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

NHS
Greater Glasgow and Clyde

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

Date: **19TH MAY 2026**
Your Ref: **MISS THERESA SINCLAIR**
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: THERESA SINCLAIR Date: 13.08.1963

Thank you for your request received **27TH 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:

QUEEN ELIZABETH UNIVERSITY HOSPITAL – WEST AMBULATORY CARE – WESTERN 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

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

Including:

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

19

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Queen Elizabeth University Hospital

CHI: 1308636407

Total Att: 20

12 Mth Att: 1

Title: **MS**

SINCLAIR **Theresa**

DOB: **13/08/1963** Age: **52y** Sex: **Female**

90a Main Street
Lennoxtown
Glasgow
G66 7DA

Next of kin: **JENKINS, TERESA**
Relationship: **Daughter**
078876623809

GP: **RM Wilson**
01360 327300

Attendance Date: **10/03/2016** Arrival Time: **01:49**

Registration Time: **01:49** Date of Incident: **10/03/2016**

Major Incident Desc:

Reason for Attendance: **chest pains**

Nursing Assessment

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

Triage Category: **3** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **10/03/2016 01:56**

Temp	36.1	C
HR	74	bpm
BP	137/76	mmHg
MAP		mmHg
RR	17	bpm
SpO2	95	%
Oxygen		%

Nurse name: **Nurse Gillian Curran**

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **bibp intoxicated c/o chest pains. hx angina**

Nursing Notes:

97607

Child Assessment Questionnaire

	YES	NO
Previous attendance (c... n previous presentations)		
History variable between...		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

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

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

1308636407 13/08/1963
SINCLAIR
Theresa

DO NOT WRITE HERE PLEASE

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

SINCLAIR, THERESA ID: 1308636407 10-Mar-2016 2:12:47 QUEEN ELIZABETH UNIVERSITY HOSPITAL

13-Aug-1963
Female

Vent. rate	66 bpm
PR interval	136 ms
QRS duration	78 ms
QT/QTc	440/461 ms
P-R-T axes	71 63 63

Normal sinus rhythm
Normal ECG

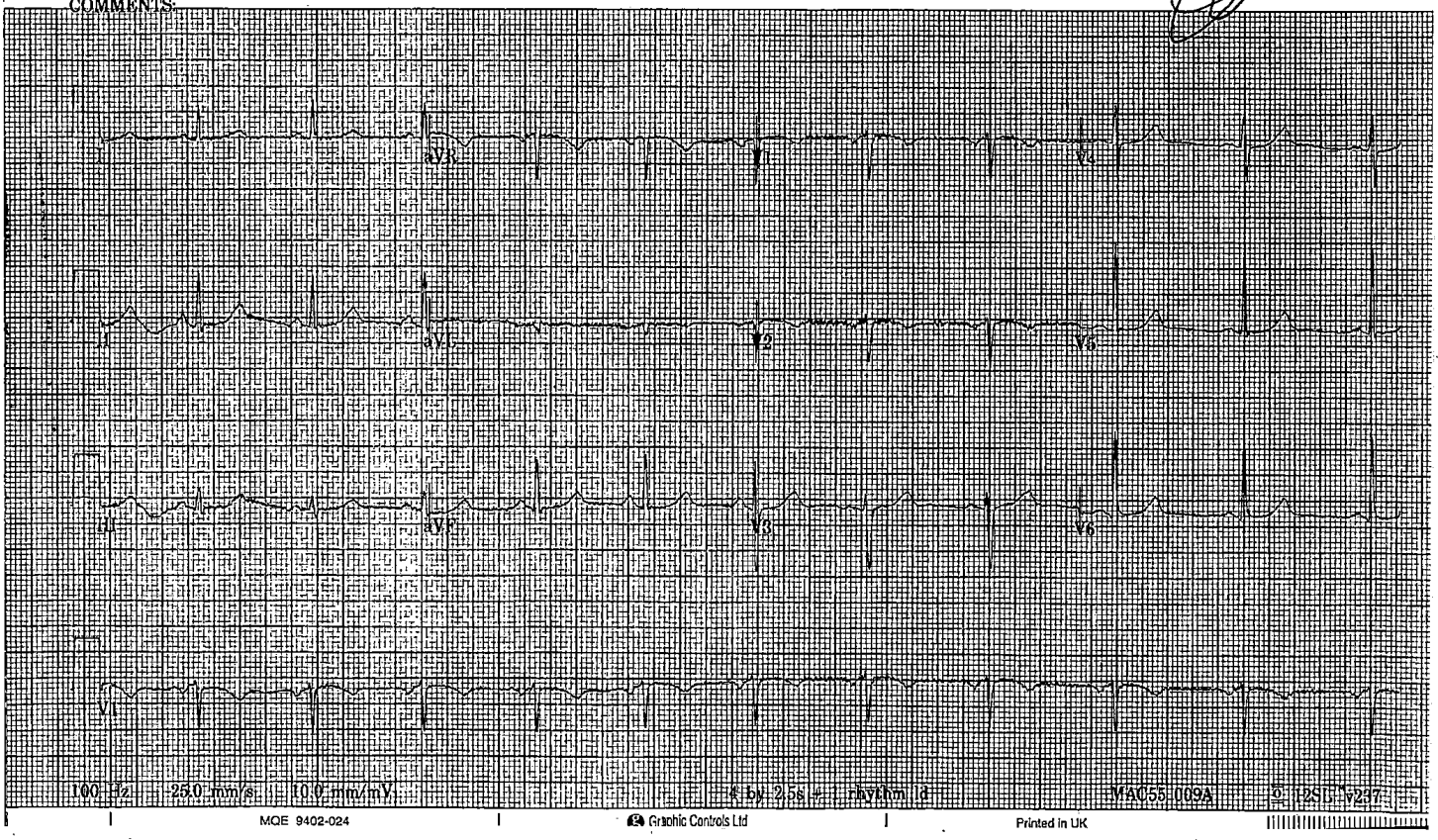
1308636407 13/08/1963
SINCLAIR
Theresa

Technician: 303
Test ind: CHEST PAIN

Referred by: AE

Unconfirmed

COMMENTS:



MQE 9402-024 Graphic Controls Ltd Printed in UK

Date	CLINICAL NOTES
	Seen by (Dr) GUCHARD Time seen 0245

1308636407 13/08/1963
SINCLAIR
Theresa

10/3/16 (52) BIBP → arrested due to breach of peace
+
✱ INTOXICATED ✱

- on way to police station when had 15 minutes of central chest pain + heaviness
- feel like angina
- took GTN + resolved by time attended A+E
- vague historian
- says no radiation or autonomic features. No cough / SOB.

PMH
alcohol XS
angina
[illegible]

D/H
ramipril
bisoprolol
simvastatin
aspirin
GTN

O/E: Intoxicated. Obs (N)
Chest clear   I+II+0   Abdo SNT
Calves SNT   ECG (N)

Imp unlikely ACS but given intoxication check troponin

Plan bloods incl troponin — if (N) d/c back to police custody.

troponin 2 → d/c to police. [illegible]

GUCHARD [illegible]

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)					Discharge date	10/3/16
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)		Discharge time	0730
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.		

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

Follow up	Arranged		Not arranged		To be arranged			
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

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

Designed by Medical Illustration Services ref 243836

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

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

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 10/03/2016

Consultant: Dr Peter Davis

RM Wilson
Lennoxtown Medical Practice
Lennoxtown Hub
46 Main Street
Lennoxtown
Glasgow
G66 7JJ

Dear RM Wilson

Re: **Sinclair Theresa** DOB: **13/08/1963** CHI: **1308636407**
90a Main Street
Glasgow G66 7DA

Attended on: **10/03/2016 at 01:49 hrs.** Departed on: **10/03/2016 at 03:34 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Other**
Previous ED Attendance in last 12 months: **1**

Presenting complaint
chest pains

Nursing Assessment:
bibp intoxicated c/o chest pains. hx angina

Investigations in ED:
1. Full Blood Count **2. Urea and Electrolytes** **3. Troponin I hs**

Diagnosis:

Diagnosis	Side	Site
Chest pain, unspecified		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

52 yo female attended intoxicated in police custody due to breach of peace. On way to police station developed central heavy chest pain - describes as usual angina and was relieved by her own GTN. No radiation/SOB/cough/autonomic features. Observations, ECG, examination, and troponin within normal limits. Discharged back to police custody with worsening statement.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Sarah Eckhardt
Doctor

Copies to:

1. RM Wilson (GP)

School Address:

HOSPITAL INFORMATION MISSING

Dr JAMES HENDERSON
LENNOXTOWN CLINIC
103 MAIN STREET LENNOXTOWN

G66 7DA

Date : 16 Apr 2011

Dear Dr JAMES HENDERSON,

Re: TERESA SINCLAIR, 90A MAIN STREET, LENNOXTOWN, GLASGOW, G66 7DA
Date of Birth: 13/08/1963 CHI number: 1308636407

HOSPITAL INFORMATION MISSING Patient attended on the 16 Apr 2011.

