admission			
Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓	
Independent (Green)	✓	✓	
Prompting / encouragement / opening packets/cutting up food (Amber)			
Full assistance with eating and drinking (Red)			
Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?			
6. Elimination			
Bladder	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Pass urine with no problems			<i>Pt. has been passing haematuric urine.</i>
Frequently pass urine during the day			
Frequently pass urine overnight			
Sense of urgency when need to pass urine			
Urine retention			

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓	 1908546042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire 19/08/1954 G13 4NA Affix patient ID label
Haematuria	✓		
Incontinent			

N.B. If new incontinence report to medical staff to rule out infection or physiological cause

What products do you normally use for this continence issue?

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

Date urinary catheter last changed ____/____/____

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

Bowels

When did your bowels last move?

How often in a day/week do you have a bowel movement? Per day Per week

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

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

What products do you normally use for this continence issue?

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

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



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

Affix patient ID label

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

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

Pressure ulcer identified on admission Yes ☐ No ☒ If yes, record on Pressure Ulcer Safety Cross
Please describe location and grade of ulcer Refer to Tissue Viability Service (as appropriate)

Datix completed (if appropriate) Yes ☐ No ☐ Datix Ref. Number _____

Wound Care	Yes ✓	No ✓	 1908546042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire 19/08/1954 G13 4NA Affix patient ID label
Do you have any wounds? N.B. If yes, complete an assessment chart for wound management.			

8. Mobility

Mobility	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's mobility needs
Fully mobile and independent			Pt. has decompressed spinal cord.
Unsteady when walking	✓	✓	
Do you use a mobility aid	Yes ☒	No ☐	
Do you have your mobility aid with you?	Yes ☐	No ☐	

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

9. Maintaining a Safe Environment

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

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

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

10. Sleep and Rest

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



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11. Social Circumstances

Affix patient ID label

Do you:

Live alone ☐Live with family/ friend/ other ☒Live in a nursing home ☐Live in a care home ☐Live in residential supported care ☐Live in student accommodation ☐Live in 'homeless' accommodation ☐Have no fixed abode ☐Other please specify ☐**Dependants**Yes
✓No
✓

Do you have any dependants?

Do you support anyone (e.g. partner, children, relatives, animals)?

Do they need support from someone else whilst you are in hospital?

Would someone else be able to provide this support when you are in hospital?
If yes, who?

If no support available contact Duty Social Worker

Duty Social Worker Required ☐Not required ☒Referred ☐**Services**Yes
✓No
✓

Do you have support from social work, social services or a care package?

If yes, please provide details:

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

Informal SupportYes
✓No
✓

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

If yes, what do they do?

What involvement do you want them to have in your care while in hospital?

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

If yes, has the help or support listed above been confirmed with the patient's informal carer

Required Support

Has the carer been advised of the Carers Information Line (provide carer information leaflet)?

Yes ☐ No ☒ Not appropriate at this time ☐



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Affix patient ID label

Are you:

Employed ☐ Self-employed ☐ Full Time Education ☐ Unemployed ☐ Retired ☒

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

Yes ☐ No ☒

Do you have any money worries? Yes ☐ No ☒ Not appropriate to ask at this time ☐

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

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

Would you like a referral to a service that can support you with employment/education/training/skills volunteering Yes ☐ No ☒ Not applicable ☐ Not appropriate to ask at this time ☐

If yes when was the patient referred ___/___/___

12. Person Centred Care

What do we need to know about you as a person to help give you the best possible care whilst in hospital?

Do you have any anxieties or fears that staff should be aware of?

Yes ☐ No ☒

If yes, how can we support you with these?

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

13. Emotional and Spiritual Care

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

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

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

Healthcare Chaplain informed. Yes ☐ N/A ☒

Name (Please PRINT): J. RITCHIE

Signature: [Signature]

Designation: S.N.

Date: 12/9/20



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 Glasgow, Lanarkshire
 G13 4NA

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Risk Assessments/Other Documentation

Additional NHSGGC Documentation	Required		Required documents completed		Date, Print and Sign when completed
	Yes ✓	No ✓	Yes ✓	No ✓	
Glasgow Assessment and Management of Alcohol (GAMA)		✓		✓	
Generic Pain Scale Assessment Chart		✓		✓	
Abbey Pain Scale (if unable to self report pain)		✓		✓	
4AT and TIME for Detection, Management and Prevention of Delirium	✓		✓		12/9/20 K Wardner
Getting to Know Me – Relatives to complete		✓		✓	
What Matters to Me		✓		✓	
Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)		✓		✓	
Malnutrition Universal Screening Tool (MUST)	✓		✓		K Wardner 12/9/20
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan		✓		✓	
Bristol Stool Chart		✓		✓	
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓		✓		K Wardner 12/9/20
Assessment Chart for Wound Management		✓		✓	
Moving and Handling Assessment	✓		✓		K Wardner 12/9/20
Falls Risk Assessment	✓		✓		K Wardner 12/9/20
Bedrail Risk Assessment		✓		✓	

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
12/9/20 21:00	Pt. transferred to ward 11C from E.D.	
	Pt. admitted with frank haematuria, dysuria, urgency, incontinence and pain.	
	Bloods checked in ED, eGFR-49	
	CRP-2.	



Georgina

KNIGHTSWOOD

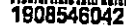
Glasgow, Lanarkshire

19/08/1954

G13 4NA.

Clinical Notes (cont.)

11/11/1941
KATROINER
KATROINER JN



Georgina

KNIGHTSWOOD

19/08/1954

G13 4NA-

Affix patient ID label

Date and Time

Notes

**Print Name,
Signature
and Designation**

12/9/20 10:40

Stent. R. accepted this explanation.

Shade to be reported today and
at the home of (2). R. repeat
all made this morning as she
has phlegm in throat now and
she says she is sick if she does
not eat with her mother.

Also takes AD row. Independent
with personal hygiene needs.

Independently mobile. Pink uniform
to @ hard v10 @.

Shirley Longenecker

13/9/20 13:00

Shade (N). Pig's name.

Verizon removed all usual notes
there. At on list for 2 pers.

NEWS @ Pt has all our needs
for discharge home.

1/15/15

This form should be stored at the front of the patient's nursing notes during the period of admission and then filed on discharge.



Name
 Addre 1908546042
 LOGAN F
 Georgina
 DoB: 17 SOLLAS PLACE 19/08/1954
 KNIGHTSWOOD
 Chi ni Glasgow, Lanarkshire
 G13 4NA

Hospital: QEH Ward: 11C

[illegible]

Carers Information Line: 0141 353 6504
NHSGCC Support & Information Services: 0141 452 2387

[illegible]

Patient Label

Care Plan.

[illegible]

Date: 12/9/20

1. Signed [Signature] Name J. RITCHIE Designation SP
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Y = Yes **N = No** **NA = Not applicable** **NT = No Thanks** **S = Sleeping** **O = Off the ward** **I = Independent**

1908546042
LOGAN F
Georgina 18/08/1954
17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire
G13 4NA

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

[illegible]

Care Rounds Checklist

Date: 13/9/20

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

1. Signed [Signature] Name SKITCHIE Designation SW.
 2. Signed [Signature] Name L. ADAMS Designation SW
 3. Signed _____ Name _____ Designation _____

USE FOLLOWING CODES:

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

Attach



1908546042
 LOGAN
 Georgina F
 17 SOLLAS PLACE
 KNIGHTSWOOD
 Glasgow, Lanarkshire
 19/08/1954
 G13 4NA

Ward
 MC



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

		Times	01	05	09	13	17	21	25	29	33	37	41	45	49	53	57	61	65	69	73	77	81	85	89	93	97	101	105	109	113	117	121	125	129	133	137	141	145	149	153	157	161	165	169	173	177	181	185	189	193	197	201	205	209	213	217	221	225	229	233	237	241	245	249	253	257	261	265	269	273	277	281	285	289	293	297	301	305	309	313	317	321	325	329	333	337	341	345	349	353	357	361	365	369	373	377	381	385	389	393	397	401	405	409	413	417	421	425	429	433	437	441	445	449	453	457	461	465	469	473	477	481	485	489	493	497	501	505	509	513	517	521	525	529	533	537	541	545	549	553	557	561	565	569	573	577	581	585	589	593	597	601	605	609	613	617	621	625	629	633	637	641	645	649	653	657	661	665	669	673	677	681	685	689	693	697	701	705	709	713	717	721	725	729	733	737	741	745	749	753	757	761	765	769	773	777	781	785	789	793	797	801	805	809	813	817	821	825	829	833	837	841	845	849	853	857	861	865	869	873	877	881	885	889	893	897	901	905	909	913	917	921	925	929	933	937	941	945	949	953	957	961	965	969	973	977	981	985	989	993	997	1001	1005	1009	1013	1017	1021	1025	1029	1033	1037	1041	1045	1049	1053	1057	1061	1065	1069	1073	1077	1081	1085	1089	1093	1097	1101	1105	1109	1113	1117	1121	1125	1129	1133	1137	1141	1145	1149	1153	1157	1161	1165	1169	1173	1177	1181	1185	1189	1193	1197	1201	1205	1209	1213	1217	1221	1225	1229	1233	1237	1241	1245	1249	1253	1257	1261	1265	1269	1273	1277	1281	1285	1289	1293	1297	1301	1305	1309	1313	1317	1321	1325	1329	1333	1337	1341	1345	1349	1353	1357	1361	1365	1369	1373	1377	1381	1385	1389	1393	1397	1401	1405	1409	1413	1417	1421	1425	1429	1433	1437	1441	1445	1449	1453	1457	1461	1465	1469	1473	1477	1481	1485	1489	1493	1497	1501	1505	1509	1513	1517	1521	1525	1529	1533	1537	1541	1545	1549	1553	1557	1561	1565	1569	1573	1577	1581	1585	1589	1593	1597	1601	1605	1609	1613	1617	1621	1625	1629	1633	1637	1641	1645	1649	1653	1657	1661	1665	1669	1673	1677	1681	1685	1689	1693	1697	1701	1705	1709	1713	1717	1721	1725	1729	1733	1737	1741	1745	1749	1753	1757	1761	1765	1769	1773	1777	1781	1785	1789	1793	1797	1801	1805	1809	1813	1817	1821	1825	1829	1833	1837	1841	1845	1849	1853	1857	1861	1865	1869	1873	1877	1881	1885	1889	1893	1897	1901	1905	1909	1913	1917	1921	1925	1929	1933	1937	1941	1945	1949	1953	1957	1961	1965	1969	1973	1977	1981	1985	1989	1993	1997	2001	2005	2009	2013	2017	2021	2025	2029	2033	2037	2041	2045	2049	2053	2057	2061	2065	2069	2073	2077	2081	2085	2089	2093	2097	2101	2105	2109	2113	2117	2121	2125	2129	2133	2137	2141	2145	2149	2153	2157	2161	2165	2169	2173	2177	2181	2185	2189	2193	2197	2201	2205	2209	2213	2217	2221	2225	2229	2233	2237	2241	2245	2249	2253	2257	2261	2265	2269	2273	2277	2281	2285	2289	2293	2297	2301	2305	2309	2313	2317	2321	2325	2329	2333	2337	2341	2345	2349	2353	2357	2361	2365	2369	2373	2377	2381	2385	2389	2393	2397	2401	2405	2409	2413	2417	2421	2425	2429	2433	2437	2441	2445	2449	2453	2457	2461	2465	2469	2473	2477	2481	2485	2489	2493	2497	2501	2505	2509	2513	2517	2521	2525	2529	2533	2537	2541	2545	2549	2553	2557	2561	2565	2569	2573	2577	2581	2585	2589	2593	2597	2601	2605	2609	2613	2617	2621	2625	2629	2633	2637	2641	2645	2649	2653	2657	2661	2665	2669	2673	2677	2681	2685	2689	2693	2697	2701	2705	2709	2713	2717	2721	2725	2729	2733	2737	2741	2745	2749	2753	2757	2761	2765	2769	2773	2777	2781	2785	2789	2793	2797	2801	2805	2809	2813	2817	2821	2825	2829	2833	2837	2841	2845	2849	2853	2857	2861	2865	2869	2873	2877	2881	2885	2889	2893	2897	2901	2905	2909	2913	2917	2921	2925	2929	2933	2937	2941	2945	2949	2953	2957	2961	2965	2969	2973	2977	2981	2985	2989	2993	2997	3001	3005	3009	3013	3017	3021	3025	3029	3033	3037	3041	3045	3049	3053	3057	3061	3065	3069	3073	3077	3081	3085	3089	3093	3097	3101	3105	3109	3113	3117	3121	3125	3129	3133	3137	3141	3145	3149	3153	3157	3161	3165	3169	3173	3177	3181	3185	3189	3193	3197	3201	3205	3209	3213	3217	3221	3225	3229	3233	3237	3241	3245	3249	3253	3257	3261	3265	3269	3273	3277	3281	3285	3289	3293	3297	3301	3305	3309	3313	3317	3321	3325	3329	3333	3337	3341	3345	3349	3353	3357	3361	3365	3369	3373	3377	3381	3385	3389	3393	3397	3401	3405	3409	3413	3417	3421	3425	3429	3433	3437	3441	3445	3449	3453	3457	3461	3465	3469	3473	3477	3481	3485	3489	3493	3497	3501	3505	3509	3513	3517	3521	3525	3529	3533	3537	3541	3545	3549	3553	3557	3561	3565	3569	3573	3577	3581	3585	3589	3593	3597	3601	3605	3609	3613	3617	3621	3625	3629	3633	3637	3641	3645	3649	3653	3657	3661	3665	3669	3673	3677	3681	3685	3689	3693	3697	3701	3705	3709	3713	3717	3721	3725	3729	3733	3737	3741	3745	3749	3753	3757	3761	3765	3769	3773	3777	3781	3785	3789	3793	3797	3801	3805	3809	3813	3817	3821	3825	3829	3833	3837	3841	3845	3849	3853	3857	3861	3865	3869	3873	3877	3881	3885	3889	3893	3897	3901	3905	3909	3913	3917	3921	3925	3929	3933	3937	3941	3945	3949	3953	3957	3961	3965	3969	3973	3977	3981	3985	3989	3993	3997	4001	4005	4009	4013	4017	4021	4025	4029	4033	4037	4041	4045	4049	4053	4057	4061	4065	4069	4073	4077	4081	4085	4089	4093	4097	4101	4105	4109	4113	4117	4121	4125	4129	4133	4137	4141	4145	4149	4153	4157	4161	4165	4169	4173	4177	4181	4185	4189	4193	4197	4201	4205	4209	42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1908546042

**ed
e:**

P. uses a walking stick. (not with pt)

Continuation Sheet

[illegible]

1808546042
LOGAN F
Georgina 19/08/1954
17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire
G13 4NA

FALLS RISK ASSESSMENT

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



GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

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

	Ward: 11C Date: 12/9/20 Time: 21:00	Ward: Date: Time: -----	Ward: Date: Time: -----	Ward: Date: Time: -----	Ward: Date: Time: -----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	✓				
2. Check walking aid (if required) is in reach and in use.	Pl. 2 walking aid check not working Pl.				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	✓				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	✓				
5. If glasses are worn, check they are available and in use.	✓				
6. If hearing aid/s are worn, check they are working and in use.	N/A				

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls' Interventional plan (overleaf).

Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.

****ALL patients in older people's wards must have an interventional plan in place (overleaf)****

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

Highlight risk of fall at the ward safety brief.

FALLS INTERVENTION CHECKLIST

Complete for all patients identified at risk of falling.

Ward: _____	Ward: _____	Ward: _____	Ward: _____	Ward: _____
Date: _____	Date: _____	Date: _____	Date: _____	Date: _____
Time: _____	Time: _____	Time: _____	Time: _____	Time: _____

BED AND SEATING

Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice.
(Patient care plan 8)

Assess if a low bed is required
(Patient care plan 9)

SAFETY

Complete / update bedrails risk assessment if bedrail in use.
(Patient care plan 9)

Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart.
(Patient care plan 9)

If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.

HEALTH

Complete /Document 4AT – follow THINK DELIRIUM guidelines.
(Patient care plan 4)

Document continence problems and link to care rounding
(Patient care plan 6)

Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns.
(Patient care plan 1)

If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.

COMMUNICATION

Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative.
(Patient care plan -negotiated care)

Update the ward team of the patient's mobility status.
(Patient care plan 8)

Discuss the patient's fall risk at safety briefs and MDT meetings.
(If appropriate)

Consider a referral to the Hospital Falls Service for advice using trackcare.
(If appropriate)

Signature of nurse completing Interventional plan / or update

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team
EVIDENCE ALL INTERVENTIONS IN NURSING CARE PL

Pressure Ulcer Daily Risk Assessment (PUDRA)

 1908546042 LOGAN F Georgina 19/08/1954 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA	Hospital: QEDH Ward: 11C	Points to consider: • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes
1 Pressure Damage Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan overleaf.		

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

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

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

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

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
21/9/20	11:00	N	N	Y	N	N	N	4 hrly	
13/9/20	01:30	N	N	Y	N	N	N	4 hrly	KG
/ /	:							__hrly	
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Complete prevention of pressure ulcer interventional plan overleaf for all patients with redness/pressure damage and for those at risk.

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

Write on

Name: 1908546042

DOB: 19/08/1954

Ward: KNIGHTSWOOD

Glasgow, Lanarkshire

19/08/1954

ital:



G13 4NA

Insertion criteria: Please complete this section at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☐

Resuscitation/Chest Pain ☐

IV Drugs ☐

Fluids ☒

Transfusion ☐

PVC inserted: Day 0	Date: <u>12/9/20</u>	Hospital: <u>QEUH</u>
	Area: ED ☒ Theatre ☐ ITU/HDU ☐ Ward ☐ Unknown ☐	
Insertion site:	R Hand ☒ R Arm ☐ R Foot ☐ L Hand ☐ L Arm ☐ L Foot ☐ Other: _____	
Colour of cannula:	Blue ☐ Pink ☒ Green ☐ White ☐ Grey ☐ Orange ☐	
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: <u>Inserted in ED</u>	

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? Diagnostics Resuscitation/ Chest Pain IV Drugs Fluids Transfusion	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day <u>13/9/20</u>	Yes ☒ No ☐ If No, remove PVC and record date and reason*.	VIP: <u>0</u>	Yes ☒ No ☐	Yes ☐ No ☒ N/A ☐	<u>U</u>
Day 1 Check 2 Night ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: ____/____/____ Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: 13/9/20

*Reason For Removal: NOT REQUIRED

Fluid Balance Chart

 1908546042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA		Hospital: <u>QEODH</u> Ward: <u>11C</u> Date: <u>13/9/20</u>		Reason for Fluid Balance Chart <u>Monitor</u> Is patient fluid restricted? Yes ☐ No ☒ If yes how many ml in 24 hours? _____ Fluid balance from previous 24hrs +/- _____		Does patient require thickened fluids? Yes ☐ No ☒ Stage _____ Is the patient on an oral supplement? Yes ☐ No ☒ IF YES please Indicate: 1. Type _____ circle how many daily 1 2 3 2. Type _____ circle how many daily 1 2 3 Signature: <u>K. Ordonez</u> Designation: <u>SW</u>											
		ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT															
Time	Input				Running Total				Output				Running Total OUTPUT	Initials			
	Oral Fluids		Enteral		IV / Other		INPUT		Urine	Gastric / Vomit	Bowel	Type			Type	Type	
00:00	Fasting																
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
08:00																	
09:00																	
10:00																	
11:00																	
12:00																	
13:00	Lunch 300						300		100					300	MM		
14:00																	
15:00																	
16:00																	
17:00																	
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
*Total Intake									*Total Output								

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

Discharge Checklist

Patient  1808546042 CHI nu LOGAN F Georgina 19/08/1954 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA ^{el}		Ward: 11C Discharge destination: Home Estimated Discharge Date (1) 15 19 120 Estimated Discharge Date (2) 1 1 Final date of discharge: 13 19 120		
Checklist	Yes	N/A	Initials	Comments
Patient informed	✓			
Relative/carer informed	✓			
Relative/carer involved in discharge planning discussions				
Others informed: Care Home		✓		
Transport arranged				
Own transport (preferred option)	✓			
Ambulance: 1 man/ 2 man am/pm		✓		
Other: Flight, Air ambulance etc.		✓		
Discharge medication				
Immediate Discharge Letter completed	✓			
Compliance aids e.g. Dosette 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		✓		
Homecare		✓		
Homecare request form completed?		✓		
Discharge lounge handover completed?		✓		
Physiotherapist		✓		
Occupational Therapist		✓		
Dietitian		✓		
Speech and Language Therapist		✓		
Clinical Nurse specialist		✓		
Liaison/ District Nurse/Practice Nurse		✓		
Other discharge items				
Access arrangements (e.g. keys, door entry)	✓			
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				
Outpatient clinic appointment				
Arranged	✓			on list for 2 weeks
To follow		✓		
If unknown at time of discharge state reason		✓		
Additional Information / leaflets / factsheets		✓		
Time of Discharge: 15:50				
Nurse's signature: 	Designation: SCN	Date: 13 19 120		

NEWS – National Early Warning Score

Name	 1808545042 19/08/1954 LOGAN Georgina
Address	
CHI No.	
DoB	

	Date	Ward
Admitted	12.9.20	11C
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.

Patient name

Patient CHI

 1908546042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA		F 19/08/1954
--	--	-----------------

Emergency Care Nursing Documentation

Presenting complaint - and relevant past medical history including allergies

Date and Time	Name/Signature
17/8/2020 1800 Pain	

Nursing notes - on admission

Date and Time	Name/Signature
17/8/2020 Pt changed into hospital gown, attached to monitors. IV morphine given.	

Triage

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

Communication

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

Risk Assessments and Screening Tools

SEPSIS	☒ Y	☐ N	GMAWS	☒ Y	☐ N
FAST	☒ Y	☐ N	Adult Support and Protection	☒ Y	☐ N
Swallow Testing	☒ Y	☐ N	Mental Health Triage Assessment	☒ Y	☐ N
Falls Risk (clinical judgement)	☒ Y	☐ N	Child Protection Concerns	☒ Y	☐ N

Signature:

Patient name

Patient CHI

or use sticker

are Rounds Checklist

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

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Use the following Codes:

Y = Yes **N** = No **NA** = Not Applicable **NT** = No Thanks **S** = Sleeping **O** = Off the ward **I** = Independent

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

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

Patient name

Patient CHI

or use sticker

Hospital:

Ward:

Points to consider:

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



PUDRA

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

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

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

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

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

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

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

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

Patient name

Patient CHI

or use sticker

4AT assessment - for delirium and cognitive impairment

(1) ALERTNESS This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.		Circle Score
Normal (alert, but not agitated, through assessment)		0
Mild sleepiness (<10 secs) after waking, then normal		0
Clearly abnormal		4
(2) AMT4 Age, date of birth, place (name of the hospital/building), current year.		No mistakes 1 mistake 2 or more mistakes/untestable
		0 1 2
(3) ATTENTION Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.		wAchieves 7 months or more correctly Starts but scores <7 months / refuses to start Untestable (cannot start, unwell, drowsy, inattentive)
		0 1 2
(4) ACUTE CHANGE OR FLUCTUATING COURSE Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs.		No Yes
		0 4
4 or more possible delirium + /- cognitive impairment 1-3 possible cognitive impairment 0 delirium or severe cognitive impairment unlikely (but delirium still possible if (4) information incomplete)		TOTAL

Frailty Assessment Tool

(Healthcare Improvement Scotland)

Step 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?		circle Y or N	
F	Functional Impairment (new or worsening) eg difficulty with self care	Y	N
R	Resident in a care home	Y	N
A	Altered mental state such as delirium or dementia (4AT Assessment)	Y	N
I	Immobility/Instability decline in mobility, difficulty mobilising without help, fall leading to presentation	Y	N
L	Living at home with support on a daily basis (homecare, one visit or more per day)	Y	N
If YES to any of the criteria in Step 1 move to Step 2			
Step 2 Would this person be better managed by another speciality team at present?		circle Y or N	
Clear need for other specialty input eg exacerbation of known long-term condition such as COPD		Y	N
Need for HDU/ITU (including non-invasive ventilation)		Y	N
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit		Y	N
Head Injury with loss of consciousness		Y	N
Acute abdominal pain/ surgical presentation		Y	N
Upper GI Bleed		Y	N
Chest pain with suspected acute coronary syndrome		Y	N
Trauma with suspected fracture		Y	N
Are any of the criteria met?			
If YES to any criteria in Step 2: Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.			
If YES to any criteria in Step 1 and NO to ALL criteria in STEP 2: Prioritise transfer of care to specialist geriatric assessment service.			

Patient CHI

NHS
Greater Glasgow
and Clyde

[illegible]

Date and Time		Name/Signature

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

Signature: _____

My Admission Record



Hospital: QELH Ward: 11C
 Date of Admission: 11-8-20 Time: _____
 Information obtained from: Name: _____
 Patient ☒ Relative ☐ Other ☐ _____
Preferred Name: _____
 Age: 65yrs Telephone Number: 07774400790
 Consultant: _____

Name: _____
 Address: 
 1908546042
 LOGAN F
 DoB: 19/08/1954
 CHI: Georgina
 Affix pi: 17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire
G13 4NA

Communication

What is your first language? English

Do you require an interpreter? Yes ☐ No ☒

If yes, provide details of arrangements made _____

Do you use British Sign Language (BSL)? Yes ☐ No ☐

Do you need someone to help you to communicate? Yes ☐ No ☐ If yes, who _____

Preferred first contact

Name: George Logan

Relationship: as per label

Address: _____

Telephone: 07437685618
07774400790

Is this person aware of your admission? Yes ☒ No ☐

Can we share information with this person? Yes ☒ No ☐

Preferred second contact

Name: _____

Relationship: _____

Address: _____

Telephone: _____

Is this person aware of your admission? Yes ☐ No ☐

Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

back pain/vomiting

Explained to the patient? Yes ☐ No ☐ Not Applicable ☐

Do you understand the reason for your admission? Yes ☐ No ☐

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

No known allergies ☒

Relevant past medical history

Asthma, Af, Diverticulosis - chronic
low mood
cholecystectomy
decompressed spinal cord
removal of gallbladder

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place

Yes ☐ No ☒ If yes, Who asked for a copy? _____

Date they asked for a copy / / Date Obtained / /

Power of Attorney / Guardianship / Adult with Incapacity

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

Yes ☐ No ☒**OR**

Does someone have Guardianship?

Yes ☐ No ☒If yes, is this for:- Finance ☐ Welfare ☐ Both ☐Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

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

Name

Add:



1908546042

LOGAN

Georgina

19/08/1954

DoB 17 SOLLAS PLACE

KNIGHTSWOOD

CHI: Glasgow, Lanarkshire

Affix _____ G13 4NA

MRSA Screening – Complete if the patient will be an Inpatient for >23hrs1. Have you ever previously had MRSA? Yes ☐ No ☒ Not known ☐2. Have you been admitted from another hospital or care home? Yes ☐ No ☐

3. Do you have a wound / skin ulcer or invasive device which you had before admission?

Yes ☐ No ☐ Not known ☐

If yes, to any of the above questions OR if the patient is admitted into a 'high impact specialty' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabs

Creutzfeldt-Jakob Disease (CJD)

Have you ever been notified that you are at increased risk of CJD or vCJD for public health purposes?

Yes ☐ No ☒ Not known ☐

If yes, contact Infection Control Team. Infection Control Team Informed ____/____/____

Healthcare outside Scotland

Have you ever been told that you are carbapenemase-producing enterobacteriaceae (CPE) positive?

Yes ☐ No ☐

In the past 12 months have you:

1. Been an inpatient in a hospital outside Scotland? Yes ☐ No ☒2. Received holiday dialysis outside Scotland? Yes ☐ No ☒

3. Been a close contact of a person who has been colonised or infected with CPE?

Yes ☐ No ☒

If the answer is yes to any of the questions in this section, isolate the patient and contact the Infection Control Team for advice and undertake the following screen:

Rectal swab obtained ☐ Patient refused rectal swab, stool specimen obtained ☐

Nar	
Add	
	1908546042
	LOGAN
	Georgina
DoB	17 SOLLAS PLACE
CHI	KNIGHTSWOOD
Affix	Glasgow, Lanarkshire
	19/08/1954
	G13 4NA

Lifestyle

Smoking

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

Never smoked ☒

Do you use eCigarettes? Yes ☐ No ☐

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

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

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

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

Drugs

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

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

Alcohol

Do you drink alcohol? Yes ☐ No ☒

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

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

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

Name (Please PRINT): *CARTUNRUSSEN*

Signature: *Chusell*

Designation: *5*

Date: *17.6.20*

My Assessment Record

Name:  -
 Address: 1908546042 -
 LOGAN F -
 Georgina 19/08/1954 -
 17 SOLLAS PLACE -
 KNIGHTSWOOD -
 DoB: Glasgow, Lanarkshire -
 CHI: G13 4NA -
 Affix patient ID label

1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems			<i>Asthma.</i>
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers	✓	✓	
Oxygen therapy			
Do you have any other symptoms?			
Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems			<i>At</i>
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

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

Name: _____
 Add: _____
 1908546042
 LOGAN F
 Georgina 19/08/1954
 DoB 17 SOLLAS PLACE
 CHI KNIGHTSWOOD
 Affd Glasgow, Lanarkshire
 G13 4NA

3. Senses

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

Can you describe where and what the pain is like?