The presenting complaint was: **APPEARS INTOXICATED**

Triage information:	**BIBP TOLD POLICE SHE HAD TAKEN AN OD. NOW DENIES THIS. DISRUPTIVE**
The following investigations were carried out:	**None**
The A&E diagnosis was:	**INTENTIONAL SELF HARM - OTHER DRUG/S**
The following treatment was given:	**None**
At the conclusion of treatment the patient was:	**DIRECT ADMISSION TO LEVEL 8 ASSESSMENT UNIT**

Follow-up: **LEVEL 8 ASSESSMENT UNIT**

Additional information: **None**

Yours sincerely,

RHONA BRIGGS

EMERGENCY DEPARTMENT DOCTOR

Medical Assessment Unit
Western Infirmary, Glasgow G11 6NT.
Tel No. 0141-211-2850

NHS
Greater Glasgow and Clyde

OUR REF: SL/GF
CHI NO: **1308636407**

Date Dictated: 15/06/2011
Date Typed: 16/06/2011

Dr James Henderson
Campsie Surgery
Lennoxtown Clinic
103 Main Street
G66 7DA

Dear Dr Henderson

Teresa Sinclair - 13/08/1963 - CRN: 23004807E
90a Main Street, Lennoxtown, Glasgow, G66 7DA

This patient was due to have a repeat out patient chest x-ray after an incidental finding of a small lesion in the right mid zone, thought to be a granuloma on a chest x-ray performed when she was recently an in patient with an impulsive overdose of Citalopram. She failed to attend for the x-ray and I have sent one further appointment request. If she fails to attend this another one will not be offered.

Yours sincerely

Dr Sam Ley
ACCS1 Acute Medicine

Medical Assessment Unit
Western Infirmary, Glasgow G11 6NT.
Tel No. 0141-211-2850

NHS
Greater Glasgow and Clyde

OUR REF: SL/GF
CHI NO: **1308636407**

Date Dictated: 16/06/2011
Date Typed: 16/06/2011

Teresa Sinclair
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Dear Teresa

CRN: 23004807E

I hope you are keeping well after your recent admission to the Western Infirmary. You may remember that while you were in the hospital you had an x-ray of your chest which has shown a small area of change thought to be an infection. I would be keen for you to come back and have the chest x-ray repeated so that we can make sure your chest x-ray is back to normal. I believe you have already had one request sent out which you did not attend. If you are having any problems making the appointment if you could let us know so we can arrange a more convenient time, if you do not attend this appointment another one will not be offered.

Yours sincerely

Dr Sam Ley
ACCS1 Acute Medicine

Medical Assessment Unit
Western Infirmary, Glasgow G11 6NT.
Tel No. 0141-211-2850

NHS
Greater Glasgow and Clyde

OUR REF: SL/GF
CHI NO: **1308636407**

Date Dictated: 31/05/2011
Date Typed: 02/06/2011

Date of Admission: 16/04/2011 Date of Discharge: 18/04/2011

Dr James Henderson
Campsie Surgery
Lennoxtown Clinic
103 Main Street
G66 7DA

Dear Dr Henderson

Teresa Sinclair - 13/08/1963 - CRN: 23004807E
90a Main Street, Lennoxtown, Glasgow, G66 7DA

Diagnosis Intentional overdose of Citalopram

This 47 year old lady took an impulsive overdose of Citalopram as she felt she could not cope with the bereavement from 2 years ago and the fact her grandson was being admitted to Yorkhill for cardiac surgery. She was assessed as having a low risk of further self harm or suicide and was discharged. I note a history of previous alcohol excess, self harm and overdose, An incidental finding during her admission was a small granuloma in her right mid zone on her chest x-ray which was not present 2 years ago. I have arranged for an out patient repeat film and will forward the results to you.

Yours sincerely

Dr Sam Ley
ACCS1 Acute Medicine

NHS Greater Glasgc

First Issued: //
Printed: //

Hospital No: **Date of Birth:** //
CHI:

REGISTERED GP **PATIENT**

Pharmacy Comments

GENERAL COMMENTS

This letter has been produced by the NHS Greater Glasgow Incremental Discharge Letter System

Referral letter:

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

North East Quadrant

Nail Surgery

Main Switchboard: 0141 201 1100
Department: Podiatry
Contact Tel: 0141 304 7430
Enquiries to: Donna Ann Bodel
Letter Date: 06/01/2020
Reference:
Dictated Date: 06/01/2020
Transcribed Date: 06/01/2020

Dear Nail Surgery,

Theresa Sinclair; D.O.B: 13/08/1963; CHI: 1308636407
90a Main Street, Lennoxtown, Glasgow, G66 7DA

Please see this patient fot nail surgery.

Many thanks.

Donna Ann Bodel.

Band 5 Podiatrist

Electronically Signed: ,

cc.

EBUS TBNA FROM MULTIPLE SITES

Performed	11-May-2026 11:09	Received	11-May-2026 16:42
Reported	15-May-2026 20:27	Order Number	F,26.0001898.T
Status	Final	Source System	Telepath

Pathology Final

NHS GREATER GLASGOW AND CLYDE
PATHOLOGY DEPARTMENT ENQUIRIES TO: 0141-354-9487 (89487)

Date collected: 11.05.2026
Date received : 11.05.2026 Date reported: 15.05.2026

Reporting Pathologist : Nicola Gilmour PATH
Consultant Pathologist: Fraser Duthie

N.B. SUPPLEMENTARY REPORT ADDED on 15/05/26

EBUS TBNA FROM MULTIPLE SITES

CLINICAL HISTORY

T1 N0 on L, T1 N2 on R. Staging EBUS TBNA 7L, 4R, 11R inf, 11L with new needle

MACRO

A. EBUS TBNA 7L: Specimen in PreservCyt

B. EBUS TBNA 4R: Specimen in PreservCyt

C. EBUS TBNA 11R inf: Specimen in PreservCyt

D. EBUS TBNA 11L: Specimen in PreservCyt

MICROSCOPY

A - D. COMPOSITE REPORT

All of the 4 cytological specimens contain prominent small lymphocytes in keeping with lymph node sampling.

In addition, in the cell block for 4R (sample B) there are sheets of cytologically atypical epitheliod cells with vacuoles and occasional gland openings. The appearances are those of METASTATIC ADENOCARCINOMA.

Furthermore, in the thin prep for 11L (sample D) there is a single papillary group of atypical cells, raising suspicion of further adenocarcinoma. However, these cells are not identified on cell block and it is not possible to be definitive on such few atypical cells. Immunohistochemical testing is underway on this sample to identify any occult epitheliod cells. The supplementary report will follow.

ALK1, ROS1, PDL1, KRAS, BRAF and EGFR studies are currently underway.

Dr C Maxwell , ST1
Dr Fraser Duthie, Consultant

Report written: 14/05/26
Authorised: 15/05/26 by Dr F Duthie

SUPPLEMENTARY REPORT - 15/05/26

Immunocytochemical staining highlights occasional crushed cells are felt most likely to represent benign epithelium from overlying bronchial mucosa, but does not highlight any convincing malignant cells within specimen D.

Dr C Maxwell , ST1
Dr Fraser Duthie, Consultant

Report written: 15/05/26
Authorised: 15/05/26 by Dr F Duthie

Intestinal Polyp

Performed	11-Feb-2025 14:14	Received	12-Feb-2025 12:18
Reported	31-May-2025 22:47	Order Number	D,25.0010812.Q
Status	Final	Source System	Telepath

Pathology Final

NHS GREATER GLASGOW AND CLYDE
PATHOLOGY DEPARTMENT ENQUIRIES TO: 0141-354-9487 (89487)

Date collected: 11.02.2025
Date received : 12.02.2025 Date reported: 31.05.2025

Reporting Pathologist : Will Smith PATH
Consultant Pathologist: Will Smith PATH

SIGMOID COLON POLYP - DISTAL

CLINICAL HISTORY

Alternating bowel habit & qFIT - 36.

Colonoscopy: 1 sessile polyp (3 mm) within the distal sigmoid colon. Background diverticular disease with associated diverticulitis within the left colon noted.

MACRO

5 mm piece of tissue.

MICROSCOPY

Microscopy shows sections of hyperplastic polyp. There is no dysplasia or malignancy.

Dr W Smith, ST4

Report written: 26/05/25
Authorised: 31/05/25 by Dr Will Smith

Reported via digital pathology (validated but currently out of scope for UKAS)

NM Whole body PET FDG

Performed	23-Apr-2026 13:32	Received	28-Apr-2026 11:56
Reported	28-Apr-2026 11:54	Order Number	G504H43373715
Status	Final	Source System	MiSys

NM Whole body PET FDG Final
Theresa Sinclair
Clinical History :
Multifocal changes. Growing RUL nodule, and LUL nodule. For PET to further characterise.

FDG-PET CT
Technique: FDG-PET from skull base to mid femur with low dose unenhanced CT. Reference made to CT of 20/03/26 and 25/03/25.

Findings:
Intensely FDG avid 12 mm right apical nodule and 8mm left apical nodule highly suspicious of malignancy.
Faint FDG uptake in a GGO in the LLL and RUL - may represent lowgrade adenocarcinoma spectrum lesions.

Intensely FDG avid short axis 8 mm AP W node suspicious of nodal involvement.
Mild - moderately avid right hilar, subcarinal and right lower paratracheal nodes - nonspecific but may be benign.
No FDG avid supraclavicular lymphadenopathy.

FDG uptake of the liver, adrenals, pancreas and spleen is unremarkable.
No evidence of skeletal metastasis.

Conclusions:
Intensely FDG avid right apical nodule and left apical nodule highly suspicious of malignancy.
Suspicious intensely FDG avid APW node.
Right hilar, subcarinal right lower paratracheal node - nonspecific but may be benign.
No evidence of distant metastasis.
GGO in RUL and LLL may be lowgrade adenocarcinoma spectrum lesions - for follow-up CT.
Key images on PACS.

Reported by: Dr Sai Han
Verified by: Dr Sai Han

CT Thorax abdomen pelvis with contrast

Performed	25-Sep-2024 11:16	Received	26-Sep-2024 08:44
Reported	26-Sep-2024 08:42	Order Number	G504H41311963
Status	Final	Source System	MiSys

CT Thorax abdomen pelvis with contrast Final
Theresa Sinclair
Clinical History :

Suspicion of cancer but with no obvious localising features? : Yes
Do any signs, symptoms or investigations (including CXR and FBC) suggest malignancy in a specific system or alternative diagnosis? : No
Intractable back pain L sided abdominal pain tender over L2-L4 vertebrae, this lady had CT scan suspicious of lung malignancy in may'24 and has app for repeat CT chest at Gartnaval hosp on 5/9/24, she has 2weeks of intractable low back pain with tenderness over Lumbar vertebrae ? meta disease, would you be able to extend CT to abdomen and pelvis and lumbar spine please at same app?

CT Thorax abdomen pelvis with contrast :
Comparison made with the previous CT dated 23/05/2024. Note is made of the previous CT dated 05/09/2024.

Unchanged 9 mm right apical nodule. Other foci of ground-glass change within both lungs are also unchanged. No new significant pulmonary nodule or central endobronchial lesion. Slightly enlarged right lower paratracheal node measuring 11 mm and prominent 9 mm subcarinal node are unchanged from previous. No other mediastinal, hilar or axillary lymphadenopathy.

The solid upper abdominal organs appear unremarkable. Unremarkable gallbladder and nondilated biliary tree. No gross focal oesophageal or gastric abnormality. Uncomplicated mild sigmoid diverticulosis. The remainder of the unprepared bowel loops appear grossly normal. No abdominal or pelvic lymphadenopathy. Sterilisation clips.

Mild degenerative changes at the L2/L3 level. No significant bony abnormality.

Impression:
Unchanged intrathoracic appearances. No definite evidence of malignancy.

Reported by: Dr V-Liem Soon and None
Verified by: Dr V-Liem Soon

XR Chest

Performed	16-Apr-2011 18:05	Received	18-Apr-2011 13:59
Reported	18-Apr-2011 13:37	Order Number	G516H25803521
Status	Final	Source System	MiSys

XR Chest Final
Teresa Sinclair
Clinical History : Overdose with alcohol excess, crackles right lower zone. ? aspiration.

XR Chest :

Normal cardiac and mediastinal contour.
There is some hazy opacity in both lower zones which is symmetrical and thought due to overlying soft tissue rather than representing pulmonary pathology. Small calcified opacity in the right midzone consistent with a granuloma.

Reported by: Dr John Sheridan
Verified by: Dr John Sheridan

MANUAL PATIENT RECORDS

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

Including:

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

Medical Assessment Unit
Western Infirmary, Glasgow G11 6NT.
Tel No. 0141-211-2850

NHS
Greater Glasgow and Clyde

OUR REF: SL/GF
CHI NO: **1308636407**

Date Dictated: 16/06/2011
Date Typed: 16/06/2011

Teresa Sinclair
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Dear Teresa

CRN: 23004807E

I hope you are keeping well after your recent admission to the Western Infirmary. You may remember that while you were in the hospital you had an x-ray of your chest which has shown a small area of change thought to be an infection. I would be keen for you to come back and have the chest x-ray repeated so that we can make sure your chest x-ray is back to normal. I believe you have already had one request sent out which you did not attend. If you are having any problems making the appointment if you could let us know so we can arrange a more convenient time, if you do not attend this appointment another one will not be offered.

Yours sincerely

Dr Sam Ley
ACCS1 Acute Medicine

Medical Assessment Unit
Western Infirmary, Glasgow G11 6NT.
Tel No. 0141-211-2850

NHS
Greater Glasgow and Clyde

OUR REF: SL/GF
CHI NO: **1308636407**

Date Dictated: 15/06/2011
Date Typed: 16/06/2011

Dr James Henderson
Campsie Surgery
Lennoxtown Clinic
103 Main Street
G66 7DA

Dear Dr Henderson

Teresa Sinclair - 13/08/1963 - CRN: 23004807E
90a Main Street, Lennoxtown, Glasgow, G66 7DA

This patient was due to have a repeat out patient chest x-ray after an incidental finding of a small lesion in the right mid zone, thought to be a granuloma on a chest x-ray performed when she was recently an in patient with an impulsive overdose of Citalopram. She failed to attend for the x-ray and I have sent one further appointment request. If she fails to attend this another one will not be offered.

Yours sincerely

Dr Sam Ley
ACCS1 Acute Medicine

Acute Services Division

Diagnostics Directorate

Radiology Department
Western Infirmary
Dumbarton Road
Glasgow
G11 6NT

NHS
Greater Glasgow and Clyde

Dr Scott Muir
Western Infirmary
Dumbarton Road
Glasgow
G11 6NT

Tel: 0141 211 2794
Date: 14/06/11
CHI No: 1308636407
Hosp No: 23004807E

Dear Doctor,

We would like to inform you that the patient below has failed to arrive for a radiology appointment.

Patient: Teresa Sinclair
Date of birth: 13/08/1963
CHI No: 1308636407
Referrer: Dr Scott Muir Source: Western Infirmary

For: **a Chest x-ray**
On: **Monday, 13 June, 2011 at 9:30 am**
At: **Western Infirmary, Radiology Department**

We are concerned that your patient still requires their examination. If this is the case, could you please confirm this and re-request in the normal manner?

Yours sincerely
Appointments Officer

Medical Assessment Unit
Western Infirmary, Glasgow G11 6NT.
Tel No. 0141-211-2850

NHS
Greater Glasgow and Clyde

OUR REF: SL/GF
CHI NO: **1308636407**

Date Dictated: 31/05/2011
Date Typed: 02/06/2011

Teresa Sinclair
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Dear Ms Sinclair

CRN: 23004807E

I hope you are feeling better after your recent admission to the Western Infirmary. You may remember while you were in that you had an x-ray of your chest. The formal report of this has shown a small area which may be related to a minor infection you have had in the past and we would be keen for you to come back for an x-ray in 6 weeks time to check that it has resolved. I will send the results on to your GP.

Yours sincerely

Dr Sam Ley
ACCS1 Acute Medicine

Medical Assessment Unit
Western Infirmary, Glasgow G11 6NT.
Tel No. 0141-211-2850

NHS
Greater Glasgow and Clyde

OUR REF: SL/GF
CHI NO: **1308636407**

Date Dictated: 31/05/2011
Date Typed: 02/06/2011

Date of Admission: 16/04/2011 Date of Discharge: 18/04/2011

Dr James Henderson
Campsie Surgery
Lennoxtown Clinic
103 Main Street
G66 7DA

Dear Dr Henderson

Teresa Sinclair - 13/08/1963 - CRN: 23004807E
90a Main Street, Lennoxtown, Glasgow, G66 7DA

Diagnosis Intentional overdose of Citalopram

This 47 year old lady took an impulsive overdose of Citalopram as she felt she could not cope with the bereavement from 2 years ago and the fact her grandson was being admitted to Yorkhill for cardiac surgery. She was assessed as having a low risk of further self harm or suicide and was discharged. I note a history of previous alcohol excess, self harm and overdose. An incidental finding during her admission was a small granuloma in her right mid zone on her chest x-ray which was not present 2 years ago. I have arranged for an out patient repeat film and will forward the results to you.