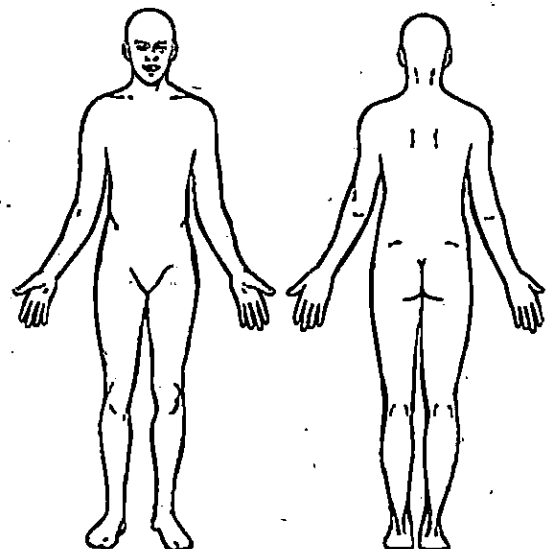
Mark current pain on body chart

Have you had treatment / intervention for the pain?

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

Can you describe any chronic pain that you have?

What makes the pain better?



Name: _____
 Address: _____

 DoB: _____
 CHI: _____
 Affix patient ID label

4. Cognitive Status **THINK DELIRIUM**

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

N.B. Think Delirium

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

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

and follow the guidance

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

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

diary

What do you like to eat and drink?

naarioni

What do you not like to eat and drink?

No

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

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓	Name Address 1908546042 LOGAN Georgina DoB: 17 SOLLAS PLACE CHI: KNIGHTSWOOD Glasgow, Lanarkshire Affix p G13 4NA
Normal diet and fluids			19/08/1954 F
Therapeutic diet	✓	✓	
Cultural, ethnic or religious diet			
Texture Modified Diet Please state _____			Assessment of the patient's hydration and nutrition needs
Thickened Fluid Please state _____			<i>not meant to eat diary</i>
Oral Nutritional supplements Preferred flavour _____			
Enteral Nutrition			
Parenteral Nutrition			
Nil by Mouth			
N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS) within 4 hours of admission			
Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓	
Independent (Green)	✓	✓	
Prompting / encouragement / opening packets/cutting up food (Amber)			
Full assistance with eating and drinking (Red)			
Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?			
6. Elimination			
Bladder	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Pass urine with no problems			<i>UTI not passed urine since admission</i>
Frequently pass urine during the day			
Frequently pass urine overnight			
Sense of urgency when need to pass urine			
Urine retention			

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓	Name: _____ Address: _____ _____ DoB: _____ CHI: _____ Affix patient ID label
Haematuria			
Incontinent			

N.B. If new incontinence report to medical staff to rule out infection or physiological cause

What products do you normally use for this continence issue?

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

Date urinary catheter last changed ____/____/____

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

Bowels

When did your bowels last move?

17.8.20

How often in a day/week do you have a bowel movement? Per day Per week

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

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

What products do you normally use for this continence issue?

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

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

Name: _____

Addr _____



1908546042

LOGAN

Georgina

F

19/08/1954

DoB: _____

CHI: _____

Affix | _____

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

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

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

Pressure ulcer identified on admission Yes ☐ No ☒ If yes, record on Pressure Ulcer Safety Cross
Please describe location and grade of ulcer Refer to Tissue Viability Service (as appropriate)

Datix completed (if appropriate) Yes ☐ No ☐ Datix Ref. Number _____

Wound Care	Yes ✓	No ✓	Name: _____ Address: _____ _____ DoB: _____ CHI: _____ Affix patient ID label
Do you have any wounds? N.B. If yes, complete an assessment chart for wound management		✓	

8. Mobility

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

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

9. Maintaining a Safe Environment

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

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

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

10. Sleep and Rest

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

Name: _____
 Address: 1908546042
 _____: LOGAN
 _____: 4 Georgina 19/08/195
 DoB: _____
 CHI: _____
 Affix patient ID label

11. Social Circumstances

Do you:

- Live alone ☐ Live with family/ friend/ other ☒
 Live in a nursing home ☐ Live in a care home ☐
 Live in residential supported care ☐ Live in student accommodation ☐
 Live in 'homeless' accommodation ☐ Have no fixed abode ☐
 Other please specify _____ ☐

Dependants	Yes ✓	No ✓
Do you have any dependants?		✓
Do you support anyone (e.g. partner, children, relatives, animals)?		✓
Do they need support from someone else whilst you are in hospital?		✓
Would someone else be able to provide this support when you are in hospital? If yes, who?		✓
If no support available contact Duty Social Worker Duty Social Worker Required ☐ Not required ☒ Referred ☐		

Services	Yes ✓	No ✓
Do you have support from social work, social services or a care package?		✓
If yes, please provide details:		
If yes, has contact been made to cancel arrangements during admission?		

Informal Support	Yes ✓	No ✓
Do you have someone who looks after you or someone that helps you, i.e. an informal carer?		✓
If yes, what do they do?		
What involvement do you want them to have in your care while in hospital?		
N.B. If the person who helps is not a preferred contact please ensure their details are listed below		
If yes, has the help or support listed above been confirmed with the patient's informal carer		

Required Support

Has the carer been advised of the Carers Information Line (provide carer information leaflet)?

Yes ☐ No ☒ Not appropriate at this time ☐

Are you:

Employed ☐ Self-employed ☐ Full Time Education ☐ Unemployed ☐ Retired ☒

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

Yes ☐ No ☒

Do you have any money worries? Yes ☐ No ☒ Not appropriate to ask at this time ☐

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

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

Would you like a referral to a service that can support you with employment/education/training/skills volunteering Yes ☐ No ☒ Not applicable ☐ Not appropriate to ask at this time ☐

If yes when was the patient referred ___/___/___

12. Person Centred Care

What do we need to know about you as a person to help give you the best possible care whilst in hospital?

Do you have any anxieties or fears that staff should be aware of?

Yes ☐ No ☒

If yes, how can we support you with these?

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

13. Emotional and Spiritual Care

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

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

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

Healthcare Chaplain informed Yes ☐ N/A ☒

Name (Please PRINT): *DEITUN RUWELL*

Signature: *duwæll*

Designation: *(5)*

Date: *17.8.20*

Name

Addr



1908546042

LOGAN

Georgina

19/08/195

DoB:

CHI:

Affix

Name: _____
 Address: _____

 DoB: _____
 CHI: _____
 Affix patient ID label

Risk Assessments/Other Documentation

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

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
17/8/20	Patient admitted to ward	
1830	ILC. Alert and Orientated	
	NEWS O. CT KUB SHOWS 4mm	
	Stone. Kardex to be written.	
	Patient do pain asked	
	F41 several times to	
	Prescribe painkillers. Patient	

Na  _____
 Adr 1908545042 _____
 LOGAN F _____
 — Georgina 19/08/1954 _____
 — 17 SOLLAS PLACE _____
 Do KNIGHTSWOOD _____
 CH Glasgow, Lanarkshire _____
 G13 4NA _____
 Affix patient ID label

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
17/8/20 18 ⁰⁰ cont'd	buzzed 1 hour later asking for pain relief shouting and swearing. Flora (uro reg) prescribed co-codamol 30/500 and oramorph. Given co-codamol patient refused co-codamol stating it doesn't work for her. Smg oramorph given. Patient very disgruntled.	K. Khan K. Khan^{SN}
18/8/20 02 ¹⁰	Georgina settled in bed at the moment. All signs stable. Meats given as per order; required oramorph for pain relief with a fair effect. Stated voided urine earlier on. Mobilising independently. She did not bring her regular meats with her - ordered.	K. Khan K. Khan
04 ⁰⁰	Pain still an issue - stated she couldn't pass urine overnight - Hadden/Don showed nil relief. Shortc/Dmg given.	K. Khan K. Khan
18/8/20 12 ³⁰	Independant with personal hygiene. News ① due to BP 101/59. Encouraged to drink plenty. Voiding urine spontaneously. Bowels inactive.	

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A 1908546042
— LOGAN F
— Georgina 19/08/1954
— 17 SOLLAS PLACE
D KNIGHTSWOOD
C Glasgow, Lanarkshire
A..... G13 4NA

Clinical Notes (cont.)		
Date and Time	Notes	Print Name, Signature and Designation
18/8/20 1230 cont'd.	Tolerating diet and fluids as able. Mobile around room. Medications given as prescribed - some not given and has been ordered.	
	Reviewed on ward round by Mr. Hendry for x-ray KUB.	
	Stop edoxaban. for ? lithotripsy in 48 hours. 10mg Oramorph given with good effect.	K. UAN
	VENFLON removed.	Kuan SN
215	Obstetric approval. NEWS: 1 BP = 104/67	
	C/O pain - coxibane/x-tab given @ 1046H with no effect, so Oramorph 5mg given 2104H now pain has settled down.	
	Other due meds also given.	
	Increased oral fluid intake encouraged (reluctant to swallow this evening).	
	Please observed.	Geoffrey - AM/PA SN
1918 to OSN	Quite settled overnight and sleep fairly well.	
	Independently changed own position.	
	Vomiting well. Bowels inactive.	
	No bloods taken on 18/8/20.	
	Per rectum this morning.	Geoffrey - AM/PA SN
19/8/20 1130	Settled morning. Independent personal hygiene. Thirsty diet + fluids. PU. Sore	

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 Ad: 1908546042
 — LOGAN F
 — Georgina 19/08/1954
 — 17 SOLLAS PLACE
 Do: KNIGHTSWOOD
 CH Glasgow, Lanarkshire
 G13 4NA
 Affix patient ID label

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
	H. R/L W/LR. Encourage oral fluids for theatre on Friday re laser stone.	
19/8/20	Very sore this afternoon -	M. King
1730	Analgesia as charted	J. Dorey
20/8/20	Call to hospital - mobile - changing own position in bed.	M. King
0130	NEWS 0.	
	WF continue - now 4 hourly - monitor	
	U&Es: Olanzapine given for pain relief.	
	Dial lipase commenced.	
	? for theatre Friday for laser fragmentation of stone.	St. Shumway
20/8/20	Unsettled at times this morning. Very sore. Analgesia as per Kardex Independent personal hygiene; R/L W/LR to fast today. For theatre if bloods don't improve.	M. King
21/8/20	Started on return from theatre.	J. Dorey
18 ⁰⁰	O2 2L via face mask - NEWS 4.	
	W/L via cannula (R) W/LR	
	Catheter in situ - draining very dark urine. Can eat & drink as able. Hourly urine very overnight.	
	Monitor for sepsis —	M. King
		J. Dorey

CLINICAL NOTES - MEDICAL
NURSING

1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

F
19/08/1954

G13 4NA

Please tick ☒ appropriate directorate

Date & Time		Signature, Print Name & Designation
21/8/20 0645	Georgina settled in bed. States she is very tired and sleepy. felt nauseated. Cyclidine given and good effect. 'Refused' breakfast meals. BPT 96/58/102, slow bog of HF continues. Cerebral function good. All values of clear urine. For hourly values till am. Independent with personal change in bed.	
21/8/20 0910	Unreviewed this morning very sore from catheter. RIR WIL. CATH to be removed & Monitor blood. Independent Personal hygiene. F/NP/LY yet Diet & fluids taken. Ph'd. Lost void can One	M. Thuy J. Thuy
21/8/20 1730	Settled afternoon. Tolerating diet & fluids. Bowels not opened. Painful. Wind.	M. Thuy
21/8/20 0140	Georgina settled tonight. Vital signs stable. Meds given as per Kardex. Cb on laxatives; given and assisting effect. Independent with personal changes.	M. Thuy
21/8/20 1050	Independent with personal hygiene. NEWS O. Voiding urine spontaneously. Bowels inactive - on laxatives. Tolerating diet and fluids as able. Mobile around room. Medications given as prescribed. Reviewed on	

Date & Time		Signature, Print Name & Designation
22/8/20	ward round by Mr. Underwood	
1050	home today if bloods improving	
cont'd	and Stone MDT. Has been	
	advised to attend G.R.1 if	
	any symptoms come back.	KUAM
	Bloods been taking. ———	KUAM SN
22/8/20	Patient has been Settled.	
1725	Bloods improving CRP & ESR ↑	
	Patient can go home but	
	patient still doesn't feel 100%.	
	clin home tomorrow. Patient	
	still do bowels not moving	
	asked if she wanted laxatives ^{enemas}	
	Supps - patient declined but	KUAM.
	states she will let us know.	KUAM SN
22/8/20	Patient decided she wanted to go home.	
2100	She stated she opened her bowels and	
	is ready for discharge. FYI completed.	
	MDL. Oral cipro given	
	Follow up with Stone MDT.	

Mrs G Logan
17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow
Renarkshire
G13 4NA

Care Plan

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
18/8/20 <i>GL</i>	<i>Independent</i>		18/8/20 <i>GL</i>	<i>No Issues</i>	
			18/8/20 <i>GL</i>	10. Sleep and Rest	
				<i>Provide sleep at night</i>	
18/8/20 <i>GL</i>	8. Mobility		18/8/20 <i>GL</i>	12. Privacy, dignity and sexuality	
	<i>Independent</i>			<i>Nursed in a single room</i>	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

Mrs G Logan
17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow
Lanarkshire
G13 4NA

Care Plan

Care discussed with patient Unable		☐ Yes	☐ No	☐	If unable, give reason:	
Care discussed with family Unable		☐ Yes	☐ No	☐	If unable, give reason:	
Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature	
18/8/20	Vital signs checked as per NEWS chart					
			18/8/20	5. Hydration and Nutrition NDF		
18/8/20	2, 3. Communication and senses No issues					
18/9/20	4. Cognitive status Alert & oriented		18/8/20	6. Elimination voiding line integrity No issues		

Date: 17.5.26

1. Signed Alison Name Alison Designation 5
2. Signed Kiran Name Kiran Designation 5
3. Signed _____ Name _____ Designation _____

1908548042 F
Georgina 19/08/1954
17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire
G13 4NA

NHS
Greater Glasgow
and Clyde

Ward: 110

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

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

[illegible]

Date: 19/8/65

1. Signed M. S. S. S. S. Name M. S. S. S. S. Designation IN
2. Signed SE Name S. S. S. S. Designation SE
3. Signed _____ Name _____ Designation _____

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

G13 4NA

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and Clyde

[illegible]

Date: 20-8-20

1. Signed S Name Suma Designation S
2. Signed M. K. Jeyaraj Name N. C. W. Jeyaraj Designation JN
3. Signed J Name _____ Designation _____

G134N²

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Greater Glasgow
and Clyde

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

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

[illegible]

Date: 21/8/20

1. Signed [Signature] Name U622 Designation SN
2. Signed NCS Name NCS Designation SN
3. Signed _____ Name _____ Designation _____

11-11-11

1908546042
LOGAN F
Georgina 19/08/1954
17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire
G13 4NA

Ward: 11C

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

[illegible]

Date: 22/8/20

1. Signed [Signature] Name U. K. Singh Designation SN
2. Signed [Signature] Name K. U. Singh Designation SN
3. Signed _____ Name _____ Designation _____

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

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

[illegible]

1908546042
LOGAN
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17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire
G13 4NA
19/08/1954

FALLS RISK ASSESSMENT

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



GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

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

	Ward: 11C Date: 17.8.20 Time: 16.15	Ward: Date: Time: ---:---	Ward: Date: Time: ---:---	Ward: Date: Time: ---:---	Ward: Date: Time: ---:---
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	Yes				
2. Check walking aid (if required) is in reach and in use.	N/A				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	Yes				
4. Check footwear is safe (refer to NHS GGC Footwear guidance).	Yes				
5. If glasses are worn, check they are available and in use.	Yes				
6. If hearing aid/s are worn, check they are working and in use.	No				

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).

Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.

****ALL patients in older people's wards must have an interventional plan in place (overleaf)****

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

Highlight risk of fall at the ward safety brief.

FALLS INTERVENTION CHECKLIST

Complete for all patients identified at risk of falling.

Ward:	Ward:	Ward:	Ward:	Ward:
Date:	Date:	Date:	Date:	Date:
Time: -----	Time: -----	Time: -----	Time: -----	Time: -----

BED AND SEATING

Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice.

(Patient care plan 8)

Assess if a low bed is required

(Patient care plan 9)

SAFETY

Complete / update bedrails risk assessment if bedrail in use.

(Patient care plan 9)

Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart.

(Patient care plan 9)

If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.

HEALTH

Complete /Document 4AT – follow THINK DELIRIUM guidelines.

(Patient care plan 4)

Document continence problems and link to care rounding

(Patient care plan 6)

Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns.

(Patient care plan 1)

If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.

COMMUNICATION

Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative.

(Patient care plan -negotiated care)

Update the ward team of the patient's mobility status.

(Patient care plan 8)

Discuss the patient's fall risk at safety briefs and MDT meetings.

(If appropriate)

Consider a referral to the Hospital Falls Service for advice using trackcare.

(If appropriate)

Signature of nurse completing interventional plan / or update

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team
EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

Pers it) Moving and Handling Assessment Form

1908546042

Person's Name:	LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire		19/08/1954	Famed nurse: <i>Chusell</i>	Person is totally independent (tick here and go to date box)	☒
1. General						
Weight		G13 4NA				
Kg		cm				
BMI		Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):				
Risk of Falls:		Yes ☐ No ☒				
2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)						
Hoist	Standaid	Walking Aid	Assistance		Supervision	Independent
Model		Aid Type	People: 1	2	>3	Additional Information / Equipment:
Sling type						
Sling Size						
3. Toileting						
Hoist	Standaid	Walking Aid	Assistance		Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1	2	>3	Additional Information:
4. Move on / off bed pan						
Hoist	Manoeuvre	Assistance		Supervision	N/A	
See No 2 Sit to Stand Transfers for details		Roll patient	People: 1	2	>3	Additional Information:
		Monkey pole				
		Independent bridging				
5. Move up / down bed						
Hoist	Handling Aids	Assistance		Supervision	Independent	
See No 2 Sit to Stand Transfers for details		Sliding sheets	People: 1	2	>3	Additional Information:
		Monkey pole				
		Rope ladder				
6. Lateral Transfer to / from trolley / bed						
Hoist	Handling Aids	Assistance		Supervision	Independent	
See No 2 Sit to Stand Transfers for details		Rigid Transfer Board	People: 1	2	>3	Additional Information / Equipment (eg sliding sheets):
		Other (Please specify)				
7. Sit up over side of bed						
Bed Rest		Assistance		Supervision	Independent	
		People: 1	2	>3	Additional Information / Equipment (eg rope ladder, swivel cushion):	
8. Into Bath or Shower						
Equipment	Handling Aid	Assistance		Supervision	Independent	
Shower	Shower chair	People: 1	2	>3	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley					
Bed bath	Bathing hoist (eg Alana)					
9. Walking						
No Walking	Walking Aid	Assistance		Supervision	Independent	
see 'sit to stand transfers'		People: 1	2	>3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	
10. Other Instructions / Observations / Equipment Used						
Recording Symbol:		1 st Assessment		2 nd Assessment		3 rd Assessment
		Forward slash		X Where a forward slash exists, add a back slash to make a cross		* Where a slash or cross exists add slashes to make a star
Date Assessed:	17.8.20					
Assessor's signature:	<i>Chusell</i>					
Proposed Review date:	24.8.20					

Continuation Sheet

[illegible]

Pressure Ulcer Daily Risk Assessment (PUDRA)

 1908546042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA F 19/08/1954	Hospital: QCUH Ward: 11C	Points to consider: • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes
--	---	--

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

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

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

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

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
17/8	20/06:30	N	N	N	N	N	N	4 hrly	u
18/8	20/02:00	N	N	N	N	N	N	4 hrly	u
19/8	20/04:30	N	N	N	N	N	N	4 hrly	u
20/8	20/01:30	N	N	N	N	N	N	4 hrly	u
21/8	20/02:00	N	N	N	N	N	N	4 hrly	u
22/8	20/03:00	N	N	N	N	N	N	4 hrly	u
/ /	:							__hrly	
/ /	:							__hrly	
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/ /	:							__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



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

Fluid Balance Chart

 1908546042 LOGAN Georgina 19/08/1954	Hospital: <u>QEH</u>	Reason for Fluid Balance Chart: <u>Post op</u>	Does patient require thickened fluids? Yes ☐ No ☒ Stage _____	 NHS Great Change and Care
	Ward: <u>Rec 711C</u>	Is patient fluid restricted? Yes ☐ No ☐	Is the patient on an oral supplement? Yes ☐ No ☒ If YES please indicate: 1. Type _____ circle how many daily 1 2 3 2. Type _____ circle how many daily 2 3	
	Date: <u>20/8/20</u>	If yes how many mls in 24 hours? _____	Signature: <u>[Signature]</u> Designation: <u>S/N</u>	
ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT				

Time	Input								Output							Running Total OUTPUT	Initials
	Oral Fluids		Enteral		IV / Other		Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type				
	Type	Volume	Type	Volume	Type	Volume								Type	Volume		
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01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
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19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
*Total Intake									*Total Output								

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

Fluid Balance Chart

 1808546042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA	Hospital: <u>QEH</u>	Reason for Fluid Balance Chart: <u>monitory</u>	Does patient require thickened fluids? Yes ☐ No ☒ Stage <u> </u>	
	Ward: <u>NC</u>	Is patient fluid restricted? Yes ☐ No ☒	Is the patient on an oral supplement? Yes ☐ No ☒ If YES please indicate:	
	Date: <u>21/8/20</u>	If yes how many mls in 24 hours? <u> </u>	1. Type <u> </u> circle how many daily 1 <u>2</u> 3 2. Type <u> </u> circle how many daily 1 <u>2</u> 3	
		Fluid balance from previous 24hrs +/- <u> </u>	Signature: <u>[Signature]</u> Designation: <u>[Signature]</u>	
ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT				

Time	Input				Output										Running Total OUTPUT	Initials	
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type			Type
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00										50						50	lu
01:00										55						85	ls
02:00										95						180	lu
03:00										50						280	lu
04:00										50						340	lu
05:00										500						400	lu
06:00	200								700	60						460	lu
07:00									700	50						510	lu
08:00	apast 200								900	50						560	lu
09:00									900	50						510	lu
10:00	tea 200								1100	50						560	lu
11:00	juice 200								1300	50						560	lu
12:00																	
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20:00																	
21:00																	
22:00																	
23:00																	
*Total Intake										*Total Output							

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/- 50ml

Fluid Balance Chart

 1808548042 LOGAN Georgina 19/08/1954 F	Hospital: <u>QKUH</u>	Reason for Fluid Balance Chart _____	Does patient require thickened fluids? Yes ☐ No ☐ Stage _____												
	Ward: <u>UG</u>	Is patient fluid restricted? Yes ☐ No ☐	Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate: 1. Type _____ circle how many daily 1 2 3 2. Type _____ circle how many daily 1 2 3												
	Date: <u>22/8/20</u>	If yes how many mls in 24 hours? _____	Signature: _____ Designation: _____												
Fluid balance from previous 24hrs +/- _____															
ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT															
Time	Input				IV / Other				Running Total INPUT	Output			Running Total OUTPUT	Initials	
	Oral Fluids		Enteral		Type	Volume	Type	Volume		Urine	Gastric / Vomit	Bowel			Type
00:00															
01:00															
02:00															
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23:00															
*Total Intake										*Total Output					

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid
Balance +/-

W: 1908546042
N: LOGAN
Ad: Georgina
CH: 17 SOLLAS PLACE
DC: KNIGHTSWOOD
Glasgow, Lanarkshire
G13 4NA

19/08/1954

F

Adult Urethral Urinary Catheter(UUC)

Insertion & Maintenance Care Plan

BRILLANT AquaPlate REF A310116
All-Silicone Long-Term (up to 12 weeks use)
Standard, 2-way Foley
SIZE Ch. 16 O. D. 5.3mm/10ml
Telco Medical, IDA Business & Technology Park,
Dublin Road, Athlone, Co. Westmeath, Ireland

LOT 20CG10

2025-02-28



Insertion - Complete all sections			
Date and time inserted 20/08/20 @ 16:50	Urethral Urinary Catheter inserted Hospital GUH ED ☐ Theatre ☒ ITU/HDU ☐ Ward ☐	Gauge 16	mls in balloon 10
Clinical indication for urethral urinary catheterisation SURGICAL		Long term urethral urinary catheter ☐ (> 28 days)	Short term urethral urinary catheter ☐ (≤ 28 days)
Patient had urethral urinary catheter inserted in the community/out with NHS GGC		Yes ☐ No ☐	Date UUC inserted (if known)
Insertion Criteria		Comments	
Alternatives to urethral urinary catheterisation considered		Yes ☐ No ☐	
Hand hygiene is performed immediately before urethral urinary catheter insertion		Yes ☐ No ☐	
Aseptic technique performed at insertion		Yes ☐ No ☐	
Urethral Urinary catheter of smallest gauge used and balloon filled to recommended level		Yes ☐ No ☐	
Urethral meatus cleaned with sterile saline and sterile lubricant used		Yes ☐ No ☐	
Aseptic technique maintained when connecting urethral urinary catheter to closed drainage system		Yes ☐ No ☐	

DAILY MAINTENANCE: FOR ALL PATIENTS WITH A URETHRAL URINARY CATHETER:

- Staff must wear gloves and apron and perform hand hygiene before and after urinary catheter procedures
- The drainage bag must be emptied when clinically indicated using a clean disposable container for each patient. Please refer to Insertion and maintenance of adult indwelling urethral urinary catheter SOP.

Maintenance - To be completed daily (observe for signs and symptoms of infection)						
Please regard Day 1 as day of insertion or the day patient is admitted to hospital with Urethral Urinary Catheter.	Ward	Does the patient still require a urethral urinary catheter?	Is the urethral urinary catheter connected to a closed drainage system and charged in line with manufacturer's instructions?	Daily meatal hygiene has been carried out? (soap and water)	Urine drainage bag is situated below the level of the bladder and not in contact with any surface e.g. floor?	Signature and Print Name
Day 1 21/08/20	11C	Yes ☒ No ☐	Yes ☒ No ☐	Yes ☒ No ☐	Yes ☒ No ☐	W. McEwan
Day 2 22/08/20		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 3 23/08/20		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	

Date removed: **21/8/20** Time removed: **day shift** Reason for Urethral Urinary Catheter removal: **100** Removed by: _____

CHI Number: _____

Maintenance – To be completed daily (observe for signs and symptoms of infection)

	Ward	Does the patient still require a urethral urinary catheter?	Is the urethral urinary catheter connected to a closed drainage system and changed in line with manufacturer's instructions?	Daily meatal hygiene has been carried out?	Urine drainage bag is situated below the level of the bladder and not in contact with any surface e.g. floor?	Signature and Print Name
Day 4	___/___/___	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 5	___/___/___	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 6	___/___/___	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 7	___/___/___	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 8	___/___/___	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 9	___/___/___	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 10	___/___/___	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 11	___/___/___	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 12	___/___/___	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 13	___/___/___	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 14	___/___/___	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 15	___/___/___	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 16	___/___/___	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 17	___/___/___	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 18	___/___/___	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 19	___/___/___	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 20	___/___/___	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 21	___/___/___	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 22	___/___/___	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 23	___/___/___	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 24	___/___/___	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 25	___/___/___	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 26	___/___/___	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 27	___/___/___	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 28	___/___/___	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

Writ

Nan

DOI

War



LOGAN
Georgina
17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire

Il:

Fldress:

ospital:



Insertion criteria: P: 19/08/2018 G13 4NA: time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☐ Resuscitation/Chest Pain ☐ IV Drugs ☐ Fluids ☐ Transfusion ☐

PVC inserted: Day 0	Date: <u>17/8/20</u> Hospital: <u>DELUH</u>
Area: ED ☒ Theatre ☐ ITU/HDU ☐ Ward ☐ Unknown ☐	
Insertion site:	R Hand ☐ R Arm ☐ R Foot ☐ L Hand ☐ L Arm ☒ L Foot ☐ Other: _____
Colour of cannula:	Blue ☐ Pink ☒ Green ☐ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☒ No ☐ If No, state reason: <u>verbal</u>

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? Diagnostics Resuscitation/ Chest Pain IV Drugs Fluids Transfusion	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 1 Check 2 Night ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: ____/____/____ Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: 18/8/20

*Reason For Removal: not being used.

Modified Visual Infusion Phlebitis (VIP) Score

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

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and *S. aureus* bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids ? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → **Can I switch my patient from IV to oral antibiotics?**

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature $\leq 37.9^{\circ}\text{C}$, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE** is available reliably (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, *S. aureus* bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abscess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy.
Record the intended duration on the medicine kardex

YES

NO

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

Write or at: 1908546042:

Name: LOGAN

DOB: 19/08/1954

Ward: 17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

19/08/1954

G13 4N



Insertion criteria: Please complete this section at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☐

Resuscitation/Chest Pain ☐

IV Drugs ☐

Fluids ☐

Transfusion ☐

PVC inserted: Day 0	Date: 19/8/20	Hospital: _____
	Area: ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☒ Unknown ☐	
Insertion site:	R Hand ☐ R Arm ☐ R Foot ☐ L Hand ☐ L Arm ☐ L Foot ☐ Other: _____	
Colour of cannula:	Blue ☒ Pink ☒ Green ☐ White ☐ Grey ☐ Orange ☐	
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: _____	

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? Diagnostics Resuscitation/ Chest Pain IV Drugs Fluids Transfusion	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 1 Check 2 Night 20/08/20	Yes ☒ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☒ No ☐	Yes ☐ No ☐ N/A ☒	MM
Day 2 Check 1 Day ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: ____/____/____ Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: 21/08/20

*Reason For Removal: not required

Modified Visual Infusion Phlebitis (VIP) Score

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

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and *S. aureus* bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → **Can I switch my patient from IV to oral antibiotics?**

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature $\leq 37.9^{\circ}\text{C}$, reduction in the NEWS score, Improving SEPSIS
- ✓ **ORAL ROUTE** is available reliably (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, *S. aureus* bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abscess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy. Record the intended duration on the medicine kardex

YES

NO

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan



1808546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

F

19/08/1954

CHI:

Address:

Hospital:



G13 4NA

Insertion criteria: Please complete this section at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☐

Resuscitation/Chest Pain ☐

IV Drugs ☐

Fluids ☐

Transfusion ☐

PVC inserted: Day 0	Date: 30.08.20	Hospital: _____
	Area: ED ☐ Theatre ☐ ITU/HDU ☒ Ward ☐ Unknown ☐	
Insertion site:	R Hand ☐ R Arm ☐ R Foot ☐ L Hand ☒ L Arm ☐ L Foot ☐ Other: _____	
Colour of cannula:	Blue ☐ Pink ☒ Green ☐ White ☐ Grey ☐ Orange ☐	
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: _____	

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? Diagnostics Resuscitation/ Chest Pain IV Drugs Fluids Transfusion	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 1 Check 2 Night 21.08.20	Yes ☒ No ☐ If No, remove PVC and record date and reason*.	VIP: 2	Yes ☒ No ☐	Yes ☐ No ☐ N/A ☒	here
Day 2 Check 1 Day ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: ____/____/____ Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: ____/____/____

*Reason For Removal: _____

Modified Visual Infusion Phlebitis (VIP) Score

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

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and *S. aureus* bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids ? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → Can I switch my patient from IV to oral antibiotics?

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CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy. Record the intended duration on the medicine kardex

YES

NO

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

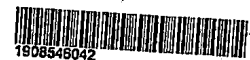
NHSGGC Bedrail Risk Assessment

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

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT

Patient Name:

CHI Number:



1908546042
LOGAN
Georgina
17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire

19/08/1954
NHS
F
Glasgow
and Clyde

G13 4NA

Use guidance on the reverse of this document when completing this Risk Assessment		DATE	17-8-20								
		TIME	16:00								
		WARD	11C								
		HOSPITAL	QUEEN								
SECTION ONE - GENERAL				Y	N	Y	N	Y	N	Y	N
1	Is the patient likely to fall, roll, slip or slide from the bed?										
2	Has the patient requested the use of bedrails?										
IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED											
SECTION TWO - COGNITIVE AND PHYSICAL STATUS											
3	Is the patient at risk of climbing out of bed?										
4	Is the patient stressed, delirious or restless?										
5	Is the patient small in stature?										
6	Does the patient have an unusually large or small head that might present an entrapment issue?										
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?										
IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE - See Guidance overleaf											
SECTION THREE - COMMUNICATION											
8	Has the patient been consulted regarding the use of bedrails?										
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition										
10	Has the use of bedrails been discussed with relatives/carers?										
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?										
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?										
IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE - See Guidance overleaf											
SECTION FOUR - DECISION MAKING											
13	Will bedrails be used for this patient at the present time?										
14	Rationale for use of bedrails: (Please insert code in the box on the right)										
	A - Risk of falling from the bed										
	B - Risk of rolling from the bed										
	C - Risk of slipping from the bed										
	D - Risk of sliding from the bed										
	E - Patient request										
15	Bedrail risk assessment completed by:										
16	Bedrails checked by:										
17	Date										
Any issues relating to the use of bedrails including discussion with family/relatives/carers should be recorded here											

A. Alternatives to bed rails:-

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

C. Safe use and application of bedrails:-

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

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

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

D. Record keeping:-

All of the following should be recorded:-

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

Bedrail risk assessments should be made as follows:-

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

4AT and TIME for Detection, Management and Prevention of Delirium

Complete for patients: age 65 and over; patients of any age with an existing cognitive impairment; previous delirium; current hip fracture; or severe illness. These patients are at high risk of delirium.

This should be done on admission; at each transition of care; if SQiD positive; or if any clinical concerns.

	
1908546042	19/08/1954
LOGAN	
Georgina	
17 SOLLAS PLACE	
KNIGHTSWOOD	
Glasgow, Lanarkshire	
G13 4NA	



4AT	Ward <u>11C</u> Date & Time <u>17.8.20</u> <u>16.00</u>	Ward _____ Date & Time	Ward _____ Date & Time	Ward _____ Date & Time	Ward _____ Date & Time
(1) Alertness This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating					
Normal (fully alert, but not agitated, throughout the assessment)	0	0	0	0	0
Mild sleepiness for <10 seconds after waking, then normal	0	0	0	0	0
Clearly abnormal	4	4	4	4	4
(2) AMT4 Ask the patient their Age, Date of Birth, Place (name of hospital) Current Year					
No mistakes	0	0	0	0	0
1 mistake	1	1	1	1	1
2 or more mistakes	2	2	2	2	2
(3) Attention Ask the patient "Please tell me the months of the year in backward order, starting at December". To assist, one prompt of "What is the month before December" is permitted.					
Achieves 7 months or more correctly	0	0	0	0	0
Starts but scores < 7 months or refuses to start	1	1	1	1	1
Untestable (cannot participate because too drowsy or inattentive)	2	2	2	2	2
(4) Acute change or fluctuating course Evidence of significant change of fluctuation in: alertness, cognition, other mental function (e.g. hallucinations, paranoia) over the past 2 weeks and still present in preceding 24 hrs.					
No	0	0	0	0	0
Yes	4	4	4	4	4
4AT TOTAL SCORE	0				
Print initials of assessor	<i>J</i>				
Score >4 This is a possible DELIRIUM +/- COGNITIVE IMPAIRMENT, start 'T' and 'I' of TIME and escalate to medical staff to confirm diagnosis	Score 1-3 This is a possible COGNITIVE IMPAIRMENT, and requires further assessment				
Score 0 DELIRIUM or SEVERE COGNITIVE impairment unlikely					

All patients scoring 0-3 are still at high risk of delirium. Use the Triggers listed overleaf to plan care and reassess daily by asking 'Is the patient more confused or drowsy?' This is the single question in delirium (SQiD)

TIME checklist to guide Delirium risk reduction, Identification and Management

The TIME checklist is a joint medical and nursing responsibility.

Affix ID Label



Triggers, Investigate, Manage and Engage		Date	Date	Date	Date	Date
Triggers	Think possible triggers for delirium	Tick box	Tick box	Tick box	Tick box	Tick box
	Is the patient in pain? Start pain chart, review analgesia and consider need for an aperient					
	Is the patient constipated or at risk of constipation? Commence bowel chart and review daily to assess for constipation, especially if on analgesia. Consider rectal examination					
	Is the patient in urinary retention? Palpate bladder/scan					
	Is the patients oral intake sufficient to prevent dehydration? Encourage hourly fluids, start fluid balance chart					
	Could any drugs trigger delirium? Doctor to review medication					
	Blood sugar, high or low?					
	Is there a history of alcohol intake/drug abuse? Intoxication or withdrawal, start GMAWS/drug misuse guidelines					
	Does the patient have sensory impairment? Ensure patient is wearing their glasses/hearing aid(s)					
	Is the patient immobile? Promote early mobilisation in order to prevent delirium					
	Document 4AT score					
	Does the patient have Delirium? (Yes/No/Unsure) Please Circle	Y N U	Y N U	Y N U	Y N U	Y N U
Investigate	Investigate					
	Record NEWS					
	Screen for infection					
	Take bloods and ensure ECG/appropriate imaging					
Manage	Management: Diagnose causes & initiate treatment					
	Document diagnosis of delirium					
	Document potential causes of delirium					
	Document treatment plan					
Engage	Engage and Explore					
	If appropriate, explain diagnosis of delirium to patient/ family/ carers and provide delirium leaflet					
	Engage with patient/ family/ carers. Complete "What matters to me"/"Getting to know me" document					
	Does the patient have capacity to consent to care? (Yes/No/Ongoing Assessment)	Y N O	Y N O	Y N O	Y N O	Y N O
	If no, complete AWI document					
	Print initials of assessor					

NEWS – National Early Warning Score



Greater Glasgow
and Clyde

Name			
Address			
CHI No.	1908546042	F	19/08/195
DoB	LOGAN Georgina	17 SOLLAS PLACE	KNIGHTSWOOD
	Glasgow, Lanarkshire	G13 4NA	

	Date	Ward
Admitted	17/8/20	11C
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.

[illegible]

[illegible]

Discharge Checklist



1908546042

LOGAN

Georgina

F
19/08/1954

graph label

Ward: 11C

Discharge destination: Home

Estimated Discharge Date (1) 1/1

Estimated Discharge Date (2) 1/1

Final date of discharge: 22/08/20

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓			
Relative/carer informed	✓		he	
Others informed: Care Home		✓		
Transport arranged				
Own transport (preferred option)	✓			
Ambulance-1 man/ 2 man am/pm		✓	he	
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	✓		he	
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		✓	OK	
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	✓		he	
Valuables e.g. cashier		✓		
Intravenous cannula removed				
Equipment ordered (inc. walking aids) in place for discharge		✓	he	
Part 2 Discharge letter - Required		✓		
- Completed		✓		
Out patient clinic appointment e.g. Anticoagulation clinic				
Arranged / To follow				MDT - Steve
If unknown at time of discharge state reason				
Additional information / leaflets / factsheets				
Time of Discharge:				2145
Nurse's signature:				22/08/20
Designation:				SN

Acute Services Division
GG&C Day Surgery/23 hour Care Plan
Admission Checklist



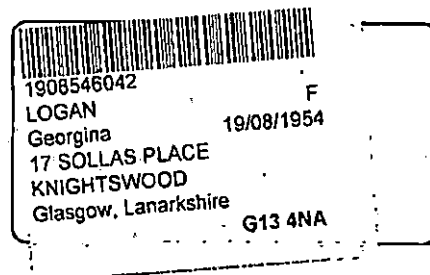
Hospital: <u>VIC ACH</u>																			
Consultant: <u>Heady</u>	Date: <u>12/10/20</u>																		
Proposed Operation: <u>FUELS</u>																			
Patient Questionnaire Completed?	Yes ☒ No ☐																		
Pre-Op Assessment Completed?	Yes ☒ No ☐																		
Escort Details (responsible Adult) Name: <u>George</u>	Telephone Number: <u>07437 685018</u>																		
Confirm "Next of Kin" on pre-assessment <u>Yes</u> Name: <u>as above</u>	Telephone No:																		
Interpreter Required? If "YES" confirmation of booking	Yes ☐ No ☒																		
Duration of booking (if known).....																			
Carer required to stay with patient?	Yes ☒ No ☐																		
Date of LMP?	Date: <u>N/A</u>																		
Are you, or could you be pregnant?	Yes ☐ No ☐																		
If "Yes" pregnancy test must be performed																			
Pregnancy test results	+VE ☐ -VE ☐																		
Group and save results checked	Yes ☐ No ☒ N/A																		
Date done.....																			
Anti D required	Yes ☐ No ☒																		
Is the patient on Anti-Coag therapy?	Yes ☒ No ☐																		
If "Yes" state type..... <u>as above stopped Friday</u>																			
Are INR results available within last 24hrs?	Yes ☐ No ☐																		
If "No" INR taken datetime.....	Result.....																		
Is the patient diabetic If "Yes"	Yes ☐ No ☒																		
BM on admission results.....	NIDD ☐ DD ☐																		
Urinalysis done Results..... <u>blood test, protein test</u>	Yes ☒ No ☐ N/A																		
CJD single question asked	Yes ☒ NO ☐																		
Answer to CJD single question	At Increased Risk ☐ Not at increased Risk ☒																		
If CJD question has not been asked then ask the question "Have you ever been notified that you are at an increased risk of CJD or vCJD for public health purposes?"	Yes, I have been notified No, I have not been notified																		
Has the patient been nursed outwith Scotland in the last 12 months?	Yes ☐ No ☒																		
Alert Sticker (if required)	Yes ☐ N/A ☒																		
Does the patient have any pressure area issues? If 'Yes': Area..... Issue+/- Tissue Viability contacted Yes ☐ N/A	Yes ☐ No ☒																		
Other Information- Document any other relevant information e.g. needle phobia, request for female practitioner 'Getting to know you' information.																			
Fit Form required	Yes ☐ No ☒																		
Baseline Observations	<table border="1"> <tr> <td></td> <td>Time: <u>12:00</u></td> <td>Time:.....</td> </tr> <tr> <td>SP02</td> <td><u>97%</u></td> <td></td> </tr> <tr> <td>BP</td> <td><u>140/70</u></td> <td></td> </tr> <tr> <td>HR</td> <td><u>68</u></td> <td></td> </tr> <tr> <td>Temp</td> <td><u>36.4</u></td> <td></td> </tr> <tr> <td>Staff Initials</td> <td><u>ELWRIGHT</u></td> <td></td> </tr> </table>		Time: <u>12:00</u>	Time:.....	SP02	<u>97%</u>		BP	<u>140/70</u>		HR	<u>68</u>		Temp	<u>36.4</u>		Staff Initials	<u>ELWRIGHT</u>	
	Time: <u>12:00</u>	Time:.....																	
SP02	<u>97%</u>																		
BP	<u>140/70</u>																		
HR	<u>68</u>																		
Temp	<u>36.4</u>																		
Staff Initials	<u>ELWRIGHT</u>																		
Weight: <u>11st</u>	Height: <u>4'10"</u>																		
Resp: <u>17</u>																			
Any relevant medical history or other information <u>Pericarditis, asthma, IBS.</u>																			
Please print & sign name when checklist completed	Name: <u>ELWRIGHT</u> Time: <u>12:00</u>																		

Acute Services Division
GG&C Day Surgery/23 hour Care Plan
Admission Checklist

A: 1908546042
 N: LOGAN
 C: Georgina
 D: KNIGHTSWOOD
 Glasgow, Lanarkshire
 19/08/1954
 G13 4NA

Patient mode of transport to theatre Trolley ☐ Walking ☒ Chair ☐			
Pre-op Checklist - to be completed immediately prior to the patient being given a Pre Med			
Preoperative Checks	Admission Check	Reception Check N/A	Anaesthetic Check
Identity band correct (Name, DOB, CHI number, Gender) and checked with Patient	Yes ☒ No ☐	Yes ☐ No ☐	Yes ☒ No ☐
Case Notes/Scanner Folder	Yes ☒ No ☐	Yes ☐ No ☐	Yes ☒ No ☐
Addressograph Labels	Yes ☒ No ☐	Yes ☐ No ☐	Yes ☒ No ☐
X-Rays and Scans	Yes ☐ No ☒ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☒ No ☐ N/A ☐
Prescription Chart	Yes ☒ No ☐	Yes ☐ No ☐	Yes ☒ No ☐
Alert sticker		Please see page 1 Checked ☐	Please see page 1 Checked ☒
Consent / Incapacity (circle) Signed & Dated	Yes ☒ No ☐	Yes ☐ No ☐	Yes ☒ No ☐
Checked against theatre list	Yes ☒ No ☐	Yes ☐ No ☐	Yes ☒ No ☐
Patient/Incapacity/Consent (Circle)	Yes ☒ No ☐	Yes ☐ No ☐	Yes ☒ No ☐
Procedure and site for Surgery	Yes ☒ No ☐	Yes ☐ No ☐	Yes ☒ No ☐
Correct site marked	Yes ☒ No ☐	Yes ☐ No ☐	Yes ☒ No ☐
Comments & details eg Welfare Guardian/ Power of Attorney	Yes ☐ No ☒	Yes ☐ No ☐	Yes ☒ No ☐
Allergies/Sensitivities and Reactions	Yes ☒ No ☐	Yes ☐ No ☐	Yes ☒ No ☐
If Yes, please specify	Latex - Rash		Latex
Fasted from - specify time (24hr clock)	Food: Midnight Fluid: 0900	Checked:	Checked: TW ST/loop
Blood Glucose Score N/A	Time: Score:	Time: Score	Time: Score
Internal Prosthesis in situ e.g metalwork, pacemaker, implant. If 'Yes' state location and type	Yes ☐ No ☒	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☒ N/A ☐
External prosthesis e.g. hair extensions, hair pieces. If left in situ, state location on patient	Yes ☐ No ☐ N/A ☒	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☒ N/A ☐
If removed state where stored			
Jewellery/Body piercing removed	Yes ☐ No ☒ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☒ N/A ☐
If 'Yes' state where stored.			
Jewellery/Body piercing taped	Yes ☒ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☒ No ☐ N/A ☐
If 'Yes' state Location on body	Chand taped to ring		Ring taped (C)
Make-up/Nail polish removed	Yes ☐ No ☐ N/A ☒	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☒ N/A ☐
Comments			
False Nails	Yes ☐ No ☐ N/A ☒	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☒ N/A ☐
Comments			
Loose Teeth /caps/crowns/bridges /dental work	Yes ☐ No ☐ N/A ☒	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☒ N/A ☐
State Location:			
Dentures Removed	Yes ☐ No ☒ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☒ No ☐ N/A ☐
If "Yes" state where stored:	Top Set only in situ		Top only
Spectacles/ contact lenses removed (circle) If 'Yes' state where stored:	Yes ☐ No ☐ N/A ☒	Yes ☐ No ☐ N/A ☐	Yes ☒ No ☐ N/A ☐

Acute Services Division
GG&C Day Surgery/23 hour Care Plan
Admission Checklist



Preoperative Checklist <i>continued</i>			
Pre-operative checks	Admission Check	Reception Check N/A	Anaesthetic Check
Hearing aid(s) Hearing aid(s) removed	R ☐ L ☐ N/A ☒	R ☐ L ☐ N/A ☐	R ☐ L ☐ N/A ☒
If removed state where stored:	Insitu ☐ Removed ☐	Insitu ☐ Removed ☐	Insitu ☐ Removed ☐
CJD question asked		Please see page 1	Please see page 1
Answer to CJD question		Checked ☐	Checked ☒
If CJD question has not been asked then ask the question "Have you ever been notified that you are at an increased risk of CJD or vCJD for public health purposes?"		Please see page 1 Checked ☐	Please see page 1 Checked ☒
MRSA screen results (if applicable)	Positive ☐ Negative ☐ Results Pending ☐ N/A ☒		
Inhalers Sprays with patient State type	Yes ☒ No ☐ N/A ☐	Type: <i>Forster</i>	
Anti-embolic/DVT Prophylaxis State type	Yes ☐ No ☒ N/A ☐	Type:	
Paper Pants in situ	Yes ☒ No ☐ N/A ☐		
Voided urine/ Catheter in situ/ Urostomy (circle)	Yes ☒ No ☐ N/A ☐	Comment if required	Comment if required
Date of Last Menstrual period		See P1 Checked ☐	See P1 Checked ☒
Is there any chance you are pregnant?		See P1 Checked ☐	See P1 Checked ☒
Pregnancy test carried out		See P1 Checked ☐	See P1 Checked ☒
Pregnancy test result			
Tampon Removed Comments:	Yes ☐ No ☐ N/A ☒	See Admission Check Checked ☐	See Admission Check Checked ☒
Local anaesthetic cream applied	Yes ☐ N/A ☒	If "Yes" time applied..... Site(s) applied.....	If "Yes" time applied..... Site(s) applied.....
Pre-Medication Given	Yes ☐ N/A ☒	Yes ☐ N/A ☐	Yes ☐ N/A ☒
Trolley/Bed checked for head down tilt and O2	Bed ☐ Trolley ☒ Operating Chair ☐ Yes ☐ No ☐	Bed ☐ Trolley ☐ Operating Chair ☐ Yes ☐ No ☐	Bed ☐ Trolley ☒ Operating Chair ☐ Yes ☐ No ☐
Please print and sign name once the checklist is complete	Admission: <i>[Signature]</i> Time: <i>12/10/04</i>	Reception: N/A ☐ Time:	Anaesthetic Assistant: <i>FW ST100P</i> Time <i>13.06</i>

Aff.	1908546042	F
Nat	LOGAN	19/08/1954
CHI	Georgina	
DOI	17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire	G13 4NA

SURGICAL BRIEF

Surgical Brief carried out: Yes ☒ No ☐		If 'No' please specify	
Baseline Observations Date & Time	Pulse: 89	BP: 151/63	Temp: 35.3°C
Anaesthetic Assistant has confirmed with Anaesthetist that cross matched blood is:	Required:	Available:	Or patient has been grouped and saved:
	Yes ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒
Venous Access	in left hand pink.		
STOP BEFORE YOU BLOCK carried out: Yes ☐ No ☒ N/A ☒			

Anaesthetic Type – Please Tick all that apply

General Anaesthetic ☒	Epidural ☐	Spinal ☐	Regional Block ☐	Throat Spray ☐
Airway	LMA 3			
Local Anaesthetic	Site: N/A	Drug:	mls:	
Sedation	Drug: N/A	mls:		

Skin Prep used for Anaesthetic Monitoring/Block(s)This section NOT applicable ☒

SPINAL/EPIDURAL	Yes ☐ N/A ☐	Specify Prep:
REGIONAL BLOCK	Yes ☐ N/A ☐	Specify Prep:
OTHER SPECIFY	Yes ☐ N/A ☐	Specify Prep:

Blood Glucose MonitoringThis section NOT applicable ☒

Time							
BM score							

Safe use of SpO2 probe to prevent injuryThis section NOT applicable ☐

SpO2 Probe rotated hourly	Yes ☒ No ☐ N/A ☐	Initial Position
Time Rotated		taped closed left index finger
Probe Position		

Prevention of Eye InjuryThis section NOT applicable ☐

Eyes protected from injury during procedure	Yes ☒ No ☐	Specify: taped closed.
---	---	------------------------

Maintenance of Norm-thermia

This section NOT applicable

Actions taken to maintain the patient's Temperature	Yes ☒	Warm air blanket device – specify:	Yes ☐ No ☒ N/A ☐
	No ☐	Warm Fluids	Yes ☒ No ☐ N/A ☐
		Warming Mat	Yes ☐ No ☒ N/A ☐
		Thermal Hat	Yes ☐ No ☒ N/A ☐
		IV fluid warmer	Yes ☐ No ☒ N/A ☐
		Other - specify	Yes ☐ No ☒ N/A ☐

Patients Temperature documented by Anaesthetist

Yes

No

Acute Services Division
GG&C Day Surgery/23 hour Care Plan
Anaesthetics

	
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Glasgow, Lanarkshire	
G13 4NA	

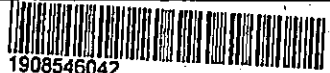
Record of Anaesthetic Pump Infusion Device Numbers

This section NOT applicable ☒

--	--	--	--	--	--

Comments/Events

X

	
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Glasgow, Lanarkshire	
G13 4NA	

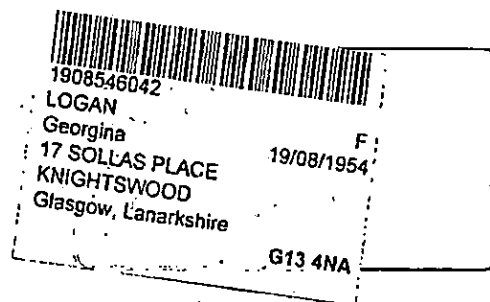
Safe Positioning		This section NOT applicable ☒			
Moving aids used to move patient <i>po</i>	Yes ☒ No ☐	Pat Slide ☒ Hover Mattress ☐	Sliding sheet ☒ Other specify: ☐	Roll Board ☐	
Pre-op Pressure Area Care					
Pre-operative skin issues (please circle)	Excoriation Level: <u>0</u> 1 2 3	PU Grade: <u>N/A</u> 1 2 3 4			
Area of concern identified (include area of body)			Actions Taken		

Position 1			
Time: <u>13³⁰</u>	Positioning Devices		Pressure Relieving
Supine ☒ Prone ☐ Left Lateral ☐ Right Lateral ☐ Lloyd Davis ☐ Jack-knife ☐ Tren-delenburg ☐ Deckchair ☐ Reverse Tren-delenberg ☐ Lower Limb Traction ☐ Lithotomy ☒ Other ☐	Head ring ☐ Pillows ☒ Straps ☐ Wedge ☐ Sandbag ☐	Lateral supports ☐ Hydraulic leg supports ☐ Limb Traction ☐ Side Supports ☒ Bolster ☐	Gel Pads ☐ Heel gel ☐ Pads ☐ Full gel mattress ☒ Gel Wedge ☐ Pillows ☐ Shoulder Roll ☐
Arm Position			
R Arm Position At side ☒ On boards ☐ Across chest ☐ Hand Table ☐ Hand Traction ☐ Secured with: Straps ☒ J Board ☒ Pressure Care: Gel / Foam Pads ☒		L Arm Position At side ☒ On boards ☐ Across chest ☐ Hand Table ☐ Hand Traction ☐ Secured with: Straps ☐ J Board ☒ Pressure Care: Gel / Foam Pads ☒	

Position 2			
This section NOT applicable ☒			
Time:	Positioning Devices		Pressure Relieving
Supine ☐ Prone ☐ Left Lateral ☐ Right Lateral ☐ Lloyd Davis ☐ Jack-knife ☐ Tren-delenburg ☐ Deckchair ☐ Reverse Tren-delenberg ☐ Lower Limb Traction ☐ Lithotomy ☐ Other ☐	Head ring ☐ Pillows ☐ Straps ☐ Wedge ☐ Sandbag ☐	Lateral supports ☐ Hydraulic leg supports ☐ Limb Traction ☐ Side Supports ☐ Bolster ☐	Gel Pads ☐ Heel gel ☐ Pads ☐ Full gel mattress ☐ Gel Wedge ☐ Pillows ☐
Arm Position			
R Arm Position At side ☐ On boards ☐ Across chest ☐ Hand Table ☐ Hand Traction ☐ Secured with: Straps ☐ J Board ☐ Pressure Care: Gel / Foam Pads ☐		L Arm Position At side ☐ On boards ☐ Across chest ☐ Hand Table ☐ Hand Traction ☐ Secured with: Straps ☐ J Board ☐ Pressure Care: Gel / Foam Pads ☐	

Electrosurgery		This section NOT applicable ☒	
Monopolar Yes ☐ N/A ☐	Bipolar Yes ☐ N/A ☐		
Site(s) of Monopolar electrode			
Skin site(s) assessed and meets safety criteria as per policy	Yes ☐ No ☐	If 'No' state reason:	
Skin site(s) hair removal	Yes ☐ N/A ☐	State site:	
Electrode site(s) checked after patient repositioned and is satisfactory	Yes ☐ No ☐ N/A ☐	If 'No' state reason and action:	

Acute Services Division
GG&C Day Surgery/23 hour Care Plan
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Tourniquets							This section NOT applicable ☒		
Tourniquet equipment applied			Yes ☐ No ☐ N/A ☐						
Padding under tourniquet			Yes ☐ No ☐ N/A ☐						
Cover over tourniquet			Yes ☐ No ☐ N/A ☐						
Post op skin check(s) satisfactory			Yes ☐ No ☐		If 'No' state reason and action:				
Site	Time inflated	Pressure	Time deflated	Time re-Inflated	Pressure	Time deflated			
Digit Tourniquets							This section NOT applicable ☒		
Digit applied:		Time applied :		Time Removed:					
Digit applied:		Time applied :		Time Removed:					
Skin Preparation							This section NOT applicable ☐		
Site	Clipped	Preparation solution used							
GROW AREA	Yes ☐	Aqueous Iodine based solution			Chlorhexidine solution ☐				
	No ☐	Alcohol Iodine based solution			Chlorhexidine acetate Solution ☒				
	N/A ☐	Aqueous Iodine and sodium chloride 50/50			 %				
					Other Specify:..... %				
Site	Clipped	Preparation solution used							
	Yes ☐	Aqueous Iodine based solution			Chlorhexidine solution ☐				
	No ☐	Alcohol Iodine based solution			Chlorhexidine acetate Solution ☐				
	N/A ☐	Aqueous Iodine and sodium chloride 50/50			 %				
					Other Specify:..... %				
Local Anaesthetic Infiltration to Wound							This section NOT applicable ☐		
Site	Drug	Quantity							
ONE TMA	INSTILAGEL	7 MLS							
Site	Drug	Quantity							
Drains							This section NOT applicable ☒		
Drain	Site	Type	Size	Secured with	Dressing				
1									
2									
3									
Wound Closure and Dressings (including Packing)							This section NOT applicable ☐		
Wound Closure used: Yes ☐ No ☐ N/A ☐			Wound Dressings: Yes ☐ No ☐ N/A ☐						
	Site	Wound closure	Dressings	Packing					
1									
2									

Acute Services Division

GG&C Day Surgery/23 hour Care Plan

Theatre



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Affix: LOGAN
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CHI: KNIGHTSWOOD
DOB: Glasgow, Lanarkshire
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Urinary Catheter **Inserted prior to admission** **This section NOT applicable** ☒

Type	Size	Anaesthetic lubricant applied / inserted	Balloon inflated with	Prepping Solution
		mls	mls	

Operation / Procedure Performed

CYSTOSCOPY / REMOVAL OF STENT / LEFT RIGID URETEROSCOPY / BASKET REMOVAL OF STONE
RETROGRADE PYELOGRAM / INSERTION OF STENT (SPRINGS ON)

Blood Tags **This section NOT applicable** ☒

Blood Tags checked and dispatched appropriately: : Yes ☐ No ☐ N/A ☐

Post-op Pressure Area Care

Skin Inspection Scores Post operative (circle)	Excoriation level: 0 1 2 3	Pressure Ulcer Grade: N/A 1 2 3 4
---	----------------------------	-----------------------------------

Action taken if required

Notes / Comments / Events **This section NOT applicable** ☒

Traceability Stickers

Disposable Grasping Forceps
REF: JHY-FG-18-70-A4
LOT: FG20050403
S13821-001 5917735
Wolf Ureteroscope 6 - 7.5
S7596-006 5912948
Cystoscope Set (Vic ACAD)

Boston Scientific
Zero Tip™
1.9F (0.63mm) x 120cm

GTIN 08714729469643
REF M0063901050
LOT 24636728



(01)09714729469643(17)21102110124636728

GS1

6.0FR (2mm) X 28 cm
DOUBLE PIGTAIL URETERAL STENT

REF 5808026

LOT MNFK880

2024-02-12

Peel Off

**Post-Op Instructions e.g. sutures, physio follow up appointments**

MS HENDRY WILL ARRANGE FOR
REMOVAL OF STENT AT GAI FOR
LATER THIS WK OR NEXT WK.