Yours sincerely

Dr Sam Ley
ACCS1 Acute Medicine

IMMEDIATE DISCHARGE LETTER

NHS Greater Glasgow

Western Infirmary
Dumbarton Road
Glasgow
G11 6NT
Telephone : 0141 - 211 - 2000

GP COPY

First Issued: 19/04/2011 19:10
Printed: 19/04/2011 19:10

Admitted: 16/04/2011 **Discharged:** 16/04/2011
Discharged to: Home
Ward: Medical Assessment Unit (WIC)
Consultant: MRW TULLETT, General Medicine
Hospital No: 23004807E **Date of birth:** 13/08/1963
CHI: 1308636407

REGISTERED GP

Dr JAMES HENDERSON
CAMPSIE SURGERY, LENNOXTOWN CLINIC
103 MAIN STREET
LENNOXTOWN
G66 7DA

PATIENT

TERESA SINCLAIR
90A MAIN STREET
LENNOXTOWN
GLASGOW
G66 7DA

DIAGNOSES	ICD10	PROCEDURES	OPCS4
1. Self-poisoning (unspecified), 16/04/2011	T36-T50		

MEDICATION

Drug Name	Format	Route	Dose	Admin Times 8 12 14 18 22	PRN/Comment	Course Length	Quantity Dispensed
Omeprazole	Cap	Oral	20mg	X		Indefinite	Patients Own

Pharmacy Comments

FOLLOW UP ARRANGEMENTS

Outpatient Clinic	Consultant	Date
No arrangements made		

Outpatient Investigations	Date
No arrangements made	

Community Care	Date	Reason
No arrangements made		

GENERAL COMMENTS

Final discharge letter to follow

This lady was admitted following an overdose of unknown quantity consisting of her citalopram, we are not sure where this was obtained, and other tablets belonging to a friend.

She was also intoxicated with alcohol, she now regrets her actions and has no suicidal idealation. Her paracetamol level was undetectable

She is fit for discharge home

Signed: _____ **Designation:** _____

Contact: Christopher Lawrence **Pager Number:**

THERESA SINCLAIR 16-Apr-2011 16:46:49 WESTERN INF GLASGOW 01412112000

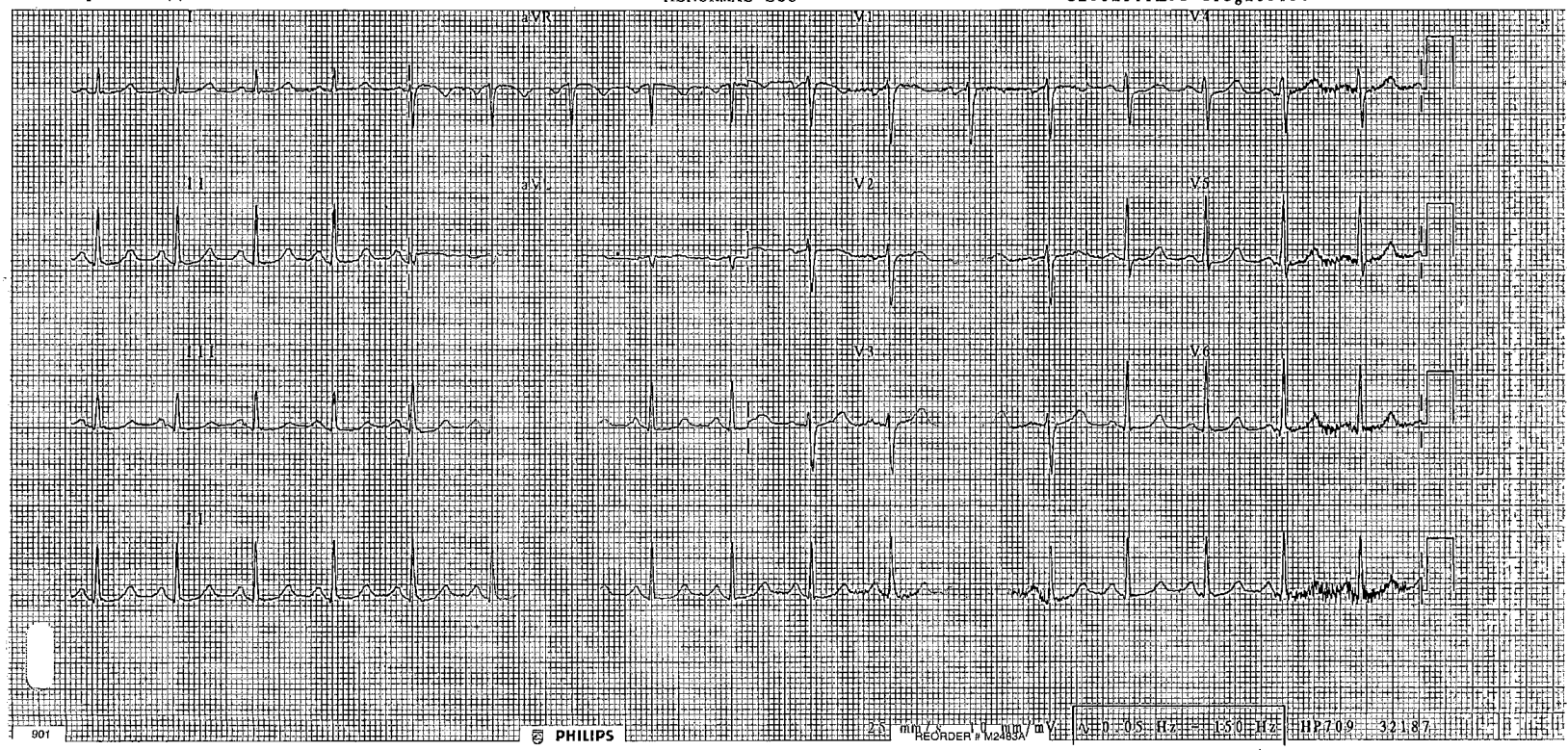
Rate	101	. AGE NOT ENTERED, ASSUMED TO BE 50 YEARS FOR PURPOSE OF ECG INTERPRETATION
PR	150	. SINUS TACHYCARDIA, RATE 101.....normal P axis, rate>=100
QRSD	78	. LEFT ATRIAL ABNORMALITY.....P>60mS, <-.15mV V1
QT	336	
QTc	435	

--Axis--

P	71
QRS	72
T	44

Nil acute
Cogle

- ABNORMAL ECG - Unconfirmed diagnosis.



12

DRUGS PRESCRIBED

Date given	Drug (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given by

PARENTERAL FLUID PRESCRIPTION SHEET

Date	FLUID	Volume	Time to run	Rate mls/hr	ADDED DRUGS	Quantity	Doctors Signature	Added by	Start time 24hr Clock	Put up by	Checked by	Serial/ Batch no

N.B. IF USING A SYRINGE DRIVER/INFUSION PUMP PLEASE USE THE "PRESCRIPTION AND ADMINISTRATION SHEET FOR MEDICINES GIVEN BY SYRINGE DRIVER/INFUSION PUMP"

REFUSAL TO REMAIN UNDER HOSPITAL CARE

I wish to take my discharge. I appreciate that this is against the advice and wishes of the Consultant or his or her deputy looking after me. I acknowledge that I have been informed of the risks of doing so and I accept full responsibility for my actions and any consequences arising from them.

Name *(print)* ____________________ Signature ____________________

I confirm that I have explained to the patient the risks that might arise out of his / her decision to take his / her own discharge.

Date ____________________ Signature ____________________
(Medical Practitioner)

DISCHARGE DETAILS (NURSING)

Treatment ____________________

____________________ Signed ____________________

(Please put initials in box)

Crutches [ ] Return appointment [ ] Advice Card [ ] Medication [ ]

Escort to ward [ ] Relatives informed [ ] IRIS [ ] Transport [ ] Time booked

Discharged with ____________________ Admitted / transferred to ____________________

109437

Accident and Emergency Department
Western Infirmary

NHS Greater Glasgow and Clyde

Glasgow G11 6NT
Tel: 0141 211 2409/2304
Fax: 0141 2112559

A&E No. 11000016614

23004807E

4

Name: SINCLAIR   Forename: TERESA   Title: MS

Address: 90A MAIN STREET, LENNOXTOWN, GLASGOW   Postcode: G66 7DA   CHI No: 1308636407

Telephone: 077866 01685

Date of Birth: 13.08.63   Sex: F   Age: 47 yrs

Number: 1308636407

Name: HENDERSON JAMES
Address: LENNOXTOWN CLINIC, 103 MAIN STREET, LENNOXTOWN   Postcode: G66 7DA
Telephone: 01360310357

TR11014994

Next of Kin: TERESA JENKINS
Relationship: DAUGHTER
Address: 275 MAIN STREET, LENNOXTOWN, GLASGOW   Postcode: G66 7DH
Telephone: 078876623809

Key Carer:

Attendance: 16.04.11 16:39

Incident:

Presenting Complaint: APPEARS INTOXICATED

BIBP
TOLD POLICE SHE HAD TAKEN AN OD, NOW DENIES
THIS DISRUPTIVE

Tetanus Cover:

Allergies:

BP= 131/88   RR= 16   Sat= 98   BM= 5.4   Temp=

GCS= E:4 M:6 V:5 Total: 15

Drugs Prescribed

Drug	Dose	Route	Signature	Given By	Time

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WESTERN INFIRMARY
RESUS

Patient Sample Report

Patient

ID:	23004807E
Last Name:	SINCLAIR
First Name:	TERESA
Gender/Age:	Female, 47 years
Birth Date:	13.08.1963
Status:	ACCEPTED
Analyzed:	16.04.2011 18:01:46
Sample Type:	Venous
Account Number:	
Clinician:	
Operator ID:	RHONA BRIGGS0

Analyzer

Model:	GEM® *Premier 4000*
Area:	WIGRESUS
Name:	AERESUS
S/N:	06110216

Measured (37.0°C)		
cH	47.1	nmol/L
pCO_2	7.0	kPa
pO_2	3.6	kPa
Na^+	146	mmol/L
K^+	3.7	mmol/L
Cl^-	111	mmol/L
Ca^{++}	1.17	mmol/L
Hct	42	%
Glu	5.0	mmol/L
Lac	1.7	mmol/L

CO-Oximetry		
tHb	14.1	g/dL
O_2Hb	46.8	%
COHb	3.3	%
MetHb	2.4	%
HHb	47.5	%
sO_2	49.6	%

Derived		
BE(B)	0.9	mmol/L
HCO_3^-(c)	27.9	mmol/L
Hct(c)	42	

Operat

Patient's name _____ Age _____ Date of Birth _____ 1

NURSING DOCUMENTATION - EMERGENCY DEPARTMENT

Date _____ Time _____ Triage Nurse _____ PC _____

Triage category 1 2 3 4 5

Relatives present: Relatives informed:

INITIAL MANAGEMENT

Nurse _____

Oxygen started _____ %: Signed _____ ECG: Signed _____

Signed _____

Other Treatment _____

INITIAL VITAL SIGNS

at:(Time) _____
HR: _____
BP: _____
RR: _____
SaO_2: _____
Temp: _____
G.C.S: _____
Signed _____

NEUROLOGICAL OBSERVATIONS

RESPONSIVENESS	TIME	hrs	
	EYES OPEN	spontaneously 4 to speech 3 to pain 2 none 1	eye closed by swelling = C
	BEST VERBAL RESPONSE	orientated 5 confused 4 inappropriate words 3 incomprehensible sounds 2 none 1	Endotracheal tube or Tracheostomy = E Dysphasia = D
	BEST MOTOR RESPONSE	obey commands 6 localises pain 5 normal flexion to pain 4 abnormal flexion to pain 3 extention to pain 2 none 1	Record the best arm response Paralysed = P
		COMA SCORE 15	
PUPILS	RIGHT	size (mm) Reaction	+ = Reacts - = No Reaction C= Eye closed SL= sluggish pupil
	LEFT	size (mm) Reaction	
LIMB MOVEMENT	ARMS	Normal power Mild weakness Severe weakness Extention No response	Record right (R) and left (L) separately if there is a difference between the two sides
	LEGS	Normal power Mild weakness Severe weakness Extention No response	Fractured limb = F
	BLOOD PRESSURE mm Hg	230 220 210 200 190 180 170 160 150 140 130 120 110 100 90	40 39 38 37 Temp C° 36 35 34 33 32 31 30
	PULSE RATE	80 70 60 50 40 30	
		RESPIRATORY RATE	

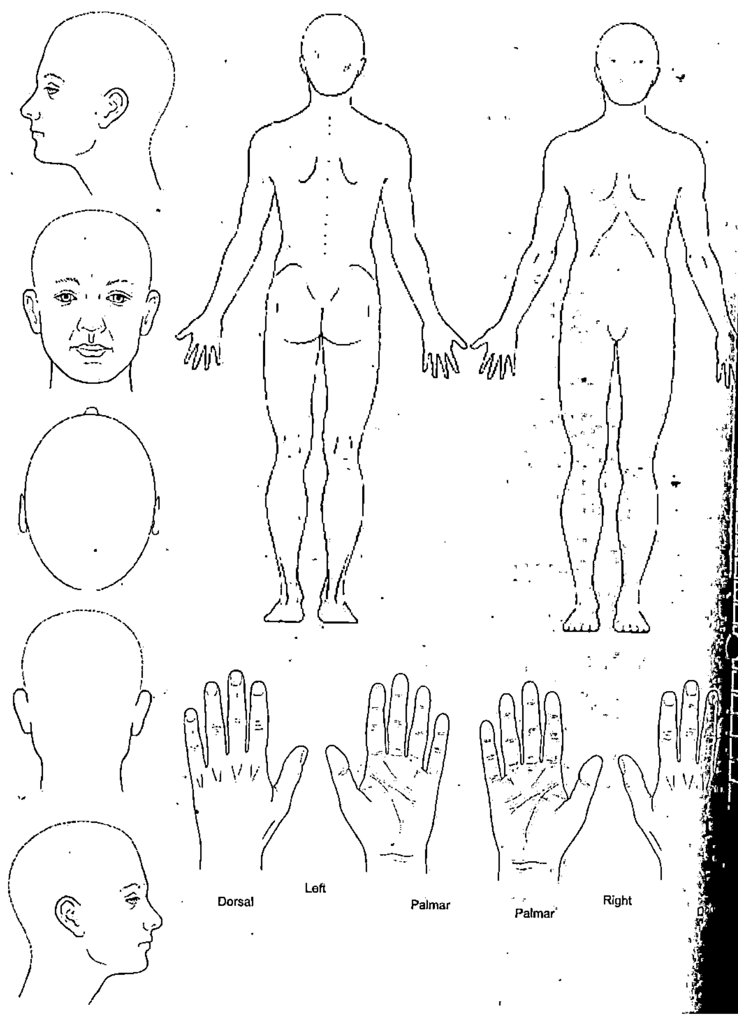
BLOOD GLUCOSE	Time							
BM STIX	BM							
PEAK FLOW	Time							
	PF							
VISUAL ACUITY	R. eye aided/unaided							
	L. eye aided/unaided							
	pH L. eye				R. eye			

Signed: _____

URINALYSIS

Urobilinogen µmol/L	Normal 3 ☐	16 ☐	33 ☐	66 ☐	131 ☐		
Protein gm/L	Neg ☐	Trace ☐	0.30 + ☐	1 ++ ☐	3 +++ ☐	>20 ++++ ☐	
pH	5.0 ☐	6.0 ☐	6.5 ☐	7.0 ☐	7.5 ☐	8.0 ☐	8.5 ☐
Blood	Neg ☐	Non Haem ☐	Haem Trace ☐	Small + ☐	Mod ++ ☐	Large +++ ☐	
Specific Gravity	1.000 ☐	1.005 ☐	1.010 ☐	1.015 ☐	1.020 ☐	1.025 ☐	1.030 ☐
Ketones mmol/L	Neg ☐	Trace 0.5 ☐	Small 1.5 ☐	Mod 4 ☐	Large 8 ☐	Large 16 ☐	
Bilirubin	Neg ☐	Small + ☐	Mod ++ ☐	Large +++ ☐			
Glucose mmol/L	Neg ☐	5.5 Trace ☐	14 + ☐	28 ++ ☐	55 +++ ☐	111 ++++ ☐	
Nitrites	Neg ☐	Positive ☐					
Leucocytes	Neg ☐	Trace ☐	Small + ☐	Mod ++ ☐	Large +++ ☐		
BHCG	+ ve	- ve					

Please annotate area of: Tenderness / Bruising / Swelling / Abrasions / Lacerations / Incised wounds



CLINICAL NOTES - EMERGENCY MEDICINE

Consultant: TWEED Seen by: BRIGGS Staff Grade

Grade: FY1, FY2, ST1, ST2, ST3, ST4-6, FTSTA, LOCUM, ENP, CONSULTANT, OTHER (circled) *(Please circle)* At (time) 1725

Date: 16 Oct 11

47♀ Brought in by police
Alcohol excess
OD
Suicidal.

Confused / difficult history
Drinking today.
Took unknown number of tablets at unknown time.
Some were her own - "Citalopram".
Some belonging to a friend named Paul.

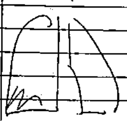
Says her boyfriend, Eddie, was killed on the road 2/12 ago - and all she wanted was to take his tobacco tin at the time
Says her grandson who has Downs Syndrome is due admission for cardiac surgery soon.

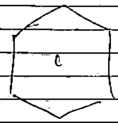
PMH → Prev. overdoses
Alcohol problem.

DH Repeats - Omeprazole
Acutes - Diazepam 2mg March + April
Amoxicillin March.

O/E Smells of alcohol
Rather unsteady
Garrulous
Emotionally labile
BM = 5.4

Obs HR 106
BP 131/88
RS 14 [illegible] added

RS  RR 16.
O2sat 98% on air
few crackles (R)
lower zone

Abdo  Soft
Non tender
BS ✓.