Verbal Handover from Theatre to Recovery

Verbal Handover given by:

ANAESTHETIST

To:

P. PROCTOR

Handover should include the following:

Patient	Anaesthetic	Theatre	Other
Patient's Name	Anaesthetic Type	Drains	
Theatre	Airway Type	Wounds/Dressings	
Procedure	Peripheral IV	Urinary Catheter	
Allergies	Local Anaesthetic Infiltration	Skin Inpsection results	
	Pain management	Intra-operative events	
		Post-Op Instructions	

Pressure Area Issues

N/A ☐

(Skin inspection score post-operative see page 9)

Area of Concern identified (include area of body)

Actions Taken

Notes / Comments / Events**This section NOT applicable** ☐

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 Glasgow, Lanarkshire

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Post-operative Observations									
Time	14 ¹⁵	14 ²⁰	25	30	35	50	55		
210	116	135	134	129	116	145	129		
200	68	60	52	64	64	71	68		
190									
180									
170									
160									
150									
140									
130									
120									
110									
100									
90									
80									
70									
60									
50									
40									
30									
Airway type	1	1	1	1	1	1	1		
O ₂ Therapy	6L	6L	6L	6L	6L	6L	6L		
SpO ₂	99	99	98	98	98	100	1		
Resp. Rate	12	14	16	12	12	14	14		
CVP	N/A								
Temp.	35.3								
Pain Score	0	0	0	0	0	0	0		
P.O.N.V.	0	1	1	0-1	0-1	0	0		
Sedation Score	1	0-1	0-1	0-1		0	0		
BM Score									
HemoCue Score									
Hourly Urine Vol.									
Total Urine Vol.									
Wound Score									
Wound Score									
Wound Score									
PV Staining	0			0	0				
Circulation +ve/-ve									
Sensation +ve/-ve									
Movement +ve/-ve									
Pedal Pulse - Left									
Pedal Pulse - Right									
Drain 1									
Drain 2									
Drain 3									
Drain 4									
Staff Initials	P.P	P.P	P.P	P.P	P.P	P.P	P.P		

GG&C Day Surgery/23 hour Care Plan

LOGAN

Georgina

17 SOLIAS PLACE

17 SULLAST FIVE
KNIGHTSWOOD

Glasgow, Lanarkshire

F
19/08/1954

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Verbal Handover from Immediate Recovery to 2nd Stage Recovery

Handover should include the following:

Pre-Mobilisation Patient Checks

Events / Comments

This section NOT applicable

12

Discharge Criteria



1908546042

LOGAN

F

Georgina

19/08/1954

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

G13 4NA

Discharge Criteria			
	Yes	N/A	Comments
Able to dress, sit and walk unaided	✓		
Stable NEWS	✓		BP 109/70 HR 75 SpO2 %99
Sedation Score (alert & orientated)	✓		
Pain controlled (mild <3)	✓		
Post-op Nausea & vomiting satisfactory	✓		
Tolerating Food & Fluids	✓		
Voided urine post-op	✓		
Advice given if not voided urine post-op	✓		
wound site(s) checked & satisfactory		✓	
1.			
2.			
CSM of operated limb checked & satisfactory		✓	
IV Cannula removed	✓		
ID Bracelet/ECG electrodes removed	✓		
Anti-D given		✓	
Post-Op discharge letter (IDL)	✓		
Follow up appointment arranged		✓	By Post ☐ Given ☐
Practice/District Nurse referral		✓	
Post-Op Instructions given	✓		
Discharge medication	✓		Paracetamol
Responsible adult escort	✓		
Responsible adult supervision overnight	✓		
Any skin issues prior to discharge reported		✓	
Patient advised that while awaiting collection after discharge that they must alert staff if there is any change in their condition.	✓		
Admission, dosage, frequency and contraindications of discharge drugs discussed with patient.	✓		
Patient met discharge criteria at 17.20 hrs			By: RMA CARLUCCI
Patient left DSU at: 1810			Destination: HOME
Discharged into the care of:			Relationship: SON

Risk Assessment



1908546042

LOGAN

Georgina

19/08/1954

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

G13 4NA

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

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
12/10/20 14 ²⁰	90. menses - Long Ovarian function	
14 ²⁵	I.V. Buscopan 2mg for bladder sensitivity - Patient distressed by sensation of needing to pass urine - Unable to use bedpan	
14 ⁴⁰	Used commode in recovery - Passed good volume urine -	

Notes



1908546042

LOGAN
GeorginaF
19/08/1954

Date and Time	Notes	Print Name, Signature and Designation
12.10.20 1610	11:50 - more settled - Transfer to 2nd stage NURSING NOTES: Patient transferred from first stage. Patient irritated - needing to pass urine also needing to sit up - uncomfortable in bed. Vitals as documented. Managing diet. Up to bathroom, passed urine in toilet. Up to a recliner chair. Patient still feeling irritated, up + down to relieve same. Bladder Scan came out - 59mls with IV continues, IV paracetamol to go up next.	R. HODGE R. ARMSTRONG
12.10.20 (1700)	Reviewed by consultant. Stent removed and is happy for patient to get home today.	R. Carmichael

BladderScan's BVI9400 Results

10/9/2020 13:36
Exam Time And Date

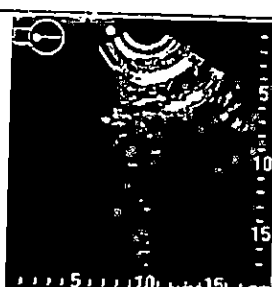
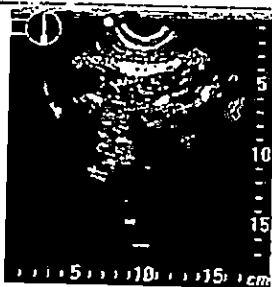
Patient ID

Patient Name

Operator ID

Physician

Procedure Code



Urine Volume: 59ml

Pre-Operative Patient Questionnaire

For the attention of patients receiving a general anesthetic or sedation

Have you arranged a carer for 24hrs at home	Yes ☒ No ☐
Do you have a cough, cold or nose trouble?	Yes ☐ No ☒
What time did you last have something to eat?	Midnight
What time did you last have something to drink?	Sips only water
Do you require a sick line or self certificate?	Yes ☐ No ☒
Do you have any known skin problems e.g. pressure ulcers or sores?	Yes ☐ No ☒

allergic to latex causes rash

Patient Agreement

I understand that following day surgery I must:

- Have a carer for the next 24 hrs
- Have a method of transport home and escort.

I understand that following day surgery I must NOT:

- Drive a vehicle or ride a bicycle for 24 hrs
- Drink any alcohol for 24 hrs
- Be alone in charge of a baby or child for 24 hrs
- Operate machinery, use a cooker or kettle for 24 hrs
- Climb a ladder or work at heights for 24 hrs
- Sign any important documents for 24 hrs

I certify that I understand and will comply with these restrictions?

Patient signature: Date:

Registered practitioner signature: *[Signature]* Date: 12-10-20

Comments

g logan

Day Surgery Patient Questionnaire

	
1908546042	
LOGAN	F
Georgina	19/08/1954
17 SOLLAS PLACE	
KNIGHTSWOOD	
Glasgow, Lanarkshire	
G13 4NA	

Patient ID Label

Georgina Logan

Urology

Flow Coordinator to give facemask to patient and advise how to use correctly.

Flow Coordinator to ask the following:-

1. Have you received a letter advising you are to stay at home for 12 weeks? Please circle as appropriate:-

Yes ☒ No ☒

2. In the last 7 days have you developed any of the following symptoms: a new continuous cough, a high temperature (37.8c or higher), a loss of or change of your sense of smell or taste? Please circle as appropriate:-

Yes ☒ No ☒

3. In the last 14 days has any member of your household developed symptoms described in question 2? Please circle as appropriate:-

Yes ☒ No ☒

If the patient has answered yes to any questions above please speak to the nurse in charge and do not progress the patient any further. Isolate the patient.

If the patient has answered no to all questions; then patient should be directed to the front desk for admission.

Discharge Checklist

Patient's n: 
 1908546042
 Unit num: LOGAN F
 Georgina 19/08/1954
 CHI numb: 17 SOLLAS PLACE
 KNIGHTSWOOD
 Glasgow, Lanarkshire
 G13 4NA

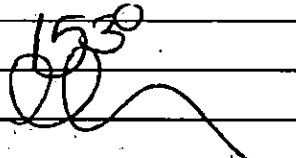
Ward: 9D

Discharge destination: Home

Estimated Discharge Date (1) 1 1

Estimated Discharge Date (2) 1 1

Final date of discharge: 3 12 19

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓			
Relative/carer informed		✓		
Others informed: Care Home		✓		
Transport arranged				
Own transport (preferred option)	✓			
Ambulance-1 man/ 2 man am/pm		✓		
Other: Flight, Air ambulance etc.		✓		
Discharge medication				
Discharge prescription completed		✓		
Compliance aids e.g. Dosette 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. cash		✓		
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	✓			OP flex sig
If unknown at time of discharge state reason				
Additional information / leaflets / factsheets				
Time of Discharge: 1530				
Nurse's signature: 				
Designation: 				
Date: 3 12 19				

My Admission Record



Name: LOGAN Georgina
 1908546042 F
 19/08/1954
 17 SOLLAS PLACE
 KNIGHTSWOOD
 Glasgow, Lanarkshire G13 4NA

Hospital: Q&H Ward: ARUS
 Date of Admission: 11/12/19 Time: 16:35
 Information obtained from: Name: _____
 Patient ☒ Relative ☐ Other ☐
 Preferred Name: _____
 Age: 65 Telephone Number: _____
 Consultant: med / cardio

WSat nod

Communication

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

Preferred first contact

Name: George
 Relationship: husband
 Address: SIA
 Telephone: _____
 Is this person aware of your admission? Yes ☒ No ☐
 Can we share information with this person? Yes ☒ No ☐

Preferred second contact

Name: _____
 Relationship: _____
 Address: _____
 Telephone: _____
 Is this person aware of your admission? Yes ☐ No ☒
 Can we share information with this person? Yes ☐ No ☒

Presenting Complaint / Diagnosis

abdo pain & loose stools
 Explained to the patient? Yes ☒ No ☐ Not Applicable ☐
 Do you understand the reason for your admission? Yes ☒ No ☐

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

No known allergies ☒ N/A

Relevant past medical history

Asthma
Angina
Chronic lower back pain
AF - edoxaban
pericarditis
prev diagnosis of Zollinger's
diagnosed as US on oct 2019

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place

Yes ☐ No ☒ If yes, Who asked for a copy? _____

Date they asked for a copy ___/___/___ Date Obtained ___/___/___

Power of Attorney / Guardianship / Adult with Incapacity

Name: _____

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

Yes ☐No ☒**OR**

Does someone have Guardianship?

Yes ☐No ☒

1908546042

LOGAN

Georgina

F 19/08/1954

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

G13 4NA

If yes, is this for:- Finance ☐ Welfare ☐ Both ☐Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

N.B. If you think the patient may lack capacity inform Medical Staff to assess and, if required, consider the need for an 'Adult with Incapacity' Section 47**Carbapenemase-producing enterobacteriaceae (CPE)**

Have you ever:

1. Been an inpatient in a hospital outside Scotland?

Yes ☐No ☒

2. Received holiday dialysis outside Scotland?

☐☒

3. Been told that you have CPE?

☐☒

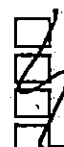
4. Been in close contact with a person with CPE?

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

Isolate the patient in a side room

Obtain Rectal swab marked 'for CPE'

If patient refuses rectal swab, obtain a stool specimen marked 'for CPE'

and inform the IPCT**MRSA Screening**

Will the patient be an inpatient for more than 23 hours

Yes ☒No ☐Unsure ☐If **YES** complete the following section

1. Have you ever been told that you have MRSA?

☐☒☐

2. Have you been admitted from another hospital/ residential setting or care home?

☐☒☐

3. Do you have a wound / skin ulcer or invasive device which you had before admission?

☐☒☐If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabsNasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐**Creutzfeldt-Jakob Disease (CJD)**

Have you ever been informed that you are at increased risk of CJD or vCJD?

Yes ☐No ☒Unsure ☐If **YES** inform the IPCT ☐


 1908546042
 LOGAN
 Georgina
 17 SOLLAS PLACE
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 Glasgow, Lanarkshire
 19/08/1954
 G13 4NA

Lifestyle

Smoking

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

Never smoked ☒

Do you use eCigarettes? Yes ☐ No ☐

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

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

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

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

Drugs

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

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

Alcohol

Do you drink alcohol? Yes ☐ No ☒

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

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

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

Name (Please PRINT): Georgina Logan

Signature: [Signature]

Designation: SN/S

Date: 11/2/19

My Assessment Record


 N 1908546042
 / LOGAN
 Georgina F
 17 SOLLAS PLACE 19/08/1954
 KNIGHTSWOOD
 Glasgow, Lanarkshire
 G13 4NA
 Affix patient ID label

1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems			
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers	✓	✓	
Oxygen therapy			
Do you have any other symptoms?			
Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems			GIN spray
Chest pain at rest			
Chest pain on exertion			
Angina	✓	✓	
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

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



1808546042

LOGAN

Georgina

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Glasgow, Lanarkshire

F

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3. Senses

Patient ID label

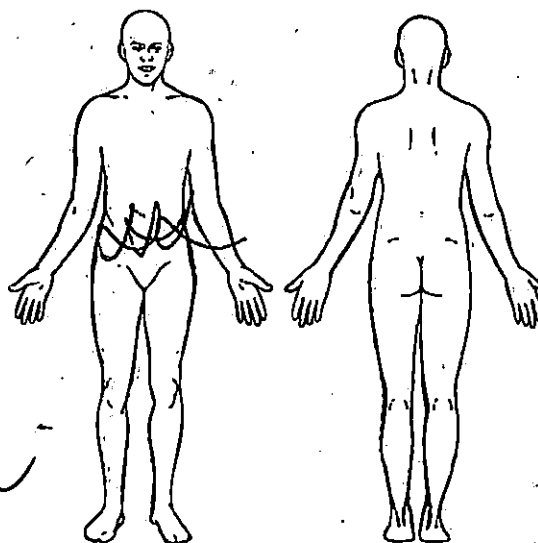
Vision	Yes ✓	No ✓	Assessment of the patient's vision
Do you have any problems with your vision?	✓		Distance ☐ Reading ☐ Both ☒
Do you wear glasses?	✓		
Do you have your glasses with you?	✓		
Do you wear contact lenses?			
Do you have your lenses with you?			
Do you wear a prosthesis?			
Hearing	Yes ✓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

Can you describe where and what the pain is like?

lower back

Mark current pain on body chart

Have you had treatment / intervention for the pain?



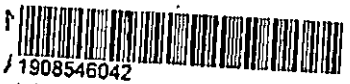
**N.B. Complete generic pain assessment chart.
If unable to self report complete Abbey
Pain Scale.**

Can you describe any chronic pain that you have?

leg cramps + muscle pain

What makes the pain better?

pregabalin, lidocaine patches.
katec


 / 1908546042
 LOGAN
 Georgina F
 17 SOLLAS PLACE 19/08/1954
 KNIGHTSWOOD
 Glasgow, Lanarkshire
 G13 4NA

4. Cognitive Status THINK DELIRIUM

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

N.B. Think Delirium

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

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

and follow the guidance

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

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

try to avoid dairy products

What do you like to eat and drink?

varied diet

What do you not like to eat and drink?

(Handwritten line)

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

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓	 1908546042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire 19/08/1954 G13 4NA F Affix patient ID
Normal diet and fluids			
Therapeutic diet			
Cultural, ethnic or religious diet			
Texture Modified Diet Please state _____			
Thickened Fluid Please state _____			
Oral Nutritional supplements Preferred flavour _____			
Enteral Nutrition			
Parenteral Nutrition			Assessment of the patient's hydration and nutrition needs
Nil by Mouth			
N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS) within 4 hours of admission			
Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓	
Independent (Green)			
Prompting / encouragement / opening packets/cutting up food (Amber)			
Full assistance with eating and drinking (Red)			
Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?			
6. Elimination			
Bladder	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Pass urine with no problems			
Frequently pass urine during the day			
Frequently pass urine overnight			
Sense of urgency when need to pass urine			
Urine retention			

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓	Name: _____  1908546042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA 19/08/1954 F
Haematuria			
Incontinent			

N.B. If new incontinence report to medical staff to rule out infection or physiological cause

What products do you normally use for this continence issue?

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

Date urinary catheter last changed ____/____/____

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

Bowels

When did your bowels last move?

11/12/19

How often in a day/week do you have a bowel movement? Per day Per week

Do you use any medication e.g. laxative to help your bowels move? Yes ☐ No ☒

Bowel Habit	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Regular		✓	anytime I eat it run's out + amb pains.
Constipated			
Diarrhoea / loose stools	✓		
Blood in stools			
Incontinent			

What products do you normally use for this continence issue?

N.B. if concerned about bowel patterns (e.g. infrequent movement or frequent loose stools) consider using the Bristol Stool Chart

Stoma	Yes ✓	No ✓	Assessment of the patient's needs in relation to their stoma
Do you have a stoma?			
Do you require assistance with your stoma care?			
Have you brought any of your stoma products with you?			



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Allix patient ID

7. Personal Hygiene, Oral Health, Skin Care and Wound Care

Personal Hygiene	Admission Presentation	Normal for the patient	Assessment of the patient's personal hygiene needs
Independent	✓	✓	(Sometimes my sister showers me)
Requires assistance with washing and dressing			
Oral Health	Admission Presentation	Normal for the patient	Assessment of the patient's oral health needs
No problems	✓	✓	
Sore mouth / mucositis / ulcer			
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)			
Dental work	Yes	No	Description of any dental work
Do you wear dentures?	✓	✓	
Do you have your dentures with you?	✓		
Are your dentures a good fit?	✓		
Do you have any other dental work that we need to be aware of?			
Skin Care	Admission Presentation	Normal for the patient	Assessment of the patient's skin care needs
No problems	✓	✓	
Skin broken			
Skin oedematous			
Skin discoloured / red			

N.B. Complete PUDRA for all patients within 8 hours of admissionPressure ulcer identified on admission: Yes ☐ No ☒

Pressure Ulcer Grade: _____

Pressure Ulcer Site: _____ Adult wound assessment and management chart required

N.B If Grade 2 pressure damage on ankle or below refer to Podiatry via TrakCare

Wound Care	Yes ✓	No ✓	N.  A. 1908546042 — LOGAN — Georgina — 17 SOLLAS PLACE D KNIGHTSWOOD C Glasgow, Lanarkshire A 19/08/1954 F G13 4NA
Do you have any wounds? N.B. If yes, complete an assessment chart for wound management		✓	

8. Mobility

Mobility	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's mobility needs
Fully mobile and independent	✓	✓	Stick @mes
Unsteady when walking			
Do you use a mobility aid	Yes ☒	No ☐	
Do you have your mobility aid with you?	Yes ☐	No ☒	

N.B. If not fully mobile and independent on admission complete moving and handling assessment within 24 hours of admission

9. Maintaining a Safe Environment

N.B. Complete a falls risk assessment for all patients within 24 hours of admission. If a falls risk is identified complete the falls intervention checklist and document all nursing actions in the care plan.

Safety	Yes ✓	No ✓	Assessment of the patient's ability to maintain a safe environment
Is the patient at risk of falling, rolling, slipping or sliding from the bed?		✓	fall downstairs 7 weeks ago + had pericarditis
Would you like bedrails to be used while in hospital?		✓	

N.B. If yes, to either of the two questions above complete a bedrail risk assessment

10. Sleep and Rest

Sleep	Yes ✓	No ✓	Assessment of the patient's sleep and rest needs
Do you have any difficulties with sleeping?	✓		Zanaxam or clonazepam
Do you do or use anything to help you sleep?	✓		

Name: _____

1908546042

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Georgina

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KNIGHTSWOOD

Glasgow, Lanarkshire

19/08/1954

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11. Social Circumstances

Do you:

Live alone ☐

Live in a nursing home ☐

Live in residential supported care ☐

Live in 'homeless' accommodation ☐

Other please specify _____ ☐

Live with family/ friend/ other ☒ *husband*

Live in a care home ☐

Live in student accommodation ☐

Have no fixed abode ☐

Dependants

Yes

No

Do you have any dependants? ☐ Yes ☒ No

Do you support anyone (e.g. partner, children, relatives, animals)? ☐ Yes ☒ No

Do they need support from someone else whilst you are in hospital? ☐ Yes ☒ No

Would someone else be able to provide this support when you are in hospital? ☐ Yes ☒ No

If yes, who? _____

If no support available contact Duty Social Worker

Duty Social Worker Required ☐

Not required ☒

Referred ☐

Services

Yes

No

Do you have support from social work, social services or a care package? ☐ Yes ☒ No

If yes, please provide details: *care for meds BD. Was doing but family help @ times. taking*

If yes, has contact been made to cancel arrangements during admission? *wrong one's* ☐ Yes ☒ No

12. Emotional and Spiritual Care

Do you have a religion or beliefs that we can help you observe while you are in hospital?

Protestant

Is there anything else with regards to your values, religion or culture that we can support you with during your stay in hospital (e.g. prayer meditation)?

Would you like to talk to someone (e.g. Hospital Healthcare Chaplain) about you, your loved ones, your values and beliefs, or any worries you have? Yes ☐ No ☒

Healthcare Chaplain informed

Yes ☐

N/A ☒

Name: _____

1908546042
LOGAN
Georgina
17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire

19/08/1954 F

G13 4NA

13. Person Centred Care

What matters and is important to you whilst you are in hospital?

This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

(get out + get home)

N.B. Participating in 'What Matters to Me' should be offered to all patients

Informal Support

Who is important to you, to help support you whilst you are in hospital?

(husband)

NB. If the person who helps is not a preferred contact please ensure their details are listed below.

Name:

Contact Details:

.....

.....

How do you want the people who matter to you to be involved in your care?

Do you have someone who looks after you or someone that helps you, i.e. an informal carer?

Yes ☒ No ☐

all my sisters

If yes, has the help or support listed above been confirmed with the patient's family/ friends?

(please tick)

Yes ☐ No ☐

Name:  _____
 1908546042 _____
 LOGAN _____ F _____
 Georgina 19/08/1954 _____
 17 SOLLAS PLACE _____
 KNIGHTSWOOD _____
 Glasgow, Lanarkshire _____
 G13 4NA _____

Required Support

Has the patient and / or carer been advised of the hospital Support and Information Service?

Yes ☐ No ☒

Referrals can be made via the central phone number: 0141 452 2387

Has the carer been advised of the Carers Information Line?

Yes ☐ No ☐ Not appropriate at this time ☒

Carers' Information Line: 0141 353 6504

Carers Information Leaflet provided?

Yes ☐ No ☐

Are you:

Employed ☐

Unemployed ☐

Self-employed ☐

Retired ☒

Full time education ☐

Has your health had an impact on your ability to carry out your day to day activities at work?

Yes ☐ No ☐ Not applicable ☒

Do you have any money worries?

Yes ☐ No ☐ Not appropriate to ask at this time ☐

If yes would you like referred to a money advice service that can offer confidential advice/ support?

Yes ☐ No ☐ If yes when was patient referred ____ / ____ / ____

Would you like a referral to a service that can support you with employment / education/ training/ skills volunteering?

Yes ☐ No ☐ Not applicable ☐

Not appropriate to ask at this time ☒

If yes when was patient referred ____ / ____ / ____



1908546042

LOGAN

Georgina

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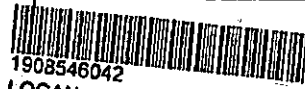
Attach patient ID label

Risk Assessments/Other Documentation

Additional NHSGGC Documentation	Required		Required documents completed		Date, Print and Sign when completed
	Yes ✓	No ✓	Yes ✓	No ✓	
Glasgow Assessment and Management of Alcohol (GAMA)					
Generic Pain Scale Assessment Chart					
Abbey Pain Scale (if unable to self report pain)					
4AT and TIME for Detection, Management and Prevention of Delirium					
Getting to Know Me – Relatives to complete					
What Matters to Me					
Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)					
Malnutrition Universal Screening Tool (MUST)	✓				
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan					
Bristol Stool Chart					
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓				
Adult Wound Assessment and Management Chart					
Moving and Handling Assessment					
Falls Risk Assessment	✓				
Bedrail Risk Assessment					

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
17:00	Admitted to ARUS under medicals.	
1/12/19.	acute pain + loose stools	
	Known chron's.	
	Bloods (N) wait R/V	
18:00	Patient s/B medicals	
	Imp: 61BS bumped	
	Plan: AXR	



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17 SOLLAS PLACE
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Glasgow, Lanarkshire

F
19/08/1954

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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
CSU	Thyroid octasa (pt. reduced dx himself) - b1p vs o.p. flexisig ↳ stomach down	ASW(S) P. Steen
1830	Attended for PPR	
1/12/19 21:00	News 1 BP 101/56 Uncomplaining Settled and slept well overnight. Meds as charted	Twelwe(S)
05:45	News 1 BP 109/64	
2/12/19	News 1 BP 106/69	
1150	(A) Alert + orientated (B) Diet + fluids tolerated. (C) Spontaneously passing urine. Bowels loose. (D) Independent + self caring. (E) Independently mobile. Imp. Darkhaem evidence of IBD infection Plan PR exam Srg vlv + L IP/OP sigmoidoscopy check Hb Stool Sample Med bed.	
1650	Reviewed by Surgical ST8 Imp functional gut issues Plan flex as O/P.	Sarah Preen Sarah Preen Ato 15

 1908546042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA ATTIX patient ID card		F 19/08/1954
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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
2/12/19 1650	Awaiting med re-review ? Home.	Baron Prie
20:50	pm shorter long given at 12:35 hrs. NEWS @ BP 108/59 Mobile off ward. Pain O.K. @ present. No-one come back to know patron and she is keen to stay tonight & plan for home tomorrow.	
3/12/19 00:35	NEWS = 1 BP 104/62. No complaints of pain. Bed available in 90. Pt made aware. Analgesics given due to time of transfer. lg paracetamol given @ 22 ⁰⁰ effective for pain. Regular meds as per books.	
03 ¹⁰	Pt settled upon transfer to 90. Ment/oriented. N&V as charted. ? home today or flex-piggy.	
13 ⁵⁵	Pt independent, ffd. mobile about room Obs as charted + meds as per kardex. Pt keen to go home - for home. CALL WIDL + OP flex lig.	
1550	Discharge home. for OP flex lig.	

Care Rounds Variance Sheet

Attach Addressograph Label

Wärd:



Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

[illegible]

Date: 2/12/19

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (please circle) 1hr 2hr 3hr 4hr

1. Signed [Signature] Name CCOVLE Designation SN
2. Signed [Signature] Name Jaden J. Smith Designation SN
3. Signed _____ Name _____ Designation _____

USE FOLLOWING CODES:

Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

Attach Add



1908546042

LOGAN

1-Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

F
08/1954

G13 4N

NHS
Greater Glasgow
and Clyde

Ward:

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

[illegible]

Date: 1/12/19

Atti 1908546042
LOGAN
Georgina
F
19/08/1954
W

NHS
Greater Glasgow
and Clyde

1. Signed [Signature] Name Jagdish Singh Designation SW
2. Signed [Signature] Name PWEIR Designation SW
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

[illegible]

NEWS – National Early Warning Score



Name	LOGAN	
Address	1908546042	F
	LOGAN	19/08/1954
	Georgina	
CHI No.		
DoB		

	Date	Ward
Admitted	1/12/19	W115
Transferred	3/12/19	90
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	- Inform trained nurse. - Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	- Trained Nurse assessment. - Inform medical team caring for the patient. - Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. - Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	- Trained Nurse to assess immediately. - Inform medical team caring for the patient – this should be at least senior medical staff level. - Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. - Consider referral to high dependency or ITU.

DATE:		TIME:		NEW	
				0 1	
Resp. Rate Mark: •					
SpO ₂ (Enter Value)					
Any Supl O ₂ Room air					
Temp. Mark X					
Pulse Mark: •					
Blood sure Mark ◇					
NEWS SCORE using Systolic BP					
Conscious Level Mark: •					
Total NEWS (with all obs)					
BM					
Pain					
Nausea					
Urine output					
Obs due					
Initials					



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.

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

mi • 231261 Version 1_0 • GGC0084

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

Write 1908546042
Name: LOGAN
Georgina
DOB: 17 SOLLAS PLACE
Ward: KNIGHTSWOOD
Glasgow, Lanarkshire

F: 19/08/1954

ress:

pital:



G13 4NA

Insertion criteria: Please complete this section at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☐

Resuscitation/Chest Pain ☐

IV Drugs ☐

Fluids ☐

Transfusion ☐

PVC inserted: Day 0	Date: 12/19 Hospital: GGH
Insertion site:	Area: ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☐ Unknown ☐
Colour of cannula:	R Hand ☐ R Arm ☐ R Foot ☐ L Hand ☐ L Arm ☐ L Foot ☐ Other: _____
Explanation and PVC leaflet provided to patient/ carer	Blue ☐ Pink ☐ Green ☐ White ☐ Grey ☐ Orange ☐ Yes ☐ No ☐ If No, state reason: _____

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? Diagnostics Resuscitation/ Chest Pain IV Drugs Fluids Transfusion	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 1 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: ___/___/___ Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: 5/12/19

*Reason For Removal: not in situ

Modified Visual Infusion Phlebitis (VIP) Score

Modified V.I.P (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phlebitis : Observe cannula
One of the following is evident : slight pain or redness near site	1	Possible first signs : Observe cannula
Two or more of the following are evident: pain, redness, swelling	2	Early stage of phlebitis : Remove & resite cannula
All of the following are evident: pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: Remove & resite cannula
As above including: palpable venous cord	4	Seek further advice
As above including: pyrexia	5	

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and *S. aureus* bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids ? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → **Can I switch my patient from IV to oral antibiotics?**

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature $\leq 37.9^{\circ}\text{C}$, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE** is available reliably (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, *S. aureus* bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abscess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy.
Record the intended duration on the medicine kardex

YES

NO

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

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FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs of Admission
and on Transfer to Another Ward



GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

Action the following safety precautions on admission to your ward.
Update weekly or on change of condition.

	Ward: 90 Date: 17/12/19 Time: 17:10	Ward: 90 Date: 31/12 Time: 01:10	Ward:	Ward:	Ward:
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	Indep	✓			
2. Check walking aid (if required) is in reach and in use.	Small chair ✓	✓			
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	yes	✓			
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	yes	✓			
5. If glasses are worn, check they are available and in use.	yes	✓			
6. If hearing aid/s are worn, check they are working and in use.	N/A	✓			

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).

Whether Yes or No, update this assessment weekly in acute wards or; at the time of a fall or, upon a change in patient's clinical condition.

ALL patients in older people's wards must have an interventional plan in place (overleaf)

	Tick Yes or No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has the patient fallen in the last 6 months – including during this admission?			✓		✓						
2. Does the patient have cognitive impairment or a possible delirium?			✓		✓						
3. Does the patient attempt to walk alone although unsteady or unsafe?			✓		✓						
4. Does the patient or their relative have a fear or anxiety of the patient falling?			✓		✓						
5. Based on your clinical judgement; is this patient at high risk of falling?			✓		✓						
Signature of nurse completing assessment / update											

Highlight risk of fall at the ward safety brief.

FALLS INTERVENTION CHECKLIST



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Complete for all patients identified at risk of falling.

Ward:	Ward:	Ward:	Ward:	Ward:
Date:	Date:	Date:	Date:	Date:
Time: -----	Time: -----	Time: -----	Time: -----	Time: -----

BED AND SEATING

Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice.
(Patient care plan 8)

Assess if a low bed is required
(Patient care plan 9)

SAFETY

Complete / update bedrails risk assessment if bedrail in use.
(Patient care plan 9)

Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart.
(Patient care plan 9)

If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.

HEALTH

Complete /Document 4AT
– follow THINK DELIRIUM guidelines.
(Patient care plan 4)

Document continence problems and link to care rounding
(Patient care plan 6)

Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns.
(Patient care plan 1)

If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.

COMMUNICATION

Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative.
(Patient care plan -negotiated care)

Update the ward team of the patient's mobility status.
(Patient care plan 8)

Discuss the patient's fall risk at safety briefs and MDT meetings.
(If appropriate)

Consider a referral to the Hospital Falls Service for advice using trackcare.
(If appropriate)

Signature of nurse completing interventional plan / or update

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team
EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

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Care Plan

Care discussed with patient Unable		☐ Yes	☐ No	☐ If unable, give reason:	
Care discussed with family Unable		☐ Yes	☐ No	☐ If unable, give reason:	
Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
11/12/19	Spouse HMO		11/12/19	Mr. Logan & husband	
			11/12/19	5. Hydration and Nutrition	
				Water & fluids	
11/12/19	2, 3. Communication and senses				
	Wears glasses				
11/12/19	4. Cognitive status		11/12/19	6. Elimination	
	Older to be tested			continence	



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Care Plan

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
11/12/19	Independent		11/12/19	Buzzed	
			11/12/19	10. Sleep and Rest	
				18 hrs sleeping	
11/12/19	8. Mobility			12. Privacy, dignity and sexuality	
	Independent				
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

Pressure Ulcer Daily Risk Assessment (PUDRA)

 1908546042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA	Hospital: <u>QCVT</u> Ward: <u>QUS</u>	Points to consider: • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes
---	---	--

1 Pressure Damage	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan overleaf.
--------------------------	--

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2 Mobility	Does the person require assistance to mobilise?
3 Continence	Does the person have continence issues with urine and/or faeces?
4 Nutrition	Does the person appear malnourished and/or unable to eat or drink?
5 Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?
6 Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY pressure relieving care interventions and complete the pressure ulcer interventional plan overleaf.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
12/12/19	11:00	N	N	N	N	N	N	4 hrly	
2/12/19	:							hrly	
3/12/19	01:00	N	N	N	N	N	N	4 hrly	OB
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	

Complete prevention of pressure ulcer interventional plan overleaf for all patients with redness/pressure damage and for those at risk.

Prevention of Pressure Ulcer Intervention Plan



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Aim: To incorporate effective pressure ulcer prevention strategies to reduce/eliminate potential for pressure ulcer development.

Outcome: To prevent pressure ulcer development through establishment of effecting work practices in line with SSKINS bundle.

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan: 11/2/19	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly. • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree plan with patient / family / carer YES ☒ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☒	 Date discontinued:
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly. • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family / carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued:
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly. • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family / carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued:

My Admission Record



N 1908548042

A. LOGAN
Georgina
17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire
G13 4NA

19/08/1954

Affix patient ID label

Hospital: QUEEN Ward: ARU2

Date of Admission: 10/7/19 Time:

Information obtained from: Name: GEORGINA

Patient ☒ Relative ☐ Other ☐

Preferred Name: GINA

Age: 64 Telephone Number:

Consultant:

Communication

What is your first language? ENGLISH

Do you require an interpreter? Yes ☐ No ☒

If yes, provide details of arrangements made

Do you use British Sign Language (BSL)? Yes ☐ No ☒

Do you need someone to help you to communicate? Yes ☐ No ☒ If yes, who

Preferred first contact	Preferred second contact
Name:	Name:
Relationship:	Relationship:
Address:	Address:
Telephone:	Telephone:
Is this person aware of your admission?	Is this person aware of your admission?
Yes ☐ No ☐	Yes ☐ No ☐
Can we share information with this person?	Can we share information with this person?
Yes ☐ No ☐	Yes ☐ No ☐

Presenting Complaint / Diagnosis

CENTRAL CHEST PAIN

Explained to the patient? Yes ☒ No ☐ Not Applicable ☐

Do you understand the reason for your admission? Yes ☒ No ☐

Allergies / Sensitivities (Record food allergies in the Hydration and Nutrition section)

No known allergies ☐ TRIMETOPRIM / ? NSAIDS

Relevant past medical history

IBS
DIVERTICULITIS
CROHNS
ANGINA

CHRONIC PAIN BACK
ASTHMA
DECOMPRESSION OF SPINAL CORD
CHOLECYSTECTOMY

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place

Yes ☐ No ☐ If yes, Who asked for a copy?

Date they asked for a copy / / Date Obtained / /

Power of Attorney / Guardianship / Adult with Incapacity

Does someone have Power of Attorney (POA) for you?

Yes ☐ No ☐**OR**

Does someone have Guardianship?

Yes ☐ No ☐If yes, is this for:- Finance ☐ Welfare ☐ Both ☐Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

Please obtain a copy and place in the patient's notes

Who asked for a copy? _____ Date they asked for a copy ____/____/____ Date Obtained ____/____/____

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

N.B. If you think the patient may lack capacity inform Medical Staff to assess and, if required, consider the need for an 'Adult with Incapacity' Section 47

N  _____
A: 1908546042 _____
LOGAN _____ F _____
— Georgina _____ 19/08/1954 _____
— 17 SOLLAS PLACE _____
KNIGHTSWOOD _____
D: Glasgow, Lanarkshire _____
CL: _____ G13 4NA _____
Affix patient ID label

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:

1. Been an inpatient in a hospital outside Scotland?
2. Received holiday dialysis outside Scotland?
3. Been told that you have CPE?
4. Been in close contact with a person with CPE?

Yes

No

☐
☐
☐
☐☒
☒
☒
☒If the answer is yes to **ANY** of the questions in this section, you must

Isolate the patient in a side room

Obtain Rectal swab marked 'for CPE'

If patient refuses rectal swab, obtain a stool specimen marked 'for CPE'
and inform the IPCT☐
☐
☐
☐**MRSA Screening**

Will the patient be an inpatient for more than 23 hours

If **YES** complete the following section

1. Have you ever been told that you have MRSA?
2. Have you been admitted from another hospital/ residential setting or care home?
3. Do you have a wound / skin ulcer or invasive device which you had before admission?

Yes

No

Unsure

☒
☐
☐
☐☐
☒
☒
☒☐
☐
☐
☐If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabsNasal ☐ Perineum ☐ - Other ☐ Specify _____ Patient refused ☐**Creutzfeldt-Jakob Disease (CJD)**

Have you ever been informed that you are at increased risk of CJD or vCJD?

If **YES** inform the IPCT ☐

Yes

No

Unsure

☐☒☐

Nat		
Ad	1908546042	
	LOGAN	F
	Georgina	19/08/1954
	17 SOLLAS PLACE	
	KNIGHTSWOOD	
Do	Glasgow, Lanarkshire	
CH		G13 4NA
Affix patient ID label		

Lifestyle

Smoking

Are you a: smoker ☐ ex-smoker ☐ when did you stop? _____

Never smoked ☒

Do you use eCigarettes? Yes ☐ No ☐

If a smoker, the NHSGGC Smokefree policy has been explained and Nicotine Replacement Therapy (NRT) has been offered

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

Do you want to talk to someone about your smoking? Yes ☐ No ☐

If yes, refer to Smokefree Services (Trakcare) Date referred: ____/____/____

Drugs

Do you use recreational or illicit drugs or are you receiving opiate replacement therapy (ORT / Methadone / Suboxone)? Yes ☐ No ☒

If yes, please specify and refer to the NHSGGC Guidelines for the Management of Drug Users in Glasgow and Clyde Acute Hospitals

Alcohol

Do you drink alcohol? Yes ☐ No ☒

How often do you have more than 6 units of alcohol on one occasion:

Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐

NB: If daily or almost daily commence the Glasgow Assessment and Management of Alcohol (GAMA), complete FAST Tool and take further action as per guidance.

Name (Please PRINT): *D PATTERSON*

Signature: *[Signature]*

Designation: *STAFF NURSE*

Date: *10/7/19*

My Assessment Record

Name: _____
 Ad:  _____
 1908546042 _____
 LOGAN _____ F _____
 Georgina _____ 19/08/1954 _____
 DoI 17 SOLLAS PLACE _____
 CHI KNIGHTSWOOD _____
 Affi> Glasgow, Lanarkshire _____ G13 4NA _____

1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems			ASTHMA
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers	✓	✓	
Oxygen therapy			
Do you have any other symptoms?			
Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems			GTN SPRAY
Chest pain at rest			
Chest pain on exertion			
Angina	✓	✓	
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

	Yes ✓	No ✓	Assessment of the patient's communication needs
Do you have any difficulties communicating your needs?		✓	
Do you have any difficulties with your speech?		✓	
Do you have a Learning Disability?		✓	
Do you have support from a Learning Disability Team? Contact details:		✓	

Name: _____
 Ad:  _____
 1908546042 F: _____
 LOGAN 19/08/1954
 Georgina
 DoB 17 SOLLAS PLACE
 CHI: KNIGHTSWOOD
 Glasgow, Lanarkshire G13 4NA
 Affix: _____

3. Senses

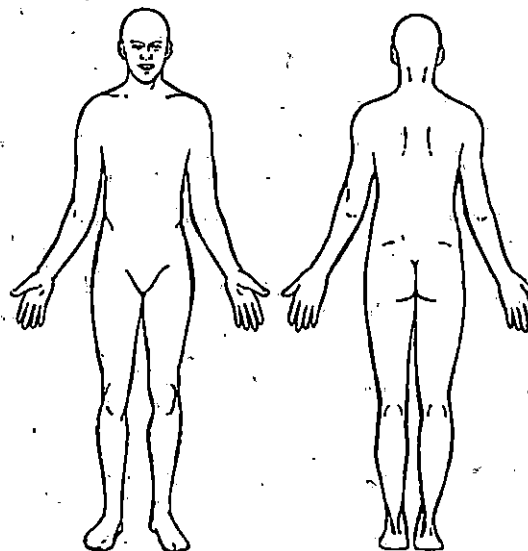
Vision	Yes ✓	No ✓	Assessment of the patient's vision
Do you have any problems with your vision?	✓		Distance ☒ Reading ☒ Both ☐
Do you wear glasses?	✓		
Do you have your glasses with you?	✓		
Do you wear contact lenses?		✓	
Do you have your lenses with you?		✓	
Do you wear a prosthesis?		✓	
Hearing	Yes ✓	No ✓	Assessment of the patient's hearing
Do you have any problems with your hearing?		✓	
Do you have any hearing loss?		✓	
Do you use a hearing aid?		✓	
Do you have your hearing aid(s) with you?			
Pain	Yes ✓	No ✓	Assessment of the patient's pain
Do you have pain?	✓		

Can you describe where and what the pain is like?

CENTRAL
 CHEST PAIN
 CRUSHING

Mark current pain on body chart

Have you had treatment / intervention for the pain?



**N.B. Complete generic pain assessment chart.
 If unable to self report complete Abbey
 Pain Scale.**

Can you describe any chronic pain that you have?

What makes the pain better?

HOLDING SITE

Name:  —
 Address: 1908546042 —
 LOGAN —
 Georgina — F —
 17 SOLLAS PLACE — 19/08/1954 —
 KNIGHTSWOOD —
 DoB: Glasgow, Lanarkshire —
 CHI: — G13 4N —
 Affix patient ID label —

4. Cognitive Status **THINK DELIRIUM**

	Admission Presentation	Normal for the patient	Assessment of the patient's cognitive status
Alert and orientated	✓	✓	
Impaired conscious level			
Confused			
Dementia			
Stressed / Distressed			

N.B. Think Delirium
 Complete 4AT for all patients 65 and over, AND for patients of any age with one or more of the following:

- existing cognitive impairment
- previous delirium
- current hip fracture
- severe illness

and follow the guidance

N.B. 'Getting to Know Me' and 'What Matters to Me' should be completed for all patients with dementia, cognitive impairment or complex needs

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

CANT EAT DAIRY PRODUCTS

What do you like to eat and drink?

What do you not like to eat and drink?

FATTY FOODS.

N.B. Malnutrition Universal Screening Tool (MUST) to be completed for all patients within 24 hours of admission

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓	Name:  Address: 1908546042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire DoB: 19/08/1954 CHI: G13 4NA Affix patient ID label
Normal diet and fluids	✓	✓	
Therapeutic diet			
Cultural, ethnic or religious diet			
Texture Modified Diet Please state _____			
Thickened Fluid Please state _____			
Oral Nutritional supplements Preferred flavour _____			
Enteral Nutrition			
Parenteral Nutrition			Assessment of the patient's hydration and nutrition needs
Nil by Mouth			
N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS) within 4 hours of admission			
Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓	
Independent (Green)	✓	✓	
Prompting / encouragement / opening packets/cutting up food (Amber)			
Full assistance with eating and drinking (Red)			
Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?			
6. Elimination			
Bladder	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Pass urine with no problems	✓	✓	
Frequently pass urine during the day			
Frequently pass urine overnight			
Sense of urgency when need to pass urine			
Urine retention			

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓	Name: 1908546042 Address: LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire DoB: 19/08/1954 CHI: G13 4NA Affix patient ID label
Haematuria			
Incontinent			

N.B. If new incontinence report to medical staff to rule out infection or physiological cause

What products do you normally use for this continence issue?

No urinary catheter ☐ Urinary catheter in situ: Urethral ☐ Suprapubic ☐

Date urinary catheter last changed ____/____/____

N.B. If Urinary Urethral Catheter (UCC) in situ commence NHSGGC Adult UCC Insertion and Maintenance Care Plan

Bowels

When did your bowels last move?

How often in a day/week do you have a bowel movement? Per day 6/7 Per week

Do you use any medication e.g. laxative to help your bowels move? Yes ☐ No ☐

Bowel Habit	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Regular			IBS CROHN'S
Constipated			
Diarrhoea / loose stools	✓	✓	
Blood in stools			
Incontinent			

What products do you normally use for this continence issue?

N.B. if concerned about bowel patterns (e.g. infrequent movement or frequent loose stools) consider using the Bristol Stool Chart

Stoma	Yes ✓	No ✓	Assessment of the patient's needs in relation to their stoma
Do you have a stoma?		✓	
Do you require assistance with your stoma care?			
Have you brought any of your stoma products with you?			

N: 
 Ac: 1908546042
 LOGAN F: _____
 — Georgina 19/08/1954
 — 17 SOLLAS PLACE
 — KNIGHTSWOOD
 D: Glasgow, Lanarkshire
 Cl: G13 4NA
 Afrix patient ID label

7. Personal Hygiene, Oral Health, Skin Care and Wound Care

Personal Hygiene	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's personal hygiene needs
Independent	✓	✓	
Requires assistance with washing and dressing			
Oral Health	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's oral health needs
No problems	✓	✓	
Sore mouth / mucositis / ulcer			
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)			
Dental work	Yes ✓	No ✓	Description of any dental work
Do you wear dentures?	✓		TOP SET
Do you have your dentures with you?	✓		
Are your dentures a good fit?	✓		
Do you have any other dental work that we need to be aware of?		✓	
Skin Care	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's skin care needs
No problems	✓	✓	
Skin broken			
Skin oedematous			
Skin discoloured / red			

N.B. Complete PUDRA for all patients within 8 hours of admission

Pressure ulcer identified on admission Yes ☐ No ☐ If yes, record on Pressure Ulcer Safety Cross
 Please describe location and grade of ulcer Refer to Tissue Viability Service (as appropriate)

Datix completed (if appropriate) Yes ☐ No ☐ Datix Ref. Number _____

Wound Care	Yes ✓	No ✓	Name: _____ Address: _____ 1908546042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire DoB: _____ CHI: _____ Affix: _____ 19/08/1954 G13 4NA
Do you have any wounds? N.B. If yes, complete an assessment chart for wound management		✓	

8. Mobility

Mobility	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's mobility needs
Fully mobile and independent	✓	✓	
Unsteady when walking			
Do you use a mobility aid	Yes ☐	No ☐	
Do you have your mobility aid with you?	Yes ☐	No ☐	

N.B. If not fully mobile and independent on admission complete moving and handling assessment within 24 hours of admission

9. Maintaining a Safe Environment

N.B. Complete a falls risk assessment for all patients within 24 hours of admission. If a falls risk is identified complete the falls intervention checklist and document all nursing actions in the care plan.

Safety	Yes ✓	No ✓	Assessment of the patient's ability to maintain a safe environment
Is the patient at risk of falling, rolling, slipping or sliding from the bed?		✓	
Would you like bedrails to be used while in hospital?		✓	

N.B. If yes, to either of the two questions above complete a bedrail risk assessment

10. Sleep and Rest

Sleep	Yes ✓	No ✓	Assessment of the patient's sleep and rest needs
Do you have any difficulties with sleeping?	✓		
Do you do or use anything to help you sleep?	✓		

SLEEPS 3 HRS PER NIGHT
DIAZEPAM

N.  1908546042

A: LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

19/08/1954

G13 4NA

Affix patient ID label

11. Social Circumstances

Do you:

- Live alone ☐
- Live in a nursing home ☐
- Live in residential supported care ☐
- Live in 'homeless' accommodation ☐
- Other please specify ☐
- Live with family/ friend/ other ☒
- Live in a care home ☐
- Live in student accommodation ☐
- Have no fixed abode ☐

Dependants

Yes
✓

No
✓

Do you have any dependants?

Do you support anyone (e.g. partner, children, relatives, animals)?

Do they need support from someone else whilst you are in hospital?

Would someone else be able to provide this support when you are in hospital?
If yes, who?

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

Services

Yes
✓

No
✓

Do you have support from social work, social services or a care package?

If yes, please provide details:

If yes, has contact been made to cancel arrangements during admission?

Informal Support

Yes
✓

No
✓

Do you have someone who looks after you or someone that helps you, i.e. an informal carer?

If yes, what do they do?

What involvement do you want them to have in your care while in hospital?

N.B. If the person who helps is not a preferred contact please ensure their details are listed below

If yes, has the help or support listed above been confirmed with the patient's informal carer

Required Support

Has the carer been advised of the Carers Information Line (provide carer information leaflet)?

Yes ☐ No ☐ Not appropriate at this time ☐

Are you:

Employed ☐ Self-employed ☐ Full Time Education ☐ Unemployed ☐ Retired ☐

Has your health had an impact on your ability to carry out your day to day activities at work?

Yes ☐ No ☐

Do you have any money worries? Yes ☐ No ☐ Not appropriate to ask at this time ☐

If yes would you like referred to a money advice service that can offer confidential advice/support?

Yes ☐ No ☐ If yes when was the patient referred ___/___/___

Would you like a referral to a service that can support you with employment/education/training/skills volunteering Yes ☐ No ☐ Not applicable ☐ Not appropriate to ask at this time ☐

If yes when was the patient referred ___/___/___

12. Person Centred Care

What do we need to know about you as a person to help give you the best possible care whilst in hospital? *no*

Do you have any anxieties or fears that staff should be aware of?

Yes ☐ No ☒

If yes, how can we support you with these?

no

N.B. Participating in 'What Matters to Me' should be offered to all patients

13. Emotional and Spiritual Care

Do you have a religion or beliefs that we can help you observe while you are in hospital?

C O F S

Is there anything else with regards to your values, religion or culture that we can support you with during your stay in hospital (e.g. prayer meditation)?

Would you like to talk to someone (e.g. Hospital Healthcare Chaplain) about you, your loved ones, your values and beliefs, or any worries you have? Yes ☐ No ☒

Healthcare Chaplain informed Yes ☐ N/A ☒

Name (Please PRINT): *D. PATERSON*

Signature: *D. Paterson*

Designation: *STAFF NURSE*

Date: *10/7/19*

Risk Assessments/Other Documentation

Name: _____
 Address: 1908546042
 — LOGAN F —
 — Georgina 19/08/1954 —
 DO: 17 SOLLAS PLACE
 CH: KNIGHTSWOOD
 CH: Glasgow, Lanarkshire
 Affi: _____ G13 4NA

Additional NHSGGC Documentation	Required		Required documents completed		Date, Print and Sign when completed
	Yes ✓	No ✓	Yes ✓	No ✓	
Glasgow Assessment and Management of Alcohol (GAMA)					
Generic Pain Scale Assessment Chart					
Abbey Pain Scale (if unable to self report pain)					
4AT and TIME for Detection, Management and Prevention of Delirium					
Getting to Know Me – Relatives to complete					
What Matters to Me					
Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)					
Malnutrition Universal Screening Tool (MUST)	✓		✓		10/7/19 <i>op</i>
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan					
Bristol Stool Chart					
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓		✓		10/7/19 <i>op</i>
Assessment Chart for Wound Management					
Moving and Handling Assessment					
Falls Risk Assessment	✓		✓		10/7/19 <i>op</i>
Bedrail Risk Assessment					

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
10/7/19 21.45.	Patient admitted to ARV2 from A&E with Chest pain attended this morning has discharged home then returned this evening Observations checked as per NEWS = <i>op</i> .	

Narr: 
 Add: 1908546042
 LOGAN
 Georgina F
 17 SOLLAS PLACE
 DoB KNIGHTSWOOD
 CHI Glasgow, Lanarkshire
 Affi: G13 4NA

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
	WJ	
10/7/19	Independently mobile	
21.50	Independent with ADL's.	
	Normal diet + fluids	
	passing urine freely	
	patient states bowel's.	
	Active 6/7 times per	
	day this normal for	
	patient, lbs, cramps	
	diverticulitis	
	Patient settled at present	
	awaiting medical review	Opateron OPATERON
11/7/19	for Analgesia	
3.30	repeat ECG	
	repeat Troponin	
	am home in morning	Opateron OPATERON
11/7/19	Patient required shorter	
06.40	for pain x1 overnight	
	Settled at time of writing	Opateron OPATERON
11.7.19	Independant with	
11.10	personal care. Normal	
	diet and fluids	
	Mobile to toilet independantly	
	Monitor BP as low	
	earlier while feeling	
	nauseous. PRN ondansetron	
	given. For discharge home	
	later.	Claire Bellish

Nam: 1908546042

Addr: LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

DoB:

CHI:

Affix patient ID label

19/08/1954

G13 4NA

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
11/7/19 13 ⁰⁵	Reviewed by Cardiology; ECG SR - D AF.	
	For 6C/D bed, antiemetic as required. Check DDimer.	
	Now on telemetry.	
	Had PRN Ondansetron.	
	Refusing cyclizine at present.	CLAIRE BELLIN
11/7/19 16 ⁰⁵	Bed available in 6D. NEWS=2, BP 90/60. PRN paracetamol and cyclizine given. 500mg of paracetamol given only at patients request. Telemetry continues. For inpatient ECHO	Claire BELLIN
1720	BP 95/58, news=2.	Claire BELLIN
11/7/19 1900	Transferred to Ward 6D tonight. Alert and orientated. Mobilising independantly on telemetry. Plan as per medical notes. Unable to obtain blood pressure at present.	S.ummisley
12/7/19 0050	Settled night so far. Independent with ADLs. Mobilising unaided. NEWS Stable, BP 110 systolic.	