Imp Alcoh
Alcohol problem.
Suicidal ideation
Heavily intoxicated.
Overdose unknown amount, unknown
substance, unknown time.

P. IV access
· Bloods- AE11 + Paracetamol, Salicylate + alcohol
· ECG - NSR ° acute rate 101/min
· CXR · COPD Δ ° focal

Ref -> medicine for likely observation
overnight + Referral in morning
Police officers will stay c pt. for now.

[signature]
B[illegible]
Staff Grade

16/4/11 cont

Date [redacted]

UNITARY MEDICAL RECORD and EXAMINATION

Consultant ______ Seen by Conw

Grade: FY1, FY2, (ST1), ST2, ST3, ST4-6, FTSTA, LOCUM, ENP, CONSULTANT, OTHER *(Please circle)* At (time) ______

Date

HISTORY

Presenting Complaint: Overdose / Intoxicated

History of Presenting Complaint:

(47) Alcohol XS
\+ ~~[illegible]~~ self harm
Prev. admission w/OD / intoxicat

Taken into custody this morning due to intoxicat
at Maryhill police station → stated had taken OD
under quantity / which

Now ~~[illegible]~~ Emotional, Regret not admission facts

States took 5 antidepressants ~09:00 this AM
- Venlafaxine
No paracetamol / opiates

Took tablets because she 'couldn't cope'
- bereavement 2 yrs ago
- grandson to be admitted to Yorkhill tomorrow for cardiac surgery
Now regrets actions
Clearly states no ongoing suicidal ideation
Keen to go (H)

O/E HR 90 reg ~~[illegible]~~ Tearful
ECG – Sinus tachy, nil else

~~[illegible]~~ Clear Abdomen SNT
HS I, II, 0

→ Safe to discharge
No ongoing suicidal ideation
Paracetamol level undetectable

Home.

[signature]

MEDICAL NOTES - HISTORY and EXAMINATION *(cont)*

Date

Past Medical History:

- Diabetes
- Obesity
- Hypertension
- MI
- CABG
- Rheumatic Fever
- TB

Allergies

Drug History:

Family and Social History:

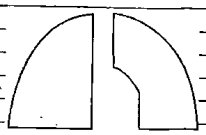
EXAMINATION

Vital Signs: BP P RR T General Appearance:

O_2 Sat

Cardiovascular

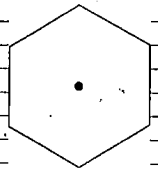
Respiratory



MEDICAL NOTES - HISTORY and EXAMINATION *(cont)*

Date

Abdominal



Central / Peripheral Nervous System GCS

EO MR VR

Other

INVESTIGATIONS DONE Time

U & E's		GLUC		LFT's		Para/Sal		Troponin		D - Dimer	
FBC		COAG		Blood Cultures		MSU		ABG			

ECG

CXR

Other

DIFFERENTIAL DIAGNOSIS

MEDICAL NOTES - HISTORY and EXAMINATION *(cont)*

Date

PLAN

Name Sign Grade

Date Time

SENIOR REVIEW

Name Sign Grade Date Time

CONSULTANT REVIEW

Name Sign Date Time

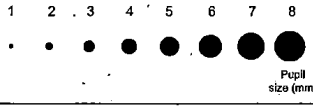
Results

Biochemistry				Haematology		Other
Na	145	Paracetamol	<15	Hb	129	CXR
K	4.3	Salicylate	<50	MCV	96.8	
CL	108			WCC	9.6	
Ur	3.0	D - Dimer		NEUT	2.7	
Cr	70			Platelets	488	
Gluc	5.1					
Ca^{2+}	2.23	ABG		INR	1.1	
Troponin				APTT		
Amylase		O_2		PT		
Bil	3	CO_2				
AST	23	H^+				
ALT	12	BI				
ALP	18	BE				
YGT	84					
ALB	41	COHb				
CRP	3.1					

Neurological Observation Chart

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

Glasgow Coma Scale



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		No response																			
	LEGS	Normal power																			
		Mild weakness																			
		Severe weakness																			
		Extension																			
		No response																			

Patient Observation Chart

NHS Greater Glasgow and Clyde

Name
Address

23004907E
SINCLAIR F
TERESA 13/08/1963
90A MAIN STREET
LENNOXTOWN
GLASGOW G66 7DA
CHI-1308636407

Hospital No.
DOB

Admitted Date 16/11 Ward MAU
Transferred Date _____ Ward _____
Transferred Date _____ Ward _____

Patient Observation Chart Guidelines

Not all patients will require every part of this observation chart to be completed. Clinical judgement should be used to dictate the type and frequency of vital sign monitoring required.

The following patients are considered to be at high risk of developing a critical illness therefore it would be considered good practice to commence MEWS at the earliest opportunity.

- All emergency admissions
- Unstable patients
- Patients whose condition is causing concern
- Patients requiring frequent or increasing frequency of observations
- Patients who have stepped down from a higher level of care
- Patients with a chronic health problem
- Patients who are failing to progress
- Post-operative patients

There are also patients in whom the use of MEWS may be inappropriate:

- Day case patients
- Patients requiring no observations
- Patients who are terminally ill
- Planned discharges.

This is not an exhaustive list. Although the majority of patients may benefit from utilisation of the scoring system, a nurse's own clinical judgement dictates whether he/she feels the patient requires scoring. For guidance on the use of MEWS, refer to the Nurse in Charge.

Pain Score
Remember to check scores after pain relief.
Patient asked to report pain at rest and on movement.
0 = No pain at rest or on movement
1 = No pain at rest, slight pain on movement
2 = Intermittent pain at rest, moderate on movement
3 = Continuous pain at rest severe on movement
Review 5 mins after I/V, 1 hour after I/M, S/C or oral analgesia.
Sustained pain score of 2 or pain score of 3 requires intervention.

Sedation Score
0 = Awake, alert, orientated
1 = Mild, aroused by verbal stimulus
2 = Moderate, aroused by physical stimulus
3 = Severe, no response
S = Normal sleep, easy to rouse
Score 2 or 3 requires immediate intervention

Nausea Score
0 = No nausea
1 = Mild (No treatment wanted)
2 = Moderate (Treatment required)
3 = Severe (Clinical problem persists despite treatment)
Review 1 hour after treatment. Inform doctor if additional treatment required.

95497

23004807E
SINCLAIR F
TERESA 13/08/1963
90A MAIN STREET
LENNOXTOWN
GLASGOW G66 7DA
CHI-1308636407

Adult Intravenous (IV) Cannulation Care Plan

NHS
Greater Glasgow and Clyde

Potential Complications of IV Cannulation

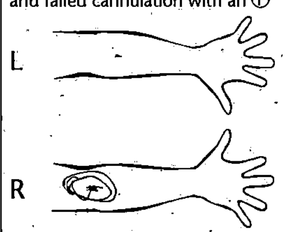
1. Redness, pain or inflammation at insertion site due to phlebitis or local infection
2. Local oedema due to infiltration
3. Bloodstream infection
4. Extravasation

Required Interventions

[illegible] minimise the above complications. Those highlighted in bold are necessary to assist in compliance with the [illegible] Vascular Catheter (PVC) Care Bundle

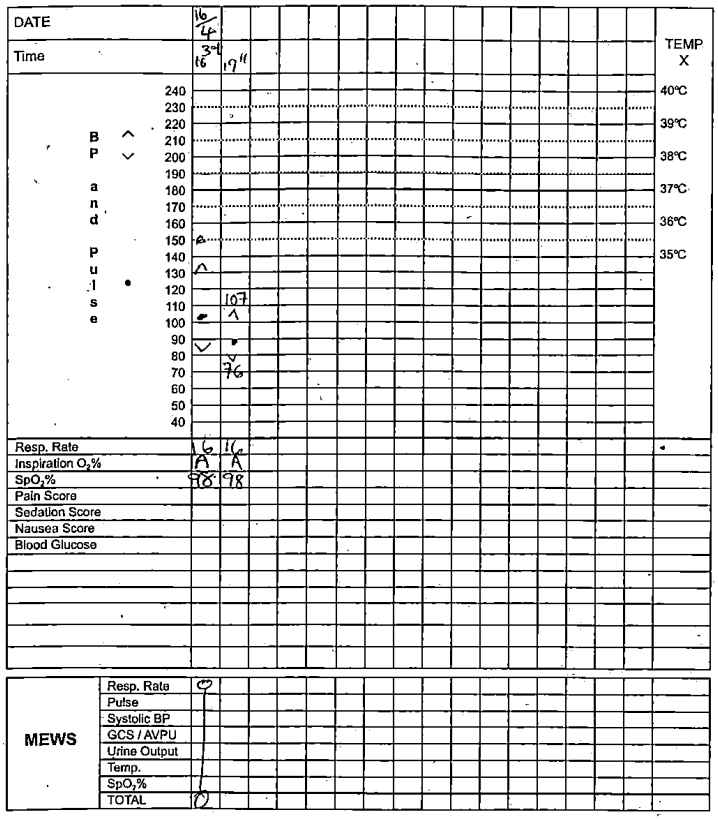
1. **Hand hygiene must be performed before and after IV cannula insertion or manipulation is undertaken.**
2. Decontaminate the patients' skin for at least 30 seconds and allow to dry before inserting the IV cannula. Non-sterile gloves must be worn and the insertion site should never be directly touched.
3. **Document the date, time,** gauge and **site of IV cannula insertion below.** Use the date strip contained within the IV dressing to label the date of insertion on the cannula dressing.
4. Assess and document the reasons for insertion and removal of IV cannulae below. **The IV cannula site and ongoing clinical need should be assessed at least once per shift and must be documented in the Monitoring and Recording Chart overleaf.** When the IV cannula is not in use, maintain patency by flushing with 0.9% sodium chloride every 24 hours.
5. **The IV cannula should be changed every 72 hours or immediately if indicated by VIP score of 2 or more. If the patient has poor venous access, a risk assessment should be carried out using VIP scoring tool overleaf. If score is less than or equal to 1 then the decision can be documented by nursing staff in the chart overleaf to retain cannula up to a maximum of 96 hours. If the cannula has to remain in situ for longer than this, then this decision must be made and documented by medical staff.**
6. **Check IV cannula dressing is dry and intact and that site of insertion can be easily observed. Replace dressing immediately if indicated and document procedure overleaf.**
7. Ensure IV cannula has a needle-free access system with integrated extension. This must be decontaminated for at least 30 seconds and allowed to dry before and after use.
8. If there has been a breach in aseptic technique during insertion (e.g. cannula was inserted during an emergency) then the cannula must be replaced within 24 hours of insertion *. If the cannula has to remain insitu for longer than this, then this decision must be documented overleaf.

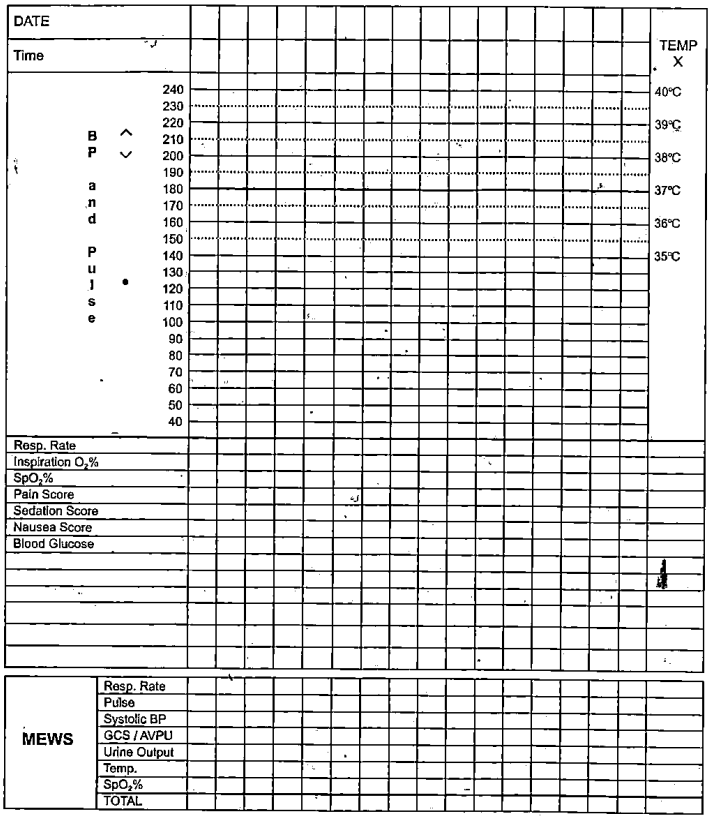
[illegible]	Insertion Reason Codes		[illegible]
Please mark successful cannulation with a number e.g. ① and failed cannulation with an Ⓕ	Emergency IV Access = E Routine IV Access = R Radiological Procedure = RP Nil by Mouth = NBM	Chemotherapy = C IV Fluids / IV Medicine Administration = IV Blood = B Other (Please state)	Not Required = NR Phlebitis = P Infiltration = I Extravasation = E Other (Please state)



Other Site Used ______

Cannula Number	Date and Time	Inserted by (print name)	Insertion Reason Code	Gauge	Was aseptic technique breached?	Removed by (print name)	Date and Time	Removal Reason Code
①	16/4/11	AAE	E	[illegible]	Yes*/No	[illegible]	16/4/11	[illegible]
					Yes*/No			
					Yes*/No			
					Yes*/No			





Modified Early Warning Score (MEWS)

Score	3	2	1	0	1	2	3
Resp. Rate		≤8	9-10	11-20	21-25	26-30	≥31
Pulse		≤40	41-50	51-100	101-110	111-130	≥131
Systolic BP	≤84	85-89	90-100	101-199		>200	
GCS / AVPU	≤8	9-13	14 New agitation or confusion	15 / Alert	Voice	Pain	Unresponsive
Urine	<10mls/hr for 2 hrs	<30mls/hr for 2 hrs					
Temp. (°C)		≤35.0	35.1-35.9	36.0-37.4	37.5-38.5	≥38.6	
SpO2%	≤87	88-91	92-94	95-100			

Calling Criteria

Score is 1-3	Increase frequency of patient observations, monitor trends and inform Nurse in Charge.
Score is 3 in one category	Contact Senior Nurse and increase frequency of patient observations.
Score is 4 and above or increasing by 2 or more Patient's GCS falls by 2 or more Any patient whose condition is causing concern	Contact Senior Nurse and increase frequency of patient observations Contact Critical Care Outreach Team.

The Senior Nurse will direct patient care and contact the appropriate medical staff who ...

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 IV site	1	Possible first signs **OBSERVE CANNULA**
Two of the following are evident: • Pain • Erythema • Swelling	2	Early stages of phlebitis **RESITE CANNULA**
All of the following are evident: • Pain along the path of the cannula • Erythema • Induration	3	Mid-stage phlebitis **RESITE CANNULA and SEEK FURTHER ADVICE**
All of the following are evident and extensive: • Pain along the path of cannula • Erythema • Induration • Palpable venous cord	4	Advanced stage of phlebitis or start of thrombophlebitis **RESITE CANNULA and SEEK FURTHER ADVICE**
All of the following are evident and extensive: • Pain along path of cannula • Erythema • Induration • Pyrexia • Palpable venous cord	5	Advanced thrombophlebitis **RESITE CANNULA and SEEK FURTHER ADVICE**

IV Cannula Monitoring & Recording Chart

(Based on the HPS PVC Care Bundle)

Cannula Number	Date and Time	Appropriate Hand Hygiene Undertaken?	Has cannula been insitu for 72 hours?	Continuing Clinical Indication	VIP Score	IV Dressing Dry and Intact?	Comments / Action Taken	Initials
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		

Patient Profile

North Glasgow Hospitals

NHS Greater Glasgow and Clyde

Ward: MAU **Date:** 16/4/2011 **Time:** (24hr clock)

Please print clearly in BLOCK CAPITALS

23004807E
SINCLAIR
TERESA F
90A MAIN STREET 13/08/1963
LENNOXTOWN
GLASGOW G66 7DA
CHI-1308636407

Title
Name
Preferred
Address

Post Code:
☎:

DOB: 13/08/1963 Age: 47
Hosp. No:
Occupation:
Religion:
S.O.S. ☐ date: ☐☐/☐☐/☐☐
Interpreter required: ☐
(specify:)
Lives alone ☐

1 NOK/Friend/Contact: Anne-Marie Jenkins
Address: 32 Main St
LENNOXTOWN
☎Day:
☎Night:
Relationship: DAUGHTER
2 NOK/Friend/Contact:
Address:
☎Day:
☎Night:
Relationship:
NOK informed of admission ☐
NOK informed by:
GP:
Address:
☎:

Consultant:
Named Nurse ①:
Admitting Nurse:
Named Nurse ②:
Relatives seen by Doctor ☐

REASON FOR ADMISSION

O.D of unknown amount
Alcohol excess –

Patient's perception of illness:
Upset doesn't know why

Diagnosis:

Operation/Treatment:

Relevant PMH:
Antidepressants – stopped because of O.D
Diazepam

MEDICATION

With patient	☐
Stored & receipt given	☐
No medication required	☐
Taken home	☐
details:	

PERSONAL BELONGINGS

Clothing listed ✓	☐
Valuables listed	☐
Valuables in ward	☐
Valuables in hospital safe	☐

OBSERVATIONS ON ADMISSION

Temperature	36.5	°C
Pulse	89	bpm
BP	107 / 76	
Resp	16	
Pain Score	0	
Urinalysis		
Waterlow Score		
Height		m
Weight		kg
Body Mass Index		
Blood sugar(if appropriate)		mmols
Allergies	Yes ☐	No ☒
details:		