Name: _____

At:  _____

1908546042

LOGAN

Georgina F

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G13 4NA

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
	Due medications given as prescribed.	
	Some medicines unavailable and have been ordered from pharmacy.	
	No nausea or vomiting tonight.	
	Communicates needs well to staff.	
	States she has no elimination issues.	
	Telemetry - monitoring in Sinus Rhythm	
	No complaints voiced. Has PVC in place due to previous vomiting - VIO.	HEATHER MANN
15/5	② Showered independently ③ Recording stable - Telemetry discontinued ④ Communicates needs well ⑤ Mobile to toilet passing urine ⑥ Diet and fluids accepted well ⑦ Uncomplaining ⑧ Mobile unaided ⑨ Charging air positum pressure area undamaged.	Heather Mann
13/7/19 0445	All care given as planned observation stable, mobile - independent. Medication taken as per orders Telemetry diet fluid OK No issues with @ medication kept well over night no concerns	P.T.O

NHSGGC Bedrail Risk Assessment

This Risk Assessment Tool is an aide memoire for staff. It should be used in conjunction with the Bedrail Guidance (see reverse) and Guidelines for Falls Prevention and Management (Adults).

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT



1908546042 F

LOGAN Georgina 19/08/1954

17 SOLLAS PLACE KNIGHTSWOOD

Glasgow, Lanarkshire



Patient Name

CHI Number

G13 4NA

Use guidance on the reverse of this document when completing this Risk Assessment

DATE 11/07/19
TIME 1815
WARD 6D
HOSPITAL QEUI-1

SECTION ONE - GENERAL

		Y	N	Y	N	Y	N	Y	N
1	Is the patient likely to fall, roll, slip or slide from the bed?								
2	Has the patient requested the use of bedrails?								

IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED

SECTION TWO - COGNITIVE AND PHYSICAL STATUS

3	Is the patient at risk of climbing out of bed?								
4	Is the patient stressed, delirious or restless?								
5	Is the patient small in stature?								
6	Does the patient have an unusually large or small head that might present an entrapment issue?								
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?								

IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE - See Guidance overleaf

SECTION THREE - COMMUNICATION

8	Has the patient been consulted regarding the use of bedrails?								
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition								
10	Has the use of bedrails been discussed with relatives/carers?								
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?								
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?								

IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE - See Guidance overleaf

SECTION FOUR - DECISION MAKING

		Y	N	Y	N	Y	N	Y	N
13	Will bedrails be used for this patient at the present time?								
14	Rationale for use of bedrails: (Please insert code in the box on the right)								
	A - Risk of falling from the bed								
	B - Risk of rolling from the bed								
	C - Risk of slipping from the bed								
	D - Risk of sliding from the bed								
	E - Patient request								
15	Bedrail risk assessment completed by:								
16	Bedrails checked by:								
17	Date								

Any issues relating to the use of bedrails including discussion with family/relatives/carers should be recorded here

A. Alternatives to bed rails:-

- Move the patient to a more observable area
- Increase patient observation
- Ensure the bed is returned to the lowest height appropriate to the patient needs; after care delivery
- Ensure patient needs are anticipated e.g. drinks are accessible, regular toileting, call bell to hand
- Nursing patient on mattress on the floor should be the last resort, and safety checks should be made for hot pipes, trailing wires, electrical sockets etc
- A generic moving and handling assessment must be carried out for staff caring for patients nursed on mattress on the floor.
- Contact Hospital Falls team for advice where appropriate

C. Safe use and application of bedrails:-

- If bedrail is fitted and there is a gap between the lower rail and the mattress then a bedrail should not be used
- If the gap between the bars on the bedrail is greater than 12cm then a bedrail should not be used
- If the bedrail moves away from the side of the mattress then a bedrail should not be used
- If the gap between the bedrail and the headboard is between 6cm and 25cm then a bedrail should not be used
- If the gap between the bedrail and the footboard is between 6cm and 25cm then a bedrail should not be used
- If the bedrail has not been fitted correctly then the bedrail should not be used
- If the bedrail is not secure then the bedrail should not be used
- If the bedrail is not compatible with the frame it will be fitted to then a bedrail should not be used
- If the bedrail is not in good working order then the bedrail should not be used

**B. If bedrails are to be used, please consider the following:-
Is patient:-**

- Stressed, delirious or restless
- At risk of entrapment
- At risk of climbing over the top of the bed-rail
- At risk of being psychologically affected by the use of the bed rail

D. Record keeping:-**All of the following should be recorded:-**

- Date and time of assessment
- Bedrail information leaflet given to patient and/or next of kin
- Rationale for decision in care plan or in AWI treatment plan
- Where bedrails are considered appropriate and patient has declined their use
- Any other actions implemented
- Care planning should be reviewed and updated as per record keeping standards

Bedrail risk assessments should be made as follows:-

- On admission
- If patient's condition changes or fall / suspected fall from bed
- Daily/weekly depending on the patient's status

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 LOGAN
 Georgina
 17 SOLLAS PLACE
 KNIGHTSWOOD
 Glasgow, Lanarkshire
 G13 4NA
 19/08/1954
 F

Care Plan

Care discussed with patient Unable		☒ Yes ☐ No ☐	If unable, give reason:		
Care discussed with family Unable		☐ Yes ☐ No ☐	If unable, give reason:		
Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
10/7/19 Sp	observations: as per news known asthma known AF				
			10/7/19 Sp	5. Hydration and Nutrition normal diet + fluids	
10/7/19 Sp	2, 3. Communication and senses Communicates freely wears glasses distance + Reading				
10/7/19 Sp	4. Cognitive status Alert + orientated		10/7/19 Sp	6. Elimination Independent	



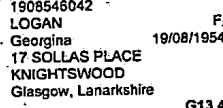
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Glasgow, Lanarkshire
G13 4NA

Care Plan

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
10/7/19 ep	Independent		10/7/19 ep	Nurse Call system in place	
	No skin checks as per plan.				
			10/7/19 ep	10. Sleep and Rest	
				promote peaceful environment	
10/7/19 ep	8. Mobility				
	Independent		10/7/19 ep	12. Privacy, dignity and sexuality	
				maintain at all times	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

Date: 12/07/19

Attach Add



NHS
Greater Glasgow
and Clyde

Ward:

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

[illegible]

Date: 11/7/19

Georgina Logan
1908546042

ARUZ

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

NHS
Greater Glasgow
and Clyde

1. Signed W. Paterson Name D. PATERSON Designation SN.
2. Signed C. Bell Name CLAUDE BELL Designation SN.
3. Signed Heather McLean Name H. McLEAN Designation S

Y = Yes · N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

[illegible]

Date: 10/7/19

Attach Address  1908546042
LOGAN
Georgina
17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire
F
19/08/1954
Ward:
ARUZ
G13 4N

NHS
Greater Glasgow
and Clyde

Ward: ARUZ Glasgow, Lanarkshire G13 4N

NO THANKS.

Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

[illegible]

Date: 13/07/19

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (please circle) 1hr 2hr 3hr 4hr

1. Signed [Signature] Name Lyella Kirul Designation SN
2. Signed [Signature] Name [Signature] Designation 5
3. Signed _____ Name _____ Designation _____

USE FOLLOWING CODES:

Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

Attach Addressog



1908546042
LOGAN
Georgina

19/08/1954

NHS
Greater Glasgow
and Clyde

Ward: 60

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

[illegible]

This form should be stored at the front of the patient's nursing notes during the period of admission and then filed on discharge.



1908546042
LOGAN
Georgia
17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire
19/08/1955
G13 4NA

Hospital: QEH Ward: 6D

[illegible]

Staff Codes: **N** – Nursing. **M** – Medical. **P** – Physiotherapist. **OT** – Occupational Therapist. **V** – Social Worker. **SLT** – Speech and Language Therapist. **D** – Dietician. **O** – Other.

Carers Information Line: 0141 353 6504
NHSGGC Support & Information Services: 0141 452 2387

Discharge Checklist

Patient: 1908546042 F
 Uni: LOGAN 19/08/1954
 CHI: Georgina
 17 SOLLAS PLACE
 KNIGHTSWOOD
 Glasgow, Lanarkshire G13 4NA

Apply addressograph label

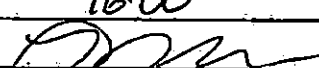
Ward: 60

Discharge destination: Home

Estimated Discharge Date (1) 13 / 7 / 19

Estimated Discharge Date (2) / /

Final date of discharge: 13 / 7 / 19

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓		AM	
Relative/carer informed	✓		AM	
Others informed: Care Home		✓	AM	
Transport arranged				
Own transport (preferred option)	✓		AM	
Ambulance-1 man/ 2 man am/pm		✓	AM	
Other: Flight, Air ambulance etc.		✓	AM	
Discharge medication				
Discharge prescription completed	✓		AM	
Compliance aids e.g. Dosette Box (involve pharmacist)		✓	AM	
Medication received	✓		AM	
Medication explained to patient and/or relative/carer	✓		AM	
Own medication returned to patient		✓	AM	
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)		✓	AM	
Informed of discharge				
Social work/ Other agencies/Home help		✓	AM	
Physiotherapist		✓	AM	
Occupational Therapist		✓	AM	
Dietician		✓	AM	
Speech and Language Therapist		✓	AM	
Clinical Nurse specialist e.g. Care Home Liaison		✓	AM	
Liaison/ District Nurse/Practice Nurse		✓	AM	
Other discharge items				
Access arrangements (e.g. keys, door entry)	✓		AM	
Patients clothing available for day of discharge	✓		AM	
Valuables e.g. cashier		✓	AM	
Intravenous cannula removed		✓	AM	
Equipment ordered (inc. walking aids) in place for discharge		✓	AM	
Part 2 Discharge letter - Required		✓	AM	
- Completed		✓	AM	
Out patient clinic appointment e.g. Anticoagulation clinic				
Arranged / To follow	✓		AM	SEE FDL
If unknown at time of discharge state reason		✓	AM	
Additional information / leaflets / factsheets		✓	AM	
Time of Discharge: 1600				
Nurse's signature: 				
Designation: 5				Date: 13 / 7 / 19

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Glasgow, Lanarkshire
19/08/1954
G13 4NA

FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs of Admission
and on Transfer to Another Ward



GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

Action the following safety precautions on admission to your ward.
Update weekly or on change of condition.

	Ward: <u>ARU2</u> Date: <u>10/7/19</u> Time: <u>21:10</u>	Ward: <u>GD</u> Date: <u>11/07/19</u> Time: <u>18:10</u>	Ward: _____ Date: _____ Time: _____	Ward: _____ Date: _____ Time: _____	Ward: _____ Date: _____ Time: _____
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	<u>Yes</u>	<u>✓</u>			
2. Check walking aid (if required) is in reach and in use.	<u>NA</u>	<u>NA</u>			
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	<u>Yes</u>	<u>✓</u>			
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	<u>Yes</u>	<u>✓</u>			
5. If glasses are worn, check they are available and in use.	<u>Yes</u>	<u>✓</u>			
6. If hearing aid/s are worn, check they are working and in use.	<u>NA</u>	<u>NA</u>			

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).

Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.

****ALL patients in older people's wards must have an interventional plan in place (overleaf)****

	Tick Yes or No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has the patient fallen in the last 6 months – including during this admission?	☒	☒		☒							
2. Does the patient have cognitive impairment or a possible delirium?			☒		☒						
3. Does the patient attempt to walk alone although unsteady or unsafe?			☒		☒						
4. Does the patient or their relative have a fear or anxiety of the patient falling?			☒		☒						
5. Based on your clinical judgement, is this patient at high risk of falling?			☒		☒						
Signature of nurse completing assessment / update		<u>Georgina</u>		<u>50</u>							
		<u>17/7/19</u>									

Highlight risk of fall at the ward safety brief.

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Georgina
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Glasgow, Lanarkshire
19/08/1954

FALLS INTERVENTION CHECKLIST



G13 4NA Complete for all patients identified at risk of falling.

Ward: <u>ARV2</u>	Ward: <u>6D</u>	Ward: _____	Ward: _____	Ward: _____
Date: <u>14/11</u>	Date: <u>11/11/19</u>	Date: _____	Date: _____	Date: _____
Time: <u>12:15</u>	Time: <u>18:10</u>	Time: _____	Time: _____	Time: _____

BED AND SEATING					
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)	✓	✓			
Assess if a low bed is required (Patient care plan 9)	NA	NA			
SAFETY					
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)	✓	✓			
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)		NA			
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.		NA			
HEALTH					
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)		NA			
Document continence problems and link to care rounding (Patient care plan 6)		NA			
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)		NA			
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.		✓			
COMMUNICATION					
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)		✓			
Update the ward team of the patient's mobility status. (Patient care plan 8)		✓			
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)		NA			
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)		NA			
Signature of nurse completing interventional plan / or update		SL			

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team
EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN



LOGAN

Georgina

17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire

19/08/1954

G13 4N

Moving and Handling Assessment Form

Continuation Sheet

1. General Information (Only complete this section if changed from over page)									
Body Build			Problems with comprehension, behaviour, co-operation (specify):						
Weight		Height							
Kg		cm	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):						
BMI									
Risk of Falls: Yes ☐ No ☐									
2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)									
Hoist	Standaid	Walking Aid	Assistance			Supervision		Independent	
Model:		Aid Type	People: 1	2	>3	Additional Information / Equipment:			
Sling type									
Sling Size									
3. Toileting									
Hoist	Standaid	Walking Aid	Assistance			Supervision		Independent	
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1	2	>3	Additional Information:			
4. Move on / off bed pan									
Hoist	Manoeuvre	Assistance			Supervision		N/A		
See No 2 Sit to Stand Transfers for details		Roll patient	People: 1	2	>3	Additional Information:			
		Monkey pole							
		Person bridges							
5. Move up / down bed									
Hoist	Handling Aids	Assistance			Supervision		Independent		
See No 2 Sit to Stand Transfers for details		Sliding sheets	People: 1	2	>3	Additional Information:			
		Monkey pole							
		Rope ladder							
6. Lateral Transfer to / from trolley / bed									
Hoist	Handling Aids	Assistance			Supervision		Independent		
See No 2 Sit to Stand Transfers for details		Rigid Transfer Board	People: 1	2	>3	Additional Information / Equipment (eg sliding sheets):			
		Other (Please specify)							
7. Sit up over side of bed									
Bed Rest		Assistance			Supervision		Independent		
		People: 1	2	>3	Additional Information / Equipment (eg rope ladder, swivel cushion):				
8. Into Bath or Shower									
Equipment	Handling Aid	Assistance			Supervision		Independent		
Shower	Shower chair	People: 1	2	>3	Additional Information / Equipment (eg sling lifting hoist after risk assess):				
Variable / Fixed height bath	Shower trolley								
Bed bath	Bathing hoist (eg Alend)								
9. Walking									
No Walking	Walking Aid	Assistance			Supervision		Independent		
see 'sit to stand transfers'		People: 1	2	>3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)				
10. Other Instructions / Observations / Equipment Used									
		4 th Assessment		5 th Assessment		6 th Assessment			
Recording Symbol:		/ Forward slash		X Where a forward slash exists, add a back slash to make a cross		* Where a slash or cross exists add slashes to make a star			
Date Assessed:									
Assessor's signature:									
Proposed Review date:									



1808546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

19/08/1954

G13 4N

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS

 Greater Glasgow
and Clyde

Date <u>07/19</u> Time <u>21.20</u> of initial height and weight on admission to hospital,	Actual	* Patient reported	* If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
---	--------	--------------------	--

Admission Height	<u>150</u> cm	☐	☒
Admission Weight	<u>71</u> Kg	☐	☐

* Obtain accurate height/weight and rescreen as soon as possible

Patients reported normal weight _____ Unable to Recall ☐

Any unplanned weight loss in the last 6 months Yes ☐ how much _____ No ☐ Don't Know ☐

Date	<u>10/7/19</u>	<u>13/7/19</u>						
Time	<u>12.30</u>	<u>15.00</u>						
Ward	<u>PRU2</u>	<u>6D</u>						
Oedema/ Ascites present Y/N	<u>N</u>	<u>N</u>						
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes		<u>CH</u>						
Weight (kgs)	<u>71</u>							
BMI	<u>32</u>							

Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days

Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	<u>0</u>							
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	<u>0</u>							
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	<u>0</u>							
Step 4 Overall Risk of Malnutrition TOTAL	<u>0</u>							
Rescreen on	<u>11/11/19</u>							
Signature	<u>[Signature]</u>							

Step 5 Management Guidelines (excludes patients who are Nil by Mouth)	
Overall Risk of Malnutrition	Ensure plan of care for specific nutritional requirements, MUST score and plans to improve / increase nutritional intake are documented in the patients care plan
0	LOW RISK - Repeat screening every 7 days
1	MEDIUM RISK - Follow the flowchart for MUST 1 overleaf
2 or greater	HIGH RISK - Follow the flowchart for MUST 2 or greater overleaf

NEWS – National Early Warning Score



Name	G. Logan
Address	APTIX
CHI No.	PATIENT
DoB	ID

	Date	Ward
Admitted		
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8	92-93 Yes	9-11	12-20		21-24	≥25
Oxygen Saturations	≤91		94-95	≥96			
Any Supplemental Oxygen				No			
Temperature	≤35.0°	91-100	35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1° 111-130	
Pulse	≤40		41-50	51-90	91-110		≥131
Systolic BP	≤90		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.

60

DATE: 10/7/19																DATE:		NEW!					
TIME: 0500		0600	0700	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	TIME:	0	1	
Resp. Rate Mark: •	35																				35		
	30																				30		
	25																				25		
	20																				20		
SpO ₂ (Enter Value)	≥96	96	97	98	98	98	98	96	96	99	95	96	96	96	95	96	96	98	96		≥96		
	94-95																				94-95		
	92-93																				92-93		
	≤91																				≤91		
Any Sup'l O ₂ Room air	%																			%			
Temp. Mark: X	39.0																				39.0		
	38.5																				38.5		
	38.0																				38.0		
	37.5																				37.5		
Pulse Mark: •	37.0																				37.0		
	36.5																				36.5		
	36.0																				36.0		
	35.5																				35.5		
Blood pressure Mark: ◇	35.0																				35.0		
	35.0																				35.0		
	35.0																				35.0		
	35.0																				35.0		
NEWS SCORE using Systolic BP	170																				170		
	160																				160		
	150																				150		
	140																				140		
Conscious Level Mark: •	130																				130		
	120																				120		
	110																				110		
	100																				100		
Total NEWS (with all obs)	90																				90		
	80																				80		
	70																				70		
	60																				60		
Pain Nausea Urine output	50																				50		
	40																				40		
	30																				30		
	20																				20		
Obs due Initials	10																				10		
	9																				9		
	8																				8		
	7																				7		

KEY																		DATE
2	3																	TIME
35																		35
30																		30
25																		25
20																		20
16																		16
12																		12
8																		8
≥ 96	91																	≥ 96
94-95																		94-95
92-93																		92-93
≤ 91																		≤ 91
%																		%
39°	RA																	39°
38.5°																		38.5°
38°																		38°
37.5°																		37.5°
37°																		37°
36.5°	X																	36.5°
36°																		36°
35.5°																		35.5°
35°																		35°
170																		170
160																		160
150																		150
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190																		190
180																		180
170																		170
160																		160
150																		150
140																		140
130																		130
120	110																	120
110	A																	110
100																		100
90																		90
80																		80
70	V																	70
60	72																	60
50																		50
Alert																		Alert
Verbal																		Verbal
Pain																		Pain
Unresp																		Unresp
NEWS SCORE	1																	NEWS SCORE
BM																		BM
Pain	0																	Pain
Nausea	0																	Nausea
Uri	put																	U/O
Obs due	1000																	Obs due
Initials	MM																	Initials

Adult



Write or affix patient label

In:

1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

19/08/1954

Name:

CHI:

DOB:

Address:

Ward:

Hospital:



Please complete this section at time of insertion.

Intrava: **G13 4NA** in increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☐ Resuscitation/Chest Pain ☐ IV Drugs ☐ Fluids ☐ Transfusion ☐

PVC inserted: Day 0	Date: <u>11/07/19</u>	Hospital: <u>GEUH</u>
	Area: ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☒ <u>ARU</u> Unknown ☐	
Insertion site:	R Hand ☐ R Arm ☐ R Foot ☐ L Hand ☐ L Arm ☒ L Foot ☐ Other: _____	
Colour of cannula:	Blue ☐ Pink ☐ Green ☐ White ☐ Grey ☐ Orange ☐	
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: _____	

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? Diagnostics Resuscitation/ Chest Pain IV Drugs Fluids Transfusion	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day <u>12/7/19</u>	Yes ☒ No ☐ If No, remove PVC and record date and reason*.	VIP: <u>0</u>	Yes ☒ No ☐	Yes ☒ No ☐ N/A ☐	<u>CS</u>
Day 1 Check 2 Night ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: 12/7/19

Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: 12/7/19*Reason For Removal: Not Required

Modified Visual Infusion Phlebitis (VIP) Score

Modified V.I.P (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phlebitis : Observe cannula
One of the following is evident : slight pain or redness near site	1	Possible first signs : Observe cannula
Two or more of the following are evident: pain, redness, swelling	2	Early stage of phlebitis : Remove & resite cannula
All of the following are evident: pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: Remove & resite cannula
As above including: palpable venous cord	4	Seek further advice
As above including: pyrexia	5	

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and *S. aureus* bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → Can I switch my patient from IV to oral antibiotics?

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature $\leq 37.9^{\circ}\text{C}$, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE** is available reliably (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, *S. aureus* bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abscess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy. Record the intended duration on the medicine kardex

YES

NO

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

Pressure Ulcer Daily Risk Assessment (PUDRA)

 1908546042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire	Hospital: QUEVH	Points to consider: • Use within 6 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes
	Ward: ARU2	

G13 4NA

1 Pressure Damage NO	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
10/7/19	22:00	NO	NO	NO	NO	NO	NO	4 hrly	[Signature]
11/7/19	00:00	N	N	N	N	N	N	4 hrly	[Signature]
12/7/19	01:00	N	N	N	N	N	N	4 hrly	[Signature]
12/7/19	09:00	N	N	N	N	N	N	12 hrly	[Signature]
13/07/19	00:00	N	N	N	N	N	N	12 hrly	[Signature]
/ /	:							__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 Interventior Plan



Aim: To incorporate effective pressure ulcer prevention strategies to reduce/eliminate potential for pressure ulcer development.

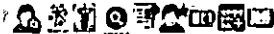
Outcome: To prevent pressure ulcer development through establishment of effecting work practices in line with SSKINS bundle.

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 <u>4</u> hourly. • Skin under medical devices <u>4</u> hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition <u>4</u> hourly in bed and chair. • Overnight patient / carer has agreed to repositioning <u>4</u> hourly • Specify any manual handling equipment used:	• Skin care to be carried out <u>4</u> 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: 11/7/19	Check: • Pressure areas <u>4</u> hourly. • Skin under medical devices <u>4</u> hourly. • Specify medical devices used:	Specify: • Mattress: <u>Soft foam</u> • Cushion: • Detail additional pressure redistributing equipment:	• Reposition <u>4</u> hourly in bed and chair. • Overnight patient / carer has agreed to repositioning <u>4</u> hourly • Specify any manual handling equipment used:	• Skin care to be carried out <u>4</u> 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: 12/7/19
Date Reviewed: 12/7/19	Check: • Pressure areas <u>12</u> hourly. • Skin under medical devices <u>12</u> hourly. • Specify medical devices used:	Specify: • Mattress: <u>Soft foam</u> • Cushion: <u>Nil</u> • Detail additional pressure redistributing equipment:	• Reposition <u>1</u> hourly in bed and chair. • Overnight patient / carer has agreed to repositioning <u>1</u> hourly • Specify any manual handling equipment used:	• Skin care to be carried out <u>1</u> 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:

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CHI: 1908546042 Name: Georgina Logan Gender: Female DOB: 19/08/1954 Age: 64 Yrs Phone: 01419523728



WARD PATIENT TRANSFER DOCUMENT

Diagnosis	Chest pain Troponin negative
Relevant Medical History	IBS Diverticulitis Crohn's Angina Chronic Back Pain Asthma Decompression of spinal cord cholecystectomy
Current Treatments	likely home S/E CARDIOLOGY FOR TELEMETRY B CIMA ANTIEMETIC START ELNADAN 12/07019 FCHO
Any Outstanding/Planned Investigations	
NEWS Score	0
	- Aggregate 0 - Aggregate 1-4 - Aggregate ≥5 or 3 in one parameter - Aggregate 7 or more
Is the patient on oxygen?	No
Is there DNACPR in place	No
Allergies/Alerts	timaroprim GLAIF
Please state any communication issues	None
4AT	0
	4 or above possible delirium +/- cognitive impairment 1-3 possible cognitive impairment 0 delirium or severe cognitive impairment unlikely
Behavioural issues	
Is the patient exhibiting risk taking behaviours?	No
Is the patient a falls risk?	No
Skin Assessment	

CHI: 1908545042	Name: <u>Georgia Logan</u>	Gender: Female	DOB: 19/08/1954	Age: 64 Yrs	Phone: 01419523728	
STOPSS (Has STOPSS been done?)						
Have all the required risk assessments been completed? (e.g. MUST)	Yes					
Fasting	No					
Special Diet/Nutrition	normal diet & fluids					
Patient infection	No					
Any other relevant information						
Is the patient included in criteria for discharge						
EDD Date	12/07/2019					
NOX informed of transfer						
User	Lynn Brown					
Contact telephone number	82350					

Update

Print

[Audit Trail](#)

Last Update User: Patricia Connelly
Last Update Date: 11/07/2019
Last Update Time: 11:49

Gartnavel Day Surgery Unit

LOCAL ANAESTHETICS



Please tick appropriate box

Minor surgery	☒
Hand surgery	☐
Urology	☒
Chronic pain	☐
Allergies (Write in red)	☐ NKA

BOOKLET FOR DAY PROCEDURES CONFIDENTIAL PATIENT INFORMATION

Name	
Address	AFFIX PATIENT
	
	1908546042
	LOGAN
	Georgina
	17 SOLLAS PLACE
	KNIGHTSWOOD
	Glasgow, Lanarkshire
Hosp. No.	
	19/08/1954 F
	D.C.B
	G13 4NA

Procedure Appointment Date

6/8/18

Time

0800

Consultant

Dr C. Cairns

Consultant C. Carrns Named Nurse [Signature]
Proposed procedure hump
Next of kin Husband George Telephone number 07
Escort Taxi

Pre-procedure check

Case notes Yes ☒ No ☐

Name band Yes ☒ No ☐

Hand surgery patients only

Hand to be operated

Left ☐ Right ☐

Have rings been removed if required?

Yes ☐ No ☐ N/A ☐

Past medical history

	Yes	No	Specify
Allergies	☐	☒	
Diabetes	☐	☒	
Breathing problems	☒	☐	<u>Asthma - 3 wks since last attack</u>
Epilepsy	☐	☒	
Heart condition	☒	☐	<u>Angina - 9th Nov</u>
Hypertension	☐	☒	
Any action required if patient for future GA? Yes ☐ No ☐			
Any other serious illness?	☒	☐	<u>Chronic, IRS</u>
Medication	☒	☐	<u>Takes many meds - see script in notes</u>
Other problems	☐	☒	

Pre-operative observations B/P 115/78 P 76 SAOs 97%

Signature of Admitting Nurse [Signature]

Comments _____

Post-operative instructions _____
 SK Cairns gave patient post-operative instructions

KEY: B.P. III
PULSE AA
RESP XXX

Discrepancy _____ Surgeon's signature _____

Drugs to be given in hospital

Date	Drug Name	Dose	Route	Frequency	Times of administration	Doctor's Signature
Nurse record of administration				Sign Box		

Date	Drug Name	Dose	Route	Frequency	Times of administration	Doctor's Signature
Nurse record of administration				Sign Box		

Post-operative progress

Patient stated feels well
for discharge. Obs: BP 92/75 mmHg
P- 71
SpO2 - 96%

Discharge drugs

Date	Name of Drug	Strength	Quantity	Doctor's Signature	Nurse's Signature

Does patient require...

Out patient appointment?

Yes ☐

No ☒

Date _____

Details _____

To visit practice nurse?

Yes ☐

No ☒

Details _____

Discharged at

10.10hrs

Accompanied by _____

Discharge information received by patient (please sign)

Signature of discharge nurse

F. Madge

Additional Questionnaire		For use with Local Anaesthetic perioperative care plan	
CJD question	Yes	No	
Have you ever been notified that you are at an increased risk of CJD or vCJD?		☒	If answered 'Yes' please inform theatre staff / Infection control and comment as required
Consent	Yes	No	Comment as required
Consent / Incapacity (circle)			
Signed & Dated			
Checked against theatre list			
Check with:			
Patient /Incapacity /Consent (circle)			
Procedure and site for surgery			
Consent site marked			
Comments & details e.g Welfare Guardian/ Power of Attorney			
Cognitive Impairment			
For all patients 65years and over, ask the following 4 AMT questions:			
1. How old are you?.....years			
2. What is your date of birth? / /			
3. What is this place?.....			
4. What year is it?.....			
If the patient does not answer all questions correctly then refer to medical staff.			
AMT Score:.....out of 4			
Name of Doctor informed (if required)			
			Grade.....

Nursing Admission & Assessment

1. Admission



Hospital: <u>Qent</u>	Ward: <u>AR03</u>
Date of admission: <u>28/5/16</u>	Time: <u>0100</u>
Admitting Consultant: <u>Dr. Morris</u>	Admitting Nurse: <u>SN McAlister</u>
Expected date of discharge: <u>1 / 1</u>	

Nz		
Ad	1908546042	
....	LOGAN	F
Do	Georgina	19/08/1954
CH	17 SOLLAS PLACE	
	KNIGHTSWOOD	
	Glasgow, Lanarkshire	
	G13 4NA	

1. Patient Details

Preferred name: <u>GINA</u>	Next of Kin (NoK): <u>George</u>
Age: <u>61</u>	Relationship: <u>HUSBAND</u>
Religion:	NoK Address:
Telephone:	<u>NA</u>
GP: <u>Dr. PJ Weir</u> <u>Victoria Park Medical Practice</u>	NoK Telephone: <u>07774400790</u>
GP address: <u>1398 Dumbarton Road</u> <u>Glasgow</u> <u>G14 9DS</u>	NoK Aware of admission: ☒ Yes ☐ No
	Consent for information to be given to relatives: ☒ Yes ☐ No
	Nominated family contact:
GP telephone: <u>08444 773318</u>	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 'No' to 'b' please inform medical staff. Name of doctor informed:

2. Presenting Complaint / Diagnosis

ABDO PAIN
LOOSE STOOLS
Why does the patient think they are in hospital? Use patients own words:

3. Allergies (including food allergies)

No known allergies: ☒ LATEX ALLERGY

4. Observations

Cannard	Waterlow	MUST	Pulse	BP	Resp	SaO ₂	Temp
	<u>PADRA</u>	<u>0</u>	<u>68</u>	<u>106/68</u>	<u>18</u>	<u>93% (A)</u>	<u>36.8</u>
Urinalysis:	AMT4 Score	BM	NEWS Score	Weight Estimated / Actual	Height Estimated / Actual	BMI	
<u>REQ</u>	<u>NA</u>	<u>NA</u>	<u>3</u>	<u>10stone 8</u>	<u>4ft 11</u>		

5. Current Medication

6. Relevant Past Medical History

Medicines reconciled on admission? ☒ Yes ☐ No	<u>ASTHMA</u> <u>CHRONIC BACK PAIN</u>
--	---

7. Risk Assessment

MUST

- Is the patient's BMI:
 > 20 Score 0
 18.5-20 Score 1
 <18.5 Score 2
 Score 0
- Has the patient had unplanned weight loss in the past 3-6 months?
 < 5% Score 0
 5-10% Score 1
 >10% Score 2
 Score 0
- 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 0

MUST Score: 0

If score 1 or more, complete full Nutrition Profile

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 KNIGHTSWOOD
 CHI Glasgow, Lanarkshire
 G13 4NA

8. Cognitive Impairment

For all patients ≥ 65 years, ask the following 4 AMT questions:

- How old are you? years
- What is your date of birth? / /
- What is this place?
- What year is it?

If the patient does not answer all questions correctly then refer to medical staff.

AMT Score: out of 4

Name of Doctor informed (if required)

Grade:

9. MRSA Screening / CJD / Healthcare outside Scotland

Will the patient be an inpatient >23 hours? ☒ Yes ☐ No If 'Yes' complete the following section.

- Has the patient ever had a previous positive MRSA result? ☐ Yes ☐ No ☒ Not known
- Has the patient been admitted from a Care Home/ institutional setting or another hospital? ☐ Yes ☒ No ☐ Not known
- 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:

Does the patient smoke? ☐ Yes ☒ No

If 'Yes' how many per day:

Does the patient use nicotine replacement therapy? ☐ Yes ☐ No

Does the patient wish referral to Smoking Cessation Service?

☐ Yes ☐ No If 'Yes', date of referral: / /

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): Vmealyse

Signature: W

Designation: SW

Date: 26/5/16

Nursing Admission & Assessment

2. Assessment

Hospital: <u>Geff</u>	Ward: <u>ARW3</u>
Date of Assessment: <u>28/5/15</u>	Time: <u>0100</u>

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A-1908546042	LOGAN	F
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C	KNIGHTSWOOD	
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1. Breathing and Circulation

Breathing:

- ☒ 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:

- ☒ No symptoms
☐ Known cardiac or circulatory problems

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial

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2. Communication

Assessment of ability to communicate:

What language does the patient speak?

ENGLISHInterpreter: Required ☐ Not required ☐

If required, provide details and arrangement made:

Does the patient have:

- a. Speech difficulties? ☐ Yes ☒ No
 b. A learning disability e.g. Down's Syndrome?
☐ Yes ☒ No

If 'Yes' please specify:

If 'Yes' contact Liaison Learning Disability Team.

Liaison Learning Disability Team contacted:

☐ Yes ☒ No

c. A learning difficulty e.g. dyslexia, dyspraxia?

☐ Yes ☒ No

If 'Yes' please specify:

3. Senses

Senses:

Eyesight

- ☐ Normal vision
☒ Glasses - ☐ Distance ☒ Reading
☐ Prosthesis - ☐ Left ☐ Right
☐ Contact lenses
☐ Registered blind

Hearing

- ☒ Normal
☐ Hearing impaired
☐ Hearing aid - ☐ Left ☐ Right

4. Mental Status

Mental Status:

- ☒ Orientated
☐ Confused
☐ Distressed
☐ Aggressive / Abusive
☐ Unconscious

Problem identified: ☐ Yes ☒ No If 'Yes' please describe

Initial

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5. Hydration and Nutrition

MUST Score: 0 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:

NO DAIRY

5a 2. Fluid likes / dislikes:

NIL

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

W

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' - 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

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	G13 4NA	

7. Personal Hygiene, Oral Health and Skin Assessment

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) and implement Oral Care Bundle.

Oral Hygiene Care Bundle:

☐ Required ☒ Not required

Dentures:

☐ Not worn

☒ Upper set

☐ Lower set

☐ Full 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

Initial

8. Mobility

Patient fully mobile / independent? ☐ Yes ☐ No If 'No' complete Moving and Handling Assessment.

☐ Limited mobility

☒ Mobile with aid – Specify: *stick*

☐ 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

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10 Sleep and Rest**Sleep habits:**

- ☐ Less than 8 hours ☐ Afternoon nap
☐ Morning nap

Sleep difficulties:

- ☒ None ☐ Disturbed
☐ Early waking e.g. nocturia, insomnia

Medication required: ☐ Yes ☒ No

Problem identified: ☐ Yes ☒ No If 'Yes' please describe

Initial

Name



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Georgina

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11 Social Circumstances

- ☐ Employed ☐ Unemployed ☒ Retired
☐ Lives alone
☒ Lives with Family
☐ Friend
☐ Dependants
☐ Other: ☐ Nursing Home ☐ Residential

Current Care / Support arrangements:

- ☐ Social Services ☐ Unpaid carer e.g. family, friends
☐ Private Carers ☒ None

If support services in place, please provide details:

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 ☒

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): Unasue

Signature: Unasue

Designation: SN

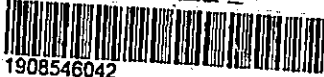
Date: 26/8/16

Clinical Notes

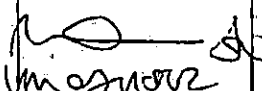
Date and Time	Notes	Name, Signature and Designation
0105 26/8/16	Admitted to A&E for A&E with hx of over 100 runs from A&E	
	Blue verfla, poor access	
	Washed off trolley and to toilet	
	News 3. Hypertension 108/68	
	SpO2 93% on air the stable	
	Appraisal: fluids no diet	
	Awaits medical to clerk in	
	No diarrhoea as yet	<u>Unasue</u>
	Barrier nursed, precautions taken	
0700	Spk for long spells	
	Mobate to toilet no diarrhoea	
	News 4 this m. Hypertension	
	96/77, SpO2 93% on air. Appraisal	

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Clinical Notes continue on next page

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Add	1908546042	
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Clinical Notes (continued)

Date and Time	Notes	Name, Signature and Designation
	W continue, however behind time due to small l/c in hand	
	Revised by medic on not convinced of acute issue	
	Patient was sleepy, however as soon as medic entered room clc abdo	
	pain and was guarding her stomach ? home with af follow up.	
	For stool culture, chart. For buscopan PRN	 Mason
26/5/16	Wash independently. Mobile,	
SSN		
1120	has voided urine, complains bawels. small hard stool.	
	Axx taken faecal loading	
	for PicoLax.	
	Medication ordered from	
	pharmacy. Given Oxycodone.	
	Quite an anxious lady.	
	Seen by DR Morris - Axx 13	
	- Stool faecal calprotectin - Pharmacy 21V - Stop Asacol	
	? home tomorrow. - PicoLax New 1120 95?	EVEN DWE

Discharge Checklist

Patient's 
 Unit num 1908546042
 LOGAN F
 Georgina 19/08/1954
 CHI num 17 SOLLAS PLACE
 KNIGHTSWOOD
 Glasgow, Lanarkshire
 G13 4NA

Ward: 10^c

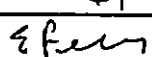
Discharge destination: Home

Estimated Discharge Date (1) / /

Estimated Discharge Date (2) / /

Final date of discharge : 2 / 6 / 16

Checklist

	Yes	N/A	Initials	Comments
Patient informed	✓		g	
Relative/carer informed	✓		g	
Others informed: Care Home		✓	g	
Transport arranged				
Own transport (preferred option)	✓		g	
Ambulance-1 man/ 2 man am/pm		✓	g	
Other: Flight, Air ambulance etc:		✓	g	
Discharge medication				
Discharge prescription completed	✓		g	
Compliance aids e.g. Dossette Box (involve pharmacist)		✓	g	
Medication received	✓		g	
Medication explained to patient and/or relative/carer	✓		g	
Own medication returned to patient		✓	g	
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)		✓	g	
Informed of discharge				
Social work/ Other agencies/Home help		✓	g	
Physiotherapist		✓	g	
Occupational Therapist		✓	g	
Dietician		✓	g	
Speech and Language Therapist		✓	g	
Clinical Nurse specialist e.g. Care Home Liaison		✓	g	
Liaison/ District Nurse/Practice Nurse		✓	g	
Other discharge items				
Access arrangements (e.g. keys, door entry)	✓		g	
Patients clothing available for day of discharge	✓		g	
Valuables e.g. cashier	✓		g	
Intravenous cannula removed	✓		g	
Equipment ordered (inc. walking aids) in place for discharge		✓	g	
Part 2 Discharge letter - Required		✓	g	
- Completed		✓	g	
Out patient clinic appointment e.g. Anticoagulation clinic				
Arranged / To follow	✓	✓	g	NFU
If unknown at time of discharge state reason		✓	g	
Additional information / leaflets / factsheets		✓	g	
Time of Discharge:				
Nurse's signature: 				
Designation: CN				Date: 2/6/16

CLINICAL NOTES - MEDICAL ☐
NURSING ☒Please tick ☒ appropriate directorate

 1908546042
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 Georgina
 17 SOLLAS PLACE
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19/08/1954

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QEH

10/C

Date & Time		Signature, Print Name & Designation
26/5/16	Alert and Oriented	
23 ⁰⁰	on arrival / transfer to ward 10/C - vital signs stable. Light diet and fluids managed. No abdo. pain - R/I	
	prescribed Paracetamol 1g - administered with good effect.	
	Note: Patient has a "Soap Box" full of loose medications - in P.O.D. Self-administered her own meds. including her OXYCODONE 10mg.	
27/5/16	Patient settled and asleep. No report of loose stool. No complaints.	
05 ⁰⁰		
11 ⁵⁵	Awaiting R/I by medics. Remains NBM. Some bowel activity - small + loose.	
	Vonited this am.	
	- am meds withheld.	
	Anti-Emetic refused when offered this am.	
	IVI insitu, laxative taken this am.	
	Oxycodone tab not given	

L Sayre (S)

(L SAYRE)

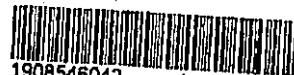
L Sayre (S)

Date & Time		Signature, Print Name & Designation
	due to vomiting.	
	No other concerns @ this time to report.	K. Watson
16 ⁰⁰	R/V by medics.	K. Watson
	PLAN: Continue on IV 2L ¹ /h.	
	Senna prescribed	
	obtain formal spec!	
	obtain cal protection spec	
	Can take diet + fluids as able.	
	Independent in ADL,	K. Watson
	Prescribed phosphate cream if req'd.	K. Watson
27/5/16	PVC inserted. IV fluids stopped.	
22:30	temperatures will recommence once new PVC inserted.	R. Drummond S/N/S
28/5/16	Patient continues on IV fluids overnight.	
overnight	Slept for long periods. No more visible or reported episodes of loose stools or vomiting overnight. News 1 due to hypotension. All other obs satisfactory.	
	All meds given & taken as charted on Kardex. Longtec given as recorded.	
	Patient remains independent & mobile.	
	No further issues to report overnight.	R. Drummond S/N/S
06:00	No stool sample obtained overnight.	
	Requested patient to do so. 2x BC overnight with reports of loose stools.	R. Drummond S/N/S
	News 2 due to hypotension will monitor. IV fluids currently running.	R. Drummond S/N/S

CLINICAL NOTES - MEDICAL
NURSING
☐
☒
LOGAN
GeorginaPlease tick ☒ appropriate directorate

Date & Time		Signature, Print Name & Designation
26/5	Anxious + complained of pain leaning over bed in hall	
1845	not wanting to take Picolox but then rock & has been settled since but bowels inactive.	
	Ndr for IVF. ? home tomorrow.	
	A taking some of her own medication will prompt if we don't have spray	Ewan Blair
	NEWS (2) HR 91 SP290.	
26/5	Transfer to 10 C.	
1945	SBAR ID	Ewan Blair
27/5	Adding RV by	
1155	Medics	
	Phosphate enema given tonight but unable to retain for any length of time.	
	Apperients as prescribed	
29/5/16	Settled and slept well overnight.	
	Mobile as able. Bowels not active - Awaiting specimen faeces	C. M. (S)
29/5/16	Independent with Care - Reviewed by medics, for abdominal x-ray to confirm impaction. Catheter regular apperients. All other medication as prescribed - patient self medicating most of tablet.	
	No nausea / vomiting today.	J. W. Small SR

Date & Time		Signature, Print Name & Designation
29/5/16 1400	NEWS 0 due to slight hypotension - asymptotic CRA 133 mm; for Surgical review. For MSSU	J. Ward 1st
1800	Urinolysis NAD. PR examination carried out by doctor. Laxido dose increased.	J. Ward 1st
20/5 1800	NEWS 2. Bp 93/58. encouraged oral fluids. rechecked. Bp 107/63. will continue to monitor. Medications taken as per Kardex. passing urine BNO. Contacted FYI regarding Bp (hypotensive). Not for IV fluids at present. patient does not appear dry. To contact FYI if Bp drops again. Independently mobile + independent with pressure area care	R. McDonald S/N.
30.5.16 1025	Independent in ADL, Bazels remain intact, NEWS = 0. Medications taken as prescribed by patient. Awaiting medical R/LV.	K. Watson K. Watson
1300	R/LV by physician + referral /email being sent by physician to gastro for them to R/LV Mrs. Logan Stool chart commenced + patient asked to use bedpan for bowel	

CLINICAL NOTES - MEDICAL ☐
NURSING ☒Please tick ☒ appropriate directorate

1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

F
19/08/1954

G13 4NA

Date & Time		Signature, Print Name & Designation
	activity so staff	
	can observe + document	
	on stool chart, however	
	patient leaves the	
	ward + is away for	
	long periods at a time	
	so unsure of bowel	
	regime (if any) during	
	these absent periods.	
	? Diverticulitis	
	urgent bloods taken	
	@ physician's request	
	* CRP as has been	K. Watson
	increasing.	K. Watson
	Bowels not active tonight. Mobile	
	as able. Still awaiting specimen	
31/5/16	Settled and slept very well	
	overnight	cm. Reid (S)
31/5/16	Patient for phosphate	
14 ¹⁵	exema - currently	
1/6/16	NEWS 3 on arrival (Sats 95% on	
N/S	air, SBP 98) encouraged oral	
2 ³⁰	fluid intake, then NEWS 2 later	
	(SBP 99, Sats ↑ to 96% after	
	deep breathing) F71 informed and	
	unassessed,	
	bowel opened slightly only	
	- sample obtained,	
	meds given as per order, some	

Date & Time		Signature, Print Name & Designation
	of them self administer, Longtec 10mg given, mobility independently, Ad. with positioning checks.	
	CRP 11 (24)	ABJ (S)
8 ⁰⁰	Pt still hypotensive SBP 97 - unresponsive - oral fluid intake encouraged	ABJ
6 ²⁰	Pt c/o inability to pass urine - FYI informed, awaits S/V	ABJ (S)
7 ⁰⁰	FYI - no for IV fluids now, to encourage + monitor oral intake, for medical team s/c. Started on fluid chart.	ABJ
11/6/16	Settled morning,	
10:30	Independent c ADL, NEWS = 2 due to BP + 4 Ruler. Ruler's more active since administration of phosphate cream yesterday. Patient has not passed urine too as c/o difficulty pu overnight. Fecal sample sent this am.	K. A. (S) K. A. (S)
2/6/16	Settled. News as checked.	
2.00	Medication given as required. Cont on stool chart. Passing urine. Mob independently around ward. Await result of faecal sample. No complaints. Independent with care around ward Take diet/fluid band given x3 PU well News 0. More is placed CRP-MI dsy this & better given	J. A. (S) J. A. (S)

NHS Greater Glasgow and Clyde Active Care Checklist

Date: 2/6/16

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (Please circle): 1hr 2hr 3hr 4hr 6hr

1. Signed [Signature] Name S. J. Dick Designation SP

2. Signed Name: Designation:

3. Signed Name Designation

USE FOLLOWING CODE:

O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

Attach Address

1908546042

LOGAN

Georgina

17 SOLINAS PLACE

17 SULLAS PLACE
KNIGHTSWOOD

KNIGHT SWORD

F
19/08/1954

19/08/1954

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1999

NHS
Greater Glasgow
and Clyde

Ward: 10C.

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:

[illegible]

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 1/5/16

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (Please circle): 1hr 2hr 3hr 4hr 6hr

1. Signed AS Name Seunor Designation Nurse
2. Signed K Watson Name K Watson Designation S/N
3. Signed _____ Name _____ Designation _____

Attach Addressograph label

1908546042
LOGAN
Georgina
17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire
19/08/1954
G13 4NA

Ward: 10c

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	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
	1.	Pain: assess and address If in pain inform registered nurse Y / N or N/A		Y	Y	Y	Y	O	N	N								
S	2.	SKIN INSPECTION Pressure areas checked: Y / N / I (Independent)		I	I	I	I	O	I	I								
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)		W	W	W	W	O	I	I								
K	3.	KEEP MOVING: Have you moved or walked Y / N / I (Independent)		I	I	I	I	O	I	I								
		Bed Right side (30° tilt) - R Left Side (30° tilt) - L Back - B		/	/	/	/	O	I	I								
		Chair Assist to walk, stand or tilt (W / ST / T)		W	B	B	W	O	W	B								
I	4.	ELIMINATION: Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine or faeces		I	I	I	I	O	I	I								
N	5.	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)		N	N	N	N	O	N	N								
		Encourage the patient to drink? Y / N / N/A		Y	Y	Y	Y	O	O	Y								
		Food, snack or supplement taken? Y / N / N/A		N	N	N	Y	O	Y	Y								
	6.	ENVIRONMENT: Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S		Y	Y	Y	Y	O	W	Y								
	7.	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return. Y/N/O/S		Y	Y	Y	Y	O	N/A	Y								
	8.	ESCALATION: Escalate any issues to the Registered Nurse Y / N/A		W	W	W	W	O	N/A	W								
		Nurse Initials		<u>AS</u>	<u>AS</u>	<u>AS</u>	<u>AS</u>	<u>AS</u>	<u>AS</u>	<u>AS</u>								

NHS Greater Glasgow and Clyde Active Care Checklist

Date: 31/5/16

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (Please circle): 1hr 2hr 3hr **4hr** 6hr

1. Signed [Signature] Name S. M. D. A. D. Designation S/N
2. Signed [Signature] Name K. D. A. T. E. A. Designation S/N
3. Signed _____ Name _____ Designation _____

USE FOLLOWING CODE:

O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

Attach Addresso.

1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

19/08/1954

Ward: 106

G13 4NA

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:

[illegible]

Ward:

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

[illegible]

NHS Greater Glasgow and Clyde Active Care Checklist

Date: 30/5/15

I have evaluated and deemed that the frequency of care delivery over the next work shift based on the patient's most critical need should be every (Please circle): 1hr 2hr 3hr 4hr 6hr

1. Signed Khs Name Khs Designation Shr
2. Signed K. Watson Name K. Watson Designation Shr
3. Signed C. M. Daid Name C. M. Daid Designation Shr

Attach Addressograph



1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

19/08/1954

• 2

G13 4NA

Ward: 10C

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

[illegible]

Ward:

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

[illegible]

NHS Greater Glasgow and Clyde Active Care Checklist

Date: 29/5/16

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (Please circle): 1hr 2hr 3hr 4hr 6hr

1. Signed C. M. D. A. D. Name C. M. D. A. D. Designation ST

2. Signed Name Designation

3. Signed Name Designation

USE FOLLOWING CODE:

O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

Attach Addressor



1908546042

LOGAN

Georgina
17.5011A

17 SOLLAS' PLACE

KNIGHTSWOOD
Worcestershire

Glasgow, Lanarkshire

19/08/1954

G13 4NA

Ward: 10C

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:

[illegible]

NHS Greater Glasgow and Clyde Active Care Checklist

Date: 27/5/16

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (Please circle): 1hr 2hr 3hr 4hr 6hr

1. Signed L. Sayre Name L. SAYRE Designation SIN
2. Signed K. Janson Name K. JATSON Designation SIN
3. Signed _____ Name _____ Designation _____

USE FOLLOWING CODE:

O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

Attach Addressograph lab



1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

¹ Glasgow, Lanarkshire

19/08/1954

G13 4NA

Ward: 10/C

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:

[illegible]

NHS Greater Glasgow and Clyde Active Care Checklist

Date: 26/8/16

I have evaluated and deemed that the frequency of care delivery over the next work shift based on the patient's most critical need should be every (Please circle): 1hr 2hr 3hr 4hr 6hr

1. Signed [Signature] Name UNOJUGA Designation EN

2. Signed Name Designation...../-

3. Signed [Signature] Name L. S. Ayyar Designation SV

USE FOLLOWING CODE:

O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

Attach Addr

1908546042

LOGAN

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17 SOLAS PLACE
KNIGHTSWOOD

KNIGHT SWORD.
Gleeson, Lee & Co.

Glasgow, Lanarkshire

19/08/1954

G13 4NA

Ward: AR 3

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:

		Times	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
	1. Pain: assess and address If in pain inform registered nurse Y / N or N/A		2	2	2	2																				
S	2. SKIN INSPECTION Pressure areas checked: Y / N / I (Independent)		I	I	I	I																				
	Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)		/	/	/	/																				
K	3. KEEP MOVING: Have you moved or walked Y / N / I (independent)		I	I	I	I																				
	Bed Right side (30° tilt) – R Left Side (30° tilt) – L Back– B		B	L	/	/																				
	Chair Assist to walk, stand or tilt (W / ST / T)		W	T	W	W																				
I	4. ELIMINATION: Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine or faeces		I	S	I	I																				
N	5. FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)		N	S	N	N																				
	Encourage the patient to drink? Y / N / N/A		Y	S	Y	Y																				
	Food, snack or supplement taken? Y / N / N/A		N	S	Y	Y																				
	6. ENVIRONMENT: Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? Y/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		Y	Y	Y	Y																				
	8. ESCALATION: Escalate any issues to the Registered Nurse Y / N/A		N/A	N/A	N/A	N/A																				
			Nurse Initials																							

N
1908546042
D. LOGAN
Georgina
17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire
A

19/08/1954

F

G13 4NA

Hospital: QEAM

Ward: 10C

Date: 21/6/15

Reason for Fluid Balance Chart _____

Is patient fluid restricted? Yes ☐ No ☐

If yes how many mls in 24 hours? _____

Fluid balance from previous 24hrs
+/- _____

Does patient require thickened fluids?
Yes ☐ No ☐ Stage _____

Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input				IV / Other				Running Total INPUT	Output				Running Total OUTPUT	Initials	
	Oral Fluids		Enteral		Type	Volume	Type	Volume		Urine	Gastric / Vomit	Bowel	Type			Type
00:00																
01:00																
02:00																
03:00																
04:00																
05:00																
06:00																
07:00																
08:00																
09:00																
10:00																
11:00																
12:00																
13:00																
14:00																
15:00																
16:00																
17:00																
18:00																
19:00																
20:00																
21:00																
22:00																
23:00																
									*Total Intake						*Total Output	

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

Fluid Balance Chart

 1908546042 LOGAN Georgina 19/08/1954 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA	Hospital: <u>Qeew</u>	Reason for Fluid Balance Chart _____	Does patient require thickened fluids? Yes ☐ No ☐ Stage _____	 NHS Greater Glasgow and Clyde
	Ward: <u>10C</u>	Is patient fluid restricted? Yes ☐ No ☐	Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:	
	Date: <u>1/6/16</u>	If yes how many mls in 24 hours? _____	1. Type _____ circle how many daily 1 2 3	
	Fluid balance from previous 24hrs +/- _____		2. Type _____ circle how many daily 1 2 3	
Signature: _____ Designation: _____				

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

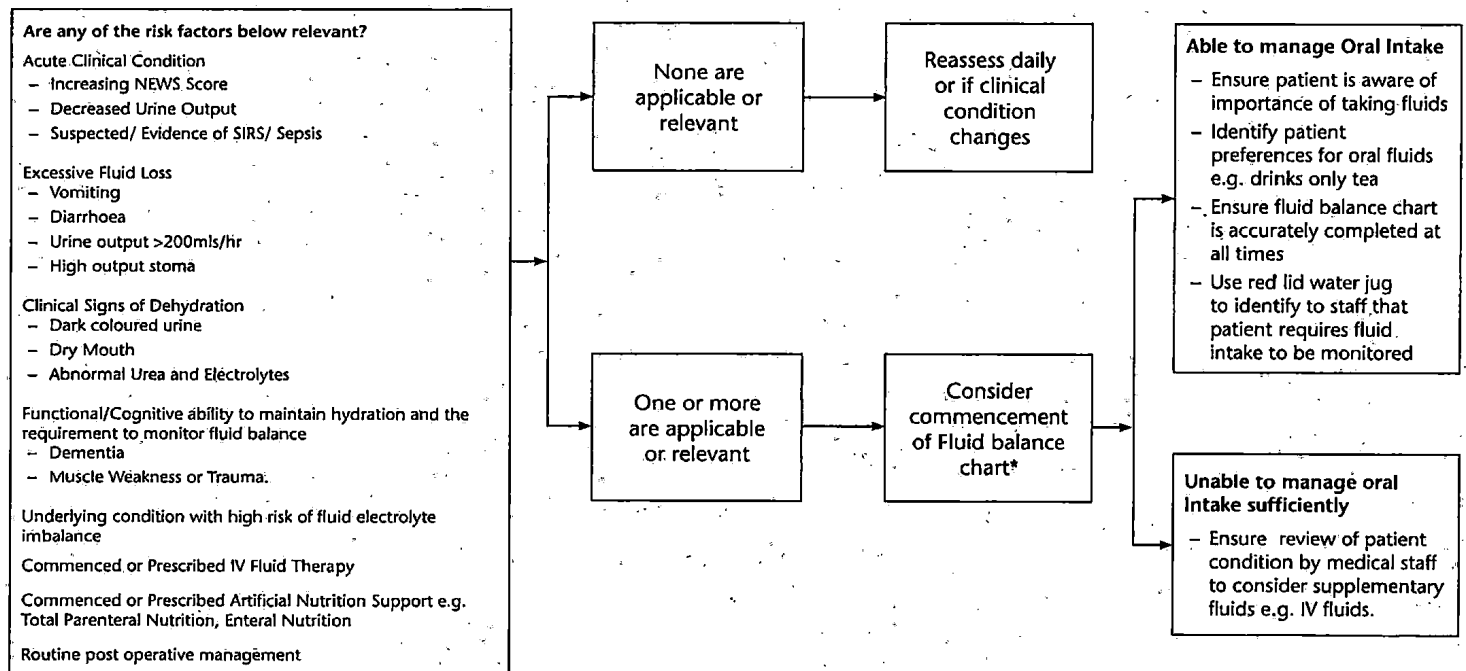
Time	Input								Output							Running Total OUTPUT	Initials
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type		
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00	10m. blue	50							50	NPU							
08:00																	
09:00																	
10:00																	
11:00																	
12:00																	
13:00																	
14:00																	
15:00																	
16:00																	
17:00																	
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
*Total Intake										*Total Output							

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

NHS Greater Glasgow and Clyde Active Care Checklist

Date: 28/05/16

Attach Addressograph label

1908546042

Georgina Logan

17 SOLAS PLACE

KALHES WOOD, 513 4NA

Ward: 10-C

NHS
Greater Glasgow
and Clyde

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (Please circle): 1hr 2hr 3hr 4hr 6hr

1. Signed [Signature] Name [Signature] Designation [Signature]

2. Signed Name Designation

3. Signed C. Mustafa Name C. Mustafa Designation S/N

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

[illegible]

QEH

Cannard Falls Risk Assessment Pack

	
Patient name: 1908546042	F
LOGAN Georgina	19/08/1954
Ward: <i>AW 3</i>	
CHI number:	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: 28/5	Date:	Date:	Date:	Date:	Date:
						Ward: 10	Ward:	Ward:	Ward:	Ward:	Ward:
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			0					
Sex	Male 1	Female 2				2					
Age	13-59 0	60-70 1	71-80 2	81+ 1		1					
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 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		0					
Medical history	Cardiovascular Disease / Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	0					
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed / chairbound / wheelchair 1		0200					
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		1					
TOTAL SCORE						6					
ACTION(S) TAKEN Enter action code(s) from Care Plan below						see below					
SCORE 13+ = HIGH RISK If patient unconscious score as N/A until patient status improves.					NURSE SIGNATURE	W					

Please see back page for glossary of terms relating to the assessment above.