00553 All belongings at Maryhill Police Station

DISCHARGE PLANNING

Boarding 1st 2nd 3rd	Signature	Time	Comments/Information
Informed: ward ☐ ☐ ☐ patient ☐ ☐ ☐ relatives ☐ ☐ ☐			
Date patient boarded: 1st: ☐☐/☐☐/☐☐ 2nd: ☐☐/☐☐/☐☐ 3rd: ☐☐/☐☐/☐☐			
Internal Transfers			
Transfer destination:			
Planned transfer date: ☐☐/☐☐/☐☐			
Medical consent ☐			
Arranged with receiving area ☐			
Patient informed ☐			
NOK/Contact informed ☐			
Transport: stretcher ☐			
2 hand seat ☐			
chair ☐			
Escort ☐			
Case notes ☐			
X-rays ☐			
Nursing notes & Drug Form ☐			
Property/Valuables listed ☐			
Catering ☐			
Dietitian ☐			
Physiotherapy ☐			
Occupational Therapist ☐			
Speech and Language Therapist ☐			
Discharge Checklist			
Planned discharge date: ☐☐/☐☐/☐☐			
Medical consent ☐			
Date discussed with patient: ☐☐/☐☐/☐☐			
Date discussed with NOK/Contact: ☐☐/☐☐/☐☐			
Transport: own ☐ ambulance ☐			
Ambulance ordered on: ☐☐/☐☐/☐☐ • type: _____ • order no.: _____			
District nurse ☐/Liaison nurse ☐			
Home help: ☐			
Social work dept. ☐			
Discharge prescription ☐			
Discharge dressings ☐			
Patient information ☐			
Valuables/Cashier ☐			
Physiotherapy ☐			
Speech and Language Therapist ☐			
Out patient appointment ☐☐/☐☐/☐☐			
Other:			

Name: TERESA SINCLAIR Ward: MAU Date: 16/4/2011 Case Record No.:

CARE PLAN EVALUATION		
1. Basic Care and Hygiene	5. Observations	9. Sleep
2. Nutrition	6. Technical Care	10. Special Needs
3. Elimination	7. Wound Care	11. Other Relevant Information
4. Mobility	8. Specimens/Investigations	

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
16/4/2011	1925		Admitted from A+E with Alcohol Excess and ? Over dose. Police escort as arrested from Drunk + Disorderly. Not under arrest. Patient unaware of name of tablets and unaware of amount of alcohol Orientated to ward, police in attendance	
16/4/2011	2100		R/V By medical staff Safe to Discharge NO on going suicidal ideals Paracetomol level undetectable	
			Discharged home Venflon Removed and taken Home by police.	

00630

EVALUATION OF CARE

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE

NHS
Greater Glasgow and Clyde

NATVNS
SCOTLAND

23004807E
SINCLAIR F
TERESA 13/08/1963
90A MAIN STREET
LENNOXTOWN
GLASGOW G66 7DA
CHI-1308636407

ADAPTED WATERLOW PRESSURE AREA RISK ASSESSMENT CHART

More than one score/category can be used: **10+= 'At Risk': 15+= 'High Risk': 20+= 'Very High Risk'**

Complete assessment on admission/1st visit, if there is a change in individuals condition and repeat regularly according to local protocol

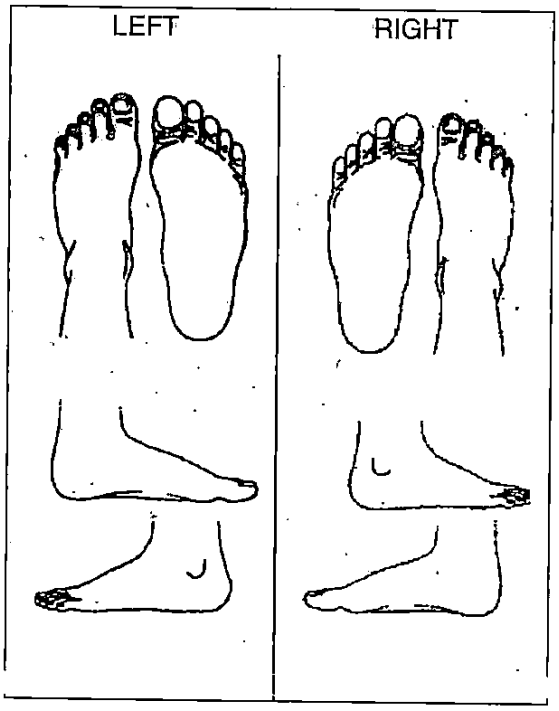
Sex										
Male	1									
Female	2	2								
Age										
14 -49	1	1								
50 -64	2									
65 - 74	3									
75 - 80	4									
81+	5									
Build/Weight for Height (BMI=weight in Kg/height in m²)										
Average - BMI 20-24.9	0	0								
Above average - BMI 25-29.9	1									
Obese - BMI > 30	2									
Below average - BMI < 20	3									
Continence										
Complete/catheterised	0	0								
Incontinent urine	1									
Incontinent faeces	2									
Doubly incontinent (urine & faeces)	3									
Skin Type - Visual Risks Area										
Healthy	0									
Tissue paper (thin/fragile)	1									
Dry (appears flaky)	1	1								
Oedematous (puffy)	1									
Clammy (moist to touch)/pyrexia	1									
Discoloured (bruising/mottled)	2									
Broken (established ulcer)	3									
Mobility										
Fully mobile	0	0								
Restless/fidgety	1									
Apathetic (sedated/depressed/reluctant to move)	2									
Restricted (restricted by sever pain or disease)	3									
Bedbound (unconscious/unable to change position/traction)	4									
Chairbound (unable to leave chair without assistance)	5									
Nutritional Element										
Unplanned weight loss in past 3-6 months										
<5% Score **0**, 5-10% Score **1**, >10% Score **2**	0-2									
BMI > 20 Score **0**, BMI 18.5-20 Score **1**, BMI < 18.5 Score **2**	0-2									
Patient acutely ill or no nutritional intake > 5 days	2									
Special Risks - Tissue Malnutrition										
Multiple organ failure/terminal cachexia	8									
Single organ failure e.g. cardiac, renal, respiratory	5									
Peripheral vascular disease	5									
Anaemia = Hb < 8	2									
Smoking	1	1								
Special Risks - Neurological Deficit										
Diabetes/MS/CVA/motor/sensory/paraplegia *Max 6*	4-6									
Special Risks - Surgery/Trauma										
On table > 6 hours	8									
Orthopaedic/below waist/spinal (up to 48 hours post op)	5									
On table > 2 hours (up to 48 hours post op)	5									
Special Risks - Medication										
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*	4									
Total Score										
Date										
Initials										
Time										

83826

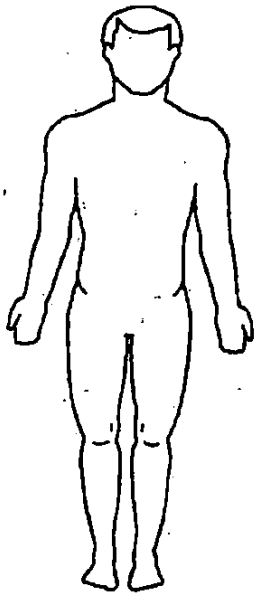
Ensure plan of care is implemented / reviewed for all identified areas of concern.

PRESSURE ULCER RECORD

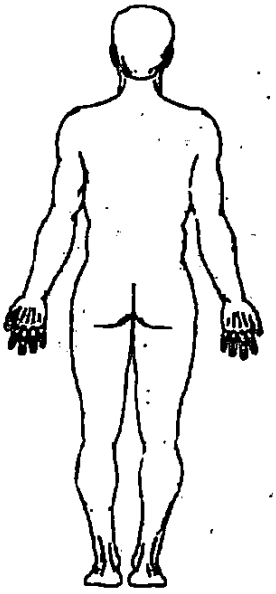
Indicate by circling and numbering all pressure damage on diagrams, then complete box below. Indicate care plan/wound assessment chart.



Anterior view



Posterior view



SCOTTISH ADAPTED EPUAP PRESSURE ULCER GRADING TOOL

GRADE 1 Non-blanchable erythema of intact skin. Discolouration of the skin. warmth. oedema, induration or hardness may also be used as indicators. particularly on individuals with darker skin.

GRADE 2 Partial thickness skin loss involving epidermis, dermis or both. The ulcer is superficial and presents clinicallv as an abrasion or blister.

GRADE 3 Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia.

GRADE 4 Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss.

DATE	NUMBER OF ULCER(S)	LOCATION OF ULCER(S)	GRADE OF ULCER(S)	LOCATION OF ULCER(S)

Pressure Ulcers may deteriorate from Grade 1 to Grade 4, but can not be reversed and should be documented as a healing grade of pressure ulcer, eg healing grade 4.