Falls Risk Assessment Plan
Applicable nursing interventions

NURSING INTERVENTIONS		Date: 25/5	Date:	Date:	Date:	Date:	Date:
Code		Ward: 25/5	Ward:	Ward:	Ward:	Ward:	Ward:
1	Falls prevention and general safety precautions discussed with patient and family.	✓					
2	Move to more observable area of ward to optimise supervision.						
3	Advise patient they may experience dizziness when they mobilise initially.						
4	Requires assistance with mobilisation.						
5	Observe trip hazard due to invasive lines, drains and catheters.	✓					
6	Do not leave the patient unattended when using commode, toilet, in shower or the bathroom area.						
7	If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.						
8	Monitor lying and standing / sitting BP and pulse.						
9	A. Patient requires footwear or podiatry referral. (Date referred: / requested :) B. Request family / carer to provide suitable footwear.						
10	Commence continence assessment, follow Local Guidelines.						
11	Refer to Occupational Therapist.						
12	Select suitable seating (refer to policy).						
13	Non slip mat on chair /floor following advice from therapists.						
14	Refer to Physiotherapist.						
15	Review Transfer techniques.						
16	Request medication review.						
17	Bed/chair monitor in use.						
18	Falls map in use for seven days for patient who has second or subsequent falls.						
19	Bed rails/bumpers to be used (refer to policy).						
20	Patient requires low bed / mattress on the floor (refer to policy).						
21	Patient requires one to one nursing care.						
22	Refer to Hospital Falls Prevention Co-ordinator (see criteria on front cover).						
23	Other interventions.						

Review Cannard score weekly / monthly as per policy. Enter action code(s) selected in action taken section on Falls Risk Assessment page above.

Cannard Falls Risk Assessment

Glossary of terms used in risk assessment

SIGHT DEFICIT means patient cannot see well even when wearing glasses or is registered blind.

HEARING DEFICIT means person has hearing problems even with a hearing aid or has hearing problems and does not wear a hearing aid.

BALANCE DEFICIT means person is unable to stand without the support of another person or a walking frame.

MEDICINES FOR SOME MENTAL ILLNESSES include Chlorpromazine (Largactil), Risperidone (Risperdal), Lithium (Camcolit or Priadel), Haloperidol, Chloral hydrate (Welldorm), Clomethiazole (Heminevrin), antidepressants, Diazepam, Lorazepam and Amitriptyline.

CARDIOVASCULAR SYSTEM MEDICATION all antihypertensive medication and inotropes including Captopril, atenolol and many others.

WATER TABLETS (DIURETICS) are such as Bendroflumethiazide, Furosemide and Co-amilofruse.

SEDATIVES / ANALGESIA AT NIGHT include medicines such as Diazepam, Temazepam, Nitrazepam, Chlordiazepoxide and Zopiclone (Zimovane) Morphine PCA, Fentanyl, Tramadol and Oxycotin.

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.



1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

19/08/1954

G13 4NA

Care Plan

Date Commenced and Signature	1. Breathing and circulation	Date Discontinued and Signature	Date Commenced and Signature	7. Personal Hygiene, oral care and skin care	Date Discontinued and Signature
2015 W	TR + SpO2 4.6"		2015 W	Independent	
2015	2. 3. Communication and senses		2015	8. Mobility	
	W/ issues			Independent	
				uses stick	
2015	4. Cognitive status		2015	9. Maintaining a safe environment	
	Amr 4/4			PSIRG	
	Getting to Know Me / What matters to me			10. Sleep and Rest	
2015	5. Hydration and Nutrition			12. Privacy, dignity and sexuality	
	W/ issues D + F				
2015	W/ issues				
	6. Elimination		2015	Negotiated care -	
2015	W/ issues			Care discussed with patient / family	Yes / No
				Patient able to participate	Yes / No

Care Plan Guidance

Below are some prompt questions to help you record the individualised care that your patient requires during their inpatient stay. You should record the care that the nurse / nursing staff require to provide. The 'Negotiated Care' component provides opportunity to record any care that the patients family or carers are participating in and care that patients are being taught to support changing self care. If the patient is independent in any of the activities of living and requires no nursing intervention then you should record this in the relevant section.

When care changes a note should be made in the nursing clinical notes / progress notes to confirm why this is required.

1. Breathing and circulation	7. Personal Hygiene, oral care and skin care
Record frequency of observations, TPR BP and SAO2. Record any other care that the patient requires for their breathing or their circulation e.g. seating position, apex beat with radial pulse, pedal pulse measurement, lying and standing Blood Pressure measurement etc.	Does the patient need assistance with personal hygiene? If so what needs to be done. Do they require assistance with oral care? If so what is this. Does the patient require any specific pressure area care outwith the Active Care documentation. If totally independent record 'self caring'.
2, 3. Communication and senses	8. Mobility
What assistance does the patient need with communication? If they use spectacles or a hearing aid what assistance do they need with these? Does the patient require an interpreter?	Does the patient require assistance when mobilising? Does the patient use mobility aids? Is the patient at risk of falling? Record key information from falls risk assessment, e.g. Cannard tool, to prevent falls
4. Cognitive status	9. Maintaining a safe environment
What care is required to minimise risk of harm due to behavioural disturbance? Think about capacity and adults with incapacity and what you need to do with the patient to alleviate distress.	How is the patients pain being assessed? Is a specific pain assessment tool used? What does the patient require to maintain their safety?
Getting to Know Me / What matters to me	10. Sleep and Rest
The 'Getting to know me' Document should be used for all patients with cognitive impairment. Once completed by the patients relatives / carer record the key information to plan care in the care plan. Ask the patient what matters to them during their hospital stay and record in this area.	What would help the patient achieve a good nights rest? Does the patients sleep pattern need to be monitored? if yes record what needs to be done.
5. Hydration and Nutrition	12. Privacy, dignity and sexuality
Does the patient require any assistance with eating and / or drinking? Does the patient require a special diet? Do they require fluid balance monitoring?	What do you need to do to maintain the patients modesty and dignity?
6. Elimination	Negotiated care -
	Care discussed with patient / family Yes / No Patient able to participate Yes / No
Does the patient require assistance to go to the toilet? Do they use continence aids? Does their urinary output require to be monitored? Are the patients stools / bowel activity being monitored?	Discuss patient care needs with them. If the patient is learning a new self care procedure record their process and progress of learning. If the patient has a learning disability or dementia use the information obtained in the Getting to Know Me document to identify the care that the family / carer could participate in.

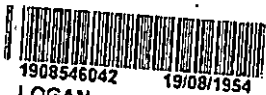
Fluid Balance Chart

 1908546042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA	Hospital: <u>RAH</u> Ward: <u>10/C</u> Date: <u>27/5/16</u>	Reason for Fluid Balance Chart <u>NBM/IV Monitor</u> Is patient fluid restricted? Yes ☐ No ☒ If yes how many mls in 24 hours? _____ Fluid balance from previous 24hrs +/- _____	Does patient require thickened fluids? Yes ☐ No ☒ Stage _____ Is the patient on an oral supplement? Yes ☐ No ☒ If YES please indicate: 1. Type _____ circle how many daily 1 2 3 2. Type _____ circle how many daily 1 2 3 Signature: <u>[Signature]</u> Designation: <u>SIN</u>												
ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT															
Time	Input				Output										
	Oral Fluids		Enteral		IV / Other		Running Total	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total	Initials
	Type	Volume	Type	Volume	Type	Volume	INPUT							OUTPUT	
00:00															
01:00															
02:00															
03:00															
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20:00															
21:00															
22:00															
23:00															
*Total Intake								*Total Output							

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

NEWS – National Early Warning Score

Name	 1908546042 19/08/1954 LOGAN Georgina
Address	
CHI No.	
DoB	

	Date	Ward
Admitted	22/08/16	22/03
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8	92-93 Yes	9-11	12-20		21-24	≥25
Oxygen Saturations	≤91		94-95	≥96			
Any Supplemental Oxygen				No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40	91-100	41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90		101-110	111-219			≥220
Conscious Level				A			V, P or U

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	- Inform trained nurse. - Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	- Trained Nurse assessment. - Inform medical team caring for the patient. - Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. - Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	- Trained Nurse to assess immediately. - Inform medical team caring for the patient – this should be at least senior medical staff level. - Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. - Consider referral to high dependency or ITU.

DATE	TIME	NEWS
01/15/2015	01:15	0
01/15/2015	01:15	1

DATE	TIME	NEWS
01/15/2015	01:15	0
01/15/2015	01:15	1

DATE	TIME	NEWS
01/15/2015	01:15	0
01/15/2015	01:15	1

DATE	TIME	NEWS
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01/15/2015	01:15	1

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01/15/2015	01:15	1

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01/15/2015	01:15	1

DATE	TIME	NEWS
01/15/2015	01:15	0
01/15/2015	01:15	1

DATE	TIME	NEWS
01/15/2015	01:15	0
01/15/2015	01:15	1

[illegible]

Pressure Ulcer Daily Risk Assessment (PUDRA)

 1908546042 LOGAN Georgina 19/08/1954	Hospital: <i>Qeff</i> Ward: <i>ARW3</i>	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
26/5/16	09:00	N	N	N	N	N	N	4 hrly	<i>[Signature]</i>
28/5/16	08:00	N	N	N	N	N	N	4 hrly	<i>[Signature]</i>
29/5/16	06:00	N	N	N	N	N	N	4 hrly	<i>[Signature]</i>
30/5/16	08:00	N	N	N	N	N	N	4 hrly	<i>[Signature]</i>
31/5/16	06:00	N	N	N	N	N	N	4 hrly	<i>[Signature]</i>
1/6/16	2:20	N	N	N	N	N	N	4 hrly	<i>[Signature]</i>
2/6/16	12:00	N	N	N	N	N	N	4 hrly	<i>[Signature]</i>
/ /	:							__hrly	
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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



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 effective 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 <u>4</u> hourly. • Skin under medical devices <u>4</u> hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition <u>4</u> hourly in bed and chair. • Overnight patient / carer has agreed to repositioning <u>4</u> hourly • Specify any manual handling equipment used:	• Skin care to be carried out <u>4</u> 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: <u> </u>
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: <u> </u>
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: <u> </u>

1908546042
LOGAN
Georgina

19/08/1954

Peripheral Vascular Cannula(PVC) Insertion & Maintenance

Modified V.I.P. (Visual Infusion Phlebitis) Score

IV site appears healthy	1	Possible first signs : Observe cannula
One of the following is evident : slight pain or redness near site	2	Early stage of phlebitis - Remove & resite cannula
Two or more of the following are evident: pain,redness,swelling	3	Phlebitis/Thrombophlebitis: Remove & resite cannula Seek further advice
All of the following are evident: pain,redness,hardening of surrounding tissue	4	
As above including: palpable venous cord	5	
As above including :pyrexia	6	

Insertion - Complete all sections

PVC inserted <u>ED</u>	Theatre	Ward	Date inserted <u>25/5/16</u>	Insertion site <u>L Hand</u>	Colour of PVC <u>BW</u>	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 <u>25/5/16</u>	Yes ☒ No ☐	V.I.P: <u>0</u>	Yes ☒ No ☐	Yes ☒ No ☐	Yes ☒ No ☐	Left in situ ☒ Removed ☐	<u>[Signature]</u>
Day 2 <u>26/5/16</u>	Yes ☒ No ☐	V.I.P: <u>1</u>	Yes ☒ No ☐	Yes ☒ No ☐	Yes ☒ No ☐	Left in situ ☐ Removed ☒	<u>Tissued R10</u>
Day 3 <u>27/5/16</u>	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 <u>28/5/16</u>	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 <u>29/5/16</u>	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		
	One of the following is evident: slight pain or redness near site	1	Possible first signs: Observe cannula
	Two or more of the following are evident: pain, redness, swelling	2	Early stage of phlebitis - Remove & resite cannula
	All of the following are evident: pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis - Remove & resite cannula
	As above including: palpable venous cord	4	As above including: pyrexia
	As above including: pyrexia	5	As above including: pyrexia

Insertion - Complete all sections					
PVC inserted ED	Theatre	Ward <u>10c</u>	Date inserted <u>27/5/16</u>	Insertion site <u>(L) AF</u>	Colour of PVC <u>Pink</u>
Clinical indication <u>IV Fluids / IV Medication</u>			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 _____



.OGAN

Georgina

17 SOLLA

19/08/1954

Name 17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire

G13 4NA

CHI:

Date Commenced, 30 / 8 / 15

NHS
Greater Glasgow
and Clyde

Adapted from the Bristol Stool Scale developed by KW Heaton and SJ Lewis at the University of Bristol, 1997

NHS
Greater Glasgow
and Clyde

Date Commenced:/...../.....

[illegible]

Adapted from the Bristol Stool Scale developed by KW Heaton and SJ Lewis at the University of Bristol, 1997

NAM
.....
1908546042
WAI LOGAN F
Georgia 19/08/1954
CAS
.....
CONSULTANT:

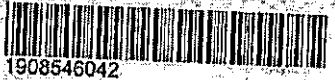
KEY		
CONSISTENCY	COLOUR	AMOUNT
0 = Watery	0 = Chalky	0 = Very Small
1 = Soft	1 = Pale	1 = Small
2 = Normal	2 = Normal	2 = Normal
3 = Firm	3 = Dark	3 = Large
4 = Constipated	4 = Black	4 = Very Large
	5 = Red	

[illegible]

patient
reported

70815.

Discharge Checklist

Patient:  UIN: 1908546042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA 19/08/1954 F ph label	Ward: 6B Discharge destination: Home Estimated Discharge Date (1): 1 / 1 Estimated Discharge Date (2): 1 / 1 Final date of discharge: 21/2/15			
Checklist	Yes	N/A	Initials	Comments
Patient informed	☒			
Relative/carer informed		☒		
Others informed: Care Home		☒		
Transport arranged		☒		
Own transport (preferred option)	☒			
Ambulance-1 man/ 2 man am/pm		☒		
Other: Flight, Air ambulance etc.		☒		
Discharge medication		☒		
Discharge prescription completed	☒			
Compliance aids e.g. Dossette Box (involve pharmacist)		☒		
Medication received		☒		Pt will return late
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		☒		Referred to Gastro
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. cash/ID		☒		
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:	1530			
Nurse's signature: 	Designation:	Date: 21/2/15		

1. Admission

Hospital: <u>WIG</u>	Ward: <u>MAU</u>
Date of admission: <u>25/1/15</u>	Time: <u>0540</u>
Admitting Consultant: <u></u>	Admitting Nurse: <u>S.W. Carrick</u>
Expected date of discharge: <u>1/1</u>	

Name: Georgina Logan

Address: 1908546042
LOGAN
Georgina
17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire
G13 4NA

DoB: 19/08/1954

CHI numl:

1. Patient Details

Preferred name: <u>Georgina</u>	Next of Kin (NoK): <u>George Logan</u>
Age: <u>60yrs</u>	Relationship: <u>Husband</u>
Religion: <u></u>	NoK Address: <u></u>
Telephone: <u></u>	NoK Telephone: <u>0777 4400790</u>
GP: <u>Power</u> <u>Storia Park Medical Practice</u> <u>98 Dumbarton Road</u> <u>Glasgow</u> <u>14 9DS</u>	NoK Aware of admission: ☐ Yes ☐ No
GP address: <u></u>	Consent for information to be given to relatives: ☐ Yes ☐ No
GP telephone: <u></u>	Nominated family contact: Telephone - Day: <u></u> Telephone - Evening: <u></u>

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 'No' to 'b' please inform medical staff. Name of doctor informed:

2. Presenting Complaint / Diagnosis

Sudden onset central chest pain
associated vomiting

Why does the patient think they are in hospital? Use patients own words:

? ACS ? unstable angina

3. Allergies (including food allergies)

No known allergies: ☒

4. Observations

Cannard	Waterflow	MUST	Pulse	BP	Resp	SaO ₂	Temp
<u>8</u>	<u>5</u>	<u>0</u>	<u>60</u>	<u>90/46</u>	<u>16</u>	<u>97</u>	<u>36.0</u>
Urinalysis:		AMT4 Score	BM	NEWS Score	Weight Estimated / Actual	Height Estimated / Actual	BMI
<u>Red</u>		<u>4</u>	<u>-</u>	<u>2</u>	<u>lost 7</u>	<u>5FT</u>	<u>29</u>

5. Current Medication

See Med Rec.

6. Relevant Past Medical History

Asthma Chronic Back Pain
Angina
Diabetes
Cirrhosis (persistent diarrhoea)

Medicines reconciled on admission? ☒ Yes ☐ No

7. Risk Assessment

MUST

- Is the patient's BMI:
 - > 20 Score 0
 - 18.5-20 Score 1
 - < 18.5 Score 2
 Score ☒
- Has the patient had unplanned weight loss in the past 3-6 months?
 - < 5% Score 0
 - 5-10% Score 1
 - > 10% Score 2
 Score ☒
- 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

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 G13 4NA

8. Cognitive Impairment

For all patients > 65 years, ask the following 4 AMT questions:

- How old are you? years
- What is your date of birth? / /
- What is this place?
- What year is it?

If the patient does not answer all questions correctly then refer to medical staff.

AMT Score: 4 out of 4

Name of Doctor informed (if required)

Grade

9. MRSA Screening / CJD / Healthcare outside Scotland

Will the patient be an inpatient > 23 hours? ☒ Yes ☐ No If 'Yes' complete the following section.

- Has the patient ever had a previous positive MRSA result? ☐ Yes ☐ No ☒ Not known
- Has the patient been admitted from a Care Home/ institutional setting or another hospital? ☐ Yes ☒ No ☐ Not known
- 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:

Does the patient smoke? ☐ Yes ☒ No

Does the patient use nicotine replacement therapy? ☐ Yes ☐ No

Does the patient wish referral to Smoking Cessation Service?

If 'Yes' how many per day:

☐ Yes ☐ No If 'Yes', date of referral: / /

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): A. CARRICK

Signature: A. Carrick

Designation: SN

Date: 25/1/15

Nursing Admission & Assessment

2. Assessment

Hospital: <u>WIG</u>	Ward: <u>MAM</u>
Date of Assessment: <u>25/1/15</u>	Time: <u>0850</u>

Name:	
Address:	1908546042
DoB:	LOGAN Georgina 19/08/1954
CHI number:	17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA

1. Breathing and Circulation

Breathing:

- ☐ No symptoms or history of respiratory problems
 ☐ Productive / non-productive cough evident
☐ Dyspnoeic at rest
 ☐ Normally receives oxygen therapy
☒ Dyspnoeic on minimal exertion
 ☐ If 'Yes' provide details:
☐ Dyspnoeic on maximum exertion

Circulation:

- ☐ No symptoms
 ☒ Known cardiac or circulatory problems

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Uses inhalers

Initial
AC

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 ☒ No
 b. A learning disability e.g. Down's Syndrome?
☐ Yes ☒ No

If 'Yes' please specify:

If 'Yes' contact Liaison Learning Disability Team.

Liaison Learning Disability Team contacted:

☐ Yes ☒ No

c. A learning difficulty e.g. dyslexia, dyspraxia?

☐ Yes ☒ No

If 'Yes' please specify:

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial

3. Senses

Senses:

Eyesight:

- ☐ Normal vision
☒ Glasses – ☒ Distance ☒ Reading
☐ Prosthesis – ☐ Left ☐ Right
☐ Contact lenses
☐ Registered blind

Hearing:

- ☒ Normal
☐ Hearing impaired
☐ Hearing aid – ☐ Left ☐ Right

4. Mental Status

Mental Status:

- ☒ Orientated
☐ Confused
☐ Distressed
☐ Aggressive / Abusive
☐ Unconscious

5. Hydration and Nutrition

MUST Score: 0..... 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:

Eats varied diet. Dislikes pasta / mince

5a.2. Fluid likes / dislikes:

Milk tea / coffee

5b. Cultural or religious diet needed (e.g. vegetarian, vegan, halal, kosher etc):

☐ Yes ☒ No

If 'Yes' specify diet needed:

5c. Help needed with eating and drinking:

☐ Yes ☒ No

If 'Yes' provide details:

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

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' - 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 *Crhmes*

Stoma: ☐ Yes ☐ No

If 'Yes' please specify and list appliances used:

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial

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7. Personal Hygiene, Oral Health and Skin Assessment

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) and implement Oral Care Bundle.

Oral Hygiene Care Bundle:

☐ Required ☒ Not required

Dentures:

- ☐ Not worn
☐ Upper set
☐ Lower set

- ☐ Full 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

Initial

8. Mobility

Patient fully mobile / independent? ☒ Yes ☐ No If 'No' complete Moving and Handling Assessment.

☐ Limited mobility

☒ Mobile with aid – Specify: *mobile & stick*

☐ 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

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0 Sleep and Rest

Sleep habits:

- ☒ Less than 8 hours
 ☐ Afternoon nap
☐ Morning nap

Sleep difficulties:

- ☐ None
 ☐ Disturbed
☒ Early waking
 ☐ e.g. nocturia, insomnia

Medication required: ☐ Yes ☐ No

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Name:

Address:

DoB:

CHI number:

Affix patient data label

Initial

1 Social Circumstances

☐ Employed
 ☐ Unemployed
 ☒ Retired

☒ Lives alone

☐ Lives with Family

☐ Friend

☐ Dependants

☐ Other:
 ☐ Nursing Home
 ☐ Residential

Current Care / Support arrangements:

☐ Social Services
 ☐ Unpaid carer e.g. family, friends

☐ Private Carers
 ☒ None

If support services in place, please provide details:

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial

2 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 ☐

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): A. CARRICK

Signature: A. Carrick

Designation: SN

Date: 25/1/15

Clinical Notes

Date and Time	Notes	Name, Signature and Designation
25/1/15 0600	Admitted to ward with chest pain	
	OK to ward painfree	
	⑤ News = 2 BP 90/46	
	⑥ Initial troponin < 0.01	
	Repeat troponin @ 10am	A.C.O.
25-1-15 1320	PATIENT HAS HAD SETTLED MORNING - INDEPENDENTLY WASHED/DRESSED, PATIENT STATES NO CHEST PAIN THIS AM - ONLY BACK PAIN. ALSO STATES NO FURTHER BOWEL MOVEMENTS YET TODAY (CHRONIC CROHNS) FOR PATIENT GIVEN ASPIRIN 300MG AS PRESCRIBED FOR TROP - AWAITING TEST R/V BY CARDIOLOGIST - STATE AWAIT TROP RESULT ? (H) AS THEY ARE NOT CONVINCED CLINICALLY PATIENT HAS ISCHEMIA.	SN R. GUN

Name:
Address:
DoB:
CHI number:
Affix patient data label

Clinical Notes continue on next page

Name:...



Address: 1908546042

LOGAN

F

Georgina

19/08/1954

DoB: 17 SOLLAS PLACE

KNIGHTSWOOD

CHI num Glasgow, Lanarkshire

G13 4NA

Clinical Notes (continued)

Date and Time	Notes	Name, Signature and Designation
25.1.15 1920	PATIENT 2ND TROP -ve. MEDIC R/V BUT STATED SHE COULD NOT GO HOME. PATIENT STATED SHE ONLY TAKES PREGABELINE AT HOME. PEN. DUE TO THIS MORNING'S DOSE SHE FEELS TOO 'SHAKY' TO GO HOME. MEDIC IS HAPPY TO KEEP PATIENT TIL TOMORROW AND HAS STOPPED PREGABELINE. PATIENT HAPPY WITH THIS.	SIN E. GUNO
26/1/15 0530	appears to have settled + slept well overnight. obs stable as charted.	
	no complaints reported.	
	likely home today following medical review	FR O'Grady SIN
1930	independent with own needs, hypotensive and dizzy R/V by medics for lying and standing Bp - no deficit mobilising around ward less dizzy than this morning.	
	pregabalin, Betablocker, peptac tramadol stopped. likely home tomorrow.	CMURR (SIN)
2030	FOR TRANSFER TO GA CARTWHEEL - HOWEVER	
	WABLE TO TAKE HANDOVER DUE TO EMERGENCY - PATIENT INFORMED OF PLANNED TRANSFER	
	PATIENT STATES SHE WILL CONTACT NUR HERSELF	EMILY (SIN)
21:00	HANDOVER GIVEN TO GA -	RIN
26/1/15	Arrived to GB approx 21:30. Fully mobile independently. News 1 - Bp 108/58.	SIN



1908546042

LOGAN

Georgina

19/08/1954

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

G13 4NA

CLINICAL NOTES - NURSING

Date & Time	Signature, Print Name & Designation
26/11/15	
CONF	
Medications not sent from MAU - they will try to send tomorrow am	
Vomiting came spontaneously	
Patient has long term back pain - butrans patch in situ - applied yesterday - lasts 1 week	
? home tomorrow	S. L. Shillman SL
27/11/15	
Sept. for long periods ? home later today	
BP this am: BP 98 Systolic	SL
27/11/15	
Independent with hygiene	
Medications have arrived from MAU	
Vomiting came spontaneously	
Poor appetite + fluid intake due to nausea + c/o abdominal cramping	
Bowels have NOT moved since Friday when pt states she took "Six"	
Loperamide tablets (Suffer from Crohn's disease - and had frequency of bowels - up to 10-18 x daily)	
Main issue at present is persistent low BP Systolic 80-90 with dizziness on standing	
Causative medications stopped with no improvement (Aldactone)	
Plan from medics = Antiemetics to improve nausea & ↑ oral intake	
If no improvement in BP - may require IV fluids plus further intervention	
Repeat bloods in morning	XG 6146 SN
10pm	
NHS ② = BP 93 Systolic - oral fluids encouraged